Tests for the III year

1. CM. The mechanisms of protection in the oral cavity are:
   A. Lizozom
   B. Lactoperoxidaza antibacterial system – \( \text{H}_2\text{O}_2 \)
   C. Blood bethalizins and the salivary glycoproteins
   D. Fagocitosys and the bacterial fags
   E. Salivary immunoglobulins: IgA, IgG, IgM

2. CM. In the oral cavity, the sources of potential pathogen infection are:
   A. Dental plaque
   B. Dental caries
   C. The periodontal pockets
   D. Apical paradontitis
   E. Lingual sediments

3. CM. The human body immunity system is formed by:
   A. Natural immunity (inherited)
   B. Acquired immunity
   C. Humoral immunity
   D. Cellular immunity
   E. No one is correct

4. CS. In the case of infection the human body forms antibodies. Who is producing them?
   A. Sanguine elements (erythrocytes, monocytes)
   B. Lymphocytes B
   C. Lymphatic ganglions
   D. Tissues structures (mucosa, sub mucosa)
   E. Macrophages

5. CM. Inflammatory process evolution has 2 varieties of the inflammation:
   A. Local inflammation
   B. Acute
   C. Generalized inflammation (septicemia)
   D. Chronic or proliferative
   E. No one from them

6. CM. The acute inflammatory process (described in the III century by Celsius and Galen) has the following signs:
   A. Calor
   B. Tumor
   C. Rubor
   D. Dolor
   E. Functions lease

7. CS. The abscess is:
   A. A diffuse inflammatory process in the bone tissue
   B. A diffuse inflammatory process in the soft subcutaneous, intramuscular tissues, in the parenchymatous organs
   C. Localized, limited pus collection
   D. Skin inflammation
   E. None one is correct

8. CS. The phlegmon is:
   A. A localized pus collection
   B. A diffuse inflammatory process
   C. A pseudemembranous process
   D. A process with a serous infiltration
   E. A process with a fibrin infiltration
9. CM. The phlegmon is characterized by:
   A. Defuse infiltration of the tissues (without an exact limitation)
   B. Hyperemia, painful, hard, inflammatory edema
   C. An exudation with polymorphonuclears, bacteria and necrotic tissue
   D. Aggressive, pathogenic microbes with a pronounced virulence (streptococcus)
   E. Local and general antibacterial defense is reduced

10. CM. The ways of infection diffusion:
    A. Lymphatic
    B. Hematogen
    C. Along the nerve and vessels
    D. Through the interfacial and intermuscular spaces
    E. Through intratisular spaces

11. The starting mechanisms in an inflammatory process are presented by:
    A. General reaction of the body (high temperature, changing in blood tests)
    B. Local reactions (increasing of the vascular permeability caused by mediatory substances)
    C. Local (rubor, tumor, calor, dolor, functio laesae)
    D. Phagocytosis activation (micro- and macrophages)
    E. XII factor, plasmogen, chininogen activation

12. CS. For chronic inflammation is more common:
    A. Inflammation with proliferation
    B. Inflammation with serous character
    C. Inflammation with the fibrin character
    D. Inflammation with the catarrhal character
    E. Inflammation with the pseudo membranous character

13. CM. The pathogenic ways of diffusion from the bone to the soft parts are:
    A. The tansosal way through the Hawers channels
    B. The sub mucosal way
    C. The direct way
    D. The lymphatic way
    E. The venous way

14. CM. The most frequently microbial flora in the oral-maxillo-facial infections is:
    A. Nonspecific
    B. Mixed
    C. Polymorphic
    D. Specific
    E. All flora types

15. CM. From the anatomy-pathologic point of view, the acute cellulite is characterized by:
    A. The vascular septic thrombosis, followed by necrosis, with gaze bubbles.
    B. The capillary congestion and defuse hemorrhage.
    C. A severe vasodilatation, serous exudates.
    D. The leucocytes diapedesis and the cellular infiltrate.
    E. All of them

16. CS. From the anatomy-pathologic point of view, the chronic cellulite is characterized by:
    A. Severe vasodilatation, serum exudates, diapedesis and the cellular infiltrate.
    B. The vascular septic thrombosis, followed by necrosis, with gaze bubbles.
    C. The pyogen membrane which is containing in the interior vessels of neo formation, the partial or total destroying of the cells, along with histiocites, plasmocytes, lymphocytes
    D. The capillary congestion and defuse hemorrhages
    E. All are true

17. CS. The abscess, from the anatomy-pathologic point of view, is characterized by:
    A. The capillary congestion and defuse hemorrhage
B. The pyogen membrane which is containing neo formation vessels, histiocytes, plasmocytes, lymphocytes and polymophonucleares
C. The vascular septic thrombosis
D. Necrosis with gaze bubbles
E. Severe vasodilatation serous exudates, the leukocyte diapedesis and the cellular infiltrate.

18. CS. The most important sign of one abscess can be:
   A. Soft edema
   B. Induration
   C. Fluctuation
   D. Pulsatory pain

19. CS. The trismus in suppurative pericoronaritis is explained by:
   A. Forced position caused by pain
   B. Intermaxillar commensurate edema which limits the mandible movements
   C. Reflexive contraction of the mastic muscles
   D. Suppuration diffusion to the maseteric region
   E. Tetanigen infection

20. CS. The transosal diffusion in perimaxillar infection starts in:
   A. Tooth eruption pathology
   B. Apical paradontities
   C. Marginal paradontities
   D. The presents of foreign bodies
   E. Pharynx and amygdales infection

21. CS. Perimaxillary infections with transosal diffusion are caused by:
   A. Apical paradontitis
   B. Marginal paradontitis
   C. Tonsil infection
   D. Foreign bodies
   E. Face furuncle

22. CS. The limited pus collection is characteristic for:
   A. Acute cellulites
   B. Chronic cellulites
   C. Abscess
   D. Flegmon
   E. Chronic fistula

23. CM. The inflammatory process has the general signs:
   A. The high body temperature (37,8 - 40,5°C)
   B. Deshidratation – a dry, warm skin, chapped lips, the dry oral mucosa, reduced salivary secretion
   C. Altered general state: apathy, adynamia, irritation, insomnia
   D. Adenopathy
   E. The blood and urinary test changes

24. CM. Pus microbiologic analyses are made for:
   A. Precisely determining of the caused microorganism
   B. Antibirograma
   C. Correct planning of surgery and anestheology assistance
   D. Correct administer of a complex treatment
   E. Future evolution estimation

25. CS. The periostitis are caused by:
   A. The chronic apical paradontitis
   B. The odontogen osteomelities
   C. Activation of chronic apical paradontites
D. Difficult eruption of the wisdom inferior molar
E. Complicated pulp gangrene

26. CM. The periosal abscesses appear most frequently at:
   A. Mandible
   B. Maxillae
   C. Vestibular region
   D. Lingual region
   E. Palatine region

27. CM. The periostites types are:
   A. Acute serous periostitis
   B. Acute purulent periostitis
   C. Hyperplasic (productive) chronic periostitis
   D. Chronic purulent periostitis
   E. No one is correct

28. CS. In a vestibular abscess the pain is more intensive in the following stage:
   A. Endoosal stage
   B. Subperiostal stage
   C. Submucosal stage
   D. Fistula stage
   E. In all the stage the pain is the same

29. CS. The internal perimandibular sub mucosal abscess can be confused with:
   A. The submandibular abscess
   B. Oral floor cyst
   D. Sublingual abscess
   E. All of them

30 CM. Which tooth can produce palatine abscess:
   A. Superior canine
   B. The superior lateral incisive
   C. First superior molar
   D. Central superior incisive
   E. First superior premolar

31. CS. The palatine abscess treatment consists of:
   A. The puncture and aspiration, considering the risks of the palatine artery lesion
   B. The parallel incision with the palatine arteries, as possible near to the median line
   C. Incision with the excision in “slice of the orange”
   D. Drainage with rubber
   E. Drainage with the iodoform bandage

32. CS. After the abscess incision, we use the drainage with a rubber in:
   A. Vestibular abscess
   B. Mentonier abscess
   C. Palatine abscess
   D. Sublingual abscess
   E. All of them

33. CM. The odontogen osteomyelities is an extensive infection, which affects:
   A. Yellow morrow
   B. Hawersian system
   C. The maxilla and mandible cortical layer
   D. Periostum
   E. The surrounding soft tissues

34. CM. Acute osteomyelities etiology is:
   A. The pulp gangrene, complicated with acute apical periodontitis
   B. Activation of chronic periapical process
C. Maxillary fracture  
D. Haematogen diffusion way  
E. The post extraction wound, unerupted tooth

35. CM. According to the localization and clinical form, the maxillary bone infections are classified in:
   A. The purulent and nonpurulent osteomyelitis  
   B. Periostities  
   C. Alveolar osteities  
   D. Primary and secondary osteomyelities  
   E. Acute and chronic osteomyelities

