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39	☒ A	☐ B	☐ C	☐ D	☐ E

PRACTICE QUESTIONS

American Board of Oral and Maxillofacial Surgery (ABOMS)

SITE

OMSITE

EDITION

Demo

QUESTIONS

9

FORMAT

Limited Edition PDF

Before you begin

What this is

9 practice questions for American Board of Oral and Maxillofacial Surgery (ABOMS) **SITE**, each with its answer key and an explanation. Answer a question before you read its key — the explanation is worth more once you have committed.

If something looks wrong

Send us three things and we will check it:

- the exam code, **SITE**
- the question number
- the email address on your order

Write to **support@mometrix.net**. We reply within one business day.

QUESTION 1

SINGLE CHOICE

A 24-year-old patient presents with a dry socket 3 days after surgical removal of an impacted mandibular third molar. Which of the following is the most appropriate initial management?

- ☐ A Prescribe a course of oral antibiotics and instruct the patient to return in one week
- ☒ B Irrigate the socket with warm saline, place an obtundent dressing such as iodoform-based paste, and prescribe analgesics
- ☐ C Curettage of the socket under local anesthesia to stimulate fresh bleeding
- ☐ D Incision and drainage with placement of a Penrose drain

ANSWER B

WHY Dry socket (alveolar osteitis) is managed conservatively with gentle irrigation of the socket, placement of an obtundent/medicated dressing (e.g., iodoform-based paste) to relieve pain, and NSAIDs or other analgesics. Antibiotics are not indicated in the absence of infection. Aggressive curettage is contraindicated because it may spread any incipient infection and damages the socket walls. Incision and drainage is reserved for true fluctuant abscesses.

QUESTION 2

SINGLE CHOICE

A patient with a progressing odontogenic infection of the sublingual and submandibular spaces develops elevation of the floor of the mouth, muffled voice, and difficulty swallowing saliva. What is the most appropriate next step in management?

- ☐ A Schedule elective incision and drainage in 24 hours under outpatient general anesthesia
- ☒ B Admit the patient, secure the airway as needed, and proceed with urgent surgical drainage of the involved fascial spaces and broad-spectrum IV antibiotics
- ☐ C Prescribe oral clindamycin and re-evaluate in 48 hours
- ☐ D Obtain a CT scan only and defer surgical intervention until imaging is reviewed

ANSWER B

WHY Ludwig's angina is a clinical diagnosis characterized by rapid bilateral involvement of the sublingual, submandibular, and subphrenic spaces with elevation of the tongue and floor of the mouth, odynophagia, and a muffled 'hot potato' voice. Because airway compromise can develop precipitously, immediate hospital admission, airway protection when indicated, IV broad-spectrum antibiotics, and urgent surgical decompression of the involved spaces are required. Delaying treatment risks airway loss, mediastinal extension, and sepsis.

QUESTION 3

SINGLE CHOICE

A patient with a displaced bilateral mandibular body fracture also complains of malocclusion and lower lip paresthesia. Which fixation approach best restores occlusion while allowing early function?

- ☐ A Maxillomandibular fixation with arch bars alone for 6 weeks
- ☒ B Open reduction and internal fixation using load-bearing reconstruction plates
- ☐ C External pin fixation with intraoral elastic guidance
- ☐ D Closed reduction with a lingual splint

ANSWER B

WHY Displaced, comminuted, or bilateral mandibular body fractures typically require open reduction and internal fixation. For body fractures, load-sharing miniplates along the line of osteosynthesis (Champy's technique) generally suffice, while load-bearing reconstruction plates are used for atrophic edentulous mandibles or highly comminuted defects. This restores anatomic reduction, occlusion, and allows early return to function without prolonged maxillomandibular fixation. Purely closed techniques are inadequate for displaced bilateral body fractures.

QUESTION 4

SINGLE CHOICE

A panoramic radiograph of a 35-year-old patient shows a well-corticated, unilocular radiolucency at the apex of a non-vital mandibular incisor. The lesion is asymptomatic. Which is the most likely diagnosis?

- ☐ A Dentigerous cyst
- ☐ B Odontogenic keratocyst
- ☒ C Radicular (periapical) cyst
- ☐ D Ameloblastoma

ANSWER C

WHY A well-corticated, unilocular radiolucency associated with the apex of a non-vital tooth is most consistent with a radicular (periapical) cyst—an inflammatory odontogenic cyst arising from epithelial cell rests of Malassez stimulated by pulpal necrosis. Treatment involves endodontic therapy or extraction, often with enucleation or marsupialization. Dentigerous cysts surround the crown of an unerupted tooth; odontogenic keratocysts typically occur in the posterior mandible and have a propensity for recurrence; ameloblastomas usually present as multilocular or soap-bubble lesions in the posterior mandible.

QUESTION 5

SINGLE CHOICE

A 22-year-old patient with a long-standing Class II malocclusion and mandibular retrognathia has completed pre-surgical orthodontics and is planned for a bilateral sagittal split osteotomy (BSSO). Which is a recognized complication specific to BSSO?

