

ENDGAMES

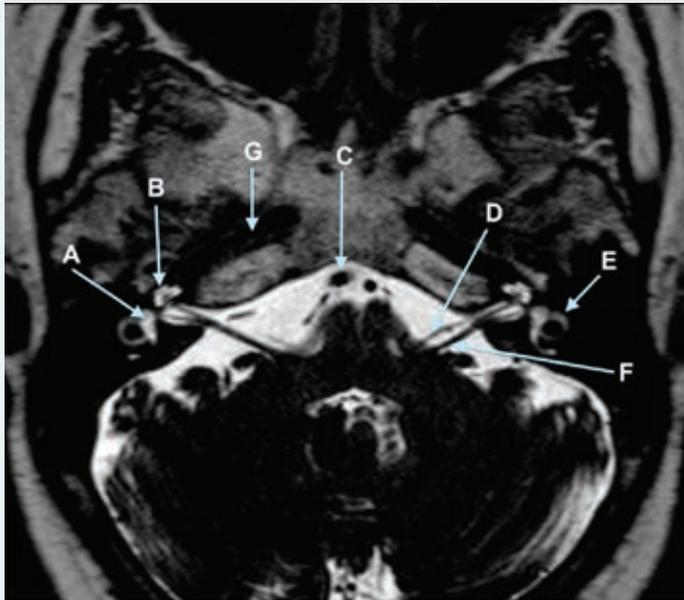
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ANATOMY QUIZ

High resolution axial T2 weighted magnetic resonance imaging of the posterior fossa



Name the structures labelled A, B, C, D, E, F, and G on this high resolution axial T2 weighted magnetic resonance image of the posterior fossa.

Submitted by Aniket Tavare and Mufudzi Maviki

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STATISTICAL QUESTION

Retrospective cohort studies: advantages and disadvantages

Researchers investigated whether differences exist between the sexes in the risk of ischaemic stroke in patients with atrial fibrillation. A nationwide retrospective cohort study design was used. Data were taken from the Swedish national discharge register. Participants were 100 802 patients with a first diagnosis of atrial fibrillation between 1 July 2005 and 31 December 2008, with a total follow-up of 139 504 years at risk (median 1.2). Information about drug treatment was taken from the Swedish drug register. Patients were excluded if at baseline they were prescribed warfarin, had mitral stenosis, or had previous valvular surgery. Patients who died less than 14 days from baseline were also excluded.

The primary outcome measure was the occurrence of ischaemic stroke. It was reported that ischaemic strokes were more common in women than in men (6.2% v 4.2% per year; $P < 0.0001$). The unadjusted hazard ratio of ischaemic stroke for women compared with men was 1.47 (95% confidence 1.40 to 1.54). After adjustment for 35 co-risk factors for stroke, an increased risk of stroke in women remained (1.18, 1.12 to 1.24). It was concluded that women with atrial fibrillation have a moderately increased risk of stroke compared with men, and thus, female sex should be considered when making decisions about anticoagulation treatment.

Which of the following statements, if any, are true?

- Patient data were collected retrospectively
- Selection bias was minimised
- Recall bias was minimised
- It was possible to estimate the population at risk
- Causality could be inferred from the association between female sex and ischaemic stroke in patients with atrial fibrillation

Submitted by Philip Sedgwick

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CASE REPORT

Caring for a woman with intellectual disabilities who refuses clinical diagnostic investigations

A 56 year old woman with moderate intellectual disabilities who lived in a residential care home presented to her general practitioner with iron deficiency anaemia, weight loss, and dyspepsia. She had severe osteoarthritis of one hip as a consequence of untreated Perthes' disease, which necessitated her using a wheelchair. Her vision was severely impaired and her speech was unclear. She was able to make day to day decisions about her choice of food and clothing but required a full assessment of her capacity to make more complex decisions. Her behaviour was described as "difficult" at times, and she had severe anxiety about medical consultations and interventions.

A "fast track" referral was made for an endoscopy, but she refused to attend. Two months later her haemoglobin had dropped to 68 g/L and faecal occult blood testing at that time was positive. She was referred for an ultrasound scan of her abdomen but again refused to attend.

- The Mental Capacity Act states a presumption of capacity unless proved otherwise. When people refuse examination or clinical diagnostic investigations, how should a doctor question the assumption of capacity?
- Everything that is done for (or on behalf of) a person who lacks capacity must be in that person's best interests. What should a doctor consider when deciding what would be in this woman's best interests?
- If a patient resists examination and treatment that has been agreed to be in his or her best interests, what should a doctor do, and what safeguards are available for the person?
- What two additional provisions were introduced by the Mental Capacity Act to protect vulnerable people and what are the implications for doctors?

Submitted by Pauline Heslop, Anna Marriott, Matthew Houghton, Marcus Jepson, and Antonia Noble

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