CONTROL AND MEASURING INSTRUMENTS

Questions of the program for midterm control 1,2

Course title: "Propaedeutics of Internal Diseases"

Course code: PVB 2219

OP title: 6B10117«Dentistry»

Amount of study hours/credits: 120 hours / 4 credits

Course and semester of study: 3rd year, VI semester

Shymkent, 2025

The control and measuring tools were developed in accordance with the working curriculum of the discipline (sillabus) and discussed at a department meeting.

Protocol: № 11 «26» 06. 2025y.

Head of department, d.m.s., professor Bekmurzaeva E.K. Бекм

Border control No. 1:

1. Task to demonstrate practical skills.

1) Percussion characteristics in the main clinical syndromes of the respiratory system. Diagnostic value.
2) Auscultation features of the main clinical syndromes of the respiratory system. Additional breath sounds. Diagnostic value.
3) Features of detection and auscultation of pulmonary cavity syndromes. Diagnostic value.
4) Auscultation features of the main clinical syndromes of the cardiovascular system. Additional heart murmurs. Diagnostic value.
5) Percussion characteristics in the main clinical syndromes of the cardiovascular system. Diagnostic value.
6) Palpation characteristics for the main clinical syndromes of the respiratory organs. Diagnostic value.
7) Features of interpretation of results of laboratory research methods for leading syndromes of cardiovascular pathology.
8) Features of interpretation of results of instrumental research methods in leading syndromes of cardiovascular pathology.
9) Features of interpretation of results of instrumental research methods for the main clinical syndromes of the respiratory organs.
10) Features of interpretation of results of instrumental research methods in patients with diseases of the upper and lower digestive system.
11) Features of interpretation of results of laboratory research methods for the main clinical syndromes of the respiratory organs.
12) Questioning and general examination, auscultation of patients with heart valve disease syndrome.
13) Questioning and general examination, palpation of patients with pulmonary congestion syndrome.
14) Questioning, general examination and percussion of patients with heart valve disease syndrome.
15) Survey and general examination of patients with air accumulation syndrome in the pleural cavity.
16) Survey and general examination of patients with pleural effusion syndrome.
17) Questioning and general examination of patients with arterial hypertension syndrome, measurement of blood pressure.
18) Survey and general examination of patients with coronary insufficiency syndrome.
19) Survey and general examination of patients with acute and chronic heart failure syndrome.
20) Method and means for determining the lower border of the stomach.
21) Survey and general examination of patients with broncho-obstructive syndrome.
22) Survey and general examination of patients with gastric and intestinal dyspepsia syndrome.
23) Deep abdominal palpation according to Obraztsov. Determination of noise.
24) Survey and general examination of patients with increased airiness syndrome.

2. Completing the educational medical history.

The form is attached to the library collection of the department and the academy.

3. Test tasks:

<question>Unfavorable signs of unstable angina include:
<variant>ST segment depression less than 1 mm

<variant>duration of an angina attack is more than 20 minutes
<variant>ST segment depression greater than 1 mm
<variant>unstable hemodynamics (low blood pressure, labile pulse)
<variant>increased content of the MB fraction of CPK
<question>Optimal cholesterol concentration in the blood:
<variant>5 mmol/L
<variant> 6 mmol/L
<variant> 7 mmol/L
<variant>6.5 mmol/L
<variant>9-5.5 mol/l
<question>Typical localization of pain in ischemic heart disease:
<variant>behind the sternum
<variant>in the region of the apex of the heart
<variant>in the right hypochondrium
<variant>in the left half of the chest
<variant>in the right half of the chest
<question>Nitroglycerin relieves pain in cases of:
<variant>attack of angina pectoris
<variant>myocardial infarction
<variant>pericarditis
<variant>myocarditis
<variant>cardiac neurosis
<question>Violet hyperemia of the cheeks (facies mitralis) is characteristic of:
<variant>bicuspid valve stenosis
<variant>tricuspid valve stenosis
<variant>pulmonary artery stenosis
<variant>aortic stenosis
<variant>atrial septal defect
<question>Select the signs of congestion in the pulmonary circulation:
<variant>attacks of cardiac asthma
<variant>headache
<variant>pneumothorax
<variant>coughing in an upright position
<variant>vomiting
<question>Signs of congestion in the systemic circulation include:
<variant>ascites
<variant>pericarditis
<variant>swelling of the face
<variant>pneumothorax
<variant>hemoptysis
<question>Systolic murmur in aortic stenosis is best performed:
<variant>on the vessels of the neck
<variant>at the Botkin-Erb point
<variant>on the top of the heart
<variant>on the jugular veins
<variant>in the armpit area
<question>The functional murmur of relative pulmonary valve insufficiency is:
<variant> diastolic murmur

<variant> systolic-diastolic murmur
<variant> presystolic murmur
<variant> protodiastolic murmur
<variant> systolic murmur
<question>The concept of acute coronary syndrome includes:
<variant>myocardial infarction with pathological Q wave
<variant>ST segment depression on ECG
<variant>widening of the QRS complex on the ECG
<variant>the presence of a negative T wave on the ECG
<variant>stable angina
<question>Ischemic heart disease is characterized by:
<variant>imbalance between coronary blood flow and myocardial needs
<variant>lesion of the pericardium
<variant>myocardial hypertrophy
<variant>by avulsion of the papillary muscle
<variant>endocardial damage
<question>An attack of angina can be triggered by:
<variant>exposure to cold, psycho-emotional stress
<variant>eating food enriched with vitamins
<variant>pungent odors
<variant>acute respiratory viral infections
<variant>frequent sore throats
<question>Characteristics of pain in angina pectoris:
<variant>Retrosternal pain during physical exertion, pain relief with nitroglycerin
<variant>pain in the left chest when taking a deep breath
<variant>retrochest pain lasting 3-4 hours
<variant>pain associated with eating
<variant>pain in the left side of the chest when turning the torso
<question>Irreversible risk factors for coronary heart disease:
<variant>age 40-50 years and older
<variant>obesity
<variant>smoking
<variant>female
<variant>overeating
<question>Pathological processes occurring in the heart muscle during myocardial infarction:
<variant>ischemic zone, necrotic area
<variant>fibrinoid swelling
<variant>hyalinosis
<variant>hyperesthesia
<variant>mucoid swelling
<question>The cause of atrial fibrillation is:
<variant>ischemic heart disease, mitral stenosis
<variant>neurocirculatory dystonia
<variant>pericarditis
<variant>myocarditis
<variant>infective endocarditis
<question>Corvisart's face is characteristic of patients with:
<variant>with heart failure

<variant>with renal failure
<variant>with liver failure
<variant>with acromegaly
<variant>with respiratory failure
<question>Musset's symptom is characteristic of:
<variant>aortic valve insufficiency
<variant>aortic valve stenosis
<variant>mitral stenosis
<variant>mitral valve insufficiency
<variant>pulmonary trunk insufficiency
<question>In acute myocardial infarction, the necrosis zone corresponds to the following ECG changes:
<variant>deep and wide Q wave
<variant>RS-T segment depression
<variant>RS-T segment lift
<variant>deep negative T wave
<variant>decrease in R wave amplitude
<question>Stage I hypertension is characterized by:
<variant>absence of changes in the retinal vessels
<variant>presence of signs of left ventricular hypertrophy
<variant>presence of proteinuria
<variant>elevated creatinine level
<variant>the presence of atherosclerotic plaques in large arteries
<question>A characteristic ECG sign of heart failure is:
<variant>signs of cardiac hypertrophy
<variant>sinus bradycardia
<variant>heart block
<variant>signs of cardiac hypotrophy
<variant>extrasystole
<question>Left ventricular overload with blood volume develops when:
<variant> aortic valve insufficiency
<variant> mitral stenosis
<variant> non-closure of the oval foramen
<variant> aortic stenosis
<variant> tetrad of Fallot
<question>Left ventricular overload with systolic pressure develops when:
<variant>aortic stenosis
<variant>aortic valve insufficiency
<variant>mitral stenosis
<variant>mitral valve insufficiency
<variant>tetralogy of Fallot
<question>Objective method of examining patients:
<variant>inspection, palpation, percussion, auscultation
<variant>questioning, palpation, percussion
<variant>questioning, auscultation, percussion
<variant>questioning, examination, palpation
<variant>questioning, palpation, percussion

<question>The examination required for a patient to verify the diagnosis when arterial hypertension and systolic murmur above the navel are detected:
<variant>Ultrasound Doppler imaging of the renal arteries
<variant>Ultrasound of the kidneys
<variant>Chest X-ray
<variant>fundus
<variant>excretory urography
<question>During auscultation, the patient has a systolic “cat purr” sound in the second intercostal space on the right, which occurs with:
<variant>Aortic stenosis
<variant>Aortic valve insufficiency
<variant>Mitral stenosis
<variant>Mitral insufficiency
<variant>Coarctation of the aorta
<question>Diastolic tremor in patients with mitral stenosis at the apex is explained by the same reasons as:
<variant>clapping 1 tone
<variant>quail rhythm
<variant>emphasis of the 2nd tone on the pulmonary artery
<variant>diastolic murmur at the apex
<variant>split 2 tones at the top
<question>The section that causes absolute cardiac dullness:
<variant>left ventricle
<variant>left atrium and ventricle
<variant>right ventricle
<variant>right atrium
<variant>right atrium and ventricle
<question>The normal limit of relative cardiac dullness on the right is located:
<variant>1–2 cm outward from the right edge of the sternum in the 4th intercostal space
<variant>2.5 cm outward from the right edge of the sternum in the 4th intercostal space
<variant>on the right edge of the sternum
<variant>along the left edge of the sternum in the 4th intercostal space
<variant>3.5 cm outward from the right edge of the sternum in the 4th intercostal space
<question>Pulsus paradoxus is a diagnostic sign: a decrease in pulse volume during inspiration. Pulsus paradoxus is observed when...
<variant>myocarditis
<variant>typhoid fever
<variant>heart failure
<variant>adhesive pericarditis
<variant>myocardial infarction
<question>The patient has a weakened first heart sound at the apex, and a louder second heart sound in the pulmonary artery compared to the second heart sound in the aorta. A systolic murmur is heard at the apex and radiates to the axillary region. Systolic murmur is:
<variant>1 heart sound
<variant>11th heart sound
<variant>111 heart sound
<variant>1 Heart tone
<variant>11, 111, 1 Heart sounds

<question>Place of auscultation of the tricuspid valve:
<variant>at the base of the xiphoid process on the right
<variant>at the apex of the heart
<variant>in the middle of the sternum at the level of the 3 ribs
<variant>in the 2nd intercostal space on the right at the edge of the sternum
<variant>in the 2nd intercostal space on the left at the edge of the sternum
<question>Location of the Botkin-Erb point:
<variant>between the 3rd and 4th ribs on the left at the edge of the sternum
<variant>in the 2nd intercostal space at the right edge of the sternum
<variant>in the 2nd intercostal space at the left edge of the sternum
<variant>at the base of the xiphoid process
<variant>at the top of the heart
<question>The "quail" rhythm is revealed when:
<variant>mitral stenosis
<variant>aortic stenosis
<variant>aortic insufficiency
<variant>tricuspid insufficiency
<variant>mitral regurgitation
<question>The splitting of the 2nd tone at the apex is caused by…
<variant>increased mitral valve opening tone in mitral stenosis
<variant>by amplifying the 3rd tone
<variant>blockade of one of the legs of the His bundle
<variant>desynchronization of the activity of the right and left halves of the heart
<variant>disturbance of intraventricular conduction
<question>The first standard ECG lead is performed by placing electrodes on:
<variant>both forearms
<variant>left arm and left leg
<variant>right arm and left leg
<variant>left arm and right leg
<variant>right arm and right leg
<question>Atrial depolarization reflects:
<variant>P wave
<variant>descending P wave
<variant>QRS complex
<variant>ascending portion of the P wave
<variant>T wave
<question>Mitral stenosis is almost always a consequence of...
<variant>rheumatism
<variant>atherosclerosis
<variant>systemic lupus erythematosus
<variant>congenital developmental anomaly
<variant>bacterial endocarditis
<question> Sensitive indicator showing the degree of bronchial obstruction:
<variant> decreased FEV1 and FVC
<variant> decreased vital capacity
<variant> decreased FVC
<variant> decreased vital capacity and FEV1
<variant> decreased residual capacity of the lungs

<question>The main clinical sign according to the clinical protocol of nephrotic syndrome is:
<variant> edema
<variant> increased blood pressure
<variant> heartbeat
<variant> dysuria
<variant> fever
<question> Dysuria:
<variant> frequent, painful, and difficult urination
<variant> frequent urination
<variant> painful urination
<variant> increase in daily urine output
<variant> decrease in daily urine output
<question> Polyuria:
<variant> excretion of more than 2 liters of urine
<variant> urinates mainly at night
<variant> more fluid is released than is drunk
<variant> painful urination
<variant> determination of protein in urine
<question> Pollakiuria:
<variant> frequent urination
<variant> painful urination
<variant> infrequent urination
<variant> cessation of urination
<variant> urination in small portions
<question> Nocturia:
<variant> predominance of nocturnal diuresis over daytime
<variant> predominance of daytime diuresis
<variant> frequent urination
<variant> painful urination
<variant> frequent painful urination
<question> A fruity odor (or the smell of rotting apples) is characteristic of urine containing:
<variant> urates
<variant> ketone bodies
<variant> large amounts of protein
<variant> leukocytes
<variant> blood
<question> Polyuria is typical for patients:
<variant> with diabetes
<variant> with increased sweating
<variant> with profuse diarrhea
<variant> with cardiac decompensation
<variant> located in a dry, hot room
<question> The main cause of true leukocyturia:
<variant> inflammation of the renal pelvis and calyces
<variant> inflammatory diseases of the appendages
<variant> inflammation of the prostate gland
<variant> inflammatory diseases of the uterus
<variant> inflammatory diseases of the bladder

<question> Hematuria is characteristic of:
<variant> glomerulonephritis
<variant> cystitis
<variant> pyelonephritis
<variant> urethritis
<variant> inflammatory disease of the bladder
<question> The leukocyte content in urine is not subject to counting in the following cases:
<variant> pyuria
<variant> leukocyturia
<variant> hyperleukocyturia
<variant> leukocytosis
<variant> cystitis
<question> A 36-year-old patient was admitted with complaints of facial swelling, headache, and decreased urine output, which was dark in color. His medical history includes a history of tonsillitis two weeks ago. Examination revealed blood pressure of 170/100 mmHg, urine protein of 3.5 g/L, and a high red blood cell count. Which complication of rapidly progressive glomerulonephritis is present?
<variant> acute renal failure
<variant> arterial hypertension
<variant> pulmonary edema
<variant> heart failure
<variant> respiratory failure
<question> Specify the morphological feature characteristic of membranous glomerulonephritis:
<variant>Thickening of the basement membrane
<variant> Proliferation of mesangial cells
<variant> increase in kidney size
<variant> Decreased glomerular volume
<variant> Increase in CLS
<question> Specify the type of glomerulonephritis characterized by the formation of crescents in the glomeruli:
<variant> Rapidly progressive
<variant> Post-infectious
<variant> Membranous
<variant> Focal segmental
<variant> Right-handed
<question> A 25-year-old man was admitted with complaints of severe edema, decreased daily urine output, headache, and shortness of breath. A blood chemistry panel revealed total protein 48 g/L, albumin 20 g/L, and cholesterol 8.9 mmol/L. Urinalysis revealed protein 5.5 g/L, erythrocytes 8-10 per field of view, and hyaline and granular casts. Blood pressure 120/80 mmHg. Your preliminary diagnosis:
<variant> nephrotic syndrome
<variant> acute glomerulonephritis
<variant> systemic lupus erythematosus
<variant> hypertension
<variant> chronic pyelonephritis
<question> A 22-year-old patient was admitted with complaints of severe edema, increased blood pressure, decreased urine output, and weakness. Blood pressure is 170/110 mmHg. Blood chemistry: creatinine 620 μmol/L, urea 25 mmol/L, potassium 5.8 mmol/L. Urinalysis: red blood

cells 30-40 per field of view, protein 4.6 g/L, granular casts. Kidney biopsy: crescents in more than 70% of glomeruli. Indicate the type of glomerulonephritis in this patient:
<variant> rapidly progressive glomerulonephritis
<variant> membranoproliferative glomerulonephritis
<variant> minimal changes
<variant> ΦIgA nephropathy
<variant> focal segmental glomerulosclerosis
<question> A 27-year-old man was admitted with complaints of edema and high blood pressure. His medical history includes a recent skin infection. A blood chemistry panel reveals creatinine 170 μmol/L, decreased complement C3. Urinalysis reveals protein 3.0 g/L, erythrocytes 20-30 per field of view. A kidney biopsy revealed prominent subepithelial "humps" on electron microscopy. Your preliminary diagnosis:
<variant> Acute poststreptococcal glomerulonephritis
<variant>Goodpasture's syndrome
<variant>Lupus nephritis
<variant> Minimal change disease
<variant> Thrombotic microangiopathy
<question> A 21-year-old female patient with chronic pyelonephritis complains of worsening condition: lower back pain, weakness, and weight loss. A blood biochemistry panel reveals elevated creatinine and urea. Urinalysis reveals specific gravity of 1.008, leukocytes 20-30 per high-power field, and bacteriuria (+++). Ultrasound reveals scarring of one kidney. Your preliminary diagnosis:
<variant> chronic kidney disease
<variant> acute renal failure
<variant> hydronephrosis
<variant> polycystic kidney disease
<variant> renal arterial hypertension
<question> Select the main clinical symptom characteristic of nephritic syndrome:
<variant> arterial hypertension
<variant> hyperlipidemia
<variant> hyperglycemia
<variant> hypoglycemia
<variant> nocturia
<question> Indicate the elevated laboratory indicator in nephritic syndrome:
<variant> creatinine and urea
<variant> albumin
<variant> glucose
<variant> sodium
<variant> potassium
<question> A 25-year-old patient came to the clinic complaining of loss of appetite, itchy skin, frequent nocturnal urination, and weakness. Over the past two weeks, he has noted an increase in blood pressure (up to 180/110 mmHg). His medical history includes hypertension for over 15 years. Urinalysis revealed proteinuria 2.6 g/day, isosthenuria, and microhematuria. Blood chemistry: creatinine 440 μmol/L, urea 16 mmol/L, potassium 5.6 mmol/L. Your preliminary diagnosis:
<variant> chronic renal failure
<variant> acute glomerulonephritis
<variant> nephrotic syndrome
<variant> acute tubulointerstitial nephritis
<variant> polycystic kidney disease

<question> A 26-year-old patient complained of severe weakness, loss of appetite, itchy skin, and frequent nocturnal urination. Over the past two weeks, he has noted an increase in blood pressure (up to 180/110 mmHg). His medical history includes hypertension for over 15 years. Urinalysis revealed proteinuria 2.6 g/day, isosthenuria, and microhematuria. Blood chemistry: creatinine 450 µmol/L, urea 18 mmol/L, potassium 5.6 mmol/L.
<variant> chronic renal failure
<variant> acute glomerulonephritis
<variant> nephrotic syndrome
<variant> acute tubulointerstitial nephritis
<variant> polycystic kidney disease
<question> A 30-year-old female patient presented with complaints of lumbar pain, a fever of 38.5°C (100.4°F), weakness, and frequent and painful urination. Urinalysis revealed 5-6 white blood cells (WBCs), traces of protein, and bacteria++. What is your preliminary diagnosis?
<variant> acute pyelonephritis
<variant> glomerulonephritis
<variant> cystitis
<variant> urolithiasis
<variant> acute appendicitis
<question> A 45-year-old woman with chronic pyelonephritis presents with complaints of recurrent lumbar pain and fatigue. Select a test to assess renal function:
<variant> renal scintigraphy
<variant> cystoscopy
<variant> urine analysis according to Nechiporenko
<variant> complete blood count
<variant> excretory urography
<question> A 32-year-old female patient presented with complaints of lumbar pain, high fever (up to 39°C), chills, and frequent, painful urination. Urinalysis revealed leukocytes covering the entire visual field, bacteria (+++), and protein 0.5 g/L. Specify the necessary tests to determine the cause of pyelonephritis:
<variant> urine culture
<variant> Zimnitsky's urine analysis
<variant> complete blood count
<variant> MRI of the lumbar spine
<variant> Reberg's urine analysis
<question> A 40-year-old woman was admitted with complaints of lumbar pain, fever, and chills. The doctor made a preliminary diagnosis of acute pyelonephritis. Indicate the elevated laboratory values in the complete blood count in this case:
<variant> leukocytes and ESR
<variant> platelets
<variant> hemoglobin
<variant> creatinine and urea
<variant> amylase
<question> A 52-year-old man has suffered from chronic pyelonephritis for several years and complains of worsening condition. Ultrasound shows a decrease in kidney size, thickening of the renal pelvis, and calyceal deformity. Indicate the complication of chronic pyelonephritis in this case:
<variant> renal failure
<variant> hypertensive crisis

<variant> essential hypertension
<variant> renal tuberculosis
<variant> hydronephrosis
<question> A 37-year-old female patient with recurrent pyelonephritis reports the onset of severe nocturnal diuresis, fatigue, and pruritus. Blood test results: creatinine 280 μmol/L, urea 15 mmol/L. Urinalysis results: specific gravity 1.010, leukocytes 10-15 per high-power field. Your preliminary diagnosis:
<variant> chronic renal failure
<variant> acute renal failure
<variant> exacerbation of pyelonephritis
<variant> nephrotic syndrome
<variant> glomerulonephritis
<question> A 48-year-old man complained of high blood pressure (180/110 mmHg), headaches, general weakness, and decreased exercise tolerance. His medical history included a diagnosis of chronic pyelonephritis. Examination revealed no significant edema, pulse rate of 82 beats/min. Biochemical analysis revealed creatinine of 150 μmol/L, urea of 10.5 mmol/L, and no hyperkalemia. Renal ultrasound revealed the right kidney was reduced to 8.5 cm, with thinned parenchyma; the left kidney was unchanged. What was the cause of hypertension in this patient?
<variant> renoparenchymal hypertension
<variant> endocrine hypertension (pheochromocytoma)
<variant> renovascular hypertension
<variant> primary arterial hypertension
<variant> hypertension due to hyperaldosteronism
<question> A 70-year-old patient suffers from type 2 diabetes. Due to high blood pressure, edema has developed, proteinuria is 3 g/day, and creatinine level is 250 μmol/L. Specify the complication of diabetes:
<variant> diabetic nephropathy
<variant> diabetic ketoacidosis
<variant> acute pyelonephritis
<variant> glomerulonephritis
<variant> chronic heart failure
<question> A 65-year-old female patient was admitted with complaints of headache, swelling, and weakness. Blood chemistry: creatinine level - 550 μmol/L, urea - 25 mmol/L. She suffers from hypertension and chronic kidney disease. Your preliminary diagnosis:
<variant> chronic renal failure, terminal stage
<variant> acute renal failure
<variant> chronic kidney disease, stage 3
<variant> glomerulonephritis
<variant> renovascular hypertension
<question>For hemorrhagic stroke, the cerebrospinal fluid is characterized by the presence of:
<variant>presence of red blood cells
<variant>lowering glucose levels
<variant>increased glucose levels
<variant>presence of leukocytes
<variant>presence of neutrophils
<question>The optimal time for hospitalization of a patient with suspected stroke in a vascular center is considered to be the first … from the onset of symptoms of the disease.
<variant>3-6 hours

<variant>12-18 hours
<variant>6-9 hours
<variant>9-12 hours
<variant>4-6 hours
<question> In the acute period of ischemic stroke, it is necessary to carry out
<variant>swallowing test
<variant>six-minute walk test
<variant>test for the presence of cognitive impairment
<variant>treadmill test
<variant>lidocaine electrophoresis
<question>Name the breakdown of all components of speech due to damage to the cortical speech areas:
<variant>Aphasia
<variant>Alalia
<variant> Dysarthria
<variant> Mutism
<variant>Autism
<question>Non-traumatic subarachnoid hemorrhage:
<variant> usually begins with an intense headache
<variant> occurs mainly in old age
<variant> has a chronic course
<variant> is often caused by a ruptured intracranial aneurysm
<variant> may be complicated by ischemic stroke
<question>For hypertensive subarachnoid hemorrhage, the obligatory sign is
<variant> meningeal syndrome
<variant> loss of consciousness
<variant> pupillary disorders
<variant> nystagmus
<variant> bilateral pyramidal pathological signs
<question>Patient with chronic pancreatitis for 15 years. A simple way to detect pancreatic calcification. . .
<variant>radiography
<variant>laparoscopy
<variant> laparotomy
<variant>irrigoscopy
<variant>cholangiography
<question>Patient K., at an appointment with his family doctor, was diagnosed with a newly diagnosed duodenal ulcer. The leading method of examining the patient...
<variant>FGDS with biopsy
<variant>general blood test
<variant>gastric juice analysis
<variant>stool occult blood test
<variant>duodenal intubation
<question>Specify the symptoms characteristic of exocrine pancreatic dysfunction:
<variant>weight loss, creatorrhea, steatorrhea
<variant>dry skin
<variant>hyperglycemia
<variant>dilation of the veins of the anterior abdominal wall

