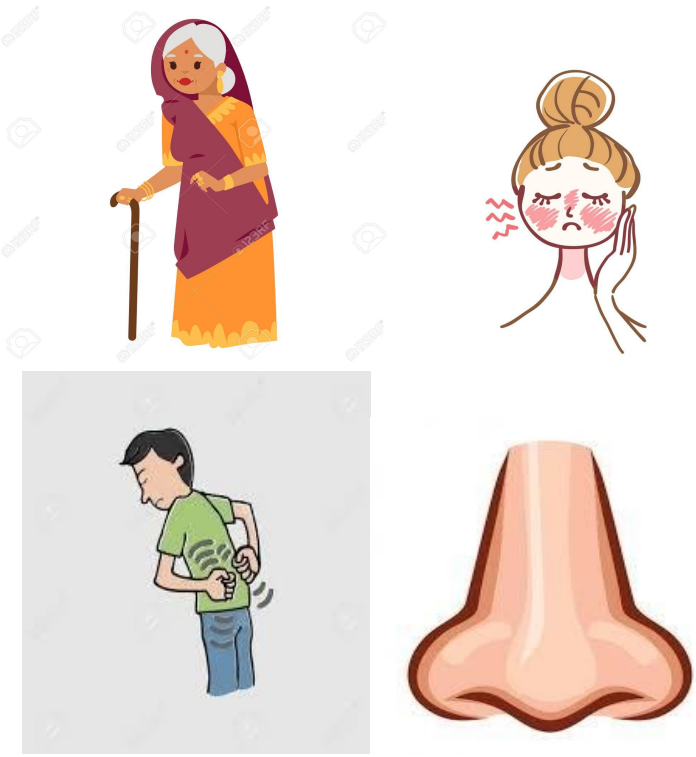
# Consultation Skills Placement

# Student Guide

# 2022-2023



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# Student Guide

During this extraordinary time we have had to adapt our structured face-to-face teaching to a virtual model, however this year we are pleased to announce it will be going back to F2F for many reasons but mostly due to your feedback. These sessions are mandatory, attendance will be taken and remediation will be given if poor attendance noted.

The simulated surgeries for Health Care of the Elderly, Dermatology and Musculoskeletal Medicine, and will take place on Tuesday, Thursday and Friday afternoons of the Central teaching week in the Robin Brook Centre. **Please exercise current COVID recommendations as per current guidance.**

During the afternoon the groups will run three clinical scenarios. This student guide contains the learning objectives, student instructions, useful references, some clinical notes and an appendix on consultation skills for all of the scenarios

The aim of the module is to provide clinical knowledge of conditions commonly encountered in primary care but also to give you the opportunity to develop and improve your consultation skills.

**Preparation for teaching session…**

You may be asked to do any one of the scenarios.

- **Please bring this student guide to each simulated surgery session, which you will need to read in advance**. **You will find the consultations easier if you have read up the clinical background beforehand. These sessions give you an opportunity to integrate clinical knowledge with good communication.**
- **Mondays ENT PM sessions are run slightly differently to the other days.**
- **Pen and paper** – to aid you with observing your colleagues and allow for more constructive feedback

These sessions provide a good opportunity to role-play with actors and receive constructive feedback during your 4th year. We hope these will help develop your consultation skills and also enable you to start thinking about how you might investigate and manage patients. This should help you in real-life situations with patients, as a FY doctor and in preparation for OSCE examinations.

These sessions are facilitated by General Practitioners who are experienced in communicating and consulting with patients and also have clinical knowledge and practical wisdom to share regarding the reality of working as a doctor. Please as always treat them with respect and arrive on time.

If your GP tutor has concerns about your consultation skills, they may address this with you privately at the end of the session and inform the academic lead for the session. The academic lead may contact you directly if any follow up is needed.

**Please above all enjoy and GET INVOLVED!**

# Dermatology cases

## Case 1 Dermatology – 3 year old boy with eczema

### Student Information

**Learning objectives**

- To understand the routine management of eczema and to be able to explain this to patients and their carers.
- To understand the ways in which atopic eczema may impact a patient and/or their family psychosocially.
- To manage parental anxiety and set realistic management goals to manage moderate eczema

### Student Instructions

You are a FY1 doctor on your GP attachment. During your morning surgery you are asked to see Mrs/Mr Jones with her/his 3-year-old son. He has been irritable for the past 4 weeks, constantly rubbing a rash on his arms and legs. He was seen by one of the partners 2 weeks previously with the same complaint.

He was diagnosed with eczema and diprobase ointment, oilatum bath oil, aqueous cream and hydrocortisone 1% ointment were prescribed. Mrs/Mr Jones feels that this has not helped.

- Take a history from the parent, ask to examine the rash (you will be shown a picture of this)
- Then explain your management plan. Please take into consideration how the eczema could be better controlled as well as supporting Mrs/Mr Jones.

You may want to think about

- Adequate use and application of prescribed medication
- Is it necessary to increase medication, add in further medication?
- Looking for possible triggers (e.g. food allergy, atopic history).
- Indications for referral
- Patient quality of life

### Key Points

**Quality of life**

Research on the impact of chronic skin disease on patient's quality of life generally shows that relative to the general population, patients report a lower level of psychological and

social well being. Consequently, when assessing a patient with a chronic skin disease it is essential to explore the psychological and social impact of this condition on their life. It is well documented that the quality of life of a parent with a child with atopic eczema can be adversely impacted by the condition particularly when it is poorly controlled. NICE 2007 recommend asking about the effect of eczema on daily activities (school, work, and social life), sleep, and mood and categorising the impact of eczema on quality of life and psychosocial well-being in terms of

- No impact on quality of life.
- Mild: little impact on everyday activities, sleep, and psychosocial well being.
- Moderate: moderate impact on everyday activities and psychosocial well-being, and frequently disturbed sleep.
- Severe: severe limitation of everyday activities and psychosocial functioning, and loss of sleep every night.

**Eczema – Atopic Eczema: NICE CKS 2007. Last revised in April 2022.**

The stepped approach, recommended by the National Institute for Health and Care Excellence (NICE), for the treatment of atopic eczema is shown in Table 1.

Treatment can be stepped up or down according to the severity of the condition. Treatment of a flare will often require temporarily 'upping' the intensity of treatment (for example the strength of corticosteroid).

https://cks.nice.org.uk/topics/eczema-atopic/

**Table 1.** Stepped treatment options for atopic eczema.

| **Mild atopic eczema** | **Moderate eczema** | **Severe eczema** |
|---|---|---|
| Emollients | Emollients | Emollients |
| Mild potency topical corticosteroids | Moderate potency topical corticosteroids | Potent topical corticosteroids |
| | Topical calcineurin inhibitors (tacrolimus or pimecrolimus)* | Topical calcineurin inhibitors (tacrolimus or pimecrolimus)* |
| | Bandages* | Bandages* |
| | | Phototherapy† |
| | | Oral corticosteroids‡ |

* Usually only prescribed by a specialist (for example a GP with a specialist interest in dermatology, a dermatologist, or a paediatrician).

† Phototherapy is available in secondary care for the treatment of very severe eczema that has proved resistant to standard treatment. Systemic immunosuppressants (for example ciclosporin and azathioprine) are also available in secondary care for the same indication.

‡ Oral corticosteroids can be prescribed short-term in primary care for severe flares. Other systemic treatments suitable for maintenance of severe eczema (for example ciclosporin or azathioprine) require referral to secondary care.

With the use of potent immunosuppressive drugs initiated in Secondary Care and once stabilised, there are often "Shared Care Guidance" between specialists and generalists. Agreeing that the GP with take responsibility of prescribing the medication and any blood monitoring etc. which is needed as a consequence.

**Steroid Ladder**

| **Brand/Product Name** | **Generic Name** | **Relative potency** |
|---|---|---|
| Dermovate | Clobetasone Proprionate 0.05% | Very Potent |
| Elocon | Mometasone furorate 0.1% | Potent |
| Betnovate | Beclomethasone valerate 0.1% | |
| Eumovate | Clobetasone butyrate 0.05% | Moderately Potent |
| Hydrocortisone 1% | Hydrocortisone 1% | Mild |

**Application of Emollients**

**Primary Care Dermatologist Society**

Step 1: General measures

- As with other chronic skin conditions time is needed by the GP and / or practice nurse to discuss the condition, advise on how best to use emollients and to provide an individual management plan
- Note patient a patient information leaflet is helpful
- Provide a management plan:
    - PCDS management plan
    - The University of Bristol Written Eczema Management Plan
- Advise on a pre-payment certificate where appropriate (know the cost) https://www.nhsbsa.nhs.uk/help-nhs-prescription-costs/prescription-prepayment-certificates-ppcs

- At each step it is essential to ensure patient compliance and to make sure that copious amounts of emollients are being used

- For patients presenting with a flare-up go to step 2, for those presenting with relatively mild eczema go to step 3

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Step 2: initial management for patients presenting with a flare-up

- In both children and adults it is more effective and safer to 'hit hard' using more potent treatments for a few days than it is to use less potent treatments for longer periods of time

- For marked sleep disturbance consider the short-term use of a sedating anti-histamine at night

- Take a skin swab if not settling

- Review the patient in one to two weeks to discuss long-term management (see step 3 below)

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Step 3: long-term management

Consists of a) complete emollient therapy, b)topical steroids, and sometimes c)bandages

a) Complete emollient therapy

Emollients are the mainstay of therapy and without them it is not possible to manage eczema effectively. Good evidence shows that the more emollients are used, the less topical steroids are needed. Compliance is essential and so always review patients to check they are happy with what has been prescribed - it may be necessary to try a range of emollients before the patient settles on the best combination.

- Moisturisers
    - Most patients prefer creams and gels. The most important factor is to find one that the patient likes and is happy to use

    - Ointments tend to be less well tolerated by patients, but they are less likely to cause contact allergic dermatitis as they do not contain preservatives

    - Encourage appropriate usage by prescribing generous amounts eg 500 grams of moisturisers to use regularly (often QDS)

    - As with other topical treatments, moisturisers should be gently rubbed into the skin until they are no longer visible.

    - Warn that they may sting (also red) for the first couple of days before soothing the skin

    - Order of application - if topical steroids are also being used, moisturisers can be applied first and allowed to dry for 15-20 minutes before applying the topical steroid

- Bath / shower formulations

    - In general, there is no good evidence to support the use of specific products to use in the bath/shower

    - Patients should be encouraged to have short showers/baths and not have the water over hot

    - The same emollients used to moisturise with can be used as a soap substitute should the patient so wish

    - Careful consideration must be given as to whether or not to use emollients to wash with in patients with poor mobility due to the increased risk of slipping in the bath or shower

- Hand eczema and soap substitutes
    - Although patients like soaps as they make a lather, they damage the skin barrier and so should be avoided where possible

    - Although specific soap substitutes can be prescribed it is probably more cost effective to use one of the prescribed moisturisers as a wash - ointments in particular can provide an effective wash

b) Topical steroids

- Use the lowest appropriate potency and only apply thinly to inflamed skin

- Allow moisturisers to dry into skin for 20 minutes before applying the steroid

- Strength of steroid to be determined by the age of patient, site and severity:

- If used appropriately it is uncommon to develop steroid atrophy, however extra care needs to be taken in the following sites:
    - Around the eyes: unless used very infrequently topical steroid preparations should be avoided due to the risks of glaucoma
    - The face - the regular use of topical steroids should be avoided

c) Bandages and dressings

- Some patients find dry bandages or medicated dressings helpful

- There is no good evidence to support the use of wet wraps, although some patients find them soothing

Step 4: management of flare-ups

- For infrequent flares, eg every four to eight weeks, manage as in step 2
- For more frequent flares
    - Check treatment compliance
    - Consider the steroid weekend regime for both children and adults - Betnovate ® or Elocon ® should be applied thinly to inflamed areas OD for two weeks and then alternate days for a further two weeks. Once the eczema is under control use the treatment on two consecutive days
    - An alternative to using topical steroids is to use Protopic ® ointment
    - In general, antibiotics have a limited role in eczema, however, if the eczema continues to flare swab the skin and treat if results are relevant.
    - Patients not responding to the above - consider the possibility of a contact allergic dermatitis, which can sometimes be caused by topical therapies.

