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QUESTION 1

A45-year-old woman, seen by her medical internist, has been experiencing fears that she may have a serious illness. She complains that after eating she experiences "a lot of gas" and abdominal pain, followed by diarrhea on occasion. Her heart at times seems to be beating rapidly, and she feels faint at times, has chest "discomfort," and wonders if she is having a heart attack. Multiple tests have identified only a mild irritable bowel syndrome. The woman\\'s fears are not allayed by this. She makes repeated calls to be seen by her doctors as well as seeking consultation from other specialists. She insists that "there\\'s something there" and believes the doctors are not taking her seriously.

Which of the following is the most likely diagnosis?

A. factitious disorder

B. major depression

C. reaction psychosis

D. hypochondriasis

E. pain disorder

Correct Answer: D

Hypochondriasis is a somatoform disorder in which misperceptions or distortions of somatic signs and symptoms lead to preoccupation with fears of having a serious illness. In factitious disorders, one deliberately manufactures signs and symptoms to enter the sick role. The preoccupation with fear of serious illness is not part of factitious disorder. Major depression is characterized by symptoms of depression: sleep disturbance, appetite disturbance, and so forth.

It may be complicated by hypochondriasis. In the case study, no supporting evidence for major depression (for which she would have been evaluated) is provided. This woman\\'s symptoms as described are not of a psychotic level; thus, reactive psychosis would be inappropriate. In pain disorder, pain in a specific body site is the predominant focus, unlike the predominance of fear seen in hypochondriasis. Care of these patients is best managed supportively by developing a therapeutic alliance with them. Anticipating their needs by establishing regular office visits and physical examinations with them will help allay fears as well as reassure them of one\\'s concern for them, and that if an occult condition becomes evident it will be diagnosed early. Certainly, regular consultation with other specialists is in order to manage these patients. Although the course of hypochondriasis tends to be chronic, there are indications that factor in for a good outcome. One of these is the absence of secondary gain. This disorder is seen equally in both men and women. The prevalence in a general medical practice is approximately 46%. There is no relationship between hypochondriasis and increased ESR.

QUESTION 2

A 48-year-old man complains of fatigue and shortness of breath. His hematocrit is 32% and hemoglobin is

10.3 g/100 mL. Peripheral blood smear reveals macrocytosis. His serum vitamin B12 level is 90 pg/mL (normal, 170940); serum folate level is 6 ng/mL (normal, 214). Which of the following is the most likely cause of this patient\\'s symptoms?

A. poor dietary habits

B. colonic diverticulosis

C. regional enteritis

D. chronic constipation

E. vagotomy

Correct Answer: C

The most common causes of megaloblastic anemia are folate and vitamin B12 deficiencies. Vitamin B12 deficiency rarely results from inadequate intake, but has been associated with strict vegetarianism. Decreased absorption may be due to insufficient intrinsic factor (as in pernicious anemia and after gastrectomy), malabsorption of the intrinsic factor-vitamin B12 complex in the terminal ileum (as in regional enteritis, sprue, pancreatitis, and after ileectomy), or competition for vitamin B12 by gut bacteria (as in the blind loop syndrome and Diphyllobothrium latum infections). Because diverticulosis and constipation do not interfere with stomach or small-bowel functioning, they are not causes of vitamin B12 deficiency.

QUESTION 3

A 38-year-old G4P3013 woman is seeing you for her annual gynecologic examination. She has no specific complaints, but notes that her menses have gradually become heavier over the past 23 years. Your pelvic examination is normal aside from an enlarged uterus, which you estimate at 12 weeks\\' size. Office ultrasonography confirms that she has multiple uterine fibroids. Which of the following statements is true regarding leiomyomata?

Your patient comes back 6 months later with a calendar demonstrating continued worsening of her menstrual bleeding, now 10 days in duration and requiring one pad hourly during her heaviest days. Which of the following statements are true regarding treatment of leiomyomata?

A. Because fibroids are responsive to sex steroids, treatment with GnRH agonists (e.g., leuprolide) will produce up to a 50% reduction in volume.

B. Treatment with leuprolide appears to be long lasting, making this an attractive alternative to hysterectomy or myomectomy.

C. Myomectomy (i.e., removal of uterine fibroids without removal of the uterus) is replacing hysterectomy as it is associated with less complications and less blood loss.

D. Because it requires no abdominal or uterine incisions, uterine artery embolization is the preferred method of treatment for women who desire future pregnancy.

