The Ochsner Journal
Continuing Medical Education
CME QUESTIONS VOL. 8, NO. 4

This section provides a review. Mark each statement (circle the correct answer) according to the factual material contained in this issue and the opinions of the authors. A score of 70% per article is required to qualify for CME credit.

Treatment of Periocular Malignancy by Interdisciplinary Approach (pp 163-165)

1. Microsurgical excision and pathology of a tumor specimen is referred to as:
   a. Frozen section.
   b. Histopathological analysis.
   c. Moh's microsurgery.
   d. None of the above.
2. Reconstruction of resultant surgical defects is usually referred by the Moh's surgeon to an appropriate subspecialist because:
   a. The Moh's surgeon is too busy to be involved in reconstruction.
   b. Surgeons specifically trained in subspecialty techniques generally achieve superior cosmetic and functional results.
   c. Moh's surgery is bloodless.
   d. Moh's surgeons are usually dermatologists.
3. Reconstruction of periorbital defects can involve:
   a. Advancement flaps.
   b. Cheek rotation flaps.
   c. Rhomboid flaps.
   d. All of the above.

Sphenoid Sinus Myxoma: A Case Report and Literature Review (pp 166-171)

1. Myxomas of the head and neck most commonly present in the paranasal sinuses.
   True or False
2. Histologically, myxomas of the paranasal sinuses contain all of the following, except:
   a. Myxoid fragments.
   b. Sinonasal mucosa.
   c. Adipose tissue.
   d. Stellate neoplastic cells.
3. The most common reason for recurrence of a head and neck myxoma is:
   a. Metastatic disease.
   b. Inadequate excision.
   c. The presence of bony erosion.
   d. Preoperative cerebrospinal fluid leak.

The Surgical Management of Minor Salivary Gland Neoplasms of the Palate (pp 172-180)

1. What is the most common malignant tumor of the palate encountered in this series? ____________________
2. On average, how long are symptoms, usually pain or swelling, present prior to diagnosis? ____________________
3. What factors are at high risk for recurrence?
   a. Aggressive histology.
   b. Tumors greater than 3 cm.
   c. Perineural invasion.
   d. Bone invasion.
   e. Positive surgical margins.

Malignant Melanoma of the Head and Neck: A Brief Review of Pathophysiology, Current Staging, and Management (pp 181-185)

1. Which of the following subtypes of melanoma carries the worst prognosis?
   a. Nodular.
   b. Lentigo maligna.
   c. Superficial spreading.
   d. Acral lentiginou.
2. What is the current standard of care for assessing the neck for nodal metastases in a patient with intermediate thickness melanoma?
   a. Computed tomography scan.
   b. Sentinel lymph node biopsy.
   c. Elective neck dissection.
   d. Serum melanoma antigen.
3. What is the basis for treatment of all types of melanoma?
   a. Chemotherapy.
   b. Radiation.
   c. Immunotherapy.
   d. Excision with depth-appropriate margins.

Reconstruction of Large Lateral Facial Defects Utilizing Variations of the Cervicopectoral Rotation Flap (pp 186-190)

1. What cervicopectoral flap variation is ideal for a patient undergoing a wide local resection of a nodular melanoma and an ipsilateral neck dissection with neurovascular exposure?
   a. A cervicopectoral rotation flap with an underlying pectoralis major myocutaneous rotation flap with skin paddle.
   b. A cervicopectoral rotation flap with an underlying pectoralis major myofascial rotation flap.
   c. A cervicopectoral rotation flap.
2. The blood supply of the cervicopectoral flap is derived from the:
   a. Thoracodorsal artery.
   b. Thoracoacromial artery.
   c. Transverse cervical arteries.
   d. Internal mammary artery.
3. What cervicopectoral flap variation is ideal for a patient undergoing a wide local resection of a squamous cell carcinoma of the lower face and lip eroding intraorally?
   a. A cervicopectoral rotation flap with an underlying pectoralis major myocutaneous rotation flap with skin paddle.
   b. A cervicopectoral rotation flap with an underlying pectoralis major myofascial rotation flap.
   c. A cervicopectoral rotation flap.

