MBBS Main Examinations 2016-17 Medicine Long Cases (Arranged by Systems)

Adult Medicine – Cardiology

1. Mitral Regurgitation Cx Infective Endocarditis & Decreased Effort Tolerance, 2. Hypertension with Poor Insight Approach to Shortness of Breath Approach to Fever Examiner gave instruction: Please take a history from this patient.	Not sure, sorry. Lady active examiner who observed PE, male passive examiner but also asked questions at the end.	Name: Mr N, Age: 68yo, NKDA HPC: -Please tell me about your medical condition: Patient went to NUH 5 years ago because of breathlessness while climbing stairs and playing golf. Found that his heart valve "not working as well". 2.5 years later had an infection and given antibiotics. -Hx of 1st Event: Approach to SOB >>Breathlessness while walking up stairs and playing golf. >>Screened AMI: No chest pain/diaphoresis. >>Screened CHF: No orthopnoea/PND, No LL swelling. >>Screened other cardiac (AF/Outflow Obst.): No palpitations/syncope. >>Screened pneumonia: No productive cough/fever. >>Systems Review normal (no weakness/numbness/facial droop/BOV, no abdominal pain, no rash/joint pain). >>Went to hospital, was told that had heart valve problem. Unsure whether Aortic or Mitral, unsure if right or left side, unsure if stenotic (not big enough) or regurgitant (blood flows back). >>Asked if any heart problems when younger, any infection when younger (screen Rheumatic Heart Disease) - said no. >>Asked if given any medications - none. >>Asked whether any line put through thigh/groin (for angioplasty) - none, but patient said they did a scan through a tube down the mouth - likely TOE. (Ideally would have explored more about the acute event - eg: SOCRATES for Breathlessness, explored other DDx eg: Asthma/COPD, DVT, asked about more scans eg: CXR, ECG etc. - but no time!!) -Hx of 2nd Event: Approach to Fever >Had fever, went to A&E, told had blood infection - hence likely bacteremia +/- sepsis. >Patient volunteered that he had blood in urine - was thinking UTI vs IE. >Asked if gross or microscopic hematuria - said couldn't see but GP said think there is - likely microscopic. >Patient then went to A&E, warded. Asked if received antibiotics through veins, he said yes for 6 weeks. - Likely	Offered to examine cardio, examiner said proceed. -Hand Hygiene -Bed was not your typical ward bed, elevated at abt 20 degrees, had no idea how to raise it, examiner said never mind, proceed. -Did cardiac dance. (Offered JVP at 45deg examiner said it's ok. Offered manouveres for MS, AR but said unlikely, examiner said ok, reminded me to just do targeted as needed.) -Hand Hygiene -Offered standard 3 things at the end: fundoscopy for roth spots, urinalysis for hematuria, vitals for BP and temp. -Found very obvious and very typical MR signs with no complications.	-Medicine history for long case can be very rushed. There may be more than 1 medical problem to discuss (which may only come up in PMH rather than as the presenting complaint!); unlike surgery where main focus is on one disease. -According to Dr Soon, they are moving away from acute diagnostic cases to chronic management ones, hence didn't focus so much on taking the acute history like in A&E, in order to have time for all the chronic management issues and other medical conditions. (Although be prepared to be quizzed by the examiner on your initial differentials if seeing this patient for the 1st time.) -Always be flexible and let the patient tell his story, but have a template ready to act as a checklist and double check that all areas are covered. -No need to present full history as per surgery, only problem list, hence don't need to write everything down. HOWEVER - the 2mins is not enough time to fully consolidate - hence might want to have a corner of your paper ready to jot down the likely problems as you go along. eg: As the history progressed I quickly noted down ?IHD, ?NYHA 2 CHF (when he said initial symptoms), then IE, ?AS (when he mentioned valve problem + infection), then HTN, compliance (when he talked about the drug) - this was very helpful in reminding me about the problem list during the 2mins, almost forgot to mention the HTN until I saw what I wrote. -ALWAYS ask patient's concerns, impact on function. -Know your acute management very well, examiners want to see if you can manage a patient during the first few minutes until help	

		IE. >Asked if he knows which one, said no. No Cx of Antibiotics like vomiting/nausea, diarrhoea. >Clarified urinary symptoms - no dysuria, has discomfort while passing urine, but turns out to be hesitancy and straining. No flank pain, No abdo pain. Was still thinking UTI but in hindsight likely renal involvement of IE (part of Duke's Criteria!) >Screened other infective symptoms: No productive cough, No chest pain. No abdo pain. Patient volunteered had blood in urine, was thinking UTI. >No recent travel or contact history. (Ideally would have explored more about acute event again - eg: Abdo Infection? Septic Shock? ICU stay? - again: NO TIME!) >Asked if any scans done after - said got US again (should have clarified TOE vs TEE) - said normal. Also said had MRI done, normal (patient pointed to chest so was thinking cardiac MRI???, should ideally have clarified though). -Asked Current Symptoms -No current chest pain, no palpitations. -No syncope, no previous fainting, never had giddiness. -Breathlessness only while walking up slope while golfing, but doesn't stop him from playing golf. No breathlessness at rest. (Ideally should have quantified effort tolerance). -Breathlessness stable, not progressive, no acute worsening. Asked Current Management >Not on any medications. >On Q6/12 follow-up with NUH. >Next scan to be done in 3 months, last one done 3 months ago, normal. >Not on any medications. No prophylactic antibiotics. (Ideally should have specifically asked about dental procedures). >Asked if Dr offered surgery, patient said yes but he declined. Asked if Dr told him that should do surgery urgently, he said no. Asked why he doesn't one, he said doesn't think it's necessary because no bad symptoms. >No change in management planned for the future currently. PMH/DH: -No other medical conditions. -Asked if tested for Diabetes before, he said had a $20		arrive. -Practice consistently from the start, including reading accounts early and thinking about PE dances (including "non-CSFP" PEs for Acromegaly, Scleroderma, Myaesthenia etc.). Personal regret is that I focused too much on studying theory during the postings and didn't see as many cases as ideal... was fairly worried about the clinical components of MBBS as a result during the revision period. All the best! :)	

		checkup at CC last year, not sure what, but nothing abnormal. -Asked if have high cholesterol - no. -Patient offered that he takes BP tablet - EVERY 2 WEEKS!! >>Clarified why, he said when his pressure is high that he will take 1 tablet. >>Asked him if he measures at home, he said yes, everyday. Asked BP range - 130-155/60-70. Asked if higher or lower than 140 most of the time, he said higher. - hence likely HTN. >>Asked where he takes tablets from, he says doctor gives him - but never told him to take regularly, never told him he has high blood pressure - hence likely poor insight into HTN. >>Asked if he knows what tablet, not sure, is "pink tablet". Asked if he has a drug list or brought the tablet - no. -No other hospitalisation or surgery. -Completely healthy until event 5 years ago. (Ideally could have asked about vaccinations also, OTC meds & TCM.) -No PMH of cancer. FH: -Any medical conditions in family - mother had kidney problem, passed away recently. Expressed sympathy. Said no other medical conditions. -No IHD in family. -No cancer in family. SH: -Asked permission to ask sensitive question, asked if any previous injection of illicit drugs - said no. -Asked if any smoking/drinking, none currently or in the past. -Asked if working - he said no, retired 5 years ago. Asked what he did, self-employed in ???renovation (can't rmb sorry.) Asked if stopped worked because of SOB, he said no. Asked if was having a harder time with work towards the end cos of symptoms, he said no. -Asked about family setup: said he lives with wife and 3 children. Age of children all mid 30-40s. Asked if they have own family, said yes. Clarified as to whether they are all together, he said neighbouring. (Ideally should have clarified exactly who is in the same unit but no time!!!) -Asked if he can take care of himself at home, eg: bathing, dressing - ADL-I. -Asked if any problems walking about the house - none.			

		(Ideally should have asked lift landing). -Asked if he needs someone to help take care of him - no. Asked if he needs to help take care of anyone - no. -Asked if he goes out alot - yes, no problems. Still does golf weekly and dancing twice weekly at night. Specifically clarified that he has not changed his activities at all because of symptoms, does not feel hindered in anyway. Fully comm ambulant. -No financial concerns. -No specific worries about disease. (Ideally should have asked diet for CVS risk, asked specifically about mood. But was super rushed for time - started social history at 12mins.... examiner started prompting to examine just before I asked about concerns at about 19mins). Felt ok in delaying start of examination a bit though as I decided it would just be a single cardiac examination rather than multiple systems - can finish fairly quickly.			
NSTEMI s/p primary PCI and stenting of RCA, currently well on dual anti-platelets Approach to chest pain Please take a history from this patient -.- (such an informative stem, thanks profs)	Sorry not too sure	Young Indian gentleman in late 40s with fantastic English, good historian Pertinent history: 2 months ago, had central chest pain, dull in nature while at rest. Radiated to the back bilaterally. Pain reached maximum in 5-10min, not maximal in onset or tearing/crushing in nature. No associated diaphoresis or dyspnoea. Pain score 7-8/10. No exacerbating or relieving factors, not relieved by panadol. Was his first ever episode of chest pain Patient went to the doctor, pain was increased on exertion. Given 'tablet under the tongue' and the pain score became 0/10. Was sent to the NUH ED subsequently. There was some confusion about his results; ?heart attack. The ecg was normal but his blood results were abnormal (I assumed that he meant cardiac enzymes) Did CT angiogram in the ed, normal. (Was very confused whether it was CT angiogram and assumed it was coronary angiogram and the patient was confused. Should NOT have done that) Called cardiologist and was sent for coronary angiogram and found that RCA was 90% stenosed, the others were 30-40% stenosed. Did primary PCI via right radial artery with stent placement in RCA	100000% normal cvs exam	When profs came in again, they just asked me for an issue list: 1. NSTEMI s/p primary PCI, currently on dual anti-platelets with omeprazole cover and atorvastatin 2. Significant FHx acute coronary syndrome 3. Secondary prevention needed to prevent further episodes 4. ?not back to baseline function yet as patient has yet to go back to normal exercise regimen Mean prof: are you sure that's in issue? Isn't he going back to work and started exercise yesterday? Me: oh yes prof. It's not an issue. I would like to retract that statement -.- What are your ddx you need to rule out, and how have you ruled it out? 1. Aortic dissection since the pain radiated to the back; but ruled out since on PE there's no thoracotomy or midline sternotomy scar Prof: so... what investigations would you do to r/o AD? - I can do a CXR to look for mediastinum widening (prof: actually his mediastinum was widened) - Oh then I would like to do a CT aortogram (prof: isn't that what he told you in his history? Me: oh sorry prof I forgot. I didn't know you can do it in the ED. Prof: doesn't that make sense to rule it AD	Yay end of mbbs!! All the best juniors! As much as you want to practice the super tough stuff, basic and common things do come out too! This is actually my first full mbbs exam style ACS history hahahahaha oops never mind **hope I pass **

		Stayed in hospital for 2 days after, no significant complications of further chest pain, bleeding/infection at cath site, or significant SOB. Just had some ?gastric pain which was attributed to the aspirin by the ward doctors. Was placed on omeprazole after, no further dyspepsia. No melena or PR bleed, no need for scopes Medications started after PCI: aspirin, omeprazole, atovarstatin, GTN - remember to ask to see his Med's, cause actually he was also on ticagrelor and metoprolol (stopped the metoprolol 2 weeks ago at TCU) After discharge, given 1.5 months hospitalisation leave/MC in total, just went back to work a few weeks ago Currently well, effort tolerance is at baseline (very good) with no further episodes of chest pain PHx: NOTHING Risk factors: FHx: brother died of AMI at 47 years old (super significant), father had AMI at 72. No other Hx of sudden cardiac death or HOCM type of family history Eats very healthily: loads of vegetables, occasional Indian curry, no red meat No alcohol, no smoking history Exercises every day: badminton twice a week, goes jogging and does other stuff on other days. Only recently returned to exercising 2 days ago, so far so good Social: Has a wife and 2 sons, all aware of his condition and supportive, no significant concerns Works as an engineer, usually desk bound. Workplace is also supportive, gave him loads of hospitalisation leave, no threats of firing him Personally, no fears or concerns about his condition. Wants to continue living his life well Then asked the patient if he's aware of signs to look out for, and when to come into the ED again. Asked g he knows when to take the GTN and if he has had the need to take it since his discharge (no need), and whether he brings it around		before calling the cardiologists? Me: yes prof. Sorry sorry) hahaha sian 2. Pneumonia - no SOB or productive cough, would like to check his vitals to see if he's febrile 3. GI problems: esophageal rupture but no vomiting before the pain, peptic ulcer disease but no Hx or past episodes of it 4. PTX: no SOB 5. PE: no DVT, calves were supple on PE How would you manage in the ED if you were the ho? 1. Assess ABCs and resuscitate as necessary. Supplemental oxygen, Insert 2 large bore IV cannula in the antecubital fossas and run fluids 2. Investigations - cardiac enzymes and 12 lead ecg - FBC for anemia (type 2 AMI), leukocytosis in pneumonia, platelet count for PCI - UECr for baseline creatinine before angiogram, look for any AKI from hypoperfusion - CXR for mediastinal widening, focal consolidations (pneumonia), signs of acute heart failure (Pulmonary edema) - GXM and coagulation profile for pre-PCI 3. Dual antiplatelets, morphine - aspirin 300mg + ticagrelor since its NSTEMI - Prasugrel if STEMI, or clopidorel if have contraindications - Mean prof started raising her eyebrows and opened her mouth to say smth so I quickly added: - But these are institutional, I would follow the dual antiplatelet guidelines of my institution - Mean prof nodded and looked happier 4. Call cardiologist for emergent coronary angiogram and PCI as indicated How would you manage the patient in the ward before discharge 1. Ensure no further episodes of chest pain or any other complications of PCI 2. Ensure tolerating medications well 3. Educate on signs and symptoms of further acute coronary events, and when to come in to ED 4. Educate on secondary prevention and need to continue balanced lifestyle and good diet with exercise	

				5. Reminder to come to TCU and be compliant to medications Nice Prof: Why is the patient on statins? Does he have a Hx of HLD? Me: no prof, he doesn't have HLD. But it's considered best medical practice to give statins in post-ACS patients no matter the LDL levels Nice Prof: what if i told you his LDL levels were 3.4? Do you know of any targets? Me: 3.4 is actually acceptable in normal patients, but if you had a previous AMI, it's too high. The target would be 1.8-2.0mmol/L, or in the newest guidelines, reducing LDL levels by 50% from baseline Nice prof nods and looks very happy	
Bilateral pedal oedema secondary to heart failure Approach to pedal oedema Stem was "Mdm X came in complaining of leg swelling, please talk to her"	Dr Goh Lay Hoon (main) and ?Some nice Indian male doctor	A pleasant Chinese lady in her 60s sitting stopped in her chair, looking rather sleepy and talked slowly. Introduced herself as an accountant doing mainly desk bound work. Presented to the GP 2 months ago for a one week duration of a dry, non productive cough. Was associated with limb heaviness bilaterally which was not painful and started roughly a few days before the cough. GP noticed something abnormal and sent her to the hospital. In the hospital, she was told her thyroid levels were low. Patient mentioned she previously was on thyroxine but defaulted because she felt ok. No hypothyroid symptoms reported during this episode. Took a thyroid history - patient unable to remember why she was started on thyroxine 20 years ago but she did not have surgery or radioiodone ablation. She said the doctor told her her low thyroid was causing the cough and leg swelling. After quite some time invested in thyroid history, the Indian doctor said it's ok, let's move on from here. Patient finally revealed that the doctor also told her her heart was not good and that was the real thing causing the problem. She had an ECG and echo done in hospital, and took some IV medications that made her pee a lot. She has a cardiology outpatient appointment in a week. Reports that she does not have any chest pain, shortness of breath, palpitations; systemic review unremarkable.	Told the doctors my goal was to look for fluid overload and to determine cardiac status. Was told kindly to ignore the thyroid issues as it was not the focus of the case. CVS normal sinus rhythm, NAD. Pacemaker site clean with no overlying skin changes. No lung crepitations heard. No pulsatile liver. No shifting dullness. Patient was not anaemic. Bilateral pitting oedema at the ankles.	Gave a very short summary and went straight to questions; Dr Goh led the questioning. Q: Why do you think the patient has a cough and pitting oedema? A: Fluid overload secondary to heart failure. The fluid overload may also be contributed by hypothyroidism and acute on chronic renal failure. Q: Why do you think she developed heart failure? A: Bradyarrhythmia possibly due to atherosclerotic coronary ischaemia Q: So you're the HO on call when the patient comes in, what investigations would you do! Q: what would you expect to see on ECG and echo? We discussed a little more about the drugs used in heart failure here, and I said I would want to put the patients on diuretics and ACE-I, avoiding	Be kind and gentle with your patient even if they aren't the best historians or if they have a difficult issue. The examiners can see you taking a history, and it doesn't reflect well on you if you can't treat a patient with respect and compassion just because it's an exam. If you're tense and firing off questions like a machine gun, the examiners will be tense too and you won't have a comfortable set of questions later. Remember to take a holistic history after settling the presenting complaint, and use your two minutes well! Be super clear

		Patient reports she has diabetes on basal bolus insulin, and her HbA1C is 8.4%. She claimed she does not have hypertension, but revealed she's on some kind of ACE-I - at this point the Indian doctor said just assume she has hypertension and it is 140/90. She says her kidneys are not too good also but was unable to elaborate more - still able to pass urine, no renal replacement therapy. No other past medical history apart from 2 Caesarean sections. Regarding her heart condition, she reported that no surgery was done on her heart so far. Unfortunately, she took a long time to recall that they put in a pacemaker for her after the most recent episode. She was planning to go overseas but they found her heart to be beating at 40 BPM. Wasn't able to determine if the device had cardioversion capabilities. Patient is otherwise well, and engaged in some small chit chat to tease out more details. The actual history taking was not so smooth as patient was very slow talking and would forget to mention key things until repeatedly prompted. She does regular exercise and physiotherapy, and says she tries to watch her diet but isn't very successful. I decided to try and squeeze out more of the chronic DM history because Dr Goh does family medicine stuff, and was probably waiting to grill me a little on those bread and butter issues.		beta blockers + diuretics combinations as it is not ideal for her renal condition. Q: So her HbA1c is 8.4%, what do you think about that? This bit was basically the starter to the discussion on diabetes. Questions included if I thought the control was ideal, what interventions could be done, what kind of regime the patient is on, what is a basal bolus regime, what are the complications of DM. Was asked about patient function and I said I had missed out on asking how her chronic illnesses were affecting her. The toughest question I had was "So the patient is already on insulin, on diet control, exercises - what else can you do? Think primary prevention". I couldn't answer the question so I just stoned and they smiled. Ended the session a minute early. At the end, Dr Goh at the other examiner gave me feedback which was very nice (although to the chagrin of the administrators). They said they wanted me to mention the patient should get regular vaccinations as part of her chronic care primary prevention, and to remember to ask about function in the future. They also suggested I be more focused with my investigation - I should have just listened to lung bases since I was looking for effusion rather than do a semi-full respi exam. For pedal oedema, they also corrected my amateur mistake of not feeling up to the level where pitting ends.	about the presenting complaint and the other issues (including social, financial, and chronic medical) so the examiners follow your train of thought. For PE, I found it useful to scribble down all the different systems (Abdo, cardio, etc) and tick off the ones I wanted to examine while taking a history. If you aren't expecting much, a running commentary can be useful - examiners don't know what the flow of your examination is like, and it is good to say "I am doing X to look for Y" (e.g. I am feeling for the liver to look for a pulsatile liver present in right heart failure). Enjoy your freedom!

Adult Medicine – Respiratory

Asthma with background HTN and HLD Management of asthma You are a resident in the respiratory follow-up clinic. Please take a history.	Prof Suresh Pillai & Dr Limin Wijaya	Mr Y, 51yo Malay M NKDA, non smoker non drinker ADL-independent, community ambulant History of Presenting Complaint 1) Asthma - Diagnosed 10 years ago: had breathlessness, went polyclinic, diagnosed asthma on lung function tests but cannot remember results - Currently on seretide once morning & once at night (ADR dry mouth, so changed to turbuhaler, forgot to ask if he was told to gargle after using ICS) & ventolin PRN (no recent changes to meds) - Previously followed-up with polyclinic asthma programme until recent admissions (where the bag of worms opened) - Recently admitted 4 times (Nov 2015, Dec 2015, Jan 2016, Feb 2016) for asthma exacerbations, no intubation, no ICU stay (forgot to ask about discharge medications and specific triggers for each admission) Current control - daytime symptoms: ?SOB every morning - night-time symptoms: >2 times awakening due to cough past 1 month, but no symptoms past 1 week - salbutamol use: not used in past 1 month, though previously used whenever SOB - activity limitation: yes, cannot exercise due to breathlessness (should have asked further about exercise tolerance) - patient's thoughts on control: good - Currently followed up with TTSH asthma clinic (next appointment in 4 months) Triggers - Worse on exercise, exposure to construction site, 2nd hand smoke and haze - No pets at home - Not sure how often bedsheets changed as wife changed it, but on further probing if bedsheets changed at least once in 2 weeks, he said wife changes it more often. Not sure if wash in hot water and sun properly - Not affected by hot and cold weather Inhaler technique	- Vesicular breath sounds with bilateral wheezing (?crepitations but i think it was more like the patient's singlet moving) - No signs of eczema rash - No turbinate enlargement due to allergic rhinitis	Told to present summary of issues and physical findings. Issues 1) Asthma on seretide BD and salbutamol PRN (Said it was poorly controlled due to daytime symptoms and activity limitations. Got grilled about it and asked why i said it was poorly controlled, said he had 4 hospital admissions in 5 months so I was worried in view of the frequency but patient was quite compliant to medications except for occassional forgetfulness) 2) B/g HTN on 3 anti-hypertensives and aspirin, as well as HLD on statin on follow-up with NUH cardio 6 monthly apppointment 3) Inflammatory neck pain & stiffness on follow-up with NUH neuro Prof Suresh (S): If patient presented with acute breathlessness, what would be the management in the A&E? A: - Stabilise ABC, call senior - Give inhaled salbutamol and ipratropium bromide (S: What is it? It is a short-acting anti-muscarinic) - (I totally forgot and was prompted n times before realising 8min into the discussion) Give PO prednisolone or IV hydrocortisone - KIV adrenaline - If severe, KIV intubation and call ICU Dr Limin (L): What would your management be if you see the patient in clinic? A: Multidiscplinary approach with involvement of allied health care - Refer to asthma nurse for assessment of inhaler technique - Patient education and counselling - Smoking cessation (but not applicable for this patient cuz he is a non-smoker so Suresh frowned when i said it) - Pulmonary vaccinations: yearly influenza and pneumococcal (both examiners nodded thank god)	For management cases like these, ask past medical history briefly then focus on CURRENT issues. For me i spent too much time on general asthma questions like control, compliance and triggers so i totally had no time to ask specifically about each admission (Sighs. Why poor uncle have to admit 4 times in the past 5 months ><). And also, my patient don't know why came back after the 2min reflection with my examiners so i abit paiseh to say his asthma was poorly controlled when he thought it was good. I guess on hindsight, the control for the past week for good but i should have tried to find out the reasons why he got admitted 4 times in 5 months! Sorry juniors for the incomplete account. All the best you can do it!

		- Able to explain step-by-step how to use: shake inhaler, attach to turbuhaler chamber, press once before breathe in and out 5 times - Able to explain how to clean turbuhaler: rinse with warm water (patient didn't mention detergent) and air dry it without wiping using tissue or cloth Personal history of atopy - No allergic rhinitis (morning itchy nose & sneezing) - No atopic dermatitis (red itchy skin) Family history: NIL Past Medical History 1) HTN (diagnosed > 10 years ago) - on 3 anti-HTN: amlodipine, lisinopril and 1 more patient cannot remember - aspirin (For secondary AMI/stroke prevention? Not sure...) - On follow-up with NUH cardiology Q6-monthly 2) HLD (diagnosed >10 years) - On statins (patient not able to name the drug) - On follow-up with NUH cardio as above 3) Neck pain (only came out on systemic review, and i really don't know what it is) - Inflammatory in nature (pain and stiffness worse in morning, for more than 1 hour, better on movement) - No numbness or weakness - No previous trauma - No other joints involved - On follow-up with NUH neurology and given some "blue pill" for the pain (panadol???) Past Surgical History: NIL Drug History: as above, no traditional "Jamu" Social history - Non-smoker, non-drinker - Job: NEA manager (SOB affected job; should have asked further if the job was physically straining, or have occupational exposure to dust etc.) - Lives with: forgot to ask as ran out of time - Diet: often eat take-outs like roti prata and mee goreng, told to watch out for salt intake by heart doctor but don't		- (Forgot to mention) Pulmonary rehabilitation - Control with medications such as salbutamol and inhaled corticosteroids - Have a written asthma action plan with the patient (L: what is it?) It is a written plan for patients to increase their inhaler dose based on their symptoms, and if they have very severe symptoms, to come to the hospital. L: You mentioned that the patient has poorly controlled asthma, the patient will be worried for the next one month. Why did you say his control was poor? A: Admitted 4 times in past 5 months, although no exacerbation in the past 1 month. Hence I would like to explore further for triggers of each previous admission. S: Did you ask what his job was? A: National Environment Agency manager (S: is it important?) Yes. I would like to ask more details about his job to see if he was exposed to dust or other triggers. L: If his control continues to be poor, what do you do? - Assess his compliance (L: how go improve compliance?) by asking him to set alarms and family to remind him if he forgets - Increase dose of inhalers (S: anything else you can start him on? X n times) - Steroids! (S: Did you ask for it?) Sorry Prof, ideally i would like to ask for discharge medications for each admission	

		consciously look out for it - Exercise: hardly exercises as it makes him SOB (but should have asked specifically for effort tolerance) Systemic review: - No LOA/LOW - No fever/night sweats/chronic cough - SOB but no chest pain/orthopnoea/palpitations - Otherwise unremarkable			
Adult Asthma Management case This patient has asthma. Please speak to him to evaluate his control, issues and formulate a management plan	Dr Chua Hong Ruey (NUH Renal), A/P Ding Yew Yoong (TTSH Geri)	52/ Indian/ Male Smoker: 1pack/day for 20y, currently 6-7sticks a day (started cutting down 2y ago) Asthma - Since age 4/5, unsure of symptoms then but was told by mother - Worse in the past 10 years - Usual symptoms: SOB, wheezing, chest tightness, itchy throat. Well in between episodes. - Quickly screened for DDX of SOB > No CP/SOBOE, no orthorpnea/ PND, no history of IHD > No sour taste in mouth or retrosternal burning chest pain > COPD: But symptoms started before smoking, complete resolution in between exacerbations. But complains of non-productive chronic cough for last 2 years, mostly white sputum +/- blood when coughs hard (Got such a shock when I decided to ask uncle have you ever coughed out blood before when i had 2 mins left and was feeling for cervical LN during PE and he told me YES?!??!) then quickly screened for lung Ca but did not have LOW/ LOA and asked directly did Dr ever say you have lung cancer (thank God he said no) - Control > Last attack 2 years ago requiring hospitalization (in total 5-6 hospitalizations for asthma). Usually will step up treatment on his own but come in if symptoms not alleviated. Severity of attacks: ranges from speaking in words to phrases. Did not require ICU/ HD/ intubation before. Usually treated with nebs and steroids (says not always, only in severe exacerbation). Usually stays for 5 days > Uses salbutamol 2-3x a week (when throat itchy but no SOB), no nighttime symptoms, no limitation in activity, no daytime symptoms > Compliant to meds, inhaler technique assessed every	Did a quick respi exam Positive findings: Nicotine stains on fingers, inspiratory/ expiratory wheeze (but didnt present) Not in respiratory distress No loud P2 or parasternal heave Not cachexic, clubbed or cervical lymphadenopathy (Malignancy) No tracheal tug, hyperinflation, hyperresonance (COPD)	1. Please tell us what you think the issues for him are 2. What is the most pertinent issue for him? (Smoking cessation) 3. What do you think of his asthma control? 4. What are some differentials you considered? (Asthma-COPD overlap, COPD, bronchiectasis, CCF, GERD etc) 5. Noticed you spent quite some time asking him about the written asthma action plan, can you tell us abit more about it? 6. How would you manage him if you see him in follow up? 7. What are the things you are most concerned about in the long run? (Risk of lung ca in view of strong smoking history)	Quite alot to cover for asthma but practice with friends!

		hospitalization and says competent > Aware of asthma action plan but does not have a physical paper, knows how to step up symbicort inhalers, keeps oral steroids at home but does not use > Does not measure PEFR at home, last time used to but not anymore - Triggers: Smoking. Not triggered by URTI (says seldom gets sick), haze, dust, construction, pets - No other personal history of atopy (no eczema, AR, allergic conjunctivitis) - Family history of asthma: ?father. Siblings/ children do not have any hx of asthma - Diagnosed on spirometry: obstructive picture with bronchodilator reversibility - Comorbids: no OSA (nobody has told him he snores)/ GERD/ obesity - Forgot to ask about vaccinations (but requested later haha) - Currently f/u NUH respi (6-8monthly)- will ask for symptoms, do lung function, advise him to stop smoking Unsure of ACT score - Recent adm to hospital last month for ?pneumonia- presented with right sided chest pain with cough, no fever, treated with antibiotics (Didn't really have enough time to explore this but said would have liked to if given more time) Not for an asthma attack Meds - NKDA - Salbutamol (ventolin) - PRN - Symbicort - 2 puffs nightly > Compliant, doesn't forget because will puff every night after spitting out phlegm and before brushing teeth > No SE: no sore throat/ candida, palpitations Social - Stays with wife and 2 daughters (no asthma)- supportive - No financial issues, MSW on board - Works at the stables as a horse boy, doesn't feel that it triggers his asthma as has been working there for past 30y - Smoker: 1pack/day for 20y, cut down 2y ago to 6-7sticks/day. Aiming to stop within the next year. Has been to the smoking cessation clinic but says that they will not force him to stop but encourage him to do so on his own. Knows that it triggers his asthma, doctors have been			

		telling him to stop - Non drinker Issues 1. Asthma - Moderately controlled on ventolin and symbicort, uses relievers 2-3x a week - No high risk features - Triggers: Smoking 2. Smoking cessation - Already at contemplative stage, support him with smoking cessation clinic and nicotine replacement therapy and psychotherapy to ensure he follows through with it 3. Education - To increase awareness on written asthma action plan as he does not currently have a physical copy - Monitoring control with PEFR			
Adult onset asthma Mx of asthma This patient has asthma. Please assess	Not sure	40+yo Med - didn't bring list but just said seretide 1 BD, ventolin PRN, Oral Pred for emergency, nasal spray for AR, cream for Rosacea PMH- asthma, AR, rosacea, hysterectomy for ? Excessive menstrual bleed? Nothing else First presentation 25yo- 1 w cough, nocturnal, wheeze. Triggers dust and carpets. No sputum no blood no smoking. But lol she had orthopnea and PND but no leg swelling or chest pain went hosp, diagnosed asthma, oral Pred x5d and went home Follow up w spiro, started on seretide n salbu Subsequently only 1 exacerbation, triggered by haze 2y ago. Moderate using BATWRAPPP. Used WAAP, not relieved w ventolin n oral Pred. Went hosp, IV Pred and stayed 2 days. Discharged w no Med changes Subsequently no admission or exacerbation at all Control- no day symptom, night symptom, activity limitation, haven't used ventolin for 2y! So impressive Compliance - gr8888 Complications from dz - no pulm HTN, no lifestyle limit Complications from tx- no oral thrush or hoarse voice and she rinses her mouth every time!!! And no tremors or tachy from ventolin. Oral Pred only took twice in her life. Triggers - dust, carpet but she washes her house every day!!! Sooo good I was like woowwwww!!!! No smoking herself or others around her, haze now she closes windows to avoid, no EIA, no polllen, no construction.	PE - did respi exam and look for atopy. NAD	Present 40+yo lady w 20y hx of well controlled asthma, confirmed w spiro, on bg of personal and fhx atopy Issues 1. Well controlled asthma because (day symptom etc), last admission 2y ago not severe 2. AR - well controlled. But can affect asthma control so must monitor 3. Vaccines - received influenza 2y ago but none after. Never received pneum 4. Habitus - large. But currently no cx of DM HTN etc 5. No psychosocial or financial isusss Q what do u think of her control of asthma? R u happy? A yes I'm very happy!! Asthma management involves : 1. Pt education 2. Controller 3. Reliever 4. Trigger avoidance 5. WAAP and escalate to hospital. Then elaborate on each for her and everything v good Q what do u think of her use of WAAP) A appropriate cuz ... talk abt steps of WAAP and how she knows when to use ventolin, oral Pred an the zone Colours	

		Apparently she had allergy to the detergent at home but I didn't pick that up RF for severe exacerbation - compliant to inhaled steroid, not on or withdrawal from oral steroid, didn't use >1 ventolin canister in a month, no ICU stay etc etc and very good psychosocial and insight Quickly evaluated AR and rosacea, Med compliance and SE Occupation - housewife. Used to be account assistant (asked to screen for ILD) but omg this part was so embarrassing cuz I heard CAR ASSISTANT then I was like ohhh car workshop what kind of chemicals are there? Then she was like HUH??? Examiners also HUH??? Then she was like ACCOUNT ASSISTANT haha Psychosocial good		Q what Color then do what, what dose A each pt has different dose for each. But in general ... talk abt WAAP Q how Long does oral Pred take to start working? A Not sure, estimate 30min Q what if she snores at night A OSA Q How to diagnose OSA A sleep study looking at AHI Q anything simpler? Questionnaire? A can't rmb!! (It's epworth sleepiness scale!) but I'll ask for OSA symptoms like (list out) Q complications of OSA? A list out Q what do u think of her habitus A large, will encourage wt loss through conservative methods like diet and exercise (elaborate on each) Q what is the evidence for medical therapy? Does she qualify for surgery? A Not for surgery cuz BMI not >37 and not >32.5 with DM and HTN. Med options are like meetformin and orlistat. I'm not sure of evidence but would hesitate to try cuz of SE of Med and shld always encourage conservative first Q what is cardiac wheeze Q what is paroxysmal nocturnal dyspnea Q pathophysio of PND lol then this was like last few seconds Q what is pickwinian syndrome Hahaha. Then the bell rang. They were like HAHA SAVED BY THE BELL!!! But ANYWAY "Pickwickian syndrome is obesity hypoventilation syndrome. It's coined after a character in Charles Dickens' book, the Pickwick papers. I loved The Great Expectations." - clare Fong. If anything call her ya	
Asthma Approach to shortness of breath Examiner said: This patient presented with breathlessness. You are	Dr Christopher (surname that starts with a C but I didn't really register), Dr	Ms K 34yo Chinese lady Allergic to aspirin (said her eyes will swell up, but no symptoms suggestive of anaphylaxis) Breathless for a few months since August (if I remember correctly) last year	Patient was dressed in home clothes and examiners said there was no need for proper exposure so did my examination over clothes.	Summarized as newly-diagnosed asthma as evidenced by diurnal variation and response to inhalers, partially controlled (although in retrospect she's technically well-controlled by her ACT score oops) likely due to her occasionally forgetting her controller medication. This is complicated by GERD for	-Even if the patient tells you the diagnosis (as mine did), try to always keep an open mind and rule out other differentials! Can also ask about

now in clinic seeing her, please speak to her and come up with a management plan.	Huma Jaffar	Occurs in the middle of the night when she is sleeping, wakes her up from sleep (able to fall asleep but wakes up halfway feeling breathless) A/w dry cough, no phlegm no blood Also has chest tightness, especially when coughing I asked about noisy breathing but don't remember her answer anymore sorry :/ No haemoptysis No fevers/chills/rigors/night sweats throughout the entire period No contact history or travel history Asked whether she is able to sleep while lying flat with 1 pillow or if she needs multiple pillows - says she has to sleep sitting up O: (In retrospect maybe should have clarified whether this was during her exacerbation in December - see below - but when I discussed this with my CG mates they said this can happen in asthma too?) Otherwise perfectly fine in the day - no breathlessness/cough during the day, no activity limitation No previous episodes of breathlessness, childhood was unremarkable Had a severe episode of breathlessness in December - speaking in phrases but not confused / drowsy / agitated Not febrile (although should have probed about triggers more) Was given nebulizations and told to have bronchitis Returned for follow-up in January, did a breathing test and was told to have asthma Started on 2 inhalers (not sure of names, but 1 red and 1 blue), nasal spray (clarified whether the nasal spray was for sensitive nose but she said it wasn't, was more to help clear the nose of mucus) and gastric medication - she didn't bring the medications with her and wasn't quite sure of the names No PMHx otherwise, no personal history of atopy Screened for symptoms suggestive of atopy (e.g. itchy nose/eyes, rashes/sensitive skin, frequent sneezing, sinus problems) but she didn't have any No skin prick tests done thus far No family history of atopy No significant family history No LOA Some LOW but has regained weight	Palpated for apex beat (not displaced), auscultated the heart (normal), checked for JVP (not elevated), no pitting edema. Listened to the lungs anteriorly and posteriorly - clear (although was concerned for a bit because I thought I heard stuff - but after a while figured this was from clothes) Looked into the nose for enlarged turbinates - not enlarged Asked for any skin rash again and she said she didn't have any Took some time to consolidate along the way and I remember she mentioned something about regaining weight after starting medications here so quickly checked for oral thrush - there wasn't any so thought probably didn't need to dig more for Cushing's-related stuff	which she is on medication although she recently ran out of supply. Functionally this has affected her job caushing her to change jobs three times in the last few months, although she is currently in an environment that is conducive for her. Otherwise no social or financial issues. Discussed a little about whether the breathlessness could be cardiac in origin since there was some ?orthopnea/PND. Said from the history she didn't really have any chest pain - was more of chest tightness and seemed pleuritic in nature, didn't have any CVRF and didn't have other symptoms such as leg swelling; on examination JVP wasn't elevated and there was no pitting edema. Was asked if there was anything else - couldn't think here so Dr Huma asked which side of the heart those were for, so added that I didn't hear any creps at the lung bases. Then was asked what the causes for her ?orthopnea/PND could be - said that asthma has symptoms in the middle of the night due to diurnal variation of smooth muscle tone, then for the part about her having to sleep sitting up I suggested that it might be because of the GERD (although I honestly wasn't very sure what was going on here :/) Was asked about the triggers I identified during history-taking and how these can be addressed - we talked about washing bedding, changing the curtains/carpets regularly, avoiding triggers such as cold air as far as possible etc. Then was asked whether the rabbits were a problem! Said pets usually don't cause problems and in her case she's had them long before her symptoms started. Moved on to talk about how I'd manage her, what I thought the inhalers most likely were and was also asked about the mechanism of action for SABAs and ICS. Then asked about what I would do if she comes back subsequently with worsening of her symptoms - talked about identifying and managing triggers, assessing for compliance, checking inhaler technique, managing the GERD. Then if persistently poor	investigations/treatment so far to help guide you along. -Something they taught us during the NUH Respi lecture - assess for common comorbidities! For asthma it's GERD and OSA (although I forgot OSA oops); for COPD it'll be things like right heart failure, depression etc! -We were told that we don't really need to do the full examination for long case - just targeted stuff that will help you assess the patient. -Practise with each other! It really helps (: Very thankful for my CG mates! -Jiayou and God bless (:

		Was a bit concerned given the ?orthopnea, the lack of atopy history and adult-onset so tried to ask about as many differentials as I could think of (especially since during the CGH Respi review lecture they told us about this case of a 20-ish year old lady who was initially diagnosed as having asthma but later turned out to have Churg-Strauss! So throughout this history I was worried ++ that this wasn't straightforward asthma) - No chest pain except during coughing, no nausea/vomiting, no CVRF, no smoking - No other symptoms of fluid overload - no leg swelling, no facial/periorbital swelling, no stomach distension ; did not notice any decrease in urine output - No jaundice/liver dysfunction, no frothy urine, no chronic diarrhea (says she has constipation instead - BO 1x/week although she's vegan, but this has been a long-standing thing; quickly screened off red flags for change in bowel habits and symptoms of hypothyroidism and neurological dysfunction though) - Was worried about SLE causing pericardial effusion/pleural effusion and other autoimmune conditions, so asked about joint pains/rashes/oral ulcers, but she didn't have any - Also got worried about TB given the chronic cough so confirmed that there was no fever/night sweats/chills and that there was no TB contact - Clarified again if there were other tests such as CT scan and blood tests done for her to diagnose her condition - she said it was only the breathing test Then went on to ask about her progress thus far Symptoms have improved since starting on the medication No daytime symptoms, no activity limitation, no nightime symptoms However has had to use her blue inhaler (salbutamol) 4 times in the last month, so average of 1x/week Aware of what the inhalers are for (one for control, one for symptomatic relief), uses inhaler without spacer, inhaler technique assessed by asthma nurse to be good However occasionally forgets her controller inhaler in the morning especially when she's rushing off to work (I think I managed to quantify how often this happens but I can't remember now sorry :/) Otherwise no exacerbations since the one in December Last follow-up was in March with no issues, next follow-up planned in a few months' time		control, consider going up on medications. If still poorly controlled, may need to consider other diagnoses. Bell rang soon after! Was still super super worried that this wasn't just asthma so after it ended I asked the examiners if it was really asthma. :/ They said that that's what the patient has been labelled as so far! But they were really really nice about it and said I did fine phew. (:	

		Triggers: Cold air, Emotions (she volunteered this), Workplace stress/environment (had to change jobs a few times because it was affecting her condition) No dusty environment or construction in or around her house No exercise-induced symptoms Should have asked about exposure to secondhand smoke but didn't :/ Social History - Works as legal assistant - Non-smoker, non-drinker - Stays with husband and 4 rabbits (technically pets shouldn't be a trigger but asked if she had any concerns about the rabbits affecting her asthma - she said she's had them for 4 years with no problems before all this happened so doesn't think it's an issue) - No financial concerns - No limitations in daily activities or occupation Then remembered to assess for comorbidities of asthma! So asked about GERD symptoms (also cos she mentioned she was on some gastric medication) - to which she said she occasionally had this sour taste coming up to her mouth, worse on lying down after heavy meals! Asked a bit about compliance to the gastric medication - says she actually ran out of supply 2 weeks ago so checked if she's gone back to get a refill and she said she has Think this was most of what I got! Went back here and there to clarify stuff too. Sorry if the structure is a bit messy!			
Asthma/bronchiectasis SOB but more of a management case This gentleman has asthma and bronchiectasis, please take a history and formulate a management plan.	Sorry not sure	Basically it's a management case, the examiners gave the chronic condition you have to clerk at the beginning. The patient has a lot of comorbids like multiple myeloma and DM but when the patient told me about it (he kept saying I have triple myeloma triple myeloma I was like what?! Then the examiner interjected and said he has multiple myeloma. Then I was like shit uh ok but I won't focus on that right? The examiner was like what did your stem say. Sian haha. Also the entire discussion centered around asthma vs COPD. Actually at the beginning I heard the stem as this gentleman has COPD and bronchiectasis but at the beginning of the discussion when the examiners came	Bronchiectasis on the right lobe, left lobe ok No hyperresonance for COPD No bibasal creps to suggest CCF but had bilateral pitting edema Heart sounds normal Had clubbing on peripheries	Present your physical findings - as above + no complications of Pul HTN, Cor pulmonale, CO2 retention, resp failure or resp distress - also no features suggestive of COPD (I said this cos at this point I still thought it was COPD fml la Ok so how would you manage his asthma - vaccinations, smoking cessation, avoid triggers - pharm with the usual, cornerstone is ICS - listed all the other classes of meds for asthma but not as widely used There's always this confusion between asthma	Just keep calm it all goes over very quickly!

		back in the first thing he said was, ok so what do you think of this gentleman's asthma?? I WAS LIKE WTF DID YOU JUST SAY OMG I AM DYING WHY ARE YOU DOING THIS TO ME WHAT IS LIFE. But just keep calm and continue and pretended that I knew it was asthma all along (also the history wasn't consistent with COPD but also not with asthma the guy presented at 60YO man wth) Mr I 67 YO Malay gentleman Presented with SOB in 2008, no prior SOB before that SOB at rest during exacerbations Exacerbation once a year, usually requiring hospital admission Each exacerbation associated with purulent sputum Will get hospitalized and get antibiotics No hemoptysis Last exacerbation 3 months ago Usually trigger is URTI (preceded by runny nose) Otherwise SOB on walking one bus stop Relieved by rest Smoked 30 years ago for 20 years 5 sticks a day (I took a long while to clarify this man I couldn't believe it) Nobody who smokes at home (Here I should have asked about atrophy, like allergic rhinitis and conjunctivitis and eczema etc and family history of asthma but I didn't cos I thought it was COPD damn it) No PND, but orthopnea, sleeps with 3 pillows at night cos of SOB No chest pain palpitations before No LOW LOA night sweats No travel history No DVT/PE risk factors No occupational risk factors for ILD Did spirometry before (the blow into a machine thing to tell how good the lung function is) does it at every follow up but doesn't remember the number Did HRCT before (went into the tunnel thing to do a scan) Each visit to the doctor not sure if medicines tailed up or down		and COPD, how to tell the difference? - history: diurnal variation, age of presentation, association with atopy, with smoking, with family history - Course of disease, asthma variations very marked with baseline back to normal while COPD is a progressive gradual decline with less reversibility - On spirometry will get bronchodilator response with asthma not so much with COPD What investigations would you do other than spirometry - HRCT for Bronchiectasis looking for signet ring and dilation of bronchioles all the way to near the pleural surface How would you manage this patient long term - on history ask for exacerbations, ask for symptom control, assess technique and compliance - if well controlled consider tailing down if not then stepping up treatment How would you advice this patient with regards to his asthma - explain patient education - send for vaccination - avoid triggers stay away from sick people - explain that ICS is the cornerstone of treatment, not to abuse the Salbutomol - talk to the maid who is the one giving the meds and ensure compliance to ICS And that was all! Very standard questions. Jiayou guys!!	

