

Specialty Certificate in Nephrology Sample Questions

Questions 1 to 10 were written by the Nephrology question-writing team and reviewed by the Nephrology Examination Board as examples of questions to be used as Nephrology Specialty Certificate Examination questions. Questions 11–20 were similarly written and reviewed but in addition have already been used in a Nephrology Specialty Certificate Examination – the latter have therefore been given a percentage of how many candidates answered the particular question correctly.

Question 1

A 66-year-old woman who had been undergoing regular haemodialysis for 2 years suffered repeated episodes of hypotension during dialysis. She usually arrived for dialysis approximately 1.5 kg over her dry weight and, during the second hour of each dialysis, her blood pressure fell to <80 mmHg systolic. She was otherwise well and was taking no antihypertensive drugs. She had no oedema.

Investigations (performed before a mid-week dialysis session):

serum sodium	134 mmol/L (137–144)
serum potassium	4.3 mmol/L (3.5–4.9)
serum corrected calcium	2.50 mmol/L (2.20–2.60)
serum phosphate	1.4 mmol/L (0.8–1.4)
serum albumin	31 g/L (37–49)

What intervention is most likely to be helpful?

- A intradialytic parenteral nutrition
- B low calcium dialysate
- C perform dialysis but not ultrafiltration at start of dialysis sessions
- D reduce sodium concentration in dialysate at start of dialysis sessions
- E reduce temperature of dialysate

Question 2

A 56-year-old man complained of bruising over his arms. He had presented with acute renal failure because of interstitial nephritis 2 weeks previously, and had initially been treated with continuous haemofiltration in the intensive care unit for 10 days before being switched to haemodialysis three times per week. He was taking prednisolone 40 mg daily and omeprazole 20 mg daily.

Investigations:

haemoglobin	91 g/L (130–180)
white cell count	$7.2 \times 10^9/L$ (4.0–11.0)
platelet count	$12 \times 10^9/L$ (150–400)
serum sodium	134 mmol/L (137–144)
serum potassium	4.3 mmol/L (3.5–4.9)
serum creatinine	513 $\mu\text{mol/L}$ (60–110)

A diagnosis of heparin-induced thrombocytopenia was made.

What anticoagulation should be used now for his dialysis?

- A aspirin
- B danaparoid
- C enoxaparin
- D intravenous citrate
- E minimal heparin with only a heparin flush of the dialysis circuit

Question 3

A 31-year-old man was reviewed at a routine clinic visit having been undergoing continuous ambulatory peritoneal dialysis for 6 months. He felt well, had no specific complaints, and was clinically euvolaemic. He was using 4 × 1.5 L dextrose 1.36% exchanges.

Investigations:

serum creatinine	899 µmol/L (60–110)
urine volume	220 mL/day
ultrafiltration volume	400 mL/day
Kt/V	1.28
creatinine clearance	42 L/week

What is the most appropriate management?

- A change nocturnal exchange to icodextrin
- B increase volume of exchanges to 2 L
- C no change to dialysis regimen
- D reduce to 3 × 1.5 L exchanges
- E start oral furosemide 500 mg daily

Question 4

A 62-year-old man with diabetic nephropathy, who had been undergoing dialysis for 9 months, received a kidney transplant from his wife. Immunosuppressive therapy comprised basiliximab, prednisolone and tacrolimus.

The operation was uneventful, and in the first 24 hours postoperatively he passed 3.5 L of urine. Thirty-six hours after the operation he was noted to have a falling urine output, with volumes of 60, 50 and 30 mL urine per hour for the previous 3 hours.

On examination, he had no oedema, his pulse was 88 beats per minute, his blood pressure was 110/62 mmHg and central venous pressure was +4 cmH₂O.

Investigations:

haemoglobin	129 g/L (130–180)
white cell count	$13.2 \times 10^9/L$ (4.0–11.0)
platelet count	$222 \times 10^9/L$ (150–400)
serum sodium	141 mmol/L (137–144)
serum potassium	5.1 mmol/L (3.5–4.9)
serum creatinine	330 $\mu\text{mol/L}$ (60–110)
serum corrected calcium	2.10 mmol/L (2.20–2.60)
serum phosphate	0.7 mmol/L (0.8–1.4)
serum albumin	31 g/L (37–49)

ultrasound and Doppler scan of transplant kidney

normal appearance, normal resistive index, normal flow in renal artery and vein

What is the most appropriate management?

