Fellowship SAQ 2017\_Eyes ENT Derm

**Question 1**

**A 72 year old man presents with acute painless loss of vision.**

**P 100**

**BP 190/99**

**Sats 99%**

**RR 18**

**T 37.1**

i) List six (6) potential causes of his visual loss you will consider (6 marks)

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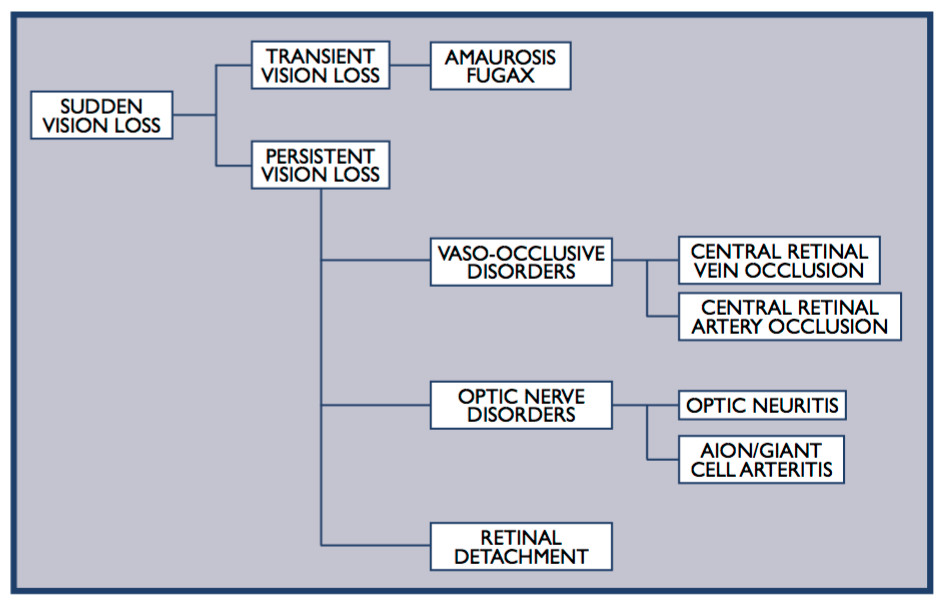
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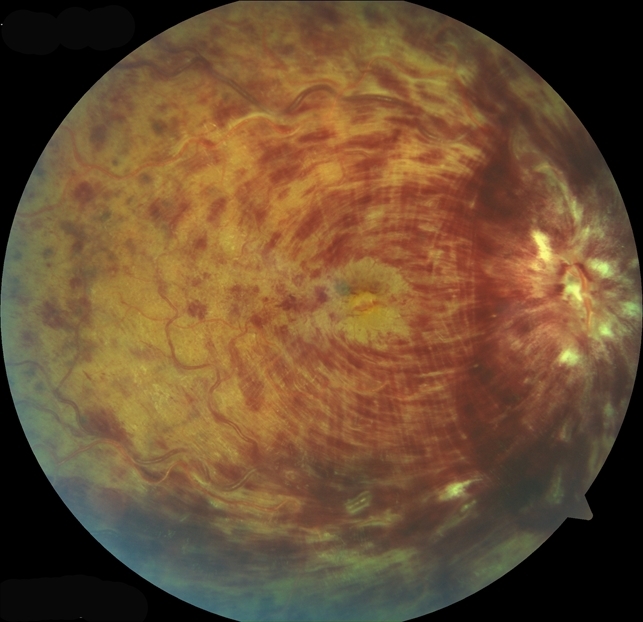
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Methanol Toxicity

Hysterical Blindness ??

