QUESTIONS FOR THE GRADUATION EXAM
DENTAL MEDICINE - ENGLISH SECTION

PEDIATRIC DENTISTRY

1. *The advantages of the preformed stainless steel crowns (SSC) are the following:
   A. Unaesthetic
   B. Extensive primary tooth preparation
   C. Patient cooperation required
   D. Durable
   E. Aeshtetic
2. Restoring the primary posterior teeth with composites resins has as indications:
   A. Small to moderately sized occlusal cavities
   B. Hypomineralized primary teeth
   C. Dentitions of children at high risk of caries
   D. Small to moderately sized proximal cavities
   E. Primary molars that have undergone pulp therapy
3. The indications for restoring primary teeth with stainless steel crowns (SSC) are:
   A. Children having treatment under general anaesthesia
   B. Small to moderately sized occlusal cavities
   C. Hypomineralized primary teeth
   D. Occlusal enamel caries
   E. Occlusal caries with extension into dentine
4. The Hall crown technique in primary dentition is characterised by the following aspects:
   A. Involves the placement of stainless steel crowns, directly over carious lesions, with extensive tooth preparation
   B. Involves the placement of stainless steel crowns, directly over carious lesions, with little tooth preparartion
   C. Involves the placement of stainless steel crowns, directly over carious lesions, with no caries removal
   D. Means the restoration of primary anterior teeth with compomers
   E. Involves the restoration of primary anterior teeth using composite resin strip crowns
5. *The new techniques for tooth preparation in paediatric dentistry reffer to:
   A. Preventive resin restoration (PRR)
   B. Lasser-assisted dentistry
   C. Hall crown technique
   D. Interproximal stripping
   E. Sealed restoration

6. In paediatric dentistry, the method for preventive resin restoration of occlusal caries in permanent teeth, includes the following steps:
   A. Isolation
   B. Obtaining acces into the questionable fissure
   C. It is important not to remove the carious dentine
   D. Unsupported enamel need not be removed if access and vision are clear
   E. Deeper dentinal caries should be removed

7. The objective of any restorative technique in primary teeth is to:
   A. Maintain space for the developing permanent dentition
   B. Always restore aesthetics
   C. Restore aesthetics where applicable
   D. Maintain arch length
   E. Protect the remaining pulp and tooth structure

8. The clinical significance of a relatively large pulp compared to the crown and pulp horns that are closer to the surface as an anatomical feature of primary teeth is:
   A. Pulpectomy is difficult
   B. Pulp exposure
   C. Limited room for cavity preparation
   D. Enamel at floor of box is not undermined
   E. There is no clinical significance

9. *The clinical significance of the roots features in primary teeth is:
   A. There is no clinical significance
   B. Pulpectomy is difficult
   C. Pulp exposure
   D. Limited room for cavity preparation
   E. Enamel at floor of box is not undermined

10. In pediatric dentistry, the indications for using preventive resin restoration for the treatment of occlusal caries in permanet teeth are:
    A. Small class II lesions
    B. Small class I lesions
    C. Enamel-only lesions
    D. Profound caries lesions
    E. Incipient occlusal lesions just into dentine

11. Chronic infection in the primary dentition can cause:
    A. Disturbance to enamel formation in the permanent dentition
    B. Malocclusion
    C. Imminent enamel fracture of tooth crowns in permanent dentition.
    D. Pulp necrosis in permanent dentition
    E. Turner tooth

12. Indicators of pulp necrosis and abcess formation in immature permanent teeth are:
    A. Root maturation
    B. Apical fenestration
    C. Coronal discoloration
    D. Root fracture
    E. Alveolar swelling

13. Which of the following statements about indirect pulp capping in primary or immature permanent teeth are false:
    A. It is indicated if the preoperative radiograph confirms the presence of radicular pathology
    B. It is used in small iatrogenic or carious pulp exposures
    C. It is also known as caries control by promoting pulpal healing with the formation of reactionary dentine
    D. Uncontaminated mechanical pulp exposures have a more favourable response to indirect pulp capping
    E. Indirect pulp capping in lower first molars always requires a preformed metal crown

14. *In paediatric dentistry, ineffective or inappropriate pulp therapy is associated with which chronic signs and symptoms:
    A. Failure of exfoliation of primary teeth
    B. Facial cellulitis, including spread of infection into the tissue planes around the airway
    C. Periapical or intra-radicular abcess
    D. Pain
    E. Ludwig's angina

15. The following statements about pulpotomy in primary teeth are true:
    A. The 'bleeding sign' after amputation, is an indication for pulpectomy or extraction
    B. Pulpotomy in primary teeth is an important indication for a non-restorable tooth
    C. The treated tooth must be caries-free before proceeding with the pulpotomy
    D. The next step after removing the coronal and the radicular pulp is the haemostasis
    E. Pulpotomy cannot be done if the pulp is necrotic

16. Regarding the therapeutic agents used for pulpotomy in primary teeth, the following statements are true:
    A. Calcium hydroxide appears to have a higher success rate than formocresol, ferric sulphate, elecrocautery and MTA
    B. Mineral trioxide aggregate (MTA) paste should only be applied after haemostasis has been obtained
    C. Ferric sulphate is applied at the pulpotomy site using a micro-brush for 5 minutes or more
    D. The formaldehyde component in formocresol is strongly bactericidal and does not bioaccumulate
    E. Electrosurgical pulpotomy uses radiofrequency energy to produce a controlled superficial tissue burn

17. Pulpotomy in immature permanent teeth:
    A. The aim is to amputate the inflamed coronal pulp and preserve the vitality of the remaining pulp to promote apexification
    B. Apexification is the only option once pulp necrosis has occurred in the immature permanent teeth
    C. A small carious exposure of the pulp horn can be managed by a superficial pulpotomy of only 1-2 mm
    D. Apexogenesis optimizes root anatomy and strenght
    E. An alternative to apexification is the use of haematogenous stem cells to induce calcification of the root canal space

18. *Which of the following is false regarding the pulpectomy in primary teeth:
    A. Pulpectomy is the partial removal of the pulp tissue from the tooth
    B. Pulpectomy can only be considered for primary teeth that have intact roots
    C. Over-instrumentation of the primary tooth root canal has the potential to damage the underlying permanent tooth
    D. After chemo-mechanical preparation of the root canal, copious irrigation with sodium hypochlorite is required
    E. Obturation of the root canal space in a primary tooth requires a resorbable paste root filling

19. *The treatment option for primary teeth in case of caries with possible or near exposure that are close to exfoliation is:
    A. Pulpectomy with resorbable dressing
    B. Direct pulp capping
    C. Consider elective extraction
    D. Pulpectomy with non-resorbable dressing
    E. Pulpotomy and apexogenesis

20. The treatment options for carious exposure with necrotic pulp in immature permanent teeth, that includes draining sinus, swelling, mobility, and radiographic pathology are:
    A. Indirect pulp capping with caries control
    B. Extraction
    C. Pulpotomy and apexogenesis
    D. Direct pulp capping
    E. Pulpectomy and apexification

21. In intrusive luxation of the primary teeth :
    A. There is usually a palatal and superior displacement of the crown
    B. The lower primary incisors are the most affected
    C. If the whole tooth is intruded leave the tooth to re-erupt
    D. If the alveolar cortical plate is perforated the tooth should be extracted
    E. If the crown is visible leave the tooth to re-erupt

22. Possible damage to primary and permanent teeth after primary teeth trauma involves :
    A. Hypoplasia or hypomineralization of the primary tooth
    B. Ankylosis of the primary tooth
    C. Necrosis of the pulp of the primary tooth
    D. Internal resorption of the permanent tooth
    E. Hypoplasia or hypomineralization of the succedaneous teeth

23. Avulsed primary teeth should not be replanted because of :
    A. Possible damage of the developing permanent tooth
    B. High degree of patient cooperation
    C. Splinting of primary teeth may be difficult in traumatized children
    D. Blood clot may be forced in the socked
    E. Lack of traumatized patient cooperation

24. The following statements regarding trauma of primary teeth are true:
    A. In concussion there is mobility without displacement of the tooth
    B. In subluxation the tooth is mobile but is not displaced
    C. Concussion and subluxation involve minor damage to the periodontal ligament
    D. In concussion and subluxation teeth are tender to percussion
    E. Gingival bleeding and mobility occurs only in concussion

25. Crown fractures of primary teeth :
    A. Are less common than luxations of primary teeth
    B. Are uncomplicated if the pulp is exposed
    C. Complicated fractures involve the pulp and extend below the gingival margin
    D. If there are multiple fractures in individual teeth it should be extracted
    E. In uncomplicated fractures a pulp polip may occur after several days after the trauma

26. Extrusive luxation of the permanent teeth is characterized by :
    A. There is no displacement and mobility
    B. Pulp sensibility tests may give negative results initially
    C. A flexible splint is recommended for 10-14 days
    D. Repositioning can be achieved with digital pressure
    E. A rigid splint is recommended for 3-4 months

27. In avulsion of permanent teeth :
    A. The prognosis depends on how much time the tooth has been out of the mouth
    B. It is better for the tooth to be stored in water until it can be replanted
    C. It is recommended to splint for 14 days after replantation
    D. The prognosis depends on the type of splinting
    E. Water is not recommended to store the tooth because it can cause lysis of the ligament cells

28. In intrusion of permanent teeth the following statements are false :
    A. There is minor damage of the periodontal ligament and bone
    B. Treatment depends on the state of apical development
    C. If the crown remains visible and it is an immature apex let the tooth re-erupt
    D. Immediate repositioning is preferred for mature teeth
    E. Removal of the pulp is not essential regardless of the case

29. In complicated crown fracture of permanent teeth :
    A. Fracture involves enamel and dentine without pulp exposure
    B. Healing occurs spontaneously without complications
    C. Fracture involves enamel, dentine with pulp exposure
    D. A Cvek pulpotomy is recommended if the tooth is immature
    E. Apexogenesis is a procedure recommended in immature necrotic teeth

30. *. In dental trauma of permanent teeth splinting is recommended for :
    A. 3-4 months in lateral luxation
    B. 3-4 weeks in avulsion after replantation
    C. 3-4 months in root fracture if the coronal fracture is mobile
    D. 2-3 weeks in subluxation
    E. 2-3 months in extrusive luxation

31. *Which of the following is/are true about microdontia:
    A. This anomaly most often affects mandibulary lateral incisors
    B. All teeth are smaller than the normal
    C. It is more rare in the permanent dentition
    D. Orthodontic allingnment and extraction of the tooth may be required in some cases
    E. It is more common in males

32. The clinical appearance of developmental defects of enamel is/are:
    A. Discolouration
    B. Joining of two teeth
    C. Opacity
    D. Hypoplasia
    E. Occlusal caries with extension into dentine

33. In pediatric dentistry deep intrinsic stains of the tooth:
    A. Can not be removed with microabrasion techniques
    B. Require removal of the affected enamel and restauration with composite resin
    C. Treatment can be accomplished by use of full-face veneers
    D. May be corrected using peroxide-based bleaching agents
    E. Treatment can be accomplished by use of full-face crowns

34. *Tooth discoloration caused by tetracycline is:
    A. Pink
    B. Yellow
    C. White
    D. Red-brown
    E. Blue-brown

35. Which of the following statements is correct regarding Molar-Incisor hypomineralization (MIH):
    A. It presents as a qualitative change of enamel
    B. The enamel is initially of normal thickness
    C. The cervical enamel is the most affected
    D. Affected teeth are not sensitive
    E. A familial tendency of the condition has been recognised

36. The hypoplastic form of amelogenesis imperfecta is characterized by:
    A. Thin enamel
    B. Normal thickness of enamel
    C. Delayed eruption of teeth
    D. Unerupted teeth may undergo resorption
    E. Anterior open bite in 50% of the cases

37. The essential features of osteogenesis imperfecta are:
    A. Bone fragility
    B. Blue sclera
    C. Dentinal changes
    D. Short stature
    E. Pulp canal obliteration

38. Dental effects of prematurity and low birth weight are:
    A. There are no dental implications
    B. Hyperbilirubinaemia, causing intrinsic staining of teeth
    C. Hypercalcaemia
    D. Chronological opacities
    E. Hypoplasia

39. Management of infraoccluded (submerged) primary molars includes the following treatment options:
    A. Surgical removal of the ankylosed tooth before the eruption of the first molar
    B. Wait for normal exfoliation in case of radiographic evidence of root resorption
    C. Orthodontic consultation
    D. Retain space
    E. If the premolar is congenitally absent, early removal of submerging primary molar may be indicated

40. *Prevention of erosion of teeth includes the following :
    A. Limit the intake of fruit juices
    B. Onlays on posterior teeth
    C. Histamine blockers
    D. Stainless steel crowns on posterior teeth
    E. Anti-emetics

PREVENTIVE DENTISTRY. COMMUNITY DENTISTRY

41. A pit and fissure sealant:
    A. Is a thick plastic coating
    B. Is made of an organic polymer
    C. Acts as a chemical barrier to oral bacteria
    D. Prevents dental caries
    E. Bonds mainly by mechanical retention to the enamel

42. Dental sealant placement is indicated for:
    A. Low, moderate or high-risk individuals
    B. No risk individuals
    C. Deep fissure anatomy
    D. Developmental defects
    E. Smooth surfaces

43. Contraindications to sealant placement:
    A. Deep fissure anatomy
    B. Radiographic evidence of proximal dental caries
    C. Well coalesced pits and fissures
    D. Irregular pits and fissures
    E. Incipient occlusal caries

44. *Sealant retention:
    A. Influences the ability of a sealant to treat dental caries
    B. Salivary contamination helps the retention
    C. A two-handed technique should be used
    D. Resin-based sealants are superior to glass ionomer sealants
    E. Glass ionomer sealants are superior to resin-based sealants

45. Autopolymerized sealants:
    A. No mixing time is required
    B. Come in two components
    C. Polymerization starts within 60-90 seconds after mixing begins
    D. Are used in community health or school-based programs
    E. Increase the clinician's working time

