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QUESTION 1

A newborn male is brought to you in the neonatal intensive care unit (NICU). On physical examination, you notice that the infant has deficient abdominal musculature and undescended testes. Your suspicion is high for a certain condition.

You presumptively diagnose the child with which of the following?

- A. VATER association
- B. Cushing's triad
- C. Potter's syndrome
- D. Jones criteria
- E. Eagle-Barrett syndrome

Correct Answer: E Section: (none)

Explanation:

The constellation of cryptorchidism, posterior urethral valves, and abnormal abdominal musculature is called Eagle-Barrett syndrome. Another name is prune belly syndrome. The greatest morbidity comes from the poor amniotic fluid production, due to bladder outlet obstruction, with a resulting pulmonary hypoplasia. Cushing's triad are hypertension, bradycardia, and widened pulse pressure. This is seen as terminal findings associated with increased intracranial pressure. VATER association has multiple anomalies, none of which are the three mentioned. VATER is a mnemonic which stands for Vertebral anomalies, Anal atresia (imperforate), Tracheo-Esophageal fistula, and Renal anomalies (the R also indicated Radial anomalies). It is sometimes referred to as VACTERL association in which the C indicates Cardiac anomalies with the L indicating Limb anomalies. Potter's syndrome is bilateral renal agenesis. This condition is fatal, due to marked pulmonary hypoplasia. The Jones criteria are used in the diagnosis of ARF.

QUESTION 2

A 39-year-old woman presents to the office for the evaluation of a mole on her left arm. It has been present and enlarging over the past 6 months. It itches and occasionally bleeds. Which of the following attributes would be considered high risk for skin cancer?

- A. diameter of greater than 6 mm
- B. a sharply demarcated, regular border
- C. a uniform coloration
- D. a symmetric, circular shape
- E. a flat lesion

Correct Answer: A Section: (none)



Explanation:

The mnemonic "ABCDE" is often used to remember some of the attributes of skin lesions that would make them more suspicious for being malignancies. "A" is for asymmetry; "B" for border that is irregular or indistinct from the surrounding skin; "C" for color such as dark black or variations in colors within the same lesion; "D" for diameter greater than 6 mm, or larger than the size of a pencil eraser; "E" for elevation of lesion with surface irregularity. Of the choices in question 56, the presence of a diameter of greater than 6 mm would be considered a higher-risk attribute. Primary skin malignancies are divided into three major categories--basal cell carcinoma, squamous cell carcinoma, and melanoma. Basal cell carcinomas may grow large and be locally destructive, but they have the lowest metastatic potential of the three types of skin cancer. Basal cell carcinomas are more common in persons with fair complexions but they occur in all skin types and colors. Squamous carcinomas of the skin have a metastatic potential greater than basal cell carcinomas and less than malignant melanomas. Squamous carcinomas most commonly occur in sun-exposed areas but are also associated with other etiologies, such as human papilloma virus (HPV), and can occur anywhere on the body. Malignant melanoma has the highest metastatic potential of the primary skin malignancies. Melanoma can occur in any skin type, but is more common in skin types I and II (fair skin). Obtaining a tissue sample for pathologic studies of suspicious skin lesions is critical for diagnosis and planning of appropriate treatment of melanoma. The thickness of the lesion is an important factor in these decisions. Therefore, shave biopsy would be inappropriate for the evaluation of a pigmented lesion. Complete excisional biopsy would be preferable, or, when that is not possible, full-thickness punch biopsy is an acceptable alternative. While sun exposure is an important risk factor for all types of skin cancers, for melanomas there is some evidence that intermittent, intense sun exposure and sunburning is more of a risk than cumulative sun exposure. Actinic keratoses are sun-induced skin lesions that are considered risks for the development of squamous carcinomas. They can be treated with local destructive methods, such as cryosurgery or the topical chemotherapeutic agent 5-fluorouracil. Protection of susceptible skin from excessive sun exposure from childhood is important in reducing the risk of developing skin cancer. Precautions such as wearing broad-brimmed hats, long sleeved clothing, and avoidance of intense midday sunlight are helpful. Using chemical sunscreens with SPF of greater than 15 with frequent reapplication is also beneficial. Even "waterproof" sunscreens need to be reapplied after bathing or swimming. A wet cotton T-shirt provides very little, if any, protection from ultraviolet light exposure. Both the UV-A and UV-B rays play roles in skin damage from the sun and it is important to use sun protection products, which block both types of rays. Sun tanning booths are also considered risks for the induction of skin damage and skin cancer as they expose skin to potentially damaging ultraviolet rays.

QUESTION 3

A patient with dyspepsia has a positive serologic test for *Helicobacter pylori* and is concerned that he could have an ulcer. Which of the following statements about *H. pylori* and ulcer disease would be most accurate?

- A. Gastric ulcers are usually caused by hypersecretion of acid, not bacteria.
- B. A positive IgG serology confirms an active infection with *H. pylori*.
- C. *H. pylori* is associated with both gastric and duodenal ulcers.
- D. Most patients with *H. pylori* have ulcers.
- E. The use of antibiotics alone is successful in eradicating *H. pylori*.

Correct Answer: C Section: (none)

Explanation:

Duodenal ulcers are usually associated with hypersecretion of acid, whereas gastric ulcers may be related to breakdown of the mucosal protective mechanisms or to malignancy. Type I gastric ulcers are the most common. They are usually associated with altered mucosal defense and not hypersecretion of acid. Type II gastric ulcers are caused by



a duodenal ulcer and the resulting pyloric obstruction. Type III gastric ulcers are found proximal to the pylorus and are associated with hypersecretion and duodenal ulcers. *H. pylori* is found in 95% of duodenal and 80% of gastric ulcer patients. However, only 10% of people who carry the bacteria actually manifest ulcer disease. Serologic testing does not determine the presence of an active infection. Active infections can be determined by endoscopic biopsy sampling or the use of urease breath testing. All currently recommended regimens to eradicate *H. pylori* utilize both antibiotics and acid suppression.

