CONTROL AND MEASURING INSTRUMENTS

Questions of the program for the midterm control-2

Name educational
Programs : 6B10112 "General Medicine"
Discipline code : ZhTDPG-6308
Discipline : "Geriatrics in the Practice of General Medicine"
Volume educational hours credits : 120 hour/4 credit
Course and semester: 6th year 11-th semester

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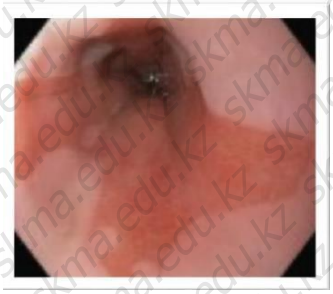
Protocol No. 1 “28” 08.2025

Shymkent 2025

<question> A 61-year-old man presented with fatigue, diarrhea, and cramping abdominal pain for 3 weeks. The pain intensifies after eating. Over the past week, he had up to 4 watery stools daily. He also had pain in the gums and mouth for 6 days. He takes levothyroxine, metoprolol, and warfarin. He has been smoking 1 pack of cigarettes a day for 40 years. Body temperature is 37.9 ° C, PS is 81 / min, BP is 120/75 mm Hg. There is mild tenderness on palpation in the right lower quadrant. Complete blood count: Hb 115 g / l, leukocytes - 11.8 x 109 \ l, platelets - 360. Colonoscopy shows non-caseating granulomas and neutrophilic inflammation of the crypts.
What is the most likely diagnosis?
<variant> Crohn's disease
<variant> Diverticulitis
<variant> Ischemic colitis
<variant> Behcet's disease
<variant> Whipple's disease
<question> A 64-year-old man has been bothered by discomfort behind the breastbone and heartburn for years. FGDS revealed areas of epithelial metaplasia (photo). How often should the patient undergo a control examination for early detection of possible complications?



<variant> 1 time in three months
<variant> 1 time per month
<variant> 1 time per year
<variant> 1 time in two years
<variant> 1 time in three years
<question> An 80-year-old woman. She notes a 7 kg weight loss over the past six months, and an aversion to meat. Her medical history includes chronic gastritis. Objectively: pale skin, painless abdominal palpation. Blood shows grade 2 anemia, ESR 48 mm Hg. What tests should be done to clarify the diagnosis?
<variant> FEGDS
<variant> X-ray of OGK
<variant> Urea breath test
<variant> Bone marrow trephine biopsy
<variant> CEA and CA 19-9
<question> A patient diagnosed with nonspecific ulcerative colitis. Has been ill for 10 years. Receives maintenance therapy with mesalazine. Follows dietary recommendations, takes probiotics, does not smoke. Relative remission for the last 2 years. What routine examination should be performed on the patient for the purpose of early detection of possible complications of this disease in this patient?
<variant> Colonoscopy with targeted biopsy
<variant> MRI of abdominal organs
<variant> Alpha-fetoprotein
<variant> Irrigoscopy
<variant> FEGDS
<question> A 62-year-old man came to us because of weight loss of 3.6 kg over 3 months, fatigue. He was diagnosed with hepatitis C 6 years ago. His father died of colon cancer. He smoked 1 pack of cigarettes a day for 35 years and drank beer. In the past, he used heroin. Height 175 cm, weight 71 kg, BMI = 22.9 kg / m2. Yellow sclera, bilateral redness of the palms, several telangiectasias on the chest

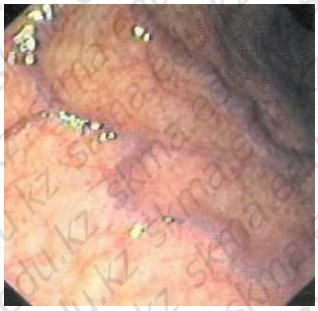
and back. The liver is dense, nodular consistency. CBC: Hb 116 g / l, leukocytes - 9.6 x 109 \ l, platelets - 223.
What outcome do we expect upon further evaluation of the patient?
<variant> Elevated alpha-fetoprotein
<variant> Positive blood cultures
<variant> Exophytic tumor on colonoscopy
<variant> Elevated carcinoembryonic antigen
<variant>Lung damage on radiographs
<question> An 80-year-old woman. She notes a 7 kg weight loss over the past six months, and an aversion to meat. Her medical history includes chronic gastritis. Objectively: pale skin, abdominal palpation is painless. Blood tests reveal grade 2 anemia. ESR is 48 mm/h. What tests should be done first to clarify the diagnosis?
<variant> FEGDS
<variant> R-graph of OGK
<variant> Urea breath test
<variant> Bone marrow trephine biopsy
<variant> CEA and CA 19-9
<question> A 74-year-old female patient complains of general weakness, dizziness, shortness of breath, epigastric pain, heaviness after eating, and rotten belching. Obvious: moderate splenomegaly, decreased tactile sensitivity in the extremities. In the complete blood count: erythrocytes 2.0 x 1012/l, Hb 88 g/l, CI 1.3; leukocytes 3.2 x 109/l, thrombus 150 x 109/l, reticulum 0.2%, bilirubin 42 mmol/l (indirect fraction
33 mmol/l). Suggest a
diagnosis:
<variant> In$_{12\text{-deficiency anemia}}$
<variant> iron deficiency anemia
<variant> hypoplastic anemia
<variant> hemolytic anemia
<variant> viral hepatitis
<question> A 74-year-old female patient complains of general weakness, dizziness, shortness of breath, epigastric pain, heaviness after eating, and rotten belching. Obvious: moderate splenomegaly, decreased tactile sensitivity in the extremities. In the complete blood count: erythrocytes 2.0 x 1012/l, Hb 88 g/l, CI 1.3; leukocytes 3.2 x 109/l, thrombus 150 x 109/l, reticulum 0.2%, bilirubin 42 mmol/l.
Select all correct statements regarding changes in additional research:
a) endoscopically - atrophic gastritis
b) in the myelogram - megaloblastoid hematopoiesis
c) in myelogram - depletion of bone marrow
d) polysegmented neutrophils in peripheral blood
e) increased serum transaminases
<variant> a,b,d
<variant> a,d,e
<variant> b,c
<variant> b,e,d
<variant> b,e
<question> A 74-year-old female patient complains of general weakness, dizziness, shortness of breath, epigastric pain, heaviness after eating, and rotten belching. Obvious: moderate splenomegaly, decreased tactile sensitivity in the extremities. In the complete blood count: erythrocytes 2.0 x 1012/l, Hb 88 g/l, CI 1.3; leukocytes 3.2 x 109/l, thrombus 150 x 109/l, reticulum 0.2%, bilirubin 42 mmol/l.
Select medications for treatment:
a) tardiferon
b) cyanocobalamin

c) red blood cell mass
d) Creon, Pancream
e) prednisolone
<variant> b, d
<variant> a, b
<variant> b, c
<variant> a, d
<variant> d, e
<question> Determine the probable diagnosis: A 65-year-old man complains that over the past year he has periodically begun to feel chest pain, difficulty in passing solid food, which disappears after a few sips of water, in addition, he began to notice that sometimes food remains eaten more than a day ago "appear" in the oral cavity. Body weight is stable. Relatives note the presence of an unpleasant odor from the patient's mouth.
<variant> esophageal diverticulum
<variant> pyloric stenosis
<variant> gastroesophageal reflux disease
<variant> idiopathic achalasia of the esophagus
<variant> gastric ulcer and 12PC
<question> Solve the clinical situation: the clinical picture of this disease is more reminiscent of the clinical picture of angina pectoris:
<variant> hiatal hernia
<variant> diseases of the esophagus
<variant> ulcer of the gastric cardia
<variant> chronic colitis
<variant> acute pancreatitis
<question> Choose the correct statement. A 63-year-old patient is bothered by sudden abdominal pain and frequent vomiting. He has not had a bowel movement and is not passing gas. General: the patient is in a moderate condition, restless, restless. There is no body temperature, pulse is 112 beats per minute. The tongue is moist, the abdomen is distended, soft on palpation, there are no symptoms of peritoneal irritation, peristaltic sounds are weak. High tympanitis is determined. There is no pathology during the examination through the rectum.
<variant> acute intestinal obstruction
<variant> acute appendicitis
<variant> food poisoning
<variant> urolithiasis
<variant> cholelithiasis
<question> Choose the right tactics. A 63-year-old patient is bothered by sudden abdominal pain and frequent vomiting. He has not had a bowel movement and is not passing gas. General: the patient is in a moderate condition, restless, restless. There is no body temperature, pulse is 112 beats per minute. The tongue is moist, the abdomen is swollen, soft on palpation, there are no symptoms of peritoneal irritation, peristaltic sounds are weak. High tympanitis is determined. There is no pathology during the examination through the rectum.
<variant> urgent consultation with a surgeon, hospitalization in a surgical (abdominal surgery) department, by ambulance
<variant> urgent consultation with a surgeon, hospitalization V surgical (thoracic surgery) department, emergency room
<variant> urgent consultation with an infectious disease specialist, hospitalization in an infectious disease hospital, by ambulance
<variant> urgent consultation with a urologist, hospitalization in the urological department, by ambulance
<variant> gastroenterologist consultation, outpatient treatment

<question> List the leading syndromes; refer to a specialist. A 62-year-old pensioner came to the clinic complaining of severe weakness, loss of appetite, nausea, aversion to food, and weight loss. He has lost 15 kg over the past year. Obvious: cachectic, pale. Height 172 cm, weight 53 kg. A 2 cm lymph node is palpated above the left clavicle. Palpation reveals pain in the epigastrium and moderate muscle tension. Hb 100 g/l, erythrocytes 3.6 x 1012/l, cirrhosis 0.84, leukocytes 8.0 x 109/l. ESR 42 mm/hour.
<variant> gastric dyspepsia; pain syndrome - in the epigastrium; lymphadenopathy; anemia, weight loss; oncologist
<variant> hyperkinetic dyskinesia of the biliary tract; pain syndrome - in the epigastrium; pain syndrome - in the right hypochondrium; gastroenterologist
<variant> lymphadenopathy, cachexia, pain syndrome - in the epigastrium; anemia; oncologist
<variant> cholestasis (mechanical jaundice); pain syndrome - in the epigastrium; pain syndrome - in the right hypochondrium; surgeon
<variant> myeloproliferative; hepatosplenomegaly; anemia; pain syndrome - in the right hypochondrium, weight loss; oncohematologist
<question> Determine the preliminary diagnosis, refer to a specialist. A 62-year-old pensioner came to the clinic complaining of severe weakness, loss of appetite, nausea, aversion to food, and weight loss. Over the past year, he has lost 15 kg. Obvious: cachectic, pale. Height 172 cm, weight 53 kg. A 2 cm lymph node is palpated above the left clavicle. Palpation reveals pain in the epigastrium, moderate muscle tension. Hb 100 g / l, erythrocytes 3.6 x 1012 / l, CP 0.84, leukocytes 8.0 x 109 </ l. ESR 42 mm / hour.
<variant> gastric cancer, stage IV (Virchow's metastases). Ref.: iron deficiency anemia; oncologist
<variant> chronic acalculous cholecystitis, acute phase. Ref.: iron deficiency anemia; therapist
<variant> chronic calculous cholecystitis, acute phase. Disclaimer: iron deficiency anemia; surgeon
<variant> chronic myelogenous leukemia. Ref.: iron deficiency anemia; oncohematologist
<variant> chronic anacid gastritis. Ref.: iron deficiency anemia; gastroenterologist
<question> A 63-year-old man complains of itchy skin, jaundice, epigastric pain that intensifies at night, radiating to the back, nausea, loss of appetite, irritability, and body temperature up to 380C. Ob-no: moderate severity, yellowness of the skin and mucous membranes. HR 52 bpm, BP 105/60 mmHg. Palpation reveals pain in the epigastrium, the liver protrudes by 3 cm, is soft, smooth. Positive Courvoisier symptom. CBC: erythrocytes 3.5x1012/l, hematology 80 g/l, cirrhosis 0.7, leukocytes 10.5x109/l, ESR 38 mm/hour. Urea: dark, reaction to bilirubin is positive. Select the leading syndromes:
<variant> cholestasis (mechanical jaundice), pain in the epigastrium, in the right hypochondrium, hepatomegaly, anemia, inflammatory; surgical oncologist
<variant> cholestasis (mechanical jaundice), pain in the right hypochondrium, biliary colic, hepatomegaly; therapist
<variant> jaundice, pain in the right hypochondrium, cytolysis, hepatomegaly, inflammatory; hepatologist
<variant> myeloproliferative (hyperplasia syndrome), hepatosplenomegaly, anemia; hematologist
<variant> epigastric pain, syndrome of morphological changes in the gastric mucosa, hepatomegaly, anemia; gastroenterologist
<question> A 63-year-old man complains of itchy skin, jaundice, epigastric pain that intensifies at night, radiating to the back, nausea, loss of appetite, irritability, and body temperature up to 380C. Ob-no: moderate severity, yellowness of the skin and mucous membranes. HR 52 bpm, BP 105/60 mmHg. Palpation reveals pain in the epigastrium, the liver protrudes by 3 cm, is soft, smooth. Positive Courvoisier symptom. CBC: erythrocytes 3.5x1012/l, hematology 80 g/l, cirrhosis 0.7, leukocytes 10.5x109/l, ESR 38 mm/hour. Urea: dark, reaction to bilirubin is positive. Select the leading syndromes:
<variant> pancreatic head cancer
<variant> cholelithiasis
<variant> acute hepatitis

