

01	A	B	C	D	E
02	A	B	C	D	E
03	A	B	C	D	E
04	A	B	C	D	E
05	A	B	C	D	E
06	A	B	C	D	E
07	A	B	C	D	E
08	A	B	C	D	E
09	A	B	C	D	E
10	A	B	C	D	E
11	A	B	C	D	E
12	A	B	C	D	E
13	A	B	C	D	E

14	A	B	C	D	E
15	A	B	C	D	E
16	A	B	C	D	E
17	A	B	C	D	E
18	A	B	C	D	E
19	A	B	C	D	E
20	A	B	C	D	E
21	A	B	C	D	E
22	A	B	C	D	E
23	A	B	C	D	E
24	A	B	C	D	E
25	A	B	C	D	E
26	A	B	C	D	E

27	A	B	C	D	E
28	A	B	C	D	E
29	A	B	C	D	E
30	A	B	C	D	E
31	A	B	C	D	E
32	A	B	C	D	E
33	A	B	C	D	E
34	A	B	C	D	E
35	A	B	C	D	E
36	A	B	C	D	E
37	A	B	C	D	E
38	A	B	C	D	E
39	A	B	C	D	E

PRACTICE QUESTIONS

American Board of Plastic Surgery (ABPS) Written Examination

PS-WE

Plastic Surgery Written Exam

EDITION

Demo

QUESTIONS

9

FORMAT

Limited Edition PDF

Before you begin

What this is

9 practice questions for American Board of Plastic Surgery (ABPS) Written Examination PS-WE , 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, PS-WE
- 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 45-year-old woman undergoes a bilateral skin-sparing mastectomy with immediate reconstruction using tissue expanders. Six months after the second-stage exchange to silicone implants, she develops capsular contracture (Baker grade III) on the right side. Which of the following is the most appropriate next step in management?

- ☐ A Closed capsulotomy with external compression
- ☒ B Open capsulotomy with implant exchange
- ☐ C Removal of the implant with delayed reconstruction
- ☐ D Observation and reassurance, as Baker III contracture is asymptomatic
- ☐ E Initiation of systemic antibiotics for presumed biofilm infection

ANSWER B

WHY Baker grade III capsular contracture is symptomatic (visible distortion, firmness, often discomfort) and does not reliably respond to closed capsulotomy, which has largely been abandoned due to risk of implant rupture. The standard surgical management of established Baker III/IV contracture is open capsulotomy (or capsulectomy) with exchange of the implant, often with site change (e.g., from subglandular to submuscular plane) and consideration of an acellular dermal matrix. Observation is inappropriate because the contracture is symptomatic; empiric antibiotics are not indicated without signs of infection; and implant removal with delayed reconstruction is reserved for refractory or infected cases.

QUESTION 2

SINGLE CHOICE

Compared with a split-thickness skin graft (STSG), a full-thickness skin graft (FTSG) is preferred for defects of the nasal ala because the FTSG provides superior:

- ☐ A Take rate on contaminated wounds
- ☐ B Ability to revascularize by imbibition
- ☒ C Color, texture match, and resistance to contraction
- ☐ D Ease of harvest from large surface areas
- ☐ E Tolerance of ischemic recipient beds such as bare cartilage

ANSWER C

WHY Full-thickness skin grafts retain the full dermal architecture and are preferred on the face, particularly on highly visible and contour-sensitive subunits such as the nasal ala, because they provide better color and texture match, less secondary contraction, and superior long-term aesthetic outcome. STSGs are easier to harvest in large quantities, survive better on less ideal beds (including bare cartilage when combined with bolster and delayed STSG techniques), and rely on the same imbibition/inosculation revascularization process as FTSGs. FTSGs have a lower take rate than STSGs because they are thicker and have higher metabolic demand.

