



## GPRA ONLINE EXAM RESOURCES CLINICAL CASES

**CASE TYPE:**

Short Case – 8 minutes

**NAME:**

Daryl Digger

**AUTHOR:**

Dr Stuart Anderson

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## SECTION A: This information is given to the candidate

### INSTRUCTIONS TO CANDIDATES

#### STANDARD INSTRUCTIONS:

- This is an 8 minute station.
- Read the following scenario.
- No further history taking is to be taken.

#### ADDITIONAL INSTRUCTIONS

- When you are ready, request the details of an appropriate physical examination from the observing examiner.
- Tell the observing examiner your differential diagnosis.
- The examiner will ask you several questions about this case and related matters.
- This is not a role playing station and there will be no patient present.

## **SECTION A: This information is given to the candidate**

SCENARIO: Daryl is a 75 year old ex-serviceman. He presents to you with a lesion on his chin.

*A copy of the patient record summary sheet is attached.*

### **FULL SUMMARY**

#### **Patient Details**

**Name:** Daryl Digger

**D.O.B.:** 75

**Allergies:** NKA

#### **Social History**

Retired labourer

Ex-serviceman

Lives with wife, Dorothy

#### **Family History**

Nil Relevant

#### **Current Medications**

Perindopril 4mg one daily

Aspirin 100mg one daily

Spiriva 18mcg/dose one puff daily

Metformin 500mg one tds

**Immunisations**

Fluvax 2006

Pneumovax 2003

**Past Medical History**

Appendicectomy 1949

Hypertension 1992

Diabetes (Type 2) 1995

COPD 2001

**Drug and Alcohol**

2 stubbies full strength beer/night

Ex-smoker (30 pack-year exposure)

**SECTION B: This information is given to the patient role player/examiner**THE STORY IN DETAIL

Daryl's wife has been nagging him for months to get the spot on his chin looked at. Daryl has been ringing the practice for his scripts so he hasn't actually seen a doctor for about 6 months. The spot on his chin has been present for 'some time,' probably 8 months, and has been slowly growing over that time. It is not painful but occasionally he will nick it with his razor and it will bleed. He has not had any other lumps like this before. He has tried some cortisone cream that his wife had at home and puts methylated spirits on it at times but nothing has seemed to help. Daryl has done a lot of outdoor work in his time and used to be tanned all year. He has had a couple of blistering sunburns.