<variant> acute myelogenous leukemia
<variant> acute gastritis
<question> One of the listed complaints is most typical for colon cancer:
<variant> change in stool diameter (eg ribbon-shaped stool)
<variant> alternating periods of constipation and diarrhea
<variant> night abdominal pain
<variant> acute abdominal pain
<variant> night diarrhea
<question> Choose the correct statement. In chronic pancreatitis, feces:
<variant> greasy, foul-smelling
<variant> tarry
<variant> bloody, odorless
<variant> discolored, normal shape
<variant> like rice water
<question> Select correct judgment. At chronic pancreatitis is developingexocrine insufficiency, feces with this secondary diarrhea:
<variant> greasy, foul-smelling
<variant> tarry
<variant> bloody, odorless
<variant> discolored, normal shape
<variant> like rice water
<question> Find the correct statement. A 66-year-old female patient complained of itchy skin, jaundice, pain in the right hypochondrium, weight loss, dark spots in the interscapular region and in the shoulder area. Pigmentation appeared in the interscapular region and in the shoulder area 7 years ago. She has been bothered by itchy skin for 3-4 years. She was treated by dermatologists without much success. Recently, the itchy skin has intensified and jaundice has appeared. The tests showed hyperbilirubinemia due to the direct fraction, a significant increase in alkaline phosphatase, GGT, and a moderate increase in transaminases.
<variant> primary biliary cirrhosis of the liver
<variant> chronic hepatitis of viral etiology
<variant> Wilson-Konovalov disease
<variant> cholelithiasis
<variant> antitrypsin deficiency
<question> Choose the correct statement. A reliable clinical sign of pyloric stenosis is:
<variant> vomiting food eaten the day before
<variant> vomiting bile
<variant> stomach rumbling
<variant> bloating
<variant> diarrhea
<question> Choose the correct statement. One of the diseases with a natural long-term course is most often complicated by colon cancer:
<variant> pseudomembranous colitis
<variant> Crohn's disease
<variant> nonspecific ulcerative colitis
<variant> ischemic colitis
<variant> chronic dysentery
<question> A 65-year-old woman is bothered by cramping pain in the lower abdomen radiating to the sacrum, bloating, cessation of gas passage, and no bowel movements in the last 4 days. The patient has been suffering from constipation for many years. Ob-no: the abdomen is bloated, moderate pain on palpation. Percussion reveals high tympanitis, a splashing sound is heard. During digital rectal examination, the ampulla is empty, the sphincter is relaxed. When trying to administer a siphon enema,

350 ml of liquid poured back out. Your preliminary diagnosis:
<variant> obstructing tumor of the sigmoid, intestinal obstruction
<variant> medicated obstirpation
<variant> reflex obstirpation
<variant> intestinal paresis
<variant> intestinal intussusception
<question> Patient T., 65 years old. On FGDS:
The gastric mucosa is pale, with a grayish tint. The folds are thinned, reduced in size, and in places are not completely visible. Submucosal vessels are clearly visible. The lumen of the stomach contains a large amount of turbid content. When touched by the endoscope tube, the mucosa is easily vulnerable.
Your conclusion:



<variant> diffuse (multifocal) atrophic gastritis
<variant> duodenogastric reflux, chronic reflux gastritis
<variant> acute gastritis, acute gastric erosions
<variant> stress gastric ulcer
<variant> stomach cancer
<question> The patient is 70 years old. The gastric mucosa is thinned, pale grayish in color, submucosal vessels are clearly visible, folds are not traced. In the fundus of the stomach there is a mucosal defect, irregular in shape with unclear corroded contours, 6x7 cm in size, without an inflammatory ridge. The bottom is bumpy, covered with a dirty gray coating. Its edges are rigid. Deformation of the stomach wall is pronounced, folds are absent, peristalsis is sluggish.
Your conclusion, tactics for treating the patient:

<variant> stomach cancer, oncologist consultation
<variant> diffuse (multifocal) atrophic gastritis, replacement therapy
<variant> duodenogastric reflux, chronic reflux gastritis, treatment by a doctor of OVP
<variant> stress gastric ulcer, treatment by a gastroenterologist
<variant> stomach polyp, does not require treatment
<question> Suggest a diagnosis: a 63-year-old patient, a long-term alcohol abuser, suffering from chronic pancreatitis, consulted a local therapist due to yellowing of the skin and sclera, darkening of urine and lightening of feces. On the skin - traces of scratches, xanthomas, xanthelasmas. Liver size according to Kurlov is 12x10x9 cm, spleen - 8x6 cm. Total bilirubin 65 mmol / ll, direct - 43 mmol / ll, ALT 0.76 mmol / ll, AST 0.45 mmol / ll. What is the most likely cause of jaundice:
<variant> cholestasis due to periductal fibrosis of the pancreas

<variant> chronic hepatitis
<variant> cholelithiasis
<variant> intravascular hemolysis
<variant> hemolysis
<question> Make a decision: a 65-year-old patient came to the city oncology dispensary after an operation 2 months ago for breast cancer. After discharge, she felt satisfactory. But in the last week, severe weakness and nausea appeared, her appetite completely disappeared, pain in large joints began to bother her, and her urine became dark. Examination revealed yellowness of the skin and sclera. There are no scratches on the skin. The liver is palpated 2 cm below the costal arch, its edge is smooth and painless. What examination should be prescribed to the patient to confirm the diagnosis?
<variant> antiHBcorIgM, antiHBcorIgG, HBsAg
<variant> anti HBcor Ig M, anti HAV Ig M
<variant> anti HAV Ig M, HBs Ag
<variant> anti HBcor Ig G, anti HCV Ig M
<variant> anti HEV IgM
<question> Suggest a diagnosis: a 64-year-old female patient was admitted with complaints of pain in the right hypochondrium, nausea and a bitter taste in the mouth in the morning, moderate itching of the skin. The anamnesis includes cholecystectomy for calculous cholecystitis. The pain in the right hypochondrium lasts from several hours to two days and recur several times a month. Recently, the patient began to experience attacks of pain in the right hypochondrium. On examination - increased nutrition, icterus of the sclera and skin, T 37.5 C. Muffled heart sounds, pulse -82 per minute, rhythmic, BP - 135/80 mm Hg. The liver protrudes from under the edge of the costal arch by 4 cm, painful on palpation.
<variant> cholangitis
<variant> chronic hepatitis
<variant> chronic recurrent pancreatitis
<variant> postcholecystectomy syndrome
<variant> pancreatic head cancer
<question> Make a decision: a 64-year-old female patient was admitted with complaints of pain in the right hypochondrium, nausea and a bitter taste in the mouth in the morning, moderate itching of the skin. The anamnesis includes cholecystectomy for calculous cholecystitis. The pain in the right hypochondrium lasts from several hours to two days and recur several times a month. Recently, the patient began to experience attacks of pain in the right hypochondrium. On examination - increased nutrition, icterus of the sclera and skin, T 37.5 C. Muffled heart sounds, pulse - 82 per minute, rhythmic, BP - 135/80 mm Hg. The liver protrudes from under the edge of the costal arch by 4 cm, painful on palpation. The initial diagnostic process is:
<variant> ultrasound examination of the liver and bile ducts
<variant> transhepatic cholangiography
<variant> endoscopic gastroduodenoscopy
<variant> endoscopic retrograde cholapancreatography
<variant> liver function tests
<question> Select the most sensitive test for hypersplenism syndrome:
<variant> determination of the number of granulocytes and platelets in the blood
<variant> determination of bilirubin in blood serum
<variant> dynamic scintigraphy with radiopharmaceutical
<variant> determination of ACT in blood serum
<variant> determination of alkaline phosphatase in blood serum
<question> High levels of gamma-glutamyl transpeptidase are characteristic of:
<variant> acute alcoholic hepatitis
<variant> chronic hepatitis B and C
<variant> hemochromatosis

<variant> diabetes mellitus
<variant> chronic pancreatitis
<question> Assess the clinical situation, choose the most probable disease: a 67-year-old patient was admitted to the clinic complaining of pain in the right hypochondrium, in the epigastric region, and repeated vomiting. The patient had been drinking alcohol for 3 days. The general condition is severe, the skin is pale and dry, body temperature is 38.6 0 C. Pulse is 110 per minute. Blood pressure is 80/40 mHg. Vesicular breathing, somewhat weakened in the lower sections on both sides. The tongue is furred and dry. The abdomen is swollen, soft, painful in the epigastrium. Positive symptoms of Kehr, Kerte, Voskresensky.
<variant> acute pancreatitis
<variant> acute cholecystitis
<variant> acute gastritis
<variant> gastric ulcer and duodenal ulcer
<variant> liver cirrhosis
<question> Suggest a diagnosis: a 68-year-old female patient has jaundice, severe weight loss, epigastric pain, nausea and vomiting. Blood tests revealed severe anemia, ESR increased to 60 mm/hour. Hyperbilirubinemia due to the bound fraction. A variant of the suspected disease.
<variant> pancreatic head cancer
<variant> hepatocellular carcinoma
<variant> chronic hepatitis with cholestasis
<variant> pseudotumorous pancreatitis
<variant> biliary dyskinesia
<question> A 78-year-old patient has weakness, dizziness and blood in the stool, has been ill for 2 months. The diagnosis is suspected - a tumor of the ascending colon. What method can confirm this diagnosis:
<variant> intestinal irrigoscopy
<variant> physical (palpation, percussion, etc.) examination of the abdominal cavity
<variant> digital rectal examination
<variant> rectoscopy
<variant> fibrocolonoscopy
<question> A 68-year-old patient came with a sharp putrid odor from the mouth. This symptom is more common in the disease -
<variant> esophageal diverticulum
<variant> esophagitis
<variant> esophageal cancer
<variant> chronic gastritis
<variant> peptic ulcer
<question> A 70-year-old patient complains of nausea, itchy skin, a sharp decrease in appetite, pain in the right hypochondrium. Has been ill for 7 years. He notes a deterioration in his health after eating fatty foods and alcohol. Objectively: the skin and visible mucous membranes are icteric. The abdomen is soft, painful on palpation in the right hypochondrium, the liver is enlarged by 3 cm, the edge is pointed, the surface is bumpy, the spleen is enlarged. Your presumptive diagnosis:
<variant> Liver cirrhosis
<variant> Acute hepatitis
<variant> Cholecystitis
<variant> Chronic hepatitis
<variant> Pancreatitis
<question> Detection of a low-intensity darkening in the lung in the absence of a cough, complaints of salivation, loss of appetite, pain in the navel area, the presence of slight leukocytosis with hypereosinophilia (up to 25%), detection of ascaris eggs in the feces with a high degree of probability allows us to suspect:

<variant> Pulmonary eosinophilic infiltrate
<variant> Pulmonary tuberculosis
<variant> Echinococcosis
<variant> Sarcoidosis
<variant> Lung cancer
<question> The most common location of ischemic colitis:
<variant> splenic flexure
<variant> cecum
<variant> rectum
<variant> sigmoid colon
<variant> hepatic flexure
<question> Drugs that do not contribute to the development of GERD include:
<variant> chlorpropamides
<variant> diltiazem
<variant> isosorbite dinitrate
<variant> atropine derivatives
<variant> theophyllines
<question> A 65-year-old woman complained of abdominal distension, malaise, and weakness. Ultrasound revealed free fluid in the abdominal cavity in a volume of over 1.5 liters. The liver and spleen are within normal sizes, the diameter of the v.portae is 1.0 cm. Tumor markers - OMMA (CA-125) are sharply elevated, alpha-fetoprotein is elevated 3 times. What is the most likely preliminary diagnosis?
<variant> ovarian cancer
<variant> hepatocellular carcinoma
<variant> pancreatic cancer
<variant> endometrioid cyst
<variant> endometriosis
<question> A 75-year-old man complains of severe, distending pain above the symphysis, weakness, and no urination for 24 hours. In his medical history: he is registered with a dispensary for stage 1 arterial hypertension, type 2 diabetes mellitus, and benign prostatic hyperplasia. He undergoes regular treatment. Objectively: the skin is pale and moist. Heart sounds are muffled and rhythmic, pulse is 100 beats per minute, blood pressure is 160/90 mm Hg. Percussion reveals the bladder at 10 cm above the pubis.
Which event is the priority in this case?
<variant> Catheter drainage of urine
<variant> Drotaverine injection
<variant> Prescribing alpha-blockers
<variant> Enalaprilat injection
<variant> Emergency hospitalization
<question> Choose the correct conclusion. Kidney damage in hypertension leads to the formation of:
<variant> primary shrunken kidney
<variant> secondary shrunken kidney
<variant> polycystic disease
<variant> hydronephrosis
<variant> amyloidosis
<question> Select a treatment that effectively controls blood pressure: a 67-year-old patient complains of stabbing pains in the heart area, headaches, muscle pain, weakness, sometimes cramps, thirst, and increased diuresis. The patient has a history of high blood pressure for 5 years with a maximum increase of up to 230/130 mm Hg. In general: blood pressure is 190/100 mm Hg. Heart rate is 70 bpm. Potassium level is 2.2 mmol/l. In the Zimnitsky test, urine specific gravity is 1006-1015.
<variant> ACE inhibitors or sartans

