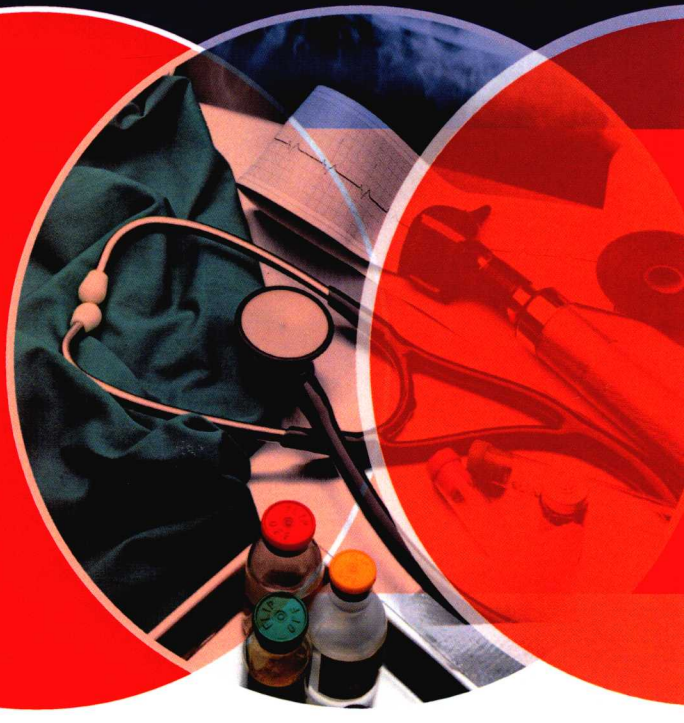
Second edition

100 Cases in General Practice



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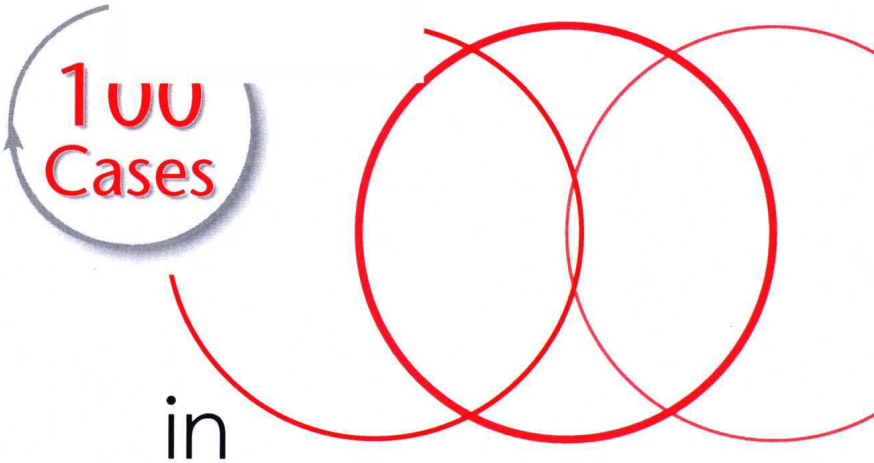

in General Practice

Second Edition

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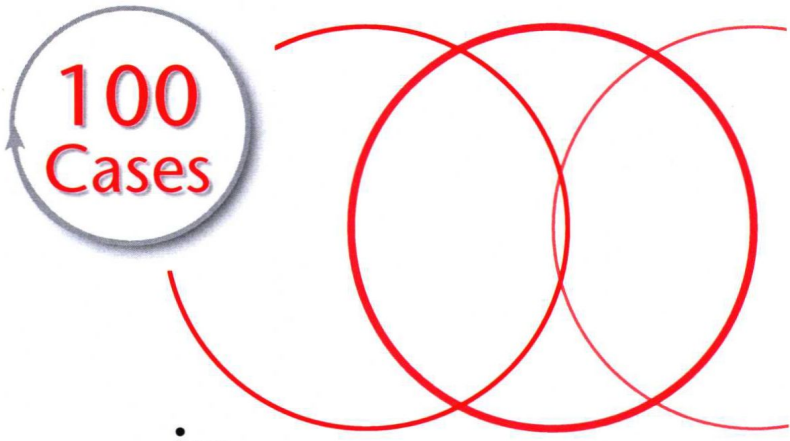

in General Practice

Second Edition

100 CASES

Series Editor: Janice Rymer

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PREFACE

For this second edition, we have updated some and replaced others of the original 100 cases in the hope that they are representative of the breadth and depth of current general practice. People bring all kinds of matters to the general practitioner; those that pertain to health, illness and disease and the physical, psychological, social and spiritual. As general practitioners, we never know who will come through our doors next and what they will bring.

