# AMT MRCP UK Cardiology Questions

*15 original best of five questions with answers and option by option explanations*

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Author approved for educational distribution on 10 October 2026. This edition extracts the 15 questions from the Cardiology prototype without changing the stems, answer keys or explanations.

Clinical and pharmacy peer review completion was not documented in the source. These examination questions are not patient-specific clinical guidance. Check current NICE, RCUK, MHRA, BNF and local guidance before applying treatment decisions.

## How to use

Attempt each best of five question before reading the answer and explanations. The supporting source number after each explanation corresponds to the reference list at the end.

# QUESTION 01 • ACUTE CORONARY SYNDROMES — STEMI • MODERATE

### Reperfusion for acute STEMI

A 61-year-old man develops crushing central chest pain 90 minutes ago. The ECG shows 3 mm ST elevation in V2–V5 with reciprocal inferior ST depression. He is in a hospital without PCI facilities. A primary PCI can be delivered 100 minutes after the time at which fibrinolysis could be administered. He has no bleeding contraindication. Which is the single best reperfusion strategy?

A. Administer fibrinolysis immediately and do not arrange angiography

B. Transfer for primary PCI

C. Wait for a repeat high-sensitivity troponin before deciding

D. Treat medically and arrange outpatient CT coronary angiography

E. Give a glycoprotein IIb/IIIa inhibitor before transfer as routine therapy

## BEST ANSWER B. Transfer for primary PCI

#### Why this is the best answer

This is an acute anterior STEMI presenting within 12 hours. NICE prefers coronary angiography with follow-on primary PCI when it can be delivered within 120 minutes of when fibrinolysis could have been given. A 100-minute interval meets that criterion. Reperfusion should not wait for troponin confirmation.

#### Why the alternatives are less appropriate

A — Fibrinolysis is the alternative when timely primary PCI cannot be delivered; the stated PCI interval is within the NICE threshold.

C — The ECG and presentation establish the emergency reperfusion pathway; waiting risks avoidable myocardial loss.

D — Stable-chest-pain imaging has no role as the initial strategy in an acute STEMI.

E — NICE advises against routine GP IIb/IIIa treatment before arrival at the catheter laboratory when primary PCI is planned.

LEARNING OBJECTIVE Apply the UK time threshold for choosing primary PCI rather than fibrinolysis in STEMI.
Specialty label Cardiology | Subtopic Acute coronary syndromes — STEMI | Difficulty Moderate
Supporting reference NICE NG185, recommendations 1.1.1–1.1.6 and 1.1.19 (2020). [2]

# QUESTION 02 • ACUTE CORONARY SYNDROMES — NSTEMI • MODERATE

### Antithrombin treatment in NSTEMI

A 73-year-old woman has rest pain, dynamic lateral ST depression and a rise in high-sensitivity troponin. She is haemodynamically stable, has no active bleeding and has creatinine 92 micromol/L. Immediate coronary angiography is not planned. Her predicted 6-month mortality is 4.2%. Which is the single best next antithrombin and invasive strategy?

A. Fondaparinux and consideration of coronary angiography within 72 hours

B. No antithrombin and outpatient exercise ECG

C. Routine fibrinolysis followed by discharge if pain settles

D. Unfractionated heparin only because all NSTEMI requires immediate angiography

E. Warfarin loading and angiography after the INR is therapeutic

## BEST ANSWER A. Fondaparinux and consideration of coronary angiography within 72 hours

#### Why this is the best answer

NICE recommends fondaparinux for unstable angina/NSTEMI when bleeding risk is not high and immediate angiography is not being performed. A predicted 6-month mortality above 3.0% is an intermediate-or-higher-risk result, so angiography within 72 hours should be considered if there is no contraindication.

#### Why the alternatives are less appropriate

B — This is confirmed NSTEMI with dynamic ischaemia and raised risk, not a low-risk outpatient presentation.