<variant>renal and hepatic failure
<question>Gastric intubation– this is one of the most frequently performed diagnostic procedures, mandatory if gastritis, peptic ulcer disease and many other gastrointestinal diseases are suspected.The scientist who proposed the method of gastric intubation:
<variant>Kussmaul
<variant>G.A. Zakharyin
<variant>R. Laennec
<variant>L. Auenbrugger
<variant>Einthoven
<question>Normal values of the fasting (1) portion of gastric juice:
<variant>up to 50 ml, total acidity 20 TE
<variant>50 – 100 ml, total acidity 15 TE
<variant>100 – 150 ml, total acidity 30 TE
<variant>150 – 200 ml, total acidity 40 TE
<variant>150 – 200 ml, total acidity 80 TE
<question>Normal parameters of gastric secretion after a test breakfast:
<variant>total acidity 40-60 TE, free acidity 20-40 TE
<variant>total acidity 20-40 TE, free acidity 10-20 TE
<variant>total acidity up to 20 TE, free acidity zero
<variant>total acidity 100-120 TE, free acidity 80-10 TE
<variant>against the background of hyposecretion, the presence of lactic acid is detected
<question>The state of hyposecretion and hypoacidity of gastric juice:
<variant>total acidity 20-40 TE, free acidity 10-20 TE
<variant>Total acidity up to 20 TE, free acidity zero
<variant>total acidity 40-60 TE, free acidity 20-40 TE
<variant>total acidity 100-120 TE, free acidity 80-10 TE
<variant>against the background of hyposecretion, the presence of lactic acid is detected
<question>Condition of hypersecretion and hyperacidity of gastric juice:
<variant>total acidity 100-120 TE, free acidity 80-10 TE
<variant>total acidity 20-40 TE, free acidity 10-20 TE
<variant>total acidity 40-60 TE, free acidity 20-40 TE
<variant>Total acidity up to 20 TE, free acidity zero
<variant>against the background of hyposecretion, the presence of lactic acid is detected
<question>Possible changes in secretory function in gastric cancer:
<variant>against the background of hyposecretion, the presence of lactic acid is detected
<variant>total acidity 20-40 TE, free acidity 10-20 TE
<variant>total acidity 40-60 TE, free acidity 20-40 TE
<variant>total acidity 100-120 TE, free acidity 80-10 TE
<variant>total acidity up to 20 TE, free acidity zero
<question>A method that allows one to better assess the motor function of the stomach:
<variant>electrogastrography
<variant>fluoroscopy
<variant>radiography
<variant>fibrogastroscopy
<variant>ultrasound examination
<question>The best method for documenting the "niche symptom" or "filling defect" of the stomach is the research method...
<variant>radiography

<variant>fluoroscopy
<variant>electrogastrography
<variant>fibrogastroscopy
<variant>ultrasound examination
<question>The research methods combined with targeted biopsy are...
<variant>fibrogastroscopy
<variant>radiography
<variant>electrogastrography
<variant>fluoroscopy
<variant> ultrasound examination
<question>Approximate parameters of intestinal residues per day:
<variant>residue volume up to 200.0 g, liquid content up to 60-80%
<variant>residue volume up to 100.0 g, liquid content up to 30%
<variant>residue volume up to 100.0 g, liquid content up to 95%
<variant>residue volume up to 300.0 g, liquid content up to 10%
<variant>residue volume up to 500.0 g, liquid content up to 10%
<question>Approximate parameters of intestinal residues per day in the presence of diarrhea:
<variant>residue volume up to 600.0 g, liquid content up to 95%
<variant>residue volume up to 200.0 g, liquid content up to 60-80%
<variant>residue volume up to 100.0 g, liquid content up to 30%
<variant>residue volume up to 300.0 g, liquid content up to 10%
<variant>residue volume up to 500.0 g, liquid content up to 10%
<question>Approximate parameters of intestinal residues per day in the presence of constipation:
<variant>residue volume up to 100.0 g, liquid content up to 30%
<variant>residue volume up to 200.0 g, liquid content up to 60-80%
<variant>residue volume up to 100.0 g, liquid content up to 95%
<variant>residue volume up to 300.0 g, liquid content up to 10%
<variant>residue volume up to 500.0 g, liquid content up to 10%
<question>Approximate parameters of fluid exchange in the intestinal lumen of healthy individuals:
<variant>about 8-9 liters are received, about 98.5% is absorbed
<variant>up to 5 liters are supplied, of which up to 98.0% is absorbed
<variant>about 12 liters are supplied, about 90% is absorbed
<variant>up to 7 liters are supplied, of which up to 98.0% is absorbed
<variant>up to 10 liters are supplied, up to 98.0% of which is absorbed
<question>Possible conditions for the development of diarrhea, taking into account the exchange of fluid in the intestines per day:
<variant>about 12 liters are supplied, about 90% is absorbed
<variant>about 8-9 liters are received, about 98.5% is absorbed
<variant>up to 5 liters are supplied, of which up to 98.0% is absorbed
<variant>about 15 liters enters, about 90% is absorbed
<variant>up to 1 liter is supplied, of which up to 98.0% is absorbed
<question>Conditions for the development of constipation, taking into account the daily fluid exchange in the intestines:
<variant>up to 5 liters are supplied, of which up to 98.0% is absorbed
<variant>about 8-9 liters are received, about 98.5% is absorbed
<variant>about 12 liters are supplied, about 90% is absorbed
<variant>about 15 liters enters, about 90% is absorbed
<variant>up to 1 liter is supplied, of which up to 98.0% is absorbed

<question>A research method that allows one to determine intestinal digestion:
<variant>coprogram
<variant>colon X-ray
<variant>colonofibroscopy
<variant>determination of intestinal microflora
<variant>intestinal irrigoscopy
<question>A research method that allows one to determine the condition of the rectum and sigmoid colon:
<variant>rectomanoscopy
<variant>radio telemetry
<variant>colon X-ray
<variant>irrigoscopy
<variant>fibrogastroscopy
<question>Percussion dimensions of the liver in healthy individuals with normosthenic body type:
<variant>9 x 8 x 7 cm
<variant>10 x 9 x 8 cm
<variant>7 x 8 x 9 cm
<variant>12 x 10 x 8 cm
<variant>8 x 6 x 4 cm
<question>Percussion dimensions of the liver in atrophic cirrhosis of the liver:
<variant>8 x 6 x 4 cm
<variant>9 x 8 x 7 cm
<variant>9 x 8 x 9 cm
<variant>12 x 10 x 8 cm
<variant>10 x 9 x 8 cm
<question>Percussion dimensions of the liver in hepatomegaly:
<variant>15 x 12 x 10 cm
<variant>9 x 8 x 7 cm
<variant>7 x 8 x 9 cm
<variant>8 x 6 x 4 cm
<variant>12 x 10 x 8 cm
<question>Auscultation of the liver is valuable in the presence of:
<variant>liver hemangiomas
<variant>liver cirrhosis
<variant>cholecystitis
<variant>liver abscess
<variant>liver cysts
<question>To determine liver function in protein synthesis, the following is used:
<variant>Corrosive sublimate test, Veltman tape
<variant>Basic phosphatase
<variant>Cholesterol, beta-lipoprotein
<variant>Trasaminase, aldolase, lactotedehydrogenase
<variant>Test of Kvyk-Pytel
<question>To determine the excretory function of the liver, the following is used:
<variant>Basic phosphatase
<variant>Corrosive sublimate test, Veltman tape
<variant>Cholesterol, beta lipoprotein
<variant>Transaminase, aldolase, lactate dehydrogenase

<variant>Test of Kvyk-Pytel
<question>Fat metabolism imbalance:
<variant>Itsenko-Cushing's disease
hypofunction of the gonads
<variant>Symonds' disease
<variant>abuse of foods rich in fat
<variant>dystrophy of the genital organs
<question>The thyroid gland produces:
<variant>T3, T4, TSH
<variant>enzymes
<variant>17-ОКСД7-КС
<variant>insulin
<variant>ACTH
<question>The pancreas produces:
<variant>insulin
<variant>ACTH
<variant>enzymes
<variant>17-ОКСД7-КС
<variant>T3, T4, TSH
<question>Insulin stimulates the deposition of carbohydrates in the form of:
<variant>glucose
<variant>lactose
<variant>glycogen
<variant>sucrose
<variant>glucosaminoglycans
<question>The endocrine glands produce:
<variant>hormones
<variant>anticholinergics
<variant>sympatholytics
<variant>beta blockers
<variant>ACE inhibitors
<question>The secretions of the endocrine glands are released into:
<variant>blood and lymph
<variant>bile
<variant>stomach
<variant>pancreas
<variant>sweat glands
<question>What is the daily human requirement for iodine?
<variant>100 mcg
<variant>50 mcg
<variant>150 mcg
<variant>250 mcg
<variant>1000 mcg
<question>The basis of the pathogenetic mechanism of development of diffuse toxic goiter is:
<variant>increased thyroid-stimulating immunoglobulins
<variant>increased secretion of catecholamines
<variant>increased secretion of thyroid-stimulating hormone
<variant>increased secretion of thyrotropin-releasing hormone

<variant>tissue hypersensitivity to thyroid hormones
<question>In diabetes mellitus, metabolism is disrupted.
<variant>carbohydrate
<variant>protein
<variant>fat
<variant>water-salt
<variant>vitamins
<question>The type of diabetes mellitus (DM) in which there is a progressive impairment of insulin secretion against the background of insulin resistance is:
<variant> Type 2 diabetes
<variant>Type 1 diabetes
<variant> gestational diabetes
<variant> secondary SD
<variant>other specific types of diabetes
<question>Indicate the characteristic laboratory sign of B12 deficiency anemia:
<variant>high color index
<variant>thrombocytosis
<variant>leukocytosis
<variant>increased erythrocyte sedimentation rate
<variant>lymphocytosis
<question>The substrate of acute leukemia is:
<variant>leukemic blast cells
<variant>leukemic maturing cells
<variant>mature leukemia cells
<variant>immature leukemia cells
<variant>plasma cells
<question>Acute leukemia is a tumor originating from:
<variant>bone marrow
<variant>hematopoietic tissue of the lymph nodes
<variant>reticuloendothelial tissue of the liver
<variant>reticuloendothelial tissue of the spleen
<variant>liver endothelial tissue
<question>Indicate the factor necessary for the absorption of vitamin B-12:
<variant>gastromucoprotein
<variant>hydrochloric acid
<variant>gastrin
<variant>pepsin
<variant>folic acid
<question>Name a common cause of anemia in acute leukemia:
<variant>disorder of red blood cell formation in the bone marrow
<variant>disorder of leukocyte formation in the bone marrow
<variant>disruption of erythropoietin production
<variant>iron malabsorption
<variant>disorder of platelet formation in the bone marrow
<question>The normal number of platelets in the blood is:
<variant>180 – 320 x 109 \l
<variant>50.0 – 180.0 x 109 \l
<variant>250.0 – 400.0 x 109 \l

<variant>350.0 – 450.0 x 109 \l
<variant>150.0 – 200.0 x 109 \l
<question>An increase in the number of platelets in the blood is called:
<variant>thrombocytosis
<variant>leukocytosis
<variant>poikilocytosis
<variant>anisocytosis
<variant>erythrocytosis
<question>"Thrombocytopenia" means:
<variant>decrease in platelet count
<variant>platelet hypofunction
<variant>increased platelet count in the blood
<variant>platelet hyperfunction
<variant>decrease in the number of red blood cells
<question>An increase in the number of leukocytes in the blood is called:
<variant>leukocytosis
<variant>erythrocytosis
<variant>lymphocytosis
<variant>thrombocytosis
<variant>anisocytosis
<question>A decrease in the number of leukocytes in the blood is called:
<variant>leukopenia
<variant>erythropenia
<variant>lymphopenia
<variant>lymphocytosis
<variant>leukocytosis
<question>A 45-year-old woman consulted a doctor complaining of general weakness, fatigue, shortness of breath during exertion, and frequent dizziness. Examination revealed pale skin, brittle nails, and dry hair. A complete blood count revealed hemoglobin of 85 g/L; red blood cells of 3.2 x 1012/L; color index of 0.7. Your preliminary diagnosis:
<variant>hypochromic iron deficiency anemia
<variant>hyperchromic B-12 deficiency anemia
<variant>hyperchromic folate deficiency anemia
<variant>myeloplastic syndrome
<variant>sidoropenic syndrome
<question>A 62-year-old man visits his primary care physician and complains of constant fatigue, dizziness, loss of appetite, and dry mouth. Examination reveals pale, slightly yellowed skin and a varnished tongue. A complete blood count reveals hemoglobin 70 g/L, red blood cells 2.5 x 1012/L, color index 1.2, macrocytosis, and hyperchromia. A biochemical analysis reveals elevated bilirubin levels. Your preliminary diagnosis:
<variant>megaloblastic anemia, vitamin B-12 deficiency
<variant>autoimmune hemolytic anemia
<variant>microcytic anemia
<variant>aplastic anemia
<variant>iron deficiency anemia
<question>A 30-year-old woman consulted a doctor complaining of shortness of breath when walking, general weakness, and decreased performance. Her medical history includes a recent viral infection. Examination revealed pale skin and a tachycardia of up to 110 beats per minute. A

complete blood count revealed hemoglobin of 95 g/L, red blood cells of 2.9 x 1012/L, and reticulocytes of 0.5. A bone marrow analysis revealed a decrease in the number of erythroid cells. Your preliminary diagnosis:
<variant>aplastic anemia
<variant>hemolytic anemia
<variant>iron deficiency anemia
<variant>B-12 deficiency anemia
<variant>microcytic anemia
<question>A 40-year-old woman consulted a doctor complaining of general weakness, dizziness, shortness of breath during physical exertion, and brittle nails. Her medical history revealed heavy menstrual periods lasting more than 7 days. Blood test results: hemoglobin - 85 g/L; red blood cells - 3.2 x 1012/L; color index - 0.7; serum iron - 5 μmol/L. Indicate the causes of anemia in this case:
<variant>chronic blood loss due to heavy menstruation
<variant>iron malabsorption in the stomach
<variant>impaired absorption of ferritin in the stomach
<variant>anemia caused by vitamin B-12 deficiency
<variant>folate deficiency anemia
<question>A 46-year-old woman consulted a doctor complaining of general weakness, dizziness, shortness of breath during exertion, hair loss, and brittle nails. Her medical history revealed heavy menstrual periods lasting more than 8 days. Blood test results: hemoglobin 83 g/L; red blood cells 3.1 x 1012/L; color index 0.6; serum iron 5 μmol/L. Your preliminary diagnosis:
<variant>iron deficiency anemia
<variant>anemia caused by vitamin B-12 deficiency
<variant>hemolytic anemia
<variant>aplastic anemia
<variant>folate deficiency anemia
<question>A 55-year-old man consulted a general practitioner complaining of constant fatigue, shortness of breath, and weight loss. Examination revealed pale skin and mucous membranes. His medical history includes chronic gastritis with low acidity. A complete blood count (CBC) revealed hemoglobin 88 g/L; red blood cells 3.4 x 1012/L; color index 0.6; serum iron 5 μmol/L; ferritin 7 ng/ml. Which additional diagnostic test would be helpful?
<variant>fibrogastroscopy
<variant>Abdominal ultrasound
<variant>lymph node puncture
<variant>stool occult blood test
<variant>determination of serum iron in the blood
<question>A 50-year-old man consulted a general practitioner complaining of constant fatigue, shortness of breath during exertion, and weight loss. Examination revealed pale skin and mucous membranes. His medical history includes chronic gastritis with low acidity. A complete blood count (CBC) revealed hemoglobin 84 g/L; red blood cells 3.2×1012/L; color index 0.5; serum iron 4 μmol/L; ferritin 6 ng/ml. Your preliminary diagnosis:
<variant>iron deficiency anemia caused by impaired iron absorption
<variant>folate deficiency anemia
<variant>aplastic anemia
<variant>anemia caused by vitamin B-12 deficiency
<variant>autoimmune hemolytic anemia
<question>A 60-year-old man consulted a general practitioner complaining of constant fatigue, drowsiness, weight loss, dry skin, and loss of appetite. Examination revealed pale skin and mucous

membranes, as well as mild tachycardia. His medical history includes chronic gastritis with low acidity. His complete blood count (CBC) revealed: hemoglobin 88 g/L; red blood cells 3.2×1012/L; color index 0.65; serum iron 4 μmol/L; ferritin 6 ng/ml. Your preliminary diagnosis:
<variant>iron deficiency anemia
<variant>aplastic anemia
<variant>folate deficiency anemia
<variant>B-12 deficiency anemia
<variant>autoimmune hemolytic anemia
<question>A 35-year-old man presents to the doctor complaining of a painful purple rash on his shins, pain in the knees and ankles, and blood in the urine. His medical history indicates that the condition began after a bout of tonsillitis. Examination reveals purple rashes symmetrically distributed throughout the lower extremities, swollen joints, and pain with movement. Urinalysis reveals proteinuria and microhematuria. Your preliminary diagnosis:
<variant>hemorrhagic vasculitis
<variant>aplastic anemia
<variant>acute leukemia
<variant>chronic myeloid leukemia
<variant>chronic lymphocytic leukemia
<question>A 27-year-old woman was admitted to the hospital complaining of blood in her urine, lumbar pain, and a rash on her lower extremities. Her medical history revealed an acute onset of the illness, a week after bronchitis. Examination revealed a severe hemorrhagic rash on her shins. Urinalysis revealed proteinuria 2 g/L and hematuria. Blood creatinine was elevated. Indicate the complication in this case:
<variant>acute renal failure
<variant>acute heart failure
<variant>aplastic anemia
<variant>B-12 deficiency anemia
<variant>autoimmune hemolytic anemia
<question>A 40-year-old man consulted a doctor complaining of severe swelling in the lower extremities, frequent purpuric rash, general weakness, and decreased daily urine output. History: chronic tonsillitis. Blood tests: decreased total blood protein - 58 g/L; hypoalbuminemia, proteinuria - 4 g/L; hematuria. Your preliminary diagnosis:
<variant>hemorrhagic vasculitis
<variant>aplastic anemia
<variant>chronic myeloid leukemia
<variant>chronic lymphocytic leukemia
<variant>autoimmune hemolytic anemia
<question>A 35-year-old man was admitted to hospital complaining of general weakness, shortness of breath, and fever. He had a viral infection two weeks prior. Examination revealed pale skin, icterus of the sclera, and moderate tachycardia. Blood test results: hemoglobin 90 g/L; reticulocytes 20%; indirect bilirubin 70 μmol/L. The Coombs test is positive. Your preliminary diagnosis:
<variant>autoimmune hemolytic anemia
<variant>aplastic anemia
<variant>chronic lymphocytic leukemia
<variant>chronic myeloid leukemia
<variant>B-12 deficiency anemia
<question>A 28-year-old man was admitted to hospital complaining of sudden weakness, shortness of breath, and palpitations. His medical history includes a history of taking an antibiotic 2 weeks

prior. Examination revealed jaundice of the sclera and skin, and tachycardia. Blood test results: hemoglobin 60 g/L; reticulocytes 18%; total bilirubin 55 μmol/L; indirect bilirubin 50 μmol/L; Coombs test positive. What is the cause of this condition?
<variant>drug-induced autoimmune hemolytic anemia
<variant>aplastic anemia
<variant>B-12 deficiency anemia
<variant>chronic lymphocytic leukemia
<variant>chronic myeloid leukemia
A 35-year-old man consulted a general practitioner complaining of severe weakness, dizziness, shortness of breath during physical exertion, and unexplained bruising. Examination revealed pale skin with numerous petechiae and ecchymoses. A complete blood count revealed hemoglobin 70 g/L; leukocytes 2.0 x 109/L; platelets 20 x 109/L; and reticulocytes 0.5%. Your preliminary diagnosis:
<variant>aplastic anemia
<variant>idiopathic thrombocytopenic purpura
<variant>autoimmune hemolytic anemia
<variant>B-12 deficiency anemia
<variant>chronic myeloid leukemia
<question>A 25-year-old woman consulted a doctor complaining of unexplained bruising, frequent nosebleeds, and increased bleeding from the gums. Her medical history includes a viral infection 2 weeks ago. Examination revealed multiple petechiae and ecchymoses on the skin of the trunk and extremities. Blood pressure is 110/70 mmHg, and her heart rate is 76 beats per minute. Blood test results: platelets 20×109/L, hemoglobin 130 g/L, and leukocytes ×109/L. Your preliminary diagnosis:
<variant>idiopathic thrombocytopenic purpura
<variant>aplastic anemia
<variant>autoimmune hemolytic anemia
<variant>B-12 deficiency anemia
<variant>chronic myeloid leukemia
A 44-year-old man's complete blood count revealed the following changes: hemoglobin - 85 g/L, red blood cells - 2.9 x 1012 \L, white blood cells - 3.7 x 109 \L, erythrocyte sedimentation rate - 52 mm/hour, platelets - 95 x 109 \L. The doctor referred him for further testing. Name an informative test to clarify the diagnosis:
<variant>sternal puncture
<variant>gastric endoscopy
<variant>lymph node puncture
<variant>stool occult blood test
<variant>determination of serum iron in the blood
<question>A 47-year-old man was admitted to hospital with complaints of spontaneous skin hemorrhages, nosebleeds, and severe weakness. There is no history of chronic diseases. On examination: multiple ecchymoses on the lower extremities, small hemorrhages on the mucous membranes. Blood test: platelets - 11 × 109 / L, hemoglobin - 118 g / L, erythrocyte sedimentation rate - 16 mm / h; leukocytes - 4 × 109 / L. Indicate an informative diagnostic method:
<variant>bone marrow examination
<variant>endoscopic examination of the stomach
<variant>lymph node puncture
<variant>stool occult blood test
<variant>determination of ferritin in the blood

<question>A 28-year-old man visits his doctor and complains of decreased appetite, unsteadiness of gait, and general weakness. Examination reveals pale skin and mucous membranes. Blood tests reveal hemoglobin 70 g/L, macrocytosis, and Joly bodies; red blood cells 1.9 ×1012/L, and color index 1.3. Bone marrow analysis reveals megaloblastic hematopoiesis. Your preliminary diagnosis:
<variant>B-12 deficiency anemia
<variant>iron deficiency anemia
<variant>acute leukemia
<variant>chronic lymphocytic leukemia
<variant>hemolytic anemia
<question>A 42-year-old woman consulted a doctor complaining of increased fatigue, dizziness, hair loss, and brittle nails. Her medical history includes uterine fibroids and menorrhagia. Blood tests revealed hemoglobin of 80 g/L, hypochromia, and microerythrocytosis. Your preliminary diagnosis:
<variant>iron deficiency anemia
<variant>B-12 deficiency anemia
<variant>sickle cell anemia
<variant>aplastic anemia
<variant>hereditary spherocytosis
<question>A 42-year-old woman,At a doctor's appointment, the patient complains of fever, frequent bleeding from the gums and nose, swollen lymph nodes, and general weakness. On examination, the patient reveals pale skin and mucous membranes, and subcutaneous hemorrhages.Blood tests revealed signs of anemia, thrombocytopenia, and blasts in the peripheral blood. Please indicate the pathological condition that is characterized by this laboratory finding:
<variant>acute leukemia
<variant>chronic myeloid leukemia
<variant>iron deficiency anemia
<variant>B-12 deficiency anemia
<variant>aplastic anemia
<question>An 18-year-old female patient is visiting the doctor,complains of enlarged cervical lymph nodes and severe weakness.Blood tests reveal pancytopenia and high blast rate in the bone marrow (78%), with a negative myeloperoxidase reaction. Your preliminary diagnosis:
<variant>acute lymphocytic leukemia
<variant>chronic myeloid leukemia
<variant>B-12 deficiency anemia
<variant>aplastic anemia
<variant>hemolytic anemia
<question> A 25-year-old man consulted a doctor complaining of severe weakness, dizziness, shortness of breath during physical exertion, and bruising on his body for no apparent reason. A blood test revealed: red blood cells - 1.8 ×1012/L, hemoglobin - 36 g/L, color index - 0.9, white blood cells - 1.6 ×109/L, platelets - 5.0 ×109/L. Your preliminary diagnosis:
<variant>aplastic anemia
<variant>hemolytic anemia
<variant>B-12 deficiency anemia
<variant>iron deficiency anemia
<variant>thrombocytopenic purpura
<question>A 72-year-old woman presented to the doctor with complaints of shortness of breath at rest, palpitations, cough producing pink sputum, anxiety, and severe weakness. History: Arterial hypertension for the past 25 years; previous myocardial infarction. Examination revealed orthopnea,

muffled heart sounds, and a regular rhythm interrupted by frequent ventricular extrasystoles. Blood pressure was 220/120 mmHg. Fundus examination revealed papilledema. Urinalysis revealed trace proteinuria. Select the probable complication in the patient:
<variant>pulmonary edema
<variant>acute cerebrovascular accident
<variant>acute renal failure
<variant>retinal detachment
<variant>myocardial infarction.
A 60-year-old man presents to the doctor with the following symptoms: high, persistent systolic hypertension, morning headaches in the occipital region, palpitations, and blurred vision. A fundus examination reveals stage IV angioretinopathy. A systolic murmur is heard in the epigastric region. The cause of the hypertension is:
<variant>atherosclerosis of the abdominal aorta
<variant>primary hyperaldosteronism
<variant>chronic glomerulonephritis
<variant>prostate adenoma
<variant>pheochromocytoma
<question>A 28-year-old woman presents to her local physician complaining of headaches and dizziness. Her medical history includes angina attacks and periodic use of nitrates and aspirin as prescribed. She has suffered from asthma for the past 8 years, and manages her attacks with inhalers. Examination reveals pale skin and pulsating neck vessels. The cardiac borders are enlarged to the left, and the cardiac impulse is resistant, shifted to the left and downward. Cardiac auscultation reveals a soft protodiastolic murmur in the second intercostal space on the right, a heart rate of 82 beats per minute, and a blood pressure of 185/60 mmHg. Cause of hypertension:
<variant>aortic valve insufficiency of atherosclerotic origin
<variant>essential arterial hypertension
<variant>drug-induced arterial hypertension
<variant>primary renal sodium retention
"White coat" hypertension
<question> A 23-year-old woman presents to her doctor complaining of brief episodes of palpitations accompanied by dizziness and fainting. She has been taking amiodarone for a long time. An ECG reveals a prolongation of the QT interval. An informative method for an accurate diagnosis is:
<variant>24-hour Holter ECG monitoring
<variant>ChPES
<variant>coronary angiography
<variant>radionuclide ventriculography
<variant>right heart catheterization
<question>A 5-year-old man complains of episodes of short-term dizziness, palpitations, and two fainting spells during a doctor's appointment. He has been registered with the "D" category of care for over 10 years with a diagnosis of ischemic heart disease. An informative diagnostic test for establishing a clinical diagnosis is:
<variant>daily ECG monitoring
<variant>ECG
<variant>EchoCG
<variant>FCG
<variant>stress EchoCG

