Тесты на итог тестирование

The main methods of patient examination include

observation, questioning, palpation, percussion, auscultation

observation, percussion, auscultation

observation, questioning

observation, questioning, palpation, percussion, auscultation, laboratory research

percussion, observation

What is history of disease (аnamnesis morbi)?

history of the present disease

the patient's life history

physical (objective) examination

complaints

additional data

Where is information about all past diseases reflected?

in the patient's life history (anamnesis vitae)

in complaints

in history of disease (anamnesis morbi)

in physical (objective) examination (status praesens)

in epicrisis

What is propaedeutics?

introduction to any science

study of methods of examination of the patient

study of the symptomatology of diseases of internal organs

study of methods of patient examination and symptomatology of diseases of internal organs

introduction to therapy

What is persistent fever?

the difference between morning and evening temperatures does not exceed 1 Co

the difference between morning and evening temperatures exceeds 1 Co

the difference between morning and evening temperatures is 1 Co and its minimum is within normal limits

morning temperature is higher than evening temperature

the difference between morning and evening temperature is 2Co

What is subfebrile temperature?

37- 38 Co

38- 39 Co

39- 40 Co

40- 41 Co

41- 42 Co

What is anasarca?

edema of the whole body

edema in the face

edema in the legs

accumulation of fluid in the pleural cavity

fluid accumulation in the abdominal cavity

What is cachexia?

extreme emaciation

forced position of the patient

extreme obesity

edema of the whole body

fluid accumulation in the abdominal cavity

Face with enlarged protruding parts (nose, lips and cheekbones) is a sign of

acromegaly

hypothyroidism

diabetes

hyperthyroidism

kidney disease

What is the most typical appearance of the face in inflammation of the lungs (pneumonia)?

one-sided blush

yellowness

cyanosis

general hyperemia

general pallor

The square shape of the head may indicate

past rickets

previous traumatic brain injury

past encephalitis

acromegaly

hypothyroidism

Puffiness of the face is observed in

kidney disease

brain diseases

diseases of the gastrointestinal tract

blood diseases

joint diseases

What is cyanosis?

bluish skin color

pallor of the skin

yellowish skin tone

itchy skin

soreness of the skin

Dyspnea with difficulty inhailing

inspiratory

expiratory

mixed

pulmonary

renal

Physiological dyspnea is observed

with hard physical work

with various diseases of the respiratory system

with diseases of the cardiovascular system

with diseases of the gastrointestinal tract

with blood diseases

The main complaints characteristic of respiratory diseases include

cough

decreased appetite

malaise

general weakness

fatigue

Increased cough and sputum discharge "with a full mouth" occurs with

bronchiectasis

exudative pleurisy

tracheitis

pneumonia

bronchial asthma

Chest pain is associated with

pleural involvement

alveolar damage

damage to the bronchi

liver damage

kidney damage

Pleural pain increases

when coughing

during sleep

in the position on the sore side

when leaning to the sore side

when leaning forward

Barrel chest is characteristic of

increased airiness of lung tissue

accumulation of air in the pleural cavity

the presence of a cavity in the lung

presence of fluid in the pleural cavity

presence of fluid in the abdomen.

Pathological forms of the chest include

funnel chest

asthenic form

hypersthenic form

normosthenic

mixed

Increased voice trembling occurs with

compaction of lung tissue

lesion of the bronchi

increased airiness of the lungs

bronchospasm

presence of fluid in the pleural cavity

Сomparative lung percussion allows to define

change in percussion sound in symmetrical areas

apex of the lungs in front

mobility of the lower pulmonary margin

Krönig fields

apexes of the lungs behind.

Sputum with foul-smelling odors is typical for

destruction of lung tissue

lesion of small bronchi

damage to the pleura

hydrothorax

pneumonia

The symptom of "drumstick fingers" is typical for

bronchiectasis

acute bronchitis

lobar pneumonia

bronchial asthma

hydrothorax

Blood in sputum occurs witt

pulmoаnary tuberculosis

croupous pneumonia

Chronic bronchitis

Focal pneumonia

Hydrothorax

Chest breathing is typical for

women

children

men

obese

skinny

What kind of voice trembling is characteristic for pulmonary emphysema?

weakened

reinforced

does not change

intermittent

undefined

Property not characteristic of pulmonary sound

short

loud

continuous

low

pulmonary

Kyphoscoliosis is

combination of side and posterior curvature

lateral curvature

backward curvature with hump formation

forward bend

curvature of the spine and obesity

Normal respiratory rate per minute is

18-20

10-12

20-22

4-6

24 and more

Decreased chest elasticity is associated with

increased airiness of lung tissue

with bronchospasm

rib fracture

flatulence

increased blood pressure

Percussion sound over the lungs of a healthy person

pulmonary

blunted

box sound

tympanic

dull

Characteristic of dull percussion sound

high, short, quiet

low, continuous, quiet

high, continuous, loud

low, continuous, loud

low, short, loud

Box percussion sound over the lungs is heard with

increased airiness of lung tissue

unchanged lung tissue

induration of lung tissue

hydrothorax

ascites

Tympanic percussion sound in a healthy person is heard

over empty bowel loops

over healthy lung tissue

over the liver

over the region of the heart

over the muscles

The upper borders of the lungs in front are located

3-4 cm above the clavicle

at the level of the clavicle

1-2 cm above the clavicle

below clavicle

at the level of the spinous process of the VII cervical vertebra

The lower border of the lungs along the midaxillary line are at the level

6 rib

7 rib

8 rib

9 rib

10 rib

The line along which the lower border of the left lung is not determined

midclavicular

paravertebral

middle axillary

scapular

anterior axillary

The line along which the mobility of the lower border of the right lung is determined

Midclavicular

perasternal

anterior axillary

anterior median

sternal

Percussion sound that occurs with pronounced compaction of lung tissue

dull

clear pulmonary

tympanic

box sound

blunted

Percussion sound that occurs when air accumulates in the pleural cavity

Tympanic

clear pulmonary

dull

box sound.

blunted

Percussion sound over the liver area is

dull

blunted

pulmonary

box sound

tympanic

Characteristics of clear pulmonary sound

high, short, quiet

low, continuous, loud, not tympanic

low, loud, continuous

high, loud, continuous

low, short, quiet

The upper border of the right lung in front can be

below the upper border of the left lung

above the upper border of the left lung

on the same level

significantly lower

significantly higher

The lower border of the lungs along the scapular line is at the level of the

10 rib

6 rib

8 rib

11 rib

7 rib

Box percussion sound over the lung tissue is heard with

with an increase in the airiness of the lung tissue

accumulation of air in the pleural cavity

with compaction of lung tissue

hydrothorax

ascites

The line along which the mobility of the lower border of the left lung is determined

middle axillary

midclavicular

paravertebral

anterior median

parasternal

Percussion sound when fluid accumulates in the pleural cavity is

dull

clear pulmonary

blunted

box sound

tympanic

Percussion sound with pronounced compaction of lung tissue is

dull

blunted

box sound

tympanic

clear pulmonary

The line along which the lower border of the right lung is not determined

anterior median

parasternal

midclavicular

scapular

anterior axillary

Comparative lung percussion is performed by

loud percussion

quiet percussion

the quietest percussion

direct percussion

topographic percussion

BASIC RESPIRATORY SOUNDS INCLUDE

all of the above

vesicular breath sounds

bronchial breathing

mixed breathing

breath with a metallic sound

AMPHORIC BREATH IS A TYPE OF WHICH KIND BREAT?

bronchial

vesicular

mixed

additional respiratory sounds

bronchophony

THE CONDITION FOR THE OCCURRENCE OF BRONCHIAL BREATHING OVER THE LUNG TISSUE IS

compaction of the lung tissue until its complete loss of airiness

accumulation of fluid in the pleural cavity

accumulation of air in the pleural cavity

uneven narrowing of the bronchi

ascites

THE CONDITION FOR THE OCCURRENCE OF CREPITUS IS

the presence of a secret in the alveoli

the presence of liquid secretion in the bronchi

the presence of fluid in the pleural cavity

the presence of viscous secret in the bronchi

the presence of pneumothorax

WHEEZING CAN BE

all of the above

dry

consonant

wet

large-bubble

HOW DOES WHEEZING CHANGE WHEN THE STETHOSCOPE IS PRESSED AGAINST THE CHEST?

do not change

intensify

disappear

all of the above

weaken

THE CONDITION FOR THE OCCURRENCE OF CONSONANT WHEEZING IS

induration of lung tissue surrounding the bronchus

the presence of liquid secretion in the bronchi

the presence of viscous secret in the bronchi

the presence of fluid in the pleural cavity

the presence of pneumothorax

WHEN IS WHEEZING HEARD?

on inhalation and exhalation

on inhalation

at the peak of inhale

during exhalation

at the beginning of inhalation

010. PLEURAL FRICTION RUB

all of the above

is heard on inhalation and exhalation

intensifies when pressing the stethoscope on the chest

persists when imitating respiratory movements

resembles crepitus

LUNG AUSCULTATION CAN REVEAL

basic respiratory sounds

tympanic noise

weakening of vocal fremitus

boxed sound

dull sound

BASIC RESPIRATORY SOUNDS INCLUDE

1bronchial breathing

pleural friction rub

crepitus

dry wheezing

wet wheezing

TYPES OF VESICULAR BREATH SOUNDS INCLUDE

hard breathing

amphoric breath

metallic breath

mixed breathing

pneumosclerotic breathing

TYPES OF BRONCHIAL BREATHING INCLUDE

amphoric breath

hard breathing

enhanced vesicular breathing

saccadic breath

pneumosclerotic breathing

ADDITIONAL RESPIRATORY SOUNDS INCLUDE

all of the above

crepitus

pleural friction rub

dry wheezing

wet wheezing

WHERE DOES THE CREPITUS OCCUR?

in the alveoli

in the bronchi

in the lung cavities

in the trachea

in all of the above

WHEN DOES THE CREPITUS OCCUR

at the peak of inhale

on inhalation

on exhalation

on inhalation and exhalation

at the end of exhalation

WHERE CAN PLEURAL FRICTION RUB BE HEARD?

on inhalation and exhalation

on inhalation

at the peak of inhale

on exhalation

at the end of exhalation

WHEN DOES PLEURAL FRICTION RUB INTENSIFY?

when pressing with a stethoscope on the chest

after coughing

while holding the breath

at the peak of inhale

at the peak of exhale.

BASIC RESPIRATORY SOUNDS INCLUDE

all of the above

vesicular breath sounds

bronchial breathing

mixed breathing

metallic breathing

008. WHEN DOES PLEURAL FRICTION RUB INTENSIFY?

when pressing with a stethoscope on the chest

after coughing

while holding the breath

at the peak of inhale

at the peak of exhale

**тема 6**

THE RIVALTA TEST ALLOWS YOU TO DISTINGUISH

exudate from transudate

sputum with bronchitis from sputum with pneumonia;

hydrothorax from pneumothorax;

abscess from gangrene

bronchitis from bronchial asthma

MAXIMUM LUNG CAPACITY IS

the sum of the tidal, inspiratory and expiratory reserve volumes and residual volumes

additional volume of air that a person can inhale after a normal inhalation

additional volume of air that a person can exhale after a normal exhalation

air remaining in the lungs after maximum expiration

the sum of the inspiratory and expiratory reserve volumes and tidal volume

X-RAY STUDY OF LUNGS ALLOWS TO DETERMINE

transparency of pulmonary fields

presence of cavities

the presence of liquid and gas in the pleural cavity

tidal volumes

dyspnea pattern

HOW MUCH PROTEIN IS USUALLY IN EXUDATE?

more than 3 %

less than 3 %

less than 2 %

less than 1,5 %

less than 1 %

WHAT IS RESIDUAL VOLUME?

air remaining in the lungs after maximum expiration

additional volume of air that a person can inhale after a normal inhalation

additional volume of air that a person can exhale after a normal exhalation

the sum of the tidal, inspiratory and expiratory reserve volumes and residual volumes

the sum of the inspiratory and expiratory reserve volumes and tidal volume

BRONCHOGRAPHY ALLOWS TO IDENTIFY

presence of bronchiectasis

presence of bronchitis;

presence of pneumonia;

pulmonary emphysema.

ascites

«RUSTY» SPUTUM IS CHARACTERISTIC FOR:

lobar pneumonia

pulmonary edema

chronic bronchitis

lung abscess

bronchial asthma

EXPIRATORY RESERVE VOLUME IS

additional volume of air that a person can exhale after a normal exhalation

additional volume of air that a person can inhale after a normal inhalation

air remaining in the lungs after maximum expiration

the sum of the tidal, inspiratory and expiratory reserve volumes and residual volumes

the sum of the inspiratory and expiratory reserve volumes and tidal volume

BRONCHOSCOPY ALLOWS TO IDENTIFY

presence of bronchitis

presence of bronchiectasis

bronchial tumor

presence of pneumonia

bronchial tumor.

presence of hydrothorax

HOW MUCH PROTEIN IS USUALLY IN TRANSUDATE?

less than 3%

more than 3%

less than 5 %

more than 5 %

more than 4 %

INSPIRATORY RESERVE VOLUME IS

additional volume of air that a person can inhale after a normal inhalation

аdditional volume of air that a person can exhale after a normal exhalation

air remaining in the lungs after maximum expiration

the sum of the tidal, inspiratory and expiratory reserve volumes and residual volumes

the sum of the inspiratory and expiratory reserve volumes and tidal volume.

PLEURAL PUNCTION IS CARRIED OUT FOR

determination of the nature of the pleural fluid

liquid removal

drug administration

examination of the pleura.

histological examination of the pleura

VITREOUS SPUTUM IS CHARACTERISTIC FOR

bronchial asthma

pulmonary edema

lobar pneumonia

chronic bronchitis

lung abscess

VITAL CAPACITY OF THE LUNG IS

the sum of the inspiratory and expiratory reserve volumes and tidal volume additional volume of air that a person can inhale after a normal inhalation

additional volume of air that a person can exhale after a normal exhalation

air remaining in the lungs after maximum expiration

the sum of the tidal, inspiratory and expiratory reserve volumes and residual volumes

TRANSUDATE IS

non-inflammatory effusion

inflammatory effusion

fluid in the abdomen

alveolar fluid

pericardial fluid

SPECIFIC WEIGHT OF EXUDATE IS

more than 1,015 g

less than 1,015 g

less than 1,010 g

1,002 g

less than 1 g

PUTRID SPUTUM IS CHARACTERISTIC FOR

lung abscess

gangrene of the lung

pulmonary edema

lobar pneumonia

chronic bronchitis

SPECIFIC WEIGHT OF TRANSUDATE USUALLY IS

less than 1,015 g

more than 1,015 g

more than 1,020 g

more than 1,025 g

1,025 g

EXUDATE IS

inflammatory effusion

non-inflammatory effusion

fluid from the abdomen

alveolar fluid

pericardial fluid

BRONCHOGRAPHY ALLOWS TO IDENTIFY

presence of bronchiectasis

presence of bronchitis

presence of pneumonia

pulmonary emphysema.

ascites

BRONCHOSCOPY ALLOWS TO IDENTIFY

presence of bronchitis

presence of bronchiectasis

presence of hydrothorax

presence of pneumonia

bronchial tumor

PUTRID SPUTUM IS CHARACTERISTIC FOR

gangrene of the lung

pulmonary edema

lobar pneumonia

chronic bronchitis

lung abscess

VITAL CAPACITY OF THE LUNGS IS

the sum of the inspiratory and expiratory reserve volumes and tidal volume

additional volume of air that a person can inhale after a normal inhalation

additional volume of air that a person can exhale after a normal exhalation

air remaining in the lungs after maximum expiration

the sum of the tidal, inspiratory and expiratory reserve volumes and residual volumes

FORCED POSITION OF ORTHOPNEA DURING NIGHT SUFFOCATION IN A PATIENT CAN BE OBSERVED IN CASE OF

left heart failure

right heart failure

circulatory disorders in the systemic circulation

circulatory disorders in the portal vein

insomnia

EDEMAS ON THE LOWER LIMBS INDICATE

circulatory disorders in the systemic circulation

circulatory disorders in the pulmonary circulation

left heart failure

left atrial insufficiency

total heart failure.

CONVOLUTED TEMPORAL ARTERIES CAN BE A MANIFESTATION OF

atherosclerosis and hypertension

aortic insufficiency

tricuspid insufficiency

mitral valve prolapse

angina pectoris.

APEX BEAT IS FORMED BY

left ventricle

right ventricle

left atrium

right atrium

transverse heart diameter.

WHAT MECHANISM IS CONNECTED WITH INCREASED BLOOD PRESSURE

increase in cardiac output

magnesium retention

increase in prolactin activity

increased venous pressure

INCREASED DIASTOLIC ARTERIAL PRESSURE DEPENDS ON

the tone of the arterial wall

the strength and volume of blood ejected into the aorta and arterial channel

systolic blood pressure.

DIFFUSED APEX BEAT IS OBSERVED WITH

hypertrophy and dilatation of the left ventricle

left atrial hypertrophy

right ventricular hypertrophy

hypertrophy and dilatation of the right ventricle

hypertrophy of the right atrium.

PULSE IN THE LOWER PART OF THE STERNUM AND EPIGASTRIC PULSATION CAN BE OBSERVED IN CASE OF

right ventricular hypertrophy

right atrial hypertrophy

left ventricular hypertrophy

left atrial hypertrophy

aneurysm of the ascending aortic arch

PAIN BEHIND THE BREAST AND IN THE HEART REGION, SHORT, WITH IRRADIATION TO THE LEFT HAND, STOPPING AT REST OR FROM NITRATE INTAKE, MAY INDICATE

angina pectoris

myocardial infarction

cardioneurosis

hypertension

heart failure

ABUNDANT ALBUMINOID SPUTUM WITH BLOOD EXCRETED BY THE PATIENT DURING A CHOCKING ATTACK CAN BE OBSERVED IN CASE OF

cardiac asthma

an attack of bronchial asthma

pneumonia

lung cancer

right heart failure

CARDIAC HUMP CAN BE OBSERVED WITH

congenital heart disease

rickets

bone tuberculosis

injury

cardiac failure acquired in adulthood

CARDIAC IMPULSE MAY BE PALPABLE

with right ventricular hypertrophy

with left ventricular hypertrophy

with right atrial hypertrophy

with left atrial hypertrophy

with ascending aortic aneurysm

PALPABLE SYSTOLIC THRILL OF THE CHEST IN THE RIGHT 2nd INTERCOSTAL SPACE CAN BE ASSOCIATED WITH

aortic stenosis

mitral stenosis

tricuspid stenosis

pulmonary trunk stenosis

tricuspid valve insufficiency

DULL ACHING PAIN IN THE RIGHT HYPOCHONDRIUM MAY INDICATE

congestion of blood in the systemic circulation

congestion of blood in the pulmonary circulation

left heart failure

left atrial insufficiency

coronary insufficiency

JUGULAR VENOUS DISTENTION INDICATES

increased venous pressure

increased systolic blood pressure

increased diastolic pressure

increased pulse pressure

hypotension

MUSSET'S SIGN (SHAKING OF THE HEAD) OCCURS WITH

aortic valve insufficiency

traumatic brain injury

brain tumors

cervical osteochondrosis

mitral stenosis

POSITIVE VENOUS PULSE OCCURS WITH

tricuspid valve insufficiency

aortic valve insufficiency

mitral valve insufficiency

mitral stenosis

aortic stenosis

DIASTOLIC THRILL AT THE APEX IS CHARACTERISTIC FOR

mitral stenosis

aortic stenosis

pulmonary artery stenosis

aortic valve insufficiency

IF YOU PALPATED THE CAPILLARY PULSE, YOU SHOULD

THINK OF

aortic valve insufficiency

mitral stenosis

mitral valve insufficiency

tricuspid valve insufficiency

aortic stenosis

HEMOPTYSIS CAN BE OBSERVED WITH

congestion of blood in the pulmonary circulation

congestion of blood in the systemic circulation

right heart failure

coronary insufficiency

venous insufficiency

PULSE PRESSURE IS

difference between systolic and diastolic pressure

increased systolic pressure

increased diastolic pressure

the force with which the properties of the pulse are determined

sharp decrease in pressure

THE RIGHT BORDER OF ABSOLUTE CARDIAC DULLNESS IS AT

the left edge of the sternum in the 4th intercostal space

the left edge of the sternum in the 3rd intercostal space

midclavicular line in the 5th intercostal space

the 4th rib to the right of the sternum

1 cm medially from the left border of relative cardiac dullness in the 5th intercostal space

THE WIDTH OF THE VASCULAR BUNDLE IS DETERMINED

in the II intercostal space

in the III intercostal space

in the IV intercostal space

in the V intercostal space

in the IV intercostal space

THE LEFT BORDER OF THE RELATIVE CARDIAC DULLNESS WITH INSUFFICIENCY OF THE AORTIC VALVES IS DISPLACED

left and down

up and left

down and up

right and up

do not change

THE NORMAL CROSS-SECTION OF THE HEART IS

4 + 8 = 12 cm

5 + 8 = 13 cm

6 + 9 = 15 cm

3 + 12 = 15 cm

8 + 4 = 12 cm.