When diagnosis is called for, our style is often hypothetico-deductive and our questions sometimes ask you to decide on the differential diagnosis on the basis of the history we give you, and then to decide what line of further history-taking, focused examination, investigations and management you might take. Other scenarios are more classically inductive, presenting all the information first and then asking you to decide on the differential diagnosis and management. Several are purely about management, communication or ethical issues. We highlight the importance in our work of effective communication, continuity of care, teamwork and the necessity of placing patients' health issues in the context of their community and their life circumstances and experiences.

We have ordered these scenarios on the basis of the presenting symptom or topic; however, be aware that the presentation may have very little to do with what actually transpires. General practice consultations have a habit of not being what they first seem.

In general practice, listening is the key and the cases that are presented to you in the following pages are from our experience as general practitioners: each scenario is an aggregate of many patients and many situations, and none is attributable.

> *When I started in practice, the thing that gave me joy was the solving of clinical puzzles, the making of good diagnoses, thus impressing my colleagues. As time went on I found myself preoccupied more and more with the patients I had come to know. It was their joys and sorrows, their suffering and healing that moved me. Of course, clinical diagnosis and management did not cease to be crucial: simply that a patient's illness or disability became interwoven with a life story. I came to see medicine as more complex, more context-dependent, more poignant, more a reflection of the human condition.*
>
> **McWhinney, IR. Being a general practitioner: What it means**
> *(Eur J Gen Pract.* 2006; 6: 135–139)

This book is for both undergraduate medical students and post-graduate doctors in training. The scenarios can be used by teachers. We hope that you will enjoy this book and that it will help to take you some way along this journey in understanding what general practice is about and how general practitioners approach the many and varied biopsychosocial, cultural and ethical issues encountered in everyday practice.

Anne Stephenson
Martin Mueller
John Grabinar

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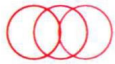
ABBREVIATIONS

5-HT$_1$	5-hydroxytryptamine
A and E	accidents and emergency
ACE	angiotensin-converting enzyme
ACR	albumin creatinine ratio
AMD	age-related macular degeneration
AUDIT	Alcohol Use Disorders Identification Test
BCG	Bacillus Calmette–Guérin
BMI	body mass index
BNP	B-type natriuretic peptide
BPPV	benign paroxysmal positional vertigo
BRCA1	breast cancer gene 1
CA 125	cancer antigen 125
CBT	cognitive behavioural therapy
CCG	clinical commissioning groups
CCP	cyclic citrullinated peptides
CHD	coronary heart disease
CK	creatine kinase
CO	carbon monoxide
COCP	combined oral contraceptive pill
COPD	chronic obstructive pulmonary disease
CPR	cardio-pulmonary resuscitation
CRP	C-reactive protein
CT	computed tomography
CVD	cardiovascular disease
CXR	chest x-ray
DAFNE	dose adjustment for normal eating
DMARD	disease modifying anti-rheumatic drug
DNACPR	do not attempt cardio-pulmonary resuscitation
DVT	deep vein thrombosis
DXA	dual-energy x-ray absorptiometry
ECG	electrocardiogram
eGFR	estimated glomerular filtration rate
EPDS	Edinburgh Postnatal Depression Scale
ESR	erythrocyte sedimentation rate
FAST	face arm speech test
FBC	full blood count
FEV$_1$	forced expiratory volume in 1 second
FSH	follicle-stimulating hormone
GP	general practitioner
Hb	haemoglobin
HIV	human immunodeficiency virus
HMG-CoA	3-hydroxy-3-methylglutaryl coenzyme A
ITU	intensive therapy/treatment unit
IUCD	intra-uterine contraceptive device
JVP	jugular venous pressure
LABA	long-acting beta2 agonist
LH	luteinizing hormone

