

INI CET ENT

Sample Paper – 7

Duration: 14 Minutes

Maximum Marks: 15

Instructions

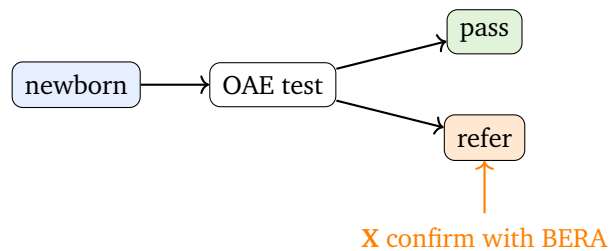
- This paper contains **15** Multiple Choice Questions (Single Best Response), modelled on the ENT (Otorhinolaryngology) content of **INI CET** (Institutes of National Importance Combined Entrance Test) conducted by AIIMS New Delhi.
- The **15-question** length matches the number of ENT items you actually 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 48-year-old man presents with a persistent *unilateral* secretory otitis media (a serous middle-ear effusion) that has failed to clear. The single most important condition to exclude before treating the effusion is:
- (A) Nasopharyngeal carcinoma blocking the Eustachian tube on that side
(B) Simple wax impaction in the ear canal
(C) A healed tympanic membrane perforation
(D) Age-related presbycusis
- Q2.** A newborn hearing-screening programme uses otoacoustic emissions (OAE) as shown in the flow schematic below. The rationale for OAE screening



is that a normal emission signals healthy outer hair cells; a 'refer' result at X must trigger confirmatory testing because untreated congenital sensorineural deafness chiefly harms:



- (A) Speech and language development if not detected and rehabilitated early
- (B) The external ear cartilage only
- (C) The facial nerve motor function
- (D) The sense of smell

Q3. A patient with otosclerosis and a conductive hearing loss opts for surgery. The operation of choice that reconstructs sound transmission by replacing the fixed stapes with a prosthesis is:

- (A) Simple cortical mastoidectomy
- (B) Stapedectomy (stapedotomy) with a stapes prosthesis
- (C) Myringotomy with grommet insertion
- (D) Radical mastoidectomy

Rhinology and Paranasal Sinuses

Q4. An immunocompetent adult has a chronic blocked, opacified maxillary sinus. Imaging shows a mass with flecks of calcification within the sinus but no bony destruction, and surgery removes a cheesy fungal debris ball. The most likely diagnosis is:

- (A) Invasive (angioinvasive) mucormycosis
- (B) Squamous cell carcinoma of the sinus
- (C) Fungal ball (aspergilloma) – a non-invasive fungal sinusitis



(D) Acute bacterial maxillary sinusitis

Q5. A boy is hit on the nose and develops a bilateral, soft, fluctuant swelling of the nasal septum with complete nasal obstruction. If this is not drained promptly, the most feared late sequel is:

- (A) A permanently deviated nasal tip only
- (B) A saddle-nose deformity from cartilage necrosis
- (C) Loss of the sense of taste
- (D) Chronic frontal sinusitis

Q6. A patient with allergic rhinitis has persistent nasal blockage from enlarged inferior turbinates that no longer shrink with topical decongestant. The most appropriate definitive management of the hypertrophied turbinate is:

- (A) Total (radical) removal of the whole inferior turbinate as first choice
- (B) Lifelong oral antibiotics
- (C) No treatment, as turbinate hypertrophy never needs intervention
- (D) Turbinate reduction (submucosal diathermy or partial turbinectomy) after medical therapy fails

Laryngology and the Airway

Q7. Regarding carcinoma of the larynx, which single statement is correct?