THE "HEART WAIST" IS

the angle between the vascular bundle and the left ventricle

the place of transition of the atria to the ventricles

the place of exit from the heart of large vessels

the angle between the left atrium and the left ventricle

the angle between the right ventricle and the right atrium

IN MITRAL STENOSIS, THE "WAIST OF THE HEART"

less pronounced

becomes more pronounced

not changed

underlined

sharply underlined.

THE RIGHT BORDER OF RELATIVE CARDIAC DULLNESS IS NORMALLY LOCATED

1 cm outside of the right edge of the sternum at the 4th intercostal space

3 cm outwards from the right edge of the sternum at the 4th intercostal space

left sternal edge at the 4 th intercostal space

1 cm outwards from the right edge of the sternum at the 5 th th intercostal space

2 cm outwards from right sternal edge at the 4th intercostal space

NAME THE CHANGES DETECTED DURING PERCUSSION OF THE HEART, THE MOST CHARACTERISTIC OF THE MITRAL CONFIGURATION OF THE HEART

upward displacement of the upper border and smoothing the "waist" of the heart 1) "triangular" heart shape

right shift of the right border

shifting to the left of the left border with the underlined "waist" of the heart

shifting the left border to the left and the right one to the right

UPPER LIMIT OF RELATIVE HEART DULLNESS IS DETERMINED

1 cm outward from the left sternal line

along the anterior midline

along the left sternal line

along the left parasternal line

along the left mid-clavicular line

NORMALLY THE WIDTH OF THE VASCULAR BUNDLE IS

5-6 cm

3-4 cm

6-8 cm

1-2 cm

UPPER BORDER OF RELATIVE CARDIAC DULLNESS INCREASES DUE TO THE

left atrial hypertrophy

right ventricular hypertrophy

left ventricular hypertrophy

right atrial hypertrophy

vascular bundle

ABSOLUTE CARDIAC DULLNESS IS FORMED BY THE

right ventricle

left atrium

left ventricle

right atrium

left atrium and right ventricle

THE "TRIANGULAR" SHAPE OF THE HEART IS TYPICAL OF THE

exudative pericarditis

mitral stenosis

tricuspid valve insufficiency

pulmonary heart

dry pericarditis (e.g. in uremia

THE RIGHT HEART CONTOUR IS FORMED BY THE

aortic arch, right atrium, superior vena cava

right ventricle, right atrium

right ventricle, right atrium, aortic arch, vena cava

aortic arch, right ventricle

superior vena cava

THE UPPER LIMIT OF RELATIVE CARDIAC DULLNESS IS INCREASED DUE TO THE

hypertrophy of the left atrium

right ventricular hypertrophy

hypertrophy of the left ventricle

hypertrophy of the right atrium

vascular bundle

IN MITRAL STENOSIS, THE "HEART WAIST"

less pronounced

becomes more pronounced

unchanged

accentuated

strongly emphasized

THE LEFT BORDER OF RELATIVE AND ABSOLUTE DULLNESS OF THE HEART MAY COINCIDE WHEN

mitral stenosis

aortic stenosis

aortic insufficiency

mitral insufficiency

acute myocardial infarction.

ABSOLUTE HEART DULLNESS IS FORMATED BY THE

right ventricle

left atrium

left ventricle

right atrium

left atrium and right ventricle.

THE UPPER BORDER OF RELATIVE HEART DULLNESS IS LOCATED

at the level of the 2nd intercostal space

at level the 2nd rib

at the level of the 3 rd rib

at the level of the 3rd intercostal space

at the level of rd 4 rib.

THE UPPER BORDER OF THE RELATIVE DULLNESS OF THE HEART IS DETERMINED

1 cm outward from the left sternal line

along the anterior midline

along the left sternal line

along the left parasternal line

along the left mid-clavicular line

"TRIANGULAR" FORM OF HEART CONFIGURATION IS CHARACTERISTIC FOR

exudative pericarditis

mitral stenosis

tricuspid valve insufficiency

cor pulmonale

dry pericarditis (for example, with uremia).

IN AORTIC STENOSE "HEART WAIST"

becomes more pronounced

less pronounced

not changed

smoothed

missing

THE WIDTH OF THE VASCULAR BUNDLE IS DETERMINED

in the II intercostal space

in the III intercostal space

in the IV intercostal space

in the V intercostal space

in the IV intercostal space

THE LEFT BORDER OF RELATIVE CARDIAC DULLNESS IS FORMED BY THE

left ventricle

aortic arch

left atrium

right atrium

right ventricle

Tell the components of S1

muscular, valvular, vascular, atrial

muscular, valvular, vascular

muscular, valvular, aortal, atrial

muscular, valvular

valvular, vascular

The pulmonary artery valve is auscultated

at the 2nd intercostal space to the left of the sternum

at the 2nd intercostal space to the right of the sternum

at the xiphoid process

at the apex of the heart

at the Botkin-Erb’s point.

Complete atrioventricular block leads to

no changes in S1

weakening of S1

reduplication of S1

splitting of S1

intensification of S1

The aorta is auscultated

at the 2nd intercostal space to the right at the sternum

at the xiphoid process, slightly to the left

at the 2nd intercostal space to the left at the sternum

at the apex of the heart

at the xiphoid process, slightly to the right

The auscultation picture of S1 in aortic ostial stenosis:

S1 is weakened at the apex of the heart

S1 is intensified at the apex of the heart

S1 is unchanged

S1 is reduplicated

S1 is split

S2 in aortic ostial stenosis is:

weakened at the aorta

intensified at the aorta

split at the aorta

intensified at the apex of the heart

weakened at the apex of the heart

Increased blood pressure in the pulmonary artery combined with right ventricle hypertrophy leads to:

accentuation and splitting of S2 at the pulmonary artery

only accentuation of S2 at the pulmonary artery

only splitting of S2 at the pulmonary artery

weakening of S2 at the pulmonary artery

intensification of S1

S1 is intensified against the background of:

mitral stenosis

aortic ostial stenosis

aortic valve failure

mitral valve failure

myocarditis

THE SEQUENCE OF HEART AUSCULTATION IS:

the apex of the heart, the 2nd intercostal space to the right of the sternum, the 2nd intercostal space to the left of the sternum, the xiphoid process, the Botkin-Erb’s point

the apex of the heart, the xiphoid process, the 2nd intercostal space to the left of the sternum, the 2nd intercostal space to the right of the sternum, the Botkin-Erb’s point

the xiphoid process, the apex of the heart, the Botkin-Erb’s point, the 2nd intercostal space to the right of the sternum, the 2nd intercostal space to the left of the sternum

the 2nd intercostal space to the right of the sternum, the 2nd intercostal space to the left of the sternum, the apex of the heart, the xiphoid process, the Botkin-Erb’s point

the apex of the heart, the 2nd intercostal space to the left of the sternum, the 2nd intercostal space to the right of the sternum, the xiphoid process, the Botkin-Erb’s point

ACCENTUATION OF S2 AT THE PULMONARY ARTERY IS FOUND IN:

hypertension of the pulmonary circulation

increased blood pressure in the systemic circulation

hypertrophy of the left ventricle

dilated left ventricle

hypotrophy of the left ventricle

TELL THE SURFACE PROJECTION OF THE AORTIC VALVE ON THE ANTERIOR CHEST WALL:

in the centre of the sternum at the level of the 3rd rib

at the level of the left 2nd costal cartilage

at the level of the right 2nd costal cartilage

at the apex of the heart

at the xiphoid process

A CHARACTERISTIC FEATURE OF MITRAL STENOSIS IS:

presystolic murmur at the apex of the heart

weakened S1 at the apex of the heart

protodiastolic murmur in the 2nd intercostal space to the right

systolic murmur at the apex of the heart

weakened S2 in the 2nd intercostal space to the right

THE PERICARDIAL FRICTION RUB IS AUSCULTATED IN:

pericarditis

heart failure

myocarditis

angina pectoris

hypertensive disease

THE AUSCULTATION PICTURE IN MITRAL VALVE FAILURE:

S1 is weakened at the apex of the heart

S1 is intensified at the apex of the heart

the “opening click” of the mitral valve

diastolic murmur at the apex of the heart

diastolic murmur at the aorta

SYSTOLIC MURMUR IN AORTIC OSTIAL STENOSIS IS TRANSMITTED:

to the vessels of the neck

to the Botkin-Erb’s point

to the xiphoid process

to the armpit

to the pulmonary artery

Tell the distinct feature of systolic ejection murmur as compared to systolic regurgitant murmur

appears shortly after S1

appears during the last 3rd of the systole

accompanied by S3

merges with S1

does not differ

Auscultation during aortic ostial stenosis reveals:

systolic murmur at the aorta

diastolic murmur at the apex of the heart

diastolic murmur at the aorta

systolic murmur in the axillary area

systolic murmur at the apex of the heart

A characteristic feature in heart auscultation for patients with pronounced heart failure is:

the protodiastolic gallop rhythm

the quail rhythm

the presystolic gallop rhythm

the systolic gallop rhythm

the extra pericardial knock

S1 IN AORTIC VALVE FAILURE IS:

weakened at the apex of the heartart

intensified at the apex of the he

unchanged

intensified at the aorta

weakened at the aorta

PROTODIASTOLIC MURMUR IN MITRAL STENOSIS APPEARS DUE TO:

the increase in the “left atrium – left ventricle” pressure gradient

the appearance of atrial fibrillation

the active atrial systole

mitral regurgitation

stretching of the left atrium.

TELL THE SURFACE PROJECTION OF THE MITRAL VALVE ON THE ANTERIOR CHEST WALL:at the level of the 3rd intercostal space

at the level of the left 2nd costal cartilage

at the level of the right 2nd costal cartilage

at the apex of the heart

at the xiphoid process

AUSCULTATION DURING AORTIC OSTIAL STENOSIS REVEALS:

systolic murmur in the 2nd intercostal space to the right of the sternum irradiating to the carotid arteries

diastolic murmur at the apex of the heart irradiating to the base of the xiphoid process

systolic murmur at the apex of the heart irradiating to the axillary area

diastolic murmur in the 2nd intercostal space to the right of the sternum irradiating to the carotid arteries

diastolic murmur irradiating to the Botkin-Erb’s point

A characteristic feature of mitral valve stenosis is:

an added high-frequency sound during the diastole 0.07-0.12s after S2

accentuation and reduplication of S2 over the aorta

systolic murmur at the apex of the heart, intensified during inspiration

systolic murmur at the apex of the heart intensified during expiration

systolic murmur at the aorta

THE CHANGE OF S2 IN AORTIC VALVE FAILURE:

S2 is weakened at the aorta

S2 is intensified at the pulmonary artery

accentuation of S2 at the aorta

S2 is intensified at the apex of the heart

S2 is weakened at the apex of the heart

CHOOSE THE FACTORS RELEVANT IN S3 FORMATION

the oscillations of the ventricular walls at the moment of their fast filling;

the oscillations of the ventricular walls at the moment of their fast filling; the position of atrioventricular valve cusps before isometric contraction; the oscillations of semilunar valves of the aorta and the pulmonary artery during their closure; fast isometric contraction of the valves

the oscillations of the ventricular walls at the moment of atrial systole;

the oscillations of semilunar valves of the aorta and the pulmonary artery during their closure

the oscillations of the ventricular walls at the moment of atrial systole; the oscillations of the ventricular walls at the moment of their fast filling;

ACCENTUATION OF S2 AT THE PULMONARY ARTERY IS OBSERVED IN:

hypertension of the pulmonary circulation

increased blood pressure in the systemic circulation

hypertrophy of the left ventricle

dilated left ventricle

hypotrophy of the left ventricle

Tell the surface projection of the pulmonary artery valve on the anterior chest wall:

at the level of the left 2nd costal cartilage

at the level of the 3rd intercostal space

at the level of the right 2nd costal cartilage

at the apex of the heart

at the xiphoid process

AUSCULTATION DURING AORTIC VALVE FAILURE REVEALS:

systolic murmur at the aorta

diastolic murmur at the aorta

diastolic murmur in the axillary area

systolic murmur at the base of the xiphoid process

diastolic murmur at the base of the xiphoid process

CHOOSE THE FACTORS RELEVANT IN S4 FORMATION

the oscillations of the ventricular walls at the moment of atrial systole

the oscillations of the ventricular walls at the moment of their fast filling; the position of atrioventricular valve cusps before isometric contraction; the oscillations of semilunar valves of the aorta and the pulmonary artery during their closure; fast isometric contraction of the valves

the oscillations of the ventricular walls at the moment of their fast filling

the oscillations of semilunar valves of the aorta and the pulmonary artery during their closure

the oscillations of the ventricular walls at the moment of atrial systole; the oscillations of the ventricular walls at the moment of their fast filling

THE CHANGE OF S2 IN MITRAL VALVE FAILURE:

S2 is intensified at the pulmonary artery

S2 is intensified at the aorta

S1 is split at the pulmonary artery

S2 is weakened at the aorta

S2 is intensified at the xiphoid process

A CHARACTERISTIC FEATURE OF THE AUSCULTATION PICTURE IN MITRAL VALVE FAILURE IS:

systolic murmur at the apex of the heart

the flapping S1

the mesodiastolic murmur

the systolic murmur at the base of the heart

systolic murmur at the aorta

IN PULMONARY ARTERY STENOSIS, S2 IS:

weakened in the 2nd intercostal space to the left of the sternum

intensified in the 2nd intercostal space to the right of the sternum

split at the aorta

intensified at the apex of the heart

weakened at the apex of the heart

TELL THE DISTINCT FEATURE OF SYSTOLIC EJECTION MURMUR AS COMPARED TO SYSTOLIC REGURGITANT MURMUR

appears shortly after S1

appears during the last 3rd of the systole

accompanied by S3

merges with S1

does not differ

RED ELECTRODE DURING ECG REGISTRATION IS APPLIED ON THE

right hand

chest

left hand

right leg

left leg

ELECTRODES ARE PLACED …TO REGISTER THE THORACIC ECG-V3 LEAD

on the left edge of the sternum in the IV intercostal space

on the right edge of the sternum in the IV intercostal space

along the left midclavicular line in the V intercostal space

along the left posterior axillary line in the V intercostal space

along the right midclavicular line in the V intercostal space

STANDARD LEADS ARE

I, II, III

I, II, III, аVR, аVL, аVF

аVR, аVL, аVF

VI, V2, V3, V4, V5, V6

D, A,J

ON A NORMAL ECG THE DURATION OF THE P-WAVE SHOULD BE NO MORE THAN

0.1s

0.08s

0.12s

0.14s

0.15s

ON A NORMAL ECG, Q-WAVE DURATION SHOULD BE NO MORE THAN

0.3s

0.01 s

0.02s

0.2s

0.1s

ON A NORMAL ECG Q-WAVE

may be absent in some lead

smust be in all leads

must be in V1

must be in V5

must be in V3

HEART RHYTHM OF A HEALTHY PERSON IS

sinus

atrial

atrioventricular

idioventricular

left ventricular

AV BLOCKADE OF THE I DEGREE IS CHARACTERIZED BY

prolongation of the PQ interval more than 0.2 s,

loss of the QRST complex

increase in the duration of the prong P more than 0.1 s.

the increase in the duration of the QRS complex is more than 0.1 s.

All RR intervals are greater than PP intervals

LEFT VENTRICULAR HYPERTROPHY ON AN ECG IS CHARACTERIZED BY

increasing the amplitude of the R wave in V3-6 and the S wave in V1

an increase in the amplitude of the R wave in V6 and the S wave in V5,6

an increase in the amplitude of the P wave of more than 2.5 mm in V3-b, and the PQ interval of more than 0.2 s.

an increase in the PQ interval > more than 0.2 s. in I, II, vi, Vz, Vp

an increase in the QT interval beyond the norm

LEFT BUNDLE BRANCH BLOCK IS CHARACTERISED BY

Increase in QRS complex duration over 0.12 s.

increase in amplitude of the S wave

increase in R-wave duration over 0.1 s.

Increase in PQ interval duration over 0.2s.

increase in amplitude of R-wave.

THE YELLOW ELECTRODE FOR ECG RECORDING SHALL BE PLACED ON

left arm

right arm

right leg

left leg

on the thorax

FOR REGISTRATION OF THE THORACIC ECG- V2, ELECTRODE IS PLACED

on the left edge of the sternum in the IV intercostal space

along the left midclavicular line in the V intercostal space

on the right edge of the sternum in the IV intercostal space

along the left anterior axillary line in the V intercostal space

along the left mid-axillary line in the V intercostal space

ELECTRODES ARE PLACED TO REGISTER THE THORACIC ECG-V6 LEAD

along the left anterior axillary line in the V intercostal space

along the left midclavicular line in the V intercostal space

on the left edge of the sternum in the IV intercostal space

along the left mid-axillary line in the V intercostal space

along the left posterior axillary line in the V intercostal space

ON A NORMAL ECG THE PQ INTERVAL SHOULD BE NO MORE THAN

0.2s.

0.16s.

0.12s

0.24s.

0.26

ON A NORMAL ECG, THE Q-WAVE AMPLITUDE SHOULD NOT EXCEED

V R wave amplitude

R wave amplitude

S wave amplitude

V2 S wave amplitude

5mm

ON A NORMAL ECG, THE U-WAVE

maybe

missing

must be in avl

must be in avf

must be in avr

CRITERION FOR DIAGNOSTICS OF SINUS RHYTHM IS

positive P waves preceding each QRS complex in lead II

equal spacing between R waves

negative P waves

triangular P waves

double-humped waves

ATRIAL FIBRILLATION IS CHARACTERISED BY

no P wave in all leads, different RR intervals and unchanged QRS complex.

a P wave before each QRS complex, but the RR intervals are different

different PQ intervals in the thoracic leads

different RR intervals in all leads

different shape of P-wave

THE … IS CHARACTERISTIC FOR A COMPLETE AV BLOCKADE

Morgagni-Adams-Stokes syndrome

Samoilov-Venkebakh period

presence of an f-wave

lengthening of PQ

double-humped R wave

DURATION OF THE QRS COMPLEX=0.18C IS

blockade of the legs of the bundle of His

AV block II degree

normal

atrial hypertrophy

ventricular hypertrophy

THE GREEN ELECTRODE FOR ECG RECORDING SHALL BE PLACED ON

left leg

right leg

left hand

right arm

on the thorax

AUGMENTED LIMB LEADS INCLUDE

аVR,аVL,аVF

I, II, III, аVR, аVL,

I, II, III

VI, V2, V3, V4, V5, Vб

DAI

ON A NORMAL ECG THE P-WAVE AMPLITUDE SHOULD BE NO MORE THAN

2.5mm

1.5mm

3.5mm

4.0mm

4.5mm

ON A NORMAL ECG THE R-WAVE MAY BE

only positive

only negative

positive and negative

have two phases: positive and negative

in the shape of the letter "M"

ON A NORMAL ECG, THE DURATION OF THE T-WAVE VARIATES FROM

0.12-0.24s.

0.12-0.32s

0.02-0.2s.

less than 0.12 s.

more than 0.32 s.

HR CALCULATION IS CARRIED OUT BY THE FORMULA WHERE RR INTERVALS ARE MEASURED IN SECONDS

60 / RR

RR / 60

RR x 60

RR x 60 / RR

RR / 60 xRR

ATRIAL HYPERTROPHY CHANGES

U wave

P wave

ST interval

T wave

QT interval

AV BLOCKADE OF THE II DEGREE IS CHARACTERIZED BY

dropout of the PQRST complex

only extended PQ interval

all RR intervals are greater than RR intervals

QRST dropout

Р dropout

RIGHT VENTRICULAR HYPERTROPHY IS CHARACTERISED BY

an increase in the amplitude of the R wave in V1-2, and the S wave in Vз-b

R-wave amplitude increase in V5-6, and S-wave amplitude increase in V1-2

an increase in the amplitude of the P wave in I, II, aVL, and the PQ interval in III, aVF

an increase in the amplitude of the P wave in III, aVF, and the PQ interval in I, II, AVl

QT prolongation

WHEN REGISTERING AN ECG, A BLACK ELECTRODE IS APPLIED TO

right leg

right hand

the left hand

the left leg

on the chest

TO RECORD THE THORACIC LEAD OF ECG V4 THE ELECTRODE IS PLACED

along the left midclavicular line in the V intercostal space

along the left anterior axillary line in the V intercostal space

on the left edge of the sternum in the IV intercostal space

along the left posterior axillary line in the V intercostal space

on the right edge of the sternum in the IV intercostal space

TO RECORD THE THORACIC LEAD OF ECG V1 THE ELECTRODE IS PLACED

along the left mid-axillary line in the V intercostal space

along the left posterior axillary line in the V intercostal space

on the right edge of the sternum in the IV intercostal space

along the left midclavicular line in the V intercostal space

on the left edge of the sternum in the IV intercostal space

ON A NORMAL ECG, THE DURATION OF THE QRS COMPLEX SHOULD BE NO MORE THAN

0.10s.

0.08s

0.12s.

0.14s

0.16s.

