**David Bourne**

**Gynaecology**

***SimPat Static Patient Cases***

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# Individual Details:

* Initials Used: XXX
* WhatsApp Number: XX XXXX XXXXX

# Notes:

Case Code:

# DWZHB\_01\_UrinaryTractInfection

Homepage Vignette:

## A 23-year-old female called Amrita presents with dysuria.

Individual Page Vignette:

You are a GP at a General Practice Clinic. Amrita, a 23-year-old teacher, comes to your consultation room complaining of painful urination.

Patient Name:

Amrita Sen (Pronunciation: Ah-m-ri-ta Se-n; Prefers to be called Amrita)

Age:

14/05/2001

Location:

General Practice

Personality:

Amrita is articulate and direct in communication. She has an analytical mind, often presenting her symptoms with specific details, reflecting her organized nature. She expresses concerns straightforwardly and appreciates clear and concise explanations.

Presenting Complaint:

Amrita reports experiencing a burning sensation when urinating and notes that she has been urinating more frequently for the past three days.

Quote: "Every time I go to the toilet, it burns, and it feels like I have to go again not long after."

Symptoms:

- Site: Urethra; "It burns right when I'm peeing."

- Onset: 3 days ago; "This started happening about three days ago."

- Character: Burning sensation; "It's like a stinging burn."

- Radiation: Does not radiate; "No, the pain stays right there, doesn't go anywhere else."

- Associated Symptoms: Increased urinary frequency; "I'm going to the loo a lot more than usual."

- Timing: Throughout the day; "It's all day, more when I drink water, but I've been trying to stay hydrated."

- Exacerbating and Relieving Factors: Pain when urinating; "It mainly just hurts when I pee."

- Severity: Moderate, affecting daily activities; "It's bad enough that I'm constantly looking for a toilet wherever I go."

PV Bleeding: None

PV Discharge: Normal, no change in volume, colour, consistency, or smell.

Abdominal or Pelvic Pain: None

Chance of Pregnancy: None

Dyspareunia: None

Post-coital PV Bleeding: None

Intermenstrual PV Bleeding: None

Post-menopausal Bleeding: N/A

Vulval skin changes or itching: None

Abdominal distention: None; No findings related to the other listed positive results.

Quote:

- "No other pains or weird symptoms, just the burning and needing the loo all the time."

- "I haven't noticed any strange discharge or bleeding. Just the pee thing."

History of Presenting Complaint:

- Symptoms started 3 days ago, with no previous similar episodes.

- No treatments attempted yet.

- Symptoms consistent and persistent for the past 3 days.

- Impact on daily life significant, leading to constant lookout for toilets.

- Work affected due to frequent bathroom breaks.

- Physical and mental well-being impacted due to discomfort and inconvenience.

Quote: "I've never had this issue before, it just came out of nowhere really. It's quite annoying, especially at work."

Systemic Symptoms:

- Fatigue: None

- Fever: None

- Night Sweats: None

- Unintended Weight Loss: None

- Chest or Shoulder Tip Pain: None

- Shortness of Breath or Cough: None

- Change in Bowel Habits: None

- Change in Urinary Habits: Increased frequency

- Dysuria:

- Frequency: Increased

- Urgency: Increased

- Oedema: None

- Rashes or Skin Changes: None

- Headache: None

- Mood Changes: None

- Sleep Disturbances: None

Quote: "Other than running to the bathroom all the time, I feel pretty normal."

Obstetric History:

Previous Obstetric History: N/A

Gravidity and Parity: N/A

Reproductive Plans: "I'm not thinking about having children at the moment."

Gynaecology History:

Menstrual History:

Duration: 5 days

Frequency: Every 28 days

Volume: Moderate

Dysmenorrhoea: Mild

Last Menstrual Period: Two weeks ago.

Menarche: Age 12

Menopause: N/A

Previous Screens: Last cervical screening 2 years ago, results normal.

Previous Gynaecology Conditions: None

Previous STIs: None

Contraception: Currently using oral contraceptive pills.

Quote: "I've been on the pill for a couple of years now, no issues there."

Past Medical History:

- No previous medical conditions

- No surgeries or hospitalizations

- No psychiatric or psychological history

- No history of alcohol or substance abuse or addiction

- Fully vaccinated, including HPV vaccine

- No previous STIs

Quote: "I've been pretty lucky health-wise, nothing major ever really."

Drug History:

- Oral contraceptive pills: Ethinylestradiol/Levonorgestrel, 20/100mcg, once daily.

- No history of medication non-compliance

- No use of herbal supplements or alternative therapies

- Folic Acid: Not taking

- Iron Supplements: Not taking

Quote: "Just the pill, and I'm pretty good about taking it every day."

Allergies:

- No known allergies

Quote: "No allergies that I know of."

Family History:

- Mother has hypertension

- Father is healthy

- No significant health issues in immediate or extended family

Quote: "My mum has high blood pressure, but that's about it for my family."

Social History:

Lifestyle: Lives alone in a flat.

Occupation: Primary school teacher.

Activities of Daily Living & Hobbies: Enjoys reading and cycling.

Smoking: Non-smoker

Alcohol: Drinks socially, approximately 4 units per week

Recreational Drug Use: None

Diet: Vegetarian

Exercise: Cycles to work, 5 times a week

Sexual History:

Last sexual intercourse: 2 weeks ago

Current and previous partners: In a monogamous relationship for 2 years

Contraception used: Oral contraceptive pills

Travel History: No recent travel

Cultural or Religious Practises: Non-specific

Recent Life Events: None relevant

Exposure to Hazards or New Environment: None

Quote:

- "I've been with my partner for two years, and it's been great."

- "I try to keep healthy, cycling to work and sticking to a vegetarian diet."

- "No, I haven't travelled anywhere recently or been exposed to anything unusual."

Ideas, Concerns, and Expectations:

- Ideas: Amrita thinks she might have a urinary tract infection.

- Concerns: Worried about the discomfort and the frequency impacting her work.

- Expectations: Hopes for a quick resolution with treatment, seeking relief from symptoms.

Quote:

- "I read a bit online and think it might be a UTI?"

- "I just want this sorted; it's really starting to affect my day-to-day life."

Observations:

Respirations (Breaths/min): 16 (0 points)

Oxygen Saturation (%): 98% on room air (0 points)

Blood Pressure (mmHg): 120/80 (0 points)

Pulse (Beats/min): 72 (0 points)

Consciousness (AVPU): Alert (0 points)

Temperature (Celsius): 36.8°C (0 points)

NEWS Total Score: 0

Physical Examination:

General Inspection

- Appears well, no signs of distress or confusion, comfortable at rest

Objects and Equipment

- No mobility aids or equipment present

Hands

- Inspection: Normal colour, no palmar erythema or peripheral oedema

- Palpitation: Warm to touch, CRT < 2 seconds, radial pulse normal rate, rhythm, and volume, no peripheral oedema

Neck

- No masses, goitres, or lymphadenopathy, JVP not raised

Face

- No abnormalities noted

Abdominal Examination

- Inspection: Abdomen flat, no scars

- Palpitation: Soft, non-tender, no masses

Vaginal Examination:

- Not indicated in this scenario

Diagnostic Tests:

Urine Dipstick: Positive for leukocytes and nitrites, suggestive of a urinary tract infection.

STI Screen: Negative

Blood Tests (Reference Ranges):

- Full Blood Count (FBC): Within normal limits

- Urea and Electrolytes: Within normal limits

Treatment:

Based on CKS guidelines, for uncomplicated UTI in women:

- First-line: Nitrofurantoin 100mg modified-release capsules twice daily for 3 days (if eGFR >45 mL/min).

- Alternative (if allergic): Trimethoprim 200mg twice daily for 3 days, if local resistance rates and patient’s allergy history permit.

- Advise increased fluid intake and regular urination.

- Discuss symptoms which would warrant re-evaluation: worsening symptoms, fever, or flank pain.

Monitoring:

- Advise to return if symptoms do not improve within 48 hours or if they worsen.

- Follow-up not routinely required if symptoms resolve.

- Consider a referral to urology if recurrent UTIs.

Prognosis:

- Uncomplicated UTIs have a good prognosis with appropriate treatment.

- Symptoms typically improve within 24-48 hours of initiating antibiotics.

- Important to complete the course of antibiotics to prevent recurrence or resistance.

- Reinforce the importance of proper hydration and urinary hygiene practices.

Differential diagnoses:

1. Interstitial cystitis/painful bladder syndrome - less likely due to acute onset and positive urine dipstick for UTI.

2. Sexually Transmitted Infection (STI) - less likely in the context of monogamous relationship and absence of vaginal discharge or sores.

3. Kidney stones - possible, but less likely given the absence of flank pain, hematuria, or history of stones.

Keyword Filters:

Speciality Filter:

Renal And Urology; General Practice; Infection;

Presenting Complaint Filter:

Dysuria; Urinary Symptoms

Condition Filter:

Urinary Tract Infection

Location Filter:

General Practice

Case created by:

David Bourne, 5th Year Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Test:

Mukhtar Sarsenbay

Case Code:

# DWZBH\_02\_Urinary Tract Infection

Homepage Vignette:

## A 27-year-old female called Amara Njoku presents with dysuria.

Individual Page Vignette:

You are a General Practitioner, and your patient today is a 27-year-old female called Amara Njoku, an engineer, living in an urban area, presenting with dysuria and increased urinary frequency.

Patient Name:

Amara Chidiebere Njoku (Pronunciation: Ah-mah-ra Chee-die-eh-bere N-joh-koo) - prefers to be called Amara.

Age:

17/06/1997

Location:

General Practice

Personality:

Amara is articulate, insightful, and maintains a calm demeanour despite clearly being in discomfort. She readily provides detailed descriptions of her symptoms and expresses concerns clearly and logically.

Presenting Complaint:

Amara presents with a two-day history of burning sensation during urination and noticing that she needs to urinate more frequently than usual.

Quote: “It's been quite uncomfortable, feels like a burning sensation every time I go to the toilet, and I’ve been needing to go way more often.”

Symptoms:

- Site: Urethra, Quote: “It hurts right where the urine comes out.”

- Onset: Acute, Quote: “This started just a couple of days ago.”

- Character: Burning, Quote: “It’s like a burning pain when I urinate.”

- Radiation: Does not radiate, Quote: “The pain just stays in one spot, it doesn’t move anywhere.”

- Associated Symptoms: Increased urinary frequency, Quote: “I’ve been going to the toilet much more often than normal.”

- Timing: Persisting for 2 days, Quote: “It’s been like this for two days now.”

- Exacerbating and Relieving Factors: Relieved slightly by over-the-counter cystitis relief sachets, Quote: “I tried some of those cystitis sachets, they’ve helped a little.”

- Severity: Moderate, Quote: “It’s pretty uncomfortable, I’d say it’s quite bad.”

PV Bleeding: None

PV Discharge: None

Abdominal or Pelvic Pain: None

Chance of Pregnancy: Not applicable, Amara is not sexually active currently.

Dyspareunia: Not applicable

Post-coital PV Bleeding: Not applicable

Intermenstrual PV Bleeding: None

Post-menopausal Bleeding: Not applicable

Vulval skin changes or itching: None

History of Presenting Complaint:

- Duration: Symptoms for 2 days.

- Previous treatments: OTC cystitis relief sachets, with some relief.

- Progression: Symptoms have remained stable.

- Frequency: Urination more frequent than usual.

- Impact on daily life: Increased discomfort and anxiety, affecting focus at work.

- Quote: “It’s been tough managing work with needing to run to the toilet all the time.”

Systemic Symptoms:

- Fatigue: Normal

- Fever: None

- Night Sweats: None

- Unintended Weight Loss: None

- Chest or Shoulder Tip Pain: None

- Shortness of Breath or Cough: None

- Change in Bowel Habits: Normal

- Change in Urinary Habits: Increased frequency, as previously detailed.

- Dysuria: Increased, as per presenting complaint.

- Oedema: None

- Rashes or Skin Changes: None

- Headache: None

- Mood Changes: None

- Sleep Disturbances: None

Obstetric History:

Previous Obstetric History: None

Gravidity and Parity: 0

Reproductive Plans: Not considering at the moment, Quote: “I’m not thinking about children right now.”

Gynaecology History:

Menstrual History: Regular, 28-day cycle, 5-day duration, moderate flow, no dysmenorrhoea.

Last Menstrual Period: 2 weeks ago, typical in character.

Menarche: Age 12

Menopause: Not reached

Previous Screens: Up-to-date with cervical screenings.

Previous Gynaecology Conditions: None

Previous STIs: None

Contraception: None currently. Past use of oral contraceptive pills.

Past Medical History:

- No previous medical conditions or surgeries.

- No known allergies.

- Immunizations up to date, including HPV vaccine.

- No history of substance abuse.

Drug History:

- OTC cystitis relief sachets (sodium citrate), started 2 days ago.

- No regular medications.

- Not taking Folic Acid or Iron Supplements.

Allergies:

- No known allergies.

Family History:

- Mother with hypertension.

- Father healthy.

Social History:

- Smoking: None

- Alcohol: Occasionally social, around 3 units per week.

- Recreational Drug Use: None

- Diet: Balanced, mostly home-cooked meals.

- Exercise: Regular, enjoys jogging and yoga.

- Occupation: Engineer.

Sexual History:

- Last sexual intercourse: Over 6 months ago.

- Contraception: Past use of oral contraceptive pills.

Ideas, Concerns, and Expectations:

- Ideas: "I think it might be a urinary infection because of the symptoms.”

- Concerns: “I’m worried it might be something serious or that I’ll need antibiotics.”

- Expectations: “I hope there’s a way to ease the symptoms quickly.”

- Quote: “I just want to get back to feeling normal again without this constant discomfort.”

Observations:

- Respirations: 16 Breaths/min

- Oxygen Saturation: 98% on room air

- Blood Pressure: 120/80 mmHg

- Pulse: 72 Beats/min

- Consciousness: Alert

- Temperature: 36.8 Celsius

- NEWS Total Score: 0

Physical Examination:

General Inspection: Patient appears well, in no acute distress, Alert and orientated.

Abdominal Examination: Soft, non-tender, no palpable masses.

Vaginal Examination:

- Speculum Examination: Not performed in this context.

- Bimanual Examination: Not indicated in this context.

Diagnostic Tests:

- Urine Dipstick: Positive for nitrites and leukocytes.

- Blood Tests: Not indicated in the primary instance for a simple urinary tract infection.

- STI Screen: Not indicated but would be negative.

Treatment:

Based on CKS guidelines, for uncomplicated UTI in women:

- First-line: Nitrofurantoin 100mg modified-release capsules twice daily for 3 days (if eGFR >45 mL/min).

- Alternative (if allergic): Trimethoprim 200mg twice daily for 3 days, if local resistance rates and patient’s allergy history permit.

- Advise increased fluid intake and regular urination.

- Discuss symptoms which would warrant re-evaluation: worsening symptoms, fever, or flank pain.

Monitoring:

- Review symptoms in 48 hours if no improvement.

- Advise to return or contact if developing fever, back pain, or symptoms worsen significantly.

Prognosis:

- Most cases of uncomplicated urinary tract infection respond well to empirical antibiotic treatment within 48 hours.

- Recurrences can occur; if so, a more detailed investigation may be needed.

Differential diagnoses:

1. Interstitial cystitis - less likely due to acute onset.

2. Sexually Transmitted Infection - less likely given history and presentation.

Patient Questions:

1. "What happens if the antibiotics don't work?"

Answer: "We would review your symptoms and potentially consider a different antibiotic or further investigation."

2. "Are there any side effects I should look out for with the antibiotic?"

Answer: "Common side effects can include nausea or diarrhoea. If you experience any severe side effects, please get in touch."

3. "Can I do anything else to help relieve my symptoms?"

Answer: "Staying well hydrated and avoiding irritants like caffeine can help. Using paracetamol for pain relief is also beneficial."

Examiner Questions:

1. What is the first-line antibiotic for uncomplicated UTI according to NICE guidelines?

Answer: Nitrofurantoin, if no contraindications.

2. How would you differentiate between an uncomplicated UTI and pyelonephritis in a primary care setting?

Answer: Pyelonephritis often presents with systemic symptoms such as fever, flank pain, and more severe systemic illness.

3. What are the criteria for sending a midstream urine (MSU) sample for culture in UTI?

Answer: Recurrent UTIs, atypical symptoms, failed treatment, or suspected resistance.

4. Why is urine dipstick analysis useful in diagnosing UTI?

Answer: It can provide immediate results, indicating the presence of nitrites and leukocytes, suggestive of UTI.

5. What should be done if a patient's symptoms of UTI do not improve with first-line antibiotics?

Answer: Review the diagnosis, consider alternative causes, and possibly change the antibiotic based on culture results.

Speciality Filter:

General Practice; Renal And Urology;

Presenting Complaint Filter:

Urinary Symptoms; Dysuria;

Condition Filter:

Urinary Tract Infection

Location Filter:

General Practice

Case created by:

David Bourne, 5th Year Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_03\_UrinaryTractInfection

Homepage Vignette:

## A 25-year-old female called Alina Novák presents with increased frequency.

Individual Page Vignette:

You are the attending GP, and Alina Novák, a 25-year-old teacher from a local primary school, visits your clinic reporting increased frequency of urination as her main complaint.

Patient Name:

Alina Novák (Ah-LEE-nah NOH-vahk); prefers to be called Alina.

Age:

14/06/1999

Location:

General Practice

Personality:

Alina is articulate, and presents herself confidently. She has a pragmatic approach to her health and communicates her symptoms clearly. She prefers to receive information in a straightforward manner without unnecessary medical jargon.

Presenting Complaint:

Alina reports that she has been experiencing painful urination and the need to urinate more frequently than normal.

Quote: "It stings every time I pee and I seem to be going to the bathroom way more often."

Symptoms:

- Site: Urethra; "The pain is right when I'm peeing."

- Onset: Acute; "This started about two days ago."

- Character: Burning sensation; "It's like a burning every time I urinate."

- Radiation: Does not radiate; "No, the pain doesn't go anywhere else."

- Associated Symptoms: Increased urinary frequency; "I've lost count of how many times I've needed to go to the loo."

- Timing: Throughout the day; "It's all day, no specific time."

- Exacerbating and Relieving Factors: Urination exacerbates; "It only hurts when I pee."

- Severity: Moderate; "It's quite uncomfortable but I can manage."

PV Bleeding: Negative.

PV Discharge: Negative.

Abdominal or Pelvic Pain: Negative.

Chance of Pregnancy: Negative.

Dyspareunia: Negative.

Post-coital PV Bleeding: Negative.

Intermenstrual PV Bleeding: Negative.

Post-menopausal Bleeding: Negative.

Vulval skin changes or itching: Negative.

Quote: "No, there's no bleeding or weird discharge. Just the pain and frequency."

History of Presenting Complaint:

- Alina has been experiencing these symptoms for the past two days.

- She has not attempted any treatments yet.

- Symptoms have remained consistent since onset.

- The frequency of urination has significantly impacted her daily activities, especially at work.

- No impact on physical well-being apart from discomfort during urination, but it is causing her stress.

Quote: "I've been putting off seeing someone hoping it would just go away, but it’s really starting to affect my teaching."

Systemic Symptoms:

- Fatigue: Negative.

- Fever: Negative.

- Night Sweats: Negative.

- Unintended Weight Loss: Negative.

- Chest or Shoulder Tip Pain: Negative.

- Shortness of Breath or Cough: Negative.

- Change in Bowel Habits: Negative.

- Change in Urinary Habits: Positive, increased frequency.

- Dysuria: Positive, painful urination.

- Frequency: Increased.

- Urgency: Increased.

- Oedema: Negative.

- Rashes or Skin Changes: Negative.

- Headache: Negative.

- Mood Changes: Negative.

- Sleep Disturbances: Negative.

Quote: "Apart from needing to pee all the time and it hurting, I feel normal."

Obstetric History:

Previous Obstetric History: Negative.

Gravidity and Parity: N/A.

Reproductive Plans: Not discussed.

Gynaecology History:

Menstrual History: Regular.

Last Menstrual Period: 3 weeks ago.

Previous Screens: Up-to-date.

Previous Gynaecology Conditions: Negative.

Previous STIs: Negative.

Contraception: Oral contraceptive pill.

Quote: "I'm pretty regular and I’ve had no issues down there before this."

Past Medical History:

- No previous medical conditions.

- No surgeries or hospitalizations.

- Blood group and rhesus status: Not known.

- No psychiatric or psychological history.

- Immunizations up-to-date including HPV.

- No previous STIs.

Quote: "I've been pretty healthy all my life, thankfully."

Drug History:

- Oral contraceptive pill, standard dosage.

- No use of herbal supplements or alternative therapies.

Quote: "I've just been on the pill. That's about it."

Allergies:

- No known allergies.

Quote: "No allergies that I know of."

Family History:

- Father with hypertension.

- Mother healthy.

- No significant health events or conditions in the extended family.

Quote: "My dad has high blood pressure, but that’s about it for family health issues."

Social History:

Lifestyle: Active and healthy.

Occupation: Primary school teacher.

Activities of Daily Living & Hobbies: Enjoys hiking and photography.

Smoking: Non-smoker.

Alcohol: Consumes alcohol socially, approximately 3 units per week.

Recreational Drug Use: Negative.

Diet: Balanced diet.

Exercise: Regularly, goes hiking on weekends.

Sexual History:

- Last sexual intercourse: Over a month ago.

- Consistent use of contraception.

Quote: "I enjoy the odd glass of wine with friends. And I love getting out for hikes when I can, it’s my way to decompress."

Ideas, Concerns, and Expectations:

- Alina understands that her symptoms may be indicative of a urinary tract infection.

- She is concerned about the potential for these symptoms to worsen or complicate her daily teaching activities.

- She expects a straightforward treatment plan and hopes for a quick resolution of her symptoms.

Quote: "I'm worried this might get worse if I don't do something about it. I just want it sorted so I can focus on my class."