<variant> selective β-blockers
<variant> surgical treatment, planned
<variant> agonists (I_1) imidazoline receptors
<variant> dihydropyridine calcium antagonists
<question> Select a drug that effectively controls blood pressure: a 67-year-old patient complains of stabbing pains in the heart area, headaches, muscle pain, weakness, sometimes cramps, thirst, increased diuresis. The anamnesis shows an increase in blood pressure over 5 years with a maximum increase to 230/130 mm Hg. In general: blood pressure 190/100 mm Hg. Heart rate 70 bpm. Potassium level 2.2 mmol/l. In the Zimnitsky test, the specific gravity of urine is 1006-1015.
<variant> telmisartan, irbesartan
<variant> bisoprolol, amlodipine
<variant> surgical treatment, planned
<variant> physiotens, amlodipine
<variant> amlodipine, concor
<question> Identify the leading syndromes; preliminary diagnosis. A 65-year-old woman suddenly began to feel pain in the lumbar region, in the left half of the abdomen, and chills. The pain began suddenly, in transport, there were no such complaints before. Ob-no: the patient is restless, excited. During the examination, the patient developed nausea and vomiting, and an urge to urinate. Body temperature is 370C. When palpating the abdomen, there is sharp pain in the right half, moderate muscle tension is determined. It was not possible to conduct a full objective examination.
<variant> renal colic; urolithiasis
<variant> pain in the right mesogastrium; acute intestinal obstruction
<variant> pain in the right mesogastrium, in the right iliac region; acute appendicitis
<variant> pain in the right mesogastrium, in the right iliac region; ectopic pregnancy
<variant> pain in the lumbar spine; osteochondrosis
<question> A 72-year-old man has been experiencing the following symptoms for a month: macrohematuria, increased body temperature, especially in the evenings, weakness, weight loss. Antibiotic treatment has not yielded any results. BP 150/90 mm Hg. In the general urine analysis: ESR 57 mm/hour. Suggest a diagnosis:
<variant> kidney cancer
<variant> chronic glomerulonephritis
<variant> urolithiasis
<variant> exacerbation of chronic pyelonephritis
<variant> tuberculosis of the kidneys
<question> A patient with fever of unknown genesis is suspected of having multiple myeloma. Note the peculiarity of urine analysis in this pathology.
<variant> proteinuria with Bence Jones proteins
<variant> isolated proteinuria
<variant> proteinuria, erythrocyturia, cylindruria
<variant> proteinuria, leukocyturia, bacteriuria
<variant> asymptomatic bacteriuria
<question> Assess the clinical situation and suggest the complication that has developed: the patient 69 years old, has been suffering from urolithiasis and secondary pyelonephritis for 11 years, underwent surgery 4 years ago. Notes constant increase in blood pressure to 160/100 mm Hg, in the last year to 190/100-200 /110 mm Hg, facial edema appeared. Hb 110 g / l, erythrocyte sedimentation rate 3.0 x 1012 / l, CI 0.8, ESR 20 mm / hour, creatinine 200.0 μmol / l.
<variant> chronic renal failure
<variant> acute renal failure
<variant> acute interstitial nephritis
<variant> chronic tubulointerstitial nephritis
<variant> paranephritis, abscess of the perirenal tissue

<question> A 70-year-old patient, upon admission to the hospital, complained of weakness, malaise, dull pain in the lumbar region on the right, periodically frequent painful urination, and the release of cloudy urine. He considers himself ill for more than 10 years, when he first noticed pain in the right lumbar region, he did not receive treatment. Over the past year, he has been bothered by frequent painful urges to urinate, and the pain in the lumbar region on the right has increased. Objectively: BP 150/100 mmHg, HR 80 per minute. The percussion symptom is positive on the right. The bladder area is painful. On examination: complete blood count: erythrocytes - 3.5x1012, hemoglobin 100 g / l, leukocytes 7.2x109, ESR 35 mm / h. Biochemical blood test: total protein 68 g / l, urea 7.8 mmol / l. Urine analysis: dark yellow, sour, no sugar, protein 0.66 g/l, leukocytes 10 in the field of view, erythrocytes up to 30 in the field of view. No microflora growth was obtained during urine culture. Renal ultrasound shows dilation of the renal pelvic system. Excretory urography shows a flask-shaped cavern against the background of dilation of the renal pelvic system. Your presumptive diagnosis:
<variant> Tuberculosis of the kidneys
<variant> Chronic pyelonephritis
<variant> Chronic glomerulonephritis
<variant> Urolithiasis
<variant> Kidney tumor
<question> A 65-year-old obese woman complains of weight loss despite a good appetite, genital itching, and frequent urination at night
Which of the following kidney diseases may develop in the patient:
<variant> Intracapillary glomerulosclerosis
<variant> Acute glomerulonephritis
<variant> Obstructive uropathy
<variant> Renal infarction
<variant> Polycystic kidney disease
<question> In old and senile age, it is common to encounter
<variant> chronic pyelonephritis
<variant> urolithiasis
<variant> acute glomerulonephritis
<variant> Berger's disease
<variant> papillitis
<question> The following proteinuria is characteristic of chronic glomerulonephritis in the terminal stage (uremia)
<variant> 1-2 g per day
<variant> trace
<variant> 10-20 g per day
<variant> 20 g per day
<variant> no protein in urine
<question> The causes of acute renal failure in the elderly and senile age do NOT include:
<variant> AG, no crises
<variant> water-electrolyte disturbances (vomiting, diarrhea)
<variant> cardiogenic shock
<variant> acute respiratory failure
<variant> thromboembolic disease
<question> The high-risk group for developing kidney damage includes patients:
<variant> diabetes mellitus
<variant> osteoarthritis
<variant> chronic persistent hepatitis
<variant> ischemic heart disease
<variant> gastric ulcer and duodenal ulcer
<question> Taking the following medications creates a high risk of kidney damage:

<variant> gentamicin
<variant> prednisolone
<variant> amoxicillin
<variant> nitrong
<variant> lisinopril
<question> The most nephrotoxic antibiotics are the groups
<variant> aminoglycosides
<variant> penicillins
<variant> macrolides
<variant> tetracyclines
<variant> chloramphenicol
<question> On the characteristic clinical and laboratory symptoms nephrotic syndromes do NOT include:
<variant> arterial hypertension
<variant> massive edema
<variant> massive proteinuria
<variant> hypoalbuminemia
<variant> hypercholesterolemia
<question> On the characteristic clinical and laboratory symptoms nephrotic syndromes do NOT include:
<variant> anorexia
<variant> massive edema
<variant> massive proteinuria
<variant> hypoalbuminemia
<variant> hypercholesterolemia
<question> It is advisable to prescribe the following group of drugs for the hypertensive form of chronic glomerulonephritis in elderly and senile patients to control SAH.
<variant> ACE inhibitors or sartans
<variant> diuretics
<variant> gangioblockers
<variant> BAB
<variant> calcium antagonists
<question> In the development of CKD in elderly and senile patients with hypertension, the drugs of choice for controlling blood pressure are:
<variant> sartans
<variant> diuretics
<variant> gangioblockers
<variant> BAB
<variant> calcium antagonists
<question> Elderly patients with arterial hypertension in combination with diabetes are recommended to take:
<variant> telmisartan
<variant> hydrochlorothiazide
<variant> bisoprolol
<variant> metoprolol
<variant> amlodipine
<question> A 75-year-old man complains of severe, distending pain above the symphysis, weakness, and no urination for 24 hours. In his medical history: he is registered with a dispensary for stage 1 arterial hypertension, type 2 diabetes mellitus, and benign prostatic hyperplasia. He undergoes regular treatment. Objectively: the skin is pale and moist. Heart sounds are muffled and rhythmic, pulse is 100 beats per minute, blood pressure is 160/90 mm Hg. Percussion reveals the bladder at 10 cm above the

pubis.
Which event is the priority in this case?
<variant> Catheter drainage of urine
<variant> Drotaverine injection
<variant> Prescribing alpha-blockers
<variant> Enalaprilat injection
<variant> Emergency hospitalization
<question> A 69-year-old man is registered with hypertension, controls blood pressure with bisoprolol 10 mg per day, the highest figures were within 180/105 mm Hg. The general urine analysis revealed constant proteinuria (0.066-0.132); blood creatinine is normal. SCF 115 ml/min. Amend the patient's previous diagnosis: hypertension stage 3. Risk group 3 (age, gender, LVH, MAU).
<variant> AG stage 3. Risk group 3 (age, gender, LVH, hypertensive nephropathy). CKD stage I (SCF 115 ml/min)
<variant> AG stage 2. Risk group 3 (age, gender, LVH, hypertensive nephropathy). CKD stage 1 (SCF 115 ml/min)
<variant> AG stage 1. Risk group 3 (age, gender, LVH, hypertensive nephropathy). CKD stage 1 (SCF 115 ml/min)
<variant> AG stage 3. Risk group 1 (age, gender, LVH, hypertensive nephropathy). CKD stage 1 (SCF 115 ml/min)
<variant> AG stage 3. Risk group 4 (age, gender, LVH, hypertensive nephropathy). CKD stage 1 (SCF 115 ml/min)
<question> A 69-year-old man, registered with hypertension, controls blood pressure with bisoprolol 10 mg per day, the highest figures were within 180/105 mmHg. General urine analysis revealed constant proteinuria (0.066-0.132); blood creatinine is normal. SCF 115 ml/min. The previous diagnosis has been changed: hypertension stage 3. Risk group 3 (age, gender, LVH, hypertensive nephropathy). CKD stage 1 (SCF 115 ml/min). Correct the hypertension.
<variant> cancel bisoprolol, replace with irbesartan
<variant> cancel bisoprolol, replace with candesartan
<variant> bisorolol add amlodipine
<variant> recommend ramipril and telmisartan
<variant> replace bisproolol with methyldopa
<question> Male 77 years old, history of coronary heart disease. Stable angina. Diabetes mellitus type 2. What target blood pressure level is most appropriate for this patient
<variant> Below 130/80 mmHg.
<variant> Below 130/85 mmHg.
<variant> Below 135/85 mmHg.
<variant> Below 140/85 mmHg.
<variant> Below 140/90 mmHg.
<question>A 64-year-old man with blood pressure rising to 150-160/90-95 mm Hg over 5 years. Type 2 diabetes mellitus, takes Diabeton. Objectively: the left border is along the left midclavicular line. Vesicular breathing in the lungs. Heart sounds are clear, the rhythm is regular. Heart rate is 80 bpm. Blood pressure is 160/94 mm Hg. Serum cholesterol is 6.0 mmol / l, serum creatinine is 75 μm / l. Blood sugar is 5.4 mmol / l. MAU is 100 mg per day. Select an antihypertensive drug.
<variant> telmisartan
<variant> enalapril
<variant> bisoprolol
<variant> hydrochlorothiazide
<variant> irbesartan
<question> A 70-year-old man presented with pain, cramps and tingling in his lower extremities for the past 6 months. Symptoms worsen when walking more than 500 m and subside with rest. History of type 2 diabetes. Has been smoking for 50 years, 1 pack of cigarettes a day. Does not drink alcohol.

