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FEDERAL STATE BUDGET EDUCATIONAL INSTITUTION OF HIGHER EDUCATION "NORTH OSSETIAN STATE MEDICAL ACADEMY" MINISTRY OF HEALTH OF THE RUSSIAN FEDERATION

Department of Human Anatomy with Topographic Anatomy and Operative Surgery

APPROVED
in accordance with the minutes of the meeting
Central Coordinating
Educational and Methodological Council
May 23, 2023, No. 5

EVALUATION MATERIALS

according to the "Topographic anatomy and operative surgery"
of the main professional educational program of higher education -the specialization program in the specialty 31.05.01 "General medicine",
approved on 24.05.2023.

for students of 3-4 courses

in the specialty 31.05.01 "General medicine"

Reviewed and approved at the meeting of the Department on May 18, 2023, Protocol No. 10.

Head of the Department, Associate Professor  O.N. Totoeva

EXAM QUESTIONS
IN THE DISCIPLINES
"TOPOGRAPHICAL ANATOMY AND OPERATIVE SURGERY"

FOR THE 4TH YEAR STUDENTS MAJORING IN
31.05.01 GENERAL MEDICINE (SPECIALTY)
(31.05.01 "General medicine")

1. THE DOCTRINE OF V. N. SHEVKUNENKO INDIVIDUAL ANATOMICAL VARIABILITY OF ORGANS AND SYSTEMS, ITS CLINICAL RELEVANCE.

2. CLINICAL ANATOMY OF THE SMALL INTESTINE. Departments, relation to peritoneum, syntopia, mesentery and its contents, the differences from the colon. Blood supply, innervation, regional lymph nodes.

3. 3TRACHEOSTOMY. Indications, types, technique of operations and their topographic and anatomical justification, possible complications and their prevention.

4. TOPOGRAPHICAL ANATOMY OF LATERAL REGION OF FACE (BUCCAL AND PAROTID-MASTICATORY). Layers and their characteristics, parotid gland and "weak spots" of its capsule, projection on the skin of the parotid gland duct and branches of the facial nerve, neurovascular formations.

5. CLINICAL ANATOMY OF THE PLEURA. Borders, divisions, and part of the pleural cavity, slit, pleural sinuses, Mainperle fields, characteristics of blood supply, innervation and lymphatic drainage from the various divisions of the pleura.

6. OPERATIONS ON THE NERVES. Neurotomy, nerve resection, nerve suture, neurolysis (indications, requirements, technique).

7. CLINICAL ANATOMY OF THE HIP JOINT. Articular surface, the line of attachment of the joint capsule, the projection of the joint space, the ligaments and weak points of the capsule. Blood supply and innervation of the joint.

8. TOPOGRAPHY OF THE PERITONEUM IN THE LOWER FLOOR OF THE ABDOMINAL CAVITY. Canals, sinuses, pockets, large omentum. Features of messages with the upper floor of the abdomen and pelvic cavities, their clinical significance.

9. CRANIOTOMY. Indications, the main types and methods, the main stages of operations, methods of closing the defects of the bones of the cranial vault.

10. CLINICAL ANATOMY OF THE BREAST. With cellotape. capsule, kletchataya space, features of the structure. Blood supply, innervation and ways of lymph outflow.

11. CLINICAL ANATOMY OF THE LIVER. Sellotape, syntopia, holotape. Attitude to the peritoneum, shape and position, ligaments, external structure (lobes, furrows and their contents), segmental structure of the liver. Blood supply to the liver and its features, innervation, lymph flow.

12. EXPOSURE AND LIGATION OF THE FEMORAL ARTERY IN SAROVSKOM TREHERNE. Indications, projection, topography, technique of operations, possible complications and their prevention, ways of collateral blood supply.

13. TOPOGRAPHIC ANATOMY OF THE BACK REGION OF THE KNEE. Boundaries, layers, walls, bottom and contents of popliteal fossa, collateral circulation pathways in violation of blood flow in the popliteal artery.

14. TOPOGRAPHIC ANATOMY OF THE MEDIASTINUM. Borders, departments. General overview of the topography of the organs of the anterior mediastinum.

15. SURGERY FOR DIRECT INGUINAL HERNIAS. Methods of plasty of the inguinal canal.

16. CLINICAL ANATOMY OF THE SHOULDER JOINT. The articular surfaces and the attachment sites of the joint capsule, ligaments, inversions and weaknesses of the joint capsule. Blood supply and innervation of the joint.

17. CLINICAL ANATOMY OF THE LUNGS. Boundaries, external structure of the lungs, lobar and segmental structure, the gate and the root of the lung (blood supply, innervation, lymph flow). The projection of the lobes of the lung on the surface of the breast.

18. OPERATIONS ON THE BLOOD VESSELS. Ligation of the vessel in the wound and throughout-anatomical and physiological justification. Vascular suture, requirements, types and methods, their essence, the technique of the seam on the Carrel.

19. OPERATIONSA ANATOMY OF THE BACK REGION OF THE TIBIA. Borders, layers, muscular-fascial bed, neurovascular bundles, their projection, the ankle-popliteal canal.

20. TOPOGRAPHICAL ANATOMY OF LUMBAR REGION. Boundaries, divisions, layers, weaknesses, lumbar plexus and its branches.

21. PRINCIPLES of Subtotal subfascial resection of the thyroid gland by O. V. Nikolaev.

22. THE DOCTRINE OF THE FASCIA. Definition, structure and types of fascia, types and characteristics of interfacial receptacles, osteo0fascial cases. Clinical significance of fascia.

23. CLINICAL ANATOMY of the gallbladder and extrahepatic zelnik ways. Attitude to the peritoneum of the gallbladder. Its projection, part, syntopia, sellotape, holotape. The topography of the extrahepatic ducts. Variants of the relationship between the common bile and pancreatic ducts. Blood supply, innervation, regional lymph nodes.

24. SURGERY for phlegmon of the extremities. Drainage space Parody-Pirogov.

25. TOPOGRAPHIC ANATOMY OF THE INTERNAL BASE OF THE SKULL. Cranial fossa. Typical places of skull base fractures and their clinical and anatomical characteristics.

26. CLINICAL ANATOMY OF THE LIVER. Sellotape, syntopia, holotape. Attitude to the peritoneum, shape and position, ligaments, external structure (lobes, furrows and their contents), segmental structure of the liver. Blood supply to the liver and its features, innervation, lymph flow.

27. EXPOSURE AND LIGATION OF THE CAROTID ARTERIES. Indications, projection, topography, technique of operations, possible complications and their prevention, ways of collateral blood supply.

28. CLINICAL ANATOMY OF THYROID AND PARATHYROID GLANDS. Skeletopy, syntopia, holotape. Capsules, blood supply and innervation, lymph drainage, "dangerous zone of the thyroid gland".

29. CLINICAL ANATOMY OF THE STOMACH. Sellotape, syntopia, holotape, divisions and part, shape and position of the ligament. Blood supply, innervation, regional lymph nodes and ways of cancer metastasis.

30. OPERATION WHEN PANARITIUMS: hypodermic, nail, tenosynovitis. Readings of topographic-anatomic substantiation, types of equipment and operations.

31. TOPOGRAPHIC ANATOMY OF THE LATERAL TRIANGLE OF THE NECK. Borders, layers, topography of subclavian arteries and veins, cervical and brachial nerve plexus.

32. TOPOGRAPHIC ANATOMY OF THE INGUINAL REGION. Layers and their characteristics, inguinal triangle, inguinal gap, inguinal canal, its walls, holes and contents. Lateral and medial inguinal fossa. Topographic and anatomical prerequisites for the formation of inguinal hernias.

33. OPERATIVE ACCESSES TO THE LUNGS.

34. TOPOGRAPHIC ANATOMY OF THE ANTERIOR REGION OF THE THIGH. Boundaries, layers, neurovascular bundles, muscular and vascular lacunae and their contents.

35. HOLOGRAPHY OF THE PERITONEUM OF THE UPPER FLOOR OF THE ABDOMINAL CAVITY. Bags, ligaments, small omentum and its contents. Features of messages with the lower floor and their clinical value.

36. SUTURE OF THE NERVE. Types, methods and techniques of surgery

37. OPERATIONAL ACCESS AND ACCEPTANCE. Definition, requirements for operational access, criteria for their evaluation, types of operational techniques, individualization of access and reception.

38. CLINICAL ANATOMY OF THE COLON. Departments, attitude to the peritoneum. Sellotape, syntopia, holotape, structure of the colon wall, the structural features of the intestine in the area of the ileocecal angle and its clinical importance. Blood supply and the concept of" critical zones", innervation, regional lymph nodes.

39. CUTS ON THE FACE WHEN ENOYNA THE MUMPS.

40. TOPOGRAPHIC ANATOMY OF THE GLUTEAL REGION. Boundaries, layers and their characteristics, the vessels and nerves, the cellular spaces of the space and ways of distribution of purulent streaks.

41. CLINICAL ANATOMY OF THE PANCREAS. Syntopia. Sellotape, syntopia, holotape. Odely, the attitude to the peritoneum, especially the relationship with large vessels. Blood supply, innervation, lymph flow.

42. SURGICAL TREATMENT OF PURULENT MEDIASTINITIS. Dorsal mediastinotomy on Naslovu modification HEIDENHAIN.

43. CLINICAL ANATOMY OF THE MENINGES OF THE BRAIN. Sinuses of the Dura mater and the pathway of venous outflow from the skull, their connection with extracranial venous formations and their importance in the spread of inflammatory processes.

44. TOPOGRAPHIC ANATOMY OF THE MEDIASTINUM. The boundaries, divisions, overview of the topography of the organs of the posterior mediastinum. Topographic anatomy of the vagus nerves and recurrent branches.

45. The CONCEPT OF SUPRAVAGINAL hysterectomy and surgery for ec Lesson pregnancy. Puncture of the abdominal cavity through the posterior vaginal vault.

46. CLINICAL ANATOMY OF THE DIAPHRAGM. Departments, weaknesses, blood supply, innervation.

47. TOPOGRAPHICAL ANATOMY OF SMALL PELVIS. The floor of the pelvis, cellular spaces of the space of the pelvis and their practical value.

48. PRIMARY SURGICAL TREATMENT OF TRAUMATIC BRAIN INJURY. Features, preparation, topographic and anatomical justification, stages and technique of the operation, ways to stop bleeding from the vessels of the soft tissues of the head, diploic veins, vessels and sinuses of the Dura and superficial vessels of the brain.

49. The TEACHINGS of V. I. SHEVKUNENKO ABOUT the INDIVIDUAL AND AGE-specific ANATOMIC variability of ORGANS AND SYSTEMS. Its main provisions and clinical significance.

50. CLINICAL ANATOMY OF THE UTERUS AND APPENDAGES. Relationship to the peritoneum. Sellotape, syntopia, holotape. The position of the uterus, ligaments. Blood supply, innervation, regional lymph nodes.

51. OPERATIONS AT FEMORAL HERNIAS. The concept of"crown of death".

52. FASCIA AND cellular spaces spaces of the NECK and their clinical significance. Classification and topography. Localization of abscesses and phlegmon, the spread of purulent numb with phlegmon of the neck.

53. TOPOGRAPHY OF THE HEART AND PERICARDIUM. Sellotape, syntopia, holotape. Blood supply, innervation.

54. PUNCTURE of the hip joint.

55. TOPOGRAPHIC ANATOMY OF THE MEDIAL TRIANGLE OF THE NECK. Carotid and scapular-tracheal triangles: boundaries, layers and their characteristics, neurovascular bundle, its projection, topography, branches of the external carotid artery.

56. CLINICAL ANATOMY OF THE COLON. Departments, relation to peritoneum, syntopia, sellotape, holotape. Features of the structure of the colon wall, especially the structure of the intestine in the ileocecal angle and their clinical significance. Blood supply and the concept of" critical zones", innervation, regional lymph nodes.

57. DISARTICULATION Definition, indications. Methods and General technique.

58. FASCIA AND cellular spaces spaces of the NECK and their clinical significance. Classification and topography. Localization of abscesses and phlegmon, the spread of purulent numb with phlegmon of the neck. Incisions in phlegmon and abscesses of the neck and their topographic and anatomical justification.

59. CLINICAL ANATOMY OF THE PANCREAS. Sellotape. syntopia, departments, relation to the peritoneum, especially the relationship with major vessels. Blood supply, innervation, lymph flow.

60. PUNCTURE and catheterization of the femoral artery by the Seldinger.

61. CLINICAL ANATOMY OF THE ELBOW JOINT. The articular surfaces and the attachment sites of the joint capsule, ligaments and weak points of the capsule. Blood supply and innervation of joints

62. CLINICAL ANATOMY OF THE STOMACH. Sellotape, syntopia, holotape, Divisions and part, shape and position of the ligament. Blood supply, innervation, regional lymph nodes and ways of cancer metastasis

63. OPERATIONS ON THE KIDNEYS. Operative access. Nephrotomy, nephrostomy. Indications. Technique of execution.

64. TOPOGRAPHIC ANATOMY OF THE FINGERS. Layers and their characteristics, the topography of the osteo-fibrous canals and synovial sheaths of the flexor tendons of the fingers.

65. TOPOGRAPHICAL ANATOMY OF THE RETROPERITONEAL SPACE. Borders, departments, layers, fascia and cellular spaces.

66. PUNCTURE OF THE PLEURAL CAVITY. Indications, technique, anatomical justification, possible complications and their prevention.

67. CLINICAL ANATOMY OF THE PHARYNX AND THE CERVICAL ESOPHAGUS. Sellotape, syntopia, holotape, Walls, posts, blood supply, innervation, lymphatic outflow.

68. CLINICAL ANATOMY OF THE BLADDER. Relation to the peritoneum, fascial sheath, and the cellular spaces of the space of the bladder layers of the walls. Blood supply and innervation, the regional lymph nodes.

69. OPERATIONS AT PURULENT MASTITIS. The location of ulcers and cuts, the anatomical substantiation and technique of operations.

70. CLINICAL ANATOMY OF THE KNEE JOINT. Articular surface, the line of attachment of the joint capsule, ligaments, menisci, and inversions. Blood supply and innervation.

71. TOPOGRAPHIC ANATOMY OF THE ANTERIOR-LATERAL ABDOMINAL WALL. Areas, projection of organs, blood supply, innervation, lymph flow. The topography of the layers of the lateral region of the abdomen.

72. OPERATIONS FOR INJURIES OF THE HEART. Operative accesses, principles, anatomical substantiation.

73. THE CONTRIBUTION OF N. And. PIROGOV IN THE DEVELOPMENT OF SURGERY. N. And. Pies as the founder of bone-plastic operations.

74. TOPOGRAPHICAL ANATOMY OF THE RETROPERITONEAL SPACE. Borders, bodies and vascular-nervous formations. Branches of the abdominal aorta, formation and tributaries of the inferior Vena cava.

75. GASTROSTOMY. Indications, types and methods, their essence. The technique of gastrostomy for Witzel.

76. TOPOGRAPHICAL ANATOMY of LATERAL REGION of FACE (buccal and parotid-masticatory). Layers and their characteristics, parotid gland and "weak spots" of its capsule, projection on the skin of the parotid gland duct and branches of the facial nerve, neurovascular formations. Cuts on the face with purulent mumps.

77. TOPOGRAPHICAL ANATOMY OF THE THORAX. Borders, departments and areas. Layers the subclavian region, the topography of the intercostal space.

78. SURGERY FOR ABDOMINAL INJURIES. Accesses the audit the abdominal cavity. Suturing the wounds of the small intestine.

79. OPERATIONAL ACCESS AND ACCEPTANCE. Definition, requirements for operational access, criteria for their evaluation, types of operational techniques, individualization of access and reception.

80. TOPOGRAPHIC ANATOMY OF THE UMBILICAL REGION. The relationship of the broad muscles of the abdomen direct. The formation of the white line of the abdomen, the umbilical ring, the layers of the area, their characteristics, weaknesses as an anatomical prerequisite for the formation of hernias, neurovascular bundles.

81. CRANIOTOMY. Indications, the main types and methods, the main stages of the operation. Methods for closing defects in the bones of the cranial vault.

82. TOPOGRAPHIC ANATOMY OF THE FOOT. Layers of muscular and fascial Lodge of the rear and sole of the foot, the neurovascular bundles and their projection, cellular spaces of space and ways of distribution of purulent streaks in phlegmon of the foot.

83. CLINICAL ANATOMY OF THE COLON. Departments, attitude to the peritoneum. Sellotape, syntopia, holotape. Features of the structure of the colon wall, especially the structure of the intestine in the ileocecal angle and their clinical significance. Blood supply and the concept of "critical zones", innervation, regional lymph nodes

84. INCISIONS at deep phlegmon of the lateral area of the face.

85. TOPOGRAPHICAL ANATOMY OF AXILLARY REGION. Boundaries and layers of the area, walls and contents of the axillary cavity, topography of the neurovascular bundle. Ways of collateral circulation in thrombosis of the axillary artery.

86. CLINICAL ANATOMY OF THE DIAPHRAGM. Departments, weaknesses, blood supply, innervation.

87. SURGERY FOR ABDOMINAL INJURIES. Accesses an audit of the abdominal cavity, suturing wounds of the liver.

88. THE SURGICAL TOOL. Groups and types, characteristics of the main instruments, rules of use of surgical instruments.

89. BLOOD FLOW TO THE HEART AND WAYS OF VENOUS OUTFLOW. The concept of the coronary circulation. Branches and blood supply areas of the coronary arteries. Characteristics of the ways of venous outflow and lymph outflow from the heart.

90. OPERATIONS ON THE STOMACH. Gastroenterostomy. Indications. Technique Perevalnogo front of the gastroenteroanastomosis.

91. TOPOGRAPHICAL ANATOMY OF FRONTO-PARIETO-OCCIPITAL REGION. Borders, layers, cellular spaces, vessels and nerves, topographic and anatomical justification of scalped wounds on the head.

92. CLINICAL ANATOMY OF THE PERICARDIUM. The walls of the pericardium and their syntopia. Sinuses of the pericardium, the structure of the pericardium, especially blood supply and innervation.

93. CHOLECYSTECTOMY. CHOLECYSTOSTOMY. Indications, accesses, methods, their essence and technique, anatomical justification.

94. TOPOGRAPHICAL ANATOMY OF TEMPORAL REGION. Boundaries, layers, their characteristics and the ratio with the layers of the front-parietal-occipital region. Neurovascular bundles and cellular spaces. The projection of the main grooves and brain vessels on the skin (scheme Cranlana Brusovo).

95. CLINICAL ANATOMY OF THE RECTUM. Sellotape, syntopia, relation to peritoneum, fascial sheaths and cellular spaces of the space of the rectum, the layers of the walls. Blood supply, innervation, regional lymph nodes.

96. PUNCTURE of the shoulder joint. Shoulder joint resection

97. CAVA KAVALENYA AND PORTO-KAVALENYA MEZVINSKY ANASTOMOSES. Species, topographic anatomy, clinical significance.

98. CLINICAL ANATOMY of the GALLBLADDER and extrahepatic biliary tract. Attitude to the peritoneum of the gallbladder, its projection, parts, syntopia. The topography of the extrahepatic bile ducts. Variants of the relationship between the common bile and pancreatic ducts. Blood supply, innervation, regional lymph nodes.

99. OPERATIONS ON THE BLOOD VESSELS. Ligation of the vessel in the wound and throughout-anatomical and physiological justification. Vascular suture-requirements, types and methods. Seam technique but Carrel.

100. TOPOGRAPHIC ANATOMY PODIGNE-MAXILLARY TRIANGLE. Borders, layers, capsule, bed and topography of the submandibular gland, vessels and nerves, lymph nodes, Pirogov's triangle.

101. CLINICAL ANATOMY OF THE UTERUS AND APPENDAGES. Relation to the peritoneum, the abdominal recess, syntopia, the position of the uterus, part of the layers of the wall of the uterus, ligaments. Blood supply, innervation, regional lymph nodes.

102. SURGERY FOR INGUINAL HERNIAS. Features of the operation with strangulated, sliding and congenital hernias.

103. TOPOGRAPHIC ANATOMY OF THE MASTOID REGION. Trepanation triangle of Shipo. the essence and main stages of trepanation of the mastoid process (antrotomy) and possible complications.

104. CLINICAL ANATOMY OF THE BREAST. Sellotape, capsule, cellular spaces of space, features of the structure. Blood supply, innervation and ways of lymph outflow.

105. APPENDECTOMY. Indications, accesses, differences in the position of the Appendix, stages and technique of operation.

106. SEPARATION AND CONNECTION OF TISSUES. Types and methods, characteristics of modern suture material, application in surgery of bonding agents, ultrasound, laser, plasma scalpel.

107. BLOOD FLOW TO THE HEART AND WAYS OF VENOUS OUTFLOW. The concept of coronary circulation. Branches and blood supply areas of the coronary arteries. Characteristics of the ways of venous outflow and lymph outflow from the heart.

108. INTESTINAL SUTURE. Requirements for intestinal suture. types, methods, equipment

109. CLINICAL ANATOMY OF THE SHOULDER JOINT. The articular surfaces and the attachment sites of the joint capsule, ligaments, inversions and weaknesses of the joint capsule. Blood supply and innervation of the joint.

110. CLINICAL ANATOMY OF THE BREAST. Sellotape, capsule, cellular spaces of space, features of the structure. Blood supply, innervation and ways of lymph outflow.

111. LAPAROTOMY. Types, stages and technique of operations, anatomic substantiation requirements of the laparotomy incision, a comparative evaluation.

112. TOPOGRAPHIC ANATOMY OF THE BACK REGION OF THE KNEE. Boundaries, layers, walls, bottom and contents of popliteal fossa, collateral circulation pathways in violation of blood flow in the popliteal artery.

113. TOPOGRAPHIC ANATOMY OF THE INGUINAL REGION. Layers and their characteristics, inguinal triangle, inguinal gap, inguinal canal, its walls, holes and contents. Lateral and medial inguinal fossa. Topographic-anatomic prerequisites for the formation of Popovych hernias.

114. BREAST SURGERY. Sectoral resection of the breast. Radical mastectomy by Halsted-Meyer. Indications. Technique of execution.

115. TOPOGRAPHICAL ANATOMY OF LATERAL REGION OF FACE (BUCCAL AND PAROTID-MASTICATORY). Layers and their characteristics, parotid gland and "weak spots" of its capsule, projection on the skin of the parotid gland duct and branches of the facial nerve, neurovascular formations..

116. TOPOGRAPHICAL ANATOMY OF LUMBAR REGION. Boundaries, divisions, layers, weaknesses, lumbar plexus and its branches.

117. THE SEAM TENDON. Requirements. Views. Technique of execution.

118. TOPOGRAPHIC ANATOMY OF THE INTERNAL BASE OF THE SKULL. Cranial fossa. Typical places of skull base fractures and their clinical and anatomical characteristics.

119. CLINICAL ANATOMY OF THE UTERUS AND APPENDAGES. Relation to the peritoneum, the abdominal recess, syntopia, the position of the uterus, part of the layers of the wall of the uterus, ligaments. Blood supply, innervation, regional lymph nodes.

120. OPERATIONS ON THE STOMACH. Gastric resection type Billroth-I, Billroth - II. Billroth II in modification of Hofmeister-Finsterer. Advantages and disadvantages of these methods of resection.

121. FASCIAS AND CELLULAR SPACES OF THE SPACE OF THE NECK, THEIR CLINICAL SIGNIFICANCE. Classification and topography. Localization of abscesses and phlegmon, the spread of purulent numb with phlegmon of the neck.

122. CLINICAL ANATOMY OF THE STOMACH. Sellotape, syntopia, holotape. The divisions and part, shape and position of the ligament. Blood supply, innervation, regional lymph nodes and ways of cancer metastasis

123. OPERATIONS ON THE BONES. Osteotomy, bone resection, extra-and intramedullary osteosynthesis.

124. TOPOGRAPHICAL ANATOMY OF TEMPORAL REGION. Boundaries, layers, their characteristics and the ratio with the layers of the front-parietal-occipital region. Neurovascular bundles and cellular spaces. The projection of the main grooves and brain vessels on the skin (scheme Cranlana Brusovo).

125. CLINICAL ANATOMY OF THE PERICARDIUM. The divisions of the pericardium and their syntopia, the sinuses of the pericardium, the structure of the pericardium, especially of the blood supply and innervation.

126. OPERATIONS ON THE NERVES. Neurolysis. Suture of the nerve. Indications. Technique of execution.

127. CLINICAL ANATOMY OF THE KNEE JOINT. Articular surface, the line of attachment of the joint capsule, ligaments, menisci, and inversions. Blood supply and innervation.

128. CLINICAL ANATOMY OF THE DIAPHRAGM. Departments, weaknesses, blood supply, innervation.

129. AMPUTATION. Definition, indications, classification, types and methods, stages and General technique, amputation stump.

130. 130.TOPOGRAPHICAL ANATOMY OF AXILLARY REGION. Boundaries and layers of the area, walls and contents of the axillary cavity, topography of the neurovascular bundle. Ways of collateral circulation in thrombosis of the axillary artery.

131. TOPOGRAPHIC ANATOMY OF THE ANTERIOR-LATERAL ABDOMINAL WALL. Areas, projection of organs, blood supply, innervation, lymph flow. The topography of the layers of the lateral region of the abdomen

132. SURGERY for HYDROCELE (methods of Winkelmann and Bergman).

133. TOPOGRAPHIC ANATOMY OF THE GLUTEAL REGION. Boundaries, layers and their characteristics, the vessels and nerves, the cellular spaces of the space and ways of distribution of purulent streaks.

134. CLINICAL ANATOMY OF THE COLON. Departments, relation to peritoneum, syntopia, structure of the colon wall, the structural features of the intestine in the area of the ileocecal angle and its clinical importance. Blood supply and the concept of" critical zones", innervation.

135. SUTURE OF THE LUNG. Marginal resection of the lung.

136. TOPOGRAPHIC ANATOMY OF THE ANTERIOR REGION OF THE THIGH. Boundaries, layers, neurovascular bundles, muscular and vascular lacunae and their contents.

137. TOPOGRAPHIC ANATOMY OF THE MEDIASTINUM. The boundaries, divisions, overview of the topography of the organs of the posterior mediastinum. Topographic anatomy of the vagus nerves and recurrent branches.

138. OPERATIONS ON the BLADDER: puncture, cystotomy. cystostomy. Statement, concept of operations and their nature, the anatomical rationale.

139. CLINICAL ANATOMY OF THE MENINGES OF THE BRAIN. Sinuses of the Dura mater and the pathway of venous outflow from the skull, their connection with extracranial venous formations and their importance in the spread of inflammatory processes.

140. TOPOGRAPHICAL ANATOMY OF THE THORAX. Borders, departments and areas. Layers of the subclavian region, topography of intercostal spaces.

141. PUNCTURE OF ABDOMINAL CAVITY THROUGH POSTERIOR VAGINAL VAULT. Operative access to the uterus.

142. TOPOGRAPHICAL ANATOMY OF FRONTO-PARIETO-OCCIPITAL REGION. Borders, layers, cellular spaces, vessels and nerves, topographic and anatomical justification of scalped wounds on the head.

143. TOPOGRAPHY OF THE PERITONEUM IN THE LOWER FLOOR OF THE ABDOMINAL CAVITY. Canals, sinuses, pockets, large omentum. Features of messages with the upper floor of the abdomen and pelvic cavities, their clinical significance.

144. SURGERY FOR OBLIQUE INGUINAL HERNIAS. Methods of plasty of the inguinal canal.

145. CLINICAL ANATOMY OF THE HIP JOINT. Articular surface, the line of attachment of the joint capsule, the projection of the joint space, the ligaments and weak points of the capsule. Blood supply and innervation of the joint.

146. TOPOGRAPHY OF THE PERITONEUM OF THE UPPER FLOOR OF THE ABDOMINAL CAVITY. Bags, ligaments, small omentum and its contents. Features of messages with the lower floor and their clinical value.

147. SEPARATION AND CONNECTION OF TISSUES. Types and methods, characteristics of modern suture material, application in surgery of bonding agents, ultrasound, laser, plasma scalpel.

148. TOPOGRAPHIC ANATOMY OF THE MEDIAL TRIANGLE OF THE NECK. Carotid and scapular-tracheal triangles: boundaries, layers and their characteristics, neurovascular bundle, its projection, topography, branches of the external carotid artery.

149. TOPOGRAPHICAL ANATOMY OF THE RETROPERITONEAL SPACE. Borders, departments, layers, fascia and cellular spaces.

150. RADICAL OPERATIONS ON THE LUNGS. Pneumonectomy, lobectomy, segmentectomy. The essence of operations, anatomical justification, operational accesses, the main stages.

QUESTIONS
"PRACTICAL SKILLS"
FOR STUDENTS IN THE SPECIALTY
31.05.01 General medicine (specialty)

Часть I.
Name it in Latin and show it on the drug:

1. the frontal bone
2. scaly part of the temporal bone
3. external auditory canal
4. the jugular hole
5. holeof the parietal emissary vein
6. large nose wing cartilage
7. buccal region
8. submandibular gland
9. scapuloclavicular fascia
10. shoulder
11. intermediate ulnar vein
12. shoulder blade awn
13. medial condyle
14. intercostal brachial nerve
15. brachial veins
16. ulnar muscle
17. lower posterior iliac spine
18. foot
19. popliteal surface
20. iliopsoas muscle
21. temporal bone
22. the head of the upper jaw
23. large occipital hole
24. central furrow
25. back of the nose
26. lateral surface of the zygomatic bone
27. laryngeal protrusion
28. jugular venous angle
29. joint capsule
30. ulnar fossa
31. shoulder blade
32. subarticular tubercle
33. scapula-hyoid muscle
34. interosseous recurrent artery
35. recurrent ulnar artery
36. little sciatic notch
37. posterior ankle area
38. scallop muscle
39. iliac-comb bag
40. lumbar-gluteal fat mass
41. frontal area
42. mastoid process
43. condylar fossa
44. internal auditory orifice
45. hole of the occipital emissary vein
46. nostrils
47. parotid-chewing area
48. superficial fascia of the neck
49. upper thyroid artery
50. back surface of the shoulder
51. radial flexor of the hand
52. subcostal fossa
53. common flexor tendon
54. medial cutaneous nerve of the shoulder
55. upper ulnar collateral artery
56. metacarpal bone
57. sciatic bone branch
58. sole area of the foot
59. medial condyle
60. gluteus maximus
61. brow arch
62. mastoid cave
63. condylar canal
64. outer opening of the vestibule water pipe
65. opening of the condylar emissary vein
66. lateral nasal cartilage
67. sternocleidomastoid muscle
68. external plate of the superficial fascia of the neck
69. lingual artery
70. The frontal bone
71. Scaly part of the temporal bone
72. External auditory canal
73. The jugular hole
74. Holeof the parietal emissary vein
75. Large nose wing cartilage
76. Buccal region
77. Submandibular gland
78. Scapuloclavicular fascia
79. Shoulder
80. Intermediate ulnar vein
81. Shoulder blade awn
82. Medial condyle

83. Intercostal brachial nerve
84. Brachial veins
85. Ulnar muscle
86. Lower posterior iliac spine
87. Foot
88. Popliteal surface
89. Iliopsoas muscle
90. Temporal bone
91. The head of the upper jaw
92. Large occipital hole
93. Central furrow
94. Back of the nose
95. Lateral surface of the zygomatic bone
96. Laryngeal protrusion
97. Jugular venous angle
98. Joint capsule
99. Ulnar fossa
100. Shoulder blade
101. Subarticular tubercle
102. Scapula-hyoid muscle
103. Interosseous recurrent artery
104. Recurrent ulnar artery
105. Little sciatic notch
106. Posterior ankle area
107. Scallop muscle
108. Iliac-comb bag
109. Lumbar-gluteal fat mass
110. Frontal area
111. Mastoid process
112. Condylar fossa
113. Internal auditory orifice
114. Hole of the occipital emissary vein
115. Nostrils
116. Parotid-chewing area
117. Superficial fascia of the neck
118. Upper thyroid artery
119. Back surface of the shoulder
120. Radial flexor of the hand
121. Subcostal fossa
122. Common flexor tendon
123. Medial cutaneous nerve of the shoulder
124. Upper ulnar collateral artery
125. Metacarpal bone
126. Sciatic bone branch
127. Sole area of the foot
128. Medial condyle
129. Gluteus maximus
130. Brow arch
131. Mastoid cave
132. Condylar canal
133. Outer opening of the vestibule water pipe
134. Opening of the condylar emissary vein
135. Lateral nasal cartilage
136. Sternocleidomastoid muscle
137. External plate of the superficial fascia of the neck
138. Lingual artery
139. Brachial artery
140. Triceps brachialis (long head)
141. Shoulder blade tenderloin
142. Subacute fascia
143. Lateral thoracic nerve
144. The head of the radius
145. Lower limb
146. Lower branch of the pubic bone
147. Sole area of the foot
148. Large adductor muscle
149. Semi-tendon muscle
150. Supra-block artery
151. Sphenoid bone
152. Large occipital opening
153. Mastoid opening
154. Sulcus of the superior sagital sinus
155. Upper nasal passage
156. Masticatory muscle
157. Scapuloclavicular fascia
158. Facial artery
159. Brachial vein
160. Forearm
161. Upper edge of the scapula
162. Glenoid-brachial ligament
163. Lateral cutaneous nerve of the forearm
164. Radius bone
165. Lower limb girdle
166. Pubic bone
167. Finger areas
168. Dorsal sacroiliac ligament
169. Semipereminous muscle
170. Supraorbital artery

171. Large wing of the sphenoid bone
172. Sulcus of the superior sagittal sinus
173. Stingray
174. Sulcus of the lower sagittal sinus
175. Middle nasal passage
176. Maxillary artery
177. Intra-cervical fascia
178. Recurrent laryngeal nerve
179. Acromial branch of the thoracoacromial artery
180. Anterior surface of the forearm
181. Lower corner of the scapula
182. Subcutaneous sac of the scapular muscle
183. Small humeral tubercle
184. Block-shaped clipping
185. Gluteal region
186. Vascular lacuna
187. The upper branch of the pubic bone
188. Ventral sacroiliac ligament
189. Long head of the biceps femoris
190. Angular vein
191. Small wing of the sphenoid bone
192. Anterior cranial fossa
193. Transverse sinus sulcus
194. Sulcus of the rectus sinus
195. Lower nasal passage
196. Parotid gland
197. Sleepy triangle
198. Subclavian artery
199. Brachial plexus
200. Posterior surface of the forearm
201. Upper corner of the shoulder blade
202. Large rhomboid muscle
203. Round pronator
204. Interosseous membrane
205. Free lower limb
206. The front surface of the thigh
207. Symphyseal surface
208. Pubic symphysis
209. Middle gluteal muscle
210. Supracranial muscle
211. Occipital bone
212. Latticed plate of the latticed bone
213. Sulcus of the occipital sinus
214. Chewing tuberosity
215. Nasal septum
216. Parotid duct
217. Sleepy vagina
218. Shield barrel
219. Upper trunk of the brachial plexus
220. Median vein of the forearm
221. Median edge of the scapula
222. Musculoskeletal system
223. Square forearm pronator
224. Oblique chord
225. Hip joint
226. Medial surface of the femur
227. Locking hole
228. Intervertebral disc
229. Small gluteal muscle
230. Tendon helmet
231. Occipital protrusion
232. Blind hole
233. Internal occipital crest
234. Condylar process
235. Coulter
236. Facial nerve
237. Cervical plexus
238. Internal thoracic artery
239. Middle trunk of the brachial plexus
240. Surface flexor of the fingers
241. Lateral edge of the scapula
242. Belt muscle of the head
243. Cellular space of the forearm
244. Styloid process of the radius
245. Hip
246. Back of the thigh
247. Femur
248. Superior pubic ligament
249. Hip broad fascia tensioner
250. Cranial periosteum
251. Lacrimal bone
252. Finger indentations
253. Internal occipital protuberance
254. Temporomandibular joint
255. Frontal process of the upper jaw
256. The sub-temporal fossa
257. Great ear nerve
258. Pharynx
259. Lower trunk of the brachial plexus
260. Elbow flexor of the hand
261. Beak-shaped process
262. Small round muscle

263. Lateral intermuscular septum of the shoulder
264. The styloid process of the ulna
265. Iliac crest
266. Drive channel
267. Femoral head
268. Arched pubic ligament
269. Large adductor muscle
270. Ear area
271. Upper nasal passage
272. Optic nerve canal
273. Dura mater of the brain
274. Chin hole
275. Maxillary sinus
276. Lateral pterygoid muscle
277. Lingual-pharyngeal nerve
278. Lymphoepithelial ring
279. Lateral bundle of the brachial plexus
280. Proximal finger fold
281. Shoulder blade neck
282. The broadest back muscle
283. Musculocutaneous nerve
284. Posterior edge of the radius
285. Posterior superior iliac spine
286. Knee area
287. Fossa of the femoral head
288. Sacro-spinous ligament
289. Long adductor muscle
290. The auricle
291. Middle nasal passage
292. Middle cranial fossa
293. Arachnoid membrane of the brain
294. Hyoid bone
295. Sphenoid sinus
296. Pterygopalebral fossa
297. Anterior stair muscle
298. Bicuspid muscle
299. Posterior brachial plexus bundle
300. Long extensor of the thumb of the hand
301. Artery encircling the scapula
302. Deltoid branch of the thoracoacromial artery
303. Radial tuberosity
304. Posterior surface of the radius
305. Coccyx
306. Knee joint
307. Ligament of the femoral head
308. Sacro-tubercular ligament
309. Short adductor muscle
310. External auditory canal
311. Lower nasal passage
312. Stony part of the temporal bone
313. Anterior cerebral artery
314. Ascending pharyngeal artery
315. Frontal sinus
316. The first cervical vertebra
317. Middle stair muscle
318. Cricoid cartilage
319. Medial bundle of the brachial plexus
320. Distal interphalangeal joint
321. Dorsal artery of the scapula
322. Anterior dentate muscle
323. Aponeurosis of the biceps muscle of the shoulder
324. Square pronator
325. Pelvic bone
326. Patella
327. Femoral head neck
328. Iliolumbar ligament
329. Piriformis muscle
330. Coronary suture
331. Coulter
332. Turkish saddle
333. Middle cerebral artery
334. Bridge of the nose
335. Latticed sinus
336. Tooth of the first cervical vertebra
337. Posterior stair muscle
338. Thyroid cartilage
339. Main vein
340. Ulnar wrist extensor
341. Deep artery of the shoulder
342. Axillary fascia
343. Brachioradialis muscle
344. Round pronator
345. Acetabulum
346. Lower leg
347. Femoral body
348. Acetabulum
349. Superior twin muscle
350. Sagital suture
351. Nasal bone
352. Upper orbital fissure

353. Posterior cerebral artery
354. Eye socket area
355. The sub-temporal fossa
356. Second cervical vertebra
357. Lateral triangle of the neck
358. Arytenoid cartilage
359. Cephalic vein
360. Acromial end
361. Beak-shaped process
362. Brachial plexus
363. The head of the radius
364. The short muscle that withdraws the thumb
365. Iliac bone
366. Anterior surface of the lower leg
367. Large skewer
368. Acetabular lip
369. Lower twin muscle
370. Parietal bone
371. Upper jaw
372. Lower orbital fissure
373. Vertebral artery
374. Supraorbital margin
375. Mouth area
376. Spinous process
377. Scapular-tracheal triangle
378. Epiglottic cartilage
379. Clavicular-sternal joint
380. Cone-shaped tubercle
381. Supraspinatus muscle
382. Shoulder blade body
383. Ulnar process
384. Long radial wrist extensor
385. Wing of the ilium
386. Posterior surface of the lower leg
387. Trochanteric fossa
388. Semilunar surface
389. Square thigh muscle
390. The crown
391. Lower jaw
392. Round hole
393. Arterial circle of the large brain
394. Subglacial margin
395. Oral fissure
396. Transverse process
397. Scapuloclavicular triangle of the neck
398. Thyroid gland
399. Cranio-clavicular ligament
400. Beak-shaped process
401. Beak-shoulder muscle
402. Axillary vein
403. Radial nerve
404. Short radial wrist extensor
405. Iliac crest
406. Medial ankle
407. Iliolumbar muscle
408. Acetabulum
409. Glute area
410. Parietal hillock
411. Palatine process
412. Oval hole
413. Sickle of the big brain
414. Upper eyelid
415. Solid sky
416. Opening of the transverse process
417. The spatula-trapezoid triangle
418. Isthmus of the thyroid gland
419. Deltoid muscle
420. Sulcus of the subclavian muscle
421. Pectoralis major
422. Median thoracic nerve
423. Posterior cutaneous nerve of the forearm
424. Ulnar extensor of the wrist
425. Anterior superior iliac spine
426. Lateral ankle
427. Intervertebral line
428. Obstructive artery
429. Glute crease
430. Big fontanelle
431. Alveolar process
432. Spinous opening
433. Frontal pole
434. Lower eyelid
435. Soft palate
436. Upper articular process
437. Common carotid artery
438. Parathyroid gland
439. Triceps of the shoulder
440. Costoclavicular ligament
441. Small pectoral muscle
442. Suspensory ligament
443. Finger extensor

444. Little finger extensor
445. Posterior superior iliac spine
446. Tibia
447. Intervertebral ridge
448. Joint capsule
449. Sacrum
450. Small fontanelle
451. Chin protrusion
452. Ragged hole
453. Lateral ventricle
454. Eyeball
455. Vestibule of the mouth
456. Lower articular process
457. External carotid artery
458. Trachea
459. Biceps brachii
460. Anatomical neck of the humerus
461. Subacute fossa
462. Musculocutaneous nerve
463. Deep artery of the shoulders
464. Long palmar muscle
465. The auricular surface of the ilium
466. Fibula
467. Rough hip line
468. Articular cavity
469. Coccyx
470. Latticed bone
471. Lower jaw branch
472. Internal opening of the carotid canal
473. Third ventricle
474. Tear lake
475. Oral cavity
476. Anterior stair muscle
477. Internal carotid artery
478. The cervical part of the esophagus
479. Long head of the biceps muscle of the shoulder
480. Interbugular furrow
481. Acromion angle
482. Ulnar nerve
483. Long head of the triceps muscle of the shoulder
484. Right forearm
485. Sacroiliac joint
486. Tibial nerve
487. Inner lip of the iliac crest
488. Circular zone
489. Great trochanter of the femur
490. Temporal muscle
491. Angle of the lower jaw
492. Cleft canal of the great stony nerve
493. Fourth ventricle
494. Semicircular conjunctival fold
495. Language
496. Middle stair muscle
497. External jugular vein
498. Border area
499. Short head of the biceps brachii
500. Deltoid tuberosity
501. Surgical neck of the humerus
502. Radial nerve
503. Ulnar nerve
504. Common flexor tendon
505. Sciatic bone
506. Peroneal nerve
507. External lip of the iliac crest
508. Ilio-femoral ligament
509. Subcutaneous trochanter bag
510. Temporal fossa
511. Zygomatic bone
512. Cleft canal of the lesser stony nerve
513. Interventricular orifice (monroe's orifice)
514. Nose area
515. Lingual nerve
516. Posterior stair muscle
517. Internal jugular vein
518. Trapezius muscle
519. Elbow area
520. Lateral supracondylar crest
521. Humerus block
522. Clavicle
523. Recurrent radial artery
524. Ulnar flexor of the hand
525. Sciatic tubercle
526. The ankle joint
527. Gluteal tuberosity
528. Sciatic-femoral ligament
529. Posterior cutaneous nerve of the thigh
530. The sub-temporal fossa
531. Zygomatic arch
532. Posterior cranial fossa

