Choose the **Correct** answer

1-Causes of acute pre-renal failure

a- Neurogenic bladder

b- Acute tubular necrosis

c- Dehydration

d- Refluxing ureters

2- As regard nephrotic syndrome

a-Remission is defined as urine trace or negative for protein for 2 consecutive days

b-Relapse is defined as mild proteinuria after a good response to corticosteroids

c-Relapse is extremely rare

d- Hypocomplemetinemia is an indication for renal biobsy before starting treatment

3-As regard pyuria

a-Defined as the presence of more than 5 leucocytes/hpf

b- Always indicate the presence of urinary tract infection

c-Tonsillitis dose not cause pyuria

d-Urinary bilharziasis never associated with pyuria

4-In acute poststreptococcal glomerulonephritis

a-Follows infection of throat or skin by nephritogenic strains of group C hemolytic streptococci

b- Urinary protein excretion & hypertension normalize by 1 – 2 years after onset

c- Microscopic hematuria may persist for 1–2 years after onset

d-Hyaline casts are predominant in urine

5- As regard nephrotic syndrome

a- Remission is defined as urine trace or negative for protein for 2 consecutive days

b- Relapse is defined as proteinuria (1 or 2+)

c- Relapse is extremely rare

d- Hypocomplemetinemia is an indication for renal biobsy before starting treatment

6- Charateristics of normal urine include

a-PH is 9

b-RBCs are 5 – 7 / HPF

c-WBCs are from 0 - 1 / HPF

d-Normal protein excretion is up to 4mg/kg/hour urine

7- As regard nephrotic syndrome

a-Rapid response to steroids & absence of relapse in 1st six months after diagnosis is associated with infrequent relapsing course

b-Dose of corticosteroid is 60 mg / kg body weight/day for 4 – 8 weeks

c- Persistent hematuria is not an indication for renal biobsy before starting treatment

d- Release of antidiuretic hormone has no relation to the etiology of edema

8- The most reliable diagnostic laboratory test diagnosing acute renal failure is

a-Blood urea nitrogen

b-Serum creatinine

c-Serum potassium

d-Blood gas analysis

9- Diagnostic laboratory investigation associated with acute renal failure include

a-hypophosphatemia

b-hypernatremia

c-metabolic alkalosis

d-metaboloic acidosis

10-As regard protein excretion in urine

a- Normal protein excretion up to 40mg/m2/hr urine

b-Nephrotic range proteinuria more than 40mg/m2/hr urine

c-Proteinuria in minimal change disease is never selective

d-Proteinuria is due to loss of positive charge of glycoproteins present in the glomerular basement membrane

11-As regard nephrotic syndrome

a-Secondary nephrotic syndrome conistitute 90% of cases in children

b-Minimal change disease is uncommon

c-Typhoid fever can be complicated by nephrotic syndrome

d-It is more common in females than males

12-As regard spot urine protein / creatinine ratio

a- Its normal level in children less than 2yrs of age is more than 0.5

b- Its normal level in children more than 2yrs of age is less than 0.2

c- Morning urine sample is not accurate

d-It diagnoses nephrotic syndrome if the ratio is more than 1

13-AS regard urinary tract infction

A-significant bacteruria is defined as bacterial count of the clean catch urine is more than or equal to 10,000/ml

b-more common in male than female childrens

c-the most common causative organism is E-coli

d-main source of infection is the urethra

14-As regard diagnosis of urinary tract inection

a-Urine culture shows 10,000 colonies of a single pathogen

B- DMSA scan is used to detect renal stones

c-Urine culture shows 1000 colonies of a single pathogen in symptomatic child

d-Acute pyelonephritis may present with acute gastroenteritis in infants

15-As regard hematuria:

a-Microscopic hematuria is defined as the presence of 15 or more RBCs / hpf

b-Terminal hematuria is upper urinary tract in origin

c-Deformed urinary RBCs signify glomerular origin of hematuria

d-Lower urinary tract lesions are associated with abnormal RBCs morphology, moderate proteinuria(more than 100mg/d)