- ☐ A Postoperative epistaxis requiring posterior nasal packing
- ☒ B Inferior alveolar nerve injury with altered lower lip and chin sensation
- ☐ C Permanent loss of smell (anosmia) due to cribriform plate disruption
- ☐ D Severe postoperative hyponatremia from third-spacing

ANSWER B

WHY The inferior alveolar nerve runs through the mandibular canal and is at risk during the sagittal split osteotomy; paresthesia of the lower lip and chin is a recognized and frequent postoperative sequela. Epistaxis and anosmia are not typical BSSO complications, and severe hyponatremia from third-spacing is not characteristic. Surgeons counsel patients preoperatively about the risk of neurosensory disturbance, with most deficits improving over months.

QUESTION 6

SINGLE CHOICE

A patient with internal derangement of the TMJ has failed conservative management (NSAIDs, soft diet, occlusal splint therapy, and physical therapy) and continues to have painful locking with limited mouth opening. What is the most appropriate next surgical intervention?

- ☐ A Total prosthetic joint replacement as the initial surgical therapy
- ☒ B Arthrocentesis with lysis and lavage of the superior joint space
- ☐ C High condylectomy
- ☐ D Preauricular skin excision with ligament tightening

ANSWER B

WHY Arthrocentesis with lysis and lavage of the superior joint space is a minimally invasive procedure often used as the next step for patients with persistent closed lock and pain after failed non-surgical therapy. It removes inflammatory mediators and adhesions, improves range of motion, and is a reasonable intervention before considering open surgery or total joint replacement. Total joint replacement is reserved for end-stage disease with severe degenerative changes and functional impairment; high condylectomy is not standard care; preauricular skin excision is not an accepted TMJ procedure.

QUESTION 7

SINGLE CHOICE

During administration of an inferior alveolar nerve block, the patient suddenly becomes unresponsive with tonic-clonic movements that resolve within one minute. Which is the most likely cause?

- ☐ A Anaphylaxis to the local anesthetic
- ☒ B Local anesthetic systemic toxicity (LAST) from intravascular injection
- ☐ C Vasovagal syncope with brief convulsive syncope
- ☐ D High spinal anesthesia from accidental epidural injection

ANSWER B

WHY Brief tonic-clonic activity after an inferior alveolar nerve block is most commonly due to local anesthetic systemic toxicity (LAST) caused by inadvertent intravascular injection, producing CNS excitation before CNS depression. Management focuses on airway support, oxygenation, and—if signs are severe—intralipid emulsion (20% lipid) per the ASRA checklist. Anaphylaxis would typically include urticaria, bronchospasm, or hypotension; vasovagal syncope rarely produces true convulsive movements; high spinal anesthesia is anatomically implausible from an intraoral injection.

QUESTION 8

SINGLE CHOICE

A patient scheduled for third molar removal takes warfarin for a mechanical mitral valve. His INR is 3.5. What is the most appropriate perioperative management?

- ☐ A Discontinue warfarin 5 days preoperatively with no bridging and resume postoperatively
- ☒ B Proceed with surgery after consulting cardiology to bridge with a short-acting agent such as intravenous unfractionated heparin or low-molecular-weight heparin, holding the heparin appropriately around surgery
- ☐ C Administer vitamin K intramuscularly the morning of surgery and proceed
- ☐ D Proceed with surgery and control bleeding with topical hemostatic agents alone

ANSWER B

WHY Patients with mechanical heart valves are at high thrombotic risk, and warfarin interruption typically requires bridging with a short-acting anticoagulant (e.g., low-molecular-weight heparin) under cardiology guidance. Simply stopping warfarin without bridging can precipitate valve thrombosis and embolic events. Vitamin K administration would leave the patient unprotected for days, and surgery at therapeutic INR levels (2–3) can be considered for minor procedures, but an INR of 3.5 is above the typical target range for dental surgery and warrants management with cardiology input.

QUESTION 9

MULTIPLE CHOICE

Which of the following spaces, if involved in an odontogenic infection, are considered potentially life-threatening because of their ability to compromise the airway or spread to the mediastinum? (Choose two.)

- ☐ A Buccal space
- ☒ B Sublingual space
- ☒ C Submandibular space
- ☐ D Pterygomandibular space

ANSWER B - C

WHY The sublingual and submandibular spaces, together with the submental space, constitute the components of Ludwig's angina when they are bilaterally involved. Infections here can rapidly elevate the floor of the mouth, displace the tongue posteriorly, and obstruct the airway; they also can descend along fascial planes into the retropharyngeal space and mediastinum. The buccal space is bounded laterally and is unlikely to compromise the airway; the pterygomandibular space, while important as a site of spread for mandibular infections and as a route to the parapharyngeal and retropharyngeal spaces, is not itself one of the three spaces defining Ludwig's angina.