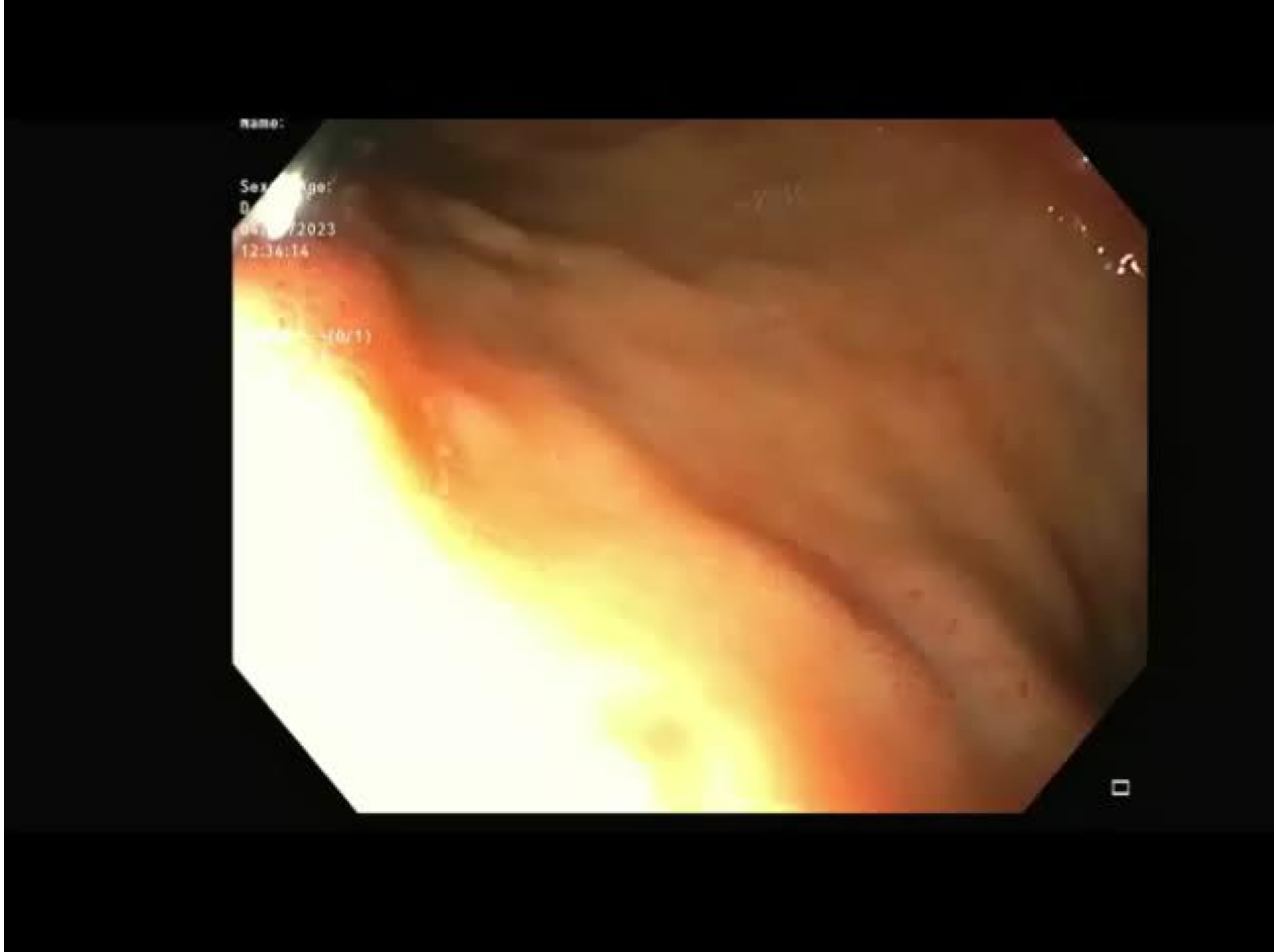
Fellows Endoscopy Pathology Quiz 2025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1a. What is the Forrest grade?

1b. What is the likely contributing cause?

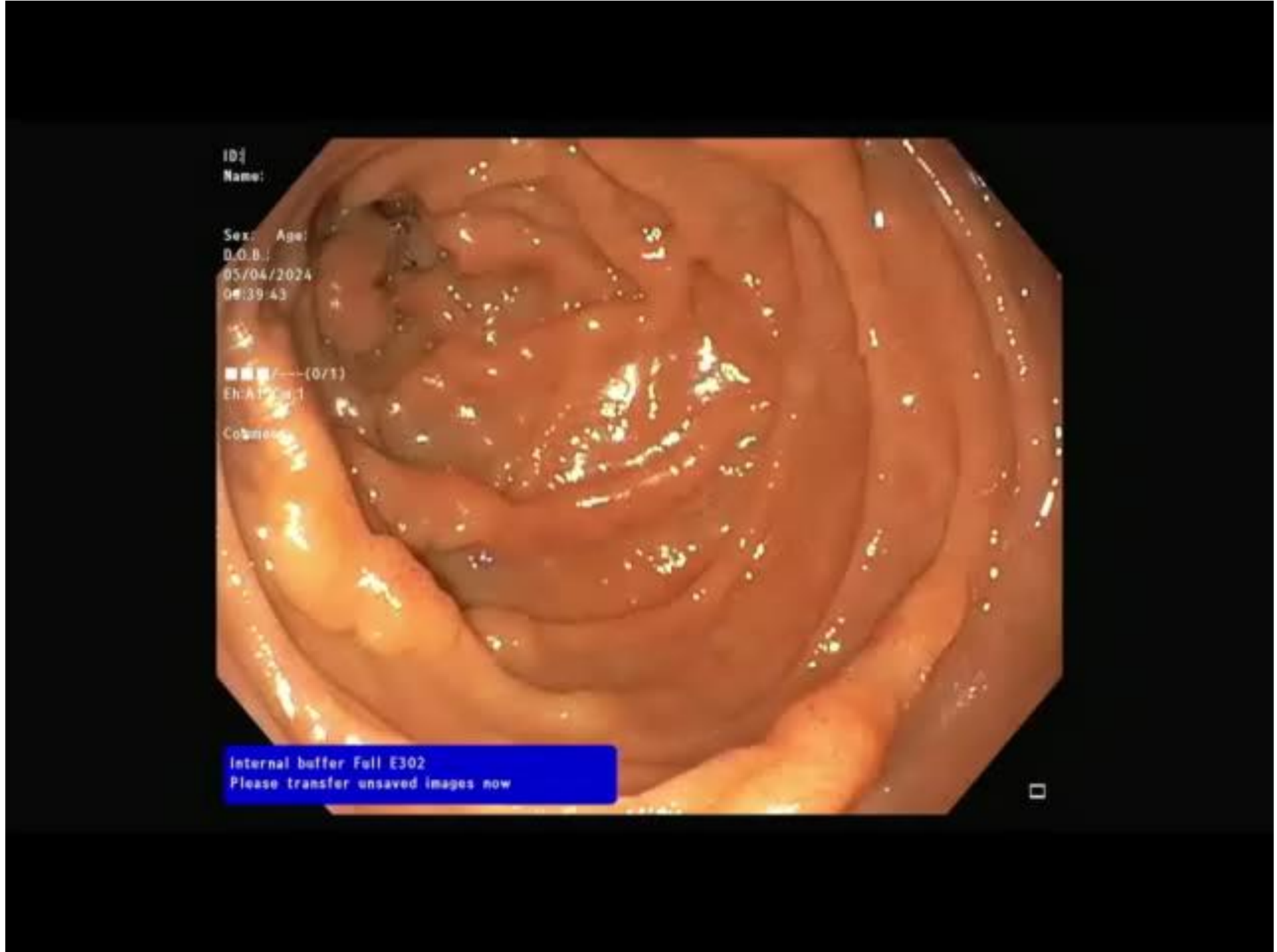
1c. Would you do anything endoscopically here or not? If yes – what?

1a. What is the Forrest grade?

1b. What is the likely contributing cause?

1c. Would you do anything endoscopically here or not? If yes – what?

GrandPa
64.8mg caffeine
(80mg = espresso)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2a. What investigation do you recommend now?

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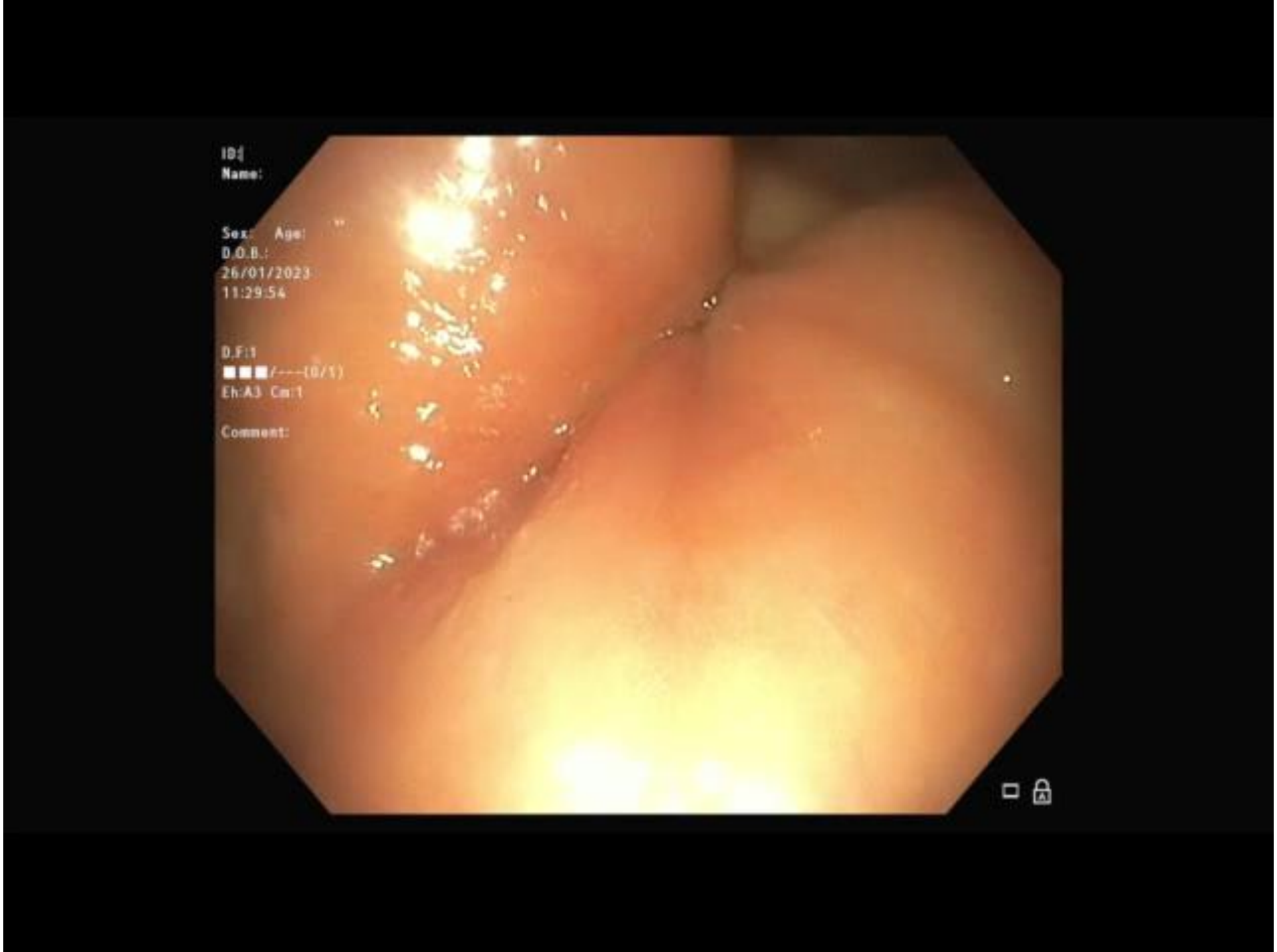
2b. What are the factors contributing to the Spiegelman grading of duodenal FAP?

2c. What is the Spiegelman grading aimed to assist you with?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3a. What is the DDx of this mass?