46. Unfilled sealants:
    A. Are clear
    B. Are twice as resistant as filled sealants
    C. Are a mixture of resins, chemicals and fillers
    D. Do not contain particles
    E. Are most useful in school-based settings

47. Glass Ionomer:
    A. Is hydrophobic
    B. Flows easily into pits and fissures
    C. Shows low rates of occlusal wear
    D. Enhances the caries resistance of the tooth
    E. Can be purchased with a slow-releasing fluoride

48. *The acid etching:
    A. Creates macroscopic pores on the enamel
    B. Is done with 47 % phosphoric acid
    C. The acid can be in liquid or gel form
    D. A wiping motion is used to apply the liquid acid
    E. A dabbing motion is used to apply the gel acid

49. Applying light-cured sealants:
    A. Apply liquid sealant at less than 45 degrees
    B. Apply liquid sealant at less than 90 degrees
    C. Apply liquid sealant at more than 90 degrees
    D. This process is known as “wetting”
    E. This process is known as “dabbing”

50. Applying self-cured sealants:
    A. Mix one drop of universal liquid and one drop of catalyst liquid
    B. Mix for 10-15 seconds
    C. Apply light-cure tip to sealant
    D. Working time : 90 seconds
    E. Allow sealant to set for 60-90 seconds

51. Ultrasonic instruments have the following modes of action:
    A. Manual activation
    B. Cavitation
    C. Mechanical action
    D. Friction
    E. Acoustic microstreaming

52. Ultrasonic units:
    A. Convert electrical energy into mechanical energy
    B. There are magnetostrictive and piezoelectric units
    C. A lower setting of frequency may be used for tenacious deposits
    D. The chemical action of the working end removes calculus
    E. The transducer converts the electrical energy to mechanical energy

53. The power of the handpiece:
    A. Is also known as frequency
    B. Is the energy in the handpiece that creates tip movement
    C. Is also known as amplitude
    D. Increasing the power setting decreases the distance the working end moves
    E. As amplitude increases, the efficiency of the tip enhances

54. Water flow:
    A. Cools the working end
    B. Heats the transducer
    C. Decreases visibility
    D. Provides lavage
    E. A decreased water flow creates a lower water temperature

55. *When water flows to the end of the insert and contacts the moving working end, tiny droplets and a fine spray result. This phenomenon is called:
    A. Lavage
    B. Irrigation
    C. Atomization
    D. Cavitation
    E. Microstreaming

56. Thin inserts:
    A. Have probelike design
    B. Are 3 to 6 mm wide
    C. Are indicated for removal of light deposits subgingivally
    D. Are 40% wider in diameter than standard inserts
    E. Are used on exposed root surfaces

57. *Slim and microslim inserts are available in several designs:
    A. Straight design- for periodontal pockets that are 4 mm or more
    B. Straight design- especially useful on posterior teeth
    C. Right and left designs- indicated for depths less than 4 mm
    D. Right and left designs- useful in narrow periodontal pockets
    E. Straight design- useful in narrow periodontal pockets

58. Advantages of power-driven instruments are:
    A. Increased efficiency
    B. Less tactile sensation
    C. No need to sharpen
    D. Less chance for repetitive stress injuries
    E. Reduced visibility

59. Indications of ultrasonic instruments:
    A. Supragingival debridement
    B. Subgingival debridement
    C. Dysphagia
    D. Removal of orthodontic cement
    E. Surgical interventions

60. For working tip adaptation, the clinician must:
    A. Use 2 to 4 mm of the active tip
    B. Think of the application in relation to a universal curet
    C. At all times the tip to tooth angle is 15 degrees or less
    D. At all times the tip to tooth angle is 30 degrees or less
    E. Never places the point of the insert on the tooth surface

ORTHODONTICS

61. Acromegaly is caractherised by :
    A. Secretes excessive amounts of growth hormone
    B. Secretes less amounts of growth hormone
    C. Can produce excessive growth of the mandible
    D. Is caused by an anterior pituitary tumor
    E. Can produce the mandibular deficiency

62. The patients with Ectodermal Dysplasia have:
    A. Thin and sparse hair
    B. Anodontia or oligodontia
    C. Supranumerary teeth
    D. Condylar fracture
    E. Absence of sweat glands

63. In the congenital syndrome of Cleidocranial Dysplasia occur :
    A. Supernumerary teeth
    B. Unerupted teeth
    C. Cleft lip and palate
    D. Anodontia
    E. Heavy and fibrous gingiva

64. *The mandibular deficiency is produced by :
    A. Sindrom Pierre Robin
    B. Anterior pituitary tumor
    C. Excessive muscle contraction
    D. Early Loss of Primary Teeth
    E. Unerupted teeth

65. * Early loss of primary teeth can cause :
    A. Class III maloclusion
    B. Facial asymmetry
    C. Anterior open bite
    D. Crowding and malalignment within the dental arches
    E. Maxilary constriction

66. Facial asymmetry is caused by :
    A. Sleeping on one side of the face
    B. Excessive contraction of the neck muscles on one side
    C. Supranumerary teeth 118, 133
    D. Crowding in one arch
    E. Condylar fracture

67. Sucking habits can produce :
    A. Anterior open bite
    B. Upper incisor protrusion
    C. Deep bite
    D. Upper incisor retrusion
    E. Oligodontia

68. Unilateral excessive growth of the mandible has some characteristics:
    A. Occurs in boys between the ages of 15 and 20
    B. Proliferation of the condylar cartilage
    C. The body of the mandible also is affected
    D. The body of the mandible also is not affected
    E. The excessive growth may stop spontaneously

69. The factors that can obstruct eruption are :
    A. Condyl fracture
    B. Supernumerary teeth
    C. Sclerotic bone
    D. Heavy fibrous gingiva
    E. Hypodontia

70. Achondroplasia has some caracteristiques :
    A. Frequently in humans
    B. Rare in humans
    C. Determine midface deficiency
    D. Increase growth at the synchondroses
    E. Influences the form of the face

71. *The Class III malocclusions:
    A. Occurs in about 10% of the North American population
    B. Include a variety of skeletal and dental components
    C. Occurs in about 12% of the North American population
    D. Do not include a variety of skeletal and dental components that may vary from the concept of normal
    E. Can be due to maxillary skeletal protrusion and mandibular skeletal retrusion

72. The orthognathic surgical procedure in Class III malocclusions:
    A. Is designed to correct the imbalance of the skeletal component
    B. Is deferred until the end of the active growth period
    C. Is designed to correct the imbalance of the dental component
    D. Is not deferred until the end of the active growth period
    E. Is designed to correct the imbalance of the dental and skeletal component

73. The treatment of Class III malocclusion in the mixed dentition can be done:
    F. With orthopedic chin cup, if the malocclusion is characterized by mandibular prognathism
    G. With Frankel type 1 (FR-1) functional regulator
    H. With Frankel type 3 (FR-3) functional regulator
    I. With Frankel type 2 (FR-2) functional regulator
    J. With orthopedic chin cup, if the malocclusion is characterized by mandibular retrognathism

74. The orthopedic facial mask:
    A. Has 4 basic components: the facial mask, a bonded maxillary splint, a bonded mandibular splint and elastics
    B. Is an extraoral device
    C. Is an intraoral device
    D. Has 2 basic components: the facial mask, a bonded maxillary splint and elastics
    E. Is used in class III malocclusions.

75. The orthopedic facial mask can produce the following treatment effects:
    A. Correction of the CO-CR discrepancy
    B. Maxillary skeletal retraction
    C. Forward movement of the maxillary dentition
    D. Lingual tipping of the upper incisors
    E. Mandibular skeletal protraction

76. *The face mask is indicated to be worn:
    A. 2 hours per day for 2 weeks
    B. 20 hours per day for 2 months
    C. 20 hours per day for 4 to 6 months
    D. 12 hours per day for 4 to 6 months
    E. 12 hours per day for 2 to 4 months

77. The FR-3 appliance of Frankel:
    A. Is an intraoral appliance used in the treatment of Class III malocclusions in the permanent dentition
    B. Is designed to restrict the forces of the associated soft tissue on the maxillary complex
    C. Is worn easily by the patients
    D. Has different effects to those produced by the facial mask
    E. Is an extraoral appliance.

78. *The orthopedic chin cup:
    A. Is the newest of the orthopedic approaches to the treatment of Class III malocclusion
    B. Can be: occipital-pull chin cup and vertical-pull chin cup
    C. Can be: vertical-pull chin cup and horizontal- pull chin cup
    D. Is the oldest of the orthopedic approaches to the treatment of Class II malocclusion
    E. Can be: occipital-pull chin cup and horizontal-pull chin cup

79. The Class III malocclusion can occur due to:
    A. Maxillary skeletal retrusion
    B. Mandibular skeletal protrusion
    C. Maxillary skeletal protrusion
    D. Mandibular skeletal retrusion
    E. Combination of maxillary skeletal protrusion and mandibular skeletal retrusion

80. The orthopedic facial mask can produce the following treatment effects:
    A. A.Redirection of the mandibular growth in a downward and backward direction
    B. B Maxillary skeletal protraction
    C. C.Forward movement of the mandibular dentition
    D. Buccal tipping of the lower incisors
    E. Mandibular skeletal protraction

81. *Who is the father of modern orthodontics:
    A. William Proffit
    B. B.Edward Angle
    C. C.Raymond Begg
    D. Lee Graber
    E. E James McNamara

82. Major steps in the evolution of edgewise appliance include:
    A. Automatic rotation control
    B. Alteration in bracket slot dimensions
    C. Straight-wire prescriptions
    D. No bracket slot dimensions
    E. Edgewise prescriptions

83. Fixed appliance prescription implies:
    A. Angulation values built into the bracket
    B. Torque values built into the bracket
    C. Colour of the bracket
    D. The material brackets are made of
    E. Size of the ligatures

84. A Straight wire appliance implies:
    A. Bracket modifications for special teeth
    B. Elimination of many repetitive bends in arch-wires
    C. Compensantion of the differences in tooth anatomy using bracket modifications
    D. The same brackets on all teeth
    E. Need of many repetitive bends in arch-wires

85. A generalized prescription to minimize first, second and third order bends:
    A. Would precisely position the average tooth
    B. Is not used at all
    C. Would not be exactly correct for any deviations from the average
    D. Does not affect teeth
    E. Is not used on thin enamel

86. *In the original edgewise appliance:
    A. Faciolingual bends in the archwires were necessary
    B. Faciolingual bends in the archwires were not necessary
    C. Variations in the contour of labial surfaces of individual teeth were compensated by bendings
    D. Unerupted teeth were used
    E. Anterior open bite was the most frequent

87. *Contemporary fixed appliances:
    A. Are predominantly variations of the edgewise appliance system
    B. Are not using rectangular archwires
    C. Are only used in adults
    D. Are only used in children
    E. Always cause pulp canal obliteration

88. *Alteration in bracket slot dimensions:
    A. The original Angle's slot was increased from 18 to 22 mils
    B. The original Angle's slot was reduced from 22 to 18 mils
    C. The 18 and 22 slot appliances can be used combined in the same patient
    D. The 18 slot appliances are not used anymore
    E. The 22 slot appliances are not used anymore

89. *The contemporary edgewise appliance retains the basic principle of:
    A. Rectangular wire in rectangular slot
    B. Round wire in round slot
    C. Rectangular wire in round slot
    D. The slot is always round
    E. The slot is not important

90. Angulation of brackets relative to the long axis of the tooth:
    A. Decreases the necessity for bends in archwires
    B. Is necessary to achive proper positioning of the roots
    C. Increases the necessity for bends in archwires
    D. Is not important
    E. It does not affect the final result

91. Removable orthodontic appliances have the following advantages:
    A. They are fabricated in the laboratory
    B. They are fabricated in the pacient's mouth
    C. They can be removed on socially sensitive occasions
    D. They don't allow some types of growth guidance
    E. The response to treatment is dependent on pacient compliance.

92. Removable orthodontic appliances have following disadvantages:
    A. The response to treatment is dependent on pacient compliance.
    B. The response to treatment is independent on pacient compliance.
    C. It is difficult to obtain the two-point contacts on teeth.
    D. It is easy to obtain the two-point contacts on teeth.
    E. They can be removed on socially sensitive occasions.

93. The Frankel appliance:
    A. Is the only tissue-borne functional appliance.
    B. Is the only tooth-borne functional appliance.
    C. Is mostly located in the vestibule.
    D. Interferes with normal speech, so that children can't wear it to school.
    E. The lingual pad dictates the maxilar position.

94. Functional components of Functional Appliances are:
    A. Lingual pad
    B. Lip pad
    C. Buccal shields
    D. Expansion screws
    E. Labial bow

95. Stabilizing components of Functional Appliances are:
    A. Lingual bow
    B. Labial bow
    C. Claps
    D. Bite blocks
    E. Occlusal stops

96. Tooth- Controling components of Functional Appliances are:
    A. Tooth-supported ramps
    B. Buccal shilds
    C. Occlusal or incisal stops
    D. Anterior torquing springs
    E. Lip pads.

97. *Adams claps:
    A. Are most useful and versatile claps for removable appliances
    B. Are made of 0,8 mm wire
    C. Do not Require retentive points that fit well into the undercuts
    D. Do not become loose after repeated insertions and removals of the appliance
    E. Are made of 0,7 mm wire

98. Removable appliances for tooth movement in children are:
    A. Active plates for arch expansion
    B. Passive plates for arch expansion
    C. RA with springs for tooth movement
    D. RA without springs for tooth movement
    E. Functional appliances.

