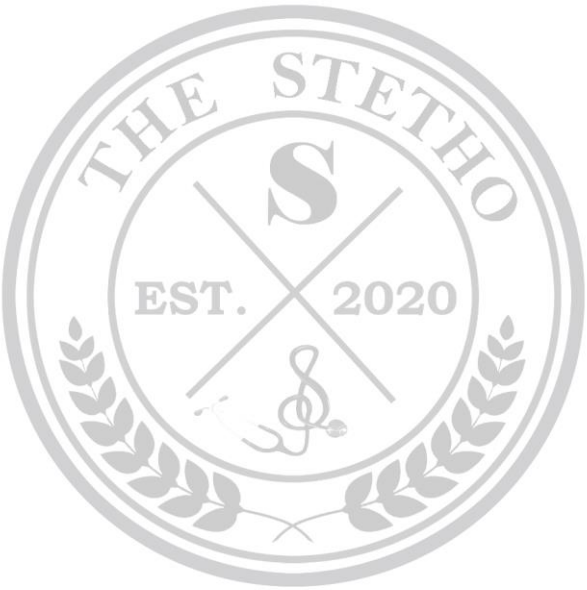
COMMON CASES IN GASTROENTEROLOGY

For Medical Students & House Officers
BY

Dr Irfan Ullah & Dr Asim Khan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ACKNOWLEDGEMENT

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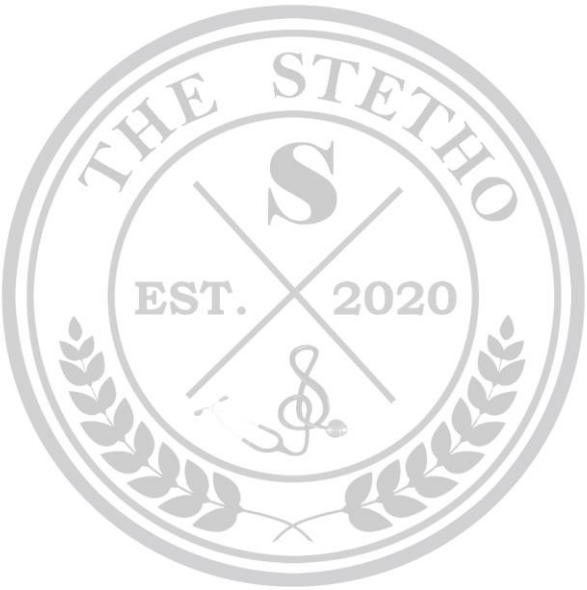
Dr. Irfan Ullah & Asim Khan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"William Osler"

" There are only two sorts of doctors: those who practice with their brains, and those who practice with their tongues"

CASE 1

A 70 YEARS OLD WOMAN WITH PROGRESSIVE DYSPHAGIA

Scenario: A 70 years old lady visits your clinic for complaints of heartburn and reflux that has progressed over the last four months but it has now become difficult for her to swallow certain foods now. She is at your clinic for further evaluation.

HISTORY

1. Level of Dysphagia: As a physician your primary concern in this patient should be to identify the level of dysphagia.

- Oropharyngeal Dysphagia: This level of dysphagia manifests as a difficulty to initiate swallowing.

- Esophageal Dysphagia: In this level, the initiation is alright but there is difficulty in swallowing seconds after initiating a swallow.

2. Type of Dysphagia:
- Liquids: A Pharyngeal cause
- Solids: A Mechanical cause
- Solids & Liquids: Esophageal Dysmotility

3. Duration of Dysphagia:
- A short progressive history points towards malignancy.

- Intermittent History of symptoms points to esophageal dysmotility, eosinophilic esophagitis or an esophageal web.

4. Past History of gastro-esophageal reflux (GERD), Barrett's esophagus, peptic stricture or esophageal web.

5. Past history of systemic sclerosis.

6. Past history of a neurological disorder.

PHYSICAL EXAM

1. General Examination: Check for dehydration or weight loss. Inspect mouth, teeth and dentures for signs of acid erosion.

2. Abdominal Examination: Inspect and palpate for an abdominal mass and organomegaly.

INVESTIGATIONS

1. Blood Tests:
    - Complete Blood Count with Peripheral Smear and Iron Panel (studies).
    - Urea and Electrolytes including Calcium
    - Liver Function Tests (LFTs)

2. Radiological Investigations:
    - Chest X-ray
    - Barium swallow
    - Upper endoscopy

DIFFERENTIALS

Esophageal Carcinoma
Peptic Stricture
Severe Esophagitis
Esophageal Web.
Schatzki Ring.
Esophageal Dysmotility

MANAGEMENT

The treatment and management should be aimed relieving the symptoms of dysphagia.

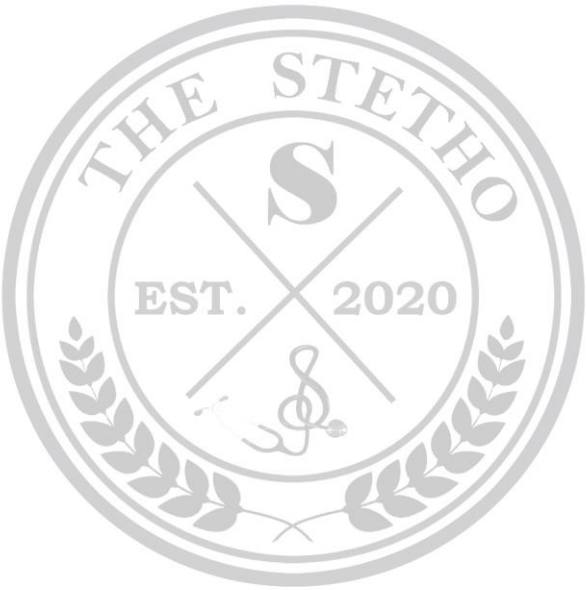
1. Surgery: If surgical resection of the tumor is required (In case of Carcinoma).

