April 2005

1.

NSTEMI
Oxygen, aspirin, nitrates, morphine, Gp2b3a,B-blockers, clopidogrel, heparin
TIMI -

Age > 65
At least 3 risk factors for CAD- family history of CAD, hypertension, hypercholesterolemia, diabetes, or being a current smoker.
ST deviation
Severe anginal symptoms- e.g >1 angina event in preceding 24h
Use of aspirin in last 7 days
Significant coronary stenosis
Eleveated serum cardiac markers
SOURCE- **The TIMI Risk Score for Unstable Angina/Non–ST Elevation MI-** A Method for Prognostication and Therapeutic Decision Making

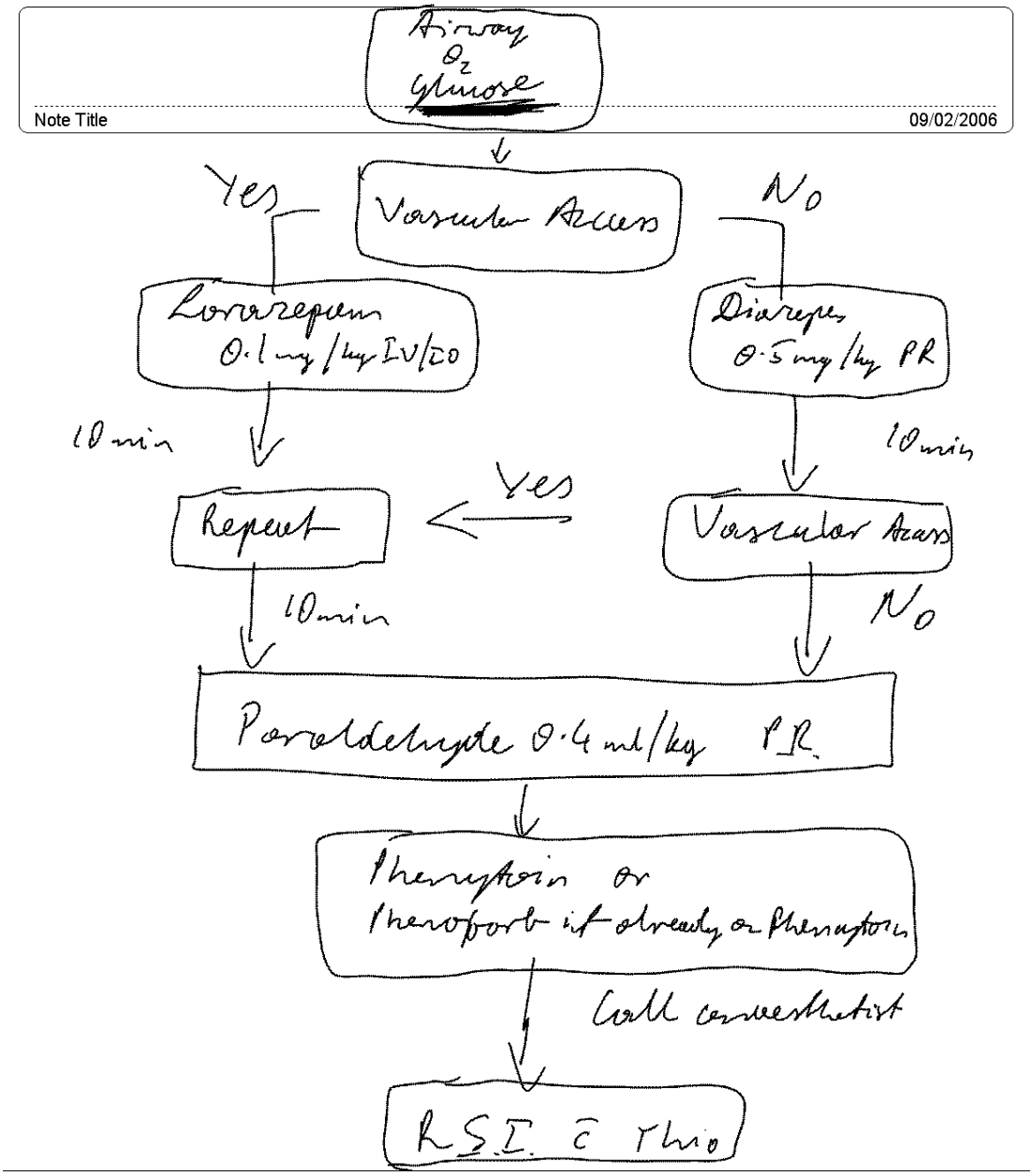
2.

