***NICOLAE TESTEMIŢANU***

**STATE UNIVERSITY OF MEDICINE AND PHARMACY**

**FACULTY OF DENTISTRY**

**department of oro-maxillo-facial surgery and oral implantology „arsenie guțan”**

**TESTS**

**3rd year exam**

**Odontectomy and OMF region`s infections**

**1.SC. Extraction of the first molar entails tilting movements for tooth luxation**:

a) Palatal-vestibular;

b) Vestibular-oral;

c) Only vestibular;

d) Vertical;

e) Only palatinal.

**2. SC. For the extraction of upper incisors and canines, the following forceps are used:**

a**)** bayonet forceps;

b) beak forceps;

c) straight forceps;

d) S-shaped forceps – without tips;

e) S-shaped forceps - with tips.

**3. S.C. For the extraction of the first two maxillary molars, the following forceps are used:**

a) beak forceps;

b) straight forceps;

c) bayonet forceps;

d) S-shaped forceps with tips on the vestibular beak;

e) Beak forceps with tips on both beaks.

**4. SC. For the extraction of the third maxillary molar, the following forceps are used:**

a) **Broad bent beak**;

b) Straight forceps;

c) S-shaped forceps without pins;

d) Forceps for the extraction of upper third molars;

e) S-shaped forceps with pins.

**5. SC. The mandibular first molar is extracted with:**

a) Straight forceps;

b) Beak forceps;

c) Beak forceps with two tips on both beaks;

d) bayonet forceps;

e) Lecluse elevator.

**6. SC. The mandibular premolars are extracted with:**

a) Straight forceps;

b) Broad beak forceps;

c) Lecluse elevator;

d) Bayonet forceps;

e) S-shaped forceps.

**7. SC. Lecluse elevators can be used for the extraction of:**

a) Maxillary teeth;

b) Mandibular teeth;

c) Incisors and canines;

d) Mandibular third molar;

e) Maxillary third molar.

**8. SC. The bent broad beak forceps are used for the extraction of:**

a) Incisors;

b) Canines and premolars;

c) First two molars;

d) Mandibular third molar;

e) All teeth.

**9. SC. Special forceps are used for the extraction of the following teeth:**

a) Incisors;

b) Canines;

c) Premolars;

d) First two molars;

e) Third molars.

1. **SC. During tooth extraction, rotational movements are allowed in:**  
   a) Third molars;  
   b) Molars in general;  
   c) Molars and premolars;  
   d) Teeth with a single straight root;  
   e) Only maxillary teeth.

**11. SC. Dental extraction with root separation is indicated in one of the following cases:**

a) Molars representing bridge pillars;

b) Molars with divergent roots;

c) Molars with longitudinal root fractures;

d) Molars with proximal caries;

e) Impacted molars.

**12. SC. During tooth extraction 1/3 of apical root fracture occurs. In this case, the best management is:**

a) to continue extraction after root separation;

b) to complete extraction by alveolotomy;

c) to extirpate 1/3 of apical root by apical resection;

d) if root remnants are very small they can be left in place but the patient is warned;

e) to use H-file.

**13. SC. Three days after extraction, the patient experiences pain radiating to the ear, hypersalivation, alveolar mucosa congestion, as well as the presence of a dirty alveolar clot, fleshy buds bleeding when touched, purulent alveolar discharge. The most likely diagnosis is:**

a) Dry alveolitis;

b) Post-anesthesia neuritis;

c) Wet alveolitis;

d) Congestive pericoronitis;

e) Suppurative pericoronitis.

**14. SC. The primary element favoring post-extraction wound healing is:**

a) Thorough curettage of the alveolar fundus;

b) Approximation of gingival margins;

c) Endoalveolar clot formation;

d) Hemorrhage of alveolar walls;

e) Applying sutures.

**15. SC. The most appropriate management of post-extraction wound is:**

a) Local washing with hydrogen peroxide and wound **protection** with a sterile intraalveolar dressing;

b) Intra-alveolar washing with an antiseptic agent and application of Gelaspon and Thrombin dressing to accelerate haemostasis;

c) Control of alveolar wound, bone beaks regularization, alveolar edges tightening and protection with sterile supraalveolar dressing;

d) After normal extraction no treatment is required;

e) Sulfamide powder is introduced into post-extraction wound and antibiotic therapy is immediately initiated to prevent septic complications.

**16. SC. After extracting a tooth affected by apical periodontitis it is recommended:**

a) to insert a dressing in the alveolus;

b) to suture alveolar wounds;

c) to apply Gelaspon and Thrombin dressing held by a mouthguard or prosthesis;

d) to wash the alveolus with antiseptic;

e) no treatment is recommended in such cases.

**17. SC. Fracture of maxillary tuberosity occurs:**

a) During the maxillary third molar **dislocation/luxation** with elevator;

b) During the second molar extraction;

c) During the 6-year molar extraction;

d) During the extraction of premolars;

e) During the mandibular third molar extraction.

**18. SC. Sinus accidents of dental extraction can occur in:**

a) all the upper teeth;

b) upper incisors and canines;

c) upper premolars and molars;

d) lower premolars and molars;

e) the location of extracted tooth does not matter.

**19. SC. In alveolar wall fracture, when the bone fragment remains attached to the periosteum, the following measures are undertaken:**

a) the periosteum is removedand bone fragments are detached, then bone margins are smoothed and suturing is performed;

b) the detached fragment is replaced and gingival mucosa suturing is performed;

c) the fragment is sutured to the existing periosteum and compression supraalveolar dressing is applied;

d) the fragment is removed only with electrocautery;

e) periosteum fragment is removed and periosteum electrocautery is performed.

**20. SC. Mandible fracture can occur:**

a) During 6-year molar extraction with distally recurved roots;

b) During extraction of the mandibular third molar with straight roots, using Lecluse elevator;

c) During extraction of the third molar with distally recurved roots, using Lecluse elevator;

d) When there are follicular cysts, tumors, osteomyelitis, or impacted mandibular teeth;

e) When curved elevators are used to extract lateral teeth with distally recurved roots.

1. **SC. Dental roots pushed under the sinus lining are extracted:**

a) After radical sinus cure;

b) Only if the Valsalva maneuver is positive;

c) Via wide alveolar path;

d) Only with root forceps;

e) Only with lateral beak elevators.

**22. SC. The inferior alveolar nerve is often damaged during tooth extraction:**  
a) First premolar;  
b) 6-year molar;  
c) Second molar;  
d) Third molar;  
e) Second premolar.

**23. SC. Normally the time of alveolar clot formation is:**  
a) 30-40 minutes;  
b) 20-30 minutes;  
c) 15-20 minutes;  
d) 40-50 minutes;  
e) 50-60 minutes.

**24. SC. The dominant symptom in post-extraction alveolitis is:**  
a) Halitosis  
b) Pain;  
c) Loco-regional adenopathy;  
d) Fever;  
e) Pruritus.

**25. SC. Post-extraction alveolitis is:**

a) A septic complication of the alveolar wound involvingthe alveolar walls;

b) A localized osteitis, the inflammatory process being associated with superficial necrosis of bone walls;

c) Blood clot necrosis;

d) Alveolar wall necrosis;

e) A complication involving the alveolus, bone, gum mucosa.

**26. SC. Post-anesthetic septic complications in the subtemporal fossa occur especially after:**

a) Plexal anesthesia or block;

b) Incisive or infraorbital anesthesia;

c) Spix spina anesthesia or tuberosity anesthesia;

d) Mandibular or palatal opening anesthesia;

e) Topical anesthesia.

**27. SC. The most common cause of sinus floor perforation is:**

a) Bone resection in tumor removal;

b) Extraction of upper molars;

c) Syphilitic coma;

d) Osteoradionecrosis;

e) Maxillary bone trauma.

1. SC. Sinus accidents of dental extraction can occur in:  
   a) All upper teeth;  
   b) Upper incisors and canines;  
   c) Upper premollars and molars;  
   d) Lower premolars and molars;  
   e) The extracted tooth location does not matter.

**29. SC. Dental extraction accidents include:**  
a) Swallowing or aspiration of tooth fragments;  
b) Facial nerve damage;  
c) Immediate prolonged haemorrhage;  
d) Wet alveolitis;  
e) Antalgic trismus.

**30. SC. High pathway alveolar pathway extraction (Wassmundt technique):**

a) It is indicated for rootremnants pushed under sinus lining;

b) An envelope flap is made;

c) The palatal bone is cut off with bone rongeur clipper or rotary instruments;

d) Root remnants are removed with forceps;

e) It does not require suture.

**31. SC. Post-extraction alveolitis manifests:**

a) 30 days postoperatively;

b) 21 days postoperatively;

c) 14 days postoperatively;

d) 3-4 days postoperatively;

e) 24 hours.

**32. SC. What term does post-extraction alveolitis does not radiologically differ from the surrounding bone?**

a) At the end of the first month;

b) 2-4 months;

c) 4-6 months;

d) 7-8 months;

e) 8-9 months.

**33. SC. In the case of oro-sinusal communication, when post-extraction alveolus tamponade with iodoform dressing allowed?**a) is not allowed;  
b) in post-extraction haemorrhages;  
c) in purulent sinusitis;  
d) in the case of root propelling under sinus mucosa without perforating it;  
e) is allowed in all cases.

**34. SC. What method is used to extract the roots pushed in the maxillary sinus?**

a) Through postextraction alveolus;

b) Sinusotomy with oro-sinusal communication plastic surgery;

c) Sinusotomy without oro-sinusal communication plastic surgery;

d) Oro-sinus communication plastic surgery without sinusotomy;

e) Postextraction alveolus suturing without root removal.

**35. SC. What is the name of hemorrhage occuring after surgery?**

a) Idiopathic;

b) Iatrogenic;

c) Symptomatic;

d) Rhinogenic;

e) Nonspecific.

**36. SC. After extraction it is indicated to perform:**

a) Intensive mouthwashes with antiseptic solutions in the first 2 hoursafter extraction;

b) Hot food ingestion in the first 2 hours after extraction;

c) Antiseptic oral baths are excluded in the first 2 hours and on extraction day;

d) Physical effort on extraction day;

e) Physiotherapy on extraction day.

**37. SC. All of the following are relative contraindications of dental extraction, except for:**

a) Prolonged corticotherapy;

b) Chronic leukemia in compensated phase;

c) Acute leukemia;

d) Diabetes mellitus;

e) Over the first 6 months after myocardial infarction.

**38. SC. Which statement about tooth extraction is false:**

a) the surgeon checks if there is no adherent gum that can break when extracting the tooth from the alveolus;

b) the surgeon avoids striking the opposing arch when the tooth "escapes" from the alveolus;

c) The gum detached after tooth extraction has to be removed;

d) The crushed and necrotic gum margin is removed;

e) The extracted tooth is examined if it is integer or there are missing root apex fragments.

**39. SC. Which of the following statements is false:**

a) Straight forceps are used for upper incisors and canines;

b) Forceps for upper premolars have the vestibular beak with a tip to insert between the two vestibular roots;

c) Forceps for upper premolars don`t have tips;

d) Premolar forceps are used for lower canine extraction are used, because they have a long and strong root;

e) Forceps for lower molars have two tips.

**40. SC. S-shaped forceps provided with a tip:**

a) are used in the front maxillary area;

b) are used for the extraction of lower molars;

c) are used for the extraction of the upper third molar;

d)the tip is positioned on the vestibular beak;

e) The position of the tip differentiates the twoforceps for 3 and 4 quadrant.

**41. SC. Dental extraction accidents are as follows, except:**

a) Swallowing of teeth or root remnants;

b) Tooth displacement in extra-alveolar spaces;

c) Post-extraction haemorrhage;

d) Nerve branch injury;

e) Fracture of mandible or maxillary tuberosity.

**42. SC. Factors that do not facilitate the lower third molar odontectomy:**

a) Direct ratio with the mandibular canal;

b) Space for the second molar;

c) Mesial-angular position;

d) Conical or fused roots;

e) Large periodontal space.

**43. MC. Main instrumentation required in an oral surgery office:**

a) Extraction forceps, elevators, chisels, hammers, syndesmotomes;

b) Scalpels, scissors, port needles, needles, hemostatic clips;

c) Mouth opener, tongue fixator, retractor;

d) Currettes, excavators, pile raspel, probes, mirrors;

e) Trays, tweezers, mirror handles, scaling instrumentation.

**44. MC. Dental extraction is:**

a) A surgery, which aims at removing a tooth that can not be recovered by conservative treatment;

b) An intervention involving surgical principles combined with a set of principles adapted from physics and mechanics, aimed at removing a tooth from its alveolus;

c) It is the most common surgery in dentistry;

d) A mutilating removal of a tooth affected by a local pathologic process, if only all conservative methods are useless;

e) A routine surgerywhich can be performed by any dentist under any conditions and on any tooth.

**45. MC. Major indications of dental extraction are as follows:**

a) Complications of marginal caries and periodontitis;

b) Teeth causing local, loco-regional or follow-upcomplications;

c) Traumatic dentoalveolar injuries;

d) Cases of necessity;

e) Teeth that can not be subjected to orthodontic therapy.

**46. MC. Delayed dental extraction until the inflammatory process remitting is required in:**

a) Acute sinusitis of dental origin;

b) Odontogenic perimaxillary suppuration;

c) Teeth involved in tumor processes;

d) Acute rhinogenic sinusitis;

e) Stomatitis.

**47. MC. Tooth extraction with elevators is recommended in the following cases:**

a) Dentoalveolar anchilosis;

b) Roots under the socket edge;

c) Teeth with conical crowns that do not allow forceps to be adapted;

d) Teeth with extensive crown destruction;

e) Roots with abnormal shape, orientation or number.

**48. MC. Permanent teeth are extracted if:**

a) They do not erupt on the arch;

b) They interfere with correct reduction in case of fractures;

c) They are implanted in osteomyelitis sequestrum;

d) They produce jugal mucosa lesions;

e) They present pulp gangrene.

**49. M. In which of the following clinical situations, the extraction of temporary teeth is required:**

a) Persistent temporary teeth in the arch, accompanied by permanent tooth agenesis;

b) Persistent temporary teeth in the arch which prevent the permanent tooth eruption in inocclusion;

c) Persistent temporary teeth in the arch which direct the permanent tooth eruption in malposition;

d) Teeth with traumatic injuries;

e) Teeth involved in chronic suppurations.

**50. MC. The main instruments for dental extraction are:**

a) Forceps;

b) Elevators;

c) Hammers;

d) Chisels;

e) Burs.

**51.MC. Dental extraction forceps consist of the following elements:**

a) Beaks;

b) Handles;

c) Hinge;

d) Rod;

e) Tips.

**52. MC. Dental extraction forceps are classified, depending on:**

a) Dental arch (upper, lower);

b) Ratio between beaks and handle (straight, parallel, angle);

c) Side (right, left);

d) Teeth with integral crown and roots;

e) Beaks width.

**53. MC. Root extraction elevators consist of:**

a) Active part;

b) Cylindrical rod;

c) Round thick handle;

d) Beaks;

e) Hinge.

**54. MC. Elevators are more often used for:**

a) extraction of root remnants;

b) luxation of lower third molars;

c) extraction of all upper teeth;

d) extraction of all lower teeth;

e) extraction of all teeth.

**55. MC. Upper teeth are extracted using the following forceps:**

a) Straight forceps;

b) S – shaped forceps without tips;

c) Bayonet forceps

d) S - shaped forceps with a vestibular tip;

e) Beak.

**56. MC. Lower teeth are extracted using the following forceps:**

a) Bayonet forceps;

b) Narrow beaks forceps;

c) Beak forceps with tips on both beaks;

d) Bent beak forceps;

e) S – shaped forceps with a vestibular beak.

**57. MC. Dental extraction with forceps is carried out in several successive stages:**

a) Application;

b) Insinuation;

c) Fixing;

d) Luxation;

e) Extraction.

**58. MC. Secondary stages of dental extraction are:**

a) Luxation;

b) Syndesmotomy;

c) Anesthesia;

d) Curettage;

e) Suture application.

**59. MC. Luxation movements are:**

a) Rotation;

b) Tilting(vestibular-oral);

c) Vertical (up, down);

d) Traction;

e) Oblique.

**60. MC. During temporary teeth extraction it is contraindicated to perform:**

a) Syndesmotomy;

b) Socket exploration with tweezers or curette;

c) Gum mucosa gripping with forceps;

d) Pronounced subgingival plunging of forceps beaks;

e) Child immobilisation.

**61.MC. In dental extraction with forceps, luxation is the procedure by which:**

a) gradual socket widening is achieved;

b) circular tooth ligament is sectioned;

c) dentoalveolar ligament fibers are broken;

d) tooth is mobilized in its alveolus;

e) tooth axis traction and extraction is performed.

**62. MC. The advantages of post-extraction suturing are:**

a) Reduction of bleeding;

b) Pain decrease;

c) Faster healing;

d) Wound protection against oral septic environment;

e) In acute inflammatory processes, the suture promotes rapid bone regeneration.

**63. MC. Extraction with root separation is recommended in molars with**:

a) Bell-shaped roots;

b) Barred roots;

c) Dentoalveolar anchilosis;

d) Divergent roots;

e) Roots affected by deep caries.

