WEAVE

100+

VIVA · ILLUSTRATED

The Practical

Recognise. Locate. Explain.

100 original answer maps | 53 selected plates

Dr. Wilfred Dsouza | Dr. Niharika Reddy

WEAVE

The original book, illustrated

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WEAVE 100 · VIVA

MD Psychiatry practical. DNB revision fits too.

The Practical

One hundred examiner questions, solved as answer maps

The practical, taken apart the way an examiner takes it: how the day is run and marked, the long case and the method behind it, the common long cases, the psychiatry and neurology short cases, the OSCE stations, and the viva tables on psychopathology and investigations, drugs and somatic treatments, scales and assessments, and the law, community and specialty psychiatry. Ten areas, sized to the marks of the day. One hundred questions chosen from Weave Viva and its verified library, each solved as a one-page answer map, with each number traced to the chapter it came from.

Dr. Wilfred D'souza · Dr. Niharika Reddy

WEAVE

A NOTE ON WHO MADE THIS

Weave, Centre for Integrative Psychiatry

Weave is a psychiatry practice and a publishing house for the things clinicians and families actually need to read. Two consultant psychiatrists run it, online across India and in person in Mumbai.

WHAT WEAVE DOES	Integrative psychiatry, online and in Mumbai, and a free library for residents, clinicians and families.
WHO RUNS IT	Dr. Niharika Reddy and Dr. Wilfred D'souza, Consultant Psychiatrists.
WHAT THAT MEANS HERE	This book is free because the practice pays for it. There is nothing to buy on any page of it.

WEAVE 100 · VIVA

The Practical

One hundred examiner questions, solved as answer maps

THE WEAVE 100 SERIES

TITLE

Weave 100 Viva: The Practical

The practical examination volume of Weave 100: one hundred examiner questions for the MD psychiatry practical, solved as answer maps.

WRITTEN BY

Dr. Wilfred D'souza and Dr. Niharika Reddy

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EDITION

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SOURCES

The hundred were chosen by the authors from Weave Viva, the deep book of the practical, and its verified library. Each number on a map names the library chapter it came from. No board has endorsed this book and none was asked to.

The clinical content is written for doctors and doctors in training. It is a study and revision aid, not a substitute for current guidelines or clinical judgement. Verify doses, thresholds and statutory detail against the current references and your local protocols before any clinical use.

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THE HUNDRED, AREA BY AREA

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02 **Long case method** V-07 to V-18 · 12 slots · 12.0% 16

03 **The common long cases** V-19 to V-32 · 14 slots · 14.0% 30

04 **Psychiatry short cases** V-33 to V-42 · 10 slots · 10.0% 46

05 **The neurology short case** V-43 to V-56 · 14 slots · 14.0% 58

06 **OSCE stations** V-57 to V-68 · 12 slots · 12.0% 74

07 **Psychopathology and investigations** V-69 to V-76 · 8 slots · 8.0% 88

08 **Drugs and somatic treatments** V-77 to V-86 · 10 slots · 10.0% 98

09 **Scales and assessments** V-87 to V-92 · 6 slots · 6.0% 110

10 **Law, community and specialty psychiatry** V-93 to V-100 · 8 slots · 8.0% 118

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HOW TO USE THIS BOOK

One question, one page

After the front matter, each page is an area banner or one question with its answer map. Nothing continues onto a second page, so a map can be read in the time you have rather than the time it deserves. Five blocks, in the same order on each map.

1	**Question band**	The slot number, the question as an examiner asks it, and three chips: the marks, the area, and the words Syllabus core.
2	**Skeleton**	Three to five rows. The mark column sums to ten, so you can see the allocation before you read a word of content.
3	**Body**	Two to four components, chosen for the question: a comparison table, a flowchart, a plate, typed lines, at most one pitfall box.
4	**What earns the marks**	Three or four things an examiner ticks. Each one names something that is on the page above it.
5	**Links**	The related slots in this book, and the part of Weave Viva that teaches the topic in full.

The colour code

Structure	The shape of the answer: headers, rules, table heads, the question band. When a line is indigo it is telling you how the answer is organised.
Key number	A figure to carry exactly: a mark split, a threshold, a count, a cut-off. Amber means memorise the number, not just the shape of it.
Trap	The mistake the examiner is waiting for. When a line is red it is warning you off an error that looks right until it costs you the mark.

Two ways to work. Read an area straight through, banner first, to see how that part of the day is examined. Or work out loud: cover a map, say its skeleton to a partner as you would at the table, then check yourself against the page.

The chips are plain. Where a Weave 100 theory map carries a recurrence count, these maps carry the words Syllabus core. No board publishes its practical questions, so there is nothing to count. What each map does carry is its sources: the numbers on it are tied to the Weave Viva library chapters they came from.

BEFORE THE MAPS

How this book was cut

No board publishes its practical questions, so there is no frequency count behind this book. The hundred were chosen by its authors.

Where the hundred came from. The authors chose them from Weave Viva, the deep book of the practical (816 pages in nine parts), and from the verified library it is built on. Each is a question an examiner can ask at the long case, a short case, an OSCE station or a viva table.

Every number keeps its source. For each dose, level, cut-off, criterion count and legal section a map prints, the map source records the library chapter the value came from. A value the library marks for checking is left in words rather than turned into a figure.

Why there is no count. The theory volumes of Weave 100 weigh their areas by counting board papers. The practical leaves no such record, so each map carries the words Syllabus core where a theory map carries a recurrence count, and nothing here predicts what you will be asked.

How the areas were sized. The ten areas and their slot counts follow the marks of the practical: the long case, the short cases, the OSCE and the viva tables. The table gives each area, the part of the day it serves, and its share of the hundred.

AREA, IN BOOK ORDER	PART OF THE PRACTICAL	SLOTS	SHARE
01 The examination and how to present	The whole day	6	6%
02 Long case method	Long case	12	12%
03 The common long cases	Long case	14	14%
04 Psychiatry short cases	Short cases	10	10%
05 The neurology short case	Short cases	14	14%
06 OSCE stations	OSCE	12	12%
07 Psychopathology and investigations	Viva tables	8	8%
08 Drugs and somatic treatments	Viva tables	10	10%
09 Scales and assessments	Viva tables	6	6%
10 Law, community and specialty psychiatry	Viva tables	8	8%

Share is the slot count out of one hundred. It describes this book, not any board's marking scheme. No board has endorsed this book.

AREA 01 OF 10 · PV-A01

The examination and how to present

6	6.0%	V-01	V-06
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

SYLLABUS CORE 6

REVISION ORDER

Read the scheme and the marking domains first, since the other four rest on them. Then rehearse the long case presentation and the thesis defence aloud.

WHAT IS IN THIS AREA

How the practical is run and marked: the scheme and pass rule, the marking domains, the OSCE checklist and the day itself. Two slots are about performance: presenting the long case and defending the thesis.

V - 01

Describe the scheme and marks of the MD Psychiatry practical, and the pass rule.

10 THE EXAMINATION AND HOW TO PRESENT SYLLABUS CORE

SKELETON

2 The head	One examination head of 400 marks, pass at 200
2 The split	Clinical and practical 300, thesis inside it, viva 100
4 The rival frame	Say which figure is university law and which the regulator's
2 Limits	The eligibility gates, and the departmental split inside the larger figure

WHAT FIXES IT	COMPONENT	MARKS	STANDING IN AN ARGUMENT
University postgraduate ordinance, Section 10.7.6	Clinical and practical work, thesis 20 marks inside it	300	University law: quote this first
The same ordinance	Viva voce across the tables	100	University law
The same ordinance	Head total, and the pass mark	400, pass at 200	Aggregate of 50 per cent, no grace marks
National regulator's public notice	Clinical and practical examination	280	Regulator's frame, not university law
National regulator's public notice	Dissertation, marked from outside the state	20	Five per cent of clinical, practical and viva voce together
Departmental sheet, this cycle	Long case 120, each short case 60, OSCE 40, thesis 20	300	Local split: confirm against your own circular

Three descriptions of one head. The first three rows hold up when an examiner presses on them.

WHAT THE ORDINANCE DOES NOT FIX

It fixes the head total and the pass rule, and nothing below that. The division inside the clinical and practical component is delegated to a subject syllabus that has not been published for psychiatry, so departmental sheets differ and the sheet in use for your cycle governs how your marks are added. The expected length of the long case presentation is stated in no university document: get it from your own circular.

WHAT EARNS THE MARKS

- **The head total and the pass rule.** 400 marks with a pass at 200 are the two figures in the grid that are university law.
- **The thesis sitting inside the larger component.** A candidate who adds the dissertation on top of it has not read the ordinance.
- **The rival frame named as the regulator's.** Row four of the grid, said as a second description rather than a contradiction.
- **The exclusions strip.** Flagging that the internal split is departmental protects you when the local sheet differs.

SEE ALSO V - 04 Defending the thesis V - 06 The day of the practical Weave Viva, Part I

V - 02

What do examiners assess in a clinical examination? Name the marking domains.

10 THE EXAMINATION AND HOW TO PRESENT SYLLABUS CORE

SKELETON

2 **The one question**	Has this trainee reached independent clinical competence
3 **The five domains**	Attitude, consultation, communication, assessment, management with risk
3 **The behaviour grid**	Pass, borderline fail and severe fail, domain by domain
2 **Weighting**	Find the construct of the station, then spend minutes in proportion

- **Professional attitude and conduct.** Respect, empathy, and sensitivity to culture and distress.
- **Consultation management.** A logical sequence, core issues prioritised, time respected.
- **Communication skills.** Active listening, no jargon, responsive to verbal and non-verbal cues.
- **Clinical assessment and formulation.** Psychopathology elicited, examination done, differentials, a formulation.
- **Clinical management and risk planning.** A safe biopsychosocial plan, with immediate and longer-term risk mitigation.
- **Weighting follows the construct.** In an alcohol dependence station: dependence features 50 per cent, consequences 30 per cent, communication 20 per cent.

DOMAIN	PASS BEHAVIOUR	BORDERLINE FAIL	SEVERE FAIL
Attitude and conduct	Warmth and respect, health beliefs explored, distress validated	Mild detachment, rote script	**Condescension or flippancy, dignity breached**
Consultation management	Open to closed funnel, time managed, complaints prioritised	Rambling consumes time, tasks rushed at the bell	**Disjointed, no presenting complaint established**
Communication	Jargon avoided, understanding checked, responsive to cues	Occasional jargon, subtle cues missed	**Speaking over the patient, distress ignored**
Assessment and knowledge	Psychopathology explored systematically, hand hygiene, diagnosis justified	Minor criteria omitted, cursory physical examination	**Gross psychopathology missed, unsafe diagnosis**
Management and risk	Safe feasible plan, risk assessed systematically, side effects explained	Generic plan, incomplete risk enquiry	**Lethal drug combinations, active intent ignored**

WHAT EARNS THE MARKS

- **The five domains named as domains.** The typed lines, given in order, before any example is offered.
- **The severe fail column, read first.** Safety and respect end examinations, and organisation only costs a band.
- **Minutes spent in proportion.** The 50, 30 and 20 per cent split in the typed line shows where a station's marks sit.

SEE ALSO V - 03 Presenting the long case V - 05 How the OSCE is marked Weave Viva, Part I

V - 03

Present a psychiatric long case: structure, timing and the phrases that earn marks.

10 | THE EXAMINATION AND HOW TO PRESENT | SYLLABUS CORE

SKELETON

1	**Reliability**	Who gave the history, and how good it is
2	**Chronology and exclusions**	Baseline to present, then what you ruled out
2	**Mental state and risk**	Findings, then risk volunteered with its factors
3	**Formulation and defence**	Four Ps, then contrast with the plausible differentials
2	**Plan**	Acute, continuation, maintenance, with the legal basis

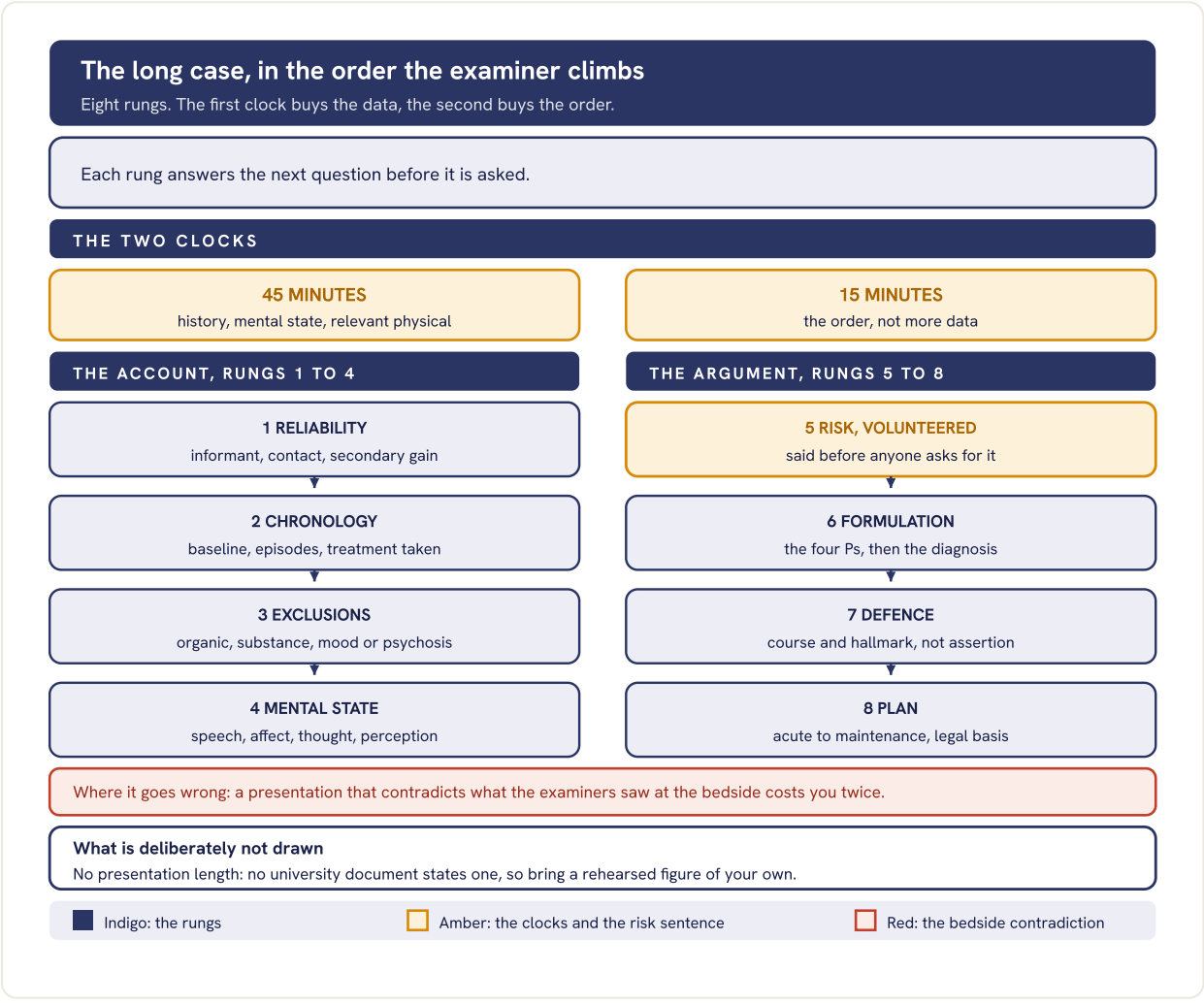


Fig 3.1 The presentation as two columns: the account in rungs one to four, the argument in rungs five to eight, risk in amber.

- **The clock.** The first 45 minutes buy history, mental state and a relevant physical examination; the 15 that follow buy the order of the argument.
- **Length.** A spoken formulation runs about 5 minutes and roughly 10 to 15 sentences, with a published model at 131 words.
- **The verb decides your entry point.** Present invites all five steps; formulate invites the analytic three.

WHAT EARNS THE MARKS

- **Rung one, said first.** Reliability licenses every statement that follows it.
- **The amber rung, volunteered.** Risk with protective and aggravating factors, before it is asked for.
- **Rung seven argued as a contrast.** Course and hallmark psychopathology, rather than assertion.
- **The legal basis inside rung eight.** Management that names its authority under the Mental Healthcare Act, 2017.

SEE ALSO V - 02 What examiners assess V - 06 The day of the practical Weave Viva, Part I

V - 04

Defend your thesis in the practical viva: the ten questions and their answers.

10 THE EXAMINATION AND HOW TO PRESENT SYLLABUS CORE

SKELETON

2	The money	20 marks, marked by an examiner from outside the state
3	The opening	Five minutes, four blocks, under 300 words
3	Methods under pressure	Sample size justified, then the analysis defended as a pipeline
2	The closing questions	Limitations volunteered, each with the change it asks for

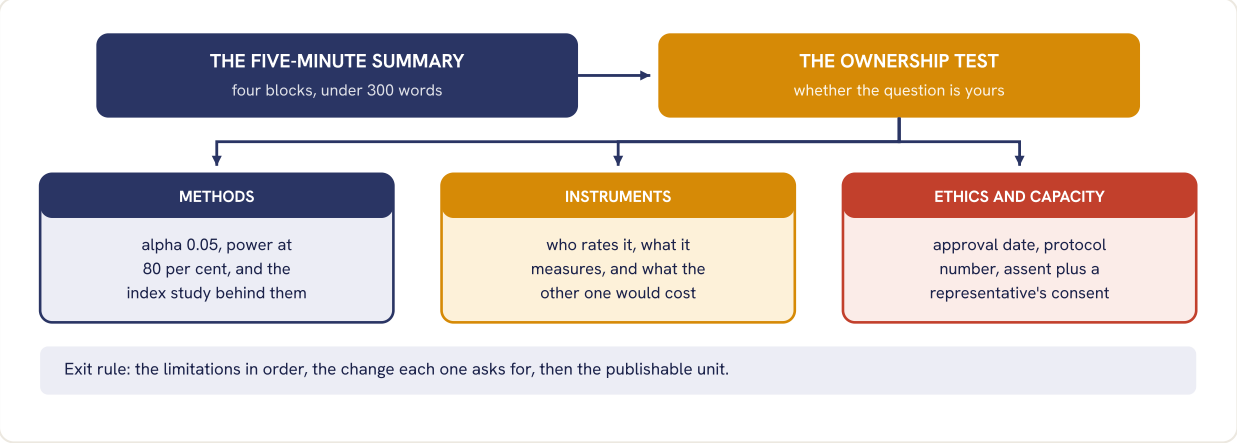


Fig 4.1 The table as an opening summary, an ownership test, then three lanes of challenge, with the closing questions as a foot strip.

- **Sample size.** Give the formula with every term named, then the assumptions: a two-sided alpha of 0.05 and power at 80 per cent, with the index study that supplied p or the standard deviation.
- **Length.** Top-range answers run about 2 to 3 minutes on the question asked; mid-range ones stray into textbook.
- **Distribution before test.** Check the distribution, then choose the test. Naming the test first is what marks a recited methodology.

PITFALL

Misstating what the dissertation percentage is a percentage of. The wording is five per cent of clinical/practical work and viva voce together, not of the clinical and practical component alone. The smaller figure invites an immediate correction.

WHAT EARNS THE MARKS

- **The four-block opening, in order.** Box one of the flowchart, rehearsed against a clock rather than told as a story.
- **The formula with its terms named.** The amber typed line: alpha at 0.05 and power at 80 per cent, each traced to a named study.
- **A limitation volunteered.** The exit strip, offered with its remedy attached rather than extracted.
- **The red lane from memory.** Approval date and protocol number are checkable at the table.

SEE ALSO V - 01 The scheme and the marks V - 06 The day of the practical Weave Viva, Part I

V - 05

How is the OSCE marked, and what does a station checklist reward?

10 THE EXAMINATION AND HOW TO PRESENT SYLLABUS CORE

SKELETON

2	What a rubric holds	A checklist, a global scale, and safety fail criteria
2	Where the cut comes from	Borderline regression, not a fixed pass percentage
4	What the items reward	Seven communication tasks, each a visible behaviour
2	How reliable it is	More stations, higher generalisability coefficient

- **The rubric has three parts.** An itemised checklist of observable actions, a global performance scale, and designated critical safety fail criteria.
- **The cut is derived, not declared.** Checklist totals are regressed on the examiners' global ratings, and the pass mark is the score predicted for a candidate at the borderline standard.
- **What the items actually test.** In calibrated psychiatry stations, 79 per cent of checklist items were communication items, and 77 to 96 per cent of those, averaging 89 per cent, assessed mastery of medical content.
- **Reliability rises with stations.** Four to five stations gave 0.54 to 0.73; ten stations 0.72 to 0.84, fifteen stations 0.79 to 0.89.
- **Communication is scored through content.** Warmth without psychopathology elicited answers the smaller part of the checklist.

CHECKLIST ELEMENT	WHAT THE EXAMINER HAS TO SEE	WHERE THE MARK IS LOST
Builds the relationship	Respect conveyed, non-verbal behaviour aligned	Passive concern, not a spoken acknowledgement
Opens the discussion	The opening statement heard uninterrupted	The second agenda item left unasked
Gathers information	Open prompts narrowing to focused, with periodic summary	Transitions without signposting
Understands the perspective	Ideas, concerns, expectations, effect on daily life	Those four asked, then set aside
Shares information	Plain language, baseline knowledge checked, chunk and check	Explanation with no comprehension probe
Reaches agreement	Choice offered, adherence barriers explored	A plan announced, not negotiated
Provides closure	Decisions summarised, safety net and follow-up named	Time expiring while still taking history

The seven consensus communication tasks, one row each. Amber cells separate a merit from a pass.

WHAT EARNS THE MARKS

- **Two instruments, not one.** The checklist and the global scale, named as separate acts of judgement.
- **The calibration figure.** 79 per cent of items communication, of which about 89 per cent test content mastery.
- **The seven tasks in order.** Column one of the grid, each tied to an observable behaviour.
- **The amber column as a warning.** Closure and the missed agenda item are the commonest losses.

SEE ALSO V - 02 What examiners assess V - 06 The day of the practical Weave Viva, Part I

V - 06

The day of the practical: sequence, clocks and the rules of conduct.

10 THE EXAMINATION AND HOW TO PRESENT SYLLABUS CORE

SKELETON

2	**The sequence**	Allocation, long case, two short cases, circuit, thesis, tables
3	**The case clocks**	45 plus 15 minutes long case, 25 plus 5 each short case
2	**The circuit clock**	5 to 10 minutes a station, rest every 30 to 40 minutes
2	**Conduct**	Examiners may interview the patient and ask you to elicit
1	**Standing**	Say which timings are draft and which are ordinance

STEP	WHAT HAPPENS	WHO ACTS	CLOCK OR CONDITION
1	Cases allocated early in the morning	The examining team	Before anything is timed
2	Long case worked up unobserved: history, mental state, relevant physical examination	You, alone with the patient	**45 minutes, then 15 to organise**
3	Bedside presentation, then the viva on it	You, then both examiners	No duration in any university document
4	Psychiatry short case, then neurology, both observed	You, watched throughout	**25 minutes each, plus 5 to prepare**
5	The objective circuit, with its rest stations	You, moving station to station	**5 to 10 minutes each, or 120 seconds in dense variants**
6	The dissertation defence	An examiner from outside the state	Opens with the five-minute summary
7	The viva tables: imaging, instruments, drugs, emergencies, law	Each table in turn	The head closes here

Order first, clock second. The written timings attach to the cases, not to the tables.

WHAT THE ORDINANCE DOES NOT COVER

The ordinance fixes marks and conduct rather than timing. The per-case durations sit in a draft curriculum that was not notified in final form, so quote them as the draft figures they are. Two things it leaves open: how long the long case presentation itself should run, and how long the viva on it lasts. Take both from your own examination circular and say so.

WHAT EARNS THE MARKS

- **The sequence, unprompted.** Column two of the stepped table in order, allocation through to the last viva table.
- **The two case clocks.** 45 plus 15 minutes, and 25 plus 5, read off rows two and four with the actor named.
- **Where a timing comes from.** The strip at the foot, naming the draft curriculum rather than asserting the figure.
- **The conduct rule.** Examiners may interview the patient themselves and may ask you to elicit a sign at the bedside.

SEE ALSO V - 01 The scheme and the marks V - 03 Presenting the long case Weave Viva, Part I

AREA 02 OF 10 · PV-A02

Long case method

12	12.0%	V-07	V-18
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

SYLLABUS CORE 12

REVISION ORDER

Take the history slots first, then the mental state slots in the order you would examine. Leave risk and the closing ladder for last, as they draw on the rest.

WHAT IS IN THIS AREA

The long case taken apart heading by heading: history, family history, premorbid personality, substance use and the mental state examination. It closes with risk assessment and the ladder from formulation to prognosis.

V - 07

Take a psychiatric history in examiner order: the headings and what each must contain.

10 LONG CASE METHOD SYLLABUS CORE

SKELETON

2 The proforma order	Name the consensus sequence before giving any content
3 Presenting illness	Each symptom on ABCDE, with its functional consequence
3 The background headings	Family, personal, premorbid personality, substance and marital
2 Negative and treatment history	Each denial excludes something; each trial carries its dose

HEADING	WHAT IT MUST CONTAIN	WHAT THE EXAMINER TICKS
Identifying data	Age, sex, address, education, occupation, income, marital status, religion	**Advance directive and nominated representative, stated present or absent**
Informant	Identity, relationship, cohabitation and the observation window it fixes	**Reliability defended on consistency, confirmability, credibility, constancy, adequacy**
Chief complaints	Verbatim, chronological, a duration attached to each one	**The patient's own words rather than jargon**
Presenting illness	Antecedents, behaviours, consequence, duration, episodic pattern	**Functional consequence on each symptom, the clause candidates drop**
Onset and course	Pace with a time frame, then pattern plus the current phase	**Within 48 hours abrupt, clearly within 2 weeks acute**
Negative history	Organic, substance, competing polarity, risk and function	**Each denial tied to what it excludes**
Treatment and past history	Molecule, dose, duration at target dose, adherence, response	**Hospitalisations with number, duration and legal status**

Amber cells are what the examiner is listening for. The order itself earns marks, because the proforma is what they are marking against.

- **Then the background.** Family history with the genogram, personal and developmental history, substance, sexual and marital history, premorbid personality.
- **Vegetative functions.** Sleep, appetite, weight, libido, diurnal variation and bowel habit sit inside the narrative, not in a separate list.
- **Identifying data as a warm-up.** Each item moves a probability, a plan or the legal position, so each is spoken for a stated reason.

WHAT EARNS THE MARKS

- **The sequence given unprompted.** It shows you are working from the proforma rather than recalling a case.
- **The two statutory items in the first row.** Advance directive and nominated representative, present or absent.
- **An exclusion attached to each denial.** A list of absent symptoms with no target scores nothing.
- **Dose and duration at target dose.** Without them no claim about an adequate trial can be made.

SEE ALSO V - 08 Genogram V - 11 Mental state order V - 18 The closing ladder Weave Viva, Part II

V - 08

Family history and the three-generation genogram.

10 LONG CASE METHOD SYLLABUS CORE

SKELETON

1 Pedigree against genogram	Descent alone, against descent plus relationships and household
3 Why three generations	Polygenic liability, carrier states, variable expression, repeating scripts
4 Symbols and lines	Structural beneath the symbols, emotional between them, shading legended
2 The Indian additions	Typology, cohabitants, and the three household roles

ENTITY	SYMBOL	CONVENTION
Index patient	Double shape or an arrow	**Marked, so the case anchor is unambiguous**
Deceased	Diagonal cross through the shape	**Age at death and cause written alongside**
Union, separation, divorce	Line beneath the partners, crossed obliquely if ended	**Label the crossing and define it in the legend**
Offspring, adopted, foster	Solid vertical, dashed or dotted if not biological	**Left to right, oldest to youngest**
Twins	Converging sibling lines, a bar added for monozygotic	**The bar is the only thing separating the two**
Consanguinity	Double horizontal line	**A single line hides a metabolic differential**
Household	Dashed perimeter	**Encloses everyone living under one roof**

THE FIGURES THE GENOGRAM IS TAKEN FOR

A first-cousin union carries a 3 to 5 percent risk of malformation, genetic disorder or stillbirth against a baseline of 2 to 3 percent, nearly double. Two recessive carrier parents give 1 in 4 per pregnancy. A maternal fragile X premutation of 55 to 200 repeats expands above 200 CGG repeats, the commonest inherited cause of intellectual disability.

- **Emotional lines.** They run between the symbols, not beneath them: solid is close, parallel enmeshed, dashed distant, zigzag conflicted, double slashes a cutoff.
- **Shading with no legend.** Define each fill used. An empty ancestral branch is undiagnosed, not healthy.

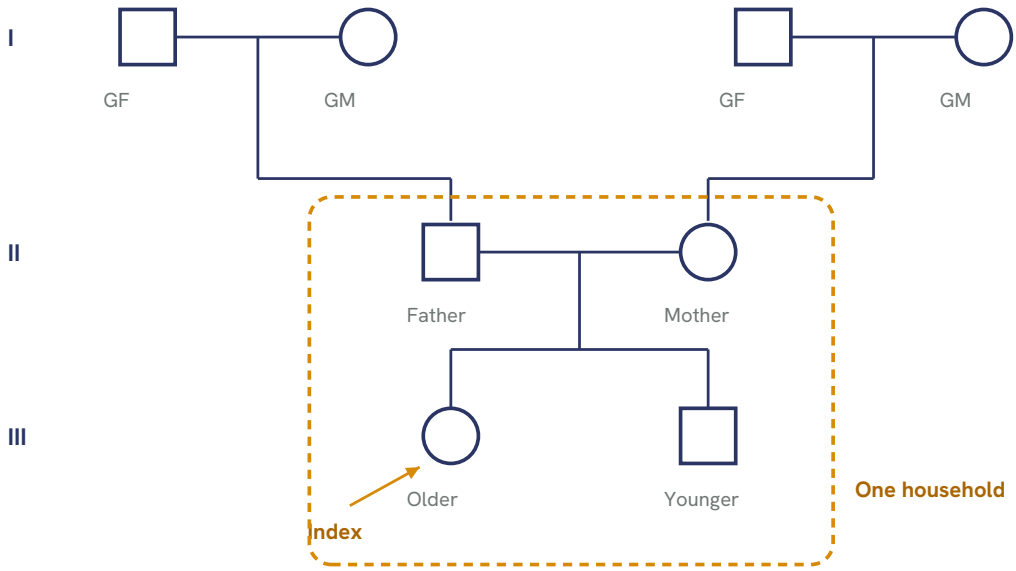
WHAT EARNS THE MARKS

- **Three generations drawn rather than described.** The diagram itself carries half the mark in a drawing station.
- **The first-cousin figure quoted from the key box.** A number beats an adjective here.
- **The three household roles named.** Earning member, caregiver and decision maker rarely sit in the same relative.

SEE ALSO V - 07 History in order V - 09 Premorbid personality V - 18 The closing ladder Weave Viva, Part II

Draw the family, not a list.

A fictional three-generation genogram with an explicit index and household.



READ THE LEGEND

Square: man Circle: woman Arrow: index

Solid lines: union and biological descent

Dashed perimeter: people living in the same household

Oldest sibling on the left. Unfilled does not mean healthy.

GF / GM: grandfather / grandmother. No clinical diagnosis is encoded.

Schematic ▪ Original teaching diagram ▪ September 2026

Schematic. A fictional family across three generations, with index arrow, birth order and household perimeter. No clinical diagnosis is encoded. Read from the grandparents to the parents and children. Squares and circles identify the symbols in the legend; the arrow identifies the index person and the dashed perimeter identifies one household. Unfilled symbols do not mean healthy.

Draw the relationships, then explain every symbol and line.

Schematic prepared by Luna for Weave Viva, based on chapter P1-03. Original edition artwork; publication licence to follow the edition.

V - 09

Premorbid personality: the headings and the questions that elicit them.

10 LONG CASE METHOD SYLLABUS CORE

SKELETON

2	Temperament or personality	Childhood onset takes temperament, adult onset takes personality
4	The six headings	Each one carries an anecdote rather than an adjective
2	Informant verification	State against trait cannot be settled by the patient alone
2	The disorder threshold	General criteria, then the prevalence and heritability figures

HEADING	WHAT IT COVERS	THE QUESTION THAT ELICITS IT
Attitude to self	Self-esteem against self-deprecation, health preoccupation, moral standards	How did he see himself before this illness began?
Attitude to others	Warmth against aloofness, dominance, trust against suspicion, empathy	How many close friends did he keep, and for how long?
Attitude to work	Conscientiousness and perfectionism against rigidity and resentment of supervision	Did he finish what he started, and how did he take instruction?
Predominant mood	Baseline tone, threshold for anger, feeling expressed or restricted	Was he usually cheerful, worried, or short-tempered?
Fantasy life	Daydreaming as creative diversion or as substitute for relationships	Did he spend long stretches absorbed in his own thoughts?
Habits and leisure	Tobacco, alcohol and other substances, interests, use of free time	How did he spend a free day before this began?

The Mayer-Gross and Schneider headings. An adjective is an assertion; a remembered incident under each heading is evidence.

TEMPERAMENT, AND THE THRESHOLD FOR A DISORDER

The 9 Thomas and Chess categories group into the easy child, the difficult child and the slow-to-warm-up child; at the bedside temperament is still recorded plainly.

Community prevalence of personality disorder is about 9 percent, clinic and inpatient prevalence up to 50 percent, heritability approximately 50 percent. Below age 18 the features are required for at least 1 year, and antisocial personality disorder is the stated exception.

- **State against trait.** A depressed patient reports lifelong worthlessness and a manic one lifelong confidence, so interview an informant or use a euthymic period.

WHAT EARNS THE MARKS

- **The right construct for the onset.** Temperament for childhood-onset illness, personality for adult-onset illness.
- **An anecdote under each of the six headings.** A list of pleasant adjectives scores nothing.
- **The general criteria stated.** Deviation in at least two of cognition, affectivity, interpersonal functioning and impulse control, traceable to adolescence.
- **The prevalence pair from the key box.** Community against clinic explains why comorbidity is the rule on a ward.

SEE ALSO V - 07 History in order V - 08 Genogram V - 12 Mood and affect Weave Viva, Part II

V - 10

Substance use history and the dependence syndrome.

10 LONG CASE METHOD SYLLABUS CORE

SKELETON

2 **Quantify the intake**	Beverage, millilitres, drinking pattern, longest abstinence
2 **Screen, then assess**	A positive screen prompts an assessment, it does not diagnose
4 **The dependence syndrome**	Edwards and Gross, then impaired control, salience, physiology
2 **Withdrawal and complications**	Uncomplicated, complicated, then organ damage by system

FEATURE	HAZARDOUS USE	HARMFUL PATTERN	DEPENDENCE
Category	A health risk factor, outside the disorders section	A substance use disorder	**A substance use disorder**
Present health harm	Absent, risk only	Present, physical or mental	**Often present, and not required**
Impaired control, salience, physiology	Absent	Absent	**Present, and these are the three core features**

A harmful pattern cannot be diagnosed once the presentation meets dependence. Organ damage alone is harmful use, however severe the cirrhosis.

THE SYNDROME, AND THE TWO SYSTEMS

Edwards and Gross in 1976 separated the core syndrome from alcohol-related disabilities: narrowing of the drinking repertoire, salience of drink-seeking, subjective compulsion, increased tolerance, repeated withdrawal symptoms, relief or avoidance drinking, and reinstatement after abstinence.

ICD-11 keeps dependence categorical. The DSM-5 continuum scores 11 criteria in total, mild requiring 2 to 3, moderate 4 to 5 and severe greater than 6, which is why it captures mild cases that do not meet ICD-11 dependence.

- **Complicated withdrawal has three forms.** Withdrawal seizures; delirium tremens, an emergency with clouded consciousness and autonomic instability; and alcohol-induced psychotic disorder in clear consciousness.
- **The laboratory markers offered as a diagnosis.** Gamma-glutamyl transferase, mean corpuscular volume and the transaminase ratio corroborate the history and monitor abstinence.

WHAT EARNS THE MARKS

- **Intake in millilitres with a beverage type.** Three pegs is not a quantity, and country liquor concentration varies.
- **The three core features in the amber column.** Impaired control, salience and physiology separate dependence from a harmful pattern.
- **The seven elements attributed to Edwards and Gross.** The biaxial point is that harm and dependence vary independently.
- **Motivation staged and matched.** Precontemplation calls for rapport and information rather than confrontation.

SEE ALSO V - 07 History in order V - 17 Risk in the long case V - 18 The closing ladder Weave Viva, Part II

V - 11

The mental state examination in order, with the elicitation question for each heading.

10 LONG CASE METHOD SYLLABUS CORE

SKELETON

2 **The fixed sequence**	Appearance to insight, eight headings in a set order
2 **Why the order is fixed**	Observable signs before intrusive probing, which protects rapport
4 **One question per heading**	A sentence you can say out loud at the bedside
2 **Attitude against rapport**	Two separate observations, each with its own descriptors

HEADING	WHAT YOU RECORD	THE ELICITATION QUESTION OR TEST
Appearance and behaviour	Age, build, dress, hygiene, marks and stigmata, eye contact, gait	**Observed from the doorway, before a question is asked**
Attitude and rapport	Cooperative to hostile; then whether rapport formed between you	**Not established but amenable for interview, for a guarded patient**
Psychomotor and speech	Level, involuntary and drug-induced signs, then speech in eight parameters	**Rate, volume, tone, reaction time, productivity, relevance, coherence, prosody**
Mood and affect	Subjective verbatim, objective appraisal, then the affect parameters	**How have you been feeling in your spirits recently?**
Thought	Stream, form, content and possession	**What has been occupying your thoughts most of the time?**
Perception	Modality, location, clarity, commentary, command and tone	**When you are sitting quietly alone, do you notice unusual sounds?**
Cognition	Consciousness, orientation, attention, memory, intelligence, abstraction	**Subtract 7 from 100, then 7 from each remainder**
Insight and judgement	Six insight grades, then personal, social and test judgement	**Were those experiences real, or part of an illness?**

- **Why that order.** It runs from what you see without asking to the reflective capacity that lets a patient judge their own illness, which is also the sequence that protects rapport.
- **Moralistic words.** Replace uncooperative and manipulative with the observation: the patient sat with arms crossed, gaze averted, and declined questions about personal history.

WHAT EARNS THE MARKS

- **The eight headings given in order.** The order itself tells the examiner you are working from a method.
- **Attitude and rapport on separate rows.** A guarded patient who permits examination is rapport not established but amenable.
- **A quoted question in each amber cell.** Naming the words that produced the finding is what separates elicitation from recitation.
- **Averted gaze read culturally.** Deference before elders and senior doctors is sanctioned, not depressive guilt.

SEE ALSO V - 12 Mood and affect V - 13 Thought V - 15 Cognitive examination Weave Viva, Part II

V - 12

Mood versus affect, and the terms that describe each.

10 LONG CASE METHOD SYLLABUS CORE

SKELETON

2	**Both defined**	Mood is the climate, affect is the weather, and both are recorded
2	**Mood recorded twice**	Subjective verbatim in quotation marks, then your objective appraisal
4	**The grid of terms**	What is reduced in each term, and where it is seen
2	**Reactivity tested**	Three probes, then record it as reactive or fixed

TERM	WHAT IS REDUCED	WHAT YOU SEE	WHERE IT IS SEEN
Broad or full	Nothing; this is baseline	Fluid, proportionate facial and vocal response	**Health, and euthymia between episodes**
Restricted	Range, the variety shown	A narrow band held with moderate depth	**Depression, dysthymia, adjustment reactions**
Blunted	Intensity, the amplitude	Unchanging face, sparse gesture, uninflected voice	**Schizophrenia as a negative symptom, melancholia, brain injury**
Flat	All outward display	Immobile face, negligible eye contact whatever the topic	**Chronic deficit schizophrenia, stupor, advanced dementia**
Labile	Nothing; it is unstable	Rapid unpredictable swing on minor stimuli	**Mixed and manic states, borderline pattern, delirium**
Expansive	Nothing; it is excessive	Boundary-crossing, over-familiar, grandiose	**Mania and hypomania**

Range is variety, intensity is amplitude: restricted narrows the range, blunted turns down the volume, flat switches it off. Kring and Neale found less facial movement with comparable subjective intensity, and the meta-analysis by Cohen and Minor pooling 26 laboratory studies confirmed that experience remains largely intact, so blunting is an expressive deficit.

- **Appropriateness against congruence.** One looks outward to the social situation, the other inward to the patient's own stated mood and thought content.
- **The overlap: pseudobulbar affect.** Display disconnected from inner feeling, sudden and stereotyped, from bilateral corticobulbar disruption; psychiatric lability tracks topic and interaction and the patient feels what is shown.

WHAT EARNS THE MARKS

- **A grid, not two paragraphs.** The reduced element in column two is what the grid is for.
- **Subjective mood quoted verbatim.** The patient's own words carry duration and diurnal variation with them.
- **Reactivity demonstrated with a probe.** An affect called fixed without a test is an assertion.
- **The overlap answered separately.** Pseudobulbar affect carries its own reasoning and its own marks.

SEE ALSO V - 11 Mental state order V - 13 Thought V - 17 Risk in the long case Weave Viva, Part II

V - 13

Thought: stream, form, content and possession, and how to elicit each.

10 LONG CASE METHOD SYLLABUS CORE

SKELETON

1	The axis	What is being examined about the thought, stated before the list
3	The four aspects	Drawn, not listed: the plate is the answer
4	Elicitation	The words that pull each phenomenon out of the patient
2	The near neighbours	The pairs candidates confuse, each with its discriminator

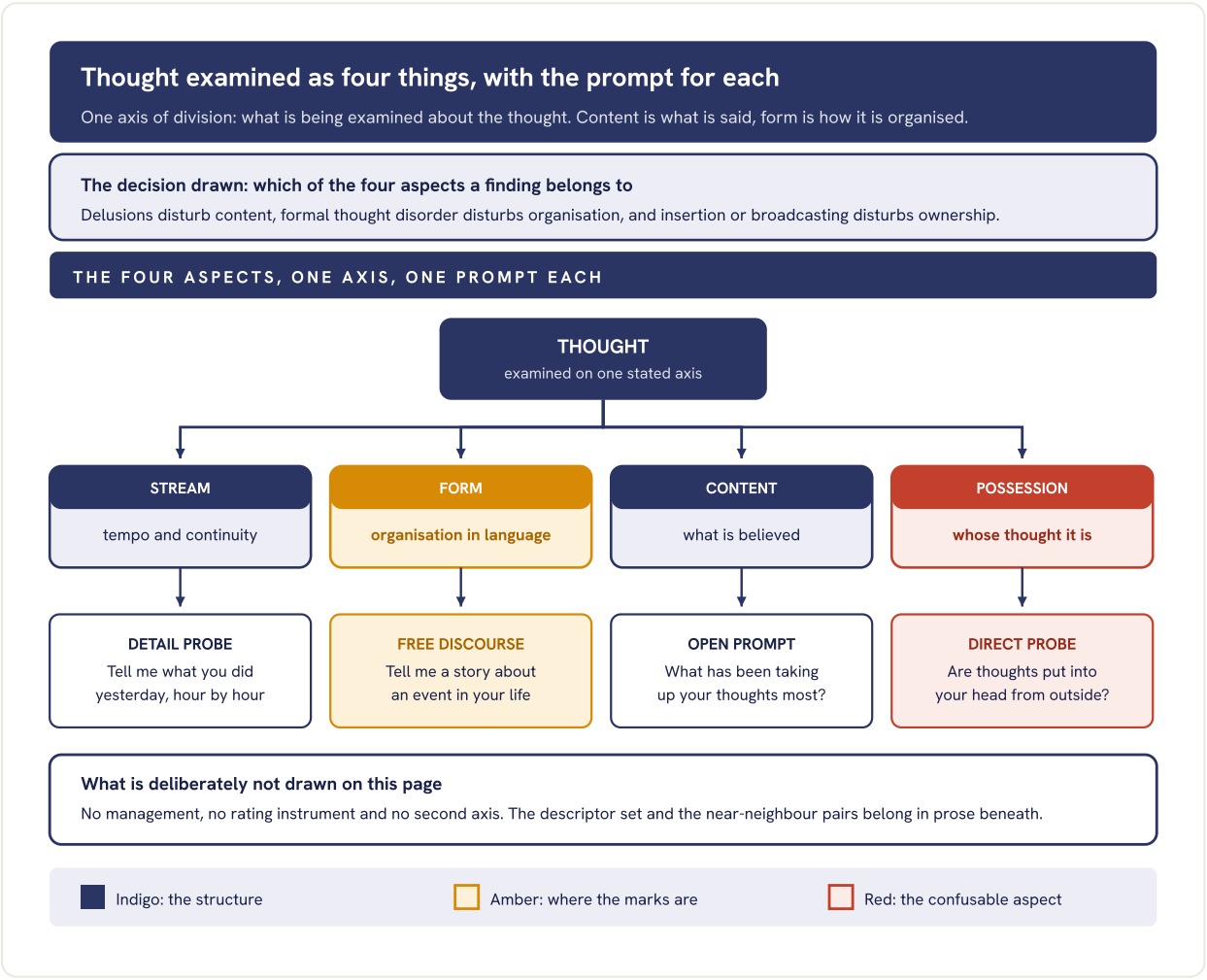


Fig 13.1 Thought drawn as four aspects on one axis, form in amber because the disorganisation marks sit there, possession in red because insertion is what candidates confuse with obsession, and the bedside prompt for each aspect carried directly beneath it.

- **Provoke, then clarify.** Formal thought disorder is a set of observable signs, so run a 15 to 20 minute structured interview: open discourse, provocation, cognitive and affective demand, then subjective verification.
- **The pivot.** Ask what did you mean by that. A patient without thought disorder repairs the slip and restores coherence; one with it derails further or becomes visibly perplexed.

THE NEAR NEIGHBOURS

Circumstantiality reaches the goal eventually, tangentiality does not return. Flight of ideas keeps understandable links at speed, derailment loses the link at normal tempo. A neologism is a new word with private meaning, a phonemic paraphasia mispronounces a real one. Withdrawal attributes the emptying to an outside agency, blocking invokes none, and an obsession is owned and resisted.

WHAT EARNS THE MARKS

- **The axis stated in one line before the plate.** Four aspects without a stated axis is a list.
- **Every branch of the plate reproduced with its prompt.** An incomplete tree loses more than a plain list would.
- **Depth in form, the branch the marks sit on.** Provocation and clarification, not passive listening.

SEE ALSO V - 11 Mental state order V - 14 Perception V - 16 Insight and judgement Weave Viva, Part II

V - 14

Eliciting hallucinations and other perceptual abnormalities at the bedside.

10 | LONG CASE METHOD | SYLLABUS CORE

SKELETON

2 Define the pair	Hallucination has no stimulus, illusion misperceives a real one
3 Elicit progressively	Setting, then noise against speech, then location and clarity
3 Characterise the voices	Number, person, complexity, commentary, command and tone
2 Denial with signs	Record the denial and the observed response together

STEP	THE QUESTION YOU ACTUALLY ASK	WHAT THE ANSWER SETTLES
Open on the setting	"Sitting quietly on your own, do you notice unusual sounds?"	**Avoids the word voices, which invites denial or false endorsement**
Noise against speech	"Sounds only, or words you can make out?"	**Simple noises point organic, complex syntax functional**
Locate it in space	"Thoughts echoing inside, or voices through your ears?"	**Space, not vividness, is the discriminator**
Grammatical person	"Do they speak to you, or about you?"	**Third-person commentary is a first-rank symptom**
Command and tone	"Do they order you to act? Hostile or soothing?"	**Commands to harm change the setting of care**
Other modalities	Foul smells nobody else detects; crawling under the skin	**Olfactory and gustatory raise suspicion of temporal lobe epilepsy**

Migraine is the commonest cause of visual hallucination and illusion.

SPACE SEPARATES TWO, STIMULUS SEPARATES THREE

A true hallucination sits in external objective space with full perceptual reality. A pseudohallucination sits in internal subjective space, keeps its sensory quality, and the patient retains insight. Illusion has a stimulus, hallucination has none, delusional perception has a normal stimulus and an abnormal self-referential meaning.

- **The perceptual first-rank members.** Schneider, in 1959: thought echo, voices arguing in the third person, voices commenting on actions, somatic hallucinations attributed to external manipulation.
- **Offering them as diagnostic.** Sensitivity and specificity are not absolute, so they also occur in affective and substance-induced psychoses.
- **Perception that is not pathology.** Hypnagogic and hypnopompic imagery, and hearing the voice of someone who has died in acute grief.
- **The dissociative pair.** Depersonalisation detaches the self, derealisation the surroundings, and reality testing is preserved in both, which separates them from psychosis.

WHAT EARNS THE MARKS

- **Progressive questioning, in the grid's order.** The generic opening question is the commonest loss.
- **Space named as the discriminator.** External objective space against internal subjective space.
- **Denial documented beside the observation.** Pausing mid-sentence and muttering at a wall is evidence.
- **The dissociative pair kept apart.** Preserved reality testing carries its own mark.

SEE ALSO V - 11 Mental state order V - 13 Thought V - 15 Cognitive examination Weave Viva, Part II

V - 15

Bedside cognitive examination: the tests and what each means.

10 LONG CASE METHOD SYLLABUS CORE

SKELETON

2 **The fixed order**	Consciousness, orientation, attention, memory, intelligence, abstraction, judgement
3 **Attention first, with a reason**	An inattentive patient cannot register, so later results are uninterpretable
3 **Memory in three compartments**	Registration, recent, remote, then cue to localise failure
2 **Cortical closers**	Abstraction, parietal signs, praxis, then the named instruments

TEST	ADMINISTRATION	SCORING OR NORMATIVE POINT
Serial sevens	Subtract 7 from 100, then 7 from each remainder	**14 correct subtractions down to 2, each independent, so one slip penalises that step only**
Spelling backwards	A five-letter word such as WORLD in reverse	**Orthographic processing and working memory**
Serial threes, reverse sequences	Threes from 40, or months and days in reverse	**Backwards from 20 to 1 replaces WORLD where English is not read**
Digit span	Digits at one per second, forward then backward	**Normal forward span 5 to 7 digits, book range 5 to 9; reverse tests working memory**
Montreal Cognitive Assessment	Scored out of 30	**Samples executive function and abstraction, so it suits broad screening**
Addenbrooke's, third edition	15 to 20 minutes, out of 100, cut-offs 82 to 88	**Sensitive for dementia, light on frontal executive function and apraxia**

PITFALL

Treating serial sevens and WORLD backwards as interchangeable. Serial sevens is harder and demands calculation, the two correlate only weakly, and both are strongly influenced by education, so failure can come from dyscalculia or low schooling.

- **Cueing localises the failure.** If recall fails at 2 to 5 minutes, give a category cue: restored recall points to frontostriatal retrieval, unhelped recall to hippocampal encoding, the Alzheimer pattern.
- **Consciousness recorded operationally.** The stimulus needed to arouse, the response given, how long it holds. Fluctuation is itself a finding.
- **An Indian-standardised instrument, named.** The Binet-Kamat Test or the Bhatia Battery, with locally familiar proverbs.

WHAT EARNS THE MARKS

- **Attention before memory, with the reason attached.** An inattentive patient cannot register.
- **The cueing line.** It turns a bedside result into a localising statement.
- **An alternative to WORLD offered.** Threes from 40, or a reverse sequence.

SEE ALSO V - 11 Mental state order V - 14 Perception V - 16 Insight and judgement Weave Viva, Part II

V - 16

Grading insight and testing judgement.

10 LONG CASE METHOD SYLLABUS CORE

SKELETON

1	The axis of division	Depth of awareness, graded, not presence or absence
2	Three dimensions	Acknowledgement, need for treatment, relabelling of symptoms
4	The six grades	Each grade with what the patient actually says
3	Judgement, and the statute	Intact or impaired, and capacity is a separate test

GRADE	LABEL	WHAT THE PATIENT SAYS
Grade 1	Complete denial	Rejects any notion of illness or of needing help
Grade 2	Slight awareness with denial	Ambivalent, fluctuating awareness of being unwell
Grade 3	External attribution	Accepts being ill, but blames others or a bodily disease
Grade 4	Unknown internal cause	Accepts something within is wrong, without naming a psychiatric condition
Grade 5	Intellectual insight	Names the illness and calls symptoms abnormal, without applying it
Grade 6	True emotional insight	Awareness of the motives behind symptoms, applied to decisions and adherence

- **The three dimensions.** Anthony David, in 1990: acknowledgement of illness, need for treatment, relabelling of experiences as abnormal. Each is held separately.
- **The discriminating question.** Were those experiences real, or part of an illness? It tests relabelling, so it separates grade 5 from grade 4.
- **The instrument to name.** David's Schedule for Assessment of Insight, of 8 questions: the first 7 give a maximum of 14, and the eighth raises it to 18.
- **Treating gained insight as uniformly good.** It tracks internalised stigma, so pair psychoeducation with stigma work. Deficits: 50 percent to 80 percent in schizophrenia.

JUDGEMENT IS REPORTED, NOT GRADED

Personal, from realistic plans; social, from ward conduct; test, from hypotheticals read against culture. One impaired component impairs judgement, and conduct outweighs a hypothetical.

Capacity under the Mental Healthcare Act 2017 turns on understanding the information, appreciating the foreseeable consequences, and communicating the decision (Section 4). A poison delusion destroys the appreciation limb.

WHAT EARNS THE MARKS

- **The axis stated before the grid.** Depth of awareness, in one line.
- **Every grade reproduced, with the patient's words.** An incomplete ladder loses more than prose would.
- **The statutory limb named.** Appreciation of consequences is where the poison delusion bites.

SEE ALSO V - 13 Thought V - 15 Cognitive examination V - 17 Risk in the long case Weave Viva, Part II

V - 17

Risk assessment in the long case: suicide, violence, self-neglect, and how to present it.

10 LONG CASE METHOD SYLLABUS CORE

SKELETON

2	**Prevention, not prediction**	Low base rate, so foreseeability is the standard of care
2	**Ask properly**	Normalise, then work the timeline to this crisis
4	**Four domains, then the classes**	Suicide, violence, self-neglect, vulnerability; static, dynamic, future
2	**Present it in five beats**	Static, dynamic, protective, formulation, then the plan

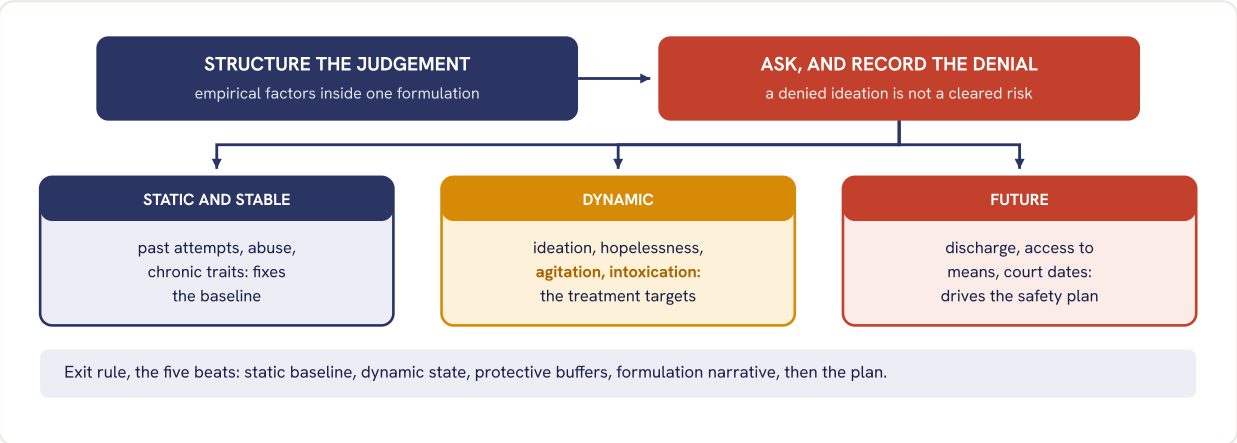


Fig 17.1 Method first, then the three factor classes; the amber lane holds the treatment targets.

- **Intent, in four inquiries.** Purpose of the act; preparatory acts such as a note; the wish to die rated 1 to 10; practical execution.
- **Self-neglect and vulnerability complete the field.** Failing nutrition or hygiene, and exposure to exploitation.
- **A falling dynamic score read as safety.** Instruments carry no predictive cut-off, and a band is not a formulation.

PITFALL

Omitting iatrogenic hazards. Of suicides within 12 months of psychiatric contact, 33.3 percent involve prescribed psychotropic overdose, so limit quantities dispensed. Wards are not protective: 16 percent of suicides under services occur there, and 30 percent of community suicides fall within 3 months of discharge.

WHAT EARNS THE MARKS

- **Foreseeability in place of prediction.** The base-rate argument is the reason, and it belongs first.
- **The three lanes used functionally.** Static fixes the baseline, dynamic supplies the targets, future drives the plan.
- **The foot strip delivered as five beats.** The mark is for the narrative, not the label.

SEE ALSO V - 10 Substance use V - 16 Insight and judgement V - 18 The closing ladder Weave Viva, Part II

V - 18

Formulation, differentials, investigations, management plan and prognosis: the closing ladder.

10 LONG CASE METHOD SYLLABUS CORE

SKELETON

2	**Summary against formulation**	One condenses findings, the other explains mechanism
3	**Differentials in tiers**	Organic first, then show how each tier was excluded
3	**Investigations and management**	Targeted hypotheses, then locus, focus and modus
2	**Prognosis on three axes**	Temporal, outcome and risk, then what is modifiable

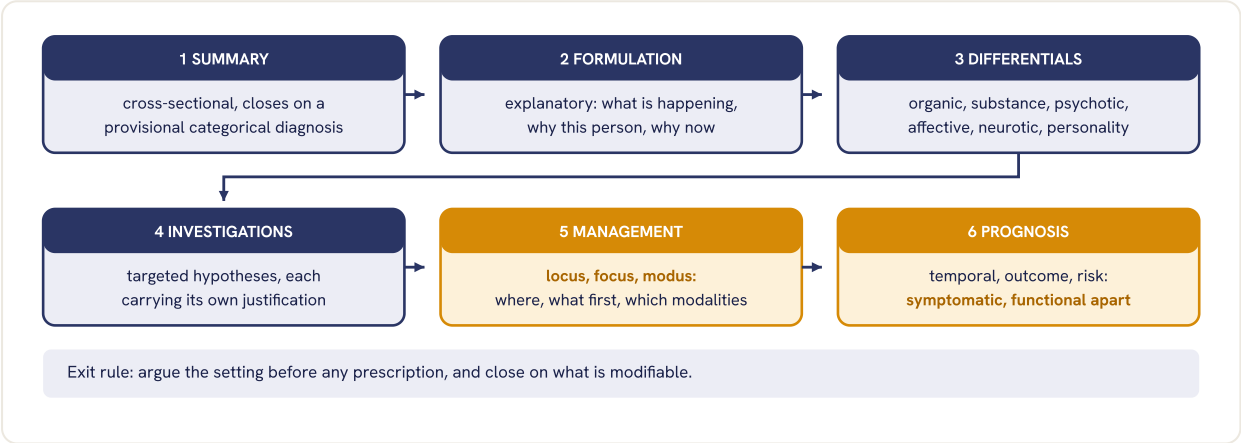


Fig 18.1 The closing ladder as six rungs in the order an examiner asks them, with the last two in amber where the final marks sit.