Additional HISTORY

As above

**SECTION B: This information is given to the patient role player/examiner****SYSTEMS REVIEW**

Not Relevant

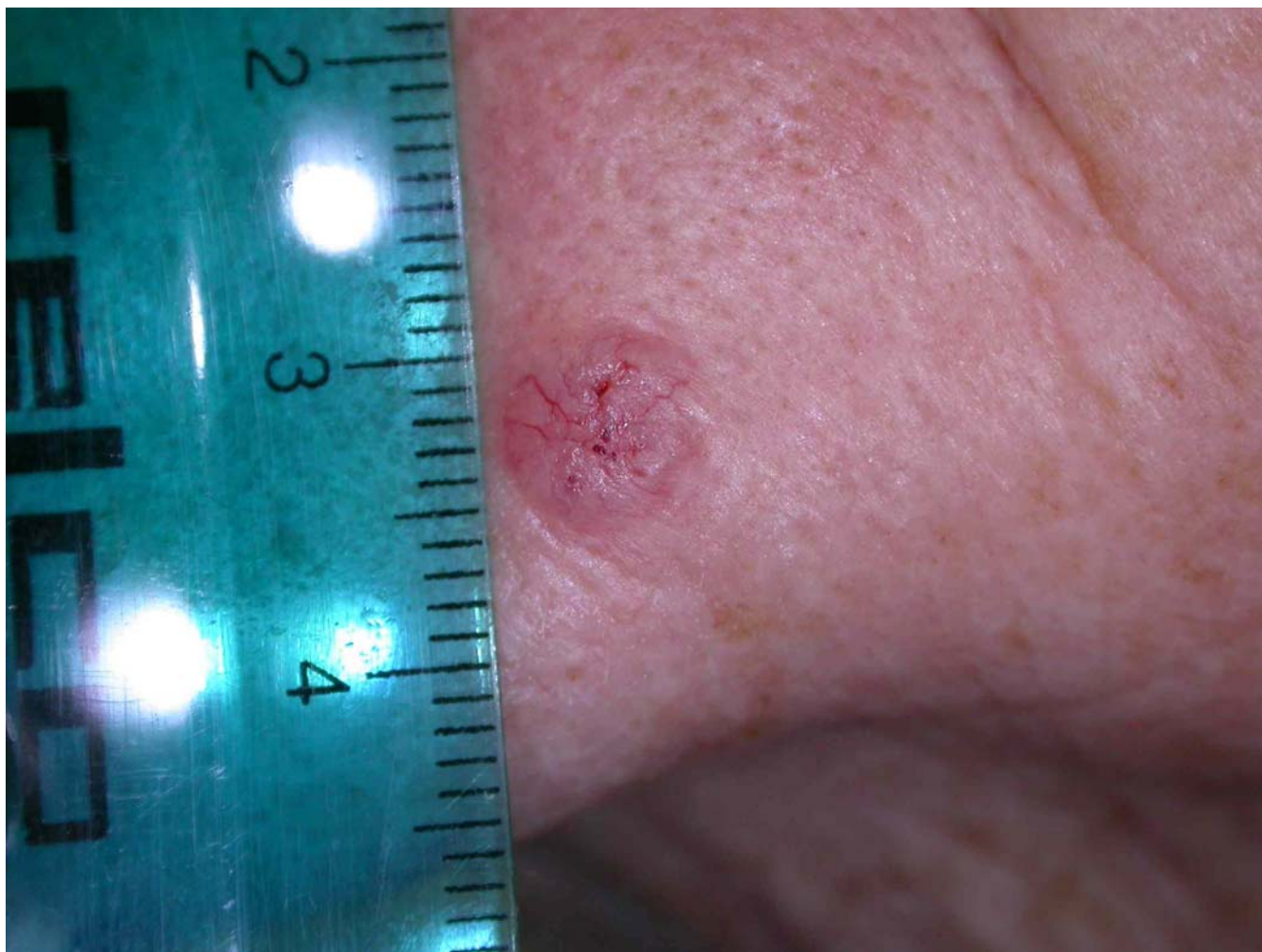
**PHYSICAL EXAMINATION**

1/Candidates are to ask for specific examination findings.

2/All other physical findings are normal.

3/Candidate is to be shown picture of the lesion when they ask to examine the lesion. The examiner should ask the candidate to describe the lesion.

<b>General Appearance</b>	Slightly overweight elderly man well dressed with regimental tie and blazer.		
<b>Weight 80kg</b>	<b>Height 170cm</b>	<b>BMI 27.7 kg/m<sup>2</sup></b>	<b>Temp 36.2°C</b>
<b>BP 145/95</b>	<b>Pulse 74</b>	<b>RespRate 12/min</b>	
<b>Skin</b>	<p>See picture below for lesion:</p> <p><b>Candidate is to describe lesion when asked:</b></p> <p>On the left jaw line there is a flesh-colored nodule with telangiectasia. The lesion is 5mm in diameter and is raised. The border is characteristically 'pearly', especially when the lesion is stretched and examined in light. It is on the verge of ulcerating centrally.</p> <p><b>Only if the candidate asks to examine the rest of the skin:</b></p> <p>Remainder of skin; sun damaged skin with multiple solar keratoses on dorsum of hands and forearms. Solar keratoses also on forehead.</p> <p>Several suspicious looking lesions on the back that may well also be BCCs. Large nodule behind the left ear that is almost certainly another BCC.</p>		
<b>Other</b>			



### **INVESTIGATIONS**

The examiner should go to section C. Candidates are to ask for specific investigations during discussion of the case which the examiner should provide as listed below

#### **Surgery Tests**

Random Blood Glucose 6.9

#### **Other Investigations**

Provide results to candidate as requested during discussion.

