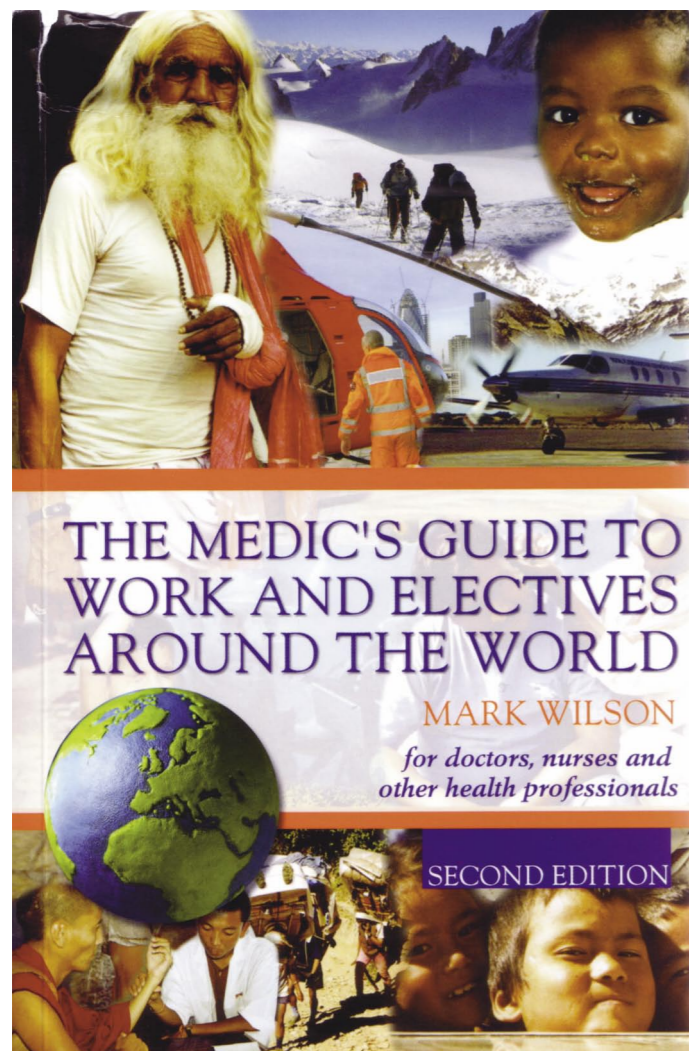


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THE MEDIC'S GUIDE TO WORK AND ELECTIVES AROUND THE WORLD, by Mark Wilson

(Arnold) London, UK 2000.
£14.99
ISBN: 0 340 810513
586 pages



Years in gloomy lecture theaters, some pretty hairy early clinical stuff and a succession of student flats ... by 5th year itchy feet are almost inevitable! Electives are a much anticipated right of passage for many of us; one last hurrah as our student years drawn to a close and we settle into this crazy profession for good. For others, it's a chance to sample an entrée from the main course of medicine, tasting some of the many possibilities that come with a sparkly new Mb ChB. For many it's a chance to reflect and reconnect with the ideals that drew us to be doctors. Regardless of what we want to experience, or how we want to spend our time, electives an inevitably marred by organization and logistic nightmares.

In time honored tradition, elective plans are very much determined by word of mouth; someone, knows someone, who met a guy in a bar once, who heard about a really cool hospital in a galaxy far, far away. Which is great, but not actually very useful.

With a sigh of relief it is now possible to reach for *The Medic's Guide to Work and Electives Around the World* and flick to detailed information about said hospital in distant galaxy. The book was written by Mark Wilson, a well-travelled British doctor, and supplemented by informal feedback from other intrepid medics. Potential elective destinations in over one hundred countries are listed, generally with descriptions of the country, possible medical experience, a blurb about the facility and, vitally, contact details. Many entries also cover the potential social life, accommodation options, transport, availability of translators, visa and registration requirements, provisions you may need to take, and the informal reputation of each hospital. The vast scope of this book is truly impressive; hospitals in Ghana, Malawi, Iceland, Luxembourg, Slovak Republic, Israel, Jamaica, Belize, Falkland Islands are all discussed (no sign of North or South Korea though, presumably for good reason). In the New Zealand section, Porirua, Kenepuru, Thames and Grey Base Hospitals are all outlined, which gives an idea of the level of detail for each country. Non-Government Organizations and Adventure Medicine groups are also listed with information and contact details.