- **The rules of form for a formulation.** Scientific terminology rather than vernacular phrasing, a length of 10 to 20 sentences, negative history omitted, and about 5 minutes of tentative delivery.
- **Aetiology on the grid.** Biological, psychological and social crossed with predisposing, precipitating, perpetuating and protective, after Weerasekera. Perpetuating factors are the treatment targets.
- **Lead investigations with yield.** Clinical history 15.6 percent, examination 14.9 percent, routine screening 1.1 percent. Call it medical screening and stabilisation, and drop medical clearance.

WHAT EARNS THE MARKS

- **Rung 1 and rung 2 kept separate.** They are asked for separately, and merging them is a tactical error.
- **Organic placed first, with an exclusion method beside it.** A timeline, a negative systemic enquiry, serial orientation.
- **The amber rungs argued in order.** Setting before drugs, and an objective written so it can be measured.
- **The foot strip on modifiability.** Psychoeducation, social rhythms and family engagement are the levers held.

SEE ALSO V - 07 History in order V - 16 Insight and judgement V - 17 Risk in the long case Weave Viva, Part II

AREA 03 OF 10 · PV-A03

The common long cases

14	14.0%	V-19	V-32
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

SYLLABUS CORE 14

REVISION ORDER

Start with the psychoses and mood disorders, which share one management ladder. Then the substance cases, then the neurotic, organic and personality cases.

WHAT IS IN THIS AREA

Fourteen of the common long cases, from schizophrenia and mania to dementia, delirium and the postpartum disorders. Each map runs from diagnosis to management and the questions that follow it.

V - 19

Schizophrenia long case: diagnosis, first-episode management and the examiner's ladder.

10 THE COMMON LONG CASES SYLLABUS CORE

SKELETON

2 Criteria	Characteristic domains held for 1 month, with exclusions
3 The four exits	Duration first, then how psychosis sits with mood
3 First prescription	Monotherapy, stratified by aggression, then monitoring
2 Resistance	Define it, then the clozapine gate at 2 failed trials

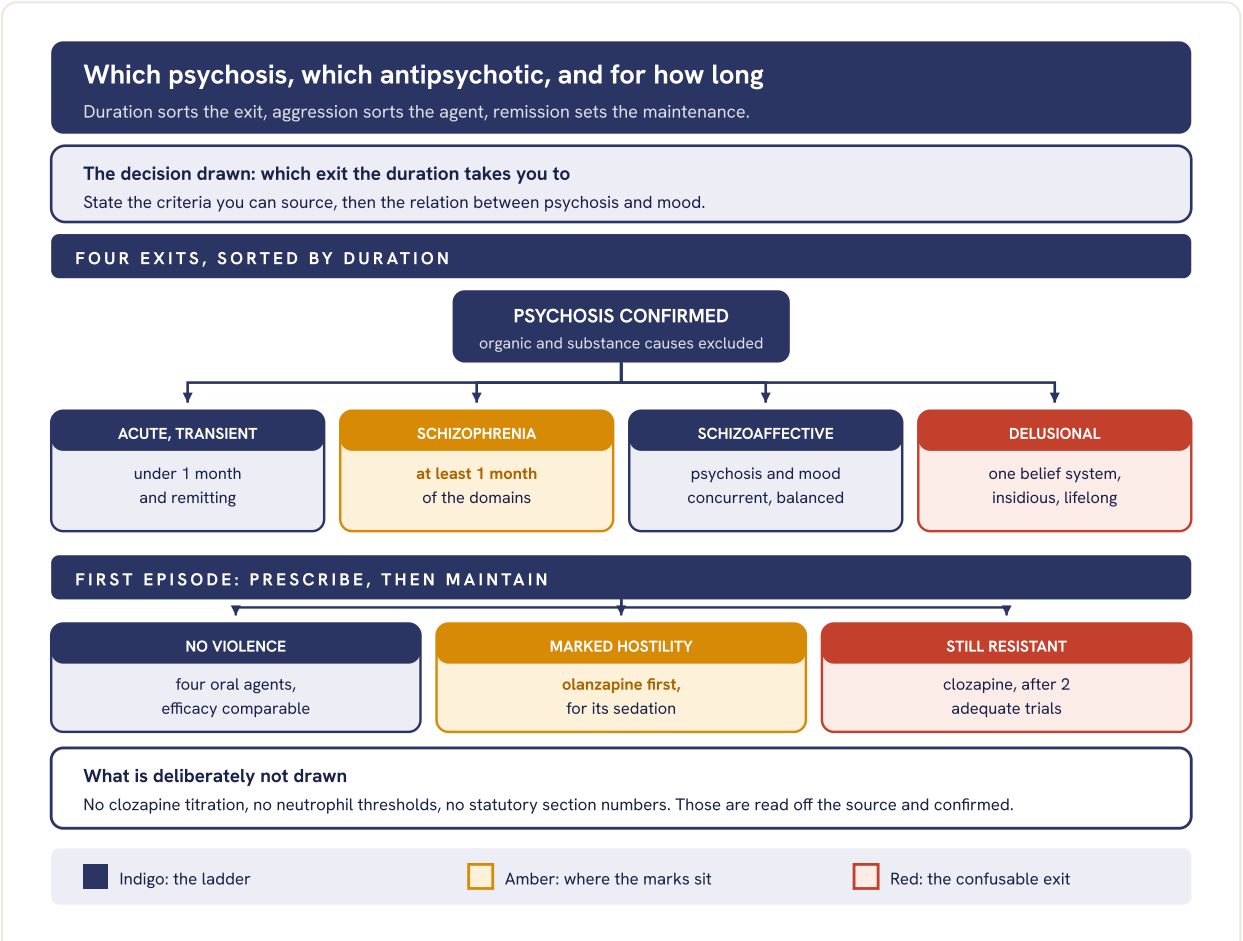


Fig 19.1 The psychosis ladder drawn as four exits sorted by duration, with the first-episode prescription stratified by aggression beneath it and the clozapine gate held in red.

- **Exclusions, said out loud.** Not a medical or central nervous system disorder, not substance intoxication or withdrawal, and affective symptoms do not dominate.
- **Maintenance.** For a first episode in remission, offer 7 to 12 months of antipsychotic treatment, then review with the patient.
- **Monitoring.** Baseline panel with a movement rating, weight at 6 weeks, the full panel at 12 weeks and annually.

WHAT EARNS THE MARKS

- **Duration used as the spine of the plate.** The four exits sort on how long the psychosis has run.
- **The middle lane of the lower tier.** Stratifying the first prescription by aggression is the step candidates omit.
- **Resistance defined before clozapine is named.** 2 adequate trials with adherence verified, not 2 prescriptions.
- **The strip that says what is not drawn.** A declared gap reads as command; a half-remembered threshold does not.

SEE ALSO V - 20 V - 22 V - 29 Weave Viva, Part II

V - 20

Bipolar disorder, current episode mania: acute and maintenance management.

10 | THE COMMON LONG CASES | SYLLABUS CORE

SKELETON

2 Entry criterion	Increased activity or energy combined with mood, not mood alone
2 Grade the episode	Hypomania at 4 days, mania at 7 days, then psychosis
4 Acute treatment	Stop the antidepressant, then combine or run monotherapy
2 Maintenance	Full dose 6 to 9 months, then who continues indefinitely

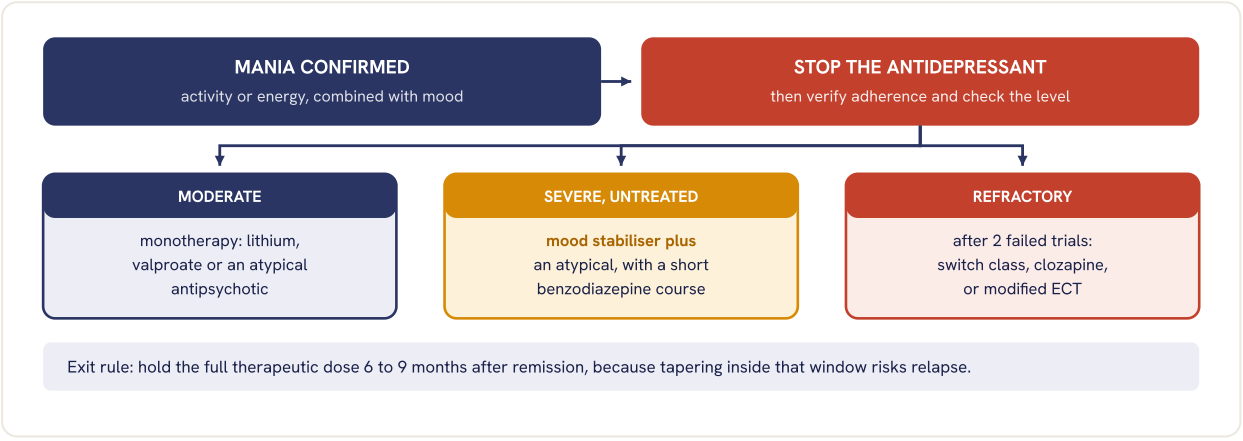


Fig 20.1 Acute mania drawn as one irreversible first step, three lanes sorted by severity and response, and the continuation rule carried as a strip along the foot.

- **Mixed episode.** Full manic criteria with 3 or more concurrent depressive symptoms, and it answers better to valproate or an atypical than to lithium alone.
- **The valproate argument.** Standardised mean difference against placebo 0.16, where the comparators run 0.37 to 0.56.
- **Indefinite maintenance.** Relapse on treatment, 2 or more affective episodes in 5 years, highly lethal attempts, residual symptoms, dependence.

PITFALL

Elevated mood on its own no longer opens the door: the current framing wants increased activity or energy alongside it. And a strong acute effect does not rescue valproate in a woman of childbearing potential, where its teratogenic liability is the highest of the bipolar agents.

WHAT EARNS THE MARKS

- **The red box, placed first.** Stopping the antidepressant precedes every other decision on the page.
- **Three lanes kept apart.** One undifferentiated list of antimanic drugs reads as recall.
- **The effect size quoted as a number.** 0.16 against 0.37 to 0.56 settles the valproate argument.
- **The foot strip.** Most candidates stop at remission and lose the maintenance mark.

SEE ALSO V - 19 V - 21 V - 31 Weave Viva, Part II

V - 21

Bipolar depression versus unipolar depression, and the treatment that differs.

10 THE COMMON LONG CASES SYLLABUS CORE

SKELETON

2	Both, defined	One cross-section, two illnesses; name the axis that separates them
4	The grid	Domain by domain, with the discriminator marked
2	The treatment fork	Quetiapine leads; antidepressant monotherapy is not recommended
2	What follows	Switch, cycle acceleration and induced rapid cycling

DOMAIN	BIPOLAR DEPRESSION	UNIPOLAR DEPRESSION	WHAT SETTLES IT
Age at onset	First episode before 25 years, averaging 6 years earlier	Later, and more evenly spread	**A first episode before 25 years with 5 or more prior episodes**
Family history	A first-degree relative with bipolar disorder, or who died by suicide	Unipolar illness or none	**A bipolar first-degree relative, asked for by name**
Episode texture	Psychotic features, psychomotor agitation, postpartum onset	Neither, as a rule	**Postpartum onset of depression or psychosis**
Drug response	Non-response 51.3 per cent	31.6 per cent	**Non-response 1.6 times commoner, and modern agents do no better than tricyclics**
Switch to mania	48.8 per cent	0.0 per cent	**Switch across classes: reuptake inhibitors 22.0 per cent, bupropion 20.7 per cent**
First line	Quetiapine, lurasidone, lithium, lamotrigine, cariprazine	A reuptake inhibitor	**Antidepressant monotherapy is not recommended on this side of the grid**

Amber cells are the discriminators. The rest of the column is supporting evidence, and saying so is itself a mark.

- **The overlap.** A mood stabiliser cuts switch to 18.8 per cent from 81.3 per cent, without preventing cycle acceleration at 25.6 per cent or induced rapid cycling at 32.1 per cent.

PITFALL

A screening questionnaire is treated as the answer. It aids case-finding and lacks the sensitivity and specificity to stand alone, so mood charting and collateral history settle the boundary. The defensible position on drugs is an adjunctive reuptake inhibitor or bupropion, second-line, and only alongside a therapeutic mood stabiliser.

WHAT EARNS THE MARKS

- **The switch figures given as numbers.** 48.8 per cent against 0.0 per cent is what carries the argument.
- **The discriminators named as discriminators.** Listing ten red flags without ranking them is a mid-band answer.
- **The overlap answered separately.** A mood stabiliser reduces switch and does not abolish cycling.

SEE ALSO V - 20 V - 22 Weave Viva, Part II

V - 22

Severe depression with psychotic symptoms: grading, ECT decision, continuation.

10 THE COMMON LONG CASES SYLLABUS CORE

SKELETON

2 Time the psychosis	Only in the episode, persisting without it, or preceding it
2 Grade and assess risk	Severity, suicidality, food and fluid refusal, medical urgency
4 Choose the route	Combination or electroconvulsive therapy, with the safeguards
2 Continuation	Full acute dose 4 to 9 months, then who is maintained

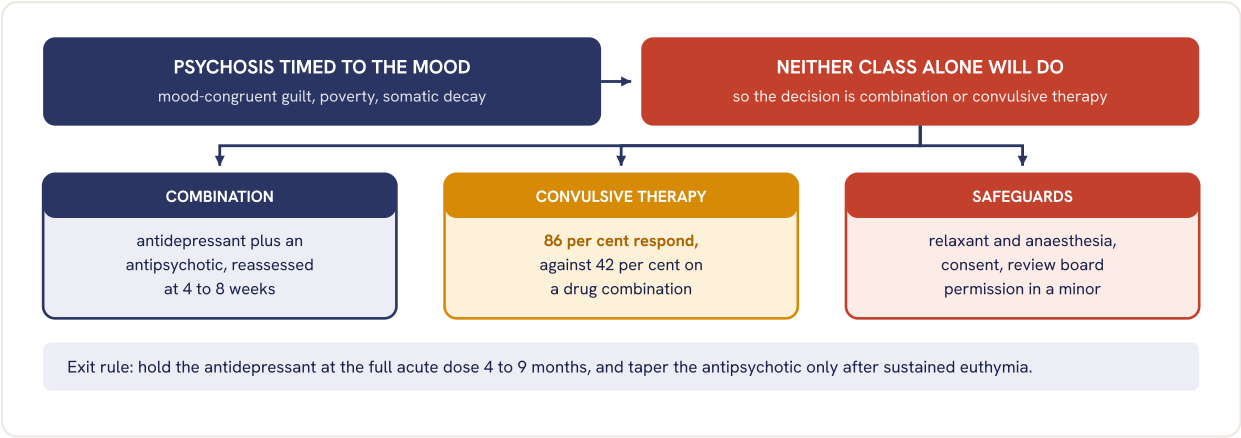


Fig 22.1 Psychotic depression drawn as one decision that forecloses monotherapy, the two routes out of it with their evidence, and the continuation rule as a strip along the foot.

- **The trial to name.** 259 patients, half aged 60 and older, olanzapine with sertraline against olanzapine with placebo over 12 weeks, combination remitting more.
- **After the course.** Relapse is rapid without prophylaxis, and the best-supported regimen is lithium with nortriptyline.
- **Maintenance.** 3 or more lifetime episodes, chronic depression, 2 severe episodes in 5 years, past psychotic or highly suicidal episodes, residual symptoms.

PITFALL

Halving the antidepressant once the psychosis clears. Continuation runs at the full acute dose, and it is the antipsychotic that comes off first, cautiously, after euthymia holds. The statutory section numbers governing this treatment are read off the bare Act and confirmed rather than recalled.

WHAT EARNS THE MARKS

- **The red box, stated before any drug.** Neither class alone clears both halves of the syndrome.
- **The comparison quoted.** 86 per cent against 42 per cent is what justifies the convulsive lane.
- **The foot strip.** Full acute dose in continuation, with the antipsychotic tapered first.
- **Safeguards named as substance plus a declared gap.** Relaxant, anaesthesia, consent, and the section confirmed.

SEE ALSO V - 21 V - 23 Weave Viva, Part II

V - 23

Obsessive compulsive disorder: Y-BOCS, SSRI dosing and duration, ERP, augmentation.

10 | THE COMMON LONG CASES | SYLLABUS CORE

SKELETON

2 **Phenomenology**	Own mind, ego-dystonic, resisted, then the insight specifier
2 **Rate the severity**	Ten core items, five each side, rated zero to four
4 **Dose, then hold**	The obsessional multiplier, then the exposure course
2 **Augment and maintain**	A low-dose antagonist, assessed and stopped on time

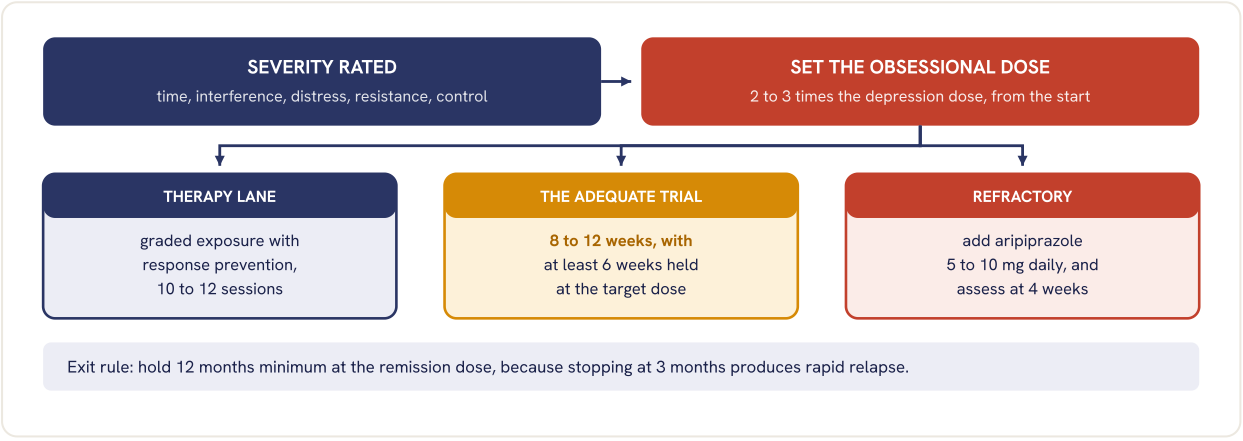


Fig 23.1 The obsessional algorithm drawn as one dose decision at the outset, three lanes for therapy, an adequate trial and refractory augmentation, with the maintenance rule along the foot.

- **Phenomenology.** Recognised as arising from the patient's own mind, ego-dystonic and resisted, which separates an obsession from depressive rumination, delusion and tic.
- **What exposure buys.** Response 70 per cent for exposure alone against 49 per cent on a reuptake inhibitor, and combining the two adds an effect size of 0.14, which does not reach significance.
- **The commonest loss.** Declaring failure at 4 to 6 weeks on fluoxetine 20 mg or sertraline 50 mg exhausts the first-line agents before either has had a fair trial.

PITFALL

The Indian severity bands, mild 16 to 19, moderate 20 to 29 and severe 30 to 40, come from the child and adolescent guideline and are scoped to people aged 16 years or younger. Adult thresholds were not available in the sourced material, and saying so is stronger than offering a paediatric cut-off as an adult one.

WHAT EARNS THE MARKS

- **The dose multiplier written out.** 2 to 3 times the depression dose, held 8 to 12 weeks with 6 weeks at target.
- **Exposure ranked above augmentation.** Its effect size is 1.53 against waitlist, while an antagonist helps about one refractory patient in three.
- **The foot strip.** Candidates who stop at response lose the maintenance mark.

SEE ALSO V - 22 V - 30 Weave Viva, Part II

V - 24

Alcohol dependence with complications: withdrawal, Wernicke, relapse prevention.

10 THE COMMON LONG CASES SYLLABUS CORE

SKELETON

2 Diagnose and quantify	Three of six features in a year, then screen and quantify
2 Decide the setting	Unit count, past seizures or delirium, comorbidity, support
4 Run the clock, prescribe	Four syndromes by onset, benzodiazepine chosen for the liver
2 Protect, then prevent	Thiamine before glucose, then anticraving with monitoring

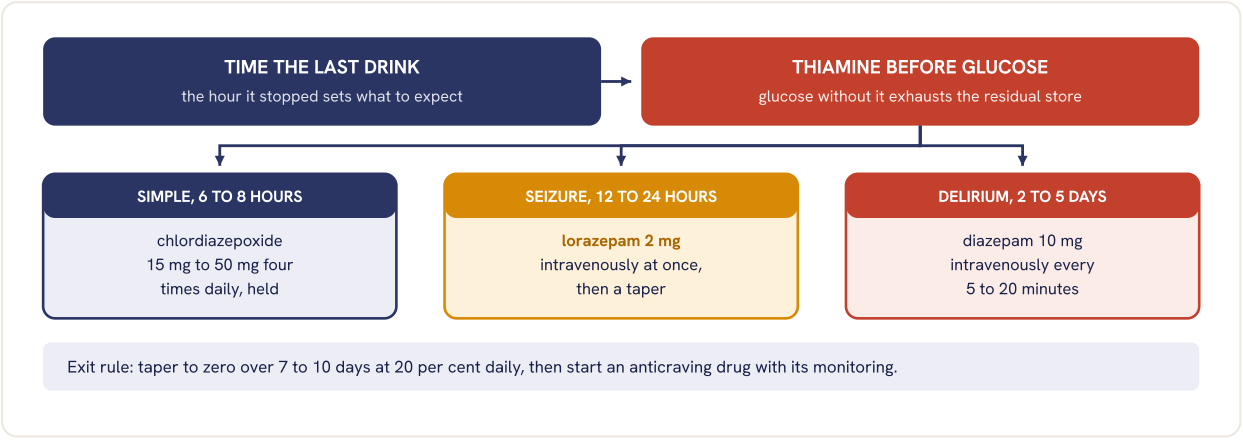


Fig 24.1 Withdrawal drawn as one protective step taken before glucose, three lanes sorted by the hour of onset, and the taper and relapse-prevention rule along the foot.

- **The liver rule.** Lorazepam and oxazepam escape phase-one hepatic oxidation, so they lead in liver disease, cognitive impairment and old age, with doses reduced there by 50 per cent.
- **Three confusions.** Delirium tremens brings an autonomic storm with coarse tremor; Wernicke encephalopathy brings quiet confusion, nystagmus, abducens palsy and truncal ataxia; hepatic encephalopathy brings asterixis and jaundice, and a benzodiazepine worsens it.
- **Anticraving choice.** Acamprosate is contraindicated above a serum creatinine of 120 micromoles per litre, and disulfiram needs written consent and a start at least 24 hours after the last drink.

PITFALL

Symptom-triggered dosing off the withdrawal scale is efficient and it is unsuitable in community care or after past withdrawal seizures, where a fixed schedule is safer. Phenytoin does not prevent withdrawal seizures, and an antiepileptic belongs to an independent seizure disorder rather than to this one.

WHAT EARNS THE MARKS

- **The red box placed first.** Thiamine precedes parenteral glucose, and the reason is given.
- **The clock given in hours.** 6 to 8, 8 to 12, 12 to 24, then 2 to 5 days, each with its discriminator.
- **An anticraving drug named with its monitoring.** A detoxification answer that stops at discharge is incomplete.

SEE ALSO V - 25 V - 29 Weave Viva, Part II

V - 25

Opioid dependence: withdrawal, buprenorphine and naltrexone, the Indian OST rules.

10 THE COMMON LONG CASES SYLLABUS CORE

SKELETON

2 **Present the history**	Agent, route, daily quantity, duration, and the last dose
2 **Time the window**	Short acting withdraws early, long acting withdraws late
4 **Induce and titrate**	Objective signs first, then the dose that retains patients
2 **Maintain or antagonise**	Supervised dispensing, naltrexone after washout, harm reduction

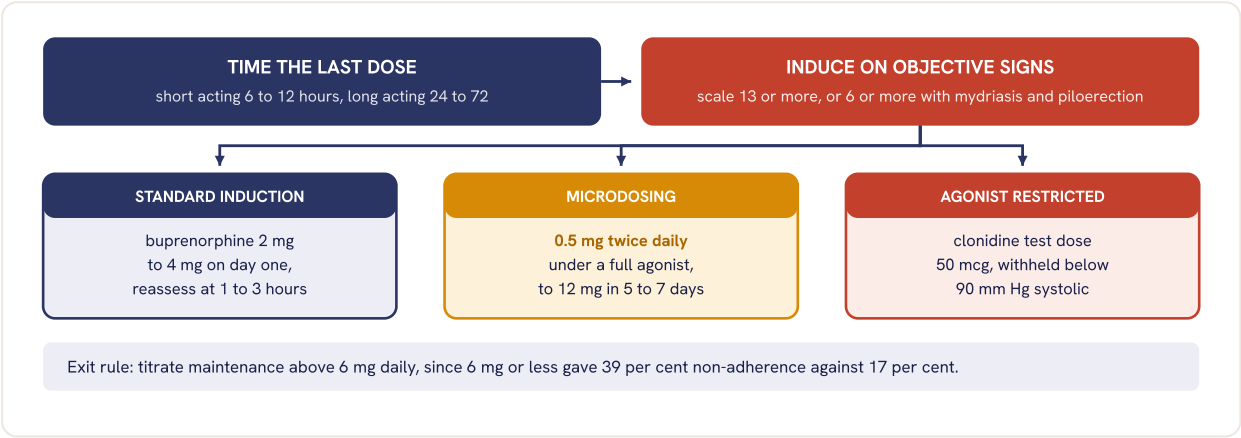


Fig 25.1 Opioid induction drawn as one objective-signs gate, three lanes for standard induction, microdosing and the agonist-restricted setting, with the retention dose along the foot.

- **The Indian profile.** Prescription opioids account for 53 per cent of cohorts starting buprenorphine and illicit opioids 38 per cent, with lifetime injecting in 35 per cent.
- **Ceiling and combination.** Half-life 37 hours and an agonist ceiling above 24 mg daily, with naloxone co-formulated, so the ceiling limits respiratory depression while sublingual naloxone deters injection only.
- **Precipitated withdrawal.** It arrives within 1 to 3 hours of the dose and is misread as under-dosing: a tighter-binding partial agonist has displaced a full one.

PITFALL

Naltrexone belongs after complete detoxification and is contraindicated while receptors remain occupied, buprenorphine included. The opioid-free interval required before the first dose and the naloxone challenge dose are not carried by the sourced material, so quote a local protocol and verify both beforehand.

WHAT EARNS THE MARKS

- **The induction gate named as objective.** A withdrawal score with mydriasis and piloerection, not reported distress.
- **The Indian maintenance figure.** Mean 6.7 mg daily, with adherent patients on 7.7 mg against 4.3 mg.
- **Harm reduction inside the plan.** Sterile equipment, testing and overdose education, not a separate afterthought.

SEE ALSO V - 24 V - 30 Weave Viva, Part II

V - 26

Dissociative convulsions versus epilepsy, and managing dissociative disorder.

10 THE COMMON LONG CASES SYLLABUS CORE

SKELETON

2 Place the phenomenon	Agency is the axis: possession against thought insertion
4 The grid	Semiology, then the tests, with the discriminator marked
2 The overlap	Frontal lobe epilepsy, and shared trance in clusters
2 What follows	Containment, gain reduction, and no antiepileptic started

DOMAIN	DISSOCIATIVE CONVULSION	EPILEPTIC SEIZURE	WHAT SETTLES IT
Setting	Emotional trigger, usually witnessed	Unprovoked, may arise from sleep	**Onset from sleep favours frontal lobe epilepsy**
Motor pattern	Asynchronous thrashing, head shaking, pelvic thrusting	Stereotyped, synchronous tonic then clonic	**Asynchrony against stereotypy, at the bedside**
Eyes	Tightly closed, resisting passive opening	Open or deviated	**Active resistance to eye opening**
Ictal video electroencephalography	No epileptiform correlate during a habitual event	Electroclinical correlate present	**The reference test, and the one that settles it**
Post-ictal prolactin	Often unchanged, and it also rises after syncope	Above 500 IU/mL in 90 per cent of generalised tonic-clonic seizures	**An adjunct: specificity 73 per cent, and focal aware seizures leave it normal**
Interictal record	Spike-and-wave may appear without concordance	Spikes support an established diagnosis	**Without ictal concordance this is not epilepsy**

Amber cells are the discriminators. The rest of the column is supporting evidence, and saying so is itself a mark.

- **What replaces the prescription.** A quiet room, protection from injury without aggressive restraint, clustered cases separated, and 6 sessions of gain-reduction work with grounding, resolving within 1 week and stable at 3-month follow-up.
- **The overlap.** Frontal lobe seizures mimic dissociation with hypermotor features; stereotypy, brevity, onset from sleep and no emotional trigger separate them.

PITFALL

Possession is read as psychosis. It disrupts agency, the sense of owning one's thoughts and actions, whereas thought insertion places alien thoughts inside a preserved identity. Sanctioned ritual trance without distress or impairment is not pathological.

WHAT EARNS THE MARKS

- **Video electroencephalography named as the reference test.** Everything else on the page is ranked below it.
- **Prolactin offered with its limits.** Specificity 73 per cent, normal after focal aware seizures, and raised after syncope.
- **The interictal spike refused as proof.** Starting an antiepileptic on it is the error the examiner is listening for.

SEE ALSO V - 27 V - 31 Weave Viva, Part II

V - 27

Somatic symptom and bodily distress disorder: reattribution and management.

10 | THE COMMON LONG CASES | SYLLABUS CORE

SKELETON

2 The conceptual shift	A rule-in diagnosis, not a hunt for the unexplained
2 The essential features	Distress, excessive attention, persistence, impairment, duration
4 Communicate, then treat	Validate, refuse the dichotomy, explain amplification, renegotiate
2 Separate the neighbours	Hypochondriasis, functional neurological signs, the acronym traps

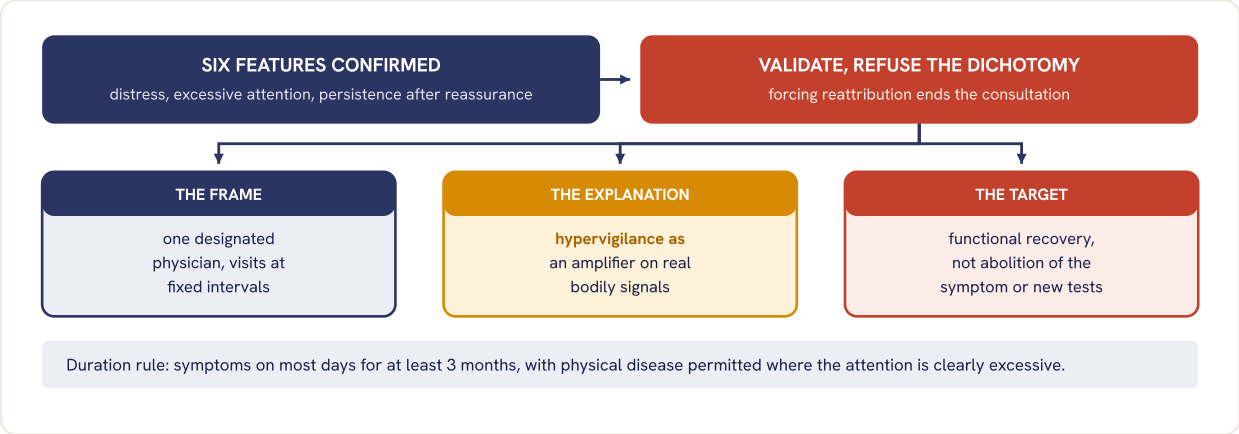


Fig 27.1 Bodily distress drawn as one communication step taken before any plan, three lanes for the consultation frame, the explanation offered and the treatment target, with the duration rule along the foot.

- **Why the shift matters.** The older framework required symptoms to be medically unexplained and left somatisation disorder near 0.1 per cent in primary care, so clinicians were asked to prove a negative.
- **The three neighbours.** Against hypochondriasis the discriminator is what the patient wants, reassurance against relief; against dissociative neurological symptom disorder it is positive signs of internal inconsistency such as the Hoover sign; against somatic passivity it is intact reality testing.

PITFALL

Three names share initials, and only one is the diagnosis. Bodily distress disorder needs positive psychobehavioural features. Bodily distress syndrome is a research construct grouping functional somatic syndromes and still requires medical inexplicability. Bodily stress syndrome is a primary care proposal. Body dysmorphic disorder sits under the obsessive compulsive group.

WHAT EARNS THE MARKS

- **The diagnosis framed as rule-in.** Six positive features, so nobody is asked to prove a negative.
- **The red box placed first.** Validation sits upstream of every explanation on the page.
- **Amplification explained rather than asserted.** Hypervigilance on genuine signals is the account a patient can accept.
- **The consultation frame named.** One designated physician and fixed-interval visits are what stop the investigation spiral.

SEE ALSO V - 26 V - 30 Weave Viva, Part II

V - 28

Dementia: Alzheimer, vascular, Lewy body and frontotemporal, told apart at the bedside.

10 THE COMMON LONG CASES SYLLABUS CORE

SKELETON

2 The informant history	Onset, course, functional decline, taken from somebody else
4 The grid	Course and imaging by subtype, with the discriminator marked
2 The overlap	Mixed disease, and the one-year rule for Lewy body
2 What follows	Reversible causes, then drugs and behavioural symptoms

SUBTYPE	COURSE AND ONSET	IMAGING OR SIGN	WHAT SETTLES IT
Alzheimer disease, 50 to 60 per cent	Insidious, smoothly progressive, early episodic memory loss	Medial temporal atrophy	**Smooth progression with memory first**
Vascular, 15 to 20 per cent	Stepwise, with executive deficits and focal signs	White matter change and lacunar infarcts	**Stepwise decline with focal neurological signs**
Lewy body disease	Attention fluctuating over hours, well-formed visual hallucinations	Spontaneous parkinsonism, dream enactment in sleep	**Cognition fails within 1 year of parkinsonian signs**
Parkinson disease dementia	Motor disease established first	Long-standing parkinsonism	**Cognition follows motor disease by at least 1 year**
Frontotemporal	Early disinhibition, apathy, language breakdown, onset 45 to 64 years	Asymmetric frontal and anterior temporal atrophy	**Frontal onset, the one misread as late-onset mania**
Reversible causes	Subacute, with a systemic clue	Thyroid, vitamin B12, syphilis, hydrocephalus	Excluded before any subtype is named

Amber cells are the discriminators. The rest of the column is supporting evidence, and saying so is itself a mark.

- **The bedside battery.** The Mini-Mental State runs 0 to 30 points, with fewer than 24 indicating impairment, but it is education-dependent, so the Montreal instrument is preferred early.
- **Neuroleptic sensitivity.** Up to 50 per cent of Lewy body patients show catastrophic neuroleptic sensitivity, so quetiapine is the oral choice and a high-potency antagonist is ruled out.

PITFALL

Behavioural symptoms are answered with a drug first. Non-pharmacological measures lead: screen pain, illness, drug effects and sensory overload, then work the antecedent, behaviour and consequence frame. Atypical antipsychotics carry roughly a threefold stroke risk, so review at least every 6 weeks and re-justify continuation beyond 3 months.

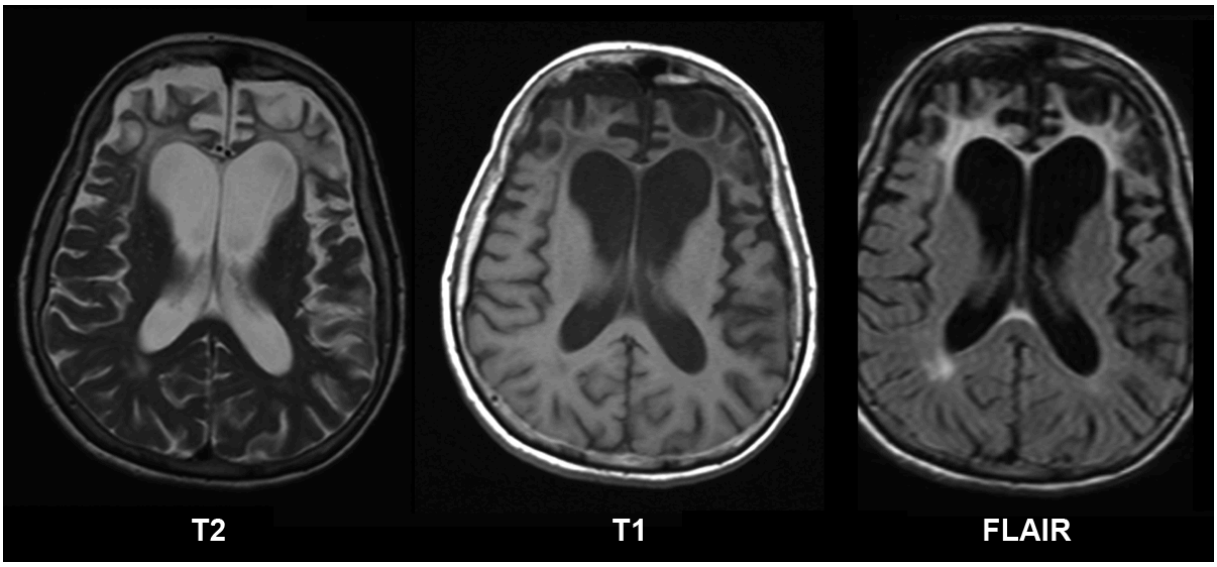
WHAT EARNS THE MARKS

- **Course used to sort the subtype.** Smooth, stepwise, fluctuating or frontal-onset, each with its imaging correlate.
- **The one-year rule stated.** It is what separates Lewy body disease from Parkinson disease dementia.
- **Reversible causes excluded first.** Naming a subtype before that is the order error.

SEE ALSO V - 29 Weave Viva, Part II

Frontal atrophy across three MRI sequences

Companion to original page 41



MRI, axial images labelled T2, T1 and FLAIR in the source. Frontal cortical and white-matter atrophy in the source case labelled Pick disease. The sequence labels belong to the source montage. MRI demonstrates an atrophy pattern, not the histological diagnosis of Pick disease.

Compare the anterior atrophy pattern with the medial temporal atrophy plate.

Mikhail Kalinin. Pick's disease.png. CC BY-SA 3.0. https://commons.wikimedia.org/wiki/File:Pick%27s_disease.png Licence: https://creativecommons.org/licenses/by-sa/3.0 Unmodified.

V - 29

Delirium: causes, the confusion assessment method, management.

10 THE COMMON LONG CASES SYLLABUS CORE

SKELETON

2 **Confirm delirium**	Four features, and the rule that makes it positive
2 **Subtype and contrast**	The quiet one is missed, then dementia and depression
4 **Treat the cause**	Screen the precipitants, then multicomponent care before any drug
2 **Drugs, honestly**	What haloperidol does, and where a benzodiazepine belongs

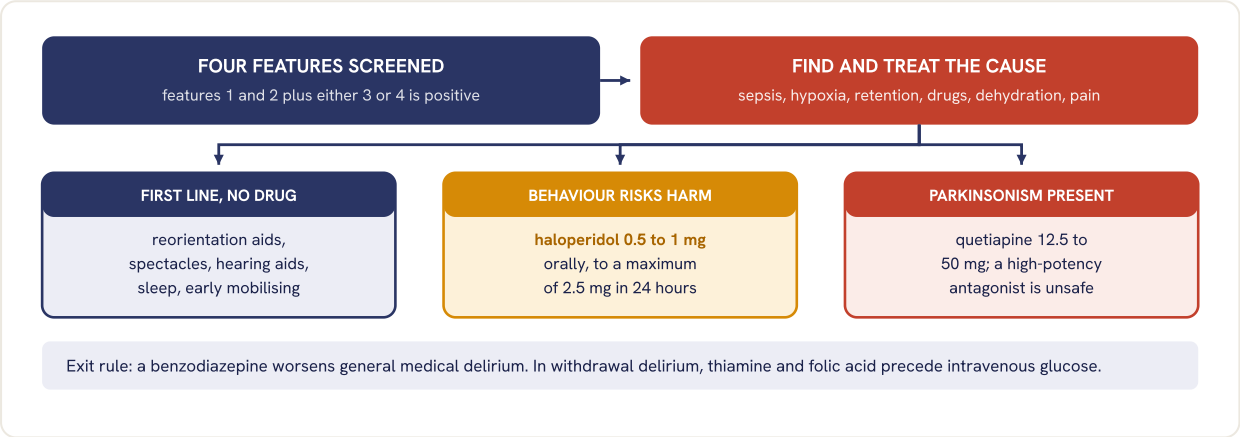


Fig 29.1 Delirium drawn as one screening rule, a cause-finding step placed before any prescription, three lanes for non-drug care and for behaviour that risks harm, with the benzodiazepine rule along the foot.

- **Thresholds worth carrying.** Oral intake below 1200 mL per 24 hours is dehydration, saturation below 90 per cent is hypoxia, and a post-void residual above 200 mL needs catheterisation at 8-hour intervals.
- **The quiet patient.** The hypoactive subtype is misread as depression, dementia or ageing. It disturbs no ward routine, so the underlying urosepsis or hypoxaemia goes undetected.

PITFALL

Haloperidol is offered as a treatment for the delirium itself. A review of 6 randomised trials in 2863 intensive care patients found no significant reduction in short-term mortality, odds ratio 0.89, and no difference in delirium resolution. It shortened intensive care stay by about a day. It stabilises behaviour in a crisis, which is a different claim.

WHAT EARNS THE MARKS

- **The diagnostic rule, not the four features alone.** Features 1 and 2 plus either 3 or 4 is what makes it positive.
- **The red box placed first.** The cause is treated before the behaviour.
- **The haloperidol evidence given honestly.** A shorter intensive care stay, with mortality and resolution unchanged.
- **The benzodiazepine exception named.** Withdrawal delirium, where thiamine precedes glucose.

SEE ALSO V - 24 V - 28 Weave Viva, Part II

V - 30

Panic disorder with agoraphobia and generalised anxiety disorder.

10 THE COMMON LONG CASES SYLLABUS CORE

SKELETON

2 Define and threshold	Worry for six months; attacks plus a month of dread
2 Exclude the mimics	Coronary and respiratory emergency, phaeochromocytoma, substances
4 Stepped care	Identification, self-help, active treatment, specialist referral
2 Titrate and review	Half the starting dose, then the interval schedule

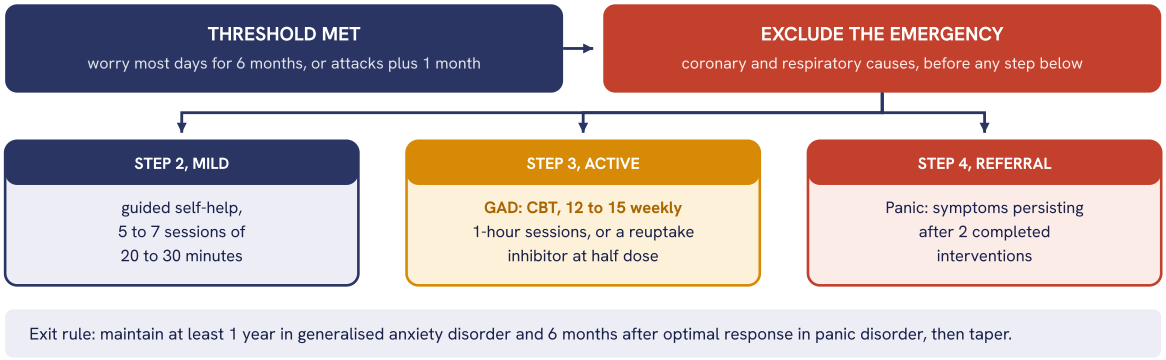


Fig 30.1 Stepped care drawn as one exclusion taken before any psychiatric step, three lanes for self-help, active treatment and specialist referral, with the maintenance rule carried along the foot.

- **The review clock.** Panic disorder at 2, 4, 6 and 12 weeks, then at 8 to 12 week intervals; generalised anxiety disorder every 2 to 4 weeks for 3 months and every 3 months after.
- **Under thirty.** Patients under 30 years carry raised risk of treatment-emergent suicidal ideation, and are reviewed within 1 week and weekly through the first month.

PITFALL

A benzodiazepine is reached for to settle the attacks. It is not prescribed in panic disorder, and in generalised anxiety disorder it is held to crisis use not normally beyond 2 to 4 weeks. Propranolol is not recommended for either. Pregabalin answers intolerance of both reuptake inhibitor classes, and it carries abuse liability, withdrawal and a pregnancy malformation signal.

WHAT EARNS THE MARKS

- **Half the usual starting dose, with the reason.** The activation syndrome is what the warning to the patient is about.
- **The red box placed first.** The medical emergency is excluded before any psychiatric step.
- **Review intervals given as numbers.** 2, 4, 6 and 12 weeks in panic disorder, not a vague promise of follow-up.
- **Maintenance stated per disorder.** A year against six months is the distinction being tested.

SEE ALSO V - 23 V - 27 Weave Viva, Part II

V - 31

Borderline personality disorder: the ICD-11 model, DBT, what drugs can and cannot do.

10 THE COMMON LONG CASES SYLLABUS CORE

SKELETON

2 General requirements	Dysfunction in self and interpersonal domains, pervasive and enduring
2 Grade severity	Five tiers, and the first two are not disorders
4 Stratify the therapy	Severity sets how many modes of therapy are needed
2 What drugs cannot do	Adjunctive, secondary to therapy, and no agent established

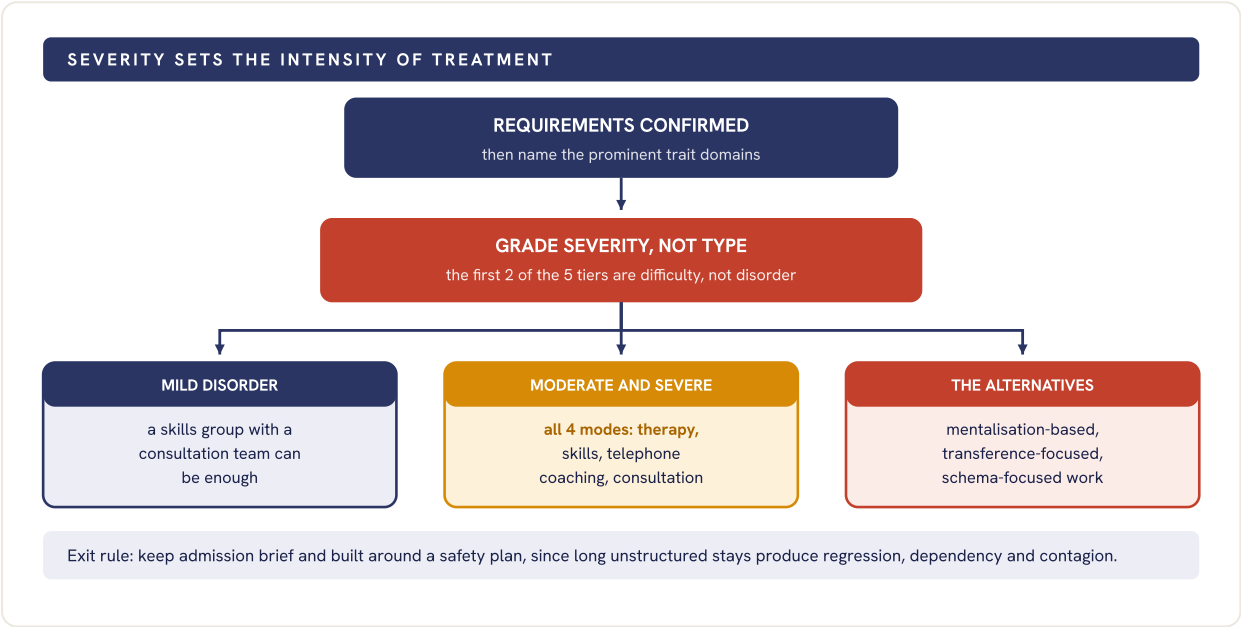


Fig 31.1 The borderline pattern drawn as one severity judgement taken before any treatment choice, three lanes for mild, moderate and severe illness and for the alternative therapies, with the admission rule along the foot.

- **The qualifier.** Its four components are affective instability, unstable self-concept with chronic emptiness, frantic efforts to avoid abandonment, and impulsive or self-harming regulation.
- **The emergency load.** It accounts for 35 per cent of suicide attempts and 22 per cent of self-harm presentations in emergency departments, at a community prevalence of 0.7 to 2.7 per cent.

PITFALL

A drug is offered as treatment for the pattern itself. No agent is established to alter the core pathology, prescribing is adjunctive and secondary to structured psychotherapy, and the sourced material carries no agent or dose to quote. Saying that plainly is worth more than naming something.

WHAT EARNS THE MARKS

- **Severity used to set therapy intensity.** Mild illness can take skills with a consultation team; moderate and severe need all four modes.
- **The trait domains named.** Negative affectivity, detachment, disinhibition, dissociality and anankastia.
- **The severity instrument with its cut-offs.** 14 items, with 12 mild, 16 moderate and 19 severe.
- **Pharmacology stated honestly.** Adjunctive, secondary, with no agent established for the core pathology.

SEE ALSO V - 21 V - 26 Weave Viva, Part II

V - 32

Postpartum psychiatric disorders: blues, depression, psychosis, and prescribing in lactation.

10 | THE COMMON LONG CASES | SYLLABUS CORE

SKELETON

2 Place it on the spectrum	Onset, perceptual disturbance and insight separate the three
2 Exclude the organic	Thyroiditis, sepsis, eclampsia, sinus thrombosis, deficiencies
4 Treat the psychosis	The stepwise algorithm, and the setting that protects the infant
2 Prescribe in lactation	Olanzapine leads, and lithium with structured monitoring

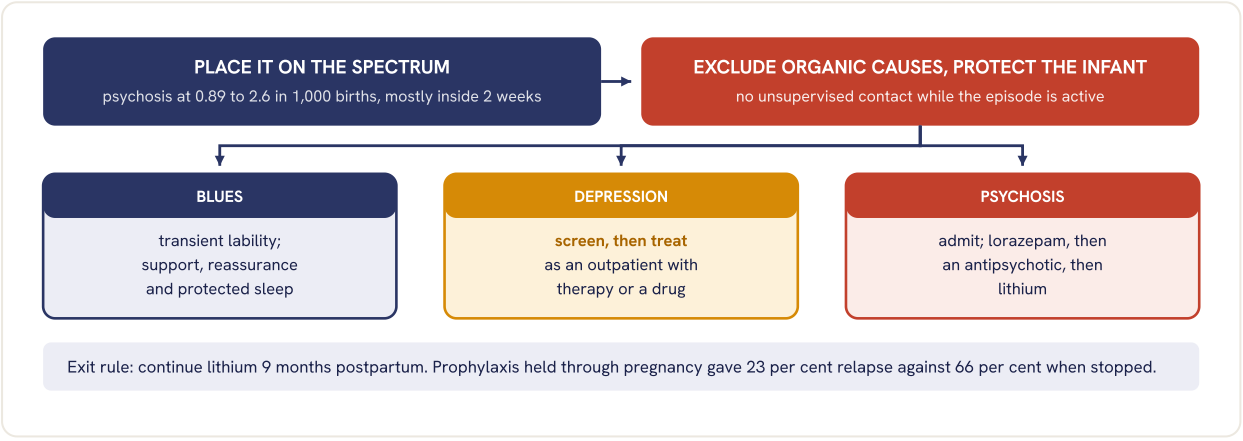


Fig 32.1 The postpartum presentation drawn as one exclusion and one safeguarding step taken together, three lanes for blues, depression and psychosis, with the prophylaxis rule carried along the foot.

- **The stepwise algorithm.** Bedtime lorazepam remitted 6.3 per cent, adding an antipsychotic for 2 weeks a further 18.8 per cent, and adding lithium a further 73.4 per cent, cumulative 98 per cent, with electroconvulsive therapy at 12 weeks.
- **Risk, named.** Infanticide 4 per cent, maternal suicide 5 per cent, recurrence 50 per cent, with motives of altruistic delusion or command hallucination, and violent methods in perinatal suicide.

PITFALL

Treatment is withheld because she is breastfeeding. Olanzapine 10 to 20 mg daily leads, with the infant watched for sedation, poor feeding and weight gain; lithium is not absolutely contraindicated where monitoring is structured; and electroconvulsive therapy has no chemical excretion into milk. The cut-off on the postnatal depression scale is not carried by the sourced material, so read it off the manual.

WHAT EARNS THE MARKS

- **The red box placed first.** Organic causes excluded, and infant contact addressed explicitly.
- **The onset window given.** Most episodes begin inside the first two weeks, and 90 per cent within four weeks.
- **Breastfeeding answered rather than avoided.** An agent named, with the infant monitoring that goes with it.

SEE ALSO V - 20 V - 22 Weave Viva, Part II

AREA 04 OF 10 · PV-A04

Psychiatry short cases

10	10.0%	V-33	V-42
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

SYLLABUS CORE 10

REVISION ORDER

Learn the short case schema first, since the other slots here are run through it. Then the drug-induced syndromes together, and the rest as they stand.

WHAT IS IN THIS AREA

The twenty-minute short case, then nine problems set as short cases: catatonia, the drug-induced syndromes, capacity, alcohol withdrawal and lithium toxicity. Epilepsy, medical illness and the patient seen after a suicide attempt complete the area.

V - 33

The twenty-minute short case: schema and what examiners cut.

10 | PSYCHIATRY SHORT CASES | SYLLABUS CORE

SKELETON

2 **Name the instrument**	Syndromic triage under time pressure, not a life history
2 **Declare the pruning**	Say what you left out, and give the reason
3 **Cross-sectional state**	Signs elicited, positives first, then pertinent negatives
3 **Formulation and disposition**	One sentence, then risk, organicity and the next hour

THE INSTRUMENT, IN ONE LINE

The long case asks who this person is; the short case asks what is wrong now and what you will do. Four beats carry it: syndrome, risk, organicity, disposition. A sign is what you elicited, a symptom what was recounted.

DOMAIN	LONG CASE	SHORT CASE	WHAT THE EXAMINER HEARS
Objective	Complete biographical and developmental life chart	Syndromic identification and risk triage	**You know which instrument is in use**
Development	Antenatal to adulthood milestones	Asked only if neurodevelopmental deficits emerge	Pruning with a stated reason
Negatives	Systematic and complete	Pertinent only: category, organicity, risk	**Selection, not omission**
Mental state	Granular inventory of phenomena	Focused evaluation of core functions	Signs with their elicitation
Presentation	Narrative, chronological	Positives first, then preserved functions	An order that needs no interrupting

Amber cells are what separates a pruned short case from a shortened long case.

- **The focused examination.** Consciousness, orientation, attention, perception, thought, memory, volition, with thought split into stream, form and content. Historical surveys subdivide it into 6 to 18 items; descriptive psychopathology settles on seven core functions.
- **The formulation.** One sentence, fixed order: age and background, premorbid baseline, course and onset, duration, the psychopathological cluster, stressors and organic triggers present or absent, decline and risk, then the provisional syndrome.
- **Two traps.** The anamnesis fallacy, calling a complaint of forgetfulness a memory sign. And quoting a fixed number of minutes as a national standard: answer with the arc, verify your own unit's allocation.

WHAT EARNS THE MARKS

- **The instrument named.** Saying this is syndromic triage shows which question is being answered.
- **The pruning row said out loud.** The omission plus its reason scores where silence does not.
- **Signs reported with their elicitation.** Digit span and delayed recall as findings, not complaints.
- **The formulation delivered without restarting.** Seven beats held in one sentence, ending in the syndrome.

SEE ALSO V - 34 catatonia at the bedside V - 42 after a suicide attempt Weave Viva, Part III

V - 34

Catatonia: Bush Francis, the lorazepam challenge, ECT, malignant catatonia.

10 PSYCHIATRY SHORT CASES SYLLABUS CORE

SKELETON

2	Define and count	Dominated by at least 3 of 12 listed features
2	Elicit the signs	The volitional signs need your hands, not observation
2	Rate it	Screen against full scale, identical threshold
3	Challenge and treat	Lorazepam, reassess by route, then scheduled dosing
1	Cause and cover	Medical workup, plus the complications of stupor

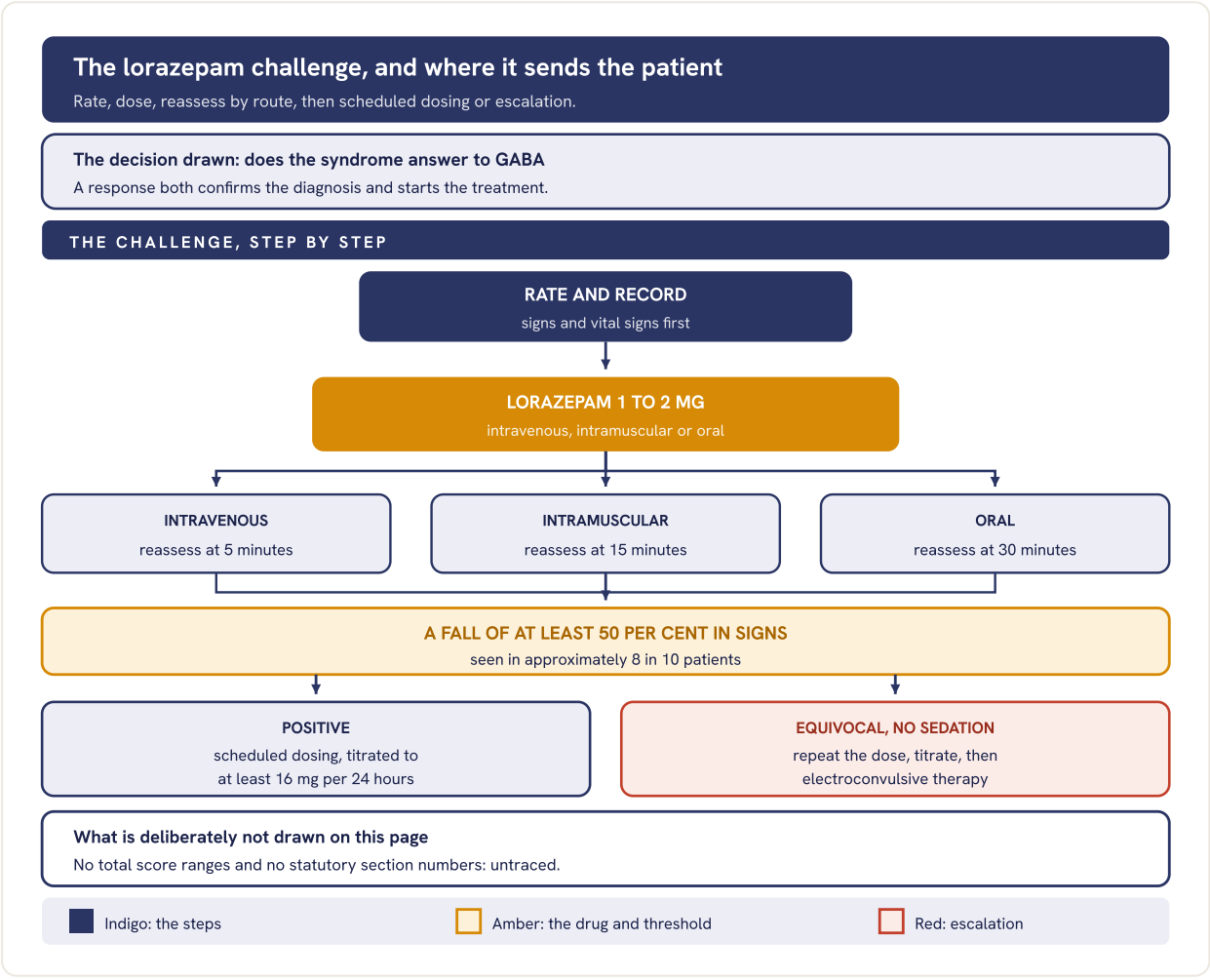


Fig 34.1 The challenge as one ladder: rate, dose by route, reassess, then scheduled dosing or escalation.

