

Cardiology SELF-ASSESSMENT QUESTIONNAIRE

SAQs – and answers – are now ONLINE for RCP Fellows and Members

From this volume onwards, the SAQs printed in the CME section can be answered online to achieve External CPD credits

The answering process

- To access the questions, log on to the Fellows and Members area <http://www.rcplondon.ac.uk/Members/SAQ> (those who have not yet registered will be automatically directed to the registration pages)
- Select: **Online learning SAQ**
- At the top of the SAQ page select the current CME question paper
- Answer all 10 questions in any order, by indicating true or false
- Check your answers and change them if you wish to
- Click on **Submit for final marking**.
(Note – after submitting your answers NO changes are possible)

The marking process

- You must submit the answers before the closing date shown at the top of the screen
- Answers will be marked automatically on the date displayed for that paper
- You can find your marks with explanations of the answers on the CME page under **My past CME papers**

Registering your External CPD credits

A pass mark of 80% allows you to claim 2 External CPD credits. Thus by answering the SAQs in each issue of *Clinical Medicine* you can achieve 12 external credits in one year.

To claim your credits:

- Online registrants: You can record your credits using the online diary system. All Clinical Medicine SAQs are listed under External Approved CPD
- Manual registrants: You can record your credits using your paper diary sheets. Manual registrants are required to keep evidence of their participation in the SAQ and the score attained.

Please note that past papers will be stored for 12 months.

For those who wish to submit their answers on paper, please see guidance at end of these SAQs

- A 49-year-old man with no previous cardiac history and no known risk factors presents with ischaemic type chest pain occurring at rest. Initial ECG is normal. Which of the following statements are true and which false?

 - He should be referred to a chest pain clinic
 - Adequate therapy at this stage is aspirin and a beta-blocker
 - The upper limit of normal for troponin T (TnT) is 0.1 ng/ml
 - An elevated soluble CD40 ligand would indicate an increased risk of adverse events even if troponin is negative
 - The patient subsequently has a negative troponin and borderline exercise stress test; subsequent cardiac catheterisation reveals minor disease with no significantly obstructive lesions. His discharge medication should include clopidogrel
- A 69-year-old female smoker with a history of hypertension and hypercholesterolaemia but no previous angina presents with increasing episodes of chest pain on minor exertion. She has had one episode of pain in the last 24 hours. Initial ECG shows minor T wave changes only, and cTnT is 1.9 ng/ml. Her current treatment is aspirin, a thiazide diuretic and a statin. Which of the following statements are true and which false?

 - The patient's TIMI risk score is 4
 - A TIMI risk score of 7 would indicate a 35% increased risk of death/myocardial infarction (MI) than a score of 1