2. Chemotherapy.

3. Radical Radiotherapy.

4. Palliation of symptoms: The most appropriate treatment in most cases.

- Endoscopic Dilatation of the Malignant Stricture
- Palliative Chemotherapy
- Palliative Photodynamic Therapy
- Palliative Radiotherapy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CASE 2

A 52 YEARS OLD MAN WITH ATYPICAL CHEST PAIN

Scenario: A 52 Years old man that complains of chest pain related to meals and exertion. The General Practitioner (GP) referred him to a cardiologist to rule out angina. His ECG was normal. The Exercise Tolerance Test was negative for ischemia. He had a diagnostic angiogram with normal coronary arteries but the chest pain persists. A chest X-ray showed normal lung fields and no bony abnormalities. Thyroid function tests and an autoimmune screen were normal. He has been referred to you to exclude a gastrointestinal cause of his chest pain.

HISTORY

Describe the Chest Pain:

- Was the pain retrosternal burning sensation?
- Does the patient feel any acid or reflux in his mouth?
- Is there any bitter taste?
- Is there relief with antacids?
- What is the duration of his symptoms?
- Has he had similar symptoms in the past?
- Did they resolve spontaneously or require treatment?
- What is the frequency and severity of these symptoms?
- Are they getting progressively worse?

PHYSICAL EXAM

- Look for evidence of weight change, especially weight loss.
- Look for conjunctival pallor of anemia.
- Inspect the mouth for evidence of acid erosion on his teeth and smell of halitosis.

- Palpate for cervical lymphadenopathy and goiter of hyperthyroidism.
- Examine the chest for evidence of cardiovascular or respiratory disease.

INVESTIGATIONS

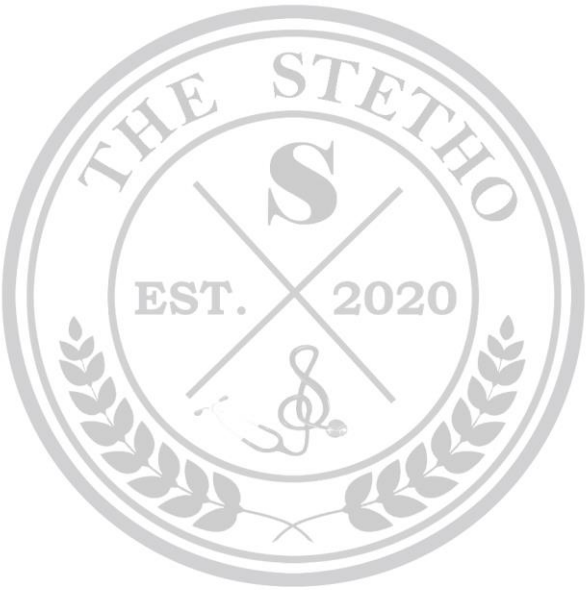
- Investigation is only needed in the presence of alarm symptoms or if they are frequent and severe or progressive.

MANAGEMENT

1. General measures should be the 1st line of treatment followed by drugs.

2. Dietary Interventions:
    - Small & Regular Meals
    - Reduce Fatty Foods
    - Eat early in the evening

3. Lifestyle Modifications:
    - Avoid Coffees and hot beverages
    - Raise the head during sleep
    - Exercise regularly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CASE 3

A 52 YEARS OLD WOMAN WITH UPPER ABDOMINAL DISCOMFORT

Scenario: A 57 Years Old banker presents with an 11-month history for on and off upper abdominal discomfort. It is progressively worsening in nature. The patient is worried if she has cancer.

HISTORY

1. Take full history of Abdominal discomfort:
    - Character, Location, Intensity, Severity, Radiation, Frequency & Associated Factors.

2. Specific aggravating factors:
    - Eating, Nocturnal Symptoms (reflux), bending/stooping (reflux) and exertion (cardiac).

    - Specific relieving factors include food (peptic ulcer), milk and antacids (reflux, ulcer and non-ulcer dyspepsia).

PHYSICAL EXAM

- Check for anemia.
- Check for weight change.
- Feel for lymphadenopathy, especially supraclavicular lymph nodes of gastric carcinoma (Virchow's node).

INVESTIGATIONS

1. Blood Tests:
    - Complete Blood Count

- Liver Function Tests
- C Reactive Protein

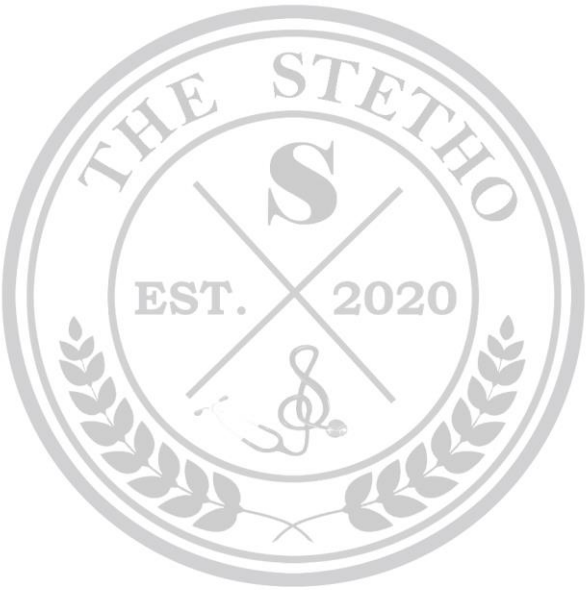
2. Radiological Investigations:
    - Abdominal Ultrasound
    - Barium meal
    - Upper endoscopy

MANAGEMENT

1. General measures should be the 1st line of treatment followed by drugs.

2. Dietary Interventions:
    - Small & Regular Meals
    - Reduce Fatty Foods
    - Eat early in the evening

3. Lifestyle Modifications:
    - Avoid Coffees and hot beverages
    - Raise the head during sleep
    - Exercise regularly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CASE 4

A 40 YEARS OLD MAN WITH UPPER ABDOMINAL DISCOMFORT & HEART BURN

Scenario: A 36 Years old driver who comes to you complaining of upper abdominal discomfort for the last few weeks. This time the symptoms are severe. He is at your clinic for further workup and evaluation.

HISTORY

It is important to differentiate signs and symptoms of dyspepsia from cardiac, respiratory or musculoskeletal illnesses.

- Any relation with eating?
- Are the symptoms related to exertion?
- Are the symptoms worsened on movement?

PHYSICAL EXAM

1. General examination: Examination is important to look for signs of serious gastrointestinal pathology.

- Check for anemia.
- Check for weight change.
- Feel for lymphadenopathy, especially supraclavicular lymph nodes of gastric carcinoma (Virchow's node).

