LONG CASE MBBS 2008/2013

Lau Xin Rou
Examiners: Prof Kalai, Prof Azmi, External
Case: Prostate CA
68 year old, chinese male, hawker owner
c/o: Elective surgery for prostate ca
chronic smoker and alcoholic
voiding symptoms, storage symptoms, retention of urine once, need to be admitted in a&e to drain the urine, past history of peptic ulcer and operated 40 years ago, hernia operated 4 years ago
p/e: tell me what you see on the abdomen – multiple scars, describe scars one by one, draining tube one by one, what else u wanna do and expected findings? Per rectal examination
There are so many lines on his hand, and a cvl there, if u are the houseman, patient already start eating, what u will do.. After prompting i said off the lines to prevent line related infections.

Other Questions:
What supports the diagnosis of prostate ca? RF, age....
Investigations you wanna do
Tell me how the cancer spread. i tell blood, lymphatic, lymph nodes.. Prof Kalai: i want micromolecular level of the spread from prostate to bone, it is in chapter 2 of Robbins.... zzz sorry i dont know prof...
What other managements you wanna do. i answer surgery and follow up, psa level, bone scan etc,
Dont know why i said chemotherapy and radiotherapy. What chemotherapy you wanna give.. my stupid tongue said metrotexate.. (no no.. we dont give that, what else you wanna give?) after prompting for so long, the answer they want is GnRH analogue.
What other managements, non pharma(stop smoking and alcohol, diet, follow up..) and pharma

nur atiqah ahwan
mine same case with lau xin rou
history basically d same as xin rou. patient is super nice.. thank u unlce.. he know we r having exam but the funny thing during clerking he ask me when ar u going to present d case? next week ka? and ask me if got anything miss out u can find me in d ward.. i will help u..hahha.. so sweet uncle..
actlly i didnt manage to get d peptic ulcer part since patient could not told me in english o malay word..he mention one chinse word so i hentam i tot its liver abscess..huhu. but prof didnt realy ask about dat.. most r d same with xin rou questions juz want to add some other question
1. differential for boo
2. how to differentiate between bph and prostate ca? from per rectal and from investigation. ultrasound?
3. what other basic investigation u want to do? i start from blood then imaging..
4. what is d normal level for psa? he give one value n ask is it raise or not?
5.what other condition can raise psa?
6.result of biopsy for prostate n bph? d different?
7.if dis patient had mets to bone what u wanna do?

8. if got bone mets what kind of treatment?
9.how do you manage this patient?
then he ask other examiner anything want to ask me..
external examiner then ask what beside radiotherapy? i said chemo.. then he ask me what type of chemo? haha.. blur for a while and then ringgggggg... huhuhu.. ya lah gnrh analogue..

Pey Pey (Paediatrics)
Examiners: Prof Lee WS (paeds), Prof Ng WM (ortho), External Malay
Case: 7 yo Indian girl, epilepsy since June last year. Recurrence in about 10 times in 9 months time. Seems idiopathic. Development normal. No hisotry suggest neurocutaneos, SOL, febrile fit, electrolytes, trauma, infection. Basically this child is NORMAL. patient is currently on epilim, last year june was 200mg, now increase to 300mg. previously HARDLY TAKE ANY (prof wants this word than non-compliance) until 2 weeks ago, her mother started to concern about the med taking. Increase weight 2kg in 2 weeks time. Low socioeconomic status.

p/e: was wasked to show whatever i want to show.
- i told him about vital signs,
- fundoscopic findings - glioma, papiloedema,
- skin lesions-types of lesion, basically mention all I know.
-Findings: ALL NORMAL again.

Questions asked: - all by Prof Lee
- Epilim. do you agree with the management 2 weeks ago, will you do the same? (no, bcz the recurrence is not due to med problems, is due to compliance issue, so will educate first, monitor then only increase)
- Why mother hardly give medication before this.
- What caused the weight increase so drastically? (i said side effects of epilim, diet and lifestyle, fluid overload...but he waiting the answer familial, after prompting. (???)
- school performance (he didn wait until I reach that part of history)
- cause of fluid overload in this case if there is.
- investigations. no blood, only specific ones . EEG, CT
- principle of management in this patient.
- what specific advice u want to give to mother (not immediate management of seizure).

Adam PCM DMProf Vivek, External, PCM (Dr Chiew/Siew i forgot)
Case: Pensioner customs officerDiabetes mellitus for 20 years. Complicated by Charcot's foot, peripheral neuropathy, hypertension, dyslipidaemia. Presented with progressive blurring of vision, DM was diagnosed incidentally. No heart failure, renal failure, no stroke, no heart disease, no orthopnoea, pnd, no ulcers no amputation, no oedema, but has erectile dysfunction. On meds and stuff, basically typical DM patient.I think they like when you ask for compliance, events of hypo and hyper, patient insight, knowledge about disease.

PE : Swelling over left foot and ankle, lipodermatosclerosis, dry skin, no fungal in interdigital space, pulses present, perheral neuropathy up to ankle, proprioceptoion and vibration loss.

Questions. Give investigations (Lipids and HBA1C) comment. Do you think control is good? Why? Name all the complications of DM macro, micro. Manage, patient see's you in clinic what do you want to do? Begin non-pharmaco then pharmaco. Why risk factors important? Risk of stroke, ACS.Bedside. Examine lower limb. Look neuropathy and vasculopathy. What other investigations? Neuro - microfilament, vibration (coss i didnt do) Vascular - (Peripheral pulses, Ankle brachial index, SPO2, Toe BP cuff thing)External ask 2 questions - Is his control good? How are you going to manage? at the end. Didn't have time to answer

Syamimi
Examiners: Prof Jamiyah, Prof CK Liam, Prof Subash, Dr Sharmila
Case: Placenta praevia with previous c-section
24yo chinese lady G3P2 @ 31 WOG
no active complaint, history of low-lying placenta detected during antenatal f/up @ 30 WOG. Unplanned pregnancy, unaware of LMP due to breast feeding her 2nd child. Pregnancy confirmed by UPT and US, both done @ 16 WOG due to quickening. Had GCT done @ 20 WOG (normal result). Otherwise, no further OGTT done, BP normal throughout pregnancy, no PV bleeding and no other complaints. Previous hx of 1 emergency c-section due to fetal distress, no significant gynae hx, PMhx, PShx (other than c-section).

Qs: All by Prof Jamiyah
Differences between POA and POG?
How breastfeeding prevent pregnancy...pathophysiology?
Give 3 obs problems in this patient- PP, previous c-section and unsure of date
What is GCT????- answer la all about GCT (glucose challenge test)
How anemia related to pregnancy?(as i mentioned about anemia in hx).....normal value Hb in pregnant women?...what reference do u use???
What r the the things u look for in US? mentioned for every trimester
What is APH?(but this patient doesnt hv)....causes?
Bedside: Do abdominal examination.....show me how u palpate for poles
Lets say this patient had classic c-section...how to check for tenderness of scar?(answer-palpate uterus)....where?
Point to me where do you put fetoscope?

Other Qs:
What ix need to be done?
Diagnosis if US showed placenta reached os?- PP type 2
If patient come again 2weeks later....what u want to do?- admit, follow Mcfee regime
@38 weeks what is ur mx?- delivery by c-section
Lastly, cx of PP....

Pang Suan Choo
Examiners : Prof Raja Amin, Prof KL Goh, Prof Cheah(pcm)
Case : Newly diagnosed eso CA
Brief History : 78 years old, I, lady
haematemesis x5days
early satiety, dysphagia, LOA, LOW, anaemia
no other associated symptoms, no risk factor, no metastatic symptoms
DM, HPT, high cholesterol

P/E :
Prof Raja Amin asked to assess ptt's hydration status and nutrition status in front of him
Prof Goh : relevant findings. I asw check for signs of palor, look for mass at epigastric, supraclavicular lymph n PR examination showed no malaenic stool.
Prof Goh : what type of anaemia do u expect in this ptt (i asw if ptt IDA if chronic bleed, normochromic normocytic in malignancy; but prof say dont expect normochromic and normocytic anaemia in GI malignancy)

Discussion :
1) Provisional Diagnosis
2) Diagnostic inv (OGDS+biopsy)
3) Further inv (endoscopic ultrasound, CT TAP, PET scan for staging purpose)
4) How do you assess ptt's nutrition status? (P/E(...) and investigation (transferrin and albumin level)
5)Acute mx for this ptt
6)Pre-op assessment
6)Prof Amin give an example of inv results n asked me to stage the ptt
7)Prof Amin asked if EF is 45%, ptt has met to supra LN, is she suitable for op?
8)After considering all factors, Ptt not suitable for op, refer palliative care
9) Prof Goh asked abt the components of palliative care
10) Prof Amin : What is the content of TPN?
11) If ptt is operable, what type of operation do u know?
12) Complication of the surgery mentioned

<u>sook lin (PSY)</u>
examiner: prof wm n(ortho) prof lee way seah external malay d
all questions from external
case: anxiety
53yrs old chinese gentleman, known case of psy illness follow up yearly
30 years ago, presented with headache, diziness, frequent multiple visits to GP, referred ummc agter 6 months, was then on follow up under psy. 10 years later, developed palpitation and shortness of breath..(ask stimulus, duration to reach peak, functional impairment..follow criterias) easily irritable(describe further) . no mood symptoms, no psychotic symptoms, no trauma, no fitting, no substance, one previous suicidal ideation due to family conflict. frequent changes in work (longest lasted 10 years as cannot perform well. SVD delivery, uneventful, think that father dont like him because will only punish him what small matter since birth of his sister. average student, frequent play truant, quit by form 4. DM diagnosed 10 years ago. currently on lexapro (escitalopram) mental status examination. (follow the psy clerking sheet)
no bedside examination.

questions
1) pt with above symtoms, what other psy problem u think of? (agorophobia)
2) pt with frequent play truant, what suspected psy illness? (conduct disorder)

3) any significant family history? (no psy only DM HPT)
4) y u think patient need to change work frequently?
5) provisional diagnosis
6) what medical illness u can think of tieh this presentation? (she want phaechromocytoma)
7) what substance can give above symptoms?(cocaine?) is coccine available in malaysia ? (no idea)
9) how to manage pt when in first presentation? investigation ? biopsychosocial
10) what medication to give if not SSRI ? (benzodiazepine) how to give? (low dose, short term, long half life) in this case should give prn..
11) short term and long term benzodiazepine which one cause more addiction?
12) if pt refused antidepressant and anxiolytic, other medication? (propanolol)
13) what is the difference of graded desensitization and flooding?
14) diffenrence of tolerance and withdrawal?

<u>Haw Chiew Yen</u>
Examiners : Prof christopher Boey, 2 externals
Case : 31yo I lady, G2P1, 21 weeks + 4 days POG, no active CC
PObsHx : poor spacing with 1 delivery in feb 2012.
pre-term @36weeks 1.6kg emergency LSCS
threatened abortion @8POG
defaulted F/u from her 24to34weeks POG, walk in @35POG due to generalised body swelling, epigastric pain & intermittent headache.
Proteinuria 2+ (dipstick) but normal BP
completed DEXA and discharge home
36POG - spontaneous PPROM -->emergency LSCS
PMH : childhood bronchial asthma (but not exacerbated by pregnancy)
PE-BP normal, dipstick protein trace, striae gravidarum, caesar scar,pinard
question :
1) tell the risk in patient's current pregnancy.(bronchail asthma, previous 1scar,
preterm delivery)
2)wat is the causes of preterm labour in prev pregnancy?
3)how to diagnose pre-eclampsia?
4)PE-tell the 2 types of striae gravidarum
what is the difference btw dilated veins and superficial viasible veins?
(dilated - pathology) (superficial - pathology/physiological)
describe the scar - hypertrophy/keloid
5)what is the mx plan in this patient?
F/u 4 weekly, check BP and do MGTT @ 24 POG. ask pt to perform dipstick &
BP check at home. Then discuss with the patient about delivery plan. SVD is opted bcz only one prev scar
6)do u think patient can go for SVD since she had poor spacing & the scar was jz
there one year ago?...
7)patient had one prev preterm delivery, do u give prophylaxis dexa to her?

Ling Yee Von (Paeds)
Examiner= same as Adam (good examiners i hope)
Case: 10/indian/girl with underlying congenital hypothyroidism currently asymptomatic
Brief History: Borned via LSCS due to prolonged 2nd stage labour and cord blood TSH was very high, diagnosed to have congenital hypothyroidism on day 2 of life. Was given syrup thyroxine. Was also noted to have jaundice(only eyes, the rest normal) since birth. No change in stool and urine colour. Undergone phototherapy for one week in UMMC, no exchange transfusion or other intervention done. Jaundice resolved after phototherapy and was discharged home. Antenatally, mother did not have any exposure to any drugs or goitrogens (took history from dad, mum wasnt there so couldnt exlicit further antenatal history) , however she was normotensive, normoglycemic throughout pregnancy, routine scan was normal. Basically, patient is on syrup thyroxine 100mg daily, however recent f/up one week ago, her medication was reduced to 50-75mg daily. Follow up at clinic every 3 months, thyroid hormones maintained. No signs and symptom of hyperthyroid or hypothyroid except for dry skin and cold intolerance. Development was bit delayed (can only walk at age of 2,can speak at age of 3) however, was able to catch up in class and is an average student in school.

P.E : Nothing significant,no lumps in neck and no signs and symptoms of hypo or hyperthyroidism except dry skin on both lower limbs.

Questions(mostly asked by the external):
1. How to diagnose one with congenital hypothyroid? (from cord TSH, and TSH level very high)
2. What will you do if TSH is high? (further confirm the overall thyroid function by check t4)
3. Will you check T4 right away? (no, normally few days time i say, prof ask why, i said need few days for maturation of thyroid hormones and gland)
5. How to treat congenital hypothyroid? (given syrup thyroxine)
6. How long to give? (lifelong)
7. How would you screen newborn for congenital hypothyroid from PE? (check for tone, reflex,umbilical hernia..... Prof Vivek so kind wanna help out, he asked would you wanna check for SP02? I said yes, he ask why? i said because respiratory muscle weakness)
8. What radioimaging can be done for newborn? (ultrasound of thyorid and radioisotope scan)
8. Why do you tink patient has delayed in walking while overall development still ok? (proximal myopathy)
9. How you gonna manage this patient in the future? (check for thyorid function, development, xray for bone age)
10. For PE, prof just ask to demonstrate what to look for in thyroid patient, basically check for thyroid status and neck examination laaaaa)

Taye Zhi Ling/ Obs/ Prof Azmi (O&G), Prof Kalai (Neurosurg), external (tak tau siapa)Bleeding in early pregnancy+1 previous LSCS28yo/M, bleeding during POA week 5, from u/s found to have two gestational sac, one got fetal pole but one empty, but at around POA week 9 empty sac hilang. one previous scar due to poor progress. Otherwise normal (normotensive, normoglycaemic)Questions ask: (mainly from Prof Azmi)
1) DD of bleeding in early pregnancy: abortion, molar preg, ectopic preg

2) What do you think is the cause of bleeding: threatened abortion or abortion of the empty sac
3) What is your concern when patient has one previous scar? Risk of scar rupture
Go bedside, do abdominal examination.
4) What do you want to check if patient want to go for normal delivery? Scar tenderness
5) What are the signs that you are looking for in patient with anaemia? Tachycardia, tachypnoea, pallor (palmar, conjunctiva), angular stomatitis and glossitis (Prof kalai wants these two), auscultate for innocent murmur
6) What is the risk of previous LSCS in this patient on current pregnancy? Risk of placenta praevia
7) How will you manage this patient when patient come to you with bleeding? First confirm pregnancy by UPT, then do transvaginal u/s make sure is intrauterine pregnancy...
8) Risk of scar rupture in 1 previous LSCS? 2-3%
9) How do you assess whether patient is fit for VBAC or not? No scar tenderness... cephalopelvic disproportion... make sure no growth prevent fetal head descend.. fetal size ok.... (talk around passenger, passage...)
10) Precaution in VBAC? Scar tenderness... (most of my answer is scar, scar, scar...haha)
11) If postdate, what would you advise the mother to encourage spontaneous prom? Mobilise more... [what else??] do more activity... [what activity] duno. the answer is sexual activity! I should have say that =.= [From external: what contain in semen that have this effect] prostaglandin
12) From prof Kalai: how would you manage if patient has anaemia and leg swelling? Depend on the Hb level... Riiiiinnngg!!!! (then I said thankyou and left the room =.= I should have finish answering the question before I left >_<)

<u>Syazwani J.</u>
Examiners : Prof Chin(main), Prof MTK, Prof Jamie..
(cuz it's already in da eve, prof MTK n Jamie were in bad mood.. Prof Jamie was yawning n with red eyes most of the time..)

70y/o,M,F, background hx of DM, n hypercholesterolaemia..
Noactive complaint..

just reached da social history, prof directly asked me to summarize..
So, i summarize da case..
Then she repeated da instruction.. Summarize bout this ptn DM.
Q1: wat do u think bout dis ptn DM status..
Ans: Not well controlled.. though based on hx, she seemed to be comliance to insulin, f/up n diet, but, she had 1 episode of Chest discomfort (ptn was unsure of da diagnosis) n, +ve peripheral neuropathy
Q2: (this question was actually asked during da hx presentation..) Wat do u think was da chest discomfort episode was:
Ans: Angina
Went to bedside..
Q3: Present da relevent bout this patient physiscal examination
Ans: BP (didnt hv time for postural BP but i told them ive forgotten.. all made not da nice faces dat u wanna c in exam.. my mistake anyway), cvs, then i went on talking bout pulse rate,

not anemic n GI system. During da CVS presentation, i started of with S1,S2 heard, then MTK suddenly got angry n said "does S1 S2 relevant in DM??" then i said no.. but before i could proceed, he started laughing (sarcastic laugh) n i just went on, ignoring him (basically raised my voice a little so dat it could be heard by da other 3 examiners). i talked bout heart failure symptoms like displaced apex beat, n lungs were clear n all.. cuz dm ptn can get heart failure (da other 3 examiners nodded)
Q4: y GI system.. wat did u look for at the abdomen..
Ans: to c if there's organomegaly?? but it's just routine check.. (Prof MTK laughed again n smirked) Then prof Chin probed further.."wat else.." Then i mentioned bout insulin injection site n started descirbing.. it was actually normal.
then i continued with CNS examination. more to LL..
multiple scars over the LL secondary to wound. No, fungal infection in between toes n no calluses no ulcers n peripheral pulses were palpable.
Q5: are the pulses normal?
Ans: (i was blurr but confidently asnwered..) Normal
then continue to present regarding the sensation (there's bilat socks peripheral neuropathy up to 10cm frm ankle joint.. For hands, up to distal IP joint.. just use ortho cuz hd no other idea how to describe da level) Then continue with Proprioceptions which were intact. Then i proceeded with vibration.. Vibration were normal..
Q6: were u surprised to find dat vibration were normal?
Ans: at first i answered no.. then Prof Chin asked, in DM which is affected 1st?? I answered, Vibration > proprio..then i changed my answer that i supposed to be surprise wen da vibration was intact.
Q6: Then how come in dis patient the vibration was intact?
Ans: (again.. blurr.. how could i know.. it just was..with silly look on my face, i answered,..) Maybe i did it wrongly.. (instantly, Prof Jamie n Prof MTK made that not-so-nice face to look at in da xm)

Went back to da room..
Q7: how u wanna manage dis ptn..
Ans: Since she has no active complaint.. so, would like to assess da compliance n do routine blood during check up..
" Me: FBG
Prof Chin: 8.9
Me: High..(prof nodded).. Hba1c level
Prof Chin : 9.9
Me: High.. Poor control (prof noded)
.. fasting lipid profile
Prof Chin : high as well
Me: Renal profile
Prof chin : Creatinine 66
Me: (blurr again.. wow.. 66??.. then i said,...) there's renal impairment.. (prof nodded).. i wanna do U dipstick.. at which, i had already did just now..
Prof: So wat's da finding
Me: No protenuria..(before i could proceed)
Prof: does protenuria help to tell renal function?? (i said yes.. MAY hv renal impairment)
Prof: wat else do u wanna look for?
Me: no ketonuria, no hematuria.. then prof stopped me..
Prof: wat other thing u wanna look for??

Me: (blurr again.. man... i continue to be blurr... then prof answered..) microalbuminaemia.. (i could only smile)
Prof: can microalbuminaemia be da indicator to say presence of renal impairment??
Me: Yes

Q8: wat else u wanna do for this patient..
Ans: (i started talking bout da heart n measure by.. but prof stopped me.. she didnt want that.. Prof MTK N Prof Jamie were just watching.. doing expression that u just dont wanna focus on in xm.. stressfull...)
Prof hinted me.. u mentioned something bout da incidents that she had..
Me: (suddenly remembered that she had multiple episodes of fall..i then answered..) I would like to assess da home environments, (lighting, stairs) since she's 70 n already menopause, so there's increase risk for # when she falls..
Q9: wat else?
Ans: assess if she requires walking aids, then i would like to encourage her to use walking aids.. (this was not da answered prof wanted..)
Q10: wat else? (i was blurr).. she's an elderly, a lady, dont u wanna think bout..
Ans: (b4 prof could finished her sentence, i cut her n directly answered..) osteoporosis.. yes, i would like to assess her for dat.. so, i wanna do..(in my mind. BMD..BMD.. but wat came out was..) Bone marrow.. (b4 i could finished.. Prof MTK laughed again sarcastically.. Prof jamie n Prof Chin were shocked.. i was shocked myself.. haha.. i laughed as well actually.. then i directly changed my answer..) Bone mineral density scan.. then, i would like to do serum Ca..
Q11: can serum Ca be affected in osteoporosis
Ans: (i tot can.. i was blurr again.. but becuz da way prof chin asked.. i answered..) Not much
Q12: wat else..
Ans: (blurr, wat else for osteoporosis or wat else in terms of mnx of da ptn.. but b4 i could answer..)
KRRRIIIIINNNNGGG!!! ~THE END~
(sorry if this is too long.. just dunno how to write this down..)

Shahirah
Case : orthopaedics (OA rt knee)
Examiner : Prof Ng WM, Prof Lee WS, external malay
79 chinese lady
c/o rt knee pain x 1 year
-had chronic bilateral knee started 33 years ago, insert implant for left knee in sunway medical centre, cannot do for right knee dt financial constraint, f/up under sunway and on analgesia for right knee
-had few falls episode, last was 1 year ago, during walking down stairs, fall on both knee in squatting position, no external injury
-rt knee pain became more severe, went to UMMC, xray was done and advised for surgery, pt refused as she scared
-rely for the analgesia for last 1 year, heard clicking sound when move the leg, stiffness after inactivity for less than 5 minutes, difficulty in initiating movement; had to hold for something, using walking stick to ambulate, no wheelchair, no morning stiffness, no recent intake of seafoods

-increasing pain and analgesia for past one year, impaired quality of life, spend rest of time at home, watching tv, lying on bed, cannot do housechores or go to the market
-no fever, LOW or LOA, put on weight this 1-2 years
PMH : HPT and IHD for 22 years, angioplasty twice, DM 3-4 years, gout few years; last attack 3 years ago. f/up UMMC once in 6 months. Compliance to medication, no cx
Drugs : simvastatin, perindopril, amlodipine, metformin, allopurinol, rocatriol -tolerant
FH : no hx of joint problem or other medical illness
Diet : low sugar, low salt, avoid seafood
Social hx : lives in Kepong, double storey house, stay in ground floor, sit toilet bowl, lives with husband, and daughter's family, not smoking or taking alcohol

(forgot most of the Q's actually,memory weak=,=)
Prof Lee : tell me the drugs again-->what is simvastatin-->why is this pt on simvastatin
External : what do you think psychological problem pt may have-->tell me the symptoms of depression
Prog Ng : give ur provisional and differentials-->primary or secondary and why

Bedside
Prof Ng : please examine the pt (rt genu valgus, no muscle wasting, medial rt knee swelling, no skin changes, normal gait, crepitus both joints, normal temperature, non tender, positive patellar tap rt side, no bony, ligament or muscle tenderness, movement range 0-1200 both side, painful on movement)
How do u check for ligamental tear,demo
Prof Lee : do u check for fundus?demo
Back to the room,
Prof Ng : Interpret this xray à how do u manage
Bell's ring

*patient can't speak malay or eng well, thus need translator..if this happen to you, relax and focus, the translator is actually houseman and they help a bitJ hope all is ok..good luck!

<u>Liew Xin Yi</u>
Examiners: Prof Vivek, Prof/Dr Isam (external), Dr Liew
Case: DM+HPT

67yo,C, male, DM for 20 yrs, hpt for 10 years, asymptomatic and no active complaint.
DM for 20 years. Diagnosed during regular medical check up. No symptoms of DM except polyphagia (take 2 bowls of rice). No macro or microvascular complications. On insulin and metformin. Compliance. Ho hypoglecemic attack. Home glucose monitoring 1/week, 6-7mmol. HbA1c on f/up: 9%.
Hpt diagnosed during DM f/up 10 years ago. On atenolol. Blood pressure monitoring at home 130/70. No complications.
Hypercholesterolemia under controlled. On medication.

Total knee replacement due to OA 3 years ago. Previously presented with bilateral knee pain. no complication after surgery. Currently have some difficulty in squatting down.
Diet: previously 2 bowl of rice. Recent 2 weeks cut down to not taking lunch, dinner = grilled chicken + cucumber.
No exercise.
Smoker for 40 years. 2 packs/day. Stopped since 10 years ago due to family advice.

P/E: normal except there was bilateral arthroplasty scar. Some dilated vein over lateral calves. Leg edema up to mid calves.