<question>A 45-year-old man visits his local physician and complains of dizziness, fainting during physical exertion or rapid changes in body position, attacks of typical angina, and fatigue. On cardiac auscultation, heart sounds are muffled, with a harsh systolic murmur in the 2nd intercostal space on the right, radiating to the carotid arteries. Blood pressure is 120/80 mmHg. An ECG reveals complete left bundle branch block. An echocardiogram reveals concentric hypertrophy of the left ventricular walls and thickening of the aortic valve leaflets. Your preliminary diagnosis:
<variant>aortic stenosis
<variant>mitral valve insufficiency
<variant>stenosis of the right atrioventricular orifice
<variant>aortic and mitral valve insufficiency
<variant>lesion of the papillary muscles of the tricuspid valve
<question>A 5-year-old man presented to the doctor with complaints of shortness of breath, palpitations, general weakness, and fainting. An echocardiogram revealed myocardial hypertrophy and right ventricular outflow tract stenosis, a subaortic ventricular septal defect, and aortic outlet of the right ventricle. Select your preliminary diagnosis:
<variant>tetralogy of Fallot
<variant>mitral valve prolapse
<variant>pulmonary artery defect
<variant>pulmonary artery stenosis
<variant>coarctation of the aorta
A 22-year-old man suddenly experienced palpitations, heart pain, and shortness of breath. Examination revealed the following symptoms: the first heart sound at the apex is increased, and the second heart sound is increased in the pulmonary artery. The heart rhythm is irregular, with tachycardia. The pulse deficit is 6-8 beats per minute. A click of the mitral valve opening is detected. Blood pressure is 110/70 mmHg. Please indicate your preliminary diagnosis:
<variant>stenosis of the left atrioventricular orifice
<variant>mitralization of aortic insufficiency
<variant>tricuspid valve insufficiency
<variant>mitral valve insufficiency
<variant>aortic stenosis
<question>A 44-year-old man was admitted to the emergency department after fainting while jogging in the morning. The patient had a history of similar fainting episodes. An ECG revealed profound T-wave inversion in leads I, AVL, and V2-V6. There was no history of chest pain or shortness of breath. A further examination would be advisable to confirm the diagnosis:
<variant>Doppler echocardiography
<variant>Holter monitoring
<variant>stress echocardiography
<variant>coronary angiography
<variant>bicycle ergometry
A 47-year-old man was admitted to the intensive care unit in a state of clinical death. He lost consciousness during exercise and went into cardiac arrest. Autopsy revealed cardiomegaly with hypertrophy of the upper third of the interventricular septum and left ventricular free wall with severe outflow tract obstruction. The underlying cause of death is:
<variant>ventricular fibrillation
<variant>paroxysmal supraventricular tachycardia
<variant>complete atrioventricular block
<variant>sick sinus syndrome
<variant>atrial fibrillation

<question>A 36-year-old patient presented to the doctor complaining of shortness of breath with minimal physical exertion, occasional attacks of suffocation, heaviness in the right upper quadrant, and edema. An echocardiogram revealed a ventricular septal defect and a narrowing of the right ventricular outflow tract. Radiographic findings revealed a "slipper"-shaped cardiac shadow in the pulmonary artery. Describe the complication of the disease:
<variant>right ventricular failure
<variant>cerebral vascular thrombosis
<variant>infective endocarditis
<variant>mesenteric vascular thrombosis
<variant>left ventricular failure
A 57-year-old man presented to his doctor with complaints of shortness of breath at rest, chest pain, and palpitations. The heart borders are enlarged to the left. A harsh systolic murmur is heard in the second left intercostal space, radiating to the left subscapular region and carotid arteries. The second heart sound over the pulmonary artery is weakened. ECG shows sinus rhythm, the electrical axis is shifted to the left, and right ventricular hypertrophy. Your preliminary diagnosis:
<variant>pulmonary artery stenosis
<variant>mitral stenosis
<variant>coarctation of the aorta
<variant>patent ductus arteriosus
<variant>atrial septal defect
<question>A 46-year-old woman presented to the doctor with complaints of shortness of breath, cough, palpitations, and irregular heartbeat. She has suffered from rheumatism since childhood. Examination revealed acrocyanosis and flushed cheeks. A systolic murmur, a flapping first heart sound, and an additional mitral valve opening sound after the second heart sound are audible. Your preliminary diagnosis:
<variant>mitral valve stenosis
<variant>aortic stenosis
<variant>mitral valve insufficiency
<variant>tricuspid valve insufficiency
<variant>tricuspid valve stenosis
<question>A 35-year-old man. On examination: The skin and visible mucous membranes are normal in color. Blood pressure is 100/70 mmHg. A systolic-diastolic murmur is heard over the pulmonary artery, with an accentuated second heart sound. The ECG shows signs of left heart strain. X-ray shows increased pulmonary markings, and the cardiac shadow is normal in shape. Your preliminary diagnosis:
<variant>atrial septal defect
<variant>tetralogy of Fallot
<variant>pulmonary artery stenosis
<variant>coarctation of the aorta
<variant>patent ductus arteriosus
<question> A 65-year-old patient presented to the doctor with complaints of squeezing pain in the heart region, unrelated to physical exertion but resolving after taking nitroglycerin. She also suffers from varicose veins in her lower extremities. Her blood pressure sometimes rises to 160/90 mmHg. A 12-lead ECG shows no specific changes. Select the most likely diagnostic test:
<variant>daily monitoring
<variant>bicycle ergometry
<variant>test with obzidan
<variant>coronary angiography

<variant>determination of enzyme levels in the blood
<question> A 44-year-old boy is admitted by ambulance with severe bilateral pneumonia. Emergency services noted a critical drop in body temperature, sudden onset of severe weakness, fainting, dizziness, tinnitus, nausea, and vomiting. Physical examination: the patient is pale, has severe acrocyanosis, cold, clammy sweat, tachycardia, thready pulse, muffled heart sounds, and low blood pressure. The cause of the rapid deterioration of the patient's condition is the development of:
<variant>infectious toxic shock
<variant>sepsis
<variant>cardiogenic shock
<variant>pulmonary embolism
<variant>acute respiratory distress syndrome
<question>A 33-year-old man presented to the doctor complaining of acute, migrating, wave-like pain behind the sternum and along the spine. Asymmetry of the pulse in the arms and legs, a systolic murmur over the aorta, and hypotension were detected. A diagnostic test to confirm the diagnosis was:
<variant>aortography
<variant>echocardiography
<variant>ECG
<variant>ventriculography
<variant>coronary angiography
<question>A 35-year-old woman with rheumatic heart disease presented to her doctor complaining of shortness of breath, palpitations, and swelling in her legs. Examination revealed pulmonary congestion, hepatomegaly, and edema. To assess left ventricular function, the patient was prescribed the following:
<variant>echocardiography
<variant>bicycle ergometry
<variant>electrocardiography
<variant>coronary angiography
<variant>Holter ECG monitoring
<question>A 21-year-old patient, during a physical examination, was found to have shortness of breath, asthma attacks, low tolerance to physical activity, infantilism, delayed physical development, and a systolic heart murmur characteristic of:
<variant>congenital heart defects
<variant>pulmonary emphysema
<variant>bronchial asthma
<variant>acquired heart defects
<variant>congenital anomalies of the bronchopulmonary system
<question>A 16-year-old girl presents to the doctor complaining of a crushing chest pain when climbing a flight of stairs, heart palpitations, and dizziness. Physical examination reveals moist rales. Heart rate is 100 beats per minute. Blood pressure is 110/80 mmHg. Symptoms likely indicating chronic circulatory failure include:
<variant>wet wheezing
<variant>increased blood pressure
<variant>dizziness
<variant>interruptions in the heart area
<variant> pressing pain behind the breastbone
<question>A 22-year-old patient, during a doctor's appointment, notes frequent flare-ups of pharyngitis, complains of palpitations, shortness of breath, and joint pain. On examination, muffled

heart sounds are noted, and a systolic murmur is heard at the apex of the heart. The following investigations should be performed:
<variant>echocardiography
<variant>phonocardiography
<variant>electrocardiography
<variant>X-ray of joints
<variant>angiography of the heart vessels
<question> A 25-year-old man visited his family doctor complaining of intense chest pain. Upon examination, the doctor found no visible changes in the heart or lungs. Blood pressure was 120/85 mmHg, and the heart rate was 88 beats per minute. The doctor reassured the patient and sent him home, recommending that he rest at home and return the next day. Is the doctor's approach appropriate?
<variant> no, an urgent ECG examination must be scheduled
<variant> yes, the pain that has arisen does not portend any danger to the patient's condition
<variant> Yes, if any complications arise, assistance can be provided the next day.
<variant> No, it is necessary to prescribe treatment with analgesics
<variant> no, the patient must be referred for planned treatment
<question> A 25-year-old woman presents to the doctor complaining of a sharp, stabbing, squeezing pain in the left side of her chest. The pain intensifies with breathing, head and arm movements, and palpation of the chest wall. The pain began two hours ago after an unpleasant experience at work. Your treatment plan:
<variant> take an electrocardiogram
<option> prescribe treatment
<option> refer to a neurologist
<variant> hospitalize
<variant> send for x-ray.
<question> A 15-year-old girl complains of chest pain at a doctor's appointment. The primary diagnostic method for chest pain associated with mitral valve prolapse is:
<variant> echocardiography
<variant> electrocardiography
<variant> coronary angiography
<variant> radiography
<variant> tomography.
<question> A 45-year-old man presented to his doctor with complaints of shortness of breath with minimal physical exertion, attacks of suffocation and hemoptysis, sometimes at night, and paroxysmal, intense chest pain radiating to the left arm, which subsides after changing body position (sitting with legs down) and taking nitroglycerin. Forced freezing during walking or physical exertion is characteristic of an attack:
<variant> angina
<variant> cardiac asthma
<variant> biliary colic
<variant> bronchial asthma
<variant> renal colic
<question> A 30-year-old man was taken to the medical center in serious condition. The skin and mucous membranes are cyanotic. The pulse is 146 beats per minute, weak. Blood pressure is 90/60 mmHg. Breathing is rapid and shallow. Body temperature is 40.6° C. The bluish coloration (cyanosis) of the skin is caused by:
<variant> increasing the level of restored hemoglobin in the blood

<variant> an increase in red blood cells and hemoglobin in the blood
<variant>increasing the level of gas exchange in the body
<variant> blood stagnation in peripheral vessels
<variant> spasm of peripheral vessels
<question> A 45-year-old man is in a forced position: he sits slightly reclined, resting his hands on the bed, and his legs are hanging down. Your preliminary diagnosis:
<variant> cardiac asthma
<variant> bronchial asthma
<variant> pericarditis
<variant> renal colic
<variant> angina pectoris
<question> A 25-year-old man with a cardiovascular condition was admitted to the hospital. He complained of shortness of breath after physical exertion. Examination revealed cyanosis. Mixed cyanosis (blue heart disease) is characteristic of:
<variant> congenital heart defects
<variant> mitral valve defects
<variant> aortic heart defects
<variant> ischemic heart disease
<variant> aortic aneurysms
<question> While examining the neck of a 24-year-old man with aortic insufficiency, the doctor immediately noticed vibrations in the paired arteries on both sides of the neck—carotid dance. Carotid dance is caused by:
<variant> increased pulsation of the carotid arteries due to high pulse pressure
<variant>collapse of the jugular veins during systole
<variant> swelling of the jugular veins during systole
<variant> swelling of the jugular veins in a horizontal position
<variant> swelling of the jugular veins at the outlet
<question> A man was admitted to the hospital complaining of shortness of breath, suffocation, and rapid fatigue. Pronounced epigastric pulsation is not caused by:
<variant> aortic insufficiency
<variant> liver pulsation
<variant> pulsation of the abdominal aorta
<variant> right ventricular hypertrophy
<variant> left ventricular hypertrophy
<question> A 19-year-old patient presents with the following complaints: mixed sputum with pus and a large amount of foul-smelling mucus, hemoptysis, fever up to 38°C (100.4°F), fatigue, and shortness of breath. The patient has a history of coughing with sputum since childhood. Over the past 5 years, outbreaks have become more frequent. Your preliminary diagnosis:
<variant>Bronchiectasis
<variant>COPD
<variant> bronchial asthma
<variant>chronic bronchitis
<variant>polycystic lung disease
<question> A patient with an abscess developed shortness of breath and sudden pain in the right chest after a severe cough. On examination, the right chest does not participate in respiration, and the intercostal spaces are widened. Percussion sounds are audible. The patient developed a complication:
<variant>Pneumothorax

<variant>Өкпеектаза летах
<variant>pulmonary infarction
<variant>pulmonary emphysema
<variant>Exudative pleurisy
<question> Patient M., 45, complains of a cough with difficult-to-expel sputum and shortness of breath during physical exertion. He has suffered from bronchospasm for 15 years. Physical examination: his fingers feel like drumsticks, his chest is barrel-shaped, his breathing is harsh, his exhalation is prolonged, and dry wheezing is heard throughout the lungs. Possible diagnosis:
<variant>chronic obstructive pulmonary disease
<variant>chronic purulent bronchitis
<variant>bronchiectasis
<variant>focal pneumonia
<variant>pulmonary emphysema
<question> A female patient named K., born in 2014, was admitted to the department. Complaints: shortness of breath at rest, increased shortness of breath with physical exertion, fever of 37.9°C (100.4°F), slight rust-colored sputum production when coughing, and pain in the right chest associated with breathing. Examination revealed diffuse cyanosis and herpetic lesions on the lips. The right chest wall is thicker than the act of breathing. Respiratory rate is 36 times per minute. The cause of the dyspnea is...
<variant>decreased respiratory volume (hardening due to inflammation of the lobe)
<variant>decreased elastic properties of the lungs caused by emphysema
<variant>spasms of the small bronchi
<variant>mechanical resistance of the pharynx
<variant>damage to the larynx
<question> A 23-year-old patient named U. was admitted to the clinic. On examination, the left side of the chest was enlarged, remaining due to breathing. The intercostal spaces were smooth and slight swelling was visible. The patient exhibited symptoms of the syndrome:
<variant>accumulation of fluid or air in the pleural space
<variant>obstructive atelectasis
<variant>compaction of lung tissue
<variant>pulmonary emphysema
<variant>pneumonia
<question> On examination, the patient revealed difficulty breathing in the right chest. Palpation of the chest revealed diminished vocal fremitus on the right. Percussion of the lungs revealed a dull, flat sound on the right. Auscultation revealed weak breath sounds and right-sided bronchophony. No extraneous breathing noises were present. The patient exhibited symptoms of the syndrome:
<variant> hydrothorax
<variant>closed pneumothorax
<variant>focal inflammatory consolidation of the lungs
<variant>compressive pelvis
<variant>pulmonary emphysema
<question> On examination, the patient revealed a slight respiratory defect in the left chest. Palpation of the chest revealed diminished vocal fremitus on the left. Pulmonary percussion revealed dullness to the left percussion sound. Auscultation revealed weak vesicular breath sounds and a left pleural friction rub. The patient exhibited symptoms of the syndrome:
<variant>thickening of the pleural petals
<variant>closed pneumothorax
<variant>focal inflammatory consolidation of the lungs

<variant>hydrothorax
<variant>pulmonary emphysema
<question> On examination, the patient's chest is barrel-shaped. The epigastric angle is more90°, horizontal ribs. The supraclavicular and infraclavicular fossae are aligned. Palpation of the chest: vocal fremitus is equal on both sides, with slight weakening. Percussion of the chest: a box-shaped percussion sound. The lower border of the lungs is depressed, the upper border is elevated. Auscultation of the lungs: equally weakened vesicular breath sounds over both lungs without extraneous breath sounds. The patient exhibited symptoms of the syndrome:
<variant>pulmonary emphysema
<variant>closed pneumothorax
<variant>pulmonary cavity associated with the bronchi
<variant>specific inflammatory consolidation of the lungs
<variant>hydrothorax
<question> On examination, the patient's respiratory movements are symmetrical. Palpation of the chest reveals no change in sound vibration. Percussion reveals a pulmonary percussion sound. Auscultation of the lungs reveals difficulty breathing, with numerous dry wheezing sounds heard on the right and left sides. The patient exhibited symptoms of the syndrome:
<variant>narrowing of the bronchi by viscous exudate
<variant>closed pneumothorax
<variant>compression atelectasis
<variant>compaction of focal inflammation
<variant>hydrothorax
<question> On examination, the patient revealed a defect in the right side of the chest during breathing. Palpation of the chest revealed increased sound vibration on the right. Percussion revealed increased percussion sound on the right. Auscultation of the lungs revealed bronchial breath sounds, increased bronchophony, and a right pleural friction rub. The patient exhibited symptoms of the syndrome:
<variant>inflammatory compaction of the lobe
<variant>narrowing of the bronchi by viscous exudate
<variant>pulmonary cavity associated with the bronchi
<variant>thickening of the pleural petals
<variant>hydrothorax
<question> On examination, the patient's left chest wall lags behind the act of breathing, and the left chest wall shrinks. Palpation of the chest wall reveals weakened vocal vibration on the left. Percussion reveals a closed percussion sound on the left. Auscultation of the lungs reveals weakened sound and bronchophony on the left, without additional breath sounds. The patient exhibited symptoms of the syndrome:
<variant> obstructive atelectasis
<variant>partial inflammatory compaction
<variant>hydrothorax
<variant>closed pneumothorax
<variant>pulmonary emphysema
<question> On examination, the patient revealed a lagging sensation on the left side of the chest during breathing. Palpation of the chest revealed a weakened voice on the left. Percussion revealed a tympanic sound on the left. The patient exhibited symptoms of the syndrome:
<variant>closed pneumothorax
<variant>hydrothorax
<variant>pulmonary cavity associated with the bronchi

<variant>partial inflammatory compaction
<variant>pulmonary emphysema
<question> An employee of a large air-conditioned hotel developed a rapid fever of 40°C (104°F), cold sweats, a cough with sputum, sputum mixed with blood, chest pain when inhaling, myalgia, nausea, and diarrhea. An X-ray revealed infiltrative changes in both lungs. A few days ago, the employee was admitted to the hospital with pneumonia. The pneumonia could be caused by:
<variant> Legionella
<variant> klebsiella
<variant> Mycoplasma pneumoniae
<variant> Pfeiffer stick
<variant> Staphylococcus aureus
<question> A 64-year-old patient presented to the ambulance with severe bilateral pneumonia. A sharp drop in body temperature, rapid development of weakness, fainting, dizziness, tinnitus, nausea, and vomiting. The patient was pale, had severe acrocyanosis, cold sweats, tachycardia, a thready pulse, inaudible heart sounds, and decreased blood pressure. The cause of the rapid worsening of the condition was:
<variant> toxic-infectious shock
<variant> sepsis
<variant>cardiogenic shock
<variant>pulmonary embolism
<variant>acute respiratory distress syndrome
<question> A 36-year-old worker named N. was admitted to the department. The patient complained of producing sputum with a purulent, unpleasant odor (250-300 ml) along with a cough. The cough intensifies when the patient lies on his right side. Examination reveals clubbing and clock-like nails. The primary location of the pathological processes is in the respiratory system:
<variant>purulent inflammatory processes (abscesses) in the lungs or bronchi
<variant>pleural injury
<variant>chronic inflammatory process in the bronchi
<variant>inflammation of the alveoli
<variant>damage to the larynx
<question> A 32-year-old fitter named O. was admitted to the department. The patient complained of pain on deep inspiration, located on the right side of the chest. His body temperature was 37.9°C. The patient was lying on his right side. The right side of the chest lags behind the act of breathing. The patient's pathological process developed:
<variant>pleural injury
<variant>chronic inflammatory process of the bronchi
<variant>bronchiectasis and pulmonary abscess
<variant>inflammatory process of the alveoli
<variant>damage to the larynx
<question> A 15-year-old teenager presented to a doctor with the following complaints: cough producing 200 ml of mucous, purulent sputum, bloody sputum, fever up to 38.2°C (100.4°F), anxiety, and shortness of breath. As a child, he frequently suffered from coughing. Over the past five years, he has experienced an exacerbation of the condition annually. First, it is necessary to rule out the following:
<variant> tuberculosis
<variant> chronic lung abscess
<variant> pneumonia
<variant> polycystic lung disease

<variant> bronchiectasis
<question> A patient with bronchiectasis developed pain and shortness of breath in the right side of the chest after a severe cough. General examination revealed a delay in breathing on the right side of the chest and swelling of the intercostal spaces; percussion revealed tympanitis. The patient developed a complication:
<variant> pneumothorax
<variant> pulmonary actase
<variant> pulmonary infarction
<variant> pulmonary emphysema
<variant> exudative pleurisy
<question> Patient F, 20, came to the hospital complaining of a cough and shortness of breath. Percussion sounds are quiet and clear.
<variant> at low amplitudes of sound waves
<variant> with marked thickening of the chest
<variant> in the presence of inflammation in the organs
<variant> on percussion of air-containing organs
<variant> on percussion of dense organs
<question>The patient has rare breathing with a gradual increase and then decrease in the depth of breathing, alternating with periods of cessation of breathing, called breathing of the type:
<variant>Chayne-Stokes
<variant>Kussmaul
<variant>Grocco
<variant> Biotta
<variant>mixed
<question>A 45-year-old man was admitted to the hospital with respiratory distress. The patient's regular breathing with pauses of up to half a minute is called "type breathing":
<variant>Biotta
<variant>Kussmaul
<variant>Chayne - Stokes
<variant>Grocco
<variant>mixed
<question> A 23-year-old female patient presented to the clinic complaining of shortness of breath, voice change, pain when swallowing, and a dry cough. She had been ill for two years. Her temperature was 38.7°C. The palate was hyperemic, the tissues were swollen, and the tonsils and soft palate were coated with a gray coating. She was breathing 10 times per minute. A whistling sound was heard during breathing. Her breathing was prolonged, and narrowing of the soft tissues and intercostal spaces was observed in the supraclavicular and subcostal fossae. Percussion and auscultation of the lungs revealed no changes. If the respiratory rate was 10-14 times per minute, then this is:
<variant> bradypnea
<variant> tachypnea
<variant> apnea
<variant> dyspnea
<variant> normal
<question> A doctor from the medical center came to a patient's home. The patient's temperature had risen to 38.2 degrees Celsius, along with a severe cough, rapid breathing, sneezing, and nasal discharge. A respiratory rate of 36 times per minute is called:
<variant> tachypnea