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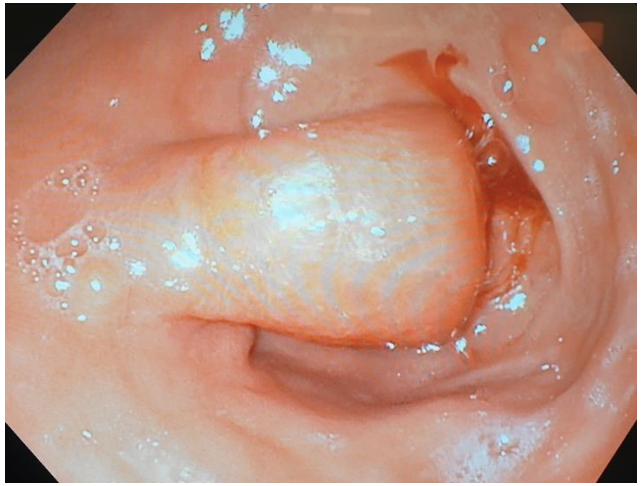
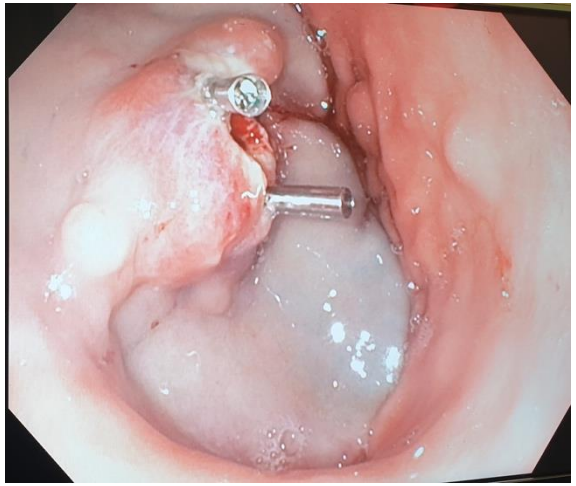
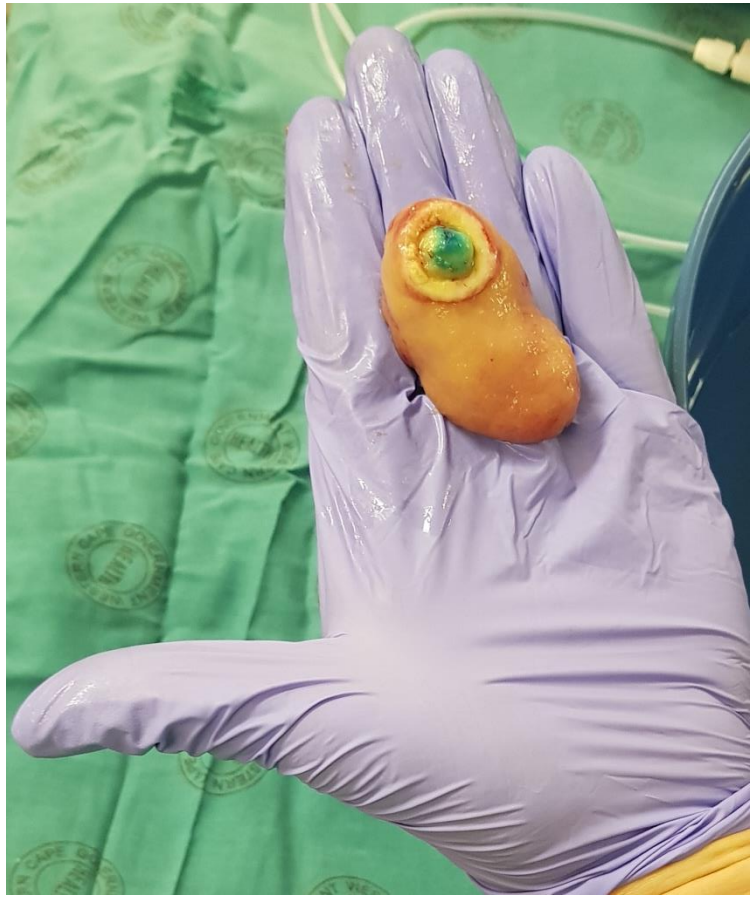
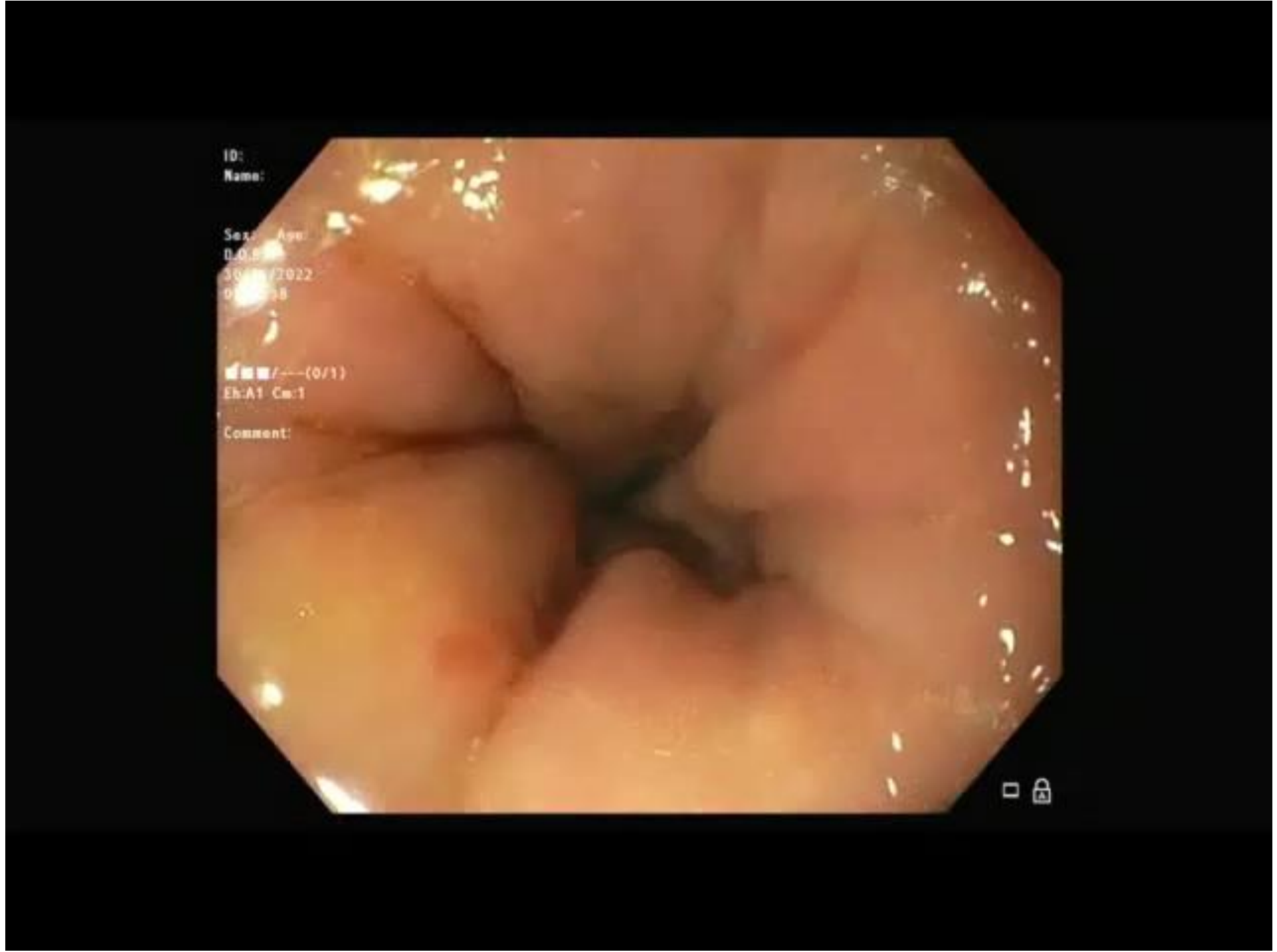
- **GIST**
- **Vanek's tumour**
- **Leiomyoma**
- **Lipoma**





3b. What is the post-procedural risk of this resection?

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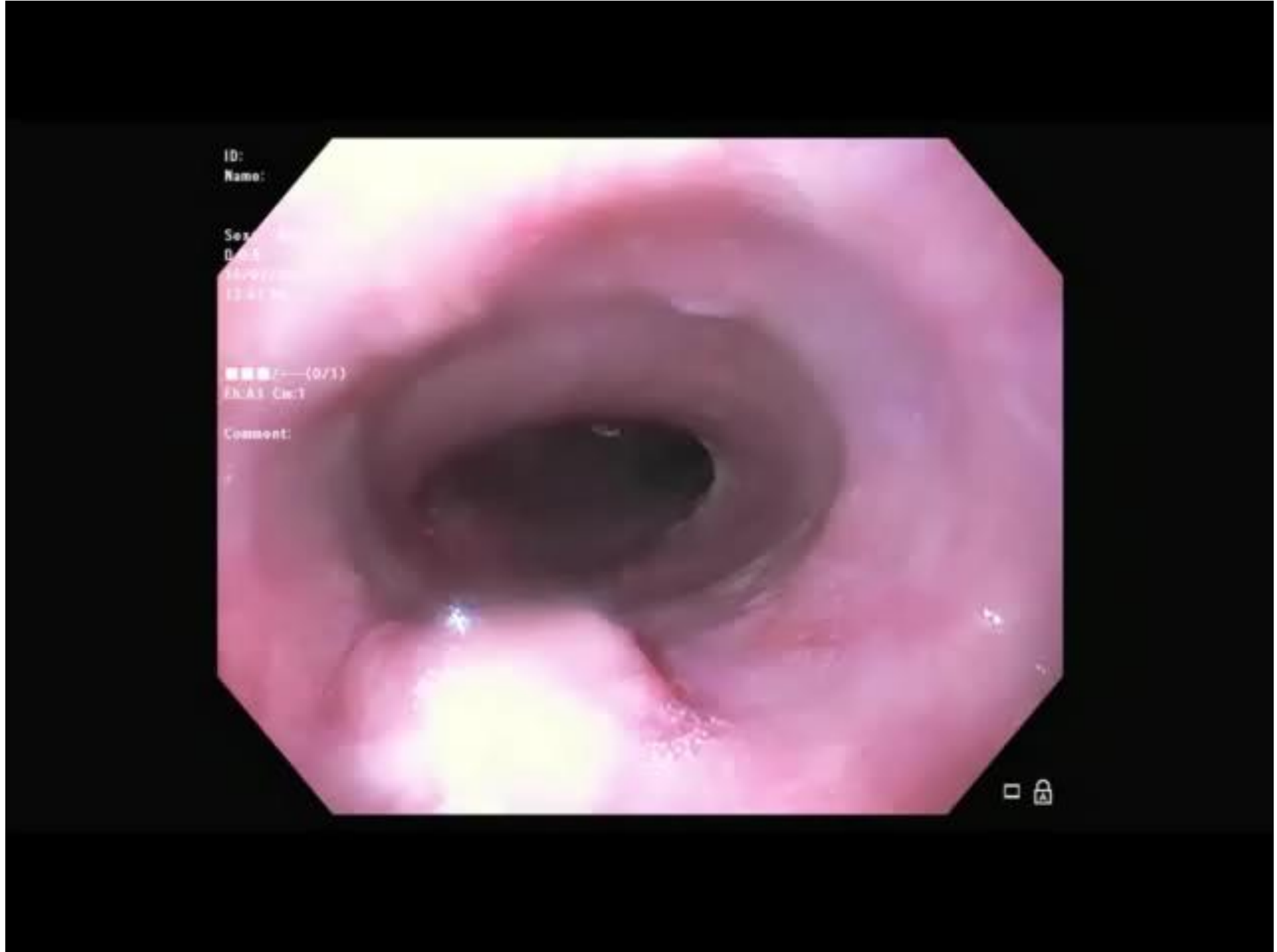
4a. What did my biopsy show?

4b. What else do you want to ask this pt?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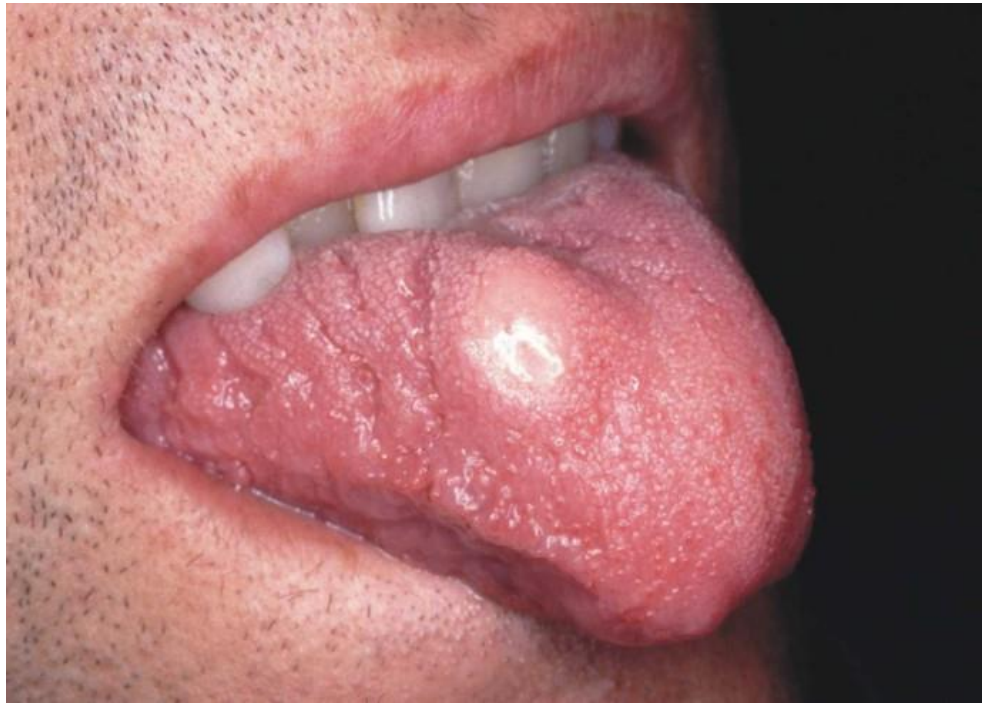
Hard, proximal incidental oesophageal mass of 10mm.

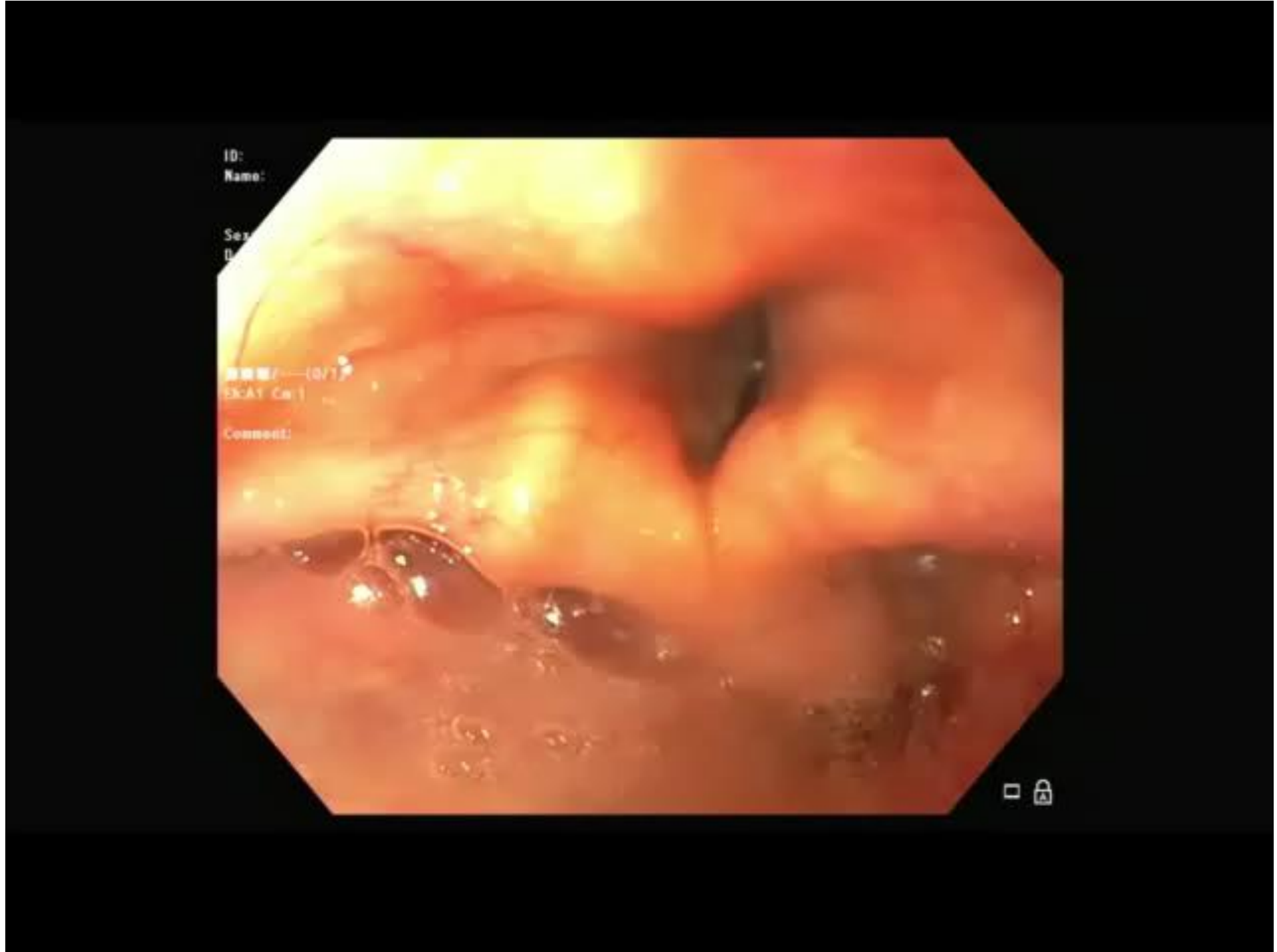
5a. What is the DDx of this mass?