36. CM. The direct ways of bone infection can occur in:
   A. Open facial bones fractures  
   B. Acute amygdalities  
   C. Medium otities  
   D. Purulent pericoronarities  
   E. The nasal septic processes

37. CM. The patient with diffuse mandible osteomyelities will complain on:
   A. Hypersalivation  
   B. Trismus  
   C. The skin or mucosa fistulas  
   D. The osteo-periostic thickening, limited near the causal teeth  
   E. Vincent d”Alger sign

38. CS. The most frequently way of the bone infection in osteomyelities can be:
   A. Direct  
   B. Indirect  
   C. Lymphatic  
   D. Hematogen  
   E. No one from them

39. CS. What is the most frequent cause pediatric reason of the osteomyelities?
   A. Trauma  
   B. Eruption pathology  
   C. Rinogen infections  
   D. Temporo- mandibular arthritis  
   E. Ear infections

40. CM. The osteomyelitis is localized most frequently:
   A. In maxilla  
   B. In mandible  
   C. Equal, at the both bones  
   D. Only in children  
   E. No one is correct

41. CM. Which one from the next clinical signs is characteristic for the diffuse mandible osteomyelities:
   A. Dental mobility  
   B. Discordance between pulse and temperature  
   C. Medium altered general state  
   D. Vincent d”Alger sign  
   E. Valsalva positive sign

42. CS. Radiologic exam in diffuse osteomyelities shows 30-60% from the bone demineralization. This changes a registered in:
   A. 2-3 days from the beginning  
   B. 6-8 days from the beginning  
   C. 30 days from the beginning
D. 3-5 days from the beginning
E. From the first day of the diseases beginning

43. CM. Which are the complications in the diffuse osteomyelities:
   A. Osteoradionecrosis
   B. Temporo–mandibular arthritis
   C. Maxillary sinusitis
   D. Malignancy
   E. Pulmonary infection

44. CS. In which period of osteomyelitis sequestrectomy is made:
   A. In 1-2 weeks from the beginning
   B. In 2-3 weeks from the beginning
   C. In one month from the beginning
   D. In 3-5 weeks from the beginning
   E. Early sequestrectomy

45. CS. The most frequent microbes in the osteomyelitis (90%) are:
   A. Hemolytic streptococcus
   B. E. Coli
   C. Pneumococcus
   D. Staphylococcus aureus and albicans
   E. Actinomycetes

46. CS. Most frequent affected bones in the odontogen osteomyelitis (80-90%) are:
   A. Nasal bone
   B. Zigomatic bone
   C. Maxillae
   D. Mandible
   E. Palatine bone

47. CS. The most frequent age affected by osteomyelitis is:
   A. 0 – 12 months
   B. 1-12 years
   C. 20 – 40 years
   D. 50 – 60 years
   E. After 60 years

48. CS. The hematogen osteomyelitis is met, most frequently at:
   A. Old people
   B. Young people
   C. Children
   D. New–born children
   E. Equal in every group

49. CS. The maxilla is less affected by odontogen osteomyelities than other bones because of anatomic and morphologic particularities:
   A. Maxilla has a thick cortical and layer, has no sponge bone
   B. The maxilla has a thin cortical layer, a rich blood supply, which is assuring a higher resistance.
   C. Maxilla is penetrated by infraorbital and incisive canal.
   D. Hawers system channels are developed
   E. No one is correct

50. CM. The mandible is more frequently affected by the odontogen osteomyelities because of anatomic and morphologic particularities:
   A. It has thin cortical layer that makes the drainage quicker
   B. Rich blood supply which is assuring a higher resistance to the infections
   C. Has too much morrow and sponge bone
D. The medullar tissue is surrounded by a thick cortical layer with a terminal type of vascularisation
E. The mandibullar canal creates good conditions for the puss diffusion

51. CM. General symptoms in the acute odontogen osteomyelities are:
A. High temperature, tachycardia, tahypneea
B. Vomiting, nausea, unappetite, digestive system dysfunction
C. Headache, insomnia
D. Altered general body state, with losing of the working capacity
E. Pale teguments, transpirations

52. CM. The local symptoms in the acute odontogen osteomyelities is presented by:
A. Defuse edema, red, shining and tensioned skin
B. Fluctuency and induration at palpation
C. The oral mucosa is hyperemic and edematiated
D. The palpation of the alveolar processes is painful on the oral and vestibular parts, with the periostal thickening
E. Spontaneous tooth pain at percussion, tooth mobility, covered by hypertrophic dental papillae, pus elimination- under the gingiva.

53. CM. In acute odontogen osteomyelitis is observed metabolic and biochemical changes, like:
A. Acidosis and deshidratation
B. Albuminuria
C. Anemia with the reducing of the number of the erythrocytes and hemoglobin
D. Leucocytes with the neutrofils increasing
E. Growing of the erythrocyte sedimentation speed

54. CS. Write the bone which is affected in case of the acute odontogen osteomyelities with signs of the acute sinusitis:
A. Mandible
B. Palatine bone
C. Zigomatic bone
D. Nasal bone
E. Maxilla

55. CM. The differential diagnosis of the chronic odontogen osteomyelitis is made with:
A. The bone benign tumors with the central or peripheral growth
B. The malign tumors with the central growth
C. The supra infected odontogen cysts
D. Specific bone infections
E. No one is correct

56. CM. The chronic odontogen osteomyelitis can cause such complications, as:
A. Mandible growth pathology
B. Temporo-mandible anchylosis
C. Extended defects
D. Mandible constrictions
E. Oro-sinususes communications

57. CM. In an infraorbital phlegmon, the starting point is:
A. Incisive teeth
B. Canines
C. Premolars
D. Molars
E. Wisdom molar

58. CM. The clinical signs of the infraorbital abscess (phlegmon) are:
A. Edema of the infraorbital region, and inferior eyelid
B. Edema of the superior lip and of the naso-palatine fold
C. The nasal wing is deviated to the healthy part
D. The superior lip is partially anesthetized
E. Prominent vestibular mucosa

59. CS. In the infraorbital abscess (phlegmon) the incision is made:
   A. On the inferior orbital margin
   B. On nasal – labial fold
   C. On the nasal versant
   D. The bottom of the vestibular bag
   E. In the canine fosse.

60. CM. After the suborbital abscess opening, in the wound is introduced:
   A. A drain from the rubber
   B. A rubber tube
   C. An iodoform bandage
   D. A strip of bandage
   E. A swab with antiseptics.

61. CM. The start infection point in the zygomatic region is:
   A. The milk maxillary molars
   B. The zygomatic bone osteomyelitis
   C. From the another neighboring regions
   D. The mandible osteomyelitis
   E. The odontogen sinusitis

62. CS. The borders of the zygomatic region are:
   A. Limited and corresponds to the zigomatic bone
   B. Limited by the temporal, maseter muscles, the square of superior lip muscle
   C. The orbit, mandible, maxilla, temporal bone.
   D. Eyelids, the nasal versant, the nasal–labial fold
   E. All of them together

63. CM. The clinical signs of the zygomatic abscess are:
   A. Edema, skin redness in zygomatic region
   B. Edema can be spread to the neighboring regions (temporal, suborbital, and parotidian region)
   C. In some trismus cases the maseter muscle is implied
   D. The local high temperature
   E. All of them

64. CS. An abscess in the zygomatic region can be opened by incision:
   A. At the bottom of the vestibular bag
   B. At the tuberositas maxillae
   C. On the inferior border of the orbit
   D. On the inferior border of the zygomatic bone
   E. In the temporal region

65. CM. The cheek region occupies the lateral part of the face and has 4 borders:
   A. Superior – the superior orbit margin
   B. Lateral – the anterior margin of the maseter muscle
   C. Medial- a line through nazolabial fold
   D. Inferior – the inferior mandible margin
   E. All of them

66. CM. From the cheek region, the infection process is easily diffused to the neighboring spaces, because:
   A. It is unlimited space
   B. It is a space with rich blood supply
   C. Contain blood vessels and nerves
   D. Contain of the fat tissue, fibrinous conjunctive tissue
   E. Contain lymphatic vessels and lymphatic nodules
67. CM. The etiology of the cheek abscess or phlegmon can be:
A. The dentoperiodontal processes with the start in premolars, superior and inferior molars
B. Purulent Stenoni channel litiasis
C. The face furuncles
D. The foreign bodies with cheek localization
E. Puss diffusion to the neighboring spaces

68. CM. The suppuration from the cheek can diffuse to the:
A. Orbit
B. The infratemporal region
C. The deep spaces
D. The sublingual region
E. The submandibular region

69. CM. A diffuse cheek abscess is drained, usually by:
A. Endooral incision
B. Exooral incision
C. Mix way
D. Only through a submandibular incision
E. No one is correct