- **Rate it.** First 14 items on the screen, all 23 on the full scale scored 0 to 3, threshold at least 2 signs on both. Specificity 96.2 against 90.7 per cent, sensitivity 100 per cent.
- **Elicit, do not observe.** Apart from waxy flexibility, item 13, the volitional signs sit in items 15 to 23. Mitgehen, gegenhalten, ambitendency need your hands.
- **Malignant catatonia.** Fever, autonomic instability, rigidity. Benzodiazepines or electroconvulsive therapy promptly, bilateral, a minimum of 2 times weekly. Cover the stupor: thromboprophylaxis, fluids, feeding.

PITFALL

Stopping at anxiolytic doses of 2 to 4 mg per 24 hours is the standard error. Dopamine blockade is the mirror hazard: antipsychotics can precipitate neuroleptic malignant syndrome, so they are held back without psychosis.

WHAT EARNS THE MARKS

- **The same threshold on both instruments.** Screen and full scale, told apart.
- **The supplementary items named.** A passive screen leaves the volitional signs unexamined.
- **The challenge carried to a real dose.** Titration before failure is declared.
- **Antipsychotics held back unprompted.** The malignant syndrome hazard named first.

SEE ALSO V - 35 rigid and febrile V - 39 medical causes Weave Viva, Part III

V - 35

Neuroleptic malignant syndrome versus serotonin syndrome versus malignant catatonia.

10 PSYCHIATRY SHORT CASES SYLLABUS CORE

SKELETON

2 The tetrad, in order	Mental state, rigidity, autonomic change, then fever
4 Separate the three	Tone, reflexes, pupils, bowel sounds, drugs
2 Criteria and enzymes	Which criteria sets, and what the enzyme can prove
2 First hour, then rechallenge	Stop the drug, support, escalate, re-expose later

DOMAIN	NEUROLEPTIC MALIGNANT	SEROTONIN SYNDROME	MALIGNANT CATATONIA
Trigger	D2 antagonists, antiemetics, agonist withdrawal	SSRIs, SNRIs, MAOIs, tricyclics, tramadol	Mood disorder or schizophrenia, no neuroleptic
Tempo	Days to weeks, 96 per cent by 4 weeks	Hours, within 24 to 72	Subacute, after excited catatonia
Tone	**Hypokinetic lead-pipe rigidity**	**Hyperkinetic, spontaneous or ocular clonus**	Posturing, waxy flexibility
Reflexes, pupils	**Hyporeflexia, normal pupils with staring**	**Hyperreflexia worse in the legs, mydriasis**	Normal or brisk, fixed unblinking gaze
Bowel sounds	**Normal or hypoactive, no diarrhoea**	**Hyperactive, cramping, diarrhoea**	Normal or decreased

Amber cells are the discriminators. Tone, reflexes and bowel sounds decide it; drug history sets the prior.

- **The criteria.** Fever is core temperature above 38.0 degrees on at least 2 occasions, and this is a diagnosis of exclusion. Hyperthermia appears in 88 per cent, rigidity in 86 per cent. Levenson takes creatine kinase above 1000 U/L, Gurrera at least 4 times the upper limit. Hunter beats Sternbach here.
- **First hour.** Stop the antipsychotic and any dopamine-blocking antiemetic, wide-bore access, saline to protect the tubules, cooling, monitored bed. Lorazepam at each severity, not intramuscularly, which corrupts the enzyme.
- **Rechallenge.** Recurrence is 30 per cent, so defer at least 2 weeks after recovery, as an inpatient, on a low D2 affinity agent. Clozapine is safest, favourable in 79 per cent.

PITFALL

Treating the enzyme as the diagnosis. It is raised in up to 70 per cent of febrile patients on antipsychotics without the syndrome. It supports and grades muscle injury. Atypicals cause this too, often with less rigidity, which delays recognition.

WHAT EARNS THE MARKS

- **The tetrad in sequence.** Mental state change precedes fever; candidates invert it.
- **Three bedside discriminators as a set.** Tone, reflexes and bowel sounds, said together.
- **The enzyme placed in context.** It supports and grades, and does not establish the diagnosis.

SEE ALSO V - 34 catatonia V - 40 drug-induced movement disorders Weave Viva, Part III

V - 36

Assessing capacity at the bedside and under the Mental Healthcare Act 2017.

10 PSYCHIATRY SHORT CASES SYLLABUS CORE

SKELETON

2	**The presumption**	Capacity presumed, decided on the balance of probabilities
3	**Three limbs**	Understand, appreciate, communicate, applied together
3	**Pick the tier**	Recent behaviour against behaviour consistent over time
2	**Safeguards**	Board notice, capacity review, advance directive, discharge planning

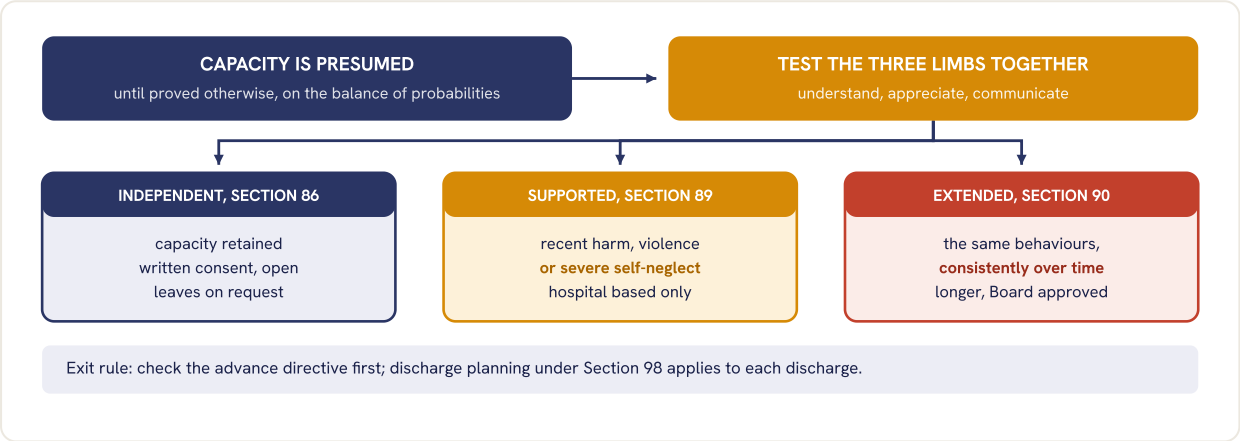


Fig 36.1 Presumption, the limbs together, then the tier by recent or consistent behaviour.

- **Probe each limb.** What do you understand of the illness and why is this treatment proposed; what follows if you take it and if you refuse; then a stable choice by speech, writing, signing or gesture. Simple language or visual aids, and capacity is decision-specific.
- **Certifiers and clock.** Section 89 takes one psychiatrist with one mental health professional or medical practitioner examining within the preceding 7 days, runs to 30 days, capacity reviewed every 7 days. Section 90 takes 2 psychiatrists examining independently, reviewed fortnightly.
- **Two safeguards.** An independent patient asking to leave goes under Section 88(1), held twenty-four hours at most and only to allow a Section 89 assessment. Board notice within 3 days for a woman or minor, 7 days otherwise.

PITFALL

Reading a diagnosis, or a decision you disagree with, as incapacity. Section 4(3) says a decision others perceive as wrong does not by itself remove capacity, and Section 3(5) says a determination of mental illness does not by itself make a person of unsound mind unless a competent court has so declared.

WHAT EARNS THE MARKS

- **The limbs with their sub-clause letters.** Given as enacted, then applied together.
- **The severity wording in the lanes.** Recent against consistent over time selects the tier.
- **The certifier count.** One psychiatrist with one professional, against two psychiatrists independently.
- **Indian provisions cited.** An unwise decision separated from incapacity on the Indian text.

SEE ALSO V - 42 after a suicide attempt V - 33 the twenty-minute short case Weave Viva, Part III

V - 37

Alcohol withdrawal: CIWA-Ar, benzodiazepine regimens, delirium tremens, thiamine.

10 PSYCHIATRY SHORT CASES SYLLABUS CORE

SKELETON

2 Stage by the clock	Hours since the last drink set the expected stage
2 Score it	Contents, thresholds, and where the scale fails
3 Choose the drug	The liver decides which benzodiazepine you reach for
3 Fits, delirium, thiamine	Benzodiazepine not phenytoin, monitored bed, parenteral thiamine

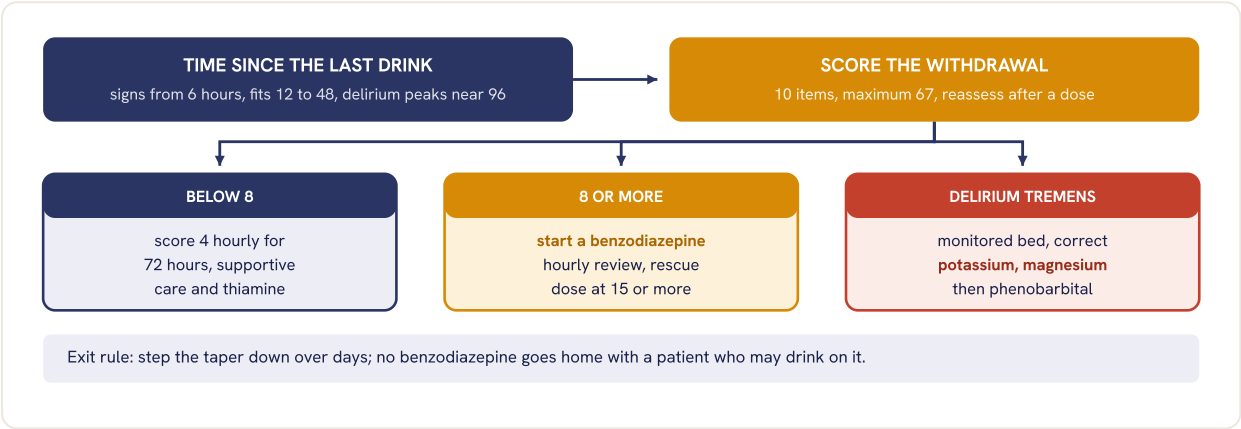


Fig 37.1 Clock and score, then the three lanes, with the exit rule on the foot.

DRUG	METABOLISM	WHERE IT FITS	CEILING
Chlordiazepoxide	Hepatic oxidation	Oral inpatient taper, liver function normal	**Maximum 200 mg in 24 hours**
Diazepam	Hepatic oxidation, long-acting metabolites	Rapid parenteral control, 5 to 20 mg every 5 to 15 minutes	Maximum 100 mg/h or 250 mg in 8 hours
Lorazepam	**Glucuronidation, no active metabolites**	**Liver disease, elderly, fits: 1 to 4 mg every 5 to 15 minutes**	Maximum 20 mg/h or 50 mg in 8 hours

The metabolic route is the whole answer in liver disease. Rapid intravenous lorazepam also carries propylene glycol toxicity.

- **Fits.** Phenytoin is not offered here: the mechanism is GABA-A hypofunction with NMDA upregulation. Give a benzodiazepine, or buccal midazolam 10 mg without access, and check capillary glucose at once.
- **Thiamine.** Oral bioavailability is 3.7 to 5.3 per cent and transport saturates near 8.3 mg, so suspected Wernicke encephalopathy takes 500 mg intravenously three times daily. Correct magnesium or replacement fails.

WHAT EARNS THE MARKS

- **The clock given first.** Staging from the last drink before any drug is named.
- **The metabolic column read aloud.** Glucuronidation when the liver is failing.
- **Phenytoin refused with its reason.** The receptor mechanism, not a preference.
- **Thiamine parenteral, magnesium corrected.** The step candidates skip.

SEE ALSO V - 35 rigid and febrile V - 42 after a suicide attempt Weave Viva, Part III

V - 38

Epilepsy and psychosis: ictal, postictal, interictal, forced normalisation.

10 PSYCHIATRY SHORT CASES SYLLABUS CORE

SKELETON

1 **Name the axis**	Timing relative to the seizure, and management follows
4 **The four categories**	Ictal, postictal, interictal, alternative psychosis
2 **Against schizophrenia**	Later onset, warm affect, little negative deficit
3 **Forced normalisation**	Criteria, the drugs, and letting the seizures back

CATEGORY	TIMING AND LATENCY	DURATION	DOMINANT FEATURES
Ictal	During the discharge, non-convulsive status	Minutes to hours	**Confusion, automatisms, bizarre behaviour, amnesia**
Postictal	**After a lucid interval of 8 to 72 hours, 10 to 20 years on**	Days to weeks, rarely beyond 2 weeks	Religious and grandiose delusions, affective flux
Interictal	Independent of seizure timing, 10 to 15 years on	Months to years	**Paranoid delusions, affect preserved, no negative deficit**
Alternative	**Reciprocal with seizure control, mean 15.2 years**	Days to weeks	Paranoid and mood symptoms, twilight states

Amber cells are the axis working: lucid interval, preserved affect, inverse relation to seizure control.

- **Scale of the problem.** Prevalence in epilepsy is 6.0 per cent against 0.7 per cent generally, incidence 2.5 times higher, 7.0 per cent in temporal lobe epilepsy. Interictal psychosis is the Slater and Beard picture: left-sided and bitemporal foci, early onset, hippocampal sclerosis.
- **Postictal delirium is the near miss.** Delirium follows at once with clouded consciousness and autonomic swing; psychosis appears only after full alertness. Severe insomnia is the first warning, and an early atypical can abort the episode.
- **Where it goes wrong.** Clozapine is uniquely epileptogenic among the atypicals and is withheld in active epilepsy. Levetiracetam gave severe psychiatric symptoms in 111 of 1,412 patients, and 57 of 57 recovered on discontinuation alone.

FORCED NORMALISATION: THE NAMES AND THE CRITERIA

Landolt described recordings that normalised during psychosis; Tellenbach called it alternative psychosis. Krishnamoorthy and Trimble require established epilepsy, then acute or subacute behavioural disturbance, then either over 50 per cent reduction in spike count on a 60-minute waking recording, or seizures stopping for at least 1 week plus a supportive criterion such as a regimen change within 30 days. It tracks the speed of suppression rather than one drug, so slow titration lowers risk.

WHAT EARNS THE MARKS

- **Timing named as the axis.** Stated before the table, so management falls out.
- **The lucid interval row.** It separates postictal psychosis from postictal delirium.
- **The criteria block, not the label.** Spike-count reduction or seizure cessation, plus a supportive criterion.
- **Clozapine withheld unprompted.** The epileptogenic atypical, named first.

SEE ALSO V - 34 catatonia V - 39 medical causes Weave Viva, Part III

V - 39

Medical causes of psychiatric syndromes: steroids, thyroid, HIV, SLE.

10 PSYCHIATRY SHORT CASES SYLLABUS CORE

SKELETON

1 **Name the axis**	Classify by the organ system driving it
4 **Picture against clue**	Each syndrome paired with its physical or laboratory clue
3 **Drug or disease**	Which way the patient moves when the dose changes
2 **Treat with it running**	Taper below threshold, then treat, then monitor

DRIVER	PSYCHIATRIC PICTURE	THE CLUE ELSEWHERE	WHAT SETTLES IT
Corticosteroid	Mania 35, depression 28, psychosis 24 per cent	Onset within 5 days of a dose change	**More steroid fails to remit**
Lupus cerebritis	Psychosis, mood change, with a flare	Fever, rash, nephritis, antinuclear titre 1:80 or more	**More steroid improves it**
Thyrotoxicosis	Anxiety, irritability, lability, insomnia	**Tremor, tachycardia, heat intolerance, goitre**	Thyroid function
Hypothyroidism	Depression, lethargy, memory lapses	**Cold intolerance, weight gain, constipation, dry skin**	Mood lags behind the laboratory
Adrenal	Cushing gives mania; Addison gives apathy	**Central obesity, against weight loss**	Cortisol studies
HIV brain injury	Slowed irritable mania, cognitive decline	Advanced immunosuppression, frontal release signs	**Progression on suppression**

Amber cells are where the body, not the mental state, decides it.

- **The steroid threshold.** Risk rises above 40 mg daily of oral prednisone and particularly at 80 mg or more, though dose sets the risk and not the picture. Where it runs on, taper below 40 mg, then risperidone 1 to 4 mg or olanzapine 2.5 to 20 mg daily. On taper, 92 per cent resolve.
- **HIV: the framing moved.** Brain injury replaced the Frascati categories, which misclassified healthy adults. Static decline under suppression is legacy; new decline means escape below 50 copies/mL, CD8 encephalitis or depression.
- **Interactions.** Ritonavir raises risperidone and lowers olanzapine. Valproate is usually first, carbamazepine avoided, glucuronidated lorazepam or oxazepam replacing alprazolam.

PITFALL

Predicting steroid psychiatry from history. It arises without prior illness; sources split on past illness and recurrence, and agree on female sex and older age. Tricyclics worsen it; prefer sertraline or citalopram. Unsafe in porphyria: chlordiazepoxide, clonazepam, quetiapine, ziprasidone.

WHAT EARNS THE MARKS

- **The organ system named as the axis.** Stated before the list.
- **The direction of change.** Improvement on more steroid points at lupus.
- **A plan with the drug still running.** Taper below threshold, treat, then monitor.
- **The porphyria list straight.** Four ordinary agents on the unsafe side.

SEE ALSO V - 35 rigid and febrile V - 38 epilepsy and psychosis Weave Viva, Part III

V - 40

Tardive dyskinesia and drug-induced movement disorders: AIMS and management.

10 PSYCHIATRY SHORT CASES SYLLABUS CORE

SKELETON

2 Examine	Cranial to caudal, at rest, on activation, walking
2 Separate by latency	Days for dystonia, months to years for tardive
2 The anticholinergic test	Classic dyskinesia worsens, tardive dystonia may improve
4 Act on the drug	Hold the dose, switch, then add a VMAT2 inhibitor

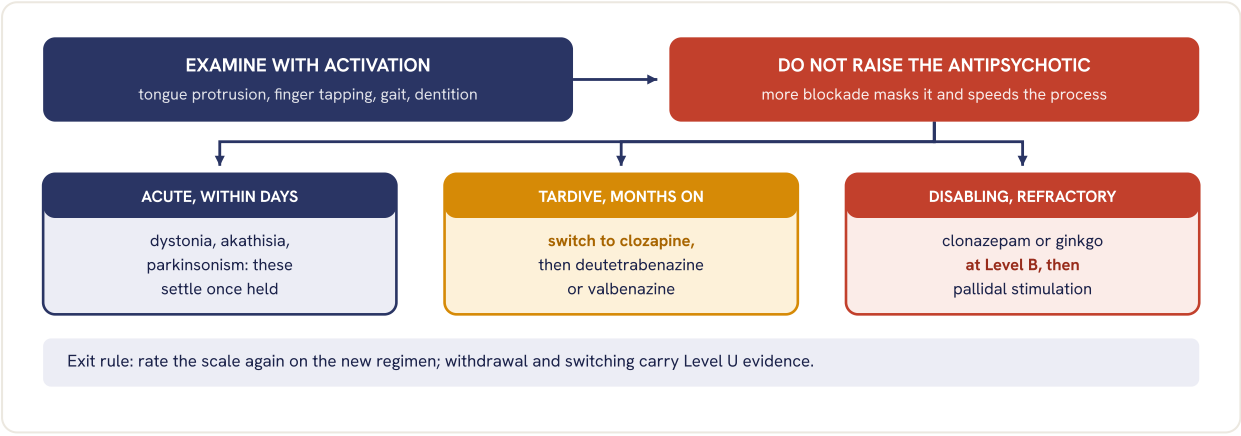


Fig 40.1 One examination, one refusal, then three lanes set by latency and disability.

- **Define and rate.** Involuntary athetoid or choreiform movement lasting at least a few weeks, on a blocking agent given at least a few months, or 1 month past age 60 years, persisting at least 1 month after the drug stops. The scale rates seven objective anatomical items, with a baseline total of 6 or more as the research cutoff.
- **The numbers that justify acting.** Cumulative incidence rises about 5 per cent a year over the first 5 years, reaching 49 per cent at 10 years. Meta-analytic prevalence is 25.3 per cent across 41 studies, 32.4 per cent on first-generation and 13.1 on second-generation agents.
- **Dose and evidence.** About 2 per cent remit on cessation alone while 33 to 55 per cent worsen acutely. Deutetrabenazine starts at 6 mg twice daily, titrating to 24, 36 or 48 mg per 24 hours; valbenazine from 40 mg daily. Both Level A.

PITFALL

Prescribing trihexyphenidyl for oral-buccal-lingual stereotypy, which it worsens while genuinely helping tardive dystonia.

WHAT EARNS THE MARKS

- **Activation manoeuvres used.** Tapping and walking unmask what rest conceals.
- **The anticholinergic row straight.** Classic dyskinesia worsens, tardive dystonia may improve.
- **A VMAT2 inhibitor with its dose ladder.** The Level A option, named and titrated.

SEE ALSO V - 35 rigid and febrile V - 41 lithium toxicity Weave Viva, Part III

V - 41

Lithium toxicity: levels, features, precipitants, dialysis criteria.

10 PSYCHIATRY SHORT CASES SYLLABUS CORE

SKELETON

2	Range and sampling	Target by phase, trough timing, steady state
3	Grade the picture	Neurology and chronicity decide, not the number
3	First hour	Stop the drug, replete volume, repeat the level
2	Dialysis and precipitants	The criteria, then the drugs that raised it

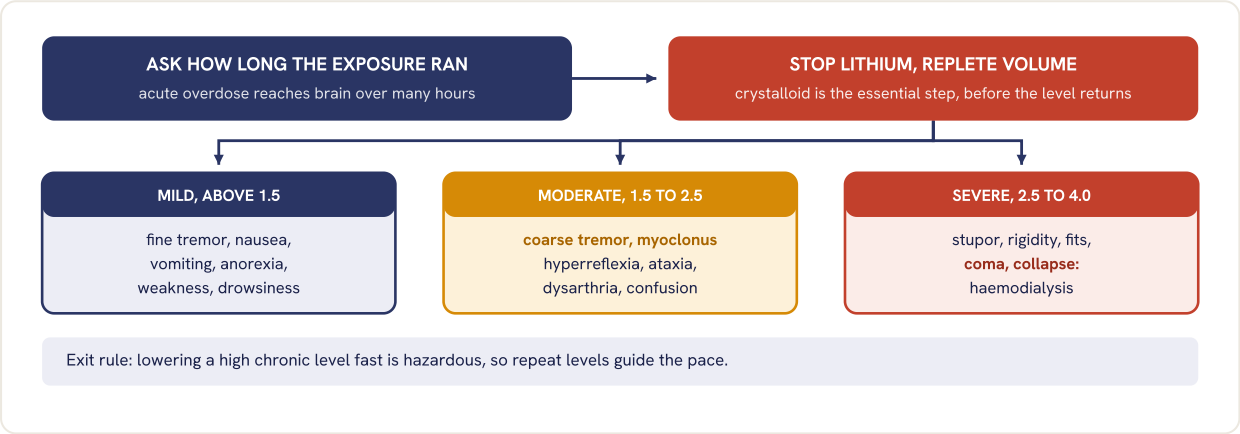


Fig 41.1 Exposure first, then one immediate action, then the three severity lanes.

- **Range and sampling.** Target 0.8 to 1.2 mmol/L in acute mania and 0.5 to 0.8 in maintenance, drawn at a trough of 12 hours after the night dose, steady state after 4 to 5 days. Clearance is 15 to 20 mL/min, half-life 18 to 36 hours, over 95 per cent renal.
- **Dialysis criteria.** Recommended for severe poisoning, for eGFR below 45 mL/min with a level above 4.0 mEq/L, and for reduced consciousness, seizures or dysrhythmia. Suggested above 5.0 mEq/L, for confusion, or where expected time below 1.0 mEq/L exceeds 36 hours.
- **Precipitants.** Thiazides raise levels by about 25 per cent and anti-inflammatory drugs by 10 to 25 per cent; paracetamol and aspirin are safe. Chronic toxicity presents at a median 1.6 mmol/L, with damage at 1.8 to 3.2.

PITFALL

The phlebotomy tube and the charcoal reflex. Green-top tubes containing lithium heparin give factitiously high readings, so use plain red-top or gel separator tubes. Charcoal does not bind lithium ions and adds aspiration risk. Volume is the intervention: often 4 to 6 litres of crystalloid then 200 to 250 mL/hr, with levels every 2 to 4 hours until the peak, then every 6 to 12 hours.

WHAT EARNS THE MARKS

- **Chronicity asked before the level is read.** A high number can sit with an intact examination.
- **The lanes given as neurology.** Coarse tremor and myoclonus, not a bare concentration.
- **Volume repletion named as the intervention.** Before dialysis is discussed.
- **The dialysis criteria, both tiers.** Recommended and suggested, told apart.

SEE ALSO V - 40 drug-induced movement disorders V - 35 rigid and febrile Weave Viva, Part III

V - 42

After a suicide attempt: intent, lethality, the Beck scale and a safety plan.

10 PSYCHIATRY SHORT CASES SYLLABUS CORE

SKELETON

2 After clearance	Exclude delirium and intoxication, then interview
2 Two dimensions	Medical lethality and suicidal intent, rated separately
3 The scale	Composition, banding, and what it cannot do
3 Safety plan	Six steps, ending in restriction of lethal means

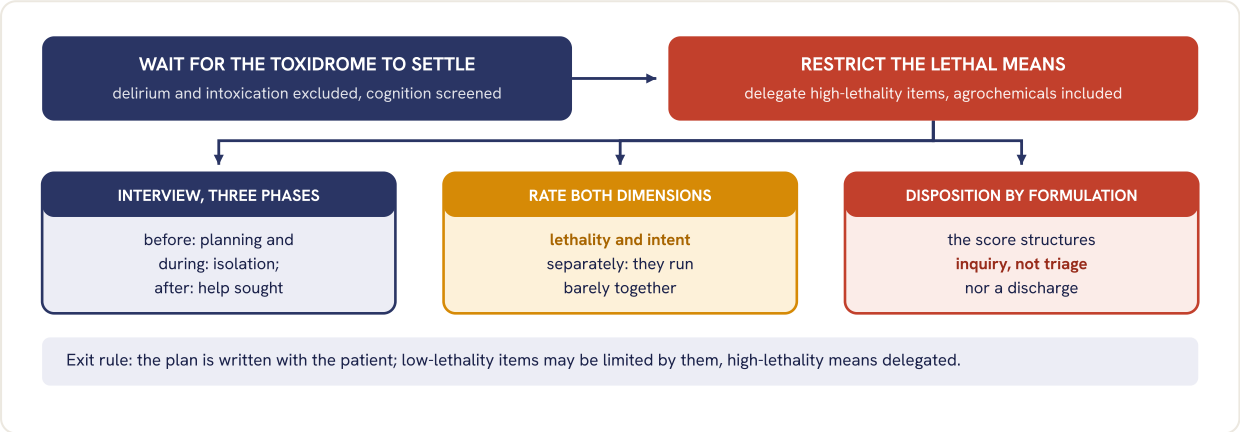


Fig 42.1 Clearance, one immediate action, then inquiry, rating and disposition.

- **The scale.** A 20-item clinician-administered interview: objective circumstances items 1 to 8, self-report items 9 to 15, other aspects items 16 to 20, those 5 excluded. Each scored item runs 0 to 2, the total across items 1 to 15 runs 0 to 30, banded 0 to 10, 11 to 19, 20 to 30.
- **Factor structure.** Two factors: Lethal Intent, items 9 to 14, alpha 0.90, correlating with hopelessness at r = 0.27; Planning, items 1 to 7 and 15, alpha 0.74, uncorrelated. Objective planning predicts physical damage; subjective intent does not.
- **What the score cannot do.** Risk of completed suicide after self-harm is 0.5 to 2 per cent at 1 year and exceeds 5 per cent after 9 years, mortality 3.3 times expected. A score of 19 or higher, age above 55 years and mood disorder predict it, yet no scale is a triage tool.

PITFALL

Reading advance communication as high intent. Item 8 loaded 0.30 on the first factor and -0.14 on the second with a negative item-total correlation, so communication is a behavioural style, not a dimension of intent. The other error is the no-suicide contract: no validation, no legal protection, no coping alternative, guilt when urges return.

WHAT EARNS THE MARKS

- **The two dimensions separated.** High intent can sit with a harmless method.
- **The scale positioned honestly.** It structures inquiry; formulation governs disposition.
- **Means restriction that fits India.** Agrochemicals named beside medicines and blades.
- **The no-suicide contract refused.** With the three reasons, not as a preference.

SEE ALSO V - 33 the twenty-minute short case V - 36 capacity at the bedside Weave Viva, Part III

AREA 05 OF 10 · PV-A05

The neurology short case

14	14.0%	V-43	V-56
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

SYLLABUS CORE 14

REVISION ORDER

The examination slots first, in the order you would perform them at the bedside. Localisation next, then the syndrome slots, which apply it.

WHAT IS IN THIS AREA

The neurological examination in exam order: higher functions, cranial nerves, motor, sensory, cerebellar and gait. Then localisation and the common syndromes, from hemiparesis and parkinsonism to neuropathy, tremor and epilepsy.

V - 43

Higher mental functions and lobe testing at the bedside.

10 | THE NEUROLOGY SHORT CASE | SYLLABUS CORE

SKELETON

2 Attention first	Awake, alert, not delirious, before any focal claim
2 Frontal	Fluency, Luria sequence, go and no-go, proverbs
2 Temporal	Delayed recall, category fluency, autobiographical milestones
3 Parietal and occipital	Gerstmann items, neglect tests, agnosia with acuity intact
1 Name the lobe	One localisation, with the test that showed it

THE ORDER THAT EARNS THE OPENING MARKS

Cognitive testing rests on an awake alert state mediated by an intact ascending reticular activating system, so attention is screened and reported before any focal claim. Separate delirium, with acute onset and fluctuating inattention, from dementia first. Screen with letter cancellation, then forward digit span at one digit per second.

LOBE	BEDSIDE TEST	DISCRIMINATOR
Frontal	Fluency, Luria sequence, go and no-go, proverbs	**Perseveration and environmental dependency**
Temporal	Word recall at three to five minutes, category fluency	**Recall fails while registration is intact**
Dominant parietal	Calculation, writing, finger naming, right-left commands	**Gerstmann tetrad**
Non-dominant parietal	Extinction, line bisection, cancellation, cube copy	**Neglect with anosognosia**
Occipital	Confrontation fields, object and face naming	**Agnosia with acuity intact**

Amber cells fix the lobe. The test is what the examiner marks, not the adjective.

- **Frontal battery.** Trail Making B, the Luria fist-edge-palm series three with you and three alone, go and no-go, proverbs, phonemic fluency on F, A and S for one minute each, then grasp and utilisation behaviour.
- **Temporal battery.** Backward digit span, three to five words recalled after three to five minutes, autobiographical milestones, and category fluency, where below 13 items in a minute indicates temporal or semantic impairment.
- **The composite to name.** The Frontal Assessment Battery: 6 subtests each scored 0 to 3 for a maximum of 18, cut-off 12, with reported sensitivity 77% and specificity 87% against Alzheimer type dementia.
- **Finger agnosia against anomia.** In anomia the patient cannot name the finger you touch but points to the one you name. In agnosia both directions fail.

WHAT EARNS THE MARKS

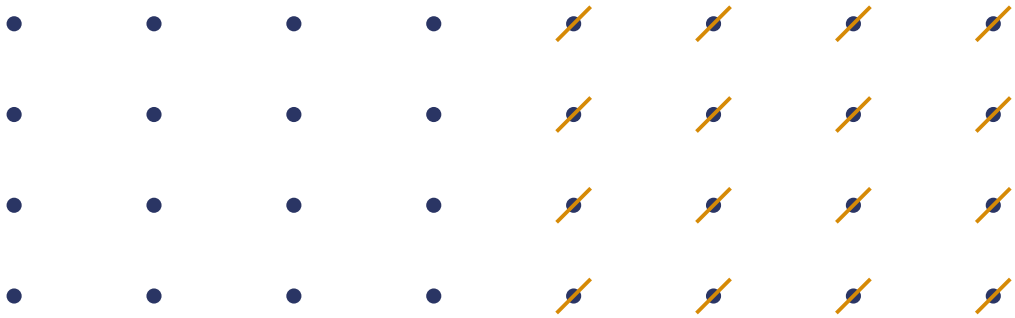
- **Attention tested and declared before the table.** A focal claim on an inattentive patient is unscorable.
- **One named test per lobe row.** The five rows of the grid are the five marks.
- **Both directions of the finger sign.** Naming and pointing, as the trap line says.
- **The composite quoted whole.** Subtest count, maximum, cut-off, then its accuracy.

SEE ALSO V - 44 the aphasias and the bedside table V - 51 hemispheric and cord syndromes Weave Viva, Part IV

Attention and vision are different questions.

Original demonstration marks, not a validated cancellation test.

Left-sided omissions



Unmarked left space

Marked right space

Compare with formal visual-field examination



Left field shaded in BOTH eyes: left homonymous loss

Schematic ▪ Original teaching diagram ▪ September 2026

Schematic. Left-sided omissions on an original cancellation example illustrate inattention to one side of space. A homonymous field defect instead concerns visual-field loss assessed in both eyes. Neglect and field loss may coexist; this diagram does not distinguish them in a real patient without examination. The cancellation array is a teaching example, not a scored instrument.

Check visual fields and attention separately; consider extinction.

Schematic prepared by Luna for Weave Viva, based on P3-15. Original vector diagram.

Change the cue. Observe the action.

Three ways to examine a learned gesture; no proprietary test form.

1 REQUEST

Pantomime using a comb



2 IMITATE

Copy the demonstrated action



3 OBJECT

Use the actual comb



Check elemental function before interpreting an action error.

Schematic ▪ Original teaching diagram ▪ September 2026

Schematic. Examine a learned action on verbal request, by imitation and with an actual familiar object. The comb diagrams represent a novel demonstration of task context, not a validated test item. Before attributing errors to apraxia, assess comprehension, power, sensation and coordination. Improvement with a different cue is informative but not obligatory.

Record the type of error rather than assuming non-cooperation.

Schematic prepared by Luna for Weave Viva, based on P3-33. Original vector diagram.

V - 44

Aphasias: Broca, Wernicke, conduction, transcortical, global, and the bedside table.

10 THE NEUROLOGY SHORT CASE SYLLABUS CORE

SKELETON

2 Handedness, then three words	Dysarthria, dysphasia and apraxia of speech, separated aloud
4 The grid	Fluency, comprehension and repetition across eight syndromes
2 Repetition as the hinge	One test turns four syndromes into eight
2 Name it	Syndrome plus lesion site, then the pen test

SYNDROME	FLUENCY, COMPREHENSION	REPETITION	LESION
Broca	Non-fluent, comprehension good	**Impaired**	Left frontal or frontoparietal, including Broca area
Transcortical motor	Non-fluent, comprehension good	**Normal**	Left frontal, outside Broca and Wernicke areas
Global	Non-fluent, comprehension poor	**Impaired**	Large left frontotemporoparietal
Mixed transcortical	Non-fluent, comprehension poor	**Normal**	Watershed lesions isolating perisylvian cortex
Wernicke	Fluent, comprehension poor	**Impaired**	Left temporoparietal, including Wernicke area
Transcortical sensory	Fluent, comprehension poor	**Normal**	Left temporoparietal, outside Wernicke area
Conduction	Fluent, comprehension good	**Disproportionately impaired**	Subcortical, under superior temporal or inferior parietal
Anomic	Fluent, comprehension good	**Normal**	Small lesion in the left language network

Amber is the discriminating column. Fluency and comprehension place the lesion front or back; repetition says whether the perisylvian arc is inside it.

- **Handedness, written down first.** Language sits in the left hemisphere in about 99% of right-handers, and the bedside examination has six components and runs in under 10 minutes.
- **Dysarthria is not dysphasia.** Dysarthria is motor, with semantics and syntax intact, so hand a mute patient a pen: grammatical writing takes aphasia off the table.
- **The third word.** Apraxia of speech is disordered planning of volitional oral motor programs, with no weakness and no linguistic breakdown.

WHAT EARNS THE MARKS

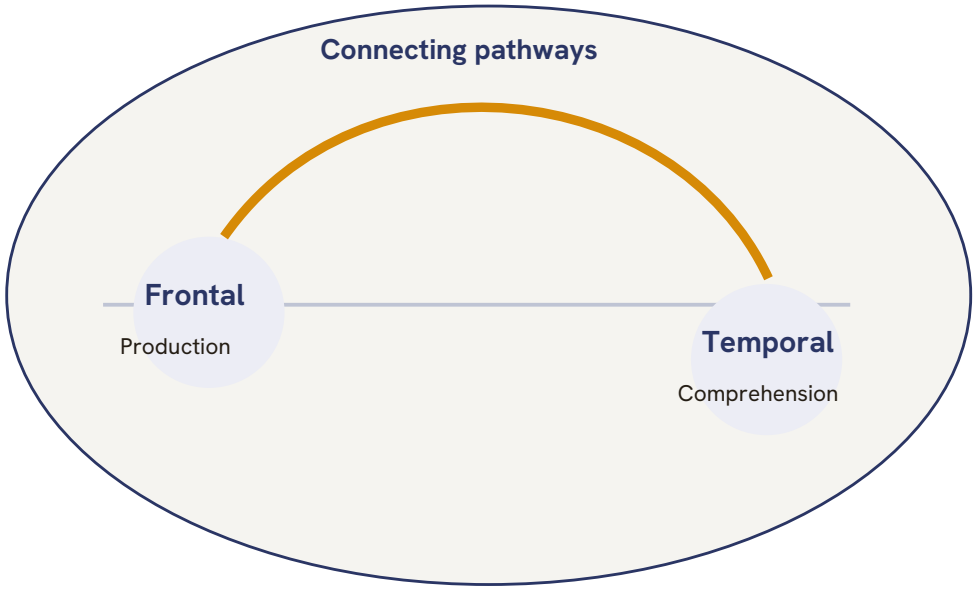
- **Handedness recorded and justified.** It decides which syndrome is even available.
- **The grid read across a row.** Fluency, comprehension and repetition, each demonstrated rather than asserted.
- **The amber column used as the hinge.** Repetition is what turns four syndromes into eight.
- **The pen test.** Grammatical writing in a mute patient rules out aphasia.

SEE ALSO V - 43 higher mental functions V - 45 cranial nerves V - 51 cord and brainstem syndromes

Weave Viva, Part IV

Test the network, not one label.

A classical left-hemisphere teaching model, deliberately simplified.



FLUENCY **COMPREHENSION** **REPETITION**

Schematic ▪ Original teaching diagram ▪ September 2026

Schematic. The classical language model links posterior temporal processing, frontal speech production and connecting pathways. Bedside assessment separates fluency, comprehension and repetition; preserved repetition helps distinguish transcortical patterns. Modern language function is distributed, so this schematic is not a literal one-area/one-function lesion map.

Describe fluency, comprehension and repetition before classifying aphasia.

Schematic prepared by Luna for Weave Viva, based on P3-32. Original vector diagram.

V - 45

Cranial nerve examination in exam order and the common palsies.

10 | THE NEUROLOGY SHORT CASE | SYLLABUS CORE

SKELETON

2 Set out and inspect	Tray ready, then speech, face, lids, pupils, alignment
2 Run the order	Olfactory through twelfth, without doubling back
3 Isolate the palsy	Primary position, then the discriminating manoeuvre
2 Localise	Nucleus, nerve or junction, and say which one
1 Two decisive tests	Forehead for the face, consensual response for the pupil

THE TRAY, THEN THE FREE FINDINGS

Set the tray out first: pen torch, Snellen chart, Ishihara plates, ophthalmoscope, cotton wool, neuro-tip, a 512 Hz tuning fork and a glass of water. Then inspect before testing, because speech quality for the ninth and tenth nerves, facial asymmetry at rest for the seventh, ptosis for the third nerve or a sympathetic lesion or the junction, pupil size and ocular alignment are free findings.

PALSY	PRIMARY POSITION	DISCRIMINATOR
Third	Down and out, marked ptosis, mydriasis	**Ptosis plus dilated pupil plus down and out**
Fourth	Extorsion and slight elevation	**Head tilt away from the lesion with chin tuck**
Sixth	Convergent squint	**Isolated failure of abduction**

Three rows, three marks. The manoeuvre is what the examiner ticks, not the adjective.

- **The two decisive tests.** Forehead movement separates upper from lower motor neuron facial palsy. The consensual response separates a relative afferent defect, where the affected pupil still constricts to light in the healthy eye, from an efferent third nerve palsy.
- **Hearing, in three rows.** Air greater than bone with Weber in the midline is normal; Rinne negative with Weber to the affected ear is conductive; both reduced with Weber to the normal ear is sensorineural, tested with the 512 Hz fork.
- **The jaw angle.** Sensation there runs in the greater auricular nerve from C2 and C3, not the mandibular division. A brisk jaw jerk means a bilateral upper motor neuron lesion above the mid-pons, and both limbs of that reflex run in V3.

WHAT EARNS THE MARKS

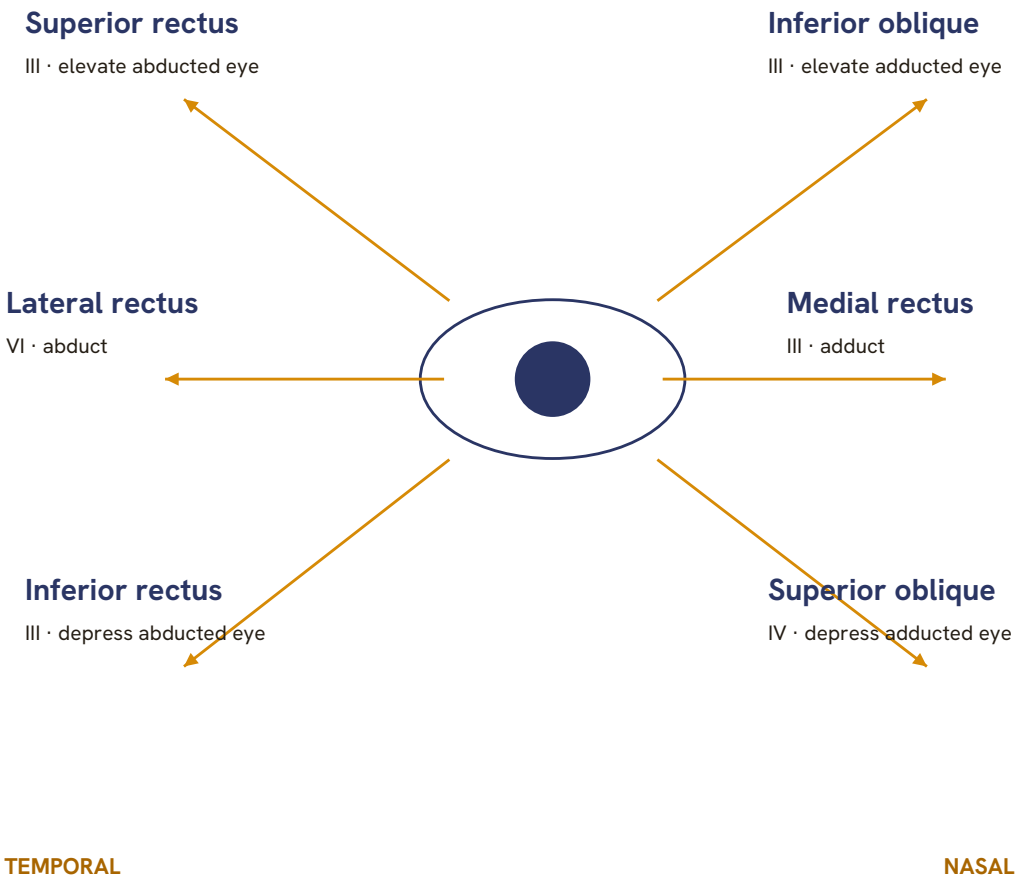
- **Inspection reported before any instrument.** Speech, lids, pupils and alignment are free findings on the box above.
- **The order kept.** Doubling back reads as an unrehearsed examination.
- **One discriminator per row of the grid.** Primary position alone does not name the palsy.
- **Forehead and consensual response, both offered.** They are the two tests that settle the face and the pupil.

SEE ALSO V - 44 the aphasias V - 48 cerebellar examination V - 51 cord and brainstem syndromes

Weave Viva, Part IV

Follow the eye through six positions.

One RIGHT eye, viewed face-on: temporal is left on this page.



Schematic ▪ Original teaching diagram ▪ September 2026

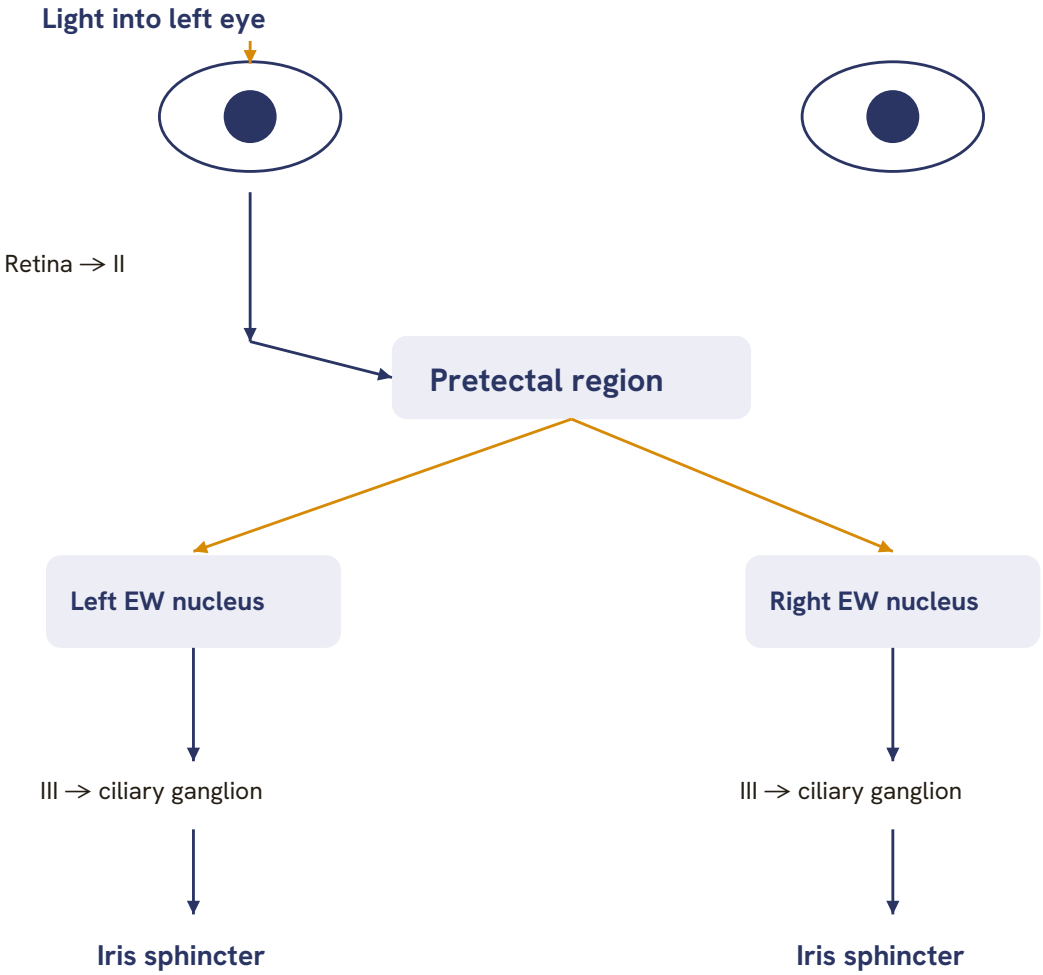
Schematic. Six cardinal gaze positions for the right eye. In abduction, elevation and depression emphasise superior and inferior rectus; in adduction they emphasise inferior and superior oblique. Lateral rectus is supplied by VI, superior oblique by IV and the others by III. The diagram is a muscle-action guide, not an eye photograph or an isolated-muscle test.

State the gaze position before identifying the weak action.

Schematic prepared by Luna for Weave Viva, based on P3-03. Original vector diagram.

One light. Two pupils.

Trace afferent input, then bilateral parasympathetic output.



Schematic ▪ Original teaching diagram ▪ September 2026

Schematic. Light input travels from the retina through the optic nerve to the pretectal region, which projects bilaterally to Edinger–Westphal nuclei. Each efferent limb travels through III and the ciliary ganglion to its iris sphincter. The bilateral connection explains direct and consensual constriction. This simplified pathway omits intermediate anatomy and is not a lesion-confirmation test.

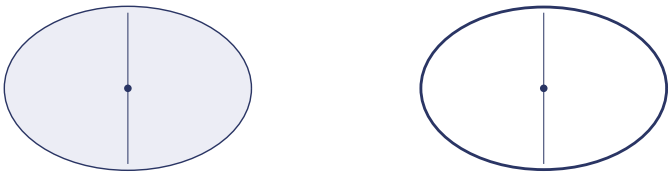
Separate an afferent defect from an efferent defect.

Schematic prepared by Luna for Weave Viva, based on P3-31. Original vector diagram.

Name the missing visual space.

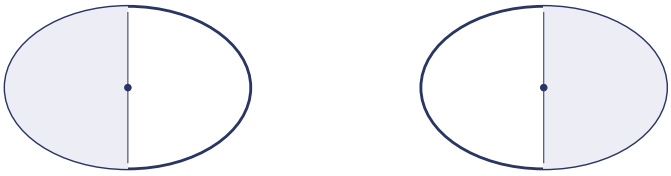
Patient's left and right visual fields; shading means loss.

Left monocular loss



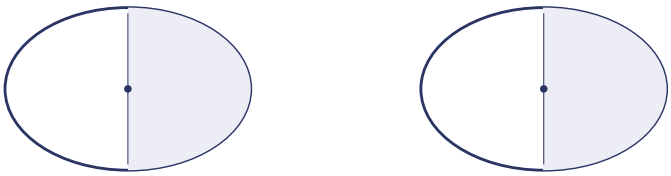
L eye R eye

Bitemporal loss



L eye R eye

Right homonymous loss



L eye R eye

Schematic ▪ Original teaching diagram ▪ September 2026

Schematic. Idealised field patterns: monocular loss, bitemporal loss and homonymous loss. Each pair represents the left and right eye, not brain hemispheres. Monocular loss suggests a prechiasmal problem; bitemporal loss points to the chiasm; homonymous loss points behind the chiasm on the opposite side. Real defects need formal examination and may be incomplete.

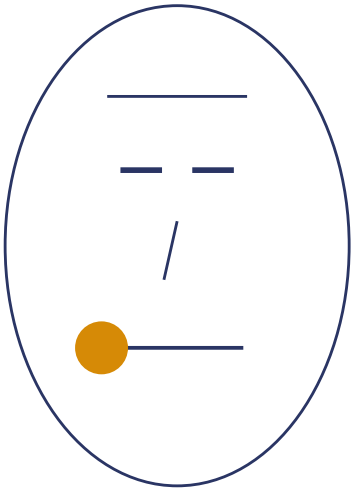
Identify whether the pattern respects the vertical meridian.

Schematic prepared by Luna for Weave Viva, based on P3-03. Original vector diagram.

Compare forehead, eye and mouth.

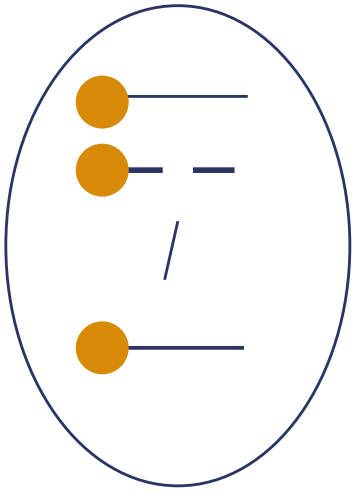
Illustrated weakness is on the patient's RIGHT (page left).

Supranuclear pattern



Forehead relatively spared
Lower face weak

Peripheral VII pattern



Forehead and eye closure weak
Lower face also weak

Amber marks the region to examine; it is not a measured severity score.

Schematic ▪ Original teaching diagram ▪ September 2026

Schematic. Conceptual facial weakness patterns. A supranuclear lesion commonly causes contralateral lower facial weakness with relative forehead sparing. A peripheral VII lesion affects the ipsilateral upper and lower face. Amber marks weak regions rather than a photograph of asymmetry. Forehead sparing is a localisation clue, not an absolute rule.

Test brow elevation, eye closure and lower facial movement separately.

Schematic prepared by Luna for Weave Viva, based on P3-30. Original vector diagram.

V - 46

Motor examination: tone, power grading, reflexes, root values, clonus, plantar.

10 THE NEUROLOGY SHORT CASE SYLLABUS CORE

SKELETON

2 Inspect	Bulk, fasciculation, posture, abnormal movements
2 Tone at two speeds	Velocity dependent or not, and in which muscle groups
3 Power	Graded against the scale you name, group by group
2 Reflexes and plantar	Reinforce, grade, then the root value for each
1 Synthesise	Upper or lower motor neuron, then the level

THE SCALE, QUOTED WHOLE

Power is graded on the Medical Research Council scale: 0 no contraction, 1 flicker, 2 movement with gravity eliminated, 3 against gravity but collapsing on added resistance, 4 against gravity and resistance, 5 normal. Grade 4 is the wide grade and the expansion to offer is mild, moderate or severe. Confirm power is grade 4 or 5 before calling limb clumsiness cerebellar, because pyramidal weakness mimics dysmetria.

FEATURE	SPASTICITY	RIGIDITY	PARATONIA
Substrate	Pyramidal	Basal ganglia	Frontal, diffuse cortical
Velocity	**Rises with faster stretch**	**Constant at any speed**	**Varies with the force applied**
Direction	Arm flexors, leg extensors	Equal across flexors and extensors	Variable in all directions
Pattern	Clasp-knife	Lead-pipe or cogwheel	Eases on distraction

The amber row is the one manoeuvre that separates the three: tone tested slowly, then fast, on the same limb.

- **Pronator drift and clonus.** Arms out with palms up for 20 to 30 seconds, then repeated with eyes closed; pronation with downward drift means a contralateral corticospinal lesion. Dorsiflex and evert the ankle briskly and hold, where more than 5 beats is pathological.
- **Root values, said with the grade.** Biceps and brachioradialis C5 and C6, triceps predominantly C7, patellar L2 to L4, Achilles S1. A reflex is not absent until reinforced, and facilitation lasts as long as the traction continues, up to 10 seconds.
- **A negative Babinski.** The sign is abnormal, so it is present or absent. Acceptable wordings are plantar flexor, toes down-going, absent, or Babinski sign present. Stroke the lateral sole only.

WHAT EARNS THE MARKS

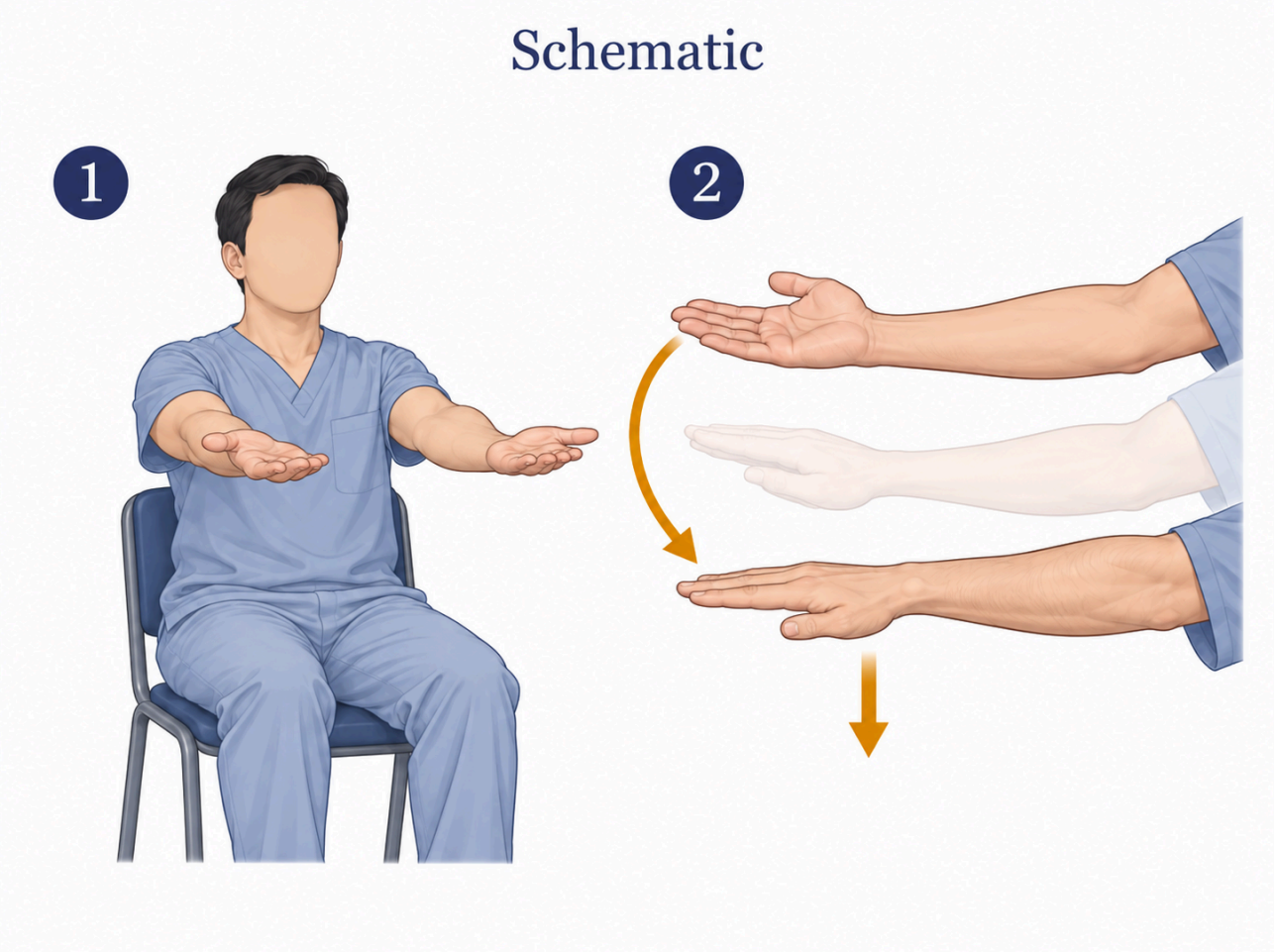
- **Inspection reported first.** Wasting and fasciculation change the answer before any manoeuvre.
- **The amber row demonstrated.** Two speeds on one limb is what separates spasticity from rigidity.
- **Grade 4 subdivided.** Mild, moderate or severe, offered without being asked.
- **The plantar worded correctly.** Flexor, absent, or Babinski sign present.

SEE ALSO V - 48 cerebellar examination V - 50 upper against lower motor neuron V - 53 parkinsonism

Weave Viva, Part IV

Pronator drift: position and direction

Companion to original page 62



Schematic. 1: seated starting position with arms extended and palms up. 2: inset illustrating pronation and downward drift. Compare both arms during the manoeuvre; the right-hand inset is a movement illustration, not another patient. The still cannot demonstrate the observation period or establish a lesion.

