

DAY 6:

SURGERY COUNSELLING

Approach to communication - The **CLASS** protocol

1. Pain management
 - Prostate cancer (189)
 - Breast cancer (120)
2. Hemiarthroplasty – post operative management (29)
3. Barrett's oesophagus (225)
4. Patient requesting for PSA (303)

OPERATIONS:

Dermoid cyst removal (138)

First go "Approach to scopes"

- Endoscopy in Celiac Disease (322)
- Cystoscopy
- Bronchoscopy
- Colonoscopy scenario A (195)

MOTIVATION STATIONS

1. Smoking Cessation (first go through to smoking cessation)
 1. COPD (129)
 2. Angioplasty (18)
2. Alcohol counselling (30) (first go through to alcohol counselling)
3. Obesity (150)

PREGNANCY

First go through approaches to **Obstetric history**
AND then approach to **Menstrual history**.

1. 1st antenatal visit (149)
2. Pre-conception wants male child (181)
3. Pre-conception with HTN (236)
4. Pre-eclampsia at 36 weeks (13)
5. Pre-eclampsia at 38 weeks (267)
6. Chickenpox exposure in pregnancy (311)

SEXUAL HEALTH AND CONTRACEPTION

First go through approaches to "Sexual A History"

STI SCENARIOS

1. Dysuria in a 26 year old (246)
2. Gonorrhoea in a man (206)
3. Gonorrhoea in a woman (40)
4. PID with IUCD (65)
5. HIV - HIV scenario A (226)
6. HIV scenario B (265)
7. HIV scenario C (251)
8. Syphilis (319)
9. Cervical smear invitation in a 25 year old (304)

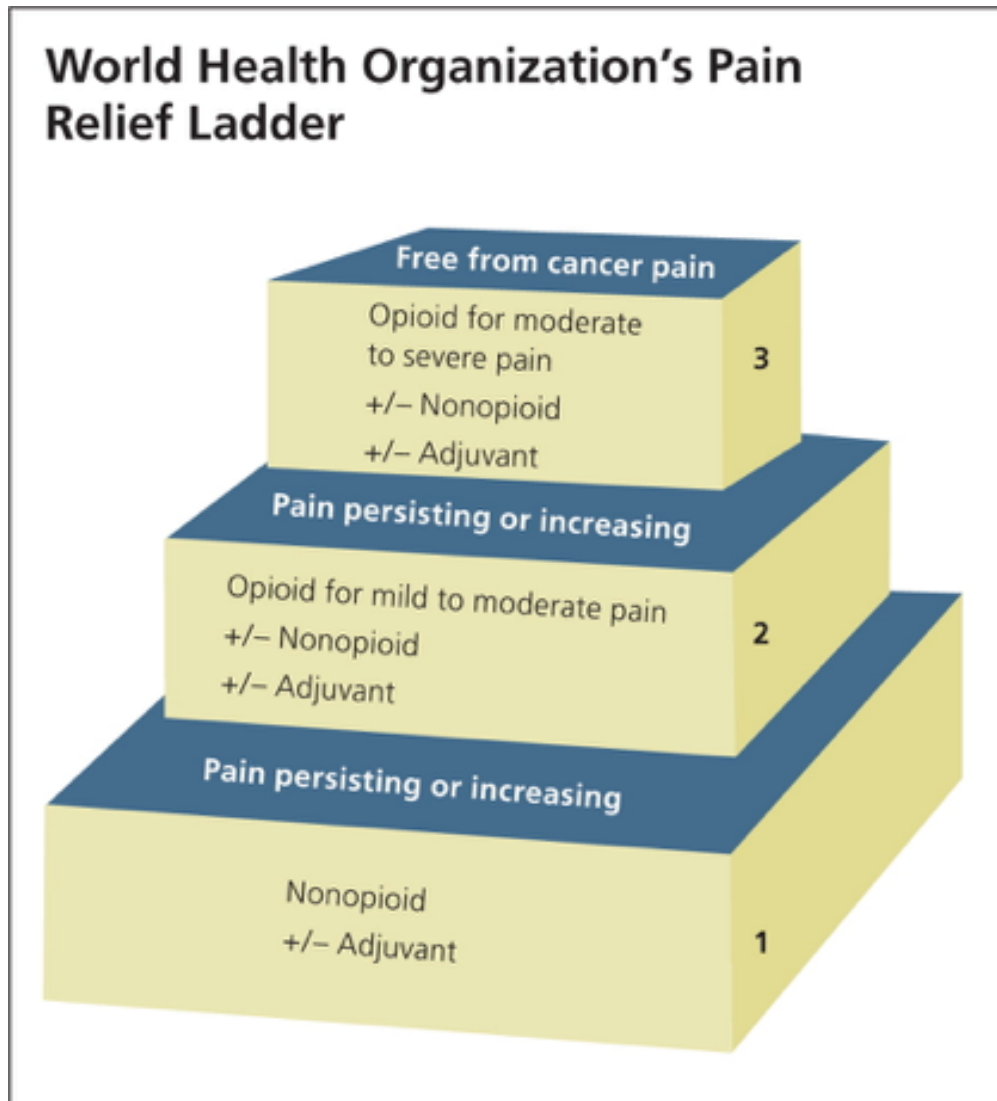
CONTRACEPTION

First go through approaches to "**Contraception in Minors**"

1. Contraception in 30 year old (2)
2. Repeated OCP prescription (302)

DAY 6

Pain management.



| PAIN MANAGEMENT (chronic pain) | | |
|--------------------------------|----------------|--|
| RUNG 1 | Non-opioid | Paracetamol, Ibuprofen etc... |
| RUNG 2 | Weak opiates | codeine, tramadol, Dihydrocodeine etc... |
| RUNG 3 | Strong opiates | Morphine, Fentanyl, oxycodone etc... |

Breast cancer

Scenario 120

You are FY2 in pain clinic. Joana Hutchinson is an 80-year old lady who has been admitted from the oncology department directly to the pain clinic. Joana had Mastectomy for breast cancer 5 years ago.

