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QUESTION 1

A 70-year-old man presents to urgent care complaining of a painful, swollen left knee. He previously has had no problems with this knee. Three days prior to onset, he went out dancing for 23 hours but recalls no specific injury. Examination of the knee reveals a moderate-sized effusion and mild pain with any range of motion. Plain x-ray shows no fracture. Which of the following is the best next management?

- A. MRI of knee
- B. aspiration of effusion fluid
- C. rest, ice, and leg elevation
- D. physical therapy referral
- E. arthroscopy

Correct Answer: B

The presence of effusion generally signifies significant disease. Aspiration of the effusion will help in evaluation for hemarthrosis, septic arthritis, and inflammatory crystal disease. Each of these is important to identify and treat early. An MRI and/or arthroscopy would be later considerations.

Orthopedic referral likely would be necessary.

QUESTION 2

A 21-year-old previously healthy woman presents with abdominal pain of 48-hour duration. The pain was initially periumbilical and on progression became localized in the right lower quadrant. The woman had nausea and a decreased appetite. She denied dysuria. Her last menstrual period was 2 weeks earlier. On examination, she was febrile (temperature 38.2°C), and was found to have localized tenderness in the right lower quadrant with guarding. Rectal examination was normal. Laboratory examination demonstrated mild leukocytosis. For the above patient with abdominal pain, select the most likely diagnosis.

- A. gastroenteritis
- B. regional enteritis
- C. acute appendicitis
- D. perforated peptic ulcer
- E. sigmoid diverticulitis
- F. acute pancreatitis
- G. acute cholecystitis
- H. superior mesenteric artery embolism
- I. ruptured abdominal aortic aneurysm



J. ruptured ovarian cyst

K. cecal volvulus

Correct Answer: C

Acute appendicitis initially presents with periumbilical pain secondary to obstruction of the appendiceal lumen. This is mediated through visceral pain fibers, and because the appendix is from the embryologic midgut, the pain is referred to the umbilicus. With obstruction of a hollow viscus, there may be associated nausea. As the inflammatory process progresses to involve the visceral and parietal peritoneal surfaces, the pain becomes localized directly over the appendix in the right lower quadrant. Fever and leukocytosis are nonspecific signs of an inflammatory process. Gastroenteritis may be associated with nausea, anorexia, and lowgrade fever. Periumbilical pain is colicky and secondary to increased peristalsis. Localized pain and signs of peritoneal irritation are uncommon. A ruptured right ovarian cyst may mimic appendicitis. Patients may exhibit right lower abdominal peritoneal irritation. However, the onset of pain is usually sudden, and the pain is initially felt in the right lower quadrant. These patients do not have anorexia or other gastrointestinal symptoms. The clinical picture of regional enteritis (Crohn's disease) is one of a chronic illness, often associated with weight loss, intermittent cramps, and diarrhea. Fever, tenderness, and a palpable right lower quadrant inflammatory mass may result from complications of ileal involvement. Sigmoid diverticulitis is more common in older patients, often with a prodromal history of irregular bowel habits. There may be left lower quadrant pain and tenderness, with a palpable left-sided inflammatory mass. A cecal volvulus presents with sudden onset of colicky abdominal pain and signs and symptoms of a bowel obstruction, including bilious emesis and abdominal distention. Alcohol-related acute pancreatitis presents with pain referred to the epigastrium, with radiation to the back mediated through the celiac ganglia. The patient may develop abdominal distention secondary to the associated paralytic ileus. Hyperamylasemia and an elevated serum lipase, in this clinical setting, are suggestive of pancreatitis. Perforated peptic ulcer and acute cholecystitis may also present with epigastric pain, and elevations of both serum lipase and amylase. Pain from a perforated ulcer, however, is sudden in onset and may be associated with shoulder-tip pain from diaphragmatic irritation. About 75% of patients with perforated duodenal ulcers have pneumoperitoneum on chest and abdominal radiographs.