Questions:
1) Why patient suddenly change his diet? Due to family advice. What will happen in this situation, as he is not taking his lunch? Hypoglycemic attack if he continues taking his insulin, but missed his meal. hypoglycemic may cause unconscious.
2) During PE, because I start with hand. What is clubbing? Loss of curvature. What is normal curvature? Dunno. What are the causes of clubbing? CVS..respi.. Do u think this patient will have clubbing? No.
3) Proceed to foot examination. Inspection. Peripheral pulses. Vibration. Pain sensation. Where is dorsalis pedis? Why we didn't check pain sensation on sole? Due to thick skin.
4) Summary. What do you think about his control?
5) Fundoscopy finding?
6) Lab result was shown to me. Glucose high. HbA1c 9%. Creatinine at upper borderline. Renal function test otherwise normal. Tell me the result of the urine dipstick. All -ve. Since his creatinine at upper borderline, what will u do for investigation? 24 hour urine protein.
7) Why do you think his home glucose monitoring is around 6mmol/L, but his HbA1c is 9%? Patient may have higher post prandial glucose. What will you advice him to do? 7 point blood glucose monitoring
8) What is the cause of leg edema in this patient? CVS, nephro. Since he has dilated vein, suspect varicose vein. He has previous arthroplasty done, can be DVT.
9) How would u manage this patient? Diet control, exercise. Cut down glucose intake. Refer dietician if necessary. What is your purpose when u refer him to dietician? For a balanced DM diet, weight loss. why weight loss is important? CVS, CNS complications, obesity can cause insulin resistance.
10) Atenolol was used in this patient. What do you think? Atenolol is a beta blocker, can mask the hypoglycemic sx. What drug u want to change to?

<u>Wei Chun Gan</u>
Pediatrics
Prof MT Koh, Prof Cheah, Prof Jamaiyah, prof Suren(observer)

Aisha
7/M/girl
CC
-no active complaint(pt was discharged 2 days ago n now come for exam)
HOPI

- antenatal mum had GDM in pregnancy, but no fever, no rash, no smoking, no alcohol, flup scan showed normal baby
- intrapartum, ELLSCS due to 4.5kg macrosomic baby
- since birth had at lump on lumbar region(5x4cm), the mum was told the baby had abnormality of spine
- flup in HKL for 1 yr and defaulted flup cz no complications arise
- from 5 to 7yo, she had recurrent fever(2-3 times per month), only went to GP, never seek specialist help and no investigation until 2 weeks ago, she had the same fever and the GP found she was anemic, then refer to UMMC
- the fever is not associated with dysuria
- the lump on the back is not enlarging, not painful
- she had to wear pampers until now
- admited to UMMC for 2 weeks, was found to hav hypertension and urinary tract infection, given antibiotic, urinary catherisation, anti-hypertensive drug, one pack of blood tranfusion

PE:
height and weight less than 3rd centile(failure to gain weight n grow), had a CBD, urine in the bottle is cloudy(protein 2+)

on the lumbar region, the lump is 4x5cm, oval in shape, the surface n surounding skin is normal, not warm, not tender, can palpate the vertebra in midline of swelling and it curve out with the swelling(?kyphus), at the sides of the was firm and ?fluctuant, is not mobile, and i should hav done the translumination test

abdomen, no palpable kidneys

lower limbs,
- broad base gait
- hypereflexia
- normal tone, normal power
- cant check sensation, proprioception n babinski cz child is not cooperative

Question:
after i presented the chief complain, prof koh ard open his mouth, kept asking questions all along the history =.=,
- did u ask any scan during pregnancy?
i din ask in detail, but is important to fo fetal anomaly scan at 18-22wk as mother has GDM
- why u ask fever and rash in antenatal history? wil congenital rubella presented with a lump on back?
jus wan to rule out other infection, congenital rubella wil not present with lump on back
- if u saw the baby after birth with a lump on back, what wil u do and any further history wil u lik to ask?=.= dunno what he reli wan
do a physical examination of lower limb, ask for urinary or bowel problems, check for other congenital defect
-what do u think the lump is?
possible meningocele or myelomeningocele...den he asked, what r the definitions
-what is the whole picture of this case?
myelomeningocele causing urninary retention then recurrent UTI, backflow

urine pressure to kidneys causing chronic pyelonephritis and renal scarring..now presented with anemia as sign of chronic kihney disease

only present until HOPI, went to bed site,
- show me the signs of CKD?
terry's nail, sign of anemia, sign of vit D deficiency(ricket, enlarged costochondral junction, enlarged wrist joints, bow leg), facial or leg edema, HPT(did u measure? no bcz time up when i tried to measure,time's is up and is very important in this this case), acidotic breathing, urine protein showed 2+, small stature(dt failure ot thrive)

=.= din ask to examine lump and lower limb which i prepared, but ask bout signs of CKD

back to room,
-assume u 2 weeks ago patient presented to u, what investigations u wil do?
FBC(anemia of chronic disease, WBC for infection), PBF, RP(urea and cr), urineFEME, urine C+S, ultrasound of the kidney, DMSA scan
-what test u wil lik to confirm renal bone disease?
DEXA scan(he accepted), serum Ca and Vit D(the answer he want)
-list of the problems patient has?
recurrent UTI, failure to gain weight n growth, chronic kidney disease, anemia, HPT
-how wound u manage this case?
anemia(iron tablet, EPO injection), blood tranfusion if less than 8 Hb
calcium supplement
anti-hypertensive(ACE-i as pt has proteinuria)
porphylatic antibiotic for recurrent UTI
frequent flup with the clinic
-what is the ultimate prognosis of this pt?
end stage renal failure

p/s-in between need prompting, i jus summarise all the questions prof koh ask, prof cheah wil try help if silence is too long, actually all of them r nice, good luck guys!!!!

Ain Shamsudin (Medicine)
Examiners: external examiner (main), Prof azmi (o&g), prof kalai (surg)
Case: 60 y/o gentleman , no active complaint, background history of gouty arthritis - 10 yrs , on treatment, compliance to medication & on regular follow up. Assessing RF - +ve family history of gout (siblings and mother) however no history of alcohol intake, high blood pressure, and renal disorder. Not taking any medication like diuretics, tb drugs, not underlying any haematological disorder. no complication of gout (no 2ndary infections, nephropathy, nerve or cord impingement, renal stones, fracture).

Also hv back pain associated wit shooting pain from lower back up to left sole, no history of trauma, heavy lifting, no neuro deficit, no chronic cough/met TB patient,no LOW LOA, no underlying cancer, MRI done, degenerative cause ?spondylosis.

Pmh & psh : renal calculi, parathryoidectomy was done, dyslipidaemia (on medication)

p/e: show whatever i want to show.
- vital signs
- look for tophi, toes, ankle , knee swelling (all normal)
- since patient hv dyslipidaemia look for xanthoma. - pinna, elbow, archilles tendon
- tell examiners if i got time, i would like to do spine xm

Questions asked: - mainly from external examiner
-How is gouty arthritis diagnosed?
Mainly just based on the history of attacks- painful, commonly involved big toe & ankle, attack one joint at one time while other arthritis condition usually attack multiple joint simultaneously. joint aspiration - look for urate crystal from tophi nodules . X-rays - look for tophi or any bony damage (cx of gout)

- U mention about joint aspiration, can u tell us more? What do u look for? Under polarized light microscopy we cn see negatively birefringent urate crystal.

- ix u wud like to do? FBC, Urinalysis, U&E and creatinine, Blood urea, Serum uric acid, 24-urine uric acid

-Treatment for gout?
1.colchicine - reduce uric acid level.
what is the mechanism of action?? *cant remember* ZZZzzzz
side effect ?? severe diarrhea, nausea and vomiting.(not sure -.-)
2.Allopurinol - preventing uric acid production.
MOA?? Inhibit xanthine oxidase .
Side effect?? Allergic?? liver toxicity?? *errrrr. tak tahu*
3. Prevention - maintain adequate fluid intake, reduce weight, change diet.

- as a doc, how do u advice to help patient in reducing uric acid level? Avoid foods rich in purines e.g seafood and red meat . Reduce weight -lower the risk of recurrent attack of gout.

- pathophysiology of gout? results d2 overload of uric acid in the body, leads to formation of crystals of urate that deposit in the joints. When crystals form in the joints it causes inflammation -arthritis.

- What is the prognosis for patients with gout? Recurrent gout lead to permanent damage to joint &bone. Need to control uric acid level to be low so it will reduce risk for flares and joint damage. so, regular monitoring of the blood uric acid is needed to hv a good prognosis. then the bell ringsssssssssssssss.......

<u>Tharisinidevi kunasekaran</u>
Prof vivek and 2 external
46 year old indian gentleman, background history of dm
history of multiple abcess(from head to toe) and diabetic foot ulcer
P/E : diabetic foot examination and lots of prompting and help from prof vivek.
question: lots from history itself.....T.T

no ix question, management : what is the best drug to give this patient as i found positive protein in urine dipstik;ACE inhibitor...then they say you may go. kriggggggggggggg

p/s : eerrr i left my brain outside the exam hall...".", prof was nice...its me who is the problem...no matter what, good luck guys...we can do this

Ong Chiew Sern
Examiners: Prof Ng Pak Cheung(neonatologist), Prof Nortina, Prof Woo
Case: Neonatal jaundice secondary to ABO incompatibility
29 days old baby girl, presented with chief complaint of jaundice since day 2 of life
(only managed to present HOPI and PE, no bedside,in the end grilling for 20+ minutes out of 30 minutes until cold sweat)
Presented with jaundice up to the lower limb, no pale stool dark urine, no HIGH PITCH CRY(important to rule out kernicterus), no poor feeding, fitting, etc etc.
Finding: only jaundice up to lower limb.How do you check for jaundice?palpate at body prominence..where do you press for chest??sternum..
Grilling time:
1.What is the cause of high pitch cry?(kernicterus)
2.Where does bilirubin deposit usually in the brain?(basal ganglia)
3.WHY???because it is more fatty@@
4.What will the patient present with kernicterus??(reduced level of consciousness, fitting, jaundice..one more important thing-posture..what posture??OPISTHOTONUS)
5.What do you screen for in cord blood in ALL patient??VERY important, but I thought blocked too long until they almost gave up,blurted G6PD and and hypothyroidism..
6.What other blood group do you screen for other than ABO?? Duffy and kelly.
7.What are the congenital infection that you know of??TORCHES lo..
8.What are the conjugated hyperbilirubinemia??Biliary atresia, choledochal cyst, neonatal hepatitis.
9.How do you know this is conjugated hyperbilirubinemia..check FBC lo@@
10. Biliary atresia (in and out)-cause, ix, management(principle of Kasai)
11. If patient come in with prolonged jaundiced, unconjugated, what do you wanna rule out?breast milk jaundice
12. How to check?take TSB 1st, then ask mother stop breast milk feeding, then repeat in 2 days.
13. Other unconjugated hyperbilirubinemia that you know of?? GRAPSD out d still got some more..@@ thought block very long until blurted out crigler-najjar syndrome reluctantly(prof says yes you do get these patients, mayb once in 10 years=(I think he wanted the other blood group -duffy, kelly)
14. Showed me the patient's FBC..interpret-high reticulocyte count-hemolytic anemia!!
15. Management-Phototherapy, if does not work-exchange transfusion.
16. What do you advise mother after discharge-monitor for rebound jaundice, kernicterus symptoms,follow up weekly kot...
17. in preterm baby why are they more prone to get jaundice??dunno prof

sorry-liver still immature ma cant process the bilirubin.

18. in what condition do you get jaundice??intrapartum-cephalohematoma and caput succadeneum!!

1) Cheong Yee Weai
2) discipline/posting: Surgery
3) examiners: Dr. Thiha, Prof Sangunan, Prof Ong (paed) and 1 external
4) diagnosis: Unsure of diagnosis (possibly esophageal Cancer)
5) brief history: Difficulty in swallowing food, only able to tolerate fluid and semi-solid food now. Duration: 2month. LOW about 12 kg in 2 months time. Past surgical: bilateral inguinal hernia repair, cataract surgery
6) questions ask:
-Ask me provisional diagnosis and differential
-Bring to bedside: assuming this patient had GI malignancy, do the relavant physical examination
a) why u want to look for jaundice (I ans met, but he had mets only cause obstruction over small portion of duct--> then i answer possibly portal hepatis node enlargement
b) why u want to look for ascites in this patient (GI malignancy)
c) this patient had epigastric tenderness and muscle guarding, tell me what are worry about. what will be next physical sign that u want to look for. (Perforation,rigidity of the muscle of abdomen)
d) Other relavant PE that I look for: pallor, supraclavicular node, liver and spleen (none of it positive)
-How do you differentiate regurgitation and vomiting (I ans one is forceful the another is forceless), they prompt me to regurgitation occur in esophageal obstruction and vomiting occur in more distal parts)
-what would u do to establish diagnosis (OGDS)
-Tell me how are u going to do OGDS (i forgot to mention fasting, basically, sedation, mouthpiece, spray, ask patient swallow, max distance reach is D2)
-Let say u r now in rural area, how do u diagnose it? X-ray with barrium swallow (Unsure what is the answer)
-what is the commonest cause of death among esophageal cancer patient (I ans met. dr. Thiha prompt me to nutritional deficiency, Prof Ong prompt me to aspiration pneumonia because of regur)

khairul
prof azlina, prof marry marret (kena lagi ngan dia ni..huhu) n external prof chinese..
patient = wong pet yi and her son very2 super duper nice patient
no active chief complain come for exam purpose..
knee pain bilaterally characterized by sharp or stinging pain, relieve by rest, locking, aggravated when walking, no radiation, no lower limb weakness, no incotinence, no spinal problem, no hip pain or hip pathology, associated with swelling bilaterally..chronologically got after joging involving right knee an later left knee after 1 month...progressively worsen throughout 2 years with unbearable pain...went to GP and treated with analgesic , glucosamine, msm and chondrocitin...advised to do surgery n refer to here for total knee replacement at ummc in this april...has hypercholesterolaemia and palpitation
p/e = genu varus, bilateral knee swelling, crepitus
1.Pdx=OA
2.DDX=gouty arthritis, septic arthritis and rheumatoid arhtritis

3.what do you think the cause of the pain beside OA...referred pain from hip joint and spine
4.so, what du you want to dig more on that? any lower limb weakness, sipne or hip pathology
5.go to bedside n ask how to check RA *(kena lagi since 3rd year pastu ngan prof marry marrot..asyik ngan dia je..ada chemitry ke apa?heheh)..check tangan lah..
6.what boutinnier (hyperextension dip n hyperflexion PIP)n swan neck deformity (hyperflexion DIP N hyperextension PIP)
7.what atalgic gait
8.why both kneee not in same line in lateral inpection..cause the left knee in flexion position
9.why genu varus..coz destruction more at the medial site of both knee
10. what is the different between patellar tap n fluid shift knee test...patellar tap for large effusion while fluid shit knee test for small effusion
11. how to test LCL...buat lah varus test
12. ix...x ray AP and lateral, lipid profile and ecg
13. x-ray..how you order to radiologist...AP and lateral view plus in standing position to look any loss of joint space
14. interprate x-ray AP and lateral....sunchondral cyst, subchondral sclerosis, osteophyte and loss of joint space..
15. management beside what patient tell you...analgesic and physiotherapy...and surgery of total knee replacement (prof buat muka)

Good luck hope we all pass!!!

<u>Tan Wee How</u>
Dr. aizura (o&g main examiner), prof Gan GG (med), Prof Koh (psy)
33 indian primi 36POA PP type 3 came in for monitoring
1 yr infertility - on clomiphine citrate, injection and folic...1st attempt IUI failed...2nd attempt without IUI...conceived naturally....then all da preg hx..bla bla bla...p/s: she has NO GDM, NO PIH, NO PV bleed throughout her preg :)
story continue until 8 days ago (35 POA) came in for monitoring and LCSC at term

Qs :
- wat is clomiphine citrate, use of it? look at wiki ya XD
- pt menarche at 16 yo, anything u worry?...say back hx..no other family member lk this....
- wat is the normal age of menarche? i say around 12 lo...
- forgot wats the next q....suddenly ask about GCT...MGTT...everything ya...normal value...how to do...
- go bed side...examination...
- why cant use pinad in pp? becoz will press agaisnt the abdomen and might cause separation of placenta
- back to room, wat ix u would lk to do now? FBC for anaemia, rbs for glc...u/s...bla bla bla...
- tell me wat are the parameter u can look for in u/s...gestational sac...amniotic fluid...placenta....fetal growth...bla bla bla...

- when we do anormaly scan.....18 -22 wks lo
- tell me about mc caffee regime (coz i aredi mentioned it in my earlier presentation)....admit pt around 35 wks?? not sure....then monitor...till LSCS...
- why need to carry term only LSCS?...for lung maturation...
- wat makes lung mature? surfactant...then i tambah its produced by type 2 pneumocyte
- so who do u wan to inform along when u r planning to do lscs...paeds...aneasth...and the reason why u inform them..
- wat u anticipate for if mother go into preterm labour...EMLSCS...and?...might need respiratory support....
- wat kind of support?...er..err....non invasive respiratory support?...examiner say is non invasive ventilation support XD
- ok..Prof Gan and Koh..anything?..
just now u mentioned about anemia...why anaemia commonly occured in preg?...err...becoz of increase plasma volume....how many percent? forgot le...other than dat...any reason?....err...for the fetus...yes...increase demand in preg rite? (haih...i noe it but dunno why go circumstantialities @@).....and the commonest aneamia is IDA in preg
- wat is obimin, wat is contain of? vit b folic acid and iron? they just focus on iron due to the above anemia issue....
-ok..thats all...thankyou and remember to bring ur sticker...

examiner are all good and nice...hope all of us pass!! all the best :)

<u>khairul anwar-psychiatric-datin shamila(main examiner) prof raja amin,and not sure about the other one doc</u>

-actually cant elicit the good history from the patient coz patient keep changing the story and the history not really convincing
when i came in (i saw patient was sleeping and when i wake up him,ohh seroius from his face i know he was a psiki patient hahaha just joking)
-mr ali 37 years old gentleman admitted last 2 day for ECT maintenance with known case of psychiatric illness and under UMMC follow-up for 20 years
-the history started on 1994 when he had a low mood for more than a week,i try to prompt patient what the stressor but he cannot recalled,the low mood associated with poor sleep and a little bit poor cocentration and lethargy.However there is no change in appetite and weight.There is no anhedonia as patient enjoyed what he used love to do before which is playing computer game and collecting stem.He was motivated,no feeling of guilty,hopelesness and also worthlesness.there is no suicidal ideation and attempt.He still mixed around with the family member and still able to function and go to the work as usual.He work as sale consultant in furniture company.(from this point,i started to think,ist called depression??furthermore there is no exact stressor
-assesing his psyhotic symptom..patient claimed to have auditory hallucination which is police sirene sound(patient claimed that it maybe related to previous history of being caught by the police for car stolen case during his school age)the sound came at night before he falled asleep,and subside by its own.he experiened this auditory hallucination almost everynight.however there is no commentary,2 or 3rd person aunditory hallucination.Beside auditory hallucination,he also claimed of one episode of

visual hallucination,its happen when he was giddiness,he described the shadow-like image.Other than that there is no gustatory,tactile and olfactory hallucination.
-at this point i also ask about delusion,all type of delusion and schizophrenia (sneider first rank) by he denial for any delusion.
-do ask all about manic symptom but again he denial
-patient claimed he was normal and nothing problem with him,but he said both of his parent claimed that he was different from before,eventhough patient said he still mix around with the family,but the parent though he become less talkative and cheerful like before, not really listen to what they advice to him or not follow instruction like he used to do before and the parent want to brought him for pschiatric consultation.
Q;datin shamila..so in this kind of patient,when they think they are normal but everyone around them think they are not ok..what it is called?? A:poor insight
-according to the patient he had been diagnosed with depression and have multiple hospital admission in UMMC.the first admission was on 1994,followed by 2010,2011 and recently on Mac 2013.He was prescribed with antipsychotic drug and mood stabiliser(however i cannot recalled the name)Q;ist this medication still available now? A:from my reading,im never cross the name of the medication, Datin syamila:yes,it a very old drug and not used anymore.
-then he was changed to medication to epiline and clonzapine for 8 years and recently he started to have ECT and continue with resperidone and epiline.(so when i reached this history,i become more confused because patient was treatment for bipolar)-so at this point of management i was thinking about bipolar,again i stress on manic symptom but still patient denied
Q:datin syamila,so from this point,what your judgment?
A:seriously i dont know what actually the problem of this patient and sorry like what i said earlier im not convincing about the history,because patient doesnt meet the criteria for MDD,schizophrenia still possible but also no bipolar,however if i looked at the management of the patient is more on bipolar and currently he was on ECT.so the history and management doest really talley because from the history look like he doest have so severe illness but the management is for the severe illness.
Q:in what condition we used ECT
A:severe depression,severe psychotic,contraindication to medication,non compliance and not respond to medication
Q,ok so how about the other hospital admission?A;according to patient the other admission just for reasses the condition and change the medication including start the ECT,and the other reason is because the parent concern and anxious.Q:so that is what patient said,what your comment?A;I think patient develop another episode of depression or manic maybe with psychotic feature and not respond well with medication,however it denied by the patient,i did ask about ist because poor control of the disease,progression of disease,ist become more severe
Q;so u already explore about manic symptom,so how do you ask about manic symptomA;answer all the symptom la bla bla bla
-so continue with the history untill the end
Q:so you mentioned about first sneider rank ,can u tell me what is it?A:ABCDS lorr auditory hallucination,(3rd person,comentary) though broadcasting,though

insertion,withdrawal,control,delusion,perception,somatic)OK let see the patient..(again patient was sleeping)
Q:so in psikiatric patient what medical condition you are concern about
A:thyroid diseasethen proceed to thyroid examination
Q:since patient was on antipsychotic drug,what physical examination you want to do
A:i look for any side effect of medication mainly for extrapyrimidal side effectso proceed to look for pseudo parkinson sign,hypokinithesia etc

OK back to the room
Q:what investigation you want to do?A:basic investigation,full blood count renal profile,liver function test,ECG,thyroid function test,its a basic investigation to look for renal and liver function because later i want to prescribe him with medication that maybe related to renal and liver.
Q:if this patient come to you with aggressive behaviour,how you want to manage the patient?
A:i will admit the patient,give him Im haloperidol and IV BZP then put in under observation,do the blood investigation,monitoring,start the medication and manage him incluidng biopshychosocialQ:if patient is a woman..what other investigation you want to do??A:blurrrr then prof raja amin give a clue..ohhh urine pregnancy test to exclude pregnancyQ:what the side effect of drug to the pregnancy?A: blurred i cannot really remember the side effect but i know it teratogenic and affect the pregnancy and the fetus...later datin shamila name specific drug and its side effect@@ then prof raja amin said..do you know that?
A:yes i know and read about that but i cannot recall @@
Q;the datin shamila start to ask more about the drug hahahha she love drug and ok la can answer
Q:so what do you think the prognosis of this patient??A:at first i said hmm patient have both good prognostic factor and poor prognostic factor,patient have poor insight,not respond to treatment and at this age already start with ECT maintenance,and for the good prognostic factor he have a good social and family support
Q:so ist poor prognosis or good prognosis??A:poor

Comment on patient;actually i fed up and start to depress because patient keep changing the story and i spent full 1 hour to clarify what the patient have,only last 10 minute i did MSE,and yet still i struggle to clarify what the problem he had.Luckily i met prof zuraidah and she calmed me as she look me so depressed ahahah it ok patient psikiatrik kott! katanya hahahah just present what u get

comment on examiner exp datin shamila:she is very nice examiner,keep me free to talk eventhough at first im not really sure and confident because the history seriously mess up,she love to ask about definition,(delusion,delusion of perception,hallucination etc) and love to ask about drug

All the examiner are very nice and ok la hahah just do the best..psychiatric case sometime are easy but sometime quiet hard expecially if the patient is not really cooperative and tell different story..ok goodluck!!

Rafidah Bt Khalid

Paeds
Prof fatimah(paeds), prof bee(medicine),dr aizura (O n g)
9 y.o/m/boy k/c/o ALL since 5 y.o
admitted for chemo 3rd cycle,2 months ago presented w bruising n fever.exclude everything n found out to be relapse.luckily just first relapse..dun hv enough time to clerk.First presentation,just neck swelling.no bleeding tendency,fever,low,loa..no cx related w neck swelling

question ask
1)dd for neck swelling (lymphoma,leukemia,tb,mumps) common is common.dun't mention rare things
2)how to diff lymphoma vs leukemia based hx,pe and ix (for lymphoma it takes time for patient to develop sx like infection,anemia,bleeding tendency unless it already infiltrate the bone marrow, ix : leukemia will hv high wcc,low platelet and low hb)
3)PE findings:normal except cvl, scar for BMA.dun forget check genitalia memorize tanner staging
4)investigations (start from blood count,pbf,dun forget ix for cx related to leukemia TLS,febrile neutropenia,LP if CNS infiltration)
5)dis patient got ALL,do u worry if neutrophil low in this patient?yes becoz neutropenic sepsis can lead to septic shock
6)mx; advise to patient about chemo s/e.name chemo regime(manage to remember vincristine hahaha),gv phase in chemo(all the induction,maintainance..but i dun't know d answer), s/e dexamethasone,how long chemo cycle(week or month or yr??) i just answer year dun know correct or not
7)show growth chart..then ringg..
remember:
practise BP measurement in paeds,urine dipstick n taking temperature,wt n ht..sounds simple but w/in 1 hr just can spend 5 min for these bedside..