70. CM. The symptoms of a cheek phlegmon are:
A. Diffuse edema of the cheek region with a red, smooth, tensioned skin
B. The nasolabial fold - lucid, edema
C. A strong collateral edema of the neighboring region
D. The check mucosa is red, with tooth prints, covered with fibrin
E. Painful palpation, fluctuant sign

71. CM. Cheek phlegmon secondary symptoms are:
A. Trismus
B. Hyper salivation
C. Unpleasant smell
D. Functional problems (mastication, phonation)
E. Ankylosis

72. CM. The parotid space limits are:
A. Anterior – the posterior part of the ascendant branch of the mandible
B. Posterior – the anterior limit of the mastoid process
C. Superior – horizontal imaginary line through the porus acusticus externus
D. Inferior – submandibular-pectinea membrane
E. Extern – the skin and the subcutaneous tissue

73. CM. The content of the parotid space is represented by:
A. The parotid gland and the Stenoni duct
B. The lymphatic nodules
C. The extern carotid artery
D. The extern jugular vein
E. The facial nerve

74. CM. In the abscess of the parotid space the etiology is:
A. The parotid gland infection
B. The intra parotid adenitis
C. Mastoid infections
D. The dento-periodontal pathology at the inferior wisdom molar level
E. Porus acusticus externus infection

75. CM. The local symptoms in parotidian abscess are:
A. The edema of the smooth skin, tenseness
B. Very painful palpation  
C. Trismus  
D. Torcicolis or a slight dysphagia  
E. Saliva secretion modification  

76. CS. The differential diagnostic of parotid abscess is made with:  
A. The parotid mix tumors  
B. The cystadenoymphomas  
C. The acute purulent parotiditis  
D. Pretrogian sebaceous cyst  
E. The epidemic parotiditis  

77. CS. Suppuration which included the parotid space will be incised:  
A. Pre auricular  
B. Sub angulomandibular  
C. Presternocleidomastoidian  
D. On the anterior margin of the mandible branch  
E. All are correct  

78. CS. In the parotid abscess, after incision and drainage of the purulent collection, is recommended the intra canaliculated lavage with tripsine, when:  
A. Through incision wasn’t evacuated the whole collection  
B. The salivary secretion is modified  
C. Obturation of the irrigation tube  
D. A small incise of 1-2 cm was performed  
E. All of them  

79. CM. The orbit topography:  
A. Correspondents to the orbit cavity from osteology  
B. Is situated back to the palpebrale region  
C. Has the shape of a four-lateral pyramid with bone walls  
D. Is under divided into 2 spaces (anterior and posterior)  
E. All are correct  

80. CM. The etiology of the orbit abscess or phlegmon:  
A. Dental-periodontal processes at the premolars and inferior molars  
B. The suppurative acute sinusitis  
C. Puss diffusion to neighboring spaces  
D. The maxilla osteomyelitis  
E. The molar osteomyelitis  

81. CM. The orbit abscess local symptoms are:  
A. Palpebral aedema  
B. Medium exoftalmia  
C. Pain localized in the orbit  
D. Closed palpebral rim  
E. Ocular globe limitation  

82.CM. In the orbit abscess, the incision is placed:  
A. At the intern angle level  
B. At the inferior limit level  
C. At the superior limit level  
D. Through the maxillary sinus perforation  
E. All are correct  

83. CM. Orbital phlegmon complications are:  
A. Complete blindness  
B. Cavernous sinus thrombosis  
C. Meningitis  
D. Septicemia
E. Intracranial abscesses

84. CM. The temporal region is a lateral superficial region and has the following anatomical limits:
   A. Inferior – the infra-temporal rim of the big wing sphenoid bone
   B. Superior – squama of temporal bone
   C. Anterior – zygomatic and the frontal bone
   D. Exterior – the temporal fascia
   E. Interior – the temporal bone

85. CM. Temporal abscess or phlegmon etiology:
   A. Dento-parodontal processes superior molar
   B. Punching of diverse origin
   C. The retention of foreign bodies in the temporal region
   D. The dental-paradontal pathology at the inferior arcade.

86. CM. The general symptoms of the temporal region abscesses are:
   A. High temperature
   B. Bad mood, insomnia, inapetite
   C. Working capacity lost
   D. Skin paleness, transpiration
   E. Sanguine, urinary, biochemical analysis changing

87. CM. The local symptoms of the temporal abscess:
   A. The edema (pillow symptom) of the temporal region, the skin is shining, smooth, skin redness
   B. Early trismus
   C. Edema in the neighbors regions (the sand watch symptom)
   D. The painful palpation, fluctuation the case of the superficial collections
   E. All are correct

88. CM. A temporal abscess is opened by the incision:
   A. At the most prominent pole of the collection
   B. Radial incision
   C. At the limit of the zygomatic arch
   D. Half-round at the level of the temporal muscle insertion
   E. By punching with a large needle

89. CM. The complications of the phlegmon (abscess) of the temporal region are:
   A. The passage in the surrounding regions, especially sub temporal
   B. The osteomelitis of the temporary bone
   C. The mandible construction
   D. Deformations, defects
   E. Facial paralysis

90. CM. The sub-temporal space occupies the lateral part of the face, and has the limits:
   A. Superior - the zygomatic arch and the infra-temporal surface of the big sphenoid wing
   B. Inferior – in the tangential plan at the inferior margin of the mandible
   C. Extern – the internal face of the ascendant branch of the mandible
   D. Anterior – the superior maxillary tuberoses
   E. Medial – the pterigoid process and the pharynx

91. CM. Subtemporal phlegmon etiology is characterized by:
   A. The dental-paradontal processes at the maxilla or mandible molars
   B. Bones or sinuses infection processes from neighboring regions
   C. Puss diffusion from neighboring regions
   D. The septic punching in the local anesthesia

92. CS. The septic post anesthesia complications in the sub temporal space appear after:
   A. The plexus or infiltrative anesthesia
   B. Incisive or infraorbital anesthesia
   C. Spina Spix anesthesia
D. Palatine anesthesia
E. No one is correct

93. CM. The local symptoms of the abscess (phlegmon) of the sub temporal region are:
   A. The supra and subzygomatic edema (the symptom of the sand watches)
   B. Collateral edema of the neighboring region
   C. Trismus
   D. Endobucal pretuberosital edema with red, light and tensioned mucosa
   E. Functional problems (mastication, swallowing, phonation)

94. CS. The infratemporal abscess signs are: chemosis, eyelid edema, a lightly exoftalmia is thanked to:
   A. The start with neuroalgeform pain
   B. A hard trismus
   C. The diffusion of the septic process to the orbit
   D. The diffusion to the perituberlal region
   E. All of them

95. CM. The infratemporal abscess incision is made:
   A. Trans-sinus incision
   B. Endobucal incision
   C. Suprazygomatic-temporal incision
   D. Combinated
   E. All of them

96. CM. In infra-temporal abscess, the lines of incision can be practiced:
   A. Subangularmandibular
   B. Peri-tuberositar
   C. Trans sinusal
   D. On the inferior orbital rim
   E. Supra and subzygomatic access

97. CM. The sub mandible space limits are:
   A. Lateral - the internal face of the mandible body
   B. Medial - the anterior venter of the digastrics muscle
   C. Distal-the posterior venter of the digastrics muscle
   D. Superior- milohioidian muscle
   E. Inferior- skin, the sub cutaneus tissue, m. platisma

98. CM. The sub mandible space contains:
   A. Sub mandible gland
   B. (2-3-4) lymphoid nodules
   C. The lingual and hypoglossal nerve
   D. The lax conjunctive tissue
   E. The maxillary extern artery, the anterior facial vein

99. CM. Abscesses and phlegmons of the submandibular etiology can be:
   A. Septic processes caused by the inferior molars
   B. Submandibular purulent adenitis
   C. Purulent submandiblar salivary litiasis
   D. Mandible osteomyelitis, the odontogen periostitis
   E. The dental-parodontal trauma, mandible body fracture

100. CM. The local clinical signs in sub mandible phlegmon are:
    A. Sub mandibular edema
    B. Skin hyperemia, tenseness
    C. Palpation – pain, fluctuant
    D. Oral mucosal edema, redness, fluctuant
101. CM. The general clinical signs in the submandibular phlegmon are:
   A. High temperature (38.5 - 40.0°C)
   B. Altered general state
   C. Functional problems (deglutition, mastication, phonation)
   D. Losing of work capacity
   E. Pale skin, transpiration, trembling

102. CS. Sub maxillary abscess incision through percutaneous way:
   A. Is indicated in suppuration, which is developing in the posterior part of the space
   B. Rare used, because of unaesthetic cicatrization
   C. 5-6 cm incision, parallel and inside of the basilar limit of the mandible
   D. Associated and an incision in recess
   E. No one is correct

