THE INTERMEDIATE ASSESSMENT IN THE DISCIPLINE

Hospital surgery, pediatric surgery

Curriculum	31.05.01 General Medicine
Specialty	General Medicine
Form of education	full-time
Designer Department	Surgical diseases
Graduate Department	Internal diseases

The stage of the control work.
Semester 9.
The test work includes:
-testing using remote technologies (Moodle Internet platform).

List of test tasks:
Test tasks

1. THE HOLLOW ORGAN MAKES UP ONE OF THE WALLS OF THE HERNIAL SAC:
A. IN a Richter hernia.
B. IN A pinched hernia.
C. IN A sliding hernia

2. YOUR TACTICS FOR A PINCHED HERNIA:
A. Cleansing enema.
B. Introduction of antispasmodics.
C. Emergency surgery.
D. Patient monitoring.
E. Try to correct the hernial protrusion.

3. UMBILICAL HERNIA SURGERY IS PERFORMED BY ALL OF THE ABOVE METHODS, EXCEPT:
A. Plastic surgery according to Postempsky.
B. Lexer's operation.
C. Alloplastic methods.
D. The Mayo method.
E. Sapezhko's method.

4. DIFFERENTIAL DIAGNOSIS IN ACUTE APPENDICITIS SHOULD BE PERFORMED WITH THE FOLLOWING DISEASES, EXCEPT:
A. Myocardial infarction.
B. Renal colic.
C. Pneumonia.
D. Zollinger–Ellisson syndrome.
E. Mesenteric lymphadenitis.

5. IN ACUTE APPENDICITIS, PRIMARY AFFECT OCCURS:

A. In the submucosal layer of the appendix
B. In the muscular layer of the appendix
C. In the mucous membrane of the appendix
D. In the serous membrane of the appendix
E. In the mesentery of the appendix

6. THE IRRADIATION OF PAIN IN THE RIGHT LUMBAR REGION IS CHARACTERISTIC OF ACUTE APPENDICITIS WITH THE LOCATION OF THE APPENDIX:

A. Retrocecally
B. Medially
C. Pelvic
D. Podpechenochno

7. WHAT IS CHARACTERISTIC OF APPENDICULAR INFILTRATION?

A. Pain in the right hypochondrium, accompanied by the appearance of jaundice.
B. The presence of a tumor-like formation in the right iliac region with a history of pain.
C. Pain in the epigastric region, accompanied by the appearance of tar-like stools.
D. Disappearance of abdominal pain in combination with increasing tachycardia.

8. YOUR TACTICS FOR APPENDICULAR ABSCESS

A. Endolymphatic administration of drugs
B. Emergency surgery
C. Physiotherapy treatment.
D. Laparoscopy followed by the introduction of antibacterial drugs.

9.WHEN TREATING A DOUGLAS SPACE ABSCESS, THE FOLLOWING IS PERFORMED:

A. Opening and drainage of the abscess cavity through the anterior wall of the rectum or the posterior arch of the vagina.
B. Low-median laparotomy.
C. The Volkovich–Dyakonov section with access expansion is one of the methods.
D. Median laparotomy.

10. IF THE PATIENT IS DIAGNOSED WITH APPENDICULAR PERITONITIS, THEN IT IS NECESSARY TO PERFORM:

A. Volkovich-Dyakonov incision
B. Lenander's incision
C. Low-median laparotomy
D. Median laparotomy

11. THE CAUSE OF ACUTE CHOLECYSTITIS IS MOST OFTEN:

A. Physical activity
B. Abnormal development of the biliary tract
C. Violation of diet and nutrition regime
D. Hematogenous infection
E. Injury to the abdominal organs

12. ACUTE OBSTRUCTIVE CHOLECYSTITIS IS CHARACTERIZED BY EVERYTHING EXCEPT:

A. Nausea, vomiting
B. Ortner's positive symptom
C. Positive Homans symptom
D. Increase of body temperature to 38
E. Murphy's positive symptom

13.COURVOSIER'S SYMPTOM IS NOT TYPICAL FOR:

A. Acute calculous cholecystitis
B. Pancreatic glans cancer
C. Tumors of the large duodenal nipple
D. Choledochus tumors

14. THE PATIENT HAS JAUNDICE ON THE BACKGROUND OF ACUTE PAIN IN THE RIGHT HYPOCHONDRIUM, AN ENLARGED PAINFUL GALLBLADDER IS PALPATED. THE MOST LIKELY DIAGNOSIS?

A. Acute hepatitis
B. Biliary dyskinesia
C. Acute cholecystitis, choledocholithiasis
D. Gallbladder cancer
E. Echonococcosis of the liver.

15. IT IS NOT TYPICAL FOR THE CLINIC OF ACUTE CHOLANGITIS:

A. Hectic temperature
B. Shingles abdominal pain
C. Jaundice
D. Unstable loose stools
E. Vomiting

16. THE CLINICAL MANIFESTATION OF ACUTE CHOLECYSTITIS COMPLICATED BY PERITONITIS IS NOT:

A. Muscle tension in the right hypochondrium
B. Positive Mayo-Robson symptom
C. Positive Shchetkin-Blumberg symptom throughout the abdomen
D. Positive Sitkovsky symptom
E. Pasternatsky symptom

17.THE FOLLOWING RESEARCH METHOD IS MOST INFORMATIVE FOR THE DIAGNOSIS OF PEPTIC ULCER OF THE STOMACH AND DUODENUM:

A. Angiography
B. Laparoscopy
C. Gastric X-ray
D. Ultrasound examination of abdominal organs (ultrasound)
E. Fibrogastroscopy

18 EVERYTHING IS CHARACTERISTIC OF AN EXACERBATION OF PEPTIC ULCER DISEASE, EXCEPT:

A. Nausea, vomiting
B. Dysuria
C. A positive Boas symptom
D. Constant dull pain in the right hypochondrium and epigastrium
E. Weakness, an admixture of blood in the vomit.

19. CHARACTERISTIC COMPLAINTS OF PATIENTS WITH DUODENAL ULCER ARE:

A. Pain in the upper abdomen
B. Nausea
C. Pain in the epigastric region on an empty stomach, worse at night, heartburn
D. Pain in the right hypochondrium radiating to the lumbar region
E. Pain in the right iliac region

20. THE PATIENT HAS COMPLAINTS OF PAIN IN THE UPPER ABDOMEN, WHICH INCREASES AFTER EATING, WEAKNESS, WEIGHT LOSS, BELCHING, VOMITING. THE MOST LIKELY DIAGNOSIS?

A. Exacerbation of duodenal ulcer
B. Colon tumor.
C. Peptic ulcer of the stomach
D. Cholelithiasis
E. Peptic ulcer complicated by pyloric stenosis.

21. DECOMPENSATED PYLORODUODINAL STENOSIS DEVELOPS:
A. Hypochloremia
B. Hyperchloremia
C. Hypochloremia and hypokalemia
D. Hyperchloremia and hyperkalemia
E. Hyperchloremia and hypokalemia

22. THE DISAPPEARANCE OF PAIN AND THE APPEARANCE OF MELENA IN DUODENAL ULCER IS CHARACTERISTIC OF:
A. Pyloroduodenal stenosis
B. Perforations of the ulcer
C. Malignancy of ulcers
D. Bleeding
E. Penetration of ulcers into the pancreas

23. HEMATURIA IS NOT TYPICAL FOR
A. Urolithiasis
B. Tuberculosis of the urinary tract
C. Testicular tumors
D. Tumors of the urinary tract
E. Goodpasture Syndrome

24. AT WHAT LOCATION OF THE CONCRETION IS THERE THE GREATEST THREAT OF COMPLETE OBTURATION?
A.The stone of the upper cup
B. Coral-shaped pelvis stone
C. Ureteral stone
D. Bladder stone

25. THE SAFEST, NON-INVASIVE DIAGNOSTIC METHOD FOR NEPHROLITHIASIS
A. Ultrasound of the kidneys
B. Excretory urography
B. Infusion urography
G. Computed tomography
D. Chromocystoscopy

26. HEMATURIA IS NOT TYPICAL FOR
A. Urolithiasis
B. Tuberculosis of the urinary tract
C. Testicular tumors
D. Tumors of the urinary tract
E. Goodpasture Syndrome

27. PROSTATE CANCER SCREENING IS CARRIED OUT ACCORDING TO THE FOLLOWING INDICATORS
A. General urinalysis
B. THE DOG
C. SA19-9
D. REA

E. Alphafetoprotein

28. THE MORPHOLOGY OF CHANGES IN PROSTATE PATHOLOGY IS EXAMINED USING THE METHOD
A. Excretory urography
B. Cystoscopy
C. Dopplerometry
D. Transrectal ultrasound with biopsy

29. CRYPTORCHIDISM IS
A. Absence of a testicle
B. Testicular dystopia
C. Testicular inflammation
D. Norma

30. THE MOST COMMON CAUSE OF HYDRONEPHROTIC KIDNEY TRANSFORMATION IS
A. Congenital pathology of the kidney parenchyma
B. Nephrolithiasis
B. Abdominal injuries
G. Kidney cancer

ANSWERS TO THE QUESTIONS OF THE TEST TASKS
1-in, 2-in, 3-in, 4-in, 5-in, 6-in, 7-in, 8-in, 9-in, 10-in, 11-in, 12-in, 13-in, 14-in, 15-in, 16-d, 17-d, 18-b, 19-c, 20-d 21-c, 22-d, 23-d, 24-c, 25-a, 26-d, 27-b, 28-d, 29-b, 30-B.

