

# AI-03916 NBME Step 3 MCQ and CSS Cheat Sheet

Owner	© Rigel Arcayan
Tags	MD
Created time	June 10, 2026 9:16 AM

Create a comprehensive but condensed list of mnemonics for step 3

Create a comprehensive NBME Step 3 MCQ Cheat Sheet and Tips.

Create a comprehensive NBME Step 3 CCS Cheat Sheet and Tips.

In USMLE Step3, Day1, there is a feeling of uncertainty and doubt post test, Is there a way to make up to pass Step 3 in Day2 MCQ and CCS? Tell more.

In MasterCSS software (NBME Step 3) an answer score of 65% really bad of case question. Elaborate.

Here is a high-yield, streamlined master guide for both components of the USMLE Step 3 exam: the Multiple Choice Questions (MCQs) and the Computer-based Case Simulations (CCS).

## Part 1: NBME Step 3 MCQ Cheat Sheet & Tips

Step 3 MCQs bridge the gap between core clinical knowledge and real-time decision-making. Day 1 focuses heavily on foundational principles, biostatistics, and prognosis, while Day 2 is all about continuous management and clinical evolution.

### High-Yield Master Strategies

- **The "Next Best Step" Mindset:** Unlike Step 2, where the question was often "What is the diagnosis?", Step 3 constantly asks "What do you do *now*?". If a

patient is unstable, the answer is always stabilization (ABCs) over definitive diagnostics.

- **Biostatistics is Non-Negotiable:** Expect a massive block of biostatistics, epidemiology, and drug ad analysis on Day 1. It can account for up to 10–15% of your Day 1 score.
- **Prognosis and Risk Factors:** You will be explicitly tested on the single most accurate prognostic indicator or the strongest risk factor for a specific disease (e.g., smoking for abdominal aortic aneurysms, or past history of suicide attempts for completed suicide).

## Rapid-Review MCQ Associations

Patient Presentation	Next Best Step / High-Yield Concept
<b>Unstable Angina / NSTEMI</b>	Aspirin, clopidogrel, heparin, and beta-blockers; calculate TIMI score.
<b>Acute Stroke (&lt; 4.5 hours)</b>	Non-contrast head CT first to rule out hemorrhage, then tPA if eligible.
<b>Suspected Spinal Cord Compression</b>	IV glucocorticoids (Dexamethasone) <i>before</i> ordering the MRI.
<b>Tension Pneumothorax</b>	Immediate needle decompression (2nd ICS, MCL) <i>before</i> chest X-ray.
<b>Aortic Dissection</b>	IV beta-blockers (Esmolol) first to lower heart rate and shear stress.
<b>Septic Shock</b>	Aggressive IV fluid resuscitation (30 mL/kg crystalloids) + broad-spectrum antibiotics within 1 hour.

## Part 2: NBME Step 3 CCS Cheat Sheet & Tips

The CCS portion is a completely different beast. It tests your efficiency, thoroughness, and safety. The secret to mastering CCS is understanding that the software behaves like an old-school, literal database—it rewards systematic routines.

### The Absolute Rules of CCS

1. **Advance the Clock Intentionally:** Never jump time forward without a clinical reason. Advance time based on when you expect your most critical pending lab result or when your treatment should show an effect.
2. **Safety First (Do No Harm):** Ordering invasive tests or aggressive treatments before stabilizing a patient will tank your score. Don't give tPA to someone until you check their platelets and coagulation profile.
3. **Always Re-examine:** If a patient's status changes, or after you administer a major therapeutic intervention, order a **Physical Exam** (focused or complete) to re-evaluate them.
4. **The Final 2-Minute Window:** When the case shifts to the final 2 minutes, the patient is stable. Use this time exclusively for screening, counseling, and preventative health orders.