103. CS. The submandibular abscess endobucal incision is made when:
   A. The puss collection is situated subangulomandibular
   B. The bone is covered with periostium
   C. The bone should be decollated from the periostum
   D. The inflammatory process is recent (48-72 hours)
   E. The inflammatory process is evolving in recess

104. CS. In the submandibular phlegmon, which is the basic cause?
   A. The acute mandible osteomielitis
   B. Opened mandible fracture
   C. The acute apical paradontitis
   D. The sub-maxillary supurative adenitis

105. CS. Which incision is indicated for the drainage of submandibular pus collection?
   A. The incise in the bottom of the vestibular bag
   B. The retro-tuberosite incision
   C. The retro-mandible incision
   D. The incision of oral floor
   E. The linear incision (6-8cm) parallel with the mandible basilar margin at 1, 5-2, 0 cm

106. CM. The submental space limits:
   A. Anterior – the mandible arch
   B. Posterior- the hyoid bone
   C. Lateral-the anterior venter of the digastrics muscles
   D. Inferior – the mylohyoid muscle
   E. Superior – the mylohyoid muscle

107. CM. The submentonier abscess and phlegmon etiologic factors are:
   A. The septic process from the interior incisive and canines
   B. The submentonier suppurative adenitis
   C. Inferior lip furuncles of the mental region furuncles
   D. From the neighboring spaces (sub-lingual, sub mandible)
   E. Menton osteomelitis, median fracture

108. CM. The submentonier abscess local symptoms are:
   A. Edema of the submentonier region
   B. Smooth hyperemic skin with deleted relief
   C. Double chin aspect
   D. Painful palpation, fluctuant sign
   E. Trismus

109. CS. The submentonier abscess is incised:
   A. Longitudinal, on the median line
   B. Parallel with the mentonier arch
   C. Endo-oral
110. CS. The surgery treatment consists of:
A. 3-5 cm curve incision under the mentonier limit
B. Endo-oral
C. Longitude on the median line
D. Combined
E. No one is correct

111. CM. The sublingual space limits are:
A. Superior- mucosa of oral floor
B. Inferior- milohyoidian muscle
C. Median- the geniogloss and hypoglossal muscles
D. Extern-the mandible body
E. No one is correct

112. CM. In the sublingual space there are:
A. Sublingual gland and the Bartholini channel
B. The Wharton channel
C. The sublingual nerve and vessels
D. The conjunctive lax tissue
E. The submaxillary gland

113. CM. The etiologic factors in a sublingual abscess are:
A. The dento-parodontal processes of the inferior premolars and molars
B. Wharton channel suppurative litiasis
C. The septic or foreign bodies localized at oral floor level
D. Pericoronaritis
E. Mandible fractures

114. CM. The local clinical symptoms of a sublingual abscess are:
A. The edema in the anterior part of oral floor
B. Hyperemic and congested mucosa.
C. The sublingual fold looks like rooster crest and is covered with fibrin deposits
D. The tongue is pushed to the healthy part
E. Palpation- pain, fluctuant signs

115. CS. The sublingual abscess is drained:
A. Per cutaneous way
B. Endooral way
C. Combined way
D. Mucosa decollation at the tooth neck
E. All are correct

116. CM. The etiology of the lingual (phlegmon) can be:
A. The dento-parodontal process of the inferior molars and premolars
B. Suprainfection of lingual hematomas
C. The traumatic lesions
D. Foreign bodies
E. Diffusion from the foreign bodies

117. CM. The local clinical signs of lingual abscess are presented by:
A. Edema hyperemic smooth and lucid skin surface
B. Tooth prints are found on the tongue margins
C. The macroglossia
D. The white –grey fibrin
E. Palpation- pain, fluctuant signs

118. CM. The functional modifications in the lingual abscess (phlegmon) can be:
A. Hyper salivation
B. Difficult deglutition  
C. Difficult respiration with asphyxias  
D. Mastication  
E. Phonation  

119. CS. In the lingual phlegmon life threatening state:  
A. Deglutition troubles  
B. Mastication trouble  
C. Phonation trouble  
D. Respiration problems with asphyxias phenomenon  
E. Trismus  

120. CM. The general symptom of the lingual phlegmon is:  
A. Altered general state  
B. High temperature (38–40°C)  
C. Agitation  
D. Insomnia  
E. The work capacity losing  

121. CM. The lingual abscess (phlegmon) treatment incision is made:  
A. Exooral, between hyoid and menton  
B. The endo-oral way, horizontal (2–3cm) incision in the most prominent part of the collection  
C. In the sublingual region (left, right)  
D. At the tongue root, on the dorsal side  
E. In the submandible region  

122. CM. The lingual phlegmon complication:  
A. The diffusion in the neighboring spaces  
B. Septicemia  
C. Asphyxia  
D. Ankylosis  
E. The lingual paralysis  

123. CS. The exo-oral incision in the lingual abscesses in practiced in the:  
A. Free tongue part abscesses  
B. The marginal tongue abscesses  
C. When the puss collection is localized posterior and diffuses to the oral floor  
D. When the appears after punching with retention of foreign bodies  
E. All of them  

124. CM. The maseterin space limits:  
A. Superior – the zygomatic arch  
B. Inferior – the inferior margin of mandibular ascendant branch  
C. Anterior- the anterior margin of the maseterin branch  
D. Posterior – the posterior margin of mandibular of the ascendant branch  
E. Intern – the periosteum and margin ascendant branch mandible  

125. CM. The infection process of the maseteric space starts with:  
A. Difficult eruption of the wisdom molars  
B. The odontogen osteomelitis of the ascendant mandible branch  
C. The diffusion from the neighboring spaces  
D. The dentoparodontals processes of the inferior molars  

126. CM. The general symptoms of the maseterian abscess can be presented by:  
A. High temperature  
B. Irritability  
C. Headache, insomnia  
D. Transpirations, pale skin  
E. The general symptoms are absent
127. CM. The local symptoms of the maseterian abscess are:
   A. Edema along the ascendant branch with red, smooth, tensioned skin
   B. Painful palpation
   C. In case of deep localization there are no indurations and fluctuant signs
   D. Fluctuant signs are present in superficial localization
   E. Pronounced trismus

128. CM. Most important functional sign in case:
   A. Hyper-salivation
   B. Dispnea
   C. Trismus
   D. Tachycardia
   E. Dysphagia

129. CS. Submaseterine deep collection incision is made:
   A. In the bottom of inferior vestibular bag
   B. The vertical incision placed outside of the anterior margin of the ascendant mandible branch
   C. The retro-tuberositar incision
   D. The transversal incision from the oral commeasure to the inter-maxillary commeasure
   E. The paralingual groove incision in the parallel with the alveolar crest

130. CM. The pterigo-mandibular space, limits are:
   A. Extern-the internal surface of the ascendant mandible branch
   B. Intern – the pterigidian medial muscle
   C. Superior – the lateral pterigodian muscle
   D. Anterior- the buccinators muscle
   E. Posterior-partial is covered with parotid gland

131. CM. The pterigo-mandible abscess causes are:
   A. The dentoparodontal pathology of the inferior molars
   B. The septic puncture at Spina Spix
   C. The difficult eruption of the wisdom molar
   D. Diffusion from the neighboring spaces
   E. Penetration of the foreign bodies

132. CM. The local symptoms of the pterigo-mandible abscess are presented by:
   A. Edema and infiltration under mandible angle
   B. The pterigo-mandible fold mucosa is hyperemic and smooth
   C. Trismus
   D. The painful swallowing
   E. Macroglossia

133. CM. The pterigo-mandible abscess (phlegmon) incision:
   A. Endo-oral, parallel with pterigo-mandible fold
   B. Exo-oral incision surrounding the angle of the mandible
   C. Submandibular 7-8 cm long
   D. Retro-mandibular a long posterior margin of the ascendant branch
   E. On the vestibular bag bottom

134. CS. The most important symptom of the pterigo-mandibular abscess (phlegmon) is:
   A. The edema of mandible angle soft tissues
   B. Strong trismus
   C. Painful deglutition
   D. A fetid smell from oral cavity
   E. High temperature

135. CM. The retro-mandible space limits:
   A. Superior-the inferior part of the external acoustic tube and the capsule of the temporal-mandible articulation
B. Inferior- the inferior mandible margin
C. Anterior- the posterior margin of the mandibular branch
D. Posterior- the mastoid and the sterno-cleido-mastoidian muscle
E. Intern- the styloid process and its muscles

136. CM. Retro-mandibles abscess (phlegmon) etiology is:
A. The dentoparodontal processes at the superior and inferior molars
B. Mandible fractures
C. The sub mandible suppurative adenitis
D. Diffusion from the neighboring spaces (latero-pharyngian, pterigo-mandible)
E. The maxilla cyst suppuration