- A human albumin solution 1 L over 2 h
- B intravenous dopamine 3 $\mu\text{g/kg/min}$
- C intravenous methylprednisolone 500 mg
- D plasma exchange 50 mL/kg
- E sodium chloride 0.9% 1 L over 2 h

Question 5

A 22-year-old man presented with a 2-week history of bilateral ankle swelling and mild ankle pain. He had no past medical history and was taking no medication. He worked as a shop assistant, and neither smoked nor used recreational drugs.

On examination, his blood pressure was 110/55 mmHg, and he had pitting oedema to mid-calf. His chest and abdomen were normal. He had small lymph nodes palpable in his groins.

Investigations:

serum sodium	141 mmol/L (137–144)
serum potassium	4.1 mmol/L (3.5–4.9)
serum creatinine	101 μ mol/L (60–110)
serum albumin	14 g/L (37–49)
urine protein:creatinine ratio	762 mg/mmol (<15)
urinalysis	protein 4+; blood 2+

What investigation is likely to be most useful?

- A anti-neutrophil cytoplasmic antibody
- B antinuclear antibody
- C Epstein–Barr virus serology
- D protein electrophoresis
- E serum cryoglobulins

Question 6

A 63-year-old woman presented with a 3-day history of haemoptysis. She also had a 4-month history of lethargy and weight loss of 3 kg. On examination, she appeared pale and had bilateral red eyes, but there were no other abnormalities.

Investigations:

haemoglobin	89 g/L (115–165)
white cell count	$13.6 \times 10^9/L$ (4.0–11.0)
eosinophil count	$0.8 \times 10^9/L$ (0.04–0.40)
platelet count	$389 \times 10^9/L$ (150–400)
serum creatinine	389 $\mu\text{mol/L}$ (60–110)
serum C-reactive protein	293 mg/L (<10)
urinalysis	protein 2+; blood 3+
chest X-ray	bilateral patchy shadowing in lower zones

What is the most likely diagnosis?

- A anti-glomerular basement membrane disease
- B Churg–Strauss syndrome
- C systemic lupus erythematosus
- D tubulointerstitial nephritis with uveitis
- E Wegener’s granulomatosis

Question 7

A 62-year-old man was found to have proteinuria on routine testing. He had a 3-year history of exertional angina but his symptoms had been well controlled since he had been taking atenolol 50 mg daily and amlodipine 10 mg daily.

On examination, his blood pressure was 129/76 mmHg, his jugular venous pressure was not raised, and he had mild ankle oedema, but his chest was clear.

Investigations:

serum creatinine	92 μ mol/L (60–110)
serum albumin	37 g/L (37–49)
urinary protein:creatinine ratio	390 mg/mmol (<30)
urinalysis	protein 4+; blood +
renal biopsy histology	membranous nephropathy

What is the most appropriate treatment?

- A ciclosporin
- B cyclophosphamide and high-dose corticosteroids during alternate months for 6 months
- C furosemide
- D high-dose oral prednisolone
- E ramipril

Question 8

A 56-year-old woman presented with swollen ankles. She had a 3-year history of back, knee and ankle pains for which she was taking ibuprofen 400 mg three times daily. There was no other significant past medical history and she was taking no other regular medication.

On examination, she was obese, her blood pressure was 164/84 mmHg and there was bilateral pitting oedema of the ankles, but there were no other abnormalities.