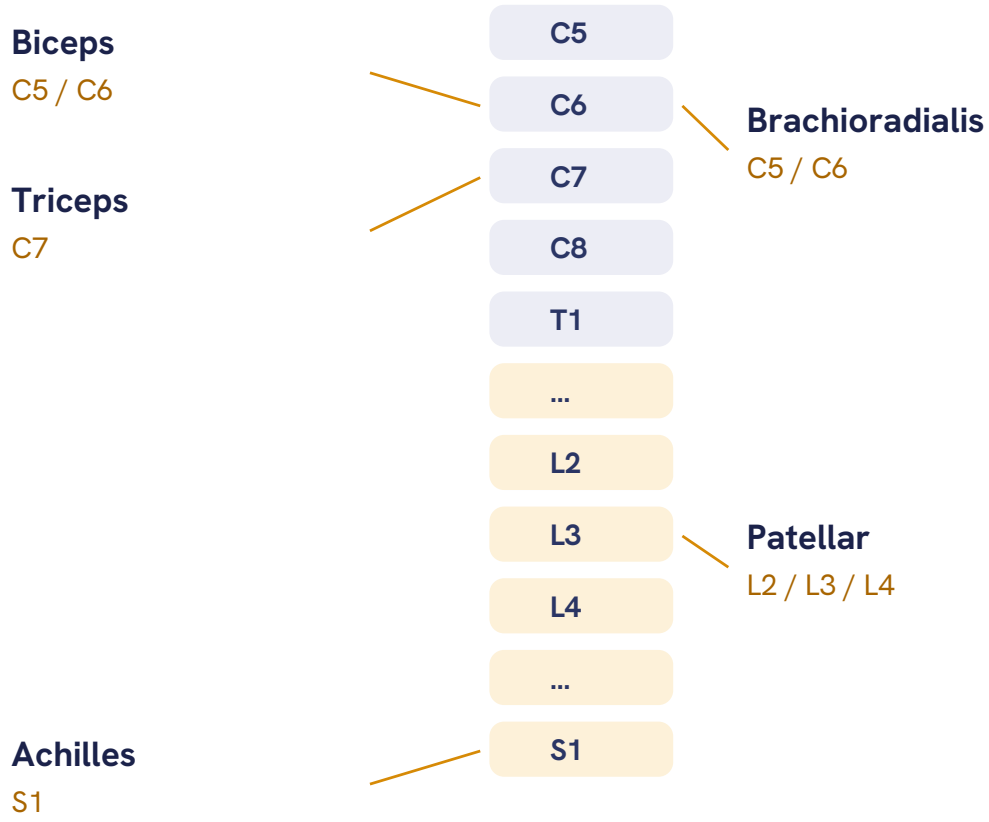
Explain the manoeuvre and observe both arms.

Schematic prepared by Luna for Weave Viva, based on P3-04. AI-generated educational illustration.

WEAVE / VIVA ▪ SCHEMATIC

Reflexes have levels.

Segmental associations for the motor examination; not hammer-placement guidance.



COMPARE SIDES, THEN INTERPRET THE PATTERN

Root contributions overlap. Combine reflexes with power and sensation.

These labels are chapter-level associations, not proof of a single-root lesion.

Schematic ▪ Original teaching diagram ▪ September 2026

Schematic. Biceps and brachioradialis C5–C6; triceps C7; patellar L2–L4; Achilles S1, following the chapter. The connecting lines organise segmental associations; they do not show tendon anatomy or hammer position. Root contributions overlap, so combine reflexes with strength and sensation.

Compare sides and combine the pattern with power and sensation.

Schematic prepared by Luna for Weave Viva, based on P3-06. Original vector diagram.

V - 47

Sensory examination and the patterns of sensory loss.

10 THE NEUROLOGY SHORT CASE SYLLABUS CORE

SKELETON

1 **The axis**	Test to confirm a pattern, rather than to survey
3 **The patterns, drawn**	Where the boundary falls decides the level
4 **Dissociation**	The branch asked for: which tract is in the lesion
2 **State the level**	Highest dermatome involved, with its segmental reflex

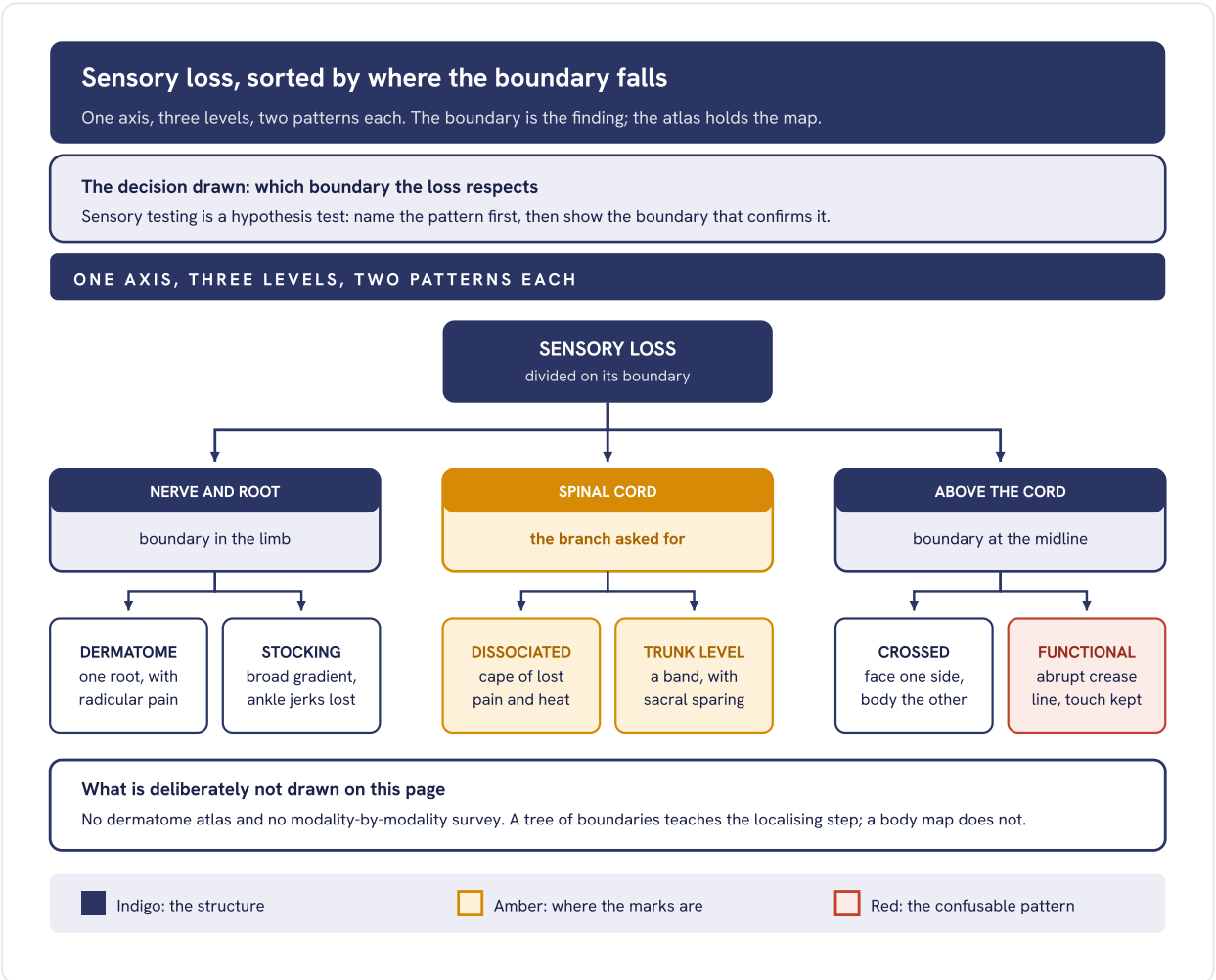
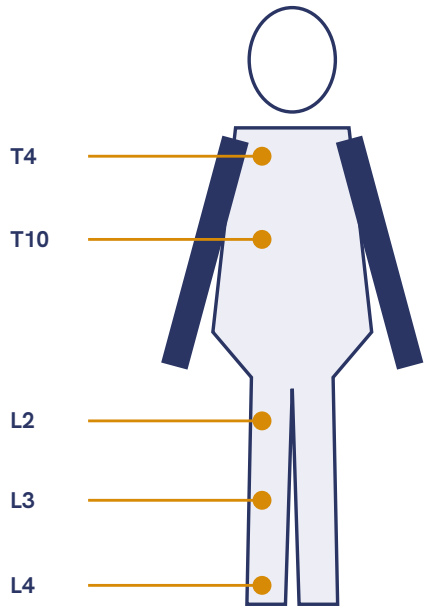


Fig 47.1 Sensory loss divided on one axis, the boundary, with the cord branch in amber and the confusable pattern in red.

- **Two systems, two routes.** Pain and temperature cross in the anterior white commissure within 1 to 2 segments of entry, while vibration and position run uncrossed in the dorsal columns, so dissociation is the sentence that localises.
- **The level with its reflex.** Dorsal thumb C6, dorsal middle finger C7, first webspace L5, lateral heel S1, each named with its segmental reflex.
- **Sacral sparing read backwards.** The lowest sacral fibres lie most superficially, so extrinsic compression hits them early and central cord lesions spare them.

Sample roots at recognisable landmarks.

Selected sensory points, not a complete dermatome atlas.



C5	Lateral elbow
C6	Thumb
C7	Middle finger
C8	Little finger
T1	Medial elbow
T4	Nipple level
T10	Umbilicus
L2	Anterior thigh
L3	Medial knee
L4	Medial ankle
L5	Dorsum of foot
S1	Lateral foot

Detailed hand landmarks are listed at right.

Schematic ▪ Original teaching diagram ▪ September 2026

Schematic. Selected dermatome landmarks organise a bedside screen: C5 lateral elbow, C6 thumb, C7 middle finger, C8 little finger, T1 medial elbow, T4 nipple level, T10 umbilicus, L2 anterior thigh, L3 medial knee, L4 medial ankle, L5 dorsum of foot and S1 lateral foot. Dermatomes overlap and vary; test and map the actual sensory border rather than treating these points as exact boundaries.

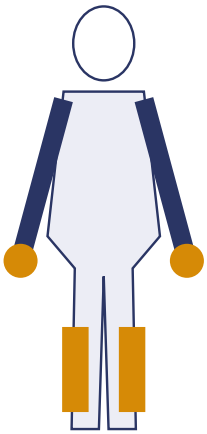
Relate a sensory point to a root, then compare it with a peripheral nerve territory.

Schematic prepared by Luna for Weave Viva, based on P3-05. Original vector diagram.

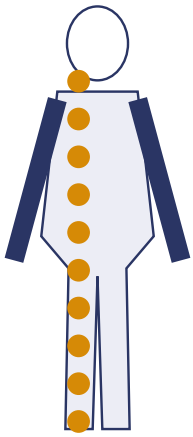
Map the shape before naming the cause.

Idealised distributions, deliberately separated from diagnostic labels.

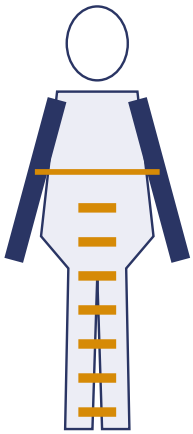
Distal symmetrical



Hemisensory



Sensory level



1 / Compare distal and proximal regions.

2 / Test the same modality on both sides.

3 / Delineate a reproducible border.

Schematic ▪ Original teaching diagram ▪ September 2026

Schematic. Conceptual sensory patterns: distal symmetrical stocking–glove loss, a hemisensory distribution and a sensory level across the trunk. Shading marks regions to map, not a validated patient finding. These shapes guide localisation; actual borders, modalities, onset and associated signs must be examined.

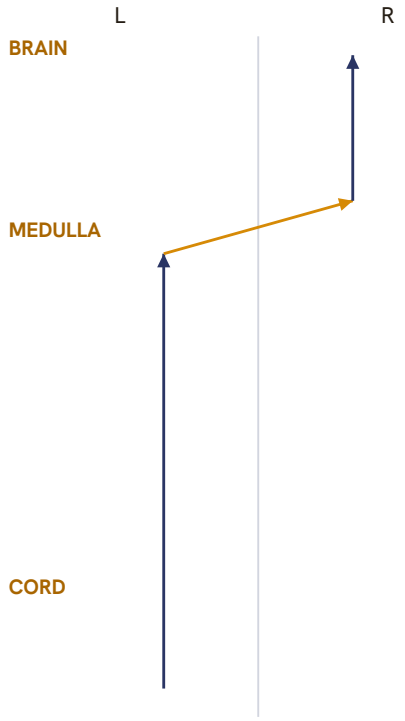
Describe the distribution and modality before proposing the lesion.

Schematic prepared by Luna for Weave Viva, based on P3-05. Original vector diagram.

Ask where the pathway crosses.

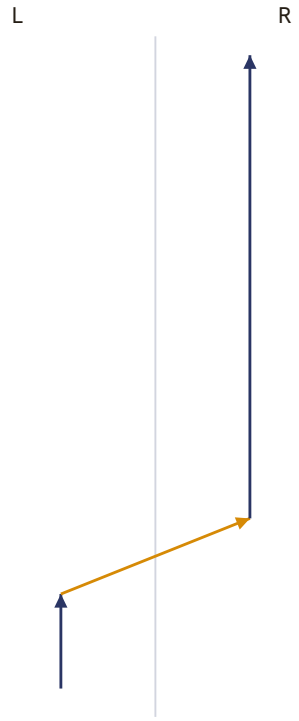
Body pathways only: face pathways are not shown.

Position / vibration



Crosses in medulla

Pain / temperature



Crosses near cord entry

Schematic ▪ Original teaching diagram ▪ September 2026

Schematic. Simplified ascending body sensory pathways. Dorsal-column fibres ascend ipsilaterally and cross in the medulla before continuing in the medial lemniscus. Pain and temperature fibres entering the cord cross near their entry level and ascend contralaterally in the anterolateral system. Segmental spread is omitted. This crossing difference helps explain dissociated sensory loss.

Use the crossing level to predict the side of a sensory deficit.

Schematic prepared by Luna for Weave Viva, based on P3-05. Original vector diagram.

WHAT EARNS THE MARKS

- **The axis stated before the tree.** A pattern named as the hypothesis, then tested.
- **The amber branch in depth.** Which tract sits inside the lesion, and which is spared.
- **The level given with its segmental reflex.** A sensory level is only as good as that check.
- **The red leaf discriminated.** An abrupt crease-line boundary with intact touch is not a neuropathy.

SEE ALSO V - 46 motor examination V - 51 cord and brainstem syndromes V - 54 peripheral neuropathy

Weave Viva, Part IV

V - 48

Cerebellar examination and the cerebellar syndrome.

10 | THE NEUROLOGY SHORT CASE | SYLLABUS CORE

SKELETON

2 Head to foot	Titubation, eyes, speech, then the limb tests
3 Trunk and stance	Sit unsupported, then stand, then Romberg
2 Walk the patient	Wide base, unsteady with eyes open and closed alike
3 Localise	Midline against hemispheric, then the side and cause

THE SEQUENCE, HEAD TO FOOT

Inspect for titubation, then the eyes for broken pursuit and gaze-evoked nystagmus beating towards the lesion, then speech for scanning dysarthria. Then the limb tests: the Stewart-Holmes rebound, pressing the outstretched forearms down by roughly 10 cm and releasing so the affected arm flies past baseline; finger-to-nose with your finger about 50 cm away; rapid alternating hand turning; heel-to-shin. Then reflexes with the legs hanging free, then the trunk sitting unsupported, then gait.

FEATURE	MIDLINE, VERMAL	HEMISPHERIC, LATERAL
Dominant deficit	Axial and locomotor equilibrium	Appendicular limb incoordination
Trunk	**Cannot sit unsupported; falls backwards**	**Truncal stability relatively preserved**
Limb tests in bed	**May be entirely normal**	Dysmetria, past-pointing, intention tremor
Tone and reflexes	Limb tone often normal; titubation	Ipsilateral hypotonia, rebound, pendular reflexes
Causes	Chronic alcohol and malnutrition, medulloblastoma	Hemisphere infarct, astrocytoma, metastasis, plaque

Amber is the trunk row. It is the one finding that a bed-bound examination cannot reach, and the reason a vermal lesion gets missed.

- **The pendular knee jerk.** With the legs hanging free, a knee jerk swinging more than 4 times is pathological, where 4 or fewer swings is normal.
- **Romberg is not a cerebellar test.** It is a proprioceptive test, and saying so earns the mark. Cerebellar unsteadiness is present with the eyes open; sensory ataxia worsens markedly in the dark.

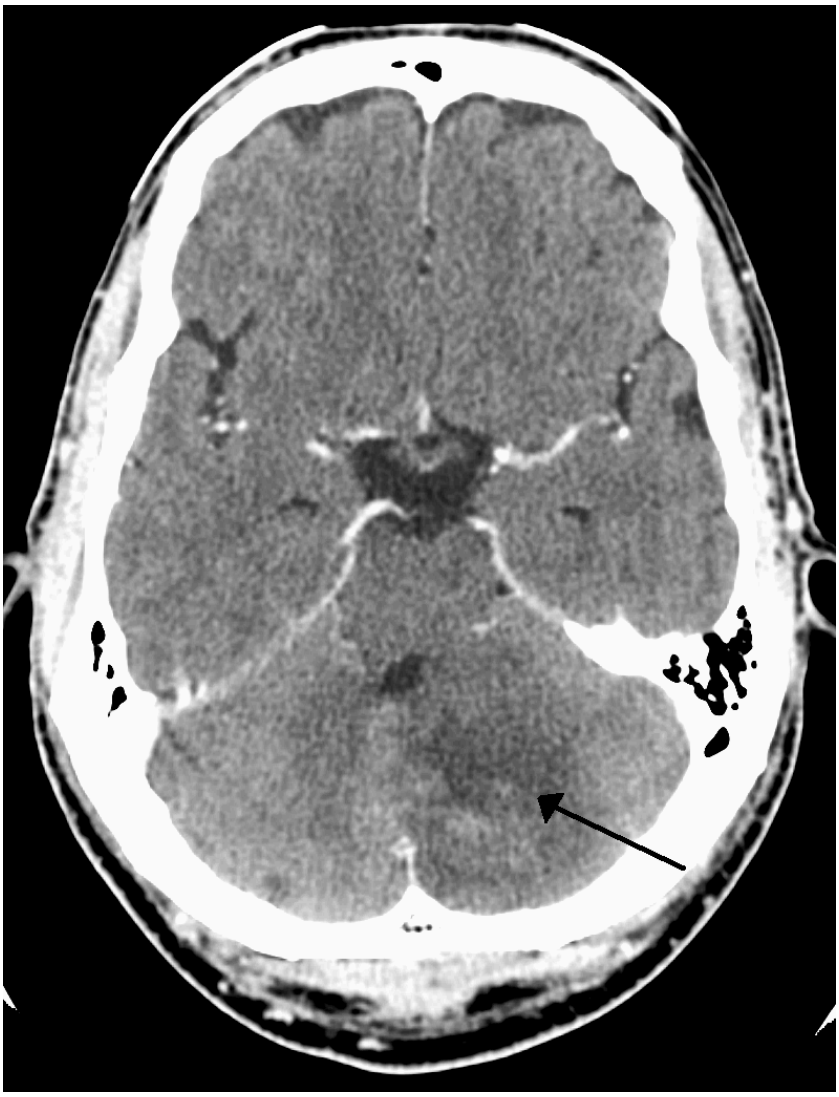
WHAT EARNS THE MARKS

- **The trunk tested and reported.** The amber row is what a vermal lesion hides from the bedside.
- **Nystagmus given a direction.** Gaze-evoked and beating towards the lesion localises the side.
- **Romberg placed correctly.** Proprioceptive, not cerebellar, said out loud.
- **Midline against hemispheric, then a cause.** The grid columns are the two answers on offer.

SEE ALSO V - 46 motor examination V - 49 the classic gaits V - 55 tremor and Wilson's disease Weave Viva, Part IV

Left cerebellar infarct on CT

Companion to original page 65



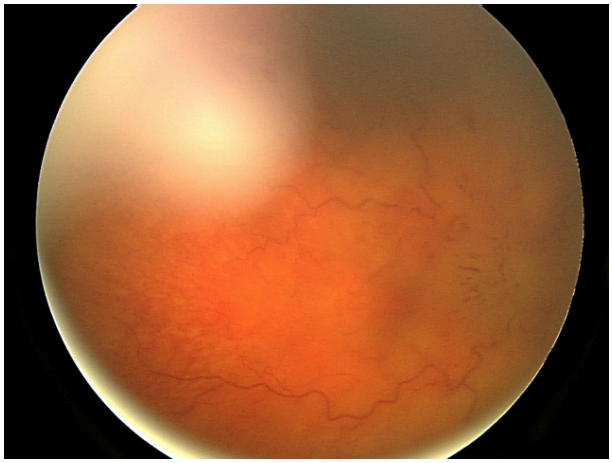
CT, axial plane. The source arrow identifies left cerebellar hypoattenuation in a stroke attributed to vertebral artery occlusion. The image is CT, not MRI. Vertebral artery occlusion is the source-case explanation and is not directly demonstrated by this slice.

Connect a posterior-fossa lesion to the cerebellar examination and verify image-side orientation.

James Heilman, MD. Leftsidedcerebellarstroke.PNG. CC BY-SA 3.0. https://commons.wikimedia.org/wiki/File:Leftsidedcerebellarstroke.PNG Licence: https://creativecommons.org/licenses/by-sa/3.0 Unmodified.

Severe papilloedema: real fundus photograph

Companion to original page 65



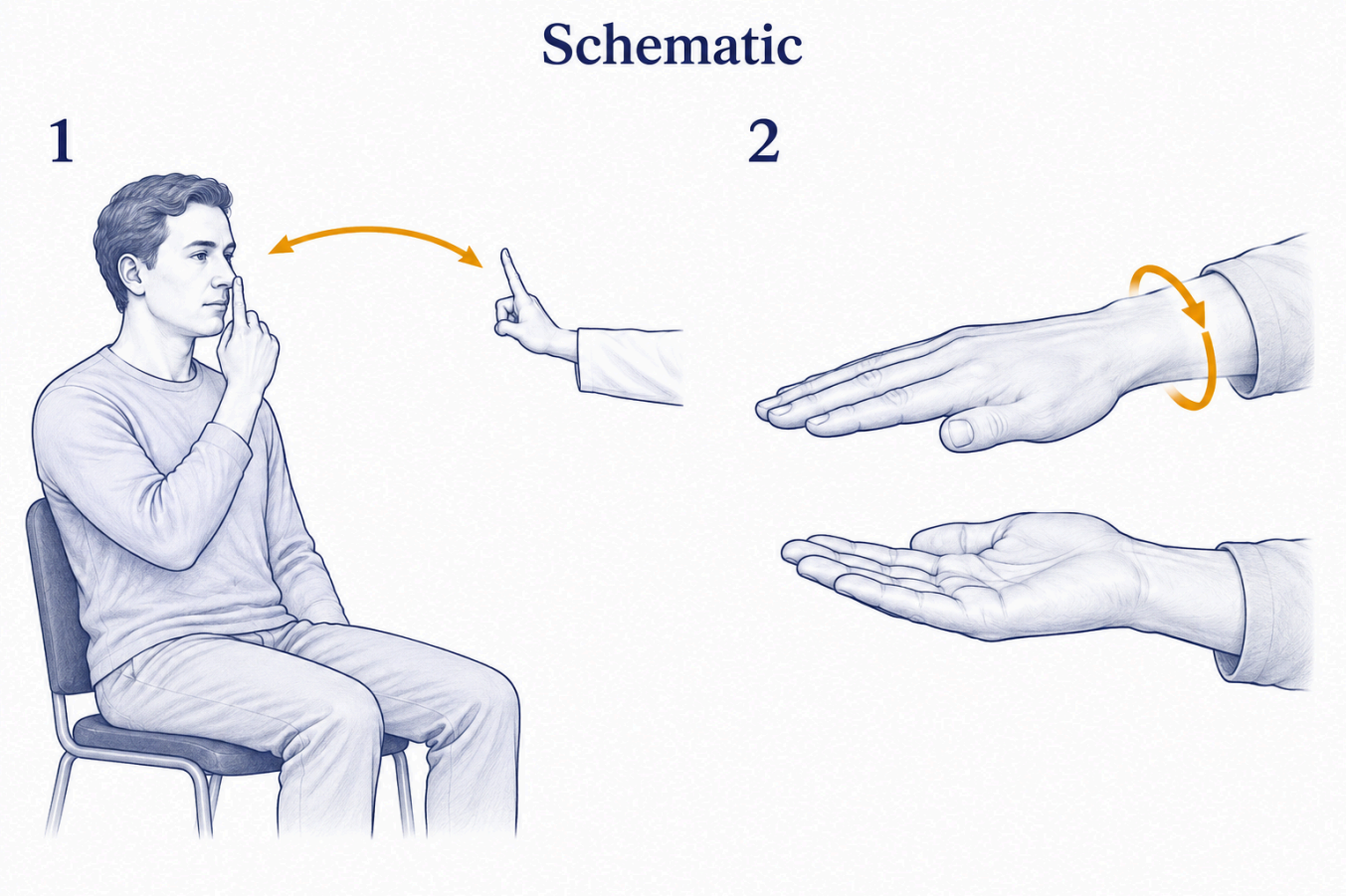
Real fundus photograph of the right eye, described by the source as severe papilloedema. Inspect the elevated, poorly defined optic-disc region in this source example. A single fundus photograph does not measure intracranial pressure or determine its cause. Display width is limited to preserve the available source detail.

Inspect the swollen disc and obscured margins. Fundus companion to the cited cerebellum/gait/fundus chapter.

Shveta Bansal , Timothy Dabbs and Vernon Long. Fundal photograph showing severe papilloedema in the right eye. Journal of Medical Case Reports 2008;2:86. CC BY 2.0. https://commons.wikimedia.org/wiki/File:Fundal_photograph_showing_severe_papilloedema_in_the_right_eye.jpg Licence: https://creativecommons.org/licenses/by/2.0. Unmodified.

Finger–nose and rapid alternating movements

Companion to original page 65



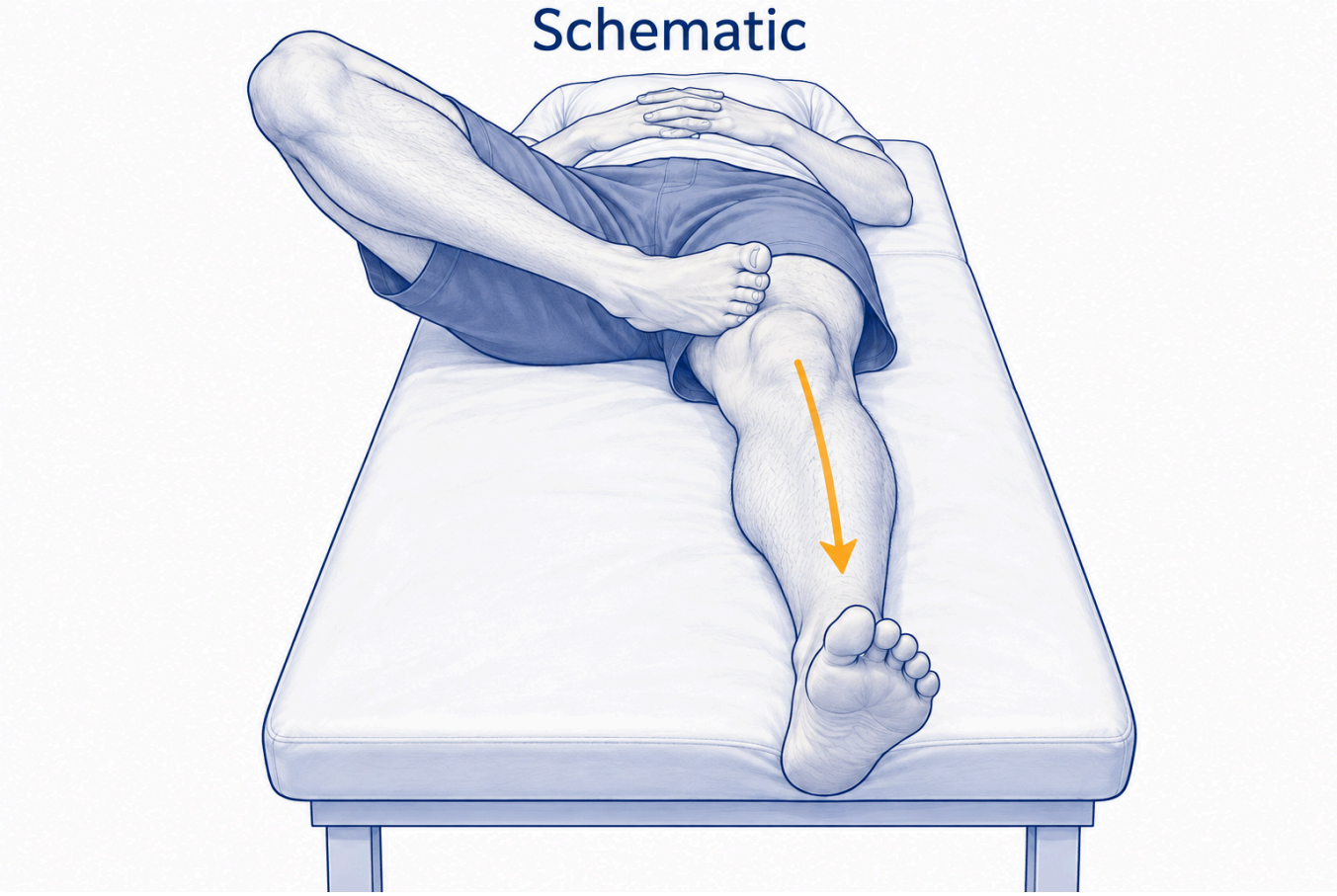
Schematic. Upper panel: the patient alternates their index finger between their nose and the examiner’s target. Lower panel: repeated pronation and supination against the opposite palm. Observe accuracy, rhythm and smoothness on each side. Static positions illustrate the manoeuvres; they cannot show dysmetria, intention tremor or dysdiadochokinesia.

Compare sides while accounting for weakness, pain and comprehension.

Schematic prepared by Luna for Weave Viva, based on P3-07. AI-generated educational illustration.

Heel–shin: follow the opposite tibia

Companion to original page 65



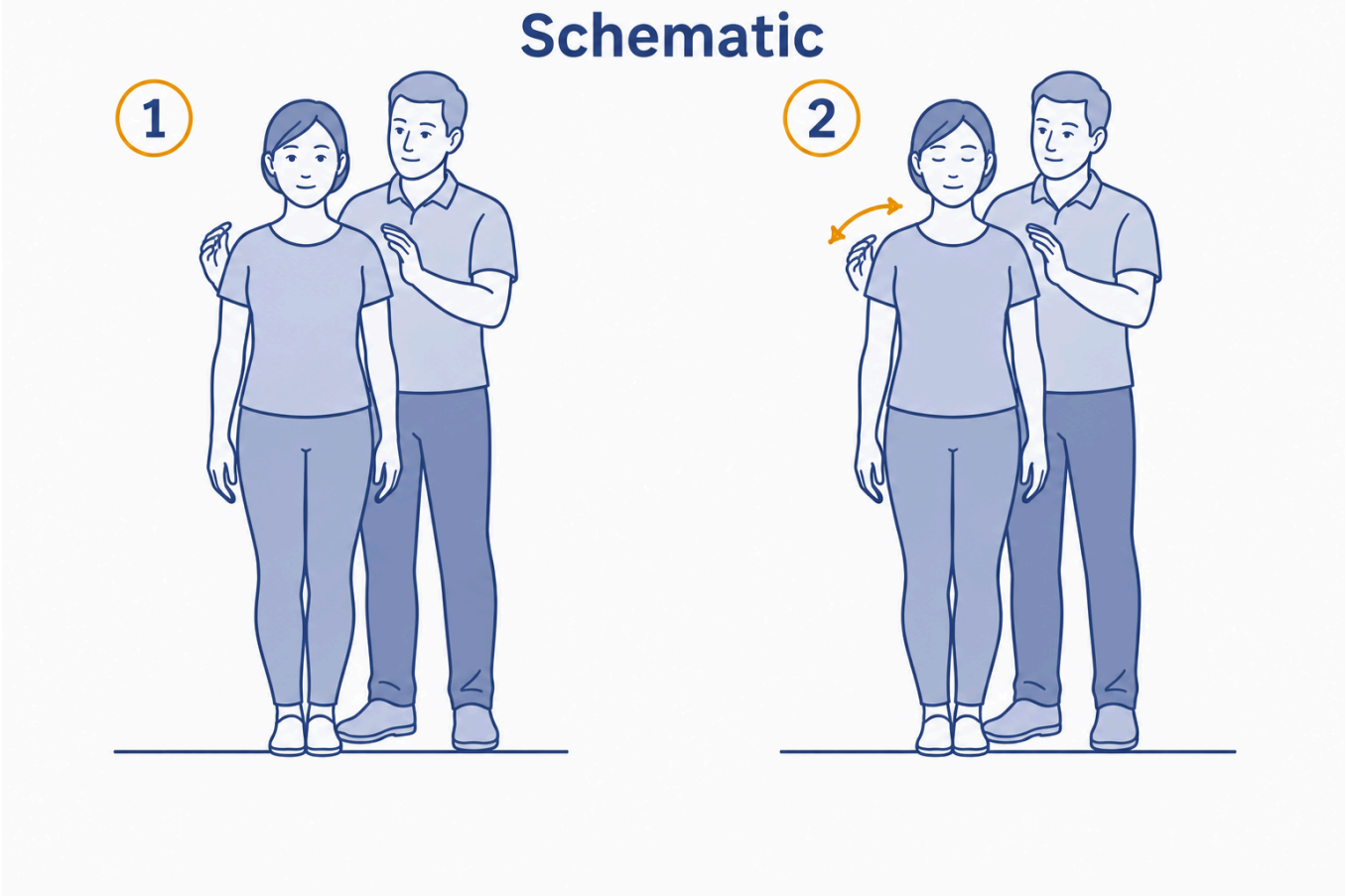
Schematic. Supine starting position: place one heel on the opposite knee, then slide it down the shin towards the ankle. The arrow shows the intended path, not a measured performance. Observe deviation, irregularity and repeated loss of contact; interpret these alongside power and position sense.

Demonstrate the task before assessing the movement.

Schematic prepared by Luna for Weave Viva, based on P3-07. AI-generated educational illustration.

Romberg: compare vision available and removed

Companion to original page 65



Schematic. 1: stand with feet together and eyes open. 2: close the eyes only when safe, with the examiner close enough to guard against a fall without steadying the patient. Increased instability on eye closure can support sensory or vestibular dependence. Instability already present with eyes open needs broader interpretation. This illustration cannot establish a positive sign.

Guard the patient and stop before a fall; do not test unsupported when unsafe.

Schematic prepared by Luna for Weave Viva, based on P3-07. AI-generated educational illustration.

V - 49

The classic gaits, told apart.

10 THE NEUROLOGY SHORT CASE SYLLABUS CORE

SKELETON

2 How you look	About 5 metres barefoot, from front, behind and side
2 What you read	Base, stride, cadence, arm swing, clearance, turning
4 The grid	Each gait with its mechanism and its discriminator
2 Name and localise	The pattern, then the lesion it implies

GAIT	MECHANISM	DISCRIMINATOR
Hemiplegic	Unilateral upper motor neuron lesion; leg functionally too long	Circumduction in a lateral arc, knee held extended
Spastic diplegic	Bilateral periventricular white matter injury	Thighs cross the midline: scissoring
Cerebellar ataxic	Vermis or hemisphere	Unsteady with eyes open and closed alike
Sensory ataxic	Dorsal columns or large sensory fibres	Stamping, much worse in the dark; Romberg positive
Parkinsonian	Basal ganglia, dopamine depletion	Narrow base with festination and reduced arm swing
High-stepping	Dorsiflexor weakness, foot drop	Vertical lift of the foot, not a lateral arc
Waddling	Bilateral hip abductor weakness	Lateral trunk sway with lumbar hyperlordosis
Apraxic, frontal	Frontal lobe, higher-level planning	Supine cycling and stepping movements preserved

Every cell in the amber column is one mark. The mechanism column is what turns a named gait into a localisation.

- **The two arcs.** Circumduction swings the foot sideways because the spastic leg cannot shorten; high-stepping lifts it vertically because the ankle cannot dorsiflex. Watching the plane of the swing separates them in one pass.
- **Why it is asked.** Gait disturbance affects around 15% of people by age 60 and more than 80% of those over age 85, so the pattern carries prognosis as well as a lesion.

WHAT EARNS THE MARKS

- **The gait walked properly.** Three views over the distance in the skeleton, barefoot, with turning.
- **The gait named with its mechanism.** Circumduction, scissoring, stamping, festination, each tied to a lesion.
- **The amber cell quoted.** A description without the discriminator is a mid-band answer.
- **The eyes-closed test used.** It separates cerebellar from sensory ataxia on one manoeuvre.

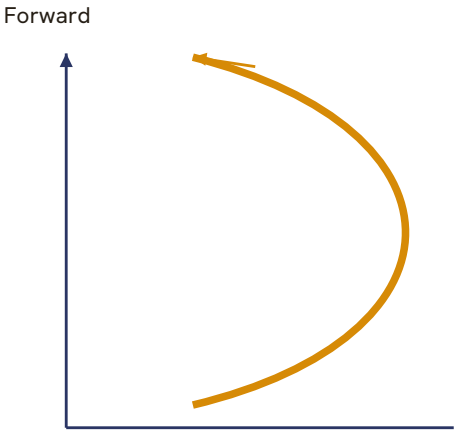
SEE ALSO V - 48 cerebellar examination V - 50 upper against lower motor neuron V - 53 parkinsonism

Weave Viva, Part IV

Watch the path of the foot.

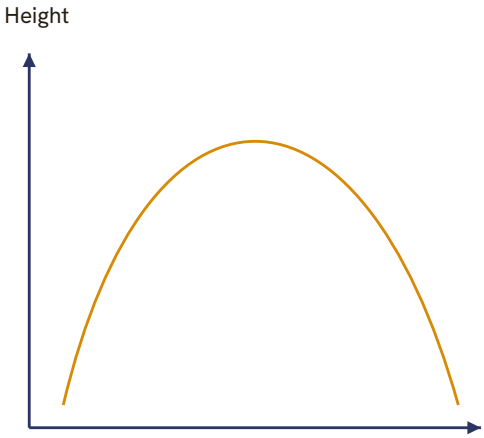
Motion diagrams distinguish trajectories; not motion-capture recordings.

CIRCUMDUCTION · TOP VIEW



Outward arc

HIGH-STEPPING · SIDE VIEW



Greater clearance

Observe joint movement, foot clearance and symmetry.

A drawing cannot show timing, speed or balance.

Schematic ▪ Original teaching diagram ▪ September 2026

Schematic. Circumduction moves the swinging leg outward in an arc; high-stepping increases hip and knee flexion to clear the foot. The first diagram is a top-view foot path; the second is a side-view clearance path. Axes differ deliberately and are labelled. These schematic trajectories are not measured data or diagnostic by themselves.

Separate lateral swing from increased vertical clearance.

Schematic prepared by Luna for Weave Viva, based on P3-08. Original vector diagram.

Compare base, step length and trunk.

Top-view footprint patterns and a frontal trunk-sway cue.

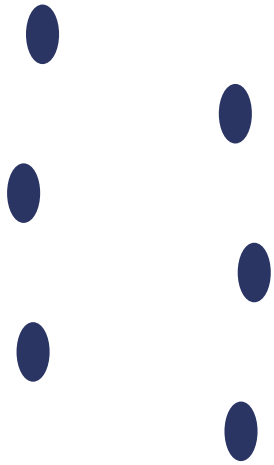
Parkinsonian



Short steps

Relatively narrow base

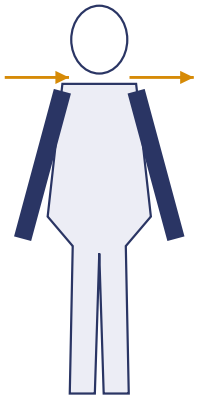
Cerebellar



Wide base

Irregular placement

Waddling



Alternating

lateral trunk sway

Schematic ▪ Original teaching diagram ▪ September 2026

Schematic. Idealised contrasts: short steps with a relatively narrow base in a parkinsonian pattern; a wide, irregular base in a cerebellar pattern; alternating lateral trunk movement in a waddling pattern. Real gait findings vary and may overlap. These footprints and arrows are conceptual, not a recording, and do not establish an aetiology.

Describe base, stride, regularity, arm swing and trunk movement.

Schematic prepared by Luna for Weave Viva, based on P3-08. Original vector diagram.

V - 50

Upper versus lower motor neuron lesions, and the localisation ladder.

10 | THE NEUROLOGY SHORT CASE | SYLLABUS CORE

SKELETON

2 **Both, defined**	Cortex and brainstem tracts against anterior horn and nerve
4 **The six features**	Bulk, fasciculation, tone, weakness, reflexes, plantar
2 **The mixed picture**	Wasting with brisk reflexes changes the diagnosis
2 **Climb the ladder**	Name the rung from cortex to muscle, with its sign

FEATURE	UPPER MOTOR NEURON	LOWER MOTOR NEURON
Bulk	Disuse atrophy only	**Marked, early atrophy**
Fasciculations	**Absent**	**Present and characteristic**
Tone	Spastic, clasp-knife; reduced acutely	Hypotonic or flaccid
Weakness	Pyramidal: arm extensors, leg flexors weaker	Segmental, root or named-nerve
Reflexes	Hyperreflexia; reduced acutely	Hyporeflexia or areflexia
Plantar	**Extensor: Babinski sign present**	**Flexor or absent**
Hand signs	Hoffmann and pronator drift positive	Absent

Amber cells are the discriminators. Tone and reflexes are supporting evidence, because both are reduced in the first days of an acute upper motor neuron lesion.

- **The ladder, in order.** Cortex gives disproportionate weakness with cortical signs; the capsule gives dense proportionate weakness; the brainstem gives crossed signs; the cord gives a sensory level with a normal jaw jerk; root, plexus and nerve give myotomal or territorial loss; junction gives fatigability; muscle gives proximal weakness with preserved reflexes.
- **The mixed picture.** Amyotrophic lateral sclerosis is commonest, with onset in the sixth and seventh decade, about 5% familial, lower limb onset in 30% and bulbar onset in 20%. Look at the tongue and elicit the jaw jerk before committing, because both are spared in cervical myelopathy, where Lhermitte sign appears on active neck flexion.

PITFALL

Calling an acutely flaccid, areflexic patient a lower motor neuron case. Acute cord transection and sudden cerebral insults begin flaccid, and spasticity appears over days to weeks. An extensor plantar can appear early and settles it.

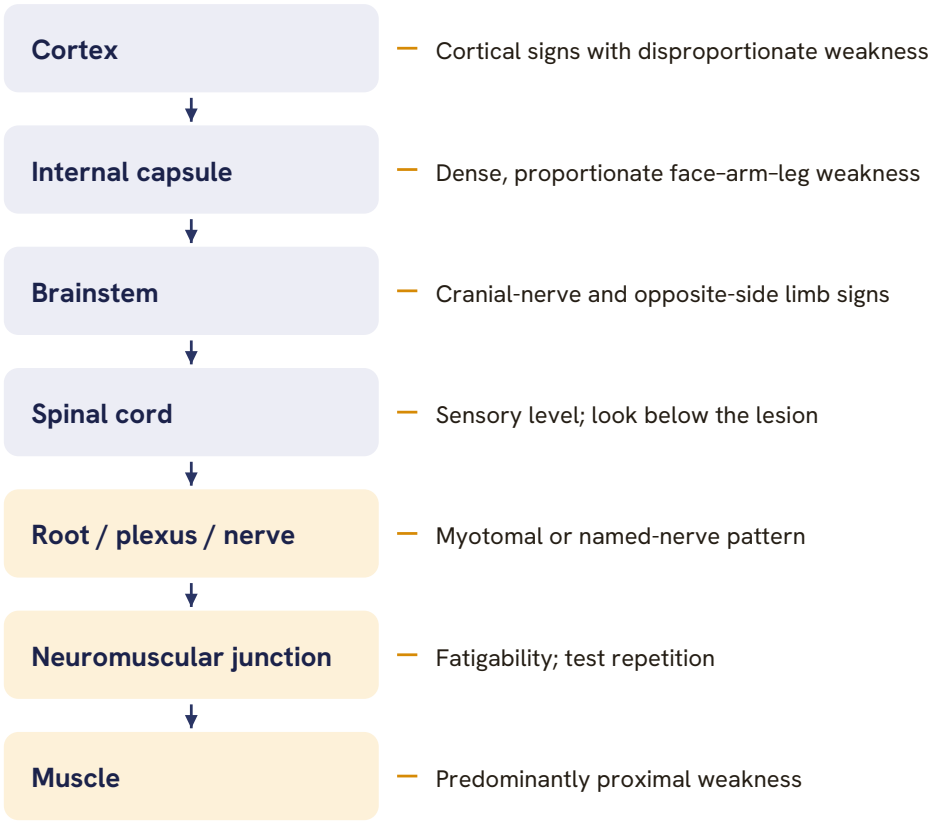
WHAT EARNS THE MARKS

- **All six rows offered.** A two-feature answer reads as a half-examined patient.
- **The amber plantar row.** It is the sign that survives spinal shock.
- **The mixed picture named.** Wasting with brisk reflexes is a diagnosis, not a contradiction.
- **A named rung, then the aetiology.** Level first shows the localisation drove the investigation.

SEE ALSO V - 46 motor examination V - 51 cord and brainstem syndromes V - 54 peripheral neuropathy
Weave Viva, Part IV

Name the level first.

A schematic localisation ladder from cortex to muscle.



CHECK THE EXCEPTION

Acute central lesions can begin with reduced tone and reflexes.
Use the distribution and the rest of the examination together.

Schematic ▪ Original teaching diagram ▪ September 2026

Schematic. A sequence of localisation levels from cortex to muscle with the bedside finding that supports each level. Acute central lesions can initially have reduced tone and reflexes. The ladder links distributions to anatomical levels rather than prescribing a diagnosis. Use the accompanying sensory, cranial-nerve and reflex findings to test the proposed level.

Name the anatomical level before proposing the cause.

Schematic prepared by Luna for Weave Viva, based on chapter P3-11. Original edition artwork; publication licence to follow the edition.

V - 51

Spinal cord syndromes and brainstem crossed signs.

10 THE NEUROLOGY SHORT CASE SYLLABUS CORE

SKELETON

2 Two axes	Vertical level, then which tracts sit in the lesion
4 The cord grid	Each syndrome with the tract it spares
2 Crossed signs	Ipsilateral cranial palsy, contralateral long tract deficit
2 Level the brainstem	The cranial nerve gives midbrain, pons or medulla

CORD SYNDROME	TRACTS DAMAGED	SPARED	PROFILE
Complete transection	All	**Nothing below the level**	Para or quadriplegia, full sensory loss, sphincter paralysis
Brown-Sequard	Ipsilateral corticospinal and dorsal columns; crossing spinothalamic	**Touch, by dual pathways**	Ipsilateral motor and proprioceptive loss, contralateral thermoalgesic loss
Anterior cord	Ventral two-thirds	**Dorsal columns**	Bilateral paralysis and thermoalgesic loss, vibration intact
Central cord	Central grey, crossing fibres, medial corticospinal	**Sacral segments**	Arms worse than legs, hand clumsiness, burning dysaesthesia
Posterior column	Bilateral dorsal columns	**Corticospinal and spinothalamic**	Sensory ataxia, positive Romberg, power and pain intact
Subacute combined degeneration	Dorsal columns and lateral corticospinal tracts	**Anterior columns**	Vibration and position loss, spastic paraparesis, extensor plantars

The amber column is the answer. A cord syndrome is named by the tract it spares, not by the tracts it destroys.

- **Crossed means brainstem.** The cranial nerve gives the level: III and IV midbrain, V to VIII pons, IX to XII medulla. Medial lesions take the motor nuclei, the medial longitudinal fasciculus, the pyramid and the lemniscus; lateral lesions take facial pain and temperature, ataxia, the sympathetic chain, and spare limb power.
- **The paradox to volunteer.** Absent ankle jerks with bilateral extensor plantars is a combined myeloneuropathy, and in practice that means cobalamin. A normal serum level is found in up to 30% of genuine tissue deficiency, so order methylmalonic acid and homocysteine.

PITFALL

Writing coma in a patient with acute anarthria and quadriplegia. Test voluntary vertical saccades and blinking to command first, because reading extensor posturing as decerebrate rigidity is the error that misses a conscious patient.

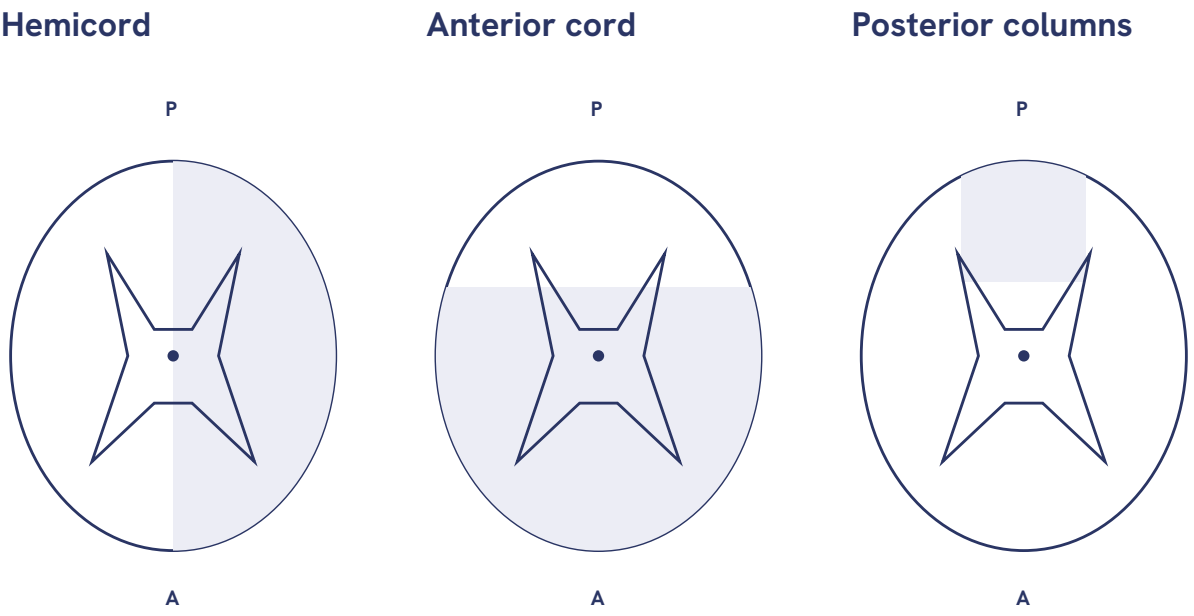
WHAT EARNS THE MARKS

- **Two axes answered separately.** A level without a tract pattern is half an answer.
- **The spared tract named.** The amber column is what makes the syndrome the one you called.
- **The word crossed used precisely.** Cranial on one side, long tract on the other.
- **Locked-in excluded aloud.** The pitfall box is the line that protects the patient.

SEE ALSO V - 47 sensory examination V - 50 upper against lower motor neuron V - 52 hemiparesis and stroke
Weave Viva, Part IV

Which tract is interrupted?

Schematic cord sections: posterior at top, anterior at bottom.



Posterior columns: position and vibration

Lateral corticospinal tract: descending motor pathway

Anterolateral system: pain and temperature

Schematic ▪ Original teaching diagram ▪ September 2026

Schematic. Idealised cord lesions: hemicord, anterior cord and posterior columns. Shading indicates lesion extent, not MRI signal. Relate corticospinal, dorsal-column and anterolateral pathways to the shaded region. Real lesions do not always respect these tidy boundaries, and the level and timing influence the examination.

Predict affected and preserved modalities before naming the syndrome.

Schematic prepared by Luna for Weave Viva, based on P3-13. Original vector diagram.

One hemicord. Different sides of loss.

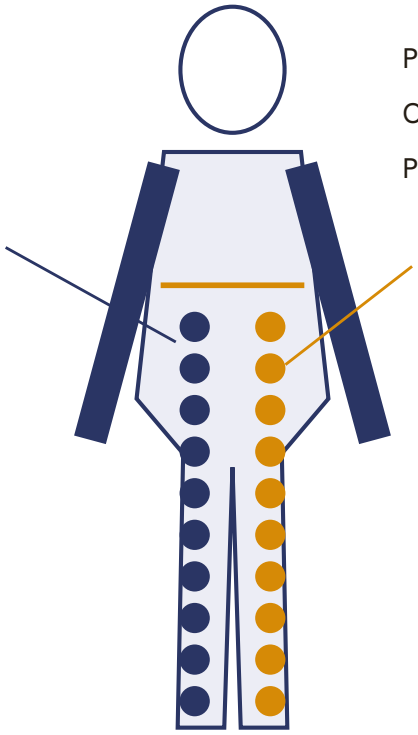
Right hemicord example; the person is shown from the front.

PATIENT RIGHT

Ipsilateral below lesion

Motor

Position / vibration



PATIENT LEFT

Contralateral below lesion

Pain / temperature

Face-on view: patient right is page left.

Schematic ▪ Original teaching diagram ▪ September 2026

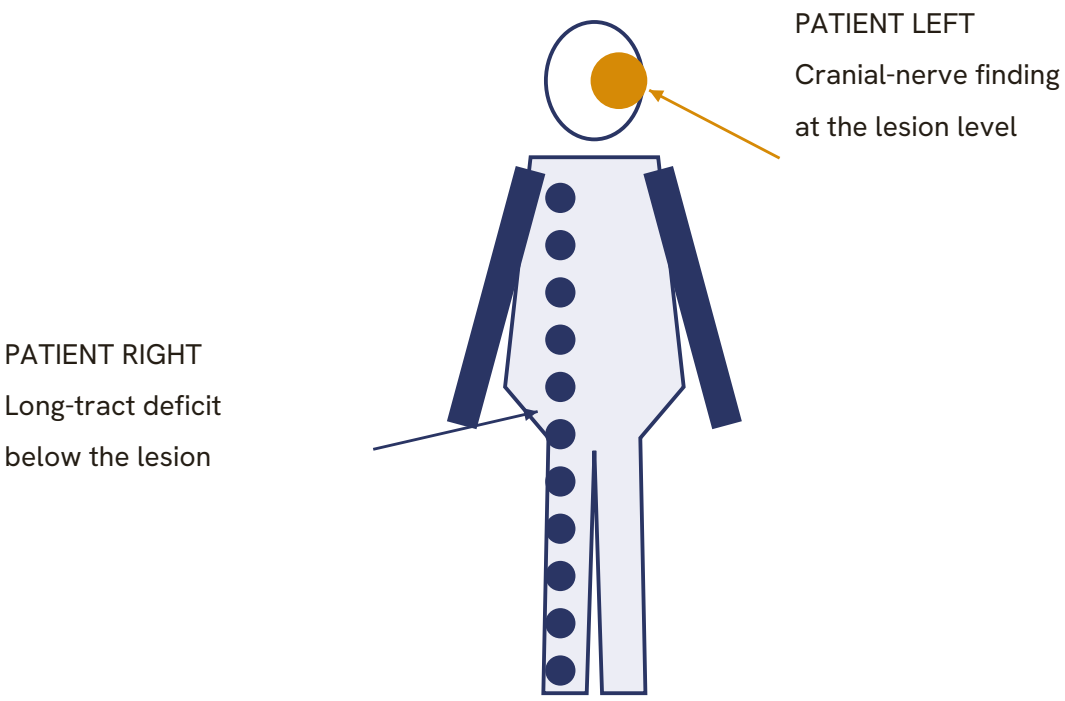
Schematic. Idealised right hemicord syndrome: below the lesion, motor weakness and loss of position/vibration are ipsilateral, while pain/temperature loss is contralateral and often starts below the lesion level. Segmental signs at the lesion are omitted. The coloured body regions are explanatory overlays, not a clinical photograph.

Explain the asymmetry using the different crossing levels.

Schematic prepared by Luna for Weave Viva, based on P3-13. Original vector diagram.

The face and body point across.

A left-sided brainstem example, illustrated face-on.



Determine the actual nerve and tract; “crossed” is a localisation clue.

Schematic ▪ Original teaching diagram ▪ September 2026

Schematic. Crossed signs combine an ipsilateral cranial-nerve finding with a contralateral long-tract deficit. This schematic shows the laterality principle, not one universal syndrome: the affected nerve and tract depend on the brainstem level. Midbrain, pontine and medullary syndromes have different combinations.

Name the cranial nerve, then the opposite-side body deficit.

Schematic prepared by Luna for Weave Viva, based on P3-14. Original vector diagram.

V - 52

Hemiparesis: localise by pattern, name the territory, manage the stroke.

10 THE NEUROLOGY SHORT CASE SYLLABUS CORE

SKELETON

2	**Distribution**	Face, arm and leg, and which of them is worst
2	**Cortical or not**	Aphasia, neglect, field cut, gaze deviation, each asked for
2	**Territory**	The vessel, then what imaging should show
3	**Acute pathway**	Glucose, imaging, then the thrombolysis decision
1	**Prevention**	Targets by domain, plus the psychiatric review

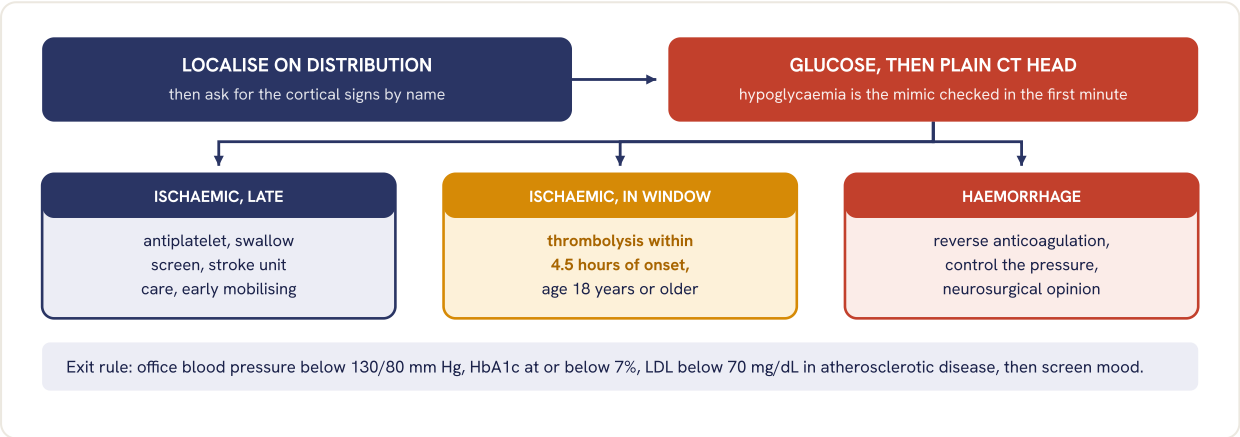


Fig 52.1 Localise, exclude the mimic, then three lanes by scan and clock; targets on the foot.

