Vishchipanov A.S.

Tests for the Colloquium

Раздел: **Final lesson on the topics of the fall semester**
Модуль: **ТОПОГРАФИЧЕСКАЯ АНАТОМИЯ И ОПЕРАТИВНАЯ ХИРУРГИЯ**
Тема: **Final lesson on the topics of the fall semester**

Vishchipanov A.S.

1. What are the top and low walls of the inguinal canal (canalis inguinalis):

1)	☐	aponeurosis of the external oblique abdominal muscle (aponeurosis m. obliquus externus abdominis)
2)	☑	inguinal ligament (ligamentum inguinale)
3)	☑	the lower edges of the internal oblique and transverse muscles (m. obliquus internus abdominis, m. transversus abdominis)
4)	☐	transverse fascia (fascia transversalis)
5)	☐	inguinal fold

2. Name the lower and anterior walls of the inguinal canal (canalis inguinalis):

1)	☑	aponeurosis of the external oblique muscle (aponeurosis m. obliquus externus abdominis) of the abdomen (aponeurosis m. obliquus externus abdominis)
2)	☐	fascia latae
3)	☐	the overhanging edges of the internal oblique and the transverse muscle (m. obliquus internus abdominis, m. transversus)
4)	☑	inguinal ligament (ligamentum inguinale)
5)	☐	transverse fascia (Fascia transversalis)

3. Name the anterior and posterior wall of the inguinal canal (canalis inguinalis):

1)	☐	the overhanging edges of the internal oblique and the transverse muscle (m. obliquus internus abdominis, m. transversus)
2)	☐	inguinal ligament (ligamentum inguinale)
3)	☑	aponeurosis of the external oblique muscle (aponeurosis m. obliquus externus abdominis) of the abdomen (aponeurosis m. obliquus externus abdominis)

4) ☐ fascia latae

5) ☑ transverse fascia (fascia transversalis)

---

4. In the vagina of the rectus abdominis muscles anastomose:

1) ☑ upper epigastric artery

2) ☐ umbilical artery

3) ☐ VII-XII intercostal artery

4) ☑ lower epigastric artery

5) ☐ obturator artery and inferior epigastric artery

---

5. The ascending and descending colon is projected:

1) ☑ in the right lateral abdomen

2) ☑ in the left lateral abdomen

3) ☐ in the right lateral and right hypochondrium

4) ☐ in the right lateral and epigastric regions

5) ☐ in epigastrium

---

6. Name the superior and posterior walls of the inguinal canal (canalis inguinalis):

1) ☑ the overhanging edges of the internal oblique and the transverse muscle (m. obliquus internus abdominis, m. transversus)

2) ☐ inguinal ligament (ligamentum inguinale)

3) ☐ aponeurosis of the external oblique muscle (aponeurosis m. obliquus externus abdominis) of the abdomen (aponeurosis m. obliquus externus abdominis)

4) ☐ fascia latae

5) ☑ transverse fascia (fascia transversalis)

7. What do you call an inguinal space?

1) ☐ distance between the anterior and posterior wall of the inguinal canal

2) ☐ the distance between the top and the rear wall of the inguinal canal

3) ☑ distance between upper and lower wall of inguinal canal

4) ☐ distance between the anterior and inferior wall of the inguinal canal

5) ☑ distance between superior and inferior wall of inguinal canal

8. Name the formation, which is the lateral and medial wall of the inguinal triangle:

1) ☐ part of the white line of the abdomen from umbilicus to symphysis

2) ☐ supravesical fossa (fossa supravesicaiis)

3) ☑ inguinal ligament (ligamentum inguinale)

4) ☐ a horizontal line drawn through a point located between the middle and distal third of the inguinal ligament

5) ☑ the outer edge of the rectus abdominis muscle (m. rectus abdominis)

9. Name the formation, which is the medial and upper wall of the inguinal triangle:

1) ☐ part of the white line of the abdomen from umbilicus to symphysis

2) ☐ supravesical fossa (fossa supravesicaiis)

3) ☐ inguinal ligament (ligamentum inguinale)

4) ☑ a horizontal line drawn through a point located between the middle and distal third of the inguinal ligament

5) ☑ the outer edge of the rectus abdominis muscle (m. rectus abdominis)

10. Name the formation, which is the lateral and upper wall of the inguinal triangle.

1) ☐ part of the white line of the abdomen from umbilicus to symphysis
2) ☐ supravesical fossa (fossa supravesicaiis)
3) ☑ inguinal ligament (ligamentum inguinale)
4) ☑ a horizontal line drawn through a point located between the middle and distal third of the inguinal ligament
5) ☐ the rectus abdominis (m. rectus abdominis)

11. On the anterior abdominal wall of the stomach is projected:

1) ☑ in the left hypochondrium
2) ☐ in the left hypochondrium and umbilical region
3) ☐ left and right hypochondrium
4) ☑ in epigastric regions proper
5) ☐ in the right hypochondrium

12. What are congenital anomalies of the anterior abdominal wall:

1) ☑ hernia of the umbilical cord
2) ☐ hernia white line of the abdomen
3) ☑ non-infection of the vaginal process of the peritoneum
4) ☑ navel urinary fistula
5) ☐ congenital femoral hernia

13. List the folds of the peritoneum formed on the inner surface of the anterior abdominal wall:

1) ☑ the median umbilical fold (plica umbilicalis mediana)

2) ☐ front umbilical fold (plica umbilicalis anterior)

3) ☑ medial umbilical fold (plica umbilicalis medialis)

4) ☐ back umbilical fold (plica umbilicalis posterior)

5) ☑ lateral umbilical fold (plica umbilicalis lateralis)

---

14. What is the formation at the base of the median umbilical fold of the peritoneum (plica umbilicalis mediana), formed on the inner surface of the anterior abdominal wall:

1) ☐ obliterated umbilical arteries(a. umbilicalis)

2) ☐ upper epigastric artery (a. epigastrica superior)

3) ☑ medial umbilical ligament (lig. umbilicale medianum)

4) ☐ lower epigastric artery (a. epigastrica inferior)

5) ☑ obliterated urachus

---

15. What is the formation at the base of the lateral umbilical fold of the peritoneum (plica umbilicalis mediana), formed on the inner surface of the anterior abdominal wall:

1) ☐ obliterated umbilical arteries(a. umbilicalis)

2) ☑ a.et v. epigastrica inferior

3) ☐ medial umbilical ligament(obliterated urachus) (lig. umbilicale medianum)

4) ☑ lower epigastric artery and veins

5) ☐ obliterated umbilical veins (V. umbilicalis)

---

16. List the inguinal fossa (fossa inguinalis) located between the folds of the peritoneum on the inner surface of the anterior abdominal wall:

1) ☑ supravesical fossa (fossa supravesicaiis)

2) ☑ medial inguinal fossa (fossa inguinalis medialis)

3) ☐ fossa pararectales

4) ☑ lateral inguinal fossa (fossa inguinalis lateralis)

5) ☐ ovarian fossa (fossa ovarica)

---

17. Between which folds of the peritoneum is the medial inguinal fossa (fossa inguinalis medialis)on the inner surface of the anterior abdominal wall:

1) ☐ the median umbilical fold (plica umbilicalis mediana)

2) ☐ front umbilical fold (plica umbilicalis anterior)

3) ☑ medial umbilical fold (plica umbilicalis medialis)

4) ☐ back umbilical fold (plica umbilicalis posterior)

5) ☑ lateral umbilical fold (plica umbilicalis lateralis)

---

18. How dangerous is a hernia?

1) ☐ discomfort

2) ☑ infringement and subsequent necrosis of hernial contents

3) ☑ possible development of intestinal obstruction

4) ☐ spikes

5) ☐ painful shock

---

19. Between which folds of the peritoneum is the supravesical fossa (fossa supravesicaiis) on the inner surface of the anterior abdominal wall:

1) ☑ the median umbilical fold (plica umbilicalis mediana)

2) ☐ front umbilical fold (plica umbilicalis anterior)

3) ☑ medial umbilical fold (plica umbilicalis medialis)

4) ☐ back umbilical fold (plica umbilicalis posterior)

5) ☐ lateral umbilical fold (plica umbilicalis lateralis)

20. Name the front and back walls of the inner femoral ring (anulus femoralis internus):

1) ☐ transverse fascia (fascia transversalis)

2) ☐ lacunar ligament (ligamentum lacunare)

3) ☑ inguinal ligament (ligamentum inguinale)

4) ☑ ligamentum pectineale

5) ☐ arcus iliopectineus

21. Name the back and lateral walls of the inner femoral ring (anulus femoralis internus):

1) ☐ transverse fascia (fascia transversalis)

2) ☐ Arcus iliopectineus

3) ☑ ligamentum pectineale

4) ☐ lacunar ligament (ligamentum lacunare)

5) ☑ vagina of the femoral vein (v. femoralis)

22. Name the lateral and front walls of the inner femoral ring (anulus femoralis):

1) ☑ inguinal ligament (ligamentum inguinale)

2) ☐ transverse fascia (fascia transversalis)

3) ☑ vagina of the femoral vein (V. femoralis)

4) ☐ arcus iliopectineus

5) ☐ lacunar ligament (ligamentum lacunare)

23. What can be the contents of a hernial SAC in umbilical hernias?

1) ☐ bladder
2) ☑ intestine
3) ☑ greater omentum
4) ☑ transverse colon
5) ☐ caecum

24. What can be the contents of a hernial SAC in hernias of the white line of the abdomen (linea alba abdominis)?

1) ☐ ascending colon (colon ascendens)
2) ☐ the descending colon (colon descendens)
3) ☑ the greater omentum (omentum majus)
4) ☑ intestine
5) ☑ transverse colon (colon transversum)

25. Types of abdominal hernia:

1) ☑ inguinal
2) ☑ femoral
3) ☐ esophageal
4) ☑ umbilical
5) ☐ xiphoid

26. A hernia consist of:

1) ☐ head
2) ☑ sac
3) ☑ contents
4) ☐ corpus
5) ☑ coverings

27. Direct inguinal hernia:

1) ☑ always acquired
2) ☑ hernia pushes its way directly forward through posterior wall of inguinal canal
3) ☑ does not go down into the scrotum
4) ☐ if large enough, descend into the scrotum
5) ☐ may be congenital

28. Indirect inguinal hernia:

1) ☐ always acquired
2) ☐ hernia pushes its way directly forward through posterior wall of inguinal canal
3) ☐ does not go down into the scrotum
4) ☑ if large enough, descend into the scrotum
5) ☑ may be congenital

29. List the weak formation of the anterior abdominal wall:

1) ☐ the triangle of Petit (trigonum lumbale)

2) ☐ quadrangle Lesgaft-Grunfeld (spatium lumbale)

3) ☑ the white line of the abdomen (Linea alba)

4) ☑ half-moon line (Linea semilunaris)

5) ☑ arc line (Linea arcuata)

30. Where is the upper border of the anterior abdominal wall?

1) ☑ along the lower edge of the clavicle (margo inferior claviculae)

2) ☑ along the edge arc

3) ☐ by the xiphoid process of the sternum (processus xiphoideus)

4) ☐ linea bispinarum

5) ☐ the line between the ends of the XII rib

31. Aethiology of hernias:

1) ☐ can occur for no reason

2) ☑ hernia occurs at sites of weakness of the abdominal wall

3) ☐ hernia occurs at sites of normal of the abdominal wall

4) ☑ increased intra-abdominal pressure

5) ☐ reduced intra-abdominal pressure

32. Congenital hernias:

1) ☑ indirect inguinal

2) ☐ direct inguinal

3) ☑ umbilical

4) ☐ femoral

5) ☐ incisional

33. Acquired hernias:

1) ☐ indirect inguinal

2) ☑ direct inguinal

3) ☐ umbilical

4) ☑ femoral

5) ☑ incisional

34. Complications of hernias:

1) ☐ ulcer

2) ☑ irreducible

3) ☑ obstruction

4) ☑ strangulated

5) ☐ portal hypertension

35. Femoral hernia:

1) ☑ most commonly in females

2) ☐ most commonly in men

3) ☑ acquired hernia

4) ☐ congenital hernia

5) ☑ located below the inguinal ligament

36. In the epigastric region are projected:

1) ☑ stomach
2) ☑ left lobe of liver
3) ☐ right lobe of liver
4) ☑ pancreas
5) ☐ ascending colon

37. In the right hypochondrium are projected:

1) ☐ left bend of the colon
2) ☑ right bend of the colon
3) ☑ right lobe of liver
4) ☑ gallbladder
5) ☐ spleen

38. In the umbilical region are projected:

1) ☐ gallbladder
2) ☑ ureters
3) ☑ transverse colon
4) ☑ duodenum
5) ☐ liver

39. Which arteries are located in the subcutaneous fat of the anterior abdominal wall?

1) ☑ superficial epigastric artery

2) ☑ arteria circumflexa ileum superficialis

3) ☑ external pudendal artery

4) ☐ internal pudendal artery

5) ☐ obturator artery

40. How many elements does the femoral canal have?

1) ☑ 2 holes

2) ☐ 2 walls

3) ☑ 3 walls

4) ☐ 3 holes

5) ☐ 4 walls

41. The superficial fascia of the anterior abdominal wall consists of:

1) ☑ superficial layer

2) ☐ superior layer

3) ☑ deep layer [Scarpa]

4) ☐ anterior layer

5) ☐ posterior layer

42. What innervates the skin of the anterior abdominal wall?

1) ☑ n. iliohypogastricus

2) ☐ n. subcostalis

3) ☑ intercostal nerves (VII to XII)

4) ☐ intercostal nerves (V to X)

5) ☐ n.genito-femoralis

43. Under the external oblique abdominal muscle, on the front surface of the internal oblique muscle, pass:

1) ☑ n. iliohypogastricus

2) ☐ n.genito-femoralis

3) ☐ n. subcostalis

4) ☐ n. femoralis

5) ☑ n. ilioinguinalis

44. What special topographic anatomical lines exist on the anterior abdominal wall?

1) ☑ linea arcuata

2) ☐ linea terminalis

3) ☑ linea semilunaris

4) ☐ linea nuhae

5) ☐ linea Nelaton

45. On the posterior surface of the rectus muscle, two main arteries pass:

1) ☐ a. epigastrica superficialis

2) ☐ a. epigastrica suprema

3) ☐ a. epigastrica intermedia

4) ☑ a. epigastrica superior

5) ☑ a. epigastrica inferior

46. The navel (umbilicus) consists of the following layers:

1) ☑ skin and scar tissue
2) ☐ visceral peritoneum
3) ☑ transverse fascia
4) ☑ parietal peritoneum
5) ☐ Scarpa fascia

47. Weaknesses of the anterior abdominal wall:

1) ☑ linea Alba
2) ☐ linea terminalis
3) ☑ umbilicus
4) ☐ epigastrium
5) ☑ inguinal gap

48. In the preperitoneal tissue, between the peritoneum and the transverse fascia, there are deep vessels the anterolateral abdominal wall:

1) ☑ a. epigastrica inferior
2) ☑ a. circumflexa ilium profunda
3) ☐ a. epigastrica superficialis
4) ☐ a. circumflexa ilium superior
5) ☐ a. obturatoria

49. The contents of the inguinal canal in men is:

1) ☐ n. iliohypogastricus

2) ☑ funiculus spermaticus

3) ☑ n. ilioinguinalis

4) ☑ ramus genitalis n. genito-femoralis

5) ☐ n. subcostalis

50. The contents of the inguinal canal in women is:

1) ☐ n. iliohypogastricus

2) ☐ funiculus spermaticus

3) ☑ n. ilioinguinalis

4) ☑ ramus genitalis n. genito-femoralis

5) ☑ lig. teres uteri

51. Specify the stages of hernia repair:

1) ☐ plastic hernia SAC

2) ☑ operative approach

3) ☑ treatment and removal of hernial SAC

4) ☐ resection of the hernial ring

5) ☑ closure of the hernial gate

52. The stage of treatment and removal of the hernial SAC includes:

1) ☑ the separation of the hernial SAC from surrounding tissues

2) ☐ closure of the hernial gate

3) ☑ opening and revision of the contents of the hernial SAC

4) ☑ suturing and ligation of the neck of the hernial SAC

5) ☐ resection of the hernial ring

53. How to close or strengthen the hernial ring:

1) ☐ deferred

2) ☑ simple

3) ☑ reconstructive

4) ☑ plastic

5) ☐ palliative

54. The stages in the surgical treatment of strangulated hernia:

1) ☑ fixation of the injured organ

2) ☑ dissection of the hernial gate

3) ☐ fixation of the hernial gate

4) ☑ the determination of the viability of the hernia contents

5) ☐ dissection of the injured organ

55. Determine the viability of the hernial contents according to the following criteria:

1) ☑ color

2) ☐ smell

3) ☑ peristalsis

4) ☑ pulsation of blood vessels

5) ☐ lymph drainage

56. Types of hernioplasty:

1) ☑ tension
2) ☐ patchwork
3) ☑ non-tension
4) ☐ complex
5) ☐ palliative

57. Tension methods of inguinal hernioplasty are aimed at strengthening:

1) ☑ anterior wall of the inguinal canal
2) ☐ the upper wall of the inguinal canal
3) ☐ lower wall of the inguinal canal
4) ☑ the posterior wall of the inguinal canal
5) ☐ all walls of the inguinal canal

58. Characteristic of inguinal hernioplasty by Martynov:

1) ☐ the internal oblique abdominal muscle is sutured to the inguinal ligament
2) ☑ used for oblique inguinal hernias
3) ☑ the upper flap of the aponeurosis of the external oblique muscle is sewn over the spermatic cord to the inguinal ligament
4) ☑ the lower flap of the aponeurosis of the external oblique muscle is sewn with nodal sutures to the upper flap
5) ☐ it can also be used for umbilical hernias

59. Specify the technical aspects of the second stage of surgical treatment of uncomplicated hernia:

1)	☐	the allocation of the hernial SAC
2)	☐	wedge-shaped resection of the necrotic part of the intestine
3)	☑	incision of the hernial SAC, immersion in the abdominal cavity of the hernia contents
4)	☐	plastic of anterior abdominal wall
5)	☑	flashing the neck and cut off the hernia SAC

60. Specify the technical aspects of the second stage of surgical treatment of hernia complicated by strangulation:

1)	☐	the allocation of the hernial SAC
2)	☐	wedge-shaped resection of the necrotic part of the intestine
3)	☑	dissection of the hernia SAC
4)	☑	fixation of hernial contents
5)	☐	incision of the hernial SAC, immersion in the abdominal cavity of the hernial contents

61. Characteristic of inguinal hernioplasty by Bassini:

1)	☐	it can also be used for umbilical hernias
2)	☑	the incision of the skin and aponeurosis of the external oblique abdominal muscle is carried out along the inguinal canal (above and parallel to the inguinal ligament)
3)	☑	the spermatic cord is taken up and under it is sewn the inner oblique and transverse muscle with transverse fascia to the inguinal ligament
4)	☐	completely eliminate the inguinal canal
5)	☑	on the muscular wall, the spermatic cord is laid and over it the edges of the aponeurosis of the external oblique abdominal muscle are sewn, leaving an opening for the exit of the spermatic cord

62. Typical of inguinal hernioplasty on Postempski:

1) ☑ completely eliminate the inguinal canal

2) ☐ the spermatic cord is taken up and under it is sewn the inner oblique and transverse muscle with transverse fascia to the inguinal ligament

3) ☑ the spermatic cord is transferred to the upper corner of the wound and the entire thickness of the abdominal wall is sewn to the inguinal ligament under the seminal cord

4) ☑ over seed with cord stitched leather

5) ☐ the lower flap of the aponeurosis of the external oblique muscle is sewn with nodal sutures to the upper flap

