

USMLE-STEP-3^{Q&As}

United States Medical Licensing Step 3

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QUESTION 1

A 67-year-old female was admitted to the hospital because of chronic fatigue and low back pain. An x-ray of the vertebral column showed diffuse osteoporosis and compression fractures of L1 and L2 vertebral bodies. The complete blood count (CBC) was within normal limits. The peripheral blood smear showed rouleaux formation. The immunoelectrophoresis showed a monoclonal spike of more than 3 g. A bone marrow biopsy was performed and showed an increase of more than 20% in plasma cells see Figure below In this particular patient what would be the electrophoretical characteristic changes?



- A. increases levels of IgG and light chains in the urine
- B. IgM spike
- C. IgA elevation
- D. increase in albumin
- E. polyclonal electrophoretic pattern

Correct Answer: A Section: (none)

Explanation:

Multiple myeloma is a plasma cell dyscrasia that is characterized by involvement of the skeleton in multiple sites. The characteristic x-ray shows punched-out bone lesions that are very easily seen in the calvarium. Extension of the disease to lymph nodes and extranodal sites, such as skin, can be seen. The bone marrow biopsy and smears reveal an increased number of plasma cells, which usually constitute greater than 20% of all of the cells. The cells either diffusely infiltrate and replace the marrow elements or can be seen scattered throughout the hematopoietic elements. The neoplastic plasma cells have a perinuclear hof and an eccentrically placed nucleus which allows the recognition. In 99% of patients with multiple myeloma, electrophoretic analysis reveals increased levels of IgG in the blood, light chains (Bence-Jones proteins) in the urine, or both. The monoclonal IgG produces a high spike when seen in the serum or in



the urine, subject to electrophoresis. In general, the quantitative analysis of the monoclonal IgG is more than 3 g. The clinicopathologic diagnosis of multiple myeloma rests on radiographic and laboratory findings. Marrow examination may reveal increased plasma cells or sheet-like aggregates that may completely replace the normal elements. The prognosis for this condition is variable, but generally poor.

QUESTION 2

A 50-year-old female presents to your office for evaluation of solid food dysphagia without weight loss. Symptoms have been present for 6 months and are progressive. The patient has had two episodes of near impaction, but copious water ingestion and repeated swallows allowed the food bolus to pass. She has never had to present to the ER for disimpaction. She drinks five to six beers per day, loves spicy foods, and smokes a pack of cigarettes daily with a total lifetime history of 30 pack-years. She has had intermittent heartburn symptoms for years and has not sought treatment. She takes hydrochlorothiazide for hypertension. Review of symptoms reveals chronic cough. Physical examination is unremarkable. Upper endoscopy reveals a distal esophageal stricture with inflammatory changes. Esophageal biopsies reveal benign mucosa with chronic inflammation. Gastric biopsies are unremarkable. Helicobacter pylori testing is negative.

What is the next best step in therapy for this patient?

- A. esophageal dilation
- B. histamine receptor antagonist therapy
- C. PPI therapy
- D. esophageal dilation with histamine receptor antagonist therapy
- E. esophageal dilation with PPI inhibitor therapy

Correct Answer: E Section: (none)

Explanation:

The patient has a peptic stricture, seen in the setting of long-standing untreated gastroesophageal reflux with esophagitis. The history of progressive solid food dysphagia without weight loss is typical. Tobacco, alcohol, thiazide diuretics, and spicy foods do not predispose to benign esophageal strictures. The patient has developed a peptic stricture, a serious complication of GERD. The patient needs esophageal dilation (either with mechanical or pneumatic dilators) and maximal acid suppression. PPI therapy is superior to histamine receptor antagonist therapy in terms of healing erosive esophageal adenocarcinoma. GERD is not a risk factor for esophageal squamous cell cancer, gastric cancer, or duodenal cancer. Patients with chronic H. pylori infection (which this patient did not have) are at increased risk for a form of gastric lymphoma known as a MALT-oma.

QUESTION 3

Which of the following statements regarding seizures in pregnancy is true?

A. Women with a seizure disorder are at increased risk for eclampsia.

B. Carbamazepine would be a better anticonvulsant during pregnancy, as it is associated with lower risk of congenital anomalies.



C. Women who take valproate during pregnancy are at increased risk for both open neural defects and congenital heart disease.

