Glomerulonephritis in children

Simple complement

1. E
2. E
3. C
4. E
5. C
6. A
7. A
8. A
9. B
10. C
11. B
12. D
13. C
14. A
15. C
16. E
17. D
18. A
19. B
20. D

Multiple Complement

1. A,B,C
2. A,B,E
3. A,C,D,E
4. A,B,C
5. A,B,C
6. A,B,D
7. A,C,D
8. A,B,D,E
9. A,B,C
10. A,C,E
11. A,B,C
12. A,D,E
13. B,C,D,E
14. A,B,E
15. A,B,D
16. A,B,C,E
17. A,B,C,D
18. A,B,E,
19. A,B,C,D
20. B,C,D
21. B,C,E
22. A,B,C,D
23. A,B,C,D
24. A,B,C
25. A,B,C,D
26. A,B,C
27. A,B,C,E
28. A,B,D
29. A,B,C,D
30. A,B,C
31. A,B,C,D
32. A,B,C
33. B,C,E
34. A,D
35. A,B,C
36. A,C,D
37. A,B,D,E
38. A,B,C,E
39. A,B,D,E
40. B,C,E

Glomerulonephritis in children. Simple complement

1. Which of the listed diseases cannot trigger acute glomerulonephritis in children?

a. DTP vaccination
b. Fabry disease
c. chickenpox
d. measles
e. Hepatitis A

2. Typical onset of acute poststreptococcal glomerulonephritis in children *is not* determined by:

a. urinary syndrome
b. hypertensive syndrome
c. edematous syndrome
d. nitrogen retention syndrome
e. heart failure onset

3. What is the most common etiologic agent of acute poststreptococcal glomerulonephritis in children?

a. ECHO viruses
b. staphylococcus
c. B-hemolytic streptococcus
d. vaccination
e. food allergies

4. Which of indicated paraclinical signs attest an unfavorable evolution of glomerulonephritis in children?

a. leukocyturia
b. proteinuria
c. macroscopic haematuria
d. frequent cylindruria
e. nonselective proteinuria

5. What injuries produce significant proteinuria?

a. at the endothelium level
b. at the level of basal membranes
c. at the level of subepithelial membranes
d. at the level of epithelial cells
e. at the mesangium level

6. The treatment of acute poststreptococcal glomerulonephritis in children *does not* include:

a. corticosteroids
b. hypoallergenic diet (salt, potassium and liquid restriction)
c. antibacterial therapy
d. antiplatelet drug (*antiaggregant*)
e. diuretics

7. Pathogenic treatment of idiopathic nephrotic syndrome in children is carried out with:

a. prednisolone
b. diuretics
c. antihypertensives
d. antibiotics
e. antiaggregants

8. Through what mechanism do glomerular lesions in chronic glomerulonephritis in children occur most frequently?

a. immune

b. metabolic
c. hemodynamic
d. toxic
e. Infectious

9. **Through what *syndrome* is acute glomerulonephritis with minimal glomerular changes in children manifested clinically?**

a. nephritic
b. nephrotic
c. urinary isolated
d. nephrotic with hematuria and high blood pressure
e. hematuria

10. What morphological variant corresponds to rapidly progressive acute glomerulonephritis?

a. glomerulonephritis with minimal glomerular changes
b. mesangioproliferative glomerulonephritis
c. Crescentic extracapillary glomerulonephritis
d. proliferative glomerulonephritis, membranoproliferative glomerulonephritis
e. diffuse sclerosing glomerulonephritis

11. How long are the children with acute glomerulonephritis monitored?

a. 2 years
b.5 years
C.10 years
d. whole life
e. up to age of 18

12. For acute poststreptococcal glomerulonephritis in children is not characteristic:

a. hypertension
b. hematuria
c. moderate edema
d. proteinuria> 3.5 g / 24h
e. proteinuria <3.5 g / 24h

13. What degree of proteinuria is typical for idiopathic nephrotic syndrome in children?

a. up to 1 g / l
b. 1.0-2.0g / l
c. over 3.5g / l
d. 2.5-3.0 g / l
e. 2.0-2.5g / l

14. For idiopathic nephrotic syndrome in children is not typical:

a. macroscopic haematuria
b. proteinuria
c. hypoalbuminemia
d. generalized edema
e . hyperlipidemia

15. What cardiovascular complications *are not* typical for acute glomerulonephritis in children?

a. pulmonary edema
b. heart failure
c. nephrosclerosis
d. hypertensive encephalopathy
e. hypertension

16. Important pathophysiological lesions in acute poststreptococcal glomerulonephritis in children *are not* determined by:
a. deposition of circulating immune complexes in glomeruli
b. local activation of complement
c. the decrease of the glomerular filter
d. the increase of permeabilization of the glomerular filter
e. podocyte injury
17. Urinary syndrome of acute poststreptococcal glomerulonephritis in children *does not* include:
a. hematuria
b. proteinuria
c. cilindruria
d. epithelial cells
e. hypoosmolarity
18. What degree of proteinuria is typical for acute glomerulonephritis with nephritic syndrome in children?
a. 0.5-3 g / l
b.> 3.0 g / l
c. is not characteristic
d.> 3.5 g / l
e. up to 0.5 g / l
19. Chronic glomerulonephritis in children *is not* manifested clinically by:
a. urinary syndrome
b. febrile syndrome
c. nephritic syndrome edematous type
d. nephrotic syndrome edematous type
e. hypertensive syndrome
20. How long children with chronic glomerulonephritis are monitored?
a. 5 years
b. 10 years
c. 2 years
d. whole life
e. up to 18 years

