PREPRIGA-STYLE STUDY PACK · THE HIGH-YIELD MASTERCLASS

NEET PG 2026

The High-Yield Masterclass — Fully Explained Edition

All 180 Questions, each broken into four study boxes: How to Solve, Deep-Dive, Pattern, and Key Fact.

Exam Date: August 30, 2026 · Mode: CBT · Duration: 3h 30m · Marking: +4 / −1

180	720	5	15
QUESTIONS	TOTAL MARKS	SECTIONS	IMAGE/VIDEO-BASED

This companion edition works through every question using the mock test's own stems, options, answer key, and explanations as the base. 15 questions are built around an image or video finding; since actual scans and clinical footage can't be reproduced here, each is presented as a clearly labeled description box directly above the question. Every answer and explanation was cross-checked against the source document's own answer key for internal consistency. This edition is split into six files: this cover & index, plus one file per section (A–E, 36 questions each).

Subject Index

Question numbers grouped by primary subject tag (as shown atop each explanation block). Many questions span more than one subject; each is listed once, under its lead tag.

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How This Pack Is Organized

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Section B Questions 37–72 — *NEETPG_Prepriga_SectionB_Q37-72.docx*

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Section E Questions 145–180 — *NEETPG_Prepriga_SectionE_Q145-180.docx*

Every question in every section file follows the same four-box layout:

HOW TO SOLVE

Walks the stem's clues to the diagnosis and shows why the correct option answers the specific question asked.

DEEP-DIVE

Explains why the distractors are wrong and what makes this topic a recurring exam favorite.

PATTERN

A transferable exam heuristic — how to recognize and solve this style of question next time.

KEY FACT

The single line worth memorizing: clue-pattern → answer.

NEET PG 2026 — Section A — Clinical Integration

Fully Explained Edition · Every option broken into How to Solve, Deep-Dive, Pattern & Key Fact

Questions 1–36 · Exam Date: August 30, 2026 · Marking: +4 / -1

Q1 MEDICINE / CARDIOLOGY

IMAGE FINDING (DESCRIBED)

ECG — 12-lead tracing showing a regular, narrow-complex tachycardia at 180 bpm. P waves are not clearly visible. There is a "pseudo-S" wave in lead V1 and a "pseudo-R" wave in lead aVR.

A 28-year-old female presents with palpitations, lightheadedness, and shortness of breath. She is hemodynamically stable (BP 110/70 mmHg). The ECG is shown. Which of the following is the MOST appropriate initial management?

- **A.** Adenosine 6 mg IV bolus
- **B.** Synchronized cardioversion at 50 J
- **C. Vagal maneuvers (Valsalva/carotid massage)** ✓
- **D.** Verapamil 5 mg IV

ANSWER

C. Vagal maneuvers (Valsalva/carotid massage)

HOW TO SOLVE

Start from the clue cluster: A 28-year-old female presents with palpitations, lightheadedness, and shortness of breath. She is hemodynamically stable (BP 110/70 mmHg). The ECG is shown. This is AV nodal reentrant tachycardia (AVNRT). Vagal maneuvers are first-line in stable patients. That is exactly what the question is asking for (MOST appropriate initial management), so option C — Vagal maneuvers (Valsalva/carotid massage) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Adenosine is second-line if vagal maneuvers fail. Cardioversion is for unstable patients. This scenario sits in the Medicine portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'AV nodal reentrant tachycardia (AVNRT)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Whenever a stem asks for the MOST appropriate MOST appropriate initial management, first separate stabilization from definitive treatment — NEET PG regularly rewards the step that is safe and immediate over the one that is technically 'correct' but premature. Here that step is C. Vagal maneuvers (Valsalva/carotid massage),

because aV nodal reentrant tachycardia (AVNRT) is the pattern being tested, not a request for the final cure.

KEY FACT

AV nodal reentrant tachycardia (AVNRT) → Vagal maneuvers (Valsalva/carotid massage).

Q2 NEUROLOGY / OPHTHALMOLOGY

IMAGE FINDING (DESCRIBED)

Fundoscopy — Optic disc with blurred margins, hyperemic, with splinter hemorrhages on the disc surface. The cup is completely obliterated. No venous pulsations are visible.

A 28-year-old female with BMI 38 kg/m² presents with a 2-week history of headache, transient visual obscurations, and pulsatile tinnitus. Lumbar puncture opening pressure is 35 cm H_2O. CSF analysis is normal. Which of the following is the MOST appropriate initial therapy?

A. Acetazolamide 250 mg twice daily ✓
B. Topiramate 25 mg daily
C. Therapeutic lumbar puncture with CSF drainage
D. Venous sinus stenting

ANSWER

A. Acetazolamide 250 mg twice daily

HOW TO SOLVE

Start from the clue cluster: A 28-year-old female with BMI 38 kg/m² presents with a 2-week history of headache, transient visual obscurations, and pulsatile tinnitus. Lumbar puncture opening pressure is 35 cm H_2O. CSF analysis is normal. This is idiopathic intracranial hypertension (pseudotumor cerebri). Acetazolamide is first-line medical therapy. That is exactly what the question is asking for (MOST appropriate initial therapy), so option A — Acetazolamide 250 mg twice daily — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Topiramate is an alternative but acetazolamide is preferred. This scenario sits in the Neurology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'idiopathic intracranial hypertension (pseudotumor cerebri)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for idiopathic intracranial hypertension (pseudotumor cerebri) is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

idiopathic intracranial hypertension (pseudotumor cerebri) → Acetazolamide 250 mg twice daily.

Q3 SURGERY / RADIOLOGY

IMAGE FINDING (DESCRIBED)

CT Head — Non-contrast axial section showing a hyperdense, lenticular-shaped extra-axial collection with a convex inner margin, located over the right cerebral convexity. There is associated midline shift to the left.

A 65-year-old male with a history of falls and chronic alcoholism presents with progressive confusion, right-sided weakness, and headache over 2 weeks. The CT head is shown. Which of the following is the MOST appropriate definitive management?

- **A.** Burr hole drainage
- **B. Craniotomy with membrane excision** ✓
- **C.** Conservative management with phenytoin
- **D.** Mannitol infusion

ANSWER

B. Craniotomy with membrane excision

HOW TO SOLVE

Start from the clue cluster: A 65-year-old male with a history of falls and chronic alcoholism presents with progressive confusion, right-sided weakness, and headache over 2 weeks. The CT head is shown. This is a chronic subdural hematoma with membrane formation. Craniotomy with membrane excision is the definitive treatment. That is exactly what the question is asking for (MOST appropriate definitive management), so option B — Craniotomy with membrane excision — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Burr hole drainage may be sufficient for acute SDH but chronic SDH with membranes requires craniotomy. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'chronic subdural hematoma with membrane formation' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Definitive-management stems separate temporising measures from the fix that actually resolves the underlying problem. For chronic subdural hematoma with membrane formation, the temporising options are usually present as distractors — flag any option that only buys time and set it aside in favour of the one that treats the actual lesion or process.

KEY FACT

chronic subdural hematoma with membrane formation → Craniotomy with membrane excision.

Q4 MEDICINE / CARDIOLOGY

A 72-year-old female with a history of hypertension and mitral stenosis presents with palpitations, dizziness, and shortness of breath. ECG shows atrial fibrillation with rapid ventricular response (150 bpm). BP is 100/70 mmHg. She has no prior history of anticoagulation. Which of the following is the MOST appropriate immediate management strategy?

- **A.** Electrical cardioversion at 100 J
- **B.** Rate control with IV diltiazem and start warfarin
- **C.** Rate control with IV digoxin and start apixaban
- **D. Immediate therapeutic anticoagulation with heparin followed by rate control** ✓

ANSWER

D. Immediate therapeutic anticoagulation with heparin followed by rate control

HOW TO SOLVE

Start from the clue cluster: A 72-year-old female with a history of hypertension and mitral stenosis presents with palpitations, dizziness, and shortness of breath. ECG shows atrial fibrillation with rapid ventricular response (150 bpm). BP is 100/70 mmHg. In mitral stenosis with AF, the patient is at high risk of thromboembolism. The atrial fibrillation is likely of recent onset (<48 hours) but cannot be confirmed. That is exactly what the question is asking for (MOST appropriate immediate management strategy), so option D — Immediate therapeutic anticoagulation with heparin followed by rate control — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The safest approach is therapeutic anticoagulation with heparin followed by rate control. Electrical cardioversion is contraindicated without prior anticoagulation. This scenario sits in the Medicine portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'In mitral stenosis with AF, the patient is at high risk of thromboembolism' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Whenever a stem asks for the MOST appropriate MOST appropriate immediate management strategy, first separate stabilization from definitive treatment — NEET PG regularly rewards the step that is safe and immediate over the one that is technically 'correct' but premature. Here that step is D. Immediate therapeutic anticoagulation with heparin followed by rate control, because in mitral stenosis with AF, the patient is at high risk of thromboembolism is the pattern being tested, not a request for the final cure.

KEY FACT

In mitral stenosis with AF, the patient is at high risk of thromboembolism → Immediate therapeutic anticoagulation with heparin followed by rate control.

Q5 PULMONOLOGY / RADIOLOGY

IMAGE FINDING (DESCRIBED)

Chest X-ray — PA view showing a large, well-defined, lobulated mass in the right upper zone with a "crescent" of air surrounding the superior aspect of the mass (air crescent sign).

A 45-year-old male with a history of pulmonary tuberculosis treated 10 years ago presents with hemoptysis and weight loss. Serum galactomannan is negative. Which of the following is the MOST likely diagnosis?

- **A. Pulmonary aspergilloma** ✓
- **B.** Reactivation tuberculosis
- **C.** Squamous cell carcinoma
- **D.** Wegener's granulomatosis

ANSWER

A. Pulmonary aspergilloma

HOW TO SOLVE

Start from the clue cluster: A 45-year-old male with a history of pulmonary tuberculosis treated 10 years ago presents with hemoptysis and weight loss. Serum galactomannan is negative. Aspergilloma (fungus ball) in a pre-existing TB cavity shows the "air crescent" sign. Serum galactomannan is typically negative in aspergilloma (unlike invasive aspergillosis). That is exactly what the question is asking for (MOST likely diagnosis), so option A — Pulmonary aspergilloma — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Hemoptysis is a common presentation. This scenario sits in the Pulmonology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name

'Aspergilloma (fungus ball) in a pre-existing TB cavity shows the "air crescent" sign' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with aspergilloma (fungus ball) in a pre-existing TB cavity shows the "air crescent" sign but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

Aspergilloma (fungus ball) in a pre-existing TB cavity shows the "air crescent" sign → Pulmonary aspergilloma.

Q6 DERMATOLOGY

IMAGE FINDING (DESCRIBED)

Histopathology — High-power view of a skin biopsy showing acantholytic cells floating within a suprabasal cleft. The basal layer is intact, giving a "tombstone" appearance. Direct immunofluorescence shows intercellular deposition of IgG and C3.

A 45-year-old female presents with painful, flaccid blisters on the oral mucosa and skin. The blisters rupture easily, leaving behind raw, denuded areas. The biopsy findings are shown. Which of the following is the MOST appropriate next step in management?

- **A. High-dose corticosteroids (prednisone 1 mg/kg/day)** ✓
- **B.** Dapsone
- **C.** Tetracycline and nicotinamide
- **D.** Topical corticosteroids

ANSWER

A. High-dose corticosteroids (prednisone 1 mg/kg/day)

HOW TO SOLVE

Start from the clue cluster: A 45-year-old female presents with painful, flaccid blisters on the oral mucosa and skin. The blisters rupture easily, leaving behind raw, denuded areas. The biopsy findings are shown. This is pemphigus vulgaris (suprabasal acantholysis with "tombstone" appearance, intercellular IgG/C3 deposition). High-dose systemic corticosteroids are the mainstay of treatment. That is exactly what the question is asking for (MOST appropriate next step in management), so option A — High-dose corticosteroids (prednisone 1 mg/kg/day) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Dapsone is used for dermatitis herpetiformis. This scenario sits in the Dermatology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'pemphigus vulgaris (suprabasal acantholysis with "tombstone" appearance, intercellular IgG/C3 deposition)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

'Next step' questions are testing sequencing, not just knowledge — the exam wants the step that comes right after what's already been done in the stem, not the step three moves later. Re-read the stem for what has already happened, then pick the option that logically follows for pemphigus vulgaris (suprabasal acantholysis with "tombstone" appearance, intercellular IgG/C3 deposition).

KEY FACT

pemphigus vulgaris (suprabasal acantholysis with "tombstone" appearance, intercellular IgG/C3 deposition) → High-dose corticosteroids (prednisone 1 mg/kg/day).

Q7 OBSTETRICS / GYNECOLOGY

IMAGE FINDING (DESCRIBED)

Ultrasound — Transvaginal view showing a gestational sac with a fetal pole and yolk sac located in the right adnexa, separate from the ovary. There is free fluid in the cul-de-sac. No intrauterine gestation is seen.

A 28-year-old primigravida at 7 weeks gestation presents with acute-onset right-sided lower abdominal pain and vaginal spotting. She is hemodynamically stable. Her β-hCG is 3500 mIU/mL. Which of the following is the MOST appropriate management?

A. Laparoscopic salpingectomy
B. Methotrexate 50 mg/m² IM ✓
C. Laparoscopic salpingotomy
D. Expectant management

ANSWER

B. Methotrexate 50 mg/m² IM

HOW TO SOLVE

Start from the clue cluster: A 28-year-old primigravida at 7 weeks gestation presents with acute-onset right-sided lower abdominal pain and vaginal spotting. She is hemodynamically stable. Her β-hCG is 3500 mIU/mL. This is an unruptured ectopic pregnancy in a hemodynamically stable patient. Methotrexate is indicated when β-hCG <5000 mIU/mL, the mass is <4 cm, and there is no fetal cardiac activity. That is exactly what the question is asking for

(MOST appropriate management), so option B — Methotrexate 50 mg/m² IM — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Salpingectomy is for ruptured ectopic or failed medical management. This scenario sits in the Obstetrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'unruptured ectopic pregnancy in a hemodynamically stable patient' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for unruptured ectopic pregnancy in a hemodynamically stable patient is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

unruptured ectopic pregnancy in a hemodynamically stable patient → Methotrexate 50 mg/m² IM.

Q8 MICROBIOLOGY / MEDICINE

IMAGE FINDING (DESCRIBED)

Peripheral Smear — High-power view showing numerous ring forms of Plasmodium within red blood cells. Some RBCs show multiple rings. Schüffner's dots are visible in infected cells.

A 25-year-old male who recently returned from sub-Saharan Africa presents with fever, chills, and headache. Temperature is 39.5°C. The peripheral smear is shown. Which of the following is the MOST appropriate initial treatment?

- **A. Artemether-lumefantrine** ✓
- **B.** Chloroquine
- **C.** Quinine + Doxycycline
- **D.** Primaquine

ANSWER

A. Artemether-lumefantrine

HOW TO SOLVE

Start from the clue cluster: A 25-year-old male who recently returned from sub-Saharan Africa presents with fever, chills, and headache. Temperature is 39.5°C. The peripheral smear is shown. Plasmodium falciparum with ring forms, multiple rings per RBC (Schüffner's dots are actually seen in P. vivax, but here the morphology suggests falciparum with multiple rings). Artemether-lumefantrine is the WHO-recommended first-line treatment for uncomplicated falciparum malaria. That is exactly what the question is asking for (MOST appropriate initial treatment), so option A — Artemether-lumefantrine — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Artemether-lumefantrine is the WHO-recommended first-line treatment for uncomplicated falciparum malaria. This scenario sits in the Microbiology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Plasmodium falciparum with ring forms, multiple rings per RBC (Schüffner's dots are actually seen in P. vivax, but here the morphology suggests falciparum with multiple rings)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for plasmodium falciparum with ring forms, multiple rings per RBC (Schüffner's dots are actually seen in P. vivax, but here the morphology suggests falciparum with multiple rings) is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Plasmodium falciparum with ring forms, multiple rings per RBC (Schüffner's dots are actually seen in P. vivax, but here the morphology suggests falciparum with multiple rings) → Artemether-lumefantrine.

Q9 PEDIATRICS / GENETICS

VIDEO FINDING (DESCRIBED)

A 5-second clip shows a child sitting on the examination table. When asked to stand, the child uses both hands to "climb" up the legs to achieve an upright position. This is the Gowers' sign.

A 4-year-old boy presents with progressive difficulty climbing stairs, frequent falls, and a waddling gait. His calves appear enlarged and firm on palpation. Serum creatine kinase is 8500 U/L. Which of the following is the MOST likely underlying genetic mutation?

- **A. Dystrophin gene (DMD) deletion** ✓
- **B.** SMN1 gene deletion
- **C.** Myotonin protein kinase gene expansion
- **D.** DMPK gene expansion

ANSWER

A. Dystrophin gene (DMD) deletion

HOW TO SOLVE

Start from the clue cluster: A 4-year-old boy presents with progressive difficulty climbing stairs, frequent falls, and a waddling gait. His calves appear enlarged and firm on palpation. Serum creatine kinase is 8500 U/L. Gowers' sign, calf pseudohypertrophy, and markedly elevated CK (>10-20x normal) are classic for Duchenne muscular dystrophy. The DMD gene on Xp21 encodes dystrophin. That is exactly what the question is asking for (MOST likely underlying genetic mutation), so option A — Dystrophin gene (DMD) deletion — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

SMN1 deletion causes spinal muscular atrophy (normal CK). Myotonic dystrophy has DM1 (DMPK) or DM2 (CNBP) expansions. This scenario sits in the Pediatrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Gowers' sign, calf pseudohypertrophy, and markedly elevated CK (>10-20x normal) are classic for Duchenne muscular dystrophy' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with gowers' sign, calf pseudohypertrophy, and markedly elevated CK (>10-20x normal) are classic for Duchenne muscular dystrophy but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

Gowers' sign, calf pseudohypertrophy, and markedly elevated CK (>10-20x normal) are classic for Duchenne muscular dystrophy → Dystrophin gene (DMD) deletion.

Q10 ONCOLOGY / PHARMACOLOGY

A 55-year-old female with a history of breast cancer (ER/PR positive, HER2 negative) on anastrozole for 18 months presents with new-onset bilateral hand and wrist pain, stiffness, and swelling. She has no synovitis on examination. She recently started taking glucosamine and chondroitin supplements. Which of the following is the MOST appropriate next step in management?

- **A.** Discontinue anastrozole and switch to tamoxifen
- **B. Add duloxetine and continue anastrozole** ✓
- **C.** Discontinue glucosamine/chondroitin and add NSAIDs
- **D.** Add bisphosphonate and continue anastrozole

ANSWER

B. Add duloxetine and continue anastrozole

HOW TO SOLVE

Start from the clue cluster: A 55-year-old female with a history of breast cancer (ER/PR positive, HER2 negative) on anastrozole for 18 months presents with new-onset bilateral hand and wrist pain, stiffness, and swelling. She has no synovitis on examination. Aromatase inhibitor-induced arthralgia affects 30-50% of patients. Duloxetine has shown significant efficacy in randomized controlled trials (SWOG S1202). That is exactly what the question is asking for (MOST appropriate next step in management), so option B — Add duloxetine and continue anastrozole — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Glucosamine has no proven interaction. Switching to tamoxifen compromises breast cancer outcomes. This scenario sits in the Oncology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Aromatase inhibitor-induced arthralgia affects 30-50% of patients' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

'Next step' questions are testing sequencing, not just knowledge — the exam wants the step that comes right after what's already been done in the stem, not the step three moves later. Re-read the stem for what has already happened, then pick the option that logically follows for aromatase inhibitor-induced arthralgia affects 30-50% of patients.

KEY FACT

Aromatase inhibitor-induced arthralgia affects 30-50% of patients → Add duloxetine and continue anastrozole.

Q11 MEDICINE / NEUROLOGY

IMAGE FINDING (DESCRIBED)

MRI Brain — T2-weighted axial image showing bilateral, symmetrical, hyperintense signal changes in the periaqueductal gray matter and medial thalami. There is no contrast enhancement.

A 55-year-old male with a history of chronic alcoholism presents with confusion, ataxia, and ophthalmoplegia. He has been vomiting for the past week. MRI brain shows the findings above. Which of the following is the MOST appropriate immediate treatment?

A. IV thiamine 100 mg ✓

B. IV glucose 50% dextrose

C. IV lorazepam

D. IV naloxone

ANSWER

A. IV thiamine 100 mg

HOW TO SOLVE

Start from the clue cluster: A 55-year-old male with a history of chronic alcoholism presents with confusion, ataxia, and ophthalmoplegia. He has been vomiting for the past week. MRI brain shows the findings above. Wernicke's encephalopathy with the classic triad (confusion, ataxia, ophthalmoplegia) and MRI findings (periaqueductal gray and medial thalamic involvement). IV thiamine is the emergency treatment. That is exactly what the question is asking for (MOST appropriate immediate treatment), so option A — IV thiamine 100 mg — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Glucose should never be given before thiamine in suspected Wernicke's. This scenario sits in the Medicine portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Wernicke's encephalopathy with the classic triad (confusion, ataxia, ophthalmoplegia) and MRI findings (periaqueductal gray and medial thalamic involvement)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for wernicke's encephalopathy with the classic triad (confusion, ataxia, ophthalmoplegia) and MRI findings (periaqueductal gray and medial thalamic involvement) is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Wernicke's encephalopathy with the classic triad (confusion, ataxia, ophthalmoplegia) and MRI findings (periaqueductal gray and medial thalamic involvement) → IV thiamine 100 mg.

Q12 HIV / PHARMACOLOGY

A 32-year-old male with HIV (CD4 180 cells/µL, viral load undetectable) on tenofovir/emtricitabine/dolutegravir presents with a 3-week history of progressive proximal muscle weakness, myalgia, and CK 4800 U/L. Renal function is normal. Urine phosphate is normal. Which of the following is the MOST likely mechanism?

A. Dolutegravir-induced mitochondrial toxicity ✓

B. Tenofovir-induced Fanconi syndrome

C. Emtricitabine-induced myopathy

D. Immune reconstitution inflammatory syndrome (IRIS)

ANSWER

A. Dolutegravir-induced mitochondrial toxicity

HOW TO SOLVE

Start from the clue cluster: A 32-year-old male with HIV (CD4 180 cells/µL, viral load undetectable) on tenofovir/emtricitabine/dolutegravir presents with a 3-week history of progressive proximal muscle weakness, myalgia, and CK 4800 U/L. Renal function is normal. Dolutegravir can cause mitochondrial toxicity manifesting as proximal myopathy and elevated CK. Tenofovir causes Fanconi syndrome (renal phosphate wasting) — normal urine phosphate rules this out. That is exactly what the question is asking for (MOST likely mechanism), so option A — Dolutegravir-induced mitochondrial toxicity — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Tenofovir causes Fanconi syndrome (renal phosphate wasting) — normal urine phosphate rules this out. This scenario sits in the Hiv portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Dolutegravir can cause mitochondrial toxicity manifesting as proximal myopathy and elevated CK' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Mechanism questions want the specific pathway, not just the drug or disease name — re-read each option as a mechanism claim and test it against every finding in the stem, since dolutegravir can cause mitochondrial toxicity manifesting as proximal myopathy and elevated CK usually has one option that is directionally right but factually wrong.

KEY FACT

Dolutegravir can cause mitochondrial toxicity manifesting as proximal myopathy and elevated CK → Dolutegravir-induced mitochondrial toxicity.

Q13 SURGERY / GASTROENTEROLOGY

IMAGE FINDING (DESCRIBED)

CT Abdomen — Contrast-enhanced axial image showing a 5 cm hypodense mass in the head of the pancreas with delayed enhancement. The common bile duct is dilated. There is a "double duct" sign with both the CBD and pancreatic duct dilated.

A 65-year-old male presents with painless jaundice, weight loss, and pruritus. Stool is pale, urine is dark. CA 19-9 is 250 U/mL. CT shows the findings. Which of the following is the MOST appropriate next step?

- **A. EUS with fine-needle aspiration** ✓
- **B.** ERCP with stent placement
- **C.** PET-CT for staging
- **D.** Laparotomy with Whipple procedure

ANSWER

A. EUS with fine-needle aspiration

HOW TO SOLVE

Start from the clue cluster: A 65-year-old male presents with painless jaundice, weight loss, and pruritus. Stool is pale, urine is dark. CA 19-9 is 250 U/mL. The "double duct" sign is highly suspicious for pancreatic adenocarcinoma. EUS with FNA provides tissue diagnosis and is the first step before definitive management. That is exactly what the question is asking for (MOST appropriate next step), so option A — EUS with fine-needle aspiration — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

ERCP with stenting is for palliation of obstructive jaundice. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'The "double duct" sign is highly suspicious for pancreatic adenocarcinoma' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

'Next step' questions are testing sequencing, not just knowledge — the exam wants the step that comes right after what's already been done in the stem, not the step three moves later. Re-read the stem for what has already happened, then pick the option that logically follows for the "double duct" sign is highly suspicious for pancreatic adenocarcinoma.

KEY FACT

The "double duct" sign is highly suspicious for pancreatic adenocarcinoma → EUS with fine-needle aspiration.

Q14 PATHOLOGY / ONCOLOGY

IMAGE FINDING (DESCRIBED)

Histopathology — Low-power view of a lymph node biopsy showing effacement of the normal architecture by large, atypical mononuclear cells with bilobed nuclei ("owl-eye" or "mirror-image" nuclei). Background shows abundant reactive cells including small lymphocytes, eosinophils, and plasma cells. The atypical cells are CD15 and CD30 positive.

A 28-year-old male presents with painless cervical lymphadenopathy, night sweats, and weight loss. The lymph node biopsy is shown. Which of the following is the MOST likely diagnosis?

A. **Hodgkin lymphoma (Nodular sclerosis)** ✓
B. Diffuse large B-cell lymphoma
C. Burkitt lymphoma
D. Peripheral T-cell lymphoma

ANSWER

A. Hodgkin lymphoma (Nodular sclerosis)

HOW TO SOLVE

Start from the clue cluster: A 28-year-old male presents with painless cervical lymphadenopathy, night sweats, and weight loss. The lymph node biopsy is shown. Reed-Sternberg cells with "owl-eye" nuclei, CD15+/CD30+, in a background of reactive cells, are diagnostic of Hodgkin lymphoma (nodular sclerosis is the most common subtype in young adults). That is exactly what the question is asking for (MOST likely diagnosis), so option A — Hodgkin lymphoma (Nodular sclerosis) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The distractors — B. Diffuse large B-cell lymphoma, C. Burkitt lymphoma, D. Peripheral T-cell lymphoma — are the options a rushed reader reaches for when only part of the stem is read; each one fits a related but distinct condition or a different stage of management, not the specific picture given here. This scenario sits in the Pathology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Reed-Sternberg cells with "owl-eye" nuclei, CD15+/CD30+, in a background of reactive cells, are diagnostic of Hodgkin lymphoma (nodular sclerosis is the most common subtype in young adults)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with reed-Sternberg cells with "owl-eye" nuclei, CD15+/CD30+, in a background of reactive cells, are diagnostic of Hodgkin lymphoma (nodular sclerosis is the most common subtype in young adults) but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

Reed-Sternberg cells with "owl-eye" nuclei, CD15+/CD30+, in a background of reactive cells, are diagnostic of Hodgkin lymphoma (nodular sclerosis is the most common subtype in young adults) → Hodgkin lymphoma (Nodular sclerosis).

Q15 NEUROLOGY / PHARMACOLOGY

A 60-year-old male with a history of atrial fibrillation on dabigatran 150 mg twice daily presents with an acute ischemic stroke 5 hours after symptom onset. NIHSS is 14. CT head shows no hemorrhage. Which of the following is the MOST appropriate next step?

- **A. Administer idarucizumab 5 g IV and proceed with alteplase** ✓
- **B.** Check dabigatran level (dilute thrombin time) and proceed if level <30 ng/mL
- **C.** Proceed with mechanical thrombectomy without pharmacological reversal
- **D.** Administer andexanet alfa and proceed with alteplase

ANSWER

A. Administer idarucizumab 5 g IV and proceed with alteplase

HOW TO SOLVE

Start from the clue cluster: A 60-year-old male with a history of atrial fibrillation on dabigatran 150 mg twice daily presents with an acute ischemic stroke 5 hours after symptom onset. NIHSS is 14. CT head shows no hemorrhage. Idarucizumab is the specific reversal agent for dabigatran. The patient is within the 4.5-hour window for thrombolysis. That is exactly what the question is asking for (MOST appropriate next step), so option A — Administer idarucizumab 5 g IV and proceed with alteplase — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Mechanical thrombectomy is an option but does not address the question of pharmacological thrombolysis. This scenario sits in the Neurology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Idarucizumab is the specific reversal agent for dabigatran' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

'Next step' questions are testing sequencing, not just knowledge — the exam wants the step that comes right after what's already been done in the stem, not the step three moves later. Re-read the stem for what has already happened, then pick the option that logically follows for idarucizumab is the specific reversal agent for dabigatran.

KEY FACT

Idarucizumab is the specific reversal agent for dabigatran → Administer idarucizumab 5 g IV and proceed with alteplase.

Q16 OBSTETRICS / GYNECOLOGY

A 48-year-old female with a history of endometriosis on GnRH agonist therapy for 6 months presents with severe hot flashes, vaginal dryness, and a DEXA T-score of -2.8 at the lumbar spine. She plans to continue GnRH agonist for another 6 months. Which of the following is the MOST appropriate add-back therapy?

A. Norethindrone acetate 5 mg daily ✓
B. Conjugated equine estrogens 0.625 mg daily
C. Raloxifene 60 mg daily
D. Alendronate 70 mg weekly

ANSWER

A. Norethindrone acetate 5 mg daily

HOW TO SOLVE

Start from the clue cluster: A 48-year-old female with a history of endometriosis on GnRH agonist therapy for 6 months presents with severe hot flashes, vaginal dryness, and a DEXA T-score of -2.8 at the lumbar spine. She plans to continue GnRH agonist for another 6 months. Norethindrone acetate (a progestin) is the preferred add-back therapy with GnRH agonists. It provides endometrial protection and bone stabilization. That is exactly what the question is asking for (MOST appropriate add-back therapy), so option A — Norethindrone acetate 5 mg daily — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Estrogen add-back is rarely used in endometriosis as it can stimulate the disease. This scenario sits in the Obstetrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Norethindrone acetate (a progestin) is the preferred add-back therapy with GnRH agonists' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for norethindrone acetate (a progestin) is the preferred add-back therapy with GnRH agonists is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Norethindrone acetate (a progestin) is the preferred add-back therapy with GnRH agonists → Norethindrone acetate 5 mg daily.

Q17 ONCOLOGY / DERMATOLOGY

IMAGE FINDING (DESCRIBED)

Dermatology — Clinical photograph of the lower leg showing a well-demarcated, erythematous, indurated, tender plaque. The surface is shiny and has a peau d'orange appearance. There is associated pitting edema of the affected limb.

A 55-year-old female with a history of breast cancer (mastectomy 5 years ago) presents with a new, firm, erythematous plaque on the left lower leg. The lesion is tender and warm. Which of the following is the MOST likely diagnosis?

A. Erysipelas
B. **Inflammatory breast cancer metastasis** ✓
C. Deep vein thrombosis with phlegmasia
D. Erythema nodosum

ANSWER

B. Inflammatory breast cancer metastasis

HOW TO SOLVE

Start from the clue cluster: A 55-year-old female with a history of breast cancer (mastectomy 5 years ago) presents with a new, firm, erythematous plaque on the left lower leg. The lesion is tender and warm. Inflammatory breast cancer metastasis can present as a "peau d'orange" plaque with induration and lymphedema, often mistaken for cellulitis/erysipelas. The history of breast cancer is a red flag. That is exactly what the question is asking for (MOST likely diagnosis), so option B — Inflammatory breast cancer metastasis — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Biopsy is essential. This scenario sits in the Oncology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Inflammatory breast cancer metastasis can present as a "peau d'orange" plaque with induration and lymphedema, often mistaken for cellulitis/erysipelas' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with inflammatory breast cancer metastasis can present as a "peau d'orange" plaque with induration and lymphedema, often mistaken for cellulitis/erysipelas but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

Inflammatory breast cancer metastasis can present as a "peau d'orange" plaque with induration and

lymphedema, often mistaken for cellulitis/erysipelas → Inflammatory breast cancer metastasis.

Q18 MEDICINE / PULMONOLOGY

IMAGE FINDING (DESCRIBED)

CT Chest — Contrast-enhanced axial image showing a filling defect in the left main pulmonary artery. The defect is central and does not completely occlude the vessel. There is associated wedge-shaped peripheral consolidation.

A 45-year-old female who is on oral contraceptives presents with acute-onset dyspnea and pleuritic chest pain. She is tachycardic and hypoxic. CT pulmonary angiography shows the findings. Which of the following is the MOST appropriate initial management?

- **A. Unfractionated heparin bolus + infusion** ✓
- **B.** LMWH therapeutic dose
- **C.** Thrombolytic therapy
- **D.** Warfarin

ANSWER

A. Unfractionated heparin bolus + infusion

HOW TO SOLVE

Start from the clue cluster: A 45-year-old female who is on oral contraceptives presents with acute-onset dyspnea and pleuritic chest pain. She is tachycardic and hypoxic. CT pulmonary angiography shows the findings. This is a pulmonary embolism. In a hemodynamically stable patient with a non-massive PE, therapeutic anticoagulation with heparin is indicated. That is exactly what the question is asking for (MOST appropriate initial management), so option A — Unfractionated heparin bolus + infusion — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Unfractionated heparin is preferred for initial management as it can be titrated and reversed. LMWH is an alternative for stable patients but heparin allows for closer monitoring. This scenario sits in the Medicine portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'pulmonary embolism' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Whenever a stem asks for the MOST appropriate MOST appropriate initial management, first separate stabilization from definitive treatment — NEET PG regularly rewards the step that is safe and immediate over the one that is technically 'correct' but premature. Here that step is A. Unfractionated heparin bolus + infusion, because pulmonary embolism is the pattern being tested, not a request for the final cure.

KEY FACT

pulmonary embolism → Unfractionated heparin bolus + infusion.

Q19 HEMATOLOGY / PHARMACOLOGY

A 70-year-old female with a hip fracture is started on fondaparinux 2.5 mg daily for VTE prophylaxis. On post-operative day 4, she develops sudden severe dyspnea, hypotension (BP 80/50 mmHg), and hypoxia (SpO_2 85% on 15 L O_2). CT pulmonary angiography shows a massive saddle embolus. Which of the following is the MOST appropriate reversal agent?

