::step2CK Aug24

Renal system

1. Young male child, Cv suggestive of VHL syndrome—what to screen for? – retinal hemangioblastoma
2. 12-13 yrs male patient with flank pain and hematuria, CT IVA done showing stone in renal pelvis. How to prevent? Increase fluid intake >2 l/day
3. Patient taking cephalosporin group drug, present with `wbc cast—to dx AIN
4. CV of orthostatic proteinuria in children--- reassurance
5. Spinal stenosis dx in cv—laminectomy done—on postoperative period, patient develop incontinence , neurological examination was normal, anal sphincter tone is normal, PVRV= 20 ml (which is normal), cause for this symptoms asked I guess. Option I forgot
6. Case of HTN, prescribed linsopril, rise of serum creatinine on follow up- dx RAS
7. Normal adolescent person goes for hiking. He used to have sedentary life style, now comes with severe pain in thigh. Serum CK level increased in > 1000. What to do next? Advise to continue exercise
8. Sudden respiratory distress in child, chest xray normal, NBS- bronchoscopy

Respiratory system

1. Updown arrow in khyposis
2. Cv of laryngomalacia in infant- reassure
3. CV of recurrent laryngeal papillomatosis with HPV6 postive in mother- MX: resection
4. Adolescent male with neck swelling with signs of inflammation, undergone supportive management, later developed chest pain and SOB, CT chest done showed pneumomediastinum with fluid collection. After starting antibiotics, NBS- debridement
5. Lung abscess to diagnose, xray shows airfluid level
6. Asbestosis to be diagnose, x- ray given
7. History suggestive of silicosis—what to look for? Pleura, carcinoma
8. Obese female, liposuction done--- develop respiratory distress, petechie---- fat embolism
9. MVA—respiratory distress suggestive of tension pneumothorax—NBS: tube thoracostomy
10. CV of tension pneumothorax, what will be the physiological change… dec right ventricle venous return
11. History of recurrent pneumonia, HRCT showing bronchiectasis, sweat chloride test is normal, no history of chronic diarrhea, nasal polyp… mx- IVIG thinking of CVID , no antibiotics in option I guess (primary ciliary dyskinesia can be ruled out from cv)
12. Female presented with leg pain, sudden onset tachypneia suggestive of PE, CT angiogram done, reports awaited.. nbs: LMWH (all form of anticoagulant given)

Cardiovascular system

1. HTN related question—I forgot

2. Subacute onset of fever, abdominal pain, abdominal distension with firm mass palpable over left lower quadrant of abdomen… what to look for? Splenic abscess
3. Cv of cholesterol emboli
4. ASCVD risk below 7 , LDL high but not above 190, no history of DM, what next--- exercise
5. Ecg of inferior wall MI, Pericarditis
6. Heart sound: AS, VSD, PDA
7. Male patient with respiratory distress, hemodynamically unstable, normal JVP mention, lung auscultation normal, however, cath lab values were given showing increased with equal diastolic pressure in RA, RV--- next best step: pericardiocentesis
8. Patient is in shock, no history to think for adrenal insufficiency , fluid bolus given, dopa/ dobuta stated @ 10mcg/kg/min, still BP in lower side… NBS: increase dose
9. Some surgical procedure going on in OT, blood transfusion done--- suddenly develop respiratory distress… BP normal (r/o TACO), ABG not given, NBS? …
10. Cv describing orthostatic hypotension: ACE inhibitors

Endocrine:

1. Operated for pituitary adenoma, presented with polyuria, sp. Gravity of urine is decrease--- DI to diagnosed
2. Multiple question on hypothyroidism and hyperthyroidism
3. CV of conns disease showing unilateral increased Aldosterone/ renin in adrenal venous sampling: adenoma
4. DKA CV: nbs: NS
5. 42 yr male, everything normal, what to screen for? FBS
6. Carcinoid tumor origin, diagnosed in biopsy: small intestine
7. Cv of hypoglycemia with slightly raised c-peptide: insulinoma
8. Patient in shock, managed with fluid.. NBS: add adrenaline
9. CCf with EF < 40%, HBA1C 8.1%, NBS: add STLG1

Immunology:

1. Recurrent staph aureus infection: oxidative brust
2. CVID to diagnose
3. BT done, feature of volume overload with increased BP: TACO
4. Ceftriaxone given, developed rash, fever, arthralgia--- serum like sickness
5. Pregnancy: Tdap to be given
6. 17 yrs old male: meningococcal vaccine

Neurology:

1. Developmental milestone related 2 question—easy one
2. CSF picture suggestive of TB to diagnose
3. Constitutional macrocephaly: reassure
4. Restless leg syndrome, what to look further: serum ferritin

5. Essential tremor: primidone
6. Case of non exertional heat exhaustation, Temp around 104F, MX: supportive
7. ALS to diagnose
8. Bell's palsy , MX: supportive
9. PCKD CV given, future risk: SAH
10. Female around 32-34 yrs with feature of normal pressure hydrocephalus, NBS: MRI brain
11. REM sleep disorder with parkinsonian feature, NBS: MRI brain, polysomnography
12. CT scan showing orbital fracture (medial side): problem??
13. CV of meniere's disease
14. CMV retinitis fundoscopy picture

Others

1. Question about pt with bloody diarrhoea describing right lower quadrant pain and on colonoscopy you see cobblestone appearance in ascending colon as well as terminal ileum. Asking for dx – chrons disease
2. In second question asking for treatment- steroids
3. 3- old pt with abdominal pain, last stool was 5 days ago, picture of sigmoid volvulus given, NBS- proctosigmoidoscopy
4. Old pt with some abdominal pain, hemodynamically stable, no fever or leukocytosis, some vague abdominal xray is given, looks like small bowel obstruction NBS- NG tube
5. 5. Some middle aged pt with history of hernia repair 10 year ago now have mass in right lower quadrant, xray given looks normal to me, asking for dx
6. Pt with 32 weeks of pregnancy comes to you with cervix dilated and effaced, intact membrane -preterm labor
7. Pt with some terminal disease and doctor discussed all the treatment option but pt dont want any treatment asking for the principle- autonomy
8. pt with some disease and doctor refuse some procedure which will harm the patient asking the principal- nonmaleficence
9. Biostats forest blot shown and asking for relative risk question
10. HIV pt with CD4 count 150, against which orangism you will give prophylaxis- P.jerovci
11. Pt went on hiking develop itchy rash on his neck that spread into chest and trunk, picture of neck rash given, also pt completed 10 day course of TMP-SMX for UTI, asking for dx- Sunburn or allergic reaction
12. Pt with gynaecomastia and small testis asking NBS- all option were hormones
13. Pt with some disease hospitalized and started on antibiotics now have diarrhoea asking the cause - C diff infection
14. Picture of tenia capitis asking for TX- oral fluconazole
15. Pt with some cat bite NBS- give antibiotics
16. Child with vesicles on soft palate and throat NBS- Reassure
17. GVHD biopsy

18. Pt with lymphoma undergoing chemotherapy what will you find in labs - increase phosphorus
19. Couple come for pregranancy counselling, both of them were more than 35y year old, what disorder will you counsel them - chromosomal trisomy
20. pt with migraine with aura and history of heavy menstrual bleeding for contraceptive what will you give - levonogestral IUD
21. Pregnant Pt with history of MDD discontinue SSRI NBS- Start SSRI again safe during pregnancy
22. 16y old with personality changes, irritability, picture of eye given asking for tx- penicillamine
23. Pt with mass in abdomen and question stem describing hemihypertrophy of calves asking for dx- nephroblastoma
24. Child with systemic system like fever malaise and a bone mass asking for dx- Ewing sarcoma, because ewing sarcoma
25. Child with bone mass asking for dx- osteosarcoma.

[redacted]

1. c. difficle- vancomycin

2. Tinea capitus

Tinea capitis is a fungal infection of the scalp that causes pruritic patchy, fine, white scales that may resemble SD. However, it does not involve the eyebrows or nasolabial folds and is uncommon in the first year.

	Tinea capitis
Epidemiology	• Most common in African American children • Transmission via direct contact or from fomite (eg, shared combs)
Clinical features	• Scaly, erythematous patch with hair loss on scalp

Dermatology Page 75 https://t.me/USMLEWorldStep2CK

Clinical features	• Scaly, erythematous patch with hair loss on scalp • ± Black dots in affected area • ± **Tender lymphadenopathy**
Management	• **Oral** griseofulvin or terbinafine

TC is often diagnosed clinically but can be confirmed with potassium hydroxide (KOH) examination of hair stubs. Oral griseofulvin or terbinafine is preferred in most patients. As dermatophyte carriers can be asymptomatic, many experts recommend that household contacts be treated with selenium sulfide or ketoconazole shampoo.

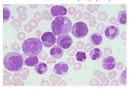
3. CML imatinib

- CML
  - Translocation? t(9,22)
  - Dx? FISH

DI Podcast Main Document 144

- CBC findings? Basophilia
- Presentation? **45 yo M with fatigue + weight loss + splenomegaly**
  - Think of "ML" = CML for "mid-life" -- presents in middle-aged pts :)
- Tx? Imatinib (tyrosine kinase inhibitor)
- Differentiating b/w CML vs leukemoid reaction
  - LAP high → is leukmoid rxn
  - LAP low → CML

28) **Diagnose CML(granulocytosis too much WBC) and histology is given - BCR-ABL /** t(9,22)



4. Anchoring and availability bias

5. Root cause analysis

6. Hemothorax- thoracotomy

Penetrating trauma accompanied by shock (eg, severe hypotension) is attributed to hemorrhage until proven otherwise.
Although **tube thoracostomy** is often sufficient to manage hemothorax, some patients (up to 15%) require **emergent thoracotomy** for extreme bleeding, including those with:

- **Initial bloody output >1,500 mL** (>20 mL/kg)
- Persistent hemorrhage: >200 mL/hr for >2 hours, or continuous need for blood transfusion to maintain hemodynamic stability

7. Splenectomy done- which vaccine to give pneumococcal and h influenza both were in option

8. Another splenectomy case- meningococcal vaccine

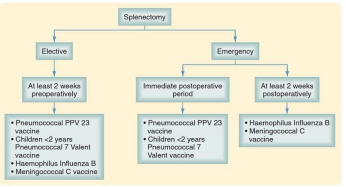


FIGURE 57-7 Splenectomy immunoprophylaxis flow chart. (From Harji DP, Jaunoo SS, Mistry P, Nesargikar PN: Immunoprophylaxis in asplenic patients. Int J Surg 7:421–425, 2009.)

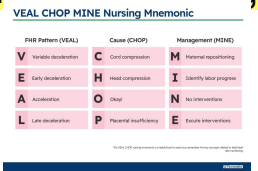
9. Asthma treatment

10. Interstitial cystitis question treatment

Avoid caffeine..

Apnea of prematurity caffeine dini

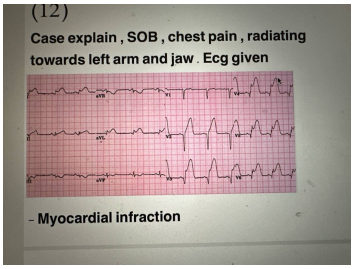
11. Ctg given - looked normal nbs in management



Head compression - early deceleration
Variable decerelation - cord compression
Late deceleration - uteroplacenta insufficiency

Paila tauko niskinxa, ani cord ani placenta , early ,variable and late

12. Ecg on MI and Wpw



13. Up and down arrows on copd and xyphosis fvc recoil elasticity and something more

Dlco- dec

14. Had to diagnose crohns and then treatment asked (sequential question)

15. Case of pertusis treatment azithro as t/t and prophylaxis

Pertussis postexposure prophylaxis	
Indications (regardless of vaccination history)	• Close contact (eg, household members, direct contact with secretions) with symptomatic patient • High-risk patients, even with limited exposure (eg, pregnant, infant, immunodeficient)
Treatment	• Age <1 month: azithromycin • Age ≥1 month: azithromycin, clarithromycin, or erythromycin

16. Ewing sarcoma

Ewing sarcoma	
Epidemiology	• Second most common pediatric bone malignancy (after osteosarcoma) • Peak incidence age 10-15
Clinical features	• Chronic, localized pain & swelling ± soft tissue mass • Involves long bone diaphyses, pelvis, axial skeleton • ± Systemic findings (fever, leukocytosis, ↑ inflammatory markers) • Early metastases common (eg, lung, bone)
Evaluation	• X-ray: central lytic lesion with moth-eaten appearance, lamellated periosteal reaction ("onion skinning") • Biopsy: small, uniform, round blue cells

Abdominal ultrasound every 3 months until 8 years of age
Alpha-fetoprotein levels every 3 months until 4 years of age

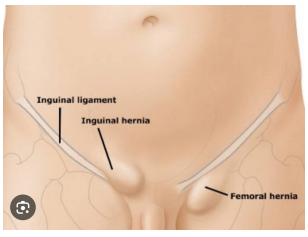
17. Rash in diaper region- did not look like Candida to me more like irritant contact dermatitis treatment asked

18. Asbestosis question what is the patient more likely at risk for it's been 10-20 years since he was exposed pleural plaques or intraparenchymal tumour

19. Lichen sclerosis is child, she had stair ia and the examination findings were describing i

adolescents ma sidhai clobetasol, adults ma suruma biopsy then clobetasol

20. Femoral hernia



21. Empyema nbs

Empyema like features = low ph , low glucose , inc LDH , ALSO SEEN IN Rheumatic pleurisy

22. OCD treatment

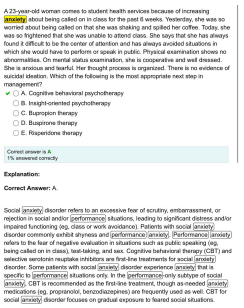
SIGECAP

23. MDD to diagnose

24. Social anxiety vs phobia

Social anxiety disorder (social phobia)	
Diagnosis	• Marked anxiety about ≥1 social situations for ≥6 months • Fear of scrutiny by others, humiliation, embarrassment • Social situations avoided or endured with intense distress • Marked impairment (social, academic, occupational) • Subtype specifier: performance only
Treatment	• SSRI/SNRI • Cognitive-behavioral therapy • Beta blocker or benzodiazepine for performance-only subtype

SNRI = serotonin-norepinephrine reuptake inhibitor; **SSRI** = selective serotonin reuptake inhibitor.


A 23-year-old woman comes to student health services because of increasing anxiety about being called on in class for the past 6 weeks. Yesterday, she was so worried about being called on that she was shaking and spilled her coffee. Today, she was so frightened that she was unable to attend class. She says that she has always found it difficult to be the center of attention and has always avoided situations in which she would have to perform or speak in public. Physical examination shows no abnormalities. On mental status examination, she is cooperative and well dressed. She is anxious and tearful. Her thought process is organized. There is no evidence of suicidal ideation. Which of the following is the most appropriate next step in management?

✔ A. Cognitive-behavioral psychotherapy
B. Insight-oriented psychotherapy
C. Bupropion therapy
D. Buspirone therapy
E. Risperidone therapy

Correct answer is A
1% answered correctly

Explanation:

Correct Answer: A.

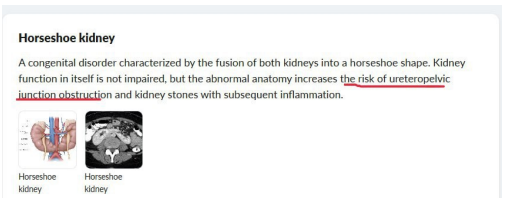
Social anxiety disorder refers to an excessive fear of scrutiny, embarrassment, or rejection in social and/or performance situations, leading to significant distress and/or impaired functioning (eg, class or work avoidance). Patients with social anxiety disorder commonly exhibit shyness and performance anxiety. Performance anxiety refers to the fear of negative evaluation in situations such as public speaking (eg, being called on in class), test-taking, and sex. Cognitive behavioral therapy (CBT) and selective serotonin reuptake inhibitors are first-line treatments for social anxiety disorder. Some patients with social anxiety disorder experience anxiety that is specific to performance situations only. In the performance-only subtype of social anxiety, CBT is recommended as the first-line treatment, though as-needed anxiety medications (eg, propranolol, benzodiazepines) are frequently used as well. CBT for social anxiety disorder focuses on gradual exposure to feared social situations.

25. Pericarditis case

26. AS heart sound I think tried to pick it from the scenario

27. Pic of horse shoe kidney- ureropelvic junction obstruction

- **Horseshoe kidney**: Fusion of the left and right inferior renal poles
  - Normal ascent interrupted as fused kidney gets caught on the inferior mesenteric artery (IMA).
  - Increased incidence in patients with chromosomal aneuploidy (e.g., trisomies 13, 18, 21, and Turner syndrome)
  - Usually asymptomatic; typically diagnosed incidentally on abdominal imaging for unrelated conditions
  - Rarely requires treatment
  - Increased risk of renal stones, ureteropelvic junction obstruction, hydronephrosis, infections, and renal cancer


Horseshoe kidney

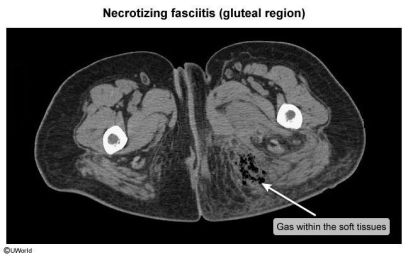
A congenital disorder characterized by the fusion of both kidneys into a horseshoe shape. Kidney function in itself is not impaired, but the abnormal anatomy increases the risk of ureteropelvic junction obstruction and kidney stones with subsequent inflammation.

Horseshoe kidney

Horseshoe kidney

28. A lot of MVA questions

29. Pic of leg with Bullae and happened after he injured himself with a nail or something c perfringens



Necrotizing fasciitis

Daptomycin/Linezolid/Vancomycin
+
Carbapenem/Tazo-pip/FQ-Metron/Xone-Metron
+
Clindamycin (if linezolid not taken on 1)

Cellulitis—-

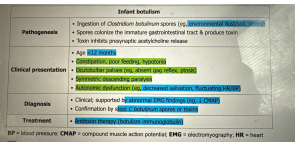
Mild - Cephalexin
Penicillin VK
Dicloxacillin
If Penicillin allergic: Clindamycin

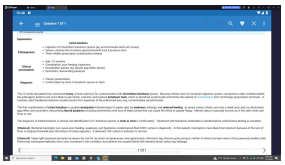
Mod - Cefazolin
Ceftriaxone
Narcillin/Oxacillin If Penicillin allergic: Clindamycin

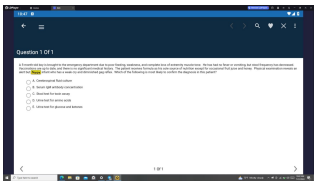
Severe - Vancomycin +/- Piperacillin/Tazobactam
Meropenem/Imipenem
Linezolid

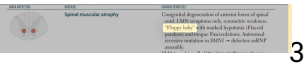
Vanco+ meropenem thyo last pool ma

30. Got a question about floppy baby and decrease tone was confused between spinal muscular atrophy and muscular dystrophy







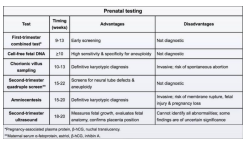


31. Female comes for prenatal counselling, on carbamazepine nbs increase dose of folic acid

Neural tube defects	
Types	• Anencephaly • Encephalocele • Spina bifida, myelomeningocele
Risk factors	• Low folic acid intake • Methotrexate, antiepileptics • Diabetes mellitus • Prior pregnancy with neural tube defe
Prenatal screening	• 2nd-trimester ultrasound • Maternal serum alpha-fetoprotein
Prevention	• Average risk: 0.4 mg folic acid daily • High risk: 4 mg folic acid daily

32. She has increased dose nbs usg, karyotype or chronic villous sampling

Aba usg garni



33. S1Q3T3 on ecg nbs

34. Blood on urethral meatus nbs retrograde urethrography

35. Intention tremor propanolol and primidone both were in option

Incase of Copd and asthma - premidone
Natra propanolol

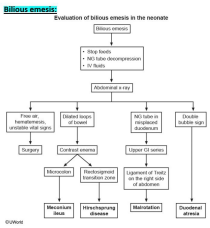
36. Femoral neck fracture repaired has buttock pain limited range of motion due to pain osteonecrosis or osteoarthritis

37. Chagas' disease no symptoms nbs

Trypanosoma cruze - Megalo organs
Large kinetoplast ,ecg or echo

Trypanosoma bruze - African sleeping sickness
Small kinetoplast

Chagas disease	
Epidemiology	• Caused by protozoan ***Trypanosoma cruzi*** • Most common in Mexico, Central & South America
Cardiac manifestations	• Biventricular heart failure (right > left) with cardiomegaly • **Ventricular apical aneurysm** • Mural thrombosis with **embolic complications** • Fibrosis leading to **conduction abnormalities** (heart block & ventricular tachycardia)
Gastrointestinal manifestations	• Progressive dilation of esophagus & colon



i think in NBME 11 mid gud volvulus huncha CV but Xray pani gareko hunna , i chose Abd xray first but ans was UGI series...

Funda , NBS — XRay abdomen , tya chai diagnostic sodheko raicha so altho X ray comes before UGI series , diagnosis lai UGI series jane raicha

38. X-ray what looked like malrotation I marked upper GI series

Pyloric stenosis - USG
Intususeption - USG
Necrotising Enterocolitis - X ray
Meckels - 99Tc
Hirschprung - Contrast enema (Diagnostic - Biopsy)
Diverticulitis - CT Abd
Malrotation - GI series
Volvulus (adult) - C

39. A couple of questions on thyroid nodules and nbs

40. Kaposi sarcoma

41. Aspiration pneumonia treatment

Aspiration pneumonia

Rx

Out patient: Amoxicillin+ Clavulinic acid (Clavam)

In patient: Ampicillin+ Sulbactum (PQ)

ICU: Piperacillin+ Tazobactum (Durataz)

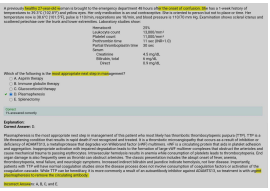
Bacterial aspiration pneumonia	
Pathophysiology	• Oropharyngeal/gastric microbes aspirated into lungs → host defenses overwhelmed due to large inoculum size
Major risk factors	• Reduced consciousness (eg, anesthesia) • Dysphagia (eg, neuromuscular disorder) • Impaired glottic closure (eg, intubation) • Protracted vomiting • Poor dental hygiene
Clinical features	• Fever & cough ± foul-smelling sputum • Infiltrate in dependent portions of lung • Aerobic + anaerobic pathogens on sputum studies
Management	• No empyema or lung abscess: treat for community-acquired pneumonia • Empyema or lung abscess present: extend coverage to include anaerobes (eg, ampicillin-sulbactam)

aspiration -ampi sulbactam, clinda amoxi clav

.

ASpiration- Ampi/ Sulbactam.. ma yesari yaad garchu

42. Case on ttp nbs plasmapheresis



Thrombotic thrombocytopenic purpura	
Pathophysiology	• ↓ ADAMTS13 level → uncleaved vWF multimers → platelet trapping & activation • Acquired (autoantibody) or hereditary
Clinical features	• Hemolytic anemia (↑ LDH, ↓ haptoglobin) with schistocytes • Thrombocytopenia (↑ bleeding time, normal PT/PTT) Sometimes with: • Renal failure • Neurologic manifestations • Fever
Management	• Plasma exchange • Glucocorticoids • Rituximab

LDH = lactate dehydrogenase; vWF = von Willebrand factor.

plasma pheresis …gluco… rituximab

43. Pic of Wilson disease nbs I think the option that made sense in my question of urinary copper

Wilson disease	
Pathogenesis	• Autosomal recessive mutation of ATP7B → hepatic copper accumulation → leak from damaged hepatocytes → deposits in tissues (eg, basal ganglia, cornea)
Clinical findings	• Hepatic (acute liver failure, chronic hepatitis, cirrhosis) • Neurologic (parkinsonism, gait disturbance, dysarthria) • Psychiatric (depression, personality changes, psychosis)
Diagnosis	• ↓ Ceruloplasmin & ↑ urinary copper excretion • Kayser-Fleischer rings on slit-lamp examination • ↑ Copper content on liver biopsy
Treatment	• Chelators (eg, D-penicillamine, trientine) • Zinc (interferes with copper absorption)

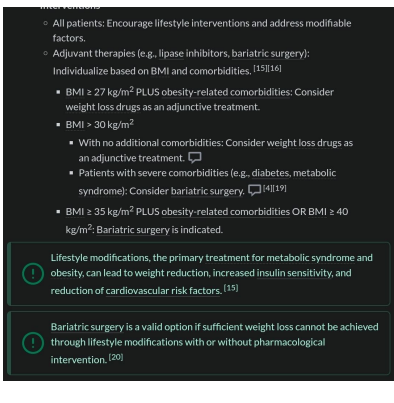
cerulo dec , urinary copper badne

44. Digeorge syndrome asking what will be less hypocalcemia

Di George
If catch22 and hypoCa already mentioned in vignette then go with - HypoMg

45. Pic of a lesion on hand I guess with histology pic I marked kaposi because I could rule out cmv and ebv I may be wrong

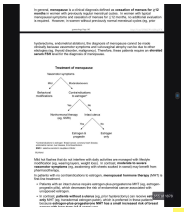
46. Very obese female wants to get pregnant nbs weight loss



- All patients: Encourage lifestyle interventions and address modifiable factors.
- Adjuvant therapies (e.g., lipase inhibitors, bariatric surgery): Individualize based on BMI and comorbidities. [15][16]
  - BMI ≥ 27 kg/m^2 PLUS obesity-related comorbidities: Consider weight loss drugs as an adjunctive treatment.
  - BMI > 30 kg/m^2
    - With no additional comorbidities: Consider weight loss drugs as an adjunctive treatment.
    - Patients with severe comorbidities (e.g., diabetes, metabolic syndrome): Consider bariatric surgery. [4][19]
  - BMI ≥ 35 kg/m^2 PLUS obesity-related comorbidities OR BMI ≥ 40 kg/m^2: Bariatric surgery is indicated.

Lifestyle modifications, the primary treatment for metabolic syndrome and obesity, can lead to weight reduction, increased insulin sensitivity, and reduction of cardiovascular risk factors. [15]

Bariatric surgery is a valid option if sufficient weight loss cannot be achieved through lifestyle modifications with or without pharmacological intervention. [20]



47. Menopause symptoms nbs she crossed her age of menopause so I marked do nothing

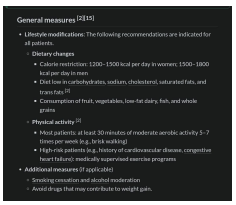
45 cut off

Menopause 40 bhnda kam POF 50 tra vasomotor symptoms HRT

regular chha ki iregular cycle chha ma depend huncha haina ?

Diagnosis hola menopause ko,if regular periods thiyo bhney no investigation,irregular bhaye fsh ?

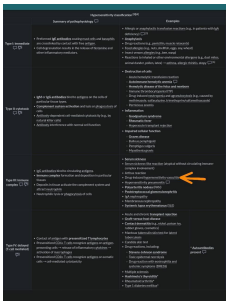
48. Person wants to loose weight, what type of diet reduced calorie diet, low fat, low protein , diet with no sweets or desserts



49. Case on adhd weird options like eeg, lead levels none made sense tbh

50. X-ray what looked like detrocardia I marked immotile sperm

kartageners

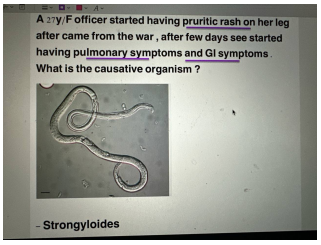


51. Post steptococcal glomerulonephritis- type of hypersensitivity

Type 3 . Good pasture 2

psgn , t-3 HSR , dec complement
IgA nephropathy — no dec in complement

52. Stronglyoides with pulmonary symptoms



53. Angular chelosis

Vitamnion b 2

Riboflavin and pyridoxine

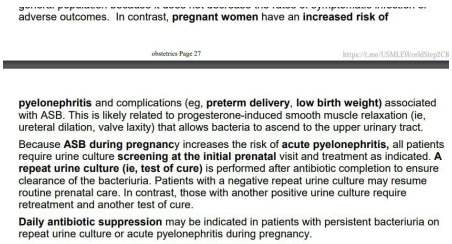
54. Initial management of transposition of great arteries

“Endomethacin” ends the PDA.
Prostaglandins E1 and E2 kEEp PDA open.

55. Complication of asymptomatic bacteruria in pregnancy

Bacteruria ko Pyelo hunxa pyelo ko preterm

Pyelonephritis risk


adverse outcomes. In contrast, **pregnant women** have an **increased risk of**

pyelonephritis and complications (eg, **preterm delivery**, **low birth weight)** associated with ASB. This is likely related to progesterone-induced smooth muscle relaxation (ie, ureteral dilation, valve laxity) that allows bacteria to ascend to the upper urinary tract.

Because **ASB during pregnancy** increases the risk of **acute pyelonephritis,** all patients require urine culture **screening at the initial prenatal** visit and treatment as indicated. **A repeat urine culture (ie, test of cure)** is performed after antibiotic completion to ensure clearance of the bacteriuria. Patients with a negative repeat urine culture may resume routine prenatal care. In contrast, those with another positive urine culture require retreatment and another test of cure.

Daily antibiotic suppression may be indicated in patients with persistent bacteriuria on repeat urine culture or acute pyelonephritis during pregnancy.

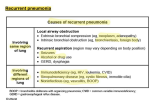
56. Megaloblastic anemia cbc finding

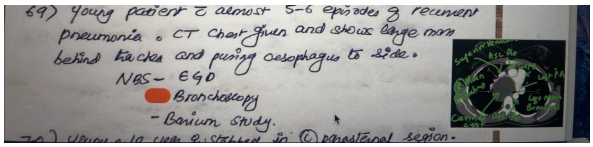
57. Couple of ethics question

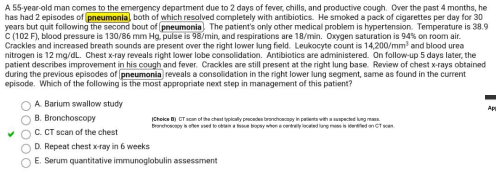
58. Couple of cps/eps

59. Biostats questions- did not get any calculations

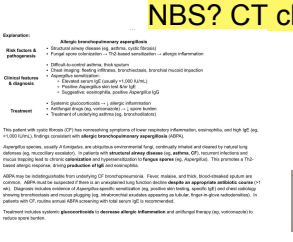
60. New abstracts don’t remember

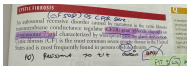


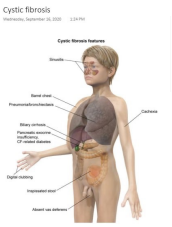


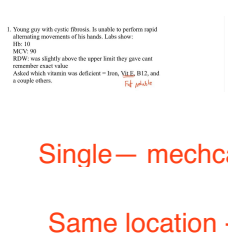


1. CV of cystic fibrosis explained. Persistent pneumonia explained. (Not recurrent pneumonia). NBS? CT chest , bronchoscopy









Recurrent pneumonia is defined as having two or more episodes of pneumonia in a year, or three or more episodes in a lifetime. The episodes must be separated by a month of being asymptomatic or by clear chest X-rays.