LPA	lasting power of attorney
MCH	mean corpuscular haemoglobin
MMR	measles, mumps and rubella
MRC	Medical Research Council
MRI	magnetic resonance imaging
MSU	mid-stream urine
NAAT	nucleic acid amplification test
NCT	National Childbirth Trust
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NSAIDs	non-steroidal anti-inflammatory drugs
PCOS	polycystic ovary syndrome
PEG	percutaneous endoscopic gastrostomy
PHQ-9	Patient Health Questionnaire-9
PMR	polymyalgia rheumatica
PND	postnatal depression
POM	prescription-only medicine
POP	progesterone-only pill
PSA	prostate-specific antigen
PTSD	post-traumatic stress disorder
QOF	Quality and Outcomes Framework
SCBU	Special Care Baby Unit
SLE	systemic lupus erythematosus
SSRIs	selective serotonin reuptake inhibitors
TNF	tumour necrosis factor
TIA	transient ischaemic attack
TSH	thyroid-stimulating hormone
UTI	urinary tract infection

CONTENTS



CASE 1: ABDOMINAL DISCOMFORT

History

The general practitioner (GP) is consulted by a 58-year-old woman who presents with abdominal discomfort. Her symptoms are vague. The GP encourages her to explain. Over the past few months, she has noticed an increasingly achy area in her left lower abdomen. Her abdomen also feels bloated. She has been passing urine more frequently and has been a bit constipated (unusual for her). She went through her menopause at 51 years of age, but over the last week or two there has been a little vaginal spotting. Other than that she feels well and continues to work as a primary schoolteacher. She has been a healthy person, has not had any serious illnesses, has not smoked for many years and is a light alcohol drinker. Her smears have always been normal, the last one a year previously, and mammograms have also been normal. She lives with her husband and has one grown-up daughter. She is an only child, her mother is still alive and well and her father died from lung cancer at 75 years of age.

The GP is worried that the symptoms that she describes could be something serious such as a tumour and asks her what she thinks could be going on. The GP knows that, if, as a result of the examination, they find a mass, then exploring the patient's concerns at this point of the consultation might make the breaking of possible bad news a little easier. The woman finds it difficult to express her worries. With some space and gentle encouragement she bursts into tears and tells the GP that she is worried that she has cancer and has been too afraid to come to the surgery to find out. The GP asks the patient whether she would like a family member, friend or chaperone to be present. The woman tells her that she would rather be there on her own and, if there is anything wrong, then she will deal with that later.

Examination

On abdominal examination, the GP thinks she can feel a small, hard mass arising out of the pelvis, and on vaginal examination, there is a fixed left iliac fossa mass of about 6 cm in diameter. The most likely diagnosis is ovarian cancer.

Questions

- How might the GP break the bad news to the patient?
- What does the GP do now?

ANSWER 1

The woman can see that the GP is concerned. It is the middle of a busy morning, but this is something that cannot be rushed. The other patients will have to wait and the GP asks the woman to get dressed and sit back down at the desk. The woman says to the GP 'It is cancer isn't it?' and the GP explains what she had found on the examination and that this is a possibility. The woman is quiet and very frightened and asks 'what should be done next?' and the GP tells her that it would be best if she was referred urgently under the 2-week rule to the local cancer services. The GP explains that it might not be cancer but that it would be best if proper investigations were carried out as soon as possible by a specialist unit. They talk about what the woman plans to do in the meantime. She is very concerned about telling her husband and daughter. She decides to go home and tell her husband who will be home at lunchtime and then, together, work out how to tell her daughter. She knows that her daughter will want to know straight away and would be very upset if she were not to hear until after the investigations. The GP arranges to see the couple again the next day at the end of the morning surgery.

Investigations did indeed show that she had ovarian cancer, Stage 3, and she went through surgery, chemotherapy and is in a period of remission.