2. Abdominal examination:

- Erythema Ab Igne (EAI): The presence of skin discoloration from the use of a hot-water bottle to relieve pain.
- Abdominal Mass.
- Abdominal tenderness in any of the Abdominal Quadrants.
- Auscultation for a 'succussion splash' suggestive of outlet obstruction.

INVESTIGATIONS

1. Blood Tests:
    - Complete Blood Count
    - Liver Function Tests
    - C Reactive Protein

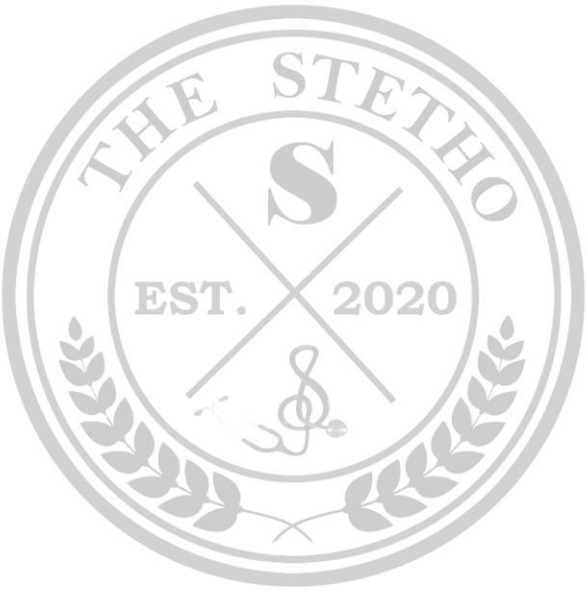
2. Radiological Investigations:
    - Abdominal Ultrasound
    - Barium meal
    - Upper endoscopy
    - Histology

3. Non-invasive tests

- 13C urea breath test
- Serology: Circulating antibodies to H. Pylori.
- Stool antigen enzyme immunoassay

MANAGEMENT

Helicobacter Pylori infection can be readily eradicated with a combination of antibiotics and acid suppressants. Many treatment regimens have been devised. Most recommend treatment for 7–14 days. Eradication failure is usually due to poor compliance.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CASE 5

A 30 YEARS OLD MAN WITH NAUSEA & VOMITING

HISTORY

Detailed history of Nausea and Vomiting.

Apply the ODIPARA (Onset, Duration, Intensity, Progression, Aggravating Factor, Relieving Factors &Anything Else???) Mnemonic.

For any fluid that comes out of the body ask the following questions: Color, Stained, Blood and amount.

PHYSICAL EXAM

1. General examination: Look for signs of dehydration such as dry mucus membranes.

- Eating, Nocturnal Symptoms (reflux), bending/stooping (reflux) and exertion (cardiac).
- loss. Does she look malnourished?

2. Abdominal examination: Look for visible peristalsis. Can you elicit a gastric succussion splash of obstruction?

- Abdominal Mass.

- Abdominal tenderness in any of the Abdominal Quadrants.
- Auscultation for a 'succussion splash' suggestive of outlet obstruction.

INVESTIGATIONS

1. Blood Tests:
    - Complete Blood Count
    - Liver Function Tests
    - C Reactive Protein

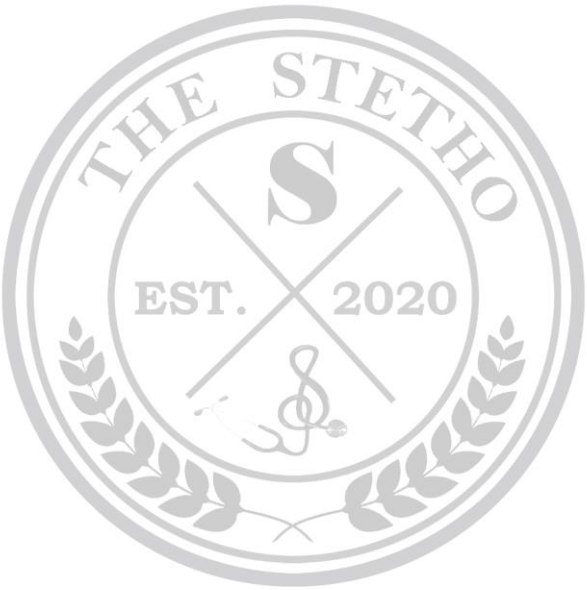
2. Radiological Investigations:
    - Abdominal Ultrasound
    - Upper endoscopy

MANAGEMENT

1. Specific Rx:
    - Give an antacid medication for symptomatic reflux and dyspepsia.
    - A trial of omeprazole 20–40 mg daily, with Gaviscon as needed.

- This should be started after the endoscopy (or discontinued for 1 week prior to endoscopy to get a representative H. pylori test

2. Supportive Rx: To replace fluid and electrolyte losses, preferably oral rehydration sachets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CASE 6

A 70 YEARS OLD MAN WITH FATIGUE, WEIGHT LOSS AND ALTERED BOWEL HABIT

Scenario: A 70 Years old man has been referred to your outpatient clinic complaining of weakness, and general malaise. The symptoms have persisted and aggravated. He describes loose bowel motions for the last few months and has lost 10 kg in weight

HISTORY

1. Fatigue: Apply the ODIPARA (Onset, Duration, Intensity, Progression, Aggravating Factor, Relieving Factors &Anything Else???) Mnemonic.

2. Weight Loss: How much has occurred and over how long? An associated loss of appetite is important.

3. Diarrhea: Apply the ODIPARA (Onset, Duration, Intensity, Progression, Aggravating Factor, Relieving Factors &Anything Else???) Mnemonic.

- For any fluid that comes out of the body ask the following questions: Color, Stained, Blood and amount.

PHYSICAL EXAM

1. General examination: Look for signs of dehydration such as dry mucus membranes.

- Eating, Nocturnal Symptoms (reflux), bending/stooping (reflux) and exertion (cardiac).
- loss. Does she look malnourished?

2. Abdominal examination: Look for visible peristalsis. Can you elicit a gastric succussion splash of obstruction?

- Abdominal Mass.
- Abdominal tenderness in any of the Abdominal Quadrants.
- Auscultation for a 'succussion splash' suggestive of outlet obstruction.

