

Gastro Questions

Question 4 (10 marks)

Name 4 stigmata of chronic liver disease on physical examination (2 marks)

Palmar erythema
Spider naevi
Jaundice
Ascites
Splenomegaly
Gynaecomastia

Other than hepatic encephalopathy, name 4 relevant differential diagnoses in this patient? (4 marks)

Alcohol / other drug intoxication
Head injury e.g. subdural haematoma
Electrolyte disturbance e.g. hyponatraemia
Endocrine cause e.g. hypoglycaemia
Anything reasonable but must have 2/4 from above

Name 4 important precipitants of hepatic encephalopathy (4 marks)

Alcohol ingestion
Upper GI bleeding
Spontaneous bacterial peritonitis
Portal vein thrombosis

Q17 (7 /11)

1.

VBG – assess degree of hypoperfusion – lactate / base excess

Hb – will guide packed cell replacement

Coag – high chance of liver disease, will guide FFP therapy

Fibrinogen / Ca – also will require replacement if low to manage coagulopathy

BSL – pt likely to have a degree of liver failure, replace if needed

2.

Hb >70

INR <1.6

Plt >50

Fibrinogen >1.0

Ionised Ca normal range

Also accept normal ROTEM parameters

3.

Urgent endoscopy for variceal banding

IV octreotide 50mcg bolus, 50mcg/hr

IV antibiotics for gram neg cover – eg ceftriaxone 1g

Also accept prevention of alcohol withdrawal with diazepam

Q26 (8 /12)

1.

Unconjugated hyperbilirubinaemia: raised bili, low fraction conjugated

Hepatocellular pattern ALT and AST > GGT and ALP consistent with hepatitis

Low albumin probably due to liver synthetic dysfunction, also maybe acute phase response due to inflammation

2.

Paracetamol toxicity

Alcohol

NASH

Autoimmune

Ischaemic hepatitis

3.

Hepatitis serology A,B,C – for cause of hepatitis (max 1 mark)

Paracetamol level – for cause, treatment for this is available

BSL – hypoglycaemia in fulminant synthetic dysfunction

Coags – synthetic dysfunction

Autoimmune markers – for diagnosis

Electrolytes – low Na common complication of liver disease

USS abdomen – define liver architecture eg cirrhosis, exclude portal vein thrombosis

SAQ 15 (11 marks)

A 75 year old man is brought by ambulance to your rural ED. He has a history of stroke, and consequently lives in a high-level care nursing home. He has been sent to hospital as he has become agitated and pulled out his PEG (gastrostomy) tube.

- a) List two (2) factors that will determine whether you will attempt to re-site the tube, and provide a brief rationale for each. **(4 marks)**

Factor	Rationale
Time since PEG placement	If < 4 weeks, tract may not have matured adequately, and gastric/abdominal wall may have separated. Risk of tube misplacement into peritoneal cavity. Should not be re-sited in ED
Time since PEG removal	Ideally should be replaced ASAP as tract will start closing in 24 hours, perhaps sooner

- Features of peritonitis
- Major bleeding
- Tract closure

You decide to re-site the tube, however a replacement PEG tube is not available in the hospital and there is no specialist gastroenterology or surgical support on site.

- b) What is a suitable alternative? **(1 mark)**

- Foley catheter (large guage)

After having difficulty during the process of re-siting the tube, you are concerned the tube may be malpositioned.

c) What would your next step be and justify? **(2 marks)**

- Imaging study – eg water soluble imaging contrast via tube and CT abdomen

d) Other than inadvertent removal, list four (4) other potential PEG complications that can result in patients presenting to the ED. **(4 marks)**

- Wound infection, ulceration, necrotising fasciitis
- Bleeding
- Leaking around stoma
- Leakage of gastric contents into peritoneal cavity
- Gastric ulceration
- Gastric outlet obstruction
- Pneumoperitoneum
- Ileus/gastroparesis
- PEG blockage
- Aspiration

Pass Mark 2 + 1 + 2 + 3 = 8

SAQ 5 (6 minutes)
(Total 12 Marks) Pass mark 7/12

A mother brings in her 2-year old son who she suspects may have swallowed a button battery sometime over the last hour whilst visiting at a friend's house.

The child had been playing on the carpet when the mother suddenly noticed he had dismantled a small alarm clock and the battery was nowhere to be found.

The boy looks well and is happy playing in the assessment cubicle.

a. List your immediate management steps (4 marks).

Keep Nil by mouth
X-ray neck AP and lateral + chest + abdomen to confirm presence or absence of battery
Obtain further history to determine whether single or multiple batteries / magnet co-ingestion
Assess patient for any signs of complications from battery ingestion such as airway compromise, haematemesis, abdominal discomfort.

b. Name two indications for immediate endoscopy and battery removal (2 marks).

Battery lodged in oesophagus
Symptomatic patient
Magnet co-ingested

After assessing the patient, you determine that there are no indications for immediate endoscopic removal. You consider managing the patient conservatively at home.

c. Name three other conditions required for conservative management of button battery ingestion (3 marks).

Small battery ≤ 12 mm
Only one battery ingested
No pre-existing oesophageal disease
Patient or caregiver is reliable, mentally competent
Able to seek evaluation promptly if symptoms develop

d. State three specific instructions you would give as part of your discharge advice (3 marks)

Seek immediate attention if any symptoms of bowel obstruction or GI bleed
Regular diet, encourage activity
Avoid laxatives
Examine the stools to confirm battery passage
Return for xray if not passed in 10-14 days

Source: button battery ingestion treatment guideline www.poison.org