		Not sure about the doses or how many puffs, just takes what the maid gives him (I was like what puff also not you meh?!) Feels that course of disease has improved over the years (but last exacerbation 3 months ago man dude) No intubation before Medications: Took out a whole box On warfarin for multiple myeloma I assume Seretide Salbutamol ("that one I don't really use, only for very very bad SOB, last time I used was a year ago") N acetylcysteine On metformin and glipizide for DM Had a spacer inside as well the one like for asthmatic kids -- noted that the guy prolly had some technique issues, impt they will ask later Takes meds everyday			
COPD Approach to SOB and cough Mr M is a 53 year old gentleman with COPD presenting with an exacerbation. Please take a detailed hx and perform the necessary examination.	My awesome IM mentor A/Prof NV Ramani :) and some other guy I don't know	53/Arab/Male NKDA ADL-I Comm-A Working as restaurant manager No other PMHx. Surgical hx includes some ?cyst excision on anterior chest HOPC: First presented in 2015 with SOB x2/52, intermittent, arose spontaneously Worse on exertion, especially when climbing stairs Assoc with productive sputum - yellow in color Worse with exposure to certain triggers (cold air) LOW of ~12kg (60 to 48) over one year, seems unintentional Nil hemoptysis Nil fever Nil night sweats/B symptoms Nil sig travel history Nil sick contacts Nil chest pain/palpitations Nil abdo pain Nil LOA Nil change of urinary/bowel habits	Respi exam. Only bothered examining the front because the history took quite long and the patient was a little slow in undressing and answering questions. Only signficant findings: - nicotine staining - hyperinflated chest Looked for but did not find any scars, not in respi distress, no signs of cor pulmonale, no cervical lymphadenopathy etc.	I'm used to my mentor Dr Ramani's style, which is to go straight to issues as he doesn't want to hear whatever you just asked once again. Summarised issues as: 1) COPD with 4-5 exacerbations requiring hospitalization but not ICU/intubation, exacerbations not severe as relieved by nebs 2) Poor compliance to medication regime + still smoking as a big risk factor 3) Possible mixed asthma/COPD picture as presence of trigger such as cold air 4) Significant LOW for invx - possible lung ca in view of smoking hx 5) Social issues of finances Standard questions: 1) How to diagnose COPD? - Clinical dx, supported by spiro, just vomited out GOLD guidelines at this point 2) How to differentiate between COPD and asthma - standard stuff 3) Interpret spiro results - fev1/fvc was 57% i think. asked for bronchodilator reversibility and explained what	Common things come out commonly. Sometimes praying does help. Like getting your mentor for exam + a bread and butter case (my last posting was NUH IM and I was in the respi ward so...I took a COPD history almost every other day, which helped a lot for this.) Good luck juniors :)

		Seen by GP -> sent to CGH (wrongly diagnosed with asthma) -> went to SGH and dx with COPD. Blood tests, CXR, CT, spiro all done, no idea about results Subsequently warded 4-5x over the past 2 years, relieved with nebs in hospital, no need for ICU or intubation. Never given abx during admission or had fever during admissions. No need for standby prednisolone either, apparently. Treatment for chronic condition: On tripropium (regimental) Seretide BD Salbutamol PRN Poor compliance, sometimes misses doses because of work/forgetfulness Complications of treatment: No Cushingnoid features Palpitations when using too much salbutamol, no tremors FHx unremarkable for anything. Has stopped drinking. Smoking history 1.5 years x 36 years = 54 py. Has tried cutting down but STILL SMOKING NOW. Impact on self/family/finances: Lives with wife and 3 children. Had to take sick leave when warded, otherwise did not miss work Finds it difficult to work when he has to rush up and down stairs serving customers Currently has financial help for meds (can't recall what he said, it's not MSW)		is considered significant (>200mls, >12%). Simple stuff 4) What meds can be given for COPD? - relievers, preventers, standby oral pred 30mg OM x5/7. Just vomit. 5) Complications of COPD 6) Pt comes in with SOB, how to manage - ABCs, supp o2, spo2 capped 90%, 2 large bore IV cannulae, investigations (ABG important here), neb (ipratropium:salbutamol:saline 1:1:2) then taper off where necessary, cover for infections if spiking temperature/clinical examination shows signs of infective exacerbation. Alert senior. Standard stuff lah. 7) How to manage and prevent infx - finally an ID qn since I love ID ttm. Baited them by giving the possible bacterial causes of infx then suggested the recommended guidelines as per IDSA. Don't forget to offer vaccinations! Couple of other things they asked like how to work up for LOW and all, but can't remember exactly how it was phrased so yeah. But this was a very standard case.	
COPD management case basically long case of COPD This gentleman presents to your clinic for COPD. Please take a history, targeted examination and present the issues	sorry cant remember	60 yo Malay gentleman Security guard worker 40x2 pack years Drink 2-3 beers everyday ADL independent, community ambulant pmhx: COPD, HTN First presented with COPD about 6 years ago - Presented with chronic dry cough and SOB of 3 months duration - acute exacerbation of SOB, and reported to A&E - no phlegm, hemoptysis, fever, pleuritic chest pain	essentially NORMAL except for barrel chest do a standard respi exam, and make sure to look out for polycythemia, pulm HTN, respiratory failure also ask patient stretch out hand and	what are the issues? (they zoomed in a lot on functional issues like can he work, can he function at home etc) why is he still smoking? (i died at this one. remember to ask your patient why he/she is still continuing the trigger!) how would you investigate? (FBC, RP, ABG, offered alpha 1 antitrypsin if my patient was younger and had no smoking hx; CXR; Spirometry) Features to look for on CXR? (hyperexpanded lung fields, thin cardiac silhouette, features of CA: mitotic lung lesions, pleural effusion collapse	study your bread and butter cases, and at least try to cover every single organ high yield things that you have to know inside out: Neuro - Stroke Lungs - COPD, Asthma Heart - CCF, AMI Liver - Cirrhosis Kidney - CKD, GN

		- no PND, orthopnea, LL swelling - no travel, contact hx - no fever, LOW, LOA - Diagnosed with pneumothorax secondary to COPD, had a chest tube insertion - no ICU or HD at that time Chronic history - 3 years after diagnosis, had another pneumothorax, and needed to be hospitalized, but no HD/ICU stay - in the same year of second pneumothorax, patient also had a severe infective exacerbation of COPD - Patient collapsed at home and required to be sent to ICU, was intubated(I did not ask if CPR was done, as i trusted his word for it. But on hindsight, should've asked for any CPR) - stayed in ICU for a week, then extubated - No more hospitalization since - Infective exacerbation once every 1-2 years, gets better after seeing the GP, who usually gives antibiotics and short course steroids - currently mmrc grade 1 (SOB when walking up hill, no need to stop for breath while walking on ground level or walking slower than peers) - currently on f/u with NUH respi Triggers: - Infection triggers it - Patient still smoking (on hindsight should ask why he never stop, but no time sigh) - negative for haze - negative for stress Complications: - 2x pneumothorax - 1x collapse - no pulmonary HTN (uncle has no heart problems) - no polycythemia - no need for long term O2 therapy - no complication of meds (no tremors, hypokalemia for beta agonists; no cushings syndrome or steroid related SE like cataracts, TB, Hep B/C/HIV reactivation, cataracts etc for ICS) Co-morbids - snores at night, but no daytime symptoms, and no nocturnal apnea (TRO OSA)	look for essential tremor from beta agonists offer cushing's exam	etc) how would you manage? (just vomit out the GOLD guidelines) what are the indications of LTOT? (this one must know, go read your jansen koh or NUH paces notes) Can you give beta blockers in COPD? (answer is yes, can give cardioselective beta blockers) what will you tell the patient if he gets an infective exacerbation? will you give the patient some PO steroids on standby during infective exacerbation? (uhh i thought can, but i dunno what she wants..)	Of course there are many many many others, like rheum/heme etc. but the ones listed above are really common, and examiners may slaughter you for not knowing enough

		- no hemoptysis to suggest bronchiectasis - no previous TB - patient has no LOA, LOW, night sweats, but has 1 first degree relative and 1 second degree relative who had lung cancer; Said a CXR and CT was done, but no findings Meds - symbicort x2 puff daily (started 3 years ago, no recent change) - tiotropium x2 puff daily (started 3 years ago, no recent change) - SABA as needed (takes about 2 times weekly, since 6 years ago) - amlodipine dose??? - not on LTOT - no traditional medications - previously taking aspirin secretly cuz his friend said it was good (WTF), but have already stopped long ago cuz doctor said no indications No surgeries done before systemic review unremarkable HTN history unremarkable, picked up on routine f/u, no end organ damage on hx or HTN urgency/emergency (very irritating, but must ask since this is a management kinda case) Psychosocial - not depressed, just wondering if his COPD is reversible by quitting smoking (told him that quitting smoking will reduce mortality, but doesnt fully reverse the damage that is already done to the lungs) - good family support - lift landing - have MSW helping, says its enough			

Adult Medicine - Gastroenterology

Autoimmune hepatitis Approach to jaundice This patient presents with yellowing of skin. take a history	Prof rajan, another rheum lady doctor forgot the name	58 yo lady, english speaking. (So happy it was adult case - mine was station no. 2, so i took the gamble of not really studying for paeds the day before as traditionally its always been station 3 or 5). Presenting complaint: yellowing of skin started in Feb - 2 weeks before went to see doctor at CGH > Obstructive jaundice picture - pale stools, dark urine > LOA, without LOW	Did a quick abdo exam (did from abdo first then moved to periphery) in 5 min. Found the liver biopsy scan. Left lobe enlargement 4 FB below costal margin.	2 min went by really fast. And i felt like i actually did a shitty job with the history because it was very messy - as i didn't really know what risk factors and stuff. and if they are going to ask me more about autoimmune hepatitis - I'm truly screwed. At least know more about PBC or PSC. SIMI AUTOIMMUNE HEPATITIS. sigh. but okay consolidated and decided to just wing it.	Im actually writing this account post MBBS day 3 liao (because forgot haha too excited after mbbs), but remembered how useful all the seniors accounts were- so

		> Pain in the right lower lobe of the lung - thats right, not epigastric or RHC pain. Dull, constant. No radiation. No aggravating or relieving factor. > All the others negative - no pain else where, no N&V, no fever, no change n bowel habits, no melena. > Rule out pulmonary pathology as well + DVT risk factors (due to patient pointing to right lower lobe lung pain). --- at this point, ALL I HAVE is OJ picture, and that it's not a surg case. Still don't know the diagnosis yet but i figured in order to take a complete history, i NEED to know this diagnosis, so i went ahead to ask the course of her treatment-- > went to CGH, did some scans + biopsy > Found to have autoimmune hepatitis (yeay thanks for telling me). > Put on dexa 12mg. now tapering down > was also on azathioprine, but complications of fluid retention + rashes (but no overt allergy symptoms) > Now changed from Aza to MMF. tolerating well > jaundice gone by then Also other complicated parts: >Previously on follow up with GP, found to have some elevated liver enzymes > Did scan and was told she has fatty liver. > But not treatment / advice given Complications of liver disease: > No sympt of portal hypertension > has US liver done. Not sure if have cirrhosis After understanding her full story, went back to ask risk factors for autoimmune hepatitis (WHICH I DONT KNOW WHAT IT IS so i just spam all autoimmune stuff) > Essentially only hypothyroidism diagnosed 4 years ago on thyroxine replacement. but was never told formal diagnosis of why have hypothyroid > Otherwise no joint pain (but have some back pain that she is seeing ortho and taking NSAIDs), chronic diarrhoea, eye symptoms, loss of hair, lung symptoms. >Systemic screening also unremarkable PMH: >Hypothyroidism on thyroxine replacement > Polio diagnosed very young. not much cx > Autoimmune hepatitis	Palmar erythema and ?spinder navei Others are all negative findings Finished off with base of lung auscultation. Also looked out for signs of cushing and insulin resistance (but i didn't present my findings so don't know if they knew what i was doing lol)	Examiners came in. Prof rajan is the active. R: Summarise your findings Me: 58 year old lady presented with obstructive jaundice... R (interrupted me): How did you tell it was OJ? Me: Pale stools and dark urine suggestive of obstructive nature. R: So what ddx do you think of when pt comes to you presenting this? Me (??? huh so we r going straight into the questions?? WHAT ABOUT MY SUMMARY???): anything along the biliary tract - gall stones disease (choledocholithais, cholangitis), malignancy at periampilllary important to rule out. Infections viral parasite. Of course it can still be hepatic causes of jaundice - listed some random examples. Pre hepatic jaundice is possible as well but don't classically present as OJ - listed some examples as well R: Which viral hepatitis? Me: Acutely can be A, B E. Chronic B and C. R: What were your PE and findings? Me: Enlarged left lobe of liver. palmar erythema and ?spider navei but otherwise no other stigmata of chronic liver disease, no signs of portal hypertension and spleen not enlarged Passive examiner: Sorry can i just cut in, so how do you tell if its spider naevi? Me: Its blanch able but i wasn't able to blanch it just now. so it might just be small hemagiomas? Passive examiner: Looked happy R continues questioning - questions asked were rather simple THANK GOD. couldn't remember all but here's some: Q: Ix Me: Justified why i want FBC, RP, LFT... Q: What else r u looking for in LFT Me: Bils to look for pre hepatic, hepatic or post hepatic. For hepatic causes it can be a mixed picture depending on how bad the hepatic damage is. ALP for cholangeal pathology. AST and ALT for liver damage Q: So if AST and ALT are both in 200s, what r u thinking of Me: Well this is unlikely to be viral hepatitis as i note they tend to be in the range of 1000s when	please write in your accounts after your mbbs! For me, i got SUPER lucky in that the entire med short + long i didn't do a single CVM or neuro! (sorry just want to brag a little here but few people will have this luck haha so don't count on it). But otherwise, really recommend everyone to practice on real patients in the wards early. Although we complained how 7 weeks of ward ban has made us forget a lot of our clinical acuity stuff, but once your hands touch the patients, YOU WONT FORGET all the previous kidneys and spleens and liver you felt. YOUR HANDS REMEMBERS. :) Trust yourself, have faith, and god bless!

		> ?Fatty liver disease > Hypertension - well controlled on single meds (can't rmb what now) Drug history: > Steroids - has some weight gain, but no signs of Cushing's. going for DEXA scan soon. Hypt did not get worse, no newly diagnosed DM > MMF - not complicated by BM suppression. Menstrual history: > menopause at 47yo. Menstrual history rather unremarkable. Social: > Non smoker > non drinker > stays with family and children - all grown up > previously work at construction sites - but due to hypothyroid, find very tiring and stopped working since 4 years ago > but no financial issues as its covered under insurance. FH: > No family history of any autoimmune diseases - asked everything i could think of. At this point it was about 18 min		it happens. I know that ALT is more specific for liver parenchymal damage.. Q: so what happens if AST is elevated? Me: omg i feel like i just dug a grave for myself hahaha (yes i literally said this in exam and they laughed lol) but AST is more for mitochondrial damage in cells so like toxins damage and stuff (they accepted and moved on lol) Q: How would you diagnosis her condition Me: Imaging and then biopsy - named the different modalities Q: Okay so if this pt comes in with confusion, what are u thinking of Me: Due to her liver pathology I'm thinking along the lines of hepatic encephalopathy after ruling out all the other causes of acute confusion. Want to look for source that precipitated the hepatic encephalopathy - look for bleeding, any active infections - work up + CT brain. And clear bowels to discourage ammonia build up for hepatic encephalopathy Seems to be satisfied with my answers, but the last question was something still on the confusion part but "now that i tell you she's on steroids..." AND THE BELL RINGS So i don't actually know whats the last question he wanted to ask - maybe if she's on steroids then what other causes of confusion r u thinking of??? to which, I AM NOT SURE. so glad to be saved by the bell!! Before leaving, the passive examiner was suddenly very excited and was like WELL DONE GOOD JOB. said thank you thank you thank you thank you thank you and quickly grabbed my paeds kid and ran out!! Overall happy with the experience. customer satisfactory 90% - because even though the diagnosis was like what the heck why would u list this for mbbs, the questions and everything else was reasonable!	
Liver cirrhosis Approach to UBGIT/liver diseases	Prof Adrian Kee (NUH Respi) and another male	Mr Lim 68/Chinese/Male NKDA Nil past medical history	Did a full abdominal examination Requested for vitals	Presented issues as Medical - Liver cirrhosis secondary to chronic Hep B infection, presented initially as UBGIT from	- Standard case, standard questions, and benign examiners. Can't

This patient has liver cirrhosis. Please take a history, do PE and come up with a management plan.	doctor	P/C 1. Hematemesis x1/7 - started in April 2016 - 2 episodes, 3 cups each - a/w 1x melena the day before - no symptoms of anaemia - no history of PUD/NSAIDs/steroids use - no LOW/LOA, early satiety, family history of gastric cancers 2. LL swelling x 2/52 - a/w abdominal distention - no SOB/orthopnea/PND - no jaundice - no oliguria/proteinuria Underlying aetiology - no chronic alcoholism (drinks 3-4 times a year) - newly diagnosed chronic Hep B infection (initially said don't have until he told me his meds) - no known family history of Hep B/C, no IVDA/tattoo/blood transfusion/high risk sexual practices - no history of autoimmune conditions - no family history of liver diseases Course - Went to NTFGH ED - Underwent oesophageal banding for bleeding varices - Stayed in ICU for a few days, no complications, no intubation - Newly diagnosed with liver cirrhosis and Chronic Hep B infection - currently on f/u with Gastro doctor every 6 months - unsure about Child Pugh score - no further exacerbations requiring hospital admissions - no plans for liver transplant thus far Complications of disease - oesophageal varices s/p 2x banding, currently on propranolol - fluid overload on fluid and salt restriction (compliant), previously on a diuretic (presumably spironolactone) due to side effect of 'chest pain' (turned out to be gynaecomastia) - no jaundice, easy bruising, fluid overload, renal failure - HCC screen every 3 months with ultrasound: no HCC	(not given) Alert, comfortable Stigmata of chronic liver disease - palmar erythema, spider naevi, sclera icterus - but no clubbing, bruising, loss of axillary hair, gynaecomastia Abdomen - distended abdomen - Mild splenomegaly (no palpable spleen but dullness over Traube's space) - ascites with positive shifting dullness Underlying aetiology - no signs of chronic alcoholism: parotidomegaly, Dupytren's contractions - no tattoo marks, signs of IV cannulation Requested to do DRE, check for testicular atrophy (examiner said don't need)	bleeding oesophageal varies - Complication of oesophageal varices s/p 2 x variceal banding currently on propranolol - Chronic Hep B infection, well controlled with Entecavir and low viral loads - Social drinker Functional - Mild functional impairment due to reduced effort tolerance Psychosocial - Good insight, motivation and family support Financial - No financial issues Questions 1. Assuming this patient first presented with UBGIT, what investigations would you like to do? (Examiner gave values which I have to interpret on the spot) - FBC (Hb 9 Hct 25.9 Plt 97 Plt 16) - U/E/Cr (didn't give values) - PT/INT (PT 16 INR 1.34) - LFT (Alb 26 Total bil 22.5 ALT 42 AST 47 ALP 76) - Hepatitis serology markers (anti-HCV negative, Hep B viral load elevated) - GGT and MCV to look for chronic alcoholism (examiner said don't have but good thought!) 2. What are the causes of liver cirrhosis? 3. What are the complications of liver cirrhosis? 4. What are the principles of management? 5. What is the Child Pugh scoring? 6. Is this patient in acute liver failure? 7. How do you know he is not in hepatic encephalopathy? - Mental status: alert, conversant, talking to me - PE: no liver flaps 8. What are the factors that can precipitate hepatic encephalopathy? - Increased protein load (BGIT, constipation, increased dietary protein) - Surgery - Sedatives - Hypokalemia - Intercurrent infections 9. What infection are you particularly worried about in this patient? - SBP	really complain. - Jiayou juniors! Just know your approaches well and you will be fine!

		detected so far Co-morbidities 1. Chronic Hep B infection - currently on Entecavir - no side effects, fully compliant - says that viral load is now low - children did not go for Hep B screening Functional/Psychosocial - decreased effort tolerance (70%) due to his condition, but otherwise ADL-independent - good insight into his condition, understands the severity of his condition and importance of compliance to medications and follow ups - good family support Social - non-smoker - retired, used to work as poultry farmer - lives with wife and 3 children - no financial issues with medications			
Variceal bleed 2' chronic liver disease b/g HIV Approach to haematemesis No stem given	Prof Tay Jam Chin (TTSH Gen Med), nice Indian female examiner (didn't get her name bc she was the passive and out of my sightline most of the time)	unlike what we'd been promised during the briefing, there was no stem and they just told me the patient's name and expected me to begin. confusedly asked if there was a stem; was given "this patient was recently admitted for a medical condition" -.- thank u v much for ur input kind examiners 63yo chinese gentleman who spoke chinese (sigh) works as matchmaker (lol i said 'wah uncle can you help to matchmake me i'm still single' and both examiners laughed uproariously so i took it as a good sign), previously worked in construction business (rough work) previous smoker of 10 years duration 5 packs/day 10 years ago = 50PY does not drink alcohol, no previous alcohol hx no known drug allergies given the stem i knew the examiners probably a bit niao and wouldn't like it if i asked for what the doctors told him he had so i started with 'uncle what problem did you have to see the medical doctors for which you're here to tell me about?'	did an abdominal system examination stigmata of CLD: palmar erythema, spider naevi over chest, no other stigmata no signs of alcoholism no asterixis huge hepatomegaly, requested to get my ruler from the table where i'd left my equipment, realised the ruler wasn't long enough to measure the hepatomegaly, went back to get my tape measure, female examiner said nvm no need to measure you	Prof: what are the issues? me: first issue is haematemesis 2' chronic liver disease- Prof: (cuts me off) i know he came in with haematemesis what is your problem list?! this did not start well. me: sorry sir first issue is variceal bleed 2' chronic liver disease complicated by portal hypertension and ascites- Prof: (cuts me off again) so what was the cause of the cirrhosis? me: (pls let me finish my problem list) (also i never said he had cirrhosis) sir on examination he had hepatomegaly which i would not expect to find in cirrhosis however it is still possible; in terms of causes there was no clear aetiology on history as he did not know his hepatitis B/C status, no intravenous drug use etc maybe the HIV? (jialat wrong answer) Prof: *proptose +++* so you think HIV can cause cirrhosis? me: (tbh idk but i thought HIV can cause everything) uh sorry prof no.	MBBS luck is real. other people in my circuit got rheumatoid arthritis and asthma. also i already got hepato for my actual GS long case except it was comparatively v straightforward so this was weird AF. then again i also heard other people who got cases like HIV lymphoma and Diamond-Blackfan anaemia so i guess it could have been a lot worse. didn't know if the lady examiner spoke/understood

		uncle straight up said he got haematemesis siaoliao macam GS long case PC: haematemesis x 2 episodes 1/12 ago - first ep: woke up at 2am, suddenly needed to vomit, went to toilet and vomited in basin, no clots, no undigested food, unable to estimate quantity by cup/bowl/etc but says 'entire basin filled with blood', went to hospital - second ep: at hospital, suddenly needed to vomit again, did not make it in time and vomited on the floor, unable to estimate quantity but says 'entire floor covered in blood', no clots no food - no preceding vomiting prior to haematemesis - a/w ?epistaxis and ?gingival bleeding ?????? (did not fit the picture at all but uncle insisted have during the hospital stay then after discharged no more so idk man ddx thrombocytopaenia but little did i know what else was to come) - no malaena, haematochezia, haematuria, muscle haematoma, haemarthrosis - reported some abdominal distension, not sure if fluid, no aspiration done by doctors - no chest pain, abdominal pain, nausea, fever - no jaundice, encephalopathy - stayed in hospital five days - OGD done, variceal banding (idk he said something in chinese i just asked is it to stop the blood vessel from bleeding and he said yes) done once, for relook banding in 1/12) - stayed in hospital 5/7 at this point i asked the uncle if he had any blood disease and any liver disease bc the internally inconsistent history was either bleeding diathesis if you believe his multiple bleeding sources, or portal hypertension if you don't; he said he was told his liver is big. asked him who told him, he said found on checkup 1y ago. asked him if the checkup was a health screening or for some other problem and he said 'YA FOR MY HIV" uncle pls y u do tis at this point, not much to go on in terms of CLD, decided to clerk HIV hx first in case it was relevant/could throw up	found...something right? me: hepatomegaly yes ma'am thank you ma'am no shifting dullness no other findings, completed full abdominal system physical examination didn't get to request DRE etc everyone left the room	Prof: what are your differentials for haematemesis? me: *gave differentials for UBGIT, prof not happy kept wanting more idk* Prof: okay... nvm what are the rest of your issues? didn't interrupt as i presented: 2. HIV x 9y on f/u CDC, on two antiretrovirals told viral count good 3. DM x long time on oral medication last HBa1c 5.8% well controlled 4. psychosocial issues of poor finances and mood 2' to medical conditions Prof: so what is the most likely cause of his cirrhosis? me: (thought i'd said hep B/C earlier so didn't say it again, got asked for more and more, wasted a lot of time here, listed everything i knew, finally nice female examiner asked me if there's some infection and i finally said it sigh) Prof: if this patient comes to you with his presenting complaint how will you manage? me: ensure patient is haemodynamically stable etc, keep nil by mouth- Prof: okay we alr know the acute management what will you give??! me: sorry sir omeprazole and since i strongly suspect variceal bleed, somatostatin, send for urgent oesophagogastroduodenoscopy which can be diagnostic, therapeutic and prognostic Prof: omeprazole... oral?? (niao +++ sigh) me: no sir intravenous (didn't let me go into further definitive mx which i rly wanted bc i wanted to demonstrate my knowledge of relook OGD for oesophageal varices after gastric varices are banded on the first scope, propranolol for rebleeding prophylaxis etc ie basic GS stuff which might sound impressive to IM people) Prof to lady examiner: any questions? lady examiner: how would you manage his HIV?	chinese and the entire history was in chinese (although she laughed at my matchmaker joke but idk it was partly in english) so hopefully she was able to assess my hx kindly without Prof telling her i'd done v badly or sth sigh just hope for good case and good patient and good examiner i guess. nothing much you can do otherwise; prepare approaches since diagnostic cases do come out (although Prof Derek Soon said in his morning briefing they were trying to phase them out in favour of management cases) don't even know if i passed lol how to give advice to juniors when y'all might become my batchmates

		more clues --> it didn't HIV x 9y f/u CDC - unsure how he got it - prev hx of multiple sexual partners - used condoms as barrier protection but not on every contact - denies CSW, intravenous drug use - has been abstinent since his dx - currently on 2 antiretrovirals (recently changed one because of proteinuria) - no pneumonia or other infection bc of HIV - most recent checkup doctor told him viral load is 'very good' - ex-wife knows about diagnosis but otherwise no one else - worried and mood low because he wants to keep it a secret and he feels his work is affected by it no idea what was going on so... back to CLD hx risk factors: - does not know his hep B/C status - no tattoos - no intravenous drug use - no previous liver diseases - previous frequent travel to China and Vietnam for work --> not sure if matchmaking or construction - no seafood - no maternal hep B/C/HIV complications: - no renal impairment (hepatorenal syndrome) - not on hepatocellular carcinoma screening (no ultrasound), not told if got cancer - no symptomatic anaemia: giddiness, palpitations, chest pain, exertional dyspnoea mx instituted: - as above for acute presentation of haematemesis - otherwise no other mx for the liver itself, said it's still being worked up PMH: - HIV as above - diabetes mellitus x many years: on one medication recently reduced from two, last HbA1c 5.8%, does not monitor CBG at home		R U SRS LIKE THIS ALSO CAN me: uhm ensure close followup with his infectious disease specialist (examiners gave the wtf look), monitor viral load, *BELL RINGS*, uhm other things thank you prof thank you ma'am thank you pt sigh felt i really didn't do well on the discussion at all hopefully nice lady examiner gave me her 2 APs	

		- renal stones many years ago which caused haematuria - no other chronic conditions or surgeries at this point it was alr 15min had to rush through the rest of the hx fast fast bc again examiners did not get the memo that we can plan the 25min ourselves and told me to examine; spent some time asking if i could complete my hx first, nice female examiner allowed Medication Hx: - taking HIV antiretrovirals, DM meds, nothing else - claims compliant to all meds - no TCM, over the counter supplements etc Family Hx: - four other siblings, no one has liver disease or HIV Social Hx: - Lives alone - Divorced 3y ago, has a 15yo daughter still studying (didn't ask who she lives with) - Finances 'very bad' - Known to MSW, receiving government welfare for HIV meds - Low mood due to condition, wants to keep diagnosis of HIV secret, claims it affects his work			
Chronic liver dz 2'dary to Hep B b/g of prev HCC s/p TACE, poorly controlled DM 2'dary hydrocort, previous SBP Approach to Fever Verbal stem. Patient has fever. Take a history then examine.	Prof Lim Si Ching (main), nice dude	57 y/o Chi male NKDA Drug hx: NKDA Hep B - tenofovir Diuretics - frusemide, spironolactone Abx for SBP prophylaxis - meropenem (pt actually said this, but since when mero can bring home and PO? confused max max) DM on insulin (3x bolus + 1x basal) HLD on statins ?Hydrocort (for idk what, he kept saying it's for the SBP/gut/liver, said different things each time I asked what it was for) Pmhx: Hep B - dx during NS when he went for blood donation in 1982 Prev HCC s/p TACE - no recurrence DM - forgot to ask how many years, last HbA1c 10%	General inspection: Virgin abdo, distended. no umbilical veins. Mild cachexia Peripheries: Palmar erythema + No clubbing, dupuytren's or other signs. Head: Mild icterus, no conjunctival pallor. Chest: No gynaecomastia, spider naevi, telangiectasia Offered axillary hair	1. Summarise. Presented really lousily but gave 3 main issues: - Likely Child's B-C CLD 2'dary to Hep B w previous HCC s/p TACE (for monitoring of new lesions and currently awaiting transplant) - Multiple comorbs, most significant is poor DM control 2'dary to hydrocort use - 2. Didn't ask for differentials. Can't really rmb, but I vaguely remember telling them in fever, i'm thinking of SBP in this dude. Other causes of PUO, though not really PUO cos not 6 weeks and fully investigated yet, i'm thinking infection, malignancy and autoimmune. 3. What kind of diet in this patient? (male examiner asked) - Offered low glycemic index, low fat, low everything for his DM/HLD. - prompted something related to diuretics, said that net effect is like low K, so maybe uhhh, high K diet? (on hindsight I think it's fluid restriction	Practice practice practice with friends. Be harsh (good friends whom you practise with wont/shouldnt be offended because it is really helpful when friends are harsh on you!) General long case template: 1. Approach to HOPC - rule out red flags, then the most likely dx, then everything else 2. Approach to chronic dz - cause

		HLD - well controlled HOPC: Fever x 1.5 days - offered T max 39.2, a/w chills and rigors - called the hospital and advised to admit: clarified on why he call the hospital, so good got privilege? Pt shared that he is on liver transplant waiting list *extra info yay* so they gave him a number to call if he became sick (NUH NUCOT service damn good ah) - tried panadol, didn't work - NO signs/symptoms, no: URTI symptoms, headache, eyepain, jaundice , SOB, CP, N/V, abdopain, increased abdo distention, pedal oedema, dysuria/urinary symptoms, diarrhoea/constpiation/PR bleed, LOA. (might as well have done systemic review on my 2nd question alrd) - Increased weight cos of abdo distention - Is this the first episode of fever recently? (smlj, did I miss something, but I wasted damn lot of time alrd, went on to hospital hx) Events in hospital: - Full septic work up done, peritoneal tap initially not done, but done after a few days because abdo swelled up ("I told them not to give me so much fluids but they still did!") - ALL NEGATIVE - Was able to tell me initial FBC results: Hb/RBC normal, TW *normal*, Plt 26 (!!!) - Said kidneys were okay - Told me he was dx with Dengue (panic max, went back to HOPC, started asking about travel/contact hx, presence of rash, postural hypotension) Then Prof Lim saves the day by saying patient had no dengue! Sheepish looking patient said, oh yar then they said it wasn't dengue (my imaginary eyes rolling 99999x). Asked about malignancies, if they scanned his liver, (because top causes of PUO is infection, malignancy, autoimmune dx) this is when he told me he had HCC previously s/p "tazer", didn't tell me previously. But this admission no scans done. Double tripled confirm that he was discharged with no dx for the fever, and he said yes.	examination. Abdo: Distended, tense but not guarded. ?palpable liver but very tympanic on percussion cos of ascites Spleen quite big (or so I think), but haven't cross midline yet, about 4-5FB below costal margin No ballotable kidneys, sacral oedema Shifting dullness +++++++++ (very nice dull-typmpanic contrast) Feet: Mild pedal oedema Petechial rash + dry skin +++ (which triggered me to ask for more) Finished hx + PE at 22 min mark, examiners asked if I still needed patient. Decided to take more history as above.	lol) - shot myself in the head by saying high protein diet for his CLD cos low albumin, then Prof Lim proptosed ++++++ that I could sense it even when I wasn't looking at her. Quickly retracted and said "oh cannot ah, will kena uremia", then she proptosed even more. She helped by saying "hepatic...?" Then I just filled in the blanks and said encephalopathy, and male examiner was happy. 4. How to manage? - ABCs, empirical broad spectrum abx after full septic work up > What abx? - (wtf i alrd said broad spectrum + he already on meropenem PO at home right) offered piptazo + gentamicin for gram + and gram - cover, esp in SBP common bugs are gram negs. 5. What are some risks in this pt if you peritoneal tap him? - offered early vs late complications, got prompted for specific cx - thought very hard and finally coughed up, oh plt 26, dk whether can tap, maybe? call senior if not sure. (can sense their lol, you stupid girl) 6. Why he got fever then TW flat? - fumble-mumbled about immunosuppress, then could feel examiners looking at me even more eagerly - scanned through the hx and localised it to hydrocortisone - both examiners laughed and say no lah - OH COS HIS DM VERY BAD RIGHT - (receives approving nod) Bell rings! Okay bye bye.	- course - complications (of dz and treatment) - costs/social issues Always include social issues, if any in your problem list.

		Cx of CLD: - abdo distention waxes and wanes - (did not ask about variceal bleed zomg) - asked about bleeding tendencies - +++ (asked these later when I had extra time) - pruritus, not much - petechial rash +++, patient offered this himself (he actually said petechiae) because I asked him after PE, that I noticed his skin looks dry. waxes and wanes with pedal oedema - TCUs are about 4x/year to NUH NUCOT. Hx of other diseases, compliance: - DM: very poor control, latest Hba1c 10% , because of hydrocortisone (did not tell me he was on this at first). asked about why he is on hydrocort, he says cos of gut/sbp/liver (screw this shit not gonna figure out why when i have so little time). Previously on OHGAs, got converted to basal-bolus after starting hydrocort. - Compliant to medications, occasionally forgets, no major SEs: e.g. nephrotoxicity, hepatotoxicity, rash, hypoglycemic episodes - Asked steroid SEs in detail when I had extra time after PE: no noticeable fat gain around face, patient thinks his face looks skinnier in fact. easy bruisability (could be due to liver dysfunction), no GERD/PUD symptoms, no #s from osteoporosis or previous falls Fmhx: Dad had Hep B liver cirrhosis, died of that. Otherwise fmhx clear, no cancers. Social hx: part time admin, financial difficulties on f/u with MSW. non smoker non drinker. didn't ask about marital status. I know Prof Lim likes sexual hx (scolded very badly by her in M3 for not taking it), so asked about sexual hx and IVDA given he has b/g of Hep B. Concluded by asking if patient had any thing else he could help me with, he was very encouraging and said nope, nth else, you were quite thorough. (not sure if cos I was first student of the day, or if he meant it)			
Alcoholic Cirrhosis Approach to Syncope	2 very nice examiners. Old Indian	68 y/o Caucasian Male. Nice guy. But not the best historian. He forgot quite a bit of what exactly happen when he was admitted.	- PE: He has the complete set of stigmata of CLD. The	- Questions 1. How wld you follow up him in clinic? What investigations wld you do?	

