Federal state budgetary educational institution

higher education

Orenburg State Medical University

Ministry of Health of the Russian Federation

**FUND OF EVALUATION FUNDS FOR CURRENT CONTROL OF PROGRESS AND INTERMEDIATE CERTIFICATION OF STUDENTS**

Neurology, medical genetics, neurosurgery

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(name of the discipline)

in the direction of training (specialty)

31.05.01 General Medicine (Faculty of Foreign Students )

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(code, name of the direction of training (specialty))

It is part of the main professional educational program of higher education in the direction of training (specialty)

31.05.01 General Medicine (Faculty of Foreign Students)

approved by the Academic Council of the FSBEI HE ORGMU of the Ministry of Health of Russia

Minutes No. 8 dated March 25 , 2016

Orenburg , 2018

1. **Valuation funds fund passport**

The fund of evaluation tools for the discipline contains standard control and evaluation materials for monitoring the progress of students, including monitoring the independent work of students, as well as for monitoring the learning outcomes formed in the process of studying the discipline at intermediate certification in the form of an exam .

Control and evaluation materials for current monitoring of progress are distributed according to discipline topics and are accompanied by an indication of the control forms used and assessment criteria. Control and assessment materials for intermediate certification correspond to the form of intermediate certification in the discipline defined in the OBEP curriculum and are aimed at checking the formation of knowledge, skills and abilities for each competence established in the discipline's work program.

As a result of studying the discipline, the student develops the **following competencies:**

OK-7 - readiness to use first aid techniques, methods of protection in emergency situations

OPK-6 - readiness to maintain medical records

OPK-8 - readiness for medical use of drugs and other substances and their combinations in solving professional problems

PC-5 - readiness for the collection and analysis of patient complaints, data of his anamnesis, laboratory, instrumental, pathological and anatomical and other studies in order to recognize the condition when establishing the presence or absence of the disease

PC-6 - the ability to determine the patient's main pathological conditions, symptoms, disease syndromes, nosological forms in accordance with the International Statistical Classification of Diseases and Health Problems, X revision.

PC-8 - the ability to determine the tactics of managing patients with various nosological forms

PC-11 - readiness to participate in the provision of emergency medical care for conditions requiring urgent medical intervention

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| Competence name | Competence achievement indicator |
| OK-7 | Ind.UK.1 .1 . Ability to apply knowledge of first aid techniques, methods of protection in emergency situations |
| Ind.UK.1.2 Knowledge of first aid techniques, methods of protection in emergency situations |
| OPK-6 | Indicator OPK 1.1 . Be able to fill out medical records |
| Indicator OPK 1.2 . Ability to fill out medical records |
| OPK-8 | Ind.PK.1.1 . Know the indications for the medical use of drugs and other substances and their combinations when solving professional problems |
| Ind.PK.1.2 . Readiness for medical use of drugs and other substances and their combinations in solving professional problems |
| PC- 5 | Ind.PK 1. The ability to independently collect and analyze patient complaints, data from his anamnesis, laboratory, instrumental, postmortem and other studies in order to recognize a condition when establishing the presence or absence of a disease |
| Ind.PK.1.2 To be   able and ready to collect and analyze patient complaints, data from his anamnesis, laboratory, instrumental, pathological and anatomical and other studies in order to recognize the state when establishing the presence or absence of a disease |
| PC-6 | Ind.PK.1.1 To be able to determine the patient's main pathological conditions, symptoms, syndromes of neurological diseases, nosological forms in accordance with the International Statistical Classification of Diseases and Problems Related to Health, X revision |
| Ind.PK.1.2. To know and determine the patient's main pathological conditions, symptoms, syndromes of diseases, nosological forms in accordance with the International Statistical Classification of Diseases and Related Health Problems, X revision |
| PC-8 | Ind.PK.1.1. To be able to determine the tactics of managing patients with various nosological forms |
| Ind.PK.1.2 . Know the tactics of managing patients with various nosological forms |
| PC-11 | Ind.PK.1.1 ... To be able to take part in the provision of emergency medical care in conditions requiring urgent medical intervention |
| Ind.PK.1.2 ... Master the stages in the provision of emergency medical care for conditions requiring urgent medical intervention |

**FOR CURRENT PROGRESS MONITORING AND MIDTERM CERTIFICATION OF STUDENTS STUDYING ON DISCIPLINE**

**Characteristics of monitoring forms**

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| **Monitoring form** | **Characteristics** |
| **Report** | A report is a public announcement or document that contains information and reflects the essence of the issue or research in relation to a given situation. It can be written or oral. An oral presentation can be accompanied by a multimedia presentation or demonstration of any visual (material) objects.  Report allows you to assess the level of student`s theoretical knowledge on a given question, as well as to check the skills of analysis, synthesis, generalization and concretization, used by students while preparing a report. |
| **Writtenquestionnaire** | A written questionnaire is a type of written assessment of students' knowledge on certain questions or topics. It can be current and final, individual and frontal. It involves posing a number of questions to students, to which they give a detailed written answer. It allows you to assess the knowledge of students on the passed topic (or module) of the discipline. |
| **Presentation** | A presentation (computer presentation) is a demonstration in a visual form of the main provisions of the oral presentation, the degree of mastering the content of the problem. It allows you to assess the level of students` knowledge on a given question (topic, section), as well as to check their skills of analysis, synthesis, generalization and concretization, information and communication skills used by students in the process of preparing a presentation. |
| **Abstract** | Abstract is a summary, in writing or in the form of a public speech, of the content of a book, scientific work, and the results of studying a scientific problem, a report on a specific topic, including a review of relevant literary and other sources. As a rule, it is an independent student's work on revealing the essence of the problem under study, presenting various points of view and their own views on it. The defense of the abstract can be accompanied by a presentation. Since the main purpose of the essay is scientific and informational, this form of control is aimed mainly at assessing the knowledge of students on a specific topic (issue), although it allows us to identify the level of formation of the skills of analysis, synthesis, generalization and concretization used by the student in the process of preparing a report. |
| **Case-task completion** | Case-tasks are technology for teaching students. The students are given a set of educational material (case) and, as a result of acquaintance with it, they ought to comprehend the essence of the problem, which, as a rule, does not have an unambiguous solution, and offer their solution using the acquired knowledge and skills. It is widely used in practical classes in a foreign language, management, law, economics and other disciplines. In medicine, it can be used to teach students to write a medical history. It allowsto evaluate, first of all, the students' skills to apply the acquired knowledge when solving specific practical situations. Knowledge assessment is present at the stage of collecting material for a case-task. |
| **Testing** | Testing is a written way of testing students' knowledge. It can be current and final (by Module or discipline as a whole). Test items can include questions with one or more correct answers, assignments for matching and sequencing, as well as problem-situation tasks that require the selection of the correct (or several correct) answer options, as well as graphic images that require interpretation or definition. In most cases, testing is aimed at assessing students' knowledge. It allows to assess the students' skills when the test tasks are presented by problem-situational tasks, tasks with graphic (visual) images that require the use of a solution algorithm (action with an object). |
| **Recitation** | Recitation is a method of testing the knowledge and skills of students, which consists in the fact that students are invited to reproduce a certain content: empirical facts, theoretical positions, formulations of concepts, examples, classifications, scientific laws. It allows you to assess the level of knowledge of students on a particular issue, topic, section, discipline. Assessment of the students' skills is possible if, in the course of answering the question posed, the student needs to demonstrate the acquired knowledge in order to solve a problem question or problem-situational task. |
| **Practicaltaskcompletionmonitoring** | A practical task is a task that contains exercises and tasks that the student must solve (complete) visually (effectively), i.e. practically manipulating real objects or their substitutes. It is widely used in mathematics, computer science, physics, chemistry, economics, and other natural science disciplines. In medicine, it can be represented by the student performing direct practical manipulations with the "patient" both in the course of practical training and directly at the bases of practical training. It allows you to assess the ability of students to apply theoretical knowledge to solve (perform) a practical task in both standard and non-standard situations. |
| **Practicalskillstesting** | Testing of practical skills can be used to control the students' practical actions (medical manipulations) with the "patient". It allows you to assess the skills and abilities of students to apply the theoretical knowledge (about certain actions and manipulations) in standard and non-standard situations. |

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| **Monitoring form** | **Assessment criteria** |
| **Recitation** | On "FIVE POINTS" the answer is assessed, which shows solid knowledge of the main questions of the studied material, is distinguished by the depth and completeness of the disclosure of the topic; knowledge of the terminological apparatus; the ability to explain the essence of phenomena, processes, events, draw conclusions and generalizations, give reasoned answers, give examples; fluency in monologue speech, consistency and consistency of the answer. |
| On "FOUR POINTS" the answer is assessed, which reveals a solid knowledge of the basic questions of the studied material, differs in the depth and completeness of the disclosure of the topic; knowledge of the terminological apparatus; the ability to explain the essence of phenomena, processes, events, draw conclusions and generalizations, give reasoned answers, give examples; fluency in monologue speech, consistency and consistency of the answer. However, one or two inaccuracies in the answer are allowed. |
| On "THREE POINTS" the answer is assessed, which testifies mainly to the knowledge of the studied material, which is characterized by insufficient depth and completeness of the disclosure of the topic; knowledge of the basic issues of theory; poorly formed skills in analyzing phenomena, processes, insufficient ability to give reasoned answers and give examples; lack of fluency in monologue speech, logic and consistency of the answer. Several mistakesare allowed in the content of the answer. |
| On "TWO POINTS" the answer is assessed, revealing ignorance of the studied material, characterized by a shallow disclosure of the topic; ignorance of the main issues of theory, unformed skills in the analysis of phenomena, processes; inability to give reasoned answers, weak command of monologue speech, lack of consistency and consistency. Serious errors in the content of the answer are allowed. |
| ZERO POINTS" is given if there is no answer |
| **Testing** | "FIVE POINTS" is given on condition of 90-100% correct answers |
| "FOUR POINTS" is given on condition of 75-89% correct answers |
| "THREE POINTS" is given on condition of 60-74% correct answers |
| "TWO POINTS" is given on condition of 59% or less correct answers. |
| "ZERO POINTS" is given if there is no answer |
| **Writtenquestionnaire** | "FIVE POINTS" is given to a student if he knows the conceptual apparatus, demonstrates the depth and complete mastery of the content of the educational material, in which he is easily oriented. |
| "FOUR POINTS" are given to the student for the ability to correctly present the material, but the content and form of the answer may have some inaccuracies. |
| "THREE POINTS" is awarded if a student discovers knowledge and understanding of the main provisions of the educational material, but expresses it incompletely, inconsistently, makes inaccuracies in the definition of concepts, does not know how to substantiate his judgments with evidence. |
| "TWO POINTS" is given if a student has scattered, unsystematic knowledge, does not know how to distinguish the main and the secondary, makes mistakes in the definition of concepts, distorts their meaning. |
| "ZERO POINTS" is set if there is no answer. |
| **Problem-situationaltasks** | "FIVE POINTS" - the student correctly and fully conducts the initial assessment of the condition, independently identifies the satisfaction of which needs are violated, determines the patient's problems, sets goals and plans nursing interventions with their justification, conducts current and final assessment. |
| "FOUR POINTS" - the student correctly conducts the initial assessment of the condition, identifies the satisfaction of what needs are violated, determines the patient's problems, sets goals and plans nursing interventions with their justification, conducts the current and final assessment. Some minor difficulties in answering are allowed; justification and final assessment is carried out with additional comments from the teacher. |
| "THREE POINTS" - the student correctly but incompletely conducts the initial assessment of the patient's condition. Identifying the satisfaction of what needs are violated, determining the patient's problem is possible with leading questions from the teacher. Sets goals and plans for nursing interventions without justification, conducts ongoing and final assessment with leading questions from the teacher; Difficulties with a comprehensive assessment of the proposed situation. |
| "TWO POINTS" - wrong assessment of the situation; incorrectly chosen tactics of action. |
| "ZERO POINTS" is set if there is no answer. |
| **Practicalskills** | "FIVE POINTS". The student has shown full knowledge of the program material, the workplace is equipped with all the requirements for preparation for performing manipulations; practical actions are performed sequentially in accordance with the algorithm for performing manipulations; all requirements for the safety of the patient and medical staff are observed; the time limit is observed; the workplace is cleaned in accordance with the requirements of the sanitary and epidemiological supervision; all actions are justified. |
| "FOUR POINTS". The student has shown complete knowledge of the program material, the workplace is not fully independently equipped to perform practical manipulations; practical actions are performed consistently, but not confidently; all requirements for the safety of the patient and medical staff are observed; time regulations are violated; the workplace is cleaned in accordance with the requirements of the sanitary and epidemiological regime; all actions are justified with clarifying questions of the teacher, made small mistakes or inaccuracies. |
| "THREE POINTS". The student showed knowledge of the basic program material in the amount necessary for the upcoming professional activity, but made no more than one fundamental mistake, the workplace is not fully equipped to perform practical manipulations; the sequence of their implementation is broken; unsure actions, leading and additional questions and comments of the teacher are needed to justify actions; all requirements for the safety of the patient and medical staff are observed; the workplace is cleaned in accordance with the requirements of the sanitary and epidemiological regime. |
| "TWO POINTS". The student discovered significant gaps in the knowledge of the practical skill algorithm, made more than one fundamental mistake, difficulties in preparing the workplace, the inability to independently perform practical manipulations; actions are taken that violate the safety of the patient and the medical staff, the requirements of the sanitary and epidemiological regime, safety measures when working with the equipment and materials used are violated. |
| "ZERO POINTS" is given if there is no answer |
| **Abstract defense** | "FIVE POINTS" is awarded if the student fulfills all the requirements for writing and defending the abstract: the problem is identified and its relevance is justified, a brief analysis of various points of view on the problem under consideration is made and their own position is logically stated, conclusions are formulated, the topic is fully disclosed, the volume is maintained, requirements for the external design, the correct answers to additional questions are given. |
| "FOUR POINTS" is given if the students meet the basic requirements for the abstract and its defense, but at the same time there are some mistakes. In particular, there are inaccuracies in the presentation of the material; there is no logical consistency in judgments; the volume of the abstract is not kept; there are omissions in the design; incomplete answers were given to additional questions during the defense. |
| "THREE POINTS" is given if the student allows significant deviations from the requirements for abstracting. In particular, the topic is covered only partially; factual errors were made in the content of the abstract or when answering additional questions; there is no output during protection. |
| "TWO POINTS" is given if the topic of the abstract is not disclosed to the students, a significant misunderstanding of the problem is revealed. |
| "ZERO POINTS" is given if there is no answer |
| **Presentation demonstration** | "FIVE POINTS" is awarded if there is a connection between the presentation and the program and curriculum, the corresponding section; the didactic and methodological goals and objectives of the presentation were achieved; provides reliable information about historical references and current events; all conclusions are confirmed by reliable sources; the language of the presentation is clear to the audience; the chronology is followed, the priorities are correctly set; logical transition to the conclusion; correct conclusions; the font is readable, the color (background, font, headers) is correctly selected, animation elements are present; no grammatical errors. |
| "FOUR POINTS" is given if the students meet the basic requirements for the presentation, but there are some mistakes. In particular, there are inaccuracies in the presentation of the material; a topic was chosen without taking into account the curriculum; there is no logical consistency in judgments; requirements for graphic content are not met; there are omissions in the design; incomplete answers were given to additional questions during the defense. |
| "THREE POINTS" is given if the student makes significant deviations from the requirements for presentation design. In particular, the topic is covered only partially; errors of fact were made in the content of the presentation or when answering additional questions; no output was presented during the demo. |
| "TWO POINTS" is given if the topic of the abstract is not revealed to the students, a significant misunderstanding of the problem is revealed. |
| "ZERO POINTS" is given if there is no answer. |

1. **Evaluation materials for monitoring the progress of students .**

Forms of ongoing monitoring of progress in the discipline "Neurology, medical genetics, neurosurgery": exam.

**Evaluation materials for each topic of the discipline**

**Module 1 .**

**General neurology**.

**Topic 1 .**Pathology of movements

**Form (s) monitoring performance***- oral questioning*

**Evaluation materials for monitoring progress**

Questions:

1) Clinical anatomy and physiology of the motor analyzer (it is necessary to pay attention to the peculiarities of the course of the pyramidal pathway in the brain and spinal cord, the types of motor neurons and their functions).

2) Levels of closing the arcs of the basic unconditioned reflexes.

3) Unconditioned reflexes and their changes (tendon, periosteal, skin reflexes and their assessment).

4) Muscle tone and its changes (pay attention to the characteristic change in muscle tone when the pyramidal path is affected).

5) Active purposeful movements and their changes (pay attention to a five-point assessment of the severity of paresis).

6) Muscle trophism and its change.

7) Changes in gait (pay attention to the change in gait with various types of paresis).

8) Pathological reflexes (pay attention to the mechanism of occurrence of pathological reflexes and the most constant wrist and foot pathological reflexes).

9) Clinical variants of synkinesis.

10) defensive reflexes

11) Clinical signs of peripheral paralysis (pay attention to the state of reflexes, tone, muscle trophism).

12) Clinical signs of central paralysis (pay attention to the peculiarities of changes in reflexes, muscle tone, the presence of pathological reflexes, protective reflexes and synkinesis).

13) Differential diagnosis of various types of paresis (central, peripheral, mixed, reflex, functional).

14) Symptom complexes with lesions of the cortical-muscular pathway at various levels (cortical, subcortical, stem, spinal at the upper palatal level, at the level of the cervical thickening, at the thoracic level, at the level of the lumbar thickening, cauda equina roots, neural).

**Topic 2***.*Pathology of sensitivity.

**Form (s) monitoring performance***- oral questioning*

**Evaluation materials for monitoring progress**

**Questions.**

1. What three types of receptors are distinguished?

2. Which doctor is responsible for interoreceptor pathology?

3. The function of which part of the nervous system must be preserved for sensation to arise? What types of sensitivity are synthesized by the proprioceptive analyzer?

4. What types of sensitivity are synthesized by the exteroreceptive analyzer?

5. How many neurons make up the exteroreceptive pathway?

6. Location of the cell of the first neuron of the exteroreceptive pathway

7. Location of the cell of the second neuron of the exteroreceptive pathway.

8. Where is the third neuron of the exteroreceptive pathway located?

9. Where is the cell of the first neuron of the proprioceptive pathway? Second? Third?

10. Which neuron of exteroreceptive sensitivity makes its transition to the opposite side? At what level?

11. In what part of the nervous system do exteroreceptive and proprioceptive pathways go separately?

12. At what level is the medial loop formed, what is its conductive composition?

13. Where is the cortical analyzer of exteroreceptive sensitivity located? Where is the proprioceptive sensitivity analyzer located?

**Topic 3***.*Pathology of higher cortical functions .

**Form (s) monitoring performance***- oral questioning*

**Evaluation materials for monitoring progress**

**Questions.**

1) Do cortical speech disorders occur when the right hemisphere of the brain is affected?

2) Does the lesion of the speech muscles occur in patients with motor aphasia?

3) Is hearing preserved in a patient with sensory aphasia?

4) Can a patient with astereognosis describe the properties of an object?

5) Is the center of stereognosis one-sided?

6) Are there any phenomena of paresis in a patient with alexia?

7) Can a patient with amnestic aphasia describe the properties and purpose of the object?

8) Does the patient with sensory aphasia understand the speech addressed to him?

9) Can a patient with alexia retell the read text?

10) Is the correct sequence of actions possible in a patient with ideatorial apraxia?

11) Are there sensitivity disorders in patients with astereognosis?

12) What type of aphasia occurs when the left frontal lobe is affected? - motor aphasia - sensory aphasia - amnestic aphasia?

13) What type of speech disorders occurs when the cortical speech centers are damaged? - aphonia - anarthria - aphasia?

14) What type of aphasia is paraphasia typical for? - motor aphasia - sensory aphasia - amnestic aphasia?

15) What occurs when the left angular gyrus is affected? -graphia - alexia - acalculia?

**Topic 4***.*Pathology of the cranial nerves. Part 1 .

**Form (s) monitoring performance -***oral questioning*

**Evaluation materials for monitoring progress**

**Questions.**

1. Draw a diagram of the conductors, subcortical centers and cortical localization of the olfactory system.

2. Describe the symptoms of damage to the olfactory nerve

3. Draw a diagram of the pathways of the visual system

4. What symptoms occur when the optic nerve, chiasm, optic tract, Graziole's bundle, occipital cortex are damaged?

5. Explain the mechanism of formation of homonymous and heteronymous hemianopsia

6. What kind of energy is specific to the visual analyzer?

7. In what formations is the energy of light waves transformed into a nerve impulse?

8. What is the name of the site of formation of the optic nerve?

9. Do all the fibers intersect in the chiasm?

10. Does the optic tract contain fibers from one eye or from two?

11. What are the main layers of the retina?

12. What formations perform the function of primary visual centers?

13. Where are the cortical parts of the visual analyzer

14. Does the Graziole bundle contain fibers from one eye or two?

15. At what localization of the lesion (transection of the nerve or the optic tract) cause anopsia, hemianopsia.

16. Where is the pupil light reflex arc closed?

17. What morphological formations make up the sensory and motor parts of this arch?

18. Where is the nucleus of the oculomotor nerve and what is its anatomical structure?

19. What is the functional organization of the nucleus of the oculomotor nerve? 20. Name the muscles that innervate the oculomotor nerve. 21. Tell us about the clinic of isolated oculomotor nerve palsy and show this pathology variant on the simulator stand?

22. What are the clinical differences between lesions of the oculomotor nerve and its nuclei?

23. Where is the nucleus of the abducens nerve?

25. How to identify an isolated lesion of the blocky nerve?

26. Tell us the mechanism of gaze regulation?

27. In what direction does gaze paralysis occur when the posterior longitudinal fascicle and the cortical center of gaze are affected?

28. What is the phenomenon of "doll eyes"?

29. At what localization of the pathological process does vertical gaze paralysis occur?

30. Indicate the location of the nuclei and the course of the peripheral neuron of the oculomotor nerve.

31. Describe the reflex arch of the pupillary reflex

32. What symptoms characterize external and internal ophthalmoplegia?

33. What are the symptoms of Argyll Robertson syndrome?

34. The location of the nuclei, the course of the peripheral neuron of the trochlear and abducent nerves. Their main functions and symptoms are paralysis.

35. What muscles are innervated by the motor portion of the trigeminal nerve? 36. Tell the signs of damage to the motor portion of the trigeminal nerve

37. Location of nuclei, course of peripheral and central neurons of the trigeminal nerve.

38. List the clinical signs of damage to the trigeminal nerve. Difference between segmental and peripheral sensory innervation on the face?

39. List the clinical signs of the superior orbital fissure syndrome.

40. Explain the pathophysiology of the Weber and Wallenberg-Zakharchenko syndrome.

**Topic 5***.*Pathology of the cranial nerves. Part 2

**Form (s) monitoring performance***- oral questioning*

**Evaluation materials for monitoring progress**

**Questions.**

1. Where is the nucleus of the facial nerve located?

2. Tell us about the course of the fibers of the facial nerve?

3. Which branches extend from the facial nerve in the falopian canal and what do they innervate?

4. Tell us about the peculiarities of clinical symptoms in case of damage to the facial nerve at different levels?

5. Show on the diagram, table, bench-simulator of a patient with peripheral palsy of the facial nerve?

6. What changes in electroexcitability are observed with peripheral paralysis of the facial nerve?

7. What is the symptom of "crocodile tears"?

8. What are the clinical differences between central and peripheral palsy of the facial nerve?

9. What symptoms indicate damage to the sound-receiving and sound-conducting apparatus?

10. Explain the structural features of the auditory and vestibular apparatus.

11. How is vestibular ataxia different from other types of ataxia?

12. What structures of the nervous system are affected by auditory and vestibular hallucinations?

13. What are the symptoms of bulbar palsy?

14. How to distinguish bulbar palsy from pseudobulbar?

15. How to distinguish between central and peripheral lesions of the hypoglossal nerve? 16. Tell us about Jackson's alternating syndrome.

17. What is the difference between dysarthria and aphasia?

18. Explain the structure of the taste analyzer.

19. What is the pathology in the lesion of the accessory nerve?

20. What are the clinical symptoms of combined lesions of the glossopharyngeal and accessory nerves?

21. What movement disorders are observed when the accessory nerve is damaged?

22. What alternating syndromes do you know in lesions of the caudal parts of the brainstem?

**Topic 6***.*Pathology of the extrapyramidal system and cerebellum .

**Form (s) monitoring performance***- oral questioning*

**Evaluation materials for monitoring progress**

**Questions.**

1. What structures of the brain belong to the extrapyramidal system?

2. How does muscle tone change when the pallidum and substantia nigra are affected?

3. What clinical signs are characterized by the amiostatic symptom complex?

4. Describe the clinical features of hyperkinesis in parkinsonism?

5. With the defeat of what formations in the brain choreiform hyperkinesis occurs?

6. Describe the clinical features of choreiform hyperkinesis?

7. Damage to what structures in the brain will manifest itself as athetosis?

8. What are the clinical features of athetotid hyperkinesis?

9. How is torsion dystonia clinically manifested?

10. How is tics clinically manifested? 11. How is hemiballism manifested clinically?

12. Under what conditions does the physical body maintain a stable position on the ground?

13. In what position in the Romberg position is it difficult to maintain vertical balance?

14. How is balance maintained when the body is thrown back in a standing position?

15. What clinical signs are revealed cerebellar disorders.

16. What functions, apart from impaired coordination, does the cerebellum perform?

**Topic 7***.*CSF, hydrocephalus , meningeal syndrome .

**Form (s) monitoring performance***- oral questioning*

**Evaluation materials for monitoring progress**

**Questions.**

1.the state and functions of the cerebrospinal fluid are normal;

2. CSF in various pathological conditions (protein-cellular and cellular-protein dissociation, subarachnoid hemorrhage, meningitis);

3. meningeal syndrome (Kernig's and Brudzinsky's symptoms);

4. CSF dynamics in norm and in pathology (CSF dynamic tests of Kvekenstedt, Stuckey, Pousssen, lumbar puncture and measurement of CSF pressure, suboccipital puncture, ventricular puncture);

5.classification of hydrocephalus (by etiology; by distribution; by the nature of liquorodynamic disorders; by the stage of the disease);

6. clinic of hydrocephalus (dynamics of changes in head circumference, condition of the fontanelles of the skull, changes in tendon and periosteal reflexes, motor activity, stem symptoms, symptoms of intracranial hypertension);

7. diagnosis of hydrocephalus (measurement of head circumference, assessment of the condition of the fontanelles of the skull, echoencephaloscopy, craniography, lumbar puncture, liquorodynamic tests, computed tomography and magnetic resonance imaging of the brain);

8. conservative therapy and modern basic methods of surgical treatment of hydrocephalus (bypass surgery).

