

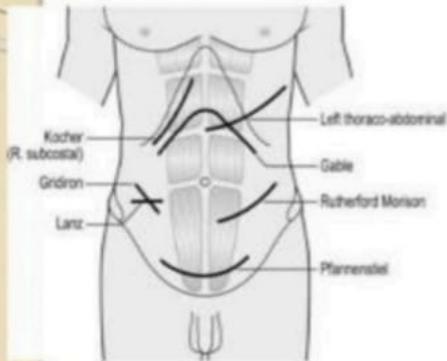
4
A 10 month old boy weighing 10 kg is brought by the mother because of coughing for the last 2 days. Examination shows his respiratory rate of 55 breaths per minute and chest indrawing. The rest of examination shows no abnormal findings.

- Q 1. Classify this child illness according to IMNCI?
Q 2. Write his treatment according to IMNCI?
Q 3. Write instructions for follow-up of this child?

1. Pneumonia
2. 1st line: amoxicillin
Symptomatic rx: paracetamol for fever. Iv fluids
breastfeeding
3. Followup after 2days.

A 7 years old boy is admitted with history of fever

Rutherford-Morrison Incision



- Oblique Muscle Cutting Incision
- Extension of McBurney incision by division of oblique fossa
- Can be used for right and left sided colonic resection, caecostomy or sigmoid colostomy

Symptoms	Score
Migratory right iliac fossa pain	1
Anorexia	1
Nausea/Vomiting	1
Signs	
Tenderness in right iliac fossa	2
Rebound tenderness	1
Elevated temperature	1
Laboratory Findings	
Leucocytosis	2
Shift to the left of neutrophils	1
Total score	10



50

**STATION 9**

A female patient of 45 years age presented with pain epig and vomiting for the last 6 hours. On examination she is tender in the upper abdomen and U/S shows G stones and gas filled bowel loops. Her TLC is 20000/cmm and serum amylase is 800 iu/l.

1. Name 2 common causes leading this condition.
2. Enumerate 3 criteria assessing the severity of this condition.
3. Name 3 local complications of this condition.

KEY 9

1.
 - a. G stone 1
 - b. Alcohol 1
2.
 - a. Ranson 1
 - b. Glasgow 1
 - c. Apache scoring 1
3.
 - a. Pancreatic abscess 1
 - b. Pseudocyst 1
 - c. Acute fluid collection 1



Edit

Annotate

Fill & Sign

Convert

All



STATION 9

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 - b. Pseudocyst 1
 - c. Acute fluid collection 1

STATION 14

A 35 years old female has presented with a history of recurrent episodes of upper abdominal pain and dyspepsia. Her LFTs are as follows

Total bilirubin 5.5mg/dl,
SGPT 45 IU/litre
Alkaline phosphatase 950 IU/litre

Carefully answer the following questions

1. What is the probable diagnosis?
2. Mention four common causes of your diagnosis
3. Mention three investigations which can help in reaching cause of diagnosis
4. How you will prepare this patient for surgery.

Chodocolithiasis diagnosis

2. Causes: billiary duct stones, strictures, d of pancreas, cholangiocarcinoma

3. InVs: abd US, mrcp, ercp

Preparation before surgery: optomization(elec lytes correct, antibiotic prophylaxis billiar mpression

Then surgery



20 year old male has presented with swelling on right forearm for last 6 months which has gradually increased in size. On examination, it is soft and lobulated and lies in subcutaneous tissue.

Carefully read the scenario, observe the given photograph and answer the following questions:

Questions:

1. What is the most likely diagnosis?
2. How can you confirm your diagnosis?
3. What is the treatment?
4. What are various types of this pathology?

Answers:

1. Lipoma
2. FNAC
3. Excision
4. Encapsulated, diffuse

Q 1. What sign does this x-ray show?
Q2. What is the diagnosis?
Q 2. Write down treatment steps?

duodenoduodenostomy my duodenojejunosomy

Mangolion spot.

Natural History:



Clubbing:

Causes:

IBD

Coeliac Disease

Empyema

Interstitial Lung Disease, Ca

Lung

Cynotic Heart Disease



41% 6:45 P

This 3 year old boy became unwell within a few hours.





Name the X-ray: Barium meal

What is the most likely diagnosis: Pyloric Stenosis

2 Common Causes of this diagnosis: congenital; chron's disease (may cause inflammation and adhesion); PUD.

Mention the electrolyte abnormality in this condition: hyponatremia, hypokalemia, and hypochloremic alkalosis

What investigations will you do to confirm? ABG;s; Abdnominal U/S

Treatment: surgery

Name another important investigation that can be done: Gastrosocopy

If it is a benign disease, name on operative and one operative treatment which can be done:

Endoscopic balloon dilation/gastrojejunostomy.

If it is a malignant condition, name one operative treatment which should be done: Radical Gastrectomy.



Edit Annotate Fill & Sign Convert All

Station 20

This 35 years old man presented with 3 days history of fever and these lesions after returning from Eidul adha leave.

Questions:

1. Describe these lesions.
2. Give 3 differentials in infectious diseases.
3. Mention 3 steps of immediate management.

Lesion: conjunctivitis/ subconjunctival hemorrhage on arm: cellulitis/ vasculitis

D/d: leptospirosis, rickettsial infection, meningococcal
Management: supportive care, empirical antibiotics, diagnostic workup.

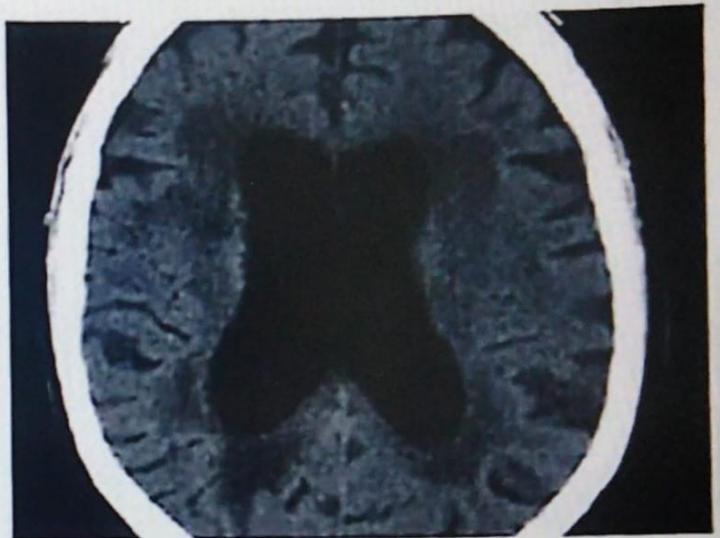


Station 76

This 70 years old gentleman presented with decreased attention, apathy and loss of memory for three months. He also had unsteady gait and incontinence of urine.

1. *What investigation is shown?*
2. *What abnormality is present?*
3. *What is the diagnosis?*
4. *What is the most effective treatment?*

Ins: MRI
Dilated ventricles with normal cortex
NPH
Treatment: Vp shunt

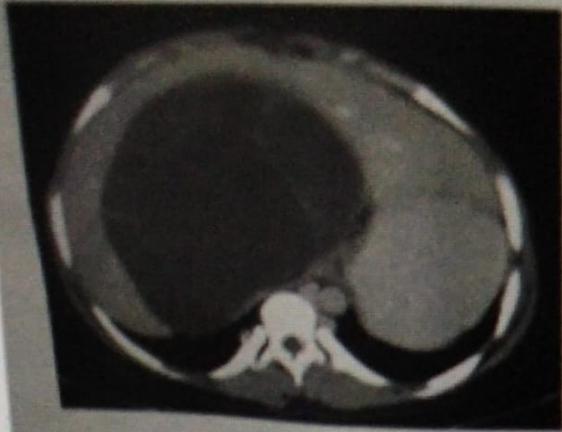


station 12

1. six nerve palsy

2.

3.

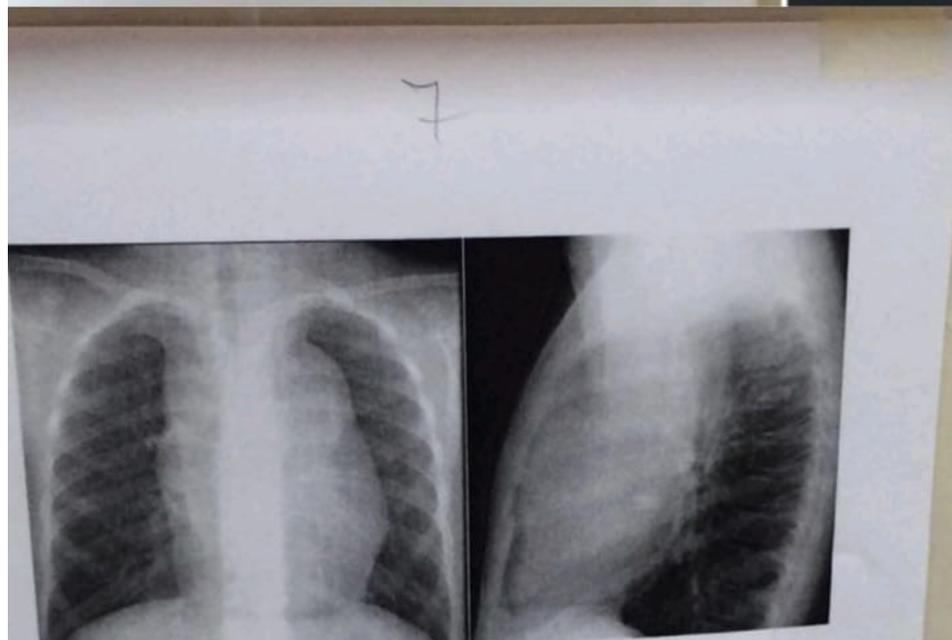
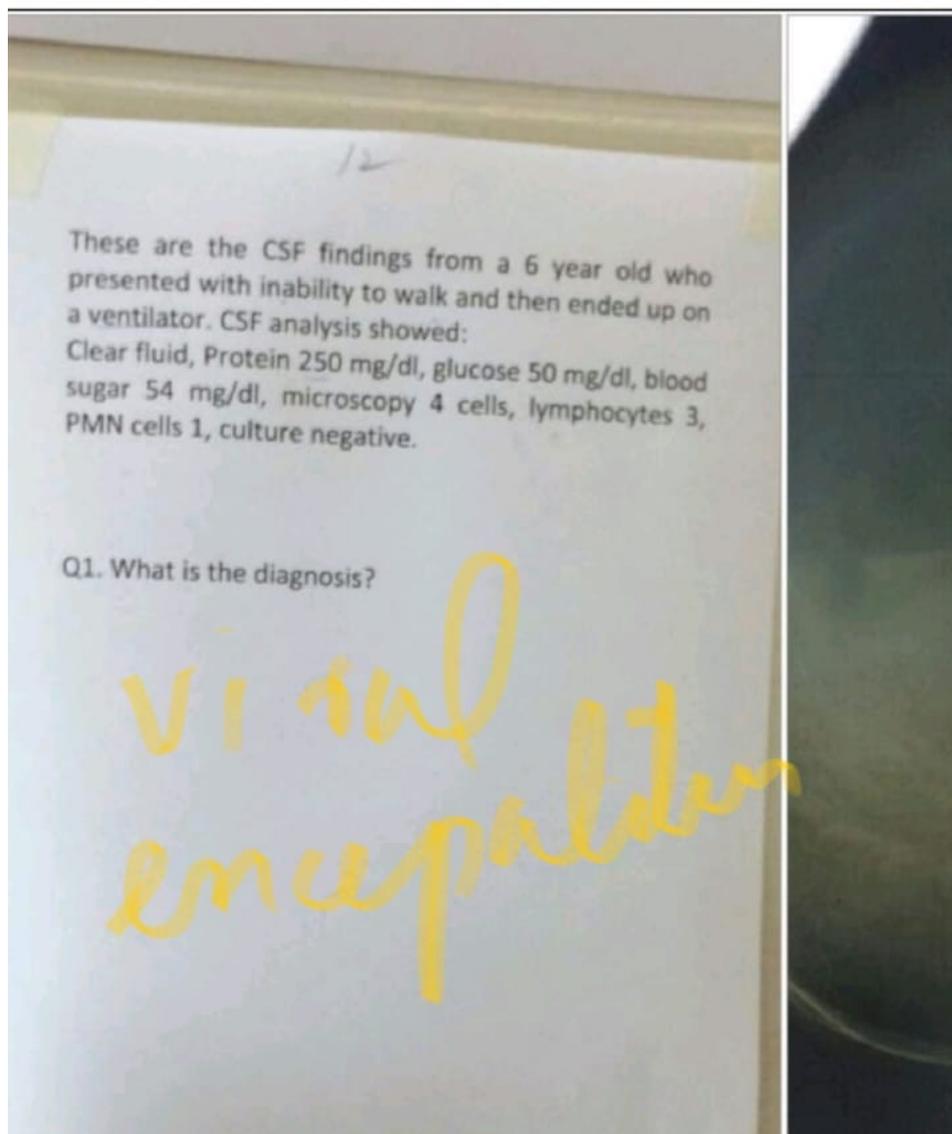


STATION 4

1. What are the positive findings in this CT Scan abdomen.
2. Name 2 other differential diagnosis
3. Enumerate 3 treatment options
4. Name 2 complications of your diagnosis

KEY 4

1. Single, well define cyst in the Rt lobe of liver /
Hydatid cyst. 2
2.
 - a. Liver abscess 1
 - b. Simple liver cyst 1
3.
 - a. Medical 1
(albendazole/mebandazole)
 - b. PAIR 1
 - c. Surgical 1
4.
 - a. Infection 0.5
 - b. Rupture 0.5



Station 07: X-Ray skull

Date:

• Hair \downarrow on-end appearance.

• Dx \Rightarrow Thallamemia major

(Extra medullary hematopoiesis).

X-Ray skull e⁻ Lytic Lesions:- (Pepper Pot sign skull)

↳ MM.

↳ Primary Hyperparathyroidism.

↳ Metastatic

Station 8:

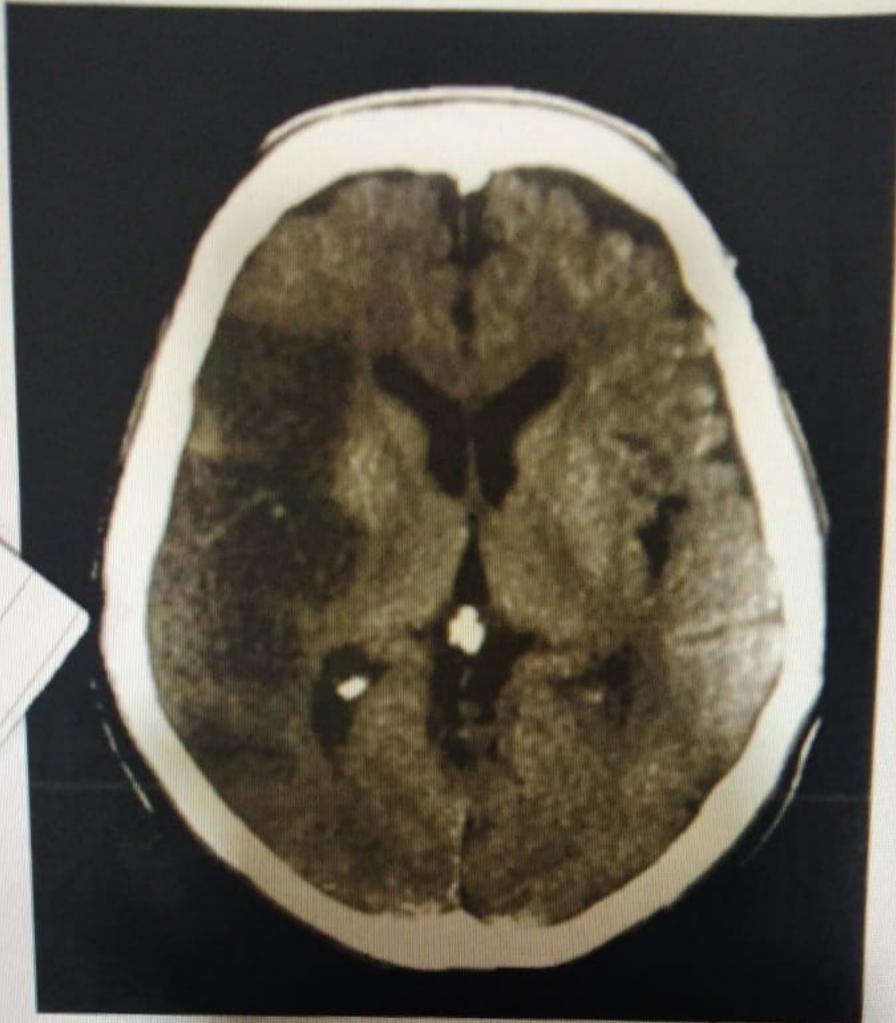
-x - x -

here, hydrocephalus.

For CT Station Consult (green \Rightarrow). Intracranial hem.

STATION NO

61



Left side involved

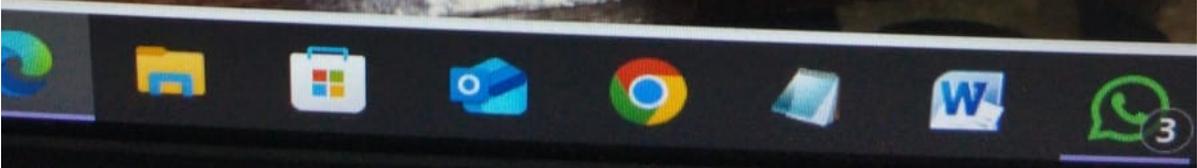
Questions:

Ischemic

Marks 06

1. Mention the abnormality and its location shown in this image. 2
2. Mention two clinical features you expect in this patient. 1
3. Name this vessel most likely involved. 1
4. Mention three major risk factors for this illness. 2

Ischemic infarcts
2 clinical features: right sided hemip
, aphasia
Left middle cerebral artery
Risk factors: DM, AF, HTN





50



- b. Urethral dilatation
- c. Urethroplasty



1. Name the X ray
2. What are the pelvic Findings?

6

3. Name 6 conditions leading to this positive finding.
4. How will you manage this patient?

KEY STATION 8

1. Erect abdomen x ray 1
2. Multiple air fluid level (step ladder pattern) 1
3.
 - a. Band / adhesions 5+5
 - b. Obst Hernia / paralytic ileus 5+5
 - c. Malignancy / TB Abd 5+5
4. Admit patient, i/v fluids, i/v analgesic, antibiotics, NG suction, catheterize, intake output record, prepare for laprotomy 3

obstruction, ileus, ischemia, gastroenteritis

other conditions: bowel



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Question 13:- (A) Malar Rash · Heliotrope rash · -

Dx: DERMATOMYOSITIS → Tx: steroids + Meta

1) Gottron's papules 2) Shaw's sign

3) Acanthosis nigricans (Mauis on neck → post surface) ^{Ev. growth}
[pigmented rough thickening of axilla, neck]

Associations ⇒ i) DM.

ii) Acromegaly

iii) Lung CA.

iv) PCOs

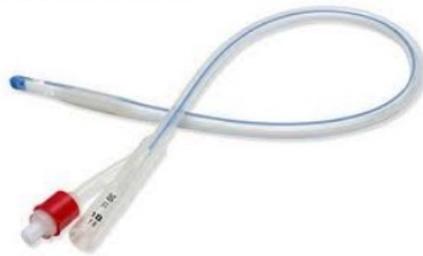
v) Gastric CA

LUCKY

2

Station 12: instruments (pictures taken from internet):

Silicon Foley Catheter:



Intestinal Clamp



2



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- 2) Echocardiography (1.0)
- 3) Myocarditis with CCF (2.0)

A newborn baby is brought to the nursery because parents are concerned about the appearance of external genitalia of the baby.

1. Describe the positive findings?
2. What is the likely diagnosis?
3. What investigations will you do?



- 1) Enlarged clitoris, rugose labia, absent testes (2)
- 2) CAH (!)
- 3) Serum electrolytes, ultrasound abdomen, serum 17-hydroxyprogesterone, karyotyping

Word Count: 1645

Steps of Appendectomy:

- The patient should be supine with both arms extended.
- The entire abdomen is prepared and draped in case a midline incision is needed (eg, unexpected disease is encountered or the operative course dictates it).
- A Foley catheter is placed to decompress the bladder.
- The patient's entire abdomen is prepared and draped.
- The classic transverse incision can be made with two thirds of the incision lateral to McBurney's point.
- Alternatively, the point of maximal tenderness or the location of the appendix based on preoperative imaging can be used to determine the location of the incision.

3/44

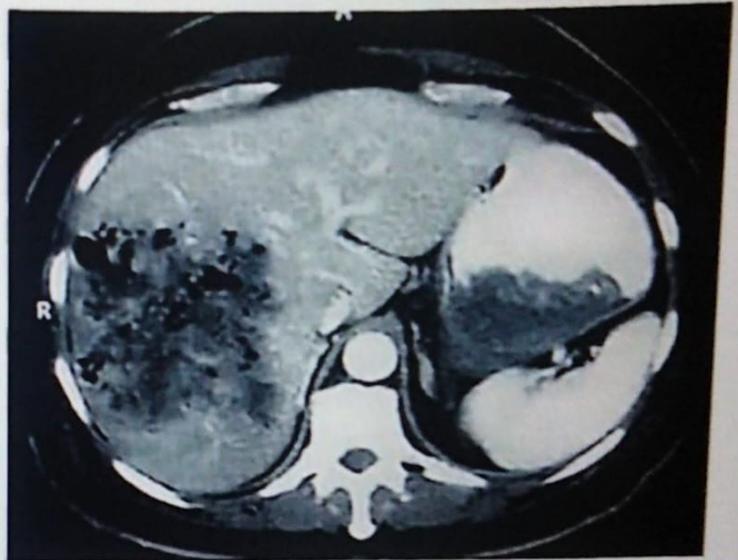


- A scalpel is used to incise the epidermis and the dermis. Bovie electrocautery is used to dissect down to the external oblique aponeurosis.
 - The aponeurosis is opened in a superolateral to inferomedial direction along the direction of its fibers to expose the internal oblique muscle.
 - The internal oblique muscle is bluntly divided perpendicular to the direction of its fibers.
 - The transverse abdominal muscle is similarly divided and the peritoneum is identified.
- The peritoneum is grasped with forceps and incised with a 15-blade knife.
- Attention is now focused on locating the appendix.
 - If the cecum is visualized, it can be used as a guide to help identify the appendix.
 - Babcock forceps can be used to grasp the taeniae coli and advanced until the appendix is externalized.
- Alternatively, a finger can be swept around the cecum, beginning superolaterally and continuing inferomedially to locate the appendix.
- Once identified, the mesoappendix is dissected and the appendiceal vessels are divided between clamps and ligated with silk sutures.
- The completely free appendix is crushed near its junction with cecum with artery forceps
- Artery forceps are removed and reapplied just distal to the crushed portion.
- Absorbable 3 0 vicryl ligature is tied around the crushed portion and the appendix is amputated between the artery forceps and the ligature.
- Hemostasis is checked, peritoneum is closed with vicryl 30 (not a necessary step)
- Internal oblique and transverse abdomenis are approximated and vicryl No1 in an interrupted manner and external oblique aponeurosis is closed in a continuous manner. Skin can be closed by a few interrupted stitches.

Station 62

55 years old man presented with c/o of abdominal pain and fever for past 6 days

1. what are the findings on this scan
2. what is the diagnosis
3. Outline the most preferred treatment



1. Abdominal CT: large hypodense lesion in right lobe of liver
2. Liver abscess
3. Empirical antibiotics: ceftriaxone+ metronidazole percutaneous Drainage, supportive care

Flaky dermatitis, hypotonia, hair colour and texture, behavior kwashiorkor

CLINICAL SCENARIO

- A 15 weeks old breast fed infant presents with failure to thrive and loose motions. Examination reveals perianal rashes and eczematous lesions over face and scalp. These lesions did not respond to antifungal therapy

Questions.

- 1-What is most likely diagnosis
- 2-How will investigate
- 3-What therapy would you want to give

KEY

- Acrodermatitis enteropathica
- Serum zinc level
- Zinc sulphate

How do you interpret APGAR Scoring

	0	1	2
Appearance			
Pulse			
Grimace			
Activity			
Respiration			

KEY

	0	1	2
Appearance	Central and peripheral cyanosis	peripheral cyanosis	Pink
Pulse	<60	60-100	>100
Grimace	No Grimace	Some	FULL CRY
Activity	Limp	Some activity	Active
Respiration	No respiration	Gasping	Normal

of rotate the pt. platelet whole blood
transfusion

station 21

Cullen sign

**extra peritoneal hemorrhage sentinel lobs
effusion**

pancreatitis

These are the CSF findings from a 6 year old who presented with inability to walk and then ended up on a ventilator. CSF analysis showed:
Clear fluid, Protein 250 mg/dl, glucose 50 mg/dl, blood sugar 54 mg/dl, microscopy 4 cells, lymphocytes 3, PMN cells 1, culture negative.

Q1. What is the diagnosis?

Viral encephalitis

of all medicines you are taking and bring them on follow up. If you have questions please ask. You can also bring someone with you when you come to OPDs.
Follow up: 1, 3, 6 months after operation.

5. COUNSELING FOR CHOLECYSTECTOMY

Cholecystectomy is a surgical procedure performed when your gall bladder is infected, inflamed or have recurrent bouts of pain due to gallstones. When medical therapy fails, then surgery is indicated under general anesthesia, with either open or laparoscopic approach.

Possible complications during surgery: bleeding, infection, injury to digestive organs, leakage of bile, injury to blood vessels.

Just after operation: you may feel mild pain in shoulder from carbon dioxide gas. (if patient has laparoscopic cholecystectomy). But you don't have to worry, as pain killers will be given to you. You will be encouraged to cough regularly to clean your lungs from general anesthesia. An overnight stay in hospital (if laparoscopic Cholecystectomy is done) otherwise hospital stay of 5-7 days for open Cholecystectomy will be advised by the surgeon.

At home: rest for 3-5 days. Avoid heavy lifting and physical exertion. You will have some short term digestive problems like bloating, toilet habit changes and abdominal pain. Many people recover within a week.

Dietary advice: immediately after the operation, you should drink at least 7-8 glasses of water every day. Increase juices intake. eat small meals more frequently. Avoid gas producing foods like broccoli, cauliflower that causes significant discomfort after gall bladder is removed. Emphasize on fruits like apples, peaches and green beans.

There are no restrictions for long term but it is better to avoid fatty food for 2 weeks.

Follow-up: in 7-10 days after surgery. Do not travel in 1 week after surgery.

Come to us immediately when:

1. If you develop fever.
2. If surgical wound becomes red, swollen and tender.

COUNSELLING FOR MULTIPLE SCLEROSIS

⇒ Introduce
 ⇒ app akoutay may baat kina chahengi - toa ghar k kisi farid ki Mojoodi may
 ⇒ ask how much do you know abt dis (if no → appko ye sx thy: tou hum ne app k test kraye thy) tou ask natooz agayle hath
 ⇒ eski roohi may apko ye baemari hoo
 ⇒ MS aasab ka Moag hy jo dimagh aur baaji ki sozish karta hy

⇒ Es MS ka hatmi elaz mumkin nae hy lekin esko control koe k liye dawa Mojood hy. apko ye dawa ta omar lenit hogi
 ⇒ dawa may interferon B k toekay aalay hain. but khonay ki gawon may eske amari aatate ⇒ ager alamat shoobed hojayain tou apko 3 se 4 din tak steroids k toekay lagaye jayngain

⇒ app ghar k liye Mojoodi rakh lain. app ghar k kisi farid ko le ayain hum se. apki baemari k baray may samjz dain ⇒ app k ye baem

⇒ es k alawa app kuch poochna chahengi
 ⇒ dawa ager app may samjhay se Motamam hogae hain; ager app chahti hy tou hum senior do se apka session arrange kra sktay hain.
 ⇒ student - doste hath se writing ki practice karain. Maie - different option like dukam karaye pe de do. Last help k liye assistant

⇒ app ghar k liye Mojoodi rakh lain. app ghar k kisi farid ko le ayain hum se. apki baemari k baray may samjz dain ⇒ app k ye baem

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Station 21

Questions

1. Name this sign.
2. Name two underlying causes.
3. Mention two other clinical features the patient may have.

Cullen sign/ intraperitoneal hemorrhage/ retroperitoneal hemorrhage
Acute pancreatitis/ ruptured ectopic preg
Abdominal pain, shock and hypotension

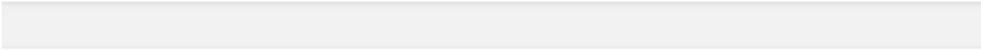


52 years female presented with history of progressive jaundice, itching, mild pain upper abdomen and pruritis from six weeks. She also complains of high colored urine and clay colored stool. She had history of anorexia, but there was no weight loss. She had asymptomatic cholelithiasis for five years. Labs revealed serum bilirubin 28mg/dl, Alkaline Phosphate: 541, GGT: 231, AST: 102, Hb: 10.1, WBC: 7800.

1. Describe four differential diagnosis
2. How will you investigate her further?
3. What would be your pre-operative measures?
4. How would you explain the change in color of urine and stool of this patient?
5. How will you treat?

Answers:

1.
 - a. Gall bladder cancer
 - b. CA head of pancreas
 - c. Choledocholithiasis
 - d. CBD stricture
2.
 - a. Ultrasound abdomen
 - b. Contrast enhanced CT scan of abdomen and chest
 - c. Tumor Markers
3.
 - a. Biliary decompression (ERCP & Stenting)
 - b. Broad spectrum antibiotics
 - c. Vitamin K / FFPs
 - d. Intravenous fluids
4. Urine becomes high colored due to soluble bile pigments being passed in urine. Stool is clay colored because bile is not reaching the stool.
5.
 - a. CA head of pancreas: Whipple's operation if no contraindication, otherwise palliative procedure and chemotherapy
 - b. Choledocholithiasis: ERCP, Sphincterotomy and stone retrieval
 - c. CBD Stricture: Benign stricture can be dilated endoscopically while surgery may be needed for malignant stricture
 - d. Gall bladder cancer: Surgical resection for stage I, II and III disease and palliation for stage IV disease



STATION NO: 18

A 30 years old man is referred to surgical clinic with a six week history of asymptomatic swelling in the Rt. testis of his scrotum. On examination, Rt. testis was hard & one can get above it. There is suspicion of testicular tumor.

- a. Give 03 differential diagnosis?
- b. What are different types of testicular tumor?
- c. Name the different tumor markers for testicular tumor.
- d. List the investigations.
- e. State the principles of treating this condition.

KEY STATION 18

a.		
	i. Inguinal Hernia	01
	ii. Hematoma	01
	iii. Testicular hydrocele	01
b.		0.5
each (total=02 marks)		
	i. Teratoma	0.5
	ii. Seminoma	0.5
	iii. Yolk sac tumor	0.5
	iv. Lymphoma	0.5
c.		
	i. Beta HCG	01
	ii. LDH	01
	iii. Alpha Feto Protein	01
d.	0.5 each (total=01 mark)	
	i. Ultrasound	0.5
	ii. CT scan	0.5
e.	Traninguinal orchidectomy, Radio for para aor Lymph node + chemotherapy	01

Q 1. What sign does this x-ray show?
Q2. What is the diagnosis?
Q 2. Write down treatment steps?

duodenoduodenostomy my duodenojejunosomy

Mangolion spot.

Natural History:



Clubbing:

Causes:

IBD

Coeliac Disease

Empyema

Interstitial Lung Disease, Ca
Lung

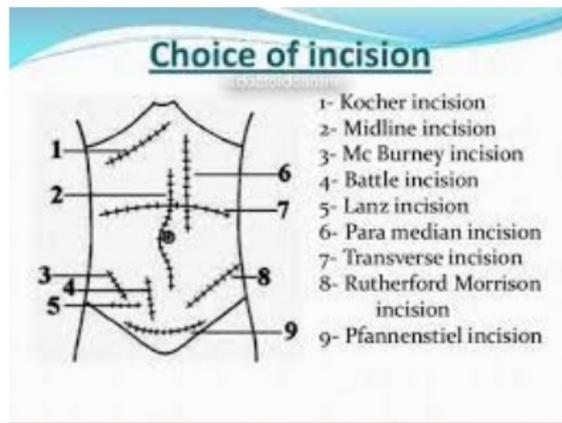
Cynotic Heart Disease



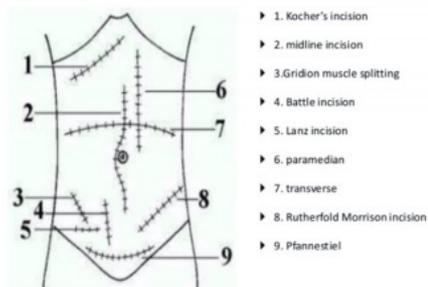
41% 6:45 P

This 3 year old boy became unwell within a few hours.





SURGICAL INCISIONS



Station 1 (picture taken from internet): air under diaphragm:



Edit Annotate Fill & Sign Convert All



50



STATION 9

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2. Enumerate 3 criteria assessing the severity of this condition.
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 - b. Alcohol 1
2.
 - a. Ranson 1
 - b. Glasgow 1
 - c. Apache scoring 1
3.
 - a. Pancreatic abscess 1
 - b. Pseudocyst 1
 - c. Acute fluid collection 1



Edit

Annotate

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Convert

All



station 13

1. tongue deviated to left
2. 12 nerve .. medulla. lateral medullary syndrome. stroke . infection. any problem in posterior vessel
- 3.



STATION 15

- Q1. Name the X ray
Q2. Which structures are outlined in this film.
Q3. What are the indications of putting this tube

KEY 15

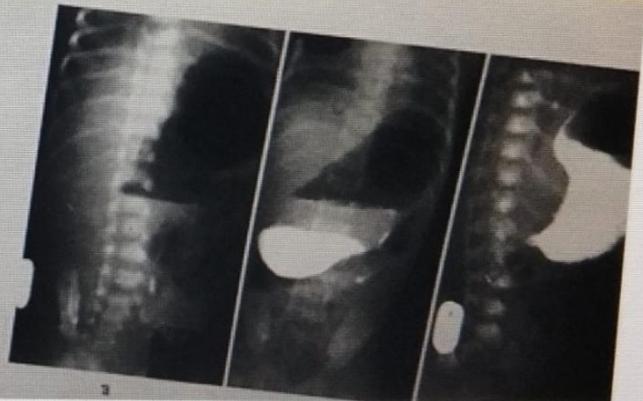
1. T. Tube cholangiogram 2
2. T tube cholangiogram outline the CBD, hepatic duct and deuodenum
 - a. T.tube 1
 - b. Common hepatic duct 1
 - c. Common bile duct 1
 - d. Deuodnum 1
3.
 - a. CBD stone / stricture 1
 - b. Iatrogenic CBD injury 1

STATION 2

Barrium swallow
D/d: G00, pyloric stenosis, gastric ca
Hypokalemic hypochloremic metabolic al
kalosis
Ins: UGIE, Abd CT

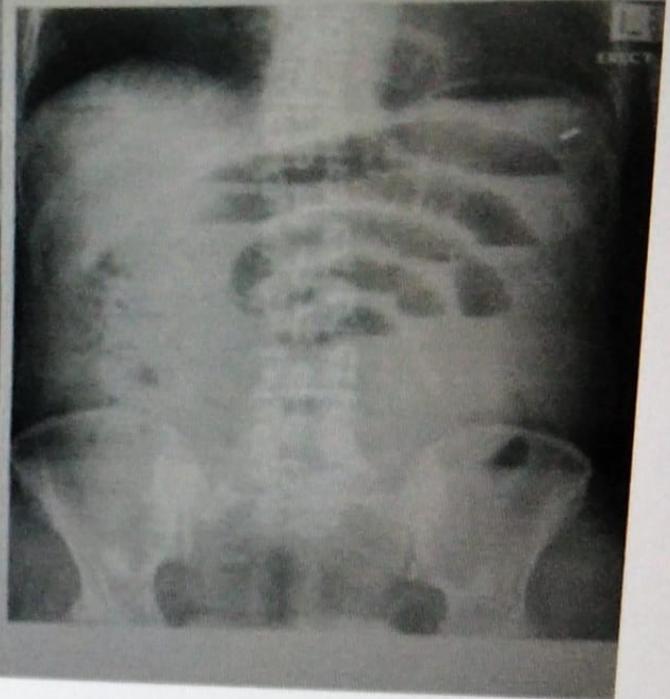
A 70 year old male with persistent vomiting
was advised this x ray.

1. Name the X ray.
2. What is most likely diagnosis?
3. Write 2 common causes of your diagnosis.
4. Mention electrolyte abnormality in this condition
5. Which investigation you will follow to confirm the cause of your diagnosis



STATION 8

1. Name the X ray
2. What are the positive findings?
3. Name 6 conditions leading to this positive findings
4. How will you manage this patient.