Single— mechcanical obstruction— suspect malignancy

Same location - mass, different location - immunocompromised

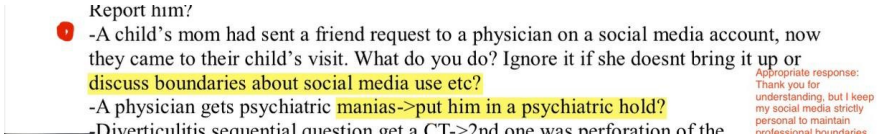
2. Female Dr goes to examine male patient. He says wow what a wonderful Dr. What is best response by Dr. Forgot option but had concept like this question

Direct approach garnu hudaina wala answer auxa …

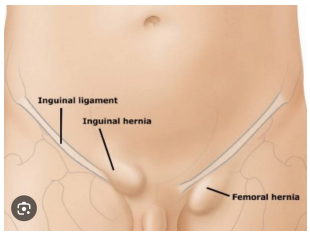
76-year-old man with chronic obstructive pulmonary disease is admitted overnight to the hospital due to worsening shortness of breath over the past 3 days. The following morning, a resident physician on the primary team introduces herself and asks the patient how he has been feeling. The patient whistles in response and says, "Wow, a doctor who's beautiful and smart. I'm the luckiest patient in the world." The resident feels uncomfortable but smiles and asks him again how he is feeling today. The patient shares how he has been and the symptoms he is experiencing. During the physical examination, as the resident leans over the bed to auscultate the lungs, the patient reaches up and hugs her. He says, "I just had to give you a hug. I couldn't stop myself." The resident finishes the examination and leaves the room. She immediately reports the incident to her supervising physician. Which of the following is the most appropriate next step for the supervising physician to take?

A. Advise the resident to tell the patient that his behaviors are unacceptable and ask if she feels comfortable continuing to care for him.
B. Discuss with the resident that inappropriate patient behaviors can occur but should not interfere with providing unbiased patient care.
C. Document the patient's behavior in the chart and assure the resident that a chaperone will accompany her for future evaluations.
D. Share that the resident should have left the patient's room when she first felt uncomfortable instead of staying to complete the evaluation.
E. Tell the resident that the patient will be informed of the hospital code of conduct and switched to another physician's care.
Correct answer is E

3. A female kiddo being treated by a physician. The kiddo send fren request to Dr on social media. Next day she comes with mother to office. They don't talk about the request on social media. Best response by Dr.... Forgot option
P.s but had it been by the mother, I'd have accepted 😁)



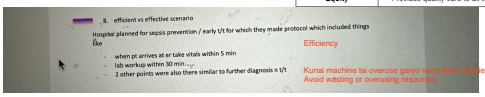
4. Femoral hernia to diagnose



5. Run chart- scenarios given...

6. Effective care

Dimensions of health care quality	
Dimension	**Description**
Safety	• Minimizes preventable errors • Avoids harms from care
Effectiveness	• Adheres to scientific guidelines evidence • Avoids undertreatment & overtreatment
Patient-centeredness	• Identifies patient values, goals & preferences • Tailors care delivery to expressed patient values
Timeliness	• Avoids delays in care, reduces wait times
Efficiency	• Avoids wasting or overusing resources
Equity	• Provides quality care to all individuals regardless of demographic attributes (eg, ethnicity, age, gender)



Effective - not (under treatment and over treatment)
Efficient - use resources that is available in system

Effective vs efficient care
Scenario: Hospital wants to improve patient treatment by taking
-Vitals imidiately, decrease stay in hospital, fast lab result

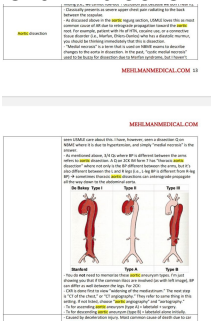
7. Randomisation - for both known and unknown confounder?

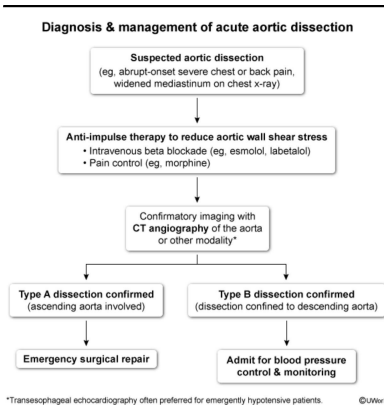
8. Digeorge syndrome explained - option 22q deletion

Di George
If catch22 and hypoCa already mentioned in vignette then go with - HypoMg

9. Aortic dissection. CT descending. Treatment - B blocker

Stanford type A - emergency surgery.
Stanford type B (stable) - B-blocker therapy.
Stanford type B (unstable) - surgery.





b blocker + nitroprusside if pressure control vayana vane

Dissections involving the ascending aorta can cause aortic regurgitation.

10. Indication of endometrial biopsy

Endometrial biopsy indications	
Age ≥45	• Abnormal uterine bleeding • Postmenopausal bleeding
Age <45	Abnormal uterine bleeding PLUS: • Unopposed estrogen (obesity, anovulation) • Failed medical management • Lynch syndrome (hereditary nonpolyposis colorectal cancer)
Age ≥35	• Atypical glandular cells on Pap test

11. Husband abuses wife. Wife says the husband doesn't beat the children but they observe it. After safety counseling, NBS? A. Contact CPS B. police c. Do nothing

12. Female has trichomoniasis. Male have no symptoms. Treatment to male? Metronidazole

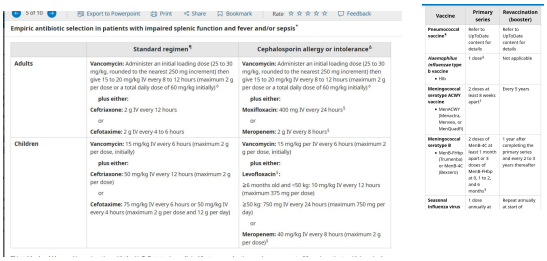
ceftriaxone+doxy in cervicitis

	Recommended vaccines for asplenic adult (age >19) patients
Pneumococcus	• PCV13 first followed by PPSV23 >8 weeks later • Revaccination with PPSV23 5 years later & at age 65
Haemophilus influenzae	• 1 dose Hib vaccine
Meningococcus	• Meningococcal quadrivalent vaccine • **Revaccinate every 5 years**
Influenza	• **Inactivated** influenza vaccine annually
Other vaccines	• HAV • HBV • Tdap (tetanus-diphtheria-acellular pertussis) once as substitute for Td (tetanus-diphtheria toxoid booster), then Td every 10 years

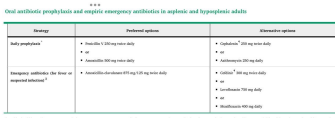
13. RTA. 8 yr child. Spleen injury- splenectomy done. What vaccine to give? Td (no strep pneumonia n Hemophilus in option)

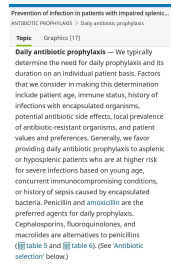
Pcv13 Natra
If h/o spleenectomy of few days and also h/o of abrasion then TT

14. Splenectomy done. What antibiotics to give. I think amoxicillin/penicillin not in option. Study all antibiotics that can be given after splenecy



Post splenectomy
Daily Amoxicillin or penicillin for 5 years BD
And
If infection at home - emergency antibiotics : amoxiclav or cefurooxime or fluoroquionolone .
And
After reaching hospital with infection: IV vanco + ceftriaxone if allergic moxifloxacin

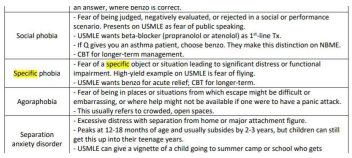




15. Student scared to do presentation in school. She is so scared that she is planning to leave school but she goes out freely with friends. Dx ? Agoraphobia? Social anxiety disorder

Agoraphobia

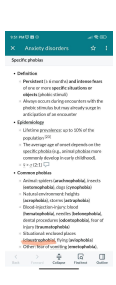
An inordinate fear or anxiety of being in situations that are perceived as difficult to escape from and/or situations in which it migh be difficult to seek help. Symptoms must occur over a period of ≥ 6 months in ≥ 2 of the following situations: 1) when using public transportation, 2) when in open spaces, 3) whe in enclosed places, 4) when in line or a crowd, when outside of the home alone.

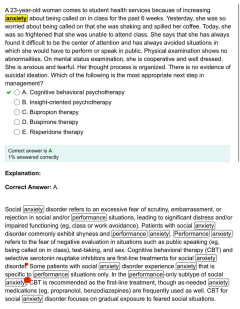


Individuals with **performance-only social anxiety** disorder do not fear **nonperformance social situations** and are not socially avoidant in general.

Social anxiety disorder (social phobia)	
Diagnosis	• Marked anxiety about ≥1 social situations for ≥6 months • Fear of scrutiny by others, humiliation, embarrassment • Social situations avoided or endured with intense distress • Marked impairment (social, academic, occupational) • Subtype specifier: performance only
Treatment	• SSRI/SNRI • Cognitive-behavioral therapy • Beta blocker or benzodiazepine for performance-only subtype

SNRI = serotonin-norepinephrine reuptake inhibitor, SSRI = selective serotonin reuptake inhibitor



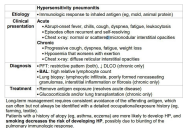


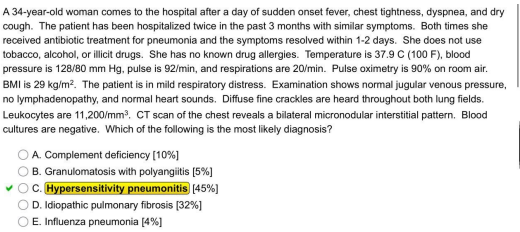
16.aortic aneurysm. Size increase> 0.5 cm in 6 months - sx

17. 1st trimester. Usg anechoic. Doesn't want surgery. Best t/t? Misoprostol, mtx, ergot

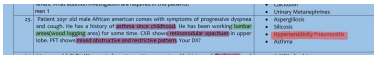
18. Neonate. High tsh, low T4, lowfT4. Dx- primary hypothyroidism

19. CV of hypersensitivity pneumonitis. Asked about investigation





Work place farm gayo Ki pneumonia Ko feature aunxa and rest ma ,house ma huda chai thik hunxa , yestai k thyo question last pool ma

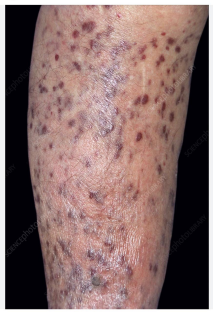


dui tin din aghi chai purai serious feature dini , imaging ma ni nana bhaati bhanne bhare 2-3 din ma sancho

Photos

20. Tineaa capitis- treatment - griseo

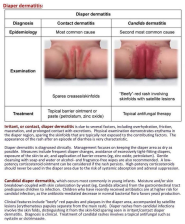
21 Kaposi sarcoma- CV explained n image given to diagnose



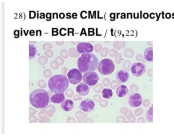
22. Erythema toxicum neonatorum- diagnose

23. Portwine stain- complication asked- seizure

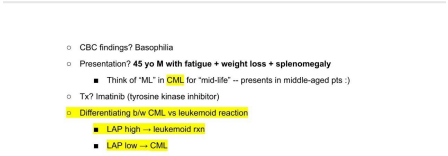
24. Candidal diaper dermatitis



25. PBS and CV explained - asked to diagnose cml



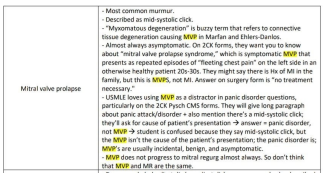
Myelocyte>metamyelocyte

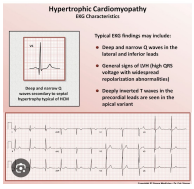


CML vignette ma Basophil + splenomegaly , LAP score LOW , hit word

26. Ecg- normal- anxiety feature explained in CV
Other- probably hocm

Cornel criteria in HOCM
MVP chai panic attack jastai hx hunxa - Mehlman





S wave in V1 + R wave in V 5 or V6 > 35

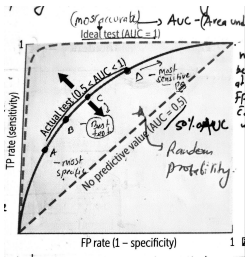
Mitral valve prolapse, albeit a common condition, is associated with ventricular arrhythmias and sudden cardiac death. Electrocardiographic features include ST-segment depression, T wave inversion or biphasic T waves in the inferior leads, QT prolongation and premature ventricular complexes

ECG findings may include [6]:

- Prominent abnormal Q waves, particularly in the inferior (II, III, and aVF) and lateral leads (I, aVL, and V4-V6). These changes reflect septal depolarization of the hypertrophied myopathic tissue. (See "Pathogenesis and diagnosis of Q waves on the electrocardiogram".)
- P wave abnormalities, reflecting left atrial (LA) or biatrial enlargement. The combination of LVH with right atrial enlargement is strongly suggestive of HCM.
- Left axis deviation.
- Deeply inverted T waves (so-called "giant negative T waves") may be seen in the mid-precordial leads (V2 through V4) in patients with the apical variant of HCM. (See "Hypertrophic cardiomyopathy: Morphologic variants and the pathophysiology of left ventricular outflow tract obstruction", section on 'Apical HCM'.)

27. CV of post herpetic neuralgia. NBS for dx. Nothing other option biopsy

28. Roc curve- best of sensitivity



29. Kaplan Meir curve

30. Sjogren- SSA, ana

Anti ssa, anti ro
Anti ssb, anti la

Similar question from nbme/ free 120

A 5-day-old boy is brought to the office for an initial well-child examination. He was born at 40 weeks' gestation and discharged at 60 hours of life. On newborn screening, hemoglobin electrophoresis showed an FS pattern. He is at the 50th percentile for length and weight. Temperature is 37.0°C (98.6°F), pulse is 136/min, and respirations are 34/min. He appears well. Examination shows no abnormalities. Which of the following is the most appropriate next step in management? (A) Deferoxamine therapy (B) Hydroxyurea therapy (C) Iron supplementation (D) Monthly blood transfusions (E) Penicillin prophylaxis (answer). (F) Vitamin B12 (cyanocobalamin) supplementation

A 42-year-old woman comes to the physician because of a lump in her left thigh since she fell on the ice while playing hockey 4 months ago. At that time, she noticed bruising on her left thigh that has resolved, but the lump has increased in size. She has not had fever, night sweats, or weight loss. She has no history of serious illness and takes no medications. Examination shows a 5 × 6-cm, painless, firm, soft tissue mass on the anterolateral aspect of the left thigh. The overlying skin is intact, and there is no discoloration. There is no inguinal lymphadenopathy. Distal pulses are normal, and sensation is intact. Range of motion of the hips and knees is full, and muscle strength is normal. X-rays of the left femur and knee show no abnormalities. An MRI of the left femur shows a deep soft tissue mass with inhomogeneous signal on T1- and T2-weighted images. Which of the following is the most appropriate next step in diagnosis?

A.
CT scan of the thigh

B.
Core-needle biopsy Fibrosarcoma.

C.
Ultrasonography

D.
Wide resection of the mass

E.
Observation and reevaluation in 1 month

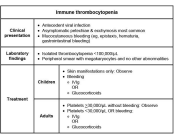
Correct answer is B

Digeorge - fisch of ch 22 Di George
If catch22 and hypoCa already mentioned in vignette then go with - HypoMg

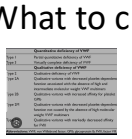
-Pul emb- to diagnose. ECG was also given, pt took 8 hrs flight. Fligh duration implies immobility

-ITP- bacha, mild infection month ago, fever 3-4 days back and rash. Platelet size normal Kei nagarm until symptomatic

Life threatening bleeding if present.. platelets infusion only if needed



-Circumcission k baad bleeding, Platelet count normal. What to check? Thrombin time, factor 8, platelet antibody etc options. Vwf factor 8



relevant q to bleeding manifestation

-Girl, factor 8 mildly decreased- type 1 vwd

sibling , father aru lai pani bleeding manifestation deko huna sakcha , aut dominant

boy with factor 8 deficiency , under regular f-8 transfusion but for past few months , inc bleeding tendency . cause

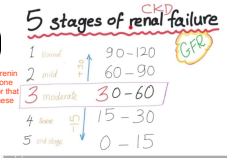
- development of Factor -8 inhibitor

Primary hyperaldo:
Inc aldo
Dec renin

Secondary hyperaldo:
Inc aldo
Inc renin

Non aldo:
Dec aldo
Dec renin

-GFR 40/min, hypokalemia/hyperkalemia (asked arrows about renin, aldo etc)



RAAS nai activation hune ho
Aldosteron badhyo so that HTN vayo
Renin inc Aldosteron inc Na inc K dec

Decreased renal perfusion and glomerular filtration leads to decreased solute delivery to the juxtaglomerular apparatus in the distal tubule, which stimulates renin secretion by juxtaglomerular cells. Activation of the renin-angiotensin-aldosterone system leads to increased production of angiotensin II, a potent vasoconstrictor that preferentially constricts the efferent arteriole to restore glomerular filtration. These hormones do not have a substantial effect on red cell production.

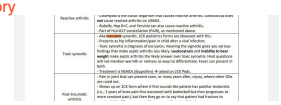
-RAS- investigation asked to diagnose(renal doppler)

-yoga abstract. 1 question was to calculate NNT

	Transient synovitis
Clinical features	• Age 3-8 • Preceding viral illness • Afebrile (or low-grade fever). • Hip pain, limp • Able to bear weight
Diagnosis	• Normal to mildly elevated WBC count, ESR, CRP • Small effusions on ultrasound
Management	• Conservative • Nonsteroidal anti-inflammatory medications
Prognosis	• Full recovery within 1-4 weeks • Recurrence uncommon (<15%)

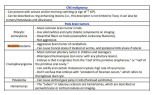
sometimes 8 year old ma perthe's ma jhukaucha, tya long history , 1-2 months , transient synovitis , short history

- Transient synovitis treatment? Nsaids? No reassurance



- Kawasaki treatment. High dose aspirin + echo 2 weeks

- Bacha ataxia, bilateral papilledema— intracranial tumor Medulobastoma



Medulloblastoma can manifest with signs of increased intracranial pressure, including headaches, nausea, vomiting, and papilledema. Furthermore, a hemorrhage from a neoplasm could manifest with the sudden onset of a severe headache and altered mental status. However, since most medulloblastomas arise within the cerebellum, the lack of any cerebellar signs (e.g., gait ataxia, truncal instability, intention tremor, double vision) makes medulloblastoma less likely. Fever and a 3-week history of tooth pain suggest another etiology for this patient's symptoms.

- Hemangioma, mathay pe lump flesh coloured enlarge ho raha. 18 months old.

- Nigerian aurat, delivery karni thi, labia majora cut, grade 4 laceration hui v jo theek kar di, family says pehli wali halat mein kar k do. What principle? Autonomy, nanmalificence

Patient demanding test-doc not doing.... Justice
Elderly psychosis/delirium wanting to discharge--doc stops..... Beneficence
Newborn holoprocenphaly-mother wants doctor to treat- doctor doesn't.... Justice
hence doctor should not provide treatment because NONMALAIFICIENCE
Doctor didn't provide same information to both patient for minimal invasive surgery.... Patient centered care
Guardian ad litem- autonomy

Africa ma female circumcision huncha

Culture respect garera autonomy

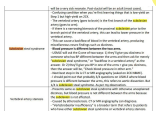
Aba nagarne - non maaa

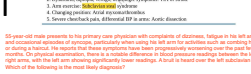
kina silaidiyo - beneficien

kti lai sodhera silayo ---- autonomy

kti ko pariwar/ kti ko against ma gayera silaidiyo — autonomy violate bhayo

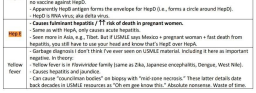
- Sharp ulcers in mouth, sore throat, female, cervical + inguinal lymphadeno. dx? HIV





- Barbar, cutting karti tou baazu mein dard. Dx? SVC?(why not subclavian steal

- Hematopoitic transplant, uske baad diarhea, rash—gvhd



- Pregnant, ast alt 500, Hep E?

- 16yrs girl, 12 yrs pe UC hogya but no flare ever,ab jaundice, ast alt raised, inc. Direct bilirubin—-Primary sclerosing. No PBC in options.

AMA=female,PBC

- Bone tumors, osteochondroma, what to do? Biopsy or reassurance?

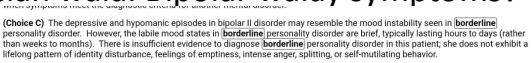
- Seq of Interstitial cystitis a)investigation cystoscopy then diagnosis(interstitial cystitis)

USG garera confirm garne then Catheterization hoina

Small prostate <40ml and serum psa <1.5ng/ml alpha blocker
Large prostate >40ml and serum psa > 1.5ng/ml finasteride

- Seq. GA mein operation, anuria. Inv? Us then b)alpha blocker Intermittent catheterization

- Covid mein excellent work by physician wala. Bipolar walay symptoms? Take to ER?



- Borderline mein sab se ziada risk? A)cyclothymia b) bipolar

- Bhcg 64000, kis cheez ka risk? Hyadatidiform mole? Choriocarcinoma?

Yedi curette garera falisakeko follow up ma ho bhane GTN jam , pet mai chha POC bhane mole jaam k bhannu huncha

Less bhaye partial mole

- 1st time 16weeks gestation, kia approp hai to establish WOG? Fetal height, ya ultrasound?

- Trauma, xray mein dono taraf pneumo. Needle compression

- Still murmur, AS ka , MR ka. PDA vayo still murmur

- Bacha ko continuous murmur, kia dogay? Indomethacin.

PDA khula rakhna —- Alprostadil

PDA banda garna — indomethacin

- Sturge weber rash? Kia develop ho sakta? Epilepsy

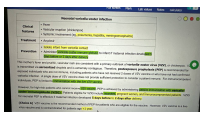
- NF 1 ka rash decribled, kia develop hoga? Perpheral sheath tumor ya Schwannoma?

- Osteo ka sawal. Kia karengay? Vigourous exercise, light exercise, resistance exercise two times a week.

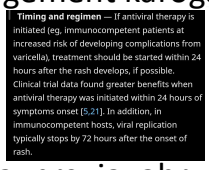
- 65 yrs old, kisi cheez ka player, weight gain ho raha tha, ostearthritis settle nai ho raha tha conservative se, ab kia karogay, 6 weeks more exercise ya topica diclo etc

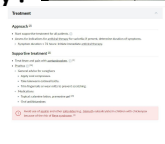
- RA, hath bhi dikhaya hua, beti ka jora seena hai? Kia dogay? Splint ya steroid? Occupational therapy

- Baba marnay wala, beti kehti continue treatment, beta(who is attorney) kehta no? Kia karogay? Go with beta ya family meeting? Family meeting more then son



- Varicella lesions pictures, most approp next step in management karogay? Coughing aur sneezing se bacho ya oral acyclovir.

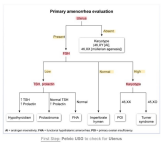


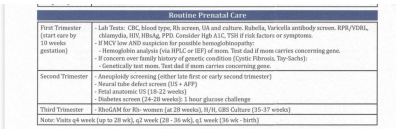


- 46 yr old homosexual, kia karogay? HPV? Hiv hepatitis syphilis garni garnu xa vani

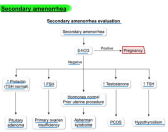
yo sab garisakya hunxa ... nothing ma jane

- DM type 1 and pregnant? Sab se ziada risk kis ka? Accreta, previa, abruption, preecclam?



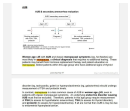


- 32 wog pe kia vaccine? Tdap 27 to 36



- Pregnancy se pehle kia check karogay? Varicella??(confirm urself)

- Aurat ko bachpan se myelomeningo, vegan, pregnant incidental? In addition to prenatal vitamins, kia dogay? Folic acid, vit d, b12?



Primary amenorrhea : First do US
Secondary: bHC

- 48 yrs old, amenorrhea, kia karogay? Bhcg, fsh, do nothing(confirm urself)

- Pt alcohol addicted, ab chhor rahi thi, kal raat ko pee k neend aajaye, kal court meeting pe jaana, kia karogay? Blood alcohol, usg, do nothing? Ast 80 tha, alt 40. (Ratio 2:1 ban rahi)

- Aortic dissec, 90/60. CT angio ya echo

complication ma gayo Rupture
TEE while preparing for OT

- Aik banda, intermittent explosive disorder, bachi ko belt se maara maheena pehle jo 6 saal ki thi but remorsed. Psychotherapy ya cps?

Regret garera kaha sukha pahixa ra …

- Seizures after party, garmi lag rahi, BP high, Temp? Coccaine, lsd, mdma.(confirm urself)

Hyponatramic seizure
mdma
hyperthermia
bruxism
hyponat

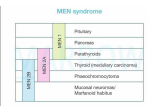
Euta MDMA chai party ma chill hanna khane wala Low sod sodhya xa

- Alzheimmer—-rivastigmine

- Parkinson ki dawai start karatay, symptoms improve but develop psychosis, he says dawai kamm nai karni, kia karogay? Quetiapine.

- smoker, hematuria, histo given(RCC), kia assoc hoga? Hb>20, ya urea nitrogen >80?

- IgG bohat ziada, ca normal. Bone biopsy he did for myeloma.



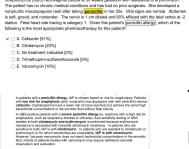
- Banday ko stones, ulcer bhi jo khanay se theek hojata hai? Kia check karogay? Gastrin.

Duodenal ulcer

Men1
3p
Pituitary tumor
Parathyroid adenoma
Pancreatic endocrine tumor

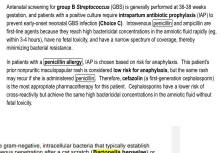
- Urine metaneph increase, ca increased? Kia karogay? Calcitonin.

Men2

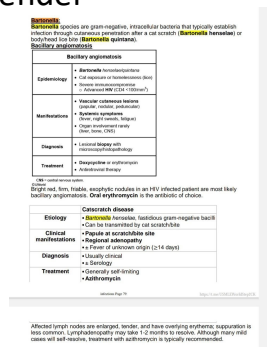


- Patient ko penicillin allergy, kia contraindicated hai? Cephalexin?

CEPHALOSPORIN nadim



- Bartonella k do questions. Aik mein papule and chronic(5-6 weeks) tender unilateral lyohadenopathy. Doosre mein hath mein scratches and again tender lymph

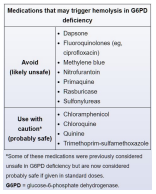


- CGD—- staph aur

- SCID ka best treat. Transplant.

- Sickle cell—- penicillin prophylaxis

- G6pd def scenerio—- all ani malarials mentioned, which ones causes it?(highest risk). Primaquine?(confirm urself) Female sulfa drugs wala autoimmune hemolytic



- Cml scenerio, metamyelocytes etc given, asks about pathophys—- bcr-abl fusion related.

- Bipolar patient, which drug contraindicated? No ssri in the options, went with ~~Lorazepam.(confirms~~ urself) Imipramine

Ma nai hu-- Narcissistic Bhane jastai huna paryo -- OCPD

- Personality disorder—- starts with something related to ADHD(patient says he has read about adhd in adults etc)— then switches to patient describing himself that he has many newspapepers and does everything perfect, wish everyone was like him etc etc… narcissistic personality disorder, histrionic, ocpd??

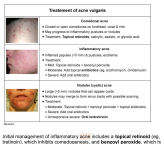
Clonus ko funda

- CJD
-serotonin syndrome
- Tay sach dis

- Pt on escitalopram therapy for mdd, takes over the counter cough syrup for 2-3 days. His roommate brings him in with symptoms like DTRs 3+, ankle clonus etc—- dx? Serotonin Syndrome.

DTR+++ --> Serotonin syndrome
Flu like symptoms --> SSRI discontinuation syndrome

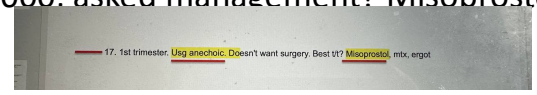
- Pregnant lady, has acne(probably comedonal, not moderate nor severe), Tx? Isotretinoin, oral doxycycline, benzoyl peroxide(he marked this). What if reassurance in the options?(confirm yourself)



- 6-7 yrs old(age could vary) bacha/bachi, adopted, easily adjust hogya with new family, shopping mall mein strangers k sath ghul mil jata hai, doctor ko bhi “big fat hug” deta hai, Dx asked? Disinhibited child disorder.

- Endometriosis scenario with associated infertility—-Tx? No ocp in options, so Laparoscopy (he did)

- Ectopic pregnancy scenario with bhcg <5000, asked management? Misoprostol, mifepristone, methotrexate(he marked)



- Mother ko endometrial cancer, behan ko ovarian, this patient has some menstruation problem, which cancer is she at inc risk for? Endometrial cancer(he did)

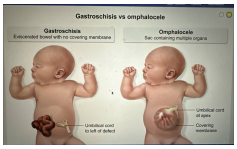
- Arrows for IDA and Anemia of Chronic disease.

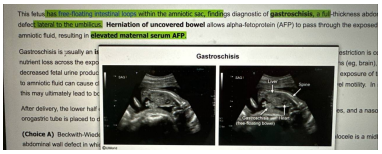
Iron studies in microcytic anemia					
Cause	MCV	Iron	TIBC	Ferritin	Transferrin saturation (Iron/TIBC)
Iron deficiency	↓	↓	↑	↓	↓
Thalassemia	↓↓	↑	↓	↑	↑↑
Anemia of chronic disease (inflammation)	Normal/↓	↓	↓	Normal/↑	Normal/↓

MCV = mean corpuscular volume; TIBC = total iron binding capacity.
©UWorld

1. Female pregnant came at the 20 weeks of gestation on ultrasound baby Intestinal content were protruding(commig out in the umbilicus) what complication it can develop in future

A. gastroschesia
B. omphalocele
C. mesentic ishenia





2. . Long history of gerd in endoscopy the squmular to columnar changes in the esophagus mention in CV no pic the beside prescribing th point what will you do

Ans= endoscopic Surveleine

3. 2-3 weeks ago have urti now have hf signs with S3 mention in CV asked for diagnosis

I did myocarditis.

4. Patient 2 to 3 days ago have the Myocardial infarction now have murmur lungs bl crakle caused aksed

I chose papillary muscle rupture.

Papillary rupture- 2- 7 days, hypotension, cardiogenic shock , MR

5. . COPD patients fev1to fvc ratio 50 what will you see in changes in the heart asked in ups and downs arrow question. >sarcomere added in series >sarcomere added in parallel.

Parallel ma - increase
Series ma - decrease

If a schizophrenia patient who is already stabilized on medication suddenly wants to get rid of schizophrenia quickly, the likely outcome would be:

A. His condition further deteriorates.

Schizophrenia is a chronic mental disorder that typically requires ongoing treatment with antipsychotic medications and often involves therapy and support. Stopping medication abruptly or trying to "get rid" of schizophrenia quickly without proper medical supervision can lead to a worsening of symptoms and a relapse of the disorder. It's important for individuals with schizophrenia to continue with their prescribed treatment plan under the guidance of healthcare professionals to maintain stability and manage symptoms effectively.