**Topic 8**. Research methods in neurology and neurosurgery .

**Form (s) monitoring performance***- oral questioning*

**Evaluation materials for monitoring progress**

**Questions.**

1.A set of additional research methods in patients with craniocerebral and spinal cord injury;

2. a set of additional research methods in patients with convulsive syndrome;

3. a set of additional research methods in patients with vascular pathology of the brain and spinal cord;

4. a set of additional research methods in patients with a consequence of past organic diseases of the nervous system, hydrocephalus;

5. a set of additional research methods in patients with a volumetric process of the brain and spinal cord.

**Topic 9***.*Pathology of the autonomic nervous system .

**Form (s) monitoring performance***- oral questioning*

**Evaluation materials for monitoring progress**

**Questions.**

1. The concept of the autonomic nervous system. What is the physiological role of the autonomic nervous system?

2. What is the anatomical organization of the segmental division of the autonomic nervous system? What are segmental autonomic disorders?

3. The suprasegmental division of the autonomic nervous system - anatomical organization. What are the suprasegmental lesion syndromes?

4. Classification of vegetative disorders (according to AM Wayne).

5. What is the sympathetic part of the autonomic nervous system represented by?

6. What is the parasympathetic part of the autonomic nervous system represented by?

7. How is the transmission of nerve impulses carried out in the sympathetic and parasympathetic nervous systems?

8. What is the study of vegetative tone based on? What tests are used to determine autonomic reactivity? What is the technique and significance of conducting a clinoorthostatic test?

9. What are the methods for the study of perspiration? How do adrenaline, pilocarpine, atropine act on the autonomic nervous system? Skin tests, research technique.

10. What are the syndromes of damage to the motor area of ​​the cerebral cortex? What are the syndromes of damage to the medial surface of the temporal, base of the temporal and frontal cortex?

11. What are the syndromes of hypothalamic lesion?

12. What are the syndromes of brain stem damage?

13. Autonomic syndromes of spinal cord injury, depending on the level of injury?

14. What are the symptoms of lesions of the sympathetic trunk, celiac plexus, nerve trunks?

15. Anatomical and functional characteristics of the limbic system, its role in the regulation of autonomic function.

16. What is the significance of the reticular formation for the activity of the autonomic nervous system?

17. How is urination regulated? What are the clinical variants of urinary disorders?

18. How is the sympathetic innervation of the eye carried out? What symptoms occur when the sympathetic innervation of the eye is turned off, and what is this syndrome called?

**Topic 10***.*Pathology of the peripheral nervous system .

**Form (s) monitoring performance***- oral questioning*

**Evaluation materials for monitoring progress**

**Questions.**

1. What is polyneuropathy (polyneuritis)?

2. [Classification of dibetic polyneuropathy](https://translate.google.com/translate?hl=ru&prev=_t&sl=auto&tl=en&u=http://www.happydoctor.ru/diabetes/neuropathy-classification) according to ICD10.

3. Variants of polyneuropathies.

4. Pathogenetic mechanisms of development of polyneuropathies.

5. The clinical picture.

6. Progression of diabetic polyneuropathy.

7. Diagnostics.

8. Scale of symptoms - NSS (Neuropathy Symptom Score) and a scale of signs - NDS (Neuropathy Dysabili ty Score).

8. Neurological examination of sensorimotor disorders.

9. Stages of distal diabetic neuropathy (International guidelines for the ambulatory management of diabetic neuropathy, 1995).

**Topic 11***.*Primary headache .

**Form (s) monitoring performance***- oral questioning*

**Evaluation materials for monitoring progress**

**Questions.**

1. Classification of migraine according to ICGB-3 beta (2013)

2. What is chronic migraine?

3. What complications of migraine do you know?

4. What are the episodic syndromes that can be combined with migraine?

5. What is the new daily persistent GB?

6.What is **GB**associated with **?**

7. Diagnostics

8. Indications for additional studies in patients with hypertension.

9. Suspicion of symptomatic (secondary) nature of cephalalgia .

**Unit 2**

**Topic 1**. Acute violation of cerebral circulation. Ischemic stroke.

**Form (s) monitoring performance -***oral questioning*

**Evaluation materials for monitoring progress**

**Questions.**

1. Classification of acute disorders.
2. Risk factors for stroke.
3. What are focal neurological symptoms? What are cerebral symptoms? What symptomatology is called meningeal?
4. The severity of ischemic stroke.
5. Criteria for acute hypertensive encephalopathy.
6. Subtypes of ischemic stroke
7. Pseudo-stroke. What is it? Differential diagnostics.
8. Pathogenetic mechanisms of development of ischemic stroke subtypes.
9. Clinic of minor stroke in the carotid system, in the vertebrobasilar system.
10. Differentiated therapy for ischemic stroke.

**Topic 2.**Acute cerebrovascular accident. Hemorrhagic stroke.

**Form (s) monitoring performance***- oral questioning*

**Evaluation materials for monitoring progress**

**Questions.**

1. Classification of hemorrhagic circulatory disorders of the brain.
2. Risk factors for stroke.
3. Hunt-Hess severity.
4. Cerebral edema and dislocation syndrome, clinical picture and CT diagnostics.
5. Indications for surgical treatment for different localization of hemorrhagic stroke.
6. Rehabilitation for strokes

**Topic 3.**Chronic cerebral ischemia / discirculatory encephalopathy

**Form (s) monitoring performance***- oral questioning*

**Evaluation materials for monitoring progress**

**Questions.**

1. Questions of terminology, definitions of discirculatory encephalopathy according to ICD-10: "cerebral atherosclerosis" (I 67.2), "progressive vascular leukoencephalopathy" (I 67.3), "hypertensive encephalopathy" (I 67.4), "other specified lesions of cerebral vessels" (I 67.8) , "Cerebrovascular disease, unspecified" (I 67.9).
2. Etiology of discirculatory encephalopathy (hypertensive, atherosclerotic).
3. Pathogenesis of discirculatory encephalopathy: changes in the arteries of the brain along their entire length according to the type of destructive processes: plasma and hemorrhages, necrosis with thinning of the wall of intracerebral vessels, reparative and adaptive processes, "hypertensive stenosis" and subsequent obliteration of the lumen, structural and functional properties of erythrocytes, platelets microcirculation, cerebral venous systems, perfusion pressure, irreversible morphological damage.
4. Clinic of discirculatory encephalopathy.
5. Clinical, neuropsychological and MRI diagnostics of discirculatory encephalopathy.
6. Differential diagnosis of discirculatory encephalopathy.
7. The main approaches to the treatment of discirculatory encephalopathy, depending on the etiological factor.

**Topic 4.**Inflammatory diseases of the nervous system (meningitis, encephalitis, meningoencephalitis).

**Form (s) monitoring performance***- oral questioning*

**Evaluation materials for monitoring progress**

**Questions.**

1. The concept of encephalitis. Division of encephalitis into primary and secondary. Isolation of acute, subacute and chronic encephalitis. Polyencephalitis and leukoencephalitis.
2. Common characteristic signs of the encephalitic process are cerebral, focal symptoms.
3. Characteristics of cerebrospinal fluid in encephalitis. Use for the diagnosis of encephalitis epidemiological, clinical, laboratory / serological, virological / data.
4. Etiology and pathogenesis of encephalitis. Group of viral encephalitis / tick-borne, mosquito-borne, epidemic, enterovirus, multi-season /, infectious-allergic and allergic encephalitis / with bark, chickenpox, rubella, scarlet fever /, vaccine / smallpox, anti-rabies, with CDS, DPT /, rheumatic encephalitis.
5. Epidemic encephalitis. The first descriptions of epidemic outbreaks. Opportunities for epidemic spread at present. Ways of spreading the infection. Features of pathological data. The initial manifestations of the acute manifestation of the disease. Features of the clinical picture of epidemic encephalitis at the present time / vestibular, hyperkinetic forms /.
6. The concept of leptomeningitis, arachnoiditis, pachymeningitis. Meningitis, primary and secondary, purulent and serous, is the main characteristic of meningeal syndrome. Changes in cerebrospinal fluid in various meningitis. The phenomenon of meningism.
7. Meningococcal meningitis. Etiology and pathogenesis. The predominant disease of childhood. Pathological anatomy, clinical picture of typical manifestations of meningococcal meningitis, complications and consequences. Atypical forms - meningococcemia, fulminant form, abortive, chronic. Principles of treatment for meningococcal meningitis.
8. Features of the clinic and the course of purulent meningitis of other etiology. Principles of treatment of purulent meningitis.
9. Serous meningitis - various forms of meningitis etiology - Comrade, united the Features serous erom inflammation of the meninges.
10. The main types of serous meningitis are enteroviral, lymphocytic, with mumps. The most common forms of serous meningitis are c. Features of treatment. Outcomes,
11. The principles of differential - Noah serous meningitis diagnosis of tuberculous meningitis. Treatment of tuberculous meningitis . Secondary infectious allergic encephalitis. Brain lesions that develop with general infections and after vaccination.
12. The predominance of lesions of the white matter of the brain, spinal cord / encephalomyelitis /, peripheral nervous system / encephalomyelopolyradiculoneuritis /.

**Topic 5.**Epilepsy, status epilepticus **.**

**Form (s) monitoring performance***- oral questioning*

**Evaluation materials for monitoring progress**

**Questions.**

1. Epilepsy. Morbidity. Prevalence.
2. Current concepts of etiology, pathogenesis, pat on the morphology with convulsive states and epilepsy.
3. Classification of convulsive conditions in children and adults.
4. Differential diagnosis of convulsive conditions with epilepsy as an organic disease of the central nervous system.
5. Epilepsy research methods. Electroencephalography, computed tomography, magnetic resonance imaging and others in the diagnosis and differential diagnosis of convulsive conditions.
6. Etiology, pathogenesis, clinical picture of epilepsy, treatment of convulsive conditions, depending on the type of seizure and the course of the disease. Clinical picture and treatment of status epilepticus.
7. Prognosis and rehabilitation of patients with convulsive conditions.

**Topic 6.**Demyelinating diseases of the nervous system. Multiple sclerosis.

**Form (s) monitoring performance***- oral questioning*

**Evaluation materials for monitoring progress**

**Questions.**

1. Give a definition of multiple sclerosis.
2. The prevalence and incidence of multiple sclerosis in different geographic areas.
3. Influence of measles, rubella, infectious mononucleosis (Epstein – Barr virus), herpes virus, various bacteria on the development of MS.
4. *Mr.*eneticheskie factors for MS *.*
5. M eelinsynthetic cells.
6. Morphologically pathological process in MS.
7. clinical manifestations.
8. Diagnostic criteria.
9. **Treatment during the attack and outside the exacerbation**

**Topic 7.**Degenerative diseases of the nervous system with motor neuron disorders.

**Form (s) monitoring performance***- oral questioning*

**Evaluation materials for monitoring progress**

**Questions.**

Questions.

1. Give the definition of amyotrophic lateral sclerosis (ALS).

2. Its prevalence and incidence.

3. Risk factors for ALS .

4. Pathogenetic mechanisms of ALS: theory of glutamate excitotoxicity; autoimmune theory; the theory of a lack of neurotrophic factor in the motor areas of the spinal cord and brain; mitochondrial dysfunction hypothesis.

5. Classification of F. Norris, domestic authors (Hondkarian OA et al., 1978).

6. Diagnostics: electromyography (ENMG), MRI of the brain, muscle biopsy.

7. Modified El Escorian diagnostic criteria for ALS, (adopted by the World Federation of Neurology , 2003).

8. Riluzole - prolonging the life of ALS patients (according to the recommendations of the European Federation of Neurological Society (European Federation of Neurological Communities).

**Topic 8.**Neuromuscular diseases. Myasthenia gravis and myasthenic syndromes.

**Form (s) monitoring performance***- oral questioning*

**Evaluation materials for monitoring progress**

**Questions.**

1. Give a definition of neuromuscular diseases.
2. Prevalence and incidence of myasthenia gravis.
3. Multifactorial development of myasthenia gravis.
4. Pathogenesis of the development of myasthenia gravis.
5. The leading clinical symptom of myasthenia gravis is pathological muscle fatigue.
6. Mr. eneralizovannaya form of myasthenia gravis.
7. Walker-reception, proserin test, stimulation electromyography.
8. *Treatment.*

**Topic 9.**Descent of the brain **.**

**Form (s) monitoring performance***- oral questioning*

**Evaluation materials for monitoring progress**

**Questions.**

1. Clinical classification of tumors of the central nervous system.
2. Topographic classification.
3. Histological classification.
4. Phases of tumor development.
5. Clinical subcompensation phase
6. The phase of moderate clinical decompensation.
7. Phase of gross clinical decompensation.
8. Terminal phase.
9. Types of surgical interventions.

**Assessment criteria used in the current control of progress, including in the control of students' independent work.**

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| --- | --- |
| **form of control** | **Evaluation criteria** |
| **oral questioning** | The score "EXCELLENT" is an answer that shows solid knowledge of the main questions of the studied material, is distinguished by the depth and completeness of the topic; knowledge of the terminological apparatus; the ability to explain the essence of phenomena, processes, events, draw conclusions and generalizations, give reasoned answers, give examples; fluency in monologue speech, consistency and consistency of the answer. |
| The score "GOOD" is an answer that reveals solid knowledge of the main questions of the material being studied, differs in the depth and completeness of the topic; knowledge of the terminological apparatus; the ability to explain the essence of phenomena, processes, events, draw conclusions and generalizations, give reasoned answers, give examples; fluency in monologue speech, consistency and consistency of the answer. However, one or two inaccuracies in the answer are allowed. |
| The score "SATISFACTORY" is the answer, which testifies mainly to the knowledge of the studied material, characterized by insufficient depth and completeness of the topic; knowledge of the basic issues of theory; poorly formed skills in analyzing phenomena, processes, insufficient ability to give reasoned answers and give examples; lack of fluency in monologue speech, logic and consistency of the answer. Several errors in the content of the answer are allowed. |
| The score "UNSATISFACTORY" evaluates the answer revealing ignorance of the studied material, characterized by a shallow disclosure of the topic; ignorance of the main issues of theory, unformed skills in the analysis of phenomena, processes; inability to give reasoned answers, weak command of monologue speech, lack of consistency and consistency. Serious errors in the content of the answer are allowed. |
| **interview** | The score "EXCELLENT" is given if the student clearly stated the essence of the topic under discussion, showed the logic of the presentation of the material, presented the argumentation, answered the questions of the interview participants. |
| The score "GOOD" is given if the student clearly stated the essence of the topic under discussion, showed the logic of the presentation of the material, but did not provide the argumentation, incorrectly answered the questions of the interview participants. |
| The score "SATISFACTORY" is given if the student clearly stated the essence of the topic under discussion, but did not show sufficient logic in the presentation of the material, did not provide argumentation, incorrectly answered the questions of the interview participants. |
| The score "UNSATISFACTORY" is given if the student poorly understands the essence of the topic under discussion, is not able to logically and reasonably participate in the discussion. |
| **testing** | The score "EXCELLENT" is given subject to 90-100% correct answers |
| The score "GOOD" is given subject to 75-89% correct answers |
| The score "SATISFACTORY" is given subject to 60-74% correct answers |
| The score "UNSATISFACTORY" is given on condition of 59% or less correct answers. |
| **Presentation presentation** | The score "EXCELLENT" is awarded if the students are provided with information on the topic in full, the logic of the presentation of the material is observed, the slides are high-quality, contain information balanced in text and graphic format, demonstrate fluency in the material and terminology, the rules are observed, the answers to the questions are correct and clear. |
| The score "GOOD" is given if the information on the topic is not presented in full, the presentation of the material is not logical enough, the slides are of high quality, but contain information that is not balanced in text and graphic format, demonstrates good knowledge of the material and terminology, the rules are observed, the answers to the questions are correct, but not clear enough. |
| The score "SATISFACTORY" is given if the information on the topic is not presented in full, the logic of the presentation of the material is not observed, the slides are not well-designed and contain information that is not balanced in text and graphic formats, the knowledge of the material is not free enough, some terms are interpreted erroneously, the regulations are not followed , answers to questions are not clear enough, with errors in details. |
| The score "UNSATISFACTORY" is given if the information on the topic is presented one-sidedly, the logic of the presentation of the material is not observed, the slides are not well designed and contain information that is not balanced in text and graphic format, the knowledge of the material is superficial, the terms are interpreted erroneously, the rules are not followed, the answers to questions are not clear , with errors, or missing. |
| **defense of the abstract** | The score "EXCELLENT" is awarded if the student meets all the requirements for writing and defending the abstract: the problem is identified and its relevance is justified, a brief analysis of various points of view on the problem under consideration is made and their own position is logically stated, conclusions are formulated, the topic is fully disclosed, the volume is maintained, the requirements are met to the external design, the correct answers to additional questions are given. |
| The score "GOOD" is given if the students have met the basic requirements for the abstract and its defense, but at the same time there are some mistakes. In particular, there are inaccuracies in the presentation of the material; there is no logical consistency in judgments; the volume of the abstract is not kept; there are omissions in the design; incomplete answers were given to additional questions during the defense. |
| The score "SATISFACTORY" is given if the student makes significant deviations from the requirements for abstracting. In particular, the topic is covered only partially; factual errors were made in the content of the abstract or when answering additional questions; there is no output during protection. |
| The score "UNSATISFACTORY" is given if the topic of the abstract is not disclosed to the student, a significant misunderstanding of the problem is revealed |

1. **Evaluation materials for intermediate attestation of students.**

The interim certification on the discipline Spend tsya in the form of examination. Sample exam ticket :

**"FEDERAL STATE BUDGETARY EDUCATIONAL INSTITUTION OF HIGHER EDUCATION**

**"ORENBURG STATE MEDICAL UNIVERSITY"**

**MINISTRY OF HEALTH OF THE RUSSIAN FEDERATION**

**Department of Neurology, Medical Genetics**

**Training of highly qualified personnel - specialty**

**Specialty: 31.05.01 General Medicine**

**Discipline: Neurology, Medical Genetics, Neurosurgery**

**EXAMINATION TICKET No. 1**

1) Option set of test items number 1.

2) Theoretical material:

1. Founders of "Patriotic Neurology" (Moscow, Petersburg, Kazan schools).

2. Dyscirculatory encephalopathy. Classification. Etiology. Clinic, diagnostics, treatment.

3) Practical skills (problem solving) №1.

Head of the Department of Neurology,

medical genetics, MD, professor A.M. Dolgov

Dean of Medical and Dental

faculties, Doctor of Medical Sciences, Associate Professor D.N. Lyaschenko

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**Criteria used for assessing students at intermediate certification**

The disciplinary rating is calculated as follows:

Рд = Рт + Рб + Рз,

**RB -**bonus rating;

**Рд -**disciplinary rating;

**R e -**examination rating;

**Рт -**current rating;

**Questions to test the theoretical knowledge of the discipline**

**Module 1. General Neurology**

1. Founders of "Patriotic Neurology". Moscow, Petersburg, Kazan schools.

2. Principles of the structural and functional organization of the nervous system.

3. Neurogeriatrics. Features of lesions of the nervous system in the elderly.

4. The cerebral cortex. Anatomy, physiology. The doctrine of aphasia.

5. The cerebral cortex. Anatomy, physiology. Disorders of praxis and gnosis.

6. Syndromes of defeat of individual fields of the cerebral hemispheres.

7. The path of voluntary movements. Anatomy, physiology, pathology. Central paralysis.

8. The path of voluntary movements. Anatomy, physiology, pathology. Peripheral paralysis.

9. Physiological organization of movement.

10. The way of deep muscular-articular feeling. Anatomy, physiology, pathology.

11. The path of surface sensitivity. Anatomy, physiology, pathology. Types of sensitivity disorders.

12. Extrapyramidal system. Anatomy, physiology, pathology. Neostriatal syndrome.

13. Extrapyramidal system. Anatomy, physiology, pathology. Parkinson's syndrome.

14. Extrapyramidal system. Neuro-motor dyskinesias. Classification, clinic.

15. Extrapyramidal system. Tics, tic-like hyperkinesis.

16. Coordination of movements and differential diagnosis of various types of ataxia.

17. Ascending connections of the cerebellum. Anatomy, physiology, pathology.

18. Descending connections of the cerebellum. Anatomy, physiology, pathology.

19. Thalamus. Anatomy, physiology, pathology. Thalamic syndrome.

20. The structure of the spinal cord diameter. Anatomy, physiology. Symptoms of spinal cord injury at different levels.

21. Brown-Séquard syndrome. Pathophysiology, clinic, diagnostics.

22. Vegetative NS. Psychovegetative syndrome.

23. Hypothalamus. Anatomy, physiology. Clinical manifestations during irritation and loss of its functions.

24. Vegetative NS. Paroxysmal vegetative dystonia. Criteria and clinic of panic attacks.

25. Innervation of the sphincters of the bladder and rectum. Pelvic disorders (central and peripheral types).

26. Inner capsule. Anatomy, physiology, pathology.

27.1 pair of cranial nerves. Anatomy, physiology, pathology.

28.2 pair of cranial nerves. Anatomy, physiology, pathology.

29. Oculomotor nerves (3, 4, 6 pairs). Anatomy, physiology, pathology. Pupil innervation and its pathology.

30.5 pair of cranial nerves. Anatomy, physiology, pathology.

31.7 pair of cranial nerves. Anatomy, physiology, pathology.

32.8 pair of cranial nerves (cochlear and vestibular branches). Anatomy, physiology, pathology.

33.9, 10 pair of cranial nerves. Anatomy, physiology, pathology.

34.11, 12 pair of cranial nerves. Anatomy, physiology, pathology.

35. Syndrome of damage to the brain stem. Syndromes Miyar-Gumbler, Weber, Jackson and Velenberg-Zakharchenko.

36. Syndrome of the cerebellar pontine angle.

37. Bulbar and pseudobulbar syndrome.

38. The membranes of the brain. Anatomy, physiology. Meningeal symptom complex.

39. Liquor (composition is normal, its physiological significance). CSF-dynamic syndromes. CSF composition pathology and clinical significance.

40. Liquorodynamic tests. Indications, contraindications for lumbar puncture.

41. Paraclinical research methods in neurology. Pneumoencephalography, EEG, ECHO-EG, rheo-EG, angiography, CT angiography, electromyography, CT, MRI, ultrasound, PET, evoked brain potentials.

42. Limbic system. Anatomy, physiology. Emotional disorder.

43. Clinical differences between peripheral and central paralysis.

44. Central and peripheral paralysis of the facial muscles. Clinical picture, pathophysiology and symptoms.

45. Violation of the higher cortical functions.

46. ​​Three functional blocks of the formation of higher cortical functions.

47. Memory disorder.

48. Attention disorder.

49. Thinking disorder.

50. Speech disorder.

51. Alternating pedicle syndromes.

52. Alternating bridge syndromes.

53. Alternating medulla oblongata syndromes.

Unit 2.