Please talk to patient and advise her on the painkillers you need to give her.

PATIENT INFORMATION:

Scenario A

- Your name is Joana Hutchinson, an 80 year old lady who had breast cancer 5 years ago and you had mastectomy done.
- You are currently taking paracetamol but your pain is not well controlled.
- You have had this pain for the past 4 months and it is 5/10.
- You are okay to carry on the conversation without taking painkillers.
- You were given morphine/codeine before but you stopped it because it caused constipation.
- This back pain was investigated, you just want something stronger so you are hoping that the doctor can give you different medications.
- Any medications the doctor offers you, you want to know the side effects and how can it be taken.
- You have your grand child's wedding to attend in a weeks' time and you worried that you might not go the wedding due to the pain.
- The back pain was investigated and they told you that the cancer has spread to the back. You know about this and you were placed on palliative therapy.
- You are interested in knowing all the side effects of the medications being offered by the doctors and ways to alleviate them.

Scenario B

You are worried about drowsiness. You look after your grandchildren and you do not want drowsiness as this may prevent you from looking after your grand children.

Questions

1. Are there any other painkillers?
2. Do you think I will be able to go to my grand daughters wedding?
3. Are there any side effects to this medications?
4. Will they cause any drowsiness?
5. Will I still be able to look after my grand children If I take Morphine?
6. When you are mentioned PCA, you ask 'Doctor, you mean I can give myself the injection?'

APPROACH:

1. GRIPS (loud, confident, eye contact, smile), offer analgesia (if in pain)
2. How can I help you?
3. SOCRATES of the back pain
 - What painkillers have you tried so far?
 - Why did they top those painkillers?
4. D/Ds (spinal cord compression, trauma, weight loss, hypercalcaemia, thirst, polyuria symptoms, last follow up by the surgeons in regard to the breast cancer she had)
5. Ask if the back pain has ever been investigated in order to find the causes
6. PMH, DH, Allergies
7. What medications are you taking currently?
8. **Ask warning Signs (spinal cord compression)**
 - Constipation
 - Urinary symptoms
 - Weakness and sensory loss in the legs
9. **Discuss pain management:**
 - Ibuprofen(S/E- indigestion- can cause damage to stomach but if we are to place you on this medication we will give you another medication to prevent your stomach).
 - Weak opiates like codeine ,tramadol but use laxatives like senna, as the pain is not severe this would ok.
 - Morphine with laxatives to prevent constipation she developed last time. What do you think about that?
 - Discuss with seniors
 - Advice that patient can still go ahead with the normal life when she is on this medication.
 - Advice that if it will cause severe drowsiness, You would stop the morphine medications and try some other medications.
 - Explain that you would take the second opinion from your senior.
 - Explain that you would try and control the pain as soon as possible so that she can go for her wedding.

NOTE: SIDE EFFECTS OF OPIATES

- Nausea and vomiting (use anti emetics)
- **Constipation** (use laxatives)
- **Drowsiness** - usually a problem in the Initial stage of taking the medication but with time gradually wears off)
 - If drowsiness becomes a big problem then we can try to change it to a different type of opiate
- **Dry mouth** (use a chewing gum or take sips of water)
- **Tolerance:** If you have been taking opioids for a long time ,the dose might need to increased in order to control the pain.This is called tolerance.
- **Dependence:** if you take the opioids medications your body may become dependent on it.It means that if you miss the dose or stop the opioid suddenly you may experience withdrawal symptoms.
 - In this situation ,if you need to stop the medication, the dose needs to be gradually reduced.

Withdrawal symptoms:

- Feeling anxious
- Difficulty falling asleep
- Muscle pain
- Sweating
- Yawning
- Diarrhoea and vomiting

ADDICTION:

Addiction is an excessive craving for the opioid .It is unusual for the people who are prescribed opioids for pain to become addicted to opioids

Barrett's oesophagus:

Scenario 225

You are FY2 in the outpatient department. Peter Smith, 52-year-old man who had an endoscopy with biopsy done. The patient has a past history of GERD and is on omeprazole 20 mg daily.

A copy of the biopsy results from the histopathology department is available in the cubicle.

Talk to the patient, explain the results and discuss management with the patient.

Patient information :

- You are 52 years old.
- You had GERD for years.
- Your symptoms are getting worse.
- The symptoms are not being controlled by Omeprazole anymore, that's why you had the endoscopy done.
- You have night symptoms which wake you up from sleep.
- You have been smoking 20 cigarettes per day for 20 years.
- You drink a lot of alcohol.
- Your diet is poor.
- You work as a pizza delivery man.

Questions:

1. Why can't you cut it out?
2. Why can't you just do an endoscopy now?

Approach:

1. Initial approach
2. Explain the purpose of consultation
3. Paraphrase the scenario and ask: "I understand that you had endoscopy done". Did they tell you reasons why an endoscopy was performed?

4. **Explain the results of endoscopy.** Endoscopy shows that you have a condition called Barrett's oesophagus. Barrett's oesophagus is formed by repeated damage from stomach acid to the oesophagus. Over years the damage can lead to changes in the cell lining of the oesophagus. Unfortunately, these abnormal cells are at increased risk of becoming cancerous in future, but the risk is small.

Because of the increased risk, it is recommended that we perform an endoscopy every 3 years. If the abnormal cells become cancer cells, then they will be discovered at an early stage and treatment such as operation may be offered.

At this stage, we just need to stop anything that may contribute to the development of any cancer. At the moment, these abnormal cells are not cancerous.

5. Alcohol:

- Drinking too much alcohol causes irritation and inflammation in the lining of the oesophagus.

