Geriatric medicine (36219)

SELF-ASSESSMENT QUESTIONNAIRE

SAQs and answers are ONLINE for RCP Fellows and Collegiate Members

The SAQs printed in the CME section can only be answered online to achieve external CPD credits. The closing date is 21 November 2007 (midnight GMT).

Change in format

As announced in the previous issues, SAQs will now follow a best of five format in line with the MRCP(UK) Part 1 exam. Candidates are asked to choose the best answer from five possible answers. The online system, passwords and pass mark will remain the same.

There may be teething problems and we would be grateful if all comments/problems could be sent in via email only: clinicalmedicine@rcplondon.ac.uk

We recommend that answers are submitted early so that any problems can be resolved before the deadline.

The answering process

1 To access the questions, log on to the Fellows and Members area www.rcplondon.ac.uk/Members/SAQ (those who have not yet registered will be automatically directed to the registration pages). Please contact the Information Centre if you have lost or forgotten your username or password: infocentre@rcplondon.ac.uk

2 Select: **Self assessment**

3 At the top of the SAQ page select the current CME question paper

4 Answer all 10 questions in any order, by selecting the best answer

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 on the CME page under **My past CME papers**.

Registering your external CPD credits

A pass mark of 80% allows you to claim two external CPD credits. Only the first seven distance-learning credits will be counted as external; the remainder can be claimed as personal credits.

To claim your credits:

- Credits can be recorded using the online diary system. All *Clinical Medicine* SAQs are listed under **External Approved CPD.**

1 A 78-year-old woman presented with a four-week history of lethargy and shortness of breath on exertion. On systemic enquiry there were no other symptoms of note and she had no significant past medical history. Examination was normal. The results of investigations were haemoglobin (Hb) 9.8 g/dl (normal range 11.5–16.5), mean cell volume (MCV) 85 fl (80–96), ferritin 38 µg/l (15–300), vitamin B12 190 ng/l (160–760), red cell folate 220 µg/l (160–640). What is the most appropriate next step in her management?

(a) Empirical treatment with ferrous sulphate
(b) Faecal occult blood testing
(c) Full dietary history
(d) Tissue transglutaminase antibody
(e) Upper and lower gastrointestinal (GI) endoscopy

2 An 85-year-old man with mild cognitive impairment was admitted with recurrent falls and poor mobility. The results of investigations were Hb 10.2 g/dl (13–18), MCV 92 fl (80–96), ferritin 125 µg/l (15–300), vitamin B12 35 ng/l (160–760), red cell folate 310 µg/l (160–640). What is the most appropriate next step in his management?

(a) Empirical treatment with hydroxycobalamin
(b) Full dietary history
(c) Parietal cell and intrinsic factor antibodies
(d) Schilling test
(e) Upper and lower GI endoscopy

3 A 92-year-old woman was admitted from home. She had an old right hemiparesis and had been nursed in bed for a number of years. On examination, she was thin and had a chronic, grade IV sacral pressure sore. The results of investigations were Hb 9.4 g/dl (11.5–16.5), MCV 85 fl (80–96), ferritin 380 µg/l (15–300), vitamin B12 500 ng/l (160–760), red cell folate 410 µg/l (160–640), erythrocyte sedimentation rate 45 mm/1st h (<30), urea 12.5 mmol/l (2.5–7.5), creatinine 150 µmol/l (60–110). What is the most likely diagnosis?

(a) Anaemia of chronic disease
(b) Iron deficiency anaemia
(c) Myelodysplasia
(d) Pernicious anaemia
(e) Sideroblastic anaemia

4 A 77-year-old woman was admitted to a general medical ward with falls and confusion. The clinical diagnosis was made of a delirium secondary to a urinary tract infection on a background of progressive vascular dementia. Before her acute presentation her carers had been struggling to manage her deteriorating mobility and mental state at home. After recovery from the delirium her Mini Mental State Examination score was 10/30. After a full multidisciplinary assessment, home visit and consideration of the alternative options it was felt that she required 24-hour nursing care. The patient was unable to state her preferred place of care and was deemed by the consultant clearly to lack capacity to make the decision regarding her future place of care. She had no family or close friends. What is the most appropriate next step in her management?

(a) Ask for a second opinion regarding her capacity
(b) Discharge the patient home to await long-term placement
(c) Involve an independent mental capacity advocate to act on her behalf
(d) Refer the patient for intermediate care
(e) Send the patient to the first available nursing home bed

5 An 82-year-old man was admitted to the medical admissions unit from his residential home. He had a history of chronic obstructive pulmonary disease (COPD) and Alzheimer's disease. His mental state had been progressively deteriorating since his admission to the home six months earlier following the death of his wife. He was assessed by the general practitioner four weeks ago and diagnosed with depression. A low dose of amitriptyline (10 mg nocte) was commenced. His other medication was donepezil 5 mg daily, tiotropium 18 µg daily and salbutamol 100 µg PRN. Over the last two weeks he had become more aggressive with episodes of wandering. On the day of admission, a member of staff had found him trying to open the front door at 4 am. When they attempted to stop him leaving he became aggressive, an ambulance was called and he was brought to hospital. The admitting doctor recorded 'residential home not coping'. The care home manager had contacted the ward and explained that she felt they could no longer manage his challenging behaviour. What is the next step in his management?