Private neurology

1. Encephalopathy. Classification. Etiology. Clinic, diagnostics, treatment.
2. Subtypes of ischemic stroke. Etiology, pathogenesis, clinic.
3. Parynchymal-subarachnoid hemorrhage (hemispheric localization). Etiology, pathogenesis, clinic. Treatment.
4. Subarachnoid hemorrhage. Hunt-Hess criteria. Etiology, pathogenesis, clinic. Treatment.
5. Vascular myelopathy. Etiology, clinic, diagnostics, treatment.
6. Primary and secondary lesions of the nervous system in AIDS.
7. Differentiated and basic treatment of acute disorders of cerebral circulation.
8. Cerebral rheumatic vasculitis. Chorea.
9. Classification of acute disorders of cerebral circulation.
10. Transient cerebrovascular accident in the vertebrobasilar basin. Clinic, diagnostics, treatment.
11. Multiple sclerosis. Etiology, pathogenesis, clinic, treatment.
12. Neuritis of the facial nerve. Etiology, pathogenesis, clinic, treatment.
13. Trigeminal neuralgia. Etiology, pathogenesis, clinic, treatment.
14. Polyneuritis and polyradiculoneuritis. Classification. Etiology, pathogenesis, clinical picture, differential diagnosis, course, treatment.
15. Status epilepticus and its treatment .
16. Functional diseases of the nervous system. Neurasthenia, neuroses, hysteria.
17. Hepatolenticular degeneration. Etiology, pathogenesis, clinic, treatment.
18. Vertebrogenic disorders of the nervous system: osteochondrosis, spondylosis, spondylitis, spondylolisthesis, spondiolysis.
19. Tick-borne encephalitis. Etiology, pathogenesis, clinical picture, treatment, prevention.
20. Primary viral encephalitis (Economo encephalitis). Etiology, pathogenesis, clinic, treatment.
21. Occupational diseases of the nervous system caused by physical factors (vibration disease).
22. Acute infectious myelitis.
23. Meningitis, classification, clinic, treatment.
24. Sirengomyelia. Hematomyelia. Clinic, treatment.
25. Poliomyelitis and poliomyelitis diseases.
26. Epilepsy. Jacksonian and Kozhevnikovsky epilepsy.
27. Gaie-Wernicke disease clinic and its treatment.
28. Vegetative dystonia. Classification, clinic, treatment.
29. Angiotrophoneurosis. Acute Quincke's edema. Migraine. Raynaud's disease.
30. Myasthenia gravis. Etiology, classification, clinic, treatment.
31. Amyotrophic lateral sclerosis.
32. Myodystorophia. Classification, diagnostics. Clinical manifestations of Duchenne muscular dystrophy.
33. Myopathy. Classification, clinic, treatment.
34. Neural and spinal amyotrophies. Classification, clinical manifestations.
35. Differentiated and basic treatment of ischemic stroke.
36. Laboratory and instrumental methods used in the differential diagnosis of strokes, their advantages and disadvantages.
37. Prehospital stroke care.
38. Trigeminal neuralgia. Clinic, diagnostics, treatment.
39. Alcoholic polyneuropathy. Clinic, differential diagnosis, treatment.
40. Consciousness. Physiology. The concept of coma. Differentiation of coma.
41. Intracranial hypertension syndrome. Etiology, clinic, treatment.
42. Brain tumors. Classification, clinic, treatment.
43. Myotonia Thompson. Clinic, treatment, course.
44. TBI. Classification, clinic, treatment. Subdural and epidural hematomas.
45. Arachnoiditis. Classification, clinic, treatment.
46. Classification and clinic of lesions of the peripheral nervous system.
47. Damage to the radial, ulnar, median nerves. Clinic, treatment.
48. Insomnia. Classification, etiology, clinic.
49. Plexites. Etiology, pathogenesis, clinical picture, diagnostics. Treatment.
50. Treatment principles for epilepsy. Treatment of epilepsy according to the types of seizures.
51. Tension headache.
52. Sections of headache classification.
53. Migraine status. Urgent Care.
54. Myasthenic crisis. Urgent Care.
55. Cholinergic crisis. Urgent Care.
56. Vestibular Syndrome. Etiology, pathogenesis, clinical picture, diagnostics. Urgent Care.
57. Edema of the brain. Urgent Care.
58. Neuropathic pain. Relief of a pain attack.
59. International Classification of Headache (2018).

**Practical tasks to test the skills and abilities formed**

Ticket number 1.

1. Smell research.
2. Study of the volume of active movements.
3. Study of the sensitive function of the trigeminal nerve.
4. Study of stereognosis.
5. Research on sustainability.
6. Identification of plantar reflexes.

Ticket number 2.

1. Study of the state of the pupils, reactions.
2. Study of the volume of active movements.
3. Study of the sensitive function of the trigeminal nerve.
4. Study of the abducens nerve.
5. Identifying the symptoms of Neri and Lassegh.

Ticket number 3.

1. Study of the function of the oculomotor nerve.
2. Identification of imitative and global synkinesis.
3. Study of corneal reflexes.
4. Study of the abducens nerve.
5. Study of the motor function of the trigeminal nerve.
6. Study of reflexes of oral automatism: proboscis, palmar-chin.

Ticket number 4.

1. Study of the sensitive function of the trigeminal nerve.
2. Study of the function of the facial nerve.
3. Study of muscle tone.
4. Study of stereognosis.
5. Research on sustainability.
6. Identifying the symptoms of Neri and Lassegh.

Ticket number 5.

1. Study of the function of the hypoglossal nerve.
2. Research on sustainability.
3. Revealing the symptoms of Vaserman and Matskevich.
4. Study of the volume of active movements.
5. Muscle strength research.
6. Identification of apraxia.

Ticket number 6.

1. Study of tone.
2. Identification of apraxia.
3. Identification of imitative and global synkinesis.
4. Research on sustainability.
5. Discrimination Sensitivity Study
6. Identifying Kernig's symptoms, upper, middle and lower.

Ticket number 7.

1. Identification of Brudzinsky's symptom.
2. Movement coordination study.
3. Study of pain and temperature sensitivity.
4. Study of tendon reflexes from the biceps and triceps muscles.
5. Study of tone.
6. Study of stereognosis.

Ticket number 8.

1. Study of proprioceptive sensitivity.
2. Identification of the pathological reflex of Babinsky.
3. Research of hypermetry and adiadochokinesis.
4. Revealing the symptoms of Vaserman and Matskevich.
5. Study of tone.
6. Study of stereognosis.

Ticket number 9.

1. Identification of the pathological reflex of Oppenheim.
2. Study of tendon reflexes from the biceps and triceps muscles.
3. Study of the motor function of the trigeminal nerve.
4. Research of hypermetry and adiadochokinesis.
5. Study of the volume of active movements.
6. Smell research.

Ticket number 10.

1. Identification of the pathological Gordon reflex.
2. Study of the volume of active movements.
3. Research on discriminatory sensitivity.
4. Identifying the symptoms of Neri and Lassegh.
5. Study of reflexes of oral automatism: proboscis, palmar-chin.
6. Study of tendon reflexes from the biceps and triceps muscles.

Ticket number 11.

1. Identification of the Schaeffer's pathological reflex.
2. Research of protective reflexes.
3. Research of hypermetry and adiadochokinesis.
4. Revealing the symptom of the upper, middle and lower Brudzinsky.
5. Research on discriminatory sensitivity.
6. Identification of plantar and abdominal reflexes.

Ticket number 12.

1. Identification of the pathological reflex of Zhukovsky.
2. Study of stereognosis.
3. Research on discriminatory sensitivity.
4. Study of tendon reflexes from the biceps and triceps muscles.
5. Research of protective reflexes.
6. Revealing the symptoms of Vaserman and Matskevich.

Ticket number 13.

1. Identification of the pathological reflex of ankylosing spondylitis.
2. Identifying the symptoms of Neri and Lassegh.
3. Research of hypermetry and adiadochokinesis.
4. Identifying Kernig's symptoms.
5. Study of knee and Achilles reflexes.
6. Identification of plantar and abdominal reflexes.

Ticket number 14

1. Smell research.
2. Study of the state of the pupils, reactions.
3. Study of the function of the oculomotor nerve.
4. Study of the sensitive function of the trigeminal nerve
5. Revealing the symptoms of Vaserman and Matskevich
6. Identifying the symptoms of Neri and Lassegh.

Ticket number 15

1. Study of the volume of active movements
2. Identification of plantar reflexes.
3. Study of the abducens nerve.
4. Study of corneal reflexes.
5. Identification of apraxia.
6. Identification of the pathological reflex of Babinsky.

Ticket number 16

1. Study of stereognosis.
2. Research on sustainability.
3. Identification of imitative and global synkinesis.
4. Study of tendon reflexes from the biceps and triceps muscles.
5. Identification of Brudzinsky's symptom.
6. Study of pain and temperature sensitivity.

Ticket number 17

1. Identification of the pathological reflex of Oppenheim.
2. Movement coordination study.
3. Study of tone .
4. Identifying Kernig's symptoms, upper, middle and lower.
5. Identifying the symptoms of Neri and Lassegh.
6. Study of stereognosis.

Ticket number 18

1. Study of tendon reflexes from the biceps and triceps muscles.
2. Research of hypermetry and adiadochokinesis.
3. Study of corneal reflexes.
4. Identification of the pathological reflex of Oppenheim.
5. Study of reflexes of oral automatism: proboscis, palmar-chin.
6. Identification of the pathological Gordon reflex.

Ticket number 19

1. Study of tendon reflexes from the biceps and triceps muscles.
2. Identification of the Schaeffer's pathological reflex.
3. Research on discriminatory sensitivity.
4. Research of protective reflexes.
5. Identification of the pathological reflex of Zhukovsky.
6. Study of stereognosis.

Ticket number 20

1. Study of knee and Achilles reflexes.
2. Identifying Kernig's symptoms.
3. Identification of plantar and abdominal reflexes.
4. Smell research.
5. Study of the state of the pupils, reactions.
6. Study of the volume of active movements.

Ticket number 21

1. Study of the abducens nerve.
2. Identifying the symptoms of Neri and Lassegh.
3. Identification of imitative and global synkinesis.
4. Study of the function of the facial nerve.
5. Research on sustainability.
6. Revealing the symptoms of Vaserman and Matskevich.

Ticket number 22

1. Study of the volume of active movements.
2. Muscle strength research.
3. Identification of apraxia.
4. Study of stereognosis.
5. Smell research.
6. Revealing the symptom of the upper, middle and lower Brudzinsky.

Ticket number 23

1. Identification of plantar and abdominal reflexes.
2. Study of tendon reflexes from the biceps and triceps muscles.
3. Identification of the pathological reflex of ankylosing spondylitis.
4. Research of hypermetry and adiadochokinesis.
5. Revealing the symptoms of Vaserman and Matskevich.
6. Research of protective reflexes.

Ticket number 24

1. Study of the sensitive function of the trigeminal nerve.
2. Identification of plantar reflexes.
3. Study of corneal reflexes.
4. Research on sustainability.
5. Identification of imitative and global synkinesis.
6. Study of tone.

Ticket number 25

1. Movement coordination study.
2. Study of pain and temperature sensitivity.
3. Identification of the pathological reflex of Babinsky.
4. Study of the motor function of the trigeminal nerve.
5. Identification of the pathological Gordon reflex.
6. Study of the volume of active movements.

Ticket number 26

1. Identification of the pathological reflex of Zhukovsky.
2. Study of the volume of active movements.
3. Research on discriminatory sensitivity.
4. Study of tendon reflexes from the biceps and triceps muscles.
5. Revealing the symptoms of Vaserman and Matskevich.
6. Research on sustainability.

Ticket number 27

1. Identification of apraxia.
2. Study of muscle tone.
3. Study of stereognosis.
4. Study of the function of the hypoglossal nerve
5. Study of tone.
6. Identifying Kernig's symptoms, upper, middle and lower.

Ticket number 28

1. Proprioceptive sensitivity study
2. Identification of the pathological reflex of Babinsky.
3. Research of hypermetry and adiadochokinesis.
4. Study of the volume of active movements
5. Identification of the Schaeffer's pathological reflex.
6. Research of protective reflexes.

Ticket number 29

1. Study of stereognosis.
2. Research on discriminatory sensitivity.
3. Study of hypermetry and adiadochokinesis
4. Identifying the symptoms of Neri and Lassegh.
5. Study of the volume of active movements.
6. Identification of Brudzinsky's symptom.

Ticket number 30

1. Research on sustainability.
2. Discrimination Sensitivity Study
3. Study of the sensitive function of the trigeminal nerve.
4. Identification of imitative and global synkinesis.
5. Identification of plantar reflexes.
6. Study of the function of the oculomotor nerve.

**Test tasks**for intermediate certification are formed on the basis of the presented theoretical questions and practical tasks. Testing of students is carried out on **paper.**

U Neurology, medical genetics, neurosurgery

# RESEARCH METHODS FOR TUMORS OF THE SPINAL CORD.

+ electroencephalography, myelography, magnetic resonan ce imaging

echoencephalography

CT scan

# CHARACTERISTIC DATA OF ADDITIONAL RESEARCH METHODS FOR HEMORRHAGIC STROKE

+ bloody / xanthochromic cerebrospinal fluid, M-echo displacement of more than 3 mm with echoencephalographic examination, leukocytosis over 10,000 with a left shift

signs of a local decrease or increase in the tone of the cerebral vessels with a simultaneous decrease in blood supply in the rheoencephalogram,

non-filling of the vasculature in the basin of the vessel without displacement or compression of the surrounding areas of the brain during cerebral angiography

# CHARACTERISTIC DATA OF ADDITIONAL RESEARCH METHODS FOR ISCHEMIC STROKE.

bloody or xanthochromic cerebrospinal fluid

M-ECHO displacement of more than 3 mm with echoencephalographic examination

leukocytosis over 10,000 with a shift to the left about

gross and diffuse disturbances in the electrical activity of the brain

+ non-filling of the vasculature in the basin of the vessel without displacement or compression of the surrounding areas of the brain during cerebral angiography, foci of reduced density in the brain according to computed tomography, local disturbances in the electrical activity of the brain

# RESEARCH METHOD FOR BRAIN TUMORS

myelography

electroencephalography

angiography

+ computed tomography with contrast, magnetic resonance imaging

# INDICATIONS FOR EEG

hemorrhagic stroke and myasthenia gravis

+ convulsive syndrome

diabetic polyneuropathy and herbs of the thoracic spine

# INDICATIONS FOR EMG

hydrocephalus

syncope

+ polyneuropathy

# SIGNS OF INTRACRANIAL HYPERTENSION ON CRANIOGRAPHY

hyperostosis

Turkish saddle back osteoporosis

attenuation of vascular pattern

+ finger impressions

# INDICATION FOR ECHO-ES

epilepsy

+ suspicion of volumetric processes

myatonia

BASS

syring omielia

# FUNCTIONAL RESEARCH METHODS IN NEUROLOGY

CT

spondylography

+ USDG, MRI spectroscopy

craniography

# INDICATIONS FOR CEREBRAL ANGIOGRAPHY

syringobulbia

suspected brain abscess, ventriculitis

+ suspicion of AVM

lacunar stroke

# THE MAIN METHODOLOGY FOR THE STUDY OF PATIENTS WITH CEREBRAL ANEURYSMS

echoencephalography

+ cerebral angiography

electroencephalography, craniography

ultrasound dopplerography

# WHAT A N ABSOLUTE CONTRAINDICATION FOR LUMBAR PUNCTURE

severe hyperthermia, volumetric process in the posterior cranial fossa

+ pustular skin lesions in the area of puncture

severe chronic diseases of the internal organs

impaired consciousness

# PATHOLOGICAL EEG RHYTHM

alpha rhythm with an amplitude of up to 100 μ V

beta - rhythm amplitude up to 100 μ V

+ delta - rhythm with an amplitude of up to 100 μ V

theta - rimt w ith an amplitude of 25-30 μ V

# EARLY DIAGNOSIS OF ISCHEMIC STROKE

rheoencephalography;

CT scan;

+ positron emission tomography;

Magnetic resonance imaging

# WHAT IS INFORMATIVE METHODS FOR THE DIAGNOSIS OF PATHOLOGICAL PROCESSES IN THE POSTERIOR CRANIAL FO SSA

computed tomography with contrast

positron emission tomography

+ magnetic resonance imaging

all methods are equally informative

# PUSSEP TEST :

pressure on the anterior abdominal wall;

jugular vein compression

+ head tilt forward

extension of a knee bent leg

pressure on pubic articulation

# CONTRAINDICATIONS FOR MRI

anemia

hyperthermia

+ metal structures and implants in the body

impaired consciousness, severe chronic somatic diseases

# SIGNS OF ATHEROSCLEROSIS ON RHEOGRAMS

increase in wave amplitude and dicrotic tooth

sharpening the top of the curve

+ flattening the top of the curve

the appearance of additional waves

# WHAT IS T HE NORM OF THE DISPLACEMENT OF THE MEDIAN M-ECHO

up to 3 mm

up to 4 mm

+ up to 2 mm

no more than 1 mm

up to 5 mm

# INVASIVE DIAGNOSTIC METHOD

ECHO Encephalography

MR angiography, rheoencephalography

+ myelography

p entgenografiya on Stenversu

# WHAT IS A N INFORMATIVE METHOD FOR THE DIAGNOSIS OF INTERVERTEBRAL HERNIAS

spondylography, echo encephalography

+ tomography

CT scan

ultrasound examination of the spine

# WHAT IS THE TIME FOR DIAGNOSIS OF ISCHEMIC LESION IN CT

2 hours

+ on the 3rd day

6-8 hours

after 72 hours

after 12 hours

# WHAT IS THE CONTRAST IN MRI

ultra-vist, omnipack

verographin

urographin

+ gadolinium

# WHAT IS THE NON-INVASIVE METHOD

myelography

ventriculography

spinal angiography

+ MR angiography

CT angiography

# WHAT IS THE M ETHOD FOR ASSESSING AUDITORY TRACT DAMAGE

dopplerography

+ method of evoked potentials

craniography

echo encephalography

cerebral angiography

# WHAT IS THE S CREENING METHOD FOR STUDYING CEREBRAL BLOOD FLOW

MR - angiography

cerebral angiography

+ ultrasound dopplerography

CT angiography

electroencephalography

# FUNCTIONAL TESTS WITH EEG

+ photostimulation and hyperventilation

head throw test

head turn tests

# METHOD FOR ASSESSING THE VISUAL PATHWAY

+ methods of evoked potentials

dopplerography, rheoencephalography

craniography

angiography

# WHAT IS THE M ETHOD FOR ASSESSING MOTOR NEURON DAMAGE

myelography, stimulatory electroneuromyography

+ needle electroneuromyography

global electroneuromyography

CT scan

# WHAT IS THE ACCURATE METHOD FOR DIAGNOSING HYDROCEPHALUS

+ tomography

echo encephalography

dopplerography

craniography

lumbar puncture

# WHAT IS THE CARRIES DEEP SENSITIVITY

painful

+ feeling of pressure

temperature

# HOW IS INVESTIGATING ASTEREOGNOSIS

with a brush

draw complex shapes on the skin

+ give a familiar item to the hand

# HOW DOES THE P OLYNEURITIC TYPE OF DISORDER MANIFESTS

+ decrease in all types of sensitivity in the distal extremities

the disappearance of deep sensitivity in the hands

decreased surface sensitivity in the distal extremities

# THE CROSS OF CONDUCTORS *-*DEEP AND TACTILE SENSITIVITY IS AT THE LEVEL OF  

spinal cord

+ medulla oblongata

subcortical structures

# CEREBRAL TYPE OF SENSITIVITY DISORDER OCCURS

with damage to the spinal cord

+ in case of damage to the thalamus

with damage to the peripheral nerve

# SENSITIVITY IS THE BODY'S ABILITY TO PERCEIVE

any irritants

+ external and internal irritants

environmental irritants

# MEISSNER'S BODY PERCEIVES IRRITATION

pressure

+ touch

temperature

# FIBERS OF LONG CONDUCTORS OF SENSITIVITY LOCATED WITHIN THE CORD OF THE SPINAL CORD

in the center

inside

+ out

# WHAT IS THE C ARR IES SURFACE SENSITIVITY

proprioceptive

+ temperature

stereognosis

# DISCRIMINATION SENSITIVITY INVESTIGATED

a pencil

needles

+ compass Weber

# IN CASE OF DAMAGE TO THE SPINAL ROOT OCCURS

violation of pain sensitivity in the innervation zone

+ violation of all types of sensitivity in the dermatome

loss of deep sensitivity in the dermatome

# INTERORECEPTORS ARE LOCATED

in the wall of blood vessels

in the mucous membrane

+ in internal organs

# TACTILE SENSITIVITY EXAMINED USING

+ brushes

needles

tuning fork

# WHAT SYMPTOMS DO NOT RELATE TO SYMPTOMS OF TENSION

Neri

Lasega

+ Babinsky

# THE MEDIAL LOOP CONSISTS OF CONDUCTORS

pain and temperature sensitivity

deep sensitivity

+ all kinds of sensitivity

# IN CASE OF DAMAGE TO THE BRAIN STEM, A TYPE OF SENSITIVITY DISORDER IS CHARACTERISTIC

+ conductor

radicular

segmental

# THE ANALYZER CONSISTS OF PARTS

+ receptor, conduction, cortical

peripheral, segmental, cortical

peripheral, subcortical, cortical

# Sympathy develops when damaged

peripheral nerve

+ nerve plexus

spinal cord

# WHEN A PERIPHERAL NERVE IS DAMAGED, A TYPE OF SENSITIVITY DISORDER DEVELOPS

conductor

+ neural

segmental

# DOES NOT APPLY TO COMPLEX TYPES OF SENSITIVITY

stereognosis

+ topanesthesia

two-dimensional spatial sense

# WHAT IS THE PHANTOM PAIN

dermatome pain

+ pain in an absent limb

pain in the distal limb

# CROSS-CONDUCTORS OF PAIN AND TEMPERATURE SENSITIVITY OCCUR AT THE LEVEL OF

+ spinal cord

medulla oblongata

medial loop

# AN ASCENDING TYPE OF SENSITIVITY DISORDER DEVELOPS WHEN THE CONDUCTORS IN THE PARTS OF THE CORD ARE DAMAGED

outdoor

+ internal

central

# CROSS-CONDUCTORS OF DEEP SENSITIVITY OCCUR AT THE LEVEL

spinal cord

+ medulla oblongata

midbrain

# FOR CEREBRAL TYPE OF SENSITIVITY DISORDER IS NOT CHARACTERISTIC

+ hemianesthesia

pseudomelia

astereognosis

# WHAT IS THE CAUSALGIA

+ paroxysmal pains of a burning character

drawing pains in limbs

limb pain with rashes

# BROWN-SECARD SYNDROME IS CHARACTERIZED BY TYPE OF SENSITIVITY DISORDERS

plexalgic

+ conductor

segmental

# A DOWNWARD TYPE OF SENSITIVITY DISORDER DEVELOPS WHEN THE CONDUCTORS IN THE PARTS OF THE SPINAL CORD ARE DAMAGED

central

+ outdoor

domestic

# WHERE P ROPRIORECEPTORS ARE LOCATED

skin

+ ligaments

mucous membranes

# THE DISSOCIATION OF SENSORY DISORDERS

+ loss of some types of sensitivity with the preservation of others

isolated loss of vibration sensitivity

sensitivity disorder in different parts of the skin of the limb

# THE SEGMENTAL TYPE OF SENSITIVITY DISORDER IS CHARACTERIZED BY

loss of all types of sensitivity in the distal extremities

+ dissociated sensitivity disorder on symmetrical areas of the skin of the chest and limbs

loss of deep types of sensitivity on the skin of symmetrical sections of the chest