137. CM. The local symptoms of retro-mandibular abscess (phlegmon) are:
A. Spontaneous pain which is increasing at head moving
B. Trismus
C. Retro-mandibular edema
D. The ear lobe is displaced
E. The hearing decreasing in the affected part

138. CS. Retro-mandibles abscess (phlegmon) incision:
A. Sub-mandibular 6-8 cm
B. Linea, 4-5 cm, parallel with the anterior margin of the sterno-cleido-mastoidian muscle
C. In the oral floor
D. In the bottom of the vestibular mandibular bag
E. Puncture with a large needle

139. CM. The latero-pharyngian limits:
A. Superior- the cranial base
B. Medial – the pharynx
C. Posterior – the prevertebral region
D. Antero-posterior ascendant mandible branch with its muscles, superficial cervical fascia and the sterno-cleido-mastoidian muscle
E. Inferior-the space communicates with the sterno-cleido-mastoid region and the carotid triangle

140. CM. The frequent pharynx abscess causes are:
A. The amygdale suppuration
B. Eruptions accidents of the inferior molars
C. The diffusion from the neighboring space
D. Septic punctures
E. The suppurative lateral-cervical adenitis

141. CM. The local symptoms of lateral-pharyngeal abscess (phlegmon) are:
A. The pre-and retro-sterno-cleido-mastoidian edema
B. Trismus
C. Endo-oral-an unilateral voluminous edema of the latero-pharynx wall
D. The neck isthmus is almost closed
E. Under the mandible angle, at palpation the infiltration or fluctuant sign is determined

142. CM. In a lateral-pharynx phlegmon, the functional troubles are marked by:
A. Mastication
B. Deglutition
C. Phonation
D. Painful torticolis
E. No one is correct

143. CM. In a latero-pharynx abscess the incision is in:
A. The pre-sterno-cleido-mastoidian
B. Retro-sterno-cleido-mastoidian
C. Sub-mandiblar
D. Sub-angular-mandibular
E. The latero-pharynx abscess is not opened by exo-oral approach

144. CM. The dental floor limits:
   A. Superior- the mucosa of the oral floor
   B. Inferior- sub-mandibular and sub-mental skin
   C. Posterior- the tongue root, the muscles, which are inserted on the styloid process
   D. Anterior-the internal mandible surface
   E. All of them

145. CS. The oral floor is divided of the mylohyiodian muscle in 2 compartments:
   A. Posterior and anterior
   B. Laterals
   C. Superior and inferior
   D. Superior and lateral
   E. Inferior and medial

146. CM. The etiology of the oral floor abscess includes:
   A. Dentoparodontal processes of the inferior teeth
   B. The suppurative litiasis of the Wharton channel
   C. Dentoparodontal processes of the superior teeth
   D. The septic puncturing or bodies
   E. Furuncles, with localization foreign at the inferior level of the face

147. CS. The oral floor phlegmon is:
   A. Inflammatory, limited serous process
   B. The inflammatory, suppurative delimited process
   C. The inflammatory, hemorrhagic, diffuse process
   D. Inflammatory, necrotic, with a diffuse character
   E. Localized suppuration

148. CM. The general symptoms of the oral floor diffuse phlegmon are:
   A. High temperature (39-40,5°C.)
   B. Septic state.
   C. High pulse, weak rate, irregular.
   D. Albuminuria, glucosuria, oliguria.
   E. Obvious blood changes.

149. CM. The local symptoms in an oral floor phlegmon are:
   A. Massive oral floor edema.
   B. Edema from up to down
   C. Tension skin with marmorate zones.
   D. Palpation denotes woody hardness, without fluctuant signs.
   E. Gases crepitating.

150. CM. The Endo-oral symptoms in a oral floor phlegmon are:
   A. The sub-lingual mucosa edema - in cook crest.
   B. The mucosa is tensioned, red, violate covered with fibrin-leukocyte deposits.
   C. The tongue volume is bigger, containing tooth prints on margins.
   D. The tongue is covered with dirty deposits
   E. Palpation-woody hardness.

151. CS. The most life threatening symptom, in oral floor phlegmon is:
   A. Painful swallowing.
   B. Epiglottis edema with danger of asphyxia
   C. Abundant salivation.
   D. Trismus
   E. Fetid smell

152. CM. The oral floor phlegmon complications are:
   A. Meningitis, trombophlebitis
B. Mediastinitis, pneumonia, pulmonary gangrene
C. Agitation with central irritation signs
D. Toxics bulbar syncope
E. Cardiac collapse

153. CM. The surgical treatment of oral floor phlegmon consists of:
A. Horseshoe incision, under and inside the mandible arch (1.5-2 cm).
B. 3-4 incisions in the sub-mandible and mentonier regions.
C. Oral floor incision
D. Puncturing with large needles
E. All of them.

154. CS. Oral floor phlegmon incision will eliminate:
A. Yellow pus in considerable volume
B. Hemorrhagic discharge
C. Serous discharge
D. A dirty serous discharge with fetid smell.
E. A little yellow pus.

155. CM. The oral floor diffuse abscess etiology is:
A. Dento-parodontal septic processes
B. Hyper-toxics gangrenous sub-lingual abscess
C. Sub-mandible septic processes
D. The tongue root phlegmon
E. Sub-mentioned phlegmon

156. CS. In oral floor diffuse phlegmon, the tongue is:
A. Normal
B. Edema with tooth prints and grey deposits.
C. Fixed
D. Without deposits on the dorsal surface
E. All the answers are correct

157. CM. In hemi-facial diffuse phlegmon is interested:
A. The submandibular, mentonier and sub-lingual spaces
B. Maxilla and mandible
C. The superficial and deep face spaces (cheek, masterin, temporal, sub-temporal, orbital, sub-mandibular)
D. The sinus and orbit
E. The tongue and palate

158. CS. In the hemi-facial phlegmon, the maxillaries are interested:
A. In total osteomelitis state.
B. Without changes
C. With destroyed, necrotized periost
D. Maxilla necrosis
E. Mandible necrosis

159. CM. The general symptoms of the diffused hemi-facial phlegmon are:
A. The general body state is toxic, septic
B. The patent is a dynamic and agitated.
C. Souse of deep toxicity
D. High temperature (39-40°C)
E. A discordance between the pulse (tachycardia (120/min), hardly perceptible) and temperature (37-37.5°C).

160. CM. The local clinical symptoms in the diffuse hemi-facial phlegmon are:
A. Enormous hemi-face edema
B. Pronounced eyelid edema, the eye is closed
C. The bone relief is neglected
D. Tensioned, white-blue with kemosis
E. Painful palpation, without fluctuant sign

161. CM. The endo-oral symptoms in a hemi-facial diffuse phlegmon are presented by:
   A. The cheek and lip mucosa are edematic, with tooth prints
   B. Viscous saliva
   C. Fetid Helena
   D. Hard trismus
   E. Nome one is correct

162. CS. The diffuse hemi-facial phlegmon is starting, with an:
   A. Maseteric abscess
   B. Parotidian abscess
   C. Vestibular abscess
   D. Gentian abscess
   E. Infra-temporal abscess

163. CS. The drainage of hemi-facial phlegmon is made by:
   A. Endo-oral way
   B. Exo-oral way
   C. Exo-and endo-oral way
   D. In recess
   E. All of them

164. CM. Hemi-facial phlegmon complications are:
   A. Septic meningitis
   B. Sub-lingual abscess
   C. Mediastinitis
   D. Septicemia
   E. Sub-temporal abscess

165. CM. Name the cervical fascias and spaces:
   A. The cervical superficial fascia
   B. Fascia coli propria
   C. Omoclavicullar aponeurosis
   D. Pre-tracheal fascia
   E. Pre-vertebral fascia

166. CM. Cervical phlegmon and abscess etiology are:
   A. The dento-parodontal tooth pathology of the inferior arcade
   B. Diffusion from the neighboring spaces (the oral floor lateropharyngeal, pterigo-mandibular etc).
   C. Furuncles, carbuncles on the neck skin
   D. The mandible cysts
   E. Cervical supra-infected cysts

167. CS. The most frequent inflammation in cervical region:
   A. Abscess
   B. Phlegmon
   C. Acute and chronic cellulitis
   D. Adeno-phlegmon
   E. All of them

168. C.S. The general symptoms of the cervical phlegmon are:
   A. High temperature (38, 9-40°C).
   B. Functional problems (respiration), swallowing
   C. Altered general state
   D. Losing of work capacity
   E. Pale skin, transpiration
169. C.S. The most dangerous symptom of the cervical phlegmon is:
   A. High temperature (38, 9-40°C).
   B. General bad condition
   C. Loosing of work capacity
   D. Pale skin, transpirations
   E. Functional problems (swallowing, respiration)

170. C.M. The local symptoms of the cervical phlegmon are presented by:
   A. Diffuse edema, with cervical relief lost, the head and the neck has the same dimension
   B. The skin is hyperemic, tensioned, smooth and shining
   C. Spontaneous pain, increasing during movements
   D. Muscles rigidity
   E. No one is correct.

