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PRACTICE QUESTIONS

Ministry of Health Kuwait Medical Licensing Department

SGI

Gastroenterology for Senior

EDITION

Demo

QUESTIONS

9

FORMAT

Limited Edition PDF

Before you begin

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9 practice questions for Ministry of Health Kuwait Medical Licensing Department **SGI**, 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.

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Send us three things and we will check it:

- the exam code, **SGI**
- the question number
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QUESTION 1

SINGLE CHOICE

A 58-year-old man presents with progressive dysphagia to both solids and liquids over the past 6 months, along with regurgitation of undigested food and halitosis. Barium swallow shows a dilated esophagus with a 'bird's beak' narrowing at the lower esophageal sphincter. Which of the following is the most likely diagnosis?

- ☒ **A** Achalasia
- ☐ **B** Diffuse esophageal spasm
- ☐ **C** Esophageal squamous cell carcinoma
- ☐ **D** Zenker's diverticulum

ANSWER A

WHY The classic clinical picture of progressive dysphagia to solids and liquids, regurgitation of undigested food, and a barium swallow showing a dilated esophagus with 'bird's beak' narrowing at the LES is characteristic of achalasia. Diffuse esophageal spasm typically presents with chest pain and intermittent dysphagia with a 'corkscrew' esophagus. Squamous cell carcinoma would show an irregular mucosal lesion or apple-core stricture, not a smooth tapered narrowing. Zenker's diverticulum is an outpouching in the upper esophagus presenting with oropharyngeal dysphagia and halitosis.

QUESTION 2

SINGLE CHOICE

A 32-year-old woman presents with chronic bloody diarrhea, urgency, and weight loss. Colonoscopy reveals continuous inflammation limited to the rectum and sigmoid colon, with friable mucosa and loss of vascular pattern. Biopsy shows crypt abscesses and a diffuse inflammatory infiltrate confined to the mucosa. Which of the following is the most appropriate first-line maintenance therapy?

- ☒ **A** Oral mesalamine (5-ASA)
- ☐ **B** Infliximab (anti-TNF)
- ☐ **C** Sulfasalazine with corticosteroids
- ☐ **D** Total proctocolectomy

ANSWER A

WHY The findings are classic for ulcerative colitis limited to the distal colon (proctosigmoiditis). The first-line maintenance therapy for mild to moderate ulcerative colitis is oral 5-aminosalicylic acid (mesalamine), often combined with topical mesalamine for left-sided disease. Infliximab is reserved for moderate to severe disease refractory to 5-ASA or steroids. Surgery is curative but reserved for refractory disease, dysplasia, or cancer. Sulfasalazine with corticosteroids would not be appropriate first-line maintenance.

QUESTION 3

SINGLE CHOICE

A 65-year-old man with a history of alcohol abuse presents with jaundice, pruritus, and weight loss. Laboratory studies show: total bilirubin 12 mg/dL, direct bilirubin 9 mg/dL, alkaline phosphatase 650 U/L, ALT 120 U/L, AST 95 U/L. CT scan reveals a mass in the head of the pancreas with biliary ductal dilation. What is the most likely diagnosis?

- ☒ **A** Pancreatic head adenocarcinoma with obstructive jaundice
- ☐ **B** Acute alcoholic hepatitis
- ☐ **C** Cholangiocarcinoma of the common bile duct
- ☐ **D** Primary sclerosing cholangitis

ANSWER A

WHY A pancreatic head mass causing painless obstructive jaundice (direct hyperbilirubinemia with markedly elevated alkaline phosphatase and only mildly elevated transaminases) is most consistent with pancreatic head adenocarcinoma. The clinical context (older age, weight loss), the cholestatic pattern, and imaging findings support this diagnosis. Acute alcoholic hepatitis would present with hepatocellular pattern (AST/ALT >2), not cholestatic. Cholangiocarcinoma would not typically show a pancreatic mass. PSC shows multifocal strictures on cholangiography rather than a discrete mass.

QUESTION 4

SINGLE CHOICE

A 45-year-old man presents with melena and hemodynamic instability (BP 90/60, HR 120). Upper endoscopy reveals a 2 cm actively bleeding ulcer in the duodenal bulb with a visible vessel (Forrest IIa). After endoscopic therapy with epinephrine injection and thermal coagulation, which of the following adjunctive pharmacologic therapies is most appropriate?

- ☒ **A** High-dose intravenous proton pump inhibitor (PPI)
- ☐ **B** Oral H2 receptor antagonist
- ☐ **C** Octreotide infusion
- ☐ **D** Sucralfate orally

ANSWER A

WHY After successful endoscopic hemostasis of a high-risk peptic ulcer lesion (Forrest IIa - visible vessel), high-dose IV PPI therapy (e.g., pantoprazole 80 mg bolus followed by 8 mg/hour infusion) is the standard of care. It maintains gastric pH >6 to stabilize clot formation and reduce rebleeding risk. H2RAs are less effective. Octreotide is used for variceal bleeding. Sucralfate is not appropriate for acute management of active bleeding.

QUESTION 5

SINGLE CHOICE

A 28-year-old man with known Crohn's disease presents with fever, right lower quadrant pain, and a palpable mass. CT scan shows thickening of the terminal ileum with surrounding mesenteric inflammation and a localized abscess. Which of the following is the most appropriate next step in management?

