

INI CET ENT

Sample Paper – 10

Duration: 14 Minutes

Maximum Marks: 15

Instructions

- This paper contains **15** Multiple Choice Questions (Single Best Response), modelled on the ENT (Otorhinolaryngology) content of **INI CET** (Institutes of National Importance Combined Entrance Test) conducted by AIIMS New Delhi.
- The **15-question** length matches the number of ENT items you actually meet in the real 200-question paper.
- Each correct answer carries **+1 mark**. There is **negative marking of one-third (0.33) mark** for every incorrect answer; unattempted questions carry no penalty.
- Every question has **exactly one best answer**. Choose the single most appropriate option.
- Attempt this practice paper in one timed sitting of about **14 minutes**, the pace the real computer-based test demands.

Otology and Hearing

- Q1.** On acoustic (stapedial) reflex testing, a reflex that is present at onset but whose amplitude fades to half its starting value within the first few seconds of a sustained tone is termed positive reflex decay. This finding points to:
- (A) A pure middle-ear (ossicular) conductive lesion
 - (B) Normal cochlear function
 - (C) A retrocochlear lesion such as a vestibular schwannoma on the eighth nerve
 - (D) A tympanic membrane perforation



- Q2.** An elderly patient has conductive hearing loss and a canal full of hard keratin plugs, with widening of the bony ear canal but no bone erosion into the mastoid, and both ears are affected. The most likely diagnosis is:
- (A) An acquired external-ear-canal cholesteatoma with focal bone erosion
 - (B) Malignant (necrotising) otitis externa
 - (C) Keratosis obturans (a plug of desquamated keratin widening the canal)
 - (D) An osteoma of the ear canal
- Q3.** The attic (epitympanum) is the part of the middle ear that lies:
- (A) Above the level of the tympanic membrane (pars flaccida), housing the head of the malleus and the body of the incus, and is the key site of dangerous cholesteatoma
 - (B) Entirely below the floor of the external ear canal
 - (C) Within the cochlea, containing the organ of Corti
 - (D) In the nasopharynx, opening the Eustachian tube

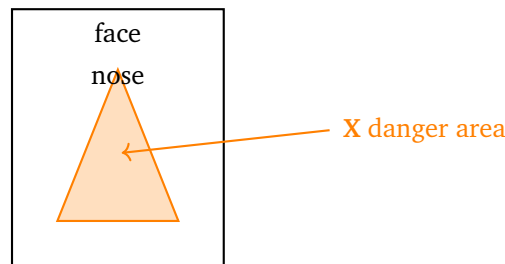
Rhinology and Paranasal Sinuses

- Q4.** A patient who had aggressive turbinate resection years ago now complains of a paradoxical feeling of nasal blockage despite a very wide, patent nasal airway, with crusting and dryness. This is best described as:
- (A) Empty nose syndrome from over-resection of the turbinates
 - (B) Simple allergic rhinitis
 - (C) Acute bacterial sinusitis
 - (D) A fresh nasal foreign body
- Q5.** Which of the following is NOT a recognised cause of a nasal septal perforation?



- (A) Chronic intranasal cocaine use
- (B) Simple seasonal allergic rhinitis without ulceration
- (C) Previous septal surgery (submucous resection)
- (D) Granulomatosis with polyangiitis (GPA / Wegener granulomatosis)

Q6. The shaded triangle in the diagram is the danger area of the face. A squeezed furuncle here can seed infection to the cavernous sinus mainly because:

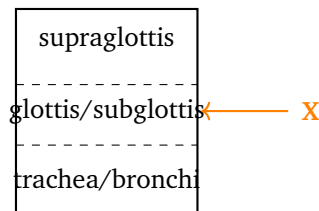


- (A) The skin here has no blood supply at all
- (B) The facial nerve directly drains pus into the brain
- (C) The maxillary sinus opens onto the skin surface here
- (D) The facial vein communicates through valveless veins with the cavernous sinus, allowing retrograde spread

