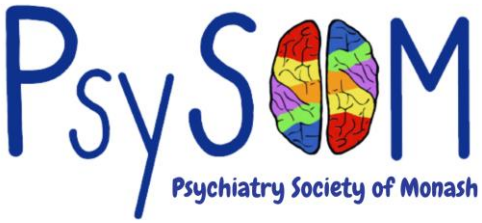
Psychiatry Society of Monash (PsySOM)



Practice Exam Two

Aged and Consultant-Liaison Psychiatry, Addiction Medicine and Additional Topics

2021

EXAM DURATION: 1 HOUR

For your own learning, treat this paper as an examination. You should not have in your possession any books, notes, mobile phones or other material/items that would otherwise not be permitted for an official examination.

There are **32 questions** to be attempted. Each question has only one correct answer. Response options may be used more than once for associated questions. You should attempt each question.

Disclaimer: All contributions have been made by post-Year 4C Monash medical students who are members of PsySOM. We hope our contributions serve as a study tool in preparation for your rotation and exams. Any resemblance to questions published or used in books or examinations are purely coincidental.

*For questions 1 to 3, use the following options for the **MOST** likely answer.*

Options:

A. Flumanezil
B. Naloxone
C. Methadone
D. Buprenorphine
E. Bupropion
F. Naltrexone
G. Varenicline
H. Acamprosate
I. Disulfiram

Question 1

A 25-year-old male is brought to the ED after he was found unconscious in the elevator of his residential apartment. On examination, he has a decreased level of consciousness, and his pupils are constricted. The patient has shallow breathing and a drastically reduced respiratory rate. His peripheries are cold, clammy, and poorly perfused. Further examination reveals several needle track marks on his arms and thighs. What is the most appropriate next step in your management?

Answer: (B) Naloxone

Naloxone is a pure competitive antagonist of opiate receptors and has no agonistic activity. It has high affinity for μ-opioid receptors, where it acts as an inverse agonist, causing the rapid removal of any other drugs bound to these receptors. Its onset of action is within minutes. A second dose can be administered every 2 to 3 minutes. Naloxone has been shown to have a very safe side effect profile, therefore large doses can be administered without significant effects. This scenario is representative of an opioid overdose commonly seen in emergency departments. The first steps in management follow the ABCDE protocol. Apart from administering naloxone, it would be pertinent to protect the patient's airway and provide supplementary oxygen - considering he has significant respiratory depression. Additionally, it would be appropriate to place the patient under full spinal precautions as he was found unconscious and may have sustained injuries.

Question 2

James is a 29-year-old with a long-standing history of heroin abuse. He is a soon-to-be father of a beautiful daughter. He is highly motivated to quit heroin completely and wishes to be drug-free to rebuild his family relationships. James has been abstinent from heroin and other opioids for 15 days and has now recovered from the withdrawal phase. What is the most appropriate medication to maintain James' abstinence?

Answer: (F) Naltrexone

Naltrexone is a non-selective opioid receptor antagonist. It is used alone after the withdrawal phase to maintain abstinence. It should be used in highly motivated and well supported individuals. It is well tolerated but adverse effects include nausea, headache, abdominal pain, reduced appetite, and tiredness. Patients commencing on naltrexone need to be fully informed of the potential adverse effects and benefits of treatment. Close monitoring is important when naltrexone is initiated because of the higher risk of fatal overdose. Similarly, discontinuation of naltrexone may also be associated with overdose from illicit opioids.

Question 3
A young woman has recently found herself to be pregnant. She informs you that she uses heroin frequently. You explain to her the ill-effects of heroin on pregnancy and on the unborn child. You offer alternatives to substitute heroin for a safer substitute. What is the most appropriate medication in her management?

Answer: (C) Methadone
Methadone is a prescribed substitute for heroin and other opiates. When taking appropriate doses of methadone, it stops the patient from having withdrawal symptoms and craving opiates. Methadone maintenance treatment has been shown to significantly improve pregnancy outcomes for opiate-dependent women. It is not known to increase the risk of congenital abnormalities in infants. Abruptly stopping methadone treatment or heroin during pregnancy is not recommended because it increases the risk of miscarriage, premature labour, foetal death and return to dependent heroin/opiate use.

Question 4 is a standalone question.

Question 4
A 28-year-old female is brought to the ED after being found to have difficulty breathing while at a party with her friends. On arrival, her temperature is 36.5°C, blood pressure is 105/75 mmHg, pulse is 60 bpm, and respirations are 22 breaths/min. She is alert but is unable to speak in full sentences and has a medical diagnosis of asthma. Examination shows dry mucous membranes and red eyes. The pupils are equal and reactive to light. No injection marks can be found on her extremities. Which of the following is the most likely cause of her symptoms?