The stage of the control work.
Semester 10.
The control work is testing using remote technologies (Moodle Internet platform).
The list of test tasks.
1. WITH AN EXTENDED STRICTURE OF THE CHOLEDOCHUS, A TEMPORARY OPTION FOR RESTORING THE PASSAGE:
A. Choledohoduodenostomy
B. Cholecystostomy
C. Hepaticoejunostomy
D. Operation Whipla
E. Liver transplantation

2. DIARRHEAL SYNDROME IS MORE TYPICAL FOR ACUTE APPENDICITIS WITH THE LOCATION OF THE APPENDIX
A. Retrocecal
B. Subhepatic
C. Pelvic
D. Mesoceliac
E. Retroperitoneal

3. AFTER A RESPIRATORY INFECTION, IT IS NECESSARY TO DIFFERENTIATE ACUTE APPENDICITIS PRIMARILY WITH
A. Acute salpingitis
B. Acute cholecystitis
C. Acute mesadenitis
D. Perforated ulcer

4.THE MAIN REASON FOR THE RAPID SPREAD OF INFECTION IN THE ABDOMINAL CAVITY IN ACUTE APPENDICITIS IN CHILDREN IS
A. Mobility of the appendix

B. Underdevelopment of the large omentum
C. Incomplete bowel rotation
D. The size of the appendix.

5. THE MAIN REASON FOR THE LATE TREATMENT OF ELDERLY PEOPLE WITH ACUTE APPENDICITIS IS
A. Poor organization of surgical care
B. Poor symptoms due to low body reactivity
C. Encephalopathy

6. CURRENTLY, MOST APPENDECTOMIES ARE PERFORMED BY
A. Traditionally
B. Using minimally invasive surgical technologies

7. WHEN PERFORMING LAPAROSCOPIC APPENDECTOMY, THE METHOD OF
A. Ligature
B. Rusanov V. Hardware IS MOST OFTEN USED TO TREAT THE STUMP OF THE APPENDIX.

8. THE MODERN METHOD OF STUDYING THE ACID-RELEASING FUNCTION OF THE STOMACH IS THE METHOD
A. Fractional examination of gastric juice
B. FGDS
C. Gastric X-ray
D. Laparoscopy
E. Intraluminal pH-measurement

9. THE MOTOR EVACUATION FUNCTION OF THE STOMACH IS EXAMINED BY THE METHOD OF
A. Fractional examination of gastric juice
B. FGDS
C. Gastric fluoroscopy
D. Laparoscopy
E. Intraluminal pH-measurement

10. THE MAIN TREATMENT METHOD FOR UNCOMPLICATED PEPTIC ULCER DISEASE IS CURRENTLY
A. Conservative
B. Operative

11. THE BASIS OF CONSERVATIVE TREATMENT OF PEPTIC ULCER DISEASE IS THE APPOINTMENT OF
A. Antacids
B. Antisecretory agents – proton pump blockers
C. Antihelicobacter therapy
D. Symptomatic agents

12. THE ONLY INDICATION FOR SURGERY IN UNCOMPLICATED GASTRODUODENAL ULCER IS
A. The patient's desire
B. The surgeon's desire
C. Social indications
D. Ineffectiveness of full-fledged and long-term complex anti-ulcer therapy

13. A CALLOUS ULCER IS

A. A large ulcer
B. A deep ulcer
C. Slit-like ulcer
D. A long-term non-healing ulcer with callused edges

14. THE ADVANTAGE IN PERFORMING HERNIATION IS
A. Tension hernioplasty
B. Non-tensioning hernioplasty

15. THE MOST COMMON PLASTIC SURGERY FOR INGUINAL HERNIA IS THE
A. Girard
B. Kimbarovsky
C. Postempsky,
D. Lichtenstein
E. Scholdais

16. WHEN A FEMORAL HERNIA IS HERNIATED, PLASTIC SURGERY BY THE METHOD OF
A. Ruggi-Parlaveccio
B. Bassini

17. THE DETECTION OF 2 OR MORE PINCHED INTESTINAL LOOPS IN THE HERNIAL SAC IS EVIDENCE IN FAVOR OF
A. Decompression
B. Richter's pinching
C. Retrograde pinching in the presence of a hernia Littre

18. IN CASE OF NECROSIS OF THE INJURED ORGAN, IT IS PERFORMED
A. Resection
B. Reduction into the abdominal cavity
C. Remaining in the hernial sac.

19. DO NOT TREAT THE COMPLICATIONS OF HERNIAS
A. Injury
B. Inflammation
C. Ineligibility
The city of Dropsy

20. DOES NOT APPLY TO SIGNS OF APPARENT NON-VIABILITY OF THE STRANGULATED INTESTINAL LOOP
A. Absence of peristalsis
B. Swelling of the intestinal wall
C. Absence of vascular pulsation
D. Black color and thinning of the intestinal wall

Answers: 1-d, 2-c, 3-b, 4-b, 5-b, 6-a, 7-d, 8-c, 9-a, 10-b, 11-d, 12-d,13-b, 14-d, 15-a, 16-c, 17-a, 18-d, 19-b, 20-c

Stage: conducting an interim assessment in the discipline (credit) for the 10th semester
The intermediate certification is carried out in the form of a test
A test assignment consists of solving test tasks

List of test tasks

1. Specify the changes in internal organs in chronic sepsis:
2. Hemochromatosis.

3. Calcification.
4. Hemosiderosis.
5. Atrophy.
2. Name the dysproteinosis that complicates the course of chronic sepsis:
1. Mucoid swelling.
2. Fibrinoid swelling.
3. Anthracosis.
4. Amyloidosis.
5. Hyalinosis.
3. Specify the changes in blood vessels characteristic of septic endocarditis:
1. Hemosiderosis.
2. Alterative-productive vasculitis.
3. Hyalinosis.
4. Sclerosis.
5. Amyloidosis.
4. Specify the location of the first metastatic foci in septicemia:
1. Lymph nodes.
2. The spleen.
3. The lungs.
4. The myocardium.
5. Skin.
5. Specify the kidney changes characteristic of septic endocarditis:
1. Glomerulonephritis.
2. Heart attack.
3. Scars.
4. Pyelonephritis.
5. Fatty degeneration.
6. Specify the most frequent localization of the septic focus in septic endocarditis:
1. Mitral valve.
2. Three-leaf valve.
3. Aortic valves.
4. Valves of the pulmonary artery.
5. The endocardium of the auricle of the left atrium.
7. Name the change characteristic of the septic focus:
1. Hyalinosis.
2. Purulent inflammation.
3. Productive inflammation.
4. Fibrinous inflammation.
5. Amyloidosis.
8. Name the changes in parenchymal organs that occur with septicemia:
1. Dystrophy.
2. Granulomatosis.
3. Interstitial inflammation.
4. Amyloidosis.
5. Purulent inflammation.
9. Specify the change in the kidneys that occurs with septic endocarditis due to thromboembolism:
1. Glomerulonephritis.
2. Amyloidosis.
3. Embolic purulent nephritis.
4. Pyelonephritis.
5. Kidney infarctions.
10. Specify the most common pathogens in septic endocarditis:
1. Streptococcus.
2. Tuberculosis bacillus.
3. Typhoid bacteria.

4. Pseudomonas aeruginosa.
5. Staphylococcus.

The stage of the control work.

Semester 11.

The control work is testing using remote technologies (Moodle Internet platform).

The list of test tasks.

1. WITH AN EXTENDED STRICTURE OF THE CHOLEDOCHUS, A TEMPORARY OPTION FOR RESTORING THE PASSAGE:
A. N. Choledohoduodenostomy
B. N. Cholecystostomy
C. N. Hepaticoejunostomy
D. N. Whipla Operation
According to J. Cookie Transplantation

2. DIARRHEAL SYNDROME IS MORE TYPICAL FOR ACUTE APPENDICITIS WITH THE LOCATION OF THE APPENDIX.
A. N. Retrocecal
B. N. Subhepatic
C. N. Pelvic
D. N. Mesoceliac
According to J. Retroperitoneal

3. AFTER A RESPIRATORY INFECTION, IT IS NECESSARY TO DIFFERENTIATE ACUTE APPENDICITIS PRIMARILY WITH
A. N. Acute salpingitis
B. N. Acute cholecystitis.
C. N. Acute mesadenitis
D. N. Perforated ulcer

4. THE MAIN REASON FOR THE RAPID SPREAD OF INFECTION IN THE ABDOMINAL CAVITY IN ACUTE APPENDICITIS IN CHILDREN IS
A. N. Mobility OF the appendix
B. N. Underdevelopment of the large omentum
C. N. Incomplete rotation of the intestine
D. N. Size of the appendix.

5. THE MAIN REASON FOR THE LATE TREATMENT OF SENILE PEOPLE WITH ACUTE APPENDICITIS IS
A. N. Poor organization of surgical care
B. N. Poor symptoms due to low body reactivity
C. N. Encephalopathy

6. CURRENTLY, MOST APPENDECTOMIES ARE PERFORMED
BY
A. N. Traditionally
B. Sc. Using minimally invasive surgical technologies

7. WHEN PERFORMING LAPAROSCOPIC APPENDECTOMY, THE METHOD

OF

A. N. Ligature
B. N. Rusanova
C. N. Hardware IS MOST OFTEN USED TO TREAT THE STUMP OF THE APPENDIX.

8. THE MODERN METHOD OF STUDYING THE ACID-RELEASING FUNCTION OF THE STOMACH IS THE METHOD OF

A. N. Fractional studies of gastric juice
B. N. FGDS
C. N. Gastric fluoroscopy
D. N. Laparoscopy
According to J. Intraluminal pH measurement

9.THE MOTOR-EVACUATION FUNCTION OF THE STOMACH IS EXAMINED BY THE METHOD OF

A. N. Fractional studies of gastric juice
B. N. FGDS
C. N. Gastric fluoroscopy
Year of Laparoscopy
According to J. Intraluminal pH measurement

10. THE MAIN METHOD OF TREATMENT OF UNCOMPLICATED PEPTIC ULCER DISEASE IS CURRENTLY AN

A. N. Conservative
B. N. Operative

11. THE BASIS OF CONSERVATIVE TREATMENT OF PEPTIC ULCER DISEASE IS THE APPOINTMENT
OF

a. n. Antacids
b. n. Antisecretory agents – proton pump blockers
c. n. Antihelicobacterial therapy
d. n. Symptomatic agents.