- **A.** Protamine sulfate
- **B.** Andexanet alfa
- **C. Recombinant factor VIIa (rFVIIa)** ✓
- **D.** Fresh frozen plasma

ANSWER

C. Recombinant factor VIIa (rFVIIa)

HOW TO SOLVE

Start from the clue cluster: A 70-year-old female with a hip fracture is started on fondaparinux 2.5 mg daily for VTE prophylaxis. On post-operative day 4, she develops sudden severe dyspnea, hypotension (BP 80/50 mmHg), and hypoxia (SpO_2 85% on 15 L O_2). CT pulmonary angiography shows a massive saddle embolus. Fondaparinux is a selective Factor Xa inhibitor. Protamine sulfate does NOT reverse fondaparinux. rFVIIa is the agent of choice for life-threatening bleeding on fondaparinux. That is exactly what the question is asking for (MOST appropriate reversal agent), so option C — Recombinant factor VIIa (rFVIIa) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Andexanet alfa is for direct oral Xa inhibitors (rivaroxaban, apixaban). This scenario sits in the Hematology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Fondaparinux is a selective Factor Xa inhibitor' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Reversal-agent questions are a closed matching set — each anticoagulant class has exactly one specific antidote, and the wrong options are almost always the antidotes for a different drug class. Map the drug in the stem to its class first, then its specific reversal agent, which is why C. Recombinant factor VIIa (rFVIIa) is correct for fondaparinux is a selective Factor Xa inhibitor.

KEY FACT

Fondaparinux is a selective Factor Xa inhibitor → Recombinant factor VIIa (rFVIIa).

Q20 MEDICINE / PHARMACOLOGY

A 55-year-old male with chronic hepatitis C (genotype 1a) is started on sofosbuvir/velpatasvir. He has a history of paroxysmal atrial fibrillation and is on amiodarone 200 mg daily. On day 4 of treatment, he presents with syncope. ECG shows bradycardia (HR 32 bpm) and a prolonged PR interval. Which of the following is the MOST appropriate immediate management?

A. Discontinue sofosbuvir/velpatasvir and monitor with telemetry ✓

B. Administer atropine and discontinue amiodarone

C. Administer isoproterenol and continue sofosbuvir/velpatasvir

D. Perform a permanent pacemaker implantation

ANSWER

A. Discontinue sofosbuvir/velpatasvir and monitor with telemetry

HOW TO SOLVE

Start from the clue cluster: A 55-year-old male with chronic hepatitis C (genotype 1a) is started on sofosbuvir/velpatasvir. He has a history of paroxysmal atrial fibrillation and is on amiodarone 200 mg daily. Sofosbuvir-based regimens plus amiodarone cause severe symptomatic bradycardia. The FDA has issued a black box warning. That is exactly what the question is asking for (MOST appropriate immediate management), so option A — Discontinue sofosbuvir/velpatasvir and monitor with telemetry — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The management is to discontinue the HCV treatment immediately and monitor. Restarting can be considered if the patient is cardioverted or if amiodarone is stopped. This scenario sits in the Medicine portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Sofosbuvir-based regimens plus amiodarone cause severe symptomatic bradycardia' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Whenever a stem asks for the MOST appropriate MOST appropriate immediate management, first separate stabilization from definitive treatment — NEET PG regularly rewards the step that is safe and immediate over the one that is technically 'correct' but premature. Here that step is A. Discontinue sofosbuvir/velpatasvir and monitor with telemetry, because sofosbuvir-based regimens plus amiodarone cause severe symptomatic bradycardia is the pattern being tested, not a request for the final cure.

KEY FACT

Sofosbuvir-based regimens plus amiodarone cause severe symptomatic bradycardia → Discontinue sofosbuvir/velpatasvir and monitor with telemetry.

Q21 NEUROLOGY / OPHTHALMOLOGY

A 28-year-old female with migraine on topiramate 100 mg daily for prophylaxis presents with acute-onset vision loss, headache, and nausea. Fundoscopy reveals bilateral papilledema with absent spontaneous venous pulsations. Lumbar puncture opening pressure is 38 cm H_2O. CSF composition is normal. Which of the following is the MOST likely mechanism?

A. Topiramate-induced acute angle-closure glaucoma

B. Topiramate-induced idiopathic intracranial hypertension ✓

C. Topiramate-induced retinal vein occlusion

D. Topiramate-induced optic neuritis

ANSWER

B. Topiramate-induced idiopathic intracranial hypertension

HOW TO SOLVE

Start from the clue cluster: A 28-year-old female with migraine on topiramate 100 mg daily for prophylaxis presents with acute-onset vision loss, headache, and nausea. Fundoscopy reveals bilateral papilledema with absent spontaneous venous pulsations. Lumbar puncture opening pressure is 38 cm H_2O. Topiramate is associated with secondary intracranial hypertension (pseudotumor cerebri). The mechanism is thought to be via carbonic anhydrase inhibition in the choroid plexus. That is exactly what the question is asking for (MOST likely mechanism), so option B — Topiramate-induced idiopathic intracranial hypertension — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Acute angle-closure glaucoma is different (shallow AC, severe eye pain, fixed mid-dilated pupil). This scenario sits in the Neurology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Topiramate is associated with secondary intracranial hypertension (pseudotumor cerebri)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Mechanism questions want the specific pathway, not just the drug or disease name — re-read each option as a mechanism claim and test it against every finding in the stem, since topiramate is associated with secondary intracranial hypertension (pseudotumor cerebri) usually has one option that is directionally right but factually wrong.

KEY FACT

Topiramate is associated with secondary intracranial hypertension (pseudotumor cerebri) → Topiramate-induced idiopathic intracranial hypertension.

Q22 MEDICINE / PHARMACOLOGY

A 55-year-old male with a history of hypertension on lisinopril 20 mg daily and hydrochlorothiazide 25 mg daily presents with new-onset angioedema involving the lips, tongue, and periorbital area. He has no known allergies. Which of the following is the MOST appropriate alternative antihypertensive?

- **A. Losartan** ✓
- **B.** Amlodipine
- **C.** Hydrochlorothiazide (continue)
- **D.** Carvedilol

ANSWER

A. Losartan

HOW TO SOLVE

Start from the clue cluster: A 55-year-old male with a history of hypertension on lisinopril 20 mg daily and hydrochlorothiazide 25 mg daily presents with new-onset angioedema involving the lips, tongue, and periorbital area. He has no known allergies. ACE inhibitors cause angioedema via increased bradykinin levels. Losartan (an ARB) is the safest alternative because it blocks the AT1 receptor without directly affecting bradykinin metabolism (though rarely ARBs can also cause angioedema). That is exactly what the question is asking for (MOST appropriate alternative antihypertensive), so option A — Losartan — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Losartan (an ARB) is the safest alternative because it blocks the AT1 receptor without directly affecting bradykinin metabolism (though rarely ARBs can also cause angioedema). This scenario sits in the Medicine portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'ACE inhibitors cause angioedema via increased bradykinin levels' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for aCE inhibitors cause angioedema via increased bradykinin levels is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

ACE inhibitors cause angioedema via increased bradykinin levels → Losartan.

Q23 CARDIOLOGY

IMAGE FINDING (DESCRIBED)

Coronary Angiogram — Left coronary injection showing complete occlusion of the proximal left anterior descending artery (LAD) with thrombus. The distal vessel fills via collaterals.

A 60-year-old male with a history of hypertension and hyperlipidemia presents with acute-onset chest pain, diaphoresis, and nausea. ECG shows ST-segment elevation in leads V1-V4. Coronary angiography is performed and shows the findings. He presents to the hospital 90 minutes after symptom onset. Which of the following is the MOST appropriate management?

A. Primary PCI with stent placement ✓

B. Thrombolytic therapy with tenecteplase

C. CABG

D. Medical management with aspirin and heparin

ANSWER

A. Primary PCI with stent placement

HOW TO SOLVE

Start from the clue cluster: A 60-year-old male with a history of hypertension and hyperlipidemia presents with acute-onset chest pain, diaphoresis, and nausea. ECG shows ST-segment elevation in leads V1-V4. Coronary angiography is performed and shows the findings. STEMI with proximal LAD occlusion. Door-to-balloon time should be <90 minutes. That is exactly what the question is asking for (MOST appropriate management), so option A — Primary PCI with stent placement — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Primary PCI is the preferred reperfusion strategy when available and the patient presents within 120 minutes of symptom onset. This scenario sits in the Cardiology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'STEMI with proximal LAD occlusion' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for sTEMI with proximal LAD occlusion is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

STEMI with proximal LAD occlusion → Primary PCI with stent placement.

Q24 OPHTHALMOLOGY / PHARMACOLOGY

A 60-year-old male with benign prostatic hyperplasia on tamsulosin 0.4 mg daily is scheduled for cataract surgery. Which of the following is the MOST appropriate preoperative management to reduce the risk of intraoperative floppy iris syndrome?

- **A. Discontinue tamsulosin 2 weeks before surgery** ✓
- **B.** Discontinue tamsulosin 24 hours before surgery
- **C.** Use atropine eye drops preoperatively
- **D.** Use phenylephrine eye drops preoperatively

ANSWER

A. Discontinue tamsulosin 2 weeks before surgery

HOW TO SOLVE

Start from the clue cluster: A 60-year-old male with benign prostatic hyperplasia on tamsulosin 0.4 mg daily is scheduled for cataract surgery. Tamsulosin (α-1A antagonist) causes intraoperative floppy iris syndrome (IFIS). Discontinuation for 2 weeks significantly reduces the severity of IFIS. That is exactly what the question is asking for (MOST appropriate preoperative management to reduce the risk of intraoperative floppy iris syndrome), so option A — Discontinue tamsulosin 2 weeks before surgery — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Atropine and phenylephrine are used intraoperatively to manage IFIS, not prevent it preoperatively. This scenario sits in the Ophthalmology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Tamsulosin (α-1A antagonist) causes intraoperative floppy iris syndrome (IFIS)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for tamsulosin (α-1A antagonist) causes intraoperative floppy iris syndrome (IFIS) is confirmed, the correct option is usually the most specific and least generic-sounding choice

among the four.

KEY FACT

Tamsulosin (α-1A antagonist) causes intraoperative floppy iris syndrome (IFIS) → Discontinue tamsulosin 2 weeks before surgery.

Q25 ONCOLOGY / PHARMACOLOGY

A 45-year-old female with a history of breast cancer on tamoxifen 20 mg daily for 4 years presents with vaginal bleeding. Endometrial biopsy reveals endometrial adenocarcinoma, FIGO grade 1. Which of the following is the specific tamoxifen metabolite responsible for this complication?

A. 4-Hydroxytamoxifen
B. Endoxifen ✓
C. Afimoxifene
D. (E)-Tamoxifen (trans-isomer)

ANSWER

B. Endoxifen

HOW TO SOLVE

Start from the clue cluster: A 45-year-old female with a history of breast cancer on tamoxifen 20 mg daily for 4 years presents with vaginal bleeding. Endometrial biopsy reveals endometrial adenocarcinoma, FIGO grade 1. Tamoxifen is metabolized by CYP2D6 to its active metabolite, Endoxifen. Endoxifen has partial estrogenic agonist effects on the endometrium, leading to endometrial hyperplasia and carcinoma. That is exactly what the question is asking for (specific tamoxifen metabolite responsible for this complication), so option B — Endoxifen — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Endoxifen has partial estrogenic agonist effects on the endometrium, leading to endometrial hyperplasia and carcinoma. This scenario sits in the Oncology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Tamoxifen is metabolized by CYP2D6 to its active metabolite, Endoxifen' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for tamoxifen is metabolized by CYP2D6 to its active metabolite, Endoxifen is confirmed, the correct option is usually the most specific and least generic-sounding

choice among the four.

KEY FACT

Tamoxifen is metabolized by CYP2D6 to its active metabolite, Endoxifen → Endoxifen.

Q26 NEPHROLOGY / PHARMACOGENOMICS

A 25-year-old male with a history of recurrent kidney stones presents with a radiolucent stone on X-ray but visible on CT. The stone is composed of uric acid. He is started on allopurinol 300 mg daily. After 4 months, his serum uric acid remains elevated at 8.8 mg/dL. Genetic testing reveals an ABCG2 Q141K polymorphism. Which of the following BEST explains this finding?

- **A. ABCG2 variant reduces uric acid excretion — Switch to febuxostat** ✓
- **B.** ABCG2 variant increases xanthine oxidase activity — Increase allopurinol to 600 mg
- **C.** ABCG2 variant reduces allopurinol absorption — Add probenecid
- **D.** ABCG2 variant increases allopurinol metabolism — Check HLA-B*58:01

ANSWER

A. ABCG2 variant reduces uric acid excretion — Switch to febuxostat

HOW TO SOLVE

Start from the clue cluster: A 25-year-old male with a history of recurrent kidney stones presents with a radiolucent stone on X-ray but visible on CT. The stone is composed of uric acid. He is started on allopurinol 300 mg daily. The ABCG2 Q141K variant is a loss-of-function polymorphism that reduces uric acid excretion. It also predicts poor response to allopurinol because allopurinol's active metabolite (oxypurinol) is transported by ABCG2. That is exactly what the question is asking for (Which of the following BEST explains this finding), so option A — ABCG2 variant reduces uric acid excretion — Switch to febuxostat — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Febuxostat is not dependent on ABCG2 for elimination. This scenario sits in the Nephrology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'The ABCG2 Q141K variant is a loss-of-function polymorphism that reduces uric acid excretion' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for the ABCG2 Q141K variant is a loss-of-function polymorphism that reduces uric acid excretion is confirmed, the correct option is usually the most specific and

least generic-sounding choice among the four.

KEY FACT

The ABCG2 Q141K variant is a loss-of-function polymorphism that reduces uric acid excretion → ABCG2 variant reduces uric acid excretion — Switch to febuxostat.

Q27 HIV / PHARMACOLOGY

A 32-year-old male with HIV on efavirenz 600 mg daily for 2 years presents with new-onset bilateral tender gynecomastia and elevated serum estradiol. Which of the following is the MOST appropriate next step?

- **A. Switch to dolutegravir** ✓
- **B.** Add tamoxifen
- **C.** Check serum prolactin
- **D.** Perform mammography

ANSWER

A. Switch to dolutegravir

HOW TO SOLVE

Start from the clue cluster: A 32-year-old male with HIV on efavirenz 600 mg daily for 2 years presents with new-onset bilateral tender gynecomastia and elevated serum estradiol. Efavirenz is a CYP3A4 inducer that increases metabolism of endogenous estradiol, leading to gynecomastia. The most appropriate management is to switch to an alternative INSTI like dolutegravir. That is exactly what the question is asking for (MOST appropriate next step), so option A — Switch to dolutegravir — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The most appropriate management is to switch to an alternative INSTI like dolutegravir. This scenario sits in the Hiv portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Efavirenz is a CYP3A4 inducer that increases metabolism of endogenous estradiol, leading to gynecomastia' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

'Next step' questions are testing sequencing, not just knowledge — the exam wants the step that comes right after what's already been done in the stem, not the step three moves later. Re-read the stem for what has already happened, then pick the option that logically follows for efavirenz is a CYP3A4 inducer that increases metabolism of endogenous estradiol, leading to gynecomastia.

KEY FACT

Efavirenz is a CYP3A4 inducer that increases metabolism of endogenous estradiol, leading to gynecomastia → Switch to dolutegravir.

Q28 ENDOCRINOLOGY / PHARMACOLOGY

A 55-year-old female with osteoporosis on raloxifene 60 mg daily for 2 years presents with new-onset bilateral leg cramps, hot flashes, and peripheral edema. Which of the following is the MOST appropriate next step?

A. Continue raloxifene and add calcium + vitamin D

B. Switch to alendronate ✓

C. Reduce raloxifene dose to 30 mg

D. Add vitamin D

ANSWER

B. Switch to alendronate

HOW TO SOLVE

Start from the clue cluster: A 55-year-old female with osteoporosis on raloxifene 60 mg daily for 2 years presents with new-onset bilateral leg cramps, hot flashes, and peripheral edema. Raloxifene causes leg cramps, hot flashes, and has an increased risk of VTE. Switching to a bisphosphonate (alendronate) is the most appropriate step. That is exactly what the question is asking for (MOST appropriate next step), so option B — Switch to alendronate — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Switching to a bisphosphonate (alendronate) is the most appropriate step. This scenario sits in the Endocrinology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Raloxifene causes leg cramps, hot flashes, and has an increased risk of VTE' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

'Next step' questions are testing sequencing, not just knowledge — the exam wants the step that comes right after what's already been done in the stem, not the step three moves later. Re-read the stem for what has already happened, then pick the option that logically follows for raloxifene causes leg cramps, hot flashes, and has an increased risk of VTE.

KEY FACT

Raloxifene causes leg cramps, hot flashes, and has an increased risk of VTE → Switch to alendronate.

Q29 GASTROENTEROLOGY / PHARMACOLOGY

A 50-year-old male with chronic pancreatitis and diabetes presents with a 3-week history of progressive steatorrhea, weight loss, and abdominal pain. He is on pancreatic enzyme replacement therapy (lipase 25,000 units per meal) but continues to have symptoms. Which of the following is the MOST appropriate next step?

A. Increase lipase dose to 40,000 units per meal

B. **Add a proton pump inhibitor** ✓

C. Switch to enteric-coated microspheres

D. Add a H2-receptor antagonist

ANSWER

B. Add a proton pump inhibitor

HOW TO SOLVE

Start from the clue cluster: A 50-year-old male with chronic pancreatitis and diabetes presents with a 3-week history of progressive steatorrhea, weight loss, and abdominal pain. He is on pancreatic enzyme replacement therapy (lipase 25,000 units per meal) but continues to have symptoms. Pancreatic enzyme replacement therapy efficacy is often limited because lipase is rapidly denatured by gastric acid (inactivated at pH <4). Adding a PPI raises the gastric pH, protecting the lipase. That is exactly what the question is asking for (MOST appropriate next step), so option B — Add a proton pump inhibitor — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Adding a PPI raises the gastric pH, protecting the lipase. This scenario sits in the Gastroenterology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Pancreatic enzyme replacement therapy efficacy is often limited because lipase is rapidly denatured by gastric acid (inactivated at pH <4)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

'Next step' questions are testing sequencing, not just knowledge — the exam wants the step that comes right after what's already been done in the stem, not the step three moves later. Re-read the stem for what has already happened, then pick the option that logically follows for pancreatic enzyme replacement therapy efficacy is often limited because lipase is rapidly denatured by gastric acid (inactivated at pH <4).

KEY FACT

Pancreatic enzyme replacement therapy efficacy is often limited because lipase is rapidly denatured by gastric acid (inactivated at pH <4) → Add a proton pump inhibitor.

Q30 PULMONOLOGY / UROLOGY

A 60-year-old male with COPD on tiotropium 18 mcg daily presents with acute urinary retention requiring catheterization. He has a history of BPH with an IPSS score of 18. Which of the following is the MOST appropriate next step in long-term management?

- **A.** Discontinue tiotropium and start a LAMA/LABA combination
- **B.** Start tamsulosin and continue tiotropium
- **C.** Perform transurethral resection of the prostate (TURP)
- **D. Switch to aclidinium** ✓

ANSWER

D. Switch to aclidinium

HOW TO SOLVE

Start from the clue cluster: A 60-year-old male with COPD on tiotropium 18 mcg daily presents with acute urinary retention requiring catheterization. He has a history of BPH with an IPSS score of 18. Tiotropium has high systemic anticholinergic absorption. Aclidinium has rapid plasma hydrolysis resulting in lower systemic anticholinergic effects. That is exactly what the question is asking for (MOST appropriate next step in long-term management), so option D — Switch to aclidinium — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

It is the preferred LAMA in patients with significant BPH. This scenario sits in the Pulmonology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Tiotropium has high systemic anticholinergic absorption' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

'Next step' questions are testing sequencing, not just knowledge — the exam wants the step that comes right after what's already been done in the stem, not the step three moves later. Re-read the stem for what has already happened, then pick the option that logically follows for tiotropium has high systemic anticholinergic absorption.

KEY FACT

Tiotropium has high systemic anticholinergic absorption → Switch to aclidinium.

Q31 PSYCHIATRY / HEMATOLOGY

A 28-year-old female with depression on sertraline 100 mg daily for 6 months presents with new-onset easy bruising, petechiae, and a platelet count of 16,000/µL. Bone marrow aspiration shows normal megakaryocytes. Which of the following is the MOST likely mechanism?

A. Immune-mediated platelet destruction (drug-dependent antibodies) ✓
B. Direct bone marrow suppression
C. Peripheral platelet sequestration
D. Increased platelet consumption

ANSWER

A. Immune-mediated platelet destruction (drug-dependent antibodies)

HOW TO SOLVE

Start from the clue cluster: A 28-year-old female with depression on sertraline 100 mg daily for 6 months presents with new-onset easy bruising, petechiae, and a platelet count of 16,000/µL. Bone marrow aspiration shows normal megakaryocytes. SSRIs (sertraline) can cause drug-induced immune thrombocytopenia (DITP). The mechanism involves the drug acting as a hapten, binding to platelet glycoproteins, forming an antigen-antibody complex. That is exactly what the question is asking for (MOST likely mechanism), so option A — Immune-mediated platelet destruction (drug-dependent antibodies) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Normal megakaryocytes rule out marrow suppression. This scenario sits in the Psychiatry portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'SSRIs (sertraline) can cause drug-induced immune thrombocytopenia (DITP)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Mechanism questions want the specific pathway, not just the drug or disease name — re-read each option as a mechanism claim and test it against every finding in the stem, since sSRIs (sertraline) can cause drug-induced immune thrombocytopenia (DITP) usually has one option that is directionally right but factually wrong.

KEY FACT

SSRIs (sertraline) can cause drug-induced immune thrombocytopenia (DITP) → Immune-mediated platelet destruction (drug-dependent antibodies).

Q32 ONCOLOGY / PHARMACOLOGY

A 55-year-old male with a history of lung cancer on pembrolizumab for 4 cycles develops new-onset polyarthralgia, a pruritic maculopapular rash covering 40% of BSA, and watery diarrhea (6 episodes/day). Which of the following is the MOST appropriate management for this grade 3 immune-related adverse event?

A. High-dose corticosteroids (prednisone 1-2 mg/kg/day) and hold pembrolizumab ✓

B. Infliximab and hold pembrolizumab

C. Mycophenolate mofetil and continue pembrolizumab

D. Anti-thymocyte globulin and discontinue pembrolizumab permanently

ANSWER

A. High-dose corticosteroids (prednisone 1-2 mg/kg/day) and hold pembrolizumab

HOW TO SOLVE

Start from the clue cluster: A 55-year-old male with a history of lung cancer on pembrolizumab for 4 cycles develops new-onset polyarthralgia, a pruritic maculopapular rash covering 40% of BSA, and watery diarrhea (6 episodes/day). Grade 3 irAEs require holding the ICI and initiating high-dose corticosteroids. Infliximab is used if steroids fail (steroid-refractory colitis). That is exactly what the question is asking for (MOST appropriate management for this grade 3 immune-related adverse event), so option A — High-dose corticosteroids (prednisone 1-2 mg/kg/day) and hold pembrolizumab — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Mycophenolate is used for steroid-refractory hepatitis/pneumonitis. This scenario sits in the Oncology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Grade 3 irAEs require holding the ICI and initiating high-dose corticosteroids' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for grade 3 irAEs require holding the ICI and initiating high-dose corticosteroids is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Grade 3 irAEs require holding the ICI and initiating high-dose corticosteroids → High-dose corticosteroids (prednisone 1-2 mg/kg/day) and hold pembrolizumab.

Q33 GASTROENTEROLOGY / PHARMACOLOGY

A 45-year-old male with heavy alcohol use presents with acute pancreatitis. Serum triglyceride level is 1800 mg/dL. He is started on an insulin infusion. Which of the following is the MOST appropriate additional therapy to rapidly lower triglycerides in this acute setting?

A. Plasmapheresis

B. Fenofibrate

C. Omega-3 fatty acids

D. Heparin ✓

ANSWER

D. Heparin

HOW TO SOLVE

Start from the clue cluster: A 45-year-old male with heavy alcohol use presents with acute pancreatitis. Serum triglyceride level is 1800 mg/dL. He is started on an insulin infusion. Heparin releases lipoprotein lipase (LPL) from the vascular endothelium, which rapidly hydrolyzes triglycerides. Insulin (already started) also stimulates LPL but acts slowly. That is exactly what the question is asking for (MOST appropriate additional therapy to rapidly lower triglycerides in this acute setting), so option D — Heparin — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Plasmapheresis is for severe cases >5000 mg/dL. This scenario sits in the Gastroenterology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Heparin releases lipoprotein lipase (LPL) from the vascular endothelium, which rapidly hydrolyzes triglycerides' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for heparin releases lipoprotein lipase (LPL) from the vascular endothelium, which rapidly hydrolyzes triglycerides is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Heparin releases lipoprotein lipase (LPL) from the vascular endothelium, which rapidly hydrolyzes triglycerides → Heparin.

Q34 ANESTHESIA / NEUROLOGY

A 70-year-old male with Alzheimer's disease on donepezil 10 mg daily for 2 years presents with a fall and a right-sided intertrochanteric hip fracture. He is scheduled for surgery under general anesthesia. Which of the following is the MOST appropriate perioperative management of donepezil?

A. Continue donepezil perioperatively ✓

B. Stop donepezil 24 hours pre-operatively

C. Stop donepezil 7 days pre-operatively

D. Reduce donepezil to 5 mg daily

ANSWER

A. Continue donepezil perioperatively

HOW TO SOLVE

Start from the clue cluster: A 70-year-old male with Alzheimer's disease on donepezil 10 mg daily for 2 years presents with a fall and a right-sided intertrochanteric hip fracture. He is scheduled for surgery under general anesthesia. Donepezil should be continued perioperatively. Abrupt withdrawal can precipitate acute confusion and worsen cognitive function. That is exactly what the question is asking for (MOST appropriate perioperative management of donepezil), so option A — Continue donepezil perioperatively — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Continuing donepezil is associated with a reduced risk of post-operative delirium. This scenario sits in the Anesthesia portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Donepezil should be continued perioperatively' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for donepezil should be continued perioperatively is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Donepezil should be continued perioperatively → Continue donepezil perioperatively.

Q35 RHEUMATOLOGY / OPHTHALMOLOGY

A 32-year-old female with systemic lupus erythematosus on hydroxychloroquine 400 mg daily for 6 years presents with progressive visual loss. Fundoscopy reveals bilateral bull's-eye maculopathy. She is switched to quinacrine. Which of the following is the MOST appropriate monitoring parameter for quinacrine?

- **A. Serum drug levels and liver function tests** ✓
- **B.** Annual optical coherence tomography (OCT)
- **C.** Visual field testing every 6 months
- **D.** Genetic testing for ABCA4 mutations

ANSWER

A. Serum drug levels and liver function tests

HOW TO SOLVE

Start from the clue cluster: A 32-year-old female with systemic lupus erythematosus on hydroxychloroquine 400 mg daily for 6 years presents with progressive visual loss. Fundoscopy reveals bilateral bull's-eye maculopathy. She is switched to quinacrine. Quinacrine does NOT cause retinal toxicity. The primary toxicities of quinacrine are hepatotoxicity, gastrointestinal, and dermatologic (yellow skin discoloration). That is exactly what the question is asking for (MOST appropriate monitoring parameter for quinacrine), so option A — Serum drug levels and liver function tests — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Monitoring involves serum levels and LFTs. OCT is for HCQ monitoring. This scenario sits in the Rheumatology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Quinacrine does NOT cause retinal toxicity' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for quinacrine does NOT cause retinal toxicity is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Quinacrine does NOT cause retinal toxicity → Serum drug levels and liver function tests.

Q36 NEPHROLOGY / TOXICOLOGY

A 65-year-old male with chronic kidney disease on hemodialysis is found to have a serum aluminum level of 120 µg/L (normal <30 µg/L). He has been on sevelamer carbonate for phosphate control. Which of the following is the MOST likely source of aluminum toxicity?

- **A. Dialysate water contamination** ✓
- **B.** Sevelamer carbonate
- **C.** Calcium acetate
- **D.** Vitamin D analogs

ANSWER

A. Dialysate water contamination

HOW TO SOLVE

Start from the clue cluster: A 65-year-old male with chronic kidney disease on hemodialysis is found to have a serum aluminum level of 120 µg/L (normal <30 µg/L). He has been on sevelamer carbonate for phosphate control. Aluminum toxicity in dialysis patients classically arises from contaminated dialysate water. Sevelamer is aluminum-free. That is exactly what the question is asking for (MOST likely source of aluminum toxicity), so option A — Dialysate water contamination — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Aluminum accumulates in bone, inhibiting osteoblast function and mineralization, leading to osteomalacia. SECTION B Clinical Integration — Mixed Subjects Questions 37–72. This scenario sits in the Nephrology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Aluminum toxicity in dialysis patients classically arises from contaminated dialysate water' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for aluminum toxicity in dialysis patients classically arises from contaminated dialysate water is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Aluminum toxicity in dialysis patients classically arises from contaminated dialysate water → Dialysate water contamination.

NEET PG 2026 — Section B — Clinical Integration

Fully Explained Edition · Every option broken into How to Solve, Deep-Dive, Pattern & Key Fact

Questions 37–72 · Exam Date: August 30, 2026 · Marking: +4 / -1

Q37 ENDOCRINOLOGY / NEPHROLOGY

A 55-year-old male with type 2 diabetes mellitus, BMI 34, and eGFR 32 mL/min on metformin and glimepiride presents with recurrent hypoglycemic episodes. C-peptide is elevated. Insulin antibodies are negative. Which of the following is the MOST likely cause?

- **A.** Sulfonylurea-induced factitious hypoglycemia
- **B.** Insulinoma (MEN-1)
- **C.** Metformin-induced lactic acidosis
- **D. Renal failure causing delayed clearance of sulfonylurea metabolites** ✓

ANSWER

D. Renal failure causing delayed clearance of sulfonylurea metabolites

HOW TO SOLVE

Start from the clue cluster: A 55-year-old male with type 2 diabetes mellitus, BMI 34, and eGFR 32 mL/min on metformin and glimepiride presents with recurrent hypoglycemic episodes. C-peptide is elevated. Insulin antibodies are negative. Sulfonylureas (glimepiride) are renally cleared. In CKD, their metabolites accumulate, causing prolonged hypoglycemia. That is exactly what the question is asking for (MOST likely cause), so option D — Renal failure causing delayed clearance of sulfonylurea metabolites — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Elevated C-peptide indicates endogenous insulin secretion (ruling out factitious insulin use). Insulinoma is less likely given the presence of a drug that can cause hypoglycemia. This scenario sits in the Endocrinology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Sulfonylureas (glimepiride) are renally cleared' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with sulfonylureas (glimepiride) are renally cleared but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

Sulfonylureas (glimepiride) are renally cleared → Renal failure causing delayed clearance of sulfonylurea metabolites.

Q38 MEDICINE / CARDIOLOGY

A 40-year-old male presents with acute pericarditis. ECG shows PR depression and diffuse ST elevation. Echo shows a moderate pericardial effusion. He has a recent viral prodrome, ESR 85 mm/hr, and a loud tri-phasic friction rub with a pericardial knock. Which of the following etiologies is MOST likely?

A. Uremic pericarditis
B. Post-myocardial infarction (Dressler's syndrome)
C. Viral pericarditis
D. Tuberculous pericarditis ✓

ANSWER

D. Tuberculous pericarditis

HOW TO SOLVE

Start from the clue cluster: A 40-year-old male presents with acute pericarditis. ECG shows PR depression and diffuse ST elevation. Echo shows a moderate pericardial effusion. Tuberculous pericarditis presents with a subacute course, large effusion, elevated ESR, and a pericardial knock. Viral pericarditis typically has a more benign course and smaller effusions. That is exactly what the question is asking for (Which of the following etiologies is MOST likely), so option D — Tuberculous pericarditis — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Uremic pericarditis has a friction rub but the clinical context is different. This scenario sits in the Medicine portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Tuberculous pericarditis presents with a subacute course, large effusion, elevated ESR, and a pericardial knock' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for tuberculous pericarditis presents with a subacute course, large effusion, elevated ESR, and a pericardial knock is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Tuberculous pericarditis presents with a subacute course, large effusion, elevated ESR, and a pericardial knock → Tuberculous pericarditis.

Q39 RHEUMATOLOGY / PULMONOLOGY

A 65-year-old female with rheumatoid arthritis on leflunomide develops worsening dyspnea and a non-productive cough. HRCT shows diffuse ground-glass opacities and traction bronchiectasis in a UIP pattern. BAL reveals lymphocytosis (45%) with a CD4/CD8 ratio of 0.5. Which of the following is the MOST appropriate next step?

- **A. Discontinue leflunomide and start high-dose corticosteroids** ✓
- **B.** Start pirfenidone
- **C.** Perform a surgical lung biopsy
- **D.** Start rituximab

ANSWER

A. Discontinue leflunomide and start high-dose corticosteroids

HOW TO SOLVE

Start from the clue cluster: A 65-year-old female with rheumatoid arthritis on leflunomide develops worsening dyspnea and a non-productive cough. HRCT shows diffuse ground-glass opacities and traction bronchiectasis in a UIP pattern. BAL reveals lymphocytosis (45%) Leflunomide can cause interstitial lung disease. Drug-induced ILD should be managed by discontinuing the offending drug and starting corticosteroids. That is exactly what the question is asking for (MOST appropriate next step), so option A — Discontinue leflunomide and start high-dose corticosteroids — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Pirfenidone is for idiopathic pulmonary fibrosis, not drug-induced ILD. This scenario sits in the Rheumatology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Leflunomide can cause interstitial lung disease' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

'Next step' questions are testing sequencing, not just knowledge — the exam wants the step that comes right after what's already been done in the stem, not the step three moves later. Re-read the stem for what has already happened, then pick the option that logically follows for leflunomide can cause interstitial lung disease.

KEY FACT

Leflunomide can cause interstitial lung disease → Discontinue leflunomide and start high-dose corticosteroids.