Options:
A. Benzodiazepines
B. Heroin
C. LSD
D. Cannabis

Answer: (D) Cannabis
In this scenario, the patient is having an acute exacerbation of asthma secondary to cannabis use. Cannabis is commonly smoked which is a potent trigger for exacerbating asthma and other lung conditions, such as bronchitis. Other patient factors that would point towards cannabis would include dry mucous membranes and red eyes which are commonly associated with cannabis use. People intoxicated on LSD usually present with distorted perceptions, tachycardia, and dilated pupils. People intoxicated on heroin usually present with lowered consciousness, pupil constriction (pin-point pupils) and since it is usually injected - obvious track marks can be found on extremities.

*For questions 5 to 8, use the following options for the **MOST** likely answer.*

Options:

A. Somatic Symptom Disorder
B. Illness Anxiety Disorder
C. Conversion Disorder
D. Factitious Disorder
E. Malingering
F. Schizophrenia
G. Acute Psychosis
H. Epilepsy
I. Brain Tumour

Question 5

Tom presents to his GP for the 3rd time in the last six months, requesting imaging of his brain. When questioned further, he denies having any symptoms suggesting a brain pathology. A brief neurological examination is conducted, and it is completely normal. Tom later reveals that his older brother recently got diagnosed with a brain tumour.

Answer: (B) Illness Anxiety Disorder

In this scenario, Tom is preoccupied with thoughts that he may have a serious illness (brain cancer) despite having no somatic symptoms. To diagnose one with illness anxiety disorder, they must be preoccupied with thoughts of having a serious illness for at least six months. This is different to somatic symptom disorder, where the patient will present with somatic symptoms. In this scenario, Tom is not complaining of any symptoms.

Question 6

Stacy is a 10-year-old girl who presents to the GP complaining of pain in her right shoulder. When you palpate her shoulder, Stacy screams in pain. However, you notice that she was able to carry her backpack and move her shoulders without complaints earlier. Additionally, Stacy's parents mentioned that they have been busy recently as they've just had another child.

Answer: (D) Factitious Disorder

Factitious disorder is when an individual falsifies an illness in order to gain attention (a primary gain). In this scenario, it is suggested that there is no true pathological basis for Stacy's symptoms as Stacy reports pain on palpation of her shoulder; yet, she has a full active range of motion with no pain or restrictions. Additionally, as Stacy's parents have recently had a child, it may mean that Stacy is getting less attention than before and thus, has falsified an illness to garner more attention from her parents. The reason the answer is not malingering is because malingering requires there to be a secondary/external gain (e.g., getting out of a criminal offense, getting money) and this is not present in the scenario.

Question 7

Mitchell is brought into the hospital after sustaining injuries while he was robbing a store. He is initially calm but when the police begin to question him, he starts running around the room stating that he is hearing voices and that they told him to rob the store. When questioned about these further, he states he hears multiple people and can only hear the voices in his left ear.

Answer: (E) Malingering

In this situation, the two main differentials would be psychosis and malingering. There are a couple of factors that would lead us away from psychosis. Firstly, it is quite atypical to hear voices unilaterally in true psychosis. Secondly, a diagnosis of psychosis cannot be made on auditory hallucinations alone. Thirdly, the voices commenced abruptly when police officers were interrogating him which increases suspicion of malingering. In malingering, there is typically something to gain from intentional production of falsely exaggerated psychological symptoms and in this case, Mitchell may be trying to prove himself not guilty due to mental health impairment.

Question 8

Sandra is a 27-year-old previously healthy lady who presents with abrupt loss of vision in her left eye and muscle twitching in all four limbs. A thorough examination and laboratory investigations were conducted. No abnormalities were found. Further discussions with Sandra revealed that Sandra's mother had recently passed away from breast cancer. Sandra shares that she has been feeling distraught and grieving since.

Answer: (C) Conversion Disorder

Conversion disorder is when a psychological state is demonstrated by physical symptoms. Typically, these symptoms are neurological in nature. This fits well with the above scenario because Sandra has recently undergone a traumatic event (losing her mother) and is now presenting with a seemingly 'random' set of neurological symptoms. Furthermore, her examination and investigations were normal which suggests that there is likely no organic cause for these symptoms.

*For questions 9 and 10, use the following options for the **MOST** likely answer.*

Options:

A. Brain Tumour
B. Delirium
C. Drug Induced Psychosis
D. Major Depressive Disorder
E. Major Neurocognitive Disorder (Alzheimer's Disease)
F. Major Neurocognitive Disorder (Lewy Body Dementia)
G. Major Neurocognitive disorder (Vascular Dementia)
H. Dementia due to Parkinson's Disease
I. Persistent Depressive Disorder

Question 9

Roy is a 73-year-old man living at home alone. His daughter reports that he has gradually become withdrawn over the past few years and that he no longer engages in his hobbies. She also thinks he is starting to become forgetful as when she checks up on Roy, he has been missing meals and appears to be neglecting his health. Roy believes this is all due to his age. He reports low energy and denies feeling 'depressed'. On examination, Roy's MMSE is 28/30 with 3/3 on short-term recall.

