READING PRACTICE TEST 22

Candidate Paper – Parts B and C

Time allowed	45 minutes
Questions	1–22
Instructions	Choose one answer for each question and mark the appropriate letter.

Part B

In this part of the test, there are six short extracts from healthcare workplaces. For questions 1–6, choose the answer (A, B or C) that fits best according to the text.

CLINICAL SAFETY NOTICE: Suspected transfusion reaction

Treat any unexpected deterioration during or soon after a transfusion as a possible reaction. Stop the transfusion immediately and call for urgent assistance if the patient's airway, breathing or circulation is compromised. Reassess observations and keep intravenous access available; do not flush the existing line, and insert a new cannula if treatment is required. Repeat the patient and blood-component identity checks, then notify the medical officer and transfusion laboratory. Do not discard the component bag or giving set, as these may be needed for investigation. Record the event in the clinical notes and complete the local incident documentation. A transfusion should be restarted only after clinical review and where the relevant protocol allows it.

1. According to the notice, a clinician who suspects a transfusion reaction should

A remove the existing intravenous cannula before treating the symptoms.
B stop the blood while preserving intravenous access for assessment and treatment.
C dispose of the component once the identity checks have been repeated.

PRIMARY CARE PATHWAY: Suspected irritable bowel syndrome

Consider a positive diagnosis of IBS in an adult who has recurrent abdominal pain related to defecation or accompanied by altered stool frequency or form, provided examination and initial investigations do not suggest another cause. Basic tests may include a full blood count, inflammatory markers and coeliac serology; routine colonoscopy is not required solely to confirm IBS. Arrange further investigation or specialist referral when red-flag features are present, including unintentional weight loss, rectal bleeding, an abdominal or rectal mass, iron-deficiency anaemia or raised inflammatory markers. A new change in bowel pattern later in life, or a clear change in previously stable symptoms, should also prompt reassessment rather than automatic attribution to IBS.

2. Which patient should be referred for further investigation rather than given a positive diagnosis of IBS at this stage?

A A 31-year-old with recurrent pain relieved by defecation, normal initial tests and no red-flag features.
B A 38-year-old with bloating and alternating stool form, normal inflammatory markers and negative coeliac serology.
C A 46-year-old with a recent change in bowel habit and laboratory-confirmed iron-deficiency anaemia.

WARD NOTICE: Daylight-saving changeover

At 02:00 on Sunday, clocks will move forward to 03:00. The electronic medication record will update automatically, but wall clocks in treatment areas must be changed manually. For time-critical medicines, base the next dose on the actual interval since the previous administration rather than on the displayed clock time alone. Record any adjusted administration time and the reason for it. Infusion pumps will continue at their programmed rates and must not be altered to “make up” for the missing clock hour. During handover, identify patients whose medicines fall within the changeover period and seek pharmacy or medical advice if the safe interval is unclear.

3. The notice is mainly intended to prevent staff from

A changing treatment intervals merely to match the altered clock time.
B using the electronic medication record during the changeover.
C allowing an infusion pump to continue through the missing hour.

PHYSIOTHERAPY NOTE: Exercise in motor neurone disease

The aim of exercise in MND is to preserve joint movement, reduce stiffness and support everyday function; it does not reverse motor-neurone loss. Programmes should be tailored to the person's current strength, respiratory status, fatigue, balance and preferences. Depending on function, low-to-moderate resistance, active-assisted or passive exercise may be appropriate. A person should not be pushed to complete a set workload when movement quality deteriorates or symptoms increase. New cramps, marked breathlessness, pain, or fatigue that persists into the following day indicate that the exercise dose should be reduced and the programme reviewed. Family members or carers who assist with movement should also receive safe manual-handling guidance.

4. What does the note advise physiotherapists to do?

A Preserve the same workload even when the quality of movement declines.
B Modify the programme when exercise produces prolonged symptoms or loss of technique.
C Introduce passive exercise from diagnosis regardless of the function retained.

STAFF WELLBEING BRIEF: Eating on night shift

Research has not established a single diet that prevents night-shift fatigue. Staff should therefore focus on regularity and individual tolerance: have a balanced meal before the shift, choose smaller meals or snacks overnight, and avoid a large meal immediately before daytime sleep if it worsens reflux or wakefulness. Caffeine may support alertness early in a shift, but taking it close to the intended sleep period can delay sleep. Meal timing may be useful, but it cannot compensate for inadequate sleep opportunity, missed rest breaks or unsafe levels of fatigue. Staff who are pregnant or who have diabetes, gastrointestinal disease or medication-related dietary needs should seek individual clinical advice.

5. What is the main message of the brief?

A Night workers should avoid eating until their shift has ended.
B A large meal before sleep is the principal cause of night-shift fatigue.
C Food and caffeine timing may help, but broader fatigue controls remain necessary.