D. Women who require multidrug therapy to control their seizures are at no greater risk for congenital anomalies than women on monotherapy.

E. It has been clearly demonstrated that women taking anticonvulsants benefit from higher doses of folic acid for prevention of neural tube defects.

Correct Answer: C Section: (none)

Explanation:

All anticonvulsant drugs are associated with at least some risk of congenital abnormalities. Most anticonvulsants are classified as FDA category D, indicating that there is some demonstrated fetal risk but that the maternal benefits of taking the medication may outweigh the risks to the fetus. Carbamazepine, which for a time was thought to have a lower risk for fetal anomalies than other agents such as phenytoin, is now known to have a risk as high or higher. It particularly contributes to an increased risk when it is part of multidrug therapy for women with epilepsy. While the risk of neural tube defects is known to be elevated in women with epilepsy, and particularly those taking anticonvulsant drugs, no data exist to show that higher doses of folic acid will prevent neural tube defects in this group of women. The risk of open neural tube defects in women taking valproate is thought to be 1% (or 10 times the risk in the general population), and the risk of congenital heart disease is also increased.

QUESTION 4

A 68-year-old retired male is accompanied by his son and daughter to a family medicine clinic. They are concerned about their father\\'s health, as they have noticed him becoming gradually more "confused" over the past year. While he had always been capable of managing to live alone, he has not been keeping up with his bills. The patient explains that he needs his bifocals, but both of his children quickly interrupt, stating that he has glasses but misplaces them frequently. He also frequently loses his keys and forgets to shut his door. The management of the condominium has complained because they recently found him wandering around the lobby and pool in the middle of the night while dressed in his underwear. He has no medical problems and takes only an aspirin daily. His MSE is significant for defensiveness to questioning with some irritability. His Mini-Mental State Examination is 19/30, with notable memory deficits and wordfinding difficulties. An MRI performed would most likely demonstrate which of the following findings?

- A. atrophy of frontal and temporal lobes
- B. caudate nucleus atrophy with cortical atrophy
- C. diffuse cortical atrophy with dilatation of ventricles
- D. dilatation of cerebral ventricles without cortical atrophy
- E. subcortical white matter infarcts

Correct Answer: C Section: (none)

Explanation: Explanations: This patient presents with a dementia, most likely Alzheimer\\'s type. Although some cases have been found to have a genetic component, genetic testing is not routinely performed. Neuropsychological testing may be used to specify or confirm the presence of cognitive deficits. Cerebrospinal fluid and MRI may be used to rule-out other causes of dementia but are not necessarily used to diagnose Alzheimer\\'s disease. Although dementia of the



Alzheimer\\'s type is a clinical diagnosis, the final diagnosis can only be made by a neuropathologic examination, which classically demonstrates senile plaques, neurofibrillary tangles, and neuronal loss. (Synopsis, p. 331) Preferential atrophy of the frontotemporal regions is consistent with Pick\\'s disease, which may present similarly to Alzheimer\\'s disease. Huntington\\'s disease, another cause of dementia, is characterized by a severe movement disorder. It demonstrates striking atrophy of the caudate nucleus along with possible cerebral atrophy. Dilatation of the ventricles without atrophy is the hallmark of NPH, one of the few potentially reversible causes of dementia. The classic triad of NPH is dementia, gait disturbance, and urinary incontinence. The second most common cause of dementia is vascular dementia, which is often caused by uncontrolled hypertension. It results in multiple small infarcts of the white matter surrounding the ventricles. Alzheimer\\'s dementia, the most common cause of dementia, is characterized by diffuse cerebral atrophy and dilatation of the ventricles.

QUESTION 5

Which factor is most directly related to prognosis in a patient with the diagnosis of squamous cell carcinoma of the esophagus?

- A. degree of differentiation
- B. duration of the symptoms
- C. method of treatment
- D. stage at the time of diagnosis
- E. type of symptoms

Correct Answer: D Section: (none)

Explanation:

Carcinoma of the esophagus is a highly lethal tumor and is a disease of the elderly. Etiology factors include alcoholism, cigarette smoking, hot drinks, aflatoxins, and smoked fish. The overall prognosis is very poor with 70% of the patients dying within 1 year after diagnosis of the disease. The most important parameter of the prognosis is the stage at the time of diagnosis, because over 80% 5-year survival is present in the tumors detected during the surveillance of Barrett esophagus.

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