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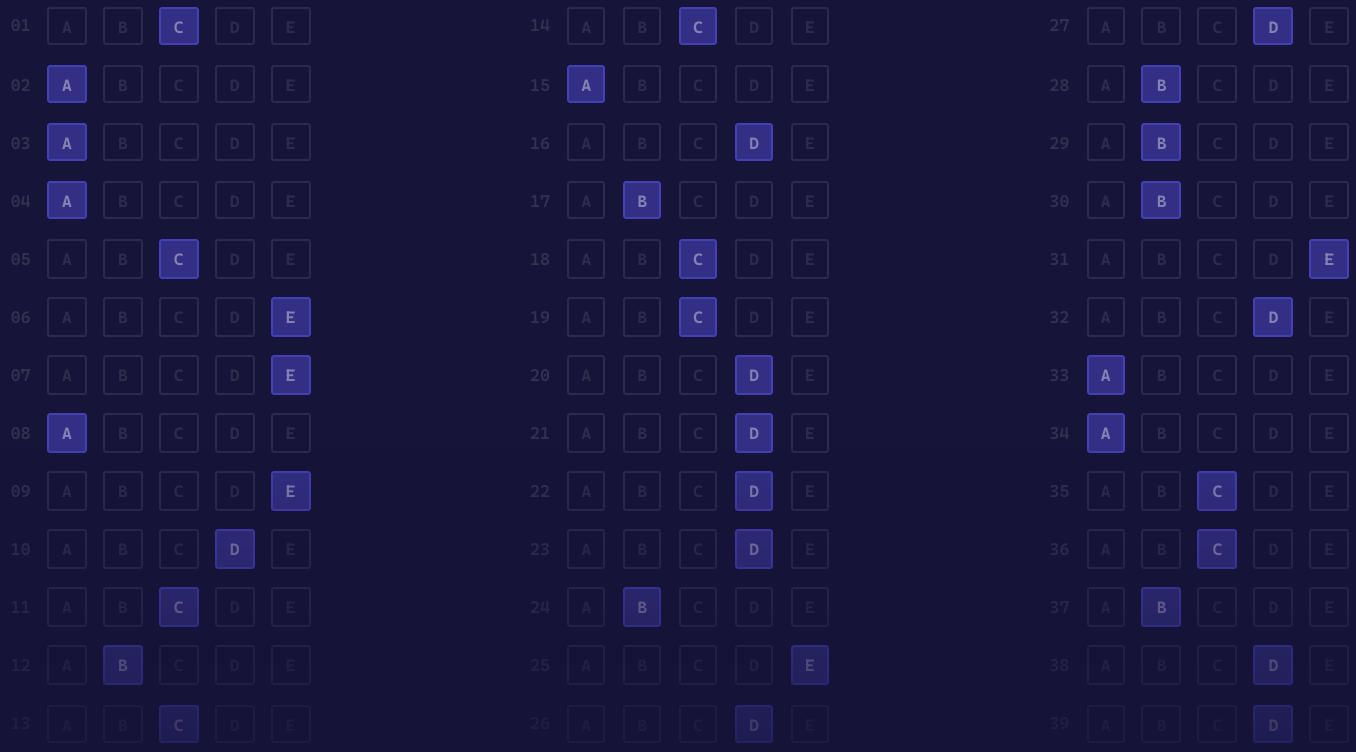

PRACTICE QUESTIONS

Dubai Health Authority (DHA)

CENT

Consultant Otolaryngology

EDITION	QUESTIONS	FORMAT
Demo	9	Limited Edition PDF

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Before you begin

What this is

9 practice questions for Dubai Health Authority (DHA) `CENT`, 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, `CENT`
- the question number
- the email address on your order

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

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QUESTION 1 SINGLE CHOICE

A 45-year-old patient presents with foul-smelling otorrhea and progressive hearing loss in the left ear. Otoscopy reveals a retraction pocket in the pars flaccida with keratin debris. Pure-tone audiometry shows a 40 dB conductive hearing loss. What is the most appropriate next step in management?

A Start topical antibiotic drops and observe

B Order a high-resolution temporal bone CT scan

C Perform myringoplasty

D Prescribe oral antibiotics for 2 weeks

ANSWER B

WHY High-resolution CT of the temporal bone is the imaging study of choice for suspected cholesteatoma. It defines the extent of disease, ossicular involvement, and any bony erosion (e.g., scutum, tegmen, lateral semicircular canal fistula) prior to surgical planning. Topical or oral antibiotics treat infection but do not address the cholesteatoma, and myringoplasty is inappropriate before imaging and surgical planning.

QUESTION 2 SINGLE CHOICE

A 60-year-old woman reports brief episodes of intense spinning vertigo triggered by rolling over in bed to the right, lasting under one minute, with no hearing loss. What is the most likely diagnosis?

A Ménière's disease

B Vestibular neuritis

C Benign paroxysmal positional vertigo

D Labyrinthitis

ANSWER C

WHY BPPV is classically triggered by changes in head position (rolling in bed, looking up, bending over), with episodes lasting seconds to less than a minute and no associated hearing loss. Ménière's disease involves fluctuating sensorineural hearing loss, tinnitus, and aural fullness with longer vertigo spells. Vestibular neuritis and labyrinthitis cause continuous, spontaneous vertigo lasting days, not positionally triggered brief episodes.

QUESTION 3 SINGLE CHOICE

A 38-year-old man presents with sudden onset of left-sided hearing loss and tinnitus that started 3 days ago. Otoscopy is normal. Weber test lateralizes to the right ear. Which of the following is the most appropriate initial treatment?

