



**Mzantsi Medics**  
**MZANTSI MEDICS TEST**  
Topic surgery

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***Hepatobiliary section part 1***

1. What percent do cholesterol stones make up of bile stone?
  - (a) 50%.
  - (b) 60%.
  - (c) 70%.
  - (d) 80%
  
2. What is the pattern of the pain of biliary colic?
  - (a) Colicky
  - (b) Intermittent.
  - (c) Steady and constant.
  - (d) Slow rising
  
3. For up to how long does a biliary colic attack last?
  - (a) 1 hour
  - (b) 2 hours
  - (c) 3 hours
  - (d) 4 hours
  - (e) 5 hours
  - (f) 6 hours
  
4. This is true about biliary colic pain
  - (a) Originate in the right upper quadrant of the abdomen or epigastrium
  - (b) Alleviated by bending and leaning forward
  - (c) Aggravated by bowel motions
  - (d) Associated with a fever.
  
5. This is true about biliary colic pain.
  - (a) Usually post prandial
  - (b) Commonly attacks patient at night
  - (c) Both (a) and (b).
  - (d) None of the above.
  
6. What is the gold standard imaging modality for biliary colic is?
  - (a) Abdominal ultrasound
  - (b) MRCP
  - (c) CT cholangiography
  - (d) ERCP
  - (e) Scintigraphy / HIDA.
  
7. On a imaging investigation for biliary colic which of the following findings would you not expect to see?
  - (a) Sludge
  - (b) Gallstones
  - (c) Thickening of gall bladder wall
  - (d) All of the above
  
8. Which of the following is good advice for a patient who suffers from biliary colic
  - (a) Eat foods high in fibre 25 g fibre per day
  - (b) Follow a low caloric diet of 10 g fat per day
  - (c) Coffee reduces risk of biliary colic
  - (d) Moderate alcohol consumption reduces risk of biliary colic
  - (e) All of the above



9. What is the first line analgesic treatment for biliary colic?
  - (a) NSAIDS
  - (b) Opioids
  - (c) Codeine and paracetamol combination
  - (d) Hyoscine butylbromide.
  
10. What is a good alternative for NSAIDS for moderate pain treatment for biliary colic?
  - (a) Opioids
  - (b) Codeine and paracetamol combination
  - (c) Hyoscine butylbromide.
  - (d) Steroids
  
11. What is a good alternative for NSAIDS for severe pain treatment for biliary colic?
  - (a) Opioids
  - (b) Codeine and paracetamol combination
  - (c) Hyoscine butylbromide.
  - (d) Steroids

***Answer to multiple choice questions***

1. (c)
2. (c)
3. (f)
4. (a)
5. (c)
6. (a)
7. (c)
8. (e)
9. (a)
10. (b)
11. (a)



**Hepatobiliary section part 3**

1. What percentage of patients with biliary colic will develop acute cholecystitis?
  - (a) 10%
  - (b) 20%
  - (c) 30%
  - (d) 40%
  
2. What percent of patients will develop acalculous acute cholecystitis?
  - (a) 10
  - (b) 20
  - (c) 30
  - (d) 40
  
3. Regarding murphy's sign and acute cholecystitis
  - (a) A  $\frac{1}{4}$  of the patients with acute cholecystitis will have a positive Murphy's sign
  - (b)  $\frac{1}{2}$  of the patients with acute cholecystitis will have a positive Murphy's sign
  - (c) A  $\frac{1}{3}$  of the patients with acute cholecystitis will have a positive Murphy's sign
  - (d)  $\frac{3}{4}$  of the patients with acute cholecystitis will have a positive Murphy's sign
  
4. What grade of fever do acute cholecystitis patients normally have?
  - (a) Low grade fever
  - (b) High grade fever
  
5. Mr Hartmann presented with sever RUQ pain radiating to right shoulder, fever of 38°C and a positive Murphy's sign. He is not jaundice. What is the best recommended imaging modality to begin with?
  - (a) Abdominal ultrasound
  - (b) Scintigraphy
  - (c) Abdominal CT Scan
  - (d) MRI
  
6. Mr Hartmann presented with history suggestive of acute cholecystitis. He was sent for a initial baseline imaging modality. What is do you expect to be the findings of
  - (a) Gallstones
  - (b) Gall bladder wall thickening
  - (c) Sonographic Murphy's sign
  - (d) Enlargement of gall bladder.
  - (e) All of the above
  