# MUSCLE TONE WITH DAMAGE TO THE PERIPHERAL MOTOR NEURON

+ decreases

increases

does not change

# MUSCLE TONE WITH DAMAGE TO THE CENTRAL MOTOR NEURON

decreases

+ in creases

does not change

# DOES NOT APPLY TO PATHOLOGICAL PYRAMIDAL SIGNS ON THE UPPER LIMB

+ Babinsky

Oppenheim

Rossolimo

Scheffer

# MUSCLE HYPOTROPHY IS CHARACTERISTIC OF A LESION

central motor neuron

+ peripheral motor neuron

cerebellum

# THE APPEARANCE OF PATHOLOGICAL REFLEXES IS CHARACTERISTIC OF A LESION

peripheral motor neuron

+ central motor neuron

cerebellum

# DEEP REFLEXES IN THE DEFEAT OF THE CENTRAL MOTOR NEURON

+ increase

do not change

decreases

# DEEP REFLEXES IN THE DEFEAT OF A PERIPHERAL MOTOR NEURON

+ increase

decreases

do not change

# WHEN A PERI PHERAL MOTOR NEURON IS AFFECTED

+ muscle hypotrophy

muscle hypertrophy

muscle trophism is not changed

# IN CASE OF DAMAGE TO THE CENTRAL MOTOR NEURON OF SYNKINESIA

can be observed

+ always observed

not observed

# WHAT IS THE SIGN OF DAMAGE TO THE INTERNAL CAPSULE

+ hemiparesis

paraparesis

monoplegia

# WHAT IS THE SIGN OF DAMAGE TO THE CENTRAL MOTOR NEURON

muscle fibrillation

hyporeflexia

muscle atony

+ pathological reflexes

# WHAT IS THE SIGN OF DAMAGE TO A PERIPHERAL MOTOR NEURON

spastic muscle tone

+ muscle hypotension

increased tendon reflexes

# WHAT IS THE SI GN OF PERIPHERAL NERVE DAMAGE

pathological reflexes

protective reflexes

+ areflexia

# WHAT IS THE SIGN OF THE DEFEAT OF THE PYRAMIDAL PATH

hemiparesis

+ increase muscle tone in paretic muscles

decreased muscle tone

# WHAT IS THE SIGN OF DAMAGE TO THE ANTERIOR HORNS OF THE SPINAL CORD

muscle hypotension

+ fibrillar twitching

pathological reflexes

# WHAT IS THE PRIMARY VISUAL CENTER

leg of the inner capsule

+ thalamus

mastoid bodies

# WHEN A NOSMIA DEVELOPS

olfactory triangle

pear-shaped gyrus

+ olfactory bulb

# TRIGEMINAL NERVE DOES NOT INNERVATE MUSCLE

temporal

chewing

+ sternocleidomastoid

# WHERE IS C HIASM A OF THE OPTIC NERVES

tops of the temporal bone pyramid

base of the frontal lobe

+ turkish saddle

# VEGETATIVE FIBERS ARE PART OF THE BRANCHES OF THE TRIGEMINAL NERVE

+ first and second

second and third

all branches

# CORTICAL VISION CENTERS LOCATED IN THE AREA

superior temporal gyrus

+ spur furrow

pear-shaped gyrus

# BLOCK NERVE INNERVATES EYE MUSCLE

inner straight

+ upper oblique

outside direct

# THE INNERVATION OF THE MUSCLES OF THE EYEBALL IS CARRIED OUT BY A PAIR OF CRANIAL NERVES

II, III, IV

+ III, IV, VI

III , IV , V

# COORDINATION OF EYEBALL MOVEMENT IS CARRIED OUT BY THE SYSTEM

front transverse beam

+ rear longitudinal beam

medial longitudinal beam

# WHAT IS H EMIANOPSIA

loss of sight

loss of the quadrant of the field of view

+ loss of half the field of view

# THE NUCLEUS OF THE ABDUCTION NERVE IS LOCATED

medulla

+ bridge

midbrain

# WHAT IS THE B ITEMPORAL HEMIANOPSIA

+ loss of the temporal halves of the field of view

prolapse of the temporal quadrants of the field of view

prolapse of the nasal halves of the field of vision

# The accesorius nerve does not innervate the muscle

trapezoid

sternocleidomastoid

+ scaleni

# BULBAR PALSY DEVELOPS WHEN CRANIAL NERVES ARE DAMAGED

X , XI , XII

+ IX , X , XII

IX , XI , XII

# IN CASE OF DAMAGE TO THE HYOID NERVE DOES NOT DEVELOP

glossoplegia

dysarthria

+ dysphonia

# IN CASE OF DAMAGE TO THE FACIAL NERVE IN THE INTERNAL AUDITORY MEATUS DEVELOPS

+ peripheral paralysis of the facial muscles on the affected side

central paralysis of the facial muscles on the affected side

paralysis of the lower part of the facial muscles on the affected side

# Palatine and pharyngeal reflexes examined using

+ spatula

cotton ball

paper tape

# THE STRUCTURE OF THE GLOSSOPHARYNGEAL NERVE INCLUDES FIBERS

sensitive, vegetative

+ motor, sensitive, autonomic

motor sensitive

# THE HYPOGLOSSUS NERVE LEAVES THE SKULL THROUGH

ragged hole

round hole

+ channel of the same name

# WHAT IS T HE MAIN DIFFERENCE BETWEEN BULBAR AND PSEUDOBULBAR PALSY

dysarthria

+ symptoms of oral automatism

dysphagia

# WHAT IS T HE ANATOMICAL FEATU RE OF THE FACIAL NERVE STROKE

+ location in the bone canal

place of exit from the cranial cavity

exit point of the nerve root from the brain stem

# WHAT IS N OT APPL Y TO VESTIBULAR NUCLEI

Schwalbe core

Deiters core

+ core Perlia

# WHAT IS N AZOLALIA

difficulty speaking

+ nasal voice

hoarseness

# WRIESBERG'S NERVE IS PART OF

glossopharyngeal nerve

+ facial nerve

trigeminal nerve

# THE MOTOR CORE OF THE GLOSSOPHARYNGEAL NERVE IS LOCATED IN

+ medulla oblongata

midbrain

brain legs

# WHAT IS ATHONIA

hoarseness

+ loss of sonority

speech impairment

# BILATERAL CORTICAL INNERVATION RECEIVE FACIAL MUSCLES

+ above the nasolabial fold

below the nasolabial fold

upper half of the face

# THE NUCLEUS OF THE FACIAL NERVE IS LOCATED IN

brain stem

medulla oblongata

+ bridge

# WHEN EXAMINING THE FUNCTION OF THE VAGUS NERVE CHECK

+ pharyngeal reflex, phonation, swallowing

phonation, swallowing, heart rate examination

tone of voice, swallowing, bowel function

# BULBAR PALSY IS CHARACTERIZED BY SYMPTOMS

dysphonia, atrophy of the tongue, nasolalia

+ dysarthria, dysphonia, dysphagia

dysphagia, lack of pharyngeal reflex, dysarthria

# WHAT IS THE C OMMON TO THE GLOSSOPHARYNGEAL AND VAGUS NERVES

core perlia

+ dual core

Royler core

# WHAT IS THE AGEVZIA

loss of smell

+ loss of taste

hearing loss

# THE FACIAL NERVE INNERVATES THE MUSCLES IN THE NECK

+ awl-sublingual, posterior abdomen of the biliary network, subcutaneous muscle of the neck

subcutaneous muscle of the neck, anterior abdomen of the bridal muscle

stylo-pharyngeal, posterior abdomen of the biceps muscle, subcutaneous muscle of the neck

# THE ANATOMICAL STRUCTURES ARE NOT INCLUDED IN THE LIMBIC SYSTEM

mastoid bodies

amygdala complex

+ lenticular nucleus

# ERGOTROPIC FUNCTION OF THE AUTONOMIC NERVOUS SYSTEM IS AIMED AT

maintaining homeostasis

+ metabolic support of motor acts

regulation of hemodynamics and function of internal organs

# IN CASE OF DYSFUNCTION OF THE HYPOTHALAMUS, NEUROENDOCRINE DISORDERS ARE OF A NATURE

constant

recurrent

+ paroxysmal

# THE HYPOTHALAMUS HAS A GROUP OF NUCLEI

medial, lateral, posterior

+ front, middle, rear

internal, medium, external

# IN THE STUDY OF THE ORTNER REFLEX ARISES

tachycardia

arrhythmia

+ heart rate reduction

# WHEN THE ANTERIOR NUCLEI OF THE HYPOTHALAMUS ARE DAMAGED

lethargy

+ diabetes insipidus

obesity

# TROPHOTROPIC FUNCTION PROVIDES AND REGULATES THE DEPARTMENT OF THE AUTONOMIC NERVOUS system

+ parasympathetic

sympathetic

both departments

# PERSISTENT HYPERTHERMIA OCCURS WITH IRRITATION OF THE NUCLEI OF THE HYPOTHALAMUS

front

secondary

+ rear

# DOES NOT APPLY TO CARDIOVASCULAR REFLEXES

reflex Prevel

Ortner's reflex

+ Schaefer's reflex

# SYMPATHOADRENAL HYPOTHALAMIC CRISES MANIFEST

arterial hypertension, hyperthermia, hyperhidrosis

arterial hypotension, hyperthermia, polyuria

+ arterial hypertension, hyperthermia, tachycardia, polyuria

# THE STATE OF PERSPIRATION IS EXAMINED USING A SAMPLE.

with diamond green

+ Minora

Ashner

# RED DERMOGRAPHISM IS CHARACTERISTIC OF

sympathicotonia

+ vagotonia

amphotonia

# THE DISAPPEARANCE OF THE PILOMOTOR REFLEX IS A SYMPTOM OF A VIOLATION

parasympathetic innervation of the skin

+ sympathetic innervation of the skin

somatic innervation of the skin

# WITH IRRITATION OF THE MIDDLE SECTIONS OF THE HYPOTHALAMUS DEVELOPS

lethargy

+ trophic disorders

polyuria

# NOT CHARACTERISTIC OF VAGOTONIA

arterial hypotension

hyperhidrosis

+ constipation

# WHAT IS THE EXPRESSIVE SPEECH

comprehension of spoken and written language

active speaking

+ active speaking and writing

# AMNESTIC APHASIA DEVELOPS WHEN DAMAGED AREAS OF THE CEREBRAL CORTEX

posterior frontal lobe

occipital lobe

+ posterior temporal lobe

# WHAT IS THE F IXATIVE AMNESIA

violation of memorization of past events

+ violation of memorization of current events

impaired memory of events before loss of consciousness

# AGRAPHIA DEVELOPS IN DAMAGED AREAS OF THE CEREBRAL CORTEX

posterior sections of the superior temporal gyrus

+ posterior sections of the second frontal gyrus

of the posterior sections of the lower frontal gyrus  
# MOTOR APHASIA DEVELOPS WHEN A PART OF THE CEREBRAL CORTEX IS DAMAGED

posterior sections of the superior temporal gyrus

posterior sections of the second frontal gyrus

+ posterior lower frontal gyrus

# ACALCULIA DEVELOPS IN DAMAGED AREAS OF THE CEREBRAL CORTEX?

posterior sections of the superior temporal gyrus

+ posterior sections of the second frontal gyrus

posterior lower frontal gyrus

# SENSORY APHASIA IS CHARACTERIZED

speech impairment

+ violation of the perception of oral speech of others and their

impaired speech and writing

# WHEN THE CENTER OF WERNICKE IS DAMAGED, APHASIA OCCURS

motor

amnestic

+ sensory

# SUFFERS FROM IDEATOR APRAXIA

+ concept of complex actions

line of action

replay assignment actions

# DOES NOT APPLY TO DIZZINESS SYNDROMES

delirium

trance

+ stupor

# WHAT IS THE A PRAXIA

loss of complex action plan

+ loss of skills developed in the process of individual experience

loss of the right direction of complex actions

# CONSTRUCTIVE APRAXIA IS CHARACTERIZED

loss of complex action plan

loss of skills developed in the process of individual experience

+ loss of the correct direction of complex actions

# MOTOR APHASIA IS CHARACTERIZED BY IMPAIRED

+ all components of expressive speech

speech perception

perception of complex speech structures

# THE DISORDER OF READING AND READING COMPREHENSION IS CALLED

agraphia

aphasia

+ alexia

# SEMANTIC APHASIA IS CHARACTERIZED BY IMPAIRED PERCEPTION

oral and written language

impressive speech

+ complex semantic constructions

# AUDITORY AGNOSIA DEVELOPS WHEN DAMAGED AREAS OF THE CEREBRAL CORTEX

+ superior temporal gyrus

posterior frontal gyrus

occipital lobe

# IF BROCK'S CORTICAL CENTER IS DAMAGED

semantic aphasia

+ motor aphasia

amnestic aphasia

# CSF CIRCULATES IN THE SPACE

epidural

subdural

+ subarachnoid

# COMPOSITION OF CEREBROSPINAL FLUID WITH HYDROCEPHALUS

+ normal

pleocytosis is characteristic

high protein content

# WHAT IS THE MOST COMMON CAUSE OF CEREBROSPINAL FLUID DISTURBANCES

head injury

a brain tumor

+ intraventricular hemorrhage

# WHEN THE CEREBROSPINAL FLUID IS OCCLUDED AT THE SILVIEV LEVEL, THERE IS AN EXPANSION IN THE PIPELINES

+ lateral ventricles of the brain

the entire ventricular system of the brain

fourth ventricle

# LIQUOR IS PRODUCED

the walls of the lateral ventricles of the brain

transparent septum of the brain

+ vascular plexus of the lateral ventricles of the brain

# BRAIN ATROPHY IS CHARACTERISTIC OF HYDROCEPHALUS

communicating

occlusal

+ aresorbent

# OCCLUSIVE HYDROCEPHALUS DEVELOPS MORE OFTEN AT CLOSURE

Monroe holes

Mohandi and Lushki holes

+ Silviev water supply

# NORMAL CEREBROSPINAL FLUID PRESSURE

90-100 mm

+ 120-140 mm

160-180 mm

# CLASSIFICATION OF VASCULAR LESIONS OF THE BRAIN AND SPINAL CORD ACCORDING TO SCHMIDT DOES NOT CONTAIN PARAGRAPH

diseases and pathological conditions leading to circulatory disorders of the brain

the nature of cerebrovascular accidents

localization of the lesion

nature and localization of vascular changes

disability status

+ severity of cerebrovascular accident

characteristic of clinical syndromes

# WHICH DISEASE IS THE MAIN CAUSE DISORDERS TH E BRAIN CIRCULATION

+ atherosclerosis

hypertonic disease

arterial hypotension

and infectious and allergic vasculitis

and abnormalities of the cardiovascular system.

b blood diseases and changes in its physicochemical properties

s abolevaniya endocrine system

# WHAT IS THE MOST FREQUENT CEREBRAL SYMPTOMS IN HEMORRHAGIC STROKE

+ with lowering level of wakefulness

pain.

nausea, vomiting.

memory loss

seizure

# ACCORDING TO THE SYMPTOMS, WHAT ARE THE SYMPTOMS OF THE CLINICAL PICTURE OF ISCHEMIC STROKE?

+ focal

meningeal

# WHAT SEVERITY OF ISCHEMIC STROKE IS NOT INCLUDED IN THE CLASSIFICATION

+ mild ischemic stroke

moderate ischemic stroke

severe stroke

# REGRESSION OF FOCAL NEUROLOGICAL SYMPTOMS WITH A SMALL STROKE OCCURS

i n 2 weeks

after 4 weeks

+ after 3 weeks

# DOES NOT APPLY TO PATHOGENETIC SUBTYPES OF ISCHEMIC STROKE

hemodynamic

lacunar

cardioembolic

+ atherosclerotic

#NOT INCLUDED IN THE CLASSIFICATION OF SUBARACHNOID HEMORRHAGES

spontaneous

traumatic

+ basal

# WHAT IS T HE MOST COMMON CAUSE OF SUBARACHNOID HEMORRHAGE

hypertonic disease

atherosclerosis

infections

injuries

+ cerebral aneurysms

# DO NOT TREAT BASIC STROKE THERAPY

correction of the function of external respiration;

correction of cardiovascular disorders

+ stimulation of hemostasis

correction of water-salt and energy balance

brain edema control

# THE PRIMARY NEUROPROTECTIVE AGENTS INCLUDE

magnesium sulfate

aminalon

+ glycine

piracetam (nootropil)

picamilon

# DO NOT INCLUDE PATHOLOGICAL VARIANTS OF CEREBRAL INFARCTION

white

reds

+ gray

# MOST COMMON ARTERIAL ANEURYSMS

+ baggy

blister

fusiform

# IN THE CLINICAL COURSE OF ANEURYSMS DO NOT DISTINGUISH PERIOD

prehemorrhagic

hemorrhagic

posthemorrhagic

+ recovery

# A LEADING ROLE IN THE DIAGN OSIS OF SUBARACHNOID HEMORRHAGE

serial angiography

ECHO Encephalography

MR angiography

+ cerebrospinal fluid examination

# HOSPITALIZATION OF PATIENTS WITH STROKE DURING THE FIRST

6 o'clock

+ 4 hours

8 ocloc'k

# WHAT IS THE I NDICATION FOR SURGICAL TREATMENT OF INTRACEREBRAL HEMORRHAGE

+ brain compression with intracerebral hematoma

predagonal state

increasing perifocal edema

# IN THE CLINICAL PICTURE OF LESIONS OF THE CAROTID ARTERIES, THE MOST COMMON SYNDROME

epileptic

vestibulo-atactic

+ optical pyramidal

# WHAT IS THE INDICATION FOR THE SURGICAL TREATMENT OF ISCHEMIC BRAIN LESIONS

temporary effect of conservative therapy

+ progressive cerebral edema

inferiority of collateral circulation

# TO DETERMINE THE SEVERITY OF PATIENTS WITH SUBARACHNOID HEMORRHAGE USE

Glasgow scale

+ Hunt-Hess scale

Orgogozo scale

# INDICATE THE PRIMARY LOCATION OF MEDULLOBLASTOMA

cerebral hemisphere

brain stem

+ cerebellum worm

# EPILEPTIC SEIZURES ARE CHARACTERISTIC OF NODULAR BRAIN TUMORS

generalized

+ focal

polymorphic

# ACCORDING TO THE FREQUENCY OF OCCURRENCE, CEREBRAL SYMPTOMS OF BRAIN TUMORS ARE DISTRIBUTED AS FOLLOWS

nausea, vomiting, dizziness, headache

dizziness, headache, nausea, vomiting

+ headache, nausea, vomiting, dizziness

# What brain tumor have a capsule

astrocytoma

+ neurinoma

glioblastoma

# THE RATE OF INCREASE IN SYMPTOMS OF A BRAIN TUMOR IS MORE DEPENDENT ON

sizes

localization

+ histological option

growth pattern

# WHAT IS THE TUMOR HAS AN I NTRAVENTRICULAR LOCALIZATION

medulloblastoma

astrocytoma

neurinoma

+ ependymoma

# PRIMARY FOCAL SYMPTOMS IN BRAIN TUMORS ARE DUE TO

dimensions

+ localization

growth pattern

# INDICATE THE MOST MALIGNANT BRAIN TUMOR

astrocytoma

neurinoma

+ glioblastoma

# THERE IS NO STAGE IN THE CLINICAL PICTURE OF EXTRAMEDULLARY TUMOR

paralytic

radicular

Brown-secar syndrome

+ Fauville syndrome

# THE MOST FREQUENT LOCALIZATION OF OLIGODENDROGLIOMAS

temporal lobe

cerebellum

+ frontal lobe

occipital lobe

# ALONG THE CEREBROSPINAL FLUID CAN METASTASIZE A BRAIN TUMOR

astrocytoma

ependymoma

+ medulloblastoma

# CHIASMAL SYNDROME IS CHARACTERISTIC IN THE CLINICAL PICTURE

main bone meningiomas

+ pituitary adenomas

gliomas of the frontal lobe

# REFERS TO BENIGN TUMORS OF THE BRAIN AND SPINAL CORD

anaplastic astrocytoma

+ meningioma

Glioblastoma

# WHAT IS T HE FIRST CLINIC AL STAGE OF PITUITARY ADENOMA

radiological

+ endocrinological

ophthalmic

# QUATERNARY SYNDROME OCCURS WITH A TUMOR

brain stem

fourth ventricle

+ pineal gland

cerebellum

# WHAT IS T HE MOST CHARACTERISTIC SYMPTOM OF A TUMOR OF THE PARIETAL LOBE OF THE BRAIN

ANISOREFLEXIA

+ sensory focal epiprises

hemiparesis

astereognosis

# THE PROBABLE LOCALIZATION OF THE EXTRAMEDULLARY TUMOR OF THE SPINAL CORD IS DETERMINED BY

LIMB PARESIS DISTRIBUTION

dissociation of sensitivity disorders

+ border conductor sensitivity disorders

top-down conductive type of sensitivity disorders

# IN THE CLINICAL PICTURE OF THE INTRAMEDULLARY TUMOR IS MORE COMMON

+ top-down conduction type of sensitivity disorders

radicular pain syndrome

Brown-secar syndrome

# THE DEVELOPMENT IN THE CLINICAL PICTURE OF SENSORY APHASIA IS MOST LIKELY WITH TUMOR LOCALIZATION IN

+ left frontal lobe

occipital lobe of the dominant hemisphere

temporal lobe of the dominant hemisphere

# INDICATE HIGH-GROWTH BRAIN TUMOR

astrocytoma

+ medulloblastoma

neurinoma

# ACCORDING TO HISTOLOGICAL CLASSIFICATION, ASTROCYTOMA IS INCLUDED IN THE GROUP OF TUMORS

meninges

embryonic tumors

+ gliomas

# FOSTER-KENNEDY SYNDROME IS CHARACTERISTIC OF A TUMOR

foundations of the frontal lobe

+ Turkish saddle

posterior cranial fossa

wings of the main bone

# THE CLINICAL PICTURE OF HYPERTENSION SYNDROME IS NOT INCLUDED

congestive optic disc

headache

vomiting

+ anisocoria

# EPILEPSY IS A CHRONIC BRAIN DISEASE CHARACTERIZED BY

a single bout of seizures

+ repeated bouts of seizures

attacks of loss of consciousness

# AT THE BEGINNING OF AG ENERALIZED TONIC-CLONIC SEIZURE

loss of consciousness, followed by the development of seizures in the limbs

stupefaction with the development of tonic seizures in the limbs

+ loss of consciousness in combination with tonic cramps in the limbs

# EPILEPTICUS STATUS SHOULD BE CONSIDERED

epileptic seizure lasting more than 30 minutes

seizures repeated several times in an hour

+ seizures recurring at short intervals without regaining consciousness

# WHAT IS THE MAIN METHOD FOR DIAGNOSING EPILEPSY

CT scan

+ electroencephalography

Magnetic resonance imaging

# AN EPILEPTIC SEIZURE CAN CAUSE ALL OF THE FOLLOWING EXCEPT

neoplasm of the brain

+ neoplasm of the spinal cord

cerebral hemorrhage

encephalitis

# SYMPTOMATIC EPILEPSY IS DUE TO:

+ brain damage

lack of structural brain damage

# THE RISK OF DEVELOPING EPILEPSY FOR SIBLINGS IS HIGHER IF THE propane suffers

+ idiopathic epilepsy

symptomatic epilepsy

cryptogenic epilepsy

# DIFFERENTIAL DIAGNOSIS OF EPILEPSY IS CARRIED OUT WITH

hypertension

hysteria

+ fainting

# FOR STOPPING THE STATUS EPILEPTICUS APPLY:

0.5% solution of Relanium

+ 20% solution of sodium oxybutyrate

6% r-thiamine bromide (vitamin B1)

# THE ANTIEPILEPTIC DEFENSE OF THE BRAIN INCLUDES

frontal lobe

+ reticular core of the bridge

cerebellum

# SYMPTOMATIC EPILEPSY IS NOT CHARACTERISTIC IN THE CLINICAL PICTURE SUBDURAL HEMATOMA

brain abscess

+ eye injuries

# WHAT IS THE MANDATORY METHODS FOR EXAMINING A PATIENT WITH EPILEPSY

cerebrospinal fluid examination

ECG

+ Brain MRI

# WHAT IS THE BASIS OF EPILEPTIC SEIZURES

+ predominance of exciting neurotransmitters

increased function of inhibitory neurotransmitters

decreased function of inhibitory neurotransmitters

# FOR SUBARACHNOID HEMORRHAGE IN A PATIENT WITH SEVERE ATHEROSCLEROSIS SHOULD NOT BE USED:

+ antifibrinolytics

dehydration preparations

antispasmodics

antihypertensive agents

# WHAT IS CHARACTERISTIC SIGN OF INTER NAL CAROTID ARTERY THROMBOSIS

alternating Zakharchenko-Wallenberg syndrome

Weber's alternating syndrome (paresis of the oculomotor nerve and pyramidal syndrome)

+ alternating opticopyramidal syndrome

sensory aphasia

# FOR BULBAR SYNDROME WITH DYSCIRCULATORY ENCEPHALOPATHY, THE PRESENCE OF

dysarthria, dysphonia, dysphagia

+ tongue fibrillation

symptoms of oral automatism

# WITH CERVICAL OSTEOCHONDROSIS, ARTERIES ARE AFFECTED

basilar (primary) and vertebral

internal carotid and external carotid

+ no damage to arteries

# SUBJECTIVE CEREBRAL SYMPTOMS IN CEREBRAL CHRONIC ISHEMIA USUALLY APPEAR

in the morning

in the evening hours

after physical exertion, emotional stress

+ under conditions requiring increased blood supply to the brain

# FOR THE CLINICAL MANIFESTATIONS OF SUPERFICIAL CEREBRAL VEIN THROMBOSIS IS MOST CHARACTERISTIC

the presence of cerebral symptoms and swelling of the optic disc

+ variability of focal hemispheric symptoms

meningeal syndrome

subfebrile condition

# WHAT IS THE MAIN CAUSE OF CARDIOCEREBRAL SYNDROME

increased blood viscosity, increased coagulation system activity

deterioration of the rheological properties of blood

+ decrease in systemic perfusion pressure

increased aggregation of blood cells

# ANTICOAGULANT THERAPY FOR ISCHEMIC STROKE IS USED TO CORRECT:

metabolic acidosis

+ hyperfibrinogenemia

hyperproteinemia

hyperlipidemia

# IN PATIENTS WITH UNEXPLODED CONVEXITAL ARTERIOVENOUS ANEURYSM OBSERVED

visual impairment, oculomotor disorders

meningeal symptoms

increased intracranial pressure

+ epileptiform seizures

# FOR AN UNEXPLODED ANEURYSM OF THE SUPRACLINOID PART OF THE INTERNAL CAROTID ARTERY, A CHARACTERISTIC LESION

+ III-VI pairs of cranial nerves

VII, VIII pairs of cranial nerves

IX, X pairs of cranial nerves

XI, XII pairs of cranial nerves

# T HE NEUROLOGICAL MANIFESTATIONS OF VERTEBRAL-BASILAR INSUFFICIENCY

apathetic-abulic syndrome

autotopagnosis syndrome

sensorimotor aphasia syndrome

+ vestibulo-cerebellar syndrome

# FOCAL BRAIN LESIONS RARELY SEEN

with nodular periarteritis Kussmaul - Meyer

with non-specific aortic arteritis (Takayasu disease)

+ for temporal arteritis of Horton - Magag - Brown

with thromboangiitis obliterans Vinivarter-Burger

# SYSTEMIC DIZZINESS WITH DEP IS OFTEN DUE TO

discirculation in the branches of the internal carotid artery

discirculation in the branches of the external carotid artery

pressure fluctuations of the endolymph in the cochlea of ​​the inner ear

+ discirculation in the arteries of the vertebrobasilar basin

# CLINICAL MANIFESTATIONS OF RUPTURE OF ANEURYSMS OF CONVEXITAL CEREBRAL ARTERIES ARE CHARACTERISTIC

loss of consciousness or headache

+ the appearan ce of focal neurological symptoms

meningeal syndrome

hormone

# THE FOLLOWING FACTORS PLAY A ROLE IN THE DEVELOPMENT OF INSUFFICIENT BLOOD SUPPLY TO THE BRAIN DURING ATHEROSCLEROSIS

mitral valve prolapse

increased fibrinolytic activity of blood

decrease in coagulation system activity

+ stenosis of the great vessels on the neck

# WITH AN ANEURYSM OF THE INTERNAL CAROTID ARTERY WITHIN THE CAVERNOUS SINUS IS OBSERVED

contralateral hemiplegia and homonymous hemianopsia

+ defeat of III-VI pairs of cranial nerves

anosognosia

amaurosis

# WITH UNEXPLODED ANEURYSM OF THE MAIN ARTERY, SYNDROME IS OFTEN OBSERVED

upper orbital fissure

outer wall of the cavernous sinus

lesions of the sylvian furrow and lesions of the spur furrow

+ cerebellar angle bridge

# HEMORRHAGIC CEREBRAL INFARCTION IS LOCALIZED ONLY IN

cerebral cortex, cerebellar cortex

+ subcortical nodes, brain stem

subcortical nodes, cerebellar cortex

subcortical nodes, cerebral cortex and cerebellum

# FOR DECOMPENSATION CEREBRAL CHRONIC ISCHEMIA IS CHARACTERISTIC

the appearance of diffuse neurological symptoms

+ increase in the frequency and duration of episodes of subjective cerebral symptoms

the appearance of focal neurological symptoms

the appearance of episodes at night

# IN THE TREATMENT OF DISORDERS OF THE VENOUS CIRCULATION OF THE BRAIN WITH A NORMAL LEVEL OF SYSTEMIC BLOOD PRESSURE ARE CONTRAINDICATED