STATION 8

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2. What are the positive findings?
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KEY STATION 8

1. Erect abdomen x ray 1
2. Multiple air fluid level (step ladder pattern) 1
3.
 - a. Band / adhesions .5+.5
 - b. Obst Hernia / paralytic ileus .5+.5
 - c. Malignancy / TB Abd .5+.5
4. Admit patient, i/v fluids, i/v analgesic, antibiotics, NG suction, catheterize, intake output record, prepare for laprotomy 3

- 1) Herniated Disc between L5-S1
(tip: T2 weighted MRI image: CSF white)
- 2) Laminectomy with spinal fixation

Q1 What is the diagnosis
How will you manage

Q2



Question No. 8

Topic: Infectious Disease

1: What is the clinical finding? (1)

2: Name the two underlying conditions leading to this finding? (2)

3: What is the management? (2)



Key:

1- Noma / Cancrum oris (1)

2- (1 each)

i. Measles

ii. Malnutrition

3- (0.5 each for any 4)

i. Nutritious diet

ii. Cap. Vitamin A

iii. Vitamins B-Complex

iv. Vitamin C

v. Iron

vi. Antibiotics

vii. Ampicillin & Metronidazole

KGMCITES BATCH 2019-2024...

only admins can send messages

➔ *Forwarded*

Carcinoid syndrome

Vertebral fracture interactive

T Tube interactive

Sepsis interactive

Examination of facial nerve

Cerebral malaria

Meningococccemia

Examination of abdomen medicine

Examination of abdomen ped

Hernia steps of surgery interactive

2 Stations of epidural hematoma

Caput medusae

Viva depression

OCD history and management

Intestinal obstruction

PCM interactive

10:09 pm

Rabia Bangash





Name the X-ray: Barium meal

What is the most likely diagnosis: Pyloric Stenosis

2 Common Causes of this diagnosis: congenital; chron's disease (may cause inflammation and adhesion); PUD.

Mention the electrolyte abnormality in this condition: hyponatremia, hypokalemia, and hypochloremic alkalosis

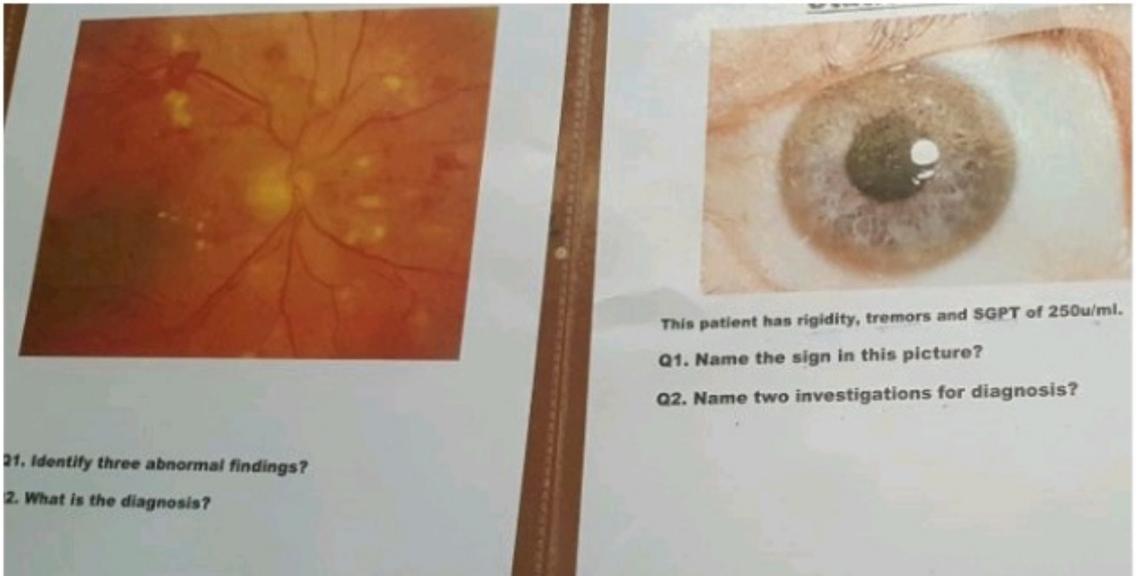
What investigations will you do to confirm? ABG;s; Abdnominal U/S

Treatment: surgery

Name another important investigation that can be done: Gastrosocopy

If it is a benign disease, name on operative and one operative treatment which can be done: Endoscopic balloon dilation/gastrojejunostomy.

If it is a malignant condition, name one operative treatment which should be done: Radical Gastrectomy.



Wilson's Disease - \downarrow Cu - \uparrow Cu - \downarrow Cu - \uparrow Cu

SGPT 250 u/ml

B)  It has rigidity, tremors + SGPT 250 u/ml

- Name sign: Kayser-Fleischer Ring.

- 2 inv?

i) \downarrow serum ceruloplasmin - (N) 20-60 mg/dl; here 200

ii) \uparrow urinary excretion of Cu. (N) 40 mg/day here \rightarrow 1000 μ g.

iii) Liver Bx.

- Mn: -

i) Avoid foods with \uparrow Copper content (liver, nuts, choc).

ii) Penicillamine \rightarrow Copper bind + agent.

iii) Zinc - Inh. Cu abs in intestine.

iv) Ammonium Tetrathiomolybdate (Chelator).

v) Liver tx.

Station 75

1. What is it?
2. What other signs in eye?
3. What is the diagnosis?
4. What is pathogenesis & S/S?
5. How will you investigate?
6. How will you treat?



a Kayser-Fleischer ring

2. What other signs can be seen in the eye?
 - Sunflower cataract
 - Kayser-Fleischer rings

3. What is the diagnosis?

Wilson's disease

4. Pathogenesis and Signs/Symptoms (S/S):

- Pathogenesis: Mutation in the ATP7B gene leads to defective copper excretion in bile, causing copper accumulation in organs.
- Symptoms:
 - Liver involvement – Hepatitis, cirrhosis, liver failure.
 - Neurological signs – Dysarthria, tremors, dystonia, parkinsonism-like features.
 - Psychiatric symptoms – Personality changes, depression, psychosis.
 - Ophthalmologic signs – Kayser-Fleischer rings, sunflower cataracts.

5. How will you investigate?

1. Serum ceruloplasmin – Low.
2. Serum copper – Low (due to ceruloplasmin deficiency).
3. 24-hour urinary copper excretion – Elevated.
4. Slit-lamp examination – Detects Kayser-Fleischer rings.
5. Genetic testing for ATP7B mutation (confirmatory).
6. Liver biopsy – Shows increased hepatic copper content.

6. How will you treat?

- Copper-chelating agents:
 - Penicillamine – First-line treatment, increases copper excretion.
 - Trientine – Alternative in case of penicillamine intolerance.
 - Zinc therapy – Blocks copper absorption.
 - Liver transplantation – In cases of fulminant liver failure.

Station 49

Questions:

1. This patient presented with fever, headache and shock. What is the most likely diagnosis?
2. What important investigation would you advise?
3. What is the suspected cause for this patient's hypotension?



The most likely diagnosis is Meningococcal septicemia (Meningococemia), caused by *Neisseria meningitidis*.

2. What important investigations would you advise?

1. Blood cultures –
2. Lumbar puncture (CSF analysis)
3. Full blood count
4. Coagulation profile
5. Serum lactate
6. Electrolytes, renal & liver function tests .
7. (PCR)

3. What is the suspected cause for this patient's hypotension?

The hypotension is likely due to septic shock caused by meningococcal endotoxins triggering widespread vasodilation, capillary leakage, and DIC. This can lead to Waterhouse-Friderichsen syndrome, characterized by bilateral adrenal hemorrhage and adrenal insufficiency, further worsening hypotension.



Figure 10

A motorcyclist was involved in roadside accident. He is unable to move his lower limbs. His X-Rays are shown in figure 10. Carefully examine this X-ray and answer the questions given below:

1. What injury does this X ray show?
2. How alignment of cervical spine is assessed?
3. What would be the initial management of this patient?
4. Write three complications of this injury?

Answers

1. Dislocation of vertebrae at the level of C5-C6
2. Alignment of cervical spine is assessed by drawing vertebral lines. The anterior vertebral line, posterior vertebral line and spinolaminar line as shown figure 11.

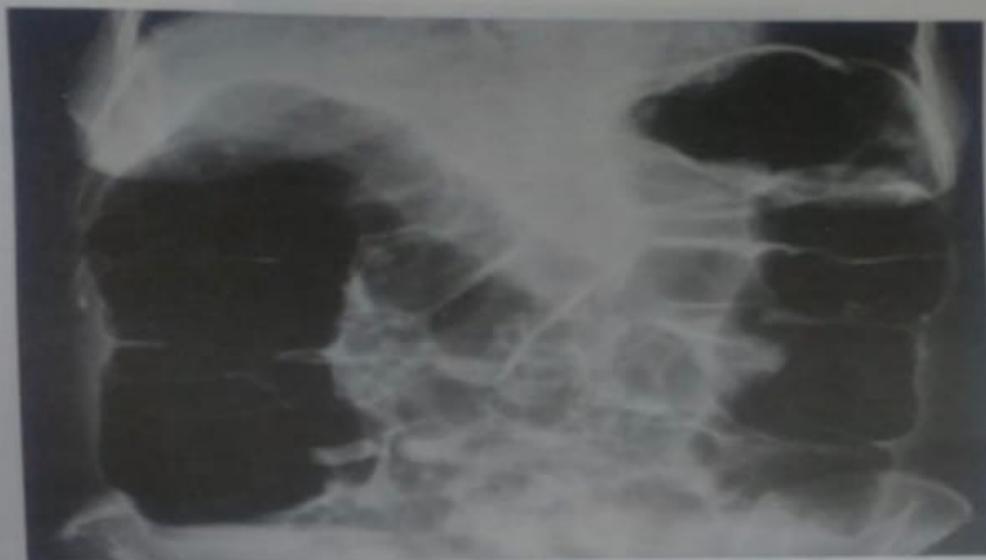


Figure 8

This is (figure 8) an X-ray of the patient who presented with abdominal distension for last 3 days. On digital rectal examination there was a rectal growth which was completely obstructing its lumen. The x-ray is showing dilated loops of colon. Note in this x-ray the dilated loops are located in the peripheral portion of the abdomen and the mucosal folds are irregularly placed. Unlike jejunum they form incomplete mucosal bands across the colonic gas shadow and they are called haustra.

pancreatitis

station 22

1 Cushing syndrome



progression over months could indicate malignancy such as hepatocellular carcinoma or pancreatic cancer and a long-term slowly progressing jaundice over years could indicate liver cirrhosis)

5. Establish predisposing events such as trauma or illness
6. Associated Symptoms:
 - a. **Pain - painless** jaundice (especially if with weight loss) may signify a serious underlying condition (such as malignancy) or **RUQ pain** and jaundice (e.g. gallstones, acute cholangitis, hepatitis)
 - b. **Nausea and vomiting** - especially important to ask about **haematemesis** (may be due to varices seen in chronic liver disease)
 - c. **Bowel habit** - loose stool, constipation

- d. **Change in stool colour** - e.g. **pale and greasy** (steatorrhea indicating bile duct obstruction seen in pancreatic malignancy or gallstones etc), **dark/black/tarry** (seen in an upper GI bleed)
- e. **Change in urine colour** - **dark urine** is seen in bile duct obstruction
- f. **Skin - pruritis** (itching due to bile salts/acids deposits in the skin), **bruising** (due to coagulation disturbances seen in liver disease)
- g. **Fever** - the trio of fever, RUQ pain and jaundice often indicate ascending cholangitis
7. Establish red flag symptoms: Weight loss, anorexia, night sweats
8. Establish risk factors: alcohol, drugs, tattoos/piercings, sexual history, travel history, family history, blood transfusions, past medical history
9. Thank patient, offer DD's and Ix

Location	Bilirubin	ALT/AST	ALP
Pre-hepatic	Normal/high	Normal	Normal
Hepatic	High	Elevated (commonly very high)	Sometimes elevated but rarely very high
Post-hepatic	High/very high	Moderately raised	High/very high

Other histories:



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STATION 24

A 35 years old female has presented with a history of recurrent episodes of upper abdominal pain and dyspepsia. Her LFTs during one of these episodes are as follows

Total bilirubin	5.5mg/dl
Direct bilirubin	4.5mg/dl
Indirect bilirubin	1mg/dl
SGOT	47IU/litre
SGPT	45 IU/litre
Alkaline phosphatase	950IU/litre

Carefully answer the following questions

1. What is the probable diagnosis?
2. Mention two further investigations which can help in reaching a diagnosis
3. Give one method of non operative management which may be curative.

KEY STATION 24

1. Choledocholithiasis
2. USG, ERCP
3. Papillotomy

Station 11 (B)

CT BRAIN



This is the CT brain of 60 year old hypertensive who presented with acute onset severe headache followed by drowsiness.

Q1. What is the radiological diagnosis?

Q2. Name any two treatment options?

Answers:
Q1: What is the radiological diagnosis? intracerebral hemorrhage (ICH)

Common locations for hypertensive hemorrhage include:

- Basal ganglia (most common)
- Thalamus
- Pons
- Cerebellum
- Lobar regions

Q2: Name any two treatment options.

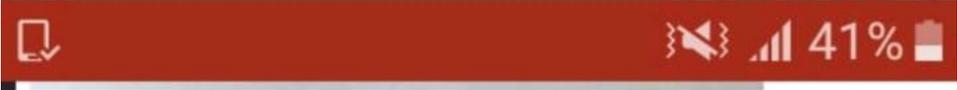
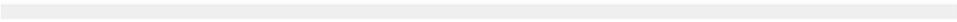
1. Medical Management:

- Blood pressure control (e.g., IV labetalol, nicardipine)
- Intracranial pressure (ICP) management with head elevation, mannitol, or hypertonic saline
- Seizure prophylaxis if needed.
- Supportive care (oxygen, fluids, nutrition, DVT prophylaxis).

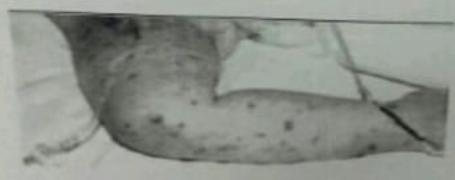
2. Surgical Management (if indicated):

- Surgical evacuation (craniotomy) if hemorrhage is large, causing mass effect or brainstem compression.
- Ventriculostomy for hydrocephalus if intraventricular extension occurs.

Empyema
Interstitial Lung Disease
Lung
Cyanotic Heart Disease



This 3 year old boy became unwell within a few hours



Meningococcal meningitis

Q1. What is the likely diagnosis?

- Meningococcal Meningitis /Meningococemia

A 10 month old boy weighing 10 kg is brought by the mother because of coughing for the last 2 days. Examination shows his respiratory rate of 55 breaths per minute and chest indrawing. The rest of examination shows no abnormal findings.

Q1. Classify this child illness according to IMNCI?

1. Severe Pneumonia
2. Give first dose of an appropriate antibiotic.
Treat wheezing if present
Treat the child to prevent hypoglycemia
Refer urgently to hospital

Q2. What treatment according to IMNCI?

station 14

1. distended abdomen e everted
umbilicus

2. cirrhosis. CHF. nephrotic

3. beta blockers. diuretics. hypertension

station 15

Key station 23

1. Subdural hematoma 2
2. Fluctuating level of consciousness
3. Burr hole & drainage of hematoma

STATION 23

A 60 years old man sustained a fall in toilet 4 days ago. His CT scan had presented here. Carefully examine the given CT and answer the following questions:

1. What positive findings does it show?
2. What clinical feature is likely to lead to suspicion of diagnosis?
3. What should be the management?



This is a 45 year old lady who has presented with an umbilical swelling.
Carefully examine the given photograph and answer the following questions:

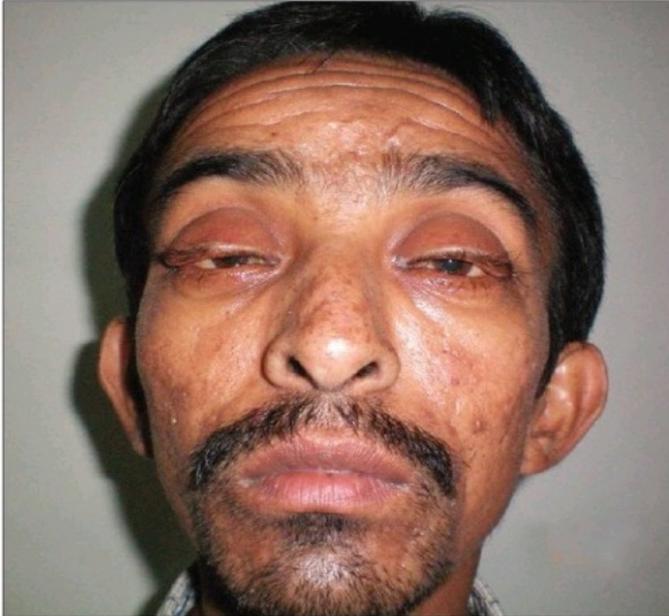
Questions:

1. What is the probable diagnosis?
2. What signs would you look for and how would you elicit them?
3. What complications can occur?
4. What are signs of strangulation?

Answers:

1. Paraumbilical hernia
2. Reducibility, cough impulse
3. Irreducibility, intestinal obstruction, strangulation
4. Tense, tender, Continuous pain, recent increase in size, irreducibility, no cough impulse.

2. Past history of cardiac problems or any hospitalization.....(9)



This patient is having diplopia mostly in afternoon,What is the most likely diagnosis?Mention at least one drug in management of this patient?What surgical treatment is needed?

Answers:

1. Myasthenia gravis.....2
2. Serological tests--anti acetylcholine antibodies, antistriated muscle antibodies, anti Musk antibodies, Tensilon test.

Radiological tests. X ray, CT and MRI for thymoma.

Electrophysiological tests—EMG.

Ice pack test.

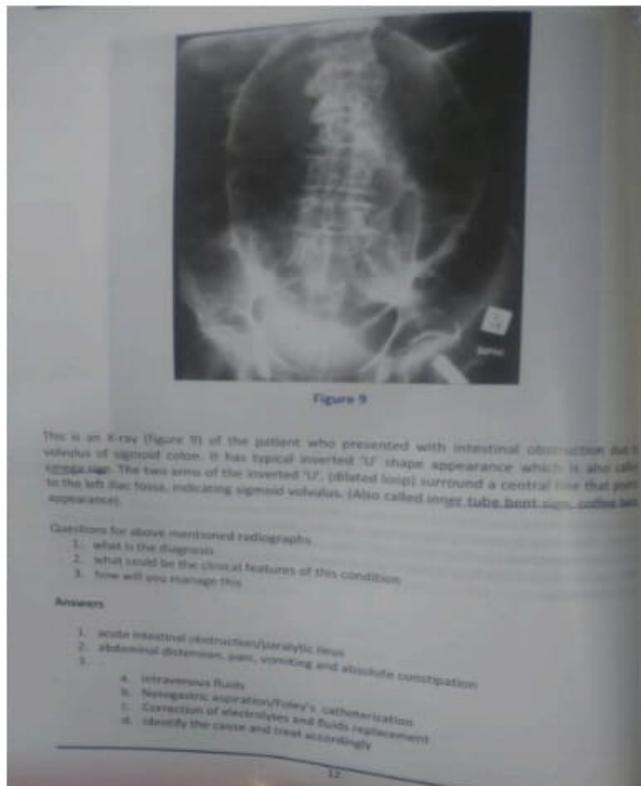


35

3. 5 Conditions: intestinal obstruction; caused by fibrous bands of tissue (adhesions); colon cancer; hernia, strictures, crohn's disease, diverticulitis, peritonitis.

4. Pass NG, decompress stomach, laparotomy

This shows the coffeebean sign which is pathonomic for intestinal obstruction due to sigmoid volvulus.



36



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only admins can send messages

7:15 p

Rabia Bangash

➔ Forwarded

Galactosemia

Lung Ca counseling

Galactosemia

Spider angiomas

Paeds abdomen exam

Adult abdomen exam

Lower limb motor exam

Organophosphorus poisoning

Meningitis

Achalasia

Appendicitis incision, complications
etc

Anxiety types , symptoms, treatment

Bile duct stone(X-ray)

GBS

Hemorrhagic stroke

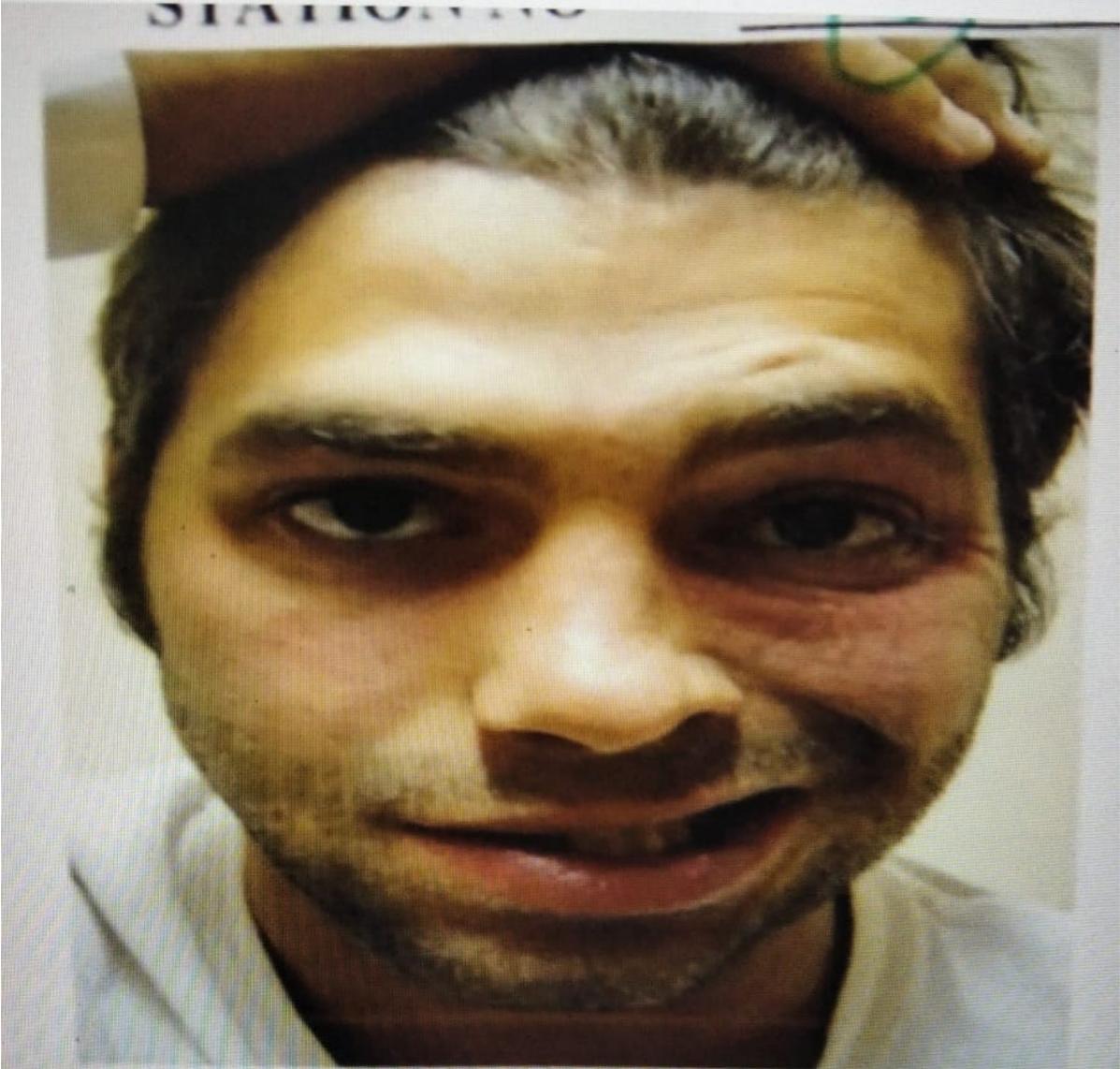
Extradural hematoma

Primary sclerosing cholangitis

7:15 pm

Rabia Bangash

➔ Forwarded



Repeat

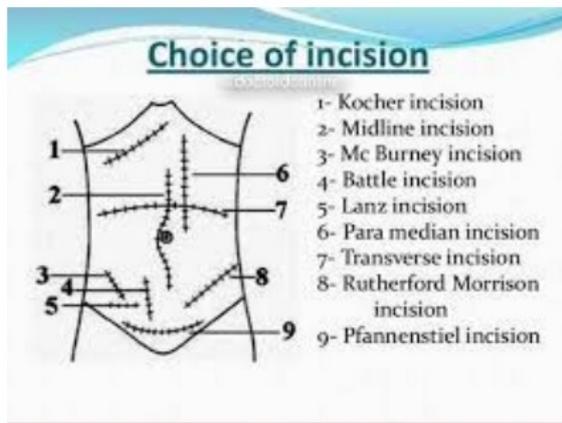
Questions:

- 1. Describe this abnormality. 2
- 2. Which nerve is involved? 2
- 3. What are the causes? 2

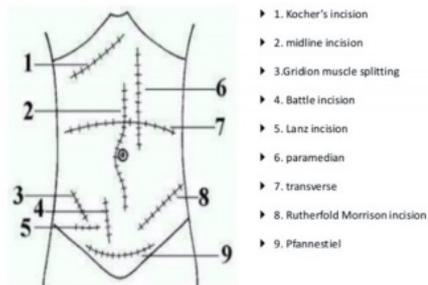
Marks 0

Being pig type

nerve



SURGICAL INCISIONS



Station 1 (picture taken from internet): air under diaphragm:



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station 6

1. dermatitis herpetiformis
2. celiac disease
3. antiglycine
4. weight barely oat Mai

(1) Malaria

(2) Types: P. Falciparum, P. malarie, P. Knowlesi,
P. Vivax

(3) Transmitted thru Bite of Anopheles

(4) Cerebral malaria.

(5) Life threatening complication of malaria when the agent infects the brain & damage neurological symp like confusion, seizures, coma:

(6) Blood smear: Thick & thin.

CBC Rapid Antigen Test:

(7) TX: hospitalize: parenteral Artemisinin.
IV Artesunate.

(8)

(9) BT = P. Vivax & ovale: Hypnozoites: Primaquine

(10) → atovaquone proguanil, mefloquine, doxy.

(11) S/E: N/V, Abd pain, Headache, Dizziness,
Skin rash.

(12) Reurrence New inf caused by the same ~~see~~ or
diff spec

Relapse: A new inf: due to reactivation
of dormant Hypnozoite

Recrudescence: A new appearance of parasite
in blood after initial TX of malaria:

(13) Primaquine.

Station 49 (Leg Case) – Key Points

- **Diagnosis:** Meningococemia
(*Neisseria meningitidis* septicemia)
- **Investigations:** Blood culture, lumbar puncture (if stable), CBC, coagulation profile, blood gas, PCR for *N. meningitidis*
- **Cause of Hypotension:** Septic shock, Waterhouse-Friderichsen Syndrome (adrenal insufficiency)

These are the CSF findings from a 6 year old who presented with inability to walk and then ended up on a ventilator. CSF analysis showed:
Clear fluid, Protein 250 mg/dl, glucose 50 mg/dl, blood sugar 54 mg/dl, microscopy 4 cells, lymphocytes 3, PMN cells 1, culture negative.

Q1. What is the diagnosis?

Repeat



1. Cushing syndrome

station 23

1 dangué

travel hx

malaria lishmenia yellow fever

ns 1 antigen pcr

station 24

dupteren contracture



BLOCK N OSCE Areej Kgmc: Photo



BLOCK O OSCE Hina New: Photo

BLOCK Q OSCE Areej Kgmc: ... +2**CLINICAL SCENARIO**

A 6 year old boy presented with complaints of progressively increasing weakness of the lower limbs for last 3 days. On examination the boy is conscious and oriented but can not walk. His both lower limbs have decreased tone, power of 1/5, and diminished reflexes. His upper limbs also have decreased power of 3/5. Cranial nerves are intact. The examination of spine and bladder is unremarkable.

Questions

- 1-What is most probable diagnosis
- 2-What is the diagnostic test you will perform
- 3-How will you manage the patient

KEY

- 1-Guillain Barre' Syndrome (AFP)
- 2-Nerve conduction studies
- 3-Management will include
 - admit
 - monitor for respiratory compromise
 - IVIG
 - Nutritional care

CLINICAL SCENARIO

- A one year old child was brought to OPD with the complaints of failure to thrive. The boy was having weight of 6Kg, length of 60 cm. He is pale and edematous. His serum albumin is 2gm/dl.

QUESTIONS

1. What three other clinically signs will you look
2. What is most probable diagnosis

KEY

Flaky dermatitis, hypotonia, hair colour and texture, behavior
kwashiorkor

CLINICAL SCENARIO

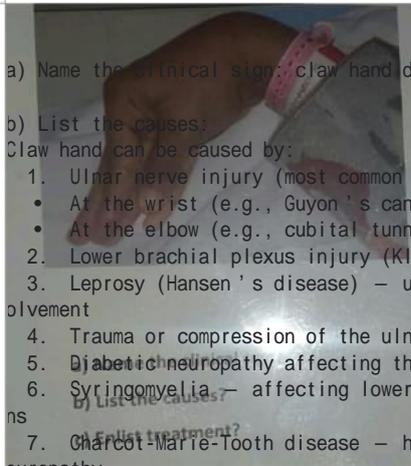
- A 15 weeks old breast fed infant presents with failure to thrive and loose motions. Examination reveals perianal rashes and eczematous lesions over face and scalp. These lesions do not respond to antifungal therapy
- Questions.

- 1-What is most likely diagnosis
- 2-How will investigate

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2019 med 1 TOACS

Me:-
 i) Avoid foods with ↑ Copper content (liver, milk, chocolate)
 ii) Penicillamine & Copper binders of copper
 iii) Zinc - inh. Cu abs in intestine
 iv) American Rhothionmolybdate (Chelator)
 v) Liver Tx.



a) Name the clinical sign: "claw hand deformity"

b) List the causes:

Claw hand can be caused by:

1. Ulnar nerve injury (most common cause)
 - At the wrist (e.g., Guyon's canal syndrome)
 - At the elbow (e.g., cubital tunnel syndrome)
2. Lower brachial plexus injury (Klumpke's palsy)
3. Leprosy (Hansen's disease) - ulnar nerve involvement
4. Trauma or compression of the ulnar nerve
5. Diabetic neuropathy affecting the ulnar nerve
6. Syringomyelia - affecting lower motor neurons
7. Charcot-Marie-Tooth disease - hereditary neuropathy

treatment:

1. Conservative Management:

- Splinting to prevent contractures
- Physiotherapy & occupational therapy
- Pain management (NSAIDs, steroids)

2. Medical Treatment:

- Nerve decompression
- Antibiotics & anti-inflammatory
- Blood sugar control in diabetic neuropathy

3. Surgical Treatment:

- Tendon transfers to restore function



a) enlist clinical signs?

b) what are its causes?

Handwritten notes on a lined paper:

Clinical signs:
 - levator palpebrae sup. (supp. by CN III)
 - superior tarsal m. (supp. by cervical symp. chain)

Causes:

- 1) CN III lesions - Unilateral comp. Ptosis
 (other signs → Dil pupil + unreactive to light)
- 2) Sympathetic Paralysis e.g. Horner's Syndrome :-
 • Unilateral Partial Ptosis
 • (other signs → Miosis + Anhidrosis on affected side)
- 3) Myopathy e.g. MG :-
 • Bilateral Partial Ptosis
- 4) Congenital :-
 • Unilateral; w/o other CNS signs

72



Ssaddle nose



Facial palsy



Bell palssy



73



Paeds final osce 2014
developmental mile stones pe
ques tha
VSD
abdominal examination
arched foot pe questions thy
malnutrition me kwashiorkor
diarrhoea IMNCI classification
chest x ray
Abdominal x Ray be
hydronephrosis
TBM pe observed
Haematology me mam
Ambreen k sath aik scenario
observed
There was an X-ray showing
rickets in child us pe questions
thy





Figure 1

1. Name this investigation?
2. How is it performed?
3. What are the findings?
4. Label the marking 1, 2 & 3?
5. What are the complications of this investigation?
6. What are various treatment options of this pathology?

ANSWERS:

1. ERCP (Endoscopic Retrograde Cholangio-pancreaticography).
2. It is performed via endoscope. The scope is passed via oral cavity and reached upto 2nd part of duodenum. Through the scope the ampulla of Vater is cannulated and dye is injected through this canula either into pancreatic duct or into CBD, then X-Ray of abdomen is obtained. In this way we can visualize pancreatic duct. (Stricture, stone) and CBD (Stricture, Stone Tumor or Leakage) and biopsy can also be obtained for diagnostic purpose. Stent across a stricture of CBD can be placed and a stone can also be extracted from CBD.
3. a. There is filling defect in CBD (mostly likely stone).
b. Dilated intrahepatic and extrahepatic biliary system
4. 1: Endoscope.
2: Dilated CBD.
3: Filling defect at lower end of CBD probably because of stone.
5. Bleeding, perforation of duodenum, pancreatitis, cholangitis.



Figure 2

This is T-Tube Cholangiogram of other patient showing filling defect (5) at the distal end of CBD (stone). In this case T-tube was left in place and stone was extracted through choledochoscope through the T-tube.

Why T-tube is placed: Handling of the common bile duct in the form of dissection, dilatation or choledocotomy invariably leads to slowing of motility in the common bile duct as well as can lead to spasm of the sphincter of Oddi. This can cause back pressure and give way of sutures used to suture the Choledocotomy incision leading to surgical catastrophe. The morbidity and mortality associated with biliary peritonitis is extremely high. Placement of a T tube prevents all these complications.

STATION 8

1. Name the X ray
2. What are the positive findings?
3. Name 6 conditions leading to this positive findings.
4. How will you manage this patient.



KEY STATION 8

1. Erect abdomen x ray 1
2. Multiple air fluid level (step ladder pattern) 1
3.
 - a. Band / adhesions .5+.5
 - b. Obst Hernia / paralytic ileus .5+.5
 - c. Malignancy / TB Abd .5+.5
4. Admit patient, i/v fluids, i/v analgesic, antibiotics, NG suction, catheterize, intake output record, prepare for laprotomy 3

STATION NO: 3

A 43 years old man gives a four months history of dyspepsia, abdominal distention and weight loss. He is of pale with negative abdominal findings, however a lymph node was palpable in the left supraclavicular fossa.

- a. State the significance of the enlarged node and how it would assist in arriving at a diagnosis.
- b. List three investigations you would perform.
- c. outline the principles of treatment.

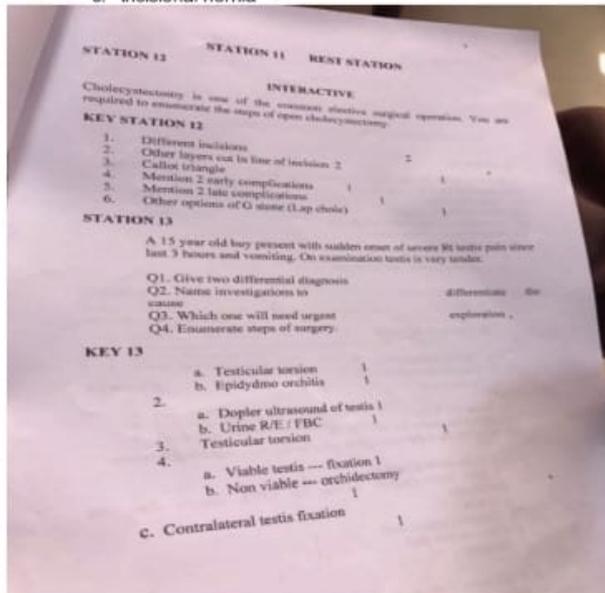
- a. Significance of enlarged node: It means the malignancy has spread. It will assist with grading and staging.
- b. Investigations:
 - a. Abdominal and Chest CT
 - b. Gastroscopy
 - c. MRI
 - d. Lymph node biopsy/FNAC
- c. Principles of treatment:
 - a. Gastrectomy (roux en y reconstruction)
 - b. Chemotherapy
 - c. Radiation
 - d. Palliative treatment

- liver. These sponges are held with Deaver's retractors by the assistants.
7. This exposes the gallbladder fully
 8. With lateral traction on the gall-bladder neck, the peritoneum overlying the triangle of Calot is incised and the cystic duct is ligated and divided after carefully tracing it onto the gallbladder.

9. Pringle's maneuver may be needed for sever bleeding
10. Abdomen is closed and peritoneum and transverse abdominis and internal oblique are closed together, then rectus muscle is closed then rectus sheath. Skin is closed with subcuticular technique.

Complications of Cholecystectomy:

1. Damage to hepatic duct or CBD
2. Damage to hepatic artery.
3. Biliary leakage leading to biliary peritonitis.
4. Missed stone in CBD or cystic duct.
5. Wound complication
 - a. Hematoma
 - b. Infection
 - c. Incisional hernia



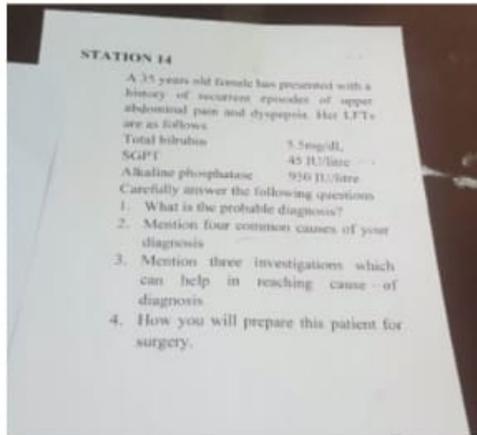
Station 10: Scenario D/D's – Testicular Torsion, epididymo-orchitis



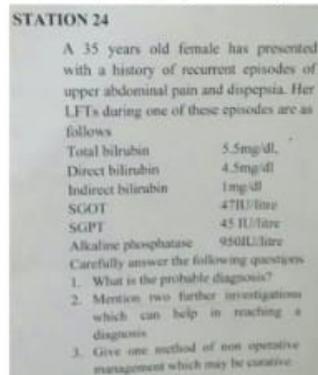
50



30



1. Obstructive Jaundice (ALP is elevated which is characteristic of OJ)
2. 4 Common Causes: Gallstones in CBD, CA Pancreas, Swelling of lymph nodes near bile duct, Pancreatic cysts, other pancreatic duct obstructions such as scarring.
3. 3 Ix which can help in reaching cause of the diagnosis: ECRP, CT scan, MRCP?
4. Prepare patient for surgery: IV fluids, NG aspiration, foley, Vitamin K, high CHO diet etc. (one other point im forgetting?)

