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Abdominal X-Ray 2017-2-D

Stem: Abdominal X-rays are performed.			
Question 3 Erect and Supine AXR Subject: CBB	a) Please describe these images b) What is the diagnosis?	Multiple centrally distributed distended bowel loops Multiple air/fluid levels Hernia not seen Bowel obstruction (level not required)	Bold concepts Diagnosis

Abdominal X-Ray 2016-2-D

Stem: Abdominal X-rays are taken. Moving onto the Clinical Building Block.			
Question 2 AXR (bowel obstruction) Clinical Building Block	Describe this abdominal x-ray	Erect abdominal x-ray showing markedly dilated small intestine. Multiple air-fluid levels. Minimal (empty) large bowel loop indicating proximal large bowel obstruction.	Bold to pass

Arm XR 2015-2-C

Stem: Here is her xray.			
Question 2 Clinical Building Block: (# humerus)	Describe the abnormality	Spiral/oblique fracture mid-shaft L humerus with displacement.	
	What structure may be injured in this fracture?	Radial nerve	

Arterial Blood Gas 2017-2-B

Stem: He is drowsy and has low oxygen saturations on room air. You perform an arterial blood gas.			
<p>Question 2</p> <p>ABG</p> <p>Subject: CBB</p>	<p>a) Describe and interpret this ABG Prompt “move along” if trying to calculate A-a gradient</p> <p>b) What are possible causes of these abnormalities in this patient?</p>	<p>a) Acidaemic, hypoxic, hypercarbic (respiratory acidosis), Acute Respiratory acidosis with no metabolic compensation, type 2 Respiratory Failure</p> <p>b) Respiratory acidosis</p> <ul style="list-style-type: none"> • CNS depression from drugs, injury, or disease. • Hypoventilation due to pulmonary disease (cancer, effusion, pneumonia, atelectasis) • Hypoventilation due to musculoskeletal or neuromuscular (paraneoplastic?) disease 	<p>Bold to pass</p> <p>1 cause</p>

Arterial Blood Gas 2017-2-A

Stem: A 60 year-old man presents to the Emergency Department with shortness of breath. An arterial blood gas is performed.			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Question 1 ABG Subject: CBB ABG	a) Please describe the abnormalities	a) <ul style="list-style-type: none"> • Alkalaemia • CO₂ low, thus primary respiratory alkalosis • Low PaO₂ and SaO₂ – profound hypoxaemia • Raised A-a gradient • Conclusion: Hypoxia leading to hyperventilation and respiratory alkalosis 	Bold to pass
	b) What conditions could cause this result in this patient?	b) <ul style="list-style-type: none"> • Any NON central causes (infection, asthma, PE, pulm oedema etc) 	Two causes to pass

Arterial Blood Gas 2016-2-C

Stem: A 75-year-old man with chronic airways disease presents unconscious after a fall down stairs. Arterial blood gases are done.			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Question 1 ABG showing acute respiratory acidosis Clinical Building Block	Describe and interpret the arterial blood gas	ABG on room air pH 7.25 – acidaemia pCO ₂ - 65 – elevated – respiratory acidosis HCO ₃ - 33 – elevated – metabolic compensation (chronic) pO ₂ / SaO ₂ decreased – hypoxia	Bold to pass

Arterial Blood Gas 2016-2-A

Stem: A set of arterial blood gases are obtained			
Question 2: Blood gas with acute respiratory acidosis Clinical Building block	Please describe the abnormalities and interpret these results. <i>Prompt</i> "What is the main acid-base disturbance?"	Low pH High CO₂ High base excess Severe respiratory acidosis without expected metabolic compensation. Low pO ₂ for FiO ₂ (likely A-a gradient high)	Bold to pass

Arterial Blood Gas 2015-2-C

Stem: Arterial blood gases are done as part of his initial trauma work up.			
Question 2	Please describe this ABG.	Primary respiratory acidosis with CO2 retention and hypoxia	Primary respiratory acidosis with CO2 retention and hypoxia
Clinical Building Block:	On O2 – FiO2 60% P02 85 pCO2 123 pH 6.99 HCO3 28		

Biochemistry 2017-2-A

Stem: Here are his blood results.			
Question 4	a) What are the abnormalities and what is your interpretation?	a) AKI (or ARF), hyperkalaemia	Bold
EUC/renal failure	b) What are the broad categories of renal failure? Please provide an example of each	b) Pre-renal, renal, post-renal	
Subject: CBB	c) Which is most likely in this man?	c) Post-renal	