6. schizophrenia patient comes to follow already drugs now stabilize doing routine activities going to college taking major courses to complete his wants to get quickly rid of schizophrenia what will happened .

Aru sathi jastai normal feel garxa
Ani khana xodxa medicine

A. His condition further deterots
B. failure of therapy
C. will get better

Hectic schedule , xito thik garna xa vanepaxi , overdose khanxa hola ni xito thik garna

Compliant chha bhane C jaam

Qn ko vignette pt aauxa stable xa aile. Ma aba khaana xaadxu thik vayisakyo jasto kura garxa.

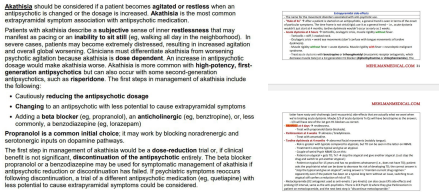
Ans is something like you have to continue the medication to get better estai estai khaalko qn xa

7. Schizophrenia patient on haloperidol develops the signs of aksthesai aksed MOA of drug

4day to 40 days

A. Sentization of dopamine receptor
B. dopamine blocks

Dopamin receptor hypersensitivity vanne auta thiyo ni paila?

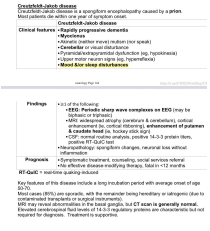


typical antipsychotic that primarily acts by blocking dopamine receptors in the brain. This blockade helps to reduce the positive symptoms of schizophrenia, such as hallucinations and delusions. Over time, however, the prolonged blockade of dopamine receptors can lead to a compensatory increase in the sensitivity of dopamine receptors (sensitization). This phenomenon may contribute to the development of side effects like akathisia, which is characterized by motor restlessness and a compelling urge to move. Therefore, option A is the correct answer regarding the MOA of haloperidol and its relation to the de

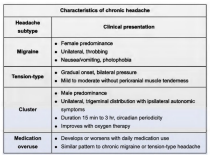
8. Patient have previous history of 3rd degree skin burned got skin graft now to work as construction have to work at outdoor what he is at risk of

A. SCC due uv light
B. Ulcer

9. Patient with 2 months history of acute memory loss cant remember things short question also there was flat effect asked cause MDD Alzheimer's crudz jacob disease



10. Womens with band like headaches for 8months pain worse when she goes to job until she comes home and pain has inc in duration previous 2 to 3 times a weeks now has inc frequency dx

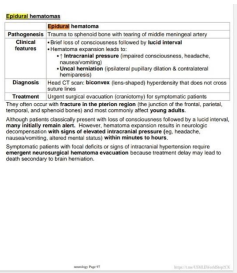


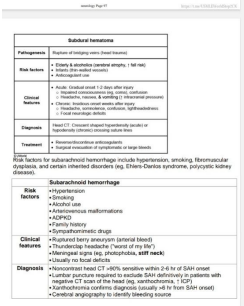
Types of headache

	Migraine	Cluster	Tension
Sex predilection	Female > male	Male > female	Female > male
Family history	Often present	No	No
Onset	Variable	During sleep	Under stress
Location	Often unilateral	Behind one eye	Band-like pattern around the head (bilateral)
Character	Pulsatile & throbbing	Excruciating, sharp & steady	Dull, tight & persistent
Duration	4-72 hours	15-90 minutes	30 minutes to 7 days
Associated symptoms	Auras, photophobia, phonophobia & nausea	Sweating, facial flushing, **nasal congestion, lacrimation & miosis**	Muscle tenderness in the head, neck, or shoulders

A. Migrane with out aura
B. Cluster Verapamil 02,100%
C. Tension headache

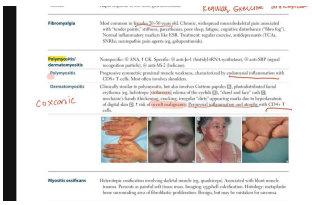
11. patient with moter vehicle accident got unconscious at the than got up having headache than Conditions further Detroit with Ipsilateral blow pupil and contraleral hemipersis dx asked





12. Dermatomyocyte question with clear picture of heliotrope rash wat investigation will you do for diagnosis

A. Skin biopsy
B. Muscle biopsy



13. 4 year child on routine examination abdominal mass on physical exam ct pic given with bid renal mass but respecting mide line was not cross mid line according to me normotensive dx asked

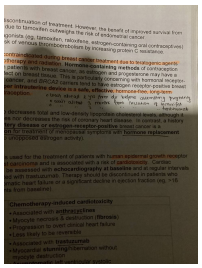
A. Wilmos tumor
B. Neuroblastoma Nephroblastoma

14. Patient heavy alcoholic asked which marker will be deranged

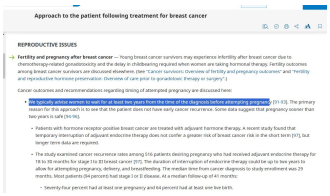
2 to 3 line question

A. Alt
B. Ast
C. Ggt.

15. 36 year old girl with family history of breast cancer undervent breast surgery due to breast cancer2 to3 months agocomes to doctor pre pregnancy counseling can I get pregnant.



A. yes you go with pregnancy
B. wait for 4 year than go for pregnancy
C. you can not go with pregnancy.



Breat cancer: pregnancy
Diagnosis pachie wait 2 yrs
Chemo pachie wait 8 month
Tamoxifen cessation for 3 mnth
Transtuzumab cessation for 7 months

16. Patient with heart sounds on right side ct given, history of infection but CFTRmutation is negative what complication can he develop I understand this case as kartagner syndrome.

A. infertility

B. mesentic ischemia

17. Baby 8 weeks year old with history of Nonbiloous vomiting and after vomiting feeling hungry asked diagnosis

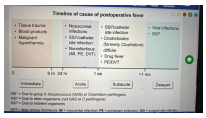
A. Pyloric stenosis

18 patient undervent some surgery 3 to 4 days ago now having Inc RR pulse rate Tachpnea what will you do.

Chest radiograph is frequently abnormal but has poor sensitivity and specificity for pulmonary embolism, and may be normal. Findings may include atelectasis, infiltrates, pleural effusions, Westermark's sign (peripheral hyperlucency due to oligemia), Hampton's hump (peripheral wedge of lung opacity due to pulmonary infarction on xray), and Fleischner sign (enlarged pulmonary artery). Chest **CT scan** showing a **wedge-shaped infarction** is virtually pathognomonic for pulmonary embolism.

Pulmonary embolism

A. Ct Spiral ct



Atlectesis ko lagi BP low dinxa

B. Xray

Diagnosis garum .... Pe - CT jam, atlectesis Vaya x-ray jam

19. Patient work in coal Furness were the burn coal and made something of marble what Organ is he at most like risk

A. Lung
B. Panncrea
C. Bladder Agent orange ,benzene factory dye factory

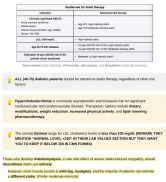
20 Abstract: Chronic Back pain yoga

GFR Japan

Long scenario,, 32yr female,, at last mentioned her ASCVD score was 2%,, what to do?

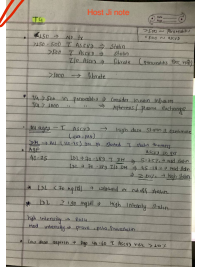
a. Life style modification

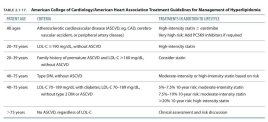
b. Aspirin c. Ezetimibe

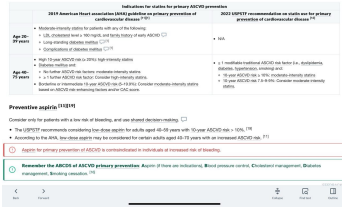


Indications for statin therapy in prevention of ASCVD	
Secondary prevention	• Established ASCVD ◦ Acute coronary syndrome ◦ Stable angina ◦ Arterial revascularization (eg, CABG) ◦ Stroke, TIA, PAD
Primary prevention	• LDL ≥190 mg/dL • Age ≥40 with diabetes mellitus • Estimated 10-year risk of ASCVD >7.5%-10%

ASCVD = atherosclerotic cardiovascular disease; **CABG** = coronary artery bypass grafting; **PAD** = peripheral artery disease; **TIA** = transient ischemic attack.



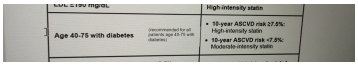




Another similar one,, around 72 yr,,,he or she needs 10% jasto aayo,, similar option

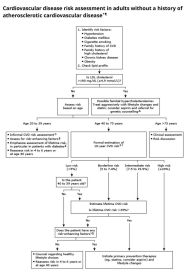
a. Life style modification

d. Gemfibrozi



b. Aspirin

c. Ezetimibe



21. Young female, chronic back pain,, progressive,, pain scale 7-8 out of 10,,, she have huge breast F size mentioned in CV,, pain medications not helping that much.. Pq

A. Breast reduction mammoplasty….

B. Not mentioned about supportive bras or other…

22. 47yr female Colon cancer,,, surgery done, biopsy positive for high grade microsatellite instability and MSH-2.. what else advice Pq

A. Prophylactic hysterectomy

Lynch CEOS Skin

B. Screen for pancreatic Ca

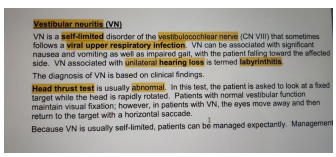
C. Screen for prostatic Ca

23. History of urti 1week ago now presents with continuous vertigo, Tinnitus. Due to?

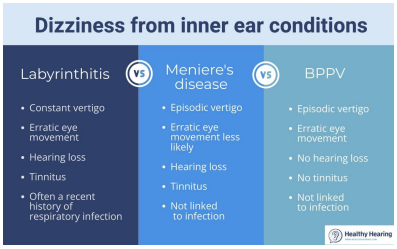
A. Bppv Dix-Hallpike maneuver causes nystagmus

B. Verstibular neuritis

C. Schwanoma



Viral prodrome
Myocarditis
Vestibular neuritis
Iga nephropathy
Transient synovitis



24. A physician A with maniac episode? In the viral illness pandemic (in emergency department). What would to do the physician A Send physician A to phychiatric department?.

Don't allow him to treat pt
And
Psychiatric hold wala thyo

25. 40 y.o man with gastric and duodenal ulcers, and a mass in pancreas. What other parameters you have to measure?

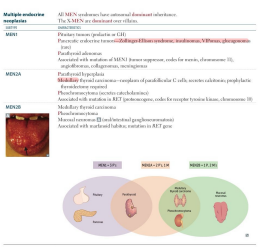
A. Prolactin,

B. PTH, 3pMEN 1

Men 1-prolactin/PTH
Men 2-calcitonin

C. calcium

Classification of multiple endocrine neoplasia	
Type 1	• **Primary hyperparathyroidism** (parathyroid adenomas or hyperplasia) • Pituitary tumors (prolactin, visual defects) • Pancreatic tumors (especially gastrinomas)
Type 2A	• **Medullary thyroid cancer** (calcitonin) • Pheochromocytoma • Primary hyperparathyroidism (parathyroid hyperplasia)
Type 2B	• **Medullary thyroid cancer** (calcitonin) • Pheochromocytoma • Mucosal neuromas/marfanoid habitus



26. Female, 30s History of intubation. Removed awhile back now presents with inspiratory stridor. No other symptoms.

A. Tracheomalacia Expiratory striode

B. Tracheal stenosis Prolonged intubation

C. Epiglotitis

In patients with a more collapsible intrathoracic airway (eg, **tracheomalacia**), the decreased pressure widens the intrathoracic tracheal airway. In contrast, expiration increases intrathoracic pressure. In patients with tracheomalacia, the increased pressure narrows the intrathoracic tracheal airway, leading to expiratory stridor. **Tracheal stenosis (ie, rigid narrowing) or tracheomalacia** (ie, weakness and collapsibility) are **complications of prolonged endotracheal intubation (>2 weeks)**, and can cause dyspnea and noisy breathing.

27. A study conducted to see the efficacy of ear drop. Randomisation done. Before study is begin run in analysis is done, subject where give dyed ear drops and only those with coloures eardrum were chosen. What did run in do?

A. Decrease confounding

B. Decrease generalizability esma randomize garexa tara feri euta particular arm matra analyse garya xa

C. Increase confounding

D. Increase generalizability

28. Unilateral massive pleural effusion after trauma x ray given

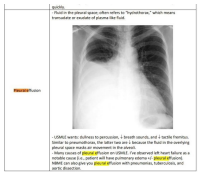
Thoracostomy

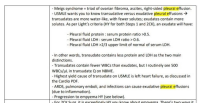
a.tube thoracostomy vs b.thoracocentesis

BOX 10-2 Indications for Surgery after Tube Thoracostomy Based on Results of Thoracostomy

Massive hemothorax, >1000- to 1500-mL initial drainage
Continued bleeding
>300 to 500 mL in the first hour
>200 mL/hr for the first 3 or more hours
Increasing size of the hemothorax on a chest film
Persistent hemothorax after two functioning tubes are placed
Clotted hemothorax
Large air leak preventing effective ventilation
Persistent air leak after placement of a second tube or inability to fully expand the lung

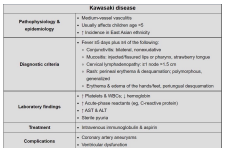
This is meant to be a guide, and clinical judgment should always be used.

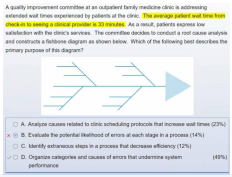


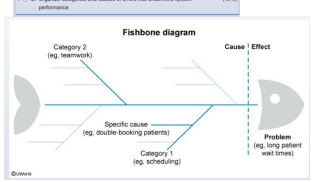


Trypanosoma cruzi Chags dz

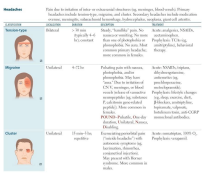
- Hopi of Trapimosigoide.----- Dilated cardiomyopathy
- Hopi Kawasaki disease---- IVIG-aspirin



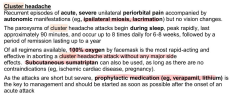




- Some error, next step: design fishbone diagram



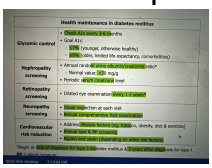
- Classic cluster headache Rx asked: verapamil sumatriptan

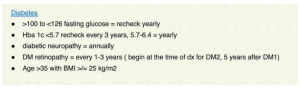


Types of headache

	Migraine	Cluster	Tension
Sex predilection	Female > male	Male > female	Female > male
Family history	Often present	No	No
Onset	Variable	During sleep	Under stress
Location	Often unilateral	Behind one eye	Band-like pattern around the head (bilateral)
Character	Pulsatile & throbbing	Excruciating, sharp & steady	Dull, tight & persistent
Duration	4-72 hours	15-90 minutes	30 minutes to 7 days
Associated symptoms	Auras, photophobia, phonophobia & nausea	Sweating, facial flushing, nasal congestion, lacrimation & miosis	Muscle tenderness in the head, neck, or shoulders

- Diverticulitis, no improvement - repeat ct
- HA1c 6.2 nbs : repeat in 1 yr (prediabetes should repeat annually)if less than 5.7 then repeat Hba1c in 3 yr





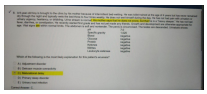
- Ectopic orthostatic hypotension: operative

so laparotomy garnu paryo

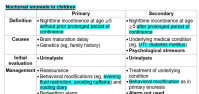
- Symptoms of celiac, Nbs: serum antibodies
- Small cell lung cancer, synaptophysin positive

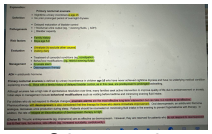
Small blue cell

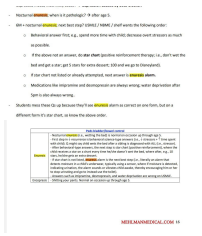
Small cell lung cancer- synaptophysin, enolase, chromogranin



- Primary enuresis in a 7 yr old: alaram

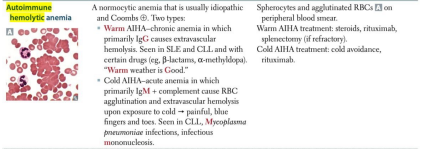






- FEMALE taking penicillin, sulpha drug what is the cause of hemolysis?

penicilline le AIHA ko kura huna sakcha female ma sulpha nahola



29. Cervical dilation 2 cm, effaced 50% contractions duration 30 seconds occur every 5 mins at 28 weak (not sure) dx asked

A. premature contractions

B. premature labor, Cervical insufficiency painless dilation

C. cervical insufficiency

30. Someone with crohns did ileocolectomy some long time ago now presenting with chronic watery diarrhea, Rx asked

cholysteramine vs crohns drugs.

Common causes of steatorrhea	
Pancreatic insufficiency	• Chronic pancreatitis due to alcohol abuse, cystic fibrosis, or autoimmune/hereditary pancreatitis • Pancreatic cancer
Bile salt–related	• Small-bowel Crohn disease • Bacterial overgrowth • Primary biliary cirrhosis • Primary sclerosing cholangitis • Surgical resection of ileum (at least 60-100 cm)
Impaired intestinal surface epithelium	• Celiac disease • AIDS enteropathy • Giardiasis
Other rare causes	• Whipple disease • Zollinger-Ellison syndrome • Medication induced

31. A study conducted to see the efficacy of ear drop. Randomisation done. Before study is begin run in analysis is done, subject where give dyed ear drops and only those with coloures eardrum were chosen. What did run in do?

A. Decrease confounding

B. Decrease generalizability

C. Increase confounding

D. Increase generalizability

32. A 30 year male presented with whitish lesion in mouth. History of asthma controlled under ics and arbuterol. What to do for diagnosis?

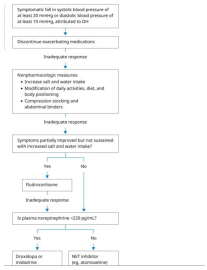
A. Biopsy

B. KOH mount Candida

C. Gramstain

D. HIV testing

33. 70year man had a episode of dizziness after abruptly standing up. His bp reading while sitting 130/90, standing 100/70. Later he was advised to drink plenty of water and stand slowly. Nbs?



A. Dexamethasone

B. Prednisolone Hydrocortisone

C. Nothing

34. A week old child presented to clinic, he has smooth philtrum, thin lips. His mother didn't have routine care during pregnancy. During examination child has murmur. What's the most likely cause?

A-VSD Fetal alcohol syndrome

B. PDA

C.TOF

35. A 18yr rugby player is tackled in the field. He was tackled by his neck and shoulder. He had tingling sensation in right arm for 30mins,mild head ache for 10mins. He didn't lose consciousness. He has history of being tackled 4 weeks back. Diagnosis?

A. Cervical strain

B. Concussion

C. SDH

36. 42yr female has completed her family with 2 children and wants a reliable contraceptive method as she doesn't want more children. She has chlamydia. Advice?

A. Hysterectomy B. Tubal ligation

C. OCP d. Diaphragm

Post amputation pain

	Post-amputation pain
Acute stump pain	• Tissue & nerve injury • Severe pain **lasting 1-3 weeks**
Ischemic pain	• Swelling, skin discoloration • Wound breakdown • ↓ Transcutaneous oxygen tension
Post-traumatic neuroma	• **Weeks to months** after amputation • **Focal tenderness**, altered local sensation • ↓ Pain with anesthetic injection
Phantom limb pain	• Onset usually **within 1 week** • Increased risk in patients with severe acute pain

37. 0s female complains of pain in her amputatated leg and difficulty to wearing her prosthetic. On examination 3mm wound dehisence is seen. What will you do to guide the antibiotic treatment?

A. Blood culture

B. Bone biopsy and

C. culture

D. Nothing

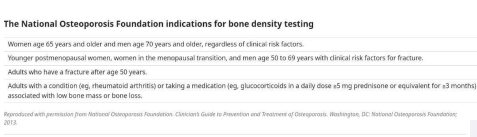
60yrs

38. Goyb / female → family history of fracture mentioned → female don't have any complication → Vaccinated as per schedule → vitals stable → asked for NBS

A. DEXA Risk xa vani DEXA natra milena

B. colonoscopy

C. No need for any Interontion Risk xaina vani opp C MA


The National Osteoporosis Foundation indications for bone density testing

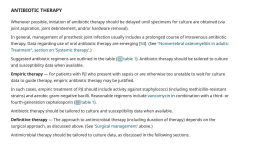
Women age 65 years and older and men age 70 years and older, regardless of clinical risk factors.

Younger postmenopausal women, women in the menopausal transition, and men age 50 to 69 years with clinical risk factors for fracture.

Adults who have a fracture after age 50 years.

Adults with a condition (eg, rheumatoid arthritis) or taking a medication (eg, glucocorticoids in a daily dose ≥5 mg prednisone or equivalent for ≥3 months) associated with low bone mass or bone loss.

Reproduced with permission from National Osteoporosis Foundation. Clinician's Guide to Prevention and Treatment of Osteoporosis. Washington, DC: National Osteoporosis Foundation; 2013.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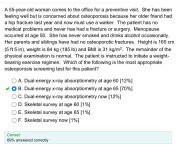
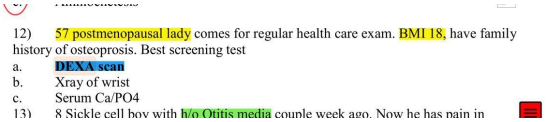


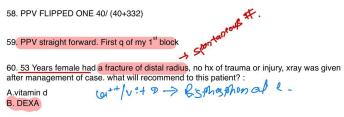

12) 57 postmenopausal lady comes for regular health care exam. BMI 18, have family history of osteoprosis. Best screening test

a. DEXA scan

b. Xray of wrist

c. Serum Ca/PO4

13) 8 Sickle cell boy with h/o Otitis media couple week ago. Now he has pain in


58. PPV FLIPPED ONE 40/ (40+332)

59. PPV straight forward. First q of my 1st block

60. 53 Years female had a fracture of distal radius, no hx of trauma or injury, xray was given after management of case, what will recommend to this patient? :

A.vitamin d

B. DEXA

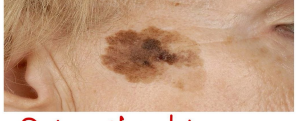
39.Inferior wall MI &CV

A. from ECG.

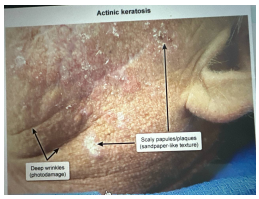
B. pt.had H/O DVT →Presented roith SOB→No chest pain→Very long CV at lact ECG finding hinting towards infecior wall NI.

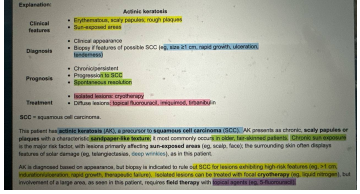
subtypes.
Histological subtypes of melanoma [16][11]

Epidemiology
Typical sites
Clinical appearance
Growth
Lentigo maligna [17]
• Peak incidence between 65 and 80 years of age [17]
• Sun-exposed areas (e.g., face, neck)
• Darkly pigmented macule
• Irregular borders and varying size
• Gradual growth, color irregularities, surrounding island-like speckling
• Premalignant lesion
• Slow growth
• Upto 50% of untreated lesions may transform into lentigo maligna melanoma. [17]

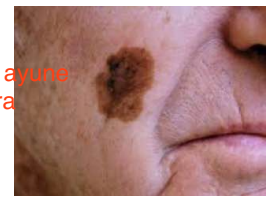


Solar lentigo

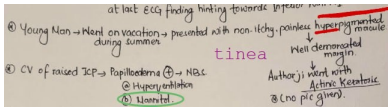




40. Young Man → went on vacation during summer → presented nith non-ltchy.painless hyperpigmanted macule →well demarcatedmargin. →authorji went noith actinic keratosis(no pic given)



moisture vairakhne pasina ayune thayuma hune body part tira hune versico



41. CV of raised ICP→ Papilloedema + → NBS

A. Hyperventilation

B. Mannitol.

Interventions to reduce intracranial pressure	
↓ Brain parenchymal volume	• Osmotic therapy (eg, hypertonic saline, mannitol) to extract water
↓ Cerebral blood volume	• Head elevation to ↑ venous outflow • Sedation to ↓ metabolic demand • Hyperventilation to ↓ $PaCO_2$, resulting in vasoconstriction
↓ CSF volume	• CSF removal (eg, external ventricular drain)
↑ Cranial volume	• Decompressive craniectomy
CSF = cerebrospinal fluid.	

42. CV of pneumothorax → resolved happens → Presented with fever(101 farh) →x rays findings → half of left lung whiteout ….asked for diagonosis

A. retained pneumoth

B. Pneumonia

C. Pemothorax.

D. Lung abscess

43. PT ↓ treatment takes Penicilin → after a wk presented with rach . Asked what type of Hypersensifivity?

A. Type I

B. Type ll

C. Type III/IV → (both in same option)

44. An old age man presented by himself with complains of forgetfullness. Recently he forgot his granddaughter birthday → Normal old age dementia.

45. Depression 3 quection.

1. SIGECAPS (+) → was to diagnase.

2. Depression with psychotic feature(+).

3. Depression scenario → SIGECAPS(+) (sucidal ldeation mentioned). →

→asked for treatment. A. CBT B.SSRI Hospital admissions ect hola ki

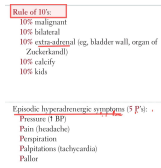
46. CV of PTSD → ↓SSRI mentioned in STEM → NBS ?
…….Nightmare → Prazosin Add

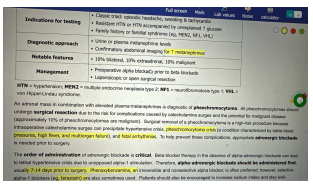
•Trauma-focused cognitive-behavioral therapy
•Antidepressants (SSRIs, SNRIs)
•Prazosin for nightmares

47. Roc curve glven → asked about the diagnosis of disease → went with top left (most sensifive &most specific).

48. ↑ed BP | episodic Headache(+) → had family h/o smoking in father & DVT in mother, Asked NBS → VMA, no option for 5-HIAA.

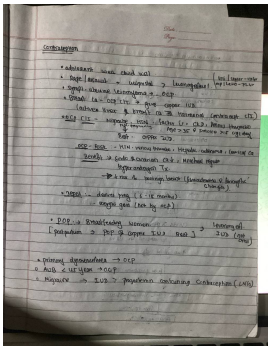
Pheochromocytoma as VHL sanga ko association ma sodhiraxa





49. Young adolosent female raped → history of Migrane(+)→ NBS details.?

- LNG.
- Cu IUD.



- contraceptire patch.
- contraceptire pillc

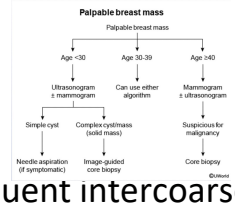
50. HOPI → fluctuant breast mass circumscribed lesion → fibroodenoma to diagnose.

Upper outer
Cyclical changes
mobile tender
hunxa

Benign breast diseases

	Benign breast disease
Diagnosis	**Clinical features**
Breast cyst	• Solitary, well-circumscribed & mobile mass • ± Tenderness
Fibrocystic changes	• **Multiple**, diffuse nodulocystic masses • **Cyclic** premenstrual tenderness
Fibroadenoma	• Solitary, **firm**, well-circumscribed & mobile mass • **Cyclic** premenstrual tenderness
Fat necrosis	• Post-trauma/surgery • Firm, irregular mass • ± **Ecchymosis, skin/nipple retraction**

51. Breast Mass + in a women 35yrs → NBS → Mammogram.



52. MSM → non receptive → frequent intercoarse with partner of STI status unknown. → Asked for NBS.

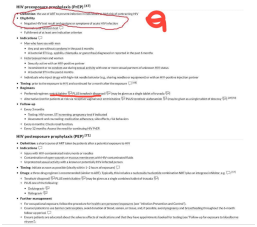
A. Antibiotic for gonorrhea

B. Pre exposure HIV prophylaxis.

Pre maa 2, post maa 3

Entricetabin, tenofovir

emtracitabine tenofovir raltegravir post



53. DMD Seenarto→NBS for diagnotis→

A. CK

B. genetic testing

C. biopsy

DMD
Duchenne Muscular Dystrophy

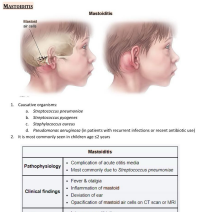
- Loss of dystrophin → **myonecrosis**
- **Creatine kinase** elevation
  - Common in early stages
  - Released from diseased muscle
- Other muscle enzymes also elevated
  - Aldolase
  - Aspartate transaminase (AST)
  - Alanine transaminase (ALT)

54. 2yr child→ 20 words → other milestone achiered as per age →language delay.

55. Mastoid tenderness tnt = fever→ History of barotrauma → asked for NBS

A. CT scan of Head.

B. CT scan of Head+sinus.



Acute mastoiditis

	Mastoiditis
Pathophysiology	• Infection of the mastoid air cells • Complication of acute otitis media • Most commonly due to *Streptococcus pneumoniae*
Clinical findings	• **Fever & otalgia** • Inflammation of mastoid • **Protrusion of the auricle** • Opacification of mastoid air cells on **CT scan or MRI**
Management	• **Intravenous** antibiotics (**vancomycin**) • Drainage of purulent material (eg, tympanostomy, mastoidectomy)
Complications	• Extracranial extension (subperiosteal abscess, **facial nerve palsy, hearing loss,** labyrinthitis) • Intracranial extension (brain abscess, meningitis)

56. CV of ICH → BP 185/100 mm of hg→contraindication of which of following.

A. Thrombolysis

B. Thromibectomy

C. Alteplase.

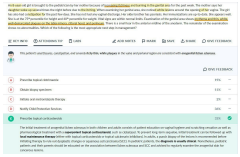
D. Anticoagulatton.

57. Lichen Sclerosis Scenario nt in child(8-9yr) →vulva finding → thin| whitish itching|→ asked for treatment

A. no trt req

B.chlobetasone

Topical steroid ___



Vulvar lichen sclerosus	
Epidemiology	• Prepubertal girls & perimenopausal or postmenopausal women
Clinical features	• Thin, white, wrinkled skin over the labia majora/minora; atrophic changes that may extend over the perineum & around the anus • Excoriations, erosions, fissures from severe pruritus • Dysuria, dyspareunia, painful defecation
Workup	• Punch biopsy of adult-onset lesions to exclude malignancy
Treatment	• Superpotent corticosteroid ointment

58. KLCLO RA →cv asked which of following value is increased?

A. DLCO

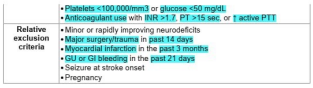
B. FEV,/fcv

Inc DLCO
Asthma
Morbid obesity
Pul hemorrhage
Polycythemia

Differential diagnosis based on DLCO			
	Obstructive pattern (FEV1/FVC <70% predicted)	Restrictive pattern (FEV1/FVC >70% predicted, FVC <80% predicted)	Normal spirometry
Low DLCO	• Emphysema	• Interstitial lung diseases • Sarcoidosis • Asbestosis • Heart failure	• Anemia • Pulmonary embolism • Pulmonary hypertension - Pulmonary edema
Normal DLCO	• Chronic bronchitis • Asthma	• Musculoskeletal deformity • Neuromuscular disease	
Increased DLCO	• Asthma	• Morbid obesity	• Pulmonary hemorrhage • Polycythemia

In diffuse pulmonary or alveolar hemorrhage (eg, pulmonary vasculitis), an abnormal increase in hemoglobin within the alveolar space increases carbon monoxide transfer, resulting in increased DLCO.