Laryngology and the Airway

- Q7.** The piriform (pyriform) fossa is a recess of the hypopharynx that lies:
- (A) On either side of the laryngeal inlet, bounded medially by the aryepiglottic fold and laterally by the thyroid cartilage, and is a common silent site of hypopharyngeal cancer
 - (B) In the middle ear, above the oval window
 - (C) At the apex of the nasopharynx
 - (D) Within the frontal sinus
- Q8.** The airway diagram marks three levels. In a patient with **biphasic** stridor (heard in both inspiration and expiration), the obstruction is most likely at the level marked **X**, which is the:





- (A) Supraglottis (which gives purely inspiratory stridor)
- (B) Glottis / subglottis (the fixed narrow region that gives biphasic stridor)
- (C) Distal trachea and bronchi (which give purely expiratory stridor)
- (D) The nasopharynx

Oral Cavity, Pharynx and Head-Neck Oncology

- Q9.** A debilitated patient on long-term antibiotics has white curd-like plaques on the tongue and buccal mucosa that *rub off* with a spatula to leave a raw, bleeding base. The most likely diagnosis is:
- (A) Leukoplakia, because the plaques cannot be wiped away
 - (B) Squamous cell carcinoma
 - (C) Lichen planus
 - (D) Oral candidiasis (thrush), because the plaques wipe off leaving a raw base
- Q10.** A slow-growing, painless mass that bulges the lateral pharyngeal wall and pushes the tonsil medially, arising from the deep lobe of the parotid, occupies which anatomical space?
- (A) The subglottic airway
 - (B) The frontal sinus
 - (C) Little's area of the septum
 - (D) The parapharyngeal space
- Q11.** Which statement about neck dissection is correct?



- (A) A selective neck dissection always removes the internal jugular vein, the sternomastoid and the accessory nerve
- (B) A modified radical neck dissection removes all five nodal levels but preserves one or more of the internal jugular vein, sternomastoid muscle and accessory nerve
- (C) A radical neck dissection deliberately spares all three non-lymphatic structures
- (D) Selective neck dissection removes more tissue than a radical neck dissection

Paediatric ENT and Emergencies

Q12. Which of the following is an accepted indication for adenotonsillectomy in a child?

- (A) A single episode of viral sore throat
- (B) Obstructive sleep apnoea from marked adenotonsillar hypertrophy
- (C) Mild seasonal sneezing controlled by antihistamines
- (D) Physiological tonsillar tissue in a healthy toddler

Q13. A child stung by a bee develops rapidly progressive lip and tongue swelling, stridor and wheeze. The single most important first drug in this airway emergency is:

- (A) Intramuscular adrenaline (epinephrine)
- (B) Oral antihistamine tablets given over the next hour
- (C) A slow intravenous antibiotic infusion
- (D) Reassurance and observation only

Audiology and Vestibular Assessment

Q14. The schematic below summarises tuning-fork results for the right ear (marked X): the Weber lateralises to the right ear and the Rinne is negative on the right (bone conduction better than air conduction). This combination indicates:



Weber	Rinne (R)
→ right ear negative (BC > AC)	

X right ear

- (A) A right sensorineural hearing loss
- (B) Completely normal hearing in both ears
- (C) A right conductive hearing loss (Weber to the poorer ear, Rinne negative on that side)
- (D) A left conductive hearing loss

Q15. In the vestibular assessment of a patient with chronic dizziness, the bithermal caloric test and the rotational chair test are used mainly to:

- (A) Measure the pure-tone hearing thresholds
- (B) Image the ossicular chain
- (C) Assess horizontal semicircular canal / vestibulo-ocular function and guide vestibular rehabilitation
- (D) Test the sense of smell



Detailed Solutions

Q1.

Solution

Concept – acoustic reflex decay: The stapedial (acoustic) reflex is a contraction of the stapedius muscle to a loud sound; its stability over time is measured during reflex decay testing.

Step 1 – read the finding: The reflex is present at onset but its amplitude falls to half within the first few seconds of a sustained tone; this is a **positive reflex decay**.

Step 2 – interpret it: Rapid decay reflects abnormal fatigue of the eighth-nerve fibres, so it is a sign of a **retrocochlear lesion** such as a vestibular schwannoma (acoustic neuroma) on the auditory nerve.