Biochemistry 2017-1-A

Stem: Some blood tests are taken upon arrival			
Question 2 Blood tests	a) Describe the abnormalities	a) Slightly low/normal sodium (or Extra: corrected Na 137), Hyperkalaemia , low bicarb (met acidosis) , Renal failure (likely intra-renal with chronic component), hyperglycaemia	Bold
Subject CBB	b) What could cause these abnormalities in this patient?	b) Sepsis, diabetic nephropathy, dehydration, drug toxicity, DKA	At least two

Biochemistry 2016-2-D

Stem: Biochemistry is performed. Moving on to the Clinical building block.			
Question 3 Renal impairment	Describe and interpret this biochemistry result	All results within reference range aside from elevated Creatinine . Indicates renal impairment .	Bold to pass
Subject: CBB	Prompt if needed: <i>"What does the elevated creatinine indicate?"</i>	Potassium and HCO ₃ normal, indicating absence of acute kidney injury.	

Biochemistry 2016-1-C

Stem: An 80 year old lady with lung cancer presents with increasing dyspnoea and lethargy. Please review her biochemistry results			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Question 1 Clinical Building Block: Hyponatraemia & Osmolarity	<ol style="list-style-type: none"> 1. What are the abnormalities? 2. What are some causes in this patient? 	<p>Hyponatraemia, hypo-osmolar plasma</p> <p>SIADH; CCF; Water intoxication; drugs/other</p>	Two causes

Biochemistry 2015-2-D

Stem: A 70 year old man presents to ED as he has become jaundiced following his return from a trip to India			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Stem: Here are his blood results.			
<p>Question 1 Clinical Building Block: (hepatic and renal failure)</p>	<p>Please interpret these biochemistry results</p> <p>Prompt: what is the pattern of the liver enzyme abnormality?</p>	<p>Bicarb 6 - Metabolic acidosis</p> <p>eGFR 31 mL/min Creatinine 151 µmol/L - Moderate-Severe renal impairment</p> <p>Bilirubin 32 µmol/L (reduced excretion) Albumin 22 g/L (reduced synthesis) - Mild hepatic impairment</p> <p>ALT 1778 U/L AST 5314 U/L ALP 272 U/L GGT 471 U/L -Abnormal liver enzymes c/w hepatitis</p>	<p>Must recognise renal failure and hepatic LFTs to pass. (bold to pass)</p>

Biochemistry 2015-2-C

<p>Question 3 Clinical Building Block: Photo myoglobinuria and biochemistry</p>	<p>Interpret her biochemistry results?</p> <p>Why is her urine dark?</p>	<p>Renal failure likely Acute kidney injury in clinical context - elevated urea + Cr Markedly elevated CK - rhabdomyolysis Normal K⁺</p> <p>Rhabdomyolysis Breakdown of skeletal muscle -> myoglobinuria</p>	<p>Essential in bold</p>
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Chest X-Ray 2017-2-B

Stem: A 23-year old woman with a history of intravenous drug use presents with severe dyspnoea.			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Question 1 CXR Subject: CBB	a) Please describe the major abnormalities on her chest x-ray	Lung parenchyma - diffuse opacities throughout	Bold
	b) What could be the causes of these findings?	Causes: aspiration, ARDS, infection (pneumonia/pneumonitis), interstitial oedema	2 causes

Chest X-Ray 2017-1-D

Stem: Post intubation he is difficult to ventilate and has decreased air entry over his right side. This is the clinical building block.			
Question 4 CXR	Describe his CXR.	AP film. Large/complete right pneumothorax with significant midline shift to left. ETT shifted to left but in correct place above carina. Left lung mid/lower zone and costophrenic angle obscured by left shifted heart with possible collapse. All suggest pneumothorax under radiological tension . Cardiac monitoring leads noted.	Bold
Subject: CBB			

Chest X-Ray 2017-1-C

Stem: A 23-year old woman with a history of intravenous drug use presents with severe dyspnoea.			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Question 1 CXR Subject: CBB	a) Please describe the major abnormalities on her chest x-ray	Lung parenchyma - diffuse opacities throughout	Bold
	b) What could be the causes of these findings?	Causes: aspiration, ARDS, infection (pneumonia/pneumonitis), interstitial oedema	2 causes