+ antifibrinolytics

anticoagulants, antiplatelet agents

xanthine preparations

antihypoxants

# INTRACEREBRAL ROBBERY OF THE FOCUS OF ISCHEMIC STROKE AFTER ADMI NISTRATION OF VASODILATOR TORI OCCURS AS A RESULT

circulatory autoregulation disorders in the outbreak

vasospasm of the affected area of ​​the brain

vasospasm of intact brain

+ expansion of healthy "vessels of the intact department

# WHAT IS THE HORMETHONY

generalized muscle hypotension in combination with respiratory rhythm disturbance

increased muscle tone in the flexors of the upper limbs and extensors of the lower extremities

increased muscle tone in the extensors of the upper limbs and flexors of the lower extremities

+ recurring paroxysms of increased muscle tone in extensor extremities

# PATHOGENETIC FACTOR OF HEADACHE IN CHRONIC CEREBRAL ISCHEMIA OFTEN

spasm of the arteries of the brain

hypotension and dilatation of the arteries of the brain

hypotension and dilation of the veins of the brain

+ stress headache

# WHEN RUPTURE OF SUPRATENTORIAL ARTERIOVENOUS ANEURYSM OCCURS

blood flow into the tanks of the base of the brain

development of meningeal syndrome and the development of asymmetric hydrocephalus

+ development of intracerebral hematoma

vision loss and oculomotor disorders

# FOR INSTRUMENTAL DIAGNOSIS OF SPONTANEOUS SUBARACHNOID HEMORRHAGE, DATA ARE ABSOLUTELY NECESSARY

angiography

rheoencephalography

ultrasound dopplerography

+ computed or magnetic resonance imaging

# FOR EMBOLISM OF CEREBRAL ARTERIES IS CHARACTERISTIC

gradual development of focal neurological symptoms

+ sudden development of focal symptoms

optic nerve edema on the embolism side

the presence of cerebral symptoms

# WHAT HAS A DECISIVE INFLUENCE ON THE PROGNOSIS OF TRANSIENT CEREBROVASCULAR ACCIDENT

adequate blood pressure

state of viscosity and fluidity

blood coagulation

+ intact patency of the leading arteries

# SYMPTOMS OF DAMAGE TO THE LEFT ANTERIOR CEREBRAL ARTERY

+ symptoms of oral automatism, the prevalence of paresis in the arm

grasping reflex

left hand apraxia

#SMALL STROKE

1 week

+ up to 3 weeks

1 month

3 months

# THE PRESENCE OF THE MAIN TRUNK OF THE RIGHT MIDDLE CEREBRAL ARTERY IS CHARACTERIZED BY THE PRESENCE OF

+ left-side hemianesthesia, grasping reflex

left hemiplegia, apraxia

anosognosia, left-sided hemiplegia

anosognosia, left-sided hemiplegia, apraxia

# ZAKHARCHENKO-WALLENBERG SYNDROME (LATERAL MEDULLARY SYNDROME) OCCURS WITH BLOCKAGE

SHORT CIRCULAR ARTERIES OF THE BRIDGE

paramedian bridge arteries

cerebellar inferior anterior artery

+ lower posterior cerebellar artery

# PSEUDOBULBAR SYNDROME DEVELOPS WITH A COMBINATION OF LESIONS

pyramidal and cerebellar paths of the dominant hemisphere

pyramidal and cerebellar pathways of the non-dominant hemisphere

pyramidal and extrapyramidal paths of the dominant hemisphere

+ pyramidal paths of dominant and non-dominant hemispheres

# APPOINTMENT REFERS TO ETIOTROPIC THERAPY OF ATHEROSCLEROTIC ENCEPHALOPATHY

antihypertensive drugs

vasoactive drugs, antiplatelet agents

antioxidants

+ lipid-normalizing drugs

# WHAT IS MANDATORY SYMPTOM OF SUBARACHNOID HEMORRHAGE

loss of consciousness

pupil disorders, nystagmus

+ meningeal syndrome

bilateral pyramidal pathological signs

# FOR CEREBRAL THROMBOSIS IS CHARACTERISTIC

history of transient ischemic attacks

gradual increase in focal symptoms

low severity of cerebral symptoms

+ no impurity of blood in the cerebrospinal fluid

# THE SYMPATHICOTONIC FORM OF VEGETATIVE-VASCULAR DYSTONIA IS CHARACTERIZED BY

distal acrocyanosis

sweating

+ tachycardia

decreased body temperature, diarrhea

# OBSTRUCTION OF THE EXTRACRANIAL VERTEBRAL ARTERY FROM OBSTRUCTION OF THE INTRACRANIAL DEPARTMENT IS DISTINGUISHED BY THE PRESENCE OF

classic alternating syndromes

oculomotor disorders and motor and sensory disorders

+ spotting "trunk lesions along the length

vestibulo-cerebellar disorders

# WHAT IS DISTINGUISHES THE SYMPTOMS OF ISCHEMIA IN THE POOL OF THE INTERNAL CAROTID ARTERY FROM ISCHEMIA IN THE VERTEBROBASILAR POOL

double vision

alternating syndromes

bilateral paresis and ataxia

+ optic hemiplegic syndrome

# DEEP CEREBRAL VEIN THROMBOSIS IS DIFFERENT FROM SUPERFICIAL CEREBRAL VEIN THROMBOSIS

cerebral symptoms

signs of stagnation in the fundus

+ signs of brain stem damage

meningeal syndrome and loss of consciousness

# ANEURYSM OF BRAIN ARTERIES WITH A DIAMETER OF 3 MM CAN BE DIAGNOSED WITH

+ angiography

rheoencephalography, ultrasound dopplerography

computed tomography

radioisotope scintigraphy

# THE DIFFERENCE BE TWEEN A HEART ATTACK IN THE POOL OF THE ANTERIOR ARTERY OF THE VASCULAR PLEXUS (ANTERIOR THORACIC SINUS) AND HEART ATTACKS IN THE POOLS OF OTHER CEREBRAL ARTERIES IS THE ABSENCE OF:

hemiplegia

hemianesthesia

+ aphasia

vasomotor disorders in the area of ​​p aralyzed limbs, hemianopsia

# WITH THE HELP OF MAGNETIC RESONANCE IMAGING, THE FOCUS OF ISCHEMIC STROKE OF THE BRAIN IS DETECTED FROM THE ONSET OF THE DISEASE

after 1 h

+ after 3 hours

by the end of the first day

only on the second day

# PATIENTS WITH CHRONIC BRAIN ISCHEMIA UNDERGO THERAPY

+ symptomatic

fibrinolytic agents

antifibrinolytic agents

vasoactive drugs

anticoagulant agents

# THE DECISIVE CONDITION FOR ADEQUATE COLLATERAL CIRCULATION OF THE BRAIN IS THE CONDITION

vascular tone and reactivity and rheological properties of blood

coagulation-anticoagulation system

+ architectonics of the arterial circle of the brain (Willis circle)

systemic and central hemodynamics

# STEM SYMPTOMS IN THE SUBCLAVIAN SYNDROME OF ROBBERY APPEARS OR INTENSIFIES

with a deep breath

when turning the head to the side of defeat

+ when doing hand exercises on the affected side

while lying down and holding your breath

# FOR AN ACCURATE DIAGNOSIS OF PATHOLOGICAL TORTUOSITY OF THE VERTEBRAL ARTERIES, YOU SHOULD USE

rheoencephalography

ultrasound dopplerography

+ angiography

computed tomography or magnetic resonance imaging

# THE PRESENCE OF THE POSTERIOR CEREBRAL ARTERY IS CHARACTERIZED BY THE PRESENCE OF

+ homonymous hemianopsia

bitemporal hemianopsia

binasal hemianopsia

concentric narrowing of the visual fields, edema of the optic disc

# A DIAGNOSIS OF TRANSIENT CEREBROVASCULAR ACCIDENT IS ESTABLISHED IF FOCAL CEREBRAL SYMPTOMS UNDERGO COMPLETE REGRESSION DURING

+24 hours

1 week

2 weeks

1 month

# SPINAL AMIOTROPHIES THIS:

+ a group of progressive neuromuscular diseases in which the weakness of the muscle apparatus is caused by damage to the spinal cord

the same, but muscle weakness is due to primary nerve damage

a group of hereditary diseases is characterized by an increase in muscle weakness and atrophy

a group of progressive neuromuscular diseases in which the focus is located in the brain stem

a group of progressive neuromuscular diseases in which muscles are primarily affected

# THE FOLLOWING DISEASES ARE SPINAL AND MYOTROPHIES:

Charcot-Marie, Dejerine-Sotta

+ Verding-Hoffmann

Kugelberg-Velander

Erba Rotta

Landusi dejerina

# FOR VERDING-Hoffmann's disease TYPE OF INHERITANCE:

autosomal dominant

+ autosomal recessive

X-linked

holondric

mitochondrial

# IN THE ACUTE PERIOD OF NEUROPATHIES IT IS IMPOSSIBLE TO APPLY:

electrophoresis of novocaine

+ electrical stimulation

diadynamic currents

dehydration therapy

anti-inflammatory therapy

# WITH VERDING-Hoffman SPINAL AMIOTROPHY, THE LEADING SIM-PTOMES ARE

flaccid paresis

muscle hypotension

tendon areflexia

decreased muscle strength, gait changes

+ all of the above

# EARLY FORM OF VERDING-Hoffmann's Disease BEGINS TO BE MANIFESTED:

from birth

+ up to 1.5 years

1.5-2 years

after 5 years

after 10 years

# FORM OF VERDING-Hoffmann's Disease, FOR WHICH IN THE FIRST DAYS AFTER BIRTH, SLEEP PARZES OF EXTREMITIES, LOW MUSCULAR TONUS, BULBAR DISORDERS ARE CHARACTERISTIC

early

late

+ congenital

ultrafast

short-term

# FOR THE CLINIC OF EARLY FORM OF WERDNIG-Hoffmann Disease CHARACTER-BUT:

+ loss of previously acquired motor skills

patients retain mobility for a long time

pseudohypertrophy of the calf muscles appears

increased reflexes

pathological stop signs

# INTELLIGENCE, AS A RULE, REMAINS CONSIDERED BY THE NEXT FORM OF HYDROCEPHALIA

congenital form

early form

+ late form

short-term

heavy

# KUGELBERG-WELANDER'S DISEASE IS DEVELOPING

in the first days after birth

up to 1.5 years

+ from 2 to 17 years

already in utero

after 50 years

# KUGELBERG-WELANDER'S DISEASE IS CHARACTERIZED

proximal paresis

pseudohypertrophy of the calf and gluteal muscles

fascicular muscle twitching

hyporeflexia, areflexia

+ all of the above

# COURSE OF KUGELBERG-WELANDER DISEASE

+ benign, patients retain the ability to move independently for a long time

independent walking ability rarely

since birth sick patients

quickly leads to death

progressive

# DURING THE BIOCHEMICAL STUDY OF BLOOD DURING KUGELBERG-WELANDER DISEASE DETECT:

+ moderate increase in creatine phosphokinase

creatine phosphokinase, aldalase normal

decreased creatine phosphokinase

bilirubin increase

decreased ALT

#TREATMENT FOR ALL FORMS OF SPINAL AMYOTROPHY:

strictly specific

+ symptomatic

not carried out

anti-resident

only massage and exercise therapy

# NEURAL AMIOTROPHIES THIS:

a group of progressive neuromuscular diseases in which the weakness of the muscle apparatus is caused by damage to the spinal cord

+ same, but muscle weakness is due to primary nerve damage

a group of hereditary diseases is characterized by an increase in muscle weakness and atrophy

a group of progressive neuromuscular diseases in which the pathological focus is located in the muscles

a group of progressive neuromuscular diseases in which the focus is located in the lateral columns of the spinal cord

# TO THE GROUP OF NEURAL AMIOTROPHIES RELATED:

+ Charcot-Marie, Dejerine-Sotta

Kugelberg-Velander

Verding-hoffman

Erba Rotta

Landusi dejerina

# FOR DISEASES OF SHARCO-MARI TYPE OF INHERITANCE:

+ autosomal dominant

autosomal recessive

linked to the X chromosome

mitochondrial

holondric

#MORE THAN SHARCO MARI DISEASE IS DEVELOPING

up to 3 years

+ at school age

in adulthood

already in utero

at 4 - 5 years old

# THE BASIC CLINICAL SYMPTOMS IN HEREDITARY LINEOPROPATHIES ARE:

distal atrophy of the feet, bones

polyneuritic type of sensitivity disorder

decrease in speed of peripheral nerves (according to EMG)

gait change

+ all of the above

# THE BASIC DIAGNOSTIC CRITERIA OF WILSON-KONOVALOV DISEASE ARE:

copper metabolism defect

enlarged liver, Kaiser-Fleischer ring around the iris

decrease in total serum copper and serum ceruloplasmin

extrapyramidal disorders

+ all of the above

# THE BASIC DIAGNOSTIC CRITERIA OF A DEFORMING WE-CERVICAL DYSTONIA ARE:

+ torsion hyperkinesis of the muscles of the trunk, limbs, head

muscle dystonia

hyperreflexia of knee, Achilles reflexes, pathological reflexes

nystagmus

cerebellar disorders

# PROGRESSING MUSCULAR DYSTROPHY (TYPICAL FORM) IS DESCRIBED:

+ the first symptoms, as a rule, appear by the end of the 1st year of life by a delay in the rate of motor development

the first symptoms appear over the age of 2 years

first symptoms appear at school age

the first symptoms appear from 20 to 25 years

the beginning of progression is still in utero

# FOR SHARCO-MARI DISEASE CHARACTERISTIC:

+ distal paresis, distal atrophy

proximal paresis

proximal atrophy

mosaic atrophy

all of the above

#MYOPATHIES - THIS:

a group of progressive neuromuscular diseases in which the weakness of the muscle apparatus is caused by damage to the spinal cord

the same, but muscle weakness is due to primary nerve damage

+ a group of hereditary diseases characterized by an increase in muscle weakness and atrophy. Pathological focus in the muscles

group of diseases in which the focus is located in the channels of the membranes

group of diseases in which the focus is located in the cerebral cortex

# IN MYOPATHY, PRIMARY INFLUENCE OF:

cells of the anterior horns of the spinal cord

peripheral nerve trunks

+ skeletal muscle

craniocerebral nuclei

back columns of the spinal cord

# CHARACTERISTICS OF PATOMORPHOLOGICAL CARD OF PRO-GRESSING MYOPATHIES ARE:

muscle destruction, proliferation of nuclei

replacement of muscle fibers with connective tissue

replacement of muscle fibers with adipose tissue

the number of mitochondria in the muscle fiber, muscle hypotension

+ all of the above

# PROGRESSING MYOPATHIES RELATED TO:

Charcot marie

Verding-hoffman

Kugelberg-Velander

Degerina Sotta

+ Landusi-Dejerine, Erba-Rotta

# TYPE OF INHERITANCE FOR DYSHENNA DISEASE:

autosomal dominant

autosomal recessive

+ linked to the X chromosome

mitochondrial

holondric

# IF FREEDREICH'S DISEASE TAKES PLACE:

+ recessive type of inheritance

dominant type of inheritance

sex-linked (via the X chromosome)

holondric type of inheritance

mitochondrial inheritance

# SUFFICIENT CLINICAL SIGNS IN THE DIAGNOSTICS OF SIRINGO-MYELIA ARE:

+ segmental dissociated, the presence of dysraphic features of the structure of the musculoskeletal system

conductor type disturbances on the opposite side

progressive muscle atrophy in areas corresponding to segmental dysfunctions

lower spastic paresis

coordination violations

# SEVERE STAGE OF DUSHEN'S DISEASE CHARACTERIZED:

the impossibility of independent movement

the rapid development of contractures

skeletal deformity

severe motor impairment

+ all of the above

# IF ERB-ROTT'S DISEASE FIRST, MUSES ARE AFFECTED:

distal extremities

faces

+ pelvic girdle, shoulder girdle

proximal limbs

backs

# FOR SPINAL AMYOTROPHY WERDNIG-Hoffmann CHARACTERISTIC

increased serum creatinine kinase

congenital disorders in the structure of muscle fiber

+ damage to the spinal cord motor neuron

hypertonicity

increased reflexes

# FOR NEUROFIBROMATOSIS CHARACTERISTIC:

the disease always proceeds for a long time, but benign

the disease can be detected in one of the parents of proband, the presence of multiple pigmented nevi

type of inheritance - autosomal dominant

neurofibromatosis gene expression variable even within the same family

+ all of the above

# CHARACTERISTIC SYMPTOMS OF ERBA-ROTT DISEASE ARE:

atrophy of the muscles of the shoulder and pelvic girdle

pterygoid scapula

wasp waist

hypomimia, the face of the "myopath"

+ all of the above

# THE COURSE OF ERBA-ROTT'S DISEASE:

+ relatively favorable

quickly leads to immobilization

quickly fatal

ultrashort

often recurring

# TYPE OF INHERITANCE FOR LANDUSI-DEGERIN DISEASE:

+ autosomal dominant

autosomal recessive

X-linked

holondric

mitochondrial

# FOR LANDUZI-DEGERIN'S DISEASE, DEFEAT PREVENTS:

distal extremities

+ faces

shoulder girdle

shoulder and pelvic girdle

backs

# UNLIKE MYOPATHY DURING ATONIC FORM OF CP:

movement disorders, gait changes

increased tendon reflexes

persistent pathological signs

improvement of motor functions

+ all of the above

# FOR FORECASTING POSSIBLE REPEATED BIRTH OF A SICK CHILD IN A FAMILY WITH A NEUROMUSCULAR DISEASE, IT IS NECESSARY TO CARRY OUT:

+ genetics consultation

neurologist consultation

orthopedic consultation

pediatrician consultation

optometrist consultation

# TOMSON'S DISEASE

after infection

+ congenital disease

after severe injury

during the epiprush

as a complication of rickets

# MYASTENIA IS CHARACTERIZED:

+ pathology of the synaptic apparatus

damage to the cells of the anterior horns of the muscles of the spinal cord

peripheral nerve damage

damage to the lateral horns of the spinal cord

damage to the posterior columns of the spinal cord

# FOR THE CLINIC OF MIASTENIA CHARACTERISTICALLY:

+ decrease in volumes and strength of movements with repeated contractions of muscles

inability to relax muscles after contraction

bone deformities

epiprules

coordination violations

# BY THE DEGREE OF PREVALENCE OF MOTOR DISORDERS IN MIASTENIA, IDENTIFY:

+ generalized

local forms

only bulbar

generalized only

ophthalmoplegic form

# FOR WHAT FORM OF MASTASTENE DYSARTRY IS CHARACTERISTIC, CHANGE OF G-LOS, SURFACE:

with damage to the oculomotor muscles

+ bulbar

mimic

generalized

born

# AT MYASTENIA TENDON REFLEXES:

promoted

+ quickly depleted

are absent

with the expansion of reflexogenic zones

with clonus stop

# TO CONFIRM DIAGNOSIS OF MYASTENIA CONDUCT

+ proserin test

amidopyrine test

caffeinated sample

diazepam test

sweat test

# ACUTE MYASTENIC CRISES CHARACTERIZE:

generalized muscle weakness

respiratory failure

bulbar disorders

cardiac impairment

+ all of the above

# TH E BASIS OF TREATING MYASTENIA :

+ anticholinesterase drugs

antiviral drugs

antibiotics

antiepileptic drugs

hormonal drugs

# ANATOMICAL AREA, WHICH MOST INFLUENCES DURING SPINAL AMIOTROPHY OF VERDING - Hoffmann:

central motor neuron

+ front-horn motor neuron

peripheral nerve

horn of the spinal cord

lateral horn of the spinal cord

# ACCORDING TO THE MODERN CLASSIFICATION OF TRAUMATIC BRAIN INJURY DO NOT DISTINGUISH:

mild brain contusion

cerebral compression due to epidural hematoma

+ severe concussion

compression of the brain against the background of its bruise

brain concussion

# DIFFUSE AXONAL DAMAGE TO THE BRAIN DURING TRAUMATIC BRAIN INJURY IS CHARACTERIZED BY:

+ prolonged coma from the moment of injury

the development of coma after the "bright" period

lack of loss of consciousness

short-term loss of consciousness

short-term loss of consciousness with retrograde amnesia

# TRAUMA REFERS TO OPEN TRAUMATIC BRAIN INJURY:

with a bruised soft tissue wound without damage to the aponeurosis

+ with damage to the aponeurosis

with a fracture of the bones of the cranial vault

with fracture of the base of the skull without cerebrospinal fluid

with the development of epidural hematoma

# A CONCUSSION COMBINED WITH SOFT TISSUE DAMAGE REFERS TO MULTIPLE BRAIN INJURY:

easy open

+ light closed

open moderate

closed moderate

heavy

# INTRACRANIAL HYPERTENSION IS CHARACTERIZED BY A HEADACHE:

+ bursting

bursting in the occipital part

throbbing throughout the head

compressive in the frontotoparietal region

burning character in the occipital region

# WHAT ARE THE TYPICAL DIAGNOSTIC SIGNS OF A SUBDURAL HEMATOMA

with computed tomography

with angiography

with echoencephalography

+ with magnetic resonance imaging

with all of the above

# IF STIFF NECK AND PHOTOPHOBIA DEVELOP IN THE ABSENCE OF FOCAL SYMPTOMS AFTER A TRAUMATIC BRAIN INJURY, THE MOST LIKELY DIAGNOSIS IS:

concussion

+ subarachnoid hemorrhage

brain contusion

intracranial hematoma

diffuse axonal damage

# A COMPLICATION OF A TRAUMATIC BRAIN INJURY WITH HEMORRHAGE IN THE VENTRICLES OF THE BRAIN IS CHARACTERIZED BY THE APPEARANCE IN THE CLINICAL PICTURE:

floating gaze

+ gormetonichesky syndrome

hypercatabolic type of autonomic functions

impaired consciousness

bilateral pyramidal stop signs

# POSITIVE DIAGNOSTIC SIGNS OF SUBARACHNOID HEMORRHAGE CAN BE OBTAINED:

when radiography of the skull

with angiography

+ for computed tomography

with transcranial Doppler ultrasonography

with echoencephalography

# ACUTE SUBDURAL HEMATOMA ON A CT SCAN IS CHARACTERIZED BY THE ZONE:

+ homogeneous increase in density

homogeneous density reduction

heterogeneous increase in density

cerebral edema

multiple areas of reduced density

# CRANIOGRAPHIC SIGNS OF ACUTE SKULL INJURY ARE CHARACTERIZED BY:

"finger impressions"

reinforced vascular pattern

increasing the depth of the Turkish saddle

osteoporosis of the occipital bone and occipital half ring

+ none of the listed signs

# PENETRATING IS CALLED A HEAD INJURY:

with a bruised soft tissue wound B) with damage to the aponeurosis

with a fracture of the bones of the cranial vault

with damage to the dura mater

+ with all of the above options

# WHAT THE THE CAUSE OF ARTERIAL HYPERTENSION IN ACUTE SEVERE TRAUMATIC BRAIN INJURY :

cerebral hypoxia

pain reaction

damage to diencephalic-mesencephalic structures

+ brain edema

all of the above

# TO DIAGNOSE POST-TRAUMATIC RHINORRHEA IN THE DISCHARGE FROM THE NOSE, IT IS NECESSARY TO EXAMINE :

protein

cytosis

+ sugar

sodium

chlorides

# INSTABILITY OF THE CERVICAL SPINE AFTER COMBINED CRANIOVERTEBRAL INJURY CAN BE DETECTED USING:

magnetic resonance imaging

computed tomography

+ lateral functional radiography

descending contrast myelography

pneumoencephalography

# POST-TRAUMATIC SYNDROME OF NORMOTENSIVE HYDROCEPHALUS (HAKIM-ADAMS) IS MANIFESTED BY A TRIAD OF SYMPTOMS:

headache, memory loss, disorientation

headache, decreased vision, ataxia

+ walk disturbance, urinary incontinence, dementia

dizziness, astasia-abasia, sensory ataxia

damage to the cranial nerves, headache, frontal ataxia

# PSYCHOEMOTIONAL POST-TRAUMATIC DISORDERS DIFFER FROM PSYCHOGENIC NEUROTIC SYMPTOM COMPLEXES:

more stable course

the prevalence of a depressive symptom complex

the predominance of the hypochondriacal symptom complex

greater resistance to treatment with psychotropic drugs

+ there are no fundamental differences

# EPILEPTIFORM SYNDROME IN POST-TRAUMATIC EPILEPSY IS MANIFESTED BY JACKSON'S SEIZURES WITH LOCALIZATION OF THE PATHOLOGICAL FOCUS IN THE REGION OF:

frontal lobe

parietal lobe

+ central gyrus

Geshl's gyrus

temporal lobe

# IN CHRONIC POST-TRAUMATIC BRAIN ABSCESSES OF CORTICAL-SUBCORTICAL LOCALIZATION IN THE CLINICAL PICTURE, THE FOLLOWING PREVAILS:

the presence of intracranial hypertension

cerebral symptoms

+ epileptiform symptom complex

meningeal syndrome

equally all of the above

# THE EARLIEST MANIFESTATION OF HEMATOMYELIA OF TRAUMATIC ORIGIN IS THE PRESENCE OF:

disorders of deep sensitivity

Brown - Sekara syndrome

motor conduction disorders

+ dissociated sensitivity disorders

meningeal syndrome

# WITH THE CONCUSSION OF THE NERVE TRUNK, NERVE CONDUCTION IS FULLY RESTORED NO LATER THAN:

first days

+3 days

weeks

2 weeks

3 weeks

# WHAT IS THE RATE OF REGENERATION OF THE DAMAGED AXON DURING TRAUMATIC RUPTURE OF A NERVE :

0.1 mm per day

+1 mm per day

10 mm per day

1 mm in 10 days

1 mm in 30 days

# WHAT IS THE EARLIEST SIGN OF AXON REGENERATION IN A PERIPHERAL NERVE INJURY :

+ the appearance of paresthesia in the innervation zone of the damaged nerve

the appearance of persistent pain in the distal parts of the zone innervated by a damaged nerve

regression of trophic disorders

pain regression in the distal parts of the injured limb

the appearance of movements in paretic muscles

# WHAT IS THE MAIN SYMPT OM OF A PHANTOM PAIN SYNDROME :

extremity hypesthesia

+ sensation of pain in a non-existent part of the removed limb

swelling, cyanosis of the stump of the limb

pain in a healthy limb

limb pain

# ACUTE NECROTIC ENCEPHALITIS IS CAUSED BY VIRUSES:

Coxsackie

+ herpes simplex

measles

mumps

adenoviruses

# TREATMENT FOR MUMPS MENINGITIS INCLUDES ALL OF THE FOLLOWING, EXCEPT:

corticosteroids

+ deoxyribonuclease

trypsin

ascorbic acid

glycerin

# THE DEVELOPMENT OF WATERHOUSE-FRIEDERICKSEN SYNDROME (ACUTE ADRENAL INSUFFICIENCY) IS CHARACTERISTIC OF A SEVERE COURSE:

staphylococcal meningitis

pneumococcal meningitis

coxsackie meningitis

+ meningococcal meningitis

lymphocytic choriomeningitis

# THE RARE SYNDROMES OF ENCEPHALITIS ECONOMO INCLUDE:

oculomotor disorders

+ pathological stop signs

sleep disturbances

autonomic disorders

facial nerve damage

# ACUTE TICK-BORNE ENCEPHALITIS IS CHARACTERIZED BY:

peak incidence in the autumn-winter period

lack of meningeal syndrome

decrease in intracranial pressure

+ flaccid paresis and paralysis of the muscles of the shoulder girdle

neutrophilic cytosis in cerebrospinal fluid

# WITH VIRAL TWO-WAVE MENINGOENCEPHALITIS USUALLY DOES NOT HAPPEN:

fever

+ atrophic spinal paralysis

pleocytosis in cerebrospinal fluid

radiculoneuritis

# SOMATIC MANIFESTATIONS OF AIDS INCLUDE:

prolonged fever and night sweat

diarrhea

generalized lymphadenopathy

+ weight loss

all of the above

# WITH VIRAL ENCEPHALITIS IN THE CEREBROSPINAL FLUID OBSERVED:

+ lymphocytic pleocytosis

protein reduction

increase in chloride

increase in glucose

all of the above is true

# THE PHENOMENON OF "CLINICAL DISSOCIATION" IN MULTIPLE SCLEROSIS IS CHARACTERIZED BY THE PRESENCE OF:

horizontal nystagmus in combination with the absence of abdominal reflexes

central paresis in the extremities and lack of sensitivity disorders

sensitivity disorders of segmental or conductor type against the background of mild central paresis of limbs