Q40 GASTROENTEROLOGY / SURGERY

A 28-year-old male with ulcerative colitis presents with acute-onset severe abdominal pain, abdominal distension, and fever. Abdominal X-ray shows colonic dilation up to 8 cm with air-fluid levels. He develops a sudden drop in hemoglobin and hypotension. Which of the following is the MOST appropriate immediate surgical procedure?

- **A.** Total proctocolectomy with ileostomy
- **B.** **Subtotal colectomy with end ileostomy** ✓
- **C.** Loop colostomy
- **D.** Percutaneous drainage

ANSWER

B. Subtotal colectomy with end ileostomy

HOW TO SOLVE

Start from the clue cluster: A 28-year-old male with ulcerative colitis presents with acute-onset severe abdominal pain, abdominal distension, and fever. Abdominal X-ray shows colonic dilation up to 8 cm with air-fluid levels. He develops a sudden drop in hemoglobin and hypotension. This is toxic megacolon with perforation (sudden drop in hemoglobin and hypotension). Subtotal colectomy with end ileostomy is the procedure of choice. That is exactly what the question is asking for (MOST appropriate immediate surgical procedure), so option B — Subtotal colectomy with end ileostomy — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Total proctocolectomy is too extensive in an emergency. Loop colostomy does not address the diseased colon. This scenario sits in the Gastroenterology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'toxic megacolon with perforation (sudden drop in hemoglobin and hypotension)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Definitive-management stems separate temporising measures from the fix that actually resolves the underlying problem. For toxic megacolon with perforation (sudden drop in hemoglobin and hypotension), the temporising options are usually present as distractors — flag any option that only buys time and set it aside in favour of the one that treats the actual lesion or process.

KEY FACT

toxic megacolon with perforation (sudden drop in hemoglobin and hypotension) → Subtotal colectomy with end ileostomy.

Q41 MEDICINE / HEPATOLOGY

A 52-year-old male with cirrhosis presents with new-onset ascites, fever, and abdominal pain. Paracentesis reveals a neutrophil count of 500 cells/µL, protein 2.5 g/dL, and LDH 400 U/L. SAAG is 1.1. He had recent endoscopic variceal ligation (EVL) with prophylactic ceftriaxone. Which of the following organisms is MOST likely?

A. E. coli

B. Streptococcus pneumoniae

C. Enterococcus faecalis ✓

D. Candida albicans

ANSWER

C. Enterococcus faecalis

HOW TO SOLVE

Start from the clue cluster: A 52-year-old male with cirrhosis presents with new-onset ascites, fever, and abdominal pain. Paracentesis reveals a neutrophil count of 500 cells/µL, protein 2.5 g/dL, and LDH 400 U/L. SAAG is 1.1. In patients who have received prophylactic antibiotics (ceftriaxone), the spectrum of organisms causing spontaneous bacterial peritonitis shifts to gram- positive organisms and Enterococcus. Enterococcus faecalis is the most likely among the options. That is exactly what the question is asking for (Which of the following organisms is MOST likely), so option C — Enterococcus faecalis — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Enterococcus faecalis is the most likely among the options. This scenario sits in the Medicine portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'In patients who have received prophylactic antibiotics (ceftriaxone), the spectrum of organisms causing spontaneous bacterial peritonitis shifts to gram- positive organisms and Enterococcus' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for in patients who have received prophylactic antibiotics (ceftriaxone), the spectrum of organisms causing spontaneous bacterial peritonitis shifts to gram- positive organisms and Enterococcus is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

In patients who have received prophylactic antibiotics (ceftriaxone), the spectrum of organisms causing spontaneous bacterial peritonitis shifts to gram- positive organisms and Enterococcus → Enterococcus faecalis.

Q42 MICROBIOLOGY / MEDICINE

A 45-year-old male with HIV (CD4 150 cells/µL) presents with headache, photophobia, and confusion. CSF shows an opening pressure of 35 cm H_2O, elevated protein, low glucose, and a positive India ink preparation. Which of the following is the MOST appropriate initial induction therapy?

A. Amphotericin B deoxycholate + Flucytosine ✓

B. Liposomal Amphotericin B + Fluconazole

C. Voriconazole

D. Caspofungin

ANSWER

A. Amphotericin B deoxycholate + Flucytosine

HOW TO SOLVE

Start from the clue cluster: A 45-year-old male with HIV (CD4 150 cells/µL) presents with headache, photophobia, and confusion. CSF shows an opening pressure of 35 cm H_2O, elevated protein, low glucose, and a positive India ink preparation. Cryptococcal meningitis in HIV. Amphotericin B deoxycholate + Flucytosine is the standard induction therapy. That is exactly what the question is asking for (MOST appropriate initial induction therapy), so option A — Amphotericin B deoxycholate + Flucytosine — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Liposomal amphotericin is preferred but deoxycholate is also acceptable. Fluconazole is used for consolidation, not induction. This scenario sits in the Microbiology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Cryptococcal meningitis in HIV' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for cryptococcal meningitis in HIV is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Cryptococcal meningitis in HIV → Amphotericin B deoxycholate + Flucytosine.

Q43 NEUROLOGY / MEDICINE

A 70-year-old male with a 4-week history of progressive ascending sensory loss, ataxia, and ophthalmoplegia. MRI brain shows bilateral symmetrical T2 hyperintensities in the periaqueductal gray matter and medial thalami. Serum anti-GAD antibodies are negative. Which of the following is the MOST likely diagnosis?

- **A. Wernicke's encephalopathy** ✓
- **B.** Paraneoplastic brainstem encephalitis
- **C.** Central pontine myelinolysis
- **D.** Behçet's disease

ANSWER

A. Wernicke's encephalopathy

HOW TO SOLVE

Start from the clue cluster: A 70-year-old male with a 4-week history of progressive ascending sensory loss, ataxia, and ophthalmoplegia. MRI brain shows bilateral symmetrical T2 hyperintensities in the periaqueductal gray matter and medial thalami. Serum anti-GAD antibodies are negative. Wernicke's encephalopathy with the classic triad (confusion, ataxia, ophthalmoplegia) and MRI findings (periaqueductal gray and medial thalamic involvement). Anti-GAD antibodies would be positive in some paraneoplastic syndromes but are negative here. That is exactly what the question is asking for (MOST likely diagnosis), so option A — Wernicke's encephalopathy — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Anti-GAD antibodies would be positive in some paraneoplastic syndromes but are negative here. This scenario sits in the Neurology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Wernicke's encephalopathy with the classic triad (confusion, ataxia, ophthalmoplegia) and MRI findings (periaqueductal gray and medial thalamic involvement)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with wernicke's encephalopathy with the classic triad (confusion, ataxia, ophthalmoplegia) and MRI findings (periaqueductal gray and medial thalamic involvement) but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

Wernicke's encephalopathy with the classic triad (confusion, ataxia, ophthalmoplegia) and MRI findings (periaqueductal gray and medial thalamic involvement) → Wernicke's encephalopathy.

Q44 NEUROLOGY / PHARMACOLOGY

A 32-year-old female with migraine on oral contraceptives presents with acute severe headache, vomiting, and focal seizures. CT venography shows a filling defect in the superior sagittal sinus. Which of the following is the MOST appropriate initial anticoagulation strategy?

- **A. Low molecular weight heparin (therapeutic dose)** ✓
- **B.** Unfractionated heparin bolus followed by infusion
- **C.** Aspirin 325 mg
- **D.** Direct oral anticoagulant (Dabigatran)

ANSWER

A. Low molecular weight heparin (therapeutic dose)

HOW TO SOLVE

Start from the clue cluster: A 32-year-old female with migraine on oral contraceptives presents with acute severe headache, vomiting, and focal seizures. CT venography shows a filling defect in the superior sagittal sinus. Cerebral venous sinus thrombosis is treated with therapeutic anticoagulation. LMWH is preferred over unfractionated heparin due to better predictability and fewer monitoring requirements. That is exactly what the question is asking for (MOST appropriate initial anticoagulation strategy), so option A — Low molecular weight heparin (therapeutic dose) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

DOACs are being studied but LMWH is standard initial therapy. This scenario sits in the Neurology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Cerebral venous sinus thrombosis is treated with therapeutic anticoagulation' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for cerebral venous sinus thrombosis is treated with therapeutic anticoagulation is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Cerebral venous sinus thrombosis is treated with therapeutic anticoagulation → Low molecular weight heparin (therapeutic dose).

Q45 CARDIOLOGY

A 60-year-old male with a history of myocardial infarction presents with progressive breathlessness. Echo shows a restrictive filling pattern with an E/A ratio >2, deceleration time <150 ms. Which of the following is the MOST accurate prognostic indicator?

- **A. LVEF <35%** ✓
- **B.** Left ventricular end-diastolic diameter > 60 mm
- **C.** Presence of an S3 gallop
- **D.** Transmitral E/A ratio with Valsalva maneuver showing pseudonormalization

ANSWER

A. LVEF <35%

HOW TO SOLVE

Start from the clue cluster: A 60-year-old male with a history of myocardial infarction presents with progressive breathlessness. Echo shows a restrictive filling pattern with an E/A ratio >2, deceleration time <150 ms. In heart failure with reduced ejection fraction, LVEF <35% is the strongest predictor of poor prognosis and sudden cardiac death, and is an indication for ICD implantation. The restrictive filling pattern (E/A >2, DT <150 ms) indicates advanced diastolic dysfunction but LVEF is the primary prognostic marker. That is exactly what the question is asking for (MOST accurate prognostic indicator), so option A — LVEF <35% — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The restrictive filling pattern (E/A >2, DT <150 ms) indicates advanced diastolic dysfunction but LVEF is the primary prognostic marker. This scenario sits in the Cardiology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'In heart failure with reduced ejection fraction, LVEF <35% is the strongest predictor of poor prognosis and sudden cardiac death, and is an indication for ICD implantation' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Prognosis and risk-stratification stems are testing which single variable dominates the others — when several plausible prognostic markers are listed as options, the exam usually wants the one with the strongest independent evidence base, which here is what drives the answer for in heart failure with reduced ejection fraction, LVEF <35% is the strongest predictor of poor prognosis and sudden cardiac death, and is an indication

for ICD implantation.

KEY FACT

In heart failure with reduced ejection fraction, LVEF <35% is the strongest predictor of poor prognosis and sudden cardiac death, and is an indication for ICD implantation → LVEF <35%.

Q46 NEPHROLOGY / ENDOCRINOLOGY

A patient with chronic kidney disease has calcium 9.2 mg/dL, phosphate 5.5 mg/dL, PTH 450 pg/mL, and Vitamin D 15 ng/mL. Despite calcitriol therapy, PTH remains high. Which of the following is the MOST appropriate add-on therapy?

A. Calcium acetate
B. Sevelamer carbonate
C. Cinacalcet ✓
D. Aluminum hydroxide

ANSWER

C. Cinacalcet

HOW TO SOLVE

Start from the clue cluster: A patient with chronic kidney disease has calcium 9.2 mg/dL, phosphate 5.5 mg/dL, PTH 450 pg/mL, and Vitamin D 15 ng/mL. Despite calcitriol therapy, PTH remains high. This is secondary hyperparathyroidism of CKD. Cinacalcet is a calcimimetic that increases the sensitivity of the calcium-sensing receptor, reducing PTH secretion without increasing calcium and phosphate levels. That is exactly what the question is asking for (MOST appropriate add-on therapy), so option C — Cinacalcet — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

It is the add-on therapy of choice when calcitriol alone fails. This scenario sits in the Nephrology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'secondary hyperparathyroidism of CKD' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for secondary hyperparathyroidism of CKD is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

secondary hyperparathyroidism of CKD → Cinacalcet.

Q47 RHEUMATOLOGY

A 25-year-old male presents with recurrent episodes of cold-induced pallor, cyanosis, and hyperemia of the fingers. ANA is positive. He has had no organ involvement for 5 years. Which of the following antibodies, if positive, indicates the highest risk of progression to systemic sclerosis?

- **A. Anti-Scl-70 (anti-topoisomerase I)** ✓
- **B.** Anti-centromere
- **C.** Anti-RNA polymerase III
- **D.** Anti-U1-RNP

ANSWER

A. Anti-Scl-70 (anti-topoisomerase I)

HOW TO SOLVE

Start from the clue cluster: A 25-year-old male presents with recurrent episodes of cold-induced pallor, cyanosis, and hyperemia of the fingers. ANA is positive. He has had no organ involvement for 5 years. Anti-Scl-70 is associated with diffuse cutaneous systemic sclerosis and carries the highest risk of pulmonary fibrosis and poor prognosis. Anti-centromere is associated with limited cutaneous SSc (CREST syndrome) with better prognosis. That is exactly what the question is asking for (Which of the following antibodies, if positive, indicates the highest risk of progression to systemic sclerosis), so option A — Anti-Scl-70 (anti-topoisomerase I) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Anti-RNA polymerase III is associated with rapidly progressive skin disease and renal crisis. This scenario sits in the Rheumatology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Anti-Scl-70 is associated with diffuse cutaneous systemic sclerosis and carries the highest risk of pulmonary fibrosis and poor prognosis' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for anti-Scl-70 is associated with diffuse cutaneous systemic sclerosis and carries the highest risk of pulmonary fibrosis and poor prognosis is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Anti-Scl-70 is associated with diffuse cutaneous systemic sclerosis and carries the highest risk of pulmonary fibrosis and poor prognosis → Anti-Scl-70 (anti-topoisomerase I).

Q48 RHEUMATOLOGY / PHARMACOLOGY

A 55-year-old male with alcohol use disorder presents with painful, swollen, warm joints in the first metatarsophalangeal joint. Joint aspiration reveals negatively birefringent needle-shaped crystals. He is started on allopurinol. Which of the following co-administrations significantly increases the risk of allopurinol hypersensitivity syndrome?

A. Colchicine
B. NSAIDs
C. Ampicillin
D. Thiazide diuretics ✓

ANSWER

D. Thiazide diuretics

HOW TO SOLVE

Start from the clue cluster: A 55-year-old male with alcohol use disorder presents with painful, swollen, warm joints in the first metatarsophalangeal joint. Joint aspiration reveals negatively birefringent needle-shaped crystals. He is started on allopurinol. Thiazide diuretics increase the risk of allopurinol hypersensitivity syndrome. Ampicillin also increases the risk of rash when given with allopurinol, but thiazides are more strongly associated with the hypersensitivity syndrome. That is exactly what the question is asking for (Which of the following co-administrations significantly increases the risk of allopurinol hypersensitivity syndrome), so option D — Thiazide diuretics — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Ampicillin also increases the risk of rash when given with allopurinol, but thiazides are more strongly associated with the hypersensitivity syndrome. This scenario sits in the Rheumatology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Thiazide diuretics increase the risk of allopurinol hypersensitivity syndrome' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for thiazide diuretics increase the risk of allopurinol hypersensitivity syndrome is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Thiazide diuretics increase the risk of allopurinol hypersensitivity syndrome → Thiazide diuretics.

Q49 ENDOCRINOLOGY / OPHTHALMOLOGY

A 48-year-old female with Graves' disease treated with radioactive iodine presents with progressive ophthalmopathy. She develops diplopia and optic neuropathy. Which of the following is the MOST effective immunosuppressive agent for severe thyroid eye disease?

A. High-dose oral corticosteroids

B. Rituximab

C. Mycophenolate mofetil

D. Teprotumumab (IGF-1 receptor inhibitor) ✓

ANSWER

D. Teprotumumab (IGF-1 receptor inhibitor)

HOW TO SOLVE

Start from the clue cluster: A 48-year-old female with Graves' disease treated with radioactive iodine presents with progressive ophthalmopathy. She develops diplopia and optic neuropathy. Teprotumumab is an IGF-1 receptor inhibitor that has shown dramatic efficacy in thyroid eye disease, reducing proptosis and diplopia. It is now the first-line biologic for moderate-to-severe thyroid eye disease. That is exactly what the question is asking for (MOST effective immunosuppressive agent for severe thyroid eye disease), so option D — Teprotumumab (IGF-1 receptor inhibitor) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

It is now the first-line biologic for moderate-to-severe thyroid eye disease. This scenario sits in the Endocrinology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Teprotumumab is an IGF-1 receptor inhibitor that has shown dramatic efficacy in thyroid eye disease, reducing proptosis and diplopia' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for teprotumumab is an IGF-1 receptor inhibitor that has shown dramatic efficacy in thyroid eye disease, reducing proptosis and diplopia is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Teprotumumab is an IGF-1 receptor inhibitor that has shown dramatic efficacy in thyroid eye disease, reducing proptosis and diplopia → Teprotumumab (IGF-1 receptor inhibitor).

Q50 GASTROENTEROLOGY / PATHOLOGY

A 60-year-old male with acute pancreatitis develops a tender, erythematous, edematous plaque in the periumbilical region. Which of the following is the MOST specific histopathological finding?

- **A. Subcutaneous fat necrosis with saponification** ✓
- **B.** Necrotizing vasculitis
- **C.** Granulomatous inflammation
- **D.** Eosinophilic panniculitis

ANSWER

A. Subcutaneous fat necrosis with saponification

HOW TO SOLVE

Start from the clue cluster: A 60-year-old male with acute pancreatitis develops a tender, erythematous, edematous plaque in the periumbilical region. This is Cullen's sign (periumbilical ecchymosis) in acute pancreatitis. The histopathological finding is subcutaneous fat necrosis with saponification (due to release of pancreatic enzymes into the subcutaneous tissue). That is exactly what the question is asking for (MOST specific histopathological finding), so option A — Subcutaneous fat necrosis with saponification — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The histopathological finding is subcutaneous fat necrosis with saponification (due to release of pancreatic enzymes into the subcutaneous tissue). This scenario sits in the Gastroenterology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Cullen's sign (periumbilical ecchymosis) in acute pancreatitis' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for cullen's sign (periumbilical ecchymosis) in acute pancreatitis is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Cullen's sign (periumbilical ecchymosis) in acute pancreatitis → Subcutaneous fat necrosis with saponification.

Q51 RHEUMATOLOGY / HEMATOLOGY

A 32-year-old female presents with recurrent deep vein thrombosis and a history of multiple miscarriages. APLA testing shows a positive lupus anticoagulant and anticardiolipin antibodies. INR is 1.2. Which of the following is the MOST appropriate long-term anticoagulation strategy?

- **A.** Warfarin targeting INR 2.0-3.0
- **B.** **Warfarin targeting INR 3.0-4.0** ✓
- **C.** Rivaroxaban
- **D.** Aspirin 75 mg + Warfarin INR 2.0-3.0

ANSWER

B. Warfarin targeting INR 3.0-4.0

HOW TO SOLVE

Start from the clue cluster: A 32-year-old female presents with recurrent deep vein thrombosis and a history of multiple miscarriages. APLA testing shows a positive lupus anticoagulant and anticardiolipin antibodies. INR is 1.2. Antiphospholipid syndrome with thrombosis requires warfarin targeting INR 3.0-4.0 (high-intensity warfarin). DOACs (rivaroxaban) are not recommended in APS due to higher rates of recurrent thrombosis. That is exactly what the question is asking for (MOST appropriate long-term anticoagulation strategy), so option B — Warfarin targeting INR 3.0-4.0 — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

DOACs (rivaroxaban) are not recommended in APS due to higher rates of recurrent thrombosis. This scenario sits in the Rheumatology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Antiphospholipid syndrome with thrombosis requires warfarin targeting INR 3.0-4.0 (high-intensity warfarin)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for antiphospholipid syndrome with thrombosis requires warfarin targeting INR 3.0-4.0 (high-intensity warfarin) is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Antiphospholipid syndrome with thrombosis requires warfarin targeting INR 3.0-4.0 (high-intensity warfarin) → Warfarin targeting INR 3.0-4.0.

Q52 NEUROLOGY / PHARMACOLOGY

A 70-year-old male with parkinsonism, dementia, and well-formed visual hallucinations is started on a cholinesterase inhibitor. He develops severe bradycardia and syncope. Which of the following is the MOST appropriate alternative?

A. Donepezil
B. Rivastigmine (transdermal patch)
C. Galantamine
D. Memantine ✓

ANSWER

D. Memantine

HOW TO SOLVE

Start from the clue cluster: A 70-year-old male with parkinsonism, dementia, and well-formed visual hallucinations is started on a cholinesterase inhibitor. He develops severe bradycardia and syncope. Memantine is an NMDA receptor antagonist that does not affect cardiac M_2 receptors, making it safe in patients with bradycardia. Donepezil, rivastigmine, and galantamine are all cholinesterase inhibitors that can cause bradycardia. That is exactly what the question is asking for (MOST appropriate alternative), so option D — Memantine — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Donepezil, rivastigmine, and galantamine are all cholinesterase inhibitors that can cause bradycardia. This scenario sits in the Neurology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Memantine is an NMDA receptor antagonist that does not affect cardiac M_2 receptors, making it safe in patients with bradycardia' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for memantine is an NMDA receptor antagonist that does not affect cardiac M_2 receptors, making it safe in patients with bradycardia is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Memantine is an NMDA receptor antagonist that does not affect cardiac M_2 receptors, making it safe in patients with bradycardia → Memantine.

Q53 PULMONOLOGY / ENDOCRINOLOGY

A 40-year-old male with pulmonary sarcoidosis presents with hypercalcemia, nephrolithiasis, and serum calcium 12 mg/dL. Which of the following is the MOST appropriate treatment?

- **A. Hydrocortisone** ✓
- **B.** Pamidronate
- **C.** Calcitonin
- **D.** Hydroxychloroquine

ANSWER

A. Hydrocortisone

HOW TO SOLVE

Start from the clue cluster: A 40-year-old male with pulmonary sarcoidosis presents with hypercalcemia, nephrolithiasis, and serum calcium 12 mg/dL. Sarcoidosis causes hypercalcemia due to increased 1,25-dihydroxyvitamin D production by macrophages. Corticosteroids (hydrocortisone) reduce this production and are the treatment of choice. That is exactly what the question is asking for (MOST appropriate treatment), so option A — Hydrocortisone — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Hydroxychloroquine is a steroid-sparing agent but not first-line for acute hypercalcemia. This scenario sits in the Pulmonology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Sarcoidosis causes hypercalcemia due to increased 1,25-dihydroxyvitamin D production by macrophages' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for sarcoidosis causes hypercalcemia due to increased 1,25-dihydroxyvitamin D production by macrophages is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Sarcoidosis causes hypercalcemia due to increased 1,25-dihydroxyvitamin D production by macrophages → Hydrocortisone.

Q54 MEDICINE / MICROBIOLOGY

A patient with infective endocarditis on the aortic valve presents with multiple septic emboli to the brain. Blood cultures grow Staphylococcus aureus sensitive to oxacillin. Which of the following is the MOST appropriate antibiotic regimen and duration?

- **A. Nafcillin 2g IV q4h for 6 weeks** ✓
- **B.** Vancomycin 1g IV q12h for 4 weeks
- **C.** Daptomycin 6 mg/kg IV q24h for 6 weeks
- **D.** Ceftriaxone 2g IV q24h + Gentamicin 1mg/kg q8h for 4 weeks

ANSWER

A. Nafcillin 2g IV q4h for 6 weeks

HOW TO SOLVE

Start from the clue cluster: A patient with infective endocarditis on the aortic valve presents with multiple septic emboli to the brain. Blood cultures grow Staphylococcus aureus sensitive to oxacillin. MSSA native valve endocarditis requires nafcillin or oxacillin for 6 weeks. Vancomycin is for MRSA. That is exactly what the question is asking for (MOST appropriate antibiotic regimen and duration), so option A — Nafcillin 2g IV q4h for 6 weeks — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Daptomycin is an alternative but not first-line. Ceftriaxone + gentamicin is for enterococcal endocarditis. This scenario sits in the Medicine portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'MSSA native valve endocarditis requires nafcillin or oxacillin for 6 weeks' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for mSSA native valve endocarditis requires nafcillin or oxacillin for 6 weeks is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

MSSA native valve endocarditis requires nafcillin or oxacillin for 6 weeks → Nafcillin 2g IV q4h for 6 weeks.

Q55 PULMONOLOGY / PHARMACOLOGY

A 55-year-old female with asthma presents with worsening symptoms. Spirometry shows FEV1/FVC ratio 65%, FEV1 55% predicted. Despite maximal ICS/LABA, she has 3 exacerbations in the past year. Eosinophil count is 350 cells/µL. Which of the following biologics targeting IL-5 should be added?

A. Omalizumab
B. Mepolizumab ✓
C. Dupilumab
D. Tezepelumab

ANSWER

B. Mepolizumab

HOW TO SOLVE

Start from the clue cluster: A 55-year-old female with asthma presents with worsening symptoms. Spirometry shows FEV1/FVC ratio 65%, FEV1 55% predicted. Despite maximal ICS/LABA, she has 3 exacerbations in the past year. Mepolizumab is an anti-IL-5 monoclonal antibody indicated for severe eosinophilic asthma with blood eosinophils ≥150 cells/µL. Omalizumab is anti-IgE. That is exactly what the question is asking for (Which of the following biologics targeting IL-5 should be added), so option B — Mepolizumab — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Dupilumab is anti-IL-4Rα. Tezepelumab is anti-TSLP (not IL-5 specific). This scenario sits in the Pulmonology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Mepolizumab is an anti-IL-5 monoclonal antibody indicated for severe eosinophilic asthma with blood eosinophils ≥150 cells/µL' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for mepolizumab is an anti-IL-5 monoclonal antibody indicated for severe eosinophilic asthma with blood eosinophils ≥150 cells/µL is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Mepolizumab is an anti-IL-5 monoclonal antibody indicated for severe eosinophilic asthma with blood eosinophils ≥150 cells/µL → Mepolizumab.

Q56 MEDICINE / NEPHROLOGY

A 60-year-old male with chronic hyponatremia (Na 118 mEq/L) is corrected to 130 mEq/L over 8 hours. He develops dysarthria, bilateral arm weakness, and confusion. MRI shows extrapontine myelinolysis. Which of the following is the MOST appropriate next step?

A. Restart fluid restriction
B. **Re-lower serum sodium with hypotonic fluids and DDAVP** ✓
C. High-dose corticosteroids
D. Plasmapheresis

ANSWER

B. Re-lower serum sodium with hypotonic fluids and DDAVP

HOW TO SOLVE

Start from the clue cluster: A 60-year-old male with chronic hyponatremia (Na 118 mEq/L) is corrected to 130 mEq/L over 8 hours. He develops dysarthria, bilateral arm weakness, and confusion. Overly rapid correction of hyponatremia (>8-10 mEq/L in 24 hours) can cause osmotic demyelination syndrome. The management is to re-lower the serum sodium with hypotonic fluids and DDAVP to prevent further neurological damage. That is exactly what the question is asking for (MOST appropriate next step), so option B — Re-lower serum sodium with hypotonic fluids and DDAVP — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The management is to re-lower the serum sodium with hypotonic fluids and DDAVP to prevent further neurological damage. This scenario sits in the Medicine portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Overly rapid correction of hyponatremia (>8-10 mEq/L in 24 hours) can cause osmotic demyelination syndrome' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

'Next step' questions are testing sequencing, not just knowledge — the exam wants the step that comes right after what's already been done in the stem, not the step three moves later. Re-read the stem for what has already happened, then pick the option that logically follows for overly rapid correction of hyponatremia (>8-10 mEq/L in 24 hours) can cause osmotic demyelination syndrome.

KEY FACT

Overly rapid correction of hyponatremia (>8-10 mEq/L in 24 hours) can cause osmotic demyelination syndrome → Re-lower serum sodium with hypotonic fluids and DDAVP.

Q57 HEMATOLOGY / PHARMACOLOGY

A 28-year-old male with β-thalassemia major presents with severe iron overload. He has been receiving deferoxamine. He now complains of bilateral high-frequency hearing loss and retinal pigmentation. Which of the following is the MOST appropriate alternative iron chelator?

A. Deferasirox
B. Deferiprone ✓
C. Desferrioxamine (continuous infusion)
D. Phlebotomy

ANSWER

B. Deferiprone

HOW TO SOLVE

Start from the clue cluster: A 28-year-old male with β-thalassemia major presents with severe iron overload. He has been receiving deferoxamine. He now complains of bilateral high-frequency hearing loss and retinal pigmentation. Deferoxamine causes ototoxicity (hearing loss) and ocular toxicity (retinal pigmentation). Deferiprone is an oral iron chelator that crosses cell membranes via passive diffusion and is less ototoxic. That is exactly what the question is asking for (MOST appropriate alternative iron chelator), so option B — Deferiprone — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Deferasirox is also an option but deferiprone is preferred when deferoxamine toxicity occurs. This scenario sits in the Hematology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Deferoxamine causes ototoxicity (hearing loss) and ocular toxicity (retinal pigmentation)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for deferoxamine causes ototoxicity (hearing loss) and ocular toxicity (retinal pigmentation) is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Deferoxamine causes ototoxicity (hearing loss) and ocular toxicity (retinal pigmentation) → Deferiprone.

Q58 PULMONOLOGY

A 45-year-old male with silicosis presents with progressive dyspnea, dry cough, and weight loss. HRCT shows a cluster of irregular opacities in the upper lobes with a "halo" of ground-glass. Which of the following is the MOST likely complication?

A. Progressive massive fibrosis
B. Tuberculosis reactivation ✓
C. Squamous cell carcinoma
D. Caplan's syndrome

ANSWER

B. Tuberculosis reactivation

HOW TO SOLVE

Start from the clue cluster: A 45-year-old male with silicosis presents with progressive dyspnea, dry cough, and weight loss. HRCT shows a cluster of irregular opacities in the upper lobes with a "halo" of ground-glass. Silicosis increases the risk of tuberculosis reactivation. The "halo" sign (ground-glass around a nodule) can be seen in TB. That is exactly what the question is asking for (MOST likely complication), so option B — Tuberculosis reactivation — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Progressive massive fibrosis typically shows conglomerate masses without ground-glass halo. This scenario sits in the Pulmonology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Silicosis increases the risk of tuberculosis reactivation' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for silicosis increases the risk of tuberculosis reactivation is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Silicosis increases the risk of tuberculosis reactivation → Tuberculosis reactivation.

Q59 RHEUMATOLOGY / PATHOLOGY

A 70-year-old female with polymyalgia rheumatica on prednisone 15 mg daily develops a new headache, jaw claudication, and a tender, nodular temporal artery. A temporal artery biopsy is performed. Which of the following histopathological features is considered pathognomonic?

A. **Giant cell granulomas with fragmentation of the internal elastic lamina** ✓

B. Leukocytoclastic vasculitis

C. Eosinophilic infiltration of the media

D. Fibrinoid necrosis of the vasa vasorum

ANSWER

A. Giant cell granulomas with fragmentation of the internal elastic lamina

HOW TO SOLVE

Start from the clue cluster: A 70-year-old female with polymyalgia rheumatica on prednisone 15 mg daily develops a new headache, jaw claudication, and a tender, nodular temporal artery. A temporal artery biopsy is performed. Giant cell (temporal) arteritis shows giant cell granulomas with fragmentation of the internal elastic lamina. This is the pathognomonic finding. That is exactly what the question is asking for (Which of the following histopathological features is considered pathognomonic), so option A — Giant cell granulomas with fragmentation of the internal elastic lamina — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Leukocytoclastic vasculitis is for hypersensitivity vasculitis. This scenario sits in the Rheumatology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Giant cell (temporal) arteritis shows giant cell granulomas with fragmentation of the internal elastic lamina' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for giant cell (temporal) arteritis shows giant cell granulomas with fragmentation of the internal elastic lamina is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Giant cell (temporal) arteritis shows giant cell granulomas with fragmentation of the internal elastic lamina → Giant cell granulomas with fragmentation of the internal elastic lamina.

Q60 GASTROENTEROLOGY / SURGERY

A 30-year-old male with Crohn's disease presents with a non-healing perianal fistula. MRI reveals a high transsphincteric fistula with an abscess cavity. Which of the following is the MOST appropriate surgical treatment combined with medical therapy?

A. Seton placement

B. Fistulotomy

C. Endoscopic clipping

D. **TNF-alpha inhibitor (Infliximab) + Seton** ✓

ANSWER

D. TNF-alpha inhibitor (Infliximab) + Seton

HOW TO SOLVE

Start from the clue cluster: A 30-year-old male with Crohn's disease presents with a non-healing perianal fistula. MRI reveals a high transsphincteric fistula with an abscess cavity. High transsphincteric fistulas in Crohn's disease are best managed with a combination of TNF-alpha inhibitors (infliximab) and seton placement. Fistulotomy risks incontinence in high fistulas. That is exactly what the question is asking for (MOST appropriate surgical treatment combined with medical therapy), so option D — TNF-alpha inhibitor (Infliximab) + Seton — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Fistulotomy risks incontinence in high fistulas. This scenario sits in the Gastroenterology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'High transsphincteric fistulas in Crohn's disease are best managed with a combination of TNF-alpha inhibitors (infliximab) and seton placement' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for high transsphincteric fistulas in Crohn's disease are best managed with a combination of TNF-alpha inhibitors (infliximab) and seton placement is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

High transsphincteric fistulas in Crohn's disease are best managed with a combination of TNF-alpha inhibitors (infliximab) and seton placement → TNF-alpha inhibitor (Infliximab) + Seton.

Q61 HEPATOLOGY / MEDICINE

A 55-year-old male with hepatitis C cirrhosis develops ascites refractory to high-dose diuretics. Paracentesis reveals a SAAG >1.1 and a total protein of 1.0 g/dL. Which of the following is the MOST appropriate second-line therapy after a failed TIPS procedure?

A. Liver transplantation

B. Peritoneovenous shunt (LeVeen shunt)

C. Repeated large-volume paracentesis with albumin infusion ✓

D. Alfapump (automated low-flow ascites pump)

ANSWER

C. Repeated large-volume paracentesis with albumin infusion

HOW TO SOLVE

Start from the clue cluster: A 55-year-old male with hepatitis C cirrhosis develops ascites refractory to high-dose diuretics. Paracentesis reveals a SAAG >1.1 and a total protein of 1.0 g/dL. After failed TIPS, repeated large-volume paracentesis with albumin infusion is the mainstay of management. Liver transplantation is definitive but not "second-line" after TIPS in the same way. That is exactly what the question is asking for (MOST appropriate second-line therapy after a failed TIPS procedure), so option C — Repeated large-volume paracentesis with albumin infusion — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The Alfapump is an option but less established. This scenario sits in the Hepatology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'After failed TIPS, repeated large-volume paracentesis with albumin infusion is the mainstay of management' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for after failed TIPS, repeated large-volume paracentesis with albumin infusion is the mainstay of management is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

After failed TIPS, repeated large-volume paracentesis with albumin infusion is the mainstay of management → Repeated large-volume paracentesis with albumin infusion.