533. Lateral aperture of the fourth ventricle (lyushka opening)
534. Pear-shaped hole
535. Zygomatic region
536. Medial triangle of the neck
537. Vagus nerve
538. Shoulder joint
539. Elbow joint
540. Lateral epicondyle
541. Ulnar nerve furrow
542. Sternocleidomastoid muscle
543. Radial collateral artery
544. Radial flexor of the hand
545. Sciatic spine
546. Anterior ankle area
547. Scallop line
548. Pubic-femoral ligament
549. Superficial fascia
550. Frontal bone protuberance
551. Awl-shaped process
552. Occipital condyle
553. Sublingual canal
554. Opening of the mastoid emissary vein
555. Nasal cavity
556. Buccal muscle
557. Subcutaneous neck muscle
558. Pre-vertebral fascia
559. Front surface of the shoulder
560. Brachioradialis muscle
561. Supraspinatus fossa
562. Ulnar muscle
563. Subcapular nerve
564. Medial brachial cutaneous nerve
565. Bridle
566. Large sciatic tenderloin
567. Arch of the foot
568. Lateral condyle
569. Tailor's muscle
570. Mammary gland
571. Edge arc
572. The deepest intercostal muscles
573. Anterior dentate muscle
574. Anterior jugular vein
575. Upper right lung
576. Transverse pericardial sinus
577. Left hypochondrium
578. Superficial inguinal ring
579. Middle umbilical fold
580. Oil seal bag
581. Gallbladder
582. The body of the pancreas
583. Abdominal aorta
584. Left common iliac vein
585. Large pelvis
586. Uterus
587. Right iliac artery
588. Coccygeal part of the sacrum
589. Sternum
590. Right edge angle
591. Short muscles that raise the ribs
592. Round back muscle
593. Jugular venous arch
594. The tip of the left lung
595. Parietal pleura
596. Oblique chord
597. The epigastric region proper
598. Medial pedicle of the inguinal ligament
599. Middle umbilical fold
600. Packing hole
601. Cystic artery
602. Tail of the pancreas
603. Visceral branches of the aorta
604. Right external iliac vein
605. Small pelvis
606. The bottom of the uterus
607. Left iliac artery
608. Coccyx
609. Clavicular sternum tenderloin
610. Left edge angle
611. Pectoralis major
612. Small rhomboid muscle
613. Right common carotid artery
614. Horizontal slit of the right lung
615. Visceral pleura
616. Coronal sinus
617. Right side area
618. Lateral leg of the inguinal ligament
619. Lateral umbilical fold
620. Inferior vena cava
621. The bed of the gallbladder
622. Excretory flow of the pancreas
623. Parietal branches of the aorta

624.Left external iliac vein
625.Iliac crest
626.The body of the uterus
627.Right iliac vein
628.Sacrococcygeal joint
629.Jugular sternum tenderloin
630.Shoulder blade
631.The clavicular part of the pectoralis major
632.The large rhomboid muscle
633.Right subclavian artery
634.Oblique fissure of the right lung
635.The mediastinal part of the parietal pleura
636.Left coronary artery
637.Left side area
638.Inguinal canal
639.Parietal peritoneum
640.Abdominal aorta
641.The bottom of the gallbladder
642.Pancreatic excision
643.The ventral trunk
644.Right internal iliac vein
645.The upper branch of the pubic bone
646.The cervix
647.Left iliac vein
648.The muscle that straightens the spine
649.Sternum handle
650. Shoulder blade awn
651. The sternal part of the pectoralis major muscle
652. Three-way opening
653. Left common carotid artery
654. Apical segment of the upper lobe of the right lung
655. The diaphragmatic part of the parietal pleura
656. Left common carotid artery
657.The umbilical region
658.Round ligament of the uterus
659.Median fossa
660.Spleen
661.The body of the gallbladder
662.Mesentery of the small intestine
663.Left gastric artery
664.Left internal iliac vein
665.The lower branch of the pubic bone
666.Anterior lip of the cervix
667.Vertebra
668. Sacroiliac joint
669. Sternum body
670. Supraspinatus fossa
671. Abdominal part of the pectoralis major muscle
672. Quadrilateral opening
673.Left subclavian artery
674.Posterior segment of the upper lobe of the right lung
675.Costal part of the parietal pleura
676.Superior vena cava
677.Navel
678.Spermatic cord
679.Middle fossa
680.The upper pole of the spleen
681.The neck of the gallbladder
682.Mesentery root of the small intestine
683.Right gastric artery
684.Square lumbar muscle
685.The iliosacral ligament
686.Posterior lip of the cervix
687.Vertebral body
688.Sacroiliac ligaments
689.Xiphoid process
690.The subacute fossa
691.Small pectoral muscle
692.Unpaired vein
693.Right vagus nerve
694.Anterior segment of the upper lobe of the right lung
695.Pleural dome
696.Inferior vena cava
697.The umbilical ring
698.The muscle that raises the testicle
699.Lateral fossa
700.The lower pole of the spleen
701.Common bile duct
702.Jejunum
703.Superior mesenteric artery
704.Fascia of the square lumbar muscle
705.Large sciatic opening
706.Broad ligament of the uterus
707.Vertebral arch
708.Iliocostal muscle
709.Clavicular-sternal joint

710.Subscapular fossa
711.Surface sub-sector space
712.Semi-detached vein
713.Left vagus nerve
714. Lateral segment of the middle lobe of the right lung
715. Lower border of the left pleural cavity
716. Diaphragm
717. Right iliac region
718. Fascia of the muscle that raises the testicle
719. Large oil seal
720.Spleen gate
721.Common hepatic duct
722.The ileum
723.Small bowel artery
724.Intra-abdominal fascia
725.Small sciatic opening
726.Round ligament of the uterus
727.Leg of the vertebral arch
728.Spinal cord
729.Clavicle
730.Cutting the shoulder blade
731.Deep sub-sector space
732.Jugular venous angle
733.Thoracic duct
734.Medial segment of the middle lobe of the right lung
735.Lower border of the right pleural cavity
736.Right dome of the diaphragm
737.Pubic area (submandibular)
738.Lacunar ligament
739.Small oil seal
740.Splenic artery
741.Right hepatic duct
742.Caecum
743.The jejunal artery
744.The adrenal gland
745.Iliac fossa
746.Fallopian tube
747.The first cervical vertebra
748.The cervical part of the spinal cord
749.Sternal edge of the clavicle
750.Upper edge of the scapula
751.Anterior dentate muscle
752.The shoulder-head trunk
753.Clavicular-thoracic fascia
754.Left lung
755.Intra-thoracic fascia
756.Left dome of the diaphragm
757.Left iliac region
758.Scallop ligament
759.Upper duodenal recess
760.Splenic vein
761.Left hepatic duct
762.The dome of the cecum
763.Right colon artery
764.Kidney
765.Locking membrane
766.Abdominal opening of the fallopian tube
767.The second cervical vertebra
768.Thoracic part of the spinal cord
769.Subclavian area
770.Lower angle of the scapula
771.Posterior dentate muscle
772.Pulmonary trunk
773.Trachea
774.The uvula of the upper lobe of the left lung
775.Internal thoracic artery
776.Tendon center of the diaphragm
777.Rectus abdominis
778.External oblique abdominal muscle
779.Lower duodenal recess
780. Liver
781. Coronal ligament
782. Ileocecal angle
783. Middle colonic artery
784. The upper pole of the kidney
785.Sacro-tubercular ligament
786.Fallopian tube funnel
787.Carotid tubercle
788.The lumbar part of the spinal cord
789.Sternal region
790.Upper corner of the scapula
791.Deltoid-thoracic triangle
792.Aorta
793.Tracheal bifurcation
794.Oblique slit of the left lung
795.Pericardium
796. The muscular part of the diaphragm

797. Vagina rectus abdominis
798. Aponeurosis of the external oblique abdominal muscle
799. Right side channel
800. Upper surface of the liver
801. Round ligament of the liver
802. Worm-like process
803. Lower mesenteric artery
804. The lower pole of the kidney
805. Pubic-rectal muscle
806. Fimbria of the fallopian tube
807. Vertebral column
808. The sacral part of the spinal cord
809. Thoracic region
810. The median edge of the scapula
811. Scapular edge of the clavicle
812. Aortic bulb
813. Right main bronchus
814. Upper lobe of the right lung
815. Pericardial cavity
816. Costal section of the diaphragm
817. The anterior wall of the vagina of the rectus abdominis
818. Internal oblique abdominal muscle
819. Left side channel
820. Back surface baking
821. Sickle ligament
822. The tip of the vermiform process
823. Left colon artery
824. Anterior surface of the kidney
825. Pubic-coccygeal muscle
826. Uterine artery
827. Cervical spine
828. Cervical thickening of the spinal cord
829. Sub-chest area
830. Lateral edge of the scapula
831. Sternal edge of the clavicle
832. Ascending part of the aorta
833. Left main bronchus
834. Middle lobe of the right lung
835. The outer leaf of the pericardium
836. The sternal part of the diaphragm
837. The posterior wall of the vagina of the rectus abdominis
838. Transverse abdominal muscle
839. Right mesenteric sinus
840. Anterior surface of the liver
841. Portal vein
842. The base of the vermiform process
843. Sigmoid artery
844. Posterior surface of the kidney
845. Coccygeal muscle
846. Ovary
847. Cervical vertebra
848. Lumbosacral thickening of the spinal cord
849. Edge
850. Beak-like process
851. Sternocostal triangle
852. Aortic arch
853. Right pulmonary artery
854. Lower lobe of the right lung
855. Inner pericardial leaf
856. Vertebral diaphragm
857. Semilunar line
858. Transverse fascia
859. Left mesenteric sinus
860. Lower edge of the liver
861. Hepatic-duodenal ligament
862. Mesentery of the vermiform process
863. Superior rectal artery
864. Kidney gate
865. Piriformis muscle
866. Ovarian gate
867. Thoracic spine
868. Anterolateral sulcus of the spinal cord
869. Rib cartilage
870. Neck of the scapula
871. Anterior midline of the chest
872. Descending part of the aorta
873. Left pulmonary artery
874. Upper lobe of the left lung
875. Heart
876. Aortic opening
877. Arc line
878. Anterior plate of the vagina of the rectus abdominis
879. Stomach
880. Lower surface of the liver
881. Hepatic-gastric ligament
882. Ascending part of the colon
883. Middle rectal artery
884. Kidney pelvis

885. Epiglottis hole
886. The vagina
887. Thoracic vertebra
888. Posterolateral sulcus of the spinal cord
889. Edge angle
890. Artery encircling the scapula
891. Sternal line
892. Right coronary artery
893. Right pulmonary veins
894. Lower lobe of the left lung
895. The tip of the heart
896. Esophageal opening
897. Aponeurosis of the external oblique abdominal muscle
898. Posterior plate of the vagina of the rectus abdominis
899. The bottom of the stomach
900. Right lobe of the liver
901. Duodenum
902. Hepatic angle of the colon
903. Lower rectal artery
904. Renal fascia
905. Podgrushevidnoe hole
906. The arch of the vagina
907. Lumbar spine
908. Terminal thread
909. Rib head
910. Internal thoracic artery
911. Mid-key line
912. Left coronary artery
913. Left pulmonary veins
914. Cardiac excision of the left lung
915. The base of the heart
916. Opening of the inferior vena cava
917. Aponeurosis of the internal oblique abdominal muscle
918. Inguinal triangle
919. The body of the stomach
920. Left lobe of the liver
921. The descending part of the duodenum
922. The horizontal part of the colon
923. Aortic bifurcation
924. Anterior leaf of the renal fascia
925. The muscle that raises the anus
926. Vesicopoietic recess
927. Lumbar vertebra
928. Gray matter of the spinal cord
929. Rib body
930. Lateral thoracic artery
931. Anterior axillary line
932. Coronal sinus
933. Pulmonary trunk
934. The diaphragmatic surface of the right lung
935. The left ear of the heart
936. White belly line
937. Transverse abdominal muscle
938. Vascular lacuna
939. The anterior wall of the stomach
940. The square fraction of the liver
941. The horizontal part of the duodenum
942. Mesentery of the horizontal part of the colon
943. Right common iliac artery
944. Posterior leaf of the renal fascia
945. Tendon arch of the muscle that raises the anus
946. The bladder
947. Intervertebral symphysis
948. White matter of the spinal cord
949. Rib furrow
950. Lateral branches of the internal thoracic artery
951. Middle axillary line
952. The phrenic nerve
953. Upper lobar bronchus
954. The diaphragmatic surface of the left lung
955. The right ear of the heart
956. Intercostal line
957. Superior epigastric artery
958. Muscle lacuna
959. Задняя стенка желудка
960. Caudate lobe of the liver
961. Ascending part of the duodenum
962. Splenic angle of the colon
963. Left common iliac artery
964. Kidney fat capsule
965. Sigmoid colon
966. The bottom of the bladder
967. Sacrum
968. Soft shell of the spinal cord

969.True edge
970.Medial branches of the internal thoracic artery
971.Posterior axillary line
972.Superior vena cava
973.Lower lobar bronchus
974.Costal surface of the right lung
975.Right atrium
976.Epigastric artery
977.Inferior epigastric artery
978.Femoral artery
979.Small curvature of the stomach
980.Common hepatic artery
981.Ligament suspending the duodenum
982.Parotid adipose tissue
983.Right external iliac artery
984.Renal artery
985.Rectum
986.The body of the bladder
987.Sacral crest
988.Arachnoid membrane of the spinal cord
989.False edge
990.Pectoral transverse muscles
991.Scapular line
992.Right brachiocephalic vein
993.Esophagus
994.Costal surface of the left lung
995.Right ventricle
996.Srednechrevye
997.Anterior superior crest of the ilium
998.Femoral vein
999.Large curvature of the stomach
1000. Own hepatic artery

QUESTIONS ABOUT PRACTICAL SKILLS

IN THE DISCIPLIN

"TOPOGRAPHICAL ANATOMY AND OPERATIVE SURGERY»

FOR THE STUDENTS MAJORING IN

31.05.01 GENERAL MEDICINE (SPECIALTY)

1. Projection and location of the brachial artery in the lunar fossa.
2. Thrombendarterectomy
3. Madelung operation
4. Percutaneous puncture catheterization of the subclavian vein by Seldinger
5. Puncture femoral catheterization
6. Neurolysis
7. Exposing the femoral nerve
8. Exposure of the sciatic nerve
9. Brown tendon suture
10. Suture tendons by Cuneo
11. Puncture of the shoulder joint
12. Resection of the elbow joint
13. Arthrotomy of the wrist joint by Langenbeck
14. Resection of the knee joint
15. Osteotomy by the method of Bogoraz
16. Bone trepanation
17. Guillotine amputation
18. Osteoplastic amputation by the PTI method
19. Consecrata drehmomente amputation of the thigh by Pirogov
20. Opening and drainage of Pirogov-Paron space
21. Opening and drainage of the phlegmon of the middle space of the palm
22. Opening and drainage of the phlegmon of the middle space of the palm by the method of Voino-Yasenetsky
23. Opening and drainage of phlegmon of the middle space of the palm by the method of Kanavell
24. Opening and drainage Of the U-shaped phlegmon of the brush
25. Oosteosynthesis according to Ilizarov
26. Gastroenterostomy
27. Billroth-I stomach resection
28. Colostomy.
29. Ovarian resection.
30. Hemicolectomy.
31. Bladder puncture
32. Cholecystostomy.
33. Billroth-II stomach resection
34. Enterostomy.
35. Bottom cholecystectomy.
36. Upper cholecystectomy.
37. Stuffing bag drainage.
38. Appendectomy.
39. Splenectomy.
40. Pancreatectomy.
41. Hernioplasty by the Kimbarovsky method.
42. Wedge-shaped liver resection.
43. Laparocentesis.
44. Rectal removal.
45. Nephrotomy.

46. Relegation of the testicle.
47. Nephrectomy.
48. Hernioplasty by Sapezhko method
49. Laminectomy
50. Gastrostomy tube by the method of Strain-Kader

SITUATIONAL TASKS ON DISCIPLINE
"TOPOGRAPHICAL ANATOMY AND OPERATIVE SURGERY»
for students in the specialty
31.05.01 General medicine (specialist)

LESSON:

«General surgical technique. Surgical instruments. Connection and separation of tissues»

1. During surgery, the surgeon uses the apodictilous method of surgery. Explain the essence of this method. What are the advantages and disadvantages of the apodictilous method?

2. The basis of the operations for malignant tumors based on aplasticheskoj principle. Explain the essence of this principle. What methods of separation of tissues in a large git mi satisfy the requirements of ablastichnost operations?

3. The surgeon performs the operation under local anesthesia by "tight creeping infiltration". Why at the end of the operation there is a need to control the quality of hemostasis?

4. When performing surgery should be guided by the General rules of use of surgical instruments. Give the name.

5. The surgeon cuts the skin with a scalpel with a subcutaneous base. Why does he only use a scalpel and only an abdominal one? Why is the skin with a subcutaneous base cut in one motion in the direction of the skin tension lines?

6. After cutting the skin with the subcutaneous base, the surgeon and the assistant began hemostasis. Explain how to put the hemostatic clamp on the bleeding vessel?? Какова последовательность перевязки кровоточащего сосуда??

7. The surgeon and the assistant began to dissect their own fascia (aponeurosis). What is the sequence of dissection of this layer?

8. To perform the surgical sutures used cutting (triangular) and pointed (circular) needle. Explain the difference in the formation of the ligature canal with these surgical needles. Specify the purpose of the dihedral landing pad at the cutting needle.

9. The surgeon sutures the operating wound. What principles should form the basis of this stage of the operation?

10. When performing skin nodular sutures should follow the rules to ensure better healing and cosmetic results. What are these rules.

11. The surgeon stitched the wound with skin nodal sutures. In what order do they perform, why? Where are the nodes, for what?

12. On the 7th day after surgery, the surgeon the noda removes l skin sutures. What is the sequence of actions of the surgeon? What complications can occur if you do not comply with the technique of removing the skin seam?

LESSON:

«Topographical anatomy of shoulder girdle: the scapula, the deltoid, the subclavian and axillary regions; shoulder joint; shoulder»

1. In traumatologic point asked M., age 17: at the rink and he fell on the allotted hand. Diagnosis:"fracture of the collarbone." Explain why the examination of the patient is undesirable definition of pathological mobility and crepitations?

2. The victim M., 15 years old, oblique fracture of the clavicle, the line of which passes through the middle of the bone. What components of the neurovascular bundle can be damaged by displacement of the lateral fragment of the clavicle?

3. The patient M., 48 years old, is scheduled for surgery on the axillary artery. Describe three methods for determining the projection line of the axillary artery.

4. The surgeon performs one of the stages of surgery for breast cancer-excise the tissue and lymph nodes of the axillary area. Specify the group of deep lymph nodes in this

area and their localization.

5. The surgeon performs operative access to the axillary artery in the thoracic triangle. Specify which components of the neurovascular bundle adjacent to the axillary artery should be shifted to the medial and lateral sides?

6. Patient P., 21 years old, in the primary surgical treatment of a gunshot wound of the axillary area, the axillary artery in the thoracic triangle (above the scapular artery) was ligated. Explain the possible ways to restore blood supply to the upper limb.

7. Patient S., 62 years old, was admitted to the department of purulent surgery. Diagnosis: "Axillary abscess". Specify the areas in which the spread of purulent leakage is possible.

8. The patient M., 71 years old, a fracture of the surgical neck of the humerus, complicated by a subdeltoid hematoma. Specify the origin of the hematoma.

9. The surgeon makes a counter incision from the back of the shoulder joint. Explain how the “exclusion zone” is defined - the projection of the axillary nerve exit onto the posterior surface of the humerus.

10. During the operation under endotracheal anesthesia, the right shoulder of the patient rested on the edge of the operating table for a long time. In the postoperative period, he had a restriction on the extension of the thumb and index fingers. Explain the cause of this complication.

11. Patient A., 41 years old, a fracture of the diaphysis of the humerus at the level of the middle third. Explain what complication will indicate the absence of skin sensitivity and motor function in the area of innervation of the radial nerve?

12. The surgeon performs non-projection access to the brachial artery in the middle third of the shoulder. Explain which nerve should be shifted to the side when approaching the artery at this level.

13. The patient, 19 years old, was admitted in the emergency ward with complaints of pain, swelling in the area of the middle third of the shoulder, limitation of movement. Locally: there is a hematoma on the shoulder, soft tissue swelling, sharp pain in palpation. What studies are needed to clarify the diagnosis? What vessels and nerves could be damaged by the localization of the fracture at this level? Name the muscles and specify the direction of displacement of the fragments, resulting from their traction.

14. The patient, 15 yearwas admitted to traumatology, of pain in the right shoulder joint, swelling and restriction of movements. On examination: the limb is brought and bent in the elbow joint. In the deltoid area, abrasion and extensive hematoma. What studies are needed to clarify the diagnosis? In what directions do the fragments move? What formations could be damaged by displacement of fragments?

LESSON:
«Topographic anatomy of elbow, elbow, forearm, hand, wrist, wrist, metacarpal and fingers, brushes»

1. Patient K., 72 years old, with the aim of intravenous infusion is supposed to venepuncture in the anterior ulnar region. Explain to me what Vienna is more often a target for percutaneous puncture? Why? What technique should be used to contour the veins of the anterior elbow area?

2. A patient with a deep cut wound of the anterior lateral part of the ulnar fossa was admitted to the surgical Department. The wound, 2 cm long, is located at the level of the elbow bend, laterally from the tendon of the biceps muscle of the shoulder. Indicate which

muscles may have been damaged? Which nerve function should be checked for diagnosis?

3. Patient K., 49 years old, was found to have purulent inflammation of the elbow joint. On examination, along with other symptoms, a protrusion was found on the sides of the olecranon. Give a topographic and anatomical rationale for this symptom..

4. The traumatology Department enrolled M., 26 years old, who has a scalped wound of the anterior region of the forearm. What are the features of the relationship between the surface and its own fascia of this area is explained by a slight detachment over a significant length of the skin flap?

5. Patient M., 48 years old, developed purulent numbness in the space of N. I. Pirogov-Paron. Name the boundaries of this space, and which external landmarks are reference points in the drainage of phlegmon of this space..

6. Patient U., 22 years old, was admitted to the surgical department, with a transverse wound at the level of the proximal transverse fold of the palm, penetrating into a deep sheet of the palmar aponeurosis. Explain which layers and anatomical formation can be dissected? What determines the contractile ability of the proximal and distal ends of these formations?

7. In the patient J., 15, years of phlegmon of the lateral fascial Lodge of the palm, occupying its medial Department. Specify, what is limited by this cellular gap? In which part of the skin fold of the thumb elevation can not continue the incision? Explain why?

8. Patient K., 26 years old, as a complication developed «U» - shaped (cross) phlegmon. Explain the inflammation of which synovial sheaths of the tendons of the flexors of the fingers is complicated by the development of «U» - shaped phlegmon? How often "this complication can be observed?

9. The patient M., 56 years old, subcutaneous panaritium of the Palmar surface of the nail phalanx of the index finger. There was a painful throbbing pain. When opening the panaritium, dry necrosis of subcutaneous tissue was found. What are the features of the structure of subcutaneous tissue due to severe pain and the possibility of its necrosis?

10. Clinical observations show that the large, index and middle fingers of the hand have a more severe course, can be complicated by the appearance of sub-pectoral phlegmon. Specify the features of the ways of lymph outflow from these fingers, explaining the more severe course of acute purulent inflammation.

11. In the surgical hospital has received the teenager of 16 years with a wound of the right hand. On the Palmar surface of the right hand at the level of the middle third of the III, IV metacarpal bones there is a wound with smooth edges, moderately bleeding. Movement in III, IV fingers are limited. What kind of formations can be damaged here? What should be the tactics of the surgeon?

12. Patient, 15 yearsentered In the surgical Departmenof, with a cut wound of the left wrist joint. On examination: on the anterior surface of the forearm, 1 cm above the projection of the styloid process of the radius bone observed wound size 1.0*0.6 cm Movement in the first finger of the left hand is limited. What are the layers in this area that may have been damaged? Tactics of the doctor on duty?

LESSON:

«Topographic anatomy of the gluteal region, hip joint, thigh»

1. Patient K., 70 years old, developed a post-injection abscess in the thickness of the right gluteus maximus muscle. Explain the cause of significant tissue tension and pronounced pain syndrome. What is the prevalence of purulent inflammatory process?

2. In an obese patient T., 68 years old, perform rapid access to the sciatic nerve in the posterior region of the thigh. Is it possible to use skin as the outer guideline: the gluteal fold? Why? How is this fold formed?

3. Explain in which quadrant of the gluteal region intramuscular injections are made? Why? Describe the methods for determining the quadrant of the region in which injections are performed?

4. Patient J., 48 years old, was admitted to the surgical department about a deep incised wound of the gluteal region, accompanied by severe bleeding. What are the features of the blood supply of this area cause difficulties of hemostasis in the wound? What operation should be carried out at unsuccessful attempt to stop the bleeding in the wound?

5. One of the symptoms indicating damage to the hip joint and a hip fracture is the displacement of the tip of the greater trochanter from the Roser-Nelaton line. How is this line determined? For which types of hip injuries does it have a practical meaning??

6. Patient T., 18 years old, coxitis. In which parts of the hip joint capsule are there "weak" places?

7. Patient K., 42 years old, is scheduled to have a puncture and catheterization of the femoral artery according to Seldinger's method for performing celiacography. Describe the projection of the femoral artery in relation to the inguinal ligament. On which side of the artery is the femoral vein located?

8. Patient T., 48 years old, addressed the surgeon. Diagnosis: "Right-sided femoral hernia." From the anamnesis, pathogenetic factors of the hernia are revealed: increased intra-abdominal pressure, degenerative changes in the layers of the abdominal wall and pelvis (cough due to bronchiectasis, three genera). Name the anatomical background of femoral hernia. Name the walls of the femoral canal

9. Patient R., 54 years old, is scheduled for a reconstructive femoral vein surgery. Explain the anatomical relationships of the femoral vessels in the femoral triangle and the middle third of the thigh to justify quick access to the femoral vein.

10. Patient S., 56 years old, suffering from hypertension, makes intramuscular injections of a solution of magnesium sulfate in the upper lateral quadrant of the berry area. As a complication, post-injection abscess of the gluteal region occurred. Specify the spread of pus?

11. Patient C., 31 years old, spondylitis of tuberculous etiology (tuberculosis of the lumbar vertebra) complicated by abscess, which has spread before small spits femur. Indicate which lacuna and fascial sheath which muscle tuberculosis sore could spread to the anterior thigh.

12. In a patient with a fracture of the femur at the level of the middle third, hematoma builds up in the posterior muscle-fascial bed. Explain which blood vessels were damaged, what internal reference points the surgeon should use to access these blood vessels in order to permanently stop the bleeding.

LESSON:

<u>«Topographic anatomy of the knee, knee-joint, lower leg, ankle, foot»</u>

1. Patient K., 23 years old, was admitted to the casualty department, with a gunshot wound of the anterior region of the right thigh 5 cm up from the patella. The surgeon suggested, and after additional examination (X-ray examination, puncture of the joint) found that this wound penetrates into the cavity of the knee joint. Explain what was the

basis for such a diagnosis?

2. A patient has an accumulation of pus in the knee joint. Opening and drainage of the anterior part of the joint cavity carried out by parapatellar incisions. In order to drain the posterior part of the joint cavity, an additional incision is made along the medial edge of the popliteal fossa. To do this, through the medial parapatellar incision, forceps are held in the posterior direction. The end of it near the tendon of the semitendinaceous muscle forms a protrusion of the soft tissues and an incision is made above it. Explain why it is not recommended to do arthrotomy along the lateral edge of the popliteal fossa.

3. Patient 3., 57 years old, developed popliteal artery occlusion above the discharge of the upper arteries of the knee from it. What collaterals can help restore the blood supply to the lower leg??

4. Patient N., 17 years old, hit the angle of the chair with the lateral part of the lower leg at the level of the base of the fibula head; she felt such a sharp pain that for a moment she lost consciousness and could not continue to take a single step. Explain which bruise of the nerve is observed in the patient.

5. The patient is scheduled femoral-posterior to the tibia shunting. In which canal of the posterior region of the leg is the posterior tibial artery? Name the muscles that make up the walls of this channel. What is the syntopia of the elements of the neurovascular bundle and the projection of the posterior tibial artery?

6. Clinical observations show that fractures of the bones of the legs are often open. What features of the relationship between soft tissues and bones of the lower leg can explain the cause of open fractures?

7. When phlegmon of the middle fascial bed of the sole of the patient, pus has accumulated in the deep space of the posterior region of the leg. Explain the distribution path.

8. Patient C., 19 years old, 4 days ago, with his right foot, stepped on a nail. The phlegmon of an average fascial bed of a sole developed. Explain the possible ways of dissemination of purulent effusions.

9. The patient came to the emergency room about a cut skin wound of the sole: on the river bank, he stepped on a fragment of bottle glass with his left foot. The skin wound gapes, bleeds, swelling of hypodermic cellulose is noted. What operative reception is shown before skin wound closure in this situation? Why is the need for this operational reception?

LESSON:

«Operations on vessels, nerves and tendons of the upper and lower extremities»

1. Patient S., 53 years, appointed clickography. Explain, what is this method of research? How to make clickography?

2. The surgeon performs a direct embolectomy of the superior mesenteric artery. Explain how they approach the embolus? What methods produce embolectomy?

3. A 16-year-old patient with a gunshot wound of the right elbow joint was admitted to the surgical Department. On examination: on the medial side there is an inlet with a diameter of 0.2 cm, and on the back surface of the elbow joint there is an outlet with a diameter of 0.5 cm, the wounds moderately bleed. The x-ray shows damage to the medial epicondyle of the humerus. The patient does not feel IV,V fingers of the right hand. What layers could be damaged? What nerve function is affected? What is the tactics of the doctor on duty?

4. Patient P., 17 years old, popliteal artery thromboembolism (complication of mitral valve disease of rheumatic etiology). The surgeon performs an indirect embolectomy. Specify what is the essence of this method, how can I remove a blood clot? What tool is used in this operation?

5. The patient M., 45 years old, due to a gunshot wound has a significant destruction of the artery wall. What methods of ligation of this vessel can be used for the final stop of bleeding?

6. In the surgical Department entered the patient N., 20 years with an ankle wound. During examination noticed the wound on the posterior surface of the ankle joint size 2.0*0.4 cm of Motion in the foot is limited and painful. Which layers are damaged? What should be the tactics of the surgeon on duty?

7. Patient 3., 26 years old, gunshot wound to the armpit. To ensure hemostasis, the surgeon decided to bandage the axillary artery. Specify the sequence of ligation of the ends of the artery: how many ligatures are applied to the Central and peripheral ends of the artery'? How is the reliability control of hemostasis?

8. The patient is 15 years old, he entered the surgical hospital with a wound in the projection of the head of the fibula. The wound is 1.5 * 0.6 cm in size with smooth edges, bleeds moderately, the feet sag (“horse's foot”). name formations that could be damaged? What is the sequence of actions of the surgeon on duty??

9. The surgeon bandages the Central end of the main artery in a deep, inaccessible wound. Explain the technique that the surgeon and assistant will use to secure the ligature before tying the second node.

10. In the trauma Department received a patient with an accident. When examining the patient in the mind, there is swelling of the middle third of the left thigh, pain, deformation of this area. You are the doctor on duty, what is your tactics?

11. The patient was admitted to traumatology 17 years old, with complaints of pain in the area of edema, hematoma, forearm deformed, movements are sharply limited and painful. Palpation is determined by fastening, the head of the radius is palpated freely. What research is required to clarify the diagnosis? What's the preliminary diagnosis? What nerves can be damaged by fractures of such localization?

12. The surgeon performs a circular vascular suture using the Carrel method. Explain for what purpose the outer shell (adventitia) is pre-excised, freeing 2-3 mm of the artery from it?

13. The patient is 13 years old, went to the surgical Department with complaints of a wound, pain in the right foot. The injury was 3 days ago, cut with glass. When examining the plantar surface of the right foot, there is a wound 2.5*0.8 cm in size, hyperemia of the skin around the wound, pain in palpation. Pain radiates to the back surface of the Shin and the rear of the foot, the wound is covered with a crust, from under which pus seeps, redness and swelling on the back surface of the foot, numbness in the area of the I-th interdigital interval. In what cellular spaces of a sole can develop phlegmons? Ways of distribution of pus in the abscesses of the sole? What branch, what nerve innervates the I-th interdigital space? What should be the breakdown for the opening of abscesses of the sole?

14. When performing a circular vascular suture using the Carrel method, the surgeon connects the ends of the artery with three "P" - shaped sutures-holders. For what purpose are used the suture-holders?

15. In phlebology, along with operations on the superficial and deep veins of the

lower limb, a ligation of the communicant veins (supra - fascial - by Cocquet and sub-fascial-by Linton) is used. Explain the purpose of these operations.

16. The patient, 35 years old, entered the Department of peripheral nerve surgery with impaired function of the radial nerve due to compression in the scar. 4.5 months ago, he was on treatment for a gunshot wound to the middle third of the shoulder. Specify in which direction with external neurolysis the surgeon will allocate the nerve from the scar, which method determines the conductivity of the nerve?

17. When performing the nodal suture of the nerve, the surgeon met with a complication-the eruption of the suture. Which suture is stronger when approaching the ends of the nerve? What are the disadvantages of this seam?

18. In the patient H., 40 years, after neurolysis and excision of the sciatic nerve ends, a large nerve defect arose. What techniques are used in peripheral nerve surgery to connect the ends?

LESSON:

«Operations for purulent inflammatory diseases of the upper and lower extremities»

1. Explain the possible complications of subcutaneous panaritium of the nail phalanx, if during the operation is not completely dissected connective tissue strands between the skin and periosteum and not carried out radical excision of necrotic areas of subcutaneous tissue.

2. During the operation, a fistula in the subcutaneous tissue was found in the skin of the nail phalanx of the thumb after removal of the detached epidermis. When pressing in the area of fistula appeared pus. What is the surgeon's tactic in this situation?

3. The patient has a subaponeurotic phlegmon of the middle fascial bed of the palm, pronounced swelling of the rear of the hand. What is the structure of the subcutaneous tissue of the rear of the hand and the ways of lymph outflow from the palm of this symptom?

4. The patient has subcutaneous panaritium of the Palmar surface of the middle phalanx of the middle finger. What is the reference point when applying the cut? Explain where the incision is made?

5. The patient has subcutaneous panaritium. The focus of destruction on the Palmar surface of the nail phalanx of the ring finger. What kind of incision will be used by the surgeon?

6. A patient K., 26 years old, addressed to the surgeon at the polyclinic reception. After manicure, she developed inflammation of the periungual roller (paronychia) at one corner of the proximal part of the nail plate. What sections are used in this situation, where it is carried out?

7. At the polyclinic reception, the surgeon has a patient sh., 44 years old, who has paronychia with a lesion of the periungual roller at the base of the nail plate. Explain the technique of the operation.

8. The patient TS, 28 years old, as a result of posttraumatic subungual hematoma, a subungual panaritium with a Central location of the ulcer appeared. Explain the scope of surgery.

9. The patient V., 25 years old, subungual panaritium with localization of purulent focus closer to the free edge of the nail. Explain the scope of surgery.

10. Patient T., 30, subungual panaritium. Most of the nail plate is detached by pus from its bed. Specify the amount of surgery.

11. The surgeon examines the zone of the greatest pain in the tendon of the index finger with the probe. What external guidelines correspond to the distal and proximal boundaries of the zone of greatest pain?

12. In arthrotomy, there is a risk of damage to the articular cartilage. What is the technique to avoid damage to the articular cartilage when dissecting the synovial membrane?

LESSON:

«Operations on the long tubular bones and joints of the upper and lower extremities. Amputation and exarticulation»

1. Anatomical and physiological features of the long tubular bone, large periods of bone wound healing and the possibility of displacement of bone fragments (due to muscle cravings) determine the features of surgical interventions on this organ. Name them.

2. In the surgical treatment of fractures of the long tubular bones, it is necessary to provide conditions for the regeneration of bone tissue. Name these conditions.

3. In the treatment of closed fractures of the long tubular bones, skeletal traction is used, which providing good reposition and fixation of bone fragments. In what cases is shown skeletal traction? What ways it is carried out?

4. In surgical practice is used subperiosteal and cross-periosteal bone resection. Explain the main differences between these operations.

5. Patient K., 15 years old, apropos ankylosis of the hip joint is performed confirmatory osteotomy of the hip by K. N. Kochev. What technique is used for stable comparison of bone fragments?

6. Patient G., 18 years old, apropos ankylosis of the hip joint is performed confirmatory osteotomy of the hip by A. A. Kozlovsky. What technique is used for stable comparison of bone fragments?

7. Patient A., 22 years old, at the end of the treatment of a shin fracture is observed shortening of the leg by 7 cm. In which way limb lengthening be achieved?

8. Больному В., 18 лет, apropos ankylosis of the knee joint was done supracondylar osteotomy of the hip by Repke. What advantage does this osteotomy have?

9. For the implementation of an open retrograde intramedullary osteosynthesis at a fracture, a traumatologist plans prompt access to the bone. What criteria should he use when choosing operational access?

10. In the traumatological department enrolled B., 15 years old, about the traumatic crush of the right foot. Soft tissues of the heel area are without damage. Radiography of the foot confirmed the integrity of the heel bone. What amputation is shown to this patient? What is its essence? What advantages does it have?

11. To the victim N., 37 years old, performed fascioplasty amputation of the leg on the level of the middle third. Which flap of soft tissue should be longer? What soft tissues are included in the anterior and posterior flap? In what sequence are the sawdust larger and fibula bones covered with these flaps?

12. What are the reasons for the formation of "conical" stump. What is the essence of reamputation?

13. Н. 27 лет, apropos of gunshot wound of knee joint was made hip amputation at the border of the middle and lower third by a double snippet skin and facial method. Name the stages of prosthetics.

14. Patient, K., 45 years old, complained of pulsation stump, which complicating

denture wearing. Explain the reason for the development of this complication. What technical technique makes it possible to prevent its development?

15. As a result of traffic accident a 4-year-old child needed to amputate the lower limb on the border of the upper and middle third of the shin. Specify the features of amputation of the tibial and fibula bones, features of the processing of periosteum in children.

16. Patient F., 40 years old, was appealed after amputation of the lower limb at the level of the lower third of the thigh about the gas gangrene to the orthopedic center for the selection of prosthesis 1 month after surgery. What type of prosthesis is shown to her to pick up? Is it possible for her to choose a permanent prosthesis in this period??

LESSON:

«Topographic Anatomy and Operative Surgery of the brain region of head»

1. Neurosurgeon prepares the surgical field for the surgical processing of wounds of soft tissues of the parietal region. At first, he processes the operative field with a swab with hartshorn (ether or gasoline). Explain the need for this step..

2. In the surgical department was admitted Z.,12 years old, with a scalped wound of the fronto-parietal-occipital region. Skin aponeurotic flap fixed "leg" 5.5 cm wide, located posterior to the mastoid process. The edges of the flap bleed. Which neurovascular bundle is part of the flap? What features of the blood supply to the fronto-parietal-occipital region can explain the significant blood loss and high regenerative abilities of the tissues?

3. In the emergency room of a multidisciplinary hospital, three victims arrived at which the construction of the canopy at the bus stop collapse. As a result of blunt trauma of the soft tissues of the cranial vault, hematomas appeared in the victims: 1) The victim A., 30years old,have a hematoma witch look like a «cone», 3 * 3cm in size, has clear boundaries. 2) The victim V., 40 years old, hematoma has no clear boundaries and occupies the entire surface of the cranial vault. 3) The victim N., 60 years old, hematoma is located in the left parietal region and coincides with the boundaries of the left parietal bone. Can you, on the basis of the examination of the victims, suggest what kind of hematomas they have?

4. N., 14 years old, as a complication of blunt trauma of the fronto-parietal region, has arisen a subaponeurotic hematoma. What local features does it have? What is the nature of the prevalence of it differs from the subperiosteal hematoma?

5. Patient K., 13 years old, because of an infected wound in the soft tissues of the mastoid process area was arise thrombosis of the transverse and sigmoid sinuses. Explain the causal relationship of these pathological processes.

6. A patient F.,28 years old, is admitted to the neurosurgical department with penetrating skull wound (hit with a metal object). At the time of admission, there is a chopped wound of soft tissue, fracture of the parietal bone on the left, near the swept seam. Create an algorithm for the examination and treatment of this patient. What methods can be used to stop bleeding from the diploic substance and from the sinuses of the dura mater?

7. Epidural hematomas are most often localized in the temporal, parietal and occipital regions. What is the source of epidural hematoma, what characterizes the dynamics of compression syndrome in “arterial” and “venous capillary” hematomas?

8. At fractures of the cranial vault the area of the detachment of the internal

bone("Glass") plate is 2-4 times larger than the size of the fracture of the external plate. What is the reason for this discrepancy between the area of damage to the external and internal bone plastics?

9. A mother with a child approached a pediatrician for an appointment 1.3 months with complaints of deformation of the child's head. According to the mother, the boy often complains of a headache, in addition, he has a "bulging eyes", child is maudlin, cranky. Survey results: on the roentgenogram of the skull there are no cranial sutures, the bones of the vault are significantly thinned, there are pronounced fingers depressions throughout the vault of the skull. The back of the Turkish saddle thinned. At computed tomography: small sizes of ventricles of a brain, reduction of subarachnoid cobweb. Consultation of the oculist: congestive optic nerve discs. Каков Ваш диагноз? What is the treatment strategy??