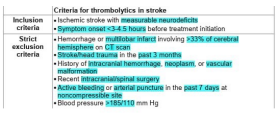
Inc DLCO WITH normal Spiro:
- Pregnancy - Left to right shunt



Relative exclusion criteria	• Platelets <100,000/mm3 or glucose <50 mg/dL • Anticoagulant use with INR >1.7, PT >15 sec, or ↑ active PTT • Minor or rapidly improving neurodeficits • Major surgery/trauma in past 14 days • Myocardial infarction in the past 3 months • GU or GI bleeding in the past 21 days • Seizure at stroke onset • Pregnancy

Aspirin should be held for 24 hours following thrombolytic therapy due to the increased risk of intracranial hemorrhage.

Therapeutic hypothermia is commonly used to prevent hypoxic ischemic brain injury in patients with out-of-hospital cardiac arrest.



Criteria for thrombolytics in stroke	
Inclusion criteria	• Ischemic stroke with measurable neurodeficits • Symptom onset <3-4.5 hours before treatment initiation
Strict exclusion criteria	• Hemorrhage or multilobar infarct involving ≥33% of cerebral hemisphere on CT scan • Stroke/head trauma in the past 3 months • History of intracranial hemorrhage, neoplasm, or vascular malformation • Recent intracranial/spinal surgery • Active bleeding or arterial puncture in the past 7 days at noncompressible site • Blood pressure >185/110 mm Hg

59. LVH scenario → ECG given → Where would you ascultate for this finding?

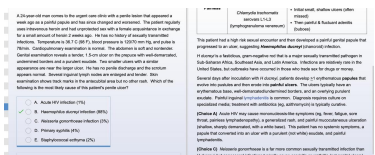
Apex ma , It 5th intercostal space ,s4 sound

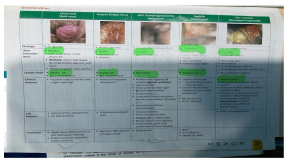
60. femur #→ 10cm below the hip→ probably along the shaft→No xray given→ asked for complication..

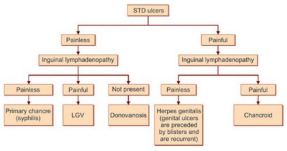
A. AVN.

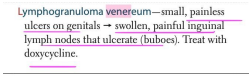
B. Malunion

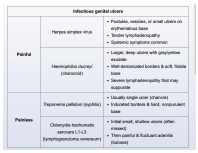
C.Nonunion











61. Painless ulcer with Painful LAD.→? diagnosis.

Lyphmogranuloma lgv,azithro

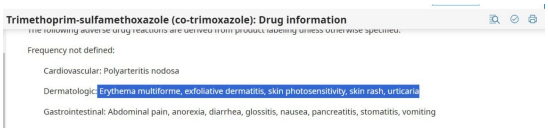
62. Motor Vehicle accident → loss of consciousness→ By the time he reaches hospital regained consciousness →Which initial Investigation to be done ?

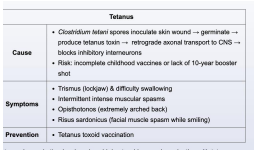
A. CT Scan

B. MRI brain.

63. Pt.multiple medication one of them being TMP-SMx. →presented with black skin over foot →No Hlo fever →asked for its cause.

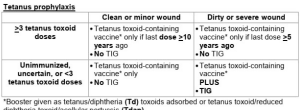
A. TMP-SMX

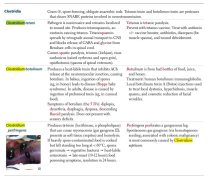




B. Clostridium Perfriences

Black skin vanya ta necrosis nai vayo





yo same set compiled ma pani cha...paila chai tmp-smx gako

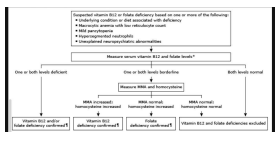
64. Vit B12 → clinical feature & lab finding suggestine of Vit B12 def→ what will you look Initially for.

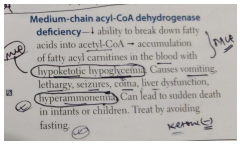
A. Vit B12

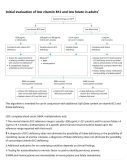
B. Methylmalonyl CoA

C. Homocystine

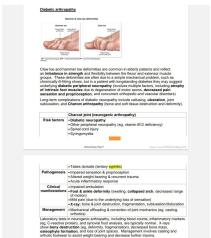
65. CV of MCAD (Hypoketotic + Hypoglycemia , mentioned in cv.) → Asked about which lab value hint towards its diagnosis.? →→(↑ Amonia level.)

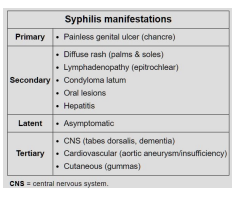


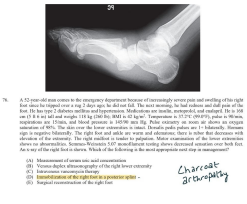


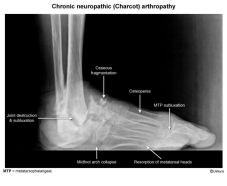


66. Sexually active pt →H/o unprotected sexual intercorse →presented with Painful, tingling sensation in lower limbs →x rays showed lytic lesion foot over









Tabes dorsalis (also called locomotor ataxia) is a disease of the posterior columns of the spinal cord and of the dorsal roots. It has the longest latent period between primary infection and onset of symptoms of all forms of neurosyphilis, with the interval averaging about 20 years, but sometimes as few as three years.

While tabes dorsalis was the most common form of neurosyphilis in the pre-antibiotic era, it is uncommon in the antibiotic era.

The most frequent symptoms of tabes dorsalis are sensory ataxia and lancinating pains. The latter are characterized by sudden, brief, severe stabs of pain that may affect the limbs, back, or face and that may last for minutes or days. Less common symptoms are paresthesia and gastric crises, characterized by recurrent attacks of severe epigastric pain, nausea, and vomiting. Bladder dysfunction with urinary retention and overflow incontinence may occur early in the course of disease.

Pupillary irregularities are among the most common signs in patients with tabes dorsalis, and the Argyll-Robertson pupil accounts for approximately one-half of these. An Argyll-Robertson pupil is small, does not respond to light, contracts normally to accommodation and convergence, dilates imperfectly to mydriatics, and does not dilate in response to painful stimuli.

Other findings seen with tabes dorsalis include absent lower extremity reflexes, impaired vibratory and position sensation, and, less commonly, impaired touch, pain, and optic atrophy.

calcenium + navicular→author wenr with charcot arthropathy.(other option :tabes dorsalis)

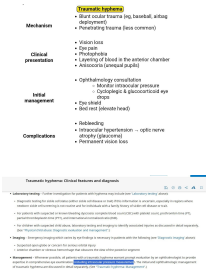
67. Pic of Hyphema given→ H/o trauma to Rt-eye during play. →NBS?

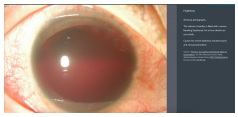
A. Measure IOP

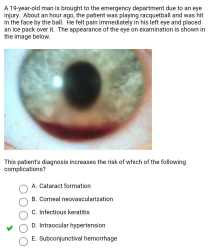
B. Refrac. Error

C. flurosence.

Traumatic hypema







68. RA prolong History→ most common occular symptom?

A. Anti Ureitis

B. Keratitis

C. scleritic

69. Discrepancy between Rt & Left breact. At breast (Tanner3) & left breast (tanner 1) CV asking about long term Complication

A. Malignancy

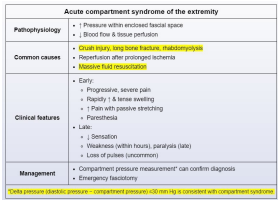
B. fibroadehoma

C. No complication

70. CV mentioned fluctuent mass with circumscribed lesion on breast.

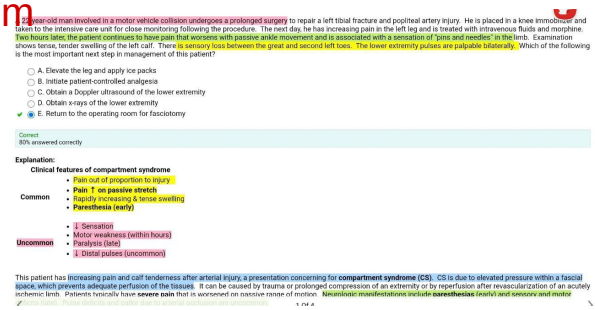
cv asking regarding its complication.

A. fibroadenoma
B. Malignancy



Acute compartment syndrome of the extremity	
Pathophysiology	• ↑ Pressure within enclosed fascial space • ↓ Blood flow & tissue perfusion
Common causes	• Crush injury, long bone fracture, rhabdomyolysis • Reperfusion after prolonged ischemia • Massive fluid resuscitation
Clinical features	• Early: ◦ Progressive, severe pain ◦ Rapidly ↑ & tense swelling ◦ ↑ Pain with passive stretching ◦ Paresthesia • Late: ◦ ↓ Sensation ◦ Weakness (within hours), paralysis (late) ◦ Loss of pulses (uncommon)
Management	• Compartment pressure measurement* can confirm diagnosis • Emergency fasciotomy

*Delta pressure (diastolic pressure – compartment pressure) <30 mm Hg is consistent with compartment syndrome.



A 22-year-old man involved in a motor vehicle collision undergoes a prolonged surgery to repair a left tibial fracture and popliteal artery injury. He is placed in a knee immobilizer and taken to the intensive care unit for close monitoring following the procedure. The next day, he has increasing pain in the left leg and is treated with intravenous fluids and morphine. Two hours later, the patient continues to have pain that worsens with passive ankle movement and is associated with a sensation of "pins and needles" in the limb. Examination shows tense, tender swelling of the left calf. There is sensory loss between the great and second left toes. The lower extremity pulses are palpable bilaterally. Which of the following is the most important next step in management of this patient?

A. Elevate the leg and apply ice packs
B. Initiate patient-controlled analgesia
C. Obtain a Doppler ultrasound of the lower extremity
D. Obtain x-rays of the lower extremity
✔ E. Return to the operating room for fasciotomy

Correct
80% answered correctly

Explanation:
Clinical features of compartment syndrome
Common
• Pain out of proportion to injury
• Pain ↑ on passive stretch
• Rapidly increasing & tense swelling
• Paresthesia (early)
Uncommon
• ↓ Sensation
• Motor weakness (within hours)
• Paralysis (late)
• ↓ Distal pulses (uncommon)

This patient has increasing pain and calf tenderness after arterial injury, a presentation concerning for compartment syndrome (CS). CS is due to elevated pressure within a fascial space, which prevents adequate perfusion of the tissues. It can be caused by trauma or prolonged compression of an extremity or by reperfusion after revascularization of an acutely ischemic limb. Patients typically have severe pain that is worsened on passive range of motion. Neurologic manifestations include paresthesias (early) and sensory and motor

71. Pt. prolonged Immobilization → well score high →DVT diagnosed→ presented with sudden calf pain→ distal pulse not palpable→swollen legs,tendon→NBS?.

A. Heparin

B. fasciotomy

72. ILD finding mentioned→ CV asked which of folowing is req for its diagonosis.

A. Fev

B. FvC

C. DLCO

(no option of fev1/fvc)

73. Huntington disease+ in dad→Similar H/o in past Pq Mother worried about her child so did genetic testing →absent in infant→ Which principal did you violate

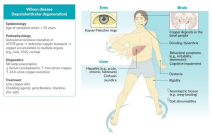
A.autonomy

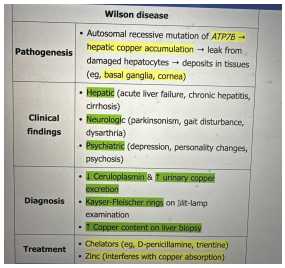
B.beneficance

C. Non-Maleficance

D. social justice.

74. Clinical Scenario of Wilsons disease→(↑ed ceruloplasmin), →asked for treatment →(Penicillamine.)





Wilson disease	
Pathogenesis	• Autosomal recessive mutation of *ATP7B* → hepatic copper accumulation → leak from damaged hepatocytes → deposits in tissues (eg, basal ganglia, cornea)
Clinical findings	• Hepatic (acute liver failure, chronic hepatitis, cirrhosis) • Neurologic (parkinsonism, gait disturbance, dysarthria) • Psychiatric (depression, personality changes, psychosis)
Diagnosis	• ↓ Ceruloplasmin & ↑ urinary copper excretion • Kayser-Fleischer rings on slit-lamp examination • ↑ Copper content on liver biopsy
Treatment	• Chelators (eg, D-penicillamine, trientine) • Zinc (interferes with copper absorption)

Dec ceruloplasmin
inc urinary copper

75. Cutaneous Larva Migrane →Pic given asked for trt→ Albendazole / Ivermectin.

76. Catch-22 scenario given→ asked for electrolyte Imbalance

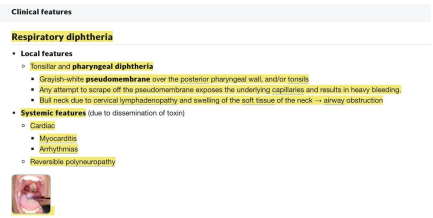
(hypocalcemia

mentioned

In question)

- Hyponatremia
- Hypernatremia
- Hypokalemia
- Hyperkalemia
- Hypomagnesma
- Hypermagnesemia

77. Red Grey Tongue , HIO ferer & cough→ CV hinting towards Diptheria. No feature of Obstruction→ asked regarding its complication→→no option of myocarditis.



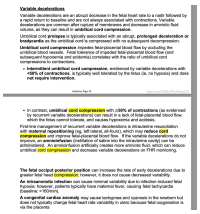
Clinical features

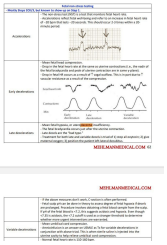
Respiratory diphtheria

- **Local features**
  - Tonsilar and **pharyngeal diphtheria**
    - Grayish-white **pseudomembrane** over the posterior pharyngeal wall, and/or tonsils
    - Any attempt to scrape off the pseudomembrane exposes the underlying capillaries and results in heavy bleeding.
    - Bull neck due to cervical lymphadenopathy and swelling of the soft tissue of the neck → airway obstruction
- **Systemic features** (due to dissemination of toxin)
  - Cardiac
    - Myocarditis
    - Arrhythmias
  - Reversible polyneuropathy

78. CV of cord compression given. →No History of fever→fetal Heart rate 110 bpm. →Asked for NBS(No option for resuscitation)

- Abx
- CIS
- Tocolytics
- observe



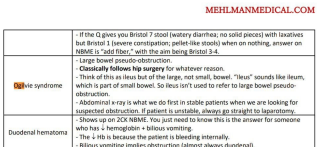


Early deceleration - head compression
Variable deceleration - cord compression
Late decelero- utero placenta insufficiency

Intermittent Variable decelleration - observe
Continuous - mat. positioning , amnioinfusion
if goes into fetal brady/acidosis - Cs

79. sharp chest pain & frequent bout of cough→ X-ray shows Mediastinitis → Pt. had pact H/o Pneumothorax. →asked for diagnosis.

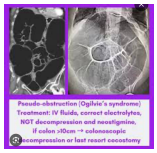
- Ecophageal rupture.
- bronchial rupture



80. Simple CV of Ogiline syndrome → asked for NBS→ look for electrolyte.

other tye of obstruction (before perforation — HYPERACTIVE bowel sounds

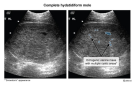
Pseudo obstruction — HYPOACTIVE bowel sound



Acute colonic pseudoobstruction (Ogilvie syndrome)	
Etiologies	• Major surgery, traumatic injury, severe infection • Electrolyte derangement (↓ K, ↓ Mg, ↓ Ca) • Medications (eg, opiates, anticholinergics) • Neurologic disorders (eg, dementia, stroke, MS, parkinson)
Clinical findings	• Abdominal distension, pain, obstipation, vomiting • Tympanic to percussion, ↓ bowel sounds • If perforation: guarding, rigidity, rebound tenderness
Imaging	• X-ray: **colonic dilation**, normal haustra, **nondilated small bowel** • CT scan: colonic dilation without anatomic obstruction
Management	• NPO, **nasogastric/rectal tube decompression** • **Neostigmine** if no improvement within 48 hour or if the cecal diameter on imaging exceeds 12 cm (which is a strong predictor of impending perforation).

Common causes include electrolyte imbalance (eg, hypokalemia, hypomagnesemia) and factors that lead to autonomic disruption of the colon (eg, major surgery, neurologic disease, anticholinergic medication).

81. Gestational size increased → H. mole (asked for diagnosis)



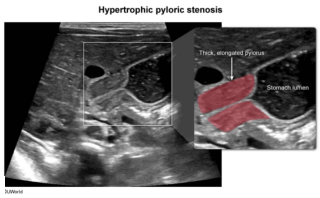
82. Infant 1 mth history→ non-billous Vomiting→ lab report awaiting→ what it is the Suspected diagnosis. →H.Pyloric stenosis

hungry still (or again) after vomiting ie hungry vomiter

Pyloromyotomy
Hungry vomiter

Infantile hypertrophic pyloric stenosis	
Pathogenesis	• Thickening of pylorus → gastric outlet obstruction • Risk factors: firstborn male, macrolide antibiotic exposure
History	• Age 3-6 weeks • Projectile nonbilious emesis ◦ Immediately postprandial ◦ Usually followed by interest in refeeding ("hungry vomiter")
Examination	• Palpable, olive-shaped epigastric mass • Visible peristalsis ± Signs of dehydration (eg, sunken fontanelle)
Laboratory/ imaging	• Hypochloremic, hypokalemic metabolic alkalosis* ± Indirect hyperbilirubinemia • Ultrasound: thickened, elongated pylorus
Treatment	• Intravenous fluids (for hydration & correction of electrolyte abnormalities) • Surgical pyloromyotomy

*Laboratory findings may be normal if diagnosed early.



83. Epiglottis feature +→ stridor+→ NBS.

A. Abr — intubation first if indicated then xone +vanco

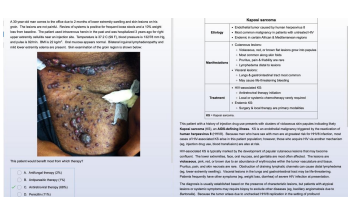
B. steroid — Airway edema
Laryngospasm

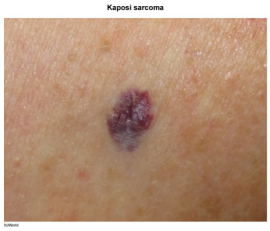
Treatment
- **Endotracheal intubation** (if needed)
- Intravenous antibiotics (**ceftriaxone plus vancomycin**)

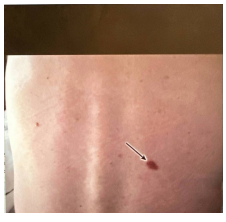
Diagnosis is confirmed via direct visualization of an edematous epiglottis. Respiratory compromise is less common in adults but can progress quickly, therefore Patients with epiglottitis who develop rapid-onset respiratory failure (eg, tripod position, hypoxia, drooling, tachypnea) require **urgent airway management**. This includes **bag-valve-mask ventilation with 100% oxygen** followed by **endotracheal intubation** with advanced equipment (eg, video laryngoscope). A single failed attempt at video-assisted endotracheal intubation should **prompt surgical cricothyrotomy**, which bypasses the epiglottal swelling and potential obstruction.
If intubation without a video laryngoscope fails, intubation with a video laryngoscope could be attempted.

Deviation of the uvula and unilateral lymphadenopathy can be helpful in distinguishing a peritonsillar abscess from epiglottitis.

84. Reddish-purple rash present on foot No H/o immunocompromised→ Author went with Kaposi .







Kaposi sarcoma (due to human herpesvirus 8)

Skin lesions usually occur on the trunk, face, oral mucosa, genitalia and lower extremities. Typically, the lesions are papules that become plaques or nodules. The color changes from light brown, to pink, to **dark violet** due to increased vascularity. AIDS-related KS is much more common among men who have sex with men than among other populations with HIV (eg, intravenous drug users).

Patients do not usually have significant pruritus or skin necrosis. Prominent lymphedema (due to vascular obstruction by KS lesion or to cytokine production), which can manifest as extremity swelling, can sometimes be seen.

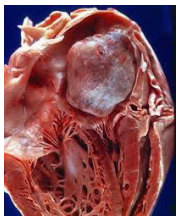
Diagnosis is made clinically, although patients with atypical lesions or systemic symptoms may require biopsy to exclude other causes (eg, bacillary angiomatosis due to Bartonella).

KS can also involve the gastrointestinal tract and lungs. Treatment is with **antiretroviral therapy** and, in severe or refractory cases, **chemotherapy.**

Histological subtypes of melanoma [15][11]

	Epidemiology	Typical sites	Clinical appearance	Growth
Superficial spreading melanoma	~70% of all melanomas	Back, chest, head, neck (in men) Legs (in women)	Flat irregular lesion with irregular borders Sometimes with nodular segments **Variable pigmentation**	Relatively slow **horizontal growth**
Nodular melanoma	15–30% of all melanomas		**Blue-black** nodule with smooth borders (may less commonly be an amelanotic melanoma) **Ulceration** with bleeding may be present	Fast **growth in depth** [116]
Lentigo maligna melanoma	~10% of all melanomas [4] Often arises from lentigo maligna in older adults	Sun-exposed skin areas (esp. the face and forearms)	Development of the following within a lentigo maligna lesion: Papules or nodules Variegated colors of red, blue, and white	Relatively slow horizontal growth
Acral lentiginous melanoma	~5% of all melanomas Most common melanoma in **dark-skinned and Asian individuals**	Palms and soles **Nail beds** (subungual melanoma)	Irregularly shaped macule with variegated colors including black, brown, and blue	Slow horizontal growth

85. Myxoma scenario → CV mentioned Mid-diastolic rumbling murmur over apex →Plop sound →+ asked complication →Stroke



pWorld
Atrial myxoma :
1. Complications: embolisation
2 . Origin: mesenchymal origin

	Cardiac myxoma
Tumor characteristics	• Benign neoplasm, 80% located in left atrium
Clinical features	• Position-dependent mitral valve obstruction • Mid-diastolic murmur • Dyspnea, lightheadedness, syncope • Embolization of tumor fragments (eg, stroke) • Constitutional symptoms (eg, fever, weight loss)
Diagnosis & management	• Echocardiography & prompt surgical resection

Myxomas are the most common primary cardiac neoplasm. Fragments of a left atrial myxoma can **embolize** into the systemic circulation, leading to stroke or other acute ischemia (eg, limb, mesenteric).

Because the mass is typically mobile, **obstructive symptoms** may be transient and **influenced by position** (ie, mitral obstruction is exacerbated by upright posture but is alleviated by lying down); tumor movement occasionally causes a characteristic **"tumor plop"** sound at the end of diastole on auscultation. In addition, some myxomas can produce cytokines (eg, IL-6) that lead to systemic inflammation (evidenced by an elevated erythrocyte sedimentation rate) and **constitutional symptoms** (eg, fever, weight loss).

Prompt surgical resection is recommended to minimize the risk of embolization and sudden cardiac death (due to impaired cardiac output).

Dr.G.Bhanu Prakash - Atrial myxoma Cardiac myxoma is the most ...

86. Grade 4 lung cancer metastasis to bone patinet asymptomatic patinet understand pros and cons and wants quality of life NBS:?hospice, ?nursing care, go with treatment.

Ans:hospice

Home hospice care	
Patient selection	• Life expectancy ≤6 months • Agreement to forgo curative & life-sustaining treatment • Family/private caregiver available for daily needs • Current symptoms can be managed with home care
Location of services	• Patient home • Assisted living facility • Nursing home
Typical services	• Periodic home visits by experienced personnel (eg, nurse) • Palliative medications (eg, analgesics, antiemetics) • Durable medical equipment (eg, hospital bed) • Physical therapy (as well as other therapy modalities)

87. Old age femaleson health prox no advance directive: daughter wants treatment son says monther does not want treatment (intubation) NBS:go with son wish.

Son is proxy

88. Baby in er pediatrics doctors duty off NBS:stablize and refer to other hospital (free 120 like) Amtala question

EMTALA
Emergency ma nai bhanna mildaina
Garnai parchha

Emg case ma doc le pt lai herni

Potential adverse event (near miss) [10]	• A medical error that could have resulted in an adverse event but did not, either incidentally or due to a prevention program or timely intervention • An incorrect order that is identified by a nurse before being completed
Never event/sentinel event [11]	• A serious adverse event that is clearly identifiable, causes serious injury, disability, or death, and is considered sufficiently preventable that it should never occur. • Wrong-site surgery • Wrong-patient surgery • Post-procedure retention of a foreign object in a patient • Suicide, suicide attempt, or self-harm within a health care facility • Using contaminated devices or medications • Using medical devices for purposes other than their intended function • Administering the wrong medication

Medical Errors

• **Continuity of care** for medications at the time of transitions of care, between inpatient and outpatient facilities and within inpatient facilities, is a potential source of medical error.

Interventions that target **pharmacy personnel** and **high-risk patients** appear to be the **most effective** in improving the quality of patient care.

• **Near Miss**: Unplanned event that doesn't cause harm but has potential to do so.

• **Active failure** is a medical error that is caused b a human error such as negligence, misinformation, incompetence or a technical mistake. and directly causes the patient harm. *(Immediate Impact)*

e.g: Wrong site incision

• **Latent conditions** are systemic conditions that can lead to medical mistakes and patient harm. They are often caused by the organization or design of a system. *(Accident waiting to happen)*

Active versus latent errors	
Active error	**Latent error**
• Proximal cause	• Distal cause
• Involves actions of frontline personnel	• Involves organizational vulnerabilities that influence actions of frontline personnel
• Occurs at interface of provider with patient or system	• Occurs at level of system, process & policy
• "Sharp end" of the subject, by of the iceberg	• "Incident waiting to happen." "blunt end" of the analyst, below the surface

• **Adverse event** is a medical error that reaches the patient and causes harm, such as giving the wrong medication to a patient.

• **Sentinel event/ Never Event** is a medical error that reaches a patient and leads to **permanent disability or death**.

Neuroleptic malignant syndrome vs serotonin syndrome

	Neuroleptic malignant syndrome	Serotonin syndrome
Causative agent	• Dopamine antagonist	• Serotonergic agent
Course	• **Slow** (onset/offset (days to weeks) • **Not dose dependent**, can occur anytime	• Rapid onset/offset (**<24 hr**) • Often associated with dose increase or additional serotonergic agent
Overlapping features	• Autonomic dysregulation • Altered mental status • Hyperthermia	• Autonomic dysregulation • Altered mental status • Hyperthermia
Distinct features	• Severe, diffuse muscle rigidity, bradythmia	• Hyperreflexia • Clonus • **Nausea, vomiting common**

- Sentinel event, Near miss and active error all 111 question

- Neroleptic malignant syndrome

Neuroleptic malignant syndrome	
Causative agents	• Antipsychotic medication (eg, haloperidol) • Antiemetic medications (eg, promethazine) • Withdrawal of Parkinson medications
Pathophysiology	• Central dopaminergic receptor blockade (hyperthermia, dysautonomia) • Disruption of nigrostriatal dopamine pathways (rigidity)
Signs/symptoms	• Fever • Altered mental status • Generalized muscle rigidity (lead-pipe rigidity) • Autonomic instability (abnormal vital signs, diaphoresis) • Elevated creatine kinase ± renal failure
Treatment	• Stop antipsychotics or restart dopamine agents • Supportive care (hydration, cooling), intensive care unit • Benzodiazepines • Bromocriptine or dantrolene if refractory

Rigidity--> NMS
Hyper reflexia->>>> Serotonin syndrome

- Generalized anxiety disorder

Multisome worries > 6 months

Myoglobinuria, Fever, Vitals unstable, Encephalopathy, INCREASE ck, muscle rigidity- Neuroleptic malignant syndrome- ttt- dantrolene

Psychosis (eg, hallucinations, delusions, paranoia) in PD is common and may be due to the underlying disease process, medication, or a combination of the two. Two of the most common anti-Parkinson medication classes associated with psychosis are dopamine precursors (eg, **levodopa) and dopamine agonists (eg, pramipexole).** PD may be complicated by **visual hallucinations,** which can be treated with dose reduction of antiparkinsonian agents and/or a low-potency, second-generation antipsychotic **(eg, quetiapine**, pimavanserin).

Treatment of hallucinations in PD often begins with an **initial trial adjustment** of a medication regimen (eg, switching pramipexole to levodopa), but regimen changes and dose reduction are often limited due to resurgent motor symptoms. When hallucinations persist despite initial efforts, **a low-dose antipsychotic may be tried**. The most frequent antipsychotics used in PD are low-potency, second-generation antipsychotics (eg, quetiapine, pimavanserin).

89. Parkinson cog wheel rigidity bradykiesia 2 weeks before levodopadose increased had syntomatic releif now patient presents with visual hallucinations NBS:

A. give dopamine

Reduce the dose first then quetiapine

Dopamine dherai bho
Hallucinations bho
Aba reduce garne hola

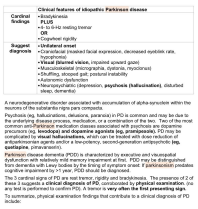
Dose dec garda motor symtoms worsen hola , low dose ma anti psychotic jada thik

B. give quetapine,

C. reduce dose of levo and carbidopa?

Systoms relief cha but hallucinations cha as a side effect so Dose decrease

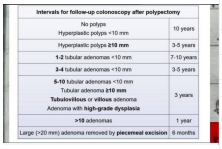
Ans:decrease dose



- Used OCP electrolyte abnormalities of Na and K?

The effects of hormonal contraceptives on electrolytes has shown that it exerts severe electrolyte derangement as there were significant reductions in serum sodium and chloride concentrations and elevation in serum potassium and bicarbonate concentration Angiotensin activity increase garchan..