RESEARCH CLINIC: Male hormonal contraceptive gel

Participants must apply the study gel once daily and attend scheduled semen testing. Suppression of sperm production takes time and varies between individuals. Couples must continue their usual reliable contraceptive method until the research team confirms that the participant's sperm concentration has reached the study threshold. After that confirmation, the gel must still be used exactly as directed, with further samples collected to verify that suppression is maintained. Missed applications, accidental transfer of gel to another person's skin, mood changes, acne or changes in sexual function should be reported promptly. The product remains investigational and does not protect either partner from sexually transmitted infections.

6. Participants may rely on the gel as the study contraceptive only after

A the laboratory has confirmed adequate suppression of sperm production.
B the first application has caused no adverse effects.
C both partners have independently stopped their previous method.

Part C

In this part of the test, there are two texts about different aspects of healthcare. For questions 7–22, choose the answer (A, B, C or D) that fits best according to the text.

Text 1: When insomnia and depression overlap

1 Sleep and mood influence each other in both directions. A night of fragmented sleep can leave a person tired, irritable and less able to regulate emotion, while low mood can make it harder to fall asleep because rumination and worry become more prominent at bedtime. The association is not limited to a difficult night followed by a difficult day: insomnia commonly accompanies depression and also predicts a higher risk of later depressive episodes. Conversely, people whose depression improves may remain vulnerable if persistent insomnia is left untreated. These patterns do not prove that one condition always causes the other, but they show why clinicians should not treat sleep and mood as unrelated complaints.

2 Chronic insomnia is more than simply sleeping fewer hours than desired. Diagnosis requires repeated difficulty initiating sleep, maintaining sleep or returning to sleep after early awakening despite adequate opportunity and circumstances for sleep, together with clinically significant daytime impairment. The symptoms usually occur at least three nights each week and persist for at least three months. This distinction matters: a shift worker who allows only five hours for sleep may be sleep deprived without having insomnia, whereas a person who reserves sufficient time but remains awake and impaired may meet the criteria. Insomnia can occur on its own or alongside depression, pain, respiratory disease and other conditions.

3 Historically, insomnia that accompanied another disorder was often labelled “secondary”. The practical implication was that clinicians could focus on the presumed primary illness and expect sleep to recover. Evidence has weakened that assumption. Insomnia can persist after the original precipitant improves, increase the likelihood of depressive relapse and respond to treatment directed specifically at sleep. Current practice therefore treats chronic insomnia as a comorbid disorder when it meets diagnostic criteria, rather than as a symptom that must wait its turn. This does not mean that insomnia treatment replaces care for depression; it means that both problems should be assessed and, where indicated, treated.

4 One reason insomnia can become functionally independent is that understandable attempts to compensate may help maintain it. After several poor nights, people may go to bed earlier, remain in bed later, cancel daytime activity or nap. These actions increase the opportunity for rest, but they can also reduce sleep pressure and create longer periods of wakefulness in bed. At the same time, the bedroom may become associated with monitoring the clock, anticipating failure and worrying about next-day performance. Repeated pairing of bed with alertness and frustration can produce conditioned arousal: the person feels sleepy elsewhere yet becomes mentally and physically activated on entering the bedroom.

5 Cognitive behavioural therapy for insomnia (CBT-I) is the recommended first-line treatment for chronic insomnia. It usually combines stimulus control, a structured adjustment of time in bed, cognitive work on unhelpful beliefs about sleep, relaxation strategies and education. Its aim is not to force sleep on a particular night but to rebuild a reliable relationship between bed and sleep over time. Some sedative or hypnotic medicines can reduce symptoms more rapidly and may be appropriate for selected patients, usually after consideration of age, comorbidities, interactions and other risks. However, tolerance, adverse effects, withdrawal and recurrence after discontinuation can limit their long-term value. CBT-I tends to produce more gradual change, but gains are often maintained after treatment ends.

6 Trials and clinical services have also examined CBT-I in people who report symptoms of depression or anxiety. In one large clinical cohort, insomnia improved substantially across patients with low, moderate and high levels of depressive symptoms at the start of treatment; greater initial mood burden did not eliminate the sleep benefit. Other studies suggest that successful insomnia treatment can also reduce depressive symptoms, although it should not be presented as a substitute for evidence-based depression care. The important point is that comorbidity is not a reason to postpone insomnia treatment automatically. Clinicians still need to assess suicide risk, bipolar symptoms, substance use, sleep apnoea and other factors that may alter the treatment plan.

7 Access remains the weak point. CBT-I is a specialised intervention, and many health systems have too few clinicians trained to deliver it. A stepped-care model may help: validated digital programmes or guided self-help can serve people with uncomplicated presentations, brief behavioural treatment can be offered in primary care, and specialist services can manage complex or treatment-resistant cases. These formats should preserve the active components of therapy and include a route to clinical review when risk or diagnostic uncertainty is present. General sleep-hygiene advice may be useful within a wider programme, but on its own it is not an adequate treatment for chronic insomnia.