**64. MC. Extraction of intraalveolar roots is mandatory:**

a) to prevent septic processes;

b) to provide an appropriate prosthetic field;

c) to prevent irritant processes;

d) to prevent tumoral processes;

e) to prevent inflammatory or proliferative gingival-periodontal processes.

**65. MC. Upper teeth roots can be removed with:**

a) Angled elevators;

b) Straight elevators;

c) Bayonet forceps;

d) Beak forceps;

e) Chisel and hammer.

**66. MC. Upper teeth have one, two, three and more roots:**

a) Teeth 1, 2, 3, 4, 5, 8 have one root;

b) Teeth 1, 2, 3, 5 have one root;

c) Tooth 4 has two roots;

d) Teeth 6, 7, 8 have three roots;

e) Teeth 4, 5, 6, 7 have three roots.

**67. MC. The upper third molar (M3) is extracted according to the following requirements:**

a) Forceps for upper third molars are used;

b) Vestibulo-palatal tilting is performed by reduced amplitude movements;

c) Extraction is carried out with Lecluse elevator;

d) First movements are rotary;

e) Beak forceps are used.

**68. MC. To extract lower teeth, the following dental instruments are used:**

a) Beak forceps for (narrow) incisors, canines and premolars (broad beak);

b) Forceps with a beak with double tips for first and second molars;

c) Forceps with wide bent beak for the third molar;

d) Angled elevator (left and right);

e) Lecluse elevator.

**69. MC. The Lecluse elevator can only be used to extract the lower third molar in some of the following situations:**

a) First and second molars present in the arch;

b) Lower third molar with straight roots;

c) Impacted lower third molar;

d) Lower third molar with an integral crown;

e) Lower third molar with suppurative pericoronitis.

**70. MC. Alveolotomy is recommended in some of the following situations:**

a) Extruded teeth:

b) Deep intraosseous root remnants;

c) Roots with hypercementosis;

d) Dento-alveolar ankylosis;

e) Extremely recurved roots with fracture risk during extraction.

**71. MC. For atypical extractions of the lower third molar, the following instruments are used:**

a) Bur (unit), drills;

b) Chisel, hammer;

c) Angled elevator (sharp);

d) Straight elevator (sharp);

e) Lecluse elevator.

**72. MC. Root morphology influences the difficulty of extraction of the lower third molar by:**

a) Root length;

b) Root curvature;

c) Direction of root curvature;

d) Mesiodistal size of root;

e) Periodontal space.

**73. MC. The post-extraction root examination aims to reveal**:

a) Rhizalysis processes

b) Root integrity;

c) False paths;

d) Hypercementosis processes;

e) Granulation tissue remnants.

**74. MC. To extract the lower third molar, forceps are used if:**

a) root is distally recurved;

b) root is straight;

c) tooth crown is resistant;

d) there are no antagonists;

e) dental arches are integral.

**75. MC. The extraction instrument is selected according to:**

a) Dental arch;

b) Tooth group;

c) Crown and root shape;

d) Dental crown destruction;

e) Patient age.

**76. MC. The purpose of curettage after tooth extraction is:**

a) to remove blood clot;

b) to remove pathological tissue (granulations);

c) to remove foreign bodies (tartar, root remnants, crown fragments etc);

d) to fill the socket with blood;

e) to stop bleeding.

**77. MC. Extraction with root forceps is indicated in the following cases:**

a) there are root application and attachment conditions or they may be made;

b) dental root has a quite protruding extraalveolar portion to fix the forceps beak;

c) dental root is within the alveolar wall and the bone allows a periradicular groove to be made to insinuate and fix the forceps;

d) dental root is below bone level;

e) dental root is found at the alveolus fundus.

**78. MC. The extraction of tooth roots with the elevator is indicated in the following cases:**

a) Dental roots present extensive destruction and it is not possible to use forceps;

b) The root is visible in the alveolus;

c) It is possible to insinuate the elevator between alveolus walls and root;

d) The root is deep in the alveolus;

e) Any tooth root.

**79. MC. Alveolotomy is performed in:**

a) Roots welded to the alveolar wall;

b) Converging roots;

c) Roots with hypercementosis;

d) Roots under dental bridges;

e) extremely recurved roots.

**80. MC. In extraction with root separation it is recommended:**

a) not to get too deeply with the bur;

b) not to section with carborundum discs;

c) not to resect the interradicular septum;

d) not to resect the alveolar wall;

e) not to separate with the chisel and hammer in the beginning.

**81. MC. Alveolotomy is indicated for:**

a) roots under dental bridges;

b) dentoalveolar ankylosis;

c) deep intraosseous root remnants remaining after old extractions;

d) root satellite odontomas;

e) roots deformed by hypercementosis processes.

82. **MC. Alveoplastic extraction is indicated in:**

a) Single extractions in extruded teeth;

b) Multiple extractions in carious teeth;

c) Single extractions of unextruded teeth;

d) Multiple extractions in marginal periodontitis;

e) Laborious extraction of root remnants.

83.MC. **The bone rongeur in the case of alveolotomy can be used for:**

a) deformed roots regularization;

b) interradicular septal resection;

c) bone regularization for suturing;

d) alveolar wall resection during trepanation;

e) extraction.

**84. MC. Root separation is indicated when:**

a) Roots are joined through the pulp chamber floor and can not be extracted together;

b) Roots are too divergent;

c) Roots are too convergent with a thick bone septum between them;

d) Small root remnants are located at the alveolar bottom ;

e) There are deep intraalveolar root remnants.

**85. MC. In root separation it is contraindicated to use:**

a) Carborundum discs;

b) Chisels;

c) Horico discs;

d) Spherical burs;

e) Cylindrical diamond burs.

**86. MC. Post-extraction wound healing is influenced by:**

a) Local factors;

b) General factors;

c) Intervention quality;

d) Patient`s attitude and wound care;

e) Season.

**87. MC. Local factors influencing post-extraction wound healing are as follows:**

a) Presence of chronic or acute septic foci;

b) Presence of microbial aggression;

c) Saliva enzymes;

d) Laborious extraction;

e) Quality of intraalveolar clot.

**88. MC. Post-extraction wound healing can be delayed by:**

a) Undermining alveolar wounds;

b) Resection of alveolar walls;

c) Persistent interradicular septum;

d) Hypovitaminosis C and D;

e) Corticotherapy.

**89. MC. In common alveolar wounds, if the bleeding persists for more than 30 minutes, the following measures are undertaken:**

a) Hemostatic iodoform dressing;

b) Resection of bone edges;

c) Gingivomucous wound suturing;

d) Compressive tamponade on the alveolus;

e) Alveolar curettage.

**90. MC. Management of common post-extration wound entails:**

a) Evacuation of secretions;

b) Smoothing of prominent bone margins;

c) Thorough curettage;

d) Tightening of alveolar edges;

e) Supra-alveolar iodoform tamponade.

**91. MC. Management of infected alveolar wounds involves:**

a) Prevention of secondary complications;

b) Complete evacuation of pathological matter;

c) Alveolar suture;

d) Thorough hemostasis;

e) Decrease of the septic process spread.

**92. MC. After chronic suppurative periodontitis, alveolar curettage can remove:**

a) Blood clots;

b) Fragments of granulation tissue;

c) Bone splinters;

d) Cystic membranes;

e) Soft bone walls.

**93. MC. Accidents and complications of dental extraction are divided into:**

a) Intraoperative incidents;

b) Postoperative complications;

c) Local accidents;

d) General accidents;

e) Light, medium and severe accidents.

**94. MC. Intraoperative accidents depending on the tissues involved are divided into:**

a) Lesions of perimaxillary soft parts;

b) Bone injuries;

c) Tooth injuries;

d) Nerve damage;

e) Vascular lesions.

**95. MC. Prevention of dental extraction accidents and complications is based on:**

a) Correct and thorough preoperative examination;

b) Compliance with basic surgical principles;

c) Exclusion of factors favoring the personal history;

d) Correct anesthesia;

e) Position of operator and patient.

**96. MC. General accidents during dental extraction are:**

a) Lipothymia;

b) Blue (respiratory) syncope;

c) White (cardiac) syncope;

d) Convulsions;

e) Traumatic shock.

**97. MC. Soft tissue lesions during dental extraction are the result of:**

a) Excessive and uncontrolled forces used;

b) Sliding of forceps at insinuation;

c) Skidding of sharp elevators;

d) Incorrect application of forceps;

e) Incomplete syndesmotomy.

**98. MC. Perimaxillary soft tissue lesions can be:**

a) Linear gingival lesions;

b) Extensive lesions with considerable bone detachment;

c) Palatal mucosa lesions;

d) Tongue lesions;

e) Mouth floor lesions.

**99. MC. Linear gum lesions are produced by:**

a) Straight elevator skidding;

b) Incorrect application of forceps over the mucosa;

c) Incomplete syndesmotomy;

d) Incorrect choice of instruments;

e) Use of vasoconstrictor anesthesia.

**100. MC. Bone lesions during dental extraction can be:**

a) Fracture of alveolar process;

b) Fracture of maxillary tuberosity;

c) Mandible fracture;

d) Maxilla fracture;

e) Malar bone fracture.

**101. MC. Alveolar process fracture occurs most commonly during the extraction of:**

a) upper canines;

b) upper third molar (M3);

c) lower incisors;

d) lower molars;

e) upper premolars.

**102. MC. Accidents associated with elevator use are:**

a) mandible fracture;

b) tongue lesions;

c) luxation of neighboring teeth;

d) extensive gingivo-alveolar lesions;

e) fracture of neighboring teeth.

**103. MC. Mandible luxation usually occurs in lower teeth extraction and is caused by:**

a) Ligament or capsular laxity;

b) Excessive pressure on the mandible;

c) Large and forced mouth opening;

d) Use of inappropriate instruments;

e) Use of vasoconstrictor substances.

**104. MC. In mandibular dislocation, the following measures are undertaken:**

a) Luxation decrease by Hippocrates;

b) Immobilization with a chin strap or menton-cephalic dressing;

c) Physiotherapeutic treatment is indicated;

d) Medical treatment is indicated;

e) Patient is hospitalized.

**105. MC. Sinus accidents occur most commonly in extractions of:**

a) Maxillary third molar;

b) Maxillary first molar;

c) Maxillary second molar;

d) Second premolar;

e) Maxillary canine.

**106. MC. Sinus accidents during dental extraction are as follows:**

a) Maxillary sinus opening;

b) Root pushing into sinus cavity;

c) Fracture of maxillary tuberosity with sinus perforation;

d) Anterior wall perforation;

e) Palatal bone fracture with sinus perforation.

**107. MC. Sinus accidents are favored by:**

a) Anatomical conditions, intimate ratio between the root and sinus bottom;

b) Resorption processes (cysts, granulomas, osteomyelitis, etc);

c) Use of inappropriate instruments;

d) Use of **high pressure** during extraction;

e) Marked osteoporosis.

**108. MC. The diagnosis of buccal-sinus communication can be determined by:**

a) Examination of the extracted tooth with a bone fragment attached to the apex;

b) Presence of blood with air bubbles;

c) Positive Valsalva test;

d) Socket exploration with a buttoned probe causes a feeling of falling down;

e) Radiography.

**109. MC. The luxation of neighboring teeth in dental extraction is caused by:**

a) Dental crowding;

b) Incorrect use of extraction instrument;

c) Incorrect use of elevator;

d) Incomplete patient examination;

e) Brutal maneuvers during extraction.

**110. MC. Dental extraction complications are as follows:**

a) Post-extraction haemorrhage;

b) Delayed post-extraction wound healing;

c) Alveolitis;

d) Abscesses, phlegmons;

e) Periostitis, osteomyelitis.

**111. MC. Post-extraction complications may be:**

a) Early (haemorrhage, alveolitis);

b) Late (occlusal-articular imbalance, exostosis, periosseous scarring adhesions, etc.);

c) Mild (abscesses, periostitis, alveolitis etc);

d) Medium (osteomyelitis, sinusitis, phlegmon etc);

e) Severe (septicemia, thrombosis, phlegmon).

**112. MC. Post-extraction bleeding may be caused by some favorable factors and particularities of the oro-maxillo-facial area:**

a) Oral and maxillary tissues are well vascularized;

b) Extraction results in an open wound which allows extra bleeding;

c) It is almost impossible to provide an effective supraalveolar compression to stop hemorrhage;

d) Tongue tends to explore the postoperative wound, sometimes dislodging the clot and causing additional bleeding;

e) Salivary enzymes may damage the clot before it is organized and granulation tissue develops.

**113. MC. By the etiological factor, post-extraction bleeding can be**:

a) Local;

b) General;

c) Post-traumatic;

d) Postoperative;

e) Sudden.

**114. MC. Local factors more frequently causing post-extraction haemorrhage are as follows:**

a) Extensive bone lesions with gingival-mucosal impairment

b) Alveolar process fractures;

c) Secondary vasodilatation following the administration of vasoconstrictor anesthetic;

d) Chronic inflammatory processes of the alveolus;

e) Bone chips and tooth fragments

**115. MC. In alveolitis the pain is characterized by:**

a) it occurs 24 hours after extraction;

b) it occurs 3-4 days after extraction;

c) persistent pain that does not subside when ordinary analgesic is administered;

d) pain radiating to the hemimaxilla or hemicranium;

e) intense pain resembling trigeminal neuralgia.

**116. MC. Wet alveolitis is characterized by:**

a) Prevalence of inflammatory lesions;

b) Absence of inflammatory processes;

c) The surrounding mucosa is swollen and turgescent with altered and purulent clots in the socket;

d) The gum is pale and atonic with no clot in the socket;

e) Prolonged vasoconstriction and trophic disorders produce necrosis of alveolar bone walls.

**117. MC. Symptoms of dry alveolitis include:**

a) Pale and atonic gingival mucosa;

b) Purulent discharges from the alveolus;

c) Whitish alveolar walls with small lamelliform sequestra;

d) Violent and radiating pain;

e) Granulation tissue in the alveolus, which slightly bleeds when touched.

**118.MC. In alveolitis there are a number of factors causing the infection of bone walls and contents, namely:**

a) Loco-regional vasomotor disorders caused by operative trauma and adrenaline action in the anesthetic solution;

b) Laborious and prolonged extractions with both bone tissue and mucoperiosteum crush;

c) Bone or tooth fragments in the alveolus;

d) Incomplete extraction with root remnants in the alveolus;

e) Acute or chronic periradicular infectious processes.

**119.MC. From the anatomo-pathological point of view, there are the following forms of post-extraction alveolitis:**

a) Wet alveolitis;

b) Necrotizing alveolitis;

c) Putrid-necrotizing alveolitis;

d) Dry alveolitis (dry socket);

e) Mixed alveolitis.

**120.** **MC. Symptoms of wet alveolitis are as follows:**

a) Violent and radiating pain occurring 3 or 4 days after extraction;

b) Halitosis;

c) Congested and swollen gingival mucosa;

d) Dirty clot covered with purulent and malodorous deposits;

e) Slightly bleeding granulation tissue in the alveolus.

**121.MC. Post-extraction recommendations are as follows:**  
a) Supraalveolar dressing is maintained for 2 hours;  
b) Mouthwashes with antiseptic solutions after the removal of suprralveolar dressing;  
c) Toothbrushing is allowed on extraction day;  
d) Applying cold dressing on soft tissues over the extraction region;  
e) Antibiotic therapy is mandatory in all cases.

**122.MC. Maxillary tuberosity fracture:**  
a) It is an accident that frequently occurs during any upper molar extraction;  
b) If the bone fragment is attached to the periosteum, it is surgically removed;  
c) The defect is closed by suturing the mucous lining;  
d) Large oro-sinusal communications may occur;  
e) If the tooth and bone tissue form a common body, they are removed together.

**123.MC. Local contraindications of dental extraction are as follows:**  
a) Local lesions of oral mucosa;  
b) Rhinogenic maxillary sinusitis;  
c) Cardiovascular diseases;  
d) Chronic suppurative processes;  
e) Acute suppurative processes.

**124.MC. Extraction of maxillary incisors:**  
a) The alveolar bone has a decreased palatal thickness;  
b) Gingival mucosa detachment has the role to increase the size of clinical tooth crown;  
c) First forceps beak is applied vestibularly, then the beak is applied palatally;  
d) Vestibulo-oral tooth luxation is performed;  
e) Rotation movements are not indicated.

**125. MC. Curettage of post-extraction alveolitis:**  
a) it is not indicated after typical extractions;  
b) it removes remaining pathological tissues;  
c) curettage of the alveolar bottom is performed with well-adjusted pressure;  
d) it is performed with a straight curette in the mandible or a curved curette in the maxilla;  
e) it is practically indicated after any dental extraction.

**126. MC. Post-extraction suture:**  
a) It is mandatory after any extraction;  
b) It is also recommended for simple extractions;  
c) If wound edges are not completely mobile, suturing is not performed;  
d) Suture protects the alveolar clot;  
e) Promotes scarring.