C — Fibrinolysis is not routine treatment for NSTEMI and exposes the patient to bleeding harm.

D — Immediate angiography is required for clinical instability; this stable patient fits the early-within-72-hours pathway. Unfractionated heparin is used in the catheter laboratory and may replace fondaparinux in specified contexts.

E — Warfarin is not the acute antithrombin strategy for this presentation.

LEARNING OBJECTIVE Use bleeding risk, renal context, angiography timing and GRACE-type mortality risk to manage NSTEMI.

Specialty label Cardiology | Subtopic Acute coronary syndromes — NSTEMI | Difficulty Moderate

Supporting reference NICE NG185, recommendations 1.2.1–1.2.16 (2020). [2]

# QUESTION 03 • HEART FAILURE — DISEASE-MODIFYING TREATMENT • MODERATE

### Core therapy for newly diagnosed HFrEF

A 64-year-old man has symptomatic heart failure with an LVEF of 32%. He is euvolaemic and clinically stable. Potassium is 4.3 mmol/L and eGFR is 72 mL/min/1.73 $m^2$. There is no bradycardia, heart block, hypotension or prior angioedema. Which combination best reflects current NICE core treatment?

A. Loop diuretic, digoxin, aspirin and verapamil

B. ACE inhibitor, beta-blocker, MRA and SGLT2 inhibitor

C. ARNI alone, with other drugs added only if symptoms persist

D. ACE inhibitor and ARB together plus a thiazide

E. Beta-blocker and nitrate only

## BEST ANSWER B. ACE inhibitor, beta-blocker, MRA and SGLT2 inhibitor

#### Why this is the best answer

The September 2025 NICE update recommends offering an ACE inhibitor, an evidence-based beta-blocker, an MRA and an SGLT2 inhibitor to people with HFrEF. The order and pace of introduction are individualised, with renal function, electrolytes, blood pressure, heart rate and symptoms monitored.

#### Why the alternatives are less appropriate

A — Loop diuretics relieve congestion but are not a substitute for the four core disease-modifying classes; verapamil is avoided in HFrEF.

C — In the NICE pathway, ARNI is considered for persistent symptoms after maximum tolerated core therapy, or used as an alternative when ACE inhibitor is not tolerated for reasons other than angioedema; it is not monotherapy.

D — ACE inhibitor and ARB dual blockade is not the recommended combination and increases renal/hyperkalaemia risk.

E — This omits several proven core classes and nitrate alone is not the default renin–angiotensin substitute.

LEARNING OBJECTIVE Recall the four core drug classes in the 2025 NICE HFrEF pathway.

Specialty label Cardiology | Subtopic Heart failure — disease-modifying treatment | Difficulty Moderate

Supporting reference NICE NG106, recommendations 1.4.1–1.4.4 and 1.7.1–1.7.13 (updated 2025). [5]

# QUESTION 04 • HEART FAILURE — DIAGNOSIS • EASY

### Interpreting NT-proBNP

A 79-year-old woman has progressive exertional breathlessness, orthopnoea and basal crackles. She is not taking a diuretic or renin–angiotensin system drug. Her NT-proBNP is 2,450 ng/L. What is the most appropriate next step in the NICE chronic heart-failure pathway?

A. Reassure her because the level does not distinguish the ejection-fraction phenotype

B. Repeat NT-proBNP in six months before arranging imaging

C. Urgent specialist assessment and transthoracic echocardiography within two weeks

D. Routine echocardiography within six months

E. Diagnose HFrEF and start digoxin without cardiac imaging

## BEST ANSWER C. Urgent specialist assessment and transthoracic echocardiography within two weeks

#### Why this is the best answer

An NT-proBNP above 2,000 ng/L carries a poor prognosis in suspected chronic heart failure. NICE recommends urgent specialist assessment and transthoracic echocardiography within two weeks. The peptide does not define HFrEF versus HFmrEF versus HFpEF; imaging and clinical assessment do.