Multiple complement
1. What conditions favor the deposition of circulating immune complexes in kidneys?
a. increased blood flow
b. endothelial surface
c. components of the glomerular filter
d. glomerular lesions
e. increased levels of complement fractions
2. List the proinflammatory substances which intervene in the pathogenesis of glomerular lesions:
a. molecules of cell adhesion
b. reactive oxygen metabolites
c. IgE
d. hyaluronic acid
e. growth factors
3. List the specific characteristics of edema of renal origin in children:
a. white

b. harsh
c. fluffy
d. localization in lax rich subcutaneous tissue
e. massive

4. Complications of glomerulonephritis in children may be the following:

a. pulmonary edema
b. tracheobronchitis
c. pneumonia
d. bronchial asthma
e. pulmonary infarction

5. Streptococcal infection can be demonstrated by the following:

a. ASO titer increased
b. Increased hyaluronidase
c. positive throat cultures
d. urine summary
e. bioptic renal puncture

6. What are the signs of severity in the prognosis of acute poststreptococal glomerulonephritis in children?

a. pulmonary edema
b. hypertensive encephalopathy
c. oliguria more than 50ml / kg / day
d. creatinine clearance under the 60 ml / m2
e. blood urea under 49mg / dl

7. What are the indications of administration of anticoagulant therapy in glomerulonephritis in children?

a. decrease of III antithrombin
b. hypoglobulinemia
c. hypoalbuminemia 15-20g / l
d. hyperfibrinogenemia > 5 g / l
e. hypocalcemia

8. The differential diagnosis of acute poststreptococal glomerulonephritis in children is performed with:

a. Alport syndrome
b. IgA nephropathy
c. glomerulonephritis with minimal changes in clusters
d. rapidly progressive glomerulonephritis
e. focal segmental glomerulonephritis

9. What are the morphological forms of idiopathic nephrotic syndrome in children?

a. glomerular lesions absent or minimal
b. diffuse mesangial proliferation
c. focal glomerulosclerosis
d. endocapillary glomerulonephritis
e. membranoproliferative glomerulonephritis

10. Classic acute glomerulonephritis in children can develop through the following syndromes:

a. edematous syndrome
b. algic syndrome
c. urinary syndrome

d. fever syndrome
e. hypertensive syndrome

11. What is characteristic for impure nephrotic syndrome in children?

a. non-selective proteinuria
b. persistent hematuria
c. unfavorable prognosis
d. selective proteinuria
e. normal serum complement

12. What is characteristic for pure nephrotic syndrome in children?

a. minimal or absent glomerular lesions
b. persistent microscopic haematuria
c. persistent macroscopic haematuria
d. selective proteinuria
e. good response to corticotherapy

13. The onset of atypical acute glomerulonephritis in children includes:

a. urinary syndrome
b. heart failure
c. acute renal failure
d. rough hypertension
e. glomerulonephritis with minimal urinary syndrome

14. Urinary signs specific for urinary nephrotic syndrome in children are:

a. increase potassium elimination
b. decrease of sodium elimination
c. absence of hyaline cylinders
d. absence of granular cylinders
e. lipiduria

15. Dyselectrolytemia in nephrotic syndrome in children is characterized by:

a. hyponatremia
b. hypokalemia
c. hypophosphatemia
d. with normal values of potassium level
e. hypernatremia

16. What are the complications of corticosteroid therapy in nephrotic syndrome in children?

a. physical retardation
b. psychosis
c. sleep disorder
d. hypotension
e. secondary infections

17. What are the indications for renal biopsy in children?

a. proteinuria and hematuria of unknown etiology
b. hypertension of unknown aetiology
c. Cortico-rezistent nephrotic syndrome
d. suspected amyloidosis
e. renal tuberculosis

18. Treatment of acute glomerulonephritis with nephritic syndrome in children includes:

a. antibiotics
b. diet by the reduction of water, salt, protein
c. corticotherapy
d. cytostatics
e. diuretics

19. Compulsory investigations in acute glomerulonephritis in children include:
a. urea, creatinine, B-lipoproteids, general protein
b. hemogram
c. urine summary
d. renal ultrasound
e. renal biopsy
20. Edema in nephrotic syndrome in children are determined by:
a. hypertension
b. reduction of colloid-osmotic pressure
c. increase of glomerular basement membrane permeability
d. increase of tubular reabsorption of sodium
e. hypervolaemia
21. Biochemical changes in idiopathic nephrotic syndrome in children include:
a. low serum complement
b. hypoalbuminemia
c. hyponatraemia
d. ASLO increased
e. high cholesterol
22. What are the diagnostic criteria for glomerulonephritis of primary immunocomplex origin in children?
a. increased level of circulating immune complexes in serum
b. low levels of serum complement
c. diffuse damage of both kidneys according to renal ultrasound
d. storage of immunoglobulins on the glomerular basement membrane
e. renal ultrasound data of unilateral renal damage
23. The prognosis in secondary forms of nephrotic syndrome in children depends on:
a. clinical and histological form
b. etiology
c. complications of the disease
d. complications as the result of the treatment
e. age of the patient
24. The efficacy of treatment steroid-resistant nephrotic syndrome in children depends on:
a. morphological variant
b. Expressiveness of tubulo-interstitial changes
c. fibroblastic component
d. clinical picture
e. hematuria
25. Pathogenic and symptomatic treatment of chronic glomerulonephritis in children include:
a. glucocorticoids
b. cytostatics
c. diuretics
d. antihypertensive treatment
e. antihypotension treatment
26. Premature death during the early development of chronic glomerulonephritis in children can occur through:
a. acute renal failure
b. heart failure
c. pulmonary edema

