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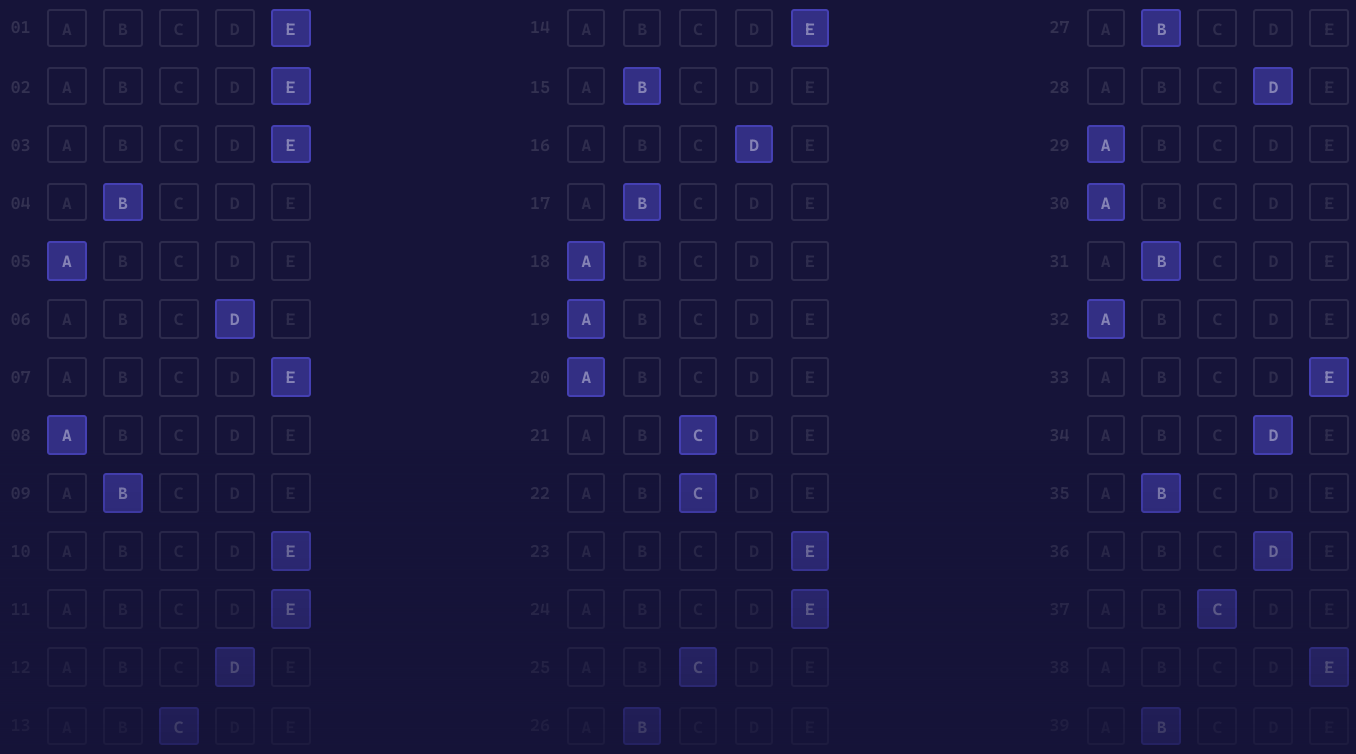

PRACTICE QUESTIONS

Saudi Commission For Health Specialties (SCFHS)

UROLO

Urology

EDITION	QUESTIONS	FORMAT
Demo	9	Limited Edition PDF

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Before you begin

What this is

9 practice questions for Saudi Commission For Health Specialties (SCFHS) `UROLO`, 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, `UROLO`
- 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 68-year-old man with symptomatic BPH has failed treatment with both an alpha-blocker (tamsulosin) and a 5-alpha-reductase inhibitor (finasteride). His prostate volume on transrectal ultrasound is 95 g. He has persistent International Prostate Symptom Score (IPSS) of 24 and recurrent urinary retention. Which of the following is the most appropriate next surgical intervention?