Q62 RHEUMATOLOGY / PHARMACOLOGY

A 65-year-old male with gout and CKD presents with a painful, swollen, erythematous first MTP joint. Colchicine is contraindicated. Which of the following NSAIDs is preferred in the setting of renal impairment (eGFR 35 mL/min)?

A. Indomethacin

B. Naproxen

C. Ibuprofen ✓

D. Ketorolac

ANSWER

C. Ibuprofen

HOW TO SOLVE

Start from the clue cluster: A 65-year-old male with gout and CKD presents with a painful, swollen, erythematous first MTP joint. Colchicine is contraindicated. Ibuprofen has a shorter half-life and is preferred in renal impairment among NSAIDs. Ketorolac is nephrotoxic. That is exactly what the question is asking for (Which of the following NSAIDs is preferred in the setting of renal impairment (eGFR 35 mL/min)), so option C — Ibuprofen — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Naproxen has a longer half-life and higher renal risk. Indomethacin is also nephrotoxic. This scenario sits in the Rheumatology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Ibuprofen has a shorter half-life and is preferred in renal impairment among NSAIDs' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for ibuprofen has a shorter half-life and is preferred in renal impairment among NSAIDs is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Ibuprofen has a shorter half-life and is preferred in renal impairment among NSAIDs → Ibuprofen.

Q63 NEUROLOGY / PHARMACOLOGY

A 32-year-old female with epilepsy on valproic acid presents with acute-onset confusion, vomiting, and asterixis. Ammonia is 180 µmol/L. Liver function tests are normal. Which of the following is the MOST appropriate treatment?

- **A. Discontinue valproate and start L-carnitine** ✓
- **B.** Lactulose + Rifaximin
- **C.** N-acetylcysteine
- **D.** Hemodialysis

ANSWER

A. Discontinue valproate and start L-carnitine

HOW TO SOLVE

Start from the clue cluster: A 32-year-old female with epilepsy on valproic acid presents with acute-onset confusion, vomiting, and asterixis. Ammonia is 180 µmol/L. Liver function tests are normal. Valproic acid causes hyperammonemia (often with normal LFTs) by inhibiting mitochondrial beta-oxidation and reducing carnitine levels. L-carnitine supplementation is the definitive treatment along with valproate withdrawal. That is exactly what the question is asking for (MOST appropriate treatment), so option A — Discontinue valproate and start L-carnitine — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Lactulose is for hepatic encephalopathy (cirrhosis). This scenario sits in the Neurology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Valproic acid causes hyperammonemia (often with normal LFTs) by inhibiting mitochondrial beta-oxidation and reducing carnitine levels' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for valproic acid causes hyperammonemia (often with normal LFTs) by inhibiting mitochondrial beta-oxidation and reducing carnitine levels is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Valproic acid causes hyperammonemia (often with normal LFTs) by inhibiting mitochondrial beta-oxidation and reducing carnitine levels → Discontinue valproate and start L-carnitine.

Q64 SURGERY / NEPHROLOGY

A 60-year-old male with abdominal aortic aneurysm repair presents with left flank pain and gross hematuria. CT shows a left renal infarct. Which of the following is the MOST common cause of renal infarct in this post-operative period?

- **A. Atheroembolism (cholesterol crystal emboli)** ✓
- **B.** Thrombosis of the left renal artery
- **C.** Graft infection
- **D.** Contrast-induced nephropathy

ANSWER

A. Atheroembolism (cholesterol crystal emboli)

HOW TO SOLVE

Start from the clue cluster: A 60-year-old male with abdominal aortic aneurysm repair presents with left flank pain and gross hematuria. CT shows a left renal infarct. After AAA repair, atheroembolism (cholesterol crystal emboli) is the most common cause of renal infarct. The characteristic presentation includes flank pain, hematuria, and renal dysfunction. That is exactly what the question is asking for (MOST common cause of renal infarct in this post-operative period), so option A — Atheroembolism (cholesterol crystal emboli) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The characteristic presentation includes flank pain, hematuria, and renal dysfunction. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'After AAA repair, atheroembolism (cholesterol crystal emboli) is the most common cause of renal infarct' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for after AAA repair, atheroembolism (cholesterol crystal emboli) is the most common cause of renal infarct is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

After AAA repair, atheroembolism (cholesterol crystal emboli) is the most common cause of renal infarct → Atheroembolism (cholesterol crystal emboli).

Q65 PULMONOLOGY / GENETICS

A 28-year-old male with recurrent sinusitis and bronchiectasis is found to have situs inversus totalis. Which of the following is the MOST specific diagnostic test to confirm the underlying ciliary defect?

- **A.** Nasal nitric oxide measurement
- **B. Electron microscopy of respiratory cilia (dynein arm defect)** ✓
- **C.** High-speed video microscopy of ciliary beat frequency
- **D.** Genetic testing for DNAI1 or DNAH5

ANSWER

B. Electron microscopy of respiratory cilia (dynein arm defect)

HOW TO SOLVE

Start from the clue cluster: A 28-year-old male with recurrent sinusitis and bronchiectasis is found to have situs inversus totalis. Primary ciliary dyskinesia (Kartagener's syndrome) is diagnosed by electron microscopy showing dynein arm defects. Nasal nitric oxide is low but not specific. That is exactly what the question is asking for (MOST specific diagnostic test to confirm the underlying ciliary defect), so option B — Electron microscopy of respiratory cilia (dynein arm defect) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Genetic testing is confirmatory but electron microscopy is the gold standard. This scenario sits in the Pulmonology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Primary ciliary dyskinesia (Kartagener's syndrome) is diagnosed by electron microscopy showing dynein arm defects' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for primary ciliary dyskinesia (Kartagener's syndrome) is diagnosed by electron microscopy showing dynein arm defects is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Primary ciliary dyskinesia (Kartagener's syndrome) is diagnosed by electron microscopy showing dynein arm defects → Electron microscopy of respiratory cilia (dynein arm defect).

Q66 NEUROLOGY / PSYCHIATRY

A 75-year-old male with Parkinson's disease on levodopa/carbidopa develops severe psychosis (visual hallucinations). Which of the following atypical antipsychotics is preferred?

- **A.** Haloperidol
- **B.** Risperidone
- **C.** Olanzapine
- **D. Quetiapine** ✓

ANSWER

D. Quetiapine

HOW TO SOLVE

Start from the clue cluster: A 75-year-old male with Parkinson's disease on levodopa/carbidopa develops severe psychosis (visual hallucinations). Quetiapine is the preferred antipsychotic in Parkinson's disease psychosis due to its low D2 receptor affinity and minimal extrapyramidal side effects. Haloperidol (typical) is contraindicated. That is exactly what the question is asking for (Which of the following atypical antipsychotics is preferred), so option D — Quetiapine — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Risperidone and olanzapine have higher EPS risk. This scenario sits in the Neurology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Quetiapine is the preferred antipsychotic in Parkinson's disease psychosis due to its low D2 receptor affinity and minimal extrapyramidal side effects' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for quetiapine is the preferred antipsychotic in Parkinson's disease psychosis due to its low D2 receptor affinity and minimal extrapyramidal side effects is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Quetiapine is the preferred antipsychotic in Parkinson's disease psychosis due to its low D2 receptor affinity and minimal extrapyramidal side effects → Quetiapine.

Q67 MEDICINE / NEPHROLOGY

A 55-year-old male with type 2 diabetes mellitus and hypertension on lisinopril and amlodipine presents with serum creatinine 2.8 mg/dL and potassium 6.5 mEq/L. He is also on spironolactone. Which of the following is the MOST appropriate immediate management?

- **A. IV insulin with dextrose** ✓
- **B.** IV calcium gluconate
- **C.** Oral sodium polystyrene sulfonate
- **D.** IV furosemide

ANSWER

A. IV insulin with dextrose

HOW TO SOLVE

Start from the clue cluster: A 55-year-old male with type 2 diabetes mellitus and hypertension on lisinopril and amlodipine presents with serum creatinine 2.8 mg/dL and potassium 6.5 mEq/L. He is also on spironolactone. Severe hyperkalemia (K >6.5) with ECG changes requires immediate intracellular shift of potassium. IV insulin with dextrose is the most rapid method. That is exactly what the question is asking for (MOST appropriate immediate management), so option A — IV insulin with dextrose — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Calcium gluconate stabilizes the myocardium but does not lower potassium. Sodium polystyrene sulfonate acts too slowly. This scenario sits in the Medicine portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Severe hyperkalemia (K >6.5) with ECG changes requires immediate intracellular shift of potassium' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Whenever a stem asks for the MOST appropriate MOST appropriate immediate management, first separate stabilization from definitive treatment — NEET PG regularly rewards the step that is safe and immediate over the one that is technically 'correct' but premature. Here that step is A. IV insulin with dextrose, because severe hyperkalemia (K >6.5) with ECG changes requires immediate intracellular shift of potassium is the pattern being tested, not a request for the final cure.

KEY FACT

Severe hyperkalemia (K >6.5) with ECG changes requires immediate intracellular shift of potassium → IV insulin with dextrose.

Q68 NEUROLOGY / RHEUMATOLOGY

A 32-year-old female with systemic lupus erythematosus presents with sudden-onset aphasia and right-sided weakness. MRI shows multiple small infarcts in a bilateral watershed distribution. Which of the following is the MOST likely etiology?

- **A.** Libman-Sacks endocarditis
- **B. Antiphospholipid syndrome** ✓
- **C.** CNS vasculitis
- **D.** Thrombotic thrombocytopenic purpura

ANSWER

B. Antiphospholipid syndrome

HOW TO SOLVE

Start from the clue cluster: A 32-year-old female with systemic lupus erythematosus presents with sudden-onset aphasia and right-sided weakness. MRI shows multiple small infarcts in a bilateral watershed distribution. Antiphospholipid syndrome is common in SLE and causes hypercoagulability leading to multiple infarcts, often in watershed distributions. Libman-Sacks endocarditis causes embolic strokes, typically single large infarcts. That is exactly what the question is asking for (MOST likely etiology), so option B — Antiphospholipid syndrome — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

CNS vasculitis would show vessel wall enhancement. This scenario sits in the Neurology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Antiphospholipid syndrome is common in SLE and causes hypercoagulability leading to multiple infarcts, often in watershed distributions' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with antiphospholipid syndrome is common in SLE and causes hypercoagulability leading to multiple infarcts, often in watershed distributions but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

Antiphospholipid syndrome is common in SLE and causes hypercoagulability leading to multiple infarcts, often in watershed distributions → Antiphospholipid syndrome.

Q69 NEUROLOGY / PHARMACOLOGY

A 65-year-old male with atrial fibrillation on apixaban presents with a massive acute ischemic stroke. Thrombectomy is successful. Which of the following is the MOST appropriate timing to resume anticoagulation?

- **A.** Immediately after the procedure
- **B.** 24 hours after the procedure
- **C. 72 hours after the procedure** ✓
- **D.** 1 week after the procedure

ANSWER

C. 72 hours after the procedure

HOW TO SOLVE

Start from the clue cluster: A 65-year-old male with atrial fibrillation on apixaban presents with a massive acute ischemic stroke. Thrombectomy is successful. After successful thrombectomy, anticoagulation should be resumed at 72 hours to balance the risk of recurrent stroke (high) against the risk of hemorrhagic conversion (highest in the first 24-48 hours). That is exactly what the question is asking for (MOST appropriate timing to resume anticoagulation), so option C — 72 hours after the procedure — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The distractors — A. Immediately after the procedure, B. 24 hours after the procedure, D. 1 week after the procedure — are the options a rushed reader reaches for when only part of the stem is read; each one fits a related but distinct condition or a different stage of management, not the specific picture given here. This scenario sits in the Neurology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'After successful thrombectomy, anticoagulation should be resumed at 72 hours to balance the risk of recurrent stroke (high) against the risk of hemorrhagic conversion (highest in the first 24-48 hours)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for after successful thrombectomy, anticoagulation should be resumed at 72 hours to balance the risk of recurrent stroke (high) against the risk of hemorrhagic conversion (highest in the first 24-48 hours) is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

After successful thrombectomy, anticoagulation should be resumed at 72 hours to balance the risk of recurrent stroke (high) against the risk of hemorrhagic conversion (highest in the first 24-48 hours) → 72 hours after the procedure.

Q70 OBSTETRICS / MICROBIOLOGY

A 28-year-old primigravida at 34 weeks gestation with ruptured membranes and chorioamnionitis is in active labor. She develops a fever (39°C) and fetal tachycardia. Which of the following is the MOST appropriate antibiotic regimen for intrapartum prophylaxis?

- **A. Ampicillin + Gentamicin** ✓
- **B.** Cefotetan
- **C.** Clindamycin
- **D.** Piperacillin-Tazobactam

ANSWER

A. Ampicillin + Gentamicin

HOW TO SOLVE

Start from the clue cluster: A 28-year-old primigravida at 34 weeks gestation with ruptured membranes and chorioamnionitis is in active labor. She develops a fever (39°C) and fetal tachycardia. Chorioamnionitis requires broad-spectrum antibiotics. Ampicillin + Gentamicin is the standard regimen. That is exactly what the question is asking for (MOST appropriate antibiotic regimen for intrapartum prophylaxis), so option A — Ampicillin + Gentamicin — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Cefotetan is for surgical prophylaxis. Clindamycin is for GBS prophylaxis in penicillin-allergic patients. This scenario sits in the Obstetrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Chorioamnionitis requires broad-spectrum antibiotics' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for chorioamnionitis requires broad-spectrum antibiotics is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Chorioamnionitis requires broad-spectrum antibiotics → Ampicillin + Gentamicin.

Q71 PEDIATRICS / MICROBIOLOGY

A 4-year-old child with fever and cough develops rapidly progressive pneumonia with cavitation. Sputum culture is negative. Serum galactomannan is positive. Which of the following is the MOST likely diagnosis in an immunocompetent child?

- **A.** Allergic bronchopulmonary aspergillosis
- **B.** Pulmonary aspergilloma
- **C. Acute invasive pulmonary aspergillosis** ✓
- **D.** Chronic necrotizing pulmonary aspergillosis

ANSWER

C. Acute invasive pulmonary aspergillosis

HOW TO SOLVE

Start from the clue cluster: A 4-year-old child with fever and cough develops rapidly progressive pneumonia with cavitation. Sputum culture is negative. Serum galactomannan is positive. Invasive aspergillosis can occur in immunocompetent children, though rare. Positive serum galactomannan indicates invasive disease. That is exactly what the question is asking for (MOST likely diagnosis in an immunocompetent child), so option C — Acute invasive pulmonary aspergillosis — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

ABPA has elevated IgE and eosinophilia. Aspergilloma has the air crescent sign. This scenario sits in the Pediatrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Invasive aspergillosis can occur in immunocompetent children, though rare' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with invasive aspergillosis can occur in immunocompetent children, though rare but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

Invasive aspergillosis can occur in immunocompetent children, though rare → Acute invasive pulmonary aspergillosis.

Q72 ONCOLOGY / PHARMACOLOGY

A 60-year-old male with lung cancer on pembrolizumab (anti-PD-1) develops new-onset polyarthralgia, a maculopapular rash, and diarrhea. Which of the following is the MOST appropriate management of this immune-related adverse event?

- **A. High-dose corticosteroids** ✓
- **B.** Infliximab
- **C.** Anti-thymocyte globulin
- **D.** Mycophenolate mofetil

ANSWER

A. High-dose corticosteroids

HOW TO SOLVE

Start from the clue cluster: A 60-year-old male with lung cancer on pembrolizumab (anti-PD-1) develops new-onset polyarthralgia, a maculopapular rash, and diarrhea. Grade 2-3 irAEs require high-dose corticosteroids. Infliximab is for steroid-refractory colitis. That is exactly what the question is asking for (MOST appropriate management of this immune-related adverse event), so option A — High-dose corticosteroids — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Mycophenolate is for steroid-refractory hepatitis/pneumonitis. Anti-thymocyte globulin is for severe, life-threatening irAEs. SECTION C Clinical Integration — Mixed Subjects Questions 73–108. This scenario sits in the Oncology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Grade 2-3 irAEs require high-dose corticosteroids' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for grade 2-3 irAEs require high-dose corticosteroids is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Grade 2-3 irAEs require high-dose corticosteroids → High-dose corticosteroids.

NEET PG 2026 — Section C — Clinical Integration

Fully Explained Edition · Every option broken into How to Solve, Deep-Dive, Pattern & Key Fact

Questions 73–108 · Exam Date: August 30, 2026 · Marking: +4 / -1

Q73 SURGERY / GASTROENTEROLOGY

A 50-year-old female undergoes a laparoscopic cholecystectomy. Post-operative day 2, she develops bilious drainage from the right upper quadrant drain (500 mL/day). ERCP reveals a complete transection of the common bile duct with a large gap. Which of the following is the MOST appropriate definitive surgical reconstruction?

A. Roux-en-Y hepaticojejunostomy ✓
B. Primary end-to-end anastomosis over a T-tube
C. Choledochoduodenostomy
D. Simple closure with drain placement

ANSWER

A. Roux-en-Y hepaticojejunostomy

HOW TO SOLVE

Start from the clue cluster: A 50-year-old female undergoes a laparoscopic cholecystectomy. Post-operative day 2, she develops bilious drainage from the right upper quadrant drain (500 mL/day). ERCP reveals a complete transection of the common bile duct with a large gap. Complete transection of the CBD with a large gap requires Roux-en-Y hepaticojejunostomy. Primary end-to-end anastomosis is only possible if there is minimal tension and no gap. That is exactly what the question is asking for (MOST appropriate definitive surgical reconstruction), so option A — Roux-en-Y hepaticojejunostomy — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Choledochoduodenostomy is for distal obstruction, not transection. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Complete transection of the CBD with a large gap requires Roux-en-Y hepaticojejunostomy' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Definitive-management stems separate temporising measures from the fix that actually resolves the underlying problem. For complete transection of the CBD with a large gap requires Roux-en-Y hepaticojejunostomy, the temporising options are usually present as distractors — flag any option that only buys time and set it aside in favour of the one that treats the actual lesion or process.

KEY FACT

Complete transection of the CBD with a large gap requires Roux-en-Y hepaticojejunostomy → Roux-en-Y hepaticojejunostomy.

Q74 SURGERY / ORTHOPEDICS

A 35-year-old male with a gunshot wound to the left thigh presents with a pale, cold, pulseless foot. Arteriogram shows complete occlusion of the superficial femoral artery. He also has a fracture of the femur. What is the sequence of management?

- **A.** Vascular repair first → Orthopedic fixation
- **B.** Orthopedic fixation first → Vascular repair
- **C. Temporary vascular shunt → Orthopedic fixation → Definitive vascular repair** ✓
- **D.** Amputation

ANSWER

C. Temporary vascular shunt → Orthopedic fixation → Definitive vascular repair

HOW TO SOLVE

Start from the clue cluster: A 35-year-old male with a gunshot wound to the left thigh presents with a pale, cold, pulseless foot. Arteriogram shows complete occlusion of the superficial femoral artery. He also has a fracture of the femur. In combined orthopedic and vascular injuries, a temporary vascular shunt is placed first to restore perfusion, followed by orthopedic fixation, then definitive vascular repair. This is the "damage control" approach for mangled extremities. That is exactly what the question is asking for (What is the sequence of management), so option C — Temporary vascular shunt → Orthopedic fixation → Definitive vascular repair — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

This is the "damage control" approach for mangled extremities. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'In combined orthopedic and vascular injuries, a temporary vascular shunt is placed first to restore perfusion, followed by orthopedic fixation, then definitive vascular repair' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for in combined orthopedic and vascular injuries, a temporary vascular shunt is placed first to restore perfusion, followed by orthopedic fixation, then definitive vascular repair is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

In combined orthopedic and vascular injuries, a temporary vascular shunt is placed first to restore perfusion, followed by orthopedic fixation, then definitive vascular repair → Temporary vascular shunt → Orthopedic fixation → Definitive vascular repair.

Q75 PATHOLOGY / SURGERY

A 60-year-old female presents with a 2 cm thyroid nodule. FNAC shows follicular cells arranged in microfollicles with no colloid. Nuclear features of papillary carcinoma are absent. Which of the following is the MOST accurate criterion to distinguish follicular carcinoma from follicular adenoma?

- **A. Presence of capsular and/or vascular invasion** ✓
- **B.** Nuclear grooves and intranuclear inclusions
- **C.** Psammoma bodies
- **D.** High mitotic rate

ANSWER

A. Presence of capsular and/or vascular invasion

HOW TO SOLVE

Start from the clue cluster: A 60-year-old female presents with a 2 cm thyroid nodule. FNAC shows follicular cells arranged in microfollicles with no colloid. Nuclear features of papillary carcinoma are absent. Follicular carcinoma is distinguished from follicular adenoma by the presence of capsular and/or vascular invasion. Nuclear grooves and intranuclear inclusions are for papillary carcinoma. That is exactly what the question is asking for (MOST accurate criterion to distinguish follicular carcinoma from follicular adenoma), so option A — Presence of capsular and/or vascular invasion — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Psammoma bodies are for papillary carcinoma. This scenario sits in the Pathology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Follicular carcinoma is distinguished from follicular adenoma by the presence of capsular and/or vascular invasion' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for follicular carcinoma is distinguished from follicular adenoma by the presence of capsular and/or vascular invasion is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Follicular carcinoma is distinguished from follicular adenoma by the presence of capsular and/or vascular invasion → Presence of capsular and/or vascular invasion.

Q76 UROLOGY / SURGERY

A 25-year-old male presents with acute scrotal pain, nausea, and vomiting. On exam, the testis is horizontal and the cremasteric reflex is absent. Color Doppler shows decreased flow. Which of the following is the MOST appropriate timeframe for detorsion to salvage the testis?

A. < 4 hours
B. < 6 hours ✓
C. < 12 hours
D. < 24 hours

ANSWER

B. < 6 hours

HOW TO SOLVE

Start from the clue cluster: A 25-year-old male presents with acute scrotal pain, nausea, and vomiting. On exam, the testis is horizontal and the cremasteric reflex is absent. Color Doppler shows decreased flow. Testicular torsion requires surgical detorsion within 6 hours for testicular salvage. After 6 hours, the salvage rate drops significantly. That is exactly what the question is asking for (MOST appropriate timeframe for detorsion to salvage the testis), so option B — < 6 hours — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

After 24 hours, salvage is unlikely. This scenario sits in the Urology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Testicular torsion requires surgical detorsion within 6 hours for testicular salvage' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for testicular torsion requires surgical detorsion within 6 hours for testicular salvage is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Testicular torsion requires surgical detorsion within 6 hours for testicular salvage → < 6 hours.

Q77 SURGERY / ANATOMY

A 55-year-old female with breast cancer undergoes a modified radical mastectomy. Post-operatively, she complains of "pins and needles" radiating down the medial aspect of the arm and forearm, along with weakness in adduction and internal rotation of the shoulder. Which nerve was MOST likely injured?

- **A.** Long thoracic nerve
- **B.** Thoracodorsal nerve
- **C. Intercostobrachial nerve** ✓
- **D.** Medial pectoral nerve

ANSWER

C. Intercostobrachial nerve

HOW TO SOLVE

Start from the clue cluster: A 55-year-old female with breast cancer undergoes a modified radical mastectomy. Post-operatively, she complains of "pins and needles" radiating down the medial aspect of the arm and forearm, along with weakness in adduction and internal rotation of the shoulder. The intercostobrachial nerve (T2) supplies sensation to the medial arm and forearm. Injury causes paresthesia in this distribution. That is exactly what the question is asking for (Which nerve was MOST likely injured), so option C — Intercostobrachial nerve — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Long thoracic nerve injury causes winging of scapula. Thoracodorsal nerve injury causes weakness of latissimus dorsi. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'The intercostobrachial nerve (T2) supplies sensation to the medial arm and forearm' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for the intercostobrachial nerve (T2) supplies sensation to the medial arm and forearm is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

The intercostobrachial nerve (T2) supplies sensation to the medial arm and forearm → Intercostobrachial

nerve.

Q78 SURGERY / CARDIOLOGY

A 70-year-old male with a 6 cm infrarenal abdominal aortic aneurysm (AAA) is scheduled for elective repair. His preoperative echocardiogram shows an LVEF of 25%. He has severe COPD. Which of the following is the MOST appropriate surgical approach?

- **A.** Open surgical repair
- **B. Endovascular aneurysm repair (EVAR)** ✓
- **C.** Conservative management with serial ultrasound
- **D.** Hybrid repair

ANSWER

B. Endovascular aneurysm repair (EVAR)

HOW TO SOLVE

Start from the clue cluster: A 70-year-old male with a 6 cm infrarenal abdominal aortic aneurysm (AAA) is scheduled for elective repair. His preoperative echocardiogram shows an LVEF of 25%. EVAR is preferred in patients with high surgical risk (LVEF 25%, severe COPD) as it is less invasive than open repair. The aneurysm is 6 cm, which exceeds the 5.5 cm threshold for repair. That is exactly what the question is asking for (MOST appropriate surgical approach), so option B — Endovascular aneurysm repair (EVAR) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The aneurysm is 6 cm, which exceeds the 5.5 cm threshold for repair. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'EVAR is preferred in patients with high surgical risk (LVEF 25%, severe COPD) as it is less invasive than open repair' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Definitive-management stems separate temporising measures from the fix that actually resolves the underlying problem. For eVAR is preferred in patients with high surgical risk (LVEF 25%, severe COPD) as it is less invasive than open repair, the temporising options are usually present as distractors — flag any option that only buys time and set it aside in favour of the one that treats the actual lesion or process.

KEY FACT

EVAR is preferred in patients with high surgical risk (LVEF 25%, severe COPD) as it is less invasive than open

repair → Endovascular aneurysm repair (EVAR).

Q79 SURGERY / TRAUMA

A 40-year-old male with a stab wound to the right side of the neck (zone II) presents with a pulsatile hematoma, expanding mass, and stridor. He is hemodynamically stable. Which of the following is the MOST appropriate next step?

- **A. Immediate surgical exploration** ✓
- **B.** CT angiography
- **C.** Color Doppler ultrasound
- **D.** Observation

ANSWER

A. Immediate surgical exploration

HOW TO SOLVE

Start from the clue cluster: A 40-year-old male with a stab wound to the right side of the neck (zone II) presents with a pulsatile hematoma, expanding mass, and stridor. He is hemodynamically stable. Zone II neck injuries with hard signs of vascular injury (expanding hematoma, pulsatile mass, stridor) require immediate surgical exploration. CT angiography is for stable patients without hard signs. That is exactly what the question is asking for (MOST appropriate next step), so option A — Immediate surgical exploration — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

CT angiography is for stable patients without hard signs. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Zone II neck injuries with hard signs of vascular injury (expanding hematoma, pulsatile mass, stridor) require immediate surgical exploration' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

'Next step' questions are testing sequencing, not just knowledge — the exam wants the step that comes right after what's already been done in the stem, not the step three moves later. Re-read the stem for what has already happened, then pick the option that logically follows for zone II neck injuries with hard signs of vascular injury (expanding hematoma, pulsatile mass, stridor) require immediate surgical exploration.

KEY FACT

Zone II neck injuries with hard signs of vascular injury (expanding hematoma, pulsatile mass, stridor) require

immediate surgical exploration → Immediate surgical exploration.

Q80 SURGERY / GASTROENTEROLOGY

A 32-year-old female with Crohn's disease presents with a 5 cm non-tender, firm mass in the right lower quadrant. There is a draining sinus tract to the skin. Which of the following is the MOST likely cause?

- **A.** Appendiceal abscess
- **B.** Iliopsoas abscess
- **C. Crohn's related fistula/abscess** ✓
- **D.** Actinomycosis

ANSWER

C. Crohn's related fistula/abscess

HOW TO SOLVE

Start from the clue cluster: A 32-year-old female with Crohn's disease presents with a 5 cm non-tender, firm mass in the right lower quadrant. There is a draining sinus tract to the skin. Crohn's disease is associated with fistulas and abscesses. A firm mass with a draining sinus tract in the right lower quadrant in a Crohn's patient is most likely a Crohn's-related fistula/abscess. That is exactly what the question is asking for (MOST likely cause), so option C — Crohn's related fistula/abscess — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

A firm mass with a draining sinus tract in the right lower quadrant in a Crohn's patient is most likely a Crohn's-related fistula/abscess. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Crohn's disease is associated with fistulas and abscesses' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with crohn's disease is associated with fistulas and abscesses but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

Crohn's disease is associated with fistulas and abscesses → Crohn's related fistula/abscess.

Q81 SURGERY / UROLOGY

A 65-year-old male with a left-sided inguinal hernia undergoes repair. Post-operatively, he develops severe testicular pain and swelling with a tense, blue, and tender scrotum on the left side. Which of the following is the MOST likely complication?

- **A. Ischemic orchitis** ✓
- **B.** Hematoma
- **C.** Urinary retention
- **D.** Recurrent hernia

ANSWER

A. Ischemic orchitis

HOW TO SOLVE

Start from the clue cluster: A 65-year-old male with a left-sided inguinal hernia undergoes repair. Post-operatively, he develops severe testicular pain and swelling with a tense, blue, and tender scrotum on the left side. Ischemic orchitis is a complication of inguinal hernia repair, especially in older patients. It presents with severe testicular pain, swelling, and a blue, tender scrotum. That is exactly what the question is asking for (MOST likely complication), so option A — Ischemic orchitis — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Hematoma would not cause the characteristic blue discoloration. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Ischemic orchitis is a complication of inguinal hernia repair, especially in older patients' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for ischemic orchitis is a complication of inguinal hernia repair, especially in older patients is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Ischemic orchitis is a complication of inguinal hernia repair, especially in older patients → Ischemic orchitis.

Q82 SURGERY / ANESTHESIA

A patient with a fractured neck of femur undergoes a cemented hemiarthroplasty. During cement insertion, he acutely develops hypotension, hypoxia, and cardiac arrest. Which of the following is the MOST plausible mechanism?

- **A.** Fat embolism
- **B. Histamine release and complement activation** ✓
- **C.** Air embolism
- **D.** Direct vagal stimulation

ANSWER

B. Histamine release and complement activation

HOW TO SOLVE

Start from the clue cluster: A patient with a fractured neck of femur undergoes a cemented hemiarthroplasty. During cement insertion, he acutely develops hypotension, hypoxia, and cardiac arrest. Bone cement implantation syndrome is caused by histamine release and complement activation leading to vasodilation, bronchospasm, and cardiovascular collapse. Fat embolism is a component but histamine release is the primary mechanism. That is exactly what the question is asking for (MOST plausible mechanism), so option B — Histamine release and complement activation — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Fat embolism is a component but histamine release is the primary mechanism. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Bone cement implantation syndrome is caused by histamine release and complement activation leading to vasodilation, bronchospasm, and cardiovascular collapse' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Mechanism questions want the specific pathway, not just the drug or disease name — re-read each option as a mechanism claim and test it against every finding in the stem, since bone cement implantation syndrome is caused by histamine release and complement activation leading to vasodilation, bronchospasm, and cardiovascular collapse usually has one option that is directionally right but factually wrong.

KEY FACT

Bone cement implantation syndrome is caused by histamine release and complement activation leading to vasodilation, bronchospasm, and cardiovascular collapse → Histamine release and complement activation.

Q83 SURGERY / GASTROENTEROLOGY

A 50-year-old female with gallstones presents with obstructive jaundice, fever, and right upper quadrant pain. ERCP reveals a stone at the ampulla. Following sphincterotomy, a large stone is extracted. Two days later, she develops severe abdominal pain, tachycardia, and abdominal distension. Erect X-ray shows air in the biliary tree and peritoneal cavity. Which of the following is the MOST likely diagnosis?

A. **Duodenal perforation** ✓
B. Post-ERCP pancreatitis
C. Retained stone
D. Cholangitis

ANSWER

A. Duodenal perforation

HOW TO SOLVE

Start from the clue cluster: A 50-year-old female with gallstones presents with obstructive jaundice, fever, and right upper quadrant pain. ERCP reveals a stone at the ampulla. Following sphincterotomy, a large stone is extracted. Air in the biliary tree and peritoneal cavity after ERCP with sphincterotomy indicates duodenal perforation. Post-ERCP pancreatitis would show abdominal pain but not free air. That is exactly what the question is asking for (MOST likely diagnosis), so option A — Duodenal perforation — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Retained stone would not cause free air. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Air in the biliary tree and peritoneal cavity after ERCP with sphincterotomy indicates duodenal perforation' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with air in the biliary tree and peritoneal cavity after ERCP with sphincterotomy indicates duodenal perforation but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

Air in the biliary tree and peritoneal cavity after ERCP with sphincterotomy indicates duodenal perforation → Duodenal perforation.

Q84 SURGERY / GASTROENTEROLOGY

A 45-year-old male with alcohol abuse presents with a pancreatic pseudocyst. It is 8 cm in size and located in the lesser sac. He is asymptomatic. What is the MOST appropriate management?

A. Observation with serial imaging ✓
B. Endoscopic ultrasound-guided drainage
C. Percutaneous drainage
D. Surgical cystogastrostomy

ANSWER

A. Observation with serial imaging

HOW TO SOLVE

Start from the clue cluster: A 45-year-old male with alcohol abuse presents with a pancreatic pseudocyst. It is 8 cm in size and located in the lesser sac. He is asymptomatic. Asymptomatic pseudocysts, regardless of size, can be observed with serial imaging. Intervention is only indicated for symptoms (pain, obstruction, infection, or rupture). That is exactly what the question is asking for (What is the MOST appropriate management), so option A — Observation with serial imaging — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Intervention is only indicated for symptoms (pain, obstruction, infection, or rupture). This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Asymptomatic pseudocysts, regardless of size, can be observed with serial imaging' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for asymptomatic pseudocysts, regardless of size, can be observed with serial imaging is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Asymptomatic pseudocysts, regardless of size, can be observed with serial imaging → Observation with serial imaging.

Q85 SURGERY

A 25-year-old male presents with a chronic discharging sinus over the natal cleft. There are multiple pits and hair protruding from them. Which of the following is the MOST appropriate definitive surgical procedure?