Examiners actually didn't give stem at first. After taking biodata and some PMH, I requested for it. Then they scrambled to look for some paper and said, this patient has background of alcoholic cirrhosis and on follow up currently. Pls take a history	male and Chinese female	- PMH: more than 50 years of drinking history. Went for some blood screening before so he kinda knew his liver wasn't very well but didn't go for any treatment. Not sure why. - Presentation: Presented with Syncope about 2 years ago. When going to toilet. No preceding symptoms. Didn't have LOC. No major injury during fall. No post-ictal symptoms. Called out to son who helped him up and eventually took him to hospital. - Associated symptoms: So he actually had Frank PR Bleed for several months during that period already. He had symptoms of anemia namely, fatigue. This led to his syncope. - Admission: Admited to Nuh. They did various blood test and scopes of which he cant quite remember well. Was admitted for 7 weeks. Doesn't actually know why and where he was bleeding, but just knew he was treated for it. From what I can make out, he most likely had OGD and colono. He also had ascites then. So they did several abdo taps. I suspected he either had esophageal varices or peptic ulcer. Lol he doesn't know. And he cant rmb what treatment he had. - Progress: Was treated and now on follow up every few months. AFP and Ultrasound scans. No HCC. Doctor said that his is improving. Doctor had not discussed with him transplant. Has cut down to 2 can of beers a day. - Drugs: Currenly on directics and beta-blockers - Social and Family: Nothing Significant. Coping well. Supportive family. Works as computer programer. Married with kids. - Complications: Only LBGIT, Symptomatic Anaemia and Ascites. Note: His history is not the best. Was more disorganised than this. In exam u are more flustered. You think slower and speak slower too. My history took 18 min.	largest gynaecomastia I have seen! Palmar erythema, spider naevi, ascites, heptomegaly. Otherwise well. - Presentation: Presented as Medical (PMH, Follow up, Long term meds, Complications), Social and Functional.	2. Why would you do a renal panel? (They wanted coz he was on diuretics) 3. What are the complications of diuretics? 4. What are complications of cirrhosis? 5. How do you screen for HCC 6. What was the cause of his syncope? 7. What meds of prevent oesophageal varices? 8. What are the complications of alcohol other than cirrhosis? 9. How wld you control his drinking habits? Couldn't rmb the rest but qns were quite standard. Didn't get hard qns. All the best juniors!:)	
Ulcerative colitis	A middle aged male active	Biodata: 64 yr old malay gentleman	The examiner told me to stop the hx to	Gave the summary and the issue list 1. long standing UC, previously well controlled	(Thanks to my study partner who

Approach to bloody diarrhoea No Stem	and a fam med/ geri/ palliative nuhs female Dr as passive. Forgot their names.	NKDA ADL-I, comm-A Presenting complaint: Bloody diarrhoea x3weeks in 2002. Fresh red blood flood entire toilet bowl. No abdominal pain. LOW of 10kg from 70kg. No symptoms of anaemia other than fatigue. Went to see doctor eventually as too much blood and thought something not right. No previous radiation to the gut. No TB. No new medications. No contact hx. No travel hx. No fever. No LOA. Went to NUH and colonoscopy was done. Diagnosed as ulcerative colitis involving the entire left side of colon including rectum. Biopsy taken, no cancer No skin tags, ulcers of peri anal region, no mouth ulcers, no rashes, no eye redness. No liver problems. No pneumautria, hematuria, recurrent urinary infections. Course of disease: Regular 3 mthly f/u with NUH, recently transferred to a nurse clinic because condition was well controlled and stable according to him. On 2 yearly colonoscopy. He has on off bloody diarrhoea still. Taking Azathioprine and Allopurinol for the UC. Steroids given each time he has exacerbations but he doesn't need them normally. Apparently the steroid got oral and a foam form that is suppository. Admitted 3 times in the past 6mths for bloody diarrhoea. Claims forgets to take medication 2 out of 7 days when he has to rush to work sometimes. Other triggers for exacerbation includes spicy and oily food which constituents his usual diet. He was told to avoid those and he trys but you know... Past medical Hx: 1. UC on Azathioprine and Allopurinol 2. Anemia on Fe tablets 3.Thalassemia minor, non transfusion dependent 4. Hypercholesterolemia, not on medication, on diet control 5. Fatty liver, ultrasound done at polyclinic, Dr said don't need follow up for that No surgical hx Social hx:	examine the pt. 6mins left Examined the hands (no clubbing, no palmar erythema) Eyes: No jaundice, No pallor, No red eye Mouth: No ulcers Abdomen: No scars, Non tender. No distended. No hepatomegaly. No stigmata of chronic liver disease. Listened to the heart dunno why. Listened to the lungs: Clear Leg: Some erythematous nodules, but he said was non tender and attributed them to eczema (honestly doesn't look like eczema but never mind didn't comment) Requested to check the perianal region for ulcers fissures tags, examiner say don't have. Requested the vitals After completing the examination, still had 2 minutes left, so asked him anything else he wanted to tell me. Then he told me about the IBD support group he is aware but he's coping well. Then he summarised his case for me. I was like wow. Thanks uncle. Thanked him and	on Azathioprine and allopurinol, recent increase in frequency of exacerbations, likely due to non compliance to medications and dietary indiscretion 2.Anemia secondary to underlying UC and Thal minor 3. Hypercholesterol with fatty liver 4. Social: impact on job 5. Smoked some psychological thing about how he could be sad from both his sister and daughter getting breast cancer Questions How would you investigate and manage this pt if he presented acutely? You listened to his heart just now, what were you looking out for? What in the heart is a/w UC? (I said I'm not sure, might be Mitral Valve prolapse) How would you stop the bleed? (Colonoscopy, Angiogram) This is UC entire left colon, anything else? (Oh panproctocolectomy) Nodded So when u see him in clinic for f/u what are the complications you are looking out for in UC? (Local ones like: Anaemia, Cancer, Acute ones like toxic megacolon, and extra intestinal manifestations of UC) He looked very happy like i just hit his next question. Ok so what are the extra GI manifestations? I regurgitated Why do you think he is anaemic? (UC and Thal) Anything else? (bone marrow suppression from drugs) Which ones? (Azathioprine) So what kind of blood picture would you expect if there is marrow suppression? (Pancytopenia) What other SE of azathioprine do you know? (Smoked something about hepatotoxity, rashes, nausea, headache, vomiting, haha dunno go read) Do you know why the azathioprine and allopurinol are given together? (I was like I'm not sure but could be because allopurinol inhibits liver enzymes, increasing the concentration of Azathioprine so less dose can be given so less side effects.) He was like haha you are partially right and partially wrong. Smiled. haha go find out yourselves guys.	practised an IBD case with me before) Juniors, study partners are the most useful thing in MBBS really. Like you gotta study on your own but don't be tempted to just drown in books the whole day. Just 1 hr of long case practise with a friend can save you! Cover grounds and common topics. And you don't even need to get out of the house. Once me and a friend did LONG CASE OVER FACETIME! heehee

		Non smoker, Non drinker Lives with wife, 2 children grown up and married off. Wife cooks. Last time his mother cooks. He likes to eat seafood, eggs, spicy,oily food. (last time he is the one to finish up all the food that his family cannot finish) Financial ok, using medisave Occupation: works in the travel industry, job requires him to travel around the country. His diarrhoea problem used to affect his job a lot but now he has gotten used to it and now its better controlled. (But first thing he does when reached any country is to find the toilet just in case) Mood and sleep ok. Coping ok. Aware of support groups available Family hx: Sister has Crohn disease Sister and daughter both got breast cancer	started writing my issues and summary. He stared at my paper ad scribbling. Haha. Bell rang, Examiner and Pt left the room. 2 more minutes to consolidate	Then he ran out of questions, asked the female passive examiner if she had anything to ask. Female Dr asked how would you advise this pt on this daily routines (Considering she's a fam med/geri home care Dr, I said Ask the wife to monitor him to take the meds everyday or can set alarm on his phone, Diet modification, Exercise!!!) What are you looking out for in his LFT? (UC a/w with Primary sclerosing cholangitis, so Im looking for raised ALP and Bilirubin..err and AST ALT) What else in the LFT you want to see? (Oh albumin! Low albumin due to malnutrition!) Then bell rang! Yay!	

Adult Medicine - Neurology

Recurrent seizure approach to recurrence of seizurw This man presents with a history of seizure	A/prof Koh Liang Pui and one more	Main thing in history was to dig and try and find why this patient was having poor control. Many social/psych issues (sorry, don't want to give too much details). Really this case was testing the heart of medicine; not so much the science	Err so funny story. I was expecting the examiners to prompt me to stop history so I was like rambling with the patient for a good 22 minutes and was wondering "eh how come there's no	I framed the issues into social ones; so the discussion was very social. Some basic acute seizure management and the drugs. Examiners were encouraging ++	Honestly I'm glad I spent more time on the historyCos he had no neuro signs and I wouldn't have known how to continue. (perhaps that's why the examiners also didn't

			prompt to start pe". So decided to proceed with pe anyway; so turned at the examiners for confirmation and they were nodding very earnestly. as I put the patient on the bed, heard the 2 mins bell. And the patient went "oops" I wanted to lol but I just did the fastest head to toe neuro exam of my life.he was generally hyperreflexic but they didn't ask me about it		stop me). My advice would be to keep track of time but if u know what ure doing, carry on. (Honestly, i didnt know what was happening at some points)Don't worry, examiners are there to help. Oh yeah and just know a bit about AEDs. If stumped just whack liver toxicity. epilin is valproate btw I almost forgot and started absence-ing. Also, know your mark scheme for case analysis; to score for discussion you need to bring in multidisciplinary stuff; so please talkand listen to your patient instead of just doing a checklist and systemic review. Works for every chronic disease.
Epilepsy Approach to chronic disease? This gentleman has epilepsy. please take a history	Dr Koh Liang Piu (active), Dr Chia Yew Woon	I walked in and saw Dr Koh and immediately felt relieved for 2 reasons: 1) NOT PAEDS OMG HENG 2) OMG DR KOH :):):):) ok so took a history from this gentleman who was only 1 year older than myself 24YO chinese guy Hx of epilepsy - first episode in sec 3/4 - unable to recall the events, all he can remember is that he walked out of his room with headache and was drowsy and that his father saw him	the 2 min bell rang and i quickly did my PE although i had no idea what to test for quickly screen cranial nerves (lift eyes smile eye movements), UL reflexes then looked at examiners say i wanna examine lower limbs neuro as well they said probably wont find anything,	Asked to present my issues - gave a quick summary of the case: 24YO chi male with b/g epilepsy well controlled on valproate, triggers are as such (listed, forgot one and was reminded by dr koh), no impact on function, social and family relationships, no intellectual disability and no financial difficulties Q: so if you saw him for the first time at the ED, how would you manage? A: ABC, seizure first aid, 2x IV cannula, abort with lorazepam. then work up for cause: FBC infection, UECr electrolytes (Q what electrolytes? A Na Mg Ca), CPG, ECG (not sure why i said that but the examiners didnt disagree)	my long case prep was rubbish so i was quite happy to get through it dont panic if the stem seems tough, just take a good history practice with friends the 2 mins consolidation time is super short - quickly run through what you wanna say in

		- Pre-ictal: no aura, no fever, was on the computer - Post-ictal: no bladder/bowel incontinence, some biting of the tongue, Todd's paralysis, no head injury (said neck pain?) - called for ambulance and went to A&E and was admitted (CT and EEG), worked up and diagnosed to have epilepsy, started on Keppra and valproate - possible triggers: lack of sleep, looking at computer for too long, stress - had 3-4 more episodes after that first one while on valproate (should have explored compliance at that time) - last episode aug last year - 2 episodes were witnessed - one by mum and one by friends - was described as a GTC, lasting no more than a minute - each time he had headache and weakness post ictally treatment - currently on valproate only - compliance is good but occasionally misses doses as he buys his drugs from china as it is easier to cut for the dose but will miscount the number of pills left and sometimes will miss a few doses - follow up NUH neuro every 6 months - blood tests on follow up are normal (no thrombocytopaenia and no liver abnormalities) - no side effects from taking the medications Impact - does not impact family and social life -does not impact function and school work - he understands he cannot swim alone and doesnt - he doesnt know he cannot drive but he doesnt have a license so isnt affected by that - intellectually not affected: currently studying in local uni and came from poly with good L1R4 score (i actually asked to look thorough and could see Dr Koh nodding away out of the corner of my eye hahah) No past medical history Social history - non smoker social drinker - no financial difficulties	what else you wanna look for? i say look for neurocutaneous signs and any petechiae to suggest thrombocytopaenia (smoking coz i have absolutely no idea what to look for) times up and examiner and patient left	Q: what other investigations do you think theyll do in the ward A: Neuroimaging for structural abnormalities, EEG for continuous seizure (?) Q: If you saw a rash, how? A: isolate patient, examine for signs of raised ICP (should have said meningism too), LP if can, broad spectrum abx (Q What abx? A IV ceftriaxone 2g) Q: now you see him in clinic for follow up and he's had a few more seizures, what to do? A: check compliance, adjust dose if compliant (they guided me say after that check drug levels and add on second drug) Q: What is keppra? A: levera.... wait no levetiracetam (Dr Koh: woah i cant even pronounce it) and sorry sir thats all i know about it Q: what other AEDs? A: carbamazepine, lamotrigine, phenytoin, phenobarbitone Q: SE of Carbamazepine? A: SJS need test HLA Q: valporate? A: thrombocytopaenia (Dr Koh: rare. yes sir you're the haematologist), liver dysfunction Q: SE of phenytoin? A: started about cosmetic SE (Dr Koh: thats long tern,. what about short term?) Me couldnt get the hint (what do we need to monitor when giving). A: oh vitals monitoring coz of cardiorespiratory depression (ok im done, looks at Dr Chia, any questions) Q: can he not drive forever? A: uh sir i think cannot, but acc to SMA guidelines can after a few years if no seizure but the law say cannot (some of my classmates were saying before) Q: are you sure? A: uh sorry sir i really not sure about this Q: SMA say can if well controlled. go read the guidelines (idk man juniors please check) A: yes sir i'll go check Q: how much impact do you think his condition has on his life? A: (thinking how to smoke my way out of this	those 2 mins. it helps if your template is well organized and you've been using it for practice. ALL THE BEST

				one) when i asked him he doesnt seem too affected by it but i guess that he doesnt tell his friends coz there's a (couldnt find the word stigma here) Q: how would you counsel him? A: uh so i would tell him that it is not a condition to be ashamed about and that for some reasons some people just get it but it can be controlled and that the plus side of more people knowing is that your friends can help you during a seizure and they know whats happening rather than standing around panicking and feeling helpless (i actually said this - idk how convincing i sounded) Dr Koh had another question: how do you think this will affect him in the future A: like his sch work affected? Q: career prospects? A: some jobs may not take people with epilepsy Q: and also got social stigma right A: yes sir of coz Ok good i think we're done talked cock with them for the remainder of the time shook both their hands at the end and went out screaming for joy internally that mbbs was finally over	
Poorly controlled epilepsy management This is mr L He has epilepsy, please take a history and assess him	Prof Koh Liang Pui (NUH haem onco, the nicest guy! I am so blessed!) Dr Phua (a more junior looking, NOT the SGD PD)	I would really like to thank Prof Koh and Dr Phua for being very very very kind amongst my blunders and stutters. Biodata: Mr L 41 y/o Allergies to penicilliN and something that I havent heard before- anaphylaxis ADL I COMM A Stays with elderly mother Not married PC 1) Poorly controlled epilepsy since 1980s 2) Unsteady gait and tremors currently- recurrent falls, feel giddy when suddenly getting up, thighs weak when climbing overhead bridge. - falls and hit head No Pmhx- No DM/HTN/HL	Not exactly sure what PE i should do because I was quite low on time; Did Full CN- Normal UL and LL- No wasting, all reflexes ++, power 5/5, sensation all intact, cerebellar normal, proprioception normal Gait normal, tandem gait normal, rhombergs Normal, no pronator drift Looked frantically for BP Set, couldnt find,	Presentation of Issues 1) poorly controlled epilepsy on epilim and keppra, number of seizures, etc - would have liked to explore triggers (whats causing stress and lack of sleep) 2) poorly educated patient and caregiver on the need of medications and acute first aid of seizures 3) financial concerns and Psychosocial- worried about burdening mother What is epilim and keppra called? - sodium valproate and levetiracetam - SE of each? (refer above) Previously on carbamazepine- what SE are lifethreatening? - SJS and agranuloctsis What investigation do you do to screen before starting?	For a poorly controlled xx, it may be good to employ a set template coz of too many episodes, each episode is different from each other: 1st episode details last episode details WORST episode details (need ICU/HD etc) Each episode medication change if any and why change? After this, I am so

		other Sx Hx 1) Pneumonectomy?? (ONLY SPECULATION because he aspirated a PEN TIP, they had to do a surgery to take it out, could not remember if he was having a seizure and someone tried to put a pen in) Decided to go for the poorly controlled epilepsy (mental note to come back to unsteady gait in the PE) HOPC currently 3 seizures per month Each seizure lasting 10mins, GTC, uprolling of eyes, jerking of limbs, incontinence. Used to be very well controlled between 1991-1997 (no seizures at all)- didn't know the reason why it was so well controlled Each time he seizures- will not be admitted to hospital, only admitted to hospital once in 1980 for diagnosis. (Suspicious) First seizure also presented with fever, scans and bloods showed infection, not sure if they treated him with Antibiotics, cannt remember how long he stayed hospital. All the other scans normal- even the EEG Last seizure was 3 weeks ago, did not get admitted- referred to TTSH for outpatient EEG for poorly controlled epilepsy, doctor suggested to him that there may be a focal lesion there (hmmm... scar epilepsy?) Known triggers- stress at work, fevers (1st presentation triggered by fever), lack of sleep (due to stress not OSA/nocturia/construction site noisy etc) - no rashes, urti, hypoglycemia, dehydration, visual field defects, hemiparesis etc Preictal- above triggers, some headaches, aura (cannot hear very well, blunted sounds, light v bright) Ictal- GTC seizures witnessed by elderly mother who stays with him. Aborts spontaneously after 10mins. (Suspicious) Post ictal- drowsy, doesn't call the ambulance, sleeps in the whole day and feels better after that. (Very suspicious) no neurological deficit/weakness numbness altered mental state. "So when you have seizure in public, will they call the ambulance?" Yes they will sometimes but when the ambulance comes, I don't want to go hospital because my seizure finish	requested for a set of vitals and postural BP for the giddiness Was prompted to look at the scar of the ?pneumonectomy- left posterior thoracotomy scar - too flustered to do Respi exam, i just offered coz no time. Patient and examiners left me for 2 minutes. And my brain left me for discussion. Thanks brain -.-	- HLA B1507 His first presentation was with fever- what could have been the ppt event? - meningitis, encephalitis, will have to check for rash What investigations would you do for him fr first presentation? - bloods: FBC RP glucose - consider CT brain, MRI brain, LP if CT brain clear What are you looking out for in RP? - electrolyte disturbances: Na, K, Ca, PO4 What do you send of in a LP? - glucose, protein, cytology, culture, gram stain and sensitivity... and LDH (NOOO STUPIAK BRAIN thinking of pleural fluid) As the HO, which one will come back that affects your management? - i answered glucose protein coz thats the first to come out - answer they wanted: cytology for lymphocytes (TB and viral) and neutrophils (bacterial) - Abx to give in bacterial meningitis: ceftriaxone (Brain was thinking paeds an i said genta, stupiak brain) - Antiviral to give in viral meningitis: Acylovir Management of acute seizure? ABC CALL SENIOR PR diazepam x2 or IV lorazepam Phenytoin Phenobarbitone Admit HD or ICU with continuous vitals monitoring (ECG ad EEG) SE of each medication? - BZD: respi depression - phenytoin: Arrhythmias BELL RINGS	done with neuro. After getting 3 neuro for shorts and 1 neuro long, I KNOW i am not cut out for neuro at all. My worst topic, and get grilled nicenice, and therein lies my DA kit, untouched. At least I ended with a high note with Prof Koh and Dr Phua!

		already, and I feel fine. "So when you seize at home, and your mother witnesses it, does she know what to do?" Oh yes! She knows what to do, shes so experienced! (Suspicious) "So what does she do?" She puts a cloth in my mouth to Absorb my saliva and to prevent me from biting my tongue. She also puts spoons, fingers etc in my mouth, splashes water at my face. She doesn't call the ambulance. (Dafuq) "Does she know how to use the medicine to put up the backside to stop the seizure- have you heard of Diazepam?" What's that? I don't have any standby medicines (dafuq) Medications: Current medications: Epilim and keppra Previously on Epilim and Carbamazepine (changed meds because meds not working, he is NOT allergic to carbamezapine/previous SJS) No SE of Epilim, starting keppra started to become more annoyed and agitated at people. - SE to ask for epilim: hepatotoxicity**, coagulopathy**, fatigue dizzy NV, tremors, aloplecia, weight gain, behavioural changes - SE to ask for keppra: **labile emotions** - SE to ask for carbamezapine: **SJS, agranulocytosis**, drowsiness, diplopia, headache, ataxia, dizziness, hyponatremia - What I didn't ask: compliance of meds and f he takes them everyday (I think this is the main reason hes poorly controlled) - In hindsight: He probably has tremors and dizziness/unsteady gait 2' epilim (juniors please check!) FmHx- nil epilepsy, nil developmental delays, nil young strokes, no cancers of the brain or otherwise. Social: - currently unemployed (shouldve explored more here) cannot find a job as he need to declare his medical status of epilepsy. Goes for interviews, submits resumes, doesnt hear a reply. --> financial issues ++ may lead to the poor compliance			

		- Studied civil engineering, previously was a on-site inspector- never had a seizure when he was working (thank God, if he did he would have fallen from heights) - Stays with elderly mother, brothers and sisters have moved out of the house with their own families, all knows of his condition, all supportive - Mood: worried that elderly mother has to take care of him all the time, slightly saddened that he cannot find a job, nor can he find a gf - not married, no children, no sexually active (advised not to start a family in fear of passing down the epilepsy to them) - no recreational drugs (IMPT TRO) - alcohol: 2 bottles beer a month - smoking: 1/2 pack in a week, smoking since 13 y/o, still smoking and used to smoke whole packs in a day (i had no capacity to calculate this in my stress, i just know it was significant) --> alcohol and smoking does not trigger his seizures (interesting) - He offered his PES status (which i cannot rmb, but he did serve army, so probably not PES F) - he does not drive Quick systemic screening of ddx: - syncope and its causes- hypogly, dehydration, orthostatic, vasovagal (on peeing), neurogenic - Stroke/TIA: no residual weakness			
Right sensorimotor stroke Approach to lower limb numbness This man was driving his car when he had left leg numbness. Please take a history.	One Malay examiner one Chinese examiner	(The examiner actually walked out right before the bell rang and looked at me, and he said how are you. I'm like WTS!! And he decided to go in with me when the bell rang. When I saw the stem, I was like shit, what's this?? Peripheral neuropathy??? AND PATIENT SPOKE MALAY cos his English not that fantastic!) P/C - 2016 presented with Left leg TINGLING??! - clarified n he said feels like lightning on his leg - was driving his car and had to stop and massage his leg - this is first time this has happened - could still stand and walk to GP - GP told him he have stroke (??! I was quite skeptical because he spoke Malay and I couldn't really understand him. The examiner who was Malay had to translate for me) and referred him to hospital - he doesn't know what the hospital did for him - no radiation, no back pain	By this time, I was rushing because I couldn't finish taking hx, and the examiners had to cue me to quickly do PE. I did neuro exam and found UMN signs on left side + unsteady gait.	Presented as right sensorimotor stroke (lacunar infarcts) b/g uncontrolled htn due to non-compliance to meds Questions: - what else would you examine? Got prompted like crazy before realizing cardio for murmur n for bruit (too nervous!!!) - What investigations would you like to do? - what are causes of stroke - Why can't he work? When can he work again? How to help him? - what are causes of embolic stroke?	Advice: - sigh, rather straightforward case, but I presented quite lousily. □ hopefully I passed, cos the examiners were prompting me. At the end, the Malay Dr said: good luck for your future. (SHIT DOES IT MEAN I FAIL?? So must take MBBS AGAIN SO HE WISH ME LUCK??? □)

		- no fever, no LOW/LOA - no rash, joint pain - no chest pain/SOB/palpitations - no bowel symptoms Course - went to hospital, no thrombolysis done Pmhx - Hypertension not compliant to meds, didn't take meds on day of event (usually around 140-150 systolic) - Gastric problem (??? Found on scope, given omeprazole) - Past cholecystectomy n removal of part of pancreas cos pancreas had stone???!!! (That's what he said, i was super confused n he kept veering off track!!!) Meds - Aspirin - Enalapril Social - not working since stroke cos he was driver and his driver got taken away - Slightly depressed cos very bored at home - Financially ok, 3 children already married n supporting him. Wife support him but nags at him			
TIA 2° poorly controlled DM Approach to syncope This patient presents with syncope	DR RANJANA :) and another Chinese guy who I can't rmb sorry :(	Mdm Z / 47 / Malay NKDA housewife ex smoker ~10 pack years, stopped 2 years ago non-alcoholic HOPC 1) syncope - 2 episodes (14 and 15 March) - vertiginous dizziness a/w irregular palpitations, cold sweat, nausea but no vomiting - better lying down - no chest pain/SOB/headache - a/w left sided weakness and numbness + eye BOV and a dark curtain drawing down on eye (lol forgot to ask which eye/both eyes but nobody picked on that hehe) - near-syncopal episode on 14 march, lasted ~½h, better lying down - syncopal episode 15 march, lasted ~10min, witnessed by children, no jerking limb movements - all in all symptoms	Did UL exam, targeted LL exam - normal tone, power 5, sensation (pinprick) intact. - essentially a normal neuro exam Requested to examine the CN (forgot cerebellar wow sigh), vitals, CVS and also look for evidence of DM Was prompted other things and forgot in the stress should've offered: - cerebellar - CVS: murmurs,	this is Mdm Z, a 47 year old Malay housewife, who is a known vasculopath with poorly controlled diabetes mellitus and hyperlipidemia who presents acutely with two episodes of syncopal episodes. This was associated with left sided weakness and numbness, and also visual loss. Issues include: 1) 2 syncopal episodes, likely to be 2° TIA. - significant ddx to exclude would be stroke, hypoglycaemia, seizures but the history is not suggestive 2) poorly controlled comorbids, DM and HLD, particularly poorly-controlled DM 3) possible cervical myelopathy 4) financial issues, in spite of MSW already being on board 5) social issues Q what are your ddx and why are they less likely - offered stroke, hypoglycaemia and	- DM TAKES UP A WHOLE BULK OF LONG CASE. and fairly so because it's so prevalent and you're expected to know how to manage this as a junior doctor, and it also affects patients regardless of which specialty you pursue :) SO PLS STUDY THIS WELL TO PASS AND MORE IMPORTANTLY TO BE A GOOD DOCTOR K. - I really can't think on my feet when put on the spot, my wish

		lasted ~2h (went to hospital) - had meals before that 2) cervical myelopathy (vs carotid artery stenosis) - left neck pain that started 2 days before syncopal episode - pain shoots down to left hand - a/w numbness, weakness and clumsiness on left hand - no trauma - no left sided facial symptoms 3) constitutional symptoms ?anemia (decided not to present this because this approach on its own was my GS long case LOL and I have no time to explore this) - LOA - attributed to stress - no LOW recently - slight SOB/fatigue on exertion - tried to elicit reasons for blood loss: periods regular and no change recently, no lower BGIT, no upper BGIT PROGRESS - went to hospital, given scans CT & MRI - BP was LOW on admission (hmmmm) - given blood thinners and started on insulin - no surgeries, doesn't know any other drugs given - post discharge, no residual neurological deficits (said everything is back to baseline) PMHx 1) DM diagnosed 2004 - defaulted F/U and medications 2° S/E of metformin (GIT discomfort) - says unable to take care of young children with these side effects :(- on traditional Malay herbs - never had eye/foot screen - cx 2 hospitalisations (1) 2009 - abscess s/p I&D (2) 2010 - pyelonephritis - doesn't know what HbA1c is but does home blood glucose monitoring - blood glucose always ~19 (previously >20 before being on traditional Malay herbs) 2) HLD diagnosed on admission 3) NO HTN Current Rx	carotid bruit - cervical myelopathy: Hoffman's etc - fundoscopy (DM changes) - DM: monofilament test, urine dipstick, CVS - evidence of under/overcoagulation omg LOL	seizures...my mind blanked and couldn't answer more, they seem to want more but moved on anyway (SO KIND) Q stroke vs TIA which is more likely and why - TIA is more likely because (1) duration was 1/2h and 2h respectively (2) no residual neurological deficit on examination (3) (also perhaps no rTPA was given even though she presented at the A&E within the 4.5h window period) Q how will you manage her acutely - resuscitate, take vitals, fluids if hypotensive - basic ix - bloods and imaging - bloods: FBC, U/E/Cr (contrasted scans), CBG, PT/PTT (anticoagulants) - imaging: non contrasted CT brain to visualise bleed/infarct Q how can you tell the DM is poorly controlled - 2 previous episodes of admission from cx of DM (abscess and pyelonephritis) - non-compliance to Rx + defaulted F/U - forgot to mention the home monitoring glucose was 19 and that patient has poor awareness (since she thought 19 was better than the >20 when she wasn't on Malay herbs) Q how to you manage the DM then - initiate foot/eye screen - look for cx: do HbA1c, urine ACR for proteinuria (forgot about fundoscopy but I guess it's covered under eye screen) - initiate pharmacological Tx Q what drugs can you give, what do you think she is on - metformin as first line, hazarded SUs as the add on - medication can be split up to oral and subcutaneous, oral can be split up to insulin sensitisers and insulin secretagogues and others, subcutaneous are insulin - I essentially rambled and listed every class of drug while they nodded their heads HAHA THEY ARE SO NICE AHHHH Q what are the complications of DM - can be split into micro and microvascular and autonomic, they include etc etc - was rambling too much but they always nod SO NICE Q other than DM, what could be other causes of	list is always short +++ so I guess one way to circumvent this is to practice and think laterally. It's actually quite fun to think of other things you wanna do for PE. - patient rapport!!! Idk how much difference a handshake makes until through MBBS itself :) It really sets a good note for the rest of the exam :) - please keep track of time maybe I enjoyed talking to my patient too much that I forgot to look at my watch haha I am also vvvvv lucky to have such nice examiners :') - GOOD LUCK JUNIORS!

		- dual therapy for DM (metformin and another blue pill) - anti-cholesterol pills - blood thinner - nerve pill (perhaps neurobion) - still on traditional Malay herbs, doctors aware and gave the green light - currently compliant (over last 2 weeks since onset of symptoms) as she wants to recover and take care of family FMHx - parents and grandparents all have DM HTN HLD Social Hx - finances: has financial issues that is inadequately supported in spite of MSW being on board, especially so now that husband is in prison :((((- mood: currently stressed. Felt low when hospitalised but feels better now. managed to squeeze in: - no previous miscarriages I LOST TRACK OF TIME MY TUTOR HAD TO STOP ME OMG it was 17.50		her presentation? - given that she is 47 I can also consider doing a young stroke workup - it includes looking for coagulopathy and anti-phospholipid syndrome, but it is not suggestive on history Q She also had symptoms of shortness of breath, what do you think? - it could be due to anaemia but I would like to investigate further with a full blood count Q she mentioned that she had hypotension on admission, why do you think that is so? - hazarded a guess that there might be autonomic dysfunction from DM - paused and said I didn't know the other possibilities but they seemed appeased and moved on OMG SO NICE Q you mentioned she has symptoms of cervical myelopathy, how can that affect her? - further confound her peripheral neuropathy from DM Q what are the ddx for her presentation - carotid artery stenosis BELL RANGGGGG THEY SAID GOOD AND BYEBYE MBBS OMG MY EXAMINERS ARE SOOOOOOOO NICE :'))))))))	
33 year old man presenting with recurrent strokes b/g of Takayasu arteritis Approach to young stroke Patient presents with young stroke. Please take a history	Not too sure. Two male examiners. Quite stern	33 yr Chinese gentleman Currently unemployed, in between jobs ADL independent and Comm ambulant Married P/c: recurrent strokes 1st episode of TIA was in 2011 Patient had right sided numbness and tingling in both upper and lower limbs No weakness Did not seek medical help, resolved within 24 hours 2nd episode was in 2015. Patient presented with right sided weakness when he was at home. Was typing on the computer when symptoms started. Went to a and e immediately and was told he had a stroke. Was told there was a block in the artery, (ischemic stroke) CT scan was done	Did a neuro LL which was unremarkable Then did vascular exam Patient had missing right DP, PT and popliteal pulses Offered to palate femoral pulses but patient's jeans was too tight. Hahahha Then did a focused CVS exam - no murmurs, no deviated Apex beat - heard the first carotid bruit in my life in his left carotid artery	What are his issues? - young stroke secondary to takayasu arteritis - hypertension - DM - unemployment Young stroke work up - anti cardiolipin antibody, lupus anticoagulant, esr, crp, ANA, ANCA, Protein s and c, factor V Leiden, antithrombin 3 - carotid ultrasound What would you do in acute setting when this young man presents at your ed - ABC - ct brain - bloods as above - fbc, PT/PTT - all the usual stuff	Don't be disheartened if u get a case with a weird diagnosis. Usually their questions are more geared towards the management and not on the condition itself. I knew next to nothing about takayasu, just that it was a type of vasculitis and was hoping that they would not ask me anything abt the condition. Just take a proper history to show that you're a

		No trauma, no headache No nausea or vomiting No fever, Low or Loa In between these episodes he also presented with symptoms of vascular Claudication. - pain when running, improves after rest - ruled out neurogenic claudication (patient had no back pain, no improvement upon flexing or extending the back) -Sees the vascular surgeon for this issue and an ultrasound was done to indicate severe stenosis at the femoral artery? (Patient wasn't very sure of the location) This was when examiners cut my history and asked me what possible diagnosis I can think of to explain patient's recurrent stroke at such a young age and also his vScular claudication. Really couldn't think of the answer they want as I said SLE/APS, RA (I did mention that these were rarer causes as they occur more often in females.) examiners allowed me to carry on with my history taking. So patient also mentioned that he has a monthly follow up with rheumatologist and then mentioned a list of medications he is on -aspirin - prednisolone -mtx - infliximab - metformin Examiner asked me again what possible diagnosis he has again and I finally managed to say vasculitis. Lol Then patient told me that he has takayasu arteritis (was primed by examiner not to mention diagnosis unless I Guess it correctly) Diagnosed in 2015 June after his stroke in April MRA aorta every 6 monthly Pmhx - hypertension 160+ - diabetes (steroid induced) fhx - no family history of rheum conditions Social history - smoker (3-4 sticks a day currently, used to smoke more	Palpated the abdomen for the aorta as well. Should have ausculated for any Bruit? But didn't have time	Are u surprised by his meds? - yes I am Cos he is not only any hypertensive meds - however, I think this may be because his vasculitis is under control and BP has returned to normal so he doesn't need the meds. Prof didn't say anything so I presume it's right Why is he on DM meds? - Should be steroid induced Tell me the side effects of steroid meds - rattles off the usual list What are two Long term side effects of this condition this man might have? - MTX- interstitial lung disease - steroids (osteoporosis, cataracts...) I think they asked me more questions but I really can't rmb anymore. I'm typing this three days after the exam while I'm relaxing in my apartment in Munich looking at mountains. Hehe	safe HO. The end is near! Your grad trip will happen very soon!!!!

		and was told to cut down) - social drinker - married with no children Systemic review unremarkable			

Adult Medicine – Endocrinology

Newly Diagnosed T2DM (atypical ppt) Approach to dizziness, approach to palpitations	Dr Pipin (NUH Electrophysiologist), Dr Ishmail?	This was Mdm Tan, 46 year old lady previously well, working in People's Association. 1) Non-vertiginous giddiness, with blackening of vision without LOC - Happened while walking around the supermarket, looking at the goods - No chest pain but had some central chest tightness - No diaphoresis, palpitations - No history of postural giddiness, no TCM intake, not septic, had been taking good amounts of water, not previously diagnosed	Fairly normal, significantly: - Pulse rate was regular, 80bpm, no ectopics - Noted goitre! (not previously noticed by the patient) - Euthyroid and no TED - Monofilament test -ve: full protective sensation	1) Summarize and present: listed out as systematically as I could - Pre-syncopal episode - Palpitations longstanding - Newly diagnosed T2DM, well controlled, no complications thus far - Incidental goitre found on examination 2) What do you think is the cause of pre-syncope then?	The DM history came up only 9 min into history, so I was slightly flustered (I had thought that it was a diagnostic case), but thank God for peace and composure,

No stem written, but examiner says: 'this patient presents with dizziness in 2016, please take a history and come to a diagnosis, and formulate a management plan'.		with autonomic neuropathy - No history of vasovagal or situational reflex-mediated syncope previously - Had previous episodes of pre-syncope like this one, but never as bad, happened at rest 2) Palpitations x 2-3y - Off and on, once every 2-3 months - Unable to tap out the beat/establish whether regular or irregular - NOT a/w syncope or giddiness (she made it quite clear) - No hyperthyroid symptoms - No family history of cardiac arrhythmias - No personal history of arrhythmias (does your heart beat abnormally slow or fast?) - No neck mass or neck pain 3) Newly diagnosed T2DM - Mentioned that when she came to the hospital, she was found to have high sugar levels - No osmotic symptoms: polyuria/phagia/dipsia, LOW - Started on Metformin + basal insulin for a few months --> weaned off insulin - Last HbA1c 5.4% - Home blood glucose monitoring pre-meal 5-6 - No symptoms of micro/macrovascular complications of DM - Wanted to screen for metabolic syndrome: >Previous BMI (was overweight -> now better) >No OSA: husband did not note snoring/no day time somnolence Systemic review unremarkable, social/functional history normal	- No diabetic dermopathy - Pronator drift -ve, CVS exam normal - Abdomen: No lipodystrophy (insulin x few months only) - Had liked to complete examination with: fundoscopy, CBG/hypocount, urine dipstick for glycosuria and proteinuria, full neuro exam	- Dehydration secondary to hyperglycemia, though not HHNK - Mentioned in detail how I excluded other DDx 3) How would you manage a newly diagnosed diabetic? - Holistic, multidisciplinary - Pharm wise: first line Metformin, then another OHGA or basal insulin 4) What are side effects of Metformin: - Lactic acidosis in renally impaired patient (examiner rolled eyes, because this is very rare) - Prompted: GI side effects, long term - vitamin B12 deficiency 5) She needed only a few months' worth of insulin, how was it possible that she is weaned off insulin? - Pancreas regains insulin-producing function, exogenous insulin tided pancreas while it recovered (lay man terms, i was just deriving from first principles) - E: "how so? why does that happen?' - silence (i was thinking) - E: 'well, it is something to think about, interesting isn't it.' -'yes sir' 6) Do you think the goitre could have contributed to the palpitations? - Clinically euthyroid, may or may not be related	able to consolidate all the various unrelated issues (and dissect them clearly, even though they seem to be somewhat related) --> stay calm!
DM 2 Approach to polyuria patient complains of freq urine, take hx	grumpy prof and nice sgh IM guy	29 YO/Indian/Male. pt hx was abit simple, basically polyuria polydipsia x months, many times in day, wake up at night. otherwise no other symptoms, no complications, no acute emergecies. presented to hosp 2 months ago and admitted one day cos 18+ glucose but no signs of hhs/dka. havent even had first follow up yet cos is in few days. no past med hx, nkda and compliant to metformin + sitagliptin, fam hx only htn and mother thyroid problem. social occasional smoke, seldom drink, job was affected but now ok, money not problem, care not problem. basically young DM with polydipsia and polyuria but nothing else	large habitus but no neurovasc complications/ suggestions of etiology/ signs of cushing/dm	diagnosis, justify, what drugs is he on and how they work, what is incretin, why did u check for certain features (cushings)	if simple jus chill, had like 5-10 mins of awkward silence after hx and PE cos this guy really like no hx one
T2DM with Complications Chronic Hx -	Dr Seow Cherng Jye (TTSH Endocrine) - active	64yo Chi Man Mr C NKDA Currently working at a hotel carpark, work involves walking a lot Non smoker non drinker	Alert comfortable, typical uncle with a little of a belly and not too tall kind of shape.	Summarise issues: 1) Long standing DM with poor control leading to complications of DM - ACS and retinopathy. 2) Has other comorbids that need to be better	Nice examiners, very nice patient. My eyes just lit up when I heard

DM This patient suffers from a chronic disease. Please speak to him.	A/Prof Kueh Yan Koon (Haem I think)	Stays with wife, has children but all moved out. T2DM for 25years. First noticed while he was working as a customs officer and found ants on the toilet bowl after he uses it. Told by colleagues better go and see doctor soon. Diagnosed with DM after OGTT. Back then had osmotic symptoms too - polyuria/polydipsia/polyphagia and lethargy. No significant loss of weight. Did not ask sexual hx. Had no other medical issues back then. Was not on any medications or alternative meds back then. Subsequently started on metformin and a blue pill. Dose has been changing up and down. HbA1c last time >10%. He admits poor dietary habits as near his work place there's this cake shop that sells fantastic pastries and cakes. Since then till now - Never been admitted to hospital before for extremely high sugar - Had one episode of hypoglycemia about 4-5y back where he experienced palpitations and sweating. Immediately made his 3-in-1 kopi and drank it. Subsequently resolved and he reported the incident to the doctors to titrate his meds - Has been compliant to his medications and follow up, goes hospital TCU 3-4 monthly. Current HbA1c is 8.2% which he admits still quite poor - Started on insulin about 4-5 years back as well. Currently on pen mixtard 70/30, 18U OM 16U ON but admits dose has been going up. Also on metformin and sitagliptin. DM complications - Had an ACS episode 4-5 years back where he had chest pain and was immediately rushed for angio from ED. Told to have small blockage in one artery. Now stented and on aspirin. - Detected diabetic retinopathy 2 years back in his right eye. Underwent laser photocoagulation, current vision 6/9 and 6/6 no issues. Still on f/u. - No peripheral neuropathy, goes for foot screening - No stroke - No renal issues, continues to go for testing - No peripheral vascular disease (asked for ulcers and wounds that don't heal) - No severe infections or recurrent infections in his limbs. Comorbids since: Hypertension	No acanthosis nigricans No obvious complications at sites of insulin injection H S1 S2 no murmur, regularly regular. apex beat not deviated. L clear, no bibasal creps A scar in the left hypochondrium, well healed no hernia Neuro - pinprick on feet bases intact, can feel well. No obvious wounds Asked about eyes, requested for fundoscopy. Should also do dipstick and complete neuro exam and pulses too, but this patient probably had nothing to see. The examiner also asked him if he was sure his pancreas was not affected by the surgery he did and he confirmed that. So it's not iatrogenic DM (though i was thinking of it as well)	controlled - HLD, HTN 3) Poor compliance to diet 4) Running barefooted. Exercise regime can be better optimized 5) No home monitoring Qns: 1) How you want to manage - Diet: send him to dietician, advice better control - Exercise: increase exercise intensity, suggested 400mins/week - Bring weight down as primary goal - Medication: since on 2 OHGA, suggests to titrate insulin mainly - advise on home monitoring 2) What are the targets? - Premeal sugar: 6-8 will be good 3) how about his other comorbids like his lipids? - lipids should be <2.6 or <1.8 if possible for LDL. - Since he is on fenofibrate, likely that he has high TG also. aim TG < 4.5 4) What do you think about his antihypertensives? - atenolol as beta blocker is not the best choice here. Suggest ACE/ARB since got DM. Can use thiazides also. 5) What is side effect of ACE to warn about? - cough with ACE, switch to ARB 6) What happens when he is sick? - Insulin requirements may change: if GE/poor intake, easily go hypoglycemic - If septic, easily go hyperglycemia - Ideal is to monitor at home himself, but since he doesn't then don't suggest for him to adjust on his own since his current control not very good yet. - Can self titrate insulin for better controlled patients. 7) What would you advice patients about hypoglycemia - Tell them about symptoms: cold sweat, palpitations, tremors, sympathetic overdrive, blur vision - Tell them to keep sweet with them, should be high GI sweet so sugar gets in quickly	him say "I have diabetes" LOL. Just go through and focus mainly on the history cause examination got less marks. I took like 19mins on the history lol but I honestly have more things to ask if I had more time, although not that important. Make sure you do targeted examination. Don't do everything under the sun.

