

INI CET ENT

Sample Paper – 5

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. A 4-year-old boy has dull hearing after repeated colds, with a retracted immobile drum and a flat (type B) tympanogram but no pain or discharge. The commonest cause of this painless conductive deafness in childhood is:

- (A) Otitis media with effusion (glue ear)
- (B) Acute suppurative otitis media
- (C) Otosclerosis
- (D) Congenital cholesteatoma

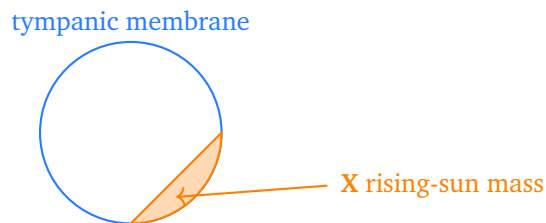
Q2. A slap to the ear leaves a young man with a small central perforation of



the tympanic membrane, mild conductive loss and no signs of infection. The expected course of this traumatic perforation is that it will usually:

- (A) Require immediate tympanoplasty within 48 hours
- (B) Heal spontaneously if kept dry and free of infection
- (C) Progress inevitably to cholesteatoma
- (D) Cause a permanent sensorineural loss

Q3. A middle-aged woman has pulsatile tinnitus and a conductive loss. Otoscopy shows a reddish mass behind the lower part of the drum that blanches on pressure, described as a 'rising sun' appearance (marked X). The most likely diagnosis is:



- (A) Serous otitis media
- (B) A high dehiscent jugular bulb only
- (C) Glomus tumour (paraganglioma) of the middle ear
- (D) Simple tympanosclerosis

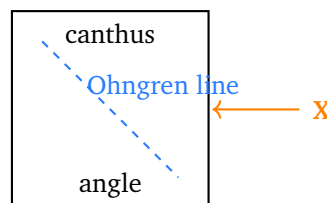
Rhinology and Paranasal Sinuses

Q4. A 9-year-old has a single, smooth, pale polyp that arises from the maxillary antrum, passes through its ostium and hangs into the choana, causing unilateral nasal obstruction. This lesion is:

- (A) Bilateral ethmoidal (multiple) nasal polyps
- (B) An inverted papilloma
- (C) An antrochoanal polyp of Killian
- (D) A juvenile nasopharyngeal angiofibroma



- Q5.** A 3-year-old girl is brought with unilateral foul-smelling, blood-stained nasal discharge for a week, with no such discharge on the other side. The most likely cause is:
- (A) Bilateral allergic rhinitis
 - (B) Acute viral rhinosinusitis
 - (C) Adenoid hypertrophy
 - (D) A nasal foreign body
- Q6.** A 60-year-old man has a cheek swelling, loose upper teeth and a mass filling the maxillary antrum. The Ohngren line (marked X), joining the medial canthus to the mandibular angle, is used to prognosticate this tumour because lesions above it fare worse. The diagnosis is:



- (A) A simple maxillary mucous retention cyst
- (B) Chronic maxillary sinusitis
- (C) Carcinoma of the maxillary sinus
- (D) A dentigerous cyst

Laryngology and the Airway

- Q7.** A schoolteacher who shouts a lot develops persistent hoarseness. Laryngoscopy shows a single, smooth, pedunculated swelling on the free edge of one vocal cord. The most likely diagnosis is:
- (A) Bilateral singer's nodules
 - (B) A unilateral vocal cord polyp
 - (C) Laryngeal carcinoma
 - (D) Vocal cord palsy



- Q8.** A patient develops stridor and marked airway obstruction after total thyroidectomy, but the voice is nearly normal. Both cords lie close to the midline and do not abduct. This picture is caused by:
- (A) Unilateral superior laryngeal nerve palsy
 - (B) A simple vocal cord polyp
 - (C) Reinke oedema
 - (D) Bilateral abductor (recurrent laryngeal nerve) palsy