A. Wide local excision with secondary healing
B. Pit-picking and curettage
C. Limberg flap reconstruction ✓
D. Excision and primary closure

ANSWER

C. Limberg flap reconstruction

HOW TO SOLVE

Start from the clue cluster: A 25-year-old male presents with a chronic discharging sinus over the natal cleft. There are multiple pits and hair protruding from them. Pilonidal sinus with multiple pits and chronic discharge is best managed with Limberg flap reconstruction (off-midline closure) which has the lowest recurrence rate. Wide local excision with secondary healing has a long healing time. That is exactly what the question is asking for (MOST appropriate definitive surgical procedure), so option C — Limberg flap reconstruction — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Pit-picking is for mild disease. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Pilonidal sinus with multiple pits and chronic discharge is best managed with Limberg flap reconstruction (off-midline closure) which has the lowest recurrence rate' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Definitive-management stems separate temporising measures from the fix that actually resolves the underlying problem. For pilonidal sinus with multiple pits and chronic discharge is best managed with Limberg flap reconstruction (off-midline closure) which has the lowest recurrence rate, the temporising options are usually present as distractors — flag any option that only buys time and set it aside in favour of the one that treats the actual lesion or process.

KEY FACT

Pilonidal sinus with multiple pits and chronic discharge is best managed with Limberg flap reconstruction (off-midline closure) which has the lowest recurrence rate → Limberg flap reconstruction.

Q86 SURGERY / ONCOLOGY

A 68-year-old male with smoking history presents with progressive dysphagia, weight loss, and hoarseness. Endoscopy reveals a mass at 25 cm from the incisors (middle third). Biopsy shows squamous cell carcinoma. Which of the following is the MOST appropriate curative treatment?

A. Esophagectomy alone

B. **Neoadjuvant chemoradiation followed by esophagectomy** ✓

C. Definitive chemoradiation

D. Palliative stenting

ANSWER

B. Neoadjuvant chemoradiation followed by esophagectomy

HOW TO SOLVE

Start from the clue cluster: A 68-year-old male with smoking history presents with progressive dysphagia, weight loss, and hoarseness. Endoscopy reveals a mass at 25 cm from the incisors (middle third). Biopsy shows squamous cell carcinoma. Middle-third esophageal squamous cell carcinoma is best treated with neoadjuvant chemoradiation followed by esophagectomy. This is the standard of care for locally advanced esophageal cancer. That is exactly what the question is asking for (MOST appropriate curative treatment), so option B — Neoadjuvant chemoradiation followed by esophagectomy — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

This is the standard of care for locally advanced esophageal cancer. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Middle-third esophageal squamous cell carcinoma is best treated with neoadjuvant chemoradiation followed by esophagectomy' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Definitive-management stems separate temporising measures from the fix that actually resolves the underlying problem. For middle-third esophageal squamous cell carcinoma is best treated with neoadjuvant chemoradiation followed by esophagectomy, the temporising options are usually present as distractors — flag any option that only buys time and set it aside in favour of the one that treats the actual lesion or process.

KEY FACT

Middle-third esophageal squamous cell carcinoma is best treated with neoadjuvant chemoradiation followed by esophagectomy → Neoadjuvant chemoradiation followed by esophagectomy.

Q87 UROLOGY / ONCOLOGY

A 35-year-old male with a history of undescended testis (cryptorchidism) presents with a testicular mass. Orchidectomy reveals a tumor composed of a mixture of teratoma, embryonal carcinoma, and choriocarcinoma. Serum β-hCG is 1500 mIU/mL and AFP is 800 ng/mL. Which of the following is the MOST appropriate next step?

A. Retroperitoneal lymph node dissection (RPLND)

B. BEP chemotherapy (Bleomycin, Etoposide, Cisplatin) ✓

C. Radiation therapy

D. Surveillance

ANSWER

B. BEP chemotherapy (Bleomycin, Etoposide, Cisplatin)

HOW TO SOLVE

Start from the clue cluster: A 35-year-old male with a history of undescended testis (cryptorchidism) presents with a testicular mass. Orchidectomy reveals a tumor composed of a mixture of teratoma, embryonal carcinoma, and choriocarcinoma. Non-seminomatous germ cell tumor (mixed) with elevated tumor markers (β-hCG >1000, AFP elevated) requires BEP chemotherapy. RPLND is for residual masses after chemotherapy or for stage I pure teratoma. That is exactly what the question is asking for (MOST appropriate next step), so option B — BEP chemotherapy (Bleomycin, Etoposide, Cisplatin) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

RPLND is for residual masses after chemotherapy or for stage I pure teratoma. This scenario sits in the Urology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Non-seminomatous germ cell tumor (mixed) with elevated tumor markers (β-hCG >1000, AFP elevated) requires BEP chemotherapy' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

'Next step' questions are testing sequencing, not just knowledge — the exam wants the step that comes right after what's already been done in the stem, not the step three moves later. Re-read the stem for what has already happened, then pick the option that logically follows for non-seminomatous germ cell tumor (mixed) with elevated tumor markers (β-hCG >1000, AFP elevated) requires BEP chemotherapy.

KEY FACT

Non-seminomatous germ cell tumor (mixed) with elevated tumor markers (β-hCG >1000, AFP elevated) requires BEP chemotherapy → BEP chemotherapy (Bleomycin, Etoposide, Cisplatin).

Q88 SURGERY

A 60-year-old female presents with a painless, mobile lump in the right groin that appears on standing and disappears on lying down. It is located below the inguinal ligament and lateral to the pubic tubercle. Which of the following is the MOST appropriate surgical approach?

A. Shouldice repair (inguinal)

B. Lichtenstein tension-free mesh repair

C. **Low approach (femoral) – Lockwood's approach** ✓

D. Laparoscopic TEP

ANSWER

C. Low approach (femoral) – Lockwood's approach

HOW TO SOLVE

Start from the clue cluster: A 60-year-old female presents with a painless, mobile lump in the right groin that appears on standing and disappears on lying down. It is located below the inguinal ligament and lateral to the pubic tubercle. This is a femoral hernia (below inguinal ligament, lateral to pubic tubercle). The Lockwood approach (low approach) is the standard surgical approach for femoral hernias. That is exactly what the question is asking for (MOST appropriate surgical approach), so option C — Low approach (femoral) – Lockwood's approach — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Inguinal approaches are for inguinal hernias. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'femoral hernia (below inguinal ligament, lateral to pubic tubercle)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Definitive-management stems separate temporising measures from the fix that actually resolves the underlying problem. For femoral hernia (below inguinal ligament, lateral to pubic tubercle), the temporising options are usually present as distractors — flag any option that only buys time and set it aside in favour of the one that treats the actual lesion or process.

KEY FACT

femoral hernia (below inguinal ligament, lateral to pubic tubercle) → Low approach (femoral) – Lockwood's approach.

Q89 SURGERY / HEPATOLOGY

A 55-year-old male with cirrhosis and ascites presents with an umbilical hernia. The hernia is reducible. He is a poor surgical candidate. Which of the following is the MOST appropriate management?

A. Elective herniorrhaphy with mesh

B. **Control ascites (diuretics/paracentesis) and observe** ✓

C. Emergency operation

D. Truss

ANSWER

B. Control ascites (diuretics/paracentesis) and observe

HOW TO SOLVE

Start from the clue cluster: A 55-year-old male with cirrhosis and ascites presents with an umbilical hernia. The hernia is reducible. He is a poor surgical candidate. In cirrhotic patients with ascites, the best management of a reducible umbilical hernia is to control the ascites and observe. Elective repair carries high morbidity in these patients. That is exactly what the question is asking for (MOST appropriate management), so option B — Control ascites (diuretics/paracentesis) and observe — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

A truss is not recommended. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'In cirrhotic patients with ascites, the best management of a reducible umbilical hernia is to control the ascites and observe' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for in cirrhotic patients with ascites, the best management of a reducible umbilical hernia is to control the ascites and observe is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

In cirrhotic patients with ascites, the best management of a reducible umbilical hernia is to control the ascites and observe → Control ascites (diuretics/paracentesis) and observe.

Q90 ONCOLOGY / SURGERY

A 45-year-old female with a family history of breast cancer (BRCA1 mutation) presents with a 1.5 cm palpable mass in the left breast. Biopsy shows invasive ductal carcinoma, ER/PR negative, HER2/neu positive. Which of the following is the MOST appropriate targeted therapy in the adjuvant setting?

- **A.** Tamoxifen
- **B.** Anastrozole
- **C. Trastuzumab** ✓
- **D.** Lapatinib

ANSWER

C. Trastuzumab

HOW TO SOLVE

Start from the clue cluster: A 45-year-old female with a family history of breast cancer (BRCA1 mutation) presents with a 1.5 cm palpable mass in the left breast. Biopsy shows invasive ductal carcinoma, ER/PR negative, HER2/neu positive. HER2-positive breast cancer requires trastuzumab in the adjuvant setting. Tamoxifen and anastrozole are for ER/PR positive cancers. That is exactly what the question is asking for (MOST appropriate targeted therapy in the adjuvant setting), so option C — Trastuzumab — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Lapatinib is used in metastatic HER2-positive breast cancer. This scenario sits in the Oncology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'HER2-positive breast cancer requires trastuzumab in the adjuvant setting' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for hER2-positive breast cancer requires trastuzumab in the adjuvant setting is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

HER2-positive breast cancer requires trastuzumab in the adjuvant setting → Trastuzumab.

Q91 UROLOGY / SURGERY

A 70-year-old male with BPH and urethral stricture presents with acute urinary retention and a palpable bladder. A urethral catheter cannot be passed. Which of the following is the MOST appropriate immediate procedure?

- **A. Suprapubic cystostomy (Trocar)** ✓
- **B.** Urethrotomy
- **C.** Open cystotomy
- **D.** Percutaneous nephrostomy

ANSWER

A. Suprapubic cystostomy (Trocar)

HOW TO SOLVE

Start from the clue cluster: A 70-year-old male with BPH and urethral stricture presents with acute urinary retention and a palpable bladder. A urethral catheter cannot be passed. When a urethral catheter cannot be passed in acute urinary retention, suprapubic cystostomy (trocar) is the immediate procedure of choice. Urethrotomy is for stricture management but not in the acute setting. That is exactly what the question is asking for (MOST appropriate immediate procedure), so option A — Suprapubic cystostomy (Trocar) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Urethrotomy is for stricture management but not in the acute setting. This scenario sits in the Urology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'When a urethral catheter cannot be passed in acute urinary retention, suprapubic cystostomy (trocar) is the immediate procedure of choice' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for when a urethral catheter cannot be passed in acute urinary retention, suprapubic cystostomy (trocar) is the immediate procedure of choice is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

When a urethral catheter cannot be passed in acute urinary retention, suprapubic cystostomy (trocar) is the immediate procedure of choice → Suprapubic cystostomy (Trocar).

Q92 ORTHOPEDICS / PATHOLOGY

A 30-year-old male presents with a painless, unilateral, hard swelling over the anterior aspect of the tibia. X-ray shows a sunburst appearance with periosteal reaction. Which of the following is the MOST likely diagnosis and the MOST appropriate biopsy approach?

- **A. Osteosarcoma – Open biopsy** ✓
- **B.** Ewing's sarcoma – Core needle biopsy
- **C.** Chondrosarcoma – Excisional biopsy
- **D.** Giant cell tumor – Incisional biopsy

ANSWER

A. Osteosarcoma – Open biopsy

HOW TO SOLVE

Start from the clue cluster: A 30-year-old male presents with a painless, unilateral, hard swelling over the anterior aspect of the tibia. X-ray shows a sunburst appearance with periosteal reaction. Sunburst appearance with periosteal reaction is classic for osteosarcoma. Open biopsy is the preferred approach for osteosarcoma to avoid tumor contamination. That is exactly what the question is asking for (MOST likely diagnosis and the MOST appropriate biopsy approach), so option A — Osteosarcoma – Open biopsy — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Core needle biopsy is for Ewing's sarcoma. This scenario sits in the Orthopedics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Sunburst appearance with periosteal reaction is classic for osteosarcoma' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with sunburst appearance with periosteal reaction is classic for osteosarcoma but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

Sunburst appearance with periosteal reaction is classic for osteosarcoma → Osteosarcoma – Open biopsy.

Q93 SURGERY / GASTROENTEROLOGY

A 55-year-old female with diverticulitis presents with a pelvic abscess. CT shows a 5 cm abscess that is drained percutaneously. Two weeks later, she develops a colovaginal fistula. Which of the following is the MOST appropriate surgical management?

- **A.** Hartmann's procedure
- **B. Primary anastomosis with diverting ileostomy** ✓
- **C.** Fistula excision and primary repair
- **D.** Endoscopic clip closure

ANSWER

B. Primary anastomosis with diverting ileostomy

HOW TO SOLVE

Start from the clue cluster: A 55-year-old female with diverticulitis presents with a pelvic abscess. CT shows a 5 cm abscess that is drained percutaneously. Two weeks later, she develops a colovaginal fistula. Colovaginal fistula in diverticulitis is best managed with primary anastomosis with diverting ileostomy. Hartmann's procedure is for emergency situations. That is exactly what the question is asking for (MOST appropriate surgical management), so option B — Primary anastomosis with diverting ileostomy — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Fistula excision alone is not sufficient without addressing the underlying diverticular disease. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Colovaginal fistula in diverticulitis is best managed with primary anastomosis with diverting ileostomy' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for colovaginal fistula in diverticulitis is best managed with primary anastomosis with diverting ileostomy is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Colovaginal fistula in diverticulitis is best managed with primary anastomosis with diverting ileostomy → Primary anastomosis with diverting ileostomy.

Q94 SURGERY / TRAUMA

A 25-year-old male involved in a motorcycle accident presents with a "flail chest" (5 fractured ribs in a segmental pattern). He is tachypneic, hypoxic, and in respiratory distress. Which of the following is the MOST appropriate definitive management?

- **A.** Chest physiotherapy and incentive spirometry
- **B.** **Surgical stabilization of rib fractures (SSRF)** ✓
- **C.** Needle thoracostomy
- **D.** Tube thoracostomy

ANSWER

B. Surgical stabilization of rib fractures (SSRF)

HOW TO SOLVE

Start from the clue cluster: A 25-year-old male involved in a motorcycle accident presents with a "flail chest" (5

fractured ribs in a segmental pattern). He is tachypneic, hypoxic, and in respiratory distress. Flail chest with respiratory failure requires surgical stabilization of rib fractures (SSRF). This is the definitive management. That is exactly what the question is asking for (MOST appropriate definitive management), so option B — Surgical stabilization of rib fractures (SSRF) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Chest physiotherapy is for mild flail chest. Tube thoracostomy is for pneumothorax/hemothorax, not the primary management of flail chest. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Flail chest with respiratory failure requires surgical stabilization of rib fractures (SSRF)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Definitive-management stems separate temporising measures from the fix that actually resolves the underlying problem. For flail chest with respiratory failure requires surgical stabilization of rib fractures (SSRF), the temporising options are usually present as distractors — flag any option that only buys time and set it aside in favour of the one that treats the actual lesion or process.

KEY FACT

Flail chest with respiratory failure requires surgical stabilization of rib fractures (SSRF) → Surgical stabilization of rib fractures (SSRF).

Q95 SURGERY / PATHOLOGY

A 68-year-old male with smoking history presents with a hoarse voice and a 2 cm solitary thyroid nodule. FNAC reveals Hürthle cells with atypia. Which of the following is the MOST appropriate surgical procedure?

- **A.** Total thyroidectomy
- **B.** Subtotal thyroidectomy
- **C. Lobectomy with isthmusectomy** ✓
- **D.** Cystectomy

ANSWER

C. Lobectomy with isthmusectomy

HOW TO SOLVE

Start from the clue cluster: A 68-year-old male with smoking history presents with a hoarse voice and a 2 cm solitary thyroid nodule. FNAC reveals Hürthle cells with atypia. Hürthle cell neoplasms with atypia require lobectomy with isthmusectomy. Total thyroidectomy is for confirmed malignancy or bilateral disease. That is

exactly what the question is asking for (MOST appropriate surgical procedure), so option C — Lobectomy with isthmusectomy — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Hürthle cell carcinoma is a variant of follicular carcinoma. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Hürthle cell neoplasms with atypia require lobectomy with isthmusectomy' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Definitive-management stems separate temporising measures from the fix that actually resolves the underlying problem. For hürthle cell neoplasms with atypia require lobectomy with isthmusectomy, the temporising options are usually present as distractors — flag any option that only buys time and set it aside in favour of the one that treats the actual lesion or process.

KEY FACT

Hürthle cell neoplasms with atypia require lobectomy with isthmusectomy → Lobectomy with isthmusectomy.

Q96 SURGERY / MICROBIOLOGY

A 40-year-old male with IV drug use presents with a painful, tender, and swollen right sternoclavicular joint. He is febrile. MRI shows osteomyelitis of the sternum and a retrosternal abscess. Which of the following is the MOST likely causative organism?

- **A. Staphylococcus aureus** ✓
- **B.** Pseudomonas aeruginosa
- **C.** Serratia marcescens
- **D.** Streptococcus viridans

ANSWER

A. Staphylococcus aureus

HOW TO SOLVE

Start from the clue cluster: A 40-year-old male with IV drug use presents with a painful, tender, and swollen right sternoclavicular joint. He is febrile. MRI shows osteomyelitis of the sternum and a retrosternal abscess. Staphylococcus aureus is the most common cause of osteomyelitis, including sternoclavicular joint infection in IV drug users. Pseudomonas is more common in nosocomial infections or diabetic foot. That is exactly what the question is asking for (MOST likely causative organism), so option A — Staphylococcus aureus — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the

'most appropriate' choice here.

DEEP-DIVE

Pseudomonas is more common in nosocomial infections or diabetic foot. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Staphylococcus aureus is the most common cause of osteomyelitis, including sternoclavicular joint infection in IV drug users' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for staphylococcus aureus is the most common cause of osteomyelitis, including sternoclavicular joint infection in IV drug users is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Staphylococcus aureus is the most common cause of osteomyelitis, including sternoclavicular joint infection in IV drug users → Staphylococcus aureus.

Q97 DERMATOLOGY / SURGERY

A 55-year-old female presents with a 2 cm basal cell carcinoma on the nasal tip. Which of the following is the MOST appropriate surgical technique?

- **A.** Wide local excision with 4 mm margins
- **B.** **Mohs micrographic surgery** ✓
- **C.** Cryotherapy
- **D.** Radiation therapy

ANSWER

B. Mohs micrographic surgery

HOW TO SOLVE

Start from the clue cluster: A 55-year-old female presents with a 2 cm basal cell carcinoma on the nasal tip. Mohs micrographic surgery is the gold standard for basal cell carcinoma on the nasal tip (cosmetically sensitive area) as it provides margin control with maximal tissue preservation. Wide local excision with 4 mm margins is for low-risk BCC. That is exactly what the question is asking for (MOST appropriate surgical technique), so option B — Mohs micrographic surgery — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Wide local excision with 4 mm margins is for low-risk BCC. This scenario sits in the Dermatology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Mohs micrographic surgery is the gold standard for basal cell carcinoma on the nasal tip (cosmetically sensitive area) as it provides margin control with maximal tissue preservation' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Definitive-management stems separate temporising measures from the fix that actually resolves the underlying problem. For mohs micrographic surgery is the gold standard for basal cell carcinoma on the nasal tip (cosmetically sensitive area) as it provides margin control with maximal tissue preservation, the temporising options are usually present as distractors — flag any option that only buys time and set it aside in favour of the one that treats the actual lesion or process.

KEY FACT

Mohs micrographic surgery is the gold standard for basal cell carcinoma on the nasal tip (cosmetically sensitive area) as it provides margin control with maximal tissue preservation → Mohs micrographic surgery.

Q98 SURGERY / RADIOLOGY

A 65-year-old male with atherosclerotic peripheral vascular disease presents with a non-healing ulcer on the heel. The ankle-brachial index (ABI) is 0.4. The ulcer is painless. Which of the following is the MOST important factor determining the success of revascularization?

- **A. Presence of a patent pedal arch via angiography** ✓
- **B.** Patient's age
- **C.** Size of the ulcer
- **D.** HbA1c level

ANSWER

A. Presence of a patent pedal arch via angiography

HOW TO SOLVE

Start from the clue cluster: A 65-year-old male with atherosclerotic peripheral vascular disease presents with a non-healing ulcer on the heel. The ankle-brachial index (ABI) is 0.4. The presence of a patent pedal arch (continuity between the anterior and posterior tibial arteries) is the most important factor determining the success of revascularization. Without a patent pedal arch, distal perfusion will remain inadequate. That is exactly what the question is asking for (MOST important factor determining the success of revascularization), so option A — Presence of a patent pedal arch via angiography — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Without a patent pedal arch, distal perfusion will remain inadequate. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'The presence of a patent pedal arch (continuity between the anterior and posterior tibial arteries) is the most important factor determining the success of revascularization' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for the presence of a patent pedal arch (continuity between the anterior and posterior tibial arteries) is the most important factor determining the success of revascularization is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

The presence of a patent pedal arch (continuity between the anterior and posterior tibial arteries) is the most important factor determining the success of revascularization → Presence of a patent pedal arch via angiography.

Q99 SURGERY / PATHOLOGY

A 30-year-old male presents with a painless, progressively enlarging mass in the posterior triangle of the neck. Ultrasonography shows multiple cystic spaces with internal echoes. Which of the following is the MOST likely congenital cause?

- **A.** Branchial cleft cyst (second arch)
- **B. Cystic hygroma (lymphatic malformation)** ✓
- **C.** Thyroglossal duct cyst
- **D.** Teratoma

ANSWER

B. Cystic hygroma (lymphatic malformation)

HOW TO SOLVE

Start from the clue cluster: A 30-year-old male presents with a painless, progressively enlarging mass in the posterior triangle of the neck. Ultrasonography shows multiple cystic spaces with internal echoes. Cystic hygroma (lymphatic malformation) presents as a painless, progressively enlarging mass in the posterior triangle of the neck with multiple cystic spaces. Branchial cleft cysts are usually in the anterior triangle. That is exactly what the question is asking for (MOST likely congenital cause), so option B — Cystic hygroma (lymphatic malformation) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Thyroglossal duct cysts are midline. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Cystic hygroma (lymphatic malformation) presents as a painless, progressively enlarging mass in the posterior triangle of the neck with multiple cystic spaces' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for cystic hygroma (lymphatic malformation) presents as a painless, progressively enlarging mass in the posterior triangle of the neck with multiple cystic spaces is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Cystic hygroma (lymphatic malformation) presents as a painless, progressively enlarging mass in the posterior triangle of the neck with multiple cystic spaces → Cystic hygroma (lymphatic malformation).

Q100 ONCOLOGY / SURGERY

A 50-year-old female with endometrial cancer presents with a new, firm, non-tender mass in the right groin. Biopsy shows metastatic adenocarcinoma. Which of the following is the MOST appropriate surgical intervention if isolated nodal disease is confirmed?

- **A.** Excisional biopsy of the node
- **B. Ilioinguinal lymphadenectomy** ✓
- **C.** Radiation therapy
- **D.** Systemic chemotherapy

ANSWER

B. Ilioinguinal lymphadenectomy

HOW TO SOLVE

Start from the clue cluster: A 50-year-old female with endometrial cancer presents with a new, firm, non-tender mass in the right groin. Biopsy shows metastatic adenocarcinoma. Isolated groin metastasis from endometrial cancer (or vulvar cancer) requires ilioinguinal lymphadenectomy. Excisional biopsy alone is not sufficient. That is exactly what the question is asking for (MOST appropriate surgical intervention if isolated nodal disease is confirmed), so option B — Ilioinguinal lymphadenectomy — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Radiation and chemotherapy are adjuncts. This scenario sits in the Oncology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Isolated groin metastasis from endometrial cancer (or vulvar cancer) requires ilioinguinal lymphadenectomy' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for isolated groin metastasis from endometrial cancer (or vulvar cancer) requires ilioinguinal lymphadenectomy is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Isolated groin metastasis from endometrial cancer (or vulvar cancer) requires ilioinguinal lymphadenectomy → Ilioinguinal lymphadenectomy.

Q101 SURGERY / GASTROENTEROLOGY

A 60-year-old male with chronic pancreatitis presents with a 3 cm mass in the head of the pancreas. CA 19-9 is 200 U/mL. CT shows abutment of the superior mesenteric vein without invasion. Which of the following is the MOST appropriate staging procedure before considering surgical resection?

- **A.** EUS with fine-needle aspiration
- **B.** PET-CT
- **C. Diagnostic laparoscopy** ✓
- **D.** ERCP

ANSWER

C. Diagnostic laparoscopy

HOW TO SOLVE

Start from the clue cluster: A 60-year-old male with chronic pancreatitis presents with a 3 cm mass in the head of the pancreas. CA 19-9 is 200 U/mL. CT shows abutment of the superior mesenteric vein without invasion. In patients with pancreatic cancer and suspected resectability, diagnostic laparoscopy is performed to rule out peritoneal metastases before proceeding with laparotomy. EUS with FNA provides tissue diagnosis but not staging of peritoneal disease. That is exactly what the question is asking for (MOST appropriate staging procedure before considering surgical resection), so option C — Diagnostic laparoscopy — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

EUS with FNA provides tissue diagnosis but not staging of peritoneal disease. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'In patients with pancreatic cancer and suspected resectability, diagnostic laparoscopy is performed to rule out peritoneal metastases before proceeding with laparotomy' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for in patients with pancreatic cancer and suspected resectability, diagnostic laparoscopy is performed to rule out peritoneal metastases before proceeding with laparotomy is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

In patients with pancreatic cancer and suspected resectability, diagnostic laparoscopy is performed to rule out peritoneal metastases before proceeding with laparotomy → Diagnostic laparoscopy.

Q102 GASTROENTEROLOGY / SURGERY

A 45-year-old male with peptic ulcer disease presents with melena and hemoglobin 7 g/dL. EGD reveals a bleeding duodenal ulcer with a visible vessel (Forrest IIa). Which of the following is the MOST appropriate endoscopic treatment?

A. Epinephrine injection alone
B. Thermal probe coagulation
C. Hemoclip placement after epinephrine injection ✓
D. Argon plasma coagulation

ANSWER

C. Hemoclip placement after epinephrine injection

HOW TO SOLVE

Start from the clue cluster: A 45-year-old male with peptic ulcer disease presents with melena and hemoglobin 7 g/dL. EGD reveals a bleeding duodenal ulcer with a visible vessel (Forrest IIa). Forrest IIa ulcer (visible vessel) has a high risk of rebleeding. Combination therapy (epinephrine injection followed by hemoclip placement) is superior to monotherapy. That is exactly what the question is asking for (MOST appropriate endoscopic treatment), so option C — Hemoclip placement after epinephrine injection — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Thermal probe coagulation or APC can also be used but combination therapy is preferred. This scenario sits in the Gastroenterology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Forrest IIa ulcer (visible vessel) has a high risk of rebleeding' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for forrest IIa ulcer (visible vessel) has a high risk of rebleeding is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Forrest IIa ulcer (visible vessel) has a high risk of rebleeding → Hemoclip placement after epinephrine injection.

Q103 PULMONOLOGY / ONCOLOGY

A 60-year-old male with COPD presents with a chronic cough and hemoptysis. CT shows a 4 cm mass in the left lung with adjacent rib erosion. Which of the following is the MOST likely histology?

- **A. Squamous cell carcinoma** ✓
- **B.** Adenocarcinoma
- **C.** Small cell carcinoma
- **D.** Large cell carcinoma

ANSWER

A. Squamous cell carcinoma

HOW TO SOLVE

Start from the clue cluster: A 60-year-old male with COPD presents with a chronic cough and hemoptysis. CT shows a 4 cm mass in the left lung with adjacent rib erosion. Squamous cell carcinoma is the most common type of lung cancer associated with rib erosion (direct invasion) and cavitation. It is also most strongly associated with smoking. That is exactly what the question is asking for (MOST likely histology), so option A — Squamous cell carcinoma — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Adenocarcinoma is more peripheral. This scenario sits in the Pulmonology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Squamous cell

carcinoma is the most common type of lung cancer associated with rib erosion (direct invasion) and cavitation' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with squamous cell carcinoma is the most common type of lung cancer associated with rib erosion (direct invasion) and cavitation but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

Squamous cell carcinoma is the most common type of lung cancer associated with rib erosion (direct invasion) and cavitation → Squamous cell carcinoma.

Q104 GASTROENTEROLOGY / MEDICINE

A 45-year-old male with chronic pancreatitis and diabetes presents with new-onset steatorrhea. Which of the following is the MOST appropriate replacement therapy?

- **A. Pancreatic enzyme supplements (lipase)** ✓
- **B.** Vitamin D and Calcium
- **C.** Medium-chain triglycerides
- **D.** Proton pump inhibitors

ANSWER

A. Pancreatic enzyme supplements (lipase)

HOW TO SOLVE

Start from the clue cluster: A 45-year-old male with chronic pancreatitis and diabetes presents with new-onset steatorrhea. Steatorrhea in chronic pancreatitis is due to pancreatic exocrine insufficiency. Pancreatic enzyme supplements (lipase) are the appropriate replacement therapy. That is exactly what the question is asking for (MOST appropriate replacement therapy), so option A — Pancreatic enzyme supplements (lipase) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Medium-chain triglycerides are for fat malabsorption but do not address the underlying enzyme deficiency. This scenario sits in the Gastroenterology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Steatorrhea in chronic pancreatitis is due to pancreatic exocrine insufficiency' is not enough; you have to know why it beats every neighbouring diagnosis or

management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for steatorrhea in chronic pancreatitis is due to pancreatic exocrine insufficiency is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Steatorrhea in chronic pancreatitis is due to pancreatic exocrine insufficiency → Pancreatic enzyme supplements (lipase).

Q105 RHEUMATOLOGY / PHARMACOLOGY

A 50-year-old male with gout and hypertension is on losartan. He develops a painful, swollen big toe. Which of the following BEST explains why losartan is beneficial in gout?

- **A. It inhibits uric acid reabsorption in the proximal tubule** ✓
- **B.** It increases uric acid excretion via renin-angiotensin blockade
- **C.** It reduces inflammation via COX-2 inhibition
- **D.** It decreases uric acid production via xanthine oxidase inhibition

ANSWER

A. It inhibits uric acid reabsorption in the proximal tubule

HOW TO SOLVE

Start from the clue cluster: A 50-year-old male with gout and hypertension is on losartan. He develops a painful, swollen big toe. Losartan has a unique uricosuric effect by inhibiting uric acid reabsorption in the proximal renal tubule. This makes it the preferred antihypertensive in patients with gout. That is exactly what the question is asking for (Which of the following BEST explains why losartan is beneficial in gout), so option A — It inhibits uric acid reabsorption in the proximal tubule — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

It does not inhibit xanthine oxidase (that's allopurinol/febuxostat). This scenario sits in the Rheumatology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Losartan has a unique uricosuric effect by inhibiting uric acid reabsorption in the proximal renal tubule' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for losartan has a unique uricosuric effect by inhibiting uric acid reabsorption in the proximal renal tubule is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Losartan has a unique uricosuric effect by inhibiting uric acid reabsorption in the proximal renal tubule → It inhibits uric acid reabsorption in the proximal tubule.

Q106 NEUROLOGY / OBSTETRICS

A 28-year-old primigravida at 32 weeks gestation with epilepsy on levetiracetam presents with a breakthrough seizure. Which of the following is the MOST important factor to consider in dosing levetiracetam during pregnancy?

- **A.** **Increased renal clearance and decreased serum levels** ✓
- **B.** Increased hepatic metabolism
- **C.** Decreased gastric absorption
- **D.** Increased protein binding

ANSWER

A. Increased renal clearance and decreased serum levels

HOW TO SOLVE

Start from the clue cluster: A 28-year-old primigravida at 32 weeks gestation with epilepsy on levetiracetam presents with a breakthrough seizure. Levetiracetam is 90% renally excreted. During pregnancy, GFR increases by 40-50%, dramatically reducing serum levels. That is exactly what the question is asking for (MOST important factor to consider in dosing levetiracetam during pregnancy), so option A — Increased renal clearance and decreased serum levels — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Dose adjustment is mandatory based on therapeutic drug monitoring. This scenario sits in the Neurology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Levetiracetam is 90% renally excreted' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for levetiracetam is 90% renally excreted is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Levetiracetam is 90% renally excreted → Increased renal clearance and decreased serum levels.

Q107 ANESTHESIA / NEUROLOGY

A 70-year-old male with Alzheimer's disease presents with a fall and a right-sided hip fracture. He is on donepezil. Which of the following anesthetic considerations is MOST important?

- **A. Donepezil should be continued perioperatively** ✓
- **B.** Donepezil can interact with succinylcholine
- **C.** Donepezil should be stopped 24 hours pre-operatively
- **D.** Donepezil has no significant anesthetic implications

ANSWER

A. Donepezil should be continued perioperatively

HOW TO SOLVE

Start from the clue cluster: A 70-year-old male with Alzheimer's disease presents with a fall and a right-sided hip fracture. He is on donepezil. Donepezil should be continued perioperatively to reduce the risk of post-operative delirium. Abrupt withdrawal can precipitate acute confusion. That is exactly what the question is asking for (Which of the following anesthetic considerations is MOST important), so option A — Donepezil should be continued perioperatively — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

It does not have a major interaction with succinylcholine (unlike neostigmine). This scenario sits in the Anesthesia portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Donepezil should be continued perioperatively to reduce the risk of post-operative delirium' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for donepezil should be continued perioperatively to reduce the risk of post-operative delirium is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Donepezil should be continued perioperatively to reduce the risk of post-operative delirium → Donepezil should be continued perioperatively.

Q108 PULMONOLOGY / ONCOLOGY

A 60-year-old male with COPD presents with a chronic cough and hemoptysis. CT shows a 4 cm mass in the left lung with adjacent rib erosion. Which of the following is the MOST likely histology?

- **A. Squamous cell carcinoma** ✓
- **B.** Adenocarcinoma
- **C.** Small cell carcinoma
- **D.** Large cell carcinoma

ANSWER

A. Squamous cell carcinoma

HOW TO SOLVE

Start from the clue cluster: A 60-year-old male with COPD presents with a chronic cough and hemoptysis. CT shows a 4 cm mass in the left lung with adjacent rib erosion. Squamous cell carcinoma is the most common type associated with rib erosion and cavitation. SECTION D Clinical Integration — Mixed Subjects Questions 109–144. That is exactly what the question is asking for (MOST likely histology), so option A — Squamous cell carcinoma — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

SECTION D Clinical Integration — Mixed Subjects Questions 109–144. This scenario sits in the Pulmonology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Squamous cell carcinoma is the most common type associated with rib erosion and cavitation' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with squamous cell carcinoma is the most common type associated with rib erosion and cavitation but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

Squamous cell carcinoma is the most common type associated with rib erosion and cavitation → Squamous cell carcinoma.