		Hyperlipidemia Current medications (showed me a receipt from his recent purchase) - isosorbide nitrate - atenolol 50mg - fenofibrate - aspirin - sitagliptin - metformin - insulin mixtard - some statin somewhere i think - Able to inject insulin on his own, knows to rotate sites around his tummy - Him and his wife knows about hypoglycemia symptoms - Has a BP machine at home to monitor, says his BP now ~140+ systolic - Does not monitor his blood sugar at home regularly, says makes him feel like he is a patient and is sick if he needs to keep monitoring. - Current weight 72kg, down from his highest point at 85kg last time but stagnating. - Exercises 2-3x a week, running 3-4miles each time, each session lasting around 45mins. Says he runs BAREFOOTED because he wants to feel the rocks on the ground and chinese says it's like accupressure treatment. - At work gets to walk around a lot cause he needs to walk up and down the carpark. - Currently his workplace (hotel) always serve a lot of good food so he admits he has poor control over his diet still - Acknowledges he can do better with his DM control to bring down the HbA1c - Says financially no issues cause of the heavy subsidies he gets at treatment. Other past medical hx: 1) Previous gastric ?resection for ?ulcer? He says done even before his diagnosis of DM and there were no complications from his resection. Family hx: 1) significant family hx of DM in his dad and his brothers but not his sisters. All got DM around 40yo. But doctors told him he had T2DM.		- Monitor their capillary sugar if they can when they have such episodes - Note down the incident and tell doctor on your appt/arrange earlier appt if happening frequently 8) The patient says he is running barefoot... - Yes prof that is very dangerous. I would suggest he wear shoes as they might not notice it when they get injuries and by that time it might be too late. 9) In your examination I noticed you checked pinprick. If you were looking for peripheral neuropathy, what's the first sign to go? - (Oops i heard this somewhere before) ankle reflex.	

Poorly controlled T2DM complicated by DM foot + peripheral neuropathy Approach to poorly controlled DM Patient with presented with lower leg swelling and ulcer 1 month ago, please take a history.	3-1 EE, 1 elderly male + 1 middle aged lady	46y/o Indian gentleman diagnosed with T2DM in 2005 due to non-healing oral ulcer, poor compliance thereafter due to occupation as freelance odd job labourer in the arts/theatre scene. Ulcer occurred as a result of poorly fitting protective footwear required for his work and subsequently got infected several weeks later with hemoserous discharge for about 1 year. Patient developed fever and greenish discharge (likely Pseudomonas infection) several months later in Nov 2016 refractory to oral antibiotics from GP, requiring admission for IV antibiotics and amputation of the right 3rd toe in EOT but no fasciotomy or ICU/HDU stay required. Complications: 1) DM foot secondary to peripheral neuropathy + vasculopathy + immunopathy (Prof Aziz's triad) 2) Chronic Venous insufficiency 3) Mild renal impairment - denied any symptoms of heart failure/AMI or CVA/TIA Cardiovascular Risk Factors 1) Poorly controlled DM 2) Smoking 20 pack years 3) Alcohol (patient evasive about amount of alcohol, but admitted to drinking hard liquor and not beer) PMHx 1) DM (on insulin and metformin since diagnosis) 2) HLD (recently diagnosed and on statins) -denied hx of steroids/pancreatitis Family/Function - unable to work due to the ulcer not being completely re-epithelialized - married with 2 young children - now relies on wife as sole caregiver - applications for financial aid not been answered, so in difficult financial straits	Targeted vascular LL exam and neuro sensation - lower limb has DM changes, cool to touch, DP 1+ , PT 2+ bilaterally - ulcer on plantar surface 2nd metatarsal head, pink granulation tissue Ended off with pronator drift + looked for lipodystrophy before the bell rang for consolidation	Discussed DM management, risk factors for ulcer formation, reasons for poor compliance, statin therapy guidelines	Had some difficulty in this station even though it is a fairly standard DM case that I practiced before as the patient was very enthusiastic and volunteered a lot of information that is not very relevant in assessing his medical situation and it was hard to cut him off =(Try to learn how to balance between empathizing with the patient and letting them talk with trying to get to the important details and learn to prioritize. I missed family hx of DM/early cardiac disease, HbA1c levels and did not specifically ask for hypoglycemic episodes (I asked if he had any other hospital admissions due to DM) but managed to cover major cardiovascular risk factors and

					complications of DM. Overall, this case was not as bad as my surgical one with the Bladder cancer and Parkinson's and I hope I can get my APs; MBBS is over!!! February ends; 5 years arduous study- Discharge summary Hang in there juniors, this too shall pass =)
TIIDM b/g recurrent R LL Cellulitis Approach to unilateral LL swelling + DM Elderly gentleman comes in with R LL swelling. Clerk.	Very nice indian man and vietnamese lady doctors =)	R LL swelling - few years ago - sudden - after ? trauma hitting side of bed stand - no ulcers - warm and red and swollen; no pain - at this point he said its because his sugar too high (okay thanks! mental note to clerk DM later and points towards cellulitis alr) - went on to tell me he got TII DM, which I got to later - a/w ?chills ?fever (he was blur about this even after I demonstrated to him, but by now I already suspecting cellulitis so ok moving on) - can walk 10 bus stops wow - no weakness and numbness - no shooting/ tingly pains from anywhere DDX: DVT – no long haul flights, recent surgeries, malignancy or pro thrombotic state Lymphedema – no masses abdominal discomfort or constipation/ hesitancy when urinating PVD – no vascular claudication rest and night pain etc (he mentioned he got discolouration so I just asked all these to be sure)	At this point of time I only had 2 mins for PE (yes the above actually took 23 mins to take omg) so I did the quickest and fullest screen for DM and his PMH stuff LOL Basically only found hyper pigmentation over bilateral lower limbs distally No peripheral neuropathy No pedal edema Knees not swollen Heart sounds normal Lungs clear Abdomen soft non tender Bell rang - requested for the whole world including fundoscopy full vascular and venous exam and cardio exam and check	Examiners were very nice said I did well and gave me 2 mins to consolidate while they walked out with the patient QnA time! Examiners were angels, super encouraging kept nodding at my answers and stuff And they let me present sitting down and admitted there were many many issues in this patient =) Issues 1) R ll swelling likely due to cellulitis b/g of poorly controlled TII DM - elaborated on the TII DM stuff upon examiners request - also explained my differentials upon their request (DVT, Lymphedema, PVD etc) 2) b/g of basically all his PMH LOL (took some time to tell them all) 3) Psychosocial - finances by cpf - would like to explore relationship with children if	Common stuff do come out commonly! i was blessed with b/l OA knees, Rectal Ca and DM long cases for the whole MBBS =) and the sweetest of examiners! study all the conditions in nigel fong and the few odd balls from senior accounts and youll be partying your way to grad trip in no time =)

		No trauma/ LOW/ LOW No travel/ contact history SR otherwise normal PMH (this is where it gets messy) 1) TII DM - diagnosed 20 years ago via routine blood tests; claims asymptomatic no polyuria polydipsia LOW and whatnot - initially started on conservative management (eat less oats lol! Prolly boiled spaghetti ._. refer to our medicine MEQ for the inside joke) - started on metformin and glipizide 2 years ago? -> no SE from these - does not know last HBA1C though claiming compliance to meds - f/u every 3 months - no micro and macro vasc complications apparently (except maybe this immunopathy leading to cellulitis thing) - no prev admissions for hyper or hypo gly (no symptoms of those as well) - last appointment was 3 months ago? Guess he is due for next one - no surgeries done for his legs before 2) HTN and HL on meds - claims compliance and f/u - no complications - no SE of enalapril and atorvastatin 3) AF on rivoroxiban (only digged this out when I asked drugged history ._.) - diagnosed 2 years ago - no easy bleeding or over anticoag 4) Gout (knee) on allopurinol (lol again only found out in drug history) - diagnosed many many years ago when he was in mexico (wow) - triggered by alcohol? And bean stuff I guess - now no more flares - no SJS from allopurinol before 5) Cataract surgery (no issues) 6) bilateral mild varicose veins - on conservative management	for over anti coag	given more time - not depressed and seems to know his diseases and meds other questions included - tell me what u found in PE and what u would like to do - his hyper pigmentation can be due to? (PVD, CVI) - how to assess this patient in clinic - how to investigate etc - presented to ED how to manage - Long term management for him? - in one line tell me about this patient few other questions scattered here and there but really pretty standard stuff about DM and all bell rang examiners shook my hand and said I did well =) YAY MBBS IS OVER! HELLO GRAD TRIP HELLO LIFE!	

		*looks so neat when I type out but it was actually a pain to get it all out from him bit by bit no TCM or supplements no family history of DM or other diseases social - stays with wife - non smoker - rare drinker (1 beer a week or none) - finances paid by CPF - not in contact with children - not working already used to work some engineer thing? Current progress - 3 x admissions to TTSH ED for R LL swelling - given IV Abx - HD stay for one of the admissions - resolved there after - no surgeries - did angiogram to heart but not legs but no issues would also like to give a shout out to examiners who kept nodding at every question i asked which was super encouraging and made me feel like im was on a roll =)			
Type 2 Diabetes Mellitus with multiple complications Management of T2DM This patient is here for his regular follow-up, please talk to him	Not sure sorry	50yo/Chi/Male. PMHx: DM, HTN, HLD, Previous L Big Toe amputation, Renal impairment, L eye retinal detachment s/p surgery Course: T2DM diagnosed in 2004, first presented with right thigh abscess, forgot diagnostic test. 6 monthly follow-up, multiple complications, admissions for surgical correction of retinal detachment, left big toe amputation and debridement of multiple abscesses. No admission for diabetic emergencies or hypoglycemia. Control/Compliance: Unsure of HbA1c readings, but does twice weekly home CBG monitoring, pre breakfast 4-7, post dinner 8. Unsure of all his medications, but is on metformin, SGLT-2, and B.D. insulin dosing, and takes his medications regularly without forgetting. Goes for yearly podiatry and eye checks, and 6-monthly polyclinic follow-ups Complications:	Targeted examination: 1. Eye examination: Left visual acuity reduced, visual field reduced to central vision, reflexes intact, offered fundoscopy. 2. Neuro examination of UL: glove and stocking distribution 3. LL examination: Arterial examination (DM dermopathy, no ulcers, infection, weak/absent distal pulses, offered	Presented summary, gave issues list (interrupted halfway as told it was more management). Questions: 1. What blood tests would you order at the polyclinic: FBC, U/E/Cr, LFT, HbA1c, H/C, fasting lipids 2. Given a list of results to interpret: urine 24hr protein 1g/day, hyperlipidemia picture, HbA1c 8.2%. Asked what to do if already 40mg statin (high LDL, high TG) 3. What are the fundoscopy findings of this patient? 4. What is the management and who to refer to? Podiatry & eye	1. Don't forget DM findings on fundoscopy 2. Learn the new 2016 Lipid guidelines

		1. Disease - Microvascular: Peripheral neuropathy (numbness and tingling), Renal impairment (frothy urine and polyclinic dipstick shows proteinuria), Retinal detachment, multiple abscesses - Macrovascular: PVD (left big toe ray amputation) 2. Treatment: Apart from tolerable metallic taste, no complications from meds (hypos, lipodystrophy, UTI, stones, euglycemic DKA). No hyperglycaemia or hypoglycaemia episodes, knows what to do during hypos. Cost: No issues, self-employed Social set-up: Not married (and insists that I don't as well LOL). 10 pack-years smoking, beer guzzler, has not impacted his life/hobbies much. No other issues.	buerger's test) 4. Offered to look for signs of fluid overload (query renal impairment), offered to examine for CVS/Stroke *Examiners were nice, guided at some parts		
Type 2 diabetes melitus Management of T2DM This lady has a history of diabetes, please take a history and come up with a management plan	Prof Ramani + 1 other	HPC - diagnosed during pregnancy screening in 1998, not GDM - Had symptoms of polyuria polydipsia loss of weight since 1996 - Uneventful delivery, except 1 episode of hypoglycaemia during 3rd pregnancy - Strong FHx of T2 DM - Fa had AMI and stroke 2' DM - Also had comorbids of HTN HLD COURSE - initially started on Glipizide, HbA1c was 10% - Subsequently switched to insulin Novomix 40U BD - Current HbA1c is 7.8% CONTROL - does not measure pre and post meal CBG - does not measure home BP - attempting to modify diet- reduce carbohydrates, spread out meals - on FU with NUH endocrine 3/12, good compliance - Claims compliance to daily medication, good knowledge of insulin preparation and administration technique - Unable to recall names and types of medications for HL HTN COMPLICATIONS - 2 x hypoglycaemic episodes in past 3 months, did not require admission. Managed symptomatically. Knows how to recognise and respond to hypoglycaemic symptoms - No previous episodes of hyperglycemic crises - But not aware of precipitants for hyperglycemic crises (eg sepsis)	PE - Large body habitus, central obesity, offer to take height and weight and BP - Noted bruising over insulin injection sites, no lipodystrophy - CVS exam normal - Striae gravidarum but no violaceous abdominal striae - LL peripheral neuropathy till ankle, power full - No LL arterial ulcers or neuropathic ulcers, foot pulses well felt - Visual acuity 9/6, offer fundoscopy	ISSUES 1. DM cx end organ complications 2. Suboptimal knowledge re medications and compliance 3. Social issues- finance and ACP Questions - issues list - what are the secondary causes of DM (exogenous steroids, Cushings acromegaly and PCOS- all ruled out) - how well controlled is the DM - at follow up how would you want to investigate - what are the targets for her BP and LDL - how might you want to modify the medications - what treatments are necessary for the end organ complications of DM - what do you make of her compliance to treatment - explain her psycho-social issues and how we can deal with them - what would be the best way to ensure patient is compliant to your management plan/advice	If given a chronic disease case, always be sure to take history in a standard manner- cause course control complications Even for DM be sure to consider 2' causes due to endocrinopathies, and to rule out GDM in females Otherwise formulate and issues list given broad categories, and deal with each issue sequentially in your management

		- Macrovascular: nil prev episodes of chest pain, AMI or strokes/TIA - Macrovascular: nil claudication hx, nil LL ulcers gangrene or rest pain. Reports delayed healing over superficial foot wounds but no cellulitis - Microvascular: complains of numbness over dorsum of both feet, no resultant falls. Regularly checks for open wounds cuts nails square covered footwear - Microvascular: treated for DR with laser photocoagulation 10 years ago, evidence of new DR and hypertensive changes in latest eye screen - Microvascular: evidence of occasional frothy urine, kidney function tested normal. Does not regularly test with urine dipstick for proteinuria SOCIAL HX - non smoker non drinker - 3 children: all teenagers, schooling. Able to cope - works as admin assistant for the past 8 years, stable income - only barely able to cope financially, requires Medifund for DR treatment - Single parent family: limited social supports as she lives apart from elderly parents - Not considered ACP - Psych: no depressive symptoms, generally positive outlook			plan, that should be adequate overall!
Falls 2' Hypoglycemia on b/g Poorly controlled DM Approach to Falls Patient recently had a fall. Take a history and do examination		40 / Malay / F 1) Fall - Dec 2016, during fasting month - woke up on floor - prefall > no blacking out or sudden change in posture > hadn't eaten for v long bc fasting > no headache/fever > no weakness - fall > unwitnessed > family came in after pt shouted for help > did not note seizing or jerking > no incontinence > no weakness postfall > some weakness, slurring of speech but rousable > called ambulance and sent to ktph > hypocount found to be low, given sugar and did not improve	Examination - the whole top part took about 23 mins bc lots of issues and the pt is nice but rambly and speaks slowly - asked for vitals + postural bp examiner said nvm - the cotton wool and satay sticks etc were lying on the bed so i was like okay i guess you want me to do the foot then - L foot in the podiatry boot thing examiner said dont examine - R foot tested 10 point discrimination, she could feel 0	Issues 1) falls 2' hypo on b/g DM with hypoglycaemic unawareness 2) DM cx as above 3) chronic diseases as above 4) ESRF on PD 5) hypoK 2' poor intake and vomiting 6) low mood 7) headaches? Qns - what else do you look for on foot PE? > trophic changes of PVD > CRT, pulses, warmth > ulcers in the various areas - what do you think of her PD? > talked about pros of PD vs HD > then said she has cx of PD so can consider trying HD - did you notice her footwear > in hindsight can be a CROW for charcots joint as a cx	- in long case its okay to focus more on hx, PE is only 3/20 marks - focus on getting a problem list and all the bio/psycho/social stuff too - the pt leaves the room and never comes back for discussion dont be surprised haha i didnt get to thank her enough - w/e no matter how it goes at

		2) Early morning headache after fall > worse on sitting up better on lying down > no neuro deficits > no photophobia neck stiffness headache > not worse on coughing PMH 1) T2DM x 9 years on glipizide OM and insulatard ON - goes for regular screening for foot/kidney/eye -Hb A1C 6.9% but > eye: some kind of bleed s/p photocoagulation > foot: PVD s/p L 2+5 ray amputation, v bad neuropathy with total sensory loss > kidney: esrf on PD - hypo: knows hypo symptoms but does not always have them when her reading is low (!) - hyper: no dka or hhs - readings: morning well controlled but after meals can be up to 12 2) HTN - measures at home 126/51 - now off meds bc well controlled idk 3) HLD - on statins 4) ESRF on PD - CCPD - competent but c/o nausea vomiting LOA and tiredness - cx peritonitis x 1 episode, tenckhoff removed and put on HD for 2 months by IJ cath Course of admission - sugars didnt come up in A&E - did K, found to be super low 2' vomiting and poor intake (see PD above) - admitted to ICU x 1 day, warded 2 weeks - brain scans normal no injury Meds - Simvastatin, glipizide, insulatard, oral K replacement, claims compliance Social - unemployed due to disease - never smoked or drank - lives w parents and sister - wheelchair bound - adl independent - low mood due to condition + hassle of dialysis considering side	- tried to do glove and stocking but her numbness extended beyond the point that her pants could roll up to so examiner said nvm - did pronator drift bc fall with ?head injury, normal. Then bell	of DM > want to look for rocker bottom sole - how to help her get back to work > said something about telling the colleagues for warning signs and treatment of hypo etc but then he wanted me to talk about PT/OT > then talked about mobility scooter and shameless moment ++ I was like she's on MSW support so we can apply for social mobility fund for her - no more qns Sat in pleasant silence for last 2 mins	the end of 40 mins its over and you can be like me typing frantically to help your juniors on the plane before it takes off for grad trip - dont book flights on the same night as long case - all the best!

		effects - financial support from queenstown something or other idk - dad has DM but well controlled no other family history .			
Nephrotic Syndrome 2' to long-standing DM Approach to bilateral lower limb swelling Patient's latest problem is lower leg swelling. Please clerk him and give an issue list.	Dr Seow Cherng Jye (such an angel), another female examiner who was my active (nice)	As I was the first student, prepare to get a poorly-primed patient. He meandered around his leg swelling for a while. He told me about a virus attacking his left lower limb and it became red and swollen and he had to go to the A&E to get antibiotics so I presumed it is cellulitis. Then I went on to rule out the differentials for bilateral lower limb swelling - CCF, CKD, chronic liver disease, drug causes like amlodipine. Found out he has bubbly urine, and no other changes in urine. Not planned for dialysis yet, but renal biopsy done showed about 30% of damage was done. As I had asked at the start what co-morbidities he had (DM, HTN, HL for 30 years), I was aware that his nephrotic syndrome is likely secondary, from long-standing DM. Then went on to rule out GN as a likely cause of kidney damage - joint pain, rashes, positive family history of autoimmune conditions. Had no time to explore the other history in detail but managed to elicit that he has poorly-controlled DM due to irregular lunches during the day when he works as a GRAB driver, and sometimes forgets his medications. His latest HBA1c is 6.5% but previously, his values were around 8%. Does not remember his medications, but remembers he is on 1L fluid restriction, which he finds it hard to comply sometimes. Claims compliance to medications in the last 3 months. Lifelong non-smoker and drinker. Did not elicit the other complications of DM, but was asked later on during discussion because examiners could tell I was pressed for time, and did not fault me on it. Later on also found out he had laser photocoagulation for diabetic retinopathy.	CVS, Respi exam and lower limb exam. Only positive finding is bilateral lower limb pitting edema up to upper thighs.	Straightforward DM nephropathy. Presented in an issues list 1. Bilateral lower limb swelling for investigation - Likely DM nephropathy - Contributed by HTN nephrosclerosis - Not CCF, CLD or drug causes 2. CVRFs of DM, HTN, HL 3. Poor compliance due to irregular working hours Questions: - What in the PE would you like to have done in real life: fundoscopy to look for DM or HTN changes, neurological exam, assess vitals - What are the complications of DM - What is the most likely diagnosis - nephrotic syndrome 2' DM - Why poorly-controlled DM - How to manage patient in the long-term in clinic - What is nephrotic syndrome	Time yourselves, and do not fret if patient is slow in his words or not forthcoming with his information. Examiners are observing you and they know the difficulty. Just remember to keep track of time and stop when necessary. Examiners are pleased to hear big frameworks to show you are structured. So simple frameworks like macrovascular and microvascular complications; manage long-term in a holistic manner involving the patient's medical and psychosocial needs all go a long way into creating the right impression during exams. Left the room feeling exhilarated because MBBS is

					over!
T2DM Management Case this man has diabetes and is in for followup. Please talk to him and take a history regarding his diabetes and formulate issues and management plans. (Something to that effect)	Dr Kurumbian Chandran (NTFGH Endocrine) Dr Teoh Chia Meng (NUH respi)	After yesterday's shorts, I really needed to get full points for this. Was freaking stressing out. And this year, they did not tell us which station was the paeds case which made it more stressful haha. But in the end it turned out well. Thank God for bringing us through to the end of MBBS! Ok here goes For some reason, my circuit wasnt allowed to sit at our rooms. Meanwhile everyone else was writing away their templates and stuffs. Finally we managed to convince the DO ladies to pass us the clipboard and paper. Once we received it we sat on the floor like hobos and began writing templates. Wrote out two templates, one adults and one paeds. Finally we were allowed to sit at our rooms. Luckily we managed to write our templates down cause the bell rang 30 seconds after we sat down and in we went. The examiners were super nice they came out to shake hands and greet me the moment the bell rang. Was desperately trying to look in to see who was the patient and lo and behold a Indian man!!!! YAYYYYY Wow didn't know I had a endocrine doctor and he was the one asking most questions too hahaha but other were angels lah haha The stem was given: this man has diabetes and is in for followup. Please talk to him and take a history regarding his diabetes and formulate issues and management plans. (Something to that effect) - heart jumped with joy OH YESSSSSSSSS THANK YOU GOD Proceeded to take history. Cause I was so happy I forgot to start the timer lol only realized it about 2 min into the history. Patient told long story kind so also ate my time. But still it's adult. And DM. I'm not complaining. History: 57/M/Indian NKDA No G6PD Pmhx DM HTN HLD IHD (asked along the way) Diagnosed with DM at 30y/o Presented with	Went to examine him - his shoes and socks were all on sien Ask him lie down on bed. Checked pulses - present Started doing monofilament - first time opening it, cost me some time - please open all the packaging HAHAHA after testing 7 spots on one foot, the examiners were like "based on your history, what do you like to examine?" (Whatever I examined until then was normal) So said neuro, fundoscopy, full cardio vascular... couldn't think so said Abdo for enlarged kidneys in early diabetics LOL what else? - uhm uhm uhm... ABDO FOR LIPO DYSTROPHY! Cause insulin Ok! Come go back and continue talking to patient Sat down. Bell rang signaling end. LAWL. Examiners: ok! Please summarize and give us an issue list. Patient shook my hands, said ALL THE BEST :") 2 mins passed by super fast	M: me E1: examiner 1 E2 examiner 2 E1: ok come give us an issue list M: this is xxx, 57 year old Indian gentleman who has pmhx of DM HLD HTN now on follow... E1: just the problem list M: he has background long standing DM 27 years. Issues for him are 1. Microvascular complications - diabetic retinopathy 2. Macrovascular complications - IHD requiring bypass 3. Neuropathy - while they are normal, he can alr feel numbness 4. Poor control - HbA1c high, likely cause of poor diet control E1: so do you think he has type 1 or type 2 DM? M: type 2! Cause I notice he started on and is still on metformin E1: you should have asked him for his Meds list he was all ready to give it to you M: shucks (like I said it loud hha) E1: on his list he had a medication called canagliflozin. Do you know what that is? M: errrr SGLT 2 inhibitor I think E1: ok tell me about it M: inhibits SGLT 2 in kidney causing glycosuria (was about to say the complications but decided against it) E1: good! So you do know about it. Ok you asked about drinking a drink to diagnose right? What is it? (Peeped at his note pad WAH he write down more notes than me sia hahaha) M: oh the OGTT E1: do you think it was done? Esp if he symptomatic M: uhm yes? Cause still need one more positive test right E1: yes lah but if symptomatic until like that don't need to do lah haha random blood glucose can alr. It's ok you are correct just to help you in your practice next time - looks at E2 and both of them chuckle E1: ok what's the home levels he should hit? M: 4-10? E1: nah mostly x-x (SORRY CANT REMEMBER) . Ok come E2 E2: so for him what should his glucose control be like?	MBBS is stressful. But practice makes perfect! Try to start revising early, and pace yourself. But M5 can still be fun I think I had the most fun, most parties in M5 LOL Find a few friends and practice long cases. Get them to be as guailan as patients when you practice history taking. Read seniors accounts. I hope when you read this it isn't too late. Practice approaches well too! Super impt. Most importantly, don't burn out! You will always feel unprepared and that normal, but as long as you have really put in your best, should be fine. ALL THE BEST JUNIORS! If you need any help feel free to approach us will be more than

		- polyuria - Polydipsia - LOW about 5 kgs - No early satiety - No DKA/HHS - Was not taking traditional medicine - Did not notice hands and feet getting bigger - Used to be obese - but no OSA (sleepy, snore) - Went to see polyclinic, was referred to toa Payoh hospital - Not warded - Diagnosed on OGTT (drink sugar water) - He said started as type 2 DM, then changed type - But was started on metformin - Drugs for diabetes - Started metformin 250mg BD, now 850mg BD - Started also on insulin 6 years ago. used to be NPH but now glargine and actrapid basal bolus regime - glargine 24U ON, actrapid 10U 12U 12U - Doesn't know sugar to insulin ratio Control - HbA1c now 7.8-8.1 - Knows not very good - Takes morning blood glucose only - Usually 6-9 - Followed up at KTPH - Was at toapayoh hosp, then CGH, now KTPH - Not at poly because hospital more convenient and service better - Goes yearly foot screen - Knows to wear covered shoes, fitting shoes, check for injuries - Eye screen 4-6 months, used to be yearly. Will elaborate why later - Doesn't carb count, but can explain how - He Explained the best diet, and recommended exercise regime to me Complications of treatment - 2 times hypo in 27 years - Knows hypo symptoms, can tell me - Sweating palpitations faint dizzy - Knows what to do - The 2 times happened at night, drank coke and resolved. Took blood sugar levels also, was 2 - Didn't need to be admitted, but told doctor who adjusted meds Complications of DZ		M: seeing that he young, should have controlled at 6.5 percent E2: how bout now? M: now quite late, with complications alr. I would say 7%? Also need to control his BP to prevent DR and more problems E2: yeah about 7%. So what do you think the prognosis for him is? M: at this state it's quite bad? Because a lot of complications alr. But still want to control tightly E2: yes. You want to still control tightly because you can still arrest the microvascular complications (or was it macro SORRY PLEASE CHECK) and prevent it from progressing. Ok you know he went for lasers and injection. What do you think his eyes are like M: quite serious? E2: yah what does he have? M: diabetic retinopathy? (inside was like UGH can't remember the eye posting) like 4 quadrants affected? E2: haha proliferation DR M: OH YAH YES YES THAT THAT CORRECT E1: ok how will you help him have better control? M: seeing that he is having irregular meals... E2: he has regular meals M: (exam induced aphasia from now) oh ask him eat small small parts all day (LOL MY BRAIN) E2: like have smaller meals spread out over the day? M: YES. Also because it's the quality he is having problems with maybe can pack meals from home! E1: yes yes. Ok he is on insulin right? What regime would be best for him? M: uhm the current one? E1: how to improve it? M: uhm... like as in it's tailored to meals alr... E1: like the insulin itself he is taking actrapid right? M: uhmmm sorry... it's short acting alr? *Bell rings* E1: nvm! Go.. M: OH NOVORAPID E1: *beams* YESSSSSSS!!!! Rapid acting! Smiles all around, shake hands, can't believe it's over, Examiners say go enjoy your hols! You deserve it! You were excellent wahhhhh examiners so nice I can holiday in peace alr hahaha Saw patient outside, he shook hands again, thank him profusely	glad to help!

		microvascular eye - Diabetic retinopathy found out 6 years ago - Had 4 lasers - Had intravitreous injection - Vision can see, no problem - Because of that, have to increase frequency of screening - No falls - Insulin regime was actually started before the eye problems Microvascular kidneys - no protein - Creatinine normal - Thinks Urine creatine albumin ratio normal - Forgot to ask for frothy urine (got asked later) Macrovascular - Can't remember how he found out, I think stress test. Found out 4 years ago - Admitted for cardiac angio - 4 vessel disease noted (4? lol) - Was PCIed, stented - On plavix - (Can't remember if he was ever on aspirin, but he was defo on plavix now) - On famotidine for GI protection - No GI bleed, no ICH before Neuropathy - feels foot is numb - But foot screen normal - No ulcers before HYpertension - Found to have HTN 6 years ago - On follow up - Takes amlodipine, atenolol - No problems, no postural drop, no falls - Home BP about 130/85 average HLD - on atorvastatin Family history - dad has DM, diagnosed at 50 years - Mum passed away at 49, due to breast CA Social history - non smoker - Drinks a cup of beer a month - Married, two kids, 26 and 24 - Stays with them		Never. Been. So. Happy. Ever. In. My. Life. Thank God for happy triad again haha	

		Finances - works as civil servant - Meds all Subsidized (helps ALOT) ICE - understands DM well (evidently) - Understands the complications - Understands it's poorly controlled - Been actively trying to reduce it. Very motivated - Cannot achieve targets cause busy. Eats out, not super regular. Quality of meals not controlled. Only eats dinner at home which wife can control. Cheats once a week with sweets and cakes - No time to exercise, at most runs 30 min a week. Used to be more but now busy Didn't explore compliance - must ah esp with so poor control LOL by the time I reached here I had 2 min left GG			
DM cx by retinopathy and vitreous haemorrhage , nephropathy and hypoglycaemic episodes Management case	Dr Quah Teik Joo	45 year old Chinese lady NKDA Sales manager Married w 3 children Management case : *HOPC* 1) Long-standing diabetes - Polydipsia and polyuria from 24 years - 26 years - diagnosed at 26 during pregnancy , as gestational dm ,but postpartum formally diagnosed with diabetes on follow up - treated with insulin during pregnancy - started on metformin postpartum, then switched to insulin due to adverse GI side effects - continued on Novomix thereafter (no recent change in medications) - HbA1c dropped from 9% to 7 % in the past 2 months due to change in diet 2) Vitreous haemorrhage b/g diabetic retinopathy - presented with weblike black "floaters" obscuring her vision that is persistent - still able to see through it - no BOV, no diplopia - nil eye redness, nil tearing, nil pain	took 5 min to examine Examined for Nil diabetic dermopathy should have checked for acanthosis nigricans - microvascular complications > RAPD on the left , w preserved visual acuity > nil pedal edema , should have also auscultated the lungs for crep > glove and stocking numbness, nil calluses, neuropathic ulcers, nil dry skin - should have also tested reflexes and offered micro-filament - macrovascular > pronator drift negative (didn't have time for	What are the patient's issues How will you investigate her How will you mx her Secondary causes of DM - did you look for them on PE (no :( ) - endocrine : acromegaly , cushing, glucagonoma - stress hyperglycaemia - pancreatic insufficiency - pancreatic resection/ cancer / pancreatitis	make sure you practice DM till sui sui make sure you practice the physical examination so that it flows well also bring a microfilament .. in my hurry i couldn't find my microfilament always consider secondary causes of DM, and other primary causes (by asking about phenotype on presentation, insulin dependence, autoimmune associations) always ask for a stem if not clear.