**KEY STATION 24**

1. Choledocholithiasis
2. USG, ERCP
3. Papillotomy

31



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Forwarded

- Carcinoid syndrome
- Vertebral fracture interactive
- T Tube interactive
- Sepsis interactive
- Examination of facial nerve
- Cerebral malaria
- Meningococccemia
- Examination of abdomen medicine
- Examination of abdomen peds
- Hernia steps of surgery interactive
- 2 Stations of epidural hematoma
- Caput medusae
- Viva depression
- OCD history and management
- Intestinal obstruction
- PCM interactive

10:09 pm

Rabia Bangash

Forwarded

Ap plz ye sb class main group men shre kr do mje or girks mang ri sb ko ni kr sakti men bar nar

10:09 pm

Rabia Bangash

Forwarded



of beta blockers, diuretics, hypertension

station 15

1. caput medosa



progression over months could indicate malignancy such as hepatocellular carcinoma or pancreatic cancer and a long-term slowly progressing jaundice over years could indicate liver cirrhosis)

5. Establish predisposing events such as trauma or illness
6. Associated Symptoms:
 - a. **Pain - painless** jaundice (especially if with weight loss) may signify a serious underlying condition (such as malignancy) or **RUQ pain** and jaundice (e.g. gallstones, acute cholangitis, hepatitis)
 - b. **Nausea and vomiting** - especially important to ask about **haematemesis** (may be due to varices seen in chronic liver disease)
 - c. **Bowel habit** - loose stool, constipation

15

- d. **Change in stool colour** - e.g. **pale and greasy** (steatorrhea indicating bile duct obstruction seen in pancreatic malignancy or gallstones etc), **dark/black/tarry** (seen in an upper GI bleed)
- e. **Change in urine colour** - **dark urine** is seen in bile duct obstruction
- f. **Skin - pruritis** (itching due to bile salts/acids deposits in the skin), **bruising** (due to coagulation disturbances seen in liver disease)
- g. **Fever** - the trio of fever, RUQ pain and jaundice often indicate ascending cholangitis
7. Establish red flag symptoms: Weight loss, anorexia, night sweats
8. Establish risk factors: alcohol, drugs, tattoos/piercings, sexual history, travel history, family history, blood transfusions, past medical history
9. Thank patient, offer DD's and Ix

Location	Bilirubin	ALT/AST	ALP
Pre-hepatic	Normal/high	Normal	Normal
Hepatic	High	Elevated (commonly very high)	Sometimes elevated but rarely very high
Post-hepatic	High/very high	Moderately raised	High/very high

Other histories:



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CLINICAL SCENARIO

An 8 month old boy presented in the emergency room with the complaints of fever and cough for 3 days, vomiting for 1 day generalized fits for ½ hour. On examination he has fever of 101F, some dehydration and irritability.

His CSF examination showed TLC-2000/cmm, DLC poly-75%, lympho-25%, RBCs-few, protein-120 mg/dl, sugar -30mg/dl.

Questions

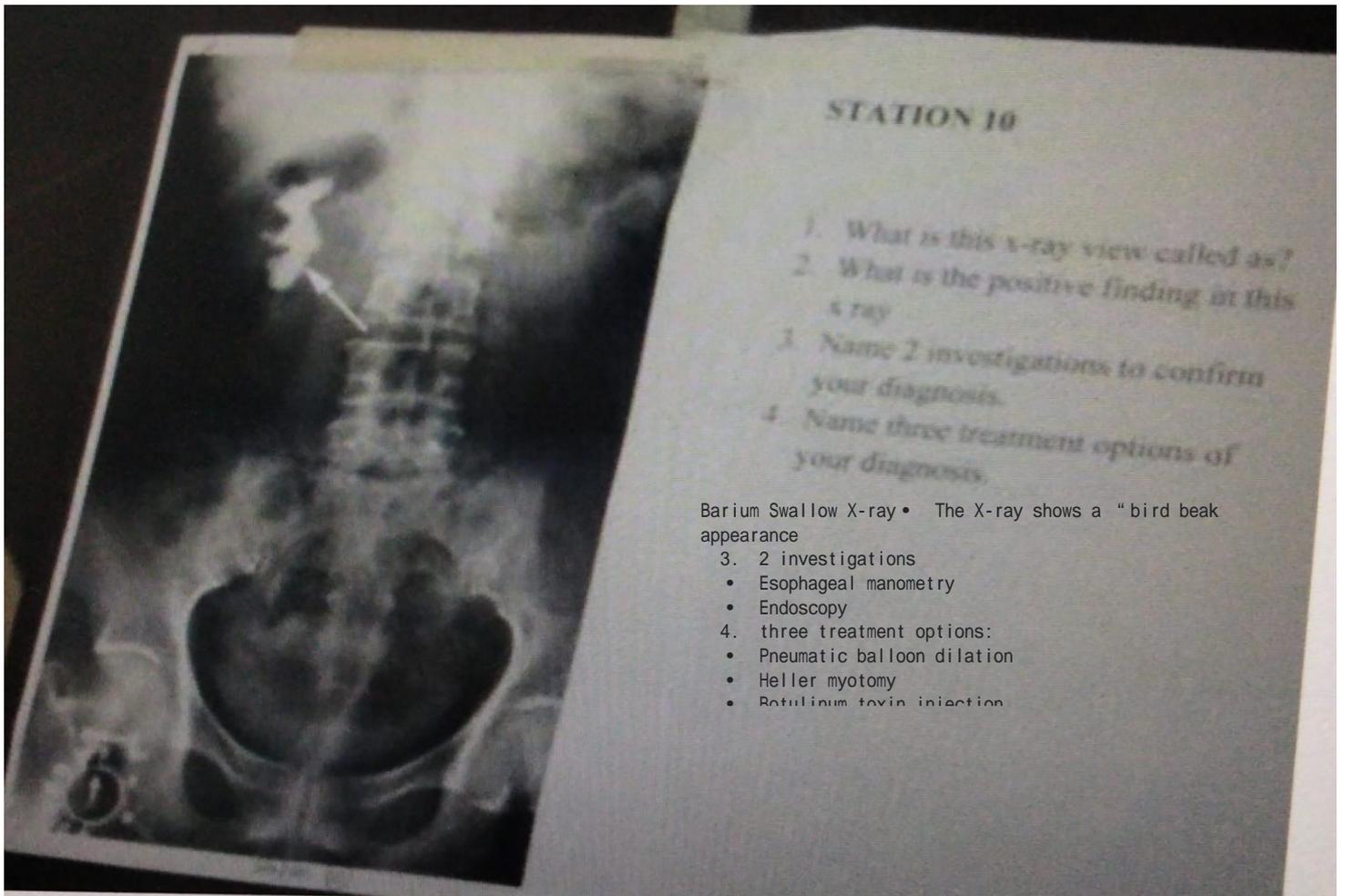
- 1-What is the diagnosis
- 2-What are the two most probable causative organisms

KEY

- 1-Acute bacterial meningitis
- 2-H –influenzae, streptococcus pneumoniae
- 3-His management will include
 - ABC
 - Anticonvulsants
 - antibiotics

Table 2. KDIGO Classification of Nephrotic Syndrome

Classification	Criterion
SSNS	CR attained with corticosteroid therapy
Initial remission	CR attained within initial 4 wk of corticosteroid therapy



STATION 10

1. What is this x-ray view called as?
2. What is the positive finding in this x ray
3. Name 2 investigations to confirm your diagnosis.
4. Name three treatment options of your diagnosis.

Barium Swallow X-ray • The X-ray shows a “bird beak appearance

3. 2 investigations
 - Esophageal manometry
 - Endoscopy
4. three treatment options:
 - Pneumatic balloon dilation
 - Heller myotomy
 - Botulinum toxin injection

A 3 year old previously healthy girl is brought to the emergency room with complaint of difficulty in breathing for the last 2 days Read her chest x-ray given below.

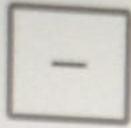
1. Describe the positive findings?
 2. What next test is indicated?
 3. What is the most likely diagnosis?
- 1) Cardiomegaly (1.5)
 - 2) Echocardiography (1.5)
 - 3) Myocarditis with CCF (2.0)

STATION # 18

REGARDING CARBAMAZEPINE

Questions:

- A. WHAT IS THE INDICATION OF THIS DRUG?
- B. WHAT IS THE DOSE OF THIS DRUG?
- C. GIVE 3 SIDE EFFECTS.
- D. WHICH INVESTIGATION WILL YOU DO BEFORE STARTING THE DRUG?
- E. HOW WILL YOU MONITOR THE TREATMENT? (Mention only 2)



+



29

of 162



STATION 211

(STATIC)

A 3 weeks old baby presented to ER with complaints of projectile non bilious vomiting for last 4 days. On examination, an olive like mass can be felt in Epigastric region.

- i. What is your clinical diagnosis?
- ii. Which investigations will you do to diagnosis this case?
- iii. What is the expected metabolic & electrolyte imbalance in this case? *hypokalemia + metabolic alkalosis*
- iv. What is the surgical treatment?

Hypertrophic Pyloric Stenosis (HPS)..

Investigations:

1. Ultrasound abdome
2. Upper GI contrast study Shows a "st g sign

• Hypochloremic, hypokalemic metabolic alkalosis

Surgical Treatment:



79.0

STATION NO:

Ans 01 Teratology of fallot.

Ans 02

01 Medical Management

- * Maintain adequate hydration
- * Temperature maintenance
- * Blood Glucose level monitored
- * Hb and Hct maintained in normal
- * Antibiotics

02 Management of hypoxic spells.

- * Oxygen inhalation
- * Place the child in knee-chest position to increase vascular resistance.
- * Morphine sulphate to decrease anxiety.
- * β -receptor blocking agent to decrease muscular spasm.

03 Surgical Management

- Palliative Surgery
 - Blalock-Taussig shunt
 - Waterston shunt
 - Potts shunt
- Corrective Surgery closing VSD and resecting outflow obstruction

PAEDS OSPE.

STATION NO: 01

1

Q1
Ans: Three signs of dehydration are:

- * Lethargic or unconscious, Restless or Irritable
- * Do not drink or drink poorly, eager to drink or thirsty
- * Sunken eyes
- * Skin pinch goes slowly or very slowly.

Q2
Ans: To classify this child for Diarrhea

For Dehydration:→

If two of signs:

- * Lethargic or unconscious
- * Not able to drink or poorly drink
- * Sunken eyes
- * Skin pinch goes very slowly

It is classified as SEVERE DEHYDRATION

If two of signs

- * Restless or Irritable
- * Eager to drink or thirsty
- * Sunken eyes
- * Skin pinch goes slowly

It is classified as SOME DEHYDRATION

If no sign, no dehydration.

02 Year Asia Presented in emergency department with history motions and vomiting for 5 days look at the picture and.

Q1: Write down 3 signs of dehydration

Q2: How will you classify according to MNCI



STATION 1

STATION NO:

24 MONTHS OLD GIRL BRINGING TO ME AS LETHARGIC THE HAS HISTORY LOSS MOTIONS AND VOMITING FOR 2 DAYS

Ans 01 Severe dehydration

Ans 02: Start IV fluid immediately

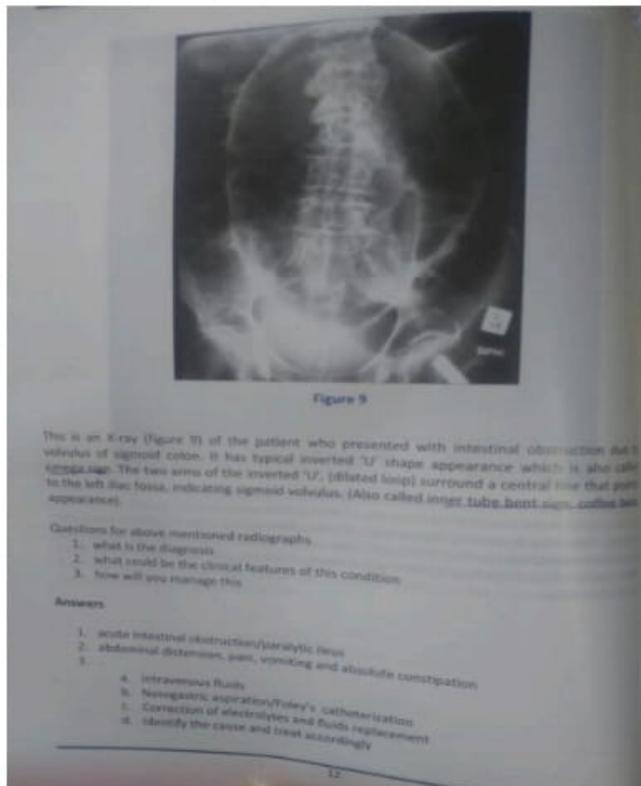


35

3. 5 Conditions: intestinal obstruction; caused by fibrous bands of tissue (adhesions); colon cancer; hernia, strictures, crohn's disease, diverticulitis, peritonitis.

4. Pass NG, decompress stomach, laparotomy

This shows the coffeebean sign which is pathonomic for intestinal obstruction due to sigmoid volvulus.



36



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A 35 years old female has presented with a history of recurrent episodes of upper abdominal pain and fever. Her LFT's during one of these episodes are as follows:

Total bilirubin	5.5mg/dl
Direct bilirubin	4.5mg/dl
Indirect bilirubin	1mg/dl
SGOT	47IU/litre
SGPT	45IU/litre
Alkaline phosphatase	950IU/litre

Task:

Carefully answer the following questions:

1. What is the probable diagnosis? 01
2. Mention two further investigations which can help in reaching a diagnosis. 02
3. Give ONE method of non operative management which may be curative. 02

KEY:

1. Choledocholithiasis 01
2. USG, ERCP 02
3. Papillotomy 02

A 35 years old female has presented with a history of recurrent episodes of upper abdominal pain and fever. Her LFT's during one of these episodes are as follows:

Total bilirubin	5.5mg/dl
Direct bilirubin	4.5mg/dl
Indirect bilirubin	1mg/dl
SGOT	47IU/litre
SGPT	45IU/litre
Alkaline phosphatase	950IU/litre

Task:

Carefully answer the following questions:

1. What is the probable diagnosis? 01
2. Mention two further investigations which can help in reaching a diagnosis. 02
3. Give ONE method of non operative management which may be curative. 02

KEY:

1. Choledocholithiasis 01
2. USG, ERCP 02
3. Papillotomy 02



Figure 44

This 20 years old boy presented with dysphagia and recurrent chest infection. Observe this picture (figure 44) and answer the questions given below.

QUESTIONS:

1. What is this investigation called?
2. What are the findings?
3. What is diagnosis?
4. What is differential diagnosis?
5. What is the treatment of this condition?

ANSWERS:

1. Barium Swallow.
2. Narrowing at the lower end of esophagus and dilated proximal esophagus.
3. Cardia achlasia.
4.
 - a. Carcinoma esophagus.
 - b. Esophageal stricture.
5.
 - a. Esophageal balloon dilatation.
 - b. Heller Myotomy.
 - c. Botulinum toxin.
 - d. Nifedipine.

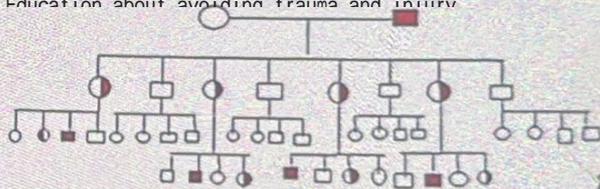
Station 29

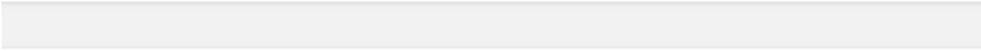
This young man presented with recurrent knee swelling while playing.

Questions:

1. What is the most likely diagnosis?
2. What sort of genetic disorder is present?
3. Mention important counseling step.

1. Most Likely Diagnosis:
 - Hemophilia (either Hemophilia A or B).
2. Type of Genetic Disorder:
 - X-linked recessive inheritance pattern
 - The affected individual is male, and the trait is inherited from a carrier mother.
3. Important Counseling Step:
 - Genetic counseling
 - Carrier screening
 - Prenatal diagnosis can be considered for at-risk pregnancies
 - Education about avoiding trauma and injury





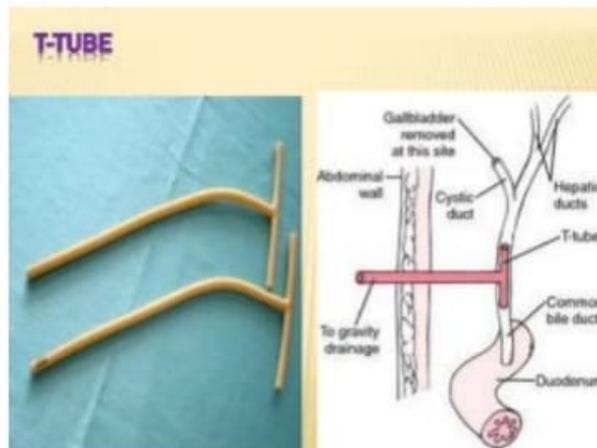
STATION NO: 18

A 30 years old man is referred to surgical clinic with a six week history of asymptomatic swelling in the Rt. testis of his scrotum. On examination, Rt. testis was hard & one can get above it. There is suspicion of testicular tumor.

- a. Give 03 differential diagnosis?
- b. What are different types of testicular tumor?
- c. Name the different tumor markers for testicular tumor.
- d. List the investigations.
- e. State the principles of treating this condition.

KEY STATION 18

a.		
	i. Inguinal Hernia	01
	ii. Hematoma	01
	iii. Testicular hydrocele	01
b.		0.5
each (total=02 marks)		
	i. Teratoma	0.5
	ii. Seminoma	0.5
	iii. Yolk sac tumor	0.5
	iv. Lymphoma	0.5
c.		
	i. Beta HCG	01
	ii. LDH	01
	iii. Alpha Feto Protein	01
d.	0.5 each (total=01 mark)	
	i. Ultrasound	0.5
	ii. CT scan	0.5
e.	Traninguinal orchidectomy, Radio for para aor Lymph node + chemotherapy	01



Uses of this device: a draining tube placed in the common bile duct after common bile duct (CBD) exploration with supra-duodenal choledochotomy. It provides external drainage of bile into a controlled route while the healing process of choledochotomy is maturing and the original pathology is resolving. T-tubes can also be used for persistent duodenal fistulas, pancreaticoduodenectomies, or hepaticojejunostomy in liver transplantation.

Complications of T-Tube: Accidental T-tube displacement leading to CBD obstruction, bile leakage, duodenal erosion, persistent biliary fistula and excoriation of the skin, dehydration, saline depletion, cholangitis and CBD stenosis. It also increases the chances of a post-operative infection.

When should a T-Tube be removed: T-tube should be removed 2 weeks after its placement.

Complications of T-tube removal: Bile leakage leading to ascites, biloma, and bile peritonitis

Station 9: Steps of a Cholecystectomy:

Laparoscopic:

1. Prepared and draped similar to open procedure after giving GA
2. Foley catheter is placed and Orogastric tube is inserted to avoid inadvertent injury and improve exposure.
3. Pneumoperitoneum is established with a veress needle through a sub-umbilical incision
4. 10mm trocar canula is inserted sub umbilically.
5. A 30 degree laparoscope is then inserted through the umbilical port, and an examination



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STATION 8

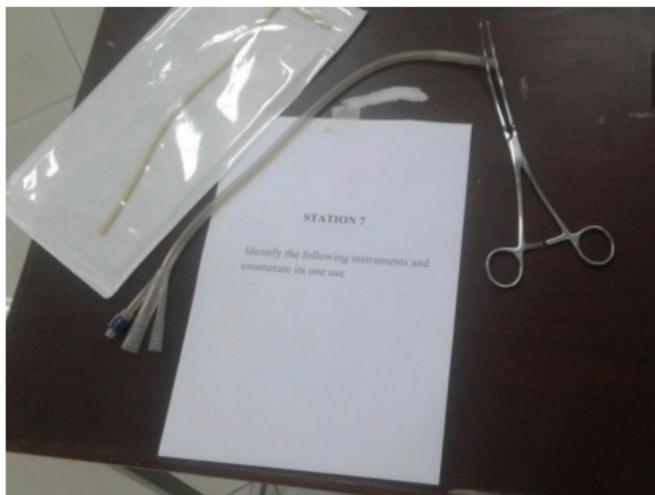
INTERACTIVE

This 45 years old patient presented to OPD with left facial swelling. Carefully examine the given photograph and answer the following questions by the examiner.

- Q1. Enumerate 2 findings
- Q2. What is the most probable diagnosis?
- Q3. How will you confirm your diagnosis?
- Q4. What surgical procedure will you do?
- Q5. Name 2 post op surgical complications.



26



T-Tube and Foley's catheter

27



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station 16.

**1.;hyperdense shadow on right side e
irregular margin e hypodense surrounding
and mass effect center shift**

2. left side

**3. bery anurysum , polycystic kidneys .
vasculitis.**

4. hypertensive

station 17

STATION 7

A young newly married woman presented to emergency room with pain Rt iliac fossa of sudden onset associated with mild fever, vomiting and hypotension. On examination she is pale, tachycardic with lower abdominal tenderness and guarding. BP is 80/40.

1. What is your most probable diagnosis?
2. Name 3 differential diagnosis
3. Enumerate 2 investigations to confirm your diagnosis.
4. Enumerate steps of initial management

1. Most Probable Diagnosis:
 - ruptured ectopic pregnancy.

2. Three Differential Diagnoses:

- Acute appendicitis
- Ovarian torsion or ruptured ovarian cyst
- Pelvic inflammatory disease (PID) with tubo-ovarian abscess

3. Two Investigations to Confirm Diagnosis:

- Transvaginal ultrasound (TVUS)
- Serum β -hCG

4. Initial Steps of Management:

- Resuscitation:

- Establish two large-bore IV lines and initiate fluid resuscitation with cry Normal Saline or Ringer's lactate).

- Blood transfusion if the patient is hemodynamically unstable.

- Confirm Diagnosis:

- Perform an urgent ultrasound and check serial β -hCG levels.

- Emergency Surgical Intervention:

- Laparoscopy or laparotomy for surgical removal of the ectopic pregnancy

- Monitor and Follow-up:

- Monitor vital signs, urine output, and hemoglobin levels • Rh immunoglobul

STATION 08



This patient is having generalized weakness & diplopia mostly after exertion.

- Question 1: What is the most likely diagnosis? 3
- Question 2: Enumerate the investigation plan? 4
- Question 3: What is the treatment? 3

1. Diagnosis:
 - Myasthenia Gravis (MG)
2. Investigation Plan:
 - Edrophonium (Tensilon)
 - Serum anti-acetylcholine receptor (AChR) antibodies
 - Repetitive nerve stimulation test
 - Single-fiber EMG
 - CT or MRI of the chest
 - Ice pack test
3. Treatment:
 - First-line treatment:
 - Acetylcholinesterase inhibitors
 - Immunosuppressive therapy
 - Corticosteroids (Prednisone)
 - Azathioprine or Mycophenolate mofetil
 - Plasmapheresis or Intravenous Immunoglobulin
 - Thymectomy

What is the risk to the student? How would you manage this student

1. What is this x-ray view called as?
2. What is the positive finding in this x ray
3. Name 2 investigations to confirm your diagnosis.
4. Name three treatment options of your diagnosis.

KEY STATION 10

- | | | | |
|----|--|---|---|
| 1. | X ray KUB | | |
| 2. | Single radio opaque shadow in Rt kidney area | | 1 |
| 3. | 2 | | |
| | a. IVU | | |
| | b. Ultrasound abd/Pelvis | | |
| 4. | | 1 | 1 |
| | a. ESWL | | |
| | b. PCNL | | |
| | c. Open surgery | | |
| | Pylo/Nephrolithotomy | 1 | 1 |
| | | | 1 |



Figure 45

A 39 years old smoker presented with vomiting after meal. This X-ray (figure 45) was taken 1 hour after taking barium sulphate.

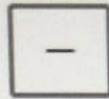
Carefully examine the radiograph and answer the following questions:

Questions:

1. What is the probable diagnosis?
2. Name another important investigation which should be done.
3. If it is a benign disease, name one non operative and one operative treatment which should be done.
4. If it is a malignant condition, name one operative treatment which should be done.

Answers:

1. Pyloric stenosis
2. Gastroscopy
3. Endoscopic balloon dilatation/Gastrojejunostomy
4. Radical Gastrectomy



s/Case

STATION 18

(INTERACTIVE)

A 40 years old female presented to you in OPD with complaints of pain in Rt. upper quadrant of abdomen which increase by intake of fatty food. Pain is colicky in nature subsides after taking medications.

- i. What is your diagnosis?
- ii. What investigations will you advise?
- iii. What is the treatment recommended?

diagnosis

- Biliary Colic due to Cholelithiasis

1. US

2. Liver function tests (LFTs)

- Elevated ALP and GGT

3. Complete blood count (CBC)

4. Amylase/Lipase

5. **HIDA scan

Lifestyle and Dietary Changes:

- Avoid fatty and greasy foods to prevent symptoms.
- Maintain a healthy weight and diet.

2. Definitive Treatment:

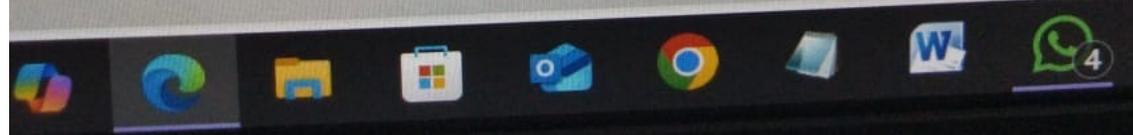
lap cholecystectomy

Ercp

3. Symptomatic Management:

NSAIDs

antispasmodic

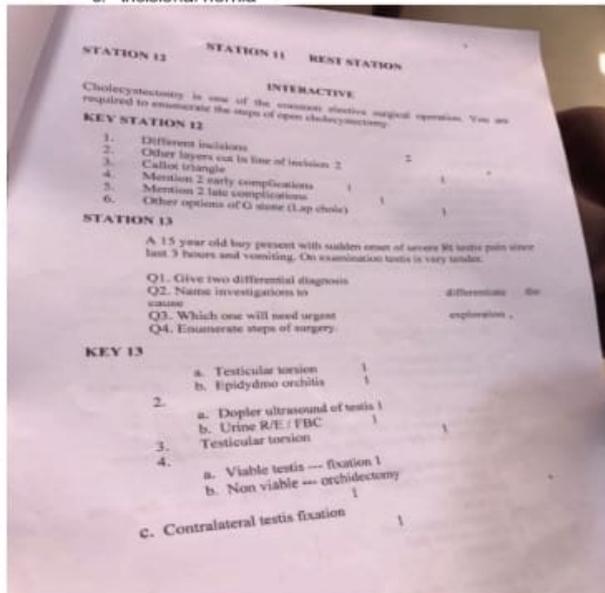


- liver. These sponges are held with Deaver's retractors by the assistants.
7. This exposes the gallbladder fully
 8. With lateral traction on the gall-bladder neck, the peritoneum overlying the triangle of Calot is incised and the cystic duct is ligated and divided after carefully tracing it onto the gallbladder.

9. Pringle's maneuver may be needed for sever bleeding
10. Abdomen is closed and peritoneum and transverse abdominis and internal oblique are closed together, then rectus muscle is closed then rectus sheath. Skin is closed with subcuticular technique.

Complications of Cholecystectomy:

1. Damage to hepatic duct or CBD
2. Damage to hepatic artery.
3. Biliary leakage leading to biliary peritonitis.
4. Missed stone in CBD or cystic duct.
5. Wound complication
 - a. Hematoma
 - b. Infection
 - c. Incisional hernia



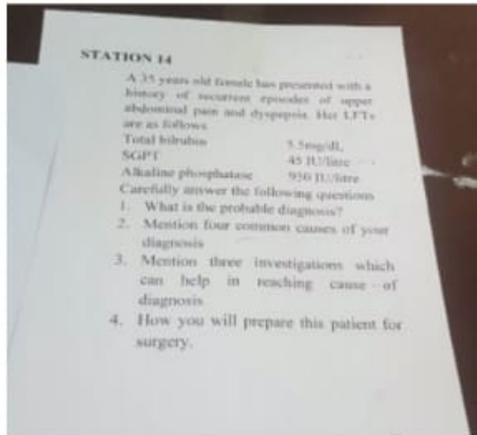
Station 10: Scenario D/D's – Testicular Torsion, epididymo-orchitis



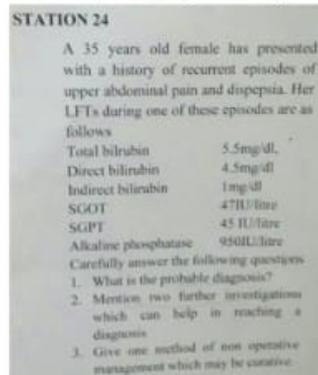
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30



1. Obstructive Jaundice (ALP is elevated which is characteristic of OJ)
2. 4 Common Causes: Gallstones in CBD, CA Pancreas, Swelling of lymph nodes near bile duct, Pancreatic cysts, other pancreatic duct obstructions such as scarring.
3. 3 Ix which can help in reaching cause of the diagnosis: ECRP, CT scan, MRCP?
4. Prepare patient for surgery: IV fluids, NG aspiration, foley, Vitamin K, high CHO diet etc. (one other point im forgetting?)

**KEY STATION 24**

1. Choledocholithiasis
2. USG, ERCP
3. Papillotomy

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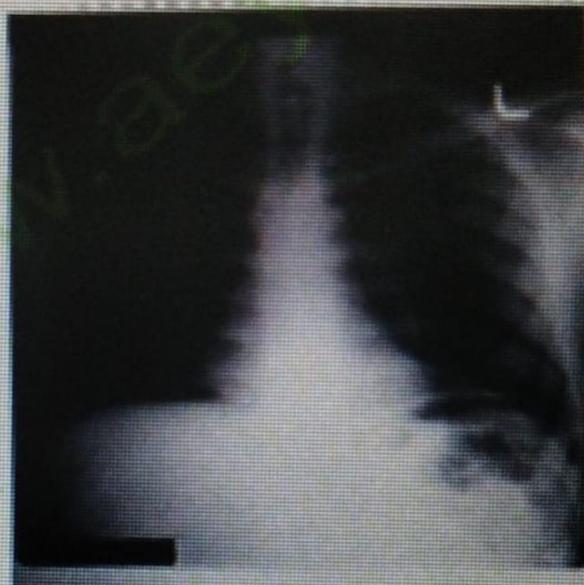
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1. What is the probable diagnosis? 01
2. Name TWO important steps in the pre op treatment of this patient. 02
3. Name the definitive procedure which needs to be done. 02



KEY:

1. Perforated duodenal ulcer 01
2. Fluid resuscitation and antibiotics 02
3. Closure of perforation, with omental patch if necessary 02



TOACS STATION#14

A NEWBORN BABY IS BROUGHT TO NURSERY BECAUSE PARENTS ARE CONCERNED ABOUT THE APPEARANCE OF EXTERNAL GENITALIA OF THE BABY

QUESTION#01

DESCRIBE THE POSITIVE FINDINGS?

QUESTION#02

WHAT IS THE MOST LIKELY DIAGNOSIS?

QUESTION#03

MENTION 2 IMPORTANT INVESTIGATIONS TO REACH THE DIAGNOSIS

positive findings:

- Ambiguous genitalia:
- Enlarged clitoris resembling a penis.
- Fusion of the labial folds, resembling rotum.
- No palpable testes in the scrotal regi

diagnosis:

Congenital Adrenal Hyperplasia (CAH)

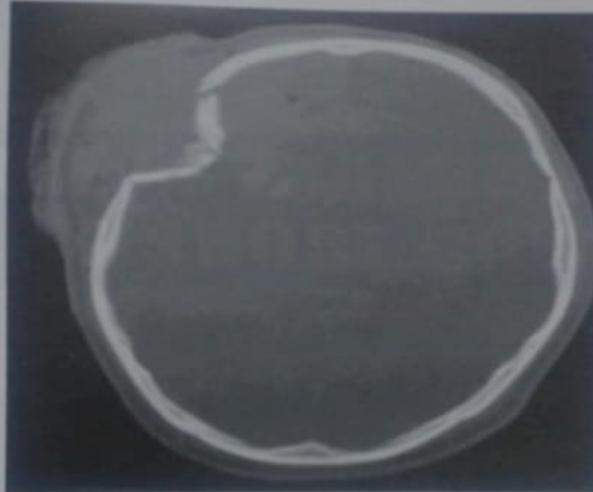
2 important investigations:

Serum 17-Hydroxyprogesterone
Elevated levels confirm 21-hydroxylase deficiency (CAH).

2. Karyotyping

Investigations (if needed):

- Electrolyte
- Ultrasound Abdomen/Pelvic



Carefully examine the given CT scan given above and answer the following questions.

1. What is the abnormality on this CT scan
2. What clinical features may be present in this patient
3. What is treatment of this abnormality

Answers:

1. Depressed fracture of the skull.
2. History of head injury with blunt object, presence of palpable depression in the skull signs of raised intracranial pressure i.e. loss of consciousness, hypertension and bradycardia.
3. Craniotomy and elevation of the depressed segment.

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A Practical Guide to OSPE/OSCE/TOACS and Clinical Methods in Surgery



Figure A
Day: 1

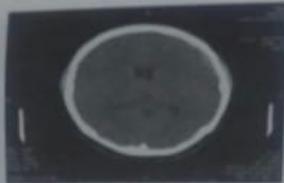


Figure B
Day: 3



Figure C
Day: 7

A 60 years old lady develops head injury in toilet. Her CT scan at 1st, 3rd and 7th day of injury is shown. Read the questions and answer.

1. What is the diagnosis
2. Describe the CT findings
3. What would be the most likely clinical features of this patient
4. What should be the management

Answers:

1. Subdural hematoma.
2. On the 1st image of the CT scan (figure A) there is bright crescent shape shadow which has distinct border and is not crossing the midline. On 2nd image (figure B taken after 3 days) the clot has faded to isodense, the lesion is difficult to see as it has same density as brain matter. On 3rd image (figure C) which was taken after 7th days of trauma the lesion is looking dark (Hypodense).
3. Headache and fluctuating level of consciousness.
4. Burr hole and drainage of hematoma.

Station 43

Questions:

1. Look carefully at this CT image of the abdomen and give at least three differentials
2. What other investigations would you want to see?
3. What four clinical signs would you expect in this patient?
4. What complication the patient can have?



differential diagnoses:

Liver abscess
Hepatocellular carcinoma (HCC)
Liver metastasis
Hemangioma
Hepatic cyst

investigations:

LFTs)
Amoebic serology
Tumor markers (AFP for HCC, CEA
Blood culture
Ultrasound abdomen
MRI
Biopsy/FNAC

clinical signs:

1. Fever and right upper quadrant (RQ) pain
2. Jaundice
3. Hepatomegaly
4. Weight loss and fatigue

complications:

Rupture of liver abscess
Sepsis and septic shock
Portal vein thrombosis
Liver failure

Nutrition

- 1- What are 4 positive findings in this picture? (2)
- 2- What is the diagnosis? (1)
- 3- What are the causes which lead to this condition? (2)



Key:

1- (0.5 each)

- i. Puffy moon face
 - ii. Miserable looking and apathetic
 - iii. Flaky paint dermatitis
 - iv. Edema feet
- 2- Kwashiorkor (1)

3- Primary malnutrition (1) (0.25 each for any 4 of the 5)

- i. Failure of lactation
- ii. Ignorance of weaning
- iii. Poverty
- iv. Cultural pattern and food fads
- v. Lack of immunization
- vi. Lack of family planning

Secondary malnutrition (1) (0.25 each for any 4 of the 5)

- i. Infections
- ii. Congenital diseases
- iii. Malabsorption
- iv. Metabolic



STATION 22

Carefully examine the given patient and answer the following questions

1. Give the descriptive name for this pathology
2. Give three differential diagnosis
3. Describe four clinical signs which you would elicit to help reach diagnosis

other D/D: lymphadenopathy, metastatic neoplasm, hydrocele, epididymitis, abscess, hematoma

Key station 22

- | | |
|---|---|
| 1. Inguinoscrotal swelling | 2 |
| 2. Inguinal hernia, infantile hydrocele | 3 |
| 3. Can reach above the swelling or not | 3 |
| a. Reducibility | |
| b. Cough impulse | |
| c. Deep ring occlusion test | |

Hydroceles may appear bluish; if hernia, there may be presence of a "silk glove sign" when the layers of the hernia sac are palpated sliding over each other.

What pathologies could you palpate in the kidneys bilaterally?



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Large gut obstruction...Haustra

Q 3. Write instructions for follow up of this child.

A 7 years old boy is admitted with history of fever, headache and unconsciousness from the last 3 days. He is unwell for the last 1 month with low grade fever, off and on headache and was coughing with lots of sputum.

TBM

His CSF finding are

Turbidity = present

Cell count = 250 cells / mm³

N = 2 %

L = 98 %

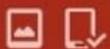
Protein = 120 mg/dl

Sugar = 28 mg/dl

Blood Sugar = 104 mg

X-ray chest show hilar lymphadenopathy interpret this data.

- What is the diagnosis?
- Discuss treatment plan



40% 6:45 PM

Q:
A 9 years old girl who had previously been

1.GBS

4. hypertensive

station 17

1 hypodense shadow e internal
hyperdensity

2. disphagia paralysis

3.

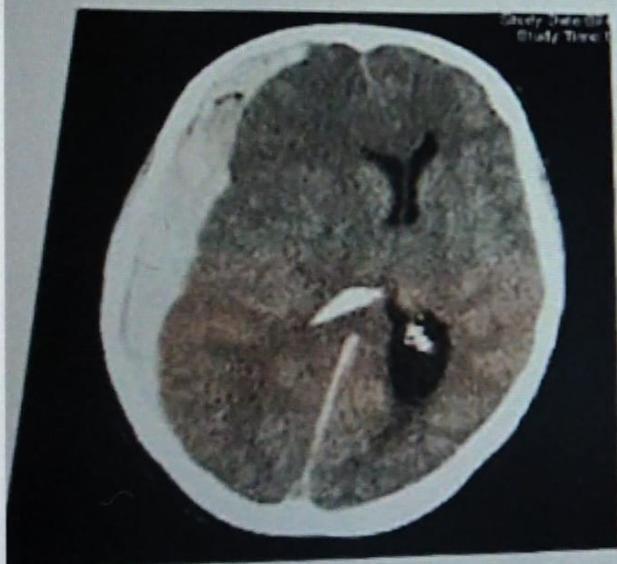
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STATION 16

A 60 years old man sustained a fall in toilet 4 days ago. His CT scan had presented here.

Carefully examine the given CT and answer the following questions:

1. What positive findings does it show?
2. What clinical feature is likely to lead to suspicion of diagnosis?
3. What should be the management?



positive findings:

- The CT scan shows a hyperdense (bright) biconvex/lentiform-shaped lesion in the right hemisphere, indicative of an epidural hematoma (EDH).
- There is midline shift, suggesting raised intracranial pressure (ICP).
- Possible compression of adjacent brain structures due to mass effect.

2. clinical feature:

- History of head trauma/fall
- Lucid interval
- Headache, vomiting, drowsiness, confusion, or loss of consciousness.