Observations:

- Respirations (Breaths/min): 16;

- Oxygen Saturation (%): 98%;

- Air or Oxygen?: Room air;

- Blood Pressure (mmHg): 120/80;

- Pulse (Beats/min): 80;

- Consciousness (AVPU): Alert;

- Temperature (Celsius): 37.2°C;

- NEWS Total Score: 0

Physical Examination:

General Inspection: Appears well, no distress.

Objects and Equipment: No medical equipment present.

Hands Inspection: Normal

Palpitation: Capillary refill time (CRT) normal, radial pulse regular.

Neck: No masses or goitres.

Face: No abnormal findings.

Abdominal Examination: Soft, non-tender.

Vaginal Examination: Negative for all checks.

Diagnostic Tests:

Urine Dipstick: Positive for nitrites and leukocytes.

Vaginal Swab: Negative.

Blood Tests: Within normal limits.

Imaging Tests: Not indicated in this case.

Treatment:

According to NICE guidelines, the initial treatment for uncomplicated urinary tract infection in non-pregnant women includes a short course of antibiotics:

- Nitrofurantoin 100mg Modified-Release capsules bi-daily for 3 days if not contraindicated.

- Alternatively, Trimethoprim 200mg twice a day for 3 days, if Nitrofurantoin is contraindicated unless high resistance is expected.

- Advise on symptom management, including pain relief with paracetamol.

- Discuss the potential need for re-evaluation if symptoms do not improve within 48 hours or worsen.

Monitoring:

- Advise Alina to monitor symptom improvement over the course of treatment.

- Recommend follow-up if her symptoms persist or worsen after completing the antibiotic course.

- Suggest a urine culture if symptoms persist to guide further management.

Prognosis:

- With the appropriate antibiotic treatment, symptoms should start to improve within 48 hours.

- Complete resolution of infection is expected with full adherence to the antibiotic course.

- UTIs are common; however, recurrent infections may require further investigation.

Differential diagnoses:

1. Interstitial Cystitis - Less likely due to acute onset.

2. Sexually Transmitted Infection - Less likely given her sexual history and negative vaginal swab.

3. Kidney Stones - Less likely due to lack of renal colic or haematuria.

Patient Questions:

- "How quickly will the antibiotics start to work?"

- "You should start to feel improvement within 48 hours."

- "What should I do if my symptoms don't improve?"

- "Contact the surgery; we might need to adjust your treatment."

- "Can I do anything else to help ease my symptoms?"

- "Stay well-hydrated, and you may take paracetamol for any pain."

Examiner Questions:

1. What is the first-line antibiotic treatment for uncomplicated UTI in non-pregnant women according to NICE?

- "Nitrofurantoin or Trimethoprim depending on local resistance patterns."

2. How do UTI symptoms differ from interstitial cystitis?

- "UTIs have acute onset and positive urine cultures, whereas interstitial cystitis has a more chronic course with negative cultures."

3. What education should you provide to a patient starting on Nitrofurantoin?

- "Warn about potential side effects like nausea. Advise to take with food or milk."

4. When should a urine culture be considered in the management of UTI?

- "If symptoms persist despite appropriate antibiotic treatment."

5. Why is it important to differentiate between uncomplicated and complicated UTIs?

- "Because complicated UTIs may require a longer course of antibiotics and further investigations."

Case created by:

David Bourne, 5th Year Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_04\_UrinaryTractInfection

Homepage Vignette:

## A 29-year-old woman called Lara presents with a painful urination.

Individual Page Vignette:

You are a General Practitioner and Lara, a 29-year-old accountant, comes to your clinic in the city. She mentions experiencing painful urination.

Patient Name:

Lara Nguyen (Pronunciation: Lah-rah N'win). Lara prefers being called by her first name.

Age:

04/07/1995

Location:

Clinic

Personality:

Lara is articulate and direct in her communication, demonstrating a high level of understanding regarding her symptoms. She appears somewhat anxious about her condition but remains composed while discussing her symptoms.

Presenting Complaint:

Lara presents with a chief complaint of dysuria and increased urinary frequency for the past three days.

Quote:

“It’s just been so uncomfortable, especially when I’m at work. I feel this stinging sensation every time I go to the loo, and it feels like I need to go way more often than normal.”

Symptoms:

- Site: Urethra; "It's mainly right down there, where the pee comes out."

- Onset: Three days ago; "This started about three days back."

- Character: Stinging sensation; "It feels like a stinging or burning every time I pee."

- Radiation: No radiation; "It doesn’t really go anywhere else, just stays in that one spot."

- Associated Symptoms: Increased urination frequency; "I'm going to the toilet so much more, almost every hour."

- Timing: Throughout the day; "It’s all day long, doesn’t get better or worse at any time."

- Exacerbating and Relieving Factors: “Haven’t found anything that makes it better but peeing seems to make it feel worse.”

- Severity: Moderate; "On a scale, I’d say it’s about a 5 or 6 out of 10. It’s bearable but really uncomfortable."

PV Bleeding: None.

PV Discharge: Normal, no change in volume, colour, consistency, or smell.

Abdominal or Pelvic Pain: No abdominal or pelvic pain reported.

Chance of Pregnancy: Low, currently using contraceptives.

Dyspareunia: Not experienced.

Post-coital PV Bleeding: None.

Intermenstrual PV Bleeding: None.

Post-menopausal Bleeding: Not applicable.

Vulval skin changes or itching: None reported.

Abdominal distention: Negative.

Breast lumps: Negative.

Excessive facial or body hair: Negative.

Dizziness: Negative.

Chronic pelvic pain: Negative.

Quote:

"No, I haven't noticed any bleeding or strange discharge. And no pain besides the stinging when I pee. I’m really regular with my periods too."

History of Presenting Complaint:

- Symptom duration: Three days.

- Previous treatments: None attempted.

- Symptom progression: Symptoms have remained consistent over the past three days.

- Frequency of symptoms: Symptoms are persistent throughout the day.

- Impact on daily life: “It’s affecting my work since I have to keep going to the toilet.”

- Impact on work: “It’s making it really hard to focus when I’m constantly looking for the next bathroom break.”

- Physical and mental wellbeing: “It’s making me pretty stressed, to be honest.”

Quote:

“I’ve never had anything like this before, so I haven’t really tried anything to make it better. Just hoping you can help.”

Systemic Symptoms:

- Fatigue: Normal.

- Fever: None.

- Night Sweats: None.

- Unintended Weight Loss: None.

- Shortness of Breath or Cough: None.

- Change in Bowel Habits: None.

- Change in Urinary Habits: Increased urination frequency.

- Dysuria:

- Frequency: Increased.

- Urgency: Increased.

- Oedema: None.

- Rashes or Skin Changes: None.

- Headache: None.

- Mood Changes: Increased stress due to symptoms.

- Sleep Disturbances: None reported.

Quote:

“No fever or anything. Just really this burning sensation and needing to pee a lot. And yeah, it’s got me worried.”

Obstetric History:

Previous Obstetric History: None reported.

Gravidity and Parity: 0.

Reproductive Plans: “Not looking to have children any time soon.”

Gynaecology History:

Menstrual History: Regular, every 28 days, lasting 5 days with moderate flow.

Last Menstrual Period: Two weeks ago.

Previous Screens: Last cervical screen 2 years ago, normal.

Previous Gynaecology Conditions: None reported.

Contraception: Currently using oral contraceptives.

Quote:

“My periods have always been regular. Last smear test was all clear, thankfully. I’m on the pill for birth control.”

Past Medical History:

- No previous medical conditions reported.

- No surgeries or hospitalizations.

- No history of alcohol, substance abuse or addiction.

- Full immunizations and vaccination history, including HPV.

- No previous STIs.

Quote:

“I’ve been pretty healthy my whole life, just the usual vaccinations and stuff.”

Drug History:

- Contraceptives: Oral contraceptive pill, taken daily as prescribed.

- No history of medication non-compliance or overdose incidents.

Quote:

“I’m pretty good about taking my pill at the same time every day. Haven’t really needed anything else.”

Allergies:

- No known allergies or intolerances.

Quote:

“Lucky me, no allergies to anything as far as I know.”

Family History:

- Parents and siblings with no significant medical history.

Quote:

“My family’s pretty healthy for the most part. No serious illnesses or anything.”

Social History:

Lifestyle: Lives alone in an apartment.

Occupation: Accountant.

Activities of Daily Living & Hobbies: Enjoys yoga and cooking in her spare time.

Smoking: Non-smoker.

Alcohol: Occasional drinker, 2-3 units per week.

Recreational Drug Use: None.

Diet: Balanced, primarily vegetarian.

Exercise: Regular, attends yoga classes 3 times a week.

Quote:

“I like to stay active with yoga, and I’m careful with what I eat. Just a glass of wine occasionally with dinner.”

Sexual History:

Last sexual intercourse: Two weeks ago.

Current and previous partners: In a monogamous relationship for the past year.

Contraception used: Oral contraceptives.

Quote:

“My partner and I have been careful. We’re not looking to start a family yet, hence the birth control.”

Ideas, Concerns, and Expectations:

- Ideas: Lara suspects a urinary tract infection based on her symptoms.

- Concerns: Worries regarding the possibility of complications or it being a signal of a more serious condition.

- Expectations: Hopes for a quick resolution with treatment and advice on prevention.

Quote:

“I’m guessing it might be a UTI? I just hope it’s nothing too serious and can be sorted out quickly. How can I prevent this in the future?”

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98% on room air

Blood Pressure (mmHg): 125/80

Pulse (Beats/min): 78

Consciousness (AVPU): Alert

Temperature (Celsius): 37.0

NEWS Total Score: 0

Physical Examination:

General Inspection: Appears well, no signs of distress.

Objects and Equipment: None.

Hands: Normal appearance; no abnormalities.

Neck: No masses or goitres; JVP not visible.

Face: No abnormal findings.

Abdominal Examination: Soft, non-tender, no masses palpated.

Vaginal Examination: Deferred in GP clinic setting unless indicated.

Diagnostic Tests:

Urine Dipstick: Presence of nitrites and leukocytes expected; awaiting formal result.

Vaginal Swab: Not indicated based on presentation.

Blood Tests (Reference Ranges):

Not immediately indicated for uncomplicated UTI diagnosis.

Imaging Tests:

Not indicated for initial diagnosis and management of uncomplicated UTI.

Treatment:

For an uncomplicated urinary tract infection, the NICE guidelines recommend prescribing a 3-day course of Nitrofurantoin (if not contraindicated and if eGFR >45 mL/min) at a dosage of 100 mg twice daily or Trimethoprim 200 mg twice daily for 3 days, if the patient has low risk of resistance and is not pregnant.

Analgesia with paracetamol for symptom control.

Advise drinking plenty of fluids and follow-up if symptoms do not improve in 48 hours or worsen at any time.

Monitoring:

- Advise Lara to complete the full course of antibiotics even if symptoms improve before finishing the medication.

- Instruct to come back to the clinic or contact a healthcare professional if there's no improvement within 48 hours or if symptoms worsen.

- Schedule a follow-up visit or phone call in one week if symptoms persist or recur.

Prognosis:

- With appropriate antibiotic treatment, symptoms of a urinary tract infection usually improve within 24 to 48 hours.

- Recurrences are common; good urinary hygiene can help prevent future infections.

- Long-term complications from a single, uncomplicated UTI are rare.

Differential diagnoses:

1. Interstitial cystitis - Less likely due to acute onset and positive findings on urine dipstick expected.

2. Sexually Transmitted Infections (STIs) - Less likely given monogamous relationship, use of contraception, and absence of related symptoms.

3. Pyelonephritis - Consider if back pain, fever, or systemic symptoms develop.

Patient Questions:

1. “How soon will the antibiotics start to work?”

- “You should start to feel relief within the first 48 hours of starting the antibiotics. If your symptoms persist or worsen, please let us know.”

2. “Can I still go to work with a UTI?”

- “Yes, you can still go to work. It’s not contagious, but ensure you stay well-hydrated and take your medication as prescribed.”

3. “Is there anything I can do to avoid getting another UTI?”

- “Drinking plenty of water, practicing good toileting habits like wiping from front to back, urinating after intercourse, and avoiding irritating feminine products can help prevent future infections.”

Examiner Questions:

1. What is the first-line treatment for uncomplicated UTI according to NICE guidelines?

- “Nitrofurantoin or Trimethoprim for 3 days, considering local antibiotic resistance patterns.”

2. How would you differentiate between a lower and upper UTI based on symptoms?

- “Upper UTIs, or pyelonephritis, typically present with more systemic symptoms such as fever, flank pain, and malaise, while lower UTIs are often limited to dysuria, frequency, and urgency.”

3. What are the indications for sending a midstream urine (MSU) for culture in a case of suspected UTI?

- “Pregnancy, men, children, recurrent UTIs, severe symptoms, or failure to respond to empirical treatment.”

4. What advice would you give a patient to prevent recurrent UTIs?

- “Stay well-hydrated, practice good urinary hygiene, and consider cranberry products if recurrent UTIs are a problem.”

5. What are the potential complications of an untreated urinary tract infection?

- “Potential complications include the spread of infection to the kidneys (pyelonephritis), recurring infections, or in rare cases, sepsis.”

Case created by:

David Bourne, 5th Year Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_05\_UrinaryTractInfection

Homepage Vignette:

## A 27-year-old woman called Aaliyah presents with dysuria.

Individual Page Vignette:

You are the GP managing a patient named Aaliyah, a 27-year-old software developer, presenting at your clinic in the city with complaints of painful urination.

Patient Name:

Aaliyah Kaito (Pronunciation: Ah-lee-yah Kay-toh). Aaliyah prefers to be called by her first name.

Age:

Random Date of Birth: “14/06/1997”.

Location:

General Practice.

Personality:

Aaliyah is articulate and highly detailed in her descriptions, reflecting her analytical occupation. She has a calm demeanour but displays signs of concern about her symptoms. She communicates clearly and directly, appreciates straightforward information, and prefers to understand the specifics of her situation.

Presenting Complaint:

Aaliyah reports experiencing painful urination and the need to urinate more often over the past few days.

Quote: “It burns every time I go to the loo, and I feel like I’m running to the bathroom every other hour.”

Symptoms:

- Site: Urethra; “It’s like the burning is right when the urine is passing.”

- Onset: Acute; “This started a few days ago, quite suddenly.”

- Character: Burning; “It’s a sharp burning sensation.”

- Radiation: Does not radiate; “It’s just in that area, nowhere else.”

- Associated Symptoms: Increased urinary frequency; “I've needed to pee more often than usual.”

- Timing: Continuous; “It’s been like this for the past few days.”

- Exacerbating Factors: Urination; “It gets worse when I pee.”

- Relieving Factors: Not applicable; “Nothing seems to make it better.”

- Severity: Moderate to severe; “It’s pretty bad, enough to make me worry.”

PV Bleeding: Negative.

PV Discharge: Negative.

Abdominal or Pelvic Pain: Negative.

Chance of Pregnancy: Negative.

Dyspareunia: Negative.

Post-coital PV Bleeding: Negative.

Intermenstrual PV Bleeding: Negative.

Post-menopausal Bleeding: Negative.

Vulval skin changes or itching: Negative.

Quote: “No, I haven’t noticed any bleeding or unusual discharge. And no, I'm not pregnant.”

History of Presenting Complaint:

- Aaliyah has been experiencing these symptoms for about three days.

- She hasn't attempted any specific treatments yet.

- The symptoms appeared quite suddenly and have remained consistent.

- She experiences symptoms throughout the day.

- The symptoms have caused her concern, impacting her concentration at work.

- No impact on physical well-being apart from the discomfort and increased bathroom visits.

Quote: “It just started out of the blue, and I kept hoping it would resolve on its own.”

Systemic Symptoms:

- Fatigue: Normal.

- Fever: Normal.

- Night Sweats: Normal.

- Unintended Weight Loss: Negative.

- Chest or Shoulder Tip Pain: Negative.

- Shortness of Breath or Cough: Negative.

- Change in Bowel Habits: Normal.

- Change in Urinary Habits: Increased frequency.

- Dysuria: Yes, with described symptoms.

- Frequency: Increased.

- Urgency: Increased.

- Oedema: Negative.

- Rashes or Skin Changes: Negative.

- Headache: Negative.

- Mood Changes: Slight anxiety over health.

- Sleep Disturbances: Normal.

Quote: “Besides having to pee all the time and the discomfort, I feel fine.”

Obstetric History:

Previous Obstetric History: None.

Reproductive Plans: Not immediately planning to have children but may consider in the future.

Quote: “I’m not thinking about kids right now, maybe in a few years.”

Gynaecology History:

Menstrual History: Regular, every 28 days, moderate flow, 5 days duration, no significant dysmenorrhoea.

Last Menstrual Period: Two weeks ago.

Previous Screens: Up-to-date with cervical screenings, no abnormalities.

Previous Gynaecology Conditions: Negative.

Previous STIs: Negative.

Contraception: Currently using an oral contraceptive pill.

Quote: “My periods are pretty regular, and I keep up with my cervical screenings.”

Past Medical History:

- No previous significant medical conditions.

- No surgeries or hospitalizations.

- No psychiatric history.

- Immunizations: Up to date, including HPV.

- No previous STIs.

Quote: “I’ve been generally healthy, nothing major really.”

Drug History:

- Currently taking an oral contraceptive pill, 20 mcg ethinylestradiol/150 mcg levonorgestrel, once daily.

- No history of medication non-compliance.

- No use of herbal supplements or alternative therapies.

Quote: “I’m just on the pill, nothing else.”

Allergies:

- No known drug allergies or intolerances.

Quote: “No, I’ve never had any allergic reactions to medicines or anything.”

Family History:

- Mother: Hypertension.

- Father: Type 2 Diabetes Mellitus.

- No known hereditary diseases.

Quote: “Mum has high blood pressure, and Dad’s diabetic.”

Social History:

- Lifestyle: Active, enjoys running and yoga.

- Occupation: Software developer.

- Activities of Daily Living & Hobbies: Enjoys coding, reading, and outdoor activities.

- Smoking: Non-smoker.

- Alcohol: Occasional, 3-4 units per week.

- Recreational Drug Use: Negative.

- Diet: Balanced, includes fruits, vegetables, and protein.

- Exercise: Regular, includes running 3 times a week and yoga.

Sexual History:

- Last sexual intercourse: One month ago.

- Current and previous partners: In a monogamous relationship.

- Contraception used: Oral contraceptive pill.

Quote: “I like to keep active and healthy. I don’t smoke or do drugs, and I only drink occasionally.”

Ideas, Concerns, and Expectations:

- Ideas: Aaliyah suspects she may have a urinary tract infection due to her symptoms.

- Concerns: Worried about the cause of the symptoms and any possible complications.

- Expectations: Hopes to get a diagnosis and appropriate treatment to relieve her symptoms.

Quote: “I think it might be a UTI, you know? I just want to make it stop hurting.”

Observations:

- Respirations (Breaths/min): 14

- Oxygen Saturation (%): 98% on room air

- Air or Oxygen?: Room air

- Blood Pressure (mmHg): 120/80 mmHg

- Pulse (Beats/min): 76

- Consciousness (AVPU): Alert

- Temperature (Celsius): 37.2°C

- NEWS Total Score: 0

Physical Examination:

General Inspection: Well-appearing, no signs of distress.

Objects and Equipment: None.

Hands: Normal colour and temperature, no peripheral oedema or palmar erythema.

Neck: No masses or lymphadenopathy.

Face: No conjunctival pallor or jaundice.

Abdominal Examination: Soft, non-tender, no masses palpable.

Vaginal Examination: Not indicated based on presenting complaints.

Diagnostic Tests:

Urine Dipstick: Positive for leukocytes and nitrites.

Vaginal Swab: Not clinically indicated based on presenting symptoms.

Blood Tests (Reference Ranges):

Full Blood Count (FBC): Within normal limits.

Urea and Electrolytes: Within normal limits.

Condition:

Urinary Tract Infection.

Patient Questions:

1. "Why do I have this infection? Have I done something wrong?"

- "Urinary Tract Infections can occur for many reasons and are quite common. It’s not necessarily something you did wrong. Factors such as hygiene practices, sexual activity, and even being female can increase the risk."

2. "Will this affect my ability to have children in the future?"

- "No, a UTI treated properly should not affect your fertility or ability to have children."

3. "Do I need to take antibiotics, and are there side effects?"

- "Yes, antibiotics are the main treatment to clear the infection. Possible side effects can include nausea, diarrhoea, and yeast infections, but most people don’t experience significant issues."

4. "Should I change my diet or drink more water?"

- "Drinking more water is beneficial as it can help flush out the bacteria from the urinary tract. There’s no specific diet change required, but staying hydrated is key."

Examiner Questions:

1. What are the common causative organisms of a UTI?

- "E. coli is the most common causative organism, followed by others like Staphylococcus saprophyticus."

2. What is the rationale behind choosing specific antibiotics for treating a UTI?

- "Antibiotics are chosen based on their effectiveness against the common bacteria causing UTIs, patient allergy history, local resistance patterns, and potential side effects."

3. How can recurrent UTIs be prevented?

- "Prevention strategies include good personal hygiene, urinating after sexual intercourse, proper hydration, and avoiding irritants such as perfumed products."

4. What are the indications for imaging in a UTI?

- "Imaging is considered in cases of recurrent UTIs, suspected anatomical abnormalities, or if there is no improvement with treatment."

5. What are potential complications of a UTI if left untreated?

- "Complications can include kidney infection (pyelonephritis), sepsis, and, in severe cases, renal damage."

Treatment:

According to NICE guidelines:

- First-choice antibiotic: Nitrofurantoin 100 mg Modified Release capsules twice a day for 3 days, if eGFR >45ml/min.

- If allergic or contraindicated, consider Trimethoprim 200 mg twice a day for 3 days, unless resistance is likely.

- Advise to complete the full course of antibiotics even if symptoms improve.

