



GPRA ONLINE EXAM RESOURCES CLINICAL CASES

CASE TYPE:

Short Case – 8 minutes

NAME:

Susie Sacks

AUTHOR:

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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 Instructions

- Take an appropriate history from the patient.
- When you are ready to examine the patient, the observing examiner will provide you with all the relevant findings and the results of surgery tests.
- 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:

Susie, a 78 yo pensioner, presents to you 2 months after you saw her with shoulder pain and sent her to the physiotherapist.

A copy of the patient record summary sheet is attached.

FULL SUMMARY

Patient Details

Name: Susie Sacks
D.O.B.: 6th October 1927
Allergies: Nil known

Social History

Lives with husband in retirement village

Current Medications

Perindopril 2mg daily
Panadol osteo 500mg, 2 tds
Voltaren EC 50mg, 1 tid prn

Immunisations

Pneumovax 2003
Fluvax 2005

Past Medical History

Hypertension
Depression
Osteoarthritis
Vaginal Hysterectomy
Appendicectomy

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

Demographics

Name: Susie Sacks

Age: 78

Occupation: Retired Process Worker

Presenting Complaint (To be stated exactly as written)

'This shoulder doesn't seem to be getting any better and it's really getting me down. In fact, it seems to be getting worse.'

THE STORY IN DETAIL

Sylvia presented with right shoulder pain consistent with impingement of the supraspinatus 2 months ago. She was referred to the physio for conservative treatment as she didn't want an injection. She has failed to improve despite physio. She now has increasing pain in both shoulders and in her hips. She describes morning stiffness and pain in both shoulder and pelvic girdles. She warms up by mid-morning, but after she sits down in the afternoon, she takes a long time to get going again. She feels generally unwell and is getting down because of the pain. She cannot play bowls, and is struggling with the housework, especially hanging out the washing. Pain is bilateral, radiates to neck, aches, and occurs daily. Slight relief with activity. Aggravated by staying in bed all day.

HISTORY

Past Medical History

Hypertension

Depression

Osteoarthritis

Vaginal Hysterectomy

Appendicectomy

Family History

Sister with 'some sort of arthritis' (only if specifically asked)

Mother – died of 'double pneumonia.'

Father – AMI

Cigarettes

Ex – quit in 1980

Alcohol

Occasional sherry

Other Drugs

Nil

Medications

Perindopril 2mg daily

Panadol osteo 500mg, 2 tds

Voltaren EC 50mg, 1 tid prn

Allergies

Nil Known

Immunisations

Pneumovax 2003

Fluvax 2005

Nutrition

Adequate, although struggling with cooking now

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

SYSTEMS REVIEW

Energy

Low feels tired.

Appetite

Slightly decreased

Weight Change

1-2 kg weight loss

Sleep Pattern

Normal, sometimes disturbed by shoulder pain

Cardiovascular

Normal

Respiratory

Normal

Gastrointestinal

Normal

Genitourinary

Normal

Neurological

Normal

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

PHYSICAL EXAMINATION

All other physical findings are normal.

Candidates are to ask for specific examination findings

General Appearance	Frail, stooped elderly lady. Looks glum.		
Weight 60kg	Height 1.58m	BMI 24.03	Temp 36.5°C
BP 110/85	Pulse 60	RespRate 10/min	
Musculoskeletal	Marked painful restriction of shoulder movements in all planes. Painful arc between 70 and 90 degrees in right shoulder – unable to abduct further Limited range of movement in lumbar spine		
Eyes	Fundoscopy normal		
Other	Temporal artery non-tender, normal to palpation		

INVESTIGATIONS

All other investigations are normal.

Candidates are to ask for specific investigations.

Surgery Tests

Urinalysis - normal

Random Blood Glucose – 5.7

Other Investigations

Pathology

FBE – 115/456/4.3

ESR – 57

CRP – 20

Rheumatoid Factor, anti CCP - ve

Imaging

Shoulder Xray normal

Ultrasound – partial tear of right supraspinatus

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

- Obtain good pain history, differentiate between mechanical and inflammatory pain
- Enquire about headache, visual disturbance to exclude temporal arteritis
- Assess how home functioning is affected by illness
- Ask about mood
- Request appropriate blood tests and imaging

Diagnosis

Define 2 problems

- Polymyalgia Rheumatica
- Right supraspinatus tear
- Possible DDX to consider and exclude;
- Rheumatoid Arthritis
- Frozen shoulder

Appropriate management and explanation:

Explains the nature and cause of PMR (giant cell vasculitis)

- Start Prednisolone 15-20 mg daily.
- Explain need to slowly taper dose to lowest effective dose
- Explain side effects of steroids
- Consider bone density scan
- Explain long-term treatment will be required (up to 2 years)
- Continue physio, may discuss steroid injection for supraspinatus tear
- Home help/Meals on Wheels etc
- Follow up in 2 weeks with repeat bloods, especially BSL and ESR

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

	Not Adequately Covered	Covered
• Communication and rapport	-----	-----
• History Taking	-----	-----
• Physical Examination Findings	-----	-----
• Investigations	-----	-----
• Diagnosis	-----	-----
• Problem Definition	-----	-----
• Medical Knowledge	-----	-----
• Management	-----	-----
• Prompting	-----	-----
•	-----	-----

Key Features Clinical Case Rating Descriptions

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.

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.

Physical Examination Findings

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

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.

Diagnosis

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

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.

Medical Knowledge

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

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.

Prompting

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

The 6 categories are: Almost continuously (bubble on far left), very frequently, frequently, occasionally, minimally, not at all (bubble on far right). Ignore the descriptors below the bubbles.

References and Study Notes

General Practice, Murtagh J, McGraw Hill