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United States Medical Licensing Step 3

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QUESTION 1

A 43-year-old morbidly obese woman presents to your office with a 3-week history of increasing vulvar burning. She has had no new sexual partners or practices. She has not noticed any change in her vaginal discharge. She has attempted to medicate herself with over-the-counter antifungals, herbal creams, and old antibiotics, none of which have provided relief. On examination, her entire labia majora and minora are markedly erythematous and tender to the touch. Her vaginal mucosa appears to have normal rugae. Her vaginal pH is normal and whiff test is negative. The wet mount shows a few WBCs and normal squamous cells.

What is the most likely diagnosis?

- A. chemical dermatitis
- B. bacterial vaginosis
- C. PID disease
- D. atrophic vaginitis
- E. lichen sclerosus et atrophicus

Correct Answer: A Section: (none)

Explanation: History is critical in the evaluation and management of vulvar diseases. Given the fact that this patient has had exposures to numerous topical medications, it is likely that she has contact dermatitis of the vulva. Given the lack of hyphae on her wet mount and no apparent abnormal vaginal discharge, a candidal infection is less likely. She is obese and not in the average age range for menopause, thus atrophic findings are unlikely. The wet mount lacks clue cells that establish the diagnosis of bacterial vaginosis

QUESTION 2

A mother brings her 4-year-old son to your office, relating that he fell earlier that morning while at the playground. She says that the boy tripped over another child and landed on his outstretched hands. On examination, the boy has some mild swelling around his left wrist, and he says that it hurts when you palpate it. What is the most appropriate next step?

- A. Call the department of Children's Protective Services to investigate the accident.
- B. Attempt a nursemaid's elbow reduction.
- C. Perform anterior-posterior (AP) and lateral x-rays of the left wrist and elbow.
- D. Wrap the wrist in an Ace wrap, and put the arm in a sling.
- E. Order a magnetic resonance imaging (MRI) of the wrist looking for a growth plate injury.

Correct Answer: C Section: (none)

Explanation:

Falling on outstretched arms is one of the most common injuries among school-aged children. This can result in a buckle, or torus, fracture of the distal radius and/or ulna. This is a common accidental mechanism and should not, by itself, raise suspicions for an inflicted injury. AP and lateral x-rays of the wrist and elbow would be diagnostic of this type of injury. Nursemaid's elbows occur from a pulling or twisting mechanism to the upper extremity and are not the result of falls. An MRI of this injury would be overkill.

QUESTION 3

A 14-year-old boy is brought to the emergency department for evaluation of fever and headache. The mother relates that her son has had a worsening headache for 56 days. She says that she took him to a walk-in clinic, and he was put on amoxicillin for a sinus infection. His headaches have been getting worse and that he is now having fevers as high as 103.6°F. The mother says that he normally is very active and that he currently has a summer job at a local park clearing out underbrush. Since he has become ill, he has had such a decrease in energy that he cannot go to work. He has had a decrease in his appetite and has been sleeping more. He denies any sore throat, abdominal pain, chest pain, dysuria, vomiting, or diarrhea. On examination, he is an uncomfortable young man whose vital signs are: temp 101.9°F, RR 26, HR 124, and BP 79/56. Head, ear, eye, nose, and throat examination reveals normal TMs, a mildly erythematous hypopharynx, and some shotty cervical lymphadenopathy. His lungs are clear. His cardiac examination is normal. His liver edge is palpable just below the right costal margin and is mildly tender. His spleen is not palpable. His skin examination is normal with the exception of scattered petechiae around his ankles and wrists. A CBC reveals WBC 13,000 with 65% segs and 22% lymphs, hematocrit of 35, and platelet count of 95,000. His electrolytes reveal a Na 125, K 5.1, Cl 102, and bicarbonate 21. His BUN and Cr are normal.

The best treatment course would include which of the following?

- A. continue amoxicillin only
- B. begin oral doxycycline
- C. add acyclovir to the amoxicillin
- D. begin oral corticosteroids
- E. stop all antimicrobials

Correct Answer: B Section: (none)

Explanation: Typical symptoms include a summertime fever, headache, petechial rash, thrombocytopenia, and hyponatremia. This may be mistaken for a systemic enteroviral infection, or enteroviral encephalitis, but the presence of thrombocytopenia and hyponatremia would exclude this diagnosis. Still disease (systemic onset JRA) would have an elevation of acute-phase reactants, including the WBC and platelet count. Fourteen years old is an unlikely age for Kawasaki disease, and the acute phase reactants would likewise also be elevated.

RMSF is a very serious infectious illness. Appropriate antimicrobial therapy, usually doxycycline, needs to be started as soon as the diagnosis is seriously considered, as this can prevent some of the more severe sequelae. The use of systemic corticosteroids has no place in the management of RMSF. Confirmation of RMSF is serologic. Rising IgG titers or the presence of IgM titers to *R. rickettsii* is a confirmation of RMSF.

QUESTION 4

A 53-year-old White female, with a history of systemic lupus erythematosus (SLE), hypertension, and peripheral vascular disease, is admitted to the hospital for chest pain and dyspnea. Her cardiac enzymes were positive for acute MI. She subsequently undergoes a cardiac catheterization and stenting of the right coronary artery. Her postcardiac catheterization course is unremarkable, and she is discharged home 3 days later with adequate blood pressure control.

