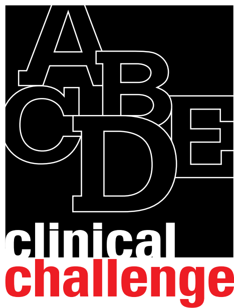

Questions for this month's clinical challenge are based on articles in this issue. The style and scope of questions is in keeping with the MCQ of the College Fellowship exam. The quiz is endorsed by the RACGP Quality Assurance and Continuing Professional Development Program and has been allocated 4 CPD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

Kate Molinari

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
Sarah Weldon

Sarah Weldon, 32 years of age, has attended your practice sporadically over the past 5 years. She has not been seen at the practice for over a year. She presents today in poor condition with several skin ulcers. On direct questioning she admits she is using IV drugs and is dependent on heroin.

Question 1

You assess Sarah and decide she can be treated with oral antibiotics. Which of the following is correct:

A. Sarah must agree to abstinence in order for you to treat her

B. discussion of treatment of addiction with opioid pharmacotherapy should be deferred until Sarah's acute infection is under control

C. it is not appropriate for you, as a GP, to manage Sarah's opioid dependence

D. management of opioid dependence uses the same principles and skills employed by GPs managing other chronic illnesses

E. although opioid dependence is a chronic disorder, it is not associated with long term morbidity.

Question 2

Sarah returns for review the following day. Her ulcers have started to respond to oral antibiotics. She asks about treatment options for heroin addiction. Which of the following is true in regard to opioid pharmacotherapy:

A. it would reduce Sarah's withdrawal symptoms and cravings

B. substitution medications were first introduced in the early 1980s

C. Sarah would join about 20 000 other Australians currently in opioid pharmacotherapy programs

D. Sarah is likely to achieve lifelong abstinence from illicit drugs

E. evidence is lacking to support its use in pharmaceutical opioid addiction treatment.

Question 3

You discuss the pros and cons of the current treatments available in Australia. Which of the following is NOT correct:

A. methadone is given once daily in liquid form with doses of 60–100 mg considered therapeutic

B. buprenorphine treatment should be commenced before patients experience withdrawal symptoms

C. methadone can be used during pregnancy

D. buprenorphine is a partial opioid agonist given in sublingual form

E. buprenorphine is less likely than methadone to cause respiratory depression.

Question 4

Sarah does not like the sound of these treatments and asks about going 'cold turkey'. Which of the following statements is true in regards to withdrawal from opioids:

A. it has no value in a long term treatment program

B. it appears to be associated with a lower risk of overdose

C. oral naltrexone is approved for use in opioid dependence as a PBS item

D. implant naltrexone is readily available in Australia

E. sublingual buprenorphine dispensed daily under supervision is an effective management of opioid withdrawal.

Case 2
Tom Harrow

Tom Harrow, 28 years of age, is a new patient at your practice. You have not been working there long and are keen to build up your own client base. Tom presents well groomed.

Question 5

You are running late and Tom has an 'urgent meeting'. He has recently moved for work and is requesting a script for oxycontin for chronic back pain. You are concerned Tom may be a 'doctor shopper'. Choose the correct statement:

A. there is a universally accepted definition of prescription drug abuse which you should refer to when managing Tom

B. consulting with a colleague about Tom is a breach of patient confidentiality

C. being a female, overseas trained doctor, you may be seen as an easier target for the doctor shopper

D. it is unusual Tom is requesting an opioid as it is generally benzodiazepines that are requested by drug seeking patients

E. there is clear data detailing the extent of prescription drug abuse in Australia.

Question 6

You decide to ring the Medicare Prescription Shopping Information Service. Which is true:

A. as a GP you do not need to be registered with the service to use it

B. Tom will be listed if he has had received scripts from seven prescribers over the past 3 months

C. Tom will be listed if he has received scripts for 30 PBS items over the past 6 months

D. Tom will be listed if he has received 20 scripts for oxycontin from the same prescriber over the past 3 months

E. the number of calls to the service is decreasing on an annual basis.

Question 7

Tom is not listed with the service. He becomes increasingly agitated when you start to ques-

tion him more. Choose the correct statement:

A. using 'borrowed protection' can be a useful strategy in dealing with Tom
B. as Tom is becoming agitated, saying no to his request is no longer an option
C. even if you feel threatened, you are still required by law to continue treating him
D. if Tom is addicted to opioids, he will have clear physical signs
E. if you give Tom a script he must agree to enter a harm reduction treatment program.

