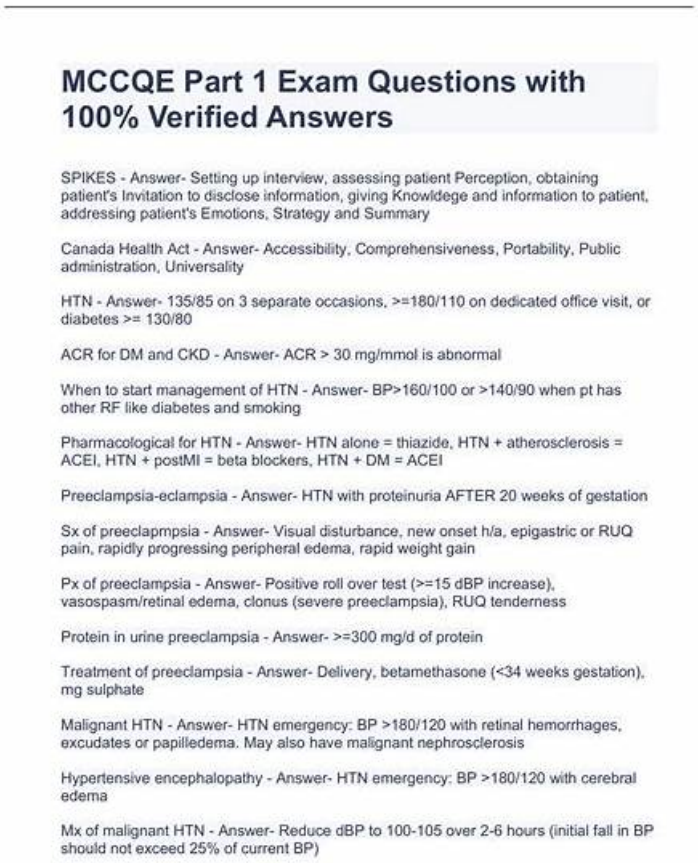
New MCCQE Test Topics, Associate MCCQE Level Exam



MCCQE Part 1 Exam Questions with 100% Verified Answers

SPIKES - Answer- Setting up interview, assessing patient Perception, obtaining patient's Invitation to disclose information, giving Knowledge and information to patient, addressing patient's Emotions, Strategy and Summary

Canada Health Act - Answer- Accessibility, Comprehensiveness, Portability, Public administration, Universality

HTN - Answer- 135/85 on 3 separate occasions, >=180/110 on dedicated office visit, or diabetes >= 130/80

ACR for DM and CKD - Answer- ACR > 30 mg/mmol is abnormal

When to start management of HTN - Answer- BP>160/100 or >140/90 when pt has other RF like diabetes and smoking

Pharmacological for HTN - Answer- HTN alone = thiazide, HTN + atherosclerosis = ACEI, HTN + postMI = beta blockers, HTN + DM = ACEI

Preeclampsia-eclampsia - Answer- HTN with proteinuria AFTER 20 weeks of gestation

Sx of preeclapmpsia - Answer- Visual disturbance, new onset h/a, epigastric or RUQ pain, rapidly progressing peripheral edema, rapid weight gain

Px of preeclampsia - Answer- Positive roll over test (>=15 dBP increase), vasospasm/retinal edema, clonus (severe preeclampsia), RUQ tenderness

Protein in urine preeclampsia - Answer- >=300 mg/d of protein

Treatment of preeclampsia - Answer- Delivery, betamethasone (<34 weeks gestation), mg sulphate

Malignant HTN - Answer- HTN emergency: BP >180/120 with retinal hemorrhages, excudates or papilledema. May also have malignant nephrosclerosis

Hypertensive encephalopathy - Answer- HTN emergency: BP >180/120 with cerebral edema

Mx of malignant HTN - Answer- Reduce dBP to 100-105 over 2-6 hours (initial fall in BP should not exceed 25% of current BP)

P.S. Free 2026 Medical Council of Canada MCCQE dumps are available on Google Drive shared by TestSimulate: https://drive.google.com/open?id=1R4jGUM4ymz4R6eqQeLJ1spF_W7QlmmGg

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iOS, Windows, Linux, and Android support the web-based Medical Council of Canada MCCQE practice questions.

Medical Council of Canada MCCQE Part 1 Exam Sample Questions (Q108-Q113):

NEW QUESTION # 108
You are counselling a couple that is concerned about the risk that their second child could be affected by the same X-linked recessive disorder (hemophilia A) as their last child, a boy. Neither parent has this disorder.
What is the probability that their second child will be affected?

