Endocrinology (36221)
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 May 2008 (midnight GMT).

Format

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

1 A 38-year-old woman presented with a nine-month history of weight gain, hirsutism, light periods and mild depressive symptoms. In the past she had struggled with her weight and her sister has polycystic ovarian syndrome (POS). On examination, her blood pressure (BP) was 144/92 mmHg, and she had facial plethora, a cervical fat pad ('buffalo hump'), bruising on skin, acne and was obese. Which of the following clinical features is most suggestive of Cushing's syndrome in this patient?

(a) Cervical fat pad
(b) Easy bruising
(c) Facial plethora
(d) Hirsutism
(e) Hypertension

2 A 34-year-old woman had a six-month history of weight gain and three-month history of type 2 diabetes. On examination, she had some clinical features of mild Cushing's syndrome and it was decided to screen her biochemically. Which of the following tests is best for this patient?

(a) 24-hour urinary free cortisol
(b) Metyrapone test
(c) Low-dose dexamethasone-suppression test
(d) Plasma chromogranin
(e) Serum cortisol

3 A 50-year-old woman presented with clinical features consistent with Cushing's syndrome. This was confirmed biochemically. Which of the following is the next most appropriate test to investigate the cause of her Cushing's syndrome?

(a) Bilateral inferior petrosal sinus sampling
(b) Corticotropin-releasing hormone (CRH) test
(c) High-dose dexamethasone-suppression test
(d) Plasma ACTH
(e) Plasma CRH

4 A 76-year-old woman was admitted to hospital with atrial fibrillation. On examination, a multinodular goitre was found. Initial investigations showed thyroid-stimulating hormone level below 0.1 mu/l with normal free triiodothyronine and free thyroxine levels. Ten weeks later she was seen in an endocrinology outpatient clinic and the blood tests were unaltered. What is the next most appropriate step?

(a) Radioiodine
(b) A course of carbimazole
(c) Thyroid ultrasound scan
(d) Advise annual thyroid function testing by general practitioner
(e) Arrange radionuclide thyroid scan

5 A 75-year-old female was under review for colonic carcinoma when she was found to have no evidence of hepatic disease on a routine contrast-enhanced computed tomography (CT) scan. However, a 3.5 cm adrenal mass was revealed instead. The mass showed marked heterogeneous enhancement on CT scanning. Markers of functional activity were negative. What is the next most appropriate course of action?

(a) A CT-guided biopsy
(b) Surgical removal
(c) Surgical biopsy
(d) Magnetic resonance imaging (MRI)
(e) Simple observation

6 A 35-year-old man was having a routine life insurance CT scan when a 5 cm adrenal mass was seen which showed marked enhancement with contrast. He was otherwise well, on a statin for hypercholesterolaemia and amlodipine 10 mg for hypertension. His BP was 140/100 mmHg. What is the most important investigation to perform?

(a) CT-guided biopsy
(b) Measurement of cortisol post-dexamethasone
(c) Measurement of plasma metanephrines
(d) ^{123}I-metaiodobenzylguanidine scan
(e) MRI

7 A 28-year-old woman was admitted to the accident and emergency unit with nausea, vomiting, lethargy and diffuse abdominal tension. Upon clinical inspection, generalised hyperpigmentation was noted and blood tests revealed a low serum sodium (130 mmol/l). Her BP supine was 80/50 mmHg; she was too weak to get up for an erect BP. What is the next most appropriate step in management?

(a) A short synacthen test
(b) Baseline serum cortisol
(c) Start physiological saline infusions
(d) Start oral hydrocortisone at a dose of 10 mg bd
(e) Start intramuscular hydrocortisone at a dose of 50 mg qds

8 A 68-year-old South-Asian man had recently been diagnosed with adrenal insufficiency. His plasma ACTH was very high, indicative of primary origin of disease. However, his adrenal autoantibodies were negative. What is the next most appropriate test in his diagnostic work-up?

(a) A short synacthen test
(b) Adrenal CT scan
(c) Measurement of very long-chain fatty acids
(d) Chest X-ray
(e) Pituitary MRI scan

9 A 28-year-old woman was referred by her GP with a history of galactorrhoea and amenorrhoea of six months' duration. She denied a history of headache or visual disturbance. She was known to have psychosis for which she had been taking risperidone 4 mg daily for the last year. Her past medical history was otherwise unremarkable and she was not on any other regular medication. She was currently single and not contemplating starting a family in the near future. Physical examination confirmed galactorrhoea but there were no gross signs of hypogonadism. Visual field testing was normal. There were no features of hypothyroidism or POS. Her biochemical profile (including liver, renal and thyroid function) was within the normal range. Pregnancy test was negative. However, serum prolactin level was noted to be raised on two occasions one month apart (1,858 mu/l and 2,173 mu/l, respectively). What is the most appropriate next step in management?

(a) Immediate withdrawal of risperidone as it is the likely culprit for her hyperprolactinaemia
(b) Initiation of dopamine agonist therapy to correct the hyperprolactinaemia and restore ovulation
(c) Liaison with her psychiatrist, with a view to switching her antipsychotic medication to an atypical antipsychotic such as olanzapine which has less antidopaminergic effect
(d) Close monitoring of her prolactin level but no other action
(e) Urgent MRI scan of the pituitary to rule out a macroadenoma

10 A 35-year-old nurse known to have a microprolactinoma had been receiving dopamine agonist therapy, cabergoline 0.5 mg twice weekly, for the last five years, during which she had remained asymptomatic and had a normal regular menstruation. Her serum prolactin level had been below 140 mu/l for the last three years and the size of her microprolactinoma had remained stable. What is the best management strategy?

(a) Maintain on dopamine agonist therapy long term until the microprolactinoma disappears
(b) Consider withdrawing cabergoline treatment while monitoring prolactin level as the likelihood of remission is high
(c) Switch to an alternative dopamine agonist to achieve further reduction in the size of the microprolactinoma
(d) Reduce the cabergoline dose and continue long-term treatment
(e) Start oestrogen replacement therapy to reduce her risk of osteoporosis

CME Poisons SAQs

Answers to the CME SAQs published in *Clinical Medicine* February 2008

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