<u>Siti Azyana</u>
psychiatry
Dr Hasanah (main,external, psy) Dr Mohazmi, Dr Thiha
Schizophrenia
23y/o, Single, Malay, Gentleman, unemployed coming for exam purpose

- Auditory Hallucination: since 3 years ago. multilple voices, non conversing, non commentary. no other hallucination
- no delusion
- loss of interest, speak slow
- Mood (only occur when he heard voices): low mood, difficult to sleep, reduce sleep, cannot perform task
- reduce weight intentionally
- suicidal thought. exclude mania, exclude head trauma. exclude thyroid sx
-parent divorce since 5 y/o. no significant family hx, no pmhx, no pshx
- LSCS, start walking at 2 year old, pass all major exam, diploma until 1 semester. Cannot perform in exam because of the voices.
-deny drugs, smoking, alcohol.
- describe himself as shy, quiet person.
-coping skill: share prob with parent, watch tv, shopping

-MSE: normal amout, reduce tone & rate
-cognitive fx: cant perform serial 7 test. forgot to ask back the 5 things :(
-Pe: tremor, tardive dyskinesia- mouth (at that time i forgot the appropriate term i just said the mouth is deviated haha)

Q: (since i forgot to ask back the 5 things) what is the test for immediate memory?A: The 5 things?? (No.. Have u ever heard digit span?) yes! (what is normal range that you can remember?) i said 5?? (ok..but should be in range right?) Sorry im not sure.
Q: what type of judgement that he had?
A: blurr... never heard of it so i just told her what i ask the pt. (ok.. there is personal n social judgement)
Q: What is ur diagnosis n discuss
A: Schizophrenia cuz hallucination, impaired social, negative sx: anhedonia diff: MDD cuz hav low mood, suicidal thought, sleep reduce
Q: other that that? how bout drug? A: He denied it. (ok.. but eventhough pt deny we should suspect) Ok. Q: what drugs can cause hallucination
A: Cannabis, amphetamineQ:What is mechanism of amphetamineA: sorry im not sure. i think related to dopamine. haha tembak.(from the book: release dopamine, norepinephrine and serotonin frm nerve ending)Q: what is the effect of amphetamine?A: elated mood (Then? what desired effect that people esp student want?) Wanted to say reduce sleep but not sure that time (so they can stay up right?) i replied yes!. Q: So what type of drug is amphetamine? (i made my face look confuse) as u know we can devide into hypnotic, stimulant ..A: yes it is stimulant!
Q: So how would u manage this patient?A: Ok biopsyhcosocial, bio, i would like to give atypical...
Q: she cut me. How bout investigation?A: oh sorry, FBC to exclude medical, RP, TFTQ; Why u want to do thyroid in asymptomatic pt?
A: i try to cover.. so i said because in PE I saw he had tremorQ: So what would u look for in thyroid examination?A: tremor, nail, exophthalmos,lid retraction, lid lag, thyroid mass, reflex (what other thing in hand?) sweaty palm (what kind of tremor?) fine tremor. Q: What is EPS?
A: my mind blank. i could only say tremor.. then she prompt me (Have u ever heard tardive dyskinesia) Yes!Q: what is tardive dyskinesia?A: blank again. the i said Im not sure but i think it is related to slow movement.Q: what other investigation?A; Drug screen test Q: what investigation for psycosocial.
A: blur.. but juz told her look if family is supportive, accept his condition or not..Q: have u ever heard express emotion?
A: NOQ: What medication would u like to give?A: atypical antipsychotic.
Q:This pt has weight gain previously, what medication would u like to give him?
A: ari..aripri... (she said Aripiprazole) Yes!Q: what is the mechanism? A: sorry im not sure. i only know there is one drug that has no weight gain/
Q: nevermind its ok. What is metabolic syndrome?
A: Obesity which can lead to dm and CVD. Which include high TG, low HDL, hypertension and impaired fasting plasma glucose (i saw dr mohazmi keep nodding his head)
Kringg... ok time finish already, u can go now..

Comment: Nice examiners :] for psy, hx, dont forget to exclude other dx and need to know effect of the medication. if unsure, juz tell the examiner and try your best to answer it! Good luck :]

Nurul Izzah Che Malek (obs)
no active complaint.... G1P2 at POG18... unsure of LMP.. x booking done... hx of fall 4 days ago... come 4 exam... Prof give scenario... pt come with PV bleed... cause? pp, abruptio, local trauma.. other quest same as Syamimi esp about PP...

Masri Ismail
mine...72 yrs old/I/lady kco poor control dm, hpt n BA. Current complaint...unresolve exacerbation bronchial asthma for 2 yr n half but worsen last 1 month. oso had past hx o gallstone, ovarian cyst, n bladder prolapse but all oready operated. pt oso depress with her current condition. so need to noe about control n severity of the asthma (Gina), side effect o medication, doc oso ask about dm, hpt. n ofkos need to noe 'bout ix n mx of asthma for this pt.

Hong Foo
60y/o malay elderly. Gouty arthritis. Ask everything about gout. No other complaints. The end. Good luck guys

Kaklia Alia Lia
Rectal ca. Hep B carrier. Mom died due to liver ca and brother also hep b carrier.Not operated yet. Cn feel the tumour on pr. But she told me she's not coming anymore for next2 day.

Nadeera Mustapha
surgery:prof ong,prof sanjiv,prof nik sherina n dr haireen(observer)

61/M/lady bckgrnd hx Hpt,asthma n hypercholesterol for 10yr..
newly dx R breast ca 5/12 admittd 1/52 ago for R MAC n currently D5 post op...
bsic hx of breast ca..asses risk for ca

Q(mostly by prof ong)-her risk for breast ca, if she was seen in clinic,what should be done
diff btween core needle biopsy n fnac,which one common(fnac cheap,faster result n larger sample)
can u dx based on biopsy alone..what finding u look..(of course la can..finding?don't know ==")
bedside:dscribe scar,type of drainage..how u know vacuum workg or not,did pt undergone axillary clearance not?how u know?(MAC was write done above scar..can't think ==")
what u look for post op cx:dvt n lymphodma
other pe?abdmen for hepatomgaly(met),lung(plueral effusn,asthma),findg for pleural effusion

back to room:adjuvant therapy u know..radio,chemo n tamoxifen..why radio?is it common to do chemo..
how long u gve tamoxifen?what u worry?(10yr..guessg..huhu..uterine ca risk)
staging of ca..

Ai Yun Loh
Med: Prof Wan (main examiner), Prof Saw, Prof BK Lim
Diagnosis: Ulcerative colitis
c/o: no active complain, come for regular F/U. since 2008, have history of alter bowel habit, diarrhea for 3 months, with passing of fresh blood (mix with stool) and mucus. Have abd pain, but no other I/O symptoms. With LOA and LOW. No oral ulcer. (I forgot to ask extraintestinal sign such as arthritis, erythema nodosum, dun forget that ya) so, diagnose by colonoscope at the end of 2008, f/u at hospital Port Dickson from 2008-2011. Multiple recurrence and taking prednisolone for control. Since 2011, transfer to ummc. Add on with azathioprine. Worsen presentation with anaemic symptoms and LOC. Admitted on Dec 2012, for one week due to recurrence and worsen of S&S. with add on of medication intusumab (can't rmb the exact spelling). Now, on remission, with no active complain.
With DM 2 years. No past surgical history. With family history of colon ca.
Question: what other history you want to ask? I said worry of mets sign if colon ca and ask for oral ulcer. but I think the answer he want is extraintestinal sign.
See patient: adb examination and check any peripheral neuropathy. With loss of vibration too. Do fundoscope ya!
Come back to room. If you see patient in A&E, complain abd pain, what you want to do? I say resus, ABC, history of I/O, any SOB (in case DKA), then abd examination (look for S&S of peritonitis such as generalised tenderness, tachycardiac, tachypnea, hypotension), ix include FBC (anemia), coagulation profile, RP (DM), ECG (DM), blood sugar and ABG (DKA), ultrasound of abd. After somehints, then I said X-ray of abd. (I forgot the simplest test, haha!) then they said look for? I said dilated bowel and air fluid level.
Then, how would you treat? I said prednisolone and azathoprine. Then he said start both together? I said no, after condition uncontrol, then add on. Since patient with DM and taking steroid, what you worry? I said cushing syndrome. Then after that only I said hyperglycemia. So what will you do? Start with insulin if uncontrol DM. do you know how to start? I said there are many regime to choose but I choose BD. What type? I said short and long acting insulin. Bell Ring!!

Rahmah Rambli
PCM - T2DM & gallstone
Examiners: Dr Mohazmi, Prof Alizan n external paeds

Hx: 39/M/lady with T2DM dx 6 years ago. hx started with GDM during 4th pregnancy, persists until now. non compliance to med at first but now compliance for the past 2 years. cx just blurring of vision. others are normal. Poorly controlled DM HbA1c 7.7% despite compliance to med, control the diet and doing exercise regularly. also had gallstone dx 7 months ago presented with RUQ pain. no cx of the gallstone, plan for op this coming june. works as a teacher.

Q mostly by Dr Mohazmi, sometimes Prof Alizan interrupt

Q: list cx of this pt. how u ask about autonomic neuropathy.
A: Sx of gastroparesis: vomiting, abd discomfort. postural hypotension-ask

whether pt experienced dizziness when changing posture such as sitting to standing
Q: does this pt experience hypoG? why is it impt?
A: bcoz it is an acute cx of DM n pt also taking dimiacron, a type of sulphonylureas that hv s/e of hypoG. (good)
Q: what are the concern n what pt expects from the doctor? (ask ICE)
Q: why do u think this pt's dm is poorly controlled despite controlling her diet n exercise?
A: bcoz of obesity (inc insulin resistant). not enough dosage. maybe pt hv underlying infection that causing stress to her body
Q: other causes? other type of stress?
A: working as a teacher will cause her to have lots of work and sometimes pt get stressed too
Dr Mohazmi: so that is called emotional stress. and it can leads to high glucose too.

Q (prof alizan): do u belive in that pt control her diet? how u want to confirm that she is telling the truth?
A: ask from her husband (prof agree). Other than that? i cannot answer. he give me a clue. 'diary'. so i try to explain as much as i can, pt hv to write the type of food, amount etc
Q (prof alizan): do u think pt is in denial? do u know the difference between denial n indifferent? when do u think pt will be in the acceptance phase? what are other stages do u know?
A: i think he wants the stages of grief that he always mention in his class. cannot answer this part.
Q (prof alizan): give me pathophy of cataract in DM pt. (I cannot answer)
Q: Enlightened me on pathophy of atherosclerosis pls? I mention about endothelial injury. he ask which layer. i said endothelium. he said no, basal membrane.
Q: Again, try to think pthophy of cataract formation pls. So i try to sell pathophy of peripheral neuropathy, sorbitol causing damage to nerve cell and increase nitric oxide causing vasoC, and he said that cataract also due to high sorbitol. now only i know..

Bedside:
- finding that i want to look for in cvs system.
- skin lesion that pt had & causes
- peripheral neuropathy
- finding expected in fundoscopy (dun forget to mention cataract on inspection)
- BP. standing and sitting.
- Urine

Q (prof alizan) : presentation of gallstone. cx of gallstone. he ask at diff site. at the gall bladder (cholocystitis), cbd (obstructive jaundice), cystic duct (pancreatitis)
Q: what investigation u want to do when this pt presented to u at the clinic.
A: fbc rp hba1c ecg lft all investigation needed basically

Malina Reffien
gynae : ovarian cancer

Nur Azierah Ahmad
Rheumatoid arthritis, lung fibrosis , DM, HPT,Hypercolestrolemia, TAHBSO, bilateral knee replacement
Examiner : Prof Phillip, Prof Subash, Prof Jamie
RA for 10 years.Lung fibrosis for 5 years.bilateral knee replacement d2 RA.currently experience back pain and hip pain.
Question 100% from Prof Phillip..(cannot remember all the questions)
1) how to diagnose RA
2) investigation
3) how do u know pt in flare or not? what are the signs u look for and what investigation u want to do?
4) Management- drugs
5) Why pt had DM?(related to her condition..d2 prednisolone)
6) If she need to undergo surgery for her hip pain, what are u worried about?
7) How to diagnose lung fibrosis?
The difference between pulmonary edema and lung fibrosis (PE)?
9) Why pt had hip and back pain?
10) What is spirometry?

Azlan Atan
65yo/M/F
discipline: medical/ortho
examiner: external(main)-prof iress?, prof azlina abbas and prof mary maret
k/c/o of Lung Cancer stage 3 was came for exam purposes
accidentally finding during pre op assessment of spinal fusion surgery 2006 (lesion in lung/liver/bone) currently on iressa(gefitinib)
also hv hypertension and IHD with 2 stents done in IJN currently on Bisoprolol, norvasc(amlodipine) and 1 more drug(forgotten)

i'm not sure to focus which side either lung cancer or ortho(spine) as she got regular follow up in chest clinic(under prof Liam n Dr chua) and spine clinic(under dr chris and prof kwan). she was unsure about Doc's name that called her. but i'm sure that doc is not from ortho so i focused more on the lung cancer.

In the room:
Q: give me the sticky,please present your case:
A- present HOPI and he ask more on the lung cancer and spinal problem. external seems agitated to know the history, so many interuptions lah. haha.. only present PMH and HOPI

PE:
Q: show us what you want to show.
A: this patient is elderly pt, obese type 1 as i'm calculated her BMI just now(33), not in respiratory distress and not in pain. i want show him the spine- spinal fusion scar.
Q: what hv you found in the lung?
A: err.. consolidation at the left upper lobe region without any pleural effusion. then confirm it again.
Q: check lower limb- weakness? reflexes?
A: show him on the weakness and absent ankle reflexes.

Q: what level do suspect?
A: L5/S1 prof?
Q: okay.lets go the room. thank you makcik.

In the room:
Q: please summarize your findings
Q: If patient with lung cancer come to you with acute onset of lower back pain, what will you think?
A: i wil think on metastatic bone lesion.
Q: besides pain? what else you want to ask?
A: weakness of the lower limb.
Q:what else?
A: urinary bowel incontinence.
Then we talk about investigations include the bone scan(hotspot), nerve conductive study, MRI and CT. then need to interpret xray lumbosacral- got spinal fusion of L3-S1 region.
then management of mets bone lesion. guided him to ask me about hypercalcaemia treatment but he don want it haha. then talk about multidisciplinary approach-physio, oncologist etc.

tips- prof azlina and mary maret very nice. they only ask few questions but always nodded vigorously when i gv correct answer. external prof not really giving encouragement. only smile if we gv correct ans. in general, all examiner very nice and you just present what you got. otherwise, be confident when you answer questions. tembak je kadang2 haha.. see their response.
May Allah pass we all together! gud luck for those yang Long case tomorrow. pray for our success together guys. be humble but confident!

Nadhra Rifangei
discipline : medicine (same case w sik thien)
examiner : prof bee, prof fatimah, dr aizura
56yo/indian muslim/lady
k/c/o asthma?, dm, gastritis, dextrocardia mainly come for exam purposes, currently no active complains.. (actually pt is having worsening of asthma sx since 5-6 months ago together with copius sputum)
at first i thot PCM case bcos so many comorbids, dengan ENT f-ups, etc.. sampai xsempat to do full PE
during the exam, examiners mainly ask about differential diagnoses other than asthma.. i said interstitial lung disease, bronchiectasis, etc.. but they probably wanna hear kartagener syndrome kot b'cos pt had lung patho n well as dextrocardia. common questions like pathophysio of finger clubbing (this pt had clubbing only on 2 FINGERS), stages of clubbing, how do lung exam, if cannot palpate apex beat how to confirm dextrocardia, interpret the CXR, asthma control, asthma severity, how to know severity of asthma from auscultation, 1 ix for dm control (ie HbA1c n its value).. that's all.. most of the time used to discussed the differentials n PE findings.. huhu.. xsampai mx pon..

Firdaus Hariri
Aliff 5y/o

Down syndrome with PDA, ASD, hypothyroidism, asthma, recurrent pneumonia
Examiner: prof raja amin, ext & datin sharmilla

Some of the questions:
1.pathophysio of ASD
2.pathophysio of VSD
3.cause of hypothyrodism in down syndrome + test + tx
4.cause of cyanosis in down
5.cause if pulmonary hypertension in down
6. Murmur in ASD
7. Routine/compulsory screening/test in down
8. Test to perform antenatally
9. Asthma status
10. P/E - features of down
11. P/E- Precordium assessment
12. P/E- Respi examination
13. Risk of getting Down baby
14. Chromosomal screening
15. Multidisciplinary management
16. Other possible condition from patient's symptoms (constipation - duod atresia)
17. Breaking bad news
18. Activities of KIWANI
19. Parents coping skills & other family issue
20. Management of ASD and PDA

Parents/patient/examiners - supernice.

All the best for the remaining days.

Lam Shu Ping
Case: Osteoarthritis
Examiners: Prof. Saw LB, Prof Wan(CVS), Prof BK Lim
Hx: 67/C/woman, with no active complain, with b/g hx of hypertension for 20 years, hypercholestrolemia for 10 years, had experienced left and right knee mechanical pain for the past 8 years.
It was preceded with varus deformity on both knee but nt symptomatic. The pain was aggravated by prolong walking~20min, relieved by rest and analgesic. she had stiffness when wake up from the bed and after prolong resting. Over the past 8 years, the pain and the varus deformity worsened. but no joint sweeling. she has no intention to seek medical consultation, until 4 years later, she was admitted to a&e because of overdose of anti-hypertensive drug and presented with dizziness. at the same time, she was found to have uterine prolapse and knee varus deformity, therefore refer to o&g and ortho. Regarding uterine prolapse, she had bleeding when pu and bo, but she was nt anemic. anterior colporaphy? done.no cx after op. ortho advised her on total knee replacement(TKR), but patient refuse since she still can walk and had financial difficulty. over time, the sx get worse and limit her walking, currently depend on walking frame. TKR was planned on 22/4/2013.
No pain and deformity over other joint. no rashes. no hx of trauma. no

constitutional sx. not ass w fever.
She had 3 mthly follow up for her hypertension and knee OA. claimed she was compliance to medication. bp monitoring range 120-170/? mmHg. no cx except had cataract surgery twice and currently have left eye visual blurring. Cholestrol level is under control.and she taking simvastatin.
No fhx of bone ds, malignancy, autoI ds. mom had kidney ds. father had hpt.

Question: (main examiner: Prof. Saw LB)
1. why want to ask for other joint pain and deformity? i ans to exclude RA which involve hand joints.
2. what other diff dx? gouty arthritis, PA.
3. where gouty arthritis affect?
4. citeria of RA.
bedside: examine the patient. so, show him full set of knee examination.
+ve findings: varus deformity, crepitation, patellar grinding +ve, tenderness on palpation over all the bony prominence. limited knee mtion, including asked to show pt cnt squat. then i said pt's house is equipped w sitting toilet..haha...prof bk lim nodded his head.
No muscle wasting, skin and temperature changes and all special test -ve.
Prof Wan asked what is d BP? luckily i measured: 168/90 mmHg.
* P/E had consume a lot of time.
back to room:
1. what invs u want to order to confirm since u have convince that she has OA from ur examination. Ans: AP and lateral X-ray of both knee.
2. intrepret the X-ray. show him all the OA findings.
3. how subchondral cyst appeared on x-ray? radiolucent.
4. how u differentiate it from RA?
5. what s d risk of TKR? percentage of infx?
6. u r a HO, what u want to do when pt come to u as she had planned for TKR? pre-op assessment.......
Bell rang!!!
Good luck!

<u>Suraya Faziella</u>
case:37/m/lady DM type1(this hx only take too long to present) with end stage renal failure now using CAPD n many more too much of dm complications,HPT, RVD +ve complicated with possible cerebral infection, pt was on epilim since a month ago. too malas to type cuz hx sooo long , just know bout all stuff bout DM,the complications,mx, CKD management,RVD tx n complications, n anatomy of dorsalis pedis which i screwed up just now about where it goes specifically after 1st n 2nd base of MTP jt (mental block). clerk super super fast n PE only mx to do lower limb but didnt open up the bandage just now...biggest concern:my PE!!

<u>Amirul Amzar</u>
examiner: Prof KS Tan (attacker), Prof wilson (external), Prof Saw Lim Beng
Mr subramaniam 53yo Indian gentleman with DM for 3 years and now have some renal impairment. Prev MVA with craniectomy but no neurological sequelae.
Question asked basically all the CPG of DM, the target, the advise, the footcare, the medication, the investigation for the complication
PE was asked to show positive finding, show loss of vibration sense and some jerk reflex. Also palpate the pulses.

talhah
medicine (acromegaly) -- external medicine erle lim (NUS), prof hussien and dr khaidir
HOPI: accidental finding acromegaly features..big hands and feet..speech difficulty due to big tongue, have DM.. no other features eg bitemporal hemianopia, screen for other pituitary hormones..done surgery transphenoidal...
Full Hx of DM...control, f/up, complications etc no HPT
FHx x significant
Social Hx..
PE: show positive signs..prognatism, maxillary widening and frontal protuberance
big nose, ears, hands, feet
abdomen for insulin injection sites
what else? what other signs you want to show me?? dunno..already blurr..check for skin tag
clinically how do you know acromegaly is active? er...dunno
Q: mostly interrupt during history...answer accordingly
how to diagnose acromegaly? serum GH, IGF features of acromegaly..what else? very simple test, if you don.t know it's ok..immediately say dunno, ans: OGTT..lol
this patient have surgery done to remove some pituitary gland, what kind of surgery that you know? transphenoidal..other? dunno...cribiform plate
what hormones are vital for survival? ACTH
since this patient had surgery, what you want to monitor? serum ADH
some other Q..don't remember..
gudluck

kimwei
medicine(myasternia gravis)---prof CT tan, dr choo, prof shaharul
Hist:31yo lady, just came to clinic for follow up after having an crisis 2 weeks ago.
presented 3 years ago starting with slurred speech... then dysphagia.... then facial weakness...then UL and LL weakness...
so in the mean time trying to rule out other causes.and ask other dx associate with MG
had thymomectomy done one year later.the control of disease was not good as having 4-5 attack per year. similar presentation.however no nid intubation.
compliance to f/up n tx.
however there is some complication of steroid tx- cushings...
PE: demonstrate all the signs of MG,patients has got bilateral partial ptosis, facial weakness, diplopia, prox muscle weakness, nasal speech, fatigability
Q asked: Onli prof tan asks Q, others r just staring at me all the time. alot Q asked during history and PE(hard to write down everything as depends on how u presents, below r asked during Discussion
-wat r the differential and y u said so? some Q on how the differential presents?
-how many MG have u seen
-Do u think this is the typical presentation of MG
-As a houseman, wat symptom will alarm u tat the condition is getting worse?
-asked drugs: how pyrigdostigmine, prednisolone, azathioprine worked in

MG
-pathophysiology of MG(in great details)
-classify MG----2 types--got thymus enlarge or not,
-----if thymus enlarge(seronegaitve)---thymomectomy
-----if thymus not enlarge(seropositive)--then divide into ocular(2 years after MG stillonli affect ocular) or generalised(spread to facial,prox muscle, respi...)---Management is different, go n read urself
-how IVIG worked during crisis
-why nid thymomectomy--control the dx and risk of thymoma
-lastly, prof ask other got Q or not but i think they are tired already after so many cases so just let me go.
**always cover good social hist, a bit of depression hist, ICE Question, functional hist
**Remember this a game for a person to show him or her off, so when the lecturer ask u a Q, answer confidently, trying not to pause(even though everyone is nervous,but be calm), AND answer more than needed if can to lead the examiner to the area that u know the best. so u can predict the next coming Q, and shoot the stars down..haha...gd luck

Medicine. Prof Tan (geriatric), prof Alizan, prof hatim
Nurquiah 24y/o malay lady, first time came for exam
cc-Came for exam purpose
HbE Thal Beta intermedia
Diagnosed since 6y/o after episode of abdo pain—referred to hosp
Both of parents and 2 older siblings also undergo same test as her
Mother- thal B carrier
Father-Hb A? or HbE? She said HbA at first, then change her answer to HbE
BOTH of siblings also carrier, while she has both of her parents genotype- thus HbE
Multiple blood transfusion because of low hb-every month
Then only need blood transfusion if Hb fall below 7. usually pre blood transfusion is also below 7 -dt the splenomegaly . post transfusion:
14-15, usually 2-3 packs transfused at once, which stands for couple of months
before she needed to be transfused again
Splenectomy when she was 14y/0
Started desferrioxamine about 11 month before the splenectomy .5x/week injection, with vit.c and folic acid supplement.
Compliance to med and f/up
Was given immunization prior to splenectomy-donno how much, donno what
She started on thyroxine after that, and couple of years later started on oral aspirin dt high platelet count
Undergo laparoscopic cholecystectomy couple of years ago for cholelithiasis
No specific advice from doc that she remember—dt this open ended Q, I missed and forgot all the detail social history eg lifestyle modification and diet, that prof
alizan very much like to ask. prof
hatim only asked psychological part - patient depress or not,

I was so nervous, forgot to asked that too . her history also quite long
because since childhood, with multiple admission last year, she slowly gave
her
answer, which wasted lots of time too . after 30min of asking and squeezing
PMH,
with her changing her answer multiple time T_T), then only she took her thal
book from her bag (I have no idea patient can bring bag into exam haha,
even
hp! I can just ask her to pls google about HbE for me- which I did not hv the
time :P) ,it was one of the reason I was so nervous, cant remember what HbE
was
, I heard of HbH disease, Hb Christmas, but cant seemed to remember HbE . I
thought prof will ask detail about it, but none of them actually did)
So…pls look around and asked whether they bring their f/up
book, that would so much save the time.
Multiple admission last year dt tonsillitis, ear infxn, and
PUO which was found later dt left renal abscess
Father has passed away dt multiple medical problem- IHD,
HPT, stroke
Mother is a housewife
Lives with family at PJ
Admin at insurance company, diploma in insurance
Normal academic achievement
Diet history- no specific restriction
Not married, no bf
Prof alizan really wanted detailed social and diet history,
include detail about bf T_T, so pls do remember about them . I did realized I
miss something in the history, and only remember when prof remind me L

After hx presentation-straight to the patient
Height, weight-normal. no classic sign of thal major
Mild palmar and conjunctival pallor. No scleral jaundice
Multiple scar on abdomen- 4 lap cholecystectomy scar, 1
splenectomy scar (transverse on the left upper abdo region, multiple
hyperpigmented scar dt desferrioxamine injxn, and one small scar from
percutaneous drainage of Left renal abscess at the left back
Liver enlarged 3-4 finger breadth below the right subcostal
margin .- firm, smooth surface, well define margin-liver shape, dull on
percussion
Other examination u want to do? No L - I should ballot for
kidney and tell want to complete examination by checking BP, as this patient
had history of renal abscess. But they didn't ask anything about the renal
abscess anyway

Then back to room
Prof alizan : why do u think this patient has multiple
admission last year?
Me: I think it was dt the thyroxine that causes
agranulocytosis (ter-mix thyroxine with antithyroid arghhhhhhh nervous sgt
benda yg dah lama tau pun boleh jadi terbalik haih3)
All prof: no no, not because of that
Prof alizan: patiet has undergo splenectomy, so?
Me: becoz of the splenectomy (haha waaaaaa freak2)

Prof alizan: what is the function of the spleen?
Me: to….filter the blood L (Huhu), immunity, and
extramedullary haematopoiesis (which
was so hard for me to remember the word 'extramedullary'
waaaaaaaaaaaaaaa, both prof tan and alizan look weird at me trying to recall that word , help pls? huhu)
Prof alizan: spleen
has so many function u know?
so what do u think
about the affinity of oxygen in thalssemia patient compare to normal person?
Me: they have low affinity becoz the RBC tend to hemolysed—wrong!
prof tried to gave me hint about the answer- which I remember back - actually high affinity
prof tan: so how do u manage this patient?
Me: screening on f/up for the complication of thalassemia
which include endocrinopathies dt hypopituitarism- which can cause thyroid problem which patient already has- TFT on
f/up. other than that is hypogonadism , but patient already attained menarche
at 15y/o
Liver function test at least 2x yearly, dt iron deposition
which can lead to CLD
Echo for cardiomyopahty- at least yearly.
Blood glucose screening for secondary DM dt iron deposition
For non pharmacological mx- advice patient on reduce the
intake of high iron food such as meat and spinach vege. Then compliance to tx,
eat the vit.c folic acid, and increase intake of tea as it can help to excrete the excess iron.
Prof alizan : but u didn't ask all that to patient right?!
Me : L sorry prof, I really forgot.
Prof alizan: what do they give before splenectomy?
Me: they gave immunization such as pneumococcal vaccine . Im
sorry I can only remember that (HUHUUUUUU- So many other maaaaa. Im sorry la I
didn't have so much time, I didn't even had study week L)

Should have said about the screening for desferral side
effect, but patient only has local skin side effect, and no abnormality on funduscopy. forgot to say…haih . should
also say support grp and all that (I
think , kinda miss on the free marks here and there arghhh)
Prof tan: why patient given aspirin again?
Me: because of the high platelet count
Prof alizan: so what if high platelet count?
Me: risk of thrombosis, stroke
Prof tan: what happen when there's splenomegaly?
Me: it causes hypersplenism lead to pancytopenia
Prof alizan kind of trick me later ….about the pancytopenia,
he ask what blood component which reduce in splenomegaly . all can be reduce

la, I already answer earlier, donno what he want. Pening2
Prof tan: if patient want to get married, what is your
advice?
Me: I will refer her to genetician
All prof: hahahahaha –LOL
honestly I don't think its funny at all, donno why they
laugh so hard ….=.=
Prof alizan : no, no . u are the consultant, so what do u
want to advice the patient
Me: I will advice patient to bring her bf/future husband for
thal screening because if her bf has thal too then their future children
will be at risk of having thal major, and possibly hydrops fetalis, eyh no no,
not hydrops, only thal major and carrier (=.– aiya)
Prof alizan : eyh? No hydrops?
Me : because hydrops is dt thal alpha major
Prof alizan : still can (cant remember actuly what he told
me, but I donno the answer though)
They did ask how many can be carrier and some other, cant
remember the detail of Q
I just answer all of them can be carrier, with at least one
thal major.