d. hepatic
e. cerebral edema

27. What does the symptomatic therapy in acute glomerulonephritis in children include?

a. macrolides
b. semisynthetic penicillins with clavulonic acid
c. diuretics
d. cytostatics
e. antihypertensives

28. What are the criteria for the cure of glomerulonephritis in children?

a. resumption of diuresis
b. disappearance of edema
c. absence of histopathological changes after 6 months
d. absence of hematuria
e. absence of histopathological changes after 1 year

29. Secondary nephrotic syndrome can occur in the following diseases:

a. Alport syndrome
b. Down syndrome
c. Orbeli syndrome
d. hypoplastic renal dysplasia
e. mucoviscidose

30. What does the clinical picture of membranoproliferative glomerulonephritis in children include?

a. nephrotic syndrome
b. high blood pressure
c. hematuria
d. hypotension
e. nephritic syndrome

31. What are the complications of diuretic therapy in children?

a. electrolytic disorders
b. ototoxicity
c. metabolic alkalosis
d. calcification in kidneys
e. increase in serum potassium

32. What are morphological variants of focal segmental glomerulonephritis in children?

a. canalicular
b. colaptoid
c. cellular
d. atypical
e. proliferative

33. What are the clinical manifestations of membranous glomerulonephritis in children?

a. nephritic syndrome
b. nephrotic syndrome
c. microhematuria
d. hypotension
e. macrohematuria

34. Treatment of nephrotic syndrome debut with minimal glomerular changes in children includes:

a. prednisolone dose 2mg / kg / 24 h for 6 weeks according to the scheme
b. prednisolone pulse therapy

c. cytostatics
d. symptomatic therapy
e. plasmapheresis

35. What syndromes are characteristic for chronic glomerulonephritis in children?
a. urinary syndrome
b. hypertensive syndrome
c. edematous syndrome (nephritic or nephrotic type)
d. nitrogen retention syndrome
e. hepato-renal syndrome

36. The diet in the treatment of nephrotic syndrome in children is characterized by:
a. protein intake 2-3g / kg / day
b. low-protein diet
c. hyposodic diet
d. liquid reduced just in the presence of massive edema
e. high-fat diet

37. Idiopathic nephritic syndrome criteria in children include:
a. generalized edema
b. proteinuria> 3.5g / 24h
c. proteinuria up to 1 g / 24h
d. hypoalbuminemia
e. hypercholesterolemia and hyperlipidemia

38. What are the contraindications to renal biopsy in children?
a. renal artery aneurysm
b. solitary kidney
c. terminal renal failure
d. hypertension
e. renal tuberculosis

39. Immune glomerular lesions are triggered by deposition in glomeruli:
a. circulating immune complexes
b. „in situ" immune complex
c. platelets
d. anti- glomerular basement membrane antibody
e. cellular immune response

40. What are the complications related to the development of nephrotic syndrome in children?
a. hypovolemic shock
b. thrombotic phenomena
c. urinary tract infections
d. chronic renal failure
e. massive hydrothorax

Hereditary tubulopathy in children

Simple complement

1. D
2. B
3. A
4. A
5. A
6. E
7. E
8. A
9. A
10. E
11. E
12. B
13. E
14. A
15. B
16. D
17. E
18. D
19. B
20. C

Multiple complement

1. B,C,E
2. A,C,D
3. A,B,C,D
4. C,D
5. A,C,D
6. A,B,C
7. B,D,E
8. A,B
9. A,C,D,E
10. A,B,D
11. A,B,C D
12. A,C,D
13. B,C,E
14. A,B,C
15. B,C,D,E
16. A,B,C,D
17. A,B,C,D
18. A,B,C,D
19. A,B,C,D
20. A,B,D
21. A,B,D,E
22. A,B,C
23. A,B,C,D
24. A,B,C,D
25. A,B,C,E
26. A,B,C,D
27. A,B,E
28. A,B,C,D
29. B,E,D
30. A,B,C,E
31. A,B,C
32. A,C,D
33. A,B,D
34. A,B,C,D
35. A,B,C,D
36. A,B
37. A,B,C,E
38. A,B,C,D
39. D,E
40. A,B

Hereditary tubulopathy

Simple complement

1. List the primary hereditary tubulopathy that do not have location at the level of proximal renal tubules:

a. diabetes glucosamine
b. renal phosphaturic diabetes
c. glycinuria
d. galactosemia
e. cystinuria

2. For phosphaturic diabetes in children is characteristic:

a. hypophosphatemia
b. hyper fosfaturia
c. glucosuria
d. hypocitraturia
e. hyperaminoaciduria