Takes metformin and aspirin. Decreased body temperature in the shins. What is the most appropriate management for this patient?
<variant> Prescribing antiplatelet agents
<variant> Wearing compression stockings
<variant> Endarectomy
<variant> Bypass surgery
<variant>Endovenous thermal ablation
<question> During screening, a 63-year-old man was found to have complaints of thirst and dry mouth. Upon examination: Height 176 cm. Weight 84 kg. BMI 27.1. In the blood: fasting glucose 6.7 mmol/l. What examination should be performed at the next stage?
<variant> glycemic profile definition
<variant> determination of leukocyte formula in blood
<variant> determination of glucose in urine
<variant> Fasting C peptide determination
<variant> lipid profile
<question> A 72-year-old woman with a history of myocardial infarction and diabetes mellitus. In the tests: cholesterol 5.97 mmol/l, LDL 4.53 mmol/l, HDL 0.98 mmol/l, triglycerides 2.24 mmol/l, atherogenic coefficient 5.09. The calculated 10-year SCORE≥10%. The doctor prescribed atorvastatin. To what target level is it necessary to reduce the LDL level (UD-1B) according to the protocol of the Ministry of Health of the Republic of Kazakhstan?
<variant> < 1.8 mmol/l
<variant> < 1.9 mmol/l
<variant> < 2.0 mmol/L
<variant> < 2.5 mmol/l
<variant> < 2.8 mmol/l
<question> A 65-year-old woman complained of dry mouth, constant thirst and general weakness. She had a 2-year medical history of acute pancreatitis. On examination, the abdomen was soft and painless. On ultrasound of the abdominal cavity, the pancreas size was within normal limits, without pathological formations. A laboratory test that allows to clarify the development of a remote complication of acute pancreatitis?
<variant> blood glucose test
<variant> urine test for diastase
<variant> blood test for diastasis
<variant> fecal occult blood test
<variant> blood clotting test
<question> A 62-year-old man with a history of stroke and diabetes mellitus, 10-year risk according to the SCORE scale≥10%. Takes antihypertensive therapy. Participates in a disease management program. What frequency of examinations by a primary care physician is recommended for this patient according to the "Rules for the Provision of Primary Health Care and the Rules for Attachment to Primary Health Care Organizations" (Order No. 281 of April 28, 2015)
<variant> 1 time in 3 months
<variant> 1 time per 1 month
<variant> 1 time in 2 months
<variant> 1 time in 6 months
<variant> 1 time in 12 months
<question> A 65-year-old woman presented with complaints of dry mouth, constant thirst and general weakness. From the anamnesis: 2 years ago, she was operated on for acute pancreatitis. On examination, the abdomen is soft and painless. On ultrasound of the abdominal cavity, the size of the pancreas is within normal limits, without pathological formations. Select a laboratory study that allows you to clarify the development of a remote complication of acute pancreatitis.
<variant> blood glucose test

<variant> urine test for diastase
<variant> blood test for diastasis
<variant> fecal occult blood test
<variant> blood clotting test
<question> Select the leading syndrome and preliminary diagnosis: a 52-year-old woman complains of constant aching pain in the heart area, nitrates do not help. She considers herself ill for 5-6 years, during this period the menstrual cycle was disturbed, she was bothered by sweating, hot flashes, there was no menstruation for the last 8 months. In general: emotionally unstable, red dermographism. Heart sounds are clear, rhythmic, pulse 80 per minute. BP 135/80 mm Hg. ECG: sinus rhythm, normal EOS, T wave V1-4 is negative, V5,6 is flattened. In dynamics, these changes persisted for 4 months.
<variant> non-coronary cardialgia, climacteric dyshormonal cardiomyopathy (myocardial dystrophy)
<variant> non-coronary cardialgia, non-rheumatic myocarditis
<variant> coronarogenic cardialgia (anginal status), acute myocardial infarction
<variant> coronary cardialgia (anginal syndrome), stable angina pectoris
<variant> non-coronary cardialgia, HCM
<question> A 70-year-old man complains of an increase in body temperature to 380C, chest pain on the right. History of gastric ulcer, diabetes mellitus, ischemic heart disease. On the chest X-ray: focal shadow in the lower lobe of the right lung. Choose the etiologic treatment:
<variant> respiratory fluoroquinolones
<variant> macrolides
<variant> immunomodulators
<variant> "protected" aminopenicillins
<variant> β-lactam antibiotics
<question> A 68-year-old female patient reports weight gain, decreased sweating, and facial puffiness. She lives in an endemic zone. About: height 158 cm, weight 89 kg. No stretch marks, pronounced hyperkeratosis. Pasty face, with swollen eye slits. Heart rate 56 bpm. Blood pressure 150/90 mm Hg. Blood glucose 3.3 mmol/l. Suggest a diagnosis, choose the optimal therapy:
<variant> hypothyroidism, therapy with thyroid drugs
<variant> hypovitaminosis, vitamin therapy
<variant> renal edema, prescription of diuretics
<variant> renal edema, anti-inflammatory therapy
<variant> obesity, subcaloric diet prescription
<question> A 64-year-old woman, receives 500 mg of Siofor per day for type 2 diabetes, is overweight, follows a 1200 kcal/day diet. She is bothered by pain in the right hypochondrium. Fasting blood glucose is 9.0-9.5 mmol/l, 2 hours after eating 12.0-14.0 mmol/l. Blood pressure is 140/80 mm Hg. The liver protrudes from under the edge of the costal arch by 3-4 cm. Determine the doctor's tactics.
<variant> cancel siofor, prescribe prolonged insulin before bedtime
<variant> keep the previous dose of Siofor
<variant> increase the dose of Siofor to 1000 mg per day
<variant> add some sulfanilamide to siofor
<variant> increase the dose of Siofor to 1000 mg per day and add prolonged insulin
<question> A 70-year-old woman with type 2 diabetes was admitted to the outpatient department. Vomiting and thirst for 2 days. Exhausted, severe dry skin and mucous membranes. Inhibited, speech is difficult, twitching of individual muscles. The liver is not enlarged. The abdomen is "calm". Glycemia is 35 mmol/ll, no acetone in the urine. ECG: sinus tachycardia, no coronary disorders. Such an onset is typical for a coma -
<variant> hyperosmolar
<variant> ketoacidotic
<variant> lactic acid
<variant> hypoglycemic

<variant> hypothyroid
<question> A 65-year-old man with type 2 diabetes, coronary heart disease, and hypertension. He takes metformin 1000 IU twice daily and glimepiride 2 mg once daily. In recent months, swelling of the lower extremities has appeared. He was admitted in serious condition with complaints of muscle pain and shortness of breath. To establish the cause of the deterioration, it is important to determine the analysis:
<variant> blood lactate
<variant> urine for glucose
<variant> urine for ketone bodies
<variant> blood for ketone bodies
<variant> blood for hematocrit
<question> A 68-year-old patient, according to relatives, has been suffering from diabetes mellitus for 8 years and takes hypoglycemic drugs. Over the past 7 days, the patient has had polyuria, polydipsia, weakness, and drowsiness. At the time of examination, consciousness is absent, areflexia is shallow, breathing is rapid (without the smell of acetone). The skin is dry, the tone of the eyeballs is reduced. In the lungs, breathing is vesicular, there are no wheezing. Heart sounds are muffled, arrhythmic. Pulse is 100 bpm, BP is 90/70 mm Hg. The abdomen is soft, b/b. Complete blood count: hyperglycemia 55 mmol / l, plasma osmolarity 380 mosm / l, hypernatremia. Urine analysis: glucosuria, acetone is absent. Your diagnosis:
<variant> hyperosmolar coma
<variant> hyperketonemic coma
<variant> cerebral coma
<variant> hyperlactacidemic coma
<variant> hypoglycemic coma
<question> A 68-year-old patient has hyperglycemia. On examination: facial features are enlarged due to enlargement of the nose, ears, lower jaw, hands and feet are enlarged. X-rays of the skull show thickening of the vault bones, occipital tubercles, enlargement of the sella turcica. Hyperproduction of somatotropic hormone. Select a preliminary diagnosis:
<variant> acromegaly
<variant> diabetes mellitus
<variant> Itsenko-Cushing's disease
<variant> glucagonoma
<variant> corticosteroma
<question> A 65-year-old overweight woman has twice been found to have elevated fasting blood glucose levels of 6.9 and 7.2 mmol/l. Which of the following diagnoses is most likely?
<variant> diabetes mellitus type 2
<variant> obesity
<variant> diabetes mellitus type 1
<variant> impaired fasting glucose
<variant> impaired glucose tolerance
<question> A general practitioner found elevated fasting blood glucose levels of up to 6.9 mmol/l in a 69-year-old woman, 160 cm tall and weighing 84 kg. Diagnostic tactics in this case:
<variant> performing a glucose tolerance test with 75 g of glucose
<variant> repeat fasting glucose determination
<variant> determination of post-meal glycemia
<variant> evening glycemia determination
<variant> hypocaloric diet and insulin therapy
<question> A 65-year-old man with normal body weight is being treated by a general practitioner for type 2 diabetes. Dietary treatment has proven ineffective, glycemia during the day is from 10 to 15 mmol/l. There is no sugar in the urine. Which of the following drugs is the most rational
<variant> sulfonylurea drugs and insulin

<variant> intensified insulin therapy
<variant> sulfonylurea drugs and biguanides
<variant> insulin semilente in a dose of 10 units.
<variant> add biguanides to treatment
<question> The criteria for compensation of type 2 diabetes include:
<variant> fasting blood glucose less than 7.0 mmol/l
<variant> glycated hemoglobin (HbA_{1c}) less than 8.0%
<variant> glycated hemoglobin (HbA_{1c}) less than 9.5%
<variant> urine glucose greater than 0.5%
<variant> cholesterol less than 6.0 mmol/l
<question> The patient is 65 years old, height 160 cm, weight 105 kg. No complaints. Fasting blood glucose level is 6.2 mmol/l. Choose the management tactics for this patient:
<variant> an oral glucose tolerance test is required
<variant> the patient has diabetes mellitus, it is necessary to follow a diet and monitor blood glucose levels dynamically
<variant> the patient is healthy, no further examinations or treatment are needed
<variant> the patient has hypoglycemia, it is necessary to take a thorough anamnesis
<variant> it is necessary to determine the level of glucose in urine
<question> A 64-year-old woman has had type 2 diabetes for 10 years. Over the last two years, blood pressure has increased to 150/90 mm Hg. Examination: Urine analysis without pathology. MAU test is twice positive. Select an antihypertensive drug:
<variant> telmisartan
<variant> propranolol
<variant> hypothiazide
<variant> indapamide
<variant>labetolol
<question> A 69 year old man has diabetes for the last 20 years. He has macro-, microangiopathic complications, as well as neuropathies. Select a symptom that is not typical for the painful form of diabetic neuropathy:
<variant> feeling of heat
<variant> numbness
<variant> spontaneous pain
<variant> sensory disturbance
<variant> paresthesia
<question> A 64-year-old patient has type 2 diabetes mellitus complicated by a neuropathic ulcer in the exudation phase. For local treatment of a neuropathic ulcer in the exudation phase, the following is indicated:
<variant> chlorhexidine bigluconate solution
<variant> brilliant green solution
<variant> hydrogen peroxide solution
<variant> ichthyol ointment
<variant> Vishnevsky liniment
<question> A 64-year-old overweight man was twice found to have elevated fasting blood glucose levels of 8.9 and 10.9 mmol/l. The clinic endocrinologist diagnosed type 2 diabetes mellitus for the first time. The goal of pathogenetic therapy for this type of diabetes is:
<variant> increasing the sensitivity of peripheral tissues to insulin
<variant> potentiation of the action of exogenous insulin
<variant> decreased sensitivity of insulin receptors
<variant> stimulation of beta cell function of the islets of Langerhans
<variant> decrease in intestinal glucose absorption
<question> An 80-year-old patient. Upon admission to the hospital, he complained of weakness,

sweating, and shortness of breath when walking. He considers himself ill for 2 months, during which time he periodically had a high temperature, weakness, and took antibiotics and sulfa drugs (Biseptol). Objectively: the patient's condition is severe, shortness of breath, and the skin is very pale. The peripheral lymph nodes are enlarged. Breathing in the lungs is weakened. The heart sounds are muffled, there is tachycardia, and the pulse is 112 beats per minute. The liver is at the edge of the costal arch and is painless. Upon examination in the complete blood count: erythrocytes 3.1x1012, hemoglobin 90 g/l, CI 0.9, leukocytes 22.1x109, n-0.5%, c-15%, lymph. 80%, ESR 18 mm/h. Your diagnosis:
<variant> Chronic lymphocytic leukemia
<variant> Acute leukemia
<variant> Chronic myelogenous leukemia
<variant> Hemorrhagic vasculitis
<variant> Amyloidosis of the spleen
<question> Patient 68 years old. For many years was observed by dermatologists about persistent skin itching. Recently began to notice an increase in blood pressure to 200/100 mm Hg, the appearance of a red-blue color of the skin, pain in the bones. Smokes since 16 years, in the morningscough with a small amount of sputum. Objectively: in the lungs, breathing is harsh with isolated wheezing. Heart sounds are muffled, the second sound is accentuated on the pulmonary artery. The edge of the liver is 2 cm below the costal arch, painless, the spleen is 9 cm below the costal arch. During examination in the complete blood count: erythrocytes 9.5x10, hemoglobin 200 g / l, leukocytes 12.8x109, E-6%, P-7%, C-45%, L-14%, M-10%, platelets 364.4x109, ESR 1 mm / h, hematocrit 75%. Your diagnosis:
<variant> Erythremia (B-zn Vaquez)
<variant> Chronic myelogenous leukemia
<variant> Symptomatic arterial hypertension in the background of COPD
<variant> Arterial hypertension
<variant> Liver cirrhosis
<question> A 72-year-old patient complained of weakness, sweating, and subfebrile body temperature upon admission to the hospital. In recent years, he had been bothered by frequent colds; a year ago, he had suffered from severe viral flu complicated by pneumonia; over the past 6 months, he has lost weight, developed a feeling of heaviness in the abdomen, and his weakness has been increasing. Objectively: poor nutrition, pale skin with a yellowish tint. Palpation reveals pea-sized, painless, mobile cervical lymph nodes. No pathology was detected in the respiratory system or cardiovascular system. The liver protrudes 1.5 cm below the costal arch, is sensitive to palpation, the spleen protrudes from under the left hypochondrium by 10 cm, is dense, and painless. During the examination in the complete blood count: erythrocytes 2.3x10, hemoglobin 74 g/l, reticulocytes 18%, leukocytes 15x109, e-1%, l-80%, m-1%, platelets 100x109, ESR 48 mm/h. Bilirubin is elevated due to the indirect fraction. Your presumptive diagnosis:
<variant> Chronic lymphocytic leukemia
<variant> Lymphogranulomatosis
<variant> Pulmonary tuberculosis
<variant> Chronic myelogenous leukemia
<variant> Lymphosarcoma
<question> A 65-year-old obese woman complains of weight loss despite a good appetite, genital itching, and frequent urination at night
Probable diagnosis:
<variant> Diabetes mellitus
<variant> Diabetes insipidus
<variant> Vaginitis and cystitis
<variant> Myxedema
<variant> Pheochromocytoma
<question> A 65-year-old obese woman complains of weight loss despite a good appetite, genital