Then, if u scared that future husband will run away if u
consult him, what will u do? This is very sensitive issue u know ?
Me: :refer to
genetician ….:(
Prof alizan : yessssssss
Me : * T_T wasn't that my first answer huhu, I am so
confused *

Prof tan ask final Q, cant remember what was it. Then loceng
berbunyi. Annoying bell!
Prof alizan : kenapa nervous sgt ni?
Me : L dont know. Im sorry huhu
Prof hatim was silent most of the time . they actuly make
lots of facial expression which made me more nervous. I thought they
shouldn't
make any facial expression in exam?
I think I was so nervous because I think they would ask
about HbE detail, because that the usual in the past years if thal case. And
also both prof alizan and prof tan has taken me for class before and I have
tendency to be nervous with prof that know me, rather than prof that doesn't
know me at all (so they don't remember my weakness :P)
What I thought was true, because prof alizan did remember
about my VP with him (his memory very good one , that was like more than
1
year ago) which was change to other student because I was not well and he
doesn't
like my video , duh, huh . I came and I tried at least even though I was not
well.
And with prof tan, I did posted to geriatric ward couple of
time, and she did realized I was not well most of the time (almost pengsan
in

one of her wr before, malu2), and even though I performed well during sc she
always comment why I seemed not interested eventhough I got all the sign correct, coincidentally all was when I had fever, should I fake happiness or smile when
I feverish? No cannot , sorry L deng

Honestly I cannot control my nervous-ness. But I tried my
best to hide it . but all of them
realized it though :P
Additional Advice: don't drink too much coffee during exam ,
prepare early, take care of your health- don't try to diagnose urself okay! and
always make good impression to your lecturer on every class. For those who have
problem with beng nervous in exam, to me practice is not enough, because I practice more but somehow I became so much nervous T_T, so pray a lot lah, I've
heard people took drug to avoid palpitation, anxiety and all,
I don't believe in drug though, u got to find other way .
one of it is to practice and revise the step everyday in your head (Prof sargunan advice).

I got simple sc- thyroid surgery (donno the doctor name), oblique lie with dr sofiah, and paeds thallassemia with prof fatimah. all was nice. another one was prof imran, which smile and say 'Good2!' all the time, even though I think i can do so much better if i wasnt nervous
good luck to the juniors!

<u>Ming Song/same case with Adam</u>
PCM DM Ortho Prof Vivek, External Paeds Prof Ng Pak Cheung, PCM Dr Liew Su May

DM 20 years, presented with blurring of vision. Further questioning he had polyuria, polydipsia, lethargy too. Blood Ix done however pt cant rmb the glucose level, then start on daonil. Since then DM uncontrolled, increasing in Med dosage & change Med. This is because he not on diet control, no exercise, missed med etc. Currently on insulin injection atrapid 20U BD, insulatard 20U ON. Perindopril start 2 years ago, pt claimed that dr said is for thinning of blood but i think he had microalbuminea (act pantai to inform the examiners.. haha). He also started on simvastation 1 years ago d2 hypercholesterolemia (he not sure his lipid profile). Currently, for the control, he claimed to had diet control (breakfast: nasi goreng, mee goreng, milo etc; lunch & dinner rice, vege, fish, meat, no fried meat, mostly soup). He no doing any exercise. He measure his blood glucose 1/week with glucometer at home, ranging from 8-10 mmol/L. Last follow up on Jan, f/up every 4 months at RUKA. For compliance, he claimed compliance to med, but will missed 3-4x/years. Complications, no macrovascular such IHD, stroke,

intermittend claudication, microvascular, + peripheral neuropathy, + nephropathy, no retinopathy. Had hypoglycemic attacks 3-4x/years, felt shivering & take small food, glucose that time is 3-4mmol/L, no fall due to hypo & reason for it is becoz he missed the food. No hyperglycemia such as polyuria, polydipsia, weight loss, lethergy etc however having nocturia 2-3x/day but not everyday. No hospital admission d2 DKA/HHS. Having bil cataract surgery 10 years ago. Currently R eye VA is (6/6), L eye VA (CF). Yearly opthalmo f/up, claimed no problem for retinopathy.
During presentation, they keep interrupt me to, i think they want it faster.. haha.. luckily what they want i got ask in history..

Bedside PE: show me peripheral neuropahty
Me: inspection, multiple hyperpigmented lesion over bil LL (diabetic dermopathy), no ulcer, no fungal infection btw the web-space, there is autonomic neuropahty evidence by loss of hair & dryness. there is charcoat join over his left LL (actually is over medial foot arch @@)..
palpation, no pain, increase warmthness all over his LL compare to other part of body (after prompt by dr liew how is the temperature of LL, but not sure correct or not). then i offer to do vibration (prof vivek ask izit correct tuning fork.. i said yes 128, he seem dun agree). vibration loss only at anterior forefoot. then do the pin prick sensory loss over the anterior forefoot only. i said shud use cottom, more accurate @@ feel for peripheral pulses. then prof vivek ask me examine charcoat joint @@.
rmb compare with normal side before doing vibration (becoz i forgot it).

Q: actually in btw got lots of question ask me to clarify my mistake.. :)
1) Diagnosis? DM complicated with peripheral neuropathy, nephropathy and hypercholesterolemia
2) Ix. FBS & HbA1c
3) Then, gv me the result to interpret.
4) How to manage him?
4) How is his control? i said good, but the answer is NO GOOD CONTROL.
5) Normal glucose values. FBS <7, RBS <11.1, HbA1c <6.5
6) Senario pt on insulatard at night, actrapid morning & dinner. how u advice him?
must take insulatard at night. increase actrapid dose if eat more food, decrease if less food
6) Risk factor? I forgot to ask smoking.. haiz.. ACS & stroke
7) How u ask about proteinuria in history? frothy urine
8) How u ix proteinuria? 24 hr protein collection
9) How is his diet control? No good. Why? He drink milo, nasi goreng, mee goreng etc
10) How u advice on diet? low sugar food. What grp? carbohydrate. What type? Low glycemic index. Exp? brown rice.. riinnnngggggggg
TOO many small small questions d2 my mistake, but cant rmb all.. good luck everyone, dun be nervous & said out something wrong in exam :)

<u>Josephine Tiong</u>
Examiners : Prof Hussein (Main), Prof Chee (cardio), Prof BK Yong (Surgery)
Psy case
39 y/o Chinese single man, Marketing and Sales associate director, electively came in

History in chronological order:
2003-2004 (4-6 months) : Quitted his job in taxation company and set up his own trading business in souvenirs. All the symptoms of mania (patient told me he had no sex before or girlfriend before as he felt that marriage is not priority in life and he plays passive role, but another candidate got the sexual history). He was out of control and spent excessively (eg. Bought four cars costed him more than RM400000). Failed his business.
Went for interview, incidental finding on X-ray with ingrown thyroid so failed to get the job. Did not go for follow up for his thyroid condition. No symptoms of hyper or hypothyroidism.
2005 – Excessive spending and debts caused his family had financial problem. Got depressed and locked himself in house for a year. Basically all the symptoms of MDD with suicidal thoughts but not plan and action.
2006- Managed to get a job as salesjob selling baby products. Performed well and got promoted in 6 months time with increment of salary twice the initial amount. Maniac phase again and started to invest in a lot of business which caused him to neglect his current job. Asked to resign and stayed at home for 1-2 months. Brought by maternal uncle to clinic and found out to be talked and manic, advised to be admitted but refused. Admitted after physically and chemically restrained for 3 weeks. Discharged and on 3 monthly follow up. On lamotrigine with no s/e then changed to Epilim till now. Currently 4 monthly follow up and no s/e of epilim. ECT done once but couldn't remember when.
Parents divorced at age of 18. Childhood hx normal developmental milestone. Naughty and disobedient in school, but very good results. Ambitious since young to own a lot of business and earned a lot of money. No drug, no sex, no alcohol. Smoked 3-5 sticks per day since Form3, stopped in between the years and currently no intention to stop. Premorbidly normal. I presented vital sign halfway then Prof Hussein stopped me, shouldn't you present the mental state. So I presented the mental state and only brief PE which is nothing significant.PE and mental state all normal. Good insight

1) Prof : Could predisposing factor occurred earlier?
J: Yes, during childhood time. Performed well and had high ambitions. Maybe got undetected.
2) Prof :How bout ppt factor?
J : Parents divorced at the age of 18.
3) Prof :Why parents divorce? Who take care of family then?
J :Dad has another wife and now live in Muar with another son. Mum is the breadwinner and currently worked as HR Manager.
4) (When I was presenting mental state) Prof :What is mood and what is affect?
I gave the full definition (Prof had no responded. Prof BK Yong just woke up)
5) Prof :You know, in manic phase, we had some terms for it.
J : Erm, elevated mood
Prof : No, there are three terms to describe mood in manic phase. Heard of euphoric and elated.
I just nodded.
Prof : Tell me what are them.
(I cant define at all). J : errr….euphoric can be found in both mania and hypomania but elated found in manic. (Prof has no respond)
6) Justify his management that he is on Epilim now.

J: Yeah, he had no s/e from taking the medication and he is compliance to it.
Prof : What other medication do we use?
J: Lithium
Prof : Why we don’t give to his patient?
J: He was found incidentally to have thyroid condition but history and physical examination wise showed that he was euthyroid. But I would to check blood TFT before giving him lithium to prevent thyrotoxicosis.
Prof : You sure?
J: Eh, sorry. It’s reversible hypothyroidism (Prof nodded. Feel like slapping myself for giving stupid answer)
7) Prof :What is so important about lithium
J : Narrow therapeutic index
Prof : Dosage?
J : 0.8 – 1.2 (Prof mentioned good)
8) What advice to give to patient if he used lithium?
J : Erm, he had no renal impairment.
Prof : What else?
J : Make sure he was not dehydrated. (Prof said ok). And also no other co-morbidity which require him to take diuretics that will further increase lithium concentration.
Prof: What you can check to see?
J: Blood lithium (He just nodded)
9) Prof : What you need to do before you give lithium?
J : TFT, Renal profile and ECG to look at the heart function
10) Prof : Now, what is your final say for this patient
J : Erm, bipolar disorder currently in remission with good insight and complicance to medication. (KRRRIING halfway when I gave the answer).
Prof Chee and Prof Hussein just nodded and said thank you, I said thank you. I don’t know why they said thank you. Prof BK Yong just nodded with me with sleepy eyes.
Time management very important. Psy case history really long. Get everything as much as you can. Not sure if I can make it. It’s over dy. Good luck to the rest! =)

Adam PCM DMProf Vivek, External, PCM (Dr Chiew/Siew i forgot)

Case: Pensioner customs officerDiabetes mellitus for 20 years. Complicated by Charcot's foot, peripheral neuropathy, hypertension, dyslipidaemia. Presented with progressive blurring of vision, DM was diagnosed incidentally. No heart failure, renal failure, no stroke, no heart disease, no orthopnoea, pnd, no ulcers no amputation, no oedema, but has erectile dysfunction. On meds and stuff, basically typical DM patient.I think they like when you ask for compliance, events of hypo and hyper, patient insight, knowledge about disease.

PE : Swelling over left foot and ankle, lipodermatosclerosis, dry skin, no fungal in interdigital space, pulses present, perheral neuropathy up to ankle, proprioceptoion and vibration loss.

Questions. Give investigations (Lipids and HBA1C) comment. Do you think control is good? Why? Name all the complications of DM macro, micro. Manage, patient see's you in clinic what do you want to do? Begin non-pharmaco then pharmaco. Why risk factors important? Risk of stroke,

ACS.Bedside. Examine lower limb. Look neuropathy and vasculopathy. What other investigations? Neuro - microfilament, vibration (coss i didnt do) Vascular - (Peripheral pulses, Ankle brachial index, SPO2, Toe BP cuff thing)External ask 2 questions - Is his control good? How are you going to manage? at the end. Didn't have time to answer

Syamimi
Examiners: Prof Jamiyah, Prof CK Liam, Prof Subash, Dr Sharmila
Case: Placenta praevia with previous c-section
24yo chinese lady G3P2 @ 31 WOG
no active complaint, history of low-lying placenta detected during antenatal f/up @ 30 WOG. Unplanned pregnancy, unaware of LMP due to breast feeding her 2nd child. Pregnancy confirmed by UPT and US, both done @ 16 WOG due to quickening. Had GCT done @ 20 WOG (normal result). Otherwise, no further OGTT done, BP normal throughout pregnancy, no PV bleeding and no other complaints. Previous hx of 1 emergency c-section due to fetal distress, no significant gynae hx, PMhx, PShx (other than c-section).

Qs: All by Prof Jamiyah
Differences between POA and POG?
How breastfeeding prevent pregnancy...pathophysiology?
Give 3 obs problems in this patient- PP, previous c-section and unsure of date
What is GCT????- answer la all about GCT (glucose challenge test)
How anemia related to pregnancy?(as i mentioned about anemia in hx).....normal value Hb in pregnant women?...what reference do u use???
What r the the things u look for in US? mentioned for every trimester
What is APH?(but this patient doesnt hv)....causes?
Bedside: Do abdominal examination.....show me how u palpate for poles
Lets say this patient had classic c-section...how to check for tenderness of scar?(answer-palpate uterus)....where?
Point to me where do you put fetoscope?

Other Qs:
What ix need to be done?
Diagnosis if US showed placenta reached os?- PP type 2
If patient come again 2weeks later....what u want to do?- admit, follow Mcfee regime
@38 weeks what is ur mx?- delivery by c-section
Lastly, cx of PP....
Pang Suan Choo
Examiners : Prof Raja Amin, Prof KL Goh, Prof Cheah(pcm)
Case : Newly diagnosed eso CA
Brief History : 78 years old, I, lady
haematemesis x5days
early satiety, dysphagia, LOA, LOW, anaemia
no other associated symptoms, no risk factor, no metastatic symptoms
DM, HPT, high cholesterol

P/E :
Prof Raja Amin asked to assess ptt's hydration status and nutrition status in front of him
Prof Goh : relevant findings. I asw check for signs of palor, look for mass at

epigastric, supraclavicular lymph n PR examination showed no malaenic stool.
Prof Goh : what type of anaemia do u expect in this ptt (i asw if ptt IDA if chronic bleed, normochromic normocytic in malignancy; but prof say dont expect normochromic and normocytic anaemia in GI malignancy)

Discussion :
1) Provisional Diagnosis
2) Diagnostic inv (OGDS+biopsy)
3) Further inv (endoscopic ultrasound, CT TAP, PET scan for staging purpose)
4) How do you assess ptt's nutrition status? (P/E(...) and investigation (transferrin and albumin level)
5)Acute mx for this ptt
6)Pre-op assessment
6)Prof Amin give an example of inv results n asked me to stage the ptt
7)Prof Amin asked if EF is 45%, ptt has met to supra LN, is she suitable for op?
8)After considering all factors, Ptt not suitable for op, refer palliative care
9) Prof Goh asked abt the components of palliative care
10) Prof Amin : What is the content of TPN?
11) If ptt is operable, what type of operation do u know?
12) Complication of the surgery mentioned

sook lin (PSY)/same case with AFIQ LATIF
examiner: prof wm n(ortho) prof lee way seah external malay d
all questions from external
case: anxiety
53yrs old chinese gentleman, known case of psy illness follow up yearly
30 years ago, presented with headache, diziness, frequent multiple visits to GP, referred ummc agter 6 months, was then on follow up under psy. 10 years later, developed palpitation and shortness of breath..(ask stimulus, duration to reach peak, functional impairment..follow criterias) easily irritable(describe further) . no mood symptoms, no psychotic symptoms, no trauma, no fitting, no substance, one previous suicidal ideation due to family conflict. frequent changes in work (longest lasted 10 years as cannot perform well. SVD delivery, uneventful, think that father dont like him because will only punish him what small matter since birth of his sister. average student, frequent play truant, quit by form 4. DM diagnosed 10 years ago. currently on lexapro (escitalopram) mental status examination. (follow the psy clerking sheet)
no bedside examination.

questions
1) pt with above symtoms, what other psy problem u think of? (agorophobia)
2) pt with frequent play truant, what suspected psy illness? (conduct disorder)
3) any significant family history? (no psy only DM HPT)
4) y u think patient need to change work frequently?
5) provisional diagnosis
6) what medical illness u can think of tieh this presentation? (she want phaechromocytoma)

7) what substance can give above symptoms?(cocaine?) is coccine available in malaysia ? (no idea)
8) what is normal value for digit span? (7 plus 2 minus 2)
9) how to manage pt when in first presentation? investigation ? biopsychosocial
10) what medication to give if not SSRI ? (benzodiazepine) how to give? (low dose, short term, long half life) in this case should give prn..
11) short term and long term benzodiazepine which one cause more addiction?
12) if pt refused antidepressant and anxiolytic, other medication? (propanolol)
13) what is the difference of graded desensitization and flooding?
14) diffenrence of tolerance and withdrawal?
Afiq- the same question been asked...remember to hve a thorough MSE, external asked a detail of it...good luck!!! =)

Haw Chiew Yen
Examiners : Prof christopher Boey, 2 externals
Case : 31yo I lady, G2P1, 21 weeks + 4 days POG, no active CC
PObsHx : poor spacing with 1 delivery in feb 2012.
pre-term @36weeks 1.6kg emergency LSCS
threatened abortion @8POG
defaulted F/u from her 24to34weeks POG, walk in @35POG due to generalised body swelling, epigastric pain & intermittent headache.
Proteinuria 2+ (dipstick) but normal BP
completed DEXA and discharge home
36POG - spontaneous PPROM -->emergency LSCS
PMH : childhood bronchial asthma (but not exacerbated by pregnancy)
PE-BP normal, dipstick protein trace, striae gravidarum, caesar scar,pinard
question :
1) tell the risk in patient's current pregnancy.(bronchail asthma, previous 1scar,
preterm delivery)
2)wat is the causes of preterm labour in prev pregnancy?
3)how to diagnose pre-eclampsia?
4)PE-tell the 2 types of striae gravidarum
what is the difference btw dilated veins and superficial viasible veins?
(dilated - pathology) (superficial - pathology/physiological)
describe the scar - hypertrophy/keloid
5)what is the mx plan in this patient?
F/u 4 weekly, check BP and do MGTT @ 24 POG. ask pt to perform dipstick &
BP check at home. Then discuss with the patient about delivery plan. SVD is opted bcz only one prev scar
6)do u think patient can go for SVD since she had poor spacing & the scar was jz
there one year ago?...
7)patient had one prev preterm delivery, do u give prophylaxis dexa to her?

Ooi Chung Ping (Ben)
Examiners: Dr. Nugluelis (O&G) Prof Rajatul (PCM) External examiner (Surgery)

39 Malay Lady
Primary infertility with fibroid
Hx:
-Married 14 years ago, fail to conceive despite regular sexual intercourse
-Seek treatment at fertility clinic after 7 years of marriage
-Investigation were normal including blood, ultrasound and husband semen
-Treated with clomiphene-> failed ->Lap & dye normal -> IUI suggested but refused because of cost->decide to use natural method and traditional therapy
-Dysmenorrhea since menarche, no menorrhagia, but with abdominal distention, therefore seek help last 4 years
-Diagnosed with fibroid-> started with progesterone pill
-Symptoms remained the same
-LIF mass felt, MRI showed large fibroid
-Refused hysterectomy, so GNRH injection given
-Fibroid shrink and currently f/u in gynae clinic
-PE: only conjunctive pallor
Q:
-Main issue : infertility and fibroid
-Causes of anovulatary: Premature ovarian failure, pcos...
-Endocrine disorder cause infertility: hypopituitarism, cushing, dm...
-How to know she is ovulating from history: menses regular, dysmenorrhea(prostaglandin secreted after ovulation)
-What test we do to check ovulation: Progesterone at 21 day of menses
-Type of anemia in menorrhagia: iron deficiency anemia
-Do you think pt has pcos: No, not obese or hirtutism
-If no mass palpable, what would you do: bimanual examination
-Investigations for infertility: female and male factor
-Normal male semen: 2ml, 20 million, morphology>50%.....
-Investigation for fibroid: U/S, MRI, hysterosalpingogram
-What is HSG: Imaging of the uterine and fallopian tube after putting contrasted dye
-Management: Pharmaco and Surgery...
-What type of medication make fibroid shrink: GNRH
-What is the risk of this pt if she got pregnant: PIH, GDM, Down's syndrome
-Surgery that can preserve fertility: myomectomy
-What can cause blockage of fallopian tube: Congenital abnormaly, Endometriosis, PID..

Sarah M
examiners:external(a lady,main examiner,psychiatrist i presumed since she is d only one bombarding me..),another external and Prof April(quiet all d time)
45yo/cninese/working in ummc daycare workshop/legally separated with wife
psy case:bipolar disorder type 1,in remission
-no c/o,came in for exam.i was stopped a lot of times during the history for clarification and questions.
-presented chronologically,symptoms started 13 years ago..(but then she kept on asking am i sure it was 13 years ago?..i justified saying yes but only presented to ummc 7 years ago..=,=..)..got some history discrepancy here maybe..:(
-i presented manic symptoms.
Qs:differences btwn hypomanic n manic.

Qs:then she asked define grandiosity..(i might have mistaken his symptom for this..=,=..)
Qs:difference btwn grandiose delusion and grandiosity..
Qs:what is another type of bipolar ds that can occur in this patient now?..(forgot how exactly she put it..but i answered rapid cycling straight away and she was waiting for that answer..)..=,=..
Qs:define rapid cycling.
-then i presented the depressive symptoms.
Qs:what are the vegetative symptoms in depression(=,=)
Qs:other relevant history you want to present?..didn't get to present all history
-i presented his family history since his relationship with d father was not good.his father left a bad impression on him..(could i be digging a grave for myself..=,=)
Qs:what could his father probably had that time?
-i answered MDD no psychosis..then she say how about cyclothymia?...ooo....=,=
Qs:define cyclothymia.
-presented MSE...
Qs:what is the normal range of affect.
-presented the cognitive function...
Qs:she asked all the parts, what is normal and not..(i forgot to categorize..=,=)
Qs:what is your provisional and differential diagnosis
Qs:then how would you like to manage this patient?
-i said to do thyroid function because he was on lithium previously,but not now.
Qs:what are the acute and long term side effects of lithium.
Qs:why do you need to check lithium blood level.
Qs:define narrow therapeutic index.
Qs:what other therapies you would consider to manage this patient.
really took a long time to get all history.she asked a lot of definitions..(the usual ones nvm la...rapid cycling?cyclothymia?...:(..).

<u>mzl</u>
examiner: prof aisha (breast) prof KJ goh (neuro) Dr Chris (ortho)
complete left brachial plexus injury with preganglionic lesion
H/o: unable to move L UL X 8 years. reduced sensation, temperature intact, assoc with tingling sensation and left shoulder muscle spasm occasionally last for 5 min with no apparent cause. It was deu to MVA. Had POP for L UL & physiotherapy.
1 year ago had another MVA and had right femur fracture, spine injury and soft tissue tear from scortum till anus. SUrgical fixation of spine & right femur and stitch back the soft tissue injury.
Sys review: productive cough 1/52, no fever, no SOB no chest pain
PSH/PMH/DH/AH: nil
social: ADL independent
chris started
Q: in the past 8 years any improvement of hand?
M: *blank* Patient nt able to recall actually. but he is able to flex his fingers now.
Q:ok. so what types of ADL that u know?