Gastric Carcinoid Tumors (pp 191-196)

1. Which of the following type/types of gastric carcinoids is/are usually associated with the typical carcinoid syndrome as manifested by flushing, diarrhea, and right-sided heart failure?
   a. Type 1.
   b. Type 2.
   c. Type 3.
   d. None of the above.
   e. All of the above.
2. Which of the following type/types of gastric carcinoids is/are associated with atypical carcinoid syndrome?
   a. Type 1.
   b. Type 2.
   c. Type 3.
   d. None of the above.
   e. All of the above.
3. Which of the following type/types of gastric carcinoids is/are associated with hypergastrinemia?
   a. Type 1.
   b. Type 2.
   c. Type 3.
   d. A and B.
   e. All of the above.
4. Which of the following has the highest risk for metastasis?
   a. Type 1.
   b. Type 2.
   c. Type 3.
   d. A and B.
   e. All of the above.
5. Somatostatin receptor scintigraphy is a very useful modality for the detection of metastasis based on the fact that more than 90% of GEP-NETs contain high concentrations of somatostatin receptors.
   True or False

Gastrointestinal Stromal Tumors—Diagnosis and Management: A Brief Review (pp 197-204)

1. A 55-year-old male undergoes an upper endoscopy for heartburn. Esophagogastroduodenoscopy reveals a submucosal lesion in the gastric antrum, which appears to be approximately 3 cm in size. The overlying mucosa appears normal. Probing with cold biopsy forceps showed a rubbery-like, slightly mobile mass without a "pillow sign." Cold biopsies demonstrated normal appearing mucosa with no histologic abnormality. What is the best step to secure a diagnosis?
   a. Computed tomography with oral and intravenous contrast.
   b. Magnetic resonance imaging.
   c. Transabdominal ultrasound.
   d. Endoscopic ultrasound-guided fine-needle aspiration.

(Questions continued on opposite side)

The maximum number of credits awarded for this activity is 10 *AMA PRA Category1 credits™*

(Questions continued from opposite side)

2. A 60-year-old female is diagnosed with a 15 cm gastrointestinal stromal tumor in the gastric body after initially presenting with nausea and vomiting. There is no evidence of metastatic disease on imaging. What is the best management approach?
   a. Surgical resection.
   b. Surgical resection and adjuvant tyrosine kinase inhibitor therapy.
   c. Surgical resection and neoadjuvant tyrosine kinase inhibitor therapy.
   d. Surgical resection and neoadjuvant cytotoxic chemotherapy.
3. All of the following are prognostic of malignancy in gastrointestinal stromal tumor except?
   a. Size.
   b. Ulceration.
   c. Mitotic count.
   d. Anatomic location.

Combination Laparoscopic Radiofrequency Ablation and Partial Excision of Hepatic Hemangioma (pp 205-207)

1. Laparoscopic radiofrequency ablation (RFA) is comparable with surgical resection.
   True or False
2. Which of the following is false about laparoscopic RFA?
   a. Is minimally invasive.
   b. Is not feasible for intra-operative ultrasound scan of the liver.
   c. Allows for detection of lesions.
   d. Allows for accurate targeting.
3. Pneumoperitoneum is dangerous in laparoscopic RFA.
   True or False
4. Laparoscopic RFA is suitable for subscapular lesions or those near the gallbladder.
   True or False

Breast Cancer Metastatic to the Urinary Bladder (pp 208-212)

1. Metastatic breast cancer to the bladder is usually associated with pelvic involvement.
   True or False
2. Urinary symptoms in a patient with cancer should be evaluated.
   True or False

Pathogenesis of Prostate Cancer: Lessons from Basic Research (pp 213-218)

1. The five-year survival of patients with localized prostate cancer is approximately:
   a. 95%.
   b. 60%.
   c. 30%.
   d. 10%.
2. Which of the following is the first-line therapy for hormone-sensitive advanced prostate cancer?
   a. Luteinizing hormone-releasing hormone agonists.
   b. Chemotherapy with platinum-based doublets.
   c. Radiation therapy.
   d. Selective estrogen-receptor modulator therapy.
3. Which of the following is true regarding advanced prostate cancer?
   a. Response to androgen depletion therapy is predictive of survival in patients with advanced prostate cancer.
   b. The majority of patients on androgen depletion therapy develop hormone-refractory disease within 18 months of therapy.
   c. Chemotherapy in combination with androgen depletion is the treatment of choice for hormone-sensitive prostate cancer.
   d. All of the above.

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Please indicate the actual time spent reading and completing this education activity. _______ hour(s) and ________ minutes.
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____________________ ____________________

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EVALUATION

Your response to these questions helps us to enhance our CME offerings. Please take the time to respond and return the evaluation. Thank you.

Please use the following codes to answer items 1-7.

SA – Strongly Agree
A – Agree
U – Undecided
D – Disagree
SD – Strongly Disagree

1. The objectives of the CME activity were clearly stated.
   SA A U D SD
2. The content of the journal articles was up-to-date.
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3. The journal articles illustrated independence, objectivity, balance, and scientific rigor.
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4. The content was closely related to objectives of my clinical practice and/or teaching.
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7. I will apply the information learned from these journal articles in my clinical practice.
   SA A U D SD

Do you have any suggestions as to how to improve the content of the journal articles?

____

What topics would you like to see in future journal articles?

____

Thank you for completing this evaluation and survey.