INVESTIGATIONS

1. Blood Tests:

- Complete Blood Count
- Liver Function Tests
- C Reactive Protein
- serology

2. Radiological Investigations:

- Abdominal Ultrasound
- Upper endoscopy

- Histology

DIFFERENTIALS

Coeliac disease.
Chronic pancreatitis and pancreatic insufficiency.
Colorectal cancer.
Inflammatory bowel disease, especially Crohn's disease.
Small bowel bacterial overgrowth.
Bile salt malabsorption.

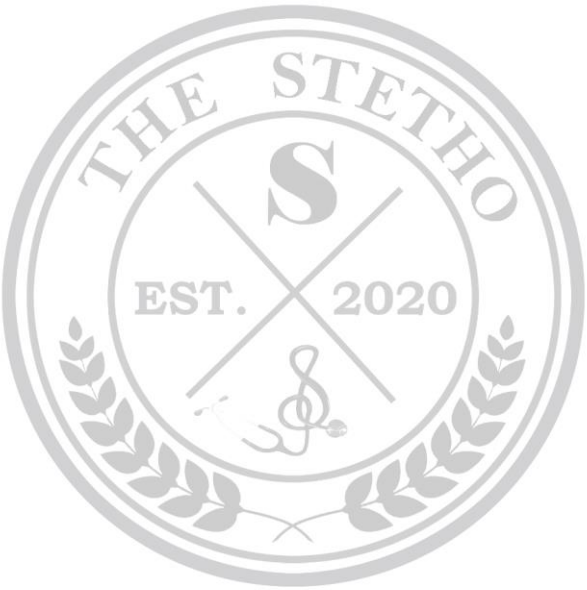
MANAGEMENT

A gluten-free diet is currently the only treatment for coeliac disease. You should arrange a consultation with a dietician to discuss the components of a gluten free diet and the importance of strict adherence.

- Serology should be rechecked to confirm response after 3–6 months. Some clinicians advocate repeat endoscopy and biopsy to ensure histological resolution of the disease with reversal of

villous atrophy. However, histology can take up to 12 months to resolve.

- If symptoms suggest intolerance to milk products, a lactose breath test should be done. Fifty percent of patients have secondary hypolactasia at diagnosis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CASE 7

A 30 YEARS OLD WOMAN WITH CHRONIC DIARRHEA

Scenario: A 30 Years old has had an increased frequency of bowel opening, up to five times a day, abdominal pain and general malaise for the last 6 months. The symptoms are aggravating and she seems concerned. She is now at your clinic for further evaluation

HISTORY

1. Diarrhea: Apply the ODIPARA (Onset, Duration, Intensity, Progression, Aggravating Factor, Relieving Factors &Anything Else???) Mnemonic.

- For any fluid that comes out of the body ask the following questions: Color, Stained, Blood and amount.

PHYSICAL EXAM

1. General examination: Look for signs of dehydration such as dry mucus membranes.

- Eating, Nocturnal Symptoms (reflux), bending/stooping (reflux) and exertion (cardiac).
- loss. Does she look malnourished?
- Check for anemia.
- Check for weight change.
- Feel for lymphadenopathy, especially supraclavicular lymph nodes of gastric carcinoma (Virchow's node).

2. Abdominal examination:

- Feel for palpable masses such as an inflamed terminal ileum and caecum in Crohn's disease, or a thickened loop of distal colon in ulcerative colitis.
- Feel for organomegaly
- Anorectal examination
- Digital rectal examination and proctoscopy can reveal anal fissures, hemorrhoids and anal or distal rectal cancer.

INVESTIGATIONS

1. Stool chart: document the frequency and consistency of the stool, and the presence of blood in the stool.

- Macroscopic examination: determine if there is blood or mucus in the stool.
-
- Microscopic examination: look for traces of blood and excessive numbers of inflammatory (white blood) cells.

- Stool culture: to detect bacterial pathogens such as Salmonella.

2. Standard blood tests:
    - Complete Blood Count
    - Liver Function Tests
    - C Reactive Protein
    - serology

3. Specialized blood tests:
    - Anti-S. cerevisiae antibody (ASCA)
    - Antibodies to gliadin peptides (anti endomysial antibody)
    - Anti-tissue transglutaminase (anti-tTG antibody)

4. Radiological Investigations:
    - Abdominal Ultrasound
    - Upper endoscopy with Biopsy
    - Colonoscopy with biopsy
    - Histology
    - Plain abdominal radiographs
    - Barium Meal and follow-through

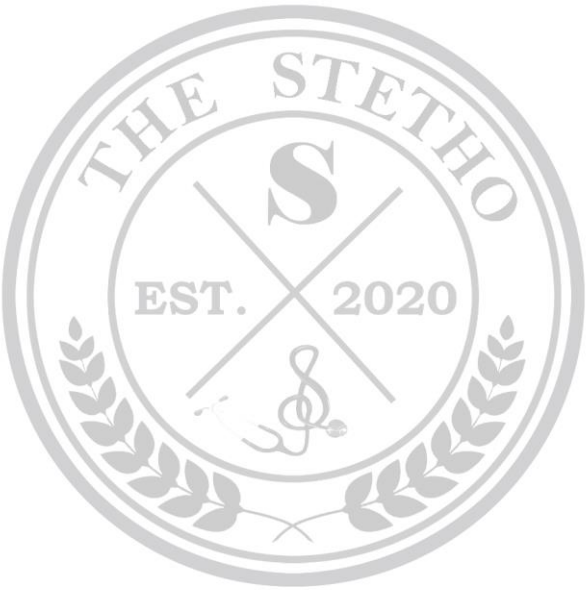
- CT and magnetic resonance imaging (MRI) scanning