**His fundi is shown in the image below**



ii) List three (3) abnormal features on this fundal image (3 marks)

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Cotton Wool Spots

Superficial Flame Haemorrhages in 4 quadrants

Dot and Blot Haemorrhages

Optic disc oedema

Macular oedema

iii) Aside from advancing age, list four (4) risk factors for this condition (4 marks)

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Hypertension

Hyperviscosity e.g. FV leiden/protein c/s def/hyperhomocysteine/myeloproliferative disorders

DM

Atherosclerosis

Glaucome/Increased IOP

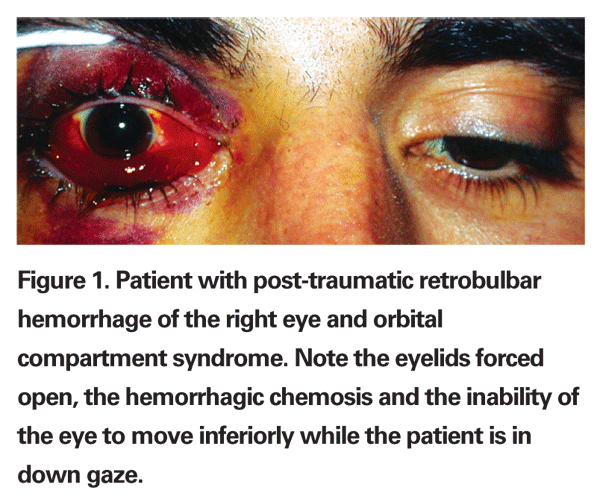
OCP

Possibly smoking - although not proven

**Question 2**

**A 32 year old man presents intoxicated. He is complaining of visual loss, eye pain and a headache. He cannot recall the events of the last 24 hrs. V/A 6/60 RIGHT, 6/9 LEFT. No correction with pinhole. He has no other obvious external injuries**

**His clinical photo is shown below**



i) In the table list five (5) acute diagnoses or complications that you need to exclude, with the expected additional clinical examination findings for each diagnosis (if any) (10 marks)

|  |  |
| --- | --- |
| **Diagnosis/Complication (5 marks)** | **Clinical Findings (5 marks)** |
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| --- | --- |
| **Diagnosis/Complication (5 marks)** | **Clinical Findings (5 marks)** |
| Orbital Compartment Syndrome | Proptosis, hard/firm eyeball, raised IOP (>40mmHg), RAPD |
| Retro-orbital Haematoma | Sometimes proptosis or above signs if raised IOP |
| Blowout fracture/other facial fractures | Entrapment of EOM – diplopia, paralysis of gaze esp upward, facial bone tenderness, sunken eye/enophthalmos |
| Ruptured Globe | Sunken or misshaped eye, positive seidel test, |
| ICH | GCS lowered, focal neurological defecits, papilloedema and cushings if raised ICP |
| Skull/BOS fractures | Palpable defect, haemotympanum, racoon eyes, battle’s sign |
| Infraorbital Nerve Damage | Reduced sensation to the maxillary area |
| CSpine Injury | Neuro defecits (state which), midline tenderness |
| Corneal Laceration | Slit lamp findings with fluorescein |
| Hyphema |  |
| Lens Dislocation |  |
| Traumatic Iritis |  |

ii) His Intraocular pressure is 50mmHg. List the name and technical steps of the procedure you will perform. Excluding explanation and consent (8 marks)

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Lateral Canthotomy

Asepsis, position supine

Lateral canthal lignocaine infiltration +/- sedation +/- topical amethocaine

Crush lateral canthus with forceps for haemostasis

Cut the lateral canthus with small scissors towards orbital rim

Find inferior canthal ligament by feel or direct vision and cut

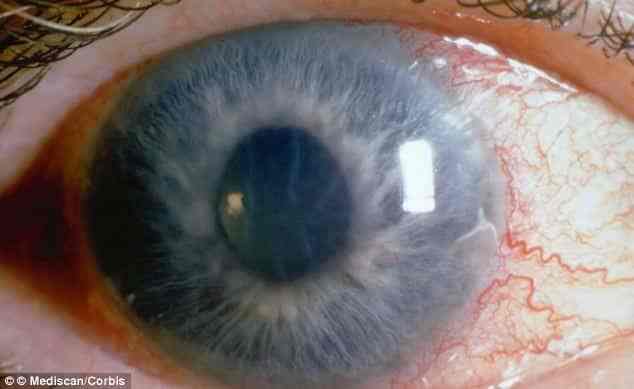
Recheck IOP

Repeat with superior crus if pressure remains high

**Question 3**

**A 62 year old female presents with a painful red eye and a headache**

**Her clinical photograph is shown below**



i) List the **MOST** likely diagnosis (1 mark)

