USMLE-STEP-3 Q&As

United States Medical Licensing Step 3

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QUESTION 1

A 55-year-old woman presents to your office with painful hands, causing difficulty opening jars and turning the key in the ignition of her car. She is fatigued and she notices joint stiffness, but limbers up by lunch. She has trouble getting her rings off because of enlarging knuckles. About a year ago, she tried some OTC ibuprofen, which seemed to help, but led to the development of a bleeding ulcer severe enough to require transfusion and ICU care. Otherwise, her health is good, and her review of systems is negative. Your physical examination reveals tenderness and swelling at the index proximal interphalangeal and metacarpophalangeal joints bilaterally. There are small effusions on both knees. She has tenderness to lateral compression of the forefoot area bilaterally.

The following data are obtained: normal CBC; normal basic metabolic panel; ESR 40 mm/h; ALT 90 U/L; AST 110 U/L; alkaline phosphatase 70 U/L; bilirubin 0.2 mg/dL; uric acid 5.1 mg/dL; urinalysis is normal. ACE level is normal. Rheumatoid factor is 60 and ANA is positive 1:40 speckled pattern. The next most important test would be which of the following?

A. hepatitis C antibody

B. anti-double-stranded DNA antibodies

C. serum protein electrophoresis

D. C-reactive protein

E. RPR

Correct Answer: A Section: (none)

Explanation:

In all likelihood, this patient is presenting with a systemic inflammatory arthritis. Clearly, treatment will need to be initiated. In order to effectively and promptly treat her, you will need to understand the current state of her physiology. Therefore, basic laboratory studies including blood count, full chemistries, and urinalysis should be obtained. At this point, the most likely diagnosis is RA, and the rheumatoid factor and sedimentation rate may be helpful. Theoretically, sarcoidosis can present in this way but, epidemiologically, this is much less likely. Because of this and because the ACE level is fairly nonspecific, it should not be part of the initial workup. Neither joint fluid aspiration nor uric acid levels are likely to be diagnostic. The elevation of serum transaminase in the face of elevated sedimentation rate, moderate or low positive ANA, and rheumatoid factors raise the question about hepatitis C. About 50% of patients with active hepatitis C will have cryoglobulinemia. Cryoglobulins can produce low moderate positive rheumatoid factors. Therefore, it is extremely important in this circumstance to be certain that hepatitis C is not present. With such a low positive ANA, the likelihood that this is classical Lupus is low, and double-stranded DNA antibodies are not likely to be revealing. C-reactive protein may confirm the presence of inflammation, but it won\\'t provide additional information over the sedimentation rate. Syphilis, "the great imitator," again may occasionally have arthritis as a manifestation--but rarely without other features. The remaining studies while they might be useful later but are unlikely to be helpful as the next most important test obtained. The probable source of the patient\\'s symptoms is RA. Osteoarthritis can produce articular swelling, but on physical examination, there is rarely bogginess in the synovium. Anti-CCP antibody is an antibody directed against the citrullinated portion of fillagen. It has the highest specificity for RA of any antibody known. It is usually present early and may predict more severe disease.

QUESTION 2

A 38-year-old married female is brought in to the primary care clinic by her husband. She is minimally responsive to

questioning, head bowed, and staring at the floor. Most of the history is obtained from her spouse. He denies any known personal or family history of mental illness, but he claims for the past several months his wife has become increasingly depressed and withdrawn. Instead of taking part in her usual hobbies, she is lying around the house. "She tosses and turns" throughout the night. Her husband ensures that she eats a limited amount of food, but she has lost a significant amount of weight. She has been ruminating about guilty feelings regarding a number of issues and recently has been speaking about suicide, although she has no plan or intent. She has refused to come in to see a doctor. Her husband insisted that she come today, as she informed him that the devil has possessed her and told her she will "go to hell."

What is her most likely diagnosis?