---

63. Specify the methods of plasty of the inguinal canal:

1) ☑ by Martynov

2) ☑ by Bassini

3) ☐ according to the Mayo

4) ☑ by Kukudzhanov

5) ☐ on Sapezhko

---

64. Specify the methods of plasty of the inguinal canal:

1) ☑ by Postempski

2) ☑ by Bassini

3) ☐ according to the Mayo

4) ☑ by Kukudzhanov

5) ☐ by Lexer

---

65. Methods of hernioplasty, in which the posterior wall of the inguinal canal is strengthened:

1)	☑	the operation to Liechtenstein
2)	☐	Mayo surgery
3)	☑	the operation of Bassini
4)	☑	Postempski operation
5)	☐	Girard-Spasokukotsky operation

66. What is the meaning of the Liechtenstein operation?

1)	☐	formation of a duplicate of aponeurosis of the external oblique muscle
2)	☑	strengthening of the posterior wall of the inguinal canal
3)	☐	closing the channel tightly
4)	☐	formation of a duplicate of the transverse fascia on the back wall of the inguinal canal
5)	☑	fixation of the mesh (implant) on the posterior wall of the inguinal canal, behind the spermatic cord

67. Typical for hernioplasty according to the method Kukudzhanov:

1)	☐	used for femoral hernias
2)	☑	used for direct inguinal hernias
3)	☑	the transverse fascia is hemmed with U-shaped seams to the comb ligament (lig. pectineale)
4)	☐	fixation of the mesh (implant) on the posterior wall of the inguinal canal, behind the spermatic cord
5)	☑	to the comb ligament (lig. pectineale) sew the outer edge of the vagina of the rectus abdominis muscle and tendon endings of the internal oblique and transverse muscles, above their lower edge

68. Typical for hernioplasty according to the method Kukudzhanov:

1)	☐	used in umbilical hernias

2)	☑	the structures are sewn together with a comb ligament (lig. pectineale)
3)	☐	the structures are sewn together with a lacunar ligament
4)	☐	fixation of the mesh (implant) on the posterior wall of the inguinal canal, behind the spermatic cord
5)	☑	to the comb ligament (lig. pectineale) sew the outer edge of the vagina of the rectus abdominis muscle and tendon endings of the internal oblique and transverse muscles, above their lower edge

69. Typical for hernioplasty according to the method Shouldice:

1)	☐	used for femoral hernias
2)	☑	used for inguinal hernias
3)	☑	a 4-layer plastic is carried out: a double seam of the transverse fascia and a double seam of the connected tendon with the inguinal ligament
4)	☐	the structures are sewn together with a comb ligament (lig. pectineale)
5)	☐	over seed with spermatic cord stitched skin

70. Typical for hernioplasty according to the method Shouldice:

1)	☐	used in umbilical hernias
2)	☑	a special role is given to the transverse fascia
3)	☑	a 4-layer plastic is carried out: a double seam of the transverse fascia and a double seam of the connected tendon with the inguinal ligament
4)	☐	the structures are sewn together with a lacunar ligament
5)	☐	over seed with spermatic cord stitched skin

71. Specify the methods of plasty of the inguinal canal:

1)	☑	by Postempski

2) ☑ by Bassini

3) ☐ according to the Mayo

4) ☑ by Shouldice

5) ☐ at Ruggi

---

72. Specify the methods of plastic surgery of the femoral canal:

1) ☑ by Lockwood

2) ☐ method of Postempski

3) ☐ by Mayo

4) ☐ method Shouldice

5) ☑ by Ruggi

---

73. Specify the methods of plastic surgery of the femoral canal:

1) ☑ by Lockwood

2) ☐ Martynov's way

3) ☑ method of Parlavecchio

4) ☐ method Shouldice

5) ☑ by Ruggi

---

74. List the forms of hernia of the umbilical cord:

1) ☑ spherical

2) ☐ cubiform

3) ☑ hemispherical

4) ☐ incomplete

5) ☑ mushroom

75. Where is the most common hernia of the white line of the abdomen (linea alba abdominis)?

1) ☑ above the navel

2) ☐ above pubic symphysis

3) ☐ below the navel

4) ☐ the lateral edge of the rectus abdominis

5) ☑ on the anterior abdominal wall

76. Specify the methods of surgical treatment of umbilical hernias:

1) ☑ by Lexer

2) ☐ by Martynov

3) ☑ by Mayo

4) ☐ by Shouldice

5) ☑ by Sapezhko

77. What can be the contents of the hernial SAC in hernias of the white line of the abdomen (linea alba abdominis)?

1) ☐ ascending colon (colon ascendens)

2) ☐ descending colon (colon descendens)

3) ☑ the greater omentum (omentum majus)

4) ☑ intestine

5) ☑ transverse colon (colon transversum)

78. Operative approaches for surgical treatment of femoral hernia:

1) ☐ transabdominal
2) ☑ femoral
3) ☑ inguinal
4) ☐ transperineal
5) ☐ through the locking hole (foramen obturatorium)

79. Specify the methods of surgical treatment of umbilical hernias:

1) ☑ Lexer method
2) ☐ method of Bassini
3) ☑ by Mayo
4) ☐ by Ruggi
5) ☑ by Sapezhko

80. Typical for hernioplasty by the method of Lockwood:

1) ☑ used for femoral hernias
2) ☐ used for oblique inguinal hernias
3) ☑ the inner opening of the femoral canal is closed by suturing the inguinal ligament to the periosteum of the bone with 2-3 interrupted silk sutures
4) ☐ used in umbilical hernias
5) ☐ a 4-layer plastic is carried out: a double seam of the transverse fascia and a double seam of the connected tendon with the inguinal ligament

81. Typical for hernioplasty according to the method of Mayo:

1) ☐ used for femoral hernias
2) ☑ oval cut of skin and subcutaneous tissue
3) ☑ impose U-shaped seams so that the lower flap of aponeurosis fell under the top
4) ☑ used in umbilical hernias
5) ☐ a 4-layer plastic is carried out: a double seam of the transverse fascia and a double seam of the connected tendon with the inguinal ligament

82. Characteristic of hernioplasty by the method of Sapezhko:

1) ☐ used for inguinal hernias
2) ☑ skin incision along the midline of the abdomen
3) ☑ hemming of the right edge of the aponeurosis to the left from the inner side
4) ☑ used in umbilical hernias
5) ☐ oval cut of skin and subcutaneous tissue

83. Typical for hernioplasty according to the method of the Lexer:

1) ☑ used in umbilical hernias
2) ☑ it is more often used in children with small hernia sizes
3) ☐ hemming of the right edge of the aponeurosis to the left from the inner side
4) ☑ applying a purse string suture around the umbilical ring
5) ☐ used for inguinal hernias

84. Typical for hernioplasty according to the method of the Lexer:

1) ☑ used in umbilical hernias

2) ☑ the imposition of interrupted sutures on the front wall of the vagina of the rectus abdominis muscles

3) ☐ hemming of the right edge of the aponeurosis to the left from the inner side

4) ☑ applying a purse string suture around the umbilical ring

5) ☐ used for femoral hernias

---

85. Typical for hernioplasty according to the method of Mayo:

1) ☐ used for inguinal hernias

2) ☑ oval cut of skin and subcutaneous tissue

3) ☑ impose U-shaped seams so that the lower flap of aponeurosis fell under the top

4) ☑ used in umbilical hernias

5) ☐ applying a purse string suture around the umbilical ring

---

86. Characteristic of hernioplasty by the method of Sapezhko:

1) ☐ used for femoral hernias

2) ☑ skin incision along the midline of the abdomen

3) ☐ applying a purse string suture around the umbilical ring

4) ☑ used in umbilical hernias

5) ☑ hemming of the right edge of the aponeurosis to the left from the inner side

---

87. Typical for hernioplasty according to the method of Girard-Spasokukotsky-Kimbarovsky:

1) ☑ used for inguinal hernias

2) ☐ used for femoral hernias

3) ☑ the seams are applied all through the inguinal canal

4) ☑ when tying the seams, a muscular-aponeurotic wall of the inguinal canal is formed

5) ☐ sutures are applied only to the medial half of the inguinal canal

88. Typical for hernioplasty according to the method of Ruggi-Parlavecchio:

1) ☐ used in umbilical hernias

2) ☑ used for femoral hernias

3) ☐ hem the comb ligament (lig. pectineale) to the lacunar ligament

4) ☑ hemming the inguinal ligament to the comb ligament (lig. pectineale)

5) ☑ plastic of the back and front walls of the inguinal canal is produced

89. Typical femoral hernioplasty by Bassini method:

1) ☐ used in umbilical hernias

2) ☑ used for femoral hernias

3) ☐ hem the comb ligament to the lacunar ligament

4) ☑ produce plastic inner ring of the femoral canal

5) ☑ hemming the inguinal ligament to the comb ligament (lig. pectineale)

90. A complication called " crown of death» (corona mortis):

1) ☐ occurs when the plastic strangulated umbilical hernia

2) ☑ occurs when plastic strangulated femoral hernia

3) ☐ damage to the femoral nerve

4) ☑ arterial bleeding

5) ☐ venous bleeding

91. The non-tension hernioplasty:

1) ☐ suturing the abdominal muscles to the inguinal ligament
2) ☑ implantation of mesh endoprosthesis
3) ☐ rarely used
4) ☑ endovideosurgical operation
5) ☑ by the method of Liechtenstein

92. Laparoscopic hernia repair hernia abdominal:

1) ☑ type of non-tension hernioplasty
2) ☐ type of tension hernioplasty
3) ☑ operative access - transabdominal
4) ☐ surgical approach - transthoracic
5) ☑ the mesh prosthesis is fixed with a stapler

93. The most frequent complications of hernias:

1) ☑ bleeding
2) ☐ pneumothorax
3) ☑ infectious wound process
4) ☐ cardiac arrhythmia
5) ☑ recurrence of the hernia

94. The main causes of relapses in tension hernioplasty:

1) ☐ the stitching of homogeneous tissues
2) ☑ the stitching of heterogeneous tissues
3) ☐ good repair in the area of sutures
4) ☑ poor repair in the area of sutures
5) ☐ low qualification of surgeon

95. In the long-term period after surgical treatment of oblique inguinal hernia, the following complications associated with the operation may occur:

1) ☐ cryptorchidism
2) ☐ coarctation of the aorta
3) ☑ male infertility
4) ☑ varicocele
5) ☑ pain with irradiation in the lumbar region

96. The main advantages of hernioplasty by the Liechtenstein method:

1) ☑ a low percentage of recurrence of hernia
2) ☐ high percentage of hernia recurrence
3) ☑ short rehabilitation period
4) ☑ the simplicity of the surgical technique
5) ☐ fast overlay

97. The boundaries of the upper floor of the abdominal cavity are:

1) ☑ diaphragm (diaphragma)

2) ☑ mesentery of the transverse colon (mesocolon transversum)

3) ☐ the lumbar spine

4) ☐ costal arch (arcus costarum)

5) ☐ the body of T12-L1

98. Intraperitoneal subphrenic space includes:

1) ☑ bursa omentalis

2) ☐ the space between the intra-abdominal fascia (fascia endoabdominalis) and the parietal peritoneum (peritoneum parietale)

3) ☑ bursa praegastrica

4) ☑ bursa hepatica

5) ☐ area nuda hepatis

99. What spaces include the upper abdomen?

1) ☑ right sub-diaphragmatic space

2) ☑ left sub-diaphragmatic space

3) ☐ the space of Pirogov-Parona

4) ☑ subhepatic space

5) ☐ intersigmoid space

100. True for gastric syntopia:

1) ☑ to the small curvature of the stomach lies the left lobe of the liver

2) ☐ to the small curvature of the stomach lies the right part of the liver

3) ☑ behind the stomach is a bursa omentalis

4) ☐ behind the stomach is a bursa hepatica

5) ☐ located in the lower abdomen

---

101. The upper part of the greater omentum is the gastrointestinal ligament (lig. gastrocolicum) contains between its leaves:

1) ☑ left gastro-omental vessels

2) ☐ contains nothing

3) ☐ the celiac trunk (truncus coeliacus)

4) ☑ right gastro-omental vessels

5) ☐ left and right gastric arteries

---

102. Bursa omentalis:

1) ☐ it is a slit-like space located in front of the stomach

2) ☑ it is a slit-like space located behind the stomach and hepatic-gastric ligament (lig. hepatogastricum)

3) ☑ it has communication with the bursa hepatica through the foramen epiploicum

4) ☐ does not have messages with other bags

5) ☐ most often, adults overgrown with connective tissue

---

103. The highest point of the stomach bottom is located at the level of:

1) ☐ the upper edge of the body of vertebra Th 11

2) ☐ the lower edge of the body of Th11 vertebrae

3) ☑ the lower edge of the body of Th9 vertebra

4) ☑ the upper edge of the body of Th10 vertebra

5) ☐ body Th11 vertebra

104. As in relation to the peritoneum is the duodenum (duodenum)?

1) ☐ completely intraperitoneal

2) ☐ a large part is located mesoperitoneal

3) ☑ the upper part is located intraperitoneal

4) ☑ most of the duodenum is extraperitoneal

5) ☐ the upper part is extraperitoneal

105. True syntopia pancreas:

1) ☐ located in the lower abdomen

2) ☐ located in the upper abdomen

3) ☐ forms the back wall of the bursa praegastrica

4) ☑ located in retroperitoneal space

5) ☑ on the upper edge of the tail are splenic vessels

106. Innervation of the duodenum (duodenum) is:

1) ☑ the superior mesenteric plexus (plexus mesentericus superior)

2) ☐ lower mesenteric plexus (plexus mesentericus inferior)

3) ☑ solar plexus (plexus coeliacus)

4) ☑ hepatic plexus (plexus hepaticus)

5) ☐ pancreatic plexus (plexus pancreaticus)

107. What plexus is carried out by the innervation of the pancreas (pancreas)?

1) ☑ the celiac plexus (plexus coeliacus)
2) ☐ sacral plexus (plexus sacralis)
3) ☑ splenic plexus (plexus lienalis)
4) ☐ lumbar plexus (plexus lumbalis)
5) ☑ the superior mesenteric plexus (plexus mesentericus superior)

108. What are the sources of innervation of the spleen?

1) ☑ left nodes of the celiac plexus (plexus coeliacus)
2) ☐ right nodes of the celiac plexus (plexus coeliacus)
3) ☑ left diaphragmatic plexus (plexus phrenicus sinister)
4) ☐ left renal plexus (plexus renalis sinister)
5) ☑ left adrenal plexus (plexus suprarenalis sinister)

109. Innervation of the stomach is carried out:

1) ☑ vagus nerve (n. vagus)
2) ☑ branches of the celiac trunk (plexus coeliacus)
3) ☐ the superior mesenteric plexus (plexus mesentericus superior)
4) ☐ splenic plexus (plexus lienalis)
5) ☐ hepatic plexus (plexus hepaticus)

110. Latarjet branches (branches of the vagus nerve) innervate:

1) ☑ small curvature of the stomach (curvatura ventriculi minor)
2) ☑ pyloric part of the stomach (pylorus)
3) ☐ large curvature of the stomach (curvatura ventriculi major)
4) ☐ the abdominal part of the esophagus (pars abdominalis oesophagi)
5) ☐ the upper horizontal part of the duodenum

111. Bursa hepatica:

1) ☑ surrounds the right lobe of the liver (lobus hepatis dexter)
2) ☐ surrounds the stomach
3) ☑ separated from bursa praegastrica falciform ligament (lig. falciforme) and coronary ligament (lig.coronarium)
4) ☐ surrounds the spleen
5) ☑ reported with the right side channel (canalis lateralis dexter)

112. Specify the name of the foramen omentale:

1) ☑ foramen omentale
2) ☐ Waldeyer hole
3) ☑ foramen intervenosum
4) ☐ foramen arteriosus
5) ☑ the foramen of Winslow [Winslow]

113. True for liver syntopia:

1) ☐ the square lobe is adjacent to the cardiac part of the stomach

2) ☑ proportion to a square adjacent to the pyloric part of the stomach

3) ☑ the left lobe borders on the abdominal esophagus

4) ☐ from above lies to the pericardium

5) ☑ the top is attached to the diaphragm

114. At the level of which vertebrae is the head of the pancreas (pancreas)?

1) ☑ to the right of the body of L1

2) ☐ bodies L1 on the median line

3) ☐ Th12 bodies to the left of the median line

4) ☐ intervertebral disc Th12-L1

5) ☑ to the right of the body L2

115. Skeletotopy of spleen:

1) ☑ the upper pole is located along the spatula line

2) ☐ the upper pole is located along the paravertebral line

3) ☑ the lower pole is located along the anterior axillary line

4) ☐ the lower pole is located at the mid-axillary line

5) ☐ the lower pole is located at the body level Th10

116. Clinically important part of duodenum (duodenum), bulb (bulbus duodeni), has a number of important features:

1) ☑ the thinnest walls

2) ☑ the absence of circular folds

3) ☐ the presence of circular folds

4) ☐ fixed and stationary

5) ☑ most mobile

117. Specify the main tributaries of the portal vein (vena porta):

1) ☑ superior mesenteric vein (a. mesenterica superior)

2) ☐ right gastric vein (a. gastrica dextra)

3) ☑ splenic vein (a. lienalis)

4) ☐ a. prepylorica

5) ☐ gallbladder vein (a. cystica)

118. The organs of the upper peritoneal cavity include:

1) ☑ the liver with the gall bladder

2) ☐ ascending colon

3) ☐ caecum with vermiform Appendix

4) ☐ jejunum and ileum

5) ☑ stomach

119. The stomach is supplied with blood by the following arteries:

1) ☑ left gastric artery

2) ☑ right gastric artery

3) ☐ superior mesenteric artery

4) ☑ short gastric arteries

5) ☐ internal thoracic artery

120. Left gastro-omental artery:

1) ☐ blood supply to the gallbladder

2) ☑ blood supply to the stomach

3) ☐ it is a branch of the common hepatic artery

4) ☐ it is located in the thickness of the small omentum

5) ☑ it is a branch of the splenic artery

121. Right gastro-omental artery:

1) ☑ blood supply to the stomach

2) ☐ blood supply to spleen

3) ☐ it is a branch of the superior mesenteric artery

4) ☐ it is a branch of its own hepatic artery

5) ☑ it is a branch of the gastroduodenal artery

122. Malformations of the cystic duct:

1) ☑ double bubble duct

2) ☑ hypoplasia of the cystic duct

3) ☐ expansion of the cystic duct

4) ☐ elongation of the cystic duct

5) ☑ the absence of the cystic duct

123. True for the hepato-gastrica ligament:

1) ☐ it is a part of the large omentum
2) ☑ it is part of the small omentum
3) ☑ intersects with a number of surgical interventions
4) ☑ the amount of fat in it decreases from the stomach to the liver
5) ☐ never intersects with surgical interventions

124. True for the gastro-splenic ligament:

1) ☐ it is a part of the large omentum
2) ☐ it is part of the small omentum
3) ☑ has two sheets of peritoneum
4) ☑ contains short gastric arteries
5) ☑ contains the splenic artery