M: don't know
KJ goh: what do u do in daily life?
M: buttoning ,shower ...
GO PE.
Show me the signs that support your diagnosis.
I described the appearance of UL : wasting bla bla.
show me myotomes.
How u wan to differentiate from cervical injury & brachial plexus injury?
Promted and I say sth like cervical more likely bilateral involvement. (dont dare to talk about hoffman and finger escape because i was not sure) and hyperreflexia
So now look at the eye. Got ptosis
so what is it? horner syndrome
what does it mean brachial plexu injury + horner syndrome?
M: can't remember but i know gt association
CHris: it showed preglanionic lesion
Demo furthter test to show preganglinic lesion: winging.
how to examine the left side??
Go back room.
what investigation u wan to do in initial presentation?
X-rays of left UL for fractures
CHris: so many x ray for only a fracture?
M: no, physical examination is enough.
what else u wan to do for the patient?
dont know...
promted to exclude cervical cord injury & vascular injury.
Q:what advice you wan to give the patient on discharge?
Me:err, must go physiotherapy.
Q:importance?
M:prevent muscle wasting
Q:the hand cannot move, how to prevent?
M:passively move it using the normal hand.
Q:Does it help?
M:NO
Q: how else? never stimulation! what else is the importance?
M: prevent contracture
Q: what else u wan to advise?
M: *blank* (then promted and I say) no sensation, so wear protetive clothing, dont ride anymore, avoid contact sports....
Chris: ok, thank you. he turn to prof goh, no need to go into management lo hor?
ok, you can go out now...
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Liew Xin Yi
Examiners: Prof Vivek, Prof/Dr Isam (external), Prof/Dr Liew(external)
Case: DM+HPT

67yo,C, male, DM for 20 yrs, hpt for 10 years, asymptomatic and no active complaint.
DM for 20 years. Diagnosed during regular medical check up. No symptoms of DM except polyphagia (take 2 bowls of rice). No macro or microvascular complications. On insulin and metformin. Compliance. Ho hypoglecemic

attack. Home glucose monitoring 1/week, 6-7mmol. HbA1c on f/up: 9%.
Hpt diagnosed during DM f/up 10 years ago. On atenolol. Blood pressure monitoring at home 130/70. No complications.
Hypercholesterolemia under controlled. On medication.
Total knee replacement due to OA 3 years ago. Previously presented with bilateral knee pain. no complication after surgery. Currently have some difficulty in squatting down.
Diet: previously 2 bowl of rice. Recent 2 weeks cut down to not taking lunch, dinner = grilled chicken + cucumber.
No exercise.
Smoker for 40 years. 2 packs/day. Stopped since 10 years ago due to family advice.

P/E: normal except there was bilateral arthroplasty scar. Some dilated vein over lateral calves. Leg edema up to mid calves.

Questions:
1) Why patient suddenly change his diet? Due to family advice. What will happen in this situation, as he is not taking his lunch? Hypoglycemic attack if he continues taking his insulin, but missed his meal. hypoglycemic may cause unconscious.
2) During PE, because I start with hand. What is clubbing? Loss of curvature. What is normal curvature? Dunno. What are the causes of clubbing? CVS..respi.. Do u think this patient will have clubbing? No.
3) Proceed to foot examination. Inspection. Peripheral pulses. Vibration. Pain sensation. Where is dorsalis pedis? Why we didn't check pain sensation on sole? Due to thick skin.
4) Summary. What do you think about his control?
5) Fundoscopy finding?
6) Lab result was shown to me. Glucose high. HbA1c 9%. Creatinine at upper borderline. Renal function test otherwise normal. Tell me the result of the urine dipstick. All -ve. Since his creatinine at upper borderline, what will u do for investigation? 24 hour urine protein.
7) Why do you think his home glucose monitoring is around 6mmol/L, but his HbA1c is 9%? Patient may have higher post prandial glucose. What will you advice him to do? 7 point blood glucose monitoring
8) What is the cause of leg edema in this patient? CVS, nephro. Since he has dilated vein, suspect varicose vein. He has previous arthroplasty done, can be DVT.
9) How would u manage this patient? Diet control, exercise. Cut down glucose intake. Refer dietician if necessary. What is your purpose when u refer him to dietician? For a balanced DM diet, weight loss. why weight loss is important? CVS, CNS complications, obesity can cause insulin resistance.
10) Atenolol was used in this patient. What do you think? Atenolol is a beta blocker, can mask the hypoglycemic sx. What drug u want to change to?

<u>Wei Chun Gan</u>
Pediatrics
Prof MT Koh, Prof Cheah, Prof Jamaiyah, prof Suren(observer)

Aisha
7/M/girl

CC
-no active complaint(pt was discharged 2 days ago n now come for exam)
HOPI
- antenatal mum had GDM in pregnancy, but no fever, no rash, no smoking, no alcohol, flup scan showed normal baby
- intrapartum, ELLSCS due to 4.5kg macrosomic baby
- since birth had at lump on lumbar region(5x4cm), the mum was told the baby had abnormality of spine
- flup in HKL for 1 yr and defaulted treatment cz no complications arise
- from 5 to 7yo, she had recurrent fever(2-3 times per month), only went to GP, never seek specialist help and no investigation until 2 weeks ago, she had the same fever and the GP found she was anemic, then refer to UMMC
- the fever is not associated with dysuria
- the lump on the back is not enlarging, not painful
- she had to wear pampers until now
- admited to UMMC for 2 weeks, was found to hav hypertension and urinary tract infection, given antibiotic, urinary catherisation, anti-hypertensive drug, one pack of blood tranfusion

PE:
height and weight less than 3rd centile(failure to gain weight n grow), had a CBD, urine in the bottle is cloudy(protein 2+)

on the lumbar region, the lump is 4x5cm, oval in shape, the surface n surounding skin is normal, not warm, not tender, can palpate the vertebra in midline of swelling and it curve out with the swelling(?kyphus), at the sides of the was firm and ?fluctuant, is not mobile, and i should hav done the translumination test

abdomen, no palpable kidneys

lower limbs,
- broad base gait
- hypereflexia
- normal tone, normal power
- cant check sensation, proprioception n babinski cz child is not cooperative

Question:
after i presented the chief complain, prof koh ard open his mouth, kept asking questions all along the history =.=,
- did u ask any scan during pregnancy?
i din ask in detail, but is important to fo fetal anomaly scan at 18-22wk as mother has GDM
- why u ask fever and rash in antenatal history? wil congenital rubella presented with a lump on back?
jus wan to rule out other infection, congenital rubella wil not present with lump on back
- if u saw the baby after birth with a lump on back, what wil u do and any further history wil u lik to ask?=.= dunno what he reli wan
do a physical examination of lower limb, ask for urinary or bowel problems, check for other congenital defect
-what do u think the lump is?
possible meningocele or myelomeningocele...den he asked, what r the

definitions
-what is the whole picture of this case?
myelomeningocele causing urninary retention then recurrent UTI, backflow urine pressure to kidneys causing chronic pyelonephritis and renal scarring..now presented with anemia as sign of chronic kihney disease

only present until HOPI, went to bed site,
- show me the signs of CKD?
terry's nail, sign of anemia, sign of vit D deficiency(ricket, enlarged costochondral junction, enlarged wrist joints, bow leg), facial or leg edema, HPT(did u measure? no bcz time up when i tried to measure,time's is up and is very important in this this case), acidotic breathing, urine protein showed 2+, small stature(dt failure ot thrive)

=.= din ask to examine lump and lower limb which i prepared, but ask bout signs of CKD

back to room,
-assume u 2 weeks ago patient presented to u, what investigations u wil do?
FBC(anemia of chronic disease, WBC for infection), PBF, RP(urea and cr), urineFEME, urine C+S, ultrasound of the kidney, DMSA scan
-what test u wil lik to confirm renal bone disease?
DEXA scan(he accepted), serum Ca and Vit D(the answer he want)
-list of the problems patient has?
recurrent UTI, failure to gain weight n growth, chronic kidney disease, anemia, HPT
-how wound u manage this case?
anemia(iron tablet, EPO injection), blood tranfusion if less than 8 Hb
calcium supplement
anti-hypertensive(ACE-i as pt has proteinuria)
porphylatic antibiotic for recurrent UTI
frequent flup with the clinic
-what is the ultimate prognosis of this pt?
end stage renal failure

p/s-in between need prompting, i jus summarise all the questions prof koh ask, prof cheah wil try help if silence is too long, actually all of them r nice, good luck guys!!!!

<u>Tan Pei Wen</u>
PCM case
Prof Datin Cheah, Prof MT Koh, Prof Jamiyah
70/M/lady, no active chief complaint
diagnosed with DM for 20 years. HPT&hyperlipidaemia for 10years on treatment.
Poor DM control now on basal bolus insulin, frequent hypoglycemic attack for the pass 1year. Complicated with vasculopathy and neuropathy(glove and stocking, postural hypotension).
*the rest is typical history.....

Q1: summarize your patient problem list

then go to bedside...
Q2: tell me your relevant findings'
Vital signs, CVS finding(no heart failure, murmur), fundoscopy, xanthelasma.......etc

Q2: is she having any cataract?
no, red light reflex present during fundoscopy

Q3: you only do lying BP?
due to time constraint i would like to do standing and lying BP, look for SBP drop 20mmHg, DBP drop 10mmHg. cause she conplaint of postural giddiness.

Q4: what particular CVS sign you want to illicit in HPT patient?
displace apex beat

Q5: tell me more abt the lower limb
multiple hyperpigmented lesion over the knees and shins bilaterally(pt loves gardening and frequently injured by torns plus poor wound healing for the pass 1year), no callus/ulcer/interdigital wedspace infection, vibration loss until knees, pin prick sensation loss until ankle and MCP(hand), loss bilateral ankle reflex, proprioception intact.

Q6: what else you want to do
peripheral pulses(demonstrate dorsalis pedis & it is weaker on the left side), capillary refill time.

back to room,
Q7: what you want to do with you patient?
RBS, HbA1C(if her reading is 8%? poor control for the pass 3months, target is 6.5%), FSL(if HDL 1.5, LDL 3.8? high LDL, target should be 2.6), RP(Creatinine 66? means no nephropathy yet)

Q8: what other test to look for nephropathy? how many percent kidney damage only cause raise Cr?
around 50%. Her urine dipstick was normal just now. So, Do urine albumin creatinine ratio, more sensitive to detect diabetic nephropathy, target for female is 3.5. 24hour urine protein plus look for microalbuminuria(30-300mg/day), check eye for diabetic retinopathy if present patient very likely has diabetic nephropahty as well.

Q9: other test?
ECG Echo,(but they dowan cause the patient clinically no symptom suggest heart failure, so dont order unneccessary investigation :P)

Q10: so how you manage her?
improve diabetic control. Since she is on diet control, exercise and complaint to medication, would like to assesss her insulin injection technique. if correct then would like to adjust the insulin dosage.

Q11: but she has multiple hypoglycemic attack? so?
then i would like to add OHA

Q12: ok, she is on Metformin so? any other OHA? new drug you know of?
sitagliptin, which is DPP-4 inhibitor, to increase incretin release and subsequently increase insulin level. EBM shows sitagliptin has less hypoglycemic side effect and can achieve better HbA1C control compare to Metformin.

Q13: why this patient got postural hypotension?
DM autonomic neuropahty, S/E of antihypertensive

Q14:what other management?
refer to podiatrist, foot care as her hobbies put her on high risk to get injured during gardening.

Q15: what else besides DM, HPT, dyslipidaemia?
offer PAP smear since her last pap smear was 35year ago. but recommended screening is up to 65yo.
since patient never practise BSE, teach her and do MMG 2yearly screening if no risk factor.

Q16: what other national screening program you can offer to her?
endometrial sampling? answer is no. then i cant think of any....

Q17: what other risk she has??? you mention about postural hypotension
risk of fall. give advise about the risk of fall like during gardening dont stand up abruptly from squarting position and etc...

Q18: other risk?? *hinting: osteoporosis. so what you want to do?
o... so she had menopause 25y ago so i would like to order bone mineral density scan...

*patient is very friendly and nice. just abit emotionally disturbed cz started 10min late cause pt praying but was given extra time. Pt abit new for exam so abit circumstantial... trying hard to recall things... erm... all in all, just be steady and dont have emotional breakdown :P
Prof very friendly and nice too
good luck peeps!!!

<u>Nabihah</u>
med case
prof hussin(psy), prof chee kok han(cardiologist), dr yoong (hbs)

mohd ruddeen/38 yr/ M/gentleman
k/c/o type 2 dm for 28 yrs, pulmonary tb(completed tx), rt ray ampution, left bka
cc- rt upper and lower limb weekness ass w blurring of vision, slurr speech
no trauma,n/v, headache, seizure. last meal and insulin injection 4 hr before event.
also ass with sob with orthopnea, no chest pain.. 2 days before had fever + dry cough. no loa/low

questions(all by prof chee)
Q1- what type of dm?

Q2- how to know dm poorly control from history....symptoms, compliance to med, self bld sugar monitoring at home, hosp admission dt dm
Q3- target bld sugar level pt on insulin
Q4- if pt already on insulin for 3 yr, can add on oha or not?
Q5- complications of dm...macro, micro
Q6- ask about depression (forgot to ask huhuhu =.=)

go to bedside
- demonstrate glove and stocking distribution sensory loss. why only have stocking loss, not glove...why must check both side of hand and leg
- how to check pedal edema
- ask about fundoscopy finding (x sempat buaaatt..sory dr =.=)

go back to the room

Q7- how u would manage this pt..urgent ct brain, all investigations and ......
Q8- how to give advise if want to start pt on insulin therapy

kringggggg..have a nice day (lol).. gudluck!

<u>Noorhafissah</u>
prof KL Goh(med), prof Datin Chia(pcm), Prof Raja Amin(surg)
Mr Pala/63/I/M/obese
kco DM for 17 years
no active complaint
had hx of multiple stenting done for multiple coronary artery occlusion(no active sx)
no hpt, no hypercholes
2001- had left BKA and now on prosthetic leg
regarding DM - currently on sc actrapid 40unit n sc insulatard 40unit n t.metformin
- blood glucose range 5-9, HBA1c 9%
had hx of bilateral retinal haemorhage and bilateral cataract

Q:
-explore more on social hx as he had left BKA, exercise,diet, type of house double or single storey etc
-ask bout depression n coping

bedsite:present the relevant finding
-BP, BMI
- fundoscopy- check for absent red reflex and neovascularization (actually x sempat buat huhu, just mention what to look for)
-no sign of heart failure
-glove n stocking sensory loss, tropic changes and check pulses

back to room:
-ix: rbs, fbg, hbA1c, RFT for urea n creatinine, urinalysis for protein, 24hour urine protein, ecg, echo for ejection fraction
-mx: lifestyle modification n diabetic foot care bla bla bla
multidisplinary approach refer to dietitian, opthalmologist,cardiologist,

nephrologist
-what can u give for his heart condition - aspirin, frusemide as preventive measure of heart failure
-do u think this pt could do regular exercise? no bcoz he is obese n on prostethic leg.
-what other thing u can offer in order to reduce weight - bariatric surgery (prof Goh help me answer this cos i forgot the name of surgery, my answer was only gastrectomy)
-what dx can inherited by his child - dm n heart disease n thus need screening earlier.
-lets say wife complaint of snoring at nigh, what is the condition called - OSA
then kringgggg...best of luck!!

Ain Shamsudin (Medicine)
Examiners: external examiner (main), Prof azmi (o&g), prof kalai (surg)
Case: 60 y/o gentleman , no active complaint, background history of gouty arthritis - 10 yrs , on treatment, compliance to medication & on regular follow up. Assessing RF - +ve family history of gout (siblings and mother) however no history of alcohol intake, high blood pressure, and renal disorder. Not taking any medication like diuretics, tb drugs, not underlying any haematological disorder. no complication of gout (no 2ndary infections, nephropathy, nerve or cord impingement, renal stones, fracture).

Also hv back pain associated wit shooting pain from lower back up to left sole, no history of trauma, heavy lifting, no neuro deficit, no chronic cough/met TB patient,no LOW LOA, no underlying cancer, MRI done, degenerative cause ?spondylosis.

Pmh & psh : renal calculi, parathryoidectomy was done, dyslipidaemia (on medication)

p/e: show whatever i want to show.
- vital signs
- look for tophi, toes, ankle , knee swelling (all normal)
- since patient hv dyslipidaemia look for xanthoma. - pinna, elbow, archilles tendon
- tell examiners if i got time, i would like to do spine xm

Questions asked: - mainly from external examiner
-How is gouty arthritis diagnosed?
Mainly just based on the history of attacks- painful, commonly involved big toe & ankle, attack one joint at one time while other arthritis condition usually attack multiple joint simultaneously. joint aspiration - look for urate crystal from tophi nodules . X-rays - look for tophi or any bony damage (cx of gout)

- U mention about joint aspiration, can u tell us more? What do u look for? Under polarized light microscopy we cn see negatively birefringent urate crystal.

- ix u wud like to do? FBC, Urinalysis, U&E and creatinine, Blood urea, Serum uric acid, 24-urine uric acid

-Treatment for gout?
1.colchicine - reduce uric acid level.
what is the mechanism of action?? *cant remember* ZZZzzzz
side effect ?? severe diarrhea, nausea and vomiting.(not sure -.-)
2.Allopurinol - preventing uric acid production.
MOA?? Inhibit xanthine oxidase .
Side effect?? Allergic?? liver toxicity?? *errrrr. tak tahu*
3. Prevention - maintain adequate fluid intake, reduce weight, change diet.

- as a doc, how do u advice to help patient in reducing uric acid level? Avoid foods rich in purines e.g seafood and red meat . Reduce weight -lower the risk of recurrent attack of gout.

- pathophysiology of gout? results d2 overload of uric acid in the body, leads to formation of crystals of urate that deposit in the joints. When crystals form in the joints it causes inflammation -arthritis.

- What is the prognosis for patients with gout? Recurrent gout lead to permanent damage to joint &bone. Need to control uric acid level to be low so it will reduce risk for flares and joint damage. so, regular monitoring of the blood uric acid is needed to hv a good prognosis. then the bell ringssssssssssssssss.......

<u>Tharisinidevi kunasekaran</u>
Prof vivek and 2 external
46 year old indian gentleman, background history of dm
history of multiple abcess(from head to toe) and diabetic foot ulcer
P/E : diabetic foot examination and lots of prompting and help from prof vivek.
question: lots from history itself.....T.T
no ix question, management : what is the best drug to give this patient as i found positive protein in urine dipstik;ACE inhibitor...then they say you may go. kriggggggggggggggg

p/s : eerrr i left my brain outside the exam hall...".", prof was nice...its me who is the problem...no matter what, good luck guys...we can do this

<u>Ong Chiew Sern</u>
Examiners: Prof Ng Pak Cheung(neonatologist), Prof Nortina, Prof Woo
Case: Neonatal jaundice secondary to ABO incompatibility
29 days old baby girl, presented with chief complaint of jaundice since day 2 of life
(only managed to present HOPI and PE, no bedside,in the end grilling for 20+ minutes out of 30 minutes until cold sweat)
Presented with jaundice up to the lower limb, no pale stool dark urine, no HIGH PITCH CRY(important to rule out kernicterus), no poor feeding, fitting, etc etc.
Finding: only jaundice up to lower limb.How do you check for jaundice?palpate at body prominence..where do you press for chest??sternum..
Grilling time:

19. What is the cause of high pitch cry?(kernicterus)
20. Where does bilirubin deposit usually in the brain?(basal ganglia)
21. WHY???because it is more fatty@@
22. What will the patient present with kernicterus??(reduced level of consciousness, fitting, jaundice..one more important thing-posture..what posture??OPISTHOTONUS)
23. What do you screen for in cord blood in ALL patient??VERY important, but I thought blocked too long until they almost gave up,blurted G6PD and and hypothyroidism..
24. What other blood group do you screen for other than ABO?? Duffy and kelly.
25. What are the congenital infection that you know of??TORCHES lo..
26. What are the conjugated hyperbilirubinemia??Biliary atresia, choledochal cyst, neonatal hepatitis.
27. How do you know this is conjugated hyperbilirubinemia..check FBC lo@@
28. Biliary atresia (in and out)-cause, ix, management(principle of Kasai)
29. If patient come in with prolonged jaundiced, unconjugated, what do you wanna rule out?breast milk jaundice
30. How to check?take TSB 1st, then ask mother stop breast milk feeding, then repeat in 2 days.
31. Other unconjugated hyperbilirubinemia that you know of?? GRAPSD out d still got some more..@@ thought block very long until blurted out crigler-najjar syndrome reluctantly(prof says yes you do get these patients, mayb once in 10 years=(I think he wanted the other blood group -duffy, kelly)
32. Showed me the patient's FBC..interpret-high reticulocyte count-hemolytic anemia!!
33. Management-Phototherapy, if does not work-exchange transfusion.
34. What do you advise mother after discharge-monitor for rebound jaundice, kernicterus symptoms,follow up weekly kot...
35. in preterm baby why are they more prone to get jaundice??dunno prof sorry-liver still immature ma cant process the bilirubin.
36. in what condition do you get jaundice??intrapartum-cephalohematoma and caput succadeneum!!

Good luck hope we all pass!!!

Masri Ismail

72 yrs old/I/lady kco poor control dm, hpt n BA. Current complaint...unresolve exacerbation bronchial asthma for 2 yr n half but worsen last 1 month. oso had past hx o gallstone, ovarian cyst, n bladder prolapse but all oready operated. pt oso depress with her current condition. so need to noe about control n severity of the asthma (Gina), side effect o medication, doc oso ask about dm, hpt. n ofkos need to noe 'bout ix n mx of asthma for this pt.

Hong Foo 60y/o malay elderly. Gouty arthritis. Ask everything about gout. No other complaints. The end. Good luck guys.

Fairuz rani

Ortho.Prof David Choon. Dr muhsin (psy). Dr goodlookingexternalguyperson lol

63 year old Chinese guy.Left hip pain for 11 years. With right hip pain. Insidious onset, worsen on walking, relief by rest. No radiation, no weakness. Investigated thoroughly and apparently diagnosis is AVN. No risk factors for AVN -no steroid use or traditional medication, no previous fracture/trauma/OM, alcohol intake minimal, no previous deep sea diving (examiners: HAHAHAHAHAHAHA). Functionally pretty independent, just unable to do sports.Anyway prof Choon didn't want to hear much about his past med history which includes hypertension (4 years), dyslipidaema (3 years) and renal stones (12 years ago but no surgery was done). He cut me short and I didn't manage to go through social history and all that and just asked me to summarize. Haih. Then we went to see the patient- PC: What would you like to show us? Did a general inspection- able to stand without aid, posture normal, there's muscle wasting PC:Where do u look for muscle wasting- which muscle? Medial rectus and anterior tibialis(think I pointed wrongly la but ah whatever)There's some skin changes at the distal third of tibia - I just briefly described it la not sure what it is.PC: are there any scars?Oh yea lol there is a scar at the left hip.PC: left hip is huge where exactly is it?-.- yeah just described where.. Sort of. Haih anywayPC: what else would u like to doShow you his gait. Trendelenburg. PC: describe the gaitHe wanted me to say waddling la. Okayy PC: what else u wanna doLie the patient down, do Thomas test.PC: how do u do Thomas test?Then the following questions after:How do u see if there's limb length descrepancy without measuring. Galeazzi.- then check range of movement. He helped me square the pelvis. Then when I was estimating the degrees everyone laughed.External: you're pretty bad at estimating the degrees. Ahhhh. Then PC : ok you're the houseman and this guy is going for surgery, what would u like to check. Neurovascular. Show me. (Palate pulses) then which nerve is at risk if we were to do a hip replacement? Answer is sciatic and we look for foot drop which I couldn't answer la lol.In the room.You're the houseman, what investigations you wanna do. X-ray of both hips. What're you gonna write on that paper. Answer is a pelvic X-ray with the symphysis pubis midline and able to view both hips. And lateral view of both hips. -.- Shows X-ray: describe. Left hip replacement. Right head of femur there's like destruction. (do you mean collapse?) err yes yes. So what will u offer for the right hip? Answer is hip replacement la I was going on about something else -.-So this patient asks you what's the success rate for hip replacement? 99%?(HAHAHAHA)What if it doesn't work- revise and replace again? What's the success rate? Err 70% ? (No apparently it's about 90+ la) okayyyy that's it.

Examiners were super nice. They kept laughing cos I said left hip knee replacement a few times. (Which is it hip or knee hahahaha). Didn't discuss about differentials or anything.. Hmm. Scary. Anyway

Just keep calm guys. All the best. Sorry this turned out to be like a grandmother story lol.

<u>Tan Choon Yean</u>
Prof Karen, external (O&G), Prof Christopher Boey
63/I/lady Rheumatoid Arthritis 11 years, DM 7 years.
Q1. what is the main concern?pain or stiffness?
Q2. functional status.
Q3. differential diagnosis.

Q4. how would you like to investigate if flare up?
Q5. what other manisfestationssss RA could have presented with?
Q6. what hand symptoms do we anticipated? describe.
Q7. how do we treat RA?
Q8. side effect of DMARDS.
Q9. steroid s/e. how do we know when patient has steroid overdose.
Q10. osteoporosis, risk, monitor, and prevention.
Q11. how do you give vitamin D? when sunlight exposure is the best. lol.
PE: show whatever you want to show. elicit carpal tunnel syndrome. elicit power of the hands.

Ahmad Sukri Nawi
ini dah kali ke 4 i wroite my case: huhu..tulis kat komen box je la>case peads (nephrotic syndrome)main examiner : Prof Asma Omar 9 y/o indian girl with k/c/o nephrotic syndrome x 7 years , currently in remission..diagnosed 7 years ago , intial presentation was periorbital swelling which progressively involved the legs as well.diagnosed in UMMC after some work-ups done ..induced with oral prednisolone then tapered down slowly ....had 3 relapses..steroid sensitive NS.questions asked - what do you think the likely cause of NS - MCD coz responds to steroid induction - what is definitive diagnostic ix u want to get if MCD - Renal Biposy "- Immunization...- differentials for MCD -- FSGS & Membranous GN - how to differentiate - investigations-management ? what is nephrotic chart ? components of nephrotic chart

Kaklia Alia Lia Surgery
Rectal ca.
Examiner - Prof April, Prof Hasanah (external Psychiatrist from USM), Dr Rajasingam? (external)
PR bleeding 1 year, worsening last 2 months. Sometimes pass mucus.Tenesmus.
No risk factors - no fam hx, no prev IBD, No HNPCC/FAP. Diet was all healthy stuff. Constitutional sx of malignancy - LOW 6kg in 2 months.
Hep B carrier. Mom died due to liver ca and brother also hep b carrier.Not operated yet. Cn feel the tumour on per rectal. No other findings. No other complaints. (initially i thought is it possible pt only have this minimal complaint for MBBS finals but after prompting she really have no other problems except she is a HEP B carrier, never do any follow up LFT, and hypercholesterolemia years back but not on any medication now)
All Question by Prof April. Other examiner kept quiet through out the exam.The Indian doctor eyes is soo red he is probably really sleepy.