itching, and frequent urination at night
The diagnosis can be confirmed by all of the following methods except:"
<variant> Insulin Tolerance Test
<variant> Determination of sugar and acetone in urine
<variant> Blood sugar lability
<variant>Glucose Tolerance Test
<variant> Determination of sugar 2 hours after lunch
<question> A 74-year-old female patient, living alone, presented with shortness of breath and weakness. Objectively: pale skin with a jaundiced tint, puffiness of the face, pastosity of the legs. Signs of peripheral neuropathy (sciatica, paresthesia). The tongue is clean and bright red. Tachycardia up to 110 bpm. Heart sounds are clear, soft systolic murmur over the entire area of the heart. The most likely diagnosis:
<variant> Vitamin B12 - deficiency anemia
<variant> IDA
<variant> IHD, heart failure
<variant> Acquired heart defect, decompensation
<variant> Hypothyroidism
<question> A 69-year-old man complained of "unreasonable" weight loss with preserved appetite and periodic temperature increase to 38-38.50, fatigue during physical exertion. Previously, he had no illnesses. Among the objective data, attention is drawn to a youthful appearance, tachycardia, a paroxysm of atrial fibrillation was registered. Primary paraclinical examination:
<variant> Thyroid ultrasound
<variant> Repeat ECG
<variant> EchoCG
<variant> Blood culture for sterility
<variant>Chest X-ray
<question> An elderly woman with type 2 diabetes mellitus (insulin-requiring stage) is in the intensive care unit with a diagnosis of ketoacidotic coma. Objectively: consciousness is absent, pupillary response to light is preserved, hyperreflexia. Skin is dry, turgor is reduced. Respiratory rate is 26 per minute. Smell of acetone. Glycemia is 22 mmol/l, pH is 7.1, potassium is 3.3 mmol/l. Which of the following treatment options is the most optimal:
<variant> 0.9% NaCl solution – 1000 ml during the first hour, actropid 6-10 U/hour intravenously by drip, KCl – 2 g/hour, 10% oxygen inhalation
<variant> 5% glucose solution – 300 ml/hour intravenously, actropid NM 4 units/hour intramuscularly or intravenously, potassium chloride 2 g/hour; oxygen inhalation
<variant> 5% glucose solution - 200 ml / hour intravenously, actropid 4 units / hour subcutaneously every 2 hours, potassium chloride 3 g / hour, dexamethasone 100 mg intravenously by jet stream, mannitol 15% - 200 ml intravenously by drip; oxygen inhalation
<variant> 40% glucose solution by jet injection until consciousness is restored, glucagon 1 mg/IM, potassium chloride 2 g/hour, 10% glucose solution – 300 ml/hour IV drip"
<variant> 0.9% NaCl solution – 300 ml during the first hour, actropid NM 6 U/hour + NHCO3 solution 140 ml + KCl - 1.5 g intravenously
<question> A patient who recently had influenza and was hospitalized due to ketoacidotic coma was given a set of emergency anti-ketoacidotic measures. However, despite the obvious improvement in laboratory parameters (glycemia 7.8 mmol/l, on admission 26.6 mmol/l, pH 7.52, on admission - 2.7 meq/l), the patient is in a state of deep coma. What is the most likely cause of unconsciousness:
<variant> Cerebral edema
<variant> Hypoglycemic state
<variant> Ketoacidosis
<variant> Concomitant neuroinfection

<variant> Lactic acidosis
<question> A 69-year-old female patient had a thyroidectomy 10 years ago. Receives euthyrox 50 mcg/day. However, her condition is deteriorating. She is concerned about pain in the heart area that occurs when walking, and shortness of breath. She has gained weight. She notes increased hair loss on her head, dry skin, and swelling of her legs by the end of the day. Objectively: height 171 cm, weight 98 kg. Dry, cold skin. Facial pastosity, waxy skin, xanthomatosis, cyanotic lips. Swelling of the hands, shins, and feet. Dense swelling. Hair is dry and brittle. Yellowness of the palms. Pulse 56 beats per minute, rhythmic. Heart sounds are sharply weakened. Vesicular breathing, weakened. The lower edge of the liver protrudes 3 cm from under the costal margin, sensitive. BP 150/70 mmHg. Blood cholesterol 8.3 mmol/l (normal 3.9-5.2), FT4-9.0 nmol\ml (10.5-22), TSH- 8.0 mE\ml (0.2-2.9). ECG voltage decrease in all teeth. Make a preliminary diagnosis:
<variant> Hypothyroidism
<variant> Autoimmune thyroiditis
<variant> Sheehan's syndrome
<variant> Hyperthyroidism
<variant> Schmidt syndrome
<question> A 69-year-old female patient had a thyroidectomy 10 years ago. Receives euthyrox 50 mcg/day. However, her condition is deteriorating. She is concerned about pain in the heart area that occurs when walking, and shortness of breath. She has gained weight. She notes increased hair loss on her head, dry skin, and swelling of her legs by the end of the day. Objectively: height 171 cm, weight 98 kg. Dry, cold skin. Facial pastosity, waxy skin, xanthomatosis, cyanotic lips. Swelling of the hands, shins, and feet. Dense swelling. Hair is dry and brittle. Yellowness of the palms. Pulse 56 beats per minute, rhythmic. Heart sounds are sharply weakened. Vesicular breathing, weakened. The lower edge of the liver protrudes 3 cm from under the costal margin, sensitive. BP 150/70 mmHg. Blood cholesterol 8.3 mmol/l (normal 3.9-5.2), FT4-9.0 nmol\ml (10.5-22), TSH- 8.0 mE\ml (0.2-2.9). ECG voltage decrease in all teeth. Your treatment:
<variant> Euthyrox should be increased to 100-150 mcg/day, increasing each month by 6.25 and/or 12.5 mcg
<variant> increase the dose of euthyrox to 100 mcg/day, without titration
<variant> increase the dose of euthyrox to 150 mcg/day, without titration
<variant> Euthyrox should be increased to 100-150 mcg/day, increasing each week by 6.25 and/or 12.5 mcg
<variant> prescribe iodine preparations at 400 mcg/day
<question> The main causes of diabetes in old age are:
<variant> hereditary pancreatic islet deficiency
<variant> viral infection of pancreatic islets
<variant> hormonally active pituitary tumors
<variant> inflammatory diseases of the brain
<variant> pancreatic diseases
<question> To recover from a hypoglycemic coma, the following measures are necessary:
<variant> intravenous jet injection of 40% glucose
<variant> intravenous drip of 10% glucose
<variant> intravenous jet injection of isotonic solution
<variant> intravenous drip of 5% glucose
<variant> intravenous drip of 40% glucose and 6-8 units of insulin
<question> Specify the indicator that is most effective in assessing compensation for diabetes mellitus.
<variant>glycosylated hemoglobin index
<variant> glycemia level during the day
<variant> glycosuria indicators during the day
<variant> fasting blood glucose level
<variant> postprandial glycemia level

<question> Choose the correct judgment. This method is mandatory in the treatment of all clinical forms of diabetes mellitus –
<variant> diet therapy
<variant> treatment with herbal hypoglycosides
<variant> treatment with physiotherapeutic means
<variant> treatment with hypoglycemic tablets
<variant> insulin therapy
<question> For kidney damage in patients with diabetes mellitus, the following oral hypoglycemic drug is used:
<variant> glurenorm
<variant> betanase
<variant> minidiab
<variant> clay
<variant> maninil
<question> The development of ketoacidosis into ketoacidotic coma is not facilitated by:
<variant> reducing calorie intake of diet
<variant> unjustified reduction in insulin dose
<variant> physical and mental trauma
<variant> alcohol consumption
<variant> acute intercurrent diseases
<question> One of the listed factors contributes to the development of secondary hypothyroidism:
<variant> thyreostatic therapy
<variant> inflammatory diseases of the thyroid gland
<variant> hypopituitarism
<variant> treatment with euthyrox
<variant> diffuse toxic goiter
<question> One of the listed clinical manifestations is not typical for diffuse toxic goiter in elderly people.
<variant> frequent presence of ophthalmopathy
<variant> predominance of low-symptom forms of circulatory organ damage
<variant> predominance of nodular forms of goiter
<variant> presence of pretibial myxedema
<variant> parkinsonian tremor of fingers of outstretched hands
<question> Treatment of hypothyroid coma does not include:
<variant> treatment of concomitant infectious diseases
<variant> administration of an adequate dose of thyroid hormones
<variant> use of glucocorticosteroids
<variant> combating hypoventilation
<variant> rehydration
<question> The development of megaloblastic hematopoiesis in the elderly may be associated with:
<variant> vitamin B12 deficiency
<variant> iron deficiency
<variant> chronic lymphocytic leukemia
<variant> ionizing radiation
<variant> aplastic anemia
<question> This paraclinical study is NOT necessary for establishing a diagnosis and identifying the form of acute leukemia.
<variant> trephine biopsy
<variant> full clinical analysis
<variant> sternal puncture
<variant> cytochemical study

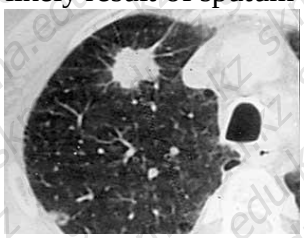
<variant> cytogenetic study
<question> This form of acute leukemia is treated with the greatest success.
<variant> acute lymphoblastic leukemia in children
<variant> acute nonlymphoblastic leukemia of adults
<variant> acute lymphoblastic leukemia in adults
<variant> acute undifferentiated leukemia
<variant> myelodysplastic syndrome
<question> Elderly and old people get sick most often
<variant> B12-deficiency anemia
<variant> autoimmune hemolytic anemias
<variant> chronic posthemorrhagic iron deficiency anemia
<variant> aplastic anemia
<variant> anemia "Olga Immerslung"
<question> This paraclinical method of research is not necessary in the diagnosis of anemia:
<variant> ECHOCG
<variant> complete blood count (Hb, erythrocytes, reticulocytes, platelet count, leukocytes, leukocyte formula, ESR)
<variant> sternal puncture
<variant> serum iron test
<variant> instrumental examination of the gastrointestinal tract
<question> Hematoma type of bleeding is characteristic For:
<variant> for hemophilia
<variant> for thrombocytopenia
<variant> for thrombocytopathy
<variant> for hemorrhagic vasculitis (Schonlein-Henoch disease)
<variant> for Rendu-Osler disease (telangiectasia)
<question> Vascular purple type of bleeding is characteristic
<variant> for hemorrhagic vasculitis (Schonlein-Henoch disease)
<variant> for hemophilia
<variant> for von Willebrand disease
<variant> for autoimmune thrombocytopenia
<variant> for Behcet's disease
<question> Before the appointment and in time of anticoagulant treatment indirect actions it is necessary to monitor the following hemostasis indicator:
<variant> prothrombin index
<variant> bleeding duration
<variant> folding time
<variant> blood clot retraction
<variant> blood platelet count
<question> A 65-year-old woman with a history of hypertension, coronary heart disease, coronary artery bypass grafting, and diabetes mellitus. She is taking therapy. The tests show: Glucose 153.7 mg/dL, Urea - 53.62 mg/dL, Creatinine 1.08 mg/dL, Uric acid - 314.2 μmol/L, total bilirubin 0.4 mg/dL, direct bilirubin - 0.06 mg/dL, ALT 19.82 U/L, AST 19.18 U/L, C-reactive protein 0.17 mg/dL, total cholesterol - 5.91 mmol/L, high-density lipoproteins - 1.07, low-density lipoproteins -4.28, triglycerides - 2.85 mg/dL. The doctor prescribed atorvastatin. What are the recommended liver function tests (ALT) when taking statins?
<variant> should not exceed >3 upper limit of normal/ULN
<variant> must not exceed >4 VGN
<variant> must not exceed >5 VGN
<variant> must not exceed >6 VGN
<variant> must not exceed >7 VGN