12. THE ONLY INDICATION FOR SURGERY IN UNCOMPLICATED GASTRODUODENAL ULCER IS THE patient's

A.n. Desire, the surgeon's
B. n. Desire, Social indications
C. N. Ineffectiveness of full-fledged and long-term complex anti-ulcer therapy

13. A CALLOUS ULCER is
a. n. A large ulcer
. n. A deep ulcer
. n. A slit-like ulcer
. n. A long-term non-healing ulcer with callused edges

14. THE ADVANTAGE IN PERFORMING HERNIA REPAIR IS

A. N. Tension hernioplasty
B. N. Non-tension hernioplasty

15. THE MOST COMMON PLASTIC SURGERY FOR INGUINAL HERNIA IS THE METHOD OF

A. N. Girard
B. N. Kimbarovsky

C. N. Postempsky
D. N. Lichtenstein
According to J. Sholdaevsky

16. IN FEMORAL HERNIA REPAIR, PLASTIC SURGERY USING THE
A. N. Ruggi-Parlaveccio METHOD GIVES THE BEST RESULTS.
B. N. Bassini

17. THE DETECTION OF 2 OR MORE PINCHED INTESTINAL LOOPS IN THE HERNIAL SAC TESTIFIES IN FAVOR OF
A. N. Decompression
B. N. Richter gorge
C. N. Retrograde gorge
D. N. The presence of a Littre hernia

18. NECROSIS OF A DAMAGED ORGAN CAUSES ITS DESTRUCTION.
A. N. Resection
B. N. Introduction into the abdominal cavity
C. N. Retention in the hernial sac.

19.DO NOT TREAT HERNIA COMPLICATIONS
A. N. Infringement
B. N. Inflammation
C. N. Injustice
D. N. Dropsy

20. DOES NOT REFER TO THE SIGNS OF OBVIOUS NON-VIABILITY OF THE PINCHED INTESTINAL LOOP
A. n. Absence of peristalsis
B. n. Swelling of the intestinal wall
C. N. Absence of vascular pulsation
D. N. Black color and thinning of the intestinal wall

Answers: 1-d, 2-c, 3-b, 4-b, 5-b, 6-a, 7-d, 8-c, 9-a, 10-b, 11-d, 12-d,13-b, 14-d, 15-a, 16-c, 17-a, 18-d, 19-b, 20-c

1. **Stage: conducting an intermediate certification in the discipline (exam)**
2. **The interim assessment takes place in the form of an exam**
3. **The exam assignment consists of several tasks:**

Testing
Solving situational problems

List of test tasks:
Test tasks

1. THE HOLLOW ORGAN MAKES UP ONE OF THE WALLS OF THE HERNIAL SAC.:
A. N. IN the Richter case.
B. N. Strangulated hernia.
C. N. Sliding hernia

2. YOUR TACTICS FOR A PINCHED HERNIA:
A. n. Cleansing enema.

B. N. Introduction of antispasmodics.
C. N. Emergency surgery.
D. N. Patient monitoring.
According to J. Attempts are being made to introduce a hernial protrusion.

3. UMBILICAL HERNIA SURGERY IS PERFORMED BY ALL OF THE ABOVE METHODS, EXCEPT:
A. N. Plastic surgery according to Postempsky.
B. N. Lexer's operation.
C. N. Alloplastic methods
D. N. The Mayo method.
According to J. The Sapezhko method.

4. DIFFERENTIAL DIAGNOSIS IN ACUTE APPENDICITIS SHOULD BE PERFORMED WITH THE FOLLOWING DISEASES, EXCEPT:
A. N. Myocardial infarction.
B. N. Renal colic.
C. N. Pneumonia.
D. N. Zollinger-Ellisson syndrome
According to J. Mesenteric lymphadenitis.

5. IN ACUTE APPENDICITIS, THE PRIMARY AFFECT OCCURS
A. IN the submucosal layer of the appendix.
B. N. In the muscular layer of the appendix.
C. N. In the mucous membrane of the appendix
D. N. In the serous membrane of the appendix
According to J. In the mesentery of the appendix.

6. THE IRRADIATION OF PAIN IN THE RIGHT LUMBAR REGION IS CHARACTERISTIC OF ACUTE APPENDICITIS WITH THE LOCATION OF THE APPENDIX:
A. N. Retrocecally
B. N. Medially
C. N. Pelvic
D. N. Podpechenochno

7. WHAT IS CHARACTERISTIC OF APPENDICULAR INFILTRATION?
A. N. Pain in the right hypochondrium, accompanied by the appearance of jaundice.
B. N. The presence of a tumor-like formation in the right iliac region with a history of pain.
C. N. Pain in the epigastric region, accompanied by the appearance of tar-like stools.
Disappearance of pain in the animal in combination with increasing tachycardia.

8. YOUR TACTICS FOR APPENDICULAR ABSCESS:
A. N. Endolymphatic administration of drugs.
B. N. Emergency surgical intervention.
C. N. Physiotherapy treatment.
D. N. Laparoscopy followed by the introduction of antibacterial drugs.

9. WHEN TREATING A DOUGLAS SPACE ABSCESS, THE FOLLOWING IS PERFORMED:
A. N. Opening and drainage of the abscess cavity through the anterior wall of the rectum or the posterior arch of the vagina.
B. N. Lower middle laparotomy.
C. The Volkovich-Dyakonov section with an extension of the block is one of the methods.
D. N. Median laparotomy.

10. IF THE PATIENT IS DIAGNOSED WITH APPENDICULAR PERITONITIS, THEN IT IS NECESSARY TO PERFORM:

A. N. Volkovich-Dyakonov incision
B. N. Lenander's incision
C. N. Lower middle laparotomy
D. N. Median laparotomy

11. THE CAUSE OF ACUTE CHOLECYSTITIS IS MOST OFTEN:

A. N. Physical activity
B. N. Biliary tract malformations
C. N. Violation of diet and nutrition regime
D. N. Hematogenous infection
According to J. Injury to the abdominal organs

12. ACUTE OBSTRUCTIVE CHOLECYSTITIS IS CHARACTERIZED BY EVERYTHING EXCEPT:

A. N. Nausea, vomiting
B. N. of Ortner's Positive symptom
C. N. Positive Homans symptom.
Year of the increase in body temperature to 38
According to J. A positive Murphy symptom.

13. COURVOSIER'S SYMPTOM IS NOT TYPICAL FOR:

A. N. Acute calculous cholecystitis
B. N. Cancer of the pancreatic head
C. N. Tumors of the large duodenal nipple
D. N. Choledochus tumors

14. THE PATIENT HAS JAUNDICE ON THE BACKGROUND OF ACUTE PAIN IN THE RIGHT HYPOCHONDRIUM, AN ENLARGED PAINFUL GALLBLADDER IS PALPATED. THE MOST LIKELY DIAGNOSIS?

A. N. Acute hepatitis
B. N. Biliary dyskinesia
C. N. Acute cholecystitis, choledocholithiasis
D. N. Gallbladder cancer
According to J. Echonococcosis of the liver.

15. IT IS NOT TYPICAL FOR THE CLINIC OF ACUTE CHOLANGITIS:

A. N. Hectic temperature
B. N. Shingles pains in the animal
C. N. Jaundice
D. N. Unstable loose stools
According to J. Vomiting

16. THE CLINICAL MANIFESTATION OF ACUTE CHOLECYSTITIS COMPLICATED BY PERITONITIS IS NOT:

A. N. Muscle tension in the right hypochondrium
B. N. Positive Mayo-Robson symptom
C. N. Positive Shchetkin-Blumberg symptom throughout the animal
D. N. Positive Sitkovsky symptom
According to J. Pasternatsky's symptom

17. THE FOLLOWING RESEARCH METHOD IS THE MOST INFORMATIVE FOR THE DIAGNOSIS OF PEPTIC ULCER OF THE STOMACH AND DUODENUM:

A. N. Angiography
B. N. Laparoscopy

C. N. Gastric X-ray
Ultrasound examination of the abdominal cavity organs (ultrasound)
According to J. Fibrogastroscopy

18. EVERYTHING IS CHARACTERISTIC OF AN EXACERBATION OF PEPTIC ULCER DISEASE, EXCEPT:
A. N. Tosca
B. N. Dysuria
C. N. Positive symptoms of Boas
D. N. Persistent dull pain in the right hypochondrium and epigastrium
According to J. Weakness, an admixture of blood in the vomit.

19. CHARACTERISTIC COMPLAINTS OF PATIENTS WITH DUODENAL ULCER ARE:
A.N. Pain in the upper abdomen
B. N. Tosca
C. N. Pain in the epigastric region on an empty stomach, aggravated at night, heartburn
D. N. Pain in the right hypochondrium radiating to the lumbar region
According to J. Pain in the right iliac region

20. THE PATIENT HAS COMPLAINTS OF PAIN IN THE UPPER ABDOMEN, WHICH INCREASES AFTER EATING, WEAKNESS, WEIGHT LOSS, BELCHING, VOMITING. THE MOST LIKELY DIAGNOSIS?
A. N. Exacerbation of duodenal ulcer
B. N. Colon tumor.
C. N. Peptic ulcer of the stomach
D. N. Cholelithiasis
According to J. Peptic ulcer complicated by pyloric stenosis.