• Focal neurological deficits

the management:

- Immediate neurosurgical evaluation.
 - Emergency craniotomy or burr hole evacuation if there is a significant hematoma (>30 mL), midline shift, or neurological deterioration.
 - Mannitol or hypertonic saline to manage raised ICP
 - Supportive care: Airway protection, oxygenation, and blood pressure control.
 - Monitoring in ICU/neurosurgical ward for deterioration
- CT scan



hydatid cyst

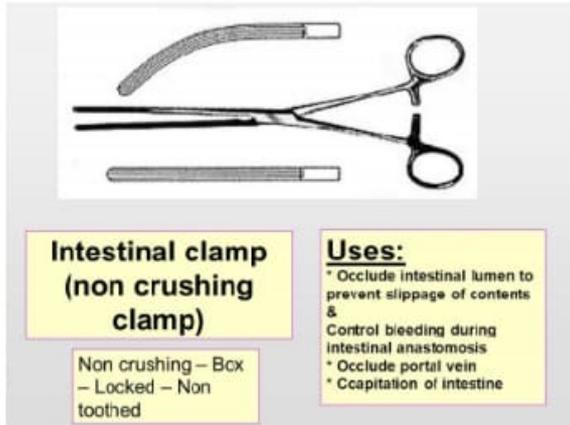


CT IVU (pouchogram)

IOACS:-

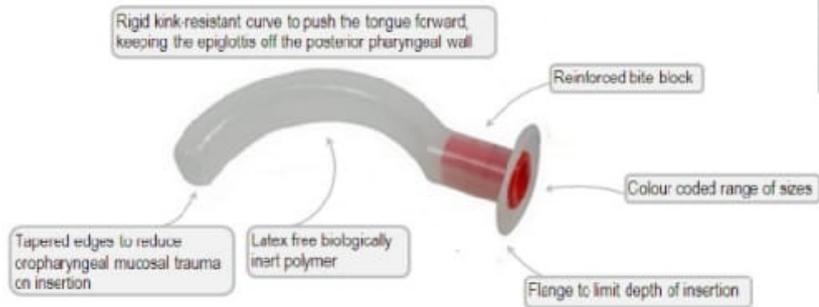
1- Identify the instrument.

- lumbar puncture needle.
- 3 uses
- 3 contraindications.



Guedel's Airway: oropharyngeal airway tube that bypasses the tongue and upper pharynx. The use of this device is reserved for incompletely conscious, as its insertion into the face of an alert person is usually greeted with violent confrontation.

Indications: unconscious patient with loss of upper airway muscle tone; unconscious patient with difficult bag/mask seal; intubated patient, in whom the oropharyngeal airway acts as a bite block, preventing the kinking of the softer endotracheal tube.



Edit Annotate Fill & Sign Convert All

A young girl is brought to you with fever, anorexia and upper abdominal discomfort for the last three days. On examination there is no definite jaundice, but there is tenderness in right upper quadrant of abdomen. Lab test shows normal CBC, bilirubin 1.9 mg/dl and SGPT is 2500 iu.

acute viral hepatitis, particularly hepatitis A or E
differential diagnoses:

- Drug-induced liver injury (DILI)
- Autoimmune hepatitis
- Wilson's disease (in pediatric patients)
- Leptospirosis (if history of exposure is present)

What is the diagnosis? How will you investigate her?

How will you treat her?

Investigations:

1. Viral Hepatitis Panel:
 - Anti-HAV IgM for hepatitis A
 - Anti-HEV IgM for hepatitis E
 - HBsAg & Anti-HBc IgM for acute hepatitis B
 - Anti-HCV IgM for hepatitis C

2. Liver Function Tests (LFTs):

- AST, ALT (already elevated), Bilirubin, ALP, Albumin

3. Coagulation Profile:

- PT/INR To assess liver synthetic function

4. Ultrasound Abdomen:

- To rule out biliary obstruction, fatty liver, or other structural causes

5. Autoimmune & Metabolic Workup (if needed):

- ANA, Anti-Smooth Muscle Antibody (autoimmune hepatitis)
- Serum ceruloplasmin (Wilson's disease)

Treatment:

1. Supportive Care:

- Rest and hydration with IV fluids if necessary
- Nutritional support with a light diet, avoiding fatty and fried foods
- Antiemetics (ondansetron) if nausea/vomiting is present

2. Monitoring:

- Serial LFTs and PT/INR

3. Avoid Hepatotoxic Drugs:

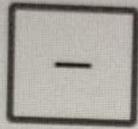
- No paracetamol, NSAIDs, or unnecessary medications

4. Specific Treatment • If hepatitis A or E No specific antiviral therapy

- If fulminant hepatitis (INR >1.5, encephalopathy) Consider ICU admission and liver transplant evaluation

5. Prevention:

- Hepatitis A vaccination for close contacts



+

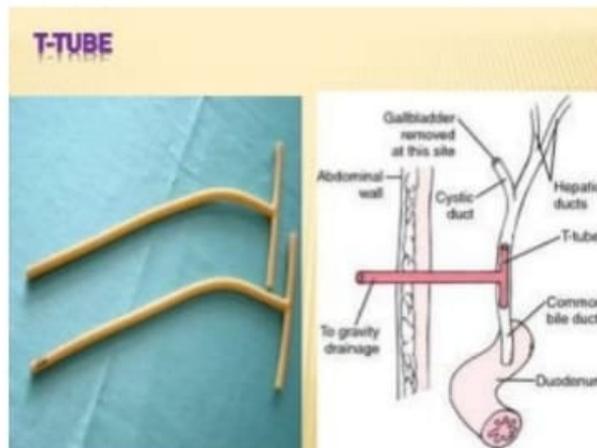


35

of 162



Light blue font



Uses of this device: a draining tube placed in the common bile duct after common bile duct (CBD) exploration with supra-duodenal choledochotomy. It provides external drainage of bile into a controlled route while the healing process of choledochotomy is maturing and the original pathology is resolving. T-tubes can also be used for persistent duodenal fistulas, pancreaticoduodenectomies, or hepaticojejunostomy in liver transplantation.

Complications of T-Tube: Accidental T-tube displacement leading to CBD obstruction, bile leakage, duodenal erosion, persistent biliary fistula and excoriation of the skin, dehydration, saline depletion, cholangitis and CBD stenosis. It also increases the chances of a post-operative infection.

When should a T-Tube be removed: T-tube should be removed 2 weeks after its placement.

Complications of T-tube removal: Bile leakage leading to ascites, biloma, and bile peritonitis

Station 9: Steps of a Cholecystectomy:

Laparoscopic:

1. Prepared and draped similar to open procedure after giving GA
2. Foley catheter is placed and Orogastric tube is inserted to avoid inadvertent injury and improve exposure.
3. Pneumoperitoneum is established with a veress needle through a sub-umbilical incision
4. 10mm trocar canula is inserted sub umbilically.
5. A 30 degree laparoscope is then inserted through the umbilical port, and an examination



Edit

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26



T-Tube and Foley's catheter

27



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Station 11

Questions:

1. What clinical sign is shown in this picture?
2. Mention at least 4 causes of this condition.
3. What is the most common clinical symptom the patient presents with?
4. Mention the diagnostic investigation in this patient

clinical sign: ptosis

2. Diagnosis: Horner's syndrome or oculomotor nerve palsy.

- Causes of Horner's Syndrome:

1. Pancoast tumor (apical lung tumor affecting the sympathetic chain)
2. Carotid artery dissection
3. Brainstem stroke (lateral medullary syndrome)
4. Cervical spinal cord injury or syringomyelia

- Causes of Oculomotor Nerve Palsy (CN III palsy):

1. Aneurysm of the posterior communicating artery (PCoM A)
2. Diabetes mellitus (microvascular ischemia)
3. Head trauma
4. Midbrain stroke (Weber's syndrome, Benedikt's syndrome)



3. What is the most common clinical symptom the patient presents with?

- If Horner's Syndrome:
 - Unilateral ptosis
 - Miosis (constricted pupil)
 - Anhidrosis (loss of sweating on the affected side of the face)
- If Oculomotor Nerve Palsy:
 - Diplopia (double vision)
 - Ptosis
 - "Down and out" eye deviation (due to unopposed lateral rectus and superior muscles)

4. Mention the diagnostic investigation in this patient.

- For Horner's Syndrome:

1. MRI/MRA of the brain and neck To rule out stroke or carotid artery dissection
2. Chest X-ray or CT scan of the chest To check for a Pancoast tumor
3. Cocaine or apraclonidine eye drop test To confirm Horner's syndrome

- For Oculomotor Nerve Palsy:

1. MRI brain with contrast To rule out midbrain stroke or tumor
2. CT angiography (CTA) or MRA To check for PCoM A aneurysm
3. Blood glucose and HbA1c To check for diabetic neuropathy

An 8 year old boy presents with increased thirst and increased urination for the last 3 months.

Now he has nausea, vomiting and abdominal pain for the last 2 days. Laboratory tests show serum glucose concentrations of 400 mg/dL, arterial pH 7.29, and serum bicarbonate concentration 14 mEq/L, urine glucose is 4+ and urinary ketones are positive.

3. What is the diagnosis?

4. Give initial treatment plan?

- 1) DKA (2)
- 2) IV Normal Saline infusion, IV Regular Insulin Infusion, IV Ceftriaxone, Close monitoring of hydration and neurological status, glucose and electrolytes and intake output record (3)

1 year old girl is brought to emergency room with history of fever, difficult breathing and severe cough. At home she was given poppy containing tea for the cough. She has become difficult to arouse. Her GCS is 9 with a respiratory rate of 15/min and pin-point pupils.

3. What is the diagnosis?

4. What is the

5. specific treatment?

- 1) Opium poisoning (2.5)
- 2) Naloxone (2.5)

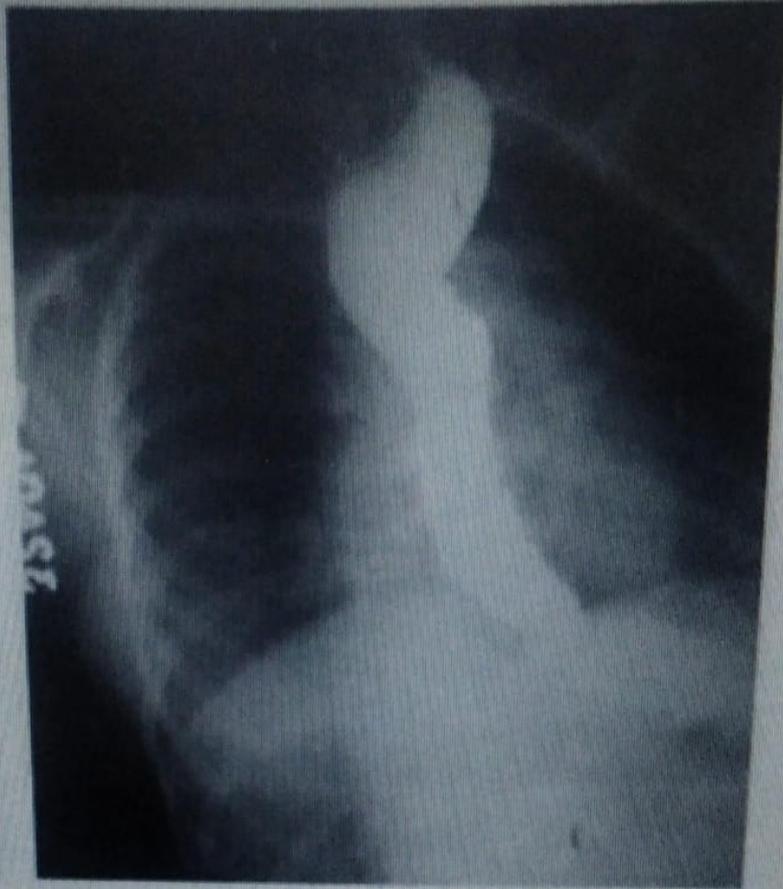


Figure 44

This 20 years old boy presented with dysphagia and recurrent chest infection. Observe this picture (figure 44) and answer the questions given below.

QUESTIONS:

1. What is this investigation called?
2. What are the findings?
3. What is diagnosis?
4. What is differential diagnosis?
5. What is the treatment of this condition?

ANSWERS:

1. Barium Swallow.
2. Narrowing at the lower end of esophagus and dilated proximal esophagus.
3. Cardia achlasia
4.
 - a. Carcinoma esophagus.
 - b. Esophageal stricture.
5.
 - a. Esophageal balloon dilatation.
 - b. Heller Myotomy.
 - c. Botulinum toxin.
 - d. Nifedipine.

Station 57

A young lady presents to the emergency with sudden onset of blindness since 2 hours while taking hot bath, she also gives history of similar episodes in the past and occasional episodes of diplopia.

- 1. What is the diagnosis?**
- 2. What is Lhermitte's sign, also give 3 causes of positive Lhermitte's?**
- 3. What is the underlying pathology?**
- 4. How would you proceed further, what is the diagnostic criterion called?**
- 5. How would you treat the patient?**
- 6. What is the prognosis of this disease?**

1. What is the diagnosis?

- The young woman presents with sudden blindness triggered by a hot bath (Uhthoff's phenomenon) and a history of similar episodes with diplopia.
- This is suggestive of multiple sclerosis (MS), specifically optic neuritis as the blindness.

2. What is Lhermitte's sign? Give 3 causes of a positive Lhermitte's sign.

- Lhermitte's sign is an electric shock-like sensation that runs down the spine in the back when the neck is flexed.
- It is a classic sign of demyelination of the cervical spinal cord.

Causes of a positive Lhermitte's sign:

1. Multiple Sclerosis (MS) (demyelination of the spinal cord)
2. Cervical spondylosis (compression of the spinal cord)
3. Vitamin B12 deficiency (subacute combined degeneration of the cord)

3. What is the underlying pathology?

- Multiple sclerosis is an autoimmune demyelinating disease of the central nervous system (CNS).
- It involves T-cell-mediated destruction of myelin, leading to plaques in the white matter of the brain and spinal cord.
- Common sites include the optic nerves, periventricular white matter, brainstem, and spinal cord.

4. How would you proceed further? What is the diagnostic criterion called?

Investigations:

1. MRI Brain and Spine with Contrast: Shows periventricular white matter lesions (in the brain), spinal cord plaques, and active contrast-enhancing lesions.
2. Lumbar puncture (CSF analysis): Presence of oligoclonal bands (IgG bands) supports the diagnosis.
3. Evoked potentials (Visual and Somatosensory): Delayed conduction suggests demyelination.

Diagnostic Criterion:

- McDonald Criteria (requires dissemination in time and space, as seen on MRI or clinically).

How would you treat the patient?

Acute Management (Relapse treatment):

- High-dose prednisolone (1g/day for 3-5 days): Reduces inflammation and speeds recovery.

Long-term Disease-Modifying Therapy (DMT) to prevent relapses:

- First-line: Interferon beta, Glatiramer acetate
- Second-line: Natalizumab (for aggressive MS), Fingolimod, Ocrelizumab

Symptomatic Treatment:

- Fatigue: Amantadine, Modafinil
- Spasticity: Baclofen, Tizanidine
- Neuropathic pain: Gabapentin, Pregabalin

6. What is the prognosis of this disease?

- MS is a chronic disease with relapsing-remitting or progressive courses.
- Early treatment with disease-modifying therapy (DMT) can significantly reduce relapses and slow disability progression.
- Some patients develop secondary progressive MS (SPMS), leading to gradual worsening.



41% 6:45 PM

Q:

The following results are from an 8 years old girl with short stature:

TSH = 100 $\mu\text{u/L}$ (Normal < 5)

T4 = 10 n mol/L (60 – 160)

Questions:

1. What is the diagnosis?
2. What is the treatment?

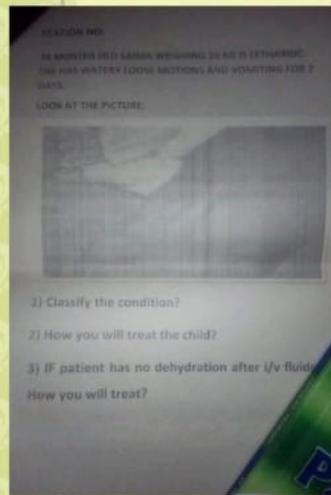
1. Congenital Hypothyroidism

2. Thyroxin life long

Q.

A child presents at 8 months age

1. Thalassaemia



Ans 01
Severe dehydration

Ans 02:-

- Start IV fluid immediately
- Give ORS by mouth if child can drink
- Give 100 ml/kg Ringer lactate solution or normal saline
- Re-assess the child every 1-2 hours if not improving give IV drip more rapidly
- Re-assess the child after 3 hours

Ans 03:-

- Counsel the mother to
- Give Extra fluid
- Breast feed frequently
- If breast feed exclusive give ORS or clean water in addition to breast milk
- Teach the mother to mix and give ORS
- Give Zinc Suspension for 10 days

Continue feeding
Re-visit or guide the mother when to return.

Station 03

03 YEAR OLD BOY PRESENTED WITH COMPLAIN OF FEVER FOR 05 DAYS INTERMITTENT IN TYPE WITH ANEMIA AND SPLENOMEGALY 3 CM WHICH IS FIRM IN CONSISTENCY. THERE IS NO HISTORY OF PREVIOUS BLOOD TRANSFUSION.

A) WHAT IS YOUR DIAGNOSIS?
B) HOW WILL YOU INVESTIGATE?
C) WHAT IS TREATMENT?

Ans 1 Malaria

Ans 2

- Thin and thick films
- Blood CBC
- Blood Sugar.

Ans 3

- Chloroquine in chloroquine-sensitive plasmodium
- For chloroquine resistant ^{Ans. mother}
 - * Quinine plus pyrimethamine-sulfadoxine
 - * Quinine plus tetracycline or doxycycline or clindamycin
 - * Mefloquine
 - * Atovaquone

STATION NO.

Ans 01 Teratology of fallot.

STATION NO.

TWO YEAR OLD GIRL CAME IN O.P.D WITH A COMPLAINT OF ... SINCE THE ...

STATION 2

A 70 year old male with persistent vomiting was advised this x ray.

1. Name the X ray.
2. What is most likely diagnosis?
3. Write 2 common causes of your diagnosis.
4. Mention electrolyte abnormality in this condition
5. Which investigation you will follow to confirm the cause of your diagnosis

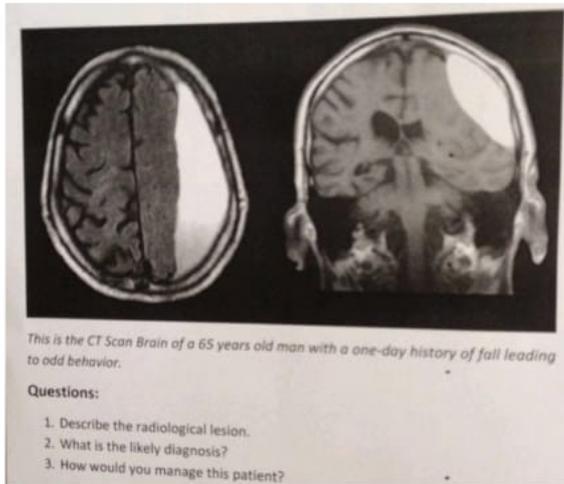
KEY 2

1. Barium meal 1
2. Gastric outlet obstruction 1
3.
 - a. Ca stomach 1
 - b. Peptic ulcer 1
4. Hyponatremic, hypochloremic, hypokalemia metabolic alkalosis 2
5. OGD 2

Edit



50



Tools

Mobile View

Share

Edit on PC

WPS AI





Management of appendicular mass

Ochsner-Sherren regimen

- Conservative treatment with
 - Nil by mouth
 - Ryle's tube aspiration
 - Antibiotic therapy
 - Cephalosporins
 - Aminoglycoside
 - Metronidazole
 - Recording of size of mass daily
 - Recording of TPR chart 4hourly
 - Input & output chart

Pancreatic cancer

- Courvoisiers Law – Jaundice in the presence of an enlarged non tender gallbladder is unlikely to be gallstone related. Therefore likely to be pancreatic or GB cancer.
- Other features
 - Weight loss
 - Steatorrhoea
 - N&V
 - New onset diabetes
- Most are palliative -5yr survival ~3%
 - Abx for cholangitis
 - Biliary stent
 - Creon replacement
 - Chemotherapy
- 10-15% are surgical candidates – Whipples procedure



This is the X-Ray abdomen of 2 days old neonate who presented with billious vomiting.



- Q 1. What sign does this x-ray show?
- Q2. What is the diagnosis?
- Q 2. Write down treatment steps?

- 1. Double Bubble Sign
- 2. Duodenal Atresia
- 3. • Correct Electrolyte deficit
 - Surgical Therapy:
duodenoduodenostomy
duodenojejunosotomy

Mangolion spot.

Natural History:



Clubbing:

Causes:



A 42 years old male has presented in surgical emergency with complaint of severe anal pain and something coming out of anus. He has 6 months history of painless fresh bleeding per rectum. On examination, the findings are shown.

Carefully read the scenario, observe the given photograph and answer the following questions:

Questions:

1. Give your diagnosis on the basis of history and finding shown in photograph.
2. What are other complications of this condition?
3. How would you treat this patient?

Answers:

1. Prolapsed thrombosed haemorrhoides
2. Ulceration, gangrene, portal pyemia, fibrosis
3. Conservative treatment / anal dilatation followed by haemorrhoidectomy when edema subsides

KEY STATION 14

- 1. Cysto urethrogram
- 2. Stricture of the bulbar urethra
- 3.
 - a. Pelvic fracture
 - b. Rec UTI
 - c. Instrumentation .5
 - d. History of fall / FAI .5
- 4.
 - a. Optical urethrotomy 1
 - b. Urethral dilatation 1
 - c. Urethroplasty



- 1. Name the X ray
- 2. What are the pelvic Findings?



Edit

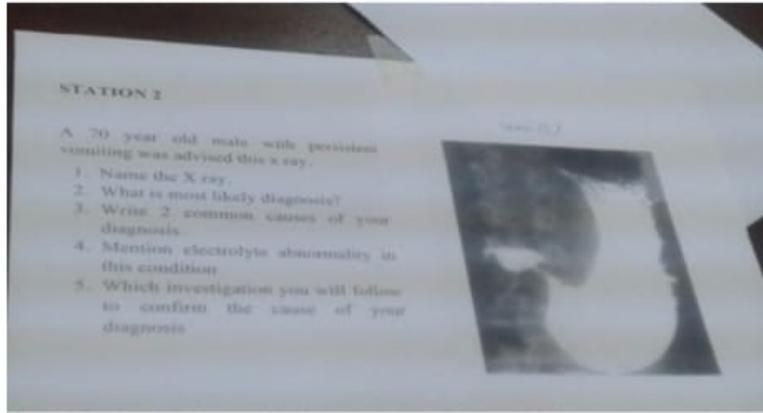
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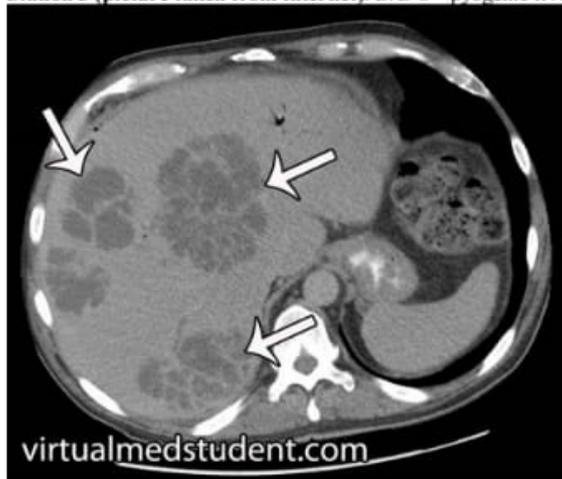
Convert

All





Station 3 (picture taken from internet): D/D's – pyogenic liver abscess and hydatid cyst.



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Introduction/rapport	0.5
Assessing the level of prior knowledge of patient	3
Enquire about his concerns	3
Appropriately address his concerns and suggest solutions	3
Advise precautions	2
Discuss the required investigations and treatment options	2
Advise regular follow up with physician	1
Thanking the patient	0.5
Total	15

This 30 year old married lady was found as Anti-HCV positive accidentally during pre-employment screening. She is worried and anxious. Your task is to talk to him and address his concerns.

Station 18 (B)



This patient presented with diplopia

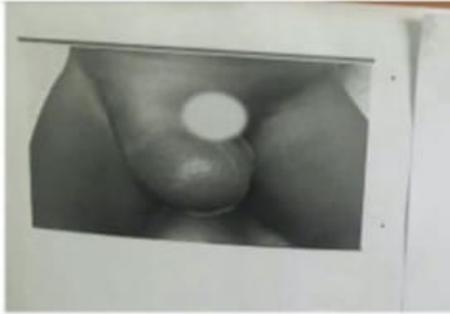
Q1. Which extra ocular muscle is involved?

Q2. Name three causes?

extraocular muscle involved:
palsy of the superior oblique muscle, which is innervated by the trochlear nerve (cranial nerve IV).

three causes:

1. Congenital
2. Head trauma
3. Microvascular diseases



STATION 22

Carefully examine the given patient and answer the following questions

1. Give the descriptive name for this pathology
2. Give three differential diagnosis
3. Describe four clinical signs which you would elicit to help reach diagnosis

other D/D: lymphadenopathy, metastatic neoplasm, hydrocele, epididymitis, abscess, hematoma

Key station 22

1. Inguinoscrotal swelling 2
2. Inguinal hernia, infantile hydrocele 3
3. Can reach above the swelling or not 3
 - a. Reducibility
 - b. Cough impulse
 - c. Deep ring occlusion test

Hydroceles may appear bluish; if hernia, there may be presence of a "silk glove sign" when the layers of the hernia sac are palpated sliding over each other.

What pathologies could you palpate in the kidneys bilaterally?



Edit Annotate Fill & Sign Convert All

STATION 2

A 70 year old male with persistent vomiting was advised this x ray.

1. Name the X ray.
2. What is most likely diagnosis?
3. Write 2 common causes of your diagnosis.
4. Mention electrolyte abnormality in this condition
5. Which investigation you will follow to confirm the cause of your diagnosis



KEY 2

1. Barium meal 1
2. Gastric outlet obstruction 1
3.
 - a. Ca stomach 1
 - b. Peptic ulcer 1
4. Hyponatremic, hypochloremic, hypokalemia metabolic alkalosis 2
5. OGD 2

Station 12

Questions:

1. Which cranial nerve involvement is shown?
2. This patient presented with headache, vomiting and papilledema, what is the most likely cause?
3. What is the most urgent investigation she needs?
4. Mention at least three differential diagnoses



Which cranial nerve involvement is shown?
sixth cranial nerve (abducens nerve) palsy.

2. This patient presented with headache, vomiting, and papilledema. What is the most likely cause?
 - Increased intracranial pressure (ICP) is the most likely cause.
 - Common etiologies include:
 - Brain tumor (most common)
 - Idiopathic intracranial hypertension (pseudotumor cerebri)
 - Hydrocephalus
 - Meningitis or encephalitis
3. What is the most urgent investigation she needs?
 - Urgent brain imaging:
 - MRI brain with contrast (preferred)
 - CT brain (if MRI is not available)
 - Lumbar puncture (LP) only after ruling out mass lesions to avoid brain herniation
4. Mention at least three differential diagnoses.
 - Brain tumor (e.g., posterior fossa tumor, glioma, meningioma)
 - Idiopathic intracranial hypertension (pseudotumor cerebri)
 - Hydrocephalus
 - Others: Meningitis, encephalitis, cerebral venous sinus thrombosis (CVST), trauma

- vi. Myocarditis
- vii. Immuno suppression
- viii. SSPE (Subacute sclerosing pain encephalitis)

Infectious diseases

- 1- What is the abnormal finding & diagnosis? (1)
- 2- What are the steps of management? (2)
- 3- How can you eliminate this disease in the neonate?



Key:

- 1- Risus sardonicus / Lockjaw & Tetanus neonatorum. (0.5 each)
- 2-
 - i. Sedation (0.25)
 - ii. Feeding (0.25)
 - iii. Nursing care (0.25)
 - iv. Antitoxin (ATS, TIG) (0.5)
 - v. Antibiotics (Benzyl penicillin to kill vegetative C.tetani) (0.25)
 - vi. Counseling 0.25)
 - vii. Follow up (0.25)

Handwritten notes: 5 dose schedule of TT to mother (1), 5 Cs (1), 1st dose A + any time, 2nd A 1 month after, 3rd A 6 months after, 4th A 1 year after. Also includes notes: 'clean delivery', 'clean cutting', 'Rube cord ktt'.

Question No. 30

Infectious diseases

- 1- What are abnormal findings in this baby. (2)
- 2- What is the diagnosis? (1)
- 3- What are the management steps of this condition. (2)



Key:

- 1-
 - i. Risus sardonicus / Lockjaw (1)
 - ii. Generalized spasm & (1)
- 2- Tetanus neonatorum (1)
- 3-
 - i. Sedation (0.25)
 - ii. Feeding (0.25)
 - iii. Nursing care (0.25)
 - iv. Antitoxin (ATS, TIG) (0.5)
 - v. Antibiotics (Benzyl penicillin to kill vegetative C.tetani) (0.25)
 - vi. Counseling 0.25)
 - vii. Follow up (0.25)

These are the CSF findings from a 6 year old who presented with inability to walk and then ended up on a ventilator. CSF analysis showed:
Clear fluid, Protein 250 mg/dl, glucose 50 mg/dl, blood sugar 54 mg/dl, microscopy 4 cells, lymphocytes 3, PMN cells 1, culture negative.

GBS

Q1. What is the diagnosis?

6 / 92



40% 6:45 PM

STATION NO

4



Ascites

Questions:

Marks 06

1. Mention the abnormality. 2
2. Mention three causes. 2
3. Mention three drugs which can be used in this condition. 2

Diagnosis: ascities

Three Causes of Ascites:

1. Liver Cirrhosis
2. Malignancy
3. Congestive Heart Failure (CHF)

Three Drugs Used for Ascites Treatment:

1. Spironolactone
2. Furosemide
3. Albumin



STATION # 05

COUNSEL THE PARENTS WHO HAVE BROUGHT THEIR 2-YEAR-OLD MALE CHILD WITH FIRST EPISODE OF SIMPLE FEBRILE CONVULSION.

STATION # 05

Meet the parents and introduce yourself	0.5
Explain what is a simple febrile and complex febrile seizure is	0.5
Ask for family history of febrile seizure	0.5
Ask for family history of epilepsy	0.5
Ask for neurodevelopmental history	0.5
Use of prophylaxis	0.5
Prophylactic intermittent use of antiepileptics and discussion	0.5
Management of a seizure at home	0.5
Risk of epilepsy in future	0.5
Thanking child and returning	0.5

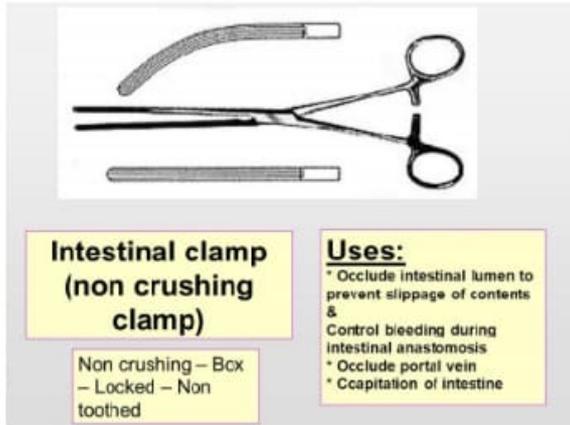
STATION # 04

A 7-YEAR-OLD CHILD IS BROUGHT IN EMERGENCY WITH UNCONSCIOUSNESS

1. OPENS EYES IN RESPONSE TO VOICE
2. UTTERS INAPPROPRIATE WORDS
3. LOCALIZES PAINFUL STIMULI

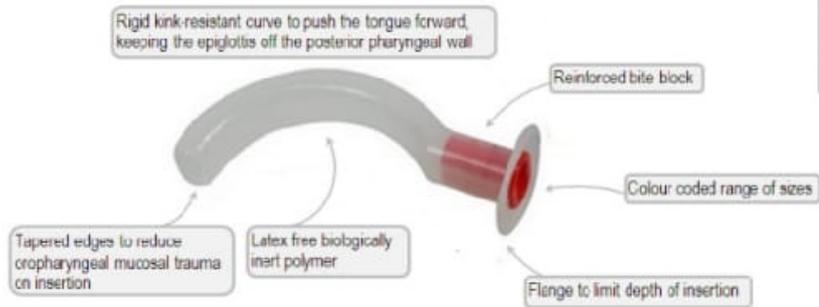
CALCULATE GLASGOW COMA SCALE OF THIS

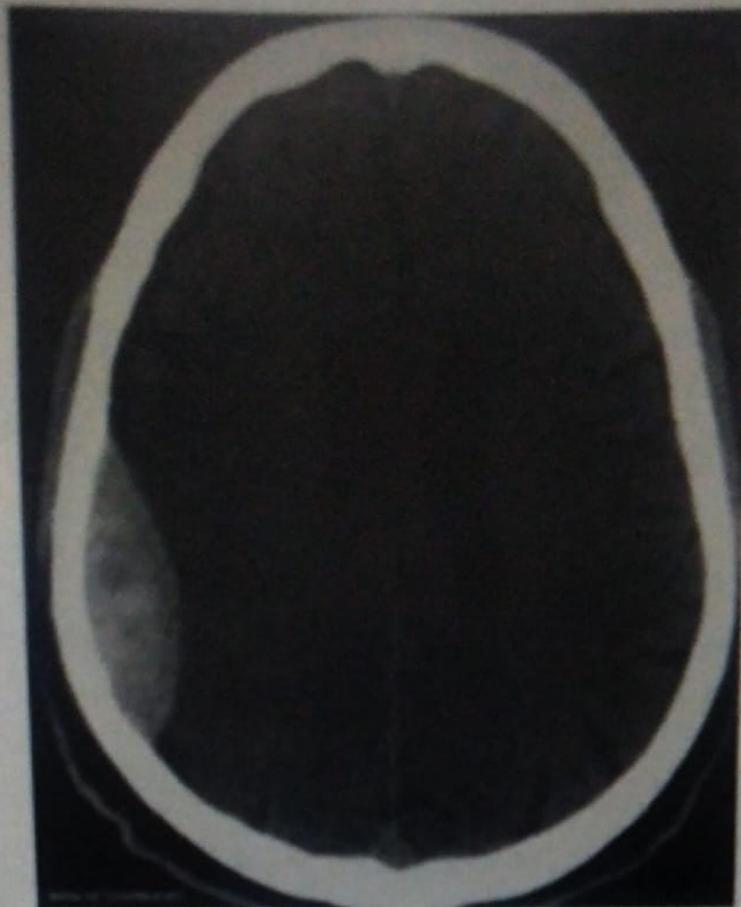
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5 3 2



Guedel's Airway: oropharyngeal airway tube that bypasses the tongue and upper pharynx. The use of this device is reserved for incompletely conscious, as its insertion into the face of an alert person is usually greeted with violent confrontation.

Indications: unconscious patient with loss of upper airway muscle tone; unconscious patient with difficult bag/mask seal; intubated patient, in whom the oropharyngeal airway acts as a bite block, preventing the kinking of the softer endotracheal tube.





A 24 years old motorcyclist is brought to the emergency after road traffic accident. He is confused, localizes painful stimuli and opens his eyes to painful stimuli. His CT scan is shown above. Carefully observe the CT scan and answer the questions given below

1. Describe this CT.
2. What is the diagnosis?
3. Name the vessel most commonly involved
4. What is GCS of this patient?
5. Give management of this disease.

Answers

1. This CT is showing bright, biconvex density in the right parietal lobe of the brain
2. Extradural Hematoma
3. Middle meningeal artery
4. 11:
 - a. Confused: 4
 - b. localize painful stimuli: 5
 - c. eye opening with pain: 2
5.
 - a. Follow ATLS guidelines (A,B,C,D,E)
 - b. Craniotomy and evacuation of hematoma.
 - c. Manage the patient in intensive care unit postoperatively.

classical i.e. Right lower
tenderness. Occasionally enlarged uterus
pushes the appendix into right upper
quadrant which gives rise to pain in this
location. Fever is less common and
leukocytosis is typical, but it too may be
absent. Delay in operation has high risk of
perforation and diffuse peritonitis. Because
omentum is less available to wall off the
infection, Treatment is early appendectomy.
While performing appendectomy during
pregnancy a bit higher incision (Rutherford
Morris) should be given depending upon the
duration of pregnancy as it is pushed
upward as shown in a figure below.

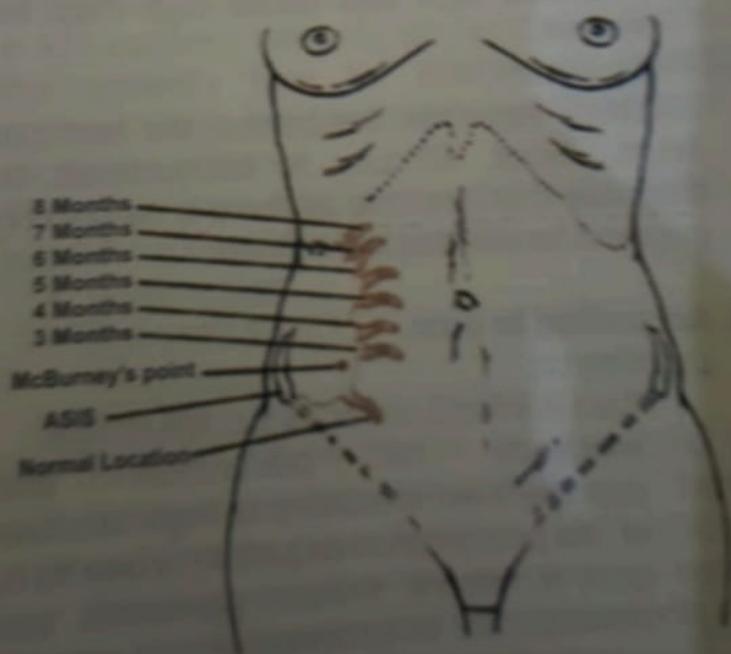


Fig: Showing various positions of appendix during pregnancy:

classical i.e. Right lower
tenderness. Occasionally enlarged uterus
pushes the appendix into right upper
quadrant which gives rise to pain in this
location. Fever is less common and
leukocytosis is typical, but it too may be
absent. Delay in operation has high risk of
perforation and diffuse peritonitis. Because
omentum is less available to wall off the
infection, Treatment is early appendectomy.
While performing appendectomy during
pregnancy a bit higher incision (Rutherford
Morris) should be given depending upon the
duration of pregnancy as it is pushed
upward as shown in a figure below.