3. Essential biochemical modification of phosphaturic diabetes in children is:

a. hypophosphatemia
b. hyperphosphatemia
c. hypercalcemia
d. hyperkalemia
e. decrease of the activity of alkaline phosphatase

4. For Toni-Debre- Fanconi syndrome *is not* characteristic:

a. hypercalciuria
b. glycosuria
c. hyperaminoaciduria
d. hyperphosphatemia
e. hyperchloremic metabolic acidosis

5. Toni-Debre- Fanconi syndrome in children *is not* associated with:

a. acute pneumonia
b. Wilson-Konovalov disease
c. galactosemia
d. cystinosis
e. phenylketonuria

6. Which calculi *are not* found in renal lithiasis in children?

a. uric calculi
b.oxalic calculi
c. cystine calculi
d. phosphate calculi
e. bilirubin calculi

7. For renal saline diabetes in children *is not* characteristic:

a. polyuria
b. hypotonia
c. staturo retardation
d. polydipsia
e. low diuresis

8. In renal phosphaturic diabetes *does not* occur the following modification:

a. glucosuria
b. rachitic skeletal changes

c. hypophosphatemia
d.hyperphosphaturia
e. serum calcium within normal range

9. Renal osteopathy <u>is not</u> found in:

a. renal glycosuria
b. Toni-Debre- Fanconi syndrome
c. vitamin D dependent rickets
d. distal tubular acidosis
e. renal phosphaturic diabetes

10. Polyuria <u>*is not*</u> present in the following tubulopathy in children:

a. renal glucosuria
b. renal diabetes insipidus
c. renal saline diabetes
d. cystinosis
e. renal phosphaturic diabetes

11. What clinical manifestation <u>*is not*</u> characteristic for renal phosphaturic diabetes?

a. clinical manifestations obviously start up to 2 years
b. bone deformation
c. phosphaturia
d. stature retardation
e. deafness

12. Tubulopathies that <u>*do not*</u> present nephrolithiasis syndrome in children are:

a. cystinuria
b. renal glucosuria
c. hyperoxaluria
d. hyperuraturia
e. glicinuria

13. The elective treatment for renal glycosuria in children includes:

a. insulin
b. diuretic
c. oral antidiabetic drug
d. glucose perfusion
e. proper diet

14. Which of the following symptoms is characteristic for renal diabetes insipidus?

a. thirst and polyuria
b. sanguinolent stools
c. increased density of urine
d. febrile syndrome
e. decrease of blood glucose

15. What is the leading cause of death in children suffering from renal diabetes insipidus?

a. toxico infectious shock
b. dehydration
c. hypoglycemic coma
d. convulsions
e. cardiac arrest

16. Which of the listed symptoms is not characteristic for renal saline diabetes in children?

a. polyuria
b. adynamia

c. hypotension
d. hypertension
e. hypotonia

17. Differential diagnosis of renal saline diabetes in children is not performed with:

a. secondary pseudohypoaldosteronism
b. diabetes mellitus
c. renal glycosuria
d. hypoaldosteronism
e. renal phosphaturic diabetes

18. When does commonly occur the onset of renal phosphaturic diabetes in children?

a. immediately after birth
b. at the age of 7-10 years
c. at puberty
d. with the onset of gait *(*independent walking)
c. after the age of 15 years

19. The treatment of renal phosphaturic diabetes is performed with:

a. group B vitamins
b. phosphorus preparations with consecutive introduction of vitamin D
c. corticosteroids
d. antibiotics
e. chemotherapeutics

20. Which disease resembles the onset of vitamin D-dependent rickets?

a. diabetes mellitus
b. acute pyelonephritis
c. deficiency rickets
d. acute poststreptococcal glomerulonephritis
e. Alport syndrome

Multiple compliment

1. In which hereditary tubulopathies polyuria can be the single manifestation?

a. renal phosphaturic diabetes
b. renal saline diabetes
c. renal diabetes insipidus
d. renal tubular acidosis
e. renal glucosuria

2. Renal osteopathy as main manifestation is found in the following tubulopathies in children:

a. diabetes phosphaturia
b. cystinuria
c. Toni-Debre- Fanconi syndrome
d. vitamin D dependent rickets
e. vitamin D independent rickets

3. Differential diagnosis of renal saline diabetes is carried out with the following diseases:

a. diabetes mellitus
b. Toni Debre-Fanconi syndrome
c. renal glucosuria
d. hypoaldosteronism
e. Alport syndrome

4. The diagnosis of renal glycosuria is based on the following criteria:

a. abnormal glycemic curve
b. presence of disorders of the renal function

c. presence of glucose in all urine portions
d. normal blood glucose levels
e. absence of glucose in the urine

5. Renal diabetes insipidus in older children is manifested by:

a. thirst
b. urinary urgency
c. enuresis
d. delay in physical development
e. fever

6. What factors determine the genesis of primary hereditary tubulopathies in children?

a. structural changes of membrane transport protein of renal tubules
b. hereditary enzymopathies
c. decrease sensitivity to the hormone action of the tubular epithelial receptor
d. increase sensitivity to the hormone action of the tubular epithelial receptor
e. infections

7. Biological changes that occur in renal diabetes insipidus in children include:

a. hyponatraemia
b. hypernatremia
c. hypochloremia
d. hyperchloraemia
e. increase of plasmatic oncotic pressure