A Transurethral resection of the prostate (TURP)

B Transurethral incision of the prostate (TUIP)

C Open simple prostatectomy

D Rezum water vapor thermal therapy

ANSWER C

WHY For large prostates (>80–100 g), especially in patients who have failed medical therapy, current AUA guidelines favor open simple prostatectomy or holmium laser enucleation over TURP because TURP becomes technically difficult and time-consuming at this size. TUIP is reserved for prostates <30 g, and Rezum is generally indicated for smaller prostates (typically <80 g) and is less appropriate after failed combination medical therapy with a gland of this size.

QUESTION 2 SINGLE CHOICE

A 62-year-old man has a serum PSA of 6.8 ng/mL and a prostate biopsy showing Gleason 4+4=8 adenocarcinoma in 4 of 12 cores, with perineural invasion but no evidence of extraprostatic extension on MRI. According to ISUP/WHO 2014 grade grouping, this tumor is classified as which Grade Group?

A Grade Group 2

B Grade Group 3

C Grade Group 4

D Grade Group 5

ANSWER C

WHY The ISUP/WHO 2014 Grade Groups are: Group 1 = Gleason ≤6; Group 2 = Gleason 3+4=7; Group 3 = Gleason 4+3=7; Group 4 = Gleason 8 (which includes 4+4, 3+5, and 5+3); Group 5 = Gleason 9–10. Gleason 4+4=8 corresponds to Grade Group 4.

QUESTION 3 SINGLE CHOICE

A 45-year-old woman presents with right flank pain and hematuria. Non-contrast CT shows a 7 mm stone in the proximal ureter with mild hydronephrosis and no signs of infection or renal failure. She is afebrile and tolerating oral intake. What is the most appropriate initial management?

A Immediate ureteroscopy

B Percutaneous nephrolithotomy (PCNL)

C Medical expulsive therapy with an alpha-blocker (e.g., tamsulosin) and analgesia

D Extracorporeal shock wave lithotripsy (ESWL)

ANSWER C

WHY For an uncomplicated ureteral stone <10 mm without infection or obstruction, current AUA/EAU guidelines recommend a trial of passage with medical expulsive therapy (alpha-blocker such as tamsulosin) plus analgesia. Stones <5 mm often pass spontaneously; stones 5–10 mm may pass with MET. Intervention is reserved for failure of passage, persistent obstruction, infection, or intractable symptoms.

QUESTION 4 SINGLE CHOICE

A 17-year-old boy presents with sudden onset severe left scrotal pain, nausea, and a high-riding left testis with absent cremasteric reflex, 3 hours after symptom onset. The most appropriate next step is:

A Urgent scrotal exploration with detorsion and bilateral orchiopexy

B Start intravenous antibiotics and observe

C Obtain a scrotal Doppler ultrasound before any intervention

D Order a urinalysis and treat for epididymitis

ANSWER A

WHY Testicular torsion is a urologic emergency. The testicular salvage rate is highest within 6 hours of symptom onset. Clinical findings of sudden pain, high-riding testis, and absent cremasteric reflex are highly suggestive, and immediate surgical exploration with detorsion and bilateral orchiopexy should not be delayed for imaging. Doppler ultrasound may show absent flow, but only if it does not delay surgery.

QUESTION 5 SINGLE CHOICE

A 52-year-old multiparous woman complains of involuntary leakage of urine with coughing, sneezing, and lifting. She has no nocturnal leakage, no urgency, and a normal post-void residual. Pelvic exam shows urethral hypermobility. Which of the following is the most appropriate first-line management?