99. The Activator:
    A. Is a tooth- borne passive appliance
    B. Is a functional appliance
    C. Does not open the bite
    D. Does not advance the mandible
    E. Passive plates for arch expansion

100. Modern removable appliance therapy consists largely of the use of:
    A. Functional appliances for growth guidance in children
    B. Active plates for tooth movement in preadolescents
    C. Functional appliances for growth guidance in adolescents
    D. Active plates for tooth movement in adolescents
    E. Pasive plates for tooth movement in preadolescents

101. The meaning of Class II Prognathism is:
    A. The mandible is forward position
    B. The maxilla is forward position
    C. The mandible is backword position
    D. The maxilla is backward position
    E. The maxilla and mandible are forwards position

102.* The meaning of Class II retrognathism :
- A. The mandible is forward position
- B. The maxilla is forward position
- C. The mandible is backword position
- D. The maxilla is backward position
- E. The maxilla and mandible are backward position

103.* The practitioner must be careful about extracting teeth in this type of facial pattern
- A. Class II: Maxillary Alveolodental Protrusion
- B. Class II: Mandibular Alveolodental Retrusion
- C. Class II: Maxillary Prognathism
- D. Class II: Mandibular Retrognathism
- E. Facial asymmetry

104.*If the permanent maxillary first molars emerge before the mandibular molars , the results can be:
- A. Abnormal Class I relationship
- B. Abnormal Class III relationship
- C. Abnormal Class II relationship
- D. Severe facial asymmetry
- E. Skeletal open-bite

105.Convex profile is characterized on:
- A. Maxillary prognathism
- B. Maxillary retrognathism
- C. Mandibular prognathism
- D. Mandibular retrognathism
- E. Maxillary retrognathism and Mandibular prognathism

106.*Mesialization of the upper first permanent molar after missing the upper second primary molar will create
- A. Skeletal class Ii
- B. Dental class III molar relationship
- C. Dental class I molar relationship
- D. Dental Class II molar relationship
- E. Skeletal class III

107.Characterize of class II division 2:
- A. Deep labiomental sulcus
- B. Short lower facial height
- C. Long lower facial height
- D. Flat labiomental sulcus
- E. Hypotonic of lower lip

108.The characters of Class II, division 1 malocclusion
- A. Retroinclination of upper incisors
- B. Proinclination of upper incisors
- C. Mesial position of the lower molar
- D. Distal position of the lower molar
- E. Mesial position of the lower canine

109.In class II division 2, will observe:
- A. FMA value more than 28 degree
- B. FMA value less than 22 degree
- C. Hyperdivergent
- D. Hypodivergent
- E. FMA value between 22 and 28 degree

110.In class II division 1, the results of the cephalometric analysis are:
- A. Increasing the value of SNB angle
- B. Increasing the value of ANB angle
- C. Decreasing the value of ANB angle
- D. Increasing the value of SNA angle
- E. Decreasing the value of SNA angle

ODONTOTHERAPY. ENDODONTICS

111.The objectives of tooth preparation are:
- A. To provide necessary protection to the pulp
- B. To extend the restoration conservatively
- C. Allow esthetic and functional placement of a restorative material
- D. Assure resistance and retention of the restoration
- E. None of the above.

112.The outline form of tooth preparation for amalgam restoration includes:
- A. No need for base materials
- B. Smoother texture of prepared cavity walls
- C. Occlusally convergence of cavity walls
- D. No need for dentin desensitizer
- E. All of the above.

113.Secondary caries:
- A. Occur at the enamel-dentin junction
- B. May progress under the restoration
- C. Are often termed recurrent caries
- D. Usually indicate the absence of microleakage
- E. All of the above.

114. Incipient caries:
   A. Is the first evidence of caries activity in the dentin
   B. This lesion has not extended to the dentin-enamel junction
   C. This lesion cannot be remineralized
   D. May be characterized as irreversible
   E. It appears opaque white when air-dried.

115. Affected dentin:
   A. Is the outer layer of carious dentin
   B. Is the inner layer of carious dentin
   C. It is desirable to be removed
   D. In a vital tooth, it can be remineralized
   E. Has bacteria present and collagen irreversibly denaturated.

116. Erosion:
   A. Is the mechanical wear of the incisal margin as a result of parafunctional tooth movements
   B. Can be caused by regurgitation of stomach acid
   C. Is the loss of tooth surface by chemo-mechanical action
   D. Is the causative factor of cervical wedge-shaped defects
   E. Results in microfractures of enamel.

117. A tunnel tooth preparation:
   A. Is indicated for a conservative removal of tooth structure
   B. Joins an occlusal lesion with a proximal lesion
   C. A tunnel is developed under the marginal ridge
   D. Is not indicated for amalgam restorations
   E. None of the above.

118. The bond to dentin deteriorates over time due to:
   A. Hydrolysis of the adhesive resin component of the hybrid layer
   B. Proteolytic degradation of the collagen component of the hybrid layer
   C. Use of chlorhexidine 2% on etched dentin
   D. Use of protease inhibitors as a final preparation step
   E. None of the above.

119. Indications of indirect Class I and Class II tooth-colored restorations include:
   A. Restorations located in areas of esthetic importance for the patient
   B. Restoration of large Class I and Class II defects
   C. Inability to maintain a dry field
   D. Deep subgingival preparations
   E. All of the above.

120. Advantages of indirect Class I and Class II tooth-colored restorations include:
   A. Improved physical properties
   B. Higher cost and increase time
   C. Wear resistance
   D. High polymerization shrinkage
   E. Reduced auxiliary support

121. Lithium Disilicate:
   A. Is a type of ceramic which is not used anymore
   B. Can be used to fabricate inlays
   C. Can be used to fabricate onlays
   D. Is available in pressed and machinable forms
   E. Is a new type of amalgam.

122. Disadvantages of indirect Class I and Class II tooth-colored restorations include:
   A. Require a high level of operator skill
   B. Reduced costs and time
   C. High potential of repair
   D. Reduced wear of opposing dentition
   E. Short clinical track record

123. *Advantages of leucite-reinforced pressed ceramics are:
   A. Similarity to traditional wax-up processes
   B. Excellent marginal fit
   C. Moderately high strength
   D. Surface hardness similar to enamel
   E. All of the above.

124. The major disadvantages of chair-side CAD/CAM systems are:
   A. The high initial cost
   B. The need for special training
   C. Poor results on longevity of CAD/CAM restorations
   D. The quality of the restorative material
   E. None of the above

125. Pulpitis is characterized by:
   A. Frequent nocturnal occurrence of pain
   B. Pain induced by hot stimuli
   C. Slight response to high levels of electric pulp tester
   D. The presence of a liquefactive tissue
   E. Pain exacerbated by cold stimuli

126.The process that leads to total necrosis of the pulp is aggravated by:
- A. The lack of collateral circulation
- B. Absence of a preexisting dental restorations
- C. Presence of inextensible walls
- D. Repeated radiographic examinations
- E. The use of fiber optic examination

127. Mineral Trioxide Aggregate (MTA):
- A. Has hydrophilic properties;
- B. Is affected by moisture or blood contamination;
- C. It is contraindicated in direct pulp capping procedures
- D. It`s alkalinity decreases during the first 3 hours after manipulation;
- E. In contact with the pulp, it causes necrosis.

128.In pulpitis:
- A. The treatment is chosen based on the histopathologic examination
- B. The pulp involvement progresses from coronal to apical
- C. The radiologic examination is not necessary during treatment
- D. The response to electric pulp testing is normal
- E. Micro-abscesses may be present in the coronal pulp.

129.During diagnosis of pulp hyperemia:
- A. The application of a cold stimulus could identify the diseases tooth
- B. The radiograph provides important information
- C. The patient cannot localize the diseased tooth
- D. The tooth responds positive to percussion
- E. The pain often crosses the midline.

130.The success of pulpotomy with Cresatin depends on:
- A. Lack of pain on palpation
- B. Positive response to vitality tests
- C. Presence of periapical pathology
- D. The presents of a recently sustained trauma
- E. All of the above.

131.In hyperemia:
- A. The pain is provoked by cold stimuli and lasts 2-3 hours
- B. The provoked pain disappears in short time after the stimulus is removed
- C. The tooth gives normal reactions to sensitivity tests
- D. The pulp is invaded by microorganisms
- E. Hyperemia is not a disease, but a symptom.

132.The dental pulp:
- A. Has no collateral circulation
- B. Compensates the rise of intra-pulpal pressure by tissue enlargement
- C. Has a terminal type of circulation
- D. Has an ectodermal origin
- E. The presence of apical foramen has no influence on pulp circulation during inflammation.

133.The following statements are true:
- A. Root canal obliteration is more frequent in young patients
- B. In the dental pulp there are no age related histological alterations
- C. Pulp revascularization depends on the diameter of apical foramen
- D. Pulp revascularization is a function of dental pulp`s blood supply
- E. In pulpitis, the patient can always indicate the origin of pain.

134.In case of necrosis secondary to trauma:
- A. The pulp can be easily extirpated with a barbed broach
- B. The blood supply of the pulp is not compromised
- C. The pulp can be extirpated without anesthesia
- D. The apex will be closed with secondary dentin
- E. The pulp degenerates suffering a process of liquefective necrosis.

135.In hyperemia:
- A. There are micro-abscesses in the coronal pulp
- B. The pain never occurs spontaneously
- C. The pain is always provoked
- D. The sensitivity tests are negative
- E. The diagnosis is based exclusively on subjective symptomatology.

136.In pulpitis:
- A. The patient can always indicate the diseased tooth
- B. There is an irreversible inflammation of the pulp tissue
- C. Spontaneous pain is a characteristic clinical symptom
- D. The treatment of choice is tooth extraction
- E. The diagnosis is based exclusively on radiologic images.

137.Lesions of endodontic origin can be clinically classified in:
- A. Acute alveolar abscess
- B. Periapical cyst
- C. Apical granuloma
- D. Acute apical periodontitis
- E. Chronic apical pulpitis

138.In chronic inflammation of endodontic origin :
- A. There is a reduction of the periodontal space
- B. The fibers of the periodontal ligament lose their insertion in the alveolar bone
- C. The fibers of the periodontal ligament preserve their insertion in the cementum
- D. The fibers preserve their insertion in the alveolar bone
- E. All of the above.

139.The differential diagnosis of a fistula with endodontic origin is made with:
- A. Osteomyelitis
- B. Lipoma
- C. Actinomycosis
- D. Small pox.
- E. All of the above.

140.* The distinction between apical granuloma and cyst is based on:
- A. Radiographic aspect
- B. Clinical signs
- C. Histological examination
- D. Therapy
- E. None of the above.

141.According to Weine, the following are histologic zones of a granuloma:
- A. Zone of infiltration
- B. Zone of contamination
- C. Zone of proliferation
- D. Zone of stimulation
- E. All of the above.

142.*Endotoxins :
- A. Are produced by bacteria
- B. Are derived from bacterial lysis
- C. Have a common origin with the exotoxins
- D. Have no influence on the size of the periapical lesion
- E. Are lipoproteins from nuclear membrane of bacterial cell.

143.*The healing of a periapical granuloma takes place:
- A. In a centrifugal direction
- B. In a centripetal direction
- C. In some cases it can heal without treatment
- D. In 100% of the cases
- E. Initially, in the center of the lesion.

144.*The treatment of acute alveolar abscess consist of:
A. Root canal obturation
B. Tooth extraction
C. Draining of the purulent collection
D. Apical resection
E. Indirect pulp capping.

145.*The reactivation of a chronic apical periodontitis:
A. Has no radiologic signs
B. It is also called Phoenix abscess
C. Has the same symptomatology with the chronic alveolar abscess
D. Leads always to tooth extraction
E. All of the above.

146.*The symptomatology of acute apical periodontitis might include:
A. Pain on percussion
B. Pain on palpation
C. The patient can identify the diseases tooth
D. Slight widening of the space of periodontal ligament
E. All of the above.

147.Histologically, the granuloma is characterized by the presence of :
A. Inflammatory granulation tissue
B. Osteoblasts
C. Peripheral capsule of connective fibers
D. Fibroblasts
E. Odontoblasts.

148.*The therapy of a granuloma requires:
A. Removal of infected canal content
B. Disinfection of the endodontic space
C. Sealing of the root canal space
D. None of the above
E. All of the above

149.The upper canine:
A. Has 2 root canals in 30% of cases
B. Needs to use instruments with a length of 30 mm
C. Has 2 pulp horns
D. The root canal may have a curvature in the apical 1/3
E. Usually it has 2 canals

150.The first upper premolar:
- A. Has a less variable endodontic anatomy
- B. Most frequently has 2 root canals
- C. In most of the cases has 1 root
- D. In maximum 6% of the cases it has 3 roots.
- E. The access cavity is oriented mesio-distal.

151.The first upper molar:
- A. The MB root is straight
- B. The DB root is straight, with round or oval shape
- C. Frequently, it has 2 root canals in the palatal root
- D. In more than 50% of the cases there are 2 canals in the MB root.
- E. Usually it has two roots.

152.*The second upper molar:
- A. Frequently has 4 roots
- B. Is smaller than the first upper molar
- C. Is the tooth most frequently endodontically treated
- D. It has always four root canals
- E. The roots are very divergent.

153.The central lower incisor:
- A. Has 1 root canal in 100% of cases
- B. Has 2 root canals in 30-40% of cases
- C. May have 2 roots
- D. The root is narrower in mesio-distal direction.
- E. The root is narrower in mesial-distal direction.

154.*The lower canine:
- A. In most of the cases has 1 root and 2 root canals that join in the apical third
- B. Is longer than the upper canine
- C. Most frequent has 1 root with 1 root canal
- D. Usually has two roots
- E. Very often has 3 cusps, one vestibular and two lingual.

155.*The second lower premolar:
- A. When it has 2 roots, one is placed mesial and one is placed lingual
- B. May have a C-shaped configuration of the root canal
- C. The root may be curved in a mesial direction
- D. May have 1 or 2 root canals.
- E. Usually has 3 roots.

156.*The first lower premolar:
- A. It`s anatomy is not characterized by a great variability
- B. Has 2 independent canals in 70% of the cases
- C. Can have a C shaped canal
- D. The dental crown is considered a transitional form between the incisor and canine
- E. Has two symmetric cusps.

157.*The lower first molar:
- A. Seldom requires endodontic treatment
- B. It generally has two separate roots
- C. In 90% of the cases, the canals of the mesial root join together at a common foramen
- D. In 5% of cases, four canals are present
- E. All of the above.