8. Under which criteria the classification of tubulopathies in children is elaborated?

a. by the location of the defect in the renal tubular system
b. by the main syndromes of the disease
c. by the nature of the metabolic disorders
d. by the mode of the hereditary transmission of the disease
e. by the age of the child who suffers from the disease

9. What changes occur in the laboratory diagnosis of renal saline diabetes?

a. metabolic acidosis
b. hypokalaemia
c. hyperkalemia
d. hyponatraemia
e. hipernatraemia

10. The main developing mechanisms of renal phosphaturic diabetes are:

a. primary transport defect of phosphate in small intestine
b. hereditary disorders of vitamin D
c. metabolic disorders of glyoxal acid
d. structural anomaly of the protein which transports the phosphates
e. insulin deficiency

11. The most common symptoms of renal phosphaturic diabetes in children are:

a. coxa varum
b. unaffected intellectual development
c. statural stagnation
d. abnormal muscle tone
e. polyuria

12. Differential diagnosis of renal phosphaturic diabetes in children is performed through the following diseases:

a. tubular acidosis
b. chronic glomerulonephritis
c. chronic kidney disease
d. Toni-Debre- Fanconi syndrome
e. acute renal failure

13. Morphological Toni-Debre- Fanconi syndrome in children is characterized by:
a. normal proximal convoluted tube
b. glomerular atrophy
c. shortened proximal convoluted tube
d. hypoplasia of the juxtaglomerular complex
e. hypertrophy of the the juxtaglomerular complex
14. Clinical manifestations specific for Toni-Debre-Fanconi syndrome in children are:
a. polyuria
b. Unmotivated hyperthermia
c. retardation in psychomotor development
d. muscular hypertonus
e. absence of skeletal changes
15. What are the biological changes specific for Toni-Debre- Fanconi syndrome?
a. cystinuria
b. hyperchloraemic metabolic acidosis
c. glucosuria
d. phosphaturia
e. hyperaminoaciduria
16. 2 years old child is hospitalized in a serious condition with the diagnoses of renal phosphaturic diabetes. The correct treatment includes:
a. phosphorus preparations
b. administration of vitamin D
c. administration of vitamin D dose increases under the control of Sulckowitsch sample
d. somatotropic hormone
e. prednisolone
17. 5 years old child is hospitalized in a serious condition with suspected Toni-Debre-Fanconi syndrome. What investigations are needed to confirm the diagnosis?
a. assessment of amino acids in the urine
b. assessment of glucose in the urine
c. assessment of phosphates in the urine
d. assessment of bicarbonates in the urine
e. assessment of Ca in the blood
18. The treatment of Toni-Debre-Fanconi syndrome includes:
a. alkaline solutions to combat the acidosis
b. calcitriol
c. calcium preparations for the elimination of hypocalcemia
d. high doses of vitamin D
e. antibacterial therapy
19. Biological changes in vitamin D dependent rickets in children include:
a. hypocalcemia
b. normophosphatemia
c. hypophosphatemia
d. high activity of alkaline phosphatase
e. low activity of alkaline phosphatase
20. Distal tubular acidosis in 2 years child is manifested by:
a. nephrolithiasis
b. pyelonephritis
c. glomerulonephritis
d. nephrocalcinosis
e. normal physical development
21. Biological changes related to distal tubular acidosis in the children include:
a. hypocalcemia

b. hyponatraemia
c. hipokaliurie
d. hypophosphatemia
e. hypocitraturia

22. Distal tubular acidosis treatment in children includes:

a. dietotherapy
b. citrus solutions
c. correction of of metabolic acidosis
d. antibiotic therapy
e. correction of hyperkalaemia

23. What are the clinical manifestations of proximal tubular acidosis in children?

a. rachitic skeletal changes
b. vomiting with episodes of dehydration
c. nephrocalcinosis
d. staturo retardation
e. edema

24. The diagnosis of cystinuria in children is based on the following factors:

a. symptomatology of urinary pathway obstruction through calculi
b. evidence of increased cystine excretion in the urine
c. absence of cystine crystals on the cornea examination
d. presence of cystine crystals in bone marrow punch
e. absence of cystine crystals in urine sediment

25. The symptomatology specific for hyperoxaluria is characterized by:

a. abdominal pain
b. micturition disorders
c. dysuria
d. polydipsia
e. recurrent pain in joints

26. Biological changes specific for hyperoxaluria are:

a. leucocyturia
b. moderate proteinuria
c. increased excretion of oxalate in urine
d. hematuria
e. low oxalate excretion in urine

27. Treatment of renal diabetes insipidus includes:

a. diet without water restriction
b. reducing the intake of sodium
c. steroids
d. antibiotic therapy
e. hypothiazid

28. Treatment of hyperoxaluria in children includes:

a. dietetic regimen
b. mg preparation
c. pyridoxine
d. orthophosphate
e. nitrofurantoin

29. What renal inflammatory process is characteristic for morphological cystinuria?

a. acute glomerulonephritis
b. interstitial nephritis
c. chronic glomerulonephritis
d. urolithiasis
e. pyelonephritis

