



# USMLE-STEP-3<sup>Q&As</sup>

United States Medical Licensing Step 3

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**QUESTION 1**

A 37-year-old woman (gravida 3, para 3) presents with a 4-month history of postcoital spotting. On pelvic examination, you visualize a 2-cm friable lesion on the anterior lip of the cervix. The next most appropriate step is which of the following?

- A. colposcopy
- B. pap smear
- C. office biopsy of the cervical lesion
- D. cervical cone biopsy
- E. metronidazole vaginal cream followed by re-examination

Correct Answer: C Section: (none)

Explanation:

An office biopsy of the cervical lesion should be taken immediately when a gross lesion is seen on physical examination. For smaller, less distinct lesions, colposcopy may be helpful in determining the best area to biopsy, but it is not always necessary for larger, distinct, gross lesions. A pap smear can be performed, but it cannot be relied on to detect invasive cervical cancer. Cervical cone biopsy is not indicated at this time, particularly because the diagnosis can be made by less invasive means with an office biopsy. Also, if a cone biopsy is performed and the cancer is invasive or more extensive than originally thought, a cone biopsy may affect the oncologist's ability to perform a radical hysterectomy or alter the effectiveness of vaginal brachytherapy. Finally, the use of metronidazole vaginal cream is not indicated in this patient since there is no evidence of a vaginal infection.

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**QUESTION 2**

A 4 1/2-year-old girl is brought to your office during summertime hours for ear pain. She has been swimming at camp for the past few days and now has copious cloudy discharge from her left external auditory canal with pain on movement of the pinna.

What is the best course of treatment for this patient?

- A. amoxicillin PO
- B. erythromycin PO
- C. erythromycin topical
- D. cefuroxime PO
- E. neomycin/polymyxin B/hydrocortisone topical

Correct Answer: E Section: (none)



Explanation:

The constellation of ear pain, pain with movement of the pinna, and cloudy discharge from the ear canal in a child who has been swimming frequently is most probably OE, also known as "swimmer's ear." Perforated TMs can occur, often as the result of an untreated otitis media, a foreign body inserted deep in the ear or from barotrauma. This can cause ear pain and may have a cloudy drainage if the perforation is the result of otitis media. Neither otitis media nor perforated TMs typically cause pain on movement of the pinna. Mastoiditis is a rare infection that usually results from extension of an untreated otitis media into the mastoid air cells. The common findings on examination would be an acute otitis media and tenderness over the mastoid area behind the ear. Temporomandibular joint dysfunction can cause ear pain, but the common finding is tenderness anterior to the ear, not pain with movement of the ear or drainage from the ear canal. It would also be uncommon in a child this age.

The most common cause of acute OE is Pseudomonas aeruginosa. Treatment for acute OE will involve topical antimicrobials which cover P. aeruginosa, often in combination with a topical steroid. A commonly used treatment consists of eardrops containing neomycin, polymyxin B, and hydrocortisone (Cortisporin Otic), four drops into the affected ear four times a day for 7-10 days. Alternative therapy consists of ofloxacin drops twice a day into the affected ear for 7-10 days. For chronic OE, yeast becomes a more important pathogen, and therapy should be directed as such.

QUESTION 3

A 53-year-old Black male, with a history of hypertension, hepatitis C, and newly diagnosed nonsmall cell lung cancer, undergoes his first round of chemotherapy, which includes cisplatin. You are called to see this patient 5 days into his hospitalization for oliguria and laboratory abnormalities. Other than the chemotherapy, he is receiving lansoprazole, acetaminophen, and an infusion of D5--0.9% normal saline at 50 mL/h. On examination, his BP is 98/60 and heart rate is irregular, between 40 and 50 bpm. His physical examination shows a middle-aged male in no acute distress. His cardiac examination is unremarkable, his lungs show bibasilar crackles, and the abdominal examination is positive for a palpable spleen tip without any hepatomegaly or abdominal tenderness. He has trace bilateral ankle edema. His distal pulses are irregular. The neurologic examination was unremarkable. His laboratory (serum sample) results are as follows What would be the most likely finding on this patient's ECG?