Answer: (I) Persistent Depressive Disorder

Roy presents with symptoms consistent with a persistent depressive disorder (dysthymia) - with low energy, poor appetite and diminished interest in hobbies. Given the timeframe of "over the past few years", this appears to be chronic, befitting the diagnosis of dysthymia (whereby 2+ depressive symptoms are present >2 years). While a major depressive disorder may be continuously present for two years, Roy does not have enough symptoms to meet this diagnosis. He also does not meet the criteria for a neurocognitive disorder given his MMSE shows good cognitive ability and 3/3 on short-term memory.

Question 10

Abigail is an 82-year-old woman brought in by police after she was found wandering the streets in the middle of the night. She is wearing a nightgown and is barefooted. Upon questioning, she appears to be confused. She believes the year is 1989 and is unable to sustain her focus on questions. A collateral history from her son reveals a family history of Alzheimer's disease. However, he states that this behaviour is new, and she is otherwise in good health.

Answer: (B) Delirium

Abigail presents with a likely delirium, characterised by disorientation, confusion, and inattention on a background of good baseline level functioning as reported by her son. Neurocognitive disorders are usually distinguished from delirium by their time course (progressive deterioration vs acute change) and the basis of collateral history on their normal state (if inconsistent with history, this suggests an acute change).

*For questions 11 and 12, use the following options for the **MOST** likely answer.*

Options:

A. Postpartum Depression
B. Baby Blues
C. Postpartum Psychosis
D. Perinatal Obsessive Compulsive Disorder (OCD)

Question 11

Emily is 3 days postpartum and was discharged 2 days ago after a normal vaginal birth. This is her second pregnancy, which was uneventful with no post-partum complications. A maternal and child health nurse has arrived for their first visit. Emily discloses to the nurse that she has been feeling empty for the past 2 days, with poor motivation and inability to concentrate. She has been very irritable with her husband and feels overwhelmed with little things. She is feeling very guilty because she thinks she is not a good mother to her new-born. What is the most likely diagnosis?

Answer: (B) Baby Blues

Baby blues is very common, affecting up to 80% of women in the postpartum period. It is characterised by feeling sad/empty within the first week of delivery and usually resolves within 2 weeks. There is no minimum number of symptoms needed for a diagnosis of baby blues. Providing psychoeducation and monitoring the symptoms are helpful in addressing these symptoms. Baby blues can increase the risk of postpartum depression. Postpartum depression has the same diagnostic criteria as major depressive disorder, with a duration of at least 2 weeks. Postpartum depression commonly develops between 1 week and 1 month after childbirth.

Question 12

Mary is a 27-year-old woman who has presented to the GP. Recently she has been having these concerning thoughts about harming her new-born baby. These thoughts have been really distressing and keep her up at night. She has also been avoiding staying alone with her baby because she is concerned, she may hurt her baby. What is the most likely diagnosis?

Answer: (D) Perinatal Obsessive Compulsive Disorder (OCD)

Mary is displaying symptoms that are in line with perinatal OCD. This is characterised by intrusive unwanted thoughts (obsessions) about the baby. Mary is having these intrusive unwanted thoughts of aggression towards her baby. This is different from postpartum psychosis where patients are influenced by delusions and hallucinations and the thoughts would not cause distress in these patients. The presence of distress from these thoughts and avoidance to act on these thoughts make the diagnosis of perinatal OCD more fitting.

Question 13 is a standalone question.

Question 13
Melissa is a 32-year-old woman who has been brought into the ED by her husband. Melissa has been sleeping for only 2-3 hours each day and is fearful that the government is conspiring to take away her new-born baby, who is now 7 days old. She has been hearing voices and is more active than she usually is. This started 2 days ago, and Melissa's husband is worried that something may be wrong. Which of the following statements is true?

Options:

A. There is a high risk of suicide and a low risk of infanticide.
B. Melissa is having a panic attack.
C. This is an emergency and Melissa needs urgent treatment.
D. The best next step is to refer Melissa to a psychologist for psychotherapy.
E. Melissa needs to be treated for at least 2 weeks to recover.
F. Melissa has a low suicide risk.

Answer: (C) This is an emergency and Melissa needs urgent treatment.
Melissa has postpartum psychosis which is a psychiatric emergency. It is characterised by the loss of inhibition, depression, paranoia, hallucinations, delusions, suicidal ideation, and thoughts of harming the baby. It is associated with an increased risk of suicide and risk of infanticide. The symptoms come on suddenly and usually within the first 2 weeks after delivery. Some risk factors for postpartum psychosis include a personal history of mental health conditions, family history of postpartum psychosis and personal history of postpartum psychosis with a previous pregnancy.

