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Question: 79

A 54-year-old woman was referred for assessment of low bone mineral density. Three months previously, after complaining of bloating and flatulence, she had been found to have coeliac disease and had been started on a gluten-free diet. She had no history of fracture and had not lost height. There was no family history of osteoporosis. Her only medication was omeprazole.

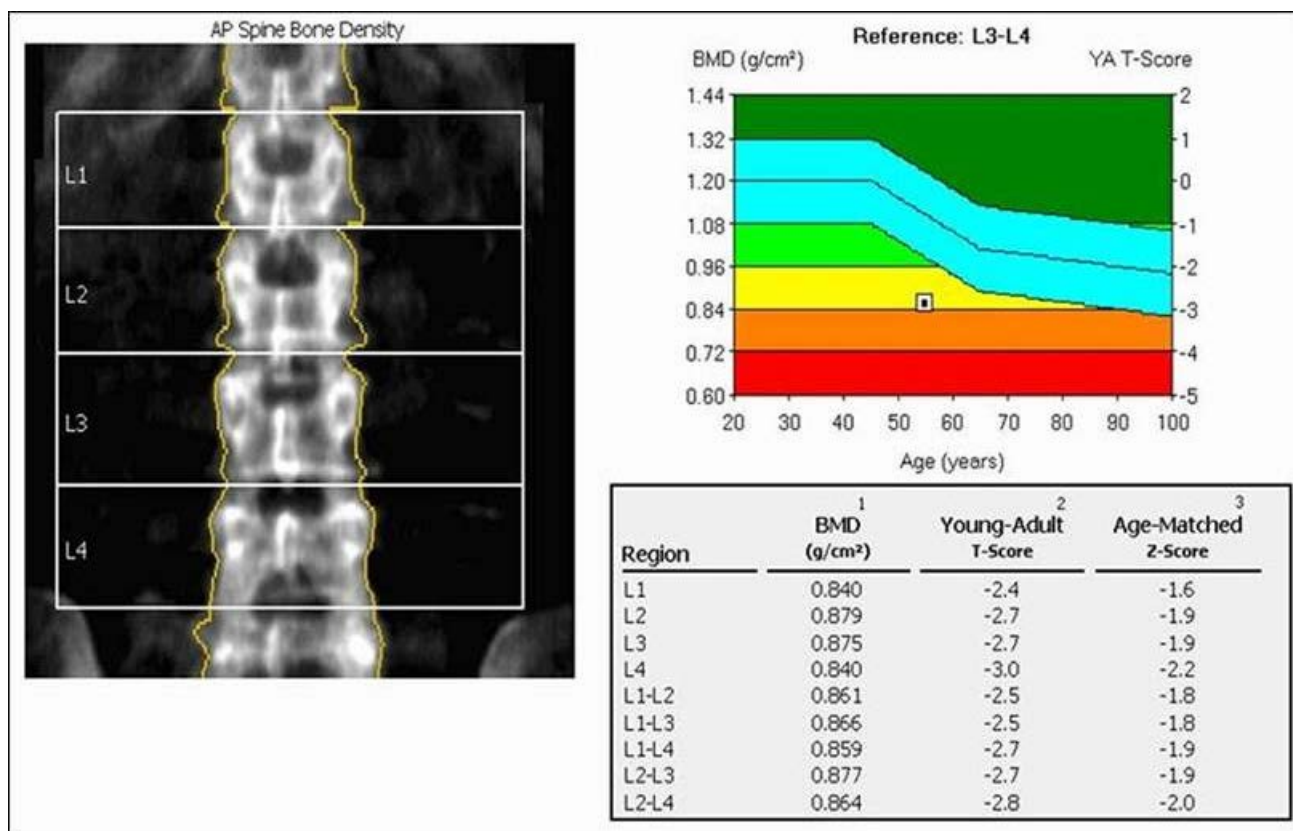
Investigations:

serum corrected calcium 2.42 mmol/L (2.20-2.60)

serum alkaline phosphatase 122 U/L (45-105)

plasma parathyroid hormone 7.9 pmol/L (0.9-5.4)

DXA scan see image



What is the most appropriate treatment?