7. One of the findings of an imaging modality has a made a doctor to be suspicious of gangrenous acute cholecystitis.
  - (a) Gall stones
  - (b) Gall bladder wall thickening
  - (c) Sonographic Murphy's sign.
  - (d) Intraluminal flap
  
8. What is treatment for Grade I acute cholecystitis
  - (a) Treatment with high dose antibiotics, intravenous fluids, intravenous analgesics, fasting and correcting electrolyte imbalances
  - (b) Early laparoscopic cholecystectomy
  - (c) Emergency cholecystectomy
  - (d) Urgent biliary drainage and index cholecystectomy upon improvement of patient's condition.
  - (e) Both (a) and (b)
  
9. What is treatment for Grade II acute cholecystitis
  - (a) Treatment with high dose antibiotics, intravenous fluids, intravenous analgesics, fasting and correcting electrolyte imbalances
  - (b) Early laparoscopic cholecystectomy
  - (c) Emergency cholecystectomy
  - (d) Urgent biliary drainage and index cholecystectomy upon improvement of patient's condition.
  - (e) Both (a) and (b)



10. What is treatment for Grade II acute cholecystitis
  - (a) Treatment with high dose antibiotics, intravenous fluids, intravenous analgesics, fasting and correcting electrolyte imbalances
  - (b) Early laparoscopic cholecystectomy
  - (c) Emergency cholecystectomy
  - (d) Urgent biliary drainage and index cholecystectomy upon improvement of patient's condition.
  
11. What is the possible complication of acute cholecystitis
  - (a) Development of gangrene
  - (b) Rupture
  - (c) Haemorrhage
  - (d) Gallstone ileus
  - (e) Cholecystoenteric
  - (f) fistula
  - (g) Mirizzi's syndrome
  - (h) All of the above

**Answers to Multiple choice questions**

1. (b)
2. (a)
3. (c)
4. (a)
5. (a)
6. (e)
7. (d)
8. (e)
9. (c)
10. (d)
11. (h)

**Hepatobiliary section part 3**

1. What is the most common cause of acute cholangitis?
  - (a) Mirizzi's syndrome
  - (b) Lemmel's syndrome
  - (c) Benign strictures
  - (d) Malignant strictures
  - (e) Choledocholithiasis
  - (f) ERCP and other ductal manipulations
  
2. The mean age for developing acute cholangitis is:
  - (a) 40 – 50 years.
  - (b) 50 – 60 years.
  - (c) 60 – 70 years.
  - (d) 70 – 80 years.
  
3. The combination of high fevers, right upper quadrant pain and obstructive jaundice is termed:
  - (a) Reynold's pentad
  - (b) Charcot's triad
  - (c) Mirizzi's syndrome
  - (d) Lemmel's syndrome
  
4. The combination of high fevers, right upper quadrant pain, obstructive jaundice, septic shock and confusion is termed:
  - (a) Reynold's pentad
  - (b) Charcot's triad
  - (c) Mirizzi's syndrome
  - (d) Lemmel's syndrome



5. The condition whereby a gall stone inside the cystic duct or gallbladder obstructs common hepatic duct or bile duct is called.
  - (a) Reynold's pentad
  - (b) Charcot's triad
  - (c) Mirizzi's syndrome
  - (d) Lemmel's syndrome
  
6. The diagnosis criteria of acute cholangitis is made up of
  - (a) Clinical picture
  - (b) Cholestasis
  - (c) Imaging
  - (d) All of the above
  
7. 50-year-old Mr Stone-Duct presented with acute cholangitis and was started on antibiotic treatment and supportive treatment. After 48 hours, he has responded well to the treatment. What is his acute cholangitis grading?
  - (a) Grade I (mild)
  - (b) Grade II(moderate)
  - (c) Grade III(severe)
  - (d) Grade IV(critical)
  
8. 75-year-old Mrs Chilli-Obstructive presented with acute cholangitis and was started on antibiotic treatment and supportive treatment. After 48 hours, he has pyrexia of 40°C, leucocytosis of 130000. What is his acute cholangitis grading?
  - (a) Grade I (mild)
  - (b) Grade II(moderate)
  - (c) Grade III(severe)
  - (d) Grade IV(critical)
  
9. 75-year-old Mrs Chilli-Obstructive presented with acute cholangitis and was started on antibiotic treatment and supportive treatment. After 48 hours, he has pyrexia of 40°C, leucocytosis of 130000. What is the recommended treatment for her?
  - (a) Supportive and antibiotic,
  - (b) Supportive, antibiotic, early biliary drainage
  - (c) Supportive, antibiotic, urgent biliary drainage
  - (d) None of the above.
  