158.The third lower molar:
- A. Has a similar anatomy with the upper third molar
- B. Is more easy to treat (endodontic access) compared to the upper third molar
- C. Has always divergent roots
- D. Frequently has a mesial tilt of the occlusal surface.
- E. All of the above.

159.C-shaped canals:
- A. Can be seen in upper molars
- B. Are present in the upper premolars with 3 roots
- C. Appear in lower second molars
- D. Are formed after the confluence of 2 root canals.
- E. None of the above.

160.The treatment of lower third molars:
- A. Presents no special technical problems
- B. Is easier in lower molars
- C. Is contraindicated, extraction is the therapeutic choice
- D. Needs the identification of 1-5 root canals.
- E. Can be performed without rubber-dam isolation.

161.Irrigating solutions for endodontic use must meet the following requirements:
- A. Must have antibacterial properties
- B. Must have a low surface tension
- C. Must be relatively harmless to the patient
- D. Must keep the root canal dry
- E. All of the above

162.Sodium hypochlorite:
A. Its effect is reduced by heat
B. Is not able to dissolve organic substances
C. Effectively removes the smear-layer
D. It has a slower action on necrotic pulp fixed with formaldehyde
E. Usually, the solution used has a concentration of 5.25%.

163.The barbed broaches:
A. Are used in wide and straight canals
B. Their use prevent the transportation of apical foramen
C. Allow to withdraw the pulp tissue in one piece
D. Are not resistant to fracture
E. Are efficient in dentin removal.

164.*A 5.25% solution of sodium hypochlorite has been shown to be active against:
A. Gram-positive bacteria
B. Gram-negative bacteria
C. Viruses
D. Spore-producing microorganisms
E. All of the above.

165.The aqueous solution of EDTA:
A. Can be used in a concentration of 10%
B. Is indicated for the removal of necrotic debris
C. Can replace sodium hypochlorite during instrumentation
D. Is indicated for the removal of smear-layer
E. Can be used in a concentration of 17%.

166.*The use of a viscous chelator:
A. Is indicated for the initial negotiation of vital cases
B. Promotes the emulsification of organic tissues
C. Facilitates the negotiation of the root canal
D. Facilitates the introduction of the sequentially larger instruments
E. All of the above.

167.Rotary instruments:
A. Have a shaping action
B. Efficiently clean the root canal
C. Create a smear layer
D. Promote the action of the irrigants
E. All of the above.

168.Cavitation:
- A. Is a phenomenon caused by ultrasonic vibration
- B. Forms micro-bubbles
- C. Produces an irregular agitation of the liquid
- D. Is used in combination with NaOCl
- E. None of the above.

169.MTAD solution contains:
- A. Neomycin
- B. EDTA
- C. Tetracycline
- D. NaOCl
- E. Detergent

170.MTAD:
- A. Induces alterations of the dentinal structures
- B. It has no antibacterial affect
- C. It is less toxic than ethanol
- D. Reduces the coronal leakage of teeth obturated with gutta-percha
- E. Does not remove the smear-layer

PERIODONTOLOGY

171.The shape of the gingiva in the interdental space depends on:
- A. Presence or absence of a filling
- B. Distance between the adjacent tooth
- C. Osseous crest
- D. Presence or absence of some degree of recession
- E. Presence or absence of a prosthetic crown

172.*Langerhans cells found in the gingival epithelium have the role of:
- A. Make a connection to adjacent cells by desmosomes
- B. Synthesize melanin
- C. Antigen-presenting cells for lymphocytes
- D. Join the underlying connective tissue to the basal lamina
- E. Synthesize fibroblasts

173.*Oral (outer) epithelium has a thickness of:
- A. 0.2-0.3 mm
- B. 0.6-0.7 mm
- C. 1-2 mm
- D. 0.5-1 mm
- E. 0.1-0.5 mm

174.Sulcular epithelium is:
- A. Thick, highly keratinized
- B. Has the potential to keratinize if it is reflected and exposed to the oral cavity
- C. Formed by the confluence of the oral epithelium and the reduced enamel epithelium during tooth eruption
- D. Acting as a semipermeable membrane through which injurious bacterial products pass into the gingiva
- E. Exhibits high glycolytic enzyme activity

175.Junctional epithelium is attached to the tooth surface (epithelial attachment) through:
- A. An internal basal lamina (hemidesmosomes)
- B. Sulcular epithelium
- C. By an external basal lamina to the gingival connective tissue
- D. Vertical fibers of the periodontal ligament
- E. Horizontal fibers of the periodontal ligament

176.Lamina propria has two layers of:
- A. Type 1 collagen layer
- B. Papillary layer
- C. Keratin layer
- D. Reticular layer
- E. Fibroblast layer

177.Fibroblasts have the following functions:
- A. Maintain the gingival margin to the normal level
- B. Reduce the inflammation through the development of new bone
- C. Synthesize collagen, elastic fibers, glycoproteins and glycosaminoglycan
- D. Regulate collagen degradation through phagocytosis and the secretion of collagenases
- E. Synthesize keratin

178.The principal fibers of the periodontal ligament are:
- A. Alveolar crest fibers
- B. Horizontal fibers
- C. Langerhans fibers
- D. Muco-gingival fibers
- E. Vertical fibers

179.*Epithelial rests of Malassez:
- A. Are distributed close to the enamel
- B. Have a close relation with the muco-gingival junction
- C. Are inserted at the cemento-enamel junction level
- D. Are considered remnants of the Hertwig root sheath
- E. Have a close relation with reticular fibers

180. Physical functions of the periodontal ligament:
   A. Maintenance of the gingival tissues in their proper relationship to the teeth
   B. Resistance to the impact of occlusal forces
   C. Transmission of occlusal forces to the neighboring teeth
   D. Attachment of the teeth to the gingiva
   E. To provide nutrients through a good vascularization

181. The two main sources of collagen fibers in cementum are:
   A. Mesenchymal tissue that forms the outer covering of the anatomic root
   B. Glycosaminoglycan and glycoproteins hyaluronic acid, proteoglycans
   C. Sharpey fibers (extrinsic) formed by fibroblasts
   D. Fibers that belong to the cementum matrix (intrinsic), produced by the cementoblasts
   E. Hyaluronic acid and proteoglycans

182. The topographic ratio between cement and enamel can be:
   A. Cement comes into contact with enamel in 60-65% of cases
   B. Cement comes into contact with enamel in 30% of cases
   C. Cement covers the enamel in 60-65% of cases
   D. Cement covers the enamel in 30% of cases
   E. Cement covers the enamel in 20% of cases

183. Which of the following systemic conditions are cited as predisposing an individual to induce cementum resorption?
   A. Calcium deficiency
   B. Paget disease
   C. Cysts and tumors
   D. Periapical disease and periodontal disease
   E. Langerhans giant cells disease

184. Cementum resorption is caused by one or more of the following factors:
   A. Trauma from occlusion
   B. Gingival hyperplasia
   C. Cysts and tumors
   D. Spacing between teeth
   E. Gingival recession

185. The remodeling process of the alveolar bone affects its height, contour and density and is manifested in the following areas:
   A. Adjacent to the periodontal ligament
   B. In relation to the periosteum (facial and lingual plates)
   C. Along the pulp chamber
   D. At the cemento-enamel junction level
   E. Parallel to the root

186.Qualitative and quantitative changes of collagen occur in the gingival connective tissue, such as:
A. Increased mechanical strength
B. Increased denaturing temperature
C. A more irregular structure
D. Increased amounts of elastic fibers
E. Increased stabilization of the tooth

187.The histologic changes that occur in the gingival tissues are:
A. Early lesion corresponds with the early stages of (clinically evident) gingivitis
B. Established lesion corresponds with chronic gingivitis
C. Advanced lesion marks the transition to gingivitis
D. Established lesion corresponds with chronic periodontitis
E. Advanced lesion marks the transition to aggressive periodontitis

188.*The gingival epithelium is more than simply a passive barrier, it also has:
A. Nutritional role
B. An active role in innate immunity
C. Sensatory capacity
D. Vascular role
E. Neuro-transmitter role

189.Which are the two critical factors that determine whether bone loss occurs or not:
A. Poor dental hygiene
B. Incorrect periodontal treatment
C. The concentration of inflammatory mediators in the gingival tissues must be sufficient to activate the pathways that lead to bone resorption
D. The inflammatory mediators must penetrate within a critical distance in the alveolar bone
E. Incorrect brushing technique

190.*Innate immune responses are orchestrated by a broad range of:
A. Reticuline fibers
B. Collagen fibers type I
C. Cytokines, chemokines
D. Lymphocytes
E. Elastine fibers

191.The following drug-groups are known to induce gingival enlargement:
A. Anticonvulsant drugs, such as Nifedipine
B. Immunosuppressive drugs, such as Phenytoin
C. Calcium channel blockers, such as Verapamil
D. Anticonvulsant drugs, such as Sodium valproate
E. Immunosuppressive drugs, such as Cyclosporine

192. Which disease manifests as white deposit on the gingiva, tongue, or oral mucous membrane, that can be removed with a gauze and that leaves a red, bleeding surface. In individuals with human immunodeficiency virus (HIV) it has been referred to as linear gingival erythema.
   A. Gingival disease of genetic origin
   B. Gingival disease of fungal origin
   C. Gingival disease of viral origin
   D. Generalized candidal infection
   E. Gingival disease of specific bacterial origin

193. *Which of the following diseases does not present periodontal pocket formation?
   A. Aggressive periodontitis
   B. Chronic periodontitis
   C. Necrotizing ulcerative periodontitis
   D. Periodontal abscess
   E. Periodontitis as a manifestation of a systemic disease

194. The endodontic-periodontal lesions are characterized by:
   A. Localized, deep periodontal probing depth
   B. A periapical lesion, that may drain to the oral cavity trough the periodontal ligament
   C. A periodontal lesion, that affects the nerve trough the accessory canals
   D. Periodontal abscess formation, which will destroy the alveolar bone until the apex, thus will produce nerve necrosis
   E. Attachment loss, which will expose the root surface, thus the nerve will be damaged trough the accessory canals

195. In pregnancy gingivitis:
   A. Pregnancy itself causes gingivitis
   B. The hormonal changes of pregnancy accentuate the response of the healthy gingiva, thus will result the clinical picture
   C. The gingival changes are usually painful
   D. The aggravation of gingivitis during pregnancy has been attributed principally to the increased levels of progesterone, which produce dilation of the gingival microvasculature, circulatory stasis
   E. The accentuation of gingivitis during pregnancy has two peaks: during the first trimester due to the gonadotropins, and during the third trimester due to estrogen and progesterone.

196. *Swollen, soft, friable gingiva, bleeding occurs spontaneously or with the slightest provocation, and it is difficult to control. Low platelet count, prolonged bleeding time, hemorrhagic vesicles in the palate, tonsillar pillars and the buccal mucosa. What is the diagnosis?
   A. Anemia
   B. Thrombocytopenia
   C. Agranulocytosis
   D. Neutropenia
   E. Leukopenia

197.In leukemia:

A. Leukemic cells infiltrate the gingiva, which will result in a leukemic gingival enlargement
B. Leukemic cells infiltrate the bone marrow; the bone marrow has effect on the sex hormones, thus will produce a hormonal change, which will lead to the enlargement of the gingiva
C. The bleeding in leukemia is caused by the thrombocytopenia
D. The bleeding in leukemia is caused by immature leukemic blast cells, which invades the gingival corion
E. Oral ulceration and infection in leukemia is caused by the thrombocytopenia

198.*Localized, painful, rapidly expanding lesion, with sudden onset. It is limited to the interdental papilla. Red swelling with smooth, shiny surface. Within 24 to 48 hours the lesion usually becomes fluctuant and pointed. What is the diagnosis?

A. Periodontal abscess
B. Gingival abscess
C. Periapical abscess
D. Leukemic gingival enlargement
E. Drug induced gingival enlargement

199.General characteristics of chronic periodontitis:

A. The calculus accumulation is not in correlation with the severity of the disease
B. Altered gingival margins and attachment loss
C. The bone destruction is very fast, which explains the tooth loss
D. Change in tooth position, root furcation involvement
E. The early stage has an incisor-molar localization

200.The characteristics of the acute necrotizing ulcerative periodontitis:

A. Necrosis and ulceration of the coronal portion of the interdental papillae and gingival margin
B. Bright-red, non-painful marginal gingiva, that bleeds easily
C. Deep interdental osseous craters with medium to deep periodontal pockets
D. Periodontal pocket formation and periodontal attachment loss are the features, that distinguish the necrotizing ulcerative periodontitis from necrotizing ulcerative gingivitis
E. Advanced lesions of necrotizing ulcerative periodontitis lead to severe bone loss, tooth mobility, tooth loss. In addition to the manifestations, patients may present oral malodor, fever, and lymphadenopathy.

201.Choose those treatment methods, which are part of phase I therapy:

A. Coverage of single gingival recessions
B. Correction or replacement of poorly fitting restorations and prosthetic devices
C. Extraction of hopeless teeth
D. Removal of the supragingival calculus
E. Bone grafting procedures

202. *The term "debridement" refers to:
   A. Scaling
   B. Root coverage in single gingival recessions
   C. Recontouring defective restorations
   D. Root planing
   E. Biofilm removal through dental flossing

203. Choose those affirmations, which are part of the Bass technique:
   A. The head of a soft toothbrush is placed parallel with the occlusal plane, with the brush head covering three-four teeth, the brushing will start at the midline and will continue towards the most distal tooth
   B. The bristles are angled approximately 45 degrees from the long axis of the teeth, pointing at apical direction
   C. The bristles are angled approximately 45 degrees from the long axis of the teeth, pointing at coronal direction
   D. The brushing will start in the front area and it will be used a circular motion to brush
   E. The brushing will start at the most distal tooth and it will be used a vibrating, back-and-forth motion

204. Choose those affirmations, which are not true regarding the dental flossing:
   A. Dental floss should be held securely in the fingers or tied in a loop
   B. Never tie the dental floss in a loop, because you can injure your gingiva
   C. The floss is slipped between the contact area of the teeth, is wrapped around the proximal surface, and removes plaque by using several back-and-forth strokes. The process must be repeated for the proximal surface of the adjacent tooth.
   D. The floss is slipped between the contact area of the teeth, is wrapped around the proximal surface, and removes plaque by using several up-and-down strokes. The process must be repeated for the proximal surface of the adjacent tooth.
   E. Floss holders are helpful for patients lacking manual dexterity and for caregivers assisting patients in cleaning their teeth.