- (A) It has no relationship to tobacco or alcohol
- (B) The glottis has abundant lymphatics and spreads to nodes earliest
- (C) It is commonest in non-smoking young children
- (D) Smoking and alcohol are the main risk factors, and supraglottic tumours spread early to neck nodes because the supraglottis is richly supplied with lymphatics

Q8. A woman has a strained, strangled, effortful voice that breaks on connected speech but is normal when she laughs or sings; the larynx looks structurally normal. This task-specific focal dystonia of the voice is:



- (A) Spasmodic dysphonia (a functional/dystonic voice disorder)
- (B) Glottic carcinoma
- (C) Bilateral vocal cord paralysis
- (D) Acute infective laryngitis

Oral Cavity, Pharynx and Head-Neck Oncology

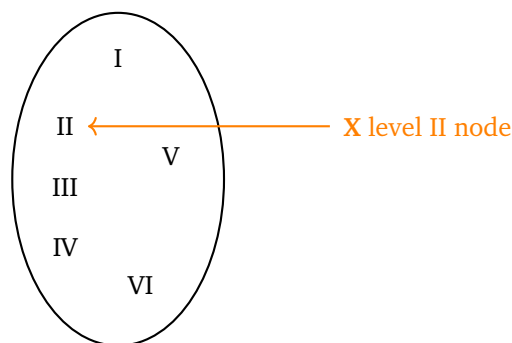
Q9. An elderly outdoor farm worker has a slowly enlarging ulcer with a rolled edge on his lip. Carcinoma of the lip most commonly affects which site, and its chief risk factor is:

- (A) The upper lip, from chewing tobacco
- (B) The lower lip, from chronic sun (ultraviolet) exposure
- (C) The angle of the mouth, from a viral infection
- (D) The inner cheek mucosa, from hot food

Q10. The commonest malignant tumour of the salivary glands is:

- (A) Mucoepidermoid carcinoma
- (B) Pleomorphic adenoma
- (C) Warthin tumour
- (D) Basal cell carcinoma

Q11. The neck lymph nodes are grouped into levels I to VI, as shown below. The submandibular group lies in level I and the internal jugular chain occupies levels II to IV. The *sentinel node* is best described as:



- (A) The largest node in the neck regardless of drainage



- (B) Always a level VI node
- (C) The first node in the lymphatic basin to receive drainage from the primary tumour
- (D) A node that is never involved by cancer

Paediatric ENT and Emergencies

Q12. A 7-year-old has recurrent acute tonsillitis. The commonest bacterial cause is the beta-haemolytic *Streptococcus*, and tonsillectomy is indicated when the child has:

- (A) A single mild sore throat
- (B) Seven or more well-documented throat infections in one year (or recurrent attacks over successive years) or obstructive sleep apnoea
- (C) Simple nasal allergy
- (D) A one-off nosebleed

Q13. A toddler is brought in having pushed a disc (button) battery into the nose an hour ago. The correct management is:

- (A) Reassure and review in one week
- (B) Give oral antibiotics and wait for it to pass
- (C) Prescribe nasal decongestant drops only
- (D) Emergency removal without delay, because the battery causes rapid liquefactive necrosis and septal perforation

Audiology and Vestibular Assessment

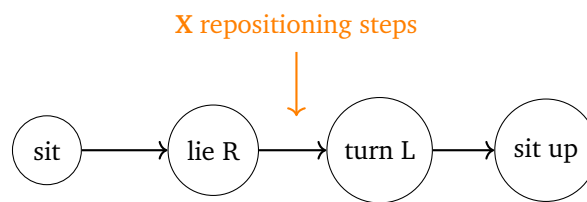
Q14. In speech audiometry, the *speech discrimination (word recognition) score* measures the percentage of standard words a patient repeats correctly when they are presented well above threshold. A very poor discrimination score that is out of proportion to the pure-tone loss classically suggests:

- (A) A purely conductive (middle-ear) loss, which always scores 100%



- (B) Completely normal cochlear and neural function
- (C) A retrocochlear (nerve) lesion such as a vestibular schwannoma
- (D) That the test cannot assess nerve function at all

Q15. The head-position sequence drawn below is used to move displaced otoconia out of the affected canal back into the utricle. This canalith-repositioning treatment (marked **X**) for posterior-canal benign paroxysmal positional vertigo is the:



- (A) Valsalva manoeuvre
- (B) Politzerisation
- (C) Epley (canalith-repositioning) manoeuvre
- (D) Caloric test



Detailed Solutions

Q1.

