



GPRA ONLINE EXAM RESOURCES CLINICAL CASES

CASE TYPE:

Short Case – 8 minutes

NAME:

Bill Harrison

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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.
- If investigations are requested, this consultation may be conducted as if it were more than one session.

ADDITIONAL / OPTIONAL INSTRUCTIONS

- Take an appropriate history from the patient.
- When you are ready, request the details of an appropriate physical examination from the observing examiner.
- Outline your diagnostic impressions to the patient and advise on the need for further investigations if any.
- Tell the observing examiner your differential diagnosis.
- If you are considering diagnoses which you do not wish to discuss with the patient at this stage, you should inform the observing examiner of these diagnoses.
- Request the results of any investigations from the observing examiner.
- Outline your conclusions and proposed management plan to the patient.

SECTION A: This information is given to the candidate

SCENARIO :

Bill is a 45 year old man who saw you last week for a check up. As part of your assessment you arranged some LFTs. Bill is here to discuss the results. The LFTs are below

Bilirubin	12	(<20)
Total protein	40	(35-50)
Albumin	65	(60-80)
GGT	<u>100</u>	(<60)
ALT	<u>115</u>	(<45)

He also had fasting BSL, lipids, FBC, and UEC which were all normal

A copy of the patient record summary sheet is attached.

FULL SUMMARY

Patient Details

Name: Bill Harrison

D.O.B.: 2/3/1962 (45 yo)

Allergies: Nil

Social History Married with 3 kids. Plays golf

Occupation- Works in steel factory.

Family History Father has type II diabetes; mother has rheumatoid arthritis

Current Medications Nil

Immunisations Last tetanus 5 years ago

Past Medical History Lumbar disc prolapse; carpal tunnel release right hand; pneumonia

Drug and Alcohol- quit smoking 5 years ago. 20 Pack year history. Drinks 1-2 beers per night

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

THE STORY IN DETAIL

This background information is given to enable the role player to respond appropriately to candidate's history taking questions.

Information to be freely given: "So what do my test results say, doc?" You have been feeling well, and have no abdominal pain or discomfort

Information only to be given with appropriate enquiry from the candidate: You have noticed no jaundice. Bowel movements and urine are normal.

No weight loss, fevers

Has cut down alcohol in recent months- maybe 1-2 beers on 3-4 days per month, as your wife is on a health kick and has encouraged you to start looking after yourself more

Not using any medication incl herbal and over the counter

Has a tattoo, done in parlour 20 yrs ago

No body piercings

No blood transfusions

Had sex with prostitutes prior to marriage 20 yrs ago, no other partners since getting married

NOTES TO EXAMINERS

Suggested Cues/prompts if candidate requires assistance:

Additional HISTORY

If there is additional information for the role player that must be elicited by the candidate, note below in green text

Nutrition Recently started eating healthier food. Lots of fruit and veg. No fatty foods. No snacks/sweets. Drinks only water.

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

SYSTEMS REVIEW

Cardiovascular Normal

Dermatological Normal

Gastrointestinal As above

Genitourinary No urethral discharge or dysuria. No rash/sores

Other e.g.

Energy normal

Appetite normal

Weight Change no

Sleep Pattern good

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

PHYSICAL EXAMINATION

Candidates are to ask for specific examination findings.

General Appearance	Looks well		
Weight 100kg	Height 180cm	BMI 30.8	Temp °C 37.0
BP 125/80	Pulse 72	RespRate 18/min	
Cardiovascular	Normal		
Respiratory	Normal		
Abdomen/PR	Normal		
Skin	No stigmata of liver disease		
Thyroid	Normal		
Lymph Nodes	Nil		

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

INVESTIGATIONS

Candidates are to ask for specific investigations.

Surgery Tests

Urinalysis - NAD

Other Investigations

Pathology Hepatitis A/B/C neg; EBV/CMV neg; TFTs neg; ceruloplasmin, alpha 1 antitrypsin, ASMA, AMA all negative; iron studies normal

Imaging Liver US normal

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)*

Specific Questions Candidate should ask

- Explains test result
- Asks about symptoms of hepatic disease
- Asks about risk factors for hepatitis
- Asks about alcohol intake
- Asks about other possible causes- medications, drugs, family history, recent illness

Diagnosis

- Makes diagnosis of non alcoholic steatohepatitis (NASH or fatty liver)

Appropriate management and explanation:

- Explains the diagnosis
- Explains the cause (obesity)
- Discusses diet and exercise
- Reinforces safe alcohol consumption guidelines
- Arrange follow up with repeat LFTs in 3-6 months

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. *(Please place an asterisk next to the Clinical Case Rating Key Features that are most relevant to this case).*

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

(*) key feature relevant to this case

Inadequately Covered Well
1

Covered
10

1	• Communication and Rapport	
2	• Inter-professional	
3	• Communication Skills 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

Remove those not used

1. Communication and Rapport

Rate the candidate on their ability to establish rapport and to communicate effectively with the patient in a pleasant, clear and logical manner using appropriate communication skills and language.

2. Inter-professional Communication Skills

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

3. History taking

Rate the candidate on their ability to take a relevant and organised history; following appropriate cues and eliciting both positive and negative details important to the assessment and management of the patient.

4. Physical examination

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.

5. History and Physical Examination

Rate the candidate on their ability to take a relevant and organised history; following appropriate cues and eliciting details important to the assessment and management of the patient. Also rate the candidate on their ability to perform an appropriate and systematic examination which is focussed and not overly inclusive.

6. Physical Examination Technique

Rate the candidate's physical examination technique. Systematic and appropriate examination techniques should be employed and explained to the patient. Candidates should demonstrate respect for the patient and concern for the patient's safety, comfort and modesty. Candidates should wash their hands at the end of the examination.

7. Physical Examination Findings

Rate the candidate on their ability to detect physical examination findings accurately and to interpret them correctly.

8. 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.

9. Diagnosis

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

10. 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.

11. Medical Knowledge

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

12. Public Health Issues

Rate the candidate's awareness of, and ability to deal with, the public health and social issues raised by this case.

13. 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.

14. Procedural Skills

Rate the candidate's ability to perform the procedure appropriately and competently with regard for patient safety and comfort.

15. Ethical and Medico Legal Issues

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

16. Critical Appraisal Skills

Rate the candidate on their ability to critically appraise an article and to identify its strength and weaknesses. This may include analysis of statistical data

17. Other

18. 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:

List any useful references relevant to this case