125. Specify the bursas of the peritoneum of the upper abdomen:

1) ☑ omental
2) ☐ splenic
3) ☑ preagastrica
4) ☐ subdiaphragmatic
5) ☑ hepatica

126. The front wall of the omental bursa form:

1) ☑ lesser omentum

2) ☐ diaphragm and anterior abdominal wall

3) ☑ gastro-colon ligament

4) ☑ the rear wall of the stomach

5) ☐ caudate lobe of liver

127. The lower wall of the omental bursa are:

1) ☐ lesser omentum

2) ☐ gastro-colon ligament

3) ☐ pancreas

4) ☑ mesentery of the transverse colon

5) ☑ transverse colon

128. The back wall of the foramen omentale is made up of:

1) ☑ parietal peritoneum

2) ☐ the gastro-pancreatic ligament

3) ☐ hepatic duodenal ligament

4) ☑ inferior Vena cava covered with parietal peritoneum

5) ☐ stomach

129. Part of the lesser omentum is composed of the following bundles:

1) ☑ hepatic esophageal

2) ☑ hepatic -diaphragmatic

3) ☑ hepatic duodenal ligament

4) ☑ hepatic-gastric ligament

5) ☐ gastro-splenic ligament

130. Define the sides of the triangle Callot:

1) ☐ common hepatic artery

2) ☑ cystic duct

3) ☑ common hepatic duct

4) ☑ cystic artery

5) ☐ portal vein

131. Specify the top and front boundaries of the foramen omentale:

1) ☐ lesser omentum

2) ☑ caudate lobe of liver

3) ☐ the square lobe of the liver

4) ☑ hepatic-duodenal ligament

5) ☐ duodenum

132. Parts of the common bile duct:

1) ☑ supraduodenal

2) ☑ retroduodenal

3) ☑ pancreatic

4) ☑ interstitial

5) ☐ paraduodenal

133. True for the gastrointestinal ligament:

1) ☐ contains its own hepatic artery

2) ☐ in surgical interventions, it is advisable to dissect the right half of the ligament

3) ☑ contains the middle colon artery

4) ☑ with surgical interventions, it is advisable to dissect the left half of the ligament

5) ☑ contains gastro-omental arteries

134. The duodenum is supplied with blood by the following arteries:

1) ☑ a.gastroduodenalis

2) ☐ a. hepatica propria

3) ☑ a. mesenterica superior

4) ☐ a. lienalis

5) ☐ a. mesenterica inferior

135. Specify the author's names of the main and additional ducts of the pancreas:

1) ☐ Pirogov duct

2) ☑ Wirsung duct

3) ☑ Santorini duct

4) ☐ the flow of Boyden [Boyden]

5) ☐ of Vater duct [Vater]

136. True syntopia the head of the pancreas:

1) ☐ on top of the head is the esophagus

2) ☑ behind the head of the most outward is the inferior Vena cava

3) ☐ ahead of the head there is a fusion of the upper mesenteric and splenic veins

4) ☑ behind the head there is a fusion of the upper mesenteric and splenic veins

5) ☑ the head covers the top, outside and bottom of the duodenum

137. The derivatives of the peritoneum include:

1) ☐ canals

2) ☑ bursa

3) ☐ deepenings

4) ☑ greater and lesser omentum

5) ☑ mesenteries

138. The primary ligaments of the spleen:

1) ☐ formed as a result of the fusion of serous membranes in the process of intestinal rotation

2) ☑ are derived from the dorsal mesentery

3) ☑ diaphragmatic-splenic

4) ☐ phrenica-colica

5) ☑ the gastro-splenic

139. Secondary ligaments of the spleen:

1) ☐ the gastro-splenic

2) ☐ are derived from the dorsal mesentery

3) ☑ formed as a result of the fusion of serous membranes in the process of intestinal rotation

4) ☑ splenica-colica

5) ☑ phrenica-colica

140. What are the features of recessus peritonei intersigmoideus:

1) ☑ located between the mesentery of the sigmoid colon (mesocolon sigmoideum) and the fold of the parietal peritoneum (peritoneum parietalis) above the passing ureter

2) ☑ it is a place of hernia formation

3) ☐ it is the site of the abscess as a complication of appendicitis

4) ☐ located between the mesentery of the sigmoid colon (mesocolon sigmoideum) and the fold of the parietal peritoneum above the passing left iliac artery (a. Iliaca sinistra)

5) ☑ it is easiest to find the left ureter (ureter sinister)

141. The boundaries of the lower floor of the peritoneal cavity are:

1) ☑ mesentery of the transverse colon (mesocolon transversum)

2) ☐ conditional plane, held between the front upper iliac spines (spina iliaca anterior superior)

3) ☑ entrance to the pelvis

4) ☐ the body of L4-L5

5) ☐ diaphragm (diaphragma)

142. Where the pus is normally distributed with a ruptured Appendix?

1) ☐ in bursa omentalis

2) ☐ in the upper pocket of bursa omentalis

3) ☑ in bursa hepatica dextra

4) ☐ In bursa subhepatica

5) ☑ in the upper floor of the abdominal cavity

143. Where can the liquid pathological contents of the right mesenteric sinus accumulate?

1) ☑ recessus ileocaecalis superior
2) ☐ recessus duodenalis superior
3) ☐ recessus ileocaecalis inferior
4) ☐ excavatio rectovesicalis
5) ☑ in the lower floor of the abdomen

144. The upper ileocecal recess (recessus ileocaecalis superior) is located between:

1) ☐ mesentery, the cecum and the ileocecal fold (plica ileocaecalis)
2) ☐ upper and lower duodenal folds
3) ☑ mesentery, ascending colon and ileum fold
4) ☐ medial and median umbilical folds
5) ☑ in the lower floor of the abdomen

145. The lower ileocecal recess (recessus ileocaecalis inferior) is located between the:

1) ☑ mesentery, the cecum and the ileocecal fold (plica ileocaecalis)
2) ☐ upper and lower duodenal folds
3) ☐ mesentery, ascending colon and ileum fold
4) ☐ medial and median umbilical folds
5) ☑ in the lower floor of the abdomen

146. The lower floor of the peritoneal cavity is divided into channels and sinuses by:

1) ☑ ascending colon (colon ascendens)
2) ☑ descending colon (colon descendens)
3) ☑ mesentery of the small intestine (mesenterium)
4) ☐ transverse colon
5) ☐ bursa omentalis

147. Within the right mesenteric sinus retroperitoneum are located:

1) ☑ the final part of the descending duodenum
2) ☑ the lower horizontal part of the duodenum (pars horizontalis inferior)
3) ☑ inferior Vena cava (vena cava inferior)
4) ☑ right ureter
5) ☐ left ureter

148. What are the organs lying intraperitoneal:

1) ☐ ascending colon (colon ascendens)
2) ☑ vermiform Appendix (appendix vermiformis)
3) ☑ cecum (caecum)
4) ☑ sigmoid colon (colon sigmoideum)
5) ☑ transverse colon (colon transversum)

150. Specify the organs of the lower floor of the peritoneal cavity, lying mesoperitoneal:

1) ☐ pancreas (pancreas)

2) ☐ liver (hepar)

3) ☑ ascending colon (colon ascendens)

4) ☑ descending colon (colon descendens)

5) ☐ spleen (lien)

151. How is the cecum covered by the peritoneum in most cases?

1) ☐ peritoneum of the cecum is not covered

2) ☐ covered with peritoneum on one side

3) ☐ covered with peritoneum on three sides

4) ☑ covered with peritoneum on all sides

5) ☑ intraperitoneal

153. Right side channel (canalis lateralis dexter):

1) ☑ limited to the left ascending colon (colon ascendens)

2) ☐ bounded on the right by the descending colon (colon descendens)

3) ☑ bounded on the right side wall of the abdomen

4) ☑ top reported with hepatic bag (bursa hepatica)

5) ☑ communication with the upper floor of the abdominal cavity is carried out more fully than on the left

154. Left side channel (canalis lateralis sinister):

1) ☐ limited to the left ascending colon (colon ascendens)

2) ☑ bounded on the right by the descending colon (colon descendens)

3) ☐ bounded on the right side wall of the abdomen

4) ☑ at the top communicates with bursa praegastrica

5) ☑ communication with the upper floor of the abdominal cavity is less complete than on the right, due to the diaphragmatic-colon ligament (lig.phenicocolicum)

155. Left mesenteric sinus (sinus mesentericus sinister) limited:

1) ☐ right ascending colon (colon ascendens)

2) ☑ on the left the descending colon (colon descendens) and the root of the mesentery of the sigmoid colon (radix mesocoloni sigmoidei)

3) ☑ top-mesentery of the transverse colon (mesocolon transversum)

4) ☐ from the bottom to the rectum

5) ☑ to the right is the root of the mesentery of the small intestine (radix mesenterii)

156. The right mesenteric sinus (sinus mesentericus dexter) is restricted:

1) ☑ right ascending colon (colon ascendens)

2) ☐ on top of the mesentery root of the small intestine (radix mesenterii)

3) ☑ top-mesentery of the transverse colon (mesocolon transversum)

4) ☐ left-descending colon (colon descendens)

5) ☑ left mesentery root of the small intestine (radix mesenterii)

157. Left mesenteric sinus (sinus mesentericus sinister):

1) ☐ does not connect to anything

2) ☑ continues directly into the cavity of the lesser pelvis (pelvis minor)

3) ☑ connects to the right mesenteric sinus (sinus mesentericus dexter) through a narrow slit

4) ☐ connected with packing bag (bursa omentalis)

5) ☐ connected with hepatic bag (bursa hepatica)

158. Right mesenteric sinus (sinus mesentericus dexter):

1) ☐ nothing is reported

2) ☑ connects to the left mesenteric sinus (sinus mesentericus sinister) through a narrow slit

3) ☑ open on the front

4) ☐ continues directly into the cavity of the lesser pelvis (pelvis minor)

5) ☑ produced in her the accumulation of pathological fluids in the beginning within the limits of the sinus

159. By side channel (canalis lateralis):

1) ☑ pus or blood can pass into the pelvic cavity (pelvis minor)

2) ☑ pus or blood can go to the upper floor of the abdomen

3) ☐ pus or blood passes more easily into the upper floor of the abdominal cavity through the left lateral canal (canalis lateralis sinister)

4) ☑ pus or blood passes more easily into the upper floor of the abdominal cavity through the right lateral canal (canalis lateralis dexter)

5) ☑ inflammation of the organs of the lower floor of the abdominal cavity can lead to the formation of a sub-diaphragmatic abscess

160. Where there may be hernia of Treitz?

1) ☑ upper duodenal recess (recessus duodenalis superior)

2) ☐ bulb of duodenum (bulbus duodeni)

3) ☐ the horizontal part of the duodenum(pars horizontalis)

4) ☑ lower duodenal recess (recessus duodenalis inferior)

5) ☐ upper ileocecal depression (recessus ileocaecalis superior)

161. Mesentery root of the small intestine (mesenterium intestini tenuis):

1) ☑ attaches from the left side of the body L2 to the right sacroiliac joint (articulatio sacroiliaca dextra)

2) ☐ from the left side of Th12 to the right iliac fossa (fossa iliacadextra)

3) ☐ on the front side of the body of the pancreas (corpus spancreatis) to the left kidney (ren sinister)

4) ☐ on the front side of the body of the pancreas (corpus pancreatic) to the right kidney (ren dexter)

5) ☑ fixes the small intestine to the back of the abdomen

162. What are the features of blood supply to the jejunum and ileum (jejunum et ileum):

1) ☐ main arterial blood supply from the branches of the celiac trunk (truncus coeliacus)

2) ☑ main arterial blood supply from the branches of the superior mesenteric artery (a.mesenterica superior)

3) ☐ main arterial blood supply from the branches of the lower mesenteric artery (a.mesenterica inferior)

4) ☑ the presence of arcades

5) ☐ venous outflow is carried out into the tributaries of the inferior Vena cava (V. cava inferior)

163. What are the features of lymphatic drainage from jejunum and ileum:

1) ☑ the presence of the lacteal sinus in the villus

2) ☐ lymph flow to regional omental lymph nodes (nodi lymphatici omentales)

3) ☑ location of lymph nodes in 4 rows

4) ☑ lymph flow to regional mesenteric lymph nodes (nodi lymphatici mesenteric)

5) ☑ the Central nodes are located on the trunks of the upper mesenteric vessels (vasa mesenterica superior)

164. Depending on the physique, the following options for the position of the loops of the small intestine are possible:

1)	☑	horizontal position
2)	☑	vertical position
3)	☑	oblique position
4)	☐	the small intestine in any type of physique is fixed in an upright position
5)	☐	the loops of the small intestine always move freely

165. What vessels in contact flexura duodenojejunalis?

1)	☑	superior mesenteric artery (a. mesenterica superior)
2)	☐	lower mesenteric artery (a. mesenterica inferior)
3)	☑	superior mesenteric vein (V. mesenterica superior)
4)	☐	lower mesenteric vein (V. mesenterica inferior)
5)	☐	pancreas-duodenal artery (a. pancreaticoduodenalis)

166. What are the features of the point Mac Burney:

1)	☐	used to find the projection of the apex of the vermiform process (appendix vermiformis)
2)	☑	used to find the projection of the base of the vermiform process (appendix vermiformis)
3)	☐	it is an accurate reference point
4)	☐	corresponds to the boundary between the inner and middle third line connecting the anterior upper iliac spine to the navel
5)	☑	corresponds to the boundary between the outer and middle third line connecting the anterior upper iliac spine to the navel

167. What are the features of the Lanz point:

1)	☑	used to find the projection of the apex of the vermiform process
2)	☐	corresponds to the boundary between the inner and middle third line connecting the anterior upper iliac spine to the navel (linea spinoubilicalis)
3)	☑	corresponds to the boundary between the outer and middle third line connecting the two anterior upper iliac awns (linea bispinalis)
4)	☐	corresponds to the boundary between the inner and middle third line connecting the two anterior upper iliac awns (linea bispinalis)
5)	☐	not clinically relevant

168. What are the derivatives of the peritoneum (peritoneum) in close proximity to the cecum (caecum):

1)	☑	recessus retrocecalis
2)	☐	right cecal sinus (sinus caecalis dexter)
3)	☐	ileum anterior cecal a hole (foramen ileocaecalis)
4)	☑	iliac-cecal pocket (recessus superior ileocaecalis)
5)	☑	lower iliac-cecal pocket (recessus inferior ileocaecalis)

169. What is the syntopia of hepatic curvature of the colon (flexura hepatica coli)?

1)	☐	left lobe of liver (lobus hepatis sinister)
2)	☑	right lobe of liver (lobus hepatis dexter)
3)	☑	gallbladder (vesica fellea)
4)	☐	stomach (gaster)
5)	☐	diaphragm

170. What is the syntopia of the ascending colon (colon ascendens)?

1) ☑ the greater omentum (omentum majus)
2) ☐ lesser omentum (omentum minus)
3) ☐ left kidney (ren sinister)
4) ☑ right kidney (ren dexter)
5) ☑ loops of the small intestine (intestinum tenue)

---

171. What is sellotape splenic curvature of the colon (flexura coli lienalis)?

1) ☑ the body of L1
2) ☐ the body L2
3) ☐ Th12 bodies
4) ☐ the cartilage of the seventh rib on the right
5) ☑ the cartilage of the VIII rib on the left

---

172. What is the skeletotopy of the points of the line of attachment of the mesentery of the sigmoid colon (colon sigmoideum)?

1) ☐ pubic symphysis (symphysis pubica)
2) ☑ between S2 and S3
3) ☐ between L2 and L3
4) ☑ iliac crest (crista iliaca)
5) ☐ the lower front iliac spine (spina iliaca anterior inferior)

---

173. The root of the mesentery:

1) ☑ passes obliquely from top to bottom, from left to right

2) ☐ passes across

3) ☐ directed obliquely from top to bottom, right to left

4) ☐ directed vertically from top to bottom

5) ☑ behind him in the retroperitoneal space are the horizontal part of the duodenum

---

174. With the help reception Gubarev find:

1) ☐ sigmoid colon

2) ☑ the initial division of the jejunum

3) ☐ caecum

4) ☐ the mesentery of the small intestine

5) ☑ duodenal-jejunal bend

---

175. Meckel's diverticulum is:

1) ☑ protrusion of the small intestine wall

2) ☐ protrusion of the colon wall

3) ☐ bulging of the wall of the sigmoid colon

4) ☑ non-infection of the yolk duct

5) ☐ protrusion of the rectal wall

---

176. Riolan’s arc is:

1) ☐ venous anastomosis

2) ☐ lymphatic anastomosis

3)	☑	arterial anastomosis
4)	☐	nerve plexus
5)	☑	anastomosis between the upper and lower mesenteric arteries

177. Riolan's arc:

1)	☐	it is formed by anastomosis between the middle colon and left colon veins
2)	☑	formed by the anastomosis between the middle colic and left colic arteries
3)	☐	formed by anastomosis between the right and middle colon arteries
4)	☐	formed by anastomosis between the superior mesenteric artery and the celiac trunk
5)	☑	anastomosis between the upper and lower mesenteric arteries

178. The location of the cecum at the level of the III sacral vertebra is:

1)	☐	more common in young people
2)	☑	means" pelvic " position of the cecum
3)	☑	more common in the elderly and senile age
4)	☐	means "obstructive" position of the cecum
5)	☐	means" typical " position of the cecum

179. The location of the cecum at level II of the lumbar vertebra is:

1)	☑	more common in young people
2)	☐	means" pelvic " position of the cecum
3)	☐	more common in the elderly and senile age
4)	☑	means "obstructive" position of the cecum

5) ☐ means" typical " position of the cecum

180. Superior mesenteric artery:

1) ☑ departs from the abdominal aorta at an acute angle at level I of the lumbar vertebra

2) ☐ blood supply to the sigmoid colon

3) ☐ it is a branch of the celiac trunk

4) ☐ ends in the left iliac fossa.

5) ☑ ends in the right iliac fossa.