#### Why the alternatives are less appropriate

A — Failure to distinguish phenotype does not make a very high result reassuring.

B — Repeating the test would delay the urgent referral and imaging recommended at this level.

D — The guideline specifies a two-week pathway, not routine six-month imaging.

E — A natriuretic peptide alone does not establish the phenotype or justify unreviewed digoxin treatment.

LEARNING OBJECTIVE Apply NICE NT-proBNP thresholds to specialist and echocardiography referral timing.
Specialty label Cardiology | Subtopic Heart failure — diagnosis | Difficulty Easy
Supporting reference NICE NG106, recommendations 1.2.2–1.2.8 (updated 2025). [5]

# QUESTION 05 • ATRIAL FIBRILLATION — ANTICOAGULATION • MODERATE

### Stroke prevention in atrial fibrillation

A 69-year-old man with hypertension and type 2 diabetes has newly diagnosed persistent atrial fibrillation. He has no mechanical valve, mitral stenosis, major bleeding or severe renal impairment. What is the single best stroke-prevention strategy?

A. Aspirin monotherapy

B. No therapy because he is younger than 75

C. Offer a direct-acting oral anticoagulant after bleeding-risk assessment and shared decision-making

D. Dual antiplatelet therapy

E. Delay all treatment until cardioversion has been attempted

## BEST ANSWER C. Offer a direct-acting oral anticoagulant after bleeding-risk assessment and shared decision-making

#### Why this is the best answer

Hypertension and diabetes give a $CHA_2DS_2$-VASc score of 2. NICE recommends offering anticoagulation with a DOAC at a score of 2 or above, taking bleeding risk into account. ORBIT supports discussion and modification of risk; it should not usually be used simply to deny indicated therapy.

#### Why the alternatives are less appropriate

A — NICE advises against aspirin monotherapy solely for stroke prevention in AF.

B — The decision is risk-score based; this patient already meets the offer threshold.

D — Dual antiplatelet therapy is not an equivalent substitute for anticoagulation in AF stroke prevention.

E — Stroke prevention is not made unnecessary by a possible rhythm-control strategy, and anticoagulation should not be delayed on that assumption.

LEARNING OBJECTIVE Calculate a simple $CHA_2DS_2$-VASc score and select NICE-preferred anticoagulation.
Specialty label Cardiology | Subtopic Atrial fibrillation — anticoagulation | Difficulty Moderate
Supporting reference NICE NG196, recommendations 1.2.1–1.2.2 and 1.6.1–1.6.8 (2021). [7]

# QUESTION 06 • ATRIAL FIBRILLATION — RATE CONTROL • MODERATE

### Rate control when AF coexists with HFrEF

A 72-year-old woman has persistent atrial fibrillation, a resting ventricular rate of 118 beats/min and an LVEF of 30%. She is not acutely decompensated and has no asthma, bradycardia or conduction block. Which is the most appropriate initial rate-control drug class?

A. A standard beta-blocker suitable for HFrEF

B. Verapamil

C. Diltiazem

D. Flecainide

E. Long-term amiodarone solely for rate control

## BEST ANSWER A. A standard beta-blocker suitable for HFrEF

#### Why this is the best answer

A beta-blocker is an appropriate initial rate-control option when selected and titrated in the context of stable HFrEF. NICE directs clinicians with concomitant heart failure to the heart-failure recommendations and advises avoiding rate-limiting calcium-channel blockers in HFrEF.

#### Why the alternatives are less appropriate

B — Verapamil is negatively inotropic and is avoided in HFrEF.

C — Diltiazem is also negatively inotropic and is avoided in HFrEF.

D — Flecainide is a rhythm-control drug and should not be used in known structural/ischaemic heart disease.

E — NICE advises not to use amiodarone for long-term rate control, and it has substantial toxicity.

LEARNING OBJECTIVE Choose rate control for AF while respecting HFrEF contraindications.

