CLINICAL**CHALLENGE**

Questions for this month's clinical challenge are based on 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. Check clinical challenge online for this month's completion date.

Kath O'Connor

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 – Natalia Kapralova

Natalia Kapralova, 6 years of age, is brought in to see you by her mother. This is the first time you have seen her as her family has just moved into the area. Natalia has had intermittent abdominal pain for about 5 months.

Question 1

Chronic abdominal pain (CAP) in this age group is usually caused by:

A. chronic urinary tract infections
B. reflux oesophagitis
C. functional gastrointestinal disorder
D. grumbling appendix
E small bowel lymphoma.

Question 2

You take a full history. Which of the following is a 'red flag' in the history which might indicate the presence of organic disease:

A. pain located in the periumbilical area
B. day time pain
C. constipation
D. dysphagia
E. pallor with episodes of pain.

Question 3

Natalia complains of pain in the peri-umbilical region every few days. It usually starts as she is getting ready for school and is sometimes associated with pallor, nausea and headache. She is well between episodes. She has no diarrhoea, constipation or dysphagia and no nocturnal pain. Her weight and height are normal for her age. Her mother says Natalia has been very anxious about going to her new school. The family has no relatives or friends in the area. You examine Natalia. Which of the following is a 'red flag' on examination which might indicate the presence of organic disease:

A. normal examination
B. child reluctant to have abdomen examined
C. child reluctant to have any examination
D. mouth ulcers
E. none of the above.

Question 4

Nothing remarkable is found on examination. You explain that the most likely diagnosis is functional CAP, however there are tests that you can do. You order: FBE, ESR, CRP and coeliac screen, faeces MCS, urine MCS and abdominal X-ray. The results are normal. You think Natalia is suffering from functional CAP. Your management plan would include all of the following EXCEPT:

A. telling the family that Natalia's pain is all in her head
B. a symptom diary
C. explanation of brain-gut interaction
D. encouraging normal activities and school attendance
E. nonpharmaceutical pain management strategies such as muscle relaxation.

Case 2 – Natalia Kapralova – continued

Question 5

Natalia returns with her mother about a month later. Her mother says she has been refusing to go to school and wonders if you can help. School refusal:

A. is more common in girls than boys
B. is more common in boys than girls
C. is an early sign of ADHD
D. occurs in 1–5% of school children
E. is most common in older teenagers.

Question 6

You take a history from Natalia and her mother and find that she is having difficulty making friends at her new school. However, her teachers have been happy with her academic progress. Natalia is happy when she is not at school. In children who refuse to go to school, which of the following indicates a poor prognosis:

A. high IQ
B. depression
C. onset in early childhood
D. shorter periods of school refusal (<2 years)
E. poor relationship with a teacher.

Question 7

Over the next few months, Natalia is likely to:

A. agree to go to school with consistent and firm parental input
B. engage in truancy
C. have difficulty concentrating in class
D. have poor peer relationships
E. have a psychiatric illness.

Question 8

You discuss a management plan with Natalia's mother. The plan includes all of the following, EXCEPT:

A. a return to school strategy
B. working with Natalia to acknowledge her feelings
C. problem solving about finding friends
D. engagement with the school
E. home tutoring.

Case 3 – Gordon Byron

Gordon Byron, 14 years of age, attends your practice with his mother. She says that over the past 12 months his behaviour has been consistently poor. He attends school but refuses to work at school or do any homework. He spends most evenings at the local skate ramp. He loses his temper easily; punching walls or throwing furniture. Throughout the consultation he plays with a handheld computer game. When his mother asks him to put it away he stares at her and mouths the words 'f*** off'. You suspect that Gordon may have oppositional defiant disorder (ODD).

Question 9

According to the DSM-IV criteria, children with ODD:

A. don't understand that their behaviour is annoying
B. refuse to test limits set by parents
C. compromise too easily
D. blame others for their problems
E. have difficulty expressing emotion.

Question 10

Factors contributing to ODD include each of the following, EXCEPT:

A. difficult temperament
B. temper tantrums
C. high motor activity
D. an excessively quiet baby
E. multiple care givers.

Question 11

You explain the diagnosis of ODD to Gordon's mother. She asks if this means he has ADHD. You explain that:

A. ADHD is the same as ODD
B. ADHD and ODD rarely occur together
C. ODD is common in patients with ADHD and it may be difficult to determine which is to blame for behaviour problems
D. all patients with ODD will have ADHD and it may be difficult to determine which is to blame for behaviour problems
E. some patients with ODD will have ADHD but this usually results in good behaviour.

Question 12

Regarding management of ODD, which of the following is MOST useful:

A. change in care giver
B. expulsion from school
C. corporal punishment
D. high dose fluoxetine
E. a mental health care plan.

Case 4 – Sara Isaak

Sara Isaak, 42 years of age, presents complaining of 'the room spinning' on head movement for about 48 hours. She is slightly nauseous but denies vomiting, headache, hearing loss, ear discharge, ear fullness, tinnitus and upper respiratory symptoms. She takes irbesartan for blood pressure. She has no past history of head trauma or ear surgery and no family history of vertigo.