10. Patient M., 29 years old, as a complication of cranial fracture in the anterior cranial fossa with the formation of liquor fistula, there were symptoms of "hanky" (a handkerchief moistened with liquor from the nasal passages, after drying, remains soft, saturated with mucus - hard) and "double spot" (in the center of the white napkin is a red spot - this is an admixture of blood in the liquor fluid, on the periphery - light coloured halo of liquor) purulent meningitis developed. Explain the mechanism of occurrence of this complication..

11. A 21-year-old boy enrolled in the neurosurgical department. Delivered from the accident site (motorcycle control). The patient is unconscious, fractures of the humerus and femur bones, significant facial damage are diagnosed. At the CT scan in axial projection, a strip of white is detected on the lateral surface of the left hemisphere, having 5 mm in thickness and 12 cm in length. What is the most likely diagnosis??

12. Patient M., 3 years old, located in the neurosurgical department of the children's hospital diagnosed with occlusive hydrocephalus. From the anamnesis of life: a child from pregnancy II, II childbirth. Childbirth was heavy, in mixed buttocks- foot previa. The baby didn't shouted right away. The Apgar score is 5-7 points. What should be the treatment strategy for this patient? Is conservative therapy acceptable?

13. The victim T., 33 years old, a skull base fracture. Along with other symptoms, there is bleeding and discharge of liquor from the external auditory canal, internal strabismus, paralysis of the facial muscles of the face, hearing loss on the affected side. Justify the Lessonal diagnosis of this type of traumatic brain injury. What complication of intracranial nature may occur in this patient?

14. A 23-year-old woman has MRI of the brain. Sagittal section of MRI passed close to midline. The visualization of which space confirms that the cut passed along the midline?

15. Patient O., 12 years old, occlusive hydrocephalus with a uniform expansion of the lateral and 3rd ventricles of the brain. At what level can occlusion of the cerebrospinal fluid pathways take place in this patient? What does "hydrocephalic brain edema" mean?

16. In the neurological department delivered a woman at the age of 70 years, with complaints of visual impairment that arose suddenly against the backdrop of increased blood pressure till 180/ millimeters of mercury. Suffering from hypertension for about 20 years. Never been examined, she was not prescribed antihypertensive therapy. Occasionally, when blood pressure rises to high numbers, she calls an ambulance, which eliminate hypertensive crisis. The last deterioration came on the background of stress. A neighbor called an ambulance. When a woman tried to get out of bed abruptly, she

complained of a sharp headache, dizziness, blurred vision. What is your diagnosis?

17. Patient K., 36 years old, repeatedly referred to a neurologist with complaints of frequent persistent headaches, dizziness, memory impairment. The examination revealed a pronounced narrowing of the left internal carotid artery. Explain why this patient developed these symptoms?

18. Neurosurgeon in the surgical processing of a cranial cerebral wound of the frontal-temporal region after excision of the soft tissues and the periosteum has begun the treatment of a bone wound. What is the sequence of this phase of the operation? What are the ways to provide bone wound hemostasis?

19. At surgical processing of a craniocerebral wound with a small shard skull fracture over the superior sagittal sinus necessitated sinus ligation. In what cases is this hemostasis method shown for sinus damage? How and what is a solid ligature? What are the consequences of using this method of hemostasis?

20. Neurosurgeon performs surgical processing of craniocerebral wound. What is the indication for autopsy an intact dura? What can be complicated by the unreasonable opening of this shell in traumatic brain injury?

21. Neurosurgeon prepares for craniotomy in the temporal-parietal region due to epidural hematoma. Before limiting the operative field with sterile linen, he with a cotton wool stick moistened with 1% solution of brilliant green,draws a Cronlane scheme. Explain the purpose of this scheme. Explain the meaning of this scheme.

22. Patient O., 51 years old, regarding the increase in intracranial pressure in an inoperable brain tumor, decompressive craniotomy in the right temporal region is performed (by Cushing). Made arcuate (horseshoe) incision of soft tissue. In which direction of the area should the base of the skin aponeurotic flap be turned? Why? What methods of hemostasis are used for this?

23. Before autopsy the tense dura mater with decompressive craniotomy by Cushing To the patient is performed lumbar puncture. Why spinal fluid is removed slowly and in small portions (10-30 ml)?

24. When osteoplastic craniotomy of the skull, it is advisable to connect the cutter holes with an Olivecron wire saw. Why?

LESSON:

<u>«Topographic anatomy and operative surgery of the facial region of the head»</u>

1. Patient I., 13 years old, who “squeezed pimple”, developed furuncle upper lip. Along with severe intoxication, a sharp swelling of the face, there is redness and soreness along the facial and angular veins to the medial edge of the palpebral fissure; upon palpation, the veins are dense and roll under the finger. What features of the skin structure determine the frequency of localization of boils of the nasolabial triangle? What terrible intracranial complication may develop in this patient? Why?

2. Woman A., 43 years old, developed pain in the cheek area and near the mouth. Previously, she noted similar pain, but they independently stopped. Currently the pain has become so severe that the patient cannot even eat, brush her teeth. What is your diagnosis?

3. Seny M., 6 years old, left-sided purulent parotitis. Along with other symptoms, there is difficulty breathing, sharp pain when swallowing, protrusion of the left side wall of the pharynx. What is the complication of purulent parotiditis in this child and the cause of its occurrence?

4. A 30-year-old male patient turned to an ENT doctor complaining of pain when

swallowing. From the history of the disease: ill a week ago, he was treated at home for angina. On examination, there is a bright hyperemia of the pharynx, protrusion of the anterior arch. What is your diagnosis and treatment algorithm?

5. Patient K., 48 years old, after suffering otitis media (not treated) had a pharyngeal abscess. With which disease is a differential diagnosis necessary? What is the technique of opening and draining the pharyngeal abscess?

6. During operations in the lateral area of the face, cuts are made in “neutral” zones. Explain what these zones represent? What complications can occur if an incision is made incorrectly?

7. In the surgical department is prepared for the operation of the patient U., 50 years old. Preoperative diagnosis: Parotid abscess of salivary gland. What are the features of the opening of the abscess of the parotid salivary gland?

8. During a street fight, a 17-year-old teenager received a incised wound to the left side of his face, 5 cm long. A teenager was taken by ambulance to the department of maxillofacial surgery. Indicate which periods are optimal for the initial surgical treatment of wounds.? What is the technique of face wound closure?

9. Patient P., 52 years old, trigeminal neuralgia. She is shown a blockade of the branches of the trigeminal nerve. Specify the place of introduction of 70% ethyl alcohol.

10. In a newborn T., congenital facial defects are diagnosed: complete cleft of the upper lip and incomplete cleft of the hard palate. What surgical interventions are shown to this patient? What goals do they pursue and within what time frame?

11. Patient S., 45 years old, was performed right-sided parotidectomy for a mixed tumor. What nerve and its branches should be repaired during the operation? What research method allows to identify (distinguish from cicatricial cords) branches of this nerve? How can hemostasis be performed when performing parotidectomy?

12. Parotid-chewing fascia forms the capsule and the case of the parotid gland. What do “case” glands mean? In which parts of the capsule is more dense and thick, in which it is poorly developed? What is the difference between the relationship of the parotid and submandibular glands with their capsules?

13. Patient P., 13 years old, post-influenza sinusitis maxillitis (sinusitis). What anatomical features of the message of the maxillary sinus with the nasal cavity can be explained by the fact that of all the paranasal sinuses purulent inflammation often develops in the maxillary sinus?

14. When examining patients, a characteristic of the pharynx is given. Explain the concept of "pharynx" and "lymphoepithelial ring." What is the frequency of inflammation of the pharynx?

15. Patient R., 19 years old, as a complication of pulpitis (7th right upper tooth), purulent sinusitis-maxillitis (sinusitis). What features of the anatomical relationship of the roots of the upper tooth 7 can explain the transition of the inflammatory process in the maxillary sinus?

LESSON:

<u>«Topographic anatomy. Topographic anatomy of the neck organs»</u>

1. Patient 3., 16 years old, was hospitalized in the department of purulent surgery. Due to perforation of the esophagus wall, the patient has a swelling of the neck more on the left side, pain when swallowing, turning the head, body temperature is 39.3 °. Indicate in which fat space of the neck phlegmon has developed? In which area can a purulent drain appear? Where make the incision for opening phlegmon?

2. Patient B., 25 years old, has a formation of an abscess, localized above the sternum jugular notch and above the collarbone as a «collar». Specify, between what fascia abscess is located? What cuts are used to open an abscess??

3. One of the stages of the surgical treatment of cancer of the lower lip is fascial-cular excision of the tissue and lymph nodes of the submandibular triangle (Vanah operation). Explain the need to remove the submandibular gland. What nerve can be damaged during the operation? What blood vessels are ligated and crossed during surgery?

4. Patient I., 32 years old, after subtotal subfascial resection of the thyroid gland celebrated a change in voice (hoarseness) and difficulty in breathing during exercise stress. What caused this symptom? Are there topographic-anatomical prerequisites for the development of this complication?

5. The operation preceding resection of the upper jaw in cancer using the "knife" technique is ligation of the external carotid artery in the carotid triangle. What caused the need for such an operation? Describe the projection line and the place of the incision to expose the external carotid artery. What signs should the surgeon use to distinguish the external carotid artery from the internal?

6. After the lower tracheostomy, the patient developed pain in the area of the surgical wound, skin flushing, soreness, swelling, increased body temperature to 39-40 °. What are the layers of fiber in the neck, in which the purulent process may develop, than they are limited, to which purulent streaks spread??

7. In the emergency room of the surgical hospital by radio from the ambulance car gave information about the arrival of the victim with a wound to the neck in the middle part. What is the duty of a surgeon on duty? What is the surgeon's tactic for wounding the neck in the lower or upper part??

8. At the 18-year-old woman the knot, with a diameter of 1,5 cm in supraclavicular area comes to light. The node is removed. Histological examination reveals normal well-differentiated thyroid tissue inside the lymph node. What should the surgeon think about when receiving such a result of the histological conclusion?

9. Patient S. was admitted to the surgical department, 21 years old with a diagnosis of neck injury. Damage to major vessels of the neck. How can the external carotid artery be distinguished from the internal carotid artery in a wound? What is the tactic for injuring: 1) the common carotid artery, 2) the internal carotid artery, 3) the external carotid artery.

LESSON:

<u>«Operative surgery of neck. Operative surgery of neck organs»</u>

1. Patient V., 15 years old, was admitted to the surgical department. Diagnosis: "Phlegmon of the suprasternal interaponevrotic space". Indicate wherewith this space is limited. Where can a purulent leak come? What education can be damaged when opening this phlegmon by a cut 1 cm up from the jugular notch of the sternum?

2. Liza M., 7 years old, phlegmon of the right submandibular region. At examination: in the lower department of the buccal region there is a festering skin wound - a consequence of an insect bite and a comb. Body temperature - 38.3 °, severe pain and swelling in the submandibular region. Explain the connection between these inflammatory processes. In which layer of the submandibular triangle phlegmon has developed? Why at the opening of this phlegmon should retreat 1.5-2 cm down from the lower edge of the lower jaw?

3. To the patient K., 42 years old, diagnosed with Diffuse toxic goiter planned to

perform a subtotal resection of the thyroid gland. Indicate how much thyroid parenchyma should be save? What are the most dangerous complications at this surgical intervention?

4. The patient with a foreign body of the esophagus entered the ENT department. Removal of a foreign body during esophagoscopy failed. Where foreign bodies of the cervical esophagus most often linger? Which cervical vertebra does it correspond to? Which side carry out accessing the esophagus, why?

5. After resection of the thyroid gland for thyrotoxic goiter, the patient developed hoarseness. What technical error caused this complication? What method of operation allows you to avoid this complication, as well as damage to other organs?

6. A child suffering from diphtheria have arisen sharp difficulties external breathing, acrocyanosis appeared, auxiliary muscles are involved in breathing. What is the urgent surgery shown to the baby? What are the complications that occur during this operation. List the special tools needed to execution it.

7. When performing a lower tracheostomy at the time of dissection of the trachea arterial bleeding occurred. What arteries can be damaged during tracheostomy? Specify measures to prevent these complications.

8. At 40-year-old woman in a state of clinical euthyroidism, which in childhood underwent radiation therapy for a thymus disease, currently there is a single asymptomatic node in the right lobe of the thyroid gland. When ultrasound in two projections found that education has a parenchymal structure. What is the most rational tactic at the moment? Whether the puncture aspiration biopsy is shown?

9. 50 year old man with episodes of transient blindness in the right eye needs aorta-femoral and femoral-popliteal shunting on the left due to marked intermittent claudication (endarteritis obliterans). Angiography revealed stenosis of up to 80% in both carotid bifurcations. What operation should be performed first for him him?

10. What blockade should be made to a patient with a penetrating wound of the chest, complicated by pleuropulmonary shock? Describe the technique of this type of blockade.

11. Patient A., 50 years old, suffered a terrorist attack. On admission to the emergency room of a surgical hospital, a wound cervical esophagus was diagnosed. What is the surgeon tactic? Under what kind of anesthesia should the operation be performed? What position provides the best access to the cervical part of the esophagus? Where is necessary to perform access?

12. At patient U., 18 years old, on ultrasound examination of the thyroid gland revealed a node with a diameter of 2.5 cm. Endocrinologist prescribes fine-needle aspiration biopsy of the thyroid gland. What is the purpose of this study? What are the options for performing this study, which one is preferable? What is the technique of manipulation ? What are the complications of this manipulation?

13. Patient C., retropharyngeal abscess. Explain why this patient needs to open an abscess on an emergency basis? What a dangerous complication threatens to him? Give a topographic-anatomical explanation of the development of this complication. Describe the technique of opening an abscess.

LESSON:

«Topographical anatomy of the chest»

1-в.Patient T., 29 years old, was hit in the right half of the chest with a blunt object at the level of the VII rib. Damage to which anatomical structures and layers of the chest wall was the cause of hemothorax?

2-в. 18 years old, was delivered by ambulance with a stab-cut wound of the VI intercostal space along the anterior axillary line on the right. On the roentgenogram, hemo- and pneumothorax are determined. What anatomical structures are damaged in the first place?

3-в. Patient S., 19 years old, fell ill with the flu. On the 3rd day, he developed severe pain in the scapular regions (no pathological changes were found on chest X-ray).What are these pains associated with?

4-в. 44 years old, mammography revealed breast cancer. What additional examinations are needed to resolve the issue of the possibility of a radical operation?

5-в. Why examination and palpation of a patient with suspected breast cancer is carried out at different positions of the trunk (vertical, horizontal, sitting, knee-elbow) and upper limb (set aside, raised up, palm on the back of the head, etc.)?

6-в. Patient U., 35 years old, has a limitation of the displacement of the mammary gland in comparison with the opposite. Name diseases of the breast, one of the symptoms of which is the limitation of the displacement of this organ.

7-в. Patient K., 33 years old, has a penetrating cut wound in the anterior part of the chest wall at the level of the III intercostal space along the middle clavicular line on the left. List the layers that make up the wound walls.

8-в. The patient was found to have fractures of the lower ribs. Complains of pain in the upper abdomen. Which abdominal organs can be damaged?

9-в. The patient has fractures of the right lower ribs in the posterior regions and soreness in the upper half of the right lumbar region. What organs of the retroperitoneal space can be damaged?

10-в. The patient was taken to the hospital with a diagnosis of mastitis. Specify the localization of purulent accumulations in inflammation of the mammary gland?

11-в.The patient has exudative pleurisy.In which pleural sinus does fluid primarily accumulate?

12-в. Patient P., 53 years old, for COPD (chronic nonspecific lung disease) perform right-sided pneumonectomy.Which blood vessels adjacent to the right main bronchus can be damaged by pneumonectomy?

13-в. Patient 3.,68 years old, for bronchogenic cancer of the left lung, produce pneumonectomy.What blood vessels can be damaged when the left main bronchus is treated?

LESSON:
«Topographical anatomy of the chest»

1-в. Patient V., 57 years old, after removal of the upper lobe of the left lung in the pleural cavity during puncture revealed a yellowish-milky liquid. What is the reason and what is the name of this complication?

2-в. Patient U., 63 years old, after surgery on the medial surface of the lower lobe of the right lung during puncture of the pleural cavity revealed a yellowish-milky fluid. What is the reason for this? What is the name of this complication.

3-в. Patient A., 27 years old, turned to the clinic with complaints of hoarseness. No pathological changes were found on the part of the upper respiratory tract. Chest fluoroscopy was done. What kind of mass can be squeezed by a tumor (or inflammatory infiltrate) with a subsequent change in the timbre of the voice?

4-в. On the chest X-ray of patient M., 10 years old, a foreign body was found in the right main bronchus. What features explain the most frequent (70%) localization of a foreign body in the right main bronchus?

5-в. Patient L., 30 years old, has a penetrating chest wound in the projection of the heart. What can the patient die from? What does “dangerous” chest area mean?

6-в.When the posterior wall of the thoracic esophagus was mobilized, a yellowish-milky fluid appeared. What formation is damaged? What do you do if this complication occurs?

7-в. Patient N., 18 years old, swallowed a foreign body and noted chest pain. In which parts of the thoracic part of the esophagus are foreign bodies most often retained?

8-в. Patient B., 40 years old, has hydropericardium. In which sinus of the pericardium, when the patient is on his back, does pathological fluid accumulate? What is this sinus limited in front, back, bottom and right, left and top?

Topographic anatomy of the breast.

15-9-в. Through which pericardial sinus during heart surgery, a tourniquet is placed on the ascending part of the aorta and the pulmonary trunk? What is this sinus limited in front and above, behind, below?

Topographic anatomy of the breast.

15-10-в. Masha 3., 5 years old, it is necessary to perform prompt access to the open arterial (Botallov's) duct. Between which nerves is the mediastinal pleura dissected?

11-в. Patient Sh., 10 years old, with chest fluoroscopy in an upright position was diagnosed with effusion pericarditis. In which sinus of the pericardium does abnormal fluid primarily accumulate?

12-в. Patient I., 17 years old, make a contrast study of the cavities of the heart through a catheter inserted into the subclavian vein. From which side is this vein being catheterized? 11 why? Which veins will the catheter go through?

13-в. An elderly patient has an ischemic cerebral circulation disorder. Which branches of the aortic arch may be occluded in this patient?

LESSON:

«Chest surgery»

1-в. Patient 3., 15 years old, has cicatricial stenosis of the esophagus, not amenable to bougienage. What kind of reconstructive surgery is indicated for him? What organs can be used for this purpose?

2-в. Patient V., 18 years old, has adhesive pericarditis. What operation needs to be performed? What a formidable complication can occur when the pericardium separates from the atrium?

3-в. Patient K., 42 years old, with cicatricial stenosis of the esophagus, it was decided to perform plastic surgery of the small intestine. What are the methods of conducting a section of the small intestine around the neck?

4-в. Patient V., 14 years old, has mitral valve insufficiency. What kind of operation is indicated for the patient?

5-в. Patient I., 55 years old, has chronic ischemic heart disease (angina pectoris of exertion and rest!). Coronary angiography made it possible to establish stenosis of the mouth of the left coronary artery by 2/3 of the diameter. What kind of restoration of blood supply to the myocardium is shown to the patient?

6-в. Tanya M, 4 years old, has non-closure of the arterial (Botallov's) duct. What types of surgical interventions can be used for this malformation?

7-в. Patient T., 6 years old, was diagnosed with congenital stenosis of the pulmonary trunk. What operations can be shown to this patient?

8-в. Patient V., 23 years old, has stenosis of the left atrioventricular opening. What operation is indicated for him? What kind of online access is used for this operation?

9-в. Patient V., 23 years old, is planned for mitral commissurotomy, through which part of the heart is access to the left atrioventricular opening performed?

10-в. Patient V., 23 years old, after left-sided anterior-lateral thoracotomy and pericardiotomy for mitral stenosis revealed a sharply enlarged pink left atrium and a reduced volume of the left ventricle of blue color. Name this symptom.

11-в. K., 20 years old, has a stab wound in the "dangerous" region of the chest (IV intercostal space) along the left peri-sternal line. Suspected injury to the pericardium and heart. What kind of prompt access is shown to the patient? In which direction is the pericardium dissected?

12-в. What characteristics of the heart wall determine the choice of wound closure method? What sutures are most often used when suturing wounds of the wall of the atria and ventricles?

13-в. Patient D., 14 years old, has exudative hydropericardium with increasing symptoms of cardiovascular failure. What operation needs to be performed?

14-в. Patient 3., 20 years old, has purulent pericarditis. What operation is indicated for her?

15-в. Patient M., 57 years old, was diagnosed with bronchogenic cancer of the right lung. What operation is indicated for him? What online access should you use?

16-в. Patient N., 65 years old, has bronchiectasis with localization of bronchiectasis in the lower lobe of the right lung. What operation is indicated for him? What access is preferable for this?

17-в. The patient has an open pneumothorax. What urgently needs to be done in the form of emergency treatment? What kind of surgery should be performed in a hospital?

18-в. The patient is diagnosed with a residual pleural cavity with a bronchial fistula. What operation should be taken in such a situation?

19-в. century During surgery for an abscess of the lung, adhesions between the parietal and visceral pleura were not found. How can an abscess be opened?

LESSON:

«Topographical anatomy of the abdomen (front side abdominal wall). Surgery for external abdominal hernias»

1-о. Misha N., 10 years old, after an injury (hitting a soccer ball in the right lumbar region) developed hepatic vein thrombosis (Budd-Hiari syndrome). On examination, one of the symptoms of portal hypertension was found - the enlargement of the veins of the anterior abdominal wall, most pronounced in the umbilical region ("the head of the medusa"). Give an anatomical rationale for this symptom.

2-о. Patient P., 21 years old, during hernia repair for a right-sided oblique inguinal hernia during the isolation of the hernial sac, the posterior wall of the inguinal canal was damaged medially from the neck of the hernial sac. Arterial bleeding has occurred. What is the source of the bleeding?

3-о. Patient M, 53 years old, bleeding during the isolation of the hernial sac with a left-side femoral hernia using the inguinal approach. Which blood vessel that forms one of the walls of the femoral canal was damaged during this stage of hernia repair?

4-o. A patient with a stab-cut wound of the anterior abdominal wall was delivered to the surgical department. The wound is 2 cm long in the projection of the right rectus abdominis muscle at the border of the middle and lateral third of its width, 5 cm downward from the navel. When examining the patient, the suspicion arose that the wound could be penetrating into the abdominal cavity. To clarify the diagnosis, the primary surgical treatment of the wound was carried out; during the revision, an extensive hematoma was found along the posterior wall of the rectus sheath. The abdomen is not damaged. Indicate the source of the bleeding. Between which layers of the anterior abdominal wall is the hematoma localized?

5-o. Patient 3., 49 years old, for the purpose of operative access to the stomach, an upper median laparotomy was performed. Name the layers that make up the walls of the laparotomic wound.

6-o. Patient 3., 67 years old, for acute appendicitis made an incision according to Lennander. After the displacement of the rectus abdominis muscle to the medial side, a vascular bundle was found on the posterior wall of the vagina. What blood vessels make up this bundle?

7-o. Patient B., 48 years old, underwent cholecystectomy. The postoperative period was complicated by suppuration of the wound (to a depth of the peritoneum), in connection with which the stitches were removed. Secondary intention wound healing. A month later, the patient developed a hernial protrusion. What is the name of this type of hernia? Explain the anatomical prerequisites for the occurrence of such hernias.

8-o. Patient T., 42 years old, underwent a lower midline laparotomy for a perforated typhoid ulcer of the ileum. The ulcer was sutured with a purse-string suture with peritonization with a flap of the greater omentum on the "leg". The laparotomic wound festered. On the third day, insolvency of the ileal sutures was suspected. The relaparotomy was performed with a right-sided pararectal incision. After relaparotomy, necrosis of the abdominal wall between the two incisions developed. Give an anatomical justification for this complication.

9-o. Patient T., 23 years old, has a right-sided lateral oblique inguinal hernia. Name the pathogenetic and anatomical prerequisites of this hernia.

10-o. Patient K., 63 years old, has a right-sided straight inguinal hernia. Name the pathogenetic and anatomical prerequisites of this hernia.

11-o. Explain the essence of hernioplasty.

12-o. Patient T., 23 years old, for a right-sided lateral oblique inguinal hernia, hernia repair is performed according to the method of S.I. Spasokukotsky-M. A. Kimbarovsky. Which wall of the inguinal canal is strengthened with this hernia? How are sutures applied to the spermatic cord?

13-o. Patient T., 23 years old, for a right-sided lateral oblique inguinal hernia, hernia repair is performed according to the method of S.I. Spasokukotsky - M.A. Kimbarovsky. Describe the stages of inguinal canal plasty.

13-o. Patient T., 23 years old, on the right-hand lateral oblique groin hernia perform a hernia in the way of S.I. Spasokukocki - M.A. Kimbarovskiy. Describe the stages of the groin canal.

LESSON:

<u>«Topographical abdominal anatomy (upper abdominal cavity)»</u>

1-o. Patient V., 44 years old, as a complication of a perforated ulcer of the posterior wall of the stomach, developed a right-sided subphrenic abscess. Explain the mechanism of this complication.

2-o. Patient T., 26 years old, who was admitted to the surgical department with a diagnosis of acute pancreatitis, showed symptoms of diffuse peritonitis. Explain the path of the spread of exudate in the lower section (floor) of the abdominal cavity.

3-o. Patient V., 16 years old, on the eighth day after appendectomy, developed intense pain in the right half of the chest and upper abdomen, aggravated by inhalation. There are symptoms of acute inflammation: fever, tachycardia, chills, leukocytosis, accelerated ESR, anemia, significant deterioration in general condition. With percussion of the right half of the chest and abdomen, Burlow's symptom was established (with percussion from the apex of the lung downwards, the following alternation of percussion sound: 1) pulmonary sound, 2) shortening (dullness), 3) tympanitis, 4) dullness).

What is the complication of appendectomy in a patient? Explain the difference in shades of the sound of the Burlow percussion phenomenon.

4-o. Explain the peculiarity of the anatomical relationship of the gastro-colonic ligament and the mesentery of the transverse colon along the pyloric part of the stomach and the practical significance of these relationships.

5-o. Patient A., 20 years old, after a perforated ulcer of the anterior wall of the stomach (accompanied by "dagger pain" in the epigastrium), the pain decreased, which makes it possible to think about covering the site of perforation. What is the abdominal organ

cavity is most often involved in limiting the inflammatory process by the formation of adhesions? Why? What kind of research will clarify the diagnosis?

6-o. In patient N., 57 years old, after suffering acute pancreatitis, ultrasound examination revealed a rounded formation of 3.5x4.0 cm adjacent to the posterior wall of the stomach. Name this pathological process and one of the methods of its surgical treatment.

7-o. What landmarks are used in cholecystectomy to isolate and ligate the biliary artery? Name the anatomical structures that make up the boundaries of the landmark, which looks like a triangle.

8-o. Patient L., 43 years old, after cholecystectomy developed acute liver failure due to necrosis of the right lobe of the liver. What mistake made during cholecystectomy led to such a formidable complication? How can this complication be avoided?

9-o. Patient N., 45 years old, was admitted to the surgical department with a diagnosis of mechanical intestinal obstruction. History: calculous cholecystitis (13.5 years). During the operation, it was found that the patient has gallstone intestinal obstruction. Explain the mechanism of mechanical intestinal obstruction as a complication of calculous cholecystitis.

10-o. Patient 3., 27 years old, has an ulcer of the posterior wall of the upper part (ampoule, or bulb) of the duodenum. Due to the violation of the diet, the ulcer was complicated by profuse bleeding. What is the source of the bleeding? What anatomical relationship does the upper part of the duodenum have with this blood vessel?

11-o. Patient K., 35 years old, was admitted to the surgical department with a picture of acute intestinal obstruction. History of prolonged fasting for weight loss. The day before, the patient had taken a copious amount of rough food. What kind of intestinal obstruction should be suspected in her? How can you try to eliminate this obstruction without surgery?

12-o. Patient I., 40 years old, was admitted to the surgical department with a picture of "acute abdomen" after blunt trauma. No pathology was revealed during laparoscopy. After 20 hours the patient developed symptoms of peritonitis. Laparotomy revealed a hematoma of the retroperitoneal space and necrosis of the wall of one of the organs of the upper abdominal cavity. The wall of which organ adjacent to the retroperitoneal space underwent necrosis? How can you inspect this organ? What is the relationship between retroperitoneal hematoma and necrosis of the organ wall?

LESSON:

«Topographical abdominal anatomy (lower abdominal cavity)»

1-o. Patient I., 22 years old, for "acute appendicitis" made an incision according to NM Volkovich-P. I. Dyakonov. Gastric contents were found in the abdominal cavity. What disease should the surgeon suspect? How did the gastric contents end up in the right iliac fossa?

2-o. Patient C, 18 years old, as a complication of acute appendicitis, developed a right-sided subphrenic abscess. Explain the path of spread of purulent exudate. What are the factors contributing to its spread.

3-o. Patient M., 66 years old, was admitted to the surgical department with a diagnosis of "Acute small bowel obstruction." Conservative treatment was ineffective. Laparotomy revealed infringement of a small area of the antimesenteric edge of the jejunal wall at the level of the II lumbar vertebra in the lower duodenal cavity. Give a definition to this pathological process. What acute surgical diseases of the organs of the upper part (floor) of the abdominal cavity can simulate the pathological process of sweat?

4-o. Patient N., 35 years old, as a complication of destructive appendicitis, exudate accumulated in the right mesenteric sinus.

Name the walls of this sinus. Can exudate spread from this sinus to the left and the pelvic cavity?

5-o. Due to the failure of the suture after suturing the brine of the small intestine, an interintestinal abscess formed, which broke into the left mesenteric sinus. Indicate the possible ways of spreading purulent exudate.

3-6-o. Patient C, 67 years old, with laparotomy for "acute abdomen" revealed necrosis of a part of the ileum, ileocecal angle, blind and ascending colon. Thromboembolism of which artery and at what level caused intestinal necrosis within the specified limits?

7-o. Patient A., 70 years old, was admitted to the surgical department. The diagnosis is acute abdomen. During the revision of the abdominal cavity, thrombosis of the inferior mesenteric artery was ascertained. In which parts of the colon is blood circulation impaired?

8-o. During appendectomy after dissection of the parietal peritoneum, the surgeon found that the intestine with a large number of omental processes located in two rows was adjacent to the wound. Which gut is adjacent to the wound? When is this position of the organ possible?

9-o. Patient C., 16 years old, for acute appendicitis made a right-sided oblique variable echelon incision. Significant difficulties arose in detecting the appendix. In what position of this body can such difficulties occur? What should be done in such a situation to isolate the appendix?

10-o. Patient P., 17 years old, for acute appendicitis made an incision according to N.M. Volkovich-P. I. Dyakonov. When the caecum with the appendix was isolated into the

wound, the latter turned out to be unchanged. The ileum was examined at a distance of up to 1 m from the ileocecal angle. Which disease should be excluded or confirmed in this situation?

11-o. Patient A., 47 years old, during an operation for acute intestinal obstruction, a strand was found from the antimesenteric edge of the ileum (50 cm from the ileocecal angle) to the navel. Name one of the types of incomplete reverse development of the vitelline duct, which caused acute intestinal obstruction. What is the surgeon's tactics (there is no violation of the blood supply to the intestine)?

12-o. M., 32 years old, entered the surgical department with a penetrating stab-cut wound of the abdomen along the midline, 4 cm downward from the navel. In order to examine the abdominal cavity, a mid-median laparotomy was performed. A small amount of blood was found in the abdominal cavity, and contents were found between the loops of the small intestine. Explain the sequence of the revision of the abdominal cavity. What landmarks of the abdominal cavity will the surgeon use during the revision?

LESSON:

«Surgery on the abdominal organs. Intestinal seam»

1-o. A patient was admitted to the surgical department 30 minutes after receiving a blunt abdominal trauma. A laparotomy was performed. During the revision of the abdominal cavity, a rupture of the small intestine was found at a distance of 60 cm from the duodenal flexure. Explain the tactics of the surgeon.

2-o. Patient C, 42 years old, in order to remove a foreign body from the small intestine, underwent enterotomy (longitudinal incision of the intestine with a length of 2.5 cm). After removing the foreign body, the surgeon proceeded to suture the wound. In which direction should the bowel wound be sutured? What sutures will the surgeon use?

3-o. When suturing the cut wound of the small intestine, the surgeon uses V.P. Mateshuk's suture. What is this intestinal suture?

4-o. N., 42 years old, entered the surgical department with a penetrating stab-cut wound of the abdomen in the epigastric region. An upper midline laparotomy was performed. During the revision of the abdominal cavity, a wound was found in the anterior wall of the stomach at the border of the cardiac and pyloric regions, 1.5x0.3 cm in size. What type of surgical procedure is indicated for the patient? What is this operational technique?

5-o. K., 25 years old, entered the surgical department with a penetrating knife wound in the abdomen 1 hour after the injury. Performed mid-median laparotomy. Examination of the small intestine at a distance of 80 cm from the duodenal bend (Treitz's ligament) revealed a longitudinal incised wound of the anterior wall of the intestine closer to the antimesenteric edge measuring 2x0.5 cm. What is the volume of surgery?

6-o. Patient V., 37 years old, was admitted to the surgical department with blunt trauma to the abdomen. A laparotomy was performed. During the revision of the abdominal cavity, a large amount of blood was found, the detachment of the mesentery of the small intestine for 15 cm. Explain the actions of the surgeon.

7-o. A patient with typhoid fever according to indications ("acute abdomen") underwent laparotomy. A revision of the abdominal cavity revealed an ulcer (0.3 cm in diameter) of the terminal ileum (20 cm from the ileocecal angle). What are the tactics of the surgeon and the technique of the operation?

8-o. Patient M., 55 years old, after resection of the small intestine and imposition of enteroenteroanastomosis "end-to-end" developed mechanical intestinal obstruction due to

cicatricial stenosis of the anastomosis. A second operation was performed. Explain how you can avoid cicatricial stenosis with end-to-end anastomosis?

9-o. Patient K., 18 years old, perform appendectomy. Operational access - oblique variable en-echelon section according to P.M. Volkovich-P. I. Dyakonov. The wall of the colon is adjacent to the laparotomic wound. When examining this intestine, the surgeon noticed a large number of omental processes. With a napkin in Mikulich's forceps, he pushed this part of the large intestine to the left. Indicate which part of the colon is adjacent to the laparotomic wound? Where can the cecum with the appendix be located?

10-o. After "classical" appendectomy, the patient was found to have an iliac process (Meckel's diverticulum). What should a surgeon do in such a situation?

11-o. Patient C., 67 years old, underwent resection of the transverse colon. An interintestinal anastomosis was imposed. In the postoperative period, the patient developed an infringement of the greater omentum in the area of the anastomosis. What stage of bowel resection has not been performed?

12-o. An unnatural anus was imposed on the patient according to Maidl's method. What is the purpose of the "spur"?

LESSON:

«Operations on abdominal organs (stomach, liver, gallbladder, extrahepatic bile tract and pancreas)»

1-o. Patient X., 56 years old, sutured a perforated ulcer of the anterior wall of the stomach. In what cases is this operational technique indicated? Explain the need for peritonization of the suture line with a pedicle flap of the greater omentum. In what situation is gastric resection indicated?

2-o. For gastrostomy, the surgeon uses a left-sided transrectal incision. When the parietal peritoneum was dissected in the upper corner of the wound, air (pneumothorax) began to flow into the pleural cavity. How is this complication prevented?

3-o. One of the surgical techniques on the stomach is gastrostomy - an external fistula of the stomach. Name its types and their differences.

4-o. One of the stages of gastrostomy, for example, according to Vitzel in the modification according to Gernez and Ho-Duck-Di, is gastropexy. Explain the nature and purpose of this technique.

5-o. A sharply weakened patient (cicatricial pyloric stenosis), the surgeon performs a posterior posterior colic gastroenteroanastomosis according to Gacker-Petersen. How long is the jejunal loop used? In which direction is this anastomosis applied?

6-o. Patient C, 38 years old, with complicated duodenal ulcer, underwent selective vagotomy in combination with gastric drainage surgery (according to Finney). Explain the goals of these surgical interventions.

7-o. During cholecystectomy, due to rupture of the liver, bleeding occurred. What are the techniques to provide temporary hemostasis? How long can a temporary stop of bleeding be applied using these techniques?

8-o. Patient 3., 43 years old, was diagnosed with portal hypertension in the hospital. Which of the intravascular studies is the safest and most informative for establishing the level of portal blood flow blockage and deciding on the method of surgical treatment?

9-o. A patient with gastroesophageal bleeding (from the submucosal venous plexus of the esophageal-gastric junction) was admitted to the department of surgery for portal hypertension. Name one of the conservative methods of stopping this bleeding.

10-o. Patient K., 54 years old, has cirrhosis of the liver. Against the background of conservative therapy, the phenomena of portal hypertension (bleeding from the submucosal venous plexus of the esophageal-gastric junction) are increasing. Which of the surgical interventions is the most rational and effective for reducing pressure in the portal vein?

11-o. Patient N., 44 years old, was diagnosed with acute destructive pancreatitis with the phenomenon of peritonitis. What are the goals of surgery for this disease?

12-o. Patient N., 44 years old, with acute pancreatitis underwent upper median laparotomy. Which of the approaches to the omental bursa is the method of choice for acute pancreatitis? How can external drainage and isolation of the bursa from the loose abdomen be ensured?

13-o. Patient D., 45 years old, has acute cholecystitis. The operative access to the gallbladder was performed according to S.P. Fedorov. A pronounced adhesive process was found in the area of the gallbladder and hepato-duodenal ligament. What method of cholecystectomy will the surgeon use? Why? What are the disadvantages of this method?

16-o. Literature data indicate that repeated operations on the biliary tract after cholecystectomy are 8-10 times more likely to be accompanied by complications (damage to the extrahepatic bile ducts, blood vessels and abdominal organs adjacent to the operation area). Explain what determines the risk of reoperations after cholecystectomy?

17-o. Patient O., 66 years old, was admitted to the surgical department, with obstructive jaundice and cholangitis complicated by hepatic-renal failure. On palpation of the abdomen, an enlarged, painful gallbladder is determined. What method of bile duct drainage is indicated for this patient?

18-o. Patient P., 11 years old, after splenoportography revealed pallor of the skin, rapid pulse, dizziness, drop in blood pressure. What formidable complication do these symptoms indicate? How can you reduce the risk of its occurrence?

19-o. Masha K., 9 years old, is undergoing splenectomy for Verlhof's disease. Explain why it is not advisable to apply hemostatic clamps to the splenic artery and vein at the hilum of the spleen.

LESSON:

«Topographical anatomy of the lumbar region and perkina space. Kidney and urinary tract surgery»

1-o. Patient C, 13 years old, in the process of appendectomy (with the retrocecal position of the appendix) revealed retroperitoneal phlegmon. In what layer of retroperitoneal tissue is the purulent focus localized? Indicate the possible boundaries of its distribution. How to explain the pronounced flexion contracture of the hip with retroperitoneal phlegmon of appendicular origin?

2-o. Patient K., 27 years old, after laparotomy and operative access to the omental bursa (through the gastro-colonic ligament) revealed necrosis of the body and tail of the pancreas, abscesses of the retroperitoneal space with the formation of leakage into the lateral cellular space of the subperitoneal cavity of the pelvis. Explain the path of purulent flow in this patient. Specify the possible level of dissemination of purulent flow in case of necrosis of the head of the pancreas.

3-o. Patient M, 52 years old, to eliminate pain in chronic (recurrent pain) pancreatitis, a perinephral blockade is performed according to A.V. Vishnevsky. What criterion indicates

to the surgeon the position of the needle in the perirenal tissue? How does the novocaine solution reach the nerve plexuses along the abdominal aorta?

4-o. Strict indications for perirenal novocaine blockade are due to the frequency of occurrence of formidable

complications due to non-compliance with the technique of its implementation. List the possible complications of this blockade according to A.V. Vishnevsky.

5-o. Patient M., 65 years old, with a presumptive diagnosis of hypernephroma of the left kidney, it was decided to make an X-ray examination of the retroperitoneal space with the imposition of pneumoretroperitoneum. In which part of the retroperitoneal space is oxygen (air) distributed? What anatomical landmarks are used to insert the needle for the purpose of applying pneumoretroperitoneum? What position is shown to the patient in this study?

6-o. Patient T., 21 years old, with a long course of spondylitis of tuberculous etiology, revealed a "cold" abscess (purulent leakage) of the anterior region of the thigh downward from the inguinal ligament (near the lesser trochanter). Explain the path of spread of purulent flow in this patient.

7-o. In order to clarify the diagnosis in kidney disease, selective angiography is used: a radiopaque substance is injected through a catheter brought to the orifice of the renal artery. What is the name of this catheter? How does it get to the orifice of the renal artery? At the level of which vertebrae are the mouths of the renal arteries located?

8-o. Patient K., 37 years old, was admitted to the urology department with a diagnosis of renal colic. Complaints about attacks of severe pain in the lumbar region with irradiation to the lower abdomen, groin, external genitalia and upper medial thigh. What topographic and anatomical relationships between the ureter and adjacent formations along the psoas major muscle can explain the irradiation of pain?

9-o. Sh., 19 years old, has a kidney injury due to blunt trauma to the right lumbar region. The extent of kidney damage is unknown. When examining the patient, there is pain on palpation and percussion, muscle tension and swelling of the right lumbar region, microhematuria. Taking into account the characteristic feature of kidney injury, the discrepancy between the severity of their damage and clinical manifestations, it was decided to perform an X-ray examination. What research is most often used in patients with closed kidney injury as an objective method of differential diagnosis?

10-o. Patient G., 36 years old, was diagnosed with right-sided nephroptosis with orthostatic arterial hypertension, which disappears in the horizontal position. The patient is expected to have functional renal artery stenosis. What are the causes of functional renal artery stenosis?

11-o. In patients with urolithiasis, in 20%, bilateral nephrolithiasis is observed, characterized by a severe course and the development of renal failure. Why, in case of anuria, due to a violation of the outflow of urine from the kidneys, is it advisable first of all to remove stones from the kidney in which the obstruction occurred later?

13-o. In the urological clinic, patient P., 50 years old, was diagnosed with pyonephrosis with a sharp dysfunction of the right kidney. The kidney looks like a multi-chamber bag filled with stones. The renal parenchyma is atrophied. The patient is shown nephrectomy. What should a surgeon be sure of when a nephrectomy is needed? What is the sequence of processing of the elements of the "leg" of the kidney in this situation?

