New MCCQE Exam Question - Interactive MCCQE Questions

MCCQE Part 1 Practice Questions

Question 1

A 65-year-old man presents with worsening dyspnea and paroxysmal nocturnal dyspnea. On examination, there are bibasilar crackles and an S3 heart sound. What is the most likely diagnosis?

- A) Chronic obstructive pulmonary disease (COPD)
- B) Pneumonia
- C) Congestive heart failure (CHF)
- D) Pulmonary embolism

Question 2

A 45-year-old woman presents with fatigue, weight loss, and hyperpigmentation. Lab results reveal hyponatremia and hyperkalemia. What is the most likely diagnosis?

- A) Hypothyroidism
- B) Addison's disease
- C) Cushing's syndrome
- D) Hyperaldosteronism

Question 3

A 30-year-old man is involved in a motor vehicle accident and presents with hypotension, muffled heart sounds, and distended neck veins. What is the most likely diagnosis?

- A) Myocardial infarction
- B) Cardiac tamponade
- C) Pulmonary embolism
- D) Aortic dissection

Question 4

A 25-year-old woman presents with palpitations, sweating, and episodic headaches. Her blood pressure is persistently elevated. What is the most likely diagnosis?

- A) Hyperthyroidism
- B) Pheochromocytoma
- C) Panic disorder

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Medical Council of Canada MCCQE Part 1 Exam Sample Questions (Q54-Q59):

NEW QUESTION # 54
A 20-year-old woman, gravida 0, para 0, presents with increased facial hair. Her periods are regular and moderate. Her BMI is 24, and her blood pressure is 110/70 mm Hg. Which one of the following is the most likely diagnosis?

- A. Idiopathic hirsutism.
- B. Adrenal hyperplasia.
- C. Hilar cell tumour.
- D. Polycystic ovary disease.
- E. Sertoli-Leydig cell tumour.

Answer: A

Explanation:
Idiopathic hirsutism is the most likely diagnosis because this patient has isolated hirsutism with normal vital signs, normal BMI, and regular menstrual cycles , suggesting preserved ovulation and no clinically significant endocrine disturbance. MCCQE objectives emphasize that the most common causes of hirsutism are PCOS and idiopathic hirsutism; PCOS typically includes menstrual irregularity/oligo-ovulation and often metabolic features (overweight, insulin resistance), none of which are present here. Androgen-secreting ovarian tumors (hilar cell or Sertoli-Leydig cell tumors) usually cause rapid onset, severe hyperandrogenism and virilization (deepening voice, clitoromegaly, marked acne) and often disrupt menses-features not described. Nonclassic congenital adrenal hyperplasia can present with hirsutism, but it more commonly associates with acne, infertility, or menstrual abnormalities and requires biochemical suspicion rather than being the "most likely" with normal cycles. Therefore, idiopathic hirsutism-often due to increased peripheral androgen sensitivity or local 5-alpha reductase activity-is the best fit.

NEW QUESTION # 55
A 65-year-old woman presents to the office for follow-up regarding vaginal bleeding. Her last visit was 2 months ago. At that visit, the results of a pelvic examination and a Papanicolaou test were normal. She also had an endometrial biopsy but there was "insufficient material for diagnosis." She reports that she is still losing small amounts of blood almost every day. On history, she has been taking continuous combined hormone replacement therapy for 10 years because of vasomotor symptoms. Which one of the following is the most appropriate next step in management?

- A. Decrease the dosage of progestin.
- B. Organize a hysteroscopy.
- C. Refer for a hysterectomy.
- D. Change hormones to a selective estrogen receptor modulator.
- E. Order a colposcopy.

Answer: B

Explanation:
Persistent postmenopausal bleeding requires thorough evaluation. An inadequate endometrial biopsy result does not rule out pathology. Hysteroscopy allows for direct visualization and targeted biopsy and is the gold standard when biopsy is non-diagnostic.
Toronto Notes 2023 - Gynecology, "Abnormal Uterine Bleeding and Endometrial Cancer" Section:
"Persistent bleeding with insufficient biopsy requires further evaluation, preferably via hysteroscopy and directed biopsy. This is especially important in patients on HRT or with risk factors for endometrial pathology." MCCQE1 Objectives (Obstetrics & Gynecology > 82-9: Postmenopausal Bleeding):
"Candidates must investigate abnormal bleeding in postmenopausal women with hysteroscopy when endometrial sampling is non-diagnostic." Changing hormones (A), reducing progestin (E), or performing colposcopy (C) are not appropriate without confirming the cause of bleeding.