IT IS PERMISSIBLE ON A NORMAL ECG TO SHIFT THE ST INTERVAL FROM THE ISOELECTRIC LINE BY

1 mm

2 mm

2.5 mm

3.0 mm

3.5mm

ON A NORMAL ECG, S-WAVE

may be missing

should always be

must be in V5

must be in V6

must be in lead III

IN A HEALTHY PERSON, THE PACEMAKER IS

sinus node

atrioventricular node

bundle of His

Purkenye fibers

leftventricle

THE SAMOILOV-WANKEBACH PERIOD IS CHARACTERISTIC FOR

AV block of the II degree

AV block of the I degree

AV-blockade of the III degree

blockade of the legs of the bundle of His

atrial fibrillation

FOR LEFT ATRIUM HYPERTROPHY IS CHARACTERISTIC

"two-humped" P wave with an amplitude of more than 2.5 mm in I, II, aVL leads

peaked P wave with an amplitude of more than 3 mm in II, III, aVF leads

ST interval is greater than 0.5 s.

R wave with an amplitude of more than 25 mm in Vз-b leads

the duration of the complex ()K.8 is more than 0.12 s.

INTERVAL Р-О=0.24С. BEFORE EACH QRS COMPLEX IS CHARACTERISTIC FOR

AV block of the I degree

atrial hypertrophy

ventricular hypertrophy

AV block of the II degree

AV blockade of the III degree

THE ECG METHOD IS ABLE TO REGISTER

electric currents (biocurrents) of the heart

heart murmurs

heart sounds

heart sizes

contractility of the heart

ISCHEMIA REFLECTION ON ECG IS

T wave

P wave

R wave

QT interval

S wave

OSCILLOGRAPHY IS A REGISTRATION METHOD OF

pulse oscillations of the arterial wall

the rate of filling and emptying of the arteries

pulsations of large veins

blood pressure

venous pressure

FOR MYOCARDIAL INFARCTION OF THE LOWER WALL OF THE LEFT VENTRICLE THE MAIN ARE THE FOLLOWING LEADS

1 (2), А VL, V 4(Y5)

3(2), АVR, VI-У2

2, 3, А VF

V1 – V6

D, A, J

NORMALLY, THE AMPLITUDE OF 1 TONE AT THE APEX IN RELATION TO THE TONE 2 IS

1,5-2:1

1:1

1:1,5

2:1

1,5:1

FCG REGISTERED DIASTOLIC NOISE, AMPLIFIED 1 TONE ABOVE THE APEX. WHAT CONDITION IS THIS CHARACTERISTIC FOR?

mitral stenosis

aortic stenosis

aortic valve insufficiency

mitral valve insufficiency

tricuspid valve insufficiency

MYOCARDIAL SCINTIGRAPHY ALLOWS TO DETECT

the size and localization of myocardial perfusion defects

aortic valve insufficiency

degree of heart failure

the degree of stenosis of the coronary vessels

myocardial contractility

THE MOST CHARACTERISTIC SIGN OF ACUTE TRANSMURAL MYOCARDIAL INFARCTION IS

the presence of the QS complex, monophasic curve

violation of rhythm and conduction

negative T wave

deep pathological Q wave

increase in QRS

A 3-MEMBER RHYTHM HAS BEEN REGISTERED ON THE PHONOGRAPH, 1 TONE IS DIVIDED, ITS AMPLITUDE IS REDUCED. WHAT IS THIS PHENOMENON CALLED IN THE CLINIC?

gallop rhythm

quail rhythm

mitral valve opening tone

atrial fibrillation

sinus arrhythmia

FCG SIGNS OF MITRAL STENOSIS

high amplitude of tone 1 at the apex, increase in amplitude of tone 2

over the pulmonary artery, diastolic murmur at the apex

decrease in amplitude of tone 1 at the apex, increase in amplitude of tone 2 above the pulmonary artery, systolic murmur at the apex

high amplitude of tone 1 at the apex, an increase in amplitude of tone 2 above the aorta, systolic murmur at the apex

THE FUNCTIONAL METHODS OF RESEARCH OF THE CARDIOVASCULAR SYSTEM INCLUD THE FOLLOWING METHODS, EXCEPT FOR

ECGs

phygmography

EGD

FCG

Echocardiography

WHAT METHOD IS THE MOST INFORMATIVE TO DETECT HIDDEN ISCHEMIC HEART DISEASE

bicycle ergometry

echocardiography

ECG

FCG

scintigraphy

MYOCARDIAL ISCHEMIA ON ECG USUALLY APPEARS AS

ST segment depression

prolongation of the PQ interval

deviation of the electric axis to the left

two-humped P

splitting R

FOR MYOCARDIAL INFARCTION OF THE LATERAL WALL OF THE LEFT VENTRICLE THE MAIN ARE THE FOLLOWING LEADS

1 (2), АУL, V 5- V 6

3(2), АVR, VI-У2

2, 3, АVR, V 3-4

2,3

AVF

THE ABSOLUTE ECG SIGN OF A POST-CARRIED MYOCARDIAL INFARCTION IS CONSIDERED

deep pathological Q wave

negative T wave

raising the ST segment

ST segment depression

QT prolongation

PHLEBOGRAPHY IS A REGISTRATION METHOD OF

pulsations of large veins

pulse oscillations of the arterial wall

the rate of filling and emptying of the arteries

blood pressure

venous pressure

T-WAVE IS EQUILATERAL, INVERTED, AND SYMMETRIC IN

myocardial ischemia

sinus tachycardia

mitral stenosis

atrial fibrillation

aortic stenosis

FCG SIGN OF THE AORTIC STENOZIS IS

systolic murmur over the aorta

an increase in the amplitude of 1 tone at the top

diastolic murmur over the aorta

2 tone is strengthened over the pulmonary artery

2 tone is strengthened over the aorta

INDICATE THE NATURE OF THE 3-MEMBER RHYTHM REGISTERED ON FLUOROGRAPHY FROM THE APEX OF THE HEART, NOISES ARE NOT REGISTERED

3 heart sound

mitral valve opening tone

artifact

pericarditis

extrasystole

NORMAL AMPLITUDE OF 2 TONES ON THE BASIS OF THE HEART IN RELATION TO THE TONE 2 IS

2:1

1:1

1: 1,5

3:1

4:1

PHLEBOGRAPHY IS A METHOD THAT ALLOWS TO

register venous pulse

determine the rate of filling and emptying of arterial vessels

register heart sounds and murmurs

identify disorders of the coronary circulation

determine venous pressure

THE ABSOLUTE ECG SIGN OF A POST-CARRIED MYOCARDIAL INFARCTION IS CONSIDERED TO BE

deep pathological Q wave

negative T wave

ST segment elevation

ST segment depression

QT prolongation

DECREASE IN AMPLITUDE OF 1 TONE AT THE APEX, 2 TONE IS AMPLIFIED ON THE PULMONARY ARTERY, SYSTOLIC NOISE AT THE APEX ARE CHARACTERISTIC FOR

mitral valve insufficiency

mitral stenosis

aortic valve insufficiency

aortic stenosis

tricuspid stenosis

EXPLAIN THE NATURE OF THE 3-MEMBER RHYTHM REGISTERED AT FCG FROM THE APEX OF THE HEART, NOISES ARE NOT REGISTERED

mitral valve opening tone

artifact

3 heart sound

pericarditis

extrasystole

WHAT METHOD IS THE MOST INFORMATIVE TO DETECT HIDDEN ISCHEMIC HEART DISEASE?

bicycle ergometry

echocardiography

ECG

FCG

scintigraphy

QT INTERVAL REFLECTS

electrical systole of the heart

electrical diastole of the heart

the phase of repolarization of the ventricular myocardium

phase of atrial excitation

depolarization phase

NORMALLY, THE AMPLITUDE OF 2 TONES ON THE BASIS OF THE HEART IN RELATION TO THE 2 TONE IS

2:1

1:1

1: 1,5

3:1

4:1

FOR MYOCARDIAL INFARCTION OF THE ANTERIOR WALL OF THE LEFT VENTRICLE THE MAIN ARE THE FOLLOWING LEADS

1(2), АVL, V4(V5)V 2

3(2),АVR, V 1-

1,2,3, АVR, АVF

2,3

1,2,3

FCG SIGNS OF AORTIC INSUFFICIENCY

weakening of the 2 tone over the aorta, diastolic murmur over the aorta

weakening of the 2 tone over the aorta, systolic murmur over the aorta

amplification of 1 tone at the apex, systolic murmur at the apex

amplification of 2 tones over the aorta

amplification of 2 tones over the pulmonary artery

MYOCARDIAL SCINTIGRAPHY ALLOWS TO REVEAL

the size and localization of myocardial perfusion defects

heart defects

degree of heart failure

the degree of stenosis of the coronary vessels

myocardial contractility

FOR MYOCARDIAL INFARCTION OF THE ANTERIOR WALL OF THE LEFT VENTRICLE, THE MAIN LEADS ARE

I (II), AVL, V4 (V5)

III (II), AVF, V1-V2

I (II), AVR, V3-V4

II, III

III, АVF

DECREASE IN AMPLITUDE OF 1 TONE AT THE APEX, INCREASED AMPLITUDE OF 2 TONE ON THE PULMONARY ARTERY, SYSTOLIC NOISE AT THE APEX ARE CHARACTERISTIC FOR

mitral stenosis

aortic stenosis

mitral valve insufficiency

aortic valve insufficiency

tricuspid stenosis

ISCHEMIA IS REFLECTED ON THE ECG BY

T wave

P wave

R wave

QRS

S wave

A 3-MEMBER RHYTHM HAS BEEN REGISTERED ON THE PHONOCARDIOGRAM, 1 TONE IS DIVIDED, ITS AMPLITUDE IS REDUCED. WHAT IS THIS PHENOMENON CALLED IN THE CLINIC?

gallop rhythm

quail rhythm

mitral valve opening tone

atrial fibrillation

sinus arrhythmia

THE MOST INFORMATIVE METHOD FOR REVEALING THE DEGREE OF CORONARY STENOSIS IS

coronary angiography

ECG

radioisotope heart scan

echocardiography

scintigraphy

ABSOLUTE ECG-SIGN OF MYOCARDIAL INFARCTION IS

deep pathological Q wave

negative T wave

ST segment depression

ST segment elevation

splitting R

QT INTERVAL REFLECTS

electrical systole of the heart

electrical ventricular diastole

the phase of repolarization of the ventricular myocardium

phase of atrial excitation

relaxation of the ventricles

WHAT METHOD IS THE MOST INFORMATIVE TO DETECT HIDDEN ISCHEMIC HEART DISEASE

bicycle ergonomics

echocardiography

ECG

FCG

scintigraphy

NORMALLY, THE AMPLITUDE OF 1 TONE AT THE APEX IN RELATION TO THE 2 TONE IS

2:1

1:1

1:2

1,5:1

3:1

ECG - SIGNS OF ANGINA AND CORONARY ATHEROSCLEROSIS ARE

change in the final part of the ventricular complex and the T wave

prolongation of the P-Q interval

Q wave with an amplitude greater than 1/3 of the R wave and a duration of more than 0.03 sec.

prolongation of the Q-T interval

"frozen" rise of the ST segment above 2 mm from the isoline

CHARACTERISTIC FOR FUNCTIONAL DYSPHAGIA

occurs paroxysmally, during the passage of liquid food

is progressive

a patient has difficulty swallowing solid food

progressive in nature and occurs during the passage of liquid food

2nd and 3d are both correct

IRRADIATING PAIN, NAUSEA, REPEATED VOMITING ARE SIGNS OF

acute pancreatitis

acute cholecystitis

acute gastritis

acute enterocolitis

acute hepatitis

BROWN VOMITING LIKE "COFFEE GROUNDS"

gastric bleeding

swallowing blood during nosebleeds

esophageal bleeding

bleeding from the lower gastrointestinal tract

intestinal obstruction

WAVE-LIKE COURSE OF DISEASE WITH RECURSIONS IN SPRING AND AUTUMN IS CHARACTERISTIC FOR

peptic ulcer

tumor process

gastritis

pancreatitis

cirrhosis of the liver

FALSE PAINFUL REQUESTS FOR DEFECATION (TENEZMAS), SMALL PORTIONS OF FECES WITH MUCUS AND BLOOD ADVERSE ARE CHARACTERISTIC FOR DEFEAT?

large intestine

small intestine

esophagus

pancreas

liver

THE PATIENT DOES NOT HAVE INTESTINAL PERISTALSIS NOISES (BORBORYGMI) DURING AUSCULTATION OF THE ABDOMINAL THIS IS OBSERVED WHEN acute intestinal obstruction

acute perivisceritis

acute inflammation of the small intestine

gastric ulcer

duodenal ulcer

PROGRESSIVE CONSTIPATION WITH DELAYED PASSING GAS IS A SIGN OF

intestinal tumors

dyskinesia of the colon

inflammation of the small intestine

gastric ulcer

esophagitis

PAIN IN THE CHAUFFARD ZONE IN TYPICAL CASES INDICATES

damage to the pyloric part of the stomach, duodenum and/or head of the pancreas

defeat of the pyloric part of the stomach;

defeat of the duodenum;

damage to the duodenum and/or pyloric part of the stomach;

damage to the gastric body

PAIN IN THE EPIGASTRIC REGION, OCCURRING 1.5-2 HOURS AFTER EATING, IS A SIGN OF

stomach diseases

duodenum diseases

esophagus diseases

liver disease

gallbladder diseases

SIGNS OF ANGULAR STOMATITIS IS

angular cheilitis;

bright hyperemia of the oral mucosa, gums;

sharp hyperemia of the pharynx;

hyperemia of the oral mucosa, gums;

bright red tongue with atrophic papillae

VOMITING WITH EATEN FOOD

pyloric stenosis

gastric bleeding

duodenal ulcer

cholecystitis

pancreatitis

HUNTER’S GLOSSITIS IS CHARACTERIZED WITH

a bright red tongue, papillae atrophied

a tongue is covered with a yellowish coating, the papillae are hypertrophied

a tongue is densely coated with white coating, the papillae are hypertrophied

a swollen, enlarged tongue

an edematous, enlarged tongue with imprints of teeth along the edges

SYNDROME OF SO-CALLED ‘SMALL SIGNS" (WEAKNESS, FATIGUE, DECREASED WORK CAPABILITY, DEPRESSION, REDUCED APPETITE, GASTRIC DISCOMFORT)

stomach cancer

gastric ulcer

chronic colitis

duodenal ulcer

chronic cholecystitis

PERSISTENT ANOREXIA IS A SIGN OF:

duodenal ulcer

gastric ulcer

stomach cancer

gastritis

chronic cholecystitis

PERITONEAL MURMUR IS HEARD WHEN

gastric ulcer

gastritis

stomach cancer

inflammation of the peritoneum

esophagitis

A PATIENT SUFFERED FROM AN ULCER, LOCALIZED IN THE BULB OF THE DUODENUMS HAS CHANGED CLINICALLY: NOW HE HAS A FEELING OF HEAVINESS AFTER EATING, NAUSEA, ABUNDANT VOMITING USUALLY IN THE AFTERNOON, UNPLEASANT MOUTH SMELL, WEIGHT LOSS. THE FOLLOWING COMPLICATION OF THIS CASE MAY BE

organic stenosis of the pyloroduodenal zone

functional stenosis

ulcer malignancy

ulcer penetration

ulcer perforation

MELENA IS A

liquid black feces

discolored feces

fatty feces

scybalous stool

ribbon-like feces

A PATIENT SUFFERED FROM A GASTRIC ULCER HAS COMPLAINTS OF WEAKNESS, NAUSEA, LOSS OF APPETITE, PERMANENT PAIN IN THE EPIGASTRIC REGION, WEIGHT LOSS. THE FOLLOWING COMPLICATION OF THIS CASE MAY BE:

ulcer malignancy

stenosis of the outlet of the stomach

ulcer penetration

microbleeding from an ulcer

ulcer perforation

PARIETAL CELLS OF THE GASTRIC MUCOSA SECRETE

hydrochloric acid

lactic acid

gastromucoprotein

mucin

pepsinogen

MUCOUS CELLS OF THE GASTRIC MUCOSA SECRETE

Castle (gastric) factors

bicarbonates

gastrin

secretin

mucin

A PATIENT WITH NO PERISTALSIS NOISES (BORBORYGMI) DURING AUSCULTATION OF THE ABDOMINAL. THIS IS OBSERVED IN A CASE OF

acute intestinal obstruction

acute perivisceritis

acute inflammation of the small intestine

gastric ulcer

duodenal ulcer

PAIN IN THE SHOFFAR ZONE IN TYPICAL CASES IS INDICATED

damage to the pyloric part of the stomach, duodenum and/or head of the pancreas;

about the defeat of the pyloric part of the stomach;

about the defeat of the duodenum;

damage to the duodenum and/or pyloric part of the stomach;

damage to the body of the stomach

THE OCCURRENCE OF NAUSEA AND VOMITING AT THE HEIGHT OF AN ATTACK OF BILIARY COLIC IN A PATIENT WITH CHOLELITHIASIS CAN BE EXPLAINE BY THE

viscero-visceral reflex caused by a sharp increase in pressure in the bile ducts and irritation of the n. vagus

viscero-visceral reflex as a result of the transition of inflammation to the visceral and parietal peritoneum

frequent concomitant stomach damage (exacerbation of atrophic gastritis)

severe intoxication and direct excitation of the emetic center

a sharp increase in blood pressure at the time of colic

COURVOISIER 'S SYMPTOM IS CHARACTERIZED BY

enlarged, painless, elastic and mobile gallbladder in a patient with mechanical jaundice

enlarged, painless, elastic gallbladder, no jaundice

mechanical jaundice, the gallbladder is not enlarged, its palpation is painful

parenchymal jaundice, the gallbladder is not enlarged, its palpation is painful

the gallbladder is not palpable

… ARE SYNTHESIZED IN THE LIVER

albumins, fibrinogen, prothrombin

albumins, trypsin, fibrinogen

lipase, albumins, prothrombin

albumins, trypsin, fibrinogen, insulin

insulin, lipase, prothrombin

WITH VIRAL HEPATITIS, … JAUNDICE DEVELOPS

hepatic

suprahepatic

subhepatic

hemolytic

mechanica

JAUNDICE IN WHICH THE COJUGATED AND UNCOJUGATED BILIRUBIN IN THE BLOOD INCREASE SIMULTANEOUSLY IS CALLED

hepatic

suprahepatic

subhepatic

hemolytic

mechanical

GYNECOMASTIA IN LIVER DISEASES IS THE MANIFESTATION OF THE

hepatocellular insufficiency

portal hypertension

biliary dyskinesia

cholangitis

jaundice

LOCALIZATION OF PAIN IN DISEASES OF THE BILIARY EXCRETION ORGANS:

area of the right hypochondrium

left iliac region

right iliac region

pain in the umbilical region

area of the xiphoid process

LEMON YELLOW SKIN COLOR IS CHARACTERISTIC FOR … JAUNDICE:

hemolytic

parenchymal

mechanical

obstructive

subhepatic

THE APPEARANCE OF VASCULAR ASTERISKS INDICATES A LESION OF THE:

liver

lungs

intestines

heart

stomach

THE DISPLACEMENT OF THE UPPER BORDER OF THE LIVER DOWNWARDS IS POSSIBLE WITH THE:

subdiaphragmatic abscess

inflammatory process in the biliary tract

cirrhosis of the liver

low diaphragm position

emphysema of the lungs

JAUNDICE, IN WHICH BILIRUBIN AND UROBILINOIDS ARE DETECTED SIMULTANEOUSLY IN THE URINE, IS CALLED

suprahepatic

subhepatic

hepatic

hemolytic

mechanical

MINOR COMPLAINTS IN DISEASES OF THE LIVER AND BILIARY TRACT INCLUDE

reduced performance

itchy skin

pain in the right hypochondrium

increase in the size of the abdomen

jaundice

THE LOWER BORDERS OF THE LIVER DURING PERCUSSION ARE SHIFTED DOWNWARDS WHEN…IS

viral hepatitis

high diaphragm

reduction of liver size (the final stage of cirrhosis)

flatulence

pregnancy

THE CAUSE OF ITCHING IN PATIENTS WITH DISEASES OF THE LIVER AND BILIARY TRACT IS:

accumulation of bile acids in the blood

accumulation of nitrogenous slags in the blood

accumulation of sugar in the blood

accumulation of melanin

accumulation of cholesterol

A VASCULAR ASTERISK IS

pulsating angiomas rising above the surface of the skin

spotted rash with a diameter of 2-3 mm

round or oval, severely itchy blisters

slightly elevated hyperemic area

small punctate rash of the "urticaria" type

CRIMSON COLOURED TONGUE IS FOUND IN

liver diseases

stomach diseases

intestinal diseases

pancreatic diseases

diseases of the gallbladder

ORTNER'S SYMPTOM IS DETERMINED BY

tapping on the rib arches with the palm of the hand

palpation at the choledocho-pancreatic point

palpation at the right diaphragmatic nerve point

palpation in projection area of gallbladder

palpation around navel

PAINFULNESS IN THE CHAUFFEUR'S AREA IN TYPICAL CASES INDICATES

lesions of the pyloric part of the stomach, duodenum and/or head of the pancreas

lesion of the pyloric part of the stomach

a lesion of the duodenum

lesions of the duodenum and/or pyloric part of the stomach

a lesion in the body of the stomach

CHOLESTEROL DEPOSITION UNDER THE EPIDERMIS OF THE EYELIDS (XANTHELASMA) INDICATES AN ABNORMALITY IN

cholesterol metabolism

bilirubin metabolism

mineral metabolism

carbohydrate metabolism

purine metabolism

NORMAL TRANSVERSE SIZE OF THE SPLEEN IS

4 - 7 cm

2- 3 cm

10 - 12 cm

12 - 14 cm

15-20 cm

NORMAL LIVER DIMENSIONS ACCORDING TO KURLOV ARE

9x8x7cm

12x8x7cm

8x7x6cm

11x10x9cm

12x11x8 cm

INFLAMMATION OF THE GALLBLADDER IS CONFIRMED BY THE

Mussy-Georguievsky symptom

Voskresensky's symptom

Schetkin's symptom

Mendel's symptom

Botkin's symptom

AN ATTACK OF HEPATIC COLIC MAY BE ACCOMPANIED BY

subfebrile fever

vomiting of food eaten the day before

loose stools

increased appetite

weight loss.

