TODAY:

1 **Review**
2 Introduction Paragraphs Examples (Homework)
3 Assignment for Para 2

Mrs Atkins

https://drive.google.com/file/d/1xz9cTEtW2CCm5pOFtH-q6L9GDmwpDG_T/view?usp=sharing

WRITING SUB-TEST: MEDICINE
TIME ALLOWED: READING TIME: 5 MINUTES
WRITING TIME: 40 MINUTES

Read the case notes and complete the writing task which follows.

Notes:

Assume that today's date is 23 March 2019

You are a doctor at Eastham Hospital treating a woman admitted with chest pain.

PATIENT DETAILS:

Name: Doreen Atkins (Mrs)
DOB: 12 Mar 1953 (65 y.o.)
Residence: 29 Oldberry Road, Eastham

Social Background:
Widow (3 yrs), no children
Retired office administrator
Interests: reading, watching TV, socialising w. friends
Sedentary lifestyle

Family history: Mother – diabetes mellitus, hypothyroidism (dec. 70 y.o.)
Father - lung cancer, heavy smoker, coronary artery disease (dec. 59 y.o.)
Sister – hypothyroidism

Medical history: 1997 R radius fracture→osteosynthesis
2000 gall bladder removal
2002 dyspepsia
2014 hypertension
2014 hyperlipidemia
NSAIDs allergy
Ex-smoker: quit 1 yr ago (20 cigs/day 18→64 y.o.)
Excessive alcohol consumption (last 5 yrs: 30-35 units/wk)

Current medications:
Losartan 50mg PO 1x/day (hypertension)
Atorvastatin 40mg PO 1x/day (hyperlipidemia)
Aspirin 100mg PO 1x/day (hypertension)
Omeprazole 20mg PO 1x/day (dyspepsia)

Presentation at Emergency Dept. 14 Mar 2019

Presenting problem:
Atypical chest pain (<10 min): 1st episode, diaphoresis, dizziness

Treatment record:
Oxygen, morphine, aspirin, nitroglycerin (sublingual) →pt. reports ↓pain/symptoms

Test results: EKG: normal (monitored during admission)
Troponin: negative (repeated pre-discharge: negative)
Chest X-ray: normal
Pt. discharged same day w. aspirin - follow-up with regular Dr 1 wk.

21 Mar 2019 Re-presentation at ED: new episodes of chest pain reported (>2 to <10 min) regular Dr phone call advice →ED
w. physical activity →need to rest to↓pain
No pain at rest, no other symptoms
Test results: CBC - total cholesterol 250mg/dl (↑), LDL 160 (↑), HDL 35 (↓), glycemia & renal function normal
EKG monitoring

Actions taken: ↑atorvastatin to 40mg/day, continue aspirin
Pt given dietary advice to stop hypertension (DASH): ↓alcohol/salt consumption
Exercise tolerance test ordered
Pt. admitted for observation

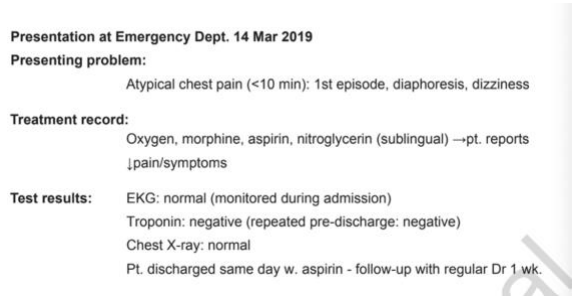
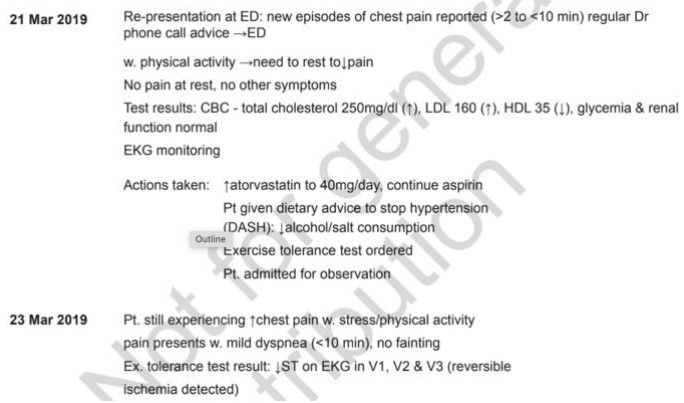
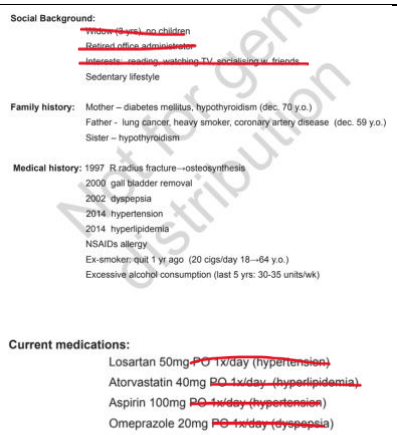
23 Mar 2019 Pt. still experiencing ↑chest pain w. stress/physical activity
pain presents w. mild dyspnea (<10 min), no fainting
Ex. tolerance test result: ↓ST on EKG in V1, V2 & V3 (reversible ischemia detected)

