

Revision spots

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A patient presents with the lesion shown. The lesions could not be scrapped off the tongue by a wooden spatula. Choose the false statement

(CHECK OTHER ORAL LESIONS IN RVD)
herpes, stomatitis, PPEs, KS, ect

Diagnosis: Oral hairy leukoplakia

Vs Oral candidiasis: usually florid, oral-opharyngeal,
Easily scrapped off.
Other ddx- SCC tongue, lichen planus, smoker's leukoplakia



Agents: EBV** (increased risk in immunocompromised states including solid organ transplant patients)

**oral red/white lesions in SLE?
Also check tylosis palmaris (esp in those with dysphagia)

- A) HIV status of patient is important contributor
- B) Aetiological virus is epstein barr virus
- C) Specific treatment is usually not indicated
- D) It represents a premalignant lesion for SCC of the tongue

(Usually requires rx to prevent progression to SCC)

A known HIV patient presents with above skin lesions a few weeks after initiation of 2nd line HAART. He has had a HB of 6g/dl and is known to have CKD. Which of the following is the most likely culprit drug

ADR dermatologic (SJS/SJS_TENoverlap/TEN)
Skin failure syndrome (>30% BSA)



A) nevirapine

Also check IRIS/ Rx failure
AEs of HAART
Drug regimens changes

B) Ritonavir

C) AZT

D) Efavirenz

E) Abacavir ABC hypersensitivity (HLA b5701)

Choose the correct statement(s)

Leprosy (most likely lepromatous/multibacillary)- multiple lesions (>5), diffuse including head&neck, delayed neuro-involvement



- a) This is tuberculoid leprosy Clofazimine not used
- b) Lesions are multibacillary
- c) Lepromin skin test would be negative
- d) Treatment of choice includes rifampin Dapsone, rifampin, clofazimine (WHO recommended combination)
- e) Dapsone is contraindicated in this subset of patients Check other skin lesions (ddx for papillosquamous lesions)

The deformity shown is described as

SWAN NECK DEFORMITY (CHECK OTHER LESIONS IN RA/ SLE/ SYST SCLEROSIS/ SJOGREN)
ANKYLOSING SPONDYLITIS/ SACROILIITIS

- a) Boutonniere
- b) Swan neck
- c) Bouchard nodes
- d) Herbedeen nodes



Types of ankylosing spondylitis and its radiographic features

The next single most important test in this patient would be

Complications of CKD (Acute vs chronic)
Indications of RRTs
ECG in CKD



- A) 24 hour urine protein proteinuria, ?cause
- B) Renal ultrasound Increased echogenicity, loss of CMJZ, other lesio
- C) Complement C3 levels (Hypocomplementemia in SLE?)
- D) Urine red cell casts Tubular injury (deformed red cells)
- E) UECs (Deranged in tandem with CKD) moderate elevation cr/urea, hyponatremia, hypocalcemia, hyperkalemia)

Differentials:

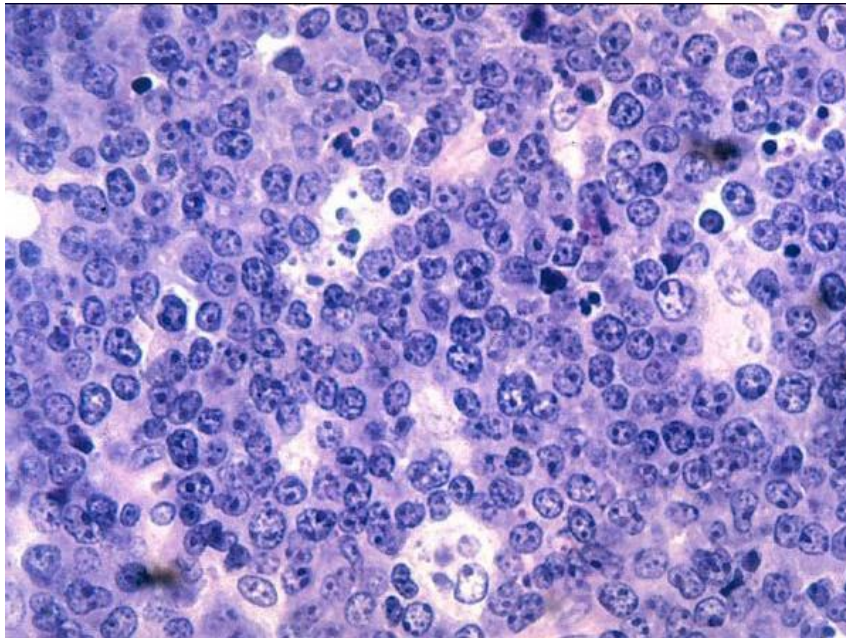
- a) Renal- nephrotic syndrome (causes?)
- b) Cardiac- congestive cardiac failure
- c) Hepatic- CLD with hypoalbuminemia
- d) Endocrine- Hypo/hyperthyroidism, Conns, etc
- e) Hypersensitivity rxns- e.g angioneurotic edema
- f) Rare: bilateral pre-septal cellulitis