PAINFULNESS IN THE CHAUFFEUR'S AREA IN TYPICAL CASES INDICATES

lesions of the pyloric part of the stomach, duodenum and/or head of the pancreas

lesion of the pyloric part of the stomach;

a lesion of the duodenum;

lesions of the duodenum and/or pyloric part of the stomach;

a lesion in the body of the stomach;

LOCALIZATION OF PAIN IN DISEASES OF THE BILIARY TRACT

the area of the right hypochondrium

left iliac region

right iliac region

pain in the umbilical region

xiphoid process area

STERCOBILINOGEN IN FAECES INCREASES WITH THE … JAUNDICE

suprahepatic

subhepatic

hepatic

mechanical

parenchymal.

DOWNWARD DISPLACEMENT OF THE UPPER LIVER BORDER IS POSSIBLE WITH

low standing aperture

inflammatory process in the biliary tract

cirrhosis of the liver

subphrenic abscess

emphysema

IN THE LIVER, … ARE SYNTHESISED

albumins, fibrinogen, prothrombin

albumins, trypsin, fibrinogen

lipase, albumin, prothrombin

albumins, trypsin, fibrinogen, insulin

insulin, lipase, prothrombin

SAFFRON COLOUR OF THE SKIN IS CHARACTERISTIC OF… JAUNDICE

parenchymal

hemolytic

mechanical

obstructive

suprahepatic

PSEUDOJAUNDICE IS CAUSED BY:

eating a lot of citrus fruits and carrots

accumulation of biliverdin

accumulation of bilirubin

eating a large amount of fatty foods

accumulation of cholesterol

COLICKY PAINS IN CHOLELITHIASIS ARE PROVOKED BY THE

heavy physical activity

eating more carbohydrates

taking diuretics

eating protein foods

eating plant fiber

EXAMINATION OF THE ABDOMEN ALLOWS YOU TO DETECT

expansion of the venous network around the navel

the shape and consistency of the liver

abdominal aortic aneurysms

the height of the diaphragm standing

lack of intestinal motility

ORTNER'S SYMPTOM IS POSITIVE IN

gall bladder inflammation

portal hypertension

fatty liver dystrophy

liver cirrhosis

gastritis

DYSPEPTIC COMPLAINTS IN DISEASES OF THE LIVER AND BILIARY TRACT INCLUDE EVERYTHING EXCEPT

perversion of taste

burping

vomiting

bloating and rumbling of the abdomen

bitter taste in the mouth

JAUNDICE, IN WHICH THERE IS UNCONJUGATED BILIRUBIN IN THE BLOOD, UROBILINOIDS IN THE URINE AND STERKOBILINOGEN IN THE FECES, IS CALLED

suprahepatic

subhepatic

hepatic

mechanical

parenchymal

LOCALIZATION OF PAIN IN DISEASES OF THE BILIARY TRACT:

the area of the right hypochondrium

left iliac region

right iliac region

pain in the umbilical region

xiphoid process area

INFLAMMATION OF THE GALLBLADDER IS CONFIRMED BY THE

the symptom of Mussy-Georgievsky

Voskresensky's symptom

Shchetkin's symptom

Mendel's symptom

Botkin's symptom.

NORMALLY, DURING PALPATION, THE EDGE OF THE LIVER HAS THE FOLLOWING PROPERTIES, EXCEPT

painful

sharp

rounded

easy to turn up

soft

THE SIZE OF THE LIVER ACCORDING TO KURLOV IS NORMAL

9x8x7cm

12x8x7cm

8x7x6 cm

11x10x9cm

12x 11x 8 cm

A VASCULAR ASTERISK IS

pulsating angiomas rising above the surface of the skin

spotted rash with a diameter of 2-3 mm

round or oval, severely itchy blisters

slightly elevated hyperemic area

small punctate rash of the "urticaria" type

X-RAY EXAMINATION OF THE STOMACH REVEALED A "NICHE", WHICH INDICATES

gastric ulcer

gastritis

stomach cancer

pancreatitis

ulcer perforation

“FILLING DEFECT” ON FLUOROSCOPY OF THE STOMACH OCCURS WITH

stomach cancer

gastritis

peptic ulcer

pancreatitis

ulcer penetration

WHAT DOES A CONSTANTLY POSITIVE REACTION TO OCCULT BLOOD IN THE FECES INDICATE WHEN EXAMINING A PATIENT

stomach cancer

gastritis

peptic ulcer.

hepatitis

cholecystitis

A POSITIVE REACTION TO LACTIC ACID IN GASTROINTESTINAL CONTENT INDICATES:

stomach cancer

hyperacid gastritis

duodenal ulcer

normoacid gastritis

gastric ulcer

AT IRRIGOSCOPY, A "FILLING DEFECT" IS NOTICED IN THE AREA OF THE SPLENIC ANGLE, THIS IS CHARACTERISTIC FOR

colon cancer

ulcerative colitis

dyskinesia of the large intestine

Crohn's disease

intestinal obstruction.

CREATORRHOEA IS CHARACTERISTIC OF

enteritis

hepatitis

duodenal ulcer

cholecystitis

colitis

A POSITIVE GREGERSEN TEST OCCURS WITH

stomach ulcer

pancreatitis

cholecystitis

gastritis

hepatitis

STEATORRHEA IS

a large amount of neutral fat in the feces

a large number of muscle fibers in the feces

increased amount of starch in stool

bile acids in the urine

a large amount of fatty acids in feces

AMYLORRHEA IS

increased amount of starch in stool

a large number of muscle fibers in the feces

a large amount of neutral fat in the feces

bile acids in the urine

a large amount of fatty acids in feces

MELENA IS

black liquid stool

"fatty", shiny, poorly washed off feces

discolored feces (gray)

feces with pieces of undigested food

black decorated feces

WITH TRADITIONAL DUODENAL LAVAGE IT IS POSSIBLE TO DETERMINE

composition of bile

motor function of the stomach

secretory function of the stomach

acidity of gastric juice

biliary dyskinesia

GASTRIC SECRETORY FUNCTION CAN BE DETERMINED WITH THE HELP OF

fractional lavage of the stomach

electrogastrography

duodenal lavage

EDS

radiography of the stomach

THE MOST INFORMATIVE TEST FOR DETERMINING GASTRIC SECRETION IS CONSIDERED

Kay's test

Lamblen test

Glass test

test with trial breakfast

submaximal test

WHAT IS CHARACTERISTIC FOR THE HYPOACID STATE?

diarrhea

constipation

heartburn

tenesmus

increased appetite

WHAT IS CHARACTERISTIC FOR THE HYPERACID STATE?

constipation

dysphagia

diarrhea

tenesmus

burps that have a rotten egg smell

THE PRESENCE OF CONNECTIVE TISSUE IN FAECES IS CHARACTERISTIC FOR

hypoacid gastritis

hyperacid gastritis

cholecystitis

gallstone disease

esophagitis

CHOLEMIA OCCURS WITH:

mechanical jaundice

cholecystitis

hemolytic jaundice

pancreatitis

peptic ulcer

AFTER RADIOSCOPY OF THE STOMACH, THE CONTRAST SUSPENSION IS DETERMINED 8 HOURS AFTER THE EXAMINATION, IT IS CHARACTERISTIC FOR

pyloric stenosis

the preserved evacuation function of the stomach

duodenal ulcer

gastritis

pancreatitis

A POSITIVE REACTION TO LACTIC ACID IN GASTROINTESTINAL CONTENT IS INDICATES:

stomach cancer

hyperacid gastritis

duodenal ulcer

normoacid gastritis

gastric ulcer

INDICATION FOR DUODENAL LAVAGE IS A SUSPECTED

helminthic invasion

cholelithiasis

duodenal ulcer

duodenitis

stomach ulcer

FOR PATIENTS WITH PYELONEPHRITIS THE MAIN COMPLAINTS ARE RELATED TO

pain in the lumbar region

anemia

normal body temperature

oliguria

painless urination

WHAT IS A SIGN OF A URINARY TRACT INFECTION?

dysuria

anemia

hypercholesterolemia

Kussmaul breathing

leukocytosis with a shift of the formula to the right

INDICATE THE FEATURES OF EDEMA IN RENAL DISEASES

starts from the face

appears in the evening

starts from the lower extremities

dense

cyanotic

WHAT IS NOCTURIA?

the predominance of nighttime diuresis over daytime

retention of urine

decrease in the specific gravity of urine

excretion of urine in small portions

urinary incontinence

WHAT IS ISOSTHENURIA?

monotonously reduced specific gravity of urine

decrease in the specific gravity of urine

the same volume of different portions of urine

increased specific gravity of urine

urinary incontinence

WHAT IS CHARACTERISTIC FOR THE NEPHROTIC SYNDROME?

hypercholesterolemia

pollakuria

anemia

oliguria

nocturia

POSITIVE PASTERNATSKY'S SYMPTOM HAPPENS WITH

pyelonephritis

glomerulonephritis

cystitis

hypertension

urethritis

WHAT IS A SIGN OF UREMIC COMA?

Kussmaul breathing

poliuria

hyperemic skin

nocturia

isostenuria

WHAT IS ANURIA?

excretion less than 50 ml of urine per day

excretion less than 500 ml of urine per day

excretion less than 200 ml of urine per day

excretion less than 300 ml of urine per day

excretion less than 250 ml of urine per day

WHAT IS A SIGN OF CHRONIC RENAL FAILURE?

increase in the level of blood creatinine

hyperemic skin

pain in the lumbar region

oliguria

edema

WHAT IS HEMATURIA?

the appearance of erythrocytes in the urine

the appearance of protein in the urine

the appearance of leukocytes in the urine

the appearance of cylinders in the urine

the appearance of sugar in the urine

CLINICAL SIGNS OF FACIES NEFRITICA ARE

swelling of the face, pale skin

swelling of the face, acrocyanosis

swelling of the face, hemorrhagic rash on the face

swelling of the face, hyperemia of the skin

swelling of the face, bronze coloration of the skin

IN POLYURIA, THE DAILY AMOUNT OF URINE EXCEEDS

2500 ml

1500 ml

800 ml

1000 ml

500 ml

THE MOST COMMON KIDNEY DISEASE IS

pyelonephritis

glomerulonephritis

kidney infarction

kidney cancer

kidney tuberculosis.

WHAT IS A SIGN OF CHRONIC RENAL FAILURE?

increase in the level of blood creatinine

hyperemic skin

pain in the lumbar region

oliguria

edema

WHAT IS A SIGN OF UREMIC COMA?

Kussmaul breathing.

poliuria

hyperemic skin

nocturia

isostenuria

WHAT IS CHARACTERISTIC FOR THE NEPHROTIC SYNDROME? hypercholesterolemia

pollakuria

anemia

oliguria

nocturia

WHAT IS A SIGN OF A URINARY TRACT INFECTION?

dysuria

anemia

hypercholesterolemia

Kussmaul breathing

leukocytosis with a shift of the formula to the right

POSITIVE PASTERNATSKY'S SYMPTOM HAPPENS WITH

urolithiasis

acute glomerulonephritis

diabetic nephropathy

cystitis

chronic glomerulonephritis

WHAT IS CHARACTERISTIC FOR THE NEPHROTIC SYNDROME?

hypercholesterolemia

pollakuria

anemia

oliguria

nocturia

ITCHING SKIN IN KIDNEY DISEASE IS CAUSED BY EXCESS LEVELS IN THE BLOOD OF

urea

bilirubin

sugar

uric acid

bile acids

WITH KIDNEY DISEASE, PATIENTS ARE RECOMMENDED A DIET

diet № 7

diet № 5

diet № 1

diet № 9

diet № 10

NAME THE SYMPTOM CHARACTERISTIC OF UREMIC PERICARDITIS

pericardial friction rub

pain in the region of the heart

increase in body temperature

accumulation of hemorrhagic fluid in the pericardial cavity

absence of azotemia

FOR PATIENTS WITH PYELONEPHRITIS THE MAIN COMPLAINTS ARE NOT RELATED TO

pain in the lumbar region

anemia

normal body temperature

oliguria

painless urination

SIGNS OF URINARY TRACT INFECTION INCLUDE

dysuria

anemia

hypercholesterolemia

Kussmaul breathing

leukocytosis with a shift of the formula to the right

HEMATURIA IS

the appearance of erythrocytes in the urine

the appearance of protein in the urine

the appearance of leukocytes in the urine

the appearance of cylinders in the urine

the appearance of sugar in the urine

INDICATIONS FOR THE ZIMNITRELATIVE CONTRASKY TEST IS

taking diuretics

heart defects

significant glucosuria

high blood pressure

taking antacids

NICTURIA IS

the predominance of nighttime diuresis over daytime

retention of urine

decrease in the specific weight of urine

excretion of urine in small portions

urinary incontinence

ISOSTENURIA IS

monotonously reduced specific weight of urine

decrease in the specific weight of urine

the same volume of different portions of urine

increased specific weight of urine

urinary incontinence

HYPOSTHENURIA IS

decrease in the specific weight of urine

decrease in the amount of urine

decreased frequency of urination

urinary incontinence

lack of urine

PYURIA IS

the appearance of pus in the urine

the appearance of erythrocytes in the urine

the appearance of protein in the urine

the appearance of cylinders in the urine

the appearance of sugar in the urine

FUNCTIONAL TEST IN KIDNEY DISEASES IS

Zimnitsky test

Nechiporenko test

Addis-Kakovsky test

three-glass urinalysis

Thompson test

THE THREE-GLASS THOMPSON TEST IS CARRIED OUT TO REVEAL A PATHOLOGICAL PROCESS IN

urinary tract

liver

lungs

intestines

spleen

URINE ANALYSIS ACCORDING TO NECHIPORENKO IS CARRIED OUT FOR

detection of the ratio of leukocytes and erythrocytes in 1 ml of urine

detection of protein in the urine

detection of glucose in the urine

detection of nocturia

detection of isosthenuria

POLLAKIURIA IS CHARACTERISTIC FOR

cystitis

kidney cancer

glomerulonephritis

kidney amyloidosis

kidney infarction

THE SPECIFIC WEIGHT OF NORMAL URINE VARIES WITHIN

1012-1028

1030-1036

1002-1012

1005-1015

1022-1040

URINE PH (URINE REACTION) NORMALLY EQUALS

5,0-7,0

4,0-4,5

6,5-9,5

2,0-3,5

2,0-8,0

ACIDIC REACTION OF URINE HAPPENS WITH

the predominance of animal proteins in the diet

the predominance of plant foods

the predominance of dairy food

with inflammatory processes in the kidneys

the predominance of plant and dairy foods

INCREASE IN URIC ACID IN URINE IS CHARACTERISTIC FOR

gout

glomerulonephritis

diabetes

pyelonephritis

kidney infarction.

STANDARDS FOR GLOMERAL FILTRATION

80-120ml/min

40-60 ml/min

160-180ml/min

40-120ml/min

100-180ml/min.

EXECRETORY UROGRAPHY IS CONTRAINDICATED IN

chronic renal failure

chronic pyelonephritis

acute pyelonephritis

urolithiasis

cystitis

RENAL CONCENTRATION FUNCTION IS ASSESSED BY

Zimnitsky's test

analysis according to Nechiporenko

three glass Thompson test

general urinalysis

sugar analysis.

THE FOLLOWING URINE IS REQUIRED FOR THE DETERMINATION OF GLOMERAL FILTRATION

daily urine

50 ml

500 ml

250 ml

1000 ml

THE ZIMNITSKY TEST ALLOWS TO ASSESS THE FOLLOWING KIDNEY FUNCTIONS

concentration

nitrogen-releasing

contractile

erythropoietic

detoxification.

THE NUMBER OF ERYTHROCYTES IN THE SAMPLE ACCORDING TO NECHIPORENKO NORMALLY SHOULD NOT EXCEED

1000

100

2000

4000

250

GLUCOSURIA IS CHARACTERISTIC FOR

diabetes

acute glomerulonephritis

acute pyelonephritis

urolithiasis

gout

BACTERIOLOGICAL STUDY OF URINE MUST DE PERFORMED WITH

pyelonephritis

glomerulonephritis

pneumonia

kidney infarction

kidney cancer

FOR THE TERMINAL STAGE OF CHRONIC RENAL FAILURE THE FOLLOWING INDICATORS OF GLOMERAL FILTRATION ARE CHARACTERISTIC

50-60ml/min

80-120 ml/min

30-40ml/min

less than 20 ml/min

more than 120 ml/min

THE NUMBER OF CYLINDERS IN THE NECHIPORENKO TEST SHOULD NOT EXCEED

250

100

1000

2000

1500

IN POLYURIA, DAILY URINE EXCEEDS

2500 ml

1500 ml

800 ml

1000 ml

500 ml

THE RATIO OF DAY TO NIGHT DIURESIS IS

3 : 1

2 : 1

1 : 1

1 : 2

1 : 3

LESS THAN 50 ML OF URINE PER DAY INDICATES

anuria

oliguria

polyuria

pollakiuria

stranguria

DECREASED GLOMERULAR FILTRATION IN CHRONIC GLOMERULONEPHRITIS CAN BE DETECTED BY

Rehberg-Tareev test

Zimnitsky test

test according to Nechiporenko

Addis-Kakovsky test

general urinalysis

BACTERIOLOGICAL STUDY OF URINE MUST BE PERFORMED WITH

pyelonephritis

glomerulonephritis

pneumonia

kidney infarction

kidney cancer

TO CLINICAL VARIANTS OF THE COURSE OF CHRONIC GLOMERULONEPHRITIS CAN BE ATTRIBUTED

latent

hypotonic

nephrosclerotic

nephritic

causes anuria

ANURIA IS

excretion less than 50 ml of urine per day

excretion more than 1500 ml of urine per day

excretion less than 500 ml of urine per day

excretion of more than 500 ml of urine per day

the absence of urine

NEPHROTIC SYNDROME INCLUDES

proteinuria

anemia

hypotension

hyperbilirubinemia

hypertension

CAUSE OF ACUTE RENAL FAILURE IS

transfusion of incompatible blood

kidney amyloidosis

diabetic nephropathy

kidney tumor

hypertensive nephropathy

THE MAIN SYMPTOM OF GLOMERULONEPHRITIS IS:

increased blood pressure

pain in the heart

cough

acrocyanosis

pyuria

HIGH SPECIFIC WEIGHT OF URINE IS CHARACTERISTIC FOR

chronic glomerulonephritis

pyelonephritis

diabetes mellitus

hypertension

chronic renal failure

GLOMERULONEPHRITIS IS A SINGLE PROCESS

no

yes

if caused by a specific pathogen

if it occurs in childhood

if it occurs in old age

PYURIA OCCURS WITH

pyelonephritis

glomerulonephritis

kidney cancer

kidney amyloidosis

chronic renal failure

UREMIA DEVELOPS WITH

chronic glomerulonephritis

acute pyelonephritis

acute glomerulonephritis

urolithiasis

cystitis

FOR PATIENTS WITH PYELONEPHRITIS, THE MAIN COMPLAINTS

INCLUDES

edema

anuria

temperature decrease

pain in the cervical region

hypercholesterolemia

WHAT IS CHARACTERISTIC IN URINALYSIS FOR

GLOMERULONEPHRITIS?

proteinuria

bacteriuria

glucosuria

isostenuria

bilirubinuria

DYSURIA IS

disorder of urination

protein detection in urine

detection of cylinders in the urine

detection of bacteria in the urine

detection of erythrocytes in urine.