21. DECOMPENSATED PYLORODUODINAL STENOSIS DEVELOPS:
A. N. Hypochloremia
B. N. Hyperchloremia
C. N. Hypochloremia and hypokalemia
D. N. Hyperchloremia and hyperkalemia
According to J. Hyperchloremia and hypokalemia

22. THE DISAPPEARANCE OF PAIN AND THE APPEARANCE OF MELENA IN DUODENAL ULCER IS CHARACTERISTIC OF:
A. N. Pyloroduodenal stenosis
B. N. Perforation of ulcers
C. N. Malignancy of ulcers
D. N. Bleeding
According to J. Penetration of ulcers into the pancreas

23. HEMATURIA IS NOT TYPICAL FOR
A. N.Urolithiasis
B. N. Tuberculosis of the urinary tract
C. N.Testicular tumor
D. N.Tumors of the urinary tract
According to J.Goodpasture Syndrome

24. AT WHAT LOCATION OF THE CONCRETION IS THERE THE GREATEST THREAT OF COMPLETE OBTURATION?
A. N.The stone of the upper cup
B. N. Coral-shaped stone of the tub
C. N. The stone of the ureter

D. N. Bladder stone

25. THE SAFEST, NONINVASIVE DIAGNOSTIC METHOD FOR NEPHROLITHIASIS.
A. N. ULTRASOUND
B. N. Excretory urography
C. N. Infusion urography
D. N. Computed tomography
According to J. Chromocystoscopy

26. HEMATURIA IS NOT TYPICAL FOR
A. N. Urolithiasis
B. N. Tuberculosis of the urinary tract
C. N. Testicular tumor
D. N. Tumors of the urinary tract
According to J. Goodpasture Syndrome

27. PROSTATE CANCER SCREENING IS CARRIED OUT ACCORDING TO THE FOLLOWING INDICATORS
A. N. General urinalysis
B. N. PSA
C. N. SA19-9
D. N. REA
According to J. Alphafetoproteins

28. THE MORPHOLOGY OF CHANGES IN PROSTATE PATHOLOGY IS EXAMINED BY THE METHOD
A. N. Excretory urography
B. N. of Cystoscopy
C. N. Dopplerometry
D. N. Transrectal ultrasound with biopsy

29. CRYPTORCHIDISM IS
A. N. Absence of testicle
B. N. Testicular dystopia
C. N. Testicular inflammation
D. N. Norm

30. THE MOST COMMON CAUSE OF HYDRONEPHROTIC KIDNEY TRANSFORMATION IS
A. N. Congenital pathology of the kidney parenchyma
B. N. Nephrolithiasis
C. N. Abdominal injuries
D. N. Cancerous kidney

ANSWERS TO THE QUESTIONS OF THE TEST TASKS
1-in, 2-in, 3-in, 4-in, 5-in, 6-in, 7-in, 8-in, 9-in, 10-in, 11-in, 12-in, 13-in, 14-in, 15-in, 16-d, 17-d, 18-b, 19-c, 20-d 21-c, 22-d, 23-d, 24-c, 25-a, 26-d, 27-b, 28-d, 29-b, 30-B.

A list of situational tasks.

Situational task No. 1
Patient K., 36 years old, was admitted to the clinic on an emergency basis with complaints of epigastric pain, nausea, heartburn, vomiting of eaten food with an admixture of blood.
It was found out from the medical history that he had been ill for about 4 days. The onset of the disease is associated with the intake of spicy food and alcohol. I was worried about

burning pains of moderate intensity in the epigastric region, a feeling of nausea, nausea, and heartburn. During these days, he refused to eat, due to increased pain after eating. He notes a gradual deterioration in his condition - the pain is constant, increasing in the evening and at night. Defecation with brown-colored feces. Deterioration 7 hours before admission, after eating, the pain increased, nausea appeared, and there was double vomiting of eaten food with streaks of blood. He was taken by ambulance.

During the examination: the general condition is satisfactory. The skin and visible mucous membranes are physiologically colored. In the lungs, breathing is vesicular, there is no wheezing, BPD is 18 per minute. Heart tones are clear, rhythmic, heart rate 98 per minute, blood pressure 120/80 mm Hg. Pulse of satisfactory filling and tension. The tongue is dried, densely covered with a greenish coating. The abdomen participates in the act of breathing, and is soft and slightly painful in the epigastrium. There is no muscular defense, peristalsis is active. The kidney area is not changed. Palpation does not detect soreness. Urination is free, daily diuresis 1400 ml.

Per rectum: the tone of the sphincter is good. In the ampoule of the rectum, the feces are decorated, on the glove, the feces are black, decorated.

Blood test: Hb - 110 g/l; erythrocytes – 3.2 x 1012, hematocrit – 34%; color index – 0.9; leukocytes - 15.9 x 109, e–0, p-24, c-55, L-19, m-2; platelets – 175.0; ESR- 26 mm/h.

Urine analysis: straw-yellow; transparent; specific gravity – 1012; reaction – acidic; protein – negative; erythrocytes – 3-4; bile – negative; sugar – negative; leukocytes – 12-15; epithelium flat – completely in the field of vision; bacteria ++++. Biochemical analysis: total billirubin - 17.8 mmol/L, direct - 12.3 mmol/L; thymol sample – 1.0 units; ALT- 0.6 mmol/L; AST-0.4 mmol/L; total protein - 66 g/l; cholesterol – 5.1 mmol/L; urea – 8.0 mmol/l; creatinine – 109 mmol/l; potassium – 5.0 mmol/L; sodium – 141 mmol/l; calcium – 1.1 mmol/l; chlorides – 110 mmol/l; glucose – 3.8 mmol/l; PTI – 89%; fibrinogen – 3.7 g/l.

With FGDS: the esophagus is freely passable. During the examination, the esophagus is freely passable, in the lower third there is hyperemia, swelling of the mucous membrane, small erosions. There is a rough folding and swelling of the gastric mucosa, multiple submucosal hemorrhages and erosion of the mucous membrane, covered with gray plaque, areas of the mucous membrane covered with black plaque. Blood leakage from areas of erosion. Contact bleeding of the mucous membrane, a large amount of mucus and "coffee grounds" in the stomach, a small admixture of fresh blood.

Questions:

1. Make a clinical diagnosis.
2. Justify the correctness of your assumptions.
3. Formulate a diagnostic program.
4. Determine the treatment strategy.
5. What complications can develop against the background of this disease?
6. Indications for surgical treatment.
7. Prognosis of the disease.

Situational task No. 2

Patient O., 42 years old, went to a local therapist with complaints of epigastric pain, which worsened after eating and, especially, at night, heartburn, belching.

It was revealed from the medical history that he suffered from peptic ulcer with ulcer localization in the duodenum bulb. He was repeatedly treated in the gastroenterology department during periods of exacerbations. Three years before the treatment, he was

operated on for a perforated duodenal ulcer. I was worried about hunger pains, heartburn, and rotten belching. The symptoms decreased during treatment with antacids. After the operation, within 6 months, the existing symptoms were joined by vomiting of eaten food, weight loss, weakness. He underwent emergency surgery one year ago. The scope of the operation is unknown. A real deterioration in the condition during the last week. Epigastric pain resumed, intense pain that could not be relieved by eating or antacids, heartburn, belching, and nighttime pain appeared. He notes a general deterioration of well-being.

On examination: the patient is exhausted. The skin is slightly pale and dry. In the lungs, breathing is vesicular, there is no wheezing, BDD is 18 per minute. The heart tones are clear, rhythmic, heart rate is 76 beats per minute, blood pressure is 120/80 mm Hg. The tongue is moist, thickly coated with a white coating at the root. The abdomen is scaphoid in shape, and there is a postoperative scar along the midline, 18 x 0.5 cm without signs of inflammation. On palpation, the abdomen is soft, painful in the epigastrium and in the right hypochondrium. Peristalsis is active. The stool is mushy 2-3 times a day and brown in color. The kidney area is not changed. Palpation - soreness is not detected. Urination is free, diuresis daily is 1300 ml.

Blood test: Hb- 100 g/l; erythrocytes – 3.8 x 1012, hematocrit – 34%; color index – 0.9; leukocytes - 6.9 x 109, e–0, p-4, c-75, L-19, m-2; platelets – 175.0; ESR- 26 mm/h.

Urine analysis: yellow; cloudy; specific gravity – 1012; reaction – acidic; protein – 0.067 g /l; blood – negative; bile – negative; sugar – negative; leukocytes – 12-18; flat epithelium – completely in the field of vision; oxalates - +++.

Biochemical analysis: total billirubin – 19.5 mmol/L, direct – 10.5 mmol/L; thymol sample – 1.0 units; ALT- 0.6 mmol/L; AST-0.4 mmol/L; total protein - 46 g/l; cholesterol – 5.1 mmol/L; urea – 18.0 mmol/l; creatinine – 179 mmol/l; potassium – 7.0 mmol/L; sodium – 141 mmol/L; calcium – 1.1 mmol/L; chlorides – 110 mmol/l; glucose – 3.8 mmol/l; PTI – 89%; fibrinogen – 3.7 g/l; alkaline phosphatase – 168 mmol/lL.

During X-ray examination: the esophagus is freely passable, its walls are elastic. The stump of the stomach on an empty stomach contains a large amount of fluid, has a funnel shape, the folds are poorly visualized, smoothed. Evacuation to the discharge loop is somewhat slowed down. The lumen of the anastomosis is 1.5 cm, immediately after the anastomosis, a stable barium depot of 1.0 x 1.0 cm (ulcerative niche) is determined.

Questions:

1. What is the preliminary diagnosis that can be given to the patient?
2. What research methods should be used to make a diagnosis.
3. What diseases should be given a differential diagnosis?
4. What complication did the patient develop after suturing a perforated ulcer?
5. Tactics of patient treatment.
6. Prognosis of treatment.
7. Rehabilitation program

Situational task No. 3

Patient V., 37 years old, was admitted to the surgical department with complaints of dull aching bursting pains in the right hypochondrium, nausea and vomiting.

It is known from the medical history that the patient has been suffering from peptic ulcer for 12 years. He was treated regularly in the hospital during periods of exacerbation. Over the past 3 years, peptic ulcer relapses have become more frequent, conservative therapy has had a short-term effect, and supportive therapy has been too expensive for the patient. In this

regard, the patient underwent surgery a year ago. In the postoperative period, there is a significant improvement in the condition. The pain, heartburn, and belching stopped completely. 3 months after the operation, dull aching pains in the right hypochondrium began to appear after eating, which went away on their own. Gradually, the pain became more intense, bursting and passed only after taking antispasmodics. Subsequently, a feeling of nausea and overcrowding was added, and therefore the patient provoked vomiting, which brought relief. He began to resort to this method regularly to alleviate his condition. Notes the presence of a large amount of bile in the vomit. Recently, eating any food has caused the listed symptoms, the patient is starving, has lost weight.

On examination: the patient is emaciated, the general condition is of moderate severity, the skin has a grayish tinge, and the skin turgor is reduced. In the lungs, breathing is vesicular, there is no wheezing, BDD-18 per minute; heart rate-78 beats per minute; BP-110/70 mm Hg. The tongue is dry, covered with a yellowish coating. The abdomen is navicular in shape. Postoperative scar along the midline measuring 15x0.5 cm. On palpation in the epigastric region, the formation has an elastic consistency of 12x6 cm, movable. Peristalsis is active. Stool 1 time in 3-4 days. The kidney area is not changed. Palpation - soreness is not detected. Urination is free, diuresis daily is 1300 ml.