Oral Cavity, Pharynx and Head-Neck Oncology

- Q9.** A 58-year-old smoker has progressive dysphagia, referred otalgia and a neck node, with a tumour in the pyriform fossa on endoscopy. Compared with glottic cancer, carcinoma of this hypopharyngeal site typically has:
- (A) A poor prognosis, because it presents late with early nodal spread
 - (B) An excellent prognosis, because it is found very early
 - (C) No tendency to lymph node metastasis
 - (D) A purely benign course
- Q10.** An obese, loudly snoring man has daytime sleepiness and witnessed apnoeas. Overnight polysomnography confirms obstructive sleep apnoea. The severity of his condition is graded by the:
- (A) Apnoea-hypopnoea index (AHI) per hour of sleep
 - (B) Body mass index alone
 - (C) Pure-tone average
 - (D) Mallampati grade alone
- Q11.** A man presents with a firm, painless upper-deep-cervical (level II) neck node that is a metastasis, but repeated examination and imaging reveal no obvious primary. The correct term and next step for this presentation is:
- (A) A reactive node needing only antibiotics



- (B) A branchial cyst requiring simple excision
- (C) A thyroid nodule to be watched
- (D) A metastatic node of unknown primary, needing panendoscopy and guided biopsies

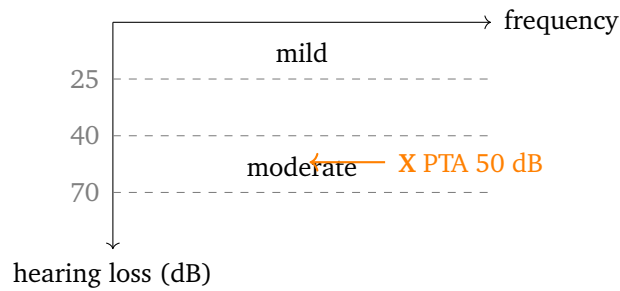
Paediatric ENT and Emergencies

- Q12.** A 3-month-old infant has worsening biphasic stridor and several strawberry cutaneous haemangiomas on the skin. Endoscopy shows a soft asymmetric swelling narrowing the subglottis. The most likely diagnosis is:
- (A) Subglottic haemangioma
 - (B) An inhaled foreign body
 - (C) Laryngomalacia
 - (D) Bilateral choanal atresia
- Q13.** A toddler is brought after swallowing a household drain cleaner, with drooling and oral burns. The correct early management of this caustic ingestion is to:
- (A) Force vigorous vomiting at once
 - (B) Neutralise the acid or alkali with the opposite chemical
 - (C) Avoid blind instrumentation and assess the oesophagus by careful early endoscopy
 - (D) Give large volumes of water and discharge home

Audiology and Vestibular Assessment

- Q14.** The audiogram below shows severity bands for hearing loss. A patient whose pure-tone average, taken as the mean of the 500, 1000 and 2000 Hz thresholds, is 50 dB falls in the band marked X. This degree of hearing loss is classified as:





- (A) Mild hearing loss (26 to 40 dB)
- (B) Moderate hearing loss (41 to 55 dB)
- (C) Severe hearing loss (71 to 90 dB)
- (D) Normal hearing (up to 25 dB)

Q15. Pressing on the tragus (or applying pressure with a pneumatic speculum) provokes vertigo and nystagmus in a patient. This positive fistula test points away from uncomplicated Meniere disease and instead indicates:

- (A) Simple age-related presbycusis
- (B) An abnormal opening (fistula) between the middle and inner ear, as in erosive cholesteatoma
- (C) A purely conductive wax impaction
- (D) Benign essential tinnitus



Detailed Solutions

Q1.

Solution

Concept – otitis media with effusion (glue ear): Glue ear is a collection of sterile, thick fluid in the middle ear without acute infection.

Step 1 – match the clues: A young child, dull hearing after repeated colds, a **retracted immobile drum** and a **flat type B tympanogram** without pain or discharge are classic for otitis media with effusion.

Step 2 – why it is the commonest: Poor Eustachian tube function in children lets fluid gather, making this the leading cause of childhood *conductive* deafness.

Why the other options are wrong:

- B, acute suppurative otitis media: is painful with a bulging red drum, not this painless picture.
- C, otosclerosis: is a disease of young adults with a normal mobile drum.
- D, congenital cholesteatoma: is rare and shows a white mass behind the drum, not an effusion.