STAGES OF ACUTE RENAL FAILURE INCLUDES

oligoanuric

polyuric

stage of albuminuria

stage of hypercholesterolemia

stage of glucosuria

URINE THE COLOR OF "MEAT SLOPS" IS CHARACTERISTIC FOR

glomerulonephritis

pyelonephritis

diabetic nephropathy

kidney amyloidosis

urolithiasis

THE CLASSIC TRIAD OF SYMPTOMS OF ACUTE

GLOMERULONEPHRITIS INCLUDES

hematuria

hypotension

glucosuria

hemorrhagic rash

edema

THE FOLLOWING STRUCTURES ARE AFFECTED WITH

GLOMERULONEPHRITIS

vessels of the renal glomeruli

pelvicalyceal system

ureters

bladder

urethra

INCREASE IN URIC ACID IN URINE IS CHARACTERISTIC FOR

gout

glomerulonephritis

diabetes

pyelonephritis

kidney amyloidosis

A POSITIVE SYMPTOM OF PASTERNATSKY IS DETERMINED WITH

pyelonephritis

diabetic nephropathy

glomerulonephritis

chronic renal failure

hypertensive nephropathy

BACTERIURIA IS CHARACTERISTIC FOR

pyelonephritis

glomerulonephritis

kidney cancer

kidney amyloidosis

polycystic kidney disease

PYELONEPHRITIS MAY BE A ONE-SIDED PROCESS

yes

no

if caused by a specific pathogen

if it occurs in childhood

if it occurs in old age

WHAT IS CHARACTERISTIC FOR NEPHROTIC SYNDROME?

high specific weight of the urine

the absence of cylindria

the presence of hematuria

the presence of leukocytes

the presence of bacteria

A COMPLICATION OF ACUTE GLOMERULONEPHRITIS IS

renal eclampsia

renal colic

acute myocardial infarction

pyelonephritis

cystitis

GLOMERULONEPHRITIS IS

infectious-allergic disease

infectious disease

allergic disease

hereditary disease

viral disease.

URINE OF THE COLOR OF "MEAT SLOPS" IS CHARACTERISTIC FOR

glomerulonephritis

pyelonephritis

diabetic nephropathy

kidney amyloidosis

urolithiasis

A FEATURE OF EDEMA IN RENAL DISEASES

starts from the face

appears at the end of the day

starts from the feet

starts from the lumbar region

has a "cyanotic" tint

THE LEADING ROLE IN THE ETIOLOGY OF PYELONEPHRITIS IS

ASSIGNED TO

klebsiella

E. coli

staphylococcus

streptococcus

proteus

CHANGES IN THE PYELOCALICEAL SYSTEM ARE CHARACTERISTIC

FOR

glomerulonephritis

pyelonephritis

cystitis

urethritis

acute renal failure.

WHAT LEADS TO THE DEVELOPMENT OF CHRONIC RENAL

FAILURE?

chronic glomerulonephritis

acute glomerulonephritis

acute pyelonephritis

hemorrhagic cystitis

urethritis

CHANGES IN THE PYELOCALICEAL SYSTEM ARE CHARACTERISTIC

FOR

pyelonephritis

glomerulonephritis

cystitis

urethritis

acute renal failure

THE MOST COMMON CAUSE OF ACUTE GLOMERULONEPHRITIS IS

NOT

dysentery

scarlet fever

tonsillitis

streptoderma

pneumonia

ECLAMPSIA CAN COMPLICATE THE COURSE

acute glomerulonephritis

chronic pyelonephritis

acute pyelonephritis

chronic glomerulonephritis

urolithiasis

INCREASED BLOOD PRESSURE IS CHARACTERISTIC FOR THE

FOLLOWING CLINICAL VARIANT OF THE COURSE OF CHRONIC

GLOMERULONEFRITIS

nephrotic

mixed

latent

slowly progressive

rapidly progressive.

PYURIA OCCURES WITH

pyelonephritis

acute glomerulonephritis

kidney cancer

kidney amyloidosis

chronic glomerulonephritis.

THE MAIN ETIOLOGICAL FACTOR OF ACUTE

GLOMERULONEPHRITIS IS

ß-hemolytic streptococcus group A

klebsiella

staphylococcus

pseudomonas aeruginosa

pneumococcus

THE CLASSIC TRIAD OF SYMPTOMS OF ACUTE

GLOMERULONEPHRITIS INCLUDES

edema, hypertension, hematuria

edema, dyspnea, hematuria

edema, hypertension, palpitations

edema, hematuria, palpitations

shortness of breath, hypertension, palpitations

THE ANTERIOR LOBE OF THE PITUITARY PRODUCES

adrenocorticotropic

parathormone

thyroxine

testosterone

vasopressin

ENDOCRINE GLANDS WITH MIXED SECRETION ARE

pancreas, gonads

pituitary gland, parathyroid glands, pancreas

adrenal glands, pancreas

thyroid gland, parathyroid glands

pituitary gland, adrenal glands, pancreas

BRONZE COLORING OF THE SKIN IS CHARACTERISTIC FOR

Addison's disease

diabetes

thyrotoxicosis

pheochromocytoma

myxedema

STRIAE ARE

longitudinal and transverse stripes corresponding to skin folds resulting from catabolic effects steroid hormones

changes in subcutaneous tissue due to insulin injections

deposition of cholesterol on the skin of the eyelids

blush on the cheeks, on the forehead, in the area of the upper eyelids due to expansion of the skin capillary network

the gap between the front teeth

A CHARACTERISTIC SIGN OF ACROMEGALY IS

an increase in the size of distal limbs

bronze coloration of the skin

dryness, peeling of the skin

weight loss

exophthalmos

THE III DEGREE OF ENLARGEMENT OF THE THYROID GLAND (ACCORDING TO NIKOLAEV) IS

symptom of "fat neck"

palpable isthmus

large goiter

huge goiter

slightly palpable lobules of the thyroid gland

MOON FACE IS CHARACTERISTIC FOR

Itsenko-Cushing's disease

Graves' disease

myxedema

acromegaly

Addison's disease.

«FACIES MECSEDEMA» IS

apathetic, wide, round with a yellowish tinge, a fixed look

round, moon face with a pronounced blush, thinned skin

a face with wide open, bulging, rarely blinking eyes

a sharp development of the superciliary arches, a disproportionately large size of the nose, lips, growth of the lower jaw

icteric face, scleral

EXOPHTHALMOS IS

bulging eyes

rare blinking

tremor of closed eyelids

drooping of the upper eyelid

retraction of the eyeball.

DIASTEMA IS

the gap between the front teeth

change in subcutaneous fat due to insulin injections

deposition of cholesterol on the skin of the eyelids

longitudinal and transverse stripes corresponding to skin folds resulting from the catabolic effect of steroid hormones

rare blinking.

HIRSUTISM IS

male pattern hair growth in women

bald patches at the temples, deep voice, broad shoulders, narrow pelvis, hypotrophy of the mammary glands

fragility of nails, hair loss on the head, distal eyebrows, eyelash loss

complete baldness

change in subcutaneous fat due to insulin injections

VON GRAEFE'S SIGN IS

the appearance of a white strip of sclera between the edge of the eyelid and the iris when the eyeball moves down

small tremor of closed eyelids

wide open palpebral fissures

eye glitter

rare blinking

DIASTEMA IS CHARACTERISTIC FOR

acromegaly

thyrotoxicosis

diabetes mellitus

myxedema

Addison's disease

STRIAE ARE OBSERVED WITH

Itsenko-Cushing's disease

diabetes mellitus

acromegaly

Addison's disease

myxedema

BMI EQUAL TO 30 KG/M2 IS

I class of obesity

cachexia

excess body weight

III class of obesity

normal body weight

WHAT IS CHARACTERISTIC FOR OBESITY OF PITUITARY ETIOLOGY

deposition of fat in the face, chest, upper and middle abdomen, non-spread to the limbs

even distribution of subcutaneous fat

fat deposition mainly in the pelvis, buttocks, thighs

pear-type fat deposition

deposition of fat in the upper abdomen

GIANTISM CAN BE DIAGNOSED WITH

hypogonadism, increased function of the anterior pituitary gland

diabetes mellitus, hypothyroidism

increased function of the anterior pituitary gland, hypothyroidism

hypogonadism, diabetes mellitus

diabetes mellitus, thyrotoxicosis

"OBSTETRICIAN'S HAND" CAN BE DIAGNOSED WITH

insufficiency of the function of the parathyroid glands

diabetes mellitus

hypothyroidism

Addison's disease

Itsenko-Cushing's disease

BRONZE COLORING OF THE SKIN IS CHARACTERISTIC FOR

Addison's disease

diabetes

thyrotoxicosis

pheochromocytoma

myxedema

STRIAE ARE

longitudinal and transverse stripes corresponding to skin folds resulting from catabolic effects steroid hormones

changes in subcutaneous tissue due to insulin injections

deposition of cholesterol on the skin of the eyelids

blush on the cheeks, on the forehead, in the area of the upper eyelids due to expansion of the skin capillary network

the gap between the front teeth

"FACIES BASEDOVICA" IS OBSERVED IN PATIENTS WITH

thyrotoxicosis

diabetes mellitus

acromegaly

hypothyroidism

Addison's disease

RUBEOSIS IS

blush on the cheeks, on the forehead, in the area of the upper eyelids due to the expansion of the skin capillary network

change in subcutaneous fat due to insulin injections

deposition of cholesterol on the skin of the eyelids

longitudinal and transverse stripes corresponding to skin folds resulting from the catabolic effect of steroid hormones

the gap between the front teeth

WHAT IS CHARACTERISTIC FOR DIABETES MELLITUS?

polydipsia

anuria

oliguria

lack of appetite

vomiting bile

THE NORMAL LEVEL OF GLUCOSE IN THE CAPILLARY BLOOD DURING FASTING IS

3,3-5,5 mmol/l

7,3-9,5 mmol/l

1,5-2,7 mmol/l

6,1-7,8 mmol/l

7,8-11,1 mmol/l

WHAT IS CONTRA-INSULAR HORMONE?

catecholamines

aldosteron

testosteron

prolactin

glucagon

WHAT IS USED FOR DIAGNOSIS OF OBVIOUS DIABETES MELLITUS?

determination of fasting blood sugar

glucose tolerance test

determination of blood sugar during the day

the level of insulin in the blood

the level of glycosylated hemoglobin

WHAT IS CHARACTERISTIC FOR TYPE 1 DIABETES MELLITUS?

tendency to ketoacidosis

development in old age

development against the background of overweight

easy course of the disease.

development of the disease at a young age

WHAT IS CHARACTERISTIC FOR TYPE 2 DIABETES MELLITUS?

development in old age

development at a young age

development in childhood

fast development

tendency to ketoacidosis.

SKIN CHANGES THAT ARE CHARACTERISTIC FOR DIABETES MELLITUS

rubeosis

hyperemic skin

bluish skin color

striae

wet skin

GLUCOCORTICOIDS LEAD TO

increase in blood sugar

lower blood sugar levels

do not affect blood sugar levels

hypoglycemia

aglucosuria

DIABETES MELLITUS IS DIAGNOSED WITH FASTING BLOOD SUGAR LEVEL

7.8 mmol/l

6.0 mmol/l

5.4 mmol/l

5.0 mmol/l

5.6 mmol/l

WHAT IS OBSEDVED IN TYPE 1 DIABETES?

absolute insulin deficiency

relative insulin deficiency

insulin resistance

hyperinsulinemia

easy course of the disease.

WHAT IS OBSEDVED IN TYPE 2 DIABETES

relative insulin deficiency

absolute insulin deficiency

tendency to ketoacidosis

labile course

severe clinical symptoms.

WHAT IS USED FOR DIFFERENTIAL DIAGNOSIS OF TYPE 1 AND 2 DIABETES MELLITUS?

C-peptide

glucose tolerance test

determination of blood sugar during the day

determination of ketone bodies in the blood

determination of glycosylated hemoglobin.

WHEN A GLUCOSE TOLERANCE TEST IS PERFORMED, DIABETES MELLITUS IS DIAGNOSED IN CASE OF THE FOLLOWING RESULTS

fasting blood sugar level ≥6,1 mmol/l, 2 hours after glucose load ≥11,1 mmol/l

fasting blood sugar level <6,1 mmol/l, 2 hours after glucose load ≥7,8 и <11,1 mmol/l

fasting blood sugar level <6,1 mmol/l, 2 hours after glucose load <7,8 mmol/l

fasting blood sugar level <6,1 mmol/l, 2 hours after glucose load <11,1 mmol/l

random measurement of blood glucose <11.1 mmol/l

CRITERIA FOR IMPAIRED GLUCOSE TOLERANCE ARE

fasting blood sugar level <6,1 mmol/l, 2 hours after glucose load ≥7,8 и <11,1 mmol/l

fasting blood sugar level ≥6,1 mmol/l, 2 hours after glucose load ≥11,1 mmol/l

fasting blood sugar level >6,1 mmol/l, 2 hours after glucose load ≥7,8 и <11,1 mmol/l

with random determination of blood sugar ≥11,1 mmol/l

fasting blood sugar level <6,1 mmol/l, 2 hours after glucose load <7,8 mmol/l

MAIN FACTORS OF THE PATHOGENESIS OF TYPE 1 DIABETES MELLITUS ARE

β-cell destruction and insulin deficiency

insulin resistance and β-cell destruction

insulin deficiency and an increase in contra-insular hormones

insulin resistance

increased production of glucose by the liver.

CRITERION FOR DETERMINING SEVERE DIABETES MELLITUS IS

the presence and severity of complicationst

determination of the patient's body weight

the use of hypoglycemic therapy

he level of glycemia

dose of hypoglycemic drugs.

IN THE DIET OF A PATIENT WITH DIABETES MELLITUS IT IS POSSIBLE TO RECOMMEND IN UNLIMITED QUANTITY

lettuce leaves

oil

potatoes

milk

chocolate

POSTPRANDIAL GLYCEMIA IS

blood glucose levels before meals

blood glucose levels at night

blood glucose level within 2 hours after eating

blood glucose level at any time

fasting blood glucose level

DETERMINATION OF GLYCATED HEMOGLOBIN ALLOWS TO JUDGE ABOUT

degree of compensation of carbohydrate metabolism

degree of compensation of protein metabolism

degree of compensation of fat metabolism

basal metabolic disorder.

type of diabetes

THE DIAGNOSIS OF DIABETES MELLITUS IS MADE WITH FASTING BLOOD SUGAR LEVEL IN CAPILLARY BLOOD EQUAL

6,1 mmol/l

6,7 mmol/l

7,8 mmol/l

11,1 mmol/l

5,5 mmol/l

DIABETES MELLITUS IS DIAGNOSED BY RANDOM DETERMINATION OF GLYCEMIA IN CAPILLARY BLOOD AT ANY TIME AT ITS LEVEL

11,1 mmol/l

7,8 mmol/l

6,1 mmol/l

5,5 mmol/l

9,1 mmol/l

SERUM C-PEPTIDE LEVEL IS INVESTIGATED FOR

definitions of the type of diabetes

diagnostics of impaired glucose tolerance

diagnosis of diabetes mellitus

diagnosis of impaired fasting glycemia

determination of diabetes compensation.

FASTING BLOOD SUGAR LEVEL IS

blood glucose level in the morning before breakfast after

preliminary fasting for 8 hours

blood glucose level immediately after a meal

blood glucose level in the morning before breakfast, regardless of the time of the last meal

blood glucose level at 3 am

blood glucose levels before bedtime.

WHAT IS CHARACTERISTIC FOR TYPE 1 DIABETES MELLITUS?

tendency to ketoacidosis

development in old age

development against the background of overweight

easy course of the disease.

development of the disease at a young age

WHAT IS CHARACTERISTIC FOR TYPE 2 DIABETES MELLITUS?

development against the background of overweight

development against the background of normal body weight

development against the background of reduced body weight

development at a young age

development in childhood

WHAT IS CONTRA-INSULAR HORMONE?

catecholamines

aldosteron

testosteron

prolactin

glucagon

SKIN CHANGES THAT ARE NOT CHARACTERISTIC FOR DIABETES MELLITUS

rubeosis

hyperemic skin

bluish skin color

striae

wet skin

SERUM IRON LEVELS WITH WHICH CHRONIC IRON DEFICIENCY ANEMIA CAN BE SUSPECTED:

6-12 µmol/l

12-20 µmol/l

20-30 µmol/l

30-40 µmol/l

40-50 µmol/l

THE HEMATOPOIETIC SYSTEM INCLUDE

kidneys

liver

heart

gonades

lymphoid tissue system.

EXAMINATION OF THE TONGUE AND MUCOUS MEMBRANE OF THE MOUTH CAVITY REVEAL

atrophic glossitis

epiglossitis

tonsillitis

koilonychia

sinusitis

ENLARGEMENT OF THE LYMPH NODES IS CHARACTERISTIC OF:

lymphocytic leukemia

hemolytic anemia

iron deficiency anemia

hemorrha

gic diathesis

posthemorrhagic anemia.

TRANSVERSE SIZE OF THE SPLEEN IN THE NORM IS

4 – 7 cm

2- 3 cm

10 – 12 cm

12 – 14 cm

15- 20 cm

KOILONYCHIA IS

spoon-shaped depressions of the nails

bulge of nails in the form of watch glasses

transverse striation of nails

brittle nails

fungal nail infection

LEUKEMOID REACTION IS CHARACTERISTIC FOR

inflammatory process or focus of necrosis

chronic leukemia

acute leukemia

aplastic anemia

erythremia

THE SEQUENCE OF THE MAIN CLASSES OF HEMATOPORTIC CELLS IN BONE MARROW, STARTING FROM STEM CELLS

stem, semi-stem, unipotent, dividing cells (blasts), maturing cells, mature cells

stem, semi-stem, maturing cells, mature cells

stem, unipotent, dividing cells (blasts), maturing cells, mature cells

stem, unipotent, maturing cells, dividing cells (blasts), mature cells

blasts, maturing cells, mature cells.

THE PERCENTAGE RATIO OF INDIVIDUAL FORMS OF LEUKOCYTES IS CALLED

color index

leukocyte formula

hematocrit

leukemic gap

ESR

THE MAIN FUNCTION OF ERYTHROCYTES IS

transport of oxygen and CO2

participation in buffer reactions of blood

participation in the processes of digestion

carbohydrate transport

immunity

LEUKOCYTES CARRY OUT THE FOLLOWING FUNCTIONS

immune reactions

transport of hormones

maintenance of oncotic pressure of blood plasma

CO2 and O2 transport

transport of glucose into the cell.

IN THE BLOOD OF A HEALTHY MAN THE LEVEL OF HEMOGLOBIN IS

130-160 g/l

100-110 g/l

170-200 g/l

90-100 g/l

90-130 g/l

JAUNDICE IS CHARACTERISTIC FOR

B12 deficiency anemia

iron deficiency anemia

hemolytic anemia

erythremia

acute leukemia

WHAT IS NOT CHARACTERISTIC FOR ERYTHREMIA?

thrombocytopenia

ESR slowdown

increase in hemoglobin

leukocytosis

erythrocytosis

BOTKIN-GUMPRECHT CELLS ARE FOUND IN THE BLOOD WITH

chronic lymphocytic leukemia

chronic myeloid leukemia

acute myeloid leukemia

chronic iron deficiency anemia

aplastic anemia

CHARACTERISTIC SIGN OF APLASTIC ANEMIA

pancytopenia

macrocytosis

poikilocytosis

increase in the level of iron in the blood serum

hypochromia

LEUKEMIC GAP IS CHARACTERISTIC FOR

acute leukemia

anemia

chronic leukemia

polycythemia

inflammatory reaction of the blood

THE APPEARANCE OF ERYTHROCYTES OF DIFFERENT SIZES IN THE BLOOD IS NAMED

anisocytosis

poikilocytosis

microcytosis

macrocytosis

hypochromia

A REDUCTION IN THE NUMBER OF RETICULOCYTES IS NOT CHARACTERISTIC FOR

acute posthemorrhagic anemia

leukemia

aplastic anemia

chronic iron deficiency anemia

chronic posthemorrhagic

THE APPEARANCE OF ERYTHROCYTES OF DIFFERENT SIZES IN THE BLOOD IS NAMED

anisocytosis

poikilocytosis

microcytosis

macrocytosis

hypochromia

WHEN EXAMINING A PATIENT WITH ERYTHREMIA SKIN COVERS ARE

cherry red

pale

icteric

bronze

cyanotic

THE PERCENTAGE OF NEUTROPHILS TO ALL LEUKOCYTES IN THE BLOOD OF A HEALTHY PERSON IS

50-70 %

5-10 %

40-65 %

10-20 %

0-40%.

THE DESTRUCTION OF ERYTHROCYTES HAPPENS IN

liver and spleen

liver

spleen

red bone marrow and liver

red bone marrow

LEUKOPENIA IS CHARACTERISTIC FOR

flu

pneumonia

sepsis

cystitis

myocardial infarction

THE ERYTHROCYTE SEDIMENTATION RATE IS INCREASED WITH

polycythemia

sepsis

myocardial infarction

infectious and inflammatory process

anemia

THE PERIPHERAL ORGANS OF THE IMMUNE SYSTEM INCLUDE

lymph nodes

intestines

red bone marrow

teeth

none of the above

COLOR INDEX IS

the degree of saturation of erythrocytes with hemoglobin

the ratio of young and mature neutrophils

percentage of saturation of hemoglobin with oxygen

ratio of red blood cells to hemoglobin

the percentage of individual forms of leukocytes.