Hard, proximal incidental oesophageal mass of 10mm.

5a. What is the DDx of this mass?

Clue: this most commonly occurs here:

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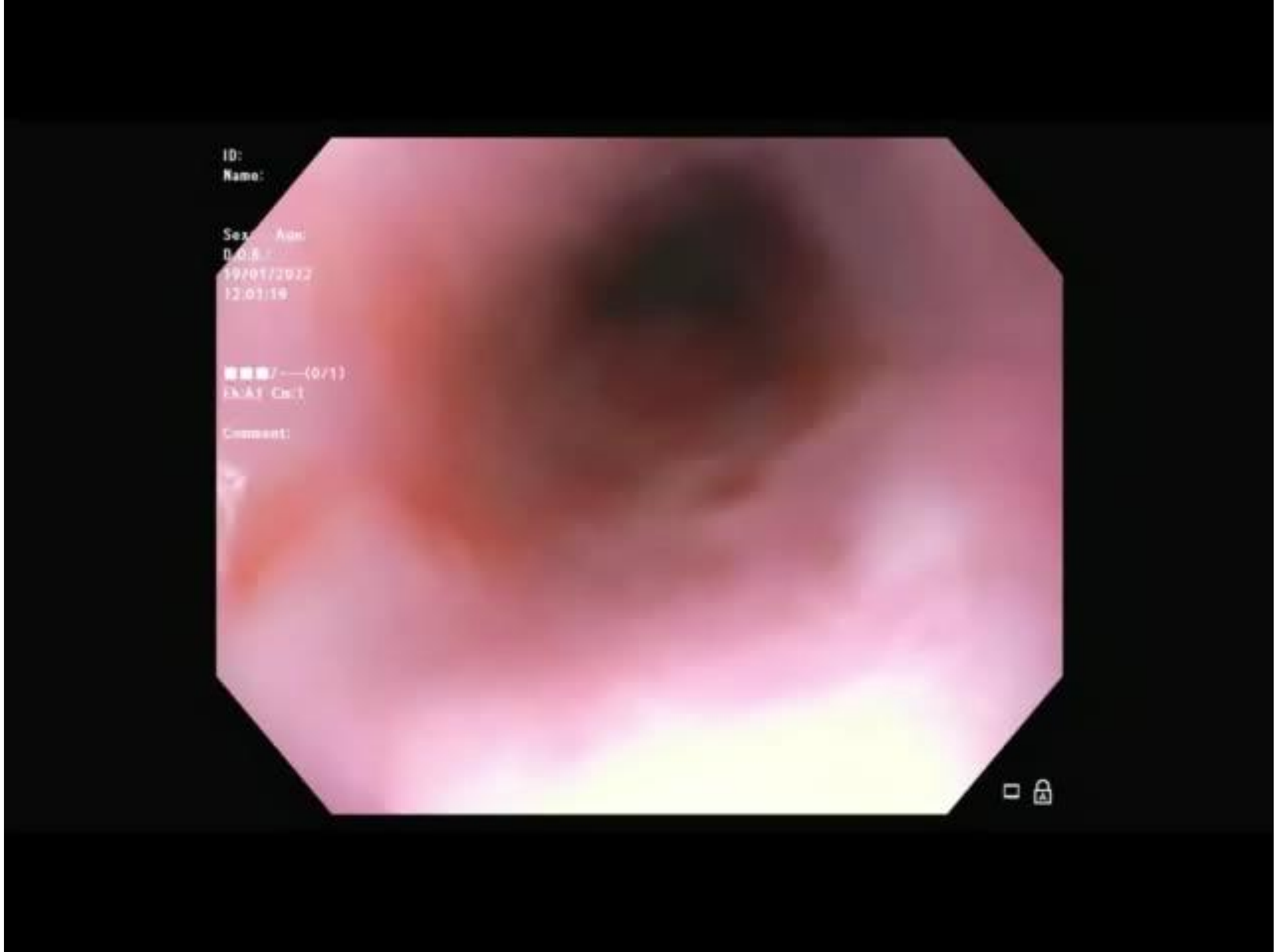
Severe coughing post-lung lobectomy for an adenoCa

6a. What are your endoscopic options here?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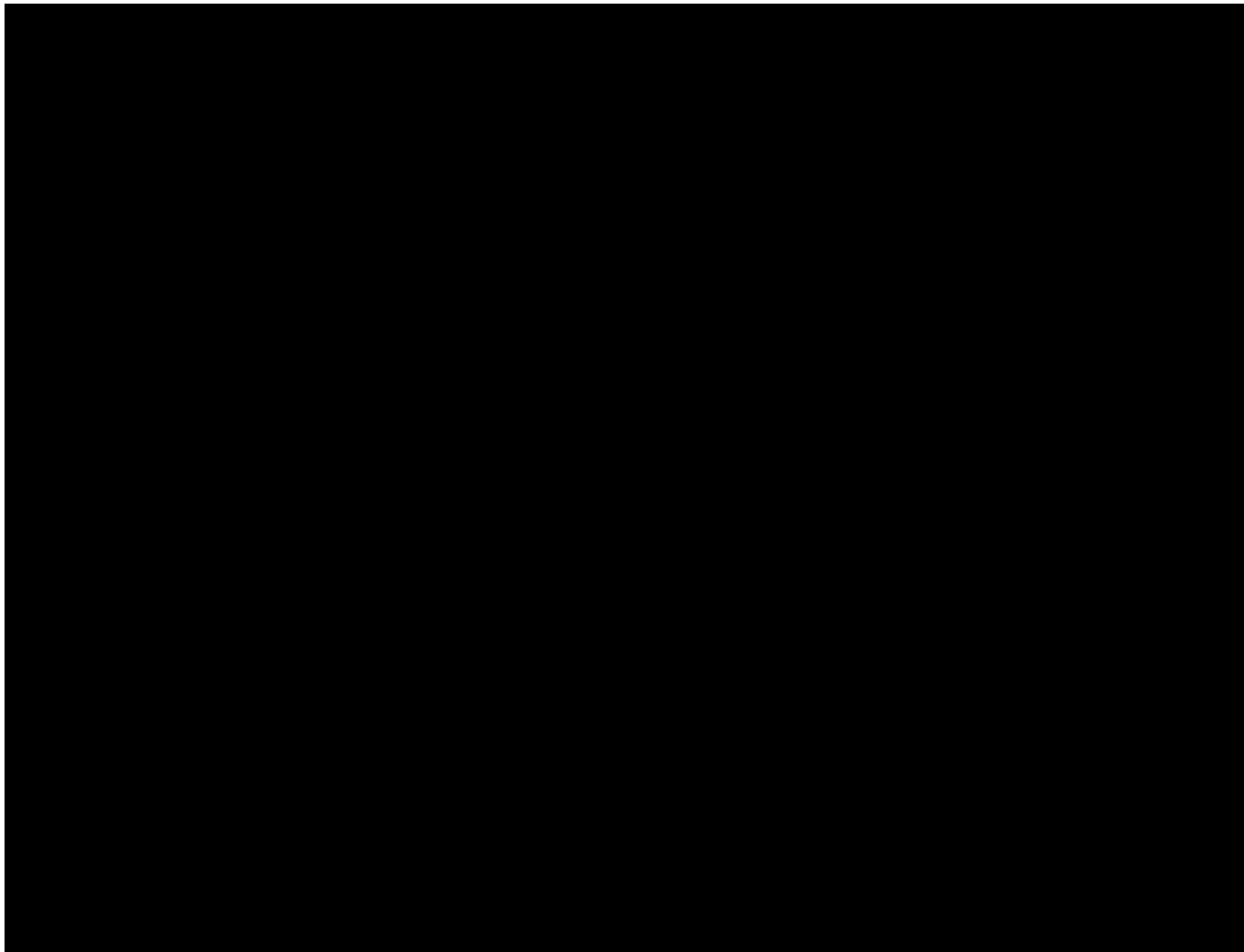
Long segment Barrett's with a subsequent EMR of a T1a adenoCa

7a. Where was the dysplasia seen? Prox/mid/distal?

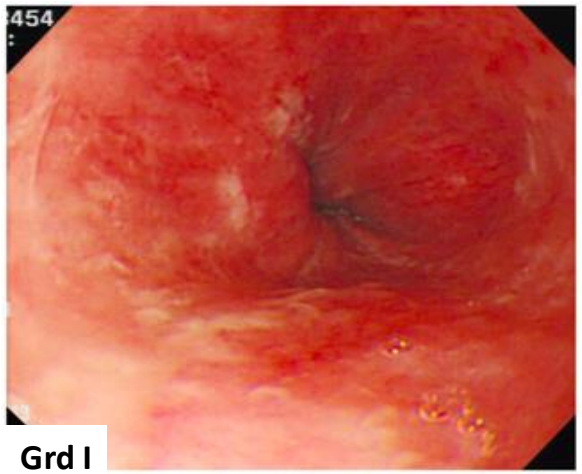
8a. Which of the pt's vocal cords is paralysed?

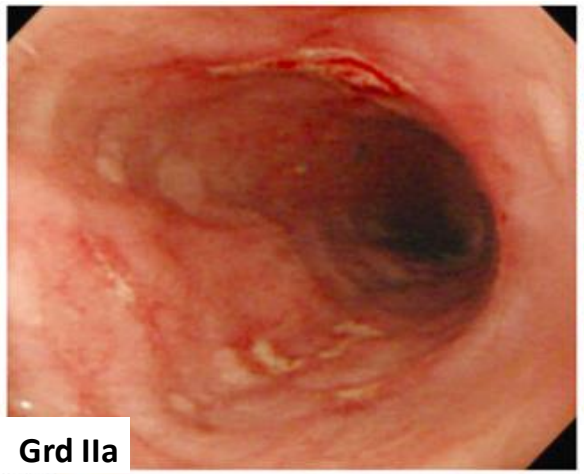
8b. What is the likely cause?

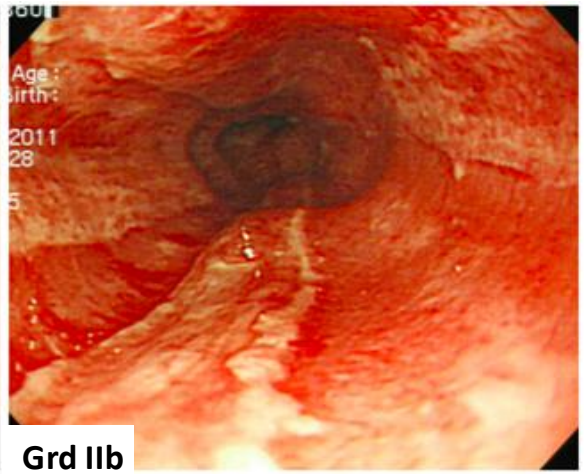
8c. With the budget cuts, do you want a CT?



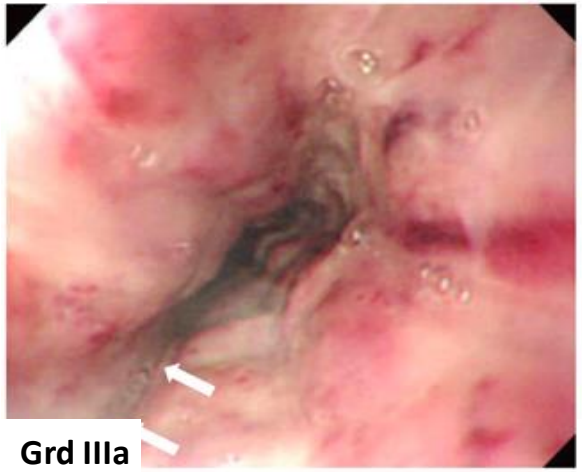
9. Endoscopic classification of caustic injuries