Step 5: treatment with topical calcineurin inhibitors

- The topical calcineurin inhibitors are Protopic ® (tacrolimus) and Elidel ® (pimecrolimus)
- Their main benefit is that they are not steroid-based and so do not cause skin atrophy
- National guidance states these treatments can be initiated by any health professional experienced in treating eczema - this of course includes General Practitioners
- Local adverse effects include stinging, burning, itch, irritation and slight photosensitivity - appropriate sun protection is recommended. Adverse effects are more common with Protopic but in many patients are transient. Topical calcineurin inhibitors should be temporarily discontinued when the skin is infected
- When to consider topical calcineurin inhibitors:
    - Eczema involving the eyelids and peri-orbital skin
    - Patients regularly using topical steroids on the face
    - Patients regularly using topical steroids on the lower legs in elderly patients and others at risk of leg ulcers
    - Any signs of skin atrophy

Step 6: management of scalp eczema

- Wash with a mild tar-based shampoo.
- For itch and erythema use a topical steroid scalp application, eg Betacap ® OD-BD until the itch settles, and then use when needed.
- If a lot of thick scale is present, before commencing topical steroids, remove the scale with Sebco ® ointment

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Step 7: referral to a specialist

The following patients should be referred to a specialist:

- Diagnostic uncertainty
- Severe eczema
- Moderate-severe eczema only partially responding to steps 1-5
- Steroid atrophy or concerns regarding the amount of topical steroids / topical calcineurin inhibitors being used
- Possible cases of contact allergic dermatitis

Habit reversal therapy

- Itchy skin conditions can understandably lead to behaviours such as scratching, rubbing, and/or picking as ways to try and cope. Eventually the behaviours can become habits. Habit reversal therapy is a treatment programme that offers a solution to the behaviour that has developed, attached is a patient information leaflet. Unfortunately, therapy is not widely available

**Finger Tip Units (FTU)**

In the UK most topical steroid tubes have a 5mm nozzle. Based on this, finger tip units (FTU) can be calculated. An FTU is the amount of ointment/cream expressed from the distal skin crease to the tip of the palmar aspect of the index finger. This is roughly the same in males and females. One finger tip unit is enough to cover an area roughly equivalent to two hand areas. If you have eczema covering the area of your palm, half a fingertip is needed of topical steroid to cover this.

**Useful references**

Atopic eczema in children http://guidance.nice.org.uk/CG57

UK National Eczema Society www.eczema.org

Please note that a study in the BMJ 2018 showed not additional benefit in childhood eczema with bath additives but soap free washes and leave on emollients continued to show benefits. https://www.bmj.com/content/361/bmj.k1332

## Case 2 Dermatology – 40 year old accountant with a longstanding rash on his/hers elbows and knees

### Student Information

**CLearning objectives**

By the end of this station the student should

- Have attempted to develop a shared management plan with a simulated patient
- Understand the basic principles of negotiating a shared management plan (**See Appendix 2)**

### Student Instructions

You are a FY1 Doctor on your GP attachment. Your next patient is a 40 year old man/women with 2 year history of a rash that seems to be worsening. He/she has recently started propranolol for stress at work and noticed that the rash got worse after starting this medication. Sam Bailey.

Please speak to this patient in order to formulate a diagnosis and negotiate a management plan.

You may want to consider general management:

- Explanation of diagnosis to patient and patient given written information
- Discuss treatment options, benefits and side effects and agree a management plan

### Key points

Topical therapy: Try to keep the number of treatments per day to a minimum to improve concordance

1st line treatments

- Regular Emollient to reduce scale and itch – even in scalp –eg hydromol. Can help soften scales and allow medication to be used more effectively subsequently.
- Topical steroids –short-term intermittent use of a potent topical steroid such as beclomethasone 0.1% or in combination with calcipitriol e.g. dovobet
- Vit D analoge eg. Dovonex

2nd line treatments

- Coal tar (solution, cream or lotion)
- Tazarotene gel

- Short contact dithranol – for 30 minute exposures in patients with a few but relatively large plaques

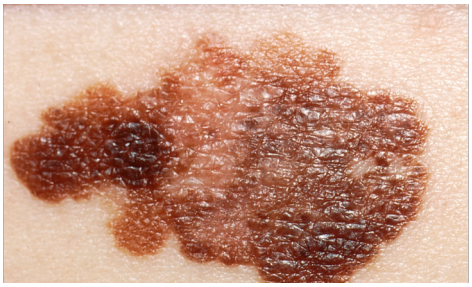
Can use with expert guidance in primary care - Topical calcineurin inhibitors (tacrolimus or pimecrolimus

**Useful references**

Primary Care Dermatology Society: A –Z of Diagnosis: Psoriasis (including drugs causing psoriasis) http://www.pcds.org.uk/p/a-z-of-clinical-guidance-how-to-use

http://www.patient.co.uk/doctor/Chronic-Plaque-Psoriasis.htm

## Case 3 Dermatology – 50 year old landscape gardener with a suspicious mole



### Student Information

**Learning objectives:**

By the end of this tutorial the student should:

- Be aware of two validated mole risk assessment tools (Glasgow seven point check list and ABCDE system)

- Have an attempt at discussing the implications of a suspicious mole and the next steps in management.

It can be daunting when referring someone for investigations to rule out cancer. This will involve breaking the "bad" news (of a sort) to the patient in a sensitive and tactful manner.

**(See Breaking Bad News Framework in Appendix 3).**

### Student Instructions:

You are a FY1 doctor on your GP attachment. This 50 year old (Kelly/Keith Wise) landscape gardener has come to see you today because the mole on his/her back has become itchy and their partner told them to.

- Please take a history from this patient.
- Describe the mole.
- What is the likely diagnosis?
- Please explain the next steps in management

### Key Points

**Malignant Melanoma of the Skin**

**Epidemiology**

1. More common in women than men. 6th most common cancer in females and males
2. Less common than non-melanoma skin cancer (BCC/SCC)
3. Incidence- women: 16.5/100,000. Men 15.9/100,000
4. Lifetime risk of developing melanoma in the UK 1in 61 for men and 1 in 60 for women
5. Amongst white populations the incidence of malignant melanoma of the skin is rising
6. Median age of diagnosis men 62 years of age, women 60 years of age

**Distribution**

- Men: head and neck (22%), trunk (41%), arm (18%), leg (13%)
- Women: head and neck (14%), trunk (19%), arm (23%), leg (40%)

**Subtypes**

- Superficial spreading malignant melanoma – most common subtype (70% of all MM. Most commonly presents on the trunks of men and legs of women)
- Others: Nodular malignant melanoma, Lentigo malignant melanoma, Amelanotic malignant melanoma, **Acral lentiginous melanoma inc subungual – most common in pigmented skins.**

**Risk Factors**

PMH or FH of MM
DH of immunosuppresants e.g. Methotrexate, Ciclosporin etc.
Naevi are the most powerful predictor of melanoma.

- A person with >100 has a 5-20 fold increased risk of MM
- Sun exposure (short sharp burst of acute exposure in childhood, severe sunburn, where did they grow up?)
    - Occupation and leisure (gardeners, air crew, cricketers and those involved with outdoor pursuits)
    - Past sunbed use particularly when <30 years of age
- Skin pigmentation (skin type 1 or 2: fair skin, red/blonde hair, blue eyes and freckles)
- Solar keratoses

- Atypical naevi
- Atypical mole syndrome
    - >100 common moles (2mm in diameter)
    - >two atypical naevi (5mm in diameter)
    - Naevi in unusual sites e.g. breast in females, buttocks, scalps, ears, dorsum of feet and hands, irises

### Useful references

Melanoma UK https://www.melanomauk.org.uk/pages/category/our-community

**Glasgow Seven point check list**

- Major features: Change in size, Irregular shape, Irregular colour
- Minor features: Diameter >7mm, Inflammation, Oozing, Change in sensation

**ABCDE system**: **A**symmetry **B**order irregularity **C**olour variation **D**iameter over 6 mm **E**volving (enlarging, changing)

**Management in Primary care** 2ww referral criteria for skin cancer.

## Case 4 Dermatology – 32 year old with Acne

### Student Information

**Learning objectives**

- Being able to describe acne in dermatological terms and have awareness of categories of severity.
- Understand common steps to management.
- Understand the psychological issues associated with acne.

### Student Instructions

You are an FY1 in GP. This 31yr old women/man has come to see you today, she/he wishes to discuss her/his acne. She/he saw your colleague 3-4 weeks ago and was prescribed a topical treatment called DUAC (benzoyl peroxide/clindamycin).

- Please take a history
- Describe the rash
- Discuss common management steps and follow up.

You will be shown a picture of her/his acne during the consultation and will be asked to describe it by the tutor.

## Key points

**What are the clinical features of acne vulgaris? NICE CKS**

Acne affects areas of the body with a high density of pilosebaceous glands such as the face, chest and back. Clinical features vary widely depending on severity and the person affected.

Comedones must be present for a diagnosis of acne to be made — if not present other diagnoses should be considered.

- Suspect acne in a person presenting with:
    - Non-inflammatory lesions (comedones), which may be, open (blackheads) or closed (whiteheads).
    - Inflammatory lesions such as:
        - Papules and pustules
        - Nodules or cysts - In very severe acne nodules may track together and form sinuses (acne conglobata).
- Scarring
- Pigmentation
- Seborrhoea

There is no universally agreed scoring system for acne severity but categorising into mild, moderate and severe can be helpful in selection of appropriate treatment and monitoring of response:

- Mild acne — predominantly non-inflamed lesions (open and closed comedones) with few inflammatory lesions.
- Moderate acne — more widespread with an increased number of inflammatory papules and pustules.
- Severe acne — widespread inflammatory papules, pustules and nodules or cysts. Scarring may be present.

Images of acne and its clinical variants can be viewed at www.dermnet.org.nz

**How should I manage a person with acne vulgaris in primary care? NICE CKS**

**https://cks.nice.org.uk/topics/acne-vulgaris/**

**General advice**

- Cleaning — Acne is not caused by poor hygiene. Aggressive washing can aggravate acne and should be avoided

- Healthy diet — The role of diet in acne remains poorly understood — emerging data suggests that high glycaemic index (GI) diets may exacerbate acne

**Follow up**

- Several guidelines recommend follow up to determine the need for ongoing patient education, escalation of treatment or maintenance therapy. Side-effects and lack of knowledge about acne treatments are the two main reasons for non-adherence .