- Analgesia can be considered for symptom relief, such as paracetamol.

Monitoring:

- Advise the patient to return or contact the clinic if symptoms worsen or do not improve within 48 hours of starting the treatment.

- Follow-up is not routinely required for uncomplicated UTIs, but recurrent infections should prompt further investigation.

Prognosis:

- With appropriate antibiotic treatment, most uncomplicated UTIs resolve within a week.

- Recurrent UTIs may require further evaluation.

- Good hydration and hygiene can help prevent future UTIs.

Differential Diagnoses:

1. Interstitial cystitis: Less likely due to the acute onset and positive signs of infection on urine dipstick.

2. Sexually Transmitted Infection (STI): Symptoms primarily urinary, no vaginal discharge, or significant pain, making STI less likely.

3. Vaginitis: Focus of symptoms on urination rather than vaginal inflammation or discharge makes it less likely.

Keyword Filters:

Speciality Filter:

General Practice; Renal And Urology

Presenting Complaint Filter:

Urinary Symptoms; Dysuria; Frequent Urination

Condition Filter:

Urinary Tract Infection

Location Filter:

General Practice

Case created by:

David Bourne, 5th Year Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZBH\_06\_Gonorrhoea

Homepage Vignette:

## A 25-year-old female called Layla presents with a vaginal discharge.

Individual Page Vignette:

You are a General Practice Trainee seeing a 25-year-old female named Layla, an accountant located in your general practice clinic. She presents with complaints of unusual vaginal discharge.

Patient Name:

Layla Farouk (Pronounced: Lay-lah Fah-rook). She prefers being called Layla.

Age:

DOB: 07/08/1998

Location:

General Practice

Personality:

Layla is articulate and direct, unafraid to ask questions and express her concerns. She maintains eye contact while explaining her symptoms, indicating her trust in receiving professional help.

Presenting Complaint:

Layla reports experiencing an unusual, purulent vaginal discharge for the past week accompanied by discomfort during urination.

Quote:

"It's quite embarrassing, but over the last week, I've had this really uncomfortable discharge and it burns when I pee."

Symptoms:

- PV Bleeding: Negligible spotting, light pink colour, thin consistency, no peculiar smell.

- PV Discharge: Increased volume, greenish-yellow colour, thick consistency, slight odour.

Quote: "I've noticed a greenish sort of discharge which is quite thick and a bit smelly."

- Abdominal or Pelvic Pain: Mild lower abdominal discomfort.

Quote: "There's this dull ache in my lower abdomen that won’t go away."

- Chance of Pregnancy: Not pregnant per the last home pregnancy test a few days ago.

- Dyspareunia: Mild discomfort reported.

Quote: "Sex has been a bit painful lately."

- Post-coital PV Bleeding: None reported.

- Intermenstrual PV Bleeding: Not applicable.

- Vulval skin changes or itching: Mild itching around the vulva.

Quote: "It's been quite itchy down there."

History of Presenting Complaint:

- Symptoms onset one week ago.

- No previous similar episodes.

- No treatments attempted.

- Symptoms have been persistent since onset.

- Daily life mildly affected due to discomfort and personal concern.

Quote: "This has been bothering me for a week now; I just had to see someone."

Systemic Symptoms:

- Fatigue: Normal.

- Fever: None reported.

- Night Sweats: Not present.

- Unintended Weight Loss: None reported.

Obstetric History:

Gravidity and Parity: G0P0

Gynaecology History:

- Menstrual History: Regular cycles, lasting 5 days with moderate flow. No dysmenorrhoea.

- Last Menstrual Period: Two weeks ago.

- Previous Screens: Last cervical screening 1 month ago, results were normal.

- Previous Gynaecology Conditions: None reported.

- Previous STIs: None reported.

- Contraception: Currently on a combination oral contraceptive pill.

Past Medical History:

- No significant past medical history.

- No surgeries or hospitalizations.

- Fully vaccinated, including HPV.

- No history of alcohol, substance abuse, or addiction.

Drug History:

- Medications: Combination oral contraceptive pill, daily.

- No history of medication non-compliance.

Allergies:

- Penicillin: Causes rash.

“I once took an antibiotic that gave me an awful rash… the cillin one?”

Family History:

- Mother has type 2 diabetes.

- Father has a history of hypertension.

Social History:

- Lifestyle: Desk-based job, minimal physical activity during work.

- Occupation: Accountant.

- Smoking: Non-smoker.

- Alcohol: Drinks socially, about 3 units per week.

- Recreational Drug Use: None.

- Diet: Balanced diet, occasional fast food.

- Exercise: Attends yoga class twice a week.

Sexual History:

- Last sexual intercourse 2 weeks ago.

- Current partner for the last 6 months, not using condoms due to being on the pill.

Ideas, Concerns, and Expectations:

- Ideas: Layla suspects it might be an STI due to the symptoms.

- Concerns: Worried about the implications of having an STI and its impact on her relationship.

- Expectations: Hopes to get tested and treated promptly. Interested in advice on preventing future occurrences.

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98

Air or Oxygen?: Room air

Blood Pressure (mmHg): 120/80

Pulse (Beats/min): 72

Consciousness (AVPU): A

Temperature (Celsius): 36.7

NEWS Total Score: 0

Physical Examination:

General Inspection: Appears well, no signs of distress or illness.

Abdominal Examination: Soft, non-tender.

Vaginal Examination:

Vulval Inspection: No visible lesions, slight erythema.

Speculum Examination: Greenish-yellow discharge present, no cervical lesions.

Bimanual Examination: Not indicated but would be non-tender, uterus and adnexa normal.

Diagnostic Tests:

Urine Dipstick: Negative

Vaginal Swab: Positive for Neisseria gonorrhoeae

Treatment:

The treatment for gonorrhoea as per the NICE and BNF guidelines includes a single dose of Ceftriaxone 500mg IM.

If allergic to Ceftriaxone, Spectinomycin can be used as an alternative.

Monitoring:

- Advise the patient to abstain from sexual contact until 7 days after treatment, and all sexual partners have been treated.

- Follow-up in one week for a test of cure.

- Discuss the importance of informing all sexual partners from the last six months to prevent the spread of infection.

Prognosis:

- With appropriate treatment, the prognosis for gonorrhoea is excellent.

- Reinfection is possible if exposed again; hence prevention measures should be discussed.

- Infertility issues may arise if left untreated or from recurrent infections.

Differential diagnoses:

1. Chlamydia: Less likely due to the presence of purulent discharge, but often coexists with gonorrhoea.

2. Trichomonas Vaginalis: Presents with frothy discharge, not the thick purulent discharge seen here.

3. Bacterial Vaginosis: Characterised by a fishy odour and grey discharge, not consistent with symptoms.

Patient Questions:

1. "How did I get this infection?" - Possible exposure through unprotected sexual contact with an infected partner.

2. "Will this affect my fertility?" - If treated promptly, gonorrhoea should not affect your fertility.

3. "How can I prevent this in the future?" - Consistent use of condoms and regular STI screenings.

Examiner Questions:

1. What are the first-line treatment options for gonorrhoea according to NICE guidelines?

- "Ceftriaxone and Azithromycin."

2. How would you monitor the effectiveness of treatment for gonorrhoea?

- "Follow up with a test of cure, usually 2 weeks post-treatment."

3. What are the complications associated with untreated gonorrhoea?

- "Pelvic Inflammatory Disease (PID), infertility, and increased risk of ectopic pregnancy (resulting from PID)."

4. Discuss the importance of partner notification and treatment in managing gonorrhoea.

- "To prevent re-infection and the spread of the disease, it’s crucial to ensure that all recent and current partners are notified and treated."

5. Can gonorrhoea lead to systemic infections?

- "Yes, disseminated gonococcal infection can occur, leading to symptoms such as fever, rash, and joint pains."

Speciality Filter:

Infection; Obstetrics and Gynaecology; Sexual Health

Presenting Complaint Filter:

Vaginal Discharge

Condition Filter:

Gonorrhoea

Location Filter:

General Practice

Case created by:

David Bourne, 5th Year Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_07\_Gonorrhoea

Homepage Vignette:

## A 25-year-old female called Ana Rodríguez presents with pelvic pain.

Individual Page Vignette:

You are a general practitioner, and Ana Rodríguez, a 25-year-old teacher located in a General Practice clinic, presents with pelvic pain.

Patient Name:

Ana López [“Ah-nah Loh-pez”]. She prefers to be called Ana.

Age:

15/06/1999

Location:

General Practice

Personality:

Ana is articulate and open about her health concerns. She communicates her symptoms with a level of detail, reflecting her organized and analytical personality. Despite her discomfort, she remains polite and cooperative throughout the consultation.

Presenting Complaint:

Ana reports experiencing sharp pelvic pain and a thick, greenish-yellow vaginal discharge for the past week.

Quote:

“My pelvic area has been really painful, sharp almost, and the discharge... it's not usual, it’s this thick and greenish-yellow stuff.”

Symptoms:

- Site: Pelvic region; “It’s centred around my lower abdomen and pelvis.”

- Onset: Sudden; “This all started out of the blue last week.”

- Character: Sharp; “The pain is quite sharp and stabbing.”

- Radiation: Does not radiate; “No, it doesn’t seem to go anywhere, just stays in that same spot.”

- Associated Symptoms: Greenish-yellow vaginal discharge; “There’s also this very unusual discharge.”

- Timing: Continuous; “It’s been constant since it started.”

- Exacerbating and Relieving Factors: Worsened during urination; “It seems to get a bit worse when I pee.”

- Severity: Moderate to severe; “On a scale, I’d say it’s around a 7 or 8.”

PV Bleeding: None reported.

PV Discharge: Thick, greenish-yellow discharge, unpleasant smell.

Abdominal or Pelvic Pain: Sharp, concentrated in the pelvic region.

Chance of Pregnancy: None.

Dyspareunia: Not reported.

Post-coital PV Bleeding: Not applicable.

Intermenstrual PV Bleeding: None reported.

Vulval skin changes or itching: Not reported.

Quote:

“The discharge is quite worrying for me, and the pain makes it uncomfortable to go through my day.”

History of Presenting Complaint:

- Ana reports the symptoms have been persistent for the past week.

- No previous treatments attempted.

- Symptoms have been constant since onset.

- Impact on daily life significant, interfering with work and physical activities.

- No impact on mental well-being mentioned apart from general concern.

Quote:

“I haven’t tried anything for it yet, hoping it might just go away on its own. But it’s been difficult to concentrate at work.”

Systemic Symptoms:

- Fatigue: None reported.

- Fever: None reported.

- Night Sweats: None reported.

- Unintended Weight Loss: None reported.

- Chest or Shoulder Tip Pain: None reported.

- Shortness of Breath or Cough: None reported.

- Change in Bowel Habits: Normal.

- Change in Urinary Habits: Increased frequency; “I’ve been needing to go more often.”

- Dysuria: Yes; “It burns a little when I urinate.”

- Frequency: Increased.

- Urgency: Increased.

- Oedema: None reported.

- Rashes or Skin Changes: None reported.

- Headache: None reported.

- Mood Changes: None reported.

- Sleep Disturbances: None reported.

Quote:

“I’ve noticed I’m going to the toilet more, and it’s a bit uncomfortable.”

Obstetric History:

Previous Obstetric History: None.

Reproductive Plans: Wishes to have children in the future.

Gynaecology History:

Menstrual History: Regular, no dysmenorrhoea.

Last Menstrual Period: Two weeks ago.

Previous Screens: Last cervical screening 2 years ago, normal results.

Previous Gynaecology Conditions: None.

Previous STIs: None reported.

Contraception: Currently using oral contraceptive pills.

Quote:

“I’ve been pretty regular with my periods, and I’ve never had issues like this before. I do worry what this means for having kids later.”

Past Medical History:

- No previous medical conditions.

- No surgeries or hospitalizations.

- No psychiatric or psychological history.

- No history of alcohol or substance abuse.

- Fully vaccinated, including HPV vaccine.

- No previous STIs.

Quote:

“Healthwise, I’ve been pretty lucky so far, just the usual vaccinations and check-ups.”

Drug History:

- Oral contraceptive pills, taken as prescribed.

- No history of medication non-compliance or overdose incidents.

Quote:

“I’ve been on the pill for a few years now, and it’s been okay. I make sure to take it at the same time every day.”

Allergies:

- No known allergies.

Family History:

- Mother has hypertension.

- Father and brother healthy.

Quote:

“Mum’s got high blood pressure, but that’s about it in the family.”

Social History:

Lifestyle: Leads an active lifestyle.

Occupation: Primary school teacher.

Activities of Daily Living & Hobbies: Enjoys hiking and painting.

Smoking: Non-smoker.

Alcohol: Drinks socially, approximately 4 units per week.

Recreational Drug Use: None.

Diet: Balanced diet, includes vegetarian meals.

Exercise: Regular, 3 times per week.

Sexual History:

Last sexual intercourse: Three weeks ago.

Current and previous partners: Currently in a monogamous relationship.

Contraception used: Oral contraceptive pills.

Quote:

“I like to keep active and healthy. Teaching can be stressful, but my hobbies help me unwind. I’m careful with contraception and have been with my partner for a few years now.”

Ideas, Concerns, and Expectations:

- Ideas: Ana suspects the symptoms might be related to a sexual health issue.

- Concerns: Worried about the potential impact on fertility.

- Expectations: Seeks reassurance, accurate diagnosis, and effective treatment.

Quote:

“I’m worried this might be something serious like an STI... I really hope it won’t affect my chances of having children. I just want to know what’s wrong and get it treated.”

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98

Air or Oxygen?: Room air

Blood Pressure (mmHg): 120/80

Pulse (Beats/min): 72

Consciousness (AVPU): Alert

Temperature (Celsius): 37.0

NEWS Total Score: 0

Physical Examination:

General Inspection: Appears mildly uncomfortable but no signs of acute distress.

Objects and Equipment: None.

Hands: Normal colour, no palmar erythema, and no peripheral oedema.

Neck: No masses or lymphadenopathy.

Face: Normal complexion, no jaundice.

Abdominal Examination: Soft, non-tender on palpation.

Vaginal Examination: Vulval Inspection: Normal appearance, no lesions.

Speculum Examination: Greenish-yellow discharge present.

Bimanual Examination: Uterus and ovaries unremarkable; no masses or tenderness.

Special Tests: N/A

Diagnostic Tests:

Urine Dipstick: Normal.

Vaginal Swab: Positive for Neisseria gonorrhoeae.

Blood Tests (Reference Ranges):

Full Blood Count (FBC): Within normal ranges.

Urea and Electrolytes: Within normal ranges.

Condition:

Gonorrhoea

Patient Questions:

1. "Could this affect my fertility?"

- "While gonorrhoea can impact fertility if left untreated, with prompt and effective treatment, the chances of this are significantly reduced. It’s important to follow through with the treatment plan and post-treatment checks."

2. "Will my partner need treatment as well?"

- "Yes, it’s very likely your partner will also need treatment to prevent re-infection and spread of the infection. It’s advisable for both of you to be treated simultaneously."

3. "How is gonorrhoea treated?"

- "Gonorrhoea is treated with antibiotics, usually a single dose of Ceftriaxone and Azithromycin. It’s crucial to complete the course as prescribed."

4. "Can I still have children after this?"

- "Yes, you can still have children. Gonorrhoea, once properly treated, should not prevent you from having children in the future. However, it’s wise to have regular health checks and follow safe sex practices."

Examiner Questions:

1. What are the first-line treatment options for gonorrhoea according to NICE guidelines?

- "Ceftriaxone and Azithromycin."

2. How would you monitor the effectiveness of treatment for gonorrhoea?

- "Follow up with a test of cure, usually 2 weeks post-treatment."

3. What are the complications associated with untreated gonorrhoea?

- "Pelvic Inflammatory Disease (PID), infertility, and increased risk of ectopic pregnancy (After potential PID)."

4. Discuss the importance of partner notification and treatment in managing gonorrhoea.

- "To prevent re-infection and the spread of the disease, it’s crucial to ensure that all recent and current partners are notified and treated."

5. Can gonorrhoea lead to systemic infections?

- "Yes, disseminated gonococcal infection can occur, leading to symptoms such as fever, rash, and joint pains."

Treatment:

1. Administer a single dose of Ceftriaxone 500mg intramuscularly.

2. If the sensitivities are known, administer a single dose of Azithromycin 1g orally.

3. Ensure both the patient and her partner receive treatment and advise them to abstain from sexual activity until the treatment is completed and a test of cure is confirmed.

4. Schedule a follow-up visit for a test of cure 2 weeks post-treatment.

5. If allergic to the initial antibiotic options, consult the latest guidelines for alternative treatments.

Monitoring:

- Advise the patient to return for a test of cure 2 weeks after completing treatment.

- Monitor for any signs of persisting or recurrent symptoms.

- Encourage annual sexual health screenings or more frequently if the patient changes sexual partners.

Prognosis:

- With adequate and timely treatment, complete recovery is expected.

- Early treatment significantly reduces the risk of complications, including infertility.

- Reinfection is possible; safe sex practices and regular screenings are crucial for prevention.

Differential diagnoses:

1. Chlamydia: Similar symptoms but requires different antibiotic treatment.

2. Bacterial Vaginosis: Usually presents with a fishy odour and grey discharge; treated with Metronidazole or Clindamycin.

3. Trichomonas Vaginalis: Typically presents with a frothy, yellow-green discharge and may have a strawberry cervix on examination.

4. Pelvic Inflammatory Disease (PID): A complication of untreated STIs with more severe abdominal pain and fever.

Speciality Filter:

Infection; Sexual Health; General Practice;

Presenting Complaint Filter:

Pelvic Pain; Vaginal Discharge;

Condition Filter:

Gonorrhoea

Location Filter:

General Practice

Case created by:

David Bourne, 5th Year Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_08\_Gonorrhoea

Homepage Vignette:

## A 25-year-old female called Maria presents with unusual vaginal discharge.

Individual Page Vignette:

You are a General Practitioner in the clinic, meeting Maria, a 25-year-old administrative assistant, located in your clinic, presenting with unusual vaginal discharge and lower abdominal pain.

Patient Name:

Maria Fernandez [muh-REE-ah fer-NAN-dez] (She prefers to be called Maria)

Age:

15/06/1999

Location:

Clinic

Personality:

Maria is articulate and straightforward. She speaks clearly and does not shy away from discussing her symptoms or her lifestyle choices. Maria is also pragmatic, often asking for clear explanations and wanting to understand the details of her condition and the available treatment options.

Presenting Complaint:

Maria reports experiencing unusual vaginal discharge that she describes as increased in volume and greenish in colour, accompanied by lower abdominal pain.

Quote:

“My discharge seems a lot more than usual, and it's sort of greenish—it's worrying me. And my lower belly has been aching for a few days now.”

Symptoms:

Site:

- Vagina for discharge; “I’m feeling it all coming from down there.”

- Lower abdomen for pain; “It’s like a constant ache right here in my lower belly.”

Onset:

- Sudden onset a few days ago for both symptoms; “This all started out of nowhere around three days ago.”

Character:

- The discharge is thick and greenish; "It's thicker than normal and kind of green."

- Abdominal pain is described as a persistent ache; “It’s more like a constant, nagging ache.”

Radiation:

- Pain does not radiate; “The pain stays in my lower belly, doesn’t really go anywhere else.”

Associated Symptoms:

- Some urination discomfort; “I’ve also felt a bit of a burning sensation when I pee.”

Timing:

- Symptoms have been persistent for the past few days; “It’s been like this day and night for the last three days.”

Exacerbating and Relieving Factors:

- No specific exacerbating or relieving factors mentioned; “Nothing I do makes it better or worse, it’s just there.”

Severity:

- The pain is moderate; "On a scale from 1 to 10, it's about a 5."

PV Bleeding: Negative.

PV Discharge: Increased volume, greenish in colour, thick consistency.

Abdominal or Pelvic Pain: Persistent lower abdominal ache.

Chance of Pregnancy: Low, but not completely ruled out.

Dyspareunia: Negative.

Post-coital PV Bleeding: Negative.

Intermenstrual PV Bleeding: Negative.

Vulval skin changes or itching: Negative.

History of Presenting Complaint:

- Symptoms started spontaneously three days ago.

- No previous similar episodes.

- Has been progressively worrying her.

- Symptoms are persistent, affecting her daily comfort.

- Negative impact on work due to distraction by discomfort.

- Seeking medical attention due to concern for the abnormal discharge and persistent lower abdominal pain.

Quote:

“I’ve never had anything like this before. The constant discomfort is really getting to me, especially at work. I just want to know what’s going on.”

Systemic Symptoms:

Fatigue: Normal.

Fever: Negative.

Night Sweats: Negative.

Unintended Weight Loss: Negative.

Chest or Shoulder Tip Pain: Negative.

Shortness of Breath or Cough: Negative.

Change in Bowel Habits: Negative.

Change in Urinary Habits: Some burning sensation on urination; discomfort during urination but no frequency or urgency.

Oedema: Negative.

Rashes or Skin Changes: Negative.

Headache: Negative.

Mood Changes: Negative.

Sleep Disturbances: Negative.

Quote:

“Besides the discharge and the pain in my belly, I’ve not noticed anything else out of the ordinary.”

Obstetric History:

Previous Obstetric History: G0P0

Reproductive Plans: Not actively planning pregnancy currently.

Quote:

“I’m not looking to have children at the moment; maybe in the future.”

Gynaecology History:

Menstrual History: Regular cycles, 28 days, moderate flow, lasts 5 days, minimal dysmenorrhoea.

Last Menstrual Period: Approximately two weeks ago.

Previous Screens: Last cervical screening 1 year ago, results were normal.

Previous Gynaecology Conditions: N/A.

Previous STIs: One previous chlamydia infection treated two years ago.

Contraception: Currently using condoms, previously on the oral contraceptive pill.

Quote:

“My cycles are pretty regular. I had chlamydia once a couple of years back, but it was treated. Right now, I’m just using condoms for protection.”