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Acute Angle Closure Glaucoma

Cannot just state “glaucoma”

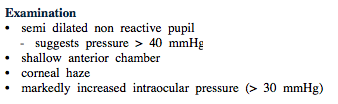
ii) Outline four (4) classic examination findings (4 marks)

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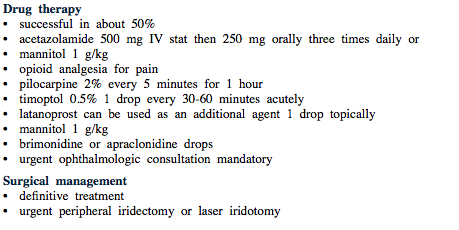
 Ref: Dunn

iii) In the table list four (4) pharmacological treatments (with dose and route) that you can employ in this setting to correct the underlying pathological process (12 marks)

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| **Pharmacological Agent** | **Drug Class** | **Dose and Route** |
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| --- | --- | --- |
| **Pharmacological Agent** | **Drug Class** | **Dose and Route** |
| Acetazolamine | Carbonic Anhydrase Inhib | 500mg stat IV then 250mg po tds |
| Mannitol | Osmotic diuretic | 1g/kg IV |
| Pilocarpine 2% | Cholinergic Agent | 1 drop every 5 mins for 1 hr |
| Timolol 0.5% | BBlocker | 1 drop every 30-60mins |
| Latanoprost | Prostaglandin analogue |  |
| Brimonidine/Apraclonidine | Alpha-2 agonist | 1-2 drops stat |

Cant have analgesics/antiemetics as don’t correct the raised IOP



iii) List three (3) potential precipitants for this condition (3 marks)

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Topical Mydriatics - tropicamide

Anticholinergic drugs/Sympathomimetic agents

Emotional stimulation

Accomodation – reading

Dim lights – e.g cinema

**Question 4**

**A 76 year old obese man presents with epistaxis. He is awaiting investigation for 10kg of weight loss in the last 6 months. He has AF and is on rivaroxaban and metoprolol. He has been in the resus room with a nurse effectively pinching his soft septum for the last 15 minutes, without effect.**

**P 90**

**BP 100/60**

**Sats 92%**

**RR 26y**

**T 37.0**

i) List five (5) stepwise treatments you will employ **IN THE EMERGENCY DEPARTMENT** to stop the bleeding (5 marks)

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Add co-phenelcaine spray as a vasoconstrictor and to anaesthetise in preparation for rapid rhino/packing

ICE

Cautery of any visable bleeding vessels with silver nitrate

Topical tranexamic acid

Procoagulant foams/gels

Rapid rhino – anterior and posterior sizes available

Formal packing – UNILATERAL THEN BILATERAL IF FAILS (requires opiate analgesia +/\_ sedation)

Foley Catheter – 7mls + 7mls in balloon of 10-14F, with anterior traction

Note – reversal of rivaroxaban is not possible

ii) All measures fail and the heavy bleeding continues, the patient requires intubation due to haemodynamic instability and an inability to protect his airway. There is insufficient time to wait for ENT or anaesthetics to attend.