Provisional diagnosis:
Stable angina

Plan: Refer to cardiologist for angiography/?angioplasty

Writing Task:

Using the information given in the case notes, write a letter of referral to Dr Gaffney, consultant cardiologist, requesting further investigation of Mrs Atkins' chest pain. Address the letter to Dr Sarah Gaffney, Consultant Cardiologist, Eastham Hospital, Eccleston Lane, Eastham.

Introduction	• **General Purpose**: "Further investigation"
Timeline: 1st admission	• 14th March:  **Presentation at Emergency Dept. 14 Mar 2019** **Presenting problem:** Atypical chest pain (<10 min): 1st episode, diaphoresis, dizziness **Treatment record:** Oxygen, morphine, aspirin, nitroglycerin (sublingual) →pt. reports ↓pain/symptoms **Test results:** EKG: normal (monitored during admission) Troponin: negative (repeated pre-discharge: negative) Chest X-ray: normal Pt. discharged same day w. aspirin - follow-up with regular Dr 1 wk. Summarise a little bit
Timeline: 2nd admission	• 21st March  **21 Mar 2019** Re-presentation at ED: new episodes of chest pain reported (>2 to <10 min) regular Dr phone call advice →ED w. physical activity →need to rest to↓pain No pain at rest, no other symptoms Test results: CBC - total cholesterol 250mg/dl (↑), LDL 160 (↑), HDL 35 (↓), glycemia & renal function normal EKG monitoring Actions taken: ↑atorvastatin to 40mg/day, continue aspirin Pt given dietary advice to stop hypertension (DASH): ↓alcohol/salt consumption Exercise tolerance test ordered Pt. admitted for observation **23 Mar 2019** Pt. still experiencing ↑chest pain w. stress/physical activity pain presents w. mild dyspnea (<10 min), no fainting Ex. tolerance test result: ↓ST on EKG in V1, V2 & V3 (reversible ischemia detected) Summarise a little but (but there is a of important things)
Background	 **Social Background:** Widow (3 yrs), no children Retired office administrator Interests: reading, watching TV, socialising w. friends Sedentary lifestyle **Family history:** Mother – diabetes mellitus, hypothyroidism (dec. 70 y.o.) Father - lung cancer, heavy smoker, coronary artery disease (dec. 59 y.o.) Sister – hypothyroidism **Medical history:** 1997 R radius fracture→osteosynthesis 2000 gall bladder removal 2002 dyspepsia 2014 hypertension 2014 hyperlipidemia NSAIDs allergy Ex-smoker: quit 1 yr ago (20 cigs/day 18→64 y.o.) Excessive alcohol consumption (last 5 yrs: 30-35 units/wk) **Current medications:** Losartan 50mg PO 1x/day (hypertension) Atorvastatin 40mg PO 1x/day (hyperlipidemia) Aspirin 100mg PO 1x/day (hypertension) Omeprazole 20mg PO 1x/day (dyspepsia) Summarise
Requests	• Further investigation

	• **EXTRA DETAILS:** Angiograph? Angioplasty? EXPAND

Assignment 1: write the Introduction paragraph and send to alain@set-english.com

In general, what makes a good Introduction paragraph?