		- nil eye trauma - nil numbness / weakness - nil headache , nausea or vomiting - told to let the blood settle before further review and intervention Complicated by - multiple hypoglycaemic episodes in the past 2 months due to change in diet > recently reduced carbohydrate intake > hypoglycaemic episodes at night - feels hungry, jittery, tremors , drinks sweet drinks thereafter when these episodes occur > have not informed doctor , no on self-glucose monitoring due $$ of strips - vitreous haemorrhage 1 month ago on the b/g diabetic retinopathy - blurring of vision for 10 years , s/p laser photocoagulation bilaterally - diabetic nephropathy - previously had frothy urine (not on ACE-inhibitors) - but says it seems to have improved after medication > sigh forgot to ask about symptoms of renal insufficiency - diabetic neuropathy > diagnosed on biothesiometer . although personally does not suffer trauma because of neuropathy . and does not feel any obvious numbness - immunopathy - previous poor healing of injuries on her feet but no active ulcers No macrovascular complications - nil ACS, nil stroke, nil vascular claudication or rest pain / gangrene No previous hospital admissions for hypoglycaemia / hyperglycaemic crisis Systemic review unremarkable PMH - htn - hyperlipidemia No surgical history medications insulin - novomix (unsure) empagliflozin losartan	neuro screen) > nil murmurs, nil carotid bruit > pulses in legs present , nil arterial ulcers, nil trophic changes ran out of time , should have examined for lipodystrophy as well :(and should have checked for secondary causes of DM like cushing's, acromegaly , examined the abdomen for epigastric pain (pancreatitis)		I didn't get a stem and on hindsight I should have clarified.. so that I would know for sure how to approach the case

		? statin ? no ace-inhibitors no TCM Prominent family hx - parents both have Type 2 DM diagnosed at 50-60s - father has had ACS before Social - nil smoking , nil alcohol - married with 3 children. not contemplating pregnancy > should have asked about children --- and glucose control during pregnancy but i forgot :(- financial concerns - cost of glucose test strips. requires medifund - no other social concerns .			
T2DM and HyperTG secondary to Cushing's Syndrome, with poor compliance and social issues Approach to DM(?) - more of a management case This is your patient, 31 year old Indian man, with DM and HyperTG. Please talk to him about his medical conditions and come up with a	2 profs that i didnt know - but quite nice	31/I/M NKDA PmHx: Leukemia s/p cord blood transplant cx by transplant rejection. Treated with steroids cx by cushing's syndrome. Currently in remission, no longer on steroids. Even has weight gain and round facies with stretch marks. - on f/u with NUH heme ADL-I Community ambulant HOPC: Happened in 2008 when he was admitted for neutropenic fever Polyuria - 5-6 times a day, increased from baseline Polydipsia - >3L a day, more than baseline Nocturia Unsure of duration Associated with frothy urine No hematuria or LUTS Systemic review unremarkable: Some SOB - but attributed it to a flu, said it was not like chest tightness or cannot catch breath Investigations: HbA1c - 10.3% Did not do OGTT HyperTG also, unsure of value Dx:	Asked for height and weight to calculate BMI - 28 Asked for vitals but was not given Started by looking for acanthosis nigricans - not very obvious Asked to take off shirt to briefly screen CVS and abdo suddenly remembered about insulin injections - says he rotates his injection sites, no lumps on tummy noted Noted striae, but not purple He has truncal obesity No dorsal or supraclavicular fat pads Examined for peripheral neuropathy with my monofilament - normal Did brief VA screen - normal Didnt know what else to do so examined for	Examiners said present issues: 1) T2DM and HyperTG secondary to Cushing's disease, currently on medication. T2DM is poorly controlled 2) B/g of leukemia s/p cord blood transplant, in remission 3) Financial difficulties on f/u with MSW What is the most important issue - T2DM with poor compliance What is your management to address this? - Possibly can change insulin regime to BD instead of basal bolus - Can start OHGA if he's keen, but not metformin. Examiner says 'he's actually on Linagliptin and something else' Must've seen me proptose cause he said' dont worry, not your fault, he didnt tell you' What classes of meds are these - DPP4 inhibitory, didnt know the other one What causes hyperTG - metabolic syndrome, shouldve said liver disease, but in state of panic, i forgot What will you do on f/u in clinic? - Measure vitals - especially BP - Ask about symptoms - Ask about complications and compliance to meds - Bloods - HbA1c, fasting lipid panel looking for HLD - possibly can start statins Examiner said ' he's actually on atorvastatin' - i apologised like mad	Study common things like DM, HTN, Stroke, Asthma, AMI

management plan.		T2DM HyperTG Management: T2DM - started on metformin originally but kept having diarrhea so switched to SC Insulin - Glargine 35U OM, Novorapid 14U pre-meals HyperTG - Started on Fenofibrates, 300mg OM Currently on f/u with NUH endocrine Control of DM: Said Dr said it's not too good Said it's because of his diet tends to have irregular meals due to nature of job and forgets insulin about 1-2 times a week. Has been referred to dietician and understands meal plan but has difficulty maintaining diet as very busy Complications: Recently went for DM Foot and Eye screen in Dec 2016, said normal Mentioned some long-sightedness, but does not wear glasses No numbness or weakness Still some occasional frothy urine Drug hx: Apart from DM and HyperTG meds mentioned above, only said he's no ursodeoxycolic acid for liver. NOT ON ANY OTHER DM MEDS NEVER DX WITH HLD Fam Hx: Mother has T2DM and HTN Brother is healthy Social: Works as lorry driver - drives for long hours and sometimes misses lunch Diet - usually eats fast food or dapao-ed food Non-smoker Occasional drinker - 2 bottles of beer on weekends Does not find that med problems affect lifestyle Mood is okay - just sian that he has DM Stays with mother and brother in 3 room HDB, with lift landing Some financial struggles but on f/u with MSW	cushings - proximal myopathy etc - all normal	Other examiner asked me what lifestyle changes can be done - diet and exercise then bell rang There were other questions also but i can't remember	
type 1 dm, poor control	prof gerald chua, another	25yo/chi/male dx with t1dm in 2013 when he had an episode of (what sounded	largely normal. did monofilament (which i	presented the poor control, no cx so far, high hba1c and blood glucose	i suppose you could consider

management case: dm this gentleman has dm, please talk to him	indian guy whose name i can't remember how to spell sorry ><	like) dka, hyperglycemic state: glucose 33. - 2-3/52 of feeling lethargic, tired, sore all over, polydipsia polyuria (not frothy, no blood, no ants). screened all my red flags there weren't any. - went to a&e got d/c - went to polyclinic later and got referred to a&e - dx t1dm and put on insulin (basal bolus, 1xglargine at night and 3xapidra before meals) since then, 2 episodes of readmission for similar dka (he told me "kentos were high" - i was a bit o.o and then i realised he meant ketones) - asked for any precipitant, he said none known (no infx, stressors etc) gets hypoglycemic episodes every 1/12 (shivering) but he knows he should take a sweet drink or sweets injects insulin into abdo, never noticed skin changes goes for f/u regularly every 3/12; does eye foot kidney screening all normal. no fluid overload symptoms. latest hba1c 8%. cbg at home usually 8-12. (dr says should be <6% and 4-8 respectively, so.) no other pmhx famhx: was ready to tell me none but i asked all the autoimmune diseases, father has thyroid (but no idea what) drug hx: once took tcm about 10 years ago, otherwise only insulin social hx: no smoking/alcohol, diet not very well controlled (only seen dietician once, usually eats out), no exercise coz no time with work. no problems with injecting insulin, no compliance issues. not affecting lifestyle or f(x). not depressed/accepted alr. working as financial advisor, no financial issues.	think i left behind in the room HAHA oh well), palpated abdo and ballotted kidneys (they asked why/i said i didn't expect any problems but that was the only thing i could do for kidneys on pe) then briefly checked heart lungs abdo. saw a few hyperpigmented spots over the sites of injection. offered to do fundo; there was no ophthalmoscope in the room. examiner proptosed a bit and went "you don't have?" so i just apologised and he said never mind.	- mentioned may be LADA since later presentation - admitted for what sounds like dka, or at least hyperglycemic state (eventually they pushed me into saying that yes it's dka) any problems since 2013 that may be concerning - hyperglycemia x2, hypoglycemia every month (shivering) possible causes for hypo - may be due to taking too much insulin, not eating meals (should have asked: timing of hypoglycemia, whether he changes his own insulin doses) anything you might consider doing - tapering insulin dose/changing it, especially if hypo episodes happen at night/early morning - discussing with him regarding the diet and possible schedule/referral to dietician - recommending exercise how to check him up - repeat concerns about retino/neuro/nephropathy, screen eye; they didn't ask further. screen foot; mentioned looking for ulcers, wounds, change in sensation, eventually possibly Charcot foot with deformity (prof went "that's quite late right?" and i agreed haha yes prof it's late but you didn't stop me so lemme elaborate on dm foot :p). screen renal; do RP regularly. (a lot of social-ish kind of smoke ><)	bringing in an ophthalmoscope if you have/are confident of doing fundo, but honestly not many examiners expect you to have it/do it i think (i mean they didn't really seem fazed la) i guess my hx could have been a bit more organised coz at first i was wondering if i should concentrate more on the initial dx or if i should try to look at the course of the disease! but otherwise yeah just a management kind of case
T1DM with Metabolic Syndrome Management of metabolic syndrome No stem outside. Walked into the room and was told "You are the doctor in the clinic.	Dr Sobhana D/O Thangaraju (renal transplant) Prof Leong Keng Hong (rheumatologist)	Indian F 55Y NKDA PMHx: DM, HLD, gallstone cholecystitis s/p cholecystectomy PC: Presented 30 years ago with generalized abdo pain x 3/7 - Assoc with nausea/vomiting NBNB and tactile fever x3/7 - Assoc with 2 months of polydipsia and polyuria, no polyphagia or LOW - Assoc with fainting on 3rd day, found by mother and brought to A&E. Found to have “very high sugar” levels and “in coma”, patient unsure if she had ketones or acidosis. - No headache, slurred speech, weakness to suggest HHNKS.	At 18 minute-mark, looked at examiners and requested to performed PE. Examiners said “Just tell us what you want to do?” Hands: Check for glucometer prick marks, AVF Face: Check for cataracts, arcus senilis, oral thrush Neck: Check for acanthosis nigricans, skin	Bell rang, consolidated alone for 2 minutes. Then examiners return; presented as per medical/social/psychological issues. Dr Sohbana (D) and Prof Leong (P), Me (M) D: You mentioned her control is quite good, why do you say so? M: *quotes all the above compliance and insight points to show good control, plus minimal complications and no admissions in the past 10 years; however she has a high HbA1c at the moment and is titrating medications. Hence control at the moment is less than ideal.*	Common things like metabolic syndrome, renal failure seem to be coming out a lot these days. Of course, one can never predict which case you will get; one of my CG mates got a very unfair case of approach to learning

This lady has Diabetes Mellitus, talk to her and formulate a management plan."		Course: - Initial ICU stay with intubation x 3/7, followed by gen ward stay x 2/52 - Started insulin immediately, cannot remember dosage at start but has decreased over the years - 6 more admissions in the initial ten years for DKA/HHNKS and hypoglycaemia, not requiring ICU. Subsequently well with no admissions in the past ten years. - Recently had several episodes of hypoglycaemia not requiring admission, hence insulin tapered from 18+6/6/5 to 16+5/5/4. HbA1C has hence increased from 6.5% to 8.1% over the last year. No further plans for titration at the moment. Complications: 1. Macrovascular - No symptoms of stroke or TIAs so far - No previous AMIs, no angina, episodes of chest pain. No 2D echo so far - No symptoms of intermittent claudication 2. Microvascular - Mild diabetic retinopathy picked up on yearly retinal photography, not for treatment yet. No BOV, no cataracts. - No symptoms of peripheral neuropathy; regular sensory testing normal. - No symptoms of diabetic nephropathy, renal function tests normal 3. DKA /HHNKS x 4 episodes 4. Hypoglycemia x 2 episodes requiring admission Drugs: 1. Metformin 500mg BD (Never changed over the years) 2. Insulin - Lantus[Glargine] 16U OM + Novorapid[Aspart] 5/5/4 TDS 3. Simvastatin 20mg ON Compliance: Follow-up: SGH Diabetic and metabolic centre 3-monthly Insulin: Never misses dose, rotates site, pinches skin, injects bolus 5min before eating. Sick day: Knows sick day rules, does not use ketostix and will just go to poly/A&E.	tags Chest: Check for Apex deviation in CHF Abdo: Check for lipodystrophy, hepatomegaly in fatty liver Legs: Check for diabetic dermopathy, trophic changes, pulses, capillary refill, neuropathy Complete with fundoscopy for retinopathy, dipstick for glucose and protein, vitals for hypertension and orthostatic hypotension Examiners kept prompting “What else” so offered check height and weight and calculate BMI. Further offered waist circumference and they looked happy. Had 3 minutes left so took more history on diet and exercise. In hindsight, should have also assessed the triggers for her DKA/HHNKS and hypoglycaemic episodes, and asked her height/weight.	D: *Examiners nod encouragingly*. What can you do to improve her control even better? M: For the time being, I would not change her insulin levels. I would talk to her and find out the cause for her hypoglycemic episodes e.g she injects too much, or injects too early, or injects and forgets to eat. If we can find the underlying cause, I would like to address it then taper her insulin back to higher levels. D: You mentioned she has T1DM and hyperlipidemia, how do these go together? M: Ma’am the patient may have metabolic syndrome. I would like to assess for the other 3 components namely obesity, waist circumference and hypertension. D: Sure, what is obesity? M: Singapore follows the definitions of >23 is overweight, >27.5 is obese and >35 is morbidly obese. I would have liked to ask her directly for her height and weight and plotted her BMI…. D: Sure, but by eyeballing just now what do you think? M: The patient was, err, somewhat prosperous looking so I would hazard she has obesity. D: Ok. How would you like to manage her obesity? M: I would counsel her on diet and exercise. Diet is already relatively healthy with brown rice and low glycemic index foods like chapatti. I’m not an expert on Indian cuisine but would advise her against eating sweet desserts like Gulab Jamun and Kulfi (CMC Vellore elective ftw haha). She can also undergo caloric restriction to lose weight. With regards to exercise her walking is low-intensity, though she does do housework. I would advise her on moderate-intensity exercise for 30 minutes at least 5 days a week e.g brisk-walking, jogging, swimming. Further optimization can involve allied health partners like our dietician and physiotherapists. D: Good. Let’s talk about something else. If she has hypertension, what would your first-line drug be and why? M: ACE-Is or ARBs, as these can preserve renal function through decreasing intraglomerular protein concentration and hence intraglomerular pressures,	disability. For those who are Christians, do remember that if God intends for you to pass, he will definitely help you pass. If his will is for you to study a few months more and be even safer, so be it. Either way, we'll give thanks and rest in him~ JY all! NQ.

		Hypoglycemia: Knows warning signs and rule of 15s, will drink ½ can coke if hypo. Did not know that should eat next meal and go hospital if repeat hypo twice; did counselling on the spot. Screening: Goes for retinopathy neuropathy nephropathy screening regularly. Does not usually check her feet unless injured. Diet: ½ bowl of brown rice or idli in morning. Other meals usually chapatti with condiments. Does not drink sugared drinks or eat ice cream. Exercise: 20min of walking to work each day, does house work twice a week. Otherwise no moderate-activity exercise. Family: - No family history of T1DM, thyroid disease, SLE, vitiligo. - Father has T2DM dx at 45 - Married with 1 child. Child has no health problems. Social: - Never smoked, no alcohol - Working in admin job - Diet and exercise as above Cost/Concerns/Function: - Needed MSW referral for initial ICU stay. Otherwise financially stable with Medisave resources. - No concerns at the moment. Mood is good and not affected by disease. Function is preserved; minimal interference with her job, just goes to inject insulin 5 min before meals.		minimizing damage. D: Right, so what's the exact mechanism? M: Err, ACE-Is cause afferent vasoconstriction and efferent vasodilation…. D: Glomerular hypertension, right? M: *oh I thought I said that already* Ah, right! D: How would the presence of renal failure affect this patient's DM? M: I would have to titrate many of her medications. For example, I would give renal dosing of half-dose Metformin at a GFR 30-45 and suspend Metformin below GFR of 30. Insulin may be reduced from 0.4U/kg to 0.3 U/kg per day. In a T2DM patient on sulfonylureas I would switch glicizide / glibenclamide / tolbutamide to Glipizide as Glipizide is short-acting and metabolized by the liver, hence does not accumulate in ESRF. D: *looks pleased* I don't have any more questions. P: You mentioned the patient has metabolic syndrome. What are the features? M: Err, the diagnostic criteria? *P: Sure, anything you know*. Sir the diagnosis requires 3 of 5 criteria, namely obesity with BMI > 27.5, an increase in waist circumference >88cm in women or >102cm in men, hypertriglyceridemia, low HDL, or DM. P: Good, any other features? Gout is also associated right? M: Yes prof! P: In a patient with DM and nephropathy, how would your management of gout be different? M: Err both acute and chronic treatment would change. Acutely, NSAIDs are usually first-line for gouty flares, however NSAIDs can worsen renal function so I would prefer Colchicine. That said, Colchicine is contraindicated in patients with poor renal function e.g on dialysis as colchicine cannot be cleared by dialysis machines and will accumulate, causing cytotoxicity. In the chronic setting, urate-lowering therapies like Allopurinol may require renal dosing. Uricosurics like Probenecid lose efficacy as GFR decreases, hence I would avoid them. There may also be an increased risk of urate nephropathy…*looks at examiner's eyes cautiously*	

				P: Haha okay. With regards to her DM, do you think her HbA1C is ideal? M: No Prof. She has many factors that tip her in favour of tighter control. Namely, she is relatively young, with minimal comorbidities, with minimal complications of disease. She has good insight, is motivated and and a strong social support system. Hence I would want a more stringent target, for example 6.0 – 6.5% *fluffs a relatively good number* P: Sure. What type of dyslipidemia does this patient have, given she has metabolic syndrome? M: *jaw drops internally. Did not study this whooooops* Errr she probably has raised triglycerides, low HDL and high LDL… P: Ah, that's type 4 which is quite common in the population. How about metabolic syndrome? M: *sighs internally* Sorry Prof, I'm not too sure… P: Haha, type 2 right? Very high VLDL and LDL. M: Ah, type 2. Right. I'll make sure to read up. P: Going forward, what do you think her long term prognosis is like? M: Her prognosis is likely good because she has *BELL RINGSSSSSS* goodcontrolgoodunderstandingminimalcomplications oversomanyyearsofdisease. P: *nods, looks happy* You can go now.	
Graves Disease Your patient is here for a follow up for Graves disease in the clinic. Please assess her and come up with a management plan.	Not sure	Not going to type a very long account because this case was pretty much TOO straightforward (too good to be true in fact). But basically, patient was diagnosed to have Graves disease when she went to see her Parkinson's doctor 3 years ago. She was totally asymptomatic. Only had tremors (which on hindsight could be the approach they were trying to test) which i didnt pick up cause I brushed it away thinking it's just because of the Parkinsons. Complications: no thyroid storm (no admissions), no thyroid eye disease, no irregular heart beat, no heart problem. Anyway I just asked for hyperthyroid symptoms, mass effects and signs of invasion. Which there were none. Doctors did some blood tests and confirmed it was Graves. No US	I requested to do a running commentary because thyroid it's just easier with running commentary. Inspection: not anxious, not sweaty, voice wasn't hoarse just now. See an anterior neck lump. Moves with swallowing, not with tongue protrusion. No overlying skin changes. Thyroid: Diffuse neck swelling. Smooth surface.	Presented the issues - which was practically none 1) Well controlled graves with no complications, no longer on treatment 2) b/g parkinson and HLD 3) no psychosocial issues noted Questioning: 1) How to investigate the patient? - Standard. 2) What are the complications of Graves? - Thyroid eye disease, AF, CCF, thyroid storm. Tried to vomit out Burch Wartofsky score but he said nevermind, not scope of exam. 3) Do you think she has thyroid eye disease previously - basically the point examiner wanted me to get was	All the best guys! Although luck is really important, but you still need to prepare and study hard!

		or FNA done. Started on Carbimazole (deduced cause patient said it was once a day) but stopped last year because blood tests said it was euthyroid. No SE from carbimazole. No hypothyroidism from carbimazole. Patient was compliant to medicine and regular follow up at CGH. PMHx: 1) Parkinson's likely idiopathic diagnosed 3 years ago. On some meds TDS which i deduced was madopa. No freezing phenomenon/dyskinesias/postural hypotension/insomnia. Forgot to ask about follow up. 2) HLD on statins. No myositis, transminases. Followup once a year at polyclinic. Social: Non-smoker (but son smokes though not at home) Non-drinker Used to work at mcdonalds but now retired Functionally very good - ADL independent and community ambulant with no walking aids needed. Didnt need to ask PTOT for the parkinson. No psychosocial issues Lives with son, daughter-in-law, grandson and maid at home. No financial issues Drug: No TCM, NKDA No family history of graves or other AI conditions.	Regular edges. Not tender. No cervical lymphadenopathy. No mass effects: trachea central, carotids ok, no retrosternal extension Eyes: no thyroid eye disease. UL: No tremors, no sweaty palms, no palmar erythema, no acropatchy or oncholysis. Pulse 80bpm, no AF. Reflexes normal. No proximal myopathy. LL: No pretibial myxedema (i said lipodermatosclerosis at least LOL) and some slight pitting edema. CVS: Can't really feel apex beat but i didnt want to get the aunty to remove her bra so i just said I would like to check properly. Then nil murmurs. Did a quick Parki exam. Rigidity R>L and pill rolling tremor R>L. with bradykinesia. Didnt bother with all the long tract signs because I was lazy haha. Plus anyway the main thing was the Graves. FORGOT TO REQUST VITALS D:	that thyroid eye disease does not regress with treatment. fumbled a lot here and wasted time 4) How to treat apart from pharmacologically? - i think i annoyed the examiners LOL. cause i went on and on about patient education, trying to show off pharmaco methods then the examiner was like "NON-PHARMACO". But sigh, trying to gain more points mah. Holistic doctor mah haha. Anyway so went to RAI - tried to bring up the worry of RAI cannot be near her grandson for 3 months and he proptosed but he said nevermind, not scope of exam. (on hindsight, maybe not that long, juniors go check it up). Then said surgery - total thyroidectomy. He proptosed again so i changed to subtotal thyroidectomy and he proptosed once again. SIGH WHAT YOU MEAN. Then he again said nevermind, not scope of exam. 2nd examiner finally speaks. 5) How would you manage her Parkinson's? - Errr stunned. No freaking idea. Just said like - let the neurologist decide on treatment. I'll ask her for symptoms, refer her to PTOT if needed. 6) Why did you ask about postural hypotension? - I said because late stages of parkinson can have postural hypo as a non-motor manifestation. Examiner proptoses. Then added on, if patient had early postural hypo, i'll be worried about parkinson plus like MSA. Examiner stopped proptosing but asked if there's anything else. So i added on it can be a side effect of madopa. 7) What's the clinical progression of Parkinson? - Explained that it will progress slowly to affect patient's function. Patient currently on Madopa and it's the best medication for parkinson but only lasts about 10 years. Therefore in a young patient, dopamine agonists are referred. If patient has dyskinesia or freezing phenomenon, can add on COMT & MAOB inhibitors or change to slow release formula or (if got peak dose dyskinesia) increase frequency and decrease dose of madopa. 8) How to treat the postural hypotension? - Education about taking care when standing up from	

				a lying down position. - Fludrocort (stumbled +++ here and examiner prompted a lot) *Bell rings* MBBS IS OVER	
Graves' disease Nothing This patient has Graves' disease. Please evaluate him.	No idea	51yo Chinese gentleman - works as a baker - allergic to aspirin and panadol (anaphylactic reaction) - PMHx of Graves' and Thal minor (never required transfusion) - first diagnosed with Graves' in 1996 - s/p hemithyroidectomy in ?1998 and then did the other side just last year (2016) - post-op was complicated by ICU stay and intubation, probably secondary to tracheomalacia - currently well on thyroxine replacement - literally NO issues/complaints/complications - only has some slight ?lower-pitched voice post-op - his ONLY issue was this loss of appetite since 1.5 years ago, even before his thyroid op - took a rather detailed diet history because there was nothing else to do - used to take three full meals but now would skip breakfast and only eat his first meal of the day at 4pm (mixed vegetable rice, three dishes usually, half-share; dinner (rice, meat/fish and vegetables) at home with family, married with a 13yo daughter) - no LOW - no vegetative symptoms of depression - does not express any stressors	- pulse regular - no AF - no thyroid eye signs - no sweaty palms - no thyroid acropachy - essentially normal	Mostly hypothetical questions related to Graves' management - Invx if this was his first presentation? - Treatment options (risks and benefits) for Graves'? - How do you dose thyroxine? It was very manageable, nothing you guys wouldn't be able to answer :)	Everything will be okay. Honestly, the way marks are distributed for the case analysis means that you will pass even if you get a super esoteric condition you don't know about. As long as you take a reasonable history (just keep asking and do a thorough systemic review if you're really desperate) and list the problems (acute medical, long-term medical and social issues) relevant to your case, you WILL pass.
Palpitations secondary to graves disease complicated by atrial fibrillation Approach to palpiations	Prof Vincent ___?? and one more lady examiner (passive)	Mr Lee 52 y/o Work as machine operator NKDA HOPC 1. Palpitations since May 2016 - worse with food - Tapped out rhythm - irregular - Better with medications	Physical examination Did a thyroid exam Inspection - Neck mass that moves upward with swallowing, no scars Palpation - Diffuse goitre	Questions During physical examination Q: What did you see in the LL? A: hyperpigmented rash around the pretibial region which does not look like pretibial myxedema as there does not seem to be swelling Q: Why not you ask the patient the more about it? - patient said present for about 6 months, L side was due to trauma?!	Dont worry guys, everyone will get through this stage. Just be nice to patients and smile at examiners and you guys will be fine!

Listen carefully to the stem: Patient presents with palpitation. Please take a history and list out possible differentials		- A/w chest discomfort but no pain, ?radiate to back but not to arm, jaw, not worse or better with lying or leaning forward 2. Symptoms of hyperthyroidism - Heat intolerance - LOW of 5kg over a year - Anxiety - But no diarrhea, no increase in appetitie Significant negatives (should have asked about Pheo and hypoglycemia here) - No chest pain, diaphoresis - No recent intake of medication that is new - Has all along been taking caffeine even before the palpiation started Progress - Went to see GP, referred to hospital for work up - Did cardiac enzyme and ECG all normal - Thyroid hormone was high - started on propanolol and carbimazole and symptoms resolved - Asked whether diagnosis is graves - he said yes Course: - On regular follow up 3 monthly: missed a couple of follow ups due to work clashes - symptoms recur as a result because of insufficient medications - Blood test done for each follow up to measure FBC, liver function and TFT - Never admitted before - Did 2DE 3 months after presentation: normal Control: - Has been good so far - no more symptoms apart from the times when he missed appointments Compliance: - Compliant to medications, understands the importance of compliance - Compliant to f/u as long as no clashes with work Complications - Disease: No SOB, LL edema to suggest HF, No numbness, weakness on one side for stroke - Treatment: no liver problem, understand the need to go hospital in infection but forgot why - had to educate him here PMH 1. Graves disease on tx as above cx by AF on aspirin 2. HTN on diet control, Never monitor Bp at home but in clinic	- Able to get below mass - Smooth, regular edge, non tender, not warm to palpation, move upwards with swallowing (didnot mention pulsatility!!) Cervical lymphnode, retrosternal extension and tracheal deviation all negative Peripheral - Hands: no tremors, no thyroid acropachy, no increased sweating, no palmer erythema, Has AF - confirmed by listening to heart as well - Arm: no proximal myopathy - LL: Said no pretibial myxedema (refer below) - Pronator drift negative to suggest stroke Offered to complete by listening to heart and lungs for evidence of heart failure Listened to heart and lungs (as I still have time) - Lungs: no crepitations, no elevated JVP, no pitting edema to suggest HF - Heart: ?ESM loudest over ULSE does not radiate to carotid, not sure so said will confirm with	A: Sorry sir not sure what it is Q: What is the heart rate? A: sorry sir, I will like to measure again... 72 beats per minute, however I would like to confirm that by doing an electrocardiogram later on. Q: What murmur do you hear? A: Ejection systolic murmur loudest over upper left sternal edge. I would like to confirm nature of lesion by doing a 2D echocardiogram. 2 min of consolidation Presented with the following statement: Mr Lee is a 52 year old chinese gentleman who presents with the chief complaint of palpitations in May last year with associated hyperthyroid symptoms and in the absence of cardiac red flags. 1) His first issue is that of a diagnostic issue of his palpitations of which differentials include: hyperthyroidism, cardiac problem, caffeine or other new medications 2) His second issue is that of a new onset murmur for investigation likely due to thyroid problems 3) on the b/g of well controlled graves on propanolol and carbimazole (got stopped here: on hindsight should have said complicated by AF on aspirin) Q: Why did you say its due to thyroid problems and how do you know its new onset? A: Sorry sir, I would like to trace and check his old notes as well as his latest 2DE report before commenting further. 4) Managed to say this after: 4th issue is that of non compliance to all follow ups due to clash with work schedule Q: What else is important in your history that you did not mention in your issues and how is that important? A: Sir, patient also has hypertension on diet control and is important because presence of hypertension and AF predispose patient to increased risk of cerebrovascular event. Q: Did you ask about his Bp control? A: Yes sir, patient did not measure his Bp at home, however he did mention that his Bp hovers around	

		around 140/90 3. HLD on diet control as well PSH - nil Medication - carbimazole, propanolol, aspirin Family hx - Mother has grave's as well on treatment and well controlled Social hx - Does not affect work in terms of symptoms - Single, stays alone, able to take care of self - smoking - 1-2 sticks occasionally but no more, no alcohol - Financial no concerns - Insight - good understand the need for compliance to both medication and follow up		140/90 when measured in clinic Q: Ok, did you measure his Bp just now? A: Sorry sir, I should have measured it just now as Bp control is important in the management of the patient in the long run. Q: If you see this patient in the clinic, how would you assess? A: Take a full hx and PE like what I did just now. In terms of investigations, I would do: - ECG and cardiac enzymes to r/o cardiac causes - TFT looking for raised T4 and low TSH - Thyroid antibodies such as thyroid stimulating immunoglobulin, AntiTSH receptor antibodies, anti thyroglobulin and .... (couldnt rmbr the last one) - CXR looking for signs of heart failure such as upper lobe diversion, cardiomegaly, bat wing appearance, kerley A and B lines - 2DE: characterise the valvular lesion Q: What else is important in the long term management of this patient, in view of his CVS risk? A: CVS risk factors: HbA1c, fasting lipids, renal panel for possible hypertensive nephropathy Q: What does raised T4 and low TSH tell you? - Likely a primary cause of hyperthyroidism Q: How would you manage him in this case? - In this case, I would be worried about thyroid storm. I would like to first ensure ABC are stable (got cut off here) Q: Do you think patient is in thyroid storm based on your physical examination? A: No sir, he is clinically euthyroid but biochemically hyper thyroid. I would like to start him on carbimazole and propanolol. Q: How else will you manage in the long run? - Educate him about his dx - Educate about complications of tx such as liver problem and agranulocytosis (if fall sick, go AnE for FBC) - Pharm: carbimazole and propanolol Q: You mentioned about CHADVAS score just now, do you think patient need warfarin?	

				A: 0-1 aspirin or no tx, 1 and above can consider warfarin. In view of CVS risk factors such as HTN and HLD, I would think warfarin is needed. Q: Ok, what if you are not sure, who will you consult? A: I would consult both the cardiologist as well as endocrinologist Q: Would you consider NOACs in this patient? A: - I would assess his renal function first, and only start NOACs if its normal. - I would also ensure the AF is not due to a valvular lesion as I am aware there is no evidence in the use of NOACs in valvular AF Q: What evidence? What do you mean? (got confused here for about 15 seconds, but ultimately managed to say out what they want) A: Oh, No evidence in prevention of thromboembolic event in valvular AF	
Grave's disease (+ Parkinson) Approach to Graves' management/ Approach to tremors?! This patient has Graves disease. She is in the clinic for follow-up. Take a history, do a physical examination and come up with a management plan for her.	Sorry cannot rmb!	Similar to the other account. Only small differences: 1. Patient told me she had tremors and went to see doctor, thats why diagnosed with BOTH Parkinson and Graves. After carbimazole, her anxiety and palpitations disappeared but tremors persisted and worsened a little so recently (a few months ago), the doctors doubled her Madopar from quarter tab to half tab. Now better but tremors still present. 2. For hyperlipidemia she told me that the doctor told her that her levels are okay but she insisted on starting meds, because she was worried (should have spent more time trying to elicit why cos got asked later on...). No history of stroke/AMI/PVD. (haha history-taking for thyroid is SO fast that I was asking all kinds of random questions just to pass time...)	Similar to other account. Did a full thyroid and full Parkinson's. Besides leadpipe rigidity, tremors and bradykinesia L > R on UL (I rmb as L more leh hmm), auntie is very well. Not affecting function. Could walk faster than me lol. Had a bit of ?facial tremor I thought, but when I talked about it later on in discussion, doctor proptosed at me so I had to retract my statement. BUT I THINK REALLY HAVE! On hindsight should have done running commentary!	Again, they asked me similar questions. Additional questions: 1. How to diagnose Graves Clinically - thyroid eye signs, thyroid acropachy, pretibial myxedema Biochemically - TFT, TRAb 2. What do you think is patient's main concern. During the history taking, I asked for concerns more than 5 times and auntie said she no concerns except grandson very naughty... So I was a bit stunned by this question, but I ventured and suggested maybe the hyperlipidemia cos she insisted on starting meds, but I didnt explore sorry sir!!!! Doctor looked thoughtful, nodded (ONLY NOD IN THE WHOLE DISCUSSION), but didnt harp on it heh. 3. How would you manage the patient in clinic as a whole. Thyroid - TFT regularly and take detailed history for hyperthyroid symptoms Parkinson - monitor for progression, including AMT for cognitive impairment HLP - monitor levels regularly and screen for other comorbids like HTN and DM yearly too. Threw in FOBT	If get unconventional cases, just go with the flow and try your best. This case was a little weird cos auntie seems SO WELL that both of us who got her were very insecure that we missed something big. But maybe just lucky :) Jiayouuu!! Yall can do it!!! :)

				also cos didnt know what they looking for LOL 4. So, if patient is poor and could only afford one component of TFT, which is the more important component? Uhhhhhhh *bell rings* Hahahaha sorry I dont know doc and thank you thank you thank you, then I went out of the room. Please go check this out juniors! TSH? T4? No clue :P	
Graves disease with failed pharmacological control Mx case Stem given by examiner "Pt has graves disease please talk to her and find out the mx issues"	Chris Tian? and a malay lady both very nice	OMG. WALKED INTO THE ROOM AND DROPPED ALL MY SHIT ON THE FLOOR. yay me now my examiners think im dum dum. But the guy was super nice he stood up and kept telling me to take a seat. I dont think it was possible for my pt to even hide her disease from me. First thing she said was "ya ya ya ya i have graves my eyes got problem, my hands shake, i lost weight, i become very anxious, my hands very sweaty" all in one breath. I was like WAH. okok sorry wait ah we go through all these one by one hahaha. Which was fantastic la. But i also did a mini ddx screen for some of the symptoms and did a full systems review coz i scared. Anw this lady has been on pharm therapy for like 6 years but OBV not working lol. She couldnt sit still during the hx taking and her eyes like gonna pops out. But shes really vvvv lovely. So i took a full GS thyroid hx plus all the social fluff. She didnt try RAI/surgery coz didnt wanna take thyroxine replaement for life... whichc didnt make sense la coz carbimazole also need to take for life what. Which i tried to reason with her to try to find out why she didnt want but no time la (anw medicine like that one, mx issue need to dig and find out why pts dont want this dont want that). Like for paeds adolescent cases, need to make sure u ask about pregnancy for all female of child bearing age. ESP for thyroid/SLE/rheum pts! My pt told me she doesnt know what birth control is. Though shes not sexually active but she was like huh what is birth control. ok lol, seems like ignorance is bliss but i was like "errrr you know condom or birth control pills.... did your doc mention this to u before" "no leh! idk all these" im like *scribbles issue no 4* Actually wanted to spend more time on the hx but the examiners rushed me once 15 mins was up... sian thyroid PE no need so long one what	Then i found out why... coz they only wanted me to hear the thyroid bruit. Walao almost forgot. Wanted to slap myself. But that was the first time ive ever heard a thyroid bruit i think. so lovely haha. Commented on how the pts palms are so dry compared to mine lol. Then proceeded to trip on my examiners foot. The room was small in my defense... T_T by this point i think they think i'm a clumsy dum dum alr... fml....	They both walked in and i was ready to stand to answer qns (like how we normally practice) but they were like sit sit pls sit. I actually got more legit questions during my short case for graves yesterday. Until I couldnt take it i just took the chance to insert all the standard answers for graves disease possible qns into my answers for other stuff. They asked me to list my ddx list, and i dumb dub again forgot the most impt issue is that its not controlled LOL. talk about birth control all that crap wtf but then in the end im like "AND HER GRAVES DISEASE IS NOT CONTROLLED" E: When would you offer surgery to the patient M: When their disease cant be controlled pharmacologically, ideally after 2 years, so this patient actually should be offered but she didnt want to coz she has some misconceptions E: Why do you think her symptoms are not controlled? M: Coz she said she only takes her propanolol every other day only when she feels the palpitations E: So how would you advise this patient on her non compliance M: bla bla bla standard fluff reply, took the chance to insert carbimazole counselling here - Need to watch out for agranulocytosis and ask the pt to come back to hosp imm if she has fever/sore throat/rashes/need to monitor for hepatitis E: You mentioned pregnancy alot in the hx, what medications do we use for such patients M: PTU in 1st trimester then carbimazole safe to use in 2nd and 3rd trimester E: Why do you think the pt may not be on RAI also	Juniors pls pls pls practice hard for long case! Make sure you know the approach to important conditions and you rmb to ask for all the ddx. Even if you come across the fabled goldenhaar/pierre robin sequence, there is still an approach to something they want u to do, like the UTI for goldenhaar. Just make sure you practice enough that your suspicions are strong right at the very beginning that you can smell the diagnosis as soon as u walk into the room. Also if you feel like they arent asking you enough qns and you're just dying to show them how much u

				M: Coz she has graves opthalmopathy and it will just worsen it. Took the chance to talk about putting eye drops, eye protection here E: When would you offer surgery M: Cancer, compression, cosmesis, suddenly pregnant and cannot control her symptoms zzzzz they didnt even ask thyroid storm and how to mx... walao... so when it ended both their stone face fell and they both smiled and said i did very well dont worry. "you were abit nervous but it's understandable, we all get nervous!" <3 omg so lovely <3 REALLY THANKGOODNESS IVE HAD SUPERB EXAMINERS FOR MY ENTIRE MBBS EVEN SURGERY. My prayers were really answered :')) GRAD TRIP TIME :D	know about the condition, just try to vomit until they tell u to stop. I think the clear sign is when they dont have qns for you! Easy for me to say coz my mbbs is over, but mbbs is truly preparing for the worst and hoping for the best! Wish you guys all the best :D
Pheochromocytoma Approach to Headache Young lady presents with headache	Prof Lee (from ID), other dr not sure but incredibly nice also	37 year old Indian lady No known drug allergy, only on analgesia currently No pmhx No prev surgeries (I was the second student to clerk this case, and I screened surgical history early in history. Pt said no surgeries done, but prev student said she forgot to ask about surg history and Drs made her go back to ask, and pt then said adrenelectomy had been done already, so I think in my case, pt was primed not to discuss inx and mx- Drs did not pick on surgical hx for me) Presents with headache localised over occipital region Throbbing in nature No radiation, no jaw pain, no scalp tenderness No fever, neck stiffness, postural headache with projectile vomiting No weakness, numbness, slurring of speech, loss of vision Claims there are auras: splotches in vision before headaches No LOW/LOA, previous malignancies Otherwise, no typical triggers of migraines, no family history, no N/V, photophobia Started in 2014, increasing in frequency and severity, currently occurs everyday and severity increased from 5/10 to 7/10, seen GP multiple times taking analgesia but doesn't help pain -> no MRIs or brain scans done before, this is her 1st time in hospital for her problem	Drs said no need to examine, just say what I want to do and they will tell me findings (examiners were seriously the best) Neuro exam normal, asked for visual fields and BP/temp Fundoscopy normal Screened for endocrine features - acromeg, cushings Abdo exam - renal bruit, and adrenal masses -> had to get prompted to say I would feel for ballotable kidneys as well (ADPKD) Screened cardio and respi There was a lot of questioning also at this point, like "if you find a left flank mass, what can	37 year old Indian lady with no PMHx and drug allergies, main issues are: 1. Chronic progressive headache, associated with palpitations and sweating *got cut off at this point for presentation on issues What are your differentials? - rule out serious causes first: worry abt pheochromocytoma, brain malignancy and ICH (fam hx of stroke) - then will think about migraine as primary cause Do you think this is a migraine? - chronic progressive pattern is worrying, likely smth more sinister, but pt does have auras and throbbing pain So what are red flag signs in headache? - regurgitate So in young pt with HTN, what are you thinking of? - regurg secondary causes Give me 2 causes of localised headaches? - temporal arteritis - I said trigeminal neuralgia or smth like that, but prof lee (being from ID) wanted herpes zoster How to confirm pheochromocytoma diagnosis? So if pt has pheochromocytoma, how to manage	Learning points: - I went into this case thinking it would be a simple migraine case ready to regurg my migraine stuff, and halfway through alarm bells started ringing in my head, and was literally LOL-ing.... Like srsly after parotid gland tumour for surg long case, then get pheochromocytoma for Med longs?!! #whylikethat #wheresmydiabetes/asthma

		Did systemic screen, discovered patient had palpitations Started after headaches Duration of 10min, occurs once every few weeks, resolves spontaneously Unable to tap out rhythm No chest pain, dyspnea No thyrotoxicosis symptoms Asked abt hypertension, found out she was diagnosed several years ago by GP, when headaches started, can't rmb sBP -> screened for other secondary causes, pt didn't have No increased sweatiness Family history: Cousin had brain tumour diagnosed in 20s Father had stroke at age 40 No migraine hx Social hx: Works as a customer service officer Affects her job, take MC 1-2x a month Other than that, no functional impairment in social life/ hobbies etc Non smoker non alcoholic Lives with husband and 3 children, no financial difficulties Pt's main concern this admission was to relief pain, and to find out if there was a more serious cause behind headache	the diagnosis be?" "If visual fields affected, what could be a serious cause besides cranial nerves being compressed?" -> they wanted PCA/VB insufficiency	HTN? So what will you do for pt with pheochromocytoma? - I said refer GS AHAHA, because gen med doesn't manage this -> dr chuckled and said ok, now we also transfer you to GS as HO, so what you gonna do? - died- smoked some extra inx and eventual surgical resection So what other masses to look for in pheochromocytoma? - MEN syndrome type 1 BELL RINGS	- But although diagnosis was fairly atypical for a Med case, but I think it was a very manageable history, 15min to clerk a headache history is really a lot of time, really can clerk everything under the sun! With so much time, rmb to explore pt's concerns, esp in pt's who have already seen many Drs and are looking for a second/third opinion - could see Drs furiously nodding their head when I started exploring pt's concerns (: (fam med gains) - I have probably spent a grand total of 10min of my 5 years in Med school studying pheochromocytoma, and knowing I was eventually going to hit a brick wall at pheochromocytoma mx, so rmb to show examiners that you have a very good approach to headaches, and you are a safe

					HO!!! Drs don't expect that much for mx of atypical conditions V V thankful for kind examiners also, discussion was 50% approach to headaches, 50% pheochromocytoma
Adrenal insufficiency 2' to ?? Approach to postural hypotension	Examiner 1: nice lady who looks familiar; Examiner 2: Prof Fock CGH gastro	so tired cos last session but ugh need to write this cos feel like postural hypotension is very under-taught in med school but it's a very impt approach to know... Patient: 80+ indian gentleman, nice but abit too talkative PMHx (when i asked at the start he said nth, no DM lol... he told me the below bit by bit throughout hx taking haiz) 1. HTN? was on ARB then stopped when he developed postural hypo, now on fludrocortisone; says the problem is stable now 2. IHD on aspirin, +omeprazole 3. HLD on statin 4. high K, on resonium (pt dk why) 5. BPH on dutasteride 6. anemia on iron supplements 7. tonsil CA s/p chemo and RT... many years ago compliant for all meds Complaint: postural hypotension for past few years, gradual onset, says that he feels like he "blackout" when he rise from bed/ stands up too fast, and also when turning suddenly... clarified that there was no LOC might be dehydrated: recommended to drink 6-7 cups of water but havent been doing so anemia, on iron supplements, but no SOB, CP, palpitations no vertigo no headache, no numbness/ weakness no tremors, rigidity, postural instability no pins and needles, polyuria, polydipsia, no DM hx no problems with gait, not unsteady no associating constipation wanna asked abt impotense but he say not sexually active so nvm	manual BP sitting, standing both 170/80, did cardio and some peripheral examination basically slightly anemic otherwise CVS normal, not dehydrated, offer to look at gait, told it's normal.	summarised as acute: now BP high but not symptomatic chronic: 1) postural hypo on fludrocortisone -ddx: autonomic dysfunction, dehydration, complicated by anemia and electrolyte imbalance (high K) 2) non compliance to water intake requirement 3) b/g hx ... 4) psychosocial: coping very well blah questions: 1. how is high K related to postural hypo: says it cause unspecific dizziness 2. why does the pt has high K? answer: pt was on ARB 3. but he is currently not on ARB, so why? answer: other drugs... hmm fludrocortisone??? i say im not sure 4. inx ? answer: FBC, RP, ECG, CXR, consider echo, tilt table etc... was totally confused by then haiz and they asked some general stuff about these tests and asked me what else ... i was soooo stuuuuuuck 5. what inx do you do when pt has high K - do serum and urine K and osmolality??? and aldosterone, renin... 6. Prof Fock: what is synacthen test? [me thinking: OOOOOMMMMMGGGGGG srsly !!!] answer: it is a screening test for adrenal suppression/ insufficiency errm patient may have that	have an approach to postural hypo, it is actually quite important; the physiological part can be confusing but ask some seniors/tutors to go through with you, during IM or geri!!