Chest X-Ray 2016-2-B

Stem: Clinical building block. A CXR is performed.			
Question 3 X-ray with large pleural effusion Subject CBB	Describe and interpret this Xray? What is your differential diagnosis	Left sided pleural effusion Cardiomegaly (but limited inspiration) Sternal wires – previous sternotomy Blunting right costophrenic angle Calcification of aortic arch (end on) Congestive cardiac failure, Empyema Pneumonia, PE, Cirrhosis/nephrotic syndrome	BOLD + organized approach to describing whole Xray 2 Causes

Chest X-Ray 2016-1-D

Stem: A 50 year old woman from Papua New Guinea presents with a chronic cough and fever. We will start with a CBB			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Question 1 CXR – RUL collapse /consolidation Clinical Building Block	Describe and interpret this CXR What are the possible diagnoses?	Opacification involving lower half of right upper lobe, consistent with consolidation. Well defined fissure – slightly elevated. Relevant negatives: no collapse (no shift of trachea / mediastinum / diaphragm), no effusion, no pneumothorax, no #, no invasive lines/tubes, no monitoring, normal heart size DDx: Pneumonia (bacterial, viral, fungal, TB) Less likely atypical infection, abscess, aspiration, PE, malignancy	Bold to pass Must have bold and 1 other

Chest X-Ray 2016-1-B

Stem: A 65 year-old man, with a long history of smoking, presents with acute dyspnoea.			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Question 1 CXR	<i>What do you see on the patient's chest x-ray?</i>	Collapse of right lung with approximately 50% loss of volume. Right-sided pneumothorax . >2cm between lung and chest wall at hilum, making it moderate to large , per BTS guidelines.	Bold.

Chest X-Ray 2016-1-A

Stem: A 50 year old man presents with dyspnoea to the Emergency Department. A Chest X-Ray is performed.			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Question 1 CXR – lung consolidation Clinical Building Block	What abnormalities are present?	Multiple (at least 3) left sided (patchy) opacities the largest of which appears to be pleurally based. Indistinct left heart border. Slight rightward tracheal deviation (?rotation). Relatively normal appearing right lung fields.	Bold required
	What is your differential diagnosis	Pneumonia, PE, Less likely in this scenario; contusion, pulmonary haemorrhage, heart failure, tumours	Infective plus one other

Chest X-Ray 2015-2-B

Stem: A motor bike accident victim is transferred from a rural ED to a trauma centre. A chest X-ray is performed post intubation			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Question 1 Clinical Building Block: CXR- Pul contusions	Describe the positive findings in this CXR.	Portable supine CXR, ETT insitu (2cm above carina), increased opacities in both lungs (interstitial & alveolar) – increased opacity in RLL & obliteration of right hemidiaphragm	Must be able to describe CXR, opacities. Pneumothorax difficult to exclude on supine film.
	What is the likely cause?	Pulmonary contusion (+/- haemothorax)	Must say pulmonary contusion

Chest X-Ray 2015-2-A

<p>Stem: An 80 year old man who is on warfarin is brought in following a motor vehicle accident in which he sustained multiple injuries. On arrival in ED, his blood pressure is 80/40 and pulse rate is 130 / minute. A chest X-ray is done.</p>			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
<p>Question 1 Clinical Building Block:</p>	<p>Please describe the abnormalities on this CXR</p>	<p>Surgical emphysema, Pneumothorax, RML changes ? consolidation or contusion</p>	<p>Bold to pass</p>

Coagulation profile 2017-1-B

Stem: You suspect he has been bitten by a snake. Blood tests are performed on this patient.			
Question 3	These are the blood test results for this patient.	See separate document of pathology results with Venom induced consumptive coagulopathy, rhabdomyolysis . DIC from other cause unlikely given clinical scenario	Recognise coagulopathy and differentials for this. Most likely envenomation.
Subject: Clinical Building block	Please interpret and provide differential diagnoses.		

Coagulation profile 2016-1-A

Stem: Blood tests were sent on arrival. Here are her coagulation and platelet results.			
Question 4 Coags - DIC Clinical Building Block (30 sec)	What is the most likely diagnosis?	Disseminated Intravascular Coagulation D-Dimer is markedly raised.	All required.
	Prompt: What are the abnormalities in this set of results? What other coagulation test is likely to be abnormal?		