- **Short** (concise)
- Purpose ("further investigations" – Reader's Task)

Keep this short because later on we "expand"

Original	Corrections
Dr Sarah Gaffney Consultant Cardiologist Eastham Hospital Eccleston Lane Eastham 23rd March 2019 Dear Dr Gaffney, Re: Mrs Dorren Atkins, 65 years old I am writing regarding Mrs Atkins, who has signs and symptoms suggestive of stable angina. She is being referred to you and now requires further investigation **~~of her~~ chest pain.** Might be redundant? Not a big thing – not to affect grade Redundant: 1. Not needed 2. "made redundant" = lose your "there have been many redundancies"	Dr Sarah Gaffney Consultant Cardiologist Eastham Hospital Eccleston Lane Eastham 23rd March 2019 Dear Dr Gaffney, Re: Mrs Doreen Atkins, 65 years old I am writing regarding Mrs Atkins, who has signs and symptoms suggestive of stable angina. She is being **referred** to you and now requires further investigation. Referral = more than one meaning 1. To send 2. To give 3. To point to

Dr Sarah Graffney Consultant Cardiologist Eastham Hospital Eccleston Eastham 23rd March 2019 RE: Mrs Doreen Atkins, DOB: 12 March 1953 Dear Dr Graffney, I am writing regarding Mrs Atkins, who has signs and symptoms suggestive of stable angina. She is being referred to you for further investigation of her chest pain.	Dr Sarah Graffney Consultant Cardiologist Eastham Hospital Eccleston Lane Eastham 23rd March 2019 RE: Mrs Doreen Atkins, DOB: 12 March 1953 Dear Dr Gaffney, I am writing regarding Mrs Atkins, who has signs and symptoms suggestive of stable angina. She is being referred to you for further investigation of her chest pain. As above

	bold: stronger writing
Dr Sarah Gaffney Consultant Cardiologist Eastham Hospital Eccleston Lane Eastham	Dr Sarah Gaffney Consultant Cardiologist Eastham Hospital Eccleston Lane Eastham
23rd March 2019	23rd March 2019
Dear Dr Gaffney,	Dear Dr Gaffney,
Re: Mrs Doreen Atkins, **DOB: 12th March 1953**	Re: Mrs Doreen Atkins, DOB: 12th March 1953
I am writing to refer Mrs Atkins, who has been provisionally diagnosed with stable angina and requires your further investigation.	I am writing regarding Mrs Atkins, who has been provisionally diagnosed with stable angina. **She is scheduled to be referred to you** and requires further investigation. **Letter type might be better?**
	Officially: 1 Transfer to another facility 2 Referral to a specialist 3 Discharge – 'care and support'
	Unofficial: 4 Update – purpose to tell them information

23 March 2019

Dr Sarah Gaffney
Consultant Cardiologist
Eastham Hospital
Eccleston Lane
Eastham

Dear Dr Gaffney,

Re: Mrs Doreen Atkins, DOB: 12 March 1953

I am writing regarding Mrs Atkins who presented to our hospital with chest pain and was provisionally diagnosed with stable angina. She is being referred to you and now requires further investigation.

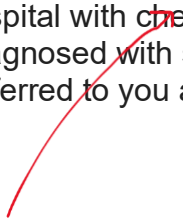
23rd March 2019

Dr Sarah Gaffney
Consultant Cardiologist
Eastham Hospital
Eccleston Lane
Eastham

Dear Dr Gaffney

Re: Mrs Doreen Atkins, DOB: 12 March 1953

I am writing regarding Mrs Atkins, who presented to our hospital with chest pain and was provisionally diagnosed with stable angina. She is now being referred to you and requires further investigation.



Grammar for why we need comma:

Non defining relative clause (EXTRA information – it does not tell us which person)

Dr Sarah Gaffney
Consultant Cardiologist
Eastham Hospital
Eccleston Lane
Eastham
23/03/2023

I am writing regarding Mrs Atkins, who was admitted to our hospital emergency department due to atypical chest pain associated with dizziness and diaphoresis. After 10 days of medical treatment, she is still experiencing chest pain and additionally ST decrease is noticed on her EKG today. She requires your further inspection for angiography.

