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Question: 1452

Tethered cord, MRI filum lipoma 4 mm. UDS overactivity. Tx threshold?

A. Age >5
B. Symptoms + abnormal UDS
C. >2 mm filum
D. MRI alone

Answer: B

Explanation: Detether if neurologic progression + abnormal UDS/MRI; asymptomatic normal UDS observe.

Question: 1453

A 4-year-old girl presents with incontinence, leg weakness, and hyperreflexia. MRI shows low conus (L4), thickened filum terminale (3 mm). UDS reveals detrusor overactivity, DLPP 45 cm H2O, normal compliance. What confirms tethered cord diagnosis?

A. Normal EMG on UDS
B. Low-lying conus and filum >2 mm on MRI
C. Normal DMSA scan
D. Grade 2 VUR

Answer: B

Explanation: Low-lying conus medullaris (2 mm diameter) on MRI confirm tethered cord syndrome diagnosis, causing traction-induced myelopathy manifesting as neurogenic bladder (overactivity 60%); detethering improves UDS in 50-70% if early.

Question: 1454

A 2-year-old with vesicoureteral reflux is scheduled for voiding cystourethrogram (VCUG). Parents are concerned about radiation exposure. What is the most appropriate counseling point?

A. VCUG should be replaced entirely with MRI in all cases
B. VCUG uses no ionizing radiation in modern equipment
C. Radiation exposure is negligible and equivalent to background radiation in one week
D. Radiation exposure is higher than abdominal CT scan in children

Answer: C

Explanation: VCUG uses low-dose fluoroscopy, and radiation exposure is generally low, often comparable to a few days to a week of background radiation. MRI is not yet a complete replacement due to functional limitations in real-time voiding assessment.

Question: 1455

A DSD patient with ambiguous genitalia requires initial workup. Key test?

A. CT brain

B. Karyotype and hormonal profile

C. ECG

D. Chest X-ray

Answer: B

Explanation: Genetic and endocrine evaluation is essential.

Question: 1456

A 10-year-old male with Cystic Fibrosis is found to have an inguinal hernia. During the repair, the surgeon notes the absence of the vas deferens on the side of the hernia. According to the embryology of the GU tract, which other structure is most likely to be absent or abnormal?

A. The prostatic utricle

B. The body and tail of the epididymis

C. The contralateral testis

D. The ipsilateral adrenal gland

Answer: B

Explanation: In CF-related vasal agenesis (CBAVD), the defect typically affects all Wolffian duct-derived structures. While the testis (germ cells and Leydig cells) is normal, the distal two-thirds of the epididymis (body and tail), the vas deferens, and the seminal vesicles are usually absent or atrophic. The head of the epididymis (caput) is often present as it arises from the efferent ductules (mesonephric tubules).

Question: 1457

A Crohn’s patient develops hydronephrosis. Mechanism?

A. Bladder tumor
B. Renal vein thrombosis
C. Congenital ureteral agenesis
D. Ureteral compression from inflammatory mass

Answer: D

Explanation: Inflammatory bowel disease can compress ureters externally.

Question: 1458

A 9-year-old child with spina bifida has persistent high-pressure bladder despite optimal medical therapy and catheterization. Serial ultrasounds show worsening hydronephrosis and declining renal cortical thickness. What is the most appropriate definitive surgical option?

A. Radical bladder removal with urinary diversion
B. Observation with increased antibiotic prophylaxis
C. Immediate unilateral nephrectomy
D. Augmentation cystoplasty to increase bladder capacity and compliance

Answer: D

Explanation: In refractory high-pressure neurogenic bladder, augmentation cystoplasty is indicated to create a low-pressure reservoir. This protects renal function and improves continence. Nephrectomy does not address underlying

bladder pathology.

Question: 1459

A 10-year-old boy develops severe abdominal pain after PCNL. CT demonstrates retroperitoneal fluid with elevated creatinine concentration and no bowel contrast extravasation. Which complication is most likely?

A. Chyloretroperitoneum from lymphatic injury
B. Retroperitoneal urinoma from collecting system leak
C. Retroperitoneal sarcoma after tract dilation
D. Subcapsular hematoma without urinary leakage

Answer: B

Explanation: Urinomas develop when urine extravasates into the retroperitoneum after collecting system injury. Elevated fluid creatinine confirms urinary origin. Drainage and urinary diversion are usually required.

Question: 1460

A 5-year-old has funguria detected on urine culture but is asymptomatic and catheterized. Best management?

A. Remove catheter and repeat culture
B. Long-term oral antifungal therapy
C. Immediate amphotericin B infusion
D. No intervention required ever

Answer: A

Explanation: Asymptomatic funguria is often colonization, especially with catheters. Removing catheter and reassessing is first step.