171. C.M. The cervical phlegmon can diffuse to:
   A. External and internal mediastin
   B. Cranium
   C. To other neighboring spaces
   D. Through the vascular system - sepsicemia
   E. Pericardium, cardiac muscles

172. C.M. The cervical phlegmon is incised through:
   A. Suprasternal region
   B. Supraclavicular region
   C. Submandible region
   D. Anterior and posterior to the sternocleidomastoidian muscle.
   E. Doesn’t matter where the incision is made.

173. C.S. After an abscess, or phlegmon drainage the pus will be collected:
   A. To determine the color, smell and consistence
   B. Antibioticograma.
   C. To clean the wound
   D. Histological examination
   E. All of them

174. C.M. As a wound drainage may serve:
   A. Strips of sterile cotton
   B. Rubber strips
   C. Perforated rubber tubs
   D. Iodoform strips
   E. Special drains with anesthetics, antiseptics, antibacterial proprieties etc.

175. C.M. The intensive medical treatment of the diffuse phlegmon and abscess includes:
   A. The phlegmon drainage with a very large incision
   B. Eliminating of all necrotized tissue, a definitive curettage
   C. Introducing antiseptic solutions through a double perforated tube for wound
   D. Active absorption of the wound secret
   E. All of them

176. C.S. To make a wound eremitic, for an (active draining), is applied:
   A. Compressive dressing
   B. Open wound
   C. Primary sutures with unresorbable thread
   D. Emplastrum
   E. No one is correct.

177. C.M. Enzymotherepy, utilized in the treatment of inflammatory processes, have the next properties:
   A. Protectolitic effect (cleaning the wound from the necrotic tissue).
   B. Anti-inflammatory effect
C. Anticoagulant effect
D. Dishidratation effect
E. No one is correct

178. C.M. The inflammatory process with tripsine, chimiotripsine, and ribonucleasis is made by:
   A. Introducing ferments in the wound
   B. Introducing strips with of ferment solutions
   C. Intra muscular administration
   D. Intra bone administration
   E. Intravenous administration

179. C.M. The selection of the physiotherapy method in abscesses and phlegmon treatment depends of:
   A. Inflammatory faze
   B. Clinical peculiarities of the inflammatory process
   C. The organism resistance and the general body state
   D. The age, gender.
   E. The cardiovascular and nervous system state.

180. C.M. Furuncle’s predisposing factors are:
   A. Immunodepresive state
   B. Bad hygiene
   C. Diabetic
   D. Mental disease
   E. No one is correct.

181. C.M. The microbial flora in furuncle is:
   A. Staphylococcus aureus
   B. White staphylococcus
   C. Anaerobe staphylococcus
   D. Staphylococcus hemoliticus
   E. Actinomicetis

182. C.M. Furuncle affects the following elements:
   A. Skin follicle
   B. Sebaceous gland
   C. Conjunctive tissue
   D. Muscles
   E. Bone with periost

183. C.M. The patho-physiological changes in furuncle are:
   A. First, the exudates with polimorfonuclears, necrosis closes the entrance into the skin follicle
   B. Pus formation (staphylococcus, polimorfonuclears, fibrins, enzymes).
   C. The exudates affect all follicle and the surrounding tissues
   D. In the process is implied the sebaceous gland
   E. Infiltration of one skin sector, around the follicle

184. C.M. The local symptom of a furuncle is presented by:
   A. Hyperemic skin, painful at palpation, surrounding a thread of hair
   B. Stingy pain, rash
   C. In 2-3 days, pustule erupts with white-yellow pus elimination
   D. The furuncle centre is presenting by necrotic tissues
   E. After elimination of the necrosis a crater-shape defect remains

185. C.M Face furuncles are very dangerous, especially, when of it is localized:
   A. At the superior lip.
   B. Peri-nasal region
   C. Frontal region
   D. Genian region
186. CM. The furuncle can be:
   A. Unic
   B. Multiple
   C. Antracoid furuncle
   D. Hydroadenitis
   E. No one is correct

187. C.M. In case of the antracoid furuncle, are present:
   A. High temperature (39-40°C).
   B. The general bad condition
   C. Headaches, dizziness, insomnia
   D. Inapetence, nauseas, vomiting
   E. Pale skin, transpirations

188. C.M. Furuncle localized in high blood supply zone could sever complications, like:
   A. Facial vein trombophlebitis
   B. Meningitis
   C. Cerebral sinus thrombosis
   D. Septicemia
   E. Endo-cranial abscess

189. C.M. The local treatment in incipient furuncle:
   A. Applying 5% iodoform solution
   B. Rivanol applying
   C. Ice applying
   D. Hyper-tonic solution
   E. Dressings with sintomycine or streptomycin unguents.

190. M.C. The furuncle general treatment is presented by administration of:
   A. Antibiotics (oxaciline, cephalosporin, tetracycline).
   B. Immunoglobulin, gamma-globulins vaccines.
   C. Auto-hemo-therapy.
   D. Blood transfusions, conserved in small dozes.
   E. Sulfamides.

191. C.S. What is not recommended to do in a face furuncle?
   A. Incision.
   B. Follicle cutting.
   C. Pressing during examination.
   D. Hot compresses applying.
   E. Physiotherapy.

192. The furuncle surgery treatment consists of:
   A. Incision and drainage.
   B. Finger pressing for pus drainage
   C. Pus collection punctuating with a large needle.
   D. Abscess is opened by 2 deep crossed incisions.
   E. No incision. Wait the auto furuncle drainage.

193. C.M. The oro-maxillo-facial infections complications are:
   A. Incorrect administrated antibiotics treatment
   B. Late coming
   C. Diagnosis mistakes
   D. The immune-depression therapy
   E. The incomplete drainage

194. C.M. The general complications of the oro-maxillo-facial infection are:
   A. Septicemia
   B. Endocarditis, miocarditis
C. Mediastinitis, pleuritis, pneumonia, cerebral abscess
D. Trombophlebitis, sinusthrombosis, meningitis, cerebral abscess.
E. Septic shock

195. C.M. Local complications of the OMF infection are:
A. Defects, deformations
B. Alkalosis, contractions
C. Vicious cicatrix
D. Facial paralysis, neuralgia, facial pain
E. Bone fracture, pseudo-artrosis

196. C.M. Limfangitis and facial vein thrombophlebitis pathogenesis is:
A. Microbial allergy and necrosis auto-allergy
B. Inflammation and vein endothelium trauma, especially, in a hyper sensible body
C. Endovascular coagulation changes with thrombus formation
D. Angularis vein communication with infrorbital and intracranial nerves
E. No one is correct

197. C.M. The local clinic signs of the facial thrombophlebitis:
A. Evident edema alonges the angular and facial vessels
B. A painful palpation, hard infiltrate
C. The skin hyperthermia along the in strips
D. Small furuncles appeared along the vessels
E. All of them

198. C.M. The general symptoms in the facial thrombophlebitis are presented by:
A. High temperature (39, 5-40°C)
B. Patients general state affected
C. Pale skin, transpirations, and furuncles
D. Headache insomnia, dizziness, agitations
E. Losing of work capacity.

199. C.M. In facial thrombophyllebitis, the blood changes are:
A. Leukocytosis, with deviations to the left
B. Sedimentation reaction acceleration
C. The fibrinogen level increasing.
D. Increasing of factor XII
E. The haemostatic index tends to hyper-coagulation.

200. C.M. The facial thrombophlebitis complicated with sinus-thrombosis has the following symptoms:
A. Palpebral edema, chemosis, exoftalm
B. Meningitis symptoms.
C. Aphasia
D. Vision problems
E. The facial nerve and other nerves paresis.

201. CM. The meningitis, caused by abscess, phlegmon of the MF region, has the symptoms:
A. Headache, vomiting, sensibility, dislalia
B. Hyperthermia
C. Occipital muscle rigidity
D. Motor deficiency.
E. Changes in the cephalo-rahidian liquid

202. C.M. The most important clinical signs of the bacterial acute meningitis are:
A. High temperature, trembling, headache, photo-phobia, nauseas, vomiting, psychomotor agitation or comma.
B. The meningitis symptom is present (the Kerning sign, the Brudzinski sign)
C. Cephalic signs (agitation, psychomotor, delirium, visual hallucinations, confuse).
D. Sleepiness, comma.
203. C.M. The symptoms of the mediastinitis are presented by:
   A. Forsed sitting position, with head down
   B. Adynamy, agitation, sleepiness
   C. Logorrhea, aggressivity
   D. High temperature (39-40°C), trembling
   E. Pulse (140-150), arrhythmia, low blood pressure.