- OCP complications:3 questions
- Typical dementia question
- Hospital acquired deleri um question gets better in 2 to 3 weeks old pq
- One singe hypoplastic polyp on colonoscopy in normal screening asymptomatic:repeat in 7 to 10 years



- 2 questions of papilledema unilateral pailledema question

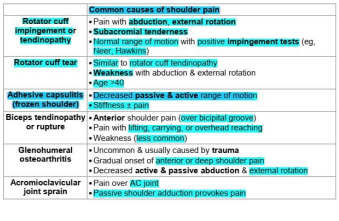
??? Jhukako hola sayad

- Player American game 15 degree banda badi hand restricted left shoulder pain not improved with nasids and steriods diagnosis?:?Adhesive capsulitis,?bicep tendionitis No rotator cuff in option

Adhesive capsulitus

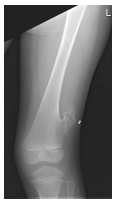
Not relieve by lidocaine/ steroids
Stiffness more than pain
Intact reflex
Gradual onset
Decrease passive and active rom

- Right arm pain shoulder blades pain along with numbness in middle finger: ? C5 ? C6 ? C7: Ans: C7



- Old pq osteochondroma treatment:do nothing

Lateral projection



- Round 2nd year surgery resident had alcohol smell youre intern NBS:report to medical supervisor

- Young female goes to study in college wants Beto drop out from college as she can't give presentation, but speaks well with normal group friends: social anxiety? ,perfomance anxiety

- Young female cervical cancer diagnosed wants to get pregnant later NBS: hysterectomy? ,chemo?, LEEP?

- Treatment of tradive:? valbenazine and clozapine?

- Tell about medical error 3 to 4 questions.

- Swan neck deformity RA mentioned grand daughter marriage hand tremor while working best advise to improve motor function? wrist splint, occupational therapy, steriod?

- Diabetic patienat pregnant what is the risk in pregnancy: diabetes before present under insulin controlled: what is the risk to the baby?

- 15 years regular follow up previously vaccinated for hpv and meningitis now what will you give:no tdap in option HPV dine?

- Bronchiolitis infant discharged after treatment late for vaccination due to broncholitis NBS:give vaccine as schedule, give all, postpone, give while discharge?ans:vaccine as schedule?

- Female brings her child due to illness unable to pay won't do tratment cant take help fromcharity due to religion what will you do?:go through court order

- 82y f staying with her daughter who is poor giver her mother rotten foods she also eats same food due to poor financial stauts mother mental satus intact NBS: APS?

- Round 2nd year surgery resident had alcohol smell youre intern NBS:report to medical supervisor

- Young female cervical cancer diagnosed wants to get pregnant later NBs:hysterectomy?, chemo?, LEEP?

- Valvular lesion ulcerative picture under ocp not like lichen panus sclerosis what might be compilations: Fistula? , infertility? Ans: Fistula?

- Sclerosis treatment colebetasone old pq

- Diabetic patient white plaque on tongue like oral thrush what would you give: cotrimazole? , chlorhexidine mouth gargle ? Ans : cotrimazole logenges?

- Chlyamdaia trachomatis young female treatment received pregnant complication in baby what screenig?:?occular herne

- Baby nose bleed no family history bleeding for 20 minutes even after minor injury factor 8 within range what is diagnosis : Vwd1? VWd2? VWD3? Hemophilia A? hemophilia B?

- Hyperchromatic niclei with keratin pearl

- 17 y /f bf pregnant want to do the abortion parents knows risk and beneift wants to abort child :go with procedure

- Picture: port wine strain : truncus arterious hearing loss ?what would be the complication.

- ECG : cardiac tamponade : mild chest pain no becks triad NBS : Echo

- DVT and pulmonary embolism : risk factor, treatment, diagnosis wells score .

- Graves disease : feeling hot tsh decrease t3 t4 increase : finding? increase t4 ? increase perioxide antibody,

- ILD:histolgy diyera diagnosis

- Right carotid bruit, numbness tingling rt hand jvp raised: sublavian stress syndrome ?venous insufficiency?

- Thoracic outlet syndrome?

- Hernia inguinal and spigelian old pq

- Somatoform disorder

- Extra pyradimal symtoms bata treatment

- Acute dystonia and tardive dyskinesia treatment

- Treatment of tardive:? valbenazine aliu.

- Dr. gives Anastrazole, and later tells not to take it. Why? No significant difference even with Anastrazole

- Calculate NNT for vasomotor system.

  NNT =1/ YARR (Intervention-control)
  NNH=1/ YAR (exposed-unexposed)

- Blinding is done. whom to be blinded to ↑ better result?

Patient (Double blind) Data analyzer (Triple blind)✓✓

- Inhaler fluticasone for allergic rhinitis.
- Colonoscopy cutaneous manifestation
- Acute otitis media treatment asked
- Ascending Cholangitis
- Asus screening
- Mucosal neuroma present paternal uncle has thyroid cancer present with symptoms of pheochromocytoma
- Fentanyp patch for pain control in multiple myeloma
- USG for thyroid nodule
- Secondary hyperthyroidism
- Uvula deviated with Duputren contracture
- Lichen sclerosis vulval lesion
- Ruptures ectopic pregnancy
- Mdma intoxication
- Alcohol
- Bulmia nervosa
- Renal stone of oxalate risk factor hypercalemia with oxaluria

- Cholecystectomy answer.. plan after discharge from gb stone leading to pancreatitis
- Enteral Vancomycin for clostridium difficle infection
- Pagets disease of breast
- Infertility hysterosalpingography
- Generalised lymphadenopathy..syphilis
- Pancytopenia methotrexate
- Infective endocarditis
- Iv drug user
- Necrotising fascitis meropenem and Vancomycin
- Venous ulcer compression
- Newborn with heart block? Cause Maternal antibodies of sle
- Roc curve.. most sensitive test for screening a disease outbreak
- History of exposure to asbestosis presented with pleural effusion.. findings
- intrapulmonary mass or pleural plaques
- Toxic megacolon treatment
- Primary prevention
- H/o Migraine contraceptive levonorgesterol IUD
- intrapulmonary mass or pleural plaques

- Toxic megacolon treatment
- Primary prevention
- Obese pregnant women...weight gain during pregnancy
- Army men gay like symptoms when stress cut his wrist.. mgmt admit the pt Mantous 18mm..isoniazid therapy
- 1. Ebv symptoms given.Asked when should the child should play sports

  - After fever subsides -after spleenomegaly subside - Afte 4wks

- Penis wart leison given. Asked future course

  - Chronic - waxing n wanning - Recurrence

- efficient vs effective scenario
- Hospital planned for sepsis prevention / early t/t for which they made protocol which included things like

  - when pt arrives at er take vitals within 5 min

  - lab workup within 30 min.....

  - 2 other points were also there similar to further diagnosis n t/t!

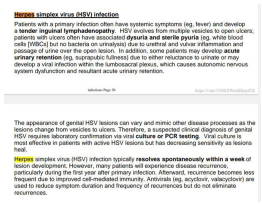
- Tourrete syndrome associated with adhd
- Anchoring bias
- ARR calculation
- Prazocin PTSD under sertraline with history of night mares

- CML cbc report with splenomegaly
- Cutena Larva migrans Albendazole
- Abstract stroke
- Intravenous thrombectomy vs tPA
- Ocp vs thromboembolism
- Dexa scan 68 yr female.
- Sequential AAA screening,
- Ecg
- AF, MI
- MR, VSD, AS
- Incomplete abortion with absent fetap cardiac activity
- Complete abortion rh negative mother
- ILD answer HRCT
- Early marker for lung function assessment in ILD DLCO
- Empyema chest xray given, pt presented with fever cough sob with history of traumatic
- pneumothorax 3 weeks back.
- Allergic rhinitis fluticasone
- MVA 15 question

- Anal fissure
- Wilson treatment penicillamine eye picture of kf ring
- History of Arcus senile
- Charcot arthropathy
- Subconjunctival hemorrhage
- Osteosarcoma xray biopsy
- ankle sprain splinting
- Bacterial meningitis
- Abscess picture I &D
- Picture genital wart treatment asked
- Chronic granulomatous disease infection risk of stap
- Tampoon indcued tss
- Inhaler fluticasone for allergic rhinitis

Pictures:

1. HSV 2 genital pic vesicles, along with CV explaining pain and burning sensation, - diagnosis



2. HPV pic given- diagnosis

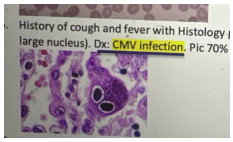
Acuminata wart ,hiv test garni que pani cha

>1cm or >5 warts - Cryo /Ablation
<1cm or <5 warts - topical ,podophyline

Genital warts (condylomata acuminata)	
Etiology	• HPV 6 & 11
Clinical features	• Multiple pink or skin-colored lesions • Lesions ranging from smooth, flattened papules to exophytic/cauliflower-like growths
Treatment	• Chemical: Podophyllin resin, trichloroacetic acid • Immunologic: Imiquimod • Surgical: Cryotherapy, laser therapy, excision
Prevention	• Vaccination • Barrier contraception

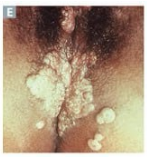
HPV = human papillomavirus.

3. CMV pic- owl eye appearance- CV explaining a renal transplant patient under immunosuppressant what t/t to be given- ans ganciclovir



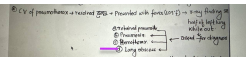
inhibits viral kinase
Acyclovir inhibits thymidine kinase

4. Condyloma lata pic given- CV explain no pain, lesion present- is sexually active, what happens if not treated- options: recurrence, latent syphilis..

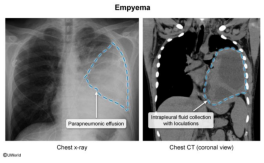


Hpv and hsv- recurrence hunxa
Syphilis - latent ma janxa

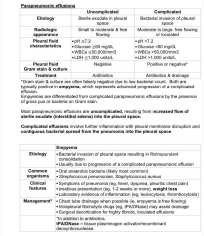
5. Pic of empyema along with CV ... ?

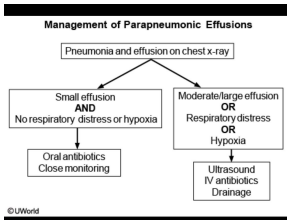


K ma? Empyema?
Pneumococcus infections ho vane yes it causes MI by releasing pneumotolysin protein which causes thrombogenic inflammation

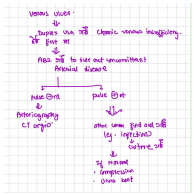


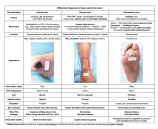
Uncomplicated - antibiotics, complicated + empyema - antibiotics+ drainage main funda yehi ho Sahi vannu vayo





6. Venous ulcer pic given of NBME, what is the treatment? Compression therapy



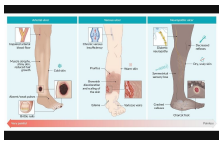


Brachial Index ko value ... For pad and normal?

Arterial ulcer - Bony region

Diabetic ulcer - ventral aspect of foot

Venous ulcer - over shin above the malleolar region



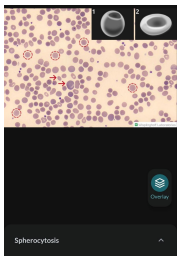
Arterial = Lateral (roughly backward pronounciation) , Venous : Medial side

7. Peripheral blood smear given, Pic of spherocytes seen, CV explained hepatomegaly, right upper abd pain, fatigue... what will you do to prevent? Splenectomy, blood transfusion..

Hereditary spherocytosis:	
	Hereditary spherocytosis
Epidemiology	• Usually autosomal dominant • Northern European descent
Clinical presentation	Classic triad • Hemolytic anemia • Jaundice • Splenomegaly
Laboratory findings	• ↑ MCHC (due to membrane loss and RBC dehydration) • Negative Coombs test • Spherocytes on peripheral smear • ↑ Osmotic fragility on acidified glycerol lysis test • Abnormal eosin-5-maleimide binding test
Treatment	• Folic acid supplementation • Blood transfusion • **Splenectomy**

• Other findings include **reticulocytosis**, normal to elevated red cell distribution width due to various RBC forms (eg, reticulocytes, spherocytes, normal RBCs), and low to normal mean corpuscular volume

AIHA ma CLL, SLE, drugs, Drug induced Ma ni spherocyte



Spherocyte (Helmet cell) - Hemolysis - Splenectomy

Hemolysis = pigment gall stone= RUQ pain. T/t= splenectomy..

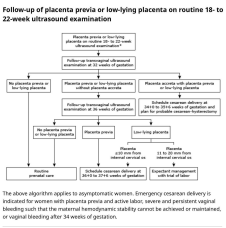
Dacrocyte (Tear Drop) - Myelofibrosis - Trapped cell

Primary myelofibrosis 5%

Primary myelofibrosis is a condition that is very rare in childhood, with a peak incidence between the 6th–7th decades. Labs can demonstrate pancytopenia and bone marrow hypocellularity, but the condition is chronic in nature and is often accompanied by splenomegaly. A peripheral smear would demonstrate nucleated erythrocyte precursors and immature myeloid cells. This young patient has both a different clinical course and a peripheral smear.

8. Pic of tear drop given diagnosis?.. Myelofibrosis

9. Pic of placenta previa given CV expaining painless vaginal bleeding in a....week pregnant patient, definitive management will be? C-section, surfactant delivery, steroid to the mother..



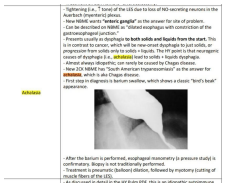
Placenta previa	
Risk factors	• Prior placenta previa • Prior cesarean delivery • Multiple gestation
Clinical features	• Painless vaginal bleeding >20 weeks gestation
Diagnosis	• Transabdominal followed by transvaginal sonogram
Management	• No intercourse • No digital cervical examination • Inpatient admission for bleeding episodes

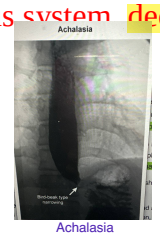
Labour ma vayeni cs

10. Pic of Achalasia cardia given, young man, with dysphasia initially for soling later for liquids but could drink water, regurgitation of food and even consolidation of right lower quadrant oc chest expained, no wt loss. What will happen? Inc peristaltic movement, problem in nervous system, dec relaxation of sphincter..

Mechanism vs cause vayo
Symptoms kina dekhiyako cha ques le k vanxa herera garni

Hamle khako food lai overcome garna ta increase presistalsis nai hune vayo... (badhne nai vayo) bcoz there is obstructio... relaxtation decrease vayo





Achalasia	
Clinical presentation	• Chronic dysphagia to solids & liquids, regurgitation • Heartburn, weight loss
Diagnosis	• Manometry: ↑ LES resting pressure, incomplete LES relaxation, ↓ peristalsis of distal esophagus • Barium esophagram: Smooth "bird-beak" narrowing at gastroesophageal junction
Management	• Upper endoscopy to exclude malignancy • Laparoscopic myotomy or pneumatic balloon dilation • Botulinum toxin injection, nitrates & CCB

CCB = calcium channel blocker; LES = lower esophageal sphincter.
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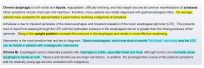
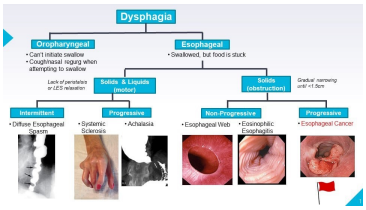
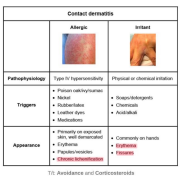
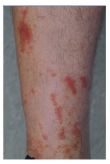


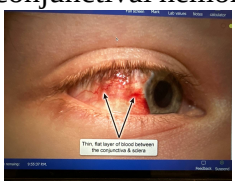


11. Contact dermatitis pic given, T/T? Steroid





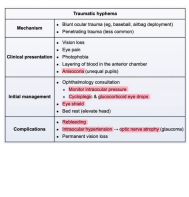
12. Subconjunctival hemorrhage pic, NBS- Tonometry, Reassurance



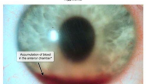
This patient with an atraumatic and **painless red eye** has a thin layer of blood on the eye surface consistent with **subconjunctival hemorrhage** (SH). SH is a **benign condition** that occurs when a small conjunctival blood vessel ruptures, leading to **blood collecting** in the space **between** the **sclera** (the white part of the eye) and the **conjunctiva** (the mucous membrane covering the sclera). SH can be due to minor trauma (eg, rubbing the eyes vigorously), but in many cases there is no apparent cause.

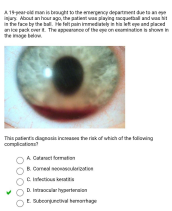
Patients with SH are typically **asymptomatic** and have a normal eye examination (eg, normal pupillary reflex, extraocular movements, and visual acuity) except for the presence of a flat and focal area of blood on the ocular surface. SH is a **clinical diagnosis** that does not require any further work-up. Patients can be **reassured** that no medications or interventions are necessary; the hemorrhage typically spreads, fades, and becomes yellow in color, and then disappears completely within 1-3 weeks.

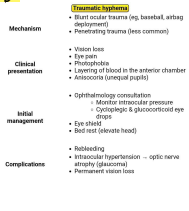
13. Hypema pic given NBS- Tonometry, observe, antibiotics..



Traumatic hyphema	
Mechanism	• Blunt ocular trauma (eg, baseball, airbag deployment) • Penetrating trauma (less common)
Clinical presentation	• Vision loss • Eye pain • Photophobia • Layering of blood in the anterior chamber • Anisocoria (unequal pupils)
Initial management	• Ophthalmology consultation ◦ Monitor intraocular pressure ◦ Cycloplegic & glucocorticoid eye drops • Eye shield • Bed rest (elevate head)
Complications	• Rebleeding • Intraocular hypertension → optic nerve atrophy (glaucoma) • Permanent vision loss

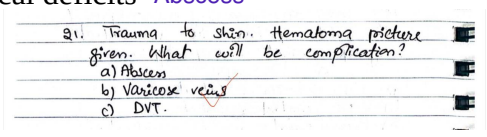




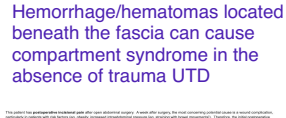


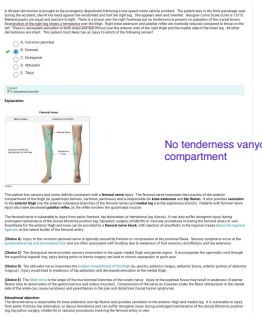
14. Pic of hematoma on leg, what is he likely to develop? Compartment syndrome, Varicose vein, neurological deficits Abscess

Anteriori part of leg ma hematoma vanera airathyo ani varicose vein vanera gairathem
But sathi haru abscess ma gairaxan re ?????



Hemorrhage/hematomas located beneath the fascia can cause compartment syndrome in the absence of trauma UTD





No tenderness vanyo so no compartment

Compartment pani jana chai milxa..d/t increase pressure within the fascial compartment which may arise from hematoma

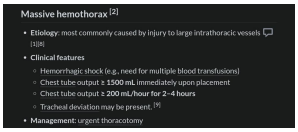
Hematoma vayo- bacterial growth- pus - cavity pressure rise - compartment - point tenderness

Sequentials:

1. Pic given of hemothorax after RTA, on auscultation, dec air entry to affected lung one, heard sound could be heard, no murmur, no JVP distention, no tracheal deviation BP dec, tachycardia..- diagnosis asked

Later after thoracocentesis 1500ml non clotted blot seen and vitals unstable NBS: chest tube, thoracotomy..

1500ml in 24hour
2 hour ma 200 ml every 1 hour
Thoracotomy



Penetrating trauma accompanied by shock (eg, severe hypotension) is attributed to hemorrhage until proven otherwise.
Although **tube thoracostomy** is often sufficient to manage hemothorax, some patients (up to 15%) require **emergent thoracotomy** for extreme bleeding, including those with:

- **Initial bloody output >1,500 mL** (>20 mL/kg)
- Persistent hemorrhage: >200 mL/hr for >2 hours, or continuous need for blood transfusion to maintain hemodynamic stability

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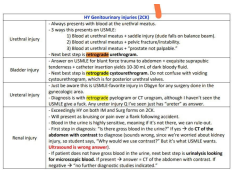
- **Initial bloody output >1,500 mL** (>20 mL/kg)
- Persistent hemorrhage: >200 mL/hr for >2 hours, or continuous need for blood transfusion to maintain hemodynamic stability

2. RTA blood in meatus, pelvis fracture with unstable pelvis explained XRAY finding, retrograde urethrography done, no spillage seen, blood in catheter, NBS- CT abd and pelvis, Retrograde cystoscopy...No spillage observation
Retrograde cystoscopy done ..NBS?...



Blood in meatus
1. Retrograde urethrogram first

Blood at urethral meatus than rug garyo
Urthral rupture with extravastation
-(if spillage,)
suprapubic catheter and do surgical intervention
2. If spillage ,not present(pass urthral catheter than hematuria do cystogram
Extravastation...is no...do observation
Extravastation of dye occur
Extraperitoneal....catheter drainage
Intraperitoneal...surgical intervention.

a. Then do cystogram
- if spillage present
I. Extraperitoneal: catheter drainage
ii. Intraperitoneal: surgical

Retrograde urethrogram —- Retro cystogram —- Retro pyelogram or CT IVU —- CT Abdominal/Pelvis (KUB) ?

CT pelvis with IV contrast is generally insufficient for evaluation of bladder injury Spill bhacha a bhney blood tah acha kata bata ayo herna paryo

CT for cystography ho dr sab. Not CT bd/pelvis. CT ko thauma fluoroscopy gareni same ho. The main kura is: Bladder injury r/o garna Retrograde Cystogram harnuparyo foleys bata dye halera.

Urine leaked from **extraperitoneal** bladder **rupture** stays contained within adjacent tissues (eg, retropubic space). Therefore, FAST is negative for intraperitoneal free fluid and pain typically remains localized to the pelvis (eg, suprapubic tenderness). In contrast, intraperitoneal bladder (eg, dome) rupture spills urine into the peritoneal space, causing a positive FAST and, if undiagnosed, abdominal distention (eg, urinary ascites) and/or chemical peritonitis (**Choice B**). Retrograde cystography, in which the bladder is passively filled (eg, via Foley catheter) with water-soluble contrast and imaged (eg, CT scan, fluoroscopy), can confirm the diagnosis.

(**Choice C**) Ureteral injury may present with hematuria. However, it is overwhelmingly caused by iatrogenic trauma (eg, pelvic surgery) or penetrating trauma rather than blunt trauma. In addition, flank/abdominal pain (depending on the location of the injury) is more common than suprapubic fullness and tenderness.

(**Choice D**) Renal laceration may present with hematuria, but suprapubic fullness and tenderness are unlikely. Patients with renal laceration typically have flank pain and/or hemorrhage into the retroperitoneal space (eg, flank ecchymosis) instead.

3. CV along with lab findings given- platelet dec, hb dec, other parameters normal- diagnosis ?- ITP TTP ma ho anemia ra tp Ttp vanera gako yo ma ma
What will be the treatment?... antibiotics given, steroid, immunosuppressants..

##suru ma retrigrade urethrography , tesma dye spillage china bhane urethra injury rule out- foleys halne- bladder herne retrograde cystourethrography or cystogrpahy, tesma dekhena bhane CT urogrpahy entire uro anatomy herne

##retrograde urethrogram then cystogram/graphy tespaxi ct abd pelvis

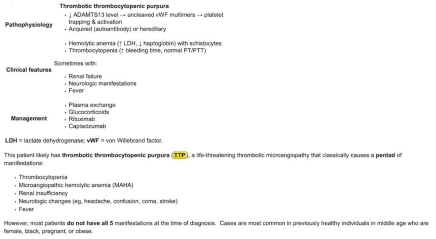
Immune thrombocytopenia	
Etiology	• Platelet autoantibodies • Preceding viral infection
Clinical findings	• Petechiae, ecchymosis • Mucosal bleeding (eg, epistaxis, hematuria)
Laboratory findings	• Isolated thrombocytopenia <100,000/mm^3 • Few platelets (size normal to large) on peripheral smear
Treatment	• Children ◦ Observe if cutaneous symptoms only ◦ Glucocorticoids, IVIG, or anti-D if bleeding • Adults ◦ Observation if cutaneous symptoms AND platelets ≥30,000/mm^3 ◦ Glucocorticoids, IVIG, or anti-D if bleeding or platelets <30,000/mm^3
IVIG = intravenous immunoglobulin.	

Anti-D immune globulin (if Rh-positive and Coombs-negative)

	Thrombotic thrombocytopenic purpura
Pathophysiology	• ↓ **ADAMTS13 level** → uncleaved vWF multimers → platelet trapping & activation • Acquired (autoantibody) or hereditary
Clinical features	• Hemolytic **anemia** (↑ LDH, ↓ haptoglobin) with **schistocytes** • **Thrombocytopenia** (↑ bleeding time, normal PT/PTT) Sometimes with: • Renal failure • Neurologic manifestations • Fever
Management	• **Plasma exchange** • Glucocorticoids • Rituximab

hematology Page 54 https://t.me/USMLEWorldStep2CK

Pathophysiology	• ↓ **ADAMTS13 level** → uncleaved vWF multimers → platelet trapping & activation • Acquired (autoantibody) or hereditary
Clinical features	• Hemolytic **anemia** (↑ LDH, ↓ haptoglobin) with **schistocytes** • **Thrombocytopenia** (↑ bleeding time, normal PT/PTT) Sometimes with: • Renal failure • Neurologic manifestations • Fever
Management	• **Plasma exchange** • Glucocorticoids • Rituximab



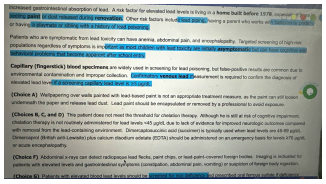
ITP is a diagnosis of exclusion; patients typically have a low platelet count with no other abnormalities

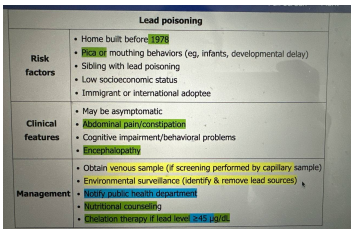
Empiric therapy [4]

- Prompt initiation of **plasma exchange therapy (PEX)**
- High-dose **glucocorticoids**
  - Prednisone
  - OR methylprednisolone
- Patients with a high pretest probability of TTP (based on clinical judgment)
  - Consider early caplacizumab.
  - Consider rituximab.

Others:

1. A child with his parent shifts to a grandmom house built in 1980, he eats a lot of junk foods, he is fatigue and many things explained, lab findings given what could be the cause- options- lead toxicity, eating habits





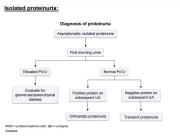
Ho lead toxicity might be distractor
Aru milne options huncha jasto lagyo malai
Estai qtn katai thyo but lead T was both the answer

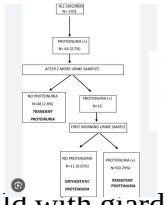
1978 samma ko lead natra aru herumla

2. ECG of Atrial fibrillation given along with pulse irregular, and patient is symptomatic, what could be the source of the ECG finding asked, options:
   Right atrial appendage
   Left atrial appendage
   Right ventricle
   Left ventricle

Flirting is always right . Flutter right
Fibrillation left

3. 1+ proteinuria in a child- ans orthostatic proteinuria





- **Transient proteinuria** is typically caused by fever, exercise, seizure, stress, or volume depletion and results from variations in glomerular blood flow. This condition usually resolves once the provoking factor is removed.
- Orthostatic proteinuria is most common in adolescent boys and presents with proteinuria when the patient is upright (ie, daytime) and absent urinary protein after a prolonged recumbent period (ie, morning).

Orthostatic proteinuria is diagnosed if the urinary protein excretion rate is normal for the nighttime collection (for children <4 mg/m2 per hour and for adults <50 mg over an eight-hour period) and the daytime collection exceeds the normal protein excretion rate.

Orthostatic proteinuria (postural proteinuria): increased protein excretion only in the upright position

4. 2yrs child with giardiasis what is the treatment?

Treatment of giardiasis

Drug	Dose	
	Adults	Children
Drugs of choice		
Tinidazole[a]	2 g orally, single dose[b]	Age ≥3 years: 50 mg/kg orally, single dose (maximum dose 2 g)
Nitazoxanide[c]	500 mg orally 2 times per day for 3 days	Age 1 to 3 years: 100 mg orally 2 times per day for 3 days Age 4 to 11 years: 200 mg orally 2 times per day for 3 days Age ≥12 years: Same as adult dose
Alternative agents		
Metronidazole[a]	500 mg orally twice daily OR 250 mg orally 3 times per day; duration 5 to 7 days[b]	15 mg/kg orally divided 3 times per day for 5 to 7 days (maximum 250 mg per dose)
Albendazole	400 mg orally once daily for 5 days	10 to 15 mg/kg orally once daily for 5 days (maximum 400 mg per dose)
Mebendazole	200 mg orally 3 times per day for 5 days	200 mg orally 3 times per day for 5 days
Paromomycin[b]	10 mg/kg orally 3 times per day for 5 to 10 days	10 mg/kg orally 3 times per day for 5 to 10 days
Furazolidone[a]	100 mg orally 4 times per day for 7 to 10 days	2 mg/kg orally 4 times per day for 7 to 10 days (maximum 100 mg per dose)
Quinacrine	100 mg orally 3 times per day for 5 days	2 mg/kg orally 3 times per day for 5 days (maximum 100 mg per dose)[d]

Giardia t/t
<1 yr = metronidazole
1-3 yrs = nitazoxanide
>3 yrs = tinidazole
Pregnancy = paramomycin

Metro-nita-zole

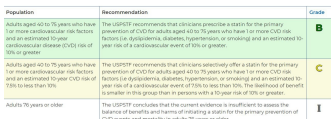
5. ASCVD 7, father MI at age 50yrs, LDH mildly raised, what lead you to prescribe statin?

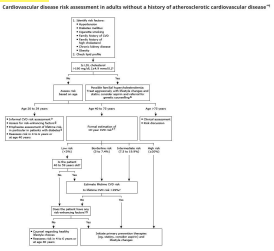
LDL more then 190 cha vannya stain gako hola

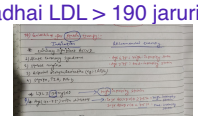
LDL more then 160 bhako bhaye dinu paryo

LDL > 190
ASCVD >= 7.5
age >= 40 with DM

LDL less than 190 but ASCVD More than 7.5 xa vane Statin dinu parxa
(sadhai LDL > 190 jaruri xaina) - Moderate dose statin







6. Atrial fibrillation, CHADVASC score 4(HTN, DM, 74 yrs,+ AF), what is NBS in management options- Aspirin, Rivaroxaban, Station, Enoxaparin

In patients with mild hypertriglyceridemia (ie, 150-500 mg/dL) who have known or are at high risk for atherosclerotic cardiovascular disease (ASCVD), initiation of a statin (eg, rosuvastatin, atorvastatin) is the recommended first-line pharmacologic therapy. Although moderate alcohol intake (no more than 2 drinks a day for men, 1 drink a day for women) may be associated with reduced cardiovascular mortality, heavy intake can significantly increase triglyceride levels

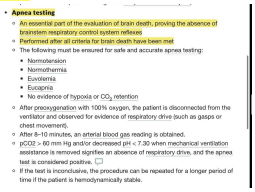
Fibrates (eg, gemfibrozil, fenofibrate) are the most effective pharmacologic therapy for reducing triglyceride levels and are recommended in patients with severe or sometimes **moderate hypertriglyceridemia (eg, 500-1000 mg/dL)**. Due to increased rates of adverse effects (eg, myopathy) and lack of proven cardiovascular benefit, the addition of a fibrate to a statin is rarely indicated.