Coagulation profile 2015-2-B

Stem: These are his coagulation blood results.			
Question 4 Clinical Building Block: Coagulopathy	What is the abnormality on this coagulation profile	Delayed clot formation in both the extrinsic (PT / INR) and intrinsic (APTT) systems. Fibrinogen low. Consistent with a consumptive coagulopathy/DIC	Must state coagulopathy / DIC with one example of possible cause
	What could cause this	Sepsis, liver failure, malignancy, trauma, envenoming (Brown / Tiger / Taipan) etc	

CSF 2016-1-D

Stem: This is a CBB question. A lumbar puncture is performed. This is the CSF result			
Question 3	Interpret this result	Turbid with low gluc, high protein and high WCC – mostly	Bold to pass
CBB: CSF	Prompt. What is the likely diagnosis?	PMNL. Likely bacterial meningitis	

CSF 2015-1-A

Stem: These are his CSF results.			
Clinical Building Block:	What is the likely diagnosis and why?	Turbid, low sugar, high protein, pleocytosis with neutrophil predominance, no bacteria Acute bacterial meningitis	Diagnosis + 2 reasons

CT Head 2017-2-C

Stem: A CT Brain is performed on this patient			
<p>Question 3</p> <p>CT Brain – intracerebral haemorrhage</p> <p>Subject: CBB</p>	<p>(a) Describe this CT Brain</p> <p><i>Prompt can you see blood anywhere else?</i></p> <p>(b) What potential clinical complications can occur as a result of this?</p>	<p>Large left basal ganglia intraparenchymal haemorrhage with intraventricular extension and mass effect: There is compression of the left frontal and parietal lobes, compression of the thalamus, 1 cm midline shift to the right, enlargement of the posterior horn of the left lateral ventricle</p> <p>Decreasing GCS, focal neurological deficits, compromised airway, seizures, impending ‘coning’ (dilated pupil, bradycardia, hypertension), death If the patient survives, there will be severe neurological deficit and disability</p>	<p>2 Bold and one other description of mass effect to pass</p> <p>At least 2 complications</p>

CT Head 2017-2-B

Stem: A 55-year-old man falls while mountain climbing. A CT brain is performed.			
Question 1 CT Brain	Describe his CT brain.	Transverse/axial CT brain slice (level of third ventricle) Right acute extradural haematoma (frontal region) – lenticular shape No midline shift, raised intracranial pressure	Bold to pass
Subject: CBB			

CT Head 2017-1-A

Stem: A 55-year-old man falls while mountain climbing. A CT brain is performed.			
Question 1 CT Brain	Describe his CT brain.	Transverse/axial CT brain slice (level of third ventricle) Right acute extradural haematoma (frontal region) – lenticular shape No midline shift, raised intracranial pressure	Bold to pass
Subject: CBB			

CT Head 2016-2-C

Stem: She is confused. A CT brain was performed.			
Question 2 Brain CT Subject: CBB	Describe the abnormality on this CT image?	Axial non-contrast CT brain Hyperdense oval area right cerebellar hemisphere – haemorrhage +/- surrounding oedema	CTcereb8.jpg Describe abn

CT Head 2016-1-C

Stem: A 70-year-old man has presented with left sided limb weakness. Here is his CT brain.			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Question 1 CT – middle cerebral artery stroke Clinical Building Block	1. What is the major abnormality on his CT?	Non contrast Head CT shows area of hypodensity in right MCA region/territory	Right thromboembolic MCA stroke

CT Head 2015-1-D

Stem: A CT brain is performed			
Clinical Building Block: CT Brain	What is the major abnormality shown on her CT?	Right sided Subdural with midline shift	Side Subdural

ECG 2017-2-A

Stem: An ECG was obtained			
<p>Question 2</p> <p>ECG – AF</p> <p>Subject: CBB</p>	<p>a) Describe and interpret the ECG</p> <p>b) What other types of narrow complex tachycardia are there?</p>	<p>a) Narrow complex tachycardia Rhythm: irregularly irregular – atrial fibrillation Rate 135/min (125-145) No P waves</p> <p>b) PSVT, Re-entrant pathway (e.g. WPW), atrial flutter, sinus tachycardia</p>	<p>Bold to pass</p> <p>2 to pass</p>

ECG 2017-1-D

Stem: A 12 lead ECG was performed. This is the clinical building block.			
Question 4 ECG (Hyperkalaemia) Subject: CCB	Describe and interpret this ECG	Sinus rhythm / sinus tachycardia (rate 100-110 bpm), normal axis, PR normal, normal QRS width, peaked T waves (esp V ₂ -V ₆ and inferior leads) Poor R wave progression Suggestive of hyperkalaemia	Structured approach or recognition of abnormalities