Paeds on call
ICU/anaesthetist
Prepare difficult intubation
Fluid bolus calc- 20ml/kg Hartman's
Glucose dose- 5ml of 10% dex/kg
Morphine- 0.2 mg/kg

Parklands (4 x wt x %) plus maintenance (100ml 1st 10, 50 next 10, 25 rest in 24h) hartman's

Then cling film, inform social services, talk to relatives, arrange transfer to specialist unit, ascertain tetanus status

3.



Phenytoin and phenobarb- 18mg/kg for both
Kopliks spots
Measles

Notifiable –Cholera, polio, anthrax, meningitis, measles, mumps, food poisoning, hepatitis- ABCD, pertussis, typhoid, paratyphoid- http://www.phls.co.uk/infections/topics_az/noids/noidlist.htm

4.

Multiple myeloma, sarcoid, TB, leprosy
Bony Mets esp lung and breast

IV access
Analgesia- Morphine IV 5-10 mg
Rehydration- N saline
Hyperkalaemia – dextrose/insulin etc
Hypercalc – bisphosphonates, steroids if MM or sarcoid, cinacalcet
Anaemia- transfuse 2 units slowly
Catheterise
Admit, may need ICU/dialysis

5.

Hepatocellular Jaundice

Alcoholic Liver disease
Acute hepatitis
Paracetamol poisoning
Paraquate poisoning
Wilson's disease
Budd-Chiari syndrome
Severe Iron toxicity

Inv – serology, paracetamol levels
USS
Liver Biopsy
CT abdomen with contrast

Asthma, Bronchiolitis, Croup, Bronchitis, pneumonia, Cystic Fibrosis, Foreign Body, whooping cough, tracheitis

Croup

Air entry
Presence of cyanosis
Accessory muscle use
Mental state
Presence of stridor
Respiratory rate
Low sats <95%
Inability to speak
Inability to feed

Adrenaline nebuliser- 0.5mg in 3-5 ml N Sal
Prednisolone- 1mg/kg
Dexomethasone- 0.3-0.5 mg/kg
Nebulised steroids- budesonide 2mg

7. Primary survey

Airway assessment with C spine immobilisation, Head blocks and cervical collar..
May need airway adjuncts or intubation.. Give high flow O2
Breathing assessment. Assess air entry and percussion note with tracheal position. Identify any immediate life threatening illness (ATOMFC)
Circulation assessment. Give 2 IV cannulae. Take bloods for FBC, UE, Amylase, X match 6 units. Give adequate analgesia. Control haemorrhage. Give Iv flui9ds with warmed crystalloid
Disability. Assess GCS and pupillary responses plus posture and tone, check abdomen, pelvis and long bones for bruising, open wounds urethral blood fractures, perform log roll & PR
Expose pt fully

Trauma series X-rays

Xray. Left large pneumothorax. Probable displacement of mediastinum and trachea to right. Suggests tension pneumothorax. Also blunting of both costophrenic angles

Immediate treatment is needle thoracocentesis followed by intercostals tube drainage

Needle, second ICS, MCL on left.
Tiube: 5th ICS in mid axillary line on left

8
Pelvic Inflamatory Disease
Threatened miscarriage
Ectopic pregnancy
Vaginal candidiasis
Colo-vaginal fistula
Endometriosis

Adnexal Tendrness
Cervical excitation
Lower abdominal pain- those are the minimum criteria for PID