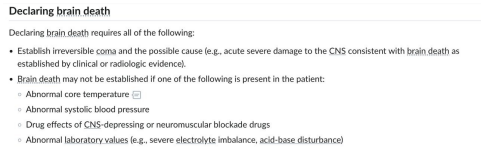
Fibrates and niacin reduce triglyceride levels but have not been shown to improve cardiovascular outcomes.

Estimated 10-year risk of ASCVD
It is generally based on an estimated future risk of cardiovascular events. Guidelines recommend using the Pooled Cohort Equations cardiovascular risk calculator, which takes into account **ethnicity, age, sex, total cholesterol, HDL, diabetes status, smoking status, and blood pressure**, to estimate the 10-year risk of ASCVD. Initiation of statin therapy is recommended in patients with an estimated 10-year risk of ASCVD of 5%-10% (guidelines vary on the specific cutoff).

7. Jelly fish sting in Hawaii, presence of tentacles, tentacles removed now what is NBS in management?

8. Temp- 36.5, BP > 100 mmHg, under phenylephrine, all test done, no narcotics detected in blood, no spontaneous respiration on disconnecting the ventilator, calori test and other tests done negative. NBS.. Declare death, Do other lab tests...

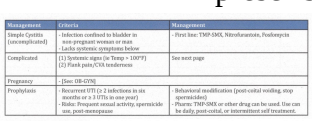




9. Polysomnography

10. Lower UTI explained, urine analysis also given, sulpha allergy, what t/t will you prescribe? TMP/ SMX, Nitrofurantoin, Fosfomycin, Ciprofloxacin..

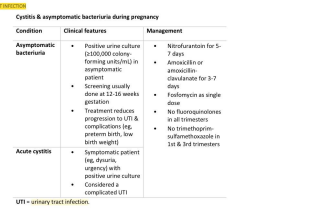
Nitrofurnatoin jam unless these features



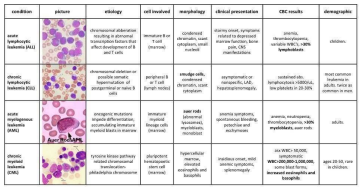
Nitro pregnancy ma pani milcha , just avoid close to delivery date

TMP smx avoid in 1st trim and after 32 weeks

-amboss



11. Basophil... % diagnosis. CML, CLL..



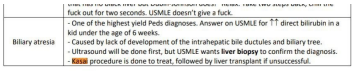
12. Membrane defect increase in unconjugated bilirubin diagnosis- G6PD

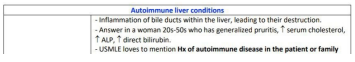
HS,G6pd

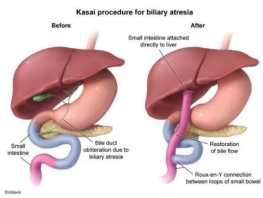
Memb defect haina ni
Oxidative injury ho G6PD Def ma

13. Neonate with incr vomiting, inc bilirubin, acholic stool, dark urine explained. What other findings will you see? Inc unconjugated bilirubin..

Inc Conjugated bili







14. Congestive heart failure, Arrow BNP, Renin, Aldosterone

All inc

15. Features of pulmonary embolism in a post op case 4 hrs after OT, ECG given ST elevation in lead II, III and avF diagnosis?.. MI

16. CRAB features explained diagnosis? Multiple myeloma

17. Child with urinary incontinence failed alarm therapy, NBS in managemnt? Imipramine, Desipramine ciprofloxacin, prednisolone

Desmopressin

@BED
B=behavior modification
E=enuresis alarm
D=Desmopressin

Secondary incontinence ma chai — check urine (dm) / psychosocial factors

<7 yr old enerusis alarm
>7 desmopressin

Primary nocturnal enuresis	
Definition	• Nighttime urinary incontinence age ≥5 • No prior prolonged period of overnight dryness
Pathogenesis	• Delayed maturation of bladder control • ↑ Nocturnal urine output (eg, ↑ evening fluids, ↓ ADH) • ↓ Bladder capacity
Risk factors	• Family history • Boys age 5-8
Evaluation	• Urinalysis (to exclude other causes) • Voiding diary
Management	• Treatment of comorbid conditions (eg, constipation) • Behavioral modifications (eg, restrict evening fluids) • Enuresis alarm • Desmopressin therapy

18. Female with features(lump in right upper outer quadrant of breast, firm, .. cm nodule) what is she likey to develop? Ductal carcinoma, intraductal papilloma, fibroadenoma

fibroadenoma- mobile hunchha

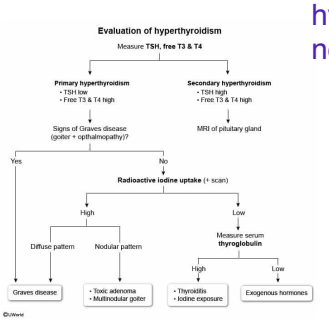
19. Female with red skin, O/E fluctuant mass on breast NBS? I and D, Dicloxacillin, Ciprofloxacin

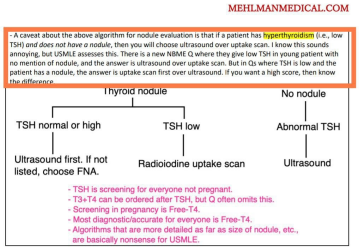
Mastitis vayera dicloxacillin desakyo but pachi Abscess formation vaisakyo so -> I & D

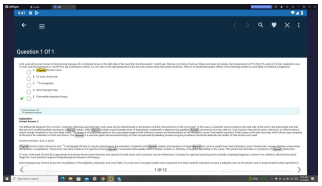
20. Thyroid nodule with dec TSH NBS? RAIU, USG, FNAC, Propylthoiuracil

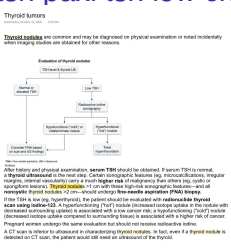
hyper ma no nodule - USG..... hyper ma nodule - RAIU

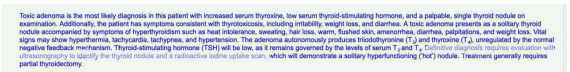
Usg ,tsh paxi tsh low cha vani raiu tira jani





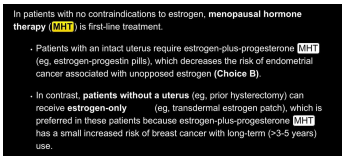






21. Teenage male right and left breast unequal, tanner stage I and 3 respectively no pain on examination, no nodule or discharge. NBS. USG, Karyotype, Serum prolactin, Reassurance

22. 65Y/F vaginal atrophy, dyspareunia, menopause at 52 yrs, hot flashes, hysterectomy done at .. yrs d/t..fibroid? NBS? MHT, Progesterone pills, OCPS, IUDs Menopausal hormonal therapy Estrogen ???



23. DMD case explained, NBS.. Aldolase Ck inc

24. Gower sign explained, muscle weakness, his other siblings normal, NBS in confirming the diagnosis? Muscle biopsy, genetic testing

25. Alcohol Use disorder t/t Naltrexone Acamprosate for maintainence

@ RN (Registered Nurse) will take you to LA (Los Angeles)

(R)enal impairment ma (N)altrexone dine

(L)iver impairment ma (A)camprostae dine

LIver c/i: naltrexone
renal c/i: acamprostate

alcohol+opiod: acamprostate
alcoho: naltrexone
Renal failure ma acamptosate contra

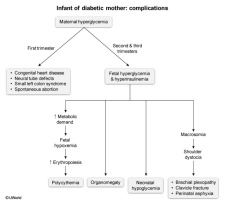
26. AAA size 3.9 what is NBS? F/U in 2-3 yrs, surgery, F/U in 5 yrs

Follow-up frequency for AAA surveillance [1]	
Maximum diameter of the abdominal aorta	Recommended follow-up interval
2.5–2.9 cm	• Repeat ultrasound after 10 years.
3–3.9 cm	• Ultrasound every 3 years
4–4.9 cm	• Ultrasound every 12 months
5.0–5.4 cm	• Ultrasound every 6 months

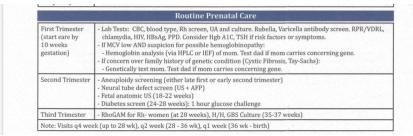
FEEDBACK

27. Cutaneous larva migrans T/t Albendazole (no Ivermectin in option)

28. Lady with Type I DM, pregnant, what will be the complications (Not clear in whom- fetus or mother), options; CHD, Preterm delivery, pre-eclampsia, Abruptio placentae



29. DM mother, pregnant now what will you check? HbA1c, Lipid profile...



Routine Prenatal Care	
First Trimester (start care by 10 weeks gestation)	- Lab Tests: CBC, blood type, Rh screen, UA and culture. Rubella, Varicella antibody screen. RPR/VDRL, chlamydia, HIV, HBsAg, PPD. Consider High A1C, TSH if risk factors or symptoms. - If MCV low AND suspicion for possible hemoglobinopathy: - Hemoglobin analysis (via HPLC or IEF) of mom. Test dad if mom carries concerning gene. - If concern over family history of genetic condition (Cystic Fibrosis, Tay-Sachs): - Genetically test mom. Test dad if mom carries concerning gene.
Second Trimester	- Aneuploidy screening (either late first or early second trimester) - Neural tube defect screen (US + AFP) - Fetal anatomic US (18-22 weeks) - Diabetes screen (24-28 weeks): 1 hour glucose challenge
Third Trimester	- RhoGAM for Rh- women (at 28 weeks), H/H, GBS Culture (35-37 weeks)
Note: Visits q4 week (up to 28 wk), q2 week (28 - 36 wk), q1 week (36 wk - birth)	

30. Child with splenectomy, what will you give? Penicillin

31. Newborn with NVD, around 10-15 lesions on mouth, uncle has also... what is he likely to develop. MEN II B

32. 3rd year resident is performing OT under the guidance of attending resident, 1st year resident is helping in holding the scalpel under ther guidance of 3rd year resident, 1st year resident injures ureter, OT extended to correct the injury. What is the error? Decision error, Surgeon error, Surgery error, Guidance error

33. Cross- sectional study (what study design will you use)

34. Tolerance, dependence,..? In case of opoid

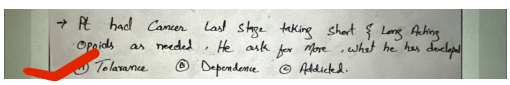


Table 1. Definition of terms commonly used in the literature relating to opioid dependence.

Term	Definition
Dependence	A diagnosed drug use disorder characterised by a pattern of maladaptive behaviours, such as loss of control over use, craving and preoccupation with non-therapeutic use, and continued use despite harm. [17]
Addiction	A commonly used term to describe a condition characterised by craving and continued use despite harm. [16] Sometimes not preferred due to associated stigma. [17]
Dependence syndrome	ICD-10 diagnostic term. Describes a cluster of physiological, behavioural and cognitive phenomena in which the use of a substance takes on a much higher priority for a given individual than other behaviours that once had greater value. [19]
Substance Use Disorder	DSM-V diagnosis to describe a mild to severe state of chronically relapsing, compulsive drug taking. [18]
Tolerance	The physical adaptation of the body such that more drug is required to reach desired effect. [16]
Physical dependence	Characterised by the presence of a withdrawal syndrome on abrupt cessation or rapid dose reduction of a drug. [16]
Misuse	Use of a drug in a way other than prescribed intentionally or unintentionally. [18]
Abuse	Misuse with medical, social or legal consequences. [18]

35. Zika virus – abstinence through out pregnancy

Male 3 month
Female 2 month

36. Patient under salbutamol what will happen- Hypermagnesemia, Hypokalemia, Hypercalcemia

B agonist hypokalemia
B antagonist hyperkalemia

37. Splenectomy done now 4 days, what vaccine will you give? Meningococcal (no pneumococcal, Hib vaccine) other diff vaccines given

Tt

Abrasion pani hunxa body ma vanya hunxa so tt

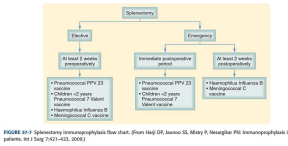
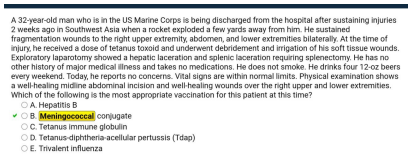


FIGURE 53-7 Splenectomy immunoprophylaxis flow chart. (From Hadi DP, Ikanoo SS, Mistry P, Nesargikar PN: Immunoprophylaxis in asplenic patients. Int J Surg 7:421–423, 2009.)

ppsv23 chai 8 weeks after PCV15

annual flu vaccine ni dina parcha hai splenectomy ma



A 32-year-old man who is in the US Marine Corps is being discharged from the hospital after sustaining injuries 2 weeks ago in Southwest Asia when a rocket exploded a few yards away from him. He sustained fragmentation wounds to the right upper extremity, abdomen, and lower extremities bilaterally. At the time of injury, he received a dose of tetanus toxoid and underwent debridement and irrigation of his soft tissue wounds. Exploratory laparotomy showed a hepatic laceration and splenic laceration requiring splenectomy. He has no other history of major medical illness and takes no medications. He does not smoke. He drinks four 12-oz beers every weekend. Today, he reports no concerns. Vital signs are within normal limits. Physical examination shows a well-healing midline abdominal incision and well-healing wounds over the right upper and lower extremities. Which of the following is the most appropriate vaccination for this patient at this time?

- A. Hepatitis B
- ✔ B. **Meningococcal** conjugate
- C. Tetanus immune globulin
- D. Tetanus-diphtheria-acellular pertussis (Tdap)
- E. Trivalent influenza

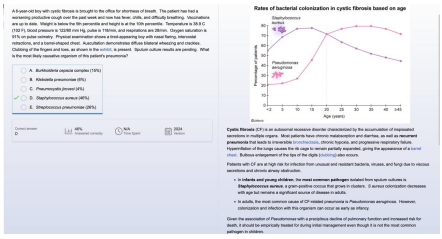
38. Facial nerve palsy

Prednisone dini first ma

39. Arrow of COPD- Lung complaince, lung elasticity, FEV1?

Idd

Vitamin E	Includes tocopherol, tocotrienol.	
FUNCTION	Antioxidant (protects RBCs and neuronal membranes from free radical damage).	
DEFICIENCY	Hemolytic anemia, acanthocytosis, muscle weakness, demyelination of posterior columns (↓ proprioception and vibration sensation) and spinocerebellar tract (ataxia). Closely mimics Friedreich ataxia.	Neurologic presentation may appear similar to vitamin B_{12} deficiency, but without megaloblastic anemia, hypersegmented neutrophils, or ↑ serum methylmalonic acid levels.
EXCESS	Risk of enterocolitis in enfants (infants) with excess of vitamin E.	High-dose supplementation may alter metabolism of vitamin K → enhanced anticoagulant effects of warfarin.



	Cystic fibrosis
Pathogenesis	• Mutation (ΔF508) of *CFTR* gene • Autosomal recessive
Clinical features	• Recurrent sinopulmonary infections (in almost all) • Intestinal obstruction (eg, meconium ileus) • Pancreatic insufficiency & diabetes • **Male infertility**
Diagnosis	• Elevated sweat chloride levels • *CFTR* mutation on genetic testing • Abnormal nasal potential difference
Management	• Nutritional support • Airway clearance • **Antibiotic coverage** (*Staphylococcus aureus, Pseudomonas aeruginosa*)

CF should be considered in a patient with failure to thrive and **recurrent respiratory symptoms** (eg, frequent coughing episodes, cough with bilateral rhonchi), **regardless of screening results.**

Classic CFTR gene mutations are identified on newborn screening and typically cause respiratory symptoms and failure to thrive in infancy and early childhood. However, **milder variants** due to less common mutations may not appear on universal screening and generally have **atypical presentations** in **adulthood**. **Infertility** may be the only feature of atypical CF, and a male patient with congenital absence of the bilateral vas deferens should have **sweat chloride and CFTR gene sequencing to confirm the diagnosis.**

mh Page 9

Up to one-third have **nasal polyps**; management includes intranasal glucocorticoids (for symptomatic relief) and, in some cases, surgical resection. In addition to the respiratory features, pancreatic insufficiency leads to malabsorption, resulting in **poor growth** and deficiency of the **fat-soluble vitamins** A, D, E, and K (eg, epistaxis).

Staphylococcus aureus is the most common cause of bacterial pneumonia in **young children** with cystic fibrosis, especially in those with coexisting influenza infection. For patients with severe pneumonia, frequent hospitalizations, or recurrent skin infections, **intravenous vancomycin** should be included for empiric therapy against **methicillin-resistant S aureus.**
Cefepime, a fourth-generation cephalosporin, provides coverage for both methicillin-sensitive *S aureus (MSSA) and Pseudomonas aeruginosa.*
Azithromycin is not used in acute CF exacerbations, but **chronic** maintenance therapy with azithromycin in patients with CF has been shown to slow lung function decline.

1. Young guy with cystic fibrosis. Is unable to perform rapid alternating movements of his hands. Labs show:
   Hb: 10
   MCV: 90
   RDW: was slightly above the upper limit they gave cant remember exact value
   Asked which vitamin was deficient = Iron, Vit E, B12, and a couple others.

	Transverse myelitis	Guillain-Barré syndrome
Motor	• Early flaccid, late spastic paralysis • If quadriplegia, weakness in LE = UE	• Ascending paralysis • Weakness in LE > UE in early disease
Sensory	• Clearly identifiable sensory level	• Mild sensory loss • No spinal cord level
Autonomic	• Bowel & bladder dysfunction	• Cardiovascular instability
Cranial nerves	• None	• Oculomotor, glossopharyngeal, or facial paralysis
Electromyography/nerve conduction velocity	• Mostly normal	• Peripheral motor &/or sensory NCV reduced
MRI	• Focal enhanced area of T2 signal	• Normal • Enhancement of anterior nerve roots or cauda equina
Cerebrospinal fluid	• Pleocytosis ± Increased IgG index	• Absence of pleocytosis • Elevated protein

LE = lower extremity; **NCV** = nerve conduction velocity; **UE** = upper extremity.

2. Man presents with lower limb weakness and numbness. Gives history of URTI 4 weeks ago. O/E has classic transverse myelitis picture of low reflexes, weakness, loss of sensation to umbilicus level. Asked next step in diagnosis.
   Options included both MRI and lumbar puncture. I went with MRI

Idiopathic transverse myelitis	
Pathophysiology	• Immune-mediated destruction of spinal cord • Often postinfectious (molecular mimicry)
Clinical features	• Bilateral motor weakness, classically early flaccid (LMN) progressing to late spastic (UMN) • Bilateral sensory dysfunction (all somatosensory systems) • Distinct sensory level • Autonomic dysfunction (bowel &/or bladder)
Diagnosis	• MRI of spine: no compressive lesion, T2 hyperintensity • Lumbar puncture: ↑ WBCs, ↑ IgG index
Treatment	• High-dose intravenous glucocorticoids • Plasmapheresis

LMN = lower motor neuron; **UMN** = upper motor neuron; **WBCs** = white blood cells.

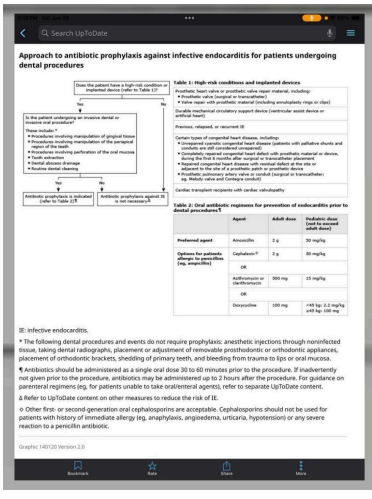
3. Woman gets a hysterectomy for some reason I can't remember, but it wasn't any malignant/cancer type reason. Afterwards histology shows endometrial hyperplasia with atypia. Asked next step in her management
   a. Follow with TVUS in 1 year
   b. No intervention needed
   c. Cant remember the rest rip sorry

Treatment of endometrial hyperplasia based on histology

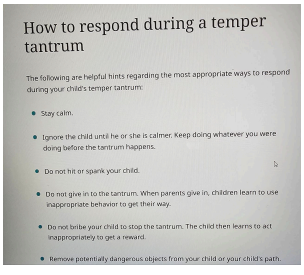
	Premenopausal women	Postmenopausal women
Endometrial hyperplasia without atypia	• Progestin therapy: cyclic progestin administration from the 12th to the 25th day of the menstrual cycle • In women with PCOS: administration of hormonal contraceptive	• Progestin therapy
	• All patients receiving progestin therapy should undergo: ◦ Ultrasonographic follow-up after 3–6 months ◦ Hysteroscopy with biopsy in the case of suspicious findings on ultrasound • Just regular surveillance without progestin therapy is indicated if progestin therapy is: ◦ Contraindicated (e.g., hormone-responsive cancer, progestin-receptor positive breast cancer) ◦ Not tolerated or declined by the patient	
Endometrial hyperplasia with atypia	• In women with completed childbearing or no future wish to conceive: total abdominal hysterectomy with or without bilateral salpingo-oophorectomy [C] • In women with a wish to conceive: progestin therapy and close surveillance with regular endometrial sampling	• Total abdominal hysterectomy with bilateral salpingo-oophorectomy

4. 2 heart murmur questions
   a. First one was a downs syndrome kid, about 7 years old I think. Audio was holosystolic, I think loudest at mitral and tricuspid area, so I thought VSD. Question asked next step in his evaluation.
      i. Echo
      ii. No tests needed
      iii. Some random blood tests
   b. Next was a young man coming for dental procedure. Question asked about which antibiotic to give for prophylaxis. Murmur sounded like MR to me so I picked no prophylaxis needed.

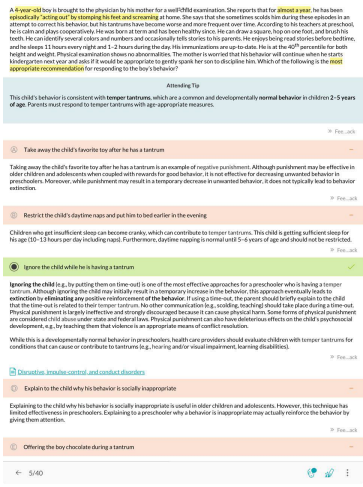
Mitral valve disease, usually mitral valve prolapse with coexisting **mitral regurgitation**, is the most common valvular abnormality detected in patients with infective endocarditis. Pulmonary stenosis is not associated with IE.
Antibiotic prophylaxis to prevent endocarditis is indicated prior to dental procedures in patients with high-risk cardiac conditions (eg, **prosthetic heart valve**).
Overall, the risk of IE following dental procedures in patients with acquired valvular defects due to rheumatic fever is low, and antibiotic prophylaxis is not indicated. However, prophylaxis is indicated in patients with a **history of IE.**



5. Mom with complain of her kid throwing tantrums in the store when she doesn't buy him what she wants. She tries to ignore but ends up giving in because the kids an annoying little shit. You advise her to continue ignoring. Question asked what is the likely outcome of the kids tantrums if she ignores them?



Δ: temper tantrums



a. Gradually decrease
b. Initially get worse
c. Stay the same
d. Continue to get worse

6. Old dementia man. Nonverbal. Lives on his own. Neighbors help with chores and daughter comes around to help with finances. Come to clinic where man looks kinda okay I think but I remember they mentioned his lips were chapped or something. Daughter asks you to write in paper that considering her dad is non verbal, that she can sell his house and take all the money and what not. What should you do?
   a. Call the police
   b. Report to APS
   c. Agree with the daughters request
   d. Get a court appointed guardian
7. Another old 72 year dementia man, lives with his wife. Wife complains he has trouble falling asleep and when he does, he wakes up in the night and paces the entire house, and doesn't know what time of day it is. He's able to nap easily in the day. What do you recommend?
   a. A strict schedule of activities and exercise in the day and sleep at night to fix his sleep habits
   b. Advise the wife to make safe arrangements in the house considering he can get hurt walking around at night
   c. Cant remember the rest of the options soz

Δ: sleep walking

8. Question about an older lady whose a retired nurse and she looks after her dementia husband. Does all the chores and care for him, giving him baths, changing his catheters etc. She complains of increase fatigue and difficulty with sleep. Also says she doesn't enjoy hanging out any more with her friends/ doesn't enjoy her usual activities. O/E everything is fine, her affect is kinda flat. Labs all normal.
   a. Caregiver stress
   b. MDD
   c. Some other psych diagnoses that didn't fit at all

9. Ethics case of 2 patients with exact same name, same date of birth, same gender. Nurse A appointed to patient A, Nurse B to the other. Nurse B takes wrong IV medication bag from the pharmacy after verifying name and DOB. Patient says bruh this don't look like the usual medication drip I get. Nurse B comes running saying yo you took my patients medication wth. What can be changed to prevent

this next time.

a. Cant remember the options, but the best one was about using the medical record number or something like that on the patients arm band to verify (Also barcode can be used)

10. Stats and QI questions that I can recall were
    a. Committee at a medical school take a bunch of kids with super poor clinical performance and designed a special training program for them where they would do clinical examinations under supervision, get scored, get feedback and what not. Analysis shows a significant improvement in their performance after the training program so they decide to adopt the program for all the medical students. But when they run the analysis on this new group of kids, results weren't significant. Why is that?
        i. Lack of power
        ii. Lack of generalizability
        iii. Cant remember da rest, but they didn't make sense at all

	Internal validity	External validity
Characteristics	Describes **causality** (ie, if change in independent variable causes change in dependent variable)	Describes **generalizability** (ie, if observed relationship applies to situations or people outside study)
	↑ As study becomes **more tightly controlled**	↓ As study becomes more tightly controlled
	↓ As study becomes more like the real world	↑ As study becomes **more like the real world**
Threats to validity	Bias due to: • Confounding • History • Maturation • Measurement • Regression toward the mean • Repeated testing • Selection	Bias due to: • Artificial research environment • Measurement effects • Nonrepresentative sample

    b. QI question on some hospital director asking for there to be a record on the time it takes for every step when a patient with sepsis presents to the ER. He wanted all the time metrics up till when the patient would get the first serum lactate level measured. Whats he trying to optimize? Timeline > efficiency
        i. Efficiency
        ii. Efficacy
        iii. Equity/ Justice something like that

Keywords: Efficacy, Effectiveness, Efficiency, Health management

ABSTRACT

Efficacy, Effectiveness, and Efficiency are widely used term in health care management. Efficacy means getting things done (is it working?), effectiveness means doing the proper things (is it actually working well?), and efficiency means doing things right (is it working within the most economical way?). It's helpful to consider them during this particular order. First, confirm the answer can actually achieve the specified result, albeit that efficacy requires very specific conditions. Then, test your solution during a real-world environment. Finally, if the answer is effective, find out ways to form it more economical more efficient. This article describes the meaning and usage of these three terminologies in context of health care setup.

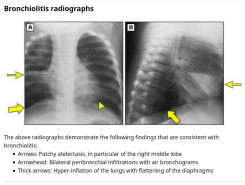
Dimensions of health care quality	
Dimension	**Description**
Safety	• Minimizes preventable errors • Avoids harms from care
Effectiveness	• Adheres to scientific guidelines evidence • Avoids undertreatment & overtreatment
Patient-centeredness	• Identifies patient values, goals & preferences • Tailors care delivery to expressed patient values
Timeliness	• Avoids delays in care, reduces wait times
Efficiency	• Avoids wasting or overusing resources
Equity	• Provides quality care to all individuals regardless of demographic attributes (eg, ethnicity, age, gender)

    c. Patient gets a new insurance type thing that takes a super high deductible. Your patient is dirt poor and cant afford to pay the deductible for the medications she needs. What can you do to help?
        i. Prescribe only the generic brands
        ii. Arrange for a social worker to help her figure out her options

11. Picture of what I think was Basal cell cancer. Asked next step in management.
    a. Excision of entire lesion along with clear skin margins
    b. Shave biopsy
        i. I got super confused because they didn't say excisional *biopsy* lol I thought they were implying just remove the whole thing and I picked shave biopsy. Probably incorrect in hindsight

→ explore CVA choose accordingly

12. 3-4 year old child with respiratory distress, low saturations. Theres expiratory wheezing, costal retractions and what not. You start giving him some O2. CXR shows peribronchial cuffing. (basically bronchiolitis but a tad severe). Asked next step in management.
    a. Listed a bunch of antibiotics and one option to just observe so I went with that



The above radiographs demonstrate the following findings that are consistent with bronchiolitis:
- Arrows: Patchy atelectasis, in particular of the right middle lobe
- Arrowhead: Bilateral peribronchial infiltrations with air bronchograms
- Thick arrows: Hyper-inflation of the lungs with flattening of the diaphragms

Bronchiolitis	
Epidemiology	• Age <2 years • RSV most common cause
Clinical presentation	• Antecedent nasal congestion/discharge & cough • Wheezing/crackles & respiratory distress (eg, tachypnea, retractions, nasal flaring)
Treatment	• Supportive care
Complications	• Apnea (especially age <2 months) • Respiratory failure
Prevention	Palivizumab for selected infants: • <29 weeks gestation • Chronic lung disease of prematurity • Hemodynamically significant congenital heart disease

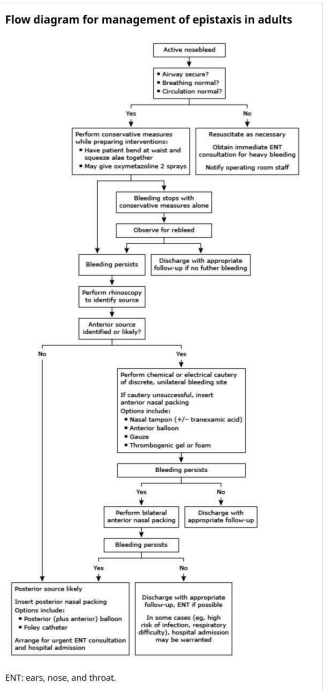
RSV = respiratory syncytial virus.

13. First trimester pregnant woman comes with complain of bleeding since she had sex with her husband. I think she was under the age of 30. She had her last pap smear 6 months ago which was normal. Examination showed a friable cervix with a giant ectropion which was bleeding. Asked next step in management.
    a. Get colposcopy and biopsy
    b. Cone biopsy
    c. Leave it alone
    d. Test for STIs

Ectropion does not need to be treated except in the rare occurrence of excessive mucous discharge or spotting that is very bothersome to the patient. In such cases, malignancy should be excluded before undertaking any treatment.

Since cases that require treatment are rare, there is no evidence to guide choice of treatment. In our experience, a two-week trial of an acidifying agent, such as boric acid suppositories 600 mg vaginally at bedtime for two weeks, may be effective. Another option is an ablative procedure using cryosurgery or electrosurgery, but this is invasive and will result in copious vaginal discharge until healing is completed, which may take weeks. Ablative treatment can also result in cervical stenosis, which can adversely affect future fertility and, if pregnancy is achieved, labor and delivery.