**Maintenance therapy**

- Maintenance therapy helps to prevent recurrence of acne by suppressing development of microcomedones, which can be present in normal looking skin.

**Explain the diagnosis and provide patient information:**

- Discuss treatment aims and advise the person:
- To avoid over cleaning the skin (which may cause dryness and irritation).
- If make-up, cleansers and/or emollients are used, non-comedogenic preparations with a pH close to the skin are recommended.
- To avoid picking and squeezing spots which may increase the risk of scarring.
- That treatments are effective but take time to work (usually up to 8 weeks) and may irritate the skin, especially at the start of treatment.
- To maintain a healthy diet.

**For people with mild-to-moderate acne:**

- Consider prescribing a single topical treatment such as:
- A topical retinoid alone or in combination with benzoyl peroxide. Retinoids are contraindicated in pregnancy and breastfeeding.
- A topical antibiotic— antibiotics should always be prescribed in combination with benzoyl peroxide to prevent development of bacterial resistance. Topical benzoyl peroxide and topical erythromycin are usually considered safe in pregnancy if treatment is felt to be necessary.
- Azelaic acid 20%.

Creams or lotions may be preferable for people with dry or sensitive skin and less greasy gels may be preferable for people with oily skin. Concentration or application frequency of topical treatments may need to be reduced or lowered if skin irritation occurs.
Advise the person that frequency of application can be gradually increased from once or twice a week to daily if tolerated.

**For people with moderate acne not responding to topical treatment:**

- If response to topical preparations alone is inadequate consider adding an oral antibiotic such as lymecycline or doxycycline (for a maximum of 3 months).
- A topical retinoid (if not contraindicated) or benzoyl peroxide should always be co-prescribed with oral antibiotics to reduce the risk of antibiotic resistance developing.
- Macrolide antibiotics (such as erythromycin) should generally be avoided due to high levels of *P. acnes* resistance but can be used if tetracyclines are contraindicated (for example in pregnancy if treatment is felt to be necessary).

Change to an alternative antibiotic if there is no improvement after 3 months, the person is unable to tolerate side effects or acne worsens while on treatment.
If the person does not respond to two different courses of antibiotics, or if they are starting to scar, refer to a dermatologist for consideration of treatment with isotretinoin.

- Combined oral contraceptives (if not contraindicated) in combination with topical agents can be considered as an alternative to systemic antibiotics in women.

**Refer the person to dermatology, with urgency depending on the clinical situation if:**

- They have a severe variant of acne such as acne conglobata or acne fulminans (immediate referral is indicated).
- They have severe acne associated with visible scarring or are at risk of scarring or significant hyperpigmentation — primary care treatment should be initiated in the interim.
- Multiple treatments in primary care have failed.
- Significant psychological distress is associated with acne regardless of severity — primary care treatment should be initiated in the interim.
- There is diagnostic uncertainty.

**Arrange follow-up and review each treatment step at 8-12 weeks.**

- If there has been an adequate response continue treatment for at least 12 weeks.
- If acne has cleared or almost cleared — consider maintenance therapy
- If there has been no response consider adherence to treatment. Discuss a trial of an alternative formulation or move on to the next step in treatment if appropriate.

**Useful references:**

**GP notebook – indications, side effects and efficacy - Roaccutane**
*https://gpnotebook.co.uk/simplepage.cfm?ID=1697972294*
**Informative patient leaflet**
**https://www.bad.org.uk/pils/isotretinoin/**

## Case 5 Dermatology – 2 year old girl presents with fever and rash

### Student Information

**Learning objectives**

By the end of this station the student should have considered the differential diagnoses of a viral rash that presents in childhood in primary care.

### Student Instructions

You are a FY1 doctor on your general practice attachment. Your next patient is a parent with a 2 year old child who has been a bit unwell for two days with fever and a rash.

- Please take a history from the child's parent
- Consider the differential diagnoses and management?
- You may be asked to describe the rash.

Please focus on the diagnosis of the rash rather than the management of a sick child with a fever since this will be covered during your human development placement

### Key Points

**Viral Exanthema (Rashes)**

The term maculopapular is non-specific and used most commonly in reference to eruptions that are caused by viral or bacterial infections. The term morbilliform means "measles-like rash" and is used in reference to eruptions that resemble those caused by viruses.

Differential diagnosis for a maculopapular/morbilliform rash include

- Viral exanthema e.g. parvovirus B19 (slapped cheek), HHV7 (roseola infantum), rubella
- Bacterial exanthema ( e.g. scarlet fever)
- Drug eruption

| Rash | Incubation | Characteristics | Location | Duration of symptoms | Infectivity | Complications |
|---|---|---|---|---|---|---|
| **Chickenpox** | 14-16 days up to 21 days | Fever, crops of red flat macules which become raised then blister and crust. Lesions at different stages. Can start anywhere | Most prominent on trunk and face | 4-10 days Spread oral/nasal route | Scabs not infectious | Pneumonia. Can be severe / fatal if immuno –compromised. |
| **Measles** (rubeola) Caused by paramyxovirus | 14 days | Preceded by fever, cough and very red eyes. Photophobia in older children. Oral Koplik's spots. Pink then red macules. Looks sick. | First face, then chest and abdomen, then arms and legs | 4-7 days | From prodromal symptoms to 4 days after the rash onset | Can cause pneumonia, encephalitis, cardiac problems and death |
| **Roseola** (exanthema subitum) – due to HHV6 or HHV7 | 9-10 days Affects the young up to 3 years old | High fever for 3 days which goes as rash starts. Occasionally URTI. Abdominal pain and malaise. Red macules occasionally with some papules. Eyelid oedema in 30% | First trunk, then arms and neck, very little on face and legs | 1-2 days | Oral spread | Rarely encephalitis or encephalopathy |
| **Rubella** (German or 3-day measles) | 16-18 days | Prodrome 1-5 days before rash with mild fever, URTI, conjunctivitis, tender lymphoadenopathy Pink or light red rash | Starts face/neck then onto trunk and limbs | One week before onset of rash until 4 days after | 7 days after rash starts | Congenital rubella if infected in pregnancy |
| **Scarlet Fever** | 3-8 days | Fever, strawberry red tongue, fine papular rash, feels like sand paper, perioral pallor | Starts face and elbows, spreads rapidly to entire body in 24 hours | 5-7 days | 5 days if penicillin given otherwise 10-21 days | Meningitis, pneumonia septicaemia, renal failure, rheumatic fever |
| **Fifth Disease** (Erythema infectiosum) due to parvovirus B19 | 4 -14 days Common in winter and spring | Low grade fever, myalgia, slapped cheek appearance. Rash flat and lacy starts 1-4 days after red cheeks | First bright red face Usually biphasic | Can wax and wane over 1-2 weeks | Not infectious once rash appears | If infected in pregnancy in first trimester can lead to Hydrops foetalis |
| **Hand-foot-mouth** disease (due to coxsackie A16) | 3-5 days | Small oval shaped pearly-grey blisters with surrounding erythema | Acral distribution, also buttocks | 3-10 days | Very infectious | Viral meningitis Encephalitis |
| **Unilateral laterothoracic exanthem** | Mainly infants | Prodrome fever from few days to several weeks. 95% have solitary patch on chest then eczematous or pink papules | Begins unilaterally in the axilla or groin, spreads centrifugally | Fades over 6 weeks | Not known | none |
| **Papular-purpuric gloves and socks syndrome** | 10 days Uncommon ?EB virus | Self- limiting sharply demarcated red petechial rash on hands and feet. Some oedema. Then scales | Gloves and socks distribution | Resolves 1-2 weeks | Not known | 50% due to parovirus B19 therefore problems if infected in pregnancy |
| **Gianotti-Crosti syndrome** (papular acrodermatitis of childhood) | Infants and young children | Low grade fever. Smalll firm papules red or purple | Face, limbs and buttocks | Lasts 2 to 8 weeks | Not known | Normally self-limiting |



**Background Information** (from patient plus. http://www.patient.co.uk/doctor/Measles.htm

**Measles**

Most cases are self limiting however approximately 10% of cases will require hospital admission and there is a 1:5000 fatality rate in the UK. Immunisation programmes in the UK and elsewhere had limited many modern clinicians' exposure to the disease. Falls in the uptake of immunisation following inappropriate concerns about the measles, mumps and rubella (MMR) vaccine safety have increased the susceptible population.

The increasing numbers of measles since 2017 are thought to be partly due to teens/young adults migrating around the world whom have had poor vaccination rates. Lowering overall heard immunity.

**Transmission**

It is caused by a single-stranded RNA *Morbillivirus* from the **paramyxovirus** family. It is highly contagious. Transmission is airborne via respiratory droplets. These spread to surfaces and the virus can remain transmissible for up to two hours, removing the need for direct person-to- person contact.

**Incubation period**: 14 days (range 6-19 days)

**Duration of infectivity:** 2-4 days before rash occurs up to 2-5 days after the rash has resolved.

**Epidemiology**:

- New Public Health England (PHE) stats – Jan to 10th Sept 2018 – 876 known cases and 259 in 2017. Last death known was 2016.
- Infection traditionally has occurred within 3 and 6 years of age on starting education. Transmission is uncommon in vaccinated children of school age; however, younger children and susceptible adults are at risk. Most were in unvaccinated or incompletely vaccinated children. Good immunity needs at least 2 doses

**Presentation**

Prodrome:

- 2-4 days with fever, runny nose, mild conjunctivitis and diarrhoea.
- Koplik's spots (can be very small) are pathognomonic and appear on the buccal mucosa - opposite the second molar teeth - as small, red spots, each with a bluish-white speck (sometimes compared with a grain of rice) in the centre. They occur in 60-70% of patients during the prodrome and for up to 2-3 days before the onset of the rash.

Rash (morbilliform = measles-like):

- This is first seen on the forehead and neck, and spreads, involving the trunk and finally the limbs over 3-4 days. It may become confluent in some areas.
- The rash then fades after 3-4 days in the order of its appearance.
- It leaves behind a brownish discoloration, sometimes accompanied by fine desquamation.
- Often, there is high fever (may be >40°C), a non-productive cough, and the patient is clearly ill.
- Also, swelling around eyes and photophobia can occur.

Clinical recovery in uncomplicated measles tends to occur soon after the appearance of the rash.

**Investigations**

WHO-recommended clinical case definition:

- Any person in whom a clinician suspects measles infection.
- Any person with fever and maculopapular rash (i.e. non-vesicular) and cough, coryza (i.e. runny nose) or conjunctivitis (i.e. red eyes).

**Laboratory confirmation sometimes required** – mainly for statistics, it is a clinical diagnosis

- Salivary swab or serum sample for measles-specific IgM taken within six weeks of onset. Usually done by Public health England (themselves or by providing support to the GP). RNA detection in salivary swabs or other samples.