- **Five patterns, five levels.** Face and arm worse than leg is the middle cerebral convexity; leg worse is the anterior cerebral parasagittal cortex; equal involvement is the posterior limb of the internal capsule or the basis pontis; crossed signs are brainstem; face spared with a normal jaw jerk is high cervical cord.
- **The split on the scan.** Plain computed tomography separates ischaemic stroke, around 85% of cases, from intracerebral haemorrhage, around 15%. Proportionate weakness with no cortical sign is a capsular lacune, and pure motor hemiparesis is the commonest lacunar syndrome.

PITFALL

Quoting a stroke severity score as the whole assessment. The scale is weighted towards anterior circulation and dominant-hemisphere deficits, so posterior circulation strokes with isolated vertigo, ataxia or dysphagia, and non-dominant strokes with anosognosia or subtle neglect, can score low despite significant impairment. Name the limitation.

WHAT EARNS THE MARKS

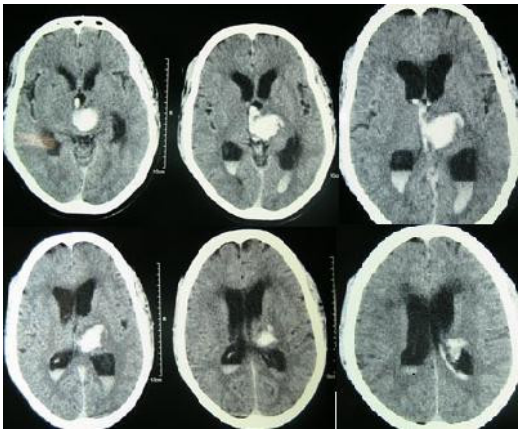
- **Distribution before diagnosis.** The pattern in the first typed line is the localisation.
- **The red box placed first.** Glucose precedes imaging, and imaging precedes the thrombolysis question.
- **Cortical signs reported as absent.** Their absence is what makes the lacunar diagnosis.
- **The foot strip quoted with targets.** Most candidates stop at the acute lane.

SEE ALSO V - 50 upper against lower motor neuron V - 51 cord and brainstem syndromes V - 49 the classic gaits

Weave Viva, Part IV

Thalamic blood with ventricular extension

Companion to original page 69



CT, serial axial slices. A thalamic haemorrhage extends into the third and lateral ventricles in the source case. Trace blood within the ventricles separately from the parenchymal focus. The small source composite is deliberately displayed at limited width to avoid false detail.

Contrast hyperattenuating blood with infarct hypoattenuation.

Yadav YR, Mukerji G, Shenoy R, Basoor A, Jain G, Nelson A. Intracerebral hemorrhage.jpg. CC BY 2.0. https://commons.wikimedia.org/wiki/File:Intracerebral_hemorrhage.jpg Licence: https://creativecommons.org/licenses/by/2.0 Unmodified.

Right MCA territory infarct

Companion to original page 69



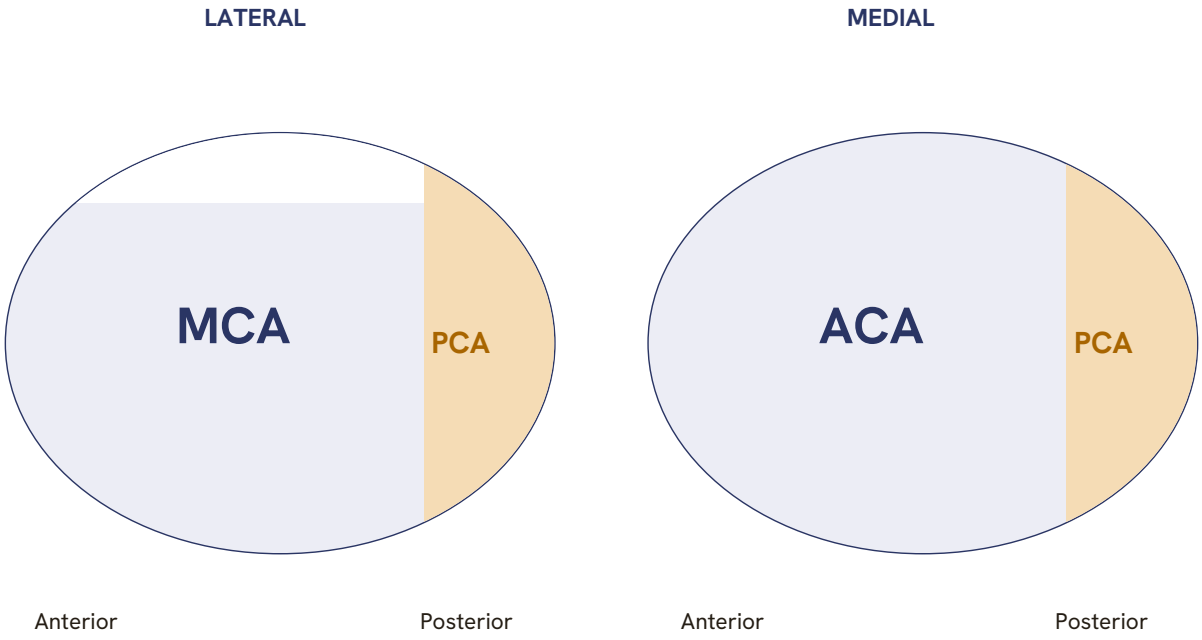
CT, axial plane. Right MCA territory hypoattenuation in the source infarct case. Describe the territory and attenuation before naming the source diagnosis. This low-resolution teaching image does not support fine vessel or early-ischaemia grading.

Recognise a lateral hemispheric arterial territory and compare it with haemorrhage.

Lucien Monfils. INFARCT.jpg. CC BY-SA 3.0. https://commons.wikimedia.org/wiki/File:INFARCT.jpg Licence: https://creativecommons.org/licenses/by-sa/3.0 Unmodified.

Relate the surface to the artery.

Idealised hemispheric territories; borders vary between people.



Surface territories are a starting point.

Check deep structures, border zones and clinical context.

Schematic ▪ Original teaching diagram ▪ September 2026

Schematic. Conceptual cortical arterial territories: MCA over much of the lateral convexity, ACA over the medial frontal/parietal surface and PCA over the occipital region. Deep perforator territories and border zones are not mapped. This is a spatial teaching diagram, not a perfusion study or a patient-specific arterial atlas.

Connect the affected body region and cortical signs to a plausible territory.

Schematic prepared by Luna for Weave Viva, based on P3-16. Original vector diagram.

V - 53

Parkinsonism: examination, causes, treatment and the neuropsychiatry.

10 | THE NEUROLOGY SHORT CASE | SYLLABUS CORE

SKELETON

2 **Is it parkinsonism**	Bradykinesia with rest tremor or rigidity, demonstrated aloud
2 **Show the decrement**	Repetition tasks, then the Froment manoeuvre
3 **Criteria**	Supportive features, absolute exclusions, red flags
3 **Treatment**	Motor complications, then psychosis without motor harm

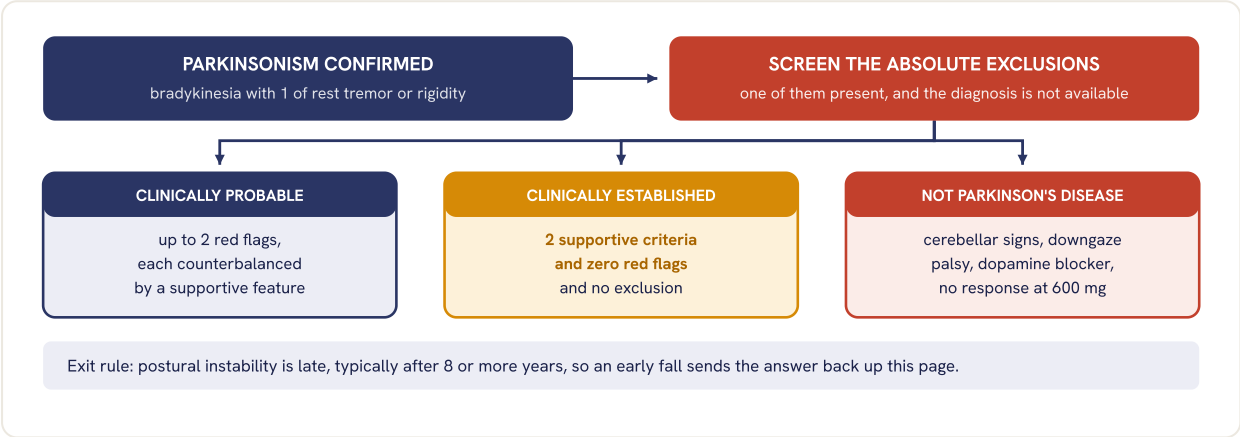


Fig 53.1 Syndrome test, exclusions screened, then the three verdicts; the tempo rule on the foot.

- **The decrement is the examination.** Bradykinesia is slowness with progressive reduction in speed and amplitude on repetition, so ask for movements as fast and as large as possible for at least 10 repetitions: finger tapping, fist opening and closing, forearm pronation and supination, and toe tapping, the most sensitive lower limb test.
- **Read the drug chart for the complication.** Peak-dose dyskinesia appears 1 to 2 hours after the dose and improves with a modest reduction; diphasic dyskinesia appears twice, as the drug takes effect and as it wears off, sits with subtherapeutic levels and improves with higher doses.

PITFALL

Treating psychosis here with a potent dopamine blocker, which can precipitate prolonged akinesia and rigidity crises. The approved reference agent is not marketed in India, so name it, then say the workable ward options are low-dose quetiapine or clozapine, the second under baseline and serial absolute neutrophil counts.

WHAT EARNS THE MARKS

- **The decrement demonstrated.** Slowness on its own is not bradykinesia.
- **The red box screened before the label.** An absolute exclusion closes the diagnosis.
- **Established against probable.** Two supportive criteria and the red flag count, as the amber lane states.
- **Psychosis handled safely.** Reference agent named, then the option an Indian ward can run.

SEE ALSO V - 46 motor examination V - 49 the classic gaits V - 55 tremor and Wilson's disease Weave Viva, Part IV

V - 54

Peripheral neuropathy and Guillain-Barre: patterns, causes, examination.

10 THE NEUROLOGY SHORT CASE SYLLABUS CORE

SKELETON

1 The axis	Classify by pattern of nerves, not by cause
4 The five patterns	Each with its causes and its bedside finding
3 The acute branch	Ascending areflexic weakness, and the tempo that names it
2 Examine for it	Large fibres, small fibres, then the drug chart

PATTERN	CAUSES	BEDSIDE FINDING
Mononeuropathy	Entrapment, trauma, ischaemia, leprosy	**Deficit confined to one named nerve**
Mononeuritis multiplex	Vasculitis, diabetes, leprosy, connective tissue disease, HIV	**Asymmetric patchy deficits in several nerves**
Distal symmetrical sensorimotor	Diabetes, alcohol, nutritional deficiency, renal disease, drugs	**Glove and stocking loss, distal wasting, early Achilles reflex loss**
Symmetrical proximal motor	Guillain-Barre syndrome, chronic inflammatory demyelinating polyradiculoneuropathy, arsenic, porphyria, vincristine	**Girdle weakness with early areflexia**
Autonomic predominant	Amyloidosis, diabetes, paraneoplastic, heavy metals	**Orthostatic hypotension, gastroparesis, anhidrosis**

The amber column is the discriminating finding. Cause follows pattern, and the reverse reads as recall.

- **The acute branch, in depth.** Guillain-Barre syndrome is symmetrical ascending weakness with absent deep tendon reflexes, or distal areflexia with proximal hyporeflexia. The nadir falls within 4 weeks, while progression or relapse beyond 8 weeks makes it the chronic form, where corticosteroids are first-line maintenance and in the acute form they are not indicated.
- **Examine both fibre classes.** A 128 Hz fork at the hallux and medial malleolus, and the 10-g monofilament until it buckles for about 1 second, for large fibres; pinprick and cold over the dorsum of the foot for small fibres. Diabetic neuropathy affects 25% to 50% of people with diabetes.
- **The psychiatry mark.** Lithium and amitriptyline give a sensorimotor neuropathy, disulfiram a painful axonal one, phenytoin a distal axonal one, nitrous oxide an acute functional cobalamin deficiency.

PITFALL

Excluding Guillain-Barre syndrome on early tests. Cerebrospinal fluid protein is frequently normal in the first 1 to 2 weeks, and nerve conduction can be entirely normal early because the inflammation is proximal at the roots. Repeat the puncture rather than closing the diagnosis.

WHAT EARNS THE MARKS

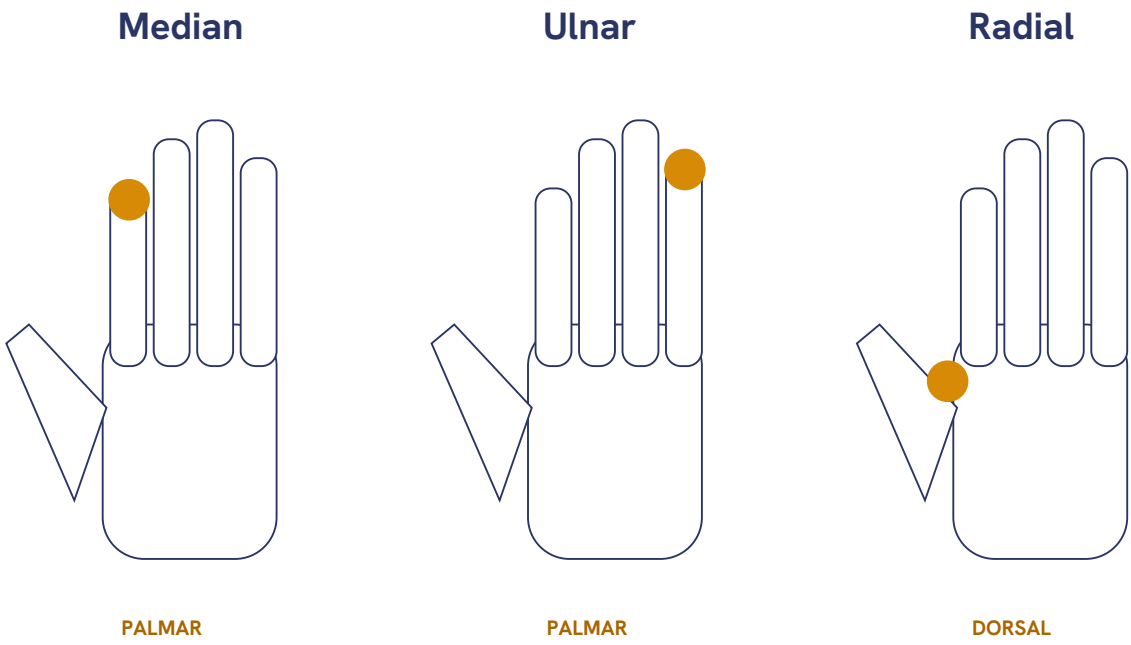
- **The axis stated before the list.** Pattern of nerves first, causes second.
- **One amber finding per row.** The five discriminators are the five bedside marks.
- **Tempo used to split the pair.** Four weeks against eight weeks, with the steroid line attached.
- **The drug chart read aloud.** The psychotropic list is the psychiatry mark on this page.

SEE ALSO V - 47 sensory examination V - 50 upper against lower motor neuron V - 51 cord and brainstem syndromes

Weave Viva, Part IV

Use a small, discriminating sensory zone.

Simplified autonomous test regions; not full nerve territories.



Median: index finger pad

Ulnar: little finger pad

Radial: first dorsal web space

Schematic ▪ Original teaching diagram ▪ September 2026

Schematic. Hand sensory test regions: palmar index fingertip for median nerve, palmar little fingertip for ulnar nerve and dorsal first web space for superficial radial nerve. These are selected discriminating zones, not drawings of each nerve's whole cutaneous supply. Compare sides and correlate with motor findings.

Do not confuse a nerve territory with a dermatome.

Schematic prepared by Luna for Weave Viva, based on P3-18. Original vector diagram.

V - 55

Tremor and Wilson's disease.

10 THE NEUROLOGY SHORT CASE SYLLABUS CORE

SKELETON

1 The axis	Classify tremor by what activates it
3 The classes	Rest, postural, kinetic and task-specific, with frequency
2 Drug chart and screen	Thyroid, calcium, glucose, liver, then the agent
4 The young patient	Copper studies before any lifelong psychiatric label

CLASS	WHAT ACTIVATES IT	FREQUENCY	THE BEDSIDE MARKER
Rest	Part relaxed and fully supported	3 to 6 Hz	Re-emergent after 5 to 10 seconds of posturing
Postural	Holding against gravity	4 to 12 Hz	Immediate, within 1 to 2 seconds
Kinetic, including intention	Movement towards a target	Variable	Amplifies as the target is approached
Task-specific	One learned motor task	Variable	Absent until that task is attempted

Amber is the timing column, and the latency on posturing is the single manoeuvre that separates the two common tremors at the bedside.

- **Read the drug chart in the same sitting.** Lithium gives postural, resting and intention tremors; valproate gives postural and resting tremor; serotonin reuptake inhibitors give a fine postural tremor; antipsychotics give a parkinsonian rest tremor at 3 to 6 Hz with cogwheel rigidity through striatal D2 blockade.
- **The young patient with any movement disorder.** Wilson's disease is autosomal recessive, from variants in ATP7B. Ceruloplasmin below 10 mg/dL is strongly suggestive yet normal in 5% of patients; urinary copper above 100 mcg per 24 h confirms overload; the Kayser-Fleischer ring is present in about 95% of neurological presentations and about 50% of hepatic ones.

PITFALL

Starting D-penicillamine at full dose. Paradoxical neurological worsening occurs in 20% to 40% of patients with pre-existing neurological symptoms in the first months, because rapid mobilisation spikes circulating free copper. Start low and titrate slowly, or use trientine or zinc as primary therapy.

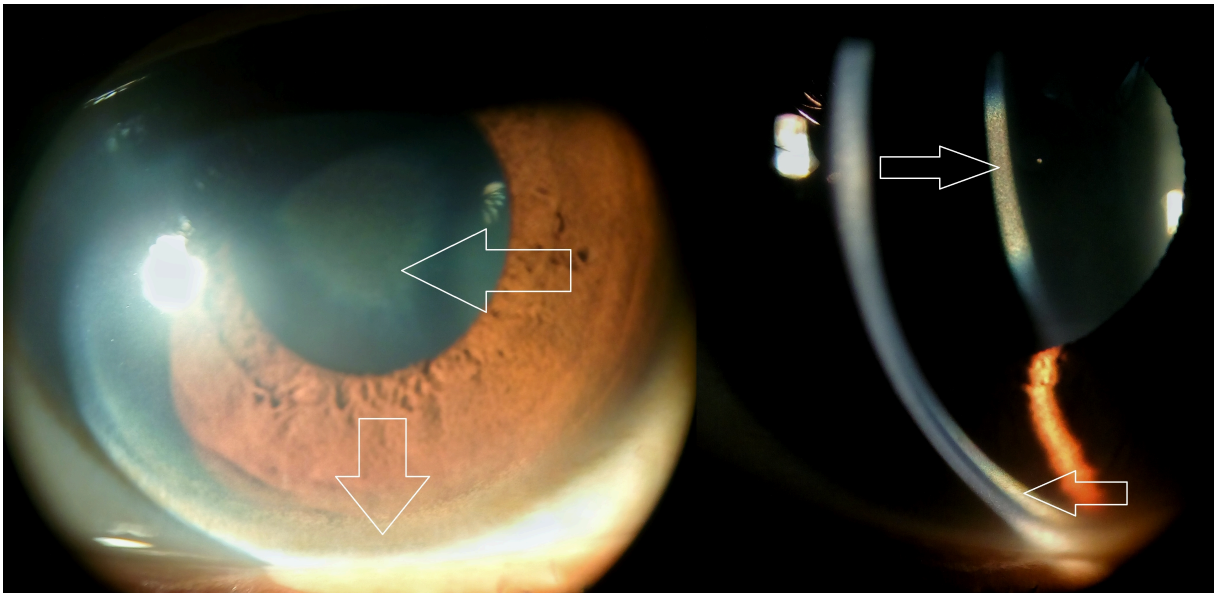
WHAT EARNS THE MARKS

- **The activation class named first.** Rest, postural, kinetic or task-specific, before any diagnosis.
- **The amber timing quoted.** Re-emergence against immediate onset is the discriminating manoeuvre.
- **The reversible screen offered.** Thyroid, calcium, glucose and liver before accepting a label.
- **Copper studies in the young patient.** Slit lamp, ceruloplasmin and urinary copper, with the caveat that a normal value does not close it.

SEE ALSO V - 48 cerebellar examination V - 53 parkinsonism V - 46 motor examination Weave Viva, Part IV

Kayser–Fleischer ring and sunflower cataract

Companion to original page 72



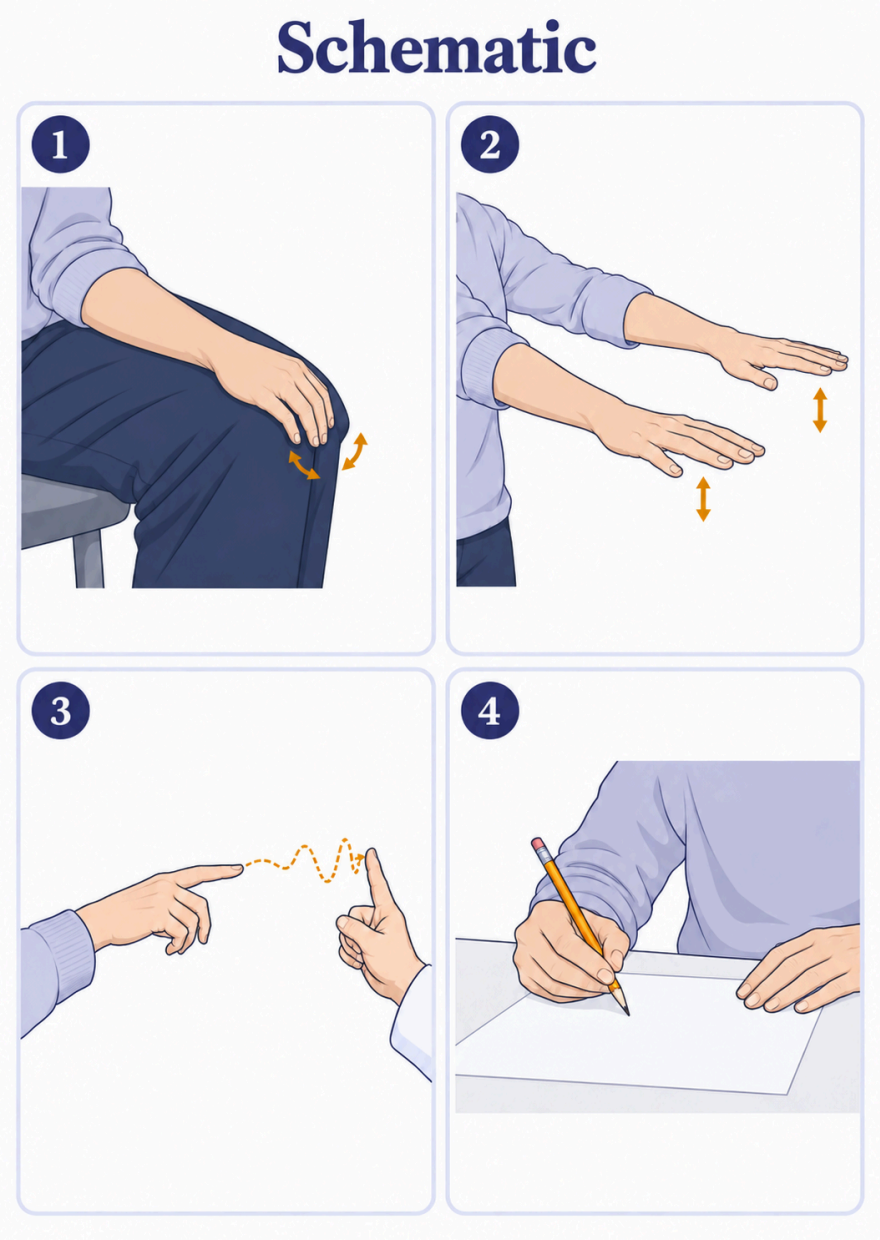
Clinical ocular photographs showing peripheral corneal copper deposition and a sunflower cataract. The source labels the Kayser–Fleischer ring at Descemet membrane and the cataract at the anterior lens capsule. The peripheral corneal ring and the lens opacity are different anatomical findings. The photographs demonstrate ocular signs; they do not establish Wilson disease independently.

Separate the peripheral corneal ring from lens involvement; use the slit illumination in the source.

Imrankabirhossain. KF ring and Sunflower cataract.jpg. CC BY-SA 4.0. https://commons.wikimedia.org/wiki/File:KF_ring_and_Sunflower_cataract.jpg
Licence: https://creativecommons.org/licenses/by-sa/4.0 Unmodified.

Tremor: examine the activation condition

Companion to original page 72



Schematic. 1: supported rest. 2: posture against gravity. 3: movement towards a target, illustrating intention as a kinetic subtype. 4: a writing task. The target panel depicts increasing oscillation near a target, while the writing panel depicts a task context. Arrows are conceptual motion cues, not measured waveforms; frequency, latency and diagnostic significance require observation.

Distinguish rest, postural, kinetic and task-specific activation conditions.

Schematic prepared by Luna for Weave Viva, based on P3-23. AI-generated educational illustration.

V - 56

Epilepsy: seizure classification, first-line drugs, status epilepticus.

10 THE NEUROLOGY SHORT CASE SYLLABUS CORE

SKELETON

2 Three levels	Seizure type, epilepsy type, then syndrome
1 Aetiology	Structural, genetic, infectious, metabolic, immune or unknown
3 Drug choice	By seizure type, and by childbearing potential
3 Status ladder	Time-banded doses, read off the clock
1 Counselling	Driving, machinery, heights, flames, and the record

SEIZURE TYPE OR SUBGROUP	FIRST-LINE MONOTHERAPY	CAUTION
Focal onset	Lamotrigine or levetiracetam	Levetiracetam with caution in active depression or anxiety
Generalised onset, men and postmenopausal women	Valproic acid, lamotrigine or levetiracetam	Carbamazepine and phenytoin worsen myoclonus
Generalised onset, women of childbearing potential	Lamotrigine or levetiracetam	Valproic acid contraindicated for teratogenicity and neurodevelopmental risk
Absence	Ethosuximide or valproic acid	Carbamazepine, phenytoin and gabapentin can aggravate absence

The amber column is the answer to the question as asked.

- **Say which level you are at.** Seizure type, then epilepsy type meaning focal, generalised, combined or unknown, then syndrome, with aetiology evaluated at every stage. The 2017 operational classification sorts seizures by onset into 3 groups.
- **The status ladder, off the clock.** Status epilepticus is 5 or more minutes of continuous seizure activity, or 2 or more discrete seizures without recovery between them. Lorazepam 4 mg intravenously over 2 minutes, repeated once; then levetiracetam 60 mg/kg to a maximum of 4,500 mg, sodium valproate 40 mg/kg to 3,000 mg, or phenytoin 20 mg/kg to 2,000 mg; beyond 30 minutes intubate and titrate to burst suppression.

PITFALL

Retired terminology, which the examiner is listening for: a focal to bilateral tonic-clonic seizure called secondarily generalised, or a focal impaired awareness seizure called complex partial. And the counselling is the medico-legal protection, so record the advice on driving, hazardous machinery, heights and cooking near open flames.

WHAT EARNS THE MARKS

- **The level declared.** Say whether you are naming a seizure, a type or a syndrome.
- **The amber column with its caution.** A drug named without its liability is half the row.
- **The clock quoted with the dose.** The ladder is scored on time bands and doses together.
- **Childbearing potential addressed unprompted.** It is the row that changes the prescription.

SEE ALSO V - 52 hemiparesis and stroke V - 54 peripheral neuropathy V - 43 higher mental functions

Weave Viva, Part IV

AREA 06 OF 10 · PV-A06

OSCE stations

12	12.0%	V-57	V-68
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

SYLLABUS CORE 12

REVISION ORDER

Rehearse these aloud with a partner, bad news and psychoeducation first. The four counselling stations share one structure, so take them as a group.

WHAT IS IN THIS AREA

Communication and counselling stations: bad news, family psychoeducation, and consent or counselling for ECT, clozapine, lithium and antidepressants. Then risk, motivational interviewing, de-escalation, eliciting psychopathology, cognitive testing and a child protection disclosure.

V - 57

Breaking bad news: SPIKES, run as a station.

10 OSCE STATIONS SYLLABUS CORE

SKELETON

2 Set up, then ask	Privacy, who is present, what they already understand
3 Invitation and knowledge	Permission, warning shot, plain words, chunk and check
3 Emotions	Name the emotion and its reason, then wait
2 Strategy and the triad	Concrete plan, care partner, planning while capacity holds

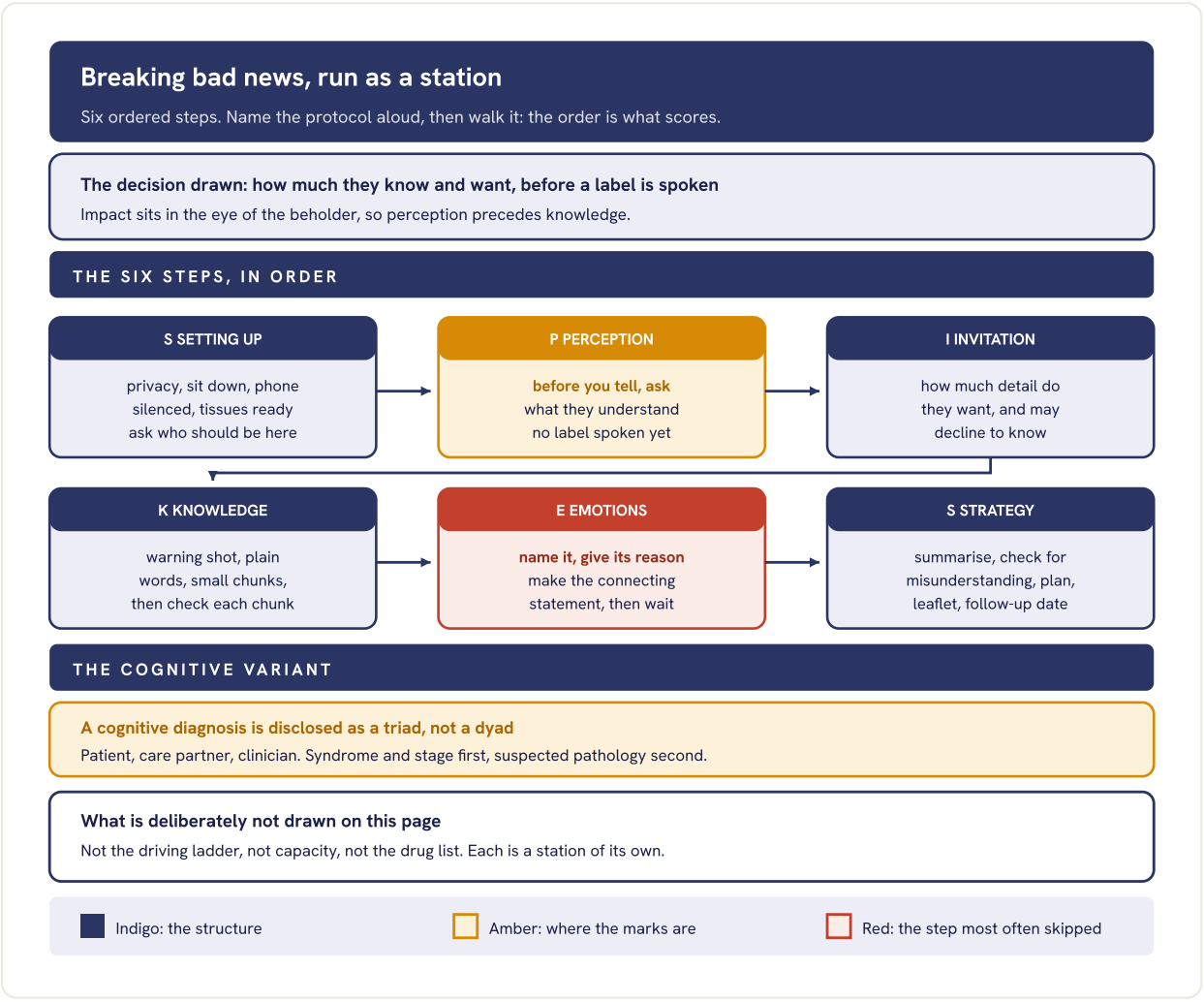


Fig 57.1 The protocol drawn in order, perception in amber because no label is spoken before it, emotions in red because information stops there until distress settles.

- **Under-disclosure is the norm.** Fewer than 50% of people with mild cognitive impairment are told their diagnosis. Say the words, then hold the room.
- **When deferral is defensible.** An explicit wish not to know, an acute exacerbation triggered by disclosure, or advanced impairment where comprehension has gone. A family request to conceal is explored, not agreed.

WHAT EARNS THE MARKS

- **The perception step, reached before any label.** Asking first is the scored behaviour.
- **The warning shot, then chunk and check.** It is the shape the checklist follows.
- **The connecting statement before logistics,** marked red because information stops until distress settles.
- **The triad strip.** The care partner gives collateral and carries out the plan.

SEE ALSO Slot V - 58 explaining schizophrenia to a family Slot V - 67 cognitive testing at the bedside Weave Viva, Part V

V - 58

Explaining schizophrenia to a family: psychoeducation and expressed emotion.

10 OSCE STATIONS SYLLABUS CORE

SKELETON

2 Their model first	Ask what the family believes before offering any account
2 Plain words	Voices, beliefs, jumbled speech, reduced drive, lost insight
3 Remove blame	Vulnerability meeting stress, not upbringing or weakness
3 Expressed emotion, then the plan	Criticism adverse, warmth protective, four phases of family work

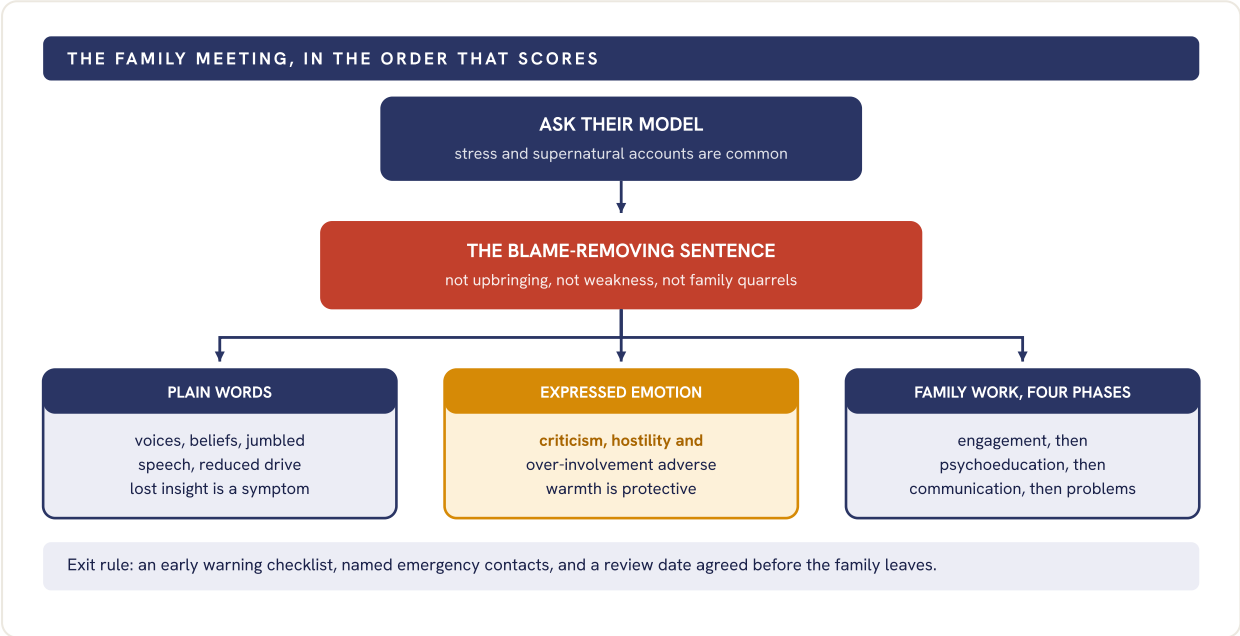


Fig 58.1 The meeting drawn in order. The blame-removing sentence sits in red because it is the step candidates skip, and expressed emotion in amber because warmth and criticism are scored on opposite sides of the same construct.

- **The relapse numbers.** High expressed emotion raises early relapse, odds ratio 4.87, confidence interval 3.22 to 7.36, while warmth is protective at 0.35, from 33 cohorts and 2284 patients.
- **Calling high expressed emotion the cause.** It is a psychosocial stressor and a predictor of relapse. Scolding relatives for criticism loses the same mark, because criticism reflects burden and missing information.

WHAT EARNS THE MARKS

- **The explanatory model, elicited before teaching.** The account you give has to land inside theirs.
- **The blame-removing sentence, drawn in red.** It is the step most often left out.
- **Warmth separated from emotional over-involvement** in the amber lane. They sit on opposite sides of the score.
- **The four phases, in order, with the exit strip.** An early warning list with named contacts closes the station.

SEE ALSO Slot V - 57 breaking bad news as a station Slot V - 60 clozapine counselling Weave Viva, Part V

V - 59

Explaining ECT and taking consent, including the Act's rules.

10 OSCE STATIONS SYLLABUS CORE

SKELETON

2 **Capacity first**	Understand, retain, weigh, communicate, then their fears
2 **Describe it plainly**	Anaesthesia, relaxant, measured current, brief therapeutic seizure
3 **Memory, said accurately**	Four effects, four time courses, no promise about any
3 **The statute**	Section 95 bars unmodified use, Section 94 bars emergency use

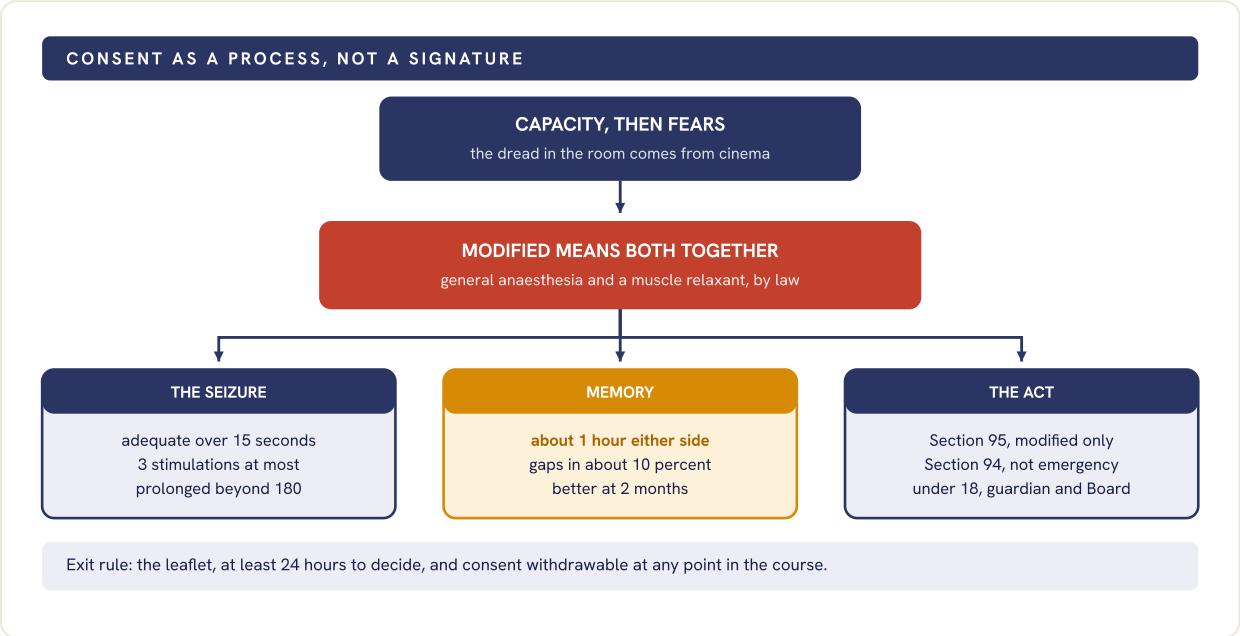


Fig 59.1 The station drawn as one definition and three lanes. Modified treatment sits in red because unmodified practice is unlawful, and memory in amber because the accurate answer earns more than a reassuring one.

- **Course, when the family asks how long.** Twice weekly in the primary guideline, an acute course of 6 to 12 sessions, improvement often visible within 2 weeks, with mental state and cognition reassessed after each session.
- **Activity restrictions.** No driving, machinery, work or major legal and financial decisions for 1 to 2 weeks after an acute course, or for at least 24 hours after an outpatient maintenance treatment.
- **Giving it as emergency treatment in a stuporous catatonic patient.** Section 94 removes that route here. Supported admission with the nominated representative's consent is the lawful path.

WHAT EARNS THE MARKS

- **The red band definition.** Modified means anaesthesia and relaxant together, which is what Section 95 requires.
- **The two seizure durations in the first lane.** Adequacy and prolonged are different numbers and are often swapped.
- **The amber memory lane, stated without a promise.** A promise of no memory effect is a scored error.
- **The exit strip.** Leaflet, time to decide, and withdrawal make consent a process.

SEE ALSO Slot V - 61 lithium counselling Slot V - 67 cognitive testing at the bedside Weave Viva, Part V

V - 60

Clozapine counselling: monitoring schedule and the warnings.

10 OSCE STATIONS SYLLABUS CORE

SKELETON

2	**Benefit before burden**	Most effective in resistance, fewer admissions, less suicidality
2	**Baseline and titration**	Counts, cardiac markers, metabolic set, slow upward steps
3	**The count schedule**	Green, amber and red, each with its own action
3	**Red flags and dose variables**	Fever, chest, bowels, dizziness, smoking, missed doses

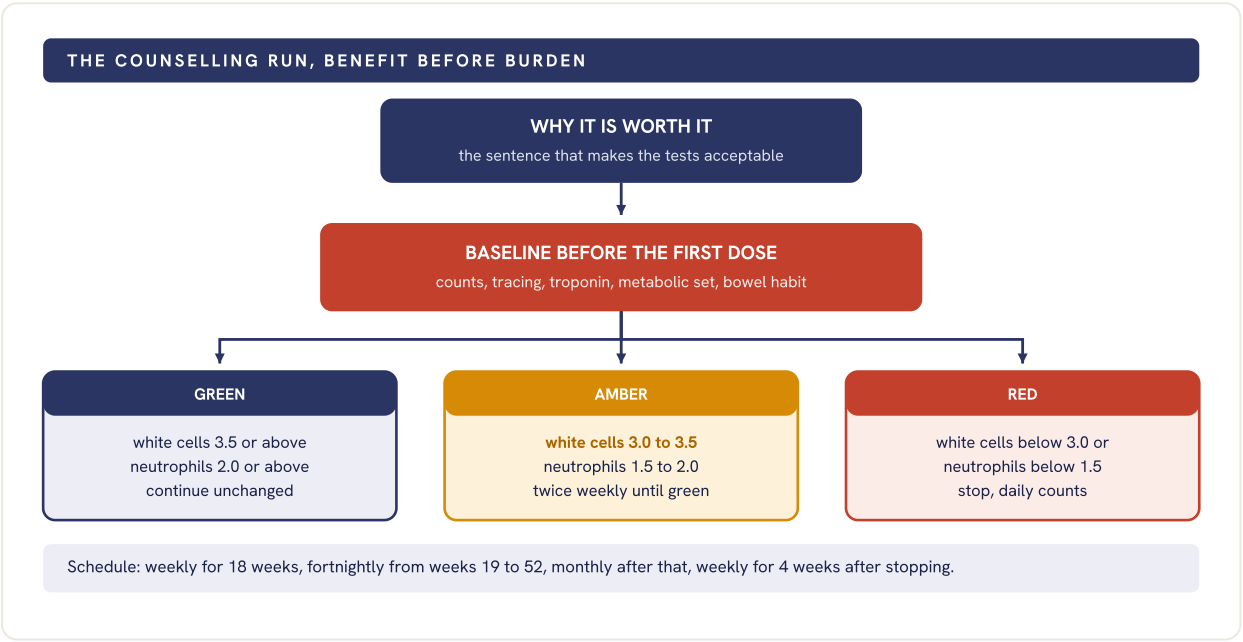


Fig 60.1 The three count bands with the action attached to each, because the count alone answers nothing. Counts are in units of 10 to the ninth per litre. The schedule rides as a strip so the answer ends where the checklist does.

- **The myocarditis window.** Within the first 28 days, peaking at 12 to 16 days, with C-reactive protein rising about 5 days before troponin. Stop above 100 mg/L or troponin over twice the upper limit.
- **Naming agranulocytosis as the main lethal hazard.** With monitoring in place, gastrointestinal hypomotility causes more deaths, and abdominal pain is under-reported. Ask about bowels at each contact.
- **Smoking and the missed dose.** Burning tobacco induces CYP1A2, so stopping smoking acts as a dose increase, and a break beyond 48 hours means restarting at 12.5 mg at night and re-titrating.

WHAT EARNS THE MARKS

- **The benefit band, spoken before the baseline band.** It is what makes the monitoring burden acceptable.
- **An action in each of the three count lanes.** Reciting thresholds without the action is a mid-band answer.
- **Bowel symptoms named as the lethal hazard** in the trap line, ahead of the blood count.
- **Smoking treated as a dosing variable.** The schedule strip and the re-titration rule close the station.

SEE ALSO Slot V - 58 explaining schizophrenia to a family Slot V - 61 lithium counselling Weave Viva, Part V

V - 61

Lithium counselling: levels, toxicity warning signs, pregnancy, interactions.

10 OSCE STATIONS SYLLABUS CORE

SKELETON

2	**Baseline and brand**	Renal, thyroid, calcium, count, tracing, pregnancy test
3	**Levels**	Trough 12 hours after the dose, target set by indication
3	**Nuisance against toxicity**	Fine tremor tolerable, coarse tremor and vomiting mean stop
2	**Salt, fluid, pregnancy**	Steady salt, more fluid in heat and fever, preconception counselling

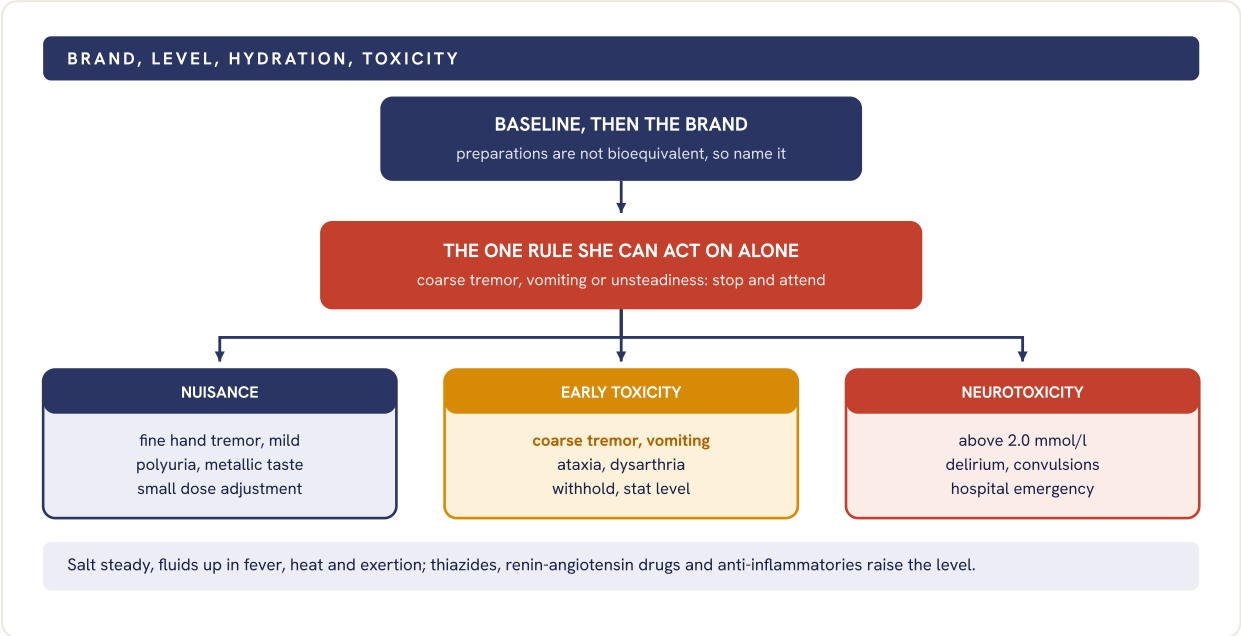


Fig 61.1 Three tiers the patient has to be able to tell apart, with the single actionable instruction in red above them. The strip carries the two variables she controls, salt and fluid, and the interactions that raise the level without any change in dose.

- **Targets by indication.** A first manic presentation 0.6 to 0.8 mmol/l, refractory mania 0.8 to 1.0, maintenance and older adults 0.4 to 0.6, sampled exactly 12 hours after the dose.
- **Pregnancy.** First-trimester exposure carries an absolute cardiac malformation risk of up to 2.25%, with right ventricular outflow tract obstruction at 0.6%. Exposure alone is not a ground for termination.
- **Trusting the number over the picture.** Neurotoxicity can occur with levels inside the target range, so clinical signs outrank a reassuring result.

WHAT EARNS THE MARKS

- **The brand named in the top band, with the reason.** Preparations are not bioequivalent.
- **The red band rule, given to the patient.** One instruction she can act on without a clinic visit.
- **Three tiers kept apart across the lanes.** A single undifferentiated side-effect list reads as recall.
- **The salt and fluid strip.** Steady salt and extra fluid in heat and fever are the counselling lines examiners wait for.

SEE ALSO Slot V - 60 clozapine counselling Slot V - 62 starting an antidepressant Weave Viva, Part V

V - 62

Starting an antidepressant: the counselling station.

10 OSCE STATIONS SYLLABUS CORE

SKELETON

2	**Set the frame**	Shared decision, their beliefs, the relative who holds the strip
3	**The seven contents**	Indication, dose, lag, early effects, contacts, duration, stopping
3	**The activation window**	Supervised dispensing, crisis contact, an early review date
2	**Duration and stopping**	Episode count drives duration, then proportional tapering

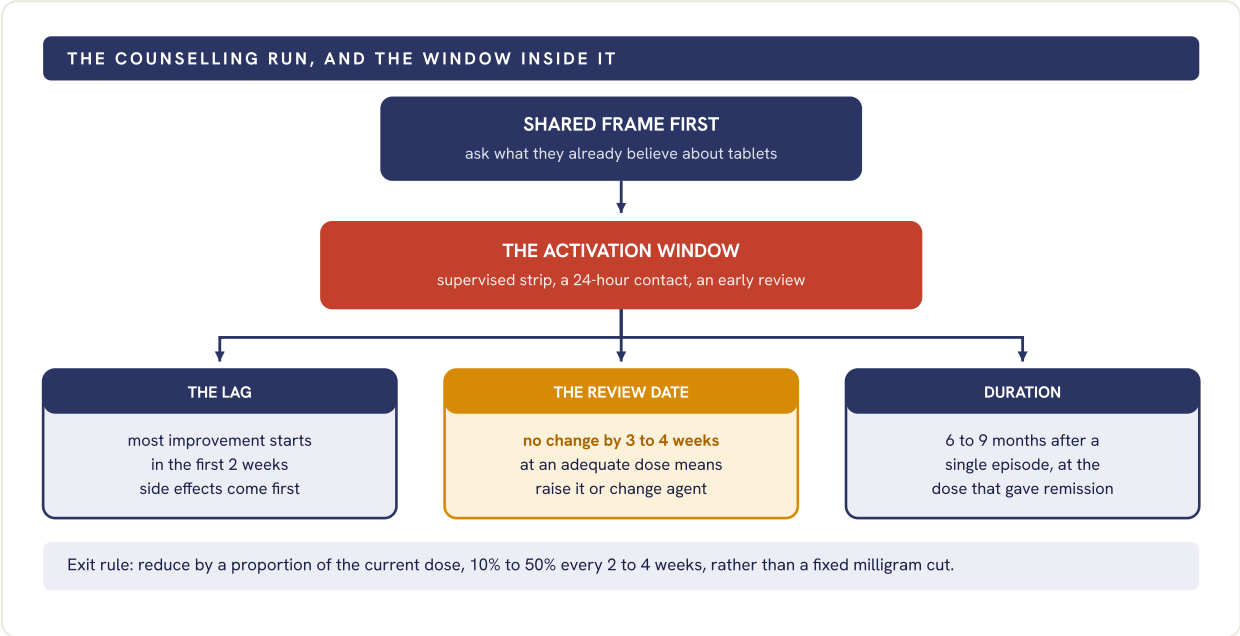


Fig 62.1 The run drawn with the activation window in red, because it is the safety-critical band and the one candidates leave implicit. The review date sits in amber: an open-ended wait is what the examiner is listening for.

- **The forgetting number.** Between 40% and 80% of what is said in a consultation is forgotten immediately, which is the argument for involving the family member who holds the strip.
- **Reading akathisia as worsening depression.** Restlessness with an inability to sit still calls for dose reduction, not escalation. Then screen for a bipolar diathesis if sleep need falls.
- **Discontinuation against relapse.** Discontinuation appears within 1 to 2 days and settles within hours to days on rechallenge; relapse builds over weeks and needs 2 to 4 weeks of re-titration.

WHAT EARNS THE MARKS

- **The three safeguards in the red band.** Supervised dispensing, a crisis contact and an early review date.
- **Adverse effects placed before benefit** in the lag lane. Saying so protects the first two weeks of adherence.
- **Episode count driving duration** in the third lane, rather than a single stock figure.
- **Proportional steps in the exit strip.** Hyperbolic occupancy is what makes a fixed milligram cut wrong at low doses.

SEE ALSO Slot V - 61 lithium counselling Slot V - 63 the suicide risk interview Weave Viva, Part V

V - 63

The suicide risk interview: how to ask and how to close safely.

10 | OSCE STATIONS | SYLLABUS CORE

SKELETON

2	**Frame the question**	Seen alone, confidentiality with its limit, positive framing
3	**The four windows**	Presenting event, recent weeks, past, immediate and future
3	**Intent against lethality**	Ask what they expected the act to do
2	**Close safely**	Six-step safety plan with means restriction, then disposition

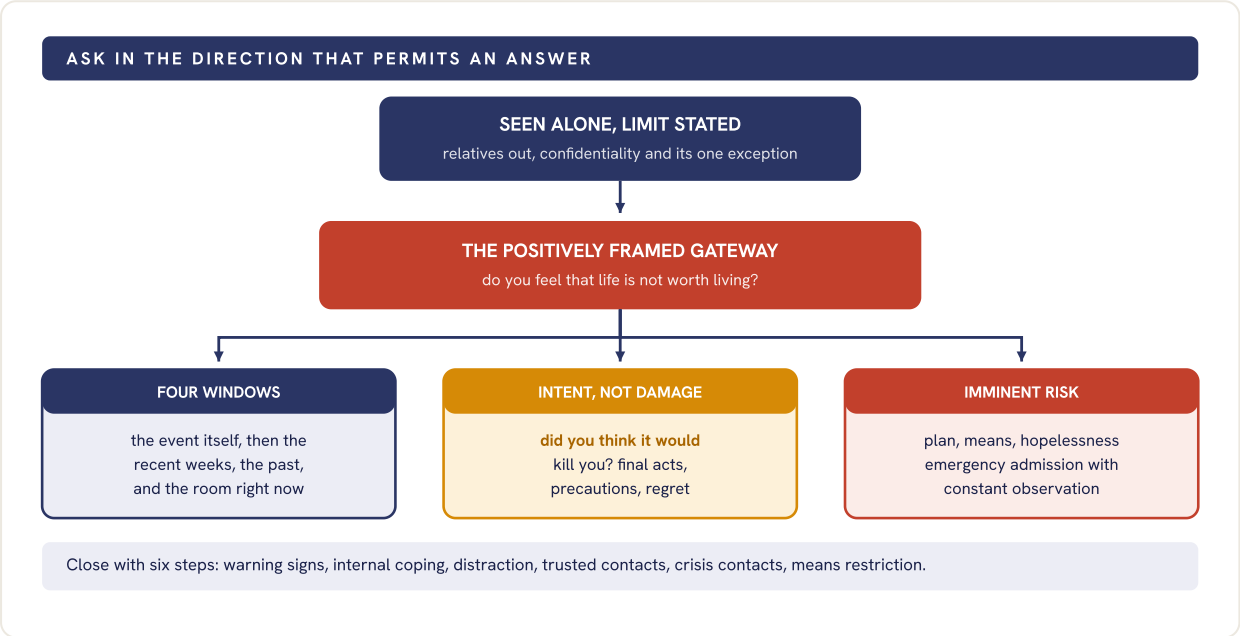


Fig 63.1 The interview drawn as one framing decision and three lanes. The gateway question sits in red because its wording changes what the patient is able to say, and intent sits in amber because it, not the medical damage, is what the disposition turns on.

- **Framing changes the answer.** Asked negatively, 66% say no and 9.7% disclose. Asked positively, 42.9% say no and 38.1% disclose, without inflating reported suicidality.
- **Scale twice, then ask both anchors.** Intensity now from 1 to 10, and likelihood of acting over the next 24 to 48 hours. At four, ask what keeps it from being five or six, and why not two or three.
- **Contracting for safety.** A no-suicide contract is unproven and indefensible, because it manufactures reassurance and suppresses disclosure. Write the plan instead.

WHAT EARNS THE MARKS

- **The red gateway band, framed positively.** Negative framing produces denial and an early exit from the topic.
- **Behavioural detail across the four windows,** rather than a yes or no. Ambivalence is itself the disclosure.
- **The amber lane separating intent from lethality.** A small ingestion believed to be fatal carries high intent.
- **The six-step strip with means restriction.** That strip is what replaces a contract.

SEE ALSO Slot V - 65 de-escalation and rapid tranquillisation Slot V - 66 eliciting the mental state Weave Viva, Part V

V - 64

Motivational interviewing for alcohol: OARS, stages of change, FRAMES.

