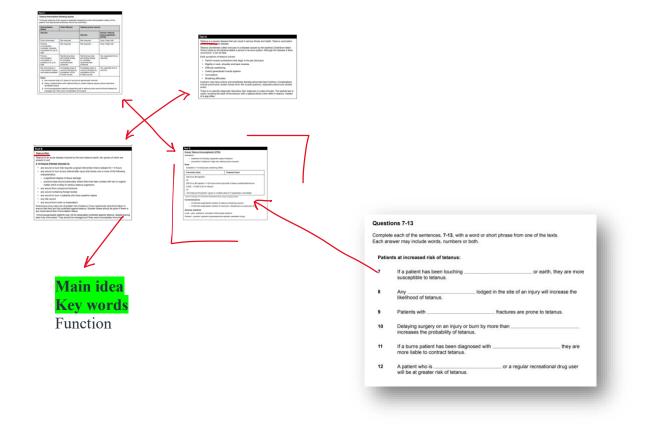


TODAY:

- 1 Review technique
- 2 Practice Step 1 (difficult texts)
- 3 Look a real mock test & do the first 7 questions

Part A Reading





STEP 1: How can we analyse texts?

- Main idea
- Key words
- Function

	How?	
MAIN IDEA	How? 1 Sub-heading / Title 2 Repeated words 3 First line of each para 4 Thematic words: e.g., fish, cat, dog, etc.	Text A Tetanus is a severe disease that can result in serious illness and death. Tetanus vaccination protects against the disease. Tetanus (sometimes called lock-jaw) is a disease caused by the bacteria <u>Clostridium tetani</u> . Toxins made by the bacteria attack a person's nervous system. Although the disease is fairly uncommon, it can be fatal. Early symptoms of tetanus include: Painful muscle contractions that begin in the jaw (lock jaw) Rigidity in neck, shoulder and back muscles Difficulty swallowing Violent generalized muscle spasms Convulsions
KEY WORDS	 Numbers Jargon: special medical words Brackets Capitals: ENT Names Anything that stands out 	 Breathing difficulties A person may have a fever and sometimes develop abnormal heart rhythms. Complications include pneumonia, broken brees from the muscle spasms) respiratory failure and cardiac arrest There is no specific diagnostic laboratory test; diagnosis is made clinically. The spatula test is useful: touching the back of the pharynx with a spatula elicits a bite reflex in telanus, instead of a gag reflex.
FUNCTION	'What is it about?' = Main Idea 'What does the text DO' = Function	There are 6 main types of sponsused by acces: <u>Networks</u> - small black or vellowish Sumps that develop on the skin; they're not filled with dirt, but are black because the inner lining of the hair folicle produces colour. which species - small red bumps that may feel tender or sore. <u>putters</u> - similar to papules, but have a white tip in the centre, cused by a build-up of pus modules - similar to papules, but have a white tip in the centre, cused by a build-up of pus modules - similar to papules that inay feel tender or sore. <u>putters</u> - similar to papules, but have a white tip in the centre, cused by a build-up of pus modules - similar to papules that inay feel tender or sore. <u>putters</u> - similar to papule and the similar to make the similar to make the similar to bolis darry the greatest risk of causing parsment scaring. <u>Putters</u> 's should be ensouraged to seek treatment for large cytit as soon as possible. To treat use dapone: 5 percent get twice dary in resummed and grimess.

TEST...

- Main idea
- Key words



TEST:

Necrotizing Fasciitis (NF): Texts

Text C

Supportive care in an ICU is critical to NF survival. This involves fluid resuscitation, cardiac monitoring, aggressive wound care, and adequate nutritional support. Patients with NF are in a catabolic state and require increased caloric intake to combat infection. This can be delivered orally or via nasogastric tube, peg tube, or intravenous hyperalimentation. This should begin immediately (within the first 24 hours of hospitalization). Prompt and aggressive support has been shown to lower complication rates. Baseline and repeated monitoring of albumin, prealbumin, transferrin, blood urea nitrogen, and triglycerides should be performed to ensure the patient is receiving adequate nutrition.

Wound care is also an important concern. Advanced wound dressings have replaced wet-to-dry dressings. These dressings promote granulation tissue formation and speed healing. Advanced wound dressings may lend to healing or prepare the wound bed for grafting. A healthy wound bed increases the chances of split-thickness skin graft take. Vacuum-assisted closure (VAC) was recently reported to be effective in a patient whose cardiac status was too precarious to undergo a long surgical reconstruction operation. With the VAC, the patient's wound decreased in size, and the VAC was thought to aid in local management of infection and improve granulation tissue.