1) Your PD?
Colorectal carcinoma. Which side? Left. DOnt you think it should be in the rectum from the history? I said yes2. i was thinking the cancer would most probably be in the rectum, and rectum is left side.
Prof April: no no no.. we dont group rectum ca, sigmoid ca on left sided colon ca. if you sure is rectal ca then it is rectal ca. (haha i just knew, actually cos she said which side, i say la left side. :/)

2) Prof :so, apart from the complaints, other risk factor that you are saying she have rectal ca? pertaining to the pt history?
I already said no RF, haha.. actually she wants the, chinese race and age. i

said mostly male get CRC but actually no difference la she said. I just agree.

Okay lets go see the patient. Do abdominal PE.
Finding : nothing, i told her no palpable mass, liver span was 6 cm, no ascites.
3) Prof : anything you find on abdominal exam. (I told her i did per rectal and felt a mass.) Okay, describe - 6 cm from anal sphincter, firm-hard in consistency, irregular shape, extend from anterior wall to posterior wall of rectum. No blood/stool. Anything else you felt? nawww> (actually i know she is asking about a stent they put they earlier in the rectum but cos i really dont know if i was feeling the stent or the rectal mass so i dont want to commit)
Prof:So from your physical findings can you stage the patient? advanced or not? Me :Cannot stage cos i dont know the extension through submucosa or not?But no symptoms or signs of mets so probably is early

4)Prof : So how can you stage the patient? - Transrectal U/S? Prof :u think the u/s probe cn pass thru? the tumour so big u said yourself? - Ok MRI pelvis
Prof : why so important i ask you to clinically stage the patient?
Me : uhh it alters the management? Prof :okay, in what way? Me : cos if metastasize then cannot do anythg beside palliative. Prof : eh2, thats too far already, how abt your patient? Me : err, it tells us if we are giving neo adjuvant chemo radiotherapy or not?
5)Prof : what is important? chemo or radio? Me : thinking (alamak2, patient says she is havg both? err2..) hmm.. chemo? Prof : chemo deals with systemic or local site? Me : ohhh,radio is important la becos this patient is early stg. Prof :okay,why is chemo important - shrink the tumour size,easier operate and also reduce local recurrence, okay, radio side effects? - local skin burns, all the proctitis,cystitis,vaginitis
6) Prof: besides all this, anythg important with the clinical staging - surgical approach cos the location from anal sphincter determines what sort of surgery to do. she say : okay, i not sure if there is anythg else..hmm :/
7) explain tenesmus, what you think she is having? why rectal mass so big she does not have constipation or IO? - its the stent
8) other surgical approach cn relieve acute obstruction? - defunctioning colostomy
9) ANy associated gene you know higher tendency with CRC -HNPCC and FAP, p53 oncogene and APC, okay that one is in which, i say HNPCC (haha i hentam only i oso dunno but unluckily i hentam wrongly, haih - it is actually in FAP) :/ penetrance? 50-100 %. Inheritance? autosomal dominant.
10) so any advice to the son of this lady? surveilance colonoscopy cos got family history, at what age?-40, why that age, we discuss just now the common age for CRC is 50 yo. I say cos family hx and also the earlier the better? so why not do at 20? - cos too early? (we go around and around this question i actualy dunno what answer she expects - okay because the progression of CRC is 10 years.)
11) lets say it is duke B- prognosis? 75% in 5 years. is that good?? yeah. any other ca u would like to compare it to? yeah definitely better compared to esophageal cancer.
12) follow up- colonoscopy and CEA.

Lee Chik Sheng
examiner prof mary(the only one talking in the discussion), prof azlina,

external examiner
1 years 6 months old myanmarian boy
Persistent Haematuria x 3 weeks
- sudden onset after 4 days of flu and chesty cough
associated with
- cloudy urine, poor feeding and progressive abdominal distention
No easy bruising/ bleeding, no reduced urine output, no fever, no loss of weight, unsure about abdominal pain(must try to ask because prof got ask me whether i did try to ask or not. significant for stone. but the child hasn't start to speak in words then she ask what is the sign that can tell you that a child in pain, i answer irritable, not much of active movement and poor feeding), no rash.
come to UMMC after the first week of haematuria. Stay for one week and discharge with antibiotic. ONe week after that come for follow-up. Haematuria persisted and U/s scan shows renal stone.. (==" last min only in form me)

5 months history of on and off high fever(40 degree celcius with rigor). visited several G and was given antibiotic but did not improve. until 1 month ago, fever was resolved after getting treatment at UMMC A&E

Antenatal history - uneventful. no maternal pyrexia, GRM, PIH. Assisted delivery(vaccum due to prolonged labour), birth weight 3.67kg. JAundiced few hour after birth and resolved after 3 days. discharged well (don't know which hospital when prof ask me) .

Developmental- all ok except language (cause i hardly hear any word from the child then Prof ask me about the expected mile stone)

feeding- weaning at 7 years old and before that fully breast fed

Immunization- Up-to-date (then prof ask me about the lastest dose of immunization)

medical and surgical history- no known of illness

Drug history- antibiotic (not sure what it is)

Allergy- tak ada

Family history - no significant

social history - dad >myanmarian 31 yrs old lorry driver stay in kuantan
mom > myanmarian 35 years old house wife stay in jalan lok yew together with husband's siblings in a rented house.

Provisional diagnosis- Post strep AGN (then prof ask for another)
recurrent UTI w renal stone(then she ask how common ==)

Go to bedside..(the child super un-coperative)
then prof ask me do a general inspection and ask me what signs should i look for if AGN) - height - 75th percentile
weight- between 5 to 15 percentile (then prof ask any problem about his

weight, i am not sure what about that, so i answer: the child looks active and not cachexic, should get the previous reading for
failure to thrive)
- pedal oedema
- fluid shift
- fluid thrill (i almost forget this until kena korek only can come out. ==)
actually i think there is no sign for me to ellicit cause the child looks well for me.

Go back to the room..
Question
ask me to summary then ask if the patient have previous on and off fever and haetmauria, what is the investigation should be done.
i vomit all the blood test but seems like she want to focus on the urine examination
FBC- High WBC then straight jump into urinalysis (rbc and cast cell) then proceed to urine microscopy and culture and sensitivity -- ask for midstream urine. C&S shows E. coli > what antibiotic ==) i cincai say one but prof say should give according to Sensitivity..
then what else you wan to do for recurrent UTI?
ultrasound, DMSA, MCUG (i can't remember ==)

keep promping... then she ask me how they do the scan and what is the principal.. ==

How you going to manage the patient.. and then prof stress on renal scarring..
- i answer treat the UTI follow patient for complication of chronic kidney failure such as anaemia, renal osteodystrophy.... and after kena drill and getting tips, then i finally manage to pop out "blood pressure" this two word ==

bell ringgg.... good luck to myself and everyone.. hope we all pass together ><

<u>LOW MAY FONG (Specialty : PAEDS)</u>
Case : Nephrotic Syndrome
Examiners : Prof.Asma (paeds), Prof.Shahrul (med-geriatric), Prof.William Osler (external surg)
Brief hx : 9yo Indian girl diagnosed with nephrotic syndrome 7 years ago at the age of 2, was on treatment with oral prednisolone 30mg daily initially and then tapered and stopped medication 3 years ago. Currently in remission. Both patient and her mother were very co-operative. Came in for exams, no active complaints. No other medical illnesses or surgical hx. Only hosp admission was at the age of 2, with complaints of swelling of the face, eyes and both legs. no abdominal distension, no frothy urine, no bloody urine and no changes in the frequency and amount of urine then. after diagnosis was on follow up in PPUM,never had any relapse episodes. i think she is steroid sensitive nephrotic syndrome. I was allowed to present my history fully without any interruption.
Questions (mainly asked by Prof.Asma) :
1) Do you think the patient has nephrotic syndrome?

- Yes, based on her history and also her sensitiveness towards treatment.
2) What about her immunizations?
- All up-to date.
3) What do you mean by that, what latest immunization would you expect her to have?
- MMR, DT, Hep B. (i forgot polio, she added for me..@.@)

WENT TO BEDSIDE

1) Pls show me what did you examine the patient for.
- I started off with general inspection, no peripheral cyanosis or signs of anemia. (she ask to show patients conjunctiva). Then proceed with mouth and then i said the only finding i got was patient had mild pitting oedema and went to her legs. Prof said the oedema was not that obvious. then i told her about patients abdomen, it was negative for shifting dullness and fluid thrill. (prof ask to show how to do shifting dullness). it was resonant all over.
- alright, then prof asked, in paediatric patients on long-term steroids, what are you worried about? i said they might have stunted growth. (which parameter are you concerned about?) height, because the steroids will cause them to have premature closure of the physeal plate, resulting in them having a short stature.
- okay,what other cutaneous signs u wana look for?
i was like neurocutaneous signs? cafe-au-lait spots? she was like, no, steroid induced cutaneous signs. haha. then okok, said about striae and bruises. which were not present in this patient.
- what else did you check for besides the urine dipstick? i said blood pressure.

BACK IN THE ROOM

1) So what investigations would you do for the child now?
- Urine dipstick, blood pressure, renal profile, liver function test, lipid profile. (i offered 24hr urinary protein as well but since the patient was negative for the urine dipstick,prof said it was not necessary)
2) What do you want to look for in the urine dipstick?
- presence of protein
3) what do you want to look for in the liver function test?
- Serum albumin levels.
4) Patients albumin is 7g/L, what do you think about that?
- I said i did not know the paeds normal range for albumin, but if according to the adults range which is 35-50g/L, patient is hypoalbuminemic.
5) okay,so can you tell me what is the relationship between low albumin and oedema?
- In patients with low albumin, the intravascular oncotic pressure is decreased, causing intravascular fluid to be sequestered to third spaces, resulting in oedema. (Prof.Shahrul wanted me to emphasize on intravascular)
6) Can you show me the patients growth chart?
- Patientz height was 144cm, weight was 37.4kg all above the 90th percentile. BMI was 17.8. Blood pressure was 122/88mmHg.
7) Do you think this is normal for a child her age? What do you think about her BMI and BP? She asked what are the normal BMI ranges for an adult.
- Patients growth is good. compared to an adults BMI, she is underweight, but for paeds, she is not considered underweight. her height and weight are all equivalent to the 50th percentile of an 11-year old.

* for this question, prof actually wanted me to say out that values for adults and paeds are not the same! so we cannot interpret them similarly. @.@*

8) What other parameters do you want to check for in this patient in view of her long-term steroid use?
- i said growth, cushingoid features and all the usual ones that i can rmbr.

BELL RANGGGGGG!!!
Prof said,ok never mind. then before i left, she said:" you should check the eyes". - Steroid-induced cataract??
Thank you.
Well, that's all from me ya.. Lecturers were very nice. Prof.asma did all the talking mostly. Prof.Shahrul was keeping the time. The external only asked me 2 questions, from the start 0 secs to 30 secs : How are you today and Are you okay? =)
All the best guys! We can do it! Just show ur stuff k! Good Luck!! ^^

Brendan Jonathan Chin Chien Chou
examiner Prof Rokiah, Prof Kamarul, Prof Eugene and our nephrologist (malay lecturer)

History. 36 yo chinese Male with 19 years history of SLE.
no active complaint.
presented 16 years ago with fever and malar rash.
currently good control last adjustment of steroid was 2012 from 1 tablet increases to 2 tablets.
systemic review unremarkable BUT FROTHY URINE.
i tercakap history of SLE for 19 years.(which i heard Prof Rokiah doesnt like that) but edi 16 years wor..hehe but in history i rule out other causes of fever such as dengue , TB and Maglinancy.
patient consent is afraid cant have children.

here the discussion,
1) what u will tell the patient about SLE when u see him 19 years ago??
i answer, tell him is a multisystemic disease which cant be cured but can be control very well if compliance to medication, follow up and avoid sun.
2) u are a doctor . how do u think u can prevent the proteinuria 19 years ago?
i say i will do urine dipstick to monitor.
so if there is frothy urine how much damage have be done on the kidneys.(quoted from pei wen is 50%) so i said 50% she nodded.
so i will check the BP, BUSE, she say wat else. then i cant figure out she say dont you want to do a renal biopsy, i said yes.
3) Prof:tell me more about renal biopsy. what can u see?
before that i also say that if there is renal involvement there is cast cell in urine, she nodded so what specific place in the kidney it affected , i said glomerular.
4) what can u see? i say there will be antibody complex on the glomerular.
Prof: a single test u want to order from pathologist. i cant think the answer she said: dont you want to order immunofluoroscent? i said yes.

Bedside:
5) tell me what you found??
i said normotensive, normoglycemic, no features of cushing, check the eyes, no catarract, She ask y?? i say because prolonged steroid can cause catarract.
6)do you did fundoscope?? yes. what u saw?
i say normal cupdisc ratio , i would like to look for diabetic and hypertensive

retinopathy as patient have long term steroid.
7) what you want to look for if the patient came to you 19 years ago??
i was like OMGGG . i answer pappiloedema if pt have lupus meningitis. She say that will be the late sign , what else ? earlier sign?
she giving me hints what u look at during fundoscopy
i say cup disc vessel macula wat else?? posterior wall. she using hand gesture to giv hint, prof kamarul too, end up they give up, the answer they want is retina.
what can you see? alot inflammatory cells. what that call? i say retinitis, prof kamarul say and laugh haha u no need to know. prof rokiah also laughing.
8) if u r the doctor in gua musang what u will look for if patient got renal insufficiency. i say check bp, bp will be high, check urine dipstick there will be proteinuria, BUSE,(NO.U in GUA MUSANG), look for consciousness level,(uremia) , look for meatabolic acidosis(acidotic breathing) what that call?? Kussmaul breathing, swallow appearance and bilateral leg edema, if severe enough patient may have pleural effusion or pulmonary edema. she nodded and asked: wat is another appearance of the skin??if you go enough renal ward u will know. i stunned and dont know.
9) show them a scar aroud the hip joint? Prof kamarul ask y the scar so small u think a hip joint can fit?? i say: no, this is not hip joint replacement, this is hip joint reconstruction, they took bone from other part of body and inject there to recontruct the head.
What it call? i cant answer. maybe he want bone graft. then he laugh and said: haha u no need to know la, nevermind..
10) prof rokiah y do u think this happen in this patient? i say Prolong steroid cause AVN and cause arthritis and patient have hip joint pain. she nodded.
11) what else you want to tell me? about the face? i said no malar rash no oral ulcer. pROf: do you think he will have? i said : no because well controlled.. i said discoid rash too .. how often u see, is it very often?? i shake my head she say it is rare.
12) i check lung too, i say want to listen to any crepitation for pulmonary fibrosis or reduced air entry for p.effusion. she ask: hw often u see them with pulmonary fibrosis? give me a figure? i answer: sorry prof i dont know. she say rare. what other autoimmune disease u know of can cause p.fibrosis. RA and scleroderma.

lets go back room
13) how u educate patient 19 years ago to prevent all the complications.
14) prof kamarul: brendan, i think this questioin is relevant, lets say i am the patient, i am young with kidney disease, how u advise me what is my prognosis.
i will answer patient compliance to drugs and follow up, i will monitor closely. if x control will progress to renal failure and end up ESRF. then oni can dialysis or do renal transplant, PRof rokiah, do you think there is CI for renal transplant in sle pt. if u r the dr will you do a transplant, i said no because the autoimmune is inside the body will attack the kidney again.
15) pt want 5 kids .. How u advise? i say their children have to be screened in future. Prof rokiah and Kamarul LOL.. Before making babies la.. hahahaha
i stunned, then prof kamarul help me, come on la brendan, what azothiopine do to sperm..i say ohhhh i will reduce sperm count so is hard to have bb.
16) prof rokiah: pt insist want bb, you r the dr wat u gona do? i say i will control his sle activities 1st den try to take out azo, if x flare up and well controlled with steroid i will let him to havve bb, if flare up and x control i

will put bk the azo.
17) how u monitor? esr crp will be normal in this patient.. somemore. c3 c4 . i said LOW Prof Rokiah say HIGH or LOW, i scare. she repeated again HIGH or LOW. my mouth saying low low low, then i speak up Low then she laugh and say : it will be low or normal in this patient i just testing u.
18)if renal biopsy negative , what other causes in this pt that can cause proteinuria, i say HPT bcx he on peridopril. she say ok , maybe . wat else, i dont know. i say dm but unlikely bcx the blood sugar normal. then she say do you heardof interstitial kidney disease, i angguk only, pt 36 yo. giv me 1 example. i said ig A nephropathy, she say yes and nod.(hantam)

lastly bell ring and i manage to answer the kids question that was my last q. then prof kamarul say u can go now, thanks you and all the best, prof rokiah oso say thank you. prof eugene x say a single word tru out the 30 mins.
all the best, every one pass, good luck. Hope she x penalise me for saying the diagnosis.... Sorry quite long.

Lee Kar Yin (interstial lung dx)
Examiners:
Prof Tan kay shin(all questions from him..super nice), Prof Azmi (O&g) and Dr KL NG (his job is jz help me open door and open the chest x ray..haha)J
Mdm Habsah/
68 y.o/ M/Housewife/married with 3 children
No active
chief complaint
With
underlying medical hx of chest disease(5 years), HPT, DM and dyslipedemia for
10 years
5 years ago
presented to chest clinic with reduced effort tolerance and short of breath associated with persistent non-purulent cough for 3 months.
So hx jz
assess her severity of ET and SoB and characteristic of cough la.
-sudden
onset ,cant climb even 1 floor of stairs, cant walk long distance(10m), aggravated on exertion, relieved by resting.
-cough..persistent
(no diurnal variation)with flame but non purulent.non copious, assoc with 1 episode of hemotypsis(size of 20cents, dark red jelly like blood clot)
-no PND,
Orthopnoea or chest pain, , no LOA,no LOW
-no TB
contact,no travelling hx..no night sweats, fever.
-no risk
factor for Pulm embolism, asthma,COPD, no recurrent chest infections for bronchiectasis.
Progression
of lung dx: increase in effort tolerance, put on steroid for 6 months, stopped cuz no changes in CT scan. Now not taking any med or MDI.so vaccination (influenza yearly and once pneumococcal)
Medical hx

of HPT, dyslipdemia,DM…establish how it was diagnosed last time, access her
control, compliance and complications lor.
Q:
differentials diagnosis and provisional diagnosis and justify ur answer.
Then go bedside:
no peripheral signs. Pink on air..no tachypnoea/tachycardia. So focus on posterior chest wall…was asked to show how to check reduced chest expansion and
check peripheral neuropathy and elict ankle reflex.
Back to
room..ask bout how to investigate pt when she 1st presented. Den interpret her chest x ray and CT scan. Den discuss how to manage pt in long term.
Den asked me how would I manage pt if she has
acute excerbation. -the end-

Jo Yen (Psy case: bipolar)
Prof Hatim, Prof Tan Maw Pin, Prof Alizan

a 26 yo malay gentleman, 6 years hx of bipolar d/o, 11 years hx of cannabis use, 19 years of chronic smoker. underlying asthma and thalassemia
Just clerk as usual but important hx here is bout smoking hx and cannabis abuse cz both are related as he mixed d cannabis in his cigarettes so he is also becoming more addicted to smoking after he used cannabis. Asthma hx is also important here coz the fers time he wanted to try cannabis is because he read from somewhere that cannabis cures asthma =.= so compare before and after effect for his asthma, how bad was it and is that reli working and cause him to be so addicted

ques:
- everything bout bipolar (dx criteria, what pt had here, mx)
- how u ask for perceptional delusion
- lithium! (those common ques la, s/e, toxicity, range, use of lithium)
- another choice of drug here besides lithium (aripiprazole cause pt had hx of wt gain from olanzapine)
- ECT (indication and c/i, side effects, expects alooooot of answers for each)
- substance (this is the main discussion in this exam: dx criteria for abuse and dependence, explain each, wat pt had, how to differentiate misuse and substance use d/o, best way to quantify their use -money spent!)
- Cannabis (all by prof tan - ways of administration, side effect, wat happens if pt is intoxicated, how bout during withdrawal, wat to monitor if he is admitted, have you seen cannabis before n can u describe it to me?)
- If u were to advise this patient to quit from substance use, wat disease u will tell him to warn him that he might get it if he continues to do so (Lung CA!)
- Mx of a substance abuser
- Mx of this patient
- Do u think all his probs are related to thalassemia?
- How severe is his thal? (juz tell like thal hx)

Conclusion: TIME IS PRECIOUS.. great thanks to my patient and examiners, good luck!

Tan Chen Long (Surgery: Hepatocellular Ca)

By prof BK yoong (Surgery), prof Chee (Medicine), prof Hussain (Psychiatry)
History:
-68 yo chinese lady, presented with sharp RUQ pain and vomiting for a year, yellowish discoloration and pale stool for 2 wks a/w LOW (9kg in 1 yr) and LOA.
- Chronic Hep B carrier for 50+ years not on any treatment
- No other risk factors like previous jaundice, gallstone dis, alcohol consumption, contact and travel hx, family hx and high risk behaviours (promiscuity, tx of blood product, IVDU, tattoo or body piercing)
- No mets symptoms
- Blood product, Ct scan, HBS usg, liver biopsy done but unsure of her result.
- Her RUQ pain, pale stool and jaundice resolved a wk ago after ERCP stent insertion.
- Currently she was awaiting her CT scan report, not on any mx yet besides ursodeoxycholic acid (UDC).
- Further mx requires large amt of money, no problem for her as she is a pensioner.

Bedside physical examination:
Abdominal examination: liver span 20cm, firm to hard in consistency, nodular surface, irregular edge, non tender, move inferiorly with inspiration, can't get above it, absence of bruit and pulsatility.
Left inguinal LN palpable
Anaemic, jaundiced but not cachetic.
No other signs of CLD, portal hpt.
Urine colour normal (straw), pt refused PR.
Vital signs normal.

Discussion: My response in bracket, might be wrong
1) What are the working dx and differential and give me the reason? (HCC.. diff dx: benign liver tumour, sec mets, pancreatic head tumour, periampullary ca, cholangioca)
2) Why not pancreatic head tumour? (Because long duration of hx, absence of risk fx)
3) Why do you think pt has vomiting? (Prof did not want mechanical cause)
4) Tell me the level of obstruction in this pt?
5) How do you differentiate vomiting dt gastric or intestinal origin?
6) Why HCC? (risk fx: chronic hep B carrier)
7) Prevalence of Hep B carrier in M'sia
8) When do you decide to start tx on a Hep B carrier? (Monitor HBVDNA)
9) Give you a choice either Hep B and Hep C, which one you choose to be infected? (Hep B)
10) Give me an ix to confirm your dx. (CT 5 phase liver)
11) How do you intepret it? (HCC: arterial enhancement wif portal venous washout, sec mets: enhanced portal venous phase)
12) How do you decide to choose pt for liver transplantation? (Milan criteria- list out all d criteria)
13) How do you want to manage this pt? (Barcelona Clinic Liver Cancer staging system, based on 1) size and no of tumour and therefore the future liver remnant,
2) performance status 3) Child-pugh score.. then list out d mx according to the stage 0, A, B, C, D, as this pt has stent inserted, she has intermediate or advanced stage, palliative tx is suitable for her- What are ur tx modalities-

TACE, sorafenib)
14) How sorafenib will be suitable for her? (as it is a palliative modality, it will only prolong life for 3 to 6 mths, in addition it costs about RM 20,000)
15) What is sorafenib? (angiogenesis inhibitor or tyrosine kinase inhibitor)
16) Assess her financial status for her mx modality.
17) Give you a scenario, a pt with single nodule 3cm, what mx? (Based on BCLC, i will assess the presence of comorbidities, if present do RFA, if absent do liver transplantation)

Yeoh Whei Chuern

Obstetric case
HOPI : 33/Chinese/Lady, G1P0, POA 35 + 3 days presented with placenta praevia type III posterior with breech presentation . Asymptomatic with no previous hospital admission.
Examiners : Prof Woo, Prof Lim SY, Dr. Haireen
Q: 1. What is Placenta praevia and the different types
2. How to manage if bleeding or if not bleeding
3. Can they be managed as out patients? If so, who are these patients?
4. Causes of PP
5. Counselling after PP (possiblity of placenta accreta,...)
6. Mx of breech
7. causes of breech
8. if 33/52, bleeding how to manage?, if not bleeding, how to manage?
9. Causes of infertility
10. How to investigate for infertility?
11. PCOS – Symptoms, complications, diagnosis, investigations and management
12. Complications of clomiphene – multiple pregnancy, ovarian hyperstimulation syndrome
13. Multiple pregnancy complications (maternal and fetal)
14. What is twin twin transfusion syndrome and how to manage? (laser ablation of the vascular anastomosis, septotomy, fetoside)
15. What is OHSS and its different gradings together with its management
16. PCM – HOw to monitor and advise the mother after delivery ?(spacing, breast feeding, possiblity of contraception)
17. What types of contraception are suitable and why?
18. Complications of prematurity
19. Causes of neonatal jaundice in a one week old baby
20. Investigations for neonatal jaundice
21. Breast milk jaundice pathophysiology and management
22. Principles of management of PPH
23. If patient's BP was 165/110mmHg on admission, do you treat?
24. Symptoms of preeclampsia and the pathophysiology
25. Investigations to do for preeclampsia and why
Bell rings...

