

Diabetes SELF-ASSESSMENT QUESTIONNAIRE

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

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

The answering process

1. 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)
2. Select: **Online learning SAQ**
3. At the top of the SAQ page select the current CME question paper
4. Answer all 10 questions in any order, by indicating true or false
5. Check your answers and change them if you wish to
6. 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

- 1 A 38-year-old barrister with type 1 diabetes was admitted with a sternal injury following a road traffic accident while driving. She had no memory for the event. In making a risk assessment of whether or not hypoglycaemia may have contributed to the accident, which of the following factors should be considered?
 - (a) Frequent nocturnal hyperglycaemia
 - (b) Pursuit of intensified insulin therapy
 - (c) Duration of diabetes
 - (d) Pregnancy
 - (e) Recurrent asymptomatic hypoglycaemia

- 2 A 55-year-old man with type 2 diabetes was found to have a blood pressure of 145/90 mmHg (two readings), with low-density lipoprotein cholesterol 3.6 mmol/l and high-density lipoprotein (HDL) cholesterol 0.8 mmol/l. He had smoked 20 cigarettes a day for 40 years. Which of the following statements are true and which false?
 - (a) He should receive antihypertensive therapy
 - (b) He should receive lipid-lowering therapy
 - (c) The HDL cholesterol conveys no additional information about cardiovascular risk
 - (d) He should receive low-dose aspirin
 - (e) Stopping smoking now will make no significant difference to his cardiovascular risk

- 3** A 65-year-old man with type 2 diabetes was admitted with dyspnoea. He had a history of myocardial infarction (MI) three years previously. On examination, his jugular venous pressure was raised and there were bilateral basal crackles. Foot pulses were all absent. There was no diabetic retinopathy. Urinalysis showed protein + only. Plasma creatinine was 170 $\mu\text{mol/l}$. Which of the following statements are true and which false?
- (a) Vascular disease is a likely cause of this patient's renal impairment
 - (b) Uncontrolled congestive cardiac failure is itself a cause of proteinuria
 - (c) Persistent microalbuminuria in type 2 diabetes does not significantly increase cardiovascular risk
 - (d) Proteinuria in type 2 diabetes is not an important indicator of risk of progression to end-stage renal failure because few type 2 patients reach dialysis
 - (e) There is good evidence to support the use of angiotensin-2 receptor antagonists in the treatment of type 2 diabetic patients with proteinuria
- 4** A 50-year-old man attended his general practitioner (GP) for a routine medical check. He was asymptomatic and there were no abnormal findings on examination. His fasting blood glucose was 6.7 mmol/l and glycated haemoglobin (HbA_{1c}) 6.7%. In a subsequent 75 g oral glucose tolerance test his 2-hour glucose was 10.0 mmol/l. Which of the following statements are true and which false?
- (a) The fasting blood glucose is abnormal
 - (b) Since the HbA_{1c} is below the target of 7.0% there is no increased risk of cardiovascular disease (above that of the normal population)
 - (c) Hyperglycaemia *per se* is established as the primary cause of macrovascular disease in type 2 diabetes
 - (d) Diet and exercise are largely ineffective in reducing glucose levels
 - (e) Metformin treatment should be considered early
- 5** A 60-year-old man with metformin-treated type 2 diabetes mellitus was admitted with a right hemiplegia and aphasia. He was noted to be drowsy. Random blood glucose was 22 mmol/l. A computed tomography brain scan showed no evidence of intracranial haemorrhage. What is the best treatment for his diabetes?
- (a) Continue metformin alone
 - (b) Continue metformin and add insulin
 - (c) Stop metformin and start twice daily intermediate-acting insulin
 - (d) Stop metformin and start a subcutaneous basal-bolus insulin regimen
 - (e) Stop metformin and start an insulin infusion regimen
- 6** A 56-year-old man, whose father and sister had diabetes, attended his GP because he was concerned that he might also have it. He had been feeling thirsty and getting up two or three times at night to pass urine. Which of the following test results would confirm a diagnosis of diabetes mellitus and which would not?
- (a) HbA_{1c} of 6.8% (normal range <6.7%)
 - (b) Fasting plasma glucose of 7.2 mmol/l
 - (c) Random plasma glucose of 10.5 mmol/l
 - (d) Plasma glucose of 11.1 mmol/l one hour after 75 g oral glucose
 - (e) Positive urinalysis for glucose
- 7** A 56-year-old man with an eight-year history of type 2 diabetes attended a diabetic clinic. His home blood glucose results were always over 10 mmol/l and he had lost 3 kg in weight over the previous six months. He was taking metformin 850 mg twice daily and gliclazide 160 mg twice daily, and reported concordance with his diet and medication. His body mass index was 32 kg/m^2 , his HbA_{1c} was 9.7% and his serum creatinine 160 $\mu\text{mol/l}$. He had background diabetic retinopathy. Which of the following statements concerning possible treatment options are true and which false?
- (a) His medication should be left unchanged
 - (b) Transfer to insulin could be expected to reduce his HbA_{1c} by about 2%
 - (c) If insulin is started, he should be advised to continue taking metformin
 - (d) If he is transferred to insulin, a once daily regimen would be suitable
 - (e) The addition of a glitazone to his therapy would be appropriate
- 8** A 22-year-old man with a 17-year history of type 1 diabetes presented with recurrent vomiting, weight loss (5% of body weight) and feeling permanently tired together with symptoms of dizziness on standing. He had required numerous admissions with diabetic ketoacidosis throughout his teenage years, but since graduating from university six months previously had made a determined effort to improve his diabetic control and his HbA_{1c} level had improved dramatically. Which of the following statements are correct?
- (a) A fall in systolic blood pressure of over 30 mmHg on standing confirms that his symptoms are due to autonomic neuropathy
 - (b) Persistent hyperglycaemia may exacerbate his symptoms
 - (c) Treatment with erythromycin may be useful
 - (d) A fixed bradycardia would be consistent with an underlying diabetic autonomic neuropathy

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- (e) He may be at increased risk of sudden death

9 Which of the following statements concerning diabetes in hospital are true and which false?

- (a) Diabetes is responsible for 5–10% of hospital bed-days in the UK
- (b) Employing a specialist nurse with special responsibility for inpatients could be expected to improve quality of life but not length of hospital stay for diabetic patients
- (c) Insulin infusion therapy in non-diabetic intensive care unit patients can improve mortality and morbidity
- (d) To improve the prognosis of metformin-treated diabetic patients with acute MI they should be switched to insulin only when their blood glucose rises above 10 mmol/l
- (e) Any symptomatic hypoglycaemia in a hospitalised patient is a sign of poor management

10 A 62-year-old retired professional golfer who has had type 2 diabetes for six months presented with an ulcer on his right foot where his golf shoe had been 'rubbing'. Examination revealed an ulcer with surrounding erythema on the plantar surface of his right foot and loss of sensation to light pressure using a 10 g monofilament in both feet. Which of the following statements are true and which false?

- (a) The short duration of diabetes makes this an unlikely cause of his peripheral neuropathy
- (b) Loss of sensation indicates that this is a predominantly neuropathic ulcer
- (c) Once the ulcer has healed he should be instructed in the removal of callus from the soles of his feet

- (d) He is at risk of recurrent foot ulceration and should be reviewed regularly in a diabetic foot clinic
- (e) A swab should be taken to guide antibiotic choice

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 September 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 and indicate either true or false for all questions
- 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 Respiratory Medicine SAQs

Answers to the CME SAQs published in *Clinical Medicine* May/June 2004

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