A Midurethral sling (e.g., transobturator tape)

B **Pelvic floor (Kegel) muscle training**

C Botulinum toxin injection into the detrusor

D Augmentation cystoplasty

ANSWER B

WHY This is classic stress urinary incontinence (SUI) without features of urgency or urge incontinence. First-line therapy for SUI is conservative: pelvic floor muscle (Kegel) training, often combined with weight loss and behavioral modification. Surgical options such as midurethral sling are offered only after failure of conservative therapy or when the patient desires surgery. Botulinum toxin and augmentation cystoplasty are treatments for refractory overactive bladder or detrusor overactivity, not SUI.

QUESTION 6 SINGLE CHOICE

A 60-year-old man undergoes transurethral resection of a bladder tumor (TURBT). Pathology shows a Ta, low-grade urothelial carcinoma without lamina propria invasion. According to AUA risk stratification, this lesion is classified as:

A **Low-risk non-muscle-invasive bladder cancer (NMIBC)**

B Intermediate-risk NMIBC

C High-risk NMIBC

D Muscle-invasive bladder cancer

ANSWER A

WHY AUA/EAU risk stratification for NMIBC classifies Ta low-grade tumors (without carcinoma in situ) as low risk. Intermediate risk includes Ta low-grade with recurrence within 1 year, multifocal, or large (>3 cm), and Ta high-grade without CIS. High risk includes Ta high-grade with CIS, T1, or CIS alone. This patient has a Ta low-grade lesion, which is low risk.

QUESTION 7 SINGLE CHOICE

A 58-year-old man with type 2 diabetes mellitus presents with progressive erectile dysfunction over 2 years. He has tried oral PDE5 inhibitors (sildenafil and tadalafil) with suboptimal response. Examination is normal and his morning total testosterone is 320 ng/dL. Which of the following is the most appropriate next-line therapy?

A Start testosterone replacement therapy

B Intracavernosal injection therapy (e.g., alprostadil)

C Penile prosthesis implantation

D Switch to a higher dose of tadalafil

ANSWER B

WHY For PDE5 inhibitor non-responders with normal testosterone levels and no contraindication, the next step is a second-line therapy such as intracavernosal injection (alprostadil or combination therapy) or a vacuum erection device, per AUA/EAU guidelines. Testosterone replacement is not indicated since the patient's testosterone is in the normal range (>300 ng/dL) and he does not have symptomatic hypogonadism. Penile prosthesis is reserved for failure of all less invasive options.

QUESTION 8 SINGLE CHOICE

A 58-year-old man is incidentally found on abdominal ultrasound to have a 4.5 cm solid enhancing right renal mass. There is no evidence of venous invasion or distant metastases. According to current guidelines, the preferred surgical approach for this patient is:

A Radical nephrectomy

B Open partial nephrectomy

C Laparoscopic or robotic partial nephrectomy

D Radiofrequency ablation

ANSWER C

WHY For a T1b renal mass (4–7 cm), current AUA and EAU guidelines recommend nephron-sparing surgery (partial nephrectomy) over radical nephrectomy when feasible, as it provides equivalent oncologic control while preserving renal function and reducing cardiovascular morbidity. Minimally invasive (laparoscopic or robotic) partial nephrectomy is the preferred approach when expertise is available. Ablative therapies such as RFA are reserved for patients who are not surgical candidates or have small (<3 cm) tumors.

QUESTION 9 MULTIPLE CHOICE

Which of the following are recognized categories of prostatitis according to the National Institutes of Health (NIH) classification? (Choose two.)

A Acute bacterial prostatitis

B Granulomatous prostatitis only

C Chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS)

D Asymptomatic inflammatory prostatitis

ANSWER A · C

WHY The NIH classification of prostatitis includes: I — Acute bacterial prostatitis; II — Chronic bacterial prostatitis; III — Chronic prostatitis/chronic pelvic pain syndrome (inflammatory and non-inflammatory subtypes); IV — Asymptomatic inflammatory prostatitis. Granulomatous prostatitis is a histologic/etiologic variant (e.g., post-BCG, tuberculous) and is not a separate NIH category. Both acute bacterial prostatitis and CP/CPPS are part of the NIH classification, making A and C correct.