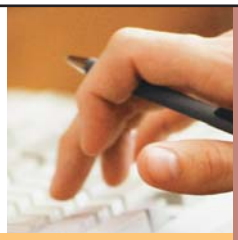
Clinical challenge



Questions for this month's clinical challenge are based on theme articles in this issue. The style and scope of questions is in keeping with the MCQ of the College Fellowship exam. The quiz is endorsed by the RACGP Quality Assurance and Continuing Professional Development Program and has been allocated 4 CPD points per issue. Answers to this clinical challenge will be published next month, and are available immediately following successful completion online at: www.racgp.org.au/clinicalchallenge. *Jenni Parsons*

SINGLE COMPLETION ITEMS

DIRECTIONS Each of the questions or incomplete statements below is followed by five suggested answers or completions. Select the most appropriate statement as your answer.

Case 1 – Penny Pearson

You are on call for the evening and Penny Pearson, aged 42 years, phones you at 9 pm. She has had 20 minutes of severe epigastric pain radiating to the right and to between her shoulder blades, feels nauseated and has vomited twice. You agree to visit her at home.

Question 1

Penny tells you she has had similar milder pains over the past few months lasting about an hour. On examination Penny is normotensive and afebrile. You guess her weight is about 95 kg. She has epigastric tenderness but no peritonism. The most likely diagnosis is:

A. biliary colic
B. cholecystitis
C. peptic ulcer because there is no right subcostal tenderness
D. pancreatitis because the pain radiates to the back
E. myocardial infarction.

Question 2

You give Penny an injection of opioid analgesia and metoclopramide and arrange to review her the following day. On review, her pain has settled and abdominal examination is normal. Blood tests were also normal. You:

A. reassure her that no further investigation is necessary
B. arrange a gastroscopy
C. arrange an upper abdominal ultrasound
D. arrange a MRCP because ultrasound is less reliable in overweight patients
E. arrange an ERCP.

Question 3

Penny returns on Friday afternoon with a severe episode of right upper quadrant (RUQ) pain that has lasted most of the day. She is febrile with RUQ and epigastric tenderness. She has a leucocytosis on her FBE, an obstructive pattern on LFT with a bilirubin of 45, and a mildly elevated serum amylase. Your working diagnosis is now:

A. pancreatitis
B. cholecystitis
C. biliary colic and suspected bile duct stones
D. cholecystitis and suspected biliary duct stones
E. hepatitis.

Question 4

You arrange Penny's admission to hospital for further management. The most appropriate investigation to assess Penny for the presence of bile duct stones is:

A. ultrasound
B. MRCP
C. CT cholangiography
D. ERCP
E. assessment for duct stones is not indicated.

Case 2 – Anna Giannopoulos

Anna, aged 57 years, has had cramping abdominal pains and bloating intermittently for many years and tends to get constipated. Over the past year she has noted more pains in her left iliac fossa relieved by defaecation. She has a screening colonoscopy because of a family history of bowel cancer and this reveals moderate sigmoid diverticulosis without inflammation or stricture.

Question 1

The likely cause of Anna's symptoms is:

A. irritable bowel syndrome (IBS)
B. diverticular disease (DD)
C. diverticulitis
D. either IBS or DD
E. endometriosis.

Question 2

You talk to Anna about managing her symptoms. You tell her:

A. codeine containing analgesics will be best for her pain
B. a high fibre diet will help if pain is due to IBS but not if it is due to DD
C. a high fibre diet will reduce progression of DD
D. a high fibre diet will prevent complications of DD
E. she should avoid eating seeds or pips to prevent diverticulitis.

Question 3

Six months later Anna presents with left iliac fossa pain and tenderness present for 2 days. She is afebrile and appears well hydrated. Which of the following investigations would be best to diagnose diverticulitis at this stage?

A. none as you plan to treat Anna empirically for diverticulitis
B. a CT scan
C. a barium enema
D. diagnostic laparoscopy
E. colonoscopy.

Question 4

The following day Anna's pain is still present. Her temperature is 37.9 and she has an elevated white cell count. She remains well hydrated, normotensive and has no signs of peritonism. Anna requires:

A. hospital admission because the risk of complications
B. clear fluids orally and treatment with metronidazole
C. referral for surgical excision of the affected colonic segment
D. urgent colonoscopy
E. clear fluids and treatment with metronidazole and amoxicillin.

Case 3 – Belinda Bracks

Belinda, aged 29 years, presents with a 12 month history of recurrent lower abdominal pain and pelvic pain. Often her abdomen feels bloated and at times she has loose stools. She feels her pain is worse toward the end of her menstrual cycle and she was experiencing dyspareunia before the break up with her fiancé 6 months ago. She has seen a number of doctors and is frustrated with her pain, and is feeling angry, anxious and depressed.

Question 1

The most likely diagnosis is:

A. pelvic inflammatory disease
B. endometriosis
C. IBS
D. psychosomatic pain
E. unable to be established without a comprehensive assessment.

Question 2

Appropriate initial investigations for Belinda include:

A. FBC and blood chemistry
B. urine microscopy and culture
C. high vaginal and cervical swabs
D. all of the above
E. A and C only as she has no urinary symptoms.

Question 3

Belinda experiences pain on defaecation, particularly in the few days before her period. Examination reveals a retroverted uterus. The cervix is normal with no inflammation or discharge and all swabs for infection are negative. You consider that Belinda may have endometriosis.

A. laparoscopic diagnosis is required before commencing treatment
B. a trial of medical therapy is appropriate without laparoscopic diagnosis
C. danazol is a first line treatment
D. endometriosis is a rare cause of CPP
E. B and C are correct.

Question 4

Belinda is treated for endometriosis and over the next 6 months her CPP improves. However, she still experiences cramping abdominal pain, bloating and loose bowel actions, and occasionally notes passage of mucus per rectum.

A. Belinda may have IBS
B. passing mucus is an 'alarm symptom'
C. the initial diagnosis of endometriosis was probably incorrect
D. colonoscopy is now indicated
E. all of the above.

Case 4 – Benjiro Akimoto

Benjiro (Ben) Akimoto, aged 20 years, is a medical student. He has been experiencing a burning pain in his upper abdomen and behind his sternum for several months, particularly after meals and when bending over. His symptoms have been worse during his recent exams. He has been taking antacids and ranitidine, which both help.

Question 1

You tell Ben he has gastro-oesophageal reflux (GORD). You ask him specifically about 'alarm symptoms'. These include all except:

A. dysphagia
B. odynophagia
C. weight loss
D. cough
E. haematemesis.

Question 2

Ben asks about the association of heliobacter infection with peptic ulceration and asks if he should be tested. You tell him H pylori

A. infection is strongly associated with the development of GORD
B. eradication will reduce the risk of recurrence of GORD
C. testing is indicated in GORD
D. testing is not routinely indicated in GORD
E. gastritis is relieved by proton pump inhibitor (PPI) therapy.

Question 3

You discuss 'step down' therapy with Ben. You tell him:

A. a once daily dose of a PPI is effective in most cases
B. initial PPI treatment is for 2–3 weeks
C. a second generation PPI should be used initially, then 'step down' to first generation
D. relapse after the initial course of treatment is an indication for endoscopy
E. A and D.

Question 4

Ben has a partial response to PPI therapy. He tells you his father died of stomach cancer 5 years ago. Ben has an endoscopy that reveals Barrett's oesophagus. You explain that Barrett's oesophagus is:

A. a type of oesophagitis
B. is a precursor of adenocarinoma
C. an area of squamous epithelium that has replaced the normal columnar epithelium of the oesophagus
D. an incidental finding that needs no further follow up
E. B and C.