<variant> dyspnea
<variant> apnea
<variant> bradypnea
<variant> normal
<question> A patient admitted in serious condition experienced a brief period of respiratory arrest. A temporary period of respiratory arrest is defined as:
<variant> apnea
<variant> normal
<variant> dyspnea
<variant> tachypnea
<variant> bradypnea
Patient V., 35, presented to the emergency department. Severe shortness of breath and a rare dry cough are present with the slightest movement. Physical examination: the left side of the chest lags in the respiratory process, the intercostal space is flattened. On the left side of the fourth rib, vocal vibrations are absent along all topographic lines. Percussion in this area produces an absolutely dull sound. There is silent tympanitis over Traub's space. Vocal vibration is associated with:
<variant> from the state of the pleural cavity, the density of the lung tissue, the permeability of the bronchial tree, the thickness of the chest wall
<variant> lung tissue density, from the height of the voice
<variant> from the patency of the bronchial tree, the pitch of the voice
<variant> from the thickness of the chest wall, the pitch of the voice
<variant> pleural cavity, from the height of the voice
<question> Patient I., 26, was hospitalized. The chest is of normal shape. Both ribs are symmetrical and remain in the act of respiration. Percussion sounds at the level of the 3rd-6th ribs on the right are tympanic. Vocal fremitus is increased. Percussion sounds below the 7th rib are tympanic. Unilateral increase in vocal fremitus is observed:
<variant> fibrothorax
<variant> hydrothorax
<variant> inflammation of the compacted part
<variant> obturator electa
<variant> pneumothorax
<question> The following was revealed during the patient's examination: the height of the anterior end of the lung is 1 cm above the clavicle, there is a dull percussion sound, and the voice vibration is weakened. Unilateral weakening of the voice vibration is observed.
<variant> obstructive atelectasis
<variant> pulmonary emphysema
<variant> a cavity slightly connected to the bronchi
<variant> localized focal inflammation
<variant> dense specific inflammation
<question> A 35-year-old patient presented to the clinic with recurrent attacks of suffocation accompanied by a severe cough. The attacks occur suddenly. During an attack, the patient sits in a forced position, leaning on his palm, and uses an accessory muscle for breathing. His breathing is wheezing, audible at a distance. Breathing is particularly difficult. Percussion of the lungs reveals a box-shaped sound, and auscultation reveals numerous dry rales. Sputum is produced at the end of the attack. No transcutaneous or auscultatory changes are observed in the lungs. Transcutaneous lung sounds in a healthy person:
<variant>clear pulmonary
<variant>dead end

<variant> eardrum
<variant> dim
<variant> box
<question> Based on the nature of the sound properties, the doctor determines the topography, physical condition, and functions of internal organs. Topographic percussion is used to detect:
<variant> organ boundaries
<variant> organ sizes
<variant> organ configurations
<variant> inflammation focus
<variant> pathological processes in organs
<question> A 22-year-old patient was admitted to the hospital. He underwent percussion, palpation, and auscultation. In healthy people, breathing can be heard in the lungs.
<variant> vesicular
<variant> pueril
<variant> mixed
<variant> bronchial
<variant> amphoric
<question> A patient with respiratory distress was admitted to the hospital. Shortness of breath and cough are observed. Temperature is 39.9°C. Breathing sounds are heard over the larynx and trachea.
<variant> bronchial
<variant> mixed
<variant> vesicular
<variant> hard
<variant> weakened vesicular
<question> A patient with thyrotoxicosis was hospitalized. Breathing during physical activity in patients with thyrotoxicosis:
<variant> enhanced vesicular
<variant> hard
<variant> weakened vesicular
<variant> saccaded
<variant> pathological bronchial
<question> A patient with bronchitis was hospitalized. Breathing sounds on auscultation:
<variant> hard
<variant> pathological bronchial
<variant> weakened vesicular
<variant> bronchial breathing with an amphoric tint
<variant> vesicular
<question> During auscultation of the patient's lungs, the physician heard weakened vesicular breath sounds. Causes of weakened vesicular breath sounds:
<variant> loss of elastic properties of the alveolar mucosa
<variant> bronchospasm
<variant> presence of fluid secretion in the bronchi
<variant> presence of viscous secretion in the bronchi
<variant> narrowing of the opening of the small bronchi due to inflammatory edema
<question> A patient with amphoric breathing was admitted to the hospital. Amphoric breathing is heard when:
<variant> second stage lung abscess

<variant> bronchial asthma
<variant> lobar pneumonia stage 2
<variant> pleurisy
<variant> pneumothorax
An ambulance crew is called to a 32-year-old patient complaining of a sudden attack of suffocation. The patient is sitting, leaning his hand on the edge of the bed, his chest is in a state of maximum respiration, respiratory rate 38 rpm. The shortness of breath is expiratory, and dry wheezing can be heard from a distance. Dry wheezing:
<variant> treble
<variant> small bubble
<variant> big bubble
<variant> silence
<variant> mixed
<question> The patient complained of a cough accompanied by sputum production, shortness of breath with minimal physical exertion, difficulty breathing at rest, and severe, persistent weakness and fatigue. Examination revealed marked diffuse cyanosis, significant involvement of accessory muscles even at rest, and a respiratory rate of 32 breaths per minute. Audible breath sounds above the lung cavity (without pus):
<variant> amphoric
<variant> hard
<variant> bronchial
<variant> weakened vesicular
<variant> vesicular
<question> The patient complains of a fever of 39°C and chills. Crepitations and weakened vesicular breath sounds are heard throughout the right chest. Your preliminary diagnosis:
<variant> lobar pneumonia
<variant> focal pneumonia
<variant> chronic bronchitis
<variant> exudative pleurisy
<variant> bronchiectasis
<question>A 48-year-old woman presented with complaints of esophageal and gastric pain, bloating, loose stools, and increased fatigue for the past 15 months. During this period, she had lost 18 kg. A serious cause of dysphagia:
<variant> esophageal neoplasm
<variant>burn esophageal stenosis
<variant>esophageal indentation from outside
<variant>esophageal diverticulum
<variant>esophageal inflammation
<question>A 40-year-old woman complains of increasing weakness, epigastric pain, especially on an empty stomach and at night, constipation, dizziness, dry skin, and heart pain unrelated to physical exertion. She had no previous illnesses, but recently had an unpleasant conflict at work. A diagnostic test is required to confirm the diagnosis:
<variant>Fibrogastroduodenoscopy
<variant>Electrocardiography
<variant>Sigmoidoscopy
<variant>Neurologist consultation
<variant>Clinical blood test

<question>A 46-year-old man presented to his family physician with complaints of acidic vomiting, postprandial belching, epigastric discomfort, and bloating. Abdominal palpation revealed epigastric tenderness. The following imaging studies are required:
<variant>Fibrogastroduodenoscopy
<variant>Fecal occult blood test
<variant>Contrast fluoroscopy with barium
<variant>Ultrasound examination
<variant>Radionuclide study
<question>A 47-year-old man has been suffering from chronic pancreatitis for the past 15 years. The simplest way to detect pancreatic calcification is:
<variant>radiography
<variant>laparotomy
<variant>laparoscopy
<variant>irrigoscopy
<variant>cholangiography
<question>A 40-year-old man was diagnosed with a new-onset duodenal ulcer by his family physician. An informative examination...
<variant>fibrogastroduodenoscopy
<variant>general blood test
<variant>gastric juice analysis
<variant>stool occult blood test
<variant>duodenal intubation
<question>A 45-year-old man visits his primary care physician and complains of weakness, nausea, and pain in the right upper quadrant. He has been ill for the past two years. He notes a worsening of his condition after drinking alcohol and eating fatty foods. His physical examination reveals yellowing of the sclera and skin, beer-colored urine, and acholic stool. The liver is enlarged by 5 cm, with a curled edge. Your preliminary diagnosis:
<variant>chronic hepatitis
<variant>acute viral hepatitis
<variant>liver cirrhosis
<variant>liver cancer
Gilbert's syndrome
A 40-year-old man has suffered from bronchial asthma for over 10 years. He regularly takes anticholinergics, inhaled glucocorticosteroids, beta-agonists, and theophylline. Recently, he has begun to notice heartburn, dysphagia, and a burning sensation behind the breastbone at night. Suspected pathology:
<variant>gastroesophageal reflux disease
<variant>candidal pharyngitis
<variant>Ischemic heart disease, angina pectoris
<variant>laryngeal stenosis
<variant>gastric ulcer
A 52-year-old man presented to the clinic complaining of persistent, intense epigastric pain, general weakness, and vomiting. The pain occurred 50-60 minutes after consuming fried foods or alcohol. Examination revealed epigastric tenderness and a positive Mayo-Robson sign. A complete blood count revealed a white blood cell count of 12x109/L and an ESR of 18 mm/h. Possible underlying medical conditions to consider include:
<variant>chronic pancreatitis
<variant>chronic cholecystitis

<variant>gastric ulcer
<variant>chronic gastritis, type B
<variant>GERD
<question>A 29-year-old woman suddenly developed nausea, vomiting, fever, and diarrhea 6-8 times a day with foul-smelling green stools. Possible underlying conditions to consider include:
<variant>infectious diarrhea
<variant>non-infectious diarrhea
<variant>nonspecific ulcerative colitis
<variant>Crohn's disease
<variant>small intestinal diverticulosis
<question>A 35-year-old man, visiting his local doctor, complains of heartburn and pain that occurs 1.5-2 hours after eating, often on an empty stomach and at night. The pain subsides after eating. Abdominal palpation reveals tenderness in the epigastric region and around the navel. The man has severe asthenovegetative syndrome. Does the patient require inpatient treatment?
<variant>Yes, because the patient has a duodenal ulcer diagnosed for the first time
<variant>Yes, because the patient has a newly diagnosed stomach ulcer.
<variant>Yes, because the patient has a pronounced asthenovegetative syndrome
<variant>No, because the patient does not have complications of peptic ulcer disease
<variant>Yes, because the patient undergoes an endoscopic examination in the hospital
<question>A 47-year-old female patient, a seamstress, complains in hospital of yellowing of the skin, darkening of the urine, paroxysmal pain in the right hypochondrium on the 2nd day, vomiting after eating fatty foods and lifting heavy objects. Previously, there was dull pain on the right side, radiating to the right shoulder blade, shoulder, bitterness in the mouth, increased body weight, BMI 38 kg / m2, green-yellow skin, xanthelasma of the eyelids, painful abdomen in the right hypochondrium, liver 8-7-6 cm. In blood tests: bilirubin 154 μmol / L, (direct 112, indirect 42), ALT - 36 IU / L, AST - 25 IU / L, cholesterol 8.1 mmol / L; alkaline phosphatase 196 IU / L. Which of the following syndromes is likely in this patient:
<variant>cholestasis
<variant>protein-synthetic deficiency
<variant>mesenchymal inflammation
<variant>hyperazotemia
<variant>cytolysis
<question>A 63-year-old patient complains of general weakness, memory loss, sleep disturbances, vomiting, and hiccups. History: liver cirrhosis has been present for over 18 years, with worsening symptoms every week: depression and apathy alternate with euphoria or aggression. Examination reveals slowness of movement and speech, liver odor, weight loss, shoulder girdle muscle atrophy, flapping tremor, jaundice, skin hemorrhages, gynecomastia, palmar erythema, and abdominal enlargement (ascites). Liver size according to Kurlov is 7x6x5 cm, spleen size 14x8 cm. Which of the following syndromes is likely with the progression of liver cirrhosis?
<variant>liver failure
<variant>hepatic coma
<variant>hepatosplenic
<variant>edematous-ascitic
<variant>hepatic encephalopathy
Patient B., in hospital, complains of general weakness, memory loss, sleep disturbances, vomiting, and hiccups. He has a 10-year history of liver cirrhosis, which worsens over the course of a week, with depression and apathy alternating with euphoria or aggression. Examination reveals slow movements and speech, liver odor, weight loss, shoulder girdle muscle atrophy, flapping tremor,

jaundice, skin hemorrhages, gynecomastia, palmar erythema, and an enlarged abdomen due to ascites. According to Kurlov, the liver size is 7x6x5 cm, and the spleen size is 15x9 cm. Which of the following serum parameters is likely to be elevated in this patient?
<variant>ammonia
<variant>albumin
<variant>cholesterol
<variant>prothrombin
<variant>total protein
<question>A 33-year-old female patient, a cook, complains of yellowing of the skin, darkening of the urine. On the 2nd day, she has been bothered by paroxysmal pain in the right hypochondrium, vomiting after eating fatty foods and lifting weights. From the anamnesis - a previous dull pain on the right, radiating to the right shoulder blade, shoulder, bitterness in the mouth was noted. On examination - overnutrition, BMI - 37 kg / m2, green-yellow skin and mucous membranes, xanthelasma of the eyelids. On palpation - abdominal pain in the right hypochondrium. Liver size is 8-7-6 cm. In the tests: bilirubin - 164 μmol / l, (direct 122, indirect 42), ALT - 38 IU / l, AST - 29 IU / l, GGT - 96 IU; albumins 40 g / l, cholesterol 8.4 mmol / l. Which of the listed examination methods is informative in this case:
<variant>Ultrasound of the abdominal organs
<variant>survey fluoroscopy of abdominal organs
<variant>needle biopsy of the liver
<variant>fibrogastroduodenoscopy
<variant>irrigoscopy

Border control #2:

1.Task to demonstrate practical skills.

1. Questioning patients with gastrointestinal diseases.
2. Methodology and technique of superficial palpation of the abdomen.
3. General examination of patients with gastrointestinal diseases.
4. Method and technique of liver percussion according to Kurlov.
5. Questioning and general examination of patients with diseases of the urinary system.
6. Methodology and technique for determining palpation and percussion of the kidneys.
7. Questioning and general examination of patients with diseases of the urinary system.
8. Methodology and technique for determining palpation and percussion of the kidneys.
9. Urine collection for general urine analysis, Zimnitsky, Nechiporenko, and Reberg tests.
10. Method and technique of liver percussion according to Kurlov.
11. Questioning and general examination of patients with diseases of the hematopoietic system.
12. Methodology and technique of palpation of the spleen.
13. Questioning and general examination of patients with diseases of the hematopoietic system.
14. Method and technique for palpation of the spleen and lymph nodes.
15. Questioning and general examination of patients with diseases of the endocrine system.
16. Methodology and technique of palpation and auscultation of the thyroid gland
17. Questioning and general examination of patients with diseases of the musculoskeletal system.
18. Palpation of small and large joints
19. Methods of external and local examination of patients with lesions of the nervous system
20. Methodology and technique for determining muscle rigidity.
21. Questioning and general examination of patients with diseases of the nervous system.
22. Methodology and technique definitions of Brudzinski's upper symptom

23. Methods of external and local examination of patients with lesions of the nervous system
24. Methodology and technique aboutdefinition of Kernig's sign.

2. Completing the educational medical history.

The form is attached to the library collection of the department and the academy.

3. **Test tasks:**

<question>A 37-year-old female patient, a cook, complains of yellowing of the skin, dark urine, paroxysmal pain in the right hypochondrium for two days, vomiting after eating fatty foods and lifting heavy objects. Previously, there was dull pain on the right, radiating to the right shoulder blade, shoulder, bitterness in the mouth. On examination: increased body weight, BMI 37 kg / m2, green-yellow skin and mucous membranes, xanthelasma of the eyelids. Palpation - abdominal tenderness in the right hypochondrium. Liver size according to Kurlov is 8-7-6 cm. In the tests: bilirubin 186 μmol / l, (direct 168, indirect 18), ALT 38 IU / l, AST 29 IU / l, GGT - 96 IU; albumin 40 g / l, cholesterol 8.4 mmol / l. Which of the following types of jaundice is likely:
<variant>mechanical jaundice
<variant>parenchymatous jaundice
<variant>hemolytic jaundice
<variant>liver, caused by acute viral hepatitis A
<variant>liver, caused by chronic viral hepatitis B
<question>A woman came to the clinic complaining of yellowing of the skin, darkening of the urine, weakness, and bloating. At the age of 12, she had viral hepatitis B. She has normal nutrition, the skin and visible mucous membranes are orange-yellowish, and there are isolated telangiectasias on the back. The abdomen is painful on palpation in the right hypochondrium, the liver is 2.5 cm below the costal arch, and the spleen is 9.0 x 5.0 cm. In the tests: bilirubin 111 μmol / L, (direct 55, indirect 56) ALT-37 IU / L, AST-27 IU / L, GGT-110 IU; albumins 43 g / L, cholesterol-4.3; alkaline phosphatase -186 IU / L, HBsAg (+).
Which of the following is a likely cause of the development of jaundice syndrome:
<variant>hepatitis B virus
<variant>alcohol consumption
<variant>hepatitis C virus
<variant>increased serum iron
<variant>taking hepatotoxic drugs
<question>A woman came to the clinic complaining of yellowing of the skin and eyes, darkening of the urine, weakness, and bloating. She has a history of viral hepatitis B in childhood. On examination, she is moderately nourished, the skin and visible mucous membranes are orange-yellowish, and there are isolated telangiectasias on the back. The abdomen is painful on palpation in the right hypochondrium, the liver is 3 cm below the costal arch, and the spleen is 8.0 x 4.0 cm. In the tests: bilirubin 110 μmol / L, (direct 55, indirect 55) ALT 38 IU / L, AST 29 IU / L, GGT 112 IU; albumins 40 g / L, cholesterol 4.1; alkaline phosphatase 200 IU / L, HBsAg (+). Which of the following types of jaundice is likely in this patient:
<variant>hepatic jaundice caused by chronic viral hepatitis B
<variant>hepatic jaundice caused by nutritional damage
<variant>subhepatic jaundice caused by nutritional deficiencies
<variant>suprahepatic jaundice caused by nutritional deficiencies
<variant>hepatic jaundice caused by acute viral hepatitis A

<question>A 22-year-old patient came to the clinic complaining of yellowing of the skin and eyes and darkening of the urine. Her medical history includes viral hepatitis and denies any history of surgery. On examination, the skin and mucous membranes are lemon-yellow, and the tongue is clean. On palpation, the abdomen is soft, the liver is not enlarged, and the lower pole of the spleen is palpable. A complete blood count (CBC) reveals Hb 100 g/L and red blood cells 2.8 x 1012/L. A blood chemistry report shows total bilirubin 67 μmol/L (indirect 52 μmol/L), and ALT 37 IU/L. Urobilinoids are present in the urine and stercobilinogens are present in large quantities in the feces. Which of the following types of jaundice is likely in this patient?
<variant>hemolytic
<variant>mechanical
<variant>parenchymatous
<variant>hepatic jaundice caused by acute viral hepatitis A
<variant>hepatic jaundice caused by chronic viral hepatitis B
<question>A 56-year-old patient, unemployed, complains of abdominal distension, shortness of breath, weakness, heaviness in the right hypochondrium, and dyspepsia. Anamnesis includes a 14-year history of hepatitis B, and weight loss and skin bruising over the past 6 months. Examination reveals icteric skin and mucous membranes, muscle atrophy of the arms and legs, telangiectasias in the shoulders and back, gynecomastia, and palmar erythema. The abdomen is markedly enlarged and tense, with a protruding umbilicus and subcutaneous venous network on the anterior abdominal wall. The liver is dense (15x12x10 cm according to Kurlov) and the spleen is 19x8 cm. Percussion reveals a dull sound in the sloping areas of the abdomen and tympanitis in the upper abdomen. Which of the following is a likely cause of abdominal distension?
<variant>the presence of fluid in the abdominal cavity
<variant>significant enlargement of the liver and spleen
<variant>significant enlargement of the spleen
<variant>presence of gases in the intestines
<variant>obesity
<question>A 56-year-old patient, a lawyer, complains in hospital of weakness, malaise, jaundice, memory loss, pain in the right hypochondrium, loss of appetite, bleeding gums, and bloating. History: he has had hepatitis C for about 20 years, with weight loss and bruising over the past 6 months. The skin and mucous membranes are jaundiced, with muscle atrophy in the arms and legs, telangiectasias in the shoulders and back, gynecomastia, and palmar erythema. The abdomen is enlarged, with a subcutaneous venous network on the anterior abdominal wall. The liver is dense on palpation. Percussion reveals liver size according to Kurlov: 15x11x9 cm, spleen: 12x8 cm. Which of the following clinical syndromes is likely in this patient?
<variant>liver failure
<variant>icteric
<variant>hepatic coma
<variant>hepatosplenic
<variant>edematous-ascitic
<question>A 47-year-old patient, a painter, came to the medical center with complaints of weakness and fatigue. The anamnesis includes a surgery with blood transfusion in 2012. On examination, the skin and mucous membranes are unchanged, there are no liver signs. On palpation, the liver is dense, painless, the liver size according to Kurlov is 13-11-8 cm. The ELISA method revealed HBsAg in the blood serum, antibodies to hepatitis C (-); bilirubin 16 μmol / ml, ALT 177 IU / L, AST 124 IU / L, PTI 81%, albumin 47 g / L. Ultrasound of the liver: diffuse changes in the liver parenchyma, the right lobe is 15.5 cm, the left - 9.5 cm. Which of the following examination methods is informative in this case:

<variant>needle biopsy of the liver
<variant>liver scintigraphy
<variant>indirect liver elastometry
<variant>Ultrasound of the abdominal organs
<variant>computed tomography of the abdominal organs
<question>A 45-year-old patient, a programmer, presented with suspected hepatitis. He reports periodic weakness and fatigue. His medical history includes surgery after a left leg fracture with a blood transfusion in 2006. On examination, the skin and mucous membranes are unchanged, there are no liver signs. On palpation, the liver is firm. Liver size according to Kurlov is 13-11-8 cm. ELISA revealed HBsAg in the serum, antibodies to hepatitis C (-); bilirubin 17 μmol/ml, ALT 197 IU/L, AST 130 IU/L, PTI 83%, albumin 41 g/L. Ultrasound: diffuse changes in the liver parenchyma, the right lobe is 14.5 cm, the left - 8 cm, the area of the spleen is 40 cm. Which of the clinical syndromes is likely in this patient:
<variant>cytolysis
<variant>protein-synthetic deficiency
<variant>mesenchymal inflammation
<variant>hyperazotemia
<variant>cholestasis
<question>A 47-year-old patient presented to a medical center complaining of intermittent weakness and fatigue. His medical history includes surgery for a left leg fracture with a blood transfusion in 2000. On examination, the skin and mucous membranes are unchanged, and there are no liver stigmas. On palpation, the abdomen is painless and the liver is firm. Liver size according to Kurlov is 13-11-8 cm, the spleen is not enlarged. ELISA revealed HBsAg in the serum, hepatitis C antibodies (-); bilirubin 17 μmol/ml, ALT 198 IU/L, AST 123 IU/L, PTI 84%, albumin 40 g/L. Ultrasound: diffuse changes in the liver parenchyma, right lobe 12.5 cm, left 8 cm, porta v. 0.8 cm, spleen area 32 cm2. Which of the following syndromes is likely in this patient?
<variant>liver inflammation of viral etiology
<variant>liver failure
<variant>portal hypertension
<variant>gastric dyspepsia
<variant>edematous-ascitic
<question>A 49-year-old patient presented to the clinic with abnormal liver function tests, hepatomegaly, and suspected hepatitis. Weakness and fatigue occur periodically. His medical history includes surgery after a left leg fracture with a blood transfusion in 2002. On examination, the skin and visible mucous membranes are unchanged. On palpation, the edge of the liver is dense. Liver size according to Kurlov is 13-11-8 cm, the spleen is not enlarged. ELISA revealed HBsAg in the serum, antibodies to hepatitis C (-); bilirubin 15 μmol/ml, ALT 200 IU/L, AST 134 IU/L, PTI 87%, albumin 42 g/L. Ultrasound: diffuse changes in the liver parenchyma, right lobe 13.5 cm, left 8 cm, porta v. 0.9 cm, spleen area 42 cm2. What is the likely cause of liver inflammation in this patient?
<variant>Hepatitis B virus
<variant>alcohol consumption
<variant>Hepatitis C virus
<variant>Increased serum iron
<variant>Taking hepatotoxic drugs
<question>A 52-year-old woman, a physician, came to the clinic with complaints of heaviness in the right hypochondrium, loss of appetite and weight, and bloating. Her medical history includes viral hepatitis B at the age of 15. Examination revealed weight 64 kg, height 175 cm; dry skin,

bruises in places, telangiectasias on the neck, palmar erythema, and pain in the right hypochondrium. Liver according to Kurlov is 15x10x7 cm, spleen is 11x5.5 cm. Test results: bilirubin 19 μmol/l; ALT 25 IU/l, AST 30 IU/l, GGT 35 IU; prothrombin index 78%, fibrinogen 7.3 g/l; cholesterol 5.1 mmol/l; Thymol test 12 units, albumin 45 g/L, gamma globulins 25%, ESR 36 mm/h. Which of the following biochemical syndromes is likely in this patient?
<variant>mesenchymal inflammation
<variant>protein-synthetic deficiency
<variant>cholestasis
<variant>cytolysis
<variant>azotemia
<question>A woman came to the clinic complaining of heaviness in the right hypochondrium, decreased appetite and weight, and an enlarged abdomen. Her medical history includes a history of viral hepatitis in childhood. Examination revealed malnutrition, jaundiced skin, bruises in places, telangiectasias on the neck and shoulders, and palmar erythema. The abdomen was enlarged due to ascites, the umbilicus was protruding, and there was a pronounced subcutaneous venous network. Liver size according to Kurlov was 15x10x7 cm, spleen 11x5.5 cm. Biochemical blood test: bilirubin 57 μmol/L; ALT 23 IU/L, AST 31 IU/L, prothrombin index 60%, fibrinogen 1.7 g/L, total protein 54 g/L, albumin 26 g/L, cholesterol 2.1 mmol/L. Which of the following biochemical syndromes is likely in this patient?
<variant>protein-synthetic deficiency
<variant>cytolysis
<variant>cholestasis
<variant>hyperazotemia
<variant>mesenchymal inflammation
<question>A 50-year-old woman, an economist, came to the clinic complaining of heaviness in the right hypochondrium, itchy skin, loss of appetite and weight, bloating, and weakness. Her medical history includes viral hepatitis at the age of 17. Examination revealed poor nutrition, icteric skin with traces of scratching, xanthelasma on the eyelids, and palmar erythema. Palpation revealed soft abdomen with pain in the right hypochondrium. Liver size according to Kurlov is 15x10x7 cm, spleen: 11x5.5 cm. Blood tests: total bilirubin 68.3 μmol/l, direct 49; ALT 43 IU/l, GGT 112 IU; albumin 40 g/l, cholesterol 8.1 mmol/l; Alkaline phosphatase 170 IU/L. Which of the biochemical syndromes is likely in this patient:
<variant>cholestasis
<variant>cytolysis
<variant>hyperazotemia
<variant>mesenchymal inflammation
<variant>protein-synthetic deficiency
<question>A 36-year-old woman, a teacher, complains of weakness, fatigue, heaviness in the right hypochondrium, and bloating. Anamnesis indicates a history of viral hepatitis at the age of 12. On examination, nutrition is normal, the sclera are slightly icteric, and there are isolated telangiectasias on the back. Palpation reveals tenderness in the right hypochondrium. Liver size according to Kurlov is 13x10x8 cm, spleen 8.0x5.0 cm. In the tests: bilirubin 23.5 μmol/L; ALT 125 IU/L, AST 90 IU/L, GGT 115 IU; albumins 42 g/L, cholesterol 4.2 mmol/L; alkaline phosphatase 76 IU/L. Which of the biochemical syndromes is likely in this patient:
<variant>cytolysis
<variant>azotemia
<variant>cholestasis
<variant>mesenchymal inflammation