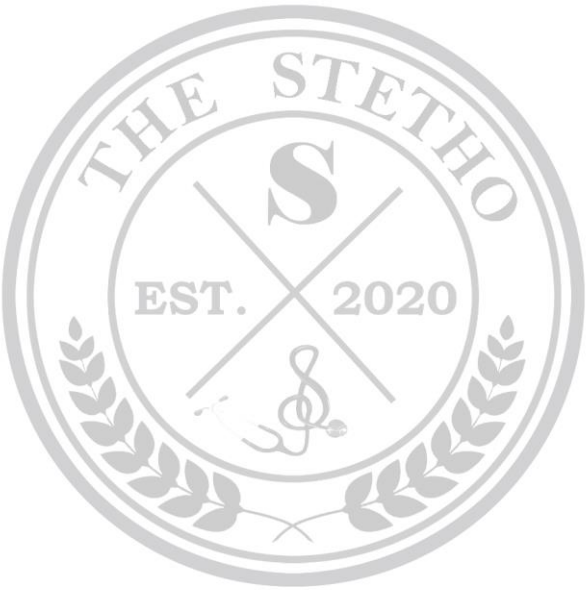
MANAGEMENT

The modern day IBD treatment is targeted at concealing safe reaction towards so far unknown antigens, and customary treatment that includes 5-aminosalicylic acid (5-ASA), thiopurines, corticosteroids and methotrexate. Although a complete cure for IBD is not yet available but ongoing revelations in the field of neurosciences and immunology have uncovered that signals in the fringe sensory system direct irritation, including levels of TNF-α show promising results. Clinical examinations utilizing vagus nerve embedded triggers for IBD treatment show empowering results. As needs be, the reflex control (neural) of aggravation is developing as a possible remedial objective in treating IBD. Here, we audit available and current treatment choices. These include the use 5-ASA, Glucocorticosteroids, Methotrexate and Thiopurines

- Stop smoking
- 5-Aminosalicylates

- Corticosteroids
- Thiopurines
- Biological agents
- Surgery

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CASE 8

A 45 YEARS OLD MAN WITH RECTAL BLEEDING

Scenario: A 45 Years old man visits your outpatient clinic because of persistent rectal bleeding. The bleeding has progressively increased and worsened. The patient is worried if he has cancer. He is here for further evaluation and management.

HISTORY

1. Bleeding: Apply the ODIPARA (Onset, Duration, Intensity, Progression, Aggravating Factor, Relieving Factors &Anything Else???) Mnemonic.

- For any fluid that comes out of the body ask the following questions: Color, Stained, Blood (dark or fresh) and amount.

PHYSICAL EXAM

1. General examination: Look for signs of dehydration such as dry mucus membranes.

- Eating, Nocturnal Symptoms (reflux), bending/stooping (reflux) and exertion (cardiac).
- loss. Does he look malnourished?
- Check for anemia.
- Check for weight change.

- Feel for lymphadenopathy, especially supraclavicular lymph nodes of gastric carcinoma (Virchow's node).

2. Abdominal examination:
    - Feel for palpable masses such as an inflamed terminal ileum and caecum in Crohn's disease, or a thickened loop of distal colon in ulcerative colitis.
    - Feel for organomegaly

3. Digital Rectal Examination: This is must in any patient with a back-passage bleed.

4. Proctoscopy: Digital rectal examination and proctoscopy can reveal anal fissures, hemorrhoids and anal or distal rectal cancer.

INVESTIGATIONS

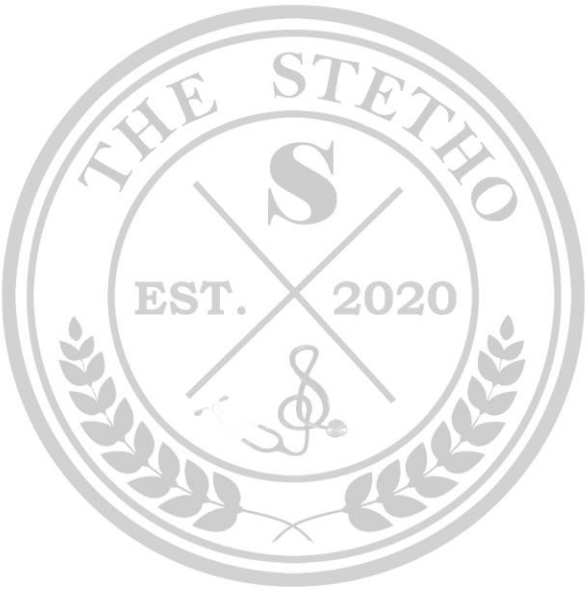
1. Standard blood tests:
    - Complete Blood Count
    - Liver Function Tests
    - C Reactive Protein

4. Radiological Investigations:
    - Abdominal Ultrasound
    - Upper endoscopy
    - Plain abdominal radiographs

MANAGEMENT

1. Hemorrhoids:
    - High Fiber Diet, Laxatives and increased Fluid Intake.
    - Photocoagulation & Injection Sclerotherapy.
    - Hemorrhoidectomy

2. Diverticular disease
    - High Fiber Diet, Laxatives and increased Fluid Intake.
    - Antispasmodics such as mebeverine 135 mg three times per day, peppermint oil 2 capsules three times per day and hyoscine 10–20 mg may help episodes of abdominal cramps.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CASE 9

A 30 YEARS OLD MAN WITH CONSTIPATION

Scenario: A 30 Years old visits your clinic for severe constipation. He feels bloated, has abdominal pain and has gained weight. He has tried home remedies with no improvement. He is here for further evaluation and checkup

HISTORY

1. Constipation: Apply the ODIPARA (Onset, Duration, Intensity, Progression, Aggravating Factor, Relieving Factors &Anything Else???) Mnemonic.

- For any fluid that comes out of the body ask the following questions: Color, Stained, Blood (dark or fresh) stained or not and frequency

PHYSICAL EXAM

1. General examination: Look for signs of dehydration such as dry mucus membranes.

- Eating, Nocturnal Symptoms (reflux), bending/stooping (reflux) and exertion (cardiac).
- loss. Does she look malnourished?
- Check for anemia.
- Check for weight change.

- Feel for lymphadenopathy, especially supraclavicular lymph nodes of gastric carcinoma (Virchow's node).