30. What are the clinical manifestations of the Albright-Buttler syndrome?
a. anorexia
b. polyuria
c. respiratory disorders
d. edema
e. vomits
31. What are the causes which determine the apparition of primary proximal forms of renal tubular acidosis in children?
a. kidney transplantation
b. hyperparathyroidism
c. pyelonephritis
d. insufficiency of vitamin D
e. Alport syndrome
32. What are the causes which determine the apparition of secondary forms of renal tubular acidosis in children?
a. celiac disease
b. overdose of vitamin D
c. galactosemia
d. Lowe syndrome
e. chronic infections
33. For correction of mitochondrial dysfunction in Toni-Debre- Fanconi syndrome is indicated:
a. vitamin A
b. vitamin B
c. vitamin K
d. coenzyme Q10
e. vitamin D
34. What changes are characteristic for renal glycosuria?
a. is not influenced by diet
b. normal glycemic curve
c. glucose is present in all portions of urine
d. normal blood glucose levels
e. glucose is not present in all portions of the urine
35. Proximal renal tubular acidosis in children is characterized by:
a. decreased reabsorption of carbohydrates
b. hyperchloraemic acidosis
c. decrease of urine pH
d. decrease of carbohydrates in blood
e. decrease of carbohydrates in urine
36. List the complications of distal tubular acidosis in children:
a. decrease in glomerular filtration function
b. chronic renal failure
c. osteomalacia
d. interstitial nephritis
e. nephrotic syndrome
37. List the clinical manifestations specific for distal tubular acidosis:
a. polyuria
b. rachitic bone changes
c. nephrolithiasis
d. normal physical development
e. polydipsia
38. What does the complex treatment of cystinuria in children include?
a. increased fluid intake

b. limiting sulfur containing products
c. hypothiazid
d. pyridoxine
e. streroids

39. What are the clinical manifestations of renal glycosuria in children?

a. polyuria
b. polyphagia
c. thirst
d. skeleton deformity
e. vomiting accompanied by dehydration

40. What determines the length of treatment with vitamin D for Toni-Debre-Fanconi syndrome in children?

a. concentration of Ca in the serum
b. concentration of P in serum
v. concentration of K in serum
d. concentration of Na in serum
e. concentration of Cl in serum

Pyelonephritis in children

Simple Complement

1. C
2. A
3. C
4. C
5. C
6. B
7. B
8. C
9. A
10. B
11. E
12. D
13. E
14. D
15. A
16. A
17. E
18. C
19. C
20. E

Multiple complement

1. A,B,C,D
2. A,C,D,E
3. A,B,C
4. A,D,E
5. B,C,E
6. A,B,C,D
7. A,C,D
8. A,C
9. A,B,D
10. A,B,C
11. A,B,E
12. B,D,E
13. B,C,E
14. A,B,C,E
15. B,D
16. A,B,C
17. A,B,E
18. C,D,E
19. A,B,C,E
20. A,B,C,E
21. A,B,C,D
22. A,B,C
23. A,D,E
24. A,B,D
25. A,B
26. A,B,D,E
27. A,B
28. A,B,C,D
29. A,B,C
30. A,B
31. A,B,C
32. A,B,C
33. A,B,C
34. A,B,C,D
35. B,C,D
36. A,B,C
37. A, B, C, D
38. A, B, C,D
39. A, B, C, D
40. A, B, C

Pyelonephritis in children. Simple Complement.

1. What is the main etiologic factor which favors renal damage in children at first years of life?

a. e.coli
b. proteus
c. staphylococus
d. mycoplasma
e. L-form bacteria

2. What does the evolution of latent chronic pyelonephritis in children characterize?

a. recurrent leucocyturia
b. prolonged febrile syndrome
c. pyuria
d. local purulent reactions
e. toxic-infectious shock

3. The clinical picture of pyelonephritis in children *does not* include:

a. chills
b. lumbar pain
c. urinary incontinence
d. fever
e. pyuria

4. The duration of attack treatment in the first spurt of pyelonephritis in children is:

a. 4-7 days
b. 5-10 days
c. 14 to 21 days
d. 10-15 days
e. 20-30 days

5. The main clinical syndrome of pyelonephritis in infants is:

a. asthenic syndrome
b. dysuria syndrome
c. dyspeptic syndrome
d. hypertensive syndrome
e. neurovegetative syndrome

6. What is the screening method for the diagnosis of pyelonephritis in children?

a. cystography and intravenous urography
b. kidneys and bladder ultrasound
c. kidneys scintigraphy and intravenous urography
d. computed tomography
e. cystourethroscopy

7. The cause of urinary passage disorder in children is determined by:

a. vesico-renal reflux
b. cystitis
c. nephroptosis
d. neurogenic bladder
e. nephrolithiasis

8. A 5 years girl, previously healthy, is diagnosed with acute pyelonephritis. What laboratory index *is not* essential for diagnosis at the moment?

a. urea, creatinine
b. urine summary
c. serum cholesterol, uric acid
d. uroculture
e. Niciporenco sample