QUESTION 3

SINGLE CHOICE

A 6-month-old infant is diagnosed with unilateral coronal craniosynostosis (anterior plagiocephaly). The characteristic compensatory skull and facial deformity expected on physical examination includes:

- ☐ A Ipsilateral frontal bossing and contralateral occipital flattening
- ☒ B Ipsilateral frontal flattening with contralateral frontal bossing and ipsilateral occipital bossing
- ☐ C Bilateral symmetric forehead recession with a wide, flat occiput
- ☐ D A trapezoidal head shape with biparietal widening
- ☐ E Midline occipital V-shaped depression without frontal involvement

ANSWER B

WHY Unilateral (unicoronal) coronal synostosis produces anterior plagiocephaly with a highly characteristic ipsilateral frontal flattening (the affected side cannot grow perpendicular to the fused suture, so it expands in a compensatory direction), contralateral frontal bossing, ipsilateral occipital and parietal bossing, ipsilateral harlequin orbit, and deviation of the nasal root toward the affected side. Option A describes the inverse pattern. Bilateral coronal synostosis (option C) produces brachycephaly, not plagiocephaly. Trapezoidal skull shape is associated with metopic synostosis (trigonocephaly). Midline occipital V-shaped depression suggests lambdoid pathology, which is uncommon and distinct from coronal synostosis.

QUESTION 4

SINGLE CHOICE

A 28-year-old sustains a deep laceration to the volar radial aspect of the wrist and is unable to extend the interphalangeal joint of the thumb. Tendon exploration most likely reveals injury to the:

- ☒ **A** Extensor pollicis longus tendon
- ☐ **B** Extensor pollicis brevis tendon
- ☐ **C** Flexor pollicis longus tendon
- ☐ **D** Abductor pollicis longus tendon
- ☐ **E** Extensor indicis proprius tendon

ANSWER A

WHY Inability to extend the interphalangeal (IP) joint of the thumb localizes the injury to the extensor pollicis longus (EPL). The EPL passes around Lister's tubercle at the dorsal wrist, where it is vulnerable to attritional rupture (classically after distal radius fracture) and to lacerations at the wrist. The extensor pollicis brevis extends the metacarpophalangeal (MCP) joint of the thumb but cannot extend the IP joint independently. The flexor pollicis longus flexes the IP joint. The abductor pollicis longus abducts the thumb at the MCP/trapeziometacarpal level, and the extensor indicis proprius extends the index finger.

QUESTION 5

SINGLE CHOICE

An adult patient with a 45% total body surface area (TBSA) thermal burn is admitted and resuscitated using the Parkland formula. The most appropriate initial 24-hour fluid administration plan is:

- ☐ A 5% albumin at $0.5 \text{ mL} \times \text{kg} \times \% \text{TBSA}$, half over the first 8 hours
- ☒ B Lactated Ringer's at $4 \text{ mL} \times \text{kg} \times \% \text{TBSA}$, half over the first 8 hours from the time of burn
- ☐ C Lactated Ringer's at $2 \text{ mL} \times \text{kg} \times \% \text{TBSA}$, half over the first 8 hours from the time of burn
- ☐ D Normal saline at $4 \text{ mL} \times \text{kg} \times \% \text{TBSA}$, half over the first 8 hours from time of burn
- ☐ E Lactated Ringer's at $4 \text{ mL} \times \text{kg} \times \% \text{TBSA}$, the entire volume over the first 8 hours from time of burn

ANSWER B

WHY The Parkland formula is $4 \text{ mL} \times \text{body weight (kg)} \times \% \text{TBSA burn}$ of lactated Ringer's over the first 24 hours, with one-half of the calculated volume given in the first 8 hours from the time of the burn (not from time of admission) and the remaining one-half over the following 16 hours. Colloid is not part of the initial Parkland resuscitation. Half normal or $0.5 \text{ mL/kg/\%TBSA}$ is not the Parkland formula. Colloid administration earlier than 12 hours may worsen edema. Crystalloid is titrated to urine output (approximately 0.5 mL/kg/hr in adults) rather than given as a fixed total.

QUESTION 6

SINGLE CHOICE

During an abdominoplasty, which intraoperative maneuver most reliably reduces the risk of postoperative venous thromboembolism related to abdominal wall plication and limited ambulation?