Solution

Concept – unilateral adult secretory otitis media: A serous middle-ear effusion forms when the Eustachian tube stops ventilating the middle ear.

Step 1 – note the red flag: In an adult, a *persistent one-sided* effusion is not a benign finding. A nasopharyngeal mass at the Eustachian tube opening can block the tube on that side.

Step 2 – the mandatory step: **Nasopharyngeal carcinoma** must be excluded by examining and, if needed, biopsying the nasopharynx before the effusion is simply treated.

Why the other options are wrong:

- B, wax impaction: causes canal blockage, not a middle-ear effusion, and is easily seen.
- C, healed perforation: does not produce a tense serous effusion.
- D, presbycusis: is a bilateral sensorineural loss, not a unilateral effusion.

Final Answer: Exclude nasopharyngeal carcinoma $\Rightarrow$ A

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

Q2.

Solution

Concept – newborn OAE screening: Otoacoustic emissions are faint sounds produced by healthy outer hair cells; their presence implies a working cochlea.

Step 1 – read the schematic: A ‘pass’ means emissions are present. A ‘refer’ result at X means no emission was recorded and the baby needs confirmatory testing (such as BERA).

Step 2 – why it matters: Undetected **congenital sensorineural deafness** chiefly harms **speech and language development**, so early detection and rehabilitation (hearing aids or cochlear implant) are essential.

Why the other options are wrong:

- B, external ear cartilage: is not what a sensorineural loss affects.
- C, facial nerve: is motor, unrelated to the OAE screen.
- D, sense of smell: is an olfactory function, not tested here.



Final Answer: Speech and language development $\Rightarrow$ A

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

Q3.

Solution

Concept – surgery for otosclerosis: Otosclerosis fixes the stapes footplate, so the aim of surgery is to restore ossicular movement.

Step 1 – name the operation: **Stapedectomy (or stapedotomy)** removes the fixed stapes and inserts a prosthesis between the incus and the oval window, bypassing the fixation.

Step 2 – the result: Sound transmission is restored and the conductive gap closes; a hearing aid is the non-surgical alternative.

Why the other options are wrong:

- A, cortical mastoidectomy: drains mastoid disease and does nothing for a fixed stapes.
- C, grommet insertion: ventilates a middle-ear effusion, not otosclerosis.
- D, radical mastoidectomy: is for extensive cholesteatoma, not stapes fixation.

Final Answer: Stapedectomy with a prosthesis $\Rightarrow$ B

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

Q4.

Solution

Concept – fungal ball (aspergilloma) of the maxillary sinus: This is a non-invasive collection of fungal hyphae within a sinus of an immunocompetent person.

Step 1 – match the clues: A chronic opacified maxillary sinus with **flecks of calcification**, *no bony destruction*, and cheesy fungal debris at surgery defines a **fungal ball (aspergilloma)**.

Step 2 – the key point: It stays outside the mucosa, so the treatment is simple endoscopic removal and aeration; antifungal drugs are usually not needed.

Why the other options are wrong:



- A, invasive mucormycosis: destroys bone and occurs in diabetic or immunocompromised patients.
- B, squamous carcinoma: causes bony erosion and a soft-tissue mass, not a debris ball.
- D, acute bacterial sinusitis: is a short painful illness with pus, not chronic calcified debris.

Final Answer: Fungal ball (aspergilloma) ⇒ C

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

Q5.

Solution

Concept – septal haematoma: Blunt nasal trauma can strip blood between the septal cartilage and its perichondrium.

Step 1 – recognise it: A **bilateral, soft, fluctuant** septal swelling with obstruction after trauma is a septal haematoma, and it must be drained promptly.

Step 2 – the danger: The cartilage gets its blood supply from the overlying perichondrium; a haematoma lifts this off, so the cartilage undergoes avascular necrosis, collapsing the bridge into a **saddle-nose deformity** (an abscess may also form).

Why the other options are wrong:

- A, a deviated tip only: understates the risk; the whole dorsum can collapse.
- C, loss of taste: is unrelated to septal cartilage.
- D, frontal sinusitis: is not the recognised sequel of an undrained septal haematoma.

Final Answer: Saddle-nose deformity from cartilage necrosis ⇒ B

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

Q6.

Solution

Concept – turbinate hypertrophy: Chronically enlarged inferior turbinates block nasal airflow and may stop responding to medicine.

Step 1 – the stepwise plan: First try medical measures (topical steroid spray, allergen avoidance). When these fail and the turbinate stays enlarged, **turbinate**



reduction (submucosal diathermy, radiofrequency or a conservative partial turbinectomy) is done.

Step 2 – the principle: Reduce, do not resect wholesale; preserving mucosa keeps the nose from becoming dry and crusted.

Why the other options are wrong:

- A, total radical removal: risks an atrophic dry ‘empty nose’, so it is not first choice.
- B, lifelong antibiotics: do not treat hypertrophy.
- C, no treatment: is wrong when obstruction is troublesome and medicine has failed.

Final Answer: Turbinate reduction after medical therapy fails ⇒ D

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

Q7.

Solution

Concept – laryngeal carcinoma: Laryngeal cancer behaviour depends on the subsite and its lymphatic supply.

Step 1 – the risk factors: Smoking and alcohol are the main drivers of laryngeal carcinoma.

Step 2 – supraglottic spread: The supraglottis has a rich lymphatic network, so supraglottic tumours spread *early* to the neck nodes and often present late with a nodal mass.

Why the other options are wrong:

- A, no tobacco link: is false; smoking is the key risk factor.
- B, glottis with abundant lymphatics: is wrong; the true cords have *sparse* lymphatics and spread late.
- C, non-smoking children: is not the epidemiology of laryngeal cancer.

Final Answer: Smoking/alcohol; supraglottis spreads early to nodes ⇒ D

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



Q8.

Solution

Concept – spasmodic dysphonia: This is a task-specific focal dystonia of the laryngeal muscles.

Step 1 – match the picture: A **strained, strangled** voice that breaks on connected speech but is *normal on laughing or singing*, with a structurally normal larynx, is classic for **spasmodic dysphonia**, a functional/dystonic voice disorder.

Step 2 – management: Targeted botulinum toxin injection into the affected intrinsic muscle relaxes the spasm and improves the voice; speech therapy helps.

Why the other options are wrong:

- B, glottic carcinoma: shows a visible cord lesion and steady hoarseness, not task-specific breaks.
- C, bilateral cord paralysis: causes stridor and airway compromise, not a strangled voice on speech only.
- D, infective laryngitis: is an acute, self-limiting hoarseness with inflammation.

Final Answer: Spasmodic dysphonia ⇒ A

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

Q9.

Solution

Concept – carcinoma of the lip: Lip cancer is a squamous cell carcinoma with a clear anatomical and environmental pattern.

Step 1 – the site: It most commonly affects the **lower lip**, which is more exposed to sunlight than the upper lip.

Step 2 – the risk factor: Chronic **ultraviolet (sun) exposure** is the chief cause, so outdoor workers such as farmers are at higher risk; pipe smoking is an additional factor.

Why the other options are wrong:

- A, upper lip from chewing tobacco: is wrong on both site and cause.
- C, angle of the mouth from a virus: is not the pattern of lip carcinoma.
- D, inner cheek from hot food: describes a different subsite and cause.

Final Answer: Lower lip, from chronic sun exposure ⇒ B



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

Q10.

Solution

Concept – salivary gland malignancy: Salivary tumours are classified by cell type, and one malignant type predominates.

Step 1 – name the tumour: **Mucoepidermoid carcinoma** is the commonest malignant salivary gland tumour, most often arising in the parotid.

Step 2 – the behaviour: Low-grade lesions behave indolently, while high-grade ones are aggressive; treatment is surgical excision with facial-nerve preservation where possible.

Why the other options are wrong:

- B, pleomorphic adenoma: is the commonest *benign* salivary tumour, not a malignancy.
- C, Warthin tumour: is a benign parotid tumour.
- D, basal cell carcinoma: is a skin cancer, not a salivary gland malignancy.

Final Answer: Mucoepidermoid carcinoma $\Rightarrow$ **A**

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

Q11.

Solution

Concept – neck node levels and the sentinel node: The neck lymph nodes are mapped into levels I to VI to describe cancer spread.

Step 1 – define the sentinel node: The **sentinel node** is the *first* node in a lymphatic basin to receive drainage from a primary tumour (marked **X**); it is the first place metastasis is expected.

Step 2 – why it is used: If the sentinel node is free of tumour, the rest of the basin is usually free too, which can spare a patient a full neck dissection.

Why the other options are wrong:

- A, largest node: size does not define the sentinel node; drainage order does.
- B, always level VI: is false; the sentinel level depends on the primary site.
- D, never involved: is the opposite of the truth; it is the node most likely first involved.



Final Answer: The first node in the basin to receive tumour drainage ⇒ **C**

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

Q12.

Solution

Concept – recurrent tonsillitis and tonsillectomy: Acute tonsillitis in children is usually bacterial, and surgery is reserved for defined indications.

Step 1 – the organism: The commonest bacterial cause is the **group A beta-haemolytic Streptococcus** (*Streptococcus pyogenes*).

Step 2 – the indication: Tonsillectomy is offered for **frequent recurrent infections** (about seven or more well-documented attacks in a year, or recurrent attacks over successive years) or for **obstructive sleep apnoea** from large tonsils.

Why the other options are wrong:

- A, a single mild sore throat: is not an indication for surgery.
- C, simple nasal allergy: is unrelated to tonsillectomy.
- D, a one-off nosebleed: is a rhinological, not a tonsillar, problem.

Final Answer: Frequent recurrent throat infections or sleep apnoea ⇒ **B**

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

Q13.

Solution

Concept – nasal button-battery emergency: A disc battery lodged in the nose is a time-critical emergency.

Step 1 – the mechanism of harm: The battery generates a local current and alkali, causing rapid **liquefactive necrosis** of the mucosa and **septal perforation** within hours.

Step 2 – the correct action: It must be removed **immediately**, not observed; waiting risks permanent septal damage and even nasal collapse.

Why the other options are wrong:

- A, review in a week: allows destructive necrosis to occur.
- B, antibiotics and wait: does nothing to stop the ongoing chemical burn.
- C, decongestant drops only: neither removes the battery nor prevents necrosis.



Final Answer: Emergency removal without delay $\Rightarrow$ D

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

Q14.

Solution

Concept – speech discrimination score: Speech audiometry tests how clearly a patient understands words, not just whether they hear them.

Step 1 – what the score means: The **speech discrimination (word recognition) score** is the percentage of standard words repeated correctly at a comfortable level above threshold.

Step 2 – the classic clue: A score that is *disproportionately poor* for the pure-tone loss (poor ‘clarity’) points to a **retrocochlear (nerve) lesion** such as a vestibular schwannoma, where roll-over may also be seen.

Why the other options are wrong:

- A, conductive loss scoring 100%: is an over-generalisation and not the finding described.
- B, normal function: a very poor score is not normal.
- D, cannot assess nerve function: is wrong; this test is exactly how retrocochlear clues appear.

Final Answer: A retrocochlear (nerve) lesion $\Rightarrow$ C

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

Q15.

Solution

Concept – treating posterior-canal BPPV: BPPV is caused by displaced otoconia in a semicircular canal, usually the posterior one.

Step 1 – name the manoeuvre: The sequential head-position steps shown (marked X) are the **Epley canalith-repositioning manoeuvre**, which rolls the loose otoconia out of the posterior canal back into the utricle.

Step 2 – the result: Once the debris leaves the canal it no longer stimulates it with position change, so the vertigo settles; the manoeuvre is curative in most patients.

Why the other options are wrong:



- A, Valsalva: raises middle-ear pressure and does not reposition otoconia.
- B, politzerisation: inflates the Eustachian tube for a middle-ear effusion.
- D, caloric test: is a vestibular diagnostic test, not a treatment.

Final Answer: Epley (canalith-repositioning) manoeuvre ⇒

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



Answer Key

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

