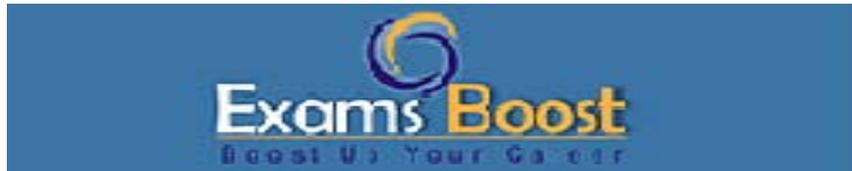


Medical Professional

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Question: 1

A 30-year-old male patient presents the clinic with fatigue, nausea, and dark urine for about a week. He denies sex with men or sexually-transmitted disease, but admits to some alcohol and heroin abuse, with needle sharing. He had mononucleosis as a teenager, but has neither a history of hepatobiliary disease, nor blood transfusions. The lab reports his aminotransferases (ALT) are markedly elevated, and his LDH, direct/total bilirubin, and alkaline phosphatase (ALP) are mildly elevated. These tests are negative: HIV; VDRL; Hepatitis A, B and C antibodies; and liver anti-cytosol 1 antibody. These tests are normal: IgG; ANA; and γ -glutamyl transferase (GGT) level. What is his most likely diagnosis?

- A. Autoimmune hepatitis
- B. Viral Hepatitis B
- C. Cholestatic jaundice
- D. Viral Hepatitis C

Answer: D

Explanation:

Viral Hepatitis C. The patient's clinical picture suggests acute viral hepatitis because the onset was sudden, with jaundice, high aminotransferases, and modest elevations in his other liver function tests. Cholestasis is characterized predominantly by alkaline phosphatase elevation, usually with elevated GGT. Autoimmune hepatitis is characterized by elevated IgG levels, and a positive ANA or liver anti-cytosol 1 antibody. Antibodies to Hepatitis A (IgM anti-HAV) and B (IgM anti-HBc) appear early in the disease, and usually increase when symptoms and jaundice are present. However, a rise in anti-HCV antibody titer is usually delayed for two or three months after the onset of Hepatitis C symptoms. Obtain a follow-up HCV antibody level several months after the onset of illness, in cases in which A and B antibodies are negative. HCV RNA by polymerase chain reaction is usually elevated early in the illness, and may be diagnostic in cases such as this man's.

Question: 2

A 25-year-old male computer programmer comes to the office complaining of intermittent abdominal pain for several months, sometimes accompanied by heartburn. Recently, his over-the-counter antacids are not helping. He denies weight loss, changes in appetite or bowel movements, or gastrointestinal bleeding. He has not used Aspirin or other NSAID drugs. His vital signs and physical examination are normal, except for slight epigastric tenderness on deep compression. The lab reports his CBC and chemistry panel are normal. What is the most reasonable next step for managing his case?

- A. Prescribe a proton pump inhibitor (PPI)
- B. Obtain a urea breath test for H. pylori, and if positive, begin antibiotic therapy
- C. Obtain a stool H. pylori antigen test, and if positive, begin a PPI and antibiotic therapy

D. Refer the patient to a gastroenterologist for an EGD endoscopy

Answer: C

Explanation:

Obtain a stool *H. pylori* antigen test, and if positive, begin a PPI and antibiotic therapy. If a young patient with upper gastrointestinal symptoms has no alarming findings (such as weight loss, anemia, changes in bowel function, or gastrointestinal bleeding) then an immediate EGD endoscopy is usually unnecessary. This patient has no history of NSAID or Aspirin use that could cause stomach bleeding. He possibly has a peptic ulcer, so order an *H. pylori* test by urea breath or stool antigen. If the result is positive for *H. pylori*, start the patient on triple therapy (PPI or bismuth compound, and two appropriate antibiotics) or quadruple therapy (PPI, and a bismuth compound, and two appropriate antibiotics) for seven to 14 days. Observe him for four to six weeks. If his symptoms persist, refer him for an endoscopy. If a patient does take NSAIDs, then discontinue them and prescribe PPI for four to six weeks. If there is no relief, then endoscopy is indicated.

Question: 3

A patient is a 55-year-old man with a 40-year history of cigarette smoking, who has mild dyspnea on exertion. Spirometry shows his FEV1 is 65% of predicted, and his FEV1/FVC is 0.60. Pulse oximetry indicates his oxygen saturation is 92% at rest. The physician diagnoses him with COPD. What therapy is most likely to improve the course of his disease?

- A. Inhaled long-acting β 2-agonist
- B. Home oxygen therapy
- C. Inhaled steroid
- D. Smoking cessation

Answer: D

Explanation:

Smoking cessation. Cessation of cigarette smoking is the only measure found to ameliorate the course of COPD, predominantly in patients with an FEV1 more than 50% of predicted. However, instruct all patients with COPD to stop smoking. β 2-agonists offer symptomatic relief in these patients, whether they are short-acting like albuterol, or long-acting like salmeterol. However, β 2-agonists do not influence the course of the disease. Inhaled long-acting anticholinergics, alone or in combination with β 2-agonists, do not alter progression of COPD. High doses of inhaled steroids may offer a small, one-time improvement in FEV1, and may also prevent exacerbations. Oral steroids, once a mainstay of treatment for stable COPD patients, are presently used less often since the advent of inhaled steroids. The latter are often given in combination with a long-acting β 2-agonist, via metered dose inhaler. Home oxygen treatment for patients with a pO_2 less than 60 mm/Hg may prolong life, and should also be considered for those who develop hypoxemia during exercise or sleep.