Jaimie

PCM. Prof Sajjah (PCM) Dr Nuguelis (o&g) dr Oliver (a caucasian surgeon)49 years old Chinese lady came in for exam purpose. Tried to clerk her in Chinese for abit then gave up. I got 3 translators, Prof Ng Chong Guan from psy, Dr Kong from renal and Prof Ng CT from rheumato. Really really really grateful for them. Cos I was really upset when the patient kept changing

history due to my broken Chinese. We both had a hard time communicating to each other cos she also dont understand what i asked and I just broke down and had a panic attack before asking for translator.
After wasted 20mins, they helped me get the history. Was given extra time and a cup of water by dr aida.
5 years ago, during routine check up, found to have HPT. From 2 meds change to 5 meds. Cannot rmbr much, everything also she forget liao. No complications so far. F/u in RUKA 6monthly
1 yr ago, diag to have DM because dr did a check up on her dt her weight. FPG was 6 so did OGTT (2hr pp was 11). Started on diet control until 1 month ago when fasting was 6.0. Then decided to start on metformin (I dunno why n pt also dunno why). Got numbness over glove n stocking.
Then developed noisy breathing during sleep. Referred to surgery clinic then done sleep test. Patient said got pharyngeal/laryngeal swelling so started on CPAP. Family history. Father died of renal ca. Bro lung ca. 3 sisters got breast ca. Diet ok. Exercise by taichi n dancing.Makes currypuff at home n earn more than 3k per month. (prof Sajjah whispered to the mat salleh dr : that must be a lot of currypuffs) P/e : left neck swelling. Glove n stocking numbness. Pedal edema up to midshin. Bmi 36.7

Ques1. Will metformin cause hypo? No. Usually is sulphonylurea
2. Why patient got echo done? Cos she complain of chest pain once and only told her dr during one f/u
3. Should echo be done? Ideally should do serial cardiac enz n ECG first.4. What cardiovascular disease will the patient present? Angina or ACS5. What will they present with? Chest pain or feeling of heaviness radiating to left arm. Assoc with sweating, palpitation or syncope. 6. Will they present with chest pain? Sometimes no, cos got silent MI.7. So how to diagnose silent MI? I say see ECG n cardiac enz then she ask before Ix what u see? I say the patient maybe present with chest pain but not so pain? Dunno la8. Dr Oliver then ask, why DM pt won't have sweating, palpitation etc during MI? Autonomic neuropathy9. Pathophysio of peripheral neuropathy? Atherosclerosis of vasa nervorum10. When did pt's sisters diag with breast ca? Sorry didn't ask. But should ask in case got BRCA gene.11. Went to pt. on general inspection wht can u see? I say pt abit on the heavy side. Patient beside me only le. Cannot say obese right? waist circum 104cm. What is the significance? I say central obesity. She say how to explain that to patient? I just say studies show that got relation btw central obesity and CVS risk.suddenly pt don't have glove n stocking numbness dy. sigh. Then dr say maybe I press too hard causing pressure sensation instead.
Which sensation is lost first? Vibration12. Demonstrate how u want to check her foot when she comes for f/u? Check interdigital webspace, pressure points, ulcers
13. What abt skin? Look for warmth, pulses,skin changes
14. Demonstrate the landmark of dorsalis pedis. Draw a line between two malleolus. Take the midline n draw to the 1st interweb space. Then lateral 1/3 (said wrongly, should be distal 1/3)
15. Go back to room. What investigations u wanna do? Check FPG and HbA1c
16. What's your target HbA1c? 6.5%
17. Pt got 6.9%. Means what? Poor control, so refer dietician.
18. What u recommend pt to eat? How many portion? Complex cbh mostly. More protein, less cbh and fat? Wronglo
19. How many calories per kg? 30-40.

Pt is 90kg, need how many calories? 2700kcal. So how much weight should u aim to lose for her? Errrr 10% body wt in 3mths?20. Is taichi considered as exercise? I think so. Maybe can suggest to her to jog?
21. Would u really ask her to jog? Oh shit no no, later get OA. Maybe ask her dance more.
22. How to counsel the pt if u detect she got BRCA gene? Not necessarily will get breast ca. Do regular mammo.
23. What other cancer u wanna look for? Lung bcos of fhx. Endometrial, cervical, ovarian bcos of BRCA?
24. What is the 5year survival rate for breast ca? I tembak 80-90%....

<u>Long case:</u>

<u>Prof hussin (psy) and another 2</u>
<u>doc I don't know..</u>
Case: obstructive jaundice..
68 y/o chinesse lady background
hx of hep b carrier, coming with RHC pain,jaundice and pruritus..then blab la..summarize
and give ddx; obstructive jaundice secondary to chronic hep b, hep c and hepatocellular carcinoma.
Q: ok..lets do the pe
Perform the PE and basically doc
want to know how do u palpate the liver..
Q: what ix u wants to do?
Q: how to manage the HCC in
detail..
Very easy case but I'm doing so
badly..aishh..gud luck junior..do your best ok!..

<u>Atikah Samad</u>
Paediatric
Dr Choo Yao Mun, Prof Shahrul, can't remember the other prof

12 yo Malay girl, k/c/o Thal intermedia. No C/c just came for exam
Both parent Thal carrier with 2 of her siblings is a Thal patient(not sure major or intermedia)
Initial presentation : at 5 month old had fever for 3 days.no other sx.
blood transfusion : 1st transfusion at 5 month old. then 3 monthly.Since 6 month ago had monthly blood transfusion bcoz of her short stature.pre transfusion level :7-9. post transfusion level : 11-12
iron chelation therapy : start when iron level 1500-2000.latest level 3000.8x/week around 6-8 hour of 3 bottle everyday
no sx of thal related complication
latest ix all normal no hepatosplenomegaly, echo normal..plan to do hormonal ix next 2 month
PE all normal. No thal feature except for prominent gum(forgot what it is called :P)

Questions :
1. What is thal intermedia and its example
2.This pt presented at 5 month old..is it common for thal intermedia to present at this age? when do they present?

3.why do the doctor want to do hormonal ix?
4.When do we start iron chelation therapy..after how many blood transfusion? what is the iron level to start ICT?
5.Now the patient is short, what do you want to do next
6.what is the cause of short stature
7.what hormonal ix you want to do?
8. Is the gum normal? why is that so?
9.Tanner staging.what is the component and what is the tanner stage for this patient
10.how long does it take for a girl to achieve menarche after they develop breast bud
11.Lets say this patient come to you for the first time, what will you do..what ix to confirm Thal?
12.what is Hb electrophoresis and its principle
13. How to differentiate intermedia and major based on electrphoresis
14.What is your management now? Do you think this patient received enough blood transfusion? why?
13. What is our aim for post transfusion Hb level
14. Do you think this patient now behave like a Thal major patient?why?
> take a complete social history..how is she doing at school.is she ok with her short stature.Does she feel embarrasses? bla bla bla...plot growth chart and know how to interpret.Gud Luck!

Noor Aini
Orthopaedics
Examiners: prof saw lim beng, prof ks tan, prof
william(external)
58/I/lady.long standing type2 dm,hpt and renal failure
currently on dialysis. Come from dressing room. Presented with left foot ulcer
for almost 1 year at the base of 1st metacarpal toe. Associated with purulent bloody dicharge until now,numbness and bilateral legs swelling. Initially have fever, chills and rigor. No pain, hx of trauma, or wearing tight shoes. do dressing
2x/wex and sometime at home. There was a
temporary period of ulcer cover with the skin. previously has foot ulcer 2x and
carbuncle at the back 2x.
Foot care history-wearing special shoes for diabetic foot
pt, not barefooted in the house except toilet but will wipe the foot with towel n let dry. Apply vaseline everyday for dry skin. Proper nail cutting.
Dm and hpt more than 20 years. Dx during pregnant 2nd
child.after birth started with OAD. Not compliance. On insulin for 10 years. Last
year diagnosed with renal failure and stop insulin and started dialysis. 2 month ago started with daonil and gliclazide. Surgery- 2 amputation , 2 carbuncle.
Details about social hx-functional status,housing,type of
toilet, how was patient coping with the non healing foot ulcer at home. Diet mainly carbohydrate n fatty meals. No exercise at all.
My dx- non healing dfu with underlying chronic om

complicated with uncontrolled dm,hpt and poor lifestyle.
PE-describe leg(right big toe and left 2nd toe amputated,trophic changes,pedal edema,loss dorsalis pedis n posterior tibialis pulses),show sensory
loss(stocking dstribution),vibration,propioception and knee and ankle reflex.fundoscopy findings. Q-what findings if pt has arterial insufficiency-6P's(pain,pulseless,perishingly cold,paralysis,paresthesia, pallor)
Q-what do you think the ulcer is not heal?
A-uncontrolled dm(as bedside glucometer 24.5mmol/l),
underlying infection, pt keep mobile n put pressure on the ulcer??
Q-what is type of amputation-Ray amputation
Q-ix-xray findings-in chronic OM-rarefaction of bone,sclerotic lesion,bone destruction.
Q-mx-conservative and surgical (wound debridement,i&d,amputation)

IK

prof shahrul(geriatric),prof asma(paeds), prof unknown(external)
22 years old, malay, lady
-k/c/o: sle,asthma,epilepsy,newly diagnosed with minor stroke
-c/o: left sided hemiparesis, asthmatic attack
-on wheelchair, paraparesis since 8 years old after diagnosed with sle, left handed
-has history of depression d/t abused by mother
-lives with adopted family 6/7 months ago(detailed social history here)
-prof asked me more on stroke features in history(i bluff here n there..lol)
-differentials for left sided hemiparesis
-history too long, after finished history, brought to bedside
-p/e: described cushingoid features(prolonged steroid uses), upper limb examination
-back to room, prof asked about medication side effects- i dun really asked d patient-not enough time :(
-what triggers stroke in dis sle patient?pathophysio?
-causes of stroke:embolic, thrombotic,hemorrhagic
-what syndrome (sle+stroke)-antiphospholipid syndrome
-hypercoagulable state?
-investigation
-what to monitor in patient with warfarin??;inr
-ice quest
-patient's relationship with family mmbers
(i dun remember much of d questions asked, sorry!)

nor fadilah mohamad yusof

examiner : dr sofia(O &G), dr saja (PCM), external (main examiner)
26 y/o chinese gentleman c/o progressive dysphagia for 5 years.
diagnosis : esophageal achalasia
history : progressive dysphagia started with solid and now more problem in swallowing liquid.
associated with frequent regurgitation and occasional heart burn
history of admission to UMMC due to severe dehydration.
no other significant medical and surgical history
work as primary school teacher.

history wise, not so much comment.
make sure cover and elaborate the chief complain in detail
exclude other possible cause of dysphagia
cover constitutional symptoms, risk factor for esophageal ca as well as complication. *in this case most important is aspiration pneumonia d2 frequent regurgitation

bedside : do respiratory examination
finding : normal.but he asked where particularly the lung area that u think most probably affected. i couldn't answer initially.but he guide me to use common sense..:)
so, answer is right side, lower lobe due to position of the bronchus (more vertical) and due to gravity.

back to room.question asked :
-whats is the common complication of frequent regurgitation.
ans : aspiration pneumonia
-how to differentiate btween vomitus and regurgitation
ans: do ph testing, look at the appearance of the content.
-test for diagnosis
i answer ogds and barium swallow.he wanted 1 more. I answer esophageal manometry (*patient told me earlier)..he said good..:)
- complication of barium swallow. ans : aspiration again..
-what is the most appropriate management since pt still young and fit
ans : surgery..
what the surgery called
i just answer, cut the unrelaxed part..he wanted the name of the surgery. ans : herller's operation (i couldn't answer, he told me.:)
- what is the epithelial lining of esophagus..
- what other causes of dysphagia..
i answer esophageal ca & barrett esophagus
so, he asked about pathophysiology of barret esophagus.
that's all I can remember..
good luck everyone :)

Adibah

Examiner : Prof Chin Kin Fah. Prof Ida Normiha, 1 externalPatient: 36/Male Dx: Recurrent colon ca, complicated with enterocutaneous fistula, and currently on TPN.Brief hx: Patient initially presented with complete IO 2 years ago. Went for right hemicolectomy, chemo,pet scan, sigmoid colectomy, radiotherapy.Then patient have enterocutaneous fistula. 10 days before current admission patient presented with diarrhea 10-15x/day for 10 days. Current admission because severe dehydration, and need dialysis because of hyperK.
Questions1.What is PET scan2. What type of shock currently pt have.3. Bedside - assess nutritional status - wasting, skinfold thickness, mid upper arm circumference, BMI, etc. how to check for ascites, what type of ascites, what is fistula, what type of discharge from the fistula, what are the components of tpn, PICC, why use PICC not branula, check pedal edema, + prof said, this patient have abdominal distension (which is not so obvious) and ask why.. actually, it's due to recurrence and currently pt have incomplete IO. 4. What is your dx - recurrence colon ca5. what ix.

Kim Lee Hui
examiners: dr. soffhea, 1 PCM Prof and 1 external...
mainly about DM as it is a PCM case...
65 yo Chinese lady came w no active complain however found out to have bilateral ankle swelling for 1 month.no PND, no orthopnea,no chest pain and intermittent claudication.no jaundice or liver failure sign.no frothy urine and other renal sign.
DM diagnosed 10 years ago and found out incidentally.OGTT was done and the post 2 hr glu was 8.so she was then on 3 months of lifestyle modification.however,it failed and she was then given metformin. currently she is taking metformin,losartan 1 more med(pt dunno drug name).compliant.no home self blood glu monitoring and usually postprandial blood glu during follow up is 10-14.follow up 4 monthly under RUKA.no hypo or hyper episode and no hosp admission due to DM.controlled diet and healthy lifestyle as she exercise 1 hour every morning including qi gong for 30 min.no complications. check eye yearly under eye clinics and normal. (i forgot to ask HbA1c)
Hyperlipidemia for 10 year as well.on statin and complicant.no complication.
She had hysterectomy 20 years ago and presented with heavy mense,intermenstrual bleeding and also dysmenorrheoa.no scope or biopsy done.did an uss but unsure finding.2 year later she had abnormal findings on her uss for her both ovaries,and thus bilateral sal-oophorectomy was done.she was not on any HRT or OCP.she had no osteoporosis as bone densitometry done few years back showed normal and she had no bone pain or any pathological fracture.
Had an brain surgery done 4 years back due to asymptomatic meningioma.it was found on CT scan and no symptoms like headache ,fit or blurring of vision.
Allergy to aspirin.
No smoke and no alcohol.
Strong FH of DM.

Q: what is the ddx of leg swelling.
A: can be cardiac,renal or liver failure. cardiac failure or nephropathy which complicated by DM.
Q: any risk factor for liver failure?
A: oopss.i forgot to assess for high risk behaviour but she not consumed alcohol. then,i added most of cases of liver failre is due to hepatitis and alcohol.so,i should assess her high risk behaviour TRO heaptitis.
Q: what do u think she need to do bilateral sal-oophorectomy 2 years after hysterectomy?
A: then i said prev she had menorrhagia,dysmenorrhea and i think most probably due to atypical hyperplasia or endometrial cancer or cancer of cervix.(i fgt to mention uterine fibroid). so,maybe mets to ovarian or ovarian tumor,cyst....
Q:what else....?
A: i said dunno...(i think the answer is endometriosis..bcos after finishing the long case,i just recalled my pt did tell me she had endometriosis but i din believe her as she is not nullparity...haha...so do believe in ur patient and they actually helped alot...!!!)
Q: what is the diff btwn DEXA scan and BMD?
A: i dunno

Q: do u think patient has hish risk for osteoporosis?
A: i said patient not consumed alcohol and not a a smoker. however,she had oophorectomy.
Q: any family history?
A: i said no
OK,let go to bedside..
Q: what do u find on the lower limb
A: there is no brittle nail,no dry skin,no ulcer.however,there is hair loss. no glove and stocking loss of sensation and no vibration loss.
Q: where is the pressure point?show me
A: i showed heel...
Q: what else?
A: web space for any tinea infection.thyen showed her
Q: patient had hyperlipidemia so what do u wan to see?
A: xanthoma and xanthelasma.
Q: show me
A: then show eye and fingers lo.but patient dun hv.
Q: what endocrine problem will u anticipate if patient has hyperlipidemia
A: hypothyroidism
Q: what do u find
A: cold skin,bradycardia and hypothyroidism facial feature such as dry and coarse skin,thin hair hair,puffy eye and loss of eyebrow.
BACK TO ROOM,and they are so funny.they looked at each others eyebrow and laughed..lol..they are so cute...
Q: how do u manage in clinics if patient come to u?
A: FBS,FBL,HbA1c, ECG,LFT,RP,fundoscopy.
they give me fasting lipid profile value and ask me to interpret.
then talk abt foot care
A: check foot every day.check sole with mirror.check webspace of tinea infection.cut nail to square.choose correct shoes and well fitted.soft shoe....
rriinnngggg

<u>Yogitagavari Yoganathan Yahambaram</u>

Examiner(Prof David Choon-main,external-quiet but
telling me relax u can answer, Dr Muhsin-quiet)
History: 64/C/gentleman
has bilateral hip pain, previously had left hip
replacement and a right hip injection
however the severity of the pain has decreased compared
previously, also has history of smoking stopped 20 yrs ago, alcohol occasionally, takes Chinese herbal medicine and allergic to tetracycline and amoxicillin. He also has history of hypertension, renal stone and hyperlipidemia.

Presenting history time
1)types of Chinese herbal medicine that you know?i was
like what....then he told me got 2 after i crapped acupuncture and all.
2)what is your provisional and differential diagnosis? I
said OA and he was not satisfied and he was waiting then I said avn he was happy....differential RA and GA...

See the patient

Show me want u want to demonstrate..
1)Do a full hip examination.Inspection got vastus
medialis wasting but not so obvious. Patient had tredenlenburg test positive and a scar at the left hip joint, he ask the exact place of the scar...(greater trochanter), then he ask the gait....i was like antalgic-no, waddling-no,then he shake his body and I was tredenlenburg gait-yes
2)lie the patient down then he inspect again, do Thomas
test-negative, then show galeazzi sign negative, but he keep asking got shortening or not and i said no again...not sure...then did range of movement...all limited at the left side...then when doing internal and external rotation he try to confuse me...finally when doing abduction and adduction i said wanna square the pelvis and he said
i ll put the hand for u in the iliac fossa then i was like how am i
suppose to know its squared or not if u put ur hand....assuming i square already
did abduction and adduction...then how u want to complete the examination(this
is where i got psychoed to the max) and finally answered neurovascular examination (after much prompting)...he was like u wont forget this for ur rest
of ur life rite...i humbly yes prof I will never forget for the rest of my
life...

Came back to room
1)In the rum what investigation u want to do? I start
with full blood count if preparing patient for op and he was like no...then hip x-ray-yes, interpret x-ray tell the avn changes (was only able to tell sclerotic area, others dun remember) and left hip replacement.
2) does OA and avn has same x-ray changes , first said
yes, then he stared at me faster change no.
3)then if u are a gp and the patient comes for 2nd
opinion for right hip replacement, he ask whats ur advice....i said ill advice him to do it bcoz he got pain and
so on...he was like so whats the complication-infection, bleeding
4)infection rate? Success rate of hip
replacement?(dunno-guessing and guessing until the bell rang)
All the best for the upcoming future doctors....

<u>Puteri</u>
Nadiah. Med/Pcm. Prof Sanjiv, Dr Nik Sherina, Prof Ong, with ?external
38 y/o Indian
gentleman
H/x:
Metabolic syndrome (dm, hpt, bmi: 53, high cholesterol)—past bariatric surgery
and defaulted weight loss programme, recurrent cellulitis, elephantiasis :(, psoriasis,
osteoarthritis..
*Current
status, control, compliance, complications, affect on daily living (has sleep disturbances), uses a waking aid.. poor insight on his diseases..

past heavy
alcohol consumer (but no abuse..ask CAGE questions), chronic smoker (9 failed
attempts to quit, access reason of failure and current desire to quit)..strong family history of IHD, diet hx (irregular meals, consumes only outside food, regular consumption of processed, deep fried foods..intake of sugar, salt, etc), not in a current sexual relationship/ not married, occupation hx (no changes
in the last 5 yrs, nature of current job)..
p/e: vitals,
random blood glucose, LL exam (leg swelling, neurovascular..), fundoscopy/visual acuity, do basic cvs, neuro, respi and GI (did very fast due to lack of time..)

(with
examiners) History presentation took a long time. Examiners did not interrupt.
Bedside:
Describe the lower limb..swelling, scars, etc..
What are the
signs and symptoms of cellulitis?
The patient
has pitting edema up to the ankle. What other examinations would you like to
do? – respi, cvs (signs of heart failure), GI (ascites, hepatomegaly)
Examine the
JVP. Discuss the anatomy. Ways to confirm it is a JV pulse.
Look at the
abdomen. Skin changes due to insulin injections.
Back in the
room: List down the main problems of this patient (include the psychological issue, affect on the daily living/ occupation..)
Discuss on
cellulitis and elephantiasis :(..
If you see
the patient in the clinic, what investigations would you like to do?
With the
multiple problems, how would you like to describe this patient in one description??I answered metabolic syndrome..
THE END.. :(

yasmin m.yusof
Case : surgery
Lecturer : Professor Alizan (Main), Prof Ng Pak Cheung
(external paeds), Dr Mohazmi
Mr Ravichandran, 62 year old Indian gentleman, was last
well 3 years ago when he presented with complain or worsening lower abdominal
pain for 1 month. Pain : initially at lower abdomen, colicky in nature, no radiation of pain, severity 5/10.. no painkiller taken. In the first 3 weeks, pain was bearable, still could perform all daily activity, work went on as usual, pain did not disturb sleep. During the 4th week of illness, he experienced unbearable abdominal pain, disturbed his sleep and

immediately came
to the hospital. Assoc with 1) altered
bowel habit: in the first 2 weeks of
pain, had overflow diarrhoea, thought it was food poisoning, and did not seek
medical attention. He could still go to work daily, and no sleep disturbance.
Subsequently, constipation, where stool amount was decreased in volume, and
oblong `sausage-like shape', no change in color and no per rectal
bleed. No tenesmus. 2)vomiting and
abdominal distension during the 4th week of illness. Investigations at
AnE showed obstructing lesion at sigmoid colon. Emergency operation.. Patient
diagnosed with colon CA stage 4 based on CT scan done. He was found to have
liver metastasis. From 2011 to 2013, he had so many interventions done for his
liver metastasis (liver resection, radiofrequency ablation therapy, chemotherapy,
embolization). He was followed up with serum CEA 3 monthly and CT scan 6
monthly, and every time there was recurrence, there would be a `vicious cycle' of
all the interventions for liver mets, dpends on the doctor.
PMH: No DM,
HPT, IHD (Phew, thank God). He has a goitre, in euthyroid status (which I only
knew upon examining him, OMG,so, I quickily asked if he was on any treatment or
any interventions done, & did a thyroid status examination & neck examination.
Just prayed doc wudn ask about it). no
FHX. Diet history : Food lover,
especially meats (a risk factor for colon cancer). Since diagnosed, he
changed to vegetarian diet, to increase fibre intake. Social history (very
important, bcz doc wna know how he is coping with the stoma and work, financial
support, lifestyle changes..thats what Prof A said) : married with 3 kids. Wife
is working, earning rm1K a month. Patient has a security company which he
shares with his friend. Income 6K a month. Still not enough bcz chemo drugs r
expnsive. Gets NGO support 50% for each Rx. Children only 1 of them working,
does not help financially. Works very long hours till he has unfixed meal
times. Does not smoke or drink alcohol. Since having stoma, even cut down
eating so he does not have to change the stoma bag while working.

Discussion
Prof A: tell me more about the presenting illness. Why did
it took him so long to see the doctor? Me:
initially patient thought it was food poisoning. patient said the pain was
still bearable, and he did not seek any medical help or take painkillers, and
he could still go to work and sleep until the last moment that the pain
disturbed the sleep that he decided to see the doctor. Prof : Ok.

Prof A: its good u told the story in chronological order.
tell me about FHx, Social history – Me: blurt everything as above
Prof A: how long is his working hours? – Me: ???. I just
said, sorry Prof, I did not ask. (hw to ask that dtail in a limited time)
Prof A: what is patient's education level? – Me: sorry, I
didn ask.
Prof A: how is patient's lifestyle –Me: (I thought for a
while, what did he want and just said what exactly patient told me).. Patient mentioned that his lifestyle has changed. Now, he cant eat all the food he loves, especially meat, lamb and chicken. He is now a vegetarian. –Prof: Yes,thats an important point u have there, means, he defines his lifestyle is his food.
Prof A: summarise
ur history –Me: Mr Ravichandran, 62 yr
old, presented with symptoms of large intestinal outlet obstruction for 1 month
diagnosed with colon cancer stage 4, has undergone multiple interventions for
liver metastasis currently has no active complain. (I gave a bad summary during
exam) Prof A : that is not how I teach u to give summary L
Went to bedside
Prof A: show me his positive finding – Me: patient has
goitre. –Prof : Okay. Hmm,no need. Just proceed with the abdomen.Tell me what u see. Me : EVERYTHING of abdomen inspection even
fullness of flanks, just say it...plus scars(scars : midline laparotomy scar and rooftop scar), stoma bag on the left hypo (Prof A was chanting good,good..hehe, gave me a booster to say more).
Prof A: did u check the stoma. Me: yes, the mucosa is pink,
no excoriation of the surrounding skin, no parastomal hernia, and the stoma is
functioning, bcz there's faeces coming out. Prof seemed satisfied.
Prof A: if patient came to u with that presenting
complain, what is one diagnostic investigation u would like to do?
Me: ct scan . prof: Ok. Other than that.. Me: serum CEA .
Prof : is CEA used for diagnosis? Me : no Prof, it will only support the diagnosis. Prof: listen to my question carefully, one Diagnostic investigation. Me : colonoscopy (I did not answer this initially, bcz I thought an obstructed bowel cannot do a colonoscopy, due to risk of perforation) Prof : okay, tell me
about colonoscopy. Me : a procedure for direct visualization of the intraluminal
part of large intestine. Prof: what are the diagnostic functions of colonoscopy. Me : told 3 (
look in oxford), he want one more ..to look for a synchronous tumor.
Back to the room
Prof A: what
pre-op assessment would u like to do
Me: FBC, Coag, RP, LFT, CXR , justify for each. Serum CEA.
Prof: CEA? Is that for pre-op?..since u like CEA so much, tell me, what is CEA. –Me: stands for carcino embryogenic antigen, it is used to monitor the recurrence of the disease. Prof : it is to? (he said `p', `p' ..haha) – Me: to prognosticate the disease. Prof : yes.