<question> A 67-year-old woman complained of abdominal pain, weight loss, a palpable mass in the right hypochondrium, and unexplained deterioration in her condition. A peritoneal friction rub is heard over the liver. She is under medical supervision. Which of the following indicators can be used as a screening test for hepatocellular carcinoma?
<variant> Alpha-fetoprotein (AFP)
<variant> Bilirubin
<variant> D-dimer
<variant> Creatinine
<variant> Glycated hemoglobin
<question> A 66-year-old man, during a home examination, complains of difficulty speaking, weakness in the right arm and leg. From the anamnesis: fell ill acutely, in the morning after sleep discovered the above complaints. Two days ago, the same symptoms were noted, went away on their own within an hour. BP = 110/70 mm Hg, HR = 110 beats / min. On examination: consciousness is clear, oriented, pupils OD = OS, marginal underadduction of the eyeballs on both sides (2 mm). The tongue deviates to the right, tendon reflexes D>S, Babinski reflex on the right, muscle strength in the right limbs is 3 points, there are no meningeal signs. What treatment tactics are indicated for the patient?
<variant> urgent hospitalization in the neurosurgical department
<variant> leave the patient at home, under the supervision of a family doctor
<variant> hospitalization in the neurovascular department the next day, for the purpose of neuroprotection
<variant> hospitalization in the neurovascular department in a week, for the purpose of neuroprotection
<variant> urgent hospitalization in neurosurgery for surgery
<question> A 72-year-old man was found lying on a bench in a park. He did not lose consciousness. During an on-site examination by an emergency doctor, he found impaired movement in his right hand and difficulty speaking - he uttered individual words, from which it can be understood that he suddenly felt dizzy. No vomiting was noted. He was taken to the emergency room. On examination: consciousness is preserved, but lethargic, apathetic. He does not enter into speech contact. He reacts to the examination with a grimace of displeasure. Pulse is arrhythmic, 104 beats per minute, heart sounds are muffled, BP is 150/100 mm Hg. The right corner of the mouth is lowered. The right hand is motionless. The right foot is turned outward. Tendon reflexes are higher on the right than on the left. Babinski reflex is on the right. What examination should be performed at the next diagnostic stage?
<variant> magnetic resonance imaging
<variant> electroencephalography
<variant> general blood test
<variant> biochemical blood test
<variant> electrocardiography
<question> A 67-year-old man complained of pain and swelling in the left knee joint, migratory pain in other large joints, muscle pain, headaches; fever up to 37.5° in the evenings, periodically rising to 38.5° for several days; weight loss by 5 kg. All symptoms appeared after hypothermia 6 months ago. History of frequent consumption of home-made dairy products. Objectively: hyperhidrosis of the palms and feet, asymmetric swelling of the knee joint, local temperature, positive patella ballottement symptom. CBC: ER - 3.2, Hb - 110 g / l, L- 4.9 x 109 / l, NF - 68%, LF - 38%, ESR 29 mm / h. RF - 22 IU / ml, CRP - +++. RH - negative; RA - negative. Which examination will most reliably confirm the diagnosis?
<variant> ELISA for antibodies to brucellosis antigens
<variant> Anti-citrulline antibodies
<variant> X-ray of the knee joints
<variant> Uric acid blood test
<variant> Mantoux test and chest X-ray
<question> A 64-year-old man complained of a mass on the right side of his body. From his medical

history, he noticed the mass 4 months ago. It has recently increased in size. During the examination, the doctor determined that the mass was soft and elastic, mobile, measuring 2.5 x 3.0 cm with clear contours within the subcutaneous tissue. What is your further treatment strategy in this case?
<variant> Refer to surgeon for excision and histology
<variant> Recommend dynamic observation
<variant> Perform a puncture of the formation
<variant> Prescribe resorption therapy
<variant> Recommend warming compresses
<question> A 64-year-old woman complained of shortness of breath with little physical exertion and a dry cough. The shortness of breath is of a mixed nature. She has been registered with the hospital for 5 years with a diagnosis of COPD. She has been smoking for over 30 years, 1-1.5 packs a day. The patient noted the appearance of streaks of blood during attacks of a hacking, unproductive cough. She notes that she had shortness of breath before, but now it is stronger and it has become more difficult to inhale than to exhale. The chest X-ray did not reveal any significant differences from the X-rays taken last year. The blood test shows ESR 54 mm/h. What examination should be done first?
<variant> Bronchoscopy with biopsy
<variant> CT scan of the chest organs
<variant>Spirography
<variant> Determination of the SYFRA tumor marker
<variant>GenExpert
<question> A 65-year-old woman presented with a 1-month history of episodic cough and dyspnea. The cough is nonproductive and worsens when climbing stairs and at night. She had a fever, sore throat, and nasal congestion 8 weeks ago. She has had hypertension for 10 years. She has smoked half a pack of cigarettes a day for 16 years. PS 78/min, RR 18/min, BP 145/95 mmHg. Pulse oximetry 96%. Auscultation reveals dry rales at the end of expiration. Spirometry: FVC 65% and FEV 60%.
The most probable diagnosis, specialist consultation.
<variant> Bronchial asthma, allergist
<variant> Community-acquired pneumonia, pulmonologist
<variant> Chronic heart failure, cardiologist
<variant> α1-antitrypsin deficiency, therapist
<variant> GERD, gastroenterologist
<question> A 64-year-old man, during screening for glaucoma, the following intraocular pressure readings were found using a non-contact method: right eye - 25 mm Hg, left eye - 18 mm Hg. What is the next step?
<variant> refer for further examination to an ophthalmologist
<variant> recommend re-examination in 3 months
<variant> refer to a therapist
<variant> refer to glaucoma clinic
<variant> send for further examination in a hospital setting
<question> A 72-year-old man. He is bothered by persistent constipation for several days. He has lost 5 kg in the last 3 months. His blood shows pancytopenia and ESR 65 mm Hg. What tests should be done to clarify the diagnosis? Refer to a specialist.
<variant> colonoscopy with targeted biopsy, oncologist
<variant> palpation examination of the rectum, proctologist
<variant> alpha-fetoprotein, oncologist
<variant> CT scan of abdominal organs, oncologist
<variant> irrigoscopy, surgeon
<question> A 65-year-old man consulted a therapist complaining of a high temperature in the evenings of 38C, weakness, fatigue, loss of appetite, cough with mucous sputum streaked with blood, chest pain on the right, weight loss of 2 kg over the past 3 months. Denies tuberculosis contact. Single fine-bubble moist rales are heard in the lungs on the right. Blood test: erythrocytes - 3.28x1012, Hb - 138, e - 2, s -

69, m - 11, l - 18, leukocytes - 10.2 x 109, ESR - 38 mm/hour. According to the diagnostic algorithm, treatment with broad-spectrum antibiotics was performed. The therapy did not produce any effect, the intoxication syndrome was not relieved. The control radiograph showed negative dynamics of pulmonary infiltrate with seeding. What is the most appropriate patient management tactic?
<variant> sputum analysis for MBT and consultation with a phthisiatrician
<variant> sputum analysis for atypical cells and oncologist consultation
<variant> sputum analysis for secondary flora with determination of drug susceptibility
<variant> sputum analysis for atypical mycobacteria
<variant> sputum analysis for candida
<question> A 63-year-old woman was admitted with complaints of shortness of breath, fever up to 38.0º, weakness, sweating. The condition worsened 2 days ago against the background of acute respiratory viral infection. Objectively: the skin is moist, pale, drumsticks. BP 130/90 mm Hg, HR - 115 per min, RR - 28 per min. Moist fine bubbling rales are heard on the left in the lower sections against the background of weakened breathing. Pulse oximetry - 88%. On the radiograph: horizontal arrangement of the ribs, widened intercostal spaces, widened roots of the lungs, increased pulmonary pattern due to fibrous and vascular components, infiltrative confluent shadows in the lower lobe of the left lung. What tactics are most appropriate?
<variant> consultation with a resuscitator, emergency hospitalization in the intensive care unit
<variant> outpatient treatment with ciprofloxacin
<variant> hospital treatment at home with levofloxacin
<variant> treatment in a day hospital with ceftriaxone
<variant> planned hospitalization in the therapeutic department, rovamycin
<question> A 67-year-old man consulted a physician because of worsening shortness of breath when walking for 2 months. He has a history of hypercholesterolemia and takes simvastatin. He worked for a demolition company for 35 years. He has smoked for 33 years, 1 pack of cigarettes per day. Fine wheezing is heard in both lungs. An X-ray shows diffuse infiltrates in the lower lobes and calcified pleural plaques. Which of the following conditions is likely to develop in the patient?
<variant> Bronchogenic carcinoma
<variant> Thyroid carcinoma
<variant> Tuberculosis
<variant> Sarcoidosis
<variant> Mesothelioma
<question> A 68-year-old man presented with a painful rash on his left foot. Over the past 2 years, he has had episodes of his toes periodically changing color in the cold from white to blue and red, which then resolve. He has smoked 2 packs of cigarettes daily for 20 years. His blood pressure is 115/78 mm Hg. On examination, he found multiple dark purple nodules on the lateral surface of his left foot with surrounding erythema. There are dry ulcers on the tip of his right index finger. What is the most likely diagnosis? Should he consult a specialist?
<variant>Obliterating thromboangiitis, vascular surgeon
<variant> Dyslipidemia, cardiologist
<variant> Takayasu's Arteritis, Rheumatologist
<variant> Polyneuropathy, neurologist
<variant> Deep vein thrombosis of the lower extremities, vascular surgeon
<question> A 72-year-old patient accompanied by relatives is seen at the reception. According to them, the patient has memory impairment, especially in the acquisition of new information. Memory impairment is a serious obstacle to the patient's everyday life. Only very well-acquired or very familiar material is retained. New information is retained only occasionally or for a very short time. The patient is unable to recall basic information about where he lives, what he has recently done, or the names of his acquaintances. Objectively, the patient's condition is satisfactory: blood pressure 150/100 mm Hg, pulse 80 beats per minute. Heart sounds are muffled, rhythm is regular. Swollen feet. What is your preliminary diagnosis?

<variant> Alzheimer's disease, neurologist
<variant> Parkinson's disease, neurologist
<variant> Hypertensive encephalopathy, neurologist
<variant> Age-related dementia, psychiatrist
<variant> Brain tumor, oncologist
<question> A 74-year-old patient received antibacterial therapy for pneumonia. The condition has not improved dynamically, weakness, weight loss, chest pain are increasing. Control CT scan showed that the lesion had increased in size somewhat, was of high density with uneven contours. What is the likely result of sputum examination?



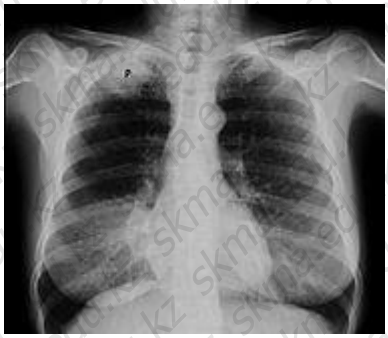
<variant> Atypical cells
<variant> Gram-negative acid-fast bacilli
<variant> Neutrophilic cytosis
<variant> Fungal mycelium
<variant> Dumbbell-shaped bodies
<question> Choose the correct conclusion. Most characteristic of angina pectoris is:
<variant> retrosternal chest pain and ST segment depression of 2 mm or more with exercise
<variant> ST segment elevation less than 1 mm
<variant> chest pain during physical exertion without changes in ECG with exercise
<variant> ventricular extrasystole after exercise
<variant> Q wave enlargement in standard and AVF leads III
<question> Select correct ECG judgments. Most reliable Electrocardiographic signs of pulmonary embolism are:
<variant> SI-QIII syndrome and upward displacement of the ST segment in leads III, V1, V2
<variant> deep Q wave in leads V4-V6
<variant> ST segment depression in leads I, II and aVL
<variant> ST segment depression in leads II, III and aVF
<variant> T wave inversion in the chest leads
<question> Select correct judgment. The most early electrocardiographic A sign of transmural myocardial infarction in patients is:
<variant> emergence of the QS complex
<variant> QRS complex change
<variant> T wave inversion
<variant> heart rhythm disturbance
<variant> ST segment elevation greater than 1 mm
<question> A 65-year-old man consulted his local doctor complaining of transient chest pain that appeared 2 weeks ago, lasting 1-2 minutes, passing spontaneously, occurring during physical exertion. He smokes a pack of cigarettes a day. Objectively: BMI 32, BP 135/65 mmHg, HR 75 bpm, heart tones are clear and rhythmic. What examination and consultation with a specialist is indicated at the first stage of the diagnostic search?
<variant> Coronary angiography, cardiologist
<variant> X-ray of the chest organs, pulmonologist
<variant> Echocardiography, cardiologist
<variant> Holter-ECG, cardiologist
<variant> Doppler sonography of the carotid artery
<question> A 68-year-old patient complains of weakness, sweating, and weight loss of 10 kg over 2