6. Smoking:

- Tobacco smoke contains many harmful toxins and chemicals. These substances irritate the cells that make up the lining of the oesophagus, which increases the likelihood that they will become cancerous.
- The longer you smoke, the greater the risk of developing cancer of the oesophagus.

7. Obesity:

- If you are overweight or obese, your risk of developing cancer of the oesophagus is higher than people of healthy weight.

8. Diet:

- Not eating enough fruit and vegetables may increase the risk of getting oesophageal cancer.

Dermoid cyst removal

Scenario 138

You are FY2 in the obstetric and gynaecology department. Mrs Jenny Thompson is a 30-year-old lady who has been scheduled for a dermoid cyst removal. The cyst is 8cm x 8cm in size. The dermoid cyst will be removed via laparotomy with an incision on the bikini line. She is planned to stay in the hospital after the procedure for at least 48 hours. The surgeon will be using absorbable sutures. Consent has been taken from the patient. Patient has some concerns. Please talk to the patient.

Patient information:

- You are Mrs. Jenny Thompson
- You have been told that you have a cyst in one of your ovaries
- You know that you are going to undergo an operation
- You are normally fit and well and not on any medications

Questions:

- How will you do the operation?
- Will I be able to have children?
- Are there any complications?
- Do I need to make any preparation?
- What can I expect after the operation?

Approach...

Colonoscopy

Scenario 195

You are working as an FY2 in GP surgery.

Lisa Atkinson a 65-year-old who has made an appointment to see you. You had referred her to the hospital for per rectal bleeding. She had sigmoidoscopy done which showed bleeding polyp. Histology was done which confirmed Benign adenoma and some dysplastic changes. The specialist would like to perform a colonoscopy. The patient would like to talk to you about it. Please talk to patient and address her concerns.

Patient Information:

- You had presented to your GP a few weeks ago following 2 episodes of blood in the stools.
- Your GP referred you to the specialist who performed a sigmoidoscopy.
- They found out that you have polyps.
- They removed the polyps, sent it to the lab and the biopsy results showed that it is benign.
- You know all the results of your sigmoidoscopy and biopsy.
- You were quite happy that all was good.
- You have some discomfort while having a sigmoidoscopy, this is why you are not very keen to go through this process again.
- Since the polyp was removed you had no bleeding from the back passage.
- You are not happy that the specialist wants to do another procedure.
- The first time you had a sigmoidoscopy you were offered a laxative.
- You live with your husband, and he can come and get you. It is not a problem.
- You are normally fit and well and not on any medication.
- You have one brother and one sister, but they never had any similar problems.
- Last time you had colonoscopy it was very embarrassing for you.
- This is why you do not want to go through it again.
- You also had severe discomfort. They did not offer sedatives initially until half way through the procedure.

Questions:

- Why do I need to do another investigation when you said that it was benign?
- Is the previous sigmoidoscopy not enough to do that?
- Do you think it could be cancer?

Approach:

1. GRIPS

2. Establishes reason for visit

3. Takes concerns

4. Checks that patient understands the results of sigmoidoscopy (Benign polyp)

5. Explains the need of colonoscopy

- You have been invited to have a colonoscopy because a growth called polyps were found when you had a sigmoidoscopy.
- This means there is a chance you have polyps further up the bowel.
- Some polyps are benign growths but they might turn into bowel cancer if not removed.
- So we need to check that there are no more polyps further up the bowel and that there is nothing else going on.
- Unfortunately, polyps are one of the risk factors of developing lung cancer
- So you need to check the whole colon (large bowel)

6. P3MAFTOSA

7. Takes risk factors of colonic cancer:

- Smoking
- Family history of lung cancer
- Family history of polyps
- Does she have brothers and sisters
- Do any of the brothers and sisters have any bowel problems of polyps
- Symptoms of cancer:
 - Weight loss
 - Diarrhoea
 - Constipation
 - Tiredness
 - Weakness
- Systemic review

Concerns: Is there anything you are worried about?

Colonoscopy – This is a procedure to look at the inside of the large bowel (colon) with a long flexible camera (endoscope) and it also allows us to take a biopsy.

- Patient needs to take bowel preparations
- Will be given special laxatives at least 24 hours before a colonoscopy.
- This will give you diarrhoea and we will advise you to stay at home during this day.
- 12 hours before the procedure to drink clear fluids only.

Explain the procedure:

- The camera is in a flexible thin tube (about the thickness of your little finger) You will be offered sedatives to make you relax. The tube is inserted through your back passage in the bowel. A colonoscopy can visualise the whole large bowel and you can also take a sample called biopsy. Procedure will last 30 -45 minutes. The doctor will insert the colonoscope (thin flexible tube) into your large bowel through your anus and look inside using the tiny camera. He will gently pump some gas inside the bowel, to inflate them so that he can see the lining of the bowels properly.

Complications:

- Perforation of the bowels (but this is very rare)
- Infection
- Allergic reaction to sedative
- Abdominal discomfort or bloating

Post- Procedure:

- Few hours of monitoring are required until sedation wears off.
- Needs someone to pick her up.
- The effects of the sedative may last up to 24 hours, we therefore advise you not to:
 - Drive or ride any type of bicycle for at least 24 hours.
 - Operate any type of electrical or mechanical equipment/ machinery for at least 24 hours.
 - Sign any legally binding documents for at least 48 hours
 - Drink any alcohol for at least 24 hours.
 - Not be responsible for young children, disabled or dependent relatives for at least 24 hours.

- You can eat as you normally would.
- Rest quietly for the remainder of the day and if possible have someone stay with you overnight.

Safety Netting: if any of the following happens, patient needs to come back.

- Abdominal pain
- Rectal bleeding
- Fever

Smoking cessation

Scenario 129

You are FY2 in general medicine. Lewis Williams is a 70-year old man who was admitted to hospital with chest infection. He is known to have Chronic Obstructive Pulmonary Disease. He does get chest infection from time to time. On this occasion his chest infection has been treated and he is stable.