Questions 7–14

7. What is the main point made in the first paragraph?

- **A** Depression is usually a consequence of prolonged use of sleep medication.
- **B** Sleep difficulty should be diagnosed only after a patient's mood has improved.
- **C** Poor sleep and low mood often coexist but generally develop independently.
- **D** Disturbed sleep can worsen mood, while low mood can also interfere with sleep.

8. Why does the writer emphasise "adequate opportunity" for sleep in paragraph 2?

- **A** To argue that most adults routinely allow themselves too little time in bed.
- **B** To distinguish insomnia from sleep loss caused mainly by a restricted schedule.
- **C** To show that objective sleep testing is required before diagnosis.
- **D** To imply that daytime impairment is a secondary diagnostic consideration.

9. In paragraphs 3 and 4, "functionally independent" means that insomnia

- **A** always begins without an identifiable trigger.
- **B** can no longer occur alongside a physical or mental illness.
- **C** may continue through mechanisms that outlast the original trigger.
- **D** cannot improve until the accompanying condition has resolved.

10. What change in clinical thinking is described in paragraph 3?

- **A** Insomnia should be assessed and treated alongside depression when both conditions are present.
- **B** Successful depression treatment usually removes the need for specific insomnia care.
- **C** Insomnia treatment is useful only after depressive symptoms have fully remitted.
- **D** Chronic insomnia should be classified as a symptom rather than a comorbid disorder.

11. According to paragraph 4, how can a patient's response to poor sleep perpetuate insomnia?

- **A** Spending longer in bed reliably increases sleep pressure and reduces arousal.
- **B** Daytime napping helps restore a strong association between the bedroom and sleep.
- **C** Concern about next-day functioning occurs only after insomnia has become chronic.
- **D** Compensatory habits can strengthen wakefulness and anxiety in the sleep environment.

12. How does paragraph 5 compare CBT-I with sedative or hypnotic medication?

- **A** They work at a similar speed, but CBT-I is generally less expensive.
- **B** Medication may act faster, whereas CBT-I tends to produce slower but more durable gains.
- **C** CBT-I is preferred because it removes the need to assess comorbid conditions.
- **D** Medication becomes more sustainable when delivered in a short course of therapy sessions.

13. What did the clinical cohort described in paragraph 6 indicate?

- **A** Improvement in insomnia was similar across different initial levels of depressive symptoms.
- **B** Only patients with mild depressive symptoms benefited from CBT-I.
- **C** CBT-I reduced depressive symptoms but produced little change in insomnia.
- **D** More severe depressive symptoms predicted a faster response to CBT-I.

14. What solution to limited CBT-I access does the final paragraph support?

- **A** Restricting delivery to general practitioners who complete specialist training.
- **B** Replacing clinician-delivered treatment with digital programmes in all cases.
- **C** Using several validated delivery formats while retaining routes for clinical review.
- **D** Offering sleep-hygiene education alone when a trained therapist is unavailable.

Text 2: Rosacea – treating the features, not the label

1 Rosacea is a chronic inflammatory condition that can affect the central face and the eyes. It may produce persistent colour change, episodic flushing, visible vessels, papules and pustules, thickened skin, or sensations such as burning and stinging. The pattern differs widely between patients, and the most troublesome feature is not always the most conspicuous one. Rosacea is sometimes dismissed as a cosmetic concern, yet discomfort, ocular symptoms and anxiety about appearance can disrupt work and social life. Recognition may be delayed in darker skin tones because erythema is less visually obvious, making history, symptoms and examination under suitable lighting especially important.

2 Modern classification has moved away from forcing every patient into one of a small number of subtypes. Instead, clinicians use a phenotype-based approach: they identify the features present in the individual and grade their severity. Persistent centrofacial erythema with periodic intensification and phymatous change are considered diagnostic phenotypes. Other major features include flushing, inflammatory papules and pustules, telangiectasia and ocular manifestations; a combination of major features can support the diagnosis. There is no single laboratory test for rosacea, so clinicians must also consider alternatives such as acne, seborrhoeic dermatitis, lupus, contact dermatitis and medication-related flushing.

3 Many patients identify triggers for flares, including ultraviolet exposure, heat, abrupt temperature change, alcohol, spicy food, exercise, emotional stress and irritating skincare products. The list is individual rather than universal. Recording the circumstances around flares can help a patient identify patterns, but trigger avoidance is only one part of management. It may reduce the frequency or intensity of episodes without removing the underlying tendency to rosacea. Overly restrictive advice can also be counterproductive if it asks a patient to avoid normal activity on the basis of a generic list rather than their own experience.