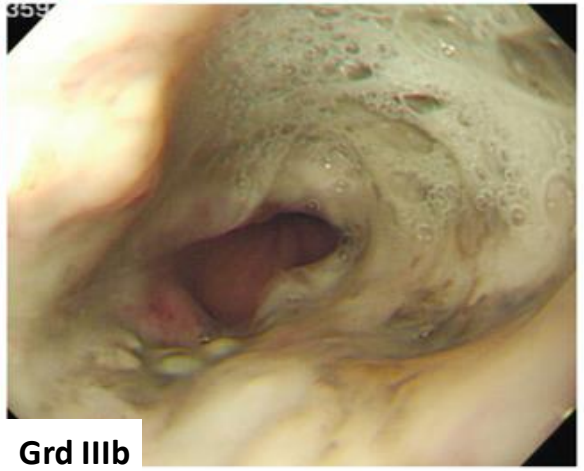


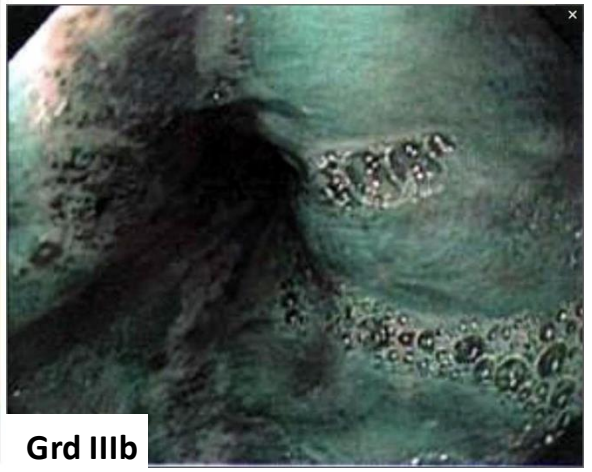




→ 30 – 70% stricture





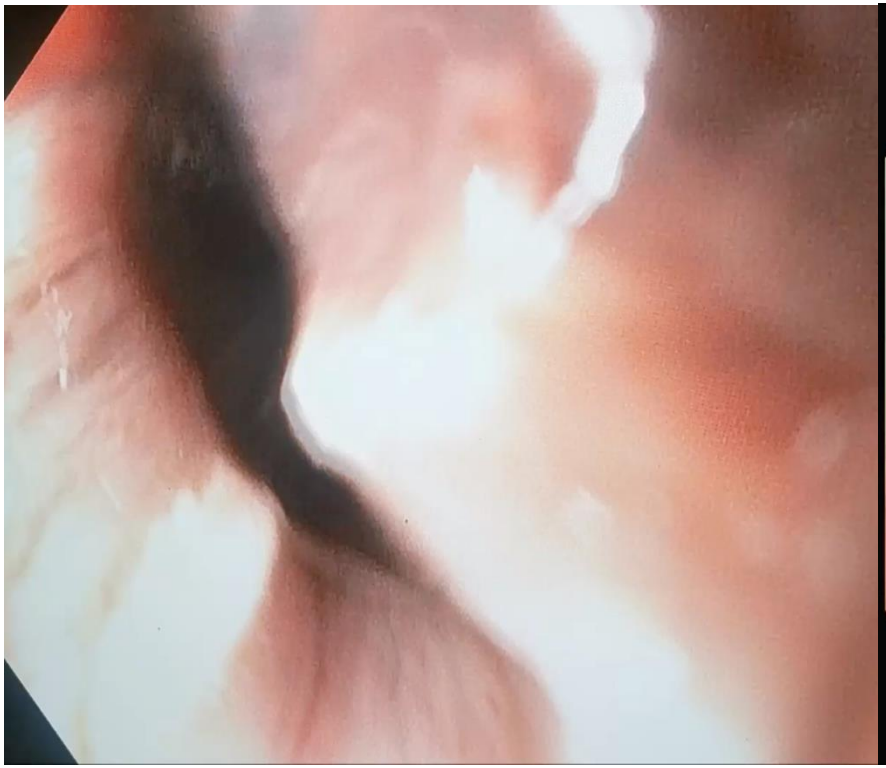


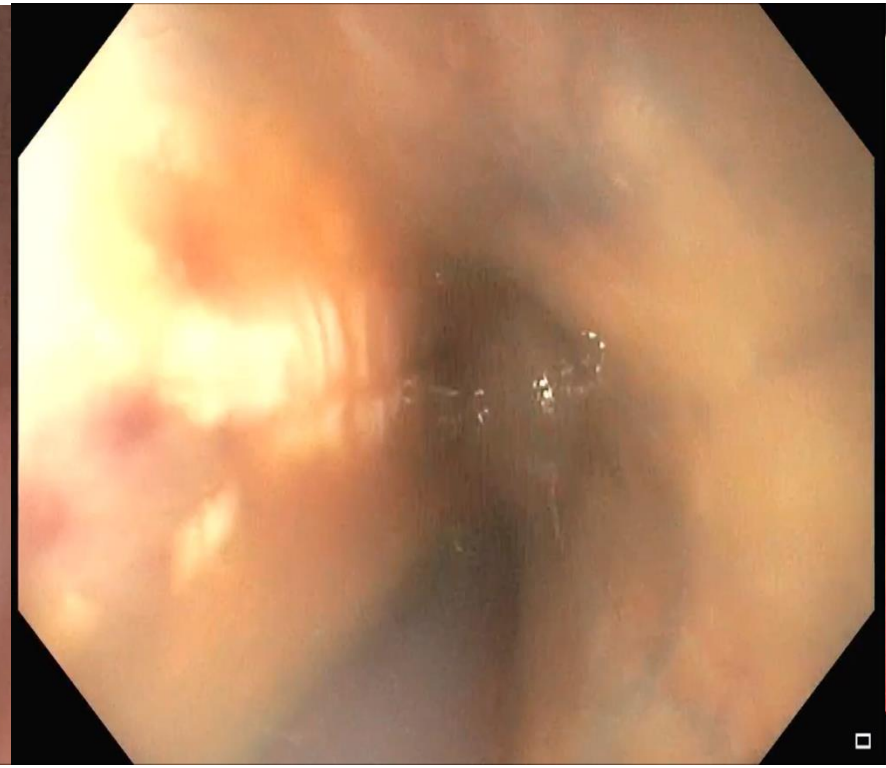
90-100% stricture ←

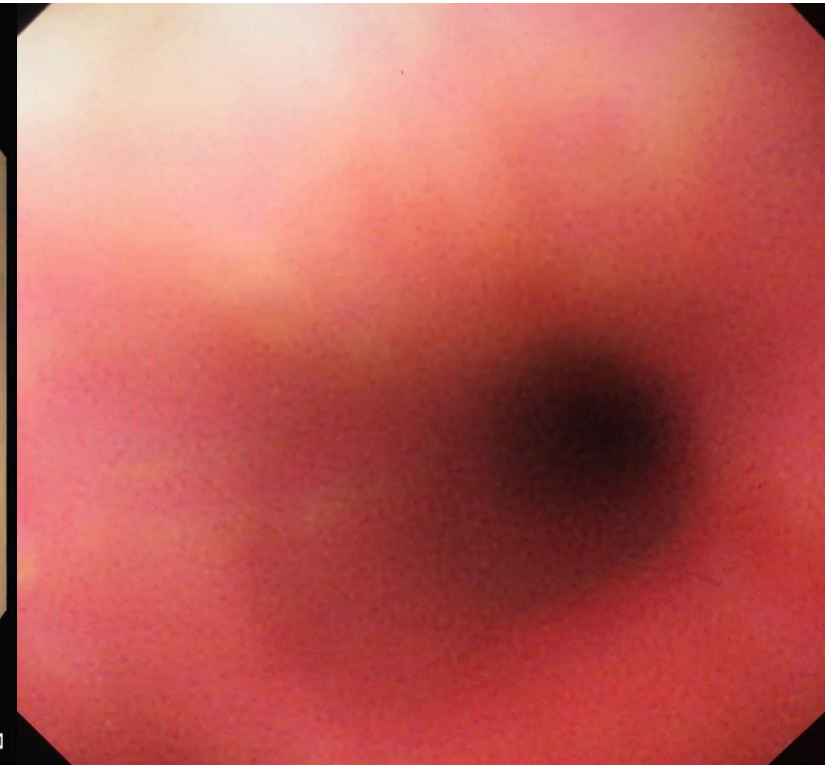
Zagar: each increase in injury grd correlates with a 9 x in morbidity/mortality

Zargar et al. The role of fiberoptic endoscopy in the management of corrosive ingestion and modified endoscopic classification of burns. *Gastrointest Endosc* 1991

9. Which of these three caustics would you operate?

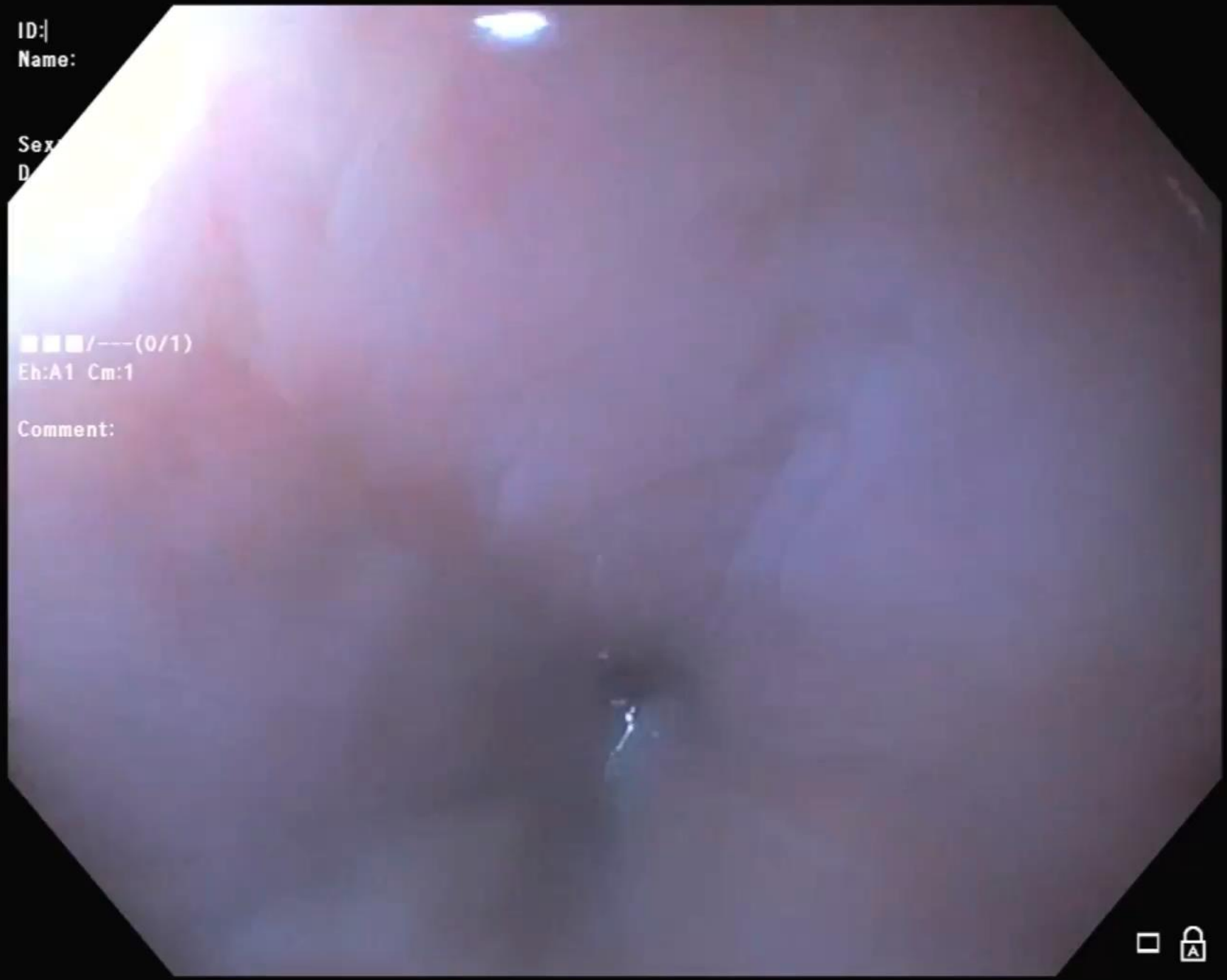






10. Who should band these varices? You or the new registrar in your firm?

A. **You**
B. **You are happy to teach banding - registrar**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11. 59 yr old lady with complete dysphagia and hoarseness on your interventional list for oesophageal stent

11a. What is your plan endoscopically?

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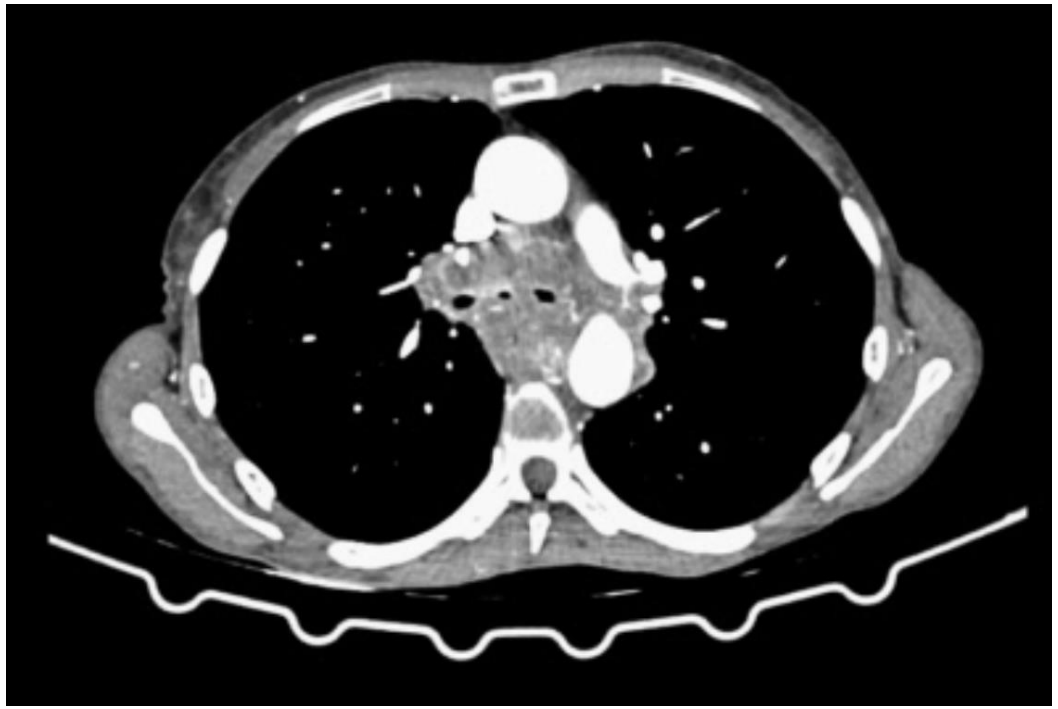