Prof A: patient day 1 post-op, fever..whats ur
impression.
Me: wound breakdown?..Prof: no. Wound breakdown would
only happen at day 3 or 4 bcz inflammation takes time to settle in. Me : line
related infection? Prof : ok. Yes, can. What else? Me : I gave a thinking look.
Prof : do u wna check the calf? Me:owh ya, DVT?... Krinngg. Prof: yes, u may
go
now.
Tips to junior : clerk the HOPI in dtail eventhough its
many years ago, if there's only 1 complain. initially when I enter, I asked
straight what he has, he said colon cancer. i askd, which clinic he has
follow up. Patient said dr BK Yooung..and while clerking , his history was soo
long abt all the treatments
he had done, and to get the chronological order. Luckily I asked in dtail also
abt HOPI, which was 3 YEARS AGO...and Prof A did not wna hear anything
much about
the disease progression, liver resection,RFA, etc. Another friend of mine, she
clerked only HOPI, but the examiner wanted disease progression. Different
docs
have different style. Just be aware. Be brave yea. No one in this world have
the
right to make u anxious (words by Dr Lee CK, thanks doc)

Khairun
Ortho. Prof Vivek (main) Prof Ng Pak Cheung (external Paeds from HK) Dr
Liew Su-May(PCM)
69/Indian/female
bilateral knee OA for the past 10 years. currently on fructosamine n
chondritin for 10 years too..not on regular painkiller. pain relief on resting.

Questions: (mostly asked by prof vivek)
1.regarding history- functional history--squatting/sitting toilet. i missed this
part.
2.he asked bout house circumstances. single/double? how does it affect
patient?
3.What is ur provisional and differential?
4. what other type of inflammatory arthropathy that u know?
5.What investigation u want to do? imaging bilateral XRay Ap n Lateral. What
position u want to do it?sitting?supine?standing?why? standing.to see the
joint space and alignment.
6.Bedside--do general examination and present the positive finding on knee
examination. he also asked where to look the bouchard n heberden nodes.
the positive finding are bilat crepitations and limited ROM on right knee. Prof
Vivek ask me to show how i do it.
7.Prof Ng asked, so based on PE which leg are more affected?
8. Back to the room--so what further treatment u would like to offer to this
patient?
-pain relief (what drug? side effect? NSAIDs-gastritis ,PUD, renal failure
-physio-muscl strengthening
-walking aid
-intraarticular injection of steroid and arachidonic acid
-lastly surgery

9.so in this patient, would u offer surgery for her? the answer is no. Why? tell based on history and PE not much pain,joint not severily affected. besides she's not on regular painkiller.so should start that first.
10.Prof Ng (since he is a paediatrician) the question was if a child age 5 year old came in with unilateral swelling and knee pain, he is febrile, what crossed ur mind, on PE what u wanna looked for?
-look fo swelling, skin changes eg redness (he said the skin is red), temperature(temperature is high),any scar (no scar),
so what is ur diagnosis? i offer malignant bone tumour.
what else which is more common?this pt is systemically febrile. i answer septic arthritis.
So what is the most common organism? Staph aureus. 2nd most common?i answer again staph aureus(i try to answer like what dr chan ortho taught-- they laugh, if first one is staph aureus, the 2nd one could not be staph aureus too..haha)
so, how u want to manage this child?

andddddd Kringgggggggg! Thank u. All the best people. Be confident! or at least looked confident. Don't forget to smile in front of the examiner.They are all very nice

Su-Ann.
Examiners : Dr aizura (O&G), Prof Fatimah (Paeds), Prof Bee (Medicine).
Case : normal pregnancy with 2 previous scars.
32yo malay lady, G3P2. Currently at POG 29th week. 1st pregnancy EMLSCS due to fetal distress. 2nd pregnancy ELLSCS due to placenta praevia. Otherwise no significant history.
Questions:
1) Why does this lady has REDD? Because she couldn't rmb her LMP and the fetal growth does not correspond with her dates during the 1st scan in 11th week.
2) What do you think the doc measured for the fetal growth? Crown rump length. Then I explained Pog=CRL +6
3) Why need to repeat US in second trimester, what do u think is the doc's biggest concern? Look for fetal abnormality(as her first baby was macrosomic although no GDM), biggest concern is another PP (due to previous PP and scars)
4) Ask about obimin. How to administer. Obimin is a medication consisting of ferum, vit b12, folate & many others vitamins and minerals for Hb production. Best given at empty stomach, but if pt complained of cramp or discomfort, can give together with food.
5) Why do you think pregnant lady has anemia? Cut off value. Most common cause of anemia in Malaysian women. Answer : Hemodilution due to increased plasma volume. 11g/L. Iron deficiency anemia.
6) Describe what you see.(scar)
7) What peripheral findings would you look for in pregnant lady? Answer : pallor, palmar erythema, hydration status, thyroid lump, breast lump, vaginal discharge.
Present ur abdominal findings. For dr aizura, must emphasize on clinical estimation(means measure the SFH without the tape, just with bare hands)
9) Elicit pedal edema. Why press against the tibia shaft. I answered coz it is the bony prominence.

10) What worries you most in this pregnancy? Uterine rupture
11) As Ho on call, the patient complained of abdominal pain. How would you know it is contraction pain or impending rupture? Contraction pain would last 30-45 secs, would go off spontaneously, pain in impending rupture is continuous.
12) What clinical findings would you look for? Tachycardia, tenderness over the scar..
13) If u r the only person in the ward, what tool would you use to confirm your findings? CTG.
14) How to differentiate? Contraction pain : presence of contraction on uterine tocograph, impending rupture : asytole.
15) What would you advise this patient after delivering this child? Permanent contraception. Why? Bcoz already got 3 scars. How to do it? Ligation of bilateral Fallopian tube. Do you think u need to discuss with her husband before this procedure? I said I would leave the decision to the pt, but would give my advice and tell her the risk. What if the patient refuse the surgery? I would tell her the risk and benefit, but in the end, the decision is still up to the pt.
16) Btw her first and second pregnancy, the gap is quite close. If u were the doc in charge, what would you have done? Advice on contraception, coz safest to have another VBAC after 18 months.
17) What about btw her 2nd and 3rd pregnancy? I didn enquire what contraceptive method she used bcoz she didn conceive for the past 3 years. Dr further asked, what contraception method would u advice? Then I said temporary like OCP, IUCD, condom (but she wasn't too happy with the answer condom, I think probably due to religion?)
18) Would u be surprised if I tell u the fetus is in oblique lie? No, because POG 29, baby still moving.
19) Would u be surprised if I tell u the lady has PP? No, because she has two previous pregnancies and scars. High risk. Also mentioned I would especially look out for placenta accreta. Then she what is accreta.
20) Assuming the lady has GDM, how would u manage the lady? Start with lifestyle modification, increase physical activity. Refer to dietician for dietary advice. Then prof Fatimah dominated the whole Q&A asking bout diet : how much calories per day (25-30kcal/day), how much ferum per day (not sure), how much calcium per day (I said two glasses) she wants how many mg/day (answer is 800mg/day)@@
21) Advise on diet to increase diet intake. (usual pcm answer)
Good luck all!

<u>Siti Fatimah</u>
Examiners: Prof Erle (NUS,main),Prof Husain(psy),Dr Khaidir(uro).
Pt,26y/o,Male,single,No past medical or surgical hx.
c/o; Sudden onset bil.lower limb paralysis 1/7 prior to admission.
with hx of 1 month hx of proximal myopathy described as difficulty to climb up stairs and getting up from squatting.
Multiple visit to clinic treated as normal muscle pain.
basically try to find the cause for proximal myopathy n sudden ll paralysis.
So hx need to rule out,
-trauma,cervical myelopathy,NMJ disorder such as MG,polyneuropathy such as GBS,charcoat marry tooth,cauda equina,
endocrine.etc

At the end pt has s/s of hyperthyroidism
Treated medically(propanolol,carbimazole,potassium,metformin) then radioiodin
P/E:Hyper/hypothyroid sign.+acantosis nigrican.
Discussion: 1) About proximal myopathy
2) Grave's disease,vitiligo,etc
3)Hypothyroidism,tx in those with previous MI n heart failure. (low dose l-thyroxine,due to possible arrythmia)
4)Hypokalaemic periodic paralysis

aini johari
examiner: prof Hatim (psy), prof BK Lim (O&G), Prof nik sherina (PCM).. . bipolar type 1 in manic.. k/c/o bipolar since 20 years ago. multiple hosp admission and Tg rambutan (aggressive behaviour). last hosp admission 3 years ago.. currently came with c/o inability to sleep for 3/7 and elevated mood (happy) for no specific reason.. other manic symptom dont have since he know early sign of relapse (very educated pt) came by his own to get treatment..on epilin and few of typical antypshycotic..prev hx of 6 cycle ECT (well response) and had 2 cycle ECT for this current admssion.. had 1 hx of EPS symptom (mouth deviated for 1 side for 1 month).. discussion:Q: justify y u said manic?? Q: what sx of manic? ur DDX? indication of ECT in this pt (failed medical therapy) .. C/indication for ECT? (increase ICP) what else? (blurr) what ix done before ECT done and y? how u manage this pt since pt already in multiple drugs? what cx of psychotic drugs? Prof ni sherina: how pt's DM control? how u ask regarding cx of DM? what is BMI? pt's BMI? (overwt) if pt 1st presented to u with mouth deviated to one side and the dx is TIA, how u managed? pt social support, is it good? how to assess compliance? (since i told her that pt is compliance w medication.. do u believe wht did pt told u? huuuuu ~~ a bit regarding issues on pt confidentialty prof BK lim: ask detailed regarding pt social hx (since pt divorced twice and who take care of the children? y divorced? r/ship with ex-wife and children?

kong soo ting
examiners: Dr musin (psy), prof elle lim?? (external) , prof david choon (ortho)
case : psychiatric illness for the past 34 years but pt unknow what is it with background history of DM,HPT, dyslipidermia and psoriasis
the psychiatric illness started with bipolar symptoms (mania and depression) , one suicide attempt before, last break out was in year 2004 , currently stable and work in the psy day care (the aunty darreon)
DM,HPT , Dyslipidermia were well controlled and no complications seen
she is on clazapine (omg clazapine is for tx resistant schizophrenia. start to nervous. actually it can be used as off labeled for bipolar too but not sure in UM got use or not)
start to focus asking schizho symptoms
but she only have disorganized of behavior , disorganized of speech (both also can seen in bipolar) and negative symptoms
she deny of having any delusion and hallucination
on further questioning she dropped off from school at F4 dt at that time she actually started to experience disorganized behavior and negative symptoms (so i put my provisional diagnosis as schizophrenia rather than bipolar)

her husband passed away 12 years ago and she described she is become more stable after her husband die.
father passed away 4 years ago but it did not seen to affect or trigger her illness

Q@A mainly by dr mushin
Q: tell me your diagnosis
A: schizo
Q: why?
A: although she did not presented with delusion and hallucination , she did presented with disorganized of behaviour and negative symptoms during form4 thus the schizophrenia came before the mood symptoms
then it can presented in schizo then blah blah
Q: pt stop school at F4 what does it tell you?
A: deterioration of functioning
Q: how do you diagnosed schizo (refer DSM criteria)
Q: if pt did not have hallucination and delusion can you still said it is schizo? why?
A: can. end up he wants the brief schi things
Q: how do you want to mx this pt
A: if it is the 1st time, i would like to confirm the diagnosis and rule other things such as thyroid problem by doing thyroid function test and ct scan to rule out any brain pathological problem
since pt have the hx of multiple drug changing in 2004 so i would like to said she is tx resistant so would like to start clozapine
Q: what do you mean by tx resistant schzo
A: max dose , and on two different type of medication
he want to add (pt must adherence to the medication and the follow up)
Q : what is the S/E of clozapine
A: 1% risk of getting agranulocytosis so need to check the FBC weekly for 18 weeks then later on monthly
suddenly i describe normal mood
what the normal mood call
i cant rmb the name of euthalmic
the external examiner: i am not happy with your diagnosis , according to the hx it does not sound like schi so tell me your differentiate dx
A: mood disorder (bipolar type 1)
Q: how to mx
A: blah blah blah (read la)

prof david choon: tell me how do you want to educate pt's family members
A: family session then tell everything about the dx
but he keep asking what more then bell ring

that's all what i can rmb

muhd su'aidi
examiner:prof sajaratul (PCM),dr nuguelis (OnG),external..case: metabolic sx plus OSA...HPT x5yrs + DM x1 yr+ complaint of difficulty in breathing,poor sleep,sleep apnea,daytime somnolence,snoring noticed by fmily members (typical OSA)..strong fmily history of malignancy (father died d/t renal ca,sisters got breast ca)..Q: 1. elicit risk factor of breast ca in dis pt..2.screening of breast ca in malaysia (according to age)..3.DM good/poor

control?..4.pt used one device during sleep to aid her breathing (nasal prong + box with monitor)prof ask what is it- i dun know the name of the machine =.=...5.provisional dx+criteria of metabolic sx (details)6.daytime somnolence-did u ask her daily activity,does she driving?..7.social hx-lives in a flat..what kind of problem could arise (no lift/environment)..PE= 1. pt came to ur clinic,whats ur general inspecton?..2.show sign of metabolic sx that u wan to look for (xanthomata,xanthelasma,acanthosis nigrican,measure waistline,funduscopy must do!!)..3.did u check the carotid? =.= forgot,need to rule out carotid bruit..4.elicit peripheral edema..5.differential dx from peripheral edema..6.why want to check urine/what to look for?..back to room..Q:ix of heart failure 1. CXR (ABCDE)+ECG(LVH findings)+echo(EF for systolic vs diatolic HF)ringgg..usaha doa tawakal iA..good luck

<u>Etty Salleh</u>
<surgery> examiner: external (DR. William), Dr. Sofia(o&g), n Dr.?(x ingat)
Hashimoto Thyroiditis (52/I/F)
bedside: examine neck, show what to expect in Thyrotoxicosis and what features for hypothyroidism and gt few discussions..(lama gak kat sini)
in the room : what Ix? TFT-TSH high..why? can we directly increase dosage of throxine? no..why? pt no compliance n hv to educate, explain and titrate TFT at least for 1 month. How to educate pt? So just telling bout thyroid function and some complications due to hypothyroid.
then i said FBC. Why? (actually this one important in hyperthyroid who is on carbimazole..tapi dah tercakap..so hv to make up :p) so look at Hb to prevent anemic..why? if pt got cardiomyopathy..worsens heart failure. What type of anemia? i said normochoromic normocytic (random guessing) but actually megaloblastic anemia..
then said RP since pt got hpt for about more than 10 yrs..just to look at creatinine as baseline..
then i said would like to offer thyroidectomy. then Dr ask would it cure her disease? i said no cause its an autoimmune. offer surgery just to relieve compression symptoms such as SOB, dysphagia (this pt got changes in her voice) but before that hv to make sure TFT is euthyroid..then times up
p.s: shud told about anti thyroglobulin test..but since at that time cant remember the anti thyroglobulin punya nama..so i avoid from digging my own grave~

<u>Chai Boon Ceng,Gynae. (sry for the late post)</u>
External(with weird slang), Prof jessie(paeds), Dr muhsin (Psy)
30/M/female
Uterine fibroid for 4 years
Dysmenorrhea,menorrhagia after getting married
Infertility for 2 years, check up shows blocked right F tube and submucosal fibroid near the cervix
Last pregnancy :
During pregnancy a colposcopy was done and shows polyps.
Baby preterm for 1 week dt leaking liquor,SVD,baby NNJ at D2 of life dt ABO incompatibility.
Treated with tranexamic acid,ferrous fumarate ,vit B complex and folic acid.
No other complaints,no significant FHx of ca

Q:what types of dysmenorrhea does she have?(give the definition as well)
A:2ndary dysmenorrhea.
Q:Pt claimed that she had blocked F tube?
A: at first I answered US of pelvis,but later change to hysterosalpingogram and he said yup..
Q:what is colposcopy for?
A: Magnifying lens to see micropic changes in the lining of cervix suggestive of premalignant lesion
Q:What is the premalignant lesion called?
A:Thought blocked a while,then blurts out cervical intraepithelial neoplasia
Q:How to differentiate fibroid fr ovarian mass fr fibroid in the US scan?
A: try to elaine bt the answer seemed not satisfying him

Bedside
Q:show me how do you look for anemia
Q:If the pt is having conjunctival pallor, u r looking at ocular or palpebral conjunctiva?
A: this Q stunned me, never heard of this Q b4.. The answer is palpebral conjunctiva..
Q:show me hw u examine this pt's abdomen
Q:what is superficial and deep palpation for?
Q:How to differentiate tenderness fr guarding?
Q: describe the mass u have found.. (shud include size in term of hw many week POG ya)
Q: what is the diff dx based on the mass u hv palpated?

Back to room
Q:what r the Ix u would order for her?
Q: what is the commonest benign ovarian mass found in this age group?
A: Stunned again,answered physiological cyst,theca lutein cyst,follicular cyst...bt the answer he wanted is dermoid cyst,aka mature cystic teratoma..ok learn sth..
Q: how would u like to mx her?
A: divide into medical , surgical and radiological intervention.

Comment: please come to exam hall at least 10 min earlier ya, I came on time n my group mates all went in d,straightaway palpitation .. Bt luckily gt more than enuf time to clerk n PE.Examiner loved to see me do mistakes zzz(my opinion la),hopefully can pass me..prof Jessie was sleeping when I presented halfway lol..Dr mushing jz smiled throughout the interview..all Q were asked by the external. Gd luck guys

Mow Wei Chin
Medicine(Prof Lim SY,Prof Woo, Dr Haireen)55y/o Eurasian, female, 26 years of SLE, come in for exam purpose. Complicated by three episodes of stroke with full recovery and lupus nephritis. Patient is depressed. suspected antiphospholipid syndrome as she had 3 recurrent miscarriage. Chronic smoker for 15 years. No bed side. Just Q&A. Q: The patient is on warfarin, why not aspirin? Q: Prior to onset of lupus nephritis, the patient had leg swelling, y do u think so? Q: Why you think the stroke is recurrent? Q: What investigations you wan to do? Q: You want to do Pap smear? what other screening test you want to do? Q: How do you diagnose depression? Q: How

can you help the patient in the aspect of finance? Q: Let say the patient come with chronic cough for two months, how you want to manage her?

Lim Chee Sem

Surgery -- Gallstone disease with chronic uncontrolled DM. 39yo malay lady presented with intermittent chronic right hypochondrium pain for 2 years. Just pain and feverish otherwise no jaundice no asc cholangitis no liver decompensation. No hx of hemolytic disease and hepatitis. Pt's not compliance to Diabetic medication for 6 years . She has peripheral numbness and blurring of left vision. Q: whats ur provisional dx for the 1st presentation ? Differential ? investigation ? Q: Discuss on Pt chronic DM and the complication Q: Show murphy sign Q: who is Murphy ? where he comes from ? Q: How u manage her now ? Q: is Shockwave therapy suitable for this pt ? why u want to do cholecystectomy ?Q: how to do cholecystectomy through laparoscopy ? Q :risk for laparoscopy and laparotomy surgery and compare between them Q:Well Score for DVT Q: How about Dm how u manage her ? would u want to start insulin on her ?

Mohd Syazwan

Medicine -Prof KS Lim(main),Prof Low(OnG),Dr Khaireen(PCM)
55 y/o eurasian lady
k/c/o SLE,lupus nephritis,antiphospholipid syndrome,3x 'mini' stroke,hypertension,gastritis,
osteoporosis and so on..long history..spend about 15min for history and PE(full PE..damn it)...
1)how she know she has Antiphospholipid syndrome?
2)why doctor inverstigate her for APS?
3)did she had any miscarriage previously?(i didnt ask)
4)why APS cause miscarriage?
5)other than stroke,what evidence there is to say she has APS?well i dont know prof..
just explain nature of the disease.but they keep asking me the same question.
6)how many time she had flare?how did she presented?(already told in the history so just clarify it)
7)how to monitor the disease?investigation...CRP,ESR,anti dsDNa.
8)what complication from the prolonged steroid use that she has?

go to patient..

show me what u want to show me..
so just show the complication from the steroid use..i got stuck at the abdomen..i mistakenly mention about
striae albican from previous pregnancy...and need to explain differences btw striae albican and striae from the steroid.
and then do neurological examination of lower limb...only manage do until tone and clonus,
prof ask, u mention patient has previous stroke,what do u expect of her tone if she recovering from it?
then kringgggggg!!!!...

no investigation no management question..but somehow i'll pass...syukran alhamdulillah...

Shikamaru Syafiq
Same case as Rahmah Rambli ..Prof william(external), prof asma, prof shahrul geriatric ...gallstone. just i present as surgery case. so history same with rahmah. typical symptoms of cholecystitis..just add husband has psy problem. not compliance to DM medication. always try traditional medicine for DM n gallstone. on insulin just for 1 months then refuse to cont. ade babi dalam insulin she said.HBA1C 9. last is 7.9 if not mistaken..father die due to hear attack.other family ok... i mention as chronic cholecystitis bcoz she had symptoms for 1 years and intermittent .. discussion mostly from external but other examiner also ask - 2 history x complete (age of father die, she teach what subject at school). so just said " i'm sorry prof i didnt ask but i know its importnt bla bla bla. just goreng" so they happy.. Q - why she has pain at RUQ? mechanism of pain in this pt.. give 2 reason possible (just goreng what u know from basic inflammation , and possibility of stone in duct) then prof william smile and said " u talk like politician u know. u give me choice to choose. haha. " haha so just cont goreng about inflam n how gallstone can cause it... Q- why patient had pain at right tip of scapula? " referred pain" Q- so what is reffered pain, what is the mechanism.. haha " so just goreng what u know la. give definition of reffered pain, concept behind it and share same nucleus bla bla bla... prof said, ok i can accept that.. then next Q more focus of patient u/s what u aspect to see, where obstructed, hbaic level, normal value and other Ix .. so just talk what u know and always relate with patient sign and symptoms.. they will b happy.. i mention about pt complain sensation and blurring vision so prof asma ask about why this happen. so then change to complication of DM lorr,... then prof shahrul ask what type of stone in this pt u think " so i just mention all type of stone and which 1 common . also give percent of common around 70% ithink.. haha so they impressed... there still a lot of Question they ask but sorry i forgot some of them. basicaly prof william not ask standard Q such as how u want Ix ths pt, how to manage but he give me example then want me to explain it.. mybe because of the simple case... some miscommunication btwen examiner. mybe becasue prof william still new with our exam system.. Prof William thought only when the bell ring we need to go see pt.prof sharul try to mention to him but he not understand mybe... so spend all 30 minute diccussion.. then he said sorry to me because of the problem. . P/s : they all very nice and smile. Just keep on talking what u know so that they dont know what u dont know... and important thing keep on praying to Allah. Only He can help us..

Kim Lee Hui
i pasted my case 1 more time here in case it lost again..
examiners: dr. soffhea, 1 PCM Prof and 1 external...
mainly about DM as it is a PCM case...
65 yo Chinese lady came w no active complain however found out to have bilateral ankle swelling for 1 month.no PND, no orthopnea,no chest pain and intermittent claudication.no jaundice or liver failure sign.no frothy urine and other renal sign.
DM diagnosed 10 years ago and found out incidentally.OGTT was done and the post 2 hr glu was 8.so she was then on 3 months of lifestyle

modification.however,it failed and she was then given metformin. currently she is taking metformin,losartan 1 more med(pt dunno drug name).compliant.no home self blood glu monitoring and usually postprandial blood glu during follow up is 10-14.follow up 4 monthly under RUKA.no hypo or hyper episode and no hosp admission due to DM.controlled diet and healthy lifestyle as she exercise 1 hour every morning including qi gong for 30 min.no complications. check eye yearly under eye clinics and normal. (i forgot to ask HbA1c)
Hyperlipidemia for 10 year as well.on statin and complicant.no complication.
She had hysterectomy 20 years ago and presented with heavy mense,intermenstrual bleeding and also dysmenorrheoa.no scope or biopsy done.did an uss but unsure finding.2 year later she had abnormal findings on her uss for her both ovaries,and thus bilateral sal-oophorectomy was done.she was not on any HRT or OCP.she had no osteoporosis as bone densitometry done few years back showed normal and she had no bone pain or any pathological fracture.
Had an brain surgery done 4 years back due to asymptomatic meningioma.it was found on CT scan and no symptoms like headache ,fit or blurring of vision.
Allergy to aspirin.
No smoke and no alcohol.
Strong FH of DM.

Q: what is the ddx of leg swelling.
A: can be cardiac,renal or liver failure. cardiac failure or nephropathy which complicated by DM.
Q: any risk factor for liver failure?
A: oopss.i forgot to assess for high risk behaviour but she not consumed alcohol. then,i added most of cases of liver failre is due to hepatitis and alcohol.so,i should assess her high risk behaviour TRO heaptitis.
Q: what do u think she need to do bilateral sal-oophorectomy 2 years after hysterectomy?
A: then i said prev she had menorrhagia,dysmenorrhea and i think most probably due to atypical hyperplasia or endometrial cancer or cancer of cervix.(i fgt to mention uterine fibroid). so,maybe mets to ovarian or ovarian tumor,cyst....
Q:what else....?
A: i said dunno...(i think the answer is endometriosis..bcos after finishing the long case,i just recalled my pt did tell me she had endometriosis but i din believe her as she is not nullparity...haha...so do believe in ur patient and they actually helped alot...!!!)
Q: what is the diff btwn DEXA scan and BMD?
A: i dunno
Q: do u think patient has hish risk for osteoporosis?
A: i said patient not consumed alcohol and not a a smoker. however,she had oophorectomy.
Q: any family history?
A: i said no
OK,let go to bedside..
Q: what do u find on the lower limb
A: there is no brittle nail,no dry skin,no ulcer.however,there is hair loss. no glove and stocking loss of sensation and no vibration loss.
Q: where is the pressure point?show me

A: i showed heel...
Q: what else?
A: web space for any tinea infection.thyen showed her
Q: patient had hyperlipidemia so what do u wan to see?
A: xanthoma and xanthelasma.
Q: show me
A: then show eye and fingers lo.but patient dun hv.
Q: what endocrine problem will u anticipate if patient has hyperlipidemia
A: hypothyroidism
Q: what do u find
A: cold skin,bradycardia and hypothyroidism facial feature such as dry and coarse skin,thin hair hair,puffy eye and loss of eyebrow.
BACK TO ROOM,and they are so funny.they looked at each others eyebrow and laughed..lol..they are so cute...
Q: how do u manage in clinics if patient come to u?
A: FBS,FBL,HbA1c, ECG,LFT,RP,fundoscopy.
they give me fasting lipid profile value and ask me to interpret.
then talk abt foot care
A: check foot every day.check sole with mirror.check webspace of tinea infection.cut nail to square.choose correct shoes and well fitted.soft shoe....
rriinnngggg