**127. MC. Extraction of the maxillary first premolar:**  
a) Themaxillary first premolar often has a root and rarely two roots;  
b) The vestibular cortical bone is thinner than the palatal one;  
c) Vestibulo-oral luxation is performed;  
d) The tooth is extracted by occlusal and slightly palatal traction;  
e) The forceps are applied apically.

**128. MC. Extraction of the maxillary canine:**  
a) Canine root determines the presence of canine eminence;  
b**)** Frequently the palatal cortical bone is thin;  
c) The gingival-mucosal detachment is performed with curved elevator or syndesmotome;  
d) Fracture of the palatal cortical bone portion is an extraction complication;  
e) After the dislocation, the tooth is tractioned vestibularly-incisally.

**129. MC. Extraction of the erupted maxillary third molar**:  
a) It usually has divergent roots;  
b) It is extracted with special forceps for maxillary third molars;  
c) It is extracted with special forceps for mandibular third molars;  
d) Extraction is frequently performed only with elevators;  
e) Bayonet forceps are used.

**130. MC. Extraction of the erupted mandibular third molar:**  
a) It usually has conical and fused roots;  
b) Alveolar bone is thinner vestibularly;  
c) The alveolar bone presents high retromolar toughness;  
d) Two distinct techniques for the mandibular third molar extraction are described;  
e) Anesthesia is different than that used for other mandibular molars.

**131. MC. Rules for using straight elevators:**  
a) They are always applied vestibularly and lingually;  
b) The convex surface of the active part must be in contact with the tooth to be extracted;  
c) During luxation, adjacent teeth are used as support;  
d) Straight elevator is not used for pluriradicular teeth extraction if the roots were not separated;  
e) The concave surface of the active part must be in contact with the tooth to be extracted.

**132. MC. Indications for permanent teeth extraction are related to:**  
a) Tooth condition;  
b) Condition of antagonist teeth;  
c) Pathology of adjacent structures;  
d) Associated diseases;  
e) The chosen technique.

**133.MC. Indications of dental extraction related to dental-paradontal pathology:**  
a) Teeth with chronic marginal parodontopathy and grade II-III mobility;  
b) Malposed teeth;  
c) Extruded teeth;  
d) Teeth causing sinus suppurative processes;  
e) Teeth maintaining odontogenic maxillary sinusitis.

**134. MC. Indications of dental extraction related to pseudotumoral or tumoral dental pathology:**  
a) Teeth causing reactive hyperplasic lesions (epulis-like);   
b) Teeth subjected to cystic changes;  
c) Neighboring teeth involved in the tumor process;  
d) Impacted teeth that can not erupt;  
e) Teeth with extensive crown and root destruction.

**135. MC. Indications of dental extraction related to traumatic OMF pathology:**  
a) Teeth with oblique or longitudinal root fractures;  
b) Teeth in fracture focus that affect the repositioning of bone fragments in the correct anatomical position;  
c) Erupted teeth that cause crowding;  
d) Malposed teeth that cause traumatic injuries;  
e) Completely luxated teeth following OMF trauma.

**136. MC. Indications of dental extraction related to abnormalities of teeth number, shape and position:**  
a) Impacted teeth that can not erupt;  
b) Impacted teeth that cause crowding;  
c) Extruded teeth;  
d) Completely luxated teeth;  
e) Malposed teeth that can not be subjected to orthodontic therapy.

**137.MC. Indications of dental extraction related to oro-maxillo-facial traumatic disease are as follows:**  
a) Teeth undergoing benign cystic / tumoral changes;  
b) Fractured or completely luxated teeth as a result of oro-maxillo-facial trauma;  
c) Teeth with oblique or longitudinal root fractures;  
d) Teeth with chronic deep marginal parodontopathy and grade 2-3 mobility;  
e) Extruded,egressedor inclined teeth.

**138.MC. Extraction of the mandibular third molar with Lecluse elevator is indicated:**  
a) When the roots of the mandibular third molar are straight;  
b) When the crown of the third molar is integral;  
c) Presence of integral first and second molars with favorable implantation;  
d) When the roots of the mandibular third molar are slightly divergent;  
e) In the case of teeth with a partially integral crown.

**139.MC. Post-extruction bleeding occurs due to the following general factors that cause hemostasis disorders:**  
a) Chronic liver diseases;  
b) Endocrine disorders;  
c) Secondary vasodilation (paralytic), resulting from the administration of vasoconstrictors together with anesthetic;  
d) Allergic conditions;  
e) Quantitative and qualitative platelet disorders.

**140. MC. Dental extraction complications are characterized by:**  
a) Pain;  
b) Delayed post-extraction healing of the alveolus;  
c) Infectious complications;  
d) Lockjaw (trismus);  
e) Decreased blood sugar.

**141. MC. Depending on the time of occurrence, post-extraction haemorrhage can be classified into:**  
a) Spontaneous;  
b) Immediate**-**prolonged;  
c) Late;  
d) Late-delayed;  
e) Early.

**142. MC. Local factors involved in the occurrence of post-extraction hemorrhages:**  
a) Alveolar process fracture;  
b) Secondary vasoconstriction in the case of dental plexus anesthesia with vasoconstrictor;  
c) Extensive fibromucosa lesions;  
d) Liver failure;  
e) Allergic conditions.

**143. MC. Post-extraction infectious complications are favored by:**  
a) Incomplete alveolar curettage;  
b) Apex fracture;  
c) Socket tamponade;  
d) Extraction performed in acute inflammatory process;  
e) Wound suturing.

**144. MC. Post-extraction alveolitis is favored by:**  
a) Prolonged suprralveolar dressing;  
b) Pre-existing acute or chronic infections;  
c) Wound suturing;  
d) Alveolus curettage;  
e) Alveoplastic extraction.

**145. MC. Dental extraction with interradicular separation is indicated in pluriradicular teeth, when:**  
a) Roots are very divergent;  
b) Roots present hypercementosis;  
c) Roots are separated at the pulp chamber floor;  
d) Teeth with crown destruction that do not allow forceps to be efficiently applied;  
e) In case of crown fracture during extraction.

**146.MC. In the case of upper molars, the following root separation is performed:**a) "V"-shaped separation;  
b) "T"-shaped separation;  
c) "L"-shaped separation;  
d) "Y”-shaped separation;  
e) "Z"-shaped separation.

**147. MC. Dental roots can be extracted using the following techniques:**  
a) Extraction with syndesmotomes;  
b) Extraction with elevators;  
c) Extraction with root forceps;  
d) Extraction with bone rongeur;   
e) Alveolotomy.

**148. MC. Extraction of small root remnants, located deep in the alveolus, can be performed by:**  
a) Alveolotomy;  
b) Transeptal extraction of pluriradicular teeth;  
c) Only with tooth forceps of choice;  
d) Only with root remnants forceps;  
e) Only with bone rongeur.

**149.MC. Indications of dental extraction are as follows:**  
a) Teeth in jaws fracture foci that interfere with surgical treatment or cause complications;  
b) Impacted teeth that do not cause functional or eruption disorders;  
c) Extruded teeth or teeth with major implantation axis deviations;  
d) Longitudinally fractured teeth;  
e) Teeth of patients with compensated chronic diseases that can resist long-term dental treatments.

**150.MC. Delayed post-extraction wound healing is influenced by:**  
a) Wound dehiscence;  
b) Malnutrition;  
c) Radiotherapy;  
d) Patient`s age;  
e) Allergic conditions.

**151. MC. Post-extraction bleeding:**  
a) Post-extraction bleeding normally stops over 30-40 minutes;  
b) Depending on the moment of occurrence, there are early and late haemorrhages;  
c) Early haemorrhage - bleeding occurs 2-3 hours before extraction;  
d) Late haemorrhage - bleeding occurs a few days after extraction;  
e) Post-extraction bleeding is caused by general and local factors.

**152. MC. Local factors involved in post-extraction bleeding are as follows:**  
a) Thrombocytopenia;  
b) Vitamin deficiencies;  
c) Secondary vasodilation in the case of dental plexus anesthesia in which no vasoconstrictor is used;  
d) Persistence of granulation tissue;  
e) In cases when the patient does not comply with post-extraction care instructions.

**153. MC. General factors causing haemostasis disorders are as follows:**  
a) Vasculopathy;  
b) Lipid deficiencies;  
c) Protein deficiencies;  
d) Antithrombotic treatments;  
e) Isolated deficiencies of plasma factors.

**154. MC. Dry alveolitis:**  
a) It is an infectious complication of dental extraction;  
b) It is a form of local osteomyelitis;  
c) It is favored by laborious extractions, with injury of soft parts and bone walls;  
d) Pain occurs over 4-5 days;  
e) Treatment is mainly symptomatic.

**155. MC. Accidents of dental extraction can be classified as follows:**  
a) Dental injury;  
b) Sinus injuries;  
c) Lockjaw;  
d) Dry alveolitis;  
e) TMJ luxation.

**156. MC. In alveolotomy, the following flaps can be made:**a) Envelope flap;  
b) Triangular or "L"-shaped flap;  
c) Trapezoidal flap;  
d) Its thickness must contain mucous and submucous memranes;  
e) Detachment has to be maximum providing good visibility.

1**57. MC. Extraction of small root remnants deeply located in the alveolus:**a)A fine elevator is insinuated between the root and socket wall;  
b) A groove can be made in the alveolar wall if needed;  
c) If the root canal orifice can also be viewed and root remnants can luxate, Hedstrom needle can be used for extraction;  
d) Alveolotomy may be used if the above measures are ineffective;  
e) The doctor has to begin with interradicular separation.

1. **MC. Dental extraction with interradicular separation:**  
   a) It is indicated in monoradicular teeth;  
   b) X-ray examination reveals the presence of divergent roots;  
   c) X-ray examination reveals curved and divergent roots;  
   d) Extensive crown destruction up to the floor of the pulp chamber;  
   e) Temporary molars without any significant root resorption, where there is a risk of pulling out the permanent tooth bud, located between roots.
2. **MC. Which statements about dental extraction accidents are true:**  
   a) To prevent maxillary tuberosity fracture, distal dislocation of the maxillary third molar is avoided;  
   b) Negative Valsalva sign excludes the existence of oro-sinus communication;  
   c) If during extraction the apex of a vital tooth has been damaged, it is extracted;  
   d) Accidental extraction of the neighboring tooth occurs frequently;  
   e) When aspirating a tooth during dental extraction, the patient has to perform chest X-ray.
3. **MC. Which statements about post-extraction oro-sinus communication are true:**a) Maxillary sinus opening is one of the most common and severe post-extraction injuries;  
   b) The Valsalva maneuver certainly indicates the presence or absence of oro-sinus communication;  
   c) Molars are, most often, sinus teeth;  
   d) Diagnosis of oro-sinus communication is made by exploration with buttoned probe or X-ray examination;  
   e) The technique of oro-sinus communication plasty involves the use of palatal flap.

**161. MC. During the curettage of post-extraction alveolus, the following accidents can occur:**  
a) Lower alveolar nerve injury;  
b) Oro-sinus communication;  
c) Superior-posterior alveolar nerves injury;  
d) Aggressive curettage can cause early secondary haemorrhage;  
e) Insufficient curettage results in post-extraction alveolitis.

**162. MC. Post-extraction complications are:**a) Prolonged haemorrhage, lasting for 15-20 minutes;  
b) Post-extraction alveolitis;  
c) Early secondary haemorrhage, usually occurring at night;  
d) Late secondary bleeding, usually occurring late at night;  
e) Normal post-extraction bleeding, lasting for 30-60 minutes.

**163. MC. Local post-extraction haemostasis measures are:**  
a) Hemostatic materials are introduced into the socket;  
b) Alveolar curettage is performed to remove foreign bodies;  
c) For repeated anesthesia of the given area, truncal blockage is preferred instead of local infiltration;  
d) Supraalveolar tamponade fixed with suture threads for 48 hours;  
e) Alveolar bone edge regularization.

**164. MC. Which of the following statements about the treatment of post-extraction alveolitis are true:**  
a) Use of intraalveolar iodoform dressing;  
b) Thorough and profound curettage of osteitic alveolar bone walls;  
c) Sedation of pain by anesthetic solution infiltration;  
d) Abundant irrigation of the alveolus with warm antiseptic solutions;  
e) Physical agents are used to stimulate local reactivity.

**165. MC. Etiology of post-extraction alveolitis:**  
a) Certain materials are introduced in sockets for antiseptic and haemostatic purposes;  
b) Presence of activated proteolytic ferment in saliva;  
c) Smoking in the first 2 hours after extraction;  
d) Intraalveolar foreign bodies;  
e) Local vasomotor disorders caused by the operative act or ischemic action of adrenaline in anesthetic solution.

**166. MC. Which of the following statements about dry post-extraction alveolitis are true:**  
a) Dry alveolitis is free of congestion, with local signs of trophic disorder;  
b) In the alveolus there is burgeoning granulation tissue that bleeds gently;  
c) The gum is swollen with congested and turgescent edges;  
d) The intraalveolar clot is totally or partially absent;  
e) The exposed alveolar bone is the source of continuous neuralgic pain.

**167. MC. In the case of post-extraction dry alveolitis, the following is indicated:**  
a) Post-extraction alveolus curettage;  
b) Diathermocoagulation of socket walls and bottom;  
c) Socket tamponade with iodoform dressing;  
d) Tamponade with Vishnevski ointment dressing;  
e) Physiotherapy.

1. **MC. Post-extraction alveolitis can be:**a) Wet;  
   b) Dry;  
   c) Primary  
   d) Secondary;  
   e) Nonspecific.

**169. MC. Post-extraction recommendations are as follows:**  
a) Consumption of liquids only with the straw in order to avoid negative pressure;  
b) Supraalveolar tamponade for one hour;  
c) Tooth brushing is resumed the next day;  
d) Soft food consumption is avoided for 24-48 hours;  
e) Analgesics.

**170. MC. Permanent teeth are extracted in the following cases:**a) Teeth with simple gangrene in which endodontic methods have failed;  
b) Teeth that caused bone infections (periostitis, osteomyelitis);  
c) Traumatized teeth;  
d) Teeth transversally fractured in the apical third;  
e) Malposed teeth which can not be subject to orthodontic therapy.

**171. MC. Loco-regional or general absolute contraindications of dental extraction are:**  
a) **In the first two years after an acute myocardial infarction**;  
b) Extraction during the first 3 months and the last 2 months of pregnancy;  
c) Acute leukosis;  
d) Teeth in areas subject to radiotherapy;  
e) Teeth involvedinmalignant neoplastic processes.

**172.MC. Relative (temporary) local-regional contraindications of dental extraction are:**a) Localized or diffuse inflammatory diseases with an altered general condition;  
b) During the first days of menstruation there is an increased risk of bleeding;  
c) Acute diseases of the oropharyngeal mucosa;  
d) Bone destruction predisposing to pathological bone fractures (cysts, benign tumors);  
e) Patients with chronic viral hepatitis.

**173. MC. Application of forceps and tooth setting must meet the following conditions:**  
a) It is performed in extension of tooth implant axis;  
b) The forceps beak is applied vestibularly first, where visibility is better;  
c) The forceps are applied coronarly away from the alveolar margin in order not to injure the gum;  
d) The best setting like "common body" between forceps and tooth to be extracted;  
e) Forceps have to be well adjusted to the tooth neck in order to perform the extraction.

**174. MC. Which of the following statements about syndesmotomy are true:**  
a) It entails cutting the circular tooth ligament;  
b) It is carried out with syndesmotomes or elevators;  
c) Syndesmotomes are cutting instruments that can reduce the alveolar edge height for a better tooth setting;  
d) Complete gum detachment around the tooth neck allows subgingival insertion of extraction forceps;  
e) It is not required for extraction of root fragments.

**175. MC. Which of the following statements about root separation are correct:**a) For upper molars, the groove is T-shaped;  
b) Root separation is carried out using the spherical or fissure burs;  
c) Extraction indications with root separation include molars with convergent roots when the distance between apexes is greater than the socket opening;  
d) After performing root separation, the extraction is completed with tooth root forceps;  
e) Extraction indications with root separation include barred roots.

**176. MC. What are the indications of alveolotomy:**  
a) Divergent and marked recurved roots;  
b) Roots with dento-alveolar mobility;  
c) Dental roots without hypercementosis;  
d) Roots left under conjunct prosthetic works;  
e) Residual root fragments after old extractions.

**177. MC. The time of residual root remnants extraction by alveolotomy:**  
a) Incisions are cut to make a trapezoidal or triangular flap;  
b) Initial detachment of gingival mucosa and subsequent periosteum detachment;  
c) Bone resection by root remnant exposing;  
d) Gradual sectioning, from the near side of root remnant (tip);  
e) Flap reapplication and suturing.

**178. MC. Extraction of dental roots can be performed using the following techniques:**a) Extraction with root forceps;  
b) Extraction with syndesmotomes;  
c) Extraction with elevators;  
d) Extraction with bone rongeur;  
e) Alveolotomy.

**179. MC. Complications of the mandibular third molar odontectomy:**  
a) TMJ luxation;  
b) Mandibular fracture;  
c) Post-extraction haemorrhage;  
d) Inferior alveolar vascular nerve damage;  
e) 12-year-old molar luxation or fracture.