Past Medical History:

- No significant medical conditions.

- No surgeries or hospitalizations.

- Fully vaccinated, including HPV vaccine.

- Previous STI (chlamydia) as mentioned.

- No other significant health events.

Quote:

“I’ve been generally healthy, nothing major to report.”

Drug History:

- No current prescription medications.

- Previously used the oral contraceptive pill, stopped one year ago.

- Occasionally takes over-the-counter pain relief for headaches or menstrual cramps.

Quote:

“I don’t take much medication, just some painkillers now and then when I need them.”

Allergies:

- No known allergies.

Quote:

“Luckily, I’ve never had a reaction to anything.”

Family History:

- Mother has hypertension.

- Father is healthy.

- One sibling with asthma.

Quote:

“My mum has high blood pressure, but that’s about it for family health issues.”

Social History:

Lifestyle: Generally healthy.

Occupation: Administrative assistant.

Activities of Daily Living & Hobbies: Enjoys reading and jogging.

Smoking: Non-smoker.

Alcohol: Social drinker, approximately 2 units per week.

Recreational Drug Use: None.

Diet: Generally balanced diet.

Exercise: Regular jogging, 3 times a week.

Sexual History:

Last sexual intercourse: One month ago.

Current and previous partners: Three partners in total in the last year, currently single.

Contraception: Condom use.

Quote:

“I’m not seeing anyone at the moment. When I do, I make sure we use protection.”

Ideas, Concerns, and Expectations:

- Worried the symptoms could indicate an STI or something serious.

- Concerned about the impact on her daily life.

- Expects a full examination and hopes for effective treatment.

Quote:

“I’m worried this could be something like an STI. I just want to get it sorted so I can move on without this constant discomfort.”

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98

Air or Oxygen?: Room air

Blood Pressure (mmHg): 120/75

Pulse (Beats/min): 76

Consciousness (AVPU): Alert

Temperature (Celsius): 36.7

NEWS Total Score: 0

Physical Examination:

General Inspection: Appears well, no signs of distress.

Objects and Equipment: None.

Hands: Normal colour, no palmar erythema or peripheral oedema.

Neck: No masses or lymphadenopathy.

Face: No pallor or jaundice.

Abdominal Examination: Soft, non-tender on palpation.

Vaginal Examination:

- Vulval Inspection: No ulcers, cysts, or scarring. Notable greenish discharge noted.

Speculum Examination: Cervical os normal, no erosions or masses, greenish discharge present.

Bimanual Examination: No tenderness, uterus and ovaries normal.

Diagnostic Tests:

Urine Dipstick: Normal.

STI Screen: Sent for screening, positive result for gonorrhoea.

Blood Tests (Reference Ranges):

Full Blood Count (FBC): All within normal ranges.

Urea and Electrolytes: All within normal ranges.

Condition:

Gonorrhoea

Treatment:

For gonorrhoea, the recommended treatment according to the NICE guidelines is:

- Ceftriaxone 500mg by intramuscular injection, single dose.

- Azithromycin 1g orally as a single dose, only if sensitivities are known.

Monitoring:

- Advise the patient to avoid sexual contact until treatment is completed and all symptoms have resolved.

- Recommend a follow-up appointment in 2 weeks to ensure resolution of symptoms and discuss results of tests.

- Mention re-testing for gonorrhoea and other STIs according to local guidelines, usually 3 months post-treatment.

Prognosis:

- With appropriate treatment, symptoms should resolve within a few days, and the infection typically clears within a week.

- Reinfection is possible; patients should be counselled on safe sex practices.

- Infertility is a potential complication if left untreated.

Differential diagnoses:

1. Chlamydia: Less likely due to the colour and consistency of the discharge.

2. Bacterial vaginosis: Typically associated with a fishy odour, not present here.

3. Trichomoniasis: Could present similarly but generally causes frothy discharge.

Patient Questions:

1. "Will this treatment cure the gonorrhoea?"

- Yes, the treatment we’re giving is very effective at curing gonorrhoea.

2. "Can I have sex after the treatment?"

- You should avoid sexual contact until 7 days after you have completed the treatment and any symptoms have fully resolved.

3. "Do I need to tell my previous partners?"

- Yes, it is important to inform any recent sexual partners so they can also be tested and treated if necessary.

Examiner Questions:

1. What are the first-line treatment options for gonorrhoea according to NICE guidelines?

- Ceftriaxone 500mg IM single dose potentially with Azithromycin 1g orally single dose.

2. How do you differentiate between gonorrhoea and chlamydia based on clinical presentation?

- While both can present with discharge, the greenish-thick discharge is more characteristic of gonorrhoea.

3. What complications can arise from untreated gonorrhoea?

- Pelvic inflammatory disease, infertility, and potential spread to other parts of the body.

4. Why is dual therapy recommended for the treatment of gonorrhoea?

- To cover potential co-infections such as chlamydia.

5. How would you counsel a patient on preventing STI transmission?

- Discuss the importance of condom use, reducing the number of sexual partners, and regular STI screening.

Speciality Filter:

Infection; Sexual Health; General Practice;

Presenting Complaint Filter:

Pelvic Pain; Vaginal Discharge;

Condition Filter:

Gonorrhoea

Location Filter:

General Practice

Case created by:

David Bourne, 5th Year Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_09\_Gonorrhoea

Homepage Vignette:

## A 29-year-old female called Nadia presents with pelvic discomfort.

Individual Page Vignette:

You are a GP in a clinic faced with a 29-year-old patient named Nadia, a schoolteacher, located in a clinic, presenting with increased vaginal discharge and pelvic discomfort.

Patient Name:

Nadia Zareen (Nah-dia Zuh-reen, prefers to be called Nadia)

Age:

29 years old, DOB: 15/07/1994

Location:

Clinic

Personality:

Nadia is articulate and has an inquisitive nature. She speaks confidently and makes eye contact during the conversation.

Presenting Complaint:

Nadia reports experiencing an increase in vaginal discharge and pelvic discomfort.

Quote: “I've noticed this unusual discharge that’s quite different from before, and there’s this nagging discomfort in my pelvis.”

Symptoms:

- Site: Pelvic region; "The discomfort is mostly around here, in my lower belly."

- Onset: Started 1 week ago; "This all started about a week back."

- Character: Discomfort described as a constant, dull ache; "It feels like a constant dull ache down there."

- Radiation: Does not radiate; "No, it doesn't move from that spot."

- Associated Symptoms: Increased yellow-greenish vaginal discharge; "Along with the ache, there's also this weird yellow-green discharge."

- Timing: Constant discomfort with intermittent worsening; "It’s always there but feels worse at times."

- Exacerbating and Relieving Factors: Wearing tight clothing exacerbates discomfort; cleanliness provides slight relief; "Tight jeans make it worse, but keeping things clean down there helps a bit."

- Severity: Rated as 5/10 on the severity scale; "On a scale, I'd say it’s about a 5 out of 10.”

PV Bleeding: None reported

PV Discharge: Increased volume, yellow-greenish, sticky consistency, unpleasant smell.

Abdominal or Pelvic Pain: Present as described in symptoms.

Chance of Pregnancy: Using the Mirena coil, the chance of pregnancy is very unlikely.

Dyspareunia: Not reported

Post-coital PV Bleeding: Not reported.

Intermenstrual PV Bleeding: Not reported.

Vulval skin changes or itching: Not reported.

Quote: “No, there hasn’t been any itching or skin changes that I’ve noticed.”

History of Presenting Complaint:

- Nadia has been experiencing these symptoms for roughly 1 week.

- No previous treatments attempted.

- Symptoms have remained consistent since onset.

- The symptoms are constant with intermittent worsening.

- Impact on daily life includes discomfort during work and leisure activities.

- No impact on work efficiency reported.

- Physical wellbeing affected by discomfort; mental wellbeing slightly anxious due to symptoms.

Quote: “It’s been like this for a week now, and it’s starting to get on my nerves.”

Systemic Symptoms:

- Fatigue: Normal

- Fever: None

- Night Sweats: None

- Unintended Weight Loss: None

- Chest or Shoulder Tip Pain: None

- Shortness of Breath or Cough: None

- Change in Bowel Habits: Normal

- Change in Urinary Habits: Normal

- Dysuria: None

- Oedema: None

- Rashes or Skin Changes: None

- Headache: None

- Mood Changes: Slight anxiety due to symptoms

- Sleep Disturbances: Normal

Quote: “Other than this issue, I feel pretty normal, just a bit worried.”

Obstetric History:

- Previous Obstetric History: None

- Gravidity and Parity: Nulligravida

- Reproductive Plans: Not actively planning children currently.

Gynaecology History:

- Menstrual History before the Mirena Coil: Regular, every 28 days, moderate volume, 5-day duration, with mild dysmenorrhoea.

- Last Menstrual Period: 2 years ago.

- Previous Screens: Last cervical screening 2 years ago, normal results.

- Previous Gynaecology Conditions: None reported.

- Previous STIs: None reported.

- Contraception: Currently using Mirena coil.

Past Medical History:

- No previous medical conditions reported.

- No previous surgeries or hospitalizations.

- Fully immunized, HPV vaccinations received.

- No previous STIs.

“Healthwise, I’ve been pretty lucky so far, just the usual vaccinations and check-ups.”

Drug History:

- Mirena coil currently in use for contraception.

- No other medications taken.

- No history of medication non-compliance or missed doses.

“I don’t take any medications or anything like that, just got the Mirena coil a couple years back now.”

Allergies:

- No known allergies.

“I don’t think I have any allergies.”

Family History:

- Mother has hypertension.

- Paternal grandfather had type 2 diabetes.

- No other significant family medical history.

“My mum has high blood pressure and one of my grandads has diabetes”

Social History:

- Lifestyle: Active, enjoys hiking.

- Occupation: School teacher.

- Smoking: Non-smoker

- Alcohol: Occasional, 2-3 units per week.

- Recreational Drug Use: None

- Diet: Balanced, includes vegetables and fruits.

- Exercise: Regular, attends a yoga class weekly.

“I think I live a pretty normal life, I am a teacher at a local school which I really enjoy!”

Sexual History:

- Last sexual intercourse over a month ago.

- Has had 5 sexual partners in the past year.

- Currently uses Mirena coil for contraception, no additional methods used.

Ideas, Concerns, and Expectations:

- Ideas: Nadia suspects an infection due to the discharge and discomfort.

- Concerns: Worries about the possibility of an STI and its implications.

- Expectations: Seeks reassurance, a diagnosis, and effective treatment.

Quote: “I’m really hoping this isn’t something serious... Can you tell me what’s going on?”

Observations:

- Respirations: 16 Breaths/min

- Oxygen Saturation: 98% on room air

- Blood Pressure: 120/80 mmHg

- Pulse: 78 Beats/min

- Consciousness: Alert

- Temperature: 36.6 Celsius

- NEWS Total Score: 0

Physical Examination:

- General Inspection: Appears well, no signs of distress

- Objects and Equipment: None

- Hands: Normal colour, no peripheral oedema

- Neck: No lymphadenopathy

- Face: Normal, no pallor or jaundice

- Abdominal Examination: Soft, non-tender

- Vaginal Examination: Vulval Inspection shows no lesions or masses.

- Speculum Examination: Increased green discharge noted, no cervical erosion.

- Bimanual Examination: Uterus and ovaries normal, no masses or tenderness.

Diagnostic Tests:

- Urine Dipstick: Normal

- Vaginal Swab: Positive for Neisseria gonorrhoeae

- STI Screen: Positive for gonorrhoea, other tests negative

- MSU: Not indicated

Blood Tests (Reference Ranges):

- Full Blood Count (FBC): Within normal ranges (Not indicated)

Treatment:

- Ceftriaxone 500 mg IM as a single dose PLUS Azithromycin 1 g orally as a single dose if sensitivities known.

- Advise abstinence from sexual intercourse until 7 days after both patient and partner(s) have completed treatment.

- Educate on the importance of informing sexual partners.

- Follow-up in 2 weeks to ensure resolution of symptoms.

Monitoring:

- Follow-up appointment for symptom review and test of cure if symptoms persist.

- Discussion on safer sexual practices and regular STI screenings.

Prognosis:

- With appropriate treatment, complete resolution of symptoms is expected.

- Good prognosis if treated promptly and effectively.

- Advice on regular STI screening as part of sexual health.

Differential Diagnoses:

1. Bacterial Vaginosis: Less likely due to specific characteristics of discharge and positive gonorrhoea test.

2. Chlamydia: Considered but ruled out with STI screen.

3. Trichomoniasis: Possible, but specific testing identified gonorrhoea.

Patient Questions:

1. "Can you get rid of this completely?" - Yes, with the right treatment, gonorrhea can be completely cured.

2. "Will this affect my fertility?" - If treated promptly, gonorrhoea should not impact your fertility.

3. "How long before I can have sex again?" - You should wait at least 7 days after you and your partner have completed treatment.

4. "Should I inform my previous partners?" - Yes, it's important to inform them so they can also get tested and treated if necessary.

Examiner Questions:

1. What is the first-line treatment for gonorrhoea? - Ceftriaxone plus Azithromycin.

2. How does gonorrhoea present? - Symptoms can include increased vaginal discharge, pelvic pain, dysuria.

3. What are the potential complications of untreated gonorrhoea? - Pelvic inflammatory disease (PID), infertility, ectopic pregnancy.

4. How should a patient be counselled on sexual health following a diagnosis of gonorrhoea? - Discuss safer sex practices, the importance of using condoms, and regular STI screening.

5. What follow-up is needed after treatment for gonorrhoea? - A test of cure if symptoms persist and regular STI screening as part of ongoing sexual health care.

Speciality Filter:

Sexual Health; Obstetrics And Gynaecology; General Practice

Presenting Complaint Filter:

Vaginal Discharge; Pelvic Pain

Condition Filter:

Gonorrhoea

Location Filter:

Clinic

Case created by:

David Bourne, 5th Year Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_10\_Gonorrhoea

Homepage Vignette:

## A 28-year-old female called Beatriz presents with painful urination.

Individual Page Vignette:

As a general practitioner, you are consulting with Beatriz, a 28-year-old journalist, located in a General Practice. She presents with painful urination.

Patient Name:

Beatriz Alvarez (Phonetic Pronunciation: Bee-ah-treez Al-vah-rez) prefers to be called Bea.

Age:

14/06/1995

Location:

General Practice

Personality:

Bea is a very articulate and assertive individual. She speaks quickly, often with a humorous undertone, but is clearly concerned about her symptoms.

Presenting Complaint:

Bea reports experiencing painful urination and noticing an unusual increase in her vaginal discharge.

Quote:

"It's like every trip to the loo has become a mission. And don’t get me started on this weird discharge situation. It's unnerving!"

Symptoms:

- Site: Urethra and Vagina "It's all happening downstairs, which is just lovely."

- Onset: "This all started a few days ago, out of the blue."

- Character: Pain is burning, discharge is yellow and thick. "It burns when I pee, and the discharge looks like someone sneezed in my underwear."

- Radiation: "No, the pain doesn't go anywhere else, it just burns right where the action is."

- Associated Symptoms: None reported. "Nope, it's just these two delightful symptoms."

- Timing: "It's been constant for a few days now."

- Exacerbating and Relieving Factors: "Nothing seems to make it better or worse; it just is."

- Severity: "On a scale of 'annoying' to 'call an exorcist,' I’d say we’re solidly at 'seriously irritating.'"

PV Bleeding: None "No bonus bleeding, thankfully."

PV Discharge: Increased volume, yellow, thick consistency, no distinctive smell reported. "It's more like I've got a cold down there, sans the smell."

Abdominal or Pelvic Pain: None "No pain in the belly or pelvis, just the burning."

Chance of Pregnancy: Low "Highly unlikely, unless it's an immaculate conception."

Dyspareunia: Not reported.

Post-coital PV Bleeding: Not reported.

Intermenstrual PV Bleeding: Not reported.

Vulval skin changes or itching: None reported.

History of Presenting Complaint:

- Bea has been experiencing symptoms for several days.

- No previous treatments attempted.

- Symptoms have remained consistent since onset.

- Impact on daily life includes discomfort during urination and concern about discharge.

- Work and mental wellbeing impacted by constant discomfort and worry.

Quote:

"It’s as if my body decided to have a party without me. Not fun, especially when you're trying to work."

Systemic Symptoms:

- Fatigue: Normal

- Fever: Normal

- Night Sweats: Normal

- Unintended Weight Loss: Normal

- Chest or Shoulder Tip Pain: Normal

- Shortness of Breath or Cough: Normal

- Change in Bowel Habits: Normal

- Change in Urinary Habits: Increased frequency due to discomfort.

- Dysuria: Present

- Frequency: Increased

- Urgency: Normal

- Oedema: Normal

- Rashes or Skin Changes: Normal

- Headache: Normal

- Mood Changes: Normal

- Sleep Disturbances: Normal

Quote:

"No fever or anything else really, just this specific... situation. I sleep fine, no weird skin stuff. Just when I thought my urinary tract couldn’t get any more exciting."

Obstetric History:

Gravidity and Parity: G0 P0+0

Reproductive Plans:

Bea has no immediate plans for having children but might consider it in the future.

Quote:

"Kids? Maybe someday. But right now, I’m more concerned about not peeing fire."

Gynaecology History:

Menstrual History before the POP: Normal

Duration: 5 days

Frequency: Every 28 days

Volume: Moderate

Dysmenorrhoea: None

Previous Screens: Up to date with cervical screenings, no abnormalities.

Previous Gynaecology Conditions: None reported.

Previous STIs: None reported.

Contraception: Currently using Progesterone-only pill (POP).

Quote:

"Everything down there was hunky-dory until this. And yes, I keep up with my screenings like a good citizen."

Past Medical History:

- No previous significant medical conditions or surgeries.

- Vaccinations up to date, including HPV.

- No previous STIs.

Quote:

"I’m as healthy as a horse, usually. This is my first real rodeo with something...icky."

Drug History:

- Currently taking the Progesterone-only pill, no missed doses reported.

- No history of medication non-compliance.

- No use of herbal supplements or alternative therapies mentioned.

Quote:

"Just the pill for me, thanks. I’m not really into the whole herbal remedy scene."

Allergies:

- No known allergies.

Quote:

“Allergies? Nah, I’m tough. It takes more than a bit of pollen to knock me down."

Family History:

- No significant family medical history reported.

Quote:

"My family’s pretty robust. We’re like weeds, hard to get rid of."

Social History:

Lifestyle: Active social life, no recent changes.

Occupation: Journalist

Activities of Daily Living & Hobbies: Enjoys cycling and photography.

Smoking: Non-smoker

Alcohol: Drinks socially, approximately 4 units per week.

Recreational Drug Use: None.

Diet: Balanced diet, includes fruits and vegetables.

Exercise: Regular cycling.

"I try to keep active; you never know when you need to chase down a story."

"Photography’s my way to unwind. Nothing like capturing a moment."

"Alcohol? Only socially. I prefer to keep my wits about me."

Sexual History:

Last sexual intercourse: 1 week ago

Current and previous partners: Multiple partners in the last year, consistent use of condoms not confirmed.

Contraception used: Progesterone-only pill.

"Let’s just say, my love life is as complex as my coffee order. And no, I don’t always remember the condom."

Ideas, Concerns, and Expectations:

- Bea believes her symptoms might be related to a sexually transmitted infection due to the nature of her symptoms and her sexual history.

- She is concerned about the impact this may have on her fertility and overall health.

- Expectations include a clear diagnosis, treatment options, and advice on how to prevent future infections.

Quote:

"I’m worried this could be something serious like an STI. I mean, not exactly how I planned my week to go. What are we looking at here, doctor? I need something that works, and fast."

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98% on room air

Blood Pressure (mmHg): 122/78

Pulse (Beats/min): 78

Consciousness (AVPU): Alert

Temperature (Celsius): 36.7°C

NEWS Total Score: 0

The patient's NEWS total score is 0

Physical Examination:

General Inspection

- Overall appearance healthy, no signs of distress or confusion.

Objects and Equipment

- No equipment or aids present.

Hands

- Inspection: Normal colour, no palmar erythema or peripheral oedema.

- Palpitation: Warm, CRT <2s, radial pulse regular in rate and volume.

Neck

- No masses, goitres, or lymphadenopathy. JVP not raised.

Face

- No melasma, conjunctival pallor, or jaundice.

Abdominal Examination

- Inspection: Normal, no distension.

- Palpitation: Soft, non-tender, no masses felt.

Vaginal Examination:

- Vulval Inspection: Normal anatomy, no ulcers, cysts, or lesions.

- Speculum Examination: Yellow discharge noted, no cervical erosions or masses.

- Bimanual Examination: Cervix and uterus normal; no tenderness or masses in the adnexa.

Diagnostic Tests:

- Urine Dipstick: Leukocytes positive, Nitrites negative.

- Vaginal Swab: Sent for culture and sensitivity which is positive gonorrhoea.

Treatment:

Treatment for gonorrhoea as per NICE guidelines:

- Ceftriaxone 500mg IM single dose.

- Consider dual therapy with Azithromycin 1g orally as a single dose if chlamydia co-infection cannot be excluded.

- Advise to avoid sexual intercourse until treatment completion and partner(s) are treated.

- Inform and treat current and recent sexual partners.

- Retest for gonorrhoea and other STIs after treatment completion.

Monitoring:

- Follow-up visit in 2 weeks to ensure symptom resolution.

- Retest for gonorrhoea 3 months post-treatment per guidelines to check for reinfection.

- Advice on safer sex practices and the importance of condom use.

Prognosis:

- With appropriate antibiotic treatment, the prognosis for gonorrhoea is excellent.

- It is important to treat to prevent complications such as pelvic inflammatory disease.

- Reinfection can occur; hence, prevention and safe sex practices are crucial.