10 OSCE STATIONS SYLLABUS CORE

SKELETON

2	Spirit and processes	Partnership, acceptance, compassion, evocation across four processes
3	OARS	Open questions, affirmations, reflections, summaries inviting correction
3	Evoke change talk	Use a ruler, then ask why it is not lower
2	FRAMES, and the traps	Brief intervention structure, then the five scored failures

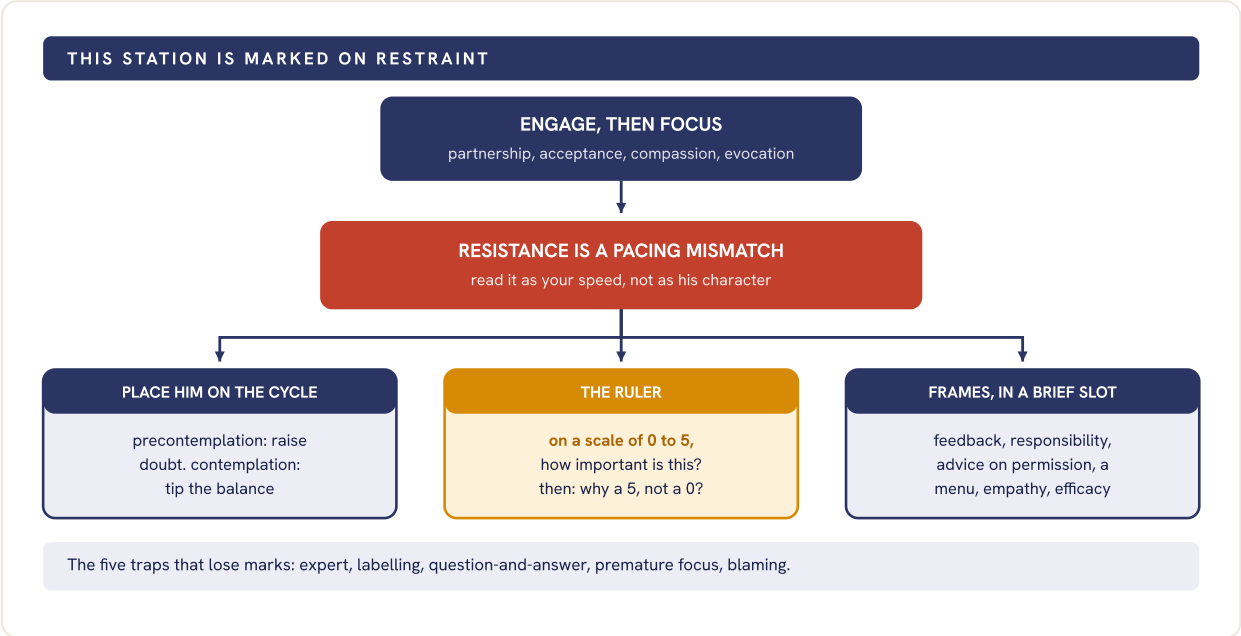


Fig 64.1 The station drawn around one reframe. Resistance sits in red because treating it as a trait is the error the whole method corrects, and the ruler in amber because the follow-up question, not the number, is what produces change talk.

- **Evidence for the follow-on viva.** A Cochrane review of 93 trials and 22,776 participants found reduced substance use against no intervention, standardised mean difference 0.48, and 0.12 at one year.
- **Dose and delivery.** 1 to 4 sessions of 15 to 45 minutes, with a minimum useful dose of 20 minutes; motivational enhancement therapy is the manualised 3 to 4 session variant.
- **The decisional balance run in the wrong order.** Good things about drinking first, then the less good, then the costs of changing, then the benefits, closing with a double-sided summary.

WHAT EARNS THE MARKS

- **The red band reframe, said out loud.** Resistance read as pacing rather than as a trait is the scored behaviour.
- **His stage named before any advice** in the first lane. Advice ahead of the stage is premature focus.
- **The amber follow-up question after the ruler.** The number alone earns nothing.
- **The five traps in the foot strip, avoided in the room.** Each one is a scored failure rather than a style note.

SEE ALSO Slot V - 62 starting an antidepressant Slot V - 63 the suicide risk interview Weave Viva, Part V

V - 65

De-escalating an agitated patient and rapid tranquillisation, with the restraint law.

10 OSCE STATIONS SYLLABUS CORE

SKELETON

2	Secure and screen	Unobstructed exit, weapons removed, reversible causes in parallel
3	Verbal de-escalation	Calm yourself, acknowledge, listen, mirror, empower, commit
3	Rapid tranquillisation	Oral first, then the named agent with its ceiling
2	Monitoring and restraint	Observations, escalation triggers, and the statutory limit

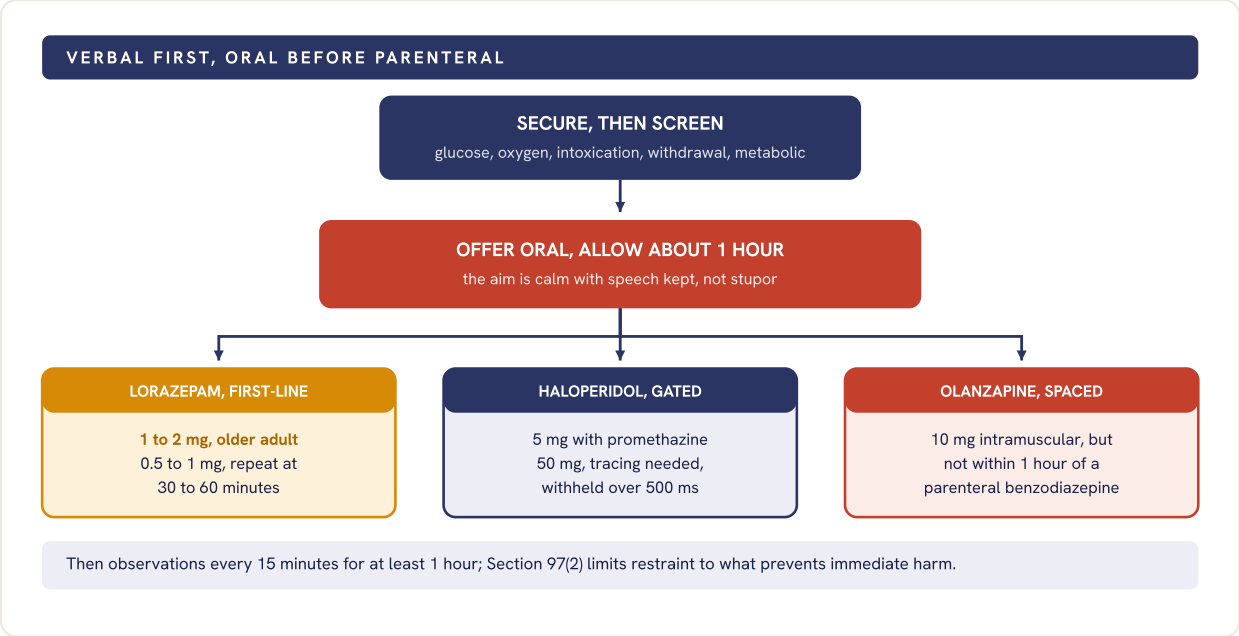


Fig 65.1 Three parenteral options ranked by what gates each one. Lorazepam is amber as first-line, olanzapine red for its interval rule, and the strip carries the observation schedule with the statutory ceiling on restraint.

- **Intramuscular olanzapine inside the hour.** Given within 1 hour of parenteral lorazepam or midazolam it can produce profound central depression, hypotension and cardiorespiratory arrest.
- **Escalation triggers to name.** Respiratory rate below 10 per minute, saturation below 94%, systolic below 90 mmHg, or pulse of 140 or more. Temperature over 38 degrees C with rigidity withholds antipsychotics.
- **Restraint as a procedure.** A coordinated team of at least 5 trained staff, 1 at the head managing airway and neck and 1 for each limb, with prone restraint avoided for positional asphyxia.

WHAT EARNS THE MARKS

- **The reversible-cause screen in the top band,** run in parallel with de-escalation rather than after it.
- **The red band goal.** Calm with speech preserved, not sedation to stupor, is the stated endpoint.
- **The interval rule in the third lane.** Olanzapine after a parenteral benzodiazepine is the commonest scored error here.
- **The statutory strip.** Section 97(2) sets the limit, and foreign restraint statutes carry no standing.

SEE ALSO Slot V - 63 the suicide risk interview Slot V - 66 eliciting the mental state Weave Viva, Part V

V - 66

Eliciting delusions, passivity and obsessions on a simulated patient.

10 OSCE STATIONS SYLLABUS CORE

SKELETON

2	**Safety and rapport**	Introduce, state the purpose, set the confidentiality frame
2	**Open, then normalise**	Sample thought stream and affect before any structured probe
3	**Ownership and agency**	Insertion, made thoughts, withdrawal, broadcasting, each with a script
3	**Obsession, then risk**	Resistance settles it, then suicidality and the children

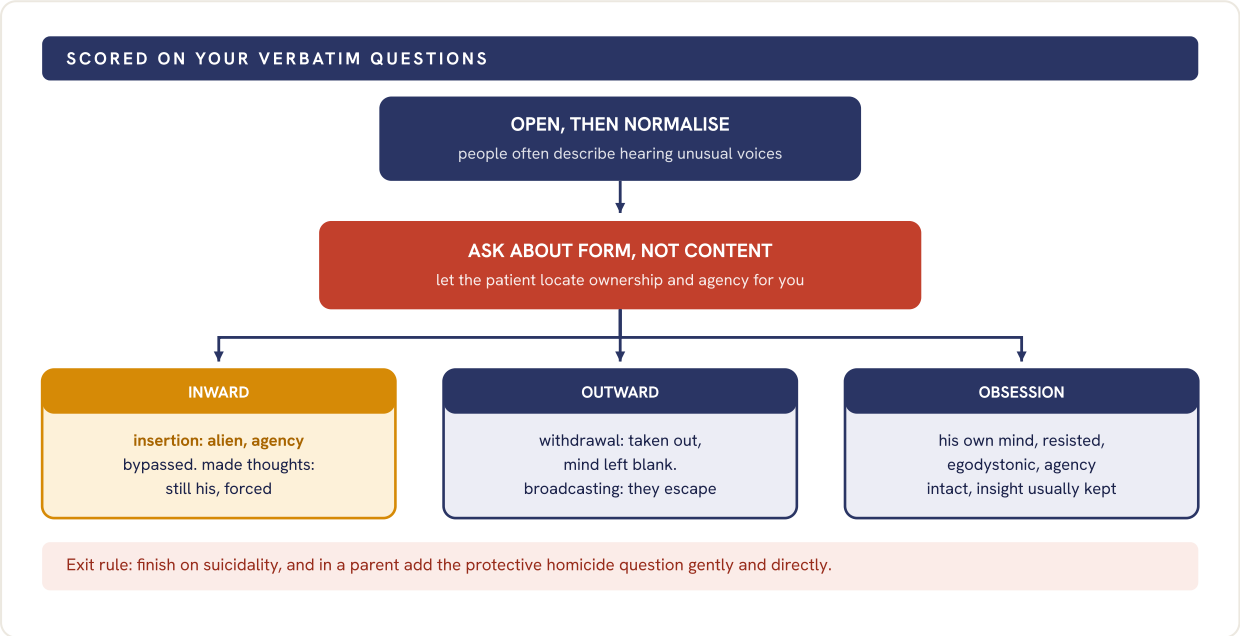


Fig 66.1 The two directions across the ego boundary, with obsession beside them because resistance and ownership separate the three. The red instruction makes the discrimination possible; the red strip is the limb candidates drop.

- **Specificity, when asked whether these are pathognomonic.** Thought insertion is elicited in 19% of patients with schizophrenia, 7.2% with mood disorders and 8% with brief reactive psychoses, so it marks psychosis rather than one diagnosis.
- **Delusions, without argument.** "Do you believe particular people or groups are watching you, following you, or trying to harm you?" then "how certain are you that it is happening this way, and could there be another explanation?" Delusional perception is a normal percept, then an unintelligible meaning.
- **Thought echo called broadcasting, and an obsession called insertion.** Modality settles the first: echo is heard, broadcasting is believed. Ownership settles the second.

WHAT EARNS THE MARKS

- **The normalising sentence in the top band,** spoken before any unusual-experience probe.
- **The red instruction to ask about form.** The patient, not the candidate, locates ownership and agency.
- **The three lanes kept distinct,** so insertion, made thoughts and obsession are not collapsed together.
- **The red exit strip.** Suicidality closes the station, and in a parent the homicide question closes it.

SEE ALSO Slot V - 58 explaining schizophrenia to a family Slot V - 67 cognitive testing at the bedside

Weave Viva, Part V

V - 67

Cognitive testing at the bedside: MMSE, MoCA, HMSE, ACE-III and their cut-offs.

10 OSCE STATIONS SYLLABUS CORE

SKELETON

2 **Choose the instrument**	Suspected pathology and literacy decide which screen
2 **Administer to script**	Permission first, no hints, a fixed number of repeats
3 **Score the awkward items**	Backwards spelling by order, subtraction errors, the figure
3 **Adjust, and the literacy caveat**	Prorate omissions, add demographic points, say the caveat aloud

INSTRUMENT	TOTAL AND CUT-OFF	BEST USED FOR	LIMITATION TO NAME
Mini-mental state examination	11 items across 7 domains, 30 points; dementia cut-off 23/24	Screening and tracking progression	**Sensitivity for mild impairment only 18% to 25%, with a ceiling effect**
Montreal cognitive assessment	30 points, normal from 26, sensitivity around 90%	Mild impairment, vascular and subcortical pictures	**Educational bias; add 1 point for 12 years of schooling or fewer**
Hindi mental state examination	Total and cut-offs unsourced here; verify first	Low-literacy and rural screening	Literacy-dependent items replaced
Addenbrooke's cognitive examination	Total, cut-offs and subscale weights unsourced here	Detailed profiling and subtyping	No figure from memory
Schooling-adjusted cut-offs	Illiterate 21, low education 22, middle 23, high 24	When only the older screen is available	**A literacy-loaded screen reads falsely low**

Amber cells are the limitations examiners ask for by name. The unsourced rows are printed as unsourced: a verified gap beats an invented total.

- **Prorate rather than score zero.** Where a disability prevents an item, omit it: the adjusted score is the raw score multiplied by 30 and divided by the maximum obtainable, rounding 0.5 up.
- **Score order, not sequence.** Backwards spelling is scored by the maximum number of non-crossing lines against the correct reversal, and that item alone carries 17% of the total.
- **Serial sevens.** Allow 5 subtractions and penalise only the erroneous step, so 93, 85, 78, 71, 64 scores 4 of 5: each later subtraction removes 7 correctly from the patient's own answer.
- **Cueing during delayed recall,** adding a demographic point to a perfect score, or counting kindergarten as schooling. Each is a mechanical error the examiner can see.

WHAT EARNS THE MARKS

- **Permission asked before memory testing,** which avoids a catastrophic reaction.
- **The prorating arithmetic, worked aloud.** That calculation is the examinable part.
- **The amber limitation cell for the instrument chosen.** A ceiling effect explains a normal score in a complaining patient.
- **The literacy caveat and the adjusted cut-off row, said out loud.**

SEE ALSO Slot V - 57 breaking bad news as a station Slot V - 66 eliciting the mental state Weave Viva, Part V

V - 68

Child abuse disclosure and mandatory reporting under POCSO.

10 OSCE STATIONS SYLLABUS CORE

SKELETON

2	What counts as knowledge	A direct disclosure, or information appealing to the senses
3	Report, do not investigate	Section 19(1), to the juvenile unit or local police
3	What follows the report	Written record, care, referral, immunity in good faith
2	Penalties and the clinical manner	Section 21 penalties, then interview once, without leading

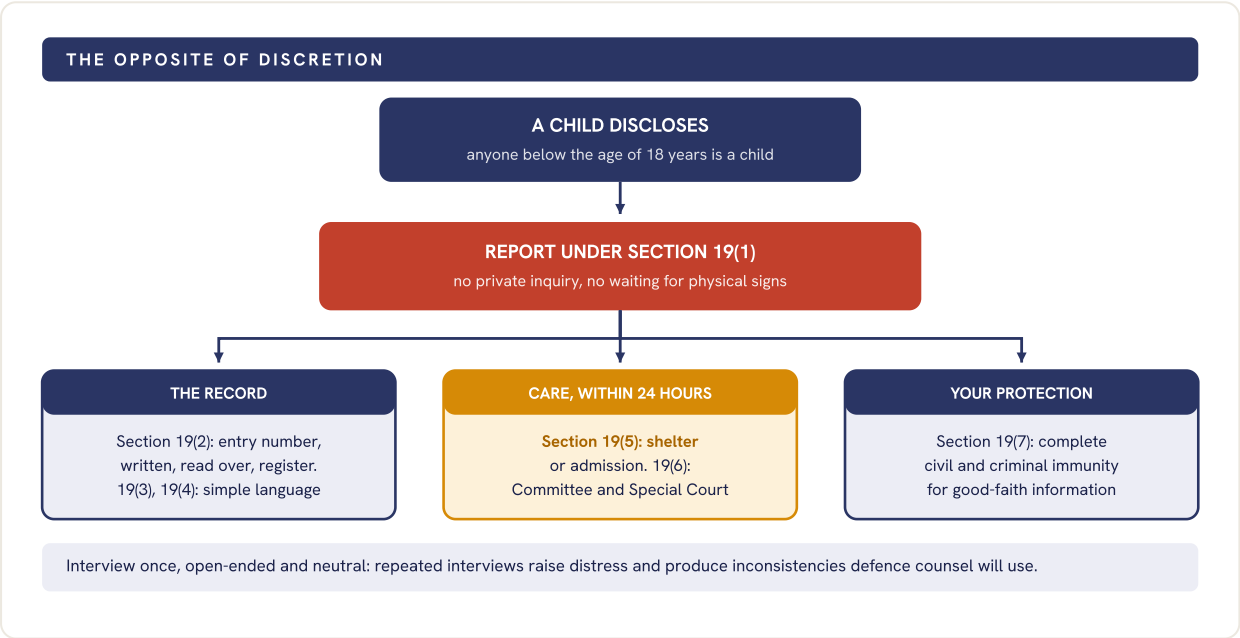


Fig 68.1 The duty drawn as one action with three consequences. Reporting sits in red because the scored failure is inquiry rather than delay, and the care limb sits in amber because the twenty-four hour clock starts with the report, not with the examination.

- **Penalties for not reporting.** Section 21(1) carries imprisonment up to 6 months, a fine, or both; Section 21(2) up to 1 year and fine for the person in charge of an institution. Section 21(3) exempts the child.
- **Examination before registration.** Section 27(1) allows the medical examination under the criminal procedure provision even before an information report is registered.
- **The termination scenario.** The duty under Section 19(1) stands, but on the request of the minor and her guardian the practitioner may omit her name and identity from that report.

WHAT EARNS THE MARKS

- **The red band, with the two conditions refused.** No private verification, and no condition on finding physical signs.
- **The amber care limb inside twenty-four hours.** Referral and shelter are part of the duty, not a courtesy.
- **The immunity lane, named for the candidate's own protection.** Good-faith reporting carries complete immunity.
- **The interview strip.** Open-ended and once, because repetition damages both the child and the evidence.

SEE ALSO Slot V - 63 the suicide risk interview Slot V - 65 de-escalation and rapid tranquillisation Weave Viva, Part V

AREA 07 OF 10 · PV-A07

Psychopathology and investigations

8	8.0%	V-69	V-76
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

SYLLABUS CORE 8

REVISION ORDER

Take the five psychopathology slots together, since they share one definitional grammar. The three investigation slots stand on their own.

WHAT IS IN THIS AREA

The descriptive psychopathology examiners ask for by name: delusions, hallucinations, thought disorder, first-rank symptoms and catatonic signs. Then the investigations: EEG, brain imaging and laboratory monitoring.

V - 69

Delusions: definition, primary delusions and types by content.

10 | PSYCHOPATHOLOGY AND INVESTIGATIONS | SYLLABUS CORE

SKELETON

2 **Definition**	Sims, then Jaspers' three criteria, then the DSM-5 wording
1 **The axis**	Mode of origin, stated before the tree is drawn
4 **Primary forms**	The drawn branch, each form with its discriminator
3 **Types by content**	Themes with their eponyms, commonest named first

THE DEFINITION

A false, unshakeable belief out of keeping with the patient's educational, social and cultural background (Sims). Jaspers gave three external criteria: incomparable subjective certainty, incorrigibility to counterargument, and impossibility of content. DSM-5 dropped falsity, defining a fixed belief not amenable to change in the light of conflicting evidence.

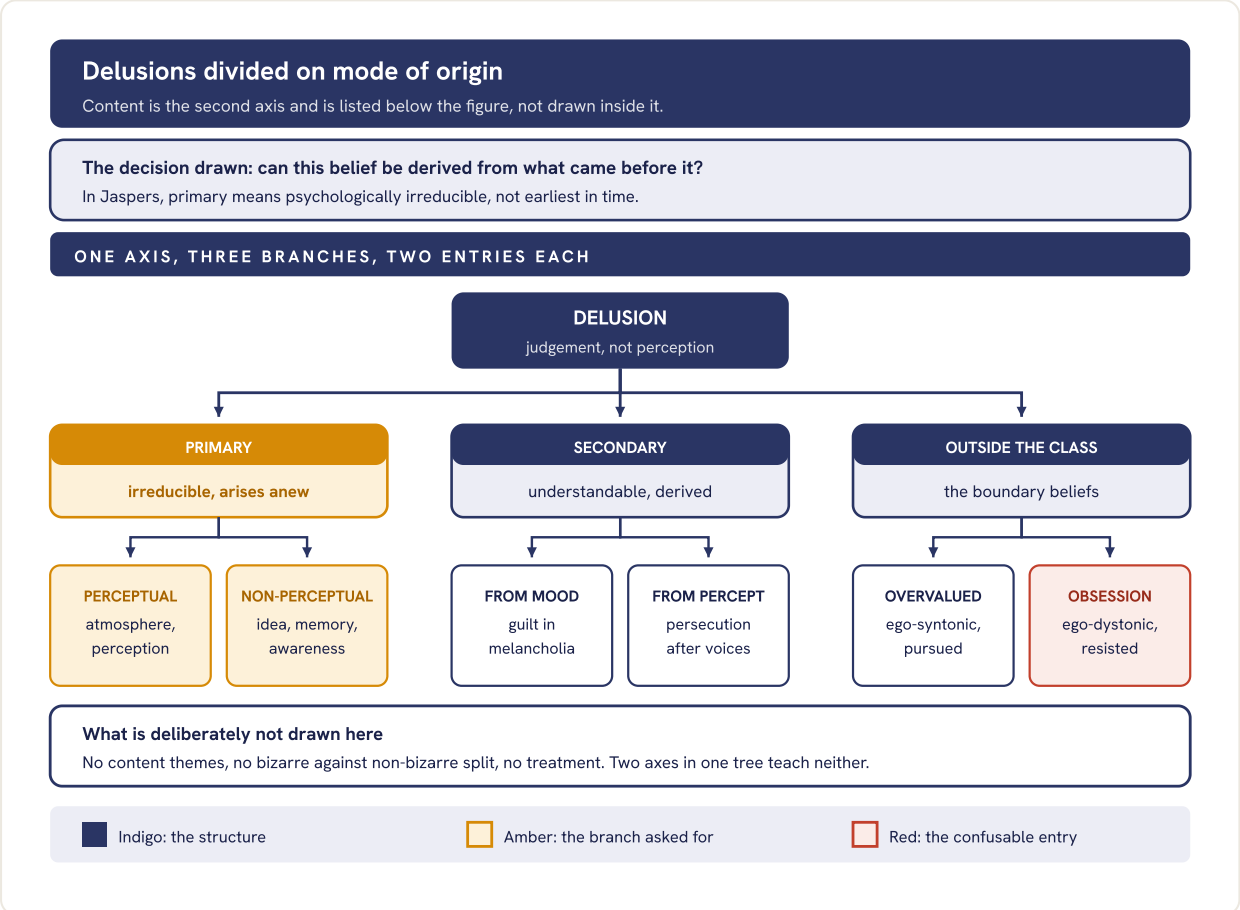


Fig 69.1 Delusions on one axis of origin, the primary branch in amber and obsession, the belief most often misplaced inside the class, in red.

- **Types by content.** Persecutory, the commonest subtype; grandiose; reference; infidelity (Othello); erotomanic (de Clerambault); somatic, including infestation (Ekbom); nihilistic (Cotard); misidentification (Capgras, Fregoli); and alien control.
- **Overvalued idea.** Wernicke's concept, Veale's model: a belief fused with an idealised value and acted on regardless of consequence, rated on the Brown Assessment of Beliefs Scale.

- **The truth fallacy.** Falsity does not define it. In delusional disorder, prevalence is about 0.2 per cent, mean age at presentation about 55 years and females about 56.5 per cent.

WHAT EARNS THE MARKS

- **The definition box with its three authorities.** Sims, Jaspers and DSM-5.
- **The axis named before the tree.** Primary means irreducible, not earliest.
- **Each primary form with its discriminator,** as the amber leaves give it.
- **Content themes carried with their eponyms,** persecutory named as commonest.

SEE ALSO V - 70 hallucinations, pseudohallucinations and illusions V - 73 catatonic signs and the named syndromes

Weave Viva, Part VI

V - 70

Hallucinations: types, pseudohallucinations and illusions.

10 | PSYCHOPATHOLOGY AND INVESTIGATIONS | SYLLABUS CORE

SKELETON

2 Definition	Esquirol's line, then Jaspers' four characteristics
4 The named types	Each with the stimulus relation that names it
2 Pseudohallucination	Inner space, and the modern diagnostic convention
2 Illusions	Three kinds, separated on what attention does

THE DEFINITION

Esquirol, 1817: a perception without an object. Jaspers held that hallucinations are false perceptions arising anew alongside genuine ones, with four characteristics: external objective space, sensory freshness, independence of the will, and full conviction of external existence.

TYPE	WHAT IT IS	THE DISCRIMINATOR
Functional	A real stimulus precipitates a hallucination in the same modality, both heard	Stimulus and hallucination coexist; in an illusion the percept is lost
Reflex	A stimulus in one modality precipitates one in another	Cross-modal. Synaesthesia is a stable non-morbid trait
Hypnagogic, hypnopompic	At sleep onset and on waking, rapid eye movement intrusion	Insight into unreality is retained
Charles Bonnet	Formed visual hallucinations in severe bilateral visual loss	Insight preserved, sensorium clear, visual only

The axis is the relation to a real stimulus: same modality, other modality, or none. Amber cells are the discriminators examiners listen for.

- **Pseudohallucination.** Inner subjective space, vivid and independent of the will, often recognised as internal. Give the phenomenology, then the convention: under Present State Examination practice, voices inside the head held with full conviction carry the diagnostic weight of external ones.
- **Illusion, after Sims.** Misperception of a real stimulus. Completion, affect and pareidolic. Attention is the discriminator: the first two dissolve when attention is directed, pareidolia grows more detailed and is normal.
- **By modality.** Auditory commonest; visual prompts an organic search rather than excluding a functional diagnosis. In a community survey 37 per cent reported hypnagogic and 12.5 per cent hypnopompic experiences.

WHAT EARNS THE MARKS

- **Esquirol's line and the four Jaspersian characteristics,** as a definition block.
- **Functional against reflex, kept apart.** Same modality against cross-modal, the commonest confusion.
- **The Present State Examination convention** stated after the phenomenology, not instead of it.
- **Attention as the discriminator among illusions,** which is the line the typed row carries.

SEE ALSO V - 69 delusions, primary forms and types by content V - 14 eliciting hallucinations at the bedside

Weave Viva, Part VI

V - 71

Formal thought disorder: the terms and how they are told apart.

10 PSYCHOPATHOLOGY AND INVESTIGATIONS SYLLABUS CORE

SKELETON

1 Which domain	Stream, form, content or possession, before any sign
2 Definition	Failure of semantic and syntactic convention
4 The term grid	Each sign with its definition and its discriminator
3 Theory and rule-out	Bleuler, Cameron, both Schneiders, then aphasia

THE DEFINITION

Failure to follow semantic and syntactic convention to a degree inconsistent with education, intelligence and culture. Thought is reached only through speech, which is why both are examined as one table.

TERM	DEFINITION	THE DISCRIMINATOR
Circumstantiality	Long-winded and convoluted, with tedious irrelevant detail, a circuitous route that arrives	It reaches the goal idea
Tangentiality	Drifts off on links from the patient's own words and does not return	It fails to reach the goal
Flight of ideas	Rapid switching with pressured speech, linked by rhyme, pun, clang or distraction	Adjacent links understandable, with distractibility. Mania
Derailment	The train slips to an obliquely related channel at normal tempo	Adjacent links illogical to the listener
Thought blocking	Abrupt arrest mid-sentence, the mind reported as going blank	Sudden arrest with subjective emptying, no external agent invoked

Say the domain before the sign. Pressure and poverty of speech, flight of ideas and blocking belong to stream; derailment, poverty of content, illogicality, incoherence and neologism to form.

- **The theorists.** Bleuler made loosening the fundamental deficit, the cognitive face of Spaltung. Cameron gave overinclusion, asyndesis, metonymy and interpenetration of themes.
- **Naming the wrong Schneider.** Carl gave the structural subtypes: transitory, drivelling and desultory thinking. Kurt gave the first-rank symptoms and thought possession. Form and possession are different domains.
- **Measurement and rule-out.** Andreasen's scale carries 18 items and takes about 30 minutes, dividing positive from negative formal thought disorder. Exclude aphasia: Wernicke has failed comprehension, impaired repetition and anosognosia.

WHAT EARNS THE MARKS

- **The domain named before the sign,** as the caption insists.
- **Flight of ideas against derailment,** on whether adjacent links stay understandable.
- **Circumstantiality against tangentiality,** on whether the goal is reached.
- **Carl kept apart from Kurt Schneider,** as the trap row states.

SEE ALSO V - 72 first-rank and Bleuler's fundamental symptoms V - 44 the aphasias and the bedside table

Weave Viva, Part VI

V - 72

Schneider's first-rank symptoms and Bleuler's fundamental symptoms.

10 | PSYCHOPATHOLOGY AND INVESTIGATIONS | SYLLABUS CORE

SKELETON

2 What each claims	Name the frame before either list
4 The first-rank list	Grouped, with the structural point attached
3 Bleuler's two axes	Fundamental against accessory, primary against secondary
1 The limits	Not pathognomonic, and what that changes

THE TWO FRAMES

Schneider gave operational criteria without inferred intrapsychic mechanism, and ICD-10 enumerates 11. Bleuler divided on two axes: fundamental symptoms are present in any manifestation, primary symptoms follow from the assumed somatic disease process.

FRAME	WHAT IT CONTAINS	THE DISCRIMINATOR
Schneider, first rank	Three auditory, three of thought possession, three made phenomena, somatic passivity, delusional perception	**7 of the 11 are ego-boundary disorders, kept apart from delusions**
Bleuler, fundamental	Loosening of associations, affective blunting or incongruity, autism, ambivalence	**Present in any manifestation, so a claim of necessity**
Bleuler, primary	What follows from the assumed disease process	**Loosening is fundamental and primary; delusions are accessory and secondary**
The Four As	A later English-language mnemonic, McNally, 2009	Not Bleuler's doctrine, and it obscures Spaltung

A self-disorder is an inner experience the patient has privileged access to; a delusion concerns external affairs, open to clinician and patient alike.

- **Why the list is short.** Schneider wrote where the diagnosis exposed patients to forced sterilisation and state killing, and more than 140,000 psychiatric patients were killed. Delusional perception was raised to first rank because the perception itself can be checked by the clinician.
- **Where the privilege went.** DSM-IV accepted one first-rank symptom for criterion A. DSM-5 removed that and requires at least 2 criterion A symptoms, after reviews found poor sensitivity and limited specificity. ICD-11 restores no privilege.
- **Not pathognomonic.** Passivity and complex self-disorders are uncommon in psychosis from medical or neurological disease, so a first presentation with none of them is a prompt to hunt a somatic or toxic cause.

WHAT EARNS THE MARKS

- **The list grouped, not flat.** Auditory, possession, made phenomena, then the two singletons.
- **7 of the 11 named as ego-boundary disorders,** the extra mark in the grid.
- **Bleuler's two axes kept apart,** necessity against biological origin.
- **The reversal stated,** absent passivity sends you after a cause.

SEE ALSO V - 71 formal thought disorder, the terms with examples V - 69 delusions, primary forms and types by content

Weave Viva, Part VI

V - 73

Catatonic signs and the named syndromes examiners fire rapidly.

10 | PSYCHOPATHOLOGY AND INVESTIGATIONS | SYLLABUS CORE

SKELETON

2 Thresholds	Three of twelve, two of fourteen on screening
4 The signs	How each is elicited, catalepsy against posturing
3 The eponyms	Grouped on familiarity before any name
1 Danger	Malignant catatonia, and why antipsychotics are withheld

THE THRESHOLDS

DSM-5 asks 3 or more of 12 signs, not attributable to delirium. ICD-11 asks 3 of 15, with altered psychomotor activity co-occurring. Bush-Francis screens on its first 14 of 23 items, 2 positive; research criteria add at least 1 hour. A positive lorazepam challenge is a fall of at least 50 per cent on a standardised scale.

SIGN	HOW IT IS ELICITED	THE DISCRIMINATOR
Catatonic stupor	Immobility, unresponsive to speech, sleep-wake cycles intact	**Awake: blink, pupils and resistance to eye-lid opening persist**
Negativism	Motiveless resistance. Passive, not executed; active, the opposite performed	**Directed against the request itself**
Gegenhalten	Resistance to passive movement rising with the force applied	**Automatic and proportional; mitgehen is the opposite**
Catalepsy	Anti-gravity postures placed by the examiner and held	**The examiner places the limb; posturing is assumed spontaneously**
Waxy flexibility	Uniform give on repositioning, like a warm candle	**Tactile, without the clasp-knife catch of spasticity or parkinsonian cogwheeling**

Echolalia and echopraxia are motor release without imitative intent. Mannerism caricatures a purposeful act, stereotypy is rhythmic and non-purposeful, and a tic carries a premonitory urge neither has.

- **The eponyms, grouped first.** Christodoulou's axis is familiarity. Capgras, same face, changed identity; Fregoli, changed face, same identity; intermetamorphosis changes both.
- **Then the rest.** Cotard, nihilistic negation; de Clerambault, erotomania; Othello, jealousy on trivial proofs; Ekbom, infestation, matchbox sign; Ganser, approximate answers; Munchausen, peregrination; Diogenes, squalor and hoarding.
- **Malignant catatonia.** Profound motor signs with dysautonomia, untreated lethality 10 per cent to 20 per cent. Antipsychotics are contraindicated; modified electroconvulsive therapy is definitive.

WHAT EARNS THE MARKS

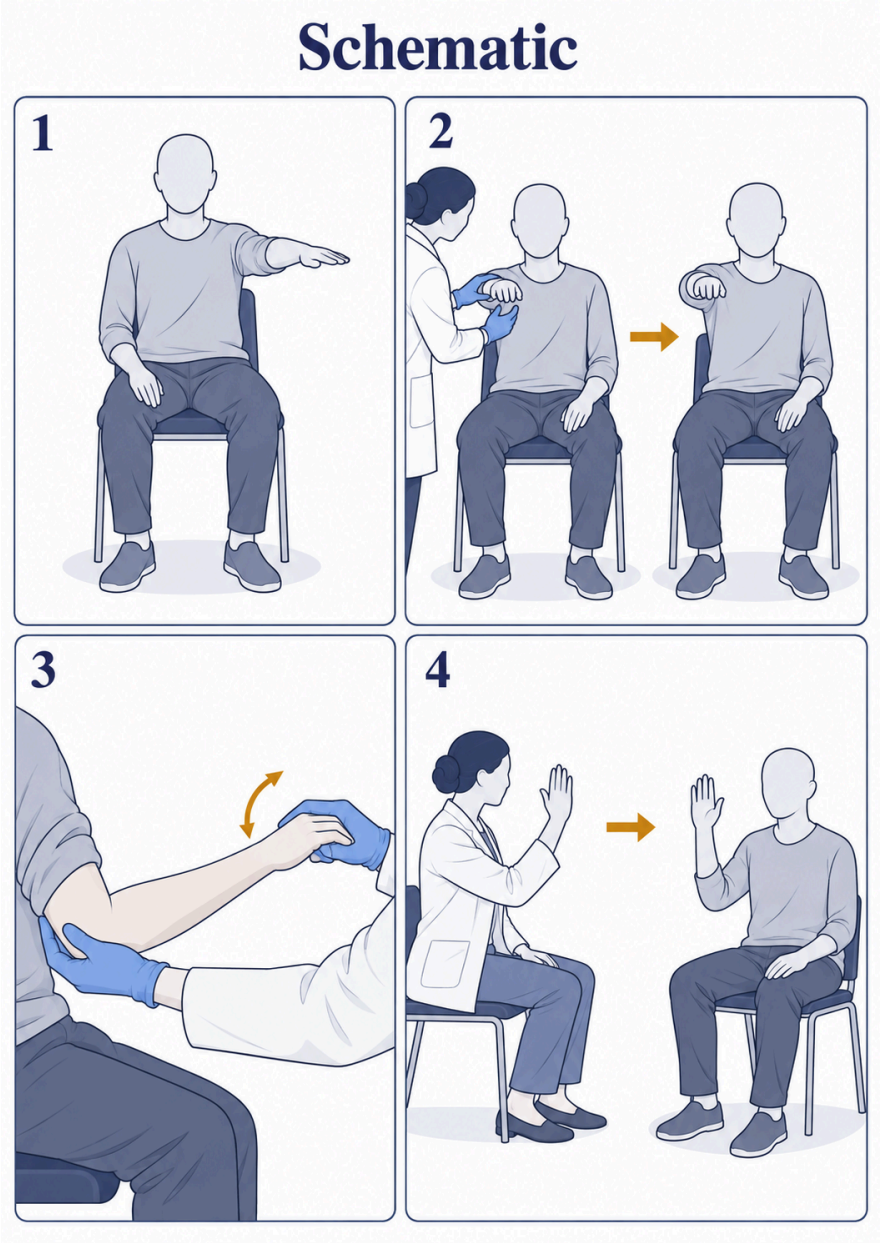
- **The thresholds as counts,** three of twelve and two of fourteen.
- **Catalepsy against posturing,** on who places the limb.
- **Capgras against Fregoli in one line,** as the eponym row has it.
- **Antipsychotics withheld in acute catatonia,** said before any treatment.

SEE ALSO V - 69 delusions, primary forms and content types V - 72 first-rank and Bleuler's fundamental symptoms

Weave Viva, Part VI

Catatonia: who initiates the movement?

Companion to original page 94



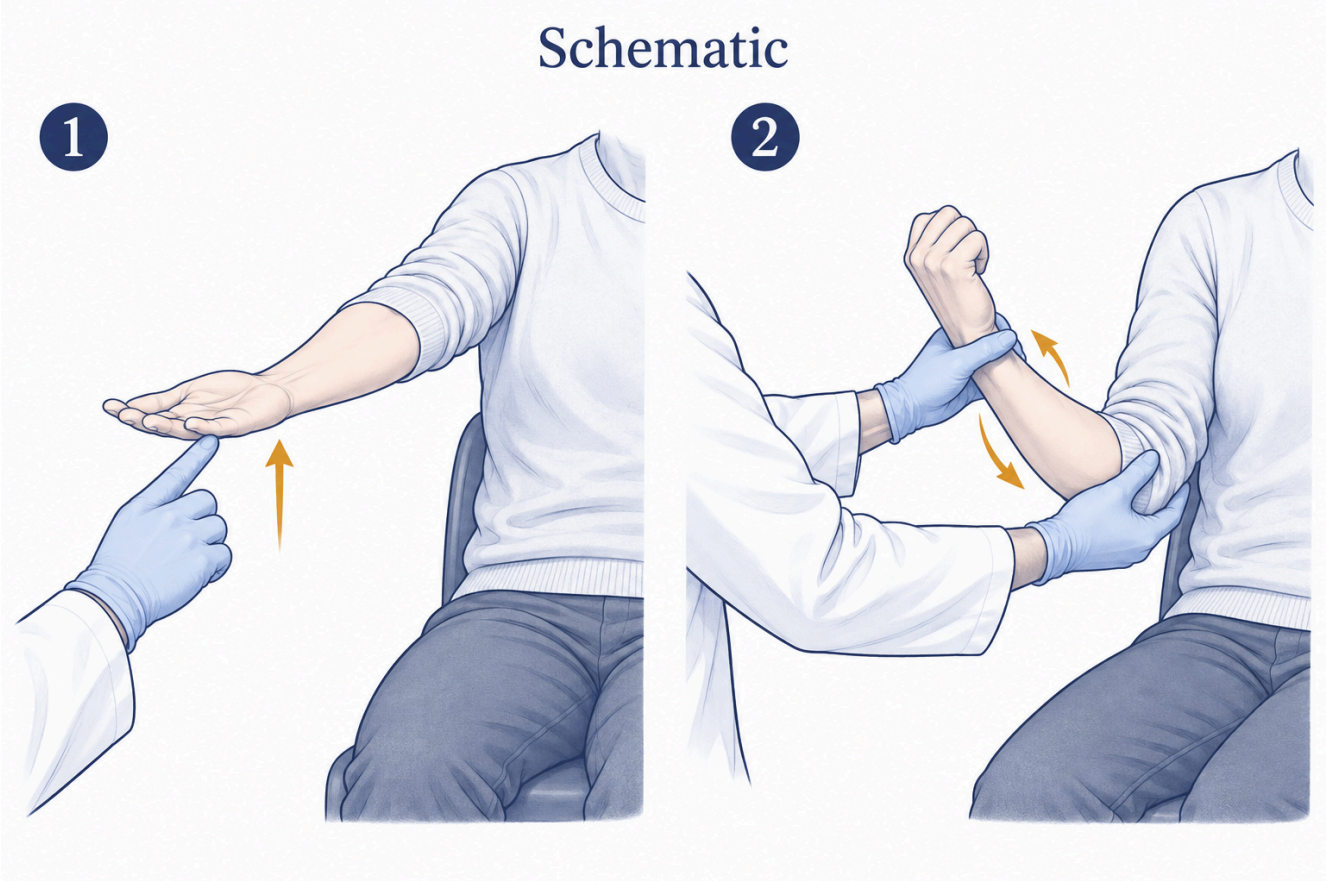
Schematic. 1: self-initiated posturing. 2: an examiner positions a limb and it remains held (catalepsy). 3: gentle passive repositioning to assess waxy flexibility. 4: imitation of an examiner gesture (echopraxia). Posturing is maintained spontaneously; catalepsy follows passive placement. Waxy flexibility is a resistance felt during examination, and echopraxia requires interpretation of imitation in context. The still cannot prove duration, resistance or involuntariness.

Distinguish spontaneous posture, maintained imposed posture, tactile resistance and imitation.

Schematic prepared by Luna for Weave Viva, based on P5A-08. AI-generated educational illustration.

Mitgehen and gegenhalten: different responses to touch

Companion to original page 94



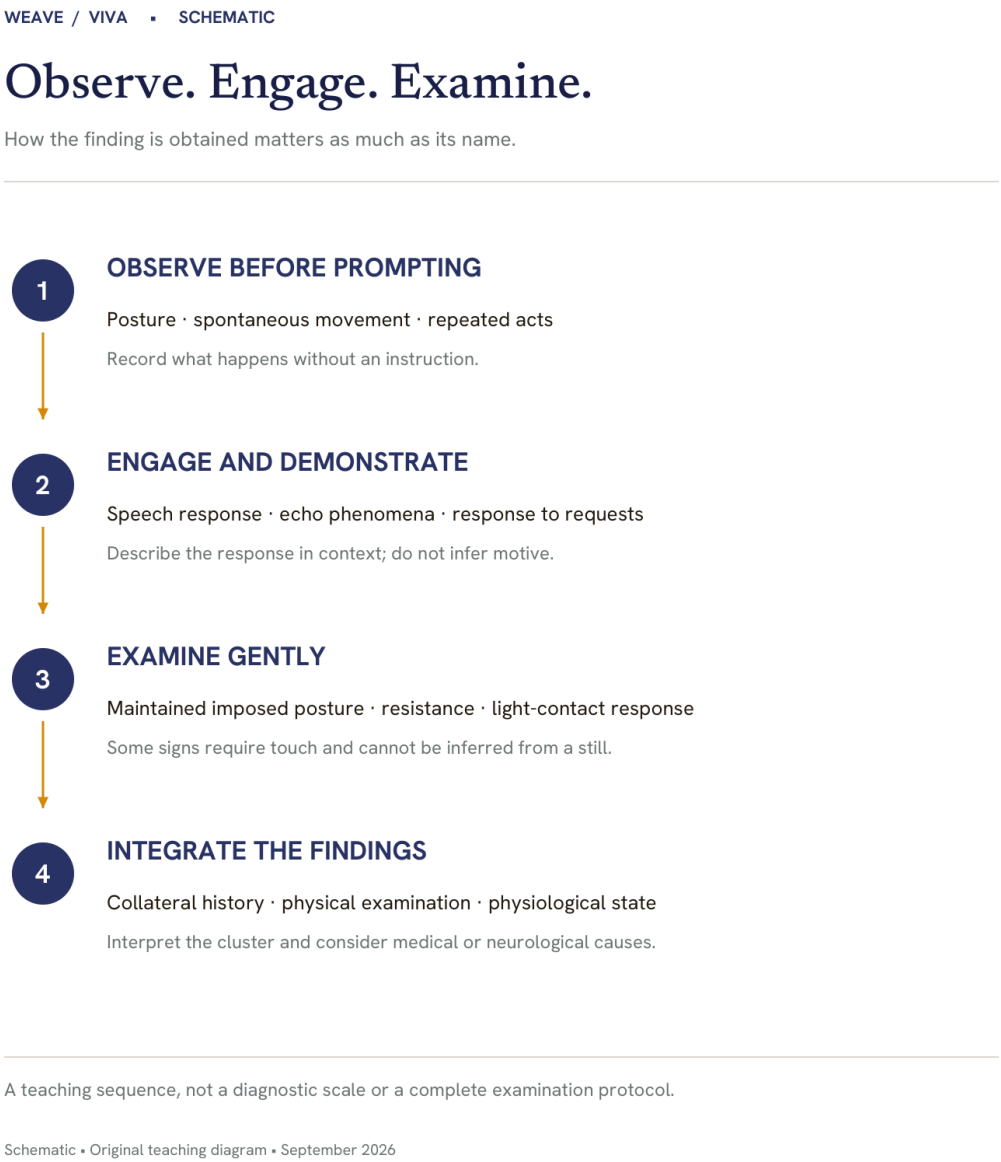
Schematic. Panel 1: mitgehen is illustrated by arm elevation with light fingertip contact beneath the palm, despite an instruction not to follow the movement. Panel 2: the examiner supports the elbow and wrist during passive movement; gegenhalten is resistance that increases with the applied force. The arrows indicate concepts, not measurements. Neither response can be diagnosed from a still image; distinguish these findings from sustained imposed posture and from behavioural opposition.

Compare the contact point, the instruction and the response before naming the sign.

Schematic prepared by Luna for Weave Viva. AI-generated anatomical illustration. Based on P5A-08; teaching references: Rogers et al., BAP catatonia guideline (2023), and University of Rochester BFCRS training manual. No source figure or scale reproduced.

Catatonia examination: how each finding is obtained

Companion to original page 94



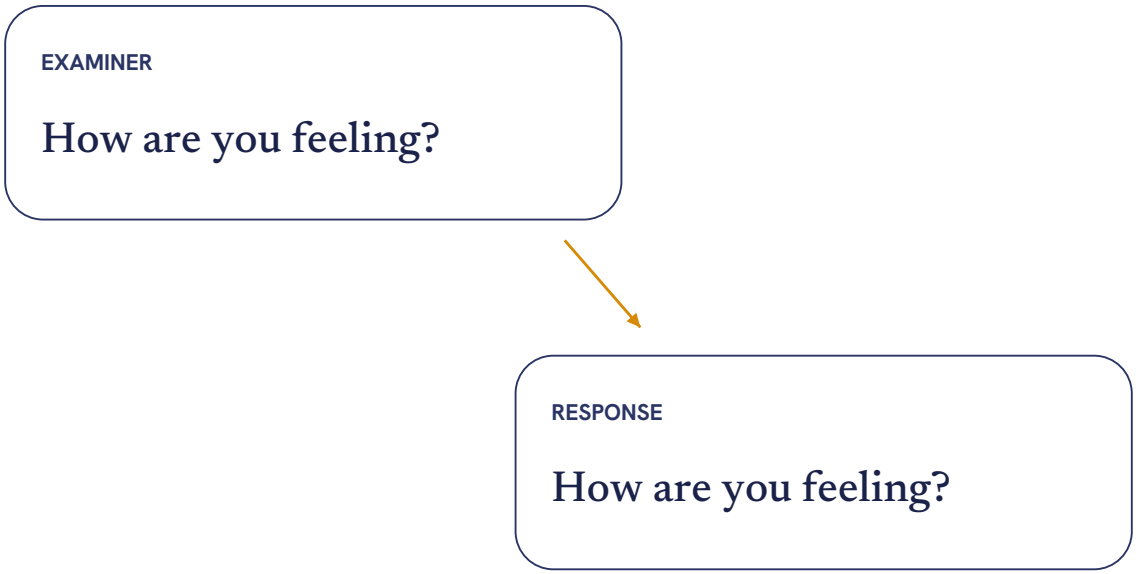
Schematic. Begin with unprompted observation, then assess interaction and responses to demonstrations or requests. Examine posture and tone gently, and integrate the findings with history and the physical assessment. The sequence separates observed behaviour from elicited responses; it is a teaching aid, not a diagnostic scale, score sheet or complete clinical protocol. An isolated illustrated sign does not establish catatonia.

Describe what you observed and how you elicited it; do not infer intention from non-response.

Schematic prepared by Luna for Weave Viva. Original vector teaching diagram. Based on P5A-08; teaching references: Rogers et al., BAP catatonia guideline (2023), and University of Rochester BFCRS training manual. No source figure or scale reproduced.

Listen to what is repeated, and when.

An invented exchange to demonstrate echoing of speech.



The words return; the intended answer does not.

Schematic ▪ Original teaching diagram ▪ September 2026

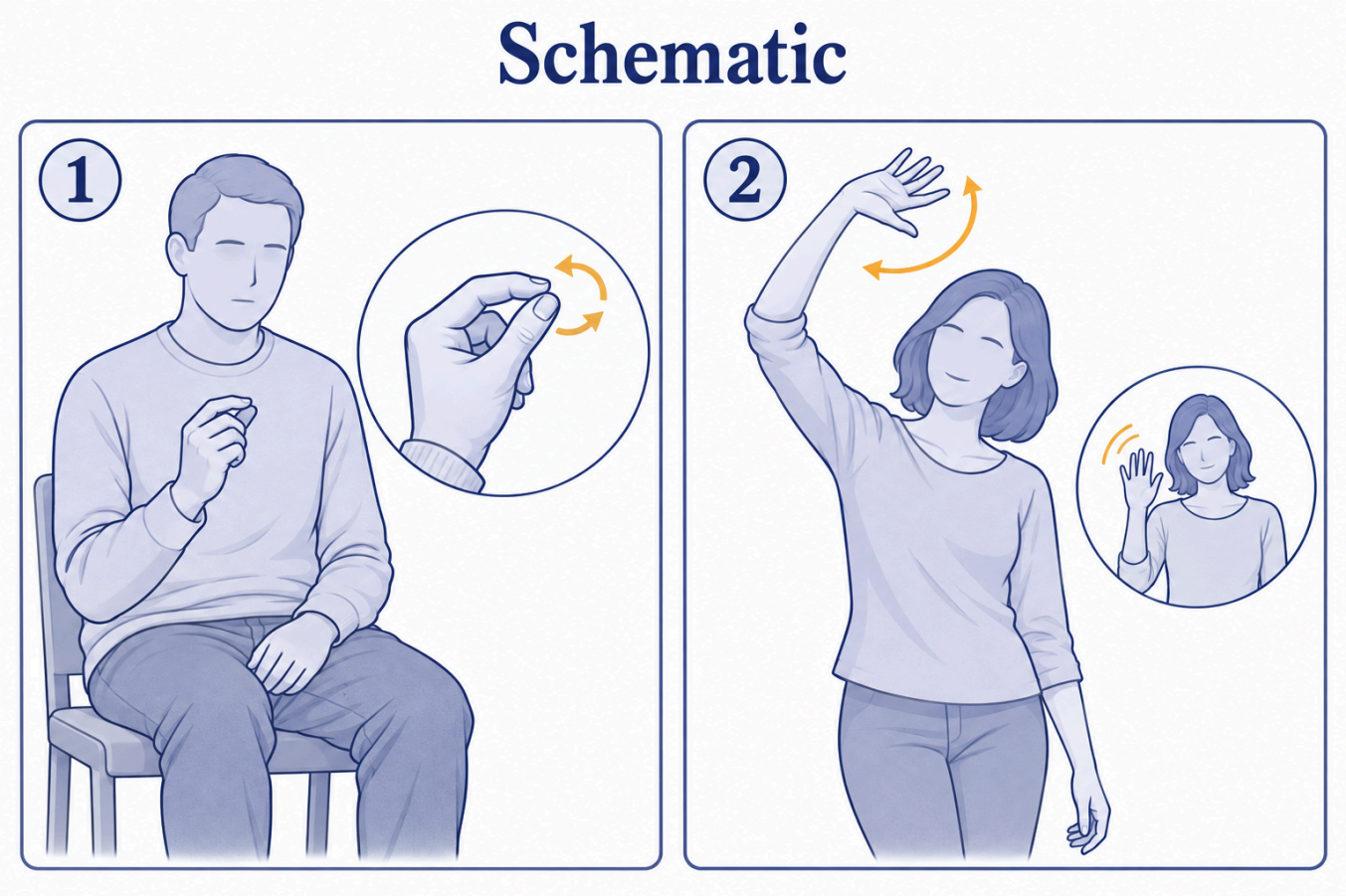
Schematic. An invented exchange illustrates repetition of another person’s words rather than a direct answer. Echolalia must be interpreted in context: repetition may be requested, developmentally expected or associated with several conditions. This diagram is not a transcript, patient record or diagnostic test.

Distinguish echoing from answering, requested repetition and spontaneous repetitive speech.

Schematic prepared by Luna for Weave Viva, based on P5A-08. Original vector diagram.

Stereotypy and mannerism: pattern and context

Companion to original page 94



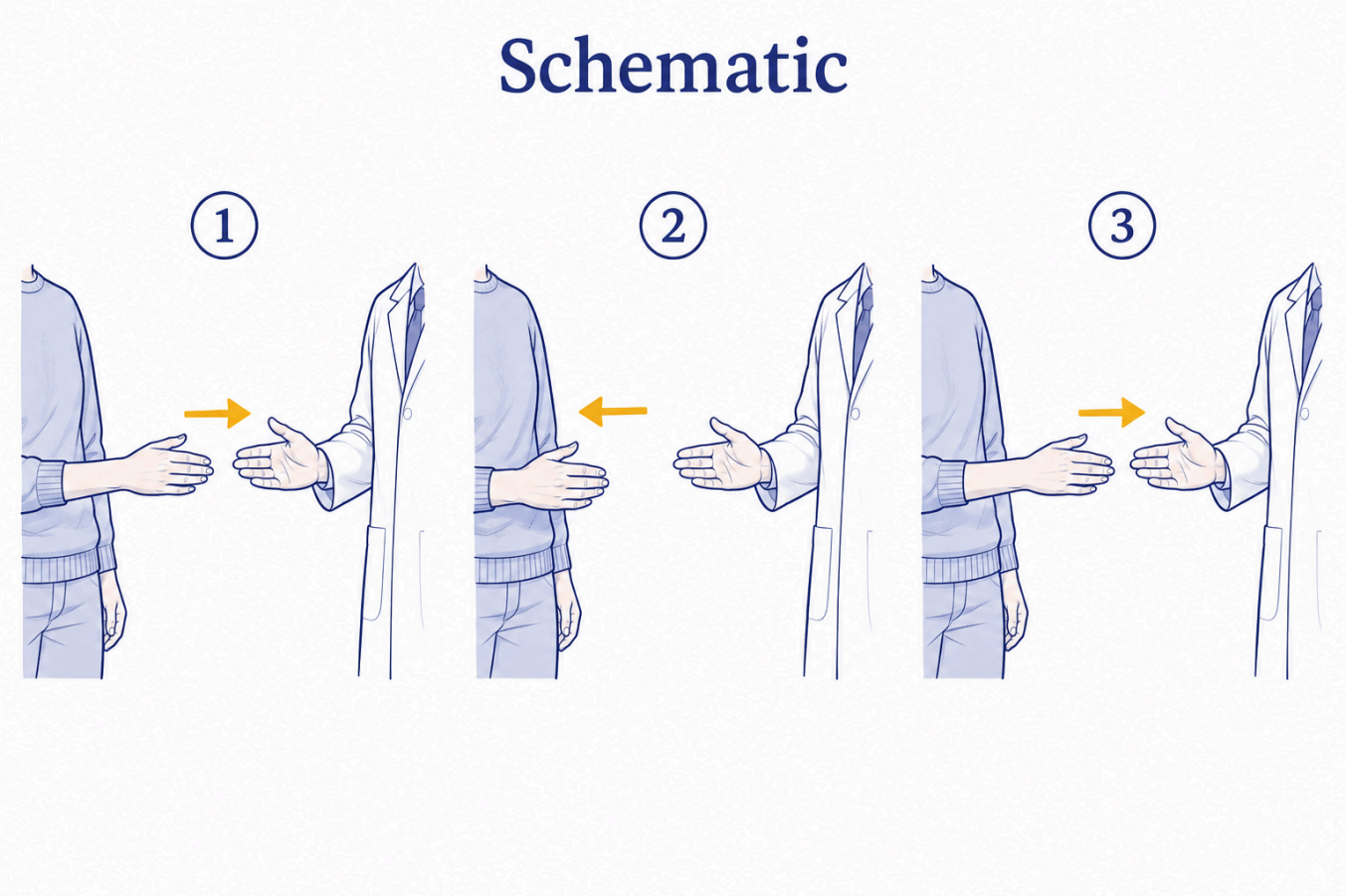
Schematic. Left: repeated finger rubbing illustrates a repetitive movement pattern. Right: an elaborate greeting is contrasted with an ordinary wave inset to illustrate an exaggerated or unusual form of a purposeful action. These are conceptual examples, not patient observations. Repetition or an unusual gesture alone does not establish catatonia; context, baseline, voluntariness and the complete examination matter.

Describe the movement before applying a phenomenological label.

Schematic prepared by Luna for Weave Viva, based on P5A-08. AI-generated educational illustration.

Ambitendency: approaching and withdrawing

Companion to original page 94



Schematic. A sequence of reaching towards an offered hand, withdrawing and approaching again illustrates motor indecision. It does not demonstrate a real patient's behaviour, and an isolated hesitation may reflect ordinary uncertainty, anxiety or misunderstanding. Assess the observed behaviour in context rather than diagnosing catatonia from a still sequence.

Distinguish observed motor indecision from an inferred feeling of ambivalence.

Schematic prepared by Luna for Weave Viva, based on P5A-08. AI-generated educational illustration.

V - 74

The normal EEG and the abnormal EEG in epilepsy, delirium and CJD.

10 | PSYCHOPATHOLOGY AND INVESTIGATIONS | SYLLABUS CORE

SKELETON

2 How to describe	Background, organisation, transients, then one impression
2 The normal record	Posterior dominant rhythm and its reactivity
4 The abnormal grid	Epileptiform against slowing, each with its number
2 Naming a cause	Periodicity and reactivity separate the encephalopathies

DESCRIBE BEFORE YOU INTERPRET

Background frequency and reactivity, then symmetry and organisation, then sleep architecture, then any transient with its field, then one impression: normal, abnormal non-epileptiform (diffuse or focal), or abnormal epileptiform. A clinical study needs 21 electrodes on the 10-20 system, bipolar montages localising by phase reversal, referential by maximal amplitude.