List six (6) measures you can employ during intubation to minimise peri-intubation complications (5 marks)

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Ramping/positioning upright until ready to pass ETT

Apnoiec oxygenation with HFNP

2 suction catheters/yannkeurs in the airway during attempts to intubate

Most experienced operator

Use of fluid preloading

Use of metaraminol to prevent hypotension

Appropriate dosing of hypotensive agents e.g. reduced dose propofol

Use of ketamine to avoid hypotension

Use of intubation checklist

Suction blood from stomach with NG prior to intubation

Cricoid (controversial) – this answer is best avoided

Use of VL – can be problematic in ++airway bleeding as camera gets bloody and obscures view

**Question 5**

**A 4 year old boy presents to ED with neck pain and refusal to eat for 3 days. There is no history of trauma. He has no respiratory distress. He has IV access in place and appropriate pathology tests have been sent. Maintenance iv fluids are running.**

**P 120**

**BP 100/60**

**Sats 100% RA**

**RR 26**

**T 37.9**

**His lateral CSpine XRay is shown**



i) List the two (2) **MOST** abnormal features on this XRay

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Abnormal alignment with pseudosubluxation C2/3

Soft tissue swelling in retropharyngeal space

ii) List your **MOST LIKELY** diagnosis and two (2) differential diagnoses (3 marks)

MOST LIKELY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Retropharyngeal Abscess

Retropharyngeal mass – benign or malignant tumours – Adenopathy/lymphoma

Occult trauma/NAI with spinal cord injury

iii) List your next actions in ED (5 marks)

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Immediate ENT/anaesthetics referral – needs drainage in theatre

Arrange CT scan ONLY if the patient is able to lie flat without airway compromise

Sit up / position of comfort

Symptom control - analgesia, antipyretics,

Antibiotics – Ceftriaxone 50mg/kg (up to 1g) IV

Disposition to HDU/PICU pending operative management

Doesn’t need immediate airway intervention in ED given the stem – appropriate to mark the neck/involve anaesthetics but shouldn’t be intervening in ED given high risk airway that is better managed with a gas induction in OT when the time for surgery comes.

**Question 6**

**A 23 year old female with schizoaffective disorder presents with difficulty swallowing. She is refusing to talk and is trying to leave the department. She appears to be in pain. She has evidence of auditory hallucinations. She has an IV canula and maintainence fluids running.**