Five days later, she is brought to the ER by her husband for abdominal pain and nausea. Her medications consist of aspirin, metoprolol, and prednisone. On physical examination, her blood pressure is 190/95 and her heart rate is 85 bpm. In general, she appears nauseated but is in no acute distress. Her cardiac examination reveals a regular rate and rhythm without murmur or rub. Her lung fields are clear bilaterally. The abdominal examination is positive for diffuse discomfort, without guarding or rebound, and normoactive bowel sounds; her stool is positive for occult blood. Her lower extremities have trace edema bilaterally with 2+ distal pulses; moreover, she has a reddish-blue discoloration on both her lower extremities. You retrieve her records from prior hospitalization. The patient's laboratory results are as follows:

Blood	5 Days prior	Now	Urine
Sodium	140	135	
Potassium	4.4	5.2	Na+: 35
Chloride	106	113	Creatinine: 45
CO ₂	24	20	Specific gravity: 1.012
BUN	15	52	Protein: trace
Creatinine	1.6	3.5	RBCs: 1-3
Glucose	80	115	WBCs: 10-12
Uric acid	6.0	5.8	+ Eosinophils
Amylase	90	205	No cellular casts
WBC	8000	12,000	
Hgb	13.5	12.1	
Platelets (PLT)	400,000	370,000	
% Eosinophils	1%	15%	

Which of the following is the optimal therapeutic agent for this patient's pain management?

- A. intravenous Demerol
- B. intramuscular ketorolac
- C. oral indomethacin
- D. intravenous morphine sulfate
- E. ibuprofen 400 mg orally three times daily as needed

Correct Answer: D Section: (none)

Explanation:

This patient has atheroembolic disease, most likely from the dislodging of arterial plaque during or after the cardiac catheterization, with subsequent kidney embolization. The findings in her history and physical examination that would suggest this are the presence of significant hypertension, abdominal pain, the red-blue rash on her extremities (livedo reticularis), and eosinophilia with urinary eosinophils. Furthermore, the time course of the development of acute renal failure is suggestive of atheroembolic disease. The typical time course for contrast nephropathy is of an immediate onset, usually with subsequent recovery.

However, in patients with atheroembolic disease, the kidney failure can occur much later after the procedure. Contrast nephropathy is not associated with the laboratory abnormalities and physical examination findings seen in this case. Interstitial nephritis is unlikely, as is a lupus nephritis flare, given her classic presentation for emboli. Calculation of the fractional excretion of sodium (FeNa) is helpful in differentiating between "prerenal" causes (FeNa 1%). A kidney ultrasound is helpful in determining the presence of urinary tract obstruction. Neither the anion gap nor calculation of

glomerular filtration rate is helpful in determining if volume depletion is a possible etiology of acute renal failure. Examination of urine sediment would be helpful in determining the presence of a glomerular etiology of acute renal failure, not a prerenal etiology. Demerol and metabolites can accumulate in patients with depressed kidney function, leading to increased levels and, potentially, convulsions. NSAIDs should be avoided in patients with acute kidney failure, as these drugs are potential nephrotoxins and could prevent a recovery of kidney function. Ketorolac, indomethacin, and ibuprofen are all NSAIDs. Therefore, morphine is the best option of those given. WBC casts are suggestive of pyelonephritis. High levels of proteinuria are significant for the diagnosis of nephrotic syndrome, but not lupus nephritis specifically. Urine eosinophils are usually seen in patients with acute interstitial nephritis or atheroembolic disease. Lupus nephritis is usually associated with depressed serum complement levels. Of these tests, RBC casts are the most suggestive of glomerulonephritis.

QUESTION 5

A 32-year-old man who is HIV-positive was found to have Burkitt's lymphoma with diffuse bulky abdominal disease. He now reports to the hospital and is scheduled to begin chemotherapy. Admission laboratory studies show elevations of his uric acid at 15 mg/dL, serum phosphorus at 8.5 mg/dL, creatinine at 2.9 mg/dL, and potassium at 6.1 mEq/L.

What therapy is most likely to reverse the patient's metabolic abnormalities?

- A. administration of intravenous saline with mannitol to try to keep urine output >2.5 L/day
- B. allopurinol 300 mg/day
- C. administration of intravenous sodium bicarbonate to keep urinary pH >7.0
- D. hemodialysis
- E. administration of the recombinant uricase enzyme rasburicase to lower uric acid levels

Correct Answer: D Section: (none)

Explanation:

This patient has tumor lysis syndrome (TLS), a group of metabolic derangements due to rapid cell turnover with release of intracellular contents, such as phosphate and potassium, and increased purine metabolism, leading to hyperuricemia. It is usually seen after the initiation of cytotoxic chemotherapy, but occasionally occurs spontaneously in patients with bulky disease such as Burkitt's lymphoma. The uric acid crystallizes in the renal tubules and can cause oliguric renal failure. Once renal failure has occurred, patients usually require hemodialysis until renal function recovers. Each of the other choices may be employed to prevent the development of TLS in high-risk patients prior to beginning chemotherapy

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