14-o. Patient M, 47 years old, performs left-sided nephrectomy. When mobilizing the upper end (pole) of the kidney, the surgeon entered the pleural cavity. Explain the anatomical prerequisites for the occurrence of this complication, what consequences it

may be accompanied by. What symptom would indicate the development of pneumothorax? How should the surgeon eliminate it?

15-o. During nephrectomy, in the process of excretion of the kidney from the fat capsule, arterial bleeding occurred. The renal vein and artery are intact. Explain the possible cause of this bleeding. How can such a complication be ruled out?

16-o. In chronic renal failure, hemodialysis (artificial kidney) is used, which has significant drawbacks - palliative treatment in the form of repeated "connections of the artificial kidney apparatus. What method of surgical treatment of chronic renal failure is the most effective at the present stage of medical development?"

LESSON:

«Topographic anatomy of the pelvis and perineum. Operations on the pelvic organs»

1-o. K., 26 years old, has a pubic bone fracture with extraperitoneal damage to the bladder wall. What principles should be the basis for the surgical treatment of a wound in this situation?

2-o. With extraperitoneal damage to the bladder, it becomes necessary to drain the retropubic (prevesical) space. What drainage methods can be used in patients with phlegmon of this space?

3-o. The urologist sutures the wound of the bladder wall. What anatomical relationship of this organ with the peritoneum determines the difference in the technique of suturing the wound of its wall? How many rows of stitches should be placed on the bladder wall? Which layers of the organ are captured in the seam?

4-o. Patient I., 26 years old, was diagnosed with parametritis. From the anamnesis: 1.5. month before going to the gynecologist, the patient was being treated for cystitis. What is the structure of the urethra that determines the frequency of cystitis in women? Explain the relationship between cystitis and parametritis.

5-o. Patient 3., 18 years old, to clarify the diagnosis: "Disturbed ec Lesson pregnancy" puncture of the posterior vaginal fornix was performed. In what case will the diagnosis be confirmed by this study? What are the tactics for confirming the diagnosis?

6-o. Patient V., 65 years old, has a prolapse of the cervix. History of chronic bronchitis, three births (the first birth was complicated by a rupture of the "obstetric perineum" of the III degree). What does "obstetric" perineum mean? What factors explain the cause of the prolapse of the cervix in patient V.?

7-o. Patient Ch., 27 years old. make a right-sided transvaginal ureterolithotomy (the wall of the ureter is dissected under visual control). In what part of the pelvic ureter are stones most often localized, why? What formidable complication should be excluded during ureterolithotomy in patient Ch.? What is the reason for the possibility of such a complication?

8-o. In proctological practice, there are two forms of hemorrhoids: external and internal. Indicate the sources of these forms of hemorrhoids. Why are hemorrhoids, as a rule, localized at 3, 7, 11 hours (when the patient is supine).

9-o. The first stage of surgical intervention for paraproctitis is the opening and drainage of the peri-rectal abscess with a radial or semilunar incision. In what form of paraproctitis is a radial incision used, in which - lunar? Explain the essence of the second stage of surgical intervention for paraproctitis.

10-o. Patient 3., 39 years old, at the surgeon's appointment. Complaints about acute, throbbing pain in the perineum at the anus, aggravated by movement, juremene position of

the body, tension of the abdominal press (cough, defecation). Stool retention, dysuric disorders are noted. Body temperature in the evenings is 38-39 °. Examination revealed: the skin of the perineum at the anus at 12 o'clock was hyperemic, radial folding was smoothed. What is the form of paraproctitis in the patient 3. How often does it occur? Why did the patient develop dysuric disorders?

11-o. Patient K., 38 years old, has submucous paraproctitis. What access will be used to open the purulent focus? In what direction is the incision made when opening the abscess?

12-o. A feature of the clinical picture of a posterior rectal abscess is a pronounced pain syndrome from the very onset of the disease: pains are localized in the rectum and sacrum, and are aggravated by defecation and sitting position. External signs of paraproctitis appear only in advanced cases (pus breaks out into the intestine or onto the skin of the perineum). What valuable diagnostic information about retrorectal paraproctitis can be obtained by palpation of the coccyx and digital examination of the rectum?

13-o. Patient B., 44 years old, was admitted to the proctology department. Diagnosis: "Pelvic-rectal paraproctitis". The operation is shown. How is the approach to such an abscess carried out? What is the disadvantage of transrectal access in pelvic-rectal paraproctitis?

14-o. Patient C, 47 years old, was admitted to the proctology department. Diagnosis: “Stage III-IV rectal cancer. The tumor is localized 10 cm from the anus ”. For what purpose should the liver be examined (ultrasound, computed tomography, etc.)? Specify the lymphogenous pathways of rectal cancer metastasis.

15-o. As V.D. Fedorov and Yu.V. Dultsev note, hemorrhoidectomy according to Milligan - Morgan in the modification of the Research Institute of Proctology is a more perfect operation compared to other operations (ligation and cutting off of hemorrhoids according to L.V. Martynov - A.N. Red). What is the essence of Milligan-Morgan hemorrhoidectomy as modified by the Research Institute of Proctology?

16-o. Patient M., 53 years old, for rectal cancer perform abdominal-perineal extirpation. During the operation, the surgeon encountered difficulties in mobilizing the anterior rectal wall. What feature of the structure of the fascial capsule of the rectum explains the difficulty of separating the anterior wall of this organ from the vagina?

FEDERAL STATE BUDGETARY EDUCATIONAL INSTITUTION OF HIGHER EDUCATION "NORTH OSSETIAN STATE MEDICAL ACADEMY" OF THE MINISTRY OF HEALTH OF RUSSIAN FEDERATION

Department of Human Anatomy with Topographic Anatomy and Operative Surgery

STANDARDS TEST TASK

For students enrolled in the specialty
(31.05.01 " General medicine»)

TABLE OF CONTENTS

GENERAL ISSUES

1. "Golotopia" is: (1)

- Position of relatively neighboring organs
- Relationship of the organ with peritoneum or pleural
- Position of the body relative to the body and its regions
- Attitude to the skeleton
- Organ size

2. "Sintopia" is: (1)

- Types of skeleton bones
- Relationship with neighboring bodies
- Position relative to the body and its regions
- Position relative to the skeleton
- Low position of the organ

3. The most important provisions on the structure and position of vascularvagina for the first time formulated: (1)

- R.D. Sinelnikov
- A.S. Vishnevsky
- N.I. Pirogov
- V.N. Shevkunenko
- P.A. Kupriyanov

4. The founder of the teachings on the individual variability of the structure and position of organs and human body systems is: (1)

- N.I. Pirogov
- B.V. Ognev
- V.N. Shevkunenko
- A.N. Maksimenkov
- V.V. Kovanov

5. The cross section of the vascular vagina is usually shaped: (1)

- Rectangle
- Circle
- Triangle
- Ovala
- Polygon

1. The edge of the vascular vagina is usually connected from: (1)

- Skin
- Muscle
- Nearest bone
- Capsule Sustava
- Nearest Bone or Capsule Sustav

2. The presence of blessed strips on its own fascia is: (1)

- Sign of intertensive interval
- The sign of the intermuscular gap containing the vascular-nervous beam
- Sign of middle line

- Sign of the fighting of surface and deep leafy fascia
- Sign of intertensive cellular space

3. Radical operation is an operation: (1)

- Made than atomic
- Fully eliminating pathological focus
- Eliminating pain syndrome
- Technically simple
- Which will perform an experienced surgeon

9. Palliamentary operation is an operation: (1)

- Liquidating life-threatening the main symptom of the disease
- Eliminating the pathological focus
- The most simple on the technique of execution
- Any operation
- Incorrectly selected operation

10. «Operation of need» is: (1)

- Operation that needs to be done after pre-conducted radiotherapy
- Operation, the possibility of executing which is determined by the condition of the patient and the qualification of the surgeon
- Operation, the possibility of executing which is determined by the qualification ofthe surgeon
- Any operation that must be performed by the patient
- Best operation for the treatment of this disease, corresponding to modern scientific achievements

11. "Selection Operation" is: (1)

- Operation that a patient or surgeon can choose
- The best operation for the treatment of this disease, corresponding to modern scientific achievements
- Operation that will eliminate the most severe effects of the disease.
- Operation, characterized by technical simplicity
- Operation described in most guidelines

12. The steps of the operation are: (3)

- Operational access
- Rana revision
- Tamponada wounds
- Operational reception
- Closing of the operating wound

13. Requirements for operational access: (1)

- Easy and speed of execution
- Minimum injury
- The exposure of the object of operational intervention by the shortest way
- Good wound healing
- All of the listed

14. Requirements for the operational reception: (3)

- Simplicity
- Radical
- Physiological
- The ability to revision adjacent anatomical formations
- Painless manipulation

15. All surgical instruments are divided into: (1)

- Tools for tissue separation
- Tools for connecting tissues
- Auxiliary tools
- Hemostatic tools
- All of the listed groups

16. The most durable is: (1)

- Double Surgical Node
- Sea node
- «female» knot
- Knot tied apartment
- The type of node does not matter

17. The gutter probe is used in the dissection of its own fascia: (1)

- By tradition
- To prevent possible damage to vessels and nerves under fascia
- To get a neat cut
- All specified correctly

18. Proper Holding Pinzeta: (1)

- Determined by the skills and habit of the surgeon
- In the position of the letter Pen
- In the fist
- In the position of the bow
- There is no definite rule

19. Usually the length of the thread fixed in the needle is equal to: (1)

- 10-15 cm
- 16-20 cm
- 20-30 cm
- The length of the needle holder
  - the lengths of the needle holder

20. Place a needle between the needle holder, follows: (1)

- Closer to the needle holder
- By 2-3 mm from the end of the branded needle holder
- In the middle of the foot of the brass needle holder
- On the border of the middle and rear third of the length of the branch
- Location of fixation depends on Surgeon skills

21. Fix an intestinal needle (stitching) needle: (1)

- Closer to the needle's eye
- Closer to the edge of the needle

- In the middle of the needle length
- On the border of the middle and rear third length
- Location of fixation depends on Surgeon skills

22. The main requirements for the scalpel: (1)

- Must be sharp, have a comfortable handle, it is easy to succumb to cleaning and sterilization
- Should be easy, having a wide blade and a long handle
- Must be sharp, have a matte surface and a handle that does not damaging thesurgeon gloves
- Must be sharp
- Must have a matte surface

23. Methods of keeping the scalpel hand: (3)

- In the form of a bow
- In the form of a letter pen
- In the form of a table knife
- In the form of a spear
- As an amputation knife

24. «Direct access to the artery» is: (1)

- Straight cut
- Incision focused on the longitudinal axis of the limb
- Access strictly on the projection line of the artery
- Access outside the projection line of the artery
- Access not related to the need to move muscle

25. The gutter probe is used in disseminating its own fascia: (1)

- To prevent possible damage to the vessels and nerves under fascia
- For the prevention of hematomas
- All specified true

26. «Occolt access to artery» is access: (1)

- Across the stroke of the vascular-nerve beam
- Associated with the need to spread muscles
- Outside the projection line of the artery
- Associated with the need to disseminate muscles
- To the artery passing in another area

27. Under the term "glearing artery during" meant: (1)

- Artery ligation at a distance of 2-3 cm from its place of damage
- Glearing artery outside the wound within healthy tissues
- Fixing the temporary shunt artery with ligatures

28. When applying a vascular seam to restore intima continuity: (1)

- Not necessarily, the main thing is to restore the integrity of the outer shell
- Necessarily - this determines the success of the operation
- Not necessarily, as it does not matter
- Necessarily for an experienced surgeon
- For a novice surgeon - the main thing to achieve seam sealantism

29. Gleaning artery for produced: (3)

- With necrosis of the distal limb
- For the treatment of varicose disease
- When bleeding from purulent wound
- When bleeding from the thrown wound
- When bleeding from the wound, located in the area with complex topographicanomatic relationships

30. The most common way to improve collateral blood circulation: (1)

- Periiaterial introduction of novocaine
- The intersection of the artery wall between two ligatures to remove the spasticeffect of vasoconstrictors
- Regional Hemoperfusion
- Massage
- Local thermal impact

31. Under the term "gleaming artery during" is meant: (1)

- Gleaning artery in the proximal department of the limb
- Gleaning artery outside the wound within Healthy Tissues
- Gleaning artery together with Vienna

32. All requirements are presented to the vascular seam, except: (1)

- Atraumaticity
- Tightness
- Prevention of blood flow disorders
- Prevention of narrowing of a vessel
- Prevention of disorders of the muscular layer of the vessel wall

33. Neuroliza or neurolysis is: (1)

- The destruction of the nerve at the place of defeat
- The release of the nerve from scar battles
- The resorption of the nervous trunk
- Scar pounding nerve
- Nerva infringement with bone fragments

34. Set the correspondence of the names of the connective tissue nerve shells to theirdefinitions:

• Epidering outer	A) Connectant-tanned sheath of the nerve beam
• Epideushinth	B) connecting tissue in a nervous beam between nerve fibers
• Períneuria	C) connecting tissue between nerve beams by beams
• Endoneurry	D) connecting shell around the nervous trunk barrel

35. The following statements relating to nerves operations are true: (3)

- Nerva's exposure produces direct access
- Nerve exposure produce opal access
- Operations are produced under the harness
- Operations produce without harness
- When crosslinking the nerve, epineural seams impose

36. Requirements for tendon seam: (1)

- Capturing the minimum amount of tendon beams
- Ensuring a smooth surface of the tendons
- Not the assumption of the arrangement of the ends of the tendon
- Preservation of vessels and blood supply to the tendon
- Ensuring the strength of the seam
- All of the above

37. At the opening of the basin, to conduct a revision of the wound: (1)

- Unacceptable
- It is necessary to open purulent chambers and pockets
- Only deeply located uluses is carried out
- Shown only in the development of complications
- Shown only in chronic inflammation

36. The limb amputation is a clip: (1)

- Non-visual fabrics
- Limbs at the joint level
- Damaged limbs
- Limbs throughout the bone
- Tissues in order to maximize the preservation of the limb

37. Exactuculation of the limb is a clip: (1)

- Limbs at the level of the joint
- Damaged limbs
- Limbs throughout the bone
- Tissues in order to maximize the preservation of the limb

38. "Amputation level" is: (1)

- Place of dissection of soft tissues
- The place of the greatest destruction of soft tissues
- The place turned the bone
- Location of nerves
- All of the above

39. In the "Catastrophe Surgery", amputations are more often used: (1)

- Patchwork
- Kostoplastical
- Circular
- With cuff
- Fasdenoplastic

40. In peacetime, amputations are used more often: (1)

- Circular
- Patchwork
- Costoplastic
- With cuff
- Atypical

41 Exactuculation of the limb - this is the clip: (1)

- Non-visual fabrics
- Limbs at the joint level
- Limbs throughout the bone
- Tissues in order to maximize the preservation of the limb

42. The position of the postoperative scar upon completion of the amputation is preferably: (1)

- On the working surface
- On the non-working surface
- At the end of the cult
- On the surface with the most durable skin
- The location of the scar does not matter

43. Depending on the composition of the flap, amputation are: (1)

- Fasdenoplastic
- Mioflatical
- Periostoplastic
- Costoplastic
- All of the above

44. Circular amputations are: (3)

- Simultaneous
- Double-met
- Three-one
- Four-member
- Five-year

45. The primary indications of the amputation of the limb include: (3)

- Gas gangrene
- Acute purulent inflammation threatening the transition to the septic phase
- Full separation of the distal limb
- Necrosis of the distal limb
- Open damage to the limb, which combines the full break of the vascular-nerve beams, the fragmentation of the bone and the destruction of more than 2/3 of the scope of soft tissues

46 To prevent bleeding during amputation, use: (4)

- Finger pressed artery
- Tight binting of limb above amputation
- Imposition of a harness
- Artery dressing throughout
- Vascular ligation as soft tissue cuts

47. The ends of the nerves during amputation are truncated: (1)

- To prevent the development of necris
- To prevent the development of phantom pain
- To prevent the development of Kauzalgiy
- To formed a non-neurom of small sizes
- For the purpose of better wound healing

48. After the dissection of the muscles in amputation, soft tissues are delayed in theproximal direction using: (2)

- Gauze retractor
- Metal retractor
- Boyl's spatula
- Spatulas for the separation of soft tissues

49. The development of acute pain syndrome in the development of purulent inflammation in closed fascial spaces is explained: (1)

- Large number of nerve endings
- Microcirculation feature
- Speed increase in the pressure in a closed space leading to the growing muscle ischemia
- The transition of inflammation to other areas
- Squeezing muscles when improving pressure

50. To prevent bleeding during amputation, use: (1)

- Fingerproof artery
- All of the listed correctly
- Overlay Zhguta
- Dressing artery throughout
- Vascular ligation as soft tissue dissemination

51. Exciration of the articular ends of bones affected by any pathological process iscalled: (1)

- Resection of the joint
- Arthoplasty
- Synovectomy
- Arthrodezom
- Arthrotomy

52. After dissemination of the muscles in amputation, soft tissues are delayed in theproximal direction using: (2)

- Gauze retractor
- Farabef hooks
- Metal retractor
- Spatulas for the separation of soft tissues

53. Alignment and comparison of bone bone bones when fractures are called: (1)

- Redress
- Osteosynthesis
- Osteotomy
- Transplantation
- Reposition

54. Fixation operation of the joint in the specified position: (1)

- Arthrodez
- Arthrollis
- Arthoplasty

- Arthrotomy
- Resection of the joint

55. Operation of restoration of mobility in the joint by excision of fibrous battles between the articular surfaces: (1)

- Arthrodez
- Arthrollis
- Arthoplasty
- Arthrotomy
- Resection of the joint

56. Operation of dissection of the bone in order to eliminate its deformation: (1)

- Osteosynthesis
- Osteotomy
- Bone resection

57. Operation of bone connection and elimination of their mobility: (1)

- Osteoplasty
- Osteosynthesis
- Osteotomy
- Bone resection

58. Operation of the restoration of anatomical intake, form and function of the bonewith the substitution of its defect bone graft: (1)

- Osteoplasty
- Osteosynthesis
- Osteotomy
- Prosthetics

59. Operation of dissection of the bone in order to eliminate its deformation: (1)

- Osteoplasty
- Osteotomy
- Bone resection

UPPER LIMB

60. The front wall of the armpit is: (1)

- Big and small breast muscles
- Breast wall with front gear muscle
- Expensive and Safety Muscle
- Shoulder bone with bertow-shoulder muscle and two-headed shoulder muscles
- Sublock, large round muscle and wide back muscle

61. For the skin of the axillary depression, two diseases are characterized: (2)

- Trophic ulcers
- Hydragenite
- Furuncula
- Eczema
- Psoriasis

62. The surgeon exposes the axillary vascular-nerving bundle of the incision along the front border of the axillary region. The first anatomical formation with which he will meet is: (1)

- Mortile Artery
- Mortal Vienna
- Shoulder plexus

63. In the course of the operation in the armpit, the surgeon was necessary to determine the middle nerve. Specify the main distinguishing feature of the middle nerve in the axillary depression: (1)

- Lateral location of the elbow nerve
- The formation of the nerve of the fusion of two legs

64. The upper and lower boundaries of the clarity-thoracic triangle of the front wallof the axillary depression are the following two formations: (2)

- Lower edge of the clavicle
- Top edge of a big breast muscle
- Upper edge of a small thoracic muscle
- Lower edge of a small breast muscle
- Lower edge of a big breast muscle

65. Two Education Two Education: (are the upper and lower boundaries of the Herd Triangle of the Front Wig

- The lower edge of the clavicle
- Top edge of a big breast muscle
- Upper edge of a small breast muscle
- Lower edge of a small thoracic muscle
- Lower edge of a big breast muscle

66. In the axillary depression at the level of the curable-thoracic triangle, the trunksof the shoulder plexus relative to the axillary artery are located: (1)

- Medial, lateral and front
- Medial, lateral and rear
- From above and in front
- On top and rear
- From all sides

67. In the course of the operation in the armpit, the surgeon was necessary to determine the middle nerve. Specify the main distinguishing feature of the middle nerve in the axillary depression: (1)

- Location on the front surface of the axillary artery
- The formation of the nerve of the fusion of two legs

68 In the axillary depression at the level of the thoracic triangle, the beams of the shoulder plexus in relation to the armpit artery are located: (1)

- Medial, lateral and front
- Medial, lateral and rear
- From above and in front
- On top and rear

- From all sides

69. Ligatures on the axillary artery should be installed: (1)

- At any level
- Somewhat above the level of dishell's. Subscapularis
- At the level of the lower edge of a small breast muscle

70. In the riving triangle of the axillary region to the axillary artery, media trails:(1)

- An armpit nerve
- Radial nerve
- Elbow nerve
- Median nerve
- Medial bunch of shoulder plexus

71. In the riving triangle of the axillary region behind the axillary artery lies: (1)

- An armpit nerve
- Radial nerve
- Medial bunch of shoulder plexus
- Rear beam of shoulder plexus
- Muscular and skin nerve

72. The axillary fiber is associated with the fiber of the connector region in the direction: (1)

- Rear artery envelope brachial bone
- Front artery envelope brachial bone
- Median nerve
- Axillary artery
- Radiation nerve

73. The axillary fiber is communicated with the fiber of a fake-shaped space in theway: (1)

- Sublock artery
- Axillary artery
- Median nerve
- Axillary nerve
- Radiation nerve

74. Surface subepacitor cellular space is concluded between: (1)

- A deep leaflet of breast-clavinary fascia and ribs
- Ribs and front gear muscles
- Big Breast Muscle and Clastic Breast Facege
- Big and small breast muscles
- Own and surface fascia of the connector region

75. Deep subepheetral cellulum space is dispensed between the muscles: (1)

- Deltoid and big breast
- Small and big chest
- Front gear and sublock
- Big round and sublock

- Small chest and intercostal

76. Ligatures on the axillary artery should be installed: (1)

- Somewhat above the level of dishell's. Subscapularis
- Below the level of disheavage a. Subscapularis
- At the level of the lower edge of the big breast muscle

77. After opening the fake-shaped phlegmon, the incision of the edge of the deltoid muscle in the patient was disturbed by the function of the hand lead in the shoulder joint. This complication was due to the intersection during the operation: (1)

- Radiation nerve
- Dumpup nerve
- Subclavian nerve
- Axillary nerve

78. Through the four-sided hole on the rear wall of the armpit, two education areheld: (2)

- Archier, envelope blade
- Front Artery, Hurry Bone
- Rear artery, envelope brachial bone
- Radial nerve
- Middle Nerve

79. Through a trilateral hole on the back wall of the armpit, passes: (1)

- Artery envelope shovel
- Sublock artery
- Front Artery Envelope Shoulder Bone
- Rear artery, rich shoulder bone

80. The front purulent chapels at the humidifice phlegmon is located in the tissuebetween: (1).

- Thoracic wall and big thoracic muscle
- Big Breast Muscle and Breast Facege

81. During the operation about the pieces of the axillary depression, purulent chapels were discovered in a fake-shaped cellular space, developed: (1)

- Through a trilateral hole along the type of artery, envelope shovel
- Through a four-sided hole along the axillary nerve
- In the course of the tendon of the long head of the three-headed muscles of the shoulder

82. At the humidifice of the axillary, purulent chapels in the rear fascial bed shoulder develops along: (1)

- Long Head Tripped Shoulder Muscle
- Kryvum-Shoulder Muscle
- Radial nerve

83. Four nerves are formed from the medial beam of the shoulder plexus: (4)

- Elbow nerve
- Radial nerve
- Lateral leg of the median nerve

- Medical leg of the median nerve
- Medial skin nerve shoulder
- Medial Skin Nerv forearm
- Muscular and skin nerve
- Middle Nerve

84. The front purulent chapels at the humidifice phlegmon is located in the tissuebetween: (1)

- Thoracic wall and big thoracic muscle
- Small and big breast muscles

85. Two nerves are formed from the lateral beam of the shoulder plexus: (2)

- Elbow nerve
- Radial nerve
- Lateral leg of the median nerve
- Medical leg of a median nerve
- Medial leak nerve
- Medial Skin Nerve forearm
- Muscular skin nerve
- Middle Nerve

86. Two nerves are formed from the rear beam of the shoulder plexus: (2)

- Elbow nerve
- Radial nerve
- Lateral leg of the median nerve
- Medical leg of a median nerve
- Medial leak nerve
- Medial Skin Nerve forearm
- Muscular and skin nerve
- Migrate nerve

87. Dislocations in the shoulder joint most often occur in the direction, the least fortified muscles and bone formations, which is: (1)

- Front
- Lateral
- Leading

88. After the removal of the brachy joint, the patient found the following symptoms:a breakdown of the shoulder lead to a horizontal level, a skin sensitivity disorder onthe lateral surface of the shoulder. Other movements in the playful joint are free, including a passive leverage. Such a complication was due to injury: (1)

- Delta muscle
- Radiation nerve
- Muscular skin nerve
- Axillary nerve
- Median nerve

89. Dislocations in the shoulder joint most often occur in the direction of the leastfortified muscles and bone entities, which is: (1)

- Front
- Rear
- Administration

90. When puncture of the cavity of the brachial joint, the needle is introduced: (1)

- Under the bevoid process of blades
- Under the convex part of the acromic process of blades through the thickness ofthe deltoid muscle
- For the rear edge of the acromic processed blade, between the rear edge of thedeltoid muscle and the lower edge of the supervoloral muscle
- At the top of the axillary pits

91 When puncture of the cavity of the shoulder joint, the needle is introduced: (1)

- Under the bevoid process
- Under the convex part of the acromial process through the thickness of the deltoid muscle
- For the rear edge of the acromic process of the blade, between the rear edge of the deltoid muscle and the lower edge of the supervature muscle
- At the top of the axillary pits

92 All muscles come up to the shoulder joint, except: (1)

- Big round
- Little round
- Supply
- Podlopathic

93. In the shoulder area there are two fascial beds: (2)

- Rear
- Lateral
- Medical
- Front

94. Three muscles are located in the front fascial bed of the shoulder: (3)

- Double-headed shoulder muscle
- Three-headed shoulder muscles
- Kryvoid-Shoulder Muscle
- Round Pronator
- Shoulder Muscle

95. In the rear fascial bed, the shoulder is located: (1)

- Twitch Muscle Blood
- Three-headed shoulder muscles
- Kryvoid-Shoulder Muscle
- Round Pronator
- Shoulder muscle

96 To the shoulder joint from the back all muscles, except: (1)

- Big round
- Supply
- SUPPLY

- Podlopathic

97. Pulsation of the shoulder artery can be determined: (1)

- At the outer edge of the two-headed muscles shoulder
- At the place of attachment to the shoulder bone of the deltoid muscle
- At the inside edge of the deltoid muscle
- In the middle of the medial surface of the shoulder
- The pulsation of the artery cannot be placed on the shoulder

98. When exposing the shoulder artery, there is incomplete access, which is due tothe location: (1)

- Median nerve on the medial surface of the shoulder artery
- Shoulder veins between the shoulder artery and their own shoulder fascia
- Elbow nerve on the medial surface of the shoulder artery

99. The projection line of the shoulder artery passes in a straight line, conducted from: (1)

- The vertices of the axillary depressure to the internal braceching supermarket
- The vertices of the armpit depressure to the outer supervision of the shoulder bone
- The vertices of the axillary depressure by the middle of the distance between the inner brave bone supermarket and the tendon double-headed shoulder muscles
- Acromial process of blades to an outdoor brachial bone superior
- Kryvo-shaped blades to the inner brachial bone supermarket

100. When contacting the shoulder artery, the skin incision is carried out: (1)

1-1.5 cm Kependе from the medial furridge shoulderBy 1-1.5 cm for the hide from the medial furrow

101. Two assertions are correct for neighboring access to the shoulder artery: (2)

- It is performed through the front fascial bed
- It is performed through the rear fascial bed
- Two-headed shoulder muscles and shoulder muscles are delayed in the lateral side.
- Three-headed shoulder muscles are delayed back and laterally

102. The surgeon exposed the shoulder artery in the upper third of the shoulder in order to dress it. Deterocate the preferred linkage level of the shoulder artery from the position of preserving the blood supply to the distal limb: (1)

- Preferably a bandage to the removal of the deep artery of the shoulder
- Preferably a bandage after the removal of the deep artery of the shoulder
- Both levels of dressings are equally possible
- Both levels are undesirable, shoulder blasting of the shoulder artery in the lowerthird of the shoulder

103. When contacting the shoulder artery, the skin incision is carried out: (1)

- On the medial furrow shoulder
- 1-1.5 cm Kependе from the medial furrow of the shoulder

104. In the patient with a fracture of the shoulder bone at the level of the surgical neck, an extensive hematoma of a fracture was formed, most likely - as a result of damage: (1)

- Arteries feeding shoulder bone

- Deep artery shoulder
- Rear artery envelope brachial bone
- Shoulder artery

105. Two statements are correct to the Muscular Channel's shoulder: (2)

- Located between the three-headed muscle of the shoulder and the spiral groove ofthe shoulder bone
- Connects the armpit depression with the rear elbow area
- Connects the armpit to the front elbow region

106. In the period of the formation of the bone corn after the closed fracture of the shoulder bone in the middle third, the patient developed the following symptoms: difficult extension of the brush, 1, 2 and 3 fingers, the brush and fingers are in a bent position, the sensitivity of the rear surface of the specified fingers and the corresponding rear site is broken. Brushes. Such a complication was the result of a nerve compression: (1)

- Elbow
- Radiation
- Muscular skin
- Middle

107. The projection of the median nerve in the elbow area used to perform conductor anesthesia is: (1)

- At the medial edge of the tendon double-headed muscles
- In the middle of the distance between the medial brachery brace and the medialedge of the tendon double-headed muscles
- cm in front of the shoulder medial supermarket
- In the lateral edge of the tendon double-headed muscles
- 0.5 cm knutri from the lateral bracket

108. Two statements are correct to the musculoskeletal channel: (2)

- Located between the three-headed muscle of the shoulder and the spiral groove ofthe shoulder bone
- Located between the shoulder muscle and the spiral groove of the shoulder bone
- Connects the armpit to the front elbow region

109. When performing venesection in the elbow, it should be borne in mind that themedian vein elbow is: (1)

- In subcutaneous fatty tissue
- In the duplication of surface fascia
- Between superficial and own fascia
- Under its own fascia

110. When the brachial artery is discovered in the elbow yam, it should be borne inmind that the middle nerve is located in relation to this artery: (1)

- Lateral
- In front
- Behind
- Medial

111. The puncture of the elbow joints of the medial bracers of the shoulder bone isnot made due to the danger of damage: (1)

- Radiation nerve
- Elbow nerve
- Shoulder veins
- Median nerve

112. The leather of the lateral surface of the forearm is innervated by the lateral skin nerve of the forearm from: (1)

- Lateral beam of shoulder plexus
- Elbow nerve
- Radiation nerve
- Muscular skin nerve
- Median nerve

113. On the forearm there are three fascial beds: (1)

- Front, rear, lateral
- Front, rear, medial
- Front, lateral, medial
- Rear, lateral, medial

114. The puncture of the elbow joint in the medial brave bone immanist is not madedue to the danger of damage: (1)

- Elbow nerve
- Shoulder artery
- Shoulder Vienna
- Middle nerve

115. In the patient - oblique rhenium in the lower third of the forearm. During the examination, it was found: no flexion of 1, 2, 3 fingers and skin sensitivity disorderson the palm surface of the first three fingers and the part of the palm of them, which indicates damage: (1)

- Elbow nerve
- The surface branch of the radiot nerve
- Median nerve

116. Deep melting space of the forearm (Paron-Pirogov space) is limited (set compliance):

- Front
- Rear

a) long thumb twin
b) square pronator
c) deep finger bent
d) intercepical membrane

117. To determine the pulse, the most convenient is the radial artery in the lowerthird of the front area of the forearm, which is primarily due to: (1)

- Arrangement of the artery directly under its own forearm fascia
- Arrangement of the artery on the surface of the radial bone
- Lack of near the artery of large veins and nerve

118. The projection line of the radial artery passes from: (1)

- Internal shoulder screwdriver to the outer edge of the pea bone
- The medial edge of the tendon double-headed shoulder muscles to a point located 0.5 cm knutrice from a semi-shaped refrigeration rate of radial bone
- Lateral shoulder bracket for the pulse point, on the forearm
- The middle of the elbow fossa to the inner edge of the pea bone
- Medial shoulder bracket for the pulse point

119. To determine the pulse, the most convenient is the radial artery in the lower third of the front area of the forearm, which is primarily due to: (1)

- The arrangement of the artery directly under its own forearm fascia
- Large diameter of radial artery
- The lack of near the artery of large veins and nerve

120. To expose the elbow artery, two statements are true: (2)

- The projection line of the artery is determined between the middle of the elbowfossa and the pea bone
- The projection line of the artery is determined between the medial brachial boneand pea bone
- Elbow artery is located laterally elbow nerve
- Lock artery is located medially elbow nerve

121. When opening the phlegmon of the fiberglass of a paron-pirogov, cuts are performed on: (1)

- The front surface of the forearm
- Rear surface of the forearm
- The lateral surface of the forearm
- The medial surface of the forearm
- Side surfaces of the forearm

122. In the patient - oblique rhenium in the lower third of the forearm. During the examination, it was found: no flexion of 1, 2, 3 fingers and skin sensitivity disorderson the palm surface of the first three fingers and the part of the palm of them, which indicates damage: (1)

- Elbow nerve
- The surface branch of the radiot nerve
- Median nerve

123. The consequence of the cutting wound in the field of the palter surface of the brush was a violation of oppression of 1 finger. The most likely cause of such a complication: (1)

- Intersection of the branch of the median nerve to the corresponding muscle
- Muscle crossing, anti-solid finger
- Rough Skin Scar

124. When performing cuts in the "Forbidden zone" of the brush, damage is possible: (1)

- Finger flexor tendons
- Tendons of the Long Finger Brush Filter

- Motor branch of the middle nerve with a thumb oppression disorder
- Surface arterial palm arc
- Muscles Elevation of the thumb

125. Surface palm arc is formed by a compound: (1)

- Elbow artery with a deep branch of the radial artery
- Elbow artery with the surface branch of the radial artery
- Radial artery with the deep branch of the elbow artery
- Radial artery with the surface branch of the elbow artery

126. The consequence of the cut wound in the field of the palm surface of the brushwas a violation of oppression of 1 finger. The most likely cause of such a complication: (1)

- Intersection of the branch of the median nerve to the corresponding muscle
- Crossing the surface branch of the radiot nerve
- Rough skin scar

127. Deep palm arc is formed by the compound: (1)

- Lock artery with a deep branch of radial artery
- Lock artery with the surface branch of the radial artery
- Radial artery with the deep branch of the elbow artery
- Rade artery with the surface branch of the elbow artery

128. Install the correspondence between the palm arterial arcs and the layer in which each of them is located:

SURFACE PALM ARC DEEP PALM ARC

- over the palm aponeurosis
- between palm aponeurosis and tendons of the surface flexor fingers
- between the tendons of surface and deep finger bent
- between the tendons of the deep flexor of the fingers and bones of the wrist

129. Publothematic fusion of peeling brushes is between: (1)

- Palm aponeurosis and tendons of the surface flexor fingers
- Superficial and deep finger bent
- Deep flexor fingers and deep palm fascia
- Deep palm fascia and intermetous muscles

130. The classification of Panaritsia includes all types, except: (1)

- Subcast
- Skin
- Muscular
- Bone
- Articular

131. A sharp pain in subcutaneous panarium of the palm surface of the finger is dueto: (1)

- Rapid accumulation of pus in subcutaneous tissue and developing ischemia nerve endings
- Irritation of skin painful receptors
- Irritation of his own finger nerves

- Stretching of fibrous jumpers of subcutaneous fatty fiber

132. Publotheric fusion of peeling brushes is between: (1)

- Skin and palm aponeurosis
- Palm aponeurosis and tendons of the surface flexor fingers
- Deep fingerfall and deep palm fascia
- Deep palm fascia and inter-care muscles

133. Through the Commission Holes of the Palm Uponeurpore, the subcutaneous palm fiber communicates with: (1)

- Suppressor cellular space palm
- The head of the palm of the palm of the palm
- Sinovial vagina 2-5 fingers
- Paron-Pirogov's fiberglass
- Cuppeat muscles

134. Subcutaneous Panariums at the level of the distal phalange of the finger may complicate: (1)

- Tendon panaritis
- Bone Panaritis
- Articular Panaritis
- Phlegmon of the palm of the palm

135. Skin cuts with finger pumping should not move through the line of interphalating joints so that not: (1)

- There were damaged by the devils
- The skin scar was formed at the level of the articular gap

136. One of the complications of acute purulent tendovaginite is the necrosis of thefinger flexor tendons, which is due to: (1)

- Squeezing the tendons of the Magnifier accumulating in the synovial vagina
- Purple melting tendon in synovial vagina
- With the squeezing of the vessels of the mesenzheki tendon in the pusaccumulating in the synovial vagina

137. U-shaped phlegmon is: (1)

- Purulent tendovaginitis 1 and 5 fingers
- Purulent tendovaginitis 2 and 4 fingers
- Purulent tendovaginitis 2 and 3 fingers
- Purulent damage to intermissile elevations of elevation 1 and 5 fingersAll of the above

138. Skin cuts with finger pumping should not move through the line of interphalating joints so as not to: (1)

- It turned out to be opened the hollow of the joint
- Occupal bundles were damaged

139. The patient's acute purulent tendovaginite 1 finger complicated by the U-shaped phlegmon brush, which was due to: (1)

- Distribution of pus on interfassal cellulum and palm spaces

- The presence of a non-permanent communication between media and lateralsynovial bags of palm

140. With the opening of purulent tendovaginitis, correctly approval: (1)

- The crossing of the mesentery is permissible, because Damage to the tendon mesentery is not dangerous for its blood supply
- Damage to the tendon mesenter will break the power of the tendon and will lead toits necrosis
- Damage to the tendon mesentery, if possible, should be avoided
- Damage to the tendon mesentery breaks its function
- The crossing of the mesentery is necessary for the mobilization of the tendon

141. In a patient, acute purulent tendovaginitis 1 finger complicated by the U-shaped phlegmon brush, which was due to: (1)

- The spread of infection on the blood vessels of the surface palm arc
- The presence of a non-permanent communication between media and lateralsynovial bags of palm

142. The need for urgent surgery with purulent tendovagaty finger flexor tenders isexplained by the possibility: (1)

- Distribution of pus into the fiberglass of a paron-pie
- Transport of the process to bone tissue
- Dimensions of the tendons due to the compression of their mesentery
- Development of Sepsis
- The ascending propagation of pus on the tight limb to the tight

143. Cuts on the fingers of the brush with purulent tendovagint should be made: (1)

- On the rear surface
- On lateral surfaces
- In the area of distal phalanx
- On the front-side surfaces outside the interfalane joints

144. With purulent tendovagint and tendobursite 1 finger, purulent processes can be distributed in all directions, except: (1)

- Fingers brushes
- Pickpoint peeling brush
- Lower third of the forearm forearm
- Vagina of the elbow springer brush
- Synovial vagina fingers brush

145. The peculiarity of the subcutaneous purulent process on the distal phalanx ofthe finger of the brush is to distribute in Pus: (1)

- Towards the bone
- Under the skin of the rear of the finger
- Under the skin along the phalanx of the finger
- All specified options
- Does not apply

146. Cuts on the fingers of the brush with purulent tendovaginate should be made:(1)

- On the palm surface
- On lateral surfaces
- In the area ofdistal phalanx
- On the front-side surfaces outside the interfalane joints

147. The sluggish paralysis of the muscles, extending the fingers and the brush, is accompanied by damage: (1)

- The surface branch of the radiot nerve
- Middle nerve
- Front intercourse nerve
- The deep branch of the radiation nerve
- Lock Nerva

148. "Brush Monkey" is found at the damage to the nerve: (1)

- Middle
- Locks
- Muscular skin

149. "Clawed paw" is detected at nerve damage: (1)

- Middle
- Muscular skin
- Elbow

150. "Brush Monkey" is detected when the nerve is defeated: (1)

- Middle
- Raevoy
- Muscular skin

LOWER LIMB

151. In the jagged area, the first muscle layer forms: (1)

- Big Muscle Muscle
- Pearing muscle
- Small Muscle Muscle
- Middle Muscle Muscle

152. The second layer of the muscles of the jagium region is five muscles: (5)

- Twin muscles
- Big Muscle Muscle
- Internal locking muscle
- Pear-shaped muscle
- Square muscle
- Small Muscle Muscle
- Middle Batio Muscle

153. An artery and nerve are held through the prugure-shaped hole in the buttockarea: (2)

- Upper Batio Artery
- Interior sexual artery

- Lower Blood Artery
- Upper berry nerve
- Rear skin thigh
- Nizhny berry nerve
- 7. Final nerve
- Sedal Nerve

154. Through a low-pelvic, two artery and four nerves: (6)

- Upper jagged artery
- Internal interground
- Lower Blood Artery
- Upper berry nerve
- Rear skin thigh
- Bottom Blood Nerve
- Sex nerve
- Sedal Nerve

155. In the engineering region, the first muscle layer forms: (1)

- Big Muscle Muscle
- Square thigh muscle
- Small Muscle Muscle
- Middle Muscle Muscle

156. The second layer of the muscles of the jagium region is five muscles: (5)

- Twin muscles
- Big Muscle Muscle
- Internal locking muscle
- Pear-shaped muscle
- Square muscle
- Outdoor locking muscle
- Middle Batio Muscle

157. An artery and nerve are passing through a small sedlication hole in a sedlicatedand straight hole: (2)

- Inner sexual artery
- Lower Blood Artery
- Rear skin thigh
- Lower berry nerve
- Sex nerve
- Sedal Nerve

158. Deep phlegmon of the berry region is most often localized between: (1)

- Large, medium and small buttock muscles
- Leather and surface fascia
- Medium and large buttock muscles
- Superficial and own fascia
- Outdoor and internal sheets of own fascia of a large berry muscle

159. In a patient with diabetes mellitus, the post-adjusting support of the phlegmonwas complicated by a rampant in the rear fascial bed of the thigh in the way: (1)

- Hip Double Muscles
- Semi-sephel muscle
- Sedal Nerva

160. An artery and nerve are passing through a small seeding hole in a sedlicate-straightforby yam: (2)

- Upper jagged artery
- Internal interground
- Rear skin thigh
- Sex nerve

161. The phlegmon of the sedlicate-straightformers was complicated by a purulentclimb in the subiagodic space, which happened through: (1)