+ central paresis in the limbs in combination with muscle hypotension

foot clonus without pathological foot reflexes

# FOR ETIOTROPIC THERAPY OF HERPETIC ENCEPHALITIS USED:

oxolin

pefloxacin

+ acyclovir

ceftriaxone

erythromycin

# WHAT IS THE CRUCIAL IN THE DIAGNOSIS OF MENINGITIS:

acute onset of the disease with fever

acute onset of the disease with meningeal syndrome

+ changes in cerebrospinal fluid

signs of stagnation in the fundus

focal neurological symptoms

# SEROUS MENINGITIS CAN BE CAUSED BY THE FOLLOWING BACTERIA:

Haemophilus influenzae Afanasyev - Pfeiffer (influenza-meningitis)

pneumococcus

+ Mycobacterium tuberculosis

staphylococcus

E. coli

# WHAT IS THE MOST EFFECTIVE ANTIBIOTIC (LISTED) IN THE TREATMENT OF PURULENT MENIN G ITIS CAUSED BY STAPHYLOCOCCUS

benzylpenicillin

lindamycin

erythromycin

+ ceftriaxone

ampicillin

# THE CLINICAL PICTURE OF ACUTE LYMPHOCYTIC CHORIOMENINGITIS OF ARMSTRONG IS SIGNIFICANT:

high fever

meningeal syndrome

+ hypertensive syndrome

impaired consciousness

photophobia

# WITH MENINGITIS CAUSED BY THE COXSACKIE AND ECHO VIRUSES, THE FOLLOWING IS OBSERVED:

subacute onset without fever

+ polymyalgia

neutrophilic pleocytosis

severe course and gross residual symptoms

all of the above is true

# WHAT IS THE MORPHOLOGICAL SUBSTRATE FOR THE RESTORATION OF THE FUNCTIONS OF NEURONAL SYSTEMS AND CLINICAL REMISSION IN MULTIPLE SCLEROSIS:

resorption of fibrous sclerotic plaque

restoration of the ability to synthesize neurotransmitters in affected neurons

restoration of the normal circulation of neurotransmitters in interneuronal synapses

+ periaxonal remyelination in the affected neurons

all of the above is true

# TO TREAT MENINGITIS CAUSED BY FRIEDLANDER'S WAND, YOU SHOULD CHOOSE:

cephalexin

clindamycin

erythromycin

+ ceftriaxone

lincomycin

# TO TREAT PNEUMOCOCCAL MENINGITIS, YOU SHOULD CHOOSE:

lincomycin

tetracycline

erythromycin

kanamycin

+ benzylpenicillin

# SUBARACHNOID HEMORRHAGE AS A COMPLICATION OF THE UNDERLYING DISEASE OCCURS WITH MENINGITIS CAUSED BY:

pneumococcus

mumps virus

klebsiella

stick Afanasyev-Pfeiffer

+ streptococcus

# BRAIN ABSCESSES AS A COMPLICATION OF THE UNDERLYING DISEASE ARE MORE LIKELY TO OCCUR WITH MENINGITIS CAUSED BY:

stick Afanasyev - Pfeiffer

+ staphylococcus

pneumococcus

leptospira

adenoviruses

# THE RARE CAUSATIVE AGENTS OF SEROUS MENINGITIS INCLUDE:

lymphocytic choreomeningitis virus

Mycobacterium tuberculosis

+ parainfluenza virus

mumps virus

enteroviruses (Coxsackie and ECHO)

# PURULENT MENINGITIS DOES NOT CAUSE:

staphylococci

meningococci

pneumococci

vulgar proteus

+ leptospira

# TO CORRECT PATHOLOGICAL MUSCLE SPASTICITY WITH MULTIPLE SCLEROSIS, IT IS ADVISABLE TO PRESCRIBE:

aminalon

phenibut

pantogam

+ tizanidine

midcalm

# ACUTE (PRIMARY) DISSEMINATED ENCEPHALOMYELITIS IS RARELY ACCOMPANIED BY DEVELOPMENT:

lower spastic paraplegia

bulbar disorders

+ extrapyramidal disorders

Brown - Sekara syndrome

cerebellar disorders

# WHAT IS THE MORPHOLOGICAL SUBSTRATE OF PYRAMIDAL SYMPTOMS IN ACUTE DISSEMINATED ENCEPHALOMYELITIS:

Mesoglia proliferation in white matter

foci of ischemia in the brain

+ myelin breakdown

perivascular edema

all of the above

# A BRAIN ABSCESS IS A RELATIVELY RARE COMPLICATION OF MENINGITIS CAUSED BY:

pneumococcus

staphylococcus

stick Afanasyev - Pfeiffer

+ meningococcus

streptococcus

# HIGH CONTAGIOUSNESS IS CHARACTERISTIC OF MENINGITIS CAUSED BY:

Pseudomonas aeruginosa

staphylococci

herpes simplex virus

+ Koksaki viruses and ECHO

Pneumococcus

# OF DECISIVE IMPORTANCE IN THE DIFFERENTIAL DIAGNOSIS OF CEREBRAL ECHINOCOCCOSIS FROM OTHER VOLUMETRIC BRAIN LESIONS BELONGS TO:

clinical features

computed tomography

anamnestic data

+ features of serological reactions

angiography

# MOTOR AND SENSORY DISTURBANCES IN ACUTE DISSEMINATED ENCEPHALOMYELITIS DUE TO DAMAGE:

+ brain and spinal cord

meninges

spinal roots

peripheral nerves

spinal ganglia

# REDUCED VISUAL ACUITY IN ACUTE DISSEMINATED ENCEPHALOMYELITIS DUE TO DAMAGE:

retina

+ optic nerve

primary visual center in the external cranked body

the radial crown of Graziole in the occipital lobe

cortical part of the visual analyzer in the occipital lobe

# IN THE TREATMENT OF ACUTE DISSEMINATED ENCEPHALOMYELITIS FOR THE CORRECTION OF AUTOIMMUNE DISORDERS, USE:

non-steroidal anti-inflammatory drugs

anabolic steroid drugs

+ synthetic glucocorticoids

estrogenic steroid drugs

immunostimulants

# MOTOR DISTURBANCES DURING THE SECOND ATTACK OF ACUTE EPIDEMIC ANTERIOR POLIOMYELITIS THAT OCCURS AFTER THE "MINOR ILLNESS" AND THE SUBSEQUENT LATENT PERIOD ARE CHARACTERIZED BY THE PRESENCE OF:

muscle atrophy

+ fibrillar twitching

flaccid paralysis of limbs

neck muscle weakness

lower spastic paraparesis

# MORPHOLOGICAL CHANGES IN DIPHTHERIA POLYNEUROPATHY ARE DUE TO:

lymphoid infiltration of peripheral nerves

axon degeneration

+ segmental demyelination

proliferation of Schwann cells

perivascular edema

# IN TH E CEREBROSPINAL FLUID IN THE SECOND WEEK OF THE PARALYTIC STAGE OF ACUTE POLIOMYELITIS (UNLIKE THE FIRST WEEK), THEY FIND:

normal glucose

+ protein-cell dissociation

normal chloride levels

eosinophilic cytosis

xanthromia

# THE MAIN PATHOGENETIC LINK IN DIPHTHERIA POLYNEUROPATHY IS THE BLOCKADE OF DIPHTHERIA TOXIN:

retrograde axonal transport

synaptic transmission

+ protein synthesis at the level of the core of the Schwann cell

"potassium-sodium pump" on the surface of the Schwann cell membrane

calcium channels

# THE DIFFERENTIAL DIAGNOSIS OF NON-PARALYTIC FORMS OF ACUTE POLIOMYELITIS SHOULD BE CARRIED OUT:

with viral serous meningitis

with bacterial serous meningitis

with acute demylinizing polyradiculoneuropathy of Guillain - Barre

with anteropodic form of tick-borne encephalitis

+ with all of the above

# SUSPICION OF A BRAIN ABSCESS OCCURS IF THE DISEASE IS CHARACTERIZED BY SIGNS:

increasing intracranial hypertension

focal cerebral lesion

cerebral symptoms

+ offset M-signal with Echoencephaloscopy

all listed

# WHEN DIAGNOSING A BRAIN ABSCESS FROM CONTRAST METHODS, YOU CAN GET A DIRECT IMAGE OF A ROUNDED PATHOLOGICAL FOCUS USING:

pneumoencephalography

ventriculography

angiography

+ g-scintigraphy

all of the above

# TO THE SUBACUTE SCLEROSING PANENCEPHALITIS AS A SINGLE DISEASE INCLUDE:

+ Schilder's leukoencephalitis, encephalitis with Dawson inclusions;

subacute Van Bogart's leukoencephalitis, Schilder's leukoencephalitis;

Pette - Dering nodular panencephalitis, Schilder's leukoencephalitis, encephalitis with Dawson inclusions;

encephalitis with Dawson inclusions, Pette-Dering nodular panencephalitis, Van Bogart subacute leukoencephalitis;

Schleder's leukoencephalitis.

# WHAT IS THE EFFECTIVE TREATMENT FOR BRAIN ABSCESS:

massive administration of antibiotics and dehydrating agents

+ surgical removal of the abscess

abscess lavage with dioxidine

washing the abscess cavity with antibiotics

the use of anti-inflammatory doses of radiation therapy

# DIFFERENTIAL DIAGNOSIS OF SUBACUTE SCLEROSING PANENCEPHALITIS IS CARRIED OUT:

with periaxial Schleder's leukoencephalitis

with multiple sclerosis

with a brain tumor

+ with hepatocerebral dystrophy

with all of the above

# GAIT DISTURBANCE IN DIPHTHERIA POLYNEUROPATHY DUE TO:

lower spastic paraparesis

cerebellar ataxia

extrapyramidal rigidity

+ sensitive ataxia

dystonia of the feet

# AMYOTROPHIC LATERAL SCLEROSIS WITH A PRIMARY LESION OF THE CERVICAL THICKENING OF THE SPINAL CORD MUST BE DIFFERENTIATED:

with vertebrogenic myelopathy

with anteropod form of syringomyelia

with intramedullary tumor

+ with spinal amyotrophy

with thyrotoxic myopathy

with all of the above

# ETIOTROPIC PHARMACOTHERAPY OF TOXOPLASMOSIS IS CARRIED OUT:

+ chloridine

kanamycin

furadonin

erythromycin

clindamycin

# ARGYLE ROBERTSON SYNDROME IS CALLED:

+ lack of reaction of pupils to light while maintaining a reaction to convergence and accommodation

lack of direct reaction to light while maintaining a friendly reaction

lack of pupil reaction to convergence while intact reaction to light

lack of response to accommodation in combination with mydriasis

lack of response to convergence and accommodation of reading with anisocoria

# WITH A HEREDITARY DISEASE OF THE ISLAND OF GUAM, AMYOTROPHIC LATERAL SCLEROSIS SYNDROME IS COMBINED:

+ with parkinsonism and dementia

with choreoathetosis

with amaurosis

with tic hyperkinesis

with cervical dystonia

# ONE OF THE FIRST NEUROLOGICAL SYMPTOMS OF BOTULISM IS:

+ paresis of accommodation

pseudobulbar syndrome

XII nerve damage

hypersalivation

respiratory distress

 # HIGH RISK OF DEATH OF POLYNEUROPATHY WITH DIPHTHERIA IS DETERMINED BY DAMAGE:

bulbar cranial nerves, diaphragm

diaphragm myocardium

myocardium, peripheral nerves

+ cranial and peripheral nerves

bulbar cranial nerves, diaphragm, myocardium

# DAMAGE TO THE NERVOUS SYSTEM CAUSED BY ANTIBODIES TO NERVOUS TISSUE DEVELOPED DURING AIDS MANIFESTS ITSELF IN THE FORM OF:

meningitis

meningoencephalitis

encephalomyelitis

+ polyneuropathy

all of the above

# DAMAGE TO THE NERVOUS SYSTEM BY HIV INFECTION MANIFESTS ITSELF:

encephalopathy, sensitive ataxia

acute recurrent meningitis

myelopathy, polyneuropathy

+ cerebellar ataxia, bulbar syndrome

encephalopathy, myelopathy, acute recurrent meningitis

# DIAGNOSTIC SIGNS OF CEREBRAL CYSTICERCOSIS ARE:

+ detection of cysts using computed tomography in the tissue and ventricles of the brain

sensitive ataxia and decreased tendon reflexes

optic atrophy

neurogenic deafness

all of the above is true

# FOR CEREBRAL CYSTICERCOSIS, PLEOCYTOSIS IS CHARACTERISTIC:

neutrophilic

neutrophilic lymphocytic

lymphocytic basophilic

lymphocytic

+ lymphocytic monocytic

# WHAT ARE THE CLINICAL FEATURES OF IMMUNODEPENDENT INDIGENOUS ENCEPHALITIS:

+ the appearance of neurological symptoms on the 3-6th day after the rash

the occurrence of neurological symptoms in the 2-3rd week after the rash

the occurrence of neurological symptoms one month after the rash

the onset of neurological symptoms two months after the rash

the occurrence of neurological symptoms three months after the rash

# THE CLINICAL PICTURE OF TABES DORZALIS IS CHARACTERIZED BY THE PRESENCE OF:

+ pain and sensitive ataxia

pathological stop signs and dysfunction of the pelvic organs

lower spastic paraparesis with decreased tendon reflexes

flaccid tetraparesis

ALS syndrome

# FOR SYPHILITIC DAMAGE TO THE AUDITORY NERVES IS CHARACTERISTIC:

+ decrease in bone conduction while maintaining air conduction

decreased air conduction while maintaining bone

decrease in bone and air conduction

preservation of bone and air conduction

increased bone and decreased air conduction

# WHAT ARE THE COMMON CAUSATIVE AGENTS OF AIDS-RELATED INFECTIONS OF THE NERVOUS SYSTEM:

Mycobacterium tuberculosis

adenoviruses

candida

listeria

+ herpes simplex viruses

# FOR DAMAGE TO THE OPTIC NERVES IN SYPHILITIC BASAL MENINGITIS, THE FOLLOWING IS CHARACTERISTIC:

visual field changes

violation of color perception

papillitis with hemorrhage

the appearance of white degenerative foci in the fundus

+ all of the above

# MENTAL DISORDERS IN AIDS ARE REPRESENTED BY THE FOLLOWING SYMPTOMS:

decreased memory and criticism

disorientation

progressive dementia

+ hallucinations

all listed

# THE DIAGNOSIS OF NEUROSYPHILIS IS CONFIRMED BY THE FOLLOWING METHODS FOR THE STUDY OF CEREBRO-PINEAL FLUID, WITH THE EXCEPTION OF:

Wassermann reactions with three dilutions of cerebrospinal fluid

colloidal reaction lange

+ colloidal reaction Takata - Macaw

immobilization reactions of pale treponemas

immunofluorescence reaction

# VIOLATION OF STATICS AND GAIT WITH DORSAL DRYNESS DUE TO:

flaccid paralysis of the legs

cerebellar ataxia

+ sensitive ataxia

visual impairment in case of optic atrophy of the optic nerves

tabetic arthropathy

# THE TERM "TABET CRISIS" IN PATIENTS WITH SPINAL CORD REFERS TO:

paroxysms of tachycardia

blood pressure fluctuations

+ paroxysms of tearing pain

episodes of profuse sweating and general weakness

paroxysms of diffuse increase in muscle tone

# PRIMARY TABETIC ATROPHY OF THE OPTIC NERVES WITH SPINAL CORD IS CHARACTERIZED BY THE FOLLOWING CHANGES IN THE FUNDUS:

blanching of the temporal halves of the discs

+ gray discs

swelling of the discs

papillitis with hemorrhage

all of the above

# THE MORPHOLOGICAL SUBSTRATE OF ARACHNOIDITIS IS A CHRONIC PRODUCTIVE PROCESS IN:

pia mater

ventricular ependyma

vascular plexus

+ arachnoid

all of the above is true

# THE FOLLOWING CLINICAL FORMS OF SCHILDER ENCEPHALITIS ARE DISTINGUISHED:

psychoorganic (hallucinations, dementia)

paralytic (pyramidal paresis)

convulsive (epileptic syndrome)

occipital-parietal (decreased vision, visual field defects)

+ there are all listed forms

# NEUROLOGICAL SYMPTOMS OF ACUTE SPINAL EPIDURITIS ARE PRESENTED:

+ radicular pain and spinal cord compression syndrome

sensitive ataxia with myalgia

loss of consciousness with meningeal syndrome

flaccid tetraparesis

common fibrillar muscle twitches

# OPTICOCHIASMAL ARACHNOIDITIS IS CHARACTERIZED BY:

decreased visual acuity

concentric narrowing of visual fields

optic nerve edema

+ increased intracranial pressure

all of the above

# OPTIOCHIASMAL ARACHNOIDITIS MAY BE MISDIAGNOSED:

with retrobulbar neuritis

with opticomyelitis

with multiple sclerosis

with hereditary atrophy of the optic nerves of Leber

+ with all of the above

# ARACHNOIDITIS OF THE POSTERIOR CRANIAL FOSSA MUST BE DIFFERENTIATED:

from a tumor of the same localization

from Arnold's syndrome - Chiari

from Klippel's syndrome - Feil

+ from cerebellar degeneration

from all of the above

# FOR THE CLINICAL PICTURE OF SUBACUTE SPONGY ENCEPHALOPATHY OF CREUTZFELDT-JAKOB, THE PRESENCE OF:

pyramidal syndrome

cerebellar ataxia

extrapyramidal syndrome

+ sensitive ataxia

epileptiform syndrome

# THE FOLLOWING PRINCIPLE IS BASED ON THE CLASSIFICATION OF POLYNEUROPATHIES:

+ etiology of the disease

peculiarity of the course of the disease

clinical feature

morphological substrate of the lesion

morphological substrate of the lesion and the clinical picture

# WHAT IS THE FACTOR DETERMINING NERVE DAMAG E IN DIPHTHERIA POLYNEUROPATHY :

infectious

+ toxic

vascular

metabolic

compression

# FOR DIPHTHERIA POLYNEUROPATHY, THE PRESENCE OF:

lower spastic paraparesis

cerebellar ataxia

dissociated sensitivity disorders

+ disorders of deep sensitivity

pseudobulbar syndrome

# ARSENIC POLYNEUROPATHY IS CHARACTERIZED BY THE PRESENCE OF

primary lesions of the nerves of the hands

crimson-cyanotic stripes on legs

+ white stripes on the nails

bulbar syndrome

pelvic disorders

# WHAT IS THE CONCOMITANT SYMPTOM OF POLYNEUROPATHIES WITH PERNICIOUS ANEMIA:

decrease in serum iron in the blood

+ funicular myelosis

hyperacid gastritis

hyperalbuminemia

bulbar syndrome

# FOR UREMIC POLYNEUROPATHY IS CHARACTERISTIC:

+ decrease in the speed of conduction of excitation along the nerves

cranial nerve damage

prevalence of axonal degeneration

lack of sensory impairment

cerebellar ataxia

# WHAT ARE THE HALLMARKS OF ACUTE INTERMITTENT PORPHYRIA:

severity of sensory ataxia

severity of pain

severity of flaccid paralysis of limbs

black feces

+ red urine

# FOR THE SYNDROME OF INFRINGEMENT OF THE TIBIAL NERVE (TARSAL CANAL SYNDROME), THE FOLLOWING ARE CHARACTERISTIC:

pain in the lower leg

swelling in the outer ankle

+ paresis of the flexor of the toes

hypotrophy of the peroneal muscle group

sensory ataxia

# WHAT IS THE MOST INFORMATIVE STUDY FOR THE DIFFERENTIAL DIAGNOSIS OF AXONOPATHIES AND MYELINOPATHIES

immunological blood test

+ electromyography

immunological study of cerebrospinal fluid

muscle biopsy

immunological examination of blood and cerebrospinal fluid

# INFECTIOUS POLYNEURITIS IS CAUSED BY PATHOGENS:

diphtheria

botulism

+ leprosy

tetanus

rabies

# FOR GUILLAIN-BARRÉ POLYNEUROPATHIES, IT IS CHARACTERISTIC:

+ damage to the cranial nerves

severe pelvic disorders

persistent bilateral pyramidal symptoms

lack of protein increase in cerebrospinal fluid

severe meningeal syndrome

# FOR GUILLAIN-BARRÉ POLYNEUROPATHIES, THE APPEARANCE OF PROTEIN-CELL DISSOCIATION IN THE CEREBROSPINAL FLUID IS CHARACTERISTIC:

from the 1st day of illness

from the 3rd day of illness

+ from the 2nd week of illness

from the 3rd week of illness

from the 4th week of illness

 # THE ATYPICAL FISHER FORM OF GUILLAIN-BARRÉ ACUTE POLYNEUROPATHY IS CHARACTERIZED BY:

lesion of the glossopharyngeal nerve

bilateral paresis of the facial nerve

damage to the caudal group of cranial nerves and respiratory failure

+ damage to the oculomotor nerves and ataxia

flaccid tetraparesis

# FOR POLYNEUROPATHY WITH NODULAR PERIARTERITIS CHARACTERISTIC

+ asymmetry of damage to nerve trunks

low severity of pain

cranial nerve damage

sensory ataxia

optic nerve damage

# POLYNEUROPATHY REFERS TO DEMYELINATING:

+ Guillain - Barre

diabetic

porphyria

hypothyroid

alcohol

# FOR TRIGEMINAL NEUROPATHY ARE CHARACTERISTIC:

+ decrease in corneal reflex

taste disorder in the posterior third of the tongue

hypalgesia in the inner zone of Zelder

masticatory hypertrophy

all of the above

# WITH COCHLEAR NEURITIS OBSERVED:

hyperacusia (score - 0)

