10.6 Gastrointestinal, liver and renal pathology

Name: _____ Class: _____ Date: _____ **Total: 24 marks**

KEY WORDS cirrhosis • nephrotic syndrome

Objective

Trace portal hypertension; split the two renal syndromes.

1 Key knowledge and worked examples

■ The blocked vein

Cirrhosis (fibrosis + nodules) → portal hypertension → varices, splenomegaly (→ thrombocytopenia), ascites, caput medusae; failure adds encephalopathy (ammonia), jaundice, coagulopathy ✓.

■ Worked example: two barrier lesions

Nephritic: torn pores – haematuria with casts, hypertension, proteinuria <3.5 g/day. Nephrotic: lost charge – ≥3.5 g/day, hypoalbuminaemia, oedema, hyperlipidaemia ✓. Panel: ALT/AST injury, ALP obstruction, albumin + INR synthesis.

2 Practice

2.1 Why does cirrhosis lower platelets? [3]

2.2 The nephrotic proteinuria line, with units? [3]

2.3 Which liver marker pair reports synthetic function? [3]

3 Exam-style questions

3.1 A fictional patient with cirrhosis: vomiting blood, distended abdomen, drowsy, bruising.

Localise the bleed (oesophageal varices – the portal collateral emergency) ✓. Explain the ascites (portal hydrostatic ↑ + low albumin oncotic ↓) and the bruising (vitamin-K factors and INR – synthetic failure) ✓. Attribute the drowsiness (ammonia → encephalopathy) ✓. [8]

3.2 Two fictional urines: A – Coca-Cola urine, red-cell casts, BP up, protein 1.2 g/day; B – frothy urine, protein 4.2 g/day, albumin 2.4 g/dL, periorbital oedema.

Classify A (nephritic – torn pores) and B (nephrotic – lost charge) with the quantitative line ✓. Explain why B oedemas (oncotic fall) while A is hypertensive (inflammatory renin and volume) ✓. [7]

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