Main idea: Supportive care & wound care



TODAY:

Source: <u>https://www.medscape.co.uk/viewarticle/pancreatic-cancer-adults-diagnosis-and-management-secondary-2022a10025n2</u>

GROUPS...

Activity will start in 1 minute after everyone joins...

Analyse 4 texts in groups

After chatting time

30 seconds per text

4 simple questions

Okay I am going to start



Pancreatic cancer: Texts

Text A

Throughout the person's pancreatic cancer care pathway, specifically assess the <u>psychological</u> impact of:

- Fatigue
- Pain
- gastrointestinal symptoms (including changes to appetite)
- nutrition
- anxiety
- depression

Provide people and their family members or carers (as appropriate) with information and support to help them manage the psychological impact of pancreatic cancer on their lives and daily activities. This should be:

- available on an ongoing basis
- relevant to the stage of the person's condition
- tailored to the person's needs

For more guidance on providing information and support, see the NICE guideline on patient experience in adult NHS services.

MAIN IDEA: Psychological support



В

People with Obstructive Jaundice

- 1 For people with obstructive jaundice and suspected pancreatic cancer, offer a pancreatic protocol computed tomography (CT) scan before draining the bile duct
- 2 If the diagnosis is still unclear, offer fluorodeoxyglucose-positron emission tomography/CT (FDG-PET/CT) and/or endoscopic ultrasound (EUS) with EUS-guided tissue sampling
- 3 Take a biliary brushing for cytology if:

endoscopic retrograde cholangiopancreatography (ERCP) is being used to relieve the biliary obstruction **and**

there is no tissue diagnosis.

People Without Jaundice who have Pancreatic Abnormalities on Imaging

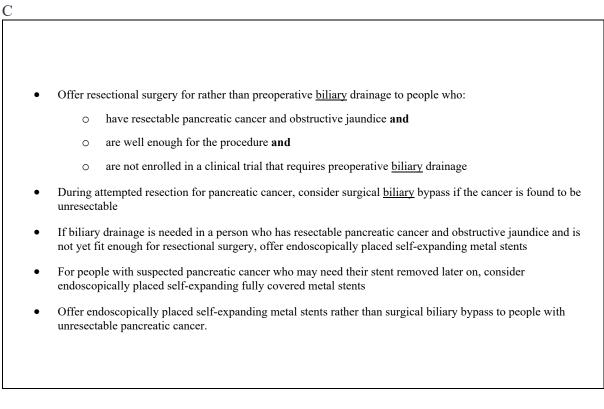
- Offer a pancreatic protocol CT scan to people with pancreatic abnormalities but no jaundice
- If the diagnosis is still unclear, offer FDG-PET/CT and/or EUS with EUS-guided tissue sampling
- If cytological or histological samples are needed, offer EUS with EUS-guided tissue sampling.

People with Pancreatic Cysts

- Offer a pancreatic protocol CT scan or magnetic resonance cholangiopancreatography (MRI/MRCP) to people with pancreatic cysts. If more information is needed after one of these tests, offer the other one
- Refer people with any of these high-risk features for resection.

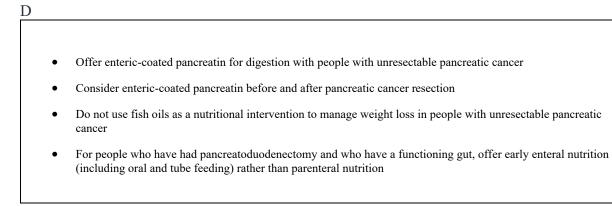
MAIN IDEA: Diagnosis





MAIN IDEA: Biliary Obstruction





MAIN IDEA:

Nutritional Management

Okay now... I am going to show you 4 questions...

You will have 40 seconds to identify A, B, C or D...



Where can I find:

- 1 Mental and emotional help dealing with cancer? A psychological
- 2 Details on how to manage nutrition? D nutrition
- 3 Details about making a diagnosis? B Thematic words
- 4 Comments on biliary obstructions? C

Okay please return....