isolated decrease in bone conduction

isolated decrease in air conduction

+ combined decrease in bone and air conduction

decreased bone and increased air conduction

# WHEN LESION OF THE GLOSSOPHARYNGEAL NERVE IS OBSERVED

taste disorder in anterior 2/3 of the tongue

paresis of the larynx

+ paresis of the soft palate

atrophy of the tongue

orofacial dystonia

# FOR NEUROPATHY OF THE ACCESSORY NERVE IS CHARACTERISTIC:

+ scapular prolapse

atrophy of the deltoid muscle

difficulty swallowing

weakness of the I and II fingers

hypotenar atrophy

# DAMAGE TO THE NUCLEUS OF THE HYOID NERVE FROM SUPRANUCLEAR LESION IS CHARACTERIZED BY THE PRESENCE OF:

dysarthria

language mobility restrictions

+ fibrillation

concomitant lesion of the vagus nerve

hypersalivation

# FOR NEUROPATHY OF THE LONG PECTORAL NERVE IS CHARACTERISTIC:

paresis of the deltoid muscle

paresis of the sternocleidomastoid muscle

+ paresis of the anterior dentate muscle

paresis of the trapezius muscle

paresis of the triceps muscle of the shoulder

# FOR AXILLARY NERVE NEUROPATHY IS CHARACTERISTIC:

difficulty bending the arm at the elbow

soreness of the arm when moving it behind the back

+ weakness and atrophy of the deltoid muscle

trapezius muscle weakness and atrophy

paresis of the sternocleidomastoid muscle

# WHAT ARE A SIGNS OF THE MEDIAN NERVE NEUROPATHY:

weakness of the fourth and fifth fingers

decreased sensitivity on the palmar surface of the IV, V fingers

+ weakness of I, II fingers

soreness of the arm when moving it behind the back

weakness and atrophy of the deltoid muscle

# WHICH SIGNS OF DAMAGE TO THE RADIAL NERVE:

claw brush

+ impossibility of extension of the brush

impossibility of abduction of the V finger

pain in the V finger

palm hyperkeratosis

# WITH NEUROPATHY OF THE ULNAR NERVE OBSERVED:

hanging brush

violation of sensitivity in the field of I, II fingers

+ inability to bring IV, V fingers

palm skin anhydrosis

pain in the II and III fingers

# WITH NEUROPATHY OF THE FEMORAL NERVE OBSERVED

Lasegue symptom

+ weakness of the quadriceps femoris

lack of an Achilles reflex

atrophy of the calf muscles

pain in the knee joint

# WHICH CLINICAL SIGNS OF NEUROPATHY OF THE EXTERNAL CUTANEOUS NERVE OF THE THIGH

knee-jerk reduction

+ hypesthesia on the outer anterior surface of the thigh

quadriceps femoris weakness

Lasegue symptom

lack of an Achilles reflex

# SCIATIC NERVE NEUROPATHY

Wasserman symptom

+ loss of the Achilles reflex

prolapse of the knee

hypoesthesia on the outer anterior thigh

swelling in the outer ankle

# WHICH CLINICAL SIGNS OF PERONEAL NERVE DAMAGE:

+ paresis of the extensors of the foot

hypoesthesia on the inner surface of the leg

prolapse of the Achilles reflex

Wasserman symptom

swelling in the outer ankle

# THE CERVICAL PLEXUS INCLUDES:

small occipital nerve

large ear nerve

phrenic nerve

supraclavicular nerve

+ all listed

# THE BRACHIAL PLEXUS DOES NOT INCLUDE:

+ supraclavicular nerve

subclavian nerve

axillary nerve

ulnar nerve

median nerve

# WITH DYSFUNCTION OF THE TEMPOROMANDIBULAR JOINT OBSERVED:

parotid swelling

pain on palpation of the temporal muscle

+ limitation of jaw mobility

trigeminal neuralgia

hyperemia of the parotid region

# FOR PAINFUL MYOFASCIAL FACE DYSFUNCTION ARE CHARACTERISTIC:

+ soreness of the affected muscle when chewing and opening the mouth

hypoesthesia in th e area of ​​the affected muscle

the presence of painful nodules in the thickness of the chewing muscle

atrophy of the affected muscle

hyperemia of the affected muscle

# WHAT ARE A CAUSES OF TRIGEMINAL NEURALGIA:

diseases of the sinuses

compression of the n erve root with tortuous vessels on the base of the brain

compression of the nerve branches in the infraorbital canal of the maxillary

+ compression of the nerve branches in the jaw canal

all of the above

# WITH CLASSICAL TRIGEMINAL NEURALGIA OBSERVED:

permanent pain

hypalgesia on the face in the field of innervation of the II and III branches of the V nerve

+ trigger zones on the face

psychomotor agitation during an attack

swelling of the face

# FOR NEURALGIA OF THE EAR-TEMPORAL NERVE ARE CHARACTERISTIC:

the presence of trigger zones in the temple area

+ hyperemia of the parotid region

lacrimation

parotid anhydrosis

lack of an attack with food

# FOR NEURALGIA OF THE GLOSSOPHARYNGEAL NERVE ARE CHARACTERISTIC:

attacks of shooting pains in the root of the tongue, tonsils

taste disorder in the posterior third of the tongue

salivary dysfunction

+ violation of swallowing

all of the above is true

# FOR OCCIPITAL NERVE NEURALGIA IS CHARACTERISTIC:

parotid pain

+ pain in the back of the head with irradiation in the shoulder girdle

pain on palpation of the spinous processes of C3-C7

neck muscle tension

all of the above

# THE MOST EFFECTIVE METHOD FOR THE PATHOGENETIC TREATMENT OF TRIGEMINAL NEURALGIA IS TO PRESCRIBE:

analgesics

antispasmodics

antidepressants

tranquilizers

+ anticonvulsants

# FOR MUSCULE SCALENUS SYNDROME ARE CHARACTERISTIC:

increased pain in the forearm and II, III fingers when turning the head to the sore side

+ increased pain in the forearm and IV, V fingers of the hand when turning the head to a healthy side

lack of pulse on the radial artery

diffuse osteoporosis of the hand

hypotrophy of hypotenar

# FOR PERIOSTITIS OF THE EXTERNAL EPICONDYLE OF THE HUMERUS (EPICONDYLOSIS) ARE CHARACTERISTIC

soreness of all movements in the shoulder joint

+ soreness when extension and rotation of the forearm in the elbow joint

narrowing of the joint space of the shoulder joint

hypotrophy of the deltoid muscle

weak extension of the V and IV fingers

# FOR THE SHOULDER-WRIST SYNDROME, THE FOLLOWING ARE CHARACTERISTIC:

+ vegetative trophic disorders of the hand

asymmetry of blood pressure

hypotrophy of the sternocleidomastoid muscle

narrowing of the joint space of the shoulder joint

all of the above is true

# FOR THE POSTERIOR CERVICAL SYMPATHETIC SYNDROME ARE CHARACTERISTIC:

+ a combination of cochleovestibular, visual, vestibulo-cerebellar disorders with a pulsating, burning unilateral headache

a combination of bilateral occipital headache with radicular sensory disorders in the ulnar region

a combination of burning pain in the supraclavicular region with bouts of muscle weakness in the arm

a combination of burning pain in the supraclavicular region with weakening of the temporal artery pulse

attacks of cochleovestibular, visual and vestibulo-cerebellar disturbances when turning the head

# SYNCOPE VERTEBRAL (VERTEBRAL) SYNDROME (UNTERHARSCHEIDT) IS CHARACTERIZED BY:

SUDDEN DROP IN THE PATIENT WITH A SHARP CHANGE IN BODY POSITION FROM HORIZONTAL TO VERTICAL WITH A DROP IN BLOOD PRESSURE

+ sudden loss of consciousness and muscle tone associated with movement of the head and neck

sudden attack of cochleovestibular, coordinating and visual disturbances associated with turning the head and neck

paroxysm of cochleovestibular, visual, vestibulo-cerebellar disorders with subsequent loss of consciousness

a combination of cochleovestibular, visual, vestibulo-cerebellar disorders with a pulsating, burning unilateral headache

# FOR VERTEBROGENIC VASCULAR CERVICAL MYELOPATHY CHARACTERIZED BY:

severe pelvic dysfunction

+ mixed upper paraparesis in combination with spastic lower paresis

gross muscle atrophy of the lower extremities

dysarthria, dysphagia, dysphonia

lack of sensitive disorders

# FOR COMPRESSION OF THE ROOT C7 ARE CHARACTERISTIC:

+ pain and paresthesia in the III finger of the hand, loss of reflex from the triceps of the shoulder muscle

pain and paresthesia in the area of ​​the I finger of the hand, loss of reflex from the biceps of the shoulder muscle

pain in the area of ​​the fifth finger of the hand, prolapse of the carporadial reflex

pain in the elbow joint

weak extension of the brush

# FOR V ASCULAR CONE SYNDROME ARE CHARACTERISTIC:

urinary retention

+ anesthesia in the anogenital zone

lower flaccid paraparesis

absence of Achilles reflexes

all of the above

# WHAT IS PLATYBASIA

+ flattening of the slope of the occipital bone

funnel-shaped depression in the occipital foramen

fusion of the 1st cervical vertebra with the occipital bone

cerebellar tonsil displacement

fusion of the cervical vertebrae

# WHAT IS THE ARNOLD-CHIARI ANOMALY:

fusion of the cervical vertebrae

fusion of the 1st cervical vertebra with the occipital bone

+ displacement down the tonsils of the cerebellum

cleavage of the arch of the I cervical vertebra

flattening of the stingray

# THE CLINICAL PICTURE OF PONYTAIL ROOT COMPRESSION IS DIFFERENT FROM CONE AND EPICONE COMPRESSION:

+ asymmetry of the lesion

lack of pain

lower flaccid paraparesis

violation of the functions of the pelvic organs

all of the above

# L5 ROOT COMPRESSION SYNDROME IS MANIFESTED:

pain on the inner surface of the leg and thigh

+ weakness of extensors of the first toe

decreased achilles reflex

decreased knee reflex

all of the above

# ROOT COMPRESSION SYNDROME S 1 IS MANIFESTED:

a decrease in the strength of the triceps muscle of the lower leg and flexor of the toes of the toes

decreased knee reflex

+ loss of the Achilles reflex

hip abduction

hip extension

# FOR TUBERCULOUS SPONDYLITIS ARE CHARACTERISTIC:

spinal scoliosis

spinal kyphosis

sphenoid deformity of the vertebrae

destruction of vertebral bodies

+ all of the above

# FOR OSTEOCHONDROSIS AT A YOUNG AGE ARE CHARACTERISTIC:

+ pronounced radicular pain syndrome

severe osteoporosis of the spine

pronounced phenomena of osteochondrosis on the radiograph of the spine

sphenoid deformity of the vertebrae

pronounced phenomena of spondylosis in a radiograph of the spine

# FOR SPONDYLITIS (ANKYLOSING SPONDYLITIS) ARE CHARACTERISTIC:

vertebral osteoporosis

+ sacroileitis

thoracic scoliosis

destruction of the lumbar vertebral bodies

hernia of Schmorl

# WITH CHARCOT-MARIE NEURAL AMYOTROPHY OBSERVED:

+ distal amyotrophy of limbs

proximal amyotrophy of limbs

amyotrophy of the body

gastrocnemius pseudohypertrophy

fibrillar jerking

# WHAT ARE THE CHARACTERISTIC RADIOLOGICAL SIGNS OF HORMONAL SPONDYLOPATHY :

foci of destruction in the vertebral bodies

+ diffuse osteoporosis of the vertebrae

deforming spondylosis

marginal growths of the end plates of the vertebrae

all listed

# WHICH AREA OF POSSIBLE COMPRESSION OF THE MEDIAN NERVE:

+ "shoulder channel"

spiral channel

external intermuscular septum of the shoulder

Guyon's bone-fibrous canal

all listed

# FOR A TUMOR OF THE PREMOTOR REGION OF THE FRONTAL LOBE ARE CHARACTERISTIC:

hemipa resis with a predominance in the leg,

motor aphasia

reverse epileptic seizures,

optic atrophy on the side swollen,

+ all of the above

# THE REMITTING COURSE OF PRIMARY TUMORS OF THE SPINAL CORD IS DETERMINED MOST OFTEN WHEN THEY ARE LOCALIZED IN:

+ lumbar

cervical spine

ponytail areas

thoracic region

cervical and thoracic.

# THE REMITTING COURSE OF SPINAL TUMORS IS MOST OBSERVED A HUNDRED:

with angioreticulomas,

+ for gliomas

with meningiomas

with neuromas,

with ependymomas,

# WHAT ARE THE PRIMARY TUMORS OF TH E SPINAL CORD, THE MOST RARE :

gliomas

+ hemangiomas

neuromas

meningiomas

astrocytomas

# FOR THE INTRAMEDULLARY SPINAL TUMOR, THE PRESENCE OF:

+ segmental dissociated disorder

radicular pain position

early blockade of the subarachnoid space

radiological symptom of Elsberg - Dyke

seismic ataxia

# SPONDYLOGRAPHY IS THE LEAST INFORMATIVE IF A SPINAL CORD TUMOR IS LOCALIZED:

+ intramedullary

subdurally

epidural

epiduralio-extravertebral

subdural and epidural

# EXTRAMEDULLARY TUMORS OF THE SPINAL CORD ARE MOST OFTEN LOCATED ON IT:

anterolateral surface

back surface

+ back and back side surface

front surface

side surface

# THE MOST SIGNIFICANT INCREASE IN PROTEIN IN CEREBROSPINAL FLUID IS OBSERVED:

with intramedullary tumors of the cervical thickening

with extramedullary subdural tumors of the chest level

with intramedullary tumors at the level of lumbar thickening

+ for horse tail tumors

with extramedullary subdural tumors at the level of lumbar thickening

# THE MOST COMMON NEUROMAS OF THE NERVE:

visual

trigeminal

+ auditory

sublingual

additional

# GENERALIZED EPILEPTIFORM SEIZURES ARE MORE LIKELY TO OCCUR WHEN THE TUMOR IS LOCALIZED IN THE FOLLOWING LOBE OF THE BRAIN:

frontal

temporal

+ parietal

occipital

parietal and occipital

# GENERALIZED EPILEPTIFORM SEIZURES ARE MORE LIKELY TO OCCUR WHEN THE TUMOR IS LOCALIZED IN THE FOLLOWING LOBE OF THE BRAIN:

frontal

+ temporal

parietal

occipital

parietal and occipital

# ADVERSIVE SEIZURES WITH A VIOLENT TURN OF THE HEAD TO THE HEALTHY SIDE MORE OFTEN OCCUR WHEN THE TUMOR IS LOCALIZED IN THE FOLLOWING LOBE OF THE BRAIN:

+ frontal

parietal

temporal

occipital

parietal and occipital

# THE SYMPTOM OF RADICULAR PAIN OF THE POSITION IS MOST CHARACTERISTIC OF:

epidural neuromas

+ subdural neurin

epidural meningiomas

subdural meningiomas

epidural neuromas and subdural meningiomas

# ECHO-ENCEPHALOSCOPY IS MOST INFORMATIVE WHEN A TUMOR IS LOCALIZED IN:

+ temporal lobe

posterior cranial fossa

brain stem

occipital lobe

frontal lobe

# THE HIGHEST LEVEL OF ACCUMULATION OF RADIOPHARMACEUTICAL DURING G-SCINTIGRAPHY IS CHARACTERISTIC OF:

+ for meningiomas

for craniopharyngiomas

for pituitary adenomas

for neuroma

for astrocytoma

# NEUROMA OF THE VIII NERVE DIFFERS FROM OTHER TUMORS OF THE POSTERIOR CRANIAL FOSSA:

early development of hypertension-hydrocephalic syndrome

early vision loss

blanching of the optic nerves

+ pronounced protein-cell dissociation

increased symptoms with a change in head position

# WITH A TEMPORAL LOBE TUMOR, THE SIDE OF THE LESION CAN BE DETERMINED BY:

large seizures

absences

visual hallucinations

+ upper quadrant hemianopsia

blanching of the optic disc

# FOR A TUMOR OF THE TEMPORAL LOBE OF THE DOMINANT HEMISPHERE IS CHARACTERISTIC:

motor, sensory aphasia

+ sensory, amnestic aphasia

motor, semantic aphasia

sensory aphasia, autotopnosia

motor aphasia, autotopnosia

# WHAT IS THE DIFFERENTIAL SIGN OF A TUMOR OF THE SUPERIOR PARIETAL LOBULE:

pyramidal hemiparesis with a predominance in the hand

contralateral hemigipalgesia

+ contralateral pain hemiparesthesia

contralateral homonymous hemianopsia

amnestic aphasia

# WHAT ARE THE EARLIEST SYMPTOMS OF A FRONTAL CALLUS TUMOR:

bilateral pyramidal paresis in the legs

impaired coordination

astasia-abasia

+ violation of behavior

bitemporal visual field defects

# WHAT IS THE APHATIC DISORDERS WITH A TUMOR OF THE LOWER PARIETAL LOBE:

motor aphasia

sensory aphasia

+ semantic aphasia

amnestic aphasia

sensorimotor aphasia

# EXTRASELLAR GROWTH AND SIGNS OF DECREASED PITUITARY FUNCTION ARE CHARACTERISTIC OF PITUITARY ADENOMAS OF THE FOLLOWING HISTOLOGICAL TYPE:

eosinophilic

basophilic

+ chromophobic

eosinphilic and basophilic

basophilic and chromophobic

# FOR THE OPHTHALMIC STAGE OF SUPRASELLAR GROWTH OF THE PITUITARY ADENOMA, HEMIANOPSIA IS CHARACTERISTIC:

homonymous

binasal

+ bitemporal

quadrant

cortical

# PITUITARY ADENOMAS LEAD TO THE DEVELOPMENT OF ACROMEGALY:

+ eosinophilic

basophilic

chromophobic

chromophobic and basophilic

eosinophilic and chromophobic

# SIGNS OF ACROMEGALY WITH PITUITARY ADENOMA CAN BE REDUCED BY:

sodium bromide

+ bromocriptine

bromcamore

bromural

bromhexine

# AMONG TUMORS OF THE TURKISH SADDLE, CALCIFICATION IS MORE OFTEN OBSERVED IN:

pituitary adenoma

+ craniopharyngioma

turkish saddle tubercle arachioidendothelioma

optic nerve glioma

meningioma

# RAPID ASEPTIC MENINGITIS OCCURS WHEN A CYST BREAKS AND EMPTIES:

eosinophilic adenoma

basophilic adenoma

chromophobic adenoma

+ craniopharyngiomas

astrocytomas

# BURDENKO-CRAMER SYNDROME (PAIN IN THE FRONTO-ORBITAL REGION, PHOTOPHOBIA AND LACRIMATION) WITH TUMORS OF THE POSTERIOR CRANIAL FOSSA DUE TO:

compression of the structures of the anterior cranial fossa with anteroposterior mixing of the brain

impaired cerebrospinal circulation with the proximity of the tumor to the midline

+ commonality of innervation of the structures of the anterior and posterior cranial fossa

brain stem compression

midbrain compression

# BITEMPORAL HEMIANOPSIA IN TUMORS OF THE POSTERIOR CRANIAL FOSSA DUE TO:

compression of chiasm in the anteroposterior dislocation of the brain

+ hydrocephalus III ventricle

circulatory disorders in chiasm

brain stem compression

the insertion of the tonsils of the cerebellum into the large occipital foramen

# THE FORCED POSITION OF THE HEAD WITH SUBTENTORIAL TUMORS IS LESS OFTEN OBSERVED WITH A TUMOR:

+ bridge-cerebellar angle

IV ventricle

cerebellar worm

cerebellar hemisphere

brain stem

# GERTWIG'S SYNDROME - MAGANDY WITH SUBTENTORIAL TUMORS IS LESS OFTEN OBSERVED WITH A TUMOR:

cerebellar worm

cerebellar hemisphere

+ bridge-cerebellar angle

Varoliev bridge

midbrain

# GERTWIG'S SYNDROME - MAGANDY WITH SUPRATENTORIAL TUMORS OFTEN OCCURS WITH A TUMOR:

pituitary gland

+ pineal gland (pineal gland)

temporal lobe

occipital lobe

frontal lobe

# WHAT IS THE SIGN OF TUMOR OF THE LOWER PARTS OF THE CEREBELLAR WORM (FLOCCULO-NODULAR SYNDROME):

violation of statics and gait

limb disorder

+ trunk ataxia without discoordination in the limbs

lower pyramidal paraparesis

vertical nystagmus

# FOR TUMORS OF THE CENTRAL NERVOUS SYSTEM OF THE VASCULAR SERIES:

astrocytomas

oligodendrogliomas

multiform spongioblastomas

+ arachnoidendoteleomas

all listed

# EARLY SYMPTOMS OF ARACHNOIDENDOTHELIOMA OF THE TURKISH SADDLE TUBERCLE INCLUDE:

sense of smell reduction

headache

+ decrease in vision

Weber's alternating syndrome

visual hallucinations

# FOR VISUAL DISTURBANCES WITH ARACHNOIDENDOTHELIOMA, THE JOCK SADDLE IS CHARACTERIZED BY:

central and paracentral scotoma

homonymous hemianopsia

+ bitemporal hemianopsia

binasal hemianopsia

quadrant hemianopsia

# WITH CONVEXITAL LOCALIZATION OF A TUMOR OF THE TEMPORAL LOBE LUCINATION, THERE ARE MORE OFTEN:

visual

+ auditory

olfactory

flavoring

tactile

# WHAT IS HALLUCINATION OF A TUMOR TEMPORAL LOBE OF BASAL LOCALIZATION:

visual

auditory

+ olfactory

flavoring

tactile

# COMPUTED TOMOGRAPHY IS MOST INFORMATIVE WHEN A TUMOR IS LOCALIZED:

+ in the hemispheres of the brain

in the basal area of ​​the brain

in the posterior cranial fossa

in the craniovertebral region

in the basal area of ​​the brain and craniovertebral region

# THE PRIMARY SOURCE OF CNS METASTATIC TUMORS IS MORE OFTEN CANCER:

+ lung

the stomach

breast

uterus

p rostate gland

# VOMITING IN SUPRATENTORIAL TUMORS IS CONSIDERED A CEREBRAL SYMPTOM, AS IT OCCURS:

out of touch with food

regardless of a change in body position

after a short feeling of nausea

+ with increased intracranial pressure

when turning your head.

# A DISTINCTIVE SIGN OF OPTIC NEURITIS FROM NERVE DAMAGE IN BRAIN TUMORS:

blurred vision complaints

concentric narrowing of visual fields

+ rapid decrease in visual acuity

picture of primary optic atrophy

optic nerve edema

# DUE TO THE LESSER EFFECT ON THE ELECTROLYTE BALANCE, FOR THE TREATMENT OF CEREBRAL EDEMA IN SEVERE TRAUMATIC BRAIN INJURY SHOULD BE USED:

hydrocortisone

prednisone

+ dexamethasone

cortisone

lasix

# TO CORRECT A FALL IN CARDIAC ACTIVITY IN ACUTE SEVERE TRAUMATIC BRAIN INJURY, IT IS ADVISABLE TO:

adrenaline

norepinephrine

mesatone

+ dopamine

sulfocamphocaine

# WHAT ARE THE MOST EFFECTIVE CORRECTORS OF HYPERMETABOLISM IN SEVERE TRAUMATIC BRAIN INJURY:

MAO inhibitors

tricyclic antidepressants

antipsychotics

+ barbiturates

all listed drugs

# TO STOP PSYCHOMOTOR AGITATION IN SEVERE TRAUMATIC BRAIN INJURY, APPLY:

diazepam

chlorpromazine

propazine

hexenal

+ any of the listed drugs

# WHAT IS THE ANTIBIOTICS, THE GREATEST ABILITY TO PENETRATE THE BBB:

cephalexin

clindamycin

rifampicin

+ ceftriaxone

erythromycin

# FOR THE TREATMENT OF HYPEROSMOLAR SYNDROME IN SEVERE TRAUMATIC BRAIN INJURY, DO NOT USE:

+ mannitol

reopoliglyukin

polyglucin

albumen

5% glucose solution

# WHAT IS THE DRUG HAS THE PREDOMINANT DEHYDRATING EFFECT IN RELATION TO AREAS OF THE BRAIN WITH EDEMA THAN WITHOU T EDEMA FOR TRAUMATIC BRAIN INJURY :

mannitol

glycerol

lasix

+ albumin

polyglucin

# TO CORRECT A DEFICIENCY OF DOPAMINERGIC ACTIVITY WHEN LEAVING THE ACUTE PERIOD OF SEVERE TRAUMATIC BRAIN INJURY (APALIC OR AKINETO-RIGID SYNDROME), THE FOLLOWING IS PRESCRIBED:

cyclodol

piracetam

encephabol

haloperidol

+ nakom

# THE "DAYTIME" TRANQUILIZERS INCLUDE:

midazolam (flormidal)

nitrazepam (eunctin)

diazepam (relanium)

+ tofizepam (grandaxin)

lorazepam (merlite)

# NOOTROPIC DRUGS FOR TRAUMATIC BRAIN INJURY CAN BE USED:

3 days after injury

one week after the injury

in the residual period

+ at any time

contraindicated

# IF YOU ARE ALLERGIC TO PENICILLIN, YOU SHOULD NOT PRESCRIBE:

gentamicin

+ ampioks

biomycin

chloramphenicol

morphocycline

# IN THE TREATMENT OF SEVERE TRAUMATIC BRAIN INJURY IN THE ACUTE PERIOD, INTRAVENOUS INFUSION IS INDICATED FOR THE CORRECTION OF METABOLIC ACIDOSIS:

5% glucose solution

+ 4% sodium bicarbonate solution

a solution of a polarizing mixture

reopoliglyukina

polyglucin

# IN CASE OF COMBINED TRAUMATIC BRAIN INJURY FOR THE TREATMENT OF ARTERIAL HYPOTENSION AS A RESULT OF BLOOD LOSS, PREFERENCE IS GIVEN TO THE APPOINTMENT:

cardiotonic agents

sympathomimetics

+ low molecular weight dextrans

osmotic diuretics

glucocorticoids

# WHAT IS THE CONTRAINDICATION FOR PHYSIOTH ERAPY IN PATIENTS WITH STROKE

violation of all types of sensitivity on the side of hemiplegia

sharp joint pain

dysfunction of the pelvic organs

+ heart failure II-III art.