205. Toothbrushes:
   A. Rounded bristle ends cause more scratches on the gingiva than flat-cut bristles with sharp ends.
   B. Brush bristles themselves contribute to abrasion more than brush designs permitting the bristles to carry more toothpaste while brushing
   C. Softer bristles are more flexible, clean slightly below the gingival margin
   D. The amount of force used to brush is not critical for effective plaque biofilm removal
   E. Most clinicians recommend that toothbrushes be replaced every 3 to 4 weeks

206. What kind of fulcrum is used extraorally to stabilize the hand and the instrument during subgingival curettage?
   A. Palm up
   B. Palm down
   C. Conventional
   D. Cross-arch
   E. Finger on finger

207.Why are the Gracey curettes superior to the universal curettes?

A. Is a double-ended instrument
B. Presents a terminal shank; the universal curettes do not have terminal shank
C. Is an area-specific instrument
D. It is a sharp instrument with two cutting edges
E. Only one cutting edge

208.What kind of material is removed during subgingival curettage?

A. Fibrin from the pocket
B. Granulation tissue
C. Exterior ulcerated wall of the gingiva
D. Necrotic cement
E. Supragingival and subgingival calculus

209.*Which is the correct angulation for blade insertion into the periodontal pocket?

A. 0 degree
B. Less, than 45 degree
C. 45 degree
D. Between 45-90 degree
E. Between 45-70 degree

210.Choose the correct affirmations regarding the ultrasonic scaling:

A. Ultrasonic instruments have been shown to be more effective than hand instruments at reducing spirochetes and motile rods in class II and III furcations.
B. Heavy lateral pressure is necessary because the vibrational energy of the instrument dislodges the calculus.
C. During scaling is recommended to use short, light, vertical, horizontal, or oblique overlapping strokes.
D. Occasionally, the clinician may find, that some slight root roughness remains after scaling and root planning; if sound principles of instrumentation have been followed, this roughness is definitely calculus.
E. Patients with respiratory disease should be treated with ultrasonic or sonic devices, because they not represent the risk group.

211.The periodontal dressings:

A. When placing the pack, the doctor has to be sure, that the pack covers both the gingiva and mucosa underneath
B. For isolated teeth separated by edentulous spaces, the pack should be made continuous from tooth to tooth to cover the edentulous area
C. For isolated teeth separated by edentulous spaces, the pack should be made interrupted: should cover only the teeth, the edentulous area has to remain uncovered by the pack
D. The pack has to cover the gingiva and the whole crown part of the tooth, including the occlusal surfaces
E. After the pack is removed, the gums most likely will bleed more than they did before the operation, and it will gradually subside.

212. *Which of the following instruments is used especially in case of gingivectomy?
   A. Ochsenbein chisel
   B. Nabers probe
   C. Crane Kaplan pocket marker
   D. Orban probe
   E. Woodson elevator

213. Indications of gingivectomy:
   A. Aesthetic considerations, particularly in the anterior region of the maxilla
   B. Elimination of suprabony pockets, regardless of their depth, if the pocket wall is fibrous and firm
   C. Elimination of suprabony periodontal abscesses
   D. Situations, in which the bottom of the pocket is apical to the mucogingival junction
   E. The need for bone surgery or examination of the bone shape and morphology

214. Choose those flap techniques, which can be used for pocket therapy:
   A. Coronally displaced semilunar flap
   B. Double papilla flap
   C. Laterally displaced flap
   D. Modified Widman flap
   E. Apically displaced flap

215. *Which flap technique is described, as it follows: the papilla is incorporated into the facial or oral flap. The papilla is dissected from the lingual or palatal aspect with an Orban knife and elevated intact with the facial flap. The flap is reflected without thinning the tissue.
   A. Conventional flap
   B. Modified Widman flap
   C. Double papilla flap
   D. Coronally displaced semilunar flap
   E. Papilla preservation flap

216. Wat is the aim of the guided tissue regeneration?
   A. To exclude the epithelium and the gingival connective tissue from the root surface during the post-surgical healing phase
   B. To place barriers of different types (membranes) to cover the gingiva
   C. To separate the gingival epithelium from the connective tissue
   D. To favor repopulation of the root surface by cells from the periodontal ligament and the bone
   E. To help the epithelial migration along the cemental wall of the pocket and to maintain space for clot stabilization

217.Choose the correct affirmations regarding the non-resorbable membranes:
- A. After membrane placement healing is allowed to proceed for 3 months
- B. The major problem with using non-resorbable membranes is that membrane is exposed to the oral environment during healing
- C. After membrane removal, the area should not be probed for 4-6 weeks
- D. Preservation of the keratinized gingiva and a relatively thick overlying surgical flap are critical to avoid perforation of the flap by the membrane during healing
- E. Radiographic evidence of bone fill is usually present after 1-2 months

218.*What means "osseous coagulum"?
- A. Bone is triturated in an autoclaved plastic capsule with a pestle, thus is transformed into a plastic-like mass
- B. Bone is pushed -from an edentulous area adjacent to the defect- into contact with the root surface without fracturing the bone at its base
- C. Demineralized freeze-dried bone allograft
- D. Mixture of small, cortical bony particles and blood
- E. Freeze-dried bone allograft

219.Emdogain:
- A. Is effective in the treatment of infrabony defects
- B. Is inducing a new attachment
- C. Is inducing a periodontal regeneration
- D. Is obtained from cortical bone
- E. Is inducing a reattachment

220.Choose the procedures, which will increase the attached gingiva apical to the area of recession:
- A. Tunnel technique
- B. Free connective tissue xenograft
- C. Free gingival autograft
- D. Coronally displaced flap
- E. Apically displaced flap

FIXED PROSTHODONTICS

221.*The mechanical consideration of the tooth preparation:
- A. Pulpal protection
- B. Conservation of the tooth structure
- C. Supragingival margins
- D. Aesthetic occlusal surface
- E. Retention form

222.Tooth structure is conserved by using the following, excepting:
A. Preparation of teeth with the minimum practical convergence angle between axial walls
B. Selection of a conservative chamfer margin in all cases of tooth preparation
C. Avoidance of unnecessary apical extension of the preparation
D. Use of complete coverage rather than partial-coverage restorations
E. Preparation of the occlusal surface so that reduction follows the anatomic planes

223.Correct answers regarding the taper of the preparation:
A. Theoretically the maximum retention is obtained at 6° angulation of the axial walls
B. As taper increases the retention of the restoration will be better
C. Clinicians have a tendency to overtaper in buccolingual direction more than mesiodistally
D. Too small taper may lead to unwanted undercuts
E. To create a taper is necessary to tilt the rotary cutting instrument

224.The feather edge preparation:
A. Provide adequate bulk at the margins
B. Results overcontoured restorations
C. May be the best option for porcelain laminate veneer preparation
D. May be a good option for metal-ceramic crowns
E. Is realized with a tapered diamond with a rounded tip

225.The chamfer preparation:
A. The width of the preparation is half of the tip of the diamond used for the preparation
B. The width of the preparation is equal with the diameter of the tip of the diamond bur
C. Tilting the diamond toward the tooth leads to the reduction of the retention
D. Tilting the diamond away from the tooth results in an excessive convergence angle
E. Is recommended for the buccal margin of a metal-ceramic crown

226. Choose the correct answers:
A. Air abrading the internal surface of the crown is recommended to increase the retention
B. Failure rarely occurs at the luting agent and tooth interface
C. Acid etching of the fitting surface of the restoration improve retention with all type of luting agents
D. Roughening the tooth preparation is recommended to increase the retention
E. Metals with high gold content are better retained than base metal alloys

227.The occlusal reduction regarding the adequate resistance form:
A. In case of malaligned tooth the occlusal reduction should follow the cuspal planes
B. In case of supra-erupted teeth the non-functional cusp needs to be reduced with 1.0 mm
C. The minimum alloy thickness is 1.5 mm over the buccal mandibular cusps
D. The adequate alloy thickness is 1.0 mm over the buccal maxillary cusps
E. In case of extreme occlusal wear, for tooth preparation design the existing occlusal plane must be considered

228.The adequate margin design for resistance:

A. To prevent distortion of the restoration margins occlusally, the design of the preparation outline should locate at the occlusal contact areas
B. To prevent distortion of the restoration margins occlusally, the design of the preparation outline should locate at 5 mm away from occlusal contact areas
C. The adequate amount of reduction in the cervical part for high-strength anatomic contour zirconia is 1.0 to 1.2 mm
D. The adequate amount of reduction in the cervical part for metal-ceramic crowns is 1.0 to 1.2 mm
E. Lower strength ceramic crowns can be fabricated on shoulder margin preparation with 0.8-1.0 mm width

229. Indications of subgingival margins:

A. Axial contour modification
B. Occlusally extended proximal contact area
C. Root sensitivity which can`t be controlled with conservative procedures
D. Increased clinical crown
E. Extruded teeth

230.*Incorrect regarding the Esthetical considerations in case of metal-ceramic crowns:

A. An incisal reduction of 2 mm is recommended for good esthetics
B. The incisal edge does not have a metal backing
C. In case of low lip line a metal supragingival collar may be placed
D. Ceramic margins generally have a more accurate fit than metal margins
E. A common error is to prepare the margins almost in one plane

231.Saliva control during impression:

A. Local anesthesia may help with saliva control during impression making
B. For the lower arch a long cotton roll in a horseshoe shape can be used in the mandibular mucolingual folds
C. Some antihypertensive drugs can reduce the salivary output
D. The moisture-absorbing card can be used to block off the submandibular salivary duct
E. The bucally placed svedopter can be used to prevent the dislodgement of the cotton rolls by the tongue

232.*The mechanical displacement is most effectively achieved by:

A. Placement of an impregnated cord
B. The use of different foam or paste systems
C. Excision with a scalpel
D. Using a laser
E. Surgical tissue removal

233.Materials used for chemical impregnation of the cord:

A. The astringents cause gingival tissue shrinkage for long period of time
B. The ferric sulfate causes significant tissue damage
C. The Visine eye wash is effective in tissue displacement
D. The aluminum chloride causes a transient ischemia of the gingival tissue
E. Epinephrine can be used because in small quantity is not causing tachycardia

234.The double cord technique:
- A. The two cords are placed at the bottom of the gingival crevice
- B. The second cord is impregnated
- C. The first cord is non-impregnated
- D. The two cords are non-impregnated
- E. The second cord remain in the sulcus during the impression

235.Regarding the displacement paste is true:
- A. The Expa-syl paste contains $AlCl_3$
- B. Less tissue displacement is achieved than with cord
- C. Cause higher discomfort than traditional cord
- D. The Magic FormCord contains hemostatic agents
- E. The expanding foam contains $AlCl_3$

236.The Roeko Comprecap:
- A. Is made from acrylic resin
- B. Is the name of the zirconia cap
- C. Contains a hemostatic agent
- D. Is a hollow cotton roll
- E. Is maintained on the abutment for 5 minutes

237.Characteristics of the different, available elastic impression materials:
- A. Condensation silicone: automixing is available
- B. Addition silicone: care is needed to avoid bubbles during pouring
- C. The polyether: after the set of the material is very stiff
- D. The polysulfide polymer: short setting time
- E. Condensation silicone: pouring of some materials must be delayed

238.In case of elastomeric impression:
- A. The custom tray must have a consistent thickness of 2 to 3 mm
- B. The impression tray must maintain an impression material thickness of 4-5 mm
- C. The retraction cord is removed cervically, in horizontal direction toward the neighbor tooth
- D. In case of pontics, before impression the appliance of block-out material is indicated
- E. To avoid the premature removal of the tray, is necessary to judge clinically when the material is set

239.Closed-mouth impression technique:
- A. The impression is made in centric relation of the jaws
- B. Is demanding the intraoral use of three, small size impression tray
- C. The technique facilitates an accurate occlusal record
- D. Is also called the triple tray technique
- E. The technique facilitates the eccentric records

240.Disinfection of the impression:
A. Polyether should be submerged and soaked in a glutaraldehyde solution
B. Addition silicone should be sprayed with iodophor spray and stored in a plastic bag
C. The irreversible hydrocolloid is not recommended to be disinfected with iodophors
D. The irreversible hydrocolloid can be sprayed with sodium hypochlorite
E. The chlorine dioxid spray cause damage of the polyether

241.Biologic requirements for an interim fixed restoration are:
A. Provide occlusal compatibility
B. Maintain tooth position
C. Resistance to the removal forces
D. Resistance to the functional loads
E. Maintain periodontal health

242.Indications for fiber-reinforced interim restoration:
A. A long-span anterior partial fixed dental prosthesis
B. Above-average masticatory muscle strength
C. Improvement of aesthetics
D. Prolonged treatment time
E. History of frequent breakage

243.*The disadvantage of a custom external surface form (ESF) produced from thermoplastic sheet:
A. It is usually not adapted easily with a high degree of precision
B. Additional adjustment time is required
C. The material is a poor dissipater of the heat released during resin polymerization
D. It is not feasible to use them for partial fixed prosthesis
E. Cannot be used in evaluating the adequacy of tooth reduction

244.*Indirect-direct procedure for tissue surface form (TSF):
A. There is no contact of free monomer with prepared tooth or gingiva
B. No laboratory work needed
C. Adjustments are frequently needed to seat the shell completely on the prepared tooth
D. Do not preset polymerization shrinkage
E. It is an easy and quick procedure

