INSTITUTE OF INDIGENOUS MEDICINE, UNIVERSITY OF COLOMBO, RAJAGIRIYA

BUMS LEVEL IV – FIRST SEMESTER EXAMINATION – OCTOBER 2015

PRINCIPLES OF CLINICAL MEDICINE –I

COURSE CODE - AS 4104

Time: 2 1/2 hours
9.45. a.m. – 12.15 p.m

Index no ☐

Answer all questions.

Part I - Structured Questions

01.

A 23 years old woman presents to her GP with a 1 month history of intermittent central abdominal pain. She also describes an increase in stool frequency such that 4 – 5 times each day, and always has loose stools. On further questioning the GP establishes that she has lost her weight about 5 kg over the last month. She has no significant past medical history or family history. On examination she has mild right iliac fossa tenderness but there is no guarding, rebound or percussion tenderness. The bowel sounds are normal.

a. What differential diagnosis would you consider at this point? **(1 mark)**

b. Given the pain in the RIF, is appendicitis a possibility here? **(0.5 marks)**

c. What initial tests would you arrange? **(0.5 marks)**

She was asked to return in a week for the results of the tests. The FBC and CRP are as follows, the remaining investigations were all reported as normal.

Hb	10.1g/dl (13 – 17)
WBC	14.3 X 10^9 /L (4 – 11)
Platelets	358 X 10^9 / L (150 – 400)
MCV	104.5 fL (80 – 100)
CRP	100mg/L (0 – 5)

d. What do the blood tests show? **(1 mark)**

e. What are the causes of macrocytic anemia? **(1 mark)**

She denies a history of alcohol excess and is not taking any medications, as we already seen, her thyroid function tests are normal.

f. Are there any other blood tests you would request at this point? **(0.5 marks)**

The GP starts her on oral vitamin B12 and refers to a gastroenterologist.

g. What are the investigations would gastroenterologist consider in this patient? **(1 mark)**

She is started on a course of oral prednisolone after his tests and given a 1 month follow up appointment to see him. However, 2 weeks later she presents to the A & E department with a 1 day history of severe RIF pain. Her temperature, CRP and WBC are all raised. An abdominal CT image shows a loop of small bowel with thickened wall and stenosed lumen.

h. What is your most probable diagnosis? **(0.5 marks)**

i. What are the extra intestinal manifestations could be associated with the above condition? **(2 marks)**

j. What are the treatment options available for this patient? **(2 marks)**

02.

(A)

a. What is Papilloedema? **(1 mark)**

b. What are the clinical features can be seen in a patient with papilloedema? **(2 marks)**

c. What are the clinical illness can cause paplloedema? **(2 marks)**

(B)

A 56 years old lady complained of a headache and difficulty with vision. The headache came on suddenly at night. It was constant, very severe, and bilateral and extended from the frontal region to the occiput. Soon after the headache began she vomited, and this made the pain worse. She noticed that her vision was abnormal the next morning: she tended to see double, and to see properly she had to keep her left eye closed. Her husband noticed that the left eye seemed a little turned out, and that the eye lid was drooping. Her doctor, who had been treating her with a diuretic for hypertension, advised her that it was probably a virus, but she felt no better the next day. At this stage she tried to walk but her back was painful and she could not bend down to pick anything up. Because her son was a doctor she telephoned him at his work, and he made the correct diagnosis from the above history.

a. What is the most likely diagnosis? **(0.5 marks)**

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b. What is the major cause for the above diagnosis? **(0.5 marks)**

c. What are the reasons for her eye problems? **(0.5 marks)**

d. Suggest the most important investigation in establishing your diagnosis? **(0.5 marks)**

e. What are the complications would you expect in this patient? **(1.5 marks)**

f. How do you plan to manage this patient? **(1.5 marks)**

Part II – Essay Questions

01.

A 26 years old civil servant, presented to her GP with a 1 month history of bilateral numbness in hands and feet, as well as fatigue and mild generalized motor weakness. She had noticed some blurred vision over the previous 2 weeks. On further questioning she admitted to experiencing similar but milder symptoms during the warm weather of the previous summer months.

1. What disease do these clinical features suggest?
2. What is the pathogenesis in the above condition?
3. What specific investigations would you request?
4. What are the areas of nervous system commonly affected in the above illness?
5. What are the diseases mimics the above illness in imaging?
6. What are the complications would you expect in this patient?
7. What therapeutic options available for this patient?

(20 marks)

02.

The patient was a 63 years old solicitor. He complained of a severe pain in the buttocks radiating down both legs associated with unsteadiness on his feet, a sensation of numbness and pins and needles in the feet, and a feeling of general weakness of the legs. These symptoms began suddenly 5 days before admission, and following the acute onset had got rather worse. There was nothing of relevance in his past history except attacks of "sciatica" 10 years previously.

On examination he was obese. There were no physical signs in the cardiovascular system, the respiratory system and abdomen. There was loss of cutaneous sensation over the buttocks, perineum and the back of the thighs, absent ankle jerks and weakness of planter flexion on the right was noted. The anal sphincter was patulous and anal reflex lost. Planter responses were flexor.

The urine contained no sugar. The chest x ray was normal rays of the spine showed sever osteoarthritis changes at L3 – L4 vertebra.

1. Where is the lesion in the nervous system?
2. What is the likely cause?
3. What is the X ray changes at L3 – L4 would you expect in this patient?
4. What other X ray examination would you like to see?
5. How do you manage this patient?

(20 marks)

03.

A 19-years-old man presented with acute swelling of his right knee and left ankle and extremely painful heels. On questioning, he admitted to a penile discharge and dysuria for 4 days. On examination, he had bilateral Achilles tendonitis and his right knee and left ankle were red, hot and tender. He had aphthous-like mouth ulcers and ulcers around the glans penis. There were no skin lesions and, in particular, no evidence of keratoderma blenorrhagica or subungual pustules.

1. What could be the most probable diagnosis?
2. What are the investigations would you request to confirm your diagnosis?
3. List out the complications which could occur in this patient if not treated properly?
4. How do you manage this patient?

(20 marks)

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17.11.2015