9. Select the correct statement regarding acute pyelonephritis in children:
a. inflammation of renal interstitial tissue
b. inflammation of the bladder
c. glomerular inflammation
d. tubular inflammation
e. ureters inflammation
10. What investigation is mandatory in enuresis in children?
a. renal biopsy
b. cystography
c. computerized tomography of the kidneys
d. renal scintigraphy
e. intravenous urography
11. What is the level of significant bacteriuria at pyelonephritis in children?
a. 50000 colony in 1ml. urine
b. 10000 colonies in 1 ml. urine
c. 40,000 colonies in 1 ml. urine
d. the absence of microbial growth
e. 100,000 colonies in 1 ml. urine
12. Specify the character of leukocytosis in bacterial pyelonephritis in children:
a. lymphocytes
b. monocytes
c. eosinophils
d. neutrophils
e. no signification
13. Duration of dispensarisation of children who have suffered from acute pyelonephritis is:
a. 1 year
b. 2 years
c. 3 years
d. 4 years
e. 5 years
14. At what age the monitoring of the patients with secondary chronic pyelonephritis stops?
a. after 10 years
b. after 15 years
c. after 18 years
d. not removed from the record
e. after age 17
15. The frequency of the check-ups of children who suffered from pyelonephritis performed by the neurologist is:
a. once every three months
b. once every five months
c. no surveillance
d. every 1 year
e. every 2 weeks
16. What is the method of investigation which may favor the penetration of kidney infection in children?
a. catheterization of the bladder
b. pleural puncture
c. liver biopsy
d. valve exam
e. catheterization of peripheral vein
17. Renal ultrasound of pyelonephritis in children *does not* determine:
a. kidneys increased in size

b. hyperechoic parenchyma
c. edematous parenchyma
d. pyelocaliceal system expansion
e. residual urine after urination

18. What is the normal version of the urinary pH in children?

a. weak alkaline
b. strong alkaline
v. weak acid
d. strong acid
e. neutral

19. What index of blood count changes at acute pyelonephritis in children?

a. hemoglobin
b. eosinophils
c. ESR (erythrocyte sedimentation rate)
d. color index
e. glucose

20. What are the contraindications for performing the intravenous urography in children?

a. leucocyturia
b. renal colic
c. abdominal trauma
d. changes in renal ultrasonography
e. anuria

CM.

1. What are the causative agents of pyelonephritis in children?

a. e.coli
b. chlamydiae
c. candida albicans
d. mycoplasma infection with M. hominis
e. mycoplasma infection with M. tuberculosis

2. What are the factors of local protection reno-urinary apparatus in children?

a. presence of IgA in urine
b. increased pH
c. low pH
d. fluctuations in osmolarity
e. Tamm-Horsfall uroprotein

3. The main routes of penetration of kidney infection in children are:

a. urogenital
b. haematogenous
c. lymphogenous
d. airborne
e. endogenous

4. The clinical signs characteristic of acute pyelonephritis in children, except:

a. fever> 38C, chills
b. sensible urination
c. pollakiuria
d. signs of intoxication
e. lumbar pain

5. What are the indications for performing renal scintigraphy in children?

a. recurrent urinary tract infections
b. urinary tract infections atypical for the age under 3 years
c. within 4-6 months after the acute episode of a urinary tract infection

d. renal agenesia
e. acute episode of urinary tract infection

6. The clinical picture of pyelonephritis in children includes the following complex of symptoms:
a. fever
b. chills
c. abdominal pain
d. lumbar pain
e. dysuria

7. Under the mask of which diseases acute pyelonephritis in children may develop?
a. acute appendicitis
b. acute pancreatitis
c. acute viral infection
d. intestinal infection
e. acute cholecystitis

8. What are the mandatory laboratory tests in the diagnosis of acute pyelonephritis in children?
a. full blood count
b. enzyme diagnostics
c. general analysis of urine
d. investigation of urine to opportunistic infections
e. investigation of immune status

9. What are the additional laboratory investigations in the diagnosis of acute pyelonephritis in children?
a. Zimniţkii sample
b. blood test to identify R-protein
c. morphology of urinary sediment
d. LYSO chemical test
e. general analysis of urine

10. What instrumental investigations are required in the diagnosis of acute pyelonephritis in children?
a. blood pressure monitoring
b. renal ultrasonography
c. intravenous urography
d. cystometry
e. micturition cystography

11. What are the laboratory changes characteristic for pyelonephritis in children?
a. inflammatory reaction of blood
b. modification of urinary sediment
c. lowering C-reactive protein in the blood
d. hypogammaglobulinemia
e. decrease in relative density of urine

12. Modification of urinary sediment in acute pyelonephritis in children is characterized by:
a. bacteriuria <50,000 colonies / ml
b. bacteriuria> 100,000 colonies / ml
c. proteinuria> 1gr / l
d. proteinuria <1gr / l
e. leucocyturia with neutrophil character> 50%

13. Disturbance of functional state of kidneys of tubulo- interstitial type occurs in the presence of:
a. increase in osmolarity
b. decrease in osmolarity
c. decrease of the relative density
d. increase of the relative density
e. low indices of acidoamoniogenesis