**Management**

- Measles is a notifiable disease in England and Wales
- Uncomplicated measles is usually self-limiting and treatment is mainly symptomatic, with paracetamol or ibuprofen and with plenty of fluids. Patients should remain at home to limit disease spread.
- Monitor patients carefully for signs of complications and consider hospitalisation if these appear. Complications can be severe and life-threatening inc encephalitis, this is why it is important to promote vaccination.

### Useful references

E-learning module on BMJ –https://learning.bmj.com/learning/module-intro/quick-quiz-rash-children.html?moduleId=10062910&locale=en_GB

http://www.patient.co.uk/doctor/Viral-Skin-Infections.htm

## Case 6 Dermatology – 45-year-old woman/man with severe pustular facial rash

### Student Information


**Learning objectives**

By the end of this scenario the student should

- Be able to use a patient centred approach to history taking and effectively explore a patient's ideas, concerns and expectations during a consultation
- Feel comfortable using dermatological terms to describe a rash
- Make a diagnosis of the facial rash and draw up a differential diagnosis
- Consider the psychological effect of the facial rash on the patient

### Student Instructions

You are a FY1 doctor on your GP attachment. During the morning surgery you are asked to take a history from a 46-year-old women/man with a longstanding severe facial rash, which has worsened recently. Edward/Edwina Rourke.

- Please take a history from the patient.

- Explore the patient's ideas, concerns and expectations regarding the effects of treatment.

### Key Points

The onset of rosacea is often preceded by a history of episodic flushing. The features of the rash include:

- Erythema – initially intermittent but becomes more permanent
- Telangiectasia
- Papules and pustules
- **Absence** of open comedones (blackheads), unlike acne vulgaris
- Thickening of the skin can occur when chronic, for example, rhinophyma represents marked thickening of the nasal skin and can cause serious disfigurement

Distribution – central face (forehead, nose, cheeks and chin with sparing of the peril-oral and peril-orbital areas)

Eye involvement

- Occurs in over 50% of patients
- Gritty eyes, conjunctivitis, blepharitis, episcleritis. Keratitis is a more serious complication

**Epidemiology** Age – adults and older patients. Bi-modal prevalence of 20 -30 years of age with a larger peak at 40 -50 years. More common in women. More common in patients with fair skin and blue eyes

**Aggravating features**

- Anything that aggravates flushing including sunlight, caffeine, alcohol, spicy foods
- Drugs that cause vasodilatation
- Topical steroids

**Differential Diagnosis**

- Acne – younger age group, blackheads, wider distribution and improvement with sunlight
- Seborrhoeic eczema – no pustules and eczematous changes present
- Systemic Lupus Erythematosus – shows light sensitivity, erythema and scarring but no pustules

- Perioral dermatitis – occurs in women with pustules and erythema around the mouth and on the chin

**Management**

- Provide a patient information leaflet
- Minimise factors that aggravate symptoms
- Emollients
- Papular/pustular lesions: Mild symptoms – topical agents e.g. metronidazole 0.75% gel or cream bd or azaleic acid 15% cream bd as first-line treatment. More severe – or where topical agents have failed, systemic treatment with a tetracycline (doxycycline 100mg is the drug of first choice). Initial treatment should be for at least three months. Severe symptoms that respond poorly to treatment or psychological distress a referral to a dermatologist can be made.
- Flushing/erythema/telangiectasia: If persistent, pulsed-dye laser treatment can be effective though not permanent. Consider camouflage creams –refer to British Red Cross clinics usually associated with hospital dermatology departments

Rhinophyma: Responds well to CO2 laser ablation). If present, referral should be initiated.

**Useful References for Dermatology Scenarios**

ABC of Dermatology 5th Edition BMJ Publications

Primary Care Dermatology Society A-Z of Diagnosis

http://www.pcds.org.uk/p/a-z-of-clinical-guidance-how-to-use

# Musculoskeletal cases

## Case 1 MSK – 74 year old woman with severe morning stiffness and pain across her shoulders

### Student Information

**Learning objectives**

- To take a history from a patient with MSK symptoms
- To manage a differential diagnosis of morning stiffness and consider treatment

## Student instructions

You are a FY1 in General Practice you have been asked to take a history from Mrs Maguire, a 74 year old woman complaining of marked stiffness across the shoulders.

- Please take a history
- Consider a management plan for her.

## Key Points

**PMR Polymyalgia Rheumatica** (GP Notebook)

PMR is a chronic inflammatory disease of unknown aetiology, which presents with pain and stiffness that is worse in the morning and particularly affects the shoulders and hips.

Features of PMR overlaps with those of Giant Cell Arteritis suggesting that they might represent different types of the same disease process.

Although it's not a common condition, polymyalgia rheumatica isn't classed as rare. In England, it is estimated that one in every 1,200 people will develop polymyalgia rheumatica in any year.

Polymyalgia rheumatica is an age-related condition. It occasionally occurs in people in their 50s but is more common in people over 60, and especially in those in their 70s and 80s.

Polymyalgia rheumatica is two to three times more common in women than in men. It is more widespread among white people, particularly those of Scandinavian descent, and it is much less common in black people.

Managed almost exclusively in Primary Care. The British Society for Rheumatology guidelines for the management of PMR recommends corticosteroids therapy in PMR should commence only after a full assessment of the underlying cause is made.

**A stepwise diagnostic approach has been proposed for the evaluation of polymyalgia rheumatic**a:

- assessment for core inclusion
    - bilateral shoulder and/or pelvic girdle aching
    - morning stiffness lasting more than 45 minutes.
    - abrupt onset
    - age over 50 years
    - duration more than 2 weeks
    - evidence of an acute phase response (increased ESR/CRP)

- assessment of core exclusion features and mimicking conditions

- active infection
- active cancer
- evidence of active giant cell arteritis
    - abrupt-onset headache (usually temporal) and temporal tenderness
    - visual disturbance, including diplopia
    - jaw or tongue claudication etc.
- other inflammatory conditions
- non inflammatory
- endocrine
- drug induced e.g. - statins

- assessment of the response to a standardised dose of 15 mg prednisolone
    - a patient-reported global improvement of 70% within a week of commencing steroids is consistent with PMR, with normalization of inflammatory markers in 4 weeks
    - a lesser response should point towards an alternative condition

- confirmation of diagnosis at early follow up
    - during follow up (4-6 weeks) PMR should be confirmed (and should be vigilant for mimicking conditions)

**Useful references:**
http://www.patient.co.uk/doctor/Polymyalgia-Rheumatica-(PMR).htm
https://patient.info/doctor/giant-cell-arteritis-pro

## Case 2 MSK – 42 year old accountant with a painful left shoulder

### Student Information

**Learning objectives**

- To take a focused history from a patient with a frozen shoulder
- To be able to discuss treatment options with someone with a frozen shoulder

## Student instructions

You are a FY1 In General Practice. A 42yr old (Mr/Ms Du Vivier) attends with a painful shoulder.

- Please take a history and discuss the diagnosis and management with them.
- If any other health issues arise during the consultation, please discuss these also if there is time.

  You do not need to examine the patient, the tutor will tell you the findings at an appropriate point during the consultation.

## Key Points

This patient has probably developed a frozen shoulder (adhesive capsulitis)

- *Stage one*: The "freezing" or painful stage, which may last from six weeks to nine months, and in which the patient has a slow onset of pain. As the pain worsens, the shoulder loses motion. The patient was at this stage.
- *Stage two*: The "frozen" or adhesive stage is marked by a slow improvement in pain but the stiffness remains. This stage generally lasts from four to nine months.
- *Stage three*: The "thawing" or recovery stage is when shoulder motion slowly returns toward normal. This generally lasts from 5 to 26 months.

If the student takes the opportunity for health promotion with regards to this patient's alcohol intake please encourage. If not it might be something you wish to explore with the group.

Diagnosis: -

The diagnosis of frozen shoulder is based on clinical findings and generally further investigations such as shoulder X-ray or US/MRI are not required – unless there is uncertainty. Specialist surgical referral is only required in complex cases resistant to usual management.

Aetiology

Thickening and contraction of the glenohumeral joint capsule and formation of adhesions causes pain and loss of movement.

- Localised trauma, Spontaneous, Conditions causing immobility

Epidemiology

- Most commonly it affects ages 40-65 years; median age is 50-55 years.
- It is more common in women.
- It is more common in diabetics.
- It is also associated with thyroid disease.

**Treatment** (patient.co.uk) and (https://cks.nice.org.uk/shoulder-pain#!scenario:1)

- Aim to treat early. Ideally you want to prevent an episode of capsulitis becoming frozen shoulder.
- A holistic approach to treatment should be used considering psychological and psychosocial factors.
- Encourage early activity
- Provide a written patient information leaflet on shoulder pain.

Use analgesia - paracetamol as first-line with non- steroidal anti-inflammatory drugs (NSAIDs) second-line provided there are no contra-indications. Use of a transcutaneous electrical nerve stimulation (TENS) machine may also be helpful. Physiotherapy can be helpful but may cause more pain. There is some evidence that intra-articular steroid injections early in management WITH physio helps with pain and ROM, but likely only for 6 weeks. This can be done by specialist GPs in Primary care as well as Ortho/Rheum specialists and Radiologists.

- Acupuncture may be helpful in the short-term.
- Some surgeons perform manipulation under anaesthetic and arthroscopic release of the adhesions if conservative treatment fails.

Please see **Appendix 2** for some useful points on "Negotiating skills", especially in regards to investigations/management and managing patient expectations.

### Useful references

For RED FLAG symptoms for shoulder pain : http://www.patient.co.uk/doctor/Shoulder-Pain.htm

## Case 3 MSK – 29 year old IT Consultant with a painful knee

### Student Information

**Learning Objectives**

- To be able to take a history of a non-traumatic painful knee
- To consider the differential diagnosis of a non-traumatic painful knee
- To understand the immediate management of a non-traumatic painful knee

### Student Instructions

You are a FY1 in General Practice. This 29-year-old patient was booked as an emergency by your colleague after a telephone call. He/she told your colleague he/she had a very painful knee and really hoped to see someone today. Anthony/Antonia Rogers.

- Please take a history from this 29-year-old patient.
- Consider diagnosis and initial investigation and management for this patient.

You will not be expected to examine the patient but the Tutor will discuss the findings at an appropriate point.

### Key Points

The differential diagnosis includes;

- Septic Arthritis
- Primary rheumatological disorders (e.g., rheumatoid arthritis, osteoarthritis), vasculitis, gout and pseudogout (synovial fluid testing can help to distinguish)
- Drug-induced arthritis.
- Reactive arthritis, post-infectious diarrhoeal syndrome, post-meningococcal and post-gonococcal arthritis, arthritis associated with intrinsic bowel disease.
- Lyme disease.
- Infective endocarditis.
- Viral arthritis.

**Useful references:**

For RED FLAG symptoms for knee pain: http://www.patient.co.uk/doctor/Knee-Assessment-(History-and-Examination).htm

https://cks.nice.org.uk/knee-pain-assessment

(Please note below new NICE Guidance on suspected Lyme Disease.)

https://www.nice.org.uk/guidance/qs186/resources/lyme-disease-pdf-75545724732613

## Case 4 MSK – 35 year old postman/women with low back pain

### Student Information

**Learning Objectives**

By the end of this tutorial the student should

- Be able to discuss the indications and know how to complete of a "Fit note"
- Know the red flag symptoms of back pain inc cauda equine syndrome.