years. The liver, spleen, and all groups of lymph nodes are enlarged. Blood test: Hb 85 g / l, Er. 3.0 x 1012 / l, WBC. 135.0 x 109 / l, p / y 3%, lymph. 96 %, mon. 1%, ESR 28 mm / h. Total bilirubin 45 μmol / l, direct 11 μmol / l. Serum iron 28 mmol / l, Coombs test is positive.
Select the research method that is sufficient in this case to confirm the main diagnosis:
<variant> peripheral blood analysis
<variant> sternal puncture
<variant> trephine biopsy
<variant> lymph node biopsy
<variant> spleen puncture
<question> A 68-year-old patient complains of weakness, sweating, and weight loss of 10 kg over 2 years. The liver, spleen, and all groups of lymph nodes are enlarged. Blood test: Hb 85 g / l, Er. 3.0 x 1012 / l, WBC. 135.0 x 109 / l, p / y 3%, lymph. 96 %, mon. 1%, ESR 28 mm / h. Total bilirubin 45 μmol / l, direct 11 μmol / l. Serum iron 28 mmol / l, Coombs test is positive.
Determine the cause of the deterioration of red blood counts and select a specialist for consultation:
<variant> autoimmune hemolysis, hematologist
<variant> blast crisis, hematologist
<variant> gastrointestinal bleeding, surgeon
<variant> acute hepatitis, hepatologist
<variant> agranulocytosis, hematologist
<question> A 68-year-old patient complains of weakness, sweating, and weight loss of 10 kg over 2 years. The liver, spleen, and all groups of lymph nodes are enlarged. Blood test: Hb 85 g / l, Er. 3.0 x 1012 / l, WBC. 135.0 x 109 / l, p / y 3%, lymph. 96 %, mon. 1%, ESR 28 mm / h. Total bilirubin 45 μmol / l, direct 11 μmol / l. Serum iron 28 mmol / l, Coombs test is positive.
Determine a preliminary diagnosis, refer to a specialist:
<variant> chronic lymphocytic leukemia, hematologist
<variant> acute leukemia, hematologist
<variant> myelofibrosis, hematologist
<variant> chronic myelogenous leukemia, hematologist
<variant> lymphosarcoma, oncohematologist
<question> A 65-year-old patient was admitted to the clinic with a humeral fracture. ESR 63 mm/hour, hyperproteinemia with M-gradient, myelogram - plasmatic infiltration 38%.
Your preliminary diagnosis, send to a specialist:
<variant> myeloma disease, oncohematologist
<variant> acute leukemia, hematologist
<variant> chronic hepatitis, hepatologist
<variant> myelofibrosis, hematologist
<variant> chronic myelogenous leukemia, hematologist
<question> Choose the correct judgment and specialist for consultation, blood test: er. 1.8 x 1012/l, Hb 36 g/l, CP 0.9; leuk. 1.6x109/l, thromb. 5.0x109/l is characteristic of:
<variant> aplastic anemia, hematologist
<variant> iron deficiency anemia, therapist
<variant> B12-deficiency anemia, therapist
<variant> hemolytic anemia, hematologist
<variant> sideroachrestic anemia, therapist
<question> Choose the correct statements plethoric syndrome and a specialist for consultation:
<variant> increased blood pressure, erythromelalgia, "rabbit eyes" symptom; hematologist
<variant> leukopenia, thrombocytopenia, hematologist

<variant> erythromelalgia, thrombocytopenia, hematologist
<variant> "rabbit eyes" symptom, high blood pressure, hematologist
<variant> nephropathy, nephrologist

<question> Select the criteria that correspond to the diagnosis of aplastic anemia:
a) pancytosis
b) pancytopenia
c) bone marrow depletion
d) megaloblastic type of hematopoiesis
e) hemorrhagic syndrome
<variant> b, c, e
<variant> a, d
<variant> b, d, e
<variant> a, b, e
<variant> a,c,e
<question> A 62-year-old pensioner came to the clinic complaining of severe weakness, loss of appetite, nausea, aversion to food, and weight loss. Over the past year, he has lost 15 kg. Obvious: cachectic, pale. Height 172 cm, weight 53 kg. A 2 cm lymph node is palpated above the left clavicle. Palpation reveals pain in the epigastrium and moderate muscle tension. Hb 100 g/l, erythrocytes 3.6x1012/l, CP 0.84, leukocytes 8.0x109/l. ESR 42 mm/hour. Choose the correct tactics:
<variant> oncologist consultation
<variant> surgeon consultation
<variant> gastroenterologist consultation
<variant> consultation with a hematologist
<variant> consultation with a therapist
<question> Choose the correct statement. A 67-year-old man complains of pain in the right and left hypochondrium, an increase in body temperature to subfebrile numbers, frequent nosebleeds, a sharp weight loss of 9 kg in 3 months. He has been ill for 2 years, when he first noticed darkening of the skin. Ob-no: bronze-colored skin, icterus of the sclera, dark pigmentation of the palmar folds and soles, "vascular stars" on the chest, back and shoulders. The abdomen is enlarged due to free fluid in the abdominal cavity. The liver and spleen are enlarged.
<variant> hemochromatosis, gastroenterologist
<variant> Wilson-Konovalov disease, gastroenterologist
<variant> primary biliary cirrhosis of the liver, gastroenterologist
<variant> Budd-Chiari disease, surgeon
<variant> liver amyloidosis, gastroenterologist
<question> Choose the correct judgment regarding the diagnosis and specialist for consultation. A 64-year-old man with a short history of ulcers and a long-term non-healing gastric ulcer came with complaints of weakness, nausea, loss of appetite, constant pain in the epigastric region, weight loss.
<variant> primary ulcerative form of cancer, oncologist
<variant> gastric outlet stenosis, surgeon
<variant> ulcer penetration, surgeon
<variant> ulcer perforation, surgeon
<variant> bleeding from an ulcer, surgeon
<question> Choose the correct statements. The patient complains of diarrhea, cramping pains throughout the abdomen, a feeling of heat, facial flushing, attacks of suffocation and palpitations.
<variant> carcinoid syndrome, endocrinologist (oncologist)
<variant> Whipple's disease, gastroenterologist
<variant> lymphosarcoma, oncologist
<variant> lymphogranulomatosis, oncologist
<variant> non-specific ulcerative colitis, gastroenterologist
<question> Select a preliminary diagnosis, specialist for consultation. A 74-year-old female patient is bothered by cramping pains in the lower abdomen radiating to the sacrum, bloating, cessation of gas passage, and no stool in the last 4 days. The patient has been suffering from constipation for many years. Obvious: the abdomen is bloated, moderate pain on palpation. Percussion reveals high

tympanitis, a splashing sound is heard. During digital rectal examination, the ampulla is empty, the sphincter is relaxed. When trying to administer a siphon enema, 350 ml of liquid poured back out.
<variant> obstructing tumor of the sigmoid, intestinal obstruction; oncologist
<variant> drug obstirpation, therapist
<variant> reflex obstirpation, gastroenterologist
<variant> intestinal paresis, surgeon, neurologist
<variant> intussusception; surgeon
<question> Draw a conclusion and refer to a specialist: a 68-year-old woman complains of cough, pain in the right shoulder joint, weakness. She fell ill 3 months ago, the pain became more intense, a cough appeared, weakness began to increase. In general: the condition is satisfactory, the range of motion in the right shoulder joint is sharply limited, pain is expressed upon palpation. Horner's symptom (ptosis, miosis, enophthalmos). Weakened breathing in the upper part of the right lung. X-ray picture:

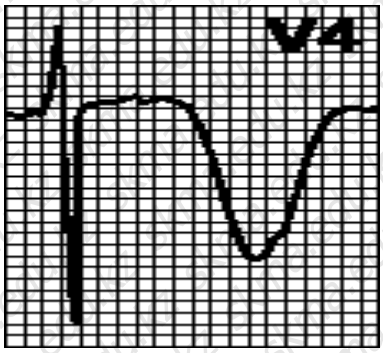


<variant> superior sulcus tumor (Pancoast cancer); oncologist
<variant> pleural tumor, oncologist
<variant> tuberculoma; oncologist
<variant> encapsulated pleurisy in/lobe; phthisiologist surgeon
<variant> lung abscess; thoracic surgeon
<question> Draw a conclusion, refer to a specialist: a 64-year-old woman complains of cough with copious sputum, shortness of breath, chest pain, weakness. She fell ill 6 months ago. X-ray examination in the lower lobes on both sides and in the middle lobe on the right shows areas of non-uniform infiltrative compaction of the lung tissue of irregular shape in places with unclear contours, infiltration from the middle lobe on the right through the interlobar fissure extends to the anterior segment of the upper lobe, and on the left - to the lingual segments.
<variant> bronchioloalveolar cancer; oncologist
<variant> bilateral pneumonia; pulmonologist
<variant> pulmonary edema; cardiologist
<variant> infiltrative pulmonary tuberculosis; phthisiatrician
<variant> idiopathic fibrosing alveolitis; pulmonologist
<question> Make a conclusion, refer to a specialist: a 67-year-old man, complains of cough, periodic hemoptysis, weakness, weight loss. He has been ill for 1.5 months, lost 5 kg. Ob-no: weakened vesicular breathing on the left in the upper section. On X-ray examination, the upper lobe of the left lung is reduced in volume, unevenly compacted,
The pulmonary pattern is thickened. The upper lobe bronchus is conically narrowed, its walls are uneven. The interlobar pleura is displaced upward. There are enlarged lymph nodes in the root zone and under the aortic arch.
<variant> central cancer, oncologist
<variant> acute pneumonia, therapist, pulmonologist
<variant> infiltrative tuberculosis, phthisiatrician
<variant> pulmonary embolism, cardiologist
<variant> lung abscess, surgeon

<question> Predict the diagnosis, refer to a specialist: a 63-year-old man complains of coughing, weakness, increased fatigue, chest pain, shortness of breath. Has been ill for two months. Obvious: vesicular breathing in the lungs, no wheezing, respiratory rate 26 per minute. Blood pressure 125/80 mm Hg, pulse 92 beats / min. On the plain radiograph in the frontal projection there is a unilateral expansion of the median shadow. A tomographic study shows an increase in the lymph nodes of the paratracheal and tracheobronchial groups on the right, merging into a single conglomerate. The external contours are bumpy, unclear. In the adjacent parts of the lung tissue, the pattern is concentrated, deformed. Bronchoscopy revealed rigidity of the right wall of the trachea and the right main bronchus, severe hyperemia and edema of the mucous membrane of the upper lobe bronchus on the right, and slight bleeding.
<variant> mediastinal lung cancer, oncologist
<variant> tuberculosis of the intrathoracic lymph nodes, phthisiatrician
<variant> lymphogranulomatosis, oncologist
<variant> sarcoidosis, therapist
<variant> thymoma, oncologist
<question> Make a decision: a 66-year-old man complains of cough with purulent sputum, weakness, shortness of breath, chest pain, fever. He fell ill acutely, the temperature rose to 39.50C, chills, chest pain, dry cough, did not receive treatment, a week later sputum appeared, which was discharged in a mouthful for 1.5-2 days, then the amount of sputum decreased, but streaks of blood appeared in it. X-ray examination showed a multi-cavity formation of a round shape with a horizontal fluid level in the lower lobe of the left lung, up to 6 cm in diameter.
<variant> lung abscess, emergency hospitalization in the thoracic surgery department
<variant> cavernous tuberculosis, emergency hospitalization in the thoracic surgery department of the tuberculosis dispensary
<variant> cavitary form of peripheral cancer, referral through the portal to oncology
<variant> pulmonary echinococcosis, emergency hospitalization in the thoracic surgery department
<variant> lung abscess, emergency hospitalization in the pulmonology department
<question> Determine the leading syndrome, preliminary diagnosis, refer to a specialist: a healthy 73-year-old man after a strong cough developed an attack of shortness of breath and intense pain in the left half of the chest. Ob-no: tympanitis over the left half of the chest, sharply weakened vesicular breathing.
<variant> thoracalgia, accumulation of air in the pleural cavity, spontaneous pneumothorax; surgeon
<variant> vertebrogenic thoracalgia, intervertebral osteochondrosis of the thoracic region; neurologist
<variant> coronarogenic cardialgia (anginal status), myocardial infarction; cardiologist
<variant> thoracalgia, dry pleurisy; pulmonologist
<variant> non-coronary cardialgia, pulmonary embolism; cardiologist
<question> A 65-year-old man complains of increasing dyspnea. Examination revealed ESR 65 mm/h. Radiological examination revealed pleural effusion. Puncture removed 500 ml of fluid. After 2 days, repeated accumulation of fluid in the pleural cavity was detected. Determine an informative study to clarify the diagnosis.
<variant> cytological examination of exudate, oncologist
<variant> transbronchial puncture, surgeon
<variant> tumor marker test, oncologist
<variant> magnetic resonance imaging of the chest organs, oncologist
<variant> computed tomography of the chest organs, neurologist
<question> Choose the correct judgment, refer to a specialist. Long-term hemoptysis with a dry cough is typical for:
<variant> bronchogenic cancer, oncologist
<variant> pulmonary tuberculosis, phthisiatrician
<variant> pneumoconiosis, occupational pathologist
<variant> chronic bronchitis, pulmonologist