A. bipolar disorder, depressed, with psychotic features

B. delusional disorder, somatic type

C. major depressive disorder with psychotic features

D. schizoaffective disorder, depressed type E. schizophrenia, paranoid type

Correct Answer: C Section: (none)

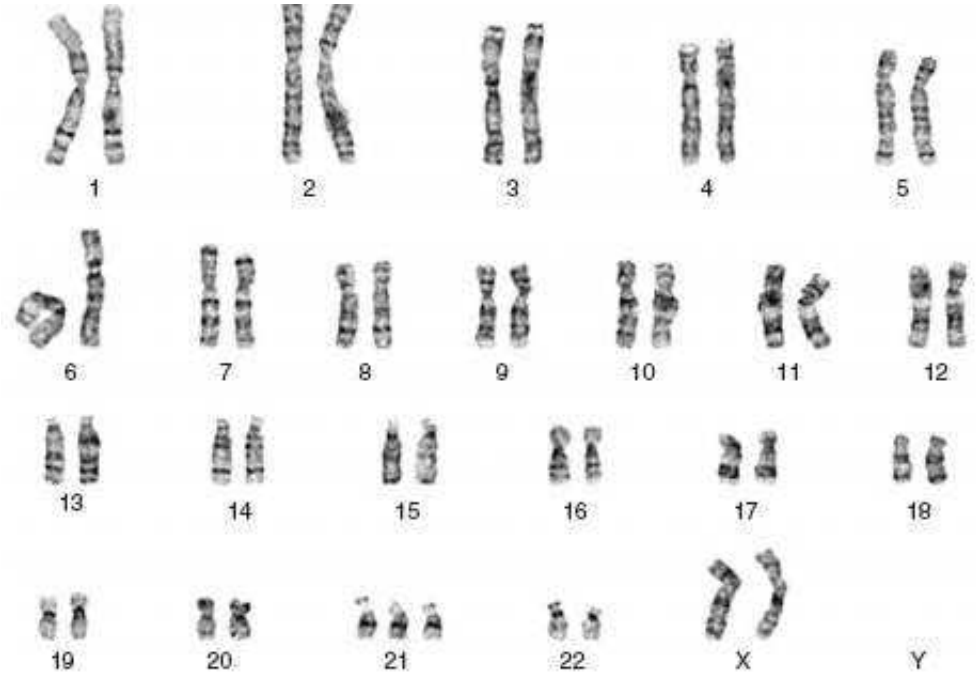
Explanation:

While patients with bipolar depression do present with psychotic features, this individual does not give any history of manic episodes, making the diagnosis difficult at this time. The bizarre delusions (those that cannot possibly exist in life) and auditory hallucinations that this patient has are not consistent with delusional disorder. Schizoaffective disorder, depressed type, includes both psychotic as well as depressive symptoms. However, the psychotic symptoms must last at least 1 month and occur in the absence of a depressed mood. The diagnosis of schizophrenia also requires at least 1 month of active psychosis but a total of 6 months of attenuated or residual symptoms. Although a depressed mood is very commonly seen in schizophrenia, the total duration of depression is brief overall compared to the psychotic symptoms. This patient presents with major depression with psychotic features, consisting of a depressed mood with neurovegetative symptoms for at least 2 weeks, as well as psychotic symptoms, which are only present along with the mood symptoms (DSM IV-TR).

Mood stabilizers alone or with antipsychotic medications are not the first-line treatments for major depression with psychotic features, but rather for mania with or without psychotic features. Studies have demonstrated that the combination of antidepressants and antipsychotics is more effective in treating major depression with psychotic features than either pharmacotherapy alone.

QUESTION 3

A healthy 38-year-old G4P3003 presents for amniocentesis. The karyotype returns as shown in the Figure. What is the diagnosis?



A. Down syndrome

B. Patau syndrome

C. Edwards syndrome

D. Turner syndrome

E. Klinefelter syndrome

Correct Answer: A Section: (none)

Explanation:

Down syndrome is a trisomy of chromosome 21. It is the most common nonlethal trisomy. Patau syndrome is trisomy 13 and Edwards syndrome is trisomy 18. Turner syndrome is 45 X, a monosomy. Klinefelter syndrome is the presence of an extra X chromosome in a male resulting in 47 X-X-Y. Down syndrome is the most commonly recognized genetic cause of mental retardation. The risk of trisomy 21 is directly related to maternal age as a result of maternal nondisjunction. The risk of having a child with Down syndrome increases in a gradual, linear fashion until about age 30 and increases exponentially thereafter. Women who will be 35 years or older at the time of delivery should be offered chorionic villus sampling or secondtrimester amniocentesis. Women younger than 35 years should be offered maternal serum screening at 1618 weeks of gestation. The maternal serum markers used to screen for trisomy 21 are alpha-fetoprotein, unconjugated estriol, and hCG. The use of ultrasound to estimate gestational age improves the sensitivity and specificity of maternal serum screening.