PATTERN	WHAT IT IS	WHERE IT POINTS
Posterior dominant rhythm	Sinusoidal 8 to 13 Hz, attenuating on eye opening	The landmark of the waking record
Graded diffuse slowing	Subnormal reactive rhythm, intermittent delta bursts, then polymorphic delta over 80 per cent	**Grade it before naming a cause. Delirium, toxic and metabolic states**
Spike, sharp wave	Under 70 milliseconds against 70 to 200 milliseconds	**Identical meaning, cortical hyperexcitability. Duration alone separates them**
Generalised spike-and-wave	Monomorphic 2.5 to 4 Hz, classically 3 Hz, background normal between bursts	**Typical absence. Under 2.5 Hz on an abnormal background is Lennox-Gastaut**
Triphasic waves	Frontally dominant positive transients at 1 to 3 Hz, anterior-to-posterior lag	**Classically hepatic, etiologically nonspecific**
Periodic sharp wave complexes	Bilateral synchronous, periodicity about 1 to 2 seconds, no lag	**Creutzfeldt-Jakob. About 4 to 10 seconds is panencephalitis**

Extreme delta brush is anti-NMDA encephalitis. Herpes gives lateralised temporal discharges resolving in weeks; prion complexes persist and generalise.

- **The prion numbers.** Periodic complexes appear in about two thirds of sporadic cases, positive predictive value 95 per cent, seizures in under 15 per cent. They attenuate in sleep and are masked by sedatives.
- **Triphasic against status.** Morphology alone does not decide. Ask for evolution in frequency, morphology or field, and the benzodiazepine response.

WHAT EARNS THE MARKS

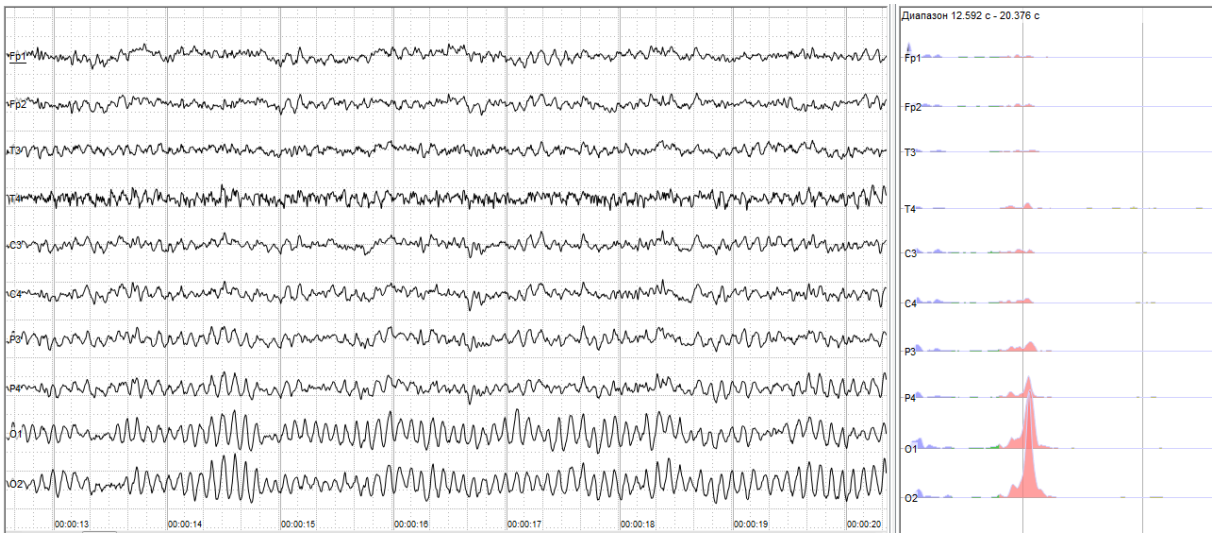
- **The description sequence in order,** the impression last.
- **Slowing graded before a cause,** as row two insists.
- **Periodicity as the prion discriminator,** one to two seconds against four to ten.
- **Evolution as the status test,** from the trap row.

SEE ALSO V - 75 brain CT and MRI, imaging the dementias V - 76 laboratory monitoring and the report

Weave Viva, Part VI

Normal adult alpha rhythm

Companion to original page 95



EEG, resting adult record. Posterior dominant alpha rhythm; the source identifies an 11 Hz rhythm. The accompanying spectra show the alpha peak. Eye-opening reactivity is not demonstrated in this excerpt. Follow the posterior channels and the spectral peak rather than treating every rhythmic segment as epileptiform.

Recognise posterior predominance and organised background before interpreting abnormal records.

Andrii Cherninskyi. Human EEG with prominent alpha-rhythm.png. CC BY-SA 4.0. https://commons.wikimedia.org/wiki/File%3AHuman_EEG_with_prominent_alpha-rhythm.png Licence: https://creativecommons.org/licenses/by-sa/4.0/ Unmodified.

Generalised 3 Hz spike-and-wave

Companion to original page 95



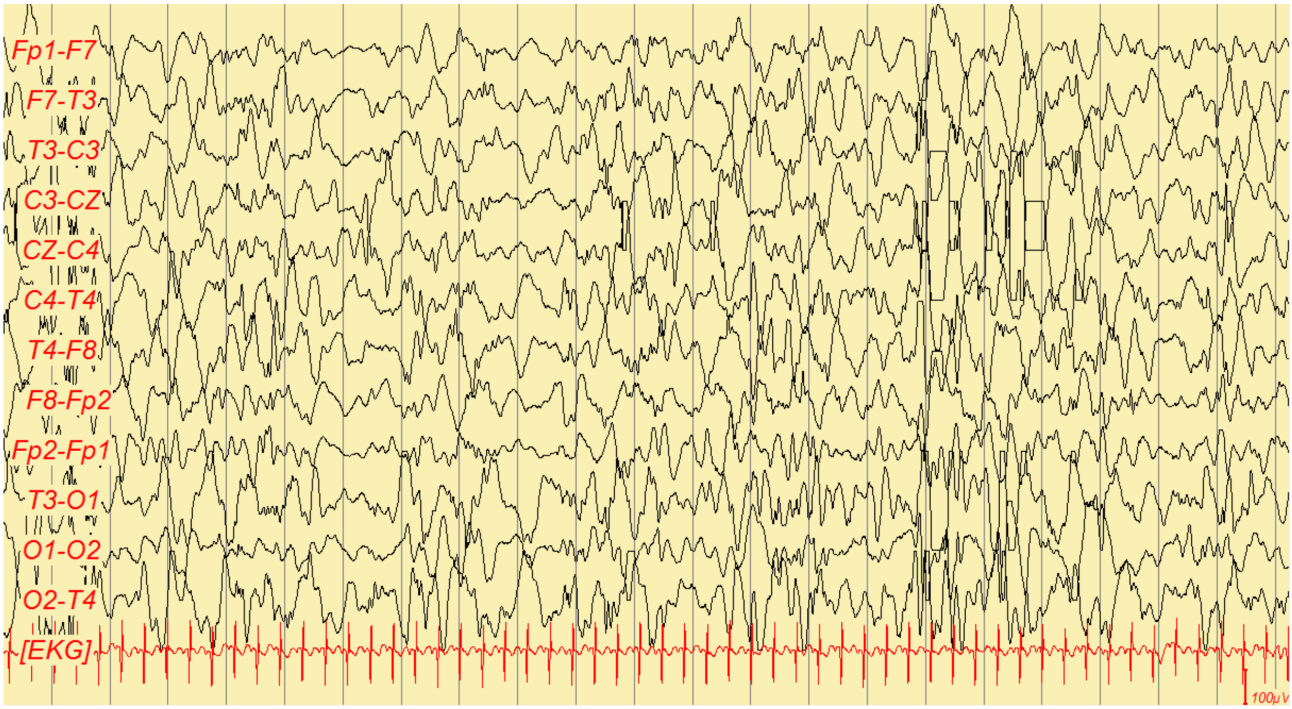
EEG showing generalised 3 Hz spike-and-wave discharges in childhood absence epilepsy. Compare the organised background before the burst with the synchronous complexes. A spike is followed by a slower wave within each repeating complex. The diagnosis and clinical event come from the source case; an EEG excerpt alone does not establish the whole syndrome.

Recognise generalised spike-and-wave and contrast it with the preceding background.

Der Lange. Spike-waves.png. CC BY-SA 2.0. https://commons.wikimedia.org/wiki/File%3ASpike-waves.png Licence: https://creativecommons.org/licenses/by-sa/2.0/ Unmodified.

Hypsarrhythmia

Companion to original page 95



Awake interictal scalp EEG showing disorganised, high-amplitude spikes and slow waves compatible with hypsarrhythmia. This is a chapter extension to the epilepsy grid. Look for the disrupted background organisation as well as the large irregular slow waves and multifocal spikes. Clinical history is needed to interpret an infantile-spasm syndrome.

Distinguish chaotic high-amplitude activity from monomorphic spike-and-wave.

Ralphelg. Hypsarrhythmia.png. CC BY-SA 3.0. https://commons.wikimedia.org/wiki/File%3AHypsarrhythmia.png Licence: https://creativecommons.org/licenses/by-sa/3.0/ Unmodified.

CJD periodic sharp-wave complexes

Companion to original page 95



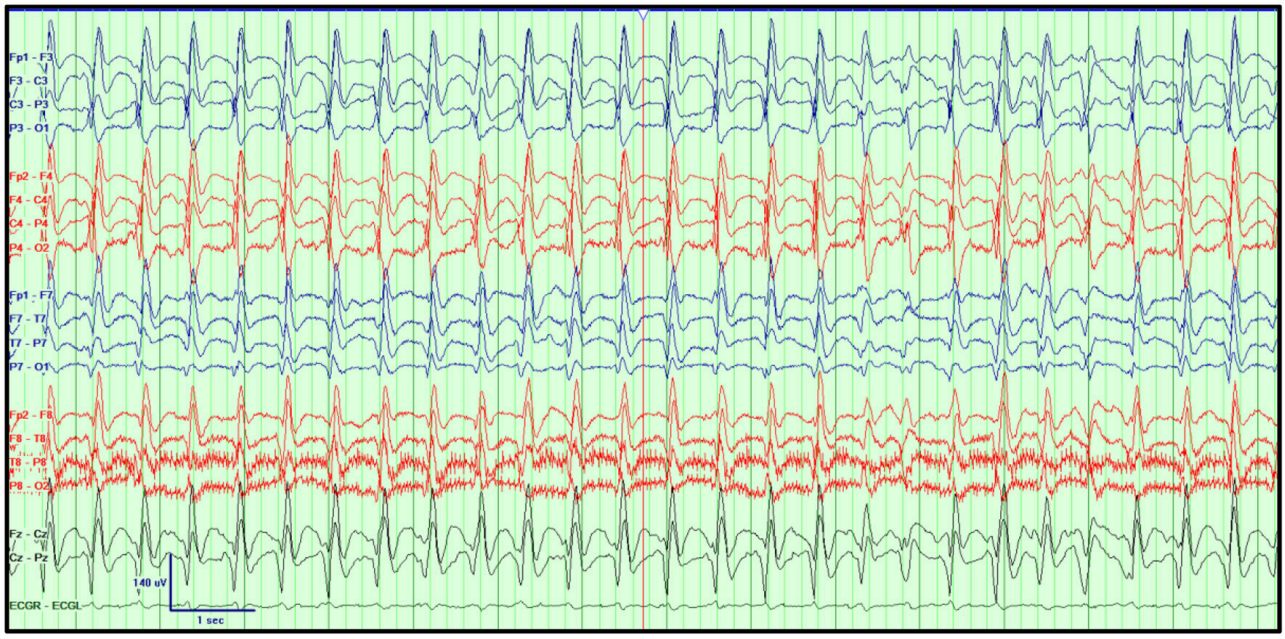
EEG showing periodic sharp-wave complexes in the source CJD case. Describe the periodicity and distribution before giving an impression. Morphology alone does not establish the cause. The source case is genetic prion disease; this is not a tracing from the separate sporadic CJD MRI case. Periodic complexes are not specific to one cause.

Recognise periodic complexes, distinct from an absence burst or disorganised hypsarrhythmia.

Konstantia Kotta, Ioannis Paspaltsis, Sevasti Bostantjopoulou, Helen Latsoudis, Andreas Plaitakis, Dimitrios Kazis, John Collinge and Theodoros Sklaviadis. Eeg CJD.jpg. CC BY 2.0. https://commons.wikimedia.org/wiki/File%3AEeg_CJD.jpg Licence: https://creativecommons.org/licenses/by/2.0/ Unmodified.

Triphasic morphology with a slow background

Companion to original page 95



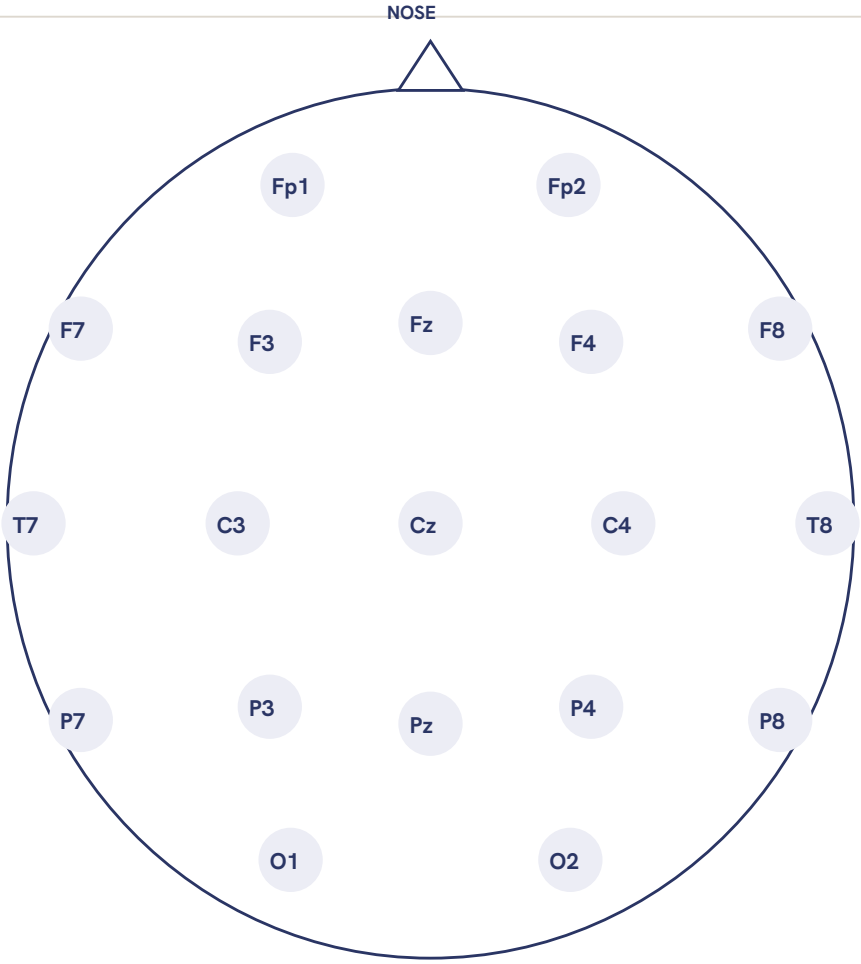
EEG in a bipolar montage showing generalised periodic discharges with triphasic morphology on diffuse irregular delta–theta activity. The source toxic-metabolic case had kidney disease, sepsis and cefepime exposure. Triphasic morphology is not specific to hepatic encephalopathy or any single metabolic cause. Interpret the periodic pattern with the background, medication history and clinical state.

Distinguish periodic complexes from the slow background and avoid treating triphasic morphology as a cause-specific diagnosis.

Sonali Sharma, Michelle Nunes and Ayham Alkhachroum. Frontiers 951286 Figure 6. CC BY 4.0. https://www.frontiersin.org/journals/neurology/articles/10.3389/fneur.2022.951286/full#F6 Licence: https://creativecommons.org/licenses/by/4.0/ Unmodified.

Read the electrode name before the trace.

Conceptual 10–20 scalp layout, viewed from above; nose at top.



Schematic ▪ Original teaching diagram ▪ September 2026

Schematic. Schematic 10–20 scalp positions: odd numbers are on the left, even numbers on the right and z denotes the midline. Frontal, central, parietal, occipital and temporal labels organise the recording locations. T7/T8 and P7/P8 correspond to older T3/T4 and T5/T6 labels. This top view is not a scaled placement template; clinical placement requires measurements.

Do not confuse EEG recording electrodes with ECT stimulus electrodes.

Schematic prepared by Luna for Weave Viva, based on P5B-01. Original vector diagram.

V - 75

Reading a brain CT and MRI, and the imaging of the dementias.

10 PSYCHOPATHOLOGY AND INVESTIGATIONS SYLLABUS CORE

SKELETON

2 First sentence	Modality, plane, and the proof
2 Windows, sequences	Width and level as a pair, then the fluid test
4 The dementia grid	One signature and one discriminator each
2 The atrophy score	Plane before score, then the age threshold

MODALITY, PLANE, PROOF

Computed tomography: bright calvarium, black sinus air, lesions described by attenuation. Magnetic resonance: the vault a signal void, lesions described by signal intensity against a named reference tissue. Cerebrospinal fluid is the sequence test: dark on T1, bright on T2, suppressed on FLAIR. Acquisition is 1 minute against 30 minutes to 1 hour.

ENTITY	STRUCTURAL SIGNATURE	THE DISCRIMINATOR
Alzheimer disease	Medial temporal and hippocampal atrophy, posterior parietal and precuneal loss	The parietal and precuneal component separates it
Behavioural variant frontotemporal dementia	Asymmetric orbitofrontal, dorsolateral prefrontal, cingulate and temporal pole atrophy	Parietal integrity preserved early
Progressive aphasias	Semantic variant, anterior temporal and left pole; non-fluent, left perisylvian	Temporal pole against perisylvian
Vascular cognitive impairment	Confluent white matter hyperintensity, lacunes, microbleeds	Fazekas grading, periventricular apart from deep change
Normal pressure hydrocephalus	Ventriculomegaly out of proportion to the sulci, high convexities crowded, Sylvian fissures dilated	The high convexities; Alzheimer passive enlargement widens them

Width sets the attenuation range displayed and level its midpoint, so a window is quoted as a pair: standard brain 80 and 40, grey-white 8 and 32, bone 2800 and 600.

- **Plane before score.** Graded on coronal T1 perpendicular to the temporal long axis, at the level of the anterior pons. Abnormal at 2 or more under 75 years, 3 or more from 75. Sensitivity about 75 per cent, specificity about 85 per cent.
- **Four ways to lose it.** Axial slices; no age adjustment; equating medial temporal atrophy with Alzheimer disease when the parietal component discriminates; blaming tau alone, when small vessel disease mediates 30 per cent to 42 per cent of the age effect.

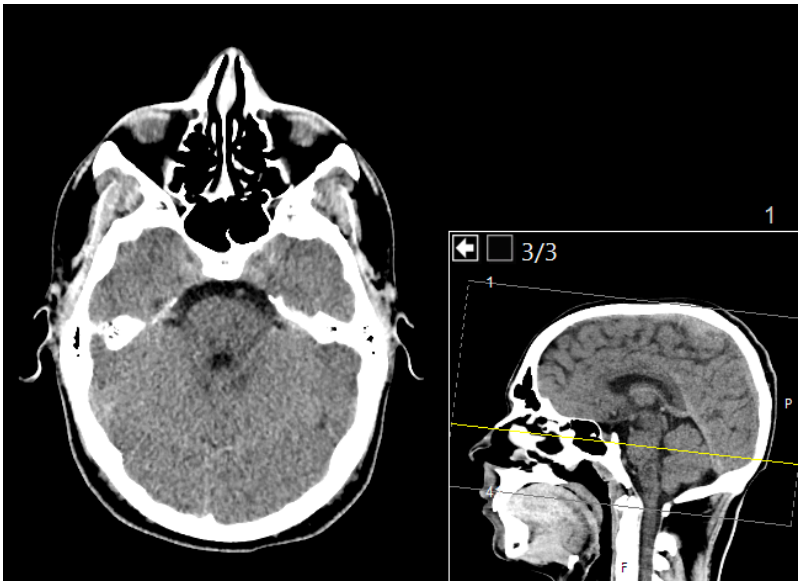
WHAT EARNS THE MARKS

- **Attenuation against signal intensity,** the vocabulary that names the modality.
- **The window quoted as a width and level pair.**
- **The parietal component named for Alzheimer disease.**
- **The age threshold on the atrophy score,** two under seventy-five, three above.

SEE ALSO V - 74 the normal and abnormal EEG V - 76 laboratory monitoring and the report Weave Viva, Part VI

Normal CT: name the modality and plane

Companion to original page 96



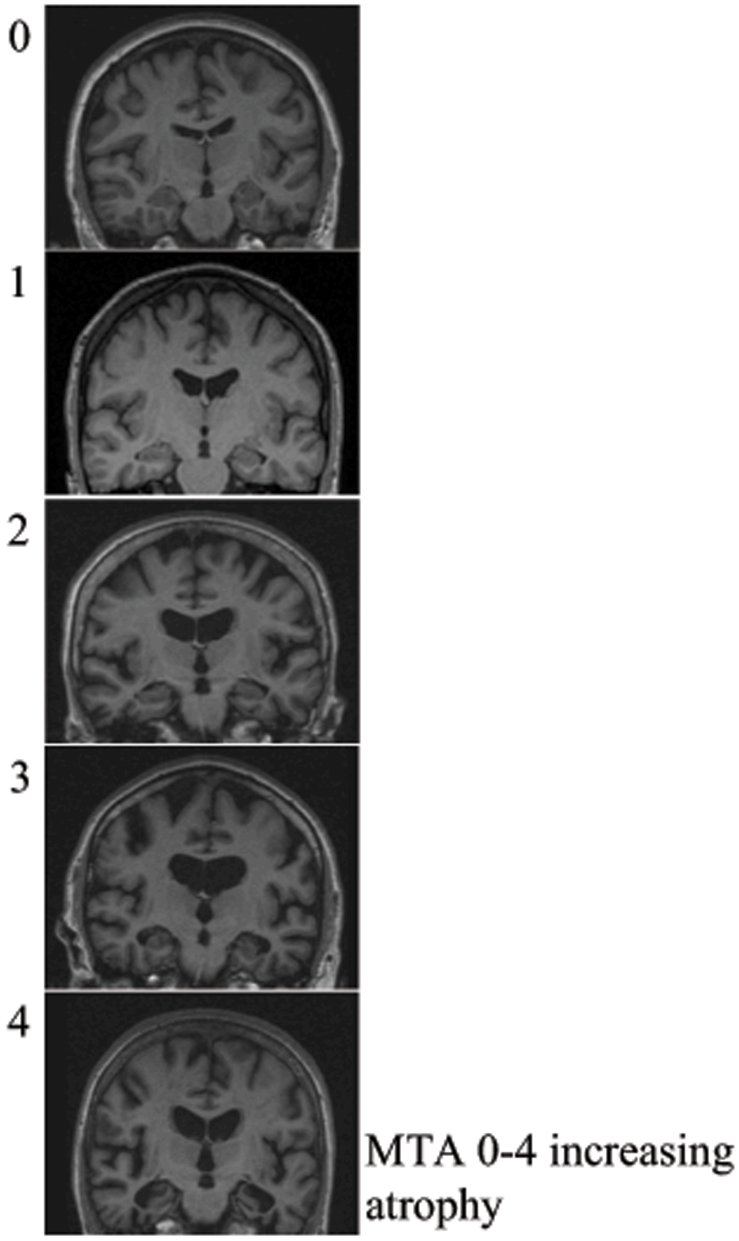
Non-contrast brain CT, axial plane, with a sagittal locator. Bright calvarium and low-attenuation sinus air help identify CT. Describe tissue by attenuation. The locator indicates slice position, not a second pathological finding. This reference slice teaches modality recognition rather than excluding disease throughout the brain.

Identify CT and the axial plane; separate attenuation vocabulary from MRI signal.

Mikael Häggström. CT of a normal brain, axial 29.png. CC0 1.0. https://commons.wikimedia.org/wiki/File%3ACT_of_a_normal_brain%2C_axial_29.png
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Medial temporal atrophy: coronal T1 comparison

Companion to original page 96



MRI, coronal reformats from T1-weighted MPRAGE, showing medial temporal atrophy scores 0 to 4 from top to bottom. Inspect the hippocampal height and surrounding cerebrospinal-fluid spaces; medial temporal atrophy alone does not establish Alzheimer disease. The panels form an ordinal comparison, not a time series from one person. Correlate an atrophy pattern with age and the clinical syndrome.

Compare the five atrophy grades on the plane required for scoring.

Eric Westman, Lena Cavallin, J-Sebastian Muehlboeck, Yi Zhang, Patrizia Mecocci, Bruno Vellas, Magda Tsolaki, Iwona Kłoszewska, Hilkka Soininen, Christian Spenger, Simon Lovestone, Andrew Simmons, Lars-Olof Wahlund, for the AddNeuroMed consortium. MTA-PLOS-Figure-2. CC BY (PLOS article; current publisher policy CC BY 4.0). https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0022506 Licence: https://creativecommons.org/licenses/by/4.0/ Unmodified.

White-matter change on FLAIR

Companion to original page 96



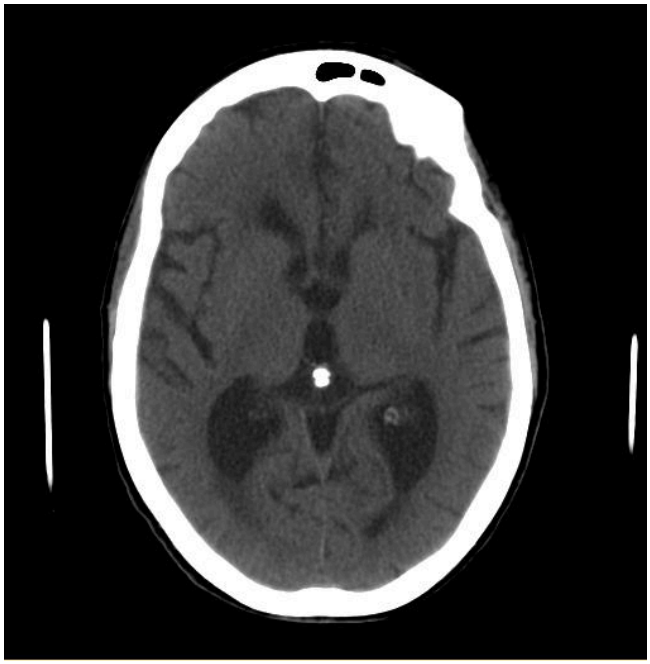
MRI, axial T2-FLAIR. Bright white-matter lesions are visible against suppressed ventricular cerebrospinal fluid. Assess periventricular and deep white-matter change separately. The signal pattern is descriptive: it does not by itself establish vascular dementia or the cause of each lesion.

Recognise white-matter hyperintensity and use fluid suppression to identify FLAIR.

Yakafaucon. Leucoaraiose1.jpg. CC BY-SA 3.0. https://commons.wikimedia.org/wiki/File%3ALeucoaraiose1.jpg Licence: https://creativecommons.org/licenses/by-sa/3.0/ Unmodified.

Ventricular enlargement on CT

Companion to original page 96



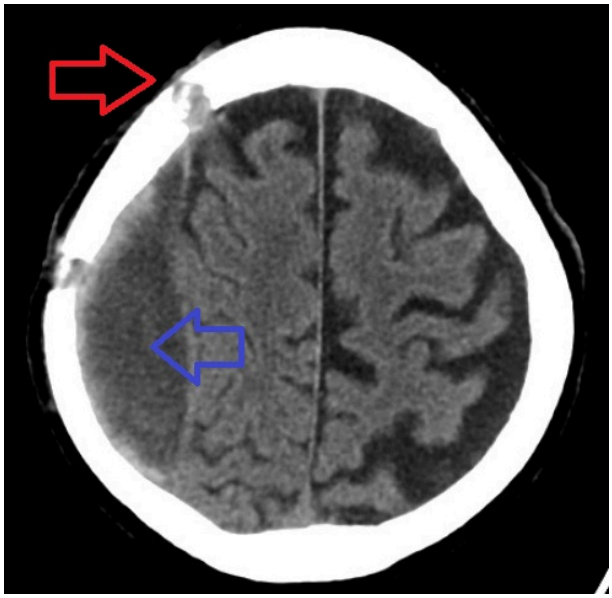
Brain CT, axial plane, from a source case of normal pressure hydrocephalus. Ventricular enlargement is visible. This slice alone does not show the high-convexity sulci needed for the full distinction from ex-vacuo enlargement. Relate ventricular size to the rest of the brain and the clinical history; ventricular enlargement alone is insufficient for the diagnosis.

Recognise ventriculomegaly and state the additional high-convexity assessment required.

RadsWiki (radswiki.net). Normal pressure hydrocephalus 001.jpg. CC BY-SA 3.0.
https://commons.wikimedia.org/wiki/File%3ANormal_pressure_hydrocephalus_001.jpg Licence: https://creativecommons.org/licenses/by-sa/3.0/
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Chronic subdural collection

Companion to original page 96



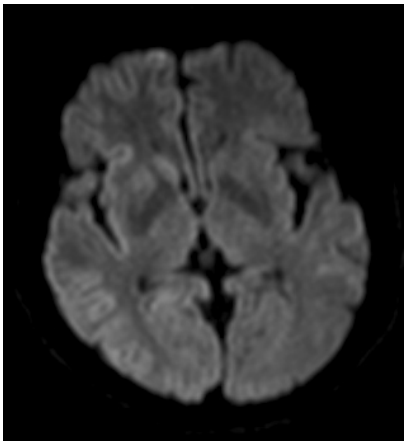
Brain CT, axial plane. A crescentic low-attenuation extra-axial collection is marked by the blue arrow; the red arrow marks an old burr hole. The source identifies a chronic subdural bleed. Retain the arrow colours when describing this treated source case; the burr hole is a prior intervention, not part of the collection.

Recognise a crescentic extra-axial collection as a structural alternative during scan review.

Doc James. ChronicSubduralPostBurrHoles.jpg. CC BY-SA 4.0. https://commons.wikimedia.org/wiki/File%3AChronicSubduralPostBurrHoles.jpg
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CJD cortical and striatal signal

Companion to original page 96



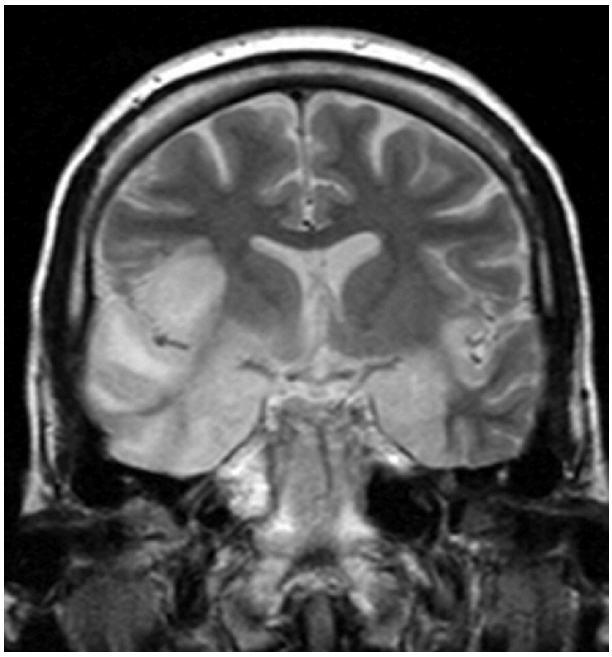
MRI, axial diffusion-weighted image. Right cortical and striatal high signal in the source sporadic CJD case. Describe the cortical ribbon and basal ganglia signal; an ADC map is needed to confirm restricted diffusion. High DWI signal must be interpreted with the apparent diffusion coefficient image and clinical context; it is not independently diagnostic of prion disease.

Recognise cortical and striatal DWI signal as the imaging counterpart to periodic EEG complexes.

Dr Laughlin Dawes. Dwi ax 2.jpg. CC BY 3.0. https://commons.wikimedia.org/wiki/File%3ADwi_ax_2.jpg Licence: https://creativecommons.org/licenses/by/3.0/ Unmodified.

Temporal change in herpes encephalitis

Companion to original page 96



MRI, coronal T2-weighted image. Temporal and insular high signal in the source confirmed herpes simplex encephalitis case. The source labels this sequence T2-weighted, not FLAIR. Signal abnormality must be interpreted with the other sequences and clinical or laboratory findings.

Compare temporal inflammatory signal change with the CJD DWI and dementia atrophy patterns.

dr Laughlin Dawes. Hsv encephalitis.jpg. CC BY 3.0. https://commons.wikimedia.org/wiki/File:Hsv_encephalitis.jpg Licence: https://creativecommons.org/licenses/by/3.0 Unmodified.

V - 76

Laboratory monitoring in psychiatry: lithium, clozapine, metabolic, and reading the report.

10 PSYCHOPATHOLOGY AND INVESTIGATIONS SYLLABUS CORE

SKELETON

2	**Sampling first**	When the sample is drawn, before a range
4	**The schedules**	Lithium, clozapine neutrophils, the metabolic set
2	**Reading the report**	Grade the abnormality before explaining it
2	**Source discipline**	Name the owner of a borrowed interval

SAMPLING BEFORE RANGE

A lithium level is a 12-hour post-dose trough: with bedtime dosing, the next morning; an earlier sample catches distribution, so repeat it. Target 0.6 to 0.8 mmol/L for mania and bipolar maintenance, 0.4 to 0.6 for depressive augmentation, permissible 0.4 to 1.0.

WHAT IS MONITORED	THE SCHEDULE OR THRESHOLD	THE DISCRIMINATOR
Lithium, timing	7 days after initiation and after any dose or brand change, then 3-monthly in year one	**After that 3-monthly if higher risk, 6-monthly if stable**
Lithium, acting on a level	1.0 to 1.5 mmol/L asymptomatic: hunt a reversible cause, recheck at 24 hours	**Above 1.5 or any toxic sign, withhold and transfer. Above 2.0, admit for dialysis**
Clozapine neutrophils	Cessation below 1.0, below 0.5 with the Duffy-null variant, in ten to the ninth per litre	**Routine counts stop after 2 years. Risk is front-loaded, mean onset 8.4 days**
Metabolic set	Weight and waist at baseline, 4, 8 and 12 weeks, then quarterly	Pressure and glucose at baseline and 12 weeks, then annually; lipids 5-yearly
Serum sodium	Hyponatraemia below 135 mmol/L, moderate 125 to 129, severe below 125	**Urine osmolality decides: concentrated in antidiuresis, maximally dilute in polydipsia**

Grade the abnormality before explaining it.

- **The renal line.** A filtration rate below 60 ml per minute is common and is not itself nephropathy. What matters is continuous decline above 4 ml per minute per year, or an unprovoked rate below 30. Raised thyrotropin with normal thyroxine is subclinical hypothyroidism.
- **Two traps.** The clozapine station is not only agranulocytosis: gastrointestinal hypomotility is the leading cause of death, so ask about bowel frequency and distension. Valproate and carbamazepine levels sit outside these sources, so quote a named formulary.

WHAT EARNS THE MARKS

- **The twelve-hour trough stated before the range.**
- **The neutrophil thresholds with their units,** Duffy-null included.
- **Urine osmolality asked for,** the discriminator candidates omit.
- **A source named for an unverified interval.**

SEE ALSO V - 74 the normal and abnormal EEG V - 75 brain CT and MRI, the dementias Weave Viva, Part VI

AREA 08 OF 10 · PV-A08

Drugs and somatic treatments

10	10.0%	V-77	V-86
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

SYLLABUS CORE 10

REVISION ORDER

Antipsychotics and their adverse effects first, with clozapine straight after. Then the mood stabilisers, the antidepressants and the remaining slots.

WHAT IS IN THIS AREA

The drug tables of the viva: antipsychotics, clozapine, lithium, the anticonvulsant mood stabilisers and the antidepressants, with treatment-resistant depression. Then drugs for substance use, prescribing in pregnancy and lactation, and ECT.

V - 77

Antipsychotics: classification, receptor profiles, dose equivalents.

10 DRUGS AND SOMATIC TREATMENTS SYLLABUS CORE

SKELETON

1	The three axes	Generation, chemistry, mode of action, named first
3	The classification	Drawn as a tree, drugs on the leaves
4	Receptors and occupancy	Response near 65%, movement risk from 78% upward
2	Dose equivalence	The percentage method, and why ratios retired

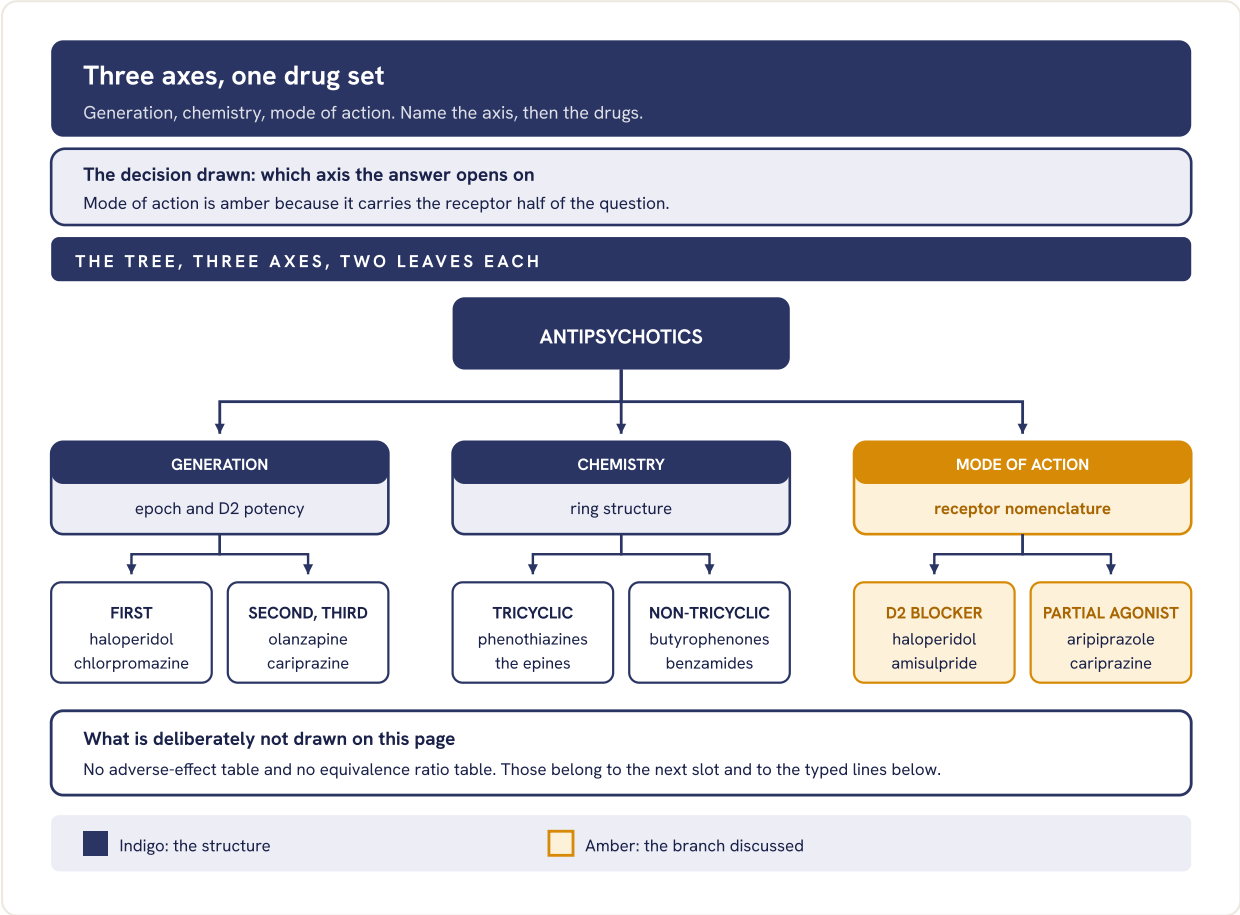


Fig 77.1 The classification drawn as one tree on three axes, with mode of action in amber because that branch carries the receptor half of the question.

- **Occupancy sets the dose.** Response needs about 65% striatal D2 occupancy and extrapyramidal risk escalates at 78% to 80%. Risperidone 2 mg gives roughly 65% and 6 mg pushes toward 80%, so atypicality is partly a dosing artefact.
- **Pharmacological definition.** Higher normalised affinity for 5-HT2A than D2, because striatal 5-HT2A blockade disinhibits local dopamine while mesolimbic blockade is kept. Receptor breadth on its own does not predict efficacy.
- **Equivalence, retired.** Against chlorpromazine 100 mg: haloperidol 2 mg, fluphenazine 2 mg, trifluoperazine 5 mg, perphenazine 10 mg. Offer the percentage method instead, each drug as a share of its own licensed maximum, summed.

WHAT EARNS THE MARKS

- **The three axes named before any drug.** The root line of the tree does it in one breath.
- **Every branch of the plate reproduced.** An incomplete tree loses more than a plain list would.
- **The two occupancy figures.** 65% for response and 78% to 80% for movement risk turn the tree into a dose decision.
- **The percentage method offered ahead of a ratio.** The ratio is the retired instrument.

SEE ALSO V - 78 Antipsychotic adverse effects V - 79 Clozapine Weave Viva, Part VII

V - 78

Antipsychotic adverse effects and their management.

10 DRUGS AND SOMATIC TREATMENTS SYLLABUS CORE

SKELETON

2 Classify by system	Movement, endocrine, metabolic, cardiac, muscarinic, marrow
3 Rank the drugs	Worst offender named for each liability
3 Act on a number	Switch at 5% to 7% gain; 500 ms stops the drug
2 Exclude the emergency	Rigidity with fever is a different answer

LIABILITY	HIGHEST RISK	THE NUMBER THAT ACTS	FIRST MOVE
Extrapyramidal	Haloperidol, fluphenazine; risperidone above 6 mg/day	Akathisia in about 25% on first-generation drugs; tardive dyskinesia 3% to 5% a year	**Reduce dose, switch, propranolol for akathisia**
Hyperprolactinaemia	Risperidone, paliperidone, haloperidol	Sustained and dose-dependent	**Exclude pregnancy and hypothyroidism, then switch to aripiprazole**
Metabolic	Clozapine, olanzapine	**Gain above 5% to 7% of baseline**	Weight at 4 and 8 weeks, glucose and lipids at 12 weeks, then switch
QTc prolongation	Pimozide, haloperidol, thioridazine	**Above 500 ms stops the drug**	Correct potassium and magnesium, refer to cardiology
Muscarinic and marrow	Low-potency phenothiazines, clozapine, olanzapine	Delirium risk in older people; clozapine seizures above 300 to 450 mg/day	Reduce the load; aripiprazole and lurasidone barely bind

Amber cells are the numbers that convert a description into a decision. Everything else in the row is the gradation across the class.

- **Timing names the movement syndrome.** Dystonia within hours, pseudoparkinsonism over days, akathisia across months, tardive dyskinesia after years, scored on general scales, Simpson-Angus, Barnes and the Abnormal Involuntary Movement Scale.
- **One class, three answers.** Anticholinergics rescue dystonia and parkinsonism, do nothing on their own for akathisia, and worsen tardive dyskinesia.
- **Aripiprazole is the pivot.** Prolactin-neutral, metabolically low, negligible QTc and muscarinic effect.

PITFALL

Akathisia read as worsening psychosis, so the dose goes up and the restlessness with it. The discriminator is a distressing subjective inner restlessness felt mainly in the legs, against delusion-driven agitation without limb-focused tension. A trial of low-dose propranolol separates them.

WHAT EARNS THE MARKS

- **A number attached to the action.** Gain above 5% to 7% triggers the switch and 500 ms stops the drug.
- **The anticholinergic rule stated three ways.** Rescue, useless alone, harmful, by syndrome.
- **The malignant syndrome excluded out loud.** Lead-pipe rigidity with fever and autonomic change leaves this page.

SEE ALSO V - 77 Antipsychotics: classification V - 79 Clozapine Weave Viva, Part VII

V - 79

Clozapine: initiation, monitoring, adverse effects, rechallenge.

10 | DRUGS AND SOMATIC TREATMENTS | SYLLABUS CORE

SKELETON

2	**Justify the indication**	Resistance by trials, dose, duration, adherence
2	**Baseline and titration**	Four domains; start 12.5 mg, target 175 to 300 mg
4	**Monitor and act**	The flowchart: count, heart, bowel, seizures
2	**Rechallenge and augment**	Conditions for rechallenge; ECT before a second antipsychotic

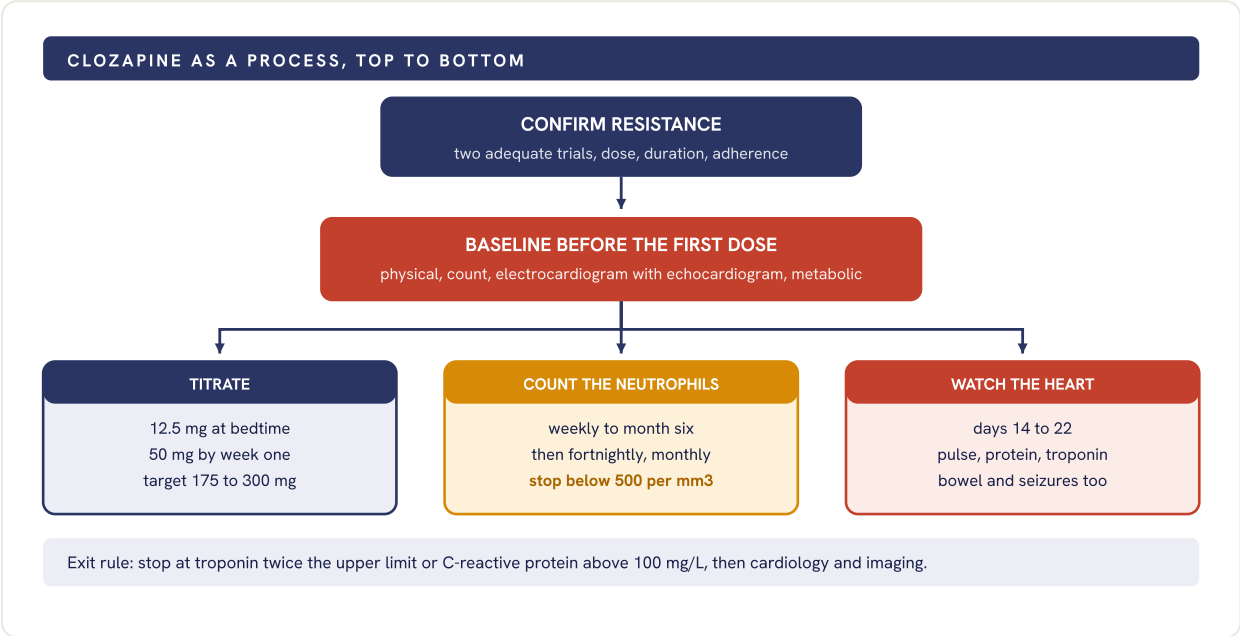


Fig 79.1 Clozapine drawn as one baseline gate followed by three surveillance lanes, with the cessation threshold carried as a strip along the foot.

- **Levels and the enzyme.** Aim for a trough of 350 to 600 ng/mL; above 600 ng/mL seizure liability rises without gain. CYP1A2 carries most of the metabolism, so stopping smoking raises the level.
- **Myocarditis against benign titration.** Onset falls between days 14 and 22 in 83% of cases, with pulse persistently at or above 120, protein rising alongside symptoms and troponin following 1 to 5 days later. Eosinophils peak too late to screen.
- **Rechallenge and augmentation.** Cautioned against after myocarditis, yet series report 63% to 75% success given full recovery, normal echocardiography, cardiology input, consent, inpatient micro-dose titration and daily markers. For incomplete response, ECT is first-line augmentation, then aripiprazole.

WHAT EARNS THE MARKS

- **The baseline gate on the page, echocardiogram included.** It shows you expect myocarditis, not only agranulocytosis.
- **The ancestry-adjusted target in the titration lane.** 175 to 300 mg on roughly half the Western dose, with CYP1A2 as the reason.
- **The exit strip quoted.** Troponin twice the upper limit or protein above 100 mg/L is what stops the drug.

SEE ALSO V - 78 Antipsychotic adverse effects V - 86 Electroconvulsive therapy Weave Viva, Part VII

V - 80

Lithium: pharmacology, dosing, levels, monitoring, adverse effects.

10 DRUGS AND SOMATIC TREATMENTS SYLLABUS CORE

SKELETON

1 Kinetics in one line	Renal, unbound, unmetabolised, distributed through body water
3 Dose against a band	Acute 0.8 to 1.2, older adults 0.4 to 0.8 mmol/L
4 Monitor by organ	Kidney, thyroid, parathyroid, nerve, sinus node
2 Grade the intoxication	Three bands, volume first, dialysis on severity

DOMAIN	THE SUBSTANCE	THE NUMBER THAT ACTS	FIRST MOVE
Handling	No cytochrome metabolism, negligible binding	80% reabsorbed proximally with sodium; half-life 18 to 36 hours	**Read sodium loss as a rising level**
Dose and band	Start 300 mg three times daily, rising by 300 mg every 3 days	**Acute 0.8 to 1.2 mEq/L, maintenance 0.8 to 1.0, elderly 0.4 to 0.8 mmol/L**	Avoided below a clearance of 30 mL/min
Sampling	Steady state within 5 days, first level at 3 days	**A 12 hour trough, into a plain red-top tube**	Repeat on a dose change or new interacting drug
Organ toxicity	Diabetes insipidus, goitre, hyperparathyroidism, sinus node disease	Thyroid-stimulating hormone at baseline, 3 months, then every 6 to 12 months	Levothyroxine added without stopping lithium
Intoxication	Coarse tremor and vomiting, then clonus, then coma	**From 1.5 mEq/L, above 2.0 to 2.5, above 3.0 to 3.5**	Isotonic saline first, dialysis on severity

Amber cells are the numbers that turn description into decision.

- **One mechanism answers the interaction table.** The tubule cannot separate sodium from lithium, so thiazides, anti-inflammatory drugs and renin-angiotensin blockers raise the level.
- **Managing intoxication.** Stop the drug, secure airway and cardiac monitoring, restore volume with isotonic saline, and cap sodium correction at 10 to 12 mEq/L in 24 hours. Charcoal does not bind lithium; recheck the level after dialysis.

PITFALL

A well patient with a level in the toxic range, treated as poisoning. Ask which tube was used: lithium heparin in a green-top tube falsely elevates the assay. The near neighbour is the tremor, fine and postural on therapy against coarse with ataxia in early intoxication.

WHAT EARNS THE MARKS

- **Renal-only handling said first.** It lets the interaction table be derived rather than recalled.
- **Timing quoted before the target.** A 12 hour trough, then 0.8 to 1.2 mEq/L for mania against 0.4 to 0.8 mmol/L in the elderly.
- **A band attached to each picture.** Grading from 1.5 mEq/L upward is what the question tests.
- **The tube named.** The discriminator in the well patient with an alarming level.

SEE ALSO V - 81 Valproate, carbamazepine, lamotrigine V - 85 Pregnancy and lactation Weave Viva, Part VII

V - 81

Valproate, carbamazepine and lamotrigine in psychiatry.

10 DRUGS AND SOMATIC TREATMENTS SYLLABUS CORE

SKELETON

2 What each one treats	Valproate mania, lamotrigine the depressive pole
3 Dose and titration	Valproate 800 to 1500 mg; lamotrigine target 200 mg
3 The interaction directions	Valproate halves it, an inducer doubles it
2 Teratogenicity and rash	Two valproate figures, then the lamotrigine rash window

DRUG	ROLE	DOSE AND TITRATION	THE HAZARD THAT DECIDES PRESCRIBING
Valproate	Acute mania; maintenance when lithium fails	Start 700 mg to 750 mg daily divided, work to 800 mg to 1500 mg; titrate against symptoms, not levels	**Malformation 10.93%; 3.3% below 1100 mg daily against 30.2% at or above it**
Carbamazepine	Second line	**Psychiatric range and serum band are not sourced: verify before the exam**	Potent inducer of CYP3A4, CYP1A2 and glucuronosyltransferase; screen HLA-B*1502 in Asian lineage
Lamotrigine	Prevents depressive relapse, not mania	**Weeks 1 and 2: 25 mg daily alone, 25 mg alternate days with valproate, 50 mg with an inducer; target 200 mg**	**Severe cutaneous reaction between weeks 2 and 8**

Valproate inhibits glucuronidation and doubles the lamotrigine half-life to roughly 56 hours, so dose and rate are halved. Oxcarbazepine, its prodrug cousin, induces CYP3A4 only moderately.

- **Valproate organ toxicity.** Fatal hepatic necrosis in 1 in 20,000, 95% inside the first 6 months; transaminase rise in about 10%; thrombocytopenia 12% to 18%; polycystic ovary syndrome at almost twofold other antiepileptics.
- **Folic acid, precisely.** It does not cover anatomical malformations, may modestly reduce neurodevelopmental risk, and is dosed at 4 mg to 5 mg daily.
- **Four directions, one enzyme.** Valproate halves the lamotrigine dose, carbamazepine doubles it, an oestrogen pill drops the level about 50% within 1 week, and stopping it doubles the level.
- **Rash rules.** Constitutional prodrome, then a coalescing rash; mucosal detachment marks the serious reaction. Stop at the first unexplained rash, ulceration or fever, and do not rechallenge.

PITFALL

Lamotrigine monotherapy offered for acutely suicidal bipolar depression. Titration takes roughly 6 weeks to target, so the patient is unprotected throughout and needs bridging cover.

WHAT EARNS THE MARKS

- **Alternatives named before valproate.** Lithium or lamotrigine first is the decision examiners listen for.
- **Two teratogenic figures, not one.** Roughly one in ten structural, three to four in ten neurodevelopmental.
- **The valproate column, not the monotherapy one.** 25 mg on alternate days answers the question asked.
- **Mucosal involvement named as the discriminator.** It separates a serious reaction from a benign rash.

SEE ALSO V - 80 Lithium V - 85 Pregnancy and lactation Weave Viva, Part VII

V - 82

Antidepressants: classes, switching, and the adverse-effect syndromes.

10 DRUGS AND SOMATIC TREATMENTS SYLLABUS CORE

SKELETON

3 Classify by mechanism	Each class named by its defining receptor action
2 Answer the latency	Transporter in hours, autoreceptor desensitisation in weeks
3 Switch or augment	Under 20% switches; 25% to 49% augments
2 Name the syndromes	Discontinuation, serotonin toxicity, bleeding, hyponatraemia

CLASS	AGENTS	MECHANISM	ITS OWN LIABILITY
Serotonin reuptake inhibitors	Fluoxetine, sertraline, paroxetine, escitalopram	Selective transporter inhibition	**Bleeding through platelet serotonin depletion; hyponatraemia; citalopram prolongs the QTc**
Dual reuptake inhibitors	Venlafaxine, duloxetine, desvenlafaxine	Serotonin and noradrenaline transporter inhibition	Sweating, sustained pressure rise; duloxetine hepatotoxicity
Tricyclics	Amitriptyline, imipramine; nortriptyline, desipramine	Mixed transporter inhibition with M1, H1 and alpha-1 antagonism	**Cardiac sodium channel blockade widens the QRS; narrow index in overdose**
Monoamine oxidase inhibitors	Phenelzine, tranylcypromine; moclobemide	Irreversible inhibition of both isoforms, or reversible	**Tyramine crisis on the irreversible agents; reversible inhibition self-corrects**
The atypicals	Mirtazapine, bupropion, trazodone, vortioxetine, agomelatine	Alpha-2 antagonism; dopaminergic reuptake; 5-HT2A block; multimodal; melatonergic	**Chosen by what each avoids: weight, sexual dysfunction, seizure threshold, transaminases**

Amber cells are the liabilities that drive a switch, so the grid answers choice as well as classification.

- **Switching, on a threshold and a clock.** Early response is 20% or more within 2 to 4 weeks and an adequate trial is 8 to 12 weeks. Washout is 5 weeks off fluoxetine, as norfluoxetine self-tapers, and 2 weeks off an irreversible inhibitor, with no cross-taper.
- **Discontinuation against relapse.** Dizziness and shock sensations at two to four days, gone within 24 hours of reinstatement; relapse takes two to three weeks and does not lift. Liability runs inverse to half-life.

PITFALL

Reading the two emergencies as one. Clonus within hours is serotonin toxicity; lead-pipe rigidity with hyporeflexia over days is the neuroleptic malignant syndrome. Reflexes discriminate before any blood test. Avoid physical restraint in the first: isometric contraction worsens hyperthermia.

WHAT EARNS THE MARKS

- **Latency explained by the autoreceptor.** It is the mechanism question inside the classification question.
- **A threshold quoted with a time.** 20% by 2 to 4 weeks turns judgement into a decision.
- **Reinstatement used as the diagnostic test.** Symptoms gone inside a day settles discontinuation against relapse.

SEE ALSO V - 83 Treatment-resistant depression V - 78 Antipsychotic adverse effects Weave Viva, Part VII

V - 83

Treatment-resistant depression: staging, STAR*D, augmentation, ketamine.

10 DRUGS AND SOMATIC TREATMENTS SYLLABUS CORE

SKELETON

2 **Define, then exclude**	Two failed adequate regimens, then pseudo-resistance ruled out
2 **Stage it twice**	Thase and Rush categorically, Maudsley dimensionally
4 **Choose the route**	The flowchart: switch, augment, or go interventional
2 **Quote the evidence**	Remission about 33%, falling to 7% to 10%

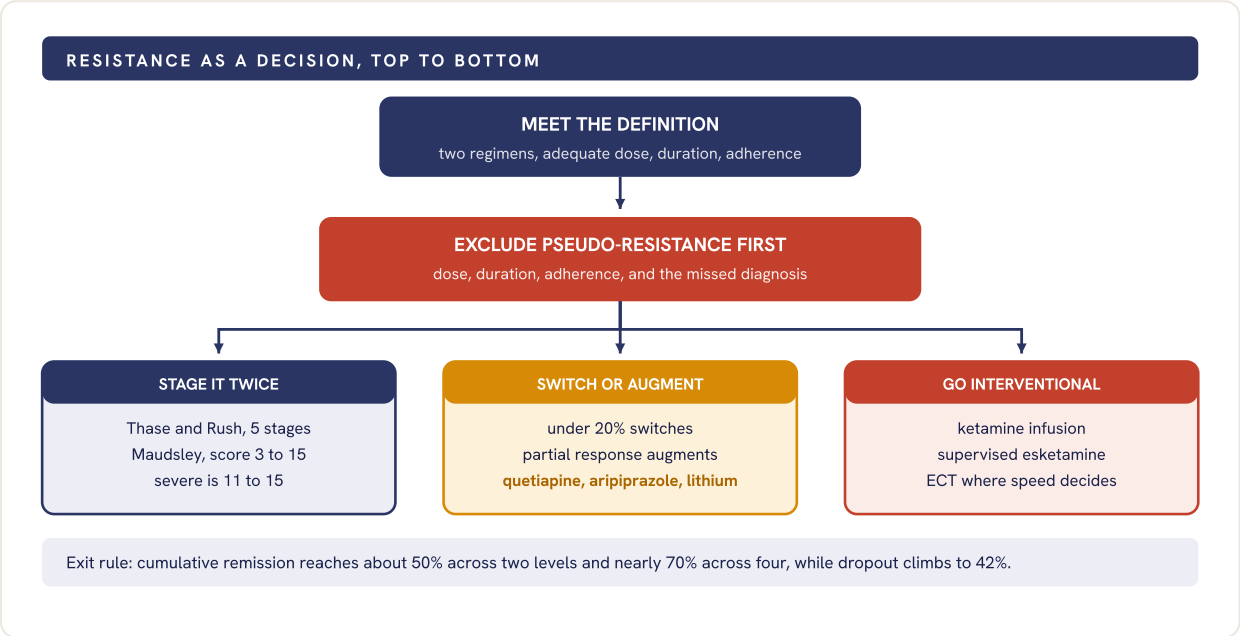


Fig 83.1 Resistance drawn as one definition gate, one exclusion gate and three routes onward, with the cumulative STAR*D yield carried as a strip along the foot.