*For questions 14 and 15, use the following options for the **MOST** likely answer.*

Options:

A. Dissociative Amnesia
B. Depersonalisation
C. Derealisation
D. Korsakoff Dementia
E. Dissociative Identity Disorder
F. Post-Traumatic Stress Disorder
G. Mental Status Change
H. Retardation of Thought

Question 14

June Lin is a 22-year-old with limited memory of her childhood years but knows that she was removed from her parents because of abuse and neglect. June often struggles to account for hours or even days of her life. Sometimes, she does not remember how and when she arrived at a specific location. Occasionally, she finds clothes she does not like in her closet, and she does not remember having bought them. Her friends can be confused by her behaviour, as sometimes she acts in a childish dependent manner and at other times becomes uncharacteristically aggressive. These symptoms are most commonly seen in which disorder?

Answer: (E) Dissociative Identity Disorder

June is most likely to be suffering from dissociative identity disorder. The disorder is characterised by at least 2 distinct personality traits which are accompanied by changes in behaviour, memory and thinking. The signs and symptoms may be observed by others or reported by the individual. There are ongoing gaps in memory about everyday events, personal information and/or past traumatic events. It is heavily associated with traumatic events and childhood abuse. Dissociative identity disorder was previously referred to as multiple personality disorder.

Question 15

Jack suffers from generalised anxiety disorder and panic attacks. During his attacks, he feels as if he is disconnected from the world, as though it were unreal or distant, but not in a hallucinatory way. In between panic and anxiety attacks, he describes being plagued by philosophical and existential thoughts about the nature of existence and reality. Which term best describes this symptom?

Answer: (C) Derealisation

Derealisation is defined as experiences of unreality or detachment from one's surroundings, where people may feel as if things and people in the world around them are not real. While depersonalization is experiences of detachment from oneself, where people may feel as if they are outside their bodies and watching events happening to them. During these altered experiences the person is aware of reality and that their experience is unusual. The experience is very distressful, even if the person appears to be unreactive or lacking emotion.

*For questions 16 to 20, use the following options to choose the **MOST** appropriate psychotherapy in each scenario.*

Options:

A. Cognitive Behavioural Therapy (CBT)
B. Supportive Therapy
C. Acceptance and Commitment Therapy (ACT)
D. Insight-Oriented Psychotherapy
E. Dialectical Behaviour Therapy (DBT)
F. Behaviour Therapy
G. Couples Therapy
H. Interpersonal Psychotherapy (IPT)
I. Family Therapy
J. Family-Based Therapy (FBT)

Question 16

Martha is a 24-year-old woman who has presented to ED after she was involved in a motor vehicle accident (MVA) where she drove while under the influence of alcohol and crashed her boyfriend's car. According to her, he was a "good-for-nothing abuser" who "deserved it anyway." She has had recurrent presentations to ED in the past due to non-suicidal self-injury. These episodes are often precipitated by the breakdown of interpersonal relationships. Her developmental history is complicated by severe childhood trauma. She cannot remember much of her childhood, and sometimes still struggles with episodes of amnesia.

Answer: (E) Dialectical Behaviour Therapy (DBT)

This scenario describes a woman affected by Borderline Personality Disorder (BPD). The relevant features of BPD demonstrated in this scenario include impulsivity in areas potentially self-damaging (e.g., substance abuse, reckless driving), recurrent suicidal or self-harming behaviours, a pattern of unstable and intense interpersonal relationships characterised by alternation between extremes of idealisation and devaluation and affective instability. Those affected by BPD have a tendency towards alternation between extremes for people affected by BPD which is also known as splitting. DBT is a modification of CBT and focuses on creating behavioural change in individuals with extreme emotional dysregulation and distress. DBT therefore aims to help individuals with BPD to overcome their tendency to be stuck in extremes, and to change related behaviour due to splitting. Other psychotherapies suited towards treatment of BPD include mentalisation-based therapy.

Question 17

John is a 65-year-old veteran who has presented to the GP. In his words he has overall been living a "happy life." However, recently he has been reflecting a great deal during lockdown and realised that he would like to explore how his mother's infidelity to his father, and his parent's divorce during his adolescence. He believes this might have affected his own relationships with his wife and past partners.

Answer: (D) Insight-Oriented Psychotherapy

Insight-Oriented Psychotherapy is a psychotherapy that seeks to generate insight into how a person's beliefs, thoughts, feelings, and experiences from the past engender unconscious processes and how these unconscious processes may in turn influence present behaviour, feelings and thoughts. Insight-Oriented Psychotherapy relies on conversation between the therapist and a patient. Forms of insight-oriented include psychoanalysis and psychodynamic therapy (which evolved from Freudian psychoanalytic theory). Insight-Oriented Psychotherapy is suited for patients who are open, curious and desire to develop increased self-awareness and understanding of the reasons and motivation behind their own behaviours.

Question 18

June is a 15-year-old girl who has been discharged home from the inpatient adolescent service. Prior to June's hospitalisation, June's parents reported a deterioration of her mental health during lockdown and a 3-month-history of increasingly restrictive eating behaviours as well as excessive exercise. Upon her hospital admission, June's BMI was 16. June's parents are working from home during lockdown and are keen to play an active and supportive role in her recovery.

