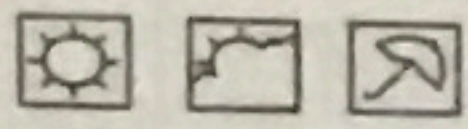


SURGERY  
ANNUAL  
2011

Memo No. \_\_\_\_\_  
Date. \_\_\_\_/\_\_\_\_/\_\_\_\_





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Q2 Rx

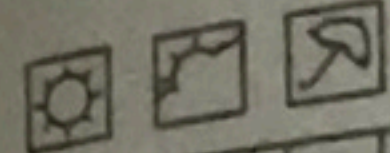
Adults:

Open reduction  
internal fixation

with plates

Plates applied to both bones via  
separate incision.

Restore length alignment rotation



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Q3

a) Thyroid carcinoma.

b) Investigations.

.) FNAC

.) incisional, true cut

biopsy.

.) CT, MRI for extent of

tumor.

c)



Q4

a) Breast carcinoma

b) Mammogram

FNAC

True cut needle biopsy

incisional biopsy

MRI

c) Manchester Staging System.

Stage I: Mobile breast lump. No axillary nodes palpable.

Stage II: Mobile lump, palpable mobile axillary nodes.

Stage III: Fixed lump without palpable axillary nodes.

Stage IV: Distant metastasis.

Q5 a) Renal Stones.

b) X-ray KUB:

Calcium oxalate  
struvite & phosphate stones are  
radio-opaque (visible on x-ray)

U/S

IV urogram

provides anatomical  
detail & functional status of  
entire renal tract.

CT KUB picks all types of  
radio-opaque & radio lucent stones  
throughout the renal tract.



c.) Observation

90% resolve.

< 5mm pass spontaneously

Analgesics, antibiotics & plenty of fluids

.) Medical expulsion therapy

6-8mm stones can pass with medication

Cap. Tamsulosin ( $\alpha$ -blocker)

Analgesis

Plenty of fluids

.) ESWL

For <sup>renal</sup> stones < 2cm

Ureteric stone < 1cm

.) Percutaneous nephrolithotomy (PCNL)

< 2cm 90% clearance

> 2cm 80% (PCNL + ESWL)

PCNL for

Staghorn stones

Large renal stones (> 2.5cm)

Failed ESWL

.) Retrograde intrarenal surgery

.) Open surgery

Failure of ESWL, PCNL

PCNL

Open surgery types:

.) Pyelolithotomy

.) Open Extended Pyelolithotomy

.) Anatomic nephrolithotomy

.) Partial nephrectomy



Q. a) CA Tongue

b) Investigation.

Biopsy

FNA C

MRI

CT scan

c) Treatment

T<sub>1</sub> (< 2cm) :

Partial glossectomy

T<sub>2</sub> :

Hemiglossectomy

T<sub>3</sub>, T<sub>4</sub> :

Total glossectomy & resection including floor of mouth & mandible.



Q7 a) Meckel's diverticulum

b)

To stop bleeding → endoscopy  
Segmental resection of ileum

Resection in case of diverticulitis  
or obstruction.

End to end anastomoses in obstruction

incidental → diverticulectomy

Q8 a) Carcinoma Caecum

b) Barium meal

CBC, ESR

U/S abdomen

Sputum for AFB

Moutoux test

c) Right hemicolectomy

ileotransversostomy

en bloc resection



Q9 a) Infantile hypertrophic pyloric stenosis

- b) .) Adequately rehydrated
- .) Correction of hypochloremic hypokalemic alkalosis
- .) Correction of dehydration by 0.9% saline
- KCl in 5% glucose
- .) Oral feeding discontinued
- .) Stomach emptied by NG tube
- .) Laproscopic or open Ramstedt pyloromyotomy

Q11 a) Caecinoma Prostate

- b) .) Digital Rectal Examination
- Prostatic specific antigen
- Transrectal U/S & biopsy
- MRI & CT scan
- Bone scan
- Radiography (CXR)
- LFTs
- c) .) Bladder injury
- Bleeding
- Electrolyte imbalance
- Infection
- Erectile dysfunction
- Dysuria
- Retrograde ejaculation



Q10

a) Anal Fissure

b) .) Conservative Rx :

Stool softness  
↑ fibre diet  
sitz bath

.) Nitrites

→ Nitric oxide

causes relaxation of smooth muscle

→ Topical glycerol trinitrate

.) Botulinum Toxin

Prevents release of Ach

.) Manual dilation of anus

.) Lat. internal sphincterotomy

.) Anal advancement flap

c) Surgical:

.) Lat. internal sphincterotomy

Fibres of internal sphincter are divided  
Sphincter tone is decreased which  
reduces pain and promotes vascularity  
and wound healing.

.) Anal advancement flap.

The edges of fissure are excised &  
wound is covered by flap.

Used in chronic non-healing  
fissure.



Q12

a) Haemothorax

b)

Erect → blunting of costophrenic angle

Supine → Epical capping of fluid

c) Chest intubation → Drain blood & air & to re-expand lungs.  
(Tube thoracostomy)

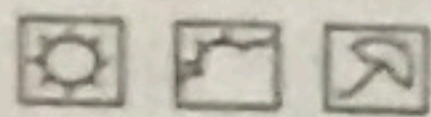
Q13 a) Spinal Shock

When spinal cord is suddenly and severely impacted the reflex functions in segments of isolated spinal cord are suspended including autonomic functions. This state is of variable duration. 1-6 weeks but may be longer. Initially there is areflexia followed by stage of hyperreflexia.

b) GCS

is the most widely used scoring system in quantifying the level of consciousness following traumatic brain injury. It is used because it is simple, has high degree of reliability and correlates well with outcome of severe brain injury.





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One determines the best eye opening responses, the best verbal response and the best motor responses.

It is the sum of numeric scores of each category.

GCS 14-15 Mild head injury

GCS 9-13 Moderate head injury

GCS 3-8 Severe head injury