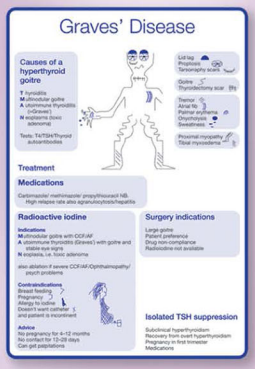
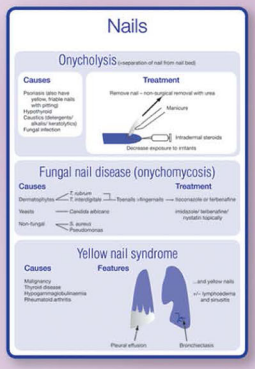
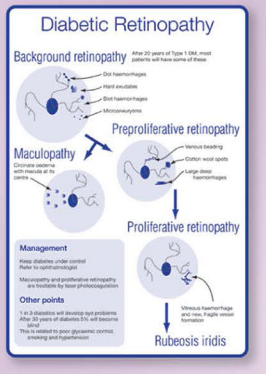
Master Pass

The Illustrated MRCP PACES Primer







Sebastian Zeki

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Contents

Preface

The MRCP PACES examination remains a rigorous assessment of a doctor's ability to diagnose and treat a variety of common and uncommon conditions. Candidates will have seen many of the conditions before but equally so, many will be unfamiliar. The examination requires an easy familiarity with all the conditions and as such the candidate is supposed to have quick access to the knowledge required for any case in PACES.

This book is an attempt to ease the burden of reading for the candidate so he or she can concentrate on actually making diagnoses and examining patients in preparation. The emphasis is on one page layouts for each of the conditions with an abundance of memory techniques to help the candidate remember as much detail as possible. These include visual as well as verbal mnemonics. Emphasis is taken away from basic sciences as they are not tested in this examination. The book is, in essence, what you actually need to know in as easy a layout as possible.

We'd be grateful to hear readers' comments, ideas for layout/pictures and especially mnemonics that can be added in future editions. All published mnemonics will receive an acknowledgement. Please send your comments to editorial@radcliffemed.com

Sebastian Zeki
April 2009

About the Author

Sebastian Zeki is a gastroenterology registrar in London. He was born in London, went to Westminster School and then attended medical school at Gonville and Caius College, Cambridge and University College London. He qualified in 2001, has gained further degrees in medical informatics and computing whilst a doctor, and gained membership to the Royal College of Physicians in 2005. He is still working on his artwork ...

Acknowledgements

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Damion Balmforth
Sophie Stevens.

Dedication

This book is dedicated to my mother and father and to Radha who spent a great deal of time laughing at the pictures ...

Abdominal System

Abdominal Masses
Ascites
Cirrhosis
Crohn's Disease
Haemochromatosis
Hepatomegaly
Primary Biliary Cirrhosis
Splenomegaly
Transplanted Kidney
Unilateral Palpable Kidney
Wilson's Disease

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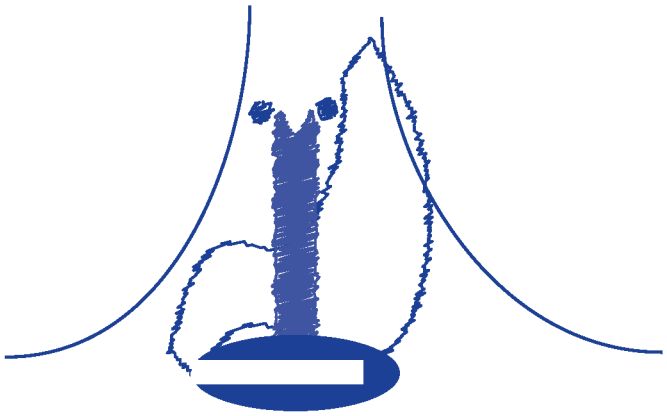
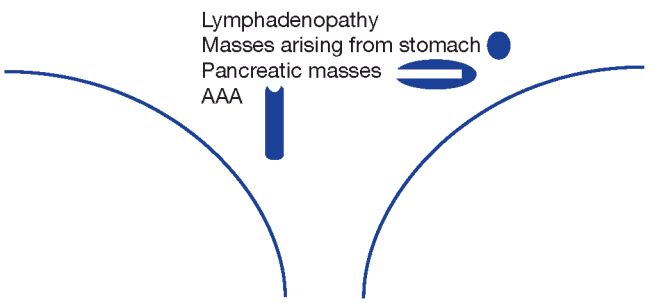
Abdominal Masses