245.Correct answers regarding the digital interim fixed restoration:
A. The abutment teeth need to be prepared on articulator-mounted diagnostic cast
B. The external surface form is made from a diagnostic waxing of the proposed restoration
C. Is an entirely indirect method
D. The CAD/CAM interim restoration are stronger and more accurate than traditional bis-acryl composite prostheses
E. The interim restoration must be placed in warm water to hasten polymerization

246.Correct answers regarding interim laminate veneers:
A. The indirect methods may be more efficient if multiple veneers are being made
B. The cementing is performed with zinc-oxide-eugenol
C. The phosphoric acid etchant gel must be used
D. The cementing is performed with glass ionomer cement
E. The interim restorations are removed with a spoon excavator

247.The interim luting agent:
A. Zinc-oxide-eugenol has an obtundent effect on the pulp
B. Eugenol-free zinc oxide has less strength than cements containing eugenol
C. Free eugenol acts as a plasticizer of methacrylate resin
D. To increase the cement's strength petrolatum can be used
E. Zinc phosphate cement is recommended in a situation in which the tooth preparation lacks retention

248.Removal of the interim restoration:
A. Can be done with hemostatic forceps
B. The Backhaus towel clamp is effective for obtaining sound purchase on a fixed dental prosthesis
C. The removal forceps are directed perpendicular on the long axis of the preparation
D. Sometimes it is helpful to loop dental floss under the connector at each end of the FDP
E. The removal forceps are directed parallel to the long axis of the preparation

249.Correct answers regarding post and core interim restoration:
A. The external surface form (ESF) must be removed when the resin becomes rigid
B. The interim can be placed in the warm water to hasten polymerization
C. The restoration no need to be cemented
D. In the post space, it is used a piece of wire
E. The external surface form (ESF) must be removed when the resin is still rubbery

250.Regarding the texture of the interim restoration:
A. Imbrication lines may be simulated with an inverted-cone green stone
B. Placement of developmental defects is best accomplished in the resin just before pumice and rag wheel finishing
C. A completely smooth and highly polished surface may not be esthetically compatible with adjacent teeth
D. Developmental defects may be made with a coarse diamond rotary instrument
E. Developmental lobes are best simulated in the wax during the final stage of the diagnostic waxing

251.*According to Siebert classification:
A. Class III defects: loss of the ridge height with normal ridge width
B. Class I defects: a combination of loss in both dimension
C. Class III defects: faciolingual loss of tissue width with normal ridge height
D. Class II defects: loss of the ridge height with normal ridge width
E. Class I defects: loss of the ridge height with normal ridge width

252.Conical pontic:
A. Is the pontic design that is most esthetically appealing
B. This type of design may be unsuitable for broad residual ridge
C. This design is recommended for replacement of mandibular posterior teeth
D. This design deficiency has been shown to result in tissue inflammation
E. Has a concave fitting surface that overlaps the residual ridge buccolingually

253.*Modified ridge-lap pontic:
A. Is the most common pontic form used in areas of the mouth that are visible during function
B. Surgical augmentation of the soft tissue is typically required
C. Is the pontic design that is most esthetically appealing
D. Is easy for patient to keep clean
E. The concave gingival surface of the pontic is not accessible to cleaning with dental floss

254.Modified ovate pontic:
A. Have a concave gingival surface
B. Have only one point of contact with the residual ridge
C. Can be used in clinical scenarios in which horizontal ridge width is not sufficient for conventional ovate pontic
D. Cleansing is easiest of all pontic types
E. Surgical augmentation of the soft tissue is always required

255.Correct answers regarding gingival architecture preservation:
A. The abutment teeth are prepared before extraction
B. The interim FDP is placed after 1 month from extraction
C. The definitive restoration can be fabricated when the gingival levels are stable (approximately 6 to 12 month)
D. The tissue side of the interim pontic should be an ovate form
E. It is recommended that interim FDP be fabricated through the direct method

256.Ovate pontic:
A. Is often called egg-shaped
B. The broad convex geometry is stronger than that of the modified ridge-lap pontic
C. Combines the best futures of the hygienic and saddle pontic design
D. Tissue contact should resemble a letter T
E. Sometimes socket depression can be sculpted into the ridge with surgical diamonds

257.Correct answers regarding pontic material:
A. Occlusal contacts should fall on the junction between metal and porcelain during centric position
B. Occlusal contacts should fall on the junction between metal and porcelain during eccentric position
C. For easier plaque removal, the tissue surface of the pontic should be made in glazed porcelain
D. The metal-ceramic junction should not be in contact with the residual ridge on the gingival surface of the pontic
E. Occlusal

258.The principles of the framework design of am metal-ceramic pontic are:
A. The metal surface must be smooth
B. The veneering area must have a sharp angle
C. Occlusal centric contacts must be placed at least 1,5 mm away from the metal-ceramic junction
D. The metal surface must have undercuts to ensure mechanical bond of the ceramic
E. In time, discoloration of the restoration can occur

259.Fiber-reinforced composite pontics:
A. Have a long-term clinical performance
B. Consist of a substructure matrix of impregnated glass fiber
C. Consist of a substructure matrix of impregnated polymer fiber
D. The marginal adaptation is poor
E. Have excellent esthetics

260.Correct answers:
A. Hygienic pontic: demands surgical intervention on the residual ridge
B. Modified ridge-lap pontic: combine esthetics with easy cleaning
C. Conical pontic: is recommended for the replacement of the posterior maxillary teeth
D. Ovate pontic: have the most esthetically appealing
E. Ridge-lap pontic: allow easy cleaning

261.After the removal of interim restoration:
A. The remaining cement should be removed from the prepared tooth surface with a diamond
B. The prepared teeth should be cleaned with a water-pumice mixture in a prophylaxis cup
C. Polishing the preparation is undesirable
D. The preparation is rinsed with sanitary alcohol
E. The remaining cement should be removed from the prepared tooth surface with an ultrasonic scaler

262.Correct answer regarding the evaluation of the marginal integrity for FDP:
A. Can be done with a periodontal probe
B. A gap could be because of excessive proximal contact
C. An open margin requires a new casting
D. A small overhang margin needs a remake of the restoration
E. A sharp explorer moved from restoration to tooth and from tooth to restoration can be used

263.*Resin-modified glass ionomer luting agent:
A. Exhibit lower strength than conventional cements
B. Post cementation sensitivity resulting from their use is minimal
C. Is particularly susceptible to moisture contamination
D. Provide less crown retention than zinc phosphate
E. It is contraindicated when cementing implant crowns on titanium abutments

264.Cementation procedures for ceramic veneers:

A. The enamel is etched with hydrofluoric acid
B. The silane coupling agent is applied on the internal surface of the restoration
C. The enamel is etched with phosphoric acid
D. The fitting surface of restoration is first treated with silane and after that is etched
E. The silane coupling agent is applied to the enamel

265.*In case of preparation of restoration for cementation:

A. Cast restoration is best prepared by etching with phosphoric acid
B. The margins must be prepared by airborne-particle abrasion
C. The restoration can be cleaned using ultrasonic units
D. The restoration can be cleaned using petrolatum
E. The internal surface of the restoration is coated with cavity varnish

266.The ceramic inlay can be cemented with:

A. Glass ionomer
B. Adhesive resin
C. Resin ionomer
D. Self-etch adhesive resin
E. Zinc phosphate

267.Cast post-and-core can be cemented:

A. Reinforced ZOE
B. Zinc phosphate
C. Zinc polycarboxylate
D. Resin ionomer
E. Adhesive resin

268.Occlusal adjustment of fixed restoration:

A. A monolithic ceramic restoration out of occlusion can be adjusted by adding porcelain and refiring
B. Can be performed with diamond rotatory instrument or white stone
C. A metallic restoration out of occlusion must be remade
D. Can be done only on restoration which is in supraocclusion
E. Is done after cementation of restoration

269.Correct answers regarding occlusal adjustment involving dental ceramics:

A. Minor adjustment may be needed after glazing
B. After adjustment, ceramic no need to be polished
C. Adjustments can be done by using carbide burs
D. Gross occlusal adjustment is better done in bisque stage
E. Minor adjustments require reglazing the restoration

270.Glass ionomer cement:

A. Adheres to enamel and dentine
B. The set cement is opaque
C. During setting should be protected with a resin coat
D. The setting reaction is changed by water
E. Have been showed to have the lowest incidence of post-operative cementation sensitivity

REMOVABLE PROSTHODONTICS

271.Factors that influence the form and the size of the supporting bone include the following:

A. The severity of the periodontal disease
B. Quantity of saliva
C. The relative length of time different parts of the jaws have been edentulous
D. The compliance of the patient
E. Quality of life

272.Mandibular stress- bearing areas are:

A. Firm tuberosities
B. Buccal shelves
C. Retromolar pads
D. Rugae
E. Hard palate

273.*To make an ideal impression, the following concepts should be adhered to:

A. The tissue of the mouth must not be healthy
B. Proper space for the selected impression material should not be provided within an impression tray
C. The impression should extend to include the entire basal seat
D. Border modeling procedure is not necessary
E. Correct positioning of the impression tray in the mouth doesn't need a guiding mechanism

274.The posterior palatal seal:

A. Create a border seal to decrease the risk of dislodgement of the denture upon speaking and mastication
B. Is created at the anterior periphery of the denture
C. A class I palate is the most favorable for denture retention
D. The tissue can be displaced several millimeters anterior to the vibrating line
E. A class III palate is the most favorable for denture retention

275.The neutral zone:

A. Is recorded in the final impression phase
B. Occupies a position of equilibrium among the groups of tongue, cheek and lip muscle
C. Is first established in the wax occlusion rim
D. It is not a guide for prosthetic teeth position
E. It is not a guide for the location of a planned denture's polished surface

276.The dentist uses occlusion rims to:

A. Determine the supporting areas
B. Determine the posterior palatal seal
C. Determine all potential denture- bearing tissues
D. Determine the neutral zone
E. Establish the level of the occlusal plane

277.A complete denture:

A. Has five surfaces
B. Has an impression/ intaglio surface
C. Has a polished surface
D. The impression surfaces make contact during functional activities
E. The occlusal surfaces don't contact during functional activities

278.*The occlusion rim:

A. Is frequently contoured labial to the ridge in the anterior region
B. Is frequently contoured lingual to the ridge in the anterior region
C. Is frequently contoured labial to the ridge in the premolar region
D. Is frequently contoured lingual to the ridge in the premolar region
E. Is slightly labial to the residual ridge in the molar region

279.The maxillary rim:

A. Is usually parallel to the interpupillary line
B. Is usually parallel to the upper lip contour
C. Is at height that accommodates the length of the natural tooth plus the amount of bone reduction
D. The pattern of bony reduction is ignored
E. Doesn't take into account the interpupillary line

280.The incisive papilla:

A. Appear to occupy a stable locale on the palate
B. Clinical and anthropometric measures indicate that the incisal edges of the maxillary central incisors are 8- 10 mm anterior to the center of the incisive papilla
C. Clinical and anthropometric measures indicate that the incisal edges of the maxillary central incisors are 4- 5 mm anterior to the center of the incisive papilla
D. Doesn' t have a stable position on the palate
E. The papilla location is not used for central incisor positioning

281.*Tooth loss will have a pronounced effect on the appearance of the lips and adjacent tissues:

A. Lips appear to be replenished
B. There is a noticeable lengthening of the lips
C. The lower part of the face is not affected
D. The effect of the degenerative changes in the skin are not obvious
E. There is a noticeable shortening/ thinning of the lips

282. In some approaches to occlusal plane determination:
   A. The starting point for establishing the occlusal plane is the maxillary occlusion rim
   B. The incisal plane is parallel to the lower lip line
   C. The occlusal plane, posteriorly, is made to parallel the ala- tragus line
   D. The incisal plane is parallel to the ala- tragus line
   E. The occlusal plane, posteriorly, is parallel to the interpupillary line

283. The most frequently used tests in establishing the correct VDO by means of occlusion rims are:
   A. Visual observation of the space between the rims when mandible is in physiological rest position
   B. Judgement of the denture stability
   C. Judgement of the support- bearing areas
   D. Old study casts, photographys
   E. Phonetic test that include the "S" sound enunciated accurately and repeatedly

284. The " free- way space" :
   A. Is the difference between the mandible physiological rest position dimension and the VDO
   B. Is usually 2- 4 mm when observed at the position of the first premolars
   C. Is usually 6- 8 mm when observed at the position of the first premolars
   D. Is usually 2- 4 mm when observed at the position of the central incisors
   E. The mandible physiological rest position coincides with the VDO

285. Phonetic tests of the vertical dimensions:
   A. When correctly placed, the lower incisors should move forward to a position nearly directly under and almost touching the upper incisors
   B. If the anterior teeth touch when "ch", "s" sounds are made, the VDO is too small
   C. If the anterior teeth touch when "ch", "s" sounds are made, the VDO is too great
   D. If the teeth click together during speech, the VDO is too small
   E. When correctly placed, the lower incisors should move backward

286. *The average measurements of the distance of the incisive papilla to the incisal edges of the maxillary central incisors are:
   A. 2 mm
   B. 4 mm
   C. 6 mm
   D. 8 mm
   E. 10 mm

287. Parallelism of the ridges:
   A. The removal of the teeth tends to leave the residual alveolar ridges nearly parallel to each other
   B. Ridge parallelism is unfavorable
   C. Due to teeth lost at different times, the residual ridges are no longer parallel
   D. The parallelism occurs rarely
   E. Ridge parallelism is causing the dentures to slide anteriorly or posteriorly

288.*The preliminary centric relation record:
A. Is made prior the height of the mandibular occlusion plane has been determined
B. Is made prior the occlusion rims have been contoured
C. Is made prior the preferred interocclusal space has been established
D. Is made prior the final impression
E. Will be transferred to an articulator

289.The materials used for the static interocclusal records of centric relations in complete denture:
A. The materials do not harden to provide a " check- bite" record
B. The consistency of the material must not offer resistance during mandibular closure
C. The material must not inadvertently guide the path of the mandible
D. The material must not support the models during the mounting process
E. The material must not retain the relationship between the occlusion rims