The BMA film was described as starry sky appearance. The diagnosis is

Hodgkins lymphoma

Subtypes: lymphocyte predominant, nodular sclerosis,
Lymphocyte depleted, mixed type

Check: NHL (esp DLBCL, mediastinal, SVC syndrome)



- A) Burkitts lymphoma
- B) Hodgkins lymphoma
- C) Non hodgkins lymphoma
- D) MDS

DDx for massive splenomegally?
BMA and PBF findings in AML, CML

Stigmata of CLD The most likely chronic disease in this patient is

- a) COPD
- b) CKD
- c) LIVER CIRRHOSIS
- d) CCF



Gynaecomastia in CKD (hyperestrogenism due to reduced metabolism of estrogen)

A patient who has a recent cut wound on the foot presented as shown

Profound generalized tetany
(Opisthotonus)

DDx

1. Infections- C. Tetani
2. Neuro with convulsions (?causes)
3. Metabolic (hypocalcemia etc)
4. Drugs (e.g trigger or lower seizure threshold)



Open fractures

Ventilatory support (indications/ ICU admission)

Neurotropic infections (incl polio, VZV/ Herpes etc)

a) A vaccine is curative at this stage

Not really, need Ig therapy

b) Patients requires aggressive antibiotic treatment

might exacerbate due to release of more toxin

c) Disease is mediated by a toxin called tetanolysin

Tetanos pasmin

d) The toxin largely affects GABAergic neurons

True (Inhibits NT release; net excitatory effect)

e) Areas close to the wound are least affected

Condition(s) likely to present with the feature shown

Diagnosis: Peripheral cynaosis

In reynaulds- check colors, temperatures, triggers- cold



A) SLE

B) Scleroderma

C) Buerger's disease Thrombocytitis obliterans

D) Diabetes mellitus Peripheral artery disease

E) All the above

ALL OF THE ABOVE

The most sensitive test for the condition shown would be

Malar rash

Primary lesion- patch/ plaque

Secondary lesions- serum crusting

Color- erythematous

Distribution- Photodistributive

DDx- SLE, Mitral facies, psoriaform lesions



- a) Anti ds DNA
- b) ANA
- c) Anti sm antibodies
- d) ANCA

The most sensitive- ANA (upto 95%)

The most specific- Anti-Ds and anti sm Abs

Diagnostic criteria RA and SLE.

Choose the most sensitive diagnostic test in this protozoal disease

Dx- Leishmaniasis (amastigotes)

Lab-

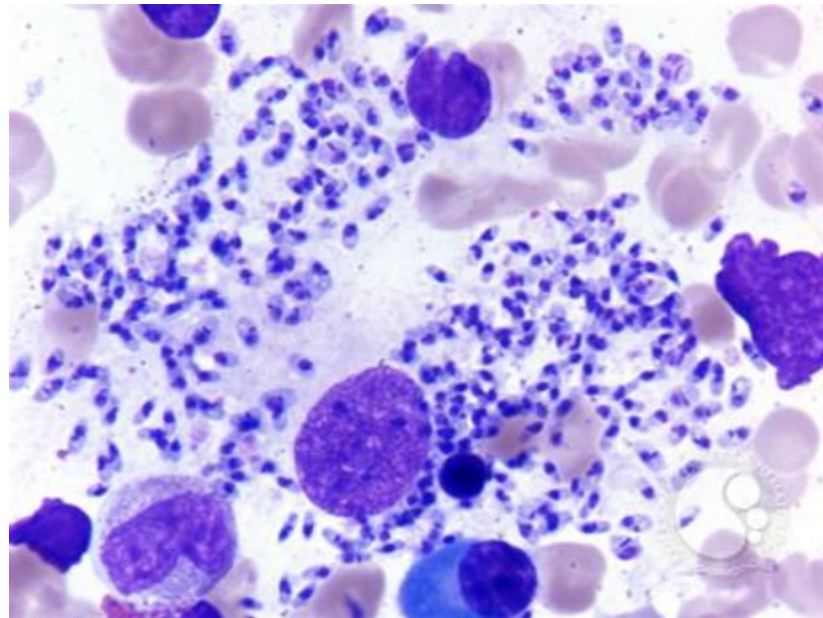
a) FHG- leucocytosis, eosinophilia

b) BMA- amastigotes

c) rk-39 antigen

Mx- Pentavalent antimonial drugs (stibugluconate)