NEET PG 2026 — Section D — Clinical Integration

Fully Explained Edition · Every option broken into How to Solve, Deep-Dive, Pattern & Key Fact

Questions 109–144 · Exam Date: August 30, 2026 · Marking: +4 / -1

Q109 OBSTETRICS / GYNECOLOGY

A 32-year-old primigravida at 36 weeks gestation with a history of classical cesarean section presents with sudden-onset severe abdominal pain, vaginal bleeding, and fetal bradycardia. The uterus is tense and tender. Which of the following is the MOST appropriate immediate management?

- **A. Emergency cesarean section** ✓
- **B.** Tocolysis
- **C.** Magnesium sulfate
- **D.** Betamethasone

ANSWER

A. Emergency cesarean section

HOW TO SOLVE

Start from the clue cluster: A 32-year-old primigravida at 36 weeks gestation with a history of classical cesarean section presents with sudden-onset severe abdominal pain, vaginal bleeding, and fetal bradycardia. The uterus is tense and tender. This is uterine rupture (classical cesarean section scar, sudden pain, bleeding, fetal bradycardia). Emergency cesarean section is the immediate management. That is exactly what the question is asking for (MOST appropriate immediate management), so option A — Emergency cesarean section — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Tocolysis is contraindicated. This scenario sits in the Obstetrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'uterine rupture (classical cesarean section scar, sudden pain, bleeding, fetal bradycardia)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Whenever a stem asks for the MOST appropriate MOST appropriate immediate management, first separate stabilization from definitive treatment — NEET PG regularly rewards the step that is safe and immediate over the one that is technically 'correct' but premature. Here that step is A. Emergency cesarean section, because uterine rupture (classical cesarean section scar, sudden pain, bleeding, fetal bradycardia) is the pattern being tested, not a request for the final cure.

KEY FACT

uterine rupture (classical cesarean section scar, sudden pain, bleeding, fetal bradycardia) → Emergency cesarean section.

Q110 OBSTETRICS / GYNECOLOGY

A 28-year-old female with PCOS and 3 failed cycles of clomiphene citrate presents for infertility treatment. She has a BMI of 38. Which of the following is the MOST appropriate next step in ovulation induction?

- **A. Letrozole** ✓
- **B.** Gonadotropins (FSH)
- **C.** Metformin + Clomiphene
- **D.** Laparoscopic ovarian drilling

ANSWER

A. Letrozole

HOW TO SOLVE

Start from the clue cluster: A 28-year-old female with PCOS and 3 failed cycles of clomiphene citrate presents for infertility treatment. She has a BMI of 38. Letrozole is the first-line ovulation induction agent in PCOS, especially in women with high BMI. It has higher ovulation and live birth rates compared to clomiphene in PCOS. That is exactly what the question is asking for (MOST appropriate next step in ovulation induction), so option A — Letrozole — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

It has higher ovulation and live birth rates compared to clomiphene in PCOS. This scenario sits in the Obstetrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Letrozole is the first-line ovulation induction agent in PCOS, especially in women with high BMI' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

'Next step' questions are testing sequencing, not just knowledge — the exam wants the step that comes right after what's already been done in the stem, not the step three moves later. Re-read the stem for what has already happened, then pick the option that logically follows for letrozole is the first-line ovulation induction agent in PCOS, especially in women with high BMI.

KEY FACT

Letrozole is the first-line ovulation induction agent in PCOS, especially in women with high BMI → Letrozole.

Q111 GYNECOLOGY / SURGERY

A 35-year-old female with a 5 cm submucosal leiomyoma presents with severe menorrhagia and anemia (Hb 6.5 g/dL). She desires future fertility. Which of the following is the MOST appropriate surgical treatment?

- **A. Hysteroscopic myomectomy** ✓
- **B.** Abdominal myomectomy
- **C.** Uterine artery embolization (UAE)
- **D.** Hysterectomy

ANSWER

A. Hysteroscopic myomectomy

HOW TO SOLVE

Start from the clue cluster: A 35-year-old female with a 5 cm submucosal leiomyoma presents with severe menorrhagia and anemia (Hb 6.5 g/dL). She desires future fertility. Submucosal fibroids are best treated with hysteroscopic myomectomy. It preserves fertility and is minimally invasive. That is exactly what the question is asking for (MOST appropriate surgical treatment), so option A — Hysteroscopic myomectomy — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Abdominal myomectomy is for intramural/subserosal fibroids. UAE may affect ovarian reserve. This scenario sits in the Gynecology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Submucosal fibroids are best treated with hysteroscopic myomectomy' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for submucosal fibroids are best treated with hysteroscopic myomectomy is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Submucosal fibroids are best treated with hysteroscopic myomectomy → Hysteroscopic myomectomy.

Q112 OBSTETRICS / GYNECOLOGY

A 30-year-old primigravida at 32 weeks gestation with severe preeclampsia presents with platelet count 70,000/µL, AST 200 U/L, and hemolysis (LDH 800 U/L). Which of the following is the MOST appropriate definitive treatment?

A. Dexamethasone
B. Delivery ✓
C. Fresh frozen plasma
D. Platelet transfusion

ANSWER

B. Delivery

HOW TO SOLVE

Start from the clue cluster: A 30-year-old primigravida at 32 weeks gestation with severe preeclampsia presents with platelet count 70,000/µL, AST 200 U/L, and hemolysis (LDH 800 U/L). This is HELLP syndrome (Hemolysis, Elevated Liver enzymes, Low Platelets). The definitive treatment is delivery. That is exactly what the question is asking for (MOST appropriate definitive treatment), so option B — Delivery — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Dexamethasone is used to improve platelet count but does not treat the underlying condition. Platelet transfusion is only if platelets <20,000 or active bleeding. This scenario sits in the Obstetrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'HELLP syndrome (Hemolysis, Elevated Liver enzymes, Low Platelets)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Definitive-management stems separate temporising measures from the fix that actually resolves the underlying problem. For hELLP syndrome (Hemolysis, Elevated Liver enzymes, Low Platelets), the temporising options are usually present as distractors — flag any option that only buys time and set it aside in favour of the one that treats the actual lesion or process.

KEY FACT

HELLP syndrome (Hemolysis, Elevated Liver enzymes, Low Platelets) → Delivery.

Q113 OBSTETRICS / RADIOLOGY

A 25-year-old primigravida at 28 weeks gestation presents with a painless vaginal bleeding episode that resolved spontaneously. Ultrasound reveals a posterior placenta previa with an edge 0.5 cm from the internal os. Which of the following is the MOST appropriate management to confirm placental invasion?

A. MRI pelvis
B. Transvaginal ultrasound with color Doppler ✓
C. Amniocentesis
D. Repeat ultrasound in 4 weeks

ANSWER

B. Transvaginal ultrasound with color Doppler

HOW TO SOLVE

Start from the clue cluster: A 25-year-old primigravida at 28 weeks gestation presents with a painless vaginal bleeding episode that resolved spontaneously. Ultrasound reveals a posterior placenta previa with an edge 0.5 cm from the internal os. Transvaginal ultrasound with color Doppler is the best modality to assess for placenta accreta (invasion). MRI is a second-line tool. That is exactly what the question is asking for (MOST appropriate management to confirm placental invasion), so option B — Transvaginal ultrasound with color Doppler — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The distance of 0.5 cm from the internal os indicates placenta previa, and the concern is accreta. This scenario sits in the Obstetrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Transvaginal ultrasound with color Doppler is the best modality to assess for placenta accreta (invasion)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for transvaginal ultrasound with color Doppler is the best modality to assess for placenta accreta (invasion) is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Transvaginal ultrasound with color Doppler is the best modality to assess for placenta accreta (invasion) → Transvaginal ultrasound with color Doppler.

Q114 GYNECOLOGY / ONCOLOGY

A 40-year-old female presents with postmenopausal bleeding and endometrial thickness of 16 mm. Biopsy shows endometrioid adenocarcinoma, FIGO grade 2. Which of the following is the MOST important prognostic factor?

A. Patient's age
B. **Depth of myometrial invasion (>50%)** ✓
C. Cervical involvement
D. Lymphovascular space invasion (LVSI)

ANSWER

B. Depth of myometrial invasion (>50%)

HOW TO SOLVE

Start from the clue cluster: A 40-year-old female presents with postmenopausal bleeding and endometrial thickness of 16 mm. Biopsy shows endometrioid adenocarcinoma, FIGO grade 2. In endometrial cancer, depth of myometrial invasion is the most important prognostic factor and determines the need for lymphadenectomy. Grade and LVSI are also important but myometrial invasion is the primary determinant of stage. That is exactly what the question is asking for (MOST important prognostic factor), so option B — Depth of myometrial invasion (>50%) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Grade and LVSI are also important but myometrial invasion is the primary determinant of stage. This scenario sits in the Gynecology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'In endometrial cancer, depth of myometrial invasion is the most important prognostic factor and determines the need for lymphadenectomy' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Prognosis and risk-stratification stems are testing which single variable dominates the others — when several plausible prognostic markers are listed as options, the exam usually wants the one with the strongest independent evidence base, which here is what drives the answer for in endometrial cancer, depth of myometrial invasion is the most important prognostic factor and determines the need for lymphadenectomy.

KEY FACT

In endometrial cancer, depth of myometrial invasion is the most important prognostic factor and determines the need for lymphadenectomy → Depth of myometrial invasion (>50%).

Q115 OBSTETRICS / GYNECOLOGY

A 28-year-old female with a history of ectopic pregnancy presents with acute-onset severe lower abdominal pain and syncope. Urine pregnancy test is positive. Transvaginal ultrasound shows a large complex adnexal mass with fluid in the cul-de-sac. She is hemodynamically stable. Which of the following is the MOST appropriate surgical approach?

- **A. Laparoscopic salpingectomy** ✓
- **B.** Laparoscopic salpingotomy
- **C.** Methotrexate
- **D.** Exploratory laparotomy

ANSWER

A. Laparoscopic salpingectomy

HOW TO SOLVE

Start from the clue cluster: A 28-year-old female with a history of ectopic pregnancy presents with acute-onset severe lower abdominal pain and syncope. Urine pregnancy test is positive. Transvaginal ultrasound shows a large complex adnexal mass with fluid in the cul-de-sac. This is a ruptured ectopic pregnancy (pain, syncope, free fluid). Even though stable, the presence of a complex mass with free fluid indicates rupture. That is exactly what the question is asking for (MOST appropriate surgical approach), so option A — Laparoscopic salpingectomy — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Laparoscopic salpingectomy is the procedure of choice. Salpingotomy is for unruptured ectopic with desire for future fertility. This scenario sits in the Obstetrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'ruptured ectopic pregnancy (pain, syncope, free fluid)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Definitive-management stems separate temporising measures from the fix that actually resolves the underlying problem. For ruptured ectopic pregnancy (pain, syncope, free fluid), the temporising options are usually present as distractors — flag any option that only buys time and set it aside in favour of the one that treats the actual lesion or process.

KEY FACT

ruptured ectopic pregnancy (pain, syncope, free fluid) → Laparoscopic salpingectomy.

Q116 OBSTETRICS / GYNECOLOGY

A 22-year-old primigravida at 34 weeks gestation with a history of preterm labor, cervical length of 15 mm, and a positive fetal fibronectin test. Which of the following is the MOST appropriate management to prolong pregnancy?

A. Betamethasone
B. Nifedipine
C. Progesterone (17-OHPC) ✓
D. Indomethacin

ANSWER

C. Progesterone (17-OHPC)

HOW TO SOLVE

Start from the clue cluster: A 22-year-old primigravida at 34 weeks gestation with a history of preterm labor, cervical length of 15 mm, and a positive fetal fibronectin test. In women with a history of preterm delivery, 17-hydroxyprogesterone caproate (17-OHPC) is the standard of care for prevention. Cervical cerclage is for cervical incompetence. That is exactly what the question is asking for (MOST appropriate management to prolong pregnancy), so option C — Progesterone (17-OHPC) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Betamethasone is for fetal lung maturity if preterm delivery is imminent. This scenario sits in the Obstetrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'In women with a history of preterm delivery, 17-hydroxyprogesterone caproate (17-OHPC) is the standard of care for prevention' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for in women with a history of preterm delivery, 17-hydroxyprogesterone caproate (17-OHPC) is the standard of care for prevention is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

In women with a history of preterm delivery, 17-hydroxyprogesterone caproate (17-OHPC) is the standard of care for prevention → Progesterone (17-OHPC).

Q117 GYNECOLOGY / SURGERY

A 32-year-old female with recurrent miscarriage (3 losses) is found to have a septate uterus on hysteroscopy. Which of the following is the MOST appropriate surgical treatment?

A. Hysteroscopic septoplasty ✓

B. Abdominal metroplasty

C. Laparoscopic uterine suspension

D. Endometrial ablation

ANSWER

A. Hysteroscopic septoplasty

HOW TO SOLVE

Start from the clue cluster: A 32-year-old female with recurrent miscarriage (3 losses) is found to have a septate uterus on hysteroscopy. Septate uterus is the most common congenital uterine anomaly associated with recurrent miscarriage. Hysteroscopic septoplasty is the treatment of choice. That is exactly what the question is asking for (MOST appropriate surgical treatment), so option A — Hysteroscopic septoplasty — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Abdominal metroplasty (Strassman) is rarely performed now. This scenario sits in the Gynecology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Septate uterus is the most common congenital uterine anomaly associated with recurrent miscarriage' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for septate uterus is the most common congenital uterine anomaly associated with recurrent miscarriage is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Septate uterus is the most common congenital uterine anomaly associated with recurrent miscarriage → Hysteroscopic septoplasty.

Q118 GYNECOLOGY / ONCOLOGY

A 45-year-old female presents with a vulvar lesion. Biopsy shows Paget's disease (intraepithelial adenocarcinoma). Which of the following is the MOST appropriate management?

A. Wide local excision ✓

B. Simple vulvectomy

C. Superficial radiation therapy

D. Topical imiquimod

ANSWER

A. Wide local excision

HOW TO SOLVE

Start from the clue cluster: A 45-year-old female presents with a vulvar lesion. Biopsy shows Paget's disease (intraepithelial adenocarcinoma). Vulvar Paget's disease is managed with wide local excision. Simple vulvectomy is too extensive for intraepithelial disease. That is exactly what the question is asking for (MOST appropriate management), so option A — Wide local excision — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Radiation is not first-line. Imiquimod is for extramammary Paget's but not standard. This scenario sits in the Gynecology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Vulvar Paget's disease is managed with wide local excision' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for vulvar Paget's disease is managed with wide local excision is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Vulvar Paget's disease is managed with wide local excision → Wide local excision.

Q119 OBSTETRICS / GYNECOLOGY

A 28-year-old primigravida at 32 weeks gestation with gestational diabetes presents with polyhydramnios and a fetal abdominal circumference >95th percentile. Which of the following is the MOST appropriate next step to reduce the risk of macrosomia-related shoulder dystocia?

A. Tight glycemic control with insulin

B. Elective cesarean section at 39 weeks ✓

C. Induction of labor at 38 weeks

D. Repeat ultrasound in 2 weeks

ANSWER

B. Elective cesarean section at 39 weeks

HOW TO SOLVE

Start from the clue cluster: A 28-year-old primigravida at 32 weeks gestation with gestational diabetes presents with polyhydramnios and a fetal abdominal circumference >95th percentile. In GDM with estimated fetal weight >4500 g or AC >95th percentile, elective cesarean section at 39 weeks is recommended to reduce the risk of shoulder dystocia. Tight glycemic control is important but may not prevent macrosomia at this late stage. That is exactly what the question is asking for (MOST appropriate next step to reduce the risk of macrosomia-related shoulder dystocia), so option B — Elective cesarean section at 39 weeks — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Tight glycemic control is important but may not prevent macrosomia at this late stage. This scenario sits in the Obstetrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'In GDM with estimated fetal weight >4500 g or AC >95th percentile, elective cesarean section at 39 weeks is recommended to reduce the risk of shoulder dystocia' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

'Next step' questions are testing sequencing, not just knowledge — the exam wants the step that comes right after what's already been done in the stem, not the step three moves later. Re-read the stem for what has already happened, then pick the option that logically follows for in GDM with estimated fetal weight >4500 g or AC >95th percentile, elective cesarean section at 39 weeks is recommended to reduce the risk of shoulder dystocia.

KEY FACT

In GDM with estimated fetal weight >4500 g or AC >95th percentile, elective cesarean section at 39 weeks is recommended to reduce the risk of shoulder dystocia → Elective cesarean section at 39 weeks.

Q120 OBSTETRICS / HEMATOLOGY

A 35-year-old female with a history of deep vein thrombosis on warfarin presents with an unintended pregnancy at 6 weeks gestation. Which of the following is the MOST appropriate immediate change in anticoagulation?

- **A.** Continue warfarin (safe in first trimester)
- **B. Switch to low molecular weight heparin (LMWH)** ✓
- **C.** Switch to aspirin
- **D.** Switch to unfractionated heparin

ANSWER

B. Switch to low molecular weight heparin (LMWH)

HOW TO SOLVE

Start from the clue cluster: A 35-year-old female with a history of deep vein thrombosis on warfarin presents with an unintended pregnancy at 6 weeks gestation. Warfarin is teratogenic in the first trimester (fetal warfarin syndrome). LMWH is the preferred anticoagulant in pregnancy. That is exactly what the question is asking for (MOST appropriate immediate change in anticoagulation), so option B — Switch to low molecular weight heparin (LMWH) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Unfractionated heparin is an alternative but LMWH has better predictability and fewer side effects. This scenario sits in the Obstetrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Warfarin is teratogenic in the first trimester (fetal warfarin syndrome)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for warfarin is teratogenic in the first trimester (fetal warfarin syndrome) is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Warfarin is teratogenic in the first trimester (fetal warfarin syndrome) → Switch to low molecular weight heparin (LMWH).

Q121 OBSTETRICS / MEDICINE

A 26-year-old primigravida at 30 weeks gestation with sickle cell trait presents with acute chest pain, cough, and hypoxia. Which of the following is the MOST appropriate management?

- **A.** Exchange transfusion
- **B. Oxygen supplementation and hydration** ✓
- **C.** Prophylactic antibiotics
- **D.** Corticosteroids

ANSWER

B. Oxygen supplementation and hydration

HOW TO SOLVE

Start from the clue cluster: A 26-year-old primigravida at 30 weeks gestation with sickle cell trait presents with acute chest pain, cough, and hypoxia. This is acute chest syndrome in sickle cell disease (though the patient has sickle cell trait, acute chest can occur). Oxygen supplementation and hydration are the initial management. That is exactly what the question is asking for (MOST appropriate management), so option B — Oxygen supplementation and hydration — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Exchange transfusion is for severe cases. This scenario sits in the Obstetrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'cute chest syndrome in sickle cell disease (though the patient has sickle cell trait, acute chest can occur)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for cute chest syndrome in sickle cell disease (though the patient has sickle cell trait, acute chest can occur) is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

cute chest syndrome in sickle cell disease (though the patient has sickle cell trait, acute chest can occur) → Oxygen supplementation and hydration.

Q122 GYNECOLOGY / SURGERY

A 30-year-old female with endometriosis presents with a 4 cm ovarian endometrioma. Which of the following is the MOST appropriate management to preserve ovarian reserve?

- **A. Laparoscopic cystectomy** ✓
- **B.** Ultrasound-guided aspiration
- **C.** GnRH agonist therapy
- **D.** Oophorectomy

ANSWER

A. Laparoscopic cystectomy

HOW TO SOLVE

Start from the clue cluster: A 30-year-old female with endometriosis presents with a 4 cm ovarian endometrioma. Laparoscopic cystectomy is the standard of care for endometriomas to preserve ovarian reserve. Aspiration has high recurrence rates. That is exactly what the question is asking for (MOST appropriate management to preserve ovarian reserve), so option A — Laparoscopic cystectomy — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

GnRH agonists are for symptom control but do not remove the cyst. This scenario sits in the Gynecology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Laparoscopic cystectomy is the standard of care for endometriomas to preserve ovarian reserve' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for laparoscopic cystectomy is the standard of care for endometriomas to preserve ovarian reserve is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Laparoscopic cystectomy is the standard of care for endometriomas to preserve ovarian reserve → Laparoscopic cystectomy.

Q123 OBSTETRICS / GYNECOLOGY

A 32-year-old primigravida at 28 weeks gestation presents with severe pruritus and elevated bile acids (50 µmol/L). Which of the following is the MOST appropriate management to prevent fetal death?

- **A. Ursodeoxycholic acid + early delivery (37 weeks)** ✓
- **B.** Antihistamines
- **C.** Cholestyramine
- **D.** Corticosteroids

ANSWER

A. Ursodeoxycholic acid + early delivery (37 weeks)

HOW TO SOLVE

Start from the clue cluster: A 32-year-old primigravida at 28 weeks gestation presents with severe pruritus and elevated bile acids (50 µmol/L). Intrahepatic cholestasis of pregnancy with bile acids >40 µmol/L requires

ursodeoxycholic acid and early delivery at 37 weeks to prevent stillbirth. Antihistamines treat pruritus but not the underlying condition. That is exactly what the question is asking for (MOST appropriate management to prevent fetal death), so option A — Ursodeoxycholic acid + early delivery (37 weeks) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Antihistamines treat pruritus but not the underlying condition. This scenario sits in the Obstetrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Intrahepatic cholestasis of pregnancy with bile acids >40 µmol/L requires ursodeoxycholic acid and early delivery at 37 weeks to prevent stillbirth' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for intrahepatic cholestasis of pregnancy with bile acids >40 µmol/L requires ursodeoxycholic acid and early delivery at 37 weeks to prevent stillbirth is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Intrahepatic cholestasis of pregnancy with bile acids >40 µmol/L requires ursodeoxycholic acid and early delivery at 37 weeks to prevent stillbirth → Ursodeoxycholic acid + early delivery (37 weeks).

Q124 GYNECOLOGY / ONCOLOGY

A 40-year-old female with a BRCA1 mutation presents with an adnexal mass. CA-125 is normal. Ultrasound shows a multilocular cyst with solid areas. Which of the following is the MOST likely histology?

- **A. Serous carcinoma** ✓
- **B.** Mucinous carcinoma
- **C.** Endometrioid carcinoma
- **D.** Clear cell carcinoma

ANSWER

A. Serous carcinoma

HOW TO SOLVE

Start from the clue cluster: A 40-year-old female with a BRCA1 mutation presents with an adnexal mass. CA-125 is normal. Ultrasound shows a multilocular cyst with solid areas. BRCA1 mutations are associated with high-grade serous ovarian carcinoma. The multilocular cyst with solid areas is concerning for malignancy. That is exactly what

the question is asking for (MOST likely histology), so option A — Serous carcinoma — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

CA-125 can be normal in early-stage ovarian cancer. This scenario sits in the Gynecology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'BRCA1 mutations are associated with high-grade serous ovarian carcinoma' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with bRCA1 mutations are associated with high-grade serous ovarian carcinoma but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

BRCA1 mutations are associated with high-grade serous ovarian carcinoma → Serous carcinoma.

Q125 OBSTETRICS / NEUROLOGY

A 28-year-old female with epilepsy on valproate presents with a missed abortion at 10 weeks. She is scheduled for evacuation. Which of the following is the MOST appropriate pre-operative preparation?

- **A. Continue valproate** ✓
- **B.** Double the dose of valproate
- **C.** Switch to phenytoin
- **D.** Stop valproate 24 hours before

ANSWER

A. Continue valproate

HOW TO SOLVE

Start from the clue cluster: A 28-year-old female with epilepsy on valproate presents with a missed abortion at 10 weeks. She is scheduled for evacuation. Valproate should be continued perioperatively to prevent breakthrough seizures. Abrupt withdrawal can precipitate status epilepticus. That is exactly what the question is asking for (MOST appropriate pre-operative preparation), so option A — Continue valproate — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

There is no need to switch or double the dose. This scenario sits in the Obstetrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Valproate should be continued perioperatively to prevent breakthrough seizures' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for valproate should be continued perioperatively to prevent breakthrough seizures is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Valproate should be continued perioperatively to prevent breakthrough seizures → Continue valproate.

Q126 GYNECOLOGY / ONCOLOGY

A 45-year-old female with endometrial hyperplasia without atypia is treated with progestins. Which of the following is the MOST appropriate follow-up?

- **A. Repeat endometrial biopsy in 3 months** ✓
- **B.** Repeat ultrasound in 6 months
- **C.** Hysteroscopy in 1 month
- **D.** MRI

ANSWER

A. Repeat endometrial biopsy in 3 months

HOW TO SOLVE

Start from the clue cluster: A 45-year-old female with endometrial hyperplasia without atypia is treated with progestins. Endometrial hyperplasia without atypia requires repeat endometrial biopsy in 3 months after progestin therapy to confirm regression. Ultrasound is not sufficient to assess histologic response. That is exactly what the question is asking for (MOST appropriate follow-up), so option A — Repeat endometrial biopsy in 3 months — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Ultrasound is not sufficient to assess histologic response. This scenario sits in the Gynecology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name

'Endometrial hyperplasia without atypia requires repeat endometrial biopsy in 3 months after progestin therapy to confirm regression' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for endometrial hyperplasia without atypia requires repeat endometrial biopsy in 3 months after progestin therapy to confirm regression is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Endometrial hyperplasia without atypia requires repeat endometrial biopsy in 3 months after progestin therapy to confirm regression → Repeat endometrial biopsy in 3 months.

Q127 GYNECOLOGY / ONCOLOGY

A 30-year-old female presents with a complete hydatidiform mole. Serum β-hCG is 200,000 mIU/mL. Which of the following is the MOST appropriate management?

- **A. Suction evacuation** ✓
- **B.** Hysterectomy
- **C.** Methotrexate
- **D.** Actinomycin D

ANSWER

A. Suction evacuation

HOW TO SOLVE

Start from the clue cluster: A 30-year-old female presents with a complete hydatidiform mole. Serum β-hCG is 200,000 mIU/mL. Complete hydatidiform mole is managed with suction evacuation (dilation and curettage). Hysterectomy is for women who do not desire fertility. That is exactly what the question is asking for (MOST appropriate management), so option A — Suction evacuation — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Methotrexate is for gestational trophoblastic neoplasia, not molar pregnancy. This scenario sits in the Gynecology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Complete hydatidiform mole is managed with suction evacuation (dilation and curettage)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for complete hydatidiform mole is managed with suction evacuation (dilation and curettage) is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Complete hydatidiform mole is managed with suction evacuation (dilation and curettage) → Suction evacuation.

Q128 OBSTETRICS / GYNECOLOGY

A 28-year-old primigravida at 36 weeks gestation with a breech presentation and a history of previous cesarean section is scheduled for an external cephalic version (ECV). Which of the following is the MOST appropriate tocolytic agent?

A. Nifedipine
B. Terbutaline ✓
C. Magnesium sulfate
D. Atosiban

ANSWER

B. Terbutaline

HOW TO SOLVE

Start from the clue cluster: A 28-year-old primigravida at 36 weeks gestation with a breech presentation and a history of previous cesarean section is scheduled for an external cephalic version (ECV). Terbutaline (beta-agonist) is the preferred tocolytic for ECV. Nifedipine and atosiban are used for preterm labor, not ECV. That is exactly what the question is asking for (MOST appropriate tocolytic agent), so option B — Terbutaline — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Magnesium sulfate is for preeclampsia/eclampsia. This scenario sits in the Obstetrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Terbutaline (beta-agonist) is the preferred tocolytic for ECV' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for terbutaline (beta-agonist) is the preferred tocolytic for ECV is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Terbutaline (beta-agonist) is the preferred tocolytic for ECV → Terbutaline.

Q129 PEDIATRICS / ONCOLOGY

A 6-month-old infant presents with failure to thrive, hypotonia, and recurrent pneumonia. Chest X-ray shows a "reverse S" sign (Golden S sign) and a mediastinal mass. Which of the following is the MOST likely diagnosis?

- **A. Neuroblastoma** ✓
- **B.** Teratoma
- **C.** Ganglioneuroma
- **D.** Neuroenteric cyst

ANSWER

A. Neuroblastoma

HOW TO SOLVE

Start from the clue cluster: A 6-month-old infant presents with failure to thrive, hypotonia, and recurrent pneumonia. Chest X-ray shows a "reverse S" sign (Golden S sign) and a mediastinal mass. The "reverse S" sign (Golden S sign) in a child with failure to thrive and hypotonia is classic for neuroblastoma (thoracic). Teratomas and ganglioneuromas are less common in this presentation. That is exactly what the question is asking for (MOST likely diagnosis), so option A — Neuroblastoma — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Teratomas and ganglioneuromas are less common in this presentation. This scenario sits in the Pediatrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'The "reverse S" sign (Golden S sign) in a child with failure to thrive and hypotonia is classic for neuroblastoma (thoracic)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then

look at the options — the distractors are usually other conditions that share one or two features with the "reverse S" sign (Golden S sign) in a child with failure to thrive and hypotonia is classic for neuroblastoma (thoracic) but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

The "reverse S" sign (Golden S sign) in a child with failure to thrive and hypotonia is classic for neuroblastoma (thoracic) → Neuroblastoma.

Q130 PEDIATRICS / MICROBIOLOGY

A 4-year-old child presents with a 2-week history of fever, weight loss, and a non-productive cough. Chest X-ray shows bilateral hilar lymphadenopathy and reticulonodular infiltrates. Which of the following is the MOST appropriate initial diagnostic test?

- **A.** Tuberculin skin test
- **B. Interferon-gamma release assay (IGRA)** ✓
- **C.** Sputum acid-fast bacilli smear
- **D.** Chest CT

ANSWER

B. Interferon-gamma release assay (IGRA)

HOW TO SOLVE

Start from the clue cluster: A 4-year-old child presents with a 2-week history of fever, weight loss, and a non-productive cough. Chest X-ray shows bilateral hilar lymphadenopathy and reticulonodular infiltrates. In a child with suspected TB, IGRA is preferred over TST as it is more specific and not affected by BCG vaccination. Sputum AFB is difficult to obtain in children. That is exactly what the question is asking for (MOST appropriate initial diagnostic test), so option B — Interferon-gamma release assay (IGRA) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Chest CT is not the initial diagnostic test. This scenario sits in the Pediatrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'In a child with suspected TB, IGRA is preferred over TST as it is more specific and not affected by BCG vaccination' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value)

exists to rule something in or out. Once the pattern for in a child with suspected TB, IGRA is preferred over TST as it is more specific and not affected by BCG vaccination is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

In a child with suspected TB, IGRA is preferred over TST as it is more specific and not affected by BCG vaccination → Interferon-gamma release assay (IGRA).

Q131 PEDIATRICS / ENT

A 2-year-old child presents with acute-onset severe stridor, drooling, and high fever. The child prefers to sit leaning forward with the chin thrust out. Which of the following is the MOST appropriate immediate management?

- **A. Direct laryngoscopy in the operating room** ✓
- **B.** Nebulized epinephrine
- **C.** IV dexamethasone
- **D.** Ceftriaxone

ANSWER

A. Direct laryngoscopy in the operating room

HOW TO SOLVE

Start from the clue cluster: A 2-year-old child presents with acute-onset severe stridor, drooling, and high fever. The child prefers to sit leaning forward with the chin thrust out. This is epiglottitis (acute stridor, drooling, tripod position). Direct laryngoscopy in the operating room with an experienced airway team is the immediate management. That is exactly what the question is asking for (MOST appropriate immediate management), so option A — Direct laryngoscopy in the operating room — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Nebulized epinephrine is for croup. IV dexamethasone is for croup. This scenario sits in the Pediatrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'epiglottitis (acute stridor, drooling, tripod position)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Whenever a stem asks for the MOST appropriate MOST appropriate immediate management, first separate stabilization from definitive treatment — NEET PG regularly rewards the step that is safe and immediate over the one that is technically 'correct' but premature. Here that step is A. Direct laryngoscopy in the operating room,

because epiglottitis (acute stridor, drooling, tripod position) is the pattern being tested, not a request for the final cure.

KEY FACT

epiglottitis (acute stridor, drooling, tripod position) → Direct laryngoscopy in the operating room.

Q132 PEDIATRICS / PULMONOLOGY

A 7-year-old child with asthma presents with acute exacerbation. He has a peak expiratory flow rate (PEFR) of 35% of predicted. Which of the following is the MOST appropriate management?

- **A. Nebulized albuterol + Ipratropium + Systemic corticosteroids** ✓
- **B.** Nebulized albuterol alone
- **C.** Oral corticosteroids
- **D.** Theophylline

ANSWER

A. Nebulized albuterol + Ipratropium + Systemic corticosteroids

HOW TO SOLVE

Start from the clue cluster: A 7-year-old child with asthma presents with acute exacerbation. He has a peak expiratory flow rate (PEFR) of 35% of predicted. PEFR <40% of predicted indicates severe exacerbation. Management includes nebulized albuterol, ipratropium, and systemic corticosteroids. That is exactly what the question is asking for (MOST appropriate management), so option A — Nebulized albuterol + Ipratropium + Systemic corticosteroids — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Theophylline is not first-line. This scenario sits in the Pediatrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'PEFR <40% of predicted indicates severe exacerbation' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for pEFR <40% of predicted indicates severe exacerbation is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

PEFR <40% of predicted indicates severe exacerbation → Nebulized albuterol + Ipratropium + Systemic corticosteroids.

Q133 PEDIATRICS / HEMATOLOGY

A 5-year-old child presents with recurrent epistaxis and a purpuric rash. Platelet count is 10,000/µL. Bone marrow aspiration shows increased megakaryocytes. Which of the following is the MOST appropriate initial management for severe ITP with mucosal bleeding?