Final Answer: Otitis media with effusion (glue ear) ⇒ A

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

Q2.

Solution

Concept – traumatic tympanic membrane perforation: A slap or blast can tear the drum by a sudden pressure change.

Step 1 – apply the rule: A small **central** traumatic perforation with no infection will **heal spontaneously** in most patients within a few weeks.

Step 2 – the key advice: Keep the ear *dry* and free of infection; do not syringe or instil drops. Surgery (myringoplasty) is reserved only for perforations that fail to close.

Why the other options are wrong:

- A, immediate tympanoplasty: is unnecessary, as most heal on their own.
- C, inevitable cholesteatoma: does not follow a simple clean central tear.
- D, permanent sensorineural loss: the loss here is mild and conductive, and recovers as the drum heals.



Final Answer: It will usually heal spontaneously if kept dry $\Rightarrow$ **B**

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

Q3.

Solution

Concept – glomus tumour (paraganglioma): A glomus tumour is a slow-growing, highly vascular tumour arising from paraganglionic tissue in the middle ear or jugular bulb.

Step 1 – read the signs: Pulsatile tinnitus, a conductive loss and a reddish mass behind the lower drum that gives a ‘**rising sun**’ appearance (marked X) point to a glomus tumour.

Step 2 – the confirming sign: Pressure raising the ear-canal pressure blanches the mass (Brown sign); imaging shows an enhancing vascular lesion. Biopsy in the clinic is avoided because it bleeds.

Why the other options are wrong:

- A, serous otitis media: gives a dull amber drum, not a pulsatile red mass.
- B, a high jugular bulb alone: is a bluish, non-pulsatile finding without a rising-sun mass.
- D, tympanosclerosis: is white chalky plaque in the drum, not a vascular mass.

Final Answer: Glomus tumour (paraganglioma) of the middle ear $\Rightarrow$ **C**

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

Q4.

Solution

Concept – antrochoanal polyp of Killian: This is a solitary polyp that grows from the maxillary antrum and extends backwards to the choana.

Step 1 – match the features: A **single** pale polyp arising in the **maxillary antrum**, passing through its ostium and hanging into the choana in a **child**, causing unilateral obstruction, is the antrochoanal polyp of Killian.

Step 2 – management: It is removed completely, including its antral origin (endoscopic sinus surgery), to prevent recurrence.

Why the other options are wrong:



- A, ethmoidal polyps: are multiple and bilateral, arising from the ethmoids.
- B, inverted papilloma: is a firm lateral-wall tumour of older adults.
- D, angiofibroma: is a vascular nasopharyngeal mass of adolescent boys with epistaxis.

Final Answer: An antrochoanal polyp of Killian ⇒ C

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

Q5.

Solution

Concept – nasal foreign body: Small children often insert objects such as beads or seeds into one nostril.

Step 1 – read the story: **Unilateral** foul-smelling, blood-stained nasal discharge in a young child is a nasal foreign body until proved otherwise.

Step 2 – management: The object is removed under good vision with a hook or suction; a button battery must be removed urgently because it causes rapid tissue burns.

Why the other options are wrong:

- A, allergic rhinitis: gives *bilateral* watery discharge and sneezing.
- B, viral rhinosinusitis: is bilateral and self-limiting, not one-sided and foul.
- C, adenoid hypertrophy: causes bilateral obstruction and mouth breathing, not unilateral foul discharge.

Final Answer: A nasal foreign body ⇒ D

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

Q6.

Solution

Concept – maxillary sinus carcinoma and the Ohngren line: Malignancy of the maxillary antrum presents late because it grows silently within the bony sinus.

Step 1 – match the clues: A cheek swelling, **loose upper teeth** and a mass filling the antrum in an older adult indicate carcinoma of the maxillary sinus.

Step 2 – the Ohngren line: The **Ohngren line** (marked X) joins the medial canthus to the angle of the mandible; tumours above and behind it (suprastructure) have a *worse* prognosis because they spread early to the orbit and skull base.