ECG 2017-1-C

Stem: A 65-year-old woman presents with chest pain and shortness of breath.			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Question 1 ECG Subject: CBB	Describe her ECG Prompt: What is your interpretation of the ECG?	Sinus rhythm , rightward axis, ST elevation Leads V2-V5 and aVL. ST depression II, III, aVF (Q waves absent) Anterolateral STEMI with reciprocal inferior changes.	Bold to pass

ECG 2017-1-B

Stem: A 66-year-old man presents with central chest pain. This is his ECG.			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Question 1 Subject: CBB	Describe the ECG. Prompt: What is the most likely rhythm?	Regular broad/wide complex tachycardia rate :150 , looks regular concordance (no RS complex) no obvious Fusion and capture beats Dx: VT	Bold to pass

ECG 2016-2-B

Stem: A 60-year-old man presents with central chest pain, diaphoresis and shortness of breath. An ECG is performed.			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Question 1 STEMI ECG Clinical Building block	Please describe this ECG.	12 lead ECG, (no calibration for paper speed or rhythm strip) ST elevation in anterior leads reciprocity (infero-lateral TWI and ST depression) Rate 90 (80-100) SR LAD PR160 (140-200) QRS 100ms (80-120) QT 360ms (320-400)	Bold + 4 others (of 8) Don't need to count mm of STElevation Accept normal if within range
	What is the diagnosis?	Ant STEMI	Bold

ECG 2015-2-A

This woman also has chronic renal failure. An ECG is obtained.			
Question 2 Clinical Building Block: ECG – hyperkalaemia	What are the abnormalities on the ECG? What is the likely diagnosis?	Widespread peaked T waves , mild tachycardia, some inverted T waves, ST elevation Suggestive of hyperkalaemia	Bold

ECG 2015-1-D

Stem: She is hypotensive and this ECG is performed.			
Clinical Building Block – ECG	What rhythm does it show?	Broad complex regular tachycardia consistent with VT. Rate approximately 180bpm.	Must identify that broad complex, regular tachycardia or VT

ECG 2015-1-C

Stem: A 60 year old woman with a history of hypertension presents with chest pain radiating into her back. An ECG is done.			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Clinical Building Block ECG with AMI	Please describe and interpret the significant abnormalities in this ECG.	<ul style="list-style-type: none"> • Sinus, rate ~100/min, normal axis • ST elevation (STEMI) • Inferior leads • ST depression and inverted T waves in I, aVL, V2, V3 (Reciprocal changes) 	Bold

ECG 2015-1-A

Stem: A 60 year old man presents to ED with palpitations.			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Stem: An ECG is done.			
Clinical Building Block: ECG Atrial Flutter	Please describe and interpret his ECG. <i>Prompt: what is the rhythm and rate</i>	Rate: Ventricular 75-100 , atrial approx. 300/min Rhythm: Irregular . Variable block (3&4:1) P waves: Atrial flutter waves (sawtooth) Axis: Normal. QRS: Narrow complex, anterior Q waves. T-waves: difficult to comment. = A flutter, variable block	Bold to pass

Elbow X-Ray 2017-2-C

Stem: A 25-year-old man presented with a painful elbow after a fall during football. An X-ray was taken.			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
<p>Question 1</p> <p>Elbow x-ray</p> <p>Subject: CBB</p>	<p>Please describe the X- ray.</p> <p><i>Prompt: What is the abnormality and outline the bony features?</i></p> <p>What other important adjacent structures are at risk from this injury?</p> <p><i>Prompt: Where do they lie in relation to the elbow?</i></p>	<p>Posterior dislocation of right elbow.</p> <p>Radial head, coronoid process of ulna, articular surfaces of humerus (trochlea or capitulum/capitellum). Empty olecranon fossa.</p> <p>Bony fragment in olecranon fossa</p> <p>Nil other obvious injury.</p> <p>Median nerve and brachial artery (anterior)</p> <p>Ulnar nerve (posteromedial)</p>	<p>Bold to pass</p> <p>2 of 3, and indicating correct location of one on XRay to pass</p>