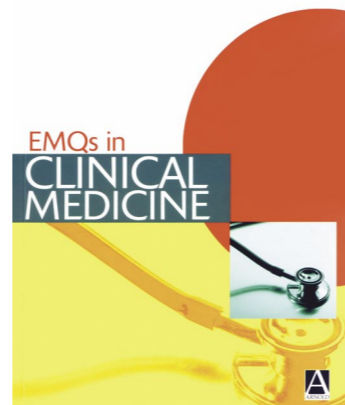
The Medic's Guide is refreshingly unbiased, the blurbs give information which is useful and interesting, not just repetitions of hospital advertising and recruitment slogans. There are no photos, probably because a world tour of hospital architecture is a bleak prospect. There are obligatory sections on travel tips, vaccinations schedules, insurance, travel safety which are undoubtedly useful, but not as exciting as reading about exotic countries and rare pathologies. All the information is recent, with the second edition of *The Medic's Guide* published in 2004 and an accompanying website with other updates (alarmingly, the population of Singapore is given as 2.8 million when, in fact, it is well over 4 million ... but what's a few million people between friends?). This book makes organizing your elusive dream elective a little easier by providing ideas, contacts and realistic, anecdotal information. A copy on your desk might also be a pleasant reminder of the possibilities that come with these funny old degrees.

EMQs IN CLINICAL MEDICINE, by Irfan Syed

(Arnold) London, UK 2004.
£12.99
ISBN: 0 340 811099
260 pages

IRFAN SYED

Once, when the world of medicine was young, students could expect cover the entire body of medical knowledge during their degree... there wasn't much to learn: anatomy, basic physiology, basic pathology and a smattering of rudimentary surgery. Obviously the finer points of doctoring took time and experience, but it was conceivable to learn all there was to know. In stark contrast, medical training in the 21st century is a litany of specialties, subspecialties, and ever new



discoveries. Today's students can not hope to cover all of the astounding things we now know about medicine, science and our bodies. Still, everyone seems very keen for students to try, and more and more facts are squeezed into tight, unforgiving, little curricula. The exponential increase of knowledge now presented during a medical degree has driven students to be increasingly selective about what, and how, they study. Unfortunately the trick seems to be covering as much examinable material in the smallest number of words possible.

Most students have a penchant for past papers and model answers so it's quite nice to have them bound in a tidy little volume like this one ... the temptation to subconsciously memorise answers is strong, potentially limiting the long term life of the book.

This necessity has given birth to a new generation of abridged textbooks presented as lecture summaries and revision guides. The trend towards exam-orientated study is also perpetuated by books of practice tests and sample exam questions. This useful genre is typified by Irfan Syed's *EMQs in Clinical Medicine*. Written when he was a final year medical student in Britain, the book provides one hundred sample questions in the Extended Matching Questions (EMQ) style. This is an increasingly common question design; students are provided with a number of clinical presentations and asked to select the most likely diagnosis from a fairly extensive list. In this book each question provides five clinical descriptions which must be matched with the correct diagnosis from a list of about ten possibilities. Paragraph answers, with reasons for the diagnosis, are provided for each clinical history. The Revision Box – ubiquitous in medical texts – makes an appearance, providing at-a-glance information about various conditions.

The book is divided into eight sections, including neurology, respiratory medicine, orthopedics and rheumatology, and cardiac medicine. Questions are of intermediate difficulty, largely based on fundamental knowledge. The level of difficulty would probably be quite reassuring prior to exams; a reasonable working knowledge of basic clinical medicine would see you through this book, and hopefully a similar exam. In essence, this book is a compilation of past exam papers, model answers, and some token revision notes. Most students have a penchant for past papers and model answers so it's quite nice to have them bound in a tidy little volume like this one. However, students are as tight on dollars as they are on spare neurons, creating a downfall for *EMQs in Clinical Medicine*...

The temptation to subconsciously memorise answers is strong, potentially limiting the long term life of the book. However, the layout of the book is user-friendly and clear, providing a good chance to assess your knowledge and direct revision. This is a handy book but may have limited long-term use beyond final examinations.

Acknowledgement

The NZMSJ is grateful to Hodder Arnold UK for the provision of these books.