<variant> bronchiectatic disease, pulmonologist
<question> Determine the leading syndrome and diagnosis, refer to a specialist. A 66-year-old man with chest X-ray revealed an enlargement of the mediastinum to the left, uneven contours. CT: uneven, merging nodular formations on the surface of the pleura of the mediastium, costal and anterior surfaces; uneven thickening of the visceral pleura along the interlobar fissures; in the later position, fluid accumulation of 3.5-4.0 cm was detected. The mediastinum is not displaced. The lumen of the large bronchi is unchanged. There are no focal or infiltrative changes in the lungs. Recurrent accumulation was noted after removal of the hemorrhagic exudate.
<variant> pleural lesion syndrome (recurrent fluid accumulation), pleural mesothelioma; oncologist
<variant> pleural lesion syndrome (recurrent fluid accumulation), pleural metastases; oncologist
<variant> pleural lesion syndrome, mediastinal form of lung cancer; oncologist
<variant> pleural lesion syndrome, lymphoma; oncologist
<variant> pleural lesion syndrome, pulmonary tuberculosis; phthisiatrician
<question> A 68-year-old man with alcohol abuse received outpatient antibiotic treatment for pneumonia, but his condition did not improve, body T increased to 390C. In the general urine analysis: leukocytosis with a neutrophilic shift, ESR 40 mm / h. X-ray of the chest organs / OGK: an infiltrate with a horizontal fluid level was detected. Select the leading syndromes, preliminary diagnosis, refer to a specialist:
<variant> syndromes of cavity formation in the lung, consolidation of the lung, fever, intoxication, non-specific inflammation, lung abscess; thoracic surgeon
<variant> syndromes of cavity formation in the lung, consolidation of the lungs, accumulation of fluid in the pleural cavity, fever, pleuropneumonia; pulmonologist
<variant> syndromes of cavity formation in the lung, increased airiness of the lungs, intoxication, fever, tuberculosis; phthisiatrician
<variant> syndromes of cavity formation in the lung, decreased airiness of the lungs, fever, pleural lesions, pleurisy; surgeon
<variant> syndromes of bronchial obstruction, decreased airiness of the lungs, compaction of the lungs, pneumosclerosis; pulmonologist
<question> A 69-year-old man has had a prolonged fever for the past 5-6 months. Syncope has developed. When auscultating, an inconstant diastolic murmur associated with body changes is heard at the apex of the heart. Make an assumption; refer to a specialist:
<variant> left atrial myxoma; oncologist
<variant> papillary muscle avulsion; cardiac surgeon
<variant> mitral valve insufficiency; rheumatologist
<variant> mitral stenosis; rheumatologist
<variant> congenital heart defect (Lutembacher syndrome); cardiac surgeon
<question> Choose the correct judgment; refer to a specialist. A 76-year-old man is worried about cough, occasional hemoptysis, weight loss, body temperature. Has been ill for 1.5 months, weight loss – 5 kg. Obvious: weakened vesicular breathing on the left, above the upper lobe. On the X-ray: the volume of the upper lobe on the left is reduced, of non-uniform density, the pattern is condensed. The walls of the bronchus in the upper lobe are non-uniform, narrowed conically. The interpleural pleura is displaced upward. The hilar lymph nodes under the aortic arch are enlarged.
<variant> central cancer; oncologist
<variant> acute pneumonia; pulmonologist
<variant> infiltrative tuberculosis; phthisiatrician
<variant> pulmonary embolism; cardiologist
<variant> lung abscess; pulmonologist
<question> A 65-year-old man has been suffering from a dry cough and pain in the right half of the chest for 8 months. He has lost 5 kg, and over the past 3 weeks, his weakness has increased, shortness of breath at rest has appeared, and his body temperature rises to 380C. Obvious: dull percussion sound on the right over the entire surface, breathing over the right lung is heard only over the apex, and

vesicular breathing on the left. Radiographically, fluid reaching the 3rd rib is detected in the right pleural cavity.
Select a research method that determines the diagnosis, refer to a specialist:
<variant> pleural puncture with laboratory examination of contents; pulmonologist
<variant> bronchoscopy; phthisiatrician
<variant> sputum analysis for atypical cells; oncologist
<variant> computed tomography of the chest organs; surgeon
<variant> thoracoscopy; surgeon
<question> A 76-year-old man has had a hemorrhagic stroke with subarachnoid hemorrhage. On the ECG:



Choose the correct statement:
<variant> a wide, deep negative T wave is recorded in CNS lesions, especially in subarachnoid hemorrhage
<variant> narrow deep negative T wave is registered in coronary artery disease
<variant> a narrow deep negative T wave is recorded when hypertrophicand the right ventricle
<variant> giant negative T waves in V3-V4 (more than 10 mm) are recorded in apical HCM (Yamaguchi cardiomyopathy)
<variant> wide deep negative T wave – normal variant
<question> In the trauma department of the hospital, a 70-year-old patient with a hip fracture suddenly developed a sharp, squeezing pain behind the sternum while trying to breathe, suffocation with a breathing rate of up to 40 per minute, pale skin, which was replaced by increasing cyanosis of the upper half of the body, covered in cold sticky sweat. Blood pressure 40/20 mm Hg, pulse 120 beats per minute, muffled tones. There are no special features from the respiratory and digestive organs. Your probable diagnosis:
<variant> TELA
<variant> IHD. Myocardial infarction
<variant> Dissecting cardiac aneurysm
<variant> Cardiogenic shock
<variant> IHD. Progressive angina
<question> A 65-year-old female patient complains of dyspnea on exertion, arthralgia, fever, and erythema nodosum on the legs. Observations: hepatosplenomegaly, generalized lymphadenopathy, and corneal opacities of the iris. Chest X-ray shows bilateral pulmonary root adenopathy. Presumptive diagnosis:
<variant> Sarcoidosis
<variant> Tuberculosis
<variant> Acute rheumatism
<variant> Rheumatoid arthritis
<variant>Hamen-Rich disease
<question> A 65-year-old female patient complains of dyspnea on exertion, arthralgia, fever and nodular erythema on the legs. Objectively: hepatosplenomegaly, generalized lymphadenopathy and corneal opacities of the iris. Chest X-ray shows bilateral adenopathy of the pulmonary roots

The patient's eye damage is a consequence of:
<variant> Uveitis
<variant> Complicated diabetes mellitus
<variant> Hypercalcemia
<variant> Congenital pathology
<variant> Infectious infiltration
<question> A 65-year-old female patient complains of dyspnea on exertion, arthralgia, fever, and nodular erythema on the legs. Objectively: hepatosplenomegaly, generalized lymphadenopathy, and corneal opacities of the iris. Chest X-ray shows bilateral adenopathy of the pulmonary roots. Optimal treatment includes:
<variant> Steroids
<variant> Aspirin
<variant> Isoniazid and streptomycin
<variant> Antiviral drugs
<variant> Antibiotics
<question> A 70-year-old man has severe and rapidly increasing dyspnea, with diffuse pulmonary infiltration detected radiographically. Biopsy showed carcinomatosis. Presumptive diagnosis, refer to specialist:
<variant> Carcinoma of the posterior nasopharyngeal region; oncologist
<variant> Bronchogenic carcinoma; oncologist
<variant> Gastric carcinoma; oncologist
<variant> Basal cell carcinoma; oncologist
<variant> Esophageal carcinoma; oncologist
<question> A 70-year-old man has severe and rapidly increasing dyspnea, with diffuse pulmonary infiltration detected radiographically. Biopsy showed carcinomatosis. Signs of pulmonary adenomatosis are:
<variant> Develops from multiple foci
<variant> No metastasis
<variant> Negative histological examination throughout the disease
<variant> Presence of multiple metastases
<variant>None of the above
<question> A 75-year-old man has been treated for right-sided exudative pleurisy for 3 months, without clinical effect, there is a relapse of fluid accumulation in the pleural cavity. He suffers from diabetes. The most likely diagnosis is:
<variant> mesothelioma, oncologist
<variant> lung tumor, oncologist
<variant> Dressler syndrome; cardiologist
<variant> heart failure; cardiologist
<variant> diabetes mellitus, decompensation, endocrinologist
<question> A 78-year-old female patient complains of stiffness and pain in the neck, shoulder and pelvic girdles, muscle weakness, and subfebrile temperature. She has been ill for 2-3 months. Objectively: pain on palpation in the neck, shoulder and pelvic girdle areas with a sharp limitation of the range of motion in them. Examination: in the complete blood count - ESR 70 mm / h and a seven-fold increase in the level of creatine phosphokinase. From the patient's story, taking 1 or 2 tablets of prednisolone dramatically improves the condition. X-ray pathology of the musculoskeletal system did not reveal. What is the probable diagnosis for the patient:
<variant> Systemic dermatomyositis
<variant> Rheumatoid arthritis
<variant> Malignant tumor
<variant> Fibryomyalgia syndrome
<variant> Tumor polymyositis

<question> A 78-year-old female patient complains of stiffness and pain in the neck, shoulder and pelvic girdles, muscle weakness, and subfebrile temperature. She has been ill for 6 months. Objectively: pain on palpation in the neck, shoulder and pelvic girdle areas with a sharp limitation of the range of motion in them. Examination: in the complete blood count - ESR 70 mm / h. From the patient's story, taking 1 or 2 tablets of prednisolone dramatically improves the condition. X-ray pathology of the musculoskeletal system did not reveal. Your tactics:
<variant> arrange a consultation with a rheumatologist
<variant> arrange a consultation with an oncologist
<variant> treatment with NSAIDs
<variant> spa treatment
<variant> does not require treatment
<question> A 68-year-old woman complained of severe muscle weakness in the shoulder and pelvic girdles, pain in the joints of the hands. Objectively: there is periorbital edema with purple-violet erythema, aphonia, the muscles of the shoulder and pelvic girdle are swollen, of a doughy consistency. The joints are externally unchanged. CT revealed a formation in the larynx; CPK is elevated to 14 IU / ml. The patient is diagnosed with:
<variant> Dermatomyositis secondary
<variant> Muscular dystrophy
<variant> Systemic lupus erythematosus
<variant> Systemic scleroderma
<variant> Primary dermatomyositis
<question> An elderly patient with a smoking history of 40 years has developed a hacking cough, periodically with blood, weight loss of about 20 kg over six months, weakness, shortness of breath during normal physical activity, neutrophilia, thrombocytosis and increased ESR. Your conclusion, choose a specialist consultation.
<variant>lung cancer, oncology
<variant>Lobar pneumonia, pulmonologist
<variant>Bronchial asthma, allergist
<variant>PE, allergist
<variant>Loeffler's syndrome, allergist
<question>If a farmer develops mixed dyspnea, chills, an increase in body temperature to 390 C, a cough with scanty sputum, sometimes with streaks of blood, and precipitating antibodies in the blood serum 6 hours after working with rotten hay, it is most likely for..., arrange a specialist consultation:
<variant>Exogenous allergic alveolitis, allergist
<variant>Miliary tuberculosis of the lungs, phthisiatrician
<variant>Bronchopneumonia, pulmonologist
<variant>Idiopathic fibrosing alveolitis, pulmonologist
<variant>Bronchial asthma, allergist
<question>A 65-year-old woman complains of redness and swelling of the interphalangeal joints of her hands. There are no other complaints about the function of the joints. The most likely diagnosis is:
<variant> erosive osteoarthritis
<variant>rheumatoid arthritis
<variant>systemic lupus erythematosus
<variant>ankylosing spondylitis
<variant>systemic scleroderma
<question>A 65-year-old woman complains of the gradual appearance of nodes in the distal interphalangeal joints of her hands. There are no other complaints about the function of the joints. Probable diagnosis:
<variant>Heberden's polyosteoarthrosis
<variant>rheumatoid arthritis
<variant>systemic lupus erythematosus

<variant>ankylosing spondylitis
<variant>systemic scleroderma
<question>A 65-year-old woman complains of the gradual appearance of nodes in the proximal interphalangeal joints of her hands. There are no other complaints about the function of the joints. Your conclusion:
<variant>Bouchard nodes
<variant>rheumatoid arthritis
<variant>systemic lupus erythematosus
<variant>ankylosing spondylitis
<variant>systemic scleroderma
<question>A 72-year-old man who has smoked 30 cigarettes a day for 30 years consulted a doctor about hemoptysis. The patient complained of coughing up 5-10 ml of sputum every morning. Physical and radiographic examination revealed no pathology. The most likely cause of hemoptysis in the patient:
<variant>bronchogenic carcinoma, oncologist
<variant>pulmonary tuberculosis, phthisiatrician
<variant>bronchiectasis, pulmonologist
<variant>chronic obstructive bronchitis, pulmonologist
<variant>alpha1-antitrypsin deficiency, pulmonologist