- Aware of the yellow flags for back pain and the impact this has on management

### Student instructions

You are a FY1 doctor working in a busy inner city general practice that serves a deprived area. A 35-year-old man/women presents to you complaining of back pain. Sam Tweed.

- Please take a history from the patient
- Suggest any further management for him.
- Consider the use of a 'Fit note' in this case.

You will not be asked to examine the patient but will be given findings at an appropriate point by the Tutor.

### Key Points

**What's new in the primary care management of low back pain**

The STarT (Subgroups for Targeted Treatment) Back Trial (Lancet 2011; 378;1560)

The STarT Back Screening tool (a 9 or 6 point questionnairehttp://www.keele.ac.uk/sbst/downloadthetool/) stratifies patients presenting with low back pain in primary care into low, medium and high risk taking into consideration the psychosocial dimension. Please see **Appendix 4**

Of first presentations in primary care:

- 55% low risk of poor outcomes – patients do well irrespective of treatment given and many may be referred unnecessarily for further care
- 33% medium risk
- 12% high risk – includes patients not only emotionally distressed by their back pain but also includes patients with complex pathology and social issues

In the research these three groups were matched to targeted treatment pathways. The research found better outcomes for those in the high-risk group treated with CBT trained physios. Using the STarT approach is the first evidence that taking a stratified approach reduces costs both direct health costs and indirect costs through days lost not working but also improves outcomes for patients. Low risk patients do not receive unnecessary treatments and high-risk patients do not have treatments denied to them.

This tool is in part derived from the idea that there are yellow flags as well as red flags.

Please see...https://www.bmj.com/content/326/7388/535

**It is very important to think about cauda equina syndrome and red flags. ANY concern in regards to below would need emergency referral to Hospital Neurosurgeons or an AE pathway**

**NICE Feb 2022**
**Red flag symptoms and signs**
**Serious conditions whose signs and symptoms can cause low back pain are listed below.**

- **Cauda equina syndrome**. Red flags include:
    - Severe or progressive bilateral neurological deficit of the legs, such as major motor weakness with knee extension, ankle eversion, or foot dorsiflexion.
    - Recent-onset urinary retention (caused by bladder distension because the sensation of fullness is lost) and/or urinary incontinence (caused by loss of sensation when passing urine).
    - Recent-onset faecal incontinence (due to loss of sensation of rectal fullness).
    - Perianal or perineal sensory loss (saddle anaesthesia or paraesthesia).
    - Unexpected laxity of the anal sphincter.
- **Spinal fracture.** Red flags include:
    - Sudden onset of severe central spinal pain which is relieved by lying down.
    - A history of major trauma (such as a road traffic collision or fall from a height), minor trauma, or even just strenuous lifting in people with osteoporosis or those who use corticosteroids.
    - Structural deformity of the spine (such as a step from one vertebra to an adjacent vertebra) may be present.
    - There may be point tenderness over a vertebral body.
- **Cancer.** Red flags include:
    - The person being 50 years of age or more.
    - Gradual onset of symptoms.
    - Severe unremitting pain that remains when the person is supine, aching night pain that prevents or disturbs sleep, pain aggravated by straining (for example, at stool, or when coughing or sneezing), and thoracic pain.
    - Localised spinal tenderness.
    - No symptomatic improvement after four to six weeks of conservative low back pain therapy.
    - Unexplained weight loss.
    - Past history of cancer — breast, lung, gastrointestinal, prostate, renal, and thyroid cancers are more likely to metastasize to the spine.
- **Infection (such as discitis, vertebral osteomyelitis, or spinal epidural abscess).** Red flags include:
    - Fever

- Tuberculosis, or recent urinary tract infection.
- Diabetes.
- History of intravenous drug use.
- HIV infection, use of immunosuppressants, or the person is otherwise immunocompromised.

### Useful references

Statement of fitness to work: a guide for general practitioners and other doctors.
http://www.dwp.gov.uk/docs/fitnote-gp-guide.pdf

http://www.patient.co.uk/health/Back-Pain.htm.

## Case 5 MSK – 30 year old shop assistant with aches and pains

### Student Information

**Learning objectives**

- To be able to take a history from a person with aches and pains
- To learn how to broach the psychological aspects of disease
- To be able to explore a diagnosis of fibromyalgia

### Student instructions

You are a FY1 in General practice and have been asked to talk to this 30-year-old patient about his/her pain. (Kelly/ Kevin Scott)

- Please try to discuss likely diagnoses
- What tests you might like to organise.

An important aspect of this case is to think about how to manage this patient's pain.

You will not be expected to examine this patient.

### Key Points

**What causes fibromyalgia?**

Research shows that there is a direct relationship between the physical, mental and psychological aspects of the illness. This means that the pain you feel is often affected by the way you are feeling and vice versa. Feeling depressed or anxious can make the pain feel worse, which in turn adds to the stress and anxiety, and so on...

Research has also shown that people with fibromyalgia are more sensitive to physical pressure – this means that what would be a relatively minor knock for many people could be extremely painful for someone with fibromyalgia. While this increased sensitivity is not fully

understood, we think this could be related to chemical changes in the nervous system. It's also thought that sleep disturbance contributes to this increased sensitivity.

**Guidelines**

**NICE CKS Chronic pain:**

**https://cks.nice.org.uk/topics/chronic-pain/management/management/**

**For Primary Care**

**https://www.guidelinesinpractice.co.uk/pain/fibromyalgia-is-a-clinical-diagnosis-for-primary-care/342046.article**

**Diagnosis**

- It is important to take a careful history and to acknowledge the individual's experience and description of pain. Patients with fibromyalgia do not look ill and do not appear clinically weak. Apart from restriction of movement due to pain and the presence of the multiple tender points, physical examination tends to be unremarkable. Blood tests, X-rays, and scans will typically yield a negative result

**Red flags indicating other potential pathology could include:**

- involvement of the joints
- systemic malaise, especially with weight loss
- evidence of thyroid dysfunction

The American College of Rheumatology (ACR) chronic widespread pain is common, along with associated symptoms of fatigue and other somatic features. In the 2010 revision, the ACR detailed three key criteria for the diagnosis of fibromyalgia:

- Presentation of widespread pain for more than 3 months
- Assessment of the number of painful body areas
- Assessment of additional symptoms, including cognitive ailments.

**Pharmacological management**

- Many patients may find available medications either insufficient to control their symptoms, or difficult to tolerate due to a high incidence of adverse effects. Therefore, all medications should be reviewed at regular intervals to monitor their efficacy. Awareness by patients that some adverse effects may resolve in time can encourage continuation with treatment

- General intolerance to medication will dictate the treatment used. Individualised programmes of pharmacological and non-pharmacological therapy may be more effective than drug treatment alone
- Management often involves the use of antidepressants and anticonvulsants. Low dose tricyclic antidepressants (TCAs), such as amitriptyline, are used commonly to reduce pain, and improve sleep and fatigue. However, tolerability and durability of TCAs is poor
- Selective serotonin reuptake inhibitors (SSRIs) can improve the symptoms of pain, fatigue, and depression. SSRIs can cause insomnia and restlessness; therefore, morning administration is recommended. Although better tolerated than TCAs, beneficial effects of SSRIs can be less reliable
- Serotonin and noradrenaline re-uptake inhibitors (SNRIs), e.g. duloxetine and milnacipran, reduce pain and improve physical function and quality of life
- The benefits due to any of the antidepressants are independent of their effect on mood
- Pregabalin and gabapentin also reduce pain and improve sleep quality, fatigue, and quality of life
- Alternatively, tramadol, a centrally acting analgesic with SNRI properties, will reduce the pain; or pramipexole, a dopamine agonist, can improve pain, fatigue, function, and global well-being
- Muscle relaxants, e.g. baclofen or tizanidine, can be helpful if muscle twitching or cramps accompany the pain
- Poor sleep quality is common in fibromyalgia and hypnotics such as zolpidem improve sleep and fatigue, but do not modify pain
- Benzodiazepines can be useful for initially re-establishing a sleep routine, but long-term use may have associated risks
- Irritable bowel syndrome is a common co-morbidity. Use of antispasmodics, e.g. mebeverine or alverine, may reduce the spasm of hypersensitive bowels. Intolerance to wheat and/or dairy products and excess fibre may exacerbate the symptoms. A well-balanced diet is required, especially if complicated by medications causing weight gain
- Symptoms of depression can arise from the fear and isolation of living with chronic pain. Coming to terms with living with fibromyalgia and adopting changes in attitude and lifestyle is often sufficient to deal with depressive symptoms. It is important to tackle any co-existing factors that may be contributing to the depression. In persistent cases antidepressants can prove effective

**Non-pharmacological management**

- Psychosocial factors play an important part in fibromyalgia and its successful treatment
- Cognitive behavioural therapy.
- **Exercise management: Graded therapy is gold standard and more evidence emerging of the benefits.**
- Fatigue and poor sleep are common adjuncts to fibromyalgia, it can be helpful for the patient to manage activity in a way that uses energy wisely. Prioritising, planning, and pacing activity can make a significant impact on the amount people can do in the long term
- There is limited empirical research to substantiate the use of alternative therapies. However, more focused on-going research is beginning to recognise some physiological and emotional benefits of these interventions:

## Case 6 MSK – 73-year-old man/women presents with a painful right hip and knee

### Student Information

**Learning Objectives**

- To be able to take a history from a person with joint pain.
- To learn how to explain about incurable progressive conditions.
- To understand the principles of management of a person with OA hip.

### Student instructions

You are a FY1 in General Practice. The next patient is a 73 year old with a painful right hip and knee. John/Joan Wise

- Please take a history
- Please consider initial management for this patient

Note: When you examine the hip it is painful in all movements. The knee has no deformity/effusion and no crepitus.

### Key Points

This case should enable you to discuss the issues that are involved with progressive conditions and how they can ultimately disable patients. Whilst NSAIDS are often prescribed in such cases please consider the risks associated with the use of NSAIDS and how to risk assess especially in the elderly.

Also consider when to investigate and refer? It is generally accepted that this is dependent on how the patient's ADLs (activities of daily living) are affected and how much pain they are

in. The orthopaedic surgeon is not necessarily the first point of call, consider the merits of physiotherapy, analgesia and facilitating weight loss/management.

**OA**

Osteoarthritis is a condition that affects the joints. It is the most common type of arthritis in the UK. Around 1 million people see their GP about it and the NHS in England and Wales performs over 140,000 hip and knee replacement operations every year.

**Pathology of OA (GP notebook)**

In osteoarthritis of the hip joint, there is a softening and fibrillation of the articular cartilage. Cyst formation and sclerosis occurs in the underlying bone.

The changes seen in the joint are usually maximal at the point of maximum loading, i.e. the top of the joint. Characteristically there is osteophyte formation at the margins of the joint.

Joint stiffness may be a result of synovial hypertrophy and capsular fibrosis.

**Treatment (GP notebook)**

Conservative treatment includes walking aids such as a stick or wheelchair. The stick is held in the hand opposite to the arthritic hip. Other options include the use of anti-inflammatory drugs, for example NSAIDS. Physiotherapy may help relieve pain. Obesity may accelerate progression and so obese patients should be advised to lose weight.