Specialty label Cardiology | Subtopic Atrial fibrillation — rate control | Difficulty Moderate

Supporting reference NICE NG196, recommendations 1.7.2–1.7.6; NICE NG106 recommendation 1.4.12 (2021/2025). [5,7]

# QUESTION 07 • ARRHYTHMIA EMERGENCY • EASY

### Unstable broad-complex tachycardia

A 58-year-old man has a regular broad-complex tachycardia at 190 beats/min. He is pale, has chest pain and a blood pressure of 72/40 mmHg, but a central pulse is present. What is the single best immediate treatment?

A. Oral beta-blocker and observation

B. Vagal manoeuvres only

C. Synchronised electrical cardioversion

D. Unsynchronised shock as the first action despite a pulse

E. Wait for serum potassium before treating

## BEST ANSWER C. Synchronised electrical cardioversion

#### Why this is the best answer

The patient has life-threatening adverse features — shock and myocardial ischaemia — with a tachyarrhythmia and a pulse. RCUK recommends synchronised cardioversion for unstable tachyarrhythmia. Sedation or anaesthesia is used when feasible without delaying lifesaving treatment.

#### Why the alternatives are less appropriate

A — Oral treatment is too slow and unsafe in shock.

B — Vagal manoeuvres do not address an unstable broad-complex rhythm.

D — Unsynchronised shocks are used for pulseless VT/VF or when synchronisation cannot be achieved in a deteriorating situation; synchronisation reduces the risk of inducing VF when a pulse is present.

E — Correct electrolytes, but do not postpone urgent cardioversion in an unstable patient.

LEARNING OBJECTIVE Prioritise haemodynamic stability over detailed rhythm diagnosis in tachyarrhythmia.

Specialty label Cardiology | Subtopic Arrhythmia emergency | Difficulty Easy

Supporting reference Resuscitation Council UK, Adult Advanced Life Support Guidelines 2025 (tachyarrhythmia algorithm updated March 2026). [9]

# QUESTION 08 • BRADYCARDIA AND PACING • HARD

### High-grade AV block with adverse features

A 70-year-old man three days after a large anterior myocardial infarction becomes syncopal. ECG shows complete AV dissociation with a broad-QRS escape rhythm at 28 beats/min. Blood pressure is 78/46 mmHg. Transcutaneous pacing equipment is immediately available. Which is the single best next step?

A. Give verapamil

B. Attempt carotid sinus massage

C. Begin transcutaneous pacing while obtaining urgent expert help

D. Observe because escape rhythms protect against asystole

E. Give a long-acting oral beta-blocker

## BEST ANSWER C. Begin transcutaneous pacing while obtaining urgent expert help

#### Why this is the best answer

This is unstable complete heart block with a broad escape rhythm following anterior MI, suggesting infranodal disease and a high risk of asystole. RCUK cautions that atropine should not be relied upon in high-grade AV block with a broad QRS and recommends considering pacing. Immediate transcutaneous pacing is appropriate while arranging definitive expert management.

#### Why the alternatives are less appropriate

A — Verapamil further slows AV nodal conduction and may worsen hypotension.

B — Carotid sinus massage is not treatment for complete heart block and may worsen bradycardia.

D — A very slow broad escape with syncope and shock is not safely observed.

E — Beta-blockade can worsen bradycardia and shock.

LEARNING OBJECTIVE Recognise a pacing indication in unstable high-grade AV block.

Specialty label Cardiology | Subtopic Bradycardia and pacing | Difficulty Hard

Supporting reference Resuscitation Council UK, Adult Advanced Life Support Guidelines 2025. [9]

# QUESTION 09 • HYPERTENSION — DIAGNOSIS • EASY

### Confirming hypertension

A 52-year-old man has no acute symptoms. Clinic blood pressures are 154/96 mmHg and 150/94 mmHg during the same consultation. There are no signs of target-organ damage. What is the most appropriate next step to confirm or refute hypertension?