181. Distinguishing features of the colon from the intestine:

1) ☐ the diameter of the colon is smaller than that of the small intestine

2) ☐ there is no difference

3) ☑ the diameter of the large intestine is larger than the small one

4) ☑ unlike the small intestine, there are omentum processes on the surface of the peritoneal cover of the colon

5) ☐ the wall of the small intestine forms haustra

182. Caecum syntopia:

1) ☑ in front of the cecum are loops of the small intestine

2) ☐ in front of the cecum is a small omentum

3) ☑ the inner edge of the cecum is adjacent to the right ureter

4) ☐ the inner edge of the cecum is adjacent to the bladder

5) ☐ posterior to the cecum located duodenum

183. Positions of the Appendix in the abdominal cavity:

1) ☐ top
2) ☑ lateral
3) ☑ retrocecal
4) ☐ paracecal
5) ☑ pelvic or descending

184. In the retrocecal position of the Appendix:

1) ☐ the process is subhepatic
2) ☑ the process lies intraperitoneal, closely adjacent to the peritoneum of the posterior wall of the cecum
3) ☐ the process lies in a small pelvis
4) ☑ the process is retroperitoneal or retroperitoneal
5) ☐ the process lies in the upper floor of the peritoneal cavity

185. In the medial position of the Appendix purulent process:

1) ☐ spreads through the left mesenteric sinus
2) ☑ spreads through the right mesenteric sinus
3) ☐ spreads to the upper floor of the abdomen
4) ☑ remains within the lower abdomen
5) ☐ distributed in a small pelvis

186. In the lateral position of the Appendix purulent process:

1) ☐ spreads through the left mesenteric sinus

2)	☐	spreads through the right mesenteric sinus
3)	☑	spreads to the upper floor of the abdomen
4)	☐	remains within the lower abdomen
5)	☑	distributed on the right side channel

187. Syntopia of ascending colon:

1)	☐	in front, it is separated from the anterior wall of the abdomen by loops of the colon and small omentum
2)	☑	on the right is attached to the right circumferential furrow
3)	☐	from above, it adheres to the small curvature of the stomach
4)	☐	inside of the posterior medial surface is the right ureter
5)	☑	in front, it is separated from the anterior wall of the abdomen by loops of the small intestine and partially by the large omentum

188. Blood supply to the ascending colon is carried out by branches:

1)	☐	truncus coeliacus
2)	☐	a. colica sinistra
3)	☑	a. colica dextra
4)	☑	a. colica media
5)	☐	a. colica intermedia

189. Syntopia of transverse colon:

1)	☐	it borders with the abdominal part of the esophagus from above
2)	☑	the posterior borderline is the duodenum, pancreas and left kidney

3) ☑ from below it adjoins the loops of the small intestine

4) ☐ from below it adjoins the loops of the colon

5) ☑ the front of the transverse colon is in contact with the front wall of the abdomen

---

190. Sigmoid colon:

1) ☐ has no mesentery

2) ☑ located in the left iliac fossa

3) ☑ covered by peritoneum intraperitoneally

4) ☐ covered by peritoneum extraperitoneal

5) ☑ it has a well-defined mesentery

---

191. To the formidable complications of intestinal suture, which improve the model (main) operational reception are:

1) ☑ the failure of the weld (intestinal fistula, peritonitis)

2) ☑ cicatricial stenosis of the intestine (intestinal mechanical obstruction)

3) ☑ infection of the abdominal cavity with intestinal microflora (peritonitis)

4) ☐ lymphorrhea

5) ☑ bleeding (into the peritoneal cavity or into the gut cavity)

---

192. The wounds of the small intestine are sutured after removing its loop from the abdominal cavity in order to:

1) ☑ reducing the probability of infection of the abdominal cavity and laparotomic wound with intestinal microflora

2) ☑ providing favorable conditions for the surgeon's work

3) ☐ prevention of intestinal paresis

4) ☐ prevention of adhesions

5) ☐ achieving thorough hemostasis

193. The outer case of the intestine form:

1) ☐ mucous membrane

2) ☐ submucosa

3) ☑ serous membrane

4) ☑ subserous base

5) ☑ muscular layer

194. The inner case of the intestine is made up of:

1) ☐ serous membrane

2) ☐ subserous base

3) ☐ muscular layer

4) ☑ submucosa

5) ☑ mucous membrane

195. The outer case of the stomach is reduced for a longer period compared to the inner due to:

1) ☐ the submucosa of the

2) ☑ the circular layer of the muscular membrane

3) ☐ serous membrane

4) ☑ longitudinal layer of the muscle membrane

5) ☑ the oblique fibers of the muscle membrane

196. The inner case of the thoracic esophagus is shortened over a longer period because of its adventitial membrane (loose fibrous unformed connective tissue):

1)	☑	fixed with connective tissue of the muscular membrane and connective tissue of the mediastinum
2)	☑	the submucosa base contains a large number of thick longitudinal bundles of collagen and elastic fibers
3)	☑	the muscle layer of the mucous membrane consists of longitudinal bundles of smooth muscle cells surrounded by a network of elastic fibers
4)	☐	the longitudinal muscle layer of the muscular membrane is formed by the striated muscles
5)	☐	the circular muscle layer is represented by smooth muscle cells

197. The intestinal suture should provide:

1)	☑	mechanical strength
2)	☐	formation of adhesions between organs
3)	☑	asepticism (i.e. biological integrity)
4)	☑	hemostasis
5)	☑	not valid cicatricial stenosis of the intestine

198. Intestinal suture N. I. Pirogov (1849) – is:

1)	☑	single-row
2)	☑	boundary
3)	☑	serous-muscular-submucosal
4)	☑	nodular with the nodules on the serous membrane
5)	☐	infected

199. Advantages of single-row continuous serous-muscular-submucosal suture using absorbable filaments (by V.

M. Buyanov, 1993):

1) ☐ Time-consuming (time-consuming)

2) ☑ the best conditions for blood circulation in the suture area are created

3) ☑ a more delicate scar is formed

4) ☑ there are no conditions for the development of microabscesses vnutrismennyh

5) ☑ reliable homeostasis is achieved

---

200. First row of Albert's double-row intestinal suture:

1) ☑ continuous

2) ☑ suture

3) ☑ catgut thread

4) ☑ infected

5) ☐ serous-muscular

---

201. The second row of the double-row suture of the intestine (esophagus) Kirpatovsky:

1) ☑ nodal

2) ☑ serous-muscular

3) ☑ boundary

4) ☐ continuous suture

5) ☐ catgut thread

---

202. For suturing of the front wall (lips) anastomosis Shmiden suggested seam:

1) ☑ screwing the mucous membrane into the intestinal cavity

2) ☑ continuous

3) ☐ The seam is not captured muscularis

4) ☑ through all of the shell

5) ☑ with the wall flashing in the sequence “mucosa -> serosa” – one side is “mucosa -> serosa” - another

203. In operations on the large intestine in classical abdominal surgery, a three-row intestinal suture is used because of:

1) ☑ high level of microbial contamination

2) ☑ the lack on the part of the ascending and descending colon intestines and serous membranes

3) ☑ the worst of the blood supply (compared to the small intestine) and a longer period of scar formation

4) ☑ greater mechanical stress on the joints

5) ☐ early resorption of suture material

204. Complete peritonization of three-row intestinal suture provides suture:

1) ☐ front row

2) ☑ grey-serous

3) ☑ nodal (by Shevkunenko, 1951)

4) ☑ third row

5) ☑ thread of non-absorbable material

205. The cut wound of the small intestine is sutured in one of the directions to the axis of the organ-tube:

1) ☑ transverse

2) ☐ longitudinal

3) ☑ cross

4) ☐ oblique-longitudinal

5) ☐ circular

206. Taking into account peristalsis, inter-intestinal anastomoses can be:

1) ☐ peristaltic

2) ☑ antiperistaltic

3) ☑ isoperistaltic

4) ☐ all answers are correct

5) ☐ there are no correct answers

207. The danger of cicatricial stenosis of intestinal anastomosis end-to-end can be reduced:

1) ☑ excision of the ends of the driving and diverting sections at an angle of 45°

2) ☑ suturing the probe

3) ☑ with the use of cuts of the ends of the driving and diverting sections in the form of a “racket”

4) ☑ the imposition of discontinuous seams (nodal, U - shaped)

5) ☐ using a continuous suture

208. Resection of the small intestine with anastomosis side to side consists of stages (performed laparotomy):

1) ☑ mobilization of the part of the intestine to be excised

2) ☑ resection and formation of a stump leading and outlet divisions

3) ☑ formation of the anastomosis

4) ☑ the suturing openings of the mesentery

5) ☐ control of anastomosis patency

209. Rules of formation of anastomoses side to side of the tubular structure of the digestive system:

1) ☑ without tension

2) ☑ the proximal (leading) department is placed up from the distal (diverting) department

3) ☑ the width of the anastomosis is 1.5-2 transverse size of the intestine

4) ☑ the length of the stump of the driving department is not more than 1-1. 5 cm

5) ☐ without taking into account the direction of peristalsis

210. When forming a thin-intestinal anastomosis "side to side" seams are applied in the following sequence:

1) ☑ posterior aseptic (serous-muscular - Lambert)

2) ☑ back infected (continuous, continuous, blanket - Mikulich)

3) ☑ infected front (cross-cutting, screwing - Sedena). The infected stage of the operation is completed

4) ☑ anterior aseptic (serous-muscular - Lambert)

5) ☐ the seam Mateshuk

211. Vulnerable zones of anastomosis "end to end" (where it may develop an inconsistency of seams) are:

1) ☑ the place of attachment of the mesentery (for 2-4 mm. there is no serous membrane)

2) ☑ the transition zone of the back row of anastomosis seams in the front

3) ☐ the middle of the aseptic suture line along the anterior wall of the anastomosis

4) ☐ the middle of the infected suture line along the posterior wall of the anastomosis

5) ☐ middle

212. "Classical" (open) appendectomy consists of stages:

1) ☑ right oblique approach
2) ☑ stage-by-stage mobilization of the worm-like process
3) ☑ ligature-invagination technique of stump treatment
4) ☑ layer-by-layer suturing of the abdominal wall wound
5) ☐ drainage of the abdominal cavity

213. For fixation of the Appendix with ligation of its mesentery and the imposition of a purse-string suture hemostatic clip is applied to Billroth:

1) ☑ the free edge of the mesentery at the apex of the vermiform process
2) ☐ base of the mesentery of the vermiform process
3) ☐ the dome of the cecum
4) ☑ the base of the vermiform process
5) ☐ place the overlay clip Billroth doesn't matter

214. The purse string suture on the dome of the cecum is applied to the intersection of the vermiform process for:

1) ☐ hemostasis's
2) ☑ aseptic
3) ☐ prevention of intracranial abscess of the cecum
4) ☐ exception slipping of ligature from the stump of the mesentery of the Appendix
5) ☑ safe shelter of the stump of the Appendix

215. One of the complications of appendectomy ligature-invagination way to:

1) ☐ bleeding from the stump of the mesentery of the Appendix

2) ☑ intracranial abscess of the cecum

3) ☐ abscess of the rectum-uterine deepening (in women)

4) ☐ damage to the right ureter

5) ☑ small bowel mechanical obstruction (due to seizure of the ileum wall in the seam)

---

216. The advantages of laparoscopic appendectomy are:

1) ☑ low injury rate

2) ☑ easy postoperative course

3) ☑ less likelihood of adhesions in the abdomen

4) ☑ cosmetic effect

5) ☐ low cost

---

217. At the point of McBurney is not projected:

1) ☑ mesentery root of the transverse colon

2) ☐ the base of the vermiform process

3) ☑ pylorus

4) ☑ gallbladder

5) ☑ duodenal-jejunal bend

---

218. Lanz's point does not match:

1) ☑ the boundary between the outer and middle third line connecting the anterior upper iliac spine to the navel

2) ☑ the boundary between the inner and middle third line connecting the anterior upper iliac spine to the navel

3) ☐ the boundary between the outer and middle third line connecting the two anterior upper iliac awns

4) ☑ the boundary between the inner and middle third line connecting the two anterior upper iliac awns

5) ☐ medial edge of rectus abdominis

219. Expedient number of sutures when suturing wounds of the small intestine:

1) ☑ single-row

2) ☑ double-row

3) ☐ three-row

4) ☐ four row

5) ☐ the number can be any

220. To aseptic (not penetrating into the cavity of the body) intestinal sutures include:

1) ☑ Albert's seam

2) ☑ a purse string suture

3) ☐ Schmiden's screwing seam

4) ☑ sero-muscular suture

5) ☑ sero-serous suture

221. Asepsis (biological integrity) of intestinal suture based on:

1) ☐ the presence in the submucosa of arterial,venous,lymphatic and nerve plexus

2) ☐ the smooth surface of the intestinal wall

3) ☑ plastic properties of the peritoneum (ability to glue serous surfaces)

4) ☐ varying degrees of contractility of the gut cases

5) ☑ 3 mm seam step

222. Through (infected) intestinal sutures include:

1) ☑ suture of Jobert

2) ☐ seam Pirogov

3) ☐ Lambert seam

4) ☑ Schmiden's screwing seam

5) ☑ Jelly seam

223. When performing operations on the hollow organs of the abdominal cavity, it is necessary to observe the rules:

1) ☑ avoid intraoperative infection of the abdomen

2) ☑ exclude hypothermia and drying of the serous lining of the intestine

3) ☐ diaphragm damage is not allowed

4) ☑ to exclude decorazione sections on

5) ☑ restore the continuity and tightness of the intestinal tube

224. Lambert's intestinal suture has the following disadvantages:

1) ☑ fragile

2) ☑ does not provide hemostasis

3) ☑ accompanied by the formation of a rough scar

4) ☑ there is no comparison of other intestinal membranes

5) ☐ a lot of time is spent

225. Rules for the suturing of the walls of hollow organs:

1) ☐ the wall of the small and large intestine is stitched in the oblique lateral direction of the serous membrane

2) ☐ when applying a through seam, the distance between the stitches (seam step) should be at least 9 mm.

3) ☑ the wall of the small and large intestine is stitched perpendicular

4) ☑ when applying a through seam, the seam step should be 3 mm.

5) ☐ the wall of the small and large intestine is stitched in the oblique medial direction from the mucosa to adventitia

226. The advantages of manual intestinal suture

1) ☑ permanent visual control of equipment each item of the seam

2) ☑ the possibility of dose load to the tightening of the ligature

3) ☑ easy to overlay

4) ☐ provides greater strength of the anastomosis (compared to the mechanical seam)

5) ☑ the possibility of stitching the edges of the wound complex shape

227. Disadvantages of manual intestinal suture:

1) ☐ does not provide strength

2) ☑ the relative complexity of the seam

3) ☑ difficulties of observance of rules of asepsis

4) ☐ the impossibility of the suturing of the wound edges of complex shapes

5) ☑ the accumulation of small technical errors that worsen the quality of the seam

228. Types of accesses to perform open surgery on the colon:

1) ☑ a lower midline laparotomy

2) ☐ upper median laparotomy

3) ☐ right oblique subcostal incision

4) ☑ left-sided hypochondrium oblique incision

5) ☑ Pfannenstiel cross section

---

229. Possible complications in the formation of inter-intestinal anastomosis:

1) ☐ bleeding from the blood vessel of the mesentery

2) ☑ cicatricial stenosis of the anastomosis

3) ☑ failure of anastomotic sutures

4) ☐ mitral valve stenosis

5) ☑ damage to adjacent abdominal organs

---

230. With operative access to the worm-like process with an open method:

1) ☑ dissect aponeurosis of the external oblique abdominal muscle

2) ☐ dissect the internal oblique abdominal muscle

3) ☑ in a blunt way, in the course of the fibers, the internal oblique abdominal muscle is separated

4) ☐ in a blunt way, in the course of the fibers, the outer oblique abdominal muscle is separated

5) ☑ in a blunt way, in the course of the fibers, the transverse abdominal muscle is separated

---

231. For unnatural anus on Midly typical:

1) ☐ online access – a lower midline laparotomy

2) ☑ the purpose of the operation-the diversion of feces out and " off " rectum

3) ☑ use sigmoid colon

4) ☑ form a "spur" - fold of the wall of the sigmoid colon, separating the leading and diverting departments

5) ☐ use the ileum

232. Mobilization of the small intestine is:

1) ☑ separation of the intestine from the mesentery

2) ☐ removal of the intestine into the wound immediately laparotomy

3) ☐ suturing of the intestine to the peritoneum of the anterior abdominal wall

4) ☐ covering the intestinal loop with tissues with warm saline

5) ☑ careful ligation of the blood vessels of the mesentery

233. As applied intestinal army, in relation to the gut before crossing?

1) ☐ at an angle open to the mesenteric edge of the intestine

2) ☐ parallel to the gut

3) ☑ at an angle, open to opposite mesenteric edge edge

4) ☑ perpendicular to the gut (in children)

5) ☐ the position of the house in relation to the gut does not matter

234. During appendectomy a purse string suture on the blind gut impose departing from the base of the Appendix:

1) ☑ 1.5 cm.

2) ☐ 3.0 cm.

3) ☐ It doesn't matter

4) ☐ 4.0 cm.

5) ☑ 1.0 cm.

235. Retrograde appendectomy is performed when:

1) ☑ involvement of the Appendix into adhesions with the posterior abdominal wall

2) ☐ subhepatic position of the vermiform process

3) ☑ pelvic position of the vermiform process

4) ☐ when removing the vermiform process together with the Meckel diverticulum

5) ☐ laparoscopic appendectomy

236. Colostomy and unnatural anus are different:

1) ☑ the presence of "spurs" unnatural anus

2) ☐ the presence of "spurs" colostomy

3) ☐ various operational accesses

4) ☑ colostomy provides decompression of the colon

5) ☑ the unnatural anus has the purpose of "turning off" the rectum

237. Operative approaches to the stomach:

1) ☐ a lower midline laparotomy

2) ☑ upper median laparotomy

3) ☐ Pfannenstiel access

4) ☑ the left upper transrectal approach

5) ☑ cross approach by Shprengel

238. If gastrotomy appropriate upper median laparotomy:

1)	☑	white abdominal incision with minimal blood loss
2)	☑	access to the " free field of the stomach"
3)	☑	access to the " vascular-free zone of the stomach"
4)	☑	the shortest (cut through fewer layers)
5)	☐	penetration into the pleural cavity is excluded

239. The purpose of gastrostomy is:

1)	☑	artificial feeding of the patient
2)	☑	preparation for surgical treatment of the underlying disease (obstruction of the pharynx, esophagus, cardia of various etiologies)
3)	☑	probing of the esophagus retrograde way
4)	☑	elimination of hypoproteinemia
5)	☐	removal of foreign body

240. Indications for gastrotomy:

1)	☑	foreign body of the stomach if it is impossible to remove it by gastroscopy
2)	☐	chronic gastritis
3)	☑	removal of bezoar
4)	☐	acute cholangitis
5)	☑	gastric bleeding (if conservative and gastroscopic methods of hemostasis are ineffective)

241. Left thoracophrenolaparotomy used in:

1) ☑ supra-diaphragmatic vagotomy

2) ☐ pyloroplasty by Heineck-Mikulich

3) ☑ resection of the thoracic esophagus

4) ☑ resection of the abdominal esophagus with cardia and the bottom of the stomach

5) ☑ esophagocardiomyotomy by Heller

---

242. With cicatricial stenosis of the esophagus, temporary gastrostomy is used for:

1) ☑ Witzel

2) ☑ Ternovsky-Yudin

3) ☑ Stamm-Kader

4) ☐ Toprover

5) ☐ Yukhtin

---

243. In inoperable cancer of the cardia, permanent gastrostomy is used for:

1) ☐ Witzel

2) ☐ Ternovsky-Yudin

3) ☐ Stamm-Kader

4) ☑ Toprover

5) ☑ Yukhtin

---

244. A model for gastrostomy for Yukhtin are anatomic relationships:

1) ☑ of the esophagus with the diaphragm opening

2) ☑ of the stomach and the left rectus

3) ☐ duodenum with pancreatic head

4) ☑ parietal peritoneum of the left half of the anterior abdominal wall with the anterior wall of the stomach

5) ☐ large curvature of the stomach with transverse colon

---

245. The possibility of food entering the peritoneal cavity with gastrostomy is warned:

1) ☐ omentopexy (suturing the greater omentum to the stomach wall)

2) ☑ suturing the anterior wall of the stomach to the parietal peritoneum

3) ☐ suturing of omental processes to the stomach

4) ☑ suturing of the anterior wall of the stomach to the aponeurosis of the anterior abdominal wall

5) ☐ suturing the stomach wall to the liver

---

246. The wound of the stomach after gastrostomy is sutured:

1) ☐ serous-muscular sutures

2) ☐ continuous suture with a suture Mikulic

3) ☑ in the transverse direction to the axis of the stomach

4) ☐ Pirogov's seam in the longitudinal direction to the stomach axis

5) ☑ double-row Albert seam

---

247. Gastrostomy for Witzel is characterized by:

1) ☐ using stenosis of the pylorus

2) ☑ it is used for cicatricial strictures of the esophagus

3) ☑ the channel for the tube is formed by a serous membrane

4) ☐ it is a kind of permanent gastrostomy

5) ☑ it belongs to the group of temporary external fistulas of the stomach

248. Gastrostomy according to Toprover is characterized by:

1) ☑ it's a persistent external fistula of the stomach
2) ☐ it is a type of temporary gastrostomy
3) ☑ it is indicated for inoperable tumors of the esophagus
4) ☑ the channel for the probe is formed by the mucous membrane
5) ☑ the front wall of the stomach is used

249. The direction of the end of the drainage tube to the bottom of the stomach cut to the cardia with gastrostomy on Ternovsky-Yudin has a purpose:

1) ☑ the possibility of a retrograde birovni of the esophagus
2) ☑ feeding the patient
3) ☐ decompression of the stomach
4) ☐ stimulation of gastrin production
5) ☐ improvement of evacuation function of the stomach

250. To form a tubular fistula of the stomach on the Stamm-Kader using the wall:

1) ☐ rear
2) ☐ greater curvature
3) ☐ front closer to the bottom
4) ☑ anterior on the border of the cardiac and pyloric parts of the stomach
5) ☑ anterior on the border of small and large curvature of the stomach