10. 60-year-old Mrs Septic Stone is diagnosed with acute cholangitis and was started on supportive treatment and antibiotics. After 48 hours of treatment she has a fever of 39°C, leukopenia of 3000 and total bilirubin is 7mg/dl. Her blood pressure is 90/40. The family is reporting that she is confused and not talking sense. What is Mrs Septic Stone's acute cholangitis grading?
  - (a) Grade I (mild)
  - (b) Grade II(moderate)
  - (c) Grade III(severe)
  - (d) Grade IV(critical)
  
11. 60-year-old Mrs Septic Stone is diagnosed with acute cholangitis and was started on supportive treatment and antibiotics. After 48 hours of treatment, she has a fever of 39°C, leukopenia of 3000 and total bilirubin is 7mg/dl. Her blood pressure is 90/40. The family is reporting that she is confused and not talking sense. What is the best treatment for Mrs Septic Stone?
  - (a) Supportive and antibiotic,
  - (b) Supportive, antibiotic, early biliary drainage
  - (c) Supportive, antibiotic, urgent biliary drainage
  - (d) None of the above.
  
12. The systemic organ failure in grade III (severe) is due to.
  - (a) Septicaemia
  - (b) Fever
  - (c) Increased bilirubin levels
  - (d) None of the above.

**Answers to multiple choice questions Hepatobiliary section**

1. (e)
2. (b)
3. (b)



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4. (a)
5. (c)
6. (d)
7. (a)
8. (b)
9. (b)
10. (c)
11. (c)
12. (a)



**The groin**

1. With regards to groin hernias.
  - (a) Most common groin hernia in a female patient is femoral hernia
  - (b) 97% of groin hernias are inguinal and 3% are femoral hernias.
  - (c) Majority of groin hernias occur on the left side with a ratio of 2:1
  - (d) The male to female ratio of groin hernias is 1:1
  
2. With regards to groin hernias.
  - (a) Inguinal hernias make 75% of all abdominal wall hernias.
  - (b) Femoral are more common in female than in males and are the most common groin hernias in females.
  - (c) Inguinal hernias are more common in the middle aged patients.
  - (d) Femoral are more common on left side
  
3. A **Pantaloon** hernia is:
  - (a) Inguinal hernias with both a direct and an indirect component.
  - (b) Is when a retroperitoneal organ forms part of the wall of the sac.
  - (c) When the antimesenteric portion of intestine
  - (d) Hernial sac that contains a Meckel's diverticulum
  - (e) Hernia that contains the appendix
  
4. A **Richter's** hernia is.
  - (a) Inguinal hernias with both a direct and an indirect component.
  - (b) Is when a retroperitoneal organ forms part of the wall of the sac.
  - (c) When the antimesenteric portion of intestine protrudes into the hernia sac
  - (d) Hernial sac that contains a Meckel's diverticulum
  - (e) Hernia that contains the appendix
  
5. A **Sliding** hernia is
  - (a) Inguinal hernias with both a direct and an indirect component.
  - (b) Is when a retroperitoneal organ forms part of the wall of the sac.
  - (c) When the antimesenteric portion of intestine
  - (d) Hernial sac that contains a Meckel's diverticulum
  - (e) Hernia that contains the appendix
  
6. A **Littre's** hernia is
  - (a) Inguinal hernias with both a direct and an indirect component.
  - (b) Is when a retroperitoneal organ forms part of the wall of the sac.
  - (c) When the antimesenteric portion of intestine protrudes into the hernia sac
  - (d) Hernial sac that contains a Meckel's diverticulum
  - (e) Hernia that contains the appendix
  