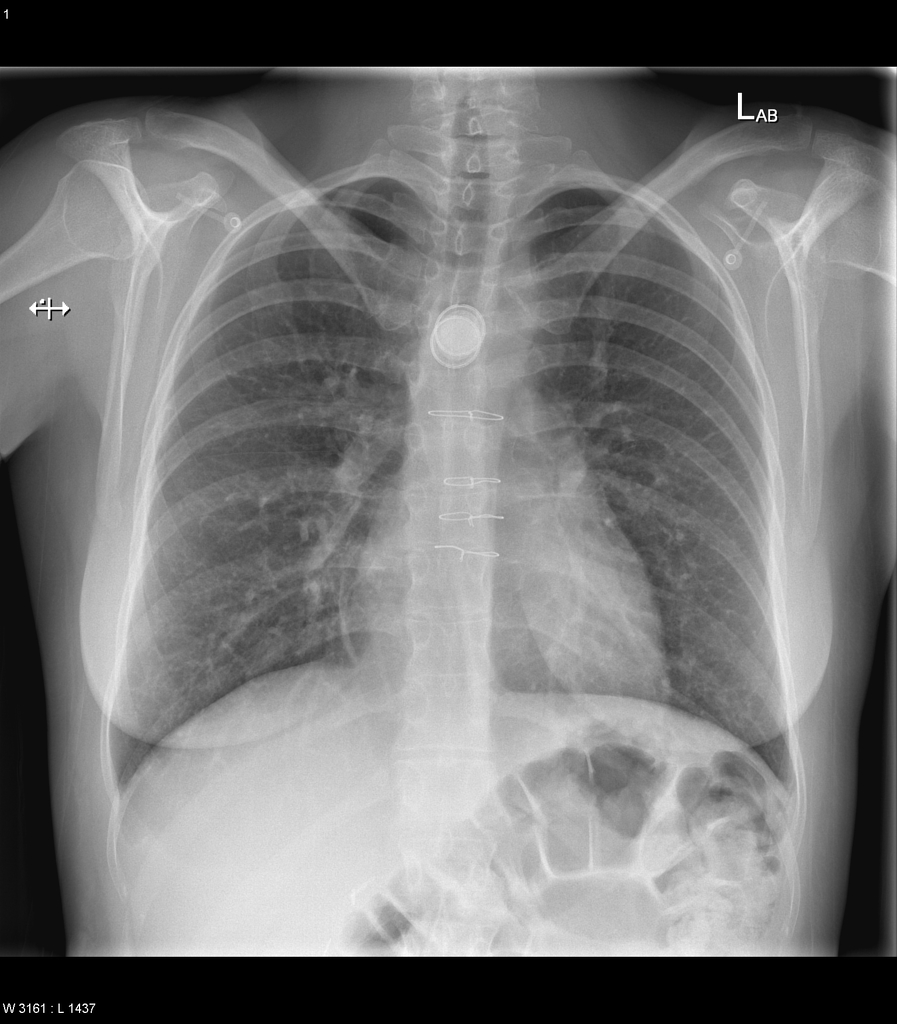
**P 130**

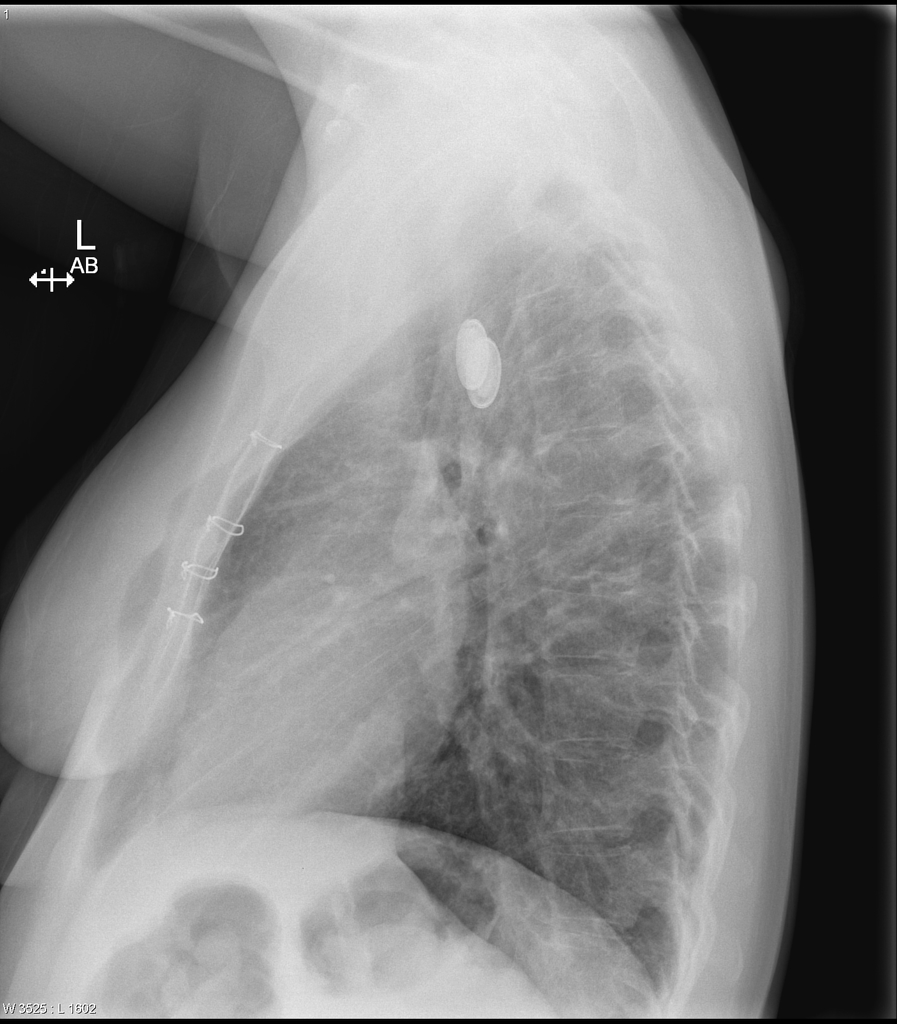
**BP 100/60**

**Sats 96%**

**RR 30**

**Temp 38.1**





i) List three (3) abnormal radiological features and their significance (3 marks)