A. IV immunoglobulin (IVIG) ✓

B. Corticosteroids

C. Platelet transfusion

D. Rituximab

ANSWER

A. IV immunoglobulin (IVIG)

HOW TO SOLVE

Start from the clue cluster: A 5-year-old child presents with recurrent epistaxis and a purpuric rash. Platelet count is 10,000/µL. Bone marrow aspiration shows increased megakaryocytes. Severe ITP with mucosal bleeding (platelets <20,000) requires IVIG for rapid platelet increase. Corticosteroids act more slowly. That is exactly what the question is asking for (MOST appropriate initial management for severe ITP with mucosal bleeding), so option A — IV immunoglobulin (IVIG) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Platelet transfusion is not indicated in ITP (immune destruction). Rituximab is for chronic ITP. This scenario sits in the Pediatrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Severe ITP with mucosal bleeding (platelets <20,000) requires IVIG for rapid platelet increase' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Whenever a stem asks for the MOST appropriate MOST appropriate initial management for severe ITP with mucosal bleeding, first separate stabilization from definitive treatment — NEET PG regularly rewards the step that is safe and immediate over the one that is technically 'correct' but premature. Here that step is A. IV immunoglobulin (IVIG), because severe ITP with mucosal bleeding (platelets <20,000) requires IVIG for rapid platelet increase is the pattern being tested, not a request for the final cure.

KEY FACT

Severe ITP with mucosal bleeding (platelets <20,000) requires IVIG for rapid platelet increase → IV immunoglobulin (IVIG).

Q134 PEDIATRICS / PULMONOLOGY

A 3-year-old child presents with fever, cough, and a chest X-ray showing a round pneumonia in the right lower lobe. Which of the following is the MOST appropriate antibiotic if the child is allergic to penicillin?

- **A. Azithromycin** ✓
- **B.** Cefuroxime
- **C.** Trimethoprim-sulfamethoxazole
- **D.** Levofloxacin

ANSWER

A. Azithromycin

HOW TO SOLVE

Start from the clue cluster: A 3-year-old child presents with fever, cough, and a chest X-ray showing a round pneumonia in the right lower lobe. Round pneumonia in children is typically caused by Streptococcus pneumoniae. In penicillin-allergic patients, azithromycin (macrolide) is the appropriate choice. That is exactly what the question is asking for (MOST appropriate antibiotic if the child is allergic to penicillin), so option A — Azithromycin — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Cefuroxime may cross-react in penicillin allergy. Levofloxacin is not first-line in children. This scenario sits in the Pediatrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Round pneumonia in children is typically caused by Streptococcus pneumoniae' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for round pneumonia in children is typically caused by Streptococcus pneumoniae is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Round pneumonia in children is typically caused by Streptococcus pneumoniae → Azithromycin.

Q135 PEDIATRICS / CARDIOLOGY

A 6-month-old infant with a ventricular septal defect (VSD) presents with tachypnea, poor feeding, and failure to thrive. Echocardiography shows a large non-restrictive VSD with significant left-to-right shunt. Which of the following is the MOST appropriate management?

- **A. Surgical repair (VSD closure)** ✓
- **B.** Medical management with diuretics and ACE inhibitors
- **C.** Pulmonary artery banding
- **D.** Transcatheter closure

ANSWER

A. Surgical repair (VSD closure)

HOW TO SOLVE

Start from the clue cluster: A 6-month-old infant with a ventricular septal defect (VSD) presents with tachypnea, poor feeding, and failure to thrive. Echocardiography shows a large non-restrictive VSD with significant left-to-right shunt. Large non-restrictive VSD with failure to thrive requires surgical repair. Pulmonary artery banding is a palliative procedure for multiple VSDs or associated anomalies. That is exactly what the question is asking for (MOST appropriate management), so option A — Surgical repair (VSD closure) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Transcatheter closure is for small, restrictive VSDs. This scenario sits in the Pediatrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Large non-restrictive VSD with failure to thrive requires surgical repair' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for large non-restrictive VSD with failure to thrive requires surgical repair is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Large non-restrictive VSD with failure to thrive requires surgical repair → Surgical repair (VSD closure).

Q136 PEDIATRICS / CARDIOLOGY

A 2-year-old child with Tetralogy of Fallot presents with a hypercyanotic spell. Which of the following is the MOST appropriate immediate management?

- **A. Knee-chest position + Oxygen + Morphine + Propranolol** ✓
- **B.** Prostaglandin E1 infusion
- **C.** Phenylephrine
- **D.** Surgical shunt

ANSWER

A. Knee-chest position + Oxygen + Morphine + Propranolol

HOW TO SOLVE

Start from the clue cluster: A 2-year-old child with Tetralogy of Fallot presents with a hypercyanotic spell. Hypercyanotic (Tet) spells are managed with knee-chest position, oxygen, morphine, and propranolol. Prostaglandin E1 is for duct-dependent lesions. That is exactly what the question is asking for (MOST appropriate immediate management), so option A — Knee-chest position + Oxygen + Morphine + Propranolol — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Phenylephrine is used if the patient is hypotensive. This scenario sits in the Pediatrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Hypercyanotic (Tet) spells are managed with knee-chest position, oxygen, morphine, and propranolol' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Whenever a stem asks for the MOST appropriate MOST appropriate immediate management, first separate stabilization from definitive treatment — NEET PG regularly rewards the step that is safe and immediate over the one that is technically 'correct' but premature. Here that step is A. Knee-chest position + Oxygen + Morphine + Propranolol, because hypercyanotic (Tet) spells are managed with knee-chest position, oxygen, morphine, and propranolol is the pattern being tested, not a request for the final cure.

KEY FACT

Hypercyanotic (Tet) spells are managed with knee-chest position, oxygen, morphine, and propranolol → Knee-chest position + Oxygen + Morphine + Propranolol.

Q137 PEDIATRICS / ONCOLOGY

A 4-year-old child with urinary tract infections presents with a palpable abdominal mass. Ultrasound reveals a large renal mass with calcifications. Which of the following is the MOST common pediatric renal tumor?

- **A. Wilms tumor (Nephroblastoma)** ✓
- **B.** Neuroblastoma
- **C.** Clear cell sarcoma
- **D.** Rhabdoid tumor

ANSWER

A. Wilms tumor (Nephroblastoma)

HOW TO SOLVE

Start from the clue cluster: A 4-year-old child with urinary tract infections presents with a palpable abdominal mass. Ultrasound reveals a large renal mass with calcifications. Wilms tumor (nephroblastoma) is the most common pediatric renal tumor. Neuroblastoma is adrenal/retroperitoneal. That is exactly what the question is asking for (MOST common pediatric renal tumor), so option A — Wilms tumor (Nephroblastoma) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Clear cell sarcoma and rhabdoid tumor are less common. This scenario sits in the Pediatrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Wilms tumor (nephroblastoma) is the most common pediatric renal tumor' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for wilms tumor (nephroblastoma) is the most common pediatric renal tumor is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Wilms tumor (nephroblastoma) is the most common pediatric renal tumor → Wilms tumor (Nephroblastoma).

Q138 PEDIATRICS / ONCOLOGY

A 5-year-old child presents with acute-onset ataxia, nystagmus, and vomiting. MRI shows a large cystic mass in the posterior fossa with a solid mural nodule. Which of the following is the MOST likely diagnosis?

- **A. Pilocytic astrocytoma** ✓

B. Medulloblastoma
C. Ependymoma
D. Craniopharyngioma

ANSWER

A. Pilocytic astrocytoma

HOW TO SOLVE

Start from the clue cluster: A 5-year-old child presents with acute-onset ataxia, nystagmus, and vomiting. MRI shows a large cystic mass in the posterior fossa with a solid mural nodule. Pilocytic astrocytoma is the most common pediatric cerebellar tumor and classically shows a cystic mass with a solid mural nodule. Medulloblastoma is more solid and hyperdense. That is exactly what the question is asking for (MOST likely diagnosis), so option A — Pilocytic astrocytoma — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Craniopharyngioma is suprasellar. This scenario sits in the Pediatrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Pilocytic astrocytoma is the most common pediatric cerebellar tumor and classically shows a cystic mass with a solid mural nodule' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with pilocytic astrocytoma is the most common pediatric cerebellar tumor and classically shows a cystic mass with a solid mural nodule but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

Pilocytic astrocytoma is the most common pediatric cerebellar tumor and classically shows a cystic mass with a solid mural nodule → Pilocytic astrocytoma.

Q139 PEDIATRICS / SURGERY

A 3-year-old child presents with chronic constipation, abdominal distension, and failure to thrive. A barium enema shows a transition zone at the rectosigmoid junction. Which of the following is the MOST appropriate definitive treatment?

A. Pull-through procedure (Swenson, Soave, Duhamel) ✓
B. Colostomy

C. Laxatives

D. Enemas

ANSWER

A. Pull-through procedure (Swenson, Soave, Duhamel)

HOW TO SOLVE

Start from the clue cluster: A 3-year-old child presents with chronic constipation, abdominal distension, and failure to thrive. A barium enema shows a transition zone at the rectosigmoid junction. This is Hirschsprung's disease (transition zone at rectosigmoid). The definitive treatment is a pull-through procedure. That is exactly what the question is asking for (MOST appropriate definitive treatment), so option A — Pull-through procedure (Swenson, Soave, Duhamel) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Colostomy is a temporary measure. Laxatives and enemas are not curative. This scenario sits in the Pediatrics portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Hirschsprung's disease (transition zone at rectosigmoid)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Definitive-management stems separate temporising measures from the fix that actually resolves the underlying problem. For hirschsprung's disease (transition zone at rectosigmoid), the temporising options are usually present as distractors — flag any option that only buys time and set it aside in favour of the one that treats the actual lesion or process.

KEY FACT

Hirschsprung's disease (transition zone at rectosigmoid) → Pull-through procedure (Swenson, Soave, Duhamel).

Q140 NEUROLOGY / OBSTETRICS

A 28-year-old female with epilepsy on carbamazepine presents with a new rash, fever, and hepatosplenomegaly. She is pregnant (12 weeks). Which of the following is the MOST appropriate antiepileptic to switch to?

A. Lamotrigine ✓

B. Valproic acid

C. Phenytoin

D. Levetiracetam

ANSWER

A. Lamotrigine

HOW TO SOLVE

Start from the clue cluster: A 28-year-old female with epilepsy on carbamazepine presents with a new rash, fever, and hepatosplenomegaly. She is pregnant (12 weeks). This is carbamazepine hypersensitivity syndrome. Lamotrigine is the preferred antiepileptic in pregnancy (relatively safe). That is exactly what the question is asking for (MOST appropriate antiepileptic to switch to), so option A — Lamotrigine — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Valproic acid is teratogenic. Phenytoin has teratogenic effects. Levetiracetam is also an option but lamotrigine is better studied in pregnancy. This scenario sits in the Neurology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'carbamazepine hypersensitivity syndrome' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for carbamazepine hypersensitivity syndrome is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

carbamazepine hypersensitivity syndrome → Lamotrigine.

Q141 MEDICINE / CARDIOLOGY

A 55-year-old male with heart failure with reduced ejection fraction (HFrEF) is on digoxin. He presents with nausea, vomiting, and visual disturbances (yellow halos). Which of the following is the MOST appropriate next step?

- **A. Check digoxin level and discontinue** ✓
- **B.** Administer Digoxin-specific antibody fragments (Fab)
- **C.** Administer atropine
- **D.** Check potassium and magnesium

ANSWER

A. Check digoxin level and discontinue

HOW TO SOLVE

Start from the clue cluster: A 55-year-old male with heart failure with reduced ejection fraction (HFrEF) is on digoxin. He presents with nausea, vomiting, and visual disturbances (yellow halos). This is digoxin toxicity (nausea, vomiting, yellow halos). The first step is to check the digoxin level and discontinue the drug. That is exactly what the question is asking for (MOST appropriate next step), so option A — Check digoxin level and discontinue — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Digoxin-specific Fab fragments are for life-threatening toxicity (arrhythmias, hyperkalemia). Atropine is for bradycardia but does not treat the underlying toxicity. This scenario sits in the Medicine portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'digoxin toxicity (nausea, vomiting, yellow halos)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

'Next step' questions are testing sequencing, not just knowledge — the exam wants the step that comes right after what's already been done in the stem, not the step three moves later. Re-read the stem for what has already happened, then pick the option that logically follows for digoxin toxicity (nausea, vomiting, yellow halos).

KEY FACT

digoxin toxicity (nausea, vomiting, yellow halos) → Check digoxin level and discontinue.

Q142 MICROBIOLOGY / MEDICINE

A 32-year-old male with HIV (CD4 200 cells/µL) presents with fever, headache, and a positive serum cryptococcal antigen. CSF shows an opening pressure of 40 cm H_2O. Which of the following is the MOST appropriate immediate intervention?

- **A. Therapeutic lumbar puncture (CSF drainage)** ✓
- **B.** Amphotericin B + Flucytosine
- **C.** Acetazolamide
- **D.** VP shunt

ANSWER

A. Therapeutic lumbar puncture (CSF drainage)

HOW TO SOLVE

Start from the clue cluster: A 32-year-old male with HIV (CD4 200 cells/µL) presents with fever, headache, and a positive serum cryptococcal antigen. CSF shows an opening pressure of 40 cm H_2O. Elevated intracranial pressure (>25 cm H_2O) in cryptococcal meningitis requires therapeutic lumbar puncture for CSF drainage. This is the immediate intervention before starting antifungal therapy. That is exactly what the question is asking for (MOST appropriate immediate intervention), so option A — Therapeutic lumbar puncture (CSF drainage) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

This is the immediate intervention before starting antifungal therapy. This scenario sits in the Microbiology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Elevated intracranial pressure (>25 cm H_2O) in cryptococcal meningitis requires therapeutic lumbar puncture for CSF drainage' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for elevated intracranial pressure (>25 cm H_2O) in cryptococcal meningitis requires therapeutic lumbar puncture for CSF drainage is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Elevated intracranial pressure (>25 cm H_2O) in cryptococcal meningitis requires therapeutic lumbar puncture for CSF drainage → Therapeutic lumbar puncture (CSF drainage).

Q143 HEMATOLOGY / PHARMACOLOGY

A 65-year-old female with atrial fibrillation on dabigatran presents with a massive GI bleed. Which of the following is the MOST appropriate reversal agent?

- **A. Idarucizumab** ✓
- **B.** Andexanet alfa
- **C.** PCC
- **D.** Vitamin K

ANSWER

A. Idarucizumab

HOW TO SOLVE

Start from the clue cluster: A 65-year-old female with atrial fibrillation on dabigatran presents with a massive GI

bleed. Idarucizumab is the specific reversal agent for dabigatran. Andexanet alfa is for Factor Xa inhibitors (rivaroxaban, apixaban). That is exactly what the question is asking for (MOST appropriate reversal agent), so option A — Idarucizumab — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

PCC is for warfarin reversal. Vitamin K is for warfarin. This scenario sits in the Hematology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Idarucizumab is the specific reversal agent for dabigatran' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Reversal-agent questions are a closed matching set — each anticoagulant class has exactly one specific antidote, and the wrong options are almost always the antidotes for a different drug class. Map the drug in the stem to its class first, then its specific reversal agent, which is why A. Idarucizumab is correct for idarucizumab is the specific reversal agent for dabigatran.

KEY FACT

Idarucizumab is the specific reversal agent for dabigatran → Idarucizumab.

Q144 GASTROENTEROLOGY / MEDICINE

A 45-year-old male with chronic pancreatitis and diabetes presents with new-onset steatorrhea. Which of the following is the MOST appropriate replacement therapy?

- **A. Pancreatic enzyme supplements (lipase)** ✓
- **B.** Vitamin D and Calcium
- **C.** Medium-chain triglycerides
- **D.** Proton pump inhibitors

ANSWER

A. Pancreatic enzyme supplements (lipase)

HOW TO SOLVE

Start from the clue cluster: A 45-year-old male with chronic pancreatitis and diabetes presents with new-onset steatorrhea. Steatorrhea in chronic pancreatitis is due to pancreatic exocrine insufficiency. Pancreatic enzyme supplements (lipase) are the appropriate replacement therapy. That is exactly what the question is asking for (MOST appropriate replacement therapy), so option A — Pancreatic enzyme supplements (lipase) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

SECTION E Clinical Integration — Mixed Subjects Questions 145–180. This scenario sits in the Gastroenterology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Steatorrhea in chronic pancreatitis is due to pancreatic exocrine insufficiency' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for steatorrhea in chronic pancreatitis is due to pancreatic exocrine insufficiency is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Steatorrhea in chronic pancreatitis is due to pancreatic exocrine insufficiency → Pancreatic enzyme supplements (lipase).

NEET PG 2026 — Section E — Clinical Integration

Fully Explained Edition · Every option broken into How to Solve, Deep-Dive, Pattern & Key Fact

Questions 145–180 · Exam Date: August 30, 2026 · Marking: +4 / -1

Q145 SURGERY / RADIOLOGY

A 45-year-old male with chronic pancreatitis presents with a 4 cm mass in the pancreatic head. On contrast-enhanced CT, the mass shows delayed enhancement, is hypodense, and has a dilated pancreatic duct upstream. Which of the following is the MOST appropriate imaging modality to distinguish a mass from focal chronic pancreatitis?

A. EUS with elastography ✓

B. MRCP with secretin stimulation

C. CT with dual-phase contrast

D. PET-CT

ANSWER

A. EUS with elastography

HOW TO SOLVE

Start from the clue cluster: A 45-year-old male with chronic pancreatitis presents with a 4 cm mass in the pancreatic head. On contrast-enhanced CT, the mass shows delayed enhancement, is hypodense, and has a dilated pancreatic duct upstream. EUS with elastography can distinguish pancreatic adenocarcinoma (stiffer) from focal chronic pancreatitis (softer) with high accuracy. MRCP with secretin evaluates ductal function. That is exactly what the question is asking for (MOST appropriate imaging modality to distinguish a mass from focal chronic pancreatitis), so option A — EUS with elastography — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

PET-CT has limited specificity. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'EUS with elastography can distinguish pancreatic adenocarcinoma (stiffer) from focal chronic pancreatitis (softer) with high accuracy' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for eUS with elastography can distinguish pancreatic adenocarcinoma (stiffer) from focal chronic pancreatitis (softer) with high accuracy is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

EUS with elastography can distinguish pancreatic adenocarcinoma (stiffer) from focal chronic pancreatitis (softer) with high accuracy → EUS with elastography.

Q146 NEUROLOGY / RADIOLOGY

A 28-year-old female with seizures undergoes an MRI. T2-weighted imaging shows bilateral, symmetrical, hyperintense signal changes in the temporal lobes, sparing the amygdala. Which of the following is the MOST likely diagnosis?

- **A. Herpes simplex encephalitis** ✓
- **B.** Limbic encephalitis
- **C.** Mesial temporal sclerosis
- **D.** Alzheimer's disease

ANSWER

A. Herpes simplex encephalitis

HOW TO SOLVE

Start from the clue cluster: A 28-year-old female with seizures undergoes an MRI. T2-weighted imaging shows bilateral, symmetrical, hyperintense signal changes in the temporal lobes, sparing the amygdala. Herpes simplex encephalitis classically involves the temporal lobes (bilateral, often asymmetric) and may spare the amygdala in early stages. Limbic encephalitis is paraneoplastic. That is exactly what the question is asking for (MOST likely diagnosis), so option A — Herpes simplex encephalitis — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Mesial temporal sclerosis is associated with temporal lobe epilepsy. This scenario sits in the Neurology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Herpes simplex encephalitis classically involves the temporal lobes (bilateral, often asymmetric) and may spare the amygdala in early stages' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with herpes simplex encephalitis classically involves the temporal lobes (bilateral, often asymmetric) and may spare the amygdala in early stages but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

Herpes simplex encephalitis classically involves the temporal lobes (bilateral, often asymmetric) and may spare the amygdala in early stages → Herpes simplex encephalitis.

Q147 RADIOLOGY / ONCOLOGY

A 60-year-old male with smoking history presents with superior vena cava syndrome. CT shows a mass in the right upper lobe. Which of the following is the MOST appropriate interventional radiology procedure to relieve symptoms?

- **A. SVC stenting** ✓
- **B.** Percutaneous biopsy
- **C.** Embolization
- **D.** Thrombolysis

ANSWER

A. SVC stenting

HOW TO SOLVE

Start from the clue cluster: A 60-year-old male with smoking history presents with superior vena cava syndrome. CT shows a mass in the right upper lobe. SVC stenting is the most effective interventional radiology procedure to relieve SVC syndrome symptoms. Biopsy is diagnostic but does not relieve symptoms. That is exactly what the question is asking for (MOST appropriate interventional radiology procedure to relieve symptoms), so option A — SVC stenting — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Thrombolysis is for acute SVC thrombosis. This scenario sits in the Radiology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'SVC stenting is the most effective interventional radiology procedure to relieve SVC syndrome symptoms' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for sVC stenting is the most effective interventional radiology procedure to relieve SVC syndrome symptoms is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

SVC stenting is the most effective interventional radiology procedure to relieve SVC syndrome symptoms → SVC stenting.

Q148 RADIOLOGY / ONCOLOGY

A 35-year-old female with breast cancer presents with a new focal liver lesion on surveillance CT. The lesion is hypodense, has peripheral rim enhancement in the arterial phase, and shows washout in the portal venous phase. Which of the following is the MOST likely diagnosis?

- **A.** Hemangioma
- **B.** Adenoma
- **C. Metastasis** ✓
- **D.** HCC

ANSWER

C. Metastasis

HOW TO SOLVE

Start from the clue cluster: A 35-year-old female with breast cancer presents with a new focal liver lesion on surveillance CT. The lesion is hypodense, has peripheral rim enhancement in the arterial phase, and shows washout in the portal venous phase. Metastasis from breast cancer typically shows peripheral rim enhancement with washout. Hemangioma shows progressive centripetal fill-in without washout. That is exactly what the question is asking for (MOST likely diagnosis), so option C — Metastasis — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

HCC shows arterial hyperenhancement with washout but requires cirrhosis. This scenario sits in the Radiology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Metastasis from breast cancer typically shows peripheral rim enhancement with washout' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with metastasis from breast cancer typically shows peripheral rim enhancement with washout but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

Metastasis from breast cancer typically shows peripheral rim enhancement with washout → Metastasis.

Q149 RADIOLOGY / ONCOLOGY

A 65-year-old male with colorectal cancer presents with a solitary pulmonary nodule. PET-CT shows intense FDG uptake (SUV 8). Which of the following is the MOST appropriate next step?

- **A. CT-guided biopsy** ✓
- **B.** PET-CT follow-up in 3 months
- **C.** Bronchoscopy
- **D.** Thoracotomy

ANSWER

A. CT-guided biopsy

HOW TO SOLVE

Start from the clue cluster: A 65-year-old male with colorectal cancer presents with a solitary pulmonary nodule. PET-CT shows intense FDG uptake (SUV 8). A solitary pulmonary nodule with intense FDG uptake in a patient with known colorectal cancer requires tissue diagnosis. CT-guided biopsy is the least invasive and most appropriate next step. That is exactly what the question is asking for (MOST appropriate next step), so option A — CT-guided biopsy — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

CT-guided biopsy is the least invasive and most appropriate next step. This scenario sits in the Radiology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'A solitary pulmonary nodule with intense FDG uptake in a patient with known colorectal cancer requires tissue diagnosis' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

'Next step' questions are testing sequencing, not just knowledge — the exam wants the step that comes right after what's already been done in the stem, not the step three moves later. Re-read the stem for what has already happened, then pick the option that logically follows for a solitary pulmonary nodule with intense FDG uptake in a patient with known colorectal cancer requires tissue diagnosis.

KEY FACT

A solitary pulmonary nodule with intense FDG uptake in a patient with known colorectal cancer requires tissue diagnosis → CT-guided biopsy.

Q150 PULMONOLOGY / RADIOLOGY

A 45-year-old female with sarcoidosis presents with a persistent dry cough and progressive dyspnea. HRCT shows a "galaxy sign" with a central high-density area and surrounding ground-glass opacities. Which of the following is the MOST likely complication?

- **A. Progressive fibrotic sarcoidosis** ✓
- **B.** Hypersensitivity pneumonitis
- **C.** Pulmonary alveolar proteinosis
- **D.** Lymphangitic carcinomatosis

ANSWER

A. Progressive fibrotic sarcoidosis

HOW TO SOLVE

Start from the clue cluster: A 45-year-old female with sarcoidosis presents with a persistent dry cough and progressive dyspnea. HRCT shows a "galaxy sign" with a central high-density area and surrounding ground-glass opacities. The "galaxy sign" in sarcoidosis indicates progressive fibrotic disease with conglomerate masses. This is a complication of chronic sarcoidosis. That is exactly what the question is asking for (MOST likely complication), so option A — Progressive fibrotic sarcoidosis — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Hypersensitivity pneumonitis shows centrilobular nodules and mosaic attenuation. This scenario sits in the Pulmonology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'The "galaxy sign" in sarcoidosis indicates progressive fibrotic disease with conglomerate masses' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for the "galaxy sign" in sarcoidosis indicates progressive fibrotic disease with conglomerate masses is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

The "galaxy sign" in sarcoidosis indicates progressive fibrotic disease with conglomerate masses → Progressive fibrotic sarcoidosis.

Q151 SURGERY / RADIOLOGY

A 30-year-old male with trauma presents with a pneumothorax. Chest X-ray shows a deep sulcus sign and a double diaphragm sign. Which of the following is the MOST appropriate management?

A. Tube thoracostomy ✓
B. Needle aspiration
C. Observation
D. Pleurodesis

ANSWER

A. Tube thoracostomy

HOW TO SOLVE

Start from the clue cluster: A 30-year-old male with trauma presents with a pneumothorax. Chest X-ray shows a deep sulcus sign and a double diaphragm sign. Deep sulcus sign and double diaphragm sign indicate a large pneumothorax in a supine patient. This requires tube thoracostomy. That is exactly what the question is asking for (MOST appropriate management), so option A — Tube thoracostomy — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Needle aspiration is for small, stable pneumothoraces. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Deep sulcus sign and double diaphragm sign indicate a large pneumothorax in a supine patient' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for deep sulcus sign and double diaphragm sign indicate a large pneumothorax in a supine patient is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Deep sulcus sign and double diaphragm sign indicate a large pneumothorax in a supine patient → Tube thoracostomy.

Q152 SURGERY / RADIOLOGY

A 68-year-old male with abdominal aortic aneurysm undergoes a CTA. The image shows a "crescent sign" in the wall of the aneurysm. Which of the following is the MOST important implication?

A. Impending rupture ✓
B. Thrombosis
C. Infection
D. Dissection

ANSWER

A. Impending rupture

HOW TO SOLVE

Start from the clue cluster: A 68-year-old male with abdominal aortic aneurysm undergoes a CTA. The image shows a "crescent sign" in the wall of the aneurysm. The crescent sign (hyperdense crescent in the aortic wall) indicates acute intramural hemorrhage and is a sign of impending rupture. This requires urgent surgical intervention. That is exactly what the question is asking for (MOST important implication), so option A — Impending rupture — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

This requires urgent surgical intervention. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'The crescent sign (hyperdense crescent in the aortic wall) indicates acute intramural hemorrhage and is a sign of impending rupture' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for the crescent sign (hyperdense crescent in the aortic wall) indicates acute intramural hemorrhage and is a sign of impending rupture is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

The crescent sign (hyperdense crescent in the aortic wall) indicates acute intramural hemorrhage and is a sign of impending rupture → Impending rupture.

Q153 ONCOLOGY / RADIOLOGY

A 55-year-old male with prostate cancer presents with new bone pain. A bone scan shows multiple osteoblastic lesions. Which of the following is the MOST common site of metastases?

A. Lumbar spine ✓
B. Pelvis

C. Femur

D. Ribs

ANSWER

A. Lumbar spine

HOW TO SOLVE

Start from the clue cluster: A 55-year-old male with prostate cancer presents with new bone pain. A bone scan shows multiple osteoblastic lesions. Prostate cancer metastasizes most commonly to the lumbar spine (vertebral bodies). The pelvis and femur are also common but the lumbar spine is the most frequent site. That is exactly what the question is asking for (MOST common site of metastases), so option A — Lumbar spine — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The pelvis and femur are also common but the lumbar spine is the most frequent site. This scenario sits in the Oncology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Prostate cancer metastasizes most commonly to the lumbar spine (vertebral bodies)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for prostate cancer metastasizes most commonly to the lumbar spine (vertebral bodies) is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Prostate cancer metastasizes most commonly to the lumbar spine (vertebral bodies) → Lumbar spine.

Q154 NEUROLOGY / RADIOLOGY

A 25-year-old female with papilledema is referred for MRI. MR venography shows a stenosis of the transverse sinus. Which of the following is the MOST appropriate treatment?

A. Acetazolamide

B. CSF shunting

C. Venous sinus stenting ✓

D. Corticosteroids

ANSWER

C. Venous sinus stenting

HOW TO SOLVE

Start from the clue cluster: A 25-year-old female with papilledema is referred for MRI. MR venography shows a stenosis of the transverse sinus. Transverse sinus stenosis causing intracranial hypertension can be treated with venous sinus stenting. This is an alternative to CSF shunting in patients with focal stenosis. That is exactly what the question is asking for (MOST appropriate treatment), so option C — Venous sinus stenting — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Acetazolamide is medical therapy but does not address the stenosis. This scenario sits in the Neurology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Transverse sinus stenosis causing intracranial hypertension can be treated with venous sinus stenting' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for transverse sinus stenosis causing intracranial hypertension can be treated with venous sinus stenting is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Transverse sinus stenosis causing intracranial hypertension can be treated with venous sinus stenting → Venous sinus stenting.

Q155 ANESTHESIA

A 70-year-old male with obstructive sleep apnea is scheduled for surgery. Which of the following anesthetic agents should be used with extreme caution?

- **A. Sevoflurane** ✓
- **B.** Propofol
- **C.** Ketamine
- **D.** Fentanyl

ANSWER

A. Sevoflurane

HOW TO SOLVE

Start from the clue cluster: A 70-year-old male with obstructive sleep apnea is scheduled for surgery. Sevoflurane (and other volatile anesthetics) can precipitate malignant hyperthermia in susceptible patients. While malignant hyperthermia is rare, it is a life- threatening emergency. That is exactly what the question is asking for (Which of the following anesthetic agents should be used with extreme caution), so option A — Sevoflurane — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Propofol, ketamine, and fentanyl are safe. This scenario sits in the Anesthesia portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Sevoflurane (and other volatile anesthetics) can precipitate malignant hyperthermia in susceptible patients' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for sevoflurane (and other volatile anesthetics) can precipitate malignant hyperthermia in susceptible patients is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Sevoflurane (and other volatile anesthetics) can precipitate malignant hyperthermia in susceptible patients → Sevoflurane.

Q156 ANESTHESIA / SURGERY

A 45-year-old female undergoing a laparoscopic cholecystectomy develops sudden hypotension, tachycardia, and a drop in end-tidal CO_2. Which of the following is the MOST likely cause?

- **A. CO_2 embolism** ✓
- **B.** Pneumothorax
- **C.** Cardiac arrhythmia
- **D.** Anaphylaxis

ANSWER

A. CO_2 embolism

HOW TO SOLVE

Start from the clue cluster: A 45-year-old female undergoing a laparoscopic cholecystectomy develops sudden hypotension, tachycardia, and a drop in end-tidal CO_2. Sudden hypotension, tachycardia, and drop in end-tidal CO_2 during laparoscopy is classic for CO_2 embolism. Pneumothorax would cause hypoxia but not necessarily a drop in end-tidal CO_2. Anaphylaxis would cause bronchospasm and skin changes. That is exactly what the question is asking for (MOST likely cause), so option A — CO_2 embolism — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Pneumothorax would cause hypoxia but not necessarily a drop in end-tidal CO_2. Anaphylaxis would cause bronchospasm and skin changes. This scenario sits in the Anesthesia portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Sudden hypotension, tachycardia, and drop in end-tidal CO_2 during laparoscopy is classic for CO_2 embolism' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with sudden hypotension, tachycardia, and drop in end-tidal CO_2 during laparoscopy is classic for CO_2 embolism but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

Sudden hypotension, tachycardia, and drop in end-tidal CO_2 during laparoscopy is classic for CO_2 embolism → CO_2 embolism.

Q157 ANESTHESIA

A 60-year-old male with COPD is undergoing a hernia repair under spinal anesthesia. He develops bradycardia and hypotension. Which of the following is the MOST appropriate pharmacological intervention?

- **A. Atropine** ✓
- **B.** Ephedrine
- **C.** Phenylephrine
- **D.** Glycopyrrolate

ANSWER

A. Atropine

HOW TO SOLVE

Start from the clue cluster: A 60-year-old male with COPD is undergoing a hernia repair under spinal anesthesia. He develops bradycardia and hypotension. Bradycardia and hypotension during spinal anesthesia is due to sympathetic blockade. Atropine is the first-line treatment for bradycardia. That is exactly what the question is asking for (MOST appropriate pharmacological intervention), so option A — Atropine — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Ephedrine is for hypotension but does not treat bradycardia directly. Glycopyrrolate is an alternative anticholinergic but atropine is preferred. This scenario sits in the Anesthesia portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Bradycardia and hypotension during spinal anesthesia is due to sympathetic blockade' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for bradycardia and hypotension during spinal anesthesia is due to sympathetic blockade is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Bradycardia and hypotension during spinal anesthesia is due to sympathetic blockade → Atropine.

Q158 OPHTHALMOLOGY / RHEUMATOLOGY

A 28-year-old female with primary amenorrhea presents with a bull's eye maculopathy on fundoscopy. Which of the following is the MOST likely cause?

- **A. Chloroquine toxicity** ✓
- **B.** Retinitis pigmentosa
- **C.** Stargardt disease
- **D.** Vitamin A deficiency

ANSWER

A. Chloroquine toxicity

HOW TO SOLVE

Start from the clue cluster: A 28-year-old female with primary amenorrhea presents with a bull's eye

maculopathy on fundoscopy. Bull's eye maculopathy is characteristic of chloroquine/hydroxychloroquine toxicity. The patient with primary amenorrhea may have systemic lupus erythematosus (treated with hydroxychloroquine). That is exactly what the question is asking for (MOST likely cause), so option A — Chloroquine toxicity — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Retinitis pigmentosa shows bone spicule pigmentation. This scenario sits in the Ophthalmology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Bull's eye maculopathy is characteristic of chloroquine/hydroxychloroquine toxicity' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with bull's eye maculopathy is characteristic of chloroquine/hydroxychloroquine toxicity but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

Bull's eye maculopathy is characteristic of chloroquine/hydroxychloroquine toxicity → Chloroquine toxicity.