7. An **Amyand** hernia is
  - (a) Inguinal hernias with both a direct and an indirect component.
  - (b) Is when a retroperitoneal organ forms part of the wall of the sac.
  - (c) When the antimesenteric portion of intestine protrudes into the hernia sac
  - (d) Hernial sac that contains a Meckel's diverticulum
  - (e) Hernia that contains the appendix
  
8. With regards to Nyhus classification.
  - (a) Type 1 hernia is an indirect inguinal hernia with an enlarged internal inguinal ring and recurrent
  - (b) Type 2 hernia is an indirect inguinal hernia with an normal internal inguinal ring and intact inguinal canal floor/posterior wall
  - (c) Type 3 hernias are hernias with a posterior wall defect hernias
  - (d) Type 4 hernias are hernias with a posterior wall defect hernias

Answers to Multiple choice questions of The groin

1. (b)
2. (a).
3. (a).



4. (c).
5. (b).
6. (d).
7. (e).
8. ().

### Peptic ulcers

1. What is the lifetime risk for developing peptic ulcer diseases
  - (a) Up to 10%
  - (b) Up to 20%
  - (c) Up to 30%
  - (d) Up to 40%
2. *H. pylori* infection is associated with:
  - (a) Poor socioeconomic background
  - (b) Wealthy socioeconomic background
3. The most common cause of peptic ulcer disease is
  - (a) *H. pylori* infection
  - (b) NSAIDS
  - (c) Chronic use of low dose aspirins.
  - (d) None of the above.
4. In the past 2 decades, how has the incidence of peptic ulcer diseases changed?
  - (a) Increased
  - (b) Decreased
  - (c) Stayed the same.
5. What evidence suggests that *H. pylori* infection is a causative agent in peptic ulcer diseases?
  - (a) Ingestion of *H. pylori* results in chronic gastritis
  - (b) When animals are inoculated with *H. pylori* they develop a gastritis similar to human gastritis
  - (c) Antibacterial treatment eradicates *H. pylori* also eliminates gastritis
  - (d) *H. pylori* are identified in most of the patients with duodenal ulcers and gastric ulcers.
  - (e) All of the above.
6. What are areas of peptic ulcer diseases
  - (a) Duodenum
  - (b) Stomach
  - (c) Oesophagus
  - (d) Areas where previous gastric resections
  - (e) All of the above.
7. 95% of duodenal ulcers are caused by:
  - (a) *H. pylori* infections
  - (b) NSAIDS.
  - (c) Reflux esophagitis.
  - (d) Nil of the above
8. Most of gastric ulcers due:
  - (a) *H. pylori* infections
  - (b) NSAIDS.
  - (c) Reflux esophagitis.
  - (d) Nil of the above
9. Most oesophageal ulcers are mainly due to:
  - (a) *H. pylori* infections
  - (b) NSAIDS.
  - (c) Reflux esophagitis.
  - (d) Nil of the above



10. What test are used to diagnose H. pylori infections
  - (a) Urease breath test
  - (b) Rapid urease
  - (c) Stool antigen test
  - (d) Serology
  - (e) All of the above
  
11. What does standard triple therapy entail?
  - (a) PPI + bismuth salt + tetracycline + metronidazole
  - (b) PPI + clarithromycin + amoxicillin + metronidazole
  - (c) PPI + amoxicillin + levofloxacin
  - (d) PPI + clarithromycin + metronidazole or amoxicillin.
  - (e) PPI + rifabutin + amoxicillin
  
12. What does a bismuth-containing quadruple therapy entail?
  - (a) PPI + bismuth salt + tetracycline + metronidazole
  - (b) PPI + clarithromycin + amoxicillin + metronidazole
  - (c) PPI + amoxicillin + levofloxacin
  - (d) PPI + clarithromycin + metronidazole or amoxicillin.
  - (e) PPI + rifabutin + amoxicillin
  
13. What does a non-bismuth concomitant therapy entail?
  - (a) PPI + bismuth salt + tetracycline + metronidazole
  - (b) PPI + clarithromycin + amoxicillin + metronidazole
  - (c) PPI + amoxicillin + levofloxacin
  - (d) PPI + clarithromycin + metronidazole or amoxicillin.
  - (e) PPI + rifabutin + amoxicillin
  