NEW QUESTION # 56
A 35-year-old woman, gravida 3, para 0, aborta 3, presents with her male partner because she has been unable to conceive despite trying for more than 1 year. Her menstrual cycles have been absent for 9 months, and she has occasional mild cyclic pain. She has a medical history of 3 suction curettages. Her BMI is 24.
Investigation results are as follows:
Hysterosalpingogram: Obliterated uterine cavity, no tubal dye spill

Progesterone (midluteal): 48.0 nmol/L (16.4-59.0)
Partner's semen: All parameters normal
Which one of the following is the most likely diagnosis?

- A. Hypothalamic insufficiency
- B. Intrauterine synechiae
- C. Perimenopause
- D. Fibroids
- E. Polycystic ovary syndrome

Answer: B

Explanation:
This patient has secondary amenorrhea, infertility, and a history of multiple uterine curettages, which strongly points toward Asherman syndrome (intrauterine adhesions or synechiae). The hysterosalpingogram shows an obliterated uterine cavity and no tubal dye spill-classic for intrauterine synechiae. Her midluteal progesterone level is normal, indicating ovulation.
Toronto Notes 2023 - Gynecology, "Infertility" section:
"Asherman syndrome results from intrauterine adhesions due to curettage, leading to amenorrhea and infertility. HSG shows an obliterated or irregular uterine cavity." MCCQE1 Objectives (Gynecology > 82-1: Infertility):
"Candidates should evaluate secondary amenorrhea and interpret imaging such as hysterosalpingogram in the diagnosis of intrauterine abnormalities." Other options are ruled out by the presence of normal ovulation (rules out hypothalamic and PCOS) and by imaging (not suggestive of fibroids or perimenopause).

NEW QUESTION # 57
A 45-year-old woman presents to the emergency department after being involved in a motor vehicle collision.
She reports severe right hip pain. On examination, the right hip is flexed and adducted. A radiograph shows a posterior dislocation.
Which one of the following is the most appropriate management?

- A. Total hip arthroplasty.
- B. Open reduction under general anesthetic.
- C. Gradual reduction with skeletal traction.
- D. Closed reduction under sedation.

Answer: D

Explanation:
A posterior hip dislocation is an orthopedic emergency . The classic position is a shortened limb held in flexion, adduction, and internal rotation after high-energy trauma. MCCQE objectives emphasize immediate recognition and urgent management to prevent complications, especially avascular necrosis (AVN) of the femoral head and sciatic nerve injury . The key treatment is prompt closed reduction (ideally within hours) under procedural sedation or anesthesia, after appropriate analgesia and neurovascular assessment.
Post- reduction priorities include confirming concentric reduction with imaging, repeating a neurovascular exam (particularly sciatic nerve function), and evaluating for associated fractures (acetabular or femoral head/neck) that may require CT and possible operative management.
Open reduction is reserved for irreducible dislocations, incarcerated fragments, or associated fractures preventing stable closed reduction. Skeletal traction is not definitive acute management. Total hip arthroplasty is not indicated as first-line in an acute traumatic dislocation in this context. Urgent closed reduction best aligns with time-sensitive limb- and joint-preserving care.

NEW QUESTION # 58
You have just completed a well-baby check on a 6-month-old in the office where you have recently begun to practice. You ask the registered nurse to give the immunizations. She refuses, saying this is not within her scope of practice. Which one of the following is the best next step?

- A. Offer to be present while she gives the immunizations so that she will be supervised.
- B. Give the immunizations yourself and then discuss the matter with the nurse later.
- C. Contact the provincial/territorial nursing regulatory body to make a complaint about her.
- D. Insist that she give the immunizations as she should be competent to do so.
- E. Recognize your error in making the request and refrain from asking again.

Answer: B

Explanation:
MCCQE ELOM objectives emphasize patient safety, appropriate delegation, and respecting professional scope of practice. If a nurse states an activity is outside their scope (or they are not authorized/competent in that setting), the physician should not pressure or coerce them to perform it. Delegation requires that the delegated act is permitted by regulation and workplace policy, that the person has the competence to perform it, and that appropriate supports/medical directives exist. Supervision alone does not make an out-of-scope act acceptable, so offering to "be present" does not address the underlying legal/professional boundary.
Escalating immediately to the regulator is inappropriate without first clarifying the issue locally, and simply "refraining from asking again" fails to ensure the infant receives indicated care today.
The best immediate step is to ensure timely care by administering the immunizations yourself. Afterward, discuss the matter with the nurse to clarify clinic policy, required medical directives, training/competency, and how immunizations should be handled in this practice going forward (e.g., establishing protocols so authorized staff can provide vaccines safely).

NEW QUESTION # 59
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