	Day 1	Day 5	
Sodium	135	145	
Potassium	4.4	6.8	
Chloride		100	108
CO2	24	20	
BUN	15	35	
Creatinine	1.5	3.4	
Glucose	118	152	
Uric acid		6.5	15.3
Phosphate	4.4	8.3	
Calcium	9.0	7.5	
Uric acid		6.5	15.3
Lactate	285	994	
dehydrogenase (LDH)			

- A. shortened P-R segment
- B. prominent U wave
- C. widened QRS complexes



D. flattened T waves

E. atrial fibrillation

Correct Answer: C Section: (none)

Explanation:

The patient has tumor lysis syndrome. The destruction of malignant cells by chemotherapeutic agents will lead to the release of intracellular contents, including potassium, phosphorus, and uric acid (from nucleic acids). This can result in hyperkalemia, hyperuricemia, and hyperphosphatemia. Hyperkalemia will produce significant ECG abnormalities, including peaked T waves and widened QRS complexes. The presence of bradycardia and irregular heart rate on physical examination are suggestive of the cardiac effects of hyperkalemia, which can lead to lifethreatening arrhythmias if not addressed. Patients with tumor lysis syndrome can develop a severe hyperuricemia. The kidneys are responsible for the excretion of uric acid. In acidic urine, the uric acid can crystallize in collecting tubules, resulting in intratubular obstruction and acute kidney failure. Calcium oxalate stones are not a part of this entity. Cisplatin can cause renal potassium and magnesium losses, which is not the case in this patient. The laboratory data suggest the release of intracellular contents (high LDH, uric acid, potassium, and phosphate) and the diagnosis of urate nephropathy as the cause of his acute kidney failure. As mentioned before, hyperkalemia will produce significant ECG abnormalities, including peaked T waves and widened QRS complexes. Prominent U waves are found in hypokalemia, not hyperkalemia. Atrial fibrillation is not typically seen in hyperkalemia

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#### QUESTION 4

A 38-year-old married woman presents to her urgent care clinic complaining of "crying spells" for several weeks since the termination of her employment. She admits to feeling "down all the time." She also has difficulty falling asleep, poor energy, decreased appetite, and is "not able to enjoy anything." She fears that her condition will never improve. She has begun to feel that "it wouldn't matter if I died," but she denies any suicidal plan or intent. She drinks one to two mixed drinks per week and denies any drug use. It is decided to begin antidepressant therapy with paroxetine (Paxil) 20 mg at bedtime.

If there is no significant improvement in her symptoms, but the medication is tolerated, after what length of time should a dosage increase be considered?

A. 4 days

B. 1 week

C. 2 weeks

D. 4 weeks

E. 7 weeks

Correct Answer: D Section: (none)

Explanation:

This woman likely suffers from major depressive disorder. Treatment with a SSRI is considered to be first-line therapy. Although the neurovegetative symptoms of depression (e.g., insomnia, change in appetite, anergia, poor concentration) can sometimes improve after several days of initiating pharmacotherapy, the feelings of depression and hopelessness



may take up to 46 weeks to significantly improve. As long as she is tolerating the SSRI, the urge to quickly increase the dose should be avoided so as to minimize side effects. Upon initiation of a SSRI, education and reassurance should be provided to the patient regarding the expected time until remission. Although there are characteristic side effects, most patients tolerate treatment with SSRIs. Many of these side effects, such as headaches, gastrointestinal disturbances, and vivid dreams, transpire at the start of treatment and may resolve over days to weeks. Sexual dysfunction, such as impotence or inhibited orgasm, not uncommonly occurs after several weeks to months of treatment with SSRIs and can continue with ongoing treatment.

## QUESTION 5

A 64-year-old female with no significant medical history presents with vague complaints of progressive generalized muscle weakness and fatigue. She denies any history of trauma or drug use and does not take any prescription, OTC or herbal medications. This is a new complaint and she has not had any prior workup. There is no evidence of trauma and a recent TSH was normal. On examination, you find mild muscle tenderness and atrophy. She has difficulty standing from a chair unless she pushes up with her arms at the same time. Her neurologic examination is normal. Which of the following tests would be most helpful in confirming your clinical diagnosis?

Your patient's test result confirms your clinical suspicion. The patient's symptoms have become more severe. Which of the following treatment options would be most appropriate?

- A. vitamin B12 injections
- B. electromyography (EMG)
- C. trigger point injections
- D. prednisone
- E. cyclobenzaprine

Correct Answer: D Section: (none)

Explanation:

Polymyositis usually presents with patients complaining of gradual muscle weakness and myalgias. The peak incidence occurs in the fifth and sixth decades, with women being affected more commonly than men. Aside from the history and physical examination, laboratory analysis such as elevated muscle enzymes such as CPK and aldolase usually confirm the diagnosis. ESR levels may not be significantly elevated in over 50% of the patients. ANA may be positive in many patients, however this does not distinguish the condition. EMG may be helpful in making the diagnosis as certain features such as polyphasic potentials, fibrillations, and high-frequency action potentials are more consistent with polymyositis. Muscle biopsy is the most specific test, however the patchy distribution may lead to false negative tests on occasion. Muscle biopsy may reveal endomysial infiltration of the inflammatory infiltrate. Usually, the initial treatment of choice is high-dose steroids, that is, prednisone 60 mg with tapering down after clinical response to the lowest effective dose. If steroids fail, immunosuppressant such as methotrexate or azathioprine may be tried.

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