Multiple-choice questions

Multiple-choice questions in gastroenterology

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Are the statements listed beneath each question true or false? Answers are given overleaf.

Question 1

Congenital pyloric stenosis:

- A Usually presents in the first few days of life
- B Occurs more commonly in males than females
- C Presents with bile-stained vomiting
- D May be accurately diagnosed by clinical examination
- E Is treated by pyloroplasty.

Question 2

Spontaneous perforation of the oesophagus:

- A Occurs after a heavy meal
- B Usually occurs in a previously abnormal oesophagus
- C Diagnosis is aided by the presence of mediastinal gas
- D Diagnosis is confirmed by oesophagoscopy
- E Is preferably treated conservatively

Question 3

The diagnosis and staging of a carcinoma of the oesophagus should ideally include:

- A Upper gastrointestinal endoscopy and biopsy
- B Carcinoembryonic antigen (CEA) level
- C Oesophageal manometry
- D Laparoscopy
- E Transoesophageal ultrasound and lymph node biopsy

Question 4

Achalasia of the cardia:

- A Is associated with hyperplasia of the lower oesophageal sphincter
- B Has an absence of ganglion cells in Auerbach's plexus
- C Presents in children with dysphagia
- D Diagnosis is confirmed by oesophageal function tests
- E Cardiomyotomy may not totally relieve symptoms

Question 5

The surgical management of peptic oesophagitis:

- A Requires correction of gastro-oesophageal reflux
- B Is the treatment of choice for the majority of patients
- C Should include vagotomy
- D Is best with oesophagogastrectomy
- E Can be carried out laparoscopically

Question 6

A feeding gastrostomy:

- A Is always a temporary method of feeding
- B Is safer than intravenous feeding
- C Can be created using a gastroscope
- D Is a suitable alternative to nasogastric tube feeding in infants
- E Requires surgical closure after cessation of feeding

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Answers**QUESTION 1**

- A False
- B True
- C False
- D True
- E False

Congenital pyloric stenosis is more common in boys than girls and usually presents between 4–8 weeks of life. It presents with vomiting of milk and must not contain bile. It is accurately diagnosed in the vast majority of children by test feeding. Treatment is pyloromyotomy, in which the thickened pyloric muscle is split.

QUESTION 2

- A True
- B False
- C True
- D False
- E False

Spontaneous perforation of the oesophagus (Boerhaave syndrome) occurs in a normal oesophagus, usually after a heavy meal and particularly with alcohol. This leads to patient collapse. On chest X-ray there is free mediastinal gas. Diagnosis should be confirmed by X-ray contrast swallow. Oesophagoscopy will increase the leak and cause further complications. The condition should be treated surgically in most cases.

QUESTION 3

- A True
- B False
- C False
- D True
- E True

All oesophageal carcinomas should have upper gastrointestinal endoscopy and biopsy. Laparoscopy is used to exclude sub-diaphragmatic disease. Transoesophageal ultrasound and lymph node biopsy are useful in assessing local and lymph node spread prior to radical surgery. CEA levels and oesophageal manometry are unhelpful.

QUESTION 4

- A False
- B True
- C True
- D True
- E True

Achalasia presents in childhood and adult life with dysphagia. It is related to an absence of ganglion cells in the lower oesophageal muscle layers. Diagnosis is made by barium swallow and oesophageal manometry which show a failure of relaxation of the lower oesophageal sphincter. Cardiomyotomy is a treatment of choice, but in long-standing cases with gross distension of the oesophagus there is often a failure to relieve the dysphagia.

QUESTION 5

- A True
- B False
- C False
- D False
- E True

The surgical management of peptic oesophagitis is by an antireflux procedure such as a Nissen fundoplication. This can be done laparoscopically in most cases. There is no evidence to suggest that including a vagotomy is helpful. Surgery treatment, however, is carried out in only a small number of patients with peptic oesophagitis. Oesophagogastrectomy is seldom used.

QUESTION 6

- A False
- B True
- C True
- D True
- E False

Gastrostomies can be done percutaneously using gastroscope assistance. They may be done as a temporary or permanent method of enteral feeding. It is safer than intravenous feeding as it eliminates the risks associated with long line insertion and infection. It is regularly used as an alternative to nasogastric feeding in infants and children, especially to allow long-term feed supplementation in children with cystic fibrosis and cerebral palsy. Once the gastrostomy tube is removed the wound heals spontaneously.