

Specialty Certificate in Gastroenterology Sample Questions

Question: 1

A 50-year-old man presented with haematemesis and melaena. He had a history of excess alcohol intake for many years. On examination, he was jaundiced with bilateral parotid enlargement, spider naevi and Dupuytren's contracture. His pulse was 100 beats per minute and his blood pressure was 95/60 mmHg. He had ascites and peripheral oedema.

While awaiting endoscopy, what is the most appropriate management?

- A insert a Sengstaken–Blakemore tube
- B intravenous pantoprazole
- C intravenous terlipressin
- D nasogastric tube and aspiration
- E oral sucralfate

Question: 2

A 67-year-old man with dysphagia was found at endoscopy to have lower oesophageal carcinoma.

For staging of local invasion in oesophageal cancer, which investigation is most sensitive?

- A contrast-enhanced CT scan of oesophagus
- B laparoscopy
- C MR scan of chest
- D PET scan
- E radial endoscopic ultrasound scan

Question: 3

A 46-year-old man presented with a 2-month history of fatigue and progressive dysphagia. He also reported night sweats and weight loss. He did not smoke and drank only occasional alcohol.

On examination, he appeared thin and had several enlarged lymph nodes in both axilla. Abdominal examination was normal.

Investigations:

chest X-ray	normal
upper gastrointestinal endoscopy	see image



What is the most appropriate next investigation?

- A bone marrow aspirate
- B CT scan of abdomen
- C HIV serology
- D lymph node biopsy
- E tuberculin test

Question: 4

A 55-year-old man with Crohn's disease underwent an ileocaecal resection. The surgical procedure was technically straightforward. Three months later, he was reviewed in the clinic. His appetite remained good and the abdominal pain had settled, but he was troubled by diarrhoea with a daytime stool frequency of six per day. He also experienced faecal urgency 20–40 minutes after eating. The stool was watery and there was no blood or pus.

Investigations:

haemoglobin	125 g/L (130–180)
white cell count	$5.6 \times 10^9/L$ (4–11)
platelet count	$256 \times 10^9/L$ (150–400)
erythrocyte sedimentation rate	12 mm/1st h (<20)
serum vitamin B ₁₂	340 ng/L (160–760)
red cell folate	420 µg/L (160–640)
serum C-reactive protein	8 mg/L (<10)

What is the most likely cause for the diarrhoea?

- A bacterial overgrowth
- B bile salt malabsorption
- C enterocolic fistula
- D lactase deficiency
- E recurrent Crohn's disease

Question: 5

A 44-year-old man presented with a 10-year history of ulcerative colitis. He was taking azathioprine 1.5 mg/kg and mesalazine 2.4 g daily. He reported that his bowels opened one to two times per day, with no rectal bleeding.

Investigations:

haemoglobin	106 g/L (130–180)
MCV	75 fL (80–96)
platelet count	$164 \times 10^9/L$ (150–400)
serum total bilirubin	43 $\mu\text{mol/L}$ (1–22)
serum alanine aminotransferase	76 U/L (5–35)
serum alkaline phosphatase	328 U/L (45–105)
serum gamma glutamyl transferase	397 U/L (<50)
rigid sigmoidoscopy	quiescent colitis

What is the most appropriate next investigation?

- A colonoscopy
- B faecal calprotectin
- C MR cholangiopancreatography
- D ultrasound scan of liver
- E upper gastrointestinal endoscopy

Question: 6

A 68-year-old man was found to have positive faecal occult blood tests (FOBT) in a national bowel cancer screening programme. He was offered colonoscopy, but before making his decision he wanted to know what the chances were of actually having a colonic carcinoma.

What is the likelihood of colonic carcinoma in a patient of this age with a positive FOBT?

- A 2%
- B 8%
- C 16%
- D 24%
- E 48%

Question: 7

A 33-year-old housewife reported lifelong constipation, worse in the preceding 2 years. She opened her bowels once every 2 weeks, and complained bitterly of painful abdominal bloating. There was a traumatic personal past-history of physical abuse. A radio-opaque marker study showed slow transit and a barium enema was normal except for showing a 'long, redundant' colon. Treatment with senna and lactulose had not helped.

What is the most appropriate next treatment option?

- A biofeedback therapy
- B cognitive behavioural therapy
- C increasing dietary fibre
- D regular use of glycerine suppositories
- E surgical resection of the redundant colon

Question: 8

A 56-year-old man with established cirrhosis secondary to genetic haemochromatosis was found to have a 3-cm focal lesion in the right lobe of his liver at a surveillance ultrasound scan of his abdomen. When reviewed in the outpatient clinic he was well with no new symptoms.

Investigations:

international normalised ratio	1.3 (<1.4)
serum albumin	32 g/L (37–49)
serum total bilirubin	37 μ mol/L (1–22)
serum alanine aminotransferase	23 U/L (5–35)
serum alkaline phosphatase	125 U/L (45–105)
serum α -fetoprotein	8 kU/L (<10)

What is the most appropriate next step in management?

- A further surveillance screening in 6 months
- B CT scan of abdomen with contrast
- C referral for consideration of resection of the hepatic lesion
- D repeat ultrasound scan of his liver in 6 weeks
- E ultrasound scan-guided biopsy of the lesion

Question: 9

A 29-year-old woman who was 32 weeks pregnant presented to the accident and emergency department with a 2-week history of malaise, nausea and vomiting.

On examination, there were no stigmata of chronic liver disease, her pulse was 100 beats per minute and her blood pressure was 160/94 mmHg. She had right upper quadrant tenderness and peripheral oedema.

Investigations:

haemoglobin	116 g/L (115–165)
platelet count	$68 \times 10^9/L$ (150–400)
international normalised ratio	1.7 (<1.4)
blood film	schistocytes, spherocytes
serum total bilirubin	74 $\mu\text{mol/L}$ (1–22)
serum alanine aminotransferase	176 U/L (5–35)
serum aspartate aminotransferase	260 U/L (1–31)
serum alkaline phosphatase	230 U/L (45–105)
serum lactate dehydrogenase	720 U/L (10–250)

What is the most likely diagnosis?

- A acute fatty liver of pregnancy
- B Budd–Chiari syndrome
- C HELLP syndrome
- D hepatitis E
- E intrahepatic cholestasis of pregnancy

Question: 10

A 68-year-old woman was referred for investigation of iron deficiency anaemia. She was taking warfarin for atrial fibrillation.

On examination, she had atrial fibrillation with a ventricular rate of 76 beats per minute. No other abnormality was detected.

Investigations:

international normalised ratio	2.1 (<1.4)
coeliac serology	positive
echocardiography	normal left ventricular systolic function; no valvular abnormality

Upper gastrointestinal endoscopy to obtain duodenal biopsies was planned.

What is the most appropriate plan for anticoagulation before this endoscopy?

- A no alteration of therapy
- B stop warfarin
- C substitute aspirin for warfarin
- D substitute clopidogrel for warfarin
- E substitute low-molecular-weight heparin for warfarin

Answers

1: Answer: C

2: Answer: E

3: Answer: C

4: Answer: B

5: Answer: A

6: Answer: B

7: Answer: A

8: Answer: B

9: Answer: C

10: Answer: A