PAEA SURGERY END OF ROTATION (EOR) PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

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How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

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Questions

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1. Which of the following sutures is classified as non-absorbable?

A. Vicryl

B. Monocryl

C. Silk

D. PDS (polydioxanone)

2. Where should the needle be inserted during a needle decompression?

A. Between the 4th and 5th rib

B. Between the 2nd and 3rd rib

C. Above the 3rd rib, midclavicular line

D. Under the 5th rib, anterior axillary line

3. What is the test of choice for diagnosing DVT?

A. CT scan

B. Doppler ultrasound

C. Venography

D. X-ray

4. What is the initial diagnostic evaluation recommended for nephrolithiasis?

A. Chest X-ray

B. Ultrasound or CT scan

C. Magnetic resonance imaging

D. Electrocardiogram

5. Which laboratory findings are typically elevated in a patient with cholecystitis?

A. Increased serum amylase

B. Increased WBC and minor LFT abnormalities

C. Increased creatinine levels

D. Decreased alkaline phosphatase

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6. What type of carcinoma is most common after proctocolectomy in patients with familial polyposis?

A. Colorectal carcinoma

B. Duodenal carcinoma

C. Pyloric carcinoma

D. Gastric carcinoma

7. In a surgical patient presenting with dyspnea on exertion, what condition should most urgently be ruled out?

A. Pneumonia

B. Pulmonary embolism

C. Asthma attack

D. Pneumothorax

8. How long does it typically take for skin and mucosa wounds to heal?

A. 3-5 days

B. 5-7 days

C. 7-10 days

D. 10-14 days

9. What are the three most common causes of small bowel obstruction?

A. Adhesions, bulge (hernia), and cancer

B. Infection, inflammation, and trauma

C. Strictures, masses, and foreign bodies

D. Crohn's disease, diverticulitis, and volvulus

10. What does the "rule of 2's" describe regarding Meckel's diverticulum?

A. 2 inches long, 2 types of ectopic tissue

B. 2 feet from ileocecal valve, 2% of population

C. All of the above

D. 2 times as common in females

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Answers

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1. C
2. C
3. B
4. B
5. B
6. B
7. B
8. B
9. A
10. C

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Explanations

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1. Which of the following sutures is classified as non-absorbable?

A. Vicryl

B. Monocryl

C. Silk

D. PDS (polydioxanone)

Silk is classified as a non-absorbable suture, which makes it suitable for applications where long-term tissue support is required. Non-absorbable sutures are typically used in situations where it is important for the suture to maintain its strength and integrity for an extended period, such as in skin closures, some types of vascular surgeries, and in areas where high tension is expected. Silk sutures are made from natural fibers and are known for their ease of use and excellent handling properties. They have a lower tissue reactivity compared to some other materials and provide a reliable option for wound closure that is intended to remain in place for an extended duration, pending the healing of the tissue. In contrast, Vicryl and Monocryl are absorbable sutures. Vicryl is a braided polyglactin suture that loses its tensile strength over time as it is gradually absorbed by the body. Monocryl is a monofilament suture made from poliglecaprone and is also absorbable, breaking down relatively quickly compared to Vicryl. PDS, while designed for longer absorption times, is also considered an absorbable suture. Therefore, silk stands out as the non-absorbable option among the sut

2. Where should the needle be inserted during a needle decompression?

A. Between the 4th and 5th rib

B. Between the 2nd and 3rd rib

C. Above the 3rd rib, midclavicular line

D. Under the 5th rib, anterior axillary line

During a needle decompression, particularly for cases such as tension pneumothorax, the most efficient and effective entry point is above the 3rd rib at the midclavicular line. This approach is critical due to the anatomical considerations of avoiding injury to the underlying structures. The intercostal vessels and nerves are located just below the ribs, so inserting a needle above the 3rd rib minimizes the risk of damaging these vessels and nerves. The midclavicular line is a standard reference point that helps ensure proper placement and effectiveness of the decompression. In cases of pneumothorax, this site allows for the rapid release of trapped air in the pleural space and can quickly relieve respiratory distress, making it a critical skill in emergency scenarios. Choosing other sites might not only be less effective in relieving the pressure but could also pose a higher risk of complications, such as vascular injury or inadequate decompression.

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3. What is the test of choice for diagnosing DVT?