Epigastric masses



Right iliac fossa mass

L ymph nodes
O vary (tumour)
C rohn's
C aecal cancer
C arcinoid
K idneys(transplanted or ectopic)
Amoebiasis

Actinomycosis
Abscesses (ileocaecal/ appendiceal)

Left iliac fossa mass

L ymph nodes
O varian cancer
C olonic – cancer
Diverticular abscess, faeces
K idney (transplanted)

Ascites

Causes

Cirrhosis

CCF

Cancer (primary/ secondary)

Nephrotic

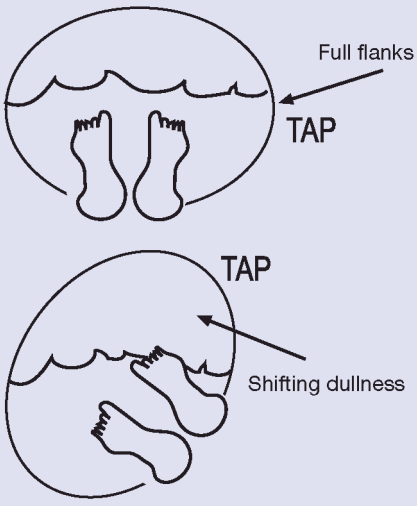
Constrictive pericarditis

TB

Budd–Chiari

NB: Separate into whether due to portal hypertension or not on the basis of the serum to ascites albumin gradient (SAAG) if >11 mmHg then due to PHTN the causes of which include cirrhosis/ Budd–Chiari, etc.

Features



Complications

Respiratory problems
Spontaneous bacterial peritonitis

Management of ascites

Diuretic responsive ascites

(NaFD)
Na: Sodium restriction (<88 mmol/day)
F: Fluid restriction (if Na <120)
D: Diuretics (spironolactone + frusemide)

Diuretic resistant ascites

Paracentesis + albumin
Peritoneovenous shunt (LeVeen shunt)
TIPPS
Extracorporeal ultrafiltration
Liver transplantation

Cirrhosis

= Fibrosis with abnormal regenerating nodules

Causes

Autoimmune (PBC/CAH)

a**L**pha1 antitrypsin

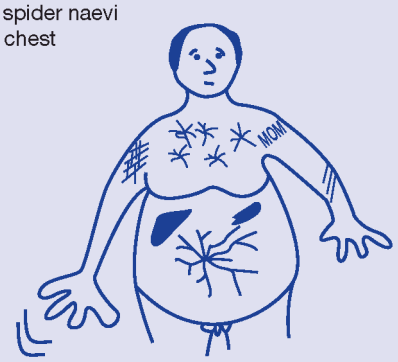
I atrogenic (methyldopa/ methotrexate/ amiodarone/ azathioprine)
Viral (Hep B)

Excess alcohol

R(haemoch**R**omatosis/ Wilson's)

Head

Jaundice
Encephalopathy
>5 spider naevi
chest



Investigations that everyone should get

Bloods: FBC/ LFT/ PT Hep B/ Auto-Ab aFP/ Ferritin
Fluids: Ascites
Radiology: Liver USS

Hand signs

Clubbing
Dupuytren's contracture
Flap
Tattoos
Excoriation marks

Abdomen

Hepatosplenomegaly (not always)
Caput medusae
Testicular atrophy
Ascites
Bruising