		80+ alr never fell down cos always make sure he has something to hold on to complications: no injury, not affecting lifestyle, social, family hx nth significant quite active still go cycling and not very bothered abt his condition		7. what cause adrenal insufficiency me: commonly 2' to long term steroids intake, but not in this pt(i didnt really ask explicitly haiz cos pt not chinese haaaiz) other causes are - panhypopit 2' to RT that the pt had - adrenal tumour/ infiltration ***bell rang***	

Adult Medicine – Renal

42/M/Malay, recurrent peritonitis b/g esrf on pd 2' DM nephropathy Mr I is a patient who presented with vomiting and diarrhea on a b/g of ESRF	Dr Eric Chong (NICE), Dr Eurasian lady??? (Quite nice!)	I took about 19~ mins? The time F L E W B Y so please have your finger at your stopwatch button whilst sitting outside the room so you'll remember to start it when you're entering cuz you have no idea how important those flying seconds are to your time management. I didn't have enough time to take a very very thorough hx on stuff other than the presenting complaint but i think.. it was ok cause i did see EC nodding a few times as i was clerking Mr I 42y/o Malay male NKDA HOPC Feb 2017 Ate curry puff at 1am, 230am felt abdo pain, had diarrhea x 5 (Non bloody non mucoid) vomiting x 2 (NBNB) a/w fever Had appt with doc the next day so went to see doctor and	I took about 5 mins for this CAUSE NO TIME !!!!! Screened for pallor (have), but not sallow, should have checked for uremic flap Abdo had cute little bag for catheter, site clean non tender balloted kidneys for fun, nothing Auscultated heart and lungs, normal Looked at minimally exposed shins - had some diabetic dermopathy Feet looked swollen but didnt seem like edema TOOK OUT MY TRUSTY MONOFILAMENT!!!!! SO HAPPY	Presented as My patient Mr I is a .... with the main issue of recurrent peritonitis on b/g of esrf on peritoneal dialysis 2' DM nephropathy. Other issues include high blood pressure and suboptimal blood sugar control as well as defaulting on eye and feet screening appointments. Otherwise patient is well with no psychosocial or financial issues. On PE i noted that he had conjunctival pallor and had peripheral neuropathy, however did not note any ulcers or wounds. Questions asked (some were phrased weirdly so i couldn't answer sigh... don't make me read your mind leh)	Sometimes it's good to get a case where there's so much to ask/ explore that you have no time to finish taking (the not so important parts of) history but must make sure you do cover the more important issues. (Rather than sit there in awkward silence looking like a fool

		shun4bian4 did dialysis inpatient as he was worried(!!!!!), was told that dialysate was cloudy. Warded x 5 days given intra-peritoneal and IV abx, subsequently well and d/c Previously Nov 2016 also had similar episode but had fresh bleeding per rectum and bowel incontinence(??) was sent to hospital via ambulance and warded in ICU x 2 weeks. did scopes up and down but no etiology of bleed found. Also told to have peritonitis and had to have IA and IV abx also. No problems whilst in ICU and was d/c well. Nov 2016 incident trigger - recapped his catheter instead of using a new cap aft dialysis. Feb 2017 attributed it to the curry puff ??? Both admissions did not have to change catheter immediately / stop PD PD Issues Started in Nov 2015, was completely fine on APD (10h at night). 3 months later switched to CAPD (4hrly, 45 mins dwell time) as felt that it was more convenient. Changes catheter every 6 months. No issues with PD otherwise, able to attain dry weight (80kg). no signs of fluid overload like swelling / SOB. Practices aseptic technique when doing dialysis. After episode in Feb 2017, NKF nurse has checked his technique and said all was good! ESRF Initially presented with facial, limb edema with SOB. Went to doctor and told to also have hypertension. Scans showed that kidney function was 36%? No biopsies done. Told to be due to poorly controlled DM (here he went on about his non compliance and terrible diet and sounded regretful so i said im sorry to hear about this cause aiya so sad he could've preserved his kidneys if he knew earlier!!!) Started on HD at first for ~2 weeks through a femoral?? catheter before he switched to PD. Screened for ESRF Cx Anemia - yes have, on Recormon 3x weekly Blood pressure - 169-171mmHg SBP at home but doctor said it's normal for dialysis patients (?!?!? really ah... i was stunned) Calcium/vitamin D - not told to have bone disease, no DEXA scan done before but on calcium and vit D replacement Electrolytes - Was told to have high K and high PO4 on his first admission, now on phosphate binders and watches his	that i actually got to use it hahaha AND he had peripheral neuropathy! Couldn't feel my cute little monofilament. I think the patient was quite shocked by the extent of his sensory deficit cause he proceeded to ask me if that was normal for patients with diabetes so i was like YAAAS come let me tell u that you're at increased risk of ulcers and they may get infected blah blah and SO PLZ GO FOR YOUR FOOT SCREENING MY FRIEND (could hear the examiners laughing cuz this wasn't supposed to happen) then the bell rang My PE was a bit haphazard though, kept making the patient sit up and down heh..	What do you think about the management of his dx? Is it adequately controlled? Said i think his esrf was ok cause he said no SOB/ swelling, PD not giving him problems, ok to achieve dry weight. But DM not so good, need to increase insulin dose, would like to have explored more on why the control wasn't so good. Blood pressure also a bit high IMO though he said his doctor thinks its ok.. What are the complications of PD - Peritonitis, peritoneal membrane fibrosis, metabolic disturbances from long dwelling, losing protein /k, psychosocial What are the complications of renal failure - Listed as per ABCDE (above) What are the complications of DM? - Microvas, macrovas (this was where they asked me if i asked about cardiac problems cause macrovas ma, so apologised and said i should have) If you have DM and renal failure what is this called? There's a term Me: what.. DM NEPHROPATHY???? Answer they wanted was Coronary artery disease equivalent *sigh* EC: For males in particular, if they have peripheral neuropathy, what else might they be worried about? I thought of sexual dysfunction but i didnt want them to think i damn kinky cause there might have been a better alternative answer so i looked stunned for awhile then I can't remember exactly what the female examiner said that made me sure that they were asking for that so i was Sexual dysfunction and they wanted me to say EReCTILE dysfunction specifically lol. What drug can you give for this? Sildenafil... (nearly forgot the name) EC: What do you need to check before giving this? Me: Postural hypotension..???? *cue EC pointing to his heart like mad* OH THE HEART THE HEART!!!!! Eric Chong is a cardioconsultant so he went on	hahaha) Come up with salient things to look out for in PE for all the cases that may come out so that you won't be like me when i was doing my PE. My patient was a super good historian which made my life so much better!!! MBBS is really down to luck - examiner luck, patient luck. Pray and be kind and everything will be well!!! :) And type your accounts cause senior accounts are so useful!!

		diet Fluid overload - No symptoms Currently on fluid restriction 800ml/day, no problems sticking to it Monitors own diet PMHx DM Home glucose monitoring always 10-11 HbA1c not known Me: Hmm, thats not so ideal right? what did your doctor say Him: Yes.. recently increased my insulin dose (Would have loved to do some counselling / ask about diet etc here but really no time liao so i just asked if any problems with insulin injections) Never go for eye/foot screen for a long time(should've asked why) but i asked for numbness and he said have, but no recent falls HLD HTN on medications (simvastatin was the only one he could remember) Says all quite well controlled, no increase in dosages. Fully compliant to all medications No significant family hx Social and financially ok. Used to be depressed about renal issues but now is ok, wants to maintain positive outlook. No smoking / drinking. Follow up 2-3 mthly, do blood tests, UECr Said that renal tests are good according to doctor No plans to change to HD SHOULD HAVE - Asked for cardiac diseases in particular, if he has done any cardiac screening - Asked if any plans for renal transplant but unlikely i think.. - Asked for all the medications (but he also couldn't remember) and associated S/E - Probably got more but mbbs is over my brain close shop alry		to ask me stuff about cardiac testing which tbh i felt was quite distant from the case itself LUL but ok lor. He asked me what stress testing and i was like huh what.. and the answer was EXERCISE stress testing aigoooooo the phrasing of the questions can kill me. Tested me until MIBI and they said its ok i think you also shag. Last case already right? I beamed and said YES LAST CASE LAST DAY FINISHHHHHH and saw them scroll their ipads (and hopefully give me marks plz)	
ESRF 2' HTN nephropathy complicated by SBP	Dr Wong Soon Tee Indian doctor (cant	Examiners wanted me to take a history of the fever and abdo pain - so I began clerking, but pt was rather confused as to what I was asking him about. Turns out that his episode of SBP occurred 2 years ago, and he is no longer on	No signs - currently functioning AVF and previous tenckhoff catheter scars x2	- Present issues - Approach to fever and abdo pain - How to treat SBP - Invx for SBP	sigh no matter how hard you prepare sometimes it still

Approach to Fever and Abdo pain Examiners told me the stem: "This is Mr D, a 49/Chi/M, who has a background of ESRF 2' HTN nephropathy. He now presents with fever and abdominal pain, please take a history re fever and abdo pain"	rmb name)	peritoneal dialysis and has since switched to hemodialysis. Examiners wanted a more diagnostic approach to "fever + abdo pain", and wanted me to clerk him as if "he is having that episode of SBP now" ??????? confusing much for BOTH the patient and me SIGH EXAMINERS Y U LIDDAT. zzz so they directed me to that instead of focusing on the ESRF history. :(turns out he had SBP bc of poor aseptic technique - emptied the peritoneal dialysate into a pail instead of sterile bags. Explored (albeit very messily) history of ESRF, types of RRT he has undergone (HD > PD > HD), management of ESRF... Ruled out IBD and GE for fever and abdo pain and couldn't think of much else -___- He had financial / social issues +++		- DDX for etiology of ESRF - Long term management of patient (address financial / social issues ++)	screws up sucks to be first session :(((((
ESRF on background of significant cardiovascular risk factors Approach to SOB and edema The patient has shortness of breath and abdominal swelling. Please evaluate	1 chinese male doctor (generally nice) and 1 Indian lady doctor (seems nice)	Stepped into the room and saw a young-ish man and the table has a soft toy on it. Was abit confused whether it was paeds. It can be a paeds patient who grew up already? Opened with what's the main issue that we will be discussing today? - "Oh my renal failure" *Heaves a sigh of relief* Mr K 37yo malay gentleman Presenting complaint: Had SOB 4 months ago With swelling of face, bilateral UL and LLs Orthopnea, sleeps almost 90 deg PND No pain in chest or limbs or anywhere else Frothy urine but no haematuria Oliguria Marked reduction in effort tolerance, only able to ambulate within the house Very lethargic, became very lazy LOA Has nausea, vomited clear stuff out once Peripheral numbness No pruritus No palpitations, giddiness No bone pain No joint pain, rash, haemoptysis No easy bruising	The examiners just asked me what I would like to examine. Didn't have to do it o.o With the exception of feeling the AVF What I mentioned I would examine: - vitals - Uremic flap - nailbed pallor - AVF - in the patient, it was a left radiocephalic AVF with good thrill, recent cannulation marks. No bruises - Pruritic scratch marks - Acanthosis nigricans - Conjunctival pallor - Neck: carotid bruit (forgot about JVP :/) - CVS: Displaced heart, murmurs, arrhythmias (should have mentioned pericardial rub from uremia too) - Respi: bibasal creps - Abdo: ascites, tenderness from SBP secondary to ascites (should have mentioned renal artery stenosis bruit too) - LL edema - Full UL and LL neurological	Presented as: 37yo gentleman with significant cardiovascular risk factors and smoking and alcohol history.Would like to divide into medical, functional and psychosocial Medical: 1) ESRF on haemodialysis with resolution of uremic and fluid overload symptoms 2) Heart disease s/p angioplasty, currently no angina symptoms 3) Stroke affecting power on left side, with 80% functional recovery 4) Diabetes mellitus complicated by retinopathy s/p panretinal photocoagulopathy and slated for surgery, as well as complicated by neuropathy. Currently still sub-optimal control, CBG 8-10 5) Hypertension that is controlled (on hindsight, JNC says SBP should be <140 for him but KDIGO says SBP should be <130. So may not be good control) 6) Hyperlipidemia Functional: 1) Left-sided weakness and vision problems affecting his ambulation as he walks with a walking stick and job as a driver Social:	

		No fever Past medical history: 1) Diagnosed with ESRF due to diabetes 4 months ago - On haemodialysis 2/4/6 at some private place - Last dialysis done yesterday - Done via left AV fistula - No cramps during dialysis. Some giddiness initially but now better - No catheter infection, obstruction - Dry weight has been steady recently, around __kg - Initially hard to cope with the fluid restriction, but now compliant to it - Didn't want PD as house has cats and was afraid of contamination - In the queue for renal transplant but unlikely to get it cos he got cardiovascular risk factors - Whatever symptoms have resolved after dialysis - no parathyroidectomy 2) Heart disease diagnosed 4 months ago at the same time the ESRF was diagnosed - Underwent angioplasty, delayed - No chest pain on exertion now 3) Stroke 1 year ago - Affected left LL and UL power, no numbness - Recovered 80% functionally 4) Diabetes mellitus type 2 - Initially on insulin, now on just 1 tablet - Doctor says control is good now - Unsure about HbA1C, home CBG 8-10 (forgot to ask whether before or after food ><) - Compliant to retinal photography and diabetic foot screen - Complicated by retinopathy with ?artery burst and loss of vision in right eye, underwent panretinal photocoagulation and now slated for surgery - No vascular claudication - Has peripheral neuropathy 5) Hypertension - Home SBP: 120-140 - Doctor cut dose of BP meds 6) Hyperlipidemia Drug history: - NKDA - Dont really know what meds he's on, his wife handles everything. Did not bring drug prescription form - No TCM	assessment - Monofilamant for peripheral neuropathy (should have mentioned peripheral pulses too) - Screen cerebellar and cranial nerves - Fundoscopy for diabetic retinopathy (should have requested visual acuity too)	1) Financial issues due to unemployment, currently MSW on-board Active doctor thanks me for the comprehensive issues. Don't know if it's a compliment or saying im very long-winded >< Questions: Active male examiner: - How do you assess alcohol intake? - *Haha stunned to get this as first question* By the alcohol units. Males should be <3-4 units a day - How do you assess alcohol dependence? - Uhhh can ask about alcohol withdrawal symptoms... - Is there a questionnaire you can use? - Yes, CAGE questionnaire. Like is it the first thing you think about in the morning when you wake up? - Start from the top. What is C? - Cut down, Annoyed when people criticised your drinking, Guilty about your drinking, Eye opener - What medication do you think he's on that can cause his palpitations? - Uhhh diuretics? - No. Something that causes leg swelling as well - Oh CCB - Palpitations can also be caused by his anemia. What are the causes in him? - Decreased epo production, loss of blood from haemodialysis, anemia of chronic disease, decreased RBC lifespan, decreased platelet lifespan causing bleeding - Peptic ulcer disease also right? - Yes, he should be on anti-platelets cos of the heart disease and stroke - Yes, in fact he might be on 2 cos of the stent. What complications do you think he had for his diabetes mellitus? - Would like to divide into macro and microvascular complications. For macro he already had stroke and heart disease. Screened for but did not find any claudication symptoms for PVD. For micro he already has ESRF and retinopathy. He has peripheral numbness for peripheral neuropathy. Could have also screened for symptoms of gastroparesis, postural hypotension and erectile dysfunction	

		- Compliant to medications, wife makes sure he takes - Has some palpitations and anxiety symptoms after taking one of the BP meds - Not taken influenza jab Family history: - Brother has sth I forgot what Social history: - Ambulates with walking stick, otherwise ADL independent - Used to work as a full-time driver, but not only does it sometimes due to functional limitations after stroke and his vision problems. Doctor says can still drive - Quit smoking after he got the heart disease. Previously smoked since he was like 14 years old or something, 2 packs a day - Previously drinked alcohol, something like 2-3 beers a day since NS days - Has financial problems, now only wife working fulltime. Has MSW on board. Will be changing to NKF next week - Since he got his diseases he stopped partying, and took up more boring hobbies like fishing lol - Wife is very knowledgeable on managing his diseases (Forgot to ask about family, diet and exercise ><)		Female examiner: - What diet should he be on? - low phosphate, fluid and salt restriction - Anything else? Why can't he eat durians? - *awkward silence* - Cos it's high in potassium - *learned something new in exams* - What is mineral bone disease - Triad of manifestations. 1) high phosphate, low/high calcium, high PTH, low vitamin D 2) Abnormal bone mineralisation, high bone turnover 3) Extra-skeletal calcification e.g. coronary arteries and skin - Why do you get high phosphate? - Impaired urinary excretion of phosphate - Anything else? what about decreased vitamin D? - Impairment in 1 hydoxylation of 25-hydroxycholecalciferol - How do you treat mineral bone disease? - low phosphate diet, phosphate binders (calcium and non-calcium based), vitamin D supplements like calcitriol, parathyroidectomy in tertiary hyperparathyroidism - What other vitamin Ds can you use? - not sure. The doctor mentions about some drugs but I can't absorb during exams - How do you think we can keep this patient's condition under control? - Lifestyle: compliance to fluid and dietary restriction, increased exercise. Medical: compliance to medication, dialysis Male examiner: - What is the definitive treatment for him? Renal transplant but I note that he's lower down in the queue cos of the cardiovascular risk factors - The queue for what? - Ohh it's for deceased donors. But there's still the option of living donors	
Nephrotic syndrome Bilateral lower limb swelling	Cannot remember, Dr. Loo something, and a Prof	So this 29YO Chinese gentleman presents with bilateral lower limb swelling, took a history of the bilateral lower limb swelling and considered differentials then asked about progress of the patient in the hospital - Diagnosed with minimal change disease and started on steroids	Did target examination - No cardiac problem - No jaundice - No signs of fluid overload - Ascites, crepitations in the lungs	1. What are your differentials for a patient coming in for bilateral lower limb swelling? (got proptosed at when I said AMI for heart differentials - less likely in a 29 YO) 2. How would you like to investigate?	Your brain will go into autopilot mode during exams. Make sure you practice

		Complications of the disease: 1. Hyperlipidaemia but there was some AKI which stopped him from it and he has not yet re started on it 2. No SBP symptoms 3. No thrombosis 4. Forgot to ask about infections and vaccinations Since then was trying to wean down the steroids and quite successful, will try to wean off steroids after MBBS period, no Cushing's syndrome No other issues	or pleural effusion, or bilateral pitting oedema - Then did a Cushing syndrome examination which was normal - Asked for wish list of BP, dipstick and examiners said it was normal	3. How do you diagnose nephrotic syndrome? 4. Are you surprised that he is well now? Why so? 5. If the minimal change disease is not responsive to steroids, what else can you do? 6. Are there any other causes outside of minimal change disease that you know of that can cause nephrotic syndrome? 7. What is the pathogenesis of hyperlipidaemia in nephrotic syndrome? 8. What are the complications of nephrotic syndrome? 9. You mentioned thrombotic tendency in nephrotic syndrome - why? 10. Is there anything you can do to prevent thrombotic episodes from happening? Then examiner asked if this was my last station and whether there was anymore exams!	until you can take history without your brain working. 15mins for history taking is actually not enough for his multiple issues. I took like 19mins and still missed out on a lot
Lupus nephritis Approach to B/L LL swelling	Goh Soon Keng, not sure the other but nice	Awesome English speaking lady with good history which made things alot easier. Really thankful 50 plus chinese lady Homemaker NKDA Diagnosed with lupus nephritis 10 years ago (she told me straight after I asked for PMHx swee) Cause: Presented with B/L LL swelling 10 years ago a/w ascites and facial/periorbital swelling Nil heart/liver/thyroid problems or Sx Nil fever/rash/jt pain/oral ulcers Nil LOA/LOW Nil FHx of renal problems Saw GP and was referred promptly to hospital Oliguria? while inpatient, asymptomatic HTN Did investigations including a renal biopsy which diagnosed lupus nephritis, didnt know what class Ultrasound also showed a blood clot in the left kidney Started on steroid medications, switched to cyclosporin then azathioprine due to SE of GERD Also started on warfarin which she took or ~9/12 Discharged after 10 days to f/u	Started PE at 22mins lol, examiners didnt seem to mind Requested vitals, told normal Nil conjunctival pallor Nil oral thrush Nil ballotable kidneys (I went to ballot not sure why lol), nil tenderness Heart, lungs normal Bell rang, examiners and patient left Didnt manage to consolidate much cause my mind was in a bit of a blur before examiners came in	Differentials for her presenting complaint of B/L LL swelling? renal, cardiac, liver, thyroid What renal differentials other than lupus nephritis? Screwed this part up a bit but I think essentially should mention the primary GNs first (FSGS, MCD, membranous) then say woud like to exclude secondary causes like infx (hep B,C, HIV), autoimmune, malignancy etc. What SE of steroid did she have? Err not sure. She said got GERD right? Oh yah How would you investigate if you saw her for the first time? Bloods, urine studies and imaging. FBC/RP/PT/INR/CRP/ESR/ANA/ASMA/C3C4 lvls/urine dipstick/FEME/phase contrast. Ultrasound What you looking for on US? Smoked some nonsense about inflammation, structural dz, chronicity before he told me she mentioned got blood clot right? Oh yah to look for blood clot lol What other blood test would you do in view of your imaging results? Anti-cardiolipin and lupus anticoagulant If pt came with foul smelling vaginal discharge,	For management cases, just go through the same few broad categories/headings and you'll be fine. Doesnt matter if you dont know much about the dz itself like I honestly didnt know much about lupus nephritis either. Really focus on your Hx cause it's a long case after all. Better to cover all your bases then miss things just to move on to PE I think most examiners won't mind. Unless

		Course: Had 2 admissions soon after discharge for titration of medications Has been on 3/12 f/u with renal physician Remained well, nil further admissions PCR dropped from 8.0 to 2.0 or 0.2 (said she couldnt remember, either way it's in remission) Does not use albustix as blood and urine tests done regularly during f/u Some heart issue which pt claimed was a heart attack (verified multiple times), however she said no invx or medications given and she was discharged after observation so unlikely ACS (didnt have time to explore further) Compliance: Takes azathioprine and omeprazole (forgot to check compliance but she has remained in remission so) Non smoker, non alcoholic Told don't need vaccinations On fluid restriction, takes less than 1L/day Seen dietician, advised for low salt, moderate protein diet No issues as does not eat much meat Does moderate exercise (didn't explore much) Complications: Nil further episodes of clotting, nil stroke/ DVT/ PE (forgot to ask about previous miscarriages) Nil SLE Sx Pancytopenia secondary to azathioprine Has recurrent infx URTI? mthly requiring Abx though never admitted Anemia never requiring transfusion Nil hepatotoxicity Nil steroid SE: nil DM/HTN/HDL/osteoporosis (BMD done 5 years ago, told suboptimal osteopenia?, advised to take more calcium)/eye problems/wt gain Nil functional/financial/social/psychological Cx		what are you thinking of? Stuck here for a while, went round and round about complicated UTI. You looked for oral thrush right? Yeahh.. (still didnt get it) Bell rang. He told me candidiasis. Lol okay sure whoops bye	they specifically tell you to move on then obviously do it. Jiayou juniors you can do it!

Adult Medicine - Rheumatology

SLE Management Case	Dr Yim (Male, active). Dr Patricia Lee	25/Malay/Female Diagnosed with SLE in end 2015 - hospitalised at the same time First had joint pains in June 2015 - elbows, knees, fingers,	This was so horribly done. I'm sorry guys i didn't have a proper examination for SLE. Advice would be to learn one and do it in	Spent 10 seconds of my 2 minutes with my eyes closed and taking deep breaths. Presented:	Er... Just know everything la. Have an examination for

This patient has SLE. She is in for routine follow up. Please take a history and formulate a management plan	(Female, passive)	toes Saw polyclinic x3, GP x1 Rashes started when GP gave her Abx Rash over face and chest - not itchy, did not notice if worsen with sunlight Joint pains: - swelling - no erythema - worse when waking up and in morning than evening - stiffness 10-15minutes every morning - Affected her walking and hands LOW 2-3kg over few months No LOA, Fever No other rashes, hair loss, chest pain, SOB, frothy urine, hematuria, abdo pains, photosensitivity, confusion, change in behaviour or other neuro shit Currently using sunblock and covering more skin Discharged in end 2015 with prednisolone x8tabs OD, HCQ, calcium tabs (lol idk why) Currently tapering pred to 1tab OD. HCQ eye check normal no maculopathy I asked if any biopsy done -she said liver not kidney Told me they found raised liver enzymes on admission, then liver bx done, told normal results and the transaminitis resolved on its own (wtf a bit at this point) No kidney Bx - no polyuria or frothy urine or hematuria No dry eyes, dry mouth No previous clots No previous miscarriages, no previous prenancies No flares since then - no joint pains or rashes or SOB or whatever Some central weight gain she noticed since starting on steroids No PMHx, no FHx Non smoker, non drinker Stays with parents in HDB with lift landing. Financially supported and meds paid by parents Currently unemployed looking for job - no insurance cover for disease at 12 minutes i panicked and decided to do PE cos my brain can't math. *Insert PE paragraph*	a smooth and suave fashion. Examiners got very annoyed that i kept jumping back and forth and moved the patient multiple times. Started with hands. No active disease, no deformities. squeezed metacarpals and wrists, no pain. looked at elbows also but didn't palpate (should have) Asked if she had any drug allergies at this point and she didn't but i got scolded for asking it during PE instead of history Looked for alopecia (none) Looked for conjunctival pallor - none Opened mouth and looked for saliva pooling - Dr Lee cuts me off when i off my torch. Since your torch is out, what else you want to look at? Then i stun... eyes. she wanted me to look at eyes for cataracts (steroids) - offered fundoscopy at this point for maculopathy from HCQ Sat her up, stupidly listened to the lungs through clothing. Got scolded by Dr Yim - your ears very good ah? can listen through TWO layers of clothes. you sure you never miss anything? Good job ah you. Me: sorry sir, ma'am can you remove your top? Dr Yim: nvm, skip it. Did a abdo - no organomegaly (Dr Yim: why you make her sit up from lying down then now lie down again? Keep moving her for what? Me: sorry sorry) Looked at her legs for rashes and felt for warmth, tenderness. Squeezed metatarsals and ankles.	25 yo malay lady with new dx of SLE for 1 year, presented first with joint pains and rash, currently on tapering doses of prednisolone, on HCQ as well. Issues include: Medical: - Newly dx SLE with tapering meds - Complications of Tx: weight gain Social: - Upcoming pregnancy - financial cost of meds (smoke smoke cos her father paying and she no job) Dr Y: So what was the cause of her liver raised markers? Me: Sir transaminitis likely from autoimmune hepatitis Dr Y: hmm... ok let's not talk about that since you probably don't know the criteria (At this point i was so annoyed that i felt the need to show off i'm not completely useless) Me: Sir we can do blood markers that can suggest if she has autoimmune hepatitis, i would do anti-LKM and anti smooth muscle Dr Y: LKM stands for? Me: (fuck... dug my grave) Uh liver kidney muscle? Dr Y: You sure its not liver kidney microsome? If you not sure you better not say Me: (give up) Sorry sir i'm not sure Dr Y: How to investigate her acutely if she presents now? Completely forgot ABCs lol Do bloods to confirm my Dx - ANA, Anti dsDNA, RF, Anti rho, anti la, consider screening for APS but she had no clots so will hold off for now Do urea electrolytes and creatinine to screen for renal disease, also do urine albumin creatinine ratio if dipstick negative Do chest xray and ECG Dr Y: WHY? Me: Uh sir to look for ILD but i note during PE she did not have fine creps so i would consider holding it off. ECG for conduction blocks and arrhythmias Dr Y: Then why just now you never offer to do	SLE. At each point you need to check for both disease and cx of disease and tx. and listen to the hx you took so you can examine the relevant joints. Don't skip anything.

		Came back and sat down. Thought a bit. Asked for jaundice, hep B, other liver disease. Dr Yim: Did you think her liver was not important? Me: Sir i did not feel any hepatomegaly Dr Yim: Did you look for stigmata of CLD? What was her liver span? Me: sorry sir i did not look Dr Yim: Cirrhosis can be shrunken right? Why you never measure... Me: Sorry sorry (walao i say sorry in this station more times than i breathe can) Dr Lee: since you have time... she is young right... Me: oh shit. She had plans to get married and get pregnant in the next year (omg waiii.) Rheumatologist told her will control dz and change her meds if needed when she plans to get pregnant Concerned about steroids side effects, pregnancy Not concerned about aesthetics cos no more rash. Not worried about work.	Offered to walk. Kena scolded again. Dr Yim: anything else? Later she get up and walk i don't want her back on the bed ok. Dr Lee: her knees how? she said got pain right? Examined her knees for warmth, swelling, did bulge test - all normal Got her to squat and stand for proximal myopathy. She went to sit down while i was thinking. Got scolded again cos i didn't get her to walk immediately then now she need to stand from sitting again to walk. Gait normal. (SIGGGGHHH) Part 2 of history as above Patient was really nice. She patted my shoulder as she was leaving i think cos she see i damn stressed alr keep getting scolded.	CVS examination? Me: .... sorry Dr Y: how to manage her now? and how to follow up? Multidisciplinary approach, involving rheumatologist, Primary care physician, MSW Patient education Goals to treat primary disease, and treat and prevent complications of disease and treatment Treat primary disease: taper pred, continue HCQ for life Consider upping meds to DMARDs like MTX if she flares without pred - because her disease is mainly joint and rash hence MTX over the other DMARDs Cx of disease and treatment F/u every 3-4 months until stable disease and stable meds At each visit do physical examination for rashes, joint pains, cushing's syndrome (mentioned striae, fat pads, thin skin, etc), hepatomegaly since she got AH. Take BP, do dipstick for glucose and protein Consider doing DEXA at year after dx and on steroids, confessed i was not sure about frequency of BMD monitoring Offered eye screening yearly for cataracts and HCQ maculopathy Offered fasting venous glucose for DM from steroids Dr Y: She want to get pregnant how? Said advise her to hold off until disease and meds stable Dr Y:you mean she cannot get pregnant until then? Uh sir i'm not sure the exact details but i know they are advised to have stable well controlled disease with few flares before getting pregnant to reduce risk fo flaring during pregnancy. ANYWAY i would get rheumato and high risk Obstetrician involved because this is a HIGH RISK PREGNANCY	

				Dr Y: Ok i'm done. your turn. Dr L: Ddx? Me: Psoriatic arthritis or rheumatoid arthritis. However rashes not typical area, no deforming arthropathy, and hers had large joint involvement hence less likely Dr L: ya got large joint right? then why just now you never examine until i say? Me:..... (this is a rhetoric qn right... i don't need to answer right...i know i fucked up, PE 3 marks only please just give me 0 there and dont minus marks from other sections) Sorry sorry ma'am. Dr L: ya see next time must examine properly and not in a haphazard way There were a few more qns but i blanked out by then. Standard stuff that i could answer without thinking. Too traumatized. Bell rang. Dr Y: Ok, last paper already, go grab a beer or something (ikr i need to drink away my sorrows after you angst me so much - no clue if i passed this long case but oh well.)	
SLE Mx case This patient has newly diagnosed SLE. Please take a history from her regarding that.	Dr Charles Vu (TTSH Gastro) and some super nice, cheery man	Presenting complaint: Abdominal discomfort x 2/7 (August 2016) vague epigastric discomfort nil radiation, could not characterise pain nil associated symptoms: no actual pain, no fever, no diarrhea, no N/V hospitalised in AH for 1 day, treated as for gastritis and symptoms resolved Abdominal distension x 2/7 a few days after discharge noted increase in abdominal girth nil pain, fever a/w orthopnea, unable to sleep flat must sleep on chair no PND, no exertional breathlessness no cough, phlegm no CP, diaphoresis, palpitations no swelling of legs, face, hands no changes in urine: no frothy urine, hematuria, decrease in	Finished my history at like 19 min??? So had to do a very rushed PE and decided to focus on looking for Cushing's signs and assess her nephrotic syndrome. Slightly rounded moonlike facies, no facial swelling Increased abdominal girth with white striae (from childbirth), no scars or masses No bruises, no thin skin No dorsal hump or supraclavicular fat pads No proximal myopathy Peripheries clean, no stigmata of CKD Abdo PE normal with no ascites No creps in lungs, no pitting	Presentation: Mdm Chong is a 45yo Chinese lady with a PMH of Grave's disease s/p total thyroidectomy currently on thyroxine replacement. Current issues: Newly diagnosed SLE complicated by lupus nephritis - treated with prednisolone, 6 cycles IV cyclophosphamide, now on Cellcept currently in remission and well controlled Cushing's syndrome secondary to chronic steroid usage Financial issues with subsidies from MSW for medications No psychosocial issues. Questions	TIME MANAGEMENT. This case felt like suuuuch a rushed case and I only finished her presenting complaint at 15min (!!!!). Then proceeded to do the fastest social/PMH review in my life. Sometimes patients can mislead you by opening with a presenting complaint that is not really related

		urine output subsequently went back to AH and was warded again Significant negatives no rash no joint pain no seizures, behavioural changes no fever no LOA, LOW recently no lymphadenopathy Progress (in AH) underwent investigations - CXR showed pleural effusion, CT abdo showed ascites urine dipstick showed proteinuria, RP showed hyponatremia, hyperlipidemia detected, FBC showed some anemia treated as for nephrotic syndrome (patient not sure if it was this, I just deduced this): started on IV drip, high dose steroids, diuretics, statins next day developed swelling of face and legs autoimmune panel came back as positive for SLE (pt not sure of which antibodies) and she was transferred to SGH Progress (in SGH) renal biopsy done (patient not sure of results but was told that she has a kidney problem) some decline in renal function continued on IV drip, high dose steroids, diuretics started IV cyclophosophomide admission complicated by pneumonia, received IV ABx no emergency dialysis or ICU no HTN discharged well after a few days Progress (so far since discharge) asymptomatic last follow up 3 weeks ago: proteinuria has resolved, kidney function returned to normal finished 6 cycles of IV cyclophosphomide, now on Cellcept no known triggers as of yet but was told to avoid sunlight and stress Drug History: steroids (tapering dose now) - noticed some weight gain but otherwise no DM, no HTN, no easy bruising or striae Cellcept - no complications of severe immunosuppression	edema Examiners hurried me to finish up at this point so I requested to percuss spine for tenderness, assess her BP for HTN and perform urine dipstick for proteinuria.	“What are the other signs and symptoms of Cushing’s?” - DM, HTN, thin skin, bruisability, increased central obesity, acne, hirsutism, cataracts, osteoporosis “What are the other manifestations of SLE?” basically talked about the ACR criteria for SLE “What sort of clinical syndrome do you think she had?” likely nephrotic syndrome, given the history of new onset hyperlipidemia, proteinuria and absence of hematuria and HTN (nice examiner says he is done with his questions haha and turns to Charles Vu who then takes over the questioning) “What do you think her renal biopsy showed?” dies inside because I cannot, for the life of me, remember anything about the histology of GN) hmm… glomerulonephritis??? “Yes it is GN, but what will the biopsy show?” sorry sir, not sure “Ok nevermind.” “This lady also had microcytic anemia. Is that in keeping with her SLE?” SLE usually NCNC anemia I would like to investigate for iron deficiency and Thal iron panel and colonoscopy (given her age, rule out malignancy) “Ok good, colonoscopy normal. Anything else?” PBF for target cells, Hb electrophoresis for Thal “This lady has a daughter, what would you tell her daughter regarding this disease.” autoimmune diseases tend to run in the family, there is a risk of her daughter	(like this lady's gastritis) so try to steer her back on the right path.

		such as serious infections statins calcium, Vit D thyroxine (the rest of her medications she was not sure of) PMH: Grave's disease s/p total thyroidectomy 2008 (she did not even know it was Grave's…. had to hurriedly dig out a hyperthyroid history from her) Fam Hx: nil autoimmune disease Social history: non smoker, non drinker works as admin officer - boss is understanding about her disease and is ok with her leaving early every month for her IV cyclophosphamide infusion financial issues: managed to get subsidies for medications stays with husband and 2 kids feels okay about her disease, just worried about weight gain from steroids Sx Hx: total thyroidectomy 2008		inheriting it can watch daughter carefully for any new onset proteinuria??? And treat her promptly to prevent progression of disease not sure of any screening available "Can you use ANA to screen, is that enough?" ANA positive in other autoimmune diseases as well anti dsDNA most specific ideally should fulfil the rest of ACR criteria as well "What is this lady's prognosis?" cutaneous SLE fairly benign course and easily treatable life limiting manifestations would be renal and any CKD, or APS causing thrombotic events * bell rings *	
Male SLE Approach to PUO This patient presents with fever for 1/12 duration, please take a history	Some nice guy ? Dr Daniel yeo (Gleneagles Cardio) & ? Dr Anselm Mak (NUH Rheum)	Mr L 42 year old chinese gentleman Allergic to mycophenolate presented in Oct 2013 with 1/12 of fever after 3/52 started to notice bubbles in urine and an increasingly dark colour (like teh o) no cough, cold, runny nose no diarrhea, abdo pain, change in BO no fever, LOW, LOA no previous drug history, TCM no joint pain, back pain, bone pain no rash basically nothing more, until he said "i also had this hair loss ..." and i was like D: probed more, saw a GP and was referred to NUH and did some blood tests and scans (i asked antibody tests, kidney scans)	alert, comfortable i had no time! so i did a quick examination of his face and hands normal chest - lungs & heart -> had him take off his shirt and discovered he had this fire cupping on the back!! i was like D: because he said no TCM & no back pain, but he clarified that no oral tabs & back pain was from his prev injuries as a paramedic carrying patients?! abdo SNT, nil masses, nil organomegaly - normal also nil pedal edema very sneaky and was wearing a bandana-like thing and i thought he was just being cool :< until he said "do you want to see my hair"	Presented as 1. SLE cx lupus nephropathy well controlled but unable to tail down pred 2. good understanding of disease 3. some financial issues but not keen for MSW Qns: 1. what is your diagnosis 2. what is your approach to PUO (infectious, inflammatory, i missed out malignancy hahaha and he was like anymore? ok nevermind) 3. what else would you be concerned about in PUO especially in our population? i said TB! hahaha 4. Anything else? if he was an IVDA etc? i said IE, HIV, other atypical infections if he was immunocompromised 5. Tell me about the diagnosis of SLE i said immunological, clinical blah blah blah (cutaneous discoid, malar-> systemic with	haha anything you see in the wards can come out! just get your approaches straight and go with what the patient leads you (:

		by this time i was like ... did the doctors ever tell you that you had an autoimmune condition, like lupus? Thankfully he said yes haha was started on steroids (i think he said Pred & cyclophosphamide x12 cycles) and had only one flare since in 2014 Had a renal biopsy done in 2014 (i asked he said either class 3 or 4 haha) since then well controlled, but have never been able to completely tail down steroids - he gave doses but i cant rmb oops) Currently on: Omeprazole, Pred, Calcium, HCQ, Lorsatan Complications: Had BMD done (normal) Does regular eye screening & bloods was counselled for infertility for cyclophosphamide but not an issue as he is single Currently on f/u for BP but well controlled on lorsatan and renal function ok Social: single, lives with his parents works as something (cant rmb haha sorry) but used to be a paramedic financially ok, but cyclophosphamide was $$ he didnt want to see an MSW though ex smoker about 30 pack years drinks socially Nil Family history of autoimmune disease (thyroid, DM, MSK) from then on had to quickly go back and clean up. no major features from SLE except a/w progressive loss of hair a/w fingers getting white in a cold room no exertional dyspnea, bruising or notice any increase in infections no SOB CP no oral ulcers looked at my watch and was like 17+ mins!! ahh no time, good thing he dont have many signs haha	at the end turns out he has patches of alopecia!	renal, blood, serositis) 6. What medications do you know for the different manifestations thank God for NUH IM elective haha where they taught me about how everyone should be on HCQ, then if skin only maybe like that enough if not DMARDS like Aza. if renal & systemic, need the "big guns" like cyclophosphamide, MMF. Then can also consider biologics 7. What biologics do you know? TNF a ones & B cell ones (just name dropped a few and admitted i didnt know too much about them, but he was ok i think! higher level stuff lol) 8. How would you monitor disease activity? i said ANA, ds DNA (think more ds dna but couldnt remember so i said both) C3, C4 will be low ESR vs CRP 9. How would you use ESR and CRP to differentiate between a flare and an infection? ESR -> flare CRP -> infection hahah something more elegant than that bell rings ok thanks bye!	