Answer: (J) Family-based therapy (FBT)

Family-based therapy (FBT), also known as the Maudsley approach, is often first-line treatment for adolescents with eating disorders, especially anorexia nervosa, who live at home with family. Evidence suggests that FBT is suitable for the treatment of children and adolescents up to the age of 19 with a diagnosis of an eating disorder, who are residing at home with their families, with an illness duration of less than 3 years. FBT relies heavily on parental and family involvement in refeeding and weight restoration, with a view of returning control eventually back to the adolescent. Family members work with a team of health professionals, including a doctor, psychologist/counsellor, and dietician, to ensure the adolescent is supported and that the treatment model is followed effectively.

Question 19

Simon is a 19-year-old male who presents to his GP with a 1-week history of recurrent nausea and diarrhoea. He has a group-based oral presentation which is due next week. Over the last 12 months, he has struggled academically as he has avoided attending his Zoom tutorials over a fear of being called upon to contribute to class discussions. Since commencing university, he has not been able to make any new friends.

Answer: (A) Cognitive Behavioural Therapy (CBT)

This scenario described a man affected by Social Anxiety Disorder. The relevant features of this disorder as demonstrated by this scenario include marked fear or anxiety regarding one or more social situations in which the individual is exposed to possible scrutiny by others, consistent fear, and anxiety out of proportion to the actual threat posed by the social situation, avoidance of the social situation, and clinically significant distress or impairment in social, occupation and other areas of functioning. CBT is a short-term structured and practical psychotherapy which focuses on the interaction between cognition, behaviour, and emotions. CBT combines both cognitive therapy (helps a person identify, challenge, and change cognitive distortions) and behaviour therapy (teaches a person new techniques or skills to change their own behaviour). CBT often involves personal education, goal setting, active practise of new skills or strategies and self-monitoring. CBT programs can be delivered through formal face-to-face sessions with a therapist or digitally through computers or smartphone applications. CBT is often the first-line psychotherapy for mild to moderate depression, anxiety disorders and has application in many other psychiatric disorders.

Question 20

Keith is a 32-year-old male who was diagnosed with schizophrenia in 2015. After a trial of brexpiprazole and aripiprazole, he is now stable on quetiapine 600mg BD. However, Keith continues to experience some distress and difficulty with residual auditory hallucinations. He has trialled CBTp (CBT for people with psychosis) previously to no effect. However, he is keen to explore further psychotherapeutic options.

Answer: (C) Acceptance and Commitment Therapy (ACT)

ACT focuses on cultivating psychological flexibility and helping patients to behave more consistently with their own values and apply mindfulness and acceptance skills to uncontrollable experiences. ACT, when used in psychotic disorders, aims to modify a person's relationship with distressing symptoms and difficult internal or phenomenal experiences such as positive symptoms. ACT focuses on acceptance, rather than control, suppression or elimination and teaches meta-cognitive awareness, meditation, and mindfulness skills. RANZCP Guidelines recommend that ACT should be considered for patients who have already received CBTp and continue to suffer distress or impairment from their symptoms.

*For questions 21 to 25, use the following options for the **MOST** likely answer.*

Options:

A. Nicotine replacement therapy (NRT)
B. Naltrexone
C. Bupropion Hydrochloride
D. Acamprosate
E. Naloxone
F. Disulfiram
G. Varenicline

Question 21

Alex, a 47-year-old man, presents to his general practitioner for advice on smoking cessation, after a 22-year pack history. He has tried, unsuccessfully, to quit before using nicotine replacement therapy and is looking for a different therapy. Relevant past medical history included hypertension (BP 140/100), cholecystectomy for cholecystitis, and epilepsy, for which he takes lamotrigine. Select the most acceptable form of smoking cessation therapy for Alex.

Answer: (G) Varenicline

There are 3 medications currently available for assisting in smoking cessation: nicotine replacement therapy (NRT), varenicline (Champix), and Bupropion hydrochloride/ Zyban. The answer is found by eliminating other options. Nicotine replacement therapy is incorrect as Alex is looking for a different therapy after already trying NRT. Bupropion is contraindicated in patients with a history of seizures, so is not appropriate for Alex. This leaves Varenicline (Champix) as the correct answer. Other incorrect answers include Naloxone (opioid withdrawal); Naltrexone, acamprosate and disulfiram (used in alcohol withdrawal).

Question 22

Alice, a 24-year-old commerce student, is newly motivated to quit smoking (4 pack year history), after discovering she is 8 weeks pregnant with her first child. What medication is most appropriate to assist Alice in quitting smoking?

Answer: (A) Nicotine replacement therapy (NRT)

Nicotine replacement therapy (NRT) is the only smoking cessation treatment that is safe for use in pregnancy, breastfeeding and for adolescents, so is the only option suitable for Alice. Bupropion hydrochloride and varenicline are also effective treatments for smoking cessation but are contraindicated in women who are pregnant. For more information on smoking cessation therapies, see summary table below.