16-In acute poststreptococcal glomerulonephritis

a- Serum C3 level is decreased & returns normal 2 weeks after onset

b- proteinuria is in the range of 4– 40mg/m/hr urine

c- long acting penicillin is given for prophylaxis to prevent reccurence

d- Fluid intake is calculated as insensible water loss (100ml/m2/24hr) + urinary out-put

17-As regard treatment of urinary tract infection

a-A 7 days course of a broad spectrum antibiotics is needed for treatment of acute pyelonephritis

b- Treatment may start before obtaining a urine specimen for culture & sensitivity test

c-Follow up include doing urine culture for 1-2 years only in symptomatic children

d-Vesico-ureteric reflux is associated with frequent recurrences of UTI

18-As regard treatment of minimal change nephrotic syndrome

a-Diet should be protein resricted

b-Judicious use of diuretics is mandatory to avoid increased risk of thromboembolic complications

c- About 50 % of children respond to prednisone within 3 – 5 weeks

d-History of BCG vaccination has no significance before starting treatment with prednisone

19-As regad management of acute renal failure

a-Protein in diet is normal

b-Potassium intake is not restricted

c-Protein in diet is high

d-Fluid intake is administered according to urine output and insensible water loss

20- Diagnostic laboratory investigations associated with acute renal failure include:

a-Hypokalemia

b-Hypercalcemia

c-Anemia,thrombocytopenia,leucopenia

d-Respiratory acidosis

21- causes of acute post- renal failure

a-Burns

b-Glomerulonephritis

c-Cyanotic congenital heart diseases

d-Bilateral pelviureteric junction obstruction

22-As regard nephrotic syndrome

a-85% of idiopathic nephrotic syndrome is membranoproliferative

b-Worest prognosis is associated with focal glomerulosclerosis

c-Only 50% of cases with minimal change disease respond to prednisone treatment

d-Proteinuria in minimal change disease is rarely selective

23- In nephrotic syndrome

a-Edema is due to increased plasma protein level

b-Renin-angiotensin system activation has no role in etiology of edema

c-Hyperlipidemia is due to decreased plasma lipoprotein lipase

d-The most common age of presentation in minimal change disease is 1- 12 years of age

24- As regard diagnosis of minimal change nephrotic syndrome

a-Renal biobsy is required for diagnosis in most children

b- Serum Complement C3 & C4 are decreased

c- Serum albumin level is less than 2.5 g / dl

d- Granular casts are predominant in urine analysis

25-As regard complications of nephrotic syndrome

a- Spontaneous peritonitis the most common type of infection and caused by staphylococcus aureus.

b- Immmunosupressive therapy is not an etiological factor

c-Increased tendency to arterial & venous thrombosis is due to decreased prothrombotic factors

d- Polyvalent pnemococcal vaccine given to all children with nephrotic syndrome when child is on alternate day therapy.

False & True

- Systemic hypertension is a common complication of idiopathic nephrotic syndrome
- Generalized non pitting odeama is a cardinal sign of idiopathic nephrotic syndrom
- Most cases of idiopathic nephrotic syndrome are steroid resistant
- Hypocomplementemia is almost always present in acute postinfecious GN
- Rt sided HF is a common complication of acute GN
- In acute poststreptococcal GN corticosteroids represents a major line of treatment

Case Senario

A 5 years old boy presenting with a one week history of generalized edema starting around the eyes. On examination there is ascites , B.P.100/70 , Spot urine Protein /creatinine ratio is 4 , serum cholsterol 285mg/dl.

Q1: What is the possible diagnosis?

Q2: Mention 2 other investigations.

Q3: Mention 2 possible complication.

Q3: What is the treatment?

Case senario 2

A 13 years old girl presenting with a 15 days history of generalized edema starting as morning buffy eyes. On examination there is ascites , B.P.140/85 mmhg , Spot urine Protein /creatinine ratio is 5 , serum cholsterol 465mg/dl.

Q1: What is the possible diagnosis?

Q2: Mention 1 important investigation .

Q3: Mention 2 possible complication.