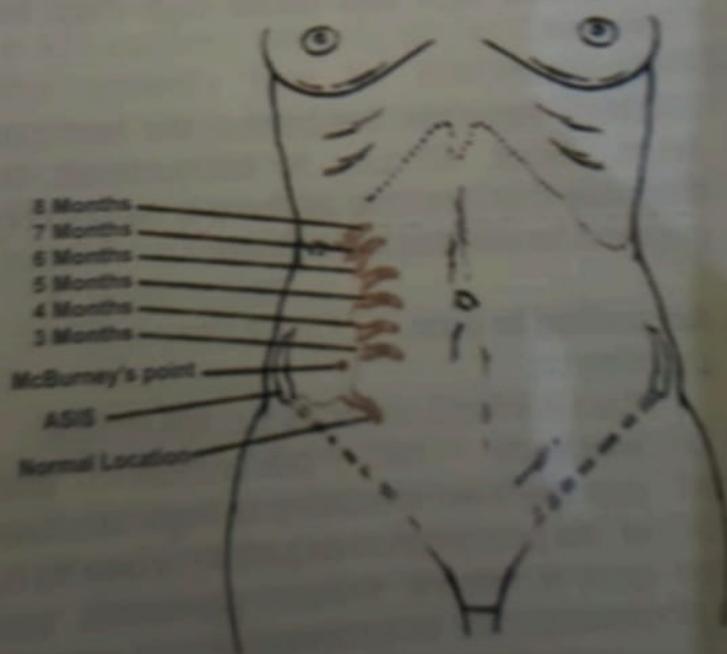


Fig: Showing various positions of appendix during pregnancy:

30-year-old female presented with exertional dyspnea. On examination she had marked pallor and huge mass arising from left hypochondrium and extending up to below umbilicus. Operative findings are shown.



Carefully read the scenario, observe the given photograph and answer the following questions:

Questions:

1. What are the three common causes of massive enlargement of the organ shown in the picture?
2. What hematological problem can arise from massive enlargement of this organ?
3. What infective complication its removal can cause and how can this be prevented.

Answers:

1. Tropical splenomegaly (malaria), myeloproliferative disorders, glycogen storage disorder (Gaucher's disease).
2. Hypersplenism is a clinical syndrome that is characterized by splenic enlargement, any combination of anaemia, leucopenia or thrombocytopenia, compensatory bone marrow hyperplasia and improvement after splenectomy
3. Post splenectomy septicemia, opportunist post-splenectomy infection (OPSI)
 - Prophylactic ampicillin
 - Vaccination against Pneumococcus, H. influenza, Meningococcus

Station 48



meningococcal meningitis

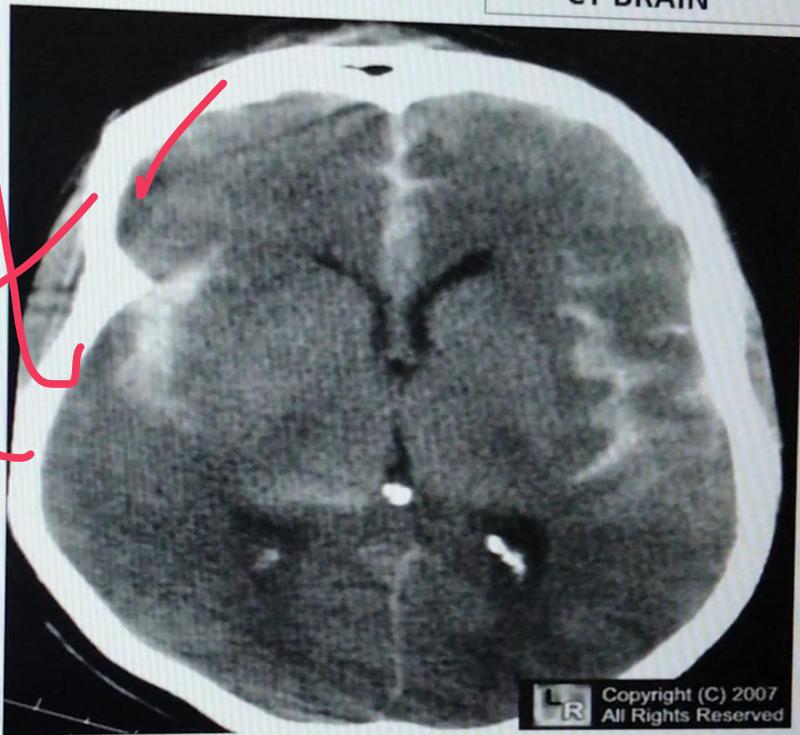
1. What is the most likely diagnosis?
2. Write two complications.
3. Write two management steps.

↓
DIC
Sepsis

↳ ABC Admin
• Fluids
Vasopressor: Ab (ceftriaxone)
• O₂ res.
• Vital monitoring
• vaccination
chemoprophylaxis

Station 11 (B)

CT BRAIN



Repeat

This is the CT brain of 60 year old hypertensive who presented with acute onset severe headache followed by drowsiness.

- Q1. What is the radiological diagnosis?**
Q2. Name any two treatment options?

NOTES ON COUNSELING:

Following are some cases that come in surgical OSCE for counseling

1. COUNSELING COLOSTOMY BAG

Colostomy is a surgical procedure that brings a portion of intestine through abdominal wall to carry feces out of body. It is done to treat various disorders. 42000-65000 people have it yearly.

A colostomy pouch will be placed on the patient's abdomen around stoma during surgery.

During hospital stay, you and your care givers will be educated on how to care for colostomy. Regular assessment and meticulous care of skin around the stoma is important.

There can be few complications of your surgery, Excessive bleeding, infection, inflammation and blood clot to veins in legs, you should not feel depressed .there will be a change in life style but you should not feel ugly or sexually unattractive.

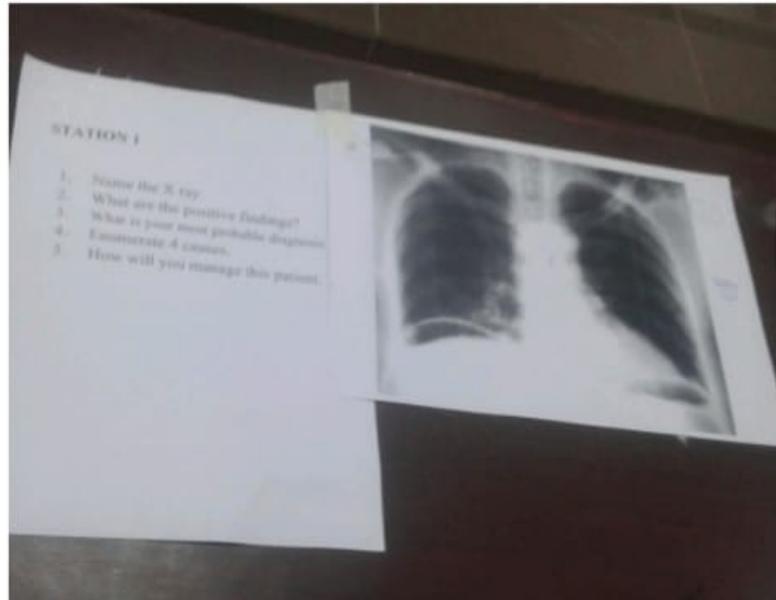
There are some highly recommended nutrition plans for colostomy patients.

1. Consuming smaller meals everyday. 4-6 small proportioned meals-as elimination of waste will be manageable.
2. Fiber intake must be reduced in colostomy diet. Wheat products, oats must be taken in moderation.
3. Chew all the food thoroughly and completely.
4. Soft food is important for you.
5. To avoid risk of dehydration, minimum 7 glasses of water or fruit juices must be taken.

Patients can easily travel with colostomy bags.

Wearing colostomy bags after colon surgery need not hamper your usual habits. As long as you eat and drink sensibly by keeping to a simple colostomy diet and ensure proper stoma care, you will be fine and many times you will even forget that you are wearing a colostomy appliance.

Follow-up, after a month



Name the X-ray: Erect PA view?

What are the positive findings? Air under the diaphragm

Most probably diagnosis: perforated peptic/duodenal ulcer; perforation of ileum due to typhoid or tb; injury to the intestine (blunt or penetrating); perforation of intestinal tumor; post laparotomy/laparoscopy which may persist up to 7 days.

4 Causes: most common cause is hollow viscous perforation. Could occur due to perforated peptic ulcer. In 10% of case, it can be due to rare causes, both abdominal and extra abdominal (intra-abdominal infection by gas forming organisms).

What is the mechanism of this finding: Normally, there is no free air in the peritoneal cavity, rather it is present in the lumen of the gut. When there is perforation of the gut due to any reason, this air enters into the peritoneal cavity along with other contents of the gut. When the patient is in standing position, this air moves upward (under the diaphragm and occupies a space between the liver and diaphragm) when xray is taken in this position then air becomes clearly visible between the liver and diaphragm. It usually takes about 3 to 4 hours after perforation of duodenal ulcer for air to be seen in the x-ray and minimum amount of air which can be detected on xray is 12cc.

Treatment: Urgent surgery. Follow all pre-op steps.

Station 2: Barium Meal (picture taken from internet):



Edit

Annotate

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Convert

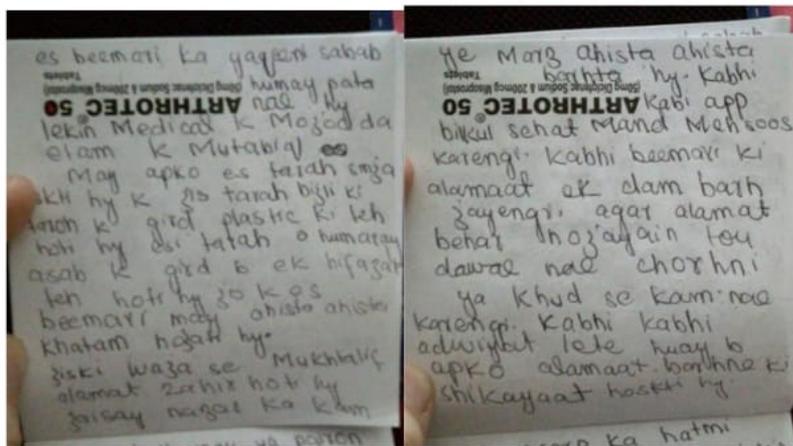
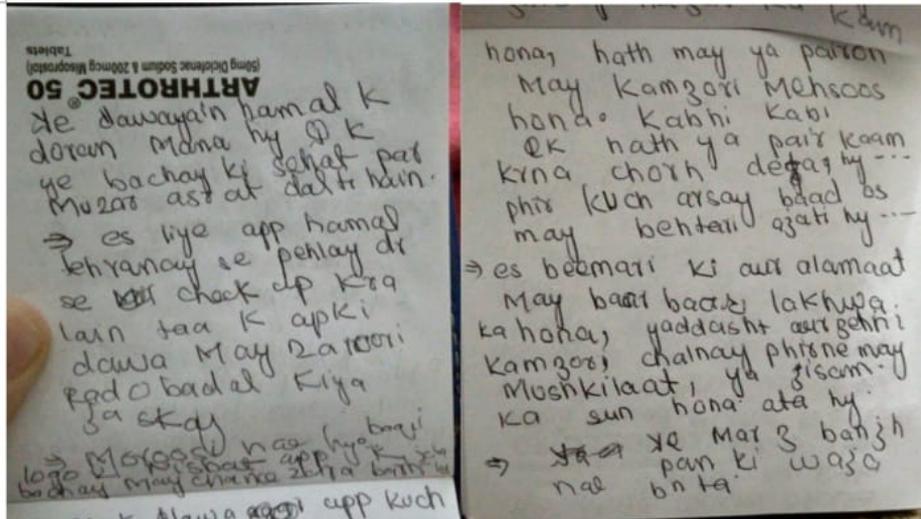
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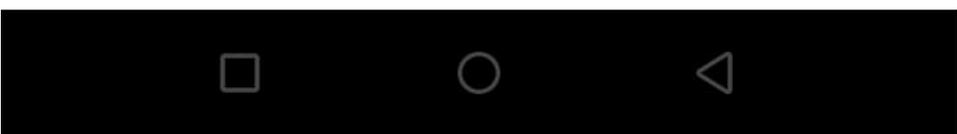
station 20

- 1. conjunctival hemorrhage**
- 2. dangué malaira**
- 3. isolate the pt. platelet whole blood transfusion**

station 21



COUNSELLING FOR SLE



Repeat ✓

STATION # 02
HEPATITIS B VACCINE

QUESTIONS:

1. What is the DOSE of Hepatitis 'B' vaccine in children?
2. What is the schedule of doses of this vaccine in children?
3. How will you manage a baby born to HBsAg-positive mother?

STATION 24

A 35 years old female has presented with a history of recurrent episodes of upper abdominal pain and dyspepsia. Her LFTs during one of these episodes are as follows

Total bilirubin	5.5mg/dl.
Direct bilirubin	4.5mg/dl
Indirect bilirubin	1mg/dl
SGOT	47IU/litre
SGPT	45 IU/litre
Alkaline phosphatase	950IU/litre

Carefully answer the following questions

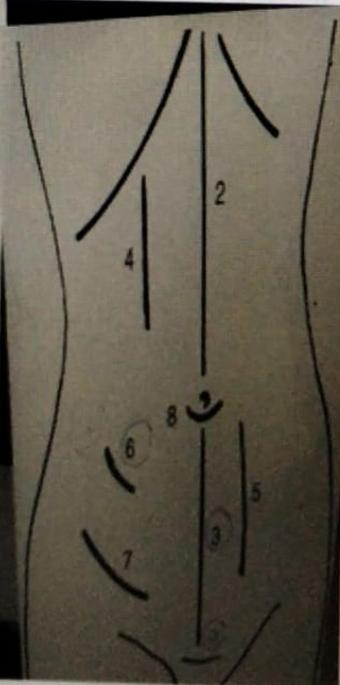
1. What is the probable diagnosis?
2. Mention two further investigations which can help in reaching a diagnosis
3. Give one method of non operative management which may be curative.

KEY STATION 24

- | | |
|------------------------|---|
| 1. Choledocholithiasis | 2 |
| 2. USG, ERCP | 3 |
| 3. Papillotomy | 3 |

STATION 17

Name incision number 3,6,9 and enumerate two indications of each.



KEY 17

A.	Midline	laprotomy
incision		
	5	
i. Abdominal trauma		1
ii. Viscus perforation / malignancy	1	
B. Grid iron		5
i. Appendicectomy		1
ii. Lower ureteric stone		1
C. Pfannel steil	1	
i. C section		1
ii. Hysterectomy		1



This is the X-Ray abdomen of 2 days old neonate who presented with billious vomiting.



Q 1. What sign does this x-ray show?
Q2. What is the diagnosis?
Q 2. Write down treatment steps?

- 1. Double Bubble Sign
- 2. Duodenal Atresia
- 3. • Correct Electrolyte deficit
• Surgical Therapy:
duodenoduodenostomy
duodenojejunosotomy

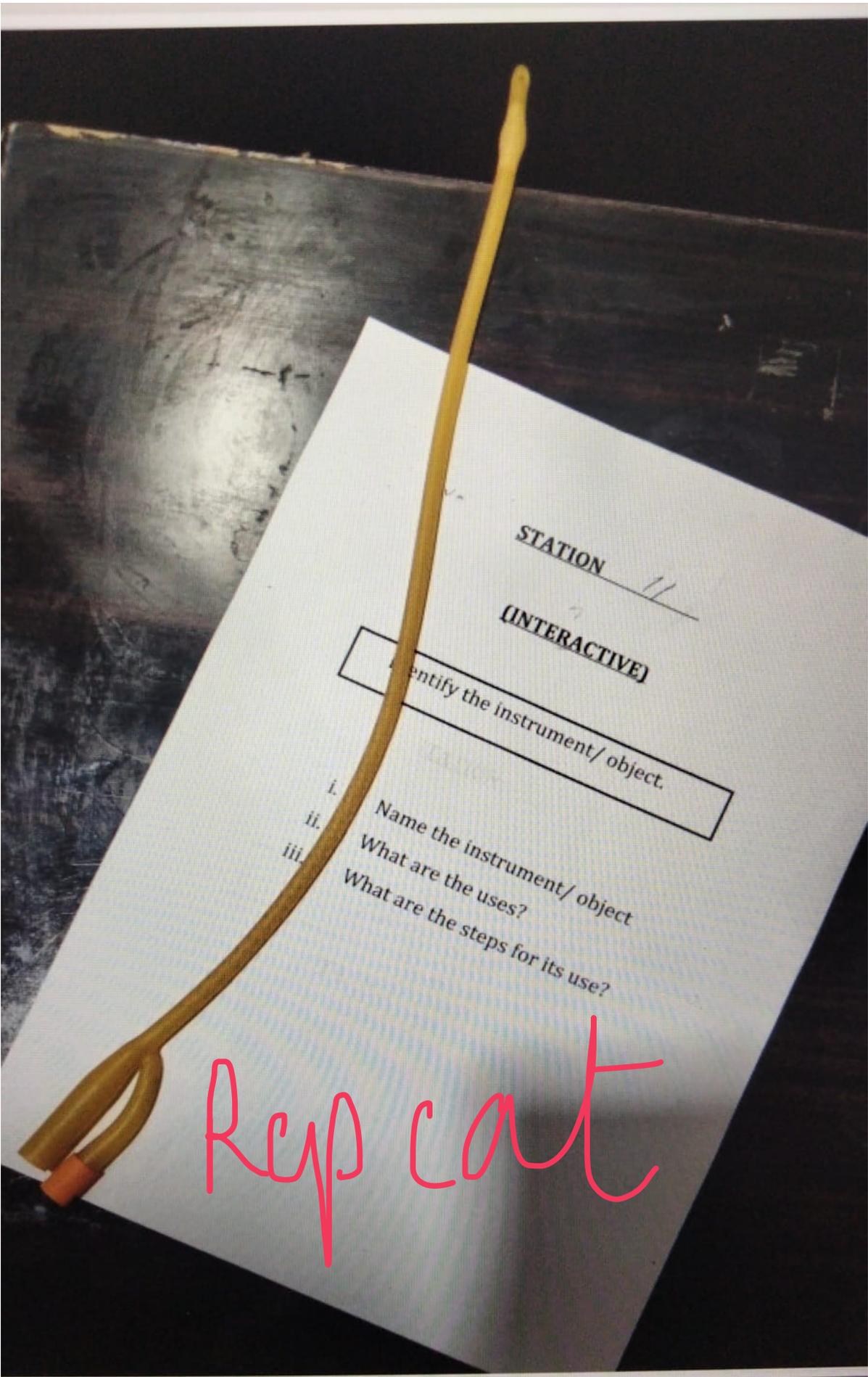
Mangolion spot.

Natural History:



Clubbing:

Causes:



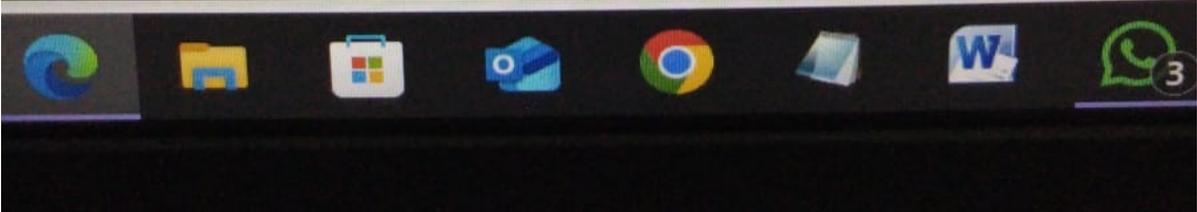
STATION / /

(INTERACTIVE)

Identify the instrument/ object.

- i. Name the instrument/ object
- ii. What are the uses?
- iii. What are the steps for its use?

Rep cat



KEY STATION 14

1. Cysto urethrogram
2. Stricture of the bulbar urethra
3.
 - a. Pelvic fracture
 - b. Rec UTI
 - c. Instrumentation .5
 - d. History of fall / FAI .5
4.
 - a. Optical urethrotomy 1
 - b. Urethral dilatation 1
 - c. Urethroplasty



1. Name the X ray
2. What are the pelvic Findings?

Based on the X-ray image and the associated questions, let's go through the details systematically.

1. Name the X-ray
 - This is an Abdominal X-ray (AXR) taken in the erect position.
 - It is typically used to evaluate bowel obstruction, perforation, or other intra-abdominal pathologies.

2. What are the positive findings?
 - The X-ray shows dilated bowel loops with multiple air-fluid levels.
 - This is characteristic of bowel obstruction, which could be in the small or large intestine.
 - There is a "step-ladder" pattern of air-fluid levels, indicating obstruction rather than just gas.

3. Name three conditions leading to this finding.

Several conditions can lead to this appearance, including:

- Small bowel obstruction (SBO): Commonly caused by adhesions (post-surgical), hernias, or tumors.
- Large bowel obstruction (LBO): Often due to malignancy, volvulus (sigmoid or cecal), or diverticular strictures.
- Paralytic ileus: Functional obstruction due to electrolyte imbalances, peritonitis, or recent surgery.

4. How will you manage this patient?

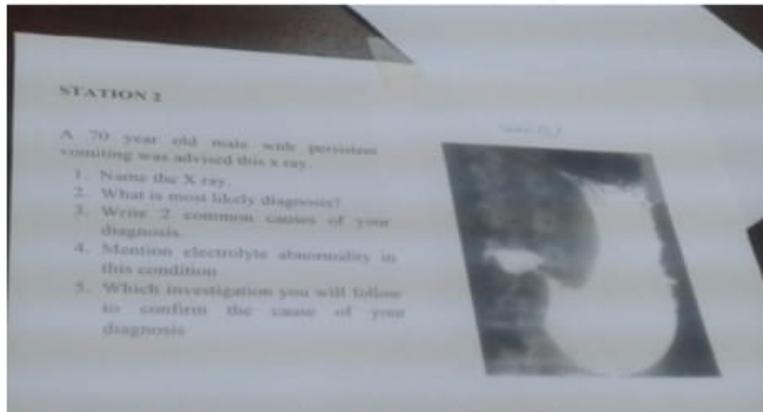
Management depends on the underlying cause and severity:

Initial Stabilization (Conservative Management)

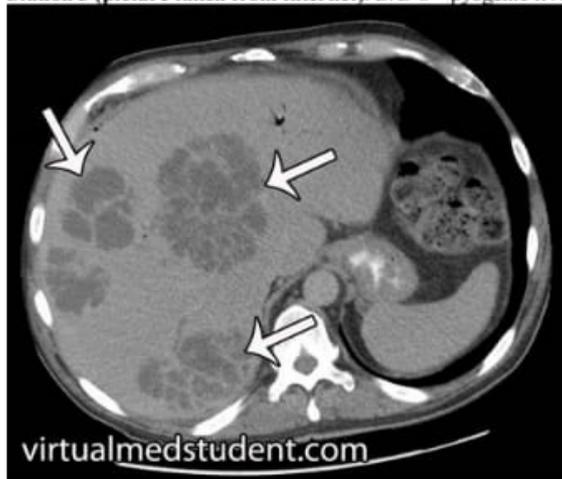
- NPO (Nil per Os): Stop oral intake to prevent worsening distension.
- IV Fluids: Correct dehydration and electrolyte imbalances.
- Nasogastric Tube (NGT): To decompress the stomach and reduce vomiting.
- Pain management: Avoid opioids (can worsen ileus).
- Monitor vitals closely for signs of perforation or worsening obstruction.

Definitive Management

- Small bowel obstruction:
 - If due to adhesions: Trial of conservative management for 24–48 hours. If no improvement, surgical intervention may be needed.
 - If due to hernia or tumor: Urgent surgery (hernia repair or tumor resection).
- Large bowel obstruction:
 - If due to volvulus: Sigmoid volvulus may be managed with endoscopic decompression or surgery.
 - If due to cancer: Requires surgical resection or stenting if palliative.



Station 3 (picture taken from internet): D/D's – pyogenic liver abscess and hydatid cyst.

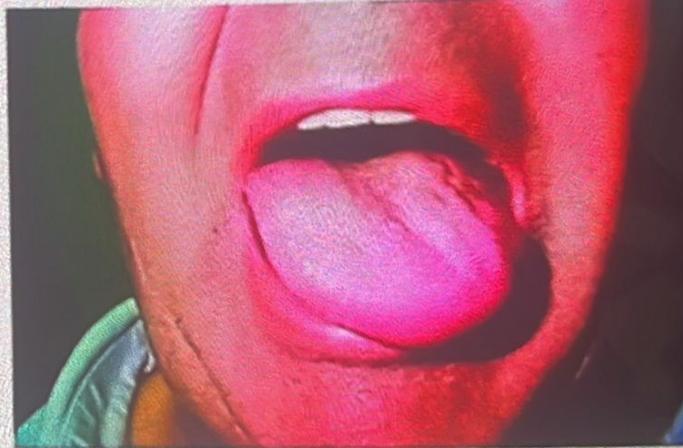


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Station 13

Questions:

1. What abnormality is visible in this picture?
2. Mention three causes for this abnormality.
3. Mention three other signs this patient may have.



Tongue Deviation - Causes and Associated Signs

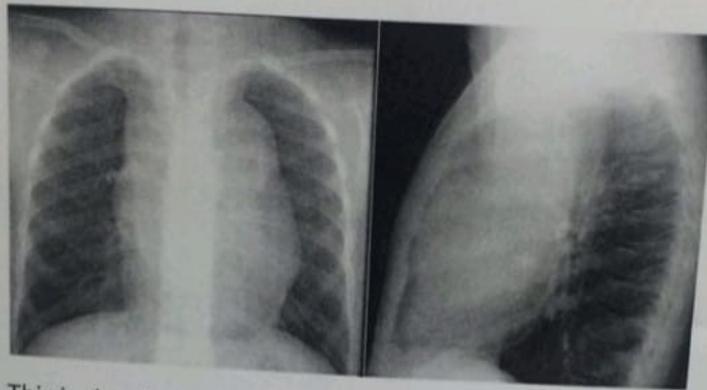
Three Causes of Tongue Deviation

1. Hypoglossal nerve (CN XII) palsy – Causes ipsilateral tongue deviation due to unopposed action of the contralateral genioglossus.
 - Causes include stroke, tumors, trauma, or neurodegenerative diseases.
2. Brainstem lesions (Medullary infarction or tumors) – Affecting the hypoglossal nucleus or nerve roots, leading to tongue deviation and other brainstem signs.
3. Motor neuron diseases (e.g., ALS) – Progressive degeneration of motor neurons, leading to tongue atrophy, fasciculations, and weakness.

Three Other Signs Seen in Hypoglossal Nerve Palsy

1. Atrophy of the tongue – Wasting of tongue muscles due to lower motor neuron damage.
2. Fasciculations – Involuntary muscle twitches, often seen in motor neuron diseases.
3. Dysarthria and dysphagia – Difficulty speaking and swallowing due to tongue weakness.

7



This is the chest radiograph of a 7 year old boy.
He presented with fever for the last 1 month with no
response to antibiotics.
On examination he has generalized
lymphadenopathy.

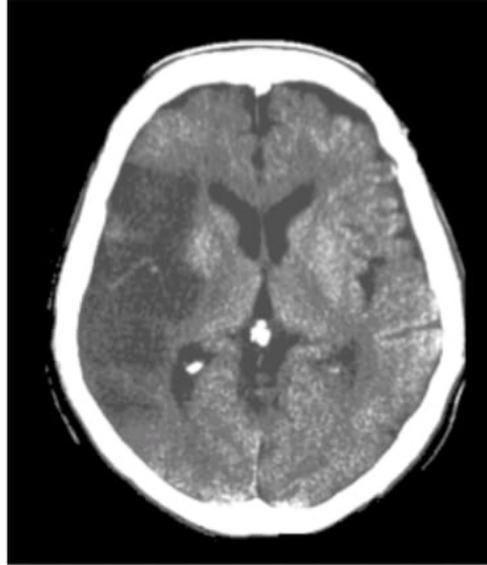
Handwritten note: All lymph nodes?

- Q 1. What does the chest radiograph show?
- Q 2. What is the next investigation needed?
- Q 3. What is the most likely diagnosis?

Bilateral hilar lymphadenopathy
Next step Ct scan, TST, biopsy
Diagnosis: tb



51



Mention the abnormality and its location shown in this image.

Mention two clinical features you expect in this patient.

Name this vessel most likely involved.

Mention three major risk factors for this illness.

Answers: 2.5 mark each.

1. Right parietofrontal infarct brain.
2. Left hemiplegia, dysphasia.
3. Middle cerebral artery.
4. Increased lipid/ cholesterol level, cigarette smoking, hypertension and diabetes mellitu.
- 5.

52



Station 64

A 25 years young lady reports to you that for difficulty in standing from sitting position especially from floor for the last 2 months. There is no history of fever, loss of appetite, difficulty in sleep, change in bowel habits, joint pains etc. She also experiences episodes of double vision in evening which she attributed to excessive use of tranquilizers. Clinical examination failed to reveal any abnormality except for a small goiter in neck with euthyroid status. Neurological examination failed to show any abnormality and deep tendon reflexes were 2+ BIL. Baseline relevant investigations are within normal limits with serum potassium 3.8 mmol/L

- 1. Which one of the following is the most likely diagnosis?*
- 2. What is the underlying pathogenesis?*
- 3. Groups of muscles involved?*
- 4. Exacerbating factors?*
- 5. How would you diagnose?*
- 6. How would you treat the condition & crisis?*

Diagnosis:

The most likely diagnosis is Hypokalemic Periodic Paralysis (HPP), a disorder characterized by episodic muscle weakness, typically triggered by factors like high carbohydrate meals, stress, or rest after exercise. The presence of difficulty rising from a sitting position, diplopia, and normal neurological examination supports this diagnosis. The small goiter with euthyroid status suggests a possibility of thyrotoxic periodic paralysis (TPP), which can occur in hyperthyroid states but sometimes presents with normal thyroid function.

Underlying Pathogenesis:

HPP is caused by abnormal potassium regulation, leading to shifts of potassium into muscle cells, reducing extracellular potassium and causing muscle paralysis. This occurs due to:

- Mutations in ion channels (e.g., CACNA1S, SCN4A, or KCNJ18 genes)
- Increased Na⁺/K⁺-ATPase pump activity triggered by thyroid hormones, insulin, or catecholamines, causing intracellular potassium sequestration.
- Reduced potassium efflux from muscles, leading to muscle fiber inexcitability and weakness.

Group of Muscles Involved:

1. Proximal limb muscles (e.g., quadriceps, hip flexors) – difficulty rising from sitting.
2. Neck flexors – may be affected in severe cases.
3. Ocular muscles (causing transient diplopia, as seen in this patient).

Precipitating (Triggering) Factors:

1. High-carbohydrate or salty meals – triggers insulin release, shifting potassium into cells.
2. Strenuous exercise followed by rest – post-exercise potassium shift.
3. Emotional stress – increases catecholamines.
4. Alcohol consumption – contributes to electrolyte imbalance.
5. Certain medications – like insulin, beta-adrenergic agonists, or excessive tranquilizer use.

Diagnosis:

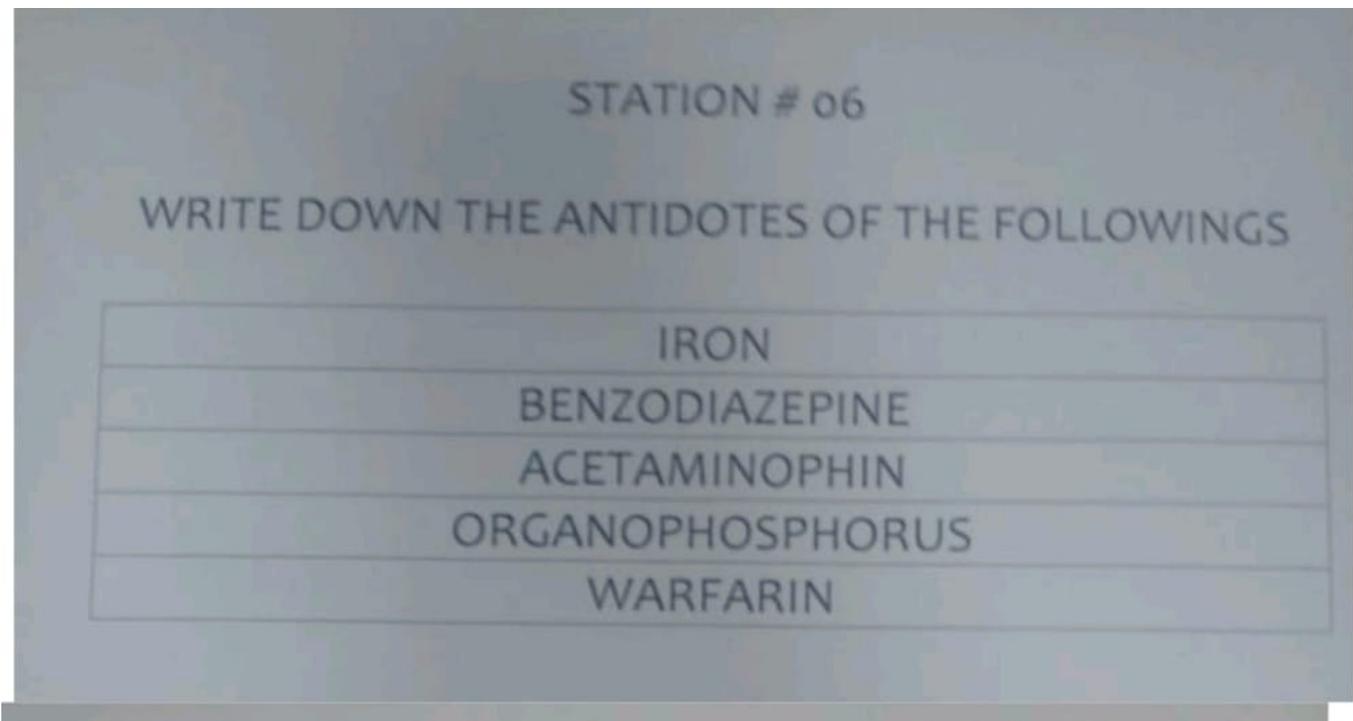
1. Serum potassium levels during an episode – typically low (<3.5 mmol/L), though can be borderline normal.
2. Thyroid function tests (T3, T4, TSH) – especially in suspected thyrotoxic periodic paralysis (TPP).
3. Electromyography (EMG) – shows reduced muscle excitability

Diagnosis:

1. Serum potassium levels during an episode – typically low (<3.5 mmol/L), though can be borderline normal.
2. Thyroid function tests (T3, T4, TSH) – especially in suspected thyrotoxic periodic paralysis (TPP).
3. Electromyography (EMG) – shows reduced muscle excitability during attacks.
4. Genetic testing – to confirm hereditary HPP (mutations in CACNA1S, SCN4A, or KCNJ18 genes).
5. Provocative testing (e.g., glucose-insulin test) – induces an attack for diagnostic purposes (rarely needed).

Emergency Treatment During Crisis:

1. Potassium supplementation – Oral potassium chloride (20–60 mEq) or IV potassium chloride (if severe paralysis) while avoiding i
tion.
2. Monitor cardiac function – as rapid potassium shifts can cause arrhythmias.
3. Avoid glucose-containing IV fluids – as insulin release can worsen hypokalemia.
4. Treat underlying cause – if due to thyrotoxicosis, manage with beta-blockers (propranolol) and antithyroid medications (methima:
TU).
5. Long-term management:
 - Potassium-sparing diuretics (e.g., spironolactone, acetazolamide) to prevent episodes.
 - Dietary potassium intake adjustment to prevent attacks



1. Iron Deferoxamine
2. Benzodiazepines Flumazenil
3. Acetaminophen (Paracetamol) N-acetylcysteine (NAC)
4. Organophosphorus compounds Atropine + Pralidoxime
5. Warfarin Vitamin K + Fresh Frozen Plasma (FFP) or Prothrombin Complex Concentrate (PCC)

Final Year MBBS Exam 2025

24/12/2024 Tuesday

Static
Station

A 2 years old female child presented to emergency department with a history of cough and fever for the last one month. On examination she is grunting, has developed extension of upper and lower limb and is responsive to pain only.

Question:

1. Give most likely diagnosis? (1)
2. What is her GCS? (3)
3. How will you investigate? (2)

Repeat.

Station No: _____
Date: ____/____/____

NAME: _____

BLOCK: _____ Station No: _____
Date: ____/____/____

A 16-year-old girl presented with excessive weight gain and decreased rate of height gain for the last 3 years. Her blood pressure is 150/100 mmHg. Her TFT's and LFT's are normal.

Cushing's



- Q 1. What features are shown in the pictures?
Q 2. What is the most likely diagnosis?

1. Hirsutism
Acne
Moon Face
Striae
Central Obesity

2. Cushing Syndrome



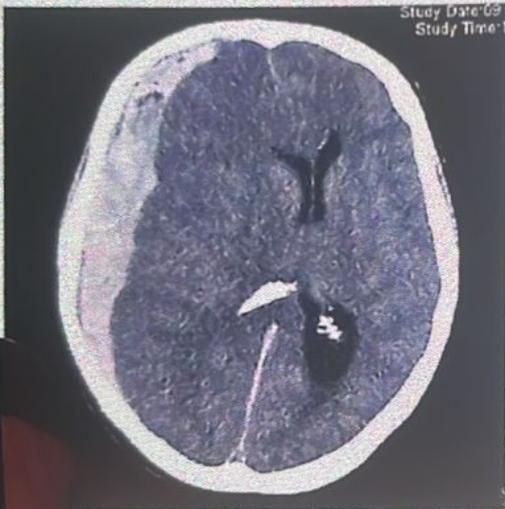
Question 1: Name these lesions?

Question 2: What are the associated complications?

Question 3: What investigations are needed?