Question: 1461

A 4-day-old male neonate presents with a palpable bladder and poor urinary stream. Initial creatinine is 3.4 mg/dL. A voiding cystourethrogram (VCUG) confirms posterior urethral valves (PUV). Following 48 hours of catheter drainage, the creatinine remains 3.2 mg/dL. Ultrasound shows massive bilateral hydroureteronephrosis and a thick-walled bladder. What is the most appropriate next step in management?

A. High-dose loop diuretic therapy
B. Bilateral cutaneous ureterostomy
C. Cutaneous vesicostomy (Blocksom)
D. Primary endoscopic valve ablation

Answer: C

Explanation: While primary valve ablation is the gold standard for PUV, this neonate has failed to demonstrate a significant decline in creatinine after catheter drainage, suggesting either high-pressure storage or a "valve bladder." In cases where the urethra is too small for a neonatal resectoscope, or where renal function does not improve with simple drainage in a sick neonate, a cutaneous vesicostomy is the preferred temporary diversion. It provides low-pressure drainage for the entire upper tract and allows for renal recovery before definitive surgery.

Question: 1462

A 16-year-old transgender male (assigned female at birth) is receiving testosterone therapy. He presents with severe, recurrent vaginal irritation and thinning of the tissue. What is the most likely cause?

A. Chronic candidiasis
B. Atrophic vaginitis due to testosterone-induced estrogen suppression
C. Prolapsed uterus
D. Bacterial vaginosis from altered flora

Answer: B

Explanation: Masculinizing hormone therapy (testosterone) suppresses the ovaries, leading to extremely low estrogen levels. This results in vaginal atrophy, similar to what is seen in menopause. The tissue becomes thin, dry, and prone to irritation and micro-tears.

Question: 1463

Which of the following UDS parameters is considered the most reliable "safety" limit for end-filling detrusor pressure in a 2-year-old child?

A. 15 cm H_2O
B. 40 cm H_2O
C. 60 cm H_2O
D. 20 cm H_2O

Answer: D

Explanation: While 40 cm H_2O is the "leak point" threshold for damage, the goal for safe storage in a neurogenic bladder is to keep end-filling pressures below 20 cm H_2O. Pressures between 20 and 40 cm H_2O are in a "grey zone" that may still cause subtle changes or predispose to VUR and UTIs over time.

Question: 1464

A 14-year-old boy with spina bifida and a low-lying bladder neck underwent placement of an artificial urinary sphincter (AMS 800) at age 12 for persistent stress-type incontinence despite multiple bladder-neck reconstructions. Six months post-operatively, he reports increasing perineal pain, a visible bulge at the urethral-sphincter site, and urinary leakage when the pump is activated. Physical examination reveals a tender, erythematous cuff with a palpable area of extrusion.

Which complication of the artificial urinary sphincter is most likely, and what is the most appropriate management?

A. Urethral stricture unrelated to the sphincter, best managed with urethral dilations and stent placement.
B. Mechanical pump-failure requiring simple cuff replacement without explantation.
C. Sphincter erosion into the urethra or surrounding tissues, best managed by immediate device explantation and delayed reimplantation.
D. Chronic urinary retention from over-tightening, best managed with cuff-pressure adjustment alone.

Answer: C

Explanation: Pain, visible protrusion, erythema, and leakage around the sphincter cuff are classic signs.

Question: 1465

A 14-year-old boy presents with gross hematuria after a minor blow to the flank during soccer. Imaging shows a large, previously unknown hydronephrotic kidney due to UPJ obstruction. This presentation of hematuria is:

A. Typical for "trauma to a pre-existing renal abnormality"
B. A sign of a malignant Wilms tumor
C. Pathognomonic for Renal Artery Aneurysm
D. Unexpected and suggests a secondary bleeding disorder

Answer: A

Explanation: In children, "disproportionate" hematuria after minor trauma often reveals a pre-existing but silent renal abnormality, such as hydronephrosis (UPJ obstruction), a renal cyst, or a tumor. The abnormal structure is more susceptible to injury than a healthy kidney.

Question: 1466

A 4-day-old neonate born at 36 weeks gestation is evaluated in the NICU for poor feeding and abdominal distension. The infant has a history of posterior urethral valves. Serum electrolytes reveal a sodium of 128 mEq/L, potassium of 6.8 mEq/L, and a creatinine of 1.4 mg/dL. The infant's weight has increased by 10% since birth despite minimal intake. Physical exam shows significant peripheral edema. Which of the following is the most appropriate initial step in fluid management for this patient?