Why the other options are wrong:

- A, ossicular conductive lesion: typically abolishes or elevates the reflex threshold, it does not cause a fatiguing decay.
- B, normal cochlear function: gives a well-sustained reflex without decay.
- D, tympanic membrane perforation: makes the reflex unrecordable, not decaying.

Final Answer: A retrocochlear lesion (vestibular schwannoma) ⇒ C

Answer: (C) [Go Back to Q1](#)

Q2.

Solution

Concept – keratosis obturans versus canal cholesteatoma: Both fill the ear canal with keratin, but they behave very differently.

Step 1 – match the clues: Hard keratin plugs, **diffuse widening** of the bony canal, *both* ears affected and *no* focal bone erosion describe **keratosis obturans**.

Step 2 – the contrast: An external-ear-canal cholesteatoma is usually *unilateral*, causes *localised* bone erosion of the canal floor and is often painful with otorrhoea.

Why the other options are wrong:

- A, canal cholesteatoma: is unilateral with focal erosion, not this bilateral diffuse widening.
- B, malignant otitis externa: gives severe pain, granulations and skull-base



osteomyelitis in diabetics.

- D, osteoma: is a hard bony swelling, not a keratin plug.

Final Answer: Keratosis obturans ⇒

Answer: (C) [Go Back to Q2](#)

Q3.

Solution

Concept – the attic (epitympanum): The middle ear is divided into levels relative to the tympanic membrane.

Step 1 – define the boundaries: The **attic (epitympanum)** lies *above* the level of the tympanic membrane (the pars flaccida region) and houses the **head of the malleus and the body of the incus**.

Step 2 – why it matters: The pars flaccida over the attic is the commonest site of **attic retraction** and dangerous cholesteatoma, so the attic is the key region to inspect in unsafe ear disease.

Why the other options are wrong:

- B, below the canal floor: describes the hypotympanum, not the attic.
- C, within the cochlea: the organ of Corti is in the inner ear, not the attic.
- D, in the nasopharynx: that is the Eustachian tube opening, not the epitympanum.

Final Answer: Above the drum, housing the malleus head and incus body ⇒

Answer: (A) [Go Back to Q3](#)

Q4.

Solution

Concept – empty nose syndrome: The turbinates warm, humidify and give sensory feedback of airflow, so removing too much of them backfires.

Step 1 – read the paradox: A **wide, patent** airway with a paradoxical sense of *blockage*, plus crusting and dryness after aggressive turbinate resection, defines **empty nose syndrome**.

Step 2 – the mechanism: Loss of turbinate tissue removes the mucosal sensors of airflow and the resistance needed for the feeling of comfortable breathing, so the patient feels obstructed despite a big airway.



Why the other options are wrong:

- B, allergic rhinitis: causes sneezing and a *narrowed* congested airway, not a wide empty one.
- C, bacterial sinusitis: gives facial pain and purulent discharge.
- D, nasal foreign body: gives unilateral foul discharge, usually in a child.

Final Answer: Empty nose syndrome from turbinate over-resection ⇒ A

Answer: (A) [Go Back to Q4](#)

Q5.

Solution

Concept – causes of septal perforation: A septal perforation follows loss of mucoperichondrium and cartilage from injury, inflammation or vasoconstriction.

Step 1 – list the real causes: Chronic **cocaine** use (intense vasoconstriction and ischaemia), previous **septal surgery** and **granulomatosis with polyangiitis** are all recognised causes.

Step 2 – find the odd one out: Simple seasonal allergic rhinitis without ulceration does *not* perforate the septum, so it is the exception.

Why the other options are wrong:

- A, cocaine: a classic cause of ischaemic perforation.
- C, septal surgery: bilateral opposing mucosal tears heal into a perforation.
- D, GPA: a granulomatous vasculitis that destroys septal cartilage.

Final Answer: Simple allergic rhinitis is NOT a cause ⇒ B

Answer: (B) [Go Back to Q5](#)

Q6.

Solution

Concept – the danger area of the face: The triangle from the upper lip to the bridge of the nose drains through veins that can carry infection backwards.

Step 1 – name the route: The **facial vein** communicates, through the *valveless* superior ophthalmic vein, with the **cavernous sinus**.

Step 2 – why squeezing is dangerous: Because these veins have no valves, pressing a furuncle here can push infected thrombus **retrogradely** into the cavernous



sinus, causing cavernous sinus thrombosis.