Question: 4

A previously well fireman is brought to the Emergency Room with second- and third-degree burns, and considerable smoke inhalation from fighting a fire. His oxygen saturation is 90% and his

carboxyhemoglobin level is 8 0/0. The physician starts him on nasal oxygen and orders him transferred to the Burn Unit for treatment. During his examination the next day, he complains of increasing dyspnea

a. His chest x-ray reveals bilateral pulmonary infiltrates. What is his most likely diagnosis?

- A. Pneumonia
- B. Carbon monoxide poisoning
- C. Acute respiratory distress syndrome (ARDS)
- D. Acute pulmonary fibrosis

Answer: C

Explanation:

Acute respiratory distress syndrome (ARDS). ARDS is a sudden, progressive lung disorder, featuring dyspnea and hypoxemia. Often, bilateral pulmonary infiltrates appear on the chest x-rays of ARDS patients. They may have direct lung injury, such as embolus, pneumonia, smoke or hot air inhalation, or aspiration. Indirect causes include sepsis, DIC, anaphylaxis, shock, and multisystem trauma. ARDS patients have a 40% to 70% mortality rate, usually due to diminished lung compliance, loss of surfactant, atelectasis, and respiratory failure. ARDS often develops in hospitalized ICU patients, even with assisted ventilation. Carboxyhemoglobin levels of 5% to 10% may cause confusion and headache, but should respond to 100% oxygen with a one-hour half-life. Carboxyhemoglobin levels that exceed 60% are usually lethal. Pneumonia is always a possibility in injured firefighters, but his clinical history is more suggestive of ARDS. The evolution of signs and symptoms is too rapid for even acute pulmonary fibrosis.

Question: 5

Which of the following statements concerning a volume-controlled ventilator is FALSE?

- A. Pressure is controlled
- B. Tidal volume is preset and fixed
- C. Lung injury may occur at high pressures
- D. Minute ventilation volume can be preset

Answer: A

Explanation:

Pressure is controlled. Mechanical respirators are classified as conventional volume-controlled ventilators (VCV) or modern pressure-controlled ventilators (PCV). The respiratory therapist sets the VCV tidal volume so the patient receives fixed minute ventilation, wherein the pressure is set, and may or may not provide adequate minute ventilation, depending on the patient's airway resistance and lung compliance. Pressure can fluctuate in a VCV. If pressure is too high to deliver an adequate tidal volume then ventilator-induced lung injury, (VILI), results. The respiratory therapist manipulates mean airway pressure in a PCV by increasing the inspiratory time, thus diminishing the mean airway pressure and reducing the likelihood of high peak values. Controlled mandatory ventilation (CMV) is the mode usually reserved for unconscious or heavily sedated patients. Assist-control (AC) is the mode in which a fixed respiratory rate and tidal volume is delivered if the patient's respiratory effort is inadequate. Synchronized intermittent mandatory ventilation (SIMV) is the mode in which the respiratory therapist delivers a set tidal volume at a set rate, but does not supplement the

patient's spontaneous breathing.

Question: 6

A patient is a 60-year-old, recently-retired construction worker, who complains of a persistent cough and dyspnea on exertion. He was a smoker in his twenties and thirties, but quit smoking about age 40. His AP chest diameter and cardiovascular exam are normal. The physician can hear fine crackles around his lung bases. His fingernails exhibit slight clubbing. His chest x-ray shows irregular opacities that are most prominent at his lung bases. The radiologist notes localized plaques on the pleural surfaces. Spirometry shows a reduced FVC, but a normal FEV1/FVC. What is the most likely diagnosis?

- A. Silicosis
- B. Asbestosis
- C. Non-small cell lung cancer (NSCLC)
- D. Metastatic carcinoma

Answer: B

Explanation:

A patient with asbestosis usually presents with a cough and progressive dyspnea at least 15 years after exposure. Asbestosis commonly affects construction, custodial, and manufacturing workers who were exposed to asbestos, especially during the 1960s and 1970s. This patient's presentation is fairly typical, because his pulmonary symptoms began at least 15 years after his initial exposure. His spirometry and chest x-ray results corroborate asbestosis. Keep in mind the patient's predisposition to mesothelioma during his evaluation. By contrast, a silicosis chest x-ray shows small nodules that tend to predominate in the upper lobes; calcification is rare. While crystallized silicone dioxide is widespread, silicosis is found predominantly in rock drillers and sandblasters. As in all patients who have a significant smoking history, consider lung cancer with metastasis. The patient's radiographic findings are typical of asbestosis, but he may require a CT scan and lung biopsy, so the physician can exclude another, superimposed disease.

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