- A . alendronic acid alone
- B . alendronic acid, and calcium and vitamin D
- C . calcium and vitamin D
- D . calcium and vitamin D, and intravenous zoledronic acid
- E . strontium ranelate

Answer: C

Question: 80

A 36-year-old man of South Asian origin presented acutely with a widespread pruritic rash involving the extensor surfaces of the limbs.

On examination, he was moderately obese with a body mass index of 33 kg/m² (18C25), and the rash was erythematous, with multiple small papules with yellow centres.

Investigations:

fasting plasma glucose 11.0 mmol/L (3.0C6.0)

haemoglobin A1c 109 mmol/mol (20C42)

serum cholesterol 8.0 mmol/L (<5.2)

serum HDL cholesterol 0.80 mmol/L (>1.55)

fasting serum triglycerides 31.00 mmol/L (0.45C1.69)

What is the most likely diagnosis?

- A . dermatitis herpetiformis
- B . eruptive xanthoma
- C . granuloma annulare
- D . nodular prurigo
- E . tinea cutis

Answer: B

Question: 81

A 26-year-old man with type 1 diabetes mellitus attended a carbohydrate-counting course to facilitate tighter glucose control. He estimated that his carbohydrate ratio was 1:10 and 1 unit correction dose reduced his glucose by 3.0 mmol/L.

He planned to eat a meal containing 50 g of carbohydrate. His pre-meal glucose was 16.0 mmol/L with a target blood glucose of 7.0 mmol/L.

What is the correct dose of bolus insulin (units) that he should administer?

- A . 2
- B . 4
- C . 6
- D . 8
- E . 10

Answer: D

Question: 82

A 26-year-old woman was recovering from diabetic ketoacidosis and had been switched to her usual basal bolus insulin regimen. Her capillary blood glucose measurements during the day were high but fasting plasma glucose was in the range 5.0C7.0 mmol/L (3.0C6.0). She was drinking and eating normally.

On examination, her pulse was 76 beats per minute and her blood pressure was 106/66 mmHg. Urinalysis showed ketones 1+.

Investigations:

serum sodium 143 mmol/L (137C144)

serum potassium 4.4 mmol/L (3.5C4.9)

serum bicarbonate 22 mmol/L (20C28)

serum creatinine 72 μ mol/L (60C110)

plasma glucose 2 h after breakfast 21 mmol/L

What is the most appropriate next step in management?

- A . change to twice daily pre-mixed insulin
- B . increase basal insulin at bed time
- C . increase bolus insulin with meal
- D . start glucose 5% with intravenous insulin
- E . start variable-rate intravenous insulin infusion

Answer: C

Question: 83

An 18-year-old man presented to the thyroid clinic complaining of a lump in his neck that had been present for 9 weeks. It was not painful. At the age of 12, he had developed acute lymphoblastic leukaemia and had undergone a bone marrow transplant preceded by total body irradiation and cyclophosphamide.

On examination, he was euthyroid. There was a 1.5-cm firm mass on the left side of the neck, which moved when he swallowed.

Investigations:

serum thyroid-stimulating hormone 1.9 mU/L (0.4C5.0)

serum free T4 16.8 pmol/L (10.0C22.0)

What is the most appropriate initial course of action?

- A . CT scan of neck and thorax
- B . FDG-PET-CT scan
- C . surgical referral for hemithyroidectomy
- D . technetium-99m scintigraphy scan of thyroid
- E . ultrasound-guided fine-needle aspiration of the nodule

Answer: E

Question: 84

A 26-year-old woman was urgently referred to clinic with a 6-week history of retroorbital headaches and deteriorating vision. Her past medical history was unremarkable, although on questioning she admitted that she had recently found it increasingly difficult to cope with her busy job.