A. Administration of 3% hypertonic saline infusion

B. Administration of 20 mL/kg normal saline bolus

C. Replacement of urinary output with 0.45% saline

D. Fluid restriction and correction of hyperkalemia

Answer: D

Explanation: This neonate presents with hypervolemic hyponatremia and hyperkalemia in the setting of acute kidney injury (AKI) from obstructive uropathy. The 10% weight gain and peripheral edema confirm fluid overload. In cases of hypervolemic hyponatremia, the primary treatment is fluid restriction rather than sodium supplementation. Furthermore, the elevation in potassium is life-threatening in a neonate and requires immediate stabilization with calcium gluconate if EKG changes are present, followed by shifting agents like insulin/glucose or resin binders. Increasing fluid intake would exacerbate the pulmonary edema and heart failure risks.

Question: 1467

A child undergoes robotic ureteral reimplantation for VUR and develops postoperative ureteral obstruction. What is the most likely cause?

A. Neurogenic bladder

B. Bladder cancer

C. Anastomotic edema or kinking

D. Renal agenesis

Answer: C

Explanation: Robotic ureteral reimplantation complications often include edema, kinking, or technical anastomotic issues causing obstruction.

Question: 1468

A 10-year-old girl with functional constipation (Rome IV criteria) and recurrent UTIs has UDS showing idiopathic detrusor overactivity, poor compliance during simulated constipation (rectal balloon 50 mL), and vesicoureteral reflux. After bowel regimen failure, what diagnostic confirms BBD contribution?

A. Anorectal manometry with rectoanal inhibitory reflex absence
B. Serum C-reactive protein elevation
C. Video-urodynamics with rectal pressure monitoring
D. Colonic transit study with Sitz marker

Answer: C

Explanation: Video-urodynamics with simultaneous rectal pressure catheter monitoring confirms BBD contribution by demonstrating elevated rectal pressure (>20 cm H2O) correlating with detrusor overactivity spikes and reduced compliance, proving mechanical rectal compression on bladder; guides targeted bowel therapy. Manometry for Hirschsprung (rare), transit for slow motility, CRP nonspecific.

Question: 1469

A 10-year-old boy presents with macroscopic hematuria after a blunt abdominal trauma. CT shows a Grades IV renal injury. He was previously healthy but the scan reveals a large, extrarenal pelvis and a horseshoe kidney. Which pole of the kidney is most commonly injured in a horseshoe kidney?

A. The superior pole

B. The lateral cortex

C. The ureteropelvic junction

D. The isthmus (lower pole fusion)

Answer: D

Explanation: In a horseshoe kidney, the isthmus is the most vulnerable part during trauma. Because it is draped over the lumbar spine and aorta, a blunt force to the abdomen can compress and fracture the isthmus against the vertebrae.

Question: 1470

A 13-year-old with Crohn's ileocolitis 3 years presents recurrent UTI, fecaluria. Cystoscopy pus from dome, CT ileovesical fistula. On adalimumab. Which surgical approach?

A. Ureteral reimplant preventive

B. Cystectomy urinary diversion

C. Diversion colostomy first

D. Infliximab escalation alone

E. Ileocecal resection, fistula excision, layered bladder closure

Answer: E

Explanation: Symptomatic Crohn's enterovesical fistula requires resection diseased segment, fistula debridement, omental interposition bladder repair. Biologics adjunct prevent recurrence; conservative if asymptomatic.

Question: 1471

A 12-year-old male with a left-sided varicocele is noted to have a persistent varicocele when lying supine. This "non-reducible" nature of the varicocele should prompt which of the following?

A. Reassurance that this is a normal variant of Grade III varicoceles
B. Treatment with high-dose aspirin to prevent thrombosis
C. Imaging of the retroperitoneum to rule out a space-occupying lesion
D. Immediate surgical ligation to prevent testicular infarction

Answer: C

Explanation: A varicocele that does not decompress (reduce) when the patient is in the supine position is concerning for secondary causes, such as a retroperitoneal mass (e.g., Wilms tumor or neuroblastoma) compressing the renal vein or the spermatic vein. While more common on the right side, any non-reducible varicocele in a child warrant imaging (usually ultrasound or CT) of the abdomen and retroperitoneum.

Question: 1472

A 16-year-old MSM with urethral discharge requests STI screen. Gram stain intracellular diplococci. HIV negative. HPV status unknown. Which concurrent vaccination?

A. Gardasil 9 3-dose series initiate now
B. Prevnar adult
C. Hepatitis B if unvaccinated
D. Meningococcal
E. Tdap booster

Answer: A

Explanation: Universal HPV vaccine recommendation ages 9-26; MSM higher anal/oral cancer risk from HPV16/18, vaccinate regardless prior STI as partial cross-protection.

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