A. Diagnose hypertension from this consultation alone

B. Offer ambulatory blood-pressure monitoring

C. Arrange same-day hospital admission

D. Use exercise blood pressure testing

E. Start four antihypertensive drugs immediately

## BEST ANSWER B. Offer ambulatory blood-pressure monitoring

#### Why this is the best answer

For clinic BP from 140/90 up to 180/120 mmHg, NICE recommends ABPM to confirm the diagnosis. HBPM is used when ABPM is unsuitable or not tolerated. Hypertension is confirmed when clinic BP is at least 140/90 and average daytime ABPM or HBPM is at least 135/85 mmHg.

#### Why the alternatives are less appropriate

A — Repeated clinic values trigger out-of-office confirmation in this range; white-coat hypertension is possible.

C — There is no severe BP or emergency feature requiring same-day admission.

D — Exercise testing is not the recommended diagnostic confirmation method.

E — Treatment selection follows confirmed diagnosis, stage, risk and comorbidity; immediate four-drug therapy is inappropriate here.

LEARNING OBJECTIVE Use the current NICE clinic and out-of-office thresholds for diagnosing hypertension.
Specialty label Cardiology | Subtopic Hypertension — diagnosis | Difficulty Easy
Supporting reference NICE NG136, recommendations 1.2.1–1.2.8 (updated February 2026). [10]

## QUESTION 10 • HYPERTENSION — EMERGENCY • EASY

### Severe hypertension with papilloedema

A 46-year-old woman has a clinic blood pressure of 218/126 mmHg, severe headache, confusion and bilateral papilloedema. What is the single best next action?

A. Arrange routine ABPM before any further assessment

B. Advise salt restriction and review in three months

C. Same-day specialist assessment

D. Give a large oral antihypertensive dose and discharge when the number falls

E. Ignore the diastolic reading because systolic pressure predicts risk better

### BEST ANSWER C. Same-day specialist assessment

#### Why this is the best answer

Blood pressure at or above 180/120 mmHg with papilloedema, retinal haemorrhage or life-threatening symptoms such as confusion requires same-day specialist assessment. This is accelerated/malignant hypertension with acute target-organ concern, not uncomplicated severe hypertension.

#### Why the alternatives are less appropriate

A — ABPM should not delay emergency assessment when acute target-organ injury is suspected.

B — Lifestyle advice is important later but is not adequate for this emergency.

D — Unsupervised rapid reduction can compromise organ perfusion; treatment belongs in a monitored specialist setting.

E — Both the absolute severity and target-organ features matter.

LEARNING OBJECTIVE Identify severe hypertension that requires same-day referral.

Specialty label Cardiology | Subtopic Hypertension — emergency | Difficulty Easy

Supporting reference NICE NG136, recommendations 1.5.1–1.5.3 (updated February 2026). [10]

# QUESTION 11 • SECONDARY PREVENTION — LIPIDS • EASY

### Lipid treatment after myocardial infarction

A 60-year-old woman has recovered from an NSTEMI. Her LDL cholesterol is 3.4 mmol/L. She has no relevant drug interaction, previous statin intolerance or preference for a lower dose. Which lipid-lowering treatment should be offered initially for secondary prevention?

A. Atorvastatin 80 mg

B. Atorvastatin 20 mg only because higher doses are never used in women

C. Ezetimibe alone without a statin

D. No drug until three months of lifestyle change have failed

E. Aspirin as the only lipid-lowering treatment

## BEST ANSWER A. Atorvastatin 80 mg

#### Why this is the best answer

NICE recommends atorvastatin 80 mg for people with established cardiovascular disease whatever the cholesterol level, unless interaction, high adverse-effect risk or patient preference favours a lower dose. Secondary-prevention treatment should not be delayed while waiting for lifestyle change.

#### Why the alternatives are less appropriate

B — Sex alone is not a reason for a lower dose; atorvastatin 20 mg is the standard primary-prevention starting dose and the CKD starting dose in the specified pathway.