Surgical treatment is employed if conservative treatment fails, or if there is nighttime pain - itself an indicator of significant disease. Surgical alternatives include:

- osteotomy, which allows redistribution of stress from a part where the joint is damaged to an undamaged part - rarely performed;
- arthrodesis, which is now rarely performed;
- hip replacement, which is the most widely used operation. However this procedure has a 10% revision rate after 10 years;
- hip resurfacing arthroplasty.

**GPs should prescribe tailored exercise for osteoarthritis, NICE says**

https://www.bmj.com/content/377/bmj.o1099

# Health care of the elderly cases

## Case 1 HCOE – 67 year old woman/men presenting with tremor (Parkinson's disease)

### Student Information

**Learning objectives for the case:**

- To be able to take a history from a patient presenting with a tremor

- To be able to discuss possible diagnoses and advise on further management
- To learn about the differential diagnosis for tremor

## Student Instructions

You are a FY1 in General Practice and you have been asked to see Mr/Mrs Jones. He/ She has a past history of asthma and is on no medication. On examination cranial nerves are intact but he/she has some rigidity in his/her forearms.

- Please take a history from this patient

  Discuss the possible diagnosis, further investigations and possible treatment

## Key Points

- No clear cause why a person should develop Parkinson's disease.

- The disease results from the degeneration of dopaminergic neurones in the substantia nigra. It becomes evident when approximately 80% of the dopaminergic neurones in the nigrostriatal pathway have degenerated.

The main **symptoms** of Parkinson's are

- hypokinesia ( poverty of movement);

- bradykinesia (slowness of movement);

- rigidity;

- rest tremor;

However, there are many other symptoms of Parkinson's, not all of which affect movement. The different types of Parkinson's symptoms are often divided into 2 categories: motor symptoms and non-motor symptoms.

Motor symptoms are related to movement, while non- motor symptoms include problems such as pain, depression, constipation and sweating.

**Diagnosis**

NICE has identified the recommendations below as priorities for implementation.

**Referral to expert for accurate diagnosis**

People with suspected Parkinson's should not be treated in Primary Care, but should be referred quickly (within 6 weeks) to a specialist with expertise in the differential diagnosis of the condition.

- There is no specific test for Parkinson's disease; often a trial of medication is used to determine if the symptoms improve.

**Treatment**

Levodopa is one of the main drugs used to treat the symptoms of Parkinson's. It is a natural amino acid that the brain converts into dopamine. It replaces the loss of the chemical caused by Parkinson's.

Dopamine agonists are mostly used with levodopa to ease the control of symptoms in people whose response to treatment is beginning to fluctuate.

**Prognosis**

The symptoms of Parkinson's Disease tend to become gradually worse over time. However, the speed of progression varies greatly from person to person. When symptoms first begin, symptoms are relatively mild, treatment may not be needed.

**Useful references**

Tremor/PatientPlus (Professional) Article http://www.patient.co.uk/doctor/Tremor.htm

## Case 2 HCOE - 68 year old for health review at the practice three months following a CVA

### Student Information

**Learning objectives for the case:**

- To be able to take a history from someone who has had a previous stroke
- To understand and manage the risk factors for CVA
- To address the issues around concordance and why patients do not take medications
- To practise the consultation skills e.g. FRAMES (behaviour change) and negotiation skills needed for this consultation **(See Appendix 2).**

### Student instructions:

You are a FY1 doctor in General Practice. You have been asked to review Mr/Mrs Dexter following his/her visit to your practice nurse who found the patient's blood pressure to be 160/98mmhg and their Hba1c was 75mmol/mol (9.0%). The nurse was concerned especially because of this patient's previous stroke, 3 months ago.

- Please take a history
- Discuss the patient's understanding of his/her condition, his/her current medication and future management.

### Please note

Review of medication and addressing lifestyle change is likely to be too much for this consultation. If you manage to review medication then you can set up for the next consultation by asking the patient if there are any areas of his lifestyle that the patient would like to address. You can suggest that you will discuss this when he comes back for review of his blood pressure and medication.

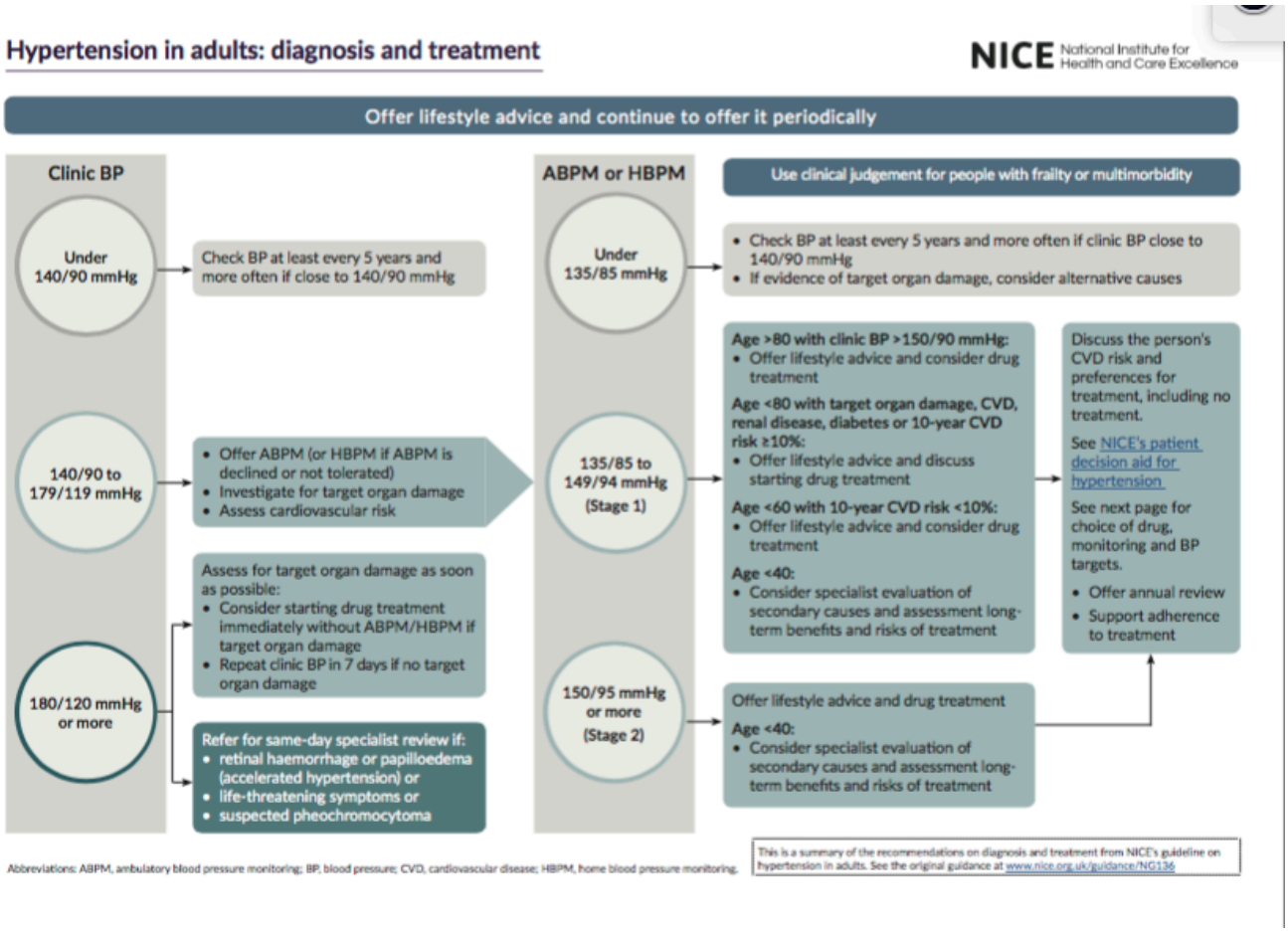
### Key Points

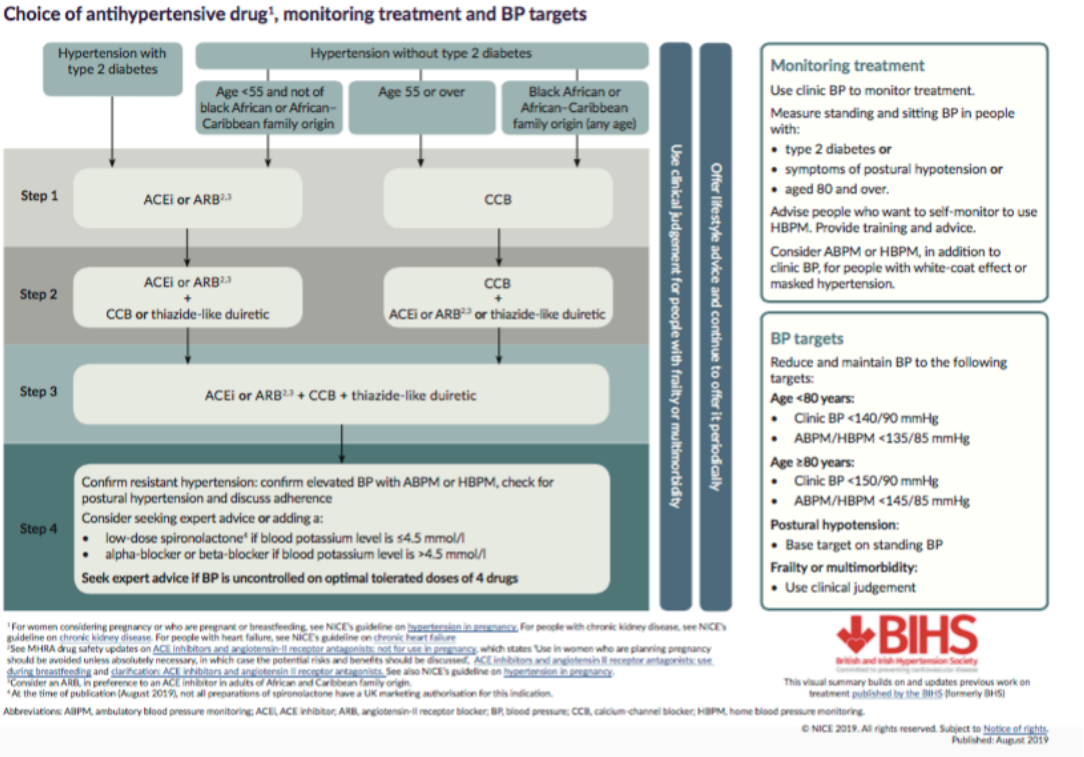
**Cerebrovascular Accident**

**Risk factors**

- Age : 75% of strokes happen in over 65-year age  group.
- African-Caribbean origin
- Smoking, obesity, poor diet and excessive alcohol consumption are also risk factors for stroke.
- Hypertension
- Diabetes
- Hyperlipidaemia
- Atrial fibrillation

**NEW NICE HYERPTENSION GUIDELINES, 2019**






## Useful references

Stroke Prevention PatientPlus (Professional) Article
http://www.patient.co.uk/doctor/Stroke-Prevention.htm

NICE Hypertension: clinical management of primary hypertension in adults
https://www.nice.org.uk/guidance/cg127

Diabetes, Oral Hypoglycaemic Agents and Exenatide PatientPlus (Professional) Article
http://www.patient.co.uk/doctor/Diabetes-Oral-Hypoglycaemic-Agents-and-Exenatide.htm

Prescribing Issues and Concordance PatientPlus (Professional) Article
http://www.patient.co.uk/doctor/Prescribing-Issues-and-Concordance.htm

## CASE 3 HCOE – 75 year old woman/man present with a fall

## Student Information

**Learning Objectives**

- To be able to take a history from a patient who has recently had a fall
- To discuss the issues that may have led to the fall.
- To review medication as necessary

- To be able to take a focused social history and how it affects on-going care

### Student instructions

You are a FY1 on clinical attachment in General Practice and the GP, Dr Ross has asked you to speak to Mrs Maureen/Mr Mo Baker at home. She/he has requested a home visit as she/he has had a fall at home in the early hours of the morning, the ambulance was called and suggested going to hospital for some further investigations/monitoring but she/he wanted to stay at home at all costs. They agreed on the basis she would call he GP in the morning. During this phone call, she/he told Dr Ross, that you that Jean (daughter) expressed concern over her/his safety at home and intends to stay with her overnight.