14. List the complications of pyelonephritis in children:
a. renal carbuncle
b. apostomatic nephritis
c. nephrolithiasis
d. Alport syndrome
e. papillary necrosis
15. What are the criteria for hospitalization of children with acute pyelonephritis?
a. mild form of acute pyelonephritis
b. acute pyelonephritis associated with other diseases under exacerbations
c. acute pyelonephritis in children of 10-15 years
d. acute pyelonephritis in children in the first months of life
e. mild forms of pyelonephritis accompanied by fever
16. Which of the listed methods confirm the diagnosis of pyelonephritis in children?
a. intravenous urography
b. renal scintigraphy
c. renal ultrasonography
d. chest radiography
e. cystoscopy
17. Risk factors related to the development of pyelonephritis in children are:
a. chronic foci of infection
b. frequent intercurrent infections
c. carential anemia
d. acute gastroduodenitis
e. vulvovaginitis and cystitis
18. What clinical manifestations are characteristic to pyelonephritis in infants?
a. dysuria syndrome
b. suprapubic pain
c. prolonged febrile syndrome
d. dyspeptic syndrome
e. generalized toxic-infectious syndrome
19. What are the local risk factors in the development of pyelonephritis in children?
a. hydronephrosis
b. urolithiasis
c. local tumor
d. Alport syndrome
e. renal polycystosis
20. With what diseases the differential diagnosis in acute pyelonephritis in children is performed?
a. glomerulonephritis
b. renal tuberculosis
c. cystitis
d. acute bronchitis
e. acute appendicitis
21. General curative measures in uncomplicated acute pyelonephritis in children include:
a. bed-regimen for 1-2 days after fever normalization
b. increased fluid intake
c. limiting the excess of protein products, extractive substances
d. compliance of the regimen of regular micturition
e. cotrimoxazole
22. Indicate the correct statements regarding the treatment of intricate acute pyelonephritis in children:
a. antibacterial therapy
b. intravenous infusions

c. nitrofurans
d. immunosuppressives
e. disaggregants

23. What are the typical clinical manifestations of pyelonephritis in children beyond the age of 3 years?

a. abdominal pain, lumbar
b. dysuria
c. diarrhea
d. generalized infectious-toxic syndrome
e. chills

24. What factors rise the degree of expression of symptoms in acute pyelonephritis children?

a. concomitant pathologies
b. age of the child
c. degree of physical development of the child
d. hereditary predisposition factors
e. body weight of the child

25. What characterizes the obstructive pyelonephritis in children?

a. constant temperature rise
b. occurrence of acute pain in the affected lumbar area
c. absence of fever
d. increased pain in the lumbar area on micturition
e. lack of pain

26. Antenatal factors predisposing to the development of pyelonephritis in children are:

a. nephropathy of the pregnancy
b. chronic pyelonephritis
c. acute allergic dermatitis
d. common intercurrent infections
e. chronic foci of infection in pregnant women

27. What changes are present at full blood count in acute pyelonephritis in children?

a. increased ESR
b. leukocytosis
c. eosinophilia
d. rise of hemoglobin
e. reduction of platelet count

28. What are the indications for micturition cystography in children?

a. enuresis beyond the age of 3-5 years
b. diurnal incontinence of urine
c. recurrent urinary infection
d. non functioning kidney
e. unilateral lumbar pain

29. What are the indications for performing radiological research methods of urinary pathways in children?

a. renal colic
b. pyelonephritis at any age
c. abdominal trauma
d. acute appendicitis
e. hypersensitivity to iodine preparations

30. The duration of administration of chemotherapeutic agents in children is:

a. 3-6 months in recurrent unobtrusive urinary tract infections
b. 6-12 months or until surgery
c. 1 month ago

d. 2 weeks
e. 2 months

31. What are the characteristics of urinary syndrome in acute pyelonephritis in children?
a. leucocyturia
b. bacteriuria> 100,000 colonies / ml. urine
c. density loss of urine
d. proteinuria> 3.0 g / l
e. erythrocyturia

32. What are the most common chemotherapy drugs used against urinary tract infections in children?
a. cotrimoxazole
b. nitrofurantoin
c. nalidixic acid
d. erythromycin
e. ciprofloxacin

33. What remedies are recommended for oral therapy of urinary tract infection in children?
a. nalidixic acid
b. cefuroxime
c. cefixime
d. biseptol
e. gentamicin

34. Hospitalization of children with urinary tract infection is performed under the following conditions:
a. age <6 months
b. do not accept liquid orally
c. toxicity
d. urinary obstruction
e. moderate state

35. What are the criteria of effectiveness of antibacterial therapy in children with acute pyelonephritis?
a. clinical improvement within 5-7 days of treatment initiation
b. diminution or disappearance of white blood cells at 2-3 days of treatment initiation
c. urine becomes sterile in 24-48 hours
d. clinical improvement within 24-48 hours after treatment initiation
e. worsening of clinical picture after 24 hours of treatment initiation

36. What are the purposes of the therapy of urinary tract infection in children?
a. urine sterilization
b. prevent dissemination of infection
c. reducing the probability of kidney damage
d. identification of the pathogenic agent
e. treatment of intercurrent infections

37. The main causes of urinary tract infection in children are:
a. urinary tract tumors
b. immaturity and disturbance of renal tissue differentiation
c. vesico-renal reflux
d. nephroptosis, renal dystopia, increased kidneys mobility
e. phosphatic diabetes

38. What remedies are used for the prevention of urinary tract infections in children?
a. nalidixic acid
b. co- trimaxozol
c. methenamine

d. nitrofurantoin
e. ampicillin

39. The effectiveness of antibiotic therapy of pyelonephritis in children is based on:

a. activity of bacterial inflammation
b. character of bacterial microflora
c. Urine pH
d. maintenance of diuresis and other renal function
e. age of the child

40. What are the contraindications to intravenous urography in children?

a. shock and syncope
b. decompensated heart defects
c. oliguria
d. chronic pyelonephritis
e. renal colic