

SELF-ASSESSMENT QUESTIONNAIRE

Gastroenterology

■ Ten self-assessment questions (SAQs) based on the published articles will appear at the end of each CME specialty featured in *Clinical Medicine*. The questions have been validated for the purpose of CME by independent experts. Two (2) CME credits will be awarded to those achieving 80% correct answers. This opportunity is open only to RCP Fellows and Collegiate Members in the UK who are registered for CME*.

■ A loose leaf answer sheet is enclosed, which will be marked electronically at the Royal College of Physicians. **Answer sheets must be returned by 15 November 2002** to:

CME Department (SAQs), Royal College of Physicians,
11 St Andrews Place, London NW1 4LE.

Correct answers will be published in the next issue of *Clinical Medicine*.

*Further details on CME are available from the CME department at the Royal College of Physicians (address above or telephone 020 7935 1174 extension 306 or 309).

Guidelines on completing the answer sheet

Your completed answer sheet will be scanned to enable a quick and accurate analysis of results. To aid this process, please keep the following in mind:

- 1 Please print your GMC Number firmly and neatly
- 2 Only write in allocated areas on the form
- 3 Only use pens with black or dark blue ink
- 4 For optimum accuracy, ensure printed numbers avoid contact with box edges
- 5 Please shade circles like this: ●
Not like this: ☒
- 6 Please mark any mistakes made like this: ✕
- 7 Please do not mark any of the black squares on the corners of each page
- 8 Please fill in your full name and address on the back of the answer sheet in the space provided; this will be used to mail the form back to you after marking.

Q1 A 34 year old man is referred from his general practitioner with abnormal liver biochemistry. He is normally fit and well, although on closer questioning he admits to a 12-month history of persistent diarrhoea. He has had no pain. He is on no regular medication. Investigations show bilirubin 10 µmol/l, alkaline phosphatase (ALP) 600 iu/l (normal <250), alanine aminotransferase (ALT) 90 iu/l, gamma-glutamyl transferase (GGT) 1,200 iu/l. His albumin, prothrombin time (PT) and full blood count are normal.

- (a) He should have an ultrasound scan
- (b) An antimitochondrial antibody is the investigation of choice
- (c) A liver biopsy is more likely to give the diagnosis than an endoscopic retrograde cholangiopancreatography
- (d) Secondary cholangitis needs to be excluded
- (e) A colonoscopy is indicated.

Q2 A 55 year old diabetic is referred having been found to have abnormal LFTs at a routine medical examination. He weighs 115 kg. His LFTs are: bilirubin 15 µmol/l, ALP 300 iu/l (normal <250 iu/l), AST 120 iu/l, ALT 130 iu/l, GGT 130 iu/l. Serum

albumin, PT and mean cell volume are normal. He is hepatitis B core antibody and hepatitis B surface antibody positive. An ultrasound scan shows an abnormal liver texture consistent with fatty infiltration.

- (a) He can be reassured that he has hepatic steatosis and be discharged
- (b) The finding of hepatitis C antibodies alone would indicate chronic hepatitis C infection
- (c) Alcohol is the most likely aetiology
- (d) Significant hepatic fibrosis is unlikely on the basis of the ultrasound scan
- (e) In the presence of a negative chronic liver disease screen, a liver biopsy is indicated.

Q3 A 25 year old athlete with no family history of ischaemic heart disease presents with a three-month history of exertional chest pain. The pain is retrosternal and described as a dull ache. It tends to persist for up to half an hour after cessation of exercise.

- (a) Cardiac disease should be excluded by a combination of risk assessment and exercise ECG
- (b) An echocardiogram should be performed

- (c) Prolonged ambulatory oesophageal pH measurement is an appropriate investigation
- (d) An acid perfusion test should be performed
- (e) The patient should be advised to cease athletic sports.

Q4 A 55 year old man is referred to gastroenterology outpatients with a one-year history of chest pain on exertion and at rest, improved by the use of short-acting nitrates. He has been 'fast tracked' to the cardiologists via a rapid access chest pain clinic, having already been investigated with a coronary angiogram which proved entirely normal. Close questioning reveals that he has suffered intermittent dysphagia for many years.