Case senario 3

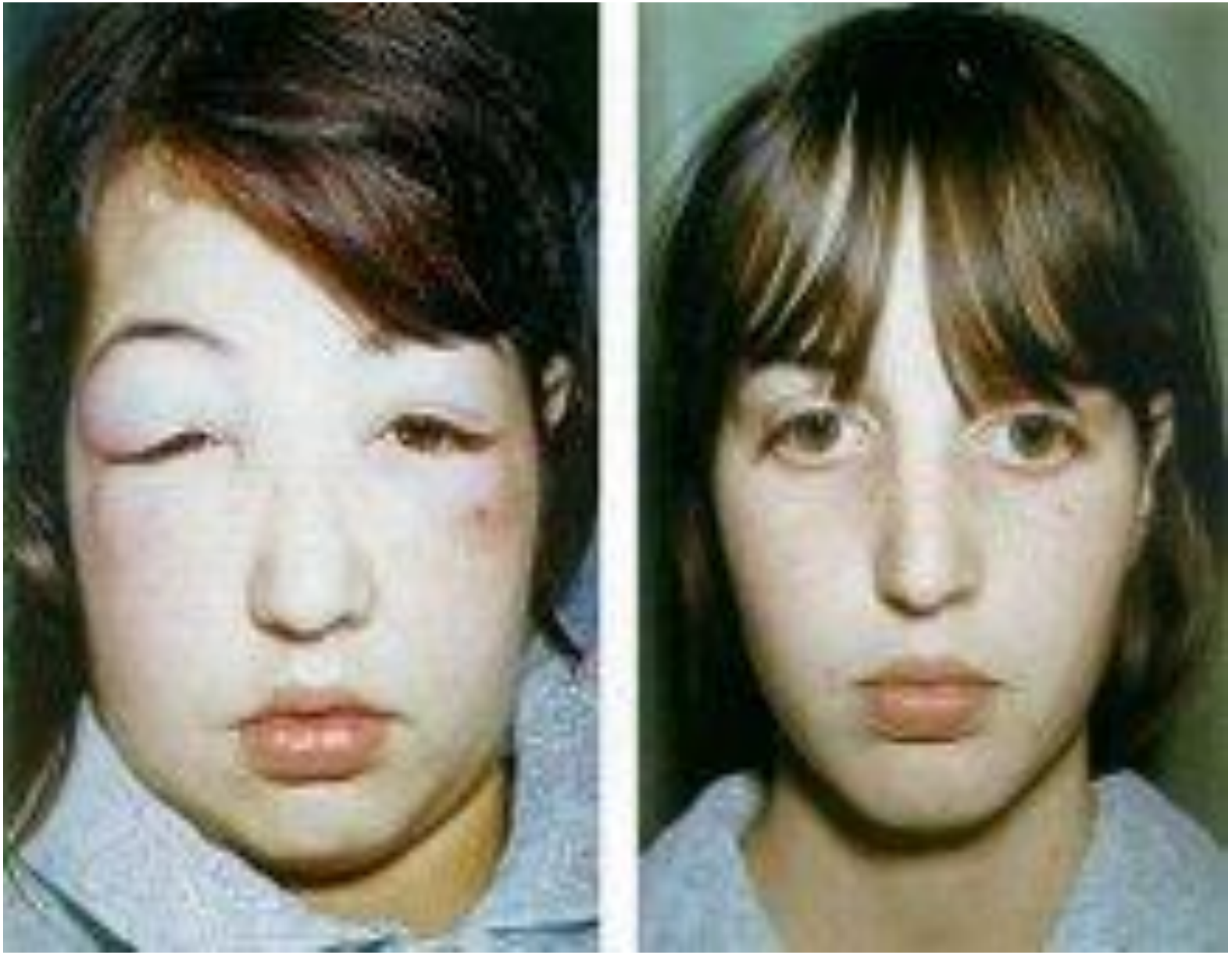
A 5 years old boy presenting with a 5 days history of cola-like urine, generalized edema starting as morning buffy eyes. On examination : B.P. is 140/85mmhg , urine analysis shows RBCs 100/hpf, ASOT 350 , C3 is decreased.