Complications

G lucose low
R enal failure
E ncephalopathy
A scites
T hypo**T**ension

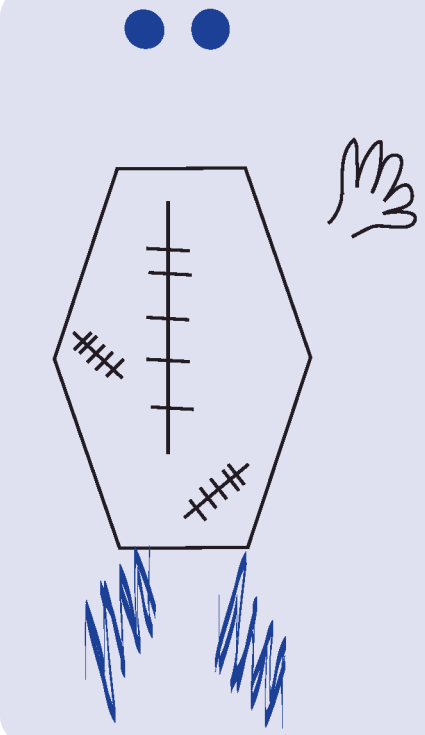
C oagulopathy
N utrition
G hypo**G**lycaemia
S epsis

TIPS

Once you have found chronic liver disease signs, you know this patient has cirrhosis – now find a cause – unkempt? (=EtOH), tattoos (=Hep B), massive hepatomegaly (+PBC). If there are no chronic liver disease signs, consider pre- (most likely in the exam) or post-hepatic causes of jaundice.

Pre-hepatic causes can be separated into congenital (haemoglobin defects, e.g. sickle cell, or membrane defects, etc.) or acquired.

Crohn's Disease



Features

Iritis

Clubbing

Multiple abdominal scars

Patient may be small (given steroids as a child)

Erythema nodosum

Pyoderma gangrenosum

Associations

Hepatobiliary: gallstones, steatosis
Eye: iritis, episcleritis
Signs of nutritional deficiencies, e.g. angular cheilosis (B12), anaemia, dermatitis (zinc)
Renal: oxalate stones

Investigations

Endoscopy
CT for abdominal masses
Barium follow through

Treatment

Metronidazole and ciprofloxacin
Elemental diet (controversial)
Steroids
Steroid-sparing agents (azathioprine/ methotrexate)
TNF-alpha antagonists

Haemochromatosis

Clinical manifestations

Liver disease (worse with Hep C and EtOH)
Hepatocellular carcinoma (increased x200)
Diabetes mellitus (selective for beta cell)
Arthropathy – (squared-off bone ends and hook-like osteophytes in the metacarpophalangeal (MCP) joints, particularly of the second and third MCP joints)
Heart disease (15% of HH)
Hypogonadism (usually pituitary origin)
Hypothyroidism (deposition in thyroid)
Extrahepatic cancer (controversial)
Susceptibility to specific infections (Listeria/ Yersinia (siderophage)/ *Vibrio vulnificus* (from uncooked seafood))
Manifestations in heterozygotes (rarely due to HH alone)

Secondary iron overload

Ineffective erythropoiesis (thalassaemia, aplastic anaemia, red cell aplasia, SCD)
Chronic liver disease
Excessive medicinal iron
Parenteral iron overload
Porphyria cutanea tarda

Investigations

Radiology
CT/MRI – liver is white/black respectively

Liver biopsy
To determine hepatic iron content

Familial things
Test all first degree relatives by PCR or HLA typing (A3)
- **Homozygote relative**
  12-monthly transferrin sats – venesect if more than 45%
- **Heterozygote relatives**
  Liver biopsies if LFTs abnormal.

Treatment

Bleed 1–2×/ week
Hct shouldn't fall >20% of previous level
Aim for ferritin between 25-50 nh/mL
Avoid Vit C/ uncooked seafood

Results

Improves everything except
- advanced cirrhosis
- arthropathy
- hypogonadism

Prognosis

Cardiac failure = bad sign
Survival normal if no diabetes/liver damage
If cirrhotic 70% 5-year survival
One-third of cirrhosis die from HCC