14. What does Levofloxacin triple therapy entail?
  - (a) PPI + bismuth salt + tetracycline + metronidazole
  - (b) PPI + clarithromycin + amoxicillin + metronidazole
  - (c) PPI + amoxicillin + levofloxacin
  - (d) PPI + clarithromycin + metronidazole or amoxicillin.
  - (e) PPI + rifabutin + amoxicillin
  
15. What is rifabutin-based triple therapy?
  - (a) PPI + bismuth salt + tetracycline + metronidazole
  - (b) PPI + clarithromycin + amoxicillin + metronidazole
  - (c) PPI + amoxicillin + levofloxacin
  - (d) PPI + clarithromycin + metronidazole or amoxicillin.
  - (e) PPI + rifabutin + amoxicillin
  
16. What is the mechanism of action of lansoprazole and omeprazole
  - (a) Inhibit gastric H<sup>+</sup>/K<sup>+</sup>-ATPase pump
  - (b) block histamine at the histamine H<sub>2</sub> receptors of parietal cells
  - (c) Increases gastric pH to greater than 4 and inhibits the proteolytic activity of pepsin
  - (d) Causes osmotic retention of fluid
  - (e) Inhibits H<sup>+</sup>, K<sup>+</sup>-ATPase in gastric parietal cells at the last stage of the acid secretory pathway
  - (f) Stimulate mucus production and promotes blood flow throughout the lining of the gastrointestinal tract.
  
17. What is the mechanism of action of Vonoprazan?
  - (a) Inhibit gastric H<sup>+</sup>/K<sup>+</sup>-ATPase pump
  - (b) block histamine at the histamine H<sub>2</sub> receptors of parietal cells
  - (c) Increases gastric pH to greater than 4 and inhibits the proteolytic activity of pepsin
  - (d) Causes osmotic retention of fluid
  - (e) Inhibits H<sup>+</sup>, K<sup>+</sup>-ATPase in gastric parietal cells at the last stage of the acid secretory pathway
  - (f) Stimulate mucus production and promotes blood flow throughout the lining of the gastrointestinal tract.



18. What is the mechanism of action of Cimetidine and Ranitidine?
- (a) Inhibit gastric H<sup>+</sup>/K<sup>+</sup>-ATPase pump
  - (b) block histamine at the histamine H<sub>2</sub> receptors of parietal cells
  - (c) Increases gastric pH to greater than four,
  - (d) and inhibits the proteolytic activity of pepsin
  - (e) Causes osmotic retention of fluid
  - (f) Inhibits H<sup>+</sup>, K<sup>+</sup>-ATPase in gastric parietal cells at the last stage of the acid secretory pathway
  - (g) Stimulate mucus production and promotes blood flow throughout the lining of the gastrointestinal tract.
19. What is the mechanism of action of an antacid like Magnesium hydroxide (Maalox)
- (a) Inhibit gastric H<sup>+</sup>/K<sup>+</sup>-ATPase pump
  - (b) block histamine at the histamine H<sub>2</sub> receptors of parietal cells
  - (c) Increases gastric pH to greater than 4 inhibits the proteolytic activity of pepsin
  - (d) Causes osmotic retention of fluid
  - (e) Inhibits H<sup>+</sup>, K<sup>+</sup>-ATPase in gastric parietal cells at the last stage of the acid secretory pathway
  - (f) Stimulate mucus production and promotes blood flow throughout the lining of the gastrointestinal tract.
20. What is the mechanism of action of an antacid like Aluminium hydroxide?
- (a) Inhibit gastric H<sup>+</sup>/K<sup>+</sup>-ATPase pump
  - (b) block histamine at the histamine H<sub>2</sub> receptors of parietal cells
  - (c) Increases gastric pH to greater than 4 inhibits the proteolytic activity of pepsin
  - (d) Causes osmotic retention of fluid
  - (e) Inhibits H<sup>+</sup>, K<sup>+</sup>-ATPase in gastric parietal cells at the last stage of the acid secretory pathway
  - (f) Stimulate mucus production and promotes blood flow throughout the lining of the gastrointestinal tract.
21. What is the mechanism of action of Misoprostol?
- (a) Inhibit gastric H<sup>+</sup>/K<sup>+</sup>-ATPase pump
  - (b) block histamine at the histamine H<sub>2</sub> receptors of parietal cells
  - (c) Increases gastric pH to greater than 4 inhibits the proteolytic activity of pepsin
  - (d) Causes osmotic retention of fluid
  - (e) Inhibits H<sup>+</sup>, K<sup>+</sup>-ATPase in gastric parietal cells at the last stage of the acid secretory pathway
  - (f) Stimulate mucus production and promotes blood flow throughout the lining of the gastrointestinal tract.
22. In the presence of a gastrinoma, what condition must be excluded?
- (a) Gastritis
  - (b) Multiple endocrine neoplasia type 1 (MEN1)
  - (c) Multiple endocrine neoplasia type 2 (MEN2)
  - (d) GIST
23. What type of test is stool antigen test?
- (a) PCR
  - (b) ELISA
  - (c) FISH
  - (d) Culture