2. Abdominal examination:
    - Feel for palpable masses
    - Feel for organomegaly

3. Digital Rectal Examination

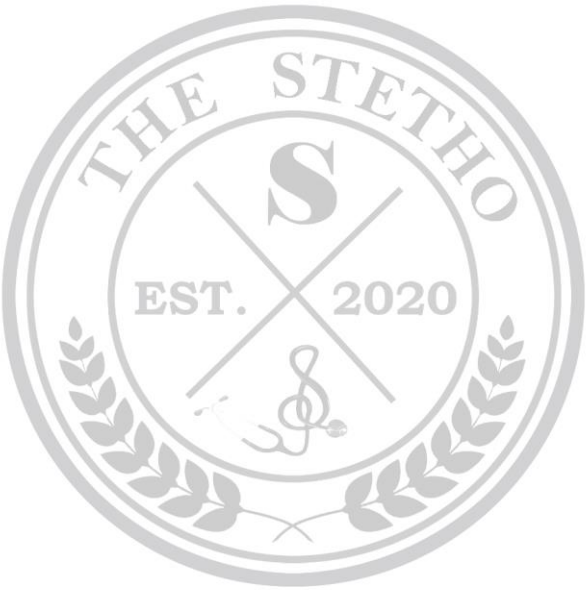
INVESTIGATIONS

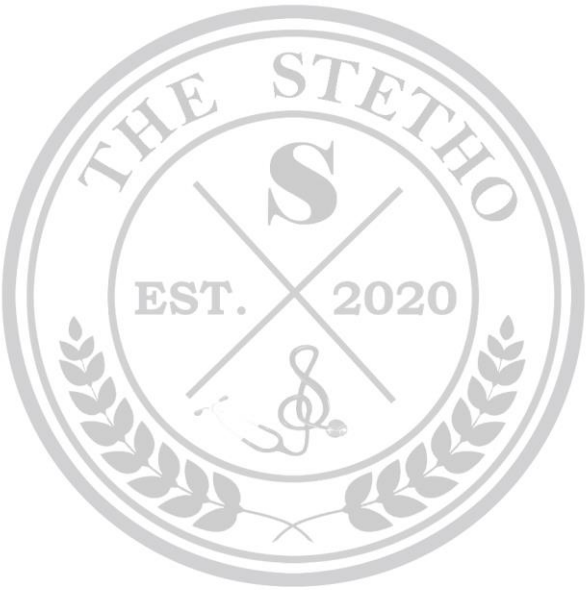
1. Standard blood tests:
    - Complete Blood Count
    - Liver Function Tests
    - Serum Electrolytes

2. Radiological Investigations:
    - Abdominal Ultrasound
    - Flexile Sigmoidoscopy
    - Plain abdominal radiographs
    - Histology
3. Urine Investigations:
    - Beta HCG

MANAGEMENT

- High Fiber Diet, Laxatives and increased Fluid Intake.
- Correct Electrolyte Imbalance (if present)

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MULTIPLE CHOICE QUESTIONS

1. Regarding patients with upper GI bleeds which is incorrect?

A. Use of NSAIDs doubles the risk for an upper GI bleed
B. Urea will increase relative to creatinine in acute bleed
C. Presence of fresh blood on aspiration of NG tube increases mortality as opposed to a clear aspirate.
D. Active bleeding seen at endoscopy has a 10% risk of rebleeding after treatment.
E. Most deaths occur from decompensation of other organ systems rather than exsanguination.

2. Which of the following therapies is proven to reduce mortality and morbidity in bleeding peptic ulcers?

A. Endoscopic procedures
B. H2 antagonists
C. Proton pump inhibitors
D. Octreotide
E. Antacids

3. Which is not true of bleeding esophageal varices?

A. Mortality approaches 25-40%
B. Use of octreotide IV is as effective as sclerotherapy controlling bleeding in 74-92% of cases.
C. Sclerotherapy has a high rate of complications (40%) including perforation, aspiration, pyrexia, chest pain, ulcers and strictures.
D. Endoscopic variceal ligation is as effective as sclerotherapy with fewer side effects.
E. Use of the sengstaken-blackmore tube is effective in controlling severe bleeding, is easy to insert and has almost no complications.

4. Which is the most common cause of lower GI bleed under 50 years of age?

A. Anal fissures
B. Benign polyps
C. Haemorrhoids
D. Inflammatory bowel disease
E. Diverticulosis

5. Which is not a characteristic of diverticulosis?

A. Acquired defects in bowel wall
B. More common in distal colon
C. Bleeding usually intermittent
D. Significant bleeding usually arises from right side of colon
E. Occur at point of entry nutrient vessel

6. A 55-year-old woman presents with intermittent bright red PR bleeding. On examination she is stable, and PR shows small external haemorrhoid. What is appropriate treatment for this lady?

A. Reassure, prescribe treatment for haemorrhoids
B. Refer to surgeons for elective haemorrhoidectomy
C. Prescribe treatment for haemorrhoids, and arrange outpatient colonoscopy with surgical follow-up.
D. No further treatment necessary.
E. Admit to hospital for colonoscopy or double contrast barium enema.

7. Which is not a predisposing factor for GORD?

A. High fatty food intake
B. Cholinergic drugs
C. Caffeine
D. Nicotine
E. Gastric outlet obstruction

8. Which is the most common cause of esophageal perforation?

A. Iatrogenic causes
B. Trauma
C. Boerhaave's syndrome
D. Foreign body
E. Tumour

9. Which of the following FB's needs to be removed as an emergency?

A. 50 cent coin in the stomach
B. 50 cent coin in the oesophagus
C. lithium button battery in stomach
D. lithium button battery in oesophagus
E. 5 grams of cocaine in condom sitting in small intestine

10. Which is incorrect of swallowed foreign bodies?

A. 80% occur in children
B. 97% of adults with distal meat impactions have pathological conditions so all need Barium swallow studies.
C. The most common area for FB's to be found in children is at the cricopharyngeal narrowing (C6).
D. Glucagon is used to relax smooth muscle but is contraindicated in phaeochromocytoma.
E. Carbonated drinks can be used safely in upper esophageal obstructions to try and dilate esophagus to allow FB to pass.

11. Which is the most common cause of peptic ulcer disease of the following?

A. Smoking
B. NSAID's
C. Zollinger-Ellison syndrome
D. Ethanol excess
E. Family hx of PUD

12. Which is not true of H. Pylori infection?

A. 80% of patients with chronic infection will develop ulcers
B. the most common cause of peptic ulcer disease
C. it is a risk factor for adenocarcinoma of the stomach
D. IgG antibody test will remain positive for up to 2 years post eradication limiting its usefulness
E. The CLO test is approx. 90% sensitive and 100% specific for H. Pylori

13. Which is not correct regarding treatment of peptic ulcer disease?

A. Antacids are as effective as H2 antagonists in healing ulcers
B. Proton pump inhibitors show more rapid healing and pain relief over 2-4 weeks compared to H2 antagonists.
C. Colloidal bismuth sub citrate will suppress H. Pylori and chelate with the base of the ulcer to aid healing.
D. H. Pylori eradication with omeprazole, Amoxil and metronidazole requires only one week of treatment.