Differential diagnoses:

1. Chlamydia: Symptoms overlap but distinct bacterial cause, diagnosed via testing.

2. Urinary Tract Infection: Could present with similar urinary symptoms, less likely due to discharge.

3. Bacterial Vaginosis: Characteristic discharge differs in smell, less likely without fishy odour.

4. Trichomoniasis: Similar presenting symptoms, different causative organism.

Keyword Filters:

Speciality Filter: General Practice;

Infectious Diseases; Sexual Health;

Presenting Complaint Filter:

Dysuria; Vaginal Discharge;

Condition Filter:

Gonorrhoea;

Case created by:

David Bourne, 5th Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_11\_Chlamydia

Homepage Vignette:

## A 23-year-old female called Lina Zhou presents with lower abdominal pain.

Individual Page Vignette:

You are a General Practice doctor seeing a 23-year-old patient named Lina Zhou, a university student, located in a General Practice setting, who presents with lower abdominal pain.

Patient Name:

Lina Zhou (Pronunciation: Lee-na Joe). She would like to be called Lina.

Age:

01/05/2001

Location:

General Practice

Personality:

Lina is articulate and inquisitive. She speaks in a measured pace and likes to understand details about her health and condition.

Presenting Complaint:

Lina is seeking medical attention due to experiencing lower abdominal pain and unusual, yellow-coloured vaginal discharge for the past week.

Quote:

"It started as a mild discomfort, but now the abdominal pain is quite nagging. I also thought I would mention that I have had some vaginal discharge too, it's not like normal for me."

Symptoms:

- Site: Hypogastric region; "It's more like a dull ache in the lower part here."

- Onset: Gradual; "It built up over a few days."

- Character: Cramping; "It kind of cramps and aches."

- Radiation: Does not radiate; "It just stays in that lower area."

- Associated Symptoms: Unusual vaginal discharge; "I've also noticed this weird discharge."

- Timing: Ongoing for the past week; "It’s been like this for around a week now."

- Exacerbating and Relieving Factors: Nothing specific; "I haven't noticed anything that makes it worse or better."

- Severity: Moderate; "It's quite uncomfortable at times."

PV Bleeding: None reported.

PV Discharge: Increased volume, yellow colour, thicker than normal consistency, no noticeable smell.

Abdominal or Pelvic Pain: Lower abdominal pain described.

Chance of Pregnancy: Low, uses contraception.

Dyspareunia: Not reported.

Post-coital PV Bleeding: Not reported.

Intermenstrual PV Bleeding: Not reported.

Vulval skin changes or itching: Not reported.

Quote:

"That discharge is not normal for me, it's yellow and thicker."

History of Presenting Complaint:

- Lina has been experiencing symptoms for about a week.

- No previous treatments have been attempted.

- Symptoms have remained consistent over the past week.

- Symptoms are affecting her comfort and concentration on daily tasks.

- No impact on work mentioned, but Lina is a student and mentions difficulty focusing on studies.

- Lina expresses concern regarding the symptoms impacting her overall wellbeing.

Quote:

"I've never had anything like this before; it's making me worry and disrupts my studies."

Systemic Symptoms:

- Fatigue: Normal

- Fever: None

- Night Sweats: None

- Unintended Weight Loss: None

- Chest or Shoulder Tip Pain: None

- Shortness of Breath or Cough: None

- Change in Bowel Habits: Normal

- Change in Urinary Habits: Normal

- Dysuria: None

- Frequency: Normal

- Urgency: Normal

- Oedema: None

- Rashes or Skin Changes: None

- Headache: None

- Mood Changes: None

- Sleep Disturbances: None

Quote:

"Besides the pain and discharge, I feel okay, no fever or anything."

Obstetric History:

Previous Obstetric History: None reported.

Gravidity and Parity: G0 P0

Reproductive Plans: Would like children in the future but not currently planning.

Quote:

"I'm not planning on having children anytime soon, but maybe one day."

Gynaecology History:

Menstrual History: Regular; 28-day cycle; Moderate flow; 5-day duration; No dysmenorrhoea.

Last Menstrual Period: Two weeks ago.

Contraception: Oral contraceptive pill for the past 2 years.

Quote:

"My periods have always been pretty regular, nothing out of the ordinary. Thankfully, it’s been much lighter since I have started the pill too"

Past Medical History:

- No significant past medical conditions.

- No past surgeries or hospitalizations.

- Full immunizations, including HPV vaccine.

- No previous STIs.

- No history of gastrointestinal conditions.

Quote:

"I've been relatively healthy all my life, thankfully."

Drug History:

- Oral contraceptive pill, details as per current prescription.

- Occasional paracetamol for headaches.

- No history of medication non-compliance.

- No herbal supplements or alternative therapies.

Quote:

"I take my pill consistently and sometimes paracetamol, that's about it."

Allergies:

- No known allergies.

Quote:

"I’ve never had an allergic reaction to anything before."

Family History:

- Mother has hypertension.

- Father: No significant medical history.

- One younger sibling, healthy.

Quote:

"My mum has high blood pressure, but that's about it for family health issues."

Social History:

Lifestyle: University student, active in student organizations.

Occupation: Full-time student.

Activities of Daily Living & Hobbies: Enjoys photography and hiking.

Smoking: Non-smoker.

Alcohol: Drinks socially, approximately 2 units per week.

Recreational Drug Use: None.

Diet: Balanced diet with a preference for vegetables and lean proteins.

Exercise: Regular, enjoys yoga and jogging 3 times per week.

Quote:

"I try to stay active and eat healthily. Being a student keeps me busy, but I manage to find time for my hobbies."

Sexual History:

Last sexual intercourse: Four weeks ago.

Current and previous partners: Has had two sexual partners in the past year, currently in a monogamous relationship.

Contraception used: Oral contraceptive pill and condoms with previous partners.

ICE:

- Quote: "I’m hoping you can tell me exactly what’s going on and that it’s nothing too serious. I need to know what the treatment involves – and how I should talk to my partner about this. Plus, what can I do to make sure I don’t end up in this situation again?"

Quote:

"I'm cautious about protecting myself; I use the pill and sometimes used to use condoms."

Abdominal Examination

Inspection: The abdomen is flat and shows no signs of distension or visible masses.

Palpation: Soft and non-tender on palpation. No hepatosplenomegaly or masses felt.

Vaginal Examination:

Vulval Inspection:

- Vulva appears normal without any ulcers, cysts, rashes, scarring, or lesions.

- No signs of atrophy or masses observed.

- No evidence of female genital mutilation (FGM), prolapses, or lichen sclerosus.

- Presence of unusual cloudy discharge noted, consistent with the patient's reported symptoms.

Speculum Examination:

- Cervical os appears normal.

- No bleeding, erosions, or masses observed on the cervix.

- Unusual discharge present.

- No cervical ectropion noted.

Bimanual Examination:

Vaginal Walls: Appear normal without nodularity or tenderness.

Cervix: Position is midline, consistency is normal, positive cervical excitation pain.

Uterus: Normal size, shape, and position; no masses or tenderness palpated.

Ovaries: Not palpable, no masses detected.

- Urine Dipstick: Leukocytes positive, Nitrites negative.

- Vaginal Swab: Sent for culture and sensitivity which is positive Chlamydia

Condition:

Chlamydia

Patient Questions:

1. "Could this mean I have an STI, even if I use protection?"

- "Yes, even with protection, STIs like chlamydia can still be transmitted. It's important to test to confirm."

2. "Will this affect my ability to have children in the future?"

- "Most cases of chlamydia, when treated promptly, don't lead to fertility issues. It's important to treat it early."

3. "How did I get this if I've been careful?"

- "STIs can be transmitted in various ways, and it's possible to contract chlamydia even with careful condom use because it only reduces, not eliminates, the risk."

4. "What kind of treatment will I need?"

- "The standard treatment includes a course of antibiotics, such as azithromycin or doxycycline."

5. “Has my boyfriend been cheating on me then?”

* “Sometimes chylamdia can be asymptomatic for many years, so you may not have known about it until now.”

Examiner Questions:

1. How would you diagnose chlamydia in a patient like Lina?

- "Through a combination of patient history, symptoms, and laboratory tests such as a nucleic acid amplification test (NAAT) on a urine sample or vaginal swab."

2. What are the complications associated with untreated chlamydia?

- "Untreated chlamydia can lead to pelvic inflammatory disease, ectopic pregnancy, and infertility."

3. Can you explain the treatment regimen for chlamydia?

- "Yes, typically a single dose of azithromycin or a seven-day course of doxycycline."

4. What advice would you give to Lina about preventing STIs in the future?

- "Use condoms consistently with all sexual activities, even if using other forms of contraception, and discuss STI testing with new or multiple partners."

5. Why is it important to test and treat Lina’s sexual partners?

- "To prevent re-infection and the spread of the infection to others."

Treatment:

Based on NICE and CKS guidelines, the treatment for chlamydia includes:

- Doxycycline 100mg orally twice a day for 7 days.

If allergic to the first-line treatment or breastfeeding, consider:

- Erythromycin 500mg orally four times a day for 7 days or

- Ofloxacin 200mg orally twice a day for 7 days.

Monitoring:

- Advise the patient not to have sexual intercourse until the treatment is completed and all partners have been treated.

- A test of cure is usually not needed unless symptoms persist, but it’s recommended for pregnant women, 3 weeks post-treatment.

Prognosis:

- With timely and appropriate treatment, the prognosis is excellent.

- Most infections clear without causing long-term issues if treated early.

- Untreated chlamydia can lead to complications such as pelvic inflammatory disease or infertility.

- Early treatment reduces the risk of transmission and complications.

Differential diagnoses:

1. Gonorrhoea - Less likely due to the absence of severe dysuria and more purulent discharge typically associated with gonorrhoea.

2. Bacterial Vaginosis - Characteristically has a fishy odor; not present in this case.

3. Trichomonas Vaginalis - Often causes frothy, greenish discharge; not reported by the patient.

4. Yeast infection - Typically presents with thick, white discharge and intense itching; not described by the patient.

Keyword Filters:

Speciality Filter:

General Practice; Obstetrics and Gynaecology; Sexual Health;

Presenting Complaint Filter:

Vaginal Discharge; Pelvic Pain;

Condition Filter:

Chlamydia

Location Filter:

General Practice

Case created by:

David Bourne, 5th Year Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_12\_Chlamydia

Homepage Vignette:

## A 22-year-old female named Alina presents with abnormal vaginal discharge and pelvic pain.

Individual Page Vignette:

You are a General Practitioner at a clinic today. 22-year-old Alina, a student living in the city, comes to you with complaints of abnormal vaginal discharge and pelvic pain.

Patient Name:

Alina Kasparova (Phonetic Pronunciation: Ah-lee-nah Kas-pah-roh-vah). She prefers to be called Alina.

Age:

22/07/2002

Location:

Clinic

Personality:

Alina is articulate and well-educated, expressing her concerns with clarity and a noticeable level of anxiety about her symptoms. She speaks with a slight accent indicative of her Eastern European heritage, reflecting a diverse cultural background. Alina is evidently worried but tries to stay composed, hoping for reassurance and effective treatment.

Presenting Complaint:

Alina comes to the clinic complaining of abnormal vaginal discharge and pelvic pain. She says, "I've noticed a change in my vaginal discharge, it's more than usual, and the pelvic pain just doesn't go away. It's really worrying me."

Symptoms:

- Site: The pelvic region; "The pain is down there, in my lower belly."

- Onset: Gradually over the past week; "This started around a week ago."

- Character: Dull ache; "It's like a constant dull ache in my lower abdomen."

- Radiation: Does not radiate; "The pain stays in the same place, it doesn't move."

- Associated Symptoms: Abnormal vaginal discharge; "There's been more discharge than normal, and it looks different."

- Timing: Constant discomfort; "It's been constant for the last week."

- Exacerbating and Relieving Factors: Not relieved by over-the-counter pain medication; "I tried taking some painkillers, but they didn't help."

- Severity: Moderate; "It's disturbing. Not unbearable, but definitely uncomfortable."

PV Bleeding: normal

PV Discharge: Increased volume, greenish-yellow colour, thick consistency, unpleasant smell.

Abdominal or Pelvic Pain: Present, dull ache.

Chance of Pregnancy: Using progesterone-only implant, low chance.

Dyspareunia: Not present

Post-coital PV Bleeding: Not present

Intermenstrual PV Bleeding: Not present

Vulval skin changes or itching: Not present

Abdominal distention: Not present

History of Presenting Complaint:

- Alina has been experiencing the symptoms for about a week.

- No previous similar episodes or treatments attempted before.

- Symptoms have been constant since onset.

- Impact on daily life: "It's been hard to concentrate on my studies with this discomfort."

Systemic Symptoms:

- Fatigue: Not present

- Fever: Not present

- Night Sweats: Not present

- Unintended Weight Loss: Not present

- Chest or Shoulder Tip Pain: Not present

- Shortness of Breath or Cough: Not present

- Change in Bowel Habits: Normal

- Change in Urinary Habits: Normal

- Dysuria: Not present

- Oedema: Not present

- Rashes or Skin Changes: Not present

- Headache: Not present

- Mood Changes: Anxiety related to symptoms; "I've been really anxious about these symptoms."

- Sleep Disturbances: Not present

Obstetric History:

Previous Obstetric History:

Gravidity and Parity: None

Reproductive Plans: "I'm not planning on having children anytime soon."

Gynaecology History:

Menstrual History: Regular cyclewith normal volume before implant insertion.

Last Menstrual Period: Irregular since implant insertion.

Contraception: Currently has a progesterone-only implant.

Previous Screens: No previous abnormal results.

Previous Gynaecology Conditions: None

Previous STIs: None

Contraception: Progesterone-only implant currently in use.

Past Medical History:

- No previous significant medical conditions or surgeries.

- Fully vaccinated, including for HPV.

- No previous STIs.

Drug History:

- No current medications apart from the progesterone-only implant.

- No history of medication non-compliance.

- "I haven't taken any other medications apart from the implant."

Allergies:

- No known allergies.

Family History:

- No significant family history of medical conditions.

Social History:

Lifestyle: Active, enjoys jogging and yoga.

Occupation: University student.

ADLs & Hobbies: Manages her daily activities and studies well despite current discomfort.

Smoking: Non-smoker.

Alcohol: Consumes occasionally, about 1-2 units/week.

Recreational Drug Use: None.

Diet: Balanced diet, mostly plant-based.

Exercise: Regular, includes jogging and yoga.

Sexual History:

Last sexual intercourse: "About two weeks ago."

Current and previous partners: "I've had the same partner for six months."

Any contraception used: Progesterone-only implant.

Ideas, Concerns, and Expectations:

- Alina is concerned that her symptoms might indicate a serious condition.

- She's anxious about the possibility of STIs and their impact on her relationship.

- "I'm expecting some tests to understand what's happening and hoping for a treatment that can ease my symptoms cause I am finding it very embarrasing currently."

Observations:

- NEWS Total Score: 0

Physical Examination:

General Inspection: Appears well, in no acute distress.

Abdominal Examination:

- Inspection: Abdomen flat, no visible scars or lesions.

- Palpitation: Mild tenderness in the lower abdomen, no masses palpated.

Vaginal Examination:

Vulval Inspection: No lesions or discharge noted externally.

Speculum Examination:

- Cervical os: Normal appearance

- No abnormal bleeding, erosions, masses, or ulcers noted

- Discharge: Cloudy-yellow.

Bimanual Examination (Not indicated):

- Vaginal Walls: Normal

- Cervix: Normal position, no cervical excitation pain

- Uterus: Normal size and shape, no tenderness

- Ovaries: Not palpable, no masses

Special Tests:

Not performed at this step.

Diagnostic Tests:

Urine Dipstick: Normal

Urine Dipstick: Normal

Vaginal Swab:

STI Screen:

* Chlamydia: Positive
* Gonorrhoea: Negative
* Syphilis (blood test): Negative
* HIV (blood test): Negative

Condition:

Chlamydia

Patient Questions:

1. “Can you tell me what's causing these symptoms? Is it an STI?”

- “Based on your symptoms, we need to consider an STI as a possibility, including chlamydia, so we'll do some tests to find out the exact cause.”

2. “Will I need to inform my partner about this? What if the test is positive?”

- “If the test comes back positive for an STI like chlamydia, it is important for the health of both you and your partner that you inform them so they can also be tested and treated if necessary.”

3. “What kind of treatment will I need?”

- “If it's confirmed to be chlamydia, the treatment is usually straightforward with antibiotics such as azithromycin or doxycycline.”

4. "How long until I start feeling better?"

- "If it's chlamydia and you're treated with antibiotics, you should start feeling better within a week. It's important to complete your course of antibiotics to ensure the infection is fully cleared."

Examiner Questions:

1. What are the common symptoms and signs of chlamydia in females?

- "Symptoms can include abnormal vaginal discharge, pelvic pain, painful urination. Many individuals may be asymptomatic."

2. How is chlamydia diagnosed?

- "Chlamydia is diagnosed through specific STI screening tests, including a nucleic acid amplification test (NAAT) from a urine sample or a swab of the affected area."

3. What are the potential complications of untreated chlamydia?

- "Untreated chlamydia can lead to pelvic inflammatory disease, infertility, and an increased risk of ectopic pregnancy."

4. What is the treatment for chlamydia?

- "The treatment for chlamydia usually involves antibiotics such as azithromycin or doxycycline."

5. How long after treatment for chlamydia should a patient be re-tested?

- "It's recommended to re-test approximately 3 months after treatment to ensure the infection has been cleared."

Treatment:

- Doxycycline 100 mg orally twice a day for 7 days.

- OR Azithromycin 1 gram orally in a single dose.

- Advise to abstain from sexual intercourse for 7 days after treatment and until all sexual partners are treated.

- Notify and refer all patients to GUM for contact tracing and notification of sexual partners.

Monitoring:

- Instruct Alina to return if symptoms persist or worsen after completion of treatment.

- Recommend a follow-up test for chlamydia about 3 months after treatment to confirm clearance of the infection.

- Discuss the importance of routine STI screening in sexually active individuals.

Prognosis:

- With appropriate antibiotic treatment, the prognosis for chlamydia is excellent.

- Timely treatment usually results in full resolution of symptoms and prevents complications.

- It's important for the patient to complete the full course of antibiotics and follow re-testing guidelines.

Differential diagnoses:

1. Gonorrhoea: Similar symptoms but caused by a different bacterium. Less likely due to the specific characteristics of the discharge.

2. Bacterial Vaginosis: Can cause abnormal discharge but usually does not cause significant pelvic pain.

3. Trichomonas Vaginalis: Can present similarly but is typically associated with frothy discharge and a distinct odour.

4. Yeast Infection: Typically causes itching and discharge but not usually pelvic pain.

Keyword Filters:

Speciality Filter:

Infection; Obstetrics and Gynaecology; Sexual Health;

Presenting Complaint Filter:

Vaginal Discharge; Pelvic Pain;

Condition Filter:

Chlamydia

Location Filter:

Clinic

Case created by:

David Bourne, 5th Year Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_13\_Chlamydia

Homepage Vignette:

## A 27-year-old female called Aria presents with pelvic pain and unusual vaginal discharge.

Individual Page Vignette:

You are a General Practitioner assessing Aria, a 27-year-old Editor, in your clinic. She presents with pelvic pain and unusual vaginal discharge.

Patient Name:

Aria Valdez (Pronunciation: Ah-ree-ah Vahl-dehz). She prefers to be called Aria.

Age:

05/07/1997

Location:

Clinic

Personality:

Aria is articulate and direct. She maintains eye contact and speaks with confidence. Her inquiries are precise, reflecting her analytical thinking as an editor. Despite her discomfort, she tries to use humour to lighten the situation.

Presenting Complaint:

Aria visited the clinic due to experiencing sharp pelvic pain and noticing an unusual vaginal discharge.

Quote:

"It's like someone's twisting a knife in my lower belly, and this discharge is definitely not normal. Trying to keep my spirits up, though!"

Symptoms:

Site: Pelvic region; "It's mainly in my lower belly."

Onset: Gradually over the past week; "This all started subtly around a week ago."

Character: Sharp pain; "It feels really sharp and intense."

Radiation: Does not radiate; "The pain stays put, doesn't really go anywhere else."

Associated Symptoms: Unusual vaginal discharge; "There's this weird discharge, not what I'm used to."

Timing: Persistent over the past week; "It's been like this consistently since it started."

Exacerbating and Relieving Factors: Not identified; "Haven't really found anything that makes it better or worse."

Severity: Moderate to severe; "On a scale, probably a 6 or 7 sometimes."

PV Bleeding: Normal

PV Discharge: Increased volume, yellow, thick, foul-smelling.

Abdominal or Pelvic Pain: Sharp, persistent pelvic pain.

Chance of Pregnancy: Not likely.

Dyspareunia: Not reported.

Post-coital PV Bleeding: Not reported.

Intermenstrual PV Bleeding: Not reported.

Vulval skin changes or itching: Normal.

Quote:

"The pain is like a constant reminder that something's not right. And the discharge... it's embarrassing and worrying."

History of Presenting Complaint:

- Symptoms started gradually about a week ago.

- No previous treatments have been attempted.

- Symptoms have remained consistent.

- Impact on daily life, causing discomfort and worry.

Quote:

"I thought it might just go away on its own, but it’s been a week now... It's definitely affecting my focus at work."

Systemic Symptoms:

- Fatigue: Mild fatigue; "I've been feeling a bit more tired lately."

- Fever: Normal.

- Night Sweats: Normal.

- Unintended Weight Loss: Normal.

- Chest or Shoulder Tip Pain: Normal.

- Shortness of Breath or Cough: Normal.

- Change in Bowel Habits: Normal.

- Change in Urinary Habits: Normal.

- Dysuria:

- Frequency: Normal.

- Urgency: Normal.

- Oedema: Normal.

- Rashes or Skin Changes: Normal.

- Headache: Occasional mild headaches; "I’ve had a few headaches here and there."

- Mood Changes: Anxious due to symptoms; "Can't help feeling a bit anxious about all this."

