Quick-Fire: General Surgery Review Questions & Topics

Quick-Fire Â Â General Surgery Review Questions & Topics ***Bradley J. Phillips, MD***
The Ranch Author: *bjpmd2@aol.com* ***from tragedy... Hope!***

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Â Review Questions Â Section I: 50 Questions & Answers Â Questions: Â

What is the most common complication of antrectomy ?
What are the three major components to MEN-I?
What is the most common cause of chronic cholestasis in children ?
What is the operation of choice in Achalasia ?
How do you diagnose a Gastrinoma ?
What is the most common site of obstruction from colon cancer ?
What is Boerhave's Syndrome ?
What is the most common neuroendocrine tumor found in MEN-I ?
What is the most common type of pituitary tumor found in MEN-I ?
How do you treat Toxic Megacolon ?
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What is MEN-II a?
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How do you manage bile reflux gastritis ?
What is Plummer-Vinson Syndrome ?
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What is Hereditary Spherocytosis ?
How do you treat Hereditary Spherocytosis ?
Where does the Inferior Thyroid Artery originate?
What chromosome is BRCA-1 located on ?
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What is a 'common' cause of massive hemoptysis in children ?
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What is Horner's Syndrome ?
What is the "Blakemore Tube" and how is it used?
What factors are in Cryoprecipitate ?
What is the deficiency in Hemophilia A ?

What is the deficiency in Hemophilia B ?
What is the toxic dose of Lidocaine... with and without epinephrine ?
What is the classic sign of lidocaine toxicity ?
How do you calculate the Gradient in Portal Hypertension ?
How do you treat a Unilateral-locked facet ?
When do you give steroids for neuro-trauma ?
What are the three immune products of the spleen ?
What are Salter-Harris Classes and which ones may impede growth ?

Â Â Â Â Â <u>Answers:</u>

Bile reflux gastritis
"Werner's Syndrome": Parathyroid Hyperplasia Pancreatic Neuroendocrine Tumor Pancreatic Tumor
Congenital Biliary Atresia
Heller myotomy with or without Nissan fundiplication *(controversial)*
a. Serum Gastrin level > 500 ucg

b. Basal acid output to maximal acid outout
ratio > 0.6

c. Calcium-stimulating test, 4 mg/ kg IV over 5 minutes: this will double the baseline gastrin level in the presence of a gastrinoma *(secretin stimulation is no longer performed)*
Sigmoid colon
Boerhave's is a post-emetic perforation of the esophagus which usually presents as fever and right-sided chest pain; early detection is the key to survival.
Gastrinoma
Prolactinoma

Treatment of toxic megacolon is dependent on the underlying state of the patient. Fluid resuscitation and intravenous broad-spectrum antibiotics are mandatory. If the patient is stable, you may consider urgent colonoscopic decompression (being careful not insufflate excessive air). If the pt is deteriorating or presents acutely unstable and actively septic, total abdominal colectomy may be necessary (in this situation, I would tend to perform a relatively quick operation utilizing an end-ileostomy rather than a primary anastamosis).
Clindamycin
Right hemicolectomy with ileocolic anastamosis; cecopexy is not preferred by most surgeons
Chromosome # 11
Neoplasia is the primary cause of death *(not the biochemical effects of the tumor)*
Colonic pseudo-obstruction which presents as massive abdominal distension
Stress ulcer associated with closed head injury
"Sipple's Syndrome":

Parathyroid hyperplasia Pheochromocytoma Medullary Thyroid Cancer
Pheochromocytoma Medullary Thyroid Cancer Neuromas (as well as a marphinoid habitus)
To optimize medical management:
2 weeks preoperative - Alpha-blockade with Phenoxybenzamine

1 week preoperative - Beta-blockade with Inderal
and, if necessary in the operating room – IV Phentolamine
Nonfusion of the Major (Wirsung) and Minor (Santorini) pancreatic ducts; the minor duct becomes the primary route of drainage
Duodenal bypass
Wraps around the aortic arch
Wraps around the right subclavian artery; the Right recurrent nerve has a more variable course compared to the Left
Large Bowel Obstruction: Carcinoma (2/3 of all)
Volvulus
Diverticular disease
Hernias Intussusceptions
Fecal impaction
Appendectomy if the cecum is not actively involved, otherwise may need to proceed with segmental resection. Remember, most fistulas do not arise from the appendiceal base but rather from the terminal ileum.
Type II is a gastric ulcer associated with a duodenal ulcer
Innervates the cricothyroid muscle to affect pitch
Sensory to the larynx
Surgical treatment of bile reflux:
Convert B-I or B-II to a Roux-en-Y gastrojejunostomy with a 40 cm. jejunal distance
Must ensure that there is a complete vagotomy and all of the antrum was previously resected
Esophageal webs, microcytic anemia, and smooth fingernails – which as a syndrome is associated with a higher risk of esophageal cancer*
partial splenectomy
autosomal dominant deficiency of spectrin leading to an inability of the red cell to deform appropriately which leads to splenomegaly and anemia
total splenectomy
the thyrocervical trunk

Chromosome # 17
Chromosome # 11
Tuberculosis (treat by embolization)
Bilateral axillary hyperpigmentation associated with underlying gastric ca or lung ca

Miosis, ptosis, anhydrosis
The Blakemore Tube: indicated in persistent UGI bleeding secondary to varices
Intubate the pt (you must secure the airway)
Place tube into the stomach
Inflate the gastric balloon with 50 cc's and confirm gastric position with KUB
After confirmation, inflate another 200 cc's
Place tube to 5lb's traction
If bleeding still persists, inflate Esophageal balloon to 40 mmHg

* remember, you must deflate the esophageal component every 12 hours to minimize wall ischemia and subsequent necrosis
Factor VIII, VonWillebrand's factor, and Fibrinogen
Factor VIII
Factor IX
The toxic dose of Lidocaine is between 5–7 mg/kg; with epinephrine the total dose injected is a bit higher secondary to local vasoconstriction.

A 1 % solution will contain 10 mg/cc. a. With Epinephrine: 6 - 7 mg/kg in a 70 kg male = 420 – 470 mg total dose = 42 – 47 cc's injected b. Without Epinephrine: 5 mg/kg in a 70 kg male = 350 mg total dose = 35 cc's injected
Seizures
Gradient = Wedged Hepatic P – Free Hepatic P
(4-6 mmHg) (5 – 10 mmHg) (0 – 5 mmHg)

Remember, only half of all cirrhotics will develop varices, and of these, only half will bleed (still adds up to major morbidity & mortality)

The role of surgery in Portal Hypertension, is only AFTER all medical and endoscopic measures have been taken
You must reduce a unilateral-locked facet with 5 lbs. of traction per vertebrae
Steroids in c-spine trauma remain controversial. They are never given for closed head injury! With c-spine injury (usually blunt), they are best if administered within 6 hrs of the traumatic mechanism.
Solumedrol 30 mg/kg IV bolus followed by 5.4 mg/kg IV gtt for 23 hrs.
Tuftsin, properidin, and IgM
Salter-Harris I - V: I - fracture line through the growth plate, separating epiphysis from metaphysis

II - fracture line into the metaphysis

III - separation of the epiphysis along the

This text is a Review Book based on focused Questions and Answers related to the discipline of General Surgery.
It is a helpful guide to medical students and residents preparing for surgical rounds, examinations, and board certification.

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