Investigations:

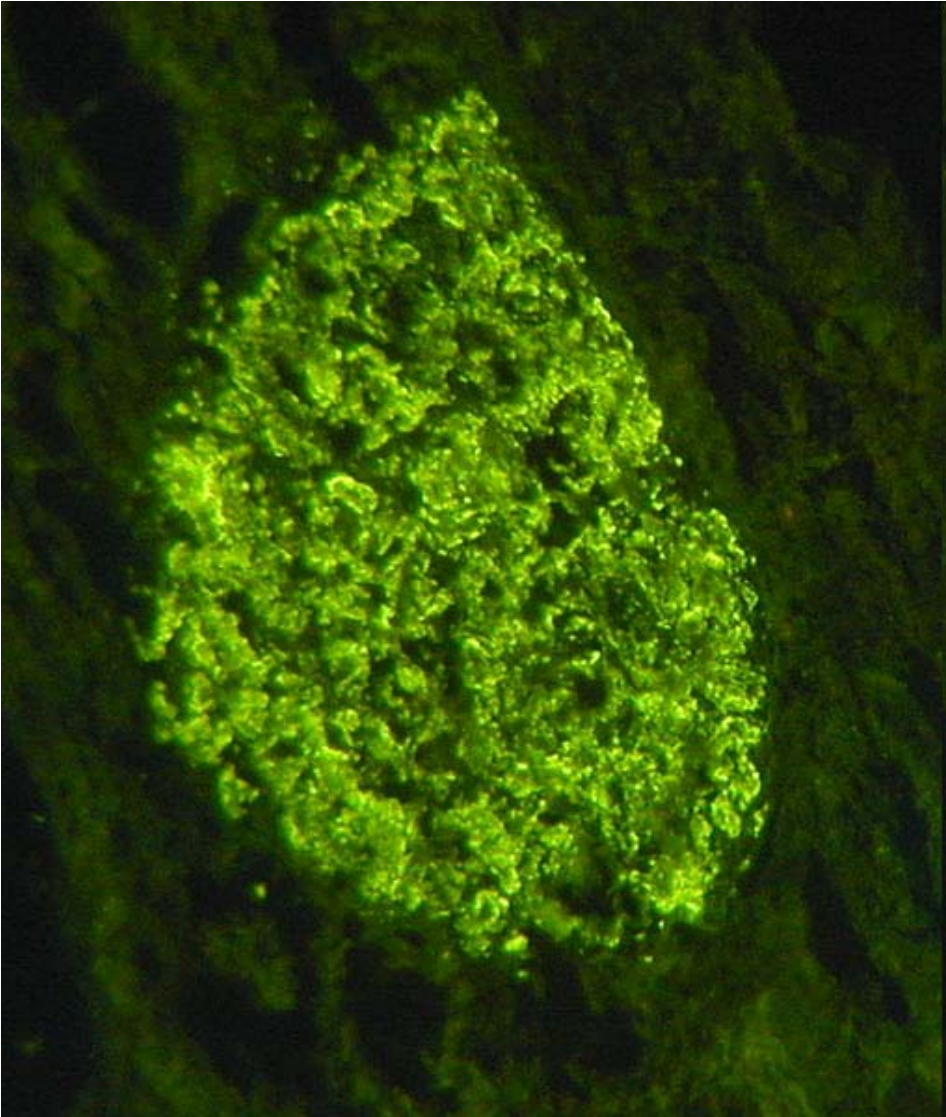
serum creatinine	130 $\mu\text{mol/L}$ (60–110)
serum albumin	26 g/L (37–49)
urinary albumin:creatinine ratio	496 mg/mmol (<3.5)
urinalysis	protein 4+
ultrasound scan of kidneys	normal

A renal biopsy was performed with difficulty because of her build. Renal tissue was present only in the sample sent for immunofluorescence (IF). The result of IF for immunoglobulin G is shown (see image). IF for complement C3 yielded a similar result. IF for other immunoglobulins and complement components was negative.

What is the most likely diagnosis?

- A focal and segmental glomerulosclerosis
- B idiopathic membranous nephropathy
- C interstitial nephritis
- D mesangiocapillary glomerulonephritis type 1
- E systemic lupus erythematosus

Image for Question 8



Question 9

A 53-year-old man presented to his general practitioner with a right inguinal hernia. He had a 6-year history of hypertension that had been initially treated with atenolol but he had neither visited a doctor nor taken any medication for 3 years. There was no other significant medical history. He smoked 30 cigarettes per day.

