with Gram-negative bacteria producing Gram-negative folliculitis, requiring treatment with trimethoprim or isotretinoin.

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Dermatology

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 five-month-old infant presents with a progressive, widespread, inflamed and eroded papular inflammatory rash of two months' duration affecting the face, scalp, extensor surfaces of limbs and trunk. He is irritable and difficult to settle and has not improved with topical emollients, twice daily baths and hydrocortisone 0.5% cream. He was breast-fed to three months and then started on a regular formula milk and weaning diet. He is failing to thrive and his parents are worried about him. A friend suggested a switch to a hypoallergenic milk formula. There is no family history of atopic disease. Which of the following statements are true and which false?

(a) Infantile atopic eczema is the most likely diagnosis

(b) It is likely that secondary bacterial infection has occurred and oral antibiotics should be prescribed (after skin swabs for microbiology)

(c) A hypoallergenic milk formula may be beneficial

(d) He should be treated with a topical immunomodulator rather than a topical steroid

(e) His lack of response is a reflection of his parents' inability to cope

2 Which of the following statements about the epidemiology of atopic eczema are true and which false?

(a) The prevalence is higher in children in well-off families

(b) The incidence falls in populations or groups who migrate from rural to urban areas

(c) The rise in incidence of atopic eczema parallels the decline in incidence of infectious diseases of childhood

(d) The hygiene hypothesis states that inadequate domestic and personal hygiene may contribute to an enhanced risk of atopic eczema

(e) There are no laboratory-based diagnostic tests so the current diagnostic criteria for atopic eczema are based on subjective features

3 A 48-year-old renal transplant patient with red hair and green eyes complains of a two-year history of a painless lesion on his forehead. It is slowly enlarging over time and has crusted over, but never healed. He remembers several episodes of sunburn both as a child and as an adult and has never tanned on exposure to the sun. On examination, he has pale, freckled skin with a 1-cm diameter telangiectatic, nodular lesion on the left side of his nose, centrally ulcerated with a pearly edge. Which of the following statements are true and which false?

(a) Basal cell carcinoma (BCC) is the most likely diagnosis

(b) Green eye colour increases the risk of development of BCC

(c) Episodic sunburn as an adult is an important risk factor

(d) Immunosuppression increases ten-fold the risk of development of BCC

(e) To achieve 85% clearance rates for this tumour, excision margins should be a minimum of 3 mm

4 An 88-year-old woman presents with a changing 'mole' on her anterior chest. The lesion has been present for 36 months and is occasionally itchy. On examination, she has a 2-cm diameter nodular lesion on her anterior chest wall with a raised, pearly edge and scattered telangiectasia. She had been given 'tonics' as a child and there are several scars from previous surgery for similar lesions in the past. A biopsy shows the lesion to be a superficial BCC. Which of the following statements are true and which false?

(a) Radiotherapy would be a suitable treatment option for this BCC

(b) The patient should be carefully examined for other lesions

(c) She does not have an increased risk of developing a squamous cell carcinoma

(d) The 'tonic' given as a child may have contained arsenic

(e) The percentage of BCCs arising on the trunk is 35%

5 A 23-year-old man presents with two non-healing lesions, one on the cheek and the other on the back. The lesion on his cheek has recurred after excision 18 months earlier. His father had multiple similar lesions removed and his sister has also developed similar problems. On examination, he has two lesions, both telangiectatic with a pearly edge and central ulceration. The lesion on his cheek is 8 mm diameter and is adjacent to a scar; the lesion on his back is 1 cm diameter. He has several palmar pits bilaterally. Which of the following statements are true and which false?

(a) Biopsies of these lesions should be performed to establish the histological diagnosis

(b) Radiotherapy is a recommended treatment option in young patients

(c) Naevoid BCC (Gorlin's) syndrome is autosomal recessive

(d) He may have bony abnormalities such as jaw cysts

(e) Mohs' micrographic surgery, where available, is the best management option for recurrent tumours in high-risk sites

6 A 28-year-old woman presents to her general practitioner (GP) with a one-year history of symmetrical, red scaly patches on elbows and knees and a history of dandruff. Her father suffered from psoriasis. For the previous 18 months she has been taking atenolol for hypertension. On examination, she has lesions, as described above, and also involvement of axillae and vulva. There is swelling and some tenderness

of the distal interphalangeal joints of the right hand. Which of the following statements are true and which false?

