	Answer
Question 1	A) Wrist drop: there are 3 nerves involved in humerus fractures – Surgical neck = axillary nerve and loss of abduction – Shaft = radial nerve and wrist drop – Supracondylar fracture = median nerve and ulnar deviation on wrist flexion, loss of opposition and loss of sensation over the palmer surface of the lateral 3 ½ digits. Ape hand deformity is caused my median nerve damage.
Question 2	B) Episodic memory
Question 3	B) The PRISMA 7 questionnaire is a 7 item self-completion questionnaire. Greater than 3 is considered to identify frailty. Points are scored for male gender, age over 85 years, health problems that require you to limit you daily activities, needing help on a regular basis, in general any health problems that require you to stay at home, lack of social support, use of mobility aid.
Question 4	D) Due to the risk of cerebropontine myelinolysis
Question 5	D) The rest may increase your BNP.
Question 6	A)
Question 7	B) *age and ageing – along with non specific symptoms One year mort is 34% High TG, obesity and DM are RF Lamivudine is equally effective Older pts have 9x higher chance
Question 8	A) Male gender Clinical med 15, pg 368
Question 9	A) Prochlorperizine
Question 10	E) Eplenerone
Question 11	D) Spironolactone
Question 12	E) A change in a non-healing ulcer in a patient who is otherwise well should raise the question of a Marjolin's ulcer (malignant transformation, usually SCC, in a pre-existing wound – often burns). Although it is important to rule out infection, swabs have already been sent and blood cultures are unlikely to add anything in a systemically well patient.
Question 13	D) Colchicine, then steroids orally and intra-articular
Question 14	A) Gold standard
Question 15	B) She is on sub-therapeutic levels of carbamezapine and this with medication omission is likely to be the cause of non-convulsive status epilepticus. Although baclofen and fluoxetine reduce the seizure threshold, starting her on appropriate anti-epileptics is going to be best for long term management
Question 16	A) She is still acidotic despite dropping oxygen therapy. ITU might well be appropriate but a trial of NIV is probably a good starting point

Question 17	E) Hydration remains cornerstone 1st line treatment of severe hypercalcaemia associated with malignancy. Suggested fluid replacement is now initially 200-300mls/hr to lead to an urine output of 100 to 150mls/hr rather than massive fluid hydration (Up to Date) Low calcium diet is not necessary as gut absorption of calcium is usually reduced in these circumstances see Clinical Knowledge summary NICE guidance
Question 18	C) A trial of iron replacement is appropriate for pre-menopausal women and pregnant women, but post menopausal women are at much higher risk of occult malignancy. Although the ferritin is 65, given the history of leg ulcer, this is likely still to represent Fe deficiency. She is microcytic so no need for B12/TFTs. Of the options given: coeliac serology is an important differential to consider and may be causative and or contributing to iron deficiency depending on clinical picture. BSG recommends checking coeliac status if no other red flag symptoms prior to referral for upper and lower gastroenterological investigations. CSK NICE guidance and BSG guidelines on management of iron deficiency anaemia
Question 19	E) Prognosis in this patient is poor. With cognitive impairment he would struggle with peritoneal dialysis and with mobility problems haemodialysis would be difficult. It is likely he is in the last year of his life and should be managed accordingly. Reviewing his renal function regularly will just subject him to unnecessary tests. Potentially his GP could take forward the end of life care but this would be revealed following discussion with the patient.
Question 20	B)
Question 21	A) The gutter frame would allow her to pass weight through the more distal portion of her arm.
Question 22	D) Although it would be nice to have the capacity to work on single therapy needs in IC, most services need clear OT and PT goals. Community physio may well be able to work with the stairs, but this sounds like an ongoing problem with re-housing in more appropriate accommodation would solve.
Question 23	D) Average waiting time is 6 days
Question 24	B) Attendance allowance is the money given for help with personal care if the individual is over the age of 65 and physically or mentally disabled. £54.45 is the rate of attendance allowance for an individual over the age of 65 who needs frequent help during the day or night. £81.30 is the rate for an individual who needs help day and night or is terminally ill. Given our lady above will be needing care day and night she qualifies for the higher rate. £61.35 is the rate for carers allowance if the individual giving care is over the age of 16 and provides care for 35 or more hours per week. The individual being cared for must be informed and receiving attendance allowance in order for carers allowance to be claimed.
Question 25	A) The vertigo and transient blurring of vision suggest a higher level balance disorder - likely due to a peripheral vestibular dysfunction - which would result in an abnormal head impulse (or thrust) test.