Full Blood Count 2016-2-A

Stem: Clinical Building Block. Laboratory investigations as part of her workup of her fall have been performed.			
Question 2 FBC and Fe studies Subject: CBB	Please describe & interpret these blood test results.	Severe anaemia Microcytic Low MCHC Low serum Ferritin Low serum iron High TIBC Low TF Interpretation: Fe deficient anemia	Bold for pass

Joint Aspirate 2016-2-D

Stem: You perform a joint aspirate of the knee. Moving on to the Clinical Building Block.			
<p>Question 3 Joint aspirate of septic arthritis Clinical Building block</p>	<p>Please describe & interpret this aspirate result. <i>Prompt: What is the differential diagnosis?</i></p>	<p>Very high WCC (>90,000), predominantly neutrophils - suggest infection more likely than other causes DDx Septic arthritis Crystal arthropathies Inflammatory arthropathies</p>	<p>Bold to pass + one extra DDx</p>

Knee XR 2017-2-C

Stem: A knee x-ray is performed.			
<p>Question 3 Knee x-ray Subject: CBB LOA:1</p>	<p>Describe this X ray <i>Prompt – is there anything else on the lateral view?</i></p>	<p>Tibial plateau fracture, depressed lateral condyle, lipohaemarthrosis (on lateral view)</p>	<p>Must identify lateral tibial condyle fracture and joint effusion</p>

Leg XR 2016-1-B

Stem: An x-ray of his injured leg is performed.			
Question 2	<i>a. Describe the abnormalities.</i>	Transverse fractures of left tibial and fibular shafts (diaphyses), at junction of distal and middle thirds. Medial displacement and approximately 3cm shortening/overlap of fractured ends. Also 90 degrees external rotation of distal fragments.	Bold and one other.
Tibial X-ray (#)	<i>b. What are potential complications of this injury within the first week?</i>	Haemorrhage, compartment syndrome, neurovascular compromise , infection, pain, fat embolism syndrome.	Bold plus 2 others.

Liver Function Tests 2017-2-D

Stem: A 52 year old man presents following a fall. He is cachectic and has multiple bruises. Liver function tests are performed.			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Question 1 Blood tests (LFTs) Subject: CBB	(a) Describe the abnormalities on this investigation?	Elevated bilirubin, ALP, GGT, transaminases Consistent with mixed picture (Normal lipase, normal albumin and coags – suggests normal synthetic function)	Bold to pass
	(b) What could be causing these abnormalities?	Biliary obstruction - intraluminal (stone), luminal (malignancy/stricture), extraluminal (malignancy); medications, autoimmune parenchymal liver – alcohol, ischemia, infection, toxins	3 causes

Liver Function Tests 2017-1-C

Stem: Liver Function tests were performed.			
Question 2 LFTS (acute hepatitis) Subject: CCB	a) Please describe these results	Acute hepatitis (elevated bilirubin, ALP, GGT, transaminases, INR; hypoglycaemia) Impaired synthetic function (low albumin, abnormal Coags)	Bold with justification e.g. transaminitis (mild ALP elevation also)
	b) What are possible causes for this blood picture?	Alcohol, viral (A, B(+/-D), C, E, EBV, CMV) toxins (paracetamol, isoniazid, methyl-dopa, methotrexate, mushrooms), others e.g. a-1-AT deficiency, Wilson's disease, AI diseases	Alcohol plus 1 toxin/drug and 2 viruses

Liver Function Tests 2016-1-A

Stem: He is also noted to be jaundiced. Here are his liver function tests.			
<p>Question 3 LFTs Clinical Building Block</p>	<p>Please comment on these results.</p>	<p>Expect comments on raised AST/ALT, with AST nearly 5 fold increase, slight rise in ALP, and marked raised in GGT...all consistent with Alcohol induced hepatitis</p>	<p>Expect recognition of marked rise in transaminases, with little rise in ALP suggesting hepatitic picture.</p>
			<p>Raised GGT suggests alcohol being cause.</p>

Metacarpal XR 2016-2-A

Stem: A 30-year-old male presents with a hand injury following getting his hand caught in a machine at work. An X-ray of his hand is performed.			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Question 1 Metacarpal # (Xray) Clinical Building Block	Please describe the abnormality on this x-ray.	Comminuted, spiral fracture of the shaft of the 4th metacarpal (ring finger).	Bold to pass.