4 The biology of rosacea is also more complex than a simple reaction to heat or embarrassment. Neurovascular dysregulation can make facial vessels dilate readily and can contribute to warmth, burning and stinging. At the same time, altered innate immune signalling can amplify inflammation; increased activity in pathways involving toll-like receptor 2, kallikrein 5 and cathelicidin peptides has been described in rosacea-prone skin. Barrier dysfunction may make the skin more sensitive to products and environmental exposure. These systems influence one another, which helps explain why visible redness, inflammatory lesions and sensory symptoms can coexist but respond differently to treatment.

5 Demodex mites illustrate the need for caution when interpreting associations. These organisms live in the follicles of many people who do not have rosacea. In some patients, however, a higher mite density or the immune response to mite-associated material may intensify inflammation, particularly when papules and pustules are prominent. Finding Demodex therefore does not by itself establish the diagnosis, and rosacea does not require a microbial cause. The evidence is more consistent with the mite acting as one possible contributor within a susceptible host than as a single explanation for every case.

6 Treatment is matched to the features present. Gentle skincare and broad-spectrum sun protection form a base. Topical agents such as ivermectin, azelaic acid or metronidazole may be used for inflammatory lesions; low-dose oral doxycycline can be considered when these are more extensive. Persistent erythema may be reduced temporarily with topical vasoconstrictors, while vascular laser or intense pulsed light can help selected patients with persistent redness or telangiectasia. Ocular disease may require lid care, lubricants, medication or ophthalmology input. Because one therapy rarely controls every phenotype, combination treatment is common, and response must be reviewed rather than assuming that improvement in one feature represents control of the whole condition.

7 Effective care also depends on how success is defined. Clinician-rated severity and patient burden do not always move together: relatively modest visible changes may cause major embarrassment or burning, while a patient with more extensive signs may be less troubled by them. Consultation should therefore include the symptoms the patient wants treated, previous responses, skin sensitivity, practical cost and the time required for maintenance. Rosacea is usually controlled rather than cured, so a plan that the patient can follow consistently is more useful than an ambitious regimen that is abandoned. Follow-up also provides an opportunity to reconsider the diagnosis if the pattern changes or treatment repeatedly fails.

Questions 15–22

15. What does the first paragraph suggest about the clinical impact of rosacea?

A It is primarily a cosmetic condition that usually resolves without treatment.
B It is recognised equally well across skin tones because its visible signs are consistent.
C Its medical and psychosocial importance may be underestimated, particularly when redness is less apparent.
D Ocular symptoms occur only when the facial disease has become clinically severe.

16. What principle of treatment planning is developed across the text?

A Oral antibiotics should be the starting treatment regardless of presentation.
B Management should target the particular combination of features present in the patient.
C Trigger avoidance should be completed before medical treatment is considered.
D Treatment should be delayed until the patient can be assigned to a fixed subtype.

17. What is the writer emphasising in paragraph 3 about rosacea triggers?

A Avoiding relevant triggers may reduce flares without removing the underlying condition.
B A trigger should be regarded as the biological cause of rosacea.
C Most patients react to the same group of environmental factors.
D Trigger avoidance is rarely useful and should not be discussed.

18. What conclusion does paragraph 5 reach about Demodex mites?

A They are normally absent from people who do not have rosacea.
B They provide a single microbial explanation for all forms of rosacea.
C Their detection is sufficient to confirm a diagnosis of rosacea.
D A higher density may contribute to inflammation, but their presence is neither unique nor essential.

19. What is the main purpose of paragraph 4?

A To challenge the value of phenotype-based diagnosis.
B To demonstrate that vascular change is the sole cause of rosacea.
C To show how interacting vascular, immune and barrier mechanisms can produce different symptoms.
D To explain why rosacea symptoms are generally confined to the eyes.

20. What does paragraph 6 imply about rosacea treatment?

A A therapy that reduces facial vessels will also reliably control inflammatory and ocular features.
B More than one intervention may be needed because treatments act on different features.
C Every patient requires an oral antibiotic in addition to skincare.
D Topical vasoconstrictors cure the disease by correcting the inflammatory pathway.

21. According to paragraph 2, which finding can be sufficient on its own to support a rosacea diagnosis?

A Inflammatory papules in the absence of any central facial change.
B A positive laboratory test for an inflammatory skin marker.
C The simultaneous presence of every major rosacea feature.
D Persistent centrofacial erythema that periodically becomes more intense.

22. What does the final paragraph say about evaluating treatment success?

A Clinician-rated severity may not accurately represent how much the condition affects the patient.
B Psychosocial burden is mainly associated with phymatous change.
C Visible clearance should take priority over the patient's own treatment goals.
D Improvement in visible signs normally removes burning and other sensory symptoms.

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