Question 8

You say no to Tom's request and he storms out of the surgery. You schedule a practice meeting to discuss strategies to help to minimise misuse of prescription drugs. Which of the following is INCORRECT:

A. ongoing prescription of Schedule 8 drugs requires a permit from health authorities
B. it can be helpful to adopt a 'universal precaution' approach for chronic pain patients
C. it can be helpful to develop a clinic policy to deal with requests from new patients for drugs of addiction
D. it is important to recognise that pain and addictive disease are two separate entities
E. a treatment plan should be developed for patients requiring ongoing prescriptions of drugs of dependence.

Case 3

Maria Joves

Maria Joves, a regular patient, is in tears in your room. She overheard her 15 year old daughter Natalie telling a friend she has started to uses 'Es' (ecstasy) at parties.

Question 9

Maria is horrified that her daughter is a 'druggie' and wants to know what to do. Which of the following is correct:

A. it is unlikely Natalie is telling the truth as ecstasy is expensive and difficult to obtain
B. effects of ecstasy include sedation and disinhibition
C. side effects of ecstasy include bruxism and hyperthermia
D. approximately 3% of 15 year olds in Australia have tried ecstasy
E. Natalie is most likely dependent on ecstasy and will need formal medical treatment.

Question 10

Maria brings Natalie in the following day and agrees to let you see her alone. Natalie admits to using ecstasy but can't see what the fuss is about. Choose the correct statement:

A. you should not discuss harm minimisation as this may be seen as condoning Natalie's behaviour
B. you should explain that you can only see her if she is ready to change her behaviour
C. you should not discuss health issues such as safe sex as Natalie is under age
D. you should not ask Natalie about using other drugs as this may give her ideas
E. you should give Natalie 'permission' to discuss her drug use confidentially.

Question 11

Natalie tells you that she goes to dance parties on the weekends and that she and her friends combine ecstasy and alcohol. Choose the correct statement:

A. as an ecstasy user, Natalie can be reassured there is no association between its use and mental health issues
B. Natalie is likely to be using cocaine as over 90% of ecstasy users also report using cocaine
C. Natalie is likely to experience sedation and disinhibition when she uses ecstasy
D. Natalie should be made aware that harmful effects include cardiovascular and cerebrovascular events
E. it is not an amphetamine type substance.

Question 12

You discuss harm minimisation with Natalie. Choose the correct statement:

A. it is important for her to stay well hydrated
B. discussing harm minimisation may be the most effective intervention at present
C. this is a good opportunity to discuss tobacco smoking with Natalie
D. you should advise her to use small amounts of the drugs when the source is uncertain
E. all answers are correct.

Case 4

Toby Bailey

Toby Bailey, 22 years of age, is a university student who comes to see you for a medical certificate as he is having trouble completing his assignments. Toby looks anxious and avoids eye contact.

Question 13

When taking a history from Toby which of the following is correct:

A. ask direct questions about illicit drug use
B. it is best to ask Toby directly if he is anxious or depressed
C. it may be relevant to ask Toby about legal problems and family relationships
D. the HEADSS framework stands for Health, Energy, Alcohol, Drugs, Sexuality, Suicide
E. you should assure Toby of confidentiality in all circumstances.

Question 14

Toby admits to increasing anxiety and low mood, which is helped by smoking marijuana. Choose the INCORRECT statement:

A. as Toby started smoking cannabis early, he is at higher risk of dependence
B. regular cannabis use is associated with a twofold increase in the relative risk of developing schizophrenia
C. anxiety, depression and paranoia can be reactions to cannabis
D. it is important to ask Toby about a recent change in weight
E. any psychotic symptoms will resolve if ceases cannabis.

Question 15

You consider which screening tools would best help you determine the extent of Toby's issues. Choose the correct statement:

A. the PsyCheck Screening tool is useful to assess mental health and somatic complaints during periods of abstinence
B. the Cannabis Use Disorder Identification Test is redundant, as Toby has already admitted to using cannabis
C. ASSIST is unlikely to be helpful as very few cannabis users are polydrug users
D. the Severity of Dependence Scale could be used to determine if Toby's usage is problematic or not
E. the K10 would assess the severity of Toby's psychotic symptoms.