THE MOST VARIABLE GROUP OF LEUKOCYTES DURING INFLAMMATION ARE

lymphocytes

neutrophils

monocytes

eosinophils

basophils

RETICULOCYTES ARE

immature red blood cells

immature forms of leukocytes

eosinophils

neutrophils

immature forms of platelets

JOLLY BODIES AND CABOT RINGS ARE CHARACTERISTIC FOR

B12 deficiency anemia

chronic lymphocytic leukemia

iron deficiency anemia

aplastic anemia

erythremia

PHYSIOLOGICAL LEUKOCYTOSIS IS OBSERVED

after eating

with anemia

with inflammation

with erythremia

with acute leukemia

"PERVERSION OF TASTE" IS CHARACTERISTIC FOR

iron deficiency anemia

aplastic anemia

hemolytic anemia

acute leukemia

B12 deficiency anemia

LEFT SHIFT OF THE LEUKOCYTE FORMULA IS CALLED

the appearance of young immature forms of neutrophils in the blood

lymphocytopenia

neutropenia

eosinophilia

basophilia

A POSITIVE COOMBS TEST CONFIRMS THE DIAGNOSIS

thrombocytopenic purpura

hemolytic anemia

B12 deficiency anemia

iron deficiency anemia

acute leukemia

AN INCREASE IN THE LEVEL OF RETICULOCYTES IN THE BLOOD IS CHARACTERISTIC OF

acute blood loss

chronic blood loss

aplastic anemia

acute leukemia

thrombocytopenic purpura

NAME THE FACTOR THAT IS NECESSARY FOR THE ABSORPTION OF VITAMIN B12

gastromucoprotein

gastrin

hydrochloric acid

pepsin

folic acid

WHAT IS CHARACTERISTIC FOR PLETHORIC SYNDROME WITH ERYTHREMIA?

all of the above are correct

increase in blood pressure numbers

pancytosis

burning sensation in the fingertips

dizziness, ringing in the ears

ENLARGEMENT OF THE LYMPH NODES IS CHARACTERISTIC OF

lymphogranulomatosis

hemolytic anemia

thrombocytopenic purpura

iron deficiency anemia

B12 deficiency anemia

SERUM IRON CONTENT IN WHICH WE MAY SUSPECT CHRONIC IRON DEFICIENCY ANEMIA

6-12 µmol/l

12-20 µmol/l

20-30 µmol/l

30-40 µmol/l

40-50 µmol/l.

WHAR IS A SIGN OF SIDEROPENIC SYNDROME?

angular stomatitis

gastritis

anemia

esophagitis

secretory insufficiency of the stomach.

BOTKIN-GUMPRECHT CELLS ARE DETECTED IN:

chronic lymphocytic leukemia

chronic myeloid leukemia

acute myeloid leukemia

myeloma

B12 deficiency anemia.

ENLARGEMENT OF LYMPH NODES IS CHARACTERISTIC FOR

lymphocytic leukemia

hemolytic anemia

iron deficiency anemia

hemorrhagic diathesis

posthemorrhagic anemia

LYMPHOADENOPATHY IS

enlarged lymph nodes

lymphocytosis in peripheral blood

high lymphoblastosis in sternal punctate

leukemic infiltration of lymph nodes

suppuration of the lymph nodes

KOILONICHIA IS

spoon-shaped depressions of the nails

bulge of nails in the form of watch glasses

transverse striation of nails

brittle nails

fungal nail infection

LEUKEMOID REACTION IS CHARACTERISTIC FOR

inflammatory process or focus of necrosis

chronic leukemia

acute leukemia

aplastic anemia

erythremia

WHAT IS CHARACTERISTIC FOR IRON DEFICIENCY ANEMIA?

hypochromia, microcytosis, increased iron-binding serum abilities

hypochromia, microcytosis, target erythrocytes

hypochromia, microcytosis, sideroblasts in sternal punctate

microcytosis, decreased iron-binding capacity serum

hyperchromia, macrocytosis

WHAT IS A SIGN OF ANEMIC SYNDROME?

flies flashing in front of the eyes

bradycardia

increased appetite

hypertension

edema

INDICATE THE CLINICAL MANIFESTATIONS OF SIDEROPENIC SYNDROME

perversion of taste and smell

yellowness of the skin

hyperemia of the skin

unsteadiness of gait

normal serum iron content

LYMPHOADENOPATHY IS

enlarged lymph nodes

lymphocytosis in peripheral blood

high lymphoblastosis in sternal punctate

leukemic infiltration of lymph nodes

suppuration of the lymph node

WHAT IS CHARACTERISTIC FOR ERYTHREMIA?

erythrocytosis

hypertension

increase in hemoglobin

leukopenia

iron deficiency

BOTKIN-GUMPRECHT CELLS ARE DETECTED IN:

chronic lymphocytic leukemia

chronic myeloid leukemia

acute myeloid leukemia

chronic iron deficiency anemia

aplastic anemia

LEUKEMIC GAP IS CHARACTERISTIC FOR

acute leukemia

anemia

chronic leukemia

polycythemia

inflammatory reaction of the blood

WHAT IS CHARACTERISTIC FOR THROMBOCYTOPENIC PURPLE?

decrease in the number of platelets in peripheral blood

increase in the number of platelets in peripheral blood

presence of blast cells in peripheral blood

the presence of leukemic failure

leukocytosis

HUNTER'S GLOSSIT IS CHARACTERISTIC FOR

B12 deficiency anemia

iron deficiency anemia

acute leukemia

aplastic anemia

erythremia

ANEMIA WITH NORMOCYTOSIS, NORMOCROMIA, A SIGNIFICANT INCREASE OF THE FORMS OF REGENERATION, IS CALLED

acute posthemorrhagic anemia

B12 deficiency anemia

aplastic anemia

chronic posthemorrhagic anemia

hemolytic anemia

WHEN EXAMINING A PATIENT WITH ERYTHREMIA, SKIN COVERS ARE

cherry red

pale

icteric

bronze

cyanotic

THE GREATEST PROLONGATION OF THE BLOOD COAGULATION TIME IS OBSERVED WITH

hemophilia

Werlhof disease

erythremia

iron deficiency anemia

B12-deficient anemia

A SIGN CHARACTERISTIC FOR APLASTIC ANEMIA IS

decreased hematopoiesis in the bone marrow

preservation of the cellular composition of the bone marrow

the presence of signs of hemoblastosis

increased serum iron levels

megaloblastic type of hematopoiesis

WHAT IS USED FOR THE HEMOPHILIA DIAGNOSIS?

clotting time determination

determination of bleeding time

determination of plasminogen

determination of platelets

determination of fibrinogen

IN THROMBOCYTOPENIC PURPLE

prolongation of bleeding

bleeding time is reduced

the bleeding time does not change

there is a tendency to thrombosis

thrombocytosis is observed

THE DIAGNOSIS OF ACUTE LEUKEMIA BECOMES OBVIOUS WHEN THERE IS

blastemia in peripheral blood

ulcerative necrotic lesions

enlarged lymph nodes

anemia

hemorrhage

BOTKIN-GUMPRECHT CELLS ARE FOUND IN THE BLOOD IN

chronic lymphocytic leukemia

chronic myeloid leukemia

acute myeloid leukemia

chronic iron deficiency anemia

aplastic anemia

WHAT IS CHARACTERISTIC FOR IRON DEFICIENCY ANEMIA?

hypochromia, microcytosis, increased iron-binding serum abilities

hypochromia, microcytosis, target erythrocytes

hypochromia, microcytosis, sideroblasts in sternal punctate

microcytosis, decreased iron-binding capacity serum

hyperchromia, macrocytosis

DIAGNOSTIC SIGN OF HEMOPHILIA IS

prolongation of bleeding time

fibrinogen reduction

prolongation of blood clotting time

decrease in prothrombin index

violation of blood clot retraction

WHAT IS CHARACTERISTIC FOR IRON DEFICIENCY ANEMI

hypochromia, microcytosis, increased iron-binding capacity of serum

hypochromia, microcytosis, target erythrocytes

hypochromia, microcytosis, sideroblasts in sternal punctate

microcytosis, a decrease in the iron-binding capacity of serum

hyperchromia, macrocytosis

FOR THE DIAGNOSIS OF B12-DEFICIENCY ANEMIA, IT IS ENOUGH TO IDENTIFY

hyperchromic, hyporegenerative, macrocytic anemia with determination of Jolly bodies and Cabot rings in erythrocytes

hypochromic, hyporegenerative, macrocytic anemia

hyperchromic, hyperrregenerative, macrocytic anemia

hyperchromic, hyporegenerative, microcytic anemia

hypochromic, microcytic anemia

CHARACTERISTIC SIGN OF APLASTIC ANEMIA IS

pancytopenia

macrocytosis

poikilocytosis

increase in the level of iron in the blood serum

hypochromia

ANEMIA WITH NORMOCYTOSIS, NORMOCROMIA, AND A SIGNIFICANT INCREASE OF THE FORMS OF REGENERATION IS

acute posthemorrhagic anemia

B12 deficiency anemia

aplastic anemia

chronic posthemorrhagic anemia

hemolytic anemia

INCREASED LYMPH NODES ARE CHARACTERISTIC FOR

lymphogranulomatosis

hemolytic anemia

thrombocytopenic purpura

iron deficiency anemia

B12 deficiency anemia

WITH CROUPOUS PNEUMONIA, BRONCHIAL BREATHING IS AUSCULTATED

at the stage of hepatization

at the stage of congestion

to the resolution stage

into the high congestion and resolution

to the stage of hepatization and resolution

MOST CHARACTERISTIC FOR FOCAL PNEUMONIA

bronchovesicular breathing

vesicular breathing

bronchial breathing

amphoric breathing

metallic breath

CREPITATION IS HEARED

at the height of inspiration

on the exhale

on inhale and exhale

at the beginning of inspiration

at the end of exhalation

DULLING OF THE PERCUTARY SOUND IS NOTICED IN

lobar pneumonia

emphysema

bronchitis

bronchial asthma

pneumothorax

CHANGES IN FINGERS BY THE TYPE OF "DRUM STICKS" MAY BE FOUND IN

bronchiectasis

bronchial asthma

pneumonia

bronchopneumonia

pneumothorax

BRONCHIECTASIS IS

expansion of the bronchi in the form of a cylinder or sac

inflammation of the bronchi

increase in the airiness of the lung tissue

sclerosis of the bronchial wall

metaplasia of the epithelium of the bronchial mucosa

VOCAL FREMITUS IN CROUPED PNEUMONIA IN THE STAGE OF HEPATIZATION

will sharply increase

will weaken

will not change

will sharply weaken

will disappear

"RASPBERRY JELLY" SPUTUM IS CHARACTERISTIC OF

lung cancer

lobar pneumonia

lung abscess

bronchial asthma

bronchitis

WHAT PERCUSSION SOUND IS CHARACTERISTIC FOR THE FIRST STAGE (CONGESTION STAGE) OF CROUPOUS PNEUMONIA?

blunt with tympanic tint

dumb

tympanic

clear lung sound

boxed

THE FOLLOWING PHYSICAL DATA ARE CHARACTERISTIC OF THE HEPATIZATION STAGE IN CROUPOUS PNEUMONIA

increased vocal fremitus and bronchophony over the lesion, dull percussion sound, bronchial breathing

weakening of vocal fremitus and bronchophony, bronchovesicular breathing, moist fine bubbling rales

increased vocal fremitus and bronchophony, tympanic percussion sound over the lesion, increased vesicular breathing, moist sonorous rales

increased vocal fremitus and bronchophony over the lesion, clear percussion sound, bronchial breathing

weakening of vocal fremitus and bronchophony over the lesion, dull percussion sound, bronchial breathing

ABSCESS FORMATION IN PNEUMONIA IS MORE OFTEN CAUSED BY

staphylococci

viruses

rickettsia

fungi

streptococci

IN THE STAGE OF THE HEIGHT OF LOBAR PNEUMONIA, YOU CAN HEAR

bronchial breathing

hard breathing

amphoric breathing

increased vesicular breathing

weakened bronchial breathing

IN THE INITIAL STAGE OF LOBAR PNEUMONIA, BREATHING WILL

weakened vesicular

enhanced vesicular

bronchovesicular

bronchial

hard

PERCUSSION FOR THE SYNDROME OF FOCAL COMPACTION OF THE LUNG TISSUE IS CHARACTERIZED BY

bluntness of percussion sound

boxed sound

dull sound

tympanic sound

none of the above

IN THE RECOVERY STAGE WITH LOBAR PNEUMONIA, BREATHING WILL BE

weakened vesicular

enhanced vesicular

mixed

bronchial

hard

THE MOST COMMON CAUSATIVE AGENT OF NOSOCOMIAL (HOSPITAL-ACQUIRED) PNEUMONIA IN ELDERLY PATIENTS IS

klebsiella

herpes simplex virus

pneumococcus

mycoplasma

chlamydia

THE DIAGNOSIS OF PNEUMONIA IS BASED ON

all of the above

physical examination data

results of x-ray examination

indicators of laboratory tests

clinical symptoms of the disease

THE MOST CHARACTERISTIC FEATURE OF SPUTUM WITH LOBAR PNEUMONIA

rusty

mucous

mucopurulent

mucous streaked with blood

"raspberry jelly"

VOCAL FREMITUS WITH CROUPOUS PNEUMONIA IN THE FIRST STAGE

will increase

will weaken

will not change

will sharply increase

will not be defined

INCREASED VOCAL FREMITUS AND BRONCHOPHONY, SHORTENING OF PERCUSSION SOUND ABOVE THE LESION, WEAKENED VESICULAR BREATHING, CREPITACIOINDUX ARE CHARACTERISTIC OF CROUPOUS PNEUMONIA IN

onset stage of the disease (congestion stage)

the stage of the height of the disease (the stage of hepatization)

resolution stage

in all stages

in none of the stages

THE MOST COMMON CAUSE OF COMMUNITY-ACQUIRED PNEUMONIA IS

klebsiella

herpes simplex virus

pneumococcus

mycoplasma

chlamydia

WHAT IS AUSCULTETED IN THE PRESENCE OF A CAVITY IN THE LUNG THAT COMMUNICATES WITH THE BRONCHUS?

amphoric breathing

weakened vesicular breathing

hard breathing

enhanced vesicular respiration

metallic breath

WHEN IS PLEURAL FRICTION RUB HEARD?

on inhalation and exhalation

at the height of inspiration

on exhalation

on inspiration

at the end of exhalation.

WHAT IS AUSCULTETED IN THE COMPRESSION ATELECTASIS?

weakened bronchial breathing

increased vesicular breathing

no breathing

hard breathing

mixed breathing.

IN OBTURATION ATELECTASIS, BREATHING IS

missing

enhanced vesicular

hard

bronchial

vesicular

THE BOUNDARIES OF DULLNESS OF PERCUSSION SOUND WITH RIGHT-SIDED HYDROTHORAX ARE LOCATED

along the Damoiseau-Ellis line on the right.

along the oblique Damoiseau-Ellis line on the left

along horizontal line on both sides

along horizontal line on the left

along the horizontal line to the right

AUSCULTATION DATA FOR LUNG ABSCESS IN THE EMPTYING STAGE

amphoric breathing

enhanced vesicular

bronchial breathing

weakened vesicular breathing

metallic breath

PERCUSSION SOUND IN PNEUMOTHORAX IS

tympanic

boxed

femoral

clear pulmonary

dumb

ABSENCE OF VOCAL FREMITUS, DULL PERCUSSION SOUND, ABSENCE OF BREATHING AND BRONCHOPHONY ARE TYPICAL FOR

exudative pleurisy

pneumonia

bronchitis

emphysema

pneumothorax

PAIN DURING BREATHING IS ASSOCIATED WITH

with damage to the pleura

with damage to the alveoli

with bronchial lesions

with damage to the trachea

with damage to the bronchi and trachea.

CHANGE OF FINGERS ACCORDING TO THE TYPE OF «DRUMSTICKS» CAN OCCUR WITH

bronchiectasis

bronchial asthma

pneumonia

bronchopneumonia

pneumothorax

THE FOLLOWING PHYSICAL DATA: PERCUSSION - TYMPANIC SOUND, BRONCHIAL BREATHING WITH A METALLIC TINGE ARE CHARACTERISTIC OF

open pneumothorax

closed pneumothorax

hydrothorax

bronchitis

lobar pneumonia

SYNDROME OF ACCUMULATION OF AIR IN THE PLEURAL CAVITY IS RELIABLE IN THE PRESENCE OF THE FOLLOWING SIGNS

chest asymmetry, vocal fremitus and bronchophony are absent, tympanic percussion sound, auscultatory - no breathing

asymmetry of the chest, vocal fremitus and bronchophony are sharply weakened, dullness of percussion sound, hard breathing

asymmetry of the chest, vocal fremitus and bronchophony are enhanced, tympanic percussion sound, bronchial breathing

asymmetry of the chest, vocal fremitus and bronchophony are absent, boxed percussion sound, auscultatory - no breathing

the chest is symmetrical, vocal fremitus and bronchophony are increased, tympanic percussion sound, auscultatory - mixed breathing

PHYSICAL DATA: ASYMMETRY OF THE CHEST, ABSENCE OF VOCAL FREMITUS AND BRONCHOPHONY, TYMPANIC PERCUSSION SOUND, NO BREATHING, ARE CHARACTERISTIC OF

syndrome of accumulation of air in the pleural cavity

syndrome of cavity formation in the lung

syndrome of accumulation of fluid in the pleural cavity

syndrome of focal compaction of the lung tissue

syndrome of lobar compaction of lung tissue

CLINICAL MANIFESTATIONS OF EXUDATIVE PLEURISY INCLUDE

lag of the “sick” half of the chest in the act of breathing, tachypnea, sharply weakened vocal fremitus, percussion - oblique fluid level, dull percussion sound, sharply weakened vesicular breathing

position on the “sick” side, tachypnea, percussion - horizontal fluid level, sharply weakened vesicular breathing

position on the "sick" side, increasing shortness of breath, increased vocal fremitus, percussion - oblique fluid level, bronchial breathing

lag of the "sick" half of the chest in the act of breathing, bradypne, sharply weakened vocal fremitus, percussion - oblique fluid level, dull percussion sound, sharply weakened vesicular breathing

lag of the “sick” half of the chest in the act of breathing, tachypnea, sharply weakened vocal fremitus, percussion - horizontal fluid level, dull percussion sound, sharply weakened vesicular breathing

VOCAL FREMITUS AND BRONCHOPHONY ARE INCREASED ABOVE THE LESION, PERCUSSION - TYMPANIC SOUND , AUSCULTATORY - BRONCHIAL BREATHING WITH AN AMPHORIC TINT, WET COARSE RALES ARE SIGNS OF

syndrome of cavity formation in the lung

respiratory distress syndrome

syndrome of accumulation of air in the pleural cavity

syndrome of accumulation of fluid in the pleural cavity

syndrome of lobar compaction of lung tissue

THE SYNDROME OF CAVITY FORMATION IN THE LUNG IS CHARACTERIZED BY THE FOLLOWING PHYSICAL DATA

increased vocal fremitus and bronchophony over the lesion, tympanic percussion sound, amphoric breathing, moist medium bubbling and large bubbling rales

increased vocal fremitus and bronchophony over the lesion, dull percussion sound, bronchial breathing, dry and wet rales

weakening of vocal fremitus and bronchophony over the lesion, boxed percussion sound, weakened vesicular breathing, moist rales

weakening of vocal fremitus and bronchophony over the lesion, tympanic percussion sound, amphoric breathing, moist medium bubbling and large bubbling rales

increased vocal fremitus and bronchophony over the lesion, clear pulmonary percussion sound, amphoric breathing, moist medium bubbling and large bubbling rales

FEMORAL PERCUSSION SOUND IS HEARD WITH

effusion pleurisy

lobar pneumonia (in the 1st stage)

pneumothorax

focal pneumonia

emphysema

OVER THE COMPRESSION ZONE WITH SEVERE COMPRESSION ATELECTASIS, IT IS MORE LIKELY TO HEAR

quiet bronchial breathing

increased vesicular breathing

hard breathing

mixed breathing

laryngotracheal breathing

AMPHORIC BREATHING CAN BE HEARD WITH

abdominal syndrome

compression atelectasis

obstructive atelectasis

pneumothorax

lobar pneumonia

METALLIC BREATHING CAN BE HEARD WITH

open pneumothorax

lung abscess

emphysema

lobar pneumonia

closed pneumothorax

EVIDENCE OF DESTRUCTION OF LUNG TISSUE WITH CERTAINTY IS

elastic fibers

leukocytes

Curschmann's spirals

Charcot–Leyden crystals

erythrocytes

IN THE PRESENCE OF A CAVITY IN THE LUNG, PERCUSSION REVEALS

tympanic sound

box sound

dull sound

bluntness of percussion sound

none of the above

WITH THE ACCUMULATION OF A SIGNIFICANT AMOUNT OF FLUID IN THE PLEURAL CAVITY, PERCUSSION REVEALS

dull sound

box sound

tympanic sound

bluntness of percussion sound

none of the above

WHAT IS THE CHARACTERISTIC OF A LUNG ABSCESS CONNECTED TO THE BRONCHUS?

bluntness with tympanic sound, amphoric breathing, large-bubble wheezing

the same, but shifted towards blunting

bluntness, decreased breathing and bronchophony, mediastinal displacement in the opposite direction

bluntness, bronchial breathing, increased bronchophony

bluntness of sound, mixed breathing, small-bubble wheezing.