14. Woman just delivered baby. Comes with complain of red swelling on her right breast. They gave a picture too. Mentioned that she had fevers and that it was fluctuant so I thought abscess tha.
    a. Start antibiotics
    b. I&D
    c. Some other dumb options



ENT: ears, nose, and throat.

15. Woman comes to ER with complain of persistent nosebleeding. Past history unremarkable. ER people pack it but its still bleeding constantly. O/E they cant identify the bleeding point. Theres blood in the posterior pharynx too and theres blood dripping out the front. Vitally stable, Hb was 10.8 ish I think. NSIM?
    a. Endoscopic cautery
    b. Silver nitrate stick
    c. Angioembolise
    d. Pack it some more (posterior nasal packing)

Management of ongoing bleeding [7][8][9]
- For anterior epistaxis with the bleeding site identified, consider:
  - Topical vasoconstrictors (e.g., oxymetazoline, phenylephrine)
  - Nasal cautery
- If bleeding persists or the bleeding site cannot be identified, place nasal packing.
- For refractory or recurrent bleeding, consider arterial embolization or endoscopic ligation of the bleeding vessel, i.e.:
  - Anterior ethmoidal artery for anterior epistaxis
  - Sphenopalatine artery for posterior epistaxis

In rare cases, retained nasal packing can cause toxic shock syndrome. [11]

16. HOPI of old lady with complain of lots of vomiting for the past day. Mentioned she's been having symptoms of bloating and abdominal pain since 5 days. 1 week of loss of apetite. Didn't mention anything about constipation sadly. She had a history of gastric bypass surgery like 15 years ago. She was vitally stable, O/E was classic bowel obstruction type with decreased sounds, distended, tympanic sounds etc. Question asked what would you most likely see on abdominal xray.
    a. Dilated small bowel loops with air fluid levels
    b. A loop of dilated colon with no air rectum

Small bowel obstruction	
Clinical presentation	• Colicky abdominal pain, vomiting • Inability to pass flatus or stool • Hyperactive bowel sounds • Distended & tympanic abdomen
Diagnosis	• Dilated loops of bowel with air-fluid levels • Partial: Air in colon • Complete: Transition point (abrupt cutoff), no air in colon
Complications	• Ischemia/necrosis (strangulation) • Bowel perforation
Management	• Bowel rest, nasogastric tube suction, intravenous fluids • Surgical exploration for signs of complications

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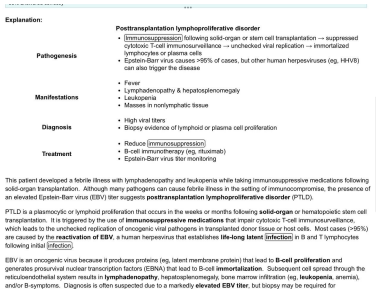
	Acute colonic pseudoobstruction (Ogilvie syndrome)
Etiologies	• Major surgery, traumatic injury, severe infection • Electrolyte derangement (↓ K, ↓ Mg, ↓ Ca) • Medications (eg, opiates, anticholinergics) • Neurologic disorders (eg, dementia, stroke, MS, parkinson)
Clinical findings	• Abdominal distension, pain, obstipation, vomiting • Tympanic to percussion, ↓ bowel sounds • If perforation: guarding, rigidity, rebound tenderness
Imaging	• X-ray: **colonic dilation**, normal haustra, **nondilated small bowel** • CT scan: colonic dilation without anatomic obstruction
Management	• NPO, nasogastric/**rectal tube decompression** • **Neostigmine** if no improvement within 48 hour or if the cecal diameter on imaging exceeds 12 cm (which is a strong predictor of impending perforation).

c. Normal nonspecific gas pattern
d. Free air under diaphragm
    i. Now I was sooo confused because, lots of vomiting is SBO, but such a slow onset of symptoms is LBO/volvulus. Cant even remember what I ended up picking last minute rip.

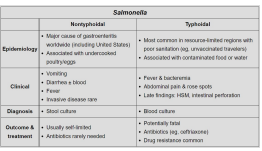
17. Patient comes to ER with same bowel obstruction complaints. There was an abdominal xray picture of what looked like SBO to me. O/E no peritonitis or anything like that, wahi BO signs. NSIM?
    a. CT with *rectal* contrast
    b. NG decompression

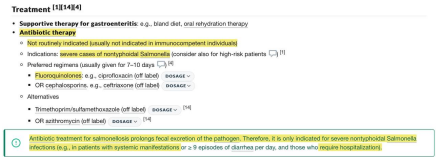
18. Some dude had a kidney transplant and was on immunosuppressants. Which of the following is he at greatest risk of infection from due to reactivation of a virus?
    a. EBV
    b. HHV-8
    c. JC virus

cmv > BK > EBV



19. Little baby with complain diarrhea. Mention that she had no complain of blood stool or abdominal pain. Vital signs were stable except for a fever of 100.4. O/E she had mild diffuse tenderness of the abdomen. Stool cultures grew *Salmonella* species. Next step?
    a. Start antibiotics
    b. Just observe





20. Some dude with cancer. Had discussions with his oncologist about chemotherapy. He comes to you (his GP) and he tells you he doesn't wanna try chemo and instead plans to jump a plane to some place to get some pseudo herbal garbage to cure his cancer. What do you do?
    a. Assess his decision making capacity
    b. Respect his autonomy and let him go eat plants to fix his cancer
    c. Call his oncologist and discuss the chemo options

?a

21. This docs wife just died 3 days ago. He comes to the office with his kids with him. His colleagues notice him making a bunch of mistakes. What should they do?
    a. Report him to state medical board
    b. Talk to him about his poor performance and that he should get some grief counseling
        i. Sadly there was no option of physician health program

22. 20 ish some girl comes with complain of epigastric pain

since 3 days. She has a lot of headaches and she takes a bunch of ibuprofen for it. Shes tried antacids and it hasn't worked. O/E theres tenderness in epigastric region. Next step? already mentioned in CV apparently. So, NBS ⇒ H.pylori related Inx ??

a. EGD

b. Switch ibuprofen to acetaminophen — If no alarming features, go c̄ PPI

c. Start triple therapy → (if Δ is MALToma)

23. The linked wala question set where first question was about some 30 year old guy who was having SOB and chest tightness everytime he would go on the elipitical at his gym. This started ever since he joined the gym for a new fitness program. He has a history of coughing with exposure to cold air, and he sometimes wakes up night coughing. Next best step?

i. Get a stress ECG

ii. Get PFTs

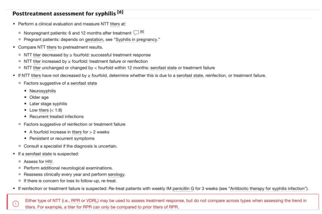
iii. Get a CXR

iv. Stress echo I think

b. Answer was PFT because the next question showed PFT results. FEV1 and FVC were about 80 or 85%, TLC FRC were like 98 or 99%. Next step in management?

i. Start him on albuterol before exercise

ii. And a bunch of options related to cardio issues



24. Man with syphilis chancre. Has a RPR titre of 1:16. If you start treatment, what will the lab results look like when you repeat them in 4 months? Ans → ? RPR 1:4 & FTA-Abs +ve

A fourfold decline in the nontreponemal titer, equivalent to a change of two dilutions (eg, from 1:32 to 1:8 or from 1:16 to 1:4), is considered an adequate serologic response.

a. RPR 1:32 FTABS +ve

b. RPR 1:1024 FTABS +ve

c. RPR –ve FTABS +ve

d. Some options with FTABS negative

	Syphilis: diagnostic serology
Nontreponemal (RPR, VDRL)	• Antibody to cardiolipin-cholesterol-lecithin antigen • Quantitative (titers) • **Possible negative result in early infection** • Decrease in titers confirms treatment • Non specific
Treponemal (FTA-ABS, TP-EIA)	• Antibody to treponemal antigens • Qualitative (reactive/nonreactive) • Greater sensitivity in early infection • Positive even after treatment

	RPR	RPR titer	TPHA
Active infection	+	>1:8	+
Latent syphilis	+	Often <1:4	+
False positive	+	Usually <1:4	–
Successful treatment	+ or –	2 titers decrease (e.g., from 1:16 to 1:4)	+

25. Dude currently has pneumonia with neiserria. Previously has had meningoccal meningitis. Asked what to test for the underlying cause. I picked Haemolytic Complement Activity Δ: Terminal complement deficiency (C5 - C9)

26. This 20 something woman who kept having sinopulmonary infections like pneumonia, sinusitis etc in the past couple of years. Has an ANA titre of 1:160. What should you test next? Δ: ? CVID

titre > 1:80 ⇒ autoimmune explore full CV

a. Anti Ds DNA

b. Anti smith

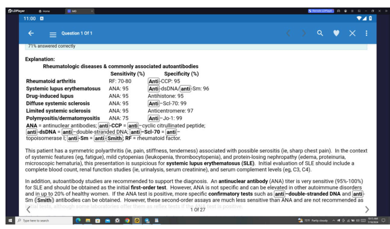
c. Immunoglobulin levels

Common variable immunodeficiency	
Pathophysiology	• Abnormal differentiation of B cells into plasma cells → decreased immunoglobulin production

Clinical manifestations	• Symptom onset classically age 20-40, as early as puberty
	• Recurrent respiratory infections (eg, pneumonia, sinusitis, otitis)
	• Recurrent GI infections (eg, *Salmonella, Campylobacter, Giardia*)
	• Chronic disease:
	  ◦ Autoimmune (eg, RA, thyroid disease)
	  ◦ Pulmonary (eg, bronchiectasis, fibrosis)
	  ◦ GI (eg, chronic diarrhea, IBD-like conditions)

Diagnosis	• ↓↓ IgG, ↓ IgA/IgM • No response to vaccination
Management	• Immunoglobulin replacement therapy

GI = gastrointestinal; **IBD** = inflammatory bowel disease; **RA** = rheumatoid arthritis.

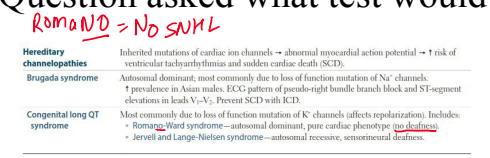


27. Blunt trauma case on a young man. They gave an xray KUB with contrast and asked what was injured. It looked

like the contrast was leaking out of the side of the bladder, so I chose bladder rupture. Options had everything from urethral injury, ureteral injury, kidney injury etc.

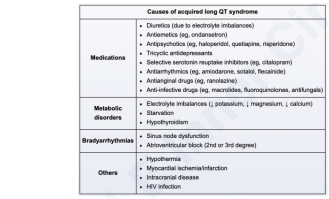
28. 17 something girl comes in for check up before joining some sports team. Her heart rate I remember was around 52 bpm. Her brother had an implantable defibrillator places for long QT syndrome. Question asked what test would you advise for the girl?
    a. ECG
    b. Echo
    c. No tests shes good to go
    d. Some other dumb options

RomaND = No SNHL

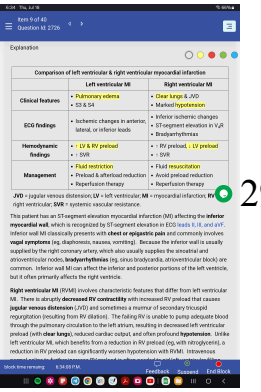


Hereditary channelopathies	Inherited mutations of cardiac ion channels → abnormal myocardial action potential → ↑ risk of ventricular tachyarrhythmias and sudden cardiac death (SCD).
Brugada syndrome	Autosomal dominant; most commonly due to loss of function mutation of Na^+ channels. ↑ prevalence in Asian males. ECG pattern of pseudo-right bundle branch block and ST-segment elevations in leads V_1–V_2. Prevent SCD with ICD.
Congenital long QT syndrome	Most commonly due to loss of function mutation of K^+ channels (affects repolarization). Includes: • Romano-Ward syndrome—autosomal dominant, pure cardiac phenotype (no deafness). • Jervell and Lange-Nielsen syndrome—autosomal recessive, sensorineural deafness.

Patients with **congenital long QT syndrome** are at risk for polymorphic ventricular tachycardia that leads to syncope or sudden cardiac death, especially during periods of rapid heart rate and high sympathetic activity (exercise).
Beta blockers especially nonselective (eg, propranolol, nadolol) dampen sympathetic activity and shorten the QT interval at high heart rates to reduce the risk of these complications. **Implantable cardioverter-defibrillator** placement or left cardiac sympathetic denervation are also appropriate in some high-risk patients.



Causes of acquired long QT syndrome	
Medications	• Diuretics (due to electrolyte imbalances) • Antiarrhetics (eg, ondansetron) • Antipsychotics (eg, haloperidol, quetiapine, risperidone) • Tricyclic antidepressants • Selective serotonin reuptake inhibitors (eg, citalopram) • Antiarrhythmics (eg, amiodarone, sotalol, flecainide) • Antianginal drugs (eg, ranolazine) • Anti-infective drugs (eg, macrolides, fluoroquinolones, antifungals)
Metabolic disorders	• Electrolyte imbalances (↓ potassium, ↓ magnesium, ↓ calcium) • Starvation • Hypothyroidism
Bradyarrhythmias	• Sinus node dysfunction • Atrioventricular block (2nd or 3rd degree)
Others	• Hypothermia • Myocardial ischemia/infarction • Intracranial disease • HIV infection
Inherited	• Jervell & Lange-Nielsen syndrome (autosomal recessive) • Romano-Ward syndrome (autosomal dominant)



Comparison of left ventricular & right ventricular myocardial infarction

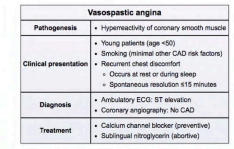
	Left ventricular MI	Right ventricular MI
Clinical features	• Pulmonary edema • S3 & S4	• Clear lungs & JVD • Marked hypotension
ECG findings	• Ischemic changes in anterior, lateral, or inferior leads	• Inferior ischemic changes • ST-segment elevation in V_4R • Bradyarrhythmias
Hemodynamic findings	• ↓ LV & RV preload • ↑ SVR	• ↑ RV preload, ↓ LV preload • ↓ SVR
Management	• Fluid restriction • Preload & afterload reduction • Reperfusion therapy	• Fluid resuscitation • Avoid preload reduction • Reperfusion therapy

JVD = jugular venous distension; LV = left ventricular; MI = myocardial infarction; RV = right ventricular; SVR = systemic vascular resistance.

This patient has an ST-segment elevation myocardial infarction (MI) affecting the **inferior myocardial wall**, which is recognized by ST-segment elevation in ECG leads II, III, and aVF. Inferior wall MI classically presents with **chest or epigastric pain** and commonly involves **vagal symptoms** (eg, diaphoresis, nausea, vomiting). Because the inferior wall is usually supplied by the right coronary artery, which also usually supplies the sinoatrial and atrioventricular nodes, **bradyarrhythmias** (eg, sinus bradycardia, atrioventricular block) are common. Inferior wall MI can affect the inferior and posterior portions of the left ventricle, but it often primarily affects the right ventricle.

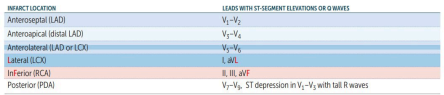
Right ventricular MI (RVMI) involves characteristic features that differ from left ventricular MI. There is abruptly **decreased RV contractility** with increased RV preload that causes **jugular venous distension** (JVD) and sometimes a murmur of secondary tricuspid regurgitation (resulting from RV dilation). The failing RV is unable to pump adequate blood through the pulmonary circulation to the left atrium, resulting in decreased left ventricular preload (with **clear lungs**), reduced cardiac output, and often profound **hypotension**. Unlike left ventricular MI, which benefits from a reduction in RV preload (eg, with nitroglycerin), a reduction in RV preload can significantly worsen hypotension with RVMI. Intravenous

29. Middle aged woman presenting to ER with chest pain, tightness, sweating etc. They do an ECG and it shows ST elevations in leads II, III, avF. They load her up on the aspirin and what not and do a repeat ecg a little while later, which they gave as a picture. From what I could tell, she no longer had elevations in II,III, avf but there were elevations in V2, V3. Question asked her diagnosis.
    a. Right sided MI
    b. Variant angina (but explore full CV)
    c. And some other options I cant remember rip



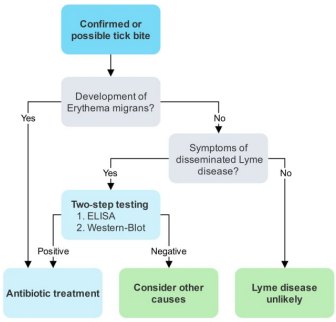
Vasospastic angina	
Pathogenesis	• Hyperreactivity of coronary smooth muscle
Clinical presentation	• Young patients (age <50) • Smoking (minimal other CAD risk factors) • Recurrent chest discomfort ◦ Occurs at rest or during sleep ◦ Spontaneous resolution ≤15 minutes
Diagnosis	• Ambulatory ECG: ST elevation • Coronary angiography: No CAD
Treatment	• Calcium channel blocker (preventive) • Sublingual nitroglycerin (abortive)

Patients with **congenital long QT syndrome** are at risk for polymorphic ventricular tachycardia that leads to syncope or sudden cardiac death, especially during periods of rapid heart rate and high sympathetic activity (exercise).
Beta blockers especially nonselective (eg, propranolol, nadolol) dampen sympathetic activity and shorten the QT interval at high heart rates to reduce the risk of these complications. **Implantable cardioverter-defibrillator** placement or left cardiac sympathetic denervation are also appropriate in some high-risk patients.

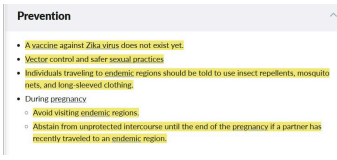


INFARCT LOCATION	LEADS WITH ST-SEGMENT ELEVATIONS OR Q WAVES
Anteroseptal (LAD)	V_1–V_2
Anteroapical (distal LAD)	V_3–V_4
Anterolateral (LAD or LCX)	V_2–V_6
Lateral (LCX)	I, aVL
Inferior (RCA)	II, III, aVF
Posterior (PDA)	V_7–V_9; ST depression in V_1–V_3 with tall R waves

30. Dude presents with complain of mass in his elbow area and they gave a picture. Looked like a lipoma to me so I picked that option. (Δ: ? olecranon bursitis CCV herera jaane)
31. Kid presents with history of fevers, arthralgias, large macular rash since 6 weeks, and a 2 week history of pain in his knee. Gives history of going camping 6 weeks ago.
    a. Options had borrelia, scarlet fever, rickettsia
    b. I went with borrelia because the *large* macular rash sounded like erythema migrans to me



32. Pregnant wife who wants to travel with her husband to Africa. Question says that she is advised not to travel due to zika outbreak there. Her husband is still going to go. What else would you advise her in addition to this?
    a. Avoid intercourse with her husband for 4 weeks when he gets back (men 3 months, female 2 months)
    b. Use condoms throughout her pregnancy (went with this)



Prevention

- A vaccine against Zika virus does not exist yet.
- Vector control and safer sexual practices
- Individuals traveling to endemic regions should be told to use insect repellents, mosquito nets, and long-sleeved clothing.
- During pregnancy
  - Avoid visiting endemic regions.
  - Abstain from unprotected intercourse until the end of the pregnancy if a partner has recently traveled to an endemic region.

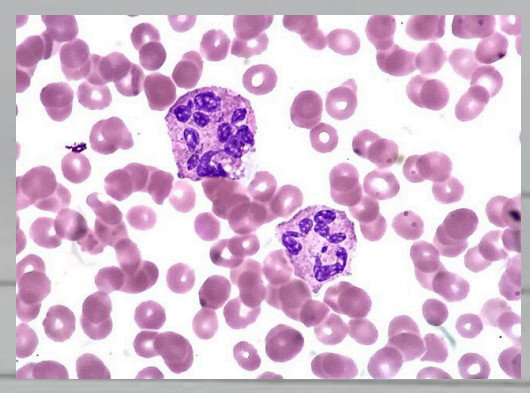
33. 90 ish year old lady comes in for a general health check up. Questions mentions that she had her last mammo in her

70s, her last colonoscopy about 7ish years ago. What screening test would you advise at this visit?

a. Mammo
b. Colonoscopy
c. DEXA
d. No testing required

23/05/2024

1) Hypersegmented neutrophils pic → folic acid + Vit. B12



Anaemia

Ans: Folic acid def.

2) Question on some vitamin toxicity, was taking double dose.

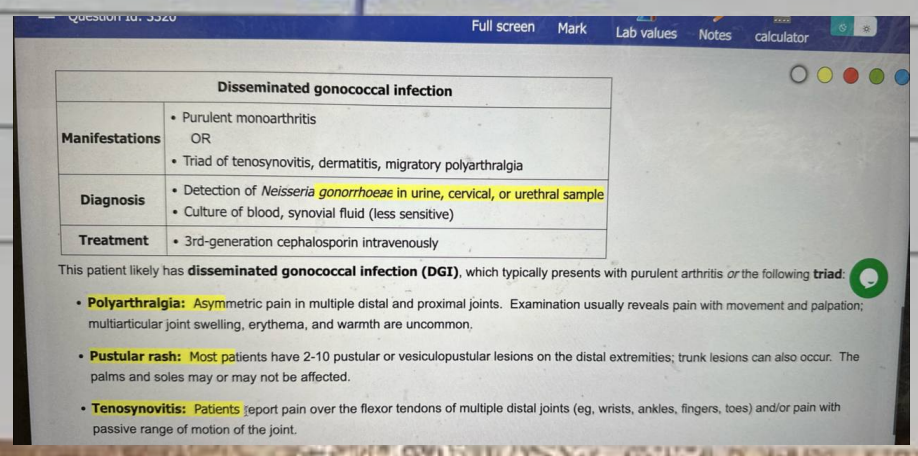
3) Chest CT picture, some lesions B/L, Sweat chloride test was -ve.
(explore full CV)

4) Sym of down Syndrome - asked for Dx.

5) Sym of DiGeorge Syndrome - asked about gene deletion.
Ans: 22q11 deletion

6) Sym of ~~Kawasaki disease~~ [redacted], asked about Rx:
a) IVIG + low dose aspirin
✓b) IVIG + High dose aspirin
c) IVIG + Something aspirin
2 other irrelavant options.

7) Sexually active young adult, pneumonia Sym, nasal bleed.
a) disseminated gonococcal inf.
other non-infectious options.



Disseminated gonococcal infection	
Manifestations	• Purulent monoarthritis OR • Triad of tenosynovitis, dermatitis, migratory polyarthralgia
Diagnosis	• Detection of *Neisseria gonorrhoeae* in urine, cervical, or urethral sample • Culture of blood, synovial fluid (less sensitive)
Treatment	• 3rd-generation cephalosporin intravenously

This patient likely has **disseminated gonococcal infection (DGI)**, which typically presents with purulent arthritis *or* the following **triad**:

- **Polyarthralgia:** Asymmetric pain in multiple distal and proximal joints. Examination usually reveals pain with movement and palpation; multiarticular joint swelling, erythema, and warmth are uncommon.
- **Pustular rash:** Most patients have 2-10 pustular or vesiculopustular lesions on the distal extremities; trunk lesions can also occur. The palms and soles may or may not be affected.
- **Tenosynovitis:** Patients report pain over the flexor tendons of multiple distal joints (eg, wrists, ankles, fingers, toes) and/or pain with passive range of motion of the joint.

Date: _____

21) Pt. ē chest pain, CXR was given, ECG of inferior wall MI was given. Now a new heart sound is present on auscultation (mentioned in CV).

→ MR (d/t papillary muscle rupture)

a - Mitral regurg
b - Aortic regurg
c - ASD
d - lateral wall rupture

Surgical management and transcatheter mitral repair

- **Chronic primary MR** [3]
  - Indications: severe primary MR with any of the following
    - Asymptomatic patients with LV systolic dysfunction (LVEF ≤ 60% and/or LVESD ≥ 40 mm)
    - Symptomatic patients irrespective of LV systolic function

	Surgical indications for severe chronic MR

Primary MR	• Surgery if LVEF 30%-60% (regardless of symptoms)
	• Consider surgery if successful valve repair is highly likely:
	  • Symptomatic & LVEF <30%
	  • Asymptomatic & LVEF >60%

Secondary MR (MI, dilated CMP)	• Medical management, valve surgery rarely indicated

22) Some mass in (L) hilar region, metastasis to LN mentioned. Histology pic was given. Acting for diagnosis?

↳ explore full CV & histo pic.

a) Adenocarcinoma
b) Small Cell Ca
c) Malignant thymoma.
(in ant. mediastinum)

Abstracts:

(1) Corelation of GFR ē overall mortality, stroke, HTN

(2) Comparison between tPA and standard therapy.

23) Immunocompromised lady living in a building. a TB pt: living in same building on different floor. what u you do:

a) Isolate TB pt.
(in negative pressure room & N95 mask)

	Infection control isolation precautions
Airborne	• Bacterial (tuberculosis) • Viral (varicella, SARS, measles)
Contact	• Multidrug-resistant organism colonization (MRSA, VRE) • Enteric (*Clostridioides difficile*, *Escherichia coli*O157:H7) • Parasitic (scabies) • Viral **(RSV)**
Droplet	• Bacterial (***Neisseria meningitidis***, *Haemophilus influenzae* type B, *Mycoplasma pneumoniae*) • Viral (influenza, adenovirus)

Droplet: When aerosolized particles are ≥5 microns (considered relatively large), they cannot stay suspended in the air for long periods and are associated with transmission within only 3-6 feet of the source. **Droplet precautions** require the use of surgical masks within this range.

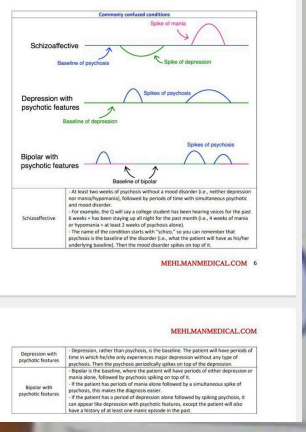
Airborne: When aerosolized particles are <5 microns, they stay suspended in the air for prolonged periods. Such cases require airborne precautions (ie, negative-pressure rooms, respiratory masks with a minimum 95% filtering capacity [eg, N95 masks]) to prevent inhalation

Infection control: isolation precautions

Type	Pathogen*	Key requirements
Airborne	• Bacterial: tuberculosis • Viral: primary VZV (chickenpox), disseminated VZV reactivation (shingles/zoster), dermatomal VZV reactivation (shingles/zoster) in immunocompromised patients, COVID-19, measles	• Negative pressure room • N95 respirator
Contact	• Multidrug-resistant organism (eg, MRSA, VRE, ESBL producing) • Bacterial: *Clostridioides difficile*, *Escherichia coli* O157:H7 • Viral: RSV, primary VZV (chickenpox), disseminated VZV reactivation (shingles/zoster), dermatomal VZV reactivation (shingles/zoster) in immunocompromised patients	• Gloves & gowns • Single-use equipment (eg, stethoscope)
Droplet	• Bacterial: *Neisseria meningitidis*, *Haemophilus influenzae* type B, *Mycoplasma pneumoniae* • Viral: influenza virus, adenovirus	• Mask within 1-2 m (3-6 ft) of patient
Standard	• Followed for all patients even when no infection is apparent	• Hand hygiene • Gowns/gloves/masks when appropriate (eg, during procedures)

*Precaution is started immediately when infection with pathogen is suspected.

COVID-19 = coronavirus disease 2019; **ESBL** = extended-spectrum beta-lactamase; **MRSA** = methicillin-resistant *Staphylococcus aureus*; **RSV** = respiratory syncytial virus; **VRE** = vancomycin-resistant *Enterococcus*; **VZV** = varicella-zoster virus.



Explanation:

Differential diagnosis of DSM-5 psychotic disorders

Brief psychotic disorder	**≥1 days & <1 month**, sudden onset, full return to function
Schizophreniform disorder	**≥1 months & <6 months**, same symptoms as schizophrenia, functional decline not required
Schizophrenia	**≥6 months** (includes ≥1 months of active symptoms, can include prodromal & residual periods), requires functional decline
Schizoaffective disorder	Mood episode with concurrent active-phase symptoms of schizophrenia + ≥2 weeks of delusions or hallucinations in the absence of prominent mood symptoms
Delusional disorder	**≥1 delusions & ≥1 months**, **no other psychotic symptoms**, normal functioning apart from direct impact of delusions

Schizoaffective disorder	
DSM-5 criteria	• Major depressive or manic episode concurrent with symptoms of schizophrenia • Lifetime history of **delusions or hallucinations for ≥2 weeks in the absence of major depressive or manic episode** • Mood episodes are prominent & recur throughout illness • Not due to substances or another medical condition
Differential diagnosis	• **Major depressive or bipolar disorder with psychotic features:** Psychotic symptoms occur exclusively during mood episodes • **Schizophrenia:** Mood symptoms may be present for relatively brief periods

Date

30) CV on diagnosis of Schizoaffective disorder.

31) CV of ADHD Rx: Methylphenidate.

32) Hx of some dysplasia at transitional zone of cervix, wasn't treated. Now comes after 3-4 years what ll you do.

a) Colposcopy
b) LEEP
c) Conization.

Giant cell arteritis: clinical manifestations	
Systemic symptoms	• Fever, fatigue, malaise, weight loss
Localized symptoms	• **Headaches:** located in temporal areas • **Jaw claudication:** most specific symptom of GCA • **PMR** • Arm claudication: associated bruits in subclavian or axillary areas • Aortic wall thickening or aneurysms • CNS: TIAs/stroke, vertigo, hearing loss
Visual symptoms	• Amaurosis fugax: transient vision field defect progressing to monocular blindness • **AION:** most common ocular manifestation
Laboratory results	• Normochromic anemia • Elevated **ESR** & CRP • Temporal artery biopsy
Treatment	• **PMR only:** low-dose oral glucocorticoids (eg, prednisone 10-20 mg daily) • **GCA:** intermediate- to high-dose oral glucocorticoids (eg, prednisone 40-60 mg daily) • **GCA with vision loss:** pulse high-dose IV glucocorticoids (eg, methylprednisolone 1,000 mg daily) for 3 days followed by intermediate- to high-dose oral glucocorticoids

AION = anterior ischemic optic neuropathy; **CRP** = C-reactive protein; **ESR** = erythrocyte sedimentation rate; **GCA** = giant cell arteritis; **IV** = intravenous; **PMR** = polymyalgia rheumatica; **TIA** = transient ischemic attack.

33) CV on diagnosis of temporal arteritis

34) Heart sound on Aortic stenosis.

	Valve replacement in aortic stenosis
Severe AS criteria	• Aortic jet velocity ≥4.0 m/sec, **or** • Mean transvalvular pressure gradient ≥40 mm Hg • Valve area usually ≤1.0 cm2 but not required
Indications for valve replacement	Severe AS & ≥1 of the following: • Onset of symptoms (eg, angina, syncope) • Left ventricular ejection fraction **<50%** • Undergoing other cardiac surgery (eg, CABG)

35) Case of Aortic stenosis, signs of heart failure. Asked about. Sarcomeres ll be added in parallel or longitudinally or added in both ways.