6) ☐ the choice of the wall doesn't matter

251. With a temporary external fistula of the stomach, after removing the tube, the hole in its wall is closed:

1) ☐ near serous-muscular sutures

2) ☐ peritonization with a flap of the large omentum on the leg

3) ☐ purse-string serous-muscular suture

4) ☑ spontaneously

5) ☑ by epithelialization of the fistulous

252. When applying a permanent fistula of the stomach by Yukhtin wall is fixed to:

1) ☑ the parietal peritoneum

2) ☑ the posterior wall of the aponeurotic vagina of the left rectus abdominis

3) ☐ the anterior wall of the aponeurotic vagina of the right rectus abdominis

4) ☐ the rectus abdominis

5) ☐ skin of the anterior abdominal wall

253. At gastrostomy on Toprover the anterior wall of the stomach is not sutured to the aponeurotic vagina of the rectus abdominis muscle at the level of:

1) ☑ the outer purse-string suture

2) ☐ medium purse-string suture

3) ☑ the inner purse-string suture

4) ☑ do not hem to the anterior abdominal wall

5) ☑ select the level of purse-string suture does not matter

254. Stages of elimination of permanent gastric fistula are:

1) ☑ excision of skin (outer) hole of the fistula bordering the slits to seal the hole
2) ☑ secrete fistula to the stomach
3) ☑ edging incisions excise the gastric end of the fistula
4) ☑ the wound of the stomach is sutured with a two-row suture, the laparotomic wound is layered
5) ☐ perform the gastric resection by Billroth-I

255. Gastric resection by Bilrot-II in the modification of Balfour is characterized by:

1) ☑ gastroenteroanastomosis end-to-side using a long loop of the jejunum
2) ☐ piloroplasty by Finney
3) ☐ perevalochny holding of the intestinal loop
4) ☑ enteroenteroanastomosis by Brown
5) ☑ duodenal switch-off

256. Branches of vagus nerves in selective vagotomy dissect in the ligament:

1) ☐ in the hepatoduodenale
2) ☑ in the hepatogastrica
3) ☐ in the gastrointestinal tract
4) ☐ in the phrenicocolica
5) ☑ in the hepatic pyloric

257. What are the branches of the posterior wandering trunk that must be preserved during vagotomy

1) ☐ renal

2) ☑ the back the nerve of lesser curvature

3) ☐ posterior gastric

4) ☑ celiac

5) ☐ gatekeeper's branch

258. Complications of vagotomy include:

1) ☑ slowing gastric emptying

2) ☑ excessive denervation of the esophagus (there is dysphagia and even cardiospasm)

3) ☐ damage to the ileum

4) ☐ damage to the transverse colon

5) ☑ incomplete vagotomy (additional branches of wandering trunks or rear wandering trunk are not dissected)

259. Operational approach to the rear wandering trunk is not carried out:

1) ☑ incision of the hepato-duodenal connection

2) ☑ through the gland opening

3) ☑ through the mesentery of the transverse colon

4) ☐ through the gastrointestinal tract

5) ☑ the dissection of gastro-splenic ligament

260. Gastrojejunostomy as a bypass anastomosis is used when obstruction

1) ☐ cardias

2) ☑ the pyloric cave

3) ☑ the pyloric channel

4) ☑ pylorus

5) ☑ the upper part of the duodenum

261. Methods of gastroenteroanastomosis:

1) ☑ posterior behind the colon

2) ☑ front behind the colon

3) ☑ rear front colon

4) ☑ anterior front colon

5) ☐ the gastro-colonic anastomosis

262. Specify the length of the loop of the jejunum, which is not used for posterior posterior vertical gastroenterostomy Gakker-Petersen:

1) ☑ long (50 cm)

2) ☐ short (10 cm)

3) ☑ small (3 cm)

4) ☑ very large (100 cm)

5) ☑ the length of the loop of the jejunum does not matter

263. At the rear behind the colon gastrojejunostomy anastomosis is not:

1) ☐ in the lower abdomen

2) ☑ in the pelvic cavity

3) ☑ in the upper abdomen

4) ☑ in the stuffing box

5) ☑ in the pancreatic bag

264. Specify the length of the loop of the jejunum from the duodenal-skinny bend, which is not used for anterior fore-lateral horizontal gastroenterostomy by Velfler:

1) ☐ long (50 cm)

2) ☑ short (10 cm)

3) ☑ the length of the loop of the jejunum does not matter

4) ☑ small (3 cm)

5) ☑ very large (100 cm)

265. Explain why in anterior front colon horizontal gastrojejunostomy use a long loop of the small intestine:

1) ☑ for applying the anastomosis without tension

2) ☑ in order to avoid compression of the transverse colon

3) ☑ to be able to impose an enteroenteroanastomosis Brown (anastomosis between the leading and diverting loops)

4) ☐ for the convenience of surgical instruments

5) ☐ in order to prevent the insolvency of the anastomotic suture

266. Enteroenteroanastomosis of gastroenterostomy is not applied with the aim:

1) ☑ improving the outflow of bile into the duodenum

2) ☑ decompression of the small intestine

3) ☐ preventing the " vicious circle"

4) ☑ prevention of peptic ulcer of small curvature of the stomach

5) ☑ reduce production of gastrin

267. The development of the "vicious circle" after the gastroenteroanastomosis on Velfler explains:

1) ☑ the position of the leading and diverting loops at the same level (violated the rule "2 M" and " 2 B»)

2) ☑ partial patency of the pyloric canal and duodenum

3) ☑ scar stenoses of the diverting loop

4) ☐ antiperistalsis of the stomach

5) ☐ the presence of adhesions of the stomach with the gallbladder

---

268. Explain the rule of gastric surgery "two M" and " two B»

1) ☑ a small (resulting loop) is fixed to a small curvature

2) ☑ the large (outlet loop) sutured to the greater curvature

3) ☐ to the great curvature of the stomach fix the duodenum

4) ☐ the small curvature of the stomach is connected to the large omentum

5) ☐ to the great curvature of the stomach, a large omentum is sutured

---

269. Resection of the stomach by Billroth I method comprises the steps of:

1) ☑ Stage 2: mobilization of the stomach

2) ☑ Stage 1: determination of the proximal border of gastric resection

3) ☑ Stage 3: gastric resection

4) ☑ Stage 4: formation of small curvature and imposition of gastroduodenostomy type " end to end"

5) ☐ suturing of a hole in the mesentery of the transverse colon

---

270. Mandatory conditions to create gastroduodenoanastomosis stomach resection Billroth I are:

1) ☑ ensuring the commensurability of the width of the stump of the stomach and duodenum

2) ☑ create gastroduodenoanastomosis tension

3) ☑ the formation of the long stump of the stomach

4) ☐ the stump of the stomach should be short

5) ☐ the stump of the stomach is fixed to the hepatic duodenal ligament

---

271. Suturing the stump of the stomach to the size of the duodenum with gastric resection by Bilrot I is performed for:

1) ☑ ensuring the commensurability of the lumen of the stomach stump and the lumen of the duodenum

2) ☐ prevention of "leading loop" syndrome"

3) ☐ inter-intestinal anastomosis by brown

4) ☑ formation of small curvature of the stomach

5) ☐ prevention of duodenogastric reflux

---

272. The mobilize duodenum according to Kocher, is:

1) ☑ elimination of tension in the gastroduodenoanastomosis zone

2) ☑ the possibility of rapprochement of the stump of the stomach and duodenum

3) ☐ creating conditions for mechanical gastroduodenoanastomosis

4) ☐ elimination of difficulties in crushing the stump of the stomach

5) ☐ facilitating the mobilization of large curvature of the stomach

---

273. The indications for gastric resection by Bilrot II include:

1) ☑ complicated gastric and duodenal ulcers

2) ☐ bleeding from the cardiac part of the stomach

3) ☐ hepatitis

4) ☑ the need for a large volume of resected stomach area

5) ☑ malignant tumors of the stomach with a violation of the evacuation of the contents of the duodenum

---

274. When resection of the stomach by Bilrot II in the modification of Balfour (with a malignant tumor) is simultaneously removed:

1) ☑ duodenum

2) ☑ esophagus

3) ☐ greater omentum

4) ☑ transverse colon

5) ☑ gallbladder

---

275. Rapid evacuation of gastric contents into the jejunum during gastric resection by Bilrot II in the modification of Reichel-Polya is due to:

1) ☑ large width of gastrointestinal anastomosis

2) ☐ lack of pyloric sphincter

3) ☑ violation of the rule "2 M" and " 2 B»

4) ☑ by eliminating the influence of the parasympathetic fibers of the vagus trunks

5) ☑ a small amount of the remaining part of the stomach

---

276. To create posudomoechnaja of the gastroenteroanastomosis resection of stomach by Billroth II (in versions Reichel - Polya and Hofmeister-Finsterer) the stump of the stomach is not carried out through:

1) ☑ small gland

2) ☐ mesentery of the transverse colon

3) ☑ greater omentum (2 rear leaf peritoneum)

4) ☑ gastro-colon ligament

5) ☑ gastric-splenic ligament

---

277. In the process pronounceing gastrectomy create gastroduodenoanastomosis "end to end". This method is not called resection:

1) ☐ Bilrot I

2) ☑ Bilrot II

3) ☑ Hofmeister-Finsterer

4) ☑ Moynihan

5) ☑ Reichel-Polya

---

278. To modifications of gastric resection by Bilrot II include ways:

1) ☑ Reichel-Polya

2) ☑ Hofmeister-Finsterer

3) ☐ Cranlana

4) ☑ Balfour.

5) ☐ Paean's

---

279. When suturing perforated stomach ulcer at the Polikarpov impose:

1) ☐ three rows of serous-muscular seams Lambert

2) ☐ the seam line corresponds to the longitudinal axis of the stomach

3) ☑ two rows of serous-muscular sutures Lambert

4) ☑ the perforating ulcer is sutured in the transverse direction to the axis of the stomach

5) ☑ the stitches peritonitic flap of the greater omentum on a leg

280. When mobilizing a small curvature of the stomach (stage of organ resection) in the hepatic-gastric ligament, the artery is tied:

1) ☐ left gastro-omental

2) ☑ the left gastric

3) ☐ gastro-duodenal

4) ☐ right gastro-omental

5) ☑ right gastric

281. The intersection of the gastric branches of the vagus trunks, together with other elements of the hepatic-gastric ligament contributes:

1) ☐ the easy mobilization of the lesser curvature of the stomach

2) ☑ hemostasis

3) ☑ the elongation of the lesser curvature

4) ☑ superposition of gastroduodenoanastomosis without tension

5) ☐ to ensure asepticity of the anastomotic suture line

282. By draining the stomach operations include:

1) ☐ the gastro-jejunal anastomosis

2) ☑ piloroplasty by Finney

3) ☐ esophagoenteroanastomosis

4) ☑ pyloroplasty by Heineck-Mikulich

5) ☑ pyloroplasty for Jabuley

283. The channel for the probe at a constant gastrostomy is not formed by the shell:

1) ☑ serous
2) ☑ muscular
3) ☐ mucous
4) ☑ submucosa
5) ☑ muscle plate of the mucous membrane

284. The channel for the probe in tubular fistula (temporary gastrostomy) is not formed by the shell:

1) ☐ serous
2) ☑ muscular
3) ☑ mucous
4) ☑ submucosa
5) ☑ subserous basis

285. Gastrectomy – surgery admission indicating the deletion:

1) ☑ stomach's
2) ☐ cardiac part
3) ☐ pyloric part
4) ☐ bodies and pyloric cave
5) ☑ together with the cardiac pyloric part

286. Advanced gastrectomy is the removal of

1) ☐ cardiac and pyloric parts
2) ☑ stomach and spleen
3) ☑ stomach, transverse colon and greater omentum
4) ☐ the body and the pyloric cave
5) ☑ stomach and left lobe of liver

287. Levels blockade of the portal circulation:

1) ☑ suprahepatic (Budd-Chiari syndrome – hepatic vein thrombosis)
2) ☐ diaphragmatic
3) ☑ hepatic (cirrhosis of the liver)
4) ☐ renal-bulk
5) ☑ subhepatic (compression of the portal vein in cancer of the pancreatic head)

288. Groups of portocaval anastomoses (on a topographic basis), contributing to the compensation of blood circulation in portal hypertension:

1) ☐ splenorenal
2) ☑ anterior parietal (on the anterior abdominal wall)
3) ☑ lower visceral (venous plexus of the rectum)
4) ☑ upper visceral (esophageal-gastric) compounds
5) ☑ rear parietal (in retroperitoneal space)

289. One of the life-threatening complications of portal hypertension is bleeding from varicose veins:

1) ☐ the anterior abdominal wall ("head of Medusa»)

2) ☐ front chest wall

3) ☐ retroperitoneal space

4) ☑ lower third of the thoracic esophagus

5) ☑ the cardia of the stomach

---

290. To stop esophageal-gastric bleeding (a complication of portal hypertension), a tampon is used with an obstructing probe:

1) ☑ Sengstaken

2) ☐ Fogarty

3) ☐ Foley

4) ☑ Blackmore-Sengstaken

5) ☐ Kocher

---

291. Veins – tributaries of the portal vein to be used for portocaval shunts:

1) ☐ the left gastric

2) ☐ right gastric

3) ☑ splenic

4) ☑ superior mesenteric

5) ☐ lower mesenteric

---

292. The number of operations in profuse bleeding from varicose veins of the esophagus should include:

1) ☑ subcardinal having varices laparotomy access

2) ☑ Tanner's operation is a transverse dissection of the stomach, followed by the connection of its parts by the imposition of a two-row intestinal suture

3) ☐ gastrectomy

4) ☐ subtotal resection of the stomach

5) ☑ splenectomy

293. In the surgical treatment of portal hypertension, portocaval anastomoses are used:

1) ☑ direct portocaval

2) ☑ splenorenal

3) ☑ mesenteric-cavalry

4) ☑ transjugular intrahepatic laser technology and subsequent stenting

5) ☐ between the umbilical and superior epigastric veins

294. Types of operative accesses to the liver:

1) ☐ a lower midline laparotomy

2) ☑ right oblique subcostal (Kocher)

3) ☑ right-hand corner (Rio Branco)

4) ☑ right-sided oblique hypochondrium (S. P. Fedorov)

5) ☐ transverse laparotomy (Pfannenstiel)

295. Surgical access to the organs hepatobiliopancreatoduodenal zones are cut:

1) ☑ right oblique subcostal

2) ☑ from the top of the xiphoid process 4 cm down the median line, then parallel to the right edge arc

3) ☐ right-sided pararectal Lennander

4) ☐ upper median laparotomy

5) ☐ left-sided oblique hypochondrium

296. The landmarks of operative access to the liver according to S. P. Fedorov are:

1) ☐ falciforme ligament of the liver

2) ☑ the top of the xiphoid process

3) ☑ front median line

4) ☐ navel

5) ☑ lower edge of the right edge arc

297. Operational approach to the gallbladder of Rio Branco perform:

1) ☐ from the top of the xiphoid process 4 cm downwards and parallel to the right edge arc

2) ☐ from the top of the xiphoid process along the white line of the abdomen for 5 cm, then parallel to the left rib arch

3) ☐ on the white line of the abdomen over 10 cm.

4) ☑ from the xiphoid process along the white line of the abdomen, not reaching 4 cm to the navel, then continues

5) ☑ right angle right to end of x rib

298. The boundaries of the right and left lobes of the liver correspond to the plane between:

1) ☐ the gate of the liver

2) ☑ the middle of the gallbladder bed

3) ☑ inferior Vena cava

4) ☐ falciforme ligament of the liver

5) ☐ hepatoduodenal ligament

299. Components of the vascular-secretory triad ("glassonby legs") of a share, sector, segment are the branches:

1) ☐ the celiac trunk

2) ☑ portal vein

3) ☑ own hepatic artery

4) ☑ common hepatic duct

5) ☐ umbilical vein

300. Liver resection, taking into account the intra-organ distribution of the vascular-secretory triad, allows to avoid a number of complications:

1) ☑ bleedings

2) ☑ flow of bile

3) ☑ embolisms

4) ☑ circulatory disorders and outflow of bile in the left part of the liver

5) ☐ hypertension in the duodenum

301. Types of liver hemostatic sutures:

1) ☑ Oppel

2) ☑ U-shaped Kuznetsova-Pensky

3) ☑ U-shaped with a greater omentum

4) ☐ edge seam Bir

5) ☑ Bregvadze's garland stitch

302. To the typical (anatomical) resections of the liver are:

1) ☐ boundary

2) ☐ wedge-shaped resections

3) ☑ lobectomies

4) ☑ segmental

5) ☑ sectoral resections

303. In cirrhosis of the liver to reduce pressure in the portal vein and prevention of esophageal-gastric bleeding is used:

1) ☑ splenectomy

2) ☑ indirect portocaval anastomoses

3) ☑ direct portocaval anastomoses

4) ☐ ligation of the celiac trunk

5) ☐ umbilical vein arterialization

304. By type of operative approach to the gallbladder distinguish:

1) ☐ combined cholecystectomy

2) ☑ open cholecystectomy (one of the laparotomic approaches)

3) ☑ cholecystectomy by probe

4) ☐ mucoceles (excision of the mucous membrane of the gall bladder)

5) ☑ laparoscopic cholecystectomy

305. Advantages of cholecystectomy from the neck:

1) ☐ the risk of damage to the left renal artery is reduced
2) ☑ reduces the risk of migration of gallstones in the common bile duct
3) ☑ applies the allocation of subserous gallbladder from the liver "bed»
4) ☑ provides a relatively " dry " operating field
5) ☐ speed of execution

306. Intraoperative complications of cholecystectomy include:

1) ☑ parenchymal bleeding from the hepatic bed of the gallbladder
2) ☑ damage (or ligation) of the right branch of the own hepatic artery
3) ☑ ligation of the common hepatic (or common bile duct)
4) ☐ biliary fistula
5) ☐ injury of the inferior Vena cava

307. In the conditions of the gallbladder junctions with the adjacent right bend of the colon and duodenum, cholecystectomy differs from the bottom:

1) ☐ technical simplicity
2) ☐ accessibility for the low-skilled surgeon
3) ☑ less risk of damage to the liver-duodenal ligament elements
4) ☑ easier identification of the cystic duct and cystic artery
5) ☐ risk of damage to the right kidney

308. When cholecystectomy in the process of ligation and treatment of the stump of the cystic duct, complications may occur:

1)	☑	leaving a long stump of the cystic duct (later " cholecystitis without gallbladder»)
2)	☑	the cystic duct is ligated at the confluence with the common hepatic (cicatricial stenosis of the extrahepatic bile ducts → obstructive jaundice)
3)	☑	incorrectly tied the common bile duct (obstructive jaundice)
4)	☑	injury of the common hepatic duct (biliary fistula)
5)	☐	portal hypertension

309. Types of drainage of the common bile duct:

1)	☑	Kerr (T-shaped drainage "common bile duct»)
2)	☐	Billroth
3)	☑	A. V. Vishnevsky (siphon drainage "common bile duct»)
4)	☑	The Halstead-Pikovsky (the drainage of "common bile duct" through the stump of the cystic duct)
5)	☐	Kocher

310. Choledochotomy is indicated for:

1)	☑	choledocholithiasis (common bile duct stones)
2)	☑	stenosis of major duodenal papilla
3)	☑	mechanical jaundice
4)	☐	gastroptosis
5)	☐	duodenoscope

311. To biliodigestive anastomoses (new ways of removal of bile) are:

1)	☑	cholecystojejunostomy

2) ☑ cholecystoduodenostomy

3) ☑ choledochojejunostomy

4) ☑ choledochoduodenostomy

5) ☐ gastrojejunostomy

---

312. When wound of the common bile duct in the process of cholecystectomy and the inability of the anastomosis end-to-end perform:

1) ☐ side to side anastomosis

2) ☐ segmental liver resection

3) ☑ hepatico jejuno on off on Roux loop of intestine with intestinal sostem

4) ☐ both ends of the duct are bandaged

5) ☑ choledochoduodenostomy with ligation of the lower section of the common bile duct