BREATHING WITH OBSTRUCTIVE ATELECTASIS IS

missing

enhanced vesicular

hard

bronchial

vesicular

WITH CLOSED PNEUMOTHORAX, THE MOST CHARACTERISTIC CHANGES IN THE CHEST ARE

reduction of half of the chest, its retraction and lagging in the act of breathing

an increase in half of the chest, its lag in the act of breathing and smoothing of the intercostal spaces

only lag in the act of breathing of half of the chest

hypersthenic shape of the chest

an increase in the anterior-posterior and transverse dimensions of the chest, retraction of the intercostal spaces on both sides

WITH SEVERE UNILATERAL HYDROTHORAX, PERCUSSION SOUND ABOVE THE CHEST IS

dull femoral

tympanic

clear pulmonary

blunted tympanic

boxed

WITH EXUDATIVE PLEURISY ON THE LEFT, THE BORDERS OF DULLNESS OF PERCUSSION SOUND ARE LOCATED

along the oblique Damoiseau-Ellis line on the left

along the horizontal line to the left

along the horizontal line on the right

along the oblique Damoiseau-Ellis line on the right

along the horizontal line on both sides

WHAT IS HEARD IN COMPRESSION ATELECTASIS?

weakened bronchial breathing

weakened vesicular breathing

hard breathing

amphoric breathing

vesicular breathing

PALPATION OF THE HEART AT THE APEX REVEALS TREMBLING THAT DOES NOT COINCIDE WITH PALSATION ON A. CAROTIS. FOR WHICH HEART DEFECT IS THIS CHARACTERISTIC?

mitral stenosis

mitral insufficiency

aortic stenosis

aortic insufficiency

insufficiency of the tricuspid valve

THE ACCENT OF THE II TONE ON THE PULMONARY ARTERY IS

with hypertension of the pulmonary circulation

with an increase in pressure in a large circle of blood circulation

with hypertrophy of the left ventricle

with hypertrophy of the left atrium

with hypertrophy of the right atrium

PULSE CHARACTERISTICS IN CASE OF MITRAL VALVE INSUFFICIENCY IN THE COMPENSATION STAGE

Not changed

Large

Small

Solid

Soft

THE UPPER LIMIT OF RELATIVE CARDIAC DULLNESS INCREASES DUE TO

hypertrophy of the left atrium

hypertrophy of the left ventricle

hypertrophy of the right atrium

hypertrophy of the right ventricle

dilatation of the right ventricle

THE HEART WAIST IS

the angle between the vascular bundle and the left ventricle

the place of exit from the heart of large vessels

the angle between the left atrium and the left ventricle

the place of transition of the atria to the ventricles

heart projection bottleneck

LEFT VENTRICULAR HEART FAILURE OCCURS

inspiratory dyspnea

enlargement of the liver

swelling of the lower extremities

iusset symptom

"cat purr"

STENOSIS OF THE LEFT ATRIOVENTRICULAR OPENING MAY DEVELOP AS A RESULT

rheumatism

myocardial infarction

chest injuries

infective endocarditis

all of the above diseases

HEART FAILURE IS NOT TYPICAL

quail rhythm

gallop rhythm

an increase in the size of the heart

decreased cardiac output

I tone attenuation

IN THE EVENT OF ATRIAL FIBRILLATION PRESYSTOLIC NOISE IN PATIENTS WITH MITRALNCHM STENOSIS

disappears

decreases

does not change

amplified

becomes impermanent

CAUSES OF ORGANIC LESIONS OF THE TRICUSPID VALVE ARE NOT

coronary heart disease

rheumatism

infective endocarditis

Ebstein anomaly

heart injury

POSITIVE VENOUS PULSE OF THE DAY

insufficiency of the tricuspid valve

mitral valve insufficiency

stenosis of the mouth of the aorta

insufficiency of aortic valves

mitral stenosis

BLOOD PRESSURE WITH SEVERE MITRAL STENOSIS

does not change

systolic increases

systolic decreases

diastolic decreases

Increases diastolic

AUSCULTATIVE PICTURE OF MITRAL INDETERMINACY

I tone is weakened at the apex of the heart;

I tone is amplified at the apex of the heart;

"click of opening" of the mitral valve

gallop rhythm

both tones are weakened

CONNECTIVE TISSUE CHANGES IN RHEUMATISM

fibrinoid swelling, hyalinosis

amyloidosis, sclerosis

atherosclerosis, hyalinosis

atrophy, lipoidosis

mucoid swelling, licking

FOR LEFT VENTRICULAR HEART FAILURE, PATHOGNOMONIC IS

Orthopnea

Ascites

Enlargement of the liver

swelling of the cervical veins

swelling on the legs

PATIENTS WITH MITRAL STENOSIS ARE NOT CHARACTERIZED BY COMPLAINTS OF

compressive pain behind the sternum when walking

heart attacks

asthma attacks at night

hemoptysis

episodes of loss of consciousness

NAME THE SYMPTOM THAT MAKES IT POSSIBLE TO SUSPECT CONCOMITANT MITRAL INSUFFICIENCY IN THE PRESENCE OF MITRAL STENOSIS

weakened I tone

loud I tone

the opening tone of the mitral valve

splitting of the II tone

II tone amplification

INDICATE THE SYMPTOM THAT UNITES DISEASES SUCH AS ANEMIA, THYROTOXICOSIS, MITRAL VALVE PROLAPSE, MITRAL VALVE INSUFFICIENCY RHEUMATIC ETIOLOGY

systolic noise at the apex

flint noise

diastolic noise at the apex

Graham-Steele noise

systolic noise on the aorta

IN CASE OF MITRAL VALVE INSUFFICIENCY, THE X-RAY PICTURE DOES NOT INCLUDE

enlargement of the right atrium

deflection of the esophagus in an arc of large radius

mitral configuration of the heart

pronounced heart waist

sclerosis of the aortic arch

WITH AUSCULTATION OF THE HEART IN PATIENTS WITH SEVERE HEART FAILURE

systolic gallop rhythm

protodiastolic gallop rhythm

presystolic gallop rhythm

the rhythm of the "quail"

additional pericardial tone

THE MOST COMMON CAUSE OF ATRIAL FIBRILLATION IS

mitral stenosis, aortic stenosis, mitral insufficiency

atherosclerosis, hypertension, bronchial asthma

aortic insufficiency, myocardial infarction, hypertensive illness

pulmonary heart, diabetes mellitus, hypertension

thyrotoxicosis, mitral stenosis, cardiosclerosis

BIFURCATION OF THE IITONE ON THE PULMONARY ARTERY OCCURS WITH

tricuspid stenosis

stenosis of the mouth of the aorta

insufficiency of aortic valves

tricuspid insufficiency

mitral stenosis

CHANGES IN II TONE IN MITRAL INSUFFICIENCY

II tone enhanced on the aorta

II tone enhanced on the pulmonary artery

II tone split on the pulmonary artery

II tone split on the aorta

II tone is unchanged

WITH MITRAL STENOSIS "WAIST OF THE HEART"

less pronounced

becomes more pronounced

not changed

aortic

Underlined

RHEUMATISM IS OFTEN PRECEDED BY AN UPPER RESPIRATORY INFECTION CAUSED BY

B-hemolytic streptococcus group A

green streptococcus

Staphylococcus aureus

Epstein-Barr virus

enterococcus

ATTENUATION OF I TONE IS NOT OBSERVED AT

stenosis of the left atrioventricular opening

tricuspid valve insufficiency

insufficiency of aortic valves

mitral valve insufficiency

stenosis of the mouth of the aorta

MITRAL INSUFFICIENCY IS CHARACTERISTIC

enlargement of the heart to the left

asthenic constitution

pulsation of the liver

systolic tremor in II m/r on the right

trembling at the left edge of the sternum

CLINICAL MANIFESTATIONS OF TRICUSPID REGURGITATION DO NOT INCLUDE

pulmonary edema

ascites

hepatomegaly

edema

pansystolic noise over the sword-shaped process

A COMPLICATION OF ATRIAL FIBRILLATION IS

thromboembolic syndrome

heart disease

hypertensive crisis

loss of consciousness

obesity

FCG-SIGNS OF MITRAL STENOSIS

high amplitude I tone at the apex

reduction of amplitude I tone at the apex

an increase in the amplitude of the II tone over the aorta

systolic noise at the apex after I tone

Diastolic noise after II tone

I TONE ENHANCED AT

mitral stenosis

stenosis of the mouth of the aorta

insufficiency of aortic valves

mitral valve insufficiency

myocarditis

SIGNS OF LEFT VENTRICULAR HEART FAILURE

cough, hemoptysis, suffocation, orthopneas

welling of the legs, cough, shortness of breath

hemoptysis, swelling of the lower legs, enlargement of the liver

cardiac asthma, forced horizontal position

pallor, swelling of the legs

DIASTOLIC TREMBLING OF THE CHEST IS DETERMINED BY

mitral stenosis

mitral insufficiency

aortic insufficiency

aortic stenosis

tricuspid insufficiency

HEART FAILURE IS NOT TYPICAL

Musset symptom

gallop rhythm

pendulum-like rhythm

an increase in the size of the heart

decreased cardiac output

FOR THE AUSCULTATORY PICTURE OF MITRAL VALVE INSUFFICIENCY IS CHARACTERISTIC

systolic noise at the apex of the heart

сlapping I tone

mesodiastolic noise

systolic murmur at the base

diastolic noise

WHAT IS NOT TYPICAL FOR MITRAL STENOSIS

hypertrophy and dilatation of the left ventricle occur

hypertrophy and dilatation of the right ventricle occur

atrial fibrillation is characteristic

diastolic noise at the apex is heard

gallop rhythm

AN AUSCULTATORY SIGN OF A COMBINED MITRAL DEFECT WITH A PREDOMINANCE OF STENOSIS OF THE LEFT ATRIOVENTRICULAR OPENING IS

amplification of the I tone at the apex of the heart

mitral valve opening tone

fourth tone

systolic murmur at the apex of the heart associated with I tone

mesodiastolic noise

THE DIAGNOSIS OF RHEUMATISM IS CHARACTERIZED BY EVERYTHING EXCEPT

all of the above is correct

the presence of "absolute signs of rheumatism" according to A.A. Kissel-

Jones

tendency to form a heart defect

connection with acute streptococcal infection

all of the above is incorrect

WITH MITRAL STENOSIS, DURING X-RAY EXAMINATION, THE CONTRASTED ESOPHAGUS DEVIATES

in an arc of small radius

in an arc of large radius

along the arc of the heart radius

in an arc of gigantic radius

PALPATION OF THE HEART AT THE APEX REVEALS TREMBLING THAT DOES NOT COINCIDE WITH PALSATION ON A. carotis. THIS IS TYPICAL FOR

mitral stenosis

mitral insufficiency

aortic stenosis

aortic insufficiency

insufficiency of the tricuspid valve

THE ACCENT OF THE II TONE ON THE PULMONARY ARTERY IS

with hypertension of the pulmonary circulation

with an increase in pressure in a large circle of blood circulation

with hypertrophy of the left ventricle

with hypertrophy of the left atrium

with hypertrophy of the right atrium

PULSE CHARACTERISTICS IN CASE OF MITRAL VALVE INSUFFICIENCY IN THE COMPENSATION STAGE

not changed

large

small

solid

soft

THE UPPER LIMIT OF RELATIVE CARDIAC DULLNESS INCREASES DUE TO

hypertrophy of the left atrium

hypertrophy of the right ventricle

hypertrophy of the left ventricle

hypertrophy of the right atrium

dilatation of the right ventricle

THE HEART WAIST IS

the angle between the vascular bundle and the left ventricle

the place of transition of the atria to the ventricles

the place of exit from the heart of large vessels

the angle between the left atrium and the left ventricle

the bottleneck of the projection of the heart

LEFT VENTRICULAR HEART FAILURE IS ACCOMPANIED WITH

inspiratory dyspnea

swelling of the lower extremities

enlargement of the liver

Musset symptom

"cat purr"

STENOSIS OF THE LEFT ATRIOVENTRICULAR OPENING MAY DEVELOP AS A RESULT

rheumatism

myocardial infarction

chest injuries

infective endocarditis

all of the above diseases

HEART FAILURE IS CHARACTERIZED WITH

gallop rhythm

reduction in the size of the heart

quail rhythm

increased cardiac output

I tone amplification

PRESYSTOLIC NOISE IN PATIENTS WITH MITRAL STENOSIS IN THE EVENT OF ATRIAL FIBRILLATION

disappears

amplified

decreases

does not change

becomes impermanent

THE CAUSES OF ORGANIC LESIONS OF THE TRICUSPID VALVE ARE

Ebstein anomaly

CHD

Psoriasis

hepatomegaly

hypertrophy of the left ventricle

THE LEFT BOUNDARY OF THE RELATIVE AND ABSOLUTE CARDIAC DULLNESS MAY COINCIDE WITH

mitral insufficiency

aortic stenosis

aortic insufficiency

mitral stenosis

acute myocardial infarction

POSITIVE VENOUS PULSE OCCURS WITH

insufficiency of the tricuspid valve

stenosis of the mouth of the aorta

mitral valve insufficiency

insufficiency of aortic valves

mitral stenosis

BLOOD PRESSURE WITH SEVERE MITRAL STENOSIS

systolic does not change

systolic increases

systolic decreases

diastolic decreases

diastolic does not change

AUSCULTATIVE PICTURE OF MITRAL INDETERMINACY

I tone is weakened at the apex of the heart;

I tone is amplified at the apex of the heart;

"click of opening" of the mitral valve

gallop rhythm

both tones are weakened

CONNECTIVE TISSUE CHANGES IN RHEUMATISM

fibrinoid swelling, hyalinosis

amyloidosis, sclerosis

atherosclerosis, hyalinosis

atrophy, lipoidosis

mucoid swelling, licking

SYMPTOM, PATHOGNOMONIC FOR LEFT VENTRICULAR HEART FAILURE

orthopnea

swelling of the cervical veins

ascites

enlargement of the liver

swelling on the legs

PATIENTS WITH MITRAL STENOSIS ARE CHARACTERIZED BY COMPLAINTS OF

heaviness in the right hypochondrium

swelling of the legs

increase in the volume of the abdomen

hemoptysis

dizziness

SYMPTOM THAT MAKES IT POSSIBLE TO SUSPECT IN THE PRESENCE OF MITRAL STENOSIS CONCOMITANT MITRAL INSUFFICIENCY

loud I tone

weakened I tone

the opening tone of the mitral valve

splitting of the II tone

II tone amplification

A SYMPTOM THAT UNITES DISEASES SUCH AS ANEMIA, THYROTOXICOSIS, MITRAL VALVE PROLAPSE, MITRAL VALVE INSUFFICIENCY OF RHEUMATIC ETIOLOGY

Graham-Steele noise

diastolic noise at the apex

flint noise

systolic noise at the apex

systolic noise on the aorta

IN CASE OF MITRAL VALVE INSUFFICIENCY, THE X-RAY PICTURE INCLUDES

emphasized heart waist

aortic configuration of the heart

deviation of the esophagus along the arc of a small radius

enlargement of the left atrium

expansion of the boundaries of the heart in toto

THE RHYTHM CHARACTERISTIC OF AUSCULTATION OF THE HEART IN PATIENTS WITH SEVERE HEART FAILURE IS CALLED

protodiastolic gallop rhythm

the rhythm of the "quail"

presystolic gallop rhythm

systolic gallop rhythm

Additional pericardial tone

THE MOST COMMON CAUSE OF ATRIAL FIBRILLATION IS

thyrotoxicosis, mitral stenosis, cardiosclerosis atherosclerosis, hypertension, bronchial asthma

mitral stenosis, aortic stenosis, mitral insufficiency

aortic insufficiency, myocardial infarction, hypertension

pulmonary heart, diabetes mellitus, hypertension

BIFURCATION OF THE II TONE ON THE PULMONARY ARTERY OCCURS WITH

Mitral stenosis

stenosis of the mouth of the aorta

insufficiency of aortic valves

tricuspid insufficiency

tricuspid stenosis

CHANGES IN II TONE IN MITRAL INSUFFICIENCY

II tone enhanced on the pulmonary artery

II tone enhanced on the aorta

II tone split on the pulmonary artery

II tone split on the aorta

II tone is unchanged

WITH MITRAL STENOSIS "WAIST OF THE HEART"

less pronounced

becomes more pronounced

not changed

aortic

emphasized

RHEUMATISM IS OFTEN PRECEDED BY AN UPPER RESPIRATORY INFECTION CAUSED BY

B-hemolytic streptococcus group A

Epstein-Barr virus

green streptococcus

Staphylococcus aureus

enterococcus

I TONE GAIN IS OBSERVED AT

stenosis of the left atrioventricular opening mitral valve insufficiency

tricuspid valve insufficiency

insufficiency of aortic valves

stenosis of the mouth of the aorta

SYMPTOM CHARACTERISTIC OF MITRAL INSUFFICIENCY

Enlargement of the heart to the left

pulsation of the liver

asthenic constitution

systolic tremor in II m/r on the right

trembling at the left edge of the sternum

CLINICAL MANIFESTATIONS OF TRICUSPID REGURGITATION INCLUDE

pulmonary edema

orthopnea

cough

swelling of the lower extremities

systolic murmur above the aorta

COMPLICATION THAT IS OBSERVED WITH ATRIAL FIBRILLATION

thromboembolic syndrome

heart disease

hypertensive crisis

loss of consciousness

obesity

FCG-SIGNS OF MITRAL STENOSIS

High amplitude I tone at the apex

reduction of amplitude I tone at the apex

an increase in the amplitude of the II tone over the aorta

systolic noise at the apex after I tone

diastolic noise after II tone

I TONE ENHANCED AT

mitral stenosis

stenosis of the mouth of the aorta

insufficiency of aortic valves

mitral valve insufficiency

myocarditis

SIGNS OF LEFT VENTRICULAR HEART FAILURE

cough, hemoptysis, suffocation, orthopnea

swelling of the legs, cough, shortness of breath

hemoptysis, swelling of the lower legs, enlargement of the liver

cardiac asthma, forced horizontal position

pallor, swelling of the legs

DIASTOLIC TREMBLING OF THE CHEST IS DETERMINED BY

mitral stenosis

mitral insufficiency

aortic insufficiency

aortic stenosis

tricuspid insufficiency

HEART FAILURE IS NOT TYPICAL

Musset symptom

an increase in the size of the heart

gallop rhythm

Pendulum-like rhythm

decreased cardiac output

FOR THE AUSCULTATORY PICTURE OF MITRAL VALVE INSUFFICIENCY IS COMMON

systolic noise at the apex

systolic murmur at the base of the heart

сlapping I tone

mesodiastolic noise

diastolic noise

MITRAL STENOSIS IS NOT TYPICAL

hypertrophy and dilatation of the left ventricle occur

hypertrophy and dilatation of the right ventricle occur

atrial fibrillation is characteristic

diastolic noise at the apex is heard

gallop rhythm

AN AUSCULTATORY SIGN OF A COMBINED MITRAL DEFECT WITH A PREDOMINANCE OF STENOSIS OF THE LEFT ATRIOVENTRICULAR OPENING IS

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along the arc of the heart radius

in an arc of gigantic radius

THE EXPANSION OF THE LEFT BORDER OF RELATIVE CARDIAC DULLNESS IS CHARACTERISTIC OF THE STAGE OF HYPERTENSION:

stage 2

stage 1

stage 3

stage 4

it is not characteristic of any stage

THE RISK FACTOR OF HYPERTENSION IS:

smoking

fast carbohydrates

labile mood

reduced body weight

bradycardia

ELEVATED BLOOD PRESSURE INCLUDES

Blood pressure > 140/90 mmHg

Blood pressure > 120/80 mmHg

Blood pressure < 130/85 mmHg

Blood pressure 130/85 mmHg

Blood pressure <120/80 mmHg.

WITH HIGH BLOOD PRESSURE THERE COMES ALONG

pulsus durus

pulsus molis

pulsus difference

pulsus tardus

pulsus vacuus

HYPERTENSION STAGE 2 INVOLVES

hypertrophy of the left ventricle

no changes in target organs

a history of myocardial infarction

a history of a brain stroke

the presence of angina attacks.

ECG CHANGES IN STAGE 2 HYPERTENSION

RV5>RV4

High prong R in V1

the highest prong R in the III standard lead

Maximum prong R in V4

absence of the prong P.

STAGE OF HYPERTENSION, IN WHICH THERE IS NO HYPERTROPHY OF THE LEFT VENTRICLE

stage 1

stage 2

stage 3

stage 4

it is present in all stages

RESISTANT ARTERIAL HYPERTENSION IS

lack of normalization of blood pressure during therapy with three or more drugs

absence of regression of left ventricular hypertrophy against the background of normalization of blood pressure

lack of normalization of blood pressure during therapy with two or more drugs

hypertension accompanied by the development of pulmonary edema

no effect when taking kapoten under the tongue

HYPERTENSION STAGE 2 IS CHARACTERIZED BY

CKD stage C3 with GFR >30-59 ml/min/1.73 m2

increased blood lipids

atrial fibrillation

hyperuricemia

smoking

THE BLOOD PRESSURE LEVEL OF 150/110 MMHG REFERS TO THE DEGREE OF ARTERIAL HYPERTENSION

3

1

2

4

0

THE MECHANISM INVOLVED IN INCREASING BLOOD PRESSURE

sodium retention

reduction of cardiac output

reduction of renin activity

decreased activity of catecholamines

increased venous pressure.

