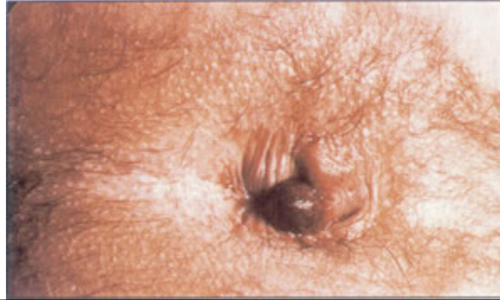
A 30 year old woman comes in to A&E complaining of abdominal pain. She is 32 weeks pregnant and has been feeling unwell for a couple of days with pain coming on more severely today. She feels nauseous and her appetite is down but she has not vomited. What factors make a diagnosis of abdominal pain more difficult in pregnancy? 4 points

| *Anatomical differences- certain organs get displaced,*<br>*Peritonism less likely- peritoneum gets pulled off its usual place*<br>*WCC is raised,*<br>*Presentation tends to be delayed*<br>*Imaging is more difficult*<br>*Presence of abnormal organs- e.g. placenta, enlarged uterus*<br>*Presence of foetus- additional source of potential pain* |
|---|
| On examination the lady has diffuse abdominal tenderness maximal in the RUQ. What are the 2 most likely diagnoses? 2 points |
| *Cholecystitis*<br>*Appendicitis* |
| What would be the investigation of choice to distinguish between the 2? 1 point |
| *USS* |
| List 3 factors which would make you think of an obstetric rather than surgical cause of pain in a woman in 3rd trimester of pregnancy. 3 points |
| *PV bleed*<br>*Foetal distress*<br>*Absence of foetal movements*<br>*Absence of foetal HR*<br>*H/O lower abdominal trauma*<br>*Waters breaking*<br>*Visible foetal parts PV* |

A 23 year old girl comes in to A&E C/O L breast pain. The pain started 3 days ago and it got so bad yesterday that she was unable to feed her 5 week old son. On examination she has a large area of erythaema over the medial aspect of the breast. The skin feels firm and indurated, it is very tender.
What is the likely diagnosis? - 1 point
What advise would you give her? - 2 points
How would you treat it? - 2 points

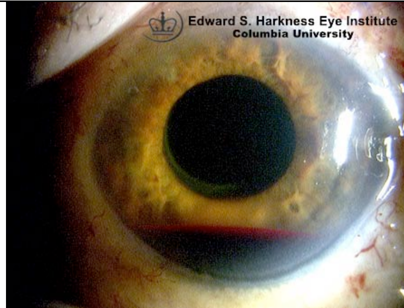
| *Mastitis*<br>*Carry on feeding, warm compress, plenty of analgesia, return if symptoms worsen or notices discharge from nipple other than milk.*<br>*Flucloxacillin 500 mg QDS for 7 days +/- phenoxymethyl penicillin- 250 mg qds* |
|---|
| What features in history or examination would point towards an abscess? 3 points |
| *Fluctuant mass*<br>*Discharge from nipple or the mass*<br>*Very localised*<br>*Nipple inversion*<br>*History of previous abscess*<br>*One point each* |
| How could you treat a breast abscess in A&E? 1 points<br>What investigation could you use to help the management?- 1 point |
| *Needle aspiration and antibiotics, 1/2 point for referring to surgeons*<br>*USS to guide the needle* |

40 year old man presents with 6h history of sudden onset of severe stabbing pain in his perianal region.
What is the diagnosis? 1point
How would you treat it? 1 point



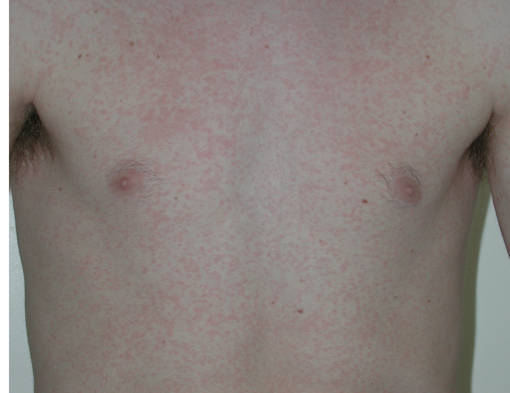
*Perianal haematoma*
*I&D or conservatively*

This man was hit in the eye yesterday. What is the diagnosis? 1
What grade is it? 1



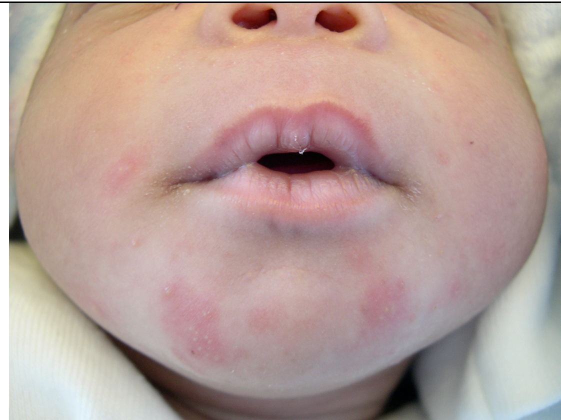

*Hyphaema*
***Grade 1 - Layered blood occupying less than one third of the anterior chamber***
*Grade 2 - Blood filling one third to one half of the anterior chamber*
*Grade 3 - Layered blood filling one half to less than total of the anterior chamber*
*Grade 4 - Total clotted blood, often referred to as blackball or 8-ball hyphema*