- You visit the patient at home. Please take a medical history
- Please explore the patient's perspective about her daughter's worries.

### Key Points

**See negotiation skills in Appendix 2**

This consultation requires particularly you to explore ICE. Students who have managed this consultation well in the past have paid particular attention to the patients concerns and needs. Before trying to negotiate…it is really important to understand the patient position. In this scenario it is important to understand the patient's feelings about staying in her own home. It is possible that fear about the future might make her aggressive or hostile towards you if she doesn't feel understood or that you are listening.

### Key Points

**Risk factors for falls** (patient.co.uk): High age, Female gender, Low weight, Previous falls, Dependency in activities of daily living, Orthostatic hypotension, Medication (especially psychotropic), Polypharmacy, Alcohol abuse, Diabetes mellitus[4], Confusion and cognitive impairment, Disturbed vision, Disturbed balance or co-ordination, Gait disorders, Inappropriate footwear, Poor foot health/strength and Environmental factors

**Why falls are so much worse in the elderly**

*Poor self-protection*. This is common in the elderly. Examples include:

- Lack of protective subcutaneous fat
- Neurological problems (prevents reflex breaking or cushioning of the the fall)
- Falls associated with loss of consciousness (for example, syncope)
- Motor and sensory problems
- Multiple contributory factors (for example slow, stiff joints, drugs and environmental factors is a common combination of factors)

**Aetiology**

The aetiology of falls is usually multifactorial. The most effective prevention of falls is likely to involve a multidisciplinary, holistic and patient specific approach. Measures should take

into account the person's medical conditions, social circumstances and psychological factors. The approaches may involve:

- Increasing exercise and physical activity
- Reviewing medication
- Changing adverse environmental factors
- Improving management of any medical conditions

**Useful references**
http://www.patient.co.uk/doctor/Recurrent-Falls.htm
http://www.patient.co.uk/doctor/Prevention-of-Falls-in-the-Elderly.htm

## CASE 4 HCOE – 75 year old man/women with change in bowel habit and weight loss

### Student Information

**Learning objectives:**

- To learn how take a history from a person with weight loss
- To be able to discuss a possible diagnoses and advise on further investigations and management
- Engage with patient anxiety and manage clinical uncertainty
- Consider principles of breaking bad news as necessary (**see Appendix 3)**

### Student Instructions

You are a FY1 in General Practice.

- Please take a focused history from this patient.
- Ask the tutor for any relevant examination findings. You will not be expected to examine.
- Discuss any further investigations you would like to do and arrange appropriate follow up

**Please note**
While this consultation is not directly about breaking bad news, it is about sharing clinical uncertainty and where the patient may have a potentially serious diagnosis. Please note framework of Breaking Bad news in **Appendix 3** as it will be helpful.

### Key Points – NOTE USE OF FIT tests

The NICE diagnostics guidance on quantitative faecal immunochemical tests to guide referral for colorectal cancer in primary care recommends tests for occult blood in faeces, for people

without rectal bleeding but with unexplained symptoms that do not meet the criteria for a suspected cancer pathway referral.

2ww lower GI Pan – London – Very important

**https://www.healthylondon.org/wp-content/uploads/2017/10/Lower-GI.pdf**

## CASE 5 HCOE – 62-year-old woman/man with memory loss

### Student Information

**Learning objectives:**

- To be able to take a history from a person with memory loss
- To be able to screen for organic conditions that may be contributing/causing the memory loss.
- To consider the management of the early stages of dementia

### Student Instructions:

You are a FY1 in General practice. Your next patient is a 62 year old.

- Please take a history from this patient. You do not need to perform a MMSE today.
- Consider further investigations and management

Although MMSE is an essential part of the assessment of memory loss, we want you to focus on history taking in this consultation and you might suggest bringing the patient back to perform MMSE.

### Key Points

Investigations should include the following:

- FBC & ESR/CRP
- B12 & Folate
- TFTs
- LFTs & Gamma GT
- Bone Profile
- Glucose/HBAIC
- Urine Dip +/- MSU
- Lipids
- HIV and Syphilis considered

- CXR
- MRI is gold standard. A CT/PET scan is considered (in secondary care)

**Facts about dementia**

Dementia is a common condition. In England alone, there are currently 570,000 people living with dementia. That number is expected to double over the next 30 years. Usually dementia occurs in people who are 65 or over. The older you get, the more likely you are to develop it.

- Alzheimer's Disease 55%
- Vascular dementia 20%
- Dementia with Lewy bodies 15%
- Other Dementias 10%

Antipsychotic meds should be prescribed only with Psychiatric or Health Care of the Elderly guidance (if used in dementia with Lewy bodies it may exacerbate symptoms)

Anticholinesterase inhibitors should be prescribed according to BNF guidance and are only initiated by old age Psychiatrists. If you are unfamiliar with the use of anticholinesterase inhibitors please could you refresh your memory from the BNF or NICE guidance.

**Useful references**

Dementia PatientPlus (Professional) Article www.patient.co.uk/doctor/dementia.htm

Screening for Cognitive Impairment PatientPlus (Professional) Article www.patient.co.uk/doctor/Screening-for-Cognitive-Impairment.htm

NICE CKS Dementia

https://www.nice.org.uk/guidance/ng97

## Case 6 HCOE – the Multi-morbid patient - 72

### Student Information

**Learning objectives**

- Being able to take a clear and focused history, taking into account multiple medical conditions.
- Understand how management of conditions affect each other.
- Understand the psychological issues associated with multi-morbid conditions.

### Student instructions

You are an F1 in a GP Surgery and the next patient is Mary/Martin Gallagher (72yrs old), they have been called in to discuss their worsening diabetes control. You know from their notes that their spouse died last year.

They will be seeing the Diabetes Nurse after your consultation to discuss adjustment of insulin dose and any possible medication change.

- Please take a focused history, concentrating on why their diabetes may have worsened.
- Please discuss ways in which their diabetes can be better-controlled using conservative methods.

**HBAIC last week** – (8.4%/68mmol/mol)

– last yr 7.5%/58mmol/mol (target 7.5%/58 mmol/mol)

**PMH:**

- **Type 2 diabetes**
- **Hypertension (recent 132/81 - good)**
- **High cholesterol (good control).**
- **Generalised OA**
- **Chronic Kidney Disease 3A – recent 53 eGFR (mild to moderate)**

### Key Points

"Being Mortal" by Atul Gawande is a good book that if a good example of trying to manage multi-morbidly.

BMJ 2015 - https://www.bmj.com/content/350/bmj.h176

**The bottom line**

- Multimorbidity is commonly defined as the presence of two or more chronic medical conditions in an individual and it can present several challenges in care particularly with higher numbers of coexisting conditions and related polypharmacy
- Practices should actively identify patients with complex multimorbidity and adopt a policy of continuity of care for these patients by assigning them a named doctor
- The adoption of a policy for routine extended consultations should be considered for particularly complex patients or the introduction of occasional "specific extended consultations." allowing protected time to deal with problems encountered in the management of chronic diseases

It is associated with decreased quality of life, functional decline, and increased healthcare utilisation, including emergency admissions, particularly with higher numbers of coexisting conditions. The management of multimorbidity with drugs is often complex, resulting in polypharmacy with its attendant risks. Patients with multimorbidity have a high treatment

burden in terms of understanding and self managing the conditions, attending multiple appointments, and managing complex drug regimens

Patients classified as multimorbid are estimated to be 1 in 6 in the UK and account for approximately one third of all consultations in general practice.

**What is the impact of multimorbidity?**

**Box 1: Problems commonly experienced by patients with multimorbidity**

**Fragmentation and poor coordination of care**

- Results from seeing multiple health professionals in primary and secondary care.

**Polypharmacy**

- Attendant risk of adverse drug events, potentially inappropriate prescribing, and problems with drug concordance

**Treatment burden**

- Results from the necessity of learning about and adhering to management plans and lifestyle changes suggested for different conditions and engaging with multiple healthcare professionals

**Mental health difficulties**

- Anxiety and depression are more common in patients with multimorbidity and can impact on patients' ability to manage other long term conditions
- Patients living in deprived areas are particularly vulnerable to multimorbidity that includes mental health conditions
- Those with cognitive impairment are also particularly vulnerable and may have added difficulties in managing their conditions.

**Functional difficulties**

- Functional difficulties increase with increasing number of conditions and in people aged more than 75 years

**Reduced quality of life**

- Associated with the number of chronic medical conditions

**Increased healthcare utilisation**

- Includes an increased risk of emergency admission to hospital

**Box 2: Practice points for dealing with challenges in caring for patients with multimorbidity**

**Disorganisation and fragmentation of care**

- Identify patients as having complex multimorbidity and adopt a practice policy of continuity of care by assigning them a named doctor

**Chronic disease management**

- Some evidence supports focusing on functional optimisation of patients with multimorbidity and on shared risk factors for several conditions, such as blood pressure and smoking cessation
- In the absence of meaningful clinical guidelines, clinical judgment is especially important in the decision making process

**Medicines management**

- Plan regular reviews (at least annually) of drugs (explicit prescribing tools for potentially inappropriate prescribing may be useful in reviewing polypharmacy)

**Promoting patient centred care**

- *Shared decision making*—asking patients at the outset of a consultation "What is bothering you most?" or "What would you like to focus on today?" can help prioritise management to those aspects of care that will have the most impact on patients
- *Self-management of multimorbidity*—research to date is mixed about the benefit of self management, but it may be an option for patients expressing an interest in group based support

**Short consultation times**

- Consider adopting a practice policy of routine extended consultations for particularly complex patients or introducing occasional "specific extended consultations," allowing protected time to deal with problems encountered in the management of chronic diseases
- Ensure practice systems are in place to maximise the value of the general practice consultation for both patient and doctor in reaching management decisions—for example, by seeing the practice nurse ahead of an appointment with the doctor
- Arrange multidisciplinary team involvement, where appropriate

**What are the challenges of chronic disease management in multimorbidity?**

- Inadequacy of single disease clinical guidelines

- Targeting function not disease
- Medicines management
- How can organisation and continuity of care be improved?
- What measures can be used to promote patient centred care?
- Shared decision making
- Self-management in patients with multimorbidity
- What can be achieved in a 10-minute consultation?