Why the other options are wrong:

- A, no blood supply: the skin here is in fact well vascularised.
- B, facial nerve draining pus: nerves do not drain pus; the route is venous.
- C, maxillary sinus on the skin: the sinus does not open onto the facial skin.

Final Answer: Valveless facial veins connect to the cavernous sinus $\Rightarrow$ **D**

Answer: (D) [Go Back to Q6](#)

Q7.

Solution

Concept – the piriform (pyriform) fossa: The hypopharynx has three subsites; the piriform fossa is the commonest cancer site among them.

Step 1 – define the anatomy: The piriform fossa is a recess on *either side of the laryngeal inlet*, bounded **medially by the aryepiglottic fold** and **laterally by the thyroid cartilage** (and thyrohyoid membrane).

Step 2 – the clinical relevance: Tumours here are *silent* early and present late with a neck node, referred otalgia or dysphagia, giving hypopharyngeal cancer its poor prognosis.

Why the other options are wrong:

- B, middle ear: the oval window region has nothing to do with the hypopharynx.
- C, nasopharynx apex: is a separate region above the soft palate.
- D, frontal sinus: is a paranasal air cavity, not part of the hypopharynx.

Final Answer: A hypopharyngeal recess beside the laryngeal inlet $\Rightarrow$ **A**

Answer: (A) [Go Back to Q7](#)

Q8.

Solution

Concept – localising stridor: The phase of stridor tells you the level of airway narrowing.

Step 1 – apply the rule: *Inspiratory* stridor = supraglottic; *expiratory* stridor = tracheobronchial; **biphasic** (both phases) = a fixed narrowing at the **glottis** /



subglottis.

Step 2 – read the marker: The level marked X is the glottic/subglottic region, so biphasic stridor localises there.

Why the other options are wrong:

- A, supraglottis: gives purely *inspiratory* stridor.
- C, distal trachea and bronchi: give purely *expiratory* stridor.
- D, nasopharynx: obstruction here causes stertor, not laryngeal stridor.

Final Answer: Glottis / subglottis ⇒ B

Answer: (B) [Go Back to Q8](#)

Q9.

Solution

Concept – candidiasis versus leukoplakia: The key bedside test is whether the white patch can be wiped off.

Step 1 – match the features: White **curd-like plaques** that *rub off* to leave a raw bleeding base, in a debilitated patient on antibiotics, are classic for **oral candidiasis (thrush)**.

Step 2 – the contrast: Leukoplakia is a white patch that *cannot* be wiped away and is a potentially premalignant lesion; candidal plaques wipe off.

Why the other options are wrong:

- A, leukoplakia: does not rub off, so it does not fit a wipeable plaque.
- B, squamous cell carcinoma: is an ulcer or fixed mass, not a wipeable plaque.
- C, lichen planus: gives fixed white lacy (Wickham) striae, not curd that rubs off.

Final Answer: Oral candidiasis (thrush) ⇒ D

Answer: (D) [Go Back to Q9](#)



Q10.

Solution

Concept – the parapharyngeal space: Deep-lobe parotid tumours grow medially into a fat-filled space lateral to the pharynx.

Step 1 – localise the mass: A painless mass that **bulges the lateral pharyngeal wall** and pushes the tonsil *medially*, arising from the deep parotid lobe, sits in the **parapharyngeal space**.

Step 2 – the clinical picture: The tonsil and soft palate are displaced towards the midline, which is the classic sign of a parapharyngeal mass.

Why the other options are wrong:

- A, subglottic airway: is within the larynx, far from the pharyngeal wall.
- B, frontal sinus: is a paranasal cavity, unrelated.
- C, Little's area: is on the nasal septum, unrelated to the pharynx.

Final Answer: The parapharyngeal space ⇒ D

Answer: (D) [Go Back to Q10](#)

Q11.

Solution

Concept – types of neck dissection: Neck dissections are classified by which nodal levels and which non-lymphatic structures they remove.

Step 1 – apply the definitions: A **modified radical neck dissection** clears all five levels (I–V) but *preserves* one or more of the **internal jugular vein, sternomastoid muscle and accessory nerve**.