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2 metallic FBs in the mid oesophagus – double ring sign c/w button batteries

Likely oesophageal as oriented in coronal plane

Sternal wires c/w previous sternotomy

ii) List four (4) potential complications associated with this presentation (4 marks)

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Mucosal burns

Perforation – can lead to sepsis/mediastinitis

Tracheoesophageal fistula

GI or resp Obstruction

Respiratory compromise due extrinsic pressure on trachea

Stricture

iii) The patient is trying to leave the department, list the actions you will take in the further management of this patient (5 marks)

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**1. Manage psychiatric disturbance -** Attempt to verbally deescalate **-** Involve security/patient safety officer/family **-** Section under the mental health act/detain under common law

May require sedation/take down to avoid patient leaving - e.g. droperidol/midazolam

**2. Plan to remove button battery** - Urgently contact anaesthetics and ENT or general/GI surgeons – button battery needs to be removed asap

**3. Symptomatic relief** - Analgesia - titrated IV opiates and antiemetics

**4. Prepare or OT –** NBM – IV fluids – pre-op safety with ECG/VBG/panadol

**5. Antibiotics -** Amp/Gent/Metronidazole – high risk of perforation/mediastinitis

**Question 7**

**A 5 year old girl presents to ED with a rash and a sore mouth.**





i) Describe the abnormalities seen in the clinical photographs (3 marks)

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Mucosal ulceration to the mouth

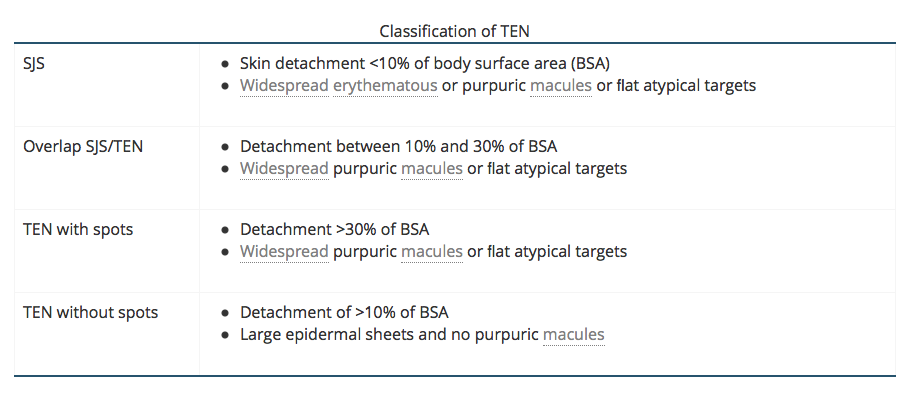
Multiple well defined, shallow erosions to the face and upper chest with some crusting

Target lesions on lower legs

ii) In the table below list the 3 variants of the condition shown in the photograph, from least to most severe, with the defining skin and mucus membrane characteristics, and the treatment (12 marks)

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **Skin involvement/BSA%** | **Mucosal Involvement** | **Treatment** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **Skin Features/BSA%** | **Mucosal Involvement** | **Treatment** |
| Erythema Multiforme | Target lesions, absence of epitheial loss | Single mucus membrane inv. | Nil specific  Withdraw offending agent |
| SJS | <10% BSA, target lesions, epithelial loss | >1 Mucus membrane | Saline MW  Topical steroids (betamethasone)  Burns care  Avoid systemic steroids |
| TEN | >30% BSA, epithelial loss | Often involved | Burns Care  IVIg  Ciclosporin  Avoid parenteral steroids |



ii) List four (4) potential categories of precipitant for the condition seen in the clinical photos, with an example of each (8 marks)