Ovarian cancer is the fourth most common cancer among woman in the United Kingdom and there about 7000 new diagnoses each year. There are usually no symptoms in the early stages, and unfortunately it is often detected late. Treatment is not usually curative. The aetiology is unknown; it is more common in nulliparous woman, less common in those women who have used the oral contraceptive pill, and rare in women under 30 years of age. In 5%–10% of women who have the disease, there appears to be a major genetic component. Usually if this diagnosis is suspected and in accord with National Institute for Health and Care Excellence (NICE) guidelines, a blood test for CA 125 is the initial test, but in this case, with the physical findings the GP decides to refer her directly under the 2-week rule.

Key Points

- When symptoms or your gut feeling lead you to think that there may be something seriously wrong with your patient, prepare for possible bad news early in the consultation.
- Be as honest as you can; patients can tell when you are hiding something from them.
- Let patients lead the consultation; this makes it easier to explain what you suspect or know in a way that is best for them.
- Do not surrender patients totally to secondary services. It is important that you remain a support for them and their family.

CASE 2: ABDOMINAL PAIN

History

It is 7 PM on a Friday night in January. Evening surgery has finished and you are about to transfer the telephone to the weekend on-call service when a call comes in from a mother of three children, aged 3, 5 and 8 years. They have all had tummy-ache, diarrhoea and vomiting in the last 24 hours. They are normally healthy children, with only minor illnesses in the past. They have not been abroad recently and their mother and father are well. The mother has already sensibly stopped them from eating and has given them just water to drink, plus a dose of paracetamol to help the pain. You know there has been a minor outbreak of winter vomiting disease (norovirus) locally. She is sorry to trouble you and is merely seeking advice on how best to manage them.

Questions

- Do you need to visit the family?
- What further questions would help to answer this question?
- What advice should you offer to the mother?

ANSWER 2

The decision to make a home visit is the doctor's responsibility. It is perfectly reasonable, after taking an adequate history, to offer her simple advice (see below) and to ask her to contact the on-call service if any of the children do not improve as expected – perfectly reasonable, but not necessarily comfortable. You may well find yourself worrying about the case over the weekend, probably needlessly. Although homes are not ideal places for clinical examination and home visits are time-consuming, they remain an essential part of the general practitioner's duties. The decision to visit remains with the doctor, but we should consider the logistics from the patient's point of view. Imposing a car journey to an out-of-hours centre on this mother, with three vomiting children, would be contrary to their, and her, best interests and would not foster that good patient–doctor relationship that we spend all our working lives trying to cultivate. We should learn to recognize our own very human feelings of irritation in this situation and deal with the problem rationally.

You may ask some 'closed' questions to elucidate the problem. Is the abdominal pain constant and does it prevent any of the children from getting up and running around? Are there any associated features, such as a rash or fever?

Since all three are described as confined to bed, you do visit, to find all three children in the parental bed, in various stages of misery. A forehead skin thermometer shows a low-grade fever in all of them. A gentle hand pressing on the abdomen reveals two who giggle and one (the eldest) who moans. For this patient, you think there is some guarding and rebound tenderness. You ask them to try sitting up with their arms folded. You start with the eldest (as the others will copy the action) who cannot do this, while his younger brother and sister manage it easily.

You decide to admit the eldest to the hospital as a potential case of appendicitis. The other two can be managed with simple fluid replacement. A prescription for flavoured glucose–electrolyte powder dissolved in 200 mL water and offered after every loose stool, is helpful. As they recover, they can have small light meals when they are hungry with minimal fat initially and no spices.

A week later, you see all three in the surgery for follow-up. They have obviously recovered and are bouncing around the room. The eldest proudly shows his right iliac fossa scar with subcuticular stitch awaiting removal by the practice nurse. Evidently, the hospital agreed with your diagnosis. The transient irritation of that Friday night call is erased by the satisfaction of a job well done.

Key Points

- Home visits remain an essential part of the GP's duties.
- Do not assume a diagnosis based purely on history and local epidemiology. It is safer to say 'there's a lot of it about' after you have examined the patient, rather than before.