- ☒ **A** Percutaneous drainage of the abscess with intravenous antibiotics
- ☐ **B** Immediate surgical resection of the terminal ileum
- ☐ **C** Start high-dose oral corticosteroids
- ☐ **D** Increase the dose of azathioprine

ANSWER A

WHY In Crohn's disease complicated by an intra-abdominal abscess, the standard initial management is percutaneous (image-guided) drainage combined with broad-spectrum IV antibiotics. This approach controls sepsis and allows for elective rather than emergency surgery, which is associated with better outcomes. Immediate surgery is reserved for failure of drainage, perforation, or complete obstruction. Steroids are contraindicated in the setting of uncontrolled infection. Escalating immunosuppression alone is inappropriate.

QUESTION 6

SINGLE CHOICE

A 50-year-old woman with autoimmune hepatitis on long-term azathioprine and prednisone presents with progressive fatigue and pruritus. Labs: ALT 65 U/L, AST 60 U/L, ALP 480 U/L, GGT 520 U/L, total bilirubin 3.5 mg/dL. MRCP shows multifocal strictures and beading of the intra- and extrahepatic bile ducts. ANA negative, p-ANCA positive. What is the most likely associated diagnosis?

- ☒ **A** Primary sclerosing cholangitis
- ☐ **B** Primary biliary cholangitis
- ☐ **C** Cholangiocarcinoma
- ☐ **D** Overlap syndrome with autoimmune hepatitis only

ANSWER A

WHY The MRCP findings of multifocal strictures and beading of intra- and extrahepatic bile ducts are diagnostic of primary sclerosing cholangitis (PSC). The p-ANCA positivity supports PSC. PSC is associated with ulcerative colitis (not specifically listed here). Primary biliary cholangitis would show AMA positivity and affect only small intrahepatic ducts. Cholangiocarcinoma may develop in PSC but would show a dominant stricture or mass, not diffuse beading. The cholestatic enzyme pattern is consistent with biliary involvement.

QUESTION 7

SINGLE CHOICE

A 35-year-old man presents with prolonged diarrhea (3 weeks), bloating, and weight loss after returning from a trip abroad. Stool microscopy reveals trophozoites with ingested red blood cells. Which of the following is the most appropriate treatment?

- ☒ **A Metronidazole**
- ☐ B Albendazole
- ☐ C Oral vancomycin
- ☐ D Nitazoxanide

ANSWER A

WHY Trophozoites with ingested red blood cells on stool microscopy are pathognomonic for *Entamoeba histolytica* (erythrophagocytosis). The treatment of choice for invasive amebiasis (dysentery or extraintestinal disease) is metronidazole followed by a luminal agent (paromomycin) to eradicate intraluminal cysts. Albendazole is for helminths. Oral vancomycin treats *C. difficile*. Nitazoxanide is used for *Giardia* or *Cryptosporidium*.

QUESTION 8

MULTIPLE CHOICE

A 52-year-old man with a strong family history of colorectal cancer (father diagnosed at age 50, brother at 45) undergoes colonoscopy. Two tubular adenomas (8 mm and 6 mm) are removed. Which of the following are appropriate recommendations for ongoing surveillance? (Choose two.)

- ☒ **A** Repeat colonoscopy in 3 years
- ☐ **B** Annual CT abdomen for metastasis screening
- ☒ **C** Genetic counseling and consideration of testing for Lynch syndrome
- ☐ **D** Initiate annual fecal immunochemical testing (FIT)
- ☐ **E** CEA level every 6 months

ANSWER A - C

WHY For a patient with a strong family history of colorectal cancer and 2 tubular adenomas removed, the appropriate surveillance includes: (A) Repeat colonoscopy in 3 years (per post-polypectomy surveillance guidelines when multiple adenomas are found, and given strong family history). (C) Genetic counseling for Lynch syndrome evaluation, given that two first-degree relatives were diagnosed with CRC, one before age 50. CT abdomen, FIT, and CEA are not appropriate for routine post-polypectomy surveillance in this setting.

QUESTION 9

MULTIPLE CHOICE

A 70-year-old woman presents with sudden severe epigastric pain radiating to the back, vomiting, and hypotension. Labs: amylase 850 U/L, lipase 1200 U/L, WBC 18,000, lactate 4.5 mmol/L, calcium 7.8 mg/dL. CT abdomen shows pancreatic necrosis involving 40% of the gland. Which of the following are appropriate early management steps? (Choose two.)

- ☒ **A** Aggressive IV fluid resuscitation with isotonic crystalloid
- ☐ **B** Prophylactic broad-spectrum IV antibiotics
- ☒ **C** NPO and early enteral feeding via nasojejunal tube
- ☐ **D** Immediate surgical debridement (necrosectomy)
- ☐ **E** ERCP with sphincterotomy within 24 hours

ANSWER A - C

WHY Early management of severe acute pancreatitis with organ failure and extensive necrosis includes: (A) Aggressive IV fluid resuscitation with isotonic crystalloid (lactated Ringer's) within the first 24 hours, as hypovolemia is a key driver of organ failure. (C) NPO with early enteral feeding (preferably via nasojejunal or oral if tolerated) is preferred over parenteral nutrition to maintain gut barrier function. Prophylactic antibiotics are no longer recommended unless infected necrosis is confirmed. Surgery is delayed (4-6 weeks) when possible. ERCP is only indicated if there is cholangitis or persistent biliary obstruction.