<variant>protein-synthetic deficiency
<question>A 63-year-old man presented with complaints of heaviness in the right hypochondrium, abdominal distension, decreased urine output, loss of appetite, weight loss, unstable stools, severe weakness, and bleeding gums. He denies a history of viral hepatitis and has a history of alcohol abuse. A general examination revealed malnutrition, jaundiced skin, and occasional petechiae and bruises. Telangiectasias and palmar erythema were present on the skin of the face, neck, and shoulders. The abdomen was enlarged and pendulous, with a protruding umbilicus. Dilated venous networks were present on the anterior and lateral abdominal walls. The doctor made a preliminary diagnosis of portal hypertension syndrome.
Which of the following symptoms is characteristic of portal hypertension:
<variant>dilated venous network on the anterior and lateral abdominal walls
<variant>telangiectasia
<variant>petechiae and bruises
<variant>palmar erythema
<variant>yellowing of the skin
<question>A 50-year-old male veterinarian presented to the emergency room complaining of abdominal distension, decreased urine output, weight loss, unstable stool, weakness, and bleeding gums. His medical history includes alcohol abuse. Examination revealed malnutrition, tremors in the eyelids and hands, and icteric skin with petechiae and bruises in places. Telangiectasias and palmar erythema were present on the nose, cheeks, neck, and shoulders. The abdomen was enlarged and pendulous, with a protruding umbilicus and a dilated venous network (Caput Medusa) around the umbilicus and on the anterior abdominal wall. Liver measurements according to Kurlov were 17x14x10 cm, and spleen 13x7 cm.
Which of the following syndromes is likely in this patient:
<variant>portal hypertension
<variant>intestinal dyspepsia with malabsorption
<variant>hepatic encephalopathy
<variant>gastric dyspepsia
<variant>cholestasis
<question>A 55-year-old man presented to the clinic complaining of heaviness in the right hypochondrium, loss of appetite, weight loss, bloating, unstable stool, and weakness. He denies a history of viral hepatitis and has a history of alcohol abuse. Examination revealed decreased body weight and a BMI of 17 kg/m². The skin is jaundiced, with petechiae and bruises in places, telangiectasias, palmar erythema, and a crimson tongue. There is moderate tenderness to palpation in the right hypochondrium, a dense liver edge, an enlarged abdomen, and a network of subcutaneous veins around the umbilicus. The liver size according to Kurlov is 13x11x8 cm, and the spleen size is 10x7 cm. Which of the following is a likely cause of liver cirrhosis?
<variant>alcohol abuse
<variant>overweight
<variant>drug use
<variant>hepatitis B or C virus
<variant>inflammation of the gallbladder
<question>A 55-year-old man, a mechanic, came to the clinic complaining of heaviness in the right hypochondrium, loss of appetite, weight loss, bloating, unstable stool, and weakness. He denies a history of viral hepatitis and has a history of alcohol abuse. Examination revealed jaundiced skin, malnutrition, localized petechiae and bruises, and telangiectasias. Palmar erythema and a crimson tongue. Palpation revealed moderate tenderness in the right hypochondrium, a dense liver edge, an enlarged abdomen, and a network of subcutaneous veins around the umbilicus. According to

Kurlov, the liver size is 14x11x7 cm, and the spleen size is 11x6 cm. Which of the following syndromes is most likely present in this patient?
<variant>liver cirrhosis
<variant>exocrine pancreatic insufficiency
<variant>inflammation of the gallbladder with stones
<variant>irritable bowel syndrome with diarrhea
<variant>subhepatic jaundice
<question>A 44-year-old man presented with complaints of epigastric pain after eating, radiating to the back, fear of eating, and vomiting that does not bring relief; large, mushy, fatty stools; and weight loss. His medical history includes alcohol abuse. He has poor nutrition, muscle atrophy in the limbs, and ruby drops. Palpation reveals pain in the epigastric region and left hypochondrium. Blood amylase and urine diastase levels are elevated. The doctor suspected exocrine pancreatic insufficiency syndrome. Which of the following diagnostic methods is most helpful in this case?
<variant>Ultrasound of the pancreas
<variant>endoscopic retrograde cholangiopancreatography
<variant>gastroduodenoscopy
<variant>colonofibroscopy
<variant>laparoscopy
<question>A 48-year-old man, a construction worker, came to the emergency room complaining of prolonged epigastric pain after eating, radiating to the back, fear of eating the next food, vomiting that does not bring relief; large volumes of mushy, fatty stools, and weight loss. His medical history shows he has had the disease for over 7 years and abuses alcohol. On examination, he shows severe malnutrition, muscle atrophy in the limbs, and ruby drops. Palpation reveals tenderness in the Chauffard zone, in the epigastric region. Liver size according to Kurlov is 11-9-7 cm. Blood amylase and urine diastase levels are elevated, stool analysis reveals steatorrhea and creatorrhea. Which of the following syndromes is likely in this patient?
<variant>exocrine pancreatic insufficiency
<variant>malabsorption
<variant>intestinal dyspepsia
<variant>irritable bowel syndrome with diarrhea
<variant>inflammation of the gallbladder with stones
<question>A 53-year-old woman visits her doctor and complains of severe heartburn and chest pain that worsens when leaning forward. Your preliminary diagnosis:
<variant>reflux esophagitis
<variant>Zenker's diverticulum of the esophagus
<variant>chronic gastritis
<variant>chronic pancreatitis
<variant>esophageal cancer
<question>A 50-year-old overweight woman was found to have twice elevated fasting blood glucose levels, to 6.9 and 7.2 mmol/L. The most likely diagnosis is:
<variant>Type 2 diabetes mellitus
<variant>Obesity
<variant>Type 1 diabetes mellitus
<variant>Impaired fasting glucose
<variant>Impaired glucose tolerance
<question>A 33-year-old woman reports irritability, general weakness, and fatigue during a doctor's appointment. Her medical history includes a subtotal thyroidectomy and 50 mcg of L-thyroxine.

Her face is puffy, and her heart sounds are muffled. Her blood pressure is 100/70 mmHg. An echocardiogram reveals fluid in the pericardial cavity. Which imaging method is most informative?
<variant>Determining T3 and T4 levels
<variant>ECG
<variant>Blood culture
<variant>CT scan of the mediastinal organs
<variant>Daily blood pressure monitoring
<question>A 44-year-old woman presented to the emergency room complaining of a hoarse voice. Her medical history revealed that she had noticed this change over the past 6 months. She had previously experienced frequent upper respiratory tract colds. On examination, her face was puffy and lethargic, she spoke slowly, her voice was low and hoarse, and her speech was somewhat slurred. She was overnourished, and her skin felt dry, tight, and flaky. Her pulse rate was 58 beats per minute, and her blood pressure was 90/60 mmHg. Her heart sounds were somewhat muffled and rhythmic. Which of the following syndromes likely developed in this case?
<variant>hypothyroidism
<variant>hyperthyroidism
<variant>hypoglycemia
<variant>hyperglycemia
<variant>hypocorticism
<question>A 35-year-old woman, a school teacher, consulted her family physician complaining of frequent bouts of irritability. During a physical examination, the physician revealed exophthalmos, infrequent blinking, and Graefe-Kocher's sign. Which of the following syndromes is likely present in this patient?
<variant>hyperthyroidism
<variant>hypothyroidism
<variant>hypoglycemia
<variant>hyperglycemia
<variant>hypercorticism
<question>A 46-year-old man with diabetes developed agitation, aggression, complaints of intense hunger, and hand tremors after an insulin injection. Which of the following conditions is likely to develop in this man's case?
<variant>hypoglycemia
<variant>hypercorticism
<variant>hyperglycemia
<variant>hyperthyroidism
<variant>hypothyroidism
A 35-year-old man was brought to the emergency room by ambulance. His wife reports that he had no previous illnesses, but he had lost weight over the past year despite an increased appetite. Over the past two days, he had complained of thirst, epigastric pain, loss of appetite, and nausea. He had also vomited once, and had become restless and agitated. Examination revealed the smell of acetone on his breath, convulsions, vomiting, and agitation. His pulse rate was 110 beats per minute; his blood pressure was 80/50 mmHg. During the examination, he became lethargic and lapsed into a coma. Which of the following types of coma likely developed in this case?
<variant>hyperglycemic
<variant>hypoglycemic
<variant>apoplectic
<variant>uremic
<variant>liver

<question>A 29-year-old woman complains to her local physician of apathy, decreased interest in the environment, weight gain, memory impairment, drowsiness, lethargy, and a feeling of chilliness, which have been bothering her for the past year. She denies any previous illnesses. 1.5 years ago, she underwent surgery for a grade 2 nodular goiter - a subtotal thyroidectomy was performed. On examination, she has slow movements, monotonous speech, a slightly puffy face, and narrowed eye slits. The skin is pale with a jaundice tint, and her nutrition is increased. PS - 64 beats per minute. BP 100/60 mmHg. Heart sounds are muffled, rhythmic. Which of the following syndromes most likely developed in this woman:
<variant>hypothyroidism
<variant>hyperthyroidism
<variant>hypoglycemia
<variant>hyperglycemia
<variant>hypocorticism
<question>A 33-year-old female auditor presented to the emergency room complaining of short sleep, increased appetite, and weight loss over the past 5-6 months. She denies any previous illnesses but notes significant psychological stress at work. A general examination revealed increased excitability, generalized motor restlessness, fidgeting, poor subcutaneous fat development, pronounced tremors of the fingers of outstretched hands, and positive Moebius and Graefe signs. PS - 104 beats per minute. BP 130/90 mmHg. Heart sounds are rapid, rhythmic, and loud. Which of the following syndromes is likely in this case?
<variant>hyperthyroidism
<variant>hypothyroidism
<variant>hypocorticism
<variant>hyperglycemia
<variant>hypercorticism
<question>A 45-year-old man, a driver, was diagnosed with dilated eye slits, increased shine, bulging eyes, and fidgeting during a routine checkup. A thorough questioning revealed that he had no previous illnesses, but lost his wife about a year ago and had been severely depressed for some time. A further examination revealed a fine tremor in the fingers in the Romberg position. Blood pressure was 100 beats per minute. Blood pressure was 140/95 mmHg. Heart sounds were rapid, rhythmic, and loud, with a short systolic murmur at the apex. Which of the following pathological conditions are characterized by these objective changes?
<variant>hyperthyroidism
<variant>hypothyroidism
<variant>hypoglycemia
<variant>hyperglycemia
<variant>hypercorticism
<question>A 56-year-old woman was admitted by ambulance to the emergency department of City Clinical Hospital No. 4 with suspected hyperglycemia syndrome. Which of the following indicators is informative in confirming this syndrome?
<variant>glucosuria
<variant>hyperproteinemia
<variant>hypoproteinemia
<variant>cholesteroluria
<variant>proteinuria
<question>A 42-year-old woman, unconscious, was brought from the street to the emergency room by ambulance. After examination, the emergency room physician concluded that this case showed

signs of hypoglycemic coma. Which of the following symptoms is pathognomonic of hypoglycemic coma?
<variant>increased tendon reflexes
<variant>lowering blood pressure
<variant>muscle hypotonia
<variant>pupil dilation
<variant>preserved tone of the eyeballs
<question>An unconscious man was brought into the emergency room by ambulance from the street. On examination, his face was pinkish, his skin dry, his muscle tone and tendon reflexes decreased, his pupils constricted; a loud, noisy Kussmaul respiration was audible at a distance. His breathing was weak and rapid. Blood pressure was 90/60 mmHg. His heart sounds were muffled and rapid. The abdomen was soft, and the liver was at the costal margin. He urinated spontaneously, and his urine was deep. Which of the following types of coma was likely present in this case?
<variant>hyperglycemic
<variant>hypoglycemic
<variant>thyrotoxic
<variant>ischemic
<variant>liver
<question>A 52-year-old woman, a manager, visited her local doctor. After questioning and examining her, the doctor determined that she had signs of hypothyroidism. Which of the following symptoms of cardiovascular damage characteristic of this syndrome was identified during her examination?
<variant>cardiomegaly
<variant>arrhythmia
<variant>tachycardia
<variant>jumping pulse
<variant>sonority of tones
<question>A 45-year-old woman, a teacher, consulted an endocrinologist complaining of obesity, red streaks on her skin, fatigue, and weakness. Her medical history revealed that she had been under medical supervision for 20 years and had been taking 20 mg of prednisolone for rheumatoid arthritis. These changes developed over the past two years. Examination revealed a moon-shaped, moderately flushed face. Muscle mass in the shoulder girdle and upper torso was prominent. Longitudinal purple-blue streaks were present on the anterior abdominal skin. Her heart rate was 118 beats per minute, arrhythmic. Blood pressure was 150/100 mmHg. Heart sounds were muffled and rapid.
Which of the following syndromes is likely in this case:
<variant>hypercorticism
<variant>hypothyroidism
<variant>hyperthyroidism
<variant>hyperglycemia
<variant>hypocorticism
<question>During an examination of a 42-year-old man complaining of severe weakness, sleep disturbances, intermittent high blood pressure, and frequent depression, the emergency room physician diagnosed hypercortisolism syndrome and scheduled an endocrinologist. Which of the following objective symptoms are likely in this case?
<variant>atrophy of the muscles of the shoulder girdle and legs
<variant>amimia
<variant>white stretch marks

<variant>general weight loss
<variant>thickening of the skin
<question> A 56-year-old man was admitted to the emergency department with complaints of discolored stool, itching, and abdominal pain. Yellowing of the skin and sclera in cardiovascular diseases is caused by:
<variant>disruption of bilirubin metabolism due to congestion in the liver
<variant>severe anemia
<variant>previous hepatitis
<variant>eating large amounts of carrots
<variant>portal hypertension
<question>A 21-year-old man was admitted to the hospital complaining of nausea, vomiting, and abdominal pain. The doctor suspected an attack of "abdominal toad." "Abdominal toad" is:
<variant>an attack of abdominal pain at the height of digestion, relieved by nitroglycerin
<variant>an attack of abdominal pain before eating, flatulence
<variant>an attack of abdominal pain after eating, dyspeptic disorders
<variant>an attack of abdominal pain before eating, diarrhea
<variant>an attack of abdominal pain, a feeling of stiffness in the joints in the morning
<question>A 53-year-old man was admitted to the hospital with upper abdominal pain and frequent, large bowel movements. His medical history: the previous day, he had consumed a large amount of strong alcohol while visiting someone, along with a heavy overeating. Scatology: a large amount of undigested muscle fibers, a lot of neutral fat, and starch.
Your preliminary diagnosis:
<variant>chronic pancreatitis
<variant>chronic enterocolitis
<variant>chronic gastritis
<variant>chronic cholecystitis
<variant>irritable bowel syndrome
A 45-year-old woman developed an acute fever of 40°C, chills, a cough with sputum production, hemoptysis, chest pain when breathing, myalgia, nausea, and diarrhea. A chest X-ray revealed infiltrative changes in both lungs. What is the cause of the pneumonia?
<variant>Legionella
<variant>Klebsiella
<variant>mycoplasma pneumonia
<variant>Pfeiffer's rod
<variant>Staphylococcus aureus
<question>A 39-year-old man visits his local doctor and complains of epigastric pain occurring 1.5-2 hours after eating, as well as at night; he also has a tendency toward constipation. A year ago, his peptic ulcer was complicated by perforation. Please indicate the location of the ulcer:
<variant>in the duodenal bulb
<variant>on the lesser curvature of the stomach
<variant>in the antral part of the stomach
<variant>on the greater curvature of the stomach
<variant>in the pyloric canal of the stomach
<question>A 53-year-old man with a history of alcohol abuse was admitted to hospital with bleeding from esophageal varices. A week ago, he developed pain in the right hypochondrium and noted yellowing of the skin. Objectively: the skin and sclera are yellowish, with telangiectasias. The abdomen is distended. The liver protrudes 3 cm from under the costal margin, is dense, and painful.

Splenomegaly. A complete blood count (CBC) reveals anemia, thrombocytopenia, and ESR of 36 mm/h. Total bilirubin is 56 μmol/L, direct fraction is 12.2 μmol/L. Your preliminary diagnosis:
<variant>alcoholic liver cirrhosis
<variant>cryptogenic liver cirrhosis
<variant>chronic alcoholic hepatitis
<variant>chronic cryptogenic hepatitis
<variant>chronic drug-induced hepatitis
<question>A patient admitted to the hospital on an emergency basis complained of burning pain at the base of the xiphoid process, radiating to the heart, occurring and intensifying half an hour after eating. This pain was not completely relieved by Almagel. Belching, choking fits, and coughing were also noted. A barium swallow revealed reflux of contrast material from the stomach into the esophagus. These signs suggest the following:
<variant>reflux esophagitis
<variant>achalasia of the cardia
<variant>esophageal cancer
<variant>bronchial asthma
<variant>chronic gastritis
<question>A 42-year-old man visits his doctor and complains of a burning sensation behind the breastbone, which intensifies after eating, when bending forward, and when lying down. Which diagnostic method is most helpful?
<variant>esophagoscopy
<variant>esophagomanometry
<variant>chest x-ray
<variant>electrocardiography with stress testing
<variant>ultrasound examination of abdominal organs
A 27-year-old man presents to the doctor complaining of epigastric pain occurring 1.5-2 hours after eating, as well as nighttime pain, sour belching, and nausea. Physical examination reveals malnutrition, a moist tongue with a white coating, and epigastric tenderness upon abdominal palpation. Which diagnostic method is most helpful?
<variant>fibrogastroduodenoscopy
<variant> irrigoscopy
<variant>esophagomanometry
<variant>X-ray of the stomach
<variant>ultrasound examination of abdominal organs
<question>A 55-year-old woman presents to her doctor complaining of a feeling of heaviness and discomfort in the right hypochondrium after eating, a bitter taste in the mouth, and occasional vomiting. Objectively, she is overnourished, her skin is normal in color, and palpation reveals tenderness in the gallbladder projection area. An informative examination method is:
<variant>ultrasound examination of abdominal organs
<variant>gastroscopy
<variant>irrigoscopy
<variant>duodenal intubation
<variant>needle biopsy of the liver
A 38-year-old man complains of pain in the left abdomen and lumbar region after heavy meals, exposure to cold, walking, and rocking. This pain subsides after taking Baralgin. Objectively: the tongue is coated white, the abdomen is soft, and there is pain under the left rib and in the left costovertebral angle (Mayo-Robson sign) when touched. Your probable diagnosis:
<variant>chronic pancreatitis, painful sensory form

<variant>gastric ulcer
<variant>chronic pyelonephritis
<variant>urolithiasis, renal attack
<variant>peptic ulcer of the duodenum
<question>A 34-year-old man complains of epigastric pain occurring 1.5 to 2 hours after eating, nighttime pain, and a tendency toward constipation. A year ago, a gastric ulcer became complicated by perforation. The patient's gastric ulcer is...
<variant> in the duodenal bulb
<variant>in the antral part of the stomach
<variant> on the lower shoulder of the stomach
<variant>on the large shoulder of the stomach
<variant>in the pyloric canal of the stomach
<question>A 53-year-old man was admitted with bleeding from esophageal varices. A week ago, he developed pain under the right rib and jaundice. He developed a drinking habit. On examination, the skin and white cornea of the eye are yellowish, with telangiectasias. The abdomen is dry. The liver protrudes beyond the costal margin by 3 cm, is dense, and painful. Splenomegaly. Blood tests show anemia, thrombocytopenia, ESR - 36 mm/h. Total bilirubin is 56 μmol/L, due to the direct fraction. Your probable diagnosis:
<variant>alcoholic liver cirrhosis
<variant>cryptogenic liver cirrhosis
<variant>chronic alcoholic hepatitis
<variant>chronic cryptogenic hepatitis
<variant>chronic drug-induced hepatitis
<question>A man at a doctor's appointment complains of a burning sensation and pain in his back when lying down or tilting his chest forward, which intensifies after eating. Informative examination method:
<variant> Esophagoscopy
<variant> Esophagomanometry
<variant>chest x-ray
<variant> electrocardiography with forced test
<variant>Abdominal ultrasound
<question>A 27-year-old man was admitted to the hospital complaining of epigastric pain, night pain, bitter belching, and regurgitation occurring 1.5-2 hours after eating. Examination revealed poor nutrition, a moist tongue, a white coating on the bottom of the tongue, and epigastric pain upon palpation. The following was used to investigate probable cause:
<variant>gastroscopy
<variant>esophagomanometry
<variant>X-ray of the stomach
<variant>Ultrasound of the abdominal organs
<variant>irrigoscopy
<question>A 52-year-old woman complains of a feeling of heaviness and discomfort under her right rib after eating, a bitter taste in the mouth, and occasional vomiting. Objectively, the skin is normal in color, and palpation reveals tenderness in the gallbladder area. Informative examination method:
<variant>Abdominal ultrasound
<variant>gastroscopy
<variant>irrigoscopy
<variant>duodenal intubation

<variant>colonoscopy
A 52-year-old patient complains of pain under the right rib, weakness, nausea, lack of sleep at night, daytime drowsiness, abdominal distension, and pain under the right rib. After eating fatty and spicy foods, liquid offal is often passed. The liver border protrudes 6 cm from the costal arch, is dense, and tender to palpation. The spleen is not palpable and measures 10 x 12 cm. Percussion reveals a closed lower abdominal cavity. Prognosis:
<variant>liver cirrhosis, decompensation stage
<variant>liver cirrhosis, compensation stage
<variant>liver cirrhosis, subcompensation stage
<variant>autoimmune hepatitis type 1
<variant>autoimmune hepatitis type 2
<question>An 18-year-old woman experienced dysphagia and chest tightness after an emotional shock. Nervousness and fatigue caused the dysphagia. She retained her appetite and had not lost weight. A physical examination revealed no pathology. The cause of the dysphagia was:
<variant>esophagospasm
<variant>esophageal cancer
<variant>peptic ulcer of the esophagus
<variant>axial hernia of the esophageal process of the diaphragm
<variant>herpetic lesion of the esophagus
<question>A 28-year-old patient complains of epigastric pain 1.5-2 hours after eating, along with belching. EGD reveals creamy hypermerization in the pyloric and antral regions of the stomach. Your diagnostic approach:
<variant>identify Helicobacter pylori
<variant>chromoendoscopy
<variant>X-ray of the stomach
<variant>intragastric pH-metry
<variant>electrocardiographic method
<question>On examination, the patient revealed hepatosplenomegaly, increased residual nitrogen and urea in the biochemical analysis with ascites, and elevated indole, skatole, and phenol in the urine. Based on the clinical symptoms, this syndrome can be considered as:
<variant>liver cellular failure
<variant>cytolysis syndrome
<variant>cholestasis syndrome
<variant>mesenchymal inflammation
<variant>hepatic bypass
<question>37-year-old Zhuravlev M. consulted his local doctor. The patient complained of pain in the upper right abdomen, fever, jaundice, hypotension, and depression. These symptoms are characteristic:
<variant>for acute cholangitis
<variant>to acute cholecystitis
<variant>for acute appendicitis
<variant>for acute pancreatitis
<variant>for acute pyelonephritis
<question>A 53-year-old man was hospitalized with upper abdominal pain, often accompanied by large bowel movements. History: in the evening, she consumed alcohol in moderation with a large meal. Coprophy revealed a large number of intact muscle fibers, high levels of neutral fats, and starch. Probable diagnosis:
<variant>chronic enterocolitis