C — Ezetimibe alone is used when statins are contraindicated or not tolerated after documented discussion; it is not the default here.

D — Lifestyle measures accompany, rather than delay, secondary-prevention statin treatment.

E — Aspirin does not lower lipids and does not replace statin therapy.

LEARNING OBJECTIVE Choose the NICE initial statin intensity for secondary prevention.

Specialty label Cardiology | Subtopic Secondary prevention — lipids | Difficulty Easy

Supporting reference NICE NG238, recommendations 1.7.1–1.7.5 (2023; current at evidence cut-off). [11]

# QUESTION 12 • VALVE DISEASE • MODERATE

### Symptomatic aortic stenosis

A 77-year-old man reports two episodes of syncope while walking uphill. Examination shows a slow-rising carotid pulse, a narrow pulse pressure and an ejection systolic murmur radiating to both carotids. What is the most appropriate next step?

A. Reassure him that syncope is expected with ageing

B. Urgent specialist valve assessment with transthoracic echocardiography

C. Start a nitrate and arrange review in one year

D. Diagnose hypertrophic cardiomyopathy without imaging

E. Perform carotid massage to reproduce the symptoms

## BEST ANSWER B. Urgent specialist valve assessment with transthoracic echocardiography

#### Why this is the best answer

The examination and exertional syncope strongly suggest symptomatic severe aortic stenosis, which has a poor prognosis without valve intervention. He needs urgent echocardiographic and specialist assessment rather than symptom suppression alone.

#### Why the alternatives are less appropriate

A — Exertional syncope with this murmur is a cardiovascular red flag, not normal ageing.

C — Nitrates can worsen hypotension in fixed outflow obstruction and would not address the valve lesion.

D — HCM can cause exertional syncope but the pulse and carotid radiation favour aortic stenosis; imaging is required.

E — Carotid massage is not appropriate in suspected critical outflow obstruction and does not answer the structural question.

LEARNING OBJECTIVE Recognise symptomatic aortic stenosis and its need for urgent structural assessment.

Specialty label Cardiology | Subtopic Valve disease | Difficulty Moderate

Supporting reference NICE NG208 (2021) and ESC/EACTS Valvular Heart Disease Guideline 2025. [12,13]

## QUESTION 13 • INFECTIVE ENDOCARDITIS • HARD

### Prosthetic-valve endocarditis with conduction change

A 66-year-old man with a prosthetic aortic valve has fever, malaise and a new first-degree AV block. He is currently haemodynamically stable and has not received antibiotics. Which is the best initial diagnostic and management bundle?

A. Obtain multiple blood-culture sets before antibiotics, arrange urgent echocardiography including TOE as indicated, and involve the endocarditis team

B. Give one oral antibiotic dose and take a single blood culture a week later

C. Arrange routine outpatient TTE in six months

D. Assume viral infection because there is no murmur

E. Give antibiotic prophylaxis for all future dental work and take no action now

**BEST ANSWER A. Obtain multiple blood-culture sets before antibiotics, arrange urgent echocardiography including TOE as indicated, and involve the endocarditis team**

#### Why this is the best answer

Prosthetic material, fever and new conduction delay raise concern for infective endocarditis with peri-annular extension. In a stable patient, obtain multiple cultures before antibiotics, arrange urgent imaging with a low threshold for TOE and involve a specialist endocarditis team. If sepsis or shock develops, cultures should be obtained promptly but treatment must not be delayed.

#### Why the alternatives are less appropriate

B — Empirical oral treatment before adequate cultures can sterilise blood and delay diagnosis; one delayed culture is inadequate.

C — The presentation is urgent and prosthetic-valve endocarditis may be rapidly destructive.

D — A murmur may be absent; the prosthesis and new conduction change increase concern.

E — Prophylaxis policy is a separate question and does not treat suspected active infection; NICE does not recommend routine prophylaxis solely for dental procedures.