This 18 year old young man was started yesterday on amoxicillin for ? tonsillitis.
What is the true diagnosis? 1 point
What caused the rash? 1 point

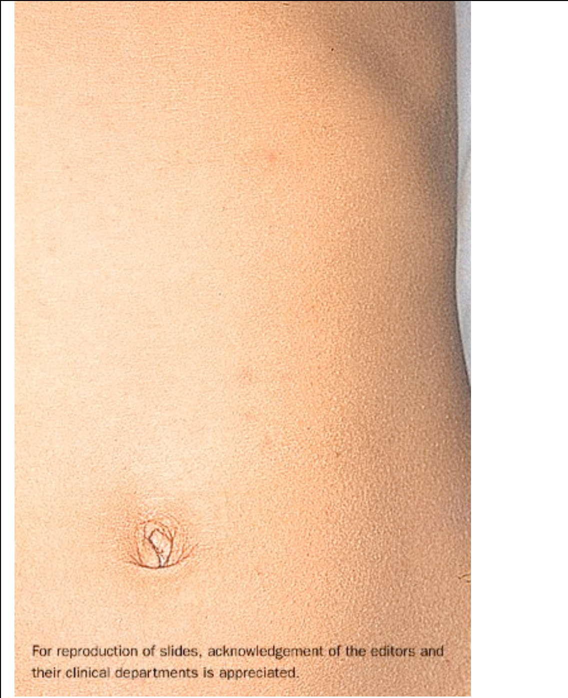


*Infectious mononucleosis*
*Amoxicillin reaction*

This 4 day old bay was brought in by his 17 year old mum concerned about the rash. He was a FTB, NVD, being breast fed. Apyrexial, good appetite, sleeping well etc.
What is the diagnosis? 1 point
What is the treatment? 1 point



*Erythaema Toxicum Neonatorum*
*No Rx- observe*

<table>
<tr>
<td>A 20 year old man comes to A&E complaining of being generally unwell. 3 weeks ago he returned from Papua New Guinea, where he'd been on Raleigh International for 3 months building a bridge to a village in the middle of a forest.<br>He started feeling unwell last week and developed a rash. His GP diagnosed a viral illness but he is feeling worse and worse.<br>On examination he is pyrexial 40, has slightly distended abdomen and palpable spleen. The rash is easily blanching.<br>His bloods are:<br>Hb 11, WCC 15, plat- 80<br>Na 130, K 3.3, Ur 8, Cr 140,<br>GGT 200, ALP 75, Bili 40<br>What is the likely diagnosis? 2 points</td>
<td>
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<tr><td colspan="2">Typhoid fever</td></tr>
<tr><td colspan="2">What is the investigation of choice to confirm the diagnosis? 2 points<br>Who would you manage this patient and what particular precautions do you need to take? 5 points</td></tr>
<tr><td colspan="2">Bone marrow aspirate<br>IV access, IV fluids, Blood cultures, start antibiotics- $3^{rd}$ gn cephalosporin or ciprofloxacin, refer to infectious diseases<br>Very thorough hand hygiene</td></tr>
<tr><td colspan="2">What else do you need to do once the patient has left the department? 1 point</td></tr>
<tr><td colspan="2">Notifiable disease</td></tr>
</table>

68 year old man is brought in by ambulance. He has been complaining of abdominal pain for the last 4 days. Pain has gradually been getting worse and his GP prescribed him senna yesterday. Today he started vomiting profusely and is unable to keep any food down. He has not opened his bowels for 5 days.
PMH – hypertension, mild arthritis, he had a Laparotomy 30 years ago following a motorcycle accident, which left him with a limp.
DH- atenolol, thiazide diuretics and enalapril
His HR is 80 with a BP of 100/75, he looks sweaty and pale. His abdomen is distended and generally tender with no guarding with loud bowel sounds.
Describe how you would manage this patient initially. 3 points

| |
|---|
| *Oxygen,*<br>*IV access & IV fluids – N Saline 1 litre stat,*<br>*analgesia- morphine IV –*<br>*1point for mentioning each of these* |
| Name 6 investigations you ought to order which could alter your<br>immediate management. 3 points |
| *Abdo X-ray,*<br>*Chest X-ray,*<br>*ECG,*<br>*Ca,*<br>*amylase,*<br>*U&Es,*<br>*blood gases*<br>*½ point each* |
| Diagnosis of small bowel obstruction is confirmed. Describe your management from then on. 4 points |
| *NGT,*<br>*continue IVF- wait for K+ results to see whether you need to give any to pt, he might be in renal failure*<br>*catheterise,*<br>*refer to surgeons for further treatment*<br>*analgesia PRN in mean time* |