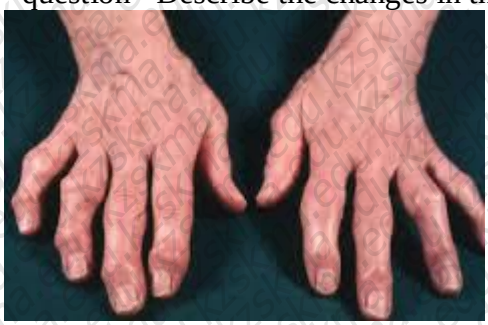
<variant>chronic gastritis
<variant>chronic cholecystitis
<variant>chronic bowel syndrome
<variant>chronic pancreatitis
<question>A patient was admitted to the hospital complaining of pain in the esophagus. The most serious complaint, according to the prognosis of patients with esophageal diseases, is...
<variant>dysphagia
<variant>vomiting
<variant>pain
<variant>salivation
<variant>stuttering
<question> Daily fluctuations in body temperature in patients ranged from 36.6 to 40.2°C. An increase in body temperature is accompanied by chills; a decrease is accompanied by profuse sweating. The characteristic temperature curve is:
<variant>febris intermittens
<variant>febris continua
<variant>febris remittens
<variant>febris reccurens
<variant>febris hectica
<question>After breaking her diet by eating fried and spicy foods, the patient experienced symptoms such as vomiting, flatulence, nausea, belching, excessive salivation, and epigastric pain radiating down the spine. Your probable diagnosis:
<variant>pancreatitis
<variant>gastritis
<variant>stomach ulcer
<variant>cholecystitis
<variant>hepatitis
<question>A 45-year-old patient complains of pain under the right rib, vomiting, and weakness. He has been ill for two years. His condition worsened after consuming fatty foods and alcohol. Physical examination: yellowish skin and sclera, beer-colored urine, and colorless stool. The liver is enlarged by 5 cm, with a rounded edge. Your preliminary diagnosis:
<variant>chronic hepatitis
<variant>liver cirrhosis
<variant>liver cancer
<variant>acute viral hepatitis
Gilbert's syndrome
<question>A patient with a gastric ulcer complained of vomiting and belching with a "rotten egg" odor after eating during an exacerbation of the disease. Complications that the patient may experience include:
<variant> stenosis
<variant> penetration
<variant>perforation
<variant>bleeding
<variant>malignancy
<question>A 26-year-old man experiences repeated vomiting, including blood, after drinking large amounts of alcohol. Your preliminary diagnosis:
<variant>Mallory-Weiss syndrome
<variant>bleeding from esophageal varices

<variant>acute pancreatitis
<variant>stomach ulcer
<variant>Crohn's disease
<question>A 29-year-old patient suddenly developed nausea, vomiting, fever, and diarrhea 6-8 times a day with foul-smelling green stool. What illness might she have?
<variant>infectious diarrhea
<variant>nonspecific ulcerative colitis
<variant>Crohn's disease
<variant>non-infectious diarrhea
<variant>diverticulosis of the small intestine
<question>After drinking alcohol, the patient began vomiting repeatedly, the last time with blood. Your preliminary diagnosis:
<variant>Mallory-Weiss syndrome
<variant>bleeding from esophageal varices;
<variant>acute pancreatitis
<variant>stomach ulcer
<variant>Crohn's disease
<question>A 38-year-old man, at a doctor's appointment, complains of a burning sensation and pain in his back when lying down and tilting his chest forward, which intensifies after eating. Probable examination method:
<variant>Esophagoscopy
<variant>Esophagomanometry
<variant>chest x-ray
<variant>electrocardiography with forced test
<variant>Abdominal ultrasound
<question>A man visits a doctor complaining of epigastric pain and night pain, bitter belching, and belching occurring 1.5-2 hours after eating. On examination, he is poorly nourished, his tongue is moist, and the bottom is coated with a white coating. Palpation reveals pain in the epigastric region. A probable and informative examination method is recommended.
:
<variant>gastroscopy
<variant>irrigoscopy
<variant>esophagomanometry
<variant>X-ray of the stomach
<variant>Ultrasound of the abdominal organs
<question>During a diabetic coma, a smell is released from the oral cavity:
<variant> acetone
<variant> ether
<variant> rotten apples
<variant>rotten eggs
<variant> ammonia
<question>The pathogenesis of polyuria is associated with:
<variant> glycosuria
<variant> insulin deficiency
<variant> significant deviations in blood sugar levels
<variant> accumulation of acetone bodies in the blood
<variant> hyperlipidemia

<question>An indication for determining glucose tolerance is the presence of the following in the patient:
<variant> thirst and polyuria, obesity, recurrent furunculosis <variant> oliguria, allergies<variant> dyslipidemia, skin itching<variant> fasting glucose level over 10 mmol/l, anuria<variant> fasting glucose level - 3.4 mmol/l, cachexia
<question>One of the main manifestations of microcirculation disorders in diabetes mellitus is:
<variant> retinopathy
<variant> atherosclerosis
<variant> cataract
<variant> symmetrical neuropathy
<variant> vascular lesion of the lower extremities
<question>The main laboratory criterion in the diagnosis of diabetes mellitus is:
<variant> hyperglycemia on an empty stomach
<variant> prolonged glucosuria
<variant> hypercholesterolemia
<variant> ketonuria
<variant> hypokalemia
<question>The main pathogenetic mechanism of diabetes mellitus:
<variant>insulin deficiency
<variant>lipid metabolism disorder
<variant>protein metabolism disorder
<variant>impaired metabolism of potassium and sodium ions
<variant>water-salt metabolism disorder
<question>The main diagnostic procedure at the outpatient level for type 1 diabetes mellitus:
<variant>determination of glycemia on an empty stomach and 2 hours after a meal
<variant>definition of ICA – islet cell antibodies
<variant>determination of C-peptide in blood serum
<variant>determination of TSH, free T4, anti-TPO and TG
<variant>definition of IAA – insulin antibodies
<question>Diagnostic procedure carried out at the stage of emergency care for type 1 diabetes mellitus:
<variant>determination of glycemic levels
<variant>Ultrasound of the abdominal organs
<variant>ECHOCG
<variant>24-hour Holter ECG monitoring
<variant>EGD
<question> A 42-year-old man was admitted to the hospital with complaints of migrating joint pain, shortness of breath with moderate physical exertion, and stabbing pain in the heart area.
Two weeks ago, he suffered from purulent tonsillitis. Objectively: the borders of relative cardiac dullness are extended to the left by 2 cm, tachycardia, and a systolic murmur at the apex. The ankles are swollen and tender. There is a rash of annular erythema on the body. What is the preliminary diagnosis for this patient?
<variant> acute rheumatic fever
<variant> rheumatoid arthritis
<variant> reactive arthritis
<variant> non-rheumatic myocarditis
<variant> systemic lupus erythematosus

<question> A 52-year-old woman presents to her doctor with knee pain for two years, including morning stiffness lasting up to half an hour. Physical examination reveals deformed knee joints, periarticular tissue thickening, moderate hyperthermia, and palpable crepitus. Which diagnostic test is recommended for diagnosis?
<variant> X-ray of the knee joints
<variant> densitometry
<variant> knee joint puncture
<variant> magnetic resonance imaging of the knee joints
<variant> arthroscopy
<question> A 52-year-old woman presents to her doctor complaining of pain and limited motion in the interphalangeal joints of her hands. Examination revealed dense nodules up to 0.5 cm in size in the distal interphalangeal joints, moderately tender to palpation. The joints are slightly deformed, and motion is limited. X-ray examination of the hand joints revealed joint space narrowing and osteosclerosis. What is the preliminary diagnosis for this patient?
<variant> osteoarthritis
<variant> rheumatoid arthritis
<variant> reactive arthritis
<variant> psoriatic arthritis
<variant> gout
<question> A 65-year-old woman presented to her doctor complaining of pain in her right knee and limited mobility. Radiographs of her right knee show narrowing of the joint space, subchondral sclerosis, flattening and unevenness of the articular surfaces, and prominent marginal bone growths. What is the preliminary diagnosis for this patient?
<variant> osteoarthritis
<variant> arthropathy
<variant> rheumatoid arthritis
<variant> ankylosis
<variant> chronic arthritis
<question> A 35-year-old patient consulted a doctor. She complained of numbness in her toes. When exposed to cold water, her fingers turned pale and gradually turned blue, becoming clearly visible. She had previously been diagnosed with Raynaud's syndrome and suspected systemic scleroderma. Which symptom would help clarify the diagnosis in this patient?
<variant> thickening of the skin on the fingers
<variant> erythema on the face
<variant> deformation of small vessels
<variant> symptoms of interstitial nephritis
<variant> numbness in the tips of the feet
<question> A 42-year-old woman is in hospital and complains of pain in her hands, toes, elbows, and knees, morning joint stiffness, and weakness. Her medical history includes: she has been ill for about two years and has not seen a doctor. Examination reveals ulnar deviation of the hands, elbows, and knees without deformity, and halux valgus in the feet. What is the preliminary diagnosis for this patient?
Rheumatoid arthritis
<variant>Bechterew's disease
<variant>Osteoporosis
<variant>Chondromatosis of the joints
<variant>Deforming arthrosis

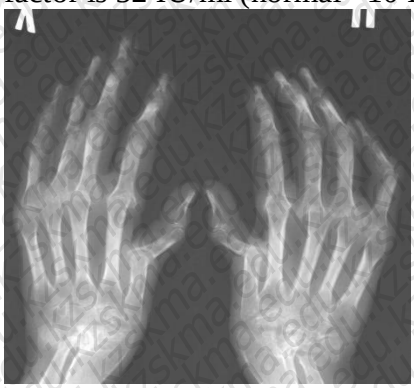
<question> Name the symptom that should be identified when questioning the medical history of a patient with arthrosis:
<variant> onset of the disease in old age
<variant> the disease begins with damage to the knee joints
<variant>Bechterew's disease in close relatives
<variant> the disease begins with damage to the spine
<variant> onset of the disease at a young age
<question> A 34-year-old woman, after recovering from an acute respiratory viral infection, developed swelling and redness of the wrist, elbow, metacarpophalangeal, and metatarsophalangeal joints, a feeling of stiffness until midnight, and a low-grade fever in the evening. These symptoms gradually worsened over three months. Determine the changes in the complete blood count:
<variant> leukocytosis
<variant> neutropenia
<variant> lymphopenia
<variant> thrombocytopenia
<variant> lymphocytosis
<question> Describe the changes in the metacarpophalangeal joints in this patient:



<variant> rough uneven deformation
<variant> destruction of bone tissue
<variant> inflammation of the periarticular soft tissues
<variant> rounded "soccer ball" type deformation
<variant> damage to the ligamentous apparatus around the joint
<question>What is the result of an immunological study in a patient with characteristic formations near the joints:

<variant> rheumatoid factor is sharply elevated
<variant> rheumatoid factor negative
<variant> C-reactive protein was not detected
<variant> antistreptolysin-O is moderately elevated
<variant> antistreptolysin-O is sharply elevated
<question> A 42-year-old woman complains of pain in the metatarsophalangeal and ankle joints, along with morning stiffness before lunch. Her body temperature rises in the evenings to 37.6-38.0°C. She considers herself ill for about 6 months, attributing the onset to hypothermia. Her mother had similar symptoms. The ankle and metatarsophalangeal joints are symmetrically swollen

and tender to pressure. Her hands are also painful. What are the results of the patient's immunological testing?
<variant> high rheumatoid factor
<variant> decreased fibrinogen levels
<variant> elevated uric acid levels
<variant> decreased levels of total protein in the blood
<variant> increased antistrepolysin levels
<question> A 39-year-old patient complains of pain in the metatarsophalangeal and ankle joints, along with morning stiffness before lunch. The ankle and metatarsophalangeal joints are symmetrically swollen and painful when pressed. He has a low-grade fever. He attributes the condition to hypothermia. His mother had similar symptoms. What changes were noted in the patient's immunological examination?
<variant> high rheumatoid factor
<variant> decreased fibrinogen levels
<variant> elevated uric acid levels
<variant> decreased levels of total protein in the blood
<variant> increased antistrepolysin levels
<question> A 36-year-old woman consulted a doctor complaining of pain and swelling in the wrist joint, severe pain and weakness in the hand, an inability to clench the hand or hold an object, and a low-grade fever in the evenings. Her joints had been painful and swollen for a year, but she did not consult a doctor until her symptoms worsened. The wrist compression test is positive. Rheumatoid factor is 52 IU/ml (normal <10 IU/ml). Describe the X-ray of the hands in this patient:



<variant> marginal erosions of articular surfaces
<variant> subchondral sclerosis
<variant> periarticular sclerosis
<variant> marginal thickenings and osteophytes
<variant> uneven widening of the joint space
<question> A 32-year-old man complains of pain and swelling in his right knee for 2-3 weeks. He also has a fever of 38.6ºC, weakness, and sweating. What are the laboratory test results for this patient?
<variant> elevated C-reactive protein
<variant> elevated uric acid levels
<variant> increased creatinine
<variant> elevated ferritin level
<variant> elevated urea levels
<question> A 20-year-old patient complains of knee pain. A few days ago, he experienced pain and swelling in his elbows, then ankles. Two weeks ago, he suffered from tonsillitis. Examination

revealed slight swelling and hyperemia of the right knee joint. What changes were noted in this patient's complete blood count?
<variant> leukocytosis
<variant> leukopenia
<variant> lymphopenia
<variant> neutropenia
<variant> lymphocytosis
<question> A 33-year-old patient presented to the doctor with complaints of a fever of 39.9°C (102.9°F), chills, a dry cough, and chest pain on the right side, which worsens with coughing and deep breathing. History: acute illness 3 days ago. Physical examination: increased vocal fremitus, decreased percussion sound, harsh breathing, and fine wheezing in the lower portions of the right lung. Your preliminary diagnosis:
<variant> pneumonia
<variant> chronic obstructive pulmonary disease
<variant> bronchial asthma
<variant> dry pleurisy
<variant> exudative pleurisy
<question> A 55-year-old patient presents to the doctor with complaints of a cough producing large amounts of purulent sputum, sometimes "mouthfuls," with an unpleasant putrid odor, lethargy, irritability, and decreased performance. A medical history notes chronic bronchitis since childhood. Examination reveals clubbed fingers and watch-glass nails. Auscultation reveals weakened vesicular breath sounds, and moist rales of varying sizes are present in the right middle lobe. Your preliminary diagnosis:
<variant> bronchial asthma
<variant> exudative pleurisy
<variant> chronic obstructive pulmonary disease
<variant> dry pleurisy
<variant> bronchiectasis
<question> A 26-year-old patient presented to the doctor with complaints of left-sided chest pain, a fever of 39°C, and increasing shortness of breath. Physical examination revealed decreased vocal fremitus on the left side and a shortened percussion sound. The respiratory rate was 22 breaths per minute, and the heart rate was 100 beats per minute. The following method is crucial for diagnosis:
<variant> chest x-ray
<variant> acute phase blood parameters
<variant> electrocardiography
<variant> general blood test
<variant> spirography
<question> A 46-year-old patient presents to the doctor complaining of a cough with difficult-to-expel sputum and shortness of breath during physical exertion. He has suffered from bronchopulmonary disease for two years and is a smoker. Physical examination: breathing is harsh, dry, buzzing rales are present throughout the lungs, and expiration is prolonged. Your preliminary diagnosis:
<variant> chronic obstructive pulmonary disease
<variant> pneumonia
<variant> bronchial asthma
<variant> bronchiectasis
<variant> chronic purulent bronchitis

<question> A 29-year-old man was admitted to the hospital complaining of an asthma attack that began two hours earlier at home, along with a cough producing a small amount of viscous, glassy sputum. Upon examination, the patient's condition was serious. He was sitting up in bed, leaning on his hands. His chest was emphysema-like. His respiratory rate was 30 breaths per minute, and exhalation was severely labored. Severe diffuse cyanosis and jugular vein distension were noted. Select the probable cause of his dyspnea:
<variant> spasm of the small bronchi
<variant> reduction of the respiratory surface of the lungs (lobar inflammatory consolidation)
<variant> decreased elasticity of the lungs due to emphysema
<variant> mechanical obstruction in the larynx
<variant> tracheal lesion
<question>A 36-year-old patient with chronic obstructive pulmonary disease is being treated in hospital for focal pulmonary tuberculosis without lysis. After clinical improvement, over the past three days, a fever of 38°C and a nonproductive cough have been noted. The examination method to determine the cause of the patient's deteriorating condition is…
<variant>sputum culture for sensitivity of accompanying microflora
<variant>brush biopsy
<variant>bronchoscopy
<variant>tuberculin test
<variant>computer spirography
<question> A 39-year-old woman consulted a doctor about a fever of 37.5 - 37.8°C (99.5 - 99.8°F) two days ago and a wet, productive cough. Heart rate is 100 beats per minute. Respiratory rate is 28 beats per minute. There is no shortening of the percussion sound under the lungs. On auscultation of the lungs: harsh breathing sounds on both sides, especially in the basal regions, dry whistling and buzzing rales, as well as medium-caliber moist rales, are detected. Your preliminary diagnosis:
<variant> non-obstructive bronchitis
<variant> pneumonia
<variant> laryngotracheitis
<variant> bronchial asthma
<variant> tuberculosis
<question> A 24-year-old girl consulted her primary care physician with complaints of intermittent episodes of shortness of breath at rest, which have developed over the past week. Objectively: localized dullness of the pulmonary sounds in the lower parts of the right lung, weakened breathing, respiratory rate of 26 beats per minute, heart rate of 86 beats per minute, blood pressure of 120/80 mmHg. Your preliminary diagnosis:
<variant> pneumonia
<variant> bronchial asthma
<variant> pulmonary embolism
<variant> neurocirculatory dystonia
<variant> acute obstructive bronchitis
<question> A 42-year-old man presents to the doctor complaining of a fever of 38°C (100.4°F), a cough with mucous sputum, and weakness. He developed the illness acutely after exposure to cold. Physical examination: labored breathing, no wheezing. Blood tests show 7,500 white blood cells and 20 mm/h of ESR. Your preliminary diagnosis:
<variant> acute bronchitis
<variant> acute nasopharyngitis
<variant> chronic bronchitis, exacerbation
<variant> community-acquired hilar pneumonia

<variant> chronic obstructive pulmonary disease, mild, exacerbation
<question> A 53-year-old patient presented to the doctor with complaints of a cough, sometimes with mucopurulent sputum, for the past 2 years. He has been smoking since age 10. Over the past 3 months, he has developed expiratory dyspnea when running and climbing to the 3rd floor. Auscultation of the lungs reveals harsh breathing and dry wheezing. The Tiffeneau index is 55%. Your preliminary diagnosis:
<variant> chronic obstructive pulmonary disease
<variant> encapsulated pleurisy
<variant> focal pneumonia
<variant> pulmonary sarcoidosis
<variant> bronchial asthma
<question> The doctor at the medical center was called to see a 14-year-old boy (weight 55 kg). He complained of a fever of 39.8 degrees Celsius, weakness, malaise, loss of appetite, sweating, and a sore throat when swallowing. His respiratory rate was 35. The normal number of breaths per minute is:
<variant> 16 – 20
<variant> 24 – 28
<variant> 32 – 36
<variant> 10 – 14
<variant> 36 – 40
<question>A 66-year-old patient came to the clinic complaining of a fever of up to 37.7˚C, cough. Dry wheezing, general weakness, and sweating are heard on auscultation.
Mechanism of dry wheezing:
<variant>narrowing of the bronchial lumen
<variant>thickening of the pleural layers
<variant>the presence of liquid secretion in the lumen
<variant>vibration of the alveolar walls
<variant>the presence of fluid in the alveoli
<question> A 27-year-old woman complains of severe shortness of breath and a cough with difficult-to-separate viscous sputum for 3 hours. Physical examination: moderate condition. She is in a forced position with a fixed shoulder girdle. Difficulty and prolonged exhalation is present. "Distant wheezing" is audible. The main auscultatory signs of bronchospastic syndrome are:
<variant>treble wheezing
<variant>coarse wheezing
<variant>fine bubbling moist rales
<variant>consonant wheezing
<variant>crepitation
<question>A 35-year-old man called an ambulance. He complained of asthma, severe coughing, sweating, palpitations, sore throat, and anxiety. His physical examination revealed moderate severity, orthopnea, and a bluish-purple face. Signs of pulmonary consolidation syndrome are not:
<variant>weakening of vesicular breathing on the healthy side
<variant>dullness of percussion sound
<variant>increased vocal fremitus
<variant>increased bronchophony and moist rales
<variant>lagging of the affected side in the act of breathing
<question>A 27-year-old woman suddenly developed shortness of breath, a paroxysmal cough, and fear of death after treating a room with a disinfectant solution. Physical examination: moderate condition, cyanotic skin, severe hyperhidrosis. Tachypnea, respiratory rate 40 beats per minute.