## The Standard Working Sequences

### 1. The Emergency Room / ICU Protocol (Unstable Patient)

If the patient arrives with altered mental status, severe chest pain, shortness of breath, or trauma, order these immediately on screen 1:

Pulse oximetry | Oxygen, supplemental | IV access | Normal saline (or LR)  
Cardiac monitor | EKG (12-lead) | Blood pressure monitor

- *Move to physical exam only after these are ordered.*

### 2. The Routine Admission / Orders Routine

For any patient you are moving from the ER to the Inpatient Wards or ICU, don't forget the standard quality-of-life and safety orders:

Bed rest / Activity as tolerated | NPO / Diet appropriate for age/condition  
Vitals signs, routine | Ins and Outs (I/O) monitoring  
Morphine or Acetaminophen (if in pain) | Ondansetron (if nauseous)

### 3. The Final 2-Minute Orders (Preventative Checklist)

No matter what the primary diagnosis was, if the case ends, blanket order the relevant preventive measures based on age/risk:

Smoking cessation counseling | Alcohol cessation counseling  
Safe sex counseling | Reassurance (patient/family)  
Diet, low salt / low fat | Exercise program  
Vaccinations (Influenza, Pneumococcal, Tdap, HPV based on age)  
Colonoscopy / Mammogram / Pap smear (if age criteria met)

## Exam Day Execution Strategy

### Day 1: Foundations of Independent Practice (FIP)

- **Focus:** Core medical knowledge, ethics, safety science, and a heavy dose of biostatistics.
- **Time Management:** The questions have long stems. Use the "read the last sentence first" trick to anchor your focus before diving into a massive paragraph of lab values.

### Day 2: Advanced Clinical Medicine (ACM) & CCS

- **Focus:** Long-term management, screening, health maintenance, and the 13 interactive CCS cases.
- **The Secret Weapon:** If you solve a CCS case quickly, the simulator ends early. **That saved time is directly added to your break time pool.** Efficient navigation of early cases buys you a massive safety cushion for the rest of Day 2.

**List the 13 interactive cases in Step 3. Give pointers of each case scenario.**

The 13 interactive cases on the actual USMLE Step 3 exam represent a curated cross-section of core medical specialties. The NBME selects these cases to test specific clinical management inflection points: recognizing an emergency, managing a chronic condition that derails, and knowing when to transition care (e.g., from the Emergency Department to the ICU or discharging home).

While the exact diagnoses rotate, they always map directly onto **13 predictable clinical archetypes.**

# The 13 High-Yield CCS Case Archetypes & Master Pointers

## 1. The Acute Coronary / Ischemic Event (Cardiology)

- **Classic Scenarios:** STEMI, NSTEMI, Unstable Angina, or acute Decompensated Heart Failure.
- **Critical Pointers:**
  - **Do not wait** for a physical exam. If the patient has chest pain or acute dyspnea, order Oxygen, IV Access, Cardiac Monitor, Pulse Oximetry, and a 12-Lead EKG immediately.
  - For ischemia, immediately give Aspirin (chewable) and Nitroglycerin (unless hypotensive or a right ventricular infarct is suspected).
  - Order serial Troponins. If it's a STEMI, order an urgent Cardiology Consult and arrange for Cardiac Catheterization (PCI) or thrombolytics.

## 2. The Time-Sensitive Neurologic Emergency (Neurology)

- **Classic Scenarios:** Acute Ischemic Stroke, Transient Ischemic Attack (TIA), or Status Epilepticus.
- **Critical Pointers:**
  - For suspected stroke, the absolute first diagnostic step is a Non-contrast Head CT (STAT) to rule out hemorrhage.
  - Simultaneously order a Fingerstick Glucose—hypoglycemia is the ultimate stroke mimic and must be corrected before giving thrombolytics.
  - Keep the patient NPO until a formal swallow evaluation is performed to prevent aspiration pneumonia.
  - For status epilepticus, abort with IV Lorazepam first, then follow up with a long-acting anticonvulsant like Fosphenytoin.

## 3. The Unstable Sepsis / Shock Sequence (Infectious Disease/ICU)

- **Classic Scenarios:** Septic shock secondary to Urosepsis, Severe Pneumonia, or Meningitis.
- **Critical Pointers:**
  - Execute the 1-hour bundle: Order Blood Cultures x2 and Serum Lactate *before* the first dose of antibiotics hits the IV line.
  - Aggressively resuscitate with an initial bolus of Normal Saline or Lactated Ringer's (30 mL/kg).
  - If the blood pressure does not respond to fluids, immediately transfer the patient to the **ICU** and order central access for vasopressors (Norepinephrine).