HYPERTENSION STAGE 2 IS CHARACTERIZED BY

hypertrophy of the left ventricle

rapid development of terminal renal failure

proceeds without damage to the target organs

the absence of changes in the fundus

the presence of a history of myocardial infarction.

A SIGN THAT IS A MANIFESTATION OF KIDNEY DAMAGE IN HYPERTENSION

proteinuria

piuria

ketonuria

macrohematuria

leukocyturia.

CRITERION OF STAGE 3 OF HYPERTENSION

retinal hemorrhages

hypertrophy of the left ventricle, without heart failure

no changes on the fundus

microalbuminuria

age over 65 years.

UNFAVORABLE PROGNOSIS IN ARTERIAL HYPERTENSION IS CAUSED BY FACTORS

all of the above.

the development of hypertension at a young age

diabetes mellitus

tobacco smoking

AG with a high renin content

A SIGN THAT IS AN INDICATION FOR DAILY BLOOD PRESSURE MONITORING

normal blood pressure values in patients with a large number of factors risk and the presence of changes in target organs characteristic of hypertension

normal blood pressure values during repeated measurements or by

self-monitoring data

high blood pressure values in patients with a large number of risk factors and/or the presence of changes in target organs characteristic of hypertension

the patient's desi

differences in the amount of blood pressure at the reception and according to self-monitoring data by 5-10 mm Hg.

A FACTOR THAT RELATES TO THE ADVANTAGES OF DAILY BLOOD PRESSURE MONITORING

more accurately assesses the antihypertensive effect of therapy, as it reduces the effect of the "white coat"

gives information about rhythm disturbances

allows to diagnose gestational hypertension

allows to exclude the diagnosis of arterial hypertension

allows to diagnose coronary heart disease

A FACTOR THAT RELATES TO THE CONDITIONS FOR MEASURING BLOOD PRESSURE

the use of coffee and strong tea for 1 hour before the study is excluded

the cuff is applied to the forearm 2cm below the elbow bend

it is recommended not to smoke for 2 hours before blood pressure measurement

Blood pressure is measured at rest after a 60-minute rest

if the blood pressure measurement procedure was preceded by significant physical activity, the rest period should be extended to 2 hours.

A METHOD THAT IS DESIGNED TO DETECT LEFT VENTRICULAR HYPERTROPHY

determination of the apical thrust

defining the boundaries of absolute heart stupidity

determination of the right boundary of relative cardiac dullness

measurement of blood pressure level

determination of the upper limit of relative cardiac dullness.

EVALUATE THE CATEGORY OF AD – 142/114 MMHG.

arterial hypertension of the 3rd degree.

normal

high normal

arterial hypertension of the 1st degree

arterial hypertension of the 2nd degree

GLUCOCORTICOIDS

increase blood pressure

do not affect the blood pressure

reduce blood pressure

first lower, then increase

first raise, then lower.

THE 3RD DEGREE OF HELL REFERS TO

AD 140/110 mmHg

AD 120/80 mmHg

AD 130/85 mmHg

AD 159/89 mmHg

AD 145/95 mmHg

THE DISEASE THAT IS THE CAUSE OF DEATH IN HYPERTENSION

chronic heart failure.

phlebothrombosis

intestinal infarction due to fibrinoid necrosis

liver failure

hemolytic jaundice

ECG CHANGES IN HYPERTENSION STAGE 2

RV5>RV4

High prong R in V1

the highest prong R in the III standard lead

Maximum prong R in V4

the absence of a prong.

HYPERTENSION STAGE 2 IS CHARACTERIZED BY

hypertrophy of the left ventricle

rapid development of terminal renal failure

proceeds without damage to the target organs

the absence of changes in the fundus

the presence of a history of myocardial infarction

EVALUATE THE CATEGORY OF AD – 149/90 MMHG.

arterial hypertension of the 1st degree

normal

high normal

atrrial hypertension of the 2nd degree

arterial hypertension of the 3rd degree.

THE TYPES OF SYMPTOMATIC ARTERIAL HYPERTENSION INCLUDE

renal, endocrine, hemodynamic, neurogenic, medicinal

renal, endocrine

hemodynamic, neurogenic, intestinal

parenchymal, endocrine, hemodynamic, intestinal, medicinal

renal, cardiac, hemodynamic, neurogenic, medicinal

PHEOCHROMOCYTOMA IS

tumor of the adrenal medulla and chromaffin cells

hypercorticism

pituitary adenoma

systemic vasculitis

adrenal adenoma

A CHARACTERISTIC FEATURE OF AORTA COARCTATION

increased blood pressure in the lower extremities

increased activity of catecholamines

rough diastolic murmur at the base of the heart

increased pulsation of the arteries of the lower extremities.

diagnosis in old age

SEVERE MUSCLE WEAKNESS, OFTEN PAROXYSMAL, PARESTHESIA, CRAMPS, PAIN IN THE MUSCLES (CALF), HANDS AND TOES WITH HYPERALDOSTERONISM ARE CAUSED BY

hypokalemia

hyponatremia

hyperglycemia

hyperosmolar blood

hyperchloremia

AORTIC COARCTATION IS -

narrowing of the aorta at a certain level

aortic atherosclerosis

aortic valve insufficiency

open ductus arteriosus

nonspecific aortoarteritis

ITSENKO–CUSHING SYNDROME IS –

hypercorticism,

hyperaldosteronism

hyperreninemia

hyperuricemia

systemic vasculitis

OBSTRUCTIVE APNEA SYNDROME IS CHARACTERIZED BY

snoring

striae

constipation

polydipsia

polyuria

IN CASE OF SUSPECTED RENAL HYPERTENSION IT IS NECESSARY TO CONDUCT

general urine analysis

general blood test

chest fluorography

analysis of feces for worm eggs

Gregersen's reaction

CHARACTERISTIC OF COHN SYNDROME IS

muscle weakness

acidosis

striae

hyperkalemia

hyperuricemia

FOR THE DIAGNOSIS OF PHEOCHROMOCYTOMA, STUDIES OF THE LEVEL OF

vanillylmindal acid, metanephrine and normetanephrine in daily urine

ACTH

blood sodium

blood renin

the ratio of aldosterone /renin in the blood

A CHARACTERISTIC FEATURE FOR RENOVASCULAR HYPERTENSION

noise in the umbilical region

leukocyturia

proteinuria and hematuria,

hyperkalemia

bilateral kidney changes on ultrasound

THE CAUSE OF HYPERTENSION IN A PATIENT WITH THE FOLLOWING CLINICAL SIGNS: SUDDEN APPEARANCE OF HEADACHE AGAINST THE BACKGROUND OF A SHARP INCREASE IN BLOOD PRESSURE, ACCOMPANIED BY NAUSEA, TACHYCARDIA, PALLOR OF THE SKIN, AFTER AN ATTACK – POLYURIA

pheochromocytoma

Cohn syndrome

Itsenko-Cushing syndrome

menopausal syndrome

thyrotoxicosis.

A 22-YEAR-OLD MAN HAS HAD SYSTOLIC MURMUR ON THE BASIS OF THE HEART SINCE CHILDHOOD. BP – 150/100 MMHG CHEST X-RAY: ENLARGEMENT OF THE LEFT VENTRICLE, UNEVEN, JAGGED LOWER EDGES OF THE 5TH-7TH RIBS ON BOTH SIDES. REDUCTION OF PULSATION ON THE LEGS. THE DIAGNOSIS IS:

aortic coarctation

aortic stenosis

open ductus arteriosus

vegetative-vascular dystonia

hypertension

ARTERIAL HYPERTENSION CAN BE SUSPECTED BY THE FOLLOWING CLINICAL SIGNS AND MANIFESTATIONS

pain in the parietal and occipital region

short-term episodes of loss of consciousness

heart rhythm and conduction disorders

the presence of peripheral edema

pain in the parietal and occipital region

violation of the rhythm of breathing

ECG-SIGNS CHARACTERISTIC OF ARTERIAL HYPERTENSION

hypertrophy of the left ventricle

pointed prong P in leads II, III

blockade of the right leg of the Gis beam

widened, double-humped prong P in leads II, III

the absence of a prong.

ARTERIAL HYPERTENSION WITH THYROTOXICOSIS IS CHARACTERIZED BY

increase in systolic and decrease in diastolic pressure

increased systolic and diastolic pressure

lowering of systolic and diastolic pressure

lowering systolic and increased diastolic pressure

normal systolic and increased diastolic pressure

ARTERIAL HYPERTENSION IN HYPOTHYROIDISM IS CHARACTERIZED BY

lowering systolic and increasing diastolic pressure

increased systolic and diastolic pressure

increase in systolic and decrease in diastolic pressure

lowering of systolic and diastolic pressure

increased systolic and normal diastolic pressure

A CHARACTERISTIC FEATURE OF COHN'S SYNDROME

muscle weakness

acidosis

striae

hyperkalemia

hyperuricemia

THE MOST PROBABLE CAUSE OF ARTERIAL HYPERTENSION IN A YOUNG PATIENT WITH OBESITY, ESPECIALLY PRONOUNCED IN THE CHEST, FACE, IN THE ABSENCE OF FAT DEPOSITION ON THE EXTREMITIES. THE SKIN IS THINNED ("PARCHMENT PAPER"), BRIGHT RED STRIAE ON THE ABDOMEN.

Itsenko-Cushing syndrome

hypertension

pheochromocytoma

Cohn syndrome (primary aldosteronism)

thyrotoxicosis

FOR THE DIAGNOSIS OF PHEOCHROMOCYTOMA, STUDIES OF THE LEVEL OF

vanillylmindal acid, metanephrine and normetanephrine in daily urine

ACTH

blood sodium

blood renin

the ratio of aldosterone /renin in the blood

GLUCOCORTICOIDS

increase blood pressure

do not affect the blood pressure

reduce blood pressure

first lower, then increase BP

first raise, then lower BP.

ECG-SIGNS CHARACTERISTIC OF ARTERIAL HYPERTENSION

the amplitude of the wave R in leads V5-6 is greater than the amplitude R in V 4

pointed prong P in leads II, III

blockade of the right leg of the Gis beam

widened, double-humped prong P in leads II, III

Wide prong P (more than 0.10 seconds).

THE MOST PROBABLE CAUSE OF ARTERIAL HYPERTENSION IN A YOUNG MAN WITH COMPLAINTS OF A DECREASE IN THE AMOUNT OF URINE DURING THE DAY, URINE IS RED, CLOUDY. A MONTH AGO, THE PATIENT SUFFERED A SORE THROAT.

acute glomerulonephritis

acute pyelonephritis

hyperaldosteronism

Itsenko-Cushing syndrome

hypertension

PRONOUNCED MUSCLE WEAKNESS, OFTEN PAROXYSMAL, PARESTHESIA, CRAMPS, PAIN IN THE MUSCLES (CALF), HANDS AND TOES WITH HYPERALDOSTERONISM ARE CAUSED BY

hypokalemia

hyponatremia

hyperglycemia

hyperosmolar blood

hyperchloremia

A 22-YEAR-OLD MAN HAS HAD SYSTOLIC MURMUR ON THE BASIS OF THE HEART SINCE CHILDHOOD. BP – 150/100 MMHG CHEST X-RAY: ENLARGEMENT OF THE LEFT VENTRICLE, UNEVEN, JAGGED LOWER EDGES OF THE 5TH-7TH RIBS ON BOTH SIDES. REDUCTION OF PULSATION ON THE LEGS. diagnosis

aortic coarctation

aortic stenosis

open ductus arteriosus

vegetative-vascular dystonia

hypertension.

ARTERIAL HYPERTENSION CAN BE SUSPECTED BY THE FOLLOWING CLINICAL SIGNS AND MANIFESTATIONS) pain in the parietal and occipital region

short-term episodes of loss of consciousness

heart rhythm and conduction disorders

the presence of peripheral edema

violation of the rhythm of breathing.

THE MOST PROBABLE CAUSE OF ARTERIAL HYPERTENSION IN A YOUNG PATIENT WITH OBESITY, ESPECIALLY PRONOUNCED IN THE CHEST, FACE, IN THE ABSENCE OF FAT DEPOSITION ON THE LIMBS. THE SKIN IS THINNED ("PARCHMENT PAPER"), BRIGHT RED STRIAE ON THE ABDOMEN.

Itsenko-Cushing syndrome

hypertension

pheochromocytoma

Cohn syndrome (primary aldosteronism)

thyrotoxicosis

DURING PALPATION OF THE BASIS OF THE HEART, THERE IS A THRILL SENSATIONS COINCIDING WITH PULSATION ON A. CAROTIS PROJECTION. THIS IS CHARACTERISTIC FOR

aortic stenosis

mitral stenosis

mitral insufficiency

aortic insufficiency

tricuspid valve insufficiency

CAROTID PULSE ("CAROTID SHUDDER") IS A SIGN OF

aortic valve insufficiency

about stenosis of the aortic mouth

about myocarditis

about mitral stenosis

POINT WHERE AORTA IS BETTER HEARD DURING AUSCULTATION

II m / r on the right at the sternum

xiphoid process

II m / r on the left at the sternum

apex of the heart

at the Botkin point

AUSCULTATIVE PICTURE I TONE IN AORTIC STENOSIS

I tone is weakened at the top

I tone is reinforced at the top

I tone is not changed

splitting of the I tone

bifurcation of the I tone

"JUMPING" PULSE CAN BE SEEN

aortic insufficiency

arterial hypertension

arterial hypotension

aortic stenosis

mitral stenosis

FEATURE OF AORTIC STENOSIS

systolic murmur on the aorta with irradiation to the vessels of the neck

carotid shudder

de Musset’s sign

flapping I tone at the top

accent II tone on the pulmonary artery

NAME MORPHOLOGICAL MANIFESTATIONS OF DECOMPENSATED HEART DEFECT

nutmeg liver

cardiac amyloidosis

hyalinosis of the spleen capsule

brown liver atrophy

hemorrhages in the brain

THIS IS NOT A CHARACTERISTIC FOR CLINICAL MANIFESTATIONS OF AORTIC STENOSIS

complaints appear immediately when the defect is formed

no complaints for several decades

angina pectoris

fainting

shortness of breath on exertion

IT IS NOT AN AUSCULTATIVE SIGNS OF COMBINED AORTIC DEFECT WITH PREDOMINATION OF AORTIC INSUFFICIENCY

mitral valve opening tone

continuous systole-diastolic murmur

fourth tone

systolic and protodiastolic murmurs

weakening of I, II heart sounds

APPEARANCE OF PATIENTS WITH AURTIC STENOSIS HAS A CHARACTERISTIC OF

pale skin

acrocyanosis

diffuse cyanosis of the skin

de Musset’s sign

carotid shudder

CHARACTERISTICS II SOUND IN AОRTIC STENOSIS

II tone is increased on the aorta

II tone is weakened on the aorta

II tone is split on the aorta

II tone is not changed

II tone is bifurcated on the aorta

WHERE SYSTOLIC NOISE IN AORTIC STENOSIS IS HEARD DURING AUSCULTATION?

on the vessels of the neck

to the Botkin-Erb point

on the xiphoid process

in the armpit

on the pulmonary artery

DE MUSSET’S SIGN IS OBSERVED WITH

aortic valve insufficiency

stenosis of the aortic mouth

mitral stenosis

hypertension

mitral insufficiency

WITH AORTIC STENOSIS "HEART WAIST"

becomes more pronounced

is less pronounced

does not changed

is reduced

is located above

DIASTOLIC NOISE IN AORTIC INSUFFICIENCY IS CARRIED OUT

into the interscapular space

to the Botkin-Erb point

on the xiphoid process

on the vessels of the neck

in the armpit

CHARACTERISTIC FOR AORTIC INSUFFICIENCY

decrease in pulse pressure

pupil pulsation

fast and high heart rate

high systolic pressure

high cardiac output

AORTIC VALVE PROJECTION POINT

in the middle of the sternum at the level of the III costal cartilage

the level of the left II costal cartilage

the level of the right II costal cartilage

the middle of the sternum at the level of the II rib

jugular fossa

IT IS A FEATURE FOR CLINICAL MANIFESTATIONS OF AORTIC REGURGITATION

mandatory development of atrial fibrillation

shortness of breath

there may be no complaints for a long time

angina pectoris

fainting

LEFT VENTRICULAR MYOCARDIAL HYPERTROPHY IS OBSERVED WITH

stenosis of the aortic mouth

aortic valve insufficiency

mitral valve insufficiency

mitral stenosis

tricuspid valve insufficiency

BLOOD PRESSURE IN CASE OF AORTIC INSUFFICIENCY

systolic rises and diastolic falls

only systolic rises

only diastolic rises

will not change

systolic decreases and diastolic increases

IN CASE OF AORTA STENOSIS \_\_ IS HEARD DURING AUSCULTATIOIN

systolic murmur on the aorta

diastolic murmur at the apex

diastolic murmur on the aorta

systolic murmur in the armpit

systole-diastolic murmur

IN CASE OF AORTIC INSUFFICIENCY \_\_\_ IS HEARD DURING AUSCULTATIOIN

diastolic murmur on the aorta

systolic murmur at the base of the xiphoid process

diastolic murmur in the armpit

systolic murmur on the aorta

mitral valve opening tone

LEFT BORDER OF RELATIVE CARDIAC DULLNESS IS DISPLACED WITH AORTA VALVE INSUFFICIENCY

left and down

up and left

down and up

right and up

does not change

SYSTOLIC THRILL OF THE CHEST IS DIAGNOSED IN CASE OF

aortic stenosis

mitral stenosis

aortic insufficiency

mitral insufficiency

tricuspid stenosis

PULSE CHARACTERISTICS IN AORTIC STENOSIS

small, slow

big, galloping

not changed

high, slow

slow, big

SYMPTOM WHICH IS A CHARACTERISTIC FOR AОRTIC STENOSIS

weakening of the I tone at the top

holosystolic murmur

begins after S2 with the opening snap

increase in systolic pressure

decrease in pulse pressure

DISEASE THAT IS A CAUSE OF AORTIC VALVE INSUFFICIENCY

rheumatism

pericarditis

hypertension

coronary arteries disease

tromboembolism

COMMON SIGNS IN THE OBJECTIVE STATUS OF A PATIENT WITH AORTIC VALVE INSUFFICIENCY AND AORTIC STENOSIS

pale skin

de Musset's sign

pulsation of the carotid, subclavian, temporal, brachial arteries

capillary pulse

epigastric pulsation

RADIOLOGICAL SIGNS WHICH ARE TYPICAL FOR AORTIC VALVE INSUFFICIENCY

the shadow of the aorta is expanded

the shadow of right side of heart is expanded

the heart waist is smoothed

the shadow of the aorta is narrow

cardiac waist is not changed

CLINICAL SYMPTOMS THAT DEPEND ON DECREASE IN DIASTOLIC PRESSURE IN THE AORTA

double noises of Traube and Vinogradov on peripheral vessels

muted apex beat

capillary pulse

low rapid pulse

vein jugularis pulsation

IN AORTIC INSUFFICIENCY

I tone is weakened at the top

I tone is reinforced at the top

I tone is not changed

I tone is split

I tone is two-pronged

IN AORTIC INSUFFICIENCY

II tone is weakened on the aorta

II tone is increased on the pulmonary artery

accent II tone on the aorta

II tone is split

II tone is forked

IN CASE OF AORTIC INSUFFICIENCY

systolic pressure rises and diastolic pressure falls

only systolic pressure rises

only diastolic pressure rises

blood pressure will not change

systolic pressure decreases and diastolic pressure increases

THE FOLLOWING AUSCULTATIVE PHENOMENON IS HEARD IN CASE OF AORTIC STENOSIS

systolic murmur at 2 m / r to the right of the sternum, radiating on the carotid arteries in the armpit

diastolic murmur at the apex of the heart, radiating to base of the xiphoid process

systolic murmur in the region of the apex of the heart, radiating

diastolic murmur at 2 m / r to the right of the sternum, to the carotid arteries

mitral valve opening tone

PULSE FEATURES IN CASE OF AORTIC INSUFFICIENCY

tall, fast

atrial fibrillation

small, slow

bradycardia

hard

EVALUATE THE SHORT DIASTOLIC NOISE AT THE APEX, WHICH APPEARED IN A PATIENT WITH AORTA INSUFFICIENCY

Flint’s noise

mitralization of the existing defect

Graham-Still noise

accession of mitral stenosis

attachment of stenosis of the aortic mouth

PULSE PRESSURE IN AORTIC STENOSIS

decreases

increases

does not change

will be hesitant

will tend to zero

CHARACTERISTIC FOR AORTIC STENOSIS

syncope

atrial fibrillation

epigastric pulsation

Musset's sign

carotid shudder

AORTIC VALVE’S PROJECTION ON THE FRONT CHEST WALL

in the middle of the sternum at the level of the III costal cartilage

the level of the left II costal cartilage

the level of the right II costal cartilage

the middle of the sternum at the level of the II rib

jugular fossa

IN CASE OF AORTIC STENOSIS, A "HEART WAIST"

becomes more pronounced

is less pronounced

does not changed

decreases

rises