Step 2 – contrast: A *radical* dissection removes all three of those structures; a *selective* dissection preserves them and removes only selected at-risk levels.

Why the other options are wrong:

- A, selective removing all three structures: false; selective spares them.
- C, radical sparing all three: false; radical sacrifices all three.
- D, selective removing more than radical: false; radical is the most extensive.

Final Answer: Modified radical preserves one or more non-lymphatic structures ⇒ B

Answer: (B) [Go Back to Q11](#)



Q12.

Solution

Concept – indications for adenotonsillectomy: Surgery is reserved for obstruction or recurrent significant infection, not trivial illness.

Step 1 – pick the valid indication: Obstructive sleep apnoea from marked adenotonsillar hypertrophy is a well-accepted indication for adenotonsillectomy in children.

Step 2 – the complication to warn of: The main early complication is *reactionary and secondary haemorrhage*, so post-operative bleeding must be watched for.

Why the other options are wrong:

- A, a single viral sore throat: is not an indication for surgery.
- C, mild seasonal sneezing: is allergic rhinitis, managed medically.
- D, physiological tonsils in a healthy child: normal lymphoid tissue is not removed.

Final Answer: Obstructive sleep apnoea from adenotonsillar hypertrophy ⇒ **B**

Answer: (B) [Go Back to Q12](#)

Q13.

Solution

Concept – anaphylactic airway obstruction: Rapid lip and tongue swelling with stridor after a sting is acute laryngeal oedema from anaphylaxis, an airway emergency.

Step 1 – give the first drug: The single most important first drug is **intramuscular adrenaline (epinephrine)**, which reverses the airway swelling and bronchospasm and supports the circulation.

Step 2 – secure the airway: Give high-flow oxygen, call for help early and be ready to secure the airway (intubation, or surgical airway if it is lost); antihistamines and steroids are only adjuncts.

Why the other options are wrong:

- B, oral antihistamine over an hour: far too slow for a collapsing airway.
- C, slow antibiotic infusion: this is allergic oedema, not infection.
- D, observation only: dangerous; untreated laryngeal oedema can be fatal.

Final Answer: Intramuscular adrenaline (epinephrine) first ⇒ **A**



Answer: (A) [Go Back to Q13](#)

Q14.

Solution

Concept – combining Weber and Rinne: Reading the two tests together localises the type and side of a hearing loss.

Step 1 – read the results: Weber **lateralises to the right** ear and the Rinne is **negative on the right** (bone conduction better than air conduction on that side).

Step 2 – interpret them: Weber lateralising to the *poorer* ear plus a *negative* Rinne on the same side is the signature of a **right conductive hearing loss**.

Why the other options are wrong:

- A, right sensorineural loss: Weber would go to the *better* (left) ear and Rinne would be positive.
- B, normal hearing: Rinne would be positive and Weber central.
- D, left conductive loss: Weber would lateralise to the left, not the right.

Final Answer: Right conductive hearing loss $\Rightarrow$ C

Answer: (C) [Go Back to Q14](#)

Q15.

Solution

Concept – caloric and rotational chair tests: Both probe the horizontal semicircular canal and the vestibulo-ocular reflex, guiding rehabilitation.

Step 1 – state the purpose: The bithermal caloric test and the rotational chair test **assess horizontal semicircular canal / vestibulo-ocular function**, identifying and quantifying a vestibular deficit.

Step 2 – the role in rehabilitation: Knowing the side and degree of vestibular loss lets the clinician plan **vestibular rehabilitation** exercises that promote central compensation.

Why the other options are wrong:

- A, pure-tone thresholds: are measured by audiometry, not caloric testing.
- B, image the ossicles: needs CT imaging, not vestibular tests.
- D, test smell: is olfactory testing, unrelated to the balance system.



Final Answer: Assess vestibulo-ocular function and guide vestibular rehabilitation

⇒

Answer: (C) [Go Back to Q15](#)



Answer Key

Q	Ans	Q	Ans	Q	Ans	Q	Ans	Q	Ans
1	C	2	C	3	A	4	A	5	B
6	D	7	A	8	B	9	D	10	D
11	B	12	B	13	A	14	C	15	C