The nurses have been advising him to stop smoking but he has been reluctant. So they have requested you to talk to him.

Please talk to Mr Lewis Williams and advise him about smoking cessation.

PATIENT INFORMATION:

Scenario A:

- You are Mr Lewis William, a 70 year old man.
- You are known to have Chronic Obstructive Pulmonary Disease.
- You do get chest infection from time to time. On this occasion your chest infection now been treated and you are well.
- The nurses have been advising you to stop smoking but you have been reluctant. So they have requested the doctor to talk to him.
- You do not want to quit.
- You smoke 30 cigarettes a day since you were in college.
- You enjoy smoking.
- You have a friend of yours who died of lung cancer and you believe that it was due to his smoking.
- You are on the following medications:
Salbutamol, Dexamethasone, Ipratropium.
- You have no home oxygen or nebulisers.
- You get admitted into the hospital every 2-3 months.

Scenario B:

If the doctor is nice with you, tell him/her at the end of conversation: I am motivated with the conversations we have had. I will now go and think about it.

But if the doctor is not being nice and supportive, insist to say I do not want to quit.

Questions:

- If the doctor talks about nicotine replacement ask him/her “How will the nicotine replacement help me?”
- If doctor asks to explain options of smoking cessation, tell him “the nurses have already done that” but if doctor wants to explain, he can go ahead.
- “Why do I need to cut? I love my smoking.”

Comments

“Doctor, I have been smoking for a long period of time and the whole idea of stopping smoking completely scares me”

APPROACH:

1. **GRIPS** (Be nice to the patient, speak loudly and smile)

2. PARAPHRASE the scenario:

- “I understand that you were admitted to the hospital with chest infection. How are you doing now from the chest infection point of view? What symptoms did you have when you came into the hospital? I have been asked to come and talk to you about your condition and discuss what type of lifestyle changes can help with your condition. In particular, I want to talk about smoking. I understand that you do smoke, is that right?” Or “I also understand that you do smoke? Is it ok if we have a chat about your smoking habit?”
- **Take history of smoking:**
 - How many cigarettes a day do you smoke?
 - How long have you been smoking?
 - Have you ever thought of stopping smoking?
 - Have you ever tried to stop smoking?

3. Discuss about COPD

- How much do you understand about COPD in terms of its cause and prognosis?
- How long have you had COPD?
- What treatment are you on?
- What do you understand about the causes of COPD and its prognosis?
- How frequent do you get admitted to hospital as a result of your COP, let's say in the last year?

4. Explain that the commonest cause of COPD is smoking

- Because smoking causes damage to the lungs.
- You have told me that you have been smoking for a long time, since you were in college, so the most likely cause of your COPD is smoking.

5. Explain the course and prognosis of COPD.

- Usually COPD is caused by longstanding smoking.
- Chest infections tend to become more frequent as time goes by.
- If the condition becomes severe it may lead to heart failure.
- There are rare cases where it runs in the family but most of the time COPD it is due to smoking.
- In your case the COPD is most likely due to smoking because you have been smoking for many years.
- Do you have any liver problems? (There is a type of COPD where it runs in the family, but then it would also give you liver problems in childhood.)
- What do you understand about the prognosis of the disease? The progression of COPD can be reduced if you can stop smoking.
- Usually COPD leads to respiratory failure and unfortunately, it usually occurs at an early stage and eventually people die from respiratory failure if someone with COPD continues to smoke.

6. Explain that the most important treatment is to stop smoking.

7. Benefits of quitting smoking (Management)

Stopping smoking is the single most important factor:

- It will reduce damage to the lungs
- It will reduce the number of times you get admitted to hospital
- Reduce the progression of the disease.
- Decrease the risk of lung cancer
- Decrease risk of IHD and heart failure.

Respiratory failure is the final stage of COPD.

- Check his opinion: “What do you think about what we have discussed?”

8. Explain that there is a smoking cessation clinic which can help you quit smoking.

“Would you like me to tell you what they can do for you in case you decide to quit?”

9. Choose a quitting date

We can give you nicotine replacement treatment.

1. Nicotinic replacement therapy (NRT)

There are different preparations available, in the form of a tablet. They reduce the desire to smoke

2. **Bupropion:** You start taking this medication 1-2 weeks before you quit a day

3. Agree a quit day to a patient. IF they agree to choose a stop date, then explain that you can prescribe then a medication for 1-2 week.

4. Offer a leaflet

1st antenatal visit

Scenario 149

You are a FY2 doctor in obstetric and gynaecology department. Mrs Audrey Jones is a 25 year old lady who came for routine antenatal follow up. Mrs Audrey Jones had her last menstrual period 6 weeks ago. This is her first antenatal visit. Please assess the patient and discuss further management plan.

Patient information

You are Mrs Audrey Brown, 25 year old lady.

You had 2 previous miscarriages at 8 weeks.

The miscarriage was 2 years ago.

You are taking folic acid at the moment.

You smoked for 5 years but then stopped last year.

This is your 3rd pregnancy.

You did a pregnancy tests and you know you are 2 weeks pregnant.

This is why you have come for routine antenatal follow up.

You are fit and well and not on any regular medications.

After the 2 miscarriages, you went to see the GP but nothing was found.

The GP simply said that you should try again.

Questions:

1. Do you think everything will be fine?
2. Is it going to happen again?
3. What are going to do for me?
4. Will I be able to have a baby?
5. How can I make sure that I do not have another miscarriage?

Approach:

1) GRIPS

- Nice
- Friendly
- Eye contact
- Smile

- Know the name

2) Paraphrase the scenario:

I understand you have come for routine antenatal follow up.