On examination, her pulse was 60 beats per minute and regular, and her blood pressure was 110/75 mmHg lying and 90/60 mmHg standing. She was pale and had dry skin. Visual acuities were reduced (6/12 right; 6/24 left), and she had a bitemporal inferior quadrantanopia.

Investigations:

serum sodium 132 mmol/L (137C144)

serum potassium 4.0 mmol/L (3.5C4.9)

short tetracosactide Synacthen® test (250 micrograms):

serum cortisol (30 min after tetracosactide) 185 nmol/L (>550)

plasma follicle-stimulating hormone 2.7 U/L

plasma luteinising hormone 3.5 U/L

serum prolactin 1050 mU/L (<360)

serum thyroid-stimulating hormone 0.3 mU/L (0.4C5.0)

serum free T4 8.0 pmol/L (10.0C22.0)

serum insulin-like growth factor 14.7 nmol/L (7.5C37.3)

MR scan of brain see image



What is the most likely diagnosis?

- A . autoimmune hypophysitis
- B . craniopharyngioma
- C . non-functioning pituitary adenoma
- D . prolactinoma
- E . Rathke's cleft cyst

Answer: B

Question: 85

A 46-year-old man of European descent was reviewed in the diabetes clinic. He had type 2 diabetes mellitus, which had been diagnosed 6 months previously. He had been symptom free and was a non-smoker but had a family history of cardiovascular disease. He exercised regularly and had managed to lose 8 kg.

On examination, his blood pressure was 148/76 mmHg, his weight was 76 kg and his body mass index was 24 kg/m² (18C25).

Investigations:

urinary albumin:creatinine ratio 0.6 mg/mmol (<2.5)

serum cholesterol 5.6 mmol/L (<5.2)

serum HDL cholesterol 0.90 mmol/L (>1.55)

fasting serum triglycerides 2.20 mmol/L (0.45-1.69)

According to NICE guidelines (CG181, July 2014), what is the most appropriate management of his lipid profile?

- A . assess cardiovascular risk using UKPDS risk engine
- B . observe and repeat lipid profile in a few months
- C . start a fibrate
- D . start a statin
- E . start nicotinic acid

Answer: D

Question: 86

A 45-year-old woman was found to be hypertensive by her general practitioner. She was otherwise well and was not taking any medication. However, she regularly ate health food containing liquorice. There was no family history of significant illness.

On examination, her blood pressure was 170/110 mmHg.

Investigations:

serum sodium 140 mmol/L (137-144)

serum potassium 3.8 mmol/L (3.5-4.9)

serum creatinine 70 μ mol/L (60-110)

plasma renin activity (after 30 min supine) 0.5 pmol/mL/h (1.1-2.7)

plasma aldosterone (after 30 min supine) 450 pmol/L (135-400)

During the investigations, her blood pressure was controlled with doxazosin.

What is the most likely diagnosis?

- A . apparent mineralocorticoid excess
- B . Gitelman's syndrome
- C . primary hyperaldosteronism
- D . pseudohyperaldosteronism
- E . renal artery stenosis

Answer: C

Question: 87

A 20-year-old man presented with a 6-month history of lethargy and weakness. His brother had been found to have adrenal failure at the age of 18. He had two sisters who were well and there was no other family history of endocrine autoimmune disease.

On examination, his blood pressure was 100/60 mmHg.

Investigations:

serum sodium 136 mmol/L (137C144)

serum potassium 4.8 mmol/L (3.5C4.9)

short tetracosactide (Synacthen®) test (250 micrograms):

baseline serum cortisol 100 nmol/L

serum cortisol (30 min after tetracosactide) 250 nmol/L (>550)

anti-adrenal antibodies negative

What is the most important diagnosis to consider?

- A . adrenoleucodystrophy
- B . autoimmune hypoadrenalism
- C . familial glucocorticoid resistance
- D . isolated adrenocorticotrophic hormone deficiency
- E . tuberculosis

Answer: A

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