Gout Patient has gout, please talk to him	no eye deer	VERY YOUNG PERSON 24 years old had gout diagnosed after a fall?! at 20 years old. Control not very good 3 flares a month still. Claimed compliant to meds until I found out the side-effects of diarrhea from colchicine stopped him from taking them. Drank 3L Martell VSOP a day, ate fried food, was a bit overweight	Nothing at all	Asked for acute management of gout His risk factors - He was young, they wanted genetics (might be a pass/fail? he harped on it for like 2mins and refused to let me move on. and he is YOUNG so... juniors please impress the examiner with this --> The SLC2A9, SLC22A12 and ABCG2 genes have been found to be commonly associated with gout and variations in them can approximately double the risk.Loss-of-function mutations in SLC2A9 and SLC22A12 cause hereditary hypouricaemia by reducing urate absorption and unopposed urate secretion. The rare genetic disorders familial juvenile hyperuricemic nephropathy, medullary cystic kidney disease, phosphoribosylpyrophosphate synthetase superactivity and hypoxanthine-guanine phosphoribosyltransferase deficiency as seen in Lesch-Nyhan syndrome, are complicated by gout To be fair he didn't really seem to have intellectual or physical disability, so Lesch-Nyhan didn't fly out of my mouth sigh. GG	
Gout on b/g of ESRF awaiting transplant Gout management Please speak to the patient	One nice chinese lady and 1 indian gentleman both very nice, told me to sit down to take history and discuss	Mr E***/58/Malay NKDA PMH: Hypertension on meds (unsure of medicine but blue in colour) First thing patient said: I am here because I got gout -> points to multiple huge tophi on the hands (fireworks bursts out internally - omg wtfggbbq this good karma I can't even) HOPC: 1) Intially presented as podagra 5 years ago -Diagnosed by GP, started on allopurinol, colchicine and NSAIDs subsequently because he had tophi - Ever since first flare had subsequent flares 3-5x/year -last flare 2 years ago already - Stopped allopurinol 2 years ago and changed to febuxostat (doesn't know why changed, but no adverse reactions, possibly because of worsening renal function since he said the GFR was going down then) -Otherwise on initial presentation no trauma, no bleeding/bruises, no fever/chills/rigors, no LOW/LOA, no other symmetrical joint pain	Alert, comfortable Wearing shoes, socks, jeans and long sleeve, wrapped until like McWrap like this Multiple tophi plus plus over all the PIPJ, all the DIPJ, pinna of both ears, ankle, metatarsal, all toes Walked -antalgic gait on the right side (cause more tophi there) Joints otherwise not red, no effusions not warm Fixed flexion deformity of right 4th and 5th PIPJ and MCPJ Cannot do prayer or reverse prayer sign Functional limitation - problem opening red bottle and picking up coins	Presented problem list: 1) Gout with gouty tophi, currently in remission, on febuxostat, presenting as podagra 5 years ago with poor dietary control 2) CKD cx by ESRF a/w renal transplant, cause unknown 3) Low mood and financial problems a/w MSW input 4) Severe function limitation with job restriction Questions: 1) What did you find on physical examination? -Vomited out as above 2) He presented with a painful 1st metatarsal joint again, what will you do as a HO? -Come on this is good - hx, pe, ix (FBC, renal panel, X ray, tap and look for gout crystals - negative birefringent and needle shaped, send for cultures and biochemistry, tro haemathrosis), give analgesia and start colchicine 3) Dose of colchicine	MBBS is luck, the other stations were VUR with hydronephrosis in paeds, RA that had a hx like SLE on hydroxychloroquine, asthma and type II DM, go pray and donate some money juniors, don't be stingy cause these good karma will come and haunt you I heard there was a f***ing diamond blackfan anemia around and it's

		-No other cx of gout like kidney stones, but has severe deformity and limitation of finger ROM -no cx of treatment - no BM suppression on colchicine, no SJS from allopurinol, no N/V/diarrhea -Good understanding of gout, knows its too much uric acid, knows cannot take too much red meat, beans, seafood but sheepishly tells me he still takes it just to "sample" all the seafood usually, loves it like gold. 2) ESRF, unsure of cause, no DM, no other autoimmune stigmata -awaiting transplant -was told eGFR <15% -Not on HD for now -no complications of CKD (anemia, B12, BMD normal, no admissions for this, just f/u with renal in NTFGH, no fluid overloaded state on usual basis) Function: -Significant limitation, can walk, ADLi and comm ambulant but had to change job from technician to cleaner cause less fine movements of the hand required -Otherwise no reduction in effort tolerance Psysocial: -Low mood from gout, no ideal why the tophi still there and causing so many problems - Financial problems awaiting MSW review -non smoker, non- drinker, stays with wife, family okay, lift landing at his floor Drugs: -No thiazide diuretics use -Single antihypertensive therapy -otherwise gout medications just febuxostat for now	Problem reaching behind head (cannot comb hair) Problem reaching to the back (but he doesnt need to wear bra) Requested Tinel's don't need to do Everyone shooed out for 2 mins to explore my inadequacy :/	-dunno, classically taught to give until patient got diarrhea but no longer the case now and he got renal impairment so need to lower the dose (uptodate says 0.3mg/kg for renal patients) 4) Analgesia, what type? - Cannot give NSAID cause he's alrdy CKD going to ESRF, will KO the kidney -Refer renal and give paracet first 5) Okay his Hb is 11 (Low), Plt normal, TW 13, Renal panel Cr 450 from 350, Urea 25, electrolytes normal, nurse complain to you say 2 hours ltr he still screaming what else to do as HO? -Die also cannot give NSAID cause maybe he bleeding, insert 2 large bore IV plugs and fluid resuscitate, give omeprazole, refer gs for scopes, change analgesia to low dose prednisolone tapering dose, refer renal urgent for AKI and KIV Hemodialysis, start colchicine at renal adjusted dose and continue allopurinol if he is alrdy on it. 6) How to manage him? -Multidisciplinary approach -Refer DNE for diet, refer PT/OT for deformities, ortho for gouty tophi aspiration and excision, psy for psychosocial and msw for financial problem, memo to GP for gout control and to avoid thiazide diuretics for ht control, give colchicine and allopurinol prophylaxis, start prophylactic Abx in case septic athritis until culture is back 7) Okay what abx choice -ceftriazone IV 8) No other Abx? -cannot give gentamicin, will refer to hospital antibiogram and call senior to ask -on hindsight I think they wanted cloxacillin or something too? *Bell Rings* Thanked profusely and heard the passive said very wonderful when I left the room (fireworks exploding deep inside myself, all them poor karma for gs has redeemed thyself)	probably the new goldenhaur syndrome in 2017 LOL Thankful I got this instead of paeds omg all these people scaring me station 5 last colour confirm paeds LOL Saw my friend jaw drop when he saw the kid coming out of station 3 room (deep inside silently thinking there goes karma..... and moves to my station all happy)
Ankylosing spondylitis		Chinese gentleman in the thirties first presented in March 2012 when he woke up with severe back pain from cervical	First got him to take off his shirt and remove his shoes. Inspected	First got him to take off his shirt and remove his shoes. Inspected his spine from the side	It did not go as well as I would

Management case This patient has ankylosing spondylitis. Please take a history, do a focused physical examination and come with up the issues and management plan.		spine all the way down to lumbar spine. Was so severe that he could not move at all. Called the ambulance and was sent to CGH. CGH did MRI as well as HLAB27 which was positive, and was diagnosed with ankylosing spondylitis. Transferred to SGH rheumatology for management. Started on 4 medications - Prednisolone, Arcorxia, Tramadol and something that I can't remember now. However, control was poor as he has flares almost everyday with incapacitating back pain and stiffness. Hence after a few months, was changed to infliximab infusions. Initially had infusion once every 2 weeks, gradually adjusted to once every 2 months. Each infusion last 8 hours. The flares has been minimal since infliximab infusion, with a frequency of around 2 times per month, each episode lasting 1-2 hours. [Thought was not optimal, but did not ask if the patient himself was happy with it, which was very important]. Now still on 2 monthly infusions. Not seeing physiotherapists, but is doing swimming daily which improves the stiffness substantially. No other hospitalisations as a result of ankylosing spondylitis. Followed up every 4 monthly at SGH rheumatology - do blood tests everytime to check liver - fatty liver was discovered incidentally. Forgot to ask: Hepatitis B,C, HIV, TB status before infliximab was started. And whether he had recurrent infections from immunosuppression. Extra-articular manifestations: Uveitis: Few episodes of painful red eyes with BOV resolved with eyedrops Enthesitis: Achilles tendonitis. No plantar fasciitis. Dactylitis: Few episodes of acute onset swollen and painful fingers Cardio: Aortic regurgitation s/p repair in 2013, started on aspirin and propanolol Respi: Decreased chest expansion, but did not have any lung fibrosis No symptoms of other seronegative spondyloarthropathies: IBD: No chronic bloody diarrhoea Psoriasis: No rashes	his spine from the side and back - loss of cervical and lumbar lordosis with extension of cervical spine to maintain horizontal gaze. Restricted ROM of cervical spine and lumbar spine except for cervical spine extension. Did not formally do Schober's test but got him to flex his lumbar spine of which he can only flex minimally. Occiput-wall distance was about 4cm. Got him to lie down. First checked for enthesitis - had Left achilles tendonitis but no plantar fasciitis. Went to check the eyes - no uveitis. Measured chest expansion - limited at 3cm. Examined the heart - mid-line sternotomy scar. Did not hear metallic click so it is a bioprosthetic aortic valve replacement. Forgot to: Formally check for aortic regurgitation which could indicate prosthetic valve failure by checking for collapsing pulse and asking the patient to lean forward and ascultate LLSE in full expiration. Was pointed out to me during discussion. Didn't manage to formally check the lungs for fibrosis too. Forgot to check for sacroilitis by doing Faber's test Time's up - Everyone left for me to consolidate.	and back - loss of cervical and lumbar lordosis with extension of cervical spine to maintain horizontal gaze. Restricted ROM of cervical spine and lumbar spine except for cervical spine extension. Did not formally do Schober's test but got him to flex his lumbar spine of which he can only flex minimally. Occiput-wall distance was about 4cm. Got him to lie down. First checked for enthesitis - had Left achilles tendonitis but no plantar fasciitis. Went to check the eyes - no uveitis. Measured chest expansion - limited at 3cm. Examined the heart - mid-line sternotomy scar. Did not hear metallic click so it is a bioprosthetic aortic valve replacement. Forgot to: Formally check for aortic regurgitation which could indicate prosthetic valve failure by checking for collapsing pulse and asking the patient to lean forward and ascultate LLSE in full expiration. Was pointed out to me during discussion. Didn't manage to formally check the lungs for fibrosis too. Forgot to check for sacroilitis by doing Faber's test Time's up - Everyone left for me to consolidate.	have liked, missed out some key points in history as well as physical examination, couldn't really answer the management questions very well. Hence, really study more and practise more because during the exam itself your brain may really work at a sub-optimal level and it would be good to raise the brain level during normal practise. Luckily I practised some ankylosing spondylitis stuff with my friends for short cases before so it was not too disastrous. Learning points - Other than asking for any limitations in work or in life, ask the patient directly if he/she is happy with the current control because it really affects your management. For each drug

		No other PMHx. Not taking any other drugs. No drug allergies. No family history of spondyloarthropathies. Social history: Works as a social worker. Lives with wife and 3 children in 4-room flat. No financial difficulties. Doesn't smoke or drink alcohol. Disease does not stop him from working - conversely his work involves a lot of moving around so it helps alleviate the symptoms. Disease does not affect his ADLs - independent in both BADLs and IADLs. Mood is still ok with regards to having the disease, is glad that he's having much lesser symptoms after the infliximab is started. Forgot to ask: If genetic counselling has been done. And if inflixmab is placing a financial burden on him since it is an expensive medicine.			started, think of the possible SE and ask accordingly. Such as immunosuppression in biologics - ask if screening was done for the hepatitis and TB etc. Though it is a focused examination, it is important to do each step properly (such as the proper manoeuvres for aortic regurgitation murmur and positioning for the different parts you are examining) Falls prevention is important for ankylosing spondylitis patients in preventing fractures! First time this fact is drilled into me today, it seems like it is always overlooked in my normal revision of the condition. All the best juniors! Study hard and practise with one another. You can do it!

Ankylosing Spondylitis Approach to joint pain Patient complains of back pain	Sorry never remember the name cause its too long… ain't nobody got time for that! (1 indian and 1 chinese doctor) Pt was very well primed and able to talk very well and SUPERBLY NICE. BEST PATIENT EVER.	Mr M/31/Malay/Male NKDA PMH: 1. Recurrent red anterior uveitis (initially just say red eyes and eye pain) - Started 12 years ago - Diagnosed with anterior uveitis - Have 2-3 episodes/year - Given steroid eyedrops - Once required intra-vitreal steroid injection, was blind for 2-3 weeks - Stopped since 7 years ago, never had any relapse since HOPC: 1. LBP x 3 years - Pulling pain, also felt in right buttock - a/w morning stiffness that last up to afternoon, alleviates with movement, difficult to get out of bed in the morning - A/w right knee pain (sharp, non-specific pain, no radiation) - Also complains of neck stiffness that alleviates with exercise - No weakness/numbness/shooting pain - No claudication symptoms - No other joint involvement No rash/skin lesions No tophi/nodules No recent infection/fever (for reactive arthritis) No bloody diarrhea No LOW/LOA (pt says cause of the pain so didn't move much and had stress eating so gained weight – LOLS literally everyone laughed) Subsequently, he was referred to rheumatology and investigations done include HLA-B27 which was positive as well as X-ray and MRI which showed inflammation of the spine and the sacroiliac joints. (Pt was damn good was like they did the test say I got the something 27… and the inflammation of the spine all these all he ownself just provided. BEST) So I asked him directly if he was diagnosed with AS and he said yah yah yah the AS. (NOICE, diagnosis liao… PASS LO, hahah jkjk). After which he was started on arcoxia and some lifestyle advice. Only said he was taking famotidine as well when I asked if he was on any gastric medicine for arcoxia. Extra-articular manifestations:	- General inspection: No kyphosis/loss of lumbar lordosis/protuberant stomach/question mark posture. Nil skin rashes noted. - Gait normal - Occiput wall distance: 0cm - Neck ROM and lumbar spine ROM full - Schoeber's >5cm. No scoliosis noted when bent. - Pump handle and Faber's test negative - Hip internal rotation ok - No red eyes noted. - Respi: Nil apical creps heard - CVS: Nil murmurs - No time to do Chest expansion.	Mr M/31/Malay/M NKDA, Significant PMH of recurrent anterior uveitis now p/w 3 year history of inflammatory LBP a/w morning stiffness, subsequently diagnosed to have AS. Issue: 1. Well-controlled AS - Currently on arcoxia and famotidine PRN - No longer on f/u 2. Recurrent anterior uveitis - Previously on steroid eye drops - Nil recurrence since 7 years ago Otherwise no other financial or psychosocial issues. Questions: 1. Why did you say this is AS? 2. What are your differentials? (differentials for spondyloarthropathy) 3. What do you think is the cause of the R knee pain? Part of AS (ans he wanted) 4. What other joints should you have examined? He wanted the sternoclavicular joints/shoulder joints as well. a. If the joints in the hand are affected what pattern do you expect them to be? Asymmetrical 5. Then he shot my PE a. Why didn't you examine the nails/scalp? (Yessir ma fault) b. Why you never examine the Right knee c. Why you never examine the shoulder and sternum 6. What are the extra-articular manifestations? Spammed as above. 7. How would you manage this patient? Lifestyle, NSAIDS, DMARDS, Biologics 8. Ok so forget this patient, just a young guy coming in for LBP, what are your other differentials other than inflammatory? So I said I would like to rule out trauma (shiz should have asked but like when I walked in, young man and back pain come on la AS HAAHAH) and also septic arthritis….(couldn't	OKAY actually just pray for good patient good examiners HAHAH nothing else. Ultimately, medicine is too broad la anything can come out, don't need to kill yourself over it, just try your best. And the waiting is always the worst just calm yourself. You have done this a gazillion times this will just be another day of another exam and WING IT! JIAYOU JUNIORS!!! ALL DA BEST! WHEE GRAD TRIP LO! (oh ya plan grad trip early so got something to look forward to MUAHAHAHA)

		Anterior uveitis No ILD (nil dry cough, SOB, did X-ray never show anything) No aortitis/AR (he say no murmur also) No Enthesitis (No archilles tendonitis/plantar fasciitis) Control: - Currently, vey good, no more flares. Was given open date for follow-up, only taking arcoxia PRN which he never even take now cause no flares. Otherwise, has been discharged from follow up since early this year. NO MORE FLARES. Compliance: Nil to talk about since not even needing PRN meds anymore. But compliant to back stretching exercises and still does them daily. F/u: previously 3monthly follow-up. Only physical exam for ROM done during follow-ups. Nil X-ray/blood test. FMH: (FUG JUST REALIZED I FORGOT THIS NOW THAT IM TYPING, HOLY FUG I WROTE IT DOWN ON MY PAPER THOUGH) DMH: - Arcoxia + famotidine (PRN) Social: - Non-smoker - Non-alcoholic - Occupation: SCDF fireman - Family: Lives with wife and daughter in HDB flat - No financial issues - Psychosocial: o Feels that back pain affected his relationship with his child when she was younger cause she was active and wanted to play but he had back pain so was very limited. But now, since his back pain has resolved, the relationship is okay now and all is well J (like your MBBS will be juniors=D)		think of anymore). a. Okay, he is young, young guy, also have red eyes? Me: Oh maybe gonococcal arthritis? b. Okay… anymore causes, young also seen commonly in India? Me: Errr leptospirosis? c. Errr oaky…young common…? Me: ….. d. Okay la its TB. Me:oh yes yes sir TB 9. Ok what else do you want to manage in patients with AS other than medical therapy? ME (FUG CATCH NO BALL?!? WHAT ELSE? Already said medical management ?!) errr……. The social aspect?.... *BELL RING* (WHOOO SAVED BY THE BELLL!!!) THANK YOU SIR THANKS THANKS BYEE!!	
Ankylosing Spondylitis Approach to back and joint pains	Didn't recognise, but they were nice!	Mdm T, 48 yo Chinese lady History PMHx: "I'm not supposed to tell you the name of my condition, but I have back pain and joint pain" Sx: nil Drug Hx: SSZ NKDA	*was quite flustered here cos only 6 mins left with the patient forgot to wash hands then realised when I touched the patient, turned around sheepishly to examiners and said "er sorry profs I actually washed my hands much earlier" hope they give chance and don't minus	*by the time everyone left the room in the chaos, I was left with only 1 minute to consolidate. Thankfully my study buddy forced me to consolidate issues in 1 min when we were practicing for long case, so I was able to sort out and rank and scribble the issues damn fast- she really had a lot of issues… THANKYOU to my dear friend for forcing me to consolidate in 1min!! juniors practice this	- You will be fine, dont worry guys - Although you technically have 2 mins after PE to consolidate, by the time everyone shuffles around

		HOPC 1. Lower back pain x 6 years - over lower lumbar area, no radiation - no trauma - insidious onset - sharp - worse in mornings, better with movement - relieved by movement, exacerbated by rest - pain score 8/10 - constantly there, just worse in mornings. Medications she is on do not help A/w Stiffness of lower back >1h every day - No shooting pain or weakness numbness in legs (wanted to rule out ortho things like PID/ spondylosis) 2. Joint pains in hands - Over prox small joints but not wrist - MECHANICAL- relieved with rest and worse with persistent use (Was a bit suspicious this is not in keeping with AS at all, so probed more and realised she works in bakery, pipes cake decorations, right handed, so pain is worse with prolonged piping and pain is worse on right hand) - > *lightbulb clicks in my head this is OA hands and nth to do with the AS!* 3. Joint pains in knees - also mechanical - seeing ortho for it, said need replacement in 10 years when older - attributes this to her overly active lifestyle because she says she was recommended aggressive PT and exercise for her back condition so she might have overdone the exercise because it helps her back pain Associations - NO rash, dandruff, sausage like fingers, nail changes, NO diarrhoea, NO previous infections - No fever/ LOW/ LOA - A/w Chronic fatigue Course - went to see Dr anita in NUH Rheum, did some tests, diagnosed with her condition (still wouldn't say her dx, think she was primed not to reveal) - Dr Anita proposed SSZ but pt refused cos felt that she didn't want to depend on meds - Dr Anita recommended PT, which pt is VERY compliant to	mark LOL* - requested vitals, they said "vitals stable, hurry up and examine, focus on locomotor system" *in my head I was thinking SHIT NEED TO DO A FULL GALS + ANK SPON PE IN 6MINS WAHHH SHAG - gait normal - lumbar spine no question mark deformity, ROM limited all directions, schober + - cervical spine ROM slightly limited in all directions - chest expansion limited (increased by 3cm only) *FORGOT TO DO HEEL OCCIPUT WALL TEST IN MY FLUSTERED STATE* - got her on the couch, did LL joint exam super fast: screened feet, enthesitis, knees, and hip rotation, all ok. Knees crepitus tho - Faber's negative surprisingly - sat her up, examined hands, wrist, elbow, shoulders quick screen - looked at watch- 1min left wtf, faster went to auscultate heart and did manoeuvre for AR (rushing so much couldn't expose properly, just stuck my steth under her shirt hope the examiners didn't mind - BELLS STARTED RINGING OUTSIDE, they opened the door to pull patient and examiners out and I was like no no no, so faster put steth at apex of lung and asked her to breathe in, didn't hear any creps thankfully -- all this was happening while they were trying to pull my patient out, it was really damn chaotic	because by the time everyone leaves the room u essentially have a minute only!!* Presentation: I had the pleasure of speaking to Mdm Teo, a 48 year old Chinese lady who presented with inflammatory back pain for 6 years duration, associated with multiple joint pains. She has multiple issues I would like to discuss: Med 1. Poorly controlled inflammatory back pain, with persistent daily pain despite medical therapy. - DDx: Ank Spon, seronegative spondyloarthropathy such as psoriatic arthropathy 2. OA hands from chronic overuse in her job as a cake decorator 3. OA knees from overly active lifestyle as part of her Physiotherapy for tx of her AS 4. Restricted chest expansion and SOBOE- I am concerned about restricted chest wall movements vs ILD, but i think less likely ILD as i did not hear any creps in the lungs 4. Side effects of SSZ therapy- patient complains of yellowing skin, I am concerned about hepatitis from SSZ 5. Refusal of infliximab - I feel patient will benefit from biologics as her back pain is severe and SSZ does not control axial disease. She seems to have misunderstanding about biologics and I would like to counsel her regarding the benefits of biologics 6. Patient has not received vaccines, worried as the treatment involves immunosuppression 7. Chronic fatigue from her inflammatory disease, ?anemia Functional 8. Impaired function- cannot enjoy hobbies like watching movie or going out as she cannot stand or sit too long 9. OA hands affects her ability to work as a baker as she gets pain when she pipes cakes 10. she feels the aggressive PT causes her to have less time to do things she enjoys	its actually 1min only. So when you practice with friends, give yourself a minute only. so that during exam u can quickly do it and be ready when they re-enter!! - they like social history.... dont omit or do it too skimpily!! leave yourself enough time in Hx to ask, so you wont exceed the 15mins hx time and have to rush thru PE like me.

		- but back pain didn't improve, and last year Nov/Dec she had a very very bad flare, had to go hospital cos so painful, couldn't get out of bed or move. Seen by Dr Cho in the ward, proposed SSZ again and she accepted Control - Still has back pain every day despite SSZ and PT - Dr Cho said in clinic recently that she will need other treatment but she refused cos she thinks its bad for her and will make her immunosuppressed. I asked if the doctor said she needed biologics and she said yes infliximab Compliance - compliant to SSZ and PT Complications - no red painful eye - no chest pain, palpitations, heart problems - no dry cough, but has SOBOE and difficulty breathing deeply (I was a bit worried at this point about ILD vs chest wall restriction) - no enthesitis - no neck pain/ weakness numbness in hands/legs (AA sublux) - no bubbly urine, no renal problems (amyloidosis) - Cx of SSZ: HAD YELLOWING SKIN SHE SAID (I asked if the doctors tested her liver, she said LFT ok so I was like ok not hepatitis, prob some pigment thing???); no headache N/V diarrhoea rash Family Hx - family all have back pain but undiagnosed. Said mum sister and brother have same symptoms but not checked **at this point I was glancing at my watch and already hit 14 mins, I contemplated skipping the social history and do a cursory one, but decided better not, and im so glad I did ask social hx properly cos I unearthed a lot of issues in this part, although I did take another 5 mins so completed history at 19mins in the end, and had to do a very rushed PE** Social Hx - non smoker non drinker - works at bakery, decorates cakes, right handed. Back pain not affecting job but hand pain is affecting job - hobbies: likes watching movies and etc, but back pain is bad when she sits too long, so she cant do this anymore		Psychosocial 11. Finance- reluctant to start biologics due to finance worries 12. Low mood, patient says she is depressed. If given more time I would like to explore this more in depth with the patient Discussion Examiner: Ok good that is a very comprehensive issue list. Now tell me why you say its AS? Me: from my hx and PE she fulfilled the clinical component of New York criteria, had inflammatory back pain > 3 months, limited lumbar ROM in sagittal and frontal planes, limited chest expansion. But I would like to correlate with XR for fusion of SIJ. E: Yep if the XR showed fusion Me: then this is AS E: ok what other differentials? Me: explored other seroneg spondyloarthropathies but she did not have rash, dandruff, sausage like fingers, nail changes, NO diarrhoea, NO previous infections/ conjunctivitis/ urethritis E: so do u think she had psoriasis Me: no sir, I looked for the rash and dandruff on PE but couldn't find also E: what do you think about her hand pain Me: -- repeated what I said in the presentation about it being OA rather than inflammatory joint disease. Likely from her job -- E: ok. How would you investigate Me: FBC for anemia, ESR, CRP, XR whole spine + SIJ, CXR and ECG for lung and heart cx, also UECr and UFEME 24UTP in case amyloidosis, and LFT (cos on SSZ). [I ACTUALLY FORGOT TO REQUEST THE HLAB27 AND ANA RF ALL THAT LOLOL BUT THEN I WAS BABBLING SO MUCH ABOUT THE OTHER THINGS and they were quite happy with the Liver and renal test reasons THAT THEY DIDN'T SEEM TO REALISE I FORGOT THE BASIC TESTS??? They didn't ask me about it or ask what else LOL. Hope they didn't notice……]	

		- exercise: exercises a LOT, but feels like the PT is taking up too much of her personal time?? - finance problems: admitted that one big reason why concerned about infliximab is cos its so expensive - mood v low, says feel depressed. Haven't told her doctor about this - concerns: mainly about the persistent back pain, says v frustrating but doesn't want inflix cos she thinks the med is v bad, even her GP told her not to take it - vaccines: not vaccinated against anything - didn't ask about social support and family situation cos really no time- 19mins alr!!!!!		E: yes good, what are you worried about when she came with the bad flare last year Me: im concerned because I think her back pain is very poorly controlled, she has pain every day and last year that episode sounded very severe. I feel her medications are not good enough- SSZ is not effective for axial disease, only peripheral joints. *examiners look q pleased here and nod a lot* I think she would really benefit from biologic therapy but seems to have some misconceptions about it, so I would like to speak with her and address her concerns and educate her on the benefits of it E: yes! Now outline how you would manage her condition Me: Multidisciplinary management involving rheum, PT, MSW and etc: - Educate pt about dz and complications to look for - aggressive PT for the spine - pharm: analgesia eg NSAIDs for her pains - counsel regarding biologics, and if planning to start, check her Hep B Hep C HIV TB status before that - vaccinate - monitor for complications: yearly eye review for uveitis, check heart and lung if symptomatic, check urine for amyloidosis, check for cx of SSZ - manage depression - MSW support for finances E: how would you manage her hand pain Me: advise rest, give analgesia, change job to sth less strenuous on hands if needed E: how to manage depression Me: *stunned a bit* Err, get her to see psychologist or psychiatrist, start some therapy first (cant rmb what therapy LOL so just stammered a bit), if severe then antidepressants **BELLS RINGING OUTSIDE SIGNALLING OUR FREEDOM** E: ok good! Well done! HURRAY MBBS IS OVERRRRRR!!!!*	
Ankylosing Spondylitis	Prof	a very straightforward and direct patient	spine was not deformed. full	U = Umapathi	

Approach to Joint Pain Lady c/o of joint pain please assess her	Umapathi, Dr Barbara	6 years of joint pain inflammatory in nature mainly back knees and hips + proximal small joints of the hand. (axial). no psoriatic rashes, no recent infection, no bloody diarrhea - asked her bluntly " do you have AS?" she said yes. severity: pain score averages 7, worst can be 9 progress: starter 6Y ago, saw doctor and was diagnosed. defaulted for 5 years cuz of fear of meds and her self stretching was good enough, then had flare last year...saw dr cho. risk: strong family history - mom sis and brother have back issues h associations. had SOB (may be scoliosis or ILD), had foot pain in the morning (enthesitis), had some unsteady gait at times (possible cervical myelopathy) no syncope or exertional intolerance (Aortic regurg/arrhythmias) triggers: cold, stress, flus cx: some functional limitation in hands, but work in bakery not affected, no fractures, no respi failure. no depressive symptoms. no cx of meds. rx: on followup with Dr cho NUH but adverse to any meds. currently on SSZ (has beeb counselled on SEs). Dr Cho wanting to start her on biologics but she wants to wait. No TCM tried b4	ROM. heel hip occiput, schobers, chest excursion all normal. only problem was tenderness across whole spine. eyes ok, no myelopathy features, no apical creps, HR not slow, no EDM, no tendon tenderness. no psoriatic rashes, no jaundice, vitals all normal function: can write, can open bottle	B = Barbara M = me U: what are her issues? M: AS with severe pain, unfounded fear of meds, functional limitation, no psychosocial or financial issues U: what wld you do for her in the wards? M: investigate then manage. FBC ESR CRP, Lat C spine XR, Lat L spine XR flex + exten views, AP pelvis, bilateral hips. No need for HLAB27 if XR Sacroilitis confirmed + clinical suggestive (nodsnods). screen Hep B TB before biologics if she agrees. U: ok good, how to manage? M: NSAIDS first line, but her fear of the meds is the first thing to address. continue PTOT. (nodsnods) U: what do you know of biologics? M: *lists out a few* they are known to be very effective and revolutionized AS management. U: do u think cost is a huge issue for her in her reluctance to do biologics? M: no its mainly her fear B: how is her function? M: ??(thought i asked infront of you) not affected maam B: did you notice her handedness? M: (wow nice try, but i got her to write) shes right handed B: ok good. both of them: ok you may go thank goodness	
Ank Spon Approach to joint pain/stiffness This patient has Ankylosing Spondylitis. Please take a history from him and address his concerns.	Not sure. One male one female, both quite pleasant.	Youngish looking guy. Stem was given to me by the examiners. 45y/o Chinese Male Diagnosed with AS in 2012 No other PMHx. History: Sudden onset (one night, just suddenly) of pain and marked stiffness in the middle of the night. Was not able to move entire body except for neck. Predominantly in the lower back but pain ++ in many joints (shoulders, hip, knee, ankle)	Started by examining gait, then occipital wall distance (>15cm) Lumbar spine examination - tenderness on lower lumbar spine, tested ROM (finger floor distance ++, extension almost 0). Fabers test + (asked if it was ok if i did it and he said yes but on was cringing because of the pain so i told examiners that I didn't want to do the other side. They both nodded)	Try to get as complete a history as you can if not the examiners might pick on that in the discussion, otherwise just listen to the patient they can give you lots of info to help you remember stuff along the way.	

		a/w stiffness/"inability to move body". - No red flags: no cauda equina symptoms, no trauma, no LOW LOA - a/w lethargy ++ for a few weeks prior - Called ambulance and was sent to the CGH. Investigations at time of diagnosis: Did MRI and bloods (told me HLAB27 when I asked what bloods) and was diagnosed with AS. Transferred to SGH rheum after. Also had SOBOE - reduced effort tolerance - a/w orthopnea and PND Extra-articular manifestations: - Anterior uveitis: said his eyes were very red, for which he was given PO steroids. Cx by b/l cataracts s/p IOL surgery in 2013 and 2016 - Cardio: AR s/p aortic valve replacement in 2013 Nil respiratory cx, no IBD (forgot to ask about this was asked about it later on), no skin manifestations. Fam Hx: No family history Surgical Hx: 1. b/l cataract surgery 2. Aortic valve replacement Drug Hx: NKDA currently on 2 monthly infliximab infusion. Day admission for infusion. Doesn't know how long he has to be on them for (but said he is 'married to infliximab') Calcium supplements PRN arcoxia and tramadol. Previously on PO steroids but stopped after cx of cataracts. Also experienced weight gain. No other SE from drug use. Currently on f/u: SGH rheum every 4/12, SNEC and National heart center every 6/12. Social: Non-smoker non-drinker Stays with wife and 3 children, all well. Supportive. Works as a social worker, his colleagues and boss know about his condition. Says that it is helpful for his AS as he has	Chest expansion <4cm. Went on to examine CVS (had to sit him up again to readjust the bed to 45deg felt so bad to make him move cos really stiff++) Bioprosthetic aortic valve replacement (confirmed with him if it was from an animal not metallic). ESM which i presented as a flow murmur. No Cx of CCF, AF, Pulm HTN, IE. No jaundice, no pallor. Bell rang by then so had to stop there. Was told to give a summary of the case: 45y/o Chi male Hx AS diagnosed in 2012 when he presented with sudden onset of stiffness and pain and constitutional symptoms. MRI and bloods confirmed diagnosis at that time. Cx by anterior uveitis for which he was given steroids, Cx by b/l cataracts s/p cataract surgery and aortic valve involvement (likely AR) s/p aortic valve replacement. Still experiences daily morning stiffness. Coping ok with regular stretching and exercises. Currently on infliximab infusion for which he expressed some financial concerns. Well supported socially. Discussion: - If the patient came in with diarrhea, what will you think of? IBD (mentioned I would have liked to ask that in the Hx) - When you first saw the patient, what did you think about? (was a bit confused by this so I just said I thought he looked q healthy). Prof said yes he actually swims		

		to move around a lot for his job. Work affected once in a while as he has to take MC if the pain/stiffness is unbearable, and for f/u appointments. Financially: infliximab very expensive (non-standard drug), had some issues with it previously but now has insurance. No issues with insurance, able to cover the costs now. Currently: Still experiences morning stiffness for about 45minutes every day, has to do stretching/go swimming which has been helpful for his stiffness. No need walking aid though he was told by his doctor to use it previously. No falls, ADL independent, coping okay with his condition now (compared to the first few months just after being diagnosed which he mentioned was a very difficult time).	every day that's why he's so buff - How will you like to address his concerns? - What treatments do you know of for AS? - What do you know about infliximab? (biologics, anti-TNF alpha drug, need to screen for Hep HIV and TB before) - Tell me how you screen for TB - What kind of treatment is given for latent TB - Do you think his acute issues are more important or things that will happen to him in 5-10 years time? (said that for the patient acute issues are important cuz that is what they experience on a day to day basis and if that is not controlled well then they might not even be thinking about 5-10 years down the line. But the role of a doctor to pre-empt all that etc etc)		
SLE with lupus nephritis	-	Stem: Ms Lim with extended history of SLE with lupus nephritis. Please take a history. Ms Lim, 40/C/lady ADL-i, community ambulant without aid Non-smoker non-drinker Currently not employed NKDA PMHx: - SLE with lupus nephritis - S/p renal transplant in Dec 2016 - HTN, HLD, otherwise no DM - gout - Cushings secondary to steroid use (DEXA scan normal, no prev #) - no other associated autoimmune conditions (sjogrens, RA, scleroderma) FHx: negative for autoimmune conditions Initial presentation: At age 11, cannot remember exact	After 20 long minutes of history, moved on to PE. Nothing much to see except features of cushings, no spinal tenderness for vertebral #.	Qns: - did you ask what kind of renal transplant she received? (cadaveric or living donor) --> I admitted that I didn't ask this qn, the examiner asked if I could guess it's relevance then I said something random about allele matching and he said nvm let's move on. - would you recommend her to get pregnant if she wanted to? (gave super politically correct answer) --> It is the patient's choice if she wants to bear children or not, but from the medical point of view it is not advisable as it may aggravate her SLE. *furious nodding* - the rest all very usual qns like investigations, management. I suck at IM but thankfully good patient + good examiner helped me pass. :)	Advise to juniors: don't study hard, PRAY HARD.