(a) Arrange comprehensive multidisciplinary assessment, including specialist medical input before considering discharge
(b) Arrange for an intermediate care team to support discharge back to the residential home
(c) Ask social services to arrange emergency nursing home placement
(d) Send the patient back to his residential home and arrange for social services to reassess his care needs urgently
(e) Start regular low-dose lorazepam and send the patient back to the residential home with urgent community mental health team review

6 An 84-year-old man with a history of chronic heart failure, minor strokes, osteoarthritis and spinal osteoporosis presented to accident and emergency (A&E) with a six-month history of recurrent falls without warning, both inside and outside the home. Friends report that he was confused with incoherent speech for an hour or so after a fall, but then made a full recovery.

(a) Syncope is the likely diagnosis
(b) Epilepsy is the likely diagnosis
(c) Osteoporosis prevention to reduce fracture risk is an urgent priority
(d) Referral for physiotherapy to improve balance and walking is a priority
(e) Home adaptations should be arranged as a priority

7 A 93-year-old woman with a history of COPD, chronic heart failure and chronic kidney disease had been struggling to cope at home for several months. Before this she was independent about her home with help from her neighbour for shopping. She presented to A&E having been found by her neighbour on the floor. She was alert and orientated but reluctant to answer questions. She said she had recently been feeling 'terrible' with 'pains all over' and had 'had enough.' Examination showed no clinical evidence of exacerbation of her heart failure or lung disease and her plasma creatinine concentration was unchanged.

(a) Delirium is the likely diagnosis
(b) Dementia is the likely diagnosis
(c) Her symptoms might be due to her age
(d) Depression is the likely diagnosis
(e) It is important to organise a computed tomography (CT) or magnetic resonance imaging scan of the head

8 A 94-year-old man who was housebound and had poor mobility presented to the medical admissions unit following a fall in his kitchen. No injuries or acute illness were apparent.

(a) He should be reassured and sent home
(b) A 'Get Up and Go' test should be undertaken
(c) Little can be done to prevent further falls
(d) He is unlikely to fall again

(e) A head CT scan would be a useful investigation

9 A 77-year-old woman with atrial fibrillation and a previous minor stroke presented to the clinic with breathlessness which was found to be caused by congestive cardiac failure. Her symptoms improved with diuretic therapy and her consultant then considered her future clinical management. National Institute for Health and Clinical Excellence guidelines indicate that:

(a) Her all-cause mortality risk would be reduced by anticoagulation therapy
(b) Her risk of an adverse outcome such as bleeding on anticoagulation therapy outweighs the potential benefit of stroke reduction
(c) She is at high risk of future thromboembolic stroke
(d) She should receive anticoagulation therapy
(e) The potential reduction of her risk of a future thromboembolic stroke outweighs her risk of an adverse outcome such as bleeding on anticoagulation therapy

10 An 82-year-old woman on long-term treatment for hypertension, myxoedema, dependent oedema secondary to venous insufficiency, and overactive bladder was admitted to hospital. She was pyrexial with severe below knee cellulitis. During the next two days she developed hyperactive delirium. Administration of her usual medication was difficult. Omission of the next few doses of the following medication may be associated with worsening of her agitation:

(a) Amlodipine
(b) Citalopram
(c) Furosemide
(d) Levothyroxine
(e) Oxybutynin

Self-Assessment Questionnaire (SAQ) Acute Medicine CME

Clinical Medicine June 2007

We have recently introduced the best of five format for the SAQs. This is in line with the changes introduced by the Federation of the Royal Colleges of Physicians of the UK and are now required in order to claim external CPD credits. This ideally should be accompanied by an expansion of the number of question but we are loath to increase the burden on our already hard-pressed authors. There have also been the technical teething problems (see below) for which we apologise. We plan to continue the new format and evaluate the outcome later this year. Any comments would be welcome and contribute towards finding an effective solution.

Erratum
Please note that the SAQ answers initially logged on 6 August, and published on page 407 of the August issue, were incorrect.

The correct answers are below. All submitted SAQs have now been remarked.

Answers to the CME SAQs published in *Clinical Medicine* June 2007

Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
(a)	(b)	(e)	(b)	(d)	(e)	(e)	(a)	(a)	(d)

Robert Allan
Editor

CME Cardiology SAQs

Answers to the CME SAQs published in *Clinical Medicine* August 2007

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

Errata

CME Cardiology SAQs. *Clin Med* 2007;7:405–7.

Question 8. Please note that the haemoglobin level should be 13.2 g/dl rather than 3.2 g/dl.

Epstein M, Barmania N, Robin J, Harbord M. Reforming the acute phase of the inpatient journey. *Clin Med* 2007;7:343–7.

Please note that the third author of this paper was incorrectly listed as J Robini in the table of contents and on the article title page. We apologise for any inconvenience caused.