- (c) Measurement of troponin allows detection of myocardial damage in a further 30% of patients presenting with acute coronary syndrome who do not have elevated creatine kinase, myocardial bound
- (d) Current evidence suggests that a glycoprotein (GP) IIb/IIIa inhibitor should be withheld until cardiac catheterisation is performed
- (e) GPIIb/IIIa inhibitors are beneficial in troponin-positive patients
- 3** A 70-year-old hypertensive man who is previously fit and well presents via his general practitioner with several prolonged episodes of central chest discomfort over the previous 24 hours. During pain, his first ECG shows ST segment depression. He is admitted and feels well the following morning on the post-take ward round. Which of the following statements are true and which false?
- (a) If his pain has settled he can go home for outpatient investigation
- (b) He should be referred to cardiology
- (c) If his TnT level is normal, he is definitely 'low risk'
- (d) His cholesterol should be measured and he should start a statin only if it is high
- (e) He should be started on aspirin, clopidogrel, beta-blocker, statin and angiotensin-converting enzyme inhibitor (ACEI)
- 4** A 45-year-old heavy smoker with a family history of ischaemic heart disease presents to casualty with central crushing chest pain and T wave inversion on the ECG from V2-V6. The pain initially settles with aspirin, clopidogrel, nitrate and beta-blocker. His 12-hour TnT is 0.1 ng/ml. Later that day he develops more pain. Which of the following statements are true and which false?
- (a) He should be referred for urgent angiography
- (b) He is unlikely to have coronary disease
- (c) Three possible outcomes from coronary angiography are medical treatment, percutaneous coronary intervention (PCI) and coronary artery bypass graft surgery
- (d) His long-term outlook is most likely to be poor
- (e) If he has PCI, it will be carried out as a separate procedure some days after the angiogram
- 5** A 77-year-old man with a history of MI and left ventricular (LV) failure is admitted with difficulty with his speech and weakness in his right arm. He has been taking aspirin, atenolol and lisinopril. His symptoms resolve rapidly and neurological examination is normal. His pulse is 130 per minute and totally irregular, and his blood pressure 150/90 mm/Hg. The rest of the cardiac and respiratory examination is normal. An ECG shows atrial fibrillation (AF) with evidence of a previous anterior MI. Which of the following statements are true and which false?
- (a) Immediate DC cardioversion is indicated
- (b) Digoxin should be substituted for atenolol in order to improve ventricular rate control
- (c) He should be considered for anticoagulation with warfarin
- (d) Aspirin is a reasonable alternative to warfarin in this situation
- (e) Strenuous attempts should be made to restore and maintain sinus rhythm with anti-arrhythmic drugs
- 6** A 65-year-old man with permanent AF and an LV ejection fraction of 30% remains highly symptomatic with palpitation and breathlessness despite treatment with digoxin, bisoprolol, ramipril, spironolactone and warfarin. Holter monitoring demonstrates AF with an average night-time ventricular rate of 80 beats per minute and an average daytime rate of over 130 beats per minute. His thyroid function tests are normal. Which of the following statements are true and which false?
- (a) Verapamil is contraindicated in view of his reduced LV ejection fraction
- (b) Catheter ablation of the atrioventricular (AV) node may improve his symptoms
- (c) Warfarin could be stopped after catheter ablation of the AV node
- (d) Digoxin and bisoprolol could be stopped after catheter ablation of the AV node
- (e) LV ejection fraction may improve after catheter ablation of the AV node
- 7** A 75-year-old woman presents in the clinic complaining of a six-month history of breathlessness and slightly swollen ankles by the end of the day. An echocardiogram reveals LV systolic dysfunction. Which therapy/therapies would you start immediately?
- (a) A beta-blocker
- (b) An ACEI
- (c) Spironolactone
- (d) A loop diuretic
- (e) Digoxin
- 8** A 56-year-old man is diagnosed with chronic heart failure (CHF) secondary to LV systolic dysfunction. What non-pharmacological approaches would you take in his management?
- (a) Confirm aetiology/seek reversible cause of CHF
- (b) Salt and fluid restriction
- (c) Smoking cessation
- (d) Regular exercise
- (e) Weight loss if overweight
- 9** A 75-year-old woman presents in the clinic complaining of a six-month history of breathlessness and slightly swollen ankles by the end of

the day. Which results make heart failure less likely?

- (a) A normal cardiac silhouette on chest radiograph
- (b) A normal 12-lead ECG
- (c) Normal peak flow and spirometry
- (d) A low plasma B-type natriuretic peptide (BNP) concentration
- (e) Anterior Q waves on the 12-lead ECG

10 A 55-year-old man with a history of chronic obstructive pulmonary disease presents with increasing breathlessness on exertion and orthopnoea. A transthoracic echocardiogram fails to provide any useful images. What additional tests may help confirm the clinical suspicion of heart failure?

- (a) A plasma BNP concentration
- (b) Peak flow
- (c) A 12-lead ECG
- (d) Radionuclide imaging
- (e) Full blood count

Guidelines on completing the answer sheet for those who wish to submit their answers on paper

A loose leaf answer sheet is enclosed, which will be marked electronically at the Royal College of Physicians. **Answer sheets must be returned by 21 March 2004** to: CME Department (SAQs), Royal College of Physicians, 11 St Andrews Place, London NW1 4LE.

Overseas members only can fax their answers to 020 7487 4156. 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).

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.

CME Renal Medicine SAQs

Answers to the CME SAQs published in *Clinical Medicine* November/December 2003

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