

Clinical Examination Cases 2002/2

CASE 1

TOM is a regular patient of yours. You see him infrequently for minor complaints. Given a front sheet showing a 50 year old man, no regular medications nil else of note.

Instructions are to take a history from him, perform an appropriate examination telling the observing examiner relevant negative as well as positive findings while you are examining him; tell the patient your diagnosis and discuss your management plan with him.

Tom gives you a history consistent with plantar fasciitis of the left foot. examination shows a tender point in the middle of the heel.

CASE 2

You have 8 minutes. When you enter the room you will be asked to perform an examination of a body system. Tell the observing examiner relevant positive and negative features of the examination as you go along. When you have finished tell the observing examiner your findings. You do not have to discuss management in this case.

CASE 3

Jason is coming to see you for his results. Your registrar ordered them and then went on holidays. They show a low TSH. Discuss these results with the patient and then perform a relevant examination, telling the observing examiner positive and negative features as you go. Discuss any further investigations you would like to do with the patient. You do not have to manage this patient.

CASE 4

Paul is complaining of ringing in his ears. Take a focussed history from him and then examine him, telling the observing examiner your findings as you go along. Explain your findings to the patient (you do not have to manage this man)

History reveals probable hearing loss with tinnitus in the left ear worse than the right. History of working in an industrial area for years. Otoscope was provided (attached to the wall) but you had to specifically ask for a tuning fork before it was given to you.

Rinne and Weber showed sensorineural hearing loss.

CASE 5

Rebecca is 17 years old and you have seen her infrequently for minor illnesses since she was a child. Take a history from her and discuss the issues as they arise. examination is not required in this case. Front sheet shows no relevant information.

Rebecca gives a history of a condom break the night before with her boyfriend. Sexually active for 6 months. One partner only, same age. Requesting the morning after pill. I talked to her about postinor and then discussed contraception with her. I was just starting to talk about PAPS and STDs etc when the bell rang!

CASE 6

Maria is just 10 weeks old. She was growing well when you saw her 2 weeks ago for her 2 month needles. She comes in today with her mother/father. Take a history, request elements of the examination from the observing examiner and discuss your management with the parent.

History is consistent with early bronchiolitis. Slightly poor feeding but OK wet nappies, activity etc. Bub is breastfed but Dad smokes.

CASE 7

Ted 73 yrs old and is a long standing patient of your practice. You saw him yesterday as he had some unusual symptoms of tiredness. You have ordered some blood tests the results of which will be available once you are inside the room. Discuss the results with him and tell him your management plan.

BGHx
Hypertension
mild CCF
Shingles July 2002

Married with adult children. Immunisations up to date

Medication
Tritace 5mg daily
that notorious diuretic that causes hyponatraemia (can't remember the name)
Tegretol
half an aspirin
2 other medications I can't remember.

Once inside the room Ted asks you what the results of his blood test show, you then have to ask the examiner for them. They say "which ones would you like to know?" and then

hand them to you. FBC is normal, UEC shows a Na of 125 and slightly low chloride, LFT is normal, TSH is normal, Glucose is normal.

Ted asks you why this has happened. Gives history of tiredness rapidly getting worse over 1-2 weeks. Has been on the diuretic for 5 years, just started the Tegretol 3 weeks ago for post herpetic neuralgia. Hasn't been particularly thirsty or weeing excessively. BP recently was 120/80. I said that "I'll have to look Tegretol up on my computer to see if that can interact with any of your other tablets" and the observing examiner stepped in and said that "your MIMS tells you that Tegretol can cause an idiosyncratic reaction causing inappropriate excretion of ADH"

My management involved stopping both the Tegretol and the diuretic, fluid restricting him and telling him to eat salt! Getting him back in 3 days to recheck his UEC and symptoms and mentioned monitoring his BP since we stopped a BP medication.

CASE 8

Maria is 54 year old asian lady who has come to see you about her stress incontinence. She has fairly typical stress incontinence that is inhibiting her life. She has a history of 3 NVDs. She is menopausal and overweight. You have already examined her and found a moderate sized cystocoele with an obvious leak of urine on coughing and her vagina was somewhat atrophic. PAP smear is normal.

You have 8 minutes to discuss management options with Maria. No further examination is required with this case.