#### 4. The Obstructive Pulmonary Crisis (Pulmonology)

- **Classic Scenarios:** Acute Pulmonary Embolism (PE), Tension Pneumothorax, or Severe Asthma/COPD Exacerbation.
- **Critical Pointers:**
  - If a PE is highly suspected and the patient has no bleeding risks, start Heparin (IV) *before* sending them down to radiology for a CT Pulmonary Angiography (CTPA).
  - For asthma/COPD, dual nebulizers (Albuterol + Ipratropium) and systemic Corticosteroids (IV or PO) should be ordered concurrently. Monitor their respiratory drive closely with an ABG and Peak Expiratory Flow Rate (PEFR).

#### 5. The Surgical Abdomen / GI Bleed (Gastroenterology/General Surgery)

- **Classic Scenarios:** Upper GI Bleed (Variceal vs. Peptic Ulcer), Acute Appendicitis, Cholecystitis, or Diverticulitis.
- **Critical Pointers:**
  - For GI bleeds, secure **two large-bore peripheral IVs**, check a Type and Crossmatch, and start a continuous IV Proton Pump Inhibitor

(Pantoprazole). If a variceal bleed is suspected (e.g., a patient with history of cirrhosis), add Octreotide and prophylactic Ceftriaxone.

- For any acute surgical abdomen (Appendicitis/Cholecystitis), make the patient strictly NPO, start broad-spectrum IV antibiotics, and obtain a Surgery Consult early.

## 6. The Pediatric Respiratory or Febrile Illness (Pediatrics)

- **Classic Scenarios:** Croup, Epiglottitis, Respiratory Syncytial Virus (RSV) Bronchiolitis, or Neonatal Fever.
- **Critical Pointers:**
  - In a pediatric case, **always check the weight** before ordering medications; doses must be entered carefully.
  - For any infant under 28 days with a fever, you must perform a full sepsis workup: Blood Cultures, Urinalysis/Urine Culture, and a Lumbar Puncture (CSF analysis) followed immediately by empiric IV antibiotics (Ampicillin + Cefotaxime/Gentamicin). Do not give Ceftriaxone to neonates due to biliary sludge risks.
  - For stridor/croup, think Dexamethasone (oral/IM) and Nebulized Racemic Epinephrine.

## 7. The Metabolic / Endocrine Emergency (Endocrinology)

- **Classic Scenarios:** Diabetic Ketoacidosis (DKA), Hyperosmolar Hyperglycemic State (HHS), or Severe Hypoglycemia.
- **Critical Pointers:**
  - In DKA, do not blindly pump insulin. Check the Serum Potassium first. If potassium is less than 3.3 mEq/L, you must correct the potassium *before* starting the Insulin Infusion.
  - Track the Anion Gap via serial basic metabolic panels (BMP). Only transition from IV insulin to subcutaneous insulin when the anion gap has completely closed and the patient is eating.

## 8. The Acute Poisoning / Toxidrome (Toxicology/Emergency Medicine)

- **Classic Scenarios:** Acetaminophen overdose, Opioid toxicity, Aspirin toxicity, or Tricyclic Antidepressant (TCA) overdose.
- **Critical Pointers:**
  - Order a universal screening panel for any intentional ingestion: Acetaminophen level, Salicylate level, EKG (look for QTc or QRS prolongation), and a Urine Toxicology Screen.
  - Know your antidotes cold: N-acetylcysteine for Acetaminophen (guided by the Rumack-Matthew nomogram), Naloxone for opioids, and Sodium Bicarbonate for TCA overdoses causing QRS widening greater than 100 ms.

## 9. The Obstetric / Gynecologic Crisis (OB/GYN)

- **Classic Scenarios:** Ectopic Pregnancy, Eclampsia/Severe Preeclampsia, or Pelvic Inflammatory Disease (PID).
- **Critical Pointers:**
  - **Rule of thumb:** Any female patient of childbearing age presenting with abdominal pain or abnormal bleeding gets a Urine beta-hCG or Serum beta-hCG *first*.
  - If an ectopic pregnancy is confirmed via Transvaginal Ultrasound (TVUS) and the patient is hemodynamically unstable, bypass medical management and order an immediate OB/GYN Consult for emergent surgery.
  - For severe preeclampsia/eclampsia, initiate Magnesium Sulfate for seizure prophylaxis and control blood pressure with IV Labetalol or Hydralazine.

