

**Part
one****Part
two****Part
three****Part
four****Part
five**

1. (a) and (b) are the initial diseases to rule out because it is crucial not to miss them, but (c) and (d) are outside possibilities. He is unlikely to have (e) without a long history of lung disease since childhood, and (f) cancer is unlikely at his age.
2. (a), (c), (d), and (e) are all possible causes of a mediastinal mass that does not involve the lungs, as in this case. Tuberculosis is now much less likely. The only way to make the diagnosis is on histology of the biopsy material.
3. (a) Reed–Sternberg cells are pathognomonic of Hodgkin’s lymphoma. They differ from giant cells found in tuberculosis and are not found in sarcoid. A raised CRP indicates inflammatory disease, not necessarily infection.
4. (a), (b), (c), and (d). All are symptoms and signs of Hodgkin’s lymphoma, but none needs to be present to make the diagnosis. Amos’s presentation, without lymphadenopathy and without the more severe symptoms, is typical of the early stages of the disease. Severe dyspnoea is not a typical feature until the later stages.
5. (f). Initial treatment is usually with the combination of doxorubicin, bleomycin, vincristine, and dacarbazine. In Amos’s case they were combined with radiotherapy to the mediastinal mass. He recovered well and is now in remission. If he had more advanced disease he would have been given an even more complex regimen of bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, procarbazine, and prednisolone. If that had failed to induce remission he would have been considered for autologous peripheral blood stem cell transplantation. Today’s chemotherapy for Hodgkin’s lymphoma is producing encouragingly good success rates.

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