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CME Gastroenterology SAQs (71574)

Self-assessment questionnaire

Nick Bosanko

SAQs and answers are ONLINE for RCP fellows and collegiate members

The SAQs printed in the CME section can only be answered online to achieve external CPD credits.

Any comments should be sent in via email only: clinicalmedicine@rcplondon.ac.uk

Format

SAQs follow a best of five format in line with the MRCP(UK) Part 1 exam. Candidates are asked to choose the best answer from five possible answers.

The answering process

1 Go to **www.rcplondon.ac.uk/SAQ**
2 Log on using your usual RCP username and password
3 Select the relevant CME question paper
4 Answer all 10 questions by selecting the best answer from the options provided
5 Once you have answered all the questions, click on **Submit**

Registering your external CPD credits

Carrying out this activity allows you to claim two external CPD credits. These will be automatically transferred to your CPD diary, where you can review the activity and claim your points.

1 A 28-year-old woman with anorexia nervosa was admitted for enteral feeding. She had no other medical history. She was taking fluoxetine 20 mg once daily. On assessment, she was found to be severely malnourished with a body mass index of 13 kg/m^2 (18–25). Continuous nasogastric feeding was initiated with her consent. Her baseline electrolytes were normal.

Three days after admission she was found on the floor of her room and was observed by the nursing staff to have a tonic–clonic seizure.

What is the most likely cause for this event?

(a) hypercalcaemia
(b) hyperkalaemia
(c) hypernatraemia
(d) hypoglycaemia
(e) hypophosphataemia

2 A 64-year-old man was admitted to hospital complaining of diarrhoea and a rash. He had been receiving home total parenteral nutrition for six months following a small bowel resection for bowel ischaemia.

On examination, he was afebrile, with a pulse of 72 beats per minute and blood pressure of 178/87 mmHg. His abdomen was soft. He had a widespread crusting erythematous rash on his trunk and limbs.

Investigations:

haemoglobin	127 g/l (130–180)
MCV	79 fl (80–96)

What is the most likely diagnosis?

(a) amyloidosis
(b) coeliac disease
(c) pellagra
(d) tuberculosis
(e) zinc deficiency

3 A 56-year-old man was referred to the outpatient department with a six-month history of worsening dysphagia. An endoscopy had revealed a pharyngeal tumour and radiotherapy followed by surgery was planned.

What is the most appropriate way to provide nutrition during treatment?

(a) nasogastric feed
(b) surgical jejunostomy
(c) oral supplement drinks
(d) percutaneous endoscopic gastrostomy
(e) total parenteral nutrition

4 A 72-year-old man was referred to the outpatient department having been found to be anaemic. He had a history of hypertension and his medications included furosemide and ramipril.

Investigations:

haemoglobin	122 g/l (130–180)
MCV	76 fl (80–96)
upper GI endoscopy	normal
duodenal biopsies	normal
faecal occult blood	negative (x3)

What is the most appropriate next test?

(a) MR enteroclysis
(b) colonoscopy
(c) CT scan of abdomen
(d) faecal calprotectin
(e) tissue transglutaminase antibody

5 An 82-year-old man presented to hospital after a fall. He had a history of diabetes mellitus, diagnosed six months previously, which was treated with metformin. He was found to have sustained a fractured neck of femur which was corrected surgically. During his post operative recovery, he developed a urine infection, treated with gentamicin. His pain was controlled with co-codamol 30/500, taken regularly. He developed episodes of explosive diarrhoea, which lasted more than one week.

What is the most likely cause for his diarrhoea?

(a) clostridium difficile
(b) codeine
(c) colonic cancer
(d) metformin
(e) norovirus

6 A 78-year-old woman was admitted to hospital with pneumonia. She had a history of ischaemic heart disease and hypertension. Six days into her admission, she developed diarrhoea. Stool cultures confirmed the presence of *Clostridium difficile* infection and she was commenced on vancomycin 125mg, four times daily. After three days she became unwell with abdominal pain. On examination she had a distended abdomen with reduced bowel sounds.

Investigations:

haemoglobin	128 g/l (115–165)
white cell count	18.5×10^9/l (4.0–11.0)
serum sodium	139 mmol/l (137–144)
serum potassium	3.2 mmol/l (3.5–4.9)
serum urea	8.2 mmol/l (2.5–7.0)
serum creatinine	153 µmol/l (60–110)
serum albumin	25 g/l (37–49)
plasma lactate	3.8 mmol/l (0.6–1.8)
abdominal X-ray	dilated colon (caecal diameter 10.5 cm)

Which is the most appropriate action?

(a) colectomy
(b) endoscopic colonic decompression
(c) increase vancomycin to 250 mg TDS
(d) intravenous immunoglobulin
(e) nasogastric tube

7 A 55-year-old man was referred with episodic watery diarrhoea. He also complained of flushing, particularly after food and alcohol consumption. Examination revealed hepatomegaly and a soft pansystolic murmur in the tricuspid area.

What is the most likely diagnosis?

(a) carcinoid syndrome
(b) glucagonoma
(c) hyperthyroidism
(d) phaeochromocytoma
(e) VIPoma

8 A 52-year-old man presented with a two-month history of diarrhea. He also complained of abdominal pain and bloating, which was worse after eating but relieved by defecation. His weight was stable. He had no significant past medical history and was taking no regular medication. Examination was normal.

Investigations:

haemoglobin	100 g/l (130–180)
MCV	76 fl (80–96)
erythrocyte sedimentation rate	25 mm/1st h (<20)
serum C-reactive protein	2 mg/l (<10)

What is the most appropriate next step?

(a) colonoscopy
(b) faecal occult blood
(c) thyroid function tests
(d) CT scan of abdomen
(e) upper GI endoscopy

9 A 55-year-old man presented with haematemesis. His alcohol consumption was estimated to be 80 units per week. On examination he was agitated, confused and clammy. Blood pressure was 100/60 with a pulse rate of 105 per minute. There were stigmata of chronic liver disease. He was started on oxygen, antibiotics and resuscitated with fluid and blood. An upper GI endoscopy was arranged.
Investigations:

Haemoglobin	102 g/l (135–165)
platelet count	110 × 109/l (150–400)
prothrombin time	20 s (11.5–15.5)

What is the next step?

(a) omeprazole
(b) propranolol
(c) terlipressin
(d) tranexamic acid
(e) vitamin k

10 A 77-year-old man presented to the emergency department with a six-hour history of severe abdominal pain and bloody diarrhoea. He had a history of a myocardial infarction five years previously, and hypertension for which he was taking amlodipine and lisinopril. He smoked 10 cigarettes a day and drank 20 units of alcohol a week. On examination, his temperature was 36.9°C. His pulse was 110 beats per minute and irregularly irregular, and his blood pressure was 160/88 mmHg. His abdomen was generally tender but with no features of peritonism. Bowel sounds were present, and per rectal examination was normal.

Investigations:

haemoglobin	137 g/l (130–180)
white cell count	10.5 × 109/l (4.0–11.0)
platelet count	350 × 109/l (150–400)
serum C-reactive protein	13 mg/l (<10)
X-ray of abdomen	normal

What is the most likely diagnosis?

(a) carcinoma of the rectum
(b) diverticulitis
(c) ischaemic colitis
(d) pseudomembranous colitis
(e) ulcerative colitis

CME Renal medicine SAQs

Answers to the CME SAQs published in *Clinical Medicine* October 2012

Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
(a)	(b)	(a)	(b)	(b)	(c)	(e)	(b)	(e)	(e)