(a) Chronic plaque psoriasis is the most likely diagnosis

(b) Flexural involvement is an indicator of the presence of atopic dermatitis

(c) The absence of nail involvement excludes the diagnosis of chronic plaque psoriasis

(d) It is likely that she has early psoriatic arthritis

(e) Atenolol may have been the trigger for her condition

7 A 40-year-old man with a 20-year history of severe chronic plaque psoriasis and psoriatic arthritis is admitted to hospital. He is taking methotrexate 25 mg weekly, supplemented by folic acid. He has received the maximum lifetime cumulative dose of irradiation with long-wave ultraviolet A (PUVA), is unable to tolerate ciclosporin because of nausea, and acitretin has not been beneficial. He is otherwise well. He and his relatives ask about treatment with one of the newer biological therapies. Which of the following statements are true and which false?

(a) Biological therapies ('biologics') are not licensed in the UK for the treatment of psoriasis

(b) An anti-T cell approach, such as efalizumab or alefacept, would be the best treatment option

(c) If rapid improvement is required (ie significant clinical improvement within four weeks of starting therapy), infliximab would be the best option

(d) Long-term treatment with an anti-tumour necrosis factor biologic requires regular monitoring of peripheral CD4 T cell counts

(e) All biologics for psoriasis are administered by subcutaneous injection

8 A 58-year-old woman is treated by her GP with trimethoprim for a suspected urinary tract infection. Three days later, she is brought into hospital unwell, with a sore mouth, sore eyes and erythematous painful patches over the trunk and limbs. Fluid-filled blisters are noted on some areas of her trunk. Which of the following statements are true and which false?

(a) Stevens-Johnson syndrome (SJS) can be diagnosed clinically according to the extent of epidermal loss which is greater than that seen in toxic epidermal necrolysis (TEN)

(b) Tense blisters usually appear early in the evolution of cutaneous involvement in TEN

(c) Any associated pain with TEN or SJS is often only mild

(d) In TEN, serious ocular complications occur in about 50% of patients

(e) Sepsis is the commonest cause of death in TEN

9 An 84-year-old man is admitted to hospital with TEN. He has recently been prescribed allopurinol and diclofenac for gout but also regularly takes carbamazepine for trigeminal neuralgia. He has no known drug allergies. Which of the following statements are true and which false?

(a) Prompt withdrawal of all his medication may improve his overall prognosis

(b) He should be managed supportively on a burns/high dependency unit

(c) Steroids should be given immediately as they are of proven benefit

(d) Intravenous immunoglobulin provides its benefit via inhibition of interleukin-6

(e) The severity-of-illness score for TEN (SCORTEN) system allows prediction of the overall prognosis in this patient

10 A 16-year-old girl is seen in the dermatology clinic with severe acne. The acne is of sudden onset and is preventing the girl from socialising and attending school. She is crying and appears depressed during the consultation. On examination, the acne is of the nodulocystic type and involves most of her face. Several of the acne cysts are over 1 cm in diameter. Many of the lesions are inflamed and painful. Very few macrocomedones are visible. Which of the following statements are true and which false?

(a) Treatment with isotretinoin is contraindicated in view of the patient's apparent depression

(b) Oral steroids should be started to reduce the acne cysts; the larger cysts should be injected with intralesional steroids

(c) If isotretinoin is used, it should be started at a low dose to avoid a flare of the acne

(d) If isotretinoin is being used at a low dose, it is not necessary for the patient to be on an oral contraceptive

(e) Isotretinoin may cause elevation of the serum cholesterol level

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 January 2006** 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 Intensive Care Medicine SAQs

Answers to the CME SAQs published in *Clinical Medicine* September/October 2005

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