Clinical challenge

Questions for this month's clinical challenge are based on articles in this issue. The style and scope of questions is in keeping with the MCQ of the College Fellowship exam. The quiz is endorsed by the RACGP Quality Assurance and Continuing Professional Development Program and has been allocated 2 CPD points per issue. Answers to this clinical challenge will be published next month.

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SINGLE COMPLETION ITEMS

DIRECTIONS

Each of the questions or incomplete statements below is followed by five suggested answers or completions. Select the most appropriate statement as your answer.

Questions 1-4 are based on the article 'Childhood ENT disorders - when to refer to specialists' by Claire Harris

Question 1

With regard to sore throats presenting in general practice which of the following is true?

A. throat complaints are the commonest presenting symptom in general practice
B. in children under three sore throats are bacterial in approximately half of cases
C. antibiotics are usually first line therapy in children aged 4-13 years
D. drooling associated with a sore throat is an indication for urgent referral
E. preschool children rarely have enlarged tonsils without having underlying chronic infection.

Question 2

Billy, aged eight years has had a recurrent sore throat. Which of the following would not be an indicator for him to have a tonsillectomy?

A. persistent enlarged tonsils
B. symptoms have been present for only two years
C. the sore throat episodes have been diagnosed as tonsillitis
D. Billy has already missed two weeks of school this year because of his sore throat
E. each episode has required at least one course of antibiotics.

Question 3

A mother presents with her three year old daughter Melissa, saying the child is febrile and complaining of a very sore left ear. Which of the following is not true?

A. more than four out of five children will have had an episode of acute otitis media by the time they are three
B. a red tympanic membrane does not necessarily indicate infection
C. analgesia and fluids are the first line treatment
D. if Melissa hasn't improved in 48 hours antibiotics should be commenced
E. if there is an acute perforation Melissa should be referred to a specialist immediately.

Question 4

Michael, aged five had an episode of acute otitis media four weeks ago which resolved. You notice he still has middle ear effusion in the affected ear. Which of the following is true?

A. one in ten children still have an effusion one month after an episode of acute otitis media
B. persistent effusions are most common in late summer and early autumn
C. persistent effusion is far less likely beyond the age of six
D. mild conductive deafness is present in approximately 80% of similar cases
E. persistent effusion needs to be treated surgically to prevent language impairment.

Questions 5-8 are based on the article 'A hole in the drum' by Paul Fagan

Question 5

While playing basketball, Adrian aged 25, suffered a blow to the right side of his head. This resulted in a sharp pain in his right ear associated with some bleeding from that ear. Which of the following is true?

A. a blow to the side of the head usually with the flat of the hand is the classic mechanism of a traumatic tympanic membrane perforation
B. such perforations are generally a neat slit in the tympanic surface
C. the drum must be visualised in order to make the diagnosis
D. Adrian's ear is likely to become infected
E. the canal should be gently syringed to remove any blood.

Question 6
Traumatic perforations of the tympanic membrane that occur in wet conditions will often:
A. be associated with a purulent discharge
B. be commonly infected with a staphylococcal infection
C. require a short course of oral antibiotics
D. not heal spontaneously
E. require surgical repair.

Question 7
Tympanic membrane perforations for which referral is not mandatory include:
A. continuously discharging central perforations
B. large dry central perforations
C. marginal perforations with discharge
D. those associated with a cholesteatoma
E. perforations that are surrounded by granulation tissue.

Question 8
The aim of surgery for the tympanic membrane is to:
A. restore hearing
B. produce a clean, dry drum to which a hearing aid may be fitted
C. improve the appearance of the drum
D. prevent further perforation
E. restore Eustachian tube function.

Questions 9-12 are based on the article 'Management of epistaxis in general practice' by Dennis Pashen

Question 9
Cases of epistaxis are unlikely to arise from:
A. injury to turbinates
B. spontaneous bleeding from the Little's area
C. anticoagulation therapy
D. enlarged adenoids
E. nasal fractures.

Question 10
Stephen, aged 18 presents with acute epistaxis. Immediate measures include:
A. applying direct pressure to the lower nose in two minute intervals
B. positioning Stephen so that he is sitting and leaning forward
C. the application of topical local anaesthetic
D. complete nil by mouth
E. nasal packing with gauze.

Question 11
Stephen has a history of recurrent epistaxis. Chemical cautery is suggested. Which statement is untrue of the procedure?
A. before the use of silver nitrate sticks, topical anaesthetic can be applied
B. the procedure can trigger further bleeding
C. only one side of the septum should be cauterised at a time
D. septal perforation is a risk of the procedure
E. silver nitrate may permanently stain the skin of the nostril.

Question 12
Epistaxis is:
A. a common presentation with over 80% of the population suffering from it at some stage in their lives
B. often influenced by environmental conditions
C. attributable to posterior nasal cavity causes in 40% of cases
D. commonly associated with congenital causes of bleeding
E. copious in less than 2% of cases.

Questions 13-15 are based on the article 'Inhaled steroids in asthma' by Simon Bowler

Question 13
With regard to inhaled corticosteroids which of the following statements is not true?
A. in the past 30 years unit doses of inhaled corticosteroids have increased exponentially
B. the majority of patients with nonacute asthma respond to relatively small doses of inhaled corticosteroids
C. doubling the daily dose of budesonide to 800 µg a day doubles the benefit but further increases in dose provide little extra benefit
D. once asthma control has been achieved dose reduction of inhaled corticosteroids should be attempted
E. a daily dose of 250 µg of fluticasone provides approximately 90% of the theoretical maximal benefit.

Question 14
Wendy, aged 30 is currently taking 250 µg of fluticasone daily to effectively control her asthma. She is concerned about the health risks associated with her medication. Advice would include:
A. inhibition of cortisol production has been associated with inhaled corticosteroids in adults
B. effects of inhaled corticosteroids on bone mineral density is idiosyncratic and not related to dose
C. there is a confirmed relationship between inhaled corticosteroid and skin fragility particularly in older patients
D. Wendy should have regular ophthalmological review because of her increased risk of raised intra-ocular pressure
E. in our current understanding, the dose of Wendy's medication means it has a very low potential for side effects.

Question 15
Which of the following is not true?
A. combination therapy with inhaled corticosteroids and long acting beta agonists is more effective in controlling asthma than doubling the dose of inhaled corticosteroid
B. long acting beta agonists reduce symptoms but do not reduce frequency of asthma exacerbations
C. combination treatment with inhaled corticosteroid and long acting beta agonists enable lower steroid doses
D. back titration from high doses of inhaled corticosteroids is essential
E. in some patients it might be suitable to commence inhaled corticosteroids in low doses, increasing the dose until asthma control is achieved.