E. Any leiomyoma larger than 5 cm should be removed by either hysterectomy or myomectomy to rule out leiomyosarcoma.

Correct Answer: A

As mentioned, leiomyomata account for more hysterectomies than any other gynecologic disorder, but alternative treatments continue to be explored. Myomectomy (e.g., removal of uterine fibroids) can be performed via laparotomy, laparoscopy, hysteroscopy, or even vaginally. However, it is generally not considered a "simpler" or safer procedure than hysterectomy, and bleeding can be excessive. Uterine artery embolization is an angiographic procedure currently reserved for women who do not desire future pregnancy, as the effects of embolizing both uterine arteries and then allowing pregnancy is uncertain. GnRH agonists are useful in reducing uterine bleeding and reducing fibroid volume up to 50%, but this effect is short-lived and completely reversible. Therefore, this therapy is useful as an adjunct to surgery in improving hemoglobin or allowing a vaginal approach rather than abdominal. No specific size limit exists for removal of a single myoma.

QUESTION 4

A 35-year-old pharmacist complains of "hurting all over." Her pain is particularly bad in her upper back and shoulders, and she notes morning stiffness. On examination, her joints are not inflamed, but she has symmetric "tender points" in the posterior neck, anterior chest, lateral buttocks, medial knees, and lateral elbows. You make a preliminary diagnosis of fibromyalgia.

Which of the following is the most appropriate therapeutic recommendation?

A. avoid most physical activity

B. trial of amoxicillin

C. benzodiazepine in low doses for sleep

D. low-dose steroid

E. low-dose antidepressant

Correct Answer: E

Sleep disturbance is a characteristic symptom associated with fibromyalgia. Patients awaken feeling tired. The examination, other than tenderness in 14 specific, symmetrical points, is usually normal. Fever, rash on the extremities, muscle weakness, and migratory joint inflammation point to Lyme disease or other rheumatologic disorders. Asedimentation rate should be normal. If elevated, it may point to another diagnosis. Lyme titers are not indicated unless the patient has symptoms or history suggestive of the disease. Electromyelography and spine radiographs are typically normal and unnecessary for help in establishing the diagnosis. Depression can be associated with pain, but screening for it early on does not make sense and might offend the patient. Low-dose antidepressants often help to correct the sleep pattern and result in relief of pain. Nonsteroidal anti-inflammatory agents can also be used as needed; low-dose steroid is not indicated. Exercise is also helpful, and patients should be encouraged to stay physically active. Amoxicillin is not used for fibromyalgia. Benzodiazepines have addictive potential and lose their effectiveness for sleep after a few weeks.

QUESTION 5

A63-year-old man with chronic bronchitis presents to the emergency department with worsening shortness of breath. He is dyspneic, his respiratory rate is 32/min, and he has peripheral cyanosis. A chest examination reveals increased anteroposterior diameter and scattered rhonchi, but no wheezes or evidence of consolidation. His ABG determinations on room air are pH of 7.36, arterial oxygen pressure (PaO2) of 40 mmHg, and PaCO2 of 47 mmHg. He is given oxygen by face mask while awaiting a CXR. His respiratory rate falls to 12/min,but his ABGs on oxygen are now pH of 7.31, PaO2 of 62 mmHg, and PaCO2 of 58 mmHg. Which of the following is the most appropriate next step in the management of this patient?

A. repeat the ABG

B. initiate mechanical ventilation

C. obtain a CXR

D. check the oxygen delivery system

E. decrease the fraction of inspired oxygen (FIO2)

Correct Answer: E

Patients with advanced chronic obstructive pulmonary disease (COPD) are at risk for development of acute respiratory failure. Common precipitants are infections, increased secretions, and superimposed bronchospasm. Oxygen therapy is

effective in reversing the hypoxemia associated with respiratory failure. Arisk of such therapy peculiar to patients with COPD is worsening hypercapnia. Affected patients are thought to have lost their respiratory center\\'s sensitivity to hypercapnia, so that their primary stimulus to breathe is hypoxemia. When the hypoxemia is corrected, they may lose their stimulus to breathe and develop carbon dioxide narcosis with worsening acidosis, confusion, stupor, and eventually coma. Because of this, the usual approach is to begin with a low fraction of inspired oxygen (FIO2) and increase gradually. Serial ABGs are obtained to ensure that as PaO2 improves,