lack of coordination

# DRUG POLYNEUROPATHY CAN CAUSE

cytostatics

tuberculostatic drugs

nitrofurans (furazolidone, furadonin)

antimalarial drugs

+ drugs of all listed groups

# DRUG MYOPATHIC SYNDROME DOES NOT CAUSE

corticosteroids

chloroquine

aminoglycosides

+ anticholinesterase drugs

all listed drugs

# PSYCHOPATHOLOGICAL SIDE EFFECTS CAN CAUSE:

corticosteroids

anticonvulsants

antiparkinsonian drugs

central antihypertensive drugs

+ all listed drugs

# MAO INHIBITORS INCLUDE:

+ nuredal, bellazone

chlorpromazine, tizercin

Seduxen, Radoredorm

amitriptyline, tryptisol

L-dopa

# ANTIPSYCHOTICS OF THE BUTYROPHENONE SERIES INCLUDE:

chlorpromazine, tizercin

triftazine, frenolone

meller, sonopax

+ haloperidol, droperidol

leponex, sulpiride

# NEUROLEPTIC EFFECT OF CHLORPROMAZINE DUE TO RECEPTOR BLOCKADE:

adrenaline

norepinephrine

+ dopamine

acetylcholine

serotonin

# ANTIPSYCHOTICS CAN CAUSE THE FOLLOWING EXTRAPYRAMIDAL DISORDERS:

akinesia and rigidity

chorea athetosis

oromandibular dyskinesia

+ athetosis

all of the above is true

# WHEN TREATED WITH ANTIPSYCHOTICS WITH A STRONG ANTIPSYCHOTIC EFFECT, THEY OFTEN DEVELOP:

cerebellar disorders

+ extrapyramidal disorders

vestibular disorders

coordination disorders

auditory and visual hallucinations

# SEDATIVE ANTIDEPRESSANTS INCLUDE:

melipramine

pyrazidol

indopan

+ amitriptyline

all listed drugs

# CHOLINERGIC CRISIS IS REMOVED BY THE INTRODUCTION OF:

ganglion blocking agents

muscle relaxants

+ atropine

adrenaline

norepinephrine

# THE FOLLOWING SYMPTOMS: PSYCHOMOTOR AGITATION, MYDRIASIS, ACCOMMODATION PARALYSIS, TACHYCARDIA, DECREASED SECRETION OF SALIVARY GLANDS, DRY SKIN, ARE OVERDOSE MANIFESTATION:

+ atropine

proserin

acetylcholine

pilocarpine

galantamine

# MUSCLE RELAXANTS USE:

with the introduction of a nasogastric tube

with catheterization of the bladder

+ with tracheal intubation

with spasm of the pylorus

with bronchospasm

# A-BLOCKERS INCLUDE:

anaprilin

obzidan

inderal

trasicore

+ phentolamine

# TREATMENT OF HEPATOCEREBRAL DYSTROPHY WITH PENICILLAMINE BEGINS WITH THE APPOINTMENT:

+ small doses with a gradual increase

high doses with a gradual decrease

long-term use of medium doses

high doses every other day

# REDUCES THE DEPTH OF SLEEP, AND THEREFORE IS USED IN THE TREATMENT OF ENURESIS:

amitriptyline

+ sydnocarb

pipolfen

piracetam

aminalon

# DRUGS THAT REDUCE THE DEPTH OF SLEEP SHOULD BE GIVEN WITH ENURESIS:

during the whole day

morning and afternoon

+ for the night

morning and evening

in the afternoon

# SANATORIUM-RESORT TREATMENT OF A PATIENT WITH FACIAL NEURITIS BEGINS:

from the first days of the disease

+ after 1-2 months from the onset of the disease

after 6 months from the onset of the disease

after 1 year from the onset of the disease

at any time, regardless of the duration of the disease

# THE TOXIC EFFECT OF HBO ON THE NERVOUS SYSTEM IS MANIFESTED:

impaired consciousness

+ development of epileptiform seizures

the development of hyperkinesis

development of akinesia and rigidity

vegetative vascular crises

# BIOAVAILABILITY OF LEVODOPA (PASSAGE OF THE BBB) IN COMBINATION WITH A PERIPHERAL DOPADECARBOXYLASE INHIBITOR INCREASES:

2 times

3 times

4 times

+ 5 times

6 times

# IN THE ACUTE PERIOD OF NEUROPATHIES, IT IS IMPRACTICAL TO APPLY:

electrophoresis of novocaine

+ electrical stimulation

microwave

diadynamic currents

all of the above

# THE MOST EFFECTIVE METHOD FOR THE PATHOGENETIC TREATMENT OF TRIGEMINAL NEURALGIA IS TO PRESCRIBE:

analgesics

antispasmodics

+ anticonvulsants

all of the above

none of the above

# ACUPUNCTURE WITH POLYNEUROPATHY OF GUILLAIN - BARRÉ IS PRESCRIBED DURING:

growth of paresis

+ stabilization of paresis

regression of paresis

all of the above is true

# IN THE ACUTE PERIOD OF VERTEBRAL RADICULAR SYNDROMES USED:

massage

spinal traction

+ acupuncture

paraffin application

mud therapy

# WHAT IS THE CONTRAINDICATION FOR THE USE OF TRACTION IN THE NEUROLOGICAL MANIFESTATIONS OF CERVICAL OSTEOCHONDROSIS:

spinal instability

spinal circulation disorder

pronounced radicular pain

vertebrobasilar insufficiency

+ all of the above

# INDICATION FOR MANUAL THERAPY OF NEUROLOGICAL MANIFESTATIONS OF OSTEOCHONDROSIS OF THE SPINE IS THE PRESENCE OF:

spondylosis and stage III spondylolisthesis

+ pain and vegetative-visceral disorders

vertebral osteoporosis

spinal circulatory disorders

hernia of Schmorl

# WHAT ARE THE FIRST-CHOICE DRUGS FOR THE ETIOTROPIC THERAPY OF ATHEROSCLEROTIC ENCEPHALOPATHY WITHOUT ARTERIAL HYPERTENSION:

antiplatelet agents

antioxidant agents

+ antihyperlipoproteinemics

nootropic drugs

all of the above is true

# WHAT ARE THE INDICATIONS FOR THE APPOINTMENT OF DEHYDRATING AGENTS FOR ISCHEMIC STROKE:

+ severity of cerebral symptoms

hypovolemia

hypercoagulopathy

combination of hypovolemia with hypercoagulopathy

the presence of hemiplegia

# INDICATION FOR HYPERVOLEMIC HEMODILUTION IN ISCHEMIC STROKE IS THE PRESENCE OF:

anuria

heart failure

blood pressure below 120/60 mm Hg st

blood pressure over 204/104 mm RT. st

+ hematocrit 52%

# WHAT FIBRINOLYTIC DRUGS CAN BE PRESCRIBED TOGETHER WITH HEPARIN IN THE TREATMENT OF CEREBRAL ARTERIAL OBSTRUCTION?

+ streptokinase

fibrinolysin

urokinase

any of the listed

none of the listed

# ANTICOAGULANTS FOR ISCHEMIC STROKE ARE NOT CONTRAINDICATED IN THE PRESENCE OF:

+ rheumatism

blood pressure over 204/104 mm RT. st

liver diseases

peptic ulcer

thrombocytopathy

# A CRITERION FOR EFFECTIVE HEMODILUTION IN THE ACUTE STAGE OF ISCHEMIC STROKE IS CONSIDERED TO BE A DECREASE IN HEMATOCRIT TO THE LEVEL OF:

45-60%

36-44%

+ 30-35%

20-29%

less than 20%

# WITH HYPERTENSIVE HEMORRHAGE IN THE BRAIN, THE USE OF ANTIFIBRINOLYTICS (EPSILONAMINOCAPROIC ACID, ETC.) IS CONTRAINDICATED, SINCE:

high risk of high blood pressure

significant increase in intracranial pressure is possible

+ hemorrhage has already ended

possibly increased cephalgic syndrome

possible development of thrombosis

# WHAT TO CHOOSE FOR DEHYDRATING THERAPY FOR HYPERTENSIVE CEREBRAL HEMORRHAGE WITH AN ARTERIAL PRESSURE OF 230/130 MM HG. AND OSMOLARITY OF BLOOD ABOVE 304 MOSM

urea

corticosteroid drugs

mannitol

+ lasix

magnesium sulfate

# WHAT IS THE CONTRAINDICATION TO TRANSPORTATION TO A NEUROLOGICAL HOSPITAL OF A PATIENT WITH HYPERTENSIVE HEMORRHAGE IN THE BRAIN:

loss of consciousness

vomiting

psychomotor agitation

myocardial infarction

+ pulmonary edem

# IN THE CONSERVATIVE TREATMENT OF SUBARACHNOID HEMORRHAGE FROM ANEURYSM IS PRESCRIBED FROM THE FIRST DAY:

fibrinolysin

heparin

+ epsilonaminocaproic acid

mannitol

magnesium sulfate

# IF THE COURSE OF HEMORRHAGIC STROKE IS COMPLICATED BY DISSEMINATED INTRAVASCULAR COAGULATION, ADDITIONALLY APPOINT:

a-tocopherol and rutin

fibrinolysin and kallikrein depot

epsilonaminocaproic acid

+ heparin and frozen plasma

all of the above

# VITAMIN E IN ACUTE CEREBROVASCULAR ACCIDENT IS PRESCRIBED TO:

lactic acidosis correction

hypercoagulation correction

correction of hyperaggregation

+ inhibitory activation of lipid peroxidation

inhibition of activation of the antifibrinolytic system

# WHEN DECOMPENSATING HYPERTENSIVE DISCIRCULATORY ENCEPHALOPATHY, THE APPOINTMENT OF DEHYDRATING AGENTS IS IMPRACTICAL IF:

arterial hypertension

cerebral symptoms

+ hypercoagulation

hypertensive headache

optic nerve marginal edema

# IN THE TREATMENT OF VEGETATIVE-VASCULAR DYSTONIA IN THE FORM OF CRANIOCEREBRAL VENOUS INSUFFICIENCY, THEY HAVE A SIGNIFICANT ADVANTAGE:

B-adrenergic blockers

anticoagulants

antiplatelet agents

+ xanthine preparations

nootropic drugs

# THE MOST EFFECTIVE ANTIBIOTIC (LISTED) IN THE TREATMENT OF PURULENT MENIN-GIT CAUSED BY Pseudomonas aeruginosa is:

benzylpenicillin

clindamycin

erythromycin

+ gentamicin

kanamycin

# WITH AN UNKNOWN PATHOGEN OF BACTERIAL PURULENT MENINGITIS, IT IS ADVISABLE TO USE:

cephalexin (tseporex)

clindamycin (dalacin)

erythromycin (erythran)

+ cefotaxime (claforan)

cephalotin (keflin)

# TO TREAT MENINGOCOCCAL MENINGITIS, YOU SHOULD CHOOSE:

clindamycin

tetracycline

erythromycin

kanamycin

+ chloramphenicol

# WHAT IS THE FIRST CHOICE DRUGS FOR TREATMENT OF GENERALIZED PAINFUL MUSCLE CRAMPS AND SEIZURES IN TETANUS :

chloral hydrate

thiopental

phenobarbital

+ seduxen

tubocurarine

# TO PREVENT EXACERBATIONS OF MULTIPLE SCLEROSIS, IT IS ADVISABLE TO ASSIGN:

+ a-interferon

b-interferon

g-interferon

combination of a and d interferon

combination of a and g-interferon

# FOR REMISSION OF MULTIPLE SCLEROSIS, THE USE OF:

+ immunostimulants

plasmapheresis

glucocorticoids

cytostatics

immunostimulants in combination with cytostatics

# IN CASE OF EXACERBATION OF MULTIPLE SCLEROSIS (T-LYMPHOPENIA, B-LYMPHOCYTOSIS), IT IS PREFERABLE TO PRESCRIBE:

+ glucocorticoid drugs

cytostatics (azathioprine, cyclophosphamide)

stimulators of B-lymphocytes (propermil, zymosan, pyrogenal)

g-interferon

complex treatment with these agents

# TO CORRECT PATHOLOGICAL MUSCLE SPASTICITY IN MULTIPLE SCLEROSIS, IT IS ADVISABLE TO PRESCRIBE ONE OF THE FOLLOWING GABA-ERGIC DRUGS

aminalon

phenibut

+ baclofen

pantogam

sodium hydroxybutyrate

# FOR THE TREATMENT OF CHRONIC ADRENAL INSUFFICIENCY IS USED:

glucocorticoid therapy

+ continuous glucocorticoid therapy

only emergency administration of glucocorticoids in the development of addison crisis,

ACTH

all of the above

# THE SEQUENCE OF DRUG SELECTION AT THE BEGINNING OF EPILEPSY TREATMENT IS DETERMINED BY:

+ type of seizure

form of epilepsy

seizure frequency

EEG features

all of the above

# AMONG ANTIEPILEPTIC DRUGS TO A LESSER EXTENT INHIBITS CORTICAL FUNCTIONS:

+ carbamazepine

phenobarbital

benzonal

hexamidine

diphenin

# WITH FREQUENT SEIZURES OF PRIMARY GENERALIZED EPILEPSY AT THE BEGINNING OF TREATMENT SHOULD BE PRESCRIBED:

maximum dose of one drug

+ minimum dose of one selected drug with a gradual increase in dose

combination of minimum doses of two or three main antiepileptic drugs

a combination of the average therapeutic dose of one main drug and one of the additional

the maximum dose of the main drug and the minimum dose of additional

# FOR THE TREATMENT OF SLEEP EPILEPSY, IT IS ADVISABLE TO:

+ carbamazepine

hexamidine

valproic acid

phenobarbital

diphenin

# WHAT IS THE FIRST MEASURE OF CARE FOR A PATIENT WITH EPILEPTIC STATUS :

head immobilization

limb immobilization

insertion of the duct into the oropharynx

+ giving inhaled anesthesia with nitrous oxide

Relanium Injection

# DOPAS-CONTAINING DRUGS FOR THE TREATMENT OF PARKINSON'S DISEASE INCLUDE:

midantan, viregit

+ nakom, madopar

parlodel, lisuride

yumex, deprenyl

pronoran

# IN THE TREATMENT OF PARKINSON'S DISEASE, THE DAILY DOSE OF L-DOPA SHOULD NOT EXCEED:

2 g

2.5 g

+ 3g

3.5 g

4g

# TREATMENT WITH ANTICHOLINERGIC DRUGS OF PARKINSON'S DISEASE IS CONTRAINDICATED IF THE PATIENT:

cataract

+ glaucoma

hypertensive retinopathy

diabetic retinopathy,

all listed diseases

# FOR THE TREATMENT OF THE HYPERKINETIC FORM OF HUNTINGTON'S CHOREA:

dopas-containing preparations

+ antipsychotics

anticholinergics

dopamine agonists

amantadines

# TO PREVENT AN ATTACK OF "MENSTRUAL" MIGRAINE, IT IS ADVISABLE TO PRESCRIBE:

a-blockers

B-blockers

antiserotonin preparations

+ non-steroidal anti-inflammatory drugs

# IN THE TREATMENT OF CHRONIC PAROXYSMAL HEMICRANIA IS MOST EFFECTIVE:

aspirin

+ indamethacin

ergotamine

anaprilin

reserpine

# MOST OFTEN, COGNITIVE DECLINE IN DEPRESSION IS ASSOCIATED WITH DYSFUNCTION:

Hippocampus

Tonsils

+ Frontal lobe

Temporal lobe

# ATROPHY of which structure is most typical for long-term depression:

Frontal cortex

Subcortical structures

Waist cortex

+ Hippocampus

# WHAT ANTIDEPRESSANTS ARE THE FIRST CHOICE IN TREATING DEPRESSION?

Tricyclic antidepressants

Monoamine Oxidase Inhibitors

Serotonin Stimulants and Modulators

+ Selective Serotonin Reuptake Inhibitors

# WHAT IS THE MINIMUM DURATION OF TREATMENT FOR DEPRESSION WITH ANTIDEPRESSANTS?

One month

Two month

+ Six months

Twelve months

# WHAT MAKES NEUROLEPTIC PARKINSONISM DIFFERENT FROM PARKINSON'S DISEASE?

Asymmetry of bradykinesia and rigidity

Prevalence of yeast forms

+ Acute or subacute development

Early onset of levodopa-induced dyskinesia

# WHAT SYMPTOMS ARE CHARACTERISTIC OF NEUROLEPTIC PARKINSONISM?

High effect of dopaminergic therapy

+ Lack of hyperechoogenicity of the substantia nigra during transcranial sonography

Progressive course

Hyposmia

# WHAT ARE THE FEATURES OF DEPRESSION IN PARKINSON'S DISEASE?

Dependence on the severity of the disease

High detection rates in male patients

High frequency of suicidal thoughts and actions

+ High frequency with akinetic-rigid forms of the disease

# WHAT DISTINGUISHES THE DEPRESSION OF THE “OFF” PERIOD FROM DEPRESSION THAT IS NOT ASSOCIATED WITH TAKING LEVODOPA DRUGS?

Lack of association with the severity of the disease

Relationship with disease duration

+ The presence of a connection with the appearance of dystonia of the “off” period

The appearance of benzodiazepines

# WHAT ARE THE RARE SYMPTOMS OF DEPRESSION IN PARKINSON'S DISEASE?

Gloom

Pessimism

Dysphoria

+ Suicidal actions

# WHAT IS THE FIRST APPROACH TO THE TREATMENT OF DOPAMINE DYSREGULATION SYNDROME IS CORRECT?

Prescribing atypical antipsychotics

Prescribing Antidepressants

+ Correction of dopaminergic therapy

Prescription of anticonvulsants

# WHAT IS THE MOST EFFECTIVE WAY TO TREAT ACUTE BACK PAIN

Diuretics

Laxatives

+ NSAIDs

Narcotic drugs

# WHAT IS THE MAIN FACTOR FOR TREATING CHRONIC PAIN?

Spine traction

Electrophoresis

Reflexology

+ Kinesiotherapy

4. Methodological recommendations for the use of the point-rating system.

As part of the implementation of the point-rating system for assessing the educational achievements of students in the discipline (module) in accordance with the regulation "On the point-rating system for assessing the educational achievements of students", the following rules for the formation

* the current actual rating of the student;
* bonus actual student rating.

A teacher in the discipline (module) or a person appointed by the head of the department from among the staff of the department, no later than one working day before the date of intermediate certification for the discipline (module), enters the values ​​of the current actual rating and bonus points (if any) in the list of calculating the disciplinary rating in accordance with the P Assumption P 076.02-2019 "on the forms, timing and procedure for ongoing monitoring of progress and interim assessment of students on educational programs of higher education - bachelor's Degree, specialty programs, graduate programs."

Deans provide control over filling out the disciplinary rating sheets in the IS of the University.

1. The current standardized rating (Pts) is expressed in points on a scale from 0 to 70 and is calculated using formula 1:

    Rts = (Rtf \* 70) / max (Rtf)                                       (1)

Where,

Rts - current standardized rating;

Ртф - current actual rating;

max (Rtf) - the maximum value of the current actual rating from the range set by the teacher for the discipline (module).

4.2 Determination of the exam / test rating by discipline (module)

1. The student's examination / test rating is formed during the intermediate certification and is expressed in points on a scale from 0 to 30.

Criteria for the formation of the examination / test rating of the student

The examination card contains three questions:

1 question. Testing. According to the test results, I scored over 70% - "passed" - 2 points, less than 70% "not credited" - 0 points;

2 question. Questions. There are 2 of them (1 in general neurology, 2 in private neurology), estimated from 0 points to 10 points (0-1-2-3-4-5 x 2 + 10 points maximum).

3 question. A task. Two tasks (clinical task and practical skill). Evaluated "passed" - 2 points, "not credited" - 0 points. Maximum 4 points.

The intermediate certification in the discipline is considered to be successfully passed by the student, provided that he receives an examination / test rating of at least 15 points and (or) the current standardized rating of at least 35 points.

If a student receives an examination / test rating of less than 15 points and (or) the current standardized rating of less than 35 points, the results of the interim certification in the discipline (module) are recognized as unsatisfactory and the student has academic debt. In this case, the student's disciplinary rating is not calculated.

4.3 Procedure for calculating the disciplinary rating

* 1. The student's disciplinary rating is formed during the intermediate certification in the discipline (module), practice and is the basis for determining the final grade in the discipline (module), practice according to a five-point system.
  2. The student's disciplinary rating is formed when the student successfully passes the intermediate certification in the discipline (module), practice.
  3. The disciplinary rating is given by the teacher who conducted the intermediate certification, depending on the form of the intermediate certification and the conditions for its conduct:
  4. in the examination (credit) statement for the discipline / practice;
  5. in the attestation sheet of the first ( second) repeated intermediate attestation;
  6. in the attestation sheet for passing the intermediate attestation according to an individual schedule;
  7. in the exam journal;
  8. in the examiner's log.
  9. The student's disciplinary rating is expressed in points on a 100-point scale and can be increased by the amount of bonus points (if any).
  10. The disciplinary rating for the discipline (module) of the student (Рд) is calculated as the sum of the current standardized rating (Ртс) and the examination (test) rating (Ре / Рз) according to the formula 4:

Рд = Ртс + Рэ / Рз (4)

Where:

Rts - current standardized rating;

Re / Rz - examination (test) rating.

* 1. The practice disciplinary rating is calculated in accordance with clauses 9.9-9.11 of this regulation.
  2. If a student has bonus points, the disciplinary rating for the discipline (module) is increased by the amount of these points.
  3. If the student successfully passes the intermediate certification in the discipline (module), the received disciplinary rating is transferred to a five-point system in accordance with Appendix 4.
  4. Based on the results of intermediate attestation in practice, the value of the credit rating is entered into the information system. The disciplinary rating, as well as the assessment on a five-point system, is determined automatically in accordance with Appendix 4 and is reflected in the practice scorecard.

REMINDER

for students on the use of the point-rating system for assessing educational achievements in the discipline

Students get acquainted with the point-rating system for assessing the results of mastering the discipline in the first lesson, against signature.

The final grade for the discipline is determined on the basis of the disciplinary rating (maximum 100 points) according to the translation table

|  |  |  |
| --- | --- | --- |
| BRS disciplinary rating | grade by discipline (module) | |
| Exam | offset |
| 86 - 105 points | 5 (excellent) | credited |
| 70 - 85 points | 4 (good) | credited |
| 50–69 points | 3 (satisfactory) | credited |
| 49 or less points | 2 (unsatisfactory) | not credited |

*The disciplinary rating*is the sum of the values ​​of the current, examination or test ratings and bonus points (if any).

As a result of assessment in the classroom in the discipline, the *current rating*is formed , which is expressed in points from 0 to 70.

Rules for the formation of the student's bonus rating

Bonus points are defined in the range from 0 to 5 points. The criteria for obtaining bonus points are:

- attendance by students of all practical classes and lectures - 2 points, when giving bonus points for attendance, only passes for a good reason are taken into account (donor certificate, participation from the Omsk State Medical University in sports, scientific, educational events of various levels);

- the results of the student's participation in the research work of the department:

\* performance of work + writing 1 thesis - 1 p, 2 - 2 p., 3-3 p ... up to 5 p .;

\* work execution + presentation preparation - 5 points;

\* implementation of a scientific literary review in the form of an abstract / presentation - 5 points;

\* implementation / creation of a program based on the results of research work - 5 points;

\* execution of educational film - participation - 1 point, 1-3 place - 5 points;

- The results of the subject Olympiad in the discipline under study, held at the department / in Russia: 1st place - 5 points, 2nd and 3rd place - 5 points, participation - 1 point.

Students no later than 1 working day before the date of the exam or test in the discipline get acquainted with the received value of the current rating and bonus points (entrance from the student's personal account) at the department.

Based on the results of a test or exam, a test *or examination rating is formed*in points from 0 to 30.

If the value of the *current rating is less than 35 points*and (or) the value of the *test or examination ratings is less than 15 points*, then the discipline is considered not mastered and, according to the results of the test and the exam, it is set as "not passed", "unsatisfactory", respectively.

The rules for transferring the discipline ranking by discipline to a five-point system.

|  |  |  |
| --- | --- | --- |
| disciplinary rating by discipline (module) | grade by discipline (module) | |
| differential test | offset |
| 86 - 105 points | 5 (excellent) | credited |
| 70 - 85 points | 4 (good) | credited |
| 50–69 points | 3 (satisfactory) | credited |
| 49 or less points | 2 (unsatisfactory) | not credited |

Appendix 5

(required)

Transfer table of the credit / examination rating to the disciplinary rating during the repeated intermediate certification

by discipline (module)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Re / s | Rd | Assessment | Re / s | Rd | Assessment | Re / s | Rd | Assessment |
| 15 | fifty | satisfactorily | 20 | 70 | well | 25 | 86 | fine |
| 16 | 54 | satisfactorily | 21 | 74 | well | 26 | 89 | fine |
| 17 | 59 | satisfactorily | 22 | 78 | well | 27 | 92 | fine |
| eighteen | 64 | satisfactorily | 23 | 82 | well | 28 | 95 | fine |
| 19 | 69 | satisfactorily | 24 | 85 | well | 29 | 98 | fine |
|  |  |  |  |  |  | thirty | one hundred | fine |

Table of conversion of credit rating to disciplinary rating

with re-intermediate certification

in practice

|  |  |  |
| --- | --- | --- |
| Rz | Rd | Assessment |
| five | 65 | credited |
| ten | 75 | credited |
| 15 | 85 | credited |

...