- A large sedlication hole
- Small Sedal Hole
- Proper Hole
- Printing hole

162. Set the correspondence of the cellular spaces and posts of the lifting fiber space:

- through a small sedlication hole — With the side melting space of the pelvis
- through the progressive hole — With the tape of the rear fascial body of thehip
- in the course of a sedlication nerve — Sedal-straightformers

163. The injured in the road accident was delivered to the traumatology department. On the radiograph in the area of the hip joint is determined by the transverse fracture of the hip neck at the level of its middle. The surgeon qualifiedthis fracture as intra-articular. The basis for such a conclusion served: (1)

- Probable damage to the articular capsule bone fragment
- A significant displacement of bone fragments with a probable gap of the articular capsule
- Attaching the articular capsule within the hip neck

164. To the pelvic bone of the hip joint capsule attached: (1)

- On the inner surface of the master's lip with the location of the latter outside the cavity of the joint
- Along the edge of the gravestone depressure with the location of the master's lip inthe custody of the joint
- At the free edge of the godded lip with the inclusion of it in the composure of the articular capsule

165. The hip capsule is attached to the femoral bone: (1)

- On the edge of the articular surface of the hip head
- On the neck of the hip: in front - between her outdoor and middle third, rear - inthe middle

- On the neck of the hip: in front - on the frequency line, behind - between the outer and middle third cervix

- **166. In a patient with diabetes mellitus, the post-adjusting lobbies of phlegmon was** complicated by a closer in the rear fascial hip bed in the course: (1)
- Semi-member muscle
- Semi-dry muscle
- Sedal Nerva

167. An artery and nerve are held through a small sedlication hole in a sedlicate-straight hole: (2)
- Upper jagged artery
- Internal interground
- Upper jagged nerve
- Sex nerve

168. The space under the groin bond is divided into: (1)
- Junk, muscular and vascular lacuna
- Muscular and hernial lacuna
- Hernial and vascular lacuna
- Muscular and vascular lacuna
- Muscular, vascular lacuna and female canal

169. With puncture of the cavity of the hip joint, the needle is introduced: (1)
- At the inner edge of the tailort muscle, to the point located in the middle of the line, spent on the top of a large skeleton of the thigh to the border between the inner andmedium third-party ligaments
- Above the top of a large spit in the frontal plane with a slightly reserved andmedially rotated limb
- Directly under the groin bunch on the border of its inner and middle third
- Laterally 2 cm from the sedellastic bulk with a slightly reserved and laterallyrotated limb

170. The skin of the back surface of the thigh is innervated by the rear skin nerve of the thigh separated from: (1)
- Lumbar plexus
- Sacral plexus
- Femur nerve
- Damping nerve
- Sedal Nerva

171. The lateral border of the femoral triangle is: (1)
- Groove bunch
- Tailoring muscle
- Long muscle leading
- Lumbelno-iliac muscle
- Swing muscle

172. In the front fascial hip bed, there is: (1)
- Big muscle leading muscle

- Blood Muscle Hip
- Tailoring muscle
- Semi-steerly muscle
- Touring Hip Muscle

173. Five muscles are located in the medial fascial bed of hips: (5)

- Large muscle leading muscle
- Great Muscle
- Hip Blood Muscle
- Long muscle leading muscle
- Short muscle leading
- Thin muscle

174. Muscular and vascular lacques of the thigh shares: (1)

- Great bunch
- Groove bunch
- Iliac-combed arc

175. Muscular lacuna is limited (set compliance):

• Front	a) iliac
• Behind and laterally	b) iliac-combed arc
• Medialion	c) groin bale

176. Vascular lacuna is limited (set compliance):

• Front	a) comb-bunch
• Rear	b) lacunar bunch
• Lateral	c) groin bale
• Medial	d) iliac-comb

177. Three anatomical entities pass through muscle lacquer: (3)

- High Artery
- High Vienna
- Female nerve
- Lateral skin thigh
- Lymphatic node
- Iliac lumbar muscle

178. Five muscles are located in the medial fascial bed: (5)

- Large muscle leading muscle
- Great Muscle
- Long muscle leading
- Short muscle leading
- Tailor muscle
- Thin Muscle

179. Muscular and vascular lacques of the hip shares: (1)

- Lacooner bunch
- Pach bunch
- Iliac-combed arc

180. Three anatomical education is located in vascular lacuna: (3)

- Femoral artery
- Femoral vein
- Poor nerve
- Lateral skin thigh
- Lymphatic node
- Iliac lumbar muscle

181. In a patient with tuberculous spondylitis of the 3rd lumbar vertebra, during the examination, the "cold" excess abscess was found in the front area of the thigh, which descended along: (1)

- Iliac and further thigh blood vessels
- High Nerva, departing from lumbar plexus
- Iliac lumbar muscle

182. The fiber of the medial fascial body of the hip is reported through a locking hole with: (1)

- Outcoma space
- Prepaulous or side melting space of the mag
- Okoloprayokychnya pits
- The back surface of the hip
- Poiled Canal

183. In relation to the subcutaneous crack (outer ring) of the femoral channel, twostatements are true: (2)

- Normally closed with lattice fascia
- Normally is an oval hole in a superficial sheet of wide fascia
- Located in a horizontal plane
- Located in the sagittal plane
- Located in the frontal plane

184. The inner ring of the femoral channel is limited (set compliance):

• Front	A) femoral vein
• Rear	B) comb bunch
• Laterally	C) lacunar bunch
• Medial	D) groin bale

185. Install the correspondence between the walls of the femoral channel and the anatomical formations, their components:

Front wall	a) femoral vein
Rear wall	b) upper horn of the cruise edge
Lateral wall	c) comb fascia

186. The femoral artery in the femoral triangle is located in relation to the femoralnerve: (1)

- In front
- Bon
- Lateral
- Medial
- Rear

187. Install the correspondence between the walls of the hip leading channel and the anatomical formations, their components:

- Outleteral wall — A) large muscle leading muscle
- Revenue wall — B) medial wide muscle
- Front wall — C) laminavastoadductoria

188. The leading canal connects the hip bed with a poned hole: (1)

- Front Fascial
- Rear fascial

189. Three anatomical entities pass in the leading channel: (3)

- Femoral artery
- Femoral vein
- Big subcutaneous vein
- Cleaning artery
- Subcutaneous nerve

- **190. Performing the surgery of the huge artery dressing, the surgeon exposedit at the level of extracting the deep artery of the hip, having received the opportunity to bandage the artery before or after the removal of its main branch. Define the preferred linkage level from the position of the reduction of blood supply to the lower leg and foot: (1)**
- Preferably a glee to the removal of the deep artery of the hip
- Preferably a bandage after the removal of the deep artery of the thigh
- Both levels of dressings are equally possible.
- Both levels are undesirable, the burning of the femoral artery in the lower third ofthe hip

191. Bloodystock on the lower limb after blockage or ligation of the femoral arteryin the middle third of the thigh is restored by: (1)

- Lateral artery envelope femoral bone
- Outdoor iliac artery
- Deep artery of the hip
- Internal iliac artery
- Downlive Array

192. The so-called Joberes Yamk can serve for: (1)

- Definitions of the position of the uppermit artery of the knee
- Access to the knee joint
- Access to the popliteal artery from the medial side
- Punctions of the knee joint
- All the above manipulations

193. The leading canal connects the hip bed with the poned hole: (1)

- Front Fascial
- Medial Fascial

194. In the leading channel there are three anatomical entities: (3)

- Femoral artery
- Femoral vein

- Poor nerve
- Large subcutaneous vein
- Subcutaneous nerve

195. The intermuscular phlegmon spread to the anterior thigh area, which occurred by: (1)

- Fascial Vagina Tailor Muscle
- Fascial Vagina Thick Muscle
- Leading channel
- The move of a sedlication nerve

196. Operating on the phlegmon, the surgeon found a purulent swelling in the posterior region of the thigh, which spread through the: (1)

- The move of the blood muscles of the thigh
- The move of the semi-sephel muscle
- Driving Channel
- The move of the sedlication nerve

197. The purulent drives complicated by the phlegmon patellied pits with the formation of a purulent chatek in the rear fascial leg bed, which happened by: (1)

- The move of the calf muscle under the fascia of the leg
- Channel's head-trap (GROBEROVA)
- Bottom Muscular and Maloberets Channel
- The move of a common small nerve

198. During the operation about the phlegmon of the popliteal fossa, the surgeon found a purulent chapel into the lateral fascial bed of the shin, by distributing the channel: (1)

- Upper Muscular-Maloberst
- Gopen-pond
- Bottom Muscular-Maloberst

199. Acute thrombosis of the patellied artery at the level of the knee burner led to the cessation of blood flow on the main vascular highway. Its recovery can occur due to the near-handing arterial network, in the formation of which the branches ofthe four arteries take part: (4)

- Femoral
- Deep artery of the thigh
- Cleaning
- Front Tibial
- Podlond

200. When highlighting a poned vascular nerve bundle in the middle line, the surgeon takes into account that its elements are located at the back in advance inthe following sequence: (1)

- Artery, nerve, Vienna
- Vienna, artery, nerve
- Nerve, Artery, Vienna
- Nerve, vein, artery

201. In relation to the knee joint, two statements are true: (2)

- In the formation of the knee joint, besides the femoral and more-ber bones, takespart
- Medial and lateral meniscus completely share the joint cavity on the upper andlower departments
- The hollow of the joint can significantly spread to the front area of the thigh due tothe message of a trapped synovial bag with the upper break
- Front and rear cross-shaped ligaments are an internal ligament apparatus

202. The kole of the knee joint with purulent arthritis is revealed: (1)

- Two vertical cuts on both sides of the patella
- Horizontal incision for 1 cm over the patella
- A horseshoe cut (arc down) from the medial to the lateral summers of the thigh
- On the lateral edge of the poplings
- On the medial edge of the poplings

203. When opening the rear-lateral switches of the knee joint, nerve damage is possible: (1)

- Tarbersoy
- General Maloberets
- High
- Sedalishche
- Deep Maloberstartsov

204. In the rear fascial leg of the shini there are four muscles: (4)

- Long Malobers Muscle
- Long elastic extensor foot
- Long finger extension
- Long Finger Figure Filter
- Long finger bent
- Rear Targertic Muscle
- Three-headed leg muscle

205. Acute thrombosis of the patellied artery at the level of the knee burner led to the cessation of blood flow on the main vascular highway. Its recovery can occur due to the near-handing arterial network, in the formation of which the branches ofthe four arteries take part: (4)

- Femoral
- Deep artery of the thigh
- Malobersova
- Front Tibial
- Podlond

206. When highlighting a poned vascular-nerve bundle in the section of the midline, the surgeon takes into account that its elements are located at the back in advance in the following sequence: (1)

- Artery, Vienna, nerve
- Vienna, artery, nerve

- Nerve, Artery, Vienna
- Nerve, vein, artery

207. Through the lower muscular-mulberry canal passes: (1)

- Common Malobers Nerve
- Deep Maloberes Nerve
- Maloberstar Artery
- Descending Knee Artery
- Rear Trubidal Artery

208. Visor-nervous beam of the front fascial leg of the lower leg includes: (3)

- Front Targetary Artery
- Maloberets artery
- Large subcutaneous vein
- Front Target Viennes
- Tarbiert nerv
- Deep Thiege Nerve
- Surface Maloberes Nerve

209. The projection line of the anterior tibial artery is direct, carried out: (1)

- From the inner edge of the tibia to the middle of the distance between the achilla tendon and the inner ankle
- From the bottom of the tendon, the blood muscles of the thigh to the head of the Mulobers
- From the middle of the poned fossa to the lateral ankle
- From the middle of the distance between the head of a small bone and the tibiajergis until the middle of the distance between the inner and outer ankles
- From the head of a small bone to the medial ankle

210. Artery, Vienna and Nerve are located in the ankle channel: (2)

- Front Tired Artery and Vienna
- Rear Trolley Artery and Vienna
- Mulberian artery and veins
- Tibial nerve
- Surface Maloberes Nerve

211. In the upper muscular-mulberry canal is: (1)

- Surface Maloberes Nerve
- Deep Maloberes Nerve
- Maloberstar Artery

212. In the formation of the walls of the Upper Muscular-Maloberets, take part: (2)

- Front Tibra Muscle
- Mulberian bone
- Long Finger Finger
- Long Finger Finger Figure
- Long Malober Muscle

213. Upon the exposure of the anterior-nerve beam in the lower half of the shin, the surgeon after the dissection of its own fascia passes between: (1)

- Tibial Bone and Front Tibra Muscle
- The front tibial muscle and long-finger extensor
- Long thumb exterminant and long finger extensor
- Long extensor of fingers and anterior intermissile septum

214. Surface small-terror nerve in the upper third of the lower leg passes: (1)

- Under the skin of the lateral surface of the tibia
- In the upper muscular and small-wire channel
- Between the front tibial muscle and long finger extension
- Between the front tibial muscle and long foot-finger extensor
- In the inter-emergency membrane

215. In the varicose veins of the lower limb, Vienna is subject to the greatest changes: (1)

- Fear
- Big subcutaneous
- Small subcutaneous
- Podlond

216. An artery, veins and nerve are located in the ankle channel: (2)

- Front Tired Artery and Vienna
- Rear Trolley Artery and Vienna
- Tolebly nerve
- Deep Maloberes Nerve
- Surface Maloberes Nerve

217. In the upper muscular-small-paper channel: (1)

- Common Malobers Nerve
- Surface Thunder Nerve
- Deep Maloberes Nerve

218. Rear Targertic artery is available for the study of the pulse in the field of ankle joint: (1)

- Ahead of the lateral ankle
- Behind the lateral ankle
- Ahead of the medial ankle
- Behind the medial ankle

219. If it is necessary to assess the condition of the arterial vessels of the lower limbin patients, primarily examine the pulse on the back artery of the foot, the projection line of which passes from the middle of the distance between the ankles: (1)

- To the medial edge of the thumb
- To the first interpalic interval
- To the second interpalic interval
- To the third interpalic interval

220. In order not to damage the total small-terror nerve, it is advisable to spend the needle in the beugrousity of the tibia with skeletal stretching: (1)

- In front
- From the lateral side
- From the medial side
- Behind
- The choice of the point does not matter and is determined by the qualification ofthe surgeon

221. Medial Issue Channel skips all the elements of the leg elements on the foot, except: (1)

- The back of the tibial artery
- Tolebly nerve
- Trembos of the rear tibial muscle
- Long Malobers Muscle Tendon
- Tendons of the long finger flexor

222. MEDIAL OK Channel Stop is proximally reported with: (1)

- Rear lower leg
- Lateral leg lies
- Front lower leg
- Subcutaneous tibia fiber
- Lateral useful channel

223. The rear artery of the foot is between the tendons: (1)

- Front Tibra Muscle and Long Finger Filter
- Long detector of fingers and long finger extensor
- Short Finger Finger
- Long finger bent

224. The subcutaneous fatty fiber of the soles of the foot is associated with the suppressive tissue through: (1)

- Medial Ankle Channel
- Heel channel
- Commander Holes
- Channels of the Channel Muscles

225. The suppression of the fiber soles is associated with the fiber of heel and the ankle channels in the way: (1)

- The plantar branch of the back artery of the foot
- Lateral vascular nerve feet beam
- Tenders of the Drawberry Muscles
- Tendon Long Malobers
- All response options are incorrect

226. Paralytic dischart ("horse") stop occurs when nerve damage: (1)

- Deep Maloberets
- Surface branches of Malobersoy
- High

- TBERBERS
- Faculated

227. The stop will be in a state of maximum extension ("Heel Stop") when nerve damage: (1)

- General Maloberstartsov
- Cleaning
- Tolebly
- Birth

228. Press the femoral artery during bleeding follows the bone: (1)

- Pubic
- Sedalishche
- Iliac

229. Explain what caused the effect of muscular-venous "pump" of the lower limb:(1)

- Muscular weight
- The presence of a valve apparatus at the veins of the lower limb
- Dual veins system
- Bending veins of the leg

230. The rear artery of the foot is located between the tendons: (1)

- Long extensor of fingers and long finger extensor
- Short finger bent
- Long finger bent
- All answers are incorrect

231. The subcutaneous fatty fiber of the sole of the foot is associated with the suppressing tissue through: (1)

- The plantar canal
- Heel Canal
- Comm spellers
- Channels of the Channel Muscles

232. In the first moment of the cone-circular amputation of the thigh by N.I. Pogging dissect: (1)

- All soft fabrics
- Skin
- Skin and subcutaneous tissue
- Skin, subcutaneous tissue and surface fascia
- Skin, subcutaneous tissue and own fascia

233. When performing the second moment of the three-year cone-circular lift amputation by N.I. Pogging dissect: (1)

- All muscles
- Surface Muscles
- Deep muscles
- All muscles and periosteum
- Soft fabrics, periosteum and bone

234. Determine the three points of the three-year cone-circular amputation of the thigh by N.I. Pogging: (3)

- Crumpled skin with subcutaneous tissue and fascia
- Dissection of muscles along the edge of the drawn leather
- Pulling the muscles with the formation of a muscular cone
- Crossing muscles on the basis of cone
- Dissection of periosteum and shifting it distally
- Cutting a femoral bone

235 Surface Bones of Bones Close: (1)

- Skin Foot Heel
- Achilla tendon
- The puff bone hill
- Bone tank

236. The stop will be in a state of maximum extension ("Heel Stop") when nerve damage: (1)

- Deep branches of Malobersoy
- Cleaning
- Tolebly
- Birth

237. Press the femoral artery during bleeding follows the bone: (1)

- Pubic
- Fear
- Iliac

238. Explain what caused the effect of muscular-venous "pump" of the lower limb:(1)

- Muscular weight
- The presence of a valve apparatus at the veins of the lower limb
- Supporting actions of the pelvis diaphragm
- Bending veins of the leg

HEAD

239. Determine the sequence of dissection of soft tissue layers when performing anoperation for the penetrating injury of the skull's arch:

- Leather
- Muscular aponeurotic layer
- Summary
- Supply Fat Fatifier
- Subcutaneous fatty fiber
- Subdoscene loose fiber

240. Each cellular layer of the front and dark-occipital region has a feature of its structure and distribution to the head of the head. Install the correspondence between the fiberal layer and its feature:

- Subcutaneous fatty fiber 1. is limited to the limits of each bone of the

Svodaccher

- Suppressing fluid fiber — 2. separated by connecting partitions
- Subdischable loose fiber — 3. applies throughout the region

241. Neurosurgeon performs intracranial operational access in the temporal area.Determine the sequence of dissection of soft tissue layers:

- Tempor muscle
- Temporal fascia, deep leaflet
- Temporal fascia, surface leaflet
- Second fiber layer
- Leather
- Vaciators
- Surface Fascia
- Subcutaneous fat layer
- Third fiber layer

242. The hospital was delivered to the hospital with an extensive scalized wound inthe parietal area. Determine the fiber layer in which the flap detachment occurred: (1)

- Subcutaneous fatty fiber
- Suppressing fluid tissue
- Subdischain loose fiber

243. The victim was detected by the hematoma of soft tissues of the front and dark-occipital region, spreading over the entire surface of the skull's arch. Determine thecellular layer in which it is: (1)

- Subcutaneous fatty fiber
- Suppressing fluid tissue
- Subdischain loose fiber

244. It is known that wounds of soft tissues of head and face are characterized by faster healing and rare suppurations compared with the wounds of other areas of the body, which is due to: (1)

- High regenerator capabilities of the epithelium
- Good blood supply to fabrics
- The presence of a variety of interventic anastomoses
- The presence of numerous clusters of lymphoid tissue

245. With the injury of soft tissues of the head cover, it is usually observed strong and long-term bleeding throughout the wound circumference, which is due to two features: (3)

- The presence of large blood vessels in subcutaneous tissue
- Multiple sources of blood supply of soft cover heads
- Forming a network of blood vessels in subcutaneous fatty tissue
- Fittings of the wall of vessels with connective tissue jumpers of subcutaneous fatty fiber
- The presence of links of surface veins of the heads of the head with venous sines ofa solid cerebral shell

246. Four arteries are the main source of arterial blood supply to the frontal-ethylene region: (4)

- Deep tempoch
- Calm
- Facial artery
- Adjust
- Non-chapted
- Surface temporal
- Average temporal
- Middle Meningheal

247. When performing bone-plastic trepanations in the frontal area, the neurosurgeon is cutting off the skin-aponeurotic flap in order to preserve its blood supply and innervation by the base facing: (1)

- Top
- Down
- Lateral
- Mediality

248. The hospital was delivered to the hospital with an extensive scalized wound inthe dark area. Determine the fiber layer in which the flap detachment occurred: (1)

- Suppressing fluid fiber
- Suppective ruble filling

249. The victim was detected by the hematoma of soft tissues of the frontal-dark-occipital region, spread over the entire surface of the skull arch. Determine the cellular layer in which it is: (1)

- Subcutaneous fatty fiber
- Suppressing fluid tissue

250. When performing bone-plastic trepanation in the dark-temporal region, the neurosurgeon is cutting a skin-aponeurotic flap in order to preserve its blood supplyto the base, facing: (1)

- Top
- Down
- Forward
- Back

251. When performing bone-plastic trepanation in the occipital region, the neurosurgeon is cutting the skin-aponeurotic flap in order to preserve its bloodsupply to the base, facing: (1)

- Top
- Down
- Right
- Left

252. Two ways are used to stop bleeding from wounds of soft tissues: (2)

- Clipping
- Ligation

- Tamponadu
- Electrocoagulation

253. Two methods are used to stop bleeding from the spongy substance of the bones of the curtain of the skull: (2)

- Rubbing the spectacle paste
- Clipping
- Wound irrigation by hydrogen peroxide

254. The doctor discovered the following symptoms from the victims: Exophthalm,Symptom of "Points", nosalikvorea. Pre-diagnosis - Fracture: (1)

- Skoreup arch
- The base of the skull in the front cranial fossa
- The base of the skull in the middle cranial fossa
- Bases of the skull in the rear cranial fossa

- **255. With a bonepoplastic trepanation of the skull, the number of cuttingholes imposed for cutting bone flap: (1)**

- 3-4
- 4-5
- 5-6.
- 7-8

256. The average meningeal artery is the branch of the artery: (1)

- Maxillary
- Outdoor sleepy
- Surface temporal
- Internal sleepy

257. The average meningeal artery penetrates the skull cavity through the hole: (1)

- Round
- Oval
- Sophisticated
- Slothematovoid

258. Delivered patient with a stupid trauma of the temporal area. After 2 hours, the symptoms of the head of the head brain appeared and began to increase. During the operation, a comma dice and large epidural hematoma were found during the operation. Determine its source: (1)

- Upper rocky sinus
- Deep temporal artery
- Average temporal artery
- Middle Meningheal Artery
- Middle Brain Artery

259. Two ways are used to stop bleeding from wounds of soft tissues: (2)

- Ligation
- Applying seam
- Tamponadu
- Electrocoagulation

260. Two methods are used to stop bleeding from the spongy substance of the bones of the curtain of the skull: (2)

- Rubbing the spectacle paste
- Irrigation wound with hydrogen peroxide
- Dying

261. Four nerves pass through the upper eye glare: (4)

- Block
- Topper-eyed
- Eye
- Ove
- Visitory
- Facial
- Disposal

262. The optic nerve passes in: (1)

- Top of the orphanage
- Visual channel
- Superwitch clipping (hole)
- Lower or

263. With the bonepalication of the skull, the number of cutting holes imposed forcutting bone flap: (1)

- 4-5
- 5-6
- 6-7
- 7-8

264. The average meningeal artery is the branch of the artery: (1)

- Maxillary
- Facial artery
- Surface temporal
- Internal sleepy

265. Determine the correct option of the exit from the skull of the 1st, 2nd and 3rdbranches of the Triple Nerva: (1)

- Round, Oval and Sweet Hole
- Upper orphanage, round and oestoid hole
- Upper Epiphany Glug, Round and Oval Holes
- Upper Epiphany, Oval and Round Holes
- Bottom Epiphany, Round and Oval Holes
- Bottom Fair Glug, Oval and Round Holes

266. The facial nerve comes out of the cavity of the skull on its base through: (1)

- Round hole
- Ostial Hole
- Mining hole
- Vehicle vehicle

267. Through the jugular hole from the skull cavity: (1)

- Language, wandering, sublingual nerves
- Language, wandering, added nerves
- Language, added, sublingual nerves

268. In a patient with a right-sided brain stroke, sensitivity disorders and paralysisof the left half of the person were detected. Determine in the pool, which brain artery hemorrhages developed: (1)

- Front
- Middle
- Rear

269. In a patient with hemorrhage in a large brain hemisphere One of the leading symptoms was a violation of vision, which is likely to assume the location of the hearth in the Artery Pool: (1)

- Front brain
- Medium cerebral
- Rear cerebral

270. The facial nerve comes out of the cavity of the skull on its base through: (1)

- Oval hole
- Ostial Hole
- Mining hole
- Vehicle vehicle

271. Through the yapper from the cavity of the skull: (1)

- Wandering, additive, sub-speaking nerves
- Language, wandering, added nerves
- Language, added, sublingualnerves

272. In the arterial (Willisyev) circle, the rear connecting artery connects the arteries: (1)

- Inner sleepy and basal
- The inner sleepy and rear brain
- The inner sleepy and vertebral
- Medium brain and rear brain
- Medium brain and vertebral

273. The patient has developed a narrowing of the left internal carotid artery, which did not lead to significant violations of the blood supply to the left hemisphereof a large brain. Specify the sequence of blood flow from the right internal carotid artery on the anterior semicircle of arterial (vilisye) circle into the left hemisphere vessels:

- Left internal carotid artery
- Left Front Brain Arteries
- Left average brain arterry
- Front Connecting Artery
- Right internal carotid artery
- Right Front Brain Artery

274. Upper eye vein flows into sinus: (1)

- Top stony
- Upper sagittal
- Wedge-shaped
- Lower Sagittal
- Cavernous

275. Determine the sequence of venous vessels and sines, according to which bloodoutflow occurs from the uphenecular latter of the heavy brain hemispheres:

- Upper Sagittal Sine (2)
- Transverse sine (4)
- Sigmid Sinus (5)
- Sine Stocks (3)
- Internal jugular vein (6)
- Surface Brain Viennes (1)

276. Two sinus fall into the sine flow: (2)

- Upper Sagittal
- Zatilichny
- Left altitude
- Direct

277. From sinus drain, venous blood flows over three sinuses: (3)

- Calm
- Left transverse
- Right transverse
- Straight

278. Of the listed venous sines of the solid cerebral shell on the inner base of the skull are located five: (5)

- Upper rocky
- Baseline
- Wedge-shaped dark
- Lower sagittal
- Lower rocky
- Cave
- Straight

279. Three artery are branches of the internal carotid artery: (3)

- Basilar
- Eye
- Rear brain
- Front Brain
- Medium brain

280. Two sinus fall into the sine flow: (2)

- Upper sagittal
- Left transverse
- Right transverse
- Direct

281. From the sinus flow of venous blood flows over three sinuses: (3)

- Top sagittal
- The occipital
- Left transverse
- Right transverse

282. The vertebral artery of each side penetrates the skull cavity through: (1)

- Large occipital hole
- Mother Channel
- Ripped hole
- Jugular hole

283. Install the correspondence between the sequence number of the branches of the trigeminal nerve and their name:

1st branch	a) maxillary nerve
2nd branch	b) eye nerve
3rd branch	c) of the mandibular nerve

284. During the examination of the patient, a neurologist to determine the state of the branches of one of the cranial nerves presses the fingers to the sections of the person corresponding to the supervisor cutting, under-judged and the chin holes. Determine what nerve condition is checked by such a reception: (1)

- Wandering
- Facial
- Triple

285. The furuncle of the person (especially the upper lip and nasolabial fold) can be complicated by the thrombophlebitis of the cavernous sinus due to the spread of infection on the venous bed. Specify the sequence of vessels that make up this path:

- Upper Eye Vienna (5)
- Facial Vienna (1)
- Medial Vienna Century (4)
- Intervenous anastomoses (3)
- Cave Sine (6)
- Corner Vienna (2)

286. Anesthesiologist, spending oil anesthesia during surgery during operation, keeps an anesthetic mask with his hands and puts forward the lower jaw of the patient, preventing the spares of the language. At the same time, it has the ability to monitor the pulse of the patient using the most convenient pulse point: (1)

- In the medial part of the cheek region above the supervalousclippord
- In the nasolabial fold of the medial corner of the eye
- Ahead of the goat of the ears over the Zhilogo Arc
- On the lower jaw at the front edge of the chewing muscle actually

287. The patient after supercooling has developed paralysis of the Mimic Muscles of half of the person, which indicates inflammation of the nerve: (1)

- Toppermite
- Facial

- Lummylylastic
- Subpidential
- Triple

288. During the examination of the patient, a neurologist to determine the state of the branches of one of the cranial nerves presses the fingers to the sections of the person corresponding to the supervised cutting, under-judged and the chin holes. Determine what nerve condition is checked by such a reception: (1)

- Overall
- Facial
- Triple

289. An important topographic feature of the near-dry salivary gland is the location of one of the listed nerves in it: (1)

- Facial
- Lumpermite
- Triple
- Earnest

290. The child suffered a patient with parotitis, the doctor discovered a loose closure of the eye slit and the omission of the angle of mouth, which indicates the involvement in the inflammatory process of the nerve: (1)

- Toppermite
- Facial
- Subpagger

291. The clinic surgeons turned to a patient with complaints of swelling, sealing and pain in the left-willed eye-chewing area. The front edge of the ear shell is a small furuncle. The doctor diagnosed purulent vapotitis. In the development ofsuch a complication, the main importance is: (1)

- The proximity of the location of the parish gland
- Presence in the variety of lymph nodes

292. Dissection of soft tissues in the primary surgical treatment of the wound wounds of the front and dark-occipital region should be made: (1)

- In the longitudinal direction
- In the transverse direction
- In the radial direction relative to the top point of the head
- Conditions
- The choice of direction does not matter

293. With the primary surgical treatment of the front and dark-occipital region, finding a major bone fragment in the wound, associated with the bones of the boneof the skull, it follows: (1)

- Delete
- Save
- With the penetrating head of the head to save
- When impenetrate head injuries to save
- Tactics depends on the experience of the surgeon

294. Penetrating is called head injuries: (1)

- Related to damage to the bones of the skull
- Associated with damage to the brain substance
- Related to the damage to the solid cerebral shell
- Related to the damage to the soft cerebral shell
- Determined by the wound gaping

295. An important topographic feature of the near-dry salivary gland is the location of one of the listed nerves in it: (1)

- Toppermite
- Facial
- Triple
- Earnest

296. In a child, a patient with a vapor, the doctor discovered a loose closure of the eye slit and the omission of an angle of mouth, which indicates the involvement in the inflammatory process of the nerve: (1)

- Toppermite
- Facial
- Lummylylastic

297. The clinic surgeons addressed the patient with complaints of swelling, sealing and pain in the left-volumen-chewing area. The front edge of the ear shell is a smallfuruncle. The doctor diagnosed purulent vapotitis. In the development of such a complication, the main importance is: (1)

- Communication of the venous bed of gland and outdoor ear
- Presence in the variety of lymph nodes

298. Trepanation at which the bone fragment is removed: (1)

- Bone-plastic
- Resection
- Laminectomy
- Somnomatnaya
- Double-met

299. Scheme serving for orientation in cranopy topography: (1)

- Delicin scheme
- Triangle Shipika
- Stromberg scheme
- Trianglepirogov
- Kronlane-Bruce

300. According to the scheme of the Kronlane-Bruce, the main trunk of the Menagenic Artery is projected at the intersection: (1)

- Front vertical and upper horizontal
- Front vertical and lower horizontal
- Medium vertical and upper horizontal
- Medium vertical and lower horizontal

301. Squeeze the periosteum at bone-plastic trepanation follows: (1)

- To the center of the flap
- To the periphery of the wound
- In the direction of the bottom up
- To the periphery of the wound after the cross-shaped dissection of the periosteum

302. To highlight bone flap with bone-plastic trepanation, you should use two tools: (2)

- Saw sheet
- Wire saw of Gil
- Jacksna buns
- Dalgrenazes

303. The projection line of the output duct of the parole salivary gland is carried out: (1)

- In the middle of the body of the lower jaw
- From the base of the goat ear to the angle of mouth
- From the base of the ear goat to the wing of the nose
- From the corner of the jaw to the corner of the mouth

304. Sections with purulent vapotitis are carried out in two directions: (2)

- In anyone through the point of the greatest fluctuation
- Radially from the goat
- Vertically, retreats Kepened 1 cm from the ear goat
- Arcuate from the ear of the ear, the rich corner of the jaw

305. Point of finger pressed facial artery is: (1)

- 1 cm below the ear goat
- 0.5-1.0 cm below the middle of the lower edge of the orbit
- Behind the corner of the lower jaw
- In the middle of the body of the lower jaw at the front edge of the chewing muscle
- 1 cm below the mid-zylovoy arc

306. Surface wounds on the face can be seulated by three species of seams: (3)

- Simple nodal
- Adapting nodes
- Single-row continuous intradermal
- Lamellar
- Double-row continuous

307. Determine the five goals of the primary surgical processing of the wound: (5)

- Cleansing wound from pollution
- Excision of polluted and non-visual fabrics
- Excision of bleeding tissues
- Final bleeding stop
- Transformation of an infected wound in wound sterile
- Removal of foreign bodies lying in the wound
- Removal of free bone fragments
- Dissection of the wound canal

308. According to the scheme of the Kronlane-Bruce, the main trunk of the Central Meningkeal Artery is projected at the intersection: (1)

- Front vertical and lower horizontal
- Rear vertical and upper horizontal
- Medium vertical and upper horizontal
- Medium vertical and lower horizontal

309. Space the periosteum at bone-plastic trepanation follows: (1)

- To the center of the flap
- To the periphery of the wound
- In the direction from top to bottom
- To the periphery of the wound after the cross-shaped dissection of the periosteum

310. To highlight bone flap during bone-plastic trepanation, you should use two tools: (2)

- Saw arc
- Wire saw of Gil
- Jacksna buns
- Dalgrenazes

311. The projection line of the output duct of the parole salivary gland is carried out: (1)

- In the middle of the body of the lower jaw
- From the base of the goat ear to the angle of mouth
- Parallel to the lower edge of the orbit, retreating the book for 5 mm
- From the corner of the jaw to the corner of the mouth

312. Sections with purulent vapotitis are carried out in two directions: (2)

- In anyone through the point of the greatest fluctuation
- Radially from the goat
- Arcuate on the edge of the parole salivary gland
- Arcuate from the ear of the ear, the rich corner of the jaw

313. Specify the three features of the primary surgical processing of wounds on theface: (3)

- Used broad dissection and excision of the wound
- Excision should be economical, dissection - moderate
- After the completion of the processing of the wound seams are not superimposed
- After the completion of the processing of the wound may be covert tightly
- With penetrating injuries of the face, insulation of cavities from the wounds of soft tissues is necessary

314. Specify three factors that should be considered when conducting primary surgical treatment of wounds in the field of face: (3)

- Increased tissue resistance to infection
- Reduced tissue resistance to infection
- Good blood supply
- No valves in veins
- The need to obtain an acceptable cosmetic result

315. On the eve of the oral cavity, the mucous membrane loses its mobility during the transition from the arch of the gum due to: (2)

- Lack of a submucosal basis
- Battle of the mucous membrane with periosteum
- Combining the above features of the structure
- The severity of the vascular network
- The severity of lymphatic vessels

316. The bridles on the eve of the oral cavity are located between the lips and the gums: (1)

- On the middle line of the body
- On the sides of the midline
- At a distance of 10 mm from the midline
- At a distance of 20 mm from the midline
- At a distance of 30 mm from the midline

317. Band of the parole salivary gland opens on the eve of the oral cavity: (1)

- At the level of the interval between 1 and 2 upper molars
- At the level of 2 top molar
- At the level 2 of the lower molar
- All of the above is true.

318 arteries: (3)

- Palatinadescendens.
- Palatinaascendens.
- Labalis Superior.
- Facialis
- Septinasi Posterior.

319. Due to the 3rd trigeminal nerve branch, the muscle is inexvained: (1)

- Tag
- Straining soft sky
- Rising Soft Sky
- Saints

320. The displacement of fragments during fractures of the lower jaw is determined: (1)

- The direction of the thrust of the muscles
- Form of the lower jaw
- Form of bite
- The mobility of the temporomandibular joint

321. With one-sided (side) mental fracture of the lower jaw, a larger fragment shifts: (1)

- Up and side of the fracture
- Down and towards the fracture
- Up and medial
- Up
- Down

322. Displacement of a long fragment of the lower jaw at the mental fracture occurs under the action of three muscles: (3)

- M. Masseter.
- M. Pterygoideusmedialis.
- M. Mylohyoideus.
- M. Geniohyoideus.
- M. Pterygoideuslateralis

323. Two factors affect the shift of a short fragment with a mental fracture of the lower jaw: (2)

- Traction of the central muscle group, located under the bottom.
- Chewing muscles
- Lack of traction of the central muscle group, omitting
- Lack of chewing muscle thrust

324. The symptom of "open bite" appears when: (1)

- Mental fracture
- Angular fracture
- Fracture of the Criminal Process
- Double-sided fracture of articular processes
- One-sided fracture of the cervical process

325. With a fracture of the coronary eight of the lower jaw, its displacement occurs: (1)

- Down
- Top
- Knab
- Knutrice
- Zada

326. The duct of the proportional salivary gland opens on the eve of the oral cavity: (1)

- At the level of the interval between 1 and 2 by the lower molars
- At level 2 of the upper molar
- At level 2 of the lower molar
- All of the above is true

327. The blood supply to the soft and solid sky is carried out by three arteries: (3)

- Palatinadescendens.
- Palatinaascendens.
- Pharyngea ascendens
- Facialis
- Septinasi Posterior.

328. At the expense of the 3rd trigeminal nerve branch, the muscle is internal: (1)

- Gentlepan
- Straining soft sky
- Lifting soft sky
- Saints

329. The displacement of fragments during fractures of the lower jaw is determined: (1)

- The direction of impact
- The direction of the thrust of the muscles
- Bite shape
- Mobility of the temporomandibular joint

330. Deep and surface areas of the face delimit: (1)

- Branch of the Lower Jaw
- Temporal muscle
- Skulian arc
- The branch of the lower jaw and the temporal muscle on the site of its attachmentto the Vernoe Mountain Friend
- Outer plate of the walled process

331. Deep area of the face with the medial side is limited by three elements: (3)

- Zicky arc
- Outer plate of the walled process
- Part of the temporal surface of the large wing of a wedge-shaped bone
- The outer jaw hill
- An awesome hole

332. From the jaw section a. Maxillaris depart four artery: (4)

- Sphenopalatina.
- Auricularisprofunda.
- Tympanica Anterior.
- Alveolarisinferior.
- Meningeamedia.

333. Distribution of the inflammatory process from the walled plexus on the sinuses of a solid cerebral shell is possible Three veins: (3)

- V. Meningea Media.
- Vienna following in fissuraorbitalis Inferior
- Veins passing in oval and round holes
- V. Facialis.
- V. Jugularisexterna.

334. From n. Mandibularis In the deep area of the face, sensitive nerves depart: (4)

- Medial wingoid
- Lateralwingoid
- Earboard
- Lower Alveolar
- Pagan

335. Topographicartomotic premise for the underworld anesthesia path of Weisblat: (2)

- The round hole and the entrance to the walled-palate pan are in one sagittal plane with the outer plate of the wing process. Oval hole is located behind the wrathid process, and the wonderland-packer is ahead - ahead
- A salted hole and an entrance to the stubborn fossa are on a single sagittal line with an outer plate of the walled process
- The outer plate of the walled process, close to which there are oval and round holes are projected at the level of the middle of the zilly arc
- Round and oval holes are in one frontal plane

336. When using a sublocking path of anesthetization of the second trigeminal nerve branch in a wonderland-pavement Point of an eye on the needle: (1)

- In the middle of the lower edge of the zickie arc
- On the border of the front and middle third of the length of the lower edge of the stoop arc
- In the middle of the line, spent from the outer edge of the orders to the ear of theear
- At the outer edge of the orbit
- At the rear edge of the zickie arc

337. To relax chewing muscles, two ways of anesthesia should be performed at theinflammatory contracture of the lower jaw: (2)

- Berry Dubov
- According to M.M. Weisbremu
- According to P.M. Egorov
- Infraorbital
- Tuberal

338. From the jaw section a. Maxillaris depart four artery: (4)

- Sphenopalatina.
- Auricularisprofunda.
- Tympanica Anterior.
- Alveolaris Inferior.
- Meningea Media.

339. The propagation of the inflammatory process from the wardoid plexus on thesinuses of a solid cerebral shell is possible through three veins: (3)

- V. Meningea Media.
- Vienna following in fissuraorbitalis Inferior
- Veins passing in oval and round holes
- V. Facialis.
- V. Jugularisexterna.