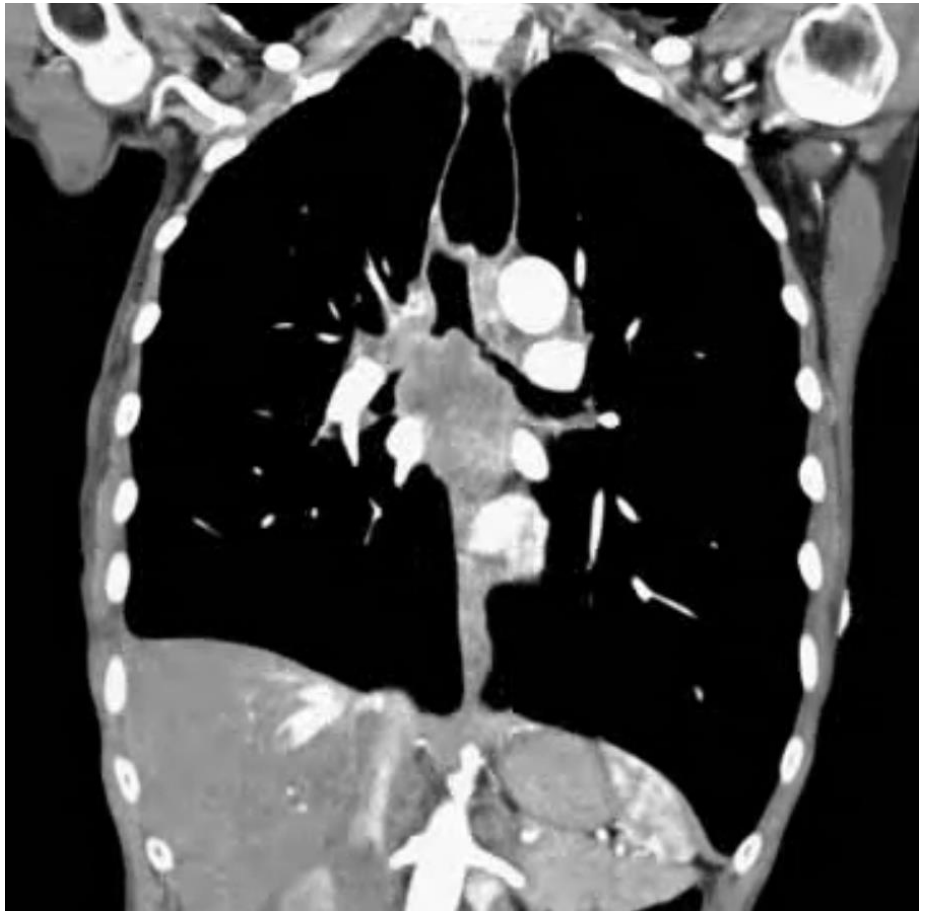

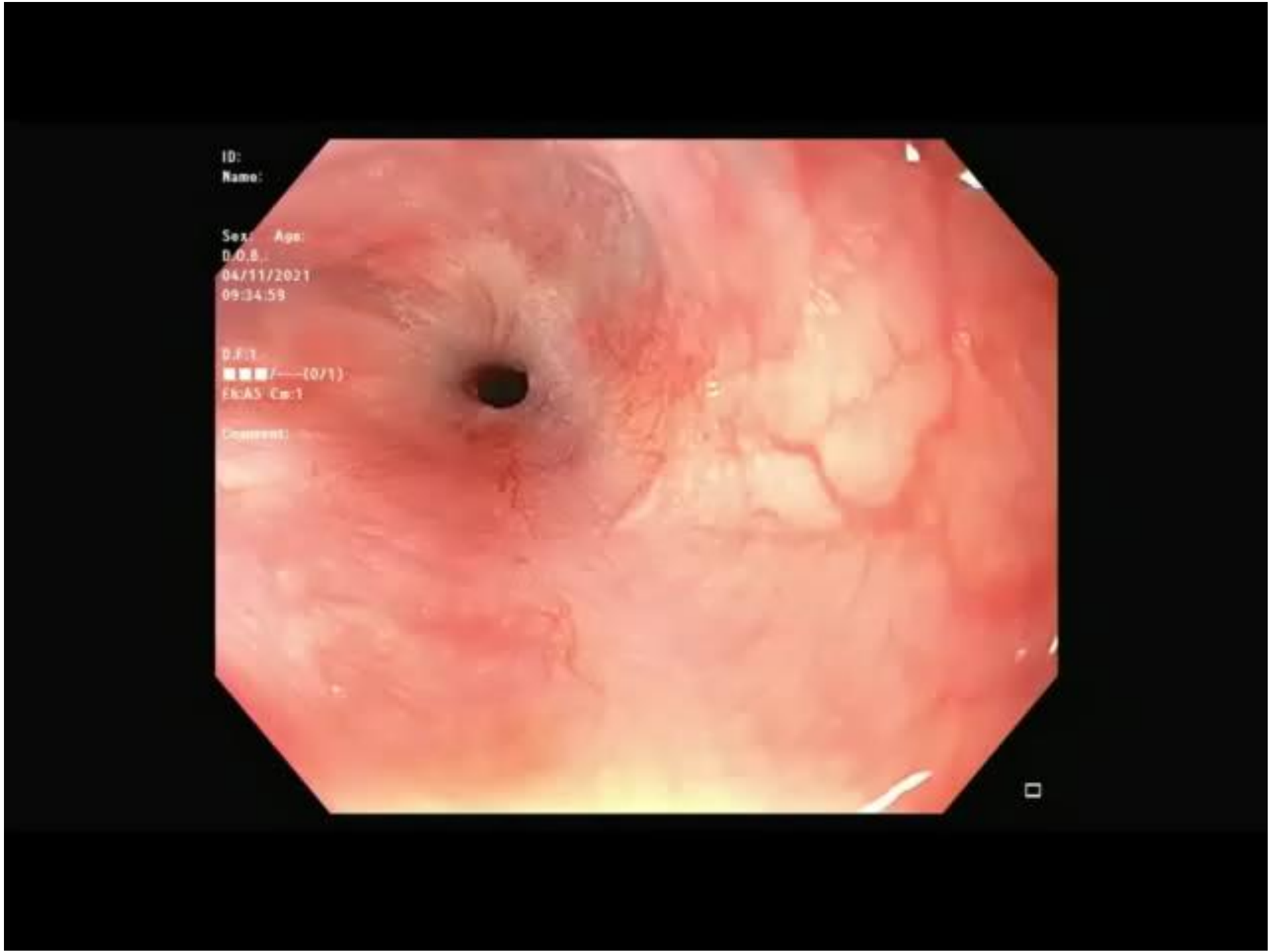
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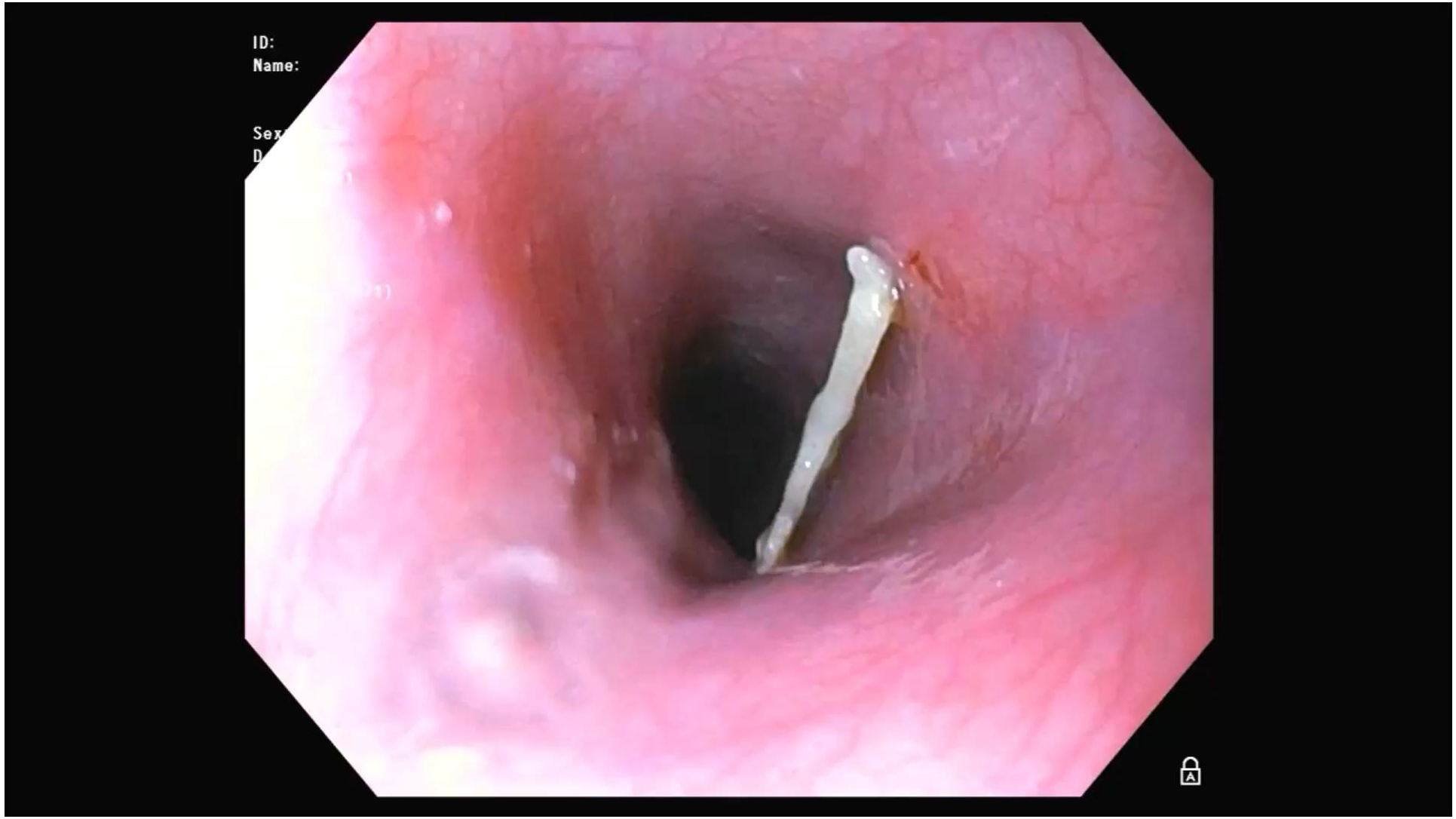
12. Choose, in order of likelihood, the cause of this very proximal oesophageal stricture:

A: Peptic – Anastomotic – Caustic – Web
B: Anastomotic – Caustic – Web – Peptic
C: Caustic – Anastomotic – Peptic – Web
D: Web – Caustic – Anastomotic - Peptic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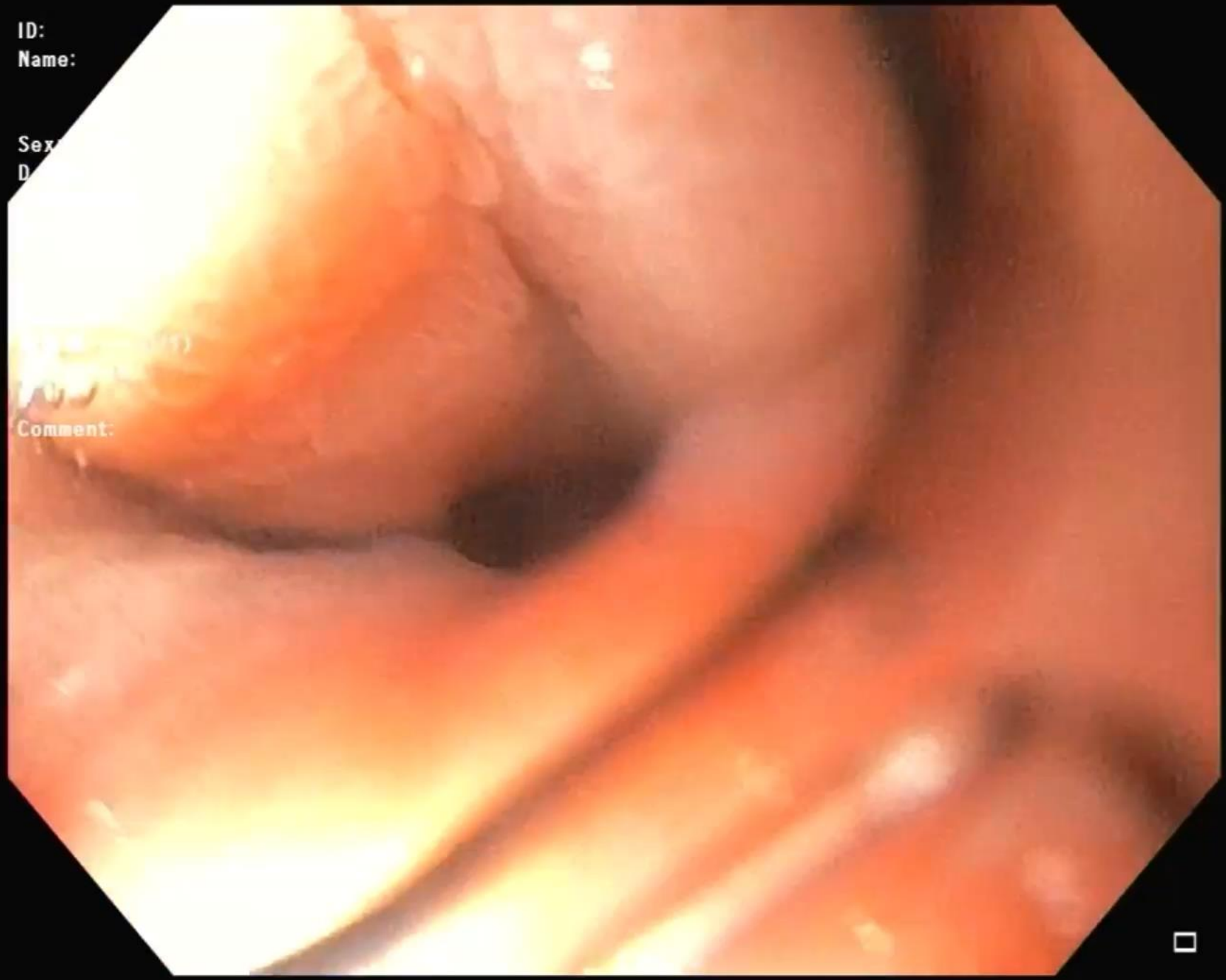
13. You remove a foreign body embedded into the proximal oesophageal wall. Which animal bone is the most likely culprit?