Question 13

Otoscopic and full neurological examination is normal. The Dix-Hallpike test is positive with nystagmus on turning the head to the right and none on turning to the left. This suggests all of the following EXCEPT:

A. a diagnosis of BPPV
B. asymmetrical vestibular input
C. a mobile canalith
D. a canalith on the left
E. the Epley manoeuvre is likely to be successful.

Question 14

You explain to Sara that you believe she has calcium crystals in her inner ear causing asymmetrical input of balance sense and that by performing an extension to the Dix-Hallpike test you may be able to dislodge it. The extension of the Dix-Hallpike test is:

A. the Brandt-Daroff manoeuvre
B. the Semont manoeuvre
C. the Epley manoeuvre
D. nonspecific vestibular habitation
E. endolymphatic dilatation.

Question 15

Sara experiences only partial improvement following the manoeuvre. She still complains of some vertigo on head movement while sitting upright. You organise to review her in a week. What advice do you give her regarding home management:

A. sleep flat on the bed (without pillows)
B. sleep only on the affected side
C. perform the modified Epley manoeuvre
D. avoid dairy products
E. avoid lying down for the week.

Question 16

Sara says she is picking up a new car the next day. She asks you whether she is allowed to drive. You explain that, according to Austroads:

A. she will be fine to drive tomorrow
B. she should not drive if she is still dizzy in an upright position
C. she requires a conditional licence
D. she can no longer drive
E. she must wait 1 month before driving.

ANSWERS TO MAY CLINICAL CHALLENGE

Case 1 – Tim Stark

1. Answer B
What constitutes maximal medical therapy is debated, but it should include nasal saline irrigation, nasal corticosteroid and a course of antibiotics.

2. Answer A
The most important factor in successful use of topical intranasal corticosteroid sprays is patient compliance.

3. Answer C
The appropriate duration of treatment is debated and can be anywhere from 3–6 weeks to 3 months.

4. Answer E
All of the above steps may be considered when a patient has not responded to maximum medical therapy.

Case 2 – Faith Morecroft

5. Answer E
In patients with a history of hoarse voice, red flags indicating urgent referral include: neck trauma with hoarseness or stridor, vocal change lasting more than 3 weeks, risk factors for malignancy (including smoking, high alcohol intake, previous malignancy or radiotherapy), weight loss, dysphagia, haemoptysis, deep voice in women and professional voice use.

6. Answer D
It is best to humidify the air with steam only. Additive agents such as eucalyptus/menthol have a drying effect.

7. Answer B
Reinke oedema is generalised oedema of both vocal cords. It is more common in women and causes lowering in voice pitch. It usually resolves with smoking cessation.

8. Answer D
Ninety-five percent of laryngeal carcinomas are squamous cell carcinomas that are heavily associated with smoking and excess alcohol intake.

Case 3 – Connor Buckley

9. Answer A
Recurrent ear infections are common in the first 3 years of life, especially during winter and spring.

10. Answer E
All of the statements are correct.

11. Answer C
In children, a septal haematoma can occur in the absence of nasal fracture. A septal collection may be seen on anterior nasal examination and confirmed by palpation.

12. Answer E
Mastoiditis, quinsy (peri-tonsillar abscess), para-retropharyngeal abscess and orbital cellulitis can all require acute surgical management.

Case 4 – Janet McInerny

13. Answer D
If Janet has sensorineural loss on the left and normal hearing on the right, in the Weber test she will localise sound to the nonaffected (right) ear. In the Rinne test on her affected left ear the test will be positive (AC>BC) unless her hearing loss in that ear is profound. The Rinne test in her normal hearing right ear will be positive (AC>BC).

14. Answer E
It is likely that Janet has idiopathic sudden sensorineural hearing loss (ISSNHL) and a space occupying lesion needs to be excluded. If an urgent ENT review is difficult to obtain, a good quality CT scan can exclude intracranial tumours over 1.5 cm. She will require an ENT review within a few weeks and an MRI to diagnose smaller tumours. Treatment is controversial for ISSNHL but in the acute setting it is reasonable to give Janet a 1 week reducing course of prednisolone.

15. Answer B
Hearing loss is unilateral in 95–100% of patients. Overall recovery rates are 50–65% with a high rate of spontaneous recovery. Recovery rates are better in patients in the 40–50 years age group with unilateral loss than in older populations with bilateral loss.

16. Answer C
Sensorineural hearing loss produces sound distortion rather than just a reduction in volume. Patients with single sided deafness (SSD) localise sound poorly as this task requires the integration of sound input from two hearing ears. Therefore patients with SSD find speech discrimination difficult in the presence of background noise and are much less aware when someone is speaking nearer the hearing impaired ear.

AFP CORRESPONDENCE afp@racgp.org.au