A. CT scan

B. Doppler ultrasound

C. Venography

D. X-ray

Doppler ultrasound is the test of choice for diagnosing deep vein thrombosis (DVT) due to its high sensitivity and specificity for detecting thrombi in the deep veins. This non-invasive imaging technique uses sound waves to visualize blood flow in the veins and can indicate the presence of a clot by assessing the patency of the venous system. It can easily be performed in an outpatient setting, is widely available, and avoids the risks associated with more invasive procedures. Other modalities, such as CT scans and venography, are less commonly used for initial DVT assessment. While CT scans can provide valuable information, they are more often utilized for other conditions, like pulmonary embolism. Venography, although considered a definitive test, is invasive and involves injecting contrast dye into the venous system, which can be risky and is typically reserved for cases where ultrasound results are inconclusive. X-rays do not provide information about soft tissues and are ineffective for diagnosing DVT, as they primarily visualize bone structures. Thus, Doppler ultrasound remains the preferred first-line diagnostic tool.

4. What is the initial diagnostic evaluation recommended for nephrolithiasis?

A. Chest X-ray

B. Ultrasound or CT scan

C. Magnetic resonance imaging

D. Electrocardiogram

The recommended initial diagnostic evaluation for nephrolithiasis is ultrasound or CT scan. These imaging modalities are advantageous for several reasons. Ultrasound is a non-invasive option that provides real-time imaging and avoids exposure to ionizing radiation, making it particularly useful in children or pregnant women. It can effectively identify the presence of kidney stones and assess the reniform structure. CT scans, specifically non-contrast helical CT, are highly sensitive and specific for detecting renal calculi. They can visualize stones in detail, providing information on size, location, and whether there are any complications such as hydronephrosis. This makes CT scanning the gold standard in many cases. In contrast to the other options, chest X-rays are not helpful in diagnosing kidney stones, as they primarily assess lung pathology. Magnetic resonance imaging (MRI) is not routinely used for evaluating nephrolithiasis due to its higher cost and longer acquisition times, even though it can provide useful information in specific scenarios. An electrocardiogram (EKG) is unrelated to the diagnosis of kidney stones, as it assesses cardiac activity rather than renal pathology. Using ultrasound or CT scan ensures that the diagnosis is accurate and can guide appropriate management effectively.

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5. Which laboratory findings are typically elevated in a patient with cholecystitis?

A. Increased serum amylase

B. Increased WBC and minor LFT abnormalities

C. Increased creatinine levels

D. Decreased alkaline phosphatase

In cases of cholecystitis, particularly acute cholecystitis, the laboratory findings that are typically observed include an increase in white blood cell (WBC) count as a response to inflammation and possible infection. This is a common hematological response that indicates the body is fighting an inflammatory process. In addition to elevated WBC counts, mild liver function test (LFT) abnormalities may be noted due to the inflammatory proximity of the gallbladder to the liver and bile duct. This can include slight elevations in liver enzymes such as AST and ALT, although these may not be as pronounced as in acute hepatitis or other liver pathologies. The other options do not align with the typical laboratory findings associated with cholecystitis. Elevated serum amylase is more commonly associated with pancreatitis rather than cholecystitis, as amylase may rise due to pancreatitis-related issues in the nearby pancreas. Increased creatinine levels would suggest renal impairment and are not directly related to cholecystitis. Decreased alkaline phosphatase would not be expected in cholecystitis; rather, it might be elevated if there is a concurrent obstructive process affecting the bile ducts, but it would not be decreased. Thus

6. What type of carcinoma is most common after proctocolectomy in patients with familial polyposis?

A. Colorectal carcinoma

B. Duodenal carcinoma

C. Pyloric carcinoma

D. Gastric carcinoma

In patients with familial polyposis, especially those who have undergone proctocolectomy, the type of carcinoma that is most commonly observed is duodenal carcinoma. This occurs due to the presence of multiple adenomatous polyps in the duodenum, which can lead to the development of cancer over time. Familial adenomatous polyposis (FAP) is characterized by the formation of numerous polyps throughout the gastrointestinal tract, and although colorectal carcinoma is a significant concern, the surgical removal of the colon and rectum (proctocolectomy) leads to the risk of other types of malignancies, particularly in the upper gastrointestinal tract. As a result, surveillance of the duodenum is essential in patients with familial polyposis, even after a proctocolectomy, because the risk for developing duodenal carcinoma increases significantly. Regular endoscopic evaluations are recommended for early detection and management of any neoplastic changes in the duodenum of these patients.

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7. In a surgical patient presenting with dyspnea on exertion, what condition should most urgently be ruled out?