340. From n. Mandibularis In the deep area of the face, sensitive nerves depart: (4)

- Medial Wingoid
- Lateralwingoid
- Earboard

341. Supported hole is projected on: (2)

- 1 cm book from the medial corner of the eye

- 0.5 cm knutrice from the middle of the porcier edge of the society and 0.5 cmbelow this reference point
- 0.5 cm dust from the middle of the puddler edge of the society and 2 cm below this landmark
- 0.5 cm below the intersection point of the under-judicial edge with a vertical line conducted through the medial edge of the second upper low native tooth
- Middle of the supporting edge of the orbit

342. In the intrarocolot method of mandibular anesthesia, it is necessary to palpatiently define two guidelines: (2)

- The articular process of the lower jaw
- Possingaolar yam and oblique line
- Skylty arc and the angle of the lower jaw
- Wonderland-mandibular fold
- Lower Jewish Temple

343. The fracture of the upper jaw on Lefor-1 passes: (1)

- Through the base of the pear-shaped hole, along the bottom of the maxillarysinuses, above the alveolar process
- Through temporal aisters, the internal side wall and the bottom of the goals,according to the zoorlerhnemide seam
- Through the midflaps
- At the level of solid sky

344. The fracture of the upper jaw on Leforu-2 passes: (1)

- Transversely through the root of the nose on the inner wall of the orbit
- Through the midflaps
- At the level of solid sky
- No specifies

345. The fracture of the upper jaw on Lefor-3 passes: (1)

- Along the line of the nobble seam, the top of the orphanage through the temporal proceeding of the zick bone or by temporo-zylovoy
- Through the base of the pear-shaped hole
- Through the middle of the height of the pear-shaped hole
- At the level of zick bones

346. The chevative-jaw gap is directly reported from above with: (1)

- Fiber of the intelligence space of the temporal area
- By the melting space located under the aponeurosis of the temporal area
- Thesubprove fiber of the front and dark-occipital region
- Subcutaneous cellular template

347. Side of the cellular spaces above the oral diaphragm are limited to four elements: (4)

- M. Mylohyoideus.
- Language Muscles
- Lower jaw
- Mucous membrane of the oral cavity

- Two muscle

348. For the opening of deep phlegmons, the subordinate region produces: (1)

- On the lower edge of the socket
- On the side surface of the back of the nose
- Along the transitional fold of the mucous membrane of the upper arm of the eve of the oral cavity, the blunt way penetrated to the bottom of the canine ("dog")
- At the place of the greatest fluctuation
- At the lower edge of the bone

349. At phlegmon, the zilly region produces two cuts: (2)

- By radius from the goat, taking into account the topography of the branches of the facial nerve
- At the bottom edge of the zick bone, taking into account the topography of the branches of the facial nerve
- Vertically at the front edge of the ear
- In the transitional fold of the mucous membrane of the opposition of the oral cavity over 4-6 teeth
- Onnasolabial fold

350. The fracture of the upper jaw on Lefor-1 passes: (1)

- Through the base of the pear-shaped hole, along the bottom of the maxillarysinuses, above the alveolar process
- Under the attachment of the facial skeleton to the bones of the base of the skull
- Through the middle of the eye
- At the level of solid sky

351. The fracture of the upper jaw on Leforu-2 passes: (1)

- Through the base of the pear-shaped hole, along the bottom of the maxillarysinuses, above the alveolar process
- Transversely through the root of the nose on the inner wall of the orbit
- At the level of solid sky
- No specifies no

352. The fracture of the upper jaw on Lefor-3 passes: (1)

- Along the line of the nobble seam, the top of the orphanage through the Vi-bone proof of the zick bone or on the temporo-zickie seam
- Through the lower surfaces of the eye
- Through the middle of the height of the pear-shaped hole
- At the level of zick bones

353. The chevative-jaw gap directly communicates with: (1)

- The fiber of the intelligence scope of the temporal area
- By the melting space located under the aponeurosis of the temporal area
- The fiber of the suppressing space of the front and dark-occipital region
- Subcutaneous cellular temporal area

354. With a felmone of a hatching fossa, the incision is produced: (1)

- To the bone at the upper edge of the opponent of the oral cavity

- To the dice along the transitional fold of the upper ardent of the eve of the oralcavity in the region of the last two large indigenous teeth
- On the lower edge of the body of the lower jaw
- At the bottom edge of the zilly arc, taking into account the topography of the branches of the facial nerve
- In the zone of the greatest fluctuation

355. Podmaseterial abscesses and phlegmons open: (1)

- Arcuate incision 5-7 cm long, bounding the angle of the lower jaw, partiallycutting off the chewing muscle
- Vertical cut at the front edge of the chewing muscle
- Vertical cut at the rear edge of the chewing muscle
- Cut along the lower edge of the lower jaw, cutting the chewing muscle in the zoneof its attachment to the bone
- Vertical cut in the middle of the chewing muscle, smelling its fiber with a bluntway

356. Flegmones the bottom of the oral cavity is opened by three cuts: (3)

- Incision for the midline from the lower edge of the lower jaw to the sub-band bone
- Cross-section in the middle of the distance from the lower edge of the lower jaw to the sub-accepted bone
- Incision of the mucous membrane of the eve of the oral cavity in the forefront ofthe front teeth closer to the surface of the lower jaw
- Incision by 1-1.5 cm below the body of the lower jaw Kependе from the front edgeof the chewing muscles
- A collar-shaped section over the top cervical fold from one corner of the lower jawto another

NECK

357. The composition of the front area of the neck includes three pair triangles: (3)

- Blasting
- Bladder tracheal
- Blatant trapezoid
- Subsiduity
- Sleepy

358. The composition of the lateral area of the neck includes two triangles: (2)

- The blade and crook
- Bladder tracheal
- Bladder trapezoidal
- Sonom

359. The breast-key-mining area is located between: (1)

- Breast and a mastoid process
- Front and lateral areas of the neck
- Side and rear areas of the neck

360. The contractile triangle is limited (set compliance):

- Rear abdrush bubbly muscle (c) a) from above
- The edge of the lower jaw (a) b) in front
- Front abdomen of bubbly muscles (b) c) from behind

361. Sleepy triangle is limited (set compliance):

- The upper belt of the blade and speaking muscle (c) a) in front
- Breast-curable-bed-like muscle (a) b) from behind
- Rear abdomen two-bit muscles (b) c) from above

362. The blade tracheal triangle is limited (set compliance):

- Brain-collection-childrowal mungo — a) medial
- The upper belt of the bladder - sub-speaking muscle — b) from above and lateral
- The middle line of the neck — c) from the bottom and lateral

363. Determine the sequence of location from the surface in the depth of five fasciaof the neck:

- Intraged
- Blade and crook
- Surface
- Poverty
- Own

364. The composition of the lateral area of the neck includes two triangles: (2)

- The blade and keyful
- Bladder trapezoidal
- Logging
- Sonom

365. The breast-clarity-bed-like area is located between: (1)

- Clavicle and maternity process
- Front and lateral areas of the neck
- Side and rear regions of the neck

366. Within the subsidiary triangle, there are two fascia: (2)

- Superficial
- Own
- Blasting-crook
- Intraged
- Poverty

367. Within the sleepy triangle there are four fascia: (4)

- Superficial
- Own
- Blasting-crook
- Intranular
- Poverty

368 within the explosive tracheal triangle there are four fascia: (41)

- Superficial
- Own

- The blade and crook
- Intranular
- Poverty

369. Logging gland is located in a fascial bed formed by Fascian: (1)

- Surface
- Own
- Blasting
- Intraged
- Poverty

370. When removing the subband gland, it is possible to complicate in the form of strong bleeding due to damage to the artery adjacent to the gland: (1)

- Ascending pharyngeal
- Fitness
- The pagan

371. The oversized inter-pineurotic space is located between the fascia of the neck:(1)

- Own and showerful-clavical
- Blade and clarifying and intracted

372. Performing the lower tracheostomy, the surgeon, passing the headband space,should be lost damage: (1)

- Venous vessels
- Nerves

373. Preserceral space is between: (1)

- Own and showerful-clavical fascia
- Scaldable and entertaining fascia
- Parietal and visceral leaflets of intrafined fascia
- Intrafined and pre-arising fascia

374. The hospital delivered a heavy patient with purulent mediastine as a complication of a cap abscess. Pump came to the rear media section on: (1)

- A surcharge of intelligible space
- Preserved space
- Poverene space
- Retroversceral space
- Vascular nerve vagina

375. The defense space is between: (1)

- Own and showerful-clavical fascia
- The blade and croileous fascia and a parietal leaflet of the intracted fascia
- Parietal and visceral leaflets of intrafined fascia
- Intrafined and pre-arising fascia

376. When the lower tracheostomy is performed by the middle access after penetration into the principal space, strong bleeding suddenly occurred. Determinethe damaged artery: (1)

- Ascending cervical

- Lower Gundy
- Lower thyroid
- Unpaired thyroid

378. When removing the subband gland, it is possible to complicate in the form of strong bleeding due to damage to the artery adjacent to the gland: (1)

- Facial
- Fitness
- Standing

379. The oversized inter-pineurotic space is located between the fascia of the neck:(1)

- Surface and own
- Own and showerful-clavish

380. Performing the lower tracheostomy, the surgeon, passing the head-per-samplespace, should beware of damage: (1)

- Arterial vessels
- Venous vessels

381. Rear to the larynx arrives: (1)

- Throat
- The fraction of the thyroid gland
- Parathyroid glands
- Esophagus
- Cervical spine

382. Side of the larynx is two anatomical entities: (2)

- Sternum-puzzle muscle
- Breast-thyroid muscle
- The fraction of the thyroid gland
- Parathyroidglands
- Thyroidgland
- Shield-lift muscle

383. Three anatomical education are located in front of the larynx: (3)

- Harness
- Sternum-puzzle muscle
- Breast-thyroid muscle
- The fraction of the thyroid gland
- Parathyroid glands
- Thyroid gland
- Shield-lift muscle

384. The sympathetic barrel on the neck is between: (1)

- Parietal and visceral leaflets of intracted fascia
- Intrafined and pre-arising fascia
- Poverty Facege and Long Muscle Neck

385. Wandering nerve, being in one fascial vagina with a common carotid artery and an inner jugular vein, is located in relation to these blood vessels: (1)

- Medially common carotid artery
- In front between the artery and veloy
- From behind between the artery and veloy

386. To the paired muscles located ahead of the trachea include two: (2)

- Breast-curable-cottage
- Sternum-ply
- Breast-thyroid
- Shield-subwit

387. Within the neck, the esophagus arrive to the rear wall of the trachea: (1)

- Speaking several left
- Speaking somewhat right

388. With subtotal resection of the thyroid gland, a part of the gland containing parathyroid glands should be left. Such part is: (1)

- Upper Pole Side Share
- Supported part of lateral fractions
- Annert part of lateral fractions
- Lower pole side fraction

389. During the operation of the structure, performed under local anesthesia, whenimposing clamps for blood vessels of the thyroid gland, the patient had witness voices due to: (1)

- Harbor blood supply disorders
- Completeness of the upper gentle nerve
- Compressance of the return near nerve

390. Mostly the vascular-nervous beam of the neck, the total carotid artery and theinner jugular vein are relative to each other as follows: (1)

- Artery medial, Vienna Lateral
- Artea Lateral, Vienna MEDIAL
- Archier in front, vein from behind
- Arching from behind, vein in front

391. In the affected - strong bleeding from the deep sections of the neck. In order to dress the outer carotid artery, the surgeon was exposed in a sleepy triangle the placeof dividing the total carotid artery to the outdoor and internal one. Determine the main sign that you can distinguish these artery from each other: (1)

- Internal carotid artery larger outdoor
- The beginning of the internal carotid artery is located deeper and the dust relativeto the beginning of the outer carotid artery.
- Side branches depart from the outer carot artery

392. Predal gap is located between: (1)

- Breast-curable and deputy and front staircase muscles
- Long muscle of neck and front staircase
- Front and medium staircase muscles

393. In the preliminary interval passes: (1)

- Plug-in artery

- Plug Vienna
- Shoulder plexus

394. Wandering nerve, being in one fascial vagina with a common carotid artery and an inner jugular vein, is located in relation to these blood vessels: (1)

- Lateral than inner jugular veins
- Front between the artery and veloy
- Rear between the artery and veloy

395. To the paired muscles, located ahead of the trachea, are two: (2)

- Breast-crooking-cottage
- Sternum-subwind
- Breast-thyroid
- Bluado-ply

396. Within the neck, the esophagus arrive to the rear wall of the trachea: (1)

- Strictly on the middle line
- Speaking several left

397. The diaphragmal nerve is located on: (1)

- Breast-curable-preceding muscle over its own fascia
- Breast-clarity-cottage muscle under its own fascia
- The front staircase over the pre-showing fascia
- The front staircase under the presidency fascia
- Medium staircase over the pre-arising fascia
- The middle staircase under the preloading fascia

398. Shoulder nervous plexus within the blade and keyful triangle is located: (1)

- Between own and scaldable-clavish fascia
- Between the blade and globular and pre-arising fascia
- Under the forelane fascia

399. Install the correspondence between the departments of the plug-in artery andderived from these departments with arterial branches:

- Before entering the intersenter Interval
- In the park interval
- On the exit of the inter-sterry interval

1) inner breast
2) vertebral artery
3) transverse artery neck
4)shield - cervical trunk
5)rib-cervical trunk

400. The needle gain point when carrying out a wagosympo blockade: (1)

- The rear edge of the breast-curable-bed-like muscle at the level of its middle
- The rear edge of the breast-curable-bed-like muscle at the place of its intersection with the outer jugular vein
- The front edge of the breast-curable-hospital muscle at the level of its middle
- The front edge of the breast-curable-bed-like muscle at the level of the top edge ofthe thyroid cartilage

401. With subtotal resection of the thyroid gland, a part of the gland containing parathyroid glands should be left. Such part is: (1)

- Supported part of lateral fractions

- Rear-line lateral sharing
- Lower pole side share

402 Determine the sequence of the surgeon's actions performing the upper tracheostomy, after dissection of the middle line of the skin with subcutaneous tissue and surface fascia:

- Separation of blunt way and shifting the book of the thyroid gland
- Spreading the sternum-ply and sternum-thyroid muscles
- Dissection of a white neckline
- Dissection of a parietal leaf of intracted fascia
- Drying the wall of the trachea
- Launching fixation

403. Determine the sequence of a surgeon's actions performing lower tracheostomy, after dissection on the middle line of the skin with subcutaneous tissue and surface fascia:

- Owning the book of the Yarem Venous Arc
- Spreading the sternum-ply and breast-thyroid muscles
- Dissection of the blade andocked fascia
- Dissection of a parietal leaf of intracted fascia
- Dissection of own fascia
- Drying the wall of the trachea

404. Install the correspondence between tracheal dissemination violations in tracheostomy and possible complications:

- Non-section dissection of the front wall of the trachea
- Section larger diameter cannula
- The cut is smaller than the diameter of the cannula
- Damage to the back wall of the trachea

a) necrosis rings trachea

b) tracheopic fistula

c) closing the lumen of the trachea

d) subcutaneous emphysema

405. Determine the three statements that characterize the operational access to the cervical esophagus: (3)

- Performed in the lower neck of the left
- Performed in the bottom of the neck on the right
- The incision is carried out along the inner edge of the breast-curable-bed-likemuscle
- The incision is carried out along the outer edge of the breast-curable-bed-likemuscle
- The exposure of the esophagus is carried out through the vagina of the breast-curable-bed-like muscle
- The exposure of the esophagus is carried out through the vascular-nervous vagina

406. With subtotal resection of the thyroid gland, a part of the gland containing parathyroid glands should be left. Such part is: (1)

- Supported part of lateral fractions
- Announcement of lateral fractions

- Lower pole side share

407 Determine the sequence of a surgeon's actions performing the upper tracheostomy, after dissemination of the middle line of the skin with subcutaneous tissue and surface fascia:

- Branch of the blunt way and shifting the book of the thyroid gland
- Spreading the sternum-ply and sternum-thyroid muscles
- Making a white neck line
- Dissection of a parietal leaf of intracted fascia
- Drying the walls of the trachea
- Laining fixation

408. According to the classification proposed by V.N. Shevkunenko, on the neck allocate: (1)

- Two fascia
- Three fascia
- Four fascia
- Five fascia
- Six fascia

409. Printed lymph nodes collect lymph from the departments of the face: (6)

- Upper lips
- Side hotels of the mucous membrane of the opposition of the mouth
- Upper teeth
- Lower teeth
- Mid-language
- Bottom of the oral cavity

410. Printed lymphatic nodes are located in a fascial case: (1)

- Visor-nervous beam of the medial triangle neck
- Lifting gland
- Facial veins
- Muscles of the mouth of the mouth

411. The bifurcation of the total carotid artery is more often located at: (1)

- The angle of the lower jaw
- The upper edge of the thyroid cartilage
- Mid-thyroid cartilage
- The lower edge of the thyroid cartilage

412. Two signs are characteristic of the outer carotid artery: (2)

- The presence of exhaust branches
- The absence of side branches
- Medial location
- Lateral location
- Weak ripple compared to the internal carotid artery

413. When performing tracheotomy, the patient should be given the position:

- On the back: The head is trapped by the post, the roller is put under the blades
- On the back: the head is turned left, the roller is put under the blades

- On the back: the head is turned left, the right hand is drawn down
- Half-sideweled with the hollow head
- Lying on the right or left side

414. The bifurcation of the total carotid artery is more often located at: (1)

- The upper edge of the thyroid cartilage
- Sub-band bone
- Mid-thyroid cartilage
- The lower edge of the thyroid cartilage

415. To carry out a cut in tracheostomy, exactly in the middle line should be combined on one line in the neck of two guidelines: (2)

- Top cutting thyroid cartilage
- The middle of the body of the sub-band bone
- Middle Chin
- Thyroid gland
- Mid-tireless Breasts

CHEST CAVITY

416. The surgeon, performing an advanced thoracotomy in the 6th interestreon, sequentially cuts the layers of the chest wall. Specify the sequence of dissection ofits layers:

- Irregular Fascination
- Breast Fascia
- Leather
- Outdoor and internal intercostal muscles
- Parietal pleura
- Front gear muscle
- Surface Fascia
- Subcutaneous fatty fiber
- Sighter tissue

417. When opening the intramammammary abscess, the radial cut should not moveto the near-block circle due to: (1)

- Damage to blood vessels
- Damage to output ducts
- Nipple deformations in the formation of the skin scar

418. Removal of breast muscles with fatty tissue with an extended mastectomy for cancer due to: (1)

- Close anatomical bond between the breast and the big thoracic muscle
- The ability to germinate a tumor into breast muscles
- Location in the subepoploral space of a group of lymph nodes

419 Metastasation for breast cancer can occur in various groups of regional lymph nodes under the influence of a number of specific conditions, including the localization of the tumor. Determine the most likely group of lymph nodes where metastasisation can occur when the tumor localization in the upper breast is: (1)

- Breasts
- Plug
- Subsecutoral

420. A small metastase was found in a patient with cancer of the left breast in the medial department of the right breast. Most likely path of metastasis: (1)

- Hematogenic - due to the ingress of malignant cells through the chest duct into the bloodstream
- Through metastasis in breast and mediochemical lymph nodes where Lymph canact from both mammary glands.
- On the connecting lymph vessels of the left and right mammary glands

421. When opening the intramammammarh abscess, a cut is applied: (2)

- Vertical
- Semicircular under the iron
- Radial

422. Location of blood vessels and nerve in the intercostal vascular-nervous beam from top to bottom as follows: (1)

- Vienna, Artery, Nerve
- Nerve, artery, vein
- Vienna, nerve, artery

423. The intercostal vascular-nerve bundle is most of all from under the edge of theedge on: (1)

- Front Breast Wall
- Breast side wall
- Rear Breast Wall

424. Performing front-side thoracotomy, the surgeon made a dissection of intercostal muscles on the front wall too close to the lower edge of the overlyingedge, which created the danger of damage to one of the listed elements of the intercostal vascular-nerve beam: (1)

- Artery
- Vienna
- Nerve

425. In case of a sideline, the clavicle has a damaged dome of the pleural, the standing height is on: (1)

- 4-5 cm above the clavicle
- 2-3 cm above clavicle
- Klyvitsky level
- The level of the first edge

426. Payments in the pleural cavity, first of all, begins to accumulate in sinus: (1)

- Editor-diaphragmal
- Rib media
- Medi-diaphragmal

427. When performing a diagnostic pleural puncture punctured: (1)

- Strangle-diaphragmal sinus

- Rib Medarized Sine
- Media-diaphragmal sinus

428. At the opening of the intramammar abscess, a cut is applied: (2)

- Semicircular under the iron
- Cross
- Radial

429. Location of vessels and nerves in the intercostal vascular-nervous beam fromtop to bottom as follows: (1)

- Artery, Vienna, nerve
- Vienna, Artery, Nerve
- Nerve, Artery, Vienna

430. Metastasation for breast cancer can occur in various groups of regional lymphnodes under the influence of a number of specific conditions, including the localization of the tumor. Determine the most likely group of lymph nodes where metastasisation can occur when the tumor localization in the upper breast is: (1)

- Breasts
- Plug
- Middle

431. Install the match. Place pleural puncture:

- Between the front and middle Axillarylines — 1) in the VI or VII intercostal
- Between the middle and rear Axillary lines — 2) in VII or VIII intercostal
- Between the axillary and Blank lines — 3) in the VIII or IX intercostal

432. When performing pleural puncture, the needle should be carried out throughthe intercostal interval: (1)

- At the lower edge of the overlying rib
- In the middle of the distance between the ribs
- At the upper edge of the underlying rib

433. Pneumothorax as a complication of pleural puncture may occur: (1)

- When damaged the needle of the lung
- Through the puncture needle

434. Intraper bleeding, as a complication of pleural puncture, may result from damage: (2)

- Diaphragm
- Liver
- Spleen

435. With thoracotomy, the dissection of the intercostal interval should be carried out by: (1)

- Lower edge of the overlying rib
- The middle of the intercostal
- The upper edge of the underlying rib

436. The projection of the lung gates to the front chest wall most often correspondsto: (1)

- I-III edges
- II-IV edges
- III-V edges

437. At the left lung gate, the main armor and pulmonary vessels are located on topdown in the following order: (1)

- Artery, Bronchi, Vienna
- Bronchi, Artery, Vienna
- Vienna, Bronchi, Artery

738. In the gate of the right lung, the main armor and pulmonary vessels are located on top down in the following order: (1)

- Artery, Bronchi, Vienna
- Bronchi, Artery, Vienna
- Vienna, Bronchi, Artery

439. Pneumothorax as a complication of pleural puncture may occur: (1)

- If the needle is damaged
- Through the puncture needle

440. Make a comparative anatomical characteristic of each main bronchus, establishing compliance with three parameters:

- The left main bronchus
- Right main bronchus

1) wider
2) already
3) longer lasting
4) shorter
5) located horizontally
6) located vertically

441. The child has a cherry bone accidentally fell into the respiratory tract, cloggingone of the equity bronchi, which led to atelectasia lung's share. Determine the mostlikely position of the cherry bone: (1)

- Upper-grade bronch
- Middle-hearted bronchus of the right light
- Low-stage bronchus of the left lung
- Lower Fallen Bronchum of the Right Lung

442. If necessary, an operational intervention on the main brumade should be launched the root of the lung, performing: (1)

- Front-side thoracotomy
- Side Thoracotomy
- Rear-side thoracotomy

443. Projection of the gates of the lungs on the front chest wall most often corresponds to: (1)

- II-IV edges
- III-V edges
- IV-VI edges

444. Bronchial arteries in the amount of 2-4 to each lungs are branches: (1)

- Internal chest arteries

- Breast Aorta Department
- Rear intercostal arteries

445. Venenous blood from the lungs reaches mainly by the bronchial veins, flowing:(1)

- To internal breast veins
- In the intercostal veins
- In the unpaired and semi-regional veins

446. Lung segment is a plot of lung, in which: (1)

- Segmental bronchi branches
- Segmental bronchi and the lung artery branch of the 3rd order branch
- Segmental bronchi branch branch, the lung artery branch of the 3rd order and the corresponding vein is formed

447. Breast capsule formed: (1)

- Breast's own fascia
- Surface fascia
- Clastic and thoracic fascia
- Milk iron lies outside the fascia

448. The lymphatic node of Zorgius is: (1)

- Over the clavicle behind the exterior edge of the breast-curable-bed-like muscle
- In the course of the inner chest artery
- In the center of the axillary depression
- Under the outer edge of the big breast muscle at the level of the 3rd rib
- Under the edge of the widest muscles of the back

449. For the opening of purulent mastits, two types of cuts are used: (2)

- Radial towards the nipple
- Arcuated in the course of the transitional folds of the breast
- Conducting
- Transverse (horizontal)

450. Intercostal vascular-nerving beam is located: (1)

- Under the chest fascia
- Between intercostal muscles
- Under surface fascia
- Between different tissues, depending on the departments of the chest wall

451. Internal chest artery moves away from: (1)

- Mortgage artery
- Subclavian artery
- Outdoor carotid artery
- Arc Aorts
- Shchezhegol trunk

452. Internal chest artery is located: (2)

- In the subephetoric tissue
- Between intercostal muscles
- Between the internal intercostal muscles and the transverse muscle of the chest

- In the preliminary tissue
- Under a small chest muscle

453. Puncture of the pleural cavity with a spilled process is obtained with the position of the patient: (1)

- Lying on the side
- Lying on the stomach
- Sitting with bent torso
- Poliysida
- The position of the patient does not matter

454. Under the substitute resection of the rib, the periosteum dishes: (1)

- P-shaped
- Arcuate
- Linear section
- 4Cross-cut
- N-shaped

455. For the opening of purulent mastits, two types of cuts are used: (2)

- Radial towards the nipple
- Arcuated in the course of the transitional folds of the breast
- Longitudinal (vertical)
- Transverse (horizontal)

456. Intercostal vascular-nerving beam is located: (1)

- Under the chest fascia
- Between intercostal muscles
- Inparapel fluid
- Between different tissues, depending on the departments of the chest wall

457. After resection of the edge in order to introduce a drainage tube to the pleuralcavity of the scalpel, the rear leaflet of the periosteum: (1)

- Along the top edge of the rib
- 2In the middle
- All of the above answers are correct.

458. The drainage tube after resection of the edge and its introduction to the splashcavity should be fixed to: (1)

- Prieucian pleura
- Intercostal muscles
- Skin
- Surface Fascia
- Own fascia

459. The most severe disorders are observed at pneumothorax: (1)

- Open
- Closed
- Valve
- Spontaneous
- Combined

460. The cervical wagosympathetic blockade during breast injuries is carried out with the goal: (1)

- Alestruction
- Reducing hypoxia phenomena
- Fighting pleurpulmonal shock
- Pneumonia prevention
- Light hyperventilation

461. After resection of the rib with the aim of introducing a drainage tube to the pleural cavity of the scalpel, the rear leaflet of the periosteum: (1)

- Along the bottom edge of the rib
- In the middle
- All of the above answers are correct.
- The dissection is determined by the peculiarities of the pathological process.

462. When the open pneumothorax is stamped into the first row of seams, you needto capture: (1)

- Parietal pleura
- Parietal pleura and intragenuary fascia
- Parietal pleura, intragenic fascia and intercostal muscles
- All listed layers and surface muscles
- All breast wall layers

MEDIASTINUM

463. The most accurate position of the frontal plane separating the mediastinum tothe front and rear departments is (1):

- Rear surfaces of the roots of the lungs and the rear wall of the trachea
- Middle tracheas and main bronchi

464. The thoracic lymphatic duct passes through the diaphragm together with: (1)

- an unpaired vein
- sympathetic trunk
- aorta
- vagus nerves

465. Install the compliance of the vessels of the mediastinum departments:

- Front mediastone
- Rear media

1) Upper Hollow Vienna
2) internal chest arteries
3) ascending aorta
4) breast duct
5) aortic arc
6) pulmonary trunk
7) downward aorta
8) Unpaired and semi-park veins

466. Install the correspondence of the nerves of the mediastinal departments:

- Frontmediastone
- Rear media

1) wandering nerves
2) large and small internal nerves

3) diaphragmal nerves
4) sympathetic trunks

467. Determine the sequence of the location in front of the anatomical formations:

- Aortic arc
- Trachea
- Milk iron
- Shchezhegoleviennes

468. The most accurate position of the frontal plane separating the mediastinum tothe front and rear departments is (1):

- Rear surfaces of the roots of the lungs and the rear wall of the trachea
- The front surfaces of the lung roots

469. For people with a delaichorphic chest characteristic of the heart position (1)

- Vertical
- Oblique

470. Install the correspondence between the position of the wall shells and their nomenclature names:

1) myocardium, 2) pericardium, 3) endocard, 4) epicard

- Inner Heart Wall Sheath
- Medium Heart Wall Sheath
- Outer sheath wall heart
- Ocoloserday bag

471. Of the four chambers of the hearts involved in the formation of its ne-rare surface, the main is: (1)

- Left atrium
- Left ventricle
- Right atrium
- Right ventricle

472. Of the three chambers of the heart, participating in the formation of its rear surface, the main is: (1)

- Left atrium
- Left ventricle
- Right atrium

473. For people with a delaichorphic chest characteristic of the heart position (1)

- Vertical
- Transverse

474. Of the three heart cameras involved in the formation of its lower surface, the main one is: (1)

- Left atrium
- Left ventricle
- Right ventricle

475. The rear surface of the heart is addressed to the organs and vessels of the rearmediastinum, among which two formations directly to the wall of the heart: (2)

- Thoracic aorta department

- Breastbank
- Unpaired Vienna
- Esophagus
- Selects Vienna

476. When the patient is performed by the coronaryrographs of the X-ray-repeat substance introduced into the bloodstream of the heart of the ascending aorta, passes sequentially through all parts of the coronary circle of blood circulation and, together with blood, it turns out in the cavity of the right atrium. Specify the sequence of blood and x-ray-contrast substance on the coron-circulation of blood circulation:

- Candy sinus heart
- Intragan artery
- Intoral veins
- Left and Right Crown Artery
- Microcirculatory course
- Subpiccardial arterial branches
- Subpiccardiale Vienna

477. The front interventricular branch departs from: (1)

- Ascending aorta
- Left Crown Artery Heart
- Light trunk
- Left pulmonary artery

478. Rear interventricular branch departs from: (1)

- Ascending aorta
- Left Crown Artery Heart
- The right corporal artery of the heart
- The right pulmonary artery

479. Envelope branch departs from: (1)

- Ascending aorta
- Left Crown Artery Heart
- Light trunk
- Left pulmonary artery

480. In the obturation of the right-wing artery in a plot of a side edge of the heart,the localization of the focus of myocardial infarction in: (1)

- The wall of the right atrium
- The front wall of the right ventricle
- Rear wall of the right ventricle
- Rear wall of the left ventricle

481. When obstructing the envelope of the branch is most characteristic of the localization of the focus of myocardial infarction in: (1)

- The front wall of the left atrium
- The front wall of the left ventricle
- Rear wall of the left atrium

- Rear wall of the left ventricle

482. The front interventricular branch departs from: (1)

- Left Crown Artery Heart
- The right corvene artery of the heart
- Light trunk
- Left pulmonary artery

483. Rear interventricular branch departs from: (1)

- Ascending aorta
- Right-wing artery heart
- Light trunk
- The right pulmonary artery

484. Envelope branch from: (1)

- Ascending aorta
- Left Crown Artery Heart
- The right corneous artery of the heart
- Light trunk

485. In the obturation of the initial department of the front interventricular branch,the localization of the focus of myocardial infarction in: (1)

- The wall of the left atrium
- The front wall of the left ventricle
- The front wall of the right ventricle
- Interventricular partition

486. Large vein heart is located in: (1)

- The front interventricular furrow and the right department of the Crown
- The front interventricular furrow and the left Department of the vernoygrozde
- Rear interventricular furrow and right-hand
- Rear interventricular furrow and the left Department of the Crown Groove

487. The bearer sinus of the heart is located in: (1)

- Front interventricular furrow
- Rear interventricular furrow
- Left Department of the Vienna Grozdy
- The right department of the coronary
- The backyard of the left coronary

488. The bearer sinus of the heart flows into: (1)

- Upper hollow vein
- Bald Vienna
- Right atrium
- Left atrium

489. The front veins of the hearts fall into: (1)

- Large Vienna Heart
- Candy sinus heart
- Right atrium

490. The most frequent operational access during heart operations is: (1)

- Left-sided front thoracotomy
- Left-sided head-side thoracotomy
- Longitudinal sternotomy
- Crowdowpheleral transverse access

491. When stamping wounds, seams are superimposed: (1)

- Nodal or P-shaped
- Nodal or continuous
- P-shaped or continuous

492. For the surveillance operation of the wound wound, the following three statements are true: (3)

- Seams should be performed by atraumatic needles.
- On the wall of the heart perform nodal seams
- When equipping the seams, endocardia cannot be calcined
- It is impossible to capture large subepicardial arteries in the seam

493. Pericarda puncture is performed most often at the Larreya point. Specify thelocation of it: (1)

- Between the sword-shaped process and the left edge arc
- In the 4th inter estreon to the left of the sternum

494. When performing a pericardial puncture, the needle is carried out in the direction of the pericardial cavity: (1)

- Oblique
- Front-bottom

495. In modern cardiac surgery, four operations are used to treat coronary heart disease: (4)

- Aorticorogonary shunting
- Balloon Dilatation of Crown Artery
- The imposition of the Vernial and Breast Anastomoz
- Dressing internal chest arteries
- Pericardiocardiocardia
- Stenting of the coronary artery

496. When operating on an open arterial exchange, the most appropriate operational reception is: (1)

- Duct bandage without dissection
- The intersection of the duct and the bandage of its ends
- The intersection of the duct and suturing its ends

497. Warm iron is: (1)

- In the upper part of the foreground
- In the lower department of the foreground
- In the upper section of the rear media
- In the lower section of the rear media
- On the border of the front and rear media

498. Behind and on the left to the upper hollow vein goes: (1)

- Trachea

- Esophagus
- Pericard and Heart
- Milk Iron
- Ascending aorta

499. Unpaired Vienna often flows: (1)

- In the front wall of the upper hollow
- In the rear wall of the upper hollow
- On the right wall of the upper hollow
- In the left wall of the upper hollow
- There is no definite place of failure

500. On the front-left surface of the aortic arc are: (2)

- The right wandering nerve
- The left wandering nerve
- Left diaphragmal nerve
- Right diaphragmal nerve
- Leftsympathetictrunk

501. At the front-left surface of the aortic arcs are: (2)

- The right wandering nerve
- The left wandering nerve
- Left diaphragmal nerve
- Right diaphragmal nerve
- Left sympathetic trunk

502. The left return mountain nerve from the left wandering nerve usually leaves:(1)

- Above the aortic arches
- At the level of the front wall of the arc aorta
- At the lower edge of the aortic arc
- On all the above levels
- Returnal nerve in the chest cavity from the wandering does not leave

503. The right Returnal Guttural nerve from the right wandering nerve usually leaves: (1)

- At the top edge of the right plug-in artery
- At the lower edge of the right plug-in artery
- At the root level of the lung
- At the placement of the shoulder barrel
- At the level of the upper edge of the aortic arc

504. The root of the right lung on top of the envelopes: (1)

- Aorta arc
- Top Hollow Vienna
- Right Shoulder Vienna
- Unpaired Vienna
- Chest dash

505. In the rear mediastrium, the esophagus in all trails to: (1)

- Midnapar Vienna
- Left sympathetic trunk
- Breast duct
- Aorte
- Fuck

506. For the surveillance operation of the wound wound, the following three statements are true: (3)

- Seams should be performed by atraumatic needles.
- On the wall of the heart perform nodal seams
- On the wall of the heart perform continuous seam
- It is impossible to capture large subepicardial arteries in the seam

507. Pericardine puncture is performed most often at the Larreya point. Specify thelocation of it: (1)

- Between the sword-shaped process and the left edge arc
- Between the Mioso-shaped process and the right edge arc

508. When performing puncture of pericardia, the needle is carried out in the sickness of the pericardial cavity: (1)

- Front-bottom
- Transverse

509. In modern cardiac surgery, four operations are used to treat coronary heart disease: (4)

- Aorticorogonary shunting
- Balloon Dilatation of Crown Artery
- Performance of the Vernial and Breast Anastomoz
- Pericardiocardiocardiosia
- Simpatectomy
- Stenting of the coronary artery

510. Being in the pre-convertible fiber, the chest duct in the rear mediastum is located between: (1)

- Esophagus and semi-regional veloy
- Chest aorta and unpaired veins
- Esophagus and sympathetic barrel
- Unpaired and semi-regional veins
- The rear surface of the lung and semi-regional veins

ABDOMINAL WALL

511. The front abdominal wall with horizontal and vertical lines are divided into: (1)

- 8 regions
- 9 regions
- 10 regions
- 12 regions

512. Performing upper-medal laparotomy, the surgeon sequentially cuts the layersof anterior abdominal wall. Specify the sequence of layers:

- White belly line
- Leather with subcutaneous fatty tissue
- Parietal peritone
- Surface Fascia
- Transverse fascia
- Preventive fiber
- Own fascia

513. When performing a transrectal section in the epigastric area, the surgeon sequences the layers of anterior abdominal wall. Specify the sequence of layers:

- Rear wall of the vagina direct abdominal muscle
- Leather with subcutaneous fatty tissue
- Parietal peritone
- Front wall of the vagina direct abdominal muscle
- Surface Fascia
- Transverse fascia
- Prettartal fiber
- Direct abdominal muscle
- Own fascia

514. The front abdominal wall with horizontal and vertical lines are divided into: (1)

- 9 regions
- 10 regions
- 11 regions
- 12 regions

515. Specify the sequence of layers in the side of the abdomen:

- Inner oblique muscle
- Leather with subcutaneous fatty tissue
- Outdoor oblique muscle
- Parietal peritone
- Surface Fascia
- Cross Muscle
- Transverse fascia
- Prealchery fiber
- Own fascia

516. The surgeon performs an appneldectomy oblique variable section of Volkovich-Dyaconov in the right iliac region. Specify the sequence of passing the layers of this area:

- Uponeurosis outer oblique abdominal muscle
- Internal oblique and transverse muscles
- Deep sheet of surface fascia
- Leather with subcutaneous fatty tissue

- Parietal peritone
- Surface Fascia
- Transverse fascia
- Prealchery fiber
- Own fascia

517 One of the anatomical prerequisites for the development of umbilical hernia is the weakness of the umbilical rings in the region: (1)

- His lower seightened
- Upper semicondancy
- Right seightened
- Left seaside

518. White belly line is formed by: (1)

- Aponeoprase outer braid abdominal muscle
- Uponodesurosis of the transverse abdominal muscle
- Tendon beams of 3 pairs of wide abdominal muscles
- Intrasty fascia

519. Within the navel, the abdominal wall is represented by the following four layers: (4)

- Leather
- Surface Fascia
- Undermined fascia
- Internal fassion
- Preview alert
- Peruny

520. When carrying out a transfectal incision in the epigastria, the surgeon openedthe front wall of the vagina's direct abdominal muscle. At the level above the semicircular line, the front wall of the vagina is formed: (1)

- Aponeurosis of the outer oblique, internal oblique and transverse muscles
- Aponeurosis of the outer oblique and inner oblique muscle

521. With transrectual cuts, it is not recommended to cross the tendon lintels of direct abdominal muscles, which is due to the presence of this: (2)

- Lymphatic vessels
- Nervous plexuses
- Powered blood vessels
- Porto-Cavalny Anastomoses

522. Performing transrectal access in the legislative area, the surgeon reveals the vagina of the straight abdominal muscle. At the level below the semicircular lines,the front wall of the vagina is formed: (1)

- Uponeurosis of the outer oblique muscle
- Aponeurosis of the outer oblique, inner oblique and transverse muscles
- Uponeurosis of the inner oblique muscle
- Aponeurosis of the external braid abdominal muscle and transverse fascia

523. White belly line is formed by: (1)

- Uponeryosis of the inner oblique muscle
- Uponodesurosis of the transverse abdominal muscle
- Tendon beams of 3 pairs of wide abdominal muscles
- Intrasty fascia

524. Within the navel, the abdominal wall is represented by the following four layers: (4)

- Leather
- Subcutaneous fatty fiber
- Surface Fascia
- Undermined fascia
- Intrabity fascia
- Peruny

525. For the arterial perfusion of the lower limbs, the palterization of the lower leftartery is produced. This vessel is located: (1)

- In subcutaneous fatty tissue
- Ahead of the direct abdominal muscle
- In the thicker, the straight muscles of the abdomen
- Behind the straight abdominal muscle

526 The median bubble-bubble fold contains: (1)

- Obliterated umbilical artery
- Obliterated umbilical vein
- Obliterated urinary duct
- Seeding duct

527. Performing transrectal access in the grave region, the surgeon reveals the vagina of the straight muscle of the abdomen. At the level below the semicircularlines, the front wall of the vagina is formed: (1)

- Uponeurosis of the outer oblique muscle
- Aponeurosis of the outer oblique, internal oblique and pop

530. When performing a transfectal incision in epigastria, the surgeon opened the front wall of the vagina's direct abdominal muscle. At the level above the semicircular line, the front wall of the vagina is formed: (1)

- Uponormaroses of the outer oblique, inner oblique muscle and transverse fascia
- Aponeurosis of the outer oblique and inner oblique muscle

531. In the right hypochritic region, are usually projected: (3)

- Part of the right lobe of the liver
- Selezenka.
- Part of the right kidney
- Tail of the pancreas
- Right bending of the colon
- Gallbladder

532. The area of the projection of the gallbladder on the front wall of the life is: (1)

- The right side area of the abdomen
- Undermined area

- Nadium region

533. On the front of the abdomen, the duodenum is projected in the following areas:(1)

- In the right and left side
- Underlands and Top
- In the rural and right side
- In the umbilical and right side

534. The projection of the pancreas on the front of the abdomen corresponds to thefollowing areas: (1)

- Left hypotherapy and left side
- Undermined and left hypo
- The prey and left hypochrit
- The right hypochrietary and fat
- Undermined and fat

535. When examining a patient with an acute appendicitis, a surgeon to assess the state of a blind intestine and a heart-shaped process, taking into account their anatomical projection, palpates: (1)

- Right side abdomen
- Left side abdomen
- Right inguinal region
- Pubic area

536. The area of the projection of the gallbladder on the front wall of the life is: (1)

- Right hypochritation area
- Undermined area
- Supported region

537. On the advanced wall of the abdomen, the duodenum is projected in the following areas: (1)

- In the right and left side
- Underlands and Top
- In the left and left side
- In the rural and right side

538. When examining a patient with an acute appendicitis, a surgeon to assess the state of a blind intestine and a heart-shaped process, taking into account their anatomical projection, palpates: (1)

- Left side abdomen
- Right inguinal region
- Left inguinal region
- Lobkovaya area

539. The borders of the inguinal triangle are: (3)

- Horizontal line conducted from the upper front axle of the ileal bone to the navel
- Groin bunch
- Horizontal line conducted from the border between the outer and medium thirdlength of the groove

- Outer edge direct abdominal muscle

540. In the inguinal channel you can allocate: (1)

- 4 walls and 4 holes
- 4 walls and 2 holes
- 2 walls and 4 holes
- 4 walls and 3 holes

541 borders of the inguinal triangle are: (3)

- Groove bunch
- Horizontal line conducted from the border between the outer and medium thirdlength of the groin ligament
- Outer edge direct abdominal muscle
- White line

542. The inguinal gap is: (1)

- Distance between the outer and inland rings of the inguinal canal
- Distance between the inguinal bunch and the lower edges of the internal obliqueand transverse muscles
- Distance between the front and rear walls of the inguinal canal
- Inguinal gap does not exist

543. Space under a groove is divided into: (1)

- Herry, muscle and vascular lacuna
- Herge and vascular lacuna
- Muscular and vascular lacuna
- Muscular, vascular lacuna and female canal