290.The simple hinge articulator in complete dentures:
A. The instrument itself is not rigid
B. Can be relied on to preserve the centric relation position precisely
C. Occlusal contacts in centric relation can be perfected
D. Can be used to relate the occlusal surfaces in excursive movements
E. Refining non- working side contacts for balanced occlusion is possible

291.*When alginate is used for preliminary impression for removable partial dentures the amount of clearance between the tray and the oral tissues is:
A. 1-2 mm
B. 2-3 mm
C. 3-4 mm
D. 4-5 mm
E. None of the above

292.Stock trays can be used for final impressions when obtaining a removable partial denture if:
A. The selected tray has suitable clearance from oral tissues for the selected impression material
B. The selected tray has sufficient coverage of the impression area
C. The selected tray is flexible
D. The selected tray does not require customization by border molding
E. The denture is constructed without any mouth preparations

293.When taking a final impression for removable partial denture one can use the following types of trays:
A. Custom tray made of self-curing acrylic
B. A stock tray
C. Custom tray made of light-curing urethane dimethacrylate
D. Flexible tray
E. None of the above

294. Advantages of custom trays:
   A. They are rigid and dimensionally stable
   B. They are flexible and dimensionally stable
   C. They are tailored to the impression area
   D. The clearance between the tray and the tissues can be adjusted prior to fabrication
   E. They can be used in conjunction with adhesive agents

295. Functional final impressions for partial removable dentures are mostly indicated for:
   A. Mandibular Kennedy Class I
   B. Mandibular Kennedy Class III
   C. Mandibular Kennedy Class II
   D. Maxillary Kennedy Class III
   E. None of the above

296. The single tray functional impression technique for removable partial denture:
   A. Uses a custom tray
   B. Uses a stock tray
   C. Is a time saving technique
   D. Produces a hybrid cast
   E. Is a relatively complicated technique

297. The altered cast technique for obtaining a removable partial denture:
   A. Starts with a conventional impression
   B. Is a multistep procedure
   C. All the denture parts are made on the same cast
   D. The laboratory work is complicated
   E. Does not involve cutting the initial cast

298. When taking the impression for removable partial denture:
   A. The tray should be positioned with mild finger pressure
   B. The tray should be kept still with fingers on the premolar area
   C. Lips should be pulled to cover the impression tray
   D. When removed, the tray should be pulled perpendicular to the long axis of teeth
   E. Cleaning and disinfection is not mandatory

299. For removable partial dentures, the alginate material:
   A. Is an acceptable choice for final impression
   B. Delivers fair surface details
   C. Cannot be use for final impression
   D. Doesn't need to be poured immediately
   E. Has strong tear resistance

300. The altered cast technique for obtaining a removable partial denture:
   A. The metal framework is used to make the impression of the free-end edentulous spaces
   B. The acrylic saddles are used as individual trays
   C. Pressure should be applied on the saddles
   D. Pressure should not be applied on the metal framework
   E. The acrylic saddles require border molding

301. *The characteristics of the major connector for removable partial denture include:
   A. Flexibility
   B. Smooth and round line angles
   C. Interference with movable tissue
   D. Use of marginal gingiva for support
   E. Allow food entrapment

302. *In the mandibular arch, the borders of the major connector in relation to the free gingival margin should be placed:
   A. 1-2 mm
   B. 2-3 mm
   C. 3-4 mm
   D. 4-5 mm
   E. 5-6 mm

303. *In the maxillary arch, the borders of the major connector in relation to the free gingival margin should be placed:
   A. 8 mm
   B. 2 mm
   C. 4 mm
   D. 6 mm
   E. None of the above

304. Lingual bar of a removable partial denture:
   A. Has a triangular shape in cross section
   B. Is flexible
   C. Can be used in every clinical situation
   D. Has a height of 4 mm
   E. Has a thickness of 2 mm

305. Indirect retainers for removable partial dentures:
   A. Prevent displacement of the denture away from the tissues
   B. Need to be positioned perpendicular to the fulcrum line
   C. Need to be positioned close to the fulcrum line
   D. Are required in Kennedy Class I, Class II dentures
   E. Can be incisal or cingulum rests

306.The Akers clasp:

A. Is a circumferential clasp
B. Is a bar clasp
C. Is an infrabulge clasp
D. Is a suprabulge clasp
E. Is an RPI clasp

307.The functions of a clasp assembly:

A. Retention
B. Parallelism
C. Encirclement
D. Flexibility
E. Resistance

308.A retentive clasp used in a removable partial denture has the following parts:

A. A reciprocal element
B. A survey line
C. A body
D. A rest
E. A retentive arm

309.An occlusal rest used in removable partial denture:

A. Does need a preparation on the lingual side of the canine
B. The recommended size is ¼ the buccolingual width of the tooth
C. The angle between the floor of the rest and the minor connector should be greater than 90°
D. The shape of the rest should be spoon shaped from the sagittal view
E. The recommended size is 1/3 to ½ the mesiodistal diameter of the abutment

310.Rest are used in removable partial denture to:

A. Act as indirect retainers
B. Transmit occlusal forces from the prosthesis to an abutment along the long axis of the tooth
C. Resist the denture base movement toward the gingival tissue
D. Favor extrusion of unopposed abutment teeth
E. Maintain clasps in the desired positions

DENTO-ALVEOLAR SURGERY. MAXILLOFACIAL SURGERY

311. Regarding force in time of extraction the following statements are correct:
   A. Considerable force is used, particularly in the upper jaw
   B. Considerable force is used in both jaws
   C. Considerable force is used, particularly in the lower jaw
   D. Never use force when you make extractions
   E. For lower jaw the force has to be limited to that which the operator can counteract by supporting the mandible with his free hand

312. About Cryer elevators are correct the following:
   A. This type of elevator is used for right side only
   B. The strong blade gives him a mechanical advantage
   C. It is used mostly for the upper jaw molars
   D. It is used when one root is retained in the socket
   E. Are not indicated to be inserted in the inter-radicular bone

313. Following cysts are arising from the epithelium of dental origin:
   A. Eruption cyst
   B. Dentigerous cyst
   C. Solitary bone cyst
   D. Nasolabial cyst
   E. Dentigerous cyst

314. Regarding primordial cysts are correct following:
   A. Recurrence rate is between 50%-60%
   B. Recurrence rate is between 5%-60%
   C. Their protein content is higher than for the dental cysts
   D. They do not content protein
   E. They increase in size by mural division

315. *Regarding radiologic exam for cysts lesions are correct:
   A. Radiolucent areas demarcated from normal bone by a thin line of cortical bone which is more radiolucent
   B. Apical periodontal cysts are associated with the roots of vital teeth
   C. Intraoral apical films are used for small dental cysts
   D. For maxilla is difficult to make a different diagnostic between a cyst or a locule of the maxillary sinus
   E. Intraoral apical films are used only at the maxilla

316. Regarding treatment for cystic lesions:
   A. Can be done by enucleation only
   B. Apicectomy can be used for small apical cysts
   C. Marsupialisation is used for small apical cysts
   D. Enucleation can be used for larger odontogenic cysts
   E. the tooth must be extracted in time of enuclation

317.Regarding globulomaxillary cysts are correct:

A. The cyst has dental origin
B. This is a developmental cysts
C. Are developing between the lateral incisor and the canine
D. Are developing between the central incisors
E. The teeth close to the cyst are nonvital

318.*Surgical steps for enucleation of cysts are:

A. Bone removal
B. Flap creation
C. Enucleation of the cysts
D. Suture
E. All answer are corect

319.Different diagnostic for dental cystic lesions can be done with:

A. Central giant cell granuloma
B. Ameloblastoma
C. Planus Hemangioma
D. Dermoid cyst
E. Mucocele

320.Aspiration for cyst treatment can be used:

A. For infected cysts only
B. For uninfected cysts before surgery with 12 hours
C. In time of surgery for those covered by thin bone
D. In time of surgery for those covered by thick bone
E. Before surgery for all cysts

321.*The gauze placed in the cavity after enucleation of the cyst is maintained in the space:

A. Up to 4 weeks
B. Up to 6 weeks
C. Up to 3 weeks
D. Up to 5 weeks
E. Up to 1 month

322.*Pathological fracture can occur in cysts:

A. Only before operation time
B. Only after the operation time
C. In time and before operation
D. Related only with the maxillary sinus
E. Related only to the tuberosity

323. Pathological characteristics of benign tumors can be:
- A. Well differentiated
- B. Fast growing
- C. Localised
- D. Erosive
- E. Nondifferentiated

324.* Oral precancer lesions are except:
- A. Sideropaenic dysphagia
- B. Actinic keratosis
- C. Lichen planus
- D. Leukoplakia
- E. Immunosupression

325.Management protocol for oral precancer include:
- A. Clinical photographic record
- B. Biopsy for mild dysplasia
- C. Monitor the skin changes
- D. Scintigraphy
- E. MRI

326.Regarding patients with oral cancer are correct following:
- A. Survival rate is 30%
- B. More than 70% are primary squamous cell carcinoma
- C. More than 90% are primary squamous cell carcinoma
- D. This type of cancer include only lips and oral cavity
- E. Posteriorly sites are rapidly growing

327.Late lesions symtoms for oral cancer can be:
- A. Discomfort
- B. Irritation
- C. Paresthesia
- D. Asympomatic
- E. Dysphagia

328.* T2 oral tumor means:
- A. Tumor smaller than 2cm
- B. Tumor smaller than 1 cm
- C. Tumor between 2-4 cm
- D. Tumor which is infiltrating deep structures
- E. Tumor bigger than 4cm

329.Indications to radiotherapy in oral cancer are:
- A. Large tumors with bony invasion and cervical limph nodes metastasis
- B. Previous local irradiation
- C. Tumors inaccessible for surgery
- D. Tumors technically unresectable by surgery
- E. Patient fit for major surgery

330.Regarding osteoradionecrosis are correct the following statements:
- A. The process in not painfull when is associated with infection
- B. The late changes are a‘ moth - eaten ’ appearance of the bone
- C. Starts as an ulceration on the oral mucosa
- D. The stimulus can be tooth extraction
- E. The process involves the high vascular bone

331.*Surgical treatment for oral cancer can be excepting:
- A. Local flap repair
- B. Primary closure
- C. Bone grafts
- D. Titanium reconstruction plates
- E. Odontectomy

332.For the treatment of oral cancer are necessary following imagistic investigations:
- A. Chest xray
- B. MRI scanning
- C. Blood chemistry
- D. Fine needle aspiration
- E. Incisional tissue biopsy

333.*Indications for tooth extraction are the following except:
- A. Caries
- B. Periodontal disease
- C. Infection
- D. Aesthetic
- E. Trauma

334.Extraction of teeth involves:
- A. Knowledge of tooth morphology
- B. Use of elevators to assist and facilitate
- C. Position of patient is not important
- D. Application of force related to bone morphology
- E. Use of forceps is the same for all teeth

335.Teeth that are potentially difficult to be extracted are:
- A. Teeth malpositioned palatally or lingually
- B. Teeth with rooth resorption
- C. Teeth with periodontal disease
- D. Teeth rotated, or inclined
- E. Teeth with extensive infection

336.Order of extraction of teeth
- A. Anterior teeth are extracted before posteriors.
- B. Posterior teeth are extracted before anteriors.
- C. There is no rule is performing extraction
- D. Lower teeth are removed before uppers
- E. Upper teeth are removed before lowers

337.*In case of fracture of the tooth during extraction the following statements are true EXCEPT:
- A. Occurs frequently
- B. The extraction may be continued using forceps and elevators
- C. Radiogrphic assessment is not necessary
- D. Retained portion may vary in size from a whole root to a tiny apex
- E. The remained root may be left on site in some situations

338.Division of roots of a lower tooth and upper tooth might be performed by:
- A. Round bur
- B. Cryer elevator to buccal aspect of a tooth
- C. Forceps
- D. Cryer elevator to palatal aspect of a tooth
- E. Fissure bur

339.After extracting teeth hemorrhage is arrested by:
- A. Asking the patient to bite on a gauze swab placed over the socket
- B. Digital pressure applied if the bleeding has not stopped after 30 minutes
- C. Gingival margins of the sockets must be displaced outward
- D. Digital pressure applied if the bleeding has not stopped after 10 minutes
- E. In all situations simple sutures are placed across the socket

340.*The following statements are post - extraction instructions, EXCEPT:
- A. Normal oral hygiene may be resumed after 24 hours
- B. Not to use a mouthwash for the first 24 hours
- C. Professional advice is required only if after 24 hours these measures fail
- D. Hot or cold foods, alcohol or exercise are best avoided in the first 24 hours
- E. Bleeding occur the patient must sit upright and bite on a rolled - up handkerchief

341. Complications of Tooth Extraction that can appear pre-extraction:
   A. Abnormal resistance
   B. Swelling
   C. Difficulty in achieving anaesthesia
   D. Damage to other teeth
   E. Difficulty of access

342. Complications of Tooth Extraction that can appear during extraction:
   A. Difficulty in co - operation
   B. Fracture of teeth
   C. Crowded or misplaced teeth
   D. Damage to other teeth
   E. Surgical emphysema

343. Complications of Tooth Extraction that can appear post-extraction:
   A. Difficulty of access
   B. Delayed healing and infection
   C. Broken instruments
   D. Dislocation of the temporomandibular joint
   E. Oroantral communication

344. Damage to other teeth during extraction involve:
   A. Extraction of the wrong tooth
   B. Oroantral communication
   C. Dislocation of adjacent teeth or of restorations in adjacent teeth
   D. Loss of tooth or root
   E. Dislocation of the temporomandibular joint

345. *Damage of soft tissues during extraction may involve the following elements EXCEPT:
   A. Tongue
   B. Floor of mouth
   C. Cheek
   D. Adjacent teeth
   E. Palate

346. Damage of soft tissues may appear through various mechanisms:
   A. During surgery the drill can damage the buccal tissues or lips
   B. When extracting lower teeth the lower lip can be trapped between the forceps and the upper teeth
   C. Soft tissues can be damaged by instruments that slip even they are properly supported
   D. Burns may be caused by hot instruments from the steriliser, overheating of burs or handpieces
   E. The inferior dental nerve can be damaged during the extraction of buried upper teeth

347.Local factors that are more often responsible for postoperative hemorrhage:

A. Tooth ankylosis
B. Infection
C. Chronic periodontal disease
D. Presence of a cyst
E. Excessive trauma

348.Dry socket has the following characteristics:

A. This condition is relatively painless
B. An increase in blood supply to the healing socket may be one of the factors
C. The socket contains either remnants of the blood clot or food debris.
D. The etiology of this condition is unclear
E. A discharge of pus localized to the socket appear a week or so after extraction.