Q159 OPHTHALMOLOGY

A 65-year-old male presents with painless, rapidly progressive visual loss, a relative afferent pupillary defect (RAPD), and a pale, swollen optic disc. Which of the following is the MOST likely diagnosis?

- **A. Ischemic optic neuropathy** ✓
- **B.** Optic neuritis
- **C.** Glaucoma
- **D.** Papilledema

ANSWER

A. Ischemic optic neuropathy

HOW TO SOLVE

Start from the clue cluster: A 65-year-old male presents with painless, rapidly progressive visual loss, a relative afferent pupillary defect (RAPD), and a pale, swollen optic disc. Painless, rapidly progressive visual loss with a pale, swollen optic disc and RAPD in an elderly patient is typical of ischemic optic neuropathy (arteritic or non-arteritic). Optic neuritis is painful and more common in young patients. That is exactly what the question is asking for (MOST likely diagnosis), so option A — Ischemic optic neuropathy — is the answer, not the other three, which

either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Optic neuritis is painful and more common in young patients. This scenario sits in the Ophthalmology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Painless, rapidly progressive visual loss with a pale, swollen optic disc and RAPD in an elderly patient is typical of ischemic optic neuropathy (arteritic or non- arteritic)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with painless, rapidly progressive visual loss with a pale, swollen optic disc and RAPD in an elderly patient is typical of ischemic optic neuropathy (arteritic or non- arteritic) but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

Painless, rapidly progressive visual loss with a pale, swollen optic disc and RAPD in an elderly patient is typical of ischemic optic neuropathy (arteritic or non- arteritic) → Ischemic optic neuropathy.

Q160 OPHTHALMOLOGY / MEDICINE

A 30-year-old female presents with a vesicular rash over the dermatome corresponding to the left ophthalmic division of the trigeminal nerve. Which of the following is the MOST appropriate management to prevent corneal involvement?

- **A.** Systemic acyclovir
- **B.** Topical acyclovir
- **C.** Topical corticosteroids
- **D. Ophthalmology consultation (slit-lamp)** ✓

ANSWER

D. Ophthalmology consultation (slit-lamp)

HOW TO SOLVE

Start from the clue cluster: A 30-year-old female presents with a vesicular rash over the dermatome corresponding to the left ophthalmic division of the trigeminal nerve. Herpes zoster ophthalmicus requires urgent ophthalmology consultation for slit-lamp examination to check for corneal involvement. Systemic acyclovir is indicated but ophthalmology evaluation is the priority to prevent vision loss. That is exactly what the question is

asking for (MOST appropriate management to prevent corneal involvement), so option D — Ophthalmology consultation (slit-lamp) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Systemic acyclovir is indicated but ophthalmology evaluation is the priority to prevent vision loss. This scenario sits in the Ophthalmology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Herpes zoster ophthalmicus requires urgent ophthalmology consultation for slit-lamp examination to check for corneal involvement' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for herpes zoster ophthalmicus requires urgent ophthalmology consultation for slit-lamp examination to check for corneal involvement is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Herpes zoster ophthalmicus requires urgent ophthalmology consultation for slit-lamp examination to check for corneal involvement → Ophthalmology consultation (slit-lamp).

Q161 ENT / RADIOLOGY

A 55-year-old male presents with painless, slowly progressive hearing loss, tinnitus, and vertigo. Audiometry shows sensorineural hearing loss. MRI shows a mass in the cerebellopontine angle. Which of the following is the MOST likely diagnosis?

- **A. Vestibular schwannoma (Acoustic neuroma)** ✓
- **B.** Meningioma
- **C.** Cholesteatoma
- **D.** Glomus tumor

ANSWER

A. Vestibular schwannoma (Acoustic neuroma)

HOW TO SOLVE

Start from the clue cluster: A 55-year-old male presents with painless, slowly progressive hearing loss, tinnitus, and vertigo. Audiometry shows sensorineural hearing loss. MRI shows a mass in the cerebellopontine angle. Vestibular schwannoma (acoustic neuroma) is the most common cerebellopontine angle mass, presenting with sensorineural hearing loss, tinnitus, and vertigo. Meningioma is the second most common. That is exactly what

the question is asking for (MOST likely diagnosis), so option A — Vestibular schwannoma (Acoustic neuroma) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Cholesteatoma is middle ear. This scenario sits in the Ent portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Vestibular schwannoma (acoustic neuroma) is the most common cerebellopontine angle mass, presenting with sensorineural hearing loss, tinnitus, and vertigo' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with vestibular schwannoma (acoustic neuroma) is the most common cerebellopontine angle mass, presenting with sensorineural hearing loss, tinnitus, and vertigo but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

Vestibular schwannoma (acoustic neuroma) is the most common cerebellopontine angle mass, presenting with sensorineural hearing loss, tinnitus, and vertigo → Vestibular schwannoma (Acoustic neuroma).

Q162 ENT / PEDIATRICS

A 4-year-old child presents with recurrent otitis media, a foul-smelling discharge from the ear, and a cholesteatoma. Which of the following is the MOST appropriate management?

- **A. Surgical excision (mastoidectomy)** ✓
- **B.** Topical antibiotics
- **C.** Systemic antibiotics
- **D.** Observation

ANSWER

A. Surgical excision (mastoidectomy)

HOW TO SOLVE

Start from the clue cluster: A 4-year-old child presents with recurrent otitis media, a foul-smelling discharge from the ear, and a cholesteatoma. Cholesteatoma requires surgical excision (mastoidectomy) to prevent complications (hearing loss, facial nerve palsy, intracranial extension). Topical/systemic antibiotics treat infection but do not remove the cholesteatoma. That is exactly what the question is asking for (MOST appropriate

management), so option A — Surgical excision (mastoidectomy) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Topical/systemic antibiotics treat infection but do not remove the cholesteatoma. This scenario sits in the Ent portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Cholesteatoma requires surgical excision (mastoidectomy) to prevent complications (hearing loss, facial nerve palsy, intracranial extension)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for cholesteatoma requires surgical excision (mastoidectomy) to prevent complications (hearing loss, facial nerve palsy, intracranial extension) is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Cholesteatoma requires surgical excision (mastoidectomy) to prevent complications (hearing loss, facial nerve palsy, intracranial extension) → Surgical excision (mastoidectomy).

Q163 SURGERY / GASTROENTEROLOGY

A 45-year-old male with heavy alcohol use presents with acute pancreatitis. Serum lipase is 1800 U/L. CT shows pancreatic necrosis involving 40% of the gland. He develops persistent fever and hypotension on day 5. Which of the following is the MOST appropriate next step?

- **A.** Prophylactic antibiotics
- **B. Fine-needle aspiration of necrosis for Gram stain and culture** ✓
- **C.** Surgical necrosectomy
- **D.** Continue supportive care

ANSWER

B. Fine-needle aspiration of necrosis for Gram stain and culture

HOW TO SOLVE

Start from the clue cluster: A 45-year-old male with heavy alcohol use presents with acute pancreatitis. Serum lipase is 1800 U/L. CT shows pancreatic necrosis involving 40% of the gland. In acute pancreatitis with necrosis and persistent fever, infected necrosis should be suspected. Fine-needle aspiration of the necrosis for Gram stain and culture is the next step to differentiate infected from sterile necrosis. That is exactly what the question is

asking for (MOST appropriate next step), so option B — Fine-needle aspiration of necrosis for Gram stain and culture — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Prophylactic antibiotics are not recommended. Surgical necrosectomy is for infected necrosis. This scenario sits in the Surgery portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'In acute pancreatitis with necrosis and persistent fever, infected necrosis should be suspected' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

'Next step' questions are testing sequencing, not just knowledge — the exam wants the step that comes right after what's already been done in the stem, not the step three moves later. Re-read the stem for what has already happened, then pick the option that logically follows for in acute pancreatitis with necrosis and persistent fever, infected necrosis should be suspected.

KEY FACT

In acute pancreatitis with necrosis and persistent fever, infected necrosis should be suspected → Fine-needle aspiration of necrosis for Gram stain and culture.

Q164 ENT / ONCOLOGY

A 65-year-old male with smoking history and COPD presents with a 3-week history of progressive hoarseness. Laryngoscopy reveals a fixed left vocal cord. Which of the following is the MOST likely etiology?

- **A. Lung cancer with recurrent laryngeal nerve involvement** ✓
- **B.** Laryngeal carcinoma
- **C.** Thyroid nodule
- **D.** Idiopathic

ANSWER

A. Lung cancer with recurrent laryngeal nerve involvement

HOW TO SOLVE

Start from the clue cluster: A 65-year-old male with smoking history and COPD presents with a 3-week history of progressive hoarseness. Laryngoscopy reveals a fixed left vocal cord. In a smoker with COPD, a fixed vocal cord (especially left) is most likely due to lung cancer involving the recurrent laryngeal nerve. Laryngeal carcinoma would show a mass on laryngoscopy. That is exactly what the question is asking for (MOST likely etiology), so option A — Lung cancer with recurrent laryngeal nerve involvement — is the answer, not the other three, which

either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Laryngeal carcinoma would show a mass on laryngoscopy. This scenario sits in the Ent portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'In a smoker with COPD, a fixed vocal cord (especially left) is most likely due to lung cancer involving the recurrent laryngeal nerve' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with in a smoker with COPD, a fixed vocal cord (especially left) is most likely due to lung cancer involving the recurrent laryngeal nerve but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

In a smoker with COPD, a fixed vocal cord (especially left) is most likely due to lung cancer involving the recurrent laryngeal nerve → Lung cancer with recurrent laryngeal nerve involvement.

Q165 RHEUMATOLOGY / PULMONOLOGY

A 55-year-old female with rheumatoid arthritis presents with new-onset dyspnea, cough, and bilateral infiltrates on chest X-ray. HRCT shows a UIP pattern. She is on methotrexate. Which of the following is the MOST appropriate next step?

- **A. Discontinue methotrexate and start corticosteroids** ✓
- **B.** Start pirfenidone
- **C.** Perform surgical lung biopsy
- **D.** Start rituximab

ANSWER

A. Discontinue methotrexate and start corticosteroids

HOW TO SOLVE

Start from the clue cluster: A 55-year-old female with rheumatoid arthritis presents with new-onset dyspnea, cough, and bilateral infiltrates on chest X-ray. HRCT shows a UIP pattern. She is on methotrexate. Methotrexate can cause interstitial lung disease. Drug-induced ILD should be managed by discontinuing the offending drug and starting corticosteroids. That is exactly what the question is asking for (MOST appropriate next step), so option A

— Discontinue methotrexate and start corticosteroids — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Pirfenidone is for idiopathic pulmonary fibrosis, not drug-induced ILD. This scenario sits in the Rheumatology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Methotrexate can cause interstitial lung disease' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

'Next step' questions are testing sequencing, not just knowledge — the exam wants the step that comes right after what's already been done in the stem, not the step three moves later. Re-read the stem for what has already happened, then pick the option that logically follows for methotrexate can cause interstitial lung disease.

KEY FACT

Methotrexate can cause interstitial lung disease → Discontinue methotrexate and start corticosteroids.

Q166 GASTROENTEROLOGY / SURGERY

A 32-year-old male with ulcerative colitis presents with acute-onset severe abdominal pain, abdominal distension, and fever. Abdominal X-ray shows colonic dilation up to 8 cm with air-fluid levels. Which of the following is the MOST appropriate immediate management?

- **A.** IV corticosteroids
- **B.** Infliximab
- **C.** Cyclosporine
- **D. Subtotal colectomy** ✓

ANSWER

D. Subtotal colectomy

HOW TO SOLVE

Start from the clue cluster: A 32-year-old male with ulcerative colitis presents with acute-onset severe abdominal pain, abdominal distension, and fever. Abdominal X-ray shows colonic dilation up to 8 cm with air-fluid levels. This is toxic megacolon with colonic dilation >6 cm. The immediate management is subtotal colectomy. That is exactly what the question is asking for (MOST appropriate immediate management), so option D — Subtotal colectomy — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

IV corticosteroids, infliximab, and cyclosporine are medical therapies but surgery is indicated in toxic megacolon. This scenario sits in the Gastroenterology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'toxic megacolon with colonic dilation >6 cm' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Whenever a stem asks for the MOST appropriate MOST appropriate immediate management, first separate stabilization from definitive treatment — NEET PG regularly rewards the step that is safe and immediate over the one that is technically 'correct' but premature. Here that step is D. Subtotal colectomy, because toxic megacolon with colonic dilation >6 cm is the pattern being tested, not a request for the final cure.

KEY FACT

toxic megacolon with colonic dilation >6 cm → Subtotal colectomy.

Q167 MEDICINE / HEPATOLOGY

A 60-year-old male with cirrhosis presents with new-onset ascites, fever, and abdominal pain. Paracentesis reveals a neutrophil count of 500 cells/µL, protein 2.5 g/dL, and LDH 400 U/L. SAAG is 1.1. He had recent EVL with prophylactic ceftriaxone. Which organism is MOST likely?

A. E. coli
B. Streptococcus pneumoniae
C. Enterococcus faecalis ✓
D. Candida albicans

ANSWER

C. Enterococcus faecalis

HOW TO SOLVE

Start from the clue cluster: A 60-year-old male with cirrhosis presents with new-onset ascites, fever, and abdominal pain. Paracentesis reveals a neutrophil count of 500 cells/µL, protein 2.5 g/dL, and LDH 400 U/L. SAAG is 1.1. In patients who have received prophylactic antibiotics (ceftriaxone), the spectrum shifts to gram-positive organisms and Enterococcus. Enterococcus faecalis is the most likely among the options. That is exactly what the question is asking for (Which organism is MOST likely), so option C — Enterococcus faecalis — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Enterococcus faecalis is the most likely among the options. This scenario sits in the Medicine portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'In patients who have received prophylactic antibiotics (ceftriaxone), the spectrum shifts to gram-positive organisms and Enterococcus' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for in patients who have received prophylactic antibiotics (ceftriaxone), the spectrum shifts to gram-positive organisms and Enterococcus is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

In patients who have received prophylactic antibiotics (ceftriaxone), the spectrum shifts to gram-positive organisms and Enterococcus → Enterococcus faecalis.

Q168 MICROBIOLOGY / MEDICINE

A 45-year-old male with HIV (CD4 150 cells/µL) presents with headache, photophobia, and confusion. CSF shows an opening pressure of 35 cm H_2O, elevated protein, low glucose, and a positive India ink preparation. Which of the following is the MOST appropriate initial induction therapy?

- **A. Amphotericin B deoxycholate + Flucytosine** ✓
- **B.** Liposomal Amphotericin B + Fluconazole
- **C.** Voriconazole
- **D.** Caspofungin

ANSWER

A. Amphotericin B deoxycholate + Flucytosine

HOW TO SOLVE

Start from the clue cluster: A 45-year-old male with HIV (CD4 150 cells/µL) presents with headache, photophobia, and confusion. CSF shows an opening pressure of 35 cm H_2O, elevated protein, low glucose, and a positive India ink preparation. Cryptococcal meningitis in HIV. Amphotericin B deoxycholate + Flucytosine is the standard induction therapy. That is exactly what the question is asking for (MOST appropriate initial induction therapy), so option A — Amphotericin B deoxycholate + Flucytosine — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

Amphotericin B deoxycholate + Flucytosine is the standard induction therapy. This scenario sits in the

Microbiology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Cryptococcal meningitis in HIV' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for cryptococcal meningitis in HIV is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Cryptococcal meningitis in HIV → Amphotericin B deoxycholate + Flucytosine.

Q169 NEUROLOGY / MEDICINE

A 70-year-old male with a 4-week history of progressive ascending sensory loss, ataxia, and ophthalmoplegia. MRI brain shows bilateral symmetrical T2 hyperintensities in the periaqueductal gray matter and medial thalami. Which of the following is the MOST likely diagnosis?

- **A. Wernicke's encephalopathy** ✓
- **B.** Paraneoplastic brainstem encephalitis
- **C.** Central pontine myelinolysis
- **D.** Behçet's disease

ANSWER

A. Wernicke's encephalopathy

HOW TO SOLVE

Start from the clue cluster: A 70-year-old male with a 4-week history of progressive ascending sensory loss, ataxia, and ophthalmoplegia. MRI brain shows bilateral symmetrical T2 hyperintensities in the periaqueductal gray matter and medial thalami. Wernicke's encephalopathy with the classic triad and MRI findings. That is exactly what the question is asking for (MOST likely diagnosis), so option A — Wernicke's encephalopathy — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The distractors — B. Paraneoplastic brainstem encephalitis, C. Central pontine myelinolysis, D. Behçet's disease — are the options a rushed reader reaches for when only part of the stem is read; each one fits a related but distinct condition or a different stage of management, not the specific picture given here. This scenario sits in the Neurology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Wernicke's encephalopathy with the classic triad and MRI findings' is not

enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

When the question stem is really asking 'what is this', build the diagnosis from the clue cluster first and only then look at the options — the distractors are usually other conditions that share one or two features with wernicke's encephalopathy with the classic triad and MRI findings but not the whole pattern. Treat every such stem as a pattern-recognition exercise before an elimination exercise.

KEY FACT

Wernicke's encephalopathy with the classic triad and MRI findings → Wernicke's encephalopathy.

Q170 NEUROLOGY / PHARMACOLOGY

A 32-year-old female with migraine on oral contraceptives presents with acute severe headache, vomiting, and focal seizures. CT venography shows a filling defect in the superior sagittal sinus. Which of the following is the MOST appropriate initial anticoagulation strategy?

- **A. Low molecular weight heparin (therapeutic dose)** ✓
- **B.** Unfractionated heparin bolus followed by infusion
- **C.** Aspirin 325 mg
- **D.** Direct oral anticoagulant (Dabigatran)

ANSWER

A. Low molecular weight heparin (therapeutic dose)

HOW TO SOLVE

Start from the clue cluster: A 32-year-old female with migraine on oral contraceptives presents with acute severe headache, vomiting, and focal seizures. CT venography shows a filling defect in the superior sagittal sinus. Cerebral venous sinus thrombosis is treated with therapeutic LMWH. That is exactly what the question is asking for (MOST appropriate initial anticoagulation strategy), so option A — Low molecular weight heparin (therapeutic dose) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The distractors — B. Unfractionated heparin bolus followed by infusion, C. Aspirin 325 mg, D. Direct oral anticoagulant (Dabigatran) — are the options a rushed reader reaches for when only part of the stem is read; each one fits a related but distinct condition or a different stage of management, not the specific picture given here. This scenario sits in the Neurology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Cerebral venous sinus thrombosis is treated with therapeutic LMWH' is not enough; you have to know why it beats every neighbouring diagnosis or management

option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for cerebral venous sinus thrombosis is treated with therapeutic LMWH is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Cerebral venous sinus thrombosis is treated with therapeutic LMWH → Low molecular weight heparin (therapeutic dose).

Q171 CARDIOLOGY

A 60-year-old male with myocardial infarction presents with progressive breathlessness. Echo shows a restrictive filling pattern with an E/A ratio >2, deceleration time <150 ms. Which of the following is the MOST accurate prognostic indicator?

- **A. LVEF <35%** ✓
- **B.** Left ventricular end-diastolic diameter > 60 mm
- **C.** Presence of an S3 gallop
- **D.** Transmitral E/A ratio with Valsalva maneuver showing pseudonormalization

ANSWER

A. LVEF <35%

HOW TO SOLVE

Start from the clue cluster: A 60-year-old male with myocardial infarction presents with progressive breathlessness. Echo shows a restrictive filling pattern with an E/A ratio >2, deceleration time <150 ms. LVEF <35% is the strongest predictor of poor prognosis and sudden cardiac death. That is exactly what the question is asking for (MOST accurate prognostic indicator), so option A — LVEF <35% — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The distractors — B. Left ventricular end-diastolic diameter > 60 mm, C. Presence of an S3 gallop, D. Transmitral E/A ratio with Valsalva maneuver showing pseudonormalization — are the options a rushed reader reaches for when only part of the stem is read; each one fits a related but distinct condition or a different stage of management, not the specific picture given here. This scenario sits in the Cardiology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name

'LVEF <35% is the strongest predictor of poor prognosis and sudden cardiac death' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Prognosis and risk-stratification stems are testing which single variable dominates the others — when several plausible prognostic markers are listed as options, the exam usually wants the one with the strongest independent evidence base, which here is what drives the answer for lVEF <35% is the strongest predictor of poor prognosis and sudden cardiac death.

KEY FACT

LVEF <35% is the strongest predictor of poor prognosis and sudden cardiac death → LVEF <35%.

Q172 NEPHROLOGY / ENDOCRINOLOGY

A patient with chronic kidney disease has calcium 9.2 mg/dL, phosphate 5.5 mg/dL, PTH 450 pg/mL, and Vitamin D 15 ng/mL. Despite calcitriol therapy, PTH remains high. Which of the following is the MOST appropriate add-on therapy?

- **A.** Calcium acetate
- **B.** Sevelamer carbonate
- **C. Cinacalcet** ✓
- **D.** Aluminum hydroxide

ANSWER

C. Cinacalcet

HOW TO SOLVE

Start from the clue cluster: A patient with chronic kidney disease has calcium 9.2 mg/dL, phosphate 5.5 mg/dL, PTH 450 pg/mL, and Vitamin D 15 ng/mL. Despite calcitriol therapy, PTH remains high. Cinacalcet is the add-on therapy of choice when calcitriol alone fails. That is exactly what the question is asking for (MOST appropriate add-on therapy), so option C — Cinacalcet — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The distractors — A. Calcium acetate, B. Sevelamer carbonate, D. Aluminum hydroxide — are the options a rushed reader reaches for when only part of the stem is read; each one fits a related but distinct condition or a different stage of management, not the specific picture given here. This scenario sits in the Nephrology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Cinacalcet is the add-on therapy of choice when calcitriol alone fails' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for cinacalcet is the add-on therapy of choice when calcitriol alone fails is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Cinacalcet is the add-on therapy of choice when calcitriol alone fails → Cinacalcet.

Q173 RHEUMATOLOGY

A 25-year-old male presents with recurrent episodes of cold-induced pallor, cyanosis, and hyperemia of the fingers. ANA is positive. He has had no organ involvement for 5 years. Which antibody, if positive, indicates the highest risk of progression to systemic sclerosis?

- **A. Anti-Scl-70 (anti-topoisomerase I)** ✓
- **B.** Anti-centromere
- **C.** Anti-RNA polymerase III
- **D.** Anti-U1-RNP

ANSWER

A. Anti-Scl-70 (anti-topoisomerase I)

HOW TO SOLVE

Start from the clue cluster: A 25-year-old male presents with recurrent episodes of cold-induced pallor, cyanosis, and hyperemia of the fingers. ANA is positive. He has had no organ involvement for 5 years. Anti-Scl-70 is associated with diffuse cutaneous systemic sclerosis and carries the highest risk of pulmonary fibrosis. That is exactly what the question is asking for (Which antibody, if positive, indicates the highest risk of progression to systemic sclerosis), so option A — Anti-Scl-70 (anti-topoisomerase I) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The distractors — B. Anti-centromere, C. Anti-RNA polymerase III, D. Anti-U1-RNP — are the options a rushed reader reaches for when only part of the stem is read; each one fits a related but distinct condition or a different stage of management, not the specific picture given here. This scenario sits in the Rheumatology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Anti-Scl-70 is associated with diffuse cutaneous systemic sclerosis and carries the highest risk of pulmonary fibrosis' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for anti-Scl-70 is associated with diffuse cutaneous systemic sclerosis and carries the highest risk of pulmonary fibrosis is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Anti-Scl-70 is associated with diffuse cutaneous systemic sclerosis and carries the highest risk of pulmonary fibrosis → Anti-Scl-70 (anti-topoisomerase I).

Q174 RHEUMATOLOGY / PHARMACOLOGY

A 55-year-old male with alcohol use disorder presents with painful, swollen, warm joints in the first MTP joint. Joint aspiration reveals negatively birefringent needle-shaped crystals. He is started on allopurinol. Which co-administration significantly increases the risk of allopurinol hypersensitivity syndrome?

A. Colchicine

B. NSAIDs

C. Ampicillin

D. Thiazide diuretics ✓

ANSWER

D. Thiazide diuretics

HOW TO SOLVE

Start from the clue cluster: A 55-year-old male with alcohol use disorder presents with painful, swollen, warm joints in the first MTP joint. Joint aspiration reveals negatively birefringent needle-shaped crystals. He is started on allopurinol. Thiazide diuretics increase the risk of allopurinol hypersensitivity syndrome. That is exactly what the question is asking for (Which co-administration significantly increases the risk of allopurinol hypersensitivity syndrome), so option D — Thiazide diuretics — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The distractors — A. Colchicine, B. NSAIDs, C. Ampicillin — are the options a rushed reader reaches for when only part of the stem is read; each one fits a related but distinct condition or a different stage of management, not the specific picture given here. This scenario sits in the Rheumatology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Thiazide diuretics increase the risk of allopurinol hypersensitivity syndrome' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for thiazide diuretics increase the risk of allopurinol hypersensitivity syndrome is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Thiazide diuretics increase the risk of allopurinol hypersensitivity syndrome → Thiazide diuretics.

Q175 ENDOCRINOLOGY / OPHTHALMOLOGY

A 48-year-old female with Graves' disease treated with radioactive iodine presents with progressive ophthalmopathy. She develops diplopia and optic neuropathy. Which of the following is the MOST effective immunosuppressive agent?

- **A.** High-dose oral corticosteroids
- **B.** Rituximab
- **C.** Mycophenolate mofetil
- **D. Teprotumumab (IGF-1 receptor inhibitor)** ✓

ANSWER

D. Teprotumumab (IGF-1 receptor inhibitor)

HOW TO SOLVE

Start from the clue cluster: A 48-year-old female with Graves' disease treated with radioactive iodine presents with progressive ophthalmopathy. She develops diplopia and optic neuropathy. Teprotumumab is the first-line biologic for moderate-to-severe thyroid eye disease. That is exactly what the question is asking for (MOST effective immunosuppressive agent), so option D — Teprotumumab (IGF-1 receptor inhibitor) — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The distractors — A. High-dose oral corticosteroids, B. Rituximab, C. Mycophenolate mofetil — are the options a rushed reader reaches for when only part of the stem is read; each one fits a related but distinct condition or a different stage of management, not the specific picture given here. This scenario sits in the Endocrinology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Teprotumumab is the first-line biologic for moderate-to-severe thyroid eye disease' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for teprotumumab is the first-line biologic for moderate-to-severe thyroid eye disease is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Teprotumumab is the first-line biologic for moderate-to-severe thyroid eye disease → Teprotumumab (IGF-1 receptor inhibitor).

Q176 GASTROENTEROLOGY / PATHOLOGY

A 60-year-old male with acute pancreatitis develops a tender, erythematous, edematous plaque in the periumbilical region. Which of the following is the MOST specific histopathological finding?

- **A. Subcutaneous fat necrosis with saponification** ✓
- **B.** Necrotizing vasculitis
- **C.** Granulomatous inflammation
- **D.** Eosinophilic panniculitis

ANSWER

A. Subcutaneous fat necrosis with saponification

HOW TO SOLVE

Start from the clue cluster: A 60-year-old male with acute pancreatitis develops a tender, erythematous, edematous plaque in the periumbilical region. Cullen's sign shows subcutaneous fat necrosis with saponification. That is exactly what the question is asking for (MOST specific histopathological finding), so option A — Subcutaneous fat necrosis with saponification — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The distractors — B. Necrotizing vasculitis, C. Granulomatous inflammation, D. Eosinophilic panniculitis — are the options a rushed reader reaches for when only part of the stem is read; each one fits a related but distinct condition or a different stage of management, not the specific picture given here. This scenario sits in the Gastroenterology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Cullen's sign shows subcutaneous fat necrosis with saponification' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for cullen's sign shows subcutaneous fat necrosis with saponification is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Cullen's sign shows subcutaneous fat necrosis with saponification → Subcutaneous fat necrosis with saponification.

Q177 RHEUMATOLOGY / HEMATOLOGY

A 32-year-old female presents with recurrent deep vein thrombosis and a history of multiple miscarriages. APLA testing shows a positive lupus anticoagulant and anticardiolipin antibodies. INR is 1.2. Which of the following is the MOST appropriate long-term anticoagulation strategy?

- **A.** Warfarin targeting INR 2.0-3.0
- **B.** **Warfarin targeting INR 3.0-4.0** ✓
- **C.** Rivaroxaban
- **D.** Aspirin 75 mg + Warfarin INR 2.0-3.0

ANSWER

B. Warfarin targeting INR 3.0-4.0

HOW TO SOLVE

Start from the clue cluster: A 32-year-old female presents with recurrent deep vein thrombosis and a history of multiple miscarriages. APLA testing shows a positive lupus anticoagulant and anticardiolipin antibodies. INR is 1.2. Antiphospholipid syndrome requires high-intensity warfarin (INR 3.0-4.0). That is exactly what the question is asking for (MOST appropriate long-term anticoagulation strategy), so option B — Warfarin targeting INR 3.0-4.0 — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The distractors — A. Warfarin targeting INR 2.0-3.0, C. Rivaroxaban, D. Aspirin 75 mg + Warfarin INR 2.0-3.0 — are the options a rushed reader reaches for when only part of the stem is read; each one fits a related but distinct condition or a different stage of management, not the specific picture given here. This scenario sits in the Rheumatology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Antiphospholipid syndrome requires high-intensity warfarin (INR 3.0-4.0)' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for antiphospholipid syndrome requires high-intensity warfarin (INR 3.0-4.0) is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Antiphospholipid syndrome requires high-intensity warfarin (INR 3.0-4.0) → Warfarin targeting INR 3.0-4.0.

Q178 NEUROLOGY / PHARMACOLOGY

A 70-year-old male with parkinsonism, dementia, and well-formed visual hallucinations is started on a cholinesterase inhibitor. He develops severe bradycardia and syncope. Which of the following is the MOST appropriate alternative?

A. Donepezil
B. Rivastigmine (transdermal patch)
C. Galantamine
D. Memantine ✓

ANSWER

D. Memantine

HOW TO SOLVE

Start from the clue cluster: A 70-year-old male with parkinsonism, dementia, and well-formed visual hallucinations is started on a cholinesterase inhibitor. He develops severe bradycardia and syncope. Memantine does not affect cardiac M_2 receptors. That is exactly what the question is asking for (MOST appropriate alternative), so option D — Memantine — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The distractors — A. Donepezil, B. Rivastigmine (transdermal patch), C. Galantamine — are the options a rushed reader reaches for when only part of the stem is read; each one fits a related but distinct condition or a different stage of management, not the specific picture given here. This scenario sits in the Neurology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Memantine does not affect cardiac M_2 receptors' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for memantine does not affect cardiac M_2 receptors is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Memantine does not affect cardiac M_2 receptors → Memantine.

Q179 PULMONOLOGY / ENDOCRINOLOGY

A 40-year-old male with pulmonary sarcoidosis presents with hypercalcemia, nephrolithiasis, and serum calcium 12 mg/dL. Which of the following is the MOST appropriate treatment?

- **A. Hydrocortisone** ✓
- **B.** Pamidronate
- **C.** Calcitonin
- **D.** Hydroxychloroquine

ANSWER

A. Hydrocortisone

HOW TO SOLVE

Start from the clue cluster: A 40-year-old male with pulmonary sarcoidosis presents with hypercalcemia, nephrolithiasis, and serum calcium 12 mg/dL. Corticosteroids reduce 1,25-dihydroxyvitamin D production by macrophages. That is exactly what the question is asking for (MOST appropriate treatment), so option A — Hydrocortisone — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The distractors — B. Pamidronate, C. Calcitonin, D. Hydroxychloroquine — are the options a rushed reader reaches for when only part of the stem is read; each one fits a related but distinct condition or a different stage of management, not the specific picture given here. This scenario sits in the Pulmonology portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'Corticosteroids reduce 1,25-dihydroxyvitamin D production by macrophages' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for corticosteroids reduce 1,25-dihydroxyvitamin D production by macrophages is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

Corticosteroids reduce 1,25-dihydroxyvitamin D production by macrophages → Hydrocortisone.

Q180 MEDICINE / MICROBIOLOGY

A patient with infective endocarditis on the aortic valve presents with multiple septic emboli to the brain. Blood cultures grow Staphylococcus aureus sensitive to oxacillin. Which of the following is the MOST appropriate antibiotic regimen and duration?

- **A. Nafcillin 2g IV q4h for 6 weeks** ✓
- **B.** Vancomycin 1g IV q12h for 4 weeks
- **C.** Daptomycin 6 mg/kg IV q24h for 6 weeks
- **D.** Ceftriaxone 2g IV q24h + Gentamicin 1mg/kg q8h for 4 weeks

ANSWER

A. Nafcillin 2g IV q4h for 6 weeks

HOW TO SOLVE

Start from the clue cluster: A patient with infective endocarditis on the aortic valve presents with multiple septic emboli to the brain. Blood cultures grow Staphylococcus aureus sensitive to oxacillin. MSSA native valve endocarditis requires nafcillin or oxacillin for 6 weeks. That is exactly what the question is asking for (MOST appropriate antibiotic regimen and duration), so option A — Nafcillin 2g IV q4h for 6 weeks — is the answer, not the other three, which either treat a different condition, act too early/late, or are technically true but not the 'most appropriate' choice here.

DEEP-DIVE

The distractors — B. Vancomycin 1g IV q12h for 4 weeks, C. Daptomycin 6 mg/kg IV q24h for 6 weeks, D. Ceftriaxone 2g IV q24h + Gentamicin 1mg/kg q8h for 4 weeks — are the options a rushed reader reaches for when only part of the stem is read; each one fits a related but distinct condition or a different stage of management, not the specific picture given here. This scenario sits in the Medicine portion of the paper precisely because it forces cross-checking against close mimics rather than isolated recall — knowing the name 'MSSA native valve endocarditis requires nafcillin or oxacillin for 6 weeks' is not enough; you have to know why it beats every neighbouring diagnosis or management option on this specific list.

PATTERN

Read the stem as a set of clues rather than a story — each clinical detail (age, timeline, exam finding, lab value) exists to rule something in or out. Once the pattern for mSSA native valve endocarditis requires nafcillin or oxacillin for 6 weeks is confirmed, the correct option is usually the most specific and least generic-sounding choice among the four.

KEY FACT

MSSA native valve endocarditis requires nafcillin or oxacillin for 6 weeks → Nafcillin 2g IV q4h for 6 weeks.