QUESTION 4

Parents bring their 12-year-old son to your clinic for evaluation. The child states that he gets teased a lot in school because of his short stature. His weight and height are below the 10th percentile for his age. His parents are of average height. Following your physical examination, you determine that he has tanner stage 1 development and his bone age is

that of a 9-year-old male. His examination is otherwise normal. What is the most likely diagnosis?

Which of the following is a true statement regarding the assessment of a child with short stature?

A. An advanced bone age indicates that the child\\'s final height will be greater than his peers.

B. A slower growth velocity means the child will have more time to "catch up."

C. A spot GH level is a good test in screening for GH deficiency.

D. Somatomedin-C (ILGF-1) will be low in a child with GH deficiency.

E. The most common cause of short stature in children is chronic renal disease.

Correct Answer: D Section: (none)

Explanation:

Short stature in an adolescent is a common reason for visiting the pediatrician or endocrinologist. Most short stature in adolescence is constitutional growth delay. These children will have normal growth velocity and delayed bone age. Growth is normal for the first 412 months, then decelerates to below the fifth percentile. These children will catch up to their peers in a slightly delayed fashion. Frequently, other family members have a history of short stature in childhood, delayed puberty, and eventual normal stature as adults. In contrast, children with familial short stature have a normal bone age and regular onset of puberty. These children will maintain their short stature as adults. Somatomedin-C (ILGF-1) is commonly used as a surrogate measure for the end-organ effect of the pulsatile GH release. In children with GH deficiency, the end-organ effect will be a low somatomedin-C level. An advanced bone age (advanced bone maturation) usually results in shorter final height. Chronic renal failure is a cause of growth delay, but not a common one

QUESTION 5

A 28-year-old White G1 woman presents to your office for an initial obstetric visit. Her LMP is certain and allows you to estimate a 9-week gestational age today. She denies bleeding, cramping, or other symptoms of concern. She is excited about being pregnant. She has already started taking her prenatal vitamins with folic acid. She reports no significant past medical history. In fact, she states that she has not been to a doctor in many years because she has not had any problems. She has had no surgeries. She does not smoke. She drank alcohol socially prior to pregnancy but has not consumed any alcohol since she became pregnant. She has family history of hypertension, but no other significant history is elicited. On physical examination, her blood pressure is 110/60. She is healthy appearing, and there are no significant findings on examination. Your pelvic examination confirms uterine size consistent with stated dates. As part of a routine laboratory evaluation, you decide to check a thyroid-stimulating hormone (TSH). The TSH is 0.4 IU/ mL (normal range 0.55.5) and a free T4 of 1.8 ng/dL (normal range 0.72.0).

What is the most appropriate management of this condition?

A. thyroid ablation with radioactive iodine

B. prescription for propylthiouracil (PTU)

C. prescription for propranolol

D. subtotal thyroidectomy

E. no intervention is necessary as the problem will go away after the pregnancy

Correct Answer: B Section: (none)

Explanation:

In question 66, this patient likely does not have thyroid disease. She is asymptomatic, has a normal physical examination, and her free T4 is normal. hCG shares a chemical subunit with TSH. The circulating hCG can cause suppression of the thyroid. This is a transient change and does not represent true thyroid disease. Graves\\' disease is the most common cause of hyperthyroidism in pregnancy. It is the cause of 9095% of such cases. Patients may complain of rapid heartbeat, weight loss, and GI symptoms such as nausea and vomiting. On examination, you may palpate diffuse thyromegaly and may note exophthalmos. The other listed causes of thyrotoxicosis are much less common in pregnancy, accounting for the remaining 510% of cases. Treatment of this problem is necessary because thyrotoxic women are at increased risk of perinatal mortality, preterm delivery, and maternal heart failure.

Treatment is typically with PTU or methimazole. Propranolol can be used initially to reduce symptoms but does not address the underlying problem. Surgery should be reserved for women who do not respond to medical therapy. Radioactive iodine is contraindicated during pregnancy as it can ablate fetal thyroid tissue, leading to the possibility of congenital hypothyroidism.