SELF ASSESSMENT QUESTIONS WITH RATIONALE & REFERENCES

Lecture 1: Spatial Approach to the Infrahyoid Neck, Bronwyn Hamilton, MD

QUESTION 1: The following statements are true regarding vocal cord paralysis EXCEPT:
1. Right-sided paralysis is more common
2. Most imaging studies for vocal cord paralysis are negative
3. CT evaluation must include the aortopulmonary window due to longer recurrent course on the left
4. Ortner’s syndrome reflects hoarseness due to a cardiovascular etiology of recurrent laryngeal nerve involvement
5. Post-operative (iatrogenic) causes and tumors account for most anatomic causes of unilateral recurrent nerve paralysis

Correct Answer = 1

Rationale: Left-, not right-sided paralysis is more common

References:

QUESTION 2: All of the following structures are contents of the infrahyoid posterior cervical space EXCEPT:
1. Fat
2. Level V (spinal accesssory) lymph nodes
3. Lymphatics
4. Vagus nerve (CN 10)
5. Spinal accessory nerve (CN 11)

Correct Answer = 4

Rationale: Vagus is in the carotid space, not PCS.

References:
QUESTION 3: What structure separates the true and false vocal folds (cords)?
   A) the aryepiglottic fold
   B) the hyoepiglottic ligament
   C) the ventricle
   D) the conus elasticus

Correct Answer = C

Rationale: The ventricle is a narrow slit-like recess between the true vocal fold and the false vocal fold. The ventricle is the boundary between the supraglottic larynx and the glottis larynx.

QUESTION 4: The bulk of the true cord (fold) is represented by the:
   A) thyroarytenoid muscle
   B) posterior cricoarytenoid muscle
   C) paraglottic fat
   D) Vocal ligament

Correct Answer = A

Rationale: The thyroarytenoid muscle stretches from the inner cortex of the thyroid cartilage to the arytenoid cartilage and represents the bulk of the true vocal fold or cord. The vocal ligament is very thin and stretches along the margin of the muscle making up the edge of the vocal fold.

References for Questions 3-4

Lecture 3: Update on Cervical Lymph Node Imaging, Anton N. Hasso, MD

QUESTION 5: What are the consensus size criteria for metastatic lymphadenopathy in the head and neck?
   a. 8 mm diameter for retro-pharyngeal nodes; 15 mm diameter for level I nodes; 10 mm diameter for other level nodes.
   b. 12 mm diameter for retro-pharyngeal nodes; 15 mm diameter for level I nodes; 10 mm diameter for other level nodes.
   c. 8 mm diameter for retro-pharyngeal nodes; 15 mm diameter for level I nodes; 10 mm diameter for other level nodes.
   d. 8 mm diameter for retro-pharyngeal nodes; 15 mm diameter for level I nodes; 12 mm diameter for other level nodes.
   e. Any of the above

Correct Answer = a

References:

QUESTION 6: What are the classic forms of selective neck dissections?

a. Supraomohyoid type (III, IV, V); Lateral type (II, III, IV); Posterolateral type (II, III, IV, V); Anterior compartment type (VI, VII)

b. Supraomohyoid type (I, II, III); Lateral type (I, II, III, IV); Posterolateral type (I, II, III, IV, V); Anterior compartment type (VI, VII)

c. Supraomohyoid type (I, II, III); Lateral type (II, III, IV); Posterolateral type (II, III, IV, V); Anterior compartment type (VI, VII)

d. Supraomohyoid type (I, II, III); Lateral type (II, III, IV); Posterolateral type (II, III, IV, V); Anterior compartment type (VI, VII)

e. Any of the above

Correct Answer = d

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References:
Controlling advanced neck disease: efficacy of neck dissection and radiotherapy.
Richards BL, Spiro JD. Laryngoscope. 2000 Jul; 110(7):1124-7

How we do it: a method of neck dissection for histopathological analysis.