Dr Sarah Gaffney
Consultant Cardiologist
Eastham Hospital
Eccleston Lane
Eastham

23rd March 2019

Dear Dr Gaffney,

Re: Mrs Doreen Atkins,
DOB: 12th March 1953

I am writing regarding Mrs Atkins, who was admitted to the hospital ED with signs and symptoms suggestive of stable angina. She is

Dr Sarah Gaffney
Consultant Cardiologist
Eastham Hospital
Eccleston Lane
Eastham

23/03/2019

RE: Mrs Doreen Atkins, D.O.B. 89/89/89

Dear Dr Gaffney

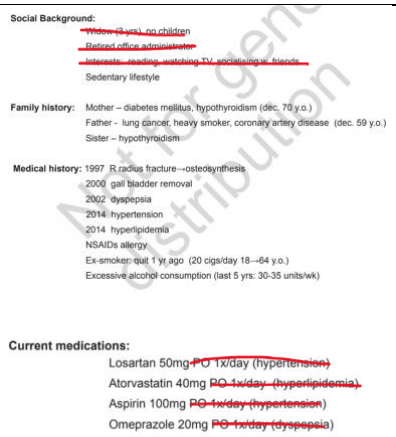
I am writing regarding Mrs Atkins, who was admitted to our hospital emergency department due to atypical chest pain. She _____ and now requires your further **investigation** ~~for angiography.~~

Save for the request paragraph (last one)

Letter type?

now being referred to you for further evaluation and investigation.	Dr Sarah Gaffney Consultant Cardiologist Eastham Hospital Eccleston Lane Eastham 23rd March 2019 Dear Dr Gaffney, Re: Mrs Doreen Atkins, DOB: 12th March 1953 I am writing regarding Mrs Atkins, who was admitted to the hospital ED with signs and symptoms suggestive of stable angina. She is now being referred to you for further evaluation and investigation.

Introduction	• General Purpose: Further investigation I am writing regarding Mrs Atkins, who was admitted to our hospital emergency department due to atypical chest pain
Timeline: 1st admission	• 14th March: **Presentation at Emergency Dept. 14 Mar 2019** **Presenting problem:** Atypical chest pain (<10 min): 1st episode, diaphoresis, dizziness **Treatment record:** Oxygen, morphine, aspirin, nitroglycerin (sublingual) →pt. reports ↓pain/symptoms **Test results:** EKG: normal (monitored during admission) Troponin: negative (repeated pre-discharge: negative) Chest X-ray: normal Pt. discharged same day w. aspirin - follow-up with regular Dr 1 wk. Write only this paragraph... and email to alain@set-english.com Use the vocab: • Aforementioned • Accordingly • Unremarkable
Timeline: 2nd admission	• 21st March **21 Mar 2019** Re-presentation at ED: new episodes of chest pain reported (>2 to <10 min) regular Dr phone call advice →ED w. physical activity →need to rest to↓pain No pain at rest, no other symptoms Test results: CBC - total cholesterol 250mg/dl (↑), LDL 160 (↑), HDL 35 (↓), glycemia & renal function normal EKG monitoring Actions taken: ↑atorvastatin to 40mg/day, continue aspirin Pt given dietary advice to stop hypertension (DASH): ↓alcohol/salt consumption Exercise tolerance test ordered Pt. admitted for observation **23 Mar 2019** Pt. still experiencing ↑chest pain w. stress/physical activity pain presents w. mild dyspnea (<10 min), no fainting Ex. tolerance test result: ↓ST on EKG in V1, V2 & V3 (reversible ischemia detected) One week later, she reported having new episodes of chest pain, which had 2-10 mins duration, during physical activity and no pain at rest. Her test results revealed elevated total cholesterol(250 mg/dl) and LDL(160) and decreased HDL(35). As a result, the continuation of aspirin and increasing the dosage of

	atorvastatin were suggested and an exercise tolerance test was ordered. She was admitted for observation.
Background	 **Social Background:** ~~Widow (3 yrs), no children~~ ~~Retired office administrator~~ ~~Interests: reading, watching TV, socialising w. friends~~ Sedentary lifestyle **Family history:** Mother – diabetes mellitus, hypothyroidism (dec. 70 y.o.) Father - lung cancer, heavy smoker, coronary artery disease (dec. 59 y.o.) Sister – hypothyroidism **Medical history:** 1997 R radius fracture→osteosynthesis 2000 gall bladder removal 2002 dyspepsia 2014 hypertension 2014 hyperlipidemia NSAIDs allergy. Ex-smoker: quit 1 yr ago (20 cigs/day 18→64 y.o.) Excessive alcohol consumption (last 5 yrs: 30-35 units/wk) **Current medications:** Losartan 50mg ~~PO 1x/day (hypertension)~~ Atorvastatin 40mg ~~PO 1x/day (hyperlipidemia)~~ Aspirin 100mg ~~PO 1x/day (hypertension~~) Omeprazole 20mg ~~PO 1x/day (dyspepsia~~) Summarise
Requests	• Further investigation • EXTRA DETAILS: Angiograph? Angioplasty?

OET Listening Part A

1 Q&A – if there is anyone who is new to OET
2 First Listen: focus on vocab / pronunciation
3 Practice Test & Answers

Format:

Extract 1: Questions 1-12

You hear a cardiologist talking to a patient called Rosie Clarkson, who has been referred from the hospital's Emergency Department. For **questions 1-12**, complete the notes with a word or short phrase. You now have thirty seconds to look at the notes.

Patient Rosie Clarkson

Onset of symptoms (July)
- aware of dull ache in (1) .....
- attributed to spending too long at her desk

Last Sunday
- on exertion, noticed
  - (2) ..... in hands and feet
  - (3) ..... and breathlessness
  - (4) ..... sensation in both arms

Last Monday
- GP found sore areas, suggesting a (5) ..... problem
- (6) ..... abnormal – referred to Emergency Department
- blood tests, chest X-ray, blood pressure – all normal
- (7) ..... – triggered chest pain, referred to cardiologist

General health
- goes (8) ..... and surfing regularly
- non-smoker /BMI 25/ normal (9) .....
- no family history of heart disease

Personal background
- married, one daughter
- works as a (10) .....

Medical history
- (11) ..... following routine screening (4 years ago)
  - followed by (12) .....

- 24 questions
- 12 questions for each audio
- Gap fill
- Situation: *consultation*
- 1 listen only
- 2 audios (2 consultations)
- 5 mins approx.
- 30 seconds before audio starts

GOOD SCORE: 22/**24**

Total questions in Listening 42

Let's practice... 1st listen

Boogie boarding	'phrase'	Like surfing but you lie down
Light house	Noun phrase	
Burgled	Verb	To break into a house to steal
Cold sweat	Noun phrase	Water from skin that is cold (fear?)
Soles of feet	Phrase	Bottom surface of foot 
Dull ache	Adj + noun	Pain that is **not sharp**
Puffing and panting	Phrase	Breathing heavily after exercise
Lurking in the back of my mind	Phrase	**Lurk** = to sort hang around / be present in a bad way / threatening way I keep returning to the same thought
Took a bit of a knock	Phrase	Something hit me
Knock me for 6	Phrase	Really shocked
Resilient	Adj.	You do not quit / keep going / fight

30 seconds.... Review

	• Severe _____ • _____ prescribed

	• Unable to _____ down stairs • _____ revealed unclear results • Usually has a _____ diet

Free Class:

Extract 1: Questions 1-12

You hear a cardiologist talking to a patient called Rosie Clarkson, who has been referred from the hospital's Emergency Department. For **questions 1-12**, complete the notes with a word or short phrase. You now have thirty seconds to look at the notes.

Patient Rosie Clarkson

Onset of symptoms (July)

- aware of dull ache in **(1)**_____
  - attributed to spending too long at her desk

Last Sunday

- on exertion, noticed
  - **(2)**_____ in hands and feet
  - **(3)**_____ and breathlessness
  - **(4)**_____ sensation in both arms

Last Monday

- GP found sore areas, suggesting a **(5)**_____ problem
- **(6)**_____ abnormal – referred to Emergency Department
- blood tests, chest X-ray, blood pressure – all normal
- **(7)**_____ – triggered chest pain, referred to cardiologist

General health

- goes **(8)**_____ and surfing regularly
- non-smoker /BMI 25/ normal **(9)**_____
- no family history of heart disease

Personal background

- married, one daughter
- works as a **(10)**_____

Medical history

- **(11)**_____ following routine screening (4 years ago)
  - followed by **(12)**_____

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- goes **(8)**_____ and surfing regularly
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Personal background
- married, one daughter
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Medical history
- **(11)**_____ following routine screening (4 years ago)
  - followed by **(12)**_____

alain@set-english.com

M: Right, so Rosie, the Emergency doctor's sent me your details, but perhaps you could just tell me, in your own words, what's brought you here today?

F: Sure. Well about six weeks ago, in July, I noticed I was getting a sort of a dull ache around my shoulder blades. I do a lot of deskwork and I just thought it was because I was, you know, spending too long in that one position. I didn't really think anything of it. But then we went out for the day last Sunday to a place by the sea – we often go there, but this time when we walked up the hill to the lighthouse the ache got worse and I came out in a cold sweat. I mean, I've never had that before, and it was strange – it seemed just to affect my hands and the soles of my feet. I also felt this really bad nausea. I've never had that before either. Anyway, my husband noticed that I was panting and puffing, which is unusual for me. Then both arms started to get this sort of tingling feeling. So anyway, I was a bit worried about this. I wondered if I'd got a bug or something, because I'm normally very fit.

M: Right.

F: So on Monday I went along to my GP. He had a look at me and he found that the areas where I was feeling the ache were a bit sore, so he thought it was probably some sort of musculo-skeletal thing. But by this time I was also feeling it in my chest. So he said, just to be on the safe side, he needed to do an ECG. He did that straightaway, and something wasn't quite right, so he said I needed to go to the Emergency Department. That's when I started to get a bit scared really. Anyway, they did lots of tests – you know, blood tests, a chest X-ray, blood-pressure – and apparently everything was normal. But then they said I needed to have something called a stress test. I didn't even get to finish that one before the pain in my chest came on again, but this time even worse than before. They said that suggested something wasn't quite right and there might be something wrong with my heart; that I needed to see someone about it straightaway. So they sent me on to you.

M: Good. Well I can understand this has all come as something of a shock to you. But I'm sure we can sort something out for you. How's your general health? You look pretty fit.

F: Yes, I get lots of exercise, horse-riding every week and boogie-boarding in the surf with my daughter. I don't smoke, and I check my BMI at the gym. That's twenty-five – so fine. So is my cholesterol, I've never had problems there.

M: Any history of heart disease in the family?

F: None.

M: Excellent. And your family situation?

F: I'm married, with just the one daughter, who's eighteen now - she's off to university this year. I love my job – I'm a reporter. It can sometimes be quite stressful though, I've covered some pretty tragic events over the years, but I've always thought of myself as quite resilient. But actually … well, even before this latest problem, my self-confidence did take a bit of a knock, because I had to have a mastectomy four years ago. It came as a bit of a shock. I'd just had a routine check, so I suppose I was lucky it was spotted in time, but it really knocked me for six, especially the chemotherapy afterwards. It took me a long time to get over it, not so much physically, it was more that it was lurking at the back of my mind all the time. I'd just about got over it and then this happened.

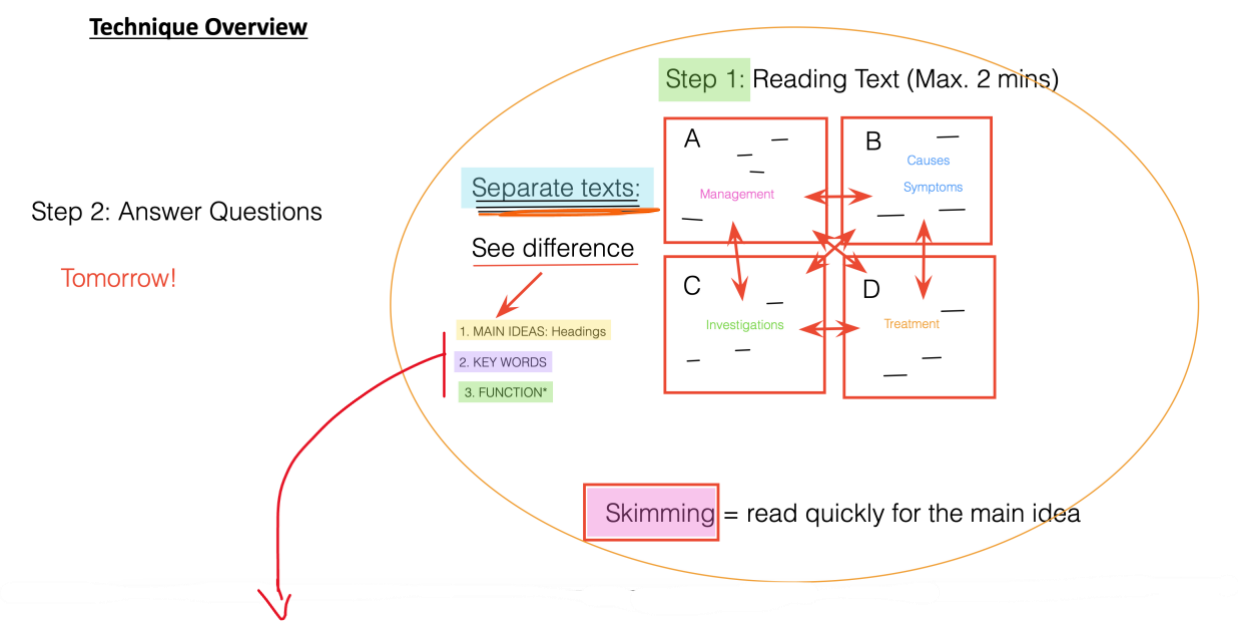
M: Well Rosie I'm sorry to hear that, but it's quite possible that this is nothing to worry about. However, what I'd like to do is … [fade]

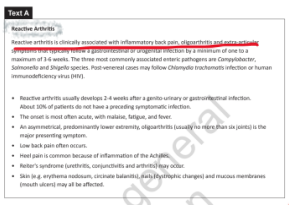
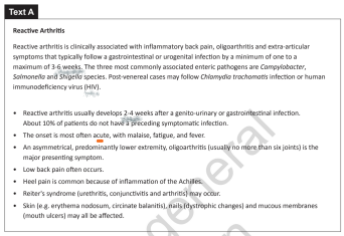
OET Reading: Part A

1 **Format**
2 Technique
3 Step 1 Practice

Format

- 20 question
- 15 mins
- 4 texts: all about 1 topic and they might be: guidelines, treatment, management, etc.



Main Ideas	Key words	Function
1. **Heading** 2. First sentence 3. Repeated Words 4. Thematic words words in same group  What is the text about?	What am I looking for? • Numbers • Brackets (..) • Capital letters: A a • Medicines • Technical language Look for any suspicious words : they will ask me later?  4 or 5	2 main functions of texts... 1 INFORMATION (Classification, definition, etc.) 2 ADVICE (guidelines, suggestions, instructions, etc.) What the test is DOING when you read

All Texts are about: ***acute cholecystitis*** (inflammation of gall bladder)

This is not the main idea we want

A patient who has acute cholecystitis may display a sudden, sharp pain in the upper right-hand side of your tummy (abdomen). This pain spreads towards your right shoulder.
The affected part of the tummy is usually very tender, and breathing deeply can make the pain worse.
Unlike other types of abdominal pain, the pain of acute cholecystitis is usually persistent and does not go away within a few hours.
Some people may have additional symptoms, such as: a high temperature, feeling sick, being sick, sweating, loss of appetite, yellowing of the skin and the whites of the eyes (jaundice) and a bulge in the tummy

SYMPTOMS / INFO

CAUSE / INFORMATION

Calculous cholecystitis is the most common, and usually less serious, type of acute cholecystitis. It accounts for around 95% of all cases.
Calculous cholecystitis develops when the main opening to the gallbladder, the cystic duct, gets blocked by a gallstone or a substance known as biliary sludge.
Biliary sludge is a mixture of bile, a liquid produced by the liver that helps digest fats, and small cholesterol and salt crystals.
The blockage in the cystic duct causes bile to build up in the gallbladder, increasing the pressure inside it and causing it to become inflamed. An inflamed gallbladder can sometimes become infected by bacteria.

TESTS / INFO

If you have severe tummy pain, a GP will probably carry out a simple test called Murphy's sign.
You'll be asked to breathe in deeply with the GP's hand pressed on your tummy, just below your rib cage.
Your gallbladder will move downwards as you breathe in. If you have cholecystitis, you'll experience sudden pain as your gallbladder reaches your doctor's hand.
If your symptoms suggest you have acute cholecystitis, your GP will refer you to hospital immediately for further tests and treatment.
Tests you may have in hospital include: blood tests (to check for signs of inflammation in your body) and also an ultrasound scan of your tummy (to check for gallstones or other signs of a problem with your gallbladder)

Advice:
If / Must / should / suggest / have top / recommend / **never** / do not

Removing your gallbladder may be recommended at some point after initial treatment to prevent acute cholecystitis coming back and reduce your risk of developing potentially serious complications.
This type of surgery is known as a cholecystectomy.
There are 2 main types of cholecystectomy:
open cholecystectomy – where the gallbladder is removed through a single cut in the tummy
laparoscopic cholecystectomy – keyhole surgery where the gallbladder is removed using special surgical instruments inserted through a number of small cuts in your abdomen
If you're fit enough to have surgery, your doctors will decide when the best time to remove your gallbladder is.
A laparoscopic cholecystectomy is often recommended within 1 week of confirming acute cholecystitis.
Some people who have had their gallbladder removed have symptoms of bloating and diarrhoea after eating certain foods, but it's possible to lead a perfectly normal life without a gallbladder.
The organ can be useful, but it's not essential as your liver will still produce bile to digest food.
Although uncommon, an alternative procedure called a percutaneous cholecystostomy may be possible if you're too unwell to have surgery. This is where a needle is inserted through your tummy to drain away the fluid that's built up in the gallbladder.

1. In what text can I find out about treatment?
2. In what text can I find out about the way a patient will present?
3. In what texts are there details of assessments?
4. In what text do we talk about the generation of a type of the condition?

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.
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.

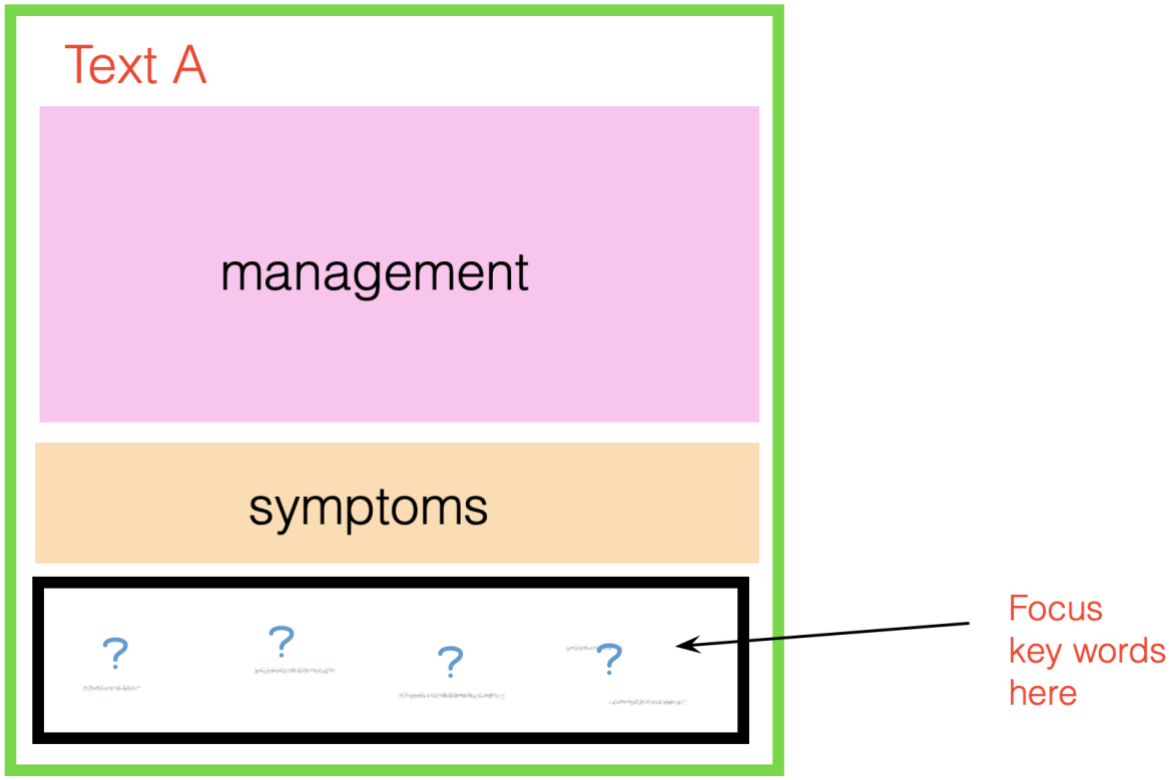
Text C

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.

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.


Text A
management
symptoms
? ? ? ?
Focus
key words
here