- How are you?
- Is this your first pregnancy? Ok, you have been pregnant before and you know what happens on your first antenatal visit.
- Usually it involves asking you some questions, doing some examinations and arranging some investigations.

3) History taking phase:

Shall I start by asking you some questions?

- Is this your first pregnancy or you mentioned this is not your first pregnancy. How many times have you been pregnant before?
- Can you please tell me how did your previous pregnancies ended?
- I am sorry to hear that
- How many weeks was your first pregnancy when did you have a miscarriage? What about your second pregnancy, how many weeks was it?
- Do you have any medical problems?
- Have you ever suffered from clots in your legs or lungs?
- Is there anyone in your family who has ever suffered from clots in lungs or legs?
- Is there anyone in your family who has ever had a miscarriage?
- Are you taking any regular medication?
- Are you married? Are you related to your partner in any other way?
- Did you attend antenatal follow ups in your previous pregnancies?
- Did you have any problems like infections?
- Did you have any investigations done on your previous pregnancies?
- Is there any chance you use recreational drugs?
- Do you smoke?
- Do you drink alcohol?
- Have you ever been diagnosed with any sexually transmitted infections?

- What do you do for your living?
- Is there anything that could be causing stress in your life?

Now I need to ask you about your menstrual history:

- When was your LMP?
- Are your periods usually regular? How many days do you normally bleed?
- Do you experience any pains during your period?
- Do you have any thyroid problems?
- Do you have any medical problems like diabetes or high blood sugar?
- Have you ever had any operations done on you?

Examinations:

- I will need to examine you.
- Observations: Temperature, BP, HR, Pulse, Oxygen
- Abdominal examinations
- PV examination

Diagnosis:

You have had two miscarriages before, so we need to check that this is no medical condition like anti-phospholipid syndrome which is one of the common causes of miscarriages.

Investigations:

1. FBC, UTE, CFR
2. Urine test for infection
3. Infection screen (Syphilis, Hepatitis, HW, Rubella, Chlamydia)
4. USS of the abdomen

Management:

- More test of after a 3rd Miscarriage
- You have got an equal; chance of having a normal pregnancy like every other woman because you had only 2 miscarriages. The chances of having another miscarriage increases after 3 consecutive miscarriages.
- Give antenatal care information e.g "The Pregnancy Book"

- Advice lifestyle:
 - Exercise; continue moderate exercises
 - Alcohol; High consumption may result in fatal alcohol syndrome
 - Smoking; is associated with miscarriage, intra-uterine deaths, premature delivery
 - Place of birth
 - Diet
 - Folic acid supplement
 - Vitamin D

Notes:

- A miscarriage is defined as loss of pregnancy before 24 weeks
- Recurrent miscarriage is defined as loss of 3 or more consecutive miscarriages

Risk factors:

- Endocrine cause (PM, thyroid disease, PCOS)
- Inherited through syphilis
- Infections
- Structured anomalies (e.g. Uterine septum)
- Genetic abnormalities

Pre-Eclampsia at 36 week: Scenario 13

You are a foundation year two doctor in the Maternity Assessment unit. 30 year old lady, Alice Smith who has come for routine antenatal follow-up. She is 36 weeks pregnant and she has been seen by the midwife who has made the following note:

Her Blood pressure today is 160/110.

Urine Dipstick shows protein +++

Her booking antenatal blood pressure: 110/70.

Take a focused history and discuss management with the patient.

SCENARIO A:

You are Alice Smith a 30 year old lady who is 36 weeks pregnant.

You have come for a routine antenatal follow up. You have been having headache for two hours and leg swelling of your legs bilaterally.

- The midwife examined and checked your blood pressure and sent you to the obstetrics ward.

- The doctor will be here to talk to you. The midwife in the antenatal clinic found your BP to be high but she did not explain this to you.
- You have noticed swelling of your feet in the last 2 weeks and you have headaches during the same period.
- You have attended all the antenatal follow up.
- Your booking blood pressure was 110/70.

Does she understand what booking BP is?

- You are really hoping all will be fine today
- This is your 2nd pregnancy; the previous pregnancies all went fine and it was normal vaginal delivery. Your children are 2 and 5 years.
- Your pregnancy was OK, no problems in current pregnancy
- You are able to feel the kicks of the baby

SCENARIO B:

- 1st pregnancy
- Swelling of the ankle
- Attended all antenatal clinics
- Works as a secretary; in 3 days time you will be having maternity leave. You will call them and inform them.
- No visual problems.

You have been trying for 2-3 years to get pregnant and you really wanted a water birth.

Your husband and yourself have been planning to have water birth.

You have also discussed with the midwife about water birth.

QUESTIONS:

- What caused it?
 - Is it serious doctor?
 - what will happen if i don't get admitted?
 - what are the complications?
 - How will i be treated?
 - What medications will be given to me?
 - Doctor can I have a water birth?
 - If water birth is not possible, please doctor try to make it a normal delivery as much as possible.
 - The midwife and I had planned a water birth.
1. I do not want to be admitted, I do not think it's serious.
 2. Can you give me the medication and I will take them at home.

Water birth is not recommended in the following situations:

- Hypertensive
- Pre-eclampsia
- Epilepsy
- Foetus Distressed
- Induced Labour

Approach: (nice approach)

- **GRIPS:**

Paraphrase the scenario.

I understand that you have come for routine antenatal follow up. And i understand that the midwife has checked your BP and tested your urine. Has she explained the results of the BP and urine test. I will explain the results of these tests before that can i just ask you a few questions?

- **Take a history**

- Is this your first pregnancy?
- How has pregnancy been so far?
- Any problems so far (bleeding, Hypertension, high blood sugar, vomiting)?
- What was your BP the first time you went for your antenatals?
- Anybody in the family had problems during pregnancies like increased BP or increased Blood Sugar?
- Do you know how many babies are you expecting?