Also PV discharge, pyrexia, dyspareunia, confirmed gonnococcal infection

Pregnancy
Inability to tolerate/follow oral regime
Inability to exclude surgical cause
Tubo-ovarian abscess
Failure of oral medication after 24-48 hours
Young age
Septic/generally unwell

9. chest xray. Left lower zone consolidation suggestive of left lower lobe pneumonia.
Oxygen tube and ecg lead

Mixed respiratory and metabolic acidosis, hypoxia

6 treatment steps.
1. Oxygen high flow 15l via rebreather mask. Question doesn't mention COPD. Also sats monitoring and p/bp. If history of COPD tirtiare O2 to sats of approx 92%
2. IV fluids . N saline -1l over 1 hour to begin with
3. IV calcium gluconate 10mls 10%. Insulin infusion 7u/hr. Nebulised salbutamol
4. IV antibiotics, Ampicillin 1g and clarithromycin 500mg
5. Consider NIV/Bipap or invasive ventilation
6. Catheterise and consider ICYU/HDU +/- dialysis

10
Wide complex regular tachycardia, rate about 130

Check pulse if pulseless- defibrillate 360 J or biphasic
Give oxygen, sats monitor
Maintain airway- recovery position +/- nasopharyngeal / oropharyngeal airway
Call anaesthetist/ICU
IV access, bloods- FBC, U&Es, Mg, BM/glucose
ABGs looking for pH mailnly- Venous will do
IV fluids- N saline 1l stat , consider hypertonic
Considr RSI if remains unresponsive

Tricyclic OD

Sodium bicarbonate- 1mmol/kg infusion until pH 7.5-7.55,
It acts as by competitively inhibits Na channel blockade acts to decrease free triciyclics by increasing protein binding

11. haemorrhagic, bullos rash, excoriated and widespread. Could possibly be target lesions?

DD. Scabies, Chicker pox, Pemphigoid,/Pemphigus. Drug eruption, toxic epidermal necrolysis, TSS, Erisypelas, cellulitis, Necrotising fasc

2 investigations. Skin scraping/biopsy of lesion. Aspiration of bullae and fluid for serology/culture. Bacteriological swabs

GP follow up and refer dermatologist
Return if rash in mouth or genital or eyes

12

Anterior circulation- Left middle cerebral artery

Onset < 3 hours
Unresolving symptoms
Age > 18
No bleed confirmed by CT
No contraindications to thrombolysis

Atrial fibrillation
Diabetes
Ischaemic heart disease
Hypertension
Smoking
Hypercholesterolaemia

13.
history and examination
Airway assessment. High flow o2 15l by rebreather bag, collar sand bags and tape if pt tolerates
Assess chest for signs of infection
Insert IV access. FBC, UE, LFT, Amylase, Clotting. Glucose, Cultures
IV fluid resuscitation with normal saline in view of tachycardia
Chesk GCS and pupils. Consider CT head
Possibly need IV ABX to cover meningitis esp pneumococcal
Consider thiamine/pabrinex plus benzodiazepine
Xrays- Cspine and CXr, consider pelvic if evidence of injury

Differential diagnosis.
Alcoholic encephalopathy or withdrawal
Encephalitis
Other septic focus
Head injury with coagulopathy
Post ictal
Drugs

Ataxia, opthalmoplegia and confusion= wernickes

14
Ebola virus
Dengue Fever
Yellow fever
Hepatitis
Malaria- failure of prophylaxis
Drug reaction to antimalarials
menigococcal,
weils disease
typhus

LFTs
Coag
FBC
U&Es
Hepatitis screen
USS/CT liver
Blood cultures
Thick and thin film
Urinalasis

irregular shaped pupil
?hyphaema
injected eye
? iris laceration
Penetrating eye injury

Hutchinsons pupil (raised ICP)
Holmes adie
Argyll roberton (syphilis)
Hormers (meiosis, ptosis, anhydrosis)
Traumatic mydriasis
Drugs e.g topical cyloplegics

Treatment
Head up
Cycloplegics cyclopentolate 1%
Patch eye
Systemic ABX
Refer ophthalmology