A. Chicken
B. Lamb
C. Beef
D. Snoek

14. When you see this specific ulcer, what are you going to ask your pt?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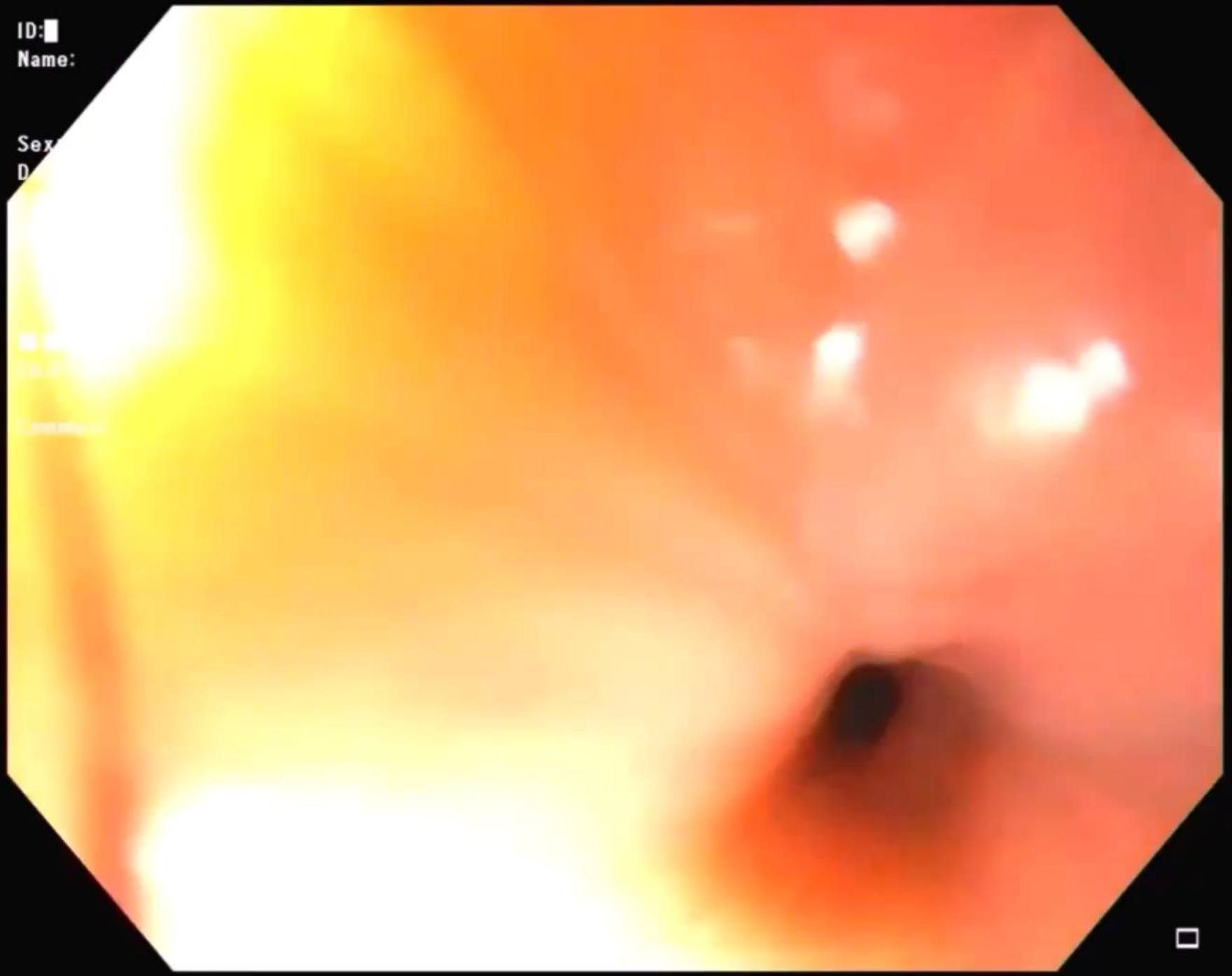
15.What do you see on this oesophagoscopy and what are you expecting the cause to be?

A. **Caustic ingestion with Grade B injury; manage conservatively**
B. **Grade D reflux oesophagitis from large hiatus hernia**
C. **Grade D reflux oesophagitis related to gastric outlet obstruction**
D. **Caustic ingestion with Grade C injury, refer for oesophagectomy**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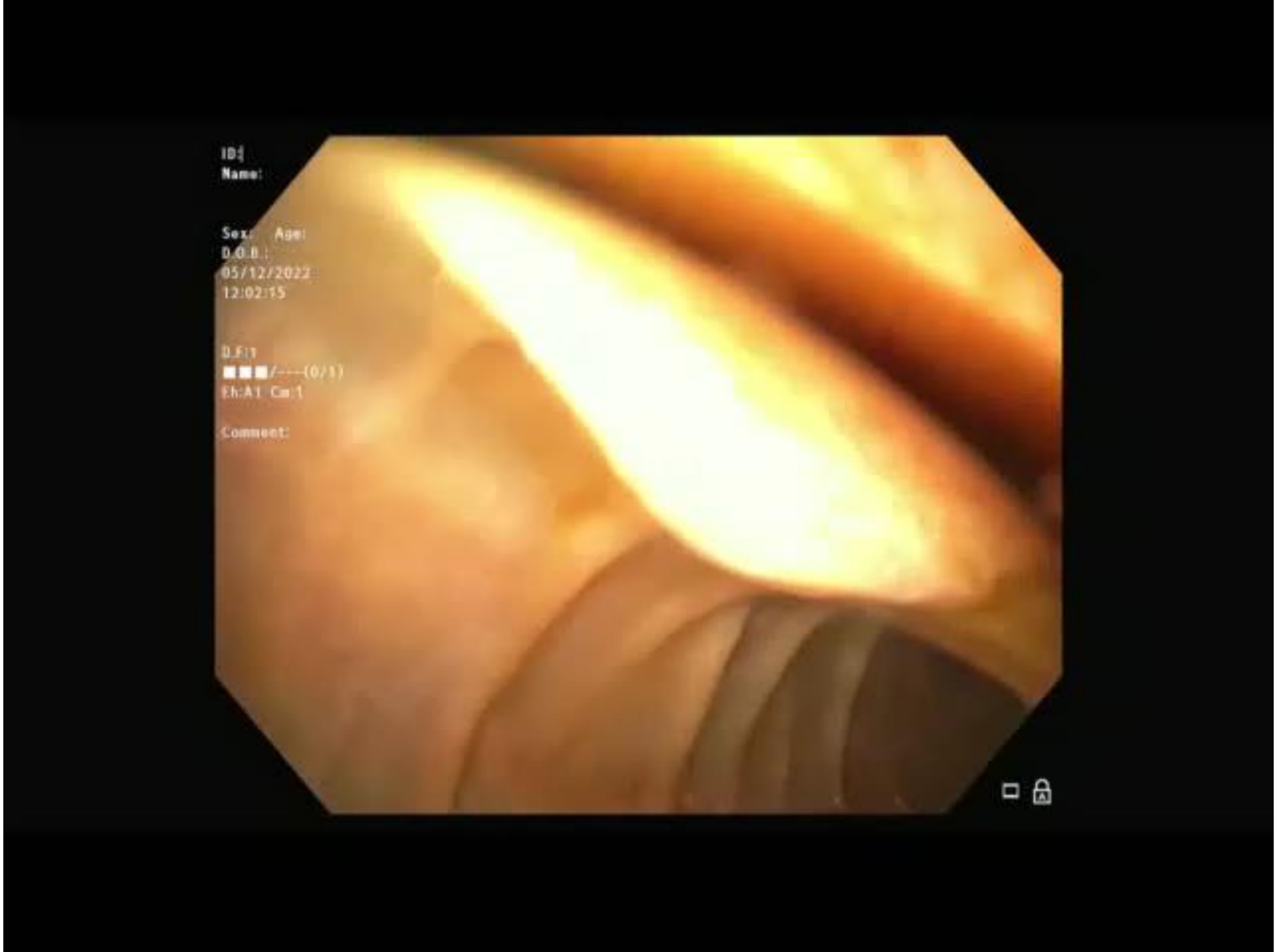
16. A 61 yr old pt is referred with significant LOW and dysphagia, tolerating only a soft liquid diet.
You notice and biopsy a large mid-oesophageal malignant appearing lesion.
What do you suspect the histology to be?

A. Oesophageal adenocarcinoma
B. Oesophageal squamous carcinoma
C. Oesophageal GIST
D. Oesophageal melanoma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17. What is the most common cause of Haemobilia?

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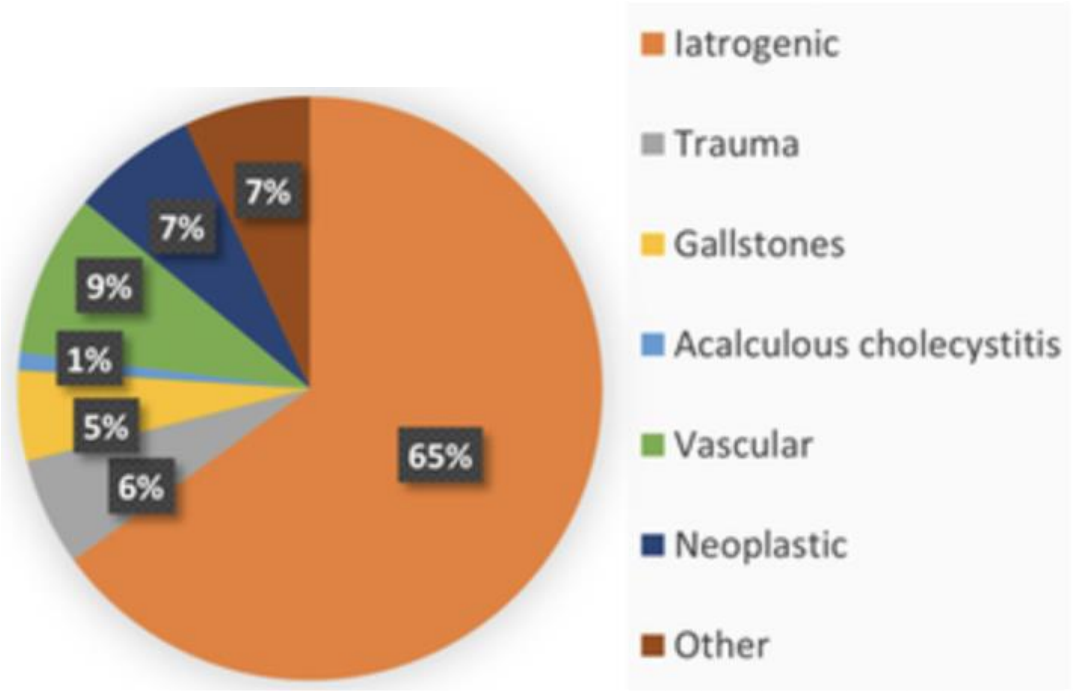

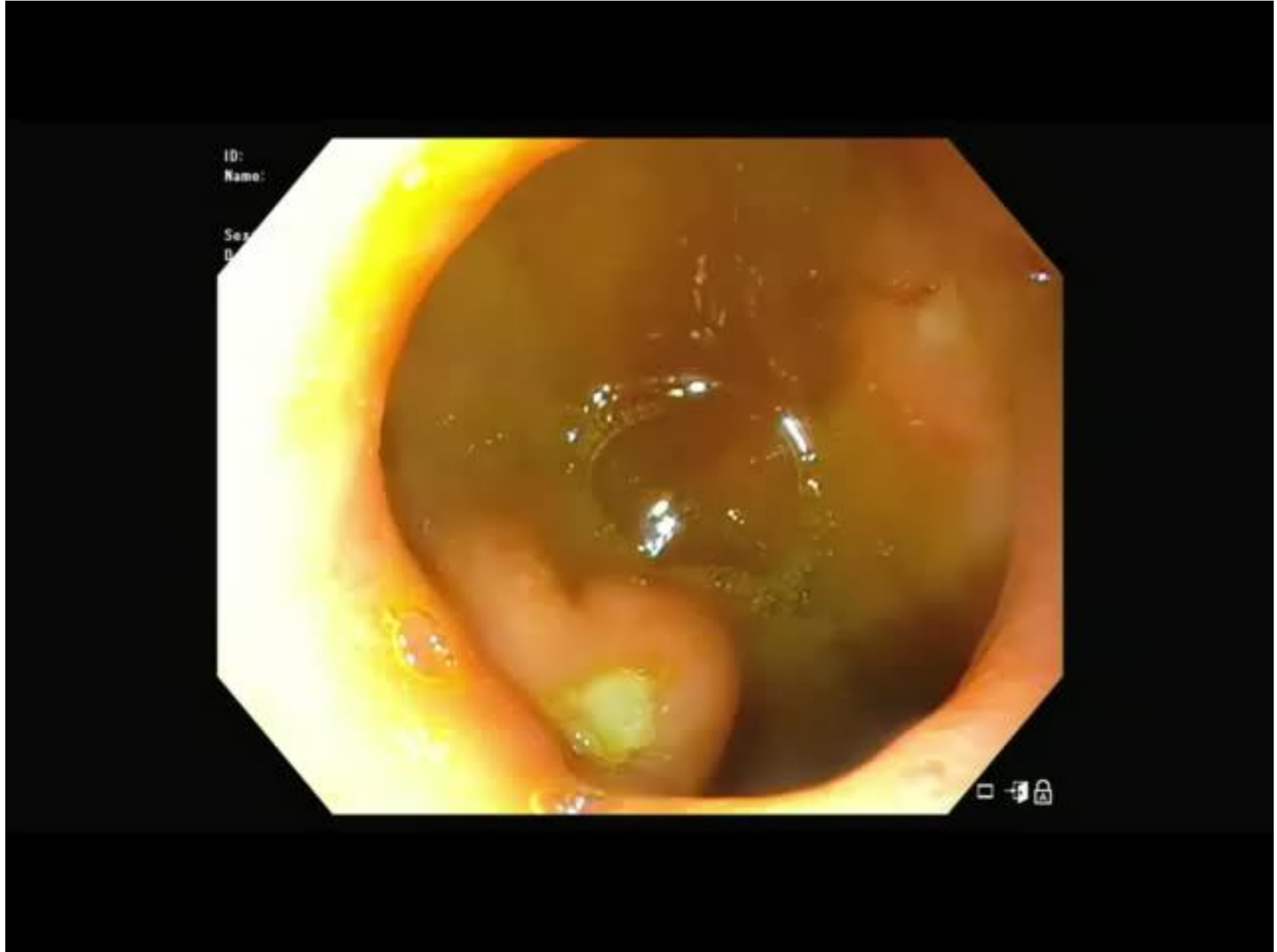
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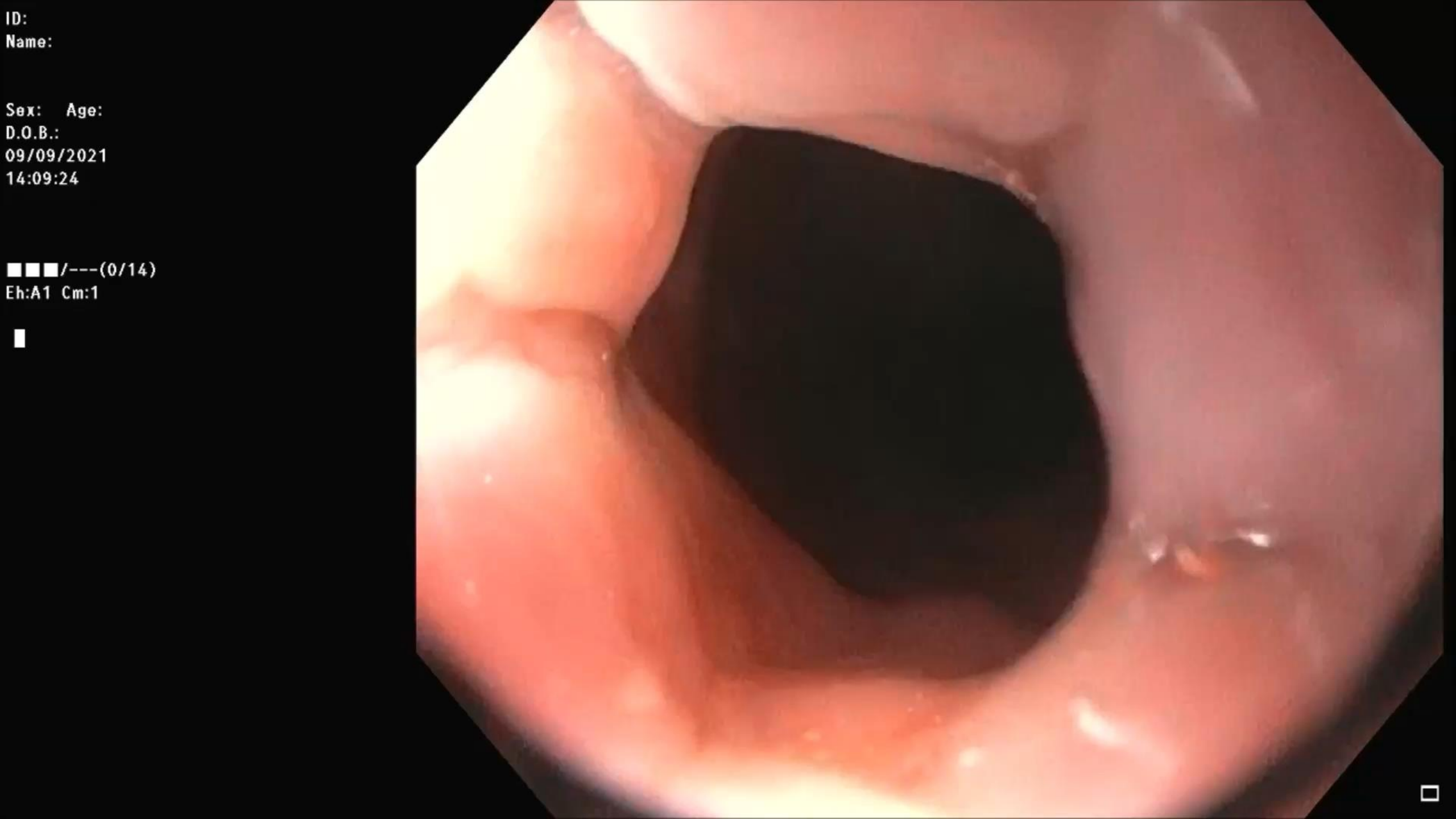
18. Which of these “kissing” ulcers is more likely to bleed?