- (a) He should be referred back to the cardiologists with the suggestion that microvascular angina should be excluded
- (b) Barium swallow would be an appropriate investigation
- (c) Prolonged ambulatory motility testing should be performed
- (d) GOR disease should be excluded
- (e) If all gastrointestinal tests prove normal, antidepressants should be prescribed.

continued

Q5 In the patient with diarrhoea of more than four weeks' duration:

- (a) Useful information is conveyed by a history of weight loss
- (b) Concurrent hypertension therapy is relevant
- (c) Abdominal examination is usually contributory
- (d) A low red cell distribution width (RDW) specifically guides further investigation
- (e) Lactase deficiency is generally important therapeutically.

Q6 In the investigation of chronic diarrhoea in a white European:

- (a) 1 ml of normal jejunal content may contain up to 10,000 colony forming units of microorganisms
- (b) The lactulose hydrogen breath test is the preferred investigation for bacterial overgrowth
- (c) Steatorrhoea is best expressed as grams of fat per gram of stool weight
- (d) An ileal bowel wall thickness on ultrasound of 5 mm is strongly suggestive of Crohn's disease
- (e) Xylose absorption testing is highly sensitive but non-specific for mucosal disease.

Q7 A 35 year old woman with constipation and bright red rectal bleeding:

- (a) Requires an urgent colonoscopy as part of her investigations
- (b) Will not have a diagnosis of irritable bowel syndrome (IBS) in the presence of defaecatory difficulty
- (c) Noticed an improvement in her symptoms following a hysterectomy
- (d) May be adequately treated by the institution of a high fibre diet
- (e) Must be seen in a specialist pelvic floor clinic.

Q8 Concerning colonic transit:

- (a) Radio-opaque marker studies reliably discriminate between right and left sided poor colonic motility
- (b) If normal in the absence of defaecatory difficulties, points towards a diagnosis of constipation dominant IBS

- (c) A scintigraphic study suggesting a total transit time of 40 hours is normal
- (d) May be reduced in patients with Parkinson's disease
- (e) Is reliably measured only in specialist centres.

Q9 A 63 year old male is seen on the third post-operative day following a total gastrectomy for gastric carcinoma. He is making a steady recovery and is currently nil by mouth and receiving intravenous fluids. Over the last three months his weight fell from 75 to 60 kg due to anorexia and early satiety. His height is 1.84 m. What nutritional support does this patient require?

- (a) He requires nasojejunal feeding.
- (b) He should have had a jejunostomy feeding tube placed at operation.
- (c) Parenteral nutrition should be given, preferably peripherally as this has a lower complication rate.
- (d) No nutritional support is required. Continue NBM and IV fluids.
- (e) He needs feeding via a gastrostomy tube.

Q10 A 78 year old woman was admitted via A&E two weeks ago with a dense CVA resulting in a right hemiparesis as well as an expressive and receptive dysphasia. The speech and language therapist has demonstrated that her swallow is unsafe as she aspirates small amounts. Nasogastric feeding was initiated but the patient removed the tube on two occasions. Currently she has a chesty cough with a temperature of 38°C.

- (a) She should remain NBM until her swallow returns.
- (b) The patient should be consented for a PEG.
- (c) Continue attempts at nasogastric feeding, despite obvious difficulties.
- (d) Discuss PEG insertion with family and the healthcare professionals looking after the patient.
- (e) Start peripheral parenteral feeding.

CME Liver disease SAQs

Answers to the CME SAQs published in *Clinical Medicine* July/August 2002

Q1	Q2	Q3	Q4	Q5
a) F	a) F	a) F	a) T	a) F
b) F	b) T	b) T	b) F	b) T
c) F	c) T	c) F	c) T	c) T
d) T	d) T	d) T	d) F	d) F
e) T	e) F	e) F	e) T	e) T
Q6	Q7	Q8	Q9	Q10
a) F	a) F	a) T	a) T	a) T
b) F	b) F	b) T	b) T	b) F
c) T	c) F	c) T	c) F	c) T
d) F	d) F	d) F	d) T	d) T
e) T	e) T	e) T	e) T	e) T