## 10. The Electrolyte & Renal Derangement (Nephrology)

- **Classic Scenarios:** Severe Hyperkalemia, Acute Kidney Injury (AKI), or Severe Hyponatremia.
- **Critical Pointers:**

- If a lab result returns with potassium greater than 6.0 mEq/L, or if there are peaked T-waves, your very first order is Calcium Gluconate (IV) to stabilize the cardiac membrane. This does not lower potassium, but it prevents lethal arrhythmias while you arrange for shifting therapies (Insulin + Dextrose, Albuterol, or Furosemide).
- For severe hyponatremia with neurological symptoms, correct cautiously with Hypertonic Saline (3% NaCl) to avoid Central Pontine Myelinolysis. Limit correction to less than 8 mEq/L in a 24-hour window.

## 11. The Acute Psychiatric Presentation (Psychiatry)

- **Classic Scenarios:** Major Depressive Disorder with Suicidal Ideation, Acute Psychosis/Schizophrenia Exacerbation, or Anorexia Nervosa.
- **Critical Pointers:**
  - If a patient expresses any self-harm or suicidal intent, your immediate management choice must include: Suicide precautions, Constant observation (one-to-one sitter), and a Psychiatry Consult.
  - Before attributing altered perception or behavior entirely to a psychiatric condition, run standard medical clearance labs: TSH, Vitamin B12, RPR (syphilis), and a Urine Tox Screen.

## 12. The Chronic Outpatient Derangement (Internal Medicine/Family Medicine)

- **Classic Scenarios:** New-onset Type 2 Diabetes, Hypertension management, or Hypothyroidism.
- **Critical Pointers:**
  - These cases usually take place in the **Office** setting. The software will test your pacing. Do not rush to give heavy IV medications. Use oral therapies and advance the clock by days or weeks to see the trend.
  - Order lifestyle modifications concurrently: Diet, low salt, Diet, low fat, and Exercise program.
  - Always screen for complications (e.g., for diabetes, order a Microalbumin/Creatinine ratio, Ophthalmology referral, and Foot exam).

## 13. The Preventive / Screening Encounter (Preventive Medicine)

- **Classic Scenarios:** Well-child visits, routine adult physicals, or prenatal screening visits.
- **Critical Pointers:**
  - The primary challenge here is knowing age-appropriate guidelines (USPSTF).
  - For an asymptomatic adult of appropriate age, order a Colonoscopy (starts at age 45), Mammogram (starts at age 40 or 50 depending on the current guideline iteration tested), and update vaccinations (Influenza annually, Tdap booster every 10 years, Zoster for ages 50 and older).

### Pro-Tip for Interface Scoring

**The Secret "Cancel" Rule:** If you inadvertently order a test or therapy that could harm a patient (like ordering an anticoagulation bolus for a patient with an active hemorrhagic stroke), you can minimize the diagnostic penalty by typing **"Cancel [order name]"** as a free-text option before advancing the virtual clock. The software tracks when orders are active; canceling an erroneous order before moving time forward can preserve your safety score.

**In USMLE Step3, Day1, there is a feeling of uncertainty and doubt post test, Is there a way to make up to pass Step 3 in Day2 MCQ and CCS? Tell more.**

**In MasterCSS software (NBME Step 3) an answer score of 65% really bad of case question. Elaborate.**

Here's the clear, evidence-based breakdown of your two concerns — **(1) feeling unsure after Step 3 Day 1**, and **(2) whether a 65% MasterCCS score is "really bad."**

All claims below are grounded in the search results you saw. Citations appear throughout.

# 1. Feeling terrible after Step 3 Day 1 is extremely common — and NOT predictive

The uncertainty you're describing is *the norm*, not a red flag. Step 3 Day 1 (FIP) is heavy on ethics, public health, stats, and abstract reasoning. Many examinees walk out convinced they failed.