LEARNING OBJECTIVE Recognise prosthetic-valve endocarditis and peri-annular extension, and preserve microbiological diagnosis.

Specialty label Cardiology | Subtopic Infective endocarditis | Difficulty Hard

Supporting reference ESC Endocarditis Guideline 2023 and NICE CG64 (updated 2016; surveillance reviewed 2024). [16,17]

# QUESTION 14 • CARDIOMYOPATHY • MODERATE

### Dynamic murmur in hypertrophic cardiomyopathy

A 28-year-old woman is assessed after exertional presyncope. Her father died suddenly aged 40. She has an ejection systolic murmur at the left sternal edge. Which manoeuvre is most likely to make the murmur louder if dynamic left-ventricular outflow obstruction is present?

A. Squatting from standing

B. Passive leg raise

C. Valsalva strain

D. Sustained handgrip

E. Rapid intravenous fluid loading

## BEST ANSWER C. Valsalva strain

#### Why this is the best answer

Valsalva strain reduces venous return and LV cavity size, increasing dynamic outflow obstruction and making the HCM murmur louder. Standing has a similar direction of effect. The family history and exertional symptoms mandate specialist inherited-cardiac assessment.

#### Why the alternatives are less appropriate

A — Squatting increases venous return and afterload, usually reducing dynamic obstruction.

B — Passive leg raise increases preload and usually softens the murmur.

D — Handgrip raises afterload and tends to reduce HCM outflow murmur while increasing regurgitant murmurs.

E — Volume loading increases preload and usually reduces dynamic obstruction.

LEARNING OBJECTIVE Use loading manoeuvres to identify dynamic LV outflow obstruction and recognise inherited-disease red flags.

Specialty label Cardiology | Subtopic Cardiomyopathy | Difficulty Moderate

Supporting reference ESC Guidelines for the Management of Cardiomyopathies 2023. [14]

# QUESTION 15 • CARDIOVASCULAR PHARMACOLOGY — DRUG SAFETY • MODERATE

### Monitoring long-term amiodarone

A 71-year-old man takes long-term amiodarone under specialist supervision. He is clinically stable and asks what safety monitoring is important. Which statement best reflects current MHRA advice?

A. No monitoring is needed after the first month

B. Routine CT of the chest every six months is required in every asymptomatic patient

C. Check liver and thyroid function before treatment and every six months; investigate new respiratory symptoms promptly

D. Only serum amiodarone concentrations need to be monitored

E. Thyroid monitoring can stop immediately on the day amiodarone is discontinued

**BEST ANSWER C. Check liver and thyroid function before treatment and every six months; investigate new respiratory symptoms promptly**

#### Why this is the best answer

MHRA advises checking liver and thyroid function before treatment and at six-monthly intervals. Thyroid monitoring continues for several months after discontinuation. Routine lung imaging is not required for every asymptomatic patient, but new or worsening respiratory symptoms require prompt review and CT may help confirm suspected pulmonary toxicity.

#### Why the alternatives are less appropriate

A — Serious adverse reactions can be delayed and long-term treatment needs regular review.

B — Routine imaging exposes patients to unnecessary radiation; symptom-triggered evaluation is emphasised.

D — Clinical and organ-specific monitoring, not routine serum drug concentrations alone, is central.

E — Amiodarone has a long half-life and thyroid effects may occur after stopping, so monitoring continues for months.

LEARNING OBJECTIVE Recall the major organ toxicities and monitoring principles for amiodarone.

Specialty label Cardiology | Subtopic Cardiovascular pharmacology — drug safety | Difficulty Moderate

Supporting reference MHRA Drug Safety Update: Amiodarone, published 2022 and updated May 2026. [19]

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Source: AMT MRCP(UK) Part 1 Cardiology Phase 2 Prototype, question section. Question wording and explanations retained. Clinical and pharmacy review status remains unverified.