Blood test: Hb - 104 g/l; erythrocytes - 4.2 x 1012, hematocrit – 34%; color index – 0.9; leukocytes - 7.9 x 109, e–0, p-4, c-75, L-19, m-2; platelets – 175.0; ESR- 26 mm/h.

Urine analysis: straw-yellow; transparent; specific gravity – 1012; reaction – acidic; protein – negative; blood – negative; bile – negative; sugar – negative; leukocytes – 2-3; epithelium flat – 4-8 in the field of vision. Biochemical analysis: total billirubin - 27.8 mol/L, direct - 15.3 mol/L; thymol sample – 1.0 units; ALT- 0.6 mmol/L; AST-0.4 mmol/L; total protein - 66 g/l; cholesterol – 5.1 mmol/L; urea – 8.0 mmol/l; creatinine – 109 mmol/l; potassium – 5.0 mmol/L; sodium – 141 mmol/l; calcium – 1.1 mmol/l; chlorides – 110 mmol/l; glucose – 3.8 mmol/l; PTI – 89%; fibrinogen – 3.7 g/l.

On ultrasound: the liver is heterogeneous, the intrahepatic ducts are not dilated, the choledochus is 0.8 cm, the terminal part of the choledochus is not located. Pancreas: head 29 mm, body 22 mm and tail 17 mm. The structure of the gland is heterogeneous, with increased density. Gallbladder: measures 12 x 8 cm, the wall is thickened – 0.4 cm, has a double contour, and there are multiple concretions in the lumen from 0.5 to 1.0 cm.

Fluoroscopy on an empty stomach: liquid in the stump of the stomach. There is a massive cast of contrast mass into the leading loop, the latter is unevenly expanded, in places up to 3.5 – 4.0 cm. The contrast medium does not remain in it for a long time.

Questions:

1. Make a clinical diagnosis.
2. What research methods should be carried out by the patient.
3. What complications developed after surgery and its causes.
4. Formulate treatment programs.
5. Formulate the indications for surgical correction of the complication.

Situational task No. 5

Patient P., 77 years old, was admitted to the clinic complaining of minor dull pains in the right hypochondrium, weakness, yellowing of the skin, itching, weight loss, darkening of urine and light feces.

It is known from the medical history that he has been ill for 2 months. According to the patient, there was an icteric staining of the sclera, a slight ictericity of the skin. The jaundice decreased and increased again, and skin itching appeared. He was examined in the infectious diseases department, where infectious hepatitis was excluded. Gradually, there were dull pains in the right hypochondrium, weakness. He notes a decrease in appetite. I've lost 8 kg recently. Due to the increasing jaundice, he was sent for examination.

On examination: general condition of moderate severity. The skin and sclera are jaundiced, and there are areas of scratching. In the lungs, breathing is weakened in the lower lateral regions, moist multi-bubbly wheezing, BDD-18 per minute. Heart tones are muted, rhythmic, pulse is 78 per minute, blood pressure is 130/80 mm Hg. The tongue is dried, covered with a yellowish coating. The belly is sunken and participates in the act of breathing. On palpation, the liver protrudes 2 cm from under the edge of the costal arch, with a dense, slightly painful edge. The bottom of the gallbladder is determined. The latter is enlarged and painless. Ortner's, Mayo-Robson's, and Murphy-Georgievsky's symptoms are negative. The peristalsis is good. Stool once every three days with grey feces. The kidney area is not changed. Palpation - soreness is not detected. Urination is free, urine is dark in color, diuresis is 1,900 ml daily.

Blood test: Hb- 108 g/l; erythrocytes – 3.8 x 1012, hematocrit – 34%; color index – 0.9; leukocytes - 8.9 x 109, e–0, p-4, c-75, L-19, m-2; platelets – 175.0; ESR- 56 mm/h.

Urine analysis: yellow; cloudy; specific gravity – 1012; reaction – acidic; protein – 0.067 g /l; blood – negative; bile – negative; sugar – negative; leukocytes – 12-18; flat epithelium – completely in the field of vision; oxalates - +++.

Biochemical analysis: total billirubin – 264.5 mmol/L, direct – 176.5 mmol/L; thymol sample – 2.0 units; ALT- 2.6 mmol/L; AST-1.4 mmol/L; total protein - 66 g/l; cholesterol – 5.1 mmol/L; urea – 18.0 mmol/l; creatinine – 179 mmol/l; potassium – 7.0 mmol/L; sodium – 141 mmol/L; calcium – 1.1 mmol/L; chlorides – 110 mmol/L; glucose – 7.8 mmol/L; PTI – 89%; fibrinogen – 3.7 g/l; alkaline phosphatase – 468 units.actECG

: horizontal position of the electrical axis of the heart, sinus tachycardia, hypertrophy of the left ventricle. Heart rate is 78 per minute.

Ultrasound: the liver is enlarged, echolastic, and the intrahepatic ducts are dilated. The choledochus is 2.5 cm, the terminal part of the choledochus is not visualized. The gallbladder is 18 x 10 cm in size, its wall is thinned and atonic. The head of the pancreas is 52 mm, the body is 41 mm, and the tail is 17 mm.

Questions:

1. What kind of disease can be suspected?
2. What diseases should be given a differential diagnosis?
3. Formulate a diagnostic program.
4. Formulate a preoperative preparation plan.
5. Indications for surgery, the volume of surgery, factors affecting the volume of intervention.
6. Prognosis of the disease.
7. Rehabilitation program.

Situational task No. 6

Patient F., 65 years old, was taken by the SP team to the emergency department of the surgical hospital 3 hours after the onset of the disease with complaints of sudden abdominal pain of a permanent nature, without a clear localization, and dry mouth.
The patient is moaning loudly, rushing about. Vomiting with the smell of intestinal contents was observed, which did not bring relief.
He has a history of hypertension: he is treated uncontrollably with antihypertensive drugs.
The general condition is serious. His face is pale and covered with cold sweat. The skin has a grayish tinge. In the lungs, breathing is vesicular, there is no wheezing. The heart tones are arrhythmic, and systolic murmur is heard above the aorta, the apex. The heart rate is 112 in 1 minute. Blood pressure 160/90 mmHg. Temperature 36.60 C. The tongue is dry, covered with a "dirty" coating. The abdomen is not swollen, participates in breathing, is mild, the pain on palpation does not increase. The liver is on the edge of the costal arch, painless. The spleen is not palpable. There are no symptoms of peritoneal irritation. Auscultation – peristalsis is not heard. Stool is frequent, watery, with an admixture of blood. During rectal examination, there was no overhanging or soreness of the rectal walls, no pathological formations were detected, and traces of watery stool with an admixture of blood were found on the glove. Palpation and percussion of the lumbar regions are painless. There are no dysuric phenomena.
Of the additional diagnostic methods:
total blood count: Hb – 119 g/l; Er. – 5.0 × 1012/l; Ht – 35%; c.p. – 0.9; ESR – 18 mm/h; L – 2.1 × 109/l; e – 1, p – 18, c – 53, L – 22, M – 6.
general urinalysis: c/w; epiphany; acid; 1022; cax. – rel.; bel. – rel.; L – 3 – 4 in n/a; ep. - 5 – 6 in n/
a. biochemical study: O/bel. – 68 g / l; O/ bil. – 15.8 mmol/ l; ALF – 425 units; L-amylase – 169 g×h/l; Alt – 0.5; Ast – 0.7; Tim. – 2.5 units; Sul. 4.0 units; Urea. – 8.8 mmol/l; Creatine. – 278 mmol/l; K+ - 5.2 mmol/l; Na++ - 138 mmol/l; Cl- - 103 mmol/l.
Questions:
1. What is your preliminary diagnosis?
2. What diseases should be differentiated from?
3. The scope of the additional examination.
4. What are the treatment tactics?

Situational task No. 6
Patient T., 28 years old, was taken to the emergency department of the surgical hospital by the SP team with complaints of intense abdominal pain of a cramping nature, without a clear localization, nausea, repeated vomiting with an admixture of bile in the vomit, dry mouth.
From anamnesis: 3 years ago, the patient underwent a right-sided adnexectomy. Since then, there have been 5 attacks of acute abdominal pain, which were easily relieved after conservative measures. The present deterioration occurs within 4 hours (associated with physical exertion), this time the onset of the disease is more abrupt and proceeds much more severely than the previous ones (according to the patient's assessment).
The general condition is serious. The patient is restless, rushes, changes position. The skin is of normal color. In the lungs, breathing is vesicular, there is no wheezing. The heart tones are rhythmic, there is no additional noise. The heart rate is 100 in 1 minute. Blood pressure is 90/60 mmHg. The tongue is moist, covered with a white coating. The abdomen is swollen, breathing is limited, there is an asymmetric protrusion to the left of the navel, soft on

palpation, painful in the area of protrusion. The liver is not enlarged, it is painless. The spleen is not palpable. There are no symptoms of peritoneal irritation. Percussive – local tympanitis over the protrusion, there is no dullness in the sloping places. During auscultation, there is a weakening of peristalsis. At the beginning of the disease, there was a single stool. Palpation and percussion of the lumbar regions are painless. There are no dysuric phenomena.
Of the additional diagnostic methods:
general blood test: Hb – 152 g/l; Er. – 4.5 × 1012/l; Ht – 48%; c.p. – 1.0; ESR – 18 mm/h; L – 12.8 × 109/l; e – 0, p – 12, s – 50, L – 33, M – 5.
general urinalysis: c/w; epiphany; acid; 1018; cax. – rel.; bel. – rel.; L – 2 – 3 in n/a.; ep. – 1 – 2 in n/a.
biochemical study: O/bel. – 86 g/l; O/bil. – 12.4 mmol/l; ALP – 333 units; L-amylase – 169 g×h/l; Alt – 0.5; Ast – 0.7; Tim. - 2.5 units; Sul. 4.0 units; Urea. – 7.8 mmol/l; Creatine - 98 mmol/L; K+ - 3.5 mmol/L; Na++ - 138 mmol/l; Cl - 92 mmol/L.
Questions:
1. Formulate a diagnosis.
2. What should be done to confirm the diagnosis?
3. What symptoms are described during examination and abdominal percussion?
4. How can we explain the difference between the present clinical picture and previous seizures?
5. Therapeutic tactics?