- **Red flags**

- Tummy pain
- Vision problems
- Headaches
- Fits

- **MAFTOSA**

- Are you feeling the kicks of the baby?
- Ask about symptoms of Pre-eclampsia: Headache, abdominal pain, swelling of the legs, blurry vision.

Booking Blood pressure

- Explain the results of BP and urine dipstick .
- Break news of the diagnosis: pre-eclampsia
- Common complications of pregnancy if not treated e.g. seizures,
- Pre-eclampsia is a potentially dangerous condition

- **Management**

- Admit
- Give medication (Labetalol) control BP less than 150mmhg
- Examine the baby-Antenatal examination (presentation, lie, position)
- CTG machine (To check that the baby is not in distress. If the baby is in distress we might suggest a cesarian section)
- Check urine
- USS to check that the baby has been growing well.
- Continue monitoring vitals i.e. BP, temp, pulse
- Blood tests especially LFTs to rule out HELLP syndrome as well as FBC and U&Es and LFTs.
- Negotiate the management with patient (Are you okay with it) and address concerns
- Explain that water-birth would not be advised due to close monitoring required in labour as a result of pre-eclampsia, CTG and BP need to be monitored.
- MgSO₄ to prevent a seizure, if the BP is above 160/110.
- C-section if the monitoring during labour suggests baby is in distress.
- Offer leaflets for more information about pre-eclampsia

Gonorrhoea in a woman

Scenario 40

You are FY2 doctor in Genito-Urinary Medicine Clinic. A 24 year old lady came to the GUM clinic 1 week ago to be tested for sexually transmitted infection. The results are back from the laboratory and shows that the patient is positive for gonorrhoea infection. Take a sexual history and discuss management with the patient.

PATIENTS INFORMATION:

You are a 24-year-old lady who came for STI testing 1 week ago.

SCENARIO A:

She saw a TV advert about STIs.

She is in a new sexual relationship for 3 weeks

2 or 3 sexual partner in the last 6 months

She is married

SCENARIO B:

She had symptoms(PV discharge, lower abdominal pain) New partner in the last 3 weeks. She was in a relationship for 5 years before and broke up 1 year ago. She is not married now

SCENARIO C: Was reading a newspaper and read about STI infections

SCENARIO D:

You are reading on the internet about STI and you decided to come for a check up.

Your partner does not have any symptoms.

Questions

- Did I get it from my partner?
- Where did I get it?
- Is it curable?
- “I do not have a problem in telling my partner about the diagnosis, I can tell him”
- Are there any complications?
- Which antibiotics will you give me?
- What treatment will you give me?
- How long do i need to take the antibiotics?
- Are there any complications?
- How common are these complications?

Approach:

1. GRIPS

2. Paraphrase the scenario: You came to the hospital to be tested for STI 1 week ago. Has anyone explained the results to you?

3. Break bad news: Unfortunately the results include bad news – the test shows that you have a sexually transmitted infection called Gonorrhoea

Pause to allow the news to sink before proceeding.

4. Reassure that Gonorrhoea is a curable condition. There are some antibiotics that can be given.

5. Take a focused History

- Can I ask some questions to see if there is anything you need to do to prevent this infection in the future?
- Some of the questions may be personal but if you find it too much, please let me know and we can stop.
- Questions:
 - Are you in a stable relationship?
 - How long have you been with your current partner?
 - Do you practice safe sex i.e. use condoms?
 - Are you experiencing any symptoms like discharge, tummy pain, fever?
 - What made you come to the clinic to get tested for STI?
 - Have you ever been diagnosed with STI before?
 - Is your partner experiencing any symptoms?
 - Are you using any form of contraception?
 - How long ago was your previous relationship?
 - Have you ever had sexual intercourse for casual purposes?
 - Other than your current partner do you have any other sexual partners?

What medications will you give me?

- A single dose (Ceftriaxone 500mg IM in 1 dose and Azithromycin 1g orally in 1 dose)
- We also need to treat your sexual partners

Did I get it from my partner?

- Unfortunately, it is a sexually transmitted infection, which means you could have gotten it from your partner.
- But you have had more than one partner in the past. So it could be from any of your partners in the past 6 months.
- Is it ok if you can discuss this situation your current partner and ask your partner for testing and treatment?
- This bug can live in our body for a very long time without showing any symptoms so we need to treat all sexual partners in the last six months.
- Is it ok if you can give us the contact details of you previous partners so that we can contact them, invite them for testing and treatment. We will not reveal that we got the details from you.

Are there any complications?

- Infertility: (there is a solution)
- Ectopic pregnancy: if you notice any tummy pains or miss a period, come back to the hospital
- Dysmenorrhea: analgesia
- Dyspareunia
- Chronic infection (PID): that can flare up from time to time and present with PV discharge and lower abdominal pain, fever then you need to go to the hospital.

But with treatment all complications can be avoided.

No sexual intercourse when on treatment.

6. Explain what will happen next:

- Advise to use barrier methods
- Follow up in 2 weeks for repeat swab to make sure that the infection has cleared.

- Avoid having sex until we have repeated the tests and show that you do not have the infection.
- Watch out for warning signs:
 - lower abdominal pain
 - fever
 - vaginal discharge
- If you have any of these symptoms please come back.

7. Advice to get tested for other STI's like HIV and Hepatitis.

8. Refer to GUM clinic if there is need for contact tracing.

- Change of partners in the last 6 months.

Prevention:

- Explain that STI can be prevented by using condoms.

Acute pelvic inflammatory disease:

Scenario 65

You are a foundation year two doctor in the Emergency Department. A 30-year old lady who has presented with right lower abdominal pain. Take a focused history, perform relevant examination and discuss management with the patient.