**180. MC. Factors facilitating the mandibular third molar odontectomy:**a) Mesio-angular position;  
b) Long and thin roots;  
c) Lack of the neighboring tooth in the dental arch;  
d) Narrow paradontal space;  
e) Roots formed on 1/3 or 2/3.

**181. MC. Factors that make the mandibular third molar odontectomy difficult:**  
a) Conicalor fused roots;  
b) Close contact with the second molar;  
c) Complete bony impaction;  
d) Divergent roots;  
e) Mesio-angular position.

**182. MC. Accidents that may occur during the maxillary third molar odontectomy:**  
a) Fracture or luxation of a12-year old molar;  
b) Tuberosity fracture;  
c) Post-extraction haemorrhage;  
d) Mandible luxation;  
e) Oro-sinusal communication.

**183. MC. Complications after the mandibular third molar odontectomy are related to:**  
a) Mandible luxation;  
b) Postoperative mandibular angle fracture;  
c) Pain, edema and postoperative trismus;  
d) Swallowing or aspiration of dental or bone fragments;  
e) Infectious complications.

**184.MC. In odontectomy of impacted canine, a series of intraoperative accidents may occur:**  
a) Luxation of neighboring teeth;  
b) Nasal fossaeopening;  
c) Alveolar process fracture;  
d) Infectious complications;  
e) Maxillary sinus opening.

**185.MC. The diagnosis of tooth impaction requires other types of radiological investigations besides orthopantomography, depending on the nature of tooth impaction, such as:**  
a) Radiological examination with occlusal film;  
b) Mouth floor radiography;  
c) Sialography;  
d) CBCT (Cone Beam Computed Tomography);  
e) Radiography of maxillary sinuses.

**186. MC. Possible intraoperative accidents of upper canine odontectomy include:**  
a) Luxation of contralateral impacted canine;  
b) Nasal fossaeopening;  
c) Maxillary sinus opening;  
d) Luxation of neighboring teeth;  
e) Crown-root sectioning.

**187. MC. In odontectomy, the following principles have to be followed:**a) Optimal exposure of the impacted tooth area;  
b) Syndesmotomy;  
c) Crown-root separation if necessary;  
d) The pericoronal pouch must not be removed;  
e) Plane suture is performed.

**188. MC. In odontectomy of the impacted mandibular third molar, a series of intraoperative accidents can occur:**  
a) Mandibular fracture;  
b) Fracture of the third molar root;  
c) Pushing the third molar in the mouth floor;  
d) Wound dehiscence;  
e) Lingual bone plate fracture.

**189. MC. In odontectomy of the impacted maxillary third molar, a series of intraoperative accidents can occur:**  
a) Maxillary tuberosity fracture;  
b) Post-extraction oro-sinusal communication;  
c) Nasal fossae opening;  
d) Tooth propulsion into the maxillary sinus;  
e) Tooth propelling into the pterygomaxillary space.

**190. MC. At the age of 18, the bone around impacted molar is characterized by:**  
a) The bone is less dense;  
b) The bone is denser;  
c) There is a faster recovery of the bone area on which the rotary instrument or elevator was applied;  
d) The bone is not flexible;  
e) Extraction is laborious.

**191. MC. The factors facilitating the mandibular third molar odontectomy are as follows:**  
a) Curved and divergent roots;  
b) Direct ratio with the mandibular canal;  
c) Oral cavity opening is not limited;  
d) Conical or fused roots;  
e) Complete bony impaction.

**192. MC. Intraoperative accidents during the maxillary third molar extraction:**a) Fracture of the impacted molar root;  
b) Mandible luxation;  
c) Maxillary tuberosity fracture;  
d) Maxillary sinus opening;  
e) Facial nerve damage.

**193.MC. Bayonet incision in the case of odontectomy of upper molars is indicated in the following cases:**  
a) Submucous vertical impaction;  
b) When a wider access is required;  
c) In deep tooth impaction;  
d) In impaction where the bone is 2 mm thick on the occlusal face of the vertical molar;  
e) In cases where the molar perforated the bone plate and a submucous cuspid is palpated.

**194.MC. Types of post-extraction alveolar wounds:**  
a) Normal alveolar wound;  
b) Infected alveolar wound;  
c) Comminuted alveolar wound;  
d) Sutured alveolar wound;  
e) Necrotic alveolar wound.

**195.MC. Suture material may be:**  
a) Natural;  
b) Synthetic;  
c) Resorbable;  
d) Non-resorbable;  
e) Combined.

**196. MC. Dental treatment in patients with acute myocardial infarction (less than 6 months after myocardial infarction) is recommended to be performed:**  
a) In an in-patient unit;  
b) In the dental office;  
c) In cooperation with the cardiologist;  
d) In cooperation with the reanimatologist;  
e) In cooperation with the general practitioner.

**197. MC. Management in the dental office of patients with stable arrhythmia is as follows:**a) Backgroundtreatment is not interrupted;  
b) Backgroundtreatment is discontinued;  
c) Stress during treatment has to be avoided;  
d) Vasoconstrictors have to be used;  
e) Vasoconstrictors are not used.

**198. MC. In the dental office, in the case of hypertensive patients the following measures are required:**  
a) Background medication is not discontinued;  
b) Background medication is discontinued;  
c) Appointments are made in the morning;  
d) Therapy sessionsare short;  
e) BP monitoring during treatment.

**199. MC. In patients with orthostatic hypotension, the following measures are undertaken:**  
a) Sedatives are not used;  
b) Local anesthetic solutions with vasoconstrictor have to be used;  
c) Sudden change from clinostatism to orthostatism has to be avoided;  
d) Sedatives are administered;  
e) Local anesthetic solutions with vasoconstrictor are not used.

**200. SC. In diabetic patients, the following measures are undertaken:**a) Blood glucose control before and after treatment;  
b) Therapy sessions have to be short to minimize the interference with diet;  
c) Antibiotic prophylaxis of local infectious complications (in patients whose blood glucose level can not be controlled effectively);  
d) Sugar and glucose infusion solution have to be at hand to be promptly administered if some signs of hypoglycaemia occur;  
e) All of these.

**201. MC. In patients with chronic renal failure receiving conservative therapy or subjected to peritoneal dialysis, the following measures are undertaken:**  
a) Compulsory collaboration with the nephrologist;  
b) Compulsory collaboration with the reanimatologist;  
c) Haemostasis control;  
d) High doses of NSAIDs;  
e) NSAIDs are decreased because they affect the renal function.

**202. MC. In patients with liver cirrhosis, the following measures are undertaken:**  
a) Preoperative evaluation of the hemostatic system;  
b) Patients with hemostatic system disorders require surgical interventions under inpatient conditions;  
c) Haemostasis control;  
d) Interventions on several quadrants have to be performed in separate sessions;  
e) Extensive and long-term interventions have to be avoided.

**203. MC. Active hemostatic agents are:**  
a) Thrombin;  
b) Products where thrombin is included as a haemostatic component;  
c) Collagen;  
d) Cellulose;  
e) Gelatin.

**204.MC. Passive haemostatic agents are:**  
a) Thrombin;  
b) Products where thrombin is included as a haemostatic component;  
c) Collagen;  
d) Cellulose;  
e) Gelatin.

**205. MC. Thrombin initiates thrombogenesis effect by:**  
a) Transforming fibrinogen of underlying tissues into fibrin;  
b) Stimulation of extrinsic blood coagulation mechanism;  
c) Stimulation of platelet aggregation;  
d) Stimulation of intrinsic blood coagulation mechanism;  
e) Formation of prothrombin activators.

**206. SC. The failure of thrombin to form blood clot occurs in patients with:**  
a) Afibrinogenemia;  
b) Hypoprothrombinemia;  
c) Hemophilia A;  
d) Hageman's disease (factor XII deficiency);  
e) None of them.

**207. SC. Fibrin adhesive contains:**  
a) Prothrombin and fibrinogen;  
b) Prothrombin and thrombin;  
c) Fibrinogen and thrombin;  
d) Prothrombin activators;  
e) None of them.

**208. MC. The disadvantages of collagen products are:**  
a) They cause allergic reactions;  
b) They cause neuro-endocrine changes;  
c) They stimulate osteogenesis;  
d) They inhibit platelet activity;  
e) They intensify bacterial multiplication and can cause abscesses.

**209.MC. The advantages of cellulose-based products are:**  
a) They are easy to handle;  
b) They do not stick to instruments;  
c) They can be cut according to bleeding wound size;  
d) They do not cause local irritation;  
e) They do not cause allergic reactions.

**210. MC. The disadvantages of oxidized cellulose are:**  
a) it does not absorb like other products;  
b) it inhibits wound epithelization;  
c) it has the ability to delay osteoformation;  
d) it can give rise to cysts;  
e) it is expensive.

**211. MC. Gelatine products have the following drawbacks:**  
a) they stick to surgical instruments, making their handling difficult;  
b) they do not form a close connection with the bleeding source;  
c) they can cause some tumors;  
d) they inhibit osteoblasts function;  
e) they bring about neuro-endocrine changes.

**212. MC. Common drawbacks of passive haemostatic agents are:**  
a) they do not adhere tightly to wet tissue and therefore have a low impact on active wound bleeding;  
b) they can cause a possible body reaction to the presence of foreign bodies;  
c) they prevent optimal wound healing;  
d) they may be the source of granulomas;  
e) they have follow-up toxic effects.

**213. MC. The properties of an ideal hemostatic agent are:**  
a) Rapid and effective in bleeding control;  
b) Ability to get effective contact with the bleeding surface;  
c) Easy to handle;  
d) Available in many different delivery modes for different bleeding types;  
e) Active and compatible with physiological peculiarities of patients.

**214.MC. The advantages of active haemostatic agents are:**  
a) they have a quick onset of action;  
b) they are easy to use;  
c) they have an acceptable profile of side effects;  
d) they have several delivery options;  
e) they are sold at a good price.

**215.MC. Until the etiologic factor of hemorrhage is determined, the patient can be administered:**a) Calcium chloride (calcium gluconate) solution 10%, 10 ml, intravenously, slowly;  
b) Etamsylate solution (Dicinon) 12.5%, 2-4 ml, intravenously or intramuscularly at first injection, then every 4 to 6 hours 2 ml or 2 tablets (500 mg);  
c) Ascorbic acid solution 5%,2-4 ml, intravenously;  
d) Antihemophilic plasma cryoprecipitate;  
e) Platelet concentrate.

**216. MC. Etamsylate has a hemostatic effect which manifests:**  
a) After i/ v injection over 5-15 minutes, maximum effect over 1-2 hours, maintaining for 4-6 hours and gradually decreasing up to 24 hours;  
b) After i / m injection over 30-40 minutes, maximum effect over 1-2 hours, maintaining for 4-6 hours and gradually decreasing up to 24 hours;  
c) After oral administration, maximum effect after 3 hours;  
d) After i / v injection over 3-4 hours, maximum effect over 5-6 hours, maintaining for 6-12 hours and gradually decreasing up to 24 hours;  
e) After i / m injection over 3-4 hours, maximum effect over 5-6 hours, maintaining for 6-12 hours and gradually decreasing up to 24 hours.

**217. MC. The antifibrinolytic effect of aminocaproic acid is due to:**  
a) Inhibition of plasminogen activator (fibrinolysin);  
b) Direct suppression (to a smaller extent) of plasmin;  
c) Inhibition of extrinsic blood clotting mechanism;  
d) Inhibition of intrinsic blood clotting mechanism;  
e) Inhibition of prothrombin activators.

**218. SC. What risk is the patient exposed to, if anticoagulant therapy is discontinued to prevent bleeding accidents:**  
a) Thromboembolic complications with significant morbidity potential;  
b) Allergic reactions;  
c) Neuro-endocrine changes;  
d) All of these;  
e) None of them.

**219. SC. Patients undergoing oral anticoagulation therapy are at increased risk of:**  
a) bleeding;  
b) thromboembolism;  
c) both hemorrhage and thromboembolism;  
d) dysmetabolism;  
e) none of them.

**220. SC. The optimal level of oral anticoagulants is assessed by:**  
a) Prothrombin time monitoring, expressed by *International Normalized Ratio (INR)*;  
b) Determination of fibrinogen content;  
c) Assessment of thrombin time;  
d) Determination of Duke bleeding time;  
e) Determination of Lee-White blood coagulation time.

**221. SC. The INR values in people with an uncompromised coagulation system are:**  
a) 0.3-0.6;  
b) 1.0 or close to 1.0 (0.7-1.3);  
c) 1.5-2.0;  
d) 2.0-3.0;  
e) 3.0-4.0.

**222. SC. The therapeutic anticoagulation level depends on the indication for which it is administered and INR values in patients with valvular prostheses vary within the following range:**  
a) 0.5-1.0;  
b) 1.0-2.0;  
c) 2.0-4.0;  
d) 4.0-5.0;  
e) 5.0-6.0.

**223. SC. For prophylaxis of severe and thromboembolic haemorrhagic accidents, the anticoagulant effect is assessed by determining INR values:**  
a) 5-7 days preoperatively;  
b) 2-5 days preoperatively;  
c) On the day of surgery;  
d) Immediately after surgery;  
e) None of them.

1. **SC. What should be done if INR values before extraction are below the therapeutic range (<2):**  
   a) to increase the dose of anticoagulant until INR is adjusted to therapeutic range and then to perform dental extraction;  
   b) to reduce the dose of anticoagulant and then to perform dental extraction;  
   c) to discontinue anticoagulant and then to perform dental extraction;  
   d) to gradually reduce the dose, to discontinue medication and then to perform dental extraction;  
   e) none of them.

**225.SC.** **What should be done if INR before extraction is higher than the individual therapeutic range recommended by the general practitioner:**  
a. to increase the anticoagulant dose until INR is adjusted to therapeutic range and to perform dental extraction;  
b. to reduce the anticoagulant dose until INR is adjusted to therapeutic range and then to perform dental extraction;  
c. to discontinuethe anticoagulant and to perform dental extraction;  
d. to gradually decrease the dose until the anticoagulant is discontinued and then to perform dental extraction;  
e. none of them.

**226. SC. What should be done if INR before extraction is within therapeutic range:**  
a) to increase the anticoagulant dose and to perform dental extraction;  
b) to reduce theanticoagulant dose and to perform dental extraction;  
c) to discontinue anticoagulant and to perform dental extraction;  
d) to gradually reduce the dose, then to discontinue anticoagulant and to perform dental extraction;  
e) to perform dental extraction and to maintain the anticoagulant medication dose within the same range.

**227.MC. Risk factors for bronchial asthma:**a) Family history of bronchial asthma;  
b) Current or past allergic diseases;  
c) Chronic occupationalexposure of airways to allergens and irritating agents;  
d) Chronic infectious bronchopneumopathy;  
e) Psychiatric factors (conflicts, psychic traumas or neurosis).

**228. SC. Risk factors for allergic asthma:**  
a) Family allergy history;  
b) Personal allergy history;  
c) Recurrence of attacks to repeated contact with allergen (pollination period, etc.);  
d) Skin tests and positive bronchial provocation (challenge) tests;  
e) All above.

**229. SC.** **Bronchial asthma attack is manifested by:**  
a) Anxiety;  
b) Cyanosis;  
c) Expiratory dyspnea;  
d) Wheezing and tachycardia;  
e) All.

**230. MC. Emergency treatment of bronchial asthma attack in the dentist's office:**a) Treatment discontinuation;  
b) Removal of potential allergens;  
c) Placing the patient in a sitting position;  
d) Oxygen therapy;  
e) Administration of ẞ-mimetic spray (2 puffs).

**231. MC. Symptoms of acute respiratory failure:**  
a) Cyanosis;  
b) Ortho-, hyper-, hypopnea;  
c) Bradi- or tachypnea;  
d) Abnormal breath sounds;  
e) Abnormal respiration types.

**232.MC. Non-invasive procedures for management of airway obstruction are:**  
a) Strokeson the back with the palm of hand between the shoulders;  
b) Manual pressure on the abdomen or thorax;  
c) Clearing the oral cavity with fingers;  
d) Mouth-to-mouth breathing;  
e) Mouth-to-nose breathing.

**233. MC. Emergency treatment in seizures:**  
a) Discontinuation of treatment;  
b) Placing the patient with the head in a "safe" position (lateral rotation);  
c) Removing blood, mobile prostheses, etc. from the oral cavity;  
d) Diazepam, i.v. fractionated (15-20 mg, 2.5 mg boluses);  
e) Phenobarbital, 1-1.5 mg kg / body, i.m.

**234. SC. In partial airway obstruction:**  
           a) Patient breathes with great difficulty;  
           b) Generalized cyanosis;  
           c) Absence of respiratory and cardiac activity;  
           d) Fixed and areactive mydriasis;  
           e) Areflexia, stiffness and cadaveric lividity.

**235. MC. In total airway obstruction:**  
           a) Patient breathes with great difficulty;  
           b) Patient does not breathe;  
           c) Patient is agitated with palms crossed on the neck (strangulation sign);  
           d) Blood pressure decreases;  
           e) Blood pressure increases.