Neck XR 2015-1-B

Stem: A 25 year old man is brought to the Emergency Department following a motor bike accident. He cannot move his limbs. Here is his cervical spine X-ray.			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Clinical Building Block:	Please describe this x-ray.	Xray C1-C7. C7/T1 not visualised Step at C5/C6 consistent with bi-facet dislocation Disruption of all 4 lines: Soft tissue, Anterior, Posterior, Spinolaminar lines	Bold. PROMPT: What are the radiological lines to examine? 3

Photo 2017-2-D

Stem: She has injured her hand. This is the clinical building block.			
<p>Question 2</p> <p>Photo of hand</p> <p>Subject: CBB <i>Moore's 7th edition page 775, figure 6.77</i></p>	<p>a) Please describe the findings on this photo.</p> <p>b) What clinical examination findings would you seek to assess the extent of her hand injury?</p>	<p>Deep horizontal laceration across distal palmar surface. Exposed fat, tendon, muscle and bone (cartilage). Reduced flexion of 2nd, third, fourth digits, pallor.</p> <p>Digital nerve – loss of distal sensation Digital artery – bleeding, loss of distal perfusion FDP – unable to flex DIP FDS – unable to flex PIP</p>	<p>Reasonable description</p> <p>Nerve plus artery plus tendon</p>

Photo 2017-2-D

Stem: She has injured her hand. This is the clinical building block.			
<p>Question 2</p> <p>Photo of hand</p> <p>Subject: CBB <i>Moore's 7th edition page 775, figure 6.77</i></p>	<p>a) Please describe the findings on this photo.</p> <p>b) What clinical examination findings would you seek to assess the extent of her hand injury?</p>	<p>Deep horizontal laceration across distal palmar surface. Exposed fat, tendon, muscle and bone (cartilage). Reduced flexion of 2nd, third, fourth digits, pallor.</p> <p>Digital nerve – loss of distal sensation Digital artery – bleeding, loss of distal perfusion FDP – unable to flex DIP FDS – unable to flex PIP</p>	<p>Reasonable description</p> <p>Nerve plus artery plus tendon</p>

Photo 2017-2-C

Stem: A 25-year-old female presents with malaise, fever and this rash.			
TOPIC	QUESTIONS	KNOWLEDGE	NOTES
Question 1 Rash (picture) Subject CBB	(a) Describe the rash. (b) What are the possible causes for her rash?	Red, maculopapular rash with areas of coalescence. Non-vesicular, non-pustular, some pigmented lesions. (a) Infective: viral exanthem, measles, rubella, erysipelas, scalded skin syndrome, TSS (b) Allergic dermatitis, atopic dermatitis (c) Drug reaction	Concept 2 infective plus one other

Photo 2017-1-D

Stem: She has sustained a laceration to her arm. This is the clinical building block.			
Question 3 Clinical image Subject: CBB	Describe this photo.	<ul style="list-style-type: none">• Laceration on posterior (dorsal) aspect of right forearm extending to the medial (ulnar) aspect• Length – any reasonable estimation accepted• Depth – extends through subcutaneous fat into muscle• No evidence of active bleeding	Bold to pass

Photo 2017-1-B

Stem: A 75-year-old man presents with a painful rash. We will start with clinical building block.			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Question 1 Shingles rash	a) Describe this rash? What is the likely diagnosis?	Herpes zoster (vesicular lesions, crusting, not crossing midline, involving eyelid)	Bold to pass
Subject: CBB Picture	b) What complications may occur?	Ocular involvement (Herpes ophthalmicus) Secondary bacterial infection / cellulitis Ramsay Hunt syndrome Disseminated herpes zoster (immunocompromised pt) Post herpetic neuralgia	2/5 to pass

Photo 2017-1-A

Stem: You review a 42-year-old man with your intern who has facial pain. We will start with the clinical building block.			
Question 1 Photo of face	a) Describe the image. b) List possible differential diagnoses	a) Swollen and erythematous right side face near angle of mandible . b) Trauma: soft tissue injury, mandible #, dental injury Infection: cellulitis, sialadenitis (parotid, submandibular), lymphadenitis, skin abscess, dental abscess Tumour: lymphoma, LN met, salivary gland	Bold to pass 1 infectious cause plus 2 others (1 non infectious)
Subject: CBB	<i>Prompt:</i> any other etiologies (non infectious)?		