99 The confused patient

- | | | | |
|---|---------------------------------|---|---------------------------------|
| A | intravenous flucloxacillin | I | intravenous bendroflumazepam |
| B | follicle acid | J | intravenous fluids, insulin |
| C | fresh frozen plasma | K | oral prednisolone |
| D | subcutaneous insulin | L | Burr hole |
| E | triiodothyronine | M | intravenous thiamine, fluids |
| F | intravenous haloperidol | N | intravenous fluids, pamidronate |
| G | intravenous hydrocortisone | O | blood transfusion |
| H | intravenous fluids, propranolol | | |

Choose, from the above options, the most appropriate therapy that is indicated for the scenarios below. Each option may be used only once.

- 1 A 53-year-old man presents to A&E confused and unsteady on his feet. On examination he has nystagmus and bilateral lateral rectus palsies. He smells strongly of alcohol.
- 2 A 28-year-old woman presents confused and weak after collapsing in the street. Examination reveals tachycardia, marked hypotension and several depigmented patches over her body. Hb 14 g/dl, glucose 3.5 mmol/l, serum Na⁺ 128 mmol/l, serum K⁺ 5.4 mmol/l, serum Ca²⁺ 2.6 mmol/l.
- 3 A 15-year-old boy presents acutely confused with hyperventilation, vomiting and abdominal pain. Hb 14 g/dl, white cell count 13.0 × 10⁹/l, glucose 19 mmol/l, platelets 160 × 10⁹/l.
- 4 A 73-year-old woman with a history of metastatic breast cancer presents with vomiting and abdominal pain. She is found to be acutely confused. On examination positive findings include dry mucous membranes. Hb 10 g/dl, white cell count 7 × 10⁹/l, glucose 4.5 mmol/l, platelets 350 × 10⁹/l, corrected calcium 4.2 mmol/l, serum K⁺ 3.5 mmol/l.
- 5 A 26-year-old woman presents with fever, confusion and agitation. Examination reveals an irregular pulse of rate about 240/min and the presence of a goitre.

Answers: see page 245.

9 The confused patient

Answers: M G J N H

- A 53-year-old man presents to A&E confused and unsteady on his feet. On examination he has nystagmus and bilateral lateral rectus palsies. He smells strongly of alcohol.
Wernicke's encephalopathy is at the top of the differential diagnosis list and so administering thiamine is a priority to avoid progression to irreversible Korsakoff's syndrome.
- A 28-year-old woman presents confused and weak after collapsing in the street. Examination reveals tachycardia, marked hypotension and several depigmented patches over her body. Hb 14 g/dl, BM 3.5 mmol/l, serum Na⁺ 128 mmol/l, serum K⁺ 5.4 mmol/l, serum Ca²⁺ 2.6 mmol/l.
This is a presentation of an Addisonian crisis. The patient may have Addison's disease or may have suddenly stopped taking long-term steroid treatment. Intravenous hydrocortisone sodium succinate is the initial treatment of choice. The patient is often hyglycaemic and so this should also be treated as required. Fludrocortisone may be required long term.
- A 15-year-old boy presents acutely confused with hyperventilation, vomiting and abdominal pain. Hb 14 g/dl, white cell count 13.0 × 10⁹/l, BM 19 mmol/l, platelets 160 × 10⁹/l.
This is a presentation of diabetic ketoacidosis (a medical emergency) for which fluids are the single most important therapeutic measure. The dehydration is a more severe complication than the prevailing hyperglycaemia.

- A 73-year-old woman with a history of metastatic breast cancer presents with vomiting and abdominal pain. She is found to be confused. On examination positive findings include dry mucous membranes. Hb 10 g/dl, white cell count 7 × 10⁹/l, BM 4.5 mmol/l, 350 × 10⁹/l, corrected calcium 4.2 mmol/l, serum K⁺ 3.5 mmol/l.
This is an emergency presentation of hypercalcaemia. In a patient with a history of metastatic breast cancer, the cause is probably malignancy. Intravenous saline is an important first-line measure to rehydrate the patient and to increase renal loss of calcium. Intravenous bisphosphonates, e.g. pamidronate, are indicated to lower the serum calcium over 24 hours.
- A 26-year-old woman presents with fever, confusion and agitation. Examination reveals an irregular pulse of rate about 240/min and the presence of a goitre.
This is a presentation of a thyroid crisis also known as a thyrotoxic storm. The symptoms are that of hyperthyroidism but more severe. Precipitating factors include recent thyroid surgery, radioiodine therapy and stress. As a result of the extreme hypermetabolic state, the priorities for management are rehydration and cooling with intravenous fluids. The next priority is to block the peripheral action of the hormone and reduce synthesis of hormone using β blockers, e.g. propranolol and antithyroid drugs, e.g. carbimazole, respectively.