19. Oncology refers this known metastatic gastric Ca with clinical features of GOO for endoscopic treatment. What is your treatment plan?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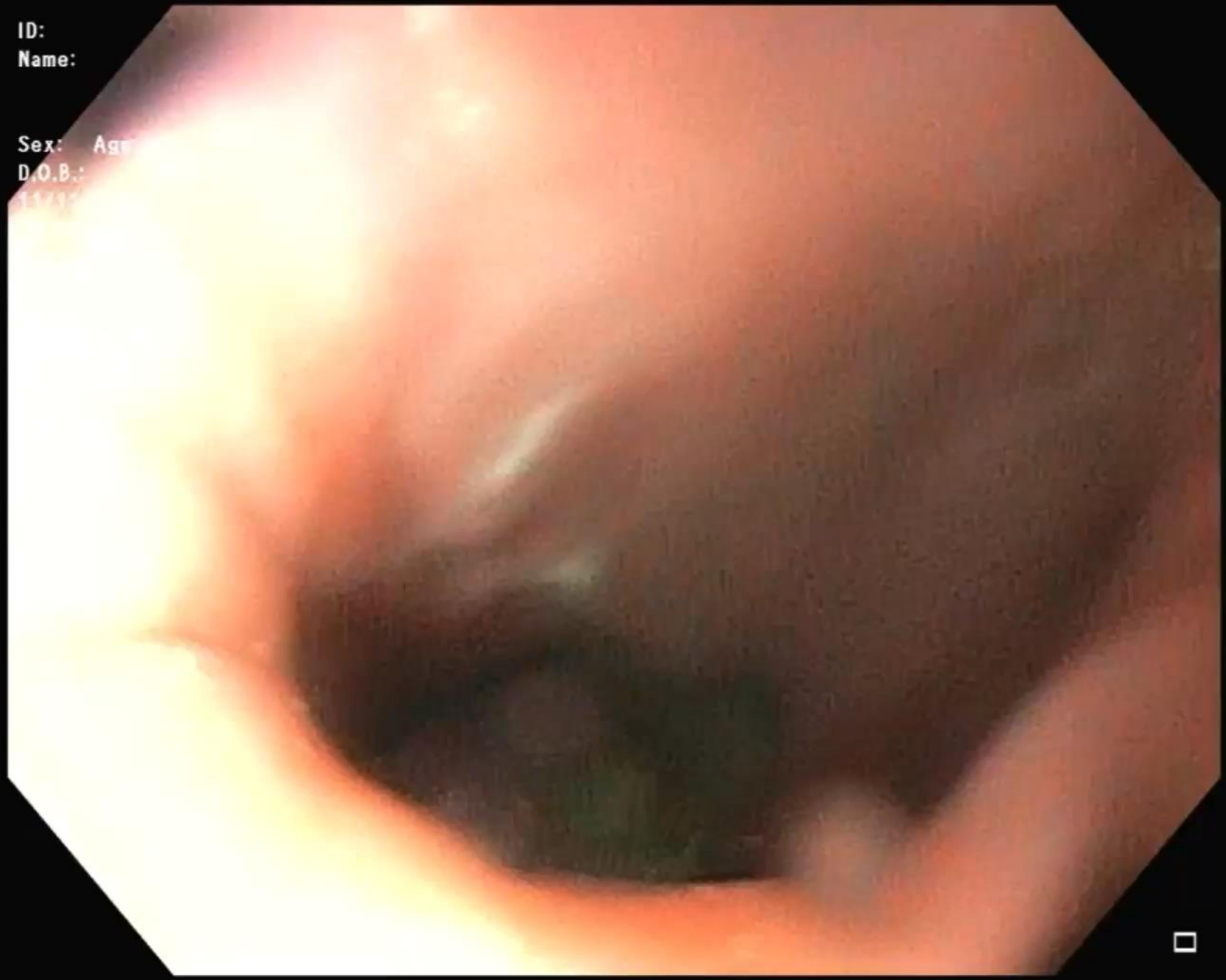
20. You scope a pt for an UGIB and admire this beauty of an ulcer. What does your biopsy come back as?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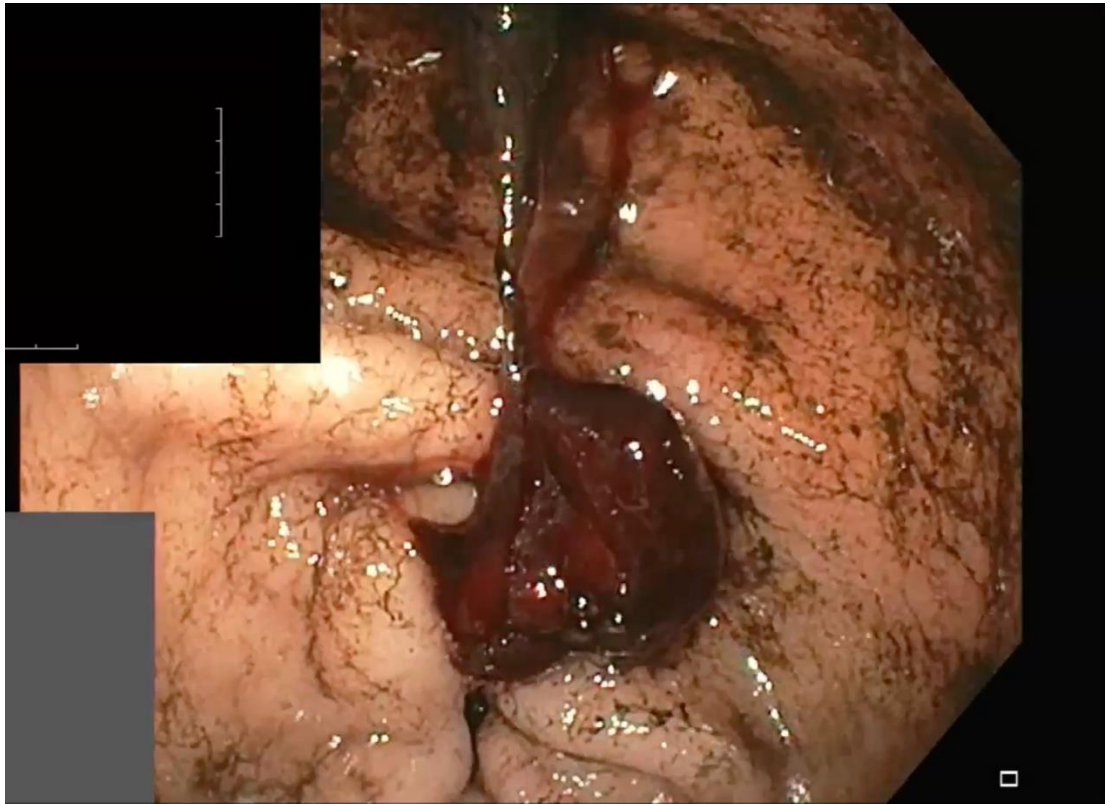
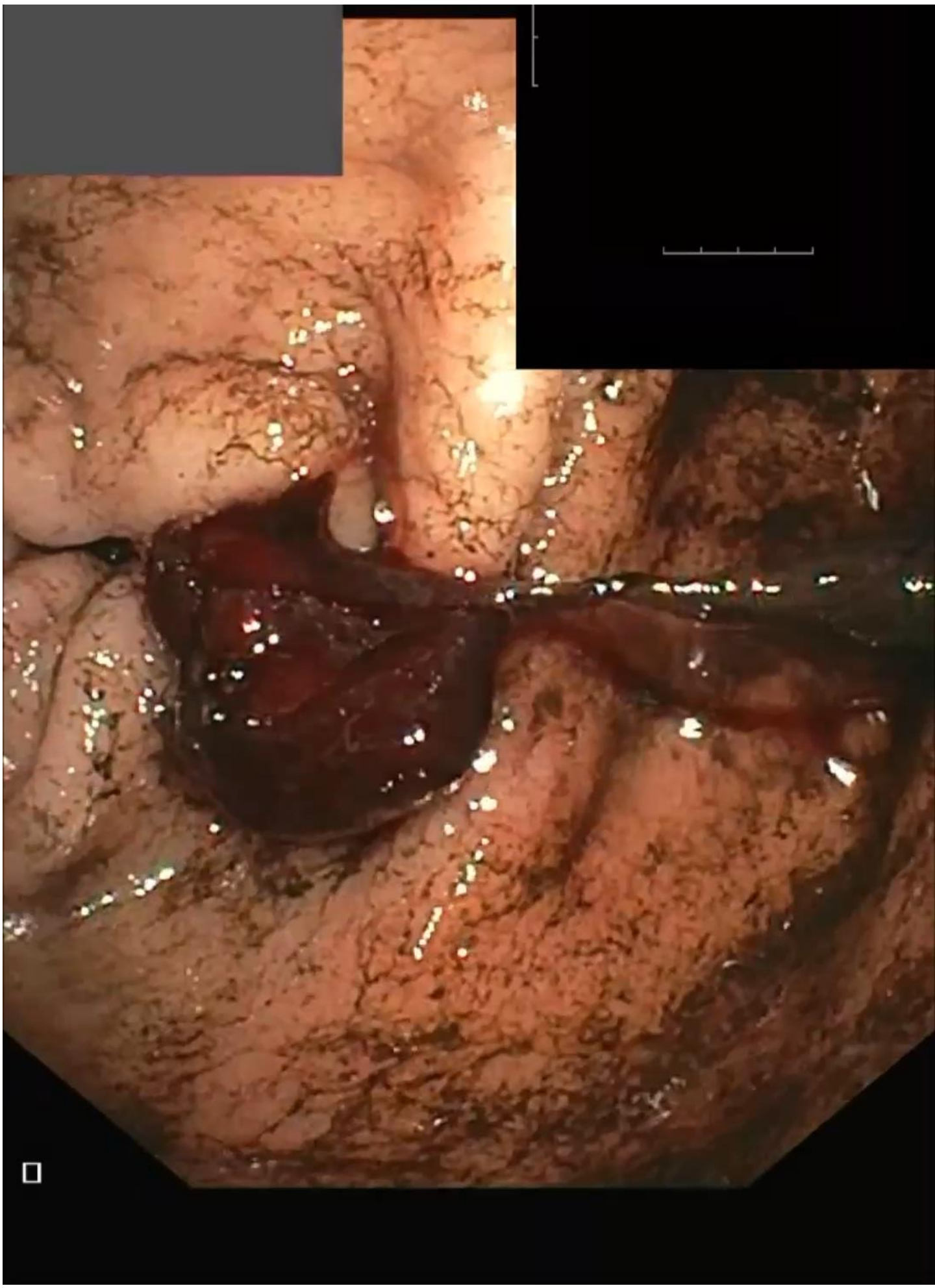
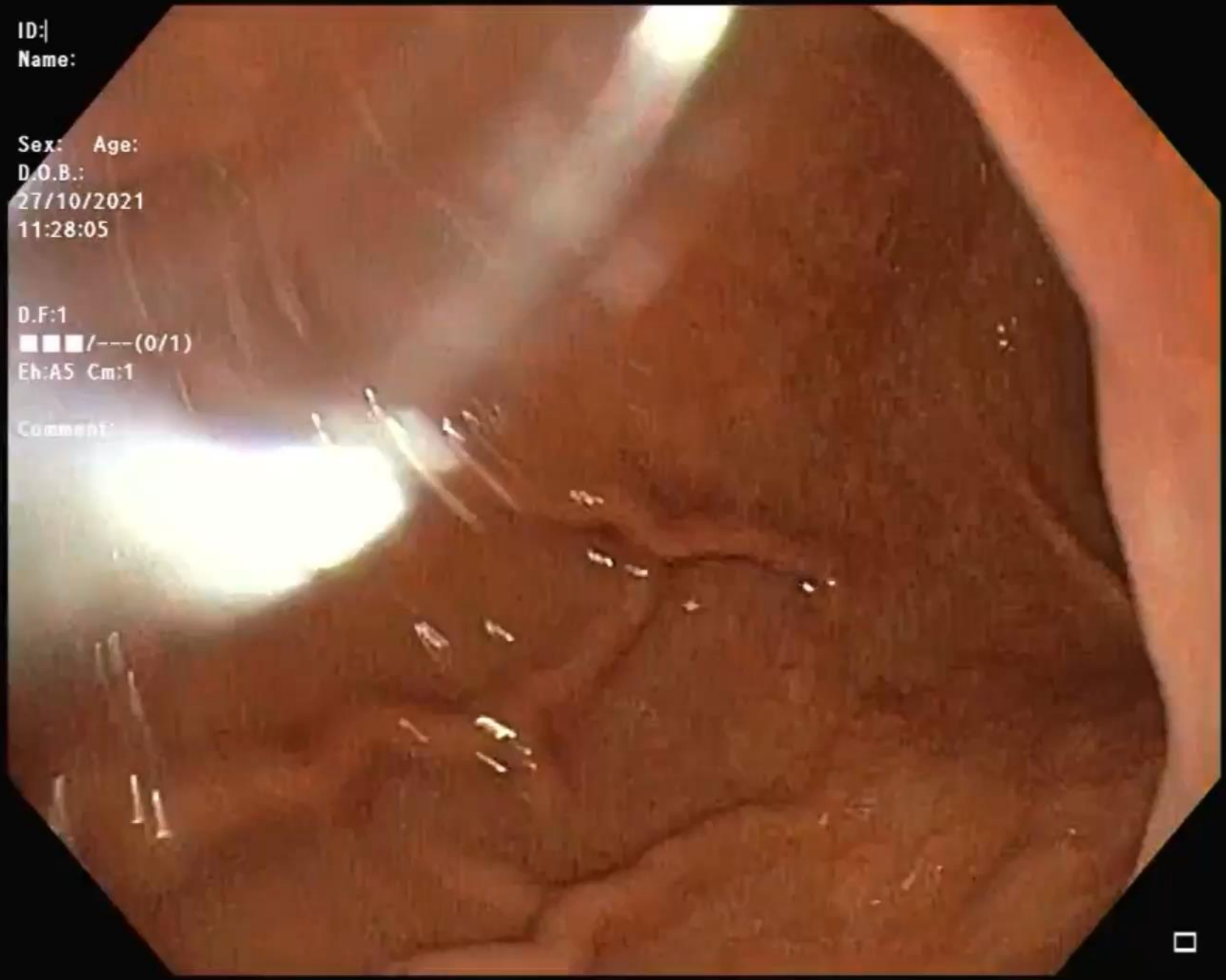
21. You scope a pt for an UGIB (Hb 5) and notice a fresh clot on a duodenal ulcer. Presently no active bleeding. What is your plan?