Muffled heart sounds, heart rate 140 beats per minute, blood pressure 100/60 mmHg. The following is heard over the lung cavity containing air and sputum:
<variant>bronchial breathing and large, moist rales
<variant>dry wheezing and bronchial breathing
<variant>crepitation and bronchial breathing
<variant>dry wheezing and vesicular breathing
<variant>fine bubbling moist rales
<question>An ambulance crew member was called to a 28-year-old woman for a sudden, several-hour-long attack of suffocation, difficulty exhaling, and a cough producing sputum that was difficult to expectorate. Repeated use of an inhaler (a beta-agonist, Berotek) provided only a temporary relief. The patient had been experiencing similar attacks for five years, triggered by the smell of gasoline and flowering plants. The main symptom of respiratory failure was:
<variant>shortness of breath
<variant>hemoptysis
<variant>cough
<variant>sputum
<variant>weakness
<question>A 27-year-old man was admitted to the hospital with respiratory distress. He was sent for pneumotachometry. Pneumotachometry determines:
<variant>volumetric air flow rate during inhalation and exhalation
<variant>additional volume
<variant>tidal volume
<variant>reserve volume
<variant>residual air volume
<question>A 29-year-old man. Over the past three months, he has noticed periodic temperature rises to 38.0°C (100.4°F), increasing weakness, drowsiness, weight loss, and increased sweating. He continued working, but two days ago, purulent sputum appeared, which prompted him to consult a doctor. Abundant purulent sputum (up to 200-300 ml per day) is produced by:
<variant>bronchiectasis
<variant>purulent obstructive bronchitis
<variant>pulmonary emphysema, pneumosclerosis
<variant>bronchial asthma
<variant>focal or lobar pneumonia
<question>A 35-year-old man was admitted complaining of chest pain, fever, and severe general weakness. The pain is usually unilateral, quite intense, and tends to intensify with deep breathing, coughing, and sneezing. His temperature rises to 38°C, rarely higher. He also experiences general weakness, sweating, headache, and intermittent muscle and joint pain. Auscultatory findings suggest pleural thickening syndrome:
<variant>weakened vesicular breathing
<variant>amphoric breathing
<variant>vesicular breathing
<variant>pathological bronchial breathing
<variant>increased vesicular breathing
<question>A 53-year-old man has been in hospital for 10 days. Auscultation of the lungs reveals various wet and dry rales. Breathing is shallow, tachypneic, and the respiratory rate is 28 beats per minute. Heart sounds are muffled and tachycardic. Heart rate is 100 beats per minute, and blood pressure is 90/60 mmHg. Dry rales are caused by:
<variant>narrowing of the bronchial lumen

<variant>swelling of the bronchial mucosa
<variant>accumulation of viscous secretion in the lumen of the bronchi
<variant>the presence of fluid in the alveoli
<variant>bronchial smooth muscle spasm
<question>A 26-year-old patient developed mitral stenosis after suffering from rheumatic fever in childhood. He had been feeling well for many years, but recently, after frequent sore throats, his condition worsened sharply: shortness of breath, a cough producing rusty sputum, palpitations, heart pain, leg swelling, and weight gain. Wheezing sounds occur with:
<variant>accumulation of liquid or semi-liquid secretion in the lumen of the bronchi
<variant>accumulation of viscous secretion in the lumen of the bronchi
<variant>swelling of the bronchial mucosa
<variant>bronchial smooth muscle spasm
<variant>the presence of fluid in the alveoli
<question>A 44-year-old patient, during an outpatient appointment with his local physician, complains of a fever rising to 38°C in the evenings, a persistent cough with mucopurulent sputum, shortness of breath during physical exertion, general weakness, and increased sweating. Crepitations are heard on lung auscultation. Crepitations are heard in the following cases:
<variant>the presence of liquid secretion in the alveoli
<variant>accumulation of liquid or semi-liquid secretion in the lumen of the bronchi
<variant>swelling of the bronchial mucosa
<variant>narrowing of the bronchial lumen by viscous secretions
<variant>bronchial smooth muscle spasm
<question>A 26-year-old man from a social risk group complains of weakness, malaise, fatigue, weight loss, cough, and night sweats. He has been ill for the past 2-3 months and frequently works night shifts. A chest x-ray revealed an infiltrative shadow in the upper lobe of the right lung, with a pathway to the root. Your management strategy:
<variant>Sputum analysis for BK
<variant>Refer to a phthisiatrician
<variant>Conduct antibacterial therapy
<variant>Prescribe anti-tuberculosis treatment
<variant>Refer to the pulmonology department
<question>A 28-year-old man visits his local doctor complaining of burning and pressing pain in the heart area, experienced almost constantly over the past two weeks. He also experiences palpitations and shortness of breath. History: He became ill about three weeks ago, when, after an illness accompanied by cough and chills, the above-mentioned cardiac complaints appeared. Heart sounds are muffled, and there are no wheezing in the lungs. The liver is not enlarged. Which diagnostic method can help confirm the diagnosis?
<variant>Spirography
<variant>ECG
<variant>ECHO-CG
<variant>X-ray
<variant> blood parameters.
<question>A 35-year-old man with a long history of smoking visited the emergency room. An examination revealed a lung cavity syndrome communicating with a bronchus. What are the likely auscultatory symptoms in this case?
<variant>amphoric breathing
<variant>weakened vesicular breathing
<variant>increased vesicular breathing

<variant>metallic breath
<variant>hard breathing
<question> A 25-year-old man presented to the emergency room physician with complaints of a high fever and a cough with a small amount of rusty sputum. His medical history indicated that he developed the illness acutely after exposure to cold. Examination revealed increased vocal fremitus and bronchophony, decreased percussion sound over the lesion, decreased vesicular breath sounds, and crepitus indux.
For what stage of the disease is this clinical picture characteristic?
<variant>onset of the disease
<variant>the height of the disease and resolution
<variant>the height of the disease
<variant>permissions
<variant>recovery
A 22-year-old man complains of shortness of breath and chest pain. The following physical findings are present: percussion reveals a tympanic sound, and auscultation reveals metallic bronchial breath sounds. Which of the following pathological conditions is the likely cause of this change?
<variant>open pneumothorax
<variant>closed pneumothorax
<variant>cavity in the lung
<variant>bronchospasm
<variant>hydrothorax
<question>A 23-year-old girl came to the doctor complaining of a high temperature and a dry cough.
During an objective examination, the physician detected increased vocal fremitus, a shortened percussion sound, increased bronchophony, and weakened bronchial breathing in a limited area of the scapular angle. Which of the following syndromes are characterized by these clinical symptoms?
<variant>focal compaction of lung tissue
<variant>obstructive atelectasis
<variant>the presence of a cavity in the lung tissue
<variant>the presence of fluid in the pleural cavity
<variant>lobar compaction of lung tissue
<question> During an objective examination, the patient's body temperature rose to 39.8°C. It turned out that he had a history of low-grade fever for the past year, and taking antipyretics such as aspirin did not normalize it. A low temperature is observed during:
<variant> lung abscess
<variant> lung cancer
<variant> lung abscess after rupture
<variant> lobar pneumonia
<variant> Purulent obstructive bronchitis
<question> Patient K., 20, was admitted to the internal medicine department with a fever of 40.5°C. The patient is pale, with dry skin. The tongue is covered with a white coating. The patient complains of joint and muscle pain, shortness of breath, a severe cough with sputum, loss of appetite, and headaches. Blood pressure is 130/90 mmHg. Pulse is 98 beats/min. The heart rate is normal. Heart sounds are muffled. Breathing is rapid and shallow.
A constant increase in body temperature is observed during:
<variant> initial stage of lobar pneumonia
<variant> lung cancer

<variant> bronchiectasis
<variant> the lung abscess is in the process of resolving
<variant> lobar pneumonia in the resolution stage
<question> Patient V. was admitted to the internal medicine department. He experienced a thready pulse, cold sweat, shortness of breath, chest tightness, and severe weakness. Hypotension is a condition in a patient receiving penicillin therapy.
<variant> pulmonary embolism
<variant> anaphylactic shock
<variant> symptoms of acute left ventricular failure (pulmonary edema)
<variant> symptoms of renal eclampsia
<variant> symptoms of acute right ventricular failure
<question>An elderly man suffering from chronic alcoholism and COPD complains of a sticky cough with difficulty expectorating, sputum with a burnt-meat odor and a consistency reminiscent of blackcurrant jelly. Significant intoxication, shortness of breath, and a slight amount of wheezing were detected. Radiographic examination revealed a phenomenon"Honeycomb lung," multiple bronchiectasis, residual cavities, pneumosclerosis. Probable pathogen:
<variant> klebsiella
<variant> chlamydia
<variant> mycoplasma
<variant> influenza virus
<variant> E. coli
<question> A 27-year-old man complains of shortness of breath and a dry cough. He has a history of colds and allergic rhinitis. The doctor heard a dry, wheezing sound throughout the lungs. Which of the following syndromes could this patient have developed?
<variant> bronchial obstruction
<variant> presence of a cavity in the lung tissue
<variant>increasing the volume of air in the lungs
<variant> compaction of lung tissue
<variant> bronchodilation
<question>In bronchial asthma, spirographic indicators are mainly reduced due to:
<variant> forced vital capacity
<variant> vital capacity of the lungs
<variant> maximum ventilation
<variant> respiratory capacity
<variant> expiratory power
<question> Main complaints in organic bronchial obstruction syndrome:
<variant> suffocation
<variant> cough
<variant> chest pain
<variant> shortness of breath on exertion
<variant> spit on the blood
<question> Cough in organic bronchial obstruction syndrome:
<variant> often appears in the morning hours
<variant> bothers me at night
<variant> mucous sputum in moderate quantities
<variant> with a small amount of "glassy" sputum
<variant> with a large amount of purulent sputum
<question> The main clinical sign of organic bronchial obstruction syndrome:

<variant> cough with phlegm
<variant> shortness of breath
<variant> spit on the blood
<variant> wheezing on auscultation of the lungs
<variant> increased blood pressure
<question>After the organic bronchial obstruction syndrome, the following may develop:
<variant> purulent pleurisy
<variant> pneumonia infarction
<variant> chronic pulmonary heart disease
<variant> exudative pleurisy
<variant> pneumonia
<question> In case of organic bronchial obstruction syndrome, percussion of the lungs reveals:
<variant> a significant increase in percussion sound is determined
<variant> defines the loss of Traube space
<variant> changes are not detected
<variant> defines the sound of the box
<variant> defines a drum percussion sound
<question>Auscultation of the lungs in organic bronchial obstruction syndrome reveals:
<variant> puerile breathing
<variant> increased vesicular breathing
<variant> heavy breathing
<variant> bronchial breathing
<variant> dry wheezing
<question> In case of organic bronchial obstruction syndrome, the audibility of dry wheezing in a limited area is associated.
<variant> with emphysema
<variant> respiratory failure
<variant> with hydrothorax
<variant> for local obstruction of large or medium bronchi
<variant> for inflammation of the lung parenchyma
<question> Common infectious agents that cause acute pneumonia are:
<variant> pneumococci
<variant> staphylococci
<variant> viruses (often respiratory)
<variant> mycoplasma
<variant> Legionella
<question>Specify the conditions that contribute to the development of acute pneumonia (risk factors):
<variant>infected with ARVI
<variant> immunodeficiency (including AIDS)
<variant> cardiovascular diseases
<variant> obstruction of the respiratory tree
<variant> diabetes
<question> A 28-year-old man presents to a doctor complaining of intermittent lower back pain, urinary retention, and facial swelling. A positive Pasternatsky's sign occurs with:
<variant> urolithiasis
<variant> diabetic nephropathy
<variant> urethritis

<variant> cystitis
<variant> prostatitis
<question> According to the Zimnitsky test, the following results were revealed: daily diuresis of 2500 ml, daytime diuresis of 1720 ml, and nocturnal diuresis of 780 ml. The maximum and minimum values of the relative density of urine in various portions were within the range of 1.005–1.012. Indicate which conclusion is correct:
<variant>polyuria, hyposthenuria
<variant>hypoisosthenuria, nocturia
<variant>polyuria, pollakiuria
<variant>isosthenuria, nocturia
<variant>polyuria, nocturia
A 38-year-old man was brought to the hospital by ambulance with complaints of nausea, vomiting, lack of urine, and muscle twitching. His medical history includes a traffic accident with severe kidney damage. Blood tests show urea is 9.3 mmol/L, creatinine is 188 μmol/L, Na is 131 mmol/L, and K+ is 6.8 mmol/L. Which syndrome would develop in this situation?
<variant>acute renal failure syndrome
<variant>chronic renal failure syndrome
<variant>renal arterial hypertension syndrome
<variant>nephrotic syndrome
<variant>nephritic syndrome
A 56-year-old woman consulted a doctor complaining of facial swelling, especially in the morning, decreased urine output, and fatigue. Her medical history included frequent colds. On examination, the patient's face was pale and puffy, her eyelids were swollen, and her palpebral fissures were narrowed. Which of the following is the correct description of her condition based on her examination data?
<variant>facies nephritica
<variant>facies febrilis
<variant>facies mitralis
<variant>facies basedovica
<variant>facies Hyppocratica
<question> A 48-year-old woman presented to the clinic with complaints of facial swelling, especially in the mornings, decreased urine output, urine discolored the color of "meat slops," palpitations, and fatigue. Past medical history: a month ago, after hypothermia, she suffered from tonsillitis and bronchitis, after which she periodically experienced aching pain in the lower back. Objectively: the patient's face is pale, puffy, and her eyelids are swollen. Blood pressure is 150/110 mmHg. A general urine analysis shows protein 0.099%, red blood cells - 45-50 in the field of view. Indicate the cause of the "meat slops"-colored urine:
<variant>decreased permeability of glomerular capillaries
<variant>inflammation of the ureters
<variant>damage to the ureters by a stone
<variant>increased red blood cell count
<variant>decreased levels of blood clotting factors
<question>Name the circulatory disorder in the brain that causes tissue damage
<variant> Stroke
<variant> Encephalitis
<variant> Autism
<variant> Polyneuropathy
<variant> Myelitis

<question>A type of stroke caused by a ruptured blood vessel in the brain
<variant> Hemorrhagic
<variant> Ischemic
<variant> Thrombotic
<variant> Lacunar
<variant> Transient
<question>A condition that causes sudden, temporary disruption of cerebral circulation
<variant>Transient ischemic attack (TIA)
<variant>Hemorrhagic stroke
<variant>Encephalitis
<variant>Migraine
<variant>Polyneuropathy
<question> A 19-year-old male college student presented to the clinic with headache, photophobia, vomiting, and fever. His medical history included contact with a patient with tuberculosis. Physical examination: he lies in the "lion-dog" position, with his head tilted back. He has nuchal rigidity on both transverse fingers. Kernig's and Brudzinski's signs are positive. Which syndrome does this patient exhibit?
<variant> meningeal
<variant> convulsive
<variant> epileptic
<variant> transient attack
<variant> hemorrhagic
<question> A., an 18-year-old woman, was brought to the emergency room complaining of a severe headache, fever, nausea, and vomiting. Her medical history revealed that she had been ill for a week and had been hiking with friends. Upon examination, she lay with her eyes closed, refused to be covered with a blanket, and experienced a sharp increase in pain sensitivity. When the doctor attempted to tilt her head, she experienced flexion of her lower extremities at the hips and knees. What symptom is present in this case?
<variant>Brudzinski syndrome
<variant> Kernig
<variant> Gordon
<variant> Oppenheim
<variant> Shoffara
<question> A 35-year-old man, a school teacher, was brought to the hospital emergency room on the referral of his local doctor. He complained of a severe headache, nausea, and an inability to move freely due to sudden, severe weakness in his left leg. His medical history revealed chronic nephritis. Examination revealed pale skin and decreased pain sensitivity. Blood pressure was 190/100 mmHg. Which pathological condition is developing in this man?
<variant> hemorrhagic stroke
<variant> meningeal syndromes
<variant> transient attack
<variant> myocardial infarction
<variant> epileptic seizure
<question> A 42-year-old woman was brought to the hospital emergency room by her relatives complaining of headache, fever, nausea, and photophobia. Her medical history revealed she had been ill for over a week following an acute respiratory infection. On examination, she lay on her side with her eyes closed and refused to be covered. Hyperesthesia, nuchal rigidity on the four

transverse fingers, and a positive Kernig's sign were revealed. Which diagnostic test would be helpful for establishing the diagnosis?
<variant> spinal puncture
<variant> computed tomography of the brain
<variant> MRI of the brain
<variant> electroencephalography
<variant> cerebral echography
<question> A 57-year-old woman with a history of hypertension for 17 years developed a severe headache, nausea, and repeated vomiting after emotional stress. A house call from her primary care physician revealed dorsiflexion of the big toe and fan-shaped splaying of the remaining toes when pressing with a bent finger on the crest of the shin. What is the likely pathological symptom?
<variant> Oppenheim
<variant> Kocher
<variant> Schaeffer
<variant> Gordon
<variant> Brudzinsky
<question> A 60-year-old man experienced a severe headache at a bus stop. He was screaming, trying to run, and swearing loudly. People around him called an ambulance. He answered the doctor's questions correctly, but not immediately. He struggled to find words, pronouncing them in single syllables. He complained of increasing weakness in his left arm and leg. He had a history of angina and was taking Isochet spray, but it was not helping. He also had decreased sensation on the left side and a positive Babinski sign. What is the probable diagnosis in this case?
<variant> ischemic stroke
<variant> epileptic seizure
<variant> transient attack
<variant> meningeal syndrome
<variant> hysterical fit
<question>A 35-year-old man consulted a doctor complaining of intermittent pain in the right side of the chest and bad breath. Dysphagia has occasionally appeared over the past few months. His medical history shows frequent colds. In this case, it can be assumed that:
<variant> esophageal diverticulum
<variant>varicose veins of the esophagus
<variant>esophageal-bronchial fistula
<variant>esophageal stenosis
<variant>achalasia of the esophagus
<question>A 26-year-old man presented to his doctor with the following complaints: epigastric pain occurring 1-1.5 hours after eating, belching, and heartburn. Examination revealed a moist tongue with a white coating, a soft abdomen, and moderate epigastric tenderness. FGDS revealed diffuse hyperemia of the gastric mucosa and superficial defects of the antral mucosa measuring up to 0.5 cm. Your preliminary diagnosis:
<variant>chronic non-atrophic gastritis with erosions
<variant>chronic atrophic gastritis
<variant>gastric ulcer
<variant>reflux gastritis
<variant>functional non-ulcer dyspepsia
<question>A 34-year-old man suffered from acute dysentery two weeks ago. Currently, he is experiencing aching pain in the lower abdomen, which intensifies 5-7 hours after eating; he also

experiences diarrhea after consuming dairy products. Select a diagnostic test to confirm the diagnosis:
<variant>coprogram
<variant>stool occult blood test
<variant>colonoscopy
<variant>Ultrasound of the abdominal organs
<variant>X-ray examination of the intestines
<question>A 27-year-old man was admitted to the emergency room with acute abdominal pain that began one hour ago. There was no vomiting or stool. Physical examination revealed muscular defense in the epigastric region. Percussion revealed resolution of hepatic dullness. Your preliminary diagnosis:
<variant>perforation of a gastric ulcer
<variant>penetration of gastric ulcer
<variant>gastric bleeding
<variant>acute cholecystitis
<variant>acute pancreatitis
<question>A 46-year-old man presented to his doctor with complaints of chest pain radiating to the interscapular region, which worsens when lying down; acid belching. Your diagnostic approach to confirm the diagnosis:
<variant>esophagogastroduodenoscopy
<variant>24-hour pH-metry
<variant>intraceophageal manometry
<variant>Ultrasound of the abdominal organs
<variant>proton pump inhibitor test
A 42-year-old man was admitted to the hospital with an attack of abdominal pain, primarily in the left upper quadrant, accompanied by moderate jaundice. His medical history includes surgery for gallstones 5 years ago. His physical examination reveals moderate severity, with moderate jaundice. His abdomen is tender to palpation in the left upper quadrant, in the Chauffard and Gubergritz zones. Your preliminary diagnosis:
<variant> chronic pancreatitis
<variant> chronic cholangitis
<variant> peptic ulcer
<variant> chronic gastritis
<variant> chronic hepatitis
<question>A 36-year-old man presents to the doctor complaining of pain in the left abdomen and lumbar region. This pain occurs periodically after overeating, hypothermia, and rough driving, and is relieved after taking No-Spa and Baralgin. Physical examination: the tongue is coated white, the abdomen is soft, and tenderness is present in the left hypochondrium and left costovertebral angle (Mayo-Robson sign). Your preliminary diagnosis:
<variant> painful form of chronic pancreatitis
<variant> gastric ulcer
<variant> chronic pyelonephritis
<variant> urolithiasis, renal colic
<variant> duodenal ulcer
A 28-year-old man was undergoing treatment for an exacerbation of bronchiectasis. After two weeks, he developed intermittent, unspecified abdominal pain of moderate intensity, flatulence, and loose stools 4-6 times a day. Pieces of undigested food were detected in the stool. The following diagnostic methods are needed to determine the cause:

<variant> microbiological examination of feces
<variant> complete blood count
<variant> irrigoscopy
<variant> ultrasound examination of the abdominal cavity
<variant> FGDS
<question>A 50-year-old man presents to the doctor complaining of asthma attacks, burning pain in the lower third of the sternum, and sour belching. An ECG shows no ischemic changes. Peak flowmetry reveals a slight decrease in peak expiratory flow rate. Your preliminary diagnosis:
<variant> gastroesophageal reflux disease
<variant> chronic gastritis
<variant> IHD, angina pectoris
<variant> bronchial asthma
<variant> chronic obstructive pulmonary disease
<question>A 75-year-old man presents to the doctor complaining of a feeling of heaviness and fullness in the epigastric region, dull pain in the epigastric region, an unpleasant taste in the mouth, nausea, loss of appetite, belching, and unstable stool. Abdominal palpation reveals diffuse tension in the anterior abdominal wall and tenderness in the epigastric region. FGDS reveals pallor, flattening, and thinning of the body and antrum of the stomach, translucent vessels, increased fragility, hypotension, hypokinesia, and bile reflux. Your preliminary diagnosis:
<variant> chronic atrophic gastritis
<variant> antral non-atrophic gastritis
<variant> peptic ulcer
<variant> nonspecific ulcerative colitis
<variant> stomach cancer
<question>A 29-year-old woman presented to her doctor with complaints of persistent constipation lasting 8-9 days, nausea, headaches, sleep disturbances, and general weakness. Laxatives are ineffective, requiring frequent cleansing enemas. Physical examination: dry, rough skin with areas of hyperpigmentation. The abdomen is soft, and a hard, non-mobile mass is palpable in the sigmoid colon. A digital rectal examination reveals empty, painless ampulla. An appropriate examination method is:
<variant> irrigoscopy
<variant> Ultrasound of the abdominal organs
<variant> computed tomography of the head
<variant> colonoscopy with biopsy
<variant> rectal manometry
<question>A 32-year-old man complains of a pressing pain in the epigastric region half an hour after eating or drinking alcohol; he also experiences excruciating heartburn, which is relieved by taking baking soda. He has had this condition for two years and has not received any treatment. Physical examination: the tongue is coated with a white coating, and deep palpation reveals tenderness in the epigastric region. An EGD revealed hyperemic and edematous gastric mucosa, with isolated hemorrhages in the antrum. An informative diagnostic method is:
<variant> Helicobacter pylori test
<variant> 24-hour pH monitoring
<variant> endoscopic pH-metry
<variant> electrogastrographic method
<variant> gastric secretion study using the gastrotest method
<question>A 20-year-old woman complains of dyspeptic disorders. Dyspeptic disorders associated with heart failure are explained by:

<variant>sharply expressed venous congestion in the liver and gastrointestinal tract
<variant>by reducing the acidity of gastric juice
<variant>violation of the motor-evacuation function of the stomach
<variant>exocrine pancreatic insufficiency
<variant>increased acidity of gastric juice
<question>A 48-year-old man, after breaking his diet by eating spicy and fried foods, is experiencing epigastric pain radiating to the spine, increased salivation, belching, nausea, flatulence, and vomiting that does not bring relief. The possible underlying condition is:
<variant>pancreatitis
<variant>gastritis
<variant>gastric ulcer
<variant>cholecystitis
<variant>hepatitis
<question>A 57-year-old woman complains of nausea, belching, heartburn, and a bitter taste in the mouth. The possible underlying condition is:
<variant>cholecystitis
<variant>esophagitis
<variant>gastritis
<variant>peptic ulcer of the stomach and duodenum
<variant>pancreatitis
<question>A 53-year-old man with a gastric ulcer developed complaints of belching like a rotten egg during an exacerbation and vomiting of food he had eaten the day before. The patient's probable complication is:
<variant>stenosis
<variant>penetration
<variant>perforation
<variant>bleeding
<variant>malignancy
<question>A 47-year-old man experienced repeated vomiting after drinking alcohol, the last of which contained bright red blood. Your preliminary diagnosis:
<variant>Mallory-Weiss syndrome
<variant>bleeding from esophageal varices;
<variant>acute pancreatitis
<variant>gastric ulcer
<variant>Crohn's disease
<question>A 51-year-old man was admitted to the hospital complaining of pain in the esophagus. Serious complaints of patients with esophageal diseases:
<variant>dysphagia
<variant>vomiting
<variant>pain
<variant>drooling
<variant>heartburn
<question>A 25-year-old woman was admitted to the hospital with complaints of belching and esophageal pain. Dysphagia is usually diagnosed based on a past medical history:
<variant>cicatricial stenosis of the esophagus
<variant>esophageal neoplasm
<variant>esophageal diverticulum
<variant>chronic atrophic esophagitis

<variant>the value of anamnestic data is equivalent
<question> A 62-year-old man consulted his primary care physician complaining of weakness, nausea, insomnia at night and daytime sleepiness, abdominal distension, and pain in the right hypochondrium. The pain intensifies after eating fatty and spicy foods and is accompanied by loose stools. The edge of the liver protrudes 6 cm from under the costal margin, is firm, and tender to palpation. The spleen is not palpable and measures 10 x 12 cm. Your preliminary diagnosis:
<variant> liver cirrhosis, decompensation stage
<variant> liver cirrhosis, compensation stage
<variant> liver cirrhosis, subcompensation stage
<variant> autoimmune hepatitis type 1
<variant> autoimmune hepatitis type 2
<question>A 20-year-old woman developed dysphagia and a feeling of fullness behind the breastbone after experiencing emotional stress. The dysphagia subsequently recurred with anxiety and fatigue. She retained her appetite and did not lose weight. A physical examination revealed no abnormalities. Select the likely cause of the dysphagia:
<variant> esophageal spasm
<variant> esophageal cancer
<variant> peptic ulcer of the esophagus
<variant> axial hernia of the esophageal opening of the diaphragm
<variant> herpetic lesion of the esophagus
A 29-year-old man presented to his doctor with complaints of epigastric pain occurring 1.5-2 hours after eating, as well as belching. An EGD revealed hyperemic mucosa in the pyloric and antral regions of the stomach. Your further diagnostic approach:
<variant> Helicobacter pylori test
<variant> chromoendoscopy
<variant> X-ray examination of the stomach
<variant> intragastric pH-metry
<variant> electrogastrographic method
<question>A 54-year-old man has suffered from chronic pancreatitis for several years. The simplest way to detect pancreatic calcification is:
<variant> radiography
<variant> laparotomy
<variant> laparoscopy
<variant> irrigoscopy
<variant> cholangiography
<question>A 49-year-old man was admitted to the hospital complaining of esophageal pain. This complaint is considered serious in patients with esophageal diseases:
<variant> dysphagia
<variant> vomiting
<variant> pain
<variant> salivation
<variant> heartburn
<question>A 54-year-old man with hepatosplenomegaly and ascites has blood biochemistry that reveals elevated residual nitrogen and urea, as well as elevated levels of indole, skatole, and phenols in his urine. Clinical symptoms suggest the development of the following syndrome:
<variant> hepatocellular insufficiency
<variant> cytolysis
<variant> cholestasis

<variant> mesenchymal inflammation
<variant> hepatic blood flow bypass
<question>A 46-year-old man, after breaking his diet by eating spicy and fried foods, developed epigastric pain radiating to the spine, increased salivation, belching, nausea, flatulence, and vomiting that does not bring relief. Your preliminary diagnosis:
<variant> pancreatitis
<variant> gastritis
<variant> gastric ulcer
<variant> cholecystitis
<variant> hepatitis
<question>A 54-year-old man consulted a doctor complaining of persistent, intense epigastric pain, general weakness, and vomiting. The pain occurred 50-60 minutes after consuming fried foods or alcohol. Examination revealed epigastric tenderness and a positive Mayo-Robson sign. A complete blood count revealed leukocytes of 12x109/L and ESR of 18 mm/h. Your preliminary diagnosis:
<variant> chronic pancreatitis
<variant> chronic cholecystitis
<variant> gastric ulcer
<variant> chronic gastritis, type B
<variant> Gastroesophageal reflux disease
<question>A 41-year-old man with a gastric ulcer developed complaints of belching like a rotten egg and vomiting the food he had eaten the day before during an exacerbation of the disease. Which complication is most likely present?
<variant> stenosis
<variant> penetration
<variant> perforation
<variant> bleeding
<variant> malignancy
<question>A 27-year-old man, an economist, came to see an endocrinologist with complaints of severe weakness and rapid fatigue, frequent dizziness, weight loss, loss of appetite, nausea and increased skin pigmentation.From the medical history, these complaints appeared about six months ago. He had no previous illnesses. He studied in China and has been working for three months. Objectively, he is asthenic, undernourished, has atrophic muscles, and has decreased strength.PS – 100 beats per minute, small, rhythmic. BP-90/60 mm Hg. Heart sounds are muffled, rapid. In blood tests – HB -72 g/l; ER- 2.9×1012/l, L -6.2×109/l; ESR -22 mm/hour. Blood sugar - 2.6 mmol/l.Which of the following syndromes is likely in this case:
<variant>hypocorticism
<variant>anemia
<variant>hypothyroidism
<variant>hypoglycemia
<variant>hypercorticism
<question>A 46-year-old man, a radiologist, was admitted to the internal medicine department with complaints of weight loss, general weakness, malaise, fatigue, frequent fainting, moderate epigastric pain, periodic vomiting, nausea, and alternating loose stools with constipation. His medical history includes a previous history of pulmonary tuberculosis. He has an asthenic build, and the skin of exposed areas of the body is hyperpigmented. The pulse is small and rapid. Blood pressure is 80/60 mmHg. Heart sounds are muffled and rapid. The tongue is moderately coated with a white coating. The abdomen is soft, and palpation is painful in the epigastric region. Which of the following syndromes is characterized by this clinical symptomatology?