14. Misoprostol is indicated for prevention of NSAID induced ulcers, when treatment necessary with NSAID's.

A. Which is the most common complication of Peptic ulcer disease?
B. Perforation
C. Gastric outlet obstruction
D. Penetration
E. Haemorrhage
F. All are uncommon occurring in less than 5% of patients.

15. Which is incorrect regarding acute appendicitis?

A. Between 50-75% of patients present with the classical symptoms and signs of acute appendicitis.
B. Presence of a good appetite makes appendicitis unlikely
C. Rovsings sign may be helpful in diagnosis especially in obese patients
D. PR tenderness is seen in 90% of patients with acute appendicitis
E. Vomiting prior to onset of pain makes appendicitis unlikely

16. Which is incorrect regarding investigation of acute appendicitis?

A. The WCC is increased in 70-90% of patients.
B. CRP will usually be normal in early appendicitis
C. USS is operator dependant but has sensitivity of around 80-90%.
D. USS sensitivity is lowered to around 30% in cases of gangrenous and perforated appendicitis.
E. CT is the investigation of choice in children due to lower sensitivity in this group with USS.

17. Which is the least common cause of large bowel obstruction?

A. Neoplasm
B. Diverticulitis
C. Volvulus
D. Adhesions
E. Faecal impaction

18. Which of the following features suggests a complete large bowel obstruction?

A. Presence of multiple loops of bowel with plicae circularis on AXR
B. Bilious vomiting
C. Distended abdomen, with high pitched bowel sounds with normal flatus.
D. Empty rectum on PR exam
E. Dilated loops of bowel with haustra visible

19. What is the upper limit of normal for large bowel?

A. 3cm
B. 4cm
C. 5cm
D. 6cm
E. 10cm

20. A 50-year-old women presents with small bowel obstruction, and on examination has a hard-tender mass lateral and inferior to symphysis pubis. What is this most likely to be?

A. direct inguinal hernia
B. indirect inguinal hernia
C. femoral hernia

D. obturator hernia
E. spigelian hernia

21. Which of the following hernia is most likely to incarcerate and strangulate?

A. Congenital umbilical hernia
B. Spigelian hernia
C. Direct inguinal hernia
D. Sportsman hernia
E. Indirect inguinal hernia

22. Which is incorrect regarding inflammatory bowel disease?

A. The risk of developing ulcerative colitis is higher in non-smokers than smokers.
B. Patients with Crohn's disease are more at risk of colorectal cancer than UC patients.
C. Effectiveness of colonoscopy surveillance in detecting colorectal cancer is controversial in IBD.
D. Toxic megacolon occurs in Crohn's and ulcerative colitis.
E. Cobblestone appearance on bowel wall is more characteristic of Crohn disease

23. Which is not an extra-abdominal manifestation of inflammatory bowel disease?

A. Erythema marginatum
B. Ankylosing spondylitis
C. Episcleritis
D. Thromboembolic disease
E. Sacroiliitis

24. Which is true of the complications of Crohn's disease?

A. Perianal complications occur in 50% of patients.
B. GI bleeding is common and often life-threatening
C. Toxic megacolon occurs in 6% but almost never perforates.
D. There is no increased risk of neoplasm of GI tract unlike UC.
E. The majority of patients will not require surgery throughout their illness.

25. Which is incorrect regarding management of Crohn's Disease?

A. Mesalamine (pentasa) has fewer side effects than sulphasalazine.

B. Azathioprine has been used in severe cases.
C. Metronidazole has a role in long-term treatment of perianal disease postoperatively to prevent relapse.
D. Corticosteroids have a proven role in maintenance therapy to prevent relapse.
E. Loperamide can be used to control diarrhoea.

26. Which is INCORRECT regarding Ulcerative Colitis?

A. Affects men more than woman
B. Mild disease affects 60% of patients and consists of less than 4 bowel motions per day, with the disease limited to rectum in 80%.
C. In severe disease there is usually hypoalbuminemia and mildly deranged LFT's.
D. Loperamide and other antidiarrheal agents should be avoided as they increase the risk of toxic megacolon.
E. Toxic megacolon is usually treated conservatively unless the bowel is wider than 6 cm or the patient severely ill.

27. Which is not true of pseudomembranous colitis?

A. Usually occurs following a course of antibiotic treatment.
B. Approx. 25% will resolve with supportive treatment only.
C. Vancomycin is the treatment of choice
D. The ELISA C. difficile toxin test is 60-90% sensitive
E. It may rarely result in toxic megacolon and perforation.

28. Which is not true of diverticulitis?

A. Occurs in 10-25% of patients with diverticula
B. Mostly occurs in the left side of the colon
C. Urinary frequency, pyuria and dysuria is not uncommon
D. Sigmoidoscopy is the best diagnostic tool at time of presentation.
E. Mild cases can be treated as outpatients with oral Amoxil plus clavulanic acid for 7 days.

29. Which is not true of hemorrhoids?

A. Portal venous hypertension can cause enlarged external haemorrhoids
B. Third degree are permanently prolapsed to some degree
C. Thrombosed external haemorrhoids can usually be excised under local anaesthetic.
D. Blood mixed in with the stool raises the possibility of other diagnoses like carcinoma.
E. Internal haemorrhoids occur proximal to the dentate line.

30. Which is true regarding these anorectal disorders?

A. Anal fissures usually occur on the anterior wall medially and any fissure outside of this area raises suspicion for other pathology.
B. Glycerol trinitrate ointment has been used with success in anal fissures.
C. Perianal abscess is usually located in the natal cleft in the midline.
D. Ischiorectal abscesses are usually very obvious on examination of the perineum with fluctuant abscess lateral to anus.

E. Anal fistulae are most commonly secondary to Crohn's disease.

31. Which of the following is not true regarding antiemetics?

A. There is a 1% incidence of dystonic reactions with metoclopramide.
B. Prochlorperazine is a category A drug in pregnancy.
C. Droperidol is from the butyrophenome family.
D. Warm flushing and headache are among the most common side effects of ondansetron.
E. Promethazine is relatively contraindicated in children less than 2 yrs.

32. Which is not true regarding diarrhea?

A. Wright's stain detects faecal leucocytes
B. C. Difficle toxin test is a rapid assay available within 2 hours.
C. Ciprofloxacin 500mg BD for 7 days has shown to shorten the duration of infectious diarrhoea secondary to bacteria.
D. Patients with acute diarrhoea should avoid caffeine.

