BGS Trainees Weekend, Nottingham 7th/8th February 2015

Mock Specialty Certificate Exam

Answers

1. E
2. B
3. A - tilts can be carried out on patients with symptomatic mitral regurg, carotid sinus massage is the Ix of choice for CSS, GTN is used as a provocative measure and it has no use in the Ix of vertigo
4. B
5. E – The clinical picture is pointing towards a diagnosis of Addison's, falls and postural drop. The aggressive and drowsy points to hypoglycaemia and the patient has the typical biochemical markers for Addison's) increased K and decreased Na. Therefore Short Synacthen test is the most appropriate Ix
6. D – Acetylcholinesterase inhibitors usually cause bradycardia
7. C – Patient has had a PACS therefore 1 year recurrence risk is 11%
8. C – This patient has suspected pagets, there is a raised Alk phos with normal bone profile and PTH, therefore radioisotope scan is the Ix of choice as you still need to exclude bone mets although in bone mets one would expect ca to be high end of normal with PTH to lower end of normal
9. C
10. E – Front door geriatrics, MDT in ED would mean the patient would be discharged with suitable walking aid and rapid access to home equipment – this would avoid an unnecessary admission. The IMC and Community falls options would not allow her to go home safely straight away as there would be a wait for these services. B – there is no evidence of UTI and d/c does not solve wide problems
11. D
12. D
13. B – Acute painless visual loss points to an ischaemic event rather than compression from an aneurysm, the fact that it is isolated CN palsy with no other neurology points to posterior circulation + loss of vision suggests CNII involvement also which would leave the left midbrain as the answer. MG usually presents with bilateral ptosis and diplopia rather than visual loss and patients may have an INO and other cranial nerve involvement such as bulbar palsy
14. D – 1x episode of angina 6/12 ago, already on treatment for IHD symptoms not worsening, no Ix needed as would not alter management or diagnosis (see ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Non cardiac Surgery)

15. D – Blood film is the key here tear drop poikilocytosis and leucoeryhtroblastic cells are seen in myelodysplasia, this plus enlarged spleen makes it the answer.
16. D – ulcer is pyoderma gangranosum, associated with Crohn's , treatment is with po steroids unless patient can't swallow then they can be given IV
17. E – CT head is normal which rules out C, no clinical evidence of a UTI(urine dips can be positive in absence of infection), CSF result rules out D as there are 0 neutrophils but points to E, encephalopathy would not give this CSF picture.
18. E – Clinical picture points to TB, guidelines state that if a patient is productive of sputum then obtaining samples for AFB should be done first line. If no sputum then bronchoscopy.

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19. B – measles is the only condition where you would get the rash on palms, soles, limbs, trunk and face + diarrhoea and chest involvement (the other conditions have a variation of these symptoms)
20. B – There are no features to suspect cancer here, no clinical features suggestive of fistulas, he is not pancytopenic. The key is the previous stroke which suggests there could be some mild dysphagia present.
21. D – The clinical picture is pointing towards normal pressure hydrocephalus with the triad of ataxia, cognitive impairment and urinary incontinence (urine stained trousers).
22. C
23. A
24. C – treatment would be with an acetylcholinesterase inhibitors which cause bradycardia
25. B
26. C –see NICE guidelines on Prucalopride
27. A – Frequency volume chart suggests early afternoon is the worst time; this is the time when furosemide would be starting to work. There is nothing in the history to suggest she is overloaded so it would be safe to stop it. Vaginal oestrogens are more useful for stress incontinence, Mirabegron is not licenced as a first line treatment. Ramipril would not cause this pattern of incontinence you could start Trospium but it would be better to stop an offending drug first.
28. B
29. A
30. C
31. D
32. D
33. C
34. D
35. D
36. A
37. A
38. C
39. A – Cyclizine worsens HF
40. B – patient is not hypoxic therefore O2 would not provide relief, opioids are in palliative care guidelines as 1st line for dyspnoea
41. D
42. D – see Stuck et al 1993 meta – analysis in the lancet for definition
43. D
44. C
45. E
46. E
47. A- trails have shown that there is a decreased IC bleeding risk vs Warfarin, Apixaban has been shown to have superiority to warfarin in terms of thrombo-embolic stroke (see NICE guidance on Apixaban), NOACs don't need monitoring, they are not contraindicated in renal failure but caution should be applied.
48. B – patient has had a PACS which carries a 30% chance of dependency at 1 year

49. B – End stage dementia = PEG contraindicated, safest consistency would give her some nutrition and give her the pleasure of eating but need to accept aspiration risk – this patient is approaching end of life but not in the actively dying phase so Nil by mouth would not be ethical here
50. D