Why the other options are wrong:

- A, a retention cyst: is a benign incidental dome-shaped shadow, not an invasive mass.
- B, chronic sinusitis: causes inflammation, not loose teeth or a destructive mass.
- D, a dentigerous cyst: is a benign cyst around an unerupted tooth.

Final Answer: Carcinoma of the maxillary sinus ⇒ **C**

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

Q7.

Solution

Concept – vocal cord polyp: A vocal cord polyp is a soft swelling on the vocal fold that follows vocal abuse or a single episode of strain.

Step 1 – match the features: Persistent hoarseness with a **single, smooth, pedunculated** swelling on the free edge of **one** cord in a heavy voice user is a vocal cord polyp.

Step 2 – management: Voice rest and speech therapy help; a persistent polyp is removed by microlaryngeal surgery.

Why the other options are wrong:

- A, singer's nodules: are *bilateral*, symmetrical and sit at the junction of the anterior and middle thirds.
- C, laryngeal carcinoma: gives an irregular, ulcerated or fixed lesion, often in an older smoker.
- D, vocal cord palsy: is a fixed immobile cord, not a discrete swelling.

Final Answer: A unilateral vocal cord polyp ⇒ **B**

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

Q8.

Solution

Concept – bilateral abductor palsy: The recurrent laryngeal nerves open (abduct) the cords; bilateral injury leaves them fixed near the midline.

Step 1 – read the picture: **Stridor** and airway obstruction after total thyroidec-



tomy with a *near-normal* voice and both cords lying close to the midline that fail to abduct define bilateral abductor (recurrent laryngeal nerve) palsy.

Step 2 – why the voice is preserved: Because the cords stay adducted (nearly closed), phonation is fair, but the narrow airway causes stridor and may need a tracheostomy.

Why the other options are wrong:

- A, superior laryngeal palsy: causes voice fatigue and pitch problems, not stridor.
- B, a vocal cord polyp: is a localised swelling, not bilateral cord fixation after surgery.
- C, Reinke oedema: is diffuse cord swelling from smoking, giving a deep voice, not acute stridor.

Final Answer: Bilateral abductor (recurrent laryngeal nerve) palsy ⇒ D

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

Q9.

Solution

Concept – carcinoma of the pyriform fossa: The pyriform fossa is part of the hypopharynx, a hidden site where tumours grow unnoticed.

Step 1 – match the clues: Progressive **dysphagia**, referred otalgia and a neck node with a pyriform fossa tumour in a smoker define hypopharyngeal carcinoma.

Step 2 – why the prognosis is poor: The region is roomy and silent, so tumours present **late**, and its *rich lymphatics* cause early nodal spread; outcome is far worse than for glottic cancer.

Why the other options are wrong:

- B, excellent prognosis found early: describes glottic, not hypopharyngeal, cancer.
- C, no lymph node spread: is wrong, as nodal spread is characteristically early.
- D, a benign course: is incorrect, as this is an aggressive malignancy.

Final Answer: A poor prognosis with late presentation and early nodal spread ⇒

A

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



Q10.

Solution

Concept – grading obstructive sleep apnoea: Sleep apnoea severity is quantified from the overnight sleep study.

Step 1 – name the index: The **apnoea-hypopnoea index (AHI)**, the number of apnoeas plus hypopnoeas per hour of sleep on polysomnography, grades the disorder (mild 5 to 15, moderate 15 to 30, severe over 30).

Step 2 – the treatment link: Moderate to severe disease is typically managed with **CPAP**, along with weight loss and treating any obstructing ENT pathology.

Why the other options are wrong:

- B, BMI alone: is a risk factor, not the severity grade.
- C, pure-tone average: measures hearing, not sleep apnoea.
- D, Mallampati grade alone: assesses the airway view but does not grade severity.

Final Answer: The apnoea-hypopnoea index (AHI) $\Rightarrow$ **A**

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

Q11.

Solution

Concept – metastatic neck node of unknown primary: A malignant cervical node whose source is not obvious needs a systematic search.

Step 1 – read the picture: A firm, painless **upper-deep-cervical (level II)** metastatic node with no visible primary is a ‘metastatic node of unknown primary’.