E. Loperamide is not harmful to use in a patient with Salmonella gastroenteritis.

33. Which is not a cause of unconjugated hyperbilirubinemia?

A. Sepsis
B. Gilberts syndrome
C. Congestive cardiac failure
D. Prematurity neonates
E. Infectious mononucleosis

34. Which is not a risk factor for gallstones?

A. Cystic fibrosis
B. Congestive cardiac failure
C. Familial tendency
D. Diabetes
E. Pregnancy

35. Which is incorrect regarding biliary tract disease?

A. Pigment stones are more radio-opaque than cholesterol stones.
B. Bacterial infection occurs in 50-80% of patients with cholecystitis.

C. Murphies sign is 97% sensitive for cholecystitis.
D. CT is as sensitive as USS for detecting gallstones.
E. The classic Charcot's triad is present in only 25% of patients with cholangitis.

36. Which is not a cause of acute hepatitis?

A. Wilson's disease
B. Mushroom poisoning – amanita phalloides
C. Halothane
D. Ecstasy poisoning
E. Cytomegalovirus

37. Which is not correct regarding viral hepatitis?

A. Anti HAV IgG indicates past infection and immunity to Hep A.
B. Chronic hepatitis occurs in about 5% of patients infected with Hep B.
C. Anti HBc indicates immunity and recovery from Hep B.
D. Hep B immunoglobulin protects 75% of people exposed to Hep B if given within 7 days of exposure.
E. Patients with Hep B have approx. 15% risk of transmission with sexual contacts.

38. Which is NOT a complication of hepatic cirrhosis?

A. Spontaneous bacterial peritonitis.
B. Hepatocellular carcinoma.
C. Thrombocytosis.
D. Portal hypertension.
E. Portal vein thrombosis.

39. Which is incorrect regarding LFT's?

A. Normally conjugated bilirubin makes up 70% of the total bilirubin.
B. ALT is a more specific marker of hepatocellular dysfunction than AST.
C. AST: ALT ratio of greater than 2 is common in alcoholic hepatitis.
D. Isolated elevation of ALP may be seen in primary biliary cirrhosis and sclerosing cholangitis.
E. Elevated ammonia levels do not correlate with worsening hepatic function in cirrhosis.

40. Which statement regarding spontaneous bacterial peritonitis is incorrect?

A. The yearly risk with ascites is about 30%.
B. Diagnosis is confirmed by paracentesis with WBC > 1000/ cubic mm, and PMN > 250/ cubic mm.
C. Bacterial are rarely grown from ascitic fluid.
D. The most common bacteria are anaerobes.
E. Antibiotic choices include cefotaxime or ceftriaxone 2g/day.

41. Which is true of hepatic encephalopathy?

A. It only occurs in chronic hepatic failure.
B. Stage 3 consists of drowsiness and asterixis.
C. Can be due to cerebral oedema as well as accumulation of toxic wastes.
D. Lactulose use is now been shown to be the treatment of choice.
E. Ammonia levels can be used as an index of encephalopathy.

42. Which is not true of acute liver failure?

A. Use of N-acetyl cysteine has been shown to reduce mortality up to 36 hrs post ingestion.
B. Hypotension is usually treated with dobutamine as it is due to cardiac suppression.
C. Mortality is higher in acute liver failure due to Hepatitis B than Hep A.
D. Mortality from paracetamol acute liver failure is higher if the patient is acidotic.
E. Encephalopathy can be managed by dietary protein withdrawal initially.

43. Which is not true of pancreatitis?

A. Alcohol is the most common cause.
B. Pain is usually severe and relieved by sitting forward.
C. Cullen's sign is blue discolouration around umbilicus secondary to hemoperitoneum.
D. Amylase is less sensitive in alcoholic pancreatitis than gallstone pancreatitis.
E. CT will be abnormal in the vast majority including mild disease.

44. Which is not part of Ranson's criteria at initial presentation?

A. Calcium < 1.9 mm/l
B. Age >55
C. WCC >16 000.
D. LDH > 400 IU
E. Glucose > 11 mmol/l

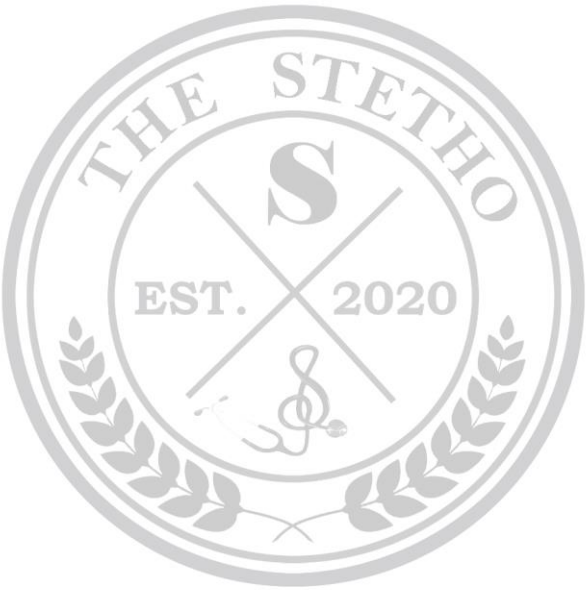
45. Which number of Ranson's criteria fits with predicted mortality?

A. 1-2 risk factors - 5% mortality
B. 3-4 risk factors – 16% mortality
C. 5-6 risk factors – 50% mortality
D. 6 risk factors – 90% mortality
E. All of the above are correct.

46. Which is not true of pancreatitis?

A. Pancreatic necrosis is often seen on CT and may result in pancreatic insufficiency.
B. Most of the mortality is secondary to systemic effects.
C. Choledocholithiasis does not cause chronic pancreatitis.

D. Abdominal pain associated with chronic pancreatitis improves with progression of the disease.
E. Serum lipase and amylase are usually normal in acute bouts of chronic pancreatitis.



KEY

1. D	9. D	17. D
2. A	10. E	18. E
3. E	11. B	19. C
4. C	12. A	20. C
5. C	13. D	21. E
6. C	14. D	22. B
7. B	15. D	23. A
8. A	16. E	24. C

25. D
26. E
27. C
28. D
29. A
30. B
31. B
32. B
33. E
34. B
35. D
36. A
37. C
38. C
39. A
40. D
41. C
42. B
43. E
44. A
45. B
46. D