A Oral antibiotics for 10 days

B Intratympanic steroids only

C **High-dose oral corticosteroids started promptly**

D Watchful waiting for 2 weeks

ANSWER **C**

WHY Sudden sensorineural hearing loss (SSNHL) is typically treated with prompt high-dose oral corticosteroids (e.g., prednisone 1 mg/kg/day) ideally within the first 2 weeks to maximize hearing recovery. Antibiotics are not indicated, watchful waiting reduces the chance of recovery, and intratympanic steroids alone is usually reserved for steroid-non-responders or as salvage therapy rather than initial monotherapy.

QUESTION 4 SINGLE CHOICE

A 58-year-old smoker presents with a 4-week history of hoarseness and a left neck mass. Laryngoscopy shows an ulcerated lesion of the left true vocal cord with impaired mobility. Fine-needle aspiration of the neck node is consistent with squamous cell carcinoma. What is the most appropriate initial imaging study for staging?

A Chest X-ray

B **Contrast-enhanced CT of the neck and chest**

C MRI of the brain

D Ultrasound of the abdomen

ANSWER **B**

WHY Contrast-enhanced CT of the neck (to assess the primary, cartilage invasion, nodal disease, and retropharyngeal nodes) plus chest imaging (CT chest) is standard for staging laryngeal squamous cell carcinoma, because the lungs are the most common site of distant spread. Brain MRI is reserved for specific indications, not routine staging, and a chest X-ray alone is less sensitive than CT chest.

QUESTION 5 SINGLE CHOICE

A patient with chronic rhinosinusitis with nasal polyps has failed maximal medical therapy, including oral corticosteroids and multiple courses of appropriate antibiotics. What is the next appropriate step?

A Another prolonged course of antibiotics

B Endoscopic sinus surgery

C Inferior turbinate reduction only

D Continued observation for 6 months

ANSWER B

WHY When chronic rhinosinusitis with nasal polyps is refractory to maximal medical therapy (intranasal saline, intranasal corticosteroids, systemic corticosteroids, and appropriate antibiotics), endoscopic sinus surgery is indicated to open the sinuses and remove polyps. Repeat antibiotics without proven infection, isolated turbinate surgery, or further observation would not address the polyp burden and diseased sinuses.

QUESTION 6 SINGLE CHOICE

A 35-year-old schoolteacher presents with hoarseness for 2 months without infection or reflux symptoms. She uses her voice heavily. Videostroboscopy shows bilateral symmetric vocal cord nodules at the mid-membranous vocal cords with a mid-membranous gap on phonation. What is the first-line management?

A Microlaryngoscopic excision of the nodules

B Voice therapy and behavioral modification

C Injection laryngoplasty

D Proton pump inhibitor therapy

ANSWER B

WHY Bilateral vocal cord nodules in a professional voice user are typically managed first with voice therapy and behavioral modification (hydration, voice rest, technique training). Surgical excision is reserved for lesions that fail a complete course of voice therapy. Injection laryngoplasty is for glottic insufficiency, and PPI therapy is indicated only when laryngopharyngeal reflux is suspected.

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QUESTION 7 SINGLE CHOICE

A 52-year-old man with BMI 34 kg/m^2, loud snoring, witnessed apneas, and Epworth Sleepiness Scale score of 16 has polysomnography showing AHI 42/h and minimal oxygen desaturation to 88%. What is the first-line treatment?

A Uvulopalatopharyngoplasty alone

B Weight loss counseling only

C CPAP therapy

D Mandibular advancement splint

ANSWER C

WHY For severe obstructive sleep apnea (AHI ≥ 30/h), CPAP is the first-line treatment regardless of symptom severity, as it is the most effective at reducing AHI and cardiovascular risk. UPPP alone has limited efficacy, weight loss alone is insufficient for severe disease in the short term, and mandibular advancement splints are typically reserved for mild-to-moderate OSA or CPAP-intolerant patients.

QUESTION 8 SINGLE CHOICE

A 2-year-old child with acute otitis media has had persistent symptoms (fever, ear pain, bulging tympanic membrane) despite 72 hours of high-dose amoxicillin. There is no history of penicillin allergy. What is the most appropriate next antibiotic choice?

A Continue amoxicillin for another 72 hours

B Switch to amoxicillin-clavulanate (high-dose)

C Start oral azithromycin

D Administer a single dose of IM ceftriaxone

ANSWER B

WHY Treatment failure of acute otitis media after 72 hours of high-dose amoxicillin in a child without penicillin allergy is most commonly due to beta-lactamase–producing Haemophilus influenzae or Moraxella catarrhalis. The recommended next step is high-dose amoxicillin-clavulanate. Continuing amoxicillin alone, switching to azithromycin (less effective against resistant pneumococcus and H. influenzae), or giving IM ceftriaxone (reserved for vomiting or severe failure) is not the preferred initial change.

QUESTION 9 MULTIPLE CHOICE

A 7-year-old presents with fever, postauricular swelling, and protrusion of the right auricle following a recent episode of acute otitis media. (Choose two.)

A **Acute mastoiditis**

B Acute petrositis

C Cerebrospinal fluid otorrhea

D **Subperiosteal abscess**

ANSWER **A** · **D**

WHY Postauricular swelling with auricular protrusion following acute otitis media is the classic presentation of acute mastoiditis, and progression commonly produces a subperiosteal abscess over the mastoid as infection erodes the cortex. Acute petrositis presents with the triad of otorrhea, pain in the trigeminal distribution, and abducens palsy (Gradenigo syndrome). CSF otorrhea reflects a dural/tegment defect, which is not implied by these findings alone.

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