Step 2 – the correct step: Perform **panendoscopy** with biopsies of likely silent sites (nasopharynx, tonsil, tongue base, pyriform fossa), guided by imaging and fine-needle aspiration; the node itself is not simply excised first.

Why the other options are wrong:

- A, antibiotics: treat a reactive node, but a hard fixed metastatic node needs a cancer workup.
- B, branchial cyst excision: a new firm node in an older adult is metastatic until proven otherwise.
- C, a thyroid nodule to watch: does not fit a level II metastatic node.

Final Answer: A metastatic node of unknown primary, needing panendoscopy



and guided biopsies $\Rightarrow$ D

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

Q12.

Solution

Concept – subglottic haemangioma: This is a benign vascular tumour of infancy that narrows the subglottic airway.

Step 1 – match the clues: Worsening **biphasic stridor** in an infant with **cutaneous haemangiomas** and a soft asymmetric subglottic swelling on endoscopy indicates a subglottic haemangioma.

Step 2 – the natural course and treatment: Such lesions often enlarge in the first months, then involute; oral **propranolol** is now first-line therapy.

Why the other options are wrong:

- B, an inhaled foreign body: causes sudden choking, not gradual stridor with skin haemangiomas.
- C, laryngomalacia: gives *inspiratory* stridor easing when prone, without a subglottic mass.
- D, choanal atresia: causes nasal obstruction and cyclical cyanosis, not subglottic stridor.

Final Answer: Subglottic haemangioma $\Rightarrow$ A

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

Q13.

Solution

Concept – caustic (corrosive) ingestion: Swallowed acids or alkalis burn the mouth, oesophagus and stomach, risking later strictures.

Step 1 – the safe early steps: Secure the airway, keep the child nil by mouth, and **avoid blind instrumentation**; assess the extent of oesophageal injury by careful early endoscopy.

Step 2 – what to avoid: Do *not* induce vomiting (it re-exposes the mucosa) and do *not* attempt chemical neutralisation (the heat produced worsens the burn).

Why the other options are wrong:



- A, forced vomiting: is harmful, causing repeat injury and aspiration.
- B, chemical neutralisation: releases heat and worsens the burn.
- D, large water loads then discharge: risks perforation and misses serious injury.

Final Answer: Avoid blind instrumentation and assess by careful early endoscopy
⇒

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

Q14.

Solution

Concept – pure-tone average and degrees of hearing loss: The pure-tone average (PTA) summarises hearing by averaging the thresholds at the speech frequencies.

Step 1 – calculate the PTA: The PTA is the mean of the 500, 1000 and 2000 Hz thresholds. Here it is stated as **50 dB** (marked X).

Step 2 – apply the bands: The usual grading is normal up to 25 dB, mild 26 to 40 dB, **moderate 41 to 55 dB**, moderately severe 56 to 70 dB, severe 71 to 90 dB, and profound over 90 dB. A PTA of 50 dB falls in the moderate band.

Why the other options are wrong:

- A, mild (26 to 40 dB): is below the patient's 50 dB level.
- C, severe (71 to 90 dB): is far above 50 dB.
- D, normal (up to 25 dB): does not fit a 50 dB loss.

Final Answer: Moderate hearing loss (41 to 55 dB) ⇒

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

Q15.

Solution

Concept – the fistula test: The fistula test looks for an abnormal opening between the middle and inner ear by changing ear-canal pressure.

Step 1 – interpret the result: Pressure on the tragus (or a pneumatic speculum) that provokes **vertigo and nystagmus** is a **positive fistula test**, meaning pressure is being transmitted to the labyrinth through a **fistula**, typically from an eroding cholesteatoma.



Step 2 – the contrast with Meniere: Uncomplicated Meniere disease has an *intact* labyrinth, so the fistula test is **negative**; a positive test therefore points away from simple Meniere and towards a bony erosion.

Why the other options are wrong:

- A, presbycusis: is age-related sensorineural loss with no positional or pressure-evoked vertigo.
- C, wax impaction: causes conductive loss, not a positive fistula sign.
- D, essential tinnitus: is ringing without vertigo or a fistula.

Final Answer: A fistula between the middle and inner ear, as in erosive cholesteatoma ⇒ B

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



Answer Key

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