QUESTION 4

A 54-year-old male presents to the ED with acute onset of severe abdominal pain. His history is significant for gnawing epigastric pain that radiates to the back for several months. Physical examination demonstrates mild hypertension and tachycardia as well as a rigid "board like" abdomen with generalized rebound tenderness and hypoactive bowel sounds. Rectal examination reveals dark hemoccult positive stools without gross blood. While you are in the process of working up the patient he becomes hypotensive and tachycardic. Bright red blood per rectum is now noted. The most likely explanation for his condition is which of the following?

- A. ruptured esophageal varices
- B. diverticulosis
- C. ruptured abdominal aortic aneurysm (AAA)
- D. ruptured splenic artery aneurysm
- E. erosion of the gastroduodenal artery

Correct Answer: E Section: (none)

Explanation:

The patient's history of gnawing epigastric pain is consistent with ulcer disease. His presentation is that of a perforated duodenal ulcer. The most appropriate first step is to obtain upright plain films of the chest and abdomen to look for free intraperitoneal air. Although the patient is in mild distress, he is not toxic and it is reasonable to confirm your suspicion with radiologic studies. If the plain films did not demonstrate free air and the patient remained hemodynamically stable, a CT scan of the abdomen and pelvis may be indicated to try to make the diagnosis. However, if the patient did show signs of increasing toxicity and evidence for sepsis, such as hypotension or mental status changes, it would be reasonable to proceed with an exploratory laparotomy to make the diagnosis. Upper endoscopy is not indicated in the acute management of a perforated duodenal ulcer and this patient is currently in significant distress and discharging to home with delayed follow-up is unwise. The patient most likely has a posterior perforation of a duodenal ulcer that has eroded into the gastroduodenal artery causing bleeding per rectum, tachycardia, and hypotension. Diverticulosis is a common cause of bright red blood per rectum in elderly patients but is often painless and not consistent with the presentation of this patient. A ruptured AAA generally presents with hypotension and profound shock. A distended abdomen and pulsatile mass can be found on physical examination. Ruptured esophageal varices present with upper GI bleeding and hematemesis and are most often associated with patients who have chronic liver disease.

QUESTION 5

A 49-year-old male postal worker presents to your office for the evaluation of a lesion on his left arm. The lesion started about a week ago as a red pustule but has grown and now has a thick black scab. The lesion is painless. A coworker showed the patient a similar appearing lesion that she developed on her arm for which her doctor prescribed an oral antibiotic. Examination reveals a 5 cm circular black eschar with some surrounding vesicles. A Gram stain of fluid



drained from a vesicle reveals chains of gram-positive bacilli. What organism is most likely responsible for this lesion?

- A. methicillin-resistant Staphylococcus aureus
- B. smallpox virus
- C. Clostridium tetani
- D. Bacillus anthracis
- E. group A beta-hemolytic Streptococcus

Correct Answer: D Section: (none)

Explanation:

B. anthracis causes three diseases in humans: cutaneous, inhalation, and gastrointestinal anthrax. Cutaneous anthrax is the most common of the naturally occurring anthrax diseases. The spores of the gram-positive bacillus can survive for years in soil. The disease cutaneous anthrax occurs when the spores contaminate a wound on the skin of the victim and then start to grow. This disease occurs most commonly in agricultural areas where the soil becomes contaminated by the presence of animals. Initially a painless papule develops, followed by vesicles which then ulcerate and a black eschar forms. In the setting of cutaneous anthrax in a postal worker who has a coworker with an apparently similar disease, bioterrorism must be suspected. This type of attack occurred in the Fall of 2001, when anthrax spores were sent through the U.S. Postal system and over 20 persons were infected. In this setting, the most appropriate initial management is to immediately contact the appropriate Public Health Authorities, usually the local or state health department. Appropriate treatment will also need to be instituted, under the guidance of the public health specialists, as untreated cutaneous anthrax may carry a 20% mortality rate. Antibiotic therapy would usually be with ciprofloxacin, penicillin, or doxycycline. Anthrax does not spread from person to person, so quarantine is not necessary. Inhalation anthrax is caused by the direct inhalation of spores into the lungs and gastrointestinal anthrax, the least common of the anthrax syndromes, is caused by ingestion. Smallpox does not occur naturally anywhere in the world. Therefore, any suspicion of smallpox must be assumed to be a bioterror event and must be reported immediately to public health officials. Physicians should be able to recognize the signs and symptoms of smallpox and be able to distinguish them from the common occurrence of chickenpox. Chickenpox lesions tend to occur in clusters and evolve asynchronously. They are often described as "dew drops on a rose petal" as they are vesicles occurring on an erythematous base. The lesions tend to start on the trunk and rapidly spread outward. The rash will be associated with a fever but there are usually few to no prodromal symptoms. Because of the asynchronous growth and outbreaks, a patient will typically have lesions in different stages of evolution. In contrast, smallpox lesions tend to occur synchronously and the lesions tend to be uniform. The rash frequently occurs on the palms and soles. It typically starts on the face and arms and then spreads to the trunk and legs. The development of the rash tends to be slower than that of chickenpox. There is often a dramatic prodrome of high fever, malaise, headache, and backache for 24 days prior to the onset of the rash. Smallpox carries an approximately 30% mortality, while mortality associated with chickenpox is very low.

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