- Sleep Disturbances: Normal.

Quote:

"I guess I'm just worried about what this could mean... Apart from the main issue, I’m physically okay, I think."

Obstetric History:

Previous Obstetric History:

Gravidity and Parity: 0 pregnancies.

Reproductive Plans:

Not planning to have children in the near future.

Quote:

"Kids might be in the picture someday, but definitely not right now."

Gynaecology History:

Menstrual History:

Duration: 5 days

Frequency: Every 28 days

Volume: Moderate

Dysmenorrhoea: None

Last Menstrual Period: Last week

Contraception: Oral contraceptive pill

Quote:

"My periods have been pretty regular, nothing out of the ordinary."

Past Medical History:

- Asthma (mild, under control)

- No significant psychiatric history.

- Immunisations up to date, including HPV vaccine.

Quote:

"Other than my mild asthma, I've been pretty healthy, thankfully."

Drug History:

- Salbutamol inhaler as needed.

- Oral contraceptive pill, daily.

Quote:

"Just the pill and my inhaler, that's about it for medications."

Allergies:

- Penicillin: Causes rash.

Quote:

"Found out the hard way that penicillin is a no-go for me."

Family History:

- Mother: Type 2 diabetes.

- Father: Hypertension.

Quote:

"Both my parents have their own health issues... Makes me a bit more cautious about my own."

Social History:

Lifestyle: Busy and sociable, enjoys dining out.

Occupation: Editor

Activities of Daily Living & Hobbies: Reading, hiking on weekends.

Smoking: Non-smoker

Alcohol: Social drinker, approximately 4 units per week.

Recreational Drug Use: None

Diet: Omnivorous, tries to eat healthily.

Exercise: Regular, hikes on weekends.

Quote:

"Between work and my social life, I keep pretty busy. Love my weekends outdoors, though."

Sexual History:

Last sexual intercourse: Two weeks ago.

Current partners: 1 in the last six months.

Contraception used: Oral contraceptive pill.

Quote:

"I've been with one person recently, and yes, I've been careful... or so I thought."

Ideas, Concerns, and Expectations:

- Aria believes she may have a sexually transmitted infection due to her symptoms.

- She is concerned about the implications this may have on her fertility and relationship.

- Expects to be tested for STIs and receive treatment.

Quote:

"I'm worried this might be an STI... I just want to know what's going on and get it treated."

Observations:

NEWS Total Score: 0

Physical Examination:

General Inspection: Well-appearing, no acute distress.

Abdominal Examination

Inspection: Normal

Palpitation: Tenderness in the lower pelvic area.

Vaginal Examination:

Vulval Inspection: Normal appearance, no lesions or discharge noted externally.

Speculum Examination:

Cervical os: Normal appearance.

Discharge: Yellow, thick discharge noted.

Bimanual Examination (Not indicated):

Vaginal Walls: Normal

Cervix: Normal position, no cervical excitation.

Uterus: Normal size and shape, no tenderness.

Ovaries: No masses palpated.

Special Tests: N/A

Diagnostic Tests:

Urine Dipstick: Normal

Vaginal Swab: Positive for Chlamydia trachomatis.

STI Screen: Positive for Chlamydia. Negative for gonorrhea, HIV, syphilis.

Urea and Electrolytes: All within normal limits.

Condition:

Chlamydia

Patient Questions:

1. "Could this affect my fertility?"

- Answer: "Chlamydia can impact fertility if left untreated, but with early treatment, the risks are greatly reduced."

2. "Will my partner need treatment too?"

- Answer: "Yes, it's important that your partner gets treated as well to prevent reinfection."

3. "How is this treated?"

- Answer: "Chlamydia is treated with antibiotics. We'll start you on a course right away."

4. "Can I have sex while I'm being treated?"

- Answer: "You should avoid sexual intercourse until you and your partner have completed the treatment and are re-tested to ensure the infection has cleared."

Examiner Questions:

1. What are the first-line treatments for Chlamydia?

- Answer: Doxycycline 100mg orally twice a day for 7 days.

2. How should a patient be counselled regarding sexual contact post-treatment for Chlamydia?

- Answer: Advise abstaining from sexual intercourse until treatment is completed and a follow-up test confirms the infection has cleared.

3. What are the potential complications of untreated Chlamydia?

- Answer: Pelvic inflammatory disease, infertility, and ectopic pregnancy.

4. What steps should be taken to prevent reinfection?

- Answer: Partner notification and treatment, consistent condom use, and regular STI screenings.

Treatment:

- Doxycycline 100mg orally twice a day for 7 days.

- Azithromycin 1g orally as a single dose is the recommended second-line treatment for Chlamydia.

- If the patient is pregnant, Azithromycin is the recommended treatment.

Monitoring:

- Advise the patient to return for a test of cure three weeks after completing the treatment.

- Ensure patient awareness regarding the importance of informing recent sexual partners.

- Schedule a follow-up screening for STIs in 3 months.

Prognosis:

- With prompt treatment, the prognosis for Chlamydia is excellent.

- Untreated, Chlamydia can lead to serious reproductive health issues, but early intervention generally prevents long-term consequences.

- Reinfection is possible, stressing the importance of safe sexual practices post-treatment.

Differential diagnoses:

1. Gonorrhoea - similar symptoms but requires different antibiotics.

2. Bacterial Vaginosis - characterised by a fishy odour discharge, not necessarily associated with pain.

3. Trichomonas Vaginalis - presents with frothy discharge and may cause discomfort.

4. Pelvic Inflammatory Disease - could be a complication of untreated Chlamydia, presenting with more severe abdominal pain.

Keyword Filters:

Speciality Filter: Sexual Health; General Practice; Infection

Presenting Complaint Filter: Pelvic Pain; Vaginal Discharge

Condition Filter: Chlamydia

Location Filter: Clinic

Case created by:

David Bourne, 5th Year Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_14\_Chlamydia

Homepage Vignette:

## A 25-year-old female called Zara presents with dyspareunia.

Individual Page Vignette:

You are tasked with assessing Zara, a 25-year-old retail manager, at the Sexual Health Clinic. She has come in today due to experiencing dyspareunia.

Patient Name:

Zara Abimbola (Zah-ra Ab-im-bo-lah). She prefers to be called Zara.

Age:

12/06/1998

Location:

Sexual Health Clinic

Personality:

Zara is articulate and quite forthright about her health concerns. She speaks candidly about her symptoms and sexual history, expecting a straightforward dialogue with healthcare professionals. Despite her apparent anxiety about her symptoms, she maintains a respectful tone throughout the conversation.

Presenting Complaint:

Zara is presenting with dyspareunia, which has been progressively worsening over the past three months.

“I’ve been finding sex really painful recently, and it’s starting to worry me.”

Symptoms:

- Site: "It's mainly deep inside, I can't pinpoint exactly where."

- Onset: "This all started a few months ago."

- Character: "It's a sharp pain, really uncomfortable."

- Radiation: “The pain doesn’t really go anywhere, it just stays put.”

- Associated Symptoms: "I've had more partners than I'd like to admit and I'm worried I caught something."

- Timing: "The pain occurs during intercourse."

- Exacerbating and Relieving Factors: "It only happens during sex. Not doing it helps, I guess."

- Severity: "On a scale of 1 to 10, it’s often around a 7."

- PV Bleeding: None.

- PV Discharge: Slight increase in volume, clear, no distinct smell.

- Abdominal or Pelvic Pain: Only during intercourse.

- Chance of Pregnancy: Unlikely.

- Dyspareunia: Present.

- Post-coital PV Bleeding: None.

- Intermenstrual PV Bleeding: None.

- Vulval skin changes or itching: None.

History of Presenting Complaint:

- Duration: 3 months.

- Previous treatments attempted and responses: None.

- Progression over time: Symptoms have gradually worsened.

- Frequency of symptoms: Consistently noted during sexual intercourse.

- Impact on daily life/ADLs/Work/Physical and Mental wellbeing: Significant concern causing anxiety and strain on relationships.

“I just kept hoping it would get better on its own, but it’s actually getting worse.”

Systemic Symptoms:

- Fatigue: Normal.

- Fever: Normal.

- Night Sweats: Normal.

- Unintended Weight Loss: Normal.

- Chest or Shoulder Tip Pain: Normal.

- Shortness of Breath or Cough: Normal.

- Change in Bowel Habits: Normal.

- Change in Urinary Habits: Normal.

- Dysuria: Normal.

- Oedema: Normal.

- Rashes or Skin Changes: Normal.

- Headache: Normal.

- Mood Changes: Increased anxiety related to health.

- Sleep Disturbances: Normal.

Obstetric History:

Previous Obstetric History: N/A

Reproductive Plans: “I’m not thinking of having kids any time soon.”

Gynaecology History:

Menstrual History: Regular, with moderate flow and mild dysmenorrhoea.

Last Menstrual Period: one week ago.

Contraception: Currently using condoms. Previously used oral contraceptives.

“I actually recently stopped my pill and switched to condoms to make STD prevention easier.”

Past Medical History:

- No significant past medical conditions.

- No surgeries or hospitalizations.

- Immunizations: Up to date, including HPV vaccine.

- STIs: One previous chlamydia infection, treated successfully. Only state if specifically asked about STIs.

“I’ve been healthy for the most part, just worried now.”

Drug History:

- No current medications.

- Contraception methods included oral contraceptives in the past, now using condoms.

“No, I don’t take any medications regularly.”

Allergies:

- No known allergies.

"I don’t react badly to anything that I know of.”

Family History:

- Mother has hypertension.

- Father has type 2 diabetes.

“No major illnesses in the family, luckily.”

Social History:

- Smoking: None.

- Alcohol: Social drinker, approx. 5 units per week.

- Recreational Drug Use: None.

- Diet: Generally balanced.

- Exercise: Gym 3 times a week.

- Occupation: Retail Manager.

“I try to stay healthy, you know, gym, eating right, and all that.”

Sexual History:

- Last sexual intercourse: Two weeks ago.

- Current and previous partners: Multiple partners, more than five in the past year.

- Contraception used: Condoms.

“I’ve had a few partners, yeah. I always make sure we use protection though so I don’t get pregnant.”

Ideas, Concerns, and Expectations:

- Ideas: “I think it might be an STD like the one I had before.”

- Concerns: “What if it’s something serious? I have heard my friends have something called endometriosis? I can’t stop thinking about it now.”

- Expectations: “I just want to know what’s wrong and get it treated.”

Observations:

- NEWS Total Score: 0.

Physical Examination:

General Inspection: Appears anxious but is cooperative.

Abdominal Examination: Normal inspection and palpation.

Vaginal Examination:

Vulval Inspection: No ulcers, cysts, rashes, discharge, scarring, atrophy, lesions, or masses noted.

Diagnostic Tests:

Urine Dipstick: Normal

Vaginal Swab:

STI Screen:

* Chlamydia: Positive
* Gonorrhoea: Negative
* Syphilis (blood test): Negative
* HIV (blood test): Negative

MSU: Not indicated

Pregnancy Test: Negative

Condition:

Chlamydia

Patient Questions:

1. "Could this be something really serious?"

- "Most conditions causing your symptoms, including chlamydia which we’re testing for, are treatable. We’re doing all necessary tests to rule out anything serious."

2. "How soon can I get my test results?"

- "Results from swabs and blood tests typically come back within a week. We’ll contact you as soon as we have all the information."

3. "Will this affect my ability to have children in the future?"

- "Chlamydia can affect fertility if untreated, but early treatment greatly reduces this risk. We’re working to get you treated quickly to prevent any long-term issues."

4. "What should I tell my sexual partners?"

- "It’s important to inform them so they can also get tested and treated if necessary. We can provide you with information on how to have this conversation."

Examiner Questions:

1. What is the first-line treatment for chlamydia?

- "The first-line treatment is Doxycycline 100mg twice a day for 7 days, or Azithromycin 1g as a single dose if doxycycline is contraindicated."

2. What are the potential complications of untreated chlamydia?

- "Untreated chlamydia can lead to pelvic inflammatory disease, infertility, and ectopic pregnancy."

3. Why is it important to take a comprehensive sexual history in this case?

- "A comprehensive sexual history helps identify risk factors for STIs, guide testing and treatment, and provide tailored sexual health advice."

4. How would you manage a patient's anxiety related to their sexual health?

- "Address their concerns empathetically, provide clear and accurate information about their condition and treatment options, and offer support and resources for sexual health."

5. What advice would you give to a patient treated for chlamydia regarding sexual activity?

- "Advise them to abstain from sexual activity until they and any partners have been treated and to use condoms consistently to prevent reinfection."

Treatment:

First-line treatment for chlamydia:

- Doxycycline 100 mg orally, twice a day for 7 days OR

- Azithromycin 1g orally, single dose

If allergic or initial treatment is ineffective, consider alternative antibiotics like Erythromycin or Levofloxacin as per BNF guidelines.

Monitoring:

- Follow-up to ensure completion of treatment.

- Test of cure should be performed 3-4 weeks after treatment completion in individuals who are pregnant or if symptoms persist.

- Advise on reducing risk of STI transmission, including consistent condom use.

- Recommend informing recent sexual partners for testing and treatment.

Prognosis:

- With appropriate and timely treatment, the prognosis for chlamydia is excellent.

- Early treatment reduces the risk of complications like PID and infertility.

- Encourage regular STI screenings as part of routine sexual health maintenance.

Differential diagnoses:

1. Gonorrhoea: Similar symptoms, but discharge may be more pronounced; less likely without confirmation from specific NAAT testing.

2. Bacterial Vaginosis: More associated with discharge and odor, less likely with pain during intercourse.

3. Pelvic Inflammatory Disease: A potential complication of untreated STIs with more severe abdominal pain; considered if symptoms escalate.

4. Urinary Tract Infection: Dysuria and urgency would be more prominent; assessed through urine analysis.

Keyword Filters:

Speciality Filter:

Sexual Health; General Practice; Obstetrics and Gynaecology;

Presenting Complaint Filter:

Dyspareunia; Vaginal Discharge;

Condition Filter:

Chlamydia;

Location Filter:

Clinic;

Case created by:

David Bourne, 5th Year Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_15\_Chlamydia

Homepage Vignette:

## A 27-year-old female called Anisa presents with dyspareunia.

Individual Page Vignette:

You are a General Practitioner in a busy clinic. Anisa, a 27-year-old office administrator from the local area, presents with dyspareunia.

Patient Name:

Anisa Patel (Pronunciation: Ah-nee-sah Pat-el). Anisa would like to be called by her first name.

Age:

27/05/1997

Location:

General Practice

Personality:

Anisa is articulate and forthright, expressing her concerns clearly but showing noticeable anxiety regarding her symptoms. She maintains a polite and cooperative demeanor throughout the consultation.

Presenting Complaint:

Anisa reports experiencing painful sexual intercourse (dyspareunia) and is worried about her sexual health due to previous unprotected encounters.

Quote: "It's been quite painful during sex lately, which isn't normal for me. I'm also really worried because I've had unprotected sex before."

Symptoms:

- Site: Deep pelvic pain. "It feels like the pain is deep inside my pelvis."

- Onset: Gradual onset over the past month. "This started about a month ago."

- Character: Sharp and cramping. "The pain is sharp, almost like cramping."

- Radiation: Does not radiate. "The pain stays in one spot, doesn't move."

- Associated Symptoms: None specified.

- Timing: During and after sexual intercourse. "It's during and sometimes after we've finished."

- Exacerbating and Relieving Factors: Pain is exacerbated by intercourse. No known relieving factors. "It only hurts during sex, haven't found anything that helps."

- Severity: Moderate to severe. "It's quite bad, sometimes I have to stop."

PV Bleeding: None.

PV Discharge: None mentioned.

Abdominal or Pelvic Pain: Described in symptoms.

Chance of Pregnancy: Low; using contraception consistently.

Dyspareunia: Present and significant.

Post-coital PV Bleeding: None.

Intermenstrual PV Bleeding: None.

Vulval skin changes or itching: None.

Quote: "I haven't noticed any bleeding or weird discharge, just the pain."

History of Presenting Complaint:

- Duration: Approximately 1 month.

- Previous treatments: None attempted.

- Symptom progression: Pain has gradually increased in intensity.

- Frequency of symptoms: Occurs with every instance of sexual intercourse.

- Impact on daily life: Significant, causing distress and affecting relationship.

- Impact on work: None reported.

- Impact on physical and mental wellbeing: Increased anxiety and fear regarding sexual health.

Quote: "It's making me tense every time, and I'm scared I might have caught something. It’s been a rough month."

Systemic Symptoms:

All systemic symptoms reported as normal including fatigue, fever, night sweats, unintended weight loss, chest or shoulder tip pain, shortness of breath or cough, change in bowel habits, change in urinary habits, dysuria, oedema, rashes or skin changes, headache, mood changes, sleep disturbances.

Quote: "Besides the pain during sex, I feel normal. But, it's the worry that’s keeping me up at night."

Obstetric History:

Previous Obstetric History: Nulliparous

Gravidity and Parity: 0/0

Reproductive Plans: Considering starting a family in the next few years.

Quote: "I’ve been thinking of having kids in a few years, so I need to sort this out."

Gynaecology History:

Menstrual History: Regular, 28-day cycles, moderate flow, lasts 5 days, no significant dysmenorrhoea.

Last Menstrual Period: one week ago.

Previous Screens: Last cervical screening 1 year ago, results normal.

Contraception: Currently using condoms consistently.

Quote: "My periods have always been pretty regular. I’ve been careful with using protection always."

Past Medical History:

- No previous significant medical conditions.

- No surgeries or hospitalizations.

- Fully vaccinated, including HPV vaccine.

- No previous STIs.

- No gynaecological conditions.

Quote: "I’ve been generally healthy, really. Just the usual colds and flus."

Drug History:

- No current prescription medications.

- No history of medication non-compliance.

- Not currently using any herbal supplements or alternative therapies.

- Current contraception method: Condoms.

Quote: "I’m not on any meds at the moment."

Allergies:

- No known allergies.

Quote: "I don’t have any allergies that I know of."

Family History:

- Mother: History of hypertension.

- Father: Type 2 diabetes.

- Siblings: No significant medical conditions.

Quote: "Mum’s been managing her blood pressure, and dad’s got diabetes, but that’s about it."

Social History:

Lifestyle: Generally active, enjoys weekend hiking.

Occupation: Office administrator.

Activities of Daily Living & Hobbies: Enjoys cooking and reading in her free time.

Smoking: Non-smoker.

Alcohol: Social drinker, about 4 units per week.

Recreational Drug Use: None.

Diet: Balanced, leans towards vegetarian.

Exercise: Regular, includes yoga twice a week and hiking on weekends.

Quote: "I try to keep active and eat well. Weekends are for hiking or just unwinding with a good book."

Sexual History:

Last sexual intercourse: two weeks ago.

Current partners: 1

Previous partners: 4 in the last year

Contraception used: Condoms consistently used with current partner.

Quote: "I always make sure we use protection. Just can’t be too careful."

Travel History: Not applicable.

Ideas, Concerns, and Expectations:

- Ideas: Worries that dyspareunia might indicate an problem with future fertility.

- Concerns: Anxious about the potential impact on future fertility and relationships.

- Expectations: Seeks reassurance through testing and appropriate treatment if needed. Hopes for advice on preventing such issues in the future.

Quote: "I’m really worried this could be an problem with my ovaries or womb or something. What if it affects me having kids? I just want to get tested and fix whatever’s wrong."

Observations:

NEWS Total Score: 0

Physical Examination:

General Inspection: Appears well, no acute distress.

Abdominal Examination:

- Inspection: Abdomen flat, no visible scars or lesions.

- Palpation: Soft, non-tender, no masses palpated.

Vaginal Examination:

- Vulval Inspection: No ulcers, cysts, rashes, scarring, lesions, or prolapses noted.

Speculum Examination:

- Cervical os: Normal appearance, no bleeding or erosions.

- No discharge or cervical ectropion observed.

Bimanual Examination:

- Vaginal Walls: Smooth, no abnormalities.

- Cervix: Anterior, firm, positive for cervical excitation pain.

- Uterus: Normal size, shape, not tender.

- Ovaries: Non-palpable, no masses.

Special Tests: Not applicable in the context provided.

Diagnostic Tests:

Urine Dipstick: Normal.

Vaginal Swab: Sent for chlamydia, gonorrhoea.

STI Screen:

- Chlamydia: Positive.

- Gonorrhoea: Negative.

- Syphilis: Negative (blood test).

- HIV: Negative (blood test).

Condition:

Chlamydia

Patient Questions:

1. "Could this really be an STI, even though we always used protection?"

- "Yes, while condoms significantly reduce the risk, there is still a small possibility of transmitting STIs. It's important to get tested to know for sure."

2. "What if this affects my ability to have children in the future?"

- "Most cases of chlamydia can be treated effectively with antibiotics, and treating it early can prevent complications, including fertility issues. Let's focus on diagnosis and treatment first."

3. "How long does the treatment take, and is it complicated?"

- "Treatment for chlamydia is usually straightforward, involving a short course of antibiotics. We'll go through the specifics once we have your test results."

4. "Should I tell my partner, and do they need to get tested too?"

- "Yes, it's important to inform your partner so they can get tested and treated if necessary, to prevent re-infection and spreading it to others."

Examiner Questions:

1. What is the first-line treatment for chlamydia according to the NICE guidelines?

- "Doxycycline 100mg twice daily for 7 days."

2. How would you advise a patient about preventing STIs in the future?

- "Discuss the importance of consistent condom use, regular STI screenings, and having open discussions with partners about sexual health."

3. What are the potential complications of untreated chlamydia?

- "Pelvic inflammatory disease, ectopic pregnancy, infertility, and chronic pelvic pain."

4. How can you differentiate chlamydia from other causes of dyspareunia based on history and examination alone?

- "Other causes might present with different symptoms or medical history; however, definitive diagnosis relies on laboratory testing as symptoms can overlap."