A. IVI PPI's only
B. IVI PPI's, remove clot and deal with whatever is underneath
C. IVI PPI's and refer to surgeon on call
D. IVI PPI's and refer for angiogram and embolisation



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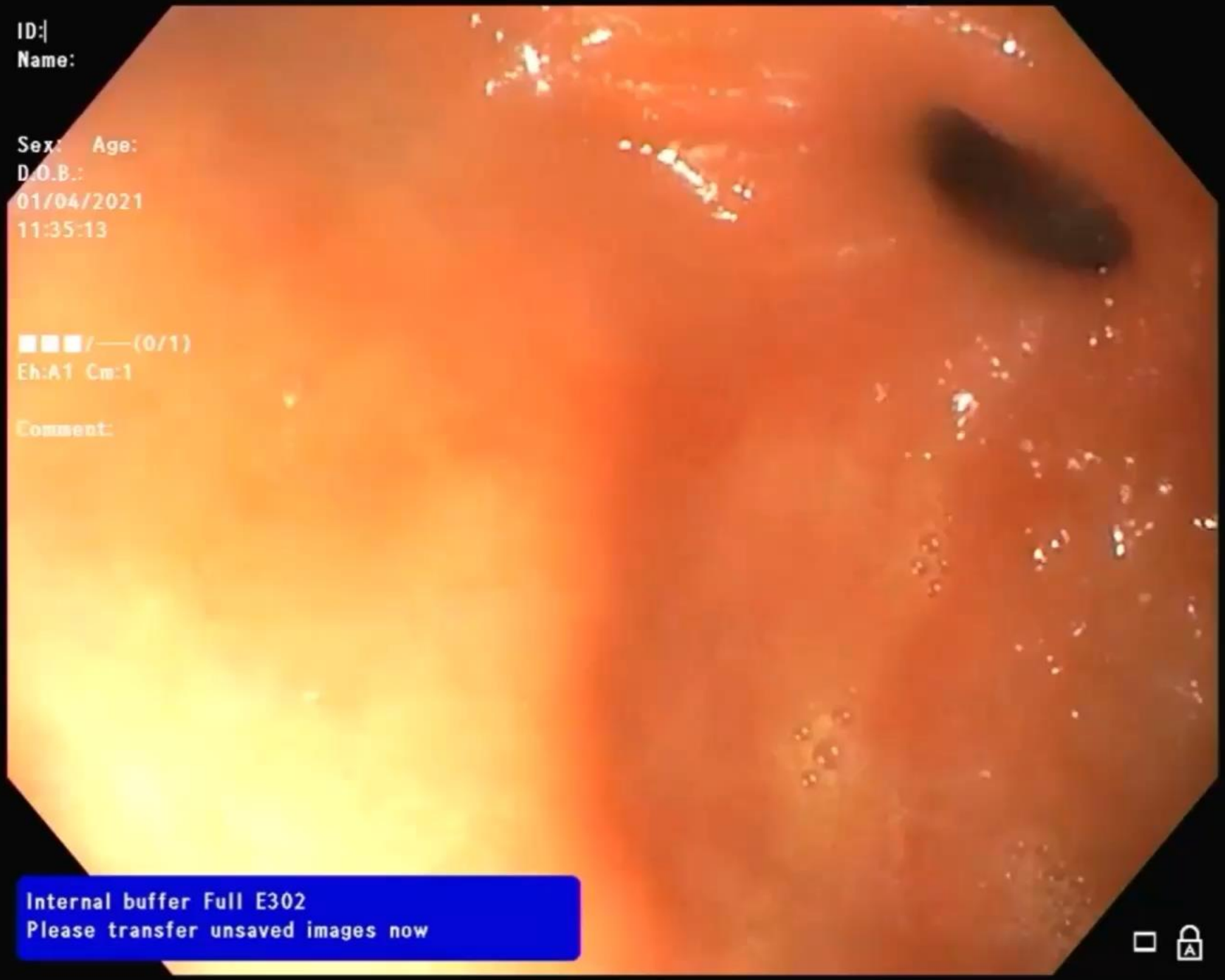
22a. What is this?

b. What is the incidence?

c. What are you going to do with it?

23. You are asked to repeat a scope for a lady of 32 yrs previously well, now with persistent vomiting and LOW. A scope by your colleague last Monday indicated no obstruction. What is your diagnosis?

A. **Normal scope**
B. **Linitis plastica**
C. **Severe pangastritis**
D. **Bile reflux**
E. **Antral extrinsic compression**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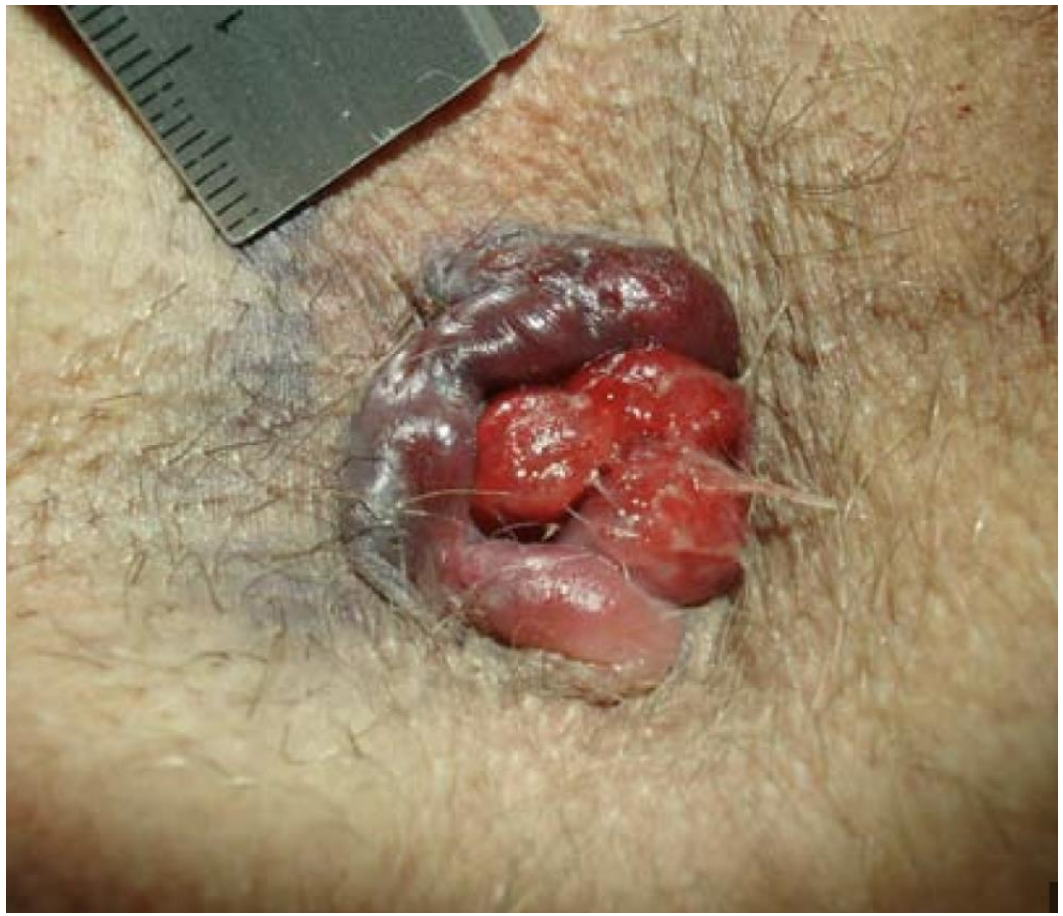
24. You scope a lady with a chronic iron def anaemia. What do you see here as a cause?

A. **Pangastritis with erosions and sliding hiatus hernia**
B. **Watermelon stomach and sliding hiatus hernia**
C. **Cameron’s lesion with sliding hiatus hernia**

25. Having asked my HPB, Medical GIT and Colorectal colleagues for interesting endoscopic pictures to broaden the pathology of this quiz, a one single photo was received back:



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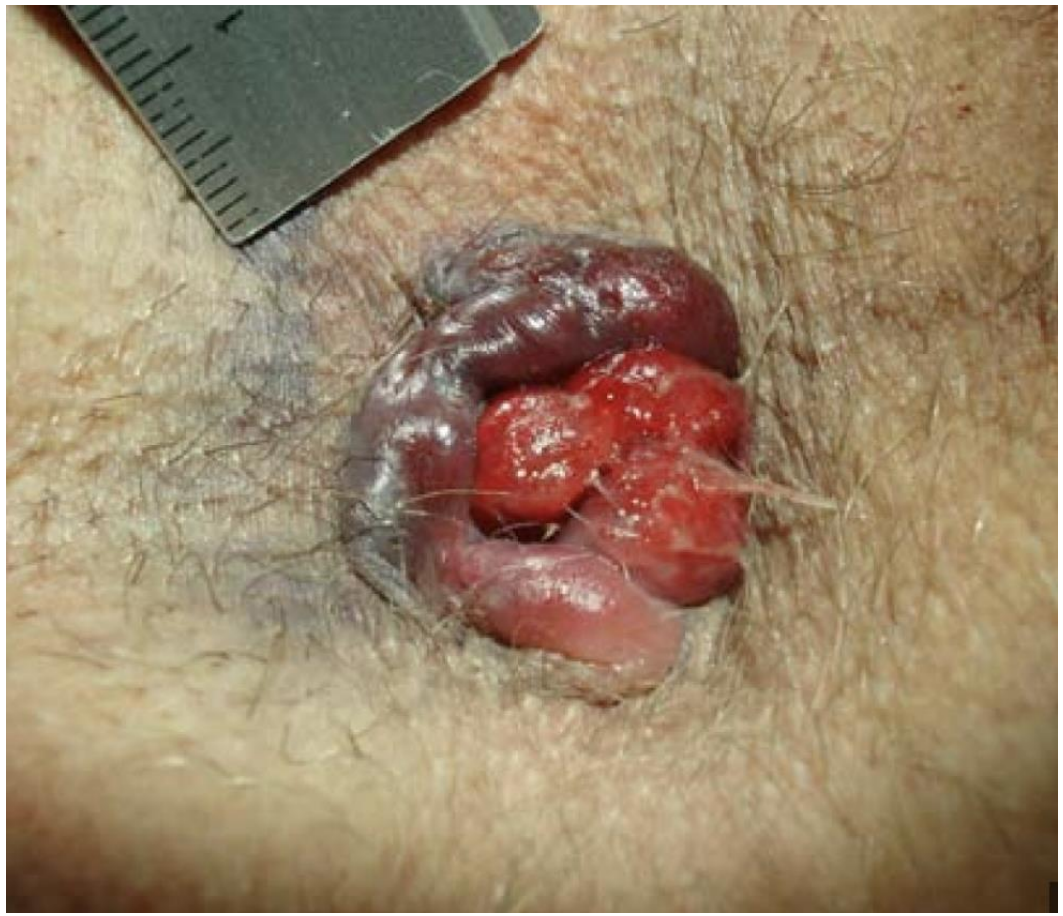

Question: whose thrombosed haemorrhoids are these?

a. **Ed Jonas**
b. **Adam Boutall**
c. **Dion Levin**
d. **Marc Bernon**