Question 23

Karen, a 29-year-old veterinarian, presents to her general practitioner asking for the most effective medication to assist in her smoking cessation. Her past medical history includes bulimia nervosa and appendicitis. What medication is most appropriate to assist Karen in quitting smoking?

Answer: (G) Varenicline

Varenicline (Champix) is a nicotine receptor partial agonist that has the highest efficacy for smoking cessation out of the three smoking cessation treatments currently on the market (NRT and bupropion). Bupropion hydrochloride is contraindicated in Alice due to her history of bulimia

(as bulimia can cause electrolyte abnormalities which may cause a seizure in a patient with bupropion). Nicotine replacement therapy is the next best answer.

Question 24

Steve, a 24-year-old university student re-presents to his general practitioner after experiencing vivid nightmares for 1 week, while on a smoking cessation treatment. In these dreams he is being chased by a hooded figure and wakes drenched in sweat, hardly having a restful night over the past week. The doctor recommended this treatment as Steve was waking at night to smoke. What medication is most likely to be responsible for Steve's symptoms?

Answer: (A) Nicotine replacement therapy (NRT)

Nicotine replacement therapy Is the medication most likely to cause Steve's nightmares and/ or vivid dreams. NRT is often given as 16hr patches, and removed at night to avoid sleep disturbances, but 24hr patches may be given to those who wake at night to smoke. Other smoking cessation options such as Varenicline and bupropion whilst causing insomnia, are less likely to cause vivid dreams. For more information on smoking cessation therapies, see summary table below.

Question 25

Lulu, a 42-year-old publisher presents to you after the breakdown of yet another relationship. She has a history of chronically unstable relationships and mood disturbances which often climax with a suicide attempt or self-harm. Today Lulu presents asking for medication to assist in her smoking cessation, as her ex-partner used to smoke, and she doesn't want anything to remind her of him. Given Lulu's history, what smoking cessation medication is contraindicated?

Answer: (G) Varenicline

Varenicline (Champix) is debated to have some risk of suicidality or neuropsychiatric effects, so is best avoided in Lulu's case. Other side effects of varenicline include nausea, vomiting and insomnia. Other drugs to assist in smoking cessation include NRT and Bupropion hydrochloride. NRT has the side effect of vivid dreams, and bupropion's most well-known side effect is seizures, so is contraindicated in patients with eating disorders or electrolyte disturbances. For more information on smoking cessation therapies, see summary table below.

QUICK SUMMARY OF TOBACCO-RELATED MEDICATIONS[1]

	NRT	Champix	Bupropion
Mechanism of action	Provides nicotine to reduce cravings, but without the other harmful chemicals found in cigarettes.	Nicotine receptor partial agonist- reduced cravings and withdrawal.	Unclear but makes smoking less rewarding.
Route	Patch, inhaled, chewing gum, spray, lozenge, sublingual tablets	Oral	Oral
Access/ Course	12 week course, PBS subsidised.	12 week course, PBS subsidised; Choose day to quit smoking and start varenicline 1-2 weeks before this date.	Need to quit 2 weeks into the course, PBS subsidised; course length varies on individual.
Indications	To aid in smoking cessation and maintenance.	To aid in smoking cessation; can be used with NRT. Proven to be most effective.	To aid in smoking cessation.
Contra-indication	A serious CVD event in the last 6 weeks, or children aged <12 years.	Pregnancy, breastfeeding, children, renal impairment (reduce dose), or history of suicidal ideation.	A history of seizures, certain medications (MAOi, antidepressants, hypoglycemics, antimalarials), pregnancy, eating disorders & children.
Side effects	Vivid dreams (because of this we usually give a patch that lasts 16hr, so no nicotine is given when sleeping-unless the patient wakes at night to smoke, in which case we use 24hr patches)	Nausea, vomiting, suicidal ideation, insomnia.	Seizures, insomnia, dry mouth, headaches, joint and muscle pain.

[1]**References:**
Cancer Council Tasmania. (2021, May 19). *Quit Tasmania*. Quit Tasmania. https://www.quittas.org.au/
Royal Australian College of General Practitioners (RACGP). (n.d.). *RACGP - Supporting smoking cessation: A guide for health professionals*. RACGP. shorturl.at/efquF

*For questions 26 to 28, use the following options for the **MOST** appropriate person(s) to provide consent.*

Options:

A. Patient
B. Spouse or domestic partner
C. Patient's child
D. Patient's carer
E. Patient appointed Medical Treatment Decision Maker (MTDM)
F. Nominated person
G. Authorised psychiatrist
H. Power of Attorney
I. Apply for administration
J. Apply for guardianship
K. VCAT
L. Office of the Public Advocate
M. Mental Health Tribunal (MHT)

Question 26

Andrea is a 49-year-old woman with chronic schizophrenia who currently lives in assisted living. She has been stable on clozapine for 5 years, still experiencing auditory hallucinations daily, but is no longer distressed by them, and is able to maintain her ADLs. She is currently not on a Treatment Order. She is financially stable, having worked as a teacher's aide for 20 years before her diagnosis. Tomorrow is her niece's 18th birthday and as a gift she has decided to buy her a $300 opal necklace with her savings. Andrea's nurse hears about this intended purchase and is unsure if it is OK for Andrea to spend such money. Who can authorise this spending?

