

## SINGAPORE MEDICAL COUNCIL CATEGORY 3B CME PROGRAMME

(Code SMJ 201504A)

	True	False
1. Chronic obstructive pulmonary disease (COPD) is characterised by airflow limitation that is usually progressive, and is associated with an enhanced chronic inflammatory response to noxious particles or gases in the airways and lungs.	<input type="checkbox"/>	<input type="checkbox"/>
2. COPD is not among the top five leading causes of death in the world, or the top ten causes of hospitalisation and death in Singapore in 2011.	<input type="checkbox"/>	<input type="checkbox"/>
3. Early diagnosis and appropriate treatment can help patients to improve symptoms, reduce the rate and severity of exacerbations, improve quality of life and exercise capacity, and prolong survival.	<input type="checkbox"/>	<input type="checkbox"/>
4. Patients with early COPD may walk slower than their peers, or face difficulties performing activities that could easily be done previously, and such problems can lead to changes in lifestyle and deconditioning.	<input type="checkbox"/>	<input type="checkbox"/>
5. Other differential diagnoses should be considered if a patient classified as having COPD consistently experience progressive dyspnoea, which typically worsens with exercise; chronic cough, which may or may not be productive; and have risk factors such as passive or active smoking.	<input type="checkbox"/>	<input type="checkbox"/>
6. The typical clinical symptoms of progression of COPD do not include weight loss, anorexia, depression and coronary heart disease.	<input type="checkbox"/>	<input type="checkbox"/>
7. Physical examination that reveals a prolonged expiratory phase and hyperinflation is consistent with airway obstruction.	<input type="checkbox"/>	<input type="checkbox"/>
8. In patients with COPD, spirometry typically shows obstruction ( $FEV1/FVC < 0.7$ ) and insignificant bronchodilator response.	<input type="checkbox"/>	<input type="checkbox"/>
9. A study found that the diagnosis of COPD can be incorrectly classified in up to a fifth of patients in primary care.	<input type="checkbox"/>	<input type="checkbox"/>
10. There is no practical implication in accurately classifying patients as having asthma or COPD, as their treatment algorithms (both steroids and beta-agonists inhalers) and lifestyle management are the same.	<input type="checkbox"/>	<input type="checkbox"/>
11. In persistent asthma, inhaled steroids are the basis of treatment, while bronchodilators are the mainstay of treatment in COPD.	<input type="checkbox"/>	<input type="checkbox"/>
12. Only patients with severe COPD may benefit from inhaled steroids.	<input type="checkbox"/>	<input type="checkbox"/>
13. The routine use of inhaled steroid therapy in the treatment of COPD may increase the risk of pneumonia in such patients.	<input type="checkbox"/>	<input type="checkbox"/>
14. Misdiagnosis of COPD as pulmonary tuberculosis will lead to further progression of the disease in the individual and spread of COPD in the community.	<input type="checkbox"/>	<input type="checkbox"/>
15. Differentials for COPD include asthma, obesity-related respiratory disease, ischaemic heart disease, congestive heart failure, bronchiectasis and tuberculosis.	<input type="checkbox"/>	<input type="checkbox"/>
16. Brief smoking cessation counselling by the physician is effective, but delivers a modest 1%–3% cessation rates.	<input type="checkbox"/>	<input type="checkbox"/>
17. A single dose of influenza and pneumococcal vaccine each is the current recommendation for treatment of patients aged > 65 years with COPD.	<input type="checkbox"/>	<input type="checkbox"/>
18. Pulmonary rehabilitation or incorporation of regular physical activity is important, as it helps to reduce hospital admissions and mortality in patients with COPD.	<input type="checkbox"/>	<input type="checkbox"/>
19. Early detection and management of COPD progression and complications such as pneumonia, pneumothorax, bronchiectasis and right heart failure is important.	<input type="checkbox"/>	<input type="checkbox"/>
20. Short courses of antibiotics in moderate, infective exacerbations of COPD may be considered when there is heightened breathlessness with increased sputum volume and purulence.	<input type="checkbox"/>	<input type="checkbox"/>

### Doctor's particulars:

Name in full : \_\_\_\_\_  
MCR number : \_\_\_\_\_ Specialty: \_\_\_\_\_  
Email address : \_\_\_\_\_

### SUBMISSION INSTRUCTIONS:

(1) Log on at the SMJ website: <http://www.sma.org.sg/publications/smjcurrentissue.aspx> and select the appropriate set of questions. (2) Provide your name, email address and MCR number. (3) Select your answers and click "Submit".

### RESULTS:

(1) Answers will be published in the SMJ June 2015 issue. (2) The MCR numbers of successful candidates will be posted online at the SMJ website by 5 June 2015. (3) Passing mark is 60%. No mark will be deducted for incorrect answers. (4) The SMJ editorial office will submit the list of successful candidates to the Singapore Medical Council. (5) One CME point is awarded for successful candidates.

**Deadline for submission: (April 2015 SMJ 3B CME programme): 12 noon, 29 May 2015.**