Xanthelesma and palmer erythema
Xanthelesma: hyperlipidemia (cvd disease)
Palmer: liver surrrosis
Ins: lipid profile
Lfts
lle



Study Date: 09/09/2020
Study Time: 10:00 AM

STATION 02

Question 1: What is the likely diagnosis? 3

Question 2: What is the likely cause? 2

Intracranial hemorrhage
Htn

STATION 03

A 53-year-old lady presented with 2-year history of weakness, fatigue and pallor which increased gradually over time. She had multiple fainting attacks in the past with emergency visits to the nearby health facility and used to improve with IV D/Saline.



Edit

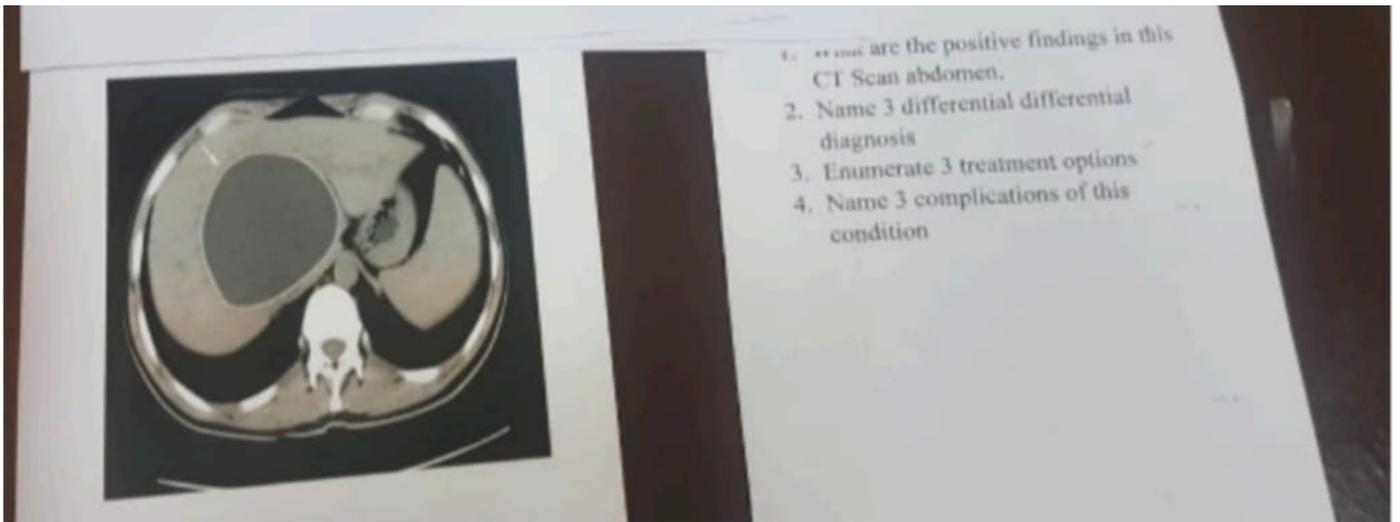
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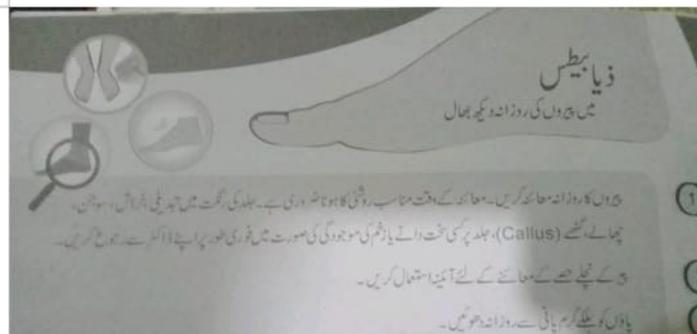




1. Large ovoid hypodense area in the liver
2. Differentials: hydatid cyst, liver abscess, benign adenoma. But this is hydatid cyst
3. Treatment: medical—albendazole; Surgical—PAIR (puncture aspiration injection reaspiration); Excision; cystopericystectomy; Captionnage; Hepatic resection
4. Complications: Ruture; Jaundince (due to compression effects of the lesions); Calcifications; Suppuration.

	Marks allocation
Introduction/rapport	0.5
Assessing the level of prior knowledge of patient	3
Enquire about his concerns	3
Appropriately address his concerns and suggest solutions	3
Advise precautions	2
Discuss the required investigations and treatment options	2
Advise regular follow up with physician	1
Thanking the patient	0.5
Total	15

This 30 year old married lady was found as Anti-HCV positive accidentally during pre-employment screening. She is worried and anxious.
Your task is to talk to him and address his concerns.



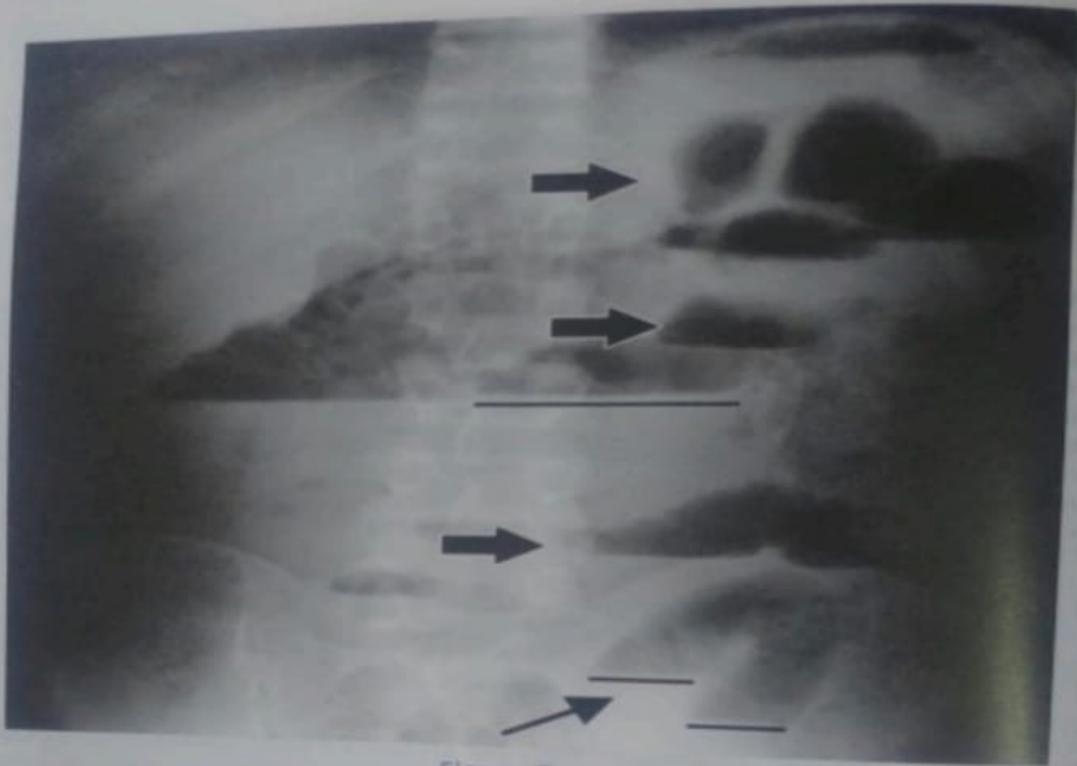


Figure 7

This is an x-ray (figure 7) of the same patient taken in erect posture showing multiple air fluid levels which are indicative of intestinal obstruction. These air fluid levels are visible only in X-rays which are taken in erect posture, because of the effect of gravity the fluids settles down & air rises up. 2-3 air fluids levels can be seen in normal individuals but presence of multiple air fluids level indicate intestinal obstruction.

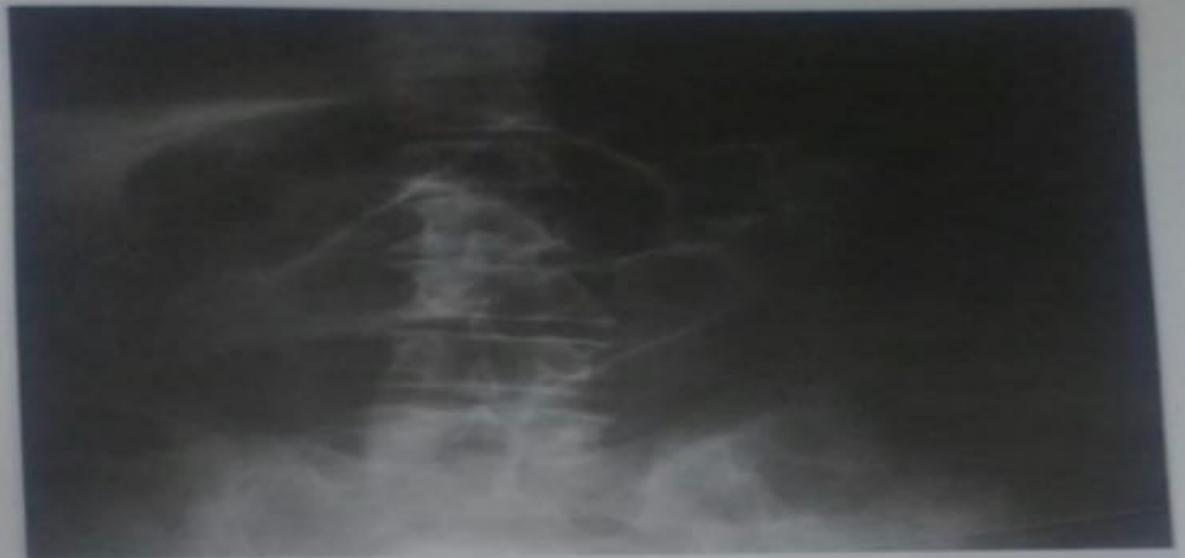


Figure 6

This is x-ray (supine posture) of the patient who presented with colicky abdominal pain & vomiting for 2 days. The x-ray is showing dilated gut loops which are located centrally jejunum they don't have valvulae conniventes. These are the features of dilated loops. figure 6.

Static Station 2

Marks: 05

Time Allowed: 05 minutes

For Candidate:

A 35 years old female has presented with a history of recurrent episodes of upper abdominal pain and fever. Her LFT's during one of these episodes are as follows:

Total bilirubin	5.5mg/dl
Direct bilirubin	4.5mg/dl
Indirect bilirubin	1mg/dl
SGOT	47IU/litre
SGPT	45IU/litre
Alkaline phosphatase	950IU/litre

Task:

Carefully answer the following questions:

1. What is the probable diagnosis? 01
2. Mention two further investigations which can help in reaching a diagnosis. 02
3. Give ONE method of non operative management which may be curative. 02

KEY:

1. Choledocholithiasis 01
2. USG, ERCP 02
3. Papillotomy 02

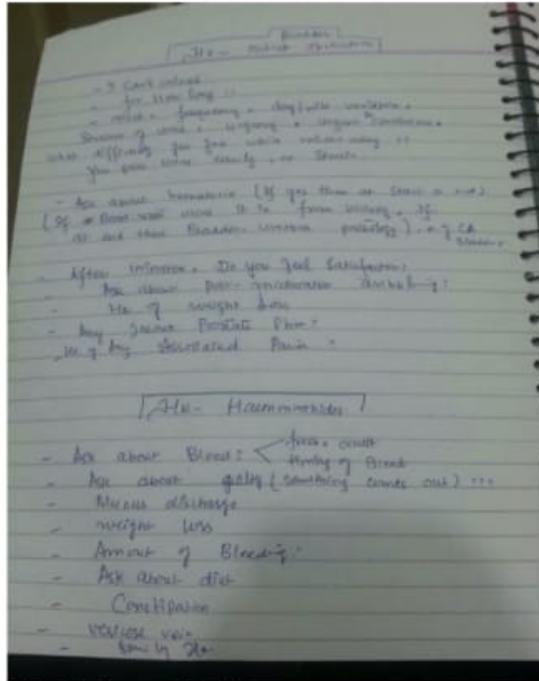
Station 22

Questions:

1. What is the most likely diagnosis?
2. What important history would you ask?
3. Enumerate three investigations.
4. Enumerate three management steps.

Liver cirrhosis with portal htn
Alcohol hx of hep b and c jaundice gi bleed
3 inv: Lfts, abd us/ ct serology
3 mx: diuretics paracentesis lufe style modifi
ons





Station 6: Identify types of incisions

Pfannestiel incision (pubic incision): most commonly for C-Sections and abdominal hysterectomies. Also used for orthopedic surgeries to treat pelvic fractures. Hernia repair is another indication.

Lanz Incision: It is a variation of the McBurney's incision that is made at the same point but in the transverse plane. It gives a cosmetically good scar. It is used for appendectomy.

Upper midline incision: For laparotomy and other abdominal surgeries

Gridiron incision (McBurney's Incision): for appendectomy.

Rutherford-Morrison incision: can be used for a right and left sided colonic resection, caecostomy or sigmoid colostomy.

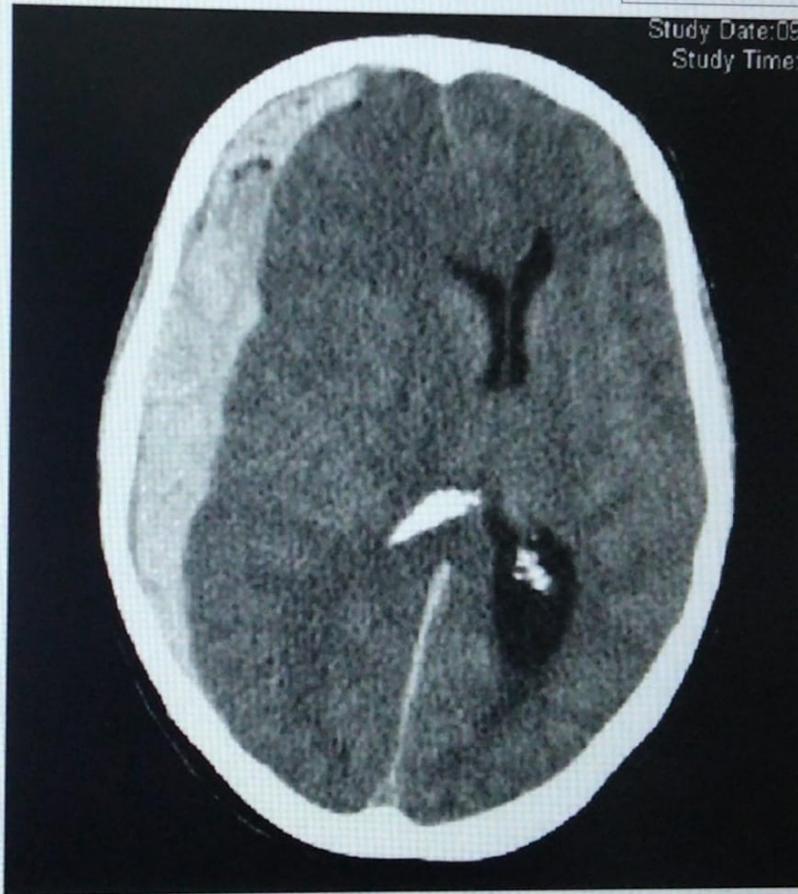


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Station 11 (A)

CT BRAIN

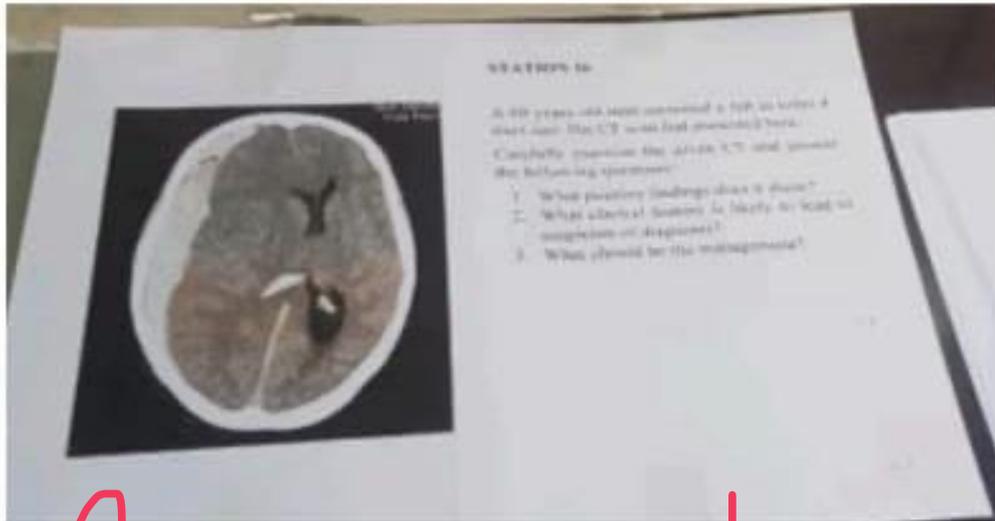
Study Date: 09/1
Study Time: 1



- Q1. Identify two abnormal findings?**
Q2. What is the diagnosis?

Repeat

3. Facial nerve injury, Frey's syndrome, meningioma, wound infection



Rep cat

1. Findings: hyperdense (white) crescent-shaped mass between the inner table of the skull and the surface of the cerebral hemisphere
2. Clinical feature: thunder-clap headache or "worst headache of life." Confusion and drowsiness, nausea and vomiting, slurred speech and changes in vision.
3. Management: craniotomy



Station 14

Questions:

1. Mention the abnormality.
2. Mention three causes.
3. Mention three drugs which can be used in this condition.



Repeat ✓

KEY STATION 7

1. T Tube (post CBD exploration) 1+1
2. 3 ways Foleys catheter (post TVP / clot retention) 1+1
3. Non crushing intestinal clamp (gut resection) 1+1
4. Air way (post anaesthesia/unconscious patient) 1+1



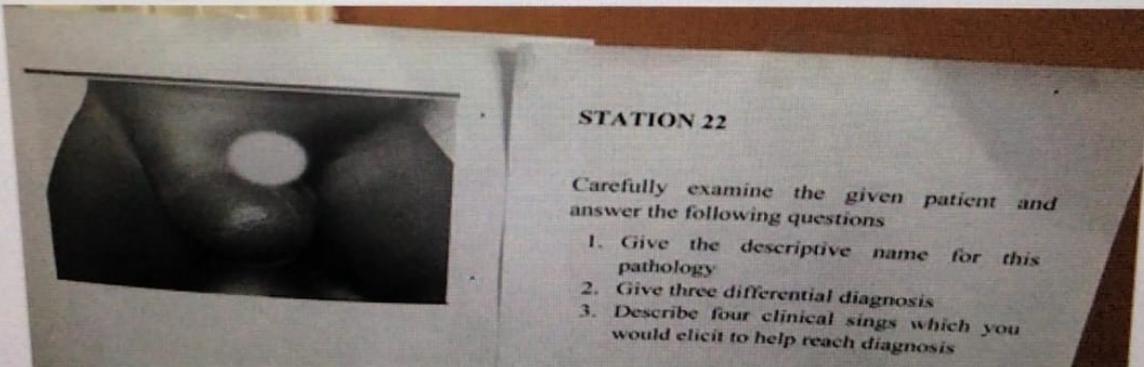
STATION 22

Carefully examine the given patient and answer the following questions

1. Give the descriptive name for this pathology
2. Give three differential diagnosis
3. Describe four clinical signs which you would elicit to help reach diagnosis

Key station 22

1. Inguinoscrotal swelling 2
2. Inguinal hernia, infantile hydrocele 3
3. Can reach above the swelling or not 3
 - a. Reducibility
 - b. Cough impulse
 - c. Deep ring occlusion test



STATION 06

This patient has prolonged history of diarrhea, weight loss, anemia & presents with these pruritic lesions on his extensor surface of elbows.

Question 01: Name the condition shown in this picture. 2

Question 02: What is the most likely underlying disease? 3

Question 03: How would you investigate? 3

Question 04: How would you manage? 2

1. Dermatitis herpetiformis
2. Celiac disease
3. Anti tTG and anti endomysial a/b skin biopsy endoscopy
4. Gluten free diet
Dapsone



ASEPTO SYRINGE



- *For irrigation of wounds, cavities, and urinary bladder.*



LUMBAR PUNCTURE NEEDLE



- *For lumbar puncture.*
- *For carotid angiography*
- *For cisternal puncture.*



Case

STATION /A

[INTERACTIVE]

A 40 years old female presented to you in OPD with complaints of pain in Rt. upper quadrant of abdomen which increase by intake of fatty food. Pain is colicky in nature subsides after taking medications.

- i. What is your diagnosis?
- ii. What investigations will you advise?
- iii. What is the treatment recommended?

Repeat ✓

STATION # 07

WRITE 1 EXAMPLE (VACCINE) OF THE FOLLOWING

LIVE BACTERIA, ATTENUATED

LIVE VIRUS, ATTENUATED

VIRAL SUBUNIT

CAPSULAR POLYSACCHARIDE

TOXOID

BCG

MMR

Hep
B

Pneumococcal
vaccine
Tetanus

Station No: 10

A 2.5 years old boy presented with diarrhoea since 3 month of age. He is fully vaccinated, on examination, he is anemic, underweight with protrudent abdomen and decrease muscle mass.

His Hb= 7.7g/dL, TLC = 8500, Platelets count = $250000 \times 10^9/L$, Stool R/E and Urine R/E is normal.

1. What is your diagnosis? (2)
2. How will you confirm the diagnosis? (2)
3. What is the management? (2)

coliac
Disorder



Likely Diagnosis:

12:44



The most probable diagnosis is Celiac Disease (Gluten-sensitive enteropathy). The history of chronic diarrhea since infancy, overweight status, protuberant abdomen, and muscle wasting strongly suggests malabsorption syndrome, with celiac disease being the most likely cause.

How to Confirm the Diagnosis?

1. Serological Tests:

- Anti-tissue transglutaminase (tTG) IgA (first-line test)
- Anti-endomysial antibodies (EMA) IgA
- Total serum IgA (to rule out IgA deficiency, which can cause false-negative results)

2. Small Bowel Biopsy (Gold Standard):

- Villous atrophy, crypt hyperplasia, and intraepithelial lymphocytosis seen on duodenal biopsy confirm the diagnosis.

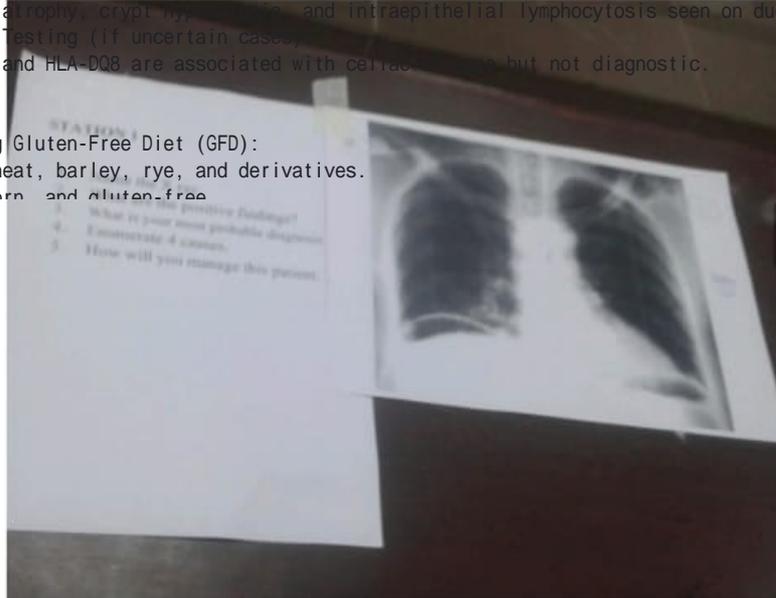
3. Genetic Testing (if uncertain cases):

- HLA-DQ2 and HLA-DQ8 are associated with celiac disease but not diagnostic.

Management:

1. Lifelong Gluten-Free Diet (GFD):

- Avoid wheat, barley, rye, and derivatives.
- Rice, corn, and gluten-free



Name the X-ray: Erect PA view?

What are the positive findings? Air under the diaphragm

Most probably diagnosis: perforated peptic/duodenal ulcer; perforation of ileum due to typhoid or tb; injury to the intestine (blunt or penetrating); perforation of intestinal tumor; post laparotomy/laparoscopy which may persist up to 7 days.

4 Causes: most common cause is hollow viscous perforation. Could occur due to perforated peptic ulcer. In 10% of case, it can be due to rare causes, both abdominal and extra abdominal (intra-abdominal infection by gas forming organisms).

What is the mechanism of this finding: Normally, there is no free air in the peritoneal cavity, rather it is present in the lumen of the gut. When there is perforation of the gut due to any reason, this air enters into the peritoneal cavity along with other contents of the gut. When the patient is in standing position, this air moves upward (under the diaphragm and occupies a space between the liver and diaphragm) when xray is taken in this position then air becomes clearly visible between the liver and diaphragm. It usually takes about 3 to 4 hours after perforation of duodenal ulcer for air to be seen in the x-ray and minimum amount of air which can be detected on xray is 12cc.

Treatment: Urgent surgery. Follow all pre-op steps.

Station 2: Barium Meal (picture taken from internet):



Edit

Annotate

Fill & Sign

Convert

All



He is unwell for the last 1 month with low grade fever, off and on headache and was coughing with lots of sputum.

His CSF finding are

Turbidity = present

Cell count = 250 cells / mm³

N = 2 %

L = 98 %

Protein = 120 mg/dl

Sugar = 28 mg/dl

Blood Sugar = 104 mg

X-ray chest show hilar lymphadenopathy interpret this data.

- a) What is the diagnosis?
- b) Discuss treatment plan



TBM

1. Tuberculous Meningitis

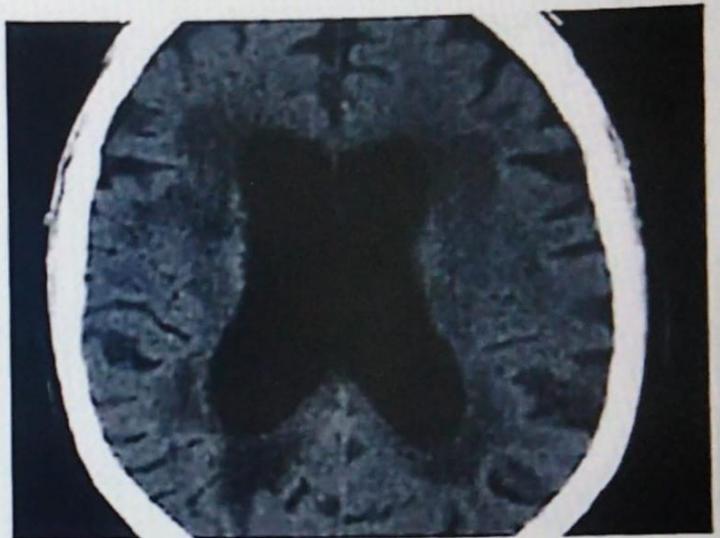
2. • Antitubercular Drugs (12-18months)

• Steroids

Station 76

This 70 years old gentleman presented with decreased attention, apathy and loss of memory for three months. He also had unsteady gait and incontinence of urine.

1. *What investigation is shown?*
2. *What abnormality is present?*
3. *What is the diagnosis?*
4. *What is the most effective treatment?*



Repeat

Station 72

1. Which nerve palsy is shown?
2. Enumerate two symptoms/ signs you expect.
3. Enumerate three causes.



Hypoglossal nerve injury
Tongue deviation+ atrophy of tongue on affected side
Causes: stroke tumors trauma during surgery



Figure 1

1. Name this procedure/examination?
2. Why it is performed?
3. How is it performed?
4. Label the marking 1, 2, 3, 4 and 5
5. What should be seen carefully
6. What is the finding?

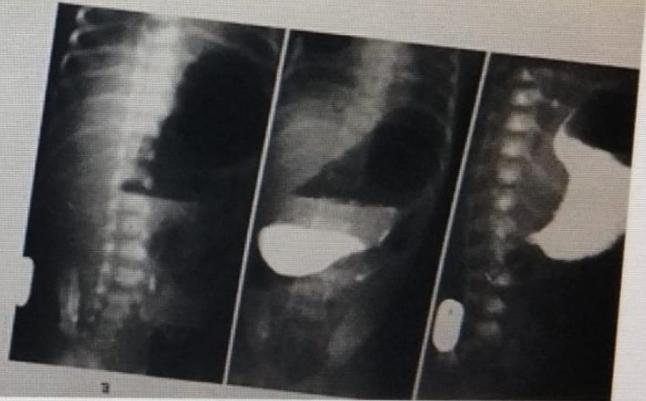
ANSWERS:

1. T-Tube cholangiogram.
2. It is performed to check the patency of CBD and is performed 2 weeks after surgery
3. A dye (urographin) is injected into the long limb of T-Tube and X-Ray of abdomen is obtained
4. **1:** Common Hepatic Duct. **2:** Long Limb of T-Tube.
3: CBD. **4:** Dye in the duodenum.
5.
 - a. Always check the positioning of the tube
 - b. Check biliary system patency and dilatation
 - c. Check for any filling defect in the biliary system.
 - d. If normal t tube Cholangiogram is seen, then T tube should be clamped for 24 hours. If no sign of biliary obstruction or leakage is observed then T-tube can be removed.
 - e. If stone (filling defect) is seen in the biliary system tube should be kept in place for 2-3 weeks to allow the tract to be performed around the t tube; after that a choledochoscope can be inserted through T tube and stone should be extracted. If stone may be needed to deal with the stone before removing the t-tube.
6. A dye has passed into the CBD and duodenum & there is no obstruction in the biliary system so it is a normal T-Tube cholangiogram.

STATION 2

A 70 year old male with persistent vomiting was advised this x ray.

1. Name the X ray.
2. What is most likely diagnosis?
3. Write 2 common causes of your diagnosis.
4. Mention electrolyte abnormality in this condition
5. Which investigation you will follow to confirm the cause of your diagnosis



Repeat ✓



Most probably diagnosis: Testicular Torsion (twisting of spermatic cord resulting in strangulation of blood supply to testes).

Investigations: Diagnosis is mainly clinical

Doppler U/S confirms absence of blood flow to the affected testis. Exploration should be considered even in doubtful conditions and must be undertaken within 6 hours of onset of pain.

Treatment: Take consent for orchidectomy in case testis is not viable. Exploration is performed through scrotal incision. The testes is inspected. If viability is doubtful, cover the testis with warm saline soaked gauze and ask the anesthetist to 100% oxygen for 5-10 mins. Then examine gain. If the testis is now pink, it can be salvaged. If it is blue-black, orchidectomy should be done.

If viable, torsion is untwisted and testis is fixed at 3 places with non absorbable sutures (prolene) between tunica albuginea and tunica vaginalis to prevent it from twisting again. The other testis should also be fixed because the anatomical pre-disposition is invariably bilateral and other testis is at risk of torsion.

Station 5: Take hx from a patient of obstructive jaundice

1. Biodata
2. What brings you into today? Can you tell me about the skin colour change? When did you first notice it?
3. Onset: Ask when the patient first noticed the jaundice and whether anyone else had commented on it before
4. Progression: ask whether it has got more noticeable and how quickly it has progressed (*rapidly progressive jaundice could indicate viral hepatitis, an insidious progression over months could indicate malignancy such as hepatocellular carcinoma or pancreatic cancer and a long-term slowly progressing jaundice over years could indicate liver cirrhosis*)
5. Establish predisposing events such as trauma or illness
6. Associated Symptoms:
 - a. **Pain - painless** jaundice (especially if with weight loss) may signify a serious underlying condition (such as malignancy) or **RUQ pain** and jaundice (e.g. gallstones, acute cholangitis, hepatitis)
 - b. **Nausea and vomiting** - especially important to ask about **haematemesis** (*may be due to varices seen in chronic liver disease*)
 - c. **Bowel habit** - loose stool, constipation



- d. **Change in stool colour** - e.g. **pale and greasy** (steatorrhoea indicating bile duct obstruction seen in pancreatic malignancy or gallstones etc), **dark/black/tarry** (seen in an upper GI bleed)



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Station 23

Questions:

This patient presented with high grade fever and body pain,

1. What is the most likely diagnosis?
2. What important history would you ask from this patient?
3. Name at least three diseases which spread through mosquito bite.
4. Mention three important investigations for this patient.



Dengue/ malaria

3disease: dengue malaria yellow fever

Invs: cbc Lftspcr dengue antigen

of rotate the pt. platelet whole blood
transfusion

station 21

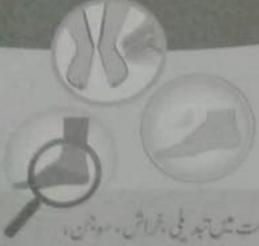
Cullen sign

**extra peritoneal hemorrhage sentinel lobs
effusion**

pancreatitis

ذیابیطس

میں پیروں کی روزانہ دیکھ بھال



پیروں کا روزانہ معائنہ کریں۔ معائنہ کے وقت مناسب روشنی کا ہونا ضروری ہے۔ جلد کی رنگت میں تبدیلی، خراش، سوجن، پھالے، گٹھے (Callus)، جلد پر کسی سخت دانے یا زخم کی موجودگی کی صورت میں فوری طور پر اپنے ڈاکٹر سے رجوع کریں۔

پہننے کے نچلے حصے کے معائنے کے لئے آئینہ استعمال کریں۔

پاؤں کو ٹھیک گرم پانی سے روزانہ دھوئیں۔

پاؤں دھونے کے بعد آہستگی سے خشک کریں خاص طور پر انگلیوں کی درمیانی جگہ اور اچھی طرح خشک کریں۔

اگر پاؤں خشک رہتے ہوں تو ان پر چمکانہت والی اشیاء (ہیڈرولیم نیلی، واپٹین، کولڈ کریم، گلیسرین یا تیل) لگا لیں۔

ان اشیاء کو کسی بھی خراش پر اور پاؤں کی انگلیوں کے درمیان نہ لگائیں۔

ذیابیطس

میں پیروں کی روزانہ دیکھ بھال



پاؤں کی انگلیوں کے ناخنوں کو زیادہ بڑھنے نہ دیں۔ ناخن ہمیشہ سیدھے کاٹیں یا فائل کریں اور کونے نہ کاٹیں۔

ناخن زیادہ گہرے بھی نہ کاٹیں۔

پاؤں کو حرارت پہچاننے کے لئے آگ یا ہیٹ کے قریب نہ رکھیں۔ پاؤں کا آگ یا ہیٹ سے کم از کم تین میٹر کا فاصلہ ہونا ضروری ہے۔ گرم پانی کی بوتل کا استعمال نہ کریں۔

گٹھے پھٹنے سے پرہیز کریں۔

ان کے گٹھوں (Callus) اور مسوں (Corns) کو خود کاٹنے سے پرہیز کریں۔

صاف ستھری جرابیں استعمال کریں۔

DM counselling station points

- 1 Introduction / report - education - language - privacy - ^{confirming}
- 2 Assessing the level of prior knowledge of patient.
- 3 " " the dietary habit of patient.
- 4 Suggesting dietary modification.
- 5 Advise life style modification.
- 6 Enquire and address the patient concerns & queries
- 7 Advise regular follow up with physicians
- 8 Thanks to patient.

Epilepsy counselling station points.

- Pt - non-compliance

- 1 Introduction " " " "
- 2 Confirming the provided information.
- 3 Probing into reasons for non-compliance.
- 4 Suggesting the solution.
- 5 Advise about legal implication of ban on driving.
- 6 To refrain from high risk activities
- 7 Advise regular follow up with physician.
- 8 Thanks to patients

Station 15

Questions:

1. Name the sign shown in this picture.
2. What underlying chronic illness you suspect.
3. Name three other signs this patient may have.
4. Mention a single most important investigation.



Repeat

STATION NO: 2

A 25 years old male opened for appendicectomy.
A suspected carcinoid tumor is found at the tip of appendix.

- a. What is carcinoid syndrome?
- b. What other organs are affected by this condition?
- c. What will be the treatment for carcinoid of 2 cm at the tip of appendix?
- d. What findings of the histology of the specimen can change the management of the patient?

Not to be used

- a. Carcinoid syndrome: a set of symptoms that might be a sign you have neuroendocrine tumors (NETs). Carcinoid syndrome symptoms include watery diarrhea and unusually flushed skin.
 - a. causes redness or a feeling of warmth in your face and neck (skin flushing), chronic diarrhea, and difficulty breathing.
- b. Other organs affected by this condition: gastrointestinal tract, including your stomach, small intestine, appendix, colon and rectum.
- c. Treatment for 2cm carcinoid at tip of appendix:
 - a. If size is <2cm, appendectomy is curative
 - b. Indications for right hemicolectomy:
 - i. If tumor size is >2cm
 - ii. Lymph nodes are involved
 - iii. Cecal wall is involved
- d. What findings of the histology of the specimen can change the management of the patient?
 - a. If lymph nodes are involved or if cecal wall is involved.

INTERACTIVE

Cholecystectomy is one of the common elective surgical operation. You are required to enumerate the steps of open cholecystectomy.

KEY STATION 12

- | | | | | | |
|----|--------------------------------------|---|---|---|--|
| 1. | Different incisions | | | | |
| 2. | Other layers cut in line of incision | 2 | | | |
| 3. | Callot triangle | | | 1 | |
| 4. | Mention 2 early complications | 1 | | | |
| 5. | Mention 2 late complications | | 1 | | |
| 6. | Other options of G stone (Lap chole) | | | 1 | |

STATION 13

A 15 year old boy present with sudden onset of severe Rt testis pain since last 3 hours and vomiting. On examination testis is very tender.

Q1. Give two differential diagnosis

Q2. Name investigations to cause

Q3. Which one will need urgent

Q4. Enumerate steps of surgery.

differentiate the

exploration.