Question 26	C) Reducing the levodopa will not help his rehabilitation as he currently still has signs of bradykinesia. Increasing levodopa will help this but will almost certainly worsen his postural hypotension, as would adding in rotigotine. An Hb of 95 is above most thresholds for blood transfusion.
Question 27	E) In this case anticoagulation is contra-indicated (or difficult/complex) as the patient has a HASBLED score of 5 and previously had a haemorrhagic stroke suggesting microangiopathic bleeds. A 24hr tape and echo are unlikely to add significant benefit currently and given her CHADSVASC score is equally high at 6 a referral to a cardiologist for a left atrial appendage occlusion may seem appropriate
Question 28	D) SSRI are less implicated in delirium whereas all of the others have evidence of causing delirium
Question 29	D) Haloperidol and olanzapine are the only antipsychotics recommended by NICE for the short term use in acute delirium in patients who are distressed and in whom de-escalation techniques have failed.
Question 30	E)
Question 31	D) all the others are known side effects
Question 32	E) Flucloxacillin causes cholestatic jaundice and is more likely to cause dysfunction when acutely given. Simvastatin causes a hepatitis picture especially when given with drugs that enhance its effects (clarithromycin). Finasteride can cause an isolated raise in ALP. Donepezil has been reported to cause hepatitic jaundice but rarely and in association with other drugs. Benzylpenicillin can also cause cholestatic jaundice but less frequently.
Question 33	D) Chronic retention is an indication for further imaging but not cystoscopy. All the rest are an indication for both further imaging and cystoscopy.
Question 34	E) Dementia is a starvation state not a state of cachexia
Question 35	C) Must score of 0
Question 36	D) 3 for weight, 1 for skin, 3 for incontinence, none for mobility, 0 for weight loss, 1 for appetite.
Question 37	E) She should be switched to a once daily, long acting insulin, with a dose reduction of 10% of total usual requirements.
Question 38	D) Palliative care for muslin patients (prolifemuslims.com)
Question 39	D) The iron def. anaemia and Barret's would be a contraindication to oral bisphosphonate treatment. IV Zolendronic acid is a suitable alternative, however benefit has only been shown when given at least two weeks following surgery (which actually also conferred a mortality reduction). With denosumab the most common complication is a reduction in serum calcium levels (which happens especially if vitamin D levels are so, so both of these need to be checked pre dose).
Question 40	C) Zolendronic acid is associated with AF. Denusumab is given every 6 months but sc injection. If a patient has a raised PTH they likely have a secondary cause of their abnormal bone health (either renal bone disease or hyperparathyroidism) in which case denusumab is unlikely to be the initial treatment.

Question 41	A)
Question 42	B) This gentleman has sustained an intra-capsular neck of femur fracture so IM nailing and DHS are not appropriate. He appears from the history relatively well and physiologically fit. He has no cognitive impairment and given he was riding a bike we must assume he was independently mobile. Given this he should have a THR in preference to a hemi-arthroplasty in guidance with NICE and the Blue Book.
Question 43	D) Risperidone is licensed for 6 wk treatment
Question 44	A)
Question 45	B) Lateral medullary syndrome
Question 46	D) The facet joint injection. BP should be checked again and can be treated with labetalol if need be, uncontrolled hypertension is a contraindication antiplatelets increase risk bleeding but no CI. NIHSS score of greater than 22, less than 4 and no dysphasia, or rapidly improving symptoms are relative contraindications.
Question 47	D) diabetes and hypertension are both risk factors for bell's palsy as well as stroke, bells palsy is most common over 65 years. A pronator drift excludes the diagnosis of bells and strongly suggests stroke.
Question 48	A)