### **1. PUNCH BIOPSY**

BIOPSY No: 0001-01

CLINICAL HISTORY: Punch biopsy L jaw

MACROSCOPIC: Labelled biopsy left jaw. A skin punch biopsy 3mm in diam. And 3mm deep with a 1mm pigmented area centrally

MICROSCOPIC: The skin punch biopsy shows basal cell carcinoma. The lesion is composed of irregular nests of basaloid cells extending down in to the reticular dermis

DIAGNOSIS: Skin punch biopsy from left jaw – Basal cell carcinoma

## 2. EXCISION OF LESION

BIOPSY No: 0001-02

CLINICAL HISTORY: Lesion L jaw ?BCC

MACROSCOPIC: Labelled lesion L jaw. A skin ellipse 13x35mm bearing an encrusted pale grey lesion 5x5mm. There is a notch in one side of the ellipse indicating 12 o'clock. The 3 o'clock and 6 o'clock sides are painted green and the remainder painted silver.

MICROSCOPIC: Sections show an ulcerated basal cell carcinoma of solid and infiltrating type extending in to the mid-dermis. There is surrounding dermal fibrosis. Perineural tumour is not identified. The excision is complete in width and depth

DIAGNOSIS: Excision on lesion left jaw – Basal cell carcinoma completely excised

**SECTION C: This information is given to the examiner/facilitator**

Listed below are the key issues to be covered in this case. *(The facilitator/examiner can "tick" these as covered during the consult)*

**Questions for discussion with candidate****1. What is your diagnosis and differential diagnoses?**

**Diagnosis:** Basal cell carcinoma

**Differential Diagnoses:**

Squamous Cell Carcinoma	Squamous cell carcinomas arising from actinic keratoses are scaly, as are actinic keratoses, but tend to grow thicker, and the pink macular to papular area develops into an erythematous raised base. Sometimes the lesion develops an overlying keratin horn. The lesions may take the form of a patch, plaque, or nodule, sometimes with scaling or an ulcerated center. The borders often are irregular and bleed easily. Unlike basal cell carcinomas, the heaped-up edges of the lesions are fleshy rather than clear in appearance.
Keratoacanthoma	Rapid growth, spontaneous remission, central plug; excise to confirm as can't be differentiated from SCC clinically and indeed is becoming regarded as a type of SCC in situ
Seborrheic keratosis	Pigmented, "stuck-on" appearance, hereditary
Extramammary Paget's Disease	Red or white plaque; eroded, anogenital location is most common.
Lichen planus	Purple polygonal patches
Nummular eczema	History of chronic atopy; lesion responds to eczema treatment
Psoriasis	Silvery-white scale, characteristic locations, nail pitting

**2. How would you proceed to manage this lesion?**

Candidate may either nominate to perform a punch/shave biopsy of the lesion, in which case the candidate is provided with the punch biopsy result and asked how they would then proceed. If the

candidate elects to perform an excision initially, they are provided with the results of the excision. Planned excision margins should be 3-5mm.

**3. Are there any issues specific to this patient that may influence your management?**

The patient is on **aspirin**. This should not be stopped prior to excision of a small lesion that can be closed primarily. Remember the dictum "Bleeding is a nuisance, a stroke is a disaster!"

The patient is **diabetic**. This may predispose him to wound infections however the face is a relatively low-risk area. There is no indication for prophylactic antibiotics, however the patient should be warned to return if infection is suspected.

Although the patient presents requesting review of 1 lesion, a full skin check should be offered. The patient has several **other lesions** that will also need to be treated. A plan needs to be formulated so that each lesion is dealt with in turn. Lesions on the face/ears/lips are more likely to metastasise so should be dealt with prior to the lesions on the back.

The patient's general health will influence the management. In this case Daryl is healthy and lives at home, however if he was unfit for surgery or had a very short life expectancy then surgical excision may be inappropriate.

**4. What should be covered in the process of obtaining consent for an excision?**

- a. The nature of the procedure
- b. Alternatives to surgery (no treatment, Moh's microsurgery, radiotherapy)
- c. Natural history of the untreated lesion (unlikely metastasis, likely rodent ulcer)
- d. Relevant complications (scarring, dehiscence, infection, bleeding, incomplete excision, tumour recurrence)
- e. How patient will receive results

**5. Does the result shown indicate adequate treatment of the lesion?**

Yes. The lesion has been excised with a 4mm margin and is clear of the margins at both the lateral and deep margins.

**6. What follow up is needed?**

Review at 1 month, then at 6+/-12 months.