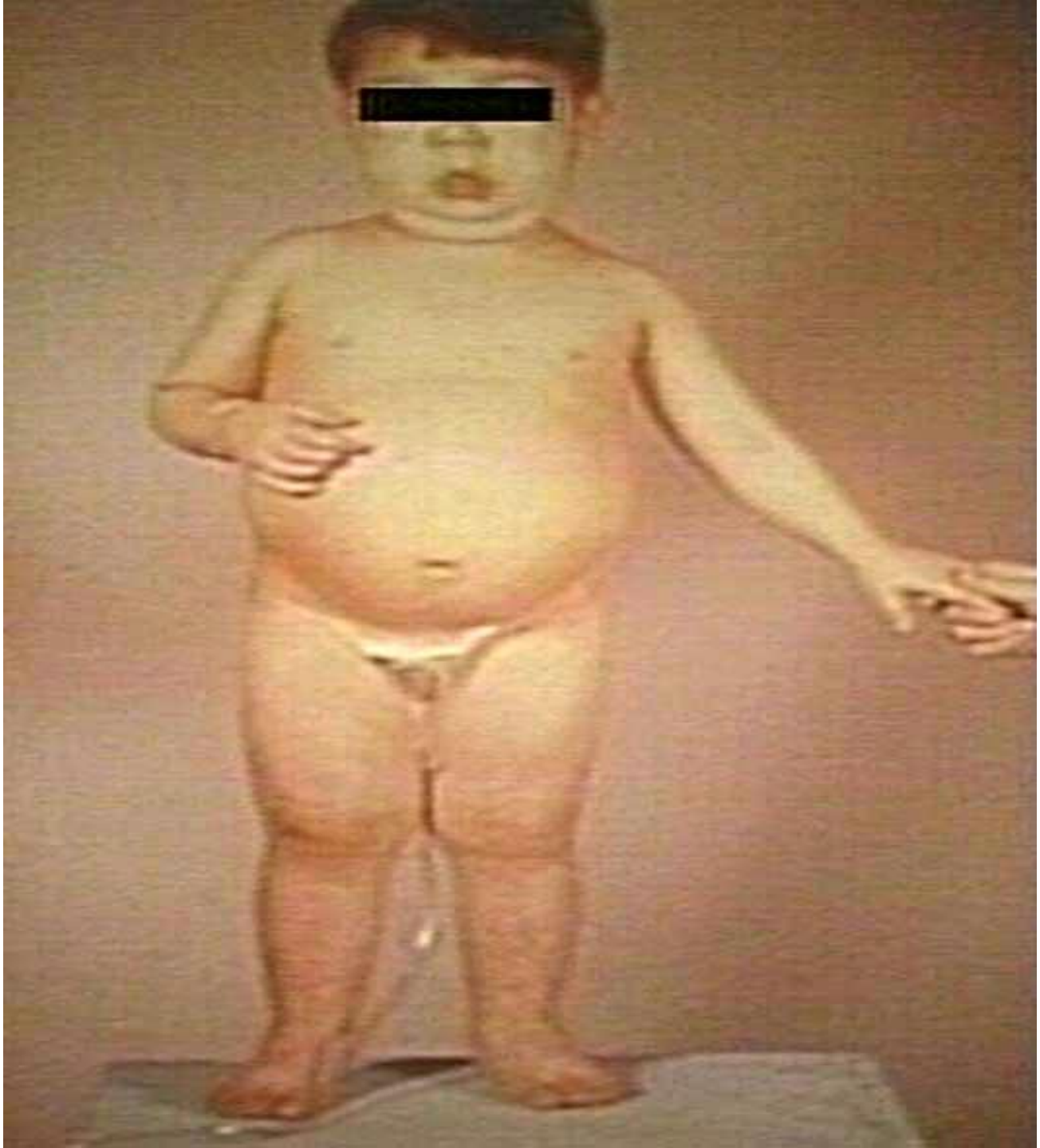
Q1: What is the possible diagnosis?