Answer: (A) Patient

Andrea can manage her finances on her own. Her history does not display high financial risks (e.g., history of erratic spending, debt, appointed administrator). As the scenario describes, she has been stable on her medication for 5 years and can maintain her own ADLs. For patients who are unable to manage their own finances (i.e., a patient with mania who spends erratically, or a patient whose mental illness prevents them in normal psycho-social functioning of daily lives such as paying bills), it would be more appropriate to apply for administration. B,C,D,E: falls in the hierarchy of medical treatment decision makers, F: A nominated person can advocate for a patient but cannot make their medical or financial decisions. G: An authorised psychiatrist can assist in medical decisions but not financial. J: a guardian can be appointed by the patient or by VCAT to make decisions about the patient's healthcare.

Question 27

Amanda is a non-verbal 23-year-old with quadriplegic cerebral palsy, epilepsy and severe intellectual disability who is currently cared for by her older brother Jeremy. Amanda has been regularly reviewed by a gynaecologist for distressing monthly heavy menstrual bleeds and dysmenorrhea since age 16. Her symptoms have not resolved despite using OCP, Implanon and Mirena. Her gynaecologist suggests that the most effective long-term treatment to perform would be a hysterectomy, and Jeremy agrees with this. Who can consent to this procedure?

Answer: (L) Office of the Public Advocate

The correct answer is The Office of the Public Advocate. This is because the proposed treatment for Amanda's heavy menstrual bleeding (HMB) would be deemed as "significant". Significant treatment includes any treatment that poses significant risk of body intrusion, risk to person, irreversible side effects or distress to the person. As a hysterectomy fits the above-mentioned risks, including infertility for Amanda, this treatment is deemed a significant treatment. As Amanda is a non-verbal patient with intellectual disability, she does not have the capacity to consent. Hence, consent for significant treatment must be gained from the office of the public advocate before commencing treatment, unless it is an emergency, and that treatment is lifesaving.

Question 28

17-year-old Kyle was diagnosed with Major Depressive Disorder (MDD) 3 years ago. His condition has not improved despite several trials of antidepressants, including clozapine. His mother, Emmy, suffered similarly from MDD when she was in her early 20s and was successfully treated with a course of electro-convulsive therapy (ECT). Because of her success with the treatment, Kyle would like to trial ECT to help his MDD. Who can consent to this treatment?

Answer: (M) Mental Health Tribunal (MHT)

Kyle is under the age of 18, and for any patient who is less than 18-years-old, an application needs to be made to the MHT for approval for ECT. This application needs to be made even if Kyle has agreed to, or requested, an ECT. In patients who are 18 years of age or older, an application to the MHT is submitted if the patient does not have capacity to give informed consent, and there is no less restrictive way to treat the patient.

*For questions 29 to 30, use the following options for the **MOST** appropriate answer.*

Options:

A. Review by psychiatrist
B. Review by any practitioner
C. Call an ambulance
D. Call the police
E. CODE Grey
F. Mental Health Tribunal (MHT)
G. Place under Assessment Order (AO)
H. Place under Temporary Treatment Order (TTO)
I. Place under Treatment Order/ Involuntary Treatment Order (TO/ITO)
J. 24 hours
K. 72 hours
L. 28 days
M. 6 months
N. 12 months
O. 3 months

Question 29

Alexander Moss is a 35-year-old carpenter who presents to the emergency department acutely distressed. He describes hearing voices when no-one is around, mocking him, and believes he was abducted last night and probed by Aliens. His wife, Sarah, says this odd behaviour has been worsening for 5 days, and she cannot think of a trigger. On examination Alexander appears distracted, his eyes darting around the room. When questioned on whether he needs hospitalisation, Alexander disagrees saying instead he needs a knife to cut the alien out of him. What is the most appropriate next step in managing Alexander?

Answer: (G) Place under Assessment Order (AO)

In this situation, Alexander should be placed under an AO. This can only be done if Alexander meets certain criteria - which includes him appearing to have a mental illness, requiring immediate treatment to prevent deterioration of his own health as well as to prevent harm to self and others. Additionally, Alexander is refusing to accept medical treatment and it is evident that he has poor insight and judgement into his own health ("knife to cut the alien out"). Option A (review by psychiatrist) is incorrect as Alexander refused to be admitted and is not a voluntary patient. Options D (call the police) and E (code grey) are incorrect because Alexander does not appear to be acutely putting others or himself at risk through aggression. Option H (place patient under temporary treatment order (TTO)) is incorrect as this can only be commenced by a psychiatrist who has assessed a patient under an assessment order and deemed, they require further treatment. A TTO lasts a total of 28 days after which the patient is reviewed by the Mental Health Tribunal (MHT) (Option F) to determine if they need to continue treatment on an involuntary treatment order (Option I).

