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Question: 1

A 57-year-old man goes to see his physician because of intermittent chest pain. It sometimes occurs with effort, and sometimes at rest, and usually lasts 5 to 10 minutes. It is midsternal with some radiation to the throat. He has a history of high blood pressure. He discontinued smoking at about age 50. His only medication is amlodipine 10 mg daily. He has a family history of hypertension and diabetes type 2. He denies other significant medical problems. On examination his blood pressure is 135/85, pulse 76 and regular, height 70 inches and weight 210 lb. His chest is clear and no cardiac murmurs or rubs are heard. The balance of the examination is negative. His electrocardiogram (ECG) is normal.
What is the next logical procedure most likely to provide a diagnosis?

A. Lipid profile
B. Hemoglobin AIC
C. Technetium Tc-99m sestamibi stress test
D. Coronary angiography
E. Esophagogastroduodenoscopy (EGD)

Answer: C

Explanation:
The most important objective is to determine if this man has coronary artery disease (CAD). A lipid profile may indicate his risk for the condition but he already has elevated risk due to his history of smoking, high blood pressure, and possibly diabetes. The hemoglobin AIC will offer information about the latter but not about CAD. EGD may be useful to rule out an upper gastrointestinal cause of his symptoms, such as gastroesophageal reflux or esophageal spasm. Most important is to detect the presence of coronary disease. Since he is stable and pain free, an isotopic stress test is preferred to immediate angiography.

Question: 2

Two days later the above patient awakens with severe, persistent chest pain. There is mild diaphoresis but no nausea or vomiting. He is given 2 chewable aspirin tablets and nitroglycerin spray by the paramedics and taken to the emergency room. His blood pressure is now 160/90 and electrocardiogram shows a sinus tachycardia with ST depressions and some inverted T waves in the lateral precordial leads. His chest pain has diminished somewhat.
What would be the next most reasonable course of action?

A. Send the patient to the catheterization laboratory immediately
B. Draw blood for a troponin level
C. Obtain a high-resolution CT scan of the chest

D. Request a cardiac ultrasound
E. Start clopidogrel

Answer: B

Explanation:
From the clinical presentation, this man has an acute coronary syndrome (ACS), most likely a non—ST-segment elevation myocardial infarction (NSTEMI). Recent evidence has shown that ST depression confers a worse prognosis than T-wave inversion alone. An elevated troponin level will indicate myocardial damage and results are now available quickly. Thirty-day mortality has been shown to be proportional to the degree of troponin I elevation. Since he is in the high-risk category, he should then be sent to the catheterization laboratory for coronary angiography as soon as possible with balloon angioplasty and stenting if needed. High-resolution CT scanning may detect coronary calcifications but angiography remains the "gold standard" for the detection of CAD. Clopidogrel is indicated for ACS patients whose catheterization is delayed more than 24 hours. Cardiac ultrasound may show some abnormalities of wall motion but will only delay the necessary heart catheterization.

Question: 3

The above patient has angiography that shows a 90% obstruction in a major branch of the left anterior descending artery (LAD). The other arteries appear less than 30% obstructed. A drug-eluting stent is placed in the severely obstructed vessel after balloon angioplasty and the patient then reports he is pain free at rest and with exercise. The resting electrocardiogram is now normal and an isotopic stress test fails to show evidence of myocardial ischemia.
The patient may be discharged on all the following drugs EXCEPT:

A. clopidogrel.
B. warfarin.
C. an angiotensin-converting enzyme (ACE) inhibitor.
D. a statin.
E. aspirin.

Answer: B

Explanation:
Warfarin is not usually indicated for CAD patients unless complicated by atrial fibrillation or venous thromboembolism. Clopidogrel, a platelet inhibitor, is generally prescribed to diminish the chance of stent thrombosis, although some patients (15% to 48%) are resistant and higher doses or a new drug, prasugrel, may be required. A statin is definitely indicated even if the LDL cholesterol is in the normal range. Many cardiologists believe that the LDL cholesterol should be reduced to less than 70 mg/dL in patients such as this one. Low-dose aspirin is often added unless there is a history of gastrointestinal or other bleeding risk. ACE inhibitors have also been shown to have a beneficial effect in these patients in addition to their antihypertensive action.

Question: 4

A 67-year-old woman consults her physician because of several episodes of weakness in the right arm and hand, accompanied by slightly garbled speech. There is no loss of conscience. The events last 5 to 15 minutes, after which she returns to her normal state. She is a widow, living alone, and right-handed. She has been treated for high blood pressure and diabetes for the past 5 years and is taking a diuretic and an angiotensin receptor blocker (ARB) and metformin. She denies blurred vision, seizures, vertigo, or other neurologic disease, or heart disease. Her last hemoglobin Alc was 6.6%. On examination her blood pressure is 150/80, pulse regular. A bruit is heard over the left carotid artery. There is a grade 2/6 midsystolic murmur at the cardiac base but no other abnormalities. Neurologic exam does not reveal extremity weakness, abnormal reflexes, or motor or sensory abnormalities. Her cranial nerves are intact.
What is the most likely diagnosis that accounts for her symptoms?

A. Transient ischemic attacks (TIA)
B. Left hemispheric stroke
C. Seizure disorder
D. Vertebrobasilar insufficiency
E. Aortic stenosis

Answer: A

Explanation:
This woman has been experiencing transient ischemic attacks, presumably arising from vascular disease of the left carotid artery. These attacks may last up to an hour or two before resolution but persistence of these symptoms beyond 24 hours suggests a completed stroke. Her diabetes and hypertension are risk factors for cerebrovascular disease and the bruit suggests narrowing of the vessel. Her symptoms do not suggest a seizure disorder. The absence of vertigo, visual symptoms, or drop attacks rules against vertebrobasilar disease. She may well have a degree of aortic stenosis but this alone should not explain her constellation of symptoms.

Question: 5

Routine blood tests for the above patient show a normal CBC and platelet count, a fasting glucose of 150 mg/dL, and mild transaminase elevations. A chest x-ray indicates a borderline enlarged cardiac silhouette and clear lung fields. An electrocardiogram is read as normal sinus rhythm with a left anterior hemiblock but without ST changes or Q waves.
The next diagnostic procedure should be:

A. echocardiogram.
B. referral to a vascular surgeon.
C. cerebral angiography.
D. duplex carotid scan.
E. MR angiography.

Answer: D

Explanation:
Since the presumptive diagnosis is carotid stenosis leading to transient ischemic attacks, duplex scanning of the carotids is a reasonable initial and noninvasive test. It combines B-mode ultrasonography and range-gated pulsed Doppler. It will usually disclose the luminal diameter and blood velocity, although only that portion of the carotid circulation between the clavicles and mandible may be visualized. This study is probably best done before referral to a vascular or neurosurgeon so that the results will be available if the consultation is required. Cerebral angiography is usually performed prior to endarterectomy to determine if the patient is likely to benefit from the surgical procedure. It exposes the patient to ionizing radiation and contrast material. MR angiography is useful for large lesions but less useful for smaller ones and tends to exaggerate the degree of stenosis. This patient should also have a cardiac ultrasound because there is a suggestion of left ventricular prominence and to rule out a possible cardiac source of emboli. A CT or MRI of the brain should also be done to exclude a previous stroke or other brain lesion.

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