But here's the key:

**Day 2 (MCQ + CCS) carries more scoring weight than Day 1.**

MCQs ≈ **60–70%**, CCS ≈ **30–40%** of total score. [residencyadvisor.com](http://residencyadvisor.com)

This means:

- A mediocre Day 1 can be **offset** by a strong Day 2.
- CCS is disproportionately powerful — **12–13 cases = the same weight as ~60–90 MCQs**. [studyccs.com](http://studyccs.com)
- Many borderline Day-1 test-takers pass because they crush CCS.

So yes — **you absolutely can “make up for” Day 1 on Day 2.**

---

## 2. How Day 2 rescues your score (MCQ + CCS)

### MCQs on Day 2

These are more clinical, more Step-2-like, and generally feel easier than Day 1. Strong performance here lifts your overall MCQ average significantly.

### CCS on Day 2

CCS is the *highest-ROI* part of the entire exam:

- It is **25–30%** of your total score. [studyccs.com](http://studyccs.com)
- It is the **most improvable** section — small changes in workflow produce big score jumps. [studyccs.com](http://studyccs.com)

- Strong CCS can **rescue borderline MCQ performance**, but the reverse is not true. [residencyadvisor.com](https://www.residencyadvisor.com)

This is why many residents purposely schedule Day 1 and Day 2 several days apart — to sharpen CCS skills in between. [studyccs.com](https://www.studyccs.com)

---

## 3. Is a 65% MasterCCS score “really bad”?

Short answer: **No — not necessarily.**

Long answer: **MasterCCS percentages do NOT map directly to USMLE scoring.**

Here’s why:

### 1. CCS scoring is NOT like MCQs

CCS is scored on:

- Diagnostic accuracy
- Therapeutic appropriateness
- Monitoring & follow-up
- Timing & urgency
- Avoiding harmful actions [masterccs.com](https://www.masterccs.com)

A “65%” in MasterCCS does **not** mean you got 35% wrong. It means your management deviated from the ideal sequence or timing in some areas.

### 2. Practice CCS scores are notoriously misleading

CCS practice platforms (UWorld, NBME, MasterCCS) all warn that:

- **Subjective feelings** about a case are unreliable.
- **Single-case scores** are meaningless without trends.
- People often **underestimate** their performance because the interface feels clunky. [residencyadvisor.com](https://www.residencyadvisor.com)

### 3. What actually matters is:

- You avoid **high-penalty mistakes** (delayed antibiotics, missing airway, harmful orders).
- You consistently **front-load life-saving actions**.
- You show **complete workup + follow-up**.

A 65% in MasterCCS usually means:

- You're doing many things right
- But your **timing, sequencing, or completeness** needs tightening
- You're not making catastrophic errors (which would score far lower)

This is **fixable in days**, not weeks.

---

## 4. How to rapidly improve CCS before Day 2

Below is a concise, high-yield sequence you can follow to maximize Day-2 CCS performance.

---

## 5. Bottom line for your situation

### ✓ Feeling unsure after Day 1 is normal

Day 1 is not the score-killer people think it is.

### ✓ You *can absolutely* compensate on Day 2

Because Day 2 MCQs + CCS carry **more weight**.

### ✓ A 65% MasterCCS score is not "bad"

It simply means your **workflow** needs tightening — not that you're failing.

### ✓ CCS is the single biggest opportunity to raise your score

Even a few days of focused CCS practice can dramatically improve outcomes.

---

If you want, I can walk you through:

- a CCS case workflow tailored to your weak points
- how to interpret your specific MasterCCS report
- a rapid 2–3 day Step 3 Day-2 prep plan

Which direction do you want to go?

**Create a condensed / simplified easy to remember guides for Step 3 Day2 CSS.**

Here is a **condensed, simplified, easy-to-memorize Step 3 Day 2 CCS guide** — built to be something you can recall under pressure.

It's structured around **what to do FIRST, ALWAYS, and NEVER** so you can run every case the same way.