- ☐ A Avoiding the use of any epinephrine-containing local anesthetic solution
- ☒ B Sequential compression devices placed before induction and used continuously intraoperatively
- ☐ C Maintenance of mild intraoperative hypothermia to reduce metabolic demand
- ☐ D Postoperative strict bed rest for the first 48 hours
- ☐ E Use of postoperative tight compression garments as the sole preventive measure

ANSWER B

WHY Abdominoplasty carries a high risk of venous thromboembolism because of long operative time, prolonged pelvic/abdominal flexion, plication of the abdominal wall, and a postoperative period of limited ambulation. Mechanical prophylaxis with properly applied sequential compression devices, started prior to induction and continued throughout the procedure, is the most consistently supported intraoperative measure to reduce venous stasis and is recommended by consensus guidelines (often combined with chemoprophylaxis in higher-risk patients per 2005 Venous Thromboembolism Prevention guidelines from the American Society of Plastic Surgeons). Epinephrine use, mild hypothermia, prolonged bed rest, and compression garments alone do not reduce VTE risk in a comparable, evidence-based manner.

QUESTION 7

SINGLE CHOICE

Six hours after an anterolateral thigh (ALT) free flap for head and neck reconstruction, the flap appears mottled, capillary refill is brisk at 1 second, and the patient has been given a single 5,000-unit bolus of heparin. The most appropriate next step is:

- ☒ **A** Immediate take-back to the operating room for exploration
- ☐ **B** Elevation of the affected limb and ice pack application only
- ☐ **C** Release of several flap sutures to relieve tension and reassess in 6 hours
- ☐ **D** Initiation of systemic antibiotics and continued observation
- ☐ **E** Application of leeches without further workup

ANSWER A

WHY Any change in flap color, turgor, capillary refill, or temperature within the first several postoperative days mandates immediate surgical re-exploration. Salvage rates decline sharply with each hour of delay, and a 'no flap is dead until explored' principle is the standard of care. Congestion (mottling, brisk capillary refill) is not managed expectantly with elevation, ice, suture release, antibiotics, or leeches as a first response when the patient is in the early postoperative window where technical problems at the anastomosis (kinking, compression, thrombus) are the most common and correctable cause. Leeches are reserved for confirmed venous congestion after exploration has been performed or is not feasible.

QUESTION 8

SINGLE CHOICE

The vascular supply of the transverse rectus abdominis myocutaneous (TRAM) flap is based on which of the following arteries?

- ☐ A Superficial inferior epigastric artery
- ☒ B Superior epigastric artery (continuation of the internal mammary artery)
- ☐ C Deep circumflex iliac artery
- ☐ D Lateral thoracic artery
- ☐ E Internal pudendal artery

ANSWER B

WHY The pedicled TRAM flap is based on the superior epigastric artery, the terminal continuation of the internal mammary (internal thoracic) artery, which enters the rectus abdominis muscle superiorly and anastomoses with the deep inferior epigastric system within the muscle. This superior pedicle is what allows rotation of the flap onto the chest for breast reconstruction. The deep inferior epigastric artery is the dominant vascular pedicle of the free TRAM and the DIEP flap, but the conventional pedicled TRAM specifically relies on the superior epigastric pedicle. The superficial inferior epigastric artery supplies a thin cutaneous flap (SIEA flap). The deep circumflex iliac artery supplies the groin/iliac crest flap, and the lateral thoracic and internal pudendal arteries do not supply TRAM flaps.

QUESTION 9

SINGLE CHOICE

A 52-year-old woman undergoes bilateral nipple-sparing mastectomy with immediate subpectoral implant reconstruction. Six weeks postoperatively she presents with acute onset of breast pain, erythema, and fever. Which is the most appropriate next step in management?

- ☐ A Oral antibiotics and observation as an outpatient
- ☒ B Initiate broad-spectrum intravenous antibiotics and obtain urgent imaging to evaluate for implant infection or periprosthetic fluid collection
- ☐ C Immediate explantation without further workup
- ☐ D Aspiration of the implant pocket only if fluctuance is present on physical examination

ANSWER B

WHY Acute postoperative implant infection after breast reconstruction requires prompt broad-spectrum IV antibiotics and imaging (typically ultrasound or CT) to assess for periprosthetic fluid collection, abscess, or device involvement. Outpatient oral therapy is inadequate, immediate explantation without imaging is premature, and waiting for fluctuance delays diagnosis.