- **STAR*D, level by level.** Citalopram gave remission of about 33%; at level 2 switching about 25% against add-on about 33%; level 3 switching 12% to 20%; level 4 only 7% to 10%. Dropout rose to 21%, 30% and 42%.
- **Augmentation, ranked with its cost.** Quetiapine, aripiprazole, thyroid hormone and lithium beat placebo for response, odds ratios 1.56 to 1.92, with no agent beating another; discontinuation for adverse events is higher for quetiapine, olanzapine, aripiprazole and lithium, odds ratios 2.30 to 5.64.
- **Volunteer the staging limits.** Thase and Rush presumes later drugs work better and a fixed sequence ending in ECT, and rests on response alone. The Maudsley method adds duration and severity, which is what the dimensional model buys.

WHAT EARNS THE MARKS

- **Pseudo-resistance excluded before the label.** Dose, duration, adherence, diagnosis, in that order.
- **Both staging methods, with what the second adds.** Duration and severity, not only failed drugs.
- **Remission quoted level by level.** About 33%, then 25%, then 12% to 20%, then 7% to 10%.
- **The interventional lane offered, not a fifth drug.** It is the argument the yield curve makes.

SEE ALSO V - 82 Antidepressants V - 86 Electroconvulsive therapy Weave Viva, Part VII

V - 84

Drugs for substance use disorders.

10 DRUGS AND SOMATIC TREATMENTS SYLLABUS CORE

SKELETON

2	Place pharmacotherapy	Alongside psychosocial treatment, offered by severity
3	Mechanism for each agent	Opioid reward, glutamate normalisation, aldehyde block
3	Choose by organ	Acamprosate barred at 30 mL/min or less
2	Set the conditions	Abstinence interval, supervision, monitoring, induction timing

AGENT	MECHANISM AND DOSE	QUANTIFIED BENEFIT	CONDITION OR CAUTION
Naltrexone	Mu-opioid antagonism blunting reward; 50 mg daily, or 380 mg intramuscularly every 4 weeks	Relative risk 0.81 (0.72 to 0.90) for heavy drinking	Withheld on an opioid agonist; liver enzymes at baseline and every 6 months
Acamprosate	Metabotropic glutamate-5 modulation normalising the hyperglutamatergic state; 666 mg three times daily	Odds ratio 1.86 (1.49 to 2.33) for abstinence at 12 months	Renally cleared: 333 mg thrice daily at 30 to 50 mL/min, barred at 30 mL/min or less
Disulfiram	Irreversible aldehyde dehydrogenase block; 250 to 500 mg daily, then 250 mg	Supervised, relative risk 1.71 (1.39 to 2.10) for abstinence	48 hours of verified abstinence first; sensitivity persists up to 14 days
Second line	Topiramate with epilepsy; baclofen in advanced liver disease; gabapentin 900 to 3600 mg daily	Gabapentin Hedges g of -0.64 for heavy drinking days	Topiramate avoided where cognition is impaired
Opioids and tobacco	Sublingual buprenorphine, a high-affinity partial mu agonist; methadone; nicotine replacement, varenicline	Induction waits for objective withdrawal	Given early, buprenorphine displaces a full agonist and precipitates withdrawal

Amber cells carry the number or rule that decides the prescription. The first two change the urge; disulfiram changes the consequence.

- **The disulfiram reaction.** Blood ethanol as low as 5 to 10 mg/dL triggers it, onset within 10 to 30 minutes: flushing, throbbing headache, then hypotension as noradrenaline depletion amplifies the vasodilation.
- **Managing it, in order.** Head-down positioning, oxygen, cardiac monitoring, an electrocardiogram with serial biomarkers, isotonic crystalloid, then a direct alpha agonist because presynaptic stores are depleted, and fomepizole 7.5 mg/kg in refractory shock.
- **Choice by comorbidity.** Acamprosate in decompensated cirrhosis, naltrexone or disulfiram at low clearance, and serotonin reuptake inhibitors refused, since they do not improve drinking outcomes.

WHAT EARNS THE MARKS

- **A mechanism attached to each drug.** Reward, glutamate, consequence, in that order.
- **One quantified benefit.** A ratio shows the choice rests on trial evidence.
- **Organ function driving the choice.** Acamprosate renal, naltrexone hepatic, with 48 hours of abstinence before disulfiram.
- **Induction timed to objective withdrawal.** The step that prevents a precipitated withdrawal.

SEE ALSO V - 82 Antidepressants V - 37 Alcohol withdrawal Weave Viva, Part VII

V - 85

Psychotropics in pregnancy and lactation.

10 DRUGS AND SOMATIC TREATMENTS SYLLABUS CORE

SKELETON

2 Frame it as a comparison	Fetal exposure against untreated maternal illness
2 Give the baseline first	A 2% to 3% malformation rate in any pregnancy
4 Go drug by drug	Valproate out, lithium watched, reuptake inhibitors reassuring
2 Then lactation	Three immature barriers, then three categories

DRUG OR CLASS	RISK IN PREGNANCY	ACTION	IN LACTATION
Sodium valproate	**The most teratogenic psychotropic, dose-dependent, with developmental deficit**	Not prescribed in pregnancy, planned pregnancy or lactation	Advised against
Lithium	A small defined rise in cardiovascular malformation, first trimester	**Fetal echocardiography with anomaly scan; trough every 4 weeks, weekly from 36**	**Advised against: relative infant dose up to 42%**
Serotonin reuptake inhibitors	No structural teratogenicity above baseline; poor adaptation in one-third; pulmonary hypertension after 20 weeks	**Pulse oximetry before discharge; routine echocardiography is not supported**	Sertraline and paroxetine first line
Antipsychotics	Metabolic risk with gestational diabetes; neonatal withdrawal near term	Glucose tolerance testing, consultant-led care, planned delivery	**Olanzapine and sulpiride first line, clozapine against**
Lamotrigine	Low malformation rate; the hazard is kinetic, as clearance rises	**Titrate up through gestation, reduce after delivery; folic acid 5 mg daily**	With caution; withhold milk if a rash appears
Carbamazepine	Craniofacial defects, nail hypoplasia, neural tube defects; fetal induction depletes vitamin K	Folic acid 5 mg daily first trimester, vitamin K at birth	Advised against

Amber cells are the actions an examiner can tick. Poor adaptation appears soon after delivery and settles within days to 2 weeks.

- **Three immature barriers explain lactation.** Hepatic cytochrome activity is roughly 50% of adult levels, filtration only 30% to 40% of capacity, and an immature blood-brain barrier allows cerebrospinal concentrations 10 to 30 times adult serum.
- **Abrupt cessation refused.** Stopping lithium before pregnancy gives almost 3 times the recurrence rate in the first postpartum month; restart maintenance promptly, with a level at 5 to 7 days.
- **Monitor the baby, not an assay.** An undetectable infant level is not reassurance alone, so feeding, sleep, tone and milestones are followed.

WHAT EARNS THE MARKS

- **Untreated illness costed as a risk.** The comparison, not avoidance, is the whole answer.
- **The background rate before any drug figure.** Without 2% to 3% no relative risk means anything.
- **Pulse oximetry named as the newborn screen.** Routine echocardiography is not supported.
- **Sepsis excluded before the drug is blamed.** The paediatric workup comes first in a sick neonate.

SEE ALSO V - 80 Lithium V - 81 Valproate, carbamazepine, lamotrigine Weave Viva, Part VII

V - 86

Electroconvulsive therapy: indications, procedure, parameters, adverse effects, the law.

10 DRUGS AND SOMATIC TREATMENTS SYLLABUS CORE

SKELETON

2 **Lead with speed**	The indications where a rapid response is the argument
2 **Prepare the patient**	One absolute contraindication, medication review, anaesthesia
4 **Dose and read the seizure**	The flowchart: placement, dose, adequacy, threshold
2 **Effects and the statute**	Three amnesias, then the three legal provisions

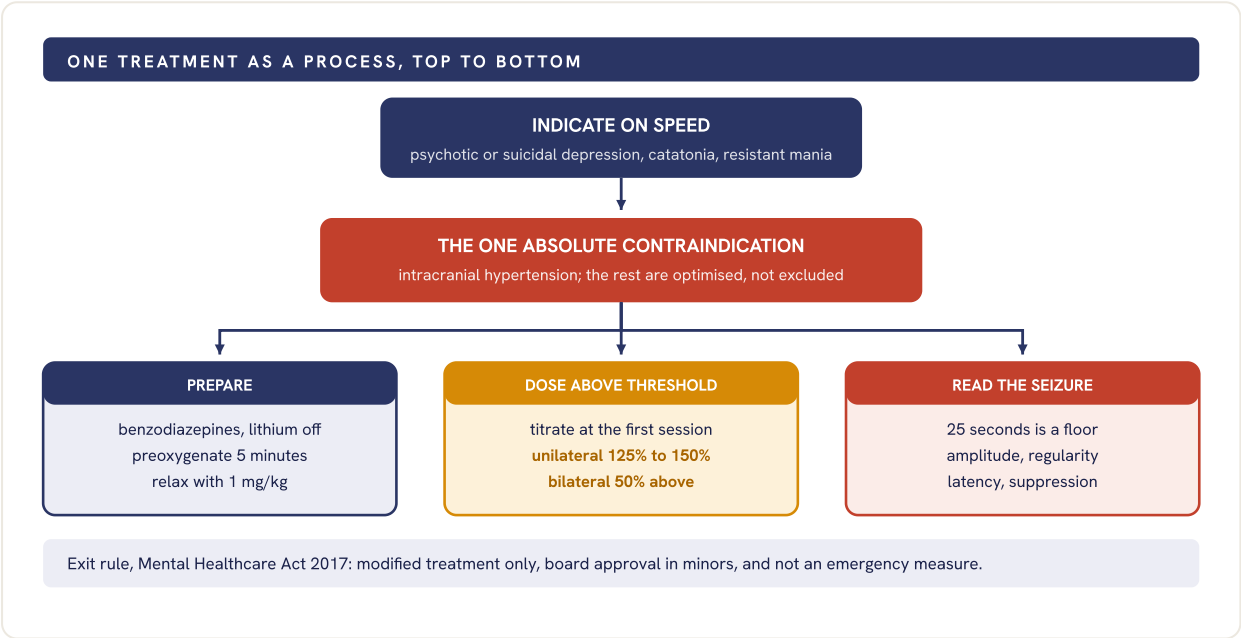


Fig 86.1 One treatment drawn as an indication gate, a single absolute bar, and three lanes for preparation, dosing and seizure reading, with the statute carried as a strip along the foot.

- **The course and the rising threshold.** An index course is 6 to 12 treatments over 2 to 4 weeks, and the anticonvulsant effect lifts the threshold by 47% to 50% between treatments 5 and 7, a mean rise of 40% over the first 6. Fixed charge with a rising threshold is treatment failure.
- **If the stimulus fails.** Where the seizure does not exceed 25 seconds on the electroencephalogram, intensity is raised by 50% and the patient is restimulated in the same session.
- **The amnesias, separated.** Postictal disorientation clears within minutes to hours; anterograde amnesia improves over subsequent weeks; retrograde amnesia covers weeks to months before treatment and persistent deficit is rare. A systematic review found no evidence of structural or cellular damage.

WHAT EARNS THE MARKS

- **Catatonia named early.** It is the indication where this is the treatment, not the last resort.
- **Dose expressed relative to threshold.** 125% to 150% unilateral against 50% bilateral; an absolute charge means nothing alone.
- **One absolute contraindication only.** Promoting a relative one costs the mark.
- **The three statutory provisions named.** Modified only, board approval for minors, and no emergency use.

SEE ALSO V - 83 Treatment-resistant depression V - 79 Clozapine Weave Viva, Part VII

Historical ECT apparatus

Companion to original page 109



Real photograph of historical ECT apparatus displayed at Glenside Hospital Museum. This is an equipment-history spotter, not a modern operating console or an electrode-placement demonstration. Its controls must not be used as guidance for current treatment or stimulus dosing.

Identify historical equipment without inferring current clinical settings.

Rodw. ECT machine 01.JPG. CC BY-SA 4.0. https://commons.wikimedia.org/wiki/File:ECT_machine_01.JPG Licence: https://creativecommons.org/licenses/by-sa/4.0. Unmodified.

AREA 09 OF 10 · PV-A09

Scales and assessments

6	6.0%	V-87	V-92
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

SYLLABUS CORE 6

REVISION ORDER

Read the psychometric principles slot first, since the scale slots assume it. The three scale slots can then be taken in any order.

WHAT IS IN THIS AREA

Psychometric principles, intelligence tests with the Indian adaptations, and projective and neuropsychological tests. Then the rating scales by domain, with their cut-offs.

V - 87

Psychometric principles: reliability, validity, sensitivity, specificity, cut-offs.

10 SCALES AND ASSESSMENTS SYLLABUS CORE

SKELETON

2 **Define the pair**	Reliability is consistency, validity is accuracy about the construct
3 **Reliability with indices**	Four types, alpha bands by purpose, r of 0.80 for stability
3 **Accuracy of a cut-off**	Test properties hold still, predictive values move with prevalence
2 **Choose the direction**	Screening tolerates false positives, confirmation does not

THE DEFINITION TO WRITE FIRST

An observed score is a true score plus random error, and reliability is the share of observed variance that is true. Validity is one construct with five evidence categories: content, response processes, internal structure, relations to other variables, and the consequences of testing. Reliability caps validity at its square root, so 0.81 permits 0.90 at most.

WHAT IS CHECKED	METHOD	INDEX	THE THRESHOLD THAT ACTS
Test-retest, alternate forms	Same test 2 to 4 weeks apart	Pearson r	**0.80 or above; state measures may drift, trait measures should not**
Internal consistency	One sitting: split-half, Kuder-Richardson, alpha	Alpha	**0.70 exploratory, 0.80 good, 0.90 to decide about one person**
Inter-rater	Independent raters, same interview	Kappa, intraclass correlation	**Chance-corrected, which raw agreement is not**
Content validity	Expert panel judges items	Item agreement	**A panel of 3 or more, agreement of 80 percent or above**

Amber cells are the thresholds asked for. A stable measure of finger length says nothing about self-esteem: reliability is necessary and not sufficient.

- **Accuracy, and where it moves.** A negative on a sensitive test rules out, a positive on a specific test rules in, and both belong to the instrument. Predictive values belong to the population: at 1 percent prevalence the positive value is 8 percent, at 10 percent 50 percent, at 20 percent 69 percent, at 50 percent 90 percent. Above 10 the positive likelihood ratio rules in whatever the setting.
- **The trade.** Lowering a cut-off buys sensitivity with specificity, so pick the direction from clinical cost, and say translation, validation and local norms before quoting an imported cut-off.

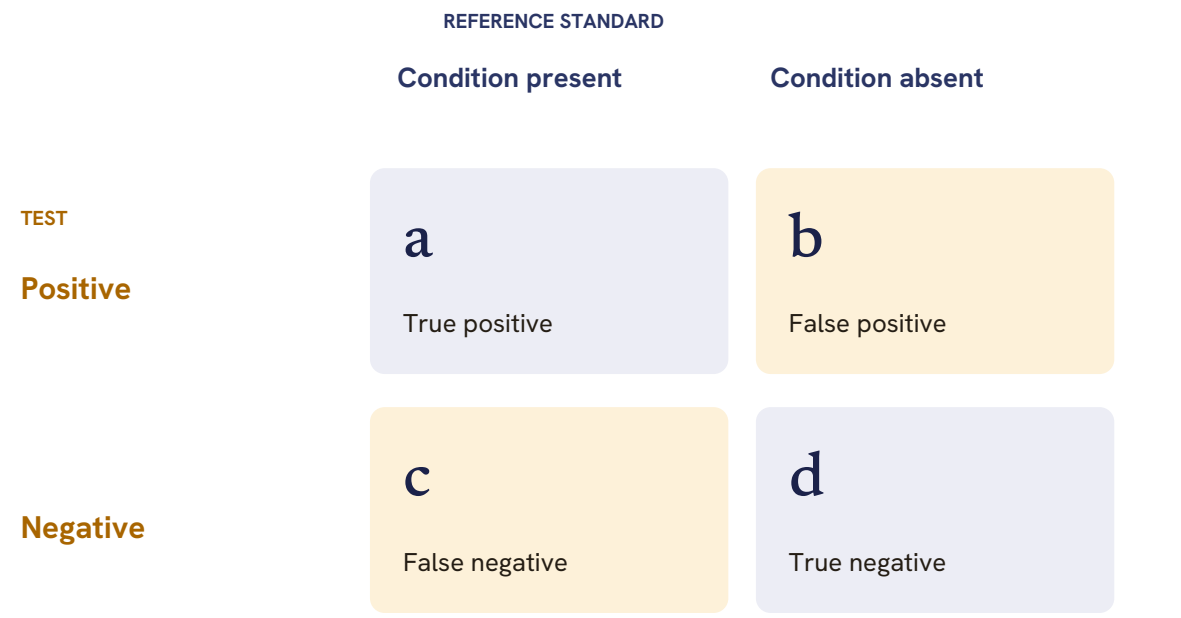
WHAT EARNS THE MARKS

- **The definition block written out.** An unreliable scale cannot be valid, and a reliable one may measure nothing useful.
- **The alpha bands by purpose.** 0.70 exploratory, 0.80 good, 0.90 to decide about one person.
- **Holding the test properties still.** Only the predictive-value line moves when the setting changes.
- **The cut-off chosen from clinical cost.** That direction is where the last two marks sit.

SEE ALSO V - 90 Psychosis and mood scales V - 91 Anxiety, OCD, substance, movement scales Weave Viva, Part VIII

Choose the denominator.

Read down for sensitivity and specificity. Read across for predictive values.



Sensitivity

$a / (a + c)$

Of those with the condition

Specificity

$d / (b + d)$

Of those without the condition

Positive predictive value

$a / (a + b)$

Of those who test positive

Negative predictive value

$d / (c + d)$

Of those who test negative

Schematic ▪ Original teaching diagram ▪ September 2026

Schematic. The two-by-two table with sensitivity, specificity and predictive-value denominators. Predictive values condition on the test result; sensitivity and specificity condition on reference status. Read the reference-standard columns for sensitivity and specificity, then the test-result rows for predictive values. The letters stand for counts; no numerical study results are implied.

Read down the reference-standard columns, then across the test-result rows.

Schematic prepared by Luna for Weave Viva, based on chapter P5D-01. Original edition artwork; publication licence to follow the edition.

V - 88

Intelligence tests and the Indian adaptations.

10 SCALES AND ASSESSMENTS SYLLABUS CORE

SKELETON

1	The quotient	Deviation quotient, mean of 100, standard deviation of 15
3	The classification	Drawn as a tree, the instruments on the leaves
4	The Indian branch	Malin's scale, Binet-Kamat, and the adaptive companion
2	Certifying disability	Three findings together, and who may sign in India

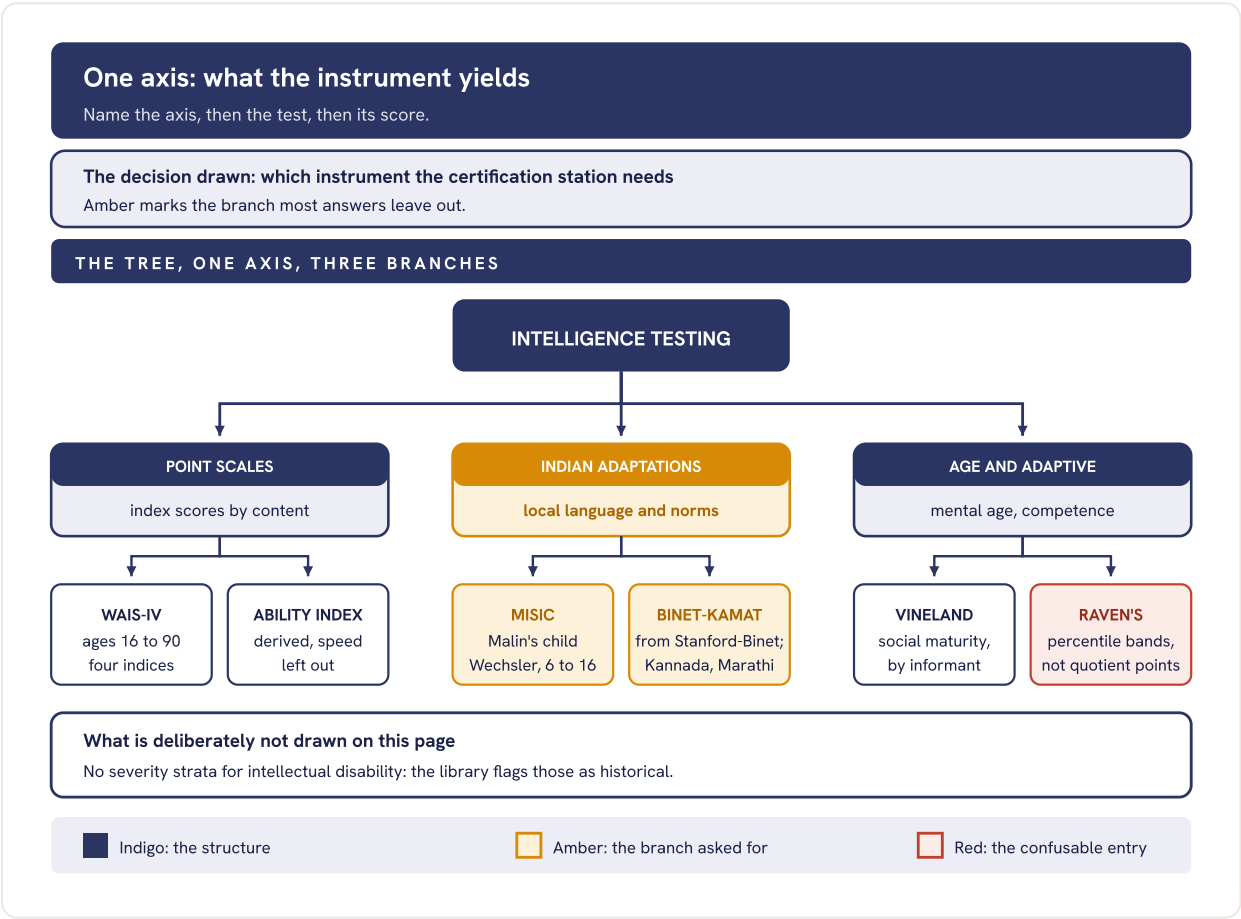


Fig 88.1 The instruments on one axis, the Indian adaptations in amber and the matrices in red because they return percentile bands, not quotient points.

- **Quotient arithmetic.** Ratio quotients fail in adults, because development plateaus while age rises. Deviation quotients use a mean of 100, standard deviation 15, so about 95 percent fall between 70 and 130.
- **Age scale against point scale.** The question behind most tables. An age scale finds a basal age where tasks pass and a ceiling where they fail, credits between them building mental age; a point scale groups items by content, returning index scores.
- **Three findings together.** A full scale quotient below 70, concurrent adaptive deficits, onset in the developmental period. Decline the onset age of 22 years, a figure from another jurisdiction. In India the cognitive test is paired with the Vineland scale and read by a psychologist registered with the Rehabilitation Council of India.

WHAT EARNS THE MARKS

- **The axis stated before the tree.** What the instrument yields sorts every leaf.
- **Every branch of the plate reproduced.** An incomplete tree loses more than a plain list.
- **Refusing to certify on a number alone.** A quotient below 70 is one of three findings.
- **Age scale separated from point scale.** Mental age from one, index scores from the other.

SEE ALSO V - 89 Projective and neuropsychological tests V - 92 Cognitive and disability scales Weave Viva, Part VIII

V - 89

Projective and neuropsychological tests.

10 SCALES AND ASSESSMENTS SYLLABUS CORE

SKELETON

1	Two families, one axis	The projective hypothesis, then lesion-referenced performance testing
3	Classify and name	Inkblot, apperceptive, completion, drawing; then battery and frontal test
4	What each defends	Formal thought disorder, and copy against recall against organisation
2	The honest limit	No categorical diagnosis, and a clean record excludes little

INSTRUMENT	WHAT IT IS	DEFENSIBLE CLAIM	THE DISCRIMINATOR
Rorschach	10 symmetrical plates, fixed order, free association then inquiry	An objective measure of formal thought disorder	**Exner scored form quality against frequency tables, replacing artistic impression**
The other projectives	Apperceptive scenes with a blank card; Sacks stems; a figure then its opposite	Story themes, and hypothesis generation	**Content sits under conscious control, and drawings score on graphic features, not symbolism**
Bender gestalt	9 designs copied on blank paper, no time limit	Visuomotor gestalt, and organicity with caution	**Hain: 15 weighted signs, 0 to 32; normal 0 to 5, critical 13 or more**
Indian batteries	PGI battery of brain dysfunction; NIMHANS Neuropsychological Battery and AIIMS Comprehensive Neuropsychological Battery, with stratified norms	A profile for a low-education patient	**The PGI memory scale covers 10 domains: one component, not the battery**
Fixed batteries	Halstead-Reitan infers damage from statistical deviation; Luria-Nebraska standardises Luria's probes	One localises, the other guides rehabilitation	**An impairment index against an education-adjusted functional profile**
Frontal tests	Card sorting, trail making, Stroop, Rey-Osterrieth figure	Executive load, read by task	**Copy is parietal, recall is temporal, organisation is frontal**

Amber cells are the discriminators; the rest of each row is the cheaper half.

- **Defend the inkblot by conceding first.** Illusory correlation, and norms that read about 50 percent of healthy subjects as showing distorted thinking. Then claim what a 2003 review supports: formal thought disorder and borderline organisation, not categorical diagnosis and not prediction of suicide or violence.
- **Read a clean Bender record cautiously.** False negatives are common with focal lesions and circumscribed epileptic foci. Rotation of 30 or 45 degrees is developmental, present in over 50 percent at age 6, and perseveration points to injury from age 8 onward.

WHAT EARNS THE MARKS

- **Structure placed above content.** Deviant verbalisation carries weight a reported theme does not.
- **Projective tests framed as adjunctive.** Inside history, mental state, an inventory and cognitive testing.
- **Localising by task.** Copy is parietal, recall is temporal, organisation is frontal.
- **Naming what each battery is for.** One localises by statistical deviation, the other guides rehabilitation.

SEE ALSO V - 88 Intelligence tests V - 92 Cognitive and disability scales Weave Viva, Part VIII

What is the task asking?

Original concept demonstrations — not standardised test items or scoring forms.

1 / Inhibition

Say the ink colour, not the word.

BLUE

Competing word and colour responses.

2 / Switch the rule

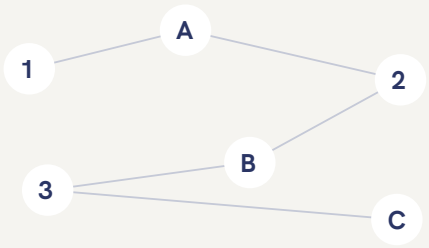
Sort by colour, then by shape.



A changed rule requires a changed set.

3 / Alternate

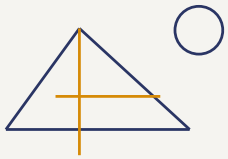
Follow 1 → A → 2 → B → 3 → C.



A novel sequence, not a Trail Making form.

4 / Copy, then recall

Observe → copy → remove → recall.



Original figure: no Rey or Bender design.

Schematic ▪ Original teaching diagram ▪ September 2026

Schematic. Four original concept demonstrations: colour-word interference, a changed sorting rule, alternating symbols, and copying then recalling a novel geometric figure. The coloured word, sorting tokens, alternating sequence and geometric figure are original teaching examples. They are not standardised test forms, validated tasks, scoring materials or substitutes for the appropriate manual and norms.

Name the cognitive demand and explain how instructions change the task.

Schematic prepared by Luna for Weave Viva, based on P5D-05. Original vector diagram.

V - 90

Psychosis and mood scales: PANSS, BPRS, HAM-D, MADRS, YMRS and their cut-offs.

10 SCALES AND ASSESSMENTS SYLLABUS CORE

SKELETON

2 Structure and floor	Thirty items rated 1 to 7, floor 30, ceiling 210
4 The grid	Items, range, and one decision point each
2 Response and remission	Response is a percentage change, remission an absolute score
2 The two refusals	No scale diagnoses, and none settles polarity

SCALE	STRUCTURE	RANGE AND BANDS	WHAT SETTLES IT
PANSS	Kay, Opler and Fiszbein, 1987; 3 subscales, 30 items rated 1 to 7	Positive and negative 7 to 49, general 16 to 112, total 30 to 210	A symptom-free patient scores 30; response is a 20 percent fall after the 30-point correction
BPRS	Overall and Gorham, 1962; 18 constructs scored 1 to 7	Interview plus behaviour over 2 to 3 days	The parent scale; sensitive to treatment effect in moderate to severe psychosis
SANS, SAPS, CAINS	Andreasen's pair, 1981 and 1984; CAINS; global impression	Intraclass correlations 0.70 to 0.88; no cut-off in the sources	The anchor the others are validated against
HAM-D-17	Hamilton, 1960; items 1 to 17 summed, items 18 to 21 subtype only	Remission under 7, mild 8 to 13, moderate 14 to 18, severe 19 to 22, above 23 very severe	Blacker cut-offs; response is a 50 percent fall, remission an absolute score
MADRS	Montgomery and Asberg, 1979; 10 items scored 0 to 6 over 2 weeks	0 to 60; remission 0 to 8, mild 9 to 17, moderate 18 to 34, severe above 35	Leaves out somatic complaint and retardation: better in medical illness
YMRS, MDQ	Mania severity, bipolarity screen	Items, anchors and thresholds absent from the sources	Carry them from a current text, not from memory

- **The scales convert.** Equipercentile linking across 31 trials puts Hamilton 10 at 13, 20 at 26, 30 at 39; percentage change transfers.
- **Two refusals.** No depression scale separates unipolar from bipolar depression: the curve ran 0.34 to 0.64 in 91 patients, below the 0.70 benchmark. A high negative score is not the deficit syndrome.

WHAT EARNS THE MARKS

- **Correcting for the floor before response.** Subtract 30 from baseline and endpoint; each item starts at 1.
- **Items 18 to 21 kept out of the total.** Subtype, not severity.
- **Opening with what the scale cannot do.** It grades severity in someone already diagnosed.
- **Declaring the unsourced row.** The mania scale's numbers are absent; describe it.

SEE ALSO V - 87 Psychometric principles V - 91 Anxiety, substance and movement scales Weave Viva, Part VIII

V - 91

Anxiety, OCD, substance and movement scales: Y-BOCS, AUDIT, CIWA-Ar, AIMS and the rest.

10 SCALES AND ASSESSMENTS SYLLABUS CORE

SKELETON

2 Sort by the job	Screening, severity, withdrawal, movement: four different jobs
4 The grid	Items, bands, the threshold that acts
2 Three decision points	Entry at 16, response 25 percent, remission 12 or less
2 The examination	Activation-only movements score one point lower than at rest

INSTRUMENT	STRUCTURE	RANGE AND BANDS	THRESHOLD THAT ACTS
Y-BOCS	Goodman, 1989; 10 items 0 to 4; five dimensions twice over	0 to 40; subclinical under 8, mild 8, moderate 16, severe 24, extreme 32	Entry 16, response 25 percent or more, remission 12 or less
HAM-A, GAD-7	14 clinician items 0 to 4; 7 self-report items 0 to 3	0 to 56; and 0 to 21, mild 5, moderate 10, severe 15	GAD-7 at 10: sensitivity 89 percent, specificity 82 percent
PCL-5	20 self-report items, past month	Probable disorder at 33 or above	Social anxiety, panic and dissociation scales have no sourced cut-off
AUDIT	10 items; 1 to 8 score 0 to 4, items 9 and 10 score 0, 2 or 4	0 to 40; low risk under 8, hazardous 8, harmful 16, dependence 20	8 or above screens positive; Indian thresholds ran lower
SADQ, COWS	20 items in 5 sections; and 11 items, 6 objective signs	Mild under 16, moderate 16, severe 31; opiate severe above 36	16 buys a chlordiazepoxide regimen; 5 objective signs permit buprenorphine
AIMS	7 regions 0 to 4, then severity, incapacitation, awareness	Items 1 to 7 summed; a 2-point fall is clinically important	Schooler-Kane: 2 in two regions or 3 in one, 3 months of exposure

- **Match the instrument to the job.** A screen cannot dose a detoxification and a withdrawal score cannot diagnose a use disorder. The CIWA-Ar titrates symptom-triggered benzodiazepines in alcohol withdrawal; its items, range and bands are unsourced: use the validation paper.
- **The movement examination is half the marks.** Two identical hard armless chairs, mouth cleared of gum, observed at rest then activated by finger tapping, standing and walking. Clear ill-fitting dentures first.

WHAT EARNS THE MARKS

- **The three decision points together.** Entry 16, response 25 percent, remission 12 or less.
- **The Indian divergence, with reasons.** Drink volume, episodic pattern, item 10, enzyme variation.
- **The activation rule.** The most asked detail on that scale.
- **The named gap.** A declared absence beats a guessed cut-off.

SEE ALSO V - 87 Psychometric principles V - 90 Psychosis and mood scales Weave Viva, Part VIII

V - 92

Cognitive and disability scales: MMSE, MoCA, HMSE, CDR, IDEAS, GAF.

10 SCALES AND ASSESSMENTS SYLLABUS CORE

SKELETON

1 **Two families**	Cognitive screens on one side, function and disability on the other
3 **The screens**	Thirty points either way, the cut-off moves from 24 to 19
4 **Disability arithmetic**	Four domains give 0 to 16, duration adds 1 to 4
2 **Who signs, and the limits**	Registered psychiatrist, government board, what a scale cannot claim

INSTRUMENT	WHAT IT IS	NUMBERS	THE DISCRIMINATOR
MMSE	Folstein, 1975; six areas, top score 30	Cut-off 26 clinically, below 24 in the community	**Heavy literacy load; sociodemographic and affective variables took 13 percent of variance**
HMSE	Five substitutions remove reading, writing and spelling	Ceiling stays 30; criterion 19 or less	**Fruit fluency 4, animal fluency 6, combined 12, object naming 13**
ACE-III	Total 100 across five domains	88 or above normal, below 84 possible dementia	**Separates Alzheimer disease from frontotemporal degeneration, at a heavy reading cost**
CDR	Informant interview about everyday function	0 no dementia, 4 severe dementia	**It survives illiteracy, so it crossed into rural India unmodified**
MoCA, frontal battery	Added executive and visuospatial load	Total, cut-off and education adjustment absent from the sources	**Describe the added load rather than a threshold**
IDEAS	Four domains 0 to 4, duration component 1 to 4	Domains 0 to 16, global 0 to 20	**8 of 20 is the 40 percent gate; omitting duration is the commonest scoring error**
GAF, SOFAS, WHODAS	Single item 1 to 100; 6 domains over 30 days	Below 50 is serious impairment	**GAF left DSM-5 for conflating severity with function; WHODAS is etiology-neutral**

- **Use category fluency where schooling is limited.** Phonemic segmentation is acquired through reading instruction, so letter fluency fails for want of schooling, not frontal pathology.
- **Who signs.** Only a registered psychiatrist diagnoses and signs; a government board carrying at least 1 psychiatrist issues the certificate, temporary for 5 years, reassessed every 2 years.
- **The standing criticism.** The duration component carries 20 percent of the weight, so chronicity alone can move a patient past the threshold.

WHAT EARNS THE MARKS

- **The five substitutions named.** They show why the Indian version exists, and the cut-off moves from 24 to 19.
- **Category fluency chosen over letter fluency.** Phonemic fluency needs reading instruction.
- **The duration component added.** 8 of 20 is the 40 percent gate.
- **Disability separated from quality of life.** Measured deficit against subjective satisfaction.

SEE ALSO V - 88 Intelligence tests V - 89 Projective and neuropsychological tests Weave Viva, Part VIII

AREA 10 OF 10 · PV-A10

Law, community and specialty psychiatry

8	8.0%	V-93	V-100
SLOTS IN THIS BOOK	SHARE OF THE HUNDRED	FIRST SLOT	LAST SLOT

SYLLABUS CORE 8

REVISION ORDER

The three Mental Healthcare Act slots together, rights before admissions and treatment rules. Then the disability and forensic slots, and the rest as they stand.

WHAT IS IN THIS AREA

The Mental Healthcare Act 2017 in three slots, the disability Act, and the forensic questions of responsibility and capacity. Then community psychiatry, the child and adolescent viva, and recent advances.

V - 93

Mental Healthcare Act 2017: rights, advance directive, nominated representative.

10 | LAW, COMMUNITY AND SPECIALTY PSYCHIATRY | SYLLABUS CORE

SKELETON

1 **Name the instrument**	Healthcare as one word, with its year and what it repealed
2 **The definition**	Mental illness, and what the definition leaves outside
3 **Capacity, Section 4**	Understand, appreciate, communicate: decision-specific and time-specific
2 **The two devices**	Advance directive and nominated representative, each with its chapter
2 **The civil-law hinge**	Mental illness alone is not unsoundness of mind

DEVICE	SECTIONS	WHAT IT DOES	THE LIMIT ON IT
Advance directive, Chapter III	5 to 13	How the person wishes, or does not wish, to be treated	**Operates only while capacity is absent; a capable decision overrides it, and Section 9 excludes emergencies**
Overriding a directive	11 and 13	Professional, relative or care-giver applies to the Board, which may uphold, modify or cancel	**No unilateral override; Section 13 protects the practitioner who followed a valid one**
Nominated representative, Chapter IV	14 to 17	Supports treatment decisions, admission applications, discharge planning	**Supported, not substitute, decision-making; inability to appoint one is not incapacity**
Rights, Chapter V	18 to 28	Access, community living, dignity, records, confidentiality, legal aid, insurance	**Section 18 is justiciable: Government services as a minimum in each district**

Amber cells carry each device's boundary: a chapter without its limit is a mid-band answer.

- **Open with the instrument.** Act 10 of 2017, 126 sections, repealing the Mental Health Act 1987 and aligning it with the Convention on the Rights of Persons with Disabilities.
- **Capacity, Section 4.** Understand the information, appreciate the foreseeable consequences of deciding or of not deciding, and communicate it by speech, expression or gesture.
- **The disqualification question.** Give the three positive conditions of Section 14(3): not a minor, competent to discharge the duties, written consent to the professional.

WHAT THE ACT DOES NOT COVER

It does not settle unsoundness of mind: Section 3(5) leaves that to a competent court, and past treatment does not justify a present determination. It carries no list disqualifying a nominated representative; the express disqualifications belong to Board members, Section 74(2). Mental retardation sits outside the statutory definition of mental illness.

WHAT EARNS THE MARKS

- **The instrument named before any section number,** Healthcare as one word.
- **Capacity given as three functional limbs,** decision-specific, not a diagnosis.
- **The amber column reproduced.** Each device stated with its limit.
- **Section 3(5) reached unprompted.** Unsoundness of mind takes a court.

SEE ALSO V - 94 Admissions under the Act V - 96 Disability Act 2016 Weave Viva, Part VIII

V - 94

Admissions under the Mental Healthcare Act 2017: Sections 85 to 90, 87, 94.

10 | LAW, COMMUNITY AND SPECIALTY PSYCHIATRY | SYLLABUS CORE

SKELETON

1	The vocabulary change	Independent and supported replaced voluntary and involuntary
3	The routes	Five routes, each with its examiners
3	The thresholds	A risk limb, absent capacity, the least restrictive option
2	The clocks	Reporting, capacity review, Board disposal
1	Exit and leave	Discharge on request, the holding limit, leave

ROUTE	WHO EXAMINES	CEILING	CLOCK AND BOARD
Independent, Section 86	The officer or professional in charge	Until discharge is requested, Section 88	**Intimation in 72 hours for a woman or minor, 7 days otherwise**
Minor, Section 87	Two independently: two psychiatrists, or one with a professional	Until discharge criteria are met	**Reported in 72 hours, Board review in 7 days, re-report at 30**
Supported, Section 89	One psychiatrist plus one other professional	30 days, no renewal under this section	**Reported in 3 days for a woman or minor, capacity every 7 days**
Beyond thirty days, Section 90	Two psychiatrists, both within the preceding week	90 days first, then 120, then 180 each time	**Board permits or discharges in 21 days, capacity every 15 days**
Emergency, Section 94	Any registered medical practitioner	72 hours, or until assessment, whichever is earlier	**Electroconvulsive therapy is barred; a directive does not apply**

Actor, ceiling and interval at once, which a paragraph cannot do.

- **The Section 89 door.** One of three limbs: recent or present threat of harm to self, recent or present violence to another, or recent inability to self-care at risk. Both examiners certify admission as the least restrictive option.
- **Two traps.** Section 89 cannot be renewed: continuation moves to Section 90 with two psychiatrists. Someone discharged under it cannot return within seven days.

WHAT THE ACT DOES NOT COVER

No judicial reception order opens a clinical admission; the Board enters afterwards. No section is headed absconding, Section 92 covering absence without leave. An independent patient may be held only twenty-four hours to complete a Section 89 assessment, and Section 94(3) keeps electroconvulsive therapy out of emergency treatment.

WHAT EARNS THE MARKS

- **Risk plus absent capacity as the door,** since diagnosis admits nobody.
- **The two ceilings held apart:** 30 days under one section, 90 under the next.
- **The amber clock column,** since vague timing is the commonest loss.
- **The readmission bar named,** sending an early relapse to the higher section.

SEE ALSO V - 93 The Act, rights and capacity V - 95 Treatment rules Weave Viva, Part VIII

V - 95

Treatment rules under the Act: ECT, restraint, prohibited procedures, Section 115.

10 | LAW, COMMUNITY AND SPECIALTY PSYCHIATRY | SYLLABUS CORE

SKELETON

2	The four prohibitions	Section 95, given in order, one of them conditional
2	The restrictions	Minors and psychosurgery, each with its authorising set
3	Restraint and seclusion	Seclusion barred, restraint only against imminent harm
1	The entry	Method, nature, justification, duration, recorded at once
2	Section 115	The rebuttable presumption of severe stress after an attempt

PROCEDURE	SECTION	STATUS	WHO MAY AUTHORISE
Unmodified electroconvulsive therapy	95(1)(a)	Prohibited	Nobody: a statutory bar; modified ECT stays valid
Electroconvulsive therapy in a minor	95(1)(b) with 95(2)	Restricted	Three together: psychiatrist in charge, guardian's informed consent, prior Board permission
Psychosurgery	96(1)	Restricted	The person's own informed consent plus Board approval; no proxy
Sterilisation as treatment, and chaining	95(1)(c) and (d)	Prohibited	Statutory bars; chaining recalls Erwadi
Seclusion or solitary confinement	97(1)	Prohibited	A statutory bar, locked side rooms included
Physical restraint	97(2)	Restricted	The psychiatrist in charge, as the sole means against imminent harm, representative told within 24 hours

Amber marks the authorising set: a prohibition and a restriction are different answers.

- **The restraint entry.** Method, nature, justification and duration recorded at once; no longer than necessary; not as punishment or for staff shortage; each instance in the monthly Board report.
- **Section 115.** A person who attempts suicide is presumed, unless proved otherwise, to have severe stress, and is not tried under Section 309 of the Penal Code. Section 115(2) obliges the Government to provide care and rehabilitation.

WHAT THE ACT DOES NOT COVER

Section 97 is silent on chemical restraint and fixes no maximum duration. Section 115 did not repeal the suicide offence; a rebuttable presumption disabled it, and severe stress is left undefined, with no scale or cut-off. Under Section 100 a person under police protection reaches a public health establishment within 24 hours, not a lock-up.

WHAT EARNS THE MARKS

- **A bar separated from a restriction,** since nobody can authorise a prohibited procedure.
- **The restraint entry recited as the section requires,** which is the defensible part.
- **The repeal claim corrected:** a presumption disabled the old offence, not a repeal.

SEE ALSO V - 94 Admissions under the Act V - 93 Rights and capacity Weave Viva, Part VIII

V - 96

Rights of Persons with Disabilities Act 2016 and disability certification.

10 | LAW, COMMUNITY AND SPECIALTY PSYCHIATRY | SYLLABUS CORE

SKELETON

1	**Two Acts, two jobs**	One governs entitlement, the other treatment
2	**The structure**	Sections, chapters, one Schedule, 21 specified disabilities
2	**Benchmark disability**	Not less than 40 percent, as the authority certifies
3	**The entitlements**	Employment and education quotas, social security, grievances
2	**Guardianship and assessment**	Limited guardianship, and when permanence is assessed

ENTITLEMENT	PROVISION	WHAT IT GIVES	THE DISCRIMINATOR
Public employment	Section 34(1)	Not less than 4% of vacancies in each group of posts	**Mental illness sits in clause (d) with autism and intellectual disability, and (d) shares 1% with (e)**
Higher education	Section 32	Not less than 5% of seats	**With an upper age relaxation of 5 years**
Social security	Section 24	Schemes at least 25% higher than comparable ones, plus free aids on an income ceiling	**Addressed to disability generally, not only to benchmark disability**
Workplace grievance	Section 23	A Grievance Redressal Officer, inquiry in two weeks	**Then the District-Level Committee under Section 72**
Discrimination	Sections 74 to 83	Inquiry by the State or Chief Commissioner, acted on in three months	**The route for refused accommodation, and not the Section 14(3) appeal**

Three doors: a refused certificate to Section 59, a guardianship order to Section 14(3), discrimination to the Commissioner.

- **Certification.** Guidelines under Section 56, authorities under Section 57, procedure in Section 58, the certificate valid nationwide. For mental illness the notified instrument is the Indian Disability Evaluation and Assessment Scale, issuable from primary health centre upwards.
- **When to assess.** When further treatment is unlikely to reduce impairment, 6 months normally being considered. Where improvement remains possible a temporary certificate may issue, valid for 5 years; a permanent one is lifelong.

WHAT THE ACT DOES NOT COVER

It governs entitlement, not treatment: the 2017 Act does that. A limited guardian under Section 14 decides within a specific period, decision or situation, and is not a nominated representative. The library leaves the scale domains and the arithmetic converting a global score into a statutory percentage unverified, so read that off the notified Gazette schedule.

WHAT EARNS THE MARKS

- **The benchmark named exactly:** not less than 40 percent of a specified disability.
- **The quota arithmetic,** since mental illness shares its share inside its clause.
- **Each grievance sent to its own door.**
- **A limited guardian held apart from a nominated representative.**

SEE ALSO V - 93 Rights and capacity V - 99 Child certification Weave Viva, Part VIII

V - 97

Criminal responsibility, fitness to stand trial and civil capacities.

10 | LAW, COMMUNITY AND SPECIALTY PSYCHIATRY | SYLLABUS CORE

SKELETON

1	Three questions, three moments	The act, the courtroom now, the civil decision
3	The provision	Section 84, carried into the new code, and its ingredients
2	The burden	Prosecution beyond reasonable doubt, accused on balance
2	The cases	Three judgments, and the conduct each weighed
2	Civil capacity	Void against voidable, decision by decision

QUESTION	RESPONSIBILITY AT THE ACT	FITNESS IN COURT NOW	THE CIVIL ANALOGUE
Provision	Section 84 Penal Code, now Section 22 of the Bharatiya Nyaya Sanhita, 2023	Sections 328 and 329 of the Criminal Procedure Code, bail under 330	**A statute per decision: Succession Act 1925, Contract Act 1872**
What is tested	Knowing the act's nature, or that it was wrong or unlawful	Following proceedings, instructing counsel, entering a rational defence	**Four limbs for a will, Banks v Goodfellow (1870)**
Who carries it	The accused, on preponderance of probabilities, Section 105 Evidence Act	The court's own duty, at inquiry or after charges	**In divorce, the petitioner proves the disorder and its severity**
Disposal	Acquittal under Section 334, safe custody under Section 335	Discharge if no prima facie case, else postponement for treatment	**A contract without sound mind is void; a marriage in breach voidable**
The expert	Advisory; the court finds	Relevant and advisory, Section 45 Evidence Act	**A court declares unsoundness of mind**

Amber is the column candidates leave out: the civil answer is per decision.

- **Three near-misses.** Brutality is not evidence of insanity, absence of motive is corroborative only, and irresistible impulse is no defence: the section tests cognition, not volition.
- **The cases.** Dayabhai Thakkar (1964): the crucial time is the moment of commission, weighing what preceded, attended and followed. Ratanlal (1965), acquitted on open conduct without concealment. Srikant Bhosale, conviction set aside on cognitive impairment.

WHAT THE LAW DOES NOT COVER

India has no diminished responsibility; the Law Commission rejected the English defence. The Criminal Procedure Code is recodified as the Bharatiya Nagarik Suraksha Sanhita, 2023, with successor numbering unsourced here: cite the Code section and name the recodification. A diagnosis disqualifies nobody.

WHAT EARNS THE MARKS

- **The three moments held apart** in the first grid row.
- **The standard stated:** preponderance of probabilities, carried by the accused.
- **Void held apart from voidable,** the amber disposal cell.

SEE ALSO V - 93 Capacity under the Act V - 95 Treatment rules Weave Viva, Part VIII

V - 98

Community psychiatry in India: NMHP, DMHP, Tele-MANAS, rehabilitation.

10 | LAW, COMMUNITY AND SPECIALTY PSYCHIATRY | SYLLABUS CORE

SKELETON

1	The axis	Policy states vision, programme moves money, Act creates rights
3	The classification	Drawn as a tree, three levels, two entries each
4	The district branch	Cadres, beds, satellite clinics, and the seeding model
2	Gap and money	Quote a gap with its population, then utilisation

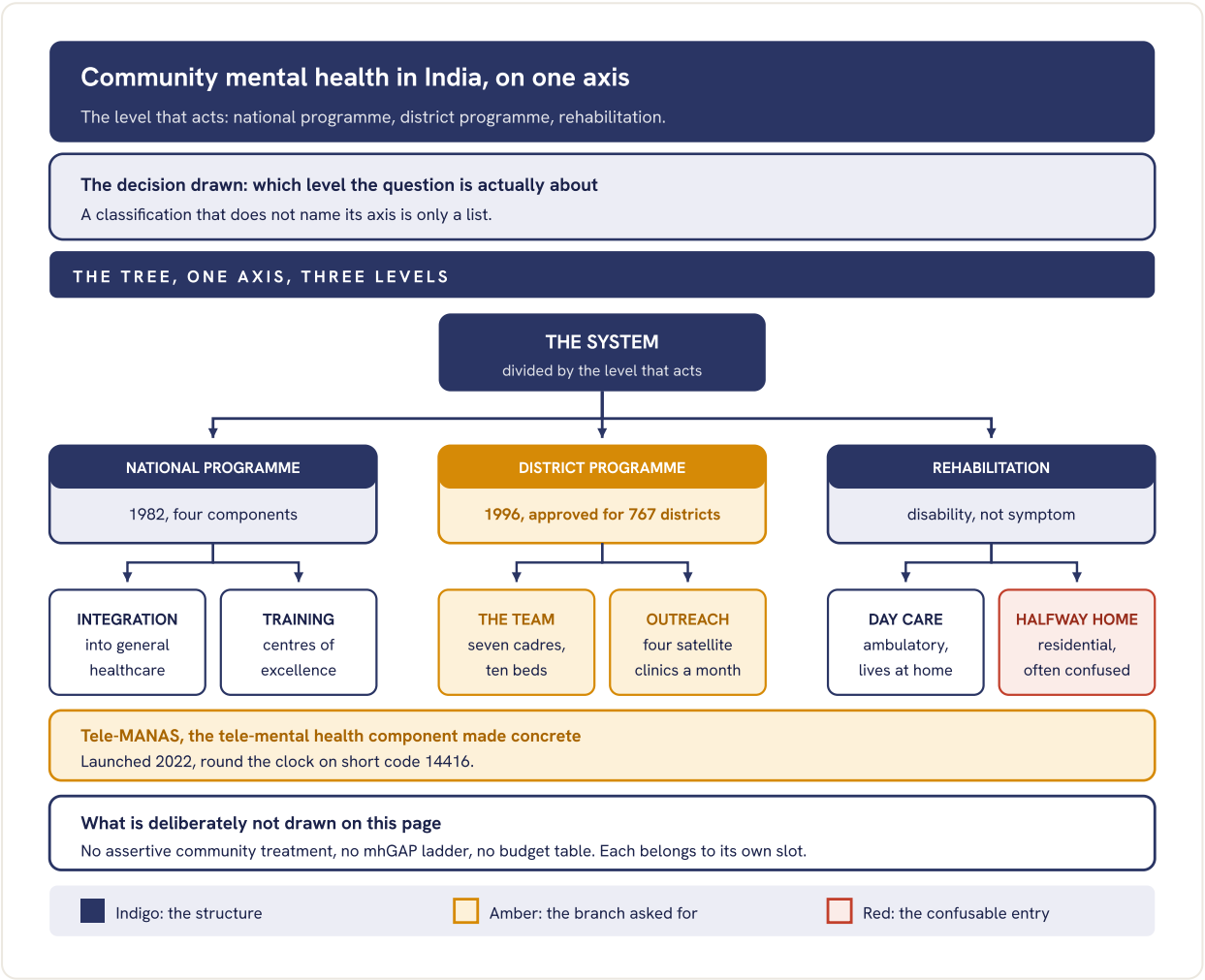


Fig 98.1 One axis, three levels: the district programme in amber because it carries the delivery half of the question, the halfway home in red because it is confused with day care.

- **Quote a gap with its population.** The older-adult analysis of the national survey gives 84%, from 76.9% for neurotic and stress-related disorders to 90.9% for severe mental disorders, recognition at 15.7%, and a median 24 months before care.
- **Then the utilisation figure.** Mental health takes under 1% of the central health budget, and in the two financial years from 2018, 96% and 93% of programme funds were surrendered unspent.
- **The rehabilitation discriminator.** Place then train: first employer contact within 30 days of entry, zero exclusion, support without a time limit.

WHAT EARNS THE MARKS

- **Policy, programme and Act separated,** since only one of the three is justiciable.
- **Every branch of the plate reproduced,** since an incomplete tree loses more than a list.
- **The population attached to the gap,** because 84% bare invites the follow-up.
- **The amber leaves named,** the cadres, the beds and the satellite clinics.

SEE ALSO V - 93 Rights under the Act Weave Viva, Part VIII

V - 99

Child and adolescent viva: ADHD, autism, intellectual disability, certification.

10 | LAW, COMMUNITY AND SPECIALTY PSYCHIATRY | SYLLABUS CORE

SKELETON

1 The axis	Divided on what the certificate is for
3 The classification	Four presentations, each with its instrument
4 The branch asked for	ADHD counts, the gate before age 12, treatment by band
2 Where it is contested	Score to percentage is notified, not clinical

PRESENTATION	DIAGNOSTIC ANCHOR	CERTIFICATION	THE DISCRIMINATOR
Attention-deficit hyperactivity disorder	6 inattention or 6 hyperactive symptoms to age 16 years, 5 from 17, over 6 months	Clinical diagnosis; educational support rather than a certificate	**Several symptoms before age 12 years and across 2 settings**
Specific learning disorder	Standard Indian battery one to one, from about age 8 years	One of the 21 specified disabilities under the 2016 Act	**Intelligence assessed concurrently, to exclude generalised impairment**
Intellectual disability	A social maturity scale with an Indian intelligence scale	A Schedule entry certified under the 2016 Act	**The severity bands are notified, not clinician-assigned**
Autism spectrum disorder	The notified Indian autism instrument	Certified under the same Schedule entry	**Its score bands are read off the notified schedule**

Amber is the cell candidates skip: three of these rows end at a statutory instrument, not a clinical judgment.

- **Treatment by band.** Preschool: parent training with classroom intervention, methylphenidate only if that fails and impairment is severe. School age: immediate-release methylphenidate 0.3 to 0.5 mg per kg a dose, to a maximum of 60 mg daily.
- **Enuresis, if the examiner turns.** Continence is developmental: by age 3 years, 98% are dry by day and 78% by night. Behavioural work first, then alarm therapy, then desmopressin from 0.2 mg at bedtime to a maximum of 0.6 mg, under the evening fluid rule.

WHERE IT IS CONTESTED

The library marks the intellectual disability and autism instruments, their severity bands and the arithmetic turning a score into a statutory percentage as unverified, so no figure for them is printed here. Read them off the notified Gazette schedule. School refusal is separated from truancy on concealment, company and distress, and that comparison is clinical grammar rather than a sourced count.

WHAT EARNS THE MARKS

- **The counts with the age break,** since the threshold falls at 17 years.
- **The developmental gate as an amber cell,** onset and two settings together.
- **Behavioural work first under six years,** medication following failure and severe impairment.
- **The unverified bands declined,** with the notified schedule named instead.

SEE ALSO V - 96 Disability Act 2016 Weave Viva, Part VIII

V - 100

Recent advances an examiner asks: new drugs, ICD-11, the landmark trials.

10 | LAW, COMMUNITY AND SPECIALTY PSYCHIATRY | SYLLABUS CORE

SKELETON

2 What changed	A mechanism, a classification and an evidence base
5 The advances	Four or five, each tied to the study behind it
2 Where they stand	Approved abroad, trial stage, or promising only
1 What is unsolved	One honest sentence about access

ADVANCE	WHAT IT DOES	EVIDENCE SO FAR	STATUS
Xanomeline with trospium	Central M1 and M4 muscarinic agonism, a peripheral antagonist shield, no D2 binding	EMERGENT-2 and EMERGENT-3, 5 weeks: PANSS fell 20.6 against 12.2 on placebo	**Approved in the United States in 2024**
Zuranolone	Oral neuroactive steroid at allosteric GABA-A sites, for postpartum depression	A 14 day evening course, with a boxed warning for 12 hours of driving impairment	**Approved in 2023, for postpartum depression only**
Brexanolone	The same class given intravenously	A 60 hour continuous infusion under pulse oximetry and sedation checks	**Resource-intensive, hard to run outside a high-dependency unit**
ICD-11 chapter 6	21 groupings in place of the F00 to F99 decimal cap, with essential features instead of symptom counts	Global field testing through a large clinician network	**Approved in 2019, reporting from 2022**
The pragmatic trials	Effectiveness under real prescribing rather than efficacy in a clean sample	CATIE: 74% discontinued within 18 months, perphenazine comparable to the newer drugs	**Settled evidence, cited as such**

Amber is the status column: a name without its study earns nothing, a study without its status earns half.

- **The side-effect hierarchy.** Huhn and colleagues compared 32 oral antipsychotics in acute schizophrenia: efficacy differences between non-clozapine drugs are small to moderate, while weight gain, sedation, movement effects and prolactin separate them sharply.

STATUS: WHERE THIS SITS TODAY

ICD-10 remains the working administrative standard in Indian records and logbooks while ICD-11 is taught, so present a case in the code the department uses and name the ICD-11 grouping alongside. For the newer molecules the library marks every Indian availability statement unverified, so give the approval abroad and read domestic status off the regulator's import and registration database. The unsolved part is access rather than mechanism.

WHAT EARNS THE MARKS

- **Each advance tied to its study,** which the evidence column does.
- **The mechanism stated for the new antipsychotic,** muscarinic rather than dopaminergic.
- **Status kept apart from promise:** approved abroad is not available here.
- **The access sentence,** which shows the field is understood.

SEE ALSO V - 98 Community psychiatry and the treatment gap Weave Viva, Part IX

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