Haematology SELF-ASSESSMENT QUESTIONNAIRE

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

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 the end of these SAQs.

1 A 43-year-old woman underwent an abdominal hysterectomy for a lifelong history of menorrhagia. Between the ages of 17 and 28 she had received the combined oral contraceptive pill which reduced menstrual blood loss. Tranexamic acid started on the first day of a period had not significantly reduced bleeding. She had had two children; neither the pregnancies nor the deliveries had any bleeding complications. Low-dose, low-molecular weight heparin was given as thromboprophylaxis. During surgery she bled excessively, and postoperatively there was persistent oozing from drains and wound for 48 hours. Which of the following statements are true and which false?

a Pre-operative measurement of prothrombin time (PT) and activated partial thromboplastin time (APTT) would have identified a mild heritable bleeding disorder

b Postoperative measurement of von Willebrand protein would exclude a reduction of the protein as the likely basis for the problem

c Taking a family history is of importance in determining the cause of bleeding

d Tranexamic acid is useful for reducing blood loss in women with menorrhagia

e The most common heritable bleeding tendency is due to a low von Willebrand protein level

2 A 60-year-old man with alcoholic liver disease underwent liver transplantation. There was excessive bleeding postoperatively whilst on the intensive care unit. Which of the following statements are true and which false?

a Bleeding is unlikely to be related to vitamin K deficiency

b A careful assessment of drug history is mandatory

c Disseminated intravascular coagulation (DIC) is unlikely to be the cause

d Thrombocytopenia is unlikely to be a problem in this setting
e Autoantibodies to clotting factors is a common problem in this setting

3 A 64-year-old man with sepsis was admitted to intensive care with respiratory failure and acute renal failure. The PT and APTT were prolonged, there was thrombocytopenia and D-dimer levels were elevated. A diagnosis of DIC secondary to sepsis was made. Which of the following statements are true and which false?

a The renal failure was likely to be due to haemorrhage into the kidneys
b The laboratory test results are diagnostic of DIC irrespective of the clinical history
c The crucial treatment is factor replacement with fresh frozen plasma
d Platelet concentrates should not be used to cover invasive procedures because of the risk of promoting thrombosis
e Dialysis will reduce the bleeding tendency

4 A 19-year-old student presented with a four-week history of lethargy, headaches and spontaneous bruising. His past medical history was unremarkable and he had been on no medication. On examination, there was pallor, generalised purpura and scattered bruises. Fundal examination revealed bilateral retinal haemorrhages. Full blood count showed haemoglobin (Hb) 5.4 g/dl, white cell count 1.2×10^9/l, neutrophil count 0.3×10^9/l and platelet count 2×10^9/l. A bone marrow aspirate and trephine biopsy were both reported to be markedly hypocellular with no abnormal cells. Which of the following statements are true and which false?

a The most likely diagnosis is acute leukaemia
b Short stature would raise the possibility of a congenital form of bone marrow failure
c He is not at risk of cerebral haemorrhage
d Blood and platelet transfusions should be given as soon as possible
e If he had an HLA identical sibling donor, bone marrow transplantation would be the treatment of choice

5 A 62-year-old man was seen by his general practitioner with a three-year history of tiredness. He had also developed shortness of breath and chest tightness on exertion in the previous four weeks. He had no significant past medical history. Clinical examination revealed marked pallor only. ECG was normal but chest X-ray showed an anterior mediastinal mass. Full blood count revealed Hb 6.0 g/dl, white cell count 6.3×10^9/l, normal differential count, platelet count 39×10^9/l and reticulocyte count 5×10^9/l (normal range $25–100 \times 10^9$/l). Bone marrow examination showed absent erythropoiesis. A diagnosis of pure red cell aplasia was made. Which of the following statements are true and which false?

a Computed tomography of the thorax is indicated
b Response rate to thymectomy in the presence of a thymoma is around 90%
c A careful drug history is mandatory
d In the absence of a thymoma, treatment is with blood transfusions alone
e The condition often coexists with other autoimmune disorders

6 Which of the following statements about polycythaemia vera (PV) are true and which false?

a The blood count shows a rise in neutrophil levels in about two-thirds of cases
b The erythropoietin (EPO) level is characteristically normal
c There are frequently abnormalities of chromosome 5
d Interferon-α is a recognised treatment for use during pregnancy
e There is no established causation between the use of chlorambucil and the subsequent incidence of leukaemia

7 A 65-year-old man with a five-year history of PV developed increasing enlargement of his spleen and some splenic discomfort. On examination, the spleen filled the abdomen. Having initially required venesection for a very high Hb level, he has now become transfusion-dependent because of the development of myelofibrosis. Which of the following statements are true and which false?

a His blood film is likely to show tear-drop poikilocytes
b He should be commenced on folic acid supplements
c Thalidomide is capable of improving his transfusion requirements
d If reduction in splenic size is achieved with radiotherapy, the effect is likely to be permanent
e Allogeneic transplantation carries a mortality risk of around 10%

8 Which of the following statements about transfusion transmitted infection (TTI) in the UK are true and which false?

a TTI is the commonest complication associated with blood transfusion
b Major morbidity due to TTI is most commonly associated with bacterial contamination of stored platelet concentrates
c The risk of HIV transmission is one in 450,000 blood donations
d The risk of transmission of hepatitis B virus is higher than that of HIV and hepatitis C virus
e There are no reports of transmission of variant Creutzfeldt-Jakob disease by blood transfusion

9 Which of the following procedures are effective in reducing transfusion requirements in surgical patients and which are not?

a The administration of desmopressin to cardiac surgery patients

b Intraoperative cell salvage in cardiac surgery patients
c Acute normovolaemic haemodilution
d Algorithms for blood management
e Adoption of restrictive thresholds for transfusion

10 Which of the following laboratory abnormalities are characteristic of the anaemia of chronic disease and which are not?

a A high serum iron concentration level
b A high serum transferrin saturation
c A low reticulocyte count
d A low serum ferritin
e Inappropriately low serum EPO levels

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 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 Rheumatology SAQs

Answers to the CME SAQs published in *Clinical Medicine* May/June 2005

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