**236. MC. The technique of cricothyroid membrane puncture entails:**  
           a) Positioning the patient with neck hyperextension;  
           b) Larynx stabilization;  
           c) Cricothyroid membrane puncture with a short and thick trocar until a feeling of collapse appears;  
           d) Positioning the patient with neck hypoxtension;  
           e) Cricothyroid membrane puncture until a feeling of obstacle appears.

**237. MC. Contraindications of cricothyrotomy:**      a) Children under 5 years;  
      b) Pre-existent laryngeal process (epiglottitis);  
      c) Lack of medical experience;  
      d) Anatomical barriers (neck trauma);  
      e) Possibility of developing uncontrollable haemorrhage.

**238. MC. Persons at risk of infection requiring antibiotic prophylaxis:**  
      a) Patients with cardiovascular disease;  
      b) Patients with chronic renal failute, undergoing dialysis;  
      c) Immunocompromised patients;  
      d) Patients subjected to organ transplantation;  
      e) Patients receiving chemotherapeutic antitumoral therapy.

**239.MC. Antibiotic prophylactic regimens in patients with valvular prostheses:**a) Amoxicillin 2 g per os, 1 hour preoperatively;  
b) Ampicillin 2 g i.m / i.v, 30 minutes preoperatively;  
c) Clindamycin 600 mg per os, 1 hour preoperatively and 300 mg every 6 hours postoperatively;  
d) Azithromycin or Clarithromycin 500 mg, 1 hour preoperatively;  
e) Cefazolin 1 g i.m / i.v, 30 minutes preoperatively.

**240. MC. Patients with cardiovascular disease requiring antibiotic prophylaxis:**a) Patients with valvular prostheses;  
b) Patients with hypertension;  
c) Patients with a history of bacterial endocarditis;  
d) Patients with cyanotic congenital heart disease;  
e) Patients with varicose veins.

**241. MC. Symptoms of cardiac arrest**:  
a) Loss of consciousness (coma);  
b) Absence of carotid pulse;  
c) Apnea;  
d) Mydriasis  
e) Accentuated pallor or cyanosis.

**242. SC. Symptoms of respiratory arrest:**  
a) Absence of respiratory movements;  
b) Absence of expiratory airflow;  
c) Absence of breath sounds;  
d) Absence of consciousness;  
e) All.

**243. SC. Diagnosis of clinical death:**  
a) Absence of pulse in large arteries;  
b) Suddenrespiratory arrest;  
c) Total absence of heart sounds;  
d) Mydriatic fixed and areactive pupils;  
e) All.

**244. MC. Basic life support measures entail:**a) Airway;  
b) Breathing;  
c) Circulation;  
d) Drugs;  
e) Electrocardiographic monitoring (Electric).

**245. MC. Subsequent life support measures entail:**  
a) Airway;  
b) Breathing;  
c) Defibrillation or electrical stimulation (Fibrillation);  
d) Drugs;  
e) Electrocardiographic monitoring (Electric).

**246.SC. Direct breathing (insufflation) methods:**  
a) mouth-to-mouth breathing;  
b) mouth-to-nose breathing;  
c) breathing assisted by simple portable devices;  
d) breathing assisted by automatic insufflation device;  
e) all.

**247.MC. Diagnosis of biological death:**  
a) Total abolition of consciousness;  
b) Generalized cyanosis;  
c) Absence of respiratory and cardiac activity;  
d) Fixed and areactive mydriasis;  
e) Areflexia, stiffness and cadaveric lividity.

**248. MC. Socket tamponade with iodoform packing for haemostatic purposes entails:**

a) The packing is stocked (0.5-0.7 MC wide) from the socket bottom to its apex;  
b) The packing is stocked from the socket apex to its bottom;  
c) The packing is applied tightly across the entire bone surface;  
d) The packing is applied well pressed only on the bleeding bone area;  
e) The packing is applied without pressure on alveolar bone walls.

**249. MC. The disadvantages of hemostatic compressive dressing are:**a) Definitive haemostasis is not always obtained, especially in patients with haemorrhagic diatheses;  
b) Intraalveolar introduction of compressive dressing is one of the factors favoring post-extraction alveolitis;  
c) It influences negatively the duration of post-extraction wound healing;  
d) It is one of the most difficult hemostatic methods;  
e) It causes local tissue necrosis.

**250. MC. The disadvantages of electrocoagulation of bleeding tissues are:**  
a) Excessive heat production causes tissue necrosis;  
b) It considerably slows post-extraction wound healing;  
c) Tissue damage can lead to increased vascular defect and increased hemorrhage;  
d) Persistent postoperative pain occurs around the cauterized area;  
e) It requires available and appropriate equipment, under emergency conditions.

**Infections in oral and maxillo-facial region**

1. C.S. The sinus communicates with the nasal cavity through an oval foramen that opens in:
2. Superior nasal meatus;
3. Medium nasal meatus;
4. Inferior nasal meatus;
5. Through the etmoidal cells;
6. None of the above.
7. C.S. The maxillary sinus has a shape of:
8. Triangular prism;
9. square;
10. triangle;
11. Oval;
12. Spheric.
13. **S.C.** The walls of the sinus are covered with::
14. Stratified squamous epithelium;
15. Cuboidal epithelium;
16. Flat epithelium;
17. Columnar epithelium;
18. Follicular epithelium.
19. **M.C.** Mandible depressors with direct action are:
20. Platisma muscle;
21. Mylohyoid muscle;
22. Digastric muscle;
23. Geniohyoid muscle;
24. Stylohyoid muscle.
25. C.S. The lymph of the maxillary sinus pours into the lymph nodes:
26. Submandibular;
27. Retropharyngeal;
28. cervical;
29. occipital;
30. genian.
31. C.M. The lymph from the upper and lower lips flows to the lymph nodes:
32. genian;
33. retroauricular;
34. Submental;
35. Submandibular;
36. Supraclavicular.
37. C.M. Lymph from lower maxilla pours into lymph nodes:
38. Submandibular;
39. Submental;
40. Parotid;
41. retropharyngeal;
42. genian.
43. C.S. At birth, the oral cavity is:
    1. Populated by a wide variety of pathogenic germs;
    2. Populated by a wide variety of nonpatogenic germs;
    3. Sterile;
    4. Populated by a polymorphic microbial flora;
    5. Populated by an anaerobic microbial flora.
44. C.M. The cells involved in phagocytosis are as follows:
    1. Polymorphonuclear blood neutrophils (leucocytes, lymphocytes, etc.);
    2. Liver tissue macrophages (Kupffer cells);
    3. Connective tissue (histiocytes);
    4. bone marrow, bone tissue (osteoclasts);
    5. Circulating mononuclear cells (monocytes).
45. C.M. Potentially pathogenic outbreaks in the oral cavity are:
    1. dental plaque;
    2. dental caries;
    3. Periodontal pockets, calculus;
    4. apical periodontitis;
    5. lingual deposits.
46. C.M. The human body's resistance to pathogen action includes:
    1. natural resistance or immunity (inherited);
    2. acquired resistance or immunity;
    3. humoral immunity;
    4. cellular immunity (cell mediated immunity);
    5. None of these.
47. C.M. The natural barriers that protect the body against pathogenic germs are:
    1. skin;
    2. oral mucosa;
    3. humoral imunity;
    4. acquired immunity;
    5. natural immunity.
48. C.M. When dental extractions can cause abscesses, phlegm, osteomyelitis:
    1. In the event that the right time is not selected (“hot” extraction without drainage);
    2. When the pathological elements in the alveolar have not been removed;
    3. Traumatic extraction;
    4. Remaining root;
    5. In any dental extraction.
49. C.S. In the case of infections, the human body acts specifically, producing antibodies, in response to the presence of microbial antigens. These antibodies produced by:
    1. by blood cells (erythrocytes, monocytes);
    2. by B lymphocytes;
    3. lymph nodes;
    4. in tissue structures (mucous, submucosa);
    5. by macrophages.
50. C.M. Antibodies are glycoprotein complexes, called immunoglobulins. They are:
    1. Ig G;
    2. Ig M;
    3. Ig A;
    4. Ig D;
    5. Ig E.
51. C.M. Antibacterial defense is the result of a synergistic and orderly action of:
    1. humoral immunity;
    2. cellular immunity;
    3. natural resistance factors;
    4. activity of the cardiovascular system;
    5. activity of the nervous system.
52. C.M. Characteristic for the acute inflammation is the formation of , consisting of a liquid and another cellular component, the composition being:
    1. plasma, containing antibacterial and antitoxic substances;
    2. chemical mediators (serotonin, bradykinin);
    3. K-ions;
    4. fibrinogen;
    5. polymorphonuclear, monocytes, macrophages.
53. C.S. The abscess is:
    1. a diffuse inflammatory process in bone tissues;
    2. a diffuse inflammatory process in soft, subcutaneous, intramuscular tissues in parenchymatous organs;
    3. localized, circumscribed, suppurative inflammation;
    4. an inflammatory process of the skin;
    5. no definition corresponds.
54. C.S. Flegmon is:
    1. localized suppurative inflammation;
    2. a diffuse inflammatory process;
    3. a pseudomembranous process;
    4. a process with serous infiltration;
    5. a process with fibrin infiltration.
55. C.M. Flegmon is characterized by:
    1. diffuse tissue infiltration (without precise delimitation);
    2. tumefaction, hyperemia, hard on palpation, painful;
    3. Containing a polymorphonuclear exudate, bacteria, necrotic tissue debris;
    4. are caused by more aggressive pathogens with pronounced virulence (steptococci);
    5. low local and general defense response.
56. C.M. The ways of spreading the infection from the inflammatory outbreak are:
    1. lymphatic;
    2. haematogen;
    3. along vascular-nerve packets;
    4. through interfascial spaces, intermuscular;
    5. through intertissue spaces.
57. C.S. In chronic inflammation, predominates:
    1. proliferative inflammation;
    2. serous inflammation;
    3. fibrinous inflammation;
    4. Cataral inflammation;
    5. pseudomembranous inflammation.
58. C.S. The pathways of diffusion of infective agents from bone to soft tissues are:
    1. the osseous pathway, through the Hawers channels;
    2. the direct route;
    3. the lymphatic pathway;
    4. the venous route.
    5. any of the enumerated ones.
59. C.S. The patognomical sign of an abscess may be:
    1. hardness;
    2. induration;
    3. Fluctuation;
    4. gassy crepiness;
    5. pulsatile pain.
60. C.M. The submucosal pathway of diffusion in perimaxial soft tissue infections has the starting point especially in:
    1. eruption accidents;
    2. apical periodontitis;
    3. marginal periodontitis;
    4. the presence of foreign bodies;
    5. pharyngeal-amygdali infection.
61. C.M. The lymphatic route of transmission of perimaxial soft tissue infections may have as its starting point:
    1. eruption accidents;
    2. apical periodontitis;
    3. marginal periodontitis;
    4. jaw fractures;
    5. pharyngeal-amygdali infection.
62. C.S. Specify which of the following conditions can cause infections of the soft tissues, transmited transosseous:
    1. apical periodontitis;
    2. marginal periodontitis;
    3. pharyngeal-amygdali infections;
    4. furuncle;
    5. Carbuncle.
63. C.M. Bacteria culture test of the purulent exudate is performed for:
    1. determine what types of bacteria this process contains;
    2. determine the sensitivity of antibiotic pathogens (antibiogram);
    3. establish a proper plan of anesthesia and surgery;
    4. correctly indicate the complex treatment;
    5. to know the prognosis of the process.
64. C.S. Obtaining a culture of infected outbreaks is done by:
    1. suction puncture;
    2. imprinting;
    3. excoriation;
    4. soft tissue excision;
    5. after the opening of the outbreak.
65. C.S. Collection of antibiogram material is correct when done:
    1. after the treatment of the inflammatory process has been instituted;
    2. during treatment;
    3. prior to antibiotic treatment;
    4. when complications occur during treatment;
    5. it is not done.
66. C.M. Which long-acting drugs reduce the body's ability to defend against OMF infections:
    1. cortisone;
    2. cytostatics;
    3. immunosuppressants;
    4. radiotherapy;
    5. none of them.
67. C.M. Treatment with antibiotics may be indicated in case of:
    1. Acute infection;
    2. diffuse swelling;
    3. compromised host defense;
    4. involvement of interfacial spaces;
    5. general altered state, body temperature 38 gr. and above.
68. C.M. The location of odontogenic infections and their evolution is dependent on a number of factors, namely:  
    a) the thickness and structure of the jaw bones;  
    b) the position of roots to the cortical bone;  
    c) soft tissue distribution and perimaxial spaces structure with abundant fat, connective and lymphatic tissue;  
    d) the insertion of the mobile mucosa relative to the apex of the teeth and the insertions of the perimaxillary muscles;  
    e) none of them.
69. CM. Clinically and topographically, nonspecific infections of perimaxial soft tissues are systematized as follows:
    1. periosteal abscesses;
    2. abscesses of superficial spaces;
    3. abscesses of deep spaces;
    4. phlegmons (oral floor, hemifacial);
    5. suppressed lymphadenitis, adenoflegmon.
70. C.M. The conditions that favor the localization of infectious processes more frequently in the mandible are:
    1. Presence of the mandibular canal;
    2. Higher fracture rate at this level;
    3. Terminal type, poor vascularization;
    4. Thick cortical bone;
    5. Increased frequency of periodontitis.
71. C.S. The most common periostitis are caused by:
    1. chronic apical periodontitis;
    2. odontogenic osteomyelitis;
    3. exacerbated apical periodontitis;
    4. difficult eruption of the inferior wisdom teeth;
    5. complicated necrose of the pulp.
72. C.M. Periosteal abscesses occur more frequently:
    1. in the mandible;
    2. in the maxilla;
    3. vestibular;
    4. lingual;
    5. palatal.
73. C.M. The swelling that accompanies a vestibular abscess with a starting point in teeth 13 is usually located at:
    1. Upper lip;
    2. cheeks, in the distal region;
    3. region of the lower eyelid;
    4. the genian region;
    5. all of this.
74. C.M. The following clinical signs are present in a palatal abscess:
    1. Pain as in acute apical periodontitis;
    2. Tumefaction that deforms the palatine vault;
    3. Trismus;
    4. Face asymmetry;
    5. High Fever.
75. C.M. In case of periostitis in patients irradiated or chemically treated antitumorally:
    1. incisions are allowed, even being indicated;
    2. incisions are not allowed, as any other interventions;
    3. in the chemotherapy, the incision of the abscess is allowed;
    4. the incision is not allowed in the chemotherapy;
    5. Spontaneous fistulization is expected in all cases.
76. C.S. Periostitis (subperiosteal abscess):  
    a) has osseous etiology;  
    b) has mucosal etiology;  
    c) has odontogenic etiology;  
    d) it is possible to occur by passing the infection into the vestible by bloodflow;
    1. it is possible to be induced lymphatically.
77. C.M. In perimaxilar cellulite:
    1. there is a purulent collection;
    2. there is no purulent collection;
    3. spontaneous regression of the inflammatory process is possible;
    4. spontaneous regression of the inflammatory process is not possible;
    5. yields only under the action of medical treatment.
78. C.M. In the abscess of the soft parts of the maxillo-facial region:
    1. the temperature is increased and the pulse is low;
    2. the temperature is low and the pulse is increased;
    3. the temperature increases in proportion to the pulse;
    4. the blood tests show leukopenya;
    5. the blood tests show leukocytosis.
79. C.S. In the phlegmon of the soft parts of the maxillofacial region the blood tests show:
    1. leucocytosis with leucocyte leakage to the left;
    2. leucocytosis with deviation of the leukocyte formula to the right;
    3. leukopenia with deviation to the left;
    4. anemic status;
    5. hyperglobulia.
80. C.M. To determine the severity of periosseous soft tissue infection:
    1. palpation has no significant value;
    2. palpation has significant value;
    3. Exploratory puncture alone is not important without diagnostic value;
    4. exploratory puncture is important only in the context of the other examinations;
    5. exploratory puncture may be significant beyond the other examinations.
81. C.S. periosseous infections of odontogenic origin are produced by the following mechanisms:
    1. by trans-haversian transmission;
    2. by transmission along the mandibular canal;
    3. transmission only from periodontium;
    4. transmission only from apex;
    5. any pathway is possible.
82. C.S. Acute cellulitis is:
    1. a cellular inflammation
    2. a tissue inflammation
    3. a purulent collection
    4. a serous collection
    5. gaseous infiltration of tissues
83. C.M. In case of subacute osteomyelitis:
    1. the general phenomena are accentuated;
    2. general phenomena improve;
    3. swelling increases;
    4. swelling diminishes;
    5. Odontogenic signs are missing.
84. C.M. Odontogenic osteomyelitis of jaws:
    1. is more common in the upper jaw;
    2. is more common in the mandible;
    3. infection gets into the bone frequently by blood;
    4. infection reaches the bone frequently by lymph;
    5. infection often reaches the bone in a direct way.
85. C.M. In the onset phase of suppuration of the infra-temporal fossa, the diagnosis is based on:
    1. anamnestic data;
    2. subjective signs;
    3. objective signs;
    4. complementary examinations;
    5. general condition.
86. C.M. The dissemination of infection from the submandibular space is possible in:
    1. the mentonian space
    2. the genian space
    3. Parotid space
    4. Sublingual space
    5. lateropharyngeal space