204. C.S. The main symptoms in the mediastenitis are:
   A. Cough
   B. Deglutition problems
   C. Dispnea with respiration rate 45-50.
   D. Nauseas, vomiting
   E. High temperature
   
205. C.M. The pathologic mechanisms of the septicemia are:
   A. Entrance site (puncture septic wounds, bone soft tissue infection).
   B. Septic source is the place where the microbes are multiplying and disseminate.
   C. The rich blood supply of the amygdale region.
   D. The pathogen germs are present in the blood, continuously and intermittently.
   E. Skeptical metastasis (pulmonary, articular, bone, peritoneal, cerebral, cardiac, mediastin).

206. C.S. In septicemia an important place has:
   A. Quantity and virulence of the pathogen agents
   B. Microbes types (aerobes, anaerobes)
   C. The immunity (immune deficit)
   D. The age, gender, social state of the patient
   E. The microbes source localization

207. C.M. The septicemia symptoms:
   A. Microorganism type
   B. Septic source state
   C. Its connection with central vascular system
   D. The body immunity
   E. No one is correct

208. C.M. For a correct septicemia diagnostic, is necessary to determine:
   A. High temperature is not corresponding to the local state
   B. Source identify (furuncle, phlegmon)
   C. Skin infection (furuncles) along the vessels
   D. Low body immunity
   E. No one is true

209. C.S. In septicemia, for microbes identifying, several haemocultures are made:
   A. Determining ordinary microbes
   B. Anaerobes
   C. For microbes, that develops in CO2 background
   D. Only one haemoculture for all types of microbes
   E. No one is correct

210. C.S. The infection adenitis causes are:
   A. Local anesthesia complications
   B. The dental-periodontal trauma
   C. Maxillary fractures
   D. The peri-maxillary inflammatory processes
   E. Maligns tumors

211. Morphologically adenitis can be:
   A. Hyperplasic.
B. Desquamatic.
C. Productive.
D. Hyperplasico-desquamatic.
E. Different form.

212. C.S. Most frequent types of adenitis:
A. Chronic adenitis
B. Specific adenitis
C. Acute serous
D. Acute purulent
E. Adeno-phlegmon

213. C.M. The acute lymphangitis symptoms are:
A. Hyperemia and edema in strips.
B. Moderate pain.
C. Palpation determines soft fillets, with moderate pain.
D. Sometimes, is presented a high temperature (37-37,5°C).
E. Palpation finds big fixed lymphatic node.

214. C.M. The main clinical symptoms of the purulent acute adenitis are:
A. Violent pain.
B. The lymph node is grown in volume
C. Skin hyperemia
D. High temperature (37, 8-37,5°C)
E. Palpation - big fixed lymphatic node

215. C.M. Adenophlegmon is debuting:
A. Spontaneously (in a few hours)
B. Acute (in 24-36 hours)
C. Slowly (in a few days, weeks)
D. Invisible
E. Without any symptoms

218. CS. The first thing what we should do in the purulent acute adenitis, is to:
A. Eliminate the source
B. Antibiotic therapy
C. Surgical treatment
D. Dressing with unguents
E. Physiotherapy

219. CM. In which forms of adenitis, the surgical treatment is first:
A. Serous acute
B. Chronic
C. Purulent acute
D. Specifics
E. Adenophlegmon

220 CS. Which form of adenitis, can have severe complications:
A. The genian adenophlegmona
B. Submentonier adenophlegmon
C. Submandible adenophlegmon
D. Cervical adeophlegmon
E. Parotidian adenophlegmon

221 CS. The adenitis prognosis is:
A. Renal complications
B. Septic severe complications
C. Satisfactory
D. From case to case, can be satisfactory
E. In some cases is provoking septicemia, mediastinitis, thrombosis
222. CM. After the adenophlegmon drainage evolution is:
   A. Body temperature increasing
   B. Edema diminishing
   C. General state alteration
   D. No pus from the wound
   E. The general body state is better.

223. CS The acute intra parotid adenitis can be confused with:
   A. Parotid mix tumors
   B. Parotid cysts
   C. Adenomas
   D. Acute parotiditis
   E. Chronic parotiditis

224. CM. The specific maxillo-facial infections are:
   A. Furuncle and carbuncle
   B. Piodermitis
   C. Actino-mycosis
   D. Tuberculosis
   E. Syphilis

225. CM. Which form is most common for actionomycosis?
   A. Actionomycosis bovi
   B. Actionomycosis israeli
   C. Actionomycosis odontoliticus
   D. Actionomycosis viscous
   E. Actionomycosis vaeslundi

226. CS. The facial bones can be invaded by actinomycosis, but, mostly frequently, is invaded the:
   A. Maxilla
   B. Nasal bones
   C. Zygomatic (malar)
   D. Mandible
   E. Palatine bone.

227 SC. The basic patho-anatomic elements of the action-mycosis are:
   A. Fistulas
   B. The pus
   C. The specific granulom
   D. The necrosis of the tissues
   E. All of them.

228. CM. The action-mycosis is localized:
   A. In the tongue.
   B. In the oral palate
   C. Salivary glands
   D. In bones
   E. Peri-mandible region.

229. CM. The treatment of the oral actinomycosis consists of:
   A. The incision of pus collection
   B. The chirurgical excision in the limited collections
   C. Limited resection of the affected
   D. Fistula chiuretage
   E. Action mycosis treatment is only conservative

230. CS. Actinomycosis starts with:
   A. Acute, in 14-36 hours, then, in some days extends to BMF territory.
B. Spontaneously, in a few hours.
C. Chronic, in a few days.
D. Slowly, without any characterized signs.
E. As a usual localized pus collection that it has a diffuse character.

231. CM. The actinomycosis signs s presented by:
A. Slow start, without characterized signs
B. Palpation, the affected region has a hard, woody edematic aspect with small abscesses formed.
C. Skin is violet-red with abscesses and fistulas
D. Trismus
E. Local processes is duration months and years.

232. CM. Tuberculosis wound in the maxillary-facial territory has:
A. Koch bacillus is present.
B. Microbe determining during microbiological analysis
C. Positive reaction at the mouse
D. Positive reaction at tuberculin.
E. Histological structure.

233. CM. OMF region tuberculosis forms:
A. Primary
B. Secondary
C. Face bone tuberculosis.
D. Lymphatic nodules tuberculosis
E. Salivary gland tuberculosis

234. CM. Secondary tuberculosis bucal eruptions
A. Ulceration
B. Oral lupus
C. Goma
D. Localized granulation
E. Bacillary adenitis

235. CM. The cervical-facial tuberculosis adenitis is caracterised by
A. Presence of fistula
B. Disappears in time
C. Become harder
D. Persistent chronic adenitis
E. No one is correct.

236 CM. The primary tuberculosis is characterized by existence of the primary complex, formed from;
A. Ulceration
B. Adenopathy
C. Goma
D. TBC lupus
E. Osteomelitis

237. CM. The syphilis is a blood disease, with chronic and intermittent evolution, with next periods:
A. Acute and chronic cellulite
B. Primary syphilis
C. Secondary syphilis
D. Tertiary syphilis
E. No one is correct

238. CS. The most frequent localization of the syphilitic goma is in:
A. The lips
B. The tongue
C. The palatine  
D. The cheek  
E. The skin-mucosa junction of the lips  

239 CM. From all the sinusitis forms, mostly frequently is organizing them according to the frequency:  
A. Allergic  
B. Traumatic  
C. Rinogens  
D. Odontogens  
E. All  

240. CM. Odontogen sinusitis etiology:  
A. The apical granular parodontitis from superior frontal teeth  
B. Low body resistance  
C. The deep periodontal pockets in the premolar region  
D. The acute and cryonic apical parodontitis from superior molars  
E. The suprainfected radicular cysts of the superior molars and premolars.  

241. CM. The most frequent factors in the odontogen sinusitis are:  
A. Molars and premolars endo-dental treatments with pushing the necrotic tissues after apex.  
B. The supra – infection of radicular cysts  
C. Difficult extractions of the 5.6.7.  
D. Apical acute or chronic parodontitis the 5, 6, 7.  
E. Low body resistance.  

242. CM. The local clinical symptoms of the acute sinusitis are:  
A. Pain with muscle contractions  
B. Violent pain with reflection in the suborbiter region  
C. Cacosmia, pulsate pain, radiating and increasing with the head position  
D. Hyperemia and edema of the nasal mucosa  
E. Rinoreea with pus.  

243 CM. The local symptoms in acute maxillary sinusitis are:  
A. Pain accompanied with muscle and vessel-motor signs  
B. Day time pain, reflected to the pretragian region  
C. Subjective cocosmia and pain with pulsate character radiating and increasing with the head position change.  
D. Mucosa edema and hyperemia.  
E. At the previous rinoscopia is observed a purulent secretion, and, sometimes, polyps.  