**Answers to multiple choice questions**

- 1. (a).
- 2. (a).
- 3. (a).
- 4. (b).
- 5. (e).
- 6. (e).
- 7. (a).
- 8. (b).
- 9. (c).
- 10. (e).
- 11. (d).
- 12. (a).
- 13. (b).



- 14. (c).
- 15. (e).
- 16. (a).
- 17. (e).
- 18. (b).
- 19. (d).
- 20. (c).
- 21. (f).
- 22. (b).
- 23. (b).

Appendix

1. The lifetime risk for getting an appendicitis is
  - (a) 5%
  - (b) 7-8%
  - (c) 20%
  - (d) 10%
2. The mortality rate for appendicitis is
  - (a) 0.08% in non-perforated appendicitis
  - (b) 0.6% in perforated appendicitis
  - (c) 2%
  - (d) 1%
  - (e) Both (a) and (b)
3. This is an example of a clinical scoring system for acute appendicitis
  - (a) Appendicitis Inflammatory Response (AIR) score
  - (b) Adult Appendicitis Score (AAS)
  - (c) RIPASA (Raja Isteri Pengiran Anak Saleha Appendicitis) score
  - (d) Alvarado score
  - (e) All of the above
4. An appendectomy is the gold standard for treatment of an acute appendicitis.
  - (a) True
  - (b) False
5. The recurrence rate within 12 months of an appendicitis that was treatment non-surgically
  - (a) 5 – 44%
  - (b) 30 – 50 %
  - (c) 80%
  - (d) 70%
6. What is the chance of missing an appendix ca if an acute appendicitis is treated non surgically
  - (a) 1%
  - (b) 2%
  - (c) 3%
  - (d) 5%
  - (e) 6%
7. The pain of acute appendicitis
  - (a) Starts periumbilical and then migrates to McBurney's point
  - (b) Starts at McBurney's' point and then migrates to the periumbilical region.
  - (c) Occurs at night
  - (d) Occurs early morning
8. With regards to the fever of acute appendicitis
  - (a) It is a high grade fever > 39 °C
  - (b) It is a low grade fever 37.5 °C to 38 °C
  - (c) In the presence of a fever greater than 38 another diagnosis must be considered
  - (d) Appendicitis rarely presents with a fever



- (e) Both (b) and (c)
9. The most common location for an appendix is:
- (a) Retrocecal
  - (b) Preileal
  - (c) Postileal
  - (d) Pelvic
  - (e) Subcecal
10. Which sign is part of RIPASA criteria
- (a) Dunphy Sign
  - (b) McBurney's Sign
  - (c) Obturator Sign
  - (d) Psoas sign
  - (e) Pointing sign
  - (f) Rovsing sign
11. These clinical scoring systems are used the most in children for acute appendicitis
- (a) Paediatric appendicitis score (PAS) and Appendicitis Inflammatory Response (AIR) score
  - (b) Paediatric appendicitis score (PAS) and Adult Appendicitis Score (AAS)
  - (c) Paediatric appendicitis score (PAS) and RIPASA (Raja Isteri Pengiran Anak Saleha Appendicitis) score
  - (d) Paediatric appendicitis score (PAS) and Alvarado score
12. What is the embryonic origin of appendix?
- (a) Foregut
  - (b) Midgut
  - (c) Hindgut
13. The innervation of appendix is from:
- (a) T10
  - (b) T11
  - (c) T12
  - (d) L1
14. Imaging studies help to reduce the negative appendectomy rate, what is the negative appendectomy rate
- (a) 5%
  - (b) 10%
  - (c) 15%
  - (d) 20%
15. This clinical grading system also includes the CRP in its criteria
- (a) Appendicitis Inflammatory Response (AIR) score
  - (b) Adult Appendicitis Score (AAS)
  - (c) RIPASA (Raja Isteri Pengiran Anak Saleha Appendicitis) score
  - (d) Alvarado score
  - (e) All of the above

