

## VAQ – Examiners marking guide

### Question 1

There are four major defects on this slice and I think 3 need to be identified for a pass.

- Left Subgaleal haematoma
- Left parenchymal intracerebral haemorrhage of the temporal lobe
- Right frontal contra coup intracerebral haematoma
- Left frontal subdural haematoma

Important negatives to include lack of generalised mass effect, mid line shift but there is localised swelling in the temporal lobe.

The interpretation can be in a few ways – such as how the injuries were sustained. Whether the ICH was primary and then fall or secondary to the fall; the likely poor outcome with significant morbidity; surgical implications – is there anything to drain/evacuate or conservative management.

### Question 2

All should recognise the quinsy /peritonsillar abscess so the focus is shifted to the procedural element. They should show thorough knowledge of either an aspiration or drainage of the abscess and appropriate consideration of possible complications or difficulties.

This questions has been included as a reminder that common emergency procedures are fair game and can crop up in many elements of the exam. Roberts and Hedges is a recommended text and they should be prepared to describe procedures commonly encountered in the ED.

Part (b) is fairly straight forward but should include all elements including antibiotics, analgesics, steroids, mouth wash, supportive care and disposition plan

### Question 3

Bilateral parenchymal opacities of the lungs but with the absence of effusions, kerly B lines, cardiomegaly should lead to a wide differential diagnosis but the order should reflect the most likely diagnoses first. Inflammatory, infective, haemorrhagic, malignancy, heart failure; would be my suggestion. I have put pulmonary oedema lower down the list due to the absence of other signs.

Within each group of the surgical sieve should have suggested possibilities. The oedema may reflect renal disease, low protein state or liver or cardiac organ failure.

The list of investigations should be tailored to answer there differential diagnoses rather than a non-specific list.

The actual case was one of WEGENERS GRANULOMATOSUS

### Question 4

This ECG shows a narrow complex irregular bradycardia with AV dissociation, with possibly atrial flutter or fibrillation There are ST segment slurring and T wave changes that should lead to Digoxin toxicity as the most likely cause. A differential of other toxicities such as bBlockers, Calcium channel blockers, and ischaemic events should be considered.

### Question 5

A very nasty case of fournier's gangrene with swelling, necrotic areas and cellulitic changes of the scrotum and perineum which is highly likely to the cause of the septic shock described in the stem. Urgent surgical debridement with removal of all affected tissue, broad-spectrum antibiotics, volume support and invasive monitoring, highly likely to need pressor support in addition. Antibiotic choice should be appropriate and with correct doses.

## Question 6

A good description of all the elements of this eyes injury. Should include at least 3 to pass

- Periorbital haematoma, most likely direct trauma rather than a possible base of skull fracture. Consider the context of the injury.
- Scleral haemorrhage
- Hyphaema
- Lens dislocation
- Possible globe rupture
- May also have a laceration not visible in picture but with blood seen in the top right of the image

Consider any additional tests/examination routines to illicit the extent of the injury and your next immediate actions.

## Question 7

A broad complex tachycardia with ST segment elevation in aVR and ST segment changes in the septal leads, very large peaked T waves and generally a bizarre morphology.

Differential should have hyperkalaemia as a most likely cause with possible ischaemia, or toxidrome or other as alternatives. Wrong answers will prioritise a rhythm disturbance as opposed to a morphological disturbance.

## Question 8

Grossly deranged results with life threatening hypernatraemia and hyperkalaemia, probable acute on chronic renal failure, highly likely to be pre-renal predominating. The excessive increase in urea over creatinine supports the pre-renal as the major contributor. The anaemia and thrombocytopenia may reflect severe sepsis or as part of a haemolysis picture. The INR and aPTT elevation could be due to anticoagulants, DIC, or a haemolytic uraemic syndrome, or Thrombotic Thrombocytopenic purpura (TTP). Some effort to piece all the elements together either as a sequence of events and derangements or for higher marks an overarching possible diagnosis.