5. What follow-up is needed after treatment for chlamydia?

- "Patients should be re-tested after three months to ensure the infection is cleared, especially if there's a risk of re-exposure."

6. Discuss the importance of partner notification and treatment in managing STI cases like chlamydia.

- "Essential to prevent re-infection and transmission to others; it plays a crucial role in controlling the spread of STIs in the community."

Treatment:

According to NICE guidelines, the treatment for chlamydia involves:

- Doxycycline 100mg orally twice a day for 7 days or

- Azithromycin 1g orally as a single dose in pregnancy or breastfeeding.

If allergic to first-line antibiotics:

- Erythromycin 500mg orally twice a day for 10-14 days or

- Levofloxacin 500mg orally once daily for 7 days,

Additionally, advise the patient on notifying and treating sexual partners to prevent re-infection and discuss safe sex practices, including consistent condom use.

Monitoring:

- Follow-up with the patient in 1 week to assess symptom resolution and discuss test results.

- Recommend re-testing for chlamydia three months post-treatment, regardless of symptom presence, to ensure infection clearance.

- Advise on regular sexual health screenings and condom use as part of preventive healthcare.

Prognosis:

- With timely and appropriate treatment, the prognosis for chlamydia is excellent.

- Most infections clear without long-term complications if treated early.

- Untreated infection increases the risk of pelvic inflammatory disease, infertility, and ectopic pregnancy.

- Importance of education on prevention and regular STI screening for sexually active individuals.

Differential diagnoses:

1. Gonorrhoea: Similar symptoms but different antibiotic treatment regime.

2. Bacterial vaginosis: Presents primarily with discharge, less likely with dyspareunia.

3. Pelvic inflammatory disease: A complication of untreated STIs, presents with more severe abdominal pain and fever.

4. Urinary tract infection: Dysuria and frequency more prominent, less likely dyspareunia.

5. Endometriosis: Chronic pelvic pain, exacerbated during menstruation, not solely associated with sexual activity.

Keyword Filters:

Speciality Filter: Sexual Health; General Practice; Infection;

Presenting Complaint Filter: Painful Sexual Intercourse; Urinary Symptoms; Vaginal Discharge;

Condition Filter: Chlamydia;

Location Filter: General Practice;

Case created by:

David Bourne, 5th Year Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_16\_Atrophic Vaginitis

Homepage Vignette:

## A 65-year-old woman called Antoinette presents with post-menopausal vaginal bleeding.

Individual Page Vignette:

You are a General Practitioner evaluating Antoinette, a 65-year-old retired school teacher from your clinic, who has come to you with concerns regarding post-menopausal vaginal bleeding.

Patient Name: Antoinette Dubois (Phonetic pronunciation: An-twuh-net Du-bwa; Prefers to be called Antoinette)

Age: 23/05/1958

Location: General Practice

Personality: Antoinette is a well-spoken, articulate woman who exhibits a calm and polite demeanor. She is very methodical in her narration of symptoms, likely a trait from her teaching years. Having been an educator, she values understanding her health condition in-depth and appreciates clear explanations.

Presenting Complaint:

Antoinette came in concerned about experiencing vaginal bleeding despite having gone through menopause several years ago.

"I thought these days were behind me, doctor. It's very unsettling to see bleeding at my age I thought."

Symptoms:

- Site: Vaginal "It's definitely happening down there, quite unexpected and unsettling."

- Onset: Gradual onset "This wasn't sudden. I first noticed some spotting a few weeks ago."

- Character: Light bleeding "It's not heavy like a period would be. More like spotting."

- Radiation: Does not apply "It's just in that one spot, doctor."

- Associated Symptoms: Mild vaginal itching and dryness "I've also felt a bit itchy and dry there, which I just attributed to my age."

- Timing: Intermittent over the past month "It's been on and off over the last four weeks."

- Exacerbating and Relieving Factors: "Nothing specific seems to trigger it, nor does anything relieve it."

- Severity: Mild "It's not a lot of blood, but it's concerning nonetheless."

PV Bleeding: Light spotting, red in color, no associated odour.

PV Discharge: Mild, colourless discharge, thin consistency, no smell.

Abdominal or Pelvic Pain: None.

Chance of Pregnancy: None.

Dyspareunia: Reports vaginal dryness has made intercourse uncomfortable.

Post-coital PV Bleeding: None.

Post-menopausal Bleeding: Yes, light spotting and bleeding.

Vulval skin changes or itching: Mild itching, no visible skin changes.

History of Presenting Complaint:

- Antoinette has been experiencing light vaginal bleeding and spotting for the past month.

- She has not sought any treatment for this symptom prior to this visit.

- The bleeding has been intermittent and light in nature.

- The symptom has had minimal impact on her daily life but has caused her significant worry.

- No impact on work as she is retired.

- Has caused moderate concern for her physical and mental wellbeing, prompting this clinic visit.

She states, "I didn't think much of it initially, but it's been going on for a month now, and it worries me."

Systemic Symptoms:

- Fatigue: Normal

- Fever: Normal

- Night Sweats: Occasional mild night sweats.

- Unintended Weight Loss: None.

- Chest or Shoulder Tip Pain: None.

- Shortness of Breath or Cough: None.

- Change in Bowel Habits: Normal.

- Change in Urinary Habits: Normal.

- Oedema: None.

- Rashes or Skin Changes: None.

- Dysuria: None.

- Headache: Normal.

- Mood Changes: Normal, aside from concern regarding symptoms.

- Sleep Disturbances: Reports occasional mild night sweats that slightly disrupt sleep.

On systemic symptoms, Antoinette remarks, "Aside from the bleeding, and perhaps more sweating at night, I've felt quite like my usual self."

Obstetric History:

Previous Obstetric History: Gravidity: 2, Parity: 2

>24 Weeks Pregnancies: 2

Gestation at Delivery(s): 38 weeks & 39 weeks

Birth Weight(s): 3.2 kg & 3.4 kg

Mode of Birth(s): Vaginal delivery without complications

Complications: None

Stillbirths: None

<24 Weeks Pregnancies: None

Miscarriages: None

Terminations: None

Ectopic Pregnancies: None

Gynaecology History:

Menstrual History: Previous to menopause - Cycles were 28 days, lasting 4-5 days with moderate flow. No significant dysmenorrhoea.

Menarche: Aged 13.

Menopause: Aged 55.

Contraception: Antoinette and her husband used condoms prior to her menopause. No hormonal or surgical contraception was used.

Previous Screens: Regular cervical screenings until menopause - all results were normal.

Previous Gynaecology Conditions: None reported.

Previous STIs: None reported.

Antoinette reflects, "I've been fortunate with my health over the years, never had any major worries until now."

Past Medical History:

- Hypertension managed with medication.

- Hypercholesterolemia.

- No previous surgeries.

- Immunisations up to date, including HPV vaccination.

- No other significant health events noted.

Antoinette professionally shares, "I have always taken my health seriously, keeping up with my doctor's visits and managing my hypertension diligently."

Drug History:

- Amlodipine 10mg once daily for hypertension.

- Atorvastatin 20mg once daily for hypercholesterolemia.

- No history of medication non-compliance.

- No use of herbal supplements or alternative therapies.

- Previous contraception method: condoms.

Antoinette notes, "I take my pills every day without fail. It’s part of my routine. I have the ones for high blood pressure, calcium blockers, and the statins."

Allergies:

- No known allergies.

“No allergies”

Family History:

- Mother had hypertension and passed away from a stroke in her late 70s.

- Father had type 2 diabetes and died of heart disease.

- One brother, alive and well, with no significant medical history.

- No significant health issues reported in her two adult children.

“My mother had high blood pressure and dad had diabetes”

Social History:

Lifestyle: Antoinette leads an active lifestyle, with walks in the park being a part of her routine.

Occupation: Retired school teacher.

Activities of Daily Living & Hobbies: Enjoys gardening and reading historical novels.

Smoking: Never smoked.

Alcohol: Drinks a glass of wine once a week with Sunday dinner.

Recreational Drug Use: None.

Diet: Follows a Mediterranean diet.

Exercise: Walks daily for 30 minutes.

“I have a wonderful life currently, enjoy a daily walk in the park near me.”

Sexual History:

Last sexual intercourse: Approximately 2 months ago.

Current and previous partners: Married for 40 years, monogamous.

Any contraception used: None, due to post-menopausal status.

Antoinette thoughtfully says, "I've had a good life, filled with love, learning, and little regret. These recent symptoms are just a bit worrying, that's all."

Ideas, Concerns, and Expectations:

- Antoinette expresses the idea that her symptoms might be a normal part of aging, but she is uncertain. "I wonder if this is something many women my age go through?"

- Her primary concern revolves around the fear of cancer or a serious underlying condition. "My main worry is that this could be something serious like cancer. Cancer runs in my family."

- Antoinette expects a thorough examination and appropriate tests to determine the cause of her symptoms. She is also looking for reassurance and information on potential treatments. "I'm hoping you can tell me what's causing this and that it's nothing too serious. What are our next steps?"

Observations:

NEWS Total Score: 0

Physical Examination:

General Inspection: Antoinette appears well, in no apparent distress, and is alert and oriented. No signs of pallor or cachexia observed. No visible scars.

Objects and Equipment: None present.

Abdominal Examination: Soft, non-tender, no masses palpable, no organomegaly.

Vaginal Examination: Mild vulvar atrophy noted, no ulcers, cysts, or rashes. No prolapse observed.

Speculum Examination Results:

- Cervical os: Normal, no visible lesions or prolapse observed.

- Bleeding: No active bleeding noted during the examination.

- Erosions: None evident.

- Masses: No cervical or vaginal masses identified.

- Ulcers: None visible.

- Discharge: Minimal, thin discharge noted, no foul odour.

- Cervical ectropion: Not observed.

Diagnostic Tests:

Urine Dipstick: Normal

Pipelle Biopsy Histopathology: Signs of atrophy with thinning of the endometrial lining. No other abnormalities or signs of malignancy.

STI Screen: Negative for Chlamydia, Gonorrhoea, Syphilis, HIV.

Blood Tests:

- Full Blood Count: Within normal range for age and sex.

- Urea and Electrolytes: Within normal limits.

Imaging Tests:

- Ultrasound Scan: Not indicated but could be used to assess the endometrial lining and pelvic organs. Findings: Normal thickness of the endometrial lining, no masses or abnormal findings noted in the uterus or ovaries.

Condition: Atrophic Vaginitis

Patient Questions:

1. "Does this mean I have cancer?"

- Answer: "The tests we've performed, including a pelvic exam and ultrasound, do not show any signs of cancer. Your symptoms are more indicative of atrophic vaginitis, which is common and treatable."

2. "Will this require surgery?"

- Answer: "No, atrophic vaginitis doesn't usually require surgery. It can often be managed with non-surgical treatments such as topical estrogen therapy, which helps alleviate symptoms."

3. "Is this condition permanent?"

- Answer: "The changes to the vaginal tissue due to decreased estrogen can be ongoing, but the symptoms can be effectively managed with treatment. We’ll find a regimen that works for you."

4. "Can I still be intimate with my partner?"

- Answer: "Absolutely, but we may need to address the dryness and discomfort first. There are lubricants and topical treatments that can help make intercourse more comfortable for you."

Examiner Questions:

1. What is the first-line treatment for atrophic vaginitis?

- Answer: Topical estrogen therapy.

2. How does one differentiate between atrophic vaginitis and endometrial cancer in a post-menopausal woman presenting with vaginal bleeding?

- Answer: Detailed history, thorough physical examination, appropriate diagnostic tests including a and endometrial biopsy.

3. What are the potential side effects of topical estrogen therapy?

- Answer: Minimal systemic absorption but may include breast tenderness, vaginal bleeding or spotting, and nausea.

4. Why is it important to rule out sexually transmitted infections in this case?

- Answer: Because STIs can also cause vaginal bleeding and discomfort, ruling them out helps narrow down the cause of symptoms to atrophic vaginitis.

5. How might systemic symptoms present in someone with atrophic vaginitis?

- Answer: Atrophic vaginitis primarily affects the vagina and vulva, so systemic symptoms are not typical of this condition, but night sweats and hot flashes may persist in post-menopausal women due to overall decreased estrogen.

Treatment:

- The first-line treatment for atrophic vaginitis is topical estrogen therapy. Options include estrogen cream applied vaginally, vaginal estrogen tablets, or a vaginal estrogen ring. Start with the lowest effective dose and reassess in 3 months.

- For patients with contraindications to estrogen therapy or those preferring not to use it, non-hormonal moisturizers and lubricants can be recommended for symptom relief.

Monitoring:

- Patients should be monitored for symptom improvement and any side effects of treatment 3 months after initiation of therapy.

- Regular follow-up visits should be scheduled annually, or sooner if symptoms re-emerge or worsen.

- Patients need to be informed about when to seek immediate medical attention, such as if they experience significant vaginal bleeding or other new symptoms.

Prognosis:

- With appropriate treatment, most patients experience significant symptom improvement.

- Regular use of topical estrogen or moisturizers can maintain vaginal health and prevent the progression of symptoms.

- The condition may persist due to the underlying cause being hormonal changes of menopause, but symptoms are manageable.

Differential diagnoses:

1. Endometrial Cancer: Less likely due to normal ultrasound findings and absence of significant risk factors or systemic symptoms.

2. STIs: Ruled out with negative STI screen.

3. Uterine polyps or fibroids: Ultrasound did not reveal any masses or anomalies.

4. Cervical Cancer: Less likely given patient's regular and recent cervical screening history.

Keyword Filters:

Speciality Filter:

Obstetrics And Gynaecology; General Practice.

Presenting Complaint Filter:

Post-menopausal Bleeding; Vulval Itching/Lesion; Menopausal Problems.

Condition Filter:

Atrophic Vaginitis

Location Filter:

General Practice

Case created by:

David Bourne, 5th Year Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_17\_Atrophic Vaginitis

Homepage Vignette:

## A 55-year-old woman called Mariana Kuznetsova presents with postmenopausal bleeding.

Individual Page Vignette:

You are a General Practitioner, and Mariana Kuznetsova, a 55-year-old retired teacher, visits your clinic in a rural town. She is here due to experiencing postmenopausal bleeding..

Patient Name:

Mariana Kuznetsova (Muh-ree-ah-na Kuz-neht-soh-vuh). Mariana would like to be called by her first name.

Age:

27/06/1969

Location:

General Practice

Personality:

Mariana is a retired teacher, calm and straightforward with her communication. She has a meticulous nature, likely attributed to her years of correcting homework and planning lessons. Despite the personal nature of her visit, she approaches the conversation with maturity and a slight hint of discomfort when discussing her symptoms.

Presenting Complaint:

Mariana reports postmenopausal bleeding which she finds distressing.

Quote: "I've noticed some spotting, and well, things have been quite uncomfortable down there. I'm quite embarrassed, but I know I need to get it checked out."

Symptoms:

- Site: Vaginal; "There’s also some dryness at the entrance, but the bleeding, I noticed a bit on my underwear."

- Onset: Gradual onset of vaginal dryness over the past year; "It's been getting worse over the past year or so." Postmenopausal bleeding noticed in the last month; "Just last month I started noticing the blood."

- Character: Dryness described as a lack of moisture; "It's like a desert down there." Bleeding described as light spotting; "Not much, just a bit of spotting."

- Radiation: No radiation of symptoms; "It's just in my vaginal area, nowhere else."

- Associated Symptoms: Mild itching; "Sometimes, it gets a bit itchy."

- Timing: Dryness constant, bleeding intermittent; "The dryness is always there, but the bleeding comes and goes."

- Exacerbating and Relieving Factors: Lack of lubrication exacerbates bleeding; "It's worse during intimacy." No relieving factors mentioned; "Nothing seems to help."

- Severity: Mild to moderate discomfort; "It's uncomfortable, especially when I'm walking around or trying to be intimate with my partner."

PV Bleeding: Light spotting, red, minimal volume, no distinct smell.

PV Discharge: No discharge reported.

Abdominal or Pelvic Pain: No pain reported.

Dyspareunia: Reported slight discomfort during intercourse due to dryness; "It's a bit painful during sex, not like before."

Post-coital PV Bleeding: No post-coital bleeding reported.

Post-menopausal Bleeding: Light spotting as described above.

Vulval skin changes or itching: Mild itching, no visible skin changes.

Quote: "The itching isn't constant, but when it's there, it's very annoying."

History of Presenting Complaint:

- Mariana has been experiencing vaginal dryness increasingly over the past year, with a noticeable exacerbation in the past few months.

- The postmenopausal bleeding was first noticed last month, with no previous instances before that.

- Attempted using over-the-counter vaginal moisturizers with minimal relief.

- Symptoms have made sexual intercourse with her partner less enjoyable, causing distress.

- Impact on daily life minimal apart from the distress during intimate moments.

- No impact on work as she is retired.

- Physical wellbeing slightly affected due to discomfort and slight itch. Mental wellbeing affected due to worry about her symptoms and what they might imply.

Quote: "I tried some of those moisturizers from the pharmacy, but they don’t seem to do much. And this bleeding... it's got me worried."

Systemic Symptoms:

- Fatigue: No unusual fatigue

- Fever: No fever

- Night Sweats: No night sweats

- Unintended Weight Loss: No unintended weight loss

- Chest or Shoulder Tip Pain: None

- Shortness of Breath or Cough: None

- Change in Bowel Habits: Normal

- Change in Urinary Habits: Normal

- Dysuria: No dysuria

- Oedema: None

- Rashes or Skin Changes: None

- Headache: None

- Mood Changes: Some anxiety regarding symptoms

- Sleep Disturbances: None

Quote: "Apart from what I've already mentioned, I feel quite normal. Just worried, you know?"

Obstetric History:

- Previous Obstetric History: Gravidity 2, Parity 2.

- >24 Weeks Pregnancies: 2 pregnancies, both resulted in full-term vaginal deliveries with no complications. Gestation at Delivery(s) were 39 and 40 weeks respectively. Birth Weight(s) were 3.2kg and 3.5kg. No stillbirths.

- <24 Weeks Pregnancies: No miscarriages, terminations, or ectopic pregnancies recorded.

- Reproductive Plans: No future plans for more children. "My family is complete, and I'm quite content with my two grown-up children."

Quote: "I've had two children, both straightforward pregnancies and births, really blessed in that sense."

Gynaecology History:

- Menstrual History: Menopause at age 52. Regular menstrual cycles before menopause occurring every 28 days, lasting for 5 days with moderate flow. Dysmenorrhoea was mild and managed with over-the-counter NSAIDs.

- Menarche: Age 13.

- Menopause: Confirmed at age 52 after 12 months with no menstruation.

- Contraception: None currently. Previously used oral contraceptive pills before opting for a vasectomy for her partner as a long-term solution.

- Previous Screens: Last cervical screening was 2 years ago, with no abnormalities detected.

- Previous Gynaecology Conditions: No significant history.

- Previous STIs: None reported.

Quote: "My periods stopped about 3 years ago, and I've not had to think much about gynaecological stuff since then, except for regular screenings."

Past Medical History:

- Hypertension managed with amlodipine 5mg daily.

- History of seasonal allergies managed with cetirizine as needed.

- No previous surgeries or hospitalizations.

- Blood group: A RhD positive.

- No significant psychiatric or psychological history.

- No history of alcohol or substance abuse.

- Fully vaccinated, including HPV vaccine received as per guidelines.

- No previous significant injuries or traumas.

Quote: "Just the high blood pressure pills every morning. Otherwise, I keep myself quite healthy."

Drug History:

- Amlodipine 5mg once daily for hypertension.

- Cetirizine 10mg as needed for allergies.

- Previously took oral contraceptive pills for birth control.

- Takes Calcium and Vitamin D supplements for bone health.

Quote: "I've been careful to take my blood pressure medication every day. I also take some allergy pills when needed during the spring."

Allergies:

- Penicillin: Hives and swelling when exposed.

- No other known allergies or intolerances.

Quote: "Found out the hard way that penicillin doesn't agree with me."

Family History:

- Mother had type 2 diabetes diagnosed at age 60.

- Father had a history of ischemic heart disease and passed away at age 75 from a myocardial infarction.

- One younger brother, healthy with no significant medical conditions.

Quote: "My mother has to watch her sugar, and we lost dad to heart trouble a few years back."

Social History:

- Lifestyle: Retired, leads a moderately active lifestyle.

- Occupation: Retired teacher, spends time volunteering locally.

- Activities of Daily Living & Hobbies: Enjoys gardening, reading, and is part of a local book club.

Smoking: Never smoked.

Alcohol: Drinks occasionally, roughly 2-4 units per week.

Recreational Drug Use: None.

Diet: Follows a balanced diet with a focus on vegetables, fruits, and lean proteins.

Exercise: Walks daily, approximately 30 minutes.

Quote: "I've been keeping myself busy since retirement, staying active and involved in things I love."

Sexual History:

- Last sexual intercourse: Within the last month.

- Monogamous relationship with her husband for the past 30 years.

- No contraception used currently due to menopause.

Quote: "My husband and I still enjoy an intimate relationship, though it's been a bit uncomfortable recently."

Ideas, Concerns, and Expectations:

- Idea: Concerned that her symptoms could indicate a more serious underlying condition, "Could this bleeding be something serious?"

- Concerns: Embarrassed by the symptoms and worried about the impact on her relationship, "It's quite embarrassing, and I'm worried it's affecting my marriage."

- Expectations: Seeks reassurance and effective treatment to alleviate symptoms, "I hope we can find a way to manage this, so I can feel normal again."

Observations:

NEWS Total Score: 0

Physical Examination:

General Inspection:

- No signs of distress or discomfort.

- Well-kept appearance, alert and engaged during consultation.

Abdominal Examination:

- Abdomen soft, non-distended with no tenderness on palpation.

Vaginal Examination:

Vulval Inspection:

- Mild atrophic changes noted, no ulcers, cysts, or masses.

Speculum Examination:

- Atrophic vaginal mucosa observed.