Maria is reserved, embarrassed and depressed about her incontinence. She is concerned about the smell and says as you walk in "well I guess there's not much you can do about my incontinence is there doc?" She doesn't leave the house much and doesn't exercise because she leaks when she walks. She has not seen anyone about it before. She has no systemic menopausal symptoms and is afraid of HRT anyway. I discussed wt loss, topical oestrogen, pelvic floor exercises (+/- physio assistance), incontinence nurses and pads, using deodorants to hide the smell, pessaries and surgical referral if all else failed

CASE 9

53 yr old middle eastern man who you see regularly for minor complaints. Usually well with no major illnesses. He has not had any kind of emotional disturbance before.

Take a history from him and discuss the issues as they arise. Physical examination is not required in this case.

"I need something to help me sleep doc!". Gives history of acute difficulty sleeping on a BG of his elderly father moving in 1 month ago. He is dying of prostate cancer and his son is the only one who can look after him. (he is an only son with no children of his

own). His dad has poorly controlled pain and hasn't been to his GP for a while due to transport difficulties. Unaware of palliative care services and respite care services. He is trying to continue working full time as well as caring for his dad.

Mostly a chat about the issues and deciding whether to prescribe benzos.

CASE 10

Trisha is a 28 yr old woman who has seen you on and off for non specific abdominal pain in the past. She went to the hospital with an episode of severe abdominal pain, was seen and discharged for GP follow up. You are given the discharge summary which reads episode of abdominal pain relived by buscopan and panadeine forte, she seen by the surgical registrar who felt that she had ? irritable bowel syndrome. All her blood tests were normal and abdominal xray was normal. Discharged for your follow up to use buscopan and panadeine forte for the pain.

Trisha is waiting to see you to discuss this further. Examination is not required in this case. Discuss management and any further investigation you wish to perform with Trisha.

Hx was of non-specific left sided abdo pain. Unrelated to cycle. Maybe a bit better after opening bowels, maybe worse after eating. Assoc with bloating. Diet really CRAP. Blah blah.....

CASE 11

VIVA

You GP registrar is coming to see you to discuss an incident that happened yesterday. She was unable to find a correct sized speculum when performing a PAP smear yesterday and came out and got one from the treatment room to use. The practice nurse then realised that it had not been sterilised. It had been scrubbed and soaked as per procedure, but not autoclaved. Your nurse told another non-medical member of staff prior to alerting the registrar and yourself about the matter.

You will be asked questions in relation to this episode.

Do you tell the patient what has happened? What are the pros and cons of doing so? What infections is the patient at risk from? Who do you discuss this with? How do you inform your medical defence organization? Where should the episode be documented and by whom? (medical record by the registrar) Issues about procedures in the practice to make sure it does not happen again and also about staff confidentiality. Plus support for the registrar.

YUCK!!!

CASE 12

VIVA

You have a patient who has been seeing you for several different minor complaints. You suspect alcohol abuse. You will be asked several questions about this.

What would make you suspect somebody had a problem with their alcohol consumption?

How would you raise this issue with them?

Do you know of any ways to help people abstain from alcohol?

CASE 13

LONG CASE

52 yr old pt who is a new patient to your practice. A copy of his file has been forwarded from his old Dr. (It says he has hypertension and is treated with metoprolol). Take a history from him and, when you are ready request elements of a physical examination from the observing examiner. You may request surgery tests and the results of any investigations. Discuss your impressions with the patient.

Bill has an annoying cough that wont go away. His last doctor told him that it might be the blood pressure tablet he was on, but he changed that and it didn't go away. No SOB, Wheeze, PND, Phlegm etc. Just a dry aggravating cough especially after he laughs a lot. Nothing else spectacular on history, wife and kids OK, retired ex-labourer, slightly overweight, ex-smoker pkt/day for about 25 years

Examination. Slightly reddened nasal mucosa but ENT otherwise normal, chest normal, HS normal.

Spirometry normal, respiratory function tests normal, CXR normal, blood test normal.

? no diagnosis just worried that he has Ca or emphysema

? PND/ Asthma triggered by metoprolol

? Who knows????

CASE 14

LONG CASE

Janet is a new Pt to your practice. Take a history from her and when you are ready request the elements of a physical examination from the observing examiner. Discuss your impressions with the patient and then you may order appropriate investigations. The results will be available from the observing examiner. Discuss your diagnosis and management plan with the patient.

Janet is 27 and is going to get married in 4 months time. Today she wants you to sort out 3 problems for her: her periods, her acne and her weight. Usually healthy on no regular medications. Family history of diabetes in her Mum. Gives classic history of PCOS with symptoms from puberty. Hirsutism, acne over face and chest, weight gain and very irregular periods.

Investigations showed elevated free androgen index, impaired glucose tolerance, high cholesterol, Normal FBC/UEC/LFT