349.*Post - extraction pain may result from the following causes EXCEPT:

A. Incomplete extraction of the tooth
B. Using an air spray
C. Infected sockets
D. Exposed bone
E. Laceration of the soft tissues

350.Trismus

A. May occur as the result of oedema and swelling
B. Could appear due to the injection for the inferior dental nerve block
C. Occurs in patients who have a lax capsule and weak supporting muscles
D. Seldom gives rise to discomfort and settles without treatment
E. May cause the fracture of the body of the mandible

351.*Host factors that are important concerning the establishment of an infection include the following EXCEPT:

A. Age
B. Virulence of the micro-organisms
C. Concurrent disease
D. Therapeutic irradiation
E. Immunosuppressant drugs

352. Infection in the orofacial region may spread by one of the following routes:

A. The bone
B. The lymphatics
C. The airways
D. The nerves
E. The blood

353. *The local classical signs of acute inflammation include the following EXCEPT:
   A. Swelling
   B. Pain or tenderness
   C. General malaise
   D. Redness
   E. Heat

354. The systemic signs of infection include:
   A. Raised temperature
   B. Swelling
   C. Loss of function
   D. Rapid pulse
   E. Pain

355. The management of an infection relies on some local measures:
   A. Analgesia
   B. Nutritional support
   C. Institution of drainage
   D. Removal of the cause
   E. Antibiotic therapy

356. Common infections in the mouth include:
   A. Pericoronitis
   B. Mediastinitis
   C. Acute periapical abscess
   D. Brain abscess
   E. Acute sinusitis

357. Spread of orofacial infection may lead to the serious consequences as:
   A. Acute periapical abscess
   B. Intracranial spread
   C. Lymphadenopathy
   D. Septicaemia
   E. Trismus

358. A number of potential tissue spaces exist in the neck and orofacial region through which infection may spread. They include the following superficial spaces:
   A. Infratemporal
   B. Submental
   C. Submandibular
   D. Retropharyngeal
   E. Pterygomandibular

359.Intracranial spread of infection may lead to:
- A. Lymphadenopathy
- B. Mediastinitis
- C. Cavernous sinus thrombosis
- D. Trismus
- E. Brain abscess.

360.Persistent and spreading infection may determine unfavorable evolution to:
- A. Ludwig ' s angina
- B. Tuberculosis
- C. Osteomyelitis
- D. Actinomycosis
- E. Mediastinitis

OCCLUSOLOGY

361.*How does the disk from TMJ become anteriorly displaced:
- A. Due to posterior ligament which is tethered to the back of the condyle by an inelastic band of collagen fibers
- B. Due to superior elastic fibers
- C. Due to superior lateral pterygoid muscle
- D. Due to medial and lateral diskal ligaments
- E. Due to masseter muscle

362.*Centric relation:
- A. Is a ligament braced position
- B. Is determined by elevator muscles
- C. Is not a physiologic position
- D. Is determined by the disk assembly
- E. It is a border position in which joints do not normally function

363.*The consequences of anteriorly disk displacement are:
- A. Clicking or popping in TMJ's area
- B. Pain
- C. The disfunction of superior lateral pterygoid muscle
- D. A lack of blood vessels and nerves
- E. Block up of the jaw in open position

364.The effects of occlusal interference are:
- A. The displacement of the condyles down and forward
- B. Laterodeviation
- C. Dental pain
- D. Occluso-muscle pain
- E. Increasing the forces on the posterior teeth

365.What movement and which muscles are involved when the condyles are displaced From CR to achieve MI?
- A. The superior belly of the lateral pterygoid muscle
- B. The inferior lateral pterygoid muscle
- C. The condyles must be pulled forward in sagittal plane
- D. The condyles are pulled down as they are pulled forward
- E. The elevator muscles

366.*Disk displacement does not occur due to the following factors:
- A. The elevator muscles
- B. The intact ligaments
- C. Applying tensive force to the posterior ligament of the disk
- D. The superior lateral pterygoid muscle
- E. An ideal occlusion

367.The features of centric relations are:
- A. Is the relationship of the maxilla and mandibula when the condyle-disk assemblies are fixed
- B. Is the most superior and midmost position of the condyle-disk assemblies
- C. Should not be confused with centric occlusion
- D. Should not be confused with maximum intercuspation
- E. Is a convenience position that is used because it is repeatable

368.The definitions of centric relation are:
- A. The uppermost position
- B. The most retruted position
- C. It occurs when the occlusion is optimal
- D. Is not about the teeth
- E. Refers to the fully seated condylar position

369.The criteria for accuracy in making an interocclusal bite record are:
- A. Using rubbery materials
- B. Use of soft materials
- C. The bite record must not cause any movement of the teeth
- D. The bite record must not cause any displacement of the soft tissues
- E. Pressing the mandibula to the posterior by the clinician

370.The features of the curve of Wilson are:
- A. It is the mediolateral curve
- B. It contacts the buccal and lingual cusp tips on each side of the arch
- C. It results from the inward inclination of the lower posterior teeth
- D. It results from the outward inclination of the upper posterior teeth
- E. It is the antero-posterior curvature of the occlusal surfaces

371.The inclination of the posterior teeth (regardinWilson curve) has the following aspects:
A. It's mesiodistal
B. It's buccolingual
C. It has to do with resistance to loading
D. It has to do with masticatory function
E. It has to do with centric relation

372.The concept of immediate side shift is characterized by:
A. It is very important to allow the condyles to translate horizontally before any rotation during lateral movement
B. It is a very popular misconception
C. It cannot occur in a healthy joint if the condyles are in centric relation at the start of the movement
D. The only way this can occur is if there is severe alteration of the shape of the articulating surfaces
E. The condylar path protection for the posterior teeth prevents such a movement

373.If it is necessary to restore the lower posterior teeth, the starting point for determining lower occlusal contours should be:
A. The contact points (mesial and distal)
B. The buccal cusps
C. The lingual cusps
D. To establish the plane of occlusion
E. To establish the canine guidance

374.If only lower posterior teeth are to be restored:
A. Cusps tip position and fossa contours for the lower teeth are aligned with the neighboring teeth
B. Lower fossa contours will be established to conform to the upper lingual cusps
C. Fossa walls can be carved to be discluded by the anterior guidance without complications
D. To ensure complete disclusionthe condylar path or the articulator can be set flatter than the patient's condylar path
E. To open up lower fossae by providing more that enough freedom for lateral path

375.If both upper and lower posterior teeth are to be restored:
A. First, we have to establish the position of the upper lingual cusps
B. First we have to establish the position of the lower buccal cusps
C. It its important to wax upper and lower arches together starting with wax cones (representing all the cusps)
D. It is important the restauration to be done in fully adjustable articulators
E. To establish the curve of occlusion

376.As the mandible moves laterally, the lower posterior teeth lea their centric contact and travel sideways down a path dictated by:
A. The condyles
B. The lateral anterior guidance
C. The inclines of the opposing teeth
D. The inclines of the opposing fossae
E. Occlusal surfaces of the teeth involved in the movement

377.Centric relation contact in usually established on restoration in the following ways:
A. Surface to surface contact
B. Tripod contact
C. Cusp-tip-to fossa contact
D. Cusp-to-cusp contact
E. Guidance cusps-to fossae

378.The condyles in the TMJs are:
A. Often symmetric
B. Rarely symmetric
C. Limited by the movement on the other
D. Inclined with 90° to each-other
E. Inclined with 30° to each-other

379.The role of the medial pole of the TMJ is:
A. To support the forces of measure into hundred of pounds
B. To form the anterior part of the articular fossa
C. To establish the midmost position at centric relation
D. To make possible to have a normal curve of occlusion
E. To form the anterior part of the TMJ

380.The options regarding the use of a facebow are:
A. Relates the upper cast to the horizontal condylar axis
B. To record the proper occlusion
C. To relate the upper arch to the condylar axis
D. To record the position of the upper arch to the lower arch (MI)
E. To record the centric relation

IMPLANTO-PROSTHETIC THERAPY. ORAL REHABILITATION

381.Complications of pre-prosthetic surgical ostetomy procedures for oral rehabilitation patients:
A. Osteonecrosis
B. Damage to anatomical formations
C. Hemorrhage
D. Stability of the repositioned segment
E. All of the above

382.The success of implant-prosthetic therapy depends on:
A. Correct planning
B. Careful evaluation of the osseous site
C. Prosthetic design
D. Durability
E. Aeshtetics

383.Occlusal overloading of implants:
A. Is one of the principal causes of osseointegration loss
B. is one of the principal causes of fracture of mechanical components
C. Causes the bone to adapt to these forces
D. Is not correlated with the incorrect adaptation of the prothetic restauration
E. Is dependent on the number and disposition of implants

384.*Screw retained prosthesis advantages:
A. Allows easy removal of the construction
B. The need for prosthesis rebuild
C. Reduced esthetic quality
D. Need for complex prefabricated components
E. Increasing the need for prosthesis rebuild

385.Bone resorbtion mode and severity are:
A. Dependent on the cortical thickness
B. Not dependent on the type of prosthesis worn by the patient
C. Not dependent on the disease that necessitated the teeth extraction
D. Dependent on the time elapsed since extraction
E. Not dependent on the extraction technique

386.In the guidelines for mandibular implant surgery:
A. The most common area for implant placement is between the mental foramina
B. The implant must be placed less than 2 mm from the mental foramina
C. Irrigation is not necessary in this area
D. Abundant irrigation is necessary in this area
E. The mandibular canal limits the quantity of available bone

387.To reduce the need for screwing and unscrewing of the prosthetic components of an implant it is possible to:
A. Adopt an alternative prosthetic technique
B. Position the final abutment after stage 2 surgery
C. Position the final abutment at stage 2 surgery
D. Immediately position the abutment for screw retained prostheses
E. Position the final abutment before stage 2 surgery

388.The key to maintaining lasting esthetic results in implantology is:
A. Evaluation of the clinical situation
B. Selection of a precise transmucosal component
C. Selection of a simple transmucosal component
D. Selection of a complex transmucosal component
E. The reconstructive procedures must me bomplex

389.*Immediate loading indicates:
A. Establishing contacts within 1 or 2 weeks
B. Establishing contacts after a period of 4 to 6 weeks
C. The possibility of establishing occlusal contacts the same day
D. The possibility of establishing occlusal contacts after 3 to 6 months
E. All of the above

390.The clinical success of implants is strictly linked to:
A. The establishment of ossteointegration
B. The gender of the patient
C. The aesthetic of the final restauration
D. The age of the patient
E. The maintainance of ossteointegration

391.*The Schroeder regions:
A. Are situated in the posterior portion of the palate
B. Are situated laterally to the median raphe
C. Are situated in the anterior portion of the sublingual area
D. Are sitated in the lateral areas of the mandible
E. Are situated in the sublingual area

392.During impression taking:
A. The frena should not be touched
B. The frena should be positioned by the clinician
C. The less mobile portion at its base should not be included in the impression
D. The less mobile portion at its base should be compressed
E. None of the above

393. Important anatomic regions and structures in mandibular denture construction:
A. Maxillary tuberosity
B. Mandibular tuberosity
C. Region of Fish
D. Mylohyoid regions
E. Anterior sublingual region

394.*The limits of the anterior sublingual region are marked:
A. Anteriorly by the ligural surface of the mandible
B. Inferiorly by the mylohyoid and genioglossus muscles
C. Posteriorly by the subligual gland
D. Posteriorly by the body of the tongue
E. All of the above

395.The mylohyoid ridge:
A. Is the site for the insertion of the mylohyoid muscle
B. Is the site fo the insertion of the masseter muscle
C. The margin of the tray must extend beyond it by less than 1 mm
D. The margin of the individual tray must extend beyond it by at least 3 to 4 mm
E. The prosthetic margin can extend beyond the ridge by about 1 mm

396.The changes in form in the subligual region are divided in the following classes:
A. Class II: The depth of the region is appreciably enlarged
B. Class III: The depth of the region is maintained
C. Class I: The depth of the region is maintained
D. Class II: The depth of the region is appreciably reduced
E. Class III: The depth of the region is in between Class I and Class II

397.The retromolar pads:
A. Represent the most disal portion of the osteomucosal ridge
B. They consist of an anterior portion coated by attached mucosa
C. They consist of an posterior portion coated by attached mucosa
D. They consist of an anterior portion coated by a more mobile mucosa
E. They consist of an posterior portion coated by a more mobile mucosa

398.In the case of ball retention implant retained removable dentures:
A. The height of the prosthetic abutment is determined by the transmucosal pathway between the head of the implant and the free gingival margin
B. The upper part of the abutment must emergefrom the mucosa by 1.5 to 2 mm
C. The upper profiles of the ball attachments must be at the same height
D. Hygiene practices are not important
E. A meter gauge should be used for measurement

399.In order to avoid the interposition if the mucosa between the attachment components of the screw retained implant abutment:
A. Imperfect adaptation between the attachment components is necessary
B. Screwdrivers for prosthetic abutments should be used
C. Perfect adaptation between the attachment components is necessary
D. Pliers for prosthetic abutments should be used
E. None of the above

400.*Whether or not to recommend prosthetic rehabilitation in the case of partial edentulism depends on:
A. Patient`s general health
B. Advantages, disadvantages, and long-term prognosis of the reconstruction
C. Cost
D. Patient motivation and expectations
E. All of the above