- Cervix appears atrophic but no erosions or bleeding.

Bimanual Examination:

- No cervical excitation tenderness.

- Uterus and ovaries non-palpable and non-tender.

Special Tests:

- Vaginal pH test showing elevated pH level.

Diagnostic Tests:

Urine Dipstick: Normal

Blood Tests (Reference Ranges):

FBC: Within normal limits.

Urea and Electrolytes: All within normal ranges.

Imaging Tests:

Ultrasound Scan: Pelvic ultrasound indicates no significant abnormalities. Ovaries of postmenopausal size without any masses. No evidence of endometrial thickening.

Endometrial Biopsy: No signs of endometrial malignancy.

Other Tests:

STI Screen: All negative, including Chlamydia, Gonorrhoea, and Syphilis.

Given the examination findings and diagnostic results, Atrophic Vaginitis is the most likely diagnosis.

Patient Questions:

1. "Is this condition normal for someone my age?" - Yes, atrophic vaginitis is quite common in postmenopausal women due to decreased estrogen levels.

2. "Can it be treated, or will I have to live with this discomfort forever?" - There are effective treatments available, including topical oestrogen preparations that can help alleviate your symptoms.

3. "Is there anything I did that caused this?" - No, it's a natural part of aging and not caused by anything you did.

4. "Will this affect my relationship with my husband?" - With treatment and open communication, it's possible to manage these symptoms and maintain a healthy sexual relationship.

Examiner Questions:

1. What is the first-line treatment for atrophic vaginitis?

- Topical estrogen therapy is considered the first-line treatment.

2. How would you differentiate between atrophic vaginitis and endometrial cancer in a postmenopausal woman with vaginal bleeding?

- Endometrial cancer would often be suspected in cases of heavy or persistent bleeding and can be investigated with endometrial biopsy. Atrophic vaginitis typically presents with light spotting or bleeding accompanied by signs of vaginal atrophy.

3. What are some non-hormonal treatments for atrophic vaginitis?

- Non-hormonal treatments include vaginal moisturizers and lubricants, which can help alleviate symptoms of dryness.

4. Discuss the role of patient education in managing atrophic vaginitis.

- Educating patients about the condition, its causes, treatment options, and lifestyle modifications can empower them to manage their symptoms effectively.

5. How would you monitor the treatment effectiveness and patient's response in a case of atrophic vaginitis?

- Monitoring would involve follow-up appointments to assess symptom improvement, side effects, and any need for treatment adjustment.

6. Can atrophic vaginitis increase the risk of urinary tract infections (UTIs), and why?

- Yes, atrophic changes can make the vaginal area more susceptible to infections due to reduced lactobacilli and changes in the pH, which can increase the risk of UTIs.

Treatment:

1. Topical Estrogen Therapy:

* Start with a low-dose vaginal estrogen cream (e.g., Estriol cream applied using an applicator). Other options inclead pessaries, tablets and rings.

2. Vaginal Moisturizers and Lubricants:

* Recommend regular use of non-hormonal vaginal moisturizers every 3 days and water-based lubricants during sexual activity to alleviate dryness and reduce discomfort.

3. Lifestyle Modifications:

* Discuss the importance of staying hydrated and regular pelvic floor exercises.

4. Review:

* Schedule a follow-up appointment in 3 months to evaluate symptom relief and adjust treatment as necessary. If symptoms persist or worsen, consider endometrial biopsy to rule out other causes of postmenopausal bleeding.

Monitoring:

- Monitor patient's response to treatment through symptoms relief and side effects.

- Instruct the patient to report any worsening of symptoms, unexpected vaginal bleeding, or possible reactions to the topical oestrogen.

- Follow-up appointment in 3 months for review, with subsequent annual check-ups for continuous users.

- Ongoing assessment for those with a uterus of endometrial thickening or unusual vaginal bleeding, which may require discontinuation of therapy and further investigation.

Prognosis:

- Most women experience significant symptom relief with the appropriate use of topical oestrogen and non-hormonal lubricants.

- The condition is chronic and may require ongoing treatment, although the severity of symptoms can decrease with consistent treatment.

- Prognostic factors including the degree of atrophy, underlying health conditions, and patient adherence to treatment can affect the overall outcome.

- Regular monitoring and follow-up can help manage symptoms effectively and ensure a good quality of life.

Differential diagnoses:

1. Endometrial Cancer: Unlikely due to the absence of significant bleeding and normal biopsy and ultrasound findings.

2. Bacterial Vaginosis: Less likely given the absence of a malodorous discharge and negative infection screen.

3. Vulvovaginal Candidiasis: Unlikely due to lack of candida typical symptoms such as thick, white discharge.

4. Cervical Ectropion: While this can cause post-coital bleeding, the speculum exam did not indicate ectropion; symptoms predominantly relate to atrophy.

Keyword Filters:

Speciality Filter: General Practice; Obstetrics And Gynaecology; Medicine Of Older Adult

Presenting Complaint Filter: Menopausal Problems; Post-menopausal Bleeding; Painful Sexual Intercourse; Vulval Itching/Lesion

Condition Filter: Atrophic Vaginitis

Location Filter: General Practice; Clinic

Case created by:

David Bourne, 5th Year Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_18\_Atrophic Vaginitis

Homepage Vignette:

## A 58-year-old woman called Marta presents with postmenopausal bleeding.

Individual Page Vignette:

You are a General Practitioner and Marta, a 58-year-old retired schoolteacher, visits your clinic in a suburban area. She complains of experiencing postmenopausal vaginal bleeding.

Patient Name:

Marta Kowalski (Pronunciation: Mar-tah Ko-val-ski). Marta would like to be called by her first name.

Age:

16/06/1966

Location:

General Practice

Personality:

Marta appears thoughtful and considerate, frequently pausing to choose her words carefully. She maintains eye contact and speaks in a calm, composed manner, albeit with an undertone of concern regarding her symptoms.

Presenting Complaint:

Marta states, "I've been noticing some spotting over the past couple of months, and it's quite unsettling since I went through menopause a few years back. Additionally, the dryness down there has been quite bothersome, especially during intimacy."

Symptoms:

- PV Bleeding: Light spotting, brownish in colour, without a significant smell.

"It's just a bit of spotting, but it never used to happen."

- PV Discharge: Reports no unusual discharge.

- Abdominal or Pelvic Pain: Denies experiencing any pain.

- Chance of Pregnancy: Negates any chances of pregnancy.

- Dyspareunia: Reports discomfort during sexual intercourse due to dryness.

"It's been quite uncomfortable during sex, quite dry."

- Post-coital PV Bleeding: Denies experiencing any bleeding post-coitus.

- Intermenstrual PV Bleeding: Reports are not applicable due to postmenopausal status.

- Post-menopausal Bleeding: Confirms spotting in the post-menopausal period.

"I've been having this spotting on and off."

- Vulval skin changes or itching: Mentions occasional itching but hasn't noticed significant skin changes.

"There's been some itching, nothing too severe."

History of Presenting Complaint:

- Duration of symptoms: The spotting has been occurring for approximately 2 months.

- Previous treatments: None attempted for current symptoms.

- Progression: The spotting has remained consistent without significant changes.

- Frequency: The light spotting occurs approximately once every two weeks.

- Impact on daily life and ADLs: Reports minimal impact but expresses concern and occasional embarrassment.

- Work impact: As a retired individual, work impact is not applicable.

- Impact on physical and mental wellbeing: Expresses anxiety over the cause of the spotting.

"It's been on my mind a lot. Makes me wonder if something's wrong."

Systemic Symptoms:

- Fatigue: Denies unusual fatigue.

- Fever: Denies having a fever.

- Night Sweats: Reports occasional night sweats, considered part of post-menopausal changes.

- Unintended Weight Loss: Denies any noticeable weight loss.

- Chest or Shoulder Tip Pain: Denies these symptoms.

- Shortness of Breath or Cough: Denies experiencing these symptoms.

- Changes in Bowel Habits: Normal bowel movements.

- Change in Urinary Habits: Denies changes.

- Dysuria: Denies experiencing pain during urination.

- Oedema: No signs of oedema reported.

- Rashes or Skin Changes: Denies significant rashes or skin changes.

- Headache: Occasional headaches, not considered unusual by the patient.

- Mood Changes: Reports mood swings, attributed to the stress of symptoms.

- Sleep Disturbances: Reports occasional difficulty sleeping, related to anxiety about health.

Obstetric History:

Previous Obstetric History:

Gravidity and Parity: G2P2

>24 Weeks Pregnancies: 2

Gestation at Delivery(s): 38 and 39 weeks, respectively.

Birth Weight(s): 3.2 kg and 3.4 kg, respectively.

Mode of Birth(s): Vaginal delivery without complications.

Complication: None reported.

Stillbirths: None.

<24 Weeks Pregnancies:

Miscarriages: None.

Terminations: None.

Ectopic Pregnancies: None.

Gynaecology History:

Menstrual History:

Duration: Reports were regular before menopause.

Frequency: Monthly cycles before menopause.

Volume: Describes as moderate.

Dysmenorrhoea: Mild cramping experienced before menopause.

Last Menstrual Period: Approximately 6 years ago.

Menarche: Began menstruating at age 13.

Menopause: Confirmed menopausal status approximately 6 years ago.

Previous Screens:

Cervical screening up to date, last performed 3 years ago with normal results.

Previous Gynaecology Conditions: Denies any significant gynaecology conditions.

Previous STIs: None reported.

Contraception: Utilized oral contraceptives before menopause, no current use.

Past Medical History:

- Hypertension, managed with medication.

- Underwent cholecystectomy 10 years ago.

- Blood group O+, Rhesus positive.

- Psychiatric History: Denies any psychiatric or psychological conditions.

- No history of alcohol or substance abuse.

- Immunizations up to date, including HPV vaccination.

- No previous STIs reported.

Drug History:

- Amlodipine 5mg daily for hypertension.

- No history of medication non-compliance.

"I've been taking my blood pressure medication regularly, nothing else."

Allergies:

- Penicillin: Experienced a rash following administration.

"I had a terrible rash the last time I took penicillin."

Family History:

- Mother had hypertension, passed away due to a stroke at age 74.

- Father alive, has type 2 diabetes.

"My mum had high blood pressure like me, and my dad's pretty healthy for his age."

Social History:

Lifestyle: Leads a generally active lifestyle, enjoys walking and gardening.

Occupation: Retired schoolteacher.

Activities of Daily Living & Hobbies: Active in the local community center, enjoys reading and knitting.

Smoking: Never smoked.

Alcohol: Consumes wine occasionally, approximately 1-2 units per week.

Recreational Drug Use: Denies any use.

Diet: Follows a balanced diet, rich in fruits and vegetables.

Exercise: Walks daily, approximately 30 minutes.

Sexual History:

Last sexual intercourse: Two weeks ago.

Current and previous partners: Married, monogamous relationship.

Contraception: None, postmenopausal.

Recent Life Events:

- Recently celebrated the wedding of her youngest daughter, which she describes as "joyful but stressful."

Exposure to Hazards or New Environment:

- Denies exposure to any unusual environmental hazards.

Ideas, Concerns, and Expectations:

- Ideas: "I've read that hormonal changes after menopause can lead to dryness and maybe bleeding. But I'm worried it could be something more serious."

- Concerns: "I'm really worried this bleeding could be a sign of cancer. My mother had health issues later in life, and it concerns me."

- Expectations: "I hope to receive some reassurance today and would like to know what treatments can help with the dryness and bleeding."

Observations:

NEWS Total Score: 0

Physical Examination:

General Inspection:

- Appears well-kept, no signs of distress or discomfort.

- No evidence of pallor, cachexia, or acute illness.

Hands:

- No cyanosis, clubbing, or peripheral edema.

Abdominal Examination:

- Soft, non-tender, no palpable masses.

Vaginal Examination:

- Vulval Inspection: Mild atrophic changes noted, no ulcers, cysts, or lesions.

- Speculum Examination: Atrophic changes evident on the vaginal walls; cervix appears healthy, without lesions or discharge.

- Bimanual Examination:

- Cervix: normal position, no motion tenderness.

- Uterus: normal size, no masses.

- Ovaries: not palpable, typical for postmenopausal women.

Diagnostic Tests:

- Urine Dipstick: Normal

- Endometrial Biopsy: Negative.

- STI Screen: Not performed, as no indication based on history.

- FBC: Within normal ranges.

- Urea and Electrolytes: Within normal ranges.

- Liver Function Tests: Within normal ranges.

Treatment:

As per NICE guidelines for the management of symptoms of the menopause:

1. Topical, non-hormonal moisturisers and lubricants for symptomatic relief of vaginal dryness.

2. Consider local oestrogen therapy if non-hormonal treatments are ineffective. (e.g., Oestriol cream 0.01%, apply intravaginally once daily for two weeks, then twice weekly.)

3. Regular follow-up appointments to reassess symptoms and adjust treatment as necessary.

4. Provide information on pelvic floor exercises to strengthen pelvic muscles.

If the patient has a history or risk factors for endometrial cancer, consider referral to a gynaecologist for further evaluation before initiating local oestrogen therapy.

Monitoring:

- Symptom relief within 1-2 weeks with topical treatments.

- Follow up in 3 months to review symptoms and treatment effectiveness.

- Annual review if on local oestrogen therapy to consider the need for continuing treatment.

Prognosis:

- Good, with most women experiencing symptom relief with appropriate treatment.

- Regular monitoring can effectively manage potential side effects of treatment.

Differential Diagnoses:

1. Endometrial hyperplasia or cancer – less likely due to the absence of significant risk factors and the pattern of bleeding.

2. Cervical cancer – less likely, given normal appearance of cervix on examination and up-to-date screening.

3. Vaginal atrophy – most likely diagnosis, supported by symptoms, age, and examination findings.

Patient Questions:

1. "Could the spotting be a sign of cancer?"

- "Based on your symptoms and examination today, cancer is less likely. However, we do perform tests to rule out anything serious whenever there are symptoms like yours."

2. "Will the treatment you're suggesting make the symptoms go away completely?"

- "Many women experience significant relief from symptoms with the treatments we've discussed, though it may take a little time to find the one that works best for you."

3. "Is there anything I should avoid while treating this condition?"

- "It's generally recommended to avoid harsh soaps or bath additives that might irritate the vaginal area. Staying hydrated and using lubricants during sexual activity can also help."

Examiner Questions:

1. What are the main symptoms of atrophic vaginitis?

- "Postmenopausal vaginal dryness, discomfort during intercourse, and light bleeding or spotting are the main symptoms."

2. How would you differentiate atrophic vaginitis from endometrial hyperplasia?

- "A thorough history, physical examination, and possibly ultrasound or endometrial biopsy can help differentiate the two, focusing on the pattern of bleeding and risk factors."

3. What are the potential side effects of local oestrogen therapy?

- "Side effects can include breast tenderness, vaginal bleeding or spotting, and local irritation. It's generally well-tolerated."

4. Why is it important to follow up with patients on local oestrogen therapy?

- "To monitor for side effects, assess symptom relief, and evaluate the continued need for treatment."

Treatment and diagnosis in this case are based on current guidelines from NICE, CKS, and BMJ Best Practice.

Case created by:

David Bourne, 5th Year Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_19\_AtrophicVaginitis

Homepage Vignette:

## A 58-year-old female called Mariam presents with post-menopausal vaginal bleeding.

Individual Page Vignette:

You are a general practitioner meeting with Mariam, a 58-year-old retired teacher, in your clinic. She presents with complaints of post-menopausal vaginal bleeding.

Patient Name: Mariam El-Hashem (Pronunciation: Ma-ree-am El-Hash-em, prefers to be called Mariam)

Age:

DOB: 15/06/1966

Location:

General Practice Clinic

Personality:

Mariam is articulate and quick to smile, showing a resilient spirit despite her concerns. She speaks thoughtfully, clearly articulating her symptoms and worries. With a background in education, she shows an active interest in understanding her medical condition and values clear and straightforward communication.

Presenting Complaint:

Mariam reports experiencing light-to-moderate vaginal bleeding over the past few weeks, which has caught her by surprise given her post-menopausal status.

Quote: "I was completely taken aback; I thought my menstruating days were long behind me. This bleeding, it's not heavy, but it's certainly noticeable."

Symptoms:

- Site: Vaginal "The bleeding's definitely coming from down there."

- Onset: Gradual onset "It started off really light at first, maybe a few weeks back?"

- Character: Non-painful, light to moderate bleeding "It's not like my normal periods used to be; it's lighter but definitely there."

- Radiation: Does not radiate "No, the bleeding is pretty much just in the one area."

- Associated Symptoms: Mild vaginal dryness and discomfort "I've also noticed it's been rather dry down there, a bit uncomfortable at times."

- Timing: Intermittent over the past few weeks "It comes and goes; some days I notice it more than others."

- Exacerbating and Relieving Factors: None identified "Nothing I do seems to make it worse or better."

- Severity: Light to moderate "It's not soaking through pads or anything, but I definitely have to wear something every day."

PV Bleeding: Light to moderate volume, red colour, no abnormal smell.

PV Discharge: None reported.

Abdominal or Pelvic Pain: None.

Chance of Pregnancy: None.

Dyspareunia: Mild discomfort reported

Post-coital PV Bleeding: Not applicable.

Intermenstrual PV Bleeding: Not applicable.

Post-menopausal Bleeding: Present.

Vulval skin changes or itching: Mild vulval itching reported.

Quote: "It's all very odd and a bit uncomfortable, especially the dryness and the occasional itch."

History of Presenting Complaint:

- Mariam has been experiencing these symptoms for approximately 3 to 4 weeks.

- No previous treatments have been tried.

- Symptoms have been gradually increasing in frequency.

- The symptoms have caused mild distress due to the uncertainty they bring, impacting her emotional wellbeing.

- No significant impact on daily life or activities of daily living (ADL), aside from the need to use sanitary products.

- Impact on work and physical wellbeing: Not applicable as she is retired.

Quote: "It's been a few weeks now. I've not tried anything for it; just been keeping an eye. It's worrying, not knowing what's causing it."

Systemic Symptoms:

- Fatigue: Normal

- Fever: Normal

- Night Sweats: Normal

- Unintended Weight Loss: Normal

- Chest or Shoulder Tip Pain: Normal

- Shortness of Breath or Cough: Normal

- Change in Bowel Habits: Normal

- Change in Urinary Habits: Normal

- Dysuria: Normal

- Oedema: Normal

- Rashes or Skin Changes: Mild vulval itching, otherwise normal

- Headache: Normal

- Mood Changes: Normal

- Sleep Disturbances: Normal

Quote: "Aside from the bleeding and a bit of itching, I feel perfectly normal, no other symptoms at all."

Obstetric History:

Previous Obstetric History:

Gravidity and Parity: G2 P2+0

>24 Weeks Pregnancies:

- Gestation at Delivery(s): 38 weeks, 39 weeks

- Birth Weight(s): 3.2kg, 3.5kg

- Mode of Birth(s): Vaginal delivery

- Complications: None

- Stillbirths: None

<24 Weeks Pregnancies:

- Miscarriages: None

- Terminations: None

- Ectopic Pregnancies: None

Gynaecology History:

Menstrual History:

- Duration: 4 days (post-menopausal)

- Frequency: 28 day cycle (post-menopausal)

- Volume: Normal (post-menopausal)

- Dysmenorrhoea: No pain (post-menopausal)

Last Menstrual Period: Approximately 8 years ago.

Menarche: Age 13

Menopause: Age 50

Previous Screens:

- Last cervical screening was 2 years ago, results normal.

Previous Gynaecology Conditions: None reported

Previous STIs: None reported

Contraception: Previous use of oral contraceptive pills, ceased prior to menopause.

Quote: "My last smear was all clear, thankfully. I've been quite healthy down there, no major issues at all."

Past Medical History:

- Hypertension, controlled on medication

- No surgeries or hospitalizations

- No psychiatric or psychological history

- No history of alcohol or substance abuse

- Immunizations up to date, including HPV

- No previous STIs

- No significant health events

Quote: "Aside from my blood pressure, which I manage with medication, I've been quite fortunate health-wise."

Drug History:

- Lisinopril for hypertension, 10mg, once daily in the morning

- No history of medication non-compliance

- No use of herbal supplements or alternative therapies

- No history of overdose incidents

Quote: "I take my blood pressure pill every morning, never missed a day."

Allergies:

- Penicillin: Causes a rash and swelling

- No known allergies to foods, materials, or environmental allergens

Quote: "Found out the hard way about Penicillin when I was younger, haven't touched it since."

Family History:

- Mother had type 2 diabetes, managed with diet and medications.

- Father had a history of coronary artery disease, passed away from a heart attack.

- One sibling with no significant medical history.

Quote: "Mum had to watch her sugar, and we lost Dad to his heart; makes you think about your own health."

Social History:

Lifestyle:

- Lives alone but has a close circle of friends and family she regularly interacts with.

- Recently retired from teaching, now spends time gardening, reading, and volunteering at the local library.

Occupation: Retired school teacher.

Activities of Daily Living & Hobbies:

- Independent in all ADLs.

- Enjoys gardening, a book club member, and volunteers her time for community services.

Smoking: Non-smoker.

Alcohol: Drinks socially, approximately 2 units per week.

Recreational Drug Use: None.

Diet: Maintains a balanced diet, eats plenty of fruit and vegetables.

Exercise: Walks daily, enjoys yoga classes twice a week.

Quote: "Retirement's given me the chance to enjoy the simpler things in life, like my garden, and staying active."

Sexual History:

Last sexual intercourse: Over a year ago.

Current and previous partners: Widowed, was in a monogamous relationship with her late husband.

Contraception used: Not applicable since menopause.

Quote: "It's been a while since I've been intimate with anyone; my husband was my only partner for years."

Ideas, Concerns, and Expectations:

- Ideas: Mariam believes the bleeding could be related to her menopause but is unsure what exactly is causing it.

- Concerns: Worried that the bleeding could signify something serious like cancer or a hidden illness