KEY 13

- | | | | | | |
|----|----|-------------------------------|---|---|--|
| | a. | Testicular torsion | 1 | | |
| | b. | Epidydm orchitis | 1 | | |
| 2. | | | | | |
| | a. | Dopler ultrasound of testis | 1 | | |
| | b. | Urine R/E / FBC | 1 | | |
| 3. | | Testicular torsion | | 1 | |
| 4. | | | | | |
| | a. | Viable testis --- fixation | 1 | | |
| | b. | Non viable --- orchidectomy | 1 | | |
| | c. | Contralateral testis fixation | | 1 | |

Rabia Bangash

➔ Forwarded

Ospe main abdomen examination

7:15 pm

Rabia Bangash

➔ Forwarded

Sspe long case

7:15 pm

Rabia Bangash

➔ Forwarded

GBS

7:15 pm

Rabia Bangash

➔ Forwarded

Ospe: GBS

7:15 pm

Rabia Bangash

➔ Forwarded

Medicine

GbS ,primary sclerosing
cholangitis,organophosphorus
poising,spider angioma

7:15 pm

Rabia Bangash

➔ Forwarded

Pneumonia due to Protein Calorie
Malnutrition. DD Bronchiolitis

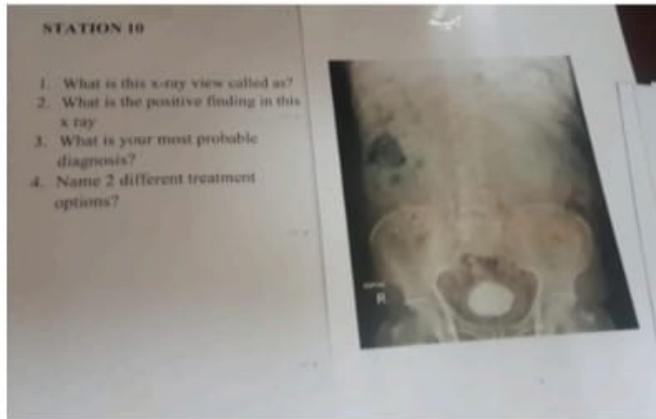
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Rabia Bangash

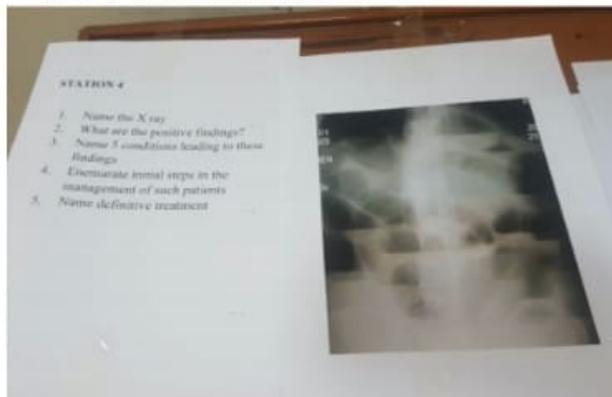
➔ Forwarded

Galactosemia
Lung Ca counseling
Galactosemia

34



1. X-Ray KUB
2. Small radio-opaque shadow on the right side
3. Renal Calculus
4. ECSWL; PNL; Open removal of stone



1. X-ray erect abdomen
2. Multiple dilated loops of gut with air fluid levels

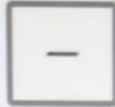
35

3. 5 Conditions: intestinal obstruction; caused by fibrous bands of tissue (adhesions); colon cancer; hernia, strictures, crohn's disease, diverticulitis,



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Ask Copilot



+



28

of 162

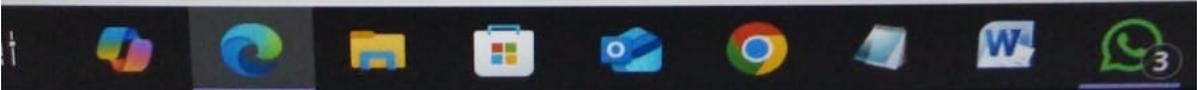


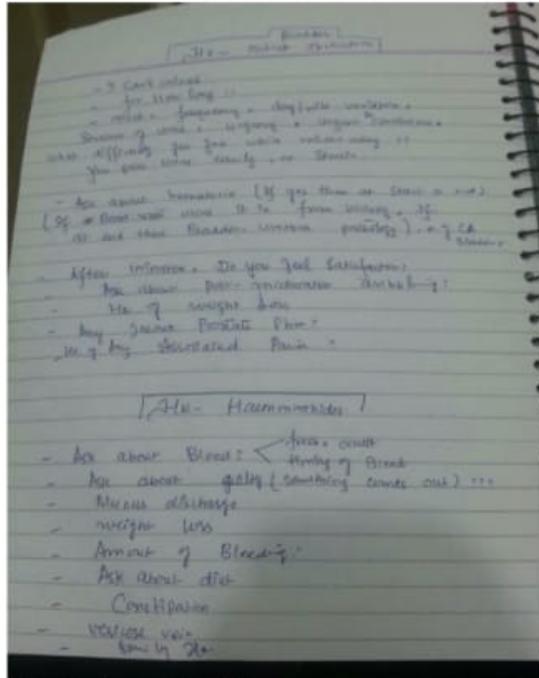
7

Q. A 44-year-old man presented with chronic diarrhea. Over the past 5 years, the patient experienced intermittent bouts of watery diarrhea associated with fatigue and a 15-kg weight loss. Past medical history included a perianal fistula, which required surgery 5 years ago. He denied use of antibiotics or nonsteroidal anti-inflammatory drugs before the onset of his symptoms. On presentation, vital signs were within the normal range. Physical examination showed a pale appearance, hyperactive bowel sounds, and mild lower-extremity edema.

1. Enumerate three differential diagnosis? *IBD (Crohn's disease)*
2. Enlist three investigations? *CRP, ESR, stool studies*

Repeat





Station 6: Identify types of incisions

Pfannestiel incision (pubic incision): most commonly for C-Sections and abdominal hysterectomies. Also used for orthopedic surgeries to treat pelvic fractures. Hernia repair is another indication.

Lanz Incision: It is a variation of the McBurney's incision that is made at the same point but in the transverse plane. It gives a cosmetically good scar. It is used for appendectomy.

Upper midline incision: For laparotomy and other abdominal surgeries

Gridiron incision (McBurney's Incision): for appendectomy.

Rutherford-Morrison incision: can be used for a right and left sided colonic resection, caecostomy or sigmoid colostomy.

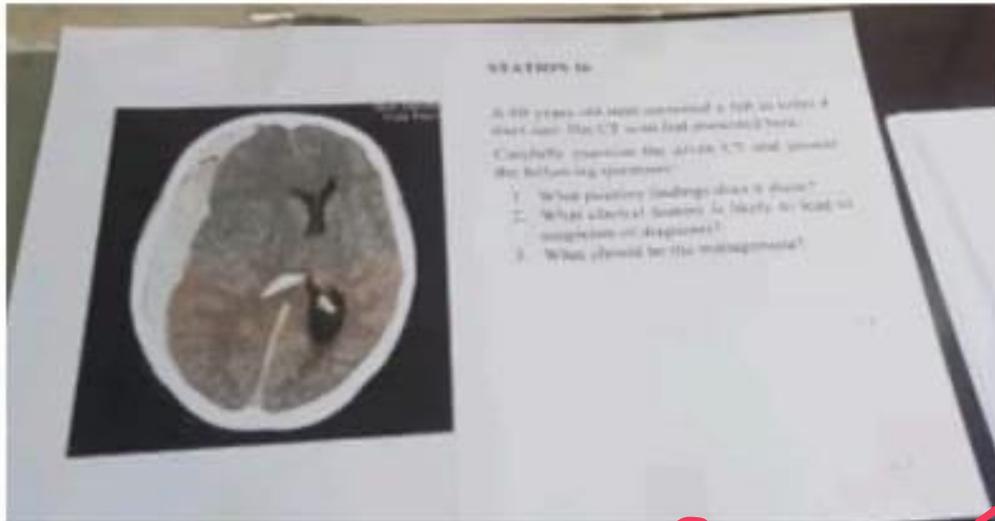


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Distinguish kidney and spleen on abdominal examination:

1. kidney is BALOTTABLE, spleen is NOT
2. NOTCH ON ANTERIOR BORDER - palpable in spleen, not in kidney
3. spleen enlarges diagonally towards RLQ, while the kidney enlarges inferiorly
4. kidney can be resonant to percussion (d/t overlying bowel), spleen should be DULL
5. UPPER EDGE of spleen NOT palpable, upper edge of kidney is
6. SPLENIC RUB on auscultation (have patient breathe in and out) and kidney its not

3. Facial nerve injury, Frey's syndrome, meningioma, wound infection



Repeat

1. Findings: hyperdense (white) crescent-shaped mass between the inner table of the skull and the surface of the cerebral hemisphere
2. Clinical feature: thunder-clap headache or "worst headache of life." Confusion and drowsiness, nausea and vomiting, slurred speech and changes in vision.
3. Management: craniotomy



Station 73

A 42 years old sports instructor develops high grade fever, conjunctival injection, jaundice and poor urinary output since last 5 days. He has been gone for swimming competition in Rawal dam during last rains about 2 weeks ago. Clinical examination reveals: BP 90/60 mmHg, pulse 120/m, low volume with signs of dehydration. Marked conjunctival injection, skin showing ecchymotic patches on arms and trunk, 2cms hepatomegaly and marked tachycardia without added sounds.
Lab investigations reveal: TLC $23 \times 10^9 / l$, serum urea 9 m mol / l, serum bilirubin 55 micro mol / l, ALT 122 U/l, urine R/E showing proteins 2+, RBC and tubular casts and ECG showing sinus tachycardia.

1. What is the probable diagnosis?
 - a. Enteric fever
 - b. Malignant tertian Malaria
 - c. Leptospirosis (Weil's disease)
 - d. Scrub typhus fever
 - e. Dengue fever
2. Organism, route & incubation?
3. s/s?
4. Diagnosis?
5. Rx?
6. Complications?
7. Rx Carrier?

Leptospirosis

Question No. 9

Topic: Infectious Disease

- 1: What is the diagnosis? (1)
- 2: Describe four causes of this condition. (2)
- 3: Describe four investigations to reach the diagnosis. (2)



Key

- 1- Cervical lymph adenitis (1)
- 2- (0.5 each)
 - i. Tuberculous lymph adenitis
 - ii. Bacterial / suppurative lymph adenitis
 - iii. Malignancy
 - iv. Non-specific / viral / Atypical micro bacteria tuberculosis
- 3- (0.5 each)
 - i. CBC including peripheral morphology & ESR
 - ii. X-ray chest
 - iii. Tuberculin test / BCG accelerated tests
 - iv. FNA / Excisional biopsy / Aspiration

Question No. 8

Topic: Infectious Disease

- 1: What is the clinical finding? (1)
- 2: Name the two underlying conditions leading to this finding? (2)
- 3: What is the management? (2)



STATION 9

Case history:

A 17 years old boy presented to the outpatient department with 10 years history of intermittent diarrhea with 3 to 5 motions per day. He also complains of abdominal pain and fullness mostly after meals. No history of fever or blood in the stool.

On examination, he is pale with poor growth of secondary sexual characteristics and a bit wasted. His pulse is regular, BP 110/70, no oral ulcers/lymphadenopathy. Abdominal examination is unremarkable.

Investigations show Hb-9.4gm%, TLC-5400/cmm, N-54% L-44% E-2%. MCV-100fl, stool RE shows ova of ascaris lumbricoides and semisolid consistency.

Questions:

1. What is the most likely diagnosis?
2. Give two differentials with differentiating points.
3. Mention two diagnostic investigations.
4. Outline the management of this patient.

	cyanosis		
Pulse	<60	60-100	>100
Grimace	No Grimace	Some	FULL CRY
Activity	Limp	Some activity	Active
Respiration	No respiration	Gasping	Normal

CLINICAL SCENARIO

A 2 years old boy presented with failure to thrive and fits which usually occur in early morning. His investigations reveal

- Fasting blood sugar ----- 40mg/dl
- ALT ----- 75U/L
- Uric acid ----- 8mg/dl
- Serum triglycerides ----- >200mg/dl

Questions

1. What is most likely diagnosis
2. What other clinical signs you will look for
3. How will you confirm your diagnosis

KEY

1. Glycogen storage disease
2. Hepatomegaly , Doll like facies
3. Liver biopsy , Enzyme assay

Nutrition

- Q1 What definition this graph reflects. (1)
 Q2 Enumerate 8 common causes of this condition. (2)
 Q3 Enumerate 8 steps to prevent malnutrition in children.(2)

Key:

- 1- Failure to thrive
- 2- (0.25 each for any 8 of 9)
 - i. Failure of lactation
 - ii. Faulty weaning
 - iii. Poverty / ignorance ✓
 - iv. Cultural food patterns ✓
 - v. Lack of immunization/family planning and primary care
 - vi. Recurrent GIT infections
 - vii. Recurrent respiratory tract infection
 - viii. Measles / malaria
 - ix. Tuberculosis
 - x. Congenital malformation
- 3- (0.25 each for any 8 of 10)
 - i. Optimum breast feeding
 - ii. Avoiding bottle feeding, pacifiers etc.
 - iii. Adequate weaning
 - iv. Immunization
 - v. Growth monitoring
 - vi. Family planning
 - vii. Health education



HYDROCEPHALUS

24



Tylosis palmaris



cutaneous horn



Hypermobile jointMarfan syndrome

25



1. What investigation has been done? 01
2. Name one positive finding in this X-Ray. 1.5
3. What part of biliary passage has not been outlined? 01
4. Name one other investigation which can be more informative. 1.5



KEY:

1. PTC 01
2. Dilated intrahepatic and part of extrahepatic biliary passages 1.5
3. Distal CBD 01
4. MRCP 1.5



A 45 years old female presented with intermitted pain RHC for 6 months but now with jaundice as well. USG does not comment on biliary channels due to bowel gas shadows. The above mentioned investigation was planned then.

Carefully examine the given radiograph/photograph and answer the following questions:

- Q.No.1: What is this investigation?
 Q.No.2: Describe the findings in this image?
 Q.No.3: What is the definite diagnosis of this patient?
 Q.No.4: What treatment options are available for this patient?

ANSWERS:

1. Magnetic Resonance Cholangio Pancreatography (MRCP)
2. Hypodense lesion in the CBD
 - Dilated intrahepatic and extrahepatic biliary system
 - No complete obstruction because contrast is present in small bowel as well
3. Choledocholithiasis (CBD stone)
4. ERCP and stone retrieval



Figure 4

A 40 year old man presented with jaundice. ERCP has been unsuccessful. This X-ray shows an alternative investigation done.

Carefully examine the given radiograph / photograph and answer the following question:

QUESTION

1. What investigation has been done?
2. Name one positive finding in this x-ray.
3. What part of biliary passage has not been outlined?
4. Enlist two differential diagnosis

ANSWERS

1. PTC
2. Dilated intrahepatic and part of extrahepatic biliary passages.
3. Distal CBD
4. CBD stricture

67



Down syndrome



Port wine stain

68



STATION NO: 5

A 16 years old boy, a recent visitor to Africa, is found to be moderately plae, febrile and having a large tender spleen.

- a. List six causes of a chronically enlarged spleen.
- b. What do you understand by the term hypersplenism?
- c. Name the vaccination given before Splenectomy.
- d. Name 04 complications of Splenectomy

300

TeACJ

- a. Causes of splenic enlargement:
 - a. Hematological cause: Sickle Cell Anemia, Thalassemia, Hereditary Spherocytosis
 - b. Malignancy: CML, CLL, Hodgkin's Lymphoma
 - c. Liver diseases like cirrhosis
 - d. Microbial causes: viral, bacterial, fungal infections
 - e. Anything else??
- b. Hypersplenism is a common disorder characterized by an enlarged spleen which causes rapid and premature destruction of blood cells. Hypersplenism refers to a group of syndromes that involve splenomegaly and peripheral cytopenia of various causes. Hypersplenism can be caused by many diseases which, in turn, affects the prognosis of hypersplenism.
- c. Name vaccinations to give before splenectomy: vaccinate against capsulated organisms
 - a. Hemophiles Influenza B
 - b. Pneumococcus
 - c. Meningococcal
- d. 4 Complications of splenectomy:
 - a. Infection, hematoma
 - b. Pancreatitis
 - c. Injury to pancreas, stomach, and colon
 - d. Incisional Hernia



12

2. Foley catheter is placed and Orogastric tube is inserted to avoid inadvertent injury and improve exposure.
3. Pneumoperitoneum is established with a veress needle through a sub-umbilical incision
4. 10mm trocar canula is inserted sub umbilically.
5. A 30 degree laparoscope is then inserted through the umbilical port, and an examination of the peritoneal cavity is performed.
6. Three additional ports are inserted; 10mm just below the xiphisternum, 5mm in the mid-clavicular line at transpyloric plane, 5mm in the anterior axillary line just below the costal margin.
7. Gallbladder fundus is identified, grasped and retracted superiorly. With a second grasper, the gallbladder infundibulum is retracted laterally to expose and open the Callot's triangle (the area bounded by the cystic duct, common hepatic duct, and inferior edge of the liver).
8. The triangle is gently dissected to clear the peritoneal covering and obtain a view of the underlying structures
9. The cystic duct and cystic artery are identified and clipped with a tiny titanium clips and divided between the lips
10. Then the gallbladder is dissected away from the liver bed and removed through one of the ports site usually through the epigastric port. This is done using electric hook.

Contraindications of laparoscopic cholecystectomy:

1. Severe COPD or CCF (these patients cannot tolerate pneumoperitoneum).
2. Severe bleeding disorder
3. End stage liver failure

Open

1. Small 6in incision is made below the umbilicus, fascia incised and peritoneum entered via finger and a canula (Hanson's canula) is inserted into the peritoneal cavity and anchored to the fascia. Kocher's (right subcostal) incision is made.
2. This incision is 3-4 cm below and parallel to the right costal margin and extends from the xiphisternum in the midline to the ninth costal cartilage.
3. Peritoneal cavity is insufflated with Co2??
4. Skin and subcutaneous tissue and anterior rectus sheath are incised. This exposes the rectus muscle at medial end and transverse abdominis and internal oblique at lateral end. The rectus abdominis muscle is divided transversally.
5. Peritoneum is opened between two forceps.
6. Gallbladder is examined and 3 sponges are placed around the gallbladder. The first packs the colon downward and prevents bowel from entering into the operative field. The second is placed so that the stomach and duodenum can be retracted laterally and the third sponge is placed of the visceral surface of the liver. These sponges are held with Deaver's retractors by the assistants.
7. This exposes the gallbladder fully
8. With lateral traction on the gall-bladder neck, the peritoneum overlying the triangle of Calot is incised and the cystic duct is ligated and divided after carefully tracing it onto the gallbladder.

13

9. Pringle's maneuver may be needed for sever bleeding
10. Abdomen is closed and peritoneum and transverse abdominis and internal oblique are closed together, then rectus muscle is closed then rectus sheath. Skin is closed with subcuticular technique.



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Annotate

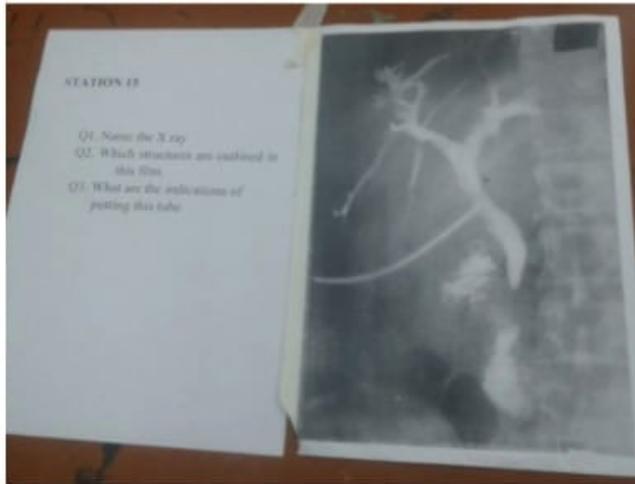
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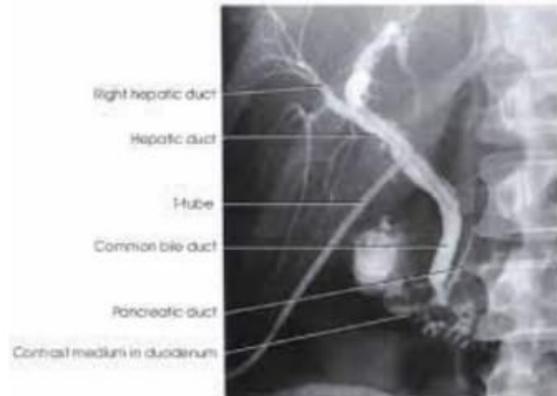
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A medical student gets a needle stick injury while drawing blood from a patient suffering from cirrhosis of liver. He is hepatitis B positive.



1. Name the X-ray: ERCP
2. What are the structures outlined in this film? Right and left hepatic ducts, CBD
3. What are the indications of putting in this tube? Already covered in T-tube





Most probably diagnosis: Testicular Torsion (twisting of spermatic cord resulting in strangulation of blood supply to testes).

Investigations: Diagnosis is mainly clinical

Doppler U/S confirms absence of blood flow to the affected testis. Exploration should be considered even in doubtful conditions and must be undertaken within 6 hours of onset of pain.

Treatment: Take consent for orchidectomy in case testis is not viable. Exploration is performed through scrotal incision. The testes is inspected. If viability is doubtful, cover the testis with warm saline soaked gauze and ask the anesthetist to 100% oxygen for 5-10 mins. Then examine gain. If the testis is now pink, it can be salvaged. If it is blue-black, orchidectomy should be done.

If viable, torsion is untwisted and testis is fixed at 3 places with non absorbable sutures (prolene) between tunica albuginea and tunica vaginalis to prevent it from twisting again. The other testis should also be fixed because the anatomical pre-disposition is invariably bilateral and other testis is at risk of torsion.

Station 5: Take hx from a patient of obstructive jaundice

1. Biodata
2. What brings you into today? Can you tell me about the skin colour change? When did you first notice it?
3. Onset: Ask when the patient first noticed the jaundice and whether anyone else had commented on it before
4. Progression: ask whether it has got more noticeable and how quickly it has progressed (*rapidly progressive jaundice could indicate viral hepatitis, an insidious progression over months could indicate malignancy such as hepatocellular carcinoma or pancreatic cancer and a long-term slowly progressing jaundice over years could indicate liver cirrhosis*)
5. Establish predisposing events such as trauma or illness
6. Associated Symptoms:
 - a. **Pain - painless** jaundice (especially if with weight loss) may signify a serious underlying condition (such as malignancy) or **RUQ pain** and jaundice (e.g. gallstones, acute cholangitis, hepatitis)
 - b. **Nausea and vomiting** - especially important to ask about **haematemesis** (*may be due to varices seen in chronic liver disease*)
 - c. **Bowel habit** - loose stool, constipation



- d. **Change in stool colour** - e.g. **pale and greasy** (steatorrhea indicating bile duct obstruction seen in pancreatic malignancy or gallstones etc), **dark/black/tarry** (seen in an upper GI bleed)



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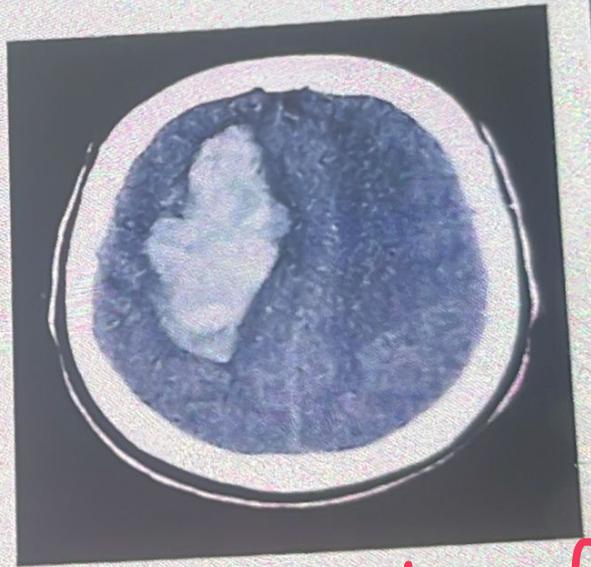
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Station 16

Questions:

1. This patient is hypertensive, what abnormalities are shown in this image?
2. Which side of hemiplegia you expect?
3. What is the commonest systemic cause for this condition?
4. What is the single most important step in the management of this patient?



large intracerebral
hemorrhage ✓

R + - side hemi-
paresis
HTN
B.P. control

Causes of Facial Nerve Palsy: Bell's Palsy (inflammation around the facial nerve and this pressure causes facial nerve paralysis), congenital, surgery (iatrogenic), neoplastic, viruses, Lyme disease.

UMN- Lower face palsy

LMN—whole face palsy

3 cause of Bell's Palsy: DM, HTN, Injury, Toxin, GBS, Myasthenia Gravis, Lyme Disease

A4; steroids—prednisolone, ANSAIDs, hydroxylchloroquine, immunosuppressants—cyclophosphamide, azathioprine, methotrexate, biological agents—rituximab



Bone marrow aspiration needle
 Bone marrow aspiration/ biopsy
 Precautions: sterile techniques, patient consent
 Assess for bleeding disorder pain mx positioning

Questions:

1. Name this instrument.
2. What is the commonest use of this Instrument?
3. What precautions would you take before this procedure?

4. What are the Complications of this Procedure?

Q No:	COMPONENT	KEY FEATURES	SCORE
1.	Name this instrument	<ul style="list-style-type: none"> ▪ Trucut Biopsy Needle 	2.0
2.	What is the commonest use of this Instrument?	<ul style="list-style-type: none"> ▪ Liver Biopsy 	2.0
3.	What precautions would you take before this procedure?	<ul style="list-style-type: none"> ▪ Coagulation Profile ▪ Complete blood Counts 	1.0 1.0
4.	What are the Complications of this Procedure?	<ul style="list-style-type: none"> ▪ Liver Hematoma ▪ Biliary Leak ▪ Shock ▪ Pneumothorax 	1.0 1.0 1.0 1.0
Total			10

- iii. X-rays spine
- iv. CT Scan spine
- 3- (0.5 each)
- i. Rifampicin orally 10-20 mg/kg OD before breakfast for 1 yr
- ii. Isoniazid 10-20 mg/kg/day OD for 1 yr.
- iii. Pyrazinamide orally, 15-30 mg/kg/day for initial 2M
- iv. Ethambutol (mg/kg) or Inj. Streptomycin (10-15 mg/kg x I/M x OD) for initial 2 months

Question No. 33

Infectious diseases

- 1- What is the diagnosis of this vaccine preventable infectious condition? (1)
- 2- How can you prevent this condition by immunization. (2)
- 3- Write 8 complications of this disease. (2)



Key:

- 1- Mumps (1)
- 2- By MMR vaccine at 15 months and before school entry (1 each)
- 3- (0.5 for any 8)
 - i. Meningoencephalomyelitis
 - ii. Epididymo-orchitis
 - iii. Pancreatitis
 - iv. Deafness
 - v. Oophoritis
 - vi. Thyroiditis
 - vii. Myocarditis
 - viii. Arthritis
 - ix. Thrombocytopenia

Question No. 32

Infectious diseases

- 1- What is the type of rash & what is diagnosis? (1.5)
- 2- Write 6 conditions which produce such type of skin irruption. (1.5)
- 3- What are 8 complications of the most likely diagnosis? (2)



Key:

- 1- Maculopapular rash (.75)
 - Measles (.75)
- 2- (0.25 Each)
 - i. Measles
 - ii. Rubella
 - iii. Scarlet fever
 - iv. Typhoid fever
 - v. Roseola infantum
 - vi. Erythema infectiosum
- 2- (0.25 Each)
 - i. Otitis media
 - ii. Pneumonia
 - iii. Encephalitis
 - iv. Hemorrhagic measles
 - v. Gastroenteritis
 - vi. Myocarditis
 - vii. Immuno suppression
 - viii. SSPE (Subacute sclerosing pain encephalitis)

KEY

1-Pulmonary TB

2-MANAGEMENT STEPS SHOULD INCLUDE

- ATT
- nutritional rehabilitation
- family counseling
- family screening for TB and management accordingly
- ensure proper follow up to check response, compliance and look for complications

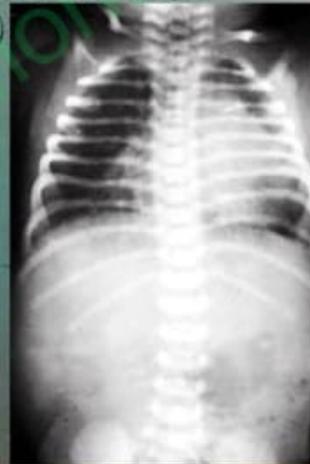
Question No. 4

Topic: Infectious Disease

- 1: What will you find on abdominal examination as shown in this photograph?(1)
- 2: Name three common diseases responsible for these findings? (1.5)
- 3: Describe the laboratory tests required for the diagnosis of above those three diseases? (2.5)

Key:

- 1- Hepatosplenomegaly (1)
- 2- (0.5 each)
 - i. Malaria
 - ii. Typhoid fever
 - iii. Tuberculosis
- 3- (0.25 each for 10 out of 11)
 - i. Hb, TLC, DLC, ESR
 - ii. Malarial parasites, thick & thin film slides
 - iii. ICT for malarial parasite
 - iv. Tuberculin test / accelerated BCG test
 - v. X-ray chest (PA view)
 - vi. Blood culture for *S. typhi* & Para typhi
 - vii. Widal test / typhidot test



A 7 year old child presented with 2 days history of haemetemesis and malena, on examination he had massive splenomegaly. His ALT WAS 65u/L, PT and APTT were within normal limit and serum albumin was 4g/dl.

Question

Blue
varicella

Station No: 8

Viva Station

A 6 months old child presented with 2 days history high-grade fever, one day history of vomiting and generalized tonic clonic fits. On examination anterior fontanelle is full.

1. What is your diagnosis? (1)
2. What other signs to look for? (1)
3. What investigation would you like to perform? (2)
4. What is the management? (2)

Bacterial meningitis

Edit



BLOCK N OSCE Areej Kgmc: Photo



BLOCK O OSCE Hina New: Photo



BLOCK Q OSCE Areej Kgmc: ... +2

STATION NO:
A NEWBORN BABY HAS BEEN
RECEIVED IN THE NURSERY WITH
H/O NOT TAKING FEED SINCE
ONE DAY AND IS DROWSY.
a) CLASSIFY THIS BABY
ACCORDING TO IMNCI.
b) IDENTIFY HIS TREATMENT
FROM IMNCI CHART.

Ans a) Very Severe disease

Ans b)
- Give first dose of IM antibiotics
- Treat to prevent low sugar
- Advise mother to keep infant
warm
- Ask the mother to make
significant changes in feeding

Question No. 20

Nutrition

- 1- What are the abnormal findings? (1)
- 2- What is the diagnosis? (1)
- 3- Write down the management steps. (3.5)



Key:

- 1-
 - i. Emaciated irritable child / wizened face / prominent rib cage (0.5)
 - ii. Loss of fat over the buttocks / body. (0.5)
- 2- Marasmus (0.5)
- 3-
 - Initial management (1.5)
 - i. Life-threatening problems are identified and treated in the hospital ✓
 - ii. Specific deficiencies are corrected
 - iii. Metabolic abnormalities are corrected ✓
 - iv. Feeding is begun
 - Rehabilitation (1)
 - i. Intensive feeding is given to recover most of the lost weight
 - ii. Emotional and physical stimulation are increased
 - iii. Training of the mother
 - iv. Preparations for the discharge



Tools



Mobile View



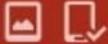
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Edit on PC



WPS AI



40% 6:45 PM

Q:

A 9 years old girl who had previously been well, present with difficulty in walking with tingling and pain in her legs.

On examination, there is decreased tone and power in both the lower limbs, with reduced reflexes and down going planters. Her sensations are intact.

Questions:

- a) What is the most likely diagnosis?
- b) What investigations would you like to do?
- c) What is the likely outcome?

1. GBS
2. CSF analysis
EMG
Nerve Conduction Studies

3.

Q:

An 11 months old girl presents to OPD with complaints of delayed walking. She has been breast fed till 9 months of age exclusively, weaning started at 9 months of age.

On examination there is bulbous, non tender enlargement of wrists and palpable enlargement of costochondral junctions. There are no deformities of legs or thorax. Her anterior fontanel is wide open and her muscle tone appears to be decreased.

- Serum calcium = 7.0 mg
- Alkaline phosphate = 2257 IU/l

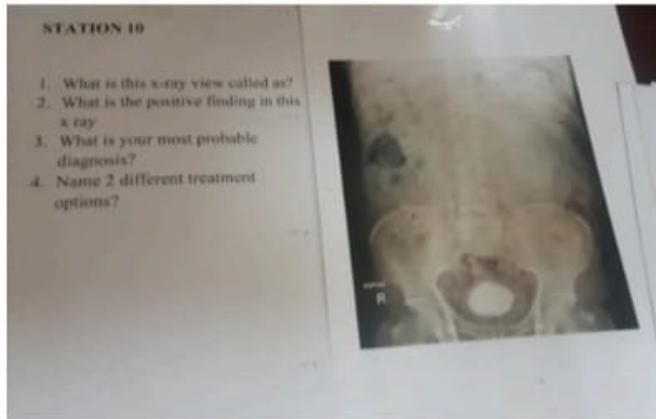
Questions:

1. What is the diagnosis?
2. How would you treat the child?

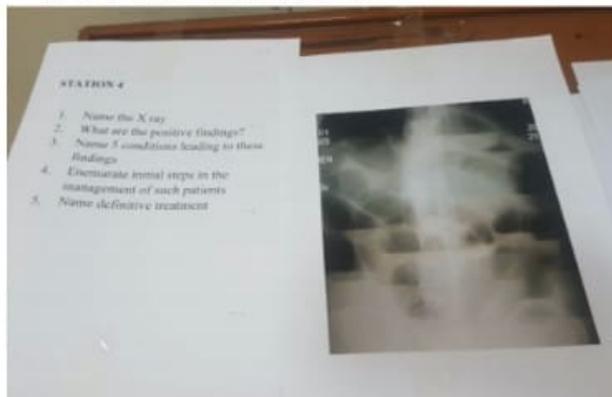
1. Nutritional Ricket

2. VitD orally (2000-6000IU) for 4Wks, VitD3 as single dose IM

34



1. X-Ray KUB
2. Small radio-opaque shadow on the right side
3. Renal Calculus
4. ECSWL; PNL; Open removal of stone



1. X-ray erect abdomen
2. Multiple dilated loops of gut with air fluid levels

35

3. 5 Conditions: intestinal obstruction; caused by fibrous bands of tissue (adhesions); colon cancer; hernia, strictures, crohn's disease, diverticulitis,



Edit Annotate Fill & Sign Convert All

STATION 1 a

STATION 1 b

This is a CT Scan Brain of a 30-year-old patient on treatment for Pulmonary Tuberculosis who presented with severe headache followed by drowsiness.

Question 1: Identify two radiological abnormal findings?
Question 2: What is the likely diagnosis?

Question 1: What is the radiological diagnosis? 5
Question 2: Name any two treatment options? 5

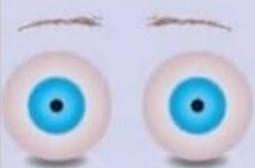
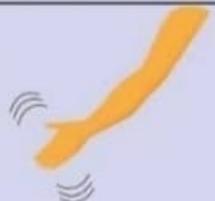


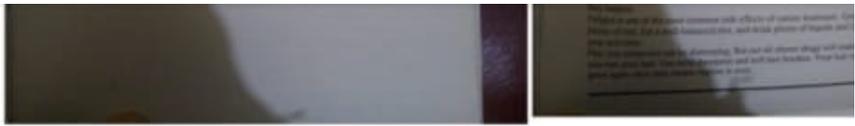
A 24 years old motorcyclist is brought to the emergency after road traffic accident. He is confused, localizes painful stimuli and opens his eyes to painful stimuli. His CT scan is shown above. Carefully observe the CT scan and answer the questions given below

1. Describe this CT.
2. What is the diagnosis?
3. Name the vessel most commonly involved
4. What is GCS of this patient?
5. Give management of this disease.

Answers

1. This CT is showing bright ,biconvex density in the right parietal lobe of the brain
2. Extradural Hematoma
3. Middle meningeal artery
4. 11:
 - a. Confused: 4
 - b. localize painful stimuli:5
 - c. eye opening with pain:2
5.
 - a. Follow ATLS guidelines (A,B,C,D,E)
 - b. Craniotomy and evacuation of hematoma.
 - c. Manage the patient in intensive care unit postoperatively.

Behaviour	Response
 <p>Eye Opening Response</p>	<ol style="list-style-type: none"> 4. Spontaneously 3. To speech 2. To pain 1. No response
 <p>Verbal Response</p>	<ol style="list-style-type: none"> 5. Oriented to time, person and place 4. Confused 3. Inappropriate words 2. Incomprehensible sounds 1. No response
 <p>Motor Response</p>	<ol style="list-style-type: none"> 6. Obeys command 5. Moves to localised pain 4. Flex to withdraw from pain 3. Abnormal flexion 2. Abnormal extension 1. No response



Station 43

Questions ;

1. Name this instrument
2. Demonstrate the technique of its use.
3. Enumerate at least two indications for its use.
use: *Dx, Therapeutic / Pressure*
4. Enumerate at least two complications associated with its use

- Positioning
- Skin preparation
- Needle insertion (L4-L5)
- CSF collection
- Needle Removal
- Bandage

→ Spinal needle





10

Key station 22

1. Inguinoscrotal swelling 2
2. Inguinal hernia, infantile hydrocele 3
3. Can reach above the swelling or not 3
 - a. Reducibility
 - b. Cough impulse
 - c. Deep ring occlusion test

Hydroceles may appear bluish; If hernia, there may be presence of a "silk glove sign" when the layers of the hernia sac are palpated sliding over each other.

What pathologies could you palpate in the kidneys bilaterally?

1. ADPKD
2. Bilateral hydronephrosis
3. Amyloid
4. Bilateral RCC
5. Tb Sclerosis

What pathologies could you palpate in the kidneys unilaterally?

1. RCC
2. Hydronephrosis
3. Bilateral cause with only one palpable kidney

In chronic renal failure, kidneys tend to be small and shrunken

D/D Hemothorax; Pleural Effusion

Treatment: place a chest tube with one side in a water seal.
Surgery is another options (open thoracotomy or a thoracoscopy)

Station 8: Interactive Station

Identify the T-tube

11



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STATION 13



This young female patient underwent a major surgery for an underlying Bleeding Disorder.

Splenectomy
Itp thalasemia HS

Question 1: Which organ is most likely organ removed?
Question 2: What is the most likely underlying disease?