244. CM The maxillary acute sinusitis is made with differential diagnosis:  
A. Maxillary osteomelitis  
B. Intra-sinusal mucosal cyst  
C. Dental cyst in the septic complications faze  
D. Cilindrom  
E. Odontogen genian cellulite  

245. CM. The mineral sedimentation is increased from:  
A. Hiposalivation  
B. Salivary stasis  
C. Saliva basic pH  
D. Bigger concentration of minerals  
E. Presence of desquamated cells.  

246. CM. Which, from next signs, are present in case of the oro-sinus communication?  
A. Passing with instrument to the sinus through the alveola  
B. Negative Valsalva sign  
C. Radiological - image of normal sinus
D. Radiological - oro-sinus communication
E. Coming fluids from mouth to the nose

247. CM. In the case of the oral-sinuses communication is needed to make:
   A. The causal tooth extraction under the antibiotics protection
   B. The sinuses puncture and oro-sinus communication plasty.
   C. The oro-sinus communication plasty
   D. The radical treatment of the affected sinus
   E. All are correct

248. CM. Which from the next method can be used to close the oro-sinus communication?
   A. The one lever suture
   B. The suture in 2 layers with pediculate flap
   C. The simple wound suture
   D. Two-layers suture, with mucosa, witch is brought from nearest tissues
   E. Suture in one layer, with iodoform protection.

249. CM. The chronic maxillary sinusitis clinical signs:
   A. Subjective permanent cacosomia
   B. The night, irradiating pain
   C. Anterior rinoscopia founds purulent secretion with mucus, with hyperemia and thickening of the mucosa
   D. The pain is present, especially, in the morning
   E. Start asymptomatic till the intrabone stage later deforming the orbit walls and pushing the ocular globe.

250. CS. In the dental chronic sinusitis the treatment is starting with:
   A. Radical sinus treatment
   B. The causal tooth extraction
   C. Physiotherapy treatment
   D. Aerosols
   E. All are correct

251. CM. The acute sinusitis types are:
   A. Catarrhal
   B. Serous
   C. Purulent
   D. Hyper-plastic
   E. Papillomatous

252. CS. In the diagnostic of the chronic sinusitis, the basic one is:
   A. Puncturing
   B. Rynoscopia
   C. Radiography
   D. Diaphanoscopy
   E. Clinic oro-sinus communication al examination

253. CM. Which way of physical examination helps in diagnostic of the oro-sinus communication?
   A. Passing through the alveola to the sinus with instrument.
   B. Puncture
   C. The positive Valvasa syndrome
   D. Anterior rinoscopia
   E. At pressure, the alveolar ridge is painful

254. C.S. The most frequent cause of inferior wall sinus perforation is:
   A. Bone resection at the tumors excision
   B. The superior molar extraction
   C. The syphilitic coma
   D. Osteo-radio-necrosis
E. The maxillary bone fracture

255. CM. In the chronic odontogen sinusitis treatment is indicated:
   A. The administration of antibiotics with large spectrum of action.
   B. The extraction of the causal tooth and the administration of antibiotics.
   C. The radical sinusotomia Caldwell-Luc
   D. The sinus drainage
   E. Puncture

256. CS. The dental extraction sinus accidents can occur:
   A. At all maxilla teeth
   B. Superior incisive and canines
   C. Superior molars and premolars
   D. Inferior molars and premolars.
   E. Extracted teeth localization is not important.

257. CM. Which are the basic steps in sinusotomia Caldwell-Luc?
   A. Incise on the bottom of the vestibular bag from the 2-7 teeth.
   B. Flap undermining and making a window at the fossa canini level
   C. Pathologic elements curettage collaged mucosa, reticular pieces obscuration substance.
   D. Creating a communication with inferior nasal meatus
   E. Filling the sinus with iodoform strip and suture the wound margins with unresorbable thread.

258. CM. In the oro-sinus communication, the communication closure is made with:
   A. A trapezoid mucoperiostal vestibular flap
   B. An oval flap, taken from the mucoperiostal palatine region
   C. An oval flap, taken from the bottom of the vestibular bag
   D. Two la flap in 2 layers
   E. With cutting the alveolar margin and 2 parallels incises (vestibular and palatine) on the orifice limit and suture.

259 CS. Through the Stenoni channel the saliva is coming from the:
   A. Sub-lingual gland
   B. Sub-mandiblar gland
   C. Parotid gland
   D. Accessorial glands
   E. No one is correct.

260. CS. The Stenoni channel opening is in the:
   A. Cheek region
   B. Sub-lingual region
   C. Cheek region at the level of the first superior molar
   D. Palatial region
   E. retro-molar region.

261. CS. The Wharton channel opening is in the
   A. Sub-lingual region
   B. Palatial region
   C. Retro-mandiblar region
   D. Cheek region
   E. Cheek region, at the level of the 6 year molar.

262. CS. Through the Whartoni channel, the saliva is eliminating from:
   A. Parotid gland
   B. Sub-lingual gland
   C. Accessorial glands
   D. Sub-mandible gland
   E. All the answers are correct.
264. CM. The parotid is the biggest salivary gland and is located in the parotid region with the next limits:
   A. Anterior-the ascendant branch of the mandible
   B. Posterior-mastoid, on which is inserted sternoceleidomastoidian and digastric muscle.
   C. Superior-ATM and the porus acusticus externus
   D. Inferior the sub mandible pectinea membrane.
   E. Median pharynx, and extern-the cervical superficial fascia.

265. CM. The secretion dysfunctions of the salivary glands are.
   A. Sialorea
   B. Ptialismus
   C. Hiper-salivation
   D. Hypo-sialia
   E. Asialia

266. CM. The sialodokites are representing inflammatory processes, localized at:
   A. Whartoni channel
   B. Stenoni channel
   C. Big salivary glands
   D. Small salivary glands
   E. All are correct.

267. CM. The sialodokitis types are:
   A. Acute sialodokitis
   B. Chronic calculous sialoodlekitis
   C. Chronic fibrin sialodokits
   D. Purulent chronic sialodokitis.
   E. All of them.

268. CS. At salivary gland X-Ray examination with contrast substances will show:
   A. Salivary gland channel narrowing.
   B. The significant channel dilatation
   C. Normal salivary channel
   D. The channel is having different zones: alternation of large and narrow zones.
   E. All the answers are correct.

269. CM. The sealodokitis treatment consists of:
   A. Of the salivary calculus removing
   B. Administering of sialogogic medicines and oral antiseptics
   C. The general and local anti-infection treatment, in case of purulent sialodokitis
   D. Salivary gland massage from the duct to ostium
   E. Physiotherapy (laser, ultrasound, electrophoresis)

270. CS. The acute sialodadenitis is the inflammations of:
   A. Big salivary ducts
   B. The small salivary gland
   C. The parotid and sub-mandiblar glands
   D. Lymphatic nodes, situated in the glands spaces
   E. All the answers are correct.

271. CM. The acute sialoadenitis cause factors are:
   A. Difficult in the salivary hygiene.
   B. The foreign bodies in the salivary channels.
   C. Chronic diseases of the salivary glands
   D. The salivary hyposecretion
   E. Infections and, especially and difficult post-chirurgical state.

272. CM. Salivary glands infection is spread:
   A. Trans-boned way
   B. Sub-mucosa way
C. Lymphatic way
D. Haematogen way
E. Though the salivary channel.

273. CM. Acute purulent parotidis, the bilateral sigh:
A. A gravity sigh:
B. Spontaneous pain remission.
C. A reserved prognostic
D. Usually, is bilateral, sometimes-unilateral
E. Bilateral, only when the debut is nodular.

274. CM. The acute purulent submaxillities
A. Sub-mandible edema with skin congestion
B. Mandible margin is hidden because of a edema
C. The gland is bigger, infiltrated painful at palpation
D. Hyperemia and edema of sublingual mucosa
E. Puss secretion through Wartoni channel at pressure

297. CS. The salivary fistulas are:
A. Multiple ways of saliva drainage
B. Normal ways of saliva secretion
C. The Stenon channel secretion
D. Exterior saliva secretion
E. Oral cavity saliva secretion

298. CS. Salivary fistula, which is not presenting clinical interest are:
A. Fistulas with in the skin drainage
B. Fistulas with mucosa drainage
C. 2 ways drainage (skin, mucosa)
D. The Stenon fistula channel
E. Parenchymatous fistulas

299. CM. The salivary fistula symptoms are orientated by:
A. The abnormal saliva secretion, which is bigger in the mastication process
B. Presence of an unclearly foramen
C. The skin, around the fistula, sometimes can be red with macerated zones
D. Obviously edema of the salivary gland
E. High temperate, headache, the bed general condition

300. CS. The sialolitiasis is a disease, characterized by:
A. Acute inflammatory process
B. Calculus in the salivary gland or in the excretory channel
C. A benign tumor
D. An acute cellulite
E. A diffuse phlegmon of the salivary gland