544. Three education participate in the formation of the outer opening of the inguinal channel: (3)

- Splitted on the legs of the aponeurosis outer oblique muscle
- Transverse fascia
- Surface Fascia
- Pubic bone
- Interchangeable fibers

545. The front wall of the inguinal canal is: (1)

- Transverse fascia
- Aponeurosis outer oblique abdominal muscle
- Lower edges of the inner oblique and transverse muscles
- Groove bunch

546. The rear wall of the inguinal canal is formed: (1)

- Parietal peritonean
- Transverse fascia
- Aponeurosis of the outer oblique abdominal muscle

547. The lower wall of the inguinal canal is formed: (1)

- Lower edges of the inner oblique and transverse muscles
- Groin bale
- Swing fascia

- Aponeurosis of the outer oblique abdominal muscle

548. Spegheliev Line is a line: (1)

- Spent on the edge of the right hypochondrium
- Connecting the front top of the ileal bone
- Line of transition of muscle fibers of the transverse abdominal muscle inaponeurosis and projected by the outer edge of the live muscle of the abdomen

549. The lower edges of the inner oblique and transverse muscles are the wall of theinguinal canal: (1)

- Upper
- Nizhnya
- Front

550. The inguinal gap is: (1)

- Distance between the groove bundle and the lower edges of the internal obliqueand transverse muscles
- Distance between the groove bunch and transverse fascia
- Distance between the front and rear walls of the inguinal canal
- Inguinal gap does not exist

551. Space under a groin bunch is divided into: (1)

- Herge and muscular lacuna
- Herge and vascular lacuna
- Muscular and vascular lacuna
- Muscular, vascular lacuna and female canal

552. Anatomical prerequisite for the formation of inguinal hernia is: (1)

- Availability of inguinal gap
- The presence of a wide inguinal gap
- The absence of inguinal gap
- No intraperous fascia

553. In the inguinal channel you can allocate: (1)

- 4 walls and 2 holes
- 2 walls and 4 holes
- 4 walls and 3 holes

554. The patient is diagnosed with a straight grocery hernia. Anatomical by the exitof this type of hernia is: (1)

- Lateral groin yam
- Summary
- Medial Packing Pack
- Muscular lacuna
- Vascular lacuna

555. The front wall of the inguinal canal is: (1)

- Parietal peritonean
- Aponeurosis of the outer oblique abdominal muscle
- Bottom edges of the inner oblique and transverse muscles
- Pach bunch

556. The rear wall of the inguinal canal is formed: (1)

- Pakhovoy Big
- Transverse fascia
- Uponeurosis of the external braid abdominal muscle

557. The lower wall of the inguinal canal is formed: (1)

- Lower edges of the inner oblique and transverse muscles
- Groin bale
- Parietal peritoneum
- Aponeurosis of the outer braid abdominal muscle

558. Spegheliev Line is a line: (1)

- Spent on the edge of the right hypochondrium
- Spent on the edge of the left hypochondrium
- Line of the transition of muscle fibers of the transverse abdominal muscle in aponeurosis and projected by the outer edge of the live muscle of the abdomen

559. The lower edges of the inner oblique and transverse muscles are the wall of theinguinal canal: (1)

- Upper
- Rear
- Front

560. Anatomical place of the output of oblique groove hernia is: (1)

- Lateral groin yam
- Medial Packing Pack
- Muscular lacuna
- Outpunny Yamca
- Vascular lacuna

561. Anatomical prerequisite for the formation of inguinal hernia is: (1)

- The presence of a wide inguinal gap
- The presence of a narrow ink
- Lack of inguinal gap
- No intraperous fascia

562. In the inguinal channel you can allocate: (1)

- 3 walls and 3 holes
- 4 walls and 2 holes
- 4 walls and 3 holes

563. The front wall of the femoral canal is: (1)

- High Vienna
- Deep sheet of wide fascia hips
- Surface leaf of wide fascia hips
- Screw fascia

564. The rear wall of the femoral canal is: (1)

- Femoral vein
- Surface leaf of wide fascia hips
- Great Fascia

- Groove bunch

565. With a retrograde infringement (hernia type "W") in the jewelry bag: (1)

- Loop fine
- A bowl of colon
- Big gland
- Somewhat small intestine loops
- None of the options fit

566. Turning out the hernia bag in a patient with a disadvantaged groin hernia, the surgeon did not find altered intestinal dishes in it. In case of easy sinking for intestinal hinges from the abdominal cavity, the modified sections of the intestinal wall appeared. This forced him to think about the following form of infringement: (1)

- Kalov
- Prieuchena
- Retrograde
- Elastic

567. The front wall of the femoral canal is: (1)

1. High Artery

- Deep sheet of wide fascia hips
- Surface leaf of wide fascia hips
- Screw fascia

568. The rear wall of the femoral canal is: (1)

- High Vienna
- Poor nerve
- Surface leaf of wide fascia hips
- Great Fascia

569. During a surgery, the surgeon drew attention to a significant amount of fatty tissue on the posterior wall of the junk bag. The hernia bag contained loops of the small intestine, the blind and part of the ascending colon. Surgeon established availability: (1)

- Improved hernia
- Congenital hernia
- Sliding hernia

570. The rear wall of the inguinal canal strengthen: (1)

- With oblique gneezhe
- With a direct groin hernia
- With congenital groin hernia
- Determined by the desire of the surgeon

571. The incision during the operation about the groin hernia is: (1)

- Parallel to the groin bundle 2 cm below it
- Parallel to the groove bundle 2 cm above it
- According to the projection of the groove
- Above hernial bag

572. Indications for emergency operation are the following hernias of an advancedabdominal wall: (1)

- Published
- Sliding
- Unspecable
- All of the listed

573. When plastic in the inguinal canal according to the bassinity method, the groove is laid: (1)

- Over the seed campus the lower edges of the inner oblique and in the peppermuscle
- Under the seed cord of the edge of the muscles and the flap of the aponeurosis ofthe outer oblique abdominal muscle
- Under the seed campus the lower edges of the inner oblique and in the list ofpepper muscles, and over the rope - the flap of the aponeurosis by the scale of the abdominal muscle

574. Plastic in the inguinal channel according to the method of Girard-Spirkukovooso Schw Kimbarovsky in Hernia Surgery is used to treat hernia: (1)

- Disadvantaged
- Oblique inguinal
- Direct grooves
- Channel channel
- Undermines

575. Indications for emergency operation are the following hernias of an advancedabdominal wall: (1)

- Congenital
- Published
- Unspecable
- All of the listed

576. When plastic in the inguinal canal according to the method of bassini to a groinbunch: (1)

- Under the seed cords of the edge of the muscles and the flap of the aponeurosis ofthe outer oblique abdominal muscle
- Under the seed campus the lower edges of the inner oblique and in the list ofpepper muscles, and over the cords - the flap of the aponeurosis by the scale of the abdominal muscle
- Over the seed cords of the flap aponeurosis outer oblique abdominal muscle

577. With the plastic of the femoral channel on the bassinity, it is stitched by its walls: (1)

- Rear and media
- Lateral and media
- Front and rear
- Front and medial

578. The rear wall of the inguinal canal strengthen: (1)

- With a direct groin hernia
- With congenital groin hernia
- With the disadvantaged hernia
- Determined by the desire of the surgeon

579. The incision when surpassing the groin hernia is: (1)

- Parallel to the groin bundle 2 cm below it
- Parallel to the groove bundle 2 cm above it
- According to the projection of the groove
- Horizontally on the boundary of the outer and middle third of the length of thegroove bundle

580. In the patient after the operation of the hernia, about the oblique gentle herniain the near-postoperative period, a small swelling of the scrotum was observed, thickening of the seed rope and the egg seal. The reason for this was the following technical error: (1)

- Capture in seams of iliac-inguinal nerve
- Capture in the seam of the iliac-grade nerve
- Infringement of seed rope
- Capture in seam of the floor branch of the femoral-sex nerve

581. When forming a sliding hernia, the wall of the junk bag can be all organs except: (1)

- The descending division of the colon
- Blind gut
- Bladder
- Toling

582. The seed edge includes three anatomical elements: (3)

- Seed-moving duct
- Urinary duct.
- Vessels and the nerves of the seed-handing duct and eggs
- Details of the vaginal abnormal process
- Iliac-grade nerve

583. With the plastic of the femoral canal on the bassini, it is stitched by its walls: (1)

- Rear and lateral
- Lateral and media
- Front and rear
- Front and medial

584. In a patient after the operation of the hernias, there was a small swelling of thescrotum in the nearest postoperative period, a small edema of the scrotum, the thickening of the seed canopa and the egg seal were observed. The reason for this was the following technical error: (1)

- Capture in the suture of the muscle raising the testicle
- Capture in the seam of the iliac-grade nerve
- Infringement of seed rope

- Capture in seam of the floor branch of the femoral-sex nerve

585. When forming a sliding hernia, the wall of the junk bag can be all organs except: (1)

- The ascending Department of the Colon
- Blind gut
- Bladder
- Toling

586. Middle Laparotomic Accessories respond to three requirements: (3)

- Ensure compliance of the incision of an anatomical projection of the organ
- Provide sufficient exposure of the organ
- Have low traumatic
- Provide the formation of a solid postoperative scar

587. The "Crown of Death" is an option for the emergence of the artery: (1)

- Femren
- Nadd-free
- Lockable
- Internal iliac

588. With the plastic of the umbilical hernia, the MEYO method connects the following fabrics: (1)

- Right and left edge of the aponeurosis of wide abdominal muscles
- Upper and lower edge of the aponeurosis wide abdominal muscles
- Inner edges of the aponeurosis of the outer oblique muscle
- Interior edges of their own fascia

589. With the plastic of the umbilical hernia, the following fabrics combine the following fabrics: (1)

- Upper and lower edge of the aponeurosis of three wide abdominal muscles
- The inner edges of the aponeurosis of three wide abdominal muscles
- Internal edges of the aponeurosis of the inner oblique muscle
- Inner edges of the aponeurosis of the outer oblique muscle

590. When performing medium-median laparotomy: (1)

- The navel bypass right
- Pup's bypassing on the left
- Pupil dissect across
- The choice of the part does not matter

591. Transverse laparotomic access responds with three requirements: (3)

- Ensure compliance of the incision of an anatomical projection of the organ
- Provide sufficient exposure of the organ
- Possess low traumatic
- Ensure the formation of a solid postoperative scar

592. One of the symptoms of a number of diseases accompanied by a stagnation in the system of a portal vein is the expansion of subcutaneous veins in the umbilical region of the front abdominal wall. This is due to the presence here: (1)

- Arterio-venous shunts

- Kava-Cavalny Anastomoses
- Lymphonic venous anastomoses
- Porto-Cavalny Anastomoses

593. "Corona of Death" is an artery disheaval option: (1)

- Updated Nizhnya
- Upper Topper
- Lockable
- Internal iliac

594. With the plastic of the umbilical hernia, the meyo method connect the followingfabrics: (1)

- Right and left edge of the aponeurosis of wide abdominal muscles
- Upper and lower edge of the aponeurosis wide abdominal muscles
- Inner edges of the direct abdominal muscle
- Inner edges of the aponeurosis of the outer oblique muscle

595. The upper and lower left arteries with the accompanying veins accompanying:(1)

- In subcutaneous fatty tissue
- In the vagina direct abdominal muscles ahead of the muscles
- In the vagina direct abdominal muscles behind the muscles
- In the prettier fiber

596. With the plastic of the umbilical hernia, the following fabrics combine the following fabrics: (1)

- Internal edges of the live abdominal muscle
- The inner edges of the aponeurosis of three wide abdominal muscles
- Internal edges of the aponeurosis of the inner oblique muscle
- Inner edges of the aponeurosis of the outer oblique muscle

597. When performing medium-median laparotomy: (1)

- The navel bypass right
- Pup's bypassing on the left
- The navel dissect along
- The choice of the part does not matter

598. Portochpatography is carried out through: (1)

- Undermined Vienna
- Undermined artery
- Hepatic Vienna
- Large subcutaneous vein
- Lower hollow vein

599. The dome of the diaphragm on the right on the midcurbicular line is located atthe rib level: (1)

- IV
- V.
- VI
- VII.

600 Dome of the diaphragm on the left of the midcurcular line is located at the rib level: (1)

- III
- IV
- V
- VI

601. Breast lymphatic duct passes through a diaphragm with: (1)

- Esword
- Sympathetic barrel
- Aorta
- Wandering nerves

602. The unpaired and semi-park veins pass through a diaphragm of the retroperitoneal space to the mediastinum: (1)

- Between the medial and medium legs of the diaphragm
- Between the medium and lateral legs of the diaphragm
- Through aortic hole
- Together with the lower hollow veloy
- Through a tendral center of the diaphragm

603. Dome of the diaphragm on the right of the midcurbicular line is located at therib level: (1)

- III
- IV
- V.
- VI

604. Dome of the diaphragm on the left of the middle-hearth line is located at the riblevel: (1)

- IV
- V
- VI
- VII.

605. To the so-called weak points of the diaphragms in which the diaphragmal hernias may occur include the following three: (3)

- Breast-Rib Triangle
- Hole of the hollow vein
- Ecoming Hole
- Lumbar-Rib Triangle

606. Breast lymphatic duct passes through a diaphragm with: (1)

- Unpaired Vienna
- Sympathetic barrel
- Aorta
- Wandering nerves

607. To the so-called weak points of the diaphragms in which diaphragmal herniasmay occur include the following three: (3)

- Aortic hole
- Breast-Rib Triangle
- Ecoming Hole
- Lumbar-Rib Triangle

ABDOMINAL CAVITY

608. The projection line on the front abdominal wall, the corresponding border between the upper and lower floors of the abdominal cavity is carried out between:(1)

- Lower points X ribs
- Lower points of XII Ribs

609. The upper and lower floors of the abdominal cavity shares: (1)

- Gastrointestinal bunch
- Mesenter of transverse colon

610. In the upper floor of the abdominal cavity there are 4 organs: (4)

- Rising colon
- Stomach
- Liver with bubble
- Pancreas
- Spleen

611. Performing upper median laparotomy, the surgeon is able to revise the three abdominal organs: (3)

- Ascending colon
- Stomach
- Downward colon
- Liver
- Spleen

612. For its position, the duodenum refers: (1)

- To the lower floor of the abdominal cavity
- Located in both floors

613. The authorities of the abdominal cavity are five: (5)

- Rising colon
- Descending colon
- Liver with gall bubble
- Spleen
- Blind intestine with a heart-shaped process
- Sigmid
- Skinny and iliac

614. For its position, the duodenum refers: (1)

- To the upper floor of the abdominal cavity
- Located in both floors

615. The projection line on the front abdominal wall, the corresponding border between the upper and lower floors of the abdominal cavity is carried out between:(1)

- Lower points x ribs
- The upper points of the wings of the ileum bones

616. The upper and lower floors of the abdominal cavity shares: (1)

- Large seal
- Mesenter of transverse colon
- Fine gut mesentery

617. The upper and lower floors of the abdominal cavity shares: (1)

- Brysenter of the transverse colon
- Bryzheka small intestine

618. In the upper floor of the abdominal cavity there are 4 organs: (4)

- Stomach
- Liver with bubble
- Pancreas
- Spleen
- Sleeping gut with a heart-shaped process

619. Performing an upper median laparotomy, the surgeon gets the possibility of revising the three organs of the abdominal cavity: (3)

- Stomach
- Downward colon
- Liver
- Spleen
- Thorning gut

620. In the upper floor of the abdominal cavity there are 4 organs: (4)

- Stomach
- Liver with bubble
- Pancreas
- Spleen
- Sleeping gut with a heart-shaped process
- Skinny and iliac

621. From the listed organs are covered with trouser intraperitoneal: (6)

- Stomach
- Skinny and iliac
- Sleeping
- Cell-shaped process
- Rising colon
- Transverse colon
- Sigmid

622. From the listed organs are covered with peritoneous mesoperitoneal: (3)

- Liver
- Spleen
- Pancreas
- Duodenal gut
- Rising colon

- Transverse colon
- Downward colon

623. From the listed organs are covered with peritinous extperperitoneal: (2)

- Stomach
- Pancreas
- Spleen
- Duodenum
- Sleeping gut

624 In the upper floor of the abdominal cavity there are 4 organs: (4)

- Stomach
- Liver with bubble
- Pancreas
- Spleen
- Sigmoid gut
- Skinny and iliac

625. From the listed bodies are covered with peritinous mesoperitoneal: (3)

- Stomach
- Liver
- Pancreas
- Duodenal gut
- Rising colon
- Transverse colon
- Downward colon

626. From the digestive tract departments has the most pronounced muscular shell:(1)

- Stomach
- Duodenal gut
- Skinny gut
- Iliac gut
- Thick intestine

627. The wall of the small intestine contains the number of cases: (1)

- 2
- 3.
- 4.
- 5.

628. One of the principles of abdominal surgery is the operating on the body withdrawn. Determine the organs that can be removed into the laparotomousincision of the anterior abdominal wall without additional mobilization: (4)

- Stomach
- Duodenal gut
- Skinny and iliac
- Blind intestine with a worm-shaped process
- Rising colon

- Transverse colon
- Descending colon
- Sigmid

629. From the listed bodies are covered with peritinous extperperitoneal: (2)

- Pancreas
- Spleen
- Duodenal gut
- Sleeping gut

630 In the upper floor of the abdominal cavity are 4 organs: (4)

- Stomach
- Liver with bubble
- Pancreas
- Spleen
- Skinny and iliac

631. From the listed bodies are covered with peritinous mesoperitoneal: (3)

- Stomach
- Liver
- Duodenal gut
- Rising colon
- Transverse colon
- Descending colon

632. From the digestive tract departments has the most pronounced muscular shell:(1)

- Stomach
- Delighteentum
- Skinny gut
- Iliac gut
- Thick intestine

633. From the listed bodies are covered with peritinous extperperitoneal: (2)

- Liver
- Pancreas
- Spleen
- Duodenum
- Sleeping gut

634. From the digestive tract departments has the most pronounced muscular shell:(1)

- Food
- Stomach
- Skinny gut
- Iliac gut
- Thick intestine

635. The wall of the small intestine contains the number of cases: (1)

- 1

- 2
- 3
- 5

636. In the upper floor of the abdominal cavity there are 4 organs: (4)

- Stomach
- Descending colon
- Liver with bubble
- Pancreas
- Spleen
- Sigmidian

637. In the course of operational intervention, after additional mobilization (dissection of peritoneal ligaments), an organ: (can be thrown into operationalwound.

Stomach Transverse colonPancreas

638. With abdominal operations, three organs cannot be displayed in an operatingwound due to the peculiarities of their location, fixation and penetration cover: (3)

- Liver
- Duodenum
- Spleen
- Pancreas
- Sleeping gut

639. Install the appropriate anatomical formations that form the borders of the hepatic bag:

From above	1) side wall of the abdomen
In front	2) coronary bunch of liver
Rear	3) Front abdominal wall
From below	4) transverse colon
Right	5) the right dome of the diaphragm
Left	6) rib arc

640. When examining a patient with the spinning of the stomach ulcers, the symptom of the disappearance of hepatic stupidity is performed, which is due to the accumulation of air in: (1)

- Left subadiaphragmal space
- Guide
- Subniption
- Right subiaphragmal space

641. In the course of surgical intervention, after additional mobilization (dissectionof permanent ligaments), the body can be thrown into operational wound: (1)

- Liver
- Stomach
- Pancreas

642 In the upper floor of the abdominal cavity there are 4 organs: (4)

- Stomach
- Liver with bubble
- Pancreas
- Spleen
- Sigmoid gut

643. In the course of operational intervention, after additional mobilization (dissection of permanent ligaments), an organ: (can be thrown into operationalwound.

- Stomach
- Pancreas

644. With abdominal operations, three organs cannot be displayed in an operatingwound due to the peculiarities of their location, fixation and penetration cover: (3)

- Liver
- Duodenum
- Pancreas
- Sleeping gut

645. With abdominal operations, three organs cannot be displayed in an operating wound due to the peculiarities of their location, fixation and penetration coverage:(3)

- Liver
- Stomach
- Duodenal gut
- Pancreas
- Sleeping gut

646. When the stomach ulcers are performed, the exit air accumulates primarily inthe highest place of the abdominal cavity, which is: (1)

- Left subadiaphragmatic space
- Right subiaphragmatic space
- Barbag
- Guide

647. With abdominal operations, three organs cannot be displayed in an operating wound due to the peculiarities of their location, fixation and penetration coverage:(3)

- Liver
- Duodenum
- Pancreas
- Sleeping gut

648. Install the appropriate anatomical formations that form the boundaries of thebargaining bag:

- From above — a) side wall of the abdomen
- Bottom — b) diaphragm
- In front — c) stomach

- Rear
- Right
- Left

d) Small gland
d) Front abdominal wall
e) transverse colon

649. In the bargain bag are: (12)

- Gallbladder
- Left lodge
- Pancreas
- Spleen

650. From the listed bodies are covered with trouser intraperitoneal: (6)

- Stomach
- Skinny and iliac
- Sleeping
- Cell-shaped process
- Transverse colon
- Descending colon

1. Sigmid

651. The abdominal cavity authorities include five: (5)

- Rising colon
- Stomach
- Descending colon
- Pancreas
- Searenka.
- Blind intestine with a heart-shaped process
- Sigmid
- Skinny and iliac

652. In the bargain bag are: (12)

- Left lodge
- Pancreas
- Right Liver Share
- Spleen

653. The sickle-shaped ligament of the liver divides: (1)

- Right and left subdiaphragmatic spaces
- Pre-ventricular and omentum bags omentum

654. All Education, except: (1)

- Horizontal part of the duodenum
- Hepatic curvature of transverse colon
- Large gland
- Upper pole of the right kidney

655. Pushun covers the liver from all sides, besides its surface: (1)

- Upper
- Front
- Rear
- All answers are incorrect

656. The right side canal of the abdominal cavity communicates with all the formations except: (1)

- Hepatic bag
- Sunting space
- Casually small pelvis
- Cavities in the gland bag
- Right mesenteric sinus

657. In the bargain bag are: (12)

- Gallbladder
- Left lodge
- Pancreas
- Spleen

658. From the listed bodies are covered with trouser intraperitoneal: (6)

- Stomach
- Skinny and iliac
- Sleeping
- Cell-shaped process
- Transverse colon
- Descending colon
- Sigmid
- Pancreas

659. The authorities of the abdominal cavity are five: (5)

- Rising colon
- Stomach
- Descending colon
- Selezenka
- Blind intestine with a heart-shaped process
- Sigmid
- Skinny and iliac

660. Sick-shaped liver bunch shares: (1)

- Guideline and Pregnant Bag
- Right and left subiaphragmatic spaces

661. All Education, except: (1), will be adjacent to the lower liver surface.

- Horizontal part of the duodenum
- Large gland
- Upper pole of the right kidney

662. Pushun covers the liver from all sides, besides its surface: (1)

- Front
- Rear
- All options for answers are incorrect

663. The left side canal of the abdominal cavity is communicated with: (1)

- Heat bag
- Bysting space

- The cavity of a small pelvis
- The cavity of the gland bag
- Left mesenter sinus

664. All Education, except: (1)

- Stomach
- Horizontal part of the duodenum
- Large gland
- Upper pole of the right kidney

665. Pushun covers the liver from all sides, besides its surface: (1)

- Upper
- Front
- Rear
- All answers are incorrect

666. The following three ligaments include the following three ligaments: (3)

- Diaphragm and gastric
- Gastrointestinal
- Hepatic duodenal
- Liver and gastric

667. In relation to the vertebral pillar, the gallbladder is at the vertebral level: (1)

- X chest
- XI chest
- I lumbar
- Ipoya

668. Know the components of the parties of the triangle Calo is necessary when performing: (1)

- Cholecystostomy
- Cholecystoyunastomoz
- Cholecyshoduodenaistomoz
- Cholecystectomy
- Recreation of the liver

669. Install the appropriate anatomical formations that form the walls of the glandbag:

- Upper — a) mesenter transverse colon
- Lower — b) stomach
- Front — c) gastrointestinal bunch
- Rear — d) small gland

e) rear sheet of parietal peritoneum
f) transverse colon
g) taper share of the liver

670. All formations in addition to the back of the stomach, except: (2)

- Left lobe liver
- Rear sheet of parietal peritoneum
- Pancreas

- Spleen
- Abdominal aorta

671. The following three bundles include the following three ligaments: (3)

- Diaphragm and gastric
- Gastrointestinal
- Hepatic duodenal
- Liver and gastric

672. The following three bundles include the following three ligaments: (3)

- Diaphragm and gastric
- Gastrointestinal
- Spiece-colon
- Hepatic duodenal
- Liver and gastric

673. In relation to the vertebral pillar, the gallbladder is at the vertebral level: (1)

- IX chest
- XI chest
- I lumbar
- Ipoya

674. In relation to the vertebral pillar, the gallbladder is at the vertebral level: (1)

- XI chest
- XII chest
- I lumbar

675. All formations in front of the stomach, except: (21)

- Transverse colon
- Front abdominal wall
- Fine intestine

676. Install the appropriate anatomical formations forming the borders of the stuffing hole:

• Upper	a) Liver and duodenal bunch
• Lowe	b) Liver and renal bunch and lower hollow vein
• Rear	c) renal-duodenal bunch
• And duodenal gut	d) tail fraction of liver

677. In a patient with a sprinkling of the rear wall of the stomach, the gastric contents were in the right iliac yam at the blind intestine, where they caused symptoms simulating the attack of appendicitis. Specify 4 formations that make upthe consistent path of income of the gastric content in this area: (4)

- Sunny space
- Right side channel
- Right mesenter sinus
- Barbag
- Suite Bag
- Selnitic hole
- The gap ahead of the transverse colon

694. Intraper hernias can occur in the following three places of the abdominal cavity, in accordance with the location of the permanent pockets: (3)

- Behind the twelve-dimensional bend
- In the region of the ileocecal corner
- In the region of the hepatic bending of the colon
- In the region of the sealer bending of the colon
- Behind the mesentery of the sigmoid gut
- Ahead of the mesentery of the Sigmid

695. The most likely ways of spreading purulent peritonitis from the right side channel are two: (2)

- Hepatic Bag
- Right mesenter sinus
- Brown pelvis

696. The lateral border of the right-hand mesenteric sinus is: (1)

- The root of the mesentery of the small intestine
- Medical edge of the ascending colon
- Right side wall of the abdomen
- Lateral edge of the ascending colon

697. The most likely ways of spreading purulent peritonitis from the right side channel are two: (2)

- Hepatic Bag
- Left mesenter sinus
- Left side canal
- Bridal floor of a small pelvis

698. The patient purulent appendicitis was complicated by the formation of intraperitoneal subadiaphragmal abscess. Determine the path of distribution of infection by: (1)

- Big sanguisa
- Right side canal
- Agricultural fiber of ascending colon

699. The stomach is bustling with arteries, outgoing: (1)

- Only from the vent
- Only from the upper mesenteric artery

700. Left gastrointestinal artery originates from: (1)

- Left gastric artery
- Crying trunk
- Right gastric artery
- Spleen artery
- Upper mesenteric artery

701. In the system of the upper floor of the vein, the blood from the stomach is subject to veins: (1)

- Spilenkoe
- Left gastrointestinal

- Left ventricle
- Gastrointestinal

702. The most likely by the spread of purulent peritalis from the right mesenteric sinus is: (1)

- Left mesenter sinus
- Left side canal

703. The duodenum is bustling all arteries, except: (1)

- Right gastric artery
- Right gastrointestinal artery
- Upper pancreatic-duodenal artery
- Bottom pancreatic and duodenal artery
- The right renal artery

704. In a patient, purulent appendicitis was complicated by the formation of intraperitoneal subadiaphragmal abscess. Determine the path of distribution of infection by: (1)

- The front wall of the ascending colon
- Right side canal
- Agricultural fiber of ascending colon

705. The stomach is bustling with arteries, outgoing: (1)

- Only from the vent
- From the ventricular barrel and the upper mesenteric artery

706. The most likely by the spread of purulent perita from the right mesenteric sinus is: (1)

- Left mesenter sinus
- Right side channel

707. The lateral border of the right-hand mesenter sinus is: (1)

- The root of the mesentery of the small intestine
- Medical edge of the ascending colon
- Lateral edge of the rising colon

708. The most likely ways of spreading purulent peritonitis from the right side channel are two: (2)

- Hepatic Bag
- Left mesenter sinus
- Brown pelvis

709. The patient purulent appendicitis was complicated by the formation of intraperitoneal subadiaphragmal abscess. Determine the path of distribution of infection by: (1)

- Right side canal
- Agricultural fiber of ascending colon

710. Left gastrointestinal artery originates from: (1)

- Clawed trunk
- Right gastric artery
- Spleen artery

- Upper mesenteric artery

711. In the system of the upper floor of the vein, blood from the stomach is subjectto veins: (1)

- Left gastrointestinal
- Left ventricle
- Gastrointestinal

712. The blood vein system from the stomach is subject to veins: (4)

- Spleen
- Right gastrointestinal
- Left Gastrointestinal
- Left gastric
- All response options are incorrect

713. One of the complications of the stomach ulcer disease is gastric bleeding. Mostoften to this brought ulcers located on: (1)

- The front wall of the body of the stomach
- The rear wall of the body of the stomach
- Small Curvatus of the Stomach
- Great Curvatina Stomach

714. With a subtotal resection of the stomach during its mobilization of its large curvature, not only gastrointestinal, but also a gastrointestinal bunch was crossed. After the operation, necrosis of the stomach cult was developed, which was due to the dressing and intersection: (1)

- Short gastric arteries
- Left gastric artery
- Left gastrointestinal artery
- Selete artery

715. The most pronounced arterial and venous plexuses of hollow organs of the abdominal cavity are located in: (1)

- Serous sheath
- Submucous basis
- Mucous membrane

716. The tightness of the intestinal anastomosis ensures the execution of the seams on: (1)

- Serous Muscular Case
- Mucoby-lower case

717. In the system of the upper floor of the vein, blood from the stomach reaches theveins: (1)

- Right gastrointestinal
- Left gastrointestinal
- Left ventricle
- Gastrointestinal

718. In the system of the portal vein, the blood from the stomach is subject to veins:(4)

- Spleen
- Right gastrointestinal
- Left Gastrointestinal
- Left gastric
- All response options are not true.

719. One of the complications of the stomach ulcer disease is gastric bleeding. Mostoften to this brought ulcers located on: (1)

- The front wall of the body of the stomach
- The rear wall of the body of the stomach
- Small Curvatus of the Stomach
- Rear wall of the pyloric part of the stomach

720. With a subtotal resection of the stomach during the mobilization of its large curvature, not only gastrointestinal, but also a gastrointestinal bunch was crossed. After the operation, necrosis of the stomach cult was developed, which was due to the dressing and intersection: (1)

- Short gastric arteries
- Left gastric artery
- Searel artery

721. One of the complications of the ulcer of the stomach is gastric bleeding. Mostoften to this brought ulcers located on: (1)

- The back wall of the body of the stomach
- Low Curvatina Stomach
- Great stomach curvature

722. With a subtotal resection of the stomach during its mobilization of its large curvature, not only gastrointestinal, but also a gastrointestinal bunch was crossed. After the operation, necrosis of the stomach cult was developed, which was due to the dressing and intersection: (1)

- Short gastric arteries
- Left gastrointestinal artery
- Searel artery

723. The most pronounced arterial and venous plexuses of hollow organs of the abdominal cavity are located in: (1)

- Serous sheath
- Submucous basis
- Mucous membrane
- Muscular shell

724. The most pronounced arterial and venous plexuses of hollow organs of the abdominal cavity are located in: (1)

- Muscular sheath
- Submucous basis
- Mucous membrane

725. The tightness of the intestinal anastomosis ensures the execution of the seams on: (1)

- Serous Muscular Case
- Muscular shell

726. In the system of the portal vein, the blood from the stomach exposes on the veins: (4)

- Spleen
- Right gastrointestinal
- Left Gastrointestinal
- Left gastric
- All response options are true.

727. One of the complications of the stomach ulcer disease is gastric bleeding. Mostoften to this brought ulcers located on: (1)

- The back wall of the body of the stomach
- Low Curvatina Stomach
- Rear wall of the pyloric part of the stomach

728. Connect serous surfaces when applying intestinal seam suggested: (1)

- Cherni.
- Lambera
- N.I. Pirogov
- Schmiden
- I.D. Kirpatovsky

729. To flash all the shells when performing an intestinal seam suggested: (1)

- Bilrota
- Albert.
- Gel
- Velfler

730. Two-row seam is used for operations on: (3)

- Stomach
- Duodenal intestine
- Fine intestine
- All of the above bodies

731. Three-row seam applies during operations on: (1)

- Stomach
- Fine gum
- Tolstone
- All of the above bodies

732. The misstate of the mucous-sublimated case occurs: (1)

- After 7-10 days
- After 20 days
- After 1 month
- More than 1 month

733. Three-row seam applies during operations on: (1)

- Thin intestine
- Tolstone

- All of the above bodies

734. The fascinating of the mucinous submissible case occurs: (1)

- After 1 day
- After 7-10 days
- More than 1 month
- Over 2 months
- More than 3 months

735. Gastrostomy is: (1)

- Introduction Probe to the stomach cavity
- Formation of artificial outdoor stomach fistula
- Formation of gastrointestinal anastomosis
- Removing part of the stomach

736. When performing gastrostomas for the method of strain-cader, a fistula isformed: (1)

- Luxury
- Tubular
- Longitory
- Circular

737. When performing gastrostomy by the foster method, a fistula is formed: (1)

- Lipid
- Tubular
- Cross
- Circular

738. The lipid fistula channel is lined with a membrane of a hollow organ: (1)

- Muscular
- Mucous
- Sublifious
- None of these shells

739. The surface of the tubular fistula is cleaned by the shell of a hollow organ: (1)

- Serous
- Muscular
- Mucous
- None of these shells

740. To flash all the shells when performing an intestinal seam suggested: (1)

- Albert.
- Gel
- Velfler

741. Two-row seam is used for operations on: (3)

- Stomach
- Duodenal intestine
- Fine intestine
- All of the above bodies
- None of the listed bodies

742. The three-row seam is applied at operations on: (1)

- Stomach
- Fine gum
- Tolstone
- All of the above bodies
- None of the listed bodies

743. Three-row seam applies during operations on: (1)

- A duodenalist
- Fine gum
- Tolstone
- All of the above bodies

744. The fascination of the mucous-sublimated case occurs: (1)

- After 1 day
- After 7-10 days
- After 1 month
- More than 1 month

745. Gastrostomy is: (1)

- Introduction Probe to the stomach cavity
- Imposition of artificial outdoor stomach fistula
- Drying the wall of the stomach for the extraction of the foreign body followed bythe wound sewing
- Removing part of the stomach

746. In the formation of gastrostomas, a fistula is formed by the Cadier strain method: (1)

- Luxury
- Tubular
- Longitory
- Cross

747. To flash all the shells when performing an intestinal seam suggested: (1)

- Pean
- Albert.
- Gel
- Velfler

748. Two-row seam is used for operations on: (3)

- Stomach
- Duodenal intestine
- Fine intestine
- Colon

749. When performing gastrostomas by the fierce method, a fistula is formed: (1)

- Lipid
- Ltdity
- Cross
- Circular

750. The lipid fistula channel is lined with a shell of a hollow organ: (1)

- Serous
- Mucous
- Sublifious
- None of these shells

750. The lipid fistula channel is lined with a shell of a hollow organ: (1)

- Serous
- Mucous
- Sublifious
- None of these shells

751. The surface of the tubular fistula is covered with a shell of a hollow organ: (1)

- Serous
- Muscular
- Sublifious
- None of these shells

752. Hole in the organ after removal of the tube can close independently when fiction: (1)

- Lithuanid
- Tubular

753. Indications for performing a fistula on the stomach are: (3)

- Stenosis of the gatekeeper
- Acute intestinal obstruction
- Basic Esophageard Cancer and Cardial Stomach Department
- Stenosis of the esophagus
- Esophageal rupture

754. During the formation of gastrostomas by the method of strain-kader, a fistulais formed: (1)

- Luxury
- Tubular
- Longitory
- Cross
- Cross-time

755. To flash all the shells when performing an intestinal seam suggested: (1)

- Pean
- Albert.
- Gel
- Velfler
- Carrel

756. Two-row seam is used for operations on: (3)

- Stomach
- Duodenal intestine
- Fine intestine
- Tolstoy Kishka

- Liver

757. The gastrostomy is known, in which the rubber tube is sewn into the front wall of the stomach with the formation of the channel, at the end of which the tube is introduced into the cavity of the stomach, and the other end of it is displayed through the front abdominal wall outward. This method is called Gastrostomy by: (1)

- Vitzel
- Cader
- Topner
- Sapozhkov

758. The lipid fistula channel is lined with a hollow organ with a shell: (1)

- Serous
- Mucous
- Sublifious
- Muscular
- None of these shells
- All specified shells

759. The surface of the tubular fistula is lined with a shell of a hollow organ: (1)

- Serous
- Muscular
- Sublifious
- None of these shells
- None of these shells
- All specified shells

760. In children of gastrostomy can be performed by administering to the gastric cavity of the rubber tube perpendicular to the front wall and fixing it to: the wall of the stomach 2-3 concentricly superimposed with brine, weaving the wall of the stomach and creating a canal wall, seeded by a serous stomach case around the tube. This method is called Gastrostomy by: (1)

- Witzel
- Kadera
- Sapozhkov

761. Warning of food pits into a free abdominal cavity at gastrostomy is achieved byexecution: (1)

- Gastropcs
- Dressing the right gastric artery
- Tamponads of the Big Salna
- Creating a muscular bar

762. By performing resection of the stomach, the surgeon put the gastrointestinal anastomosis between the stomach stomach and the duodenalist in the end to the end. This method is called resection: (1)

- Bilrot I
- Bilrot II

- According to the Gofmister-Finterer

763. The resection of the stomach is known, at which, after removing the distal part of the stomach, the culture of the stomach and duodenum is inserted tightly, and thegastrointestinal anastomosis on-launder on the front wall of the stomach with the loop of the small intestine by the type "side in the side". This method is called resection: (1)

- Bilrot I
- Bilrot II
- According to the Gofmister-Finterer
- Onmoineena

764. Selective wagotomy with stomach ulcer disease should be combined with: (1)

- Resection of the anthral department
- Resection of the piloroantral department
- Draining operations on jainemikulich or Finne
- Sympathetic liver denervation
- Resection 1/2 stomach

765. The surgical department entered the patient with the probulous gastric body, located on its front wall in a small curvature. Clinical symptoms began to fly, whichwas the basis for making the diagnosis of punching perfolation. Determine the mostlikely body, at the expense of which there was a cover of the punch of ulcers: (1)

- Large seal
- Diafragma
- Liver
- Spleen

766. In children of gastrostomy can be performed by administering to the gastric cavity of the rubber tube perpendicular to the front wall and fixing it to: the wall of the stomach 2-3 concentrically superimposed with brine, weaving the wall of the stomach and create a canal wall, seeded by a serous stomach case around the tube. This method is called Gastrostomy by: (1)

- Cader
- Freewire
- Sapozhkov

767. Warning of food pillage into a free abdominal cavity at gastrostomy is achievedby execution: (1)

- Gastropcs
- Tamponads of the Big Self
- Creating a muscular bar

768. By performing resection of the stomach, the surgeon imposed gastrointestinal anastomosis between the stomach stomach and the duodenalist in the "End to End"type. This method is called resection: (1)

- Bilrot I
- Bilrot II
- According to Finterer

- Byfinterer
- According to the Hofmeuser-Finterer

769. The resection of the stomach is known, in which, after removing the distal part of the stomach, the culture of the stomach and duodenum is stuck tightly, and the gastrointestinal anastomosis is on-laid on the front wall of the stomach with the loopof the small intestine. This method is called resection: (1)

- Bilrot I
- Bilrot II
- Onmoineen

770. Warning of food pillage into a free abdominal cavity at gastrostomy is achievedby execution: (1)

- Gastropcs
- Creating an artificial valve
- Tamponads of the Big Salna
- Creating a muscular bar

771. By performing resection of the stomach, the surgeon put the gastrointestinal anatomosis between the stomach stomach and the duodenalist in the end to the end. Thismethodiscalledresection: (1)

- Bilrot I
- Bilrot II
- Onmoineen

772. With a point (rod) penetrating wound of the small intestine, it is necessary to perform: (1)

- One series of individual nodular serous muscular seams
- Serous-muscular brush seams with immersion of the edges of the wound in the intestinal lumen
- Two-row intestinal seam (Schmiden + Lambert)
- Two-row intestinal seam (tiled + Lamber)
- Economical gut resection

773. The patient is diagnosed with an ulcer on the rear wall of the body of the stomach, penetrating in: (1)

- Left kidney
- Liver
- Pancreas
- Transverse colon
- Spleen

774. The composition of the hepatic and duodenal ligament includes: (31)

- Lower hollow vein
- Common liver duct
- Right gastric artery
- Own hepatic artery

775. In relation to hepatic veins, the following statement of hepatic veins are correct: (1)

- Go out from the gate of the liver and fall into the gate vein
- Go on the back surface of the liver and fall into the lower hollow vein

776. The bottom of the gallbladder is projected on the front abdominal wall at the point: (1)

- Intersection of the outer edge of the right-hand abdominal muscle with the rib arc
- Crossing the right media removal line with the rib arc

777. During the execution of cholecystectomy, the bubble artery is determined at thebase of the triangle of CALO, the side parties of which are two anatomical entities: (2)

- Common bile duct
- Common liver duct
- Right liver duct
- Bubble duct

778. Determine the sequence of parts of the total bile duct: (4)

- Intramural part
- Hardened part
- Pancreatic part
- Retroduodenal part

779. Mutual arrangement in the hepatic duodenal bunch of common bile duct, its own hepatic artery of the portal vein as follows: (1)

- Artery for the free edge of the ligament, the left of the left, Vienna between themand the Forward
- Duct on the free edge of the ligament, the artery of the left, Vienna between themand the stop
- Vienna via the free edge of the ligament, the left of the left, the duct between them and the kice
- Doc on the free edge of the ligament, Vienna to the left, the artery between themand the kice

780. The patient has a diagnosed ulcer on the back wall of the gastric body penetrating in: (1)

- Liver
- Pancreas
- Transverse hatch
- Searenka.