1. C.M. The drainage of the abscess of the masseteric space is done:
   1. exo-orally
   2. endo-orally
   3. retromandibular
   4. with drainage tubes
   5. drainage tubes are not required
2. C.M. Endooral drainage of the masseteric abscess:
   1. is indicated in superficial collections;
   2. is indicated in deep collections;
   3. the incision of the mucosa is made in the middle third of the anterior edge of the ascending branch;
   4. the incision of the mucosa is made in the lower and posterior mucobuccal fold;
   5. no drainage tube or blade is required.
3. C.M. In the abscess of the massteric space the purulent collection is limited:
   1. between the tegument and the maseter muscle;
   2. between the parotid gland and the masseter muscle;
   3. between the masseter and the mandible;
   4. trismus is one of the first signs;
   5. The trismus is only installed after the appearance of the suppuration.
4. C.M. In the submasseteric space abscess:
   1. Skin hyperemia is mandatory;
   2. Skin hyperemia is not mandatory;
   3. fluctuation is mandatory;
   4. Fluctuation is not mandatory;
   5. temporal region swelling is mandatory.
5. C.M. In the parotidian space abscess the opening of the collection is made:
   1. endooral;
   2. exoorally;
   3. both ways;
   4. retromandibular;
   5. subangulomandibular.
6. C.M. In the parotid space abscess:
   1. the patient has intense trismus;
   2. the patient has moderate trismus;
   3. the skin is red;
   4. endoral, the papilla of the Stenon canal is red and the saliva is purulent;
   5. endooral, Stenon canal papilla and saliva quality are unchanged.
7. C.M. In tongue abscess, in ordinary cases:
   1. the oral floor is not interested;
   2. the oral floor can also be interested;
   3. the exploratory puncture is not used;
   4. exploratory puncture is useful;
   5. Only the clinical examination establishes the diagnosis.
8. C.M. In the suppuration of the tongue, the purulent collection can be located:
   1. at the tip of the tongue;
   2. at the base of the language;
   3. may be at the tip of the tongue and at the base of the tongue;
   4. superficial, submucosal;
   5. deep, between the muscles.
9. C.M. In the abscess of the tongue:
   1. swelling includes the entire tongue;
   2. swelling is limited around the collection;
   3. the relief of the edges of the tongue is smooth, uniform;
   4. the relief of the edges of the tongue is uneven;
   5. the dorsal face remains unchanged.
10. C.M. Opening the tongue abscess orally is done:
    1. in the locations at the tip of the tongue;
    2. in locations at the base of the tongue;
    3. in locations at the edges of the tongue;
    4. in the central locations of the collection;
    5. in any locations.
11. C.M. In the abscess of the submandibular space:
    1. the purulent collection is located above the mylohyoid muscle;
    2. the purulent collection is located under the mylohyoid muscle;
    3. both situations are possible;
    4. the cause of the suppuration is exclusively odontogenic;
    5. there may be other causes of suppuration.
12. C.M. In the anaerobic phlegmon, the following symptoms are present:
    1. low pulse and high temperature;
    2. high pulse and low temperature;
    3. deviation of the leukocyte formula to the right;
    4. deviation of the leukocyte formula to the left;
    5. hyperglobulia.
13. C.M. In anaerobic phlegmon:
    1. exploratory puncture reveals purulent secretion in the swollen area;
    2. exploratory puncture is negative;
    3. the incision of the tissues is followed by the drainage of a massive purulent secretion;
    4. tissue incision does not reveal pus but a minimal sanguinolent brown secretion, with fetid smell;
    5. any of the above situations is possible.
14. C.S. The treatment of anaerobic phlegmon is done:
    1. by minimal incisions;
    2. by maximum incisions;
    3. plasma transfusions;
    4. blood transfusions;
    5. blood transfusion is devoid of therapeutic value.
15. C.S. Periodontal abscess:
    1. is a purulent collection, localized submucosal, near the causal tooth;
    2. is a collection located strictly around a tooth with a periodontal bag enclosed;
    3. usually in the fixed gum;
    4. may also involve the mobile gingival mucosa;
    5. it can also be transmitted to neighboring spaces.
16. C.M. The incision and drainage of the mandibulo-lingual abscess is done:
    1. parallel to the axis of the causal tooth;
    2. parallel to the gingival festoon;
    3. both of the variants noted above are possible;
17. (d) as close as possible to the bone;
    1. as low as possible to the oral floor.
18. C.M. In palatal abscesses with lateral evolution, to the gingival edge:
    1. drainage is done by simply lifting the gum;
    2. drainage is done by gingival excision;
    3. drainage is done by tooth extraction;
    4. Drainage is provided with a drain tube;
    5. drainage is provided with drainage blade.
19. C.M. In the palatal abscess the drainage of the pus is made:
    1. by incision of palatal fibromucosa;
    2. excision of palatine fibromucosa;
    3. the incision or excision is perpendicular to the gingival festoon;
    4. the incision or excision is parallel to the gingival festoon;
    5. apply a drain tube or blade.
20. C.M. Differential diagnosis of palatal abscess can be done:
    1. with an uninfected cystic tumor;
    2. with an infected cystic tumor;
    3. with a malignant salivary tumor;
    4. with a benign bone tumor;
    5. with a benign salivary tumor.
21. C.M. In which of the evolutionary stages of osteomyelitis, the radiological examination is more clear:
    1. in the congestion phase;
    2. in the phase of suppuration;
    3. in the necrosis phase;
    4. in the regeneration phase;
    5. in all phases is the same.
22. C.M. Differential diagnosis of actinomycosis is made with:
    1. osteomyelitis;
    2. not common with osteomyelitis;
    3. it is done with carcinoma;
    4. carcinoma is not involved;
    5. it is only done with sarcoma.
23. C.M. In mandibular osteomyelitis:
    1. Tooth extraction is carried out because it maintains the infection and it is no longer possible to consolidate it
    2. only the causal tooth is extracted;
    3. it is not expected until the sequestrums are delimitated;
    4. expected until the sequestrums are delimited;
    5. all teeth will be preserved.
24. C.M. In mandibular osteomyelitis:
    1. devitalization of mobile teethis performed, if they are not responding to the vitality test;
    2. the causal tooth is extracted;
    3. the vitality test of the teeth is valuable and necessary in the acute phase for setting the causal teeth;
    4. the vitality test is not conclusive in the acute phase;
    5. the healthy, but mobile neighboring teeth are extracted.
25. C.M. In acute osteomyelitis of the mandible:
    1. the mandibular corticotomy is useful;
    2. the mandible corticotomy is risky;
    3. only antibiotic treatment is required;
    4. extraction of the teeth is mandatory;
    5. teeth extraction is postponed.
26. C.M. Bone sequestration in osteomyelitis occurs:
    1. in the congestion phase;
    2. in the phase of suppuration;
    3. in the necrosis phase;
    4. in the repair phase;
    5. it is possible to occur in any of the last three phases.
27. C.M. After osteomyelitis:
    1. spontaneous bone regeneration is possible after removal of sequestrum;
    2. spontaneous regeneration is not possible, leading to shortening of the mandible;
    3. fracture in pathological bone is possible;
    4. fracture in pathological bone is not possible;
    5. In all cases it is necessary to immobilize the mandible as a treatment.
28. C.M. Which of the following teeth can cause palatal abscesses through their lesions:  
    a) superior canine;  
    b) upper lateral incisor;  
    c) superior molars;  
    d) the upper central incisor;  
    e) the first superior premolar.
29. C.M. The palatal abscess treatment consists of:
    1. aspirational puncture;
    2. incision parallel to the palatine artery;
    3. excision of fibromocosa "in orange slice";
    4. rubber blade drainage;
    5. iodoformed drainage.
30. C.M. The abscesses having lower molars as starting point have the following clinical signs:
    1. trismus and dysphagia;
    2. masticatory dyscomfort;
    3. facial asymmetry;
    4. suborbital edema;
    5. tapir lip.
31. C.M. The following clinical signs are present in a palatal abscess:  
    a) masticatory dyscomfort;  
    b) the feeling of a foreign body in the palatine vault;  
    c) trismus;  
    d) facial asymmetry;  
    e) high fever.
32. C.S. Osteogenic osteomyelitis is an extensive infectious process that concerns:
    1. the bone marrow portion;
    2. the Hawersian system;
    3. jaw cortical;
    4. the periosteum;
    5. soft tissues.
33. C.S. Osteomyelitis localizes more frequently:
    1. in the maxilla;
    2. in the mandible;
    3. equally in both bones;
    4. in children;
    5. None of these.
34. C.M. Which of the following clinical signs are characteristic of diffuse osteomyelitis of the mandible:
    1. teeth mobility;
    2. pulse-temperature discordance;
    3. moderately altered general condition;
    4. the Vincent sign;
    5. Positive Valsava maneuver.
35. C.M. The differential diagnosis of osteomyelitis is done with:
    1. perimaxillar suppurations;
    2. fistulised osteitis;
    3. specific infections;
    4. osteoradionecrosis;
    5. none of these.
36. C.M. The differential diagnosis of chronic osteomyelitis is done with:
    1. periostitis;
    2. the periosteal suppuration;
    3. fibrous dysplasia;
    4. acute osteomyelitis;
    5. infected bone tumors.
37. C.S. The most common in osteomyelitis are the following pathogenic germs:
    1. steptococcus hemolytic;
    2. E. coli;
    3. Pneumococci;
    4. staphylococcus aureus;
    5. Actinomycetes.
38. C.S. Hematogenic osteomyelitis is more common in:
    1. old people;
    2. adults;
    3. children;
    4. new born;
    5. to everyone equally.
39. C.S. Maxila is affected by odontogenic osteomyelia less often because:
    1. the maxilla has a thick cortical and less spongy bone;
    2. the maxilla has a thin cortical and a richer blood stream;
    3. the maxilla is pierced by the suborbital, incisive channel;
    4. the Hawersian channel system is quite developed;
    5. none of them.
40. C.M. The mandible is affected by osteogenic osteomyelitis more frequently because:  
    a) has a cortical that favors rapid drainage;  
    b) rich blood irrigation;  
    c) has more bone marrow and spongy bone;  
    d) the medullary tissue is surrounded by a thick cortical, with poor vascularization of terminal type;  
    e) the presence of the mandibular canal.
41. C.M. The following changes are observed in acute odontogenic osteomyelitis:
    1. acidosis and dehydration;
    2. albuminuria;
    3. anemia;
    4. leukocytosis with deviation to the left;
    5. VSH is increased.
42. C.S. Radiological chronic osteomyelitis is presented by:
    1. the image of sarcophagus;
    2. the image of dirty bone;
    3. marbled bone;
    4. bread crumbs;
    5. all of these.
43. C.M. In an abscess of the infraorbital region, the starting point of the infection is:
    1. incisors;
    2. canines;
    3. premolars;
    4. molars;
    5. the wisdom teeth
44. C.S. In an abscess of the infraorbital region the incision is made:
    1. on the lower edge of the orbit;
    2. on the nasolabial fold;
    3. on the nasal side;
    4. in the mucobuccal fold;
    5. in canine fossa.
45. C.M. After opening the abscess of the infraorbital region, in the wound we can introduce:
    1. a rubber blade drain;
    2. a rubber tube;
    3. a iodoformed gauze;
    4. a gauze;
    5. an antiseptic gauze.
46. C.M. A jugal abscess can be drained by:
    1. endobuccal access;
    2. exobucal access;
    3. in a mixed manner;
    4. only by a submandibular incision;
    5. none of these.
47. C.S. The differential diagnosis of a parotid abscess is done with:
    1. mixed parotid tumors;
    2. Warthin's tumor (papillary cystadenoma lymphomatosum);
    3. acute suppurative parotiditis;
    4. sebaceous cyst;
    5. epidemic parotiditis.
48. C.S. Incision in parotid space suppuration is done:
    1. preauricular;
    2. subangulomandibular;
    3. presternocleidomastoidian;
    4. on the anterior edge of the mandible;
    5. any of these incisions.
49. C.M. The etiology of the orbital abscesses can be explained by suppurative processes of the:
    1. dento-periodontal disease in premolars and lower molars;
    2. Acute suppurative sinusitis;
    3. the propagation of some suppurations from the neighborhood spaces;
    4. maxillary osteomyelitis;
    5. mandible osteomyelitis.
50. C.S. The temporal region communicates with:
    1. orbit;
    2. the parotid region;
    3. infratemporal space;
    4. suborbital region;
    5. the masseteric region.
51. C.S. The differential diagnosis of temporal region abscess is done with:
    1. the abscess of the infratemporal fossa;
    2. sting wounds of the temporal region;
    3. temporal tumors;
    4. osteomyelitis of temporal bone;
    5. all the above.
52. C.M. An abscess of the temporal region is opened by incision:  
    a) the most prominent field of the collection;  
    b) vertical - radial;  
    c) at the edge of the zygomatic arc;  
    d) semi-round at the level of the m.temporal insertion;

e) through puncture with a wide needle.