Photo 2016-2-D

Stem: A 3yo boy presents with a fever and a rash. Starting with a Clinical Building Block.			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Question 1 Rash Clinical Building Block	Please describe the photo. <i>Prompt if needed: what would be the differential diagnosis?</i>	Macular widespread (face, scalp, upper limbs and torso) rash Most marked/ erythematous on cheeks, confluent in areas ?lip involvement also right forearm lesion?papule ?vesicle ?petechial Well nourished Difficult to comment on hydration ?dry lips Likely viral exanthema, allergic reaction , Stevens-Johnson syndrome, meningococemia, erythema multiforme	Bold to pass + 2 descriptors One of two bold

Photo 2016-2-C

Stem: She has a widespread rash and she is not immunised			
Question 4 Photo – mac / pap rash Clinical Building Block	Describe and interpret the rash. What could be causing the rash in this scenario?	Diffuse maculo(papular) rash Likely viral eg measles, rubella	Bold

Photo 2016-2-A

Stem: The patient asks you to look at his leg, which is painful.			
Question 3 Leg Ulcer (Photo) Clinical building block	Please describe this image.	There are 2 areas of ulceration over the medial malleolar region of the right leg. The distal but larger ulceration has a sloughy base. The more proximal smaller ulcer has some bleeding points . Both ulcers have raised edges. There is no oedema. There is surrounding pigmentation secondary to chronic venous disease.	Pass: Bold
	What could be the cause of this?	1) Trauma or 2) Infection on background of chronic venous disease	Pass: Bold + either 1 or 2

Thoracic Spine XR 2017-2-B

Stem: He is noted to be tender over his back. A thoracic spine x-ray is arranged.			
<p>Question 4</p> <p>Lateral T-spine X-ray</p> <p>Subject: CBB</p>	<p>a) Describe this x-ray. What is the abnormality?</p> <p>b) Name possible causes for this finding.</p> <p>c) Which complications would you look for?</p>	<p>a) Thoracic spine (AP and lateral) T12 crush fracture (> 50% loss of vertebral height)</p> <p>b) Trauma, osteoporosis, pathological</p> <p>c) Looking for neurological compromise (weakness, sensory loss, bowel or bladder dysfunction)</p>	<p>Bold</p> <p>At least 2 causes</p> <p>2 signs to pass</p>

Thyroid Function Tests 2016-1-C

Stem: A 35 year old woman presents to ED with a neck mass. Her GP has done thyroid function tests			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Question 1: TFTs Clinical Building Block	1. Please interpret these results.	Raised FT4, FT3 and suppressed TSH consistent with hyperthyroidism	Bold

Urine Microscopy 2015-2-A

Stem: A 40 year old woman presents with left loin pain and fevers. Urine microscopy is performed			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Question 1 Clinical Building Block: Urine Microscopy	Please describe the abnormalities. What is the most likely diagnosis?	High poly and RBC counts with +ve protein and blood (in the absence of epi-clean catch) indicates infection In the clinical context c/w pyelonephritis +/- stone	Bold to pass

Venous Blood Gas 2017-2-A

Stem: A 60-year-old woman presents with tachypnoea and chest pain. This is her venous blood gas.			
TOPIC	QUESTIONS	KNOWLEDGE (essential in bold)	NOTES
Question 1 Venous gas Subject: Clinical Building block LOA: 1	a) Please describe this blood gas. b) What is the abnormality c) What are possible causes for this abnormality in this patient?	a) Alkalaemia, Hypocarbica , Positive base excess b) Acute respiratory alkalosis c) Hypoxia induced (Pneumonia, PE, asthma) Increased respiratory drive (CNS, Hypermetabolic states, environmental, drugs)	Bold to pass Bold One from each category

Venous Blood Gas 2016-2-C

Stem: A blood gas is performed			
<p>Question 2 Metabolic acidosis</p> <p>Clinical Building Block</p>	Describe and interpret the venous blood gas	<p>pH 7.10 – acidaemia</p> <p>pCO₂ - 23 – reduced – respiratory alkalosis/compensation</p> <p>HCO₃ - 12 – reduced – metabolic acidosis</p> <p>Lactate – 4.1 – raised – Lactic acidosis from septic shock</p> <p>pO₂ – 53 - decreased – Venous Gas sample so inaccurate (40% O₂ inspired)</p>	BOLD to pass

Venous Blood Gas 2016-1-D

Stem: CBB A venous blood gas is done.			
Question 4 Blood gas with metabolic acidosis Clinical Building Block	Describe the abnormalities on this venous gas PROMPT: What type of acidosis is it?	Low pH, low HCO₃⁻, metabolic acidosis (AG 22) with respiratory compensation	Bold