Question 30

Kat Moss is a 16-year-old girl who has been treated for Major Depressive Disorder in the community. She has poor insight into her condition, without her parents she would cease to take her medication. She is currently under a community involuntary treatment order. What is the maximum time Kat can be placed under a community treatment order for, before needing review by the Mental Health Tribunal to approve an extension?

Answer: (O) 3 months

Kat is classified as a minor (under the age of 18) so the maximum time she can be placed in an involuntary treatment order is 3 months, regardless of if the treatment order is community based or inpatient. This is different for adults, where the maximum duration of a community ITO is 12 months, and an inpatient ITO is 6 months. Option J (24 hour) is the time between placing an assessment order in which a psychiatrist must review the patient. The duration of the assessment order can be extended twice up to a total of 72 hour (Option K), if the psychiatrist is unable to perform the psychiatric assessment within 24 hours. Option L (28 days) is the maximum time on a temporary treatment order, after which the mental health tribunal must be seen to decide to extend the mental health act to an involuntary treatment order or cease the involuntary treatment.

QUICK SUMMARY OF MENTAL HEALTH ACT

	Assessment Order (AO)	Temporary Treatment Order (TTO)	Involuntary Treatment Order (ITO)
Definition	**WHO:** Any health practitioner can request for an AO. **WHY:** When a health practitioner believes the patient needs to be seen by a psychiatrist. **OUTCOME:** Patient needs to be assessed by a psychiatrist. ***Note:*** *AO doesn't permit treatment.*	**WHO:** Only a psychiatrist can sign a TTO. **WHY:** Allows to commence temporary treatment to combat symptoms. **OUTCOME:** Treatment commences and patient sees Mental Health Tribunal (MHT) in 28 days to see if an extension is needed. Alternatively, patients can request for MHT before 28 days to debate TTO.	**WHO:** Only a Mental Health Tribunal (MHT) can decide to place one on an ITO. **WHY:** To extend treatment beyond 28 days if necessary. **OUTCOME:** Treatment commences/continues. Patients can apply to MHT to debate ITO. If changing from community/inpatient or vice-versa, must see MHT in <28 days.
Length	A psychiatrist must see the patient within 24 hours. It can be extended **twice** for a total of 72 hours.	A TTO lasts for only 28 days.	This is dependent on the MHT's decision. Inpatient ITO can last up to 6 months. Outpatient ITO can last up to 12 months. If aged <18, inpatient and outpatient ITO has a maximum of 3 months.
Criteria	A. The person appears to have a mental illness. B. The person requires immediate treatment to prevent (i) serious deterioration in the person's mental or physical health and/or (ii) serious harm to the person or a different person. C. The person can be assessed. D. There are no less restrictive means to treat the patient.	A. The person has a mental illness. B. Because the person has a mental illness, they need immediate treatment to prevent (i) serious deterioration in the person's mental or physical health and/or (ii) serious harm to the person or a different person. C. Immediate treatment is available to be provided. D. There is no less restrictive means reasonably to treat the patient	

Reference:
Mental Health Act 2014. (2014). Victorian Legislation.https://www.legislation.vic.gov.au/in-force/acts/mental-health-act-2014/022

Question 31 & 32 are standalone questions.

Question 31

Steven believes he is drinking too much alcohol and has had a warning at work about his behaviour. He is now eager to reduce his alcohol consumption but has had great difficulty stopping. He states that he usually only drinks on Friday and Saturday night when he goes out with friends. When he is alone the rest of the week, he has no difficulty abstaining from alcohol. What medical management would be most appropriate for Steve?

Options:

A. Acamprosate
B. Buprenorphine
C. Bupropion
D. Disulfiram

Answer: (D) Disulfiram

Disulfiram blocks the breakdown (metabolism) of alcohol by the body, causing unpleasant symptoms such as nausea and flushing of the skin. Those unpleasant effects can help some people avoid drinking while taking disulfiram. Disulfiram is good when drinking is triggered by social situations. Acamprosate makes it easier to maintain abstinence. Bupropion is used in smoking cessation. Buprenorphine is used in opioid replacement therapy. Another possible answer, which is not an option here, would be naltrexone which can help people reduce heavy drinking.

Question 32

You are asked to speak to Steve in ED. The registrar has asked you to take a history from Steve to determine if he has an alcohol use disorder. What questions are critical to ask when assessing if a patient has an alcohol use disorder?

1. How many units of alcohol do you drink per day?
2. At what age did you start drinking alcohol?
3. Do you feel that your alcohol use interferes with your ability to perform your work or obligations in the home?
4. Has your alcohol use put yourself or others in danger?

Options:

A. 1 and 2
B. 1 and 3
C. 2 and 3
D. 3 and 4

Answer: D (3 and 4)

Based on DSM-V criteria for Alcohol Use Disorder (AUD). Although the other questions are informative and can be important to ask, they do not determine if a person has an AUD.

THE END