<variant>hypofunction of the adrenal glands
<variant>hypothyroidism
<variant>hyperfunction of the adrenal glands
<variant>gastric dyspepsia
<variant>intestinal dyspepsia
<question>A 39-year-old man came to the emergency room of the clinic with complaints of obesity, especially in the abdomen and neck, frequent headaches, dry skin, and bone pain. Anamnesis: these complaints have appeared within the last year, and are not associated with anything. Objectively: severe obesity in the abdomen and neck, atrophy of the muscles of the shoulder girdle and legs, flushed cheeks. PS - 112 beats per minute. BP - 160/100 mmHg. Heart sounds are somewhat muffled, rapid, with an accentuated 2nd sound on the aorta, a short systolic murmur at the apex. In the lungs - harsh breathing, isolated dry wheezing. Blood sugar - 7.1 mmol / L. Which of the following syndromes is likely in this case:
<variant>hyperfunction of the adrenal cortex
<variant>arterial hypertension
<variant>hypofunction of the adrenal cortex
<variant>hyperfunction of the thyroid gland
<variant>absolute insulin deficiency
<question> A 55-year-old woman had a glucose level of 6.0 mmol/L (as measured by a glucometer) during a routine checkup. A repeat fasting blood test showed a glucose level of 5.9 mmol/L, and two hours after exercise, it was 10.6 mmol/L. Could this patient possibly have:
<variant> impaired glucose tolerance
<variant> impaired fasting glucose
<variant> random glycemia
<variant> diabetes mellitus
<variant> gestational diabetes mellitus
<question> A man had a routine checkup, and his glucose level was found to be 10.9 mmol/L (as measured by a glucometer). A repeat fasting blood test showed a glucose level of 8.8 mmol/L, and two hours after exercise, it was 12.6 mmol/L. Predict whether the patient might have:
<variant> type 2 diabetes mellitus
<variant> impaired glucose tolerance
<variant> impaired fasting glucose
<variant> random glycemia
<variant> type 1 diabetes mellitus
A 50-year-old woman had a glucose level of 9.9 mmol/L (as measured by a glucometer) during a routine checkup. A repeat fasting blood test showed a glucose level of 10.8 mmol/L, and two hours after exercise, it was 13.2 mmol/L. Predict whether the patient might have:
<variant> type 2 diabetes mellitus
<variant> impaired glucose tolerance
<variant> impaired fasting glucose
<variant> random glycemia
<variant> type 1 diabetes mellitus
<question>A 42-year-old woman consulted a primary care physician complaining of general weakness, severe dry skin, hair loss, memory loss, voice changes, and drowsiness. Upon examination, the patient was apathetic, with dry, flaky skin in places. Her face was puffy, her arms and legs were swollen, and her heart sounds were muffled but rhythm was regular. Blood pressure was 80/50 mmHg. Pulse rate was 50 beats per minute.
Your preliminary diagnosis:

<variant> hypothyroidism
<variant> liver cirrhosis
<variant> severe heart failure
<variant> obesity
<variant> hyperthyroidism
<question>Diagnostic procedure carried out at the stage of emergency care for type 1 diabetes mellitus:
<variant> determination of glycemic levels
<variant> Ultrasound of the abdominal organs
<variant> ECHO-CG
<variant> 24-hour Holter ECG monitoring
<variant> EGDS
<question>Normal fasting glucose concentration in whole capillary blood (mmol/l) does NOT exceed:
<variant> 5.5 mmol/L
<variant> 7.8 mmol/L
<variant> 6.1 mmol/L
<variant> 11.1 mmol/L
<variant> 6.7 mmol/L
<question>Frequency of general blood test examination in patients with type 1 diabetes mellitus:
<variant> Once a year
<variant> Once every 3 months
<variant> at least 4 times daily
<variant> Once a year (if no changes)
<variant> according to indications
<question>An overweight woman has twice had elevated fasting blood glucose levels of 6.9 and 7.2 mmol/L. Your preliminary diagnosis is:
<variant>Type 2 diabetes mellitus
<variant> Obesity
<variant> Type 1 diabetes mellitus
<variant>Impaired fasting glucose
<variant> Impaired glucose tolerance
<question>Frequency of general urine analysis examination in patients with type 1 diabetes mellitus:
<variant> Once a year
<variant> Once every 3 months
<variant> at least 4 times daily
<variant> Once a year (if no changes)
<variant> according to indications
<question>Frequency of testing for ketone bodies in urine and blood in patients with type 1 diabetes mellitus:
<variant> according to indications
<variant> Once every 3 months
<variant> at least 4 times daily
<variant> Once a year (if no changes)
<variant> Once a year
<question>The cause of death in type 1 diabetes is:
<variant> gangrene of the lower extremities

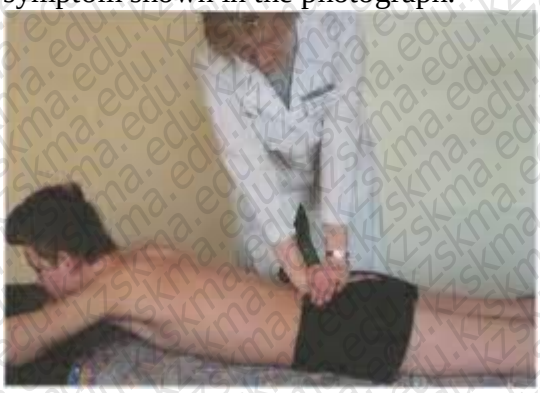
<variant> ketonemic coma
<variant> hyperosmolar coma
<variant> myocardial infarction
<variant> diabetic nephropathy
<question>Characteristic complaints of diabetes:
<variant> polydipsia, polyuria, bulimia, exhaustion
<variant> tendency to sleep, forgetfulness
<variant> weakness, adynamia, joint pain
<variant> headaches, palpitations, swelling
<variant> irritability, palpitations, sweating, exhaustion
<question>Appearance of a patient with hypothyroidism:
<variant> peeling skin, yellowness, increased turgor, cold sweat
<variant> drooping of the upper eyelid
<variant> violation of ocular convergence:
<variant> eye flickering more frequently
<variant> exophthalmos
<question>An indication for determining glucose tolerance is the presence of the following in the patient:
<variant> thirst and polyuria, obesity, recurrent furunculosis <variant> oliguria, allergies<variant> dyslipidemia, skin itching<variant> fasting glucose level over 10 mmol/l, anuria<variant> fasting glucose level - 3.4 mmol/l, cachexia
<question>One of the main manifestations of microcirculation disorders in diabetes mellitus is:
<variant> retinopathy
<variant> atherosclerosis
<variant> cataract
<variant> symmetrical neuropathy
<variant> vascular lesion of the lower extremities
<question>The main laboratory criterion in the diagnosis of diabetes mellitus is:
<variant> hyperglycemia on an empty stomach
<variant> prolonged glucosuria
<variant> hypercholesterolemia
<variant> ketonuria
<variant> hypokalemia
<question>The main pathogenetic mechanism of diabetes mellitus:
<variant> insulin deficiency
<variant> lipid metabolism disorder
<variant> protein metabolism disorder
<variant> potassium and sodium ion metabolism disorder
<variant> water-salt metabolism disorder
<question>A woman had a routine checkup and her glucose level was 6.0 mmol/L (as measured by a glucometer). A repeat fasting blood test showed a glucose level of 5.9 mmol/L, and two hours after exercise, it was 10.6 mmol/L. Predict whether the patient might have:
<variant> impaired glucose tolerance
<variant> impaired fasting glucose
<variant> random glycemia
<variant> diabetes mellitus
<variant> gestational diabetes mellitus

<question>A 45-year-old man presents to the doctor complaining of enlarged facial features, hands, and feet, persistent headaches, and sleep apnea. Five years have passed since the onset of symptoms. Objectively: enlarged nose, lips, and tongue; thickened skin; enlarged brow ridges; enlarged upper and lower jaws; widened interdental spaces; enlarged extremities. Blood pressure is 160/90 mmHg. Your preliminary diagnosis:
<variant> acromegaly
<variant> gigantism
<variant> sporadic pituitary tumor
<variant> tumor of the pharyngeal ring
<variant> sphenoid sinus tumor
<question>Symptoms of hyperthyroidism include:
<variant> tachycardia
<variant> bradycardia
<variant> quiet conversation
<variant> dry skin
<variant> psychosis
<question>The leading symptom of latent diabetes mellitus:
<variant> improving glucose tolerance
<variant> large fruit
<variant> obesity
<variant> genetic predisposition
<variant> thirst
<question> A 42-year-old man complains of severe pain in his right metatarsophalangeal joint, so severe that even touching it is unbearable. He considers himself ill after overeating and visiting a sauna (bathhouse). What changes in this patient's blood biochemistry are listed?
<variant> elevated uric acid levels
<variant> increased creatinine levels
<variant> elevated urea levels
<variant>increased glucose levels
<variant> elevated ALT and AST levels
<question> A 35-year-old woman complains of pain in her wrists and hands, along with morning stiffness until 11:00 a.m. Her body temperature rises in the evenings to 37.5-37.8°C. She considers herself ill for about three months, attributing the onset to hypothermia and a previous acute respiratory infection. The wrists are symmetrically swollen, with a positive compression sign. What changes have been observed in this patient's complete blood count?
<variant> increased ESR
<variant> leukopenia
<variant> thrombocytosis
<variant> thrombocytopenia
<variant> lymphocytosis
<question> A 26-year-old female patient, weighing 58 kg and 162 cm tall, complains of knee pain in the morning, especially in the right joint. The pain intensifies with movement and climbing stairs. She considers herself ill for approximately two weeks after exposure to cold. Select the pathological changes observed during physical examination of this patient:
<variant> gross uneven deformation of the knee joints
<variant> palpation reveals a local increase in temperature
<variant> Crepitus is felt upon palpation during passive movement of the joint.
<variant> When palpated, the skin over the joints is cold and moist

<variant> active movements in the joints are symmetrically limited
<question> A 56-year-old woman, weighing 98 kg and 156 cm tall, complains of knee pain that occurs when standing up or going down stairs. She considers herself to have had the condition for about two years; in the last two weeks, the pain has worsened, which she attributes to physical activity. Select the following changes during this patient's physical examination:
<variant> rounded, uniformly swollen knee joints
<variant> palpation reveals a local increase in temperature
<variant> Crepitus is felt upon palpation during passive movement of the joint.
<variant> palpation reveals severe pain in the joints
<variant> hyperemia of the knee joints upon examination
<question> A 43-year-old woman complains of weakness, 7 kg weight loss, muscle pain, severe pain and limited mobility in the wrists, morning stiffness in the hand joints for up to 3 a.m., and severe pain and swelling in the metacarpophalangeal, elbow, and then knee and shoulder joints. Joint changes subside in some joints, while in others they appear over 3-4 months. Which symptom in this patient is a diagnostic criterion for rheumatoid arthritis?
<variant> morning stiffness
<variant> significant weight loss
<variant> knee joint injury
<variant> weakness
<variant> muscle pain
<question> A 22-year-old female patient complains of morning stiffness in her hand joints lasting 2 hours, weakness, and a low-grade fever. These complaints began 6 months ago. Objectively: symmetrical swelling of the proximal interphalangeal joints of the second through fourth fingers of both hands and the metacarpophalangeal joints, limited motion, and hypotrophy of the lumbrical muscles. A complete blood count (CBC) reveals an ESR of 30 mm/h. What is the result of an immunological study in this patient?
<variant> rheumatoid factor is elevated
<variant> C-reactive protein is slightly elevated
<variant> rheumatoid factor is not determined
<variant> antistreptolysin-O is moderately elevated
<variant> antistreptolysin-O is sharply elevated
<question> A 38-year-old woman has been complaining of hand pain for 6 months. Objectively: positive hand clenching symptom, limited range of motion in the wrist joints. Name a predisposing factor that is significant for this pathology:
<variant> previous streptococcal infection
<variant> alcohol abuse
<variant> increased consumption of spices and smoked foods
<variant> overweight
<variant> family history
<question> A 38-year-old woman has been complaining of pain in the knee, wrist, and metacarpophalangeal joints of her hands for two months, especially in her right hand, along with morning stiffness lasting up to 30 minutes. Physical examination reveals slight swelling of the knee joints, local fever, mild muscle wasting in the back of the hands, and limited range of motion in the wrist joints. What examination method would be used to confirm the diagnosis?
<variant> X-ray of the hands
<variant> CT scan of the hands
<variant> X-ray of the right hand only
<variant> magnetic resonance imaging of the hands

<variant> magnetic resonance imaging of the knee joints
<question> A 32-year-old female patient complained of morning stiffness lasting 30-40 minutes, pain and swelling of the wrist, metacarpophalangeal and proximal interphalangeal joints; fever up to 37.5°C, weight loss of 5 kg. All symptoms appeared after hypothermia 2 months ago. Complete blood count: Erythrocytes - 3.2, Hb - 110 g/L, Leukocytes - 8.9×109/L, Hf - 78%, Lf - 16%, ESR - 29 mm/h. What laboratory tests are needed to clarify the diagnosis in this patient?
<variant> rheumatoid factor
<variant> antistreptolysin-O
<variant> ferritin level
<variant> serum iron level
<variant> uric acid level
<question> A 20-year-old girl fell ill acutely after hypothermia: temperature 38°C, a week later severe pain and swelling in the wrist joints appeared, morning stiffness until 12 noon; pain in the knee and shoulder joints. The condition was assessed as a complication of acute respiratory viral infection, antibiotic therapy was carried out without effect. Objectively: symmetrically sharp limitation of mobility of the wrist joints, swelling, local temperature, positive symptom of compression of the hands. Complete blood count: Erythrocytes - 3.0, Hb - 98 g / l, Leukocytes - 10.9 × 109 / l, Hf - 78%, Lf - 19%, ESR 48 mm / h. What is the preliminary diagnosis?
<variant> rheumatoid arthritis
<variant> acute rheumatoid fever
<variant> infectious arthritis
<variant> gouty arthritis
<variant> spondyloarthritis
<question> A 30-year-old man complains of stiffness in the thoracic and cervical spine, along with pain in the lower back and sacrum. The stiffness decreases with physical activity. He considers himself ill for about a year. Thomayer's test is 30 cm, Forestier's test is 2 cm. What is the preliminary diagnosis?
<variant> osteochondrosis of the spine
<variant> rheumatoid arthritis
<variant> rheumatic polyarthritis
<variant> chronic gouty arthritis
<variant> spondyloarthritis
<question> A 32-year-old man complains of pain and stiffness in the thoracic spine, along with swelling in the costosternal joints. Spinal motion is limited in the frontal and sagittal planes. Kushilevsky's sign is positive. What is the immunological test result for this patient?
<variant> antistreptolysin - O is sharply elevated
<variant> rheumatoid factor is moderately elevated
<variant> rheumatoid factor is sharply elevated
<variant> rheumatoid factor is not determined
<variant> antistreptolysin - O moderately elevated
<question> A 29-year-old man presented with complaints of stiffness in the cervical and thoracic spine, as well as difficulty breathing due to back pain and costosternal joint pain. Spinal motion is limited in the frontal and sagittal planes. What examination method should be performed first for this patient?
<variant> X-ray of the thoracic spine
<variant> CT scan of the thoracic spine
<variant> CT scan of the cervical spine
<variant> magnetic resonance imaging of the thoracic spine

<variant> magnetic resonance imaging of the sacroiliac joints
<question> A 26-year-old man complains of stiffness in the thoracic and lumbar spine, as well as pain in the lower back and sacrum. The stiffness decreases with physical activity. Identify the symptom shown in the photograph:



<variant> soreness
<variant> crepitation
<variant> rigidity
<variant> increase in local temperature
<variant> limited mobility
<question>The first sign of osteoarthritis of the knee joint is:
<variant> damage to the patellofemoral joint (based on radiographic data)
<variant> pain on palpation of the knee joint
<variant> crunching when moving the knee joint
<variant> osteophytes (according to radiographic data)
<variant> pain when climbing stairs
blood
<question>A 45-year-old woman visits her primary care physician and complains of severe fatigue, dizziness, and pain in her lower extremities. Examination reveals yellowing of the skin and sclera. Blood tests reveal anemia with an elevated reticulocyte count and elevated indirect bilirubin levels. Your preliminary diagnosis:
<variant>acquired autoimmune hemolytic anemia
<variant>B-12 deficiency anemia
<variant>thrombocytopenic purpura
<variant>iron deficiency anemia
<variant>hemorrhagic vasculitis
<question>Stage 4 of chronic lymphocytic leukemia is characterized by:
<variant>lymphocytosis and thrombocytopenia
<variant>thrombocytosis and leukopenia
<variant>leukocytosis and thrombocytosis
<variant>erythrocytosis and leukopenia
<variant>erythropenia and leukocytosis
<question>A 39-year-old woman visits the doctor complaining of general weakness, difficulty swallowing, and a lump in the throat. Examination reveals enlarged cervical lymph nodes, which are firm to the touch, easily movable under the skin, and not adherent to surrounding tissue. The doctor makes a preliminary diagnosis of lymphogranulomatosis. What is the characteristic objective symptom for this diagnosis?
<variant>enlarged lymph nodes
<variant>increased body temperature

<variant>enlarged spleen
<variant>enlarged liver
<variant>decrease in body temperature
<question>A 37-year-old woman visits her doctor complaining of dizziness, fainting, chest tingling, shortness of breath, and general weakness. The doctor made a preliminary diagnosis of aplastic anemia. What are the characteristic changes in a complete blood count for this diagnosis?
<variant>erythropenia with thrombocytopenia and leukopenia
<variant>erythrocytosis with leukocytosis
<variant>erythrocytopenia with leukocytosis
<variant>leukocytosis and thrombocytosis
<variant>leukocytosis and erythrocytosis
A 29-year-old woman presented with a skin examination that revealed hemorrhagic rashes. Blood tests revealed severe anemia, thrombocytopenia, and moderate neutropenia. What is the mechanism for the development of this clinical and laboratory finding?
<variant>bone marrow aplasia
<variant>bone marrow hyperplasia
<variant>Castle factor deficiency
<variant>vitamin B12 deficiency
<variant>iron deficiency
<question> A 47-year-old man, during a general blood test, the following changes were found: anemia, normocytosis, normochromia and a significant increase in regenerative forms.The level of reticulocytes in the blood is significantly elevated.Indicate the type of anemia characterized by these blood parameters:
<variant>acute posthemorrhagic
<variant>chronic lymphocytic leukemia
<variant>autoimmune hemolytic anemia
<variant>acute leukemia
<variant>aplastic anemia
<question>A 43-year-old woman, at a doctor's appointment, complains of dizziness, darkening in front of her eyes, decreased sensitivity in the lower extremities and a tingling sensation when walking, general weakness. From the anamnesis: these complaints have been bothering her for 6 months, she cannot indicate a possible cause. On examination: moderate jaundice of the skin, when palpating, the liver protrudes from under the edge of the costal arch by 2.0 cm. In the general blood test: erythrocytes - 1.3 × 1012 / l, hemoglobin - 72 g / l, color index - 1.45, leukocytes - 4.3 × 109 / l, eos. - 2, base. - 0, pal. / poison. - 5, segment. / poison. - 66, mon. - 11, lymph. – 27, erythrocyte sedimentation rate – 14 mm/hour. Endoscopic examination revealed atrophic changes in the gastric mucosa. Name the pathological process in this case:
<variant>Addison-Biermer disease
<variant>liver cirrhosis
<variant>viral hepatitis C
<variant>iron deficiency anemia
<variant>autoimmune hemolytic anemia
<question>A 56-year-old man consulted his family physician complaining of increased sweating, general weakness, fatigue despite regular physical activity, and weight loss over the past two months. Examination revealed enlarged cervical lymph nodes, firm on palpation. A complete blood count revealed: red blood cells - 2.0 x 1012/L; white blood cells - 50.0 x 109/L; platelets - 160 x 1012/L. Which syndrome is characterized by these clinical and laboratory symptoms?
<variant>lymphoproliferative

<variant>anemic
<variant>aplastic
<variant>hemorrhagic
<variant>myeloproliferative
A 39-year-old woman developed profuse nosebleeds. Her medical history shows a long history of viral hepatitis. Examination revealed a petechial-maculate rash on the skin, hepatomegaly and splenomegaly. Blood tests showed a Lee-White clotting time of 22 minutes. Which syndrome is present in this case?
<variant>hemorrhagic
<variant>lymphoproliferative
<variant>myeloproliferative
<variant>aplastic
<variant>anemic
<question>A 39-year-old man consulted his local doctor complaining of epigastric pain, general weakness, and fatigue. He has a history of duodenal ulcer for a year. On examination, the skin is pale and there is pain in the epigastric region. The liver and spleen are not palpable. Blood test results: hemoglobin - 90 g/L, erythrocytes - 3.5 ×1012/L, color index - 0.77, platelets - 195 ×109/L, reticulocytes - 0.5%. Total bilirubin - 12 μmol/L, iron - 4.5 μmol/L. Fecal occult blood test is positive. Indicate the type of anemia in this patient:
<variant>chronic posthemorrhagic anemia
<variant>aplastic anemia
<variant>hemolytic anemia
<variant>B12 deficiency anemia
<variant>acute posthemorrhagic anemia
<question>A 33-year-old man consulted a doctor about multiple petechial hemorrhages on the skin and mucous membranes. Blood test results: hemoglobin - 100 g/L, erythrocytes - 3.1×1012/L, leukocytes - 41×109/L, also in the leukocyte formula, young, immature blast forms predominate (up to 95%); mature leukocytes, intermediate forms are absent; platelets - 15×109/L, eosinophils and basophils are absent; erythrocyte sedimentation rate - 52 mm/hour. Your preliminary diagnosis:
<variant>acute leukemia
<variant>hemorrhagic vasculitis
<variant>aplastic anemia
<variant>autoimmune hemolytic anemia
<variant>thrombocytopenic purpura