---

313. Endoscopic retrograde cholangiopancreatography is indicated for:

1) ☑ mechanical jaundice

2) ☑ suspected pancreatic head cancer in the case of low informative instrumental methods of diagnosis

3) ☑ chronic pancreatitis with formation of cysts after the imposition of pancreatic jejuno anastomosis

4) ☑ indications for endoscopic papillosphincterotomy

5) ☐ high small bowel obstruction

---

314. Choledochotomy is completed in the following ways:

1) ☑ blind suture of the common bile duct

2) ☐ internal drainage of the "common bile duct»

3)	☑	external drainage of the common bile duct
4)	☐	choledochojejunostomy
5)	☑	choledochostomy

315. By the atypical liver resections are:

1)	☑	wedge resection
2)	☐	lobar
3)	☑	boundary
4)	☑	planar
5)	☐	segmental

316. Indications for cholecystostomy:

1)	☑	purulent cholecystitis in critically ill patients of advanced age
2)	☑	suppurative cholangitis in immunocompromised patients with severe intoxication
3)	☐	acute pancreatitis (pancreatic necrosis)
4)	☐	cholecystitis on the background of myocardial infarction
5)	☑	obstructive jaundice

317. Operative access to the pancreas:

1)	☐	transpleural
2)	☑	laparotomic
3)	☑	lumbotomy
4)	☑	laparoscopic

5) ☐ transduodenal

318. The transperitoneal operative accesses to the pancreas include:

1) ☑ upper median laparotomy
2) ☐ Pfannenstiel incision
3) ☑ angle cut of Cherny
4) ☐ Diakonov-Volkovich section
5) ☑ incision of Sprengel

319. Laparotomy performed. Operative access to the pancreas is carried out through:

1) ☑ mesentery of the transverse colon
2) ☑ gastro-colon ligament
3) ☐ diaphragm
4) ☐ right mesenteric sinus
5) ☑ the back two leaves of the greater omentum (in children of early age)

320. If you access the pancreas through the gastrointestinal ligament, damage may occur:

1) ☑ Riolan's arcs
2) ☐ the left colic artery
3) ☐ the right colic artery
4) ☑ middle colon artery
5) ☐ the superior mesenteric artery

321. Quick access to the pancreas through the mesocolon transversum does not provide:

1) ☑ completeness of examination of the walls of the omental bursa
2) ☑ the imposition of omentoplasty (fistula of the omental bursa)
3) ☑ adequate drainage of the gland bag
4) ☐ exclusion of exudate in the lower abdominal cavity
5) ☐ the imposition of entero-enteroanastomosis

322. The negative sides of the operative approach to the pancreas through the small omentum:

1) ☐ risk of injury to spleen
2) ☑ available head and part of the body of the pancreas
3) ☐ the probability of injury to the left kidney
4) ☑ full access to the omental bursa is not ensured
5) ☑ drains and swabs exert pressure on the small curvature of the stomach

323. Lumbar approaches to the pancreas create conditions for:

1) ☑ adequate drainage of the pathological focus in pancreonecrosis
2) ☑ combination with incision of the anterior abdominal wall
3) ☑ development of phlegmon in the lumbar region
4) ☐ formation of postoperative adhesions
5) ☐ damage to the right lobe of the liver

324. Laparotomy, drainage and tamponade of the omental bursa in acute pancreatitis (pancreonecrosis) can be combined with:

1) ☐ vagotomy

2) ☑ choledochostomy

3) ☐ gastrectomy

4) ☑ cholecystectomy

5) ☐ gastrostomy

325. In pancreatic necrosis of the head of the pancreas exudate can spread to:

1) ☐ periapical space

2) ☑ paracolon dexter

3) ☑ omental bursa

4) ☑ subhepatic recess hole through the packing

5) ☐ parametrium

326. In pancreatic necrosis of the body and tail of the pancreas exudate can spread to:

1) ☑ paracolon sinister

2) ☐ right iliac fossa.

3) ☑ the mesentery of the small intestine

4) ☐ retrorectal space

5) ☐ hepatoduodenal ligament

327. Types of operations for cyst of the pancreas:

1) ☐ drainage stuffing bags

2) ☑ excision of the cyst

3) ☑ marsupialization cyst

4) ☑ the imposition of cystojejunostomy

5) ☐ pancreatoduodenal resection

328. Pancreatoduodenal resection is performed for:

1) ☐ acute pancreatitis

2) ☑ cancer of the pancreatic head

3) ☑ cancer of major duodenal papilla

4) ☐ cholecystopancreatitis

5) ☐ duodenal ulcer

329. To perform operations on the spleen, the following types of accesses are used:

1) ☐ lumbotomy

2) ☑ laparotomic

3) ☐ extraperitoneal abdominal

4) ☑ transpleural

5) ☑ thoracoabdominal

330. Organ-preserving operations on the spleen include:

1) ☐ stenting of the splenic artery

2) ☑ suturing the wound

3) ☐ splenorenal arterial anastomosis

4) ☑ wedge resection

5) ☐ splenectomy

331. Open splenectomy completed.:

1) ☐ blind suture of the wound (no drainages)
2) ☑ surgical wound drainage
3) ☐ drainage subhepatic recesses bursa hepatica
4) ☑ restoration of anatomical continuity of the peritoneum
5) ☑ quality control of hemostasis

332. The boundaries of segments, sectors, lobes of the liver during the operation are specified using:

1) ☑ angiographies
2) ☐ the reception of Baron-Pringle
3) ☑ hepatobiliary
4) ☐ gepatoproteguoe
5) ☑ intermittent clamping "glassonby legs»

333. When revision of the liver was found bleeding wound. Hemostasis is carried out:

1) ☑ temporary tamponade with gauze tampons
2) ☑ convergence and compression of the wound edges by hand
3) ☐ wound irrigation with hydrogen peroxide solution
4) ☐ overlay clips Heppner on hepatic vein
5) ☐ intramuscular injection of menadione

334. Operational approach to the components of the "glisson leg" (portal system) can be performed:

1) ☐ focusing on the umbilical vein in the round ligament of the liver
2) ☑ from the gate of the liver
3) ☐ the falciforme ligament of the liver
4) ☐ the hepatic-duodenal ligament
5) ☑ transparenchimal approach

335. Severe bleeding from the wound of the liver prevents its revision and suturing. Stop bleeding is provided:

1) ☐ pressing the fist of the abdominal part of the aorta to the spinal column
2) ☑ compression of the hepatic duodenal ligament with the fingers of the left hand for 10-15 minutes
3) ☐ the imposition of a vascular Block clamp on the celiac trunk
4) ☑ superimposed on hepatic duodenal ligament soft intestinal sphincter wearing on jaws rubber tubes
5) ☑ ligation of the round ligament of the liver

336. The lumbar region is limited:

1) ☑ the posterior median line (line corresponding to the spinous processes of the lumbar vertebrae)
2) ☑ (middle axillary line) line from the end of the XI rib to the iliac crest
3) ☐ the inguinal ligament
4) ☑ bottom edge of XII edge
5) ☑ iliac crest

337. The difference between the layered structure of the muscle, held at the ends of the transverse processes of the vertebrae (lateral edge m. erector spinae) the lumbar region is divided into sections:

1) ☐ top

2) ☑ medial

3) ☐ right

4) ☐ left

5) ☑ lateral

---

338. The posterior renal point (projection of the reflexogenic zone – the gate of the kidney to the lumbar region) corresponds to the intersection:

1) ☐ iliac crest

2) ☑ the bottom edge of the XII rib

3) ☐ spinous-umbilical line

4) ☐ distantia spinarum

5) ☑ the lateral edge of the muscle, straightening the spine

---

339. The anterior renal point (projection of the gate of the kidney to the anterolateral abdominal wall) is determined by the intersection of:

1) ☐ distantia cristarum

2) ☑ lateral edge of rectus abdominis muscle

3) ☐ medial edge of rectus abdominis

4) ☐ mesentery root of the transverse colon

5) ☑ the lower edge of the edge arc to the front end of the XI edge

---

340. On the abdominal walls of the ureter is projected as follows:

1) ☐ on the anterior midline of the abdomen - on the anterior abdominal wall

2) ☑ along the vertical line corresponding to the transverse processes of the lumbar vertebrae - to the posterior

3) ☑ on the lateral edge of the rectus abdominis muscle - on the anterior

4) ☐ at the spinous-umbilical lines – front

5) ☐ on the back median line - on the back

---

341. The first layer of the muscles of the lateral lumbar region are:

1) ☑ external oblique abdominal muscle

2) ☐ the internal oblique muscle of the abdomen

3) ☑ m. latissimus dorsi

4) ☐ m. erecter spinae

5) ☐ lower back serratus muscle

---

342. The second layer of the muscles of the lateral lumbar region form:

1) ☐ the rectus abdominis

2) ☑ lower back serratus muscle

3) ☐ transverse abdominal muscle

4) ☑ the internal oblique muscle of the abdomen

5) ☐ external oblique abdominal muscle

---

343. Through the slit-like gap in the third muscle layer of the lateral part of the lumbar region (aponeurosis of the transverse abdominal muscle) pass:

1) ☐ upper gluteal artery and vein

2) ☑ subcostal artery and vein

3) ☐ pudendal nerve

4) ☑ subcostal nerve

5) ☐ lower epigastric artery

344. The boundaries of the lumbar triangle are:

1) ☑ external oblique abdominal muscle

2) ☑ m. latissimus dorsi

3) ☑ iliac crest

4) ☐ the internal oblique muscle of the abdomen

5) ☐ lateral edge of rectus abdominis muscle

345. Lumbar space is limited:

1) ☑ internal oblique abdominal muscle

2) ☑ muscle straightening the spine

3) ☑ XII edge

4) ☑ lower posterior serratus muscle

5) ☐ the external oblique muscle of the abdomen

346. The meaning of the" weak places " of the lumbar region is that they are the place:

1) ☑ formation of lumbar hernias

2) ☑ breakthrough of retroperitoneal ulcers into the layers of the lumbar region

3) ☑ formation of ports for laparoscopic access to the retroperitoneal organs

4) ☐ place to perform punctures and blockades

5) ☐ pain points for differential diagnosis of diseases of the abdomen

347. The walls of the bone-fibrous bed of the muscle straightening the spine are:

1) ☑ thoracolumbar fascia

2) ☐ intra-abdominal fascia

3) ☑ spinous processes of vertebrae

4) ☐ fascia is the square muscle of the loin

5) ☑ the transverse processes of the vertebrae

348. In the formation of the walls of the retroperitoneal space involved:

1) ☑ the diaphragm is lined with the lower fascia (part of the intra-abdominal fascia)

2) ☑ intra-abdominal fascia

3) ☑ the plane of the entrance to the pelvis (at the level of the boundary line)

4) ☑ the middle axillary line, which corresponds to the fascial node of the parathyroid-intestinal furrow (lateral canal)

5) ☐ mesentery root of the transverse colon

349. In retroperitoneal space, fascia is isolated:

1) ☑ intra-abdominal

2) ☐ own fascia of the abdomen

3) ☑ renal (retroperitoneal)

4) ☑ the retrocolic

5) ☐ lumbar-thoracic

350. Actually retroperitoneal fiber layer is between the fascia:

1) ☐ the retrocolic
2) ☑ renal
3) ☐ lumbar thoracic
4) ☑ intra-abdominal
5) ☐ the broad fascia of the thigh

351. Actually retroperitoneal fiber layer contains:

1) ☑ inferior Vena cava
2) ☑ abdominal aorta and abdominal aortic nerve plexus
3) ☐ the right phrenic nerve
4) ☑ the abdominal parts of the sympathetic trunks
5) ☑ the abdominal part of the chest duct

352. From its own retroperitoneal fiber layer purulent exudate can spread to:

1) ☑ preperitoneal tissue of the anterolateral abdominal wall
2) ☑ retrorectal cellular spaces space
3) ☑ lateral cellular space of the pelvic cavity
4) ☐ the medial muscle-fascial bed of the thigh
5) ☑ subpleural space of the thoracic cavity (through the lumbar-costal triangle of the diaphragm)

353. Perirenal fat body (paranephron) is between:

1) ☑ fibrous capsule of the kidney

2) ☐ intra-abdominal fascia

3) ☑ the preferred leaf of renal fascia

4) ☐ retrocolic fascia

5) ☑ posterior renal fascia leaf

354. What are the urinary organs, inflammatory processes which can be complicated by paranephritis

1) ☑ kidney (excretory urinary tract)

2) ☑ ureter

3) ☐ stomach

4) ☐ appendix

5) ☐ ascending/descending / colon

355. Retrocolic fascia of Toldt is formed by the connection in the process of embryogenesis:

1) ☑ mesentery of ascending (descending) colon

2) ☑ the back of the peritoneum of the abdominal wall

3) ☐ Prerenal renal fascia leaf

4) ☐ intra-abdominal fascia

5) ☐ own fascia of the abdomen

356. Paracolon is located between the:

1) ☑ retrocolic fascia

2) ☐ the posterior wall of the ascending/descending / colon

3) ☑ the prerenal leaf of renal fascia

4) ☐ intra-abdominal fascia

357. List the organs of the abdominal cavity, inflammatory and ulcerative processes which may be complicated by parabolica:

1) ☑ ascending/descending / colon
2) ☑ appendix (in retrocecal, retroperitoneal position)
3) ☑ pancreas
4) ☑ duodenum
5) ☐ caecum

358. Functions of the fibrous membrane of the kidney [in part fibrous, medium (muscle – incomplete layer of smooth muscle fibers) and supraregional layers] is:

1) ☐ the impediment of dislocation of the kidney
2) ☑ increase of mechanical strength of the kidney seam
3) ☑ protecting the parenchyma
4) ☑ contraction of this capsule promotes filtration of urine
5) ☑ fixation of the kidney

359. Acute edema of the kidney (in the conditions of immobility of the fibrous capsule) with the ineffectiveness of conservative measures requires the use of:

1) ☐ paranephral blockade on AV Vishnevsky
2) ☑ hemodialysis'
3) ☐ drainage of the paranephron
4) ☑ decapsulation of the kidney

5) ☐ renal artery stenting

360. The left renal vein, heading to the lower cavity, is located in the corner between the arteries:

1) ☐ the celiac trunk

2) ☑ the abdominal part of the aorta

3) ☐ left artery of the testicle (ovary)

4) ☐ the inferior mesenteric artery

5) ☑ superior mesenteric artery

361. The difference in the length of the renal artery (right-longer, left-shorter) and veins (right-shorter, left-longer) are determined by the anatomical interactions of the kidneys with:

1) ☐ the celiac trunk

2) ☑ inferior Vena cava

3) ☐ the psoas major muscle

4) ☐ testicular artery (ovary)

5) ☑ the abdominal part of the aorta

362. Area Kupriyanova-Zondec or line of natural divisibility kidney:

1) ☑ zone 1 cm posterior to the lateral edge of the kidney with the least number of anastomoses of the anterior and posterior branches of the renal artery

2) ☑ the place where a partial longitudinal nephrotomy is performed

3) ☐ area corresponding to the middle of the kidney gate

4) ☐ the area where the invalid sections of the kidney

5) ☐ area corresponding to the sinus of the kidney

363. Area of Hasselbach kidney meets the guidelines:

1) ☐ the upper end of the kidney
2) ☑ the horizontal plane that runs along the medial edge of the kidney
3) ☑ the middle gate of the kidney
4) ☐ lower end of the kidney

364. A renal "leg" form (from front to back):

1) ☐ lower adrenal artery
2) ☐ a large renal caliculus
3) ☑ renal vein
4) ☑ renal artery
5) ☑ renal pelvis with pelvic ureter segment

365. Partial longitudinal nephrotomy in the area of Kupriyanov-Zondic performed with the aim:

1) ☑ nephrostomy
2) ☑ planar resection
3) ☐ nephropexy
4) ☐ nephrolithotomies
5) ☐ nephroraphy

366. Requirements for wound closure kidney:

1) ☐ the suture captures the fascial capsule and the fatty body of the kidney
2) ☑ providing hemostasis

3)	☑	unacceptable formation of renal (urinary) fistula (needle injection in the parenchyma no more than 1 cm)
4)	☑	the suture captures the fibrous membrane of the kidney (impermissible penetration of the seam)
5)	☑	catgut stitch in "chess" order

367. If nephrotomy provide temporary hemostasis:

1)	☐	with pressure of the abdominal aorta
2)	☐	by applying a Bilrot hemostatic clamp to the renal artery and vein
3)	☑	finger compression of the vascular" leg " of the kidney
4)	☑	the tourniquet
5)	☑	by applying a vascular clamp

368. Kidney fixation provide:

1)	☑	renal vessels
2)	☑	the capsules of the kidney (fascial, adipose, fibrous)
3)	☑	intra-abdominal pressure
4)	☑	peritoneal ligaments, kidney
5)	☐	paracolon

369. Skeletotopy right kidney:

1)	☑	ThXII – the top edge is LIVE
2)	☑	the lower end is 3-5 cm up from the iliac crest
3)	☑	XII edge crosses the point on the border of the upper and middle third of the kidney
4)	☑	below the left kidney 1-1. 5 cm

5) ☐ Th XI – L III

370. Skeletotopy left kidney:

1) ☑ ThXI – top edge LIII

2) ☑ XII rib crosses the kidney in the middle of the length

3) ☑ above the right 1-1. 5 cm

4) ☑ the upper end is slightly above the XI edge

5) ☐ ThX – LII

371. Narrowing of the ureter (3-4 mm) correspond to:

1) ☑ the pelvic ureter segment

2) ☐ ThXII

3) ☑ terminalis line

4) ☑ Jucstavesicular part

5) ☐ the place of intersection with the uterine artery in the broad ligament of the uterus

372. Narrowing of the ureter are at the level of:

1) ☑ the transition of the pelvis into the ureter

2) ☑ the borderline of the pelvis

3) ☑ the place of perforation with the ureter of the bladder wall

4) ☐ the lower pole of the kidney

5) ☐ the intersection with the ovarian (testicular) artery

373. At the linea terminalis level, the ureters cross:

1) ☑ common iliac artery – left ureter
2) ☐ the internal iliac artery, right ureter
3) ☑ external iliac artery – right ureter
4) ☐ the upper rectal artery, left ureter
5) ☐ the inferior mesenteric artery, right ureter

374. The pelvic part of the ureter in women is adjacent to:

1) ☐ rounds the ampoule of the rectum
2) ☑ the free edge of the ovary
3) ☑ located laterally from the cervix
4) ☑ it is located between the vagina and the bladder
5) ☑ in the oblique direction penetrates the wall of the bladder

375. To the characteristics of the seam of the ureter include:

1) ☑ suture on ureteral catheter (prevention of hydronephrosis and scar stenosis)
2) ☑ do not capture the mucous membrane; the area of the seam is fed to the graduate
3) ☑ rare nodal cathalogue seams round atraumatic needle
4) ☑ use techniques to increase the perimeter of the connection of the ends of this body
5) ☐ impose continuous suture synthetic suture non-absorbable thread in the cutting needle

376. On the psoas major muscle, the abdominal part of the ureter is crossed:

1) ☑ blood vessels of the testicle (ovary)

2) ☐ femoral nerve

3) ☐ the inferior mesenteric artery

4) ☑ Genito-femoral nerve

5) ☐ obturator nerve

377. Name the region in which radiating pain when you migrate a stone through the ureter:

1) ☐ the umbilical region

2) ☑ in the underbelly

3) ☑ the external genitals

4) ☑ in the anterior region of the thigh

5) ☐ to the gluteal region

378. When performing nephrectomy, it should be borne in mind that the renal artery can rarely move away from the abdominal part of the aorta:

1) ☑ two truncus

2) ☑ three truncus

3) ☑ enter the kidney multiple trunks throughout the medial edge

4) ☑ have early branching

5) ☐ to move at the level of ThV

379. The celiac trunk departs from the abdominal part of the aorta:

1) ☑ at the level of the ThXII

2) ☑ in the hiatus aorticus

3) ☐ at the level of LIII

4) ☐ at the level of the diaphragm dome

5) ☑ along the upper edge of the gastric muscle

---

380. The upper mesenteric artery before entering the root of the mesentery of the small intestine is located between:

1) ☐ small curvature of the stomach (right)

2) ☐ mesentery of the transverse colon (bottom)

3) ☑ lower edge of the pancreas (front)

4) ☑ ascending colon (rear)

5) ☐ the first loop of the jejunum (below)

---

381. In operations on the kidney and abdominal ureter position of the patient on the operating table in the position of "runner" with a roller under the "healthy" side provides:

1) ☑ increasing the distance between the XII rib and the iliac crest

2) ☐ due to the bending of the vertebral column, the kidney occupies a more superficial position ("emerges" from under the XII rib) in the wound

3) ☑ intestinal loops are displaced in the opposite direction from the place of operation

4) ☑ provides a stable position of the patient on the operating table

---

382. Types of operative approaches to the kidney:

1) ☑ laparoscopic (lumbosciatica)

2) ☑ transabdominal (open)

3) ☑ extraperitoneal (lumbotomy)

4) ☑ thoracophrenolumbotomy

5) ☐ none of them

383. The Bergman-Israel lumbotomy is characterized by:

1) ☑ it's an extraperitoneal approach

2) ☑ the beginning of the section corresponds to the back point of the kidney

3) ☐ the incision is made anteriorly at the navel level

4) ☐ resection of XII rib is performed

5) ☑ the lower point of the incision along the anterior axillary line is 3-4 cm up from the spina iliaca anterior superior

384. The anatomical conditions of varicocele-varicose plexus of the spermatic cord (70-90% of left-sided localization):

1) ☑ congenital stenosis of the left renal vein

2) ☐ early branching of the renal artery

3) ☑ valve failure of the left testicular vein

4) ☑ right angle of the left renal vein to the inferior Vena cava

5) ☑ presence of arteriovenous fistula of the kidney

385. The danger of pneumothorax and infection of the pleural cavity in the allocation of the upper end of the kidney are explained:

1) ☑ the presence of a" weak " place of the diaphragm-the lumbar-rib triangle

2) ☑ the costal-diaphragmatic sinus is posterior to the upper end of the kidney

3) ☑ adhesive process involving adjacent to the upper end of the kidney organs

4) ☐ possible nephroptosis pleural bag

5) ☑ low standing (in the absence of XII edge)

386. Selection of the "small pelvis" area is based on:

1) ☑ the location of the final parts of the digestive system and genitourinary apparatus in it
2) ☑ commonality of blood-lymph circulation and innervation of pelvic organs
3) ☑ topographical principle, and the specifics of surgery
4) ☑ change in the volume of state bodies in connection with their function
5) ☐ none of these provisions is relevant to the answer

387. The division of the pelvic cavity into departments (floors) due to the difference:

1) ☑ localization of pathological processes and their complications
2) ☑ relationships with peritoneum, pelvic fascia, pelvic diaphragm, urogenital diaphragm
3) ☐ relationship with the superficial and deep muscles of the back
4) ☑ operative accesses and techniques to the internal organs of the pelvic cavity
5) ☑ methods of examination of the patient

388. The bone basis of the pelvis is made up of bones:

1) ☑ pubic
2) ☐ V lumbar vertebra
3) ☑ sciatic
4) ☑ iliac
5) ☑ sacrum and coccyx

389. Fractures of the pelvic bones are most often localized in the area:

1) ☑ pubic bone
2) ☑ less often-the sciatic bone
3) ☑ iliac wing
4) ☐ sacrum's
5) ☐ coccyx's

390. Fractures of the bones forming the anterior half-ring of the pelvis are caused by:

1) ☑ the presence of "weak" places (clippings, holes, branches)
2) ☐ the bodies of the bones form a acetabulum
3) ☐ belong to the group of flat bones
4) ☑ pieces of bone are
5) ☑ bone insufficiently covered by the respective layers of the wall of the pelvis

391. Fractures of the pelvic bones are accompanied by severe complications:

1) ☑ painful shock
2) ☐ fracture of the femoral neck
3) ☑ rupture of the wall of the internal organ adjacent to the corresponding wall, followed by infection of the cellular spaces of the pelvic cavity
4) ☑ fat embolism
5) ☑ bleeding from the spongy substance of bones and damaged blood vessels with extensive hematomas

392. Large and small sciatic clippings in the same holes turn ligaments:

1) ☐ the fibrous obturator membrane

2) ☐ the arcuate ligament of the pubis

3) ☑ the Sacro-spinous

4) ☐ ilio-femoral

5) ☑ sacroiliac-tubercle

---

393. To the parietal muscles of the pelvis are:

1) ☑ the internal obturator muscle

2) ☑ the piriformis muscle

3) ☑ M. coccegeus

4) ☐ m. gluteus maximus

5) ☐ bulbous-spongy muscle

---

394. The diaphragm of the pelvis (in the narrow sense) form:

1) ☑ muscle that raises the anus

2) ☑ upper fascia of pelvic diaphragm

3) ☑ the lower fascia of the pelvic floor

4) ☐ the internal obturator muscle

5) ☐ deep transverse perineal muscle

---

395. M. levator ani begins from:

1) ☑ lower branches of the pubic bone

2) ☑ tendon arch of the pelvic fascia

3) ☑ ischium

4) ☐ pubic tubercle

5) ☐ the greater sciatic clippings

396. By anatomical and functional purpose, the muscle that raises the anus with the upper and lower fascia of the pelvic diaphragm is called the pelvic diaphragm, because:

1) ☑ it is supported by the rectum; violation of the supporting function of this muscle is accompanied by the loss of the rectum

2) ☑ the rectum passes through it; according to its level, the organ is divided into the pelvic and perineal sections

3) ☑ part of its muscle bundles are woven into the muscle shell of the rectum, vagina, bladder and prostate

4) ☑ participates in the formation of the rectal closure apparatus

5) ☐ prevents the displacement of the bones of the pelvis

397. Urogenital diaphragm (in the narrow sense) form:

1) ☑ deep transverse perineal muscle

2) ☑ the upper fascia of the urogenital diaphragm

3) ☑ lower fascia of the urogenital diaphragm

4) ☐ the outer sphincter muscle

5) ☐ muscle that raises the anus

398. According to the anatomical and functional purpose, the deep transverse perineal muscle with the upper and lower fascia of the urogenital diaphragm is called the urogenital diaphragm because:

1) ☑ it is supported by the organs of the genitourinary apparatus; prolapse of the pelvic floor can lead to loss of the vaginal wall, cervix, uterus with impaired urination

2) ☑ through it pass the urethra and deep dorsal vein of the penis (in men), urethra, vagina and deep dorsal vein of

the clitoris (in women)

3) ☑ the circular fibers of this muscle form an arbitrary sphincter of the urethra and vaginal constrictor

4) ☑ in women, the deep transverse muscle of the perineum is developed weaker

399. The abdominal cavity of the pelvis is limited:

1) ☑ the plane of the entrance to the pelvis (border line) - on top

2) ☑ the peritoneum covering the bladder, uterus, rectum and partially the pelvic floor-from below

3) ☐ urogenital diaphragm-bottom

4) ☐ L V-top

5) ☐ iliac muscle-from above

400. In the abdominal cavity of the pelvis women are located:

1) ☑ part of the rectum having a serous membrane

2) ☑ part of the bladder covered with peritoneum

3) ☑ a large part of the uterus and the posterior part of the vaginal vault

4) ☑ ovaries and fallopian tubes

5) ☐ a large gland of the vestibule of the vagina

401. Anatomical formations, in the transition from which the peritoneum forms a transverse urogenital fold, are:

1) ☐ pubic symphysis

2) ☐ the rectus abdominis

3) ☑ anterior abdominal wall

4) ☐ large lumbar muscle

5) ☑ bladder

402. As the bladder fills the transverse vesical fold:

1) ☑ moves towards the navel
2) ☐ narrows
3) ☐ is at the level of the Cape
4) ☐ meet men podmoskovia corner (the pubic arch in females)
5) ☑ expands

403. The displacement of the transverse urogenital fold upwards provides:

1) ☑ the increase in the extraperitoneal portion of the bladder wall
2) ☑ favorable conditions for extraperitoneal abdominal access to the bladder
3) ☐ slide the bladder with the change in its bulk state
4) ☐ the possibility of palpation of the bladder
5) ☐ the formation of adhesions with the rectum (women)

404. In the transition of the peritoneum from one internal organ of the female pelvic cavity to another, recesses are formed:

1) ☐ medial inguinal fossa
2) ☑ bladder and uterine
3) ☐ femoral fossa.
4) ☑ rectouterine
5) ☐ sciatic-anal fossa

405. The front wall of the rectum-uterine excavacio form:

1) ☐ sacrum and coccyx
2) ☑ rectal surface of the uterus
3) ☐ the anterior wall of the rectum
4) ☑ the rear part of the vaginal vault
5) ☐ the broad ligament of the uterus

406. Abscess of the excavacio recto-vesicalis of appendicular etiology not confirm this finger study using:

1) ☐ the anterior wall of the rectum
2) ☑ anterior abdominal wall
3) ☑ superficial inguinal ring
4) ☑ locking hole
5) ☑ the rear part of the vaginal vault

407. Palpation of the abscess of the excavacio rectouterina in women giving birth is not carried out through:

1) ☐ the rear part of the vaginal vault
2) ☑ a large sciatic foramen
3) ☑ anterior abdominal wall
4) ☑ the lateral part of the vaginal vault
5) ☑ locking hole

408. The subperitoneal cavity of the pelvis is limited:

1) ☐ L V-top

2) ☐ the plane of the entrance to the pelvis-on top

3) ☑ parietal peritoneum, lining the walls and pelvic floor-from above

4) ☑ parietal fascia of the pelvis-from the sides and from the bottom

5) ☐ transverse fascia of the abdomen

---

409. Peritoneal-perineal fascia conditionally divides the subperitoneal cavity of the pelvis into sections:

1) ☑ front

2) ☐ left

3) ☑ rear

4) ☐ right

5) ☐ top

---

410. Fascia pelvis-continuation of fascia endoabdominalis-consists of fascia (plates):

1) ☐ iliac

2) ☑ parietal

3) ☐ cross

4) ☐ the broad fascia of the thigh

5) ☑ visceral

---

411. In subperitoneal cavity of the pelvic cavity (for the position) distinguish between groups cellular spaces:

1) ☐ fat body of the sciatic-anal fossa

2) ☑ parietal (parietal)

3) ☐ preperitoneal space

4) ☐ own layer of retroperitoneal space

5) ☑ visceral (near-organ)

412. Parietal cellular spaces of the pelvic cavity are limited:

1) ☐ the umbilical fascia

2) ☑ parietal fascia of the pelvis

3) ☐ iliac fascia

4) ☑ visceral fascia of the pelvis (fascial capsule of the internal organ)

5) ☐ thoracolumbar fascia

413. To the parietal cellular spaces of the abdominal cavity of the small pelvis are limited:

1) ☑ retropubic

2) ☐ sciatic-anal fossa

3) ☑ retroractalis

4) ☑ lateral (lateral) right

5) ☑ lateral (lateral) left

414. The clinical significance of the parietal spaces of the pelvic cavity is that they

1) ☑ provide loose fixation of the internal organ of the pelvis to the corresponding wall

2) ☑ contribute to the change in the volumetric state of the body

3) ☑ facilitate the mobilization of the authority

4) ☑ represent typical localization of hematomas and ulcers

5) ☐ separate the cellular layers of the retroperitoneal space from the visceral spaces of the pelvic cavity

415. The communication of the fiber of the subperitoneal cavity of the small pelvis with the fat body of the sciatic-anal fossa through the diaphragm of the pelvis is possible:

1) ☑ at the junction of the tendon arc m. levator ani with upper and lower fascia of pelvic diaphragm
2) ☑ at the border of the upper and lower halves of the internal locking muscle
3) ☑ from the symphysis to the ischial bones
4) ☐ in the anal-coccygeal ligament
5) ☐ large sciatic tenderloin.

416. The possibility of communicating the fiber of the abdominal cavity of the pelvis with the fat body of the sciatic-anal fossa at the junction of the tendon arc m. levator ani with upper and lower fascia of pelvic diaphragm create conditions for:

1) ☐ performing ano-and rectoscopy
2) ☐ puncture of the rectal-uterine recess through the back of the vaginal vault
3) ☑ the spread of purulent process of the cavum pelvis subperitoneale in the crotch region
4) ☐ operations in case of loss of rectum
5) ☑ drainage of small pelvic cavity ulcers by perineal access

417. Visceral cellular spaces subperitoneal space of the pelvic cavity is limited:

1) ☑ adventitia (or muscular) body shell
2) ☐ parietal fascia of the pelvis
3) ☐ iliac fascia
4) ☑ visceral fascia of the pelvis
5) ☐ aponeurotic vagina of the rectus abdominis muscle

418. Cellular spaces in the visceral space subperitoneal space of the pelvic cavity are:

1) ☐ the inferior mesenteric artery
2) ☑ arteries and veins (subfascial venous plexus) of the organ
3) ☑ nerves (nerve plexus) of the organ
4) ☑ lymphatic vessels (plexus) and lymph nodes of the organ
5) ☐ femoral nerve

419. Visceral and peritoneal-perineal fascia form strong fascial capsules of organs:

1) ☑ prostates
2) ☑ rectum
3) ☐ bladder
4) ☐ ureter's
5) ☐ uteri

420. The cellular spaces around the bladder passing to the anterior abdominal wall are:

1) ☑ retropubic
2) ☑ preperitoneal
3) ☐ lateral (lateral)
4) ☐ parametrium
5) ☐ paraureteron

421. Retropubic cellular spaces fascia space is limited:

1) ☑ fascia transversa

2) ☐ aponeurosis of the external oblique abdominal muscle

3) ☐ Obturator membrane

4) ☐ iliac

5) ☑ the fascia of the bladder

---

422. In case of rupture of the extraperitoneal part of the anterior wall of the bladder, it is possible to spread urinary congestion from the pubic space into the:

1) ☑ preperitoneal space of the bladder

2) ☑ the medial muscle-fascial bed of the thigh through the obturator canal

3) ☐ retroperitoneal space

4) ☑ in the vagina of the rectus abdominis (up to the formation of purulent navel fistula)

5) ☐ to the gluteal region

---

423. Cellular spaces, the retropubic space communicates with the front and medial muscle-fascial lodges hips through:

1) ☐ Foramen suprapiriforme

2) ☑ of the obturator channel

3) ☐ the greater sciatic foramen

4) ☑ the femoral canal

5) ☐ Alcock’s channel

---

424. Preperitoneal cellular spaces of bladder space is limited:

1) ☑ the fascia of the bladder

2) ☐ transverse fascia

3) ☐ iliac fascia

4) ☑ parietal peritoneum of the anterior abdominal wall

5) ☐ rectus abdominis muscle

425. Preperitoneal cellular spaces space is limited:

1) ☐ transverse fascia

2) ☑ adventitial membrane of the bladder

3) ☑ peritoneum

4) ☐ the pubic symphysis

5) ☐ peritoneal-perineal fascia

426. A purulent pocket in retrorectal cellular spaces space may spread from:

1) ☑ own layer of retroperitoneal space

2) ☐ retropubic space

3) ☐ parametrium

4) ☑ pararectal space

5) ☐ the lateral space

427. In the lateral cellular space of the subperitoneal cavity of the small pelvis are:

1) ☑ ureter

2) ☑ internal iliac vein

3) ☐ median sacral artery and vein

4) ☑ internal iliac artery

5) ☑ internal iliac lymph nodes

429. The lateral cellular space of the subperitoneal cavity of the small pelvis is called Central (V. V. Kovanov) because it communicates with:

1) ☑ own layer of retroperitoneal space (along the General and internal iliac vessels)

2) ☑ with all about the organ cellular spaces (along the branches of the internal iliac vessels to the pelvic organs)

3) ☐ parietal space

4) ☑ in the course of the branches of internal iliac vessels (with the desired length space, medial musculo-fascial bed of the thigh, ischial anal fossa)

5) ☐ front musculo-fascial bed of the thigh

430. The parametrium expressed:

1) ☑ between the leaves of the broad ligament of the uterus and along the edges ("ribs") of this organ

2) ☐ at the anterior (vesical) surface of uterus

3) ☐ on the posterior (rectal) surface of the uterus

4) ☑ around the cervix

5) ☐ as part of the round ligament of the uterus

431. Purulent puffiness from the parametrium can spread to:

1) ☑ lateral cellular space of the subperitoneal cavity of the small pelvis along the uterine artery and vein

2) ☑ the private layer of the retroperitoneal space along the course of the ureter and ovarian artery and vein

3) ☑ inguinal canal and pubic area along the round ligament of the uterus

4) ☑ iliac fossa.