2nd line- Amphotericin B, Paromomycin



Blood-borne parasites- plasmodium, babesia

A) PBF

B) BMA **Most sensitive**

C) Liver biopsy

D) Splenic aspirate **Risk of aspirate**

Concerning the radiograph shown all are true except

Key features:

1. Increased radiolucency
2. Increased lung fields (vertical and transverse)
3. Subtle flattening of diaphragm
4. Reduced vascular markings



Gold A, B, C and D (categories based on mMRC/exacerbations)
Stages based on FEV₁ vs expected

Diagnosis: COPD

Risk factors: age, smoking, family history, envr (biomass) etc

Diagnostic tests: FEV₁/FVC <70%; FEV₁ <80% of predicted

- a) Smoking is a major risk factor
- b) Asthma is a differential diagnosis COAA (a form of COPD)
- c) Spirometry shows reduced total lung capacity (increased in emphysema, normal in chronic bronchitis)
- d) FEV₁/FVC ratio less than 80%

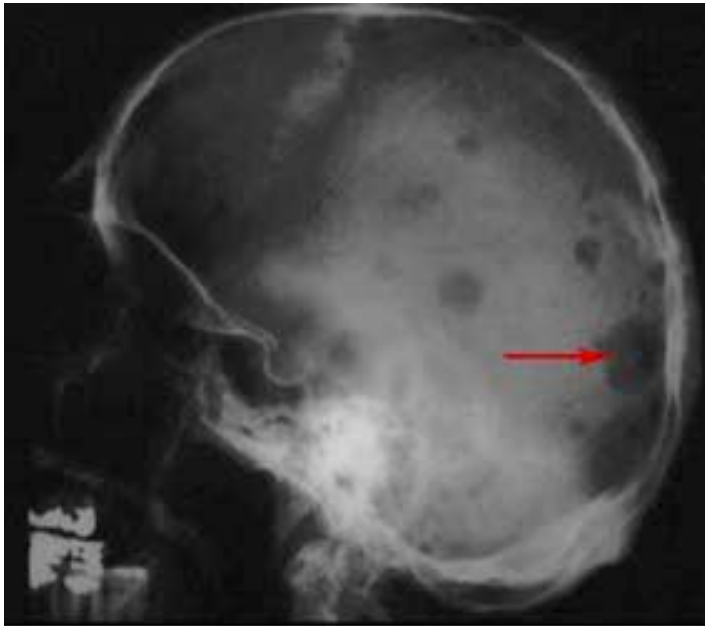
The next most important test to make a diagnosis would be

Osteolytic lesions (copper beaten/ punched lesion) in MM

Answer- Serum protein electrophoresis to demonstrated M spike

Others- urine (Bence Jones proteins)

BMA- Hypercellular marrow with plasma cells



- a) Pelvic Xray
- b) Serum protein electrophoresis
- c) Bone marrow aspiration cytology
- d) Urine protein electrophoresis

CRAB- hypercalcemia, renal impairment, anemia, bone pains

Causes of renal failure in MM

Cord compression

Treatment

Infection by the parasite whose ova is shown



- a) Associated with SCC of the bladder
- b) Adult lives in the mesenteric plexus
- c) Biomphalaria snail is the intermediate host
- d) Drug of choice is sodium stibogluconate

