

Rheumatology SELF-ASSESSMENT QUESTIONNAIRE

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

The SAQs printed here 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 should 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.

- A 24-year-old man presents with a two-year history of alternating right and left buttock pain and early morning stiffness lasting for 60 min which improves with exercise. There is a past history of iritis. On examination, there is limited lumbar spine forward and lateral flexion, reduced chest expansion and a tender, swollen right ankle. A pelvic X-ray shows bilateral sacroiliitis (grade 3). Which of the following statements are true and which false?

 - The patient is likely to be HLA-B27 positive
 - HLA-B27 positivity is necessary to make a diagnosis of ankylosing spondylitis (AS)
 - The diagnosis is AS
 - Current guidelines would advocate treatment with tumour necrosis factor (TNF)- α blocking drugs
 - AS is at least twice as common in males as in females
- A 32-year-old man, known to have severe active AS refractory to prolonged treatment with diclofenac and naproxen, is referred for consideration for treatment with TNF- α blockers. Which of the following statements are true and which false?

 - A history of septic arthritis eight months previously would contraindicate anti-TNF therapy
 - It is essential to perform a chest X-ray (CXR) before initiating therapy
 - Anti-TNF therapy can be given orally
 - If commenced, anti-TNF therapy is likely to be effective in this case
 - Infliximab and etanercept are of comparable efficacy in treating AS
- A 44-year-old man known to have AS is receiving treatment with the TNF- α blocker etanercept. He is admitted with a three-week history of night sweats. Examination reveals a fever of 37.5°C and a reduced range of spinal movement.

Which of the following statements are true and which false?

- (a) A CXR is mandatory
- (b) It is important that etanercept is continued
- (c) A normal CXR makes a diagnosis of tuberculosis (TB) unlikely
- (d) If he develops neck stiffness, central nervous system (CNS) imaging and lumbar puncture would be indicated
- (e) If etanercept is discontinued, clinical relapse of AS is likely

4 A 56-year-old man with a two-year history of rheumatoid arthritis (RA) presents with persistently active disease despite treatment with etanercept for three months. He has been unable to tolerate methotrexate (MTX) due to severe gastrointestinal side effects. He is currently being treated with sulfasalazine, hydroxychloroquine and prednisolone. He works for a mining company and wishes to travel to a yellow fever endemic area in Africa. Which of the following statements are true and which false?

- (a) He may be safely trialled on either infliximab or adalimumab
- (b) Despite lack of clinical response, joint erosions may have been retarded by the biologic therapy
- (c) Live vaccines are not contraindicated during biologic therapy
- (d) He does not require specific laboratory monitoring for biologic therapy
- (e) Infliximab, adalimumab and etanercept have an identical mode of action

5 A 35-year-old woman with mildly active RA has heard about biologic therapy and presents requesting further information. Her mother also suffered from severe RA requiring multiple joint replacements, and had ended up in a wheelchair. She is concerned that she might also

become wheelchair bound. Her only treatment until this presentation has been regular non-steroidal anti-inflammatory drugs (NSAIDs). Which of the following statements are true and which false?

- (a) Biologic agents improve signs and symptoms of RA and radiological progression of disease, but not measures of quality of life
- (b) The patient qualifies for biologic therapy as she has active disease
- (c) The development of lymphoma is a concern with biologic agents
- (d) All biologic agents are given subcutaneously
- (e) If mycobacterial infection occurs during anti-TNF treatment, it is most likely to be due to reactivation of disease rather than new infection

6 A 72-year-old woman with long-standing erosive RA presents with three days of fever, breathlessness and mildly productive cough. Her RA has been well controlled for the previous 12 months with infliximab, MTX, folic acid and hydroxychloroquine. On examination, she is febrile and tachypnoeic; chest examination does not reveal focal pathology. Which of the following statements are true and which false?

- (a) The most likely diagnosis is MTX pneumonitis
- (b) Biologic therapy increases the risk of mild infection but not major infection
- (c) Mycobacterium TB infection is the most likely diagnosis
- (d) It is usual to continue biologic treatment in possible cases of infection
- (e) A CXR is unlikely to be contributory in the presence of a normal chest examination

7 A 35-year-old woman presents with a six-week history of pain and swelling in her hands, feet and right shoulder, together with tiredness and weakness. Her symptoms interfere with

her work, particularly during the mornings. Ibuprofen treatment has been ineffective. Investigation reveals haemoglobin 10.7 g/dl, white cell count 6.5 with a normal differential, and platelet count 465. Renal function is normal and liver function tests show a mild elevation of alkaline phosphatase. X-rays of her hands are normal. Which of the following statements are true and which false?

- (a) The diagnosis is most likely to be a form of reactive arthritis
- (b) The best treatment for her would be NSAIDs
- (c) She should be given disease-modifying antirheumatic drug treatment
- (d) A positive rheumatoid factor can help to exclude RA as the diagnosis
- (e) A watch and wait policy would be best for this patient as the diagnosis is uncertain

8 A patient with diffuse cutaneous systemic sclerosis (SSc) of 10 years' duration develops increasing shortness of breath on exertion, occasional syncope and chest pain. He has a long-standing history of hypertension and diabetes. Which of the following statements are true and which false?

- (a) The presence of U3RNP would imply that pulmonary hypertension is unlikely
- (b) A right and left heart catheter would be useful here
- (c) TLCO is disproportionately reduced in pulmonary hypertension
- (d) High resolution computed tomography scan of the thorax showing ground glass attenuation would suggest reversibility of underlying interstitial lung disease
- (e) Disease severity of pulmonary hypertension is best assessed by cardiac catheterisation

9 A patient with limited cutaneous SSc of 20 years'

duration presents with increasing symptoms of abdominal distension, vomiting and a short history of absolute constipation. Which of the following statements regarding the gastrointestinal manifestations of SSc are true and which false?

- (a) A patient like this requires an urgent defunctioning colostomy
- (b) Vascular lesions of the gut mucosa are a cause of chronic anaemia requiring blood transfusion
- (c) Small bowel disease in scleroderma may be worsened by broad spectrum antibiotics
- (d) Anorectal disease is better managed by surgery
- (e) Oesophageal disease is the commonest gastrointestinal problem amongst scleroderma patients

10 A 40-year-old lady with recent onset diffuse cutaneous SSc presents with headache and visual disturbances. Her blood pressure is 190/120 mmHg and there is papilloedema. Urine dipstick reveals proteinuria and haematuria. Which of the following statements are true and which false?

- (a) Scleroderma renal crisis (SRC) can occur with a normal blood pressure
- (b) Patients requiring haemodialysis for treatment of SRC should be recommended for early renal transplantation
- (c) Angiotensin-converting enzyme inhibitors should be discontinued during haemodialysis
- (d) Renal biopsy is helpful, particularly in patients with serological features of overlap connective tissue disease
- (e) Microangiopathic haemolytic anaemia on blood film is associated with a good outcome

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 July 2005 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 Sleep SAQs

Answers to the CME SAQs published in *Clinical Medicine* March/April 2005

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