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**Drugs** – NSAIDS, penicillins, cephalosporins, sulphonamides, phenytoin, carbamazepine, allopurinol, lamotrigine

**Infections** – Herpes, Mycoplasma, HIV

**Cancer –** lymphoma, leukaemia

**Immunisations –** measles, Hep B

**Question 8**

**An 8 year old boy presents with a rash. The working diagnosis from the GP is Henoch-Schoenlein Purpura**

**P 100**

**Sats 99%**

**RR 22**

**Temp 37.0**



i) List five (5) differential diagnoses for this rash (5 marks)

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Meningitis/Meningicoccal sepsis

Other infections – strep, H.Inf, IE, influenze, measles, parvo

DIC secondary to sepsis

Platelet disorders – ITP, TTP, HUS

Leukaemia –

ii) Complete the table below with the defining features of HSP for each system (7 marks)

|  |  |
| --- | --- |
| **System** | **Exam Findings or Complications** |
| **Vitals** |  |
| **Joints** |  |
| **GIT** |  |
| **Skin** |  |
| **Neurological** |  |
| **Renal/Urinalysis** |  |
| **Respiratory** |  |

|  |  |
| --- | --- |
| **System** | **Exam findings or Complications** |
| **Vitals** | Hypertension |
| **Joints** | Arthritis/Arthralgias – large joints lower limbs |
| **GIT** | Intussusception – abdo pain, signs of obstruction |
| **Skin** | 1 - Palpable purura/petichiea/ecchymosis gravity and pressure dep areas e.g lower limbs and buttocks,  2 – Subcutanous oedema – periorbital, hands, feet and scrotum |
| **Neurological** | Altered mental status, labile mood, apathy, encephalopathy, FNS |
| **Renal/Urinalysis** | Haematuria/Proteinuria, nephrotic/nephritic syndrome |
| **Respiratory** | SOB/WOB/crackles, diffuse alveolar oedema |



iii) After review you believe the child has HSP. What criteria must the child meet to be appropriate for outpatient management (3 marks)

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Mild disease

No renal involvement/hypertension/haematuria – this requires a renal biopsy

Pain controlled with simple analgesia

Appropriate follow up for BP and urinalysis monitoring – GP or paediatrician weekly or first month

No signs of intussusception or resp/neuro compromise suggesting DAH/ICH

**Question 9**

**A 23 year old pregnant female presents to ED with her 2 year old daughter who has an itchy rash. She “doesn’t believe in vaccinations”.**





i) List the MOST LIKELY diagnosis (1 mark)

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Chicken Pox or Varicella zoster

ii) List five (5) topics you will cover and advice that that you will give to the parent regarding this presentation (5 marks)

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Advise that usually a self limiting condition but that can have complications –bacterial superinfection, pneumonitis, encephalitis.

Can be managed at home

Risk to any other children particularly neonates, and preg women – inc. period of 10-21 days

Return to school only when all lesions crusted or 7 days after the onset of the rash

Recommend symptomatic management with analgesics/antipyretics e.g. panadol, antihistamines, calamine lotion, keep nails short to avoid scratching

Address non vaccination – discuss herd immunity, offer vaccine advice, recommend re-entry into vaccine program via the GP

Assess her risk – pregnant, if unvaccinated and never had CP then she is at risk and needs VZ Ig to prevent

<http://www.rch.org.au/kidsinfo/fact_sheets/Chickenpox_Varicella/>

iii) The woman becomes angry and leaves the department in the middle of your conversation, she refuses to return. The nurse in charge wants to report the woman to DCF. List five (5) measures you will take in this situation

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No grounds to call police/DCF etc as childs risk is low

Send a discharge letter to the GP and the parent explaining the situation

Send a fact sheet to the parent

Attempt to call the parent to explain the management of the child and the potential need for VZ Ig to protect her unborn child

Record the child s unvaccinated on the hospital medical alerts

Notifiable