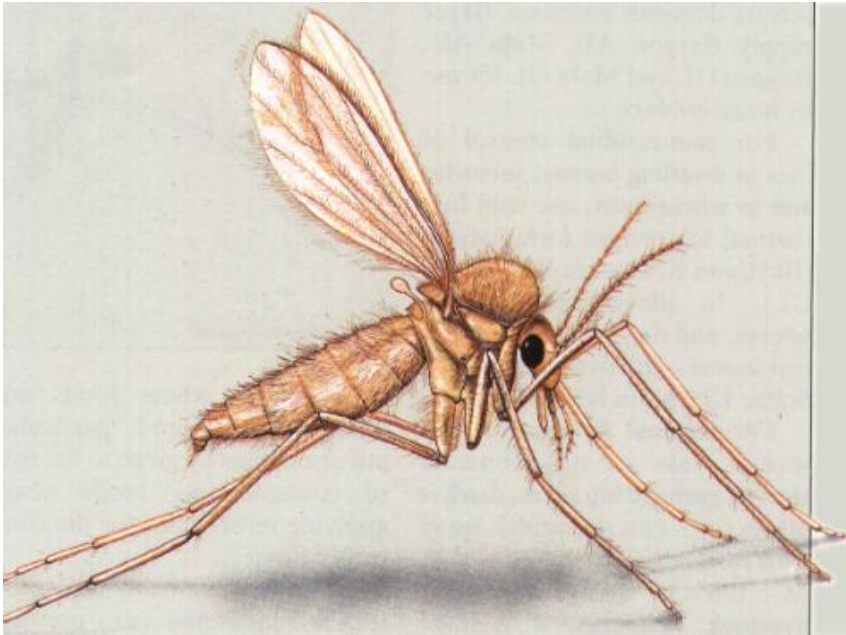
Snail shown is intermediate host for

- a) *S. japonicum*
- b) *S. hematobium*
- c) *S. mekongi*
- d) *S. Mansoni*



Vector for

- a) *Trypanosoma cruzi*
- b) *Trypanosoma brucei*
- c) *Leshmania donovani*
- d) Malaria

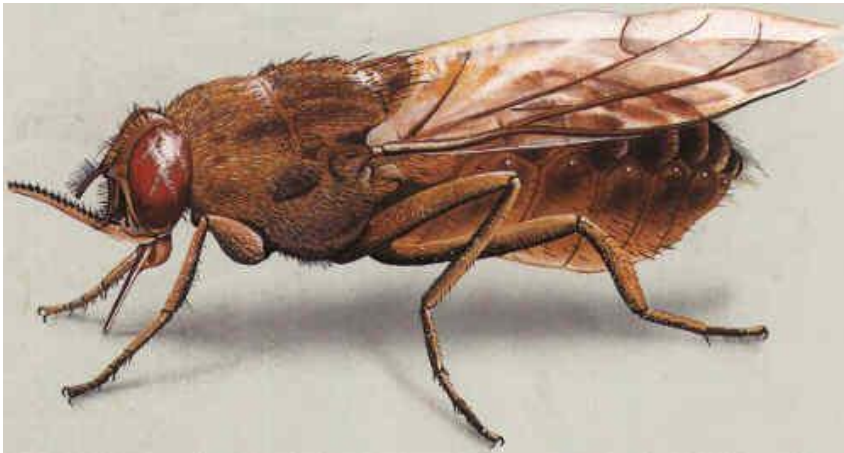


Disease caused by the parasite transmitted by this vector causes complications in which of the following three sets of organs



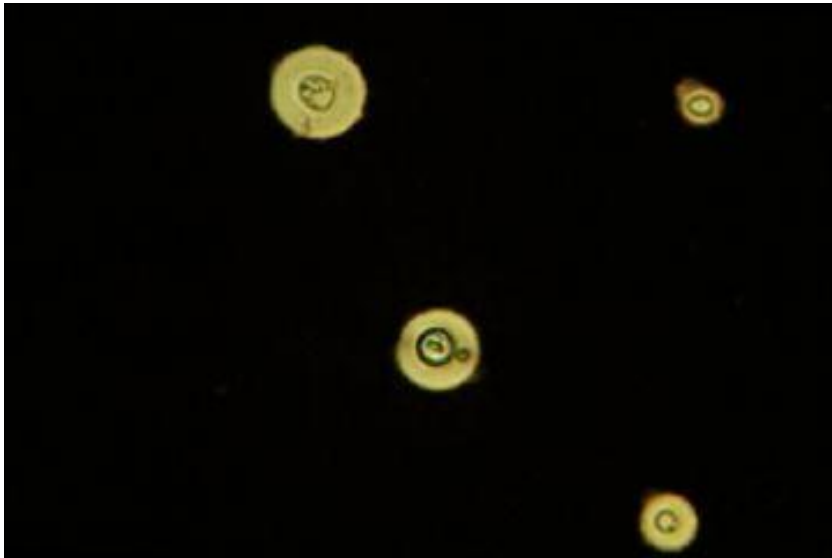
- a) brain, colon, heart
- b) Heart, stomach, liver
- c) Liver, spleen, bone marrow
- d) Colon, esophagus, heart

Which is not a drug used to treat the disease caused by this vector



- a) Melasorprol
- b) DEC
- c) Suramin
- d) Eflornithine

Concerning the organism shown which was isolated from csf of a HIV patient



- a) CD 4 count is above 500
- b) Living with a cat is a risk factor
- c) Visual loss is common if left untreated
- d) Organism infects the brain
- e) Septrin is the prophylactic drug of choice

The cranial nerve involved is

- a) Oculomotor
- b) facial
- c) Optic
- d) Abducens