**7. What treatment options are available for treating basal cell carcinomas, and which types of BCC are suitable for these treatments? What complications are there with these treatments?**

<b>Radiotherapy</b>	BCCs other than multifocal superficial. Should be considered in old patients where surgical reconstruction is very difficult or may reduce function, or if medically unfit for surgery. Complications include scarring that worsens over time, tumour recurrence and contractures at the site.
<b>Cryotherapy</b>	Superficial multifocal BCCs, esp in young keloid prone people or people in whom surgery is contraindicated for medical reasons. MUST be biopsied first. Complications include hypopigmentation, blistering and tumour recurrence.
<b>Curette and Cryo/Diathermy</b>	Superficial BCCs. Not ideal for nose, eye or ear as surgery gives better cosmetic result. Complications – scarring, hypopigmentation, keloid.
<b>Topical 5% Imiquimod</b>	Large superficial BCCs. Complications are local pain and infection (Impetigo), hypopigmentation, scarring, higher rates of recurrence than surgery.
<b>Moh's Micrographic Surgery</b>	Specialised surgery using frozen sections and involving coordination between the surgeon and histopathologist. Used for extensive locally recurrent tumours or very large tumours. Complications (other than time and money!) are as for surgery. Can only be performed by surgeon with experience and access to histopathologist.

This checklist below is a guide to Key Features used by Examiners to assist in clinical case ratings. The lists are not intended to be prescriptive or exhaustive and do not form part of the marking.

**On completion of the case, the candidate/examiner/group may wish to score themselves as part of a feedback process.**

Place a cross (X) along each line according to the candidate's performance on that item.

## CLINICAL CASE RATINGS KEY FEATURES CHECKLIST

		Inadequately Covered	Covered Well
(*) key feature relevant to this case		<b>1</b>	<b>10</b>
1	• Communication and Rapport	-----	
2	* • Inter-professional Communication Skills	-----	
3	• History taking	-----	
4	* • Physical examination	-----	
5	• History and Physical Examination	-----	
6	• Physical Examination Technique	-----	
7	• Physical Examination Findings	-----	
8	* • Investigations	-----	
9	* • Diagnosis	-----	
10	* • Problem Definition	-----	
11	* • Medical Knowledge	-----	
12	• Public Health Issues	-----	
13	* • Management	-----	
14	• Procedural Skills	-----	
15	* • Ethical and Medico Legal Issues	-----	
16	• Critical Appraisal Skills	-----	
17	•	-----	
		Frequently	Not at all
18	* • Prompting Required	-----	

## Key Features Clinical Case Rating Descriptions

### 1. Inter-professional Communication Skills

Rate the candidate on how well they communicate with other health professionals.

Rate the candidate on their ability to perform an appropriate and systematic examination which is focussed and not overly inclusive. Specific findings relevant to the case should be elicited.

### 3. Investigations

Rate the candidate on their ability to select relevant, cost-effective investigations in an appropriate sequence, displaying consideration for the safety and comfort of the patient.

### 4. Diagnosis

Rate the candidate's ability to make an accurate diagnosis based on interpretation of the history, physical examination and investigations.

### 5. Problem Definition

Rate the candidate on their ability to identify, define and prioritise the physical, psychological and social issues involved for the patient, the family and the community.

### 6. Medical Knowledge

Rate the candidate's medical knowledge of the physical, psychological and social issues involved in this question.

### 7. Management

Rate the candidate on their ability to manage the issues raised in this case, both now and in the future. Candidates should offer effective explanations, education and choices to patients, and involve the patient, family and relevant community resources in their immediate and on going management plans. Candidates should demonstrate responsibility for the immediate and ongoing management of the patient.

### 8. Ethical and Medico Legal Issues

Rate the candidate's ability to deal with the ethical, medico legal and professional issues raised by this case.

### 9. Prompting

*To what extent was prompting/probing necessary to assist the candidate?*

*The 6 categories are: Almost continuously (cross on far left), very frequently, frequently, occasionally, minimally, not at all (cross on far right).*



## References and Study Notes

Stulberg DL, Crandell B, Fawcett RS. Diagnosis and treatment of basal cell and Squamous cell carcinomas. Am Fam Physician. 2004 Oct 15;70(8):1481-8.

NHMRC Clinical Practice Guidelines: Non-melanoma skin cancer: Guidelines for treatment and management in Australia. 2002. Found at <http://www.nhmrc.gov.au/publications/synopses/cp87syn.htm> (This information is now 4 years old and may not be entirely up to date)