5
5

24

Station 2: Colostomy/Stoma (picture from internet):



Right hemicolectomy + transilial anastomosis done.

What is this stoma called??

4 complications of stoma formation: poor siting, parastomal hernia (PH), prolapse, retraction, ischemia/necrosis, peristomal dermatologic problems, mucocutaneous separation, and pyoderma gangrenosum.

Station X:

The following results are from an 8 year old child with short stature.

TSH: 100mu/L (normal <5)

T4: 10n mol/l (normal 60-160)

What is the diagnosis? Hypothyroidism?

Treatment: Anti-thyroid drugs and surgery (thyroidectomy). Radio-active iodine.

25



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Edit



50



Parotid enlargement and facial nerve palsy

70



Achondroplasia



Tools



Mobile View



Share



Edit on PC



WPS AI

ation 8

1. myesthenia gravis

anti acetylene esterase antibodies

RI ceiling test curtun test counting test

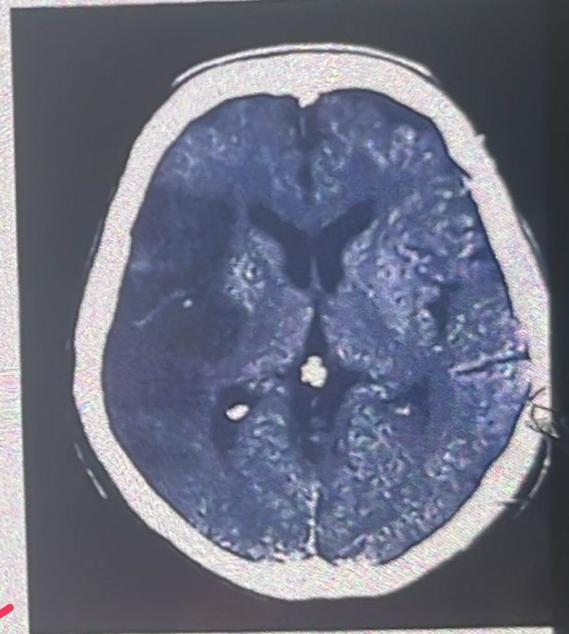
awar menure

3. pyrinistagmin

Station 17

Questions:

1. Mention the abnormality and its location shown in this image.
2. Mention two clinical features you expect in this patient.
3. Name this vessel most likely involved.
4. Mention three major risk factors for this illness.



Repeat
ischemic

C

INCISION



STATION 17

Name each incision and enumerate two indications of each.

A



B





Name this abnormality? What is the most common cause? What are the findings on blood picture?

What is the commonest cause of this pathology in Pakistan



Koilonychia



41% 6:45 PM



This boy presented with loose motions and vomiting for the last two days.

Q1. What signs are shown in these pictures?
Q2. What is the classification?
Q3. What is the treatment?

- Sunken Eyes
 - Skin pinch goes back very slowly
 - Lethargic
- Severe Dehydration
- Treatment Plan C
(start IV fluids immediately Give 100ml/kg Ringer Lactate. Give first 30ml/kg in 1 hr. Then 70ml/kg in 5hs in infants under 12 months. 30ml/kg in 30 min then 70 ml/kg in 2 n a half hrs in Children 1-5years

STATION 13

(STATIC)

A one and a half years old boy presented to OPD with complaint of Rt. Inguinal swelling since birth. According to mother it increases in size when coughing/ crying. On examination, it is non tender and reduces in size when pressure is applied on it.

- i. What is your diagnosis? *hernia*
- ii. What investigations will you advise?
- iii. What is the treatment recommended?

Indirect inguinal hernia

Full Topic
Book.



12

2. Foley catheter is placed and Orogastric tube is inserted to avoid inadvertent injury and improve exposure.
3. Pneumoperitoneum is established with a veress needle through a sub-umbilical incision
4. 10mm trocar canula is inserted sub umbilically.
5. A 30 degree laparoscope is then inserted through the umbilical port, and an examination of the peritoneal cavity is performed.
6. Three additional ports are inserted; 10mm just below the xiphisternum, 5mm in the mid-clavicular line at transpyloric plane, 5mm in the anterior axillary line just below the costal margin.
7. Gallbladder fundus is identified, grasped and retracted superiorly. With a second grasper, the gallbladder infundibulum is retracted laterally to expose and open the Callot's triangle (the area bounded by the cystic duct, common hepatic duct, and inferior edge of the liver).
8. The triangle is gently dissected to clear the peritoneal covering and obtain a view of the underlying structures
9. The cystic duct and cystic artery are identified and clipped with a tiny titanium clips and divided between the lips
10. Then the gallbladder is dissected away from the liver bed and removed through one of the ports site usually through the epigastric port. This is done using electric hook.

Contraindications of laparoscopic cholecystectomy:

1. Severe COPD or CCF (these patients cannot tolerate pneumoperitoneum).
2. Severe bleeding disorder
3. End stage liver failure

Open

1. Small 6in incision is made below the umbilicus, fascia incised and peritoneum entered via finger and a canula (Hanson's canula) is inserted into the peritoneal cavity and anchored to the fascia. Kocher's (right subcostal) incision is made.
2. This incision is 3-4 cm below and parallel to the right costal margin and extends from the xiphisternum in the midline to the ninth costal cartilage.
3. Peritoneal cavity is insufflated with Co2??
4. Skin and subcutaneous tissue and anterior rectus sheath are incised. This exposes the rectus muscle at medial end and transverse abdominis and internal oblique at lateral end. The rectus abdominis muscle is divided transversally.
5. Peritoneum is opened between two forceps.
6. Gallbladder is examined and 3 sponges are placed around the gallbladder. The first packs the colon downward and prevents bowel from entering into the operative field. The second is placed so that the stomach and duodenum can be retracted laterally and the third sponge is placed of the visceral surface of the liver. These sponges are held with Deaver's retractors by the assistants.
7. This exposes the gallbladder fully
8. With lateral traction on the gall-bladder neck, the peritoneum overlying the triangle of Calot is incised and the cystic duct is ligated and divided after carefully tracing it onto the gallbladder.

13

9. Pringle's maneuver may be needed for sever bleeding
10. Abdomen is closed and peritoneum and transverse abdominis and internal oblique are closed together, then rectus muscle is closed then rectus sheath. Skin is closed with subcuticular technique.



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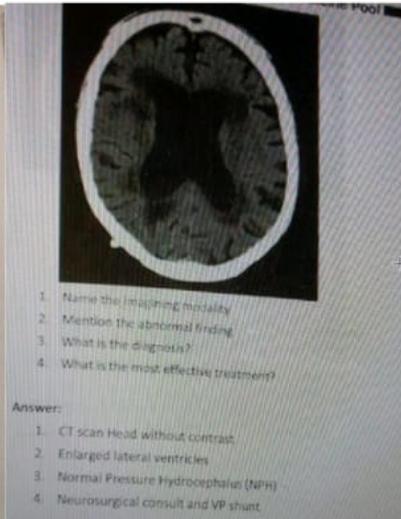
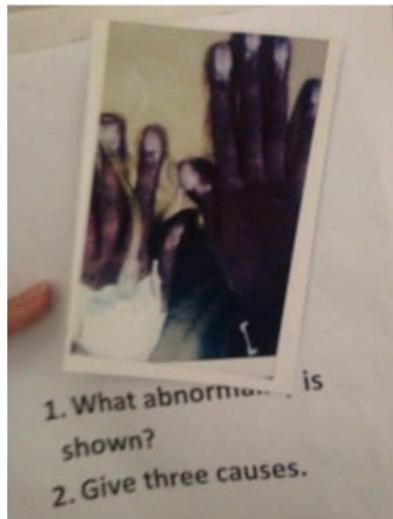


41

Station 02

This 33 year old man presented with generalized weakness and poor healing of wounds.

- Q1. Identify two clinical signs in this photo?
- Q2. What is the diagnosis?
- Q3. What two bio-chemical investigations would you advise to confirm the diagnosis?



40 / 87



Tools



Mobile View



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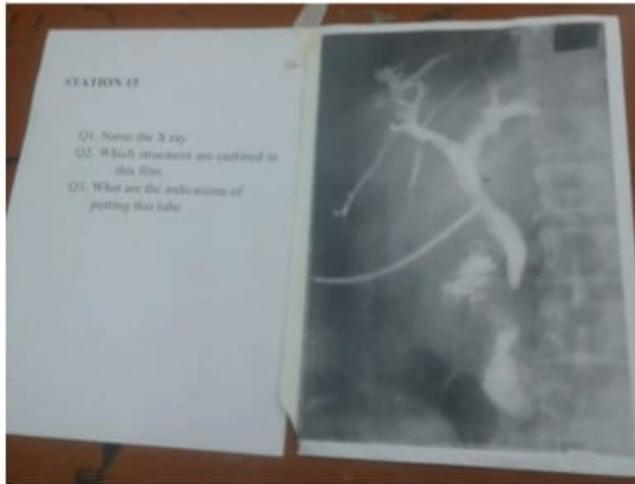


Edit on PC

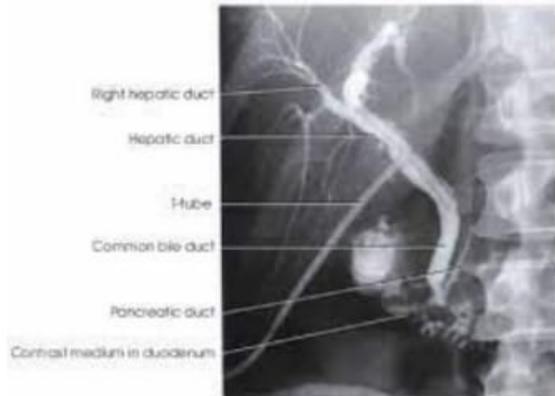


WPS AI





1. Name the X-ray: ERCP
2. What are the structures outlined in this film? Right and left hepatic ducts, CBD
3. What are the indications of putting in this tube? Already covered in T-tube



Edit Annotate Fill & Sign Convert All

Typhoid fever

Tuberculosis

(0.25 each for 10 out of 11)

Hb, TLC, DLC, ESR

Malarial parasites, thick & thin film slides

iCT for malarial parasite

Tuberculin test / accelerated BCG test

X-ray chest (PA view)

Blood culture for *S. typhi* & Para typhi

Widal test / typhidot test

Culture for AFB



Question No. 2

Topic: Infectious Disease

: Which common infectious disease can lead to this deformity?(1)

: Name four diagnostic investigations (2)

: Name four drugs along with dosage & duration. (2)



Carries spine / Tuberculous (1)
(0.5 each)

Mantoux test / Accelerated BCG test

X-ray chest

X-rays spine

CT Scan spine

(0.5 each)

Rifampicin: orally 10-20 mg/kg OD before breakfast for 1 yr

Isoniazid 10-20 mg/kg/day OD for 1 yr.

Pyrazinamide orally, 15-30 mg/kg/day for initial 2M

Ethambutol (mg/kg) or Inj. Streptomycin (10-15 mg/kg x I/M x OD) for initial 2 months

Question No. 33

Infectious diseases

What is the diagnosis of this vaccine preventable infectious condition? (1)

How can you prevent this condition by immunization. (2)

Write 8 complications of this disease. (2)



Mumps (1)

For Candidate:

This is an X-Ray of a 35 year old female who presented with upper abdominal pain and has a history of chronic headache .

Task:

Carefully examine the given radiograph/ photograph and the answer the following questions:

- | | |
|--|----|
| 1. What is the probable diagnosis? | 01 |
| 2. Name TWO important steps in the pre op treatment of this patient. | 02 |
| 3. Name the definitive procedure which needs to be done. | 02 |



KEY:

- | | |
|--|----|
| 1. Perforated duodenal ulcer | 01 |
| 2. Fluid resuscitation and antibiotics | 02 |
| 3. Closure of perforation, with omental patch if necessary | 02 |



Station 56

A 22 years shopkeeper is admitted to your ward with history of high grade fever of 12 days duration. While he was being investigated in ward, he collapsed. Later in the night patient passed red colored stools with clots. His BP dropped to 74 mmHg systolic and pulse was 144/m, low volume. He had cold clammy extremities and had drenching sweats. Temp 99F. Abdominal exam reveals 2 cm soft splenomegaly.

1. What is the most likely diagnosis?
 - a. Enteric fever with Payer's patches ulceration.
 - b. PUD with upper GI bleed due to acute gastric erosions.
 - c. PUD with NSAIDS induced ulcerations.
 - d. Viral hemorrhagic fevers (Dengue shock syndrome Or Congo Crimean hemorrhagic fever).
 - e. Diverticulitis with bleeding.
2. Organism, route & incubation?
3. s/s?
4. Diagnosis?
5. Rx?
6. Complications?
7. Rx Carrier?
8. Interpret widal?

Most Likely Diagnosis:

Enteric Fever with Peyer's Patch Ulceration Leading to GI ing.

1. Organism, Route & Incubation:

- Organism: Salmonella typhi / Salmonella paratyphi.
- Route: Fecal-oral (contaminated food/water).
- Incubation: 7-14 days.

Scanned with CamScanner

2. Signs & Symptoms:

- Step-ladder fever, relative bradycardia.
- Abdominal pain, splenomegaly, hepatomegaly.
- GI bleeding, perforation in late stages.

3. Diagnosis:

- Blood culture (1st week) - Gold standard.
- Widal test (paired rising titers).
- Stool/urine culture (carriers).
- CBC: Leukopenia, thrombocytopenia.

4. Treatment:

- IV fluids, blood transfusion if needed.
- IV Ceftriaxone / Azithromycin (10-14 days).
- Surgery (if perforation).

5. Complications:

- GI bleeding, perforation peritonitis.
- Septic shock, chronic carrier state.

Let me



THIS 5-YEAR-OLD CHILD PRESENTED WITH E
FATIGABILTY OVER THE LAST 2 YEARS

- A. IDENTIFY THE PHYSICAL SIGN
- B. WHAT IS THE MOST LIKELY DIAGNOSIS?

Ptosis: physical sign
Diagnosis: MG(myasthenia gravis)

b. Urethral dilatation
c. Urethroplasty



1. Name the X ray
2. What are the pelvic Findings?

6

3. Name 6 conditions leading to this positive finding.
4. How will you manage this patient?

KEY STATION 8

1. Erect abdomen x ray 1
2. Multiple air fluid level (step ladder pattern) 1
3.
 - a. Band / adhesions 5+5
 - b. Obst Hernia / paralytic ileus 5+5
 - c. Malignancy / TB Abd 5+5
4. Admit patient, i/v fluids, i/v analgesic, antibiotics, NG suction, catheterize, intake output record, prepare for laprotomy 3

other conditions: bowel

obstruction, ileus, ischemia, gastroenteritis



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Edit



32



dupuytrenne contracture
+jaundice..causes alcoholic
cirrhosis..primary billiary cirrhosis



subconjunctival hemorhage..acute
leukemia..trauma..viral hemorhagic
fever..congo fever..ITP

31 / 87



Tools



Mobile View



Share



Edit on PC



WPS AI





Small Gut obstruction ...

Coin on stack appearance

Station 05 (A)



- Q1. Identify the clinical sign?**
Q2. Name two gastrointestinal causes?

Diagnosis: clubbing
Gi causes: IBD , cirrhosis of

2019 med 1 TOACS

72



Ssaddle nose



Facial palsy



Bell palssy



73





This specimen was removed laparoscopically from a patient who presented with pain in upper right abdomen and USG showed stones and inflammation of the organ.
Carefully observe the provided specimen / photograph and answer the following questions:

Questions:

1. What is this organ and what name is given to the presence of stones in this organ?
2. Give four effects/ complications of these stones on containing viscus?
3. What is treatment of acute inflammation?
4. What is the standard operation for these stones when symptomatic?

Answers:

1. Gall bladder, Cholelithiasis
2. Acute cholecystitis, mucocele, empyema, carcinoma, obstructive jaundice, acute pancreatitis (Any four)
3. Conservative management followed by laparoscopic cholecystectomy
4. Laparoscopic cholecystectomy

A 20 year old man presented with DARK coloured urine and yellow discoloration of the whole body. There is no history of anorexia, nausea or vomiting.

Hb 7.5 gm/dl ,wbc 6600/mm³, polymorphs,65%

lymphocytes.20%, platelets 1,80,000/mm³..Serum bilirubin 4.2 mg/dl (up to 1.2 mg /dl...SGPT 45 Iu/L (Normal Up To 40 Iu/L...Alkaline phosphatase 147 (normal....20-117

what is the likely diagnoses?? mention three important physical finding in this patient?? mention three other investigation to conform your diagnosis??

Most Likely Diagnosis:

Intravascular Hemolysis (Possibly G6PD Deficiency or Hemolytic Anemia).

1. Three Important Physical Findings:

- Jaundice (yellow discoloration of skin & sclera).
- Dark-colored urine (hemoglobinuria).
- Pallor (due to anemia).

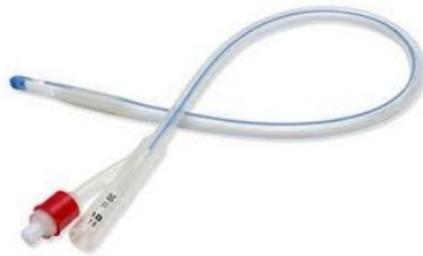
2. Three Investigations to Confirm Diagnosis:

- Peripheral Blood Smear (schistocytes, Heinz bodies if G6PD).
- Reticulocyte Count (elevated in hemolysis).
- Direct & Indirect Coombs Test (to differentiate immune vs.

2

Station 12: instruments (pictures taken from internet):

Silicon Foley Catheter:



Intestinal Clamp



Repeat

2



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REST STATION

STATION 17

Name incision number 3,6,9 and enumerate two indications of each.

KEY 17

- | | | |
|-------------------------------------|----|---|
| A. Midline laprotomy incision | 5 | |
| i. Abdominal trauma | | 1 |
| ii. Viscus perforation / malignancy | 1 | |
| B. Grid iron | | |
| i. Appendicectomy | .5 | |
| ii. Lower ureteric stone | 1 | |
| C. Pfannel steil | | |
| i. C section | 1 | |
| ii. Hysterectomy | | 1 |

TATION 18

A 45 years old lady presented to OPD with an umbilical swelling. Carefully examine the given photograph and answer the following questions.

1. What is the probable diagnosis
2. What signs would you look for and how would you elicit them.
3. What complications can occur
4. What are signs of strangulation

Key station 18

1. Paraumbilical hernia 2
2. Reducibility, cough impulse 2
3. Irreducibility, intestinal obstruction, strangulation 2
4. Continuous pain, recent increase in size, no cough impulse 2



10

Key station 22

1. Inguinoscrotal swelling 2
2. Inguinal hernia, infantile hydrocele 3
3. Can reach above the swelling or not 3
 - a. Reducibility
 - b. Cough impulse
 - c. Deep ring occlusion test

Hydroceles may appear bluish; If hernia, there may be presence of a "silk glove sign" when the layers of the hernia sac are palpated sliding over each other.

What pathologies could you palpate in the kidneys bilaterally?

1. ADPKD
2. Bilateral hydronephrosis
3. Amyloid
4. Bilateral RCC
5. Tb Sclerosis

What pathologies could you palpate in the kidneys unilaterally?

1. RCC
2. Hydronephrosis
3. Bilateral cause with only one palpable kidney

In chronic renal failure, kidneys tend to be small and shrunken

D/D Hemothorax; Pleural Effusion

Treatment: place a chest tube with one side in a water seal.
Surgery is another options (open thoracotomy or a thoracoscopy)

Station 8: Interactive Station

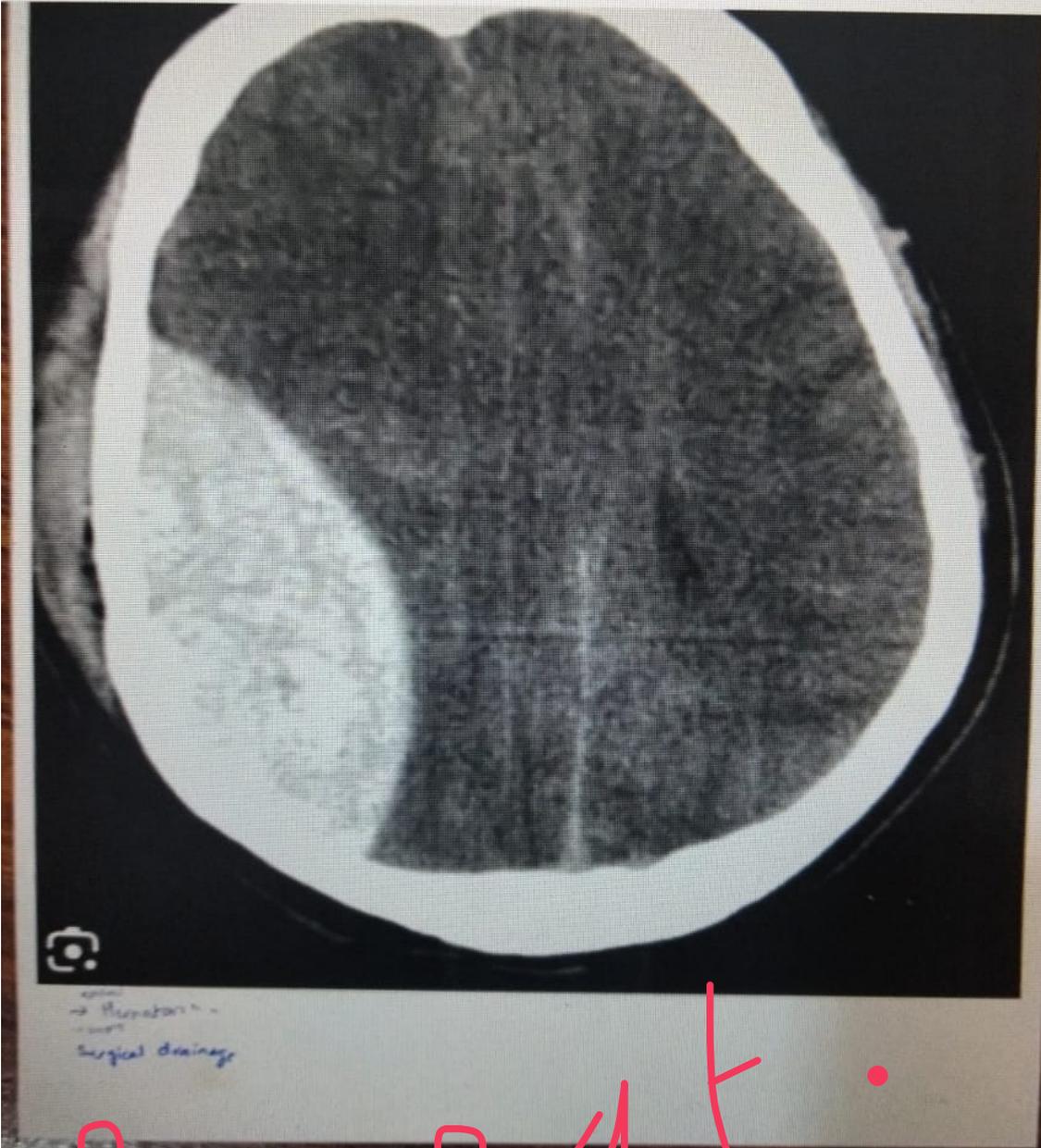
Identify the T-tube

11



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Repeat.



24

Station 2: Colostomy/Stoma (picture from internet):

Right hemicolectomy + transilial anastomosis done.

What is this stoma called??

4 complications of stoma formation: poor siting, parastomal hernia (PH), prolapse, retraction, ischemia/necrosis, peristomal dermatologic problems, mucocutaneous separation, and pyoderma gangrenosum.

Station X:

The following results are from an 8 year old child with short stature.

TSH: 100mu/L (normal <5)

T4: 10n mol/l (normal 60-160)

What is the diagnosis? Hypothyroidism?

Treatment: Anti-thyroid drugs and surgery (thyroidectomy). Radio-active iodine.

25



Edit

Annotate

Fill & Sign

Convert

All



24

Station 2: Colostomy/Stoma (picture from internet):



Right hemicolectomy + transilial anastomosis done.

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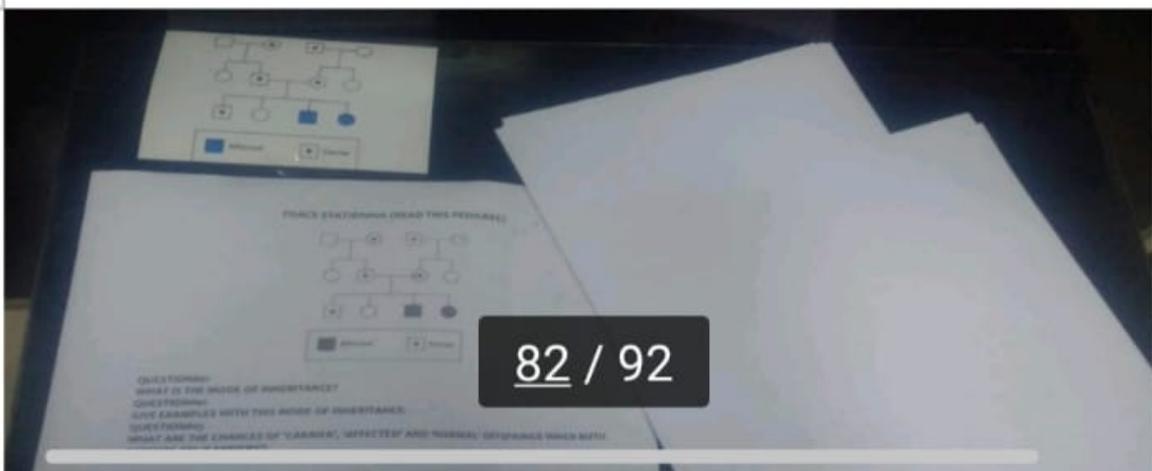
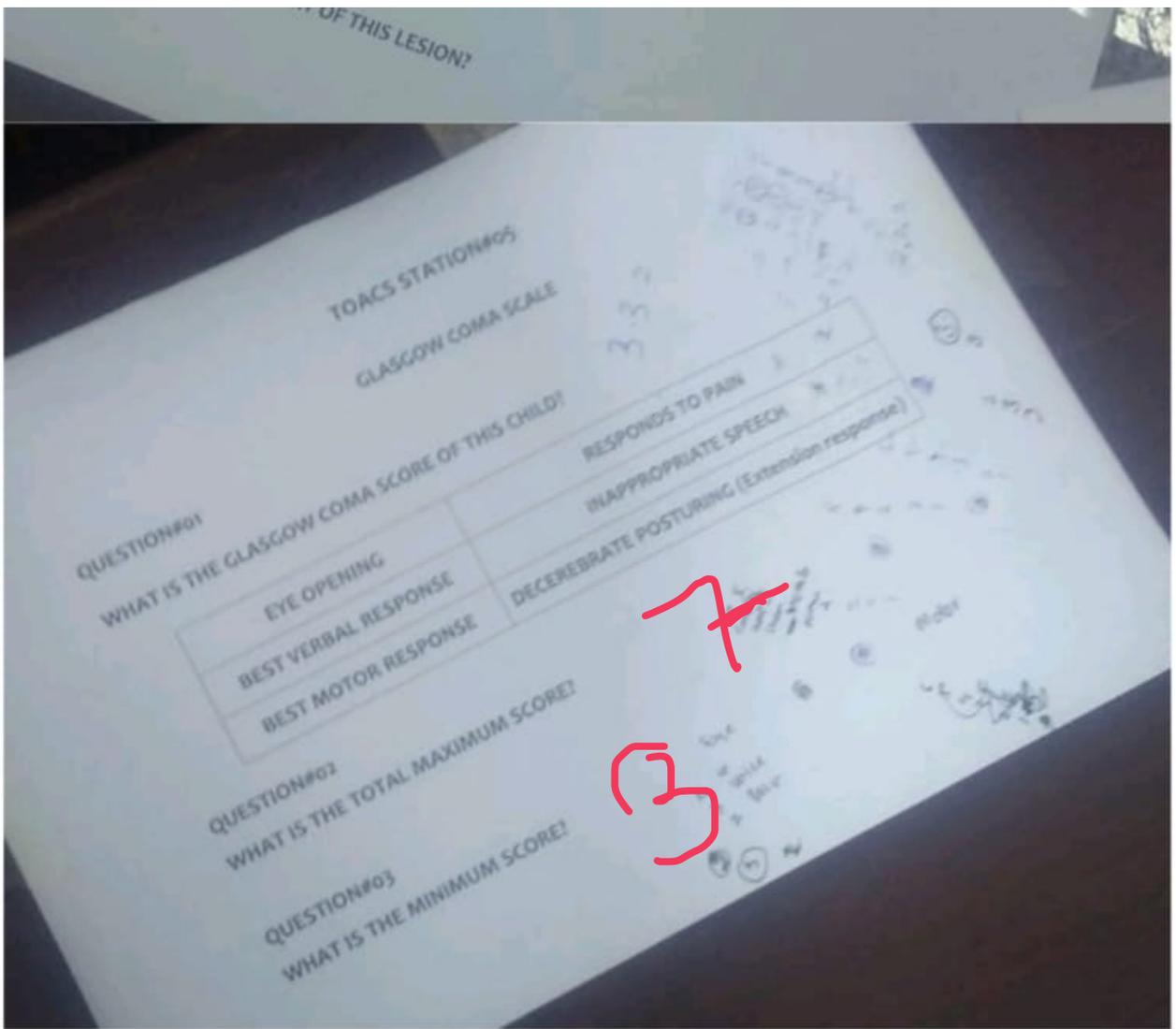
What is the diagnosis? Hypothyroidism?

Treatment: Anti-thyroid drugs and surgery (thyroidectomy). Radio-active iodine.

25



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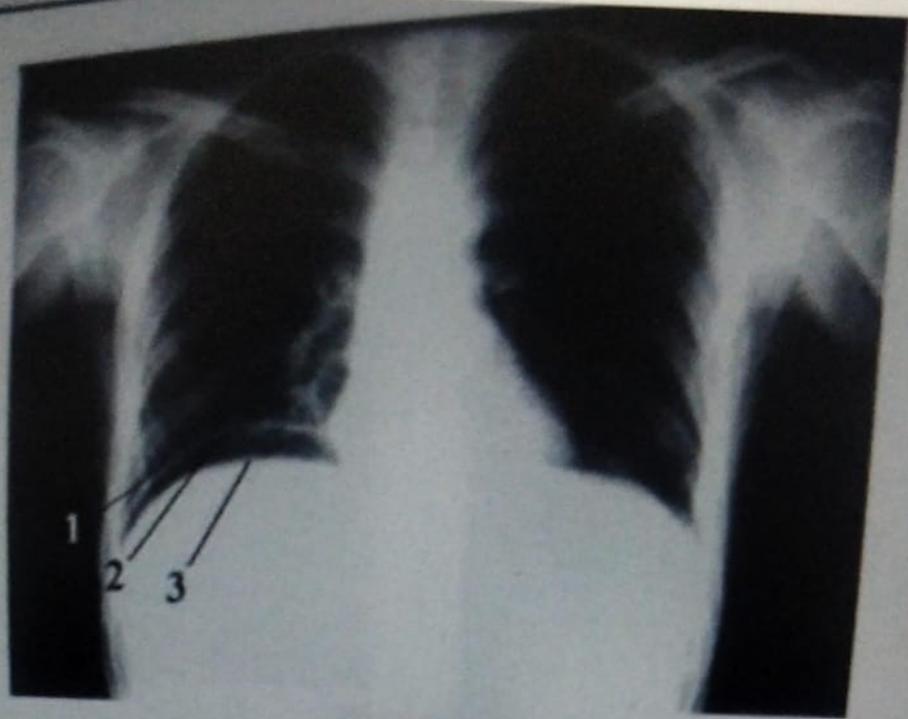


Figure 41

Read this x-ray (figure 41) of 40 years male presented with generalized pain and tenderness of the abdomen & answer the following questions:

1. What is the finding in this x-ray?
2. Give three causes of it?
3. What is the mechanism of this finding?
4. Label the marking 1, 2 & 3?
5. How will you manage this patient?

ANSWERS:

1. Air under Diaphragm.

2.

- a. Perforated duodenal ulcer.
- b. Perforation of ileum due to typhoid or tuberculosis.
- c. Injury to the intestine (blunt or penetrating).
- d. Perforation of intestinal tumor
- e. Post Laparotomy/laparoscopy which may persists up to 7 days.

3. Normally there is no free air in the peritoneal cavity rather it is present in the lumen of the gut. When there is perforation of gut due to any reason, this air enters into the peritoneal cavity along with other contents of the gut. When patient is in standing posture, this air moves upwards (under diaphragm) and occupies a space between liver and diaphragm when x-ray is taken in this position then air becomes clearly visible between liver and diaphragm. It usually takes about 3 to 4 hours after perforation of duodenal ulcer for air to be seen in the x-ray and minimum amount of air which can be detected in upright x-ray is 12cc.

4. 1: Diaphragm 2: Air Under Diaphragm

3: Liver

- a. Resuscitation: Intravenous fluids, antibiotics, analgesics, Foley's catheterization
- b. Nasogastric aspiration. Investigations.
- c. Open or laparoscopic repair.

Station 47

- ② Skin Hyperelasticity
• Facial features
• Periodontitis
• muscle weakness

- Easy Bruising
- Fatigue

Questions

→ EDS

1. Which syndrome is commonly associated with these features?
2. What are the other clinical features of this disease?
3. What complications the patient can have?
4. What cardiac abnormality he can have?



③ → Fragile Blood vessels

- Arterial ruptures
- Subluxation / dislocation of joints
- Heartburn, Constipation, Prolonged obs
- muscle weakness

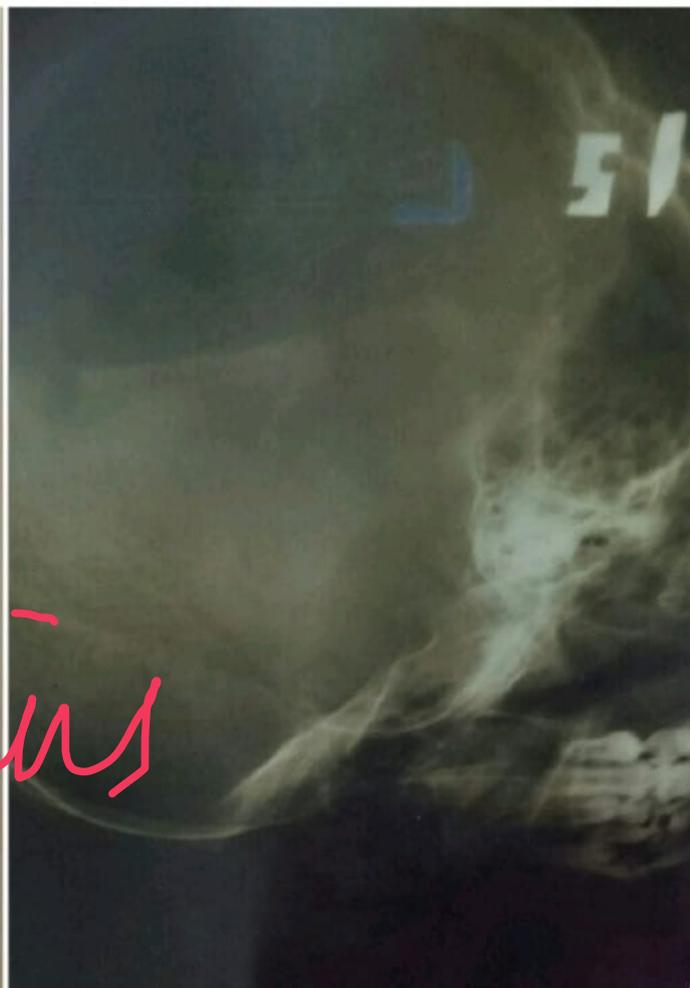
④ → MV prolapse

- Aortic root dilation
- Aortic incompetence

These are the CSF findings from a 6 year old who presented with inability to walk and then ended up on a ventilator. CSF analysis showed:
Clear fluid, Protein 250 mg/dl, glucose 50 mg/dl, blood sugar 54 mg/dl, microscopy 4 cells, lymphocytes 3, PMN cells 1, culture negative.

Q1. What is the diagnosis?

*viral
encephalitis*





Carefully examine the given CT scan given above and answer the following questions.

1. What is the abnormality on this CT scan
2. What clinical features may be present in this patient
3. What is treatment of this abnormality

Answers:

1. Depressed fracture of the skull.
2. History of head injury with blunt object, presence of palpable depression in the skull signs of raised intracranial pressure i.e. loss of consciousness, hypertension and bradycardia.
3. Craniotomy and elevation of the depressed segment.

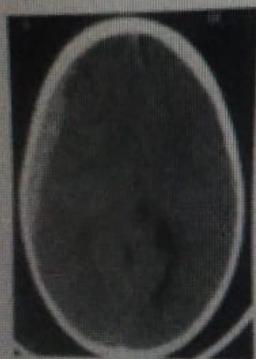


Figure 4
Day: 1

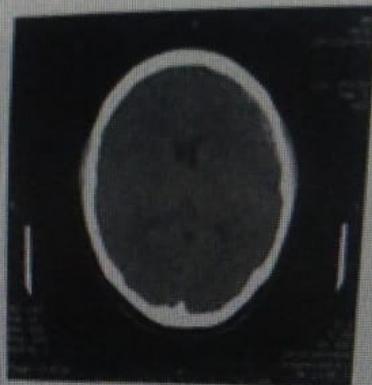


Figure B
Day: 3



Figure C
Day: 7

A 60 years old lady develops head injury in toilet. Her CT scan at 1st, 3rd and 7th day of injury is shown. Read the questions and answer.

1. What is the diagnosis
2. Describe the CT findings
3. What would be the most likely clinical features of this patient
4. What should be the management

Answers:

1. Subdural hematoma.
2. On the 1st image of the CT scan (figure A) there is bright crescent shape shadow which has distinct border and is not crossing the midline. On 2nd image (figure B taken after 3 days) the clot has faded to isodense, the lesion is difficult to see as it has same density as brain matter. On 3rd image figure C which was taken after 7th days of trauma the lesion is looking dark (Hypodense).
3. Headache and fluctuating level of consciousness.
4. Burr hole and drainage of hematoma.