Acute cholecystitis will usually commence after a large meal and initially presents as colicky epigastric pain, progressing to pain localized in the right upper abdomen when transmural inflammation of the gallbladder wall produces peritoneal irritation. Acute mesenteric occlusion presents with sudden onset of severe but poorly localized periumbilical abdominal pain, associated with acidosis. There may be elevation of serum amylase and lipase. A ruptured abdominal aortic aneurysm will present with sudden onset of midabdominal pain, back pain, and hemodynamic instability.

QUESTION 3

A woman at 31 weeks' gestation complains of feeling dizzy and lightheaded when she lies on her back.

She is Rh negative but denies vaginal bleeding, abdominal trauma, or abdominal pain. The diagnosis is probably the supine hypotensive syndrome.

In which of the following circumstances is the administration of anti-D immune globulin not necessary?

- A. threatened abortion and first-trimester bleeding
- B. genetic amniocentesis at 16 weeks' gestation
- C. at 28 weeks
- D. at 40 weeks with the onset of labor
- E. after delivery of an Rh-positive fetus



Correct Answer: D

Anti-D immune globulin should be given at the time of any vaginal bleeding, trauma, or invasive procedure (e.g., amniocentesis) during pregnancy. Although maternal isoimmunization usually occurs as a result of fetomaternal transfusion at the time of delivery, a small percentage of women become isoimmunized during pregnancy. Anti-D immune globulin is routinely given to unsensitized Rh- negative women at 28 weeks gestation to reduce this risk. Anti-D immune globulin must also be administered within 72 hours after the birth of an Rh-positive infant. Administration at 40 weeks gestation before the onset of labor is unnecessary if the infant is Rh negative and may be ineffective if the infant is Rh positive and there is a significant fetomaternal transfusion.

QUESTION 4

A 50-year-old man presents to the emergency department for increasing abdominal distention and jaundice over the last 46 weeks. Examination reveals mild jaundice, spider angiomas, and ascites.

Enlarged veins are noted around the umbilicus.

For above patient with jaundice, select the one most likely diagnosis.

- A. hepatitis A
- B. hemolysis
- C. choledocholithiasis
- D. biliary stricture
- E. choledochal cyst
- F. pancreatic carcinoma
- G. liver metastases
- H. cirrhosis
- I. pancreatitis

Correct Answer: H

Chronic liver disease, such as cirrhosis, may be a cause of jaundice. Clinical features such as spider angiomas, ascites, and varices suggest cirrhosis.

QUESTION 5

A 28-year-old man has the acute onset of colicky pain in the left costovertebral angle radiating into the groin, as well as gross hematuria. Abdominal x-ray discloses a stone in the left ureter. Which of the following is true concerning this disease?

The patient spontaneously passes the stone, which is found to contain calcium oxalate. Which of the following is the most likely cause of this stone?



- A. chronic urinary tract infection
- B. vitamin D excess
- C. primary hyperparathyroidism
- D. idiopathic hypercalciuria
- E. RTA

Correct Answer: D

More than 90% of renal stones are visible on a plain abdominal x-ray, and the majority contain calcium oxalate. Staghorn calculi usually contain magnesium ammonium phosphate (triple phosphate or struvite) and are associated with alkaline urine. This is commonly encountered in chronic urinary tract infections with urea-splitting bacteria. Radiolucent stones often contain urea, which is associated with acidic urine. A small percentage (fewer than 10%) of renal stones contain cystine. The most common cause of calcium stone disease is idiopathic hypercalciuria. Almost half these patients will excrete more than 4 mg of calcium/kg body weight/24 h in the absence of hypercalcemia. Causes of hypercalciuria to be ruled out are sarcoidosis, hyperparathyroidism, and Paget's disease of bone. Idiopathic hypercalciuria is believed to result from either increased GI absorption of calcium, increased calcium resorption from bone, or excessive renal calcium leakage into the urine.

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