**Role of MDT in Multimorbidity**

- Practice Pharmacists help patients manage their medications but also deal with polypharmacy.
- Community Matrons hold a vital role for the overall overview of the patient and help with bridging issues with medical and social care.
- When a patient is also acutely unwell " An Integrated Care team" complied of Doctor, Nurse, Social Care, OT, and Physio help patients stay out of hospital or help them with transition post discharge while waiting to clinically improve. Virtual hospitals or Ambulatory Care help with patients to receive hospital care and daily monitoring without having to be an in-patient.

## CONSULTATION SKILLS

**Evidence supporting a patient centred approach to consulting**

- History contributes 60-80% of diagnosis (Peterson et al)

- Patient centeredness and the perception of common ground means fewer follow-ups, investigations and referrals (Little et al 1997)

- Duration of illness is improved by patient centeredness( Little et al 1977)

- Undiscovered discordance between the health beliefs of patients and physicians leads to problems in patient satisfaction, adherence and outcome (Kleinmann et al 1978)

- Joint Working Party Royal College of Physicians and Royal College of Psychiatrists concluded that underlying psychological issues were an important dimension in patients presenting to hospital (2003)

## Appendix 1

**Student feedback form**

Barts and The London School of Medicine and Dentistry

Feedback4You

**CENTRAL LOCOMOTOR TEACHING - STUDENT OBSERVED CONSULTATION**

Name of Student.....
Date.....
Presenting Complaint.....

| DOMAIN | STUDENT COMMENTS | ACTOR COMMENTS | TUTOR COMMENTS |
|---|---|---|---|
| Non verbal Communication | | | |
| Verbal communication | | | |
| History taking | | | |
| Exploring Ideas, Concerns and Expectations | | | |
| Decision making | | | |

# Appendix 2

## *Appendix 2 - Negotiating skills (MSK – Case 2, 3,4 and HOE – case 2)*

A large part of daily clinical practice involves negotiating with patients. It is in your best interests to develop good skills in this area in order to serve your patients well and reduce potential conflict. Improving your skills requires the ability to observe yourself in action and evaluate what you said and did and also learning to be open minded, respecting the others' thoughts and opinions even if they make little sense to you. You are most likely to navigate a win-win path through a potential conflict if the patient feels heard and understood and they understand your position and thinking.

Self-Observation.

As we communicate with others we are usually lost in the flow of interaction. To improve your communication skills you need to be able to observe yourself at the same time as you participate in conversations (reflection-in-action). It takes a while to grow into this participating and observing at the same time. At first we look back on conversations (experience) that we have had and try to understand what went well and what went badly (reflection-on-action). Gradually we can learn to bring that observing awareness into our conversations whilst we are having them (reflection-in-action). The final stage is to make use of our observations to enhance future consultations (revision).

Negotiating

1. Try to understand the other (use open questions and active listening)

2. Acknowledge their position (summarise what they have been saying e.g. "so you are concerned that there might be something serious going on" When they know you are on their side, they may relax and be able to listen better).

3. Explain your thinking, trying to use language and ideas that would be fitting to their health beliefs and understanding

Negotiating a mutual plan of action

- Discuss options

- Obtain the patient's views regarding need for action, perceived benefits, barriers, motivation

- Elicit the patient's reactions and concerns about plans and treatments including acceptability

- Take the patient's lifestyle, beliefs, cultural background and abilities into consideration

- Accept the patient's views and advocate an alternative view point as necessary

- Encourage the patient to be involved in implementing the plan, to take responsibility, to be self-reliant

- Ask the patient about support systems and discuss other support available

Managing patient aggression

There are three main rules:

1. Resist the fight and flight instinct our natural responses may include: fear (flight) or aggression (fight).

2. Manage your own mental and emotional state. You need to be calm to be effective Becoming aware of your emotions may help you to be proactive rather than reactive – choose your response in terms of words, tone of voice and body language (quiet voice, polite manner, submissive or open body language – arms hanging by sides, palms open).

3. Get curious about the other person's feelings and needs. Try to understand their position and reflect back that understanding. Allow the patient time to "ventilate" giving them full attention, often after a few minutes they do calm down. It may be more effective to acknowledge and apologise than to explain away or justify.

# Appendix 3

## Appendix 3 – Breaking bad news framework– See-Derm – Case 6, MSK – Case3, HcoE – Case 4)

Guidance for breaking bad news (based on Neighbours 5 stage model of breaking bad news)
It is important to make sure you are in the right environment and avoid being interrupted

Connect

- Try to see the world through the patient's eyes, and discover his agenda or priorities.
- Explore the patients ICE (do they already suspect this is cancer?)
- Be alert for unspoken as well as spoken answers. Feelings perceptible at the edge of the discussion will probably indicate the real state of affairs better than the facts actually discussed.

Summarise

- Reflect back to the patient the impression that you have gained of the situation. This shows that you have understood his/her feelings and gives the patient a chance to correct, refine and expand on them.

Hand over

- Answer the questions to the best of your ability and admit any uncertainties.
- Ensure that you hand over the knowledge in such a way as to allow the patient to remain empowered and keep control of his or her own life.

- Withholding information is also to withhold control and demeans the patient.

Safety Net

- Safety netting is the doctor checking where the patient is, often acknowledging his/her pain, grief or bewilderment - "this must come as an awful shock to you". It is recognising the feelings that lie behind the stunned silence

- If the patient's feelings are "allowed", he/she is more likely to pass through them and achieve some acceptance of the situation. Give the patient the opportunity to ask for further help.

- Avoid giving too much information all at once and give the patient the opportunity to ask for further help at a later date. Leave the door open for further discussion

Housekeeping

- The doctor reviews his/her own feelings. Giving bad news can be distressing

**Why is breaking bad news difficult?**

We experience fear: Of causing pain, being blamed, of our own mortality, of making things worse, of emotions being expressed, of helplessness as a doctor.

**SPIKES – as a framework is also used. It is important to note these are principles and not to be followed in a robotic algorithm fashion**

## Appendix 4

### The Keele STarT Back Screening Tool

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** tick your response to the following questions:

| | **Disagree** 0 | **Agree** 1 |
|---|---|---|
| My back pain has **spread down my leg(s)** at some time in the last 2 weeks | ☐ | ☐ |
| I have had pain in the **shoulder** or **neck** at some time in the last 2 weeks | ☐ | ☐ |
| I have only **walked short distances** because of my back pain | ☐ | ☐ |
| In the last 2 weeks, I have **dressed more slowly** than usual because of back pain | ☐ | ☐ |
| It's not really safe for a person with a condition like mine to be physically active | ☐ | ☐ |
| **Worrying thoughts** have been going through my mind a lot of the time | ☐ | ☐ |
| I feel that **my back pain is terrible** and **it's never going to get any better** | ☐ | ☐ |
| In general I have **not enjoyed** all the things I used to enjoy | ☐ | ☐ |

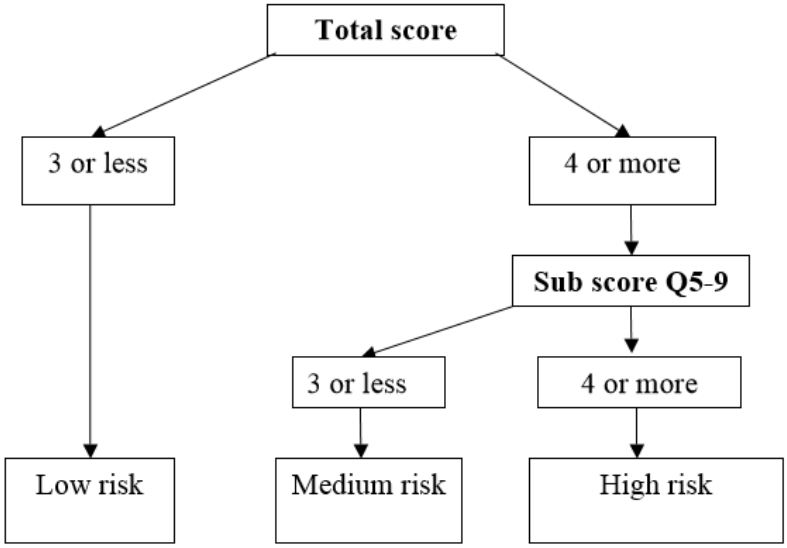
. Overall, how **bothersome** has your back pain been in the **last 2 weeks**?

| Not at all | Slightly | Moderately | Very much | Extremely |
|---|---|---|---|---|
| ☐ 0 | ☐ 0 | ☐ 0 | ☐ 1 | ☐ 1 |

**Total score (all 9):** _____ **Sub Score (Q5-9):**_____


Funded by Arthritis Research UK

**The STarT Back Tool Scoring System**





Funded by Arthritis Research UK

## Appendix 5

***Appendix 5 Abridged Calgary – Cambridge Guide – All scenarios including Derm 2***

**TASK 1: INITIATING THE SESSION**
**Establishing initial rapport**
1. Greets patient and obtains patient's name
2. Introduces self, role and nature of interview; obtains consent if necessary

**Identifying the reason(s) for the consultation**
3. Identifies the patient's problems or the issues that the patient wishes to address (e.g. "What problems brought you here today?" or "What would you like to discuss today?" or "What questions do you hope to get answered?")

**TASK 2: GATHERING INFORMATION**
**Exploration of patient's problems**
*Discover the biomedical perspective, patient's perspective and the background information*
4. Uses open and closed questioning technique, moving from open to closed
5. Listens attentively as patient tells their story, allows patient to complete statements without interruption and leaves space for patient to think
6. Facilitates patient's responses verbally and non–verbally e.g. use of encouragement, silence, repetition, paraphrasing, interpretation

**TASK 3: PROVIDING STRUCTURE**
7. Summarises at the end of a specific line of enquiry
8. Attends to timing and keeps interview on task

**TASK 4: BUILDING RELATIONSHIP**

**Using appropriate non-verbal behaviour**

9. Demonstrates appropriate non–verbal behaviour: eye contact, facial expression, posture, vocal cues e.g. rate, volume, tone

**Developing rapport**

10. Uses empathy to communicate understanding and appreciation of the patient's feelings or predicament; overtly acknowledges patient's views and feelings

**TASK 5: EXPLANATION AND PLANNING**

**Providing the correct amount and type of information**

13. Chunks and checks: gives information in manageable chunks, checks for understanding, uses patient's response as a guide to how to proceed

**Aiding accurate recall and understanding**

14. Organises explanation: divides into sections, develops a logical sequence

**Achieving a shared understanding: incorporating the patient's perspective**

15. Provides opportunities and encourages patient to contribute

**Planning: shared decision-making**

16. Involves patient by making suggestions and checks if patient accepts plans.

**TASK 6: CLOSING THE SESSION**

**Forward planning**

11. Safety nets, explaining possible unexpected outcomes, what to do if plan is not working, when and how to seek help

**Ensuring appropriate point of closure**

12. Final check that patient agrees and is comfortable with plan and asks if any corrections, questions or other items to discuss