Patient Information:

- You are Ms Nicola Addison a 30-year-old lady who presented to the emergency department with lower tummy pain.
- You have had right sided lower tummy pain for 3 days.
- It's 8/10 severity.
- You felt sick but you did not vomit.
- You have also noticed foul, smelly, greenish vaginal discharge for the past 5 days.
- You are sexually active and you use IUCD as a form of contraception.
- You are in a new relationship with your new male partner for the last 3 weeks ago.
- You have had 3 partners in the last 6 months.
- Your partner has no symptoms.
- Your IUCD was inserted 1 year ago.
- You are normally fit and well, not on any medication.
- LMP 4 weeks ago.
- You feel hot generally, but you did not check the temperature.
- You have never been diagnosed with any sexually transmitted infection before.

QUESTIONS:

1. What is wrong with me?
2. Will I be treated here?
3. Where did I get it from?
4. Did I get it from my partner?
5. Is it something you can cure?
6. Are there any complications?
7. Will I be able to get pregnant?

Observations:

- Temperature - 38°C
- Pulse - 98
- BP - 110/70
- RR - 14
- Sats - 98%

- **Per vaginal examination:** cervical excitation is positive and greenish discharge on the gloves.
- **Abdominal examination:** right iliac fossa tenderness, no rebound or guarding and no adnexal masses.

Approach:

GRIPS: Smile, be loud, confident, shake hands

History taking phase: How can I help you?

Empathy - Are you comfortable? Do you need any pain killers?

1. SOCRATES (can you tell me more about the pain?)

- Any PV bleeding or discharge?
- If any discharge, then is there any colour or smell?

2. Differential Diagnosis (endometritis, ectopic pregnancy, ovarian cyst, appendicitis, PID, miscarriage, UTI, pyelonephritis, renal stones)

3. P3MAFTOSA (Personal - Sexual and Menstrual)

- How to check the IUCD/When was it inserted?
- Do you know how to check if the IUCD is on place? And when was the last time she got checked?

Examination:

Explain what examinations you would like to perform.

1. Observations (Temp, Respiratory rate, Heart Rate, BP, Pulses, Oxygen levels)
2. Explain that you need to perform abdominal examination or examination of the tummy.
3. Vaginal examination to check for any bleeding or discharge.

Explain the findings to the patient:

From what you have told me most likely you have a condition called Pelvic Inflammatory Disease. This is an infection of the womb, tubes, and the ovaries. It is usually caused by sexually transmitted infections. The common infections are chlamydia and gonorrhoea infections. Explain the differential diagnosis: Infection of the wombs and tubes: Pelvic inflammatory disease (uterus ovaries and tubes).

Management:

- Admission
- Blood test: Inflammatory markers - to see how severe the infection is?
- FBC, U& E, LFTs, CRP, ESR
- Blood cultures: To look for any infection in the blood.
- Take swabs: Take some swab
- IV antibiotics
- Refer to the Gynaecologist
- Pregnancy test - Is it possible for you to give us urine, so that we can perform a pregnancy test?

You need to rule out pregnancy, explain why:

- No contraception is 100% safe
- IUCD is a risk to infection/ectopic pregnancy.

Q1: Where did I get the infection from?

It is a sexually transmitted infection which means you got it from one of your partners.

You mentioned that you have been in a new sexual relationship in the last 3 weeks and also you had other partners in the last 6 months

So it could be from your current partner or previous partners unfortunately.

Q2: Can it be cured?

Yes, it is a curable condition. There are antibiotics which we can give you and they can cure the infection.

Q3: Are there any complications?

Unfortunately, there are some complications that may occur

- Infertility - difficulty getting pregnant
- Ectopic pregnancy - when you get pregnant, the pregnancy could be outside your womb
- Solution: So if you miss your periods and you develop any sort of abdominal pain, you need to seek medical help. But if that were to happen, there is a solution to that as well.
- Dysmenorrhoea: Which is painful periods. But you can always take painkillers if that happens
- Dyspareunia: This is pain during intercourse.

Patient: so what are you going to do for me?

Refer to the hospital to the gynaecologist for assessment.

- Explain that sometimes they might remove an IUCD after 3 days if there is no improvement of the infection.
- Admit under gynaecologist.
- Ask if she knows about how to check that an IUCD is in place.
- USS will need to be done in order to assess that there is no collection of pus anywhere in the tubes or anywhere in the body and also to check that the IUCD is in place.
- Advise to bring partners to get screened for STI in order to treat this infection effectively. We will need to treat your partner as well
- Are you comfortable to discuss this with your partner?

- Offer leaflets to the patient.

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Contraception in a 30 Year old

Scenario 2

You are an FY2 in GP surgery. Sue Hale, aged 30, has made a routine appointment to see you. Please talk to the patient and address her concerns.

PATIENT INFORMATION

Opening sentence: Doctor I want to know about the contraception pill. You are a 30 year old lady Sue Hale. You have come to see the GP to request for contraception. You traveled to Australia 1 year ago by flight, a journey which took about 12 hours. You developed swelling in the legs. You were admitted and given blood thinner tablets (Warfarin) for about 6 months.

- You have tried diaphragm and condoms in the past but you got pregnant with your second child so you are very keen to know about the failure rate of each contraception
- You have 2 children
- You like the idea of combined pills but if the doctor advises you it is not appropriate for you, you are okay with it and you accept his/her opinion
- You are a nonsmoker
- Stable partner
- No medical history, no allergies, no medications
- Your friend recommended you a pill.

Questions

- So what options are there for me?
- What is the failure rate? (ask failure rate for each and every type of contraception)
- Are there any side effects?
- Are there any complications?
- Which is the best?

SCENARIO B.

Your boyfriend used condoms and you have tried diaphragm as well. You had DVT 2 years ago and you were treated with warfarin. Last smear was one year ago and it was normal. Your last menstrual period was 5 days ago.

1. Doctor can you tell me which one is the most effective?
2. Do the COCP and POP have the same failure rate?
3. Are there any risks for a coil?