Situational task No. 8
Patient T., 52 years old, was admitted to the emergency department with complaints of epigastric pain of a shingling nature, nausea, repeated vomiting, which did not bring relief, and weakness.
The pain appeared abruptly this morning (I had a big dinner the day before), localized in the left hypochondrium, radiating to the left half of the chest, followed by difficulty breathing
The patient has been suffering from hypertension for a long time; coronary heart disease, angina pectoris (observed and treated by a therapist).
The patient was delivered by the SP team 2 hours after the onset of the disease. Upon examination, the condition is serious. The temperature is 37.00 C. The food is excessive. The skin is pale, acrocyanosis is noted, and the skin is covered with cold sweat. Breathing is weak in the lungs, there is no wheezing. The heart tones are rhythmic, and systolic murmur is heard at the II point and at the apex. Heart rate 140 in 1 minute, low voltage. Blood pressure is 100/60 mmHg. The tongue is dry, covered with a white coating. The abdomen is moderately evenly swollen, participates to a limited extent in the act of breathing, is soft, sharply painful in the epigastric region. The liver is not palpable (due to the excessive subcutaneous fat layer of the abdominal wall). The spleen is not detected. There are no symptoms of peritoneal irritation. The symptoms of Voskresensky and Mayo-Robson are positive. Liver dullness is preserved, there is no dullness in the sloping places. Auscultation determines a decrease in peristalsis. Palpation and percussion of the lumbar regions are painless. There are no dysuric phenomena.
Of the additional diagnostic methods:
total blood count: Hb – 139 g/l; Er. – 4.8 × 1012/l; Ht – 38%; c.p. – 0.9; ESR – 15 mm/h; L – 12.5 × 109/l; e – 1, p – 7, s – 53, L – 32, M – 7.

general urinalysis: c/w; epiphany; acid; 1018; cax. – rel.; bel. – rel.; L – 2 – 3 in n/a.; ep. - 1 – 2 in n/a.; diastasis of urine 1024 units.
biochemical study: O/bel. – 82 g/l; O/bil. – 18.4 mmol/l; ALP – 255 units; L-amylase – 325 g×h/l; Alt – 0.5; Ast – 0.7; Tim. - 2.5 units; Sul. 4.0 units; Urea. – 6.8 mmol/l; Creatine – 78 mmol/L; K+ - 3.5 mmol/L; Na++ - 138 mmol/l; Cl - 96 mmol/L.
ECG: sinus rhythm, 86 per minute. EOS is deviated to the left; diffuse changes in the myocardium; in V3-6, inversion of the P wave.
Questions:
1. What is your preliminary diagnosis?
2. What is the need for differential diagnosis?
3. What research methods can confirm the diagnosis?
4. Treatment tactics?

Situational task No. 9
Patient S., 49 years old, was admitted to the emergency department with complaints of intense pain in the epigastric region radiating to the lumbar region and the left shoulder, nausea, vomiting, which did not bring relief, and dry mouth.
The sharp pain appeared suddenly 2 hours ago. I celebrated a friend's birthday the night before.
The patient has a history of duodenal ulcer for 6 years, and was treated irregularly.
Upon examination, the condition is serious. The skin is pale, acrocyanosis is noted, and the skin is covered with cold sweat. Breathing is weak in the lungs, there is no wheezing. The heart tones are rhythmic, muted. Heart rate 98 in 1 minute, low voltage. Blood pressure is 110/60 mmHg. The tongue is dry, covered with a white coating. The abdomen is of the usual shape, does not participate in the act of breathing, is sharply tense and painful in the upper abdomen. The liver and spleen are not palpable. Symptoms of peritoneal irritation are questionable. The symptoms of Voskresensky and Mayo-Robson are questionable. Liver dullness is preserved, there is no dullness in the sloping places. Auscultation determines the weakening of peristalsis. Palpation and percussion of the lumbar regions are painless. There are no dysuric phenomena.
Of the additional diagnostic methods:
total blood count: Hb – 139 g/l; Er. – 4.8 × 1012/l; Ht – 38%; c.p. – 0.9; ESR – 15 mm/h; L – 12.5 × 109/l; e – 1, p – 7, s – 53, l – 32, m – 7.
general urinalysis: c/w; epiphany; acid; 1018; cax. – rel.; bel. – rel.; L – 2 – 3 in n/a.; ep. - 1 – 2 in n/a.; urine diastasis 512 units.
biochemical study: O/bel. – 82 g/l; O/bil. – 18.4 mmol/l; ALP – 255 units; L-amylase – 325 g×h/l; Alt – 0.5; Ast – 0.7; Tim. - 2.5 units; Sul. 4.0 units; Urea. – 6.8 mmol/l; Creatine – 78 mmol/L; K+ - 3.5 mmol/L; Na++ - 138 mmol/l; Cl - 96 mmol/L.
overview R-gr. org. abdominal cavity: the air in the free abdominal cavity is not determined.
FGDS: cicatricial and ulcerative deformity of the duodenum bulb was detected, there is an ulcerative defect on its posterior wall, the bottom is covered with fibrin.
Ultrasound: it is not possible to examine the pancreas due to the interposition of the transverse colon.
Questions:
1. What is your preliminary diagnosis?
2. What diseases should be treated differentially

? 3. What research methods can be used to clarify the diagnosis?
4. Treatment tactics?

Situational task No. 10
The patient F., 29 years old, was brought to the emergency department by sanitation from the geological party. Due to the severity of the condition, it is difficult to make contact, cannot report the onset and course of the disease.
He is known to be ill for 3 days.

Situational task No. 11
Patient I., 56 years old, was admitted to the surgical department as an emergency with complaints of a painful formation in the inguinal region on the right, nausea, vomiting, and non-discharge of gases. The onset of the disease is associated with physical exertion (throwing snow). He sought medical help 22 hours after the onset of the disease.
Upon admission: general condition of moderate severity. The skin is pale in color. In the lungs, respiration is vesicular. Tachycardia of up to 112 beats per minute is noted, blood pressure is 100/60 mmHg. The tongue is dried, overlaid with a dirty coating in the center. The abdomen is swollen, participates in breathing to a limited extent, and on palpation it is tense and painful in the right iliac and inguinal regions. In the groin area on the right, a painful mobile formation measuring 4x3 cm of a dense elastic consistency is detected. The skin above the formation is not changed. Intestinal motility is weakened. Symptoms of peritoneal irritation are questionable. During rectal examination, feces of the usual consistency and color are present in the lumen of the rectum. In the general blood test, leukocytes-14.5 x 109 /l, p-10, c-72, L-16, e-2., ESR - 38 mm/hour, Hb – 142 g/l. During X-ray examination of the abdominal cavity, Cloiber bowls are determined. The diagnosis was made: a pinched right-sided inguinal hernia. 1 hour after admission, the patient underwent surgery. An oblique incision in the right inguinal region on the right exposed a hernial protrusion. The hernial sac was opened, and up to 10 milliliters of cloudy, odorless hernial water were released. The contents are 2 loops of the small intestine, hyperemic. After dissecting the infringing ring and warming the intestine, intestinal motility in the area of the strangulation groove was restored, and arterial pulsation was preserved. The intestine is recognized as viable, immersed in the abdominal cavity. Plastic surgery of the anterior wall of the inguinal canal was performed using the Girard–Spasokukotsky method. 8 hours after the operation, the patient's condition worsened. Hyperthermia up to 39C, shortness of breath, tachycardia up to 124 beats per minute, weak heart rate. The abdomen is swollen, there is soreness in all parts on palpation, and the Shchetkin–Blumberg symptom is positive. During percussion, tympanitis is detected, and peristalsis is not heard auscultatively. In the general blood count, leukocytosis increased to 18,400 per 1 ml., The leukocyte formula shifted to the left, and toxic granularity appeared.
Questions:
1. What is the complication of the early postoperative period in this patient?
2. The suspected cause of this complication?
3. Were there any tactical errors by the operating surgeon? If so, which ones?
4. What are your next steps?

Situational task No. 12

Patient I., 38 years old, was admitted to the surgical department of MGB No. 1 with complaints of weakness, abdominal pain, the presence of a painful formation in the groin area on the left, nausea, vomiting, high body temperature, chills. He got sick at work (he works as a builder) 3 days before admission, when after physical exertion he noticed the appearance of a painful formation in the groin area on the left. Gradually, the abdominal pain began. The gases stopped escaping. During the last 24 hours, the condition worsened, fever and chills joined. He did not seek medical help due to alcohol consumption and a decrease in pain in this regard. Upon admission, the general condition is severe. The skin is pale in color. Body weight 38.0 g. s. Pulse 120 beats per 1 min. Blood pressure is 100/60 mmHg In the lungs, vesicular respiration, weakened in the lower parts. Heart tones are muted, tachycardia. The abdomen is moderately evenly swollen, participates in breathing to a limited extent, the abdominal wall is regressive on palpation, painful in all parts, and the Shchetkin-Blumberg symptom is weakly positive. In the groin area on the left, a 6x4 cm formation is visualized descending into the scrotum, the skin above the formation is swollen, hyperemic. Local hyperthermia and severe soreness. The external inguinal ring on the left is not defined. The symptom of a coughing fit is negative.
In the general blood test, Hb – 128 g/l, er. 4.0x10 12 /l, leukocytes – 14.5x10 9/l, p-24, c-62, l- 14. ESR – 32 mm/hour. In the general analysis of urine – c / yellow, cloudy, protein – 0.66 g / l, leu 4-5 in subcutaneous, erythr. – 1-2 in subcutaneous, sugar rel.

Questions:
1. What is your diagnosis?
2. With what nosologies is it necessary to differentiate the disease you have identified?
3. Your tactics?
4. If surgical treatment is indicated, decide on the expected scope of the operation?

Situational task No. 13
Patient P., 32 years old, applied to the outpatient surgery center with complaints of intermittent protrusion, discomfort in the groin area on the left during prolonged walking and physical exertion. He considers himself ill for 3 years. I have not sought medical help before.
On an objective examination, the skin is of normal color. Pathology from the organs of respiratory and cardiovascular pathology was not revealed. The abdomen is not swollen, participates in breathing, is soft on palpation, and is painless in all parts. In the vertical position of the patient, there is a protrusion of the abdominal wall, movable, of a mildly elastic consistency, and disappears in the horizontal position. The external inguinal ring is expanded to 3 cm. The symptom of cough is positive.
Questions:
1. Your diagnosis?
2. Your tactics?
3. If surgical treatment is indicated, how much surgery will you choose?
4. Rehabilitation program?
Disease prognosis? Labor forecast?