5) ☐ fossa ischiorectalis

432. The fossa ischiorectalis is limited by the muscles:

1) ☑ superficial transverse perineal muscle-front
2) ☑ the outer sphincter of the rectum-from below
3) ☐ internal obturator muscle - superior
4) ☑ the edge of the great gluteal muscle in the back
5) ☑ m. levator ani - medial

433. The pudendal neurovascular bundle entering the fossa ischiorectalis through the genital canal consists of:

1) ☐ lower gluteal artery and vein of the same name
2) ☑ internal pudendal vein
3) ☑ the pudendal nerve
4) ☐ arteries accompanying the sciatic nerve
5) ☑ internal pudendal artery

434. Diagnosis:" Abscess of excavacio rectovesicalis " confirmed by finger examination through the anterior wall of the rectum (at different positions of the patient). Surgeon's tactics:

1) ☑ puncture of abscess through the anterior wall of the rectum (pus was obtained)
2) ☐ a lower midline laparotomy
3) ☐ introduction of methylene blue abscess into the cavity to identify the fistula course of the rectum
4) ☑ opening of the abscess through the anterior wall of the rectum
5) ☑ sanitation of the abscess cavity

435. The abscess of the excavacio rectouterina is punctured, opened and drained by the following access:

1)	☑	transvaginal
2)	☑	through the back of the vaginal vault
3)	☑	through the front wall of the rectum (in girls with the integrity of the hymen)
4)	☐	through the anterior abdominal wall
5)	☐	perineal

436. The lateral parameter (in the medial position of the abscess) is opened ONLY through the back of the vaginal vault to avoid damage:

1)	☐	genito-femoral nerve
2)	☐	the anterior wall of the rectum
3)	☑	ureter's
4)	☐	internal iliac arteries and veins
5)	☑	uterine artery

437. The clinical significance of the genitourinary system and rectal opening end divisions in the crotch area:

1)	☑	possibility of finger examination of bone walls and pelvic cavity organs
2)	☑	application of TRANS organ operative approaches (endosurgical)
3)	☑	the possibility of introducing a radiopaque material with the subsequent exposure
4)	☑	use of catheterization and probing of the pelvic cavity, retroperitoneal space and peritoneal cavity
5)	☐	no right answers

438. Features of embryogenesis and clinical anatomy of the pelvic organs explain the following ways of infection:

1)	☑	canalicular (upward – the genitourinary system and the rectum opens to the outside at the perineum)

2) ☑ hematogenous (vein bodies widely anastomosing)

3) ☑ lymphogenic (a large number of anastomoses and common lymph nodes)

4) ☑ according to the cellular spaces of the pelvic cavity and the cellular spaces of neighboring areas

5) ☐ transplacental

---

439. Age characteristics of skeletotopy bladder (in an emptied state):

1) ☑ 23 bladder located above the pubic symphysis-in newborns

2) ☑ the inner opening of the urethra corresponds to the pubic symphysis-in newborns

3) ☐ no significant features

4) ☑ by 20 years is located in the pelvic cavity

5) ☑ in the elderly and senile age is located below the pubic symphysis

---

440. In the emptied state, the bladder has the following options for relationships with the peritoneum:

1) ☑ is extraperitoneal (covered by peritoneum on top)

2) ☐ has serous shell all over the walls

3) ☐ completely devoid of serous membrane

4) ☑ in the filled state covered with peritoneum mesoperitoneal

5) ☐ in the filled state covered with peritoneum on all sides

---

441. The front wall of the emptied bladder is attached to the:

1) ☐ anterior abdominal wall

2) ☑ the pubic symphysis

3) ☐ ureters

4) ☐ m. iliopsoas

5) ☑ the upper branches of the pubic bones

442. The back wall of the bladder in men comes into contact with:

1) ☑ the ampoule of the rectum

2) ☑ the ureters

3) ☑ ampullae of the ductus deferens

4) ☑ the seminal vesicles

5) ☐ internal iliac artery and vein

443. When the posterior wall of the bladder ruptures, the puffiness can spread to the:

1) ☑ lateral space of the pelvic cavity

2) ☐ own layer of retroperitoneal space

3) ☐ pre-sacral space

4) ☑ inguinal canal along the spermatic cord

5) ☑ on the anterior abdominal wall

444. Urine-pushing muscle (m. detrusor vesicae) consists of interlacing layers of smooth muscle fibers:

1) ☑ the inner longitudinal

2) ☐ internal oblique

3) ☑ circular (medium)

4) ☐ circular outer

5) ☑ the longitudinal outer

445. Vesical triangle (the mucous membrane adherent to the muscle and does not form folds) limited:

1) ☐ base-posterior fossa
2) ☑ the apex corresponds to the inner opening of the urethra
3) ☐ top-the tip of the bladder
4) ☑ base – interureteral fold of mucous membrane
5) ☑ lateral boundaries-lines connecting the mouth of the ureters with the inner opening of the urethra

446. With cystoscopy, the mucous membrane of the bladder is characterized by:

1) ☑ reddish color and a large number of blood vessels
2) ☑ forms folds (with the exception of the vesical triangle)
3) ☐ the lack of folds
4) ☑ the mouths of the ureters form depressions along the edges of the base of the urogenital triangle
5) ☑ periodically (2-3 times per min) the openings of the ureters are opened, disgorging a thin stream of urine

447. Vesico-ureteral reflux apparatus are:

1) ☑ peristalsis of the ureter
2) ☑ passage of the ureter in the bladder wall in the oblique direction (2 cm)
3) ☑ around the mouth of the ureter increases the number of circular smooth fibers of the inner layer of the muscular membrane of the bladder
4) ☑ the opening of the ureters covers the inter-ureteral fold of the bladder
5) ☐ intestinal peristalsis

448. The arteries of the bladder are branches:

1) ☐ vesicalis inferior -from the genital artery

2) ☐ vesicalis superior -branch of the internal iliac artery

3) ☑ vesicalis superior is a branch of the umbilical artery

4) ☑ vesicalis inferior - branch of the internal iliac artery

5) ☐ vesicalis superior is a branch of the obturator artery

---

449. The main components of bladder fixation are:

1) ☑ tendon-fibrous bundles of the upper fascia of the pelvic diaphragm (lig. puboprostaticum-in men and pubovesicale – in women)

2) ☐ muscle lifting the rectum

3) ☑ the urethra (along with the prostate and urogenital diaphragm)

4) ☑ bladder fascia attaching to the lower half of the umbilical ring

5) ☑ ureters

---

450. The bladder performs consistently flowing functions:

1) ☑ reservoir (accumulates urine)

2) ☑ urinary retention

3) ☑ transport (tow truck)

4) ☐ changes the syntopia of the pelvic cavity

5) ☐ conditions are created for the formation of urinary stones

---

451. By mobility in the male urethra (length 16-22 cm, diameter 5-7 mm) distinguish parts:

1) ☐ spongy

2) ☐ membranous

3) ☑ mobile

4) ☐ prostatic

5) ☑ fixed

452. The male urethra has a contraction:

1) ☐ in the prostatic part of the

2) ☑ at the inner opening of the channel

3) ☐ in the scaphoid fossa

4) ☑ in the membranous portion of the

5) ☑ at the outer opening

453. Indications for capillary suprapubic bladder puncture:

1) ☑ acute urinary retention if it is impossible or there are contraindications to catheterization (urethral trauma, burns of the external genitals)

2) ☐ formation of adhesions with a worm-like process in appendicitis

3) ☑ obtaining urine for clinical and bacteriological examination

4) ☐ fracture of the coccyx

5) ☑ prostate adenoma

454. External landmarks of the needle (length 15-20cm, 1mm d) puncture of the bladder:

1) ☑ front median line

2) ☐ the medial edge of the rectus abdominis muscle

3) ☐ anterior renal point

4) ☑ point 2-3 cm up from the pubic symphysis

5) ☐ the middle of the distance between the navel and the pubic symphysis

455. Cystotomy is indicated for:

1) ☑ electrocoagulation of bladder polyps

2) ☑ of transvesical adenomectomy

3) ☑ impossibility of removal of foreign bodies of the bladder through transurethral access

4) ☑ contraindications to lithotripsy

5) ☐ rupture of the membranous portion of the urethra

456. Signs that identify the bladder:

1) ☐ organ adjacent to the anterior abdominal wall

2) ☑ the wall of the organ has a red-brown color

3) ☑ longitudinal veins of the anterior wall of the bladder

4) ☑ protrusion of the bladder wall with a catheter

5) ☑ a peculiar pattern of crisscrossing muscle fibers

457. When suturing the wound of the bladder with a two-row suture absorbable filaments (with subsequent control of tightness), use:

1) ☐ 1st row – seam the submucosa of the

2) ☑ 1 row-seam through all layers except mucosa

3) ☐ 2 row suture adventitia layer

4) ☐ 1 row-muscle sheath seam

5) ☑ 2 a number of – seam muscle membrane

458. Indications for cystostomy:

1) ☑ traumatic rupture of the extraperitoneal part of the bladder wall

2) ☑ preceding stage of transvesical adenomectomy (removal of co-infection of the urinary tract and kidneys)

3) ☐ urethral-vaginal fistula surgery

4) ☑ traumatic ruptures of the urethra

5) ☐ excision of the bladder diverticulum

459. The fascial capsule of the prostate form:

1) ☑ fascia of prostate

2) ☑ on top of the capsule is enhanced by the transition of the pelvic fascia from the medial edge m. levator ani on the lateral wall of the pelvis

3) ☐ transverse fascia of the abdomen

4) ☑ recto-vesical septum

5) ☑ on the sides-strong fascial spurs containing lateral parts of the prostatic venous plexus

460. Types of operative access to the prostate:

1) ☑ retropubic

2) ☑ perineal

3) ☑ transurethral

4) ☑ through the bladder

5) ☐ lumbotomy

461. Syntopia of prostate:

1) ☐ top-loops of the small intestine

2) ☑ front – the pubic symphysis

3) ☑ behind – the ampulla of the rectum (the prostate palpate through the rectum)

4) ☑ on the sides – m. levator ani

5) ☐ on top of the bladder, seminal vesicles and ampullae of the deferent ducts

6) ☑ bottom-urogenital diaphragm

462. The organs whose anatomical relationships explain the possibility of ureterolithotomy in pregnant women are:

1) ☐ rectum

2) ☑ vagina

3) ☐ bladder

4) ☐ urethra

5) ☑ ureter

463. The ovary is located in the ovarian fossa, which is limited:

1) ☑ uterine and internal iliac arteries-rear

2) ☑ umbilical artery-front

3) ☐ obturator neurovascular bundle-front

4) ☑ a ureter in the back

5) ☑ internal locking muscle-the bottom of the fossa

464. Suspensory ligament of ovary contains:

1) ☑ ovarian vein and lymph vessels
2) ☐ tubal branch of the uterine artery
3) ☐ ovarian branch of the uterine artery
4) ☑ ovarian artery and nerves
5) ☐ uterine artery

465. The fallopian tube has parts:

1) ☑ funnel, the fringes of which surround the abdominal opening of the fallopian tube
2) ☑ utero – in the uterus
3) ☐ mesenteric-in a wide ligament of the uterus
4) ☑ isthmus-medial, straight and narrow (d 2-3mm)
5) ☑ ampoule-is about half of the fallopian tube

466. Organs, the functional state of which affects the position of the uterus:

1) ☐ ovaries
2) ☐ fallopian tube
3) ☑ bladder
4) ☐ vagina
5) ☑ rectum

467. When the bladder is emptied in relation to the longitudinal axis of the pelvis and the body to the cervix, the uterus occupies a position:

1)	☐	deviates more often to the right (lateropositio uteri)
2)	☑	tilted anteriorly (anteversio uteri)
3)	☐	tilted back (retroversio uteri)
4)	☑	the bending of the uterus anteriorly (anteflexio uteri)
5)	☐	the uterus does not change position when filling the bladder

468. Fixation of the uterus provide:

1)	☑	cardinal ligaments-fibrous and smooth muscle bundles from the cervix to the anterior, lateral and posterior pelvic walls
2)	☑	wide ligament of the uterus (mesentery of the uterus)
3)	☑	round ligament of the uterus (from the edge of the uterus anteriorly from the fallopian tubes through the inguinal canal into the subcutaneous tissue of the labia majora and pubic elevation)
4)	☑	the vagina passes through the urogenital diaphragm
5)	☐	pubic-vesical ligament

469. The uterus supply blood to the arteries:

1)	☐	rectalis superior
2)	☑	ovarica
3)	☐	vesicalis superior
4)	☑	uterina
5)	☐	pudenda interna

470. The lymph nodes receiving the lymph from the uterus:

1) ☑ internal iliac
2) ☑ sacral
3) ☐ paravesicalis
4) ☑ lumbar
5) ☑ inguinal

471. The lymphatic vessels of the uterus are widely anastomosed with the lymphatic vessels of the pelvic organs:

1) ☐ ovaries'
2) ☑ fallopian tube
3) ☐ bladder
4) ☐ ureters'
5) ☑ rectum

472. Excavacio rectouterina from the anus is situated at altitude:

1) ☑ 5 cm
2) ☐ 1 cm
3) ☑ 6 cm
4) ☐ 8 cm
5) ☐ 3 cm

473. Operative approaches during operations on the uterus:

1) ☑ hysteroscopic

2) ☑ a lower midline laparoscopy

3) ☐ Bergman-Israel incision

4) ☑ Pfannenstiel incision

5) ☑ laparoscopic

474. The types of approaches for surgical treatment ectopic pregnancy:

1) ☑ Pfannenstiel transverse variable

2) ☐ Bergman-Israel incision

3) ☑ a lower midline laparotomy

4) ☐ on Pirogov (in parallel and 4 cm up from the inguinal ligament)

5) ☐ lower transrectal

475. Goals of tubectomy in impaired (tubular form) ectopic pregnancy:

1) ☐ resection of fallopian tube salpingo-salpingostomy on the catheter

2) ☑ salpingectomy

3) ☑ stop bleeding

4) ☑ removal of a uterine blood tumor (hematocele retrouterina)

5) ☐ replantation of the remaining part of the fallopian tube into the uterus

476. When salpingectomy for impaired (tubular form) ectopic pregnancy hemostatic clips are applied to:

1) ☐ round ligament of uterus

2) ☐ the mesentery of the ovary

3) ☑ the uterine end of the tube

4) ☐ the isthmus of the uterus

5) ☑ mesosalpinx

---

477. To ensure peritonization of the stump of the fallopian tube and ovarian fixation after salpingectomy, the suture is captured:

1) ☐ broad ligament of the uterus

2) ☑ the peritoneum in the region of the "horns of the uterus»

3) ☐ peritoneal-perineal fascia

4) ☑ round ligament of uterus

5) ☑ the remaining portion of the mesentery of the ovary

---

478. "Danger zone" in the parameter 1.5-2.5 cm laterally from the" ribs " of the uterus at the base of the broad ligament corresponding to the intersection:

1) ☐ ovarian artery

2) ☑ ureter's

3) ☐ of the obturator nerve

4) ☐ round ligament of uterus

5) ☑ uterine artery

---

479. Techniques that exclude damage to the ureter in the "danger zone" in the supravaginal amputation of the uterus:

1) ☐ palpation of the broad ligament of the uterus

2) ☑ catheterization of the ureter ureteral catheter

3) ☐ hysteroscopy

4) ☐ salpingography

5) ☑ reception of Viarta – mixed location of bladder and uterus

---

480. The goal of surgery for cryptorchidism at will Torak-Kinsly-Herzen are:

1) ☐ quick access to the testis the inguinal incision

2) ☑ bringing the testicle into the scrotum

3) ☐ providing hemostasis

4) ☑ orchipexy (temporary fixation of the testicle in the scrotum by creating a scrotal-femoral anastomosis)

5) ☐ layer-by-layer suturing of surgical wound

---

481. The outer opening of the female urethra is characterized by the fact that it:

1) ☑ opens anterior and upward from the opening of the vagina

2) ☐ this opening opens the inflow of the large gland, the vestibule of the vagina

3) ☑ represents a bottleneck of the channel

4) ☐ located at the back wall of the labia majora

5) ☑ opens on the eve of the vagina

---

482. A strong connection of the front wall of the vagina to the adjacent organs, explaining the difficulties of mobilization:

1) ☐ the anterior wall of the rectum

2) ☐ fallopian tube

3) ☑ bladder

4) ☐ ureter

5) ☑ urethra

483. The vaginal sheath of the testis consists of plates of:

1) ☐ internal seminal fascia

2) ☐ the fascia of the m. levator testis

3) ☑ the parietal peritoneum

4) ☐ external seminal fascia

5) ☑ visceral peritoneum

484. In proctology, the rectum is called an organ located below SIII, because it:

1) ☑ gradually loses its mesentery

2) ☑ no tape-longitudinal muscles evenly distributed around the circumference; the outer surface of the intestine is smooth

3) ☑ missing haustra and omental appendages

4) ☐ the intestine occupies the right-hand position

5) ☑ blood vessels have a longitudinal direction

485. The rectum is characterized by sequentially occurring features:

1) ☐ reflex relaxation of internal (smooth muscle) and external (cross-striped muscle fibers) sphincters

2) ☑ tank (accumulation of gases and feces)

3) ☑ retention of gases and feces

4) ☑ the urge to have a bowel movement with increasing pressure up to 40-50 cm of water. art.

5) ☑ excretion (excretory function) of feces outwards with the release of the anal canal from the contents

6) ☐ anterior displacement of the uterus

486. Division of the rectum into departments in relation to the diaphragm of the pelvis due to the difference:

1) ☑ methods of manual and methods of instrumental examination of patients

2) ☑ types and localization of pathological processes of organs

3) ☑ ways of metastasis of rectal cancer

4) ☑ operational access to the pelvic and perineal departments

5) ☐ the division of the rectum into sections has no practical value

487. Anatomical relationship between rectum and peritoneum:

1) ☐ all over covered intraperitoneally

2) ☑ to the level of the S III is covered by peritoneum intraperitoneally

3) ☑ at the level of the SIII and SIV partly - covered by peritoneum on the front

4) ☑ to the level of the SIII has the mesorectum

5) ☐ the rectum has no serous membrane

488. Part of the bony ring of the pelvis that can be felt through the walls of the rectum:

1) ☐ front

2) ☑ left lateral

3) ☑ right lateral

4) ☑ rear

5) ☐ the bone ring is not accessible to palpation per rectum

489. Peritoneo-perineal fascia separates and connects the rectum with:

1) ☐ ureters
2) ☑ vagina
3) ☐ bladder
4) ☑ prostate
5) ☐ a loop of the sigmoid colon

490. Syntopia of rectum in men:

1) ☑ anterior to rectum-prostate, part of the bladder wall
2) ☑ behind – the sacrum and coccyx
3) ☑ with the lateral sides of the crotch of the Department – the fat of the body the sciatic-anal pits
4) ☑ anterior to the ampullae of the deferent ducts, part of the seminal vesicles, ureters
5) ☐ posteriorly - bifurcation of the abdominal aorta

491. Finger examination of the rectum allows to determine:

1) ☑ the condition of the tonus of the external sphincter of the anus, the mucous membrane of the anal canal and capsules
2) ☑ the nature of the surface and the consistency of the prostate
3) ☐ the presence or absence of stenosis of the urethra
4) ☑ state adrectal fiber and laid in her lymph nodes
5) ☑ bowel wall displacement and its relation to the vagina and uterus

492. The man through the front wall of the rectum can be palpated organs:

1) ☐ bladder

2) ☐ ureters

3) ☑ seed bubbles

4) ☐ urethra

5) ☑ prostate

---

493. The sphincter of the rectum include:

1) ☐ pubic-rectal muscle (part of the m. levator ani)

2) ☑ the outer sphincter of the anus (part m. levator ani)

3) ☐ sciatic-cavernous muscle

4) ☑ internal sphincter of the anus (thickening of the circular layer of the muscular membrane of the anus)

5) ☑ sphincter tertius –a thickening of the circular layer of the muscular sheath of the rectum (muscle Gepner)

---

494. Bleeding from haemorrhoid due:

1) ☐ relaxes the tone m. levator ani

2) ☑ the node is a hyperplastic change in the cavernous bodies of the rectum

3) ☑ increased blood flow to the cavernous bodies through the cochlear veins

4) ☑ obstruction of outflow of blood through the veins discharge

5) ☐ the pressure increases in the bladder

---

495. Ligation of hemorrhoids is carried out at:

1) ☑ a prolapse out during bowel movements, straining, prolonged walking

2) ☑ periodic bleeding leading to anemia

3) ☑ daily blood loss with a hemoglobin of 40% and below

4) ☐ systematically repeated exacerbations (thrombophlebitis of rectal veins with edema and" infringement " of nodes)

496. Ligation of hemorrhoids in Martynov-Rezhykh is as follows:

1) ☐ catheterize the bladder

2) ☑ hemorrhoid retard clip Luera

3) ☑ around the neck nodes dissect the mucous membrane of the rectum

4) ☑ the neck of the node is stitched and tied with a silk ligature, 1-1. 5 ml of 2% novocaine solution is injected under the ligature into the base of the node

5) ☑ the node is cut off

497. Stages of hemorrhoidectomy by Milligan-Morgan

1) ☑ on the "leg" of the node perpendicular to the wall of the rectum impose clip Billroth

2) ☑ node edge slit extending perianal skin

3) ☑ the node is cut from the outside inwards to the Bilrot clamp; the neck of the node is tied with a silk ligature

4) ☑ below the ligature, the node is cut off; the skin-mucous edges of the wound are sutured with catgut to their bottom, or sutured tightly

5) ☐ drain the sciatic-anal fossa

498. The types of pararectal abscess (paraproctitis):

1) ☑ saphenous and sciatic-rectal (ileorectal)

2) ☑ submucosal

3) ☑ pelviorectal

4) ☑ retrorectal

5) ☐ abscess of the rectum-bladder (uterine) deepening

499. Chronic paraproctitis (rectal fistula) is characterized by:

1) ☑ the presence of a fistulous

2) ☑ perifocal inflammatory and scar changes in the intestinal wall and adjacent cellular spaces of the pelvis

3) ☑ the presence of holes (holes) in the wall of the intestine or the skin of the anal area

4) ☑ severe pain in the perineum, increasing with defecation

5) ☐ spread of purulent process in parameters

500. The purpose of one-stage abdominal-perineal extirpation of the rectum is:

1) ☐ mobilization of the sigmoid colon

2) ☑ removal of the rectum with the anus and its sphincter, surrounding tissue and lymph nodes

3) ☐ a lower midline laparotomy

4) ☑ formation of a permanent single-barreled artificial anus by removal of the sigmoid colon to the anterior abdominal wall

5) ☐ ensuring asepticheski and meticulous hemostasis