		presenting symptoms, but referred from family physician to hospital for work up, diagnosed SLE. Did blood tests but doesn't remember what/results. Cannot recall if biopsy done, but eventually also diagnosed with lupus nephritis at ~16 (if i remember correctly) ?symptoms at that point. Control: Had 2 episodes of acute pulmonary oedema, in 2015 and 2016. In 2015, developed APO after acute viral illness, hospitalised and started on peritoneal dialysis. After 3/12 of PD + fluid restriction to 1L/day, she was able to stop PD. Subsequently had another APO in 2016 after she "drank too much water" and was hospitalised. Had in hospital seizure secondary to hyponatremia. Resumed PD. Had 1 episode of SBP. Doesn't remember any other details of it other than a "tummy infection" because of the dialysis and not because of the tube. Subsequently underwent renal transplant Dec 2016 with no intra/post-op complications. Currently well controlled with no more flares. No issues with graft so far, no acute/chronic GvH. Apart from these, no other manifestations of SLE: joint pain, rash, alopecia, psychiatric issues, haematological, serositis, etc Otherwise, she has always been very compliant to all her meds, knows her schedule very well. Her husband also constantly reminds her to take her medications. Medications: - Prednisolone, cyclosporine, MMF - cushings, no other SE. Compliant to all. - Gout: allopurinol, colchicine - HTN: some beta blocker (can't remember which), HLD: statins - Otherwise no other supplements/TCM Social Hx: - married with no kids, (forgot to ask if intend to get pregnant and if any issues, why/why not) - Previous administrative job, currently unemployed due to "personal reasons" Briefly explored paediatric Hx (since she got it when she was 11), affected growth but otherwise no other significant things.			
Psoriasis (Ank-Spon	-	My patient is a Malay gentlemen in his late forties perhaps.	Inspection:	Presentation:	JIAYOU KAY

type)		He came to me sharing that he has had a rash for many years. When he told me this, I looked at his hairline and hands immediately and it screamed psoriasis at me. The was already a psoriasis long after a previous psoriasis short case I had the day before, so my advice for all juniors is to start psoriasis hard, it can be tested a lot. Not just the arthropathy but also the dermopathy which we will learn in derm posting. And some things to note about psoriasis before we begin, it tends to be associated with metabolic syndrome, so please remember to screen for all your DM, HLD, HTN and CVS stuff too. And cause of increased cellular turnover, there is also increased purine load and increased risk of gout, do check for that too. Lastly, precipitants of gout, other than your usual non-compliance, stress etc. drugs can too, use this acronym "LAMBI" – Lithium, Anti-Malarials, Beta blockers, Interferon (for Hep C). Well so basically his rash P/C wasn't a real PC with everything just screaming at my face, but idk why, I decided to approach the rash a bit to make sure it was definitely psoriasis and nothing serious like infection/allergic reaction. In retrospect, this might be an epic waste of time cause this was a clear management case. Confirm: So in any case, more into the management history which is the meat of this case. This gentlemen had psoriasis for almost 13 years. It started with a non-itchy rash affecting mainly extensor surfaces around 13 years ago that led him to find the doctors. Other than the rash, when he first presented, he had no joint pains and no other symptoms. He was referred to National Skin Centre and formerly diagnosed there with a biopsy. He had no preceeding URTI before the rash started. Cause: No family history of joint and skin problems. No other autoimmune personal or family history Course, Control: His course and control was very stormy in general. After the initial diagnosis, the dermopathy could initially be controlled with topicals and light therapy at NSC. But 2-3 years ago, he developed arthropathy that started at the hips and knees, subsequently affecting his lower back and minimally affecting his hands. Since then he was started on methotrexate. And around slightly more than a year ago, he	• Rash was all over, and it was more of an erythrodermic type of skin psoriasis than the usual plaque type. • I was looking for areas of sparing (around the flexures) than the areas involved cause it was so extensive • My patient was flaking and shedding everywhere and I felt kinda sorry for him • Nails didn't seem to demonstrate much problems other than some onycholysis • No obvious gouty tophi • No CBG marks on finger tips • No xanthelasma or tendon xanthoma or corneal arcus Move: • Did a quick GALS, and I knew to focus on the spine more from history • Surprising good ROM even in the spine. All other joints ROM pretty good also • Could walk fine with no problems or aids • Faber's test was normal too, did it cause I thought the arthopathy was more of an Ank Spon type and SI joints could also be affected in this case Feel: • All joints felt relatively normal, not warm or	My patient is a 40 year old Malay gentleman with a principal diagnosis of Psoriasis and I have identified the following issues in his care: 1. Poorly controlled psoriasis involving both skin and joints with recurring flares, the last one being yesterday requiring NSAIDs, and having 2 prior admissions in the last year. 2. Acute liver failure secondary to methotrexate necessitating a change in medication 3. Likely poor control resulting from acetretin medication (as no other pbvious precipitants) without any previous discussion of alternative meds that he might require like biologics, and has not previously tried physiotherapy as well. 4. Poor function affecting job from underlying poor disease control 5. Psychologically affected by condition too requiring wearing of gloves 6. Financial constraints that have been inadequately addressed despite previous MSW referrals 7. Comorbidities of DM and HLD. DM likely poorly controlled as patient demonstrates poor understanding of meds and condition. Discussion: 1. Are there any issues that you think you are missing out? a. At this point my really nice passive examiner made the smoking hand signal and I immediately said "Its also particularly concerning that this patient is still currently smoking and I think he was need a referral to the smoking cessation counsellor" b. The active examiner smiled when I could point	JUNIORS, IT IS MUCH EASIER THAN YOU THINK! ☺

		had to be admitted to hospital as he developed acute liver failure and needed admission (normal ward), this was his first admission for psoriasis. Since then he changed his meds from methotrexate to acetretin and his condition became poorly controlled with numerous recurring flares. He had another admission again 4-5 months ago for severe flare affecting joints and skin. He basically has not been coping well on the new medications and his joint pains (especially lower back), has been affecting him at work as a music teacher/drummer as he has to sit long hours. He last flare was just yesterday when he had to take NSAIDs. As I was talking to him, he appeared to be generally well. Compliance: He claims compliance to his meds, which is currently acetretin and NSAIDs for flares. Nothing much else. No longer on light therapy or methotrexate. Has not tried biologics before. Comorbidities: He has hyperlipidemia which he claims to be well controlled on diet and exercise (he further claims that he was previously started on meds, although he was subsequently stopped cause of good control, which made me raise my eyebrows cause that doesn't normally happen). He also has DM which he does not even know his meds name, does not know what HbA1c is (the doctors in the room subsequently told me its 8%), but he knows he is currently on oral meds only. Otherwise, no HTN, no heart disease, no previous strokes or kidney problems. Does not go for regular check-ups for DRP and DFS but grossly sensation and vision okay. No gout also. No other surgical histories. Complications Functionally – Arthopathy affecting his job and function, especially lower back ++. Patient is very affected by the pain. Not much hobbies to begin with to be affected. Otherwise he is still able to sleep at night. Psychologically – He does wear gloves when he teaches music to his students so his is slightly affected psychologically by his dermopathy, if not he is generally okay Medical – as explained above, it's the recurrent flares and methotrexate allergy that is a huge problem Treatment and Complications As explained above. Otherwise he is on DM meds, likely metformin and OHGAs	swollen, much better than expected • But the lower back did feel warmer than the other joints Special test: • Ideally should have done heel-occiput test • Should have done schober's test • Should have checked function of hands too… UGHH kept reminding myself to but I forgot, but I think this was a small issue cause from history his hands were relatively unaffected. Heart and Lungs otherwise ok.	this out immediately, lol, my examiners are such angels 2. So… Do you think this patient is telling you the truth about his HLD? a. A bit bad to say your patient lied but I said he didn't tell the truth, cause unlikely to start on meds then suddenly stop for HLD, might actually be him being non-compliant b. Furthermore my patient doesn't even seem compliant to DM control in the first place c. And he is on the obese side which makes me question how strict he has been with his diet and exercise 3. Good, so why do you think he is so compliant to his psoriasis treatment but so flippant about his DM and HLD? a. Sir cause his psoriasis is very severe, not just pain, but the disease is affecting him functionally and psychologically as well so its not hard to see why he is very compliant in his attempt to control the disease b. Whereas for DM and HLD, these chronic conditions tend to be silent killers that have minimal symptoms until they present with complications, which he currently has none. So with minimal symptoms and complications, it is harder for him to see the need to be compliant c. I think he needs more	

		although he is not sure. No TCM, no other meds that can worsen psoriasis. Has not tried physiotherapy NKDA Not on HLD meds. Caregiver Wife cares for patient, no children. But currently she is medically well and all, able to care for him. Cost Cost is a huge issue for this patient as he is unable to afford his treatment so far. He needs heavy subsidies and his job is further affected by his condition. He has been referred to MSW already but his financial concerns have not been adequately addressed. Concerns Mainly this patient is very concerns by the poor control of his pain and overall condition ever since he has been switched to acetretin. Claims that prior to his switch, he was previously very well managed on methotrexate. His financial problems also concern him quite a bit. Otherwise… Other PMHx quite unremarkable Social History – Non-drinker but currently still smoking, knows its bad but cannot quit. 30 pack years Understanding – He has good understanding of his disease and knows that he has to be compliant to his meds for good control and he knows what to do when he has flares. Some tips so far from my history taking: • Time management is very important. • While taking my history, I did not look at time and my eyeballs nearly flew out of my eye sockets when I saw my watch and 15 mins had passed without me noticing. Luckily mine was a psoriasis case so I knew PE had nothing much and I quickly finished up everything in 5mins and had another 5 mins to examine. • May not always be as lucky, so check time always!!		education for him to understand his underlying conditions better to promote compliance 4. So tell me, how are you going to manage the issues you have highlighted above? a. First, I think I have to make sure the acute symptoms are controlled and prescribe pain killers as necessary b. Then controlling the underlying psoriasis is key, for which I think he may need increase or change in medications to biologics. His disease seems poorly controlled with no obvious precipitants other than the change in medications and he is compliant to his meds, so a change or increase in treatment regime might benefit him. c. His skin involvement looks extensive so he may also benefit from topical treatments like steroids, emollients, coal tar and even light therapy d. I note that he has not tried physiotherapy as well and would like to start him on it to improve his function and sitting posture e. Educate him on his DM and HLD, and refer to dietitian and endocrinologist for better control f. Refer him to MSW again to see if we can address his financial concerns better g. Refer him to smoking cessation counsellor	

				5. You mentions MSW and also starting him on biologics… Why do you think he has not started on it despite his condition being severe? a. At this point I was like… OHHHH SHIATSSS… b. Sir he is likely to be unable to afford biologics due to the high costs, once again, this makes the financial concerns very important to address c. Phew good save cause he smiled. 6. So which issue do you think is the most pertinent here? a. The psoriasis control cause it is affecting him very badly b. Examiner shakes head c. Then I mentioned that he needs proper education on his DM, HLD and Smoking, and also referreal to the MSW d. Seems like the right answer and they nodded 7. Okay so, tell me how you will investigate if your patient comes to you? a. Biopsy to confirm b. HLA-B27 c. FBC – for infection and anaemia d. ESR and CRP – for flares e. U/E/Cr – for renal function which can be affected by drugs, for DM nephropathy f. Urine dipstick for microalbuminuria g. LFT – for liver functipon which can be affected by drugs h. X-rays of Joints affected, mainly spine: flexion, extension and weight	

				bearing views, look for AS changes also as a differential i. HbA1c to check DM control j. Lipid panels to check lipid control k. Check BP as well 8. Ok very good, I think that's all. Just nice, the bell rings. Please make sure you take history like this when you become a HO! (was super encouraged to hear this). Thanked everyone furiously and left cause MBBS is OVERRRRRR YAYYYYY	

Adult Medicine – Haematology

PRV cx portal vein thrombosis with variceal bleed and symptomatic anemia Approach to SOB Patient has PRV, presenting with SOB, please take a history		45 yo malay lady NKDA Non-smoker, non-drinker No Pmhx/surgeries No TCM Presenting complaint: - Exertional dyspnea x3/12 o A/w chest pain no radiation, palpitation, no diaphoresis o No postural hypotension o Relieves with rest o No OD/PND o No leg swelling o No allergy o No fever, cough o No contact/travel hx - Melena x3/12 o Painless o No hematochezia o Hematemesis x1 episode o No changes in bowel movement, stool caliber o a/w LOW 7kg over 1year, no LOA o No liver disease o No coagulopathy/bleeding elsewhere o Was told to be paler than usual by family and friends Visited GP – told to be hemorrhoids, given oral medications.	Physical examination: - Splenomegaly 6cm L subcostal, firm, smooth, no bruit, non-tender - Conjunctival pallor - No cervical lymphadenopathy - No stigmata of CLD - No bruising - No bipedal pitting edema, no swollen calves - Heart, lung clear - Should have: neuro for focal deficits - Complete: o Vitals – BP 90/?, tachycardic o Postural BP o DRE o Other LN	Questions: - Present issues - How to manage hematemesis? - How does PRV cause portal HTN? o Portal vein thrombosis o Hepatic vein thrombosis - What is the cause of her anemia? o Fe def anemia due to bleed o Anemia of chronic disease o Sequestration in spleen - How to diagnose PRV? o Hb >16.5 in female o Can have leukocytosis, thrombocytosis o Splenomegaly o +/- BMA - What gene a/w PRV? o JAK2 mutation - How to manage PRV? o Aspirin o Venesection o (another drug? I just guessed erythropoietin inhibiting factor haha, but examiners say too high level nevermind lol)	

		Continued to have symptomatic anemia, thus visited SGH A&E. - Was told that her Hb was very low, required 6x blood transfusion - Underwent OGD with esophageal banding x6 - Colonoscopy normal - Blood investigation and she said BM biopsy - Told that diagnosed with Polycythemia rubra vera Progress of disease: - f/u hematologist, gastroenterologist - Tx: aspirin, propranolol - Last variceal bleed last December - Gastroenterologist – banding is no longer advised, should consider splenectomy - No other Cx of dx: o No thrombosis – stroke, AMI, PE/DVT o No bleeding elsewhere o No signs to suggest liver decompensation - Well educated with regards to her condition, understands bleeding red flags. Has hematologist's phone number to call if she has any questions or changes to her symptoms. - Feels that condition is affecting her lifestyle Fmhx - No malignancy - No hematological conditions Social: - Childcare teacher - Financially has company insurance - Not married, stays with mother and brother			
Polycythemia Vera Approach to UBGIT/Anemia Patient diagnosed with PRV, please take a history and find out the issues and management	Prof Lau Tang Chin and Dr Chia?	(sounded like the lady from senior's account) 49 year old lady Nil PMHx prior to PRV diagnosis - Dec 2015: x1/7 melena (3-4 episodes of black stools) and hematemesis (1x episode- bright red blood, no cough, chest pain) - 1 month of exertional dyspnoea, no chest pain, no palpitation - GP gave meds ?piles (asked patient to go to A&E if bleed persists) Stopped bleeding and did not seek further invx until 3 months later	Vitals given: Cant rmb Spleenomegaly 3 finger breath below left costal margin Nil conjunctival pallor or scleral icterus Requested to complete abdo exam, DRE, CVS and Neuro (was asked why CVS- said for CCF though dont expect in patient as history doesnt suggest, Neuro- stroke though not suggestive in history as well	- Acute management of bleed: ABC, invx, call senior, E-blood, emergency OGD - How many pints to transfuse in Hb 4.3 - Transfusion reactions, complications, what to look out for (Add frusemide in CCF) - If in the middle of the night, would you call gastro for emergency OGD? How would you convince them to come down? said sth about being symptomatic, low Hb - Invx to diagnose PRV: FBC, PBF, bone marrow (forgot to mention erythropoietin and Jak2 and bell rang)	All the best!

		- Nil previous gastritis, PUD, CLD/ hepatitis (was checked and was ok and Nil RF) - Worsening chest pain, exertional dyspnoea, another episode of melena - Went to A&E - Hb 4.3, blood transfusion - Did OGD- variceal bleed, banding was done - colono, liver biopsy, 2Decho all clear (I forgot to ask for LOW LOA >,< but senior's account said yes. there was bloatedness, early satiety too) - Subsequent bone marrow showed polycythemia vera - 3-4 more episodes of variceal bleed, repeated banding from Dec 2015- 2016 - hospitalised 1x in 2016 (cant rmb the month) - Due for splenectomy in 1 month Medications: Propanolol for variceal bleed, Aspirin for PRV. Not on hydroxyurea. Antibiotics for 2-3x for her variceal bleed. (On after thought could have explored more about why there were recurrent variceal bleed...ended with too much time to spare) Social: Nil smoking, alcohol. Stays with mum and brother at HDB. No financial issues. Working as childcare. Struggles with work due to the heavy workload and stress in addition to her illness (no one else to help her with the work, and need to catch up after she takes MCs) FHx: Nil cancer			
Haemophilia A Approach to coagulopathy This patient has Haemophilia, please take a history and do the relevant examination	1 female chinese and 1 malay indian con	52 year old Indian male Course: Presented with head swelling at 7 years old after an accidental fall - no symptoms of raised ICP - no other sites of bleeding or haemarthrosis at that time - hospitalized for a few days - Did blood test and told of Hemophilia A status - did not know of any family history back then - Given IV Cryoprecipitate (yes he actually said	Has a right arm tunneled catheter which has no signs of inflammation (Threw out the 5 signs of inflammation exception loss of function) Checked for joint swellings, none there (he was wearing jeans so i just wayang touch bilateral knees and said ideally i wanna expose. Then the examiner like just stone	No differentials. This is a management case. I just presented his summary plus problem list (present problem list as Medical, Psychological and Social) 1) current hemophilia A on FVIII concentrate injection for prophylaxis 2) b/g HTN on anti-hypertensives 3) Financial issues requiring MSW Otherwise he has good insight and knowledge into his disease (i think better than my	Derrek Soon told us in the briefing that day before we all start the long case that most of us have already passed IM as we have accumulated sufficient points. So yea, do your

		cryoprecipitate) of ? units - Recovered thereafter in medical ward Had multiple episodes of hospital admission, but never requiring ICU admission. Just give cryoprecipitate or FVIII concentrate Last admission 1 year ago for a trauma to the right groin and received FVIII concentrate (he said changed from cryoprecipitate to FVIII conc these days) Currently on Cryoprecipitate for prophylaxis via a tunneled catheter. He prepares the IV cryo and does it himself. He says no issues with administration of the medication. Complications: - Since then, had multiple times of bleeding, both spontaneous and traumatic bleeds at 1) joints: usually elbow, knees --> This caused him to have arthralgia in the knees 2) hematuria 3) melena - he has otherwise no severe complications that were life threatening Control: nothing much to ask here Medication Hx - NKDA - Nil traditional medications - taking HTN meds - Taking FVIII injection via his right forearm tunneled catheter currently (forgot to ask the frequency of his injection and got asked during discussion..) PMHx - HTN on medications OM PSHx - Did an arthroscopic (yea he said arthroscopic too) procedure on left knee to prevent future bleeds Family history - His brother and uncle who both have Hemophilia A passed away. Uncle passed away because of circumcision then kept bleeding. Brother passed away from brain bleed after head trauma. (poor fella man i srsly felt sad for him)	then i also didnt bother alr). Has little bit of conjunctival pallor, no jaundice. Checked for hematosplenomegaly (actually i think probably don't need) Then i looked at the examiner cause i dont know what else to do next, then he said, "why don't you examine his gait?" Gait: He walks a bit funny, can't describe it fully but his ROM of bilaterally knees looks quite limited and he got like a bit of forward lurch. I just said his gait looks a little bit abnormal. Can't fit it into our usual neuro gaits types. And they let me off with it. At the end of PE, i still have like 4 minutes actually cause this guy is a damn good historian haha and damn nice. That is how i got more social hx from him which was just to kill time since i duno what else to ask for medical already.. Turns out got like 1 or 2 stuff i never clarify like how often he change the catheter or how often he injects the FVIII	knowledge of Hemophilia A) They never ask me for Ix or Mx also lol. The 2 examiners damn chill and nice. Q1: What are the Cx of hemophilia A - Cx can be due to the disease itself (bleeding and can cause severe bleeds that can cause death like in the brain) or due to treatment itself (Hep B, Hep C, HIV, fluid overload) - Examiner: So what are the Cx that the disease itself can cause? - Me: Errrrrrr - Examiner: He said he has some complications right? What are those - Me: (suddenly rmb he got knee problem then making things up as I go then really correct hahha). He has arthralgia likely due to repeated hemarthrosis damage the joint capsule and also resulting in his abnormal gait (at this point then i realise why he has abnormal gait lol) Q2: What would you advise him regarding dental treatment and vaccinations? - Me: Regarding dental, i would tell him to notify the dentist and ensure sufficient tamponade at the site of procedure and ensuring he has normal coagulation profile first - Examiner: Do you think he should notify his hematologist for prophylactic FVIII? - Me: YES NOTIFY THE HEMATOLOGIST! - Me: Regarding vaccinations, just give him vaccinations like influenza, pneumococcal and relevant travel vaccination - Examiner: Do you think he can go for IM vaccinations? - Me: (omg i totally forgot about this). NO. cannot do IM vaccinations!!! (i love my this indian male examiner, he just kept prompting to me the answers lol) Q3: If the patient really has to have IM injection no matter what, what would you do apart from adequate tamponade? - Check platelets and coagulation profile	best in every exams and score as best as you can for simple stations so that you dont have to stress so much at the end. I guess this station is supposedly quite easy la but i definitely skipped loads of paeds cramping since im station 1 lol. (remember paeds usu. is station 3 or 5! this year was stn 3) GLHF! Jiayou juniors who are probably having electives when we are typing these stuff. Have a plane to catch now. Byeeeee

		Social Hx - Family: Has a family of 2 boys and 1 girl (27 yr old). He said thinking of sending the girl to screen for Hemophilia A since could be carrier. For the boys, don't need to screen since they won't get it (he seriously damn knowledgeable about genetic inheritance of Hemophilia A) - Occupation: Works as a DJ since 20+ years old. (forgot to ask him which club so that i can patronize). ---> I asked him how he keeps himself safe from trauma since it is quite dark ------> He said just make sure he has enough space around him and never has problem so far. - Financial: Has difficulties with finances and is currently on MSW assistance - Hobbies: Always wanted to play sports. When he was young, he still went to play but end up bleeding. So has since stopped playing sports and understand that he can't do it anymore so he just watches sports (amazing guy man)		normal first. Ensure you tie the torniquet tight to reduce blood flow. (srsly it just made sense to me then i just say it, never seen it done before. Then the examiner tapped on her iPad means i said something correct liao) Q4: What is the inheritance of Hemophilia A and what is the chance of his son getting it? - X linked recessive. His son has 0% of getting it, unless the mother is a carrier, cause they get the Y chromosome from him and the X chromosome from the mother. Q5: What if you give the FVIII infusion but patient continues to bleed? What could be cause? - (suddenly the FVIII inhibitor thing crawled out from the deepest end of my brain) - Me: Could me FVIII inhibitor, so must do a mixing study. (Since FVIII inhibitor also cause similar features, and to differentiate it from antiphospholipid antibody is via clinical presentation! APS antibody presents as thrombosis whereas FVIII inhibitor presents as bleed! Taught in the M5 hematology lecture by this NUH hemato prof/senior con) Then there were some qns clarifying on my hx and then they caught me not asking the patient how often he takes the prophylactic VIII. I think got a 1 or 2 more questions more but i can't remember. I spent quite a while smoking some stuff cause i can't remember specific Mx of Hemophilia much except giving DDAVP in mild hemophilia but he clearly isnt so i'm kinda stuck lol. But examiners nice ++ so i manage to wriggle myself out alive.	
haemophilia A management Mr M, 37yo with haemophilia, take a history and come up w	prof teoh? cant really rmb but he either has a perma frowning face or he	Mr M, 37yo Malay hemophilia diagnosed at 7m - bruises when crawling about (screened other cell lines) - no anemic symptoms - no frequent infections	died. how to examine hemophilia. i got no system so it was super messy.. quickly did ROM of shoulder, elbow, hip, knee (actually looked q lost and prof	summarised and presented and they had no issues ^^ (i said moderately well controlled) investigations? FBC, PT PTT, mixing studies XR	- know common cases - practise clerking w friends using accounts, it really helps a lot - mbbs is a

mx plan	wasn't impressed at my performance.. dr angela (active)	course - 1 admission a year to 1 admission every 2-3 years - more admissions when younger - last admit last year Oct for R thigh bruise - never admitted for any life threatening bleed before control - latest factor 8 level 0% compliance - goes for follow up at SGH, they follow up his hep C too - knows when and how to administer factor 8 complications - joint limited ROM - hep C from one of the cryoprecipitate infusions in the past - no head injury/ ICH - no severe abdo pain (retroperitoneal bleed) - no severe hemarthrosis - no hep B/ HIV cost - receiving subsidy for factor 8 infusions - coping ok systemic - no LOA/ LOW - no fever/ night sweats social - no smoke, no alcohol - doest do contact sports, doesnt rock climb - works as researcher - ADL-I, able to manage by himself fhx - sister carrier, nephew and uncle affected - divorcee, no kids pmh - hep C since 1980s: gonna start treatment this year (should have asked when start only now then maybe i could have answered prof's question later in the discussion..) psh - (cant rmb but i think it was knee joint arthroscopy or sth)	tried to help by saying focus on the locomotor system haha did he mean GALS? idk) no conjunctival pallor offered abdo, cervical LN, examiner said all normal should have walked patient cos as he walked out after 25 mins i realised he was walking w a limp.. prob got limb length deformity then could have measured also	management in clinic? (mostly smoke cos he was q well controlled?) educate, counsel, compliance to follow up, when to admit to hospital, what to do when bleed, KIV refer PT for contractures to optimise joint function what do you think about his factor 8 infusion? (?? smoke again) patient able to recognise when to self administer factor 8, able to do it himself, knows when to admit himself what's the link between hep C and haemophilia? he got hep C from the cryoprecipitate transfusion what else? (IDK.) sorry I'm not sure what to tell him if he wants to change job? dont go for those that require climbing heights like construction cos risk fall from height what about daily activities? no contact sports, no rock climbing dr angela turns to prof and asks if any more questions AND i knew i was gonna get questioned on hep C - basically couldnt answer most of the questions cos never read :(investigations? RNA? what else? sorry not sure when to start treating? (omg idk..) based on RNA level..? you see so many patients in the wards w hep C why we dont treat all? (...) resistance..??	marathon, pace yourselves well, learn a few things a day, talk to ppl about it, discuss and hope that it will become LT memory or get packaged in some part of your brain so you can retrieve it during exams - it will be ok! all the best!! :)

		drug - allergic to aspirin: said it makes bleed worse - no traditional medicine, no blood thinners ICE - has come to term w condition over the years, not v sad/ affected by it		(prof laughs) resistance?? cost!! how much is hep C treatment do you know? (nope) it's so expensive!!! (he said some number i dont rmb) what if he gets married and wants to have children? do genetic counselling how to do genetic counselling? XLR. girls 50% carrier, boys wont be affected. (awkward pause) what else? (what else..?) sorry idk what else (prof does his laugh again which isnt the most reassuring thing) we're trying to ask you if he decides to have abortion can he! (bell rings) yes he can!! (and omg i just wanted to leave immediately after answering)	
Familial thrombophilia Approach to unilateral lower limb swelling Examiner says that this patient complains of left lower limb swelling, please take a history and do a focused examination	Idk, but they look vaguely familiar	Mdm Ho is a middle aged (forgot sorry ><) chinese lady Complains of recurrent Left lower limb swelling for many years, 'occasionally red/pain but not really', it occurs if sit for long, also occurs if stand for long, but not worse at end of day, says onset is gradual, and rises from ankle up to knee. Pain occurs at ankle and rises with the swelling, does not radiate, describes it as like a sprain. Right lower limb sometimes mild infrequent swelling but not significant. No fever, no trauma, no constitutional symptoms, no neurological symptoms, no joint pain or rashes, no heart/liver/kidney problems. Was initially told by other doctors to be 'sprain', given anarex but the swelling recurred with pain so she went to her own GP who 'diagnosed it immediately' and sent her to the ED. Had some blood investigations that showed some abnormality (and here she gives me a funny look and was like 'I can't tell you'), also found problem on ultrasound of her legs (and wouldn't tell me the findings again - wouldn't even say vein/artery/lymphatics sighhh). Finally dug it out of her that she has some form of 'blood deficiency'. (she will later tell me that she was monitored at general ward and given IV heparin then converted to oral warfarin before discharge; all these she wouldn't offer and would only confirm when I guessed correctly, which was after she showed me her medications, see below) Asked her what medical history she	No scars, noted currently no swelling, no calf tenderness, calves supple, no hyperpigmentation, no pitting oedema, no numbness/weakness, full ROM. Contemplated and should have just gone ahead to do arterial and venous exam since these were differentials that I would offer later (and kena whack cos didn't rule out during examination...) and should have wayanged for signs of pul embolism (heart rate, JVP) and could have looked for inguinal lymph nodes (which I contemplated doing also but didn't :/) Patient herself prompted me to measure her legs so I measured to confirm there indeed wasn't any calf swelling. Oh I did do pronator drift (normal) to rule out stroke/ICH.	Was asked for differentials of unilateral lower limb swelling in this patient, so I offered DVT, pelvic tumor compression, arterial/venous/lymphatic malformation, infection (quickly said less likely cos no fever), and offered some bilateral causes (heart, kidney, liver and quickly qualified that these would be bilateral). Was asked why I think the others are less likely...then I realise I didn't really rule them out (the history did sound quite venous at some point, and I didn't ask arterial symptoms) Then asked for familial causes of DVT, as above I could only recall factor V leiden (sighpie, patient herself keep saying deficiency - she prob has protein S or C deficiency and was trying to clue me in) The nice lady doctor gave up on traumatizing me and asked me how I would investigate and manage her during her initial presentation of unilateral lower limb swelling, and also asked how I would counsel regarding warfarin. And as the bell rang, the guy examiner asked me if I know how many times she was	My physical examination sucked, so my advice is that if you don't know what system to examine for diagnosis, just think about your differentials and examine those systems too; at least you'll have something to justify why your differentials are less likely.

		has, she gives me this weird look again, so I prompted DM, HTN, HLD and she admits to HTN but doesn't know how to pronouce her anti-hypertensives. No DM/HLD/IHD/CVA. She still has the weird look so I knew she was withholding her diagnosis and I had to dig really really really hard to get her to admit she has some strong familial history of a blood disorder - sister, mom and herself gets it in the legs, but brother gets it in the heart or lungs (she wasn't sure heart or lung actually). By this time I had taken a lot of time, so quickly went through the rest of the history boxes - NKDA, no familial cancers, had caesarean for kids and had fibroid removal in her twenties, no contact or travel history, non smoker non drinker, diet 'as normal' (but when I probed further, admitted that she needed to watch something in her diet but refused to tell me what it was argh). So by now I think you smart people would have caught on to her many hints (most importantly 'blood deficiency' and 'happens if I sit for long' and 'legs'/'heart') but I was really super blank and confused at that moment. The examiners took pity on me and asked her to show me her medications - I think her antihypertensives was nifedipine-enalapril and most importantly she was on ORAL WARFARIN so I was like omgggg it really is DVT. (and so I managed to piece her story together especially the hospitalization part which I typed previously). Went on to ask for complications of warfarin such as intracranial hemorrhage, GI bleed, bruising; she says she does have some bruising, at which I asked if bruising because of the warfarin or her blood deficiency and she was like BOTH so I was like ???SLE ???anti-phospholipid syndrome but she didn't recognize those terms and it was really obvious she knows her diagnosis. Tried to get her to say if a clotting factor was low and she weird look again, 'you doctor you need to tell me right'. And there I go forgetting protein C/S deficiency, and could only recall factor V leiden TT.TT Managed to do a bit of warfarin couselling before deciding it was high time to do examination.		hospitalized...and with horror I realize that the question crossed my mind but I forgot to ask it so I apologized. :(And I also realize that I didn't actually ask if she was compliant to her medications :((	
?Pure red cell aplasia Approach to shortness of breath, anaemia, vertigo, fever LOL Patient presents with shortness of breath	Prof Lau Tang Cheng Another doctor	Past history: 1. Chronic kidney disease - not requiring replacement therapy - complicated by anaemia; on erythropoietin injections 2. DM - on insulin therapy - medications all taken care by husband who was also there (made a mental note; good social support) 3. Previous hysterectomy	General inspection: Look for signs of chronic steroid use Conjunctival pallor (patient did not have as anaemia already resolved) Looked for lymphadenopathy, abdomen for hepatosplenomegaly DRE Look for bone marrow aspirate	Present your case Diagnosis Aplastic anemia --> only affecting the red cell line? Yes sir (Gahhh forgot an isolated red cell aplasia exists) How would you manage patient if you saw her in ED? Stabilise, rule out type 2 AMI (hmm they didn't really seem too into this)	Getting a diagnostic case is always very scary cause you don't really know if you're on the right track especially if its some interesting diagnosis and the

		HOPC: 1. SOB - 1/52, progressive, associated with reduced effort tolerance, generalised weakness - Episode that she had during work was pretty serious; saw GP who was unable to figure out what was wrong and directed her to the hospital (Episode occurred 2 years ago, so patient was well during time of exam) - worse on exertion but present at rest - present throughout day; no day/ night variation - Cardiac: No chest pain, dizziness, orthopnea, PND - Respi: No cough, hemoptysis, stridor - Fluid overload (cardiac, liver, renal): No pedal edema, ascites, anuria, frothy urine, jaundice - DKA: No abdominal pain, compliant to meals and insulin injection - Anemia: Palpitations, postural dizziness/ vertigo 2. Fever - 38 degrees for 1/7 - Probably incited the episode above - No localising source of infection: headache, running nose, cough, abdominal pain, diarrhoea, rash, joint pain 3. Postural dizziness/ vertigo - Wanted to rule out important causes before zooming in on anaemia - Central: No headache, neurological deficit/ focal weakness - Peripheral: No tinnitus, hearing loss, not episodic 4. Anemia - Already had long term history hence requiring iron replacement and injections previously --> was thinking/ half feeling super frantic; okay so something new happened that made it worst; calm down calm down - Blood loss: No malena, LBGIT, UBGIT, no vaginal bleeding (hysterectomy already done), no rashes, bleeding into joints, not on aspirin, anti-coagulation, no gum bleeding, bruises - Haemolytic: No jaundice, no G6PD, long term requirement for transfusion (only needed it for the episode 2 years ago) - Production problem: Pancytopenia - No petechiae, no regular infections, no LOW, LOA, night sweats to rule out infiltrative disease - Maturation problem: Microcytic hypochromic anemia: Iron deficiency: Vegetarian previously, had to change to meat diet (made a mental note to include this in social history),	scar Probably more things to do on PE but was quite shell-shocked to think it through at that moment	I would then also like to further work the patient up Investigations: FBC, PBF, U/E/Cr, LFT, PT/PTT, haemolytic screen: LDH, haptoglobin, direct coombs test (Was given NCNC anaemia; was reminded a few times to do investigations according to this patient) Anything else? Secondary causes: EBV, parvovirus Any antibodies you would like to do? Ahh yes i suddenly clicked after much prompting: ANA, dsDNA And finally also a bone marrow aspirate All of which was negative Patient went for transfusion, what complications? - Acute: allergic reaction, febrile haemolytic reaction, febrile non-haemolytic reaction, electrolyte imbalances, fluid overload, hypothermia, TRALI - Chronic: blood borne infections What further management? - Blood transfusion if symptomatic - Immunosuppressants Complications of steroids use? - Hirsutism, fat pads, thin skin, telangiectasia, proximal myopathy - osteoporosis, AVN - PUD - Opportunistic infections What must you check prior? - DEXA scan cause on long term steroids - Think they actually wanted to screen for infections HIV, Hep B, TB oh well What information in your history would predispose your patient to osteoporosis? - Long term steroid use? - Was thinking okay okay causes of osteoporosis; ortho come back to me pleasee - Examiners tried to clue me, but only found	examiners continue asking you questions based on your answers Please please read your approaches; even if most of the cases revolve around chronic management, it is the approaches that get you through in the long run and beyond

		Macrocytic: No chronic diarrhoea, liver, chronic alcoholism At this point concluded that it was a pure red cell line problem which could have been due to renal insufficiency, anaemia of chronic disease (patient did not have any), isolated pure red cell aplasia (did not occur to me till rather late) So went down the route of her renal insufficiency and asking a full chronic history of the kidney disease - Fortunately prof stepped in and told me to focus on the acute episode of the anaemia so started to ask what was done for her Progress: - Admitted into the hospital and told haemoglobin level was low - Asked what was done for her, was given multiple transfusions and had to be admitted a few times after - Patient mentioned she felt better after transfusions Transfusion history: - Patient not aware of pre-transfusion Hb - Will feel fatigue prior to transfusion - Asked about frequency (can't quite remember but think it was more than once per month for a few months; now no longer requires) - No transfusion reactions, associated complications, screened for HIV, Hep B infections - Does not require pre-treatment/ leucocyte reduced for transfusion And very very very thankfully prof stepped in again to tell me to ask the patient what was given for her anaemia after T.T Further progress: - Patient finally mentioned she was on steroids and cyclophosphamide but has since stopped - Screened for complications of both: Patient mentioned gaining weight and face getting rounder, no hirsutism, acne, no osteoporosis, peptic ulcer disease, declining renal function - Okay so this was probably some immune thing, i vaguely remember aplastic anaemia having to be treated in a similar manner (only aplastic anaemia affects ALL cell lines T.T); quickly screened primary and secondary causes - any new		out later dammits it was probably her THBSO How would you manage her osteoporosis? - Lifestyle management: exercise, keep active, diet modification - Calcium supplements - Consider bisphosphonates but would like to ensure no PUD, her kidney function is alright Getting a diagnostic case is always very scary cause you don't really know if you're on the right track especially if its some interesting diagnosis and the examiners continue asking you questions based on your answers Please please read your approaches; even if most of the cases revolve around chronic management, it is the approaches that get you through in the long run and beyond	

		drugs, reiterated again any new viral infections omg all of which don't have; i hope the examiners could see i was screening the causes though (examiners later asked me for SLE as a cause; lucky i asked rash and joint pain above but lol wasn't really thinking about this at this time T.T) Family history: - Nil Social history: - Does not smoke, take alcohol - Lives with husband who is main caregiver, has children but are married and does not stay with them - Good social support - Has stopped work, previously worked in NUS - Hopes to go back to work, had to stop work because of symptomatic anaemia - Coping well with diet change			
Red cell aplasia/aplastic anaemia secondary to?? infection/drug??? Approach to SOB and giddiness--> then approach to anaemia Lady complains of SOB and giddiness	Prof Lau Tang Ching who was a scowling tiger during my med sch interview and a smiling tiger during my med long case. start and end with a tiger oh well. and this dr chai (walla)	22mins history cause lady spoke so slowly and so many approaches. went down SOB route figured not infective. then giddiness approach vertignious or non vertiginous. she said spinning so went down this route for a while then realised not right she prob anyhow agreed with the word spinning so asked her if worse when sitting to standing and figured postural in nature. finally landed on prob symptomatic anaemia. so rule out causes of blood loss from every orifice in the body. rmb menses in ladies dont throw away O n G people. anyway she had a THBSO done when she 39/40yrs old no time to elicit why. then hospital where they told her HB low then BMA showed one cell line only cause i asked if total whites and platelets normal. then tried to elicit why just red cells by asking about infections hep b c hiv sle whatever nonsense. should have asked for TCM but i didnt. also through this 22mins it was a mix of piecing timeline and approach (diagnostic) cause i figured they would want to see diagnostic given the stem. and she talked so slowly..... hai anyways	3mins left to PE. a chaperone got called in cause the room had 2 guy examiners and her husband all (dirty) old men and me. then she couldnt get on the bed cause too high and she couldnt jump.... why so lousy bed one. so examine standing up. checked conjunctival pallor pale. then felt cervical LN. stated would like to feel axillary and inguinal as well. forgot to say abdo exam for HSmegaly as well. sigh was so nervous cos so little time by then. anyway PE is only 3/10 compared to history and she had no signs. she c/o some LL swelling and her feet were swollen indeed no time to go into that into the history sorry mam. so just casually mentioned during PE. PE was more like a wishlist rather than actual pe hurhur	so presented. IX: FBC, RP, LFT, haptoglobin, PT/PTT/INR, PBF, DCT then scope to rule out GI bleeding. and BMA based on fbc results. chai (walla) was active and smiling tiger passive but i heard they took turns knew both were bad cops. they wanted specifc things. so fbc if low HB they wanted what parameters to look out for forgot hypochromic microcytic cos stressed i said RDW and HCT, reticulocytes zzz. LFT (hyperbilirubinemia). asked me about cx of steroids which she previously on. said everything and pointed out she high risk of osteoporosis esp since she also THBSO hence early iatrogenic menopause. was asked how to manage this. then died a bit whern they asked why aplastic anaemia. said infection they said like what. said parvovirus b19 hep hiv etc then tC asked whats in hep panel said hbsAG then belll rang. saved by the bell.	Haem seems to be a common long case topic. maybe cos chief setting is haem dude. so know approach to coagulation, bleeding, anaemia etc well. it's really quite hard to spot so i would say consistency would be key. heard there were worse haem cases like some diamond-blackwell shit. but mostly i think if you can show u have a logical way of approaching this it should be fine even if you cant

					get the full diagnosis like who the hell thinks of esoteric things first line. all the best. typing this while in transit at taiwan to USA. wheeeee

Adult Medicine – ID / Gen Med

Hepatic tuberculosis Approach to loss of weight This patient presents with LOW. Please take a history		Epidemiology - 61YO - Male HOPC - LOW 5 years ago x 6 months duration (6kg over 6 months) - Associated with LOA, night sweats, chills and rigors - Systemic review otherwise normal - no SOB, abdominal pain etc. - Presented to polyclinic > Referred to NUH > HIV + TB + OGD + Colonoscopy normal > CT head thorax abdomen pelvis > 3 focal lesions in liver > biopsy done shown not cancer > started on 4 medications for 2 months > 2 medications for 4 months in NUH (previously treated in Gleneagles but 2 medications only - symptoms did not improve) (apparently TB liver can be treated at home no need polyclinic DOT) > FINALLY said that he had TB liver and was told by doctor to be definitively cured at 6 months - Experienced side effects of medications - hiccupping, discoloration of urine > NO hepatotoxicity, thrombocytopenia, peripheral neuropathy, loss of colour vision, gouty flares - No risk factors for TB liver including immunosuppression (steroids, immunosuppression, DM, HIV), previous organ transplant, previous TB episodes *Did not ask about travel/contact history as not common risk factors for TB liver - Not on any current follow up	Respiratory examination - normal Abdominal examination - normal Cervical lymph node examination normal	1. What are his issues 2. What would your differentials have been at the start (malignancy (described all the common types), infection (TB, HIV), hyperthyroidism, chronic illness (respiratory pathologies (COPD, bronchiectasis, lung CA, ILD), intra-abdominal pathologies (IBD, other rarer types causing malnutrition)), rheumatological causes (less likely because elderly and male), poorly controlled DM) 3. What would you have looked for on physical examination - cachexia, abdominal examination, respiratory examination, cervical lymphadenopathy 4. What are the signs of hyperthyroidism 5. How would you have worked this patient up - up/down scope, CXR for malignancy, CXR for TB (consolidation, cavitation, hilar lymphadenopathy), HIV screen, TFT, FBC, RP, ESR/CRP 6. Any other problems you are concerned about - voiced out that no financial social or psychosocial issues, concerned about newly detected kidney problem, need screening for all other DM complications "I am done. You have anything else for him?"	Relax in abnormal cases, just take 8 boxes of history and hopefully it'll be fine. In the end its your luck with examiners so just pray

		- *Did not ask signs of CLD as TB liver not common cause of CLD PMHx - DM well controlled on medications (unsure), last HbA1C 7.2%. Recently found to have ?abnormal urine results (microscopic proteinuria). No other complications (retinal, neuropathy, AMI, stroke, PVD). No DM emergencies (DKA HHS hypoglycemia) - HTN well controlled on medications (unsure), - HLD well controlled on medications (unsure) Drug history - No allergies - Drugs as mentioned above Family history - Nil Social history - Non-smoker - Non-drinker - No financial, psychosocial problems Surgical history - No history of surgery - TB liver treated conservatively, no liver resection, no percutaneous drainage		Passive examiner 1. Maybe name a few more causes of LOW (pheochromocytoma, diabetes insipidus, adrenocortical insufficiency (needed massive prompting)) 2. What is the histology of TB iver (non-caseating granulomas)	