1. C.M. Complications of the temporal region abscess are:
   1. switching to the surrounding regions, especially infratemporal;
   2. temporal bone osteomyelitis;
   3. constriction of the mandible;
   4. defects;
   5. facial paralysis.
2. C.M. The etiology of the abscess of the infratemporal region is characterized by:
   1. dentoparodontal processes in maxillary molars;
   2. Infectious processes of the bones or sinuses of the neighborhood;
   3. spreading infections from neighboring regions;
   4. septic punctures in anesthesia at tuberosity;
   5. septic puncture in infraorbital anesthesia.
3. C.S. Post-anesthetic septic complications in the infra-temporal phase occur especially after:
   1. plexal anesthesia;
   2. incisal or infraorbital foramen anesthesia;
   3. anesthesia at tuberosity;
   4. mandibular or palatal foramen anesthesia;
   5. in none of these situations.
4. C.M. The local symptoms of an abscess of the infratemporal region are:  
   a) supra and sub-zygomatic edema (the symptom of the hourglass);  
   b) tumefaction of neighboring regions;  
   c) trismus;  
   d) endobuccal perituberositary tumefaction with tensioned, glossy, congested mucosa;  
   e) functional disorders (mastication, glutition, phonation).
5. C.M. The opening of an abscess of the infra-temporal fosa is most done:
   1. transsinusal;
   2. endobuccal;
   3. suprazygomatic, exobuccal;
   4. combined;
   5. all of this.
6. C.M. The submandibular space communicates with:  
   a) sublingual space through a fissure located between m.hyoglos and m. mylohyoid;  
   b) anterior with the submental space;  
   c) posterior with the lateropharyngeal space;  
   d) the cervical space;  
   e) pterygomandibular space.
7. C.M. The etiology of the abscesses and phlegmon of the submandibular space can be:
   1. septic processes with a starting point from lower molars;
   2. submandibular purulent lymphadenitis;
   3. sialolithiasis of the submandibular gland;
   4. osteomyelitis, the odontogenic periostitis of the mandible body;
   5. The fractures of body of mandible;
8. C.M. Differential diagnosis in a submandibular space abscess is done with:
   1. suppurative acute adenitis;
   2. suppurated acute submaxilitis;
   3. metastatic adenopathies;
   4. specific adenopathies;
   5. abscess of the sublingual space.
9. C.S. What is the incision for pus collection opening in the submandibular space:
   1. incision in the mucobuccal fold;
   2. retrotuberal incision;
   3. retromandibular incision;
   4. incision on the fold of the buccal floor;
   5. Linear incision, parallel to the basilar edge of the mandible.
10. C.M. The submental space contains:
    1. lymph nodes 2-3;
    2. connective tissue, fat tissue;
    3. the sublingual gland;
    4. the hypogloss nerve;
    5. lingual artery and vein.
11. C.M. The **submental space** communicates with:
    1. sublingual space;
    2. submandibular space;
    3. parotid space;
    4. pterigomandibular space;
    5. retromandibular space.
12. C.M. The etiological factors of the submental abscess are:
    1. septic processes with starting point in incisors and inferior canines;
    2. suppurated supmental adenitis;
    3. lower lip or menton furuncles;
    4. propagation from neighboring spaces (sublingual, submandibular);
    5. Mental region osteomyelitis, median fractures.
13. CS. The local symptomatology of an abscess of the submental space is presented by:
    1. tumefication of the mental region;
    2. congested, glossy, smooth skin, with a erased relief;
    3. Clinical appearance of double chin;
    4. painful palpation, fluctuation;
    5. trismus.
14. C.S. The incision in case of submental abscess is performed:
    1. longitudinally, on the median line;
    2. parallel to the mental arch;
    3. endobuccal;
    4. combined;
    5. all variants are correct.
15. C.M. The sublingual space contains:
    1. the sublingual gland and the Bartholini duct;
    2. the Wharton duct;
    3. sublingual nerves and vessels;
    4. lax connective tissue;
    5. submaxillary gland.
16. C.M. The sublingual space communicates with:
    1. submaxillary space;
    2. pterigomandibular space;
    3. lateropharyngeal space;
    4. infratemporal space;
    5. Parotid space.
17. C.M. The local clinical symptoms of a sublingual abscess are:
    1. tumefaction of the anterior part of the floor of the mouth;
    2. mucosa is congested, glossy and prominent;
    3. sublingual caruncle is swollen, covered with fibrous deposits;
    4. language pushed to the healthy side;
    5. painful palpation, fluctuation.
18. C.M. Functional changes in an tongue abscess are:
    1. hypersalivation;
    2. deglutition;
    3. breathing with asphyxiating phenomena;
    4. mastication;
    5. phonation.
19. C.S. Major functional disorders occur in the abscess of the tongue, but one of them endangers the patient's life:
    1. swallowing disorders;
    2. mastication disorders;
    3. phonetic disorders;
    4. breathing disorders with asphyxia phenomena;
    5. trismus.
20. C.M. In the phlegmon of the tongue, differential diagnosis is made with:
    1. infected malignant tumors of the tongue;
    2. supra-infected thyreoglossal cysts of the base of the tongue;
    3. abscesses of the floor of the mouth;
    4. macroglossia;
    5. glossitis.
21. C.M. Complications of tongue abscess may be:
    1. diffusion into other neighboring lodges;
    2. septicemia;
    3. asphyxia;
    4. ankylosis;
    5. mandibular constrictions.
22. C.M. The infectious process of the submasseteric space can appear as a result of:
    1. the difficult eruption of lower wisdom molars;
    2. odontogenic osteomyelitis of the ramus of the mandible;
    3. suprainfected odontogenic cysts (angle, ramus);
    4. from neighboring spaces;
    5. dentoparodontal infectious processes of lower molars.
23. C.S. The submasseteric abscess more often has as its starting point:
    1. suppurations from neighboring spaces;
    2. inferior wisdom molars;
    3. traumatic hematoma of the masseter;
    4. post-anesthetic injectitis;
    5. fractures of the body of the mandible.
24. C.S. Trismus is detected in:
    1. the abscess of the submandibular space;
    2. submental abscess;
    3. genian abscess;
    4. palatal abscess;
    5. masseterin abscess.
25. C.M. The pterygomandibular space communicates with:
    1. Sublingual space;
    2. Infratemporal space;
    3. Submandibular space;
    4. floor of the mouth;
    5. Lateropharyngeal space.
26. C.M. Causes of pterygomandibular abscess are:
    1. dentoparodontal diseases of the lower molars;
    2. septic puncture at Spina Spix;
    3. difficult eruption of the inferior third molars;
    4. propagation from neighboring spaces;
    5. ranula.
27. C.M. Local symptomatology in the abscess of the pterygo-mandibular space is presented by:
    1. Edema and infiltration at the angle of the mandible;
    2. Congested, smooth, red, glossy pterigo-mandibular mucosa;
    3. trismus;
    4. painful glutition;
    5. macroglossia.
28. C.M. The abscess of the pterygo-mandibular space is incised:
    1. endobucal, parallel to the pterygo-mandibular mucosa;
    2. exobucal incision in an angle that surrounding the mandible angle;
    3. submandibular;
    4. retromandibular along the posterior edge of the ramus;
    5. in the mucobucal fold.
29. C.M. Complications of the pterygo-mandibular abscess may be:
    1. propagation in the lateropharyngeal space;
    2. propagation in the subsubmandibular space;
    3. propagation in the sublingual space;
    4. propagation in the infratemporal space;
    5. propagation in the submental space.
30. C.M. The etiological factors in the abscess of the retromandibular space are:
    1. dentoparodontal processes in upper and lower molars;
    2. mandibular fractures;
    3. submandibular suppurative adenitis;
    4. propagation of infection from neighboring spaces (submandibular, pterygomandibular);
    5. suprainfected jaw cysts.
31. C.M. Local symptomatology in an abscess of the retromandibular space is:
    1. spontaneous pains that increase in head movements;
    2. trismus;
    3. edema along the posterior edge of the ramus of the mandible;
    4. displaced ear lobe;
    5. hearing loss on the affected side.
32. C.S. At the opening of the retromandibular abscess, the incision is made:
    1. submandibular;
    2. parallel to the posterior edge of the mandibular angle;
    3. in the floor of the mouth;
    4. in the mandibular mucobuccal fold;
    5. puncture with a large needle.
33. C.M. The frequent causes of lateropharyngeal abscesses are:
    1. tonsyls suppuration;
    2. eruption accidents in lower molars;
    3. diffusion from neighboring spaces;
    4. acute parotiditis;
    5. latero-cervical suppurative adenitis.
34. C.M. The differential diagnosis of the lateropharyngeal abscess is done with:
    1. submandibular abscess;
    2. parotid abscess;
    3. submandibular adenitis;
    4. pterygomandibular abscess;
    5. Latero-cervical adenitis.
35. C.M. The floor of the mouth is formed by the following spaces:
    1. submandibular;
    2. submental;
    3. sublingual;
    4. genian;
    5. infratemporal.
36. C.M. The general symptom in a phlegmon of the floor of the mouth are:
    1. fever, chills, muscle aches;
    2. septic status;
    3. increased pulse, filiform, irregular;
    4. albuminuria, glucosuria, oliguria;
    5. high blood pressure.
37. C.M. Local symptomatology in an anaerobic phlegmon of the floor of the mouth is:
    1. volume bulging of the mucosa;
    2. cape edema (up and down);
    3. Hyperemic, tensed, marbled skin;
    4. hardness without fluctuation at palpation;
    5. crepitations.
38. C.M. Functional disorders in a phlegmon of the floor of the mouth are:
    * 1. abundant salivation with a viscous saliva;
    1. difficult swallowing;
    2. difficult phonation;
    3. difficult breathing;
    4. trismus with masticatory disorders.
39. C.S. The most complicated symptom that puts the patient's life in danger in the phlegmon of the oral floor is:
    1. painful swallowing;
    2. tongue edema and asphyxiation;
    3. abundant salivation;
    4. halitosis;
    5. difficult phonation.
40. C.M. The complications of phlegmon of the oral floorare:
    1. meningitis;
    2. mediastinitis, pneumonia;
    3. toxic nephritis;
    4. septicemia;
    5. myocarditis.
41. C.M. Changes in blood and urine in a phlegmon of the oral floor are:
    1. marked anemia;
    2. deviation of the leukocyte formula to the left;
    3. low or absent eosinophils;
    4. albuminuria, oliguria;
    5. Glucosuria.
42. C.S. Surgical treatment in an anaerobic phlegmon of the oral floor consists of:
    1. bilateral submandibular collar incision,
    2. Mini-incisions (3-4) in submandibular and mental areas;
    3. submental incision;
    4. punction with large needles;
    5. all.
43. C.S. Hemifacial phlegmon usually begins as a:
    * 1. masseteric abscess;
    1. parotidian abscess;
    2. vestibular abscess;
    3. genian abscess;
    4. abscess of infratemporal fosa.
44. C.M. The discordance between tachycardic pulse and subfebrility is specific in:
    1. hemifacial phlegmon;
    2. lateropharyngeal abscess;
    3. the phlegmon of the oral floor;
    4. Cavernous sinus thrombophlebitis;
    5. suppuration of the infratemporal fossa.
45. C.M. The cause of maxillary fistula can be:
    1. granulomas;
    2. Chronic osteomyelitis of the jaws;
    3. impacted teeth;
    4. granular apical periodontitis;
    5. lymphadenitis.
46. C.M. The cervical region has the following components:
    1. anterior region;
    2. lateral region;
    3. posterior region;
    4. Sternocleidomastoidian region;
    5. None.
47. C.M. What are the cervical fascia:
    1. superficial cervical fascia;
    2. own cervical fascia;
    3. omoclavicular aponeuros;
    4. pretraheal lamina;
    5. prevertebral lamina.
48. C.M. Cervical phlegmon can cause complications:
    * 1. mediastinitis, pneumonia;

b) pericarditis, myocarditis;

c) meningitis, encephalitis, cavernous sinus thrombosis, abscesses;

d) bacterial shock;

e) septicemia.

1. 151. C.M. What are the principles for indicating antibiotherapy in the treatment of abscess or phlegmon:
   1. determination of pathogenic germs and antibiograms;
   2. A combination of antibiotics with broad spectrum is administered;
   3. antibiotics with minimal toxicity and reduced side effects are administered;
   4. the duration of administration and the dose should be sufficient, achieving a minimum concentration for at least 5 days;
   5. patient training on dose, frequency and attitude towards antibiotics.
2. C.S. Bacteriostatic antibiotics have an effect manifested by:
   1. killing pathogenic germs;

b) prevents multiplication of pathogenic germs;

c) increases the means of defense of the body;

d) eliminates microbes from the body;

e) all.