**Answers to Multiple choice questions**

- 1. (b).
- 2. (e).
- 3. (e).
- 4. (e).
- 5. (a).
- 6. (e).
- 7. (a).
- 8. (e).
- 9. (a)
- 10. (f)
- 11. (d)



- 12. (b)
- 13. (a)
- 14. (c)
- 15. (a)

### Haemorrhoids

1. With regards to classification of haemorrhoids.
  - (a) Goligher's classification is used for internal haemorrhoids
  - (b) Goligher's classification is used for external haemorrhoids.
  - (c) Park's classification is used for internal haemorrhoids.
  - (d) Park's classification is used for external haemorrhoids
2. With regards to prevalence of haemorrhoids.
  - (a) Male to female ratio is 2:1.
  - (b) Male to female ratio is 1:1.
  - (c) Male to female ratio is 3:1
  - (d) Male to female ratio is 4:1
3. The uncommon position for haemorrhoids is
  - (a) 3 o'clock
  - (b) 7 o'clock
  - (c) 11 o'clock
  - (d) 12 o'clock
4. With regards to Goligher's Classification Haemorrhoids.
  - (a) Grade 1 haemorrhoid prolapses below the dentate/pectinate line
  - (b) Grade 2 haemorrhoid reduces spontaneously
  - (c) Grade 2 haemorrhoid requires manual reduction
  - (d) Grade 3 haemorrhoid reduces spontaneously
5. The aim of high fibre/bulk diet is to:
  - (a) Get more than 5 g of fibre per day
  - (b) Get more than 10 g of fibre per day
  - (c) Get more than 15 g of fibre per day
  - (d) Get more than 25 g of fibre per day
6. This is not an example of sclerotherapy.
  - (a) 5% phenol almond oil
  - (b) Aluminium potassium sulphate with Tannic acid (ALTA)
  - (c) Steroid cream
  - (d) Anusol
  - (e) Both C and D

### Answers to Multiple choice questions

1. (a).
2. (b).
3. (d).
4. (b).
5. (d).
6. (e).

### Anorectal abscesses

1. The male to female ratio of anorectal abscesses is:
  - (a) Male to female 2:1
  - (b) Male to female 1:2
  - (c) Male to female 1:1
  - (d) Male to female 3:1



2. The most common anorectal abscess is
  - (a) Perianal
  - (b) Ischiorectal
  - (c) Intersphincteric
  - (d) Supralelevator
  
3. The mean age for developing anorectal abscess is:
  - (a) 20 years
  - (b) 30 years
  - (c) 40 years
  - (d) 50 years
  
4. After incision and drainage of an anorectal the recurrence rate within 12 months can be up to:
  - (a) 14%
  - (b) 10%
  - (c) 44%
  - (d) 60%
  
5. Most anorectal abscess are due to:
  - (a) Trauma
  - (b) Crypto glandular infections
  - (c) Radiation
  - (d) Cancer and inflammatory bowel diseases
  
6. Regarding antibiotic treatment.
  - (a) Antibiotic alone are adequate and sufficient to treat anorectal abscesses.
  - (b) A patient with an anorectal abscess must first be given a trial of antibiotics before surgery is considered.
  - (c) Cephalosporins are the best recommended antibiotics for anorectal abscess treatment
  - (d) Antibiotics should be given to patients who are immunocompromised, diabetic, have extensive cellulitis, or have valvular heart disease.
  
7. What is the role of pus culture from an anorectal abscess.
  - (a) Pus culturing has no value in the setting of anorectal abscess.
  - (b) If gut microorganism are grown from the pus culture, 80% off these cases have an underlying fistula.
  - (c) If only skin microorganisms are grown from the pus culture, 80% off these cases have an underlying fistula.
  - (d) 90% of the cases of pus culture no organisms are grown.
  