Situational task No. 14

Patient K., 42 years old. She complained of nausea, vomiting of dark cherry-colored blood, general weakness, dizziness, loss of consciousness, periodic burning pains in the right hypochondrium, weight loss, and an increase in abdominal volume.

She has been ill for 5 years. The onset of the disease is associated with hepatitis suffered in the postpartum period. In subsequent years, I was bothered by periodic pain in the right hypochondrium, provoked by eating fatty foods, and nausea. With some deterioration of well-being, skin and sclera became icteric, regressing within 1-2 weeks. Recently, the pain has been constant, dull, aching, nausea, flatulence, and an increase in abdominal volume have joined. Nausea, vomiting of blood twice, and weakness appeared 4 hours before admission. He notes a short-term loss of consciousness. Delivered by ambulance.

Upon admission: general condition is severe. The skin is slightly pale, with a jaundiced tinge, dry. The turgor of the skin is reduced, there are areas of petechial hemorrhages. In the lungs, breathing is vesicular, there is no wheezing, breathing in the lower lateral sections is weakened, BDD is 22 per minute, heart rate is 98 beats per minute, blood pressure is 100/60 mm Hg. The tongue is dry, covered with a brown coating at the root. The abdomen is rounded on examination, slightly enlarged in volume. Palpation is soft, and the edge of the liver is determined, protruding 12 cm below the costal arch, rounded, bumpy, and moderately painful during examination. The spleen protrudes from under the costal edge by 8 cm. A wide convoluted vein is visible along the midline on the anterior abdominal wall. Peristalsis is sluggish. During percussion, there is bluntness in sloping places. On rectal examination, the tone of the sphincter is satisfactory, the anterior wall of the rectum overhangs into the lumen of the rectum, and is painless. There is black feces on the glove.

Blood test: Hb- 100 g/l; erythrocytes – 3.0 x 1012, hematocrit – 28%; color index – 0.9; leukocytes - 6.9 x 109, e–0, p-4, c-75, L-19, m-2; platelets – 175.0; ESR- 26 mm/h.

Urine analysis: straw-yellow; transparent; specific gravity – 1012; reaction – acidic; protein – 0.067; blood – negative; bile – negative; sugar – negative; leukocytes – 2-3; epithelium flat – 4-8 in the field of vision; oxalates - +++.

Biochemical analysis: total billirubin - 64.8 mol/L, direct - 32.3 mol/L; thymol sample – 2.0 units; ALT- 2.6 mmol/L; AST-1.4 mmol/L; total protein - 56 g/l; cholesterol – 5.1 mmol/L; urea – 18.0 mmol/l; Creatinine – 179 mmol/l; potassium – 5.0 mmol/L; sodium – 141 mmol/L; calcium – 1.1 mmol/l; chlorides – 110 mmol/l; glucose – 3.8 mmol/l; PTI – 89%; fibrinogen – 3.7 g/l; alkaline phosphatase – 268 mmol/L.

With FGDS: the esophagus is freely passable. Starting from the border of the middle and lower third of the esophagus, hyperemia, contact bleeding, varicose veins of the esophagus are prolapsed into the lumen of the esophagus. The mucosa on the surface of the varicose nodes is thinned, there are tears of the mucosa with moderate bleeding. There is edema, hyperemia, and multiple varicose veins in the cardia.

X-ray examination: the esophagus is dilated, varicose veins are detected in the lower third of it. The splenoportogram shows a sharply dilated umbilical vein. The ciliacogram shows a depletion of the arterial pattern of the liver and a sharply dilated splenic artery.

On ultrasound: the liver is enlarged, the structure is heterogeneous, the intrahepatic ducts are not dilated, the choledoch is 1.0 cm. Pancreas: the head is 20 mm, the body and tail are not dislocated. The gallbladder is 8 x 4 cm in size. The bladder wall is 0.2 cm, atonic. There is a large amount (up to 1000 ml) of fluid in the abdominal cavity.

Questions:

1. Make a clinical diagnosis.

2. Formulate a diagnostic algorithm.
3. Determine the treatment strategy.
4. Explain the principles of conservative therapy.
5. What will be the indications for surgery?
6. Prognosis of the disease.
7. Rehabilitation program

Situational task No. 15

Patient Z., 47 years old, was urgently transported by ambulance with complaints of pain in the upper abdomen, nausea, vomiting, weakness, dizziness.

He gets sick during the day. According to relatives, he had been drinking a lot of alcoholic beverages for the last 4 days. The day before admission, there was repeated vomiting of eaten food, gastric contents with an admixture of bile, and subsequently streaks of blood appeared in the vomit. After vomiting, pain appeared in the upper half of the abdomen, heartburn. 3 hours before admission, vomiting of "coffee grounds" with an admixture of fresh blood. There was a single lumpy black stool. I felt weak and dizzy. He fainted, and his relatives called an ambulance.

During the examination: The general condition of the patient is of moderate severity. The skin is pale and moist. There is harsh breathing in the lungs all over the fields, scattered dry wheezing. BH 18 per minute, HR 110 per minute, BP 100/70 mmHg. The tongue is dry, covered with a green-brown coating. The stomach participates in the act of breathing. On palpation, it is painful, moderately tense in the epigastrium, peristalsis is active, and the Shchetkin-Blumberg symptom is negative. The kidney area is not changed, there is no pain on palpation. Urination is free, there is no pain.

Per rectum: the tone of the sphincter is good, in the ampoule of the rectum there are remnants of feces, a mushy consistency, black feces on the glove.

Alcohol status: the patient is agitated, the smell of alcohol is coming from his mouth, he is unstable in the Romberg pose, and he performs a nasal test uncertainly.

Blood test: Hb - 82 g/l; erythrocytes – 2.8 x 1012, hematocrit – 28%; color index – 0.9; leukocytes - 4.9 x 109, e–0, p- 4, c-75, L-19, m-2; platelets – 175.0; ESR- 18 mm/h.

Urine analysis: straw-yellow; cloudy; specific gravity – 1012; reaction – acidic; protein – negative; erythrocytes – 3-4; bile – negative; sugar – negative; leukocytes – 12-15; epithelium flat – completely in the field of vision; bacteria ++++. Biochemical analysis: total billirubin - 30.8 mgol/L, direct - 12.3 mgol/L; thymol sample – 2.0 units; ALT- 1.6 mmol/L; AST-0.8 mmol/L; total protein - 66 g/l; cholesterol – 5.1 mmol/L; urea – 28.0 mmol/L; creatinine – 289 mmol/l; potassium – 5.0 mmol/L; sodium – 141 mmol/l; calcium – 1.1 mmol/l; chlorides – 110 mmol/l; glucose – 3.8 mmol/l; PTI – 89%; fibrinogen – 3.7 g/l.

FGDS: the esophagus is freely passable. Starting from the border of the middle and lower third of the esophagus, hyperemia, contact bleeding, edema in the cardia, hyperemia, wounds of the mucous membrane of 1.3-1.5 cm with moderate bleeding from wounds, the gastric mucosa is swollen, folds are straightened with difficulty, multiple erosions, merging with each other.

Questions:
1. Make a clinical diagnosis.
2. Formulate a diagnostic algorithm.
3. Determine the patient's treatment tactics.

4. Indications for surgical intervention.
5. List modern methods of conservative treatment, describe each of them.
6. Prognosis of the disease.
7. Rehabilitation program.

Situational task No. 16

Patient T., 56 years old, was taken by the SP team to the emergency department of the surgical hospital with complaints of pain in the right hypochondrium of a permanent nature with irradiation to the heart, nausea, vomiting with an admixture of bile, dry mouth, t rise to 38.50 C.

Paroxysmal pain in the right hypochondrium has been bothering me periodically for 5 years. The real aggravation occurred more than 2 days ago after eating canned food. During the day, the patient is in the hospital, where infusion, antispasmodic, and antibacterial therapy was performed, despite this, the pain syndrome has somewhat intensified and has become permanent.

In the anamnesis: coronary heart disease, angina pectoris; diabetes mellitus, type II.

The general condition is serious. The skin is normally colored, and the sclera are subicteric. In the lungs, breathing is vesicular, there is no wheezing. The heart tones are rhythmic, muted, with a II-tone accent over the aorta. The heart rate is 92 in 1 minute. Blood pressure 130/60 mmHg. The tongue is dry, covered with a white coating. The abdomen has a regular shape, participates in breathing, is tense and painful in the right hypochondrium. Due to the rigidity, it is not possible to palpate the liver and gallbladder. The spleen is not detected. The Shchetkin–Blumberg symptom is weakly positive in the right hypochondrium. Auscultation – peristalsis is not changed. Palpation and percussion of the lumbar regions are painless. There are no dysuric phenomena, the urine is of normal color.

Of the additional diagnostic methods:

total blood count: Hb – 129 g/l; Er. – 5.5 × 1012/l; Ht – 47%; c.p. – 1.0; ESR – 18 mm/h; L – 14.8 × 109/l; e – 0, p – 9, s – 55, l – 30, m – 6.

general urinalysis: s/w; epiphany; acid; 1018; cax. – rel.; bel. – rel.; L – 2 – 3 in n/a.; ep. – 1 – 2 in n/a.

biochemical study: O/bel. – 82 g/l; O/bil. – 32.4 mmol/l; ALP – 315 units; L-amylase – 169 g×h/l; Alt – 1.2; Ast – 1.0; Tim. - 2.5 units; Sul. 4.0 units; Urea. – 6.8 mmol/l; Creatine – 78 mmol/L; K+ - 4.2 mmol/L; Na++ - 138 mmol/l; Cl - - 103 mmol/L.

ECG: sinus rhythm, 86 per minute. EOS is deviated to the left; diffuse changes in the myocardium; in V3-6, inversion of the P wave.

Questions:

1. What is your preliminary diagnosis?
2. What is the reason for this course of the disease?
3. What additional methods can be used to confirm the diagnosis?
4. Tactics and scope of treatment?

