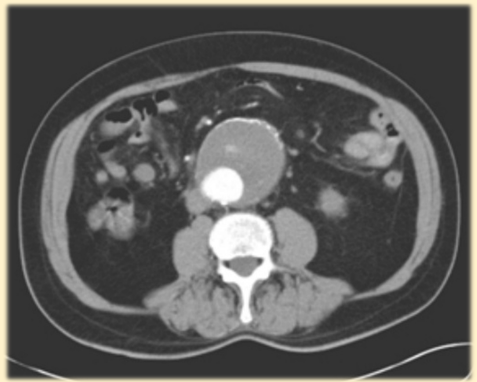
MCQ subset

Patient: Male, 65 years old. An abdominal CT enhancement scan was performed, revealing abnormalities in the abdominal aorta, as shown in the image below. The diagnosis for this case should be:

"A": "Aortic dissection aneurysm",
"B": "Aortic sclerosis",
"C": "Aortic thrombosis",
"D": "Aortic aneurysm",
"E": "Aortic rupture"

Answer: "C": "Aortic thrombosis"



Brief medical history

Medical History Collection subset

A 1-year and 1-month-old boy. Fever for 2 days, with 1 episode of seizures, was admitted to the emergency department.

Content of the Inquiry

Present Illness History Based on the chief complaint and relevant differential questions: (1) Onset Triggers: Any history of trauma, exposure to cold, or upper respiratory infections? (2) Fever: What is the severity, how has the temperature changed, and is there any history of chills? (3) Seizures: Location of limb twitching, number of episodes, duration, and any loss of consciousness, incontinence, or cyanosis during the episodes? (4) Relationship Between Fever and Seizures: When did the seizures occur, what was the temperature during the seizures, and what was the state of consciousness afterward? (5) Accompanying Symptoms: Any cough, runny nose, vomiting, diarrhea, crying, irritability, or rash?
Diagnosis and Treatment Process (1) Has the patient been to the hospital, and what tests have been done (e.g., complete blood count (2) Treatment situation: Have antipyretic or anticonvulsant medications been used, and what was the effect? General Condition: Recent mental state, diet, sleep, and bowel and bladder habits. (II) Other Relevant Medical History Any history of asphyxia at birth, feeding history, and growth and development status? Any history of drug allergies? Vaccination history? Other medical history related to the condition: Any similar episodes, contact with infectious disease patients, or family history of febrile seizures?
Inquiry Skills Strong organization and ability to grasp key points. Ask questions focused on the medical condition.

Medical summary

Medical Result Analysis subset

Female, 45 years old.
Chief Complaint: Recurrent joint swelling and pain for 6 years, worsening with fatigue for 1 week.
History of Present Illness: The patient developed multiple joint swelling and pain 6 years ago without any obvious trigger, accompanied by morning stiffness in both hands lasting about 1 hour, but did not seek treatment. One week ago, the swelling and pain in the joints of both hands and wrists worsened, with no intermittent fever. Since the onset, bowel and bladder functions, as well as sleep, have been normal. There has been no significant change in weight. The patient has a history of good health, with no history of trauma. There is no smoking or alcohol consumption, and no family history of hereditary diseases.

Physical Examination
Temperature: 36.8°C, Pulse: 90 beats/min, Respiratory Rate: 18 breaths/min, Blood Pressure: 135/70 mmHg. Mild anemia observed, with no petechiae or rash on the skin; superficial lymph nodes not enlarged; conjunctiva pale; no jaundice in the sclera; lips slightly pale; normal tongue; thyroid not enlarged. No dry or wet rales auscultated in both lungs; heart size normal with a heart rate of 90 beats/min and regular rhythm. Abdomen soft, non-tender; liver and spleen not palpable below the ribs; shifting dullness negative. Swelling noted in the proximal interphalangeal joints of both hands; mild ulnar deviation of fingers; limited wrist movement; swelling in both knee joints; patellar tap test negative; no edema in both lower limbs.

Laboratory Tests
Complete Blood Count: Hb 80 g/L, RBC 3.3 × 10(12)/L, WBC 7.5 × 10(9)/L (normal differential), PLT 345 × 10(9)/L. Serum Rheumatoid Factor: Positive. Liver and kidney function: Normal. Stool routine: Negative. Urine routine: Negative. X-ray of Both Hands: Narrowing of the joint space in the proximal interphalangeal joints of both hands (as shown in the image).

Preliminary Diagnosis, Reason, Differential Diagnosis, Further Examination, Treatment Principles

I. Preliminary Diagnosis 1. Rheumatoid Arthritis 2. Chronic Disease Anemia
II. Diagnostic Criteria (No points for incorrect preliminary diagnosis)
1. Rheumatoid Arthritis (1) Middle-aged female, chronic onset. (2) Multiple joint pain, symmetrical arthritis, morning stiffness lasting 1 hour. (3) Positive serum RF. (4) X-ray of hand joints shows narrowing of the joint space in the proximal interphalangeal joints.
2. Chronic Disease Anemia (1) History of chronic disease.(2) Anemic appearance, pale conjunctiva and lips, increased heart rate. (3) Hemoglobin below normal, presenting as microcytic anemia.
III. Differential Diagnosis 1. Systemic Lupus Erythematosus 2. Ankylosing Spondylitis 3. Osteoarthritis
IV. Further Examination 1. Anti-CCP antibodies, HLA-B27. 2. Anti-ANA antibodies, anti-ENA antibodies. 3. Serum ferritin, serum iron, total iron-binding capacity.
V. Treatment Principles 1. Non-steroidal anti-inflammatory drug treatment. 2. Disease-modifying anti-rheumatic drug treatment. 3. Corticosteroids and biological agents if necessary.