Question 16

The screening tools suggest that Toby is dependent on cannabis and is depressed. Which of the following is correct:

A. there is good evidence for pharmacological intervention for managing cannabis withdrawal
B. Toby may benefit from CBT
C. it is better to treat Toby's cannabis dependence before treating his depression
D. antidepressants are contraindicated due to Toby's cannabis use
E. if Toby is keen to stop smoking cannabis, he is very unlikely to have relapses.

Answers to July clinical challenge

Case 1
Anna Wilson

1. Answer C
Obesity is a weak risk factor for DVT. A D-dimer is frequently positive and has limited usefulness in pregnant women. Compression ultrasonography is the method of choice to evaluate the lower limbs for DVT. In the primary care setting only 29% of adults with suggestive symptoms have DVT on ultrasound.

2. Answer A
A pre-test probability less than 2 combined with a normal D-dimer assay reliably excludes DVT without the need for imaging studies. Anna is classed as low pre-test probability. A normal CUS does not exclude DVT and imaging should be repeated in a week. D-dimer levels correlate with the size of thrombus and clot activity.

3. Answer B
Anticoagulation for 6 weeks to 3 months is generally considered adequate. Warfarin is teratogenic. Idiopathic VTE have higher risk of recurrence and longer term anticoagulation may be indicated. Warfarin limits the clot extension and prevents recurrence. About 10% of patients with symptomatic DVT develop severe post-thrombotic syndrome within 5 years.

4. Answer E
All the statements are true.

Case 2
Charles Wray

5. Answer A
Charles scores 2 (hypertension and age) which means he should be considered for warfarin if there are no contraindications. The CHADS2 score does not calculate warfarin dosage. In AF the target INR is 2.0–3.0. It takes 5–7 days for anticoagulant effect of warfarin to be established.

6. Answer D
Administration of vitamin K will overcome the need to recycle vitamin K epoxide within the liver and will therefore reverse the effect of warfarin.

7. Answer D
In patients with history of falls, decisions must be made on an individual basis taking into account risk:benefit ratio. NSAIDs can result in significant bleeding due to their antiplatelet effect. INR does not need to be tested daily. Charles should eat consistent amounts of foods high in vitamin K.

8. Answer C
Metronidazole inhibits CYP2C9. Antibiotics may reduce the amount of vitamin K produced. According to MIMS approximately 250 drugs can potentially interact with warfarin. NSAIDs add to the blood thinning effect of warfarin, but will not affect the INR.

Case 3
Jackie Evans

9. Answer C
Maximal risk is at 3 weeks postsurgery and remains elevated for up to 12 weeks. Third generation OCPs have the highest risk of causing VTE. Inpatient surgery has a higher risk of causing a PE. Flights over 12 hours have five-fold increased risk. There is a high risk of VTE in brain, ovarian and pancreatic cancer.

10. Answer E
Chest pain will be present in 60–70% of patients with PE. Peripheral emboli are more likely to present with pulmonary infarction. The absence or presences of any signs/symptoms cannot be used to confirm or refute the diagnosis. Dyspnoea will be present in 70–80% of patients.

11. Answer D
The Wells score should be applied with caution in the primary care setting as it was developed for the emergency setting. If she is classed as 'PE likely' she will need diagnostic imaging regardless of D-dimer result. CTPA is the most widely used radiological investigation. One single negative CTPA safely excludes PE. VQ scanning is used in patients without pre-existing lung disease.

12. Answer C
Intravenous unfractionated heparin is preferred in patients with significant renal impairment. A short period of initial inpatient evaluation in still recommended for patients with PE.

Case 4
Gladys Wilson

13. Answer A
Age is a factor that affects warfarin requirements. Algorithms have been developed but are not validated for use in Australia. Polymorphisms in these genes explains only some of the variability. VKORC1 is the target enzyme inhibited by warfarin; CYP2C9 is responsible for the metabolic clearance of S-warfarin.

14. Answer B
A = reduce warfarin dose; C = withhold warfarin and restart when INR in therapeutic range; D and E = give 2.5–5.0 mg of oral vitamin K.

15. Answer E
All of the responses are correct.

16. Answer C
The lack of a reversal strategy is a direct disadvantage should a patient suffer from bleeding. There were no signs of increased hepatotoxicity. Dyspepsia was a significant side effect. Dabigatran is a potent direct thrombin inhibitor.

correspondence **afp@racgp.org.au**