8. Regarding the treatment of anorectal abscesses
  - (a) The skin incision must be kept close to the anal verge as possible for best cosmetic outcome.
  - (b) The skin incision must be kept as far from the anal
  - (c) Post incision and draining, in most cases the wound must be sutured
  - (d) An intersphincteric abscess is drained by an internal sphincterotomy.
  
9. The most common symptom of anorectal abscess.
  - (a) Fever
  - (b) Rectal pain
  - (c) Soiling of clothing
  - (d) Malaise
  
10. After anorectal abscess drainage, how many of the cases develop a fistula
  - (a) 1/2 of the cases
  - (b) 1/3 of the cases
  - (c) 1/4 of the cases
  - (d) 2/4 of the cases

**Answers to Multiple choice questions**

1. (a)
2. (a)
3. (c)
4. (c)



5. (b)
6. (d)
7. (b)
8. (d)
9. (b)
10. (b)

**Anal fistulas**

1. What is ratio of male: female for developing anal fistulas?
  - (a) Male: female 3:1
  - (b) Male: female 2:1
  - (c) Male: female 1:1
  - (d) Male: female 5:1
2. After anorectal abscess drainage, how many of the cases develop a fistula
  - (a) 1/2 of the cases
  - (b) 1/3 of the cases
  - (c) 1/4 of the cases
  - (d) 2/4 of the cases
3. The mean age for developing a perianal fistula is
  - (a) 20 years
  - (b) 30 years
  - (c) 40 years
  - (d) 50 years
4. This fistula is not part of the Park's classification.
  - (a) Intersphincteric fistula.
  - (b) Trans-sphincteric fistula.
  - (c) Suprasphincteric fistula.
  - (d) Extrasphincteric fistula
  - (e) Superficial (submucosal) fistula
5. Risk of recurrence for anal fistulas within 12 months is:
  - (a) 10% -20%
  - (b) 20 – 60%
  - (c) 7 – 50%
  - (d) Under 10%
6. The most common anal fistula is
  - (a) Trans-sphincteric
  - (b) Intersphincteric
  - (c) Suprasphincteric
  - (d) Extrasphincteric

**Answers to Multiple choice questions**

1. (b).
2. (b).
3. (c).
4. (e).
5. (c).
6. (a).



**Inflammatory bowel disease**

1. Which inflammatory bowel disease has the highest lifetime risk for needing surgery?
  - (a) Crohn's disease
  - (b) Ulcerative colitis
  - (c) IBD-unclassified
  - (d) Indeterminate colitis
  
2. What is lifetime risk of needing surgery in Crohn's disease
  - (a) 70 – 80%
  - (b) 20 – 30 %
  - (c) 50 – 60%
  - (d) Less than 5%
  
3. What is lifetime risk of needing surgery in ulcerative colitis
  - (a) 70 – 80%
  - (b) 20 – 30 %
  - (c) 50 – 60%
  - (d) Less than 5%
  
4. What percent of ulcerative colitis patients have backwash ileitis?
  - (a) 5%
  - (b) 10%
  - (c) 20%
  - (d) 30%.
  
5. This risk factor increases the chance of developing Crohn's disease and decreases the chance of ulcerative colitis
  - (a) Age
  - (b) Smoking
  - (c) Family history of a 1<sup>st</sup> degree relative with IBD
  - (d) History of salmonella and campylobacter infection
  
6. This risk factor is unique to Crohn's disease.
  - (a) Age
  - (b) Family history of a 1<sup>st</sup> degree relative with IBD
  - (c) History of salmonella and campylobacter infection
  - (d) Good domestic hygiene – Urban areas
  
7. This risk factor is unique to ulcerative colitis.
  - (a) Age
  - (b) Family history of a 1<sup>st</sup> degree relative with IBD
  - (c) History of salmonella and campylobacter infection
  - (d) Good domestic hygiene – Urban areas
  
8. Age as a risk factor has a bimodal distribution of 15 -35 years in 60 – 80 years in:
  - (a) Crohn's disease
  - (b) Ulcerative colitis
  
9. A high fat diet as a risk factor is associated with:
  - (a) Crohn's disease
  - (b) Ulcerative colitis

**Answers to Multiple choice questions**

1. (b).
2. (a).
3. (b).
4. (c).
5. (b).
6. (d).
7. (c).



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- 8. (b).
- 9. (b).

*The end of the question paper*