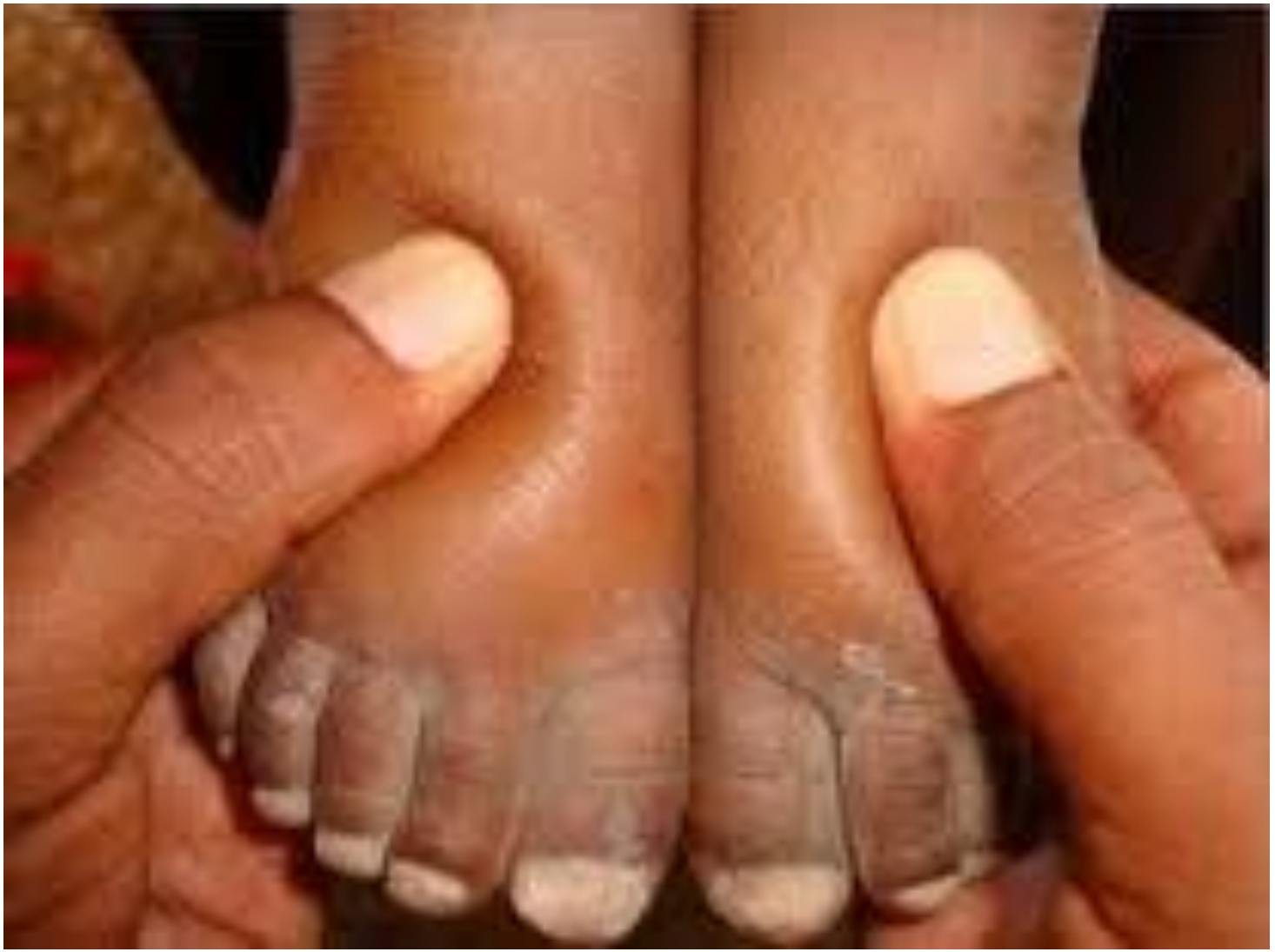
Q2: Mention 2 other investigations .

Q3: Mention 2 possible complication.

Q4: Mention 3 lines of treatment.







A Child with Nephrotic Syndrome


© Dr Rajesh Shah