Situational task No. 17

Patient Z, 65 years old, went to the surgeon complaining of shortness of breath of an inspiratory nature, more pronounced at night that the patient was afraid of suddenly suffocating. Suffocation attacks are associated with a sudden change in body position, especially when the head is tilted back. She was examined by a local therapist. Bronchial

asthma is suspected, and treatment has no effect. It is known from the medical history that about 6 years ago, an endocrinologist was diagnosed with goiter during an examination, but since he did not cause any particular concern, I did not contact the doctors about this.

The general condition is satisfactory. The patient is overweight (overweight 18 kg), short height 156 cm. The skin and visible mucous membranes are normally colored. Peripheral lymph nodes are not enlarged. The osteoarticular apparatus has no visible deformity. T-36.6 g/S, pulse 80 beats per 1 minute, blood pressure 130/80 mmHg. The neck is short, palpation in the area of the left lobe of the thyroid gland palpates a formation up to 5 cm in diameter extending beyond the sternum, it is not soldered to the skin, when swallowing it shifts along with the thyroid gland. In the lungs, breathing is vesicular, there is no wheezing, the excursion of the pulmonary margin is not limited, and the boundaries are normal. The heart tones are muted, the noises are not audible, the boundaries are within the age range. The tongue is clean and moist. The abdomen is not swollen, actively participates in breathing, and on palpation it is soft and painless in all parts. Deep palpation revealed no pathology.
UAC – Nv-149 g/l, er. – 4.5x10 12/l, leukocytes-6.4x10 9/l, ESR – 12 mm/hour e-4, s-68, m-1, l-27. Blood sugar – 5.4 mmol/l, OAM – c/w, epr, od.v.-1018, epit.- 2-3 in the field of view. Radiography of the neck – the trachea at neck level is a curved slit 4 mm wide, with calcification foci in the shadow of the left lobe of the thyroid gland. Ultrasound of the thyroid gland is a node in the projection of the left lobe up to 5.5 cm in diameter with hypoechoic inclusions.
Questions:
1. Formulate a clinical diagnosis.
2. Which research methods are not included in the diagnostic program of this patient.
3. What causes shortness of breath?
4. Which method and amount of treatment should be preferred.
5. If you are going to operate, what are the features of anesthesia and surgery techniques for this patient?

Situational task No. 18
Patient G., 55 years old, was admitted complaining of progressive weight loss (he lost 50 kg in 4 months), heart pain, palpitations, psychoemotional instability, and swelling of the lower extremities. Deterioration of the condition during the last six months, when he began to notice gradually increasing weakness, nervousness, weight loss. Two months ago, I was examined in the therapeutic department for 2 weeks due to a suspected pancreatic tumor. Instrumental research methods (ultrasound of the abdominal cavity, CT) allowed to exclude this pathology. Infusion, enzyme therapy, antispasmodics were performed. I did not notice any special effect from the treatment. 1 month ago, due to paroxysmal atrial fibrillation and the appearance of edema on the lower extremities, he was again treated in a therapeutic clinic for heart disease. Psychotic phenomena began, he was consulted by a psychiatrist.
The general condition of the patient is of moderate severity. There is an expression of fright on his face, and a glint in his eyes. The patient is malnourished, the skin turgor is reduced, the skin is dry. Tremor of fingers and eyelids. The pulse rate is 124 beats per minute. BP is 145/80 mmHg. Bone and joint apparatus without visible deformation. The neck is rounded, short, and above the sternum tenderloin to the right of the midline, a soft consistency formation extending beyond the sternum is palpable, not soldered to the skin. In the lungs, respiration is vesicular, the boundaries of the lungs are normal. Heart tones are muted, tachycardia,

expansion of the boundaries of the heart to the left by 1 cm. The tongue is moist, overlaid with a whitish coating in the center. The abdomen is not swollen – soft, but painful in the epigastric region. It is not possible to identify any pathological formations in the abdomen. The liver is located along the edge of the costal arch. Stool is prone to constipation. The kidney area is painless.
UAC Nv – 147 g/l, er. – 4.1 x 10-12/l, leukocytes- 8.6 x 109/L, e- 2, p-2, s – 58, L-38, ESR – 20 mm /hour. Blood sugar 6.0 mmol/l. Protein – 52 g/l. On the X-ray of the neck and upper half of the chest, the trachea is shifted to the left. ECG – hypertrophy of the left ventricle, tachycardia, violation of myocardial trophism. The study of thyroid hormones is thyroxine 470 nmol/l (norm 65-160), triiodothyronine – 8.6 nmol/ l (norm 1.0-2.5).
Questions:
1. Your preliminary diagnosis.
2. Formulate a comprehensive diagnostic program.
3. What are the difficulties of diagnosis?
Explain the treatment program (if you choose a surgical one, then preoperative preparation, anesthesia, access, and the scope of the operation).

Situational task No. 19
Patient E., 69 years old, was admitted to the surgical hospital with complaints of severe bursting pains in the right shin, swelling of the foot and shin, and an increase in body temperature to 38.70 C. The pain increases with movement.

I got sick three days ago when I had cramping contractions of the calf muscle, and later pain in it. Edema appeared on the third day.

The condition is satisfactory. The skin and visible mucous membranes of ordinary paint. The submandibular and inguinal lymph nodes are palpable, small, mobile, of a dense elastic consistency, and painless. The musculoskeletal system is without visible pathology, the joints are not changed. A patient with increased nutrition. Height 168 cm, body weight 92 kg. The body mass index is 32.59 kg/m2. The pulse rate is rhythmic, 86 per minute. Blood pressure is 150/90 mmHg. There is hard breathing in the lungs, there is no wheezing. The breathing rate is 18 per minute. The abdomen is soft, painless, and there are no symptoms of peritoneal irritation. The liver and spleen are not enlarged. Stool 1 time a day, decorated, without pathological impurities. There is no dysuria. Shaking in the lumbar region is painless on both sides.

Blood test: hemoglobin-155 g/l, leukocytes-15.IxlO9 /l, rod-shaped neutrophils-10%, eosinophils-2%, segmented-72%, lymphocytes-13%, monocytes-3%, ESR-34 mm/h. Glucose-4.5 mmol/l.

Urinalysis: relative density-1026; color- straw yellow, transparent; reaction- slightly acidic; protein-traces; sugar, acetone, bile pigments- absent; erythrocytes- absent; leukocytes-0-1 in the field of vision, epithelial cells -0-3 in the field of vision; cylinders, mucus-absent; oxalates + +.

Coagulogram; platelets-296xlO9 /l, bleeding time-1min; clotting time-4 min; plasma calcination-115 sec; plasma tolerance to heparin-10 min; prothrombin time-10 sec; prothrombin index-106%antithrombin activity-110%, plasma fibrinogen-2.4 g/l.

The skin on the right shin and foot is slightly hyperemic, tense, and shiny. The circumference of the middle third of the right shin is 6 cm larger than the circumference of the left shin at this level. The movements in the left ankle joint are preserved, but painful.

Palpation of the shin shows pain along the vascular bundle, especially in the popliteal fossa. Homans' symptom is positive (the appearance of pain in the calf muscle with maximum flexion in the ankle joint). There is a sharp pain when squeezing the calf muscle.
Questions:
1. What is your preliminary diagnosis?
2. What kind of additional examination will you prescribe?
3. Is your treatment plan outpatient or inpatient?

Situational task No. 20
A 45-year-old woman came to the clinic for an appointment with a surgeon with complaints of pain in her right shin, headache, weakness, and bruising. For more than 2 days, the onset of the disease is associated with the common cold factor. Body temperature rose to 39 ° C in the evening.
The condition is satisfactory. The skin and visible mucous membranes are normally colored. The submandibular and inguinal lymph nodes are palpable, small, mobile, of a dense elastic consistency, and painless. The musculoskeletal system is without visible pathology, the joints are not changed. A patient with increased nutrition, hypersthenic physique. Height 168 cm, body weight 92 kg. The body mass index is 32.59 kg/m2. The pulse rate is rhythmic, 76 per minute. BP 140/90 mmHg. Vesicular respiration in the lungs, no wheezing. The breathing rate is 17 per minute. The abdomen is soft, painless, and there are no symptoms of peritoneal distension. The liver and spleen are not enlarged. Stool 1 time per day, without pathological impurities. There is no dysuria. Shaking in the lumbar region is painless on both sides.
On the anterolateral surface of the lower and middle thirds of the tibia there is an extensive, bright red spot with several small blisters filled with serous hemorrhagic exudate. The boundaries of hyperemia are clear and uneven (in the form of a geographical map). At the site of hyperemia, the skin is testy, sharply painful on palpation.
Blood test: hemoglobin-124 g/l, leukocytes-15.1 x 9/l, rod-shaped neutrophils-7%, eosinophils-2%, segmented-62%, lymphocytes-26%, monocytes-3%, ESR-34 mm/h. Glucose-6.5mmol/l.
Urinalysis: relative density-1026; color straw yellow, transparent;
reaction - slightly acidic; protein-traces; sugar, acetone, bile pigments -absent; erythrocytes -isolated in the preparation; leukocytes-3-4 in the field of vision, epithelial cells-0-3 in the field of vision; cylinders, mucus - absent; oxalates + +.
Coagulogram: platelet count- 185x19/l, bleeding time-1 min; clotting time-8 min; plasma recalcification time-115 sec; plasma tolerance to heparin-12 min; prothrombin time-15 sec; prothrombin index-104% antithrombin activity-106%, plasma fibrinogen-2.4g/lL.
Questions:
1. What is your diagnosis?
2. Should the patient be isolated from other patients in the department during hospitalization?
3. What treatment will you prescribe for the patient?
Situational task No. 21
A patient with a clearly limited appendicular infiltrate, a subfebrile temperature and a significantly improved condition during treatment suddenly had severe abdominal pain on the 5th day of admission and on the 10th day after the onset of the disease, the temperature began to rise, thirst appeared, tachycardia, and the tongue became dry. There was a single

vomiting. The abdomen is swollen, sharply painful in all parts, the abdominal wall is limited in mobility when breathing, and the Shchetkin-Blumberg symptom is determined. Leukocytosis increased from 10.0 to 18.0. What was the patient's complication? What should be done?