Reactive Arthritis: Texts

Text A

Reactive Arthritis

Reactive arthritis is clinically associated with inflammatory back pain, oligoarthritis and extra-articular symptoms that typically follow a gastrointestinal or urogenital infection by a minimum of one to a maximum of 3-6 weeks. The three most commonly associated enteric pathogens are *Campylobacter*, *Salmonella* and *Shigella* species. Post-venereal cases may follow *Chlamydia trachomatis* infection or human immunodeficiency virus (HIV).

- Reactive arthritis usually develops 2-4 weeks after a genito-urinary or gastrointestinal infection. About 10% of patients do not have a preceding symptomatic infection.
- The onset is most often acute, with malaise, fatigue, and fever.
- An asymmetrical, predominantly lower extremity, oligoarthritis (usually no more than six joints) is the major presenting symptom.
- Low back pain often occurs.
- Heel pain is common because of inflammation of the Achilles.
- Reiter's syndrome (urethritis, conjunctivitis and arthritis) may occur.
- Skin (e.g. erythema nodosum, circinate balanitis), nails (dystrophic changes) and mucous membranes (mouth ulcers) may all be affected.



Text B Investigations Test type Details ESR/CRP Elevated at the onset of the disease. Later may become normal in the chronic stage. Positive in the majority of those affected. Rheumatoid factor and antinuclear antibodies HLA-B27 are absent. To rule out septic or crystalline arthritis. Synovial fluid analysis in patients with reactive Joint arthritis shows a high white blood cell count. aspiration Lab culture Stools, throat and urogenital tract samples taken in order to identify causative organism. For detection of chlamydia. Refer to a sexual health clinician for further genito-urinary Serology investigation in sexually active patients. Normal in early stages of disease. However, in advanced or long-term disease, they may X-rays show periosteal reaction and proliferation at sites of tendon insertion, plantar spurs, marginal erosions with adjacent bone proliferation in the hands and feet.

Text C

PPP Readir

Management

- In the acute phase, rest affected joints, aspirate synovial effusions.
- Physiotherapy.
- Non-steroidal anti-inflammatory drugs (NSAIDs).
- Corticosteroids:
 - These can be used as either intra-articular injections or systemic therapy. Joint injections can help avoid the use of other systemic therapy. Sacroiliac joints can be injected, usually under fluoroscopic guidance.
 - Systemic corticosteroids can be used (particularly in patients unresponsive to NSAIDs or who develop adverse effects).
- Antibiotics to treat an identified causative organism.
- Disease-modifying anti-rheumatic drugs (DMARDS):
 - Clinical experience with DMARDs in reactive arthritis is limited.
 - Sulfasalazine has been shown to be beneficial in some patients (potential impact on blood count or liver regular blood tests required).
 - Experiences with other DMARDs (e.g. azathioprine and methotrexate) may be used in patients unresponsive to standard treatments (NSAIDs and physiotherapy).
 - Antibiotics (tetracyclines) may be useful in uroarthritis but have not been successful in enteroarthritis. In more aggressive cases TNF alpha-blockers may represent an effective choice.



Toyt	n
Text	

	METHOTREXATE	AZATHIOPRINE
ndications & dose	 Moderate to severe Arthritis: By mouth For Adult: 7.5 mg once weekly, adjusted according to response; maximum 20 mg per week. Severe Arthritis: By intramuscular injection, or by subcutaneous injection For Adult: Initially 7.5 mg once weekly, then increased in steps of 2.5 mg once weekly, adjusted according to response; maximum 25 mg per week. Note that the dose is a weekly dose. To avoid error with low-dose methotrexate, it is recommended that only one strength of methotrexate tablet (usually 2.5 mg) is prescribed and dispensed. 	Arthritis that has not responded to other disease-modifying drugs. By mouth For Adult • Initially up to 2.5 mg/kg daily in divided doses, adjusted according to response, rarely more than 3 mg/kg daily; maintenance 1–3 mg/kg daily, consider withdrawal if no improvement within 3 months.
Side-effects	Pneumonitis (folic acid given on a different day from the methotrexate may help to reduce the frequency of the side effects).	Hypersensitivity reactions (including malaise, dizziness, vomiting, diarrhoea, fever and interstitial nephritis): call for immediate withdrawal. Nausea, vomiting and diarrhoea Nausea, vomiting and diarrhoea may occur early during the course of treatment and it may be appropriate to withdraw the drug.