1. C.M. In the complex treatment of inflammatory processes, it is necessary to administer detoxification drugs:
   1. polyglucine, reopoliglucine;
   2. hemodez 200-400 ml;
   3. glucose solution 5-10% - 500-1000 ml + insulin;
   4. Isotonic Sodium Chloride Solution - 500 ml;
   5. 5% - 300 ml sodium hydrocarbonate.
2. C.M. The selection of the physiotherapy method in the treatment of abscesses and phlegmons depends on:
   1. the inflammation phase;
   2. the clinical particularities of the inflammatory process;
   3. body resistance and general condition;
   4. age, sex;
   5. state of cardiovascular and nervous systems.
3. C.M. The microbial flora prevailing in the furuncle is:
   1. Staphylococcus aureus;
   2. white staphylococcus;
   3. anaerobic streptococci;
   4. hemolytic streptococci;
   5. actynomicetys.
4. C.M. Location of the furuncle in the facial region is very dangerous, especially if it is located:
   1. at the upper lip;
   2. perinasal;
   3. periorbital;
   4. genian;
   5. at the lower lip.
5. C.M. The local treatment of the furuncle at the incipient stage consists of:
   1. the opening of the outbreak;
   2. processing the dermis with ethyl alcohol;
   3. Applying ice bags;
   4. Primers with hypertonic solutions;
   5. Dressings with hypertonic ointments, levomicollis, heparin ointment.
6. C.S. The local clinical symptoms of facial thrombophlebitis are:
   1. Edema pronounced on the angular and facial vessels,
   2. Palpator- determines a tough, painful infiltration;
   3. Hyperemia of skin in strips;
   4. Small abscesses appear along the vessels;
   5. All.
7. CM. The general symptom of facial thrombophlebitis is presented by:
   1. Fever (39.5-40 gr.), chills;
   2. Altered general condition;
   3. Pale skin, sweating;
   4. Headache, insomnia, vertigo, agitation;
   5. Inattention, loss of work capacity.
8. CM In facial thrombophlebitis, blood changes are highlighted:
   * 1. Leucocytosis with leftward deflection;
     2. Acceleration of the sedimentation reaction;
     3. Increases fibrinogen in blood;
     4. Factor XIII increases in blood;
     5. Hemostasis indices deviate from hypercoagulaemia.
9. C.M. The intensive treatment of facial thrombophlebitis is urgently installed and consists of:
   * 1. Broad spectrum antibiotics antibiotherapy;
     2. Immunotherapy (gamma globulins, antistaphylacoccic serum);
     3. detoxification therapy (hemodez, Ringer's solution, 5% glucose solution, etc);
     4. Heparin 2.500-5000 IU over 4-6 hours with coagulogram control;
     5. Desensitizers (dimedrol, gluconate, tavegill, suprastin, etc.).
10. C.M. In some cases, facial thrombophlebitis may cause inflammatory processes of the endocranial sinus (sinustrombose) with a special symptom:
    * 1. palpebral edema, chemosis, ptosis, exophthalm;
      2. Meningitis symptomatics;
      3. Aphasia;
      4. Decrease of vision until its total loss;
      5. Ophthalmoplegia.
11. C.M. Major clinical manifestations suggesting the diagnosis of acute bacterial meningitis are:
    * 1. Sudden onset with fever, chills, headaches, photophobia, nausea, vomiting, agitation, psychomotor or coma;
      2. Presence of the meningian symptom (neck stiffness, Kerning sign, Brudzinski sign);
      3. Cephalic signs (psychomotor agitation, delirium, visual hallucinations, confusion);
      4. somnolence, coma;
      5. Seizures of epilepsy, hemiplegia, aphasia, paralysis of the cranial nerves.
12. C.M. Mediastinitis as a complication of purulent OMF and cervical processes often has as its starting point:
    * 1. Parapharyngeal spaces;
      2. oral floor;
      3. Cervical spaces;
      4. diffuse hemifacial phlegmon;
      5. Submental space.
13. C.S. The main symptom of mediastinitis can be:
    * 1. Cough;
      2. Disease impairment;
      3. Dyspnea with increased breathing rate 45-50;
      4. nausea, vomiting;
      5. Fever, chills.
14. C.S. An important symptom in the diagnosis of mediastinitis is:
    * 1. Headache, vertigo, insomnia;
      2. Fever, chills;
      3. nausea, vomiting, impaired swallowing;
      4. Retrosternal pain;
      5. All.
15. C.S. An important sign in mediastinitis is the increase in volume of the mediastinum, which can be determined:
    * 1. Visual;
      2. Palpator;
      3. Ausculatory;
      4. radiological (roentgen);
      5. Spirometric.
16. C.M. The basic functions of the lymphatic system are:
    * 1. Limphocytopoiesis;
      2. Antibodies secretion;
      3. Filtration;
      4. Metabolic;
      5. Limfocitolithics.
17. C.S. Depending on the cause and the clinical picture, the following forms of adenitis are more common:
    * 1. Chronic;
      2. Specific;
      3. Serous acute (cellulite);
      4. Acute purulent;
      5. Adenophlegmon.
18. C.M. Acute lymphangitis is characterized by the following clinical symptoms:
    * 1. Hyperthermia and string-like edema;
      2. uncontrolled pain;
      3. Palpator- determination of soft, painful threads;
      4. A fever of 37-37.5 C is rarely detected;
      5. Weaknesses, headaches, insomnia, etc.
19. C.M. The main clinical symptoms of acute purulent adenitis are:
    * 1. Violent pain;
      2. Volume increase of lymph node;
      3. Skin hyperemia;
      4. Fever of 37.8-38.5 C;
      5. Palpation determines the increase in lymph node volume, pain, fixed nodule.
20. C.S. Which clinical forms of adenitis are treated conservatively:
    * 1. Acute purulent;
      2. Specific;
      3. Acute serous (cellulite);
      4. Traumatic;
      5. All forms.
21. C.M. The differential diagnosis of chronic adenitis is performed with:
    * 1. Cysts;
      2. facial and cervical fistula;
      3. Benign tumors;
      4. Specific adenites;
      5. Cancer metastases.
22. C.M. Acute parotid adenomas can be confused with:
    * 1. Mixed tumors of the parotid gland;
      2. Parotid cysts;
      3. Adenoma;
      4. acute parotiditis;
      5. Chronic parotiditis.
23. C.M. Specific infections located in the OMF area at the soft and bones are:
    * 1. Furuncle and carbuncle;
      2. Piodermitis;
      3. Actinomycosis;
      4. Tuberculosis;
      5. Syphilis.
24. C.M. Indicate which of the 5 species of actinomycetes cause more frequent actinomycosis in humans:
    * 1. actinomicosis bovi;
      2. Israeli actinomycosis;
      3. actinomicosis odontoliticus;
      4. actinomycosis viscosus;
      5. actinomycosis vaeslundi.
25. C.S. Actinomycosis more frequently invades the bone:
    * 1. Maxilla;
      2. Nasal;
      3. Zygomatic;
      4. Mandible;
      5. Palatal.
26. C.S. The main pathological element of actinomycosis is:
    * 1. Fistula;
      2. Pus;
      3. Specific granuloma (nodule);
      4. Necrosis of tissues;
      5. All.
27. C.M. Actinomycetes can penetrate the affected tissues (bones, soft parts) from:
    * 1. Dental caries;
      2. Gingival pocket;
      3. Tonsyls;
      4. From the outside;
      5. With food.
28. C.M. Characteristic of pseudo-neoplastic bone actinomycosis is:
    * 1. Onset from the periphery to the center;
      2. endosomal central onset;
      3. Onset in the form of periostitis;
      4. Cystic and gelatinous areas appear in the bone;
      5. The favorable development is manifested by the appearance of the skin fistula.
29. C.M. In the diagnosis of actinomycosis we take into consideration:
    * 1. Slow evolution without characteristic signs;
      2. Presence of long-lasting fistulas with small elimination with actinomycotic granules;
      3. histological examination;
      4. Intradesmo reaction with actinolyzat;
      5. Microbiological examination with identification of actinomycetes.
30. C.M. Tuberculosis in the OMF region can be located:
    * 1. Mucosa and submucosa of the oral cavity;
      2. Lymph nodes;
      3. Jawbones;
      4. facial skin;
      5. Salivary glands.
31. C.M. Ulceration from TB is usually:
    * 1. Unique;
      2. Round shaped;
      3. Covered by yellowish deposits;
      4. Surrounded by yellow dots (Trelat granules);
      5. It is very painful spontaneously and to the touch.
32. C.M. Primary tuberculosis is characterized by the existence of the primary complex consisting of:
    * 1. Ulceration (chancres);
      2. Adenopathy;
      3. Gumma;
      4. TB lupus;
      5. osteomyelitis
33. C.M. Tuberculosis of the jaw bone occurs in the following forms:
    * 1. Central;
      2. Alveolar;
      3. Subperiostal;
      4. Sequestration;
      5. None of them.
34. C.M. In the primary period, syphilis presents under non-inflammatory epithelial erosions with the following characteristics:
    * 1. Round shape;
      2. The red, glossy surface;
      3. enlarged, painless nodules;
      4. Lymfangitis;
      5. all.
35. C.S. The most common location of a syphilis gumme is:
    * 1. lips;
      2. tongue;
      3. soft and hard palat;
      4. cheek;
      5. Cutaneous-mucosal junction of the lips.
36. C.M. The secondary period of syphilis in the OMF territory is as follows:
    * 1. erythematous erosion;
      2. disseminated syphilis on the oral mucosa;
      3. syphillitic tubers;
      4. gummes;
      5. none of them.
37. C.M. Paranasal sinuses are:
    * 1. the maxillary;
      2. the frontal;
      3. ethmoidal cells;
      4. sphenoid;
      5. cavernosum
38. C.S. The walls of the maxillary sinus inside are covered with:
    * 1. stratified squamos epithelium;
      2. stratified ciliated cylindrical epithelium;
      3. squamous epithelium;
      4. glandular epithelium;
      5. cubic epithelium.
39. C.S. The maxillary sinus communicates with:
    * 1. the nasal cavity;
      2. the oral cavity;
      3. orbit;
      4. the glottis;
      5. the infratemporal space.
40. C.M. The ratio of the maxillary sinus with the teeth on the upper arch is intimate, the closest to the inferior wall of the sinus being the teeth:
    * 1. the 6 year molar;
      2. the incisors;
      3. 2nd molar ;
      4. premolars;
      5. canines.
41. C.M. The differential diagnosis of acute maxillary sinusitis is done with:
    * 1. maxillary osteomyelitis;
      2. intrasinous mucosal cyst;
      3. dental cystic tumors in the stage of septic complication;
      4. Cylindroma;
      5. odontogenic cellulite.
42. C.M. Which of the following clinical signs are encountered in acute dental sinusitis:
    * 1. pain in the mid-level face, pulsatile and exacerbated by the head position;
      2. in anterior rhinoscopy- pus into the nasal fossa;
      3. sensation of plenitude and subjective cacosmy;
      4. Positive Valsava maneuver;
      5. none of the mentioned signs.
43. C.M. Which of the following signs are present in the case of orosinusal communication:
    * 1. penetration with a buttoned stiletto in the sinus, through the socket;
      2. Negative Valsava maneuver;
      3. radiologically, a normal sinus image appears;
      4. the buco-sinusal communication can be detected radiologically;
      5. refilling of liquids through the nose.
44. C.M. In the case of orosinusal communication that maintains a chronic sinusitis, it is practiced:
    * 1. tooth extraction under antibiotherapy;
      2. sinus puncture and communication plasty;
      3. communication plasty;
      4. radical treatment of the affected sinus;
      5. all.
45. C.M. Which of the following methods can be used to close orosinusal communication:
    * 1. suture in one plane;
      2. suture in two planes with pedicle flap;
      3. flushing the edges of the suture wound;
      4. suture in two planes, with neighboring mucoperiostal flaps;
      5. suture in a plane, with iodoform shield protection under the conformator.
46. C.M. Chronic maxillary sinusitis may present the following clinical signs:
    * 1. permanent subjective cacosmy;
      2. irradiated laryngeal pain, nocturnal;
      3. anterior rhinoscopy reveals the presence of a unilaterally mucopurulent secretion, hyperimmigrated and thickened mucosa;
      4. pain is present especially in the morning;
      5. none of them.
47. C.M. The differential diagnosis of chronic maxillary sinusitis is done with:
    * 1. mesostructural epithelioma;
      2. acute rhinogenic sinusitis;
      3. intrasinous mucosal cyst;
      4. specific maxillary sinusitis;
      5. Acute osteomyelitis of the jaw.
48. C.M. In the acute odontogenic maxillary sinusitis the pus is:
    * 1. abundant;
      2. fetid;
      3. located unilaterally;
      4. is eliminated through the middle meat at the change of the body position;
      5. none of the above.
49. C.M. In the treatment of chronic odontogenic sinusitis, the following are indicated:
    * 1. broad spectrum antibiotics;
      2. tooth extraction and antibiotic administration;
      3. the radical sinusotomy after Caldwell-Luc, if the treatments is not working;
      4. drainage of the sinus;
      5. punction
50. C.S. The Stenon duct opens to the mucous membrane of the mouth in the region:
    * 1. genian;
      2. sublingually;
      3. genian at the level of the first upper molar;
      4. palatal;
      5. retromolar
51. C.M. Salivary gland secretion disorders are:
    * 1. sialorrhea;
      2. ptyalism
      3. increased salivation;
      4. hyposalivation
      5. asyalia.
52. C.M. Sialodochitis are inflammatory processes located at the level:
    * 1. the Wharton duct;
      2. the Stenon duct;
      3. large salivary glands;
      4. small salivary glands;
      5. all.
53. C.M. Infection of salivary glands can be done by the following mechanisms:
    * 1. transosseous;
      2. submucosal;
      3. lymphogenic;
      4. hematogenic;
      5. via the main excretion pathway.
54. C.M. The differential diagnosis of suppurative parotiditis is done with:
    * 1. epidemic parotiditis;
      2. mandible ramus osteomyelitis;
      3. parotid lobe abscess;
      4. parotid lithiasis;
      5. parotid tumors.
55. C.M. Suppurative acute maxillitis occurs through a series of local symptoms such as:
    * 1. submandibular tumefaction with congested skin;
      2. the edge of the mandible appears to be erased;
      3. increased volume, infiltration, painful palpation;
      4. congestion and swelling of the sublingual mucosa;
      5. At pressure on the gland, through the Wharton duct, pus is eliminated.
56. C.M. The differential diagnosis of acute submaxillitis is done with:
    * 1. submaxillary space abscesses;
      2. salivary lithiasis;
      3. suprainfected tumors;
      4. submandibular acute suppurative lymphadenitis;
      5. hemodectom.
57. C.M. In lithiasis, after the crisis, salivary gland ostium:
    * 1. it is closed;
      2. is open;
      3. is widely open;
      4. is swollen;
      5. is of normal appearance.
58. C.M. Salivary lithiasis occurs more frequently:
    * 1. in the parotid gland;
      2. in the Stenon duct;
      3. in the sublingual gland;
      4. in the Wharton duct;
      5. in the submandibular gland.
59. C.M. Cutaneous salivary fistula:
    * 1. are not significant;
      2. are very important;
      3. requires mandatory treatment;
      4. does not require treatment because it heals spontaneously;
      5. there are no salivary fistulas.
60. C.M. In the parenchymal parotiditis, the sialogram shows:
    * 1. oval or round cavities on the intact parenchyma background;
      2. the image of "grape grove" or "tree in flower";
      3. the ducts in some places are steep, but well-contoured;
      4. the main duct is dilated;
      5. All the ducts of the gland are dilated.
61. C.S. The main treatment for acute sialadenitis is:
    * 1. incision in any case;
      2. gland massage and physiotherapy;
      3. antibiotics, desensitizers;
      4. balneary treatment;
      5. Removing the affected gland.
62. C.M. In the complex treatment of acute sialadenitis, the following solution is introduced in the duct:
    * 1. hydrogen peroxide 3%;
      2. iodolipol 1-2 ml;
      3. antibiotics and ferments;
      4. hot solution of furacillin;
      5. artificial saliva.
63. C.M. In advanced clinical forms of interstitial parotiditis, we can determine:
    * 1. The gland is continuously enlarged in volume;
      2. the surface at palpation is smooth;
      3. nodular area, somewhere soft;
      4. in some cases, dryness occurs in the oral cavity;
      5. Massaging the ostium gland is abundantly in saliva.
64. C.S. In the diagnosis of interstitial parotiditis the main symptom is:
    * 1. history of disease;
      2. large, hard, immobile gland with a smooth surface;
      3. Pus from the Stenon duct at the massage;
      4. Sialography with specific signs (“dead tree” picture);
      5. cytologic exam.
65. C.M. The differential diagnosis of chronic parotiditis is done with:
    * 1. parotid tumors;
      2. Sjogren's syndrome;
      3. Mickulici's disease;
      4. lithiasis parotidites;
      5. hemifacial phlegmon.
66. C.S. Acute epidemic parotiditis (mumps) is produced by:
    * 1. steptococci, staphylococci;
      2. rubella virus;
      3. urlian virus;
      4. treponema pallidum;
      5. measles virus.
67. C.S. The incubation period in epidemic parotiditis is:
    * 1. 3-5 days;
      2. 7-12 days;
      3. 16-20 days;
      4. 21-30 days;
      5. a few hours.
68. C.M. Epidemic parotiditis (mumps) is an infectious disease and it spreads mainly in:
    * 1. children aged 5-15 in kindergartens, schools;
      2. in adolescents (high schools, colleges, universities);
      3. military (in military units);
      4. to the elderly;
      5. at any age - equally.
69. C.S. Acute epidemic parotiditis can be treated:
    * 1. in the OMF surgery ;
      2. in the OMF surgery (in the hospital);
      3. in the internal diseases section;
      4. in the infectious disease department;
      5. by all doctors both.
70. C.M. Precipitation of mineral salts is favored by:
    * 1. hyposialia;
      2. salivary stasis;
      3. alkaline saliva;
      4. higher concentration of mineral salts;
      5. presence of desquamated epithelial cells.
71. C.S. The mixed saliva reaction is:
    * 1. slightly acidic (PH6);
      2. acid (PH4);
      3. alkaline (PH8);
      4. varies depending on the food content;
      5. all answers are correct.
72. C.M. The composition of the calculi is predominantly mineral and is presented by:
    * 1. calcium phosphate in the form of hydroxyapatite (over 7-5%);
      2. calcium carbonate;
      3. potassium carbonate;
      4. magnesium; iron;
      5. Organic materials that occupy the central part.
73. C.S. The clinical picture of salivary lithiasis is determined mostly by:
    * 1. the chemical composition of salivary calculus;
      2. by the size of the salivary calculus;
      3. the form of salivary calculus;
      4. by the salivary calculus;
      5. the patient's diet;
74. C.M. For the treatment of salivary lithiasis, the following procedures are possible:
    * 1. elimination of the calculus by medical procedures;
      2. surgical ablation of the calculation;
      3. sialolytic medication;
      4. anatomical suppression of the gland;
      5. Functional suppression of the gland;
75. C.M. For diagnosis of submandibular salivary lithiasis, we use:
    * 1. retroalveolar radiography;
      2. axial radiography;
      3. bite-wing radiograph;
      4. ultrasonography;
      5. teleradiography.
76. C.M. Pain in submandibular salivary colic can be:
    * 1. attenuated;
      2. acute;
      3. in the oral floor or in the cheek;
      4. in the tongue;
      5. in the ear.
77. C.M. In submandibular lithiasis:
    * 1. the duration of colic is long, over one hour;
      2. the duration of a colic is shorter than one hour;
      3. the swelling of the gland lasts for a long time;
      4. swelling of the salivary gland succumbs shortly after eating;
      5. swelling of the submandibular gland is not influenced prandial.
78. C.M. Parotid lithiasis:
    * 1. it is rarer than the submandibular one;
      2. is more frequent than the submandibular one;
      3. the calculus is more common in the gland;
      4. the calculus is more frequent in the Stenon channel;
      5. The calculus is ovoid.
79. C.M. In sialosis, among the symptoms grouped by D.Teodorescu in a symptomatic triad, there are:
    * 1. congestion of the skin;
      2. salivary abscess;
      3. salivary swelling;
      4. lingual hypoesthesia;
      5. salivary colic.
80. C.S. Salivary colic is disturbed by:
    * 1. infection;
      2. the pressure exerted by the calculus on the lingual nerve;
      3. salivary epithelium desquamation;
      4. precipitation of mineral salts;
      5. exaggerated saliva pressure in the canalicular system.
81. C.S. Which of the following exams are of no interest in the diagnosis of sialolithiasis:
    * 1. Catheterization of the Warthon duct;
      2. simple radiography;
      3. cytological diagnosis;
      4. ultrasonography;
      5. clinical examination.
82. C.S. What is the attitude towards a calculus on the Warthon duct:
    * 1. incision-drainage;
      2. submaxilectomy;
      3. Extinguishing the calculus;
      4. physiotherapy and balneotherapy;
      5. lithotripsy (breaking the calculation).
83. C.S. The method of choice for the treatment of Warthon's lithiasis is:
    * 1. insistent massage of the submandibular region until the calculus is abolished;
      2. timing of the decision, until the spontaneous elimination of the calculus;
      3. submaxilectomy;
      4. surgical ablation of the calculus;
      5. no surgical treatments applied.
84. C.M. In submandibular lithiasis, the differential diagnosis is made with one or more of the following conditions:
    * 1. Chronic adenitis;
      2. submandibular tumors;
      3. facial neuralgia;
      4. temporo-mandibular arthritis;
      5. acute stomatitis.
85. C.S. Surgical calculus ablation (sialolitectomy) is performed:
    * 1. by incision of the sublingual mucosa along the Warthon duct;
      2. by incision in the mucobuccal fold;
      3. submandibular incision;
      4. through the incision in the oral floor parallel to the internal surface of the mandible;
      5. all on a case-by-case basis.
86. C.S. If the salivary calculus is located in the gland, next procedure is performed:
    * 1. surgical ablation through the duct near the gland;
      2. remove the salivary calculus from the gland;
      3. a portion of the gland is removed with salivary calculus;
      4. the salivary gland is removed with the calculus;
      5. Salivary calculus is removed by massage.
87. C.S. What are the evolutionary possibilities in a sialolitiasys:
    * 1. spontaneous elimination of the calculus;
      2. salivary fistula;
      3. chronic sciatic sialoadenitis;
      4. the suppuration of the specific space;
      5. all;
88. C.S. Sjogren's syndrome is characterized in its clinical form through the following triple symptomatology:
    * 1. salivary gland hypertrophy, lacrimal gland hypertrophy and cervical adenopathy;
      2. diabetic parotidomegaly, hypertension, gastric mucosal atrophy;
      3. salivary, ocular and articular;
      4. parotidomegaly, cirrhosis and hypertension;
      5. asialia, cacosmya and subclavicular adenopathy.
89. C.M. Sjogren's syndrome is presented by a specific symptomatology:
    * 1. dry mouth;
      2. dry eye;
      3. rheumatoid arthritis;
      4. conjunctivitis;
      5. dermatomyositis.
90. C.M. In Sjogren's syndrome, parotid glands evolve towards:
    * 1. hypertrophy, as a rule;
      2. are normal;
      3. atrophy;
      4. rarely to bilateral asymmetric hypertrophy;
      5. malignancy.
91. C.S. The Sjogren Syndrome- Sialography shows an image of:
    * 1. irregular contour lines with "blooming tree" appearance;
      2. reduced injection of parenchyma, "dead tree" appearance;
      3. deviations of the canalicular drawing with a clear uninjected area with a ball image held in the hand;
      4. canalicular amputations with gaps;
      5. irregularly shaped contoured, dilated, snow-covered areas.
92. C.M. The differential diagnosis in Sjogren's syndrome is done with:
    * 1. chronic parenchymal parotiditis;
      2. interstitial chronic parotiditis;
      3. sialodochitis;
      4. benign and malignant tumors;
      5. None of the above.
93. C.S. Treatment of Sjogren's syndrome is done in:
    * 1. Oral surgery cabinet;
      2. the maxillo-facial surgery department;
      3. rheumatology department;
      4. the infectious diseases department;
      5. in any hospital section.
94. C.M. The composition of the calculi is predominantly mineral and is presented by:
    * 1. calcium phosphate in the form of hydroxyapatite (over 7-5%);
      2. calcium carbonate;
      3. potassium carbonate;
      4. magnesium; iron, hate;
      5. Organic materials that occupy the central part.
95. C.M. Pain in submandibular salivary colic can be:
    * 1. attenuated;
      2. collision;
      3. in the floor or in the cheek;
      4. in the language;
      5. in the ear.
96. C.S. Sialolytis occurs more frequently in:
    * 1. small salivary glands;
      2. the Stenon duct;
      3. parotid gland;
      4. the sublingual gland;
      5. the Wharton duct and the submandibular gland.
97. C.M. Salivary fistulas can be opened to:
    * 1. skin (external);
      2. mucous (internal);
      3. bilateral (to the skin and mucosa);
      4. intrasinusal;
      5. to pharynx.
98. C.M. In the complex treatment of acute sialadenitis in the outer canal:
    * 1. hydrogen peroxide 3%;
      2. lipoidol 1-2 ml;
      3. antibiotics and ferments;
      4. hot solution of furacillin;
      5. artificial saliva.