Candidate should be able to explain the following types of contraception:

- **COCP**

- Daily
- 21 days cycle
- Failure: 3:1000
- Contraindicated in this patient

- **POP**

- Daily
- Failure 3:1000
- Side effect: intermenstrual bleed

- **Patches**

- Weekly
- Failure: 3: 1000
- Side effect: intermenstrual bleed

- **Depo Provera**

- Intramuscular injection
- Have to go to GP
- 3 months once
- Failure 2:1000
- S/E: intermenstrual bleed

- **Implant**

- Device inserted under the skin of the inner arm under LA
- Protection up to 3 years
- Failure: 1:2000
- S/E: intermenstrual bleed

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- **Mirena Coil**

- Intrauterine device
- Mechanical and hormonal block
- Helps with dysmenorrhea, fibroids
- S/E: ectopic, PID
- Protection up to 5 years
- Failure: 2:1000

- **IUCD**

- Copper T
- Intrauterine device
- Mechanical block
- S/E: ectopic, PID, dysmenorrhea, uterine perforation, menorrhagia
- Protection up to 5 years
- Failure: 8:1000

- **Permanent contraception**

- Female sterilisation
- 1:200

For each and every contraception, the candidate should give the failure rate, advantages and disadvantages.

Approach:

- GRIPS
- How can I help?
- Is there any particular contraception you want to know or you just want to know the available options?
- Take a history to assess the suitability for contraception
 - PMH
 - Previous contraception used
 - DVT
 - Migraine
 - Medications
 - Allergies
 - Menstrual Hx (LMP, irregular cycle, dysmenorrhea)
 - Any children?
 - Finished family?
 - Have you tried any other contraception? How long are you planning to use the contraception for?
- Counselling
- Explain each contraception giving advantage and disadvantage of each one
- Tell the failure rates
- **Recommend contraception according to her history**

Contraception in a 15 year old.

Scenario 252

FY2 in the GP surgery. Heather Watson is a 15-year old female who has made an appointment to see you. Talk to the patient and address her concerns.

Patient information:

You are 15 year old Heather Watson and you suffer from migraines with aura. The aura begins about an hour before the migraine and you experience visual problems where you see zigzag lines. You also experience associated nausea and sometimes vomit.

The headache is usually left sided. You take paracetamol for the headaches. You are otherwise fit and well. You have a 15 year old boyfriend and you are sexually active. Up till now you have been using condoms but your boyfriend doesn't like them so you want to see the GP to discuss what other options you have for contraception.

Questions:

1. Can it be kept confidential?
2. How will I be taking POP?
3. What are the side effects?
4. What is the failure rate?

Approach

1. GRIPS

- May I know what brought you to the practice today?
- Can I ask some questions to understand your situation better?
- Usually it is a practice policy that any one under 16 years of age should attend the practice with their parents.
 - Have you come on your own?
 - And do you parents know that you are here?
 - Ok, It's ok I will see you, now that you are already here.
 - And do your parents know about your sexual relationship?
 - Is there any particular reason you have not told your parents about your relationship?

Reassure that we can definitely help with contraception.

2. Offer confidentiality: Reassure that whatever is discussed will be kept confidential .

3. Ask about her sexual relationship and assess for abuse.

Can I ask you about your sexual life:

- Are you in a stable relationship ?
- How long have you been together with your partner?
- How old is your partner?
- How has everything been going with your partner?
- Has your partner ever been aggressive towards you?
- Has he ever forced you to have sexual intercourse when you didn't want to?

4. History of contraindications - Now I need to ask you few question to assess your suitability of contraception?

- Diabetes , hypertension , heart problems. , fibroids, precious ectopic , epilepsy , headache, migraine , CVS risk , breast feeding .

5. Menstrual history-menorrhagia

- Last menstrual period?
- How many days do you bleed?
- How many days is your cycle?
- Are your periods regular?
- Are your periods heavy?
- Do you experience any pain during your periods?

6. Previous contraception:

- What contraception have you tried in the past?
- What about condoms - have you tried them?
- How does your partner feel about using condoms?

7. Assess for Gillick competence :

- I need to ask you some questions to check that you understand why you need contraception
- Can you explain to me why do you need contraception?
- What would happen if you do not use contraception ?
- And do you know some of the risks of being in a sexual relationship ?

8. Assess for Fraser criteria:

- Do you think you can try and talk to your parents about your relationship?
- Your parents were of your age at one point - they may understand .
- How would you feel if you not prescribed contraception today?
- If you are not prescribed contraception, do you think that would stop from being in sexual relationship?
- Would you consider using condoms - they would also protect you from sexually transmitted infections.
- Contraception does not protect from STI.

DISCUSSION - Fraser criteria :

Prescribe contraception only if the following criteria are met:

- The young person understands the practitioner's advice.
- The young person cannot be persuaded to inform their parents or will not allow the practitioner to inform their parents.
- The young person is likely to begin or continue to have sexual intercourse with or without protection.
- The young person's best interest requires the practitioner to give contraceptive advice or treatment without parental consent.
- Unless he or she receives contraceptive advice or treatment, the young person's physical or mental health is likely to suffer.

9. RULE OUT PREGNANCY :

- Last menstrual period
- Last sexual intercourse

10. Examinations:

- Abdominal
- Blood pressure
- BMI

11. Explain different options of contraception

- Combined contraception (vaginal ring, transdermal patch and pills)
- POP
- IUCD
- Levonorgestrel (IUS)
- Barrier methods (condoms)

12. Screening for STIs: If she has had unprotected sexual intercourse, explain that sometimes it can be symptomatic

13. Prescribe the contraception if you have reached an agreement with the patient and offer leaflets about contraception

Note:

This patient has got migraines so COCP can worsen headaches.

We should advice POP.