← concentric hypertrophy

36) Some scenario on a pt. having prothrombotic state, recurrent inflammation on arm/hand/eye. Also somewhere mentioned about bleeding. what is reason for this ??

a) Colorectal cancer
b) COPD
c) Crohn's disease.

37) Some questions on lynch Syndrome. (HNPCC).

- APC

Date: _____

38) Adolescent c difficulty breathing through nose. normal breathing from mouth.

a) Bil nasal polyps (all options are plausible)
b) DNS
c) Edema turbinates

35) Hx of rhinorrhea, unilateral (L) cheek pain (suggesting sinusitis). How to investigate.

a) CT Paranasal sinuses
b) X-ray skull

46) Signs of (L) heart failure (? (R) → ?! hepatomegaly, pulmonary edema, dyspnea, murmur of MS). what will you do next ??

a) Loop diuretic
b) Thiazide diuretic
c) ACE inhibitors
d) β-blocker

41) Recurrent Syncope, dizziness. CV of BPPV ?

Dx ⇒ Dix-Hallpike

a) Epley Maneuvr. → Rx

42) Acute Cystitis picture in young female ?? Rx.

a) Nitrofurantoin

Abstract

Anastrazole effect in Breast Cancer

ⓐ 57 Yr female had no symptoms but her mother had breast cancer at the age 57Yr and sister had breast cancer at 42Yr. Her menopause at 47Yrs. Which is the strong factor for risk of breast cancer in this patient?

ⓐ family Hx (I marked this) ⓒ Age

ⓑ Age of menopause

ⓒ Age
① Asked about RR?
② Validity of Study?

ⓑ Abstract

Estrogen only hormone Causing breast Cancer they gave multiple types of estrogen hormones like Vaginal estrogen, transdermal estrogen oral estrogen. the study compared b/w them and Calculated RR. It was so difficult don't remember exactly.

ⓐ Which of the following limits study?

ⓐ Exclusion Criteria ⓑ outcome

③ Sequential

① MVA case had chest trauma showed X-ray showing left sided opacity + tracheal deviation to opposite side asked Diagnosis?

ⓐ Hemothorax (correct)

② After diagnosing hemothorax chest tube placed but after some time still patient's condition didn't improve what to do next?

ⓐ thoracotomy (marked this).

BOX 10-2 Indications for Surgery after Tube Thoracostomy Based on Results of Thoracostomy

Massive hemothorax, >1000- to 1500-mL initial drainage
Continued bleeding
>300 to 500 mL in the first hour
>200 mL/hr for the first 3 or more hours
Increasing size of the hemothorax on a chest film
Persistent hemothorax after two functioning tubes are placed
Clotted hemothorax
Large air leak preventing effective ventilation
Persistent air leak after placement of a second tube or inability to fully expand the lung

This is meant to be a guide, and clinical judgment should always be used.

④ Sequential

① Case of Acute Rhinosinusitis had to diagnose this.

② asked its treatment don't remember options.

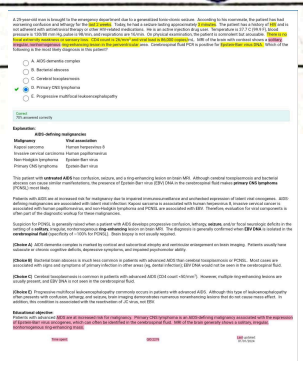
⑤ Pt: underwent stem cell transplantation develop rash + diarrhea + Jaundice → GVHD (marked)

⑥ Pt: underwent Kidney transplant has developed SOB Pneumonia Histo Pic given showing owl eye inclusions asked treatment?

ⓐ oral acyclovir (bcoz of CMV) ganciclovir

⑦ Patient was diagnosed ē HIV asked this patient is most likely to develop Cancer due to what?

ⓐ EBV (marked this) ⓑ Kaposi sarcoma ⓒ CMV



SOLO

Date

(8) 17 Yrs old patient → Vaccinations upto date what to do next → Meningococcal booster.

(9) 11Yrs old girl every thing normal what to do next?
- give HPV vaccine

<15yrs = 2dose 6montn apart
>15yrs = 3dose

(10) Scenario of Chron's disease given Pic given it looked like Perianal fissure So I marked Perianal fissure.

(11) another Qs about Crohn disease pt undergone ileocolectomy but after some days had abdominal pain + diarrhea now next step in managment?
(a) give Ceftriaxone (b) give prednisone (c) mesalamine

(12) Patient had pneumonia + recurrent skin abscess diagnosis Ko Kese Confirm Krna hai?
- I did Dihydamine test (CGD thought)

(13) Clostridium difficile prevention → hand washing

(14) Clostridium difficile treatment → (a) IV Vancomycin
(b) oral fidaxomicin (marked this)

vanco plus metro for fulminant

(15) Patient had Rt upper Quadrant pain + diarrhea watery first later bloody CT given showing liver abscess
→ E. histolytica (marked this)

t/t : metronidazole

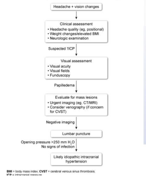
Adequate hand hygiene, which is a standard precaution, should always be performed by health care providers (HCPs) for infection control before and after contact with a patient, regardless of whether or not the patient has an infection. In most instances, the use of alcohol-based hand rubs (ABHRs) is preferred to soap and water as a method of hand hygiene than washing hands with soap and water. However, hand hygiene with soap and water rather than an ABHR is required if the HCP's hands are visibly soiled or when caring for patients with acute infectious diarrhea or infections due to spore-forming organisms such as C. difficile, because ABHRs are ineffective against spores. Wearing gloves and a gown is an important adjunct in preventing contamination with spores but is not a substitute for hand hygiene. HCPs should wash hands with soap and water before putting on gloves and gowns as well as after removing them.

When caring for patients with contact-transmitted diseases such as C. difficile infection, in addition to standard precautions, HCPs should follow contact precautions (e.g., isolating patients, wearing gloves and a gown upon room entry).

Hydrocephalus	
Communicating	- CSF can flow freely between the ventricles and subarachnoid space around the brain and spinal cord. - The answer for meningitis causing hydrocephalus, where the mechanism is "failure of CSF reabsorption by the arachnoid granulations."
Non-communicating	- Aka obstructive hydrocephalus. - When there is a blockage preventing flow of CSF between the ventricles or subarachnoid space. - There is an NBME Q where they give a tumor of the spinal cord in the setting of hydrocephalus, and the answer is obstructive hydrocephalus.

	- Can be caused by aqueductal stenosis (narrowing of the cerebral aqueduct of Sylvius between the 3rd and 4th ventricles), which is the most common cause of congenital hydrocephalus. - Can be caused by colloid cyst, which is a benign fluid-filled growth at the anterior roof of the third ventricle, just posterior to the foramen of Monro.
NPH	- Normal pressure hydrocephalus. - "Wet, wobbly, wacky" +/- Parkinsonism. - In other words: urinary incontinence, ataxia, and cognitive dysfunction. - Due to impingement on the corona radiata (asked on an NBME), which is a white-matter bundle that connects the motor cortex superiorly to the internal capsule inferiorly. - Mechanism for urinary incontinence = "failure to inhibit the voiding reflex."
Congenital	- Aqueductal stenosis is most common cause. - Most important cause on NBME, in my opinion however, is congenital toxoplasmosis, which presents as a triad of 1) hydrocephalus, 2) chorioretinitis, and 3) intracranial calcifications.
Ex-vacuo	- Appearance of enlarged lateral ventricles on imaging without true hydrocephalus. - Can be caused by loss of surrounding brain matter. - Alzheimer and schizophrenia are important causes on USMLE, where enlargement of the lateral ventricles is a finding that can sometimes show up in question stems.

Evaluation of suspected idiopathic intracranial hypertension



BMI = body mass index; **CVST** = cerebral venous sinus thrombosis; ICP = intracranial pressure

This patient has headaches and optic disc edema most likely due to **idiopathic intracranial hypertension** (IIH), a disorder in which **increased intracranial pressure** (ICP) occurs without a secondary cause. IIH is most common in **obese** (BMI ≥30 kg/m^2) **women of childbearing age**, and although pregnancy by itself is not a risk factor, excessive weight gain (as in this patient) can exacerbate the disorder.

Patients typically have **positional headaches** that are worse when lying flat, which increases ICP, and improve with sitting, which decreases ICP. **Pulsatile tinnitus** (due to increased vascular pulsations) and blurry vision (due to increased pressure on the optic nerves) also commonly occur. On physical examination, increased ICP can manifest as optic disc edema (ie, **papilledema**), abducens nerve (CN VI) palsy (lateral rectus palsy), and/or visual field deficits.

Diagnosis is with neuroimaging followed by lumbar puncture, which reveals an elevated opening pressure (>250 mm H_2O). **MRI of the brain**, often with MR venography to rule out cerebral vein thrombosis, is the preferred imaging modality and avoids fetal radiation exposure. MRI is performed **before lumbar puncture** to exclude other causes of elevated ICP (eg, space-occupying mass) that would increase the risk of cerebral herniation **(Choice B)**.

Idiopathic intracranial hypertension	
Risk factors	• Obese women of childbearing age • Medications (eg, retinoids, tetracyclines, growth hormone)
Clinical features	• Headache • Vision loss; enlarged blind spot • Pulsatile tinnitus • Diplopia; palsy of the abducens nerve (CN VI) • Papilledema
Diagnosis	• Neuroimaging • Lumbar puncture: elevated opening pressure
Treatment	• Weight loss • Acetazolamide

(16) Scenario of Pseudotumor Cerebri, fundoscopy shows papiledema what next? → LP

(17) Patient had lg lung Caner had several lymphadenopathies and also some findings in liver asked the poor prognostic factor?
→ Secondary lesions (marked this thinking of mets)

(18) Trisomomy 21 markers → β hcg, inhibin b, estriol, α-fetoprotein

Explanation:

Second-trimester quadruple screening

Diagnosis	MSAFP	β-hCG	Estriol	Inhibin A
Trisomy 18	↓	↓	↓	Normal
Trisomy 21	↓	↑	↓	↑
Neural tube or abdominal wall defect	↑	Normal	Normal	Normal

MSAFP = maternal serum α-fetoprotein.

The **quadruple marker test** screens for congenital defects and **fetal aneuploidy**. Performed in the **second trimester**, it measures 4 markers in the maternal serum: alpha-fetoprotein (AFP), estriol, β-hCG, and inhibin A. Then the measurements are compared to median levels for women at the same gestational age.

Trisomy 21, the cause of Down syndrome, produces a classic pattern of abnormal marker levels.

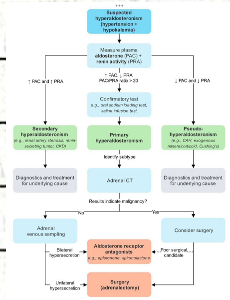
- **Low maternal serum AFP and unconjugated estriol** levels correlate with decreased fetal levels, possibly due to suboptimal fetal tissue production or function.
- **Increased β-hCG and inhibin A** are secreted by the placenta, possibly due to compensatory placental hyperfunction.

also known as painful bladder syndrome. suprapubic pain worsen by bladder filling, received by voiding

(19) diagnosis of interstitial Cystitis asked.

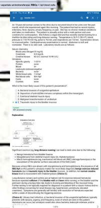
(20) Young aged male had HTN not treated ē medications asked Cause of Refractory HTN. abdominal bruit absent.

(a) fibromuscular dysplasia
(b) Renal atherosclerosis
(c) Essential HTN
(d) Hyperaldosteronism ??



Rhabdomyolysis	
Etiology	Skeletal muscle lysis/necrosis due to: • Crush injury or prolonged immobilization • Intense muscle activity (eg, seizure, exertion) • Drug/medication toxicity (eg, statins)
Clinical features	• Muscle pain & weakness • Dark urine (myoglobinuria/pigmenturia) • + Blood on urinalysis & no RBCs on microscopy • ↑ Serum K & PO_4, ↓ serum Ca, ↑ AST > ALT • Acute kidney injury
Diagnosis	• Serum creatine kinase >1,000 U/L • Consistent clinical features
Management	• Aggressive intravenous fluid resuscitation • Sodium bicarbonate in some cases

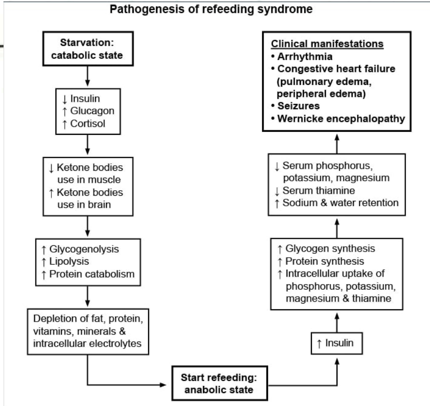
ALT = alanine aminotransferase; AST = aspartate aminotransferase; RBCs = red blood cells.



(21) Case of Rhabdomyolysis → girl doing excessive excersise had pink urine no other symptoms

(22) Refeeding Syndrome Case asked first laboratory change u get → ↓ phosphate levels (marked)

Pathogenesis of refeeding syndrome



Date

(23) Anorexia nervosa Case give asked lab changes?
→ ↓ K+

(24) Patient of MVA got 6 Pints of blood transfusions + 6 Pints of FFP, after 30 minutes he developed SOB + BIL lung infiltrates asked Cause?
(a) TACO >6hrs (b) TALI <6hrs (c) pulmonary contusion.

Always TACO if underlying cardiac disease xa vane irrespective of timing

(25) Hematuria + flank pain going to scrotum next step of diagnosis?
(a) CT Scan of Kidney (thought nephrolithiasis)

(26) 3-4 Questions on urinary incontinence

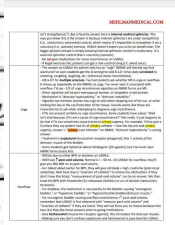
(27) child had 2nd episode of UTI age was <1 yrs what to do next?
(a) Renal ultrasound (b) Voiding Cystourethrogram

USG tes pachhi VCUG

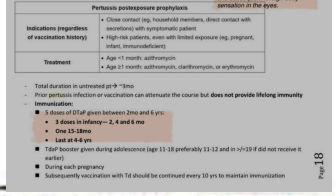
(28) 12 WOG - pregnant lady came had Hx of chronic hypertension. What is she at risk of:
→ Preeclampsia (marked this)

(29) 38 WOG pregnant lady had vaginal bleeding but now stoped U/S shown what to do next.
(a) plan for C/S (I thought this as placenta previa)

SOLO



Post tussive vomiting in infants
Post tussive syncope in adults



(30) Scenario of Pertusis Case give Paroxysmal ~~Case~~ Cough & Vomiting asked what to do next?
(a) give azithromycin to room mate (I marked that)

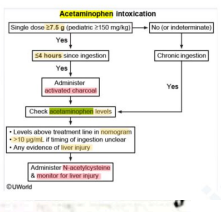
(31) other Scenario on pertusis asked it's treatment?
(a) Macrolides.

Macrolides
Vac nalako lai vaccine pani Dina parchha

(32) patient present ~~e~~ Vomiting abdominal pain Constipation ↑ bowel sounds asked diagnosis
(a) small bowel obstruction.

(33) Young girl found unconscious by her mother mother found acetaminophen bottle next to her ~~Case~~ Activated Charcoal given next step?
(a) Gastric lavage (b) Intubation (c) Fluids

Lavage contraindicated in unconious



(34) Confusing question on Hyper~~Ca~~calcemia and ↑PTH asked Cause but the options were so difficult I Couldn't interpret it as it was the Case of primary hyperparathyroidism but options were difficult.

(35) other Qs on hypercalcemia but it was moderate and asymptomatic asked treatment.
(a) I/V normal Saline.

Management of hypercalcemia	
Severe (calcium >14 mg/dL) or symptomatic	**Short-term (immediate) treatment** • Normal saline hydration plus calcitonin • Avoid loop diuretics unless volume overload (heart failure) exists **Long-term treatment** • Bisphosphonate (zoledronic acid)
Moderate (calcium 12-14 mg/dL)	• Usually no immediate treatment required unless symptomatic • Treatment is similar to that for severe hypercalcemia
Asymptomatic or mild (calcium <12 mg/dL)	• No immediate treatment required • Avoid thiazide diuretics, lithium, volume depletion & prolonged bed rest

SOLO

★ Abstracts:

1. Breast cancer Prevention by Anastrazole.

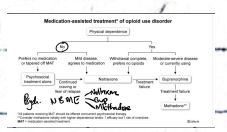
Inclusion criteria: Post. menopausal women of certain age (50-60) maybe. A very narrow range.

The study showed that there was significant difference. Anastrazole actually prevented breast cancer at the end. Alot of extra stuff like side effects and their CIs were given.

Question 1. Post menopausal woman ē family hx of breast cancer. No age of onset of menopause mentioned. Doctor prescribes Anastrazole. Why
a) Age of onset of menopause.
b) Family history.
Don't remember other options.

Dont remember other questions.

~~1. Opiod toxicity.~~



1. Opiod use disorder. Current user.
What to give.
a) Buprenorphine b) Naltrexone
c) Acamprosate

Alcohol withdrawal = chlordiazepoXide
Opoid withdrawal = buprenorphine

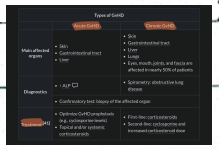
Opoid abuse= naloxone...maintainance= methadone... Relapse = naltrexone

Alcohol abuse= naltrexone(↓ opoid and liver disease)
Acamprosate = alcohol+ opoid or liver disease

2. Patient had Opioid use disorder. Now has reduced craving. What must he have taken?
a) Buprenorphine b) Naltrexone c) Acamprosate

3. Seq. 1 → Case of GVHD → T cell response
2 → What to do?
a) Start steroids b) ↑ Immuno-suppresants c) Stop immunosupresents.

* Bone marrow transplant case with features of jaundice/ pruritus/pain abdomen - GVHD
* NBS- Steroids



4. 16 year old guy. Parents came concerned saying. "You know what goes on ē teenagers these days". What to consel them about?
a) STIs b) Bullying c) Accidents
d) Drug abuse

most common cause of death in this age group is accidents> suicide> homicide

Routine adolescent screening	
Category	Screening method*
Mental health	• Validated depression questionnaire
Sexual health	• Confidential discussion about sexual activity • Gonorrhea & chlamydia testing if sexually active • HIV testing (once at age >18)
Substance use	• Confidential discussion about exposure, use, abuse
Dyslipidemia	• Lipid panel once between age 17 & 21
Safety	• Inquiry about bullying • Inquiry about seatbelt & helmet use

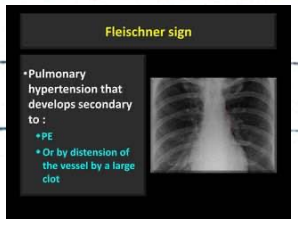
*Annually, unless otherwise indicated.

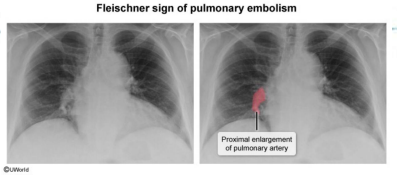
5. Pt. had exposure of something (that causes ILD) ~~maybe~~ ≡ What is the measure of earliest lung involvement.
a) FEV1 b) FVC c) DLCO d) RV.

PULMONARY FUNCTION TESTS
Most forms of ILD will eventually result in a restrictive defect on pulmonary function testing. A restrictive defect is typified by a reduced total lung capacity (TLC) and symmetrically reduced expiratory flow rates (reduced FEV1 and FVC) with a preserved vital capacity (FVC). A reduction in the diffusing capacity of the lung for carbon monoxide (D_{LCO}) is also common and may precede a reduction in lung volumes; however, there is more measurement variability in D_{LCO} measurement and the test is less specific for ILD. A reduced FEV1 to FVC ratio, which is diagnostic of airway obstruction, is unusual in many forms of ILD but can be present as an isolated finding or in conjunction with an additional restrictive deficit in ILDs involving the airways such as sarcoidosis, HP, and LAM. Although pulmonary function testing is rarely diagnostic, reductions in lung function help to characterize the extent of disease, and evidence for decline in repeated measures of pulmonary function (e.g., FVC) has been correlated with an elevated rate of

6. ECGs: * 2 ECGs of Inf. MI in 2 dif. blocks.
* Afib
* P.E (No S1Q3T3) case helped.

Inf wall + St elevation in lead 3>lead 2
RCA occlusion

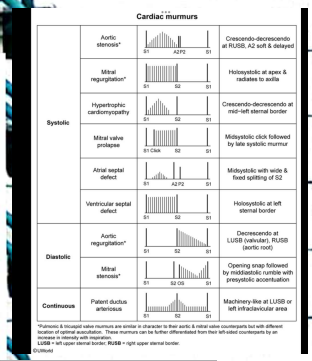


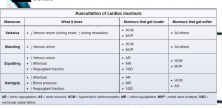


Mitral valve prolapse	- Most common murmur. - Described as mid-systolic click. - "Myxomatous degeneration" is buzzy term that refers to connective tissue degeneration causing MVP in Marfan and Ehlers-Danlos. - Almost always asymptomatic. On 2CK forms, they want you to know about "mitral valve prolapse syndrome," which is symptomatic MVP that presents as repeated episodes of "fleeting chest pain" on the left side in an otherwise healthy patient 20s-30s. They might say there is Hx of MI in the family, but this is MVPS, not MI. Answer on surgery form is "no treatment necessary." - USMLE loves using MVP as a distractor in panic disorder questions, particularly on the 2CK Psych CMS forms. They will give long paragraph about panic attack/disorder + also mention there's a mid-systolic click; they'll ask for cause of patient's presentation → answer = panic disorder, not MVP → student is confused because they say mid-systolic click, but the MVP isn't the cause of the patient's presentation; the panic disorder is; MVP's are usually incidental, benign, and asymptomatic. - MVP does not progress to mitral regurg almost always. So don't think that MVP and MR are the same.
	- Decrescendo holo-diastolic (pan-diastolic) murmur; can also be described

7. Heart sounds : Couldn't really understand from the sound. Case didn't help either.

1. Old pt. has only dyspnea → AS
2. Young lady → Aortic sclerosis
3. Complain only palpitations → MR. (No MI history). Maybe wrong.





8. Sub. Arachanoid hemorrhage CT. It clearly showed SAH. Asked NBS.

a) MRI b) LP c) MR angio d) Repeat CT

No management option. I didn't get the point. CT clearly shows SAH, why investigate further? Anyways.

Overview of subarachnoid hemorrhage (SAH)	
Clinical features	• Most commonly due to ruptured arterial saccular ("berry") aneurysm • Severe headache at onset of neurologic symptoms • Meningeal irritation (eg, neck stiffness) • Focal deficits uncommon
Complications	• Rebleeding (first 24 hr) • Vasospasm (after 3 days) • Hydrocephalus/increased intracranial pressure • Seizures • Hyponatremia (usually from syndrome of inappropriate antidiuretic hormone secretion)

Best initial test: immediate head CT without contrast [19][21]
- Confirmation of SAH: Obtain angiography to confirm source of bleeding and plan treatment.
- Nondiagnostic head CT but persisting suspicion: Perform second-line diagnostic tests

9. Asplenic patient had meningitis. What could have prevented this?

a) Prophylactic antibiotics.

b) Pneumococcal vaccine.

No option of meningeococcal. Don't remember if time of splenectomy was given.

- Prevention steps if emergency splenectomy
  - S. pneumoniae vaccines
    - 2 weeks after surgery: administer 15-valent pneumococcal conjugate vaccine (PCV15)
    - 8 weeks after PCV15: administer 23-valent pneumococcal polysaccharide vaccine (PPSV23)
    - 5 years later and at 65 years of age: revaccinate with PPSV23
  - Meningococcal quadrivalent vaccine: once 2 weeks after surgery and then every 5 years
  - Hib vaccine: once 2 weeks after surgery
- Annual inactivated influenza vaccination

10. 17 year old boy. Last visit to a doctor was when he was 10 yrs old. At that time fully immunized. Now what to give him?

a) Meningococcal Booster (No mention of 1st dose)

b) HPV.

Human papillomavirus vaccination

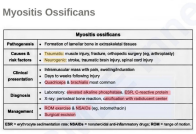
Routine vaccination

- **All persons up through age 26 years:** 2- or 3-dose series depending on age at initial vaccination or condition
  - **Age 9–14 years at initial vaccination and received 1 dose or 2 doses less than 5 months apart:** 1 additional dose
  - **Age 9–14 years at initial vaccination and received 2 doses at least 5 months apart:** HPV vaccination series complete, no additional dose needed
  - **Age 15 years or older at initial vaccination:** 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 12 weeks / dose 1 to dose 3: 5 months; repeat dose if administered too soon)

According to this 2 types KO huncha...
MO localista - more common - after trauma - radiotherapy t/t
MO progressiva -extremely rare- also after trauma - no t/t or nsaids..
Amboss

11. Trauma to leg. Then some pain & swelling. Pain gone but swelling still there. X ray given. Looked like Myositis ossificans. What to do?

a) MRI b) Biopsy c) ALP d) Rest + NSAID.

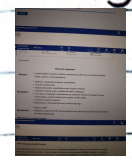


12. GBS case without hx of URTI. Rx asked?

a) IVIG. b) Steroids

13. A student saw a resident messing up. Whom to report?

a) Talk to resident.
b) Talk to other residents.
c) Talk to clerkship director.
d) Report to senior resident.
e) Report to Attending physician of resident.



Whose mistake and whom to report:
1)Med student - Dean or course director
2)Resident: Programme Director/Dept head
3) Student in training: Local Supervisor 1st
4) Attending: Department/ Division Head
5) Physician in Private practice: State Board

Source: 100 Cases

14. A resident saw a physician messing up. What to do.

a) Go talk to him.
b) Report to state board.
c) Talk to residents.
d) Report to prog. director.
e) Report to ~~state board~~ some lower board.

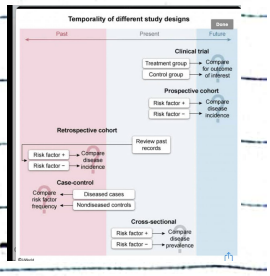
15. Sponge left in abd. of pt. Physician halfway closed the pt. And counting showed 1 sponge missing. What to do?

• **Retained surgical objects** (eg, sponges, instruments) frequently occur even when surgical counts are thought to be reconciled. **Interruptions** increase the risk of counting error; holding a **brief time-out** (ie, a pause in activities to announce that the count is about to begin) can improve situational awareness (ie, group vigilance for safety concerns), **reduce interruptions**, and **improve count quality.**

a) Close the patient & do imaging.
b) Stop suturing & count again.
c) Open sutures & explore.
d) Close patient & give antibiotics.
e) Do imaging now.

16. 2 study reports written. Study A has some cases of same disease & wrote a report about it. Study B took same cases & compared their risk factors to a control group. What study types.

Yesma cases are taken from the cases from the published cases, ~~and controls~~ are taken then risk factor frequency is compared.



A	B
a) Case Series,	Cohort.
b) Case control,	cohoto
c) Case report,	Case-control

Combinations like that.
No option of case series, case control.
Study A had large number of subjects.

17. Alot of questions on antibiotic of choice. eg: for cellulitis, PPROM, Endometritis, Pneumonia, GI infections. etc.

18. Alot of questions on screening eg: Lung cancer, colon cancer, HPV, AAA. etc.

19. Alot of questions on vaccination.

These were all impossible. Vaccines, Screening & Antibiotics. You just can't pick out of 2.

Seemed absolutely impossible to me.

20. MVA patient came to ED. Died later on. Had no family members there or any other information. What to do?
a) Tell his family he is dead.
b) Look for his cards to see if he is a donor.

21. Trauma to shin. Hematoma picture given. What will be complication?
a) Abscess
b) Varicose veins
c) DVT.

22. Strabismus case. Management asked.
a) Put patch on normal eye.
b) Put atropine in affected eye.
c) Refraction something.
d) Laser therapy.

Strabismus (ocular misalignment)	
Clinical findings	• Constant eye deviation at any age • Intermittent eye deviation at age >4 months • Eye deviation on cover test • Asymmetric corneal light reflexes • Asymmetric intensity of red reflexes • Torticollis or head tilt
Treatment	• Strengthen deviated eye (eg, patch unaffected eye, cycloplegic drops to blur unaffected eye) • Correct refractive errors (ie, prescription glasses) • Surgery
Complications	• Amblyopia (reduced visual acuity) • Diplopia

23. There were questions where BMI was not given. Weight & height were given and something asked in lieu of management. Like weightloss, starting statin or something.

24. ASCVD risk 7%, LDL <190, Family hx +ve for MI. Asked why to start statin in this pt?
a) Family Hx b) ASCVD c) LDL

Risk Category	Criteria	Treatment Goal: Non-HDL-C (mg/dL)	Treatment Goal: LDL-C (mg/dL)	Consider Drug Therapy: Non-HDL-C (mg/dL)	Consider Drug Therapy: LDL-C (mg/dL)
Low	0–1 major ASCVD risk factors Consider other risk indicators, if known	<130	<100	≥190	≥160
Moderate	2 major ASCVD risk factors Consider quantitative risk scoring Consider other risk indicators[a]	<130	<100	≥160	≥130
High	≥3 major ASCVD risk factors Diabetes 0–1 other major ASCVD risk factor No evidence of end organ damage CKD stage 3B or 4 LDL-C >190 mg/dL Quantitative risk score reaching the high risk threshold	<130	<100	≥130	≥100
Very high	ASCVD Diabetes ≥2 major risk factors or Evidence of end-organ damage[b]	<100	<70	≥100	≥70

Indications for statin therapy in prevention of ASCVD	
Secondary prevention	• Established ASCVD ◦ Acute coronary syndrome ◦ Stable angina ◦ Arterial revascularization (eg, CABG) ◦ Stroke, TIA, PAD
Primary prevention	• LDL ≥190 mg/dL • Age ≥40 with diabetes mellitus • Estimated 10-year risk of ASCVD >7.5%–10%

ASCVD = atherosclerotic cardiovascular disease; **CABG** = coronary artery bypass grafting; **PAD** = peripheral artery disease; **TIA** = transient ischemic attack.

2. Different OCPs and associated risk of VTE.

* Inclusion: Any OCP leading to even a single episode of VTE.
* Exclusion: Anyone who had a hx of abortion.

Study was comparing rate of VTE in 4 types of Progestin only OCPs.

OCP	RR	VTE rate	CIs
Levonorgestrol	e	x	a
Denogestrol	f	y	b
etc	g	z	c
etc	h	r	d

Also compared Progestin + Estrogen OCP.

OCP	RR	VTE rate	CIs
Levo + estro	e	x	a
Deno + estro	f	y	b
etc.	g	z	c
etc.	h	r.	d

Question 1: A woman came for contraception. Doc. gave her Levonorgestrol instead of Denogestrol. Why?

a) Study supports levo bcz it has lower rate of VTE.
b) Study doesn't support it bcz CI is not significant.

Similar options. Thing is, both levo & Deno had non-significant CIs. But RR with Levo was <1. and for Deno was >1. So I picked option [A].

Question 2: Something about Relative Risk decrease. I think they meant RRR. Options has values. One option was. "Can't be calculated". Relative risks were given for all OCPs so I guess it can be calculated.

Question 3: Study's drawback?
a) Didn't take confounding factors under consideration.
Don't remember other option.