- A. 25% if the child is a girl
- B. 100% whether the child is a boy or a girl
- C. 50% if the child is a boy
- D. 25% if the child is a boy
- E. 50% if the child is a girl

Answer: C

Explanation:
Comprehensive and Detailed Explanation:
In X-linked recessive disorders such as hemophilia A, carrier mothers (usually asymptomatic) have a 50% chance of passing the affected X chromosome to each son, who would then express the disease. Each daughter has a 50% chance of being a carrier but is generally not affected.
Toronto Notes 2023 - Genetics:
"X-linked recessive inheritance: Carrier mother has a 50% chance of having an affected son and a 50% chance of having a carrier daughter." MCCQE1 Objectives (Genetics > 61-1: Inheritance Patterns):
"Candidates must apply principles of X-linked inheritance to assess risk in offspring." If the mother is a known carrier (as inferred from having an affected son), the chance of a second affected boy is 50%.

NEW QUESTION # 109
A 32-year-old primigravid woman is receiving magnesium sulfate for tocolysis. Her pregnancy is at 26 weeks' gestation. You suspect magnesium sulfate toxicity. Which one of the following is the first sign of magnesium sulfate toxicity?

- A. Tachycardia
- B. Oliguria
- C. Hypotension
- D. Absent patellar reflexes
- E. Tachypnea

Answer: D

Explanation:
Magnesium sulfate toxicity is dose-dependent. The earliest and most sensitive clinical sign is theloss of deep tendon reflexes (especially patellar), which occurs before respiratory depression or cardiac changes.
Toronto Notes 2023 - Obstetrics Chapter:
"Toxicity from magnesium sulfate is progressive and typically presents first with loss of deep tendon reflexes.
Respiratory depression and cardiac arrest occur at higher serum levels. Regular monitoring of reflexes, respiratory rate, and urine output is essential." MCCQE1 Objectives (Obstetrics > 83-3: Preterm Labour and Tocolysis):
"The candidate must recognize early signs of magnesium sulfate toxicity including areflexia and respiratory depression." Tachycardia (B), hypotension (C), and tachypnea (D) are not typical early signs. Oliguria (E) may be a risk factor for accumulation but is not the first sign of toxicity.

NEW QUESTION # 110
A 20-year-old nulligravid woman presents with severe pain during menstruation. She is unable to take nonsteroidal anti-inflammatory drugs (NSAIDs) and is adamant about not taking any hormonal therapy. She has questions about non-medicinal therapeutic options. Which one of the following recommendations is the most appropriate?

- A. Progesterone-releasing intrauterine device

- B. High-frequency transcutaneous electrical nerve stimulation (TENS)
- C. Laparoscopic uterine nerve ablation (LUNA)
- D. Massage therapy
- E. Spinal manipulation

Answer: B

Explanation:
TENS has been shown to be effective for managing primary dysmenorrhea when pharmacological options are contraindicated or refused. It works by interfering with pain signal transmission and increasing endorphin levels.
Toronto Notes 2023 - Gynecology, Dysmenorrhea:
"High-frequency TENS is effective in managing primary dysmenorrhea and can be considered when NSAIDs or hormonal therapies are not acceptable to the patient." MCCQE1 Objectives - Gynecology > Menstrual Disorders:
"Candidates must be aware of non-pharmacological interventions for dysmenorrhea, including TENS and heat therapy." Options D and E involve hormonal or surgical intervention. Spinal manipulation and massage (B and C) lack consistent evidence for dysmenorrhea relief.

NEW QUESTION # 111
A 3-week-old boy is brought by his parents to your clinic for a well-child visit. The newborn was born at term after an uncomplicated pregnancy. He is exclusively breastfed and is thriving. Physical examination findings are normal except for jaundice. Total bilirubin is 172 #mol/L (#100), and conjugated bilirubin is 4 #mol/L (#5). Results of a complete blood count and reticulocyte count are within the normal range. The results of a direct antiglobulin (Coombs) test were negative. Which one of the following, if any, is the most appropriate investigation?

- A. No investigation required.
- B. Urine culture.
- C. Test for galactosemia.
- D. Hepatobiliary ultrasonography.
- E. Liver enzymes and serum albumin.

Answer: A

NEW QUESTION # 112
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. Perimenopause
- B. Hypothalamic insufficiency
- C. Polycystic ovary syndrome
- D. Intrauterine synechiae
- E. Fibroids

Answer: D

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 # 113

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