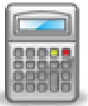
Cert Gastroenterology(SA) Surg

THE COLLEGES OF MEDICINE OF SOUTH AFRICA

Incorporated Association not for gain
Reg No 1955/000003/08

Examination for the Subspecialty Certificate in Gastroenterology of the College of Surgeons of South Africa

22 February 2019



1 Paper Only (3 hours)

Each question to be answered in a separate book (or books if more than one is required for the one answer)

---

1 Regarding colorectal malignancies

a) Write notes on the geographical variation and the role of diet and the microbiome in the development of colorectal cancer. (15)

b) Discuss the clinical criteria for the diagnosis of Lynch syndrome. (25)

c) i) What features on Haematoxylin and Eosin staining would suggest a mismatch repair gene abnormality? (10)

ii) Tabulate the interpretation of immunohistochemical staining for mismatch repair genes. (10)

d) You do a screening colonoscopy in a 40-year-old with a strong family history of colonic carcinoma. You remove 2 polyps, a 1.5 cm sessile lesion in the ascending and a 5 mm sessile lesion in the rectum. The histopathology report states that they are both hyperplastic polyps. Discuss your further management of this patient. (20)

e) Discuss the role of complete mesocolic excision for colon cancer. (20)

[100]

2 With regards to inflammatory bowel disease (IBD)

a) Discuss the diagnosis and management of a patient presenting with an acute severe colitis. (30)

b) Explain in detail what steps you would take to optimise an IBD patient prior to surgery. (20)

c) List the possible complications of an ileo-anal pouch and which would be the focus of your discussions when consenting a patient for the procedure. (20)

d) Discuss your management strategy for a patient with an IAP who presents with a 3 week history of passing 20 stools per day. (30)

[100]

PTO/Page 2 Question 3…

3 A 64-year-old male presents to you with an anterior rectal adenocarcinoma 0.5cm above the anorectal angle.

a) Discuss the indications, treatment regimens and timing of surgery in locally advanced distal rectal adenocarcinoma. (25)

b) The above patient has chemoradiotherapy and at 6 week follow up has no clinically detectable malignancy. Discuss organ preservation (watch and wait) in rectal cancer. (35)

c) Post radiation MRI on the above patient reveals persistent malignancy. On clinical examination, the tumour is anterior in the rectum and 1cm above the anus with no invasion of the sphincter or levator ani. Discuss anal preservation surgery with special focus on techniques, morbidity and long term outcomes of these techniques. (40)

[100]

4 a) In regard to Luminal Flexible Endoscopic Management of GIT perforations.

i) List the various endoscopic modalities that can be used to close GI perforations from different causes. (8)

ii) Discuss the indications and contra-indications for endoscopic closure of GIT perforations. (10)

iii) Describe the application of the various devices that can be used. (12)

[30]

b) Regarding your approach to obscure GI bleeding.

i) Define the terms obscure, overt and occult GI bleeding. (10)

ii) List the common causes of obscure GIT bleeding related to their clinical presentation. (10)

iii) Discuss your approach to the stable patient with obscure GI bleeding. (10)

iv) Discuss your approach to the unstable patient with obscure GI bleeding. (10)

[40]

c) Regarding neuro endocrine tumors (NETS) of the small bowel (excluding duodenal and appendiceal NETS).

i) Describe how small bowel NETS may present clinically. (15)

ii) Briefly discuss the diagnostic modalities available. (15)

[30]

[100]