A. Pneumonia

B. Pulmonary embolism

C. Asthma attack

D. Pneumothorax

In a surgical patient presenting with dyspnea on exertion, pulmonary embolism should be ruled out as a priority due to its potential to rapidly produce serious complications or even be life-threatening. Pulmonary embolism occurs when a blood clot travels to the lungs, blocking a pulmonary artery. This condition can present acutely with symptoms such as dyspnea, chest pain, and sometimes hemoptysis, and it is particularly critical to assess in the surgical population because they often have risk factors such as immobility and hypercoagulability. The urgency lies in the fact that untreated pulmonary embolism can lead to reduced oxygenation and can cause hemodynamic instability, resulting in shock or cardiac arrest. Immediate diagnosis and management are crucial through imaging, typically with a CT pulmonary angiogram, and prompt initiation of anticoagulation if a DVT has been confirmed. While pneumonia, asthma attacks, and pneumothorax are also significant conditions to consider in a patient with dyspnea, they generally present less acutely in the context of surgery unless there are additional clear clinical indicators pointing toward these conditions. Pneumonia may develop post-operatively due to factors such as aspiration or limited mobility but is usually less urgent than a suspected pulmonary embolism.

8. How long does it typically take for skin and mucosa wounds to heal?

A. 3-5 days

B. 5-7 days

C. 7-10 days

D. 10-14 days

The typical healing time for skin and mucosa wounds is generally around 5 to 7 days. During this period, the wound undergoes a series of stages including hemostasis, inflammation, proliferation, and remodeling, with the epithelial cells starting to migrate and cover the wound surface relatively quickly. Skin and mucosal tissues, being rich in blood supply, have efficient healing responses due to their high vascularity and the presence of various growth factors that facilitate repair mechanisms. The first few days are particularly critical as inflammation occurs, but as the days progress, new epithelial tissue begins to form, leading to closure of the wound. While 3-5 days might seem plausible for very superficial wounds or specific areas with rapid turnover, most standard skin and mucosal injuries take closer to 5-7 days to adequately heal, especially in typical clinical scenarios. Consequently, the answer that reflects this common timeline is 5-7 days.

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9. What are the three most common causes of small bowel obstruction?

A. Adhesions, bulge (hernia), and cancer

B. Infection, inflammation, and trauma

C. Strictures, masses, and foreign bodies

D. Crohn's disease, diverticulitis, and volvulus

Small bowel obstruction is a clinical condition that can result from various underlying causes, but the three most common causes are adhesions, hernias, and cancer. Adhesions are fibrous bands of tissue that can form after abdominal surgeries. They are the leading cause of small bowel obstructions due to their tendency to create strictures and pull sections of the small intestine together, leading to twisting or narrowing that obstructs the passage of contents. Hernias occur when a part of the intestine protrudes through a weakness or tear in the abdominal wall. This displacement can lead to incarceration or strangulation of the bowel, causing obstruction. Cancer can also lead to small bowel obstructions, either through the presence of neoplasms that create physical blockages or via the metastasis of tumors that obstruct the bowel lumen or compress it externally. Other options, while they describe conditions that can cause bowel issues, do not represent the most frequent causes specifically leading to small bowel obstruction. Infection and inflammation (as mentioned in one of the other choices) can lead to swelling and narrowing of the bowel but are not as common as the causes listed in the correct answer. Similarly, structural changes or complications like strictures and masses can occur but are more often secondary to the primary

10. What does the "rule of 2's" describe regarding Meckel's diverticulum?

A. 2 inches long, 2 types of ectopic tissue

B. 2 feet from ileocecal valve, 2% of population

C. All of the above

D. 2 times as common in females

The "rule of 2's" pertains to Meckel's diverticulum and includes several key characteristics that help in its identification and understanding. First, Meckel's diverticulum is often located about 2 feet away from the ileocecal valve, which is significant in surgical considerations and in diagnosing conditions related to this diverticulum. This distance is an important landmark in both anatomical studies and surgical procedures involving the small intestine. Second, it is estimated that about 2% of the population is affected by Meckel's diverticulum, emphasizing its relative rarity yet importance in gastrointestinal pathology. This statistic is crucial for medical professionals to remember, as it helps in considering differential diagnoses when patients present with abdominal pain. Additionally, the "rule of 2's" also pertains to the commonly associated ectopic tissues found in Meckel's diverticulum, which may include gastric and pancreatic tissue. The mention of "2 types of ectopic tissue" highlights the potential complications that can arise, such as gastric acid secretion leading to ulceration in adjacent structures. Overall, this rule effectively summarizes essential clinical aspects of Meckel's diverticulum, covering its location, prevalence, and potential histological features, making it a valuable mnemonic for medical professionals.

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

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We wish you the very best on your exam journey. You've got this!

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