SET English

TODAY:

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

Part A Reading

Main idea
Key words
Function

Questions 7-13

Complete each of the sentences, **7-13**, with a word or short phrase from one of the texts. Each answer may include words, numbers or both.

Patients at increased risk of tetanus:

7 If a patient has been touching ____________________ or earth, they are more susceptible to tetanus.

8 Any ____________________ lodged in the site of an injury will increase the likelihood of tetanus.

9 Patients with ____________________ fractures are prone to tetanus.

10 Delaying surgery on an injury or burn by more than ____________________ increases the probability of tetanus.

11 If a burns patient has been diagnosed with ____________________ they are more liable to contract tetanus.

12 A patient who is ____________________ or a regular recreational drug user will be at greater risk of tetanus.

STEP 1: How can we analyse texts?

- Main idea
- Key words
- Function

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 Clostridium tetani. 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 • Breathing difficulties A person may have a fever and sometimes develop abnormal heart rhythms. Complications include pneumonia, broken bones (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 tetanus, instead of a gag reflex.
KEY WORDS	• Numbers • Jargon: special medical words • Brackets • Capitals: ENT • Names Anything that stands out…	
FUNCTION	**'What is it about?' = Main Idea** **'What does the text DO…' = Function**	**TEXT A** There are 6 main types of spot caused by acne: **blackheads** – small black or yellowish bumps that develop on the skin; they're not filled with dirt, but are black because the inner lining of the hair follicle produces colour. **whiteheads** – have a similar appearance to blackheads, but may be firmer and will not empty when squeezed **papules** – small red bumps that may feel tender or sore. **pustules** – similar to papules, but have a white tip in the centre, caused by a build-up of pus **nodules** – large hard lumps that build up beneath the surface of the skin and can be painful. Treatment: for mild cases, benzoyl peroxide is recommended. **cysts** – the most severe type of spot caused by acne; they're large pus-filled lumps that look similar to boils and carry the greatest risk of causing permanent scarring. Patient's should be encouraged to seek treatment for large cysts as soon as possible. To treat use dapsone: 5 percent gel twice daily is recommended for inflammatory acne, especially in adult females with acne. Side effects include redness and dryness.

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

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 psychological 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

B

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

C

- Offer resectional surgery for rather than preoperative biliary drainage to people who:
  - have resectable pancreatic cancer and obstructive jaundice **and**
  - are well enough for the procedure **and**
  - are not enrolled in a clinical trial that requires preoperative biliary drainage
- During attempted resection for pancreatic cancer, consider surgical biliary bypass if the cancer is found to be unresectable
- If biliary drainage is needed in a person who has resectable pancreatic cancer and obstructive jaundice and is not yet fit enough for resectional surgery, offer endoscopically placed self-expanding metal stents
- For people with suspected pancreatic cancer who may need their stent removed later on, consider endoscopically placed self-expanding fully covered metal stents
- Offer endoscopically placed self-expanding metal stents rather than surgical biliary bypass to people with unresectable pancreatic cancer.

MAIN IDEA: Biliary Obstruction

D

- Offer enteric-coated pancreatin for digestion with people with unresectable pancreatic cancer
- Consider enteric-coated pancreatin before and after pancreatic cancer resection
- Do not use fish oils as a nutritional intervention to manage weight loss in people with unresectable pancreatic cancer
- For people who have had pancreatoduodenectomy and who have a functioning gut, offer early enteral nutrition (including oral and tube feeding) rather than parenteral nutrition

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.

general

Text B

Investigations

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

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.

Not for general distribution

Not for general distribution

Text D

	METHOTREXATE	AZATHIOPRINE
Indications & 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.