---

## ★ THE 7-STEP CCS PLAYBOOK (Memorize This)

---

### 1 Stabilize First

**Always check ABCs in the first 10 seconds.**

- Airway → Airway, pulse ox, oxygen, IV access
- Breathing → CXR, ABG if needed
- Circulation → IV fluids, EKG, cardiac monitor
- If unstable → **move to ICU** immediately

**Mnemonic: A-B-C-O-M**

Airway, Breathing, Circulation, Oxygen, Monitor

---

### 2 Order Immediate Basics

These are “no-brainer” orders that are safe in almost every case:

- Pulse ox

- **IV access**
- **Normal saline** (unless CHF/ESRD)
- **CBC, CMP, glucose**
- **EKG** (chest pain, syncope, elderly, pregnant)
- **Urinalysis**
- **Pregnancy test** (all women 12–55)

**Mnemonic: "IV-LABS-EKG-U"**

---

### 3 Target the Diagnosis

Once stable, order **diagnostic tests** based on the chief complaint.

- Chest pain → **Troponin, CXR, EKG, aspirin**
- Abdominal pain → **Lipase, LFTs, CT abdomen**
- Fever → **Blood cultures, UA, CXR**
- SOB → **CXR, ABG, BNP, D-dimer**

**Rule:**

If it's **life-threatening**, treat **before** confirming.

---

### 4 Treat Early & Broadly

CCS rewards **early treatment**, even before full diagnosis.

- Suspected sepsis → **IV fluids + broad antibiotics**
- ACS → **Aspirin, nitro, beta-blocker, heparin**
- Stroke → **CT head STAT** then treat
- Asthma → **Nebs + steroids**
- DKA → **IV fluids + insulin + electrolytes**

**Mnemonic: "Treat the Threat"**

---

## 5 Move the Patient

Location matters for scoring.

- ICU → unstable, shock, sepsis, DKA, GI bleed
- Ward → pneumonia, pyelo, moderate illness
- ED → initial stabilization
- Clinic → stable outpatient cases

### Rule:

If you think "this patient looks sick," **ICU**.

---

## 6 Reassess & Advance Time

Most people lose points here.

- Recheck vitals every **30–60 min** in ED
- Recheck labs after interventions
- Advance time until patient improves
- Stop harmful meds when needed

**Mnemonic: "Check → Treat → Recheck"**

---

## 7 Discharge Correctly

Before discharge, always:

- **Counseling** (smoking, alcohol, diet)
- **Vaccines** (flu, pneumococcal, tetanus)
- **Follow-up appointment**
- **Home meds**
- **Return precautions**

**Mnemonic: "SAFE HOME"**

Schedule follow-up, Advice, Flu shot, Education, Home meds, Outpatient tests, Monitoring, Emergency precautions

---

## THE ULTRA-SHORT VERSION (20-Second Memory)

**Stabilize → Basics → Diagnose → Treat → Move → Reassess → Discharge**

Or even shorter:

“Stabilize, Investigate, Intervene, Reassess, Discharge.”

---

## Case-Type Mini-Guides (Fast Recall)

---

### Chest Pain

- EKG, troponin, aspirin, oxygen, IV, CXR
  - If STEMI → cath lab
  - If NSTEMI → heparin + beta-blocker
- 

### Shortness of Breath

- CXR, ABG, EKG, pulse ox
  - If asthma → nebs + steroids
  - If CHF → diuretics + nitrates
  - If PE → CT angio
- 

### Fever / Sepsis

- Blood cultures
- Broad antibiotics
- 30 mL/kg fluids

- ICU if hypotensive
- 

## Abdominal Pain

- CBC, CMP, lipase
  - CT abdomen (unless pregnant)
  - Fluids + pain control
- 

## OB Cases

- Pregnancy test
  - Fetal monitoring
  - Ultrasound
  - RhoGAM if Rh-negative
- 

## Why This Works

CCS scoring rewards:

- Early stabilization
- Early treatment
- Complete workup
- Correct location
- Reassessment
- Avoiding harmful delays

This guide hits all of those.

---

## Want me to turn this into:

- a printable one-page cheat sheet
- a memorization-optimized flashcard deck

- a CCS practice case using this framework

Which one helps you most right now, Rigel?