781. The hepatic and duodenal ligament includes: (31)

- Common liver duct
- Right gastric artery
- Own hepatic artery

782. In relation to liver veins, the following statement of hepatic veins are correct:(1)

- Go out from the gate of the liver and fall into the gate vein
- Go on the back surface of the liver and fall into the lower hollow vein
- Go out from the gate of the liver and fall into the lower hollow vein

783. In relation to the hepatic veins, the following is the following assertion of hepatic veins: (1)

- Go out on the rear surface of the liver and fall into the unpaired vein
- Go on the back surface of the liver and fall into the lower hollow vein

784. The bottom of the gallbladder is projected on the front abdominal wall at the point: (1)

- Intersection of the outer edge of the right-hand abdominal muscle with the rib arc
- Between the right and medium thirds of the horizontal line connecting the lowerends X ribs

785. During the execution of cholecystectomy, the bubble artery is determined at thebase of the triangle of CALO, one of the lateral stories of which is: (1)

- Common bile duct
- Right liver duct
- Bubble duct

786. During the execution of cholecystectomy, the bubble artery is determined at thebase of the triangle of Calo, the side parties of which are two anatomical education: (3)

- Common bile duct
- Common liver duct
- Right liver duct
- Bubble duct
- Pancreatic Dump
- Edge of liver

787. During the execution of cholecystectomy, the bubble artery is determined at thebase of the triangle of CALO, the side parties of which are two anatomical education: (2)

- Common liver duct
- Right liver duct
- Bubbleduct
- Own hepatic artery

788. The hepatic and duodenal ligament includes: (31)

- Right Vienna
- Common liver duct
- Right gastric artery
- Ownhepaticartery

789. For a temporary stopping of bleeding from the liver, you can pour your fingersa liver and duodenal bunch: (1)

- For 2-3 minutes
- For 5-10 min
- For 15-20 min
- For 25-30 min
- Pressing time is determined by the need to complete bleeding

790. The crank trunk is usually divided into: (3)

- Left gastric artery
- Upper mesenteric artery
- Lower mesenteric artery
- Spleen artery
- Overall hepatic artery
- Vile-bubble artery

791. Determine the more frequent option of the relationship of finite departments ofthe total bile and pancreatic ducts: (1)

- Both duct opens on their own
- Both duks form a common hole
- Bothduks form a general ampoule

792. Combined lesions of the biliary liver and pancreas system are known, for example, cholecystopancreatitis. Ana-tomic basis of such lesions can be: (1)

- Community of the source of blood supply from the ventricular barrel
- Outflow of venous blood from the pancreas in the liver
- The merger of finite departments of general gall and pancreatic ducts

793. When performing cholecystostomy, the wall of the gallbladder around the drainage tube is fixed to the layers of the abdominal wall: (1)

- Parietal Pushin
- Parietal peritoneum and skin
- Skin
- Internal abdominal muscle and skin

794. After removing the gallbladder, its beds usually close: (1)

- Plate of fascia
- Part of the Big Self
- Residues of the serous cover of the gallbladder
- Parentheim liver with tightening seams

795. The blood supply to the pancreas is carried out by the branches of the three arteries: (3)

- Upper mesenter
- Gastrointestinal
- Lower mesenteric
- Renal
- Spleen

796. For stove injuries, you can use: (3)

- Single Ketgutic Sews
- Closing the wound plate of fascia
- Muscle
- Plastic free seal
- Plastic with a blanket with a leg

797. The combined lesions of the biliary liver system and the pancreas are known, for example, cholecystopancreatitis. Ana-tomic basis of such lesions can be: (1)

- Outflow of venous blood from the pancreas in the liver

- The merger of finite departments of general bile and pancreatic ducts
- Test topographicanomatic relationships between pancreas and common bull duct**798. When performing cholecystostomy, the wall of the gallbladder around the drainage tube is fixed to the layers of the abdominal wall: (1)**
- Parietal Pushin
- Parietal peritoneum and skin
- Uponeurosis of the outer oblique muscle
- Internal abdominal muscle and skin

799. After removing the gallbladder, its beds usually close: (1)
- Part of the muscle from the front abdominal wall
- Part of the Big Self
- Residues of the serous cover of the gallbladder
- Parentheim liver with tightening seams

800. The Kuznetsov-Pensky suture is used for suturing wounds: (1)
- Intestines
- Aponeurosis
- Stomach
- Esophagus
- Liver

801. One of the early clinical symptoms of cancer of the pancreas head may be theappearance of signs of jaundice, which is due to (1):
- Development of early metastasis in the liver
- Germinating a tumor into the wall of the duodenum in the region of a largeduodenal papilla
- Compression of the tumor of the total bile duct

802. Destructive pancreatitis may be complicated by peritonitis, which is most oftendeveloping in: (1)
- Pregnant bag
- The gland bag
- Left mesenter sinus
- Right-mesenteric sinus

803. Three education is located behind the head of the pancreas: (3)
- Power Vienna
- Duodenal gut
- Lower hollow vein
- General bull duct
- Right kidney

804. Viennic blood from five bodies will be subject to a portal vein: (5)
- Stomach
- Supplements
- Colon
- Liver
- Pancreas

- Kidneys
- Spleen
- Fine intestine

805. Three education are located behind the head of the pancreas: (3)

- Abdominal Aorta
- Passion Vienna
- Lower hollow vein
- General bull duct
- Right kidney

806. Venous blood from three organs recesses the lower hollow vein: (3)

- Stomach
- Adrenal glands
- Coloring gut
- Liver
- Pancreas
- Kidneys
- Selezenki.
- Thin nose

807. To stop bleeding from parenchymal organs, it is advisable to use seam: (2)

- Kuznetsova-Pensky
- Schmiden
- Alberta
- Opel

808. Soohkuznetsova-Pensky use for stake wounds: (1)

- Skin
- Uponeurosis
- Kiska
- Liver

809. Behind the head of the pancreas are located three education: (2)

- Duodenal gut
- Lower hollow vein
- Common bull duct
- Right kidney

810. Viennic blood from four organs recesses the venous vein: (4)

- Stomach
- Supplements
- The liver
- Pancreas
- Kidney
- Spleen
- Fine intestine

811. Behind the head of the pancreas are two education: (2)

- Abdominal Aorta

- Lower hollow vein
- Common bull duct
- Right kidney

812. One of the early clinical symptoms of cancer of the pancreas head can be the appearance of signs of jaundice, which is due (1):

- Metasicizing the tumor into lymph nodes of the leaf gate area
- Germinating a tumor into the wall of the duodenum in the region of a largeduodenal papilla
- Compression of the tumor of the total bile duct

813. Destructive pancreatitis may be complicated by peritonitis, which is most oftendeveloping in: (1)

- Hepatic bag
- The gland bag
- Left mesenter sinus
- Right-mesenteric sinus

814. Basic principles of seams of parenchymal organs: (3)

- The use of rare seams in places location of the largest vessels
- The use of P-shaped seams that impede the teething of tissues and contributing to squeezing bleeding vessels
- Capture in seam fibrous capsule to avoid rubberizing seams
- The use of a large seal with a hemostatic target, as well as to avoid rubberizingseams
- Turning on Muscle flap seam

815. One of the early clinical symptoms of the cancer of the pancreas head can be the appearance of signs of jaundice, which is due to (1):

- Metasicizing the tumor into lymph nodes of the leaf gate area
- Germinating a tumor into the wall of the duodenum in the region of a largeduodenal papilla
- Compression of the tumor of the total bile duct
- Metasicing the tumor into the right share of the liver
- Metasicing the tumor into the left loss of the liver

816. With splenectomy, the artery and vein of the spleen should be tied up: (1)

- In the gastrointestinal bundle, it is possible closer to the gate of the spleen in orderto avoid damage to the short branches to the stomach, as well as the tail of the pancreas
- The spleen artery is tied up at the place of her disheaval from the vent
- The spleen artery and vein should be tied up in the pancreas and spleen bond **817. Maskilize the spleen as much as possible and bring it into the wound allowsdissection: (2)**

- Diaphragm-spleen ligament
- Pancreatic spleen bunch
- Spleen and colon
- Gastrointestinal Bundles

818. The blood supply to the pancreas is carried out by the branches of the three arteries: (3)

- Upper mesenter
- Gastrointestinal
- Renal
- Spleen

819. To stop bleeding from parenchymal organs, it is advisable to use seam: (2)

- Kuznetsova-Pensky
- Lambon
- Alberta
- Opel

820. When operating on the organs of the abdominal cavity, the surgeon conducts anesthesia of the root root of the small intestine, located along the line: (1)

- From the spleen bending of the colon to the blind intestine
- From the left half of the body of the 1st lumbar vertebra to the right sacratling and ileum
- From the left half of the body of the 2nd lumbar vertebrae to the right sacratlingand ileum
- Vertically along the lumbar spine

821. The blood supply to the cushion is carried out at the expense of the branches ofthe arteries: (1)

- Lower mesenteric
- Upper mesenter
- Spleen
- Left and right gastrointestinal

822. The blood supply to the ileum is carried out at the expense of the branches of the arteries: (1)

- Lower mesenteric
- Upper mesenter
- General hepatic
- Left and right gastrointestinal

823. Maskilize the spleen as much as possible and bring it into the wound allows dissection: (2)

- Diaphragm-spleen ligament
- Pancreatic spleen bunch
- Spleen and colon
- Gastrointestinal Bundles
- Liver and gastric ligament

824. Pancreas blood supply is carried out by the branches of the three arteries: (3)

- Upper mesenter
- Gastrointestinal
- Renal
- Spleen

- Hepatic

825. The venous outflow from the peak is carried out in the Vienna system: (1)

- Lower hollow
- Upper hollow
- Pass
- Passion and lower hollow
- Paletandupperhollow

826. The length of the root mesentery of the small intestine in an adult is: (1)

- 5-10 cm
- 10-15 cm
- 15-20 cm
- 20-25 cm

827. With splenectomy, the artery and vein of the spleen should be tied up: (1)

- Between gastrointestinal and gastrointestinal ligaments
- The spleen artery is tied up at the place of her disheaval from the vent
- The spleen artery and vein should be tied up in the pancreas and spleen bond **828. Maskilize the spleen as much as possible and bring it into the wound allowsdissection: (2)**
- Diaphragm-spleen ligament
- Pancreatic spleen bunch
- Diaphragm and gastric ligament
- Gastrointestinal Bundles

829. Pancreas blood supply is carried out by the branches of the three arteries: (3)

- Upper mesenter
- Gastrointestinal
- Left ventricle
- Spleen

830. Mekkel'sdiverticulus is: (1)

- Unexpressed urinary duct
- Uncassedumous Vessels
- Embryonic residue of the yolk-intestinal duct

831. The cause of the thin intestine in the late stage of the abdominal typhoid may be: (1)

- Necrosis of Peyer Plaques
- Necrosis of the intestine
- The defeat of the nervous apparatus of the intestine

832. Artery take part in the blood supply to the stomach: (4)

- Left gastric
- Right gastric
- Branches of Riolane Arc
- Right gastrointestinal
- Left gastrointestinal

833. Two-row seam, consisting of through sutures through all the shells of the intestinal wall and serous-serous seam, is called seam: (1)

- Albert
- Lambon
- Cherni.
- Schmiden

834. The blood supply is carried out at the expense of the branches of the arteries:(1)

- Upper mesenter
- Spilenkoe
- General hepatic
- Left and right gastrointestinal

835. The blood supply to the ileum is carried out at the expense of the branches of the arteries: (1)

- Lower mesenteric
- Upper mesenter
- Spleen
- General hepatic

836. Maskilize the spleen as much as possible and bring it into the wound allows dissection: (2)

- Diaphragm-spleen ligament
- Pancreatic spleen bunch
- Diaphragm and gastric ligament

837. Pancreas blood supply is carried out by the branches of the three arteries: (3)

- Upper mesenter
- Left hepatic
- Gastrointestinal
- Left gastric
- Spleen
- General hepatic
- Right liver

838. Mekkel'sdiverticulus is: (1)

- Uncassed Upper Vessels
- Embryonic residue of the yolk-intestinal duct
- Embryonic residue of the primary intestinal tube

839. The inserting pass through the seam through all the shells of the intestinal wallis called seam: (1)

- Alberta
- Lambon
- Pirogov-Bira
- Cherni.
- Schmiden

840. When performing intercircuit anastomosis "side in side" use sequentially individual seams (by the authors): (1)

- Lambera - Zhea - Schmeden - Lambera
- Weave Schmeden - Lambera - Lambert
- Lambert - Schmiden - Lambera - Zhea
- Zhea - Zhea - Lambera - Lambera
- Schmiden - Zhea - Lambera - Lambera

841. When stamping point-bore wounds, the small intestine is rational: (1)

- Nodal serous muscular seams
- Shovschmiden
- Brushing serous-muscular seam
- Seam Gel

842. The blood supply is carried out at the expense of the branches of the arteries:(1)

- Upper mesenter
- Spilenkoe
- General hepatic
- Left and right gastrointestinal
- Right and left liver

843. Wounds of hollow tubular organs are shed in the transverse direction: (1)

- Due to the convenience of work
- For better adaptation of the layers
- To avoid the narrowing of the lumen
- By virtue of the established tradition

844. Decraction of the small intestine as an operation of the choice applies with thewound of the small intestine: (1)

- 3-5 cm long
- More than 1/3 of the circumference of the small intestine
- Length less than 2/3 of the circumference of the small intestine
- More than 2/3 of the circumference of the small intestine
- The zone is invented in all cases, regardless of the size

845. When performing "seams-holders" usually capture: (1)

- All wicker wall cases
- Serous Muscular Case
- Mucoby-lower case
- All shell
- Seryo-musculo-sublimated case

846. When stamping point-bore wounds, the small intestine is rational to use: (1)

- Seam Schmiden
- Brushing serous-muscular Seam
- Seam Alberta
- Seam Geli

847. Wounds of hollow tubular organs are sutured in the transverse direction: (1)

- Due to the convenience of work
- To avoid the narrowing of the lumen
- By virtue of the established tradition
- To preserve the peristaltics

848. In the resection of the small intestine, two types of enteroanastomoses are mostoften used: (2)

- "End to the end"
- "End in Side"
- "Side to the end"
- "Side in side"

849. Mekkel'sdiverticulus is: (1)

- Unexpressed venous duct
- Uncassedumous Vessels
- Embryonic residue of the yolk-intestinal duct

850. The cause of the thin intestine in the late stage of the abdominal typhoid may be: (1)

- Necrosis of Peyer Plaques
- The defeat of intestinal villi
- The defeat of the nervous apparatus of the intestine

851. Artery takes part in the blood supply to the stomach: (4)

- Left gastric
- Medium rimming
- Right gastric
- Right gastrointestinal
- Left gastrointestinal

852. Decraction of the small intestine as an operation of the choice is used at the wound of the small intestine: (1)

- 3-5 cm long
- More than 1/3 of the circumference of the small intestine
- Length less than 2/3 of the circumference of the small intestine
- More than 2/3 of the circumference of the small intestine
- The zone is invented in all cases, regardless of the size

1. All answers are true.

853. When performing "seams-holders" usually capture: (1)

- All wicker wall cases
- Serous Muscular Case
- Mucoby-lower case
- All shell
- Seryo-musculo-sublimated case
- All answers are true.

854. Two-row seam, consisting of through seam through all the shells of the intestinal wall and the serous-serous seam, is called seam: (1)

- Albert

- Pirogova-Bira
- Cherni.
- Schmiden

855. The technical disadvantage of enteroeeroanastomose "End to the end" when comparing with the rational "side in side" may be: (1)

- The complexity of the formation of the rear lip of the anastomosis
- The narrowing of the lumen of the anastomosis
- Low strength anastomosis
- Low aseptic anastomosis

856. Distinguish the thick intestine from fine by: (3)

- Relationship to the peritoneum
- The presence of blinking over the intestine
- Thepresenceofmuscletapes
- Color

857. The edge seam is often used for the exterior lips of the anastomosis when usingcontinuous seam: (1)

- Schmiden
- P.Ya. Multanovsky
- Kohler
- N.I. Pirogov

858. To prevent the development of the "vicious" circle with a gastroenteroanastomosis according to a velfler method, it is necessary: (1)

- Gastrointestinal collapse in size of more than 2 sister diameters
- Interchetian Sustain on Brown
- Produce pyloroplasty
- Runwagotomy

859. Detection of mesenter during the resection of the small intestine is invented: (1)

- Due to the danger of bleeding
- To prevent the infringement of the loop of the small intestine
- Forperitonization
- All specified options are correct.

860. The technical disadvantage of enteroeateanastomose "End to the end" when compared with the "side in side" by the rationality: (1)

- The complexity of the formation of the rear lip of the anastomosis
- The narrowing of the lumen of the anastomosis
- The complexity of the formation of an anastomosis front lip
- Low aseptic anastomosis

861. Distinguish the thick intestine from fine by: (3)

- The presence of gland processes
- The presence of blinking over the intestine
- The presence of muscle tapes
- Color

862. The edge seam: (is used to use the external lips of the anastomosis when usingcontinuous seam.

- Alberta
- P.Ya. Multanovsky
- Kohler
- N.I. Pirogov

863. Two-row intestinal seams can be applied to all departments of the gastrointestinal tract, except: (1)

- Food
- Stomach
- Duodenal gut
- Iliac gut
- Blind intestine

864. Install the compliance of the listed arteries of the colon waste, for which they are the main sources of blood supply:

• Sleeping gut	a) Left colon artery
• Rising intestine	b) iliac-sloping artery
• Transverse colon	c) Right shear artery
• Downward intestine	d) Sigmoid artery
• Sigmid intestine	d) medium colon artery

865. The clinical picture of appendicitis, similar to the right-sided kidney colic, is most likely when the design of a worm-like grip: (1)

- Retrocecalintraperitoneal
- Retrocecal retroperitoneal

866. To prevent the development of the "vicious" circle with a gastroenteroanastomosis by a velfler method, it is necessary: (1)

- Gastrointestinal collapse in size of more than 2 sister diameters
- Interchetian Sustain on Brown
- Produce pyloroplasty
- Run Wagotomy
- All specified options are correct.
- All specified options are incorrect

867. Detection of mesenter during the resection of the small intestine is invented: (1)

- Due to the danger of bleeding
- To prevent the infringement of the loop of the small intestine
- Forperitonization
- All specified options are correct.
- All specified options are incorrect

868. The clinical picture of appendicitis, similar to the cholecystitis clinic, may be due to: (1)

- Reflex influences in appendicitis from the ileocecal region to the region of the gallbladder,
- The tuned position of the blind intestine and a heart-shaped process

869. Indicate the damage to the nervous apparatus of which intestine leads to the development of Girshprung disease: (1)

- Sigmid
- Direct
- Duodenal

870. Two-row intestinal seams can be applied on all departments of the gastrointestinal tract, except: (1)

- Food
- Stomach
- Duodenal gut
- Iliac gut
- Blind intestine
- All answers are correct.

871. During the execution of appendectomy, the most reliable and convenient sign offinding a heart-shaped process is: (1)

- Location of the base of the process on the posterior wall of the blind intestine
- Location of the base of the outflow from the bottom of the blind
- Location of the base of the process of convergence of three longitudinal tapes of a blind intestine
- Continuation of the front (free) ribbon on the basis of the process

872. To prevent the development of the "vicious" circle with a gastroenteroanastomosis according to the velfler method, it is necessary: (1)

- "Isoperistal" liner bug
- Interchetian Sustain on Brown
- Produce pyloroplasty
- Run Wagotomy

873. Defect mesentery during the resection of the small intestine invented: (1)

- To prevent adhesive disease
- To prevent the infringement of the loop of the small intestine
- Forperitonization
- All specified options are correct.

874. Name the authors of operational access to a worm-like process: (1)

- Dyakonov-Volkovich
- Gerard-Spirkukotsky
- Khchetkin-Blumberg
- JV. Fedorov
- N.I. Pirogov

875. The clinical picture of appendicitis, similar to the right-sided renal colic, is most likely when the CHAIR-shaped process is positioned: (1)

- Retrocenest intramural
- Retrocecal retroperitoneal

876. The clinical picture of appendicitis, similar to the cholecystitis clinic, may be due to: (1)

- Distributing the inflammatory process on the right side channel to the bustlingbubble
- The tuned position of the blind intestine and a heart-shaped process

877. Indicate the defeat of the nervous apparatus of which intestine leads to the development of Girshprung disease: (1)

- Sigmid
- Duodenal
- Blind

878. Access to mcburnea-Volkovich is called Kosoperented due to: (1)

- Alternations of acute and stupid ways of separation of tissues
- Missing the skin cut line with muscle separation line
- Invisions of the skin cut line with peritoneous dissection line
- Consistent diffusion of muscles with different fiber areas in a blunt way
- Oblique cut direction

879. Paragreotal access to a worm-shaped process offered: (1)

- Kocher
- SP. Fedorov
- N.I. Pirogov
- A.V. Vishnevsky
- Lennander

880. Options for the position of a worm-shaped process are: (3)

- Medial
- Lateral
- Pelvic
- Retrocecal
- All of the above

881. Detection of mesenter during resection of the small intestine is invented: (1)

- To prevent adhesive disease
- To prevent the infringement of the loop of the small intestine
- Forperitonization

882. Name the authors of operational access to a worm-shaped process: (1)

- Dyakonov-Volkovich
- Gerard-Spirkukotsky
- Khchetkin-Blumberg
- N.I. Pirogov

883. The clinical picture of appendicitis, similar to the right-sided renal colic, is most likely when the standing of a heart-shaped process: (1)

- Retrocenest intramural
- Retrocecal retroperitoneal
- Horizontal
- Cross
- Vertical

884. The clinical picture of appendicitis, similar to the cholecystitis clinic, may be due to: (1)

- Distributing the inflammatory process on the right side channel to the bustlingbubble
- The tuned position of the blind intestine and a heart-shaped process
- Long mesentery of the black-shaped process

885. Indicate the damage to the nervous apparatus of which intestine leads to the development of Girshprung disease: (1)

- Sigmid
- Duodenal
- Blind
- Iliac

886. The clinical picture of appendicitis, similar to the right-hand renal colic, is most likely at the position of a worm-shaped process: (1)

- Retrocenestintramural
- Retrocecalretroperitoneal
- Ventral
- Downward

887. Determine the sequence of the stages of removal of a worm-like transformationin appendectomy:

- Performing a brine on the wall of the blind intestine
- Performing a serous muscular Z-shaped seam
- Performance of ligature on the base of the draft-like process
- Cutting off a draft-like process
- Rebuilding and crossing the mesentery of the draft-like process
- Immersion of the cult of the process in the blind intestine and tightening the brush seam

888. Indicate the defeat of the nervous apparatus of which intestine leads to the development of Girshprung disease: (1)

- Sigmid
- Duodenal
- Blind
- Toe

889. Access on mcburnea-Volkovich is called Kosoperented due to: (1)

- Alternations of acute and stupid ways of separation of tissues
- Missing the skin cut line with muscle separation line
- Invisions of the skin cut line with peritoneous dissection line
- Consistent diffusion of muscles with different fiber areas in a blunt way
- Oblique cut direction
- Atypical position of Appendix

890. Retrograde Appendectomy has to be performed: (1)

- In the pelvic position of the process
- When fixing the process of spikes to the rear abdominal wall

- With a very short worm-shaped process
- The choice of the method of appendectomy depends on the desire of the surgeon

891. The blood supply to the descending colon is carried out due to the artery: (1)

- Left colon
- Left kidney
- Left gastrointestinal
- Spilenkoe

892. The transverse colon is bustling from the artery pool: (2)

- Upper mesenter
- Lower mesenteric
- General hepatic
- Right ventricle

893. The transverse semicircle is heavily suited: (2)

- Iliac rim
- Right collapse
- Left rim
- Right gastrointestinal
- Medium colon

894. To create an unnatural rear pass, most often use: (1)

- Direct gut
- Sigmoid
- Downstorming gut
- Transverse colon
- Blind gut

895. Features of the differences in the colon of the colon from the transactions on the small intestine are that: (3)

- The thick intestine has a thinner wall than the small intestine
- The thick intestine has a thicker wall than the small intestine
- The thick intestine has a more infected content than the small intestine
- The small intestine has a more infected content than the thick intestine
- Uneven distribution of muscle beams in the wall of the colon

896. Access to mcburnea-Volkovich is called Kos-variable due to: (1)

- Missing the line of the skin section with muscle separation line
- Missets of the line of the skin section with the line of abuse
- Consistent diffusion of muscles with different fibers in a blunt way
- Oblique cut direction
- Atypical position of Apandix

897. Retrograde Appendectomy has to be performed: (1)

- In the pelvic position of the process
- When fixing the process of spikes to the rear abdominal wall
- With a very short worm-shaped process
- The choice of the method of appendectomy depends on the desire of the surgeon
- Selection of the method of appendectomy depends on the skill of the surgeon

898. Retrograde Appendectomy has to be performed: (1)

- With the length of the process of more than 10 cm
- When fixing the process of spikes to the rear abdominal wall
- With a very short worm-shaped process
- The choice of the method of appendectomy depends on the desire of the surgeon

899. The blood supply to the descending colon is carried out due to the artery: (1)

- Left colon
- Left kidney
- Left testicle (ovarian)
- Spilenkoe

900. The transverse semicircle is blood supply to the artery: (2)

- Right colon
- Left rim
- Right gastrointestinal
- Medium colon

901. To create an unnatural rear pass, the most commonly used: (1)

- Direct gut
- Sigmoid
- Downstorming gut
- Transverse colon

902. The blood supply to the downstream gut is carried out due to the artery: (1)

- Left colon
- Left kidney
- Left gastrointestinal
- Spilenkoe
- General hepatic

903. The transverse colon is bustling from the Basin Artery: (2)

- Upper mesenter
- Lower mesenteric
- General hepatic
- Right ventricle
- Spleen

904. The transverse semicircle is blood supply to the artery: (2)

- Iliac rim
- Right collapse
- Left rim
- Right gastrointestinal
- Medium colon
- SPLEEN

905. The transverse colon is bustling from the Basin Artery: (2)

- Upper mesenter
- Lower mesenteric
- Right ventricular

- Right gastrointestinal

906. Features of the differences in the colon of the colon from the transactions on the small intestine are that: (3)

- The thick intestine has a thinner wall than the small intestine
- The thick intestine has a thicker wall than the small intestine
- The thick intestine has a more infected content than the small intestine
- The small intestine has a more infected content than the thick intestine
- Uneven distribution of muscle beams in the wall of the colon
- The colon has a thinner wall, less infected content

907. In the course of the operation of the formation of an unnecessary rear pass, theparietal peritoneum is stitched to the skin: (1)

- To isolate the cavity of the peritoneum
- To isolate the abdominal fiber layers and the preset to rotate their infection
- For fixation
- For washing the peritoneal cavity
- To prevent the development of adhesive disease

908. Copy can be applied on: (3)

- Kill
- A rising hatch
- Transverse hatch
- Descendingcolon
- Sigmoid

909. The transverse colon ranks from the Artery Pool: (2)

- Upper mesenter
- Lower mesenteric
- General hepatic
- Spilenkoe

910. The transverse colon is heavily suited by Artery: (2)

- Right colon
- Left rim
- Right gastrointestinal
- Medium colon
- Spleen

RETROPERITONEAL SPACE, PELVIS

911. The boundary between the lumbar region and the retroperitoneal space is: (1)

- Square Muscle Liminas
- Intra-painted fascia
- Retroperitian fascia

912. In the retroperitoneal space between intra-abdominal and retroperitoneal fascia: (1)

- Scribbed fiber layer
- Calopal fiber

913. Conductive fiber is located between: (1)

- Ascending or descending colon and early fascia
- Poseartable and advanced fascia

914. The octopoid fiber is located around the kidneys: (1)

- Under the fibrous kidney capsule
- Between fibrous and fascial capsules

915. The crank barrel departs from the abdominal aorta most often at the level of the vertebrae: (1)

- TH11
- TH12
- L1
- L2

916. Upper mesenteric artery departs from the abdominal aorta at the level of thevertebrae:

- TH12
- L1
- L2.
- L3

917. Renal arteries depart from the abdominal aorta at the level of the vertebrae: (1)

- TH12-L1
- L1-L2
- L2-L3
- L3-L4

918. Lower mesenteric artery departs from the abdominal aorta at the vertebral level: (1)

- L1
- L2.
- L3
- L4

919. The boundary between the lumbar region and the retroperitoneal space is: (1)

- Cross belly muscle
- Intra-painted fascia
- Retroperitian fascia

920. In the retroperitoneal space between intraper and retroperitoneal fascia, thereis: (1)

- Scribbed fiber layer
- Pondogenic fiber

921. Against fiber is between: (1)

- Poseartable and advanced fascia
- Poseartable and intra-abdominal fascia

922. The octopic fiber is located around the kidneys: (1)

- Between fibrous and fascial capsules
- On top of the fascial kidney capsule

923. Determine the sequence of veins constituting an anastomotic path between thelower and the upper hollow veins in the retroperitoneal space:

- Upper hollow vienna
- Ascending lumbar viennes
- Unpaired and semi-park veins
- Lower hollow vein
- Lumbar veins

924. Determine the procedure for the location of the three kidney capsules, rangingfrom its parenchyma: (3)

- Fatty
- Fascial
- Fibrous

925. The kidneys are covered with trousers: (1)

- Intraperitoneal
- Extraperitoneal

926. The kidney gate is projected at the level of the vertebrae: (1)

- TH11-TH12
- TH12-L1
- L1-L2
- L2-L3

927. The 12th edge crosses the left kidney at the level: (1)

- Upper poles kidney
- Between the top and middle third
- At the level of the middle
- Between the middle and lower third

928. Lower mesenteric artery departs from the abdominal aorta at the vertebral level: (1)

- L11
- L2.
- L3
- L4.

929. The boundary between the lumbar region and the retroperitoneal space is: (1)

- Cross belly muscle
- Intra-painted fascia
- Retroperitian fascia
- Renal fascia

930. In the retroperitoneal space between intra-abdominal and retroperitoneal fascia: (1)

- Scribbed fiber layer
- Pondogenic fiber
- Okolopochny fascia

931. The 12th edge crosses the right kidney at the level: (1)

- Upper poles kidney

- Between the upper and middle third
- At the middle level
- Between the middle and lower third

932. The kidneys are covered with trousers: (1)

- Mesoperitoneal
- Extraperitoneal

933. The kidney gate is projected at the level of the vertebrae: (1)

- TH11-TH12
- TH12-L1
- L1-L2

934. Front from the left kidney are four organs: (4)

- Liver
- Stomach
- Pancreas
- Duodenal gut
- Loops fine intestine
- Rising colon
- Splenic bending of the colon

935. Front from the right kidney there are three organs: (31)

- Liver
- Stomach
- Pancreas
- Duodenum
- Rising colon

936. The elements of the renal leg are located in the front direction back in the sequence: (1)

- Renal Vienna, Renal Artery, Tub
- Tub, Renal Vienna, Renal Artery
- Tub, renal artery, renal vein

937. The basis of the segment of the kidney segments lies: (1)

- Renal artery branching
- Formation of renal vein
- Location of small and large renal cups

938. The number of segments allocated in the kidney is: (1)

- 3
- 4.
- 5
- 6

939. The ureter has: (1)

- One narrowing
- Two narrowings
- Three narrowings
- Four narrowings

940. Three organs are located in front of the right kidney: (31)

- Liver
- Pancreas
- Duodenal gut
- Loops fine intestine
- Rising colon

941. Elements of the renal leg are arranged in the front direction back in the sequence: (1)

- Renal Artery, Renal Vienna, Tub
- Renal Vienna, Renal Artery, Tub
- Tub, renal artery, renal vein

941. The basis of the segment of the kidney lies: (1)

- Renal artery branching
- Location of small and large renal cups
- Location of renal pyramids

943. The narrowing of the ureter is at the level: (3)

- Tub transition to ureter
- Lower Pole Kidney
- Crossing with ovarian (egg) artery
- Middle of the ureter's abdominal part
- Borderline small pelvis
- Over the versatile venue by the ureter of the bladder wall

944. At the level of the border line, the left ureter crosses the artery: (1)

- General iliac
- Internal iliac
- Outdoor iliac

945. Elements of the renal leg are arranged in the front direction back in the sequence: (1)

- Renal Vienna, Renal Artery, Tub
- Tub, renal artery, renal vein

946. The basis of the segment of the kidney lies: (1)

- Renal artery branching
- Formation of renal vein
- Location of small and large renal cups
- Natural Survection of the Kidney Surface

947. At the level of the border line, the right ureter crosses the artery: (1)

- Internal iliac
- Outdoor iliac

948. The venue for the introduction of the needle with panefral blockade is: (1)

- The middle of the 12th edge at the bottom edge
- The top of the corner between the 12th edge and the outer edge of the muscle, straightening the spine

949. With a panefral blockade, the novel solution is entered into: (1)

- Kidney fat capsule
- Kidney Gateway

950. Specify the sequence of the location of the layers, which the surgeon dissect when accessing the kidney along the Bergman-Iravel:

- Internal fassion
- Deep leaflet lumbly-spinal fascia and transverse abdominal muscle
- Leather with subcutaneous tissue and surface fascia
- Lower rear gear muscle and inner abdominal muscle
- Surface leaflet lumbly-spinal fascia
- The widest muscle of the back and the outer oblique abdominal muscle

951. With nephrectomy, the dressing and intersection of the elements of the renal leg is carried out in the sequence: (1)

- Renal artery, renal vein, ureter
- Renal vein, renal artery, ureter
- Ureter, renal artery, renal vein

952. At the level of the borderline pelvis, the right ureter crosses the artery: (1)

- General iliac
- Outdoor iliac

953. The place of introduction of the needle with panefral blockade is: (1)

- Point of intersection of the rear axillary line and the 12th edge
- The top of the corner between the 12th edge and the outer edge of the muscle, straightening the spine

954. With a panefral blockade, the novel solution is entered into: (1)

- Abrainy fiber layer
- Buric kidney capsule

955. The lumbar triangle (triangle of the PC) limit: (3)

- Outdoor abdominal muscle
- Inner oblique muscle
- Transverse abdominal muscle
- Spin extensor
- 12th edge
- The widest muscle of the back
- Comb of the iliac

956. The sides of the Lesgafta-Grunefeld rhombus form: (4)

- Outdoor oblique muscle
- Inner oblique muscle
- Transverse abdominal muscle
- Spin extensor
- 12th edge
- The widest muscle of the back
- Rear Bottom Muscle

957 The practical value of the triangle of the PC is that it is: (2)

- Herge Output

- The place of the yield of glans from the retroperitoneal space
- Place for performing punctures and blockades
- Pain point for differential diagnosis of abdominal diseases

958. Access to the kidney in Bergman-Iravel is characterized by: (1)

- This is extra-abreastsed access.
- It is an alert access
- Necessarily accompanied by resection of the 12th edge
- These are variable access

959. The front and rear borders of the retroperitoneal space are: (1)

- Rear Parietal Peritone
- Fascia Endoabdominalis
- Fascia Retroperitonealis
- Lumbar region muscles
- Fasciantoldta

960. The main melting spaces of the cavity of the small pelvis are within the floors of the pelvis: (1)

- British
- Stiffitish
- Subcutaneous

961 The practical value of the triangle of the PC is that it is: (2)

- Herge Output
- The place of the yield of glans from the retroperitoneal space
- Place to perform access to the scanitoneal space authorities
- Pain point for differential diagnosis of abdominal diseases

962. Access to the kidney in Bergman-Irasely is characterized by: (1)

- This is extra-abreastsed access.
- Requires the mandatory opening of the pleural cavity
- Necessarily accompanied by resection of the 12th edge
- These are variable access

963. With a panefral blockade, the novel solution is introduced in: (1)

- Abrainy fiber layer
- Buric kidney capsule
- Okolopochnye fiber
- Under the kidney capsule

964. Lagnical triangle (triangle of the PC) limit: (3)

- Outdoor abdominal muscle
- Inner oblique muscle
- The widest muscle back
- Comb of the iliac

965. On the front surface of the magnifier, the brush covers: (1)

- Only the body of the uterus
- Body and overall part of the cervix
- The body of the uterus, the overall part of the neck and front of the vagina

966. On the back surface of the uterus, the brush covers: (1)

- Only the body of the uterus
- Body and all cervical
- The body of the uterus, the overall part of the cervix and the rear arch of the vagina

967. The urinary diaphragm is formed by two muscles: (2)

- Deep transverse crotch muscle
- Copchicker muscle
- Sedal Cave Muscle
- Urinary sphincter

968. The pelvic diaphragm is formed by two muscles: (21)

- Deep transverse crottest muscle
- Copchicker muscle
- Muscle raising the rear pass
- Sedal Cave Muscle
- Ureyeing channel sphincter

969. The seeded nerve comes out of the cavity of the small pelvis to the buttock areathrough the hole: (1)

- Cleaning
- Nadgroiudoid
- Progressive
- Small sedanistic

970. On the front surface of the vita, the peritonese covers: (1)

- Only the body of the uterus
- Body and all cervical
- The body of the uterus, the overall part of the neck and front of the vagina

971. On the back surface of the uterus, the brush covers: (1)

- Only the body of the uterus
- Body and overall part of the cervix
- The body of the uterus, the overall part of the cervix and the rear arch of the vagina

972. The urinary diaphragm is formed by two muscles: (2)

- Deep transverse crotch muscle
- Muscle raising the rear pass
- Sedal Cave Muscle
- Urinary sphincter

973. The rear skin nerve of the thigh comes out of the cavity of the small pelvic to the buttock area through the hole: (1)

- Cleaning
- Nadgroiudoid
- Progressive
- Small sedanistic

974. Sex nerve, internal genital arteries and veins penetrate into a sedlicate-straighthole through a hole: (1)

- Cleaning

- Front sacrats
- Podgrushoid
- Smallsedanized

975. Of the listed bundles of the uterine dupicature of the peritoneum is: (1)

- Cardinal bunch of uterus
- Round bunch of uterus
- Straightening-uterine bunch
- Own bunch of ovary
- Wide bunch of uterus

976. In the course of the operation about the suppuration of the fiber of the near-cooler space, a mixture of pus was discovered in the prettier's fiber of the front abdominal wall in the inner hole of the inguinal channel. Identify, in the course of which anatomical education, the Vnight process was distributed: (1)

- In the course of a round bunch of uterus
- In the course of the lower left artery
- In the course of a wide bundle of uterus

977. The uterine tube is located: (1)

- Along the top edge of a wide bunch of uterus
- Along the side edge of the bodies of the uterus
- In the middle department of a wide bunch of uterus
- Based on a wide bundle of uterus

978. The uterine artery is the branch of the artery: (1)

- Internal iliac
- Nizhnyaneshshenny
- Common iliac

979. Ovarian artery is a branch: (1)

- Abdominalaorta
- Internal iliac artery
- Common iliac artery

980. With pipe pregnancy, the rupture of the uterine tube is accompanied by a cluster of blood in: (1)

- Side Pelvic Space Space
- Ranomascular cellular space
- Straightforward-uterine deepening
- Bubble-uterine deepening

981. Determine the anatomical premise of the possibility of an extra-bubble point ofbladder through the front abdominal wall: (1)

- The presence of prettier tissue in the front wall of the bladder
- The presence of a visceral sheet of internal frames
- The presence of the preposter cellular space
- High standing transverse folds of peritoneum with a filled bubble

982. In the course of surgery for the suppuration of the cellular space, the accumulation of inserts was found in the prettier tissue of the front abdominal wall

in the inner opening of the inlet channel. Identify, in the course of which anatomical education, the Vnight process was distributed: (1)

- In the course of a round bunch of uterus
- Over the aircraft and prepaulous spaces
- In the course of a wide bundle of uterus

983. The uterine tube is located: (1)

- Along the top edge of a wide bunch of uterus
- Along the side edge of the bodies of the uterus
- In the middle department of a wide bunch of uterus
- Based on a wide bundle of uterus

984. The uterine artery is the branch of the artery: (1)

- Internal iliac
- Outdoor iliac
- Nizhnyaneshryzna

985. Ovarian artery is a branch: (1)

- Abdominal aorta
- Uterine artery
- Common iliac artery

986. Prostate gland is located in relation to the bladder: (1)

- In front
- From the bottom
- Behind

987. Egg arterie is a branch: (1)

- Abdominal aorta
- Internal iliac artery
- Cleaning artery
- Outdoor iliac artery
- Common iliac artery

988. With the catheterization of the male urethra among the three of its essences, the greatest obstacle represents: (1)

- Outer hole
- Reflection part
- Interior hole

989. Determine the sequence of the layers of the scrotum and the membranes of theEgg: (1)

- Vaginal Egg Shell
- Internal seed fascia
- Leather
- Funny shell
- Muscle raising egg
- Outdoor seed fascia

990. The finger rectal study in men is carried out in order to determine the state primarily: (1)

- Bladder
- Prostate gland
- Front sacral lymph nodes

991. Install the correspondence between the arteries supplying the right integer andthe sources of their formation:

- Upper recycling artery
- Middle Black Arterie
- Lower recycling artery

a) Inner interground
b) internal iliac artery
c) Upper mesenteric artery
d) outdoor iliac artery
e) bottom mesenteric artery

992. In case of liver disease, straightforce chloral hydrate anesthesia (in the enema)can aggravate the lesion of the liver. Describe the venous path of the flow of chloralhydrate into the liver sequentially for three veins: (3)

- Upper mesenteric
- Upper straightforward
- Passion
- Lower mesenteric
- Lower hollow
- Medium straightforward

993. Nadampular part of the rectum is covered with peritoneous: (1)

- From all sides
- On three sides

994. A ampoule of the rectum at a high extent is covered with peritoneous: (1)

- From all sides
- On three sides
- Only in front

995. The bottom of the rectum is covered with peritoneous: (1)

- On three sides
- Only in front
- Not covered with peritoneous

996. Among the three ways of outflow of lymphs from the rectum is the main way to: (1)

- Inguinal lymph nodes
- Sacrals and further - in internal iliac lymph nodes
- Upper straight and further in the lower mesenteric lymph nodes

997. In the operation of the extirpation of the rectum over cancer, a complete removal of the transshipment of the grinding space is made due to: (1)

- Purpicular communication of fatty fiber with the wall of the rectum
- The possibilities of metastasis of the tumor in the front sacral lymph nodes **998. The finger rectal study in men is carried out in order to determine the stateprimarily: (1)**
- Ureterals
- Prostate gland

- Front sacral lymph nodes

999. In the stiffer floor of a small pelvic, cellulums are isolated: (3)

- Preposter
- Beforeading
- Posadigar-blur
- Prieucum cellular spaces
- Parameter cellular spaces

1000. Nadampular part of the rectum is covered with peritoneous: (1)

- From all sides
- Only in front