On examination, his blood pressure was 176/96 mmHg, his heart sounds were normal and his chest was clear. The abdomen was normal. Fundoscopy revealed bilateral dot haemorrhages, microaneurysms and hard exudates.

Investigations

serum creatinine	176 $\mu\text{mol/L}$ (60–110)
fasting plasma glucose	16.7 mmol/L (3.0–6.0)
urinary albumin:creatinine ratio	287 mg/mmol (<2.5)
urinalysis	protein 4+; blood 2+
ultrasound scan of kidneys	normal appearances, left kidney 10.4 cm, right kidney 11.2 cm

What is the most likely diagnosis?

- A diabetic nephropathy
- B focal and segmental glomerulosclerosis
- C hypertensive nephropathy
- D idiopathic membranous nephropathy
- E ischaemic nephropathy

Question 10

A 21-year-old man presented with progressive deafness and was found to have bilateral high-tone hearing loss. Further investigations revealed chronic kidney disease stage 5. No family history was available as he had been adopted as a baby.

What eye abnormality is most likely to be present?

- A anterior lenticonus
- B corneal deposits
- C lens dislocation
- D optic atrophy
- E retinitis pigmentosa

Question 11

A 52-year-old man presented with a 4-week history of nausea, anorexia, fever, bilateral flank pains and polyuria. There was a past history of asthma and gastro-oesophageal reflux disease. His medication comprised omeprazole and a compound, over-the-counter analgesic (paracetamol 500 mg/aspirin 300 mg/caffeine per tablet) for flank pain.

On examination, his pulse was 72 beats per minute and his blood pressure was 128/81 mmHg. There were no palpable abdominal masses.

Investigations:

haemoglobin	152 g/L (130–180)
white cell count	$8.6 \times 10^9/L$ (4.0–11.0)
platelet count	$475 \times 10^9/L$ (150–400)
serum sodium	141 mmol/L (137–144)
serum potassium	5.2 mmol/L (3.5–4.9)
serum urea	16.5 mmol/L (2.5–7.0)
serum creatinine	223 $\mu\text{mol/L}$ (60–110)
serum creatinine (5 months previously)	86 $\mu\text{mol/L}$ (60–110)
urinalysis	trace blood

What is the most likely diagnosis?

- A acute interstitial nephritis
- B acute papillary necrosis
- C acute tubular necrosis
- D Churg–Strauss syndrome
- E urinary tract obstruction

Question 12

A 26-year-old woman with spina bifida had become increasingly confused over the preceding 12 hours. Her past medical history included recurrent urinary tract infections and anaphylaxis secondary to penicillin. MRSA had been cultured from her urine during her previous two admissions.

Her temperature was 38.9°C, her pulse was 112 beats per minute and her blood pressure was 90/56 mmHg. Her Glasgow coma score was 10.

Investigations:

haemoglobin	136 g/L (115–165)
white cell count	$23.6 \times 10^9/L$ (4.0–11.0)
neutrophil count	$18.4 \times 10^9/L$ (1.5–7.0)
serum sodium	132 mmol/L (137–144)
serum potassium	4.9 mmol/L (3.5–4.9)
serum urea	14.7 mmol/L (2.5–7.0)
serum creatinine	212 $\mu\text{mol/L}$ (60–110)
urinalysis	leucocytes and erythrocytes

Which antibiotic should be included in her regimen?

- A cefuroxime
- B ciprofloxacin
- C piperacillin/tazobactam
- D rifampicin
- E vancomycin

Question 13

A 74-year-old man presented with acute renal failure. He had a past medical history of hypertension, ischaemic heart disease and type 2 diabetes mellitus. He smoked 25 cigarettes a day. He had recently been found to be in atrial fibrillation and anticoagulation with warfarin was started. Shortly before presentation he had developed lower abdominal pain, associated with watery diarrhoea that had become blood-stained.

On examination, he was afebrile, his pulse was 104 beats per minute and irregularly irregular, his blood pressure was 176/94 mmHg, and he was euvolaemic. He had abdominal tenderness below the umbilicus without guarding or rebound. No abdominal masses were palpable. A purpuric rash was noted on his feet, legs and buttocks. His peripheral pulses were absent below the knees bilaterally.

Investigations:

haemoglobin	106 g/L (130–180)
white cell count	$22 \times 10^9/L$ (4.0–11.0)
neutrophil count	$18 \times 10^9/L$ (1.5–7.0)
lymphocyte count	$3.1 \times 10^9/L$ (1.5–4.0)
eosinophil count	$0.9 \times 10^9/L$ (0.04–0.40)
platelet count	$164 \times 10^9/L$ (150–400)
erythrocyte sedimentation rate	75 mm/1st h (<20)
serum creatinine	305 $\mu\text{mol/L}$ (60–110)
serum complement C3	55 mg/dL (65–190)
serum complement C4	12 mg/dL (15–50)
urinalysis	blood 2+; protein 2+

What is the most likely cause of acute renal failure?

- A acute interstitial nephritis
- B aortic dissection
- C athero-embolic renal disease
- D cryoglobulinaemia
- E Henoch–Schönlein purpura

Question 14

A 54-year-old man was admitted to hospital with a 2-day history of increasing shortness of breath, 6 months after a renal transplant. One month earlier, he had sustained a single episode of severe acute vascular rejection treated with methylprednisolone and anti-thymocyte globulin. Following this episode he was converted from tacrolimus to sirolimus, and continued mycophenolate mofetil and prednisolone. He was a non-smoker and worked as farm worker. He had a past medical history of asthma.

Investigations:

arterial blood gases, breathing air	
PO ₂	9.2 kPa (11.3–12.6)
PCO ₂	3.2 kPa (4.7–6.0)
pH	7.40 (7.35–7.45)
H ⁺	40 nmol/L (35–45)
bicarbonate	21 mmol/L (21–29)
oxygen saturation	89% (94–99)
chest X-ray	normal

What is the most appropriate investigation?

- A aspergillus precipitins
- B atypical serology
- C bronchoalveolar lavage
- D CT scan of chest
- E lung biopsy

Question 15

A 50-year-old woman was referred with a 6-month history of myalgia and arthralgia. She had a history of recurrent renal stones and was undergoing intermittent lithotripsy. Her grandmother and father had experienced renal problems.

On examination, she had generalised muscle weakness but her tendon reflexes, plantar responses and sensory examination were normal.

Investigations:

serum sodium	140 mmol/L (137–144)
serum potassium	2.9 mmol/L (3.5–4.9)
serum chloride	118 mmol/L (95–107)
serum bicarbonate	16 mmol/L (20–28)
serum creatinine	185 μ mol/L (60–110)
serum corrected calcium	2.05 mmol/L (2.20–2.60)
24-h urinary calcium	6.5 mmol (2.5–7.5)
urinary pH	7.0

What is the most likely diagnosis?

- A Bartter's syndrome
- B cystinuria
- C distal renal tubular acidosis
- D hyporeninaemic hypoaldosteronism
- E proximal renal tubular acidosis

Question 16

A 28-year-old man was found to have protein 2+ on a routine urinalysis done during a life insurance medical. His general practitioner confirmed this and referred him to the outpatient clinic. There had been a similar finding at his occupational health screen when he started at university. He had undergone further tests at the time and had been told there was nothing to worry about.

Physical examination was normal and his blood pressure was 118/76 mmHg.

Investigations:

serum urea	5.6 mmol/L (2.5–7.0)
serum creatinine	92 μ mol/L (60–110)
estimated glomerular filtration rate (MDRD)	>60 mL/min (>60)
urinalysis	protein 2+
urinary protein:creatinine ratio (clinic sample)	103 mg/mmol (<30)
urinary protein:creatinine ratio (early morning)	14 mg/mmol (<30)

How should the patient be advised?

- A he can be reassured that he is at no increased risk of developing renal disease
- B he needs blood tests to exclude renal inflammation
- C he needs regular blood tests because he is at risk of worsening renal function
- D he should be started on an ACE inhibitor
- E he should have a renal biopsy to find out the cause of his proteinuria

Question 17

A 54-year-old man presented after an episode of central chest pain lasting 60 minutes, which was unrelieved by sublingual nitrate spray and required opioid analgesia. He had end-stage kidney disease secondary to polycystic kidney disease and he had been dialysis-dependent for 3 years.

On examination, his pulse was 110 beats per minute and his blood pressure was 120/66 mmHg. He had no signs of heart failure and no pericardial rub.

Investigation:

ECG

ST segment depression in leads V1 to V6

Which serum indicator is most specific for the diagnosis of acute coronary syndrome in this man?

- A brain natriuretic peptide
- B creatine kinase
- C creatine kinase MB fraction
- D troponin I
- E troponin T

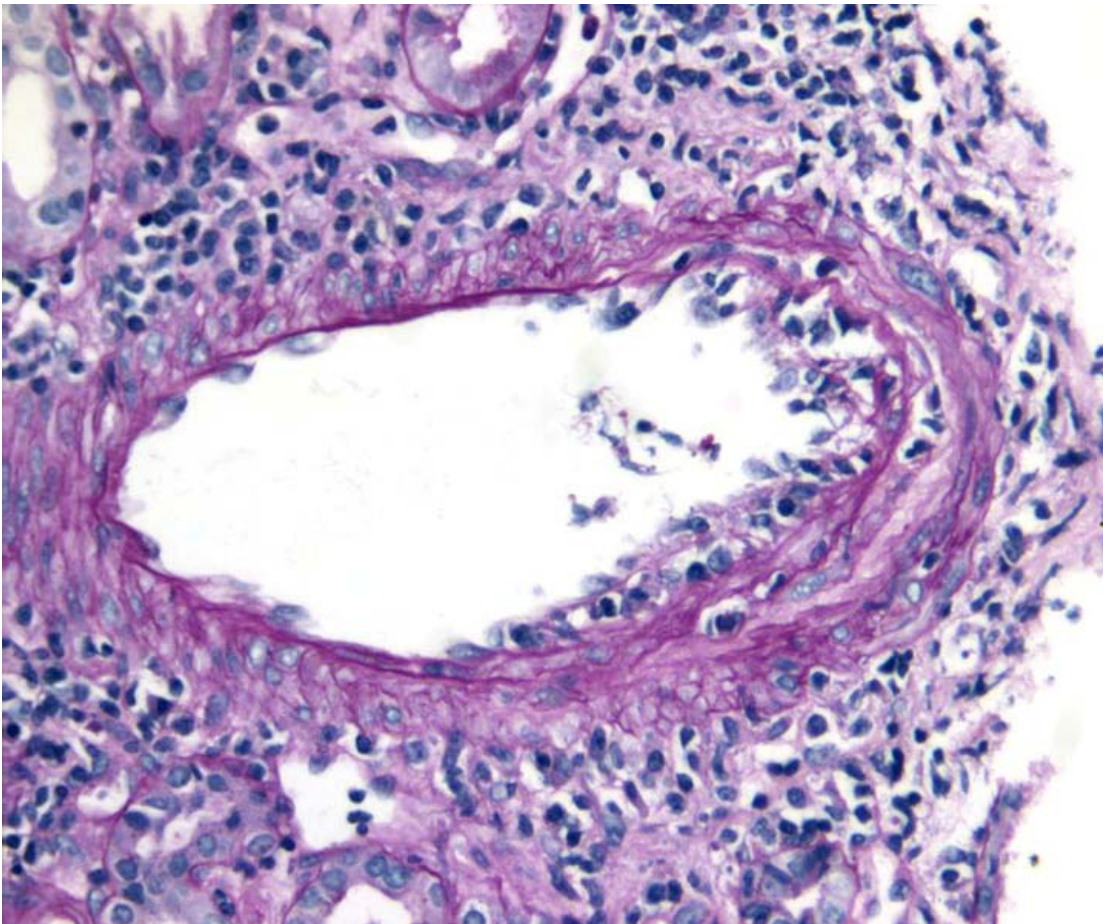
Question 18

A 48-year-old woman presented with acute graft dysfunction 3 weeks after renal transplantation. At the time of presentation her maintenance immunosuppressive therapy consisted of trough-level-controlled ciclosporin, azathioprine 100 mg once a day and prednisolone 20 mg once a day. Acute cellular rejection was diagnosed on transplant biopsy. Despite treatment with pulsed methylprednisolone, there was continued deterioration in function and she underwent a second renal biopsy 6 days later (see image).

What is the most appropriate next step in management?

- A anti-T-lymphocyte globulin
- B further pulsed methylprednisolone
- C intravenous valganciclovir
- D stop azathioprine and start mycophenolate mofetil
- E stop ciclosporin and start tacrolimus

Image for Question 18



Question 19

A 78-year-old man presented with a 2-week history of ankle swelling and headache. He had a 4-year history of rheumatoid arthritis. His medication, which had remained unaltered for 3 years, comprised methotrexate 10 mg weekly, folic acid 5 mg daily and diclofenac 75 mg daily.

On examination, his blood pressure was 188/122 mmHg and he had bilateral ankle oedema. There were chronic changes of rheumatoid arthritis in the hands but no evidence of active synovitis. Examination of the optic fundi showed grade 3 hypertensive retinopathy.

Investigations:

serum creatinine	258 μ mol/L (60–110)
serum albumin	33 g/L (37–49)
serum C-reactive protein	17 mg/L (<10)
24-h urinary total protein	2.4 g (<0.2)

What is the most likely renal diagnosis?

- A amyloidosis
- B analgesic nephropathy
- C hypertensive nephropathy
- D idiopathic membranous nephropathy
- E methotrexate nephrotoxicity

Question 20

A 71-year-old man with IgA (immunoglobulin A) nephropathy was reviewed in the renal clinic. He complained of pain in the right big toe of recent onset. His renal function was stable and he was otherwise well. He was taking perindopril, amlodipine and thyroxine.

On examination, he had swelling and erythema over the distal joint of the toe. He was afebrile and did not look acutely ill. His body mass index was 32 kg/m².

Investigations:

serum creatinine	245 µmol/L (60–110)
serum urate	0.68 mmol/L (0.23–0.46)

A clinical diagnosis of gout was made.

What is the most appropriate treatment?

- A allopurinol
- B colchicine
- C diclofenac
- D prednisolone
- E probenecid

Answers and Comments

1. Answer: E

Comment:

Reduced dialysate temperature has been shown to reduce the incidence of intradialytic hypotension. Option A has not been shown to be beneficial. Options B, C and D may worsen the problem.

2. Answer: B

Comment:

This is severe heparin-induced thrombocytopenia (HIT) and heparin in any form should be avoided, so C & E are incorrect. Aspirin is not effective. Regional but not intravenous citrate might be used. Danaparoid is a non-heparin anticoagulant, which can be used in patients with HIT. Anticoagulant-free haemodialysis might be tried but is not given as an option.

3. Answer: B

Comment:

He is underdialysed by all criteria. Only B will significantly increase dialysis dose.

4. Answer: E

Comment:

This patient is hypovolaemic because of polyuria from the transplant kidney. Intravenous sodium chloride is the most appropriate treatment.

5. Answer: B

Comment:

This man has nephrotic syndrome. Given the ankle pain and lymphadenopathy, it would be reasonable to screen for systemic lupus erythematosus. Options A, C, D and E are very unlikely to be helpful.

6. Answer: E

Comment:

This presentation is consistent with a pulmonary renal syndrome due to Wegener's granulomatosis. Eye abnormalities, particularly conjunctivitis, and a mild eosinophilia are common in Wegener's granulomatosis. The extra-renal features make anti-glomerular basement membrane disease less likely. The clinical features are not consistent with tubulointerstitial nephritis with uveitis, Churg–Strauss syndrome or systemic lupus erythematosus.

7. Answer: E

Comment:

Although he has idiopathic membranous nephropathy (IMN) with heavy proteinuria, he does not have nephrotic syndrome and, in the UK, it would be usual practice to treat 'conservatively' with a regimen including an ACE inhibitor for at least 6 months before considering specific therapy. The mild ankle oedema has probably been caused by amlodipine and does not require treatment with furosemide. Prednisolone alone is not an effective treatment for IMN.

8. Answer: B

Comment:

The image shows the typical granular pattern of deposition of immunoglobulin G (IgG) (and complement C3) of membranous nephropathy. A similar pattern for complement C3, but not usually for IgG, can occur in mesangiocapillary glomerulonephritis type 1 but the clinical features make this much less likely. In membranous lupus nephritis, IF for other immunoglobulins and complement components is positive and, in the other two options, IF is usually negative or non-specific.

9. Answer: A

Comment:

This man has type 2 diabetes mellitus that is newly diagnosed but has clearly been present for some time as he has diabetic retinopathy. He has heavy proteinuria and diabetic nephropathy is the most likely renal diagnosis. In type 2 diabetes mellitus, unlike in type 1, diabetic nephropathy may be present when the diagnosis of diabetes is first made.

10. Answer: A

Comment:

This man has Alport's syndrome. Of the options given, anterior lenticonus is the most common eye abnormality, occurring in about 25% of adult males with Alport's syndrome. A retinopathy is present in over 80% of affected adult males but this is not listed as an option.

11. Answer: A

Comment:

This patient is most likely to have an acute interstitial nephritis caused by omeprazole. Acute papillary necrosis is much less likely and would have to have been bilateral to cause the serum creatinine to rise to 223 $\mu\text{mol/L}$. There is no clear precipitant for acute tubular necrosis. The history of asthma and the constitutional symptoms raise the possibility of Churg–Strauss syndrome but this would cause proteinuria and haematuria. Urinary tract obstruction, in this context, would not produce all the symptoms described.

39% of candidates answered this question correctly.

12. Answer: E

Comment:

This patient may have septicaemia as a result of the MRSA urinary tract infection so a glycopeptide antibiotic (in this case vancomycin) should be included in her regimen.

85% of candidates answered this question correctly.

13. Answer: C

Comment:

This man with vascular disease is likely to have developed athero-embolic renal disease related to starting warfarin. The combination of eosinophilia and hypocomplementaemia makes acute interstitial nephritis, aortic dissection and Henoch–Schönlein purpura unlikely. Cryoglobulinaemia is very uncommon in this context.

73% of candidates answered this question correctly.

14. Answer: C

Comment:

The combination of breathlessness and hypoxia with a clear chest X-ray in this setting raise the suspicion of *Pneumocystis jirovecii* pneumonia, so bronchoalveolar lavage is the most appropriate investigation of the options given.

39% of candidates answered this question correctly.

15. Answer: C

Comment:

This patient has distal renal tubular acidosis. None of the other options can account for all the clinical and biochemical features.

58% of candidates answered this question correctly.

16. Answer: A

Comment:

This man has orthostatic proteinuria, which is not associated with an increased risk of developing renal disease.

88% of candidates answered this question correctly.

17. Answer: D

Comment:

For reasons that are still not clear, serum troponin T is raised in many patients on dialysis without acute coronary syndrome (20–82% depending on the cut-off used). Troponin I is elevated in only 0.4–6% of stable dialysis patients and is the most specific marker for acute coronary syndrome in this setting.

70% of candidates answered this question correctly.

18. Answer: A

Comment:

The image shows severe vascular rejection for which administration of an anti-T-lymphocyte globulin is the most appropriate next step.

85% of candidates answered this question correctly.

19. Answer: C

Comment:

This man is most likely to have hypertensive nephropathy related to malignant hypertension. The history of rheumatoid arthritis and non-steroid anti-inflammatory drug use is too short for amyloidosis or analgesic nephropathy to be likely. Idiopathic membranous nephropathy is very rarely associated with malignant hypertension. Methotrexate may cause a crystal nephropathy (when given in high doses) but does not cause either malignant hypertension or heavy proteinuria.

64% of candidates answered this question correctly.

20. Answer: B

Comment:

This man has acute gout. Allopurinol should not be started during an acute attack. Diclofenac and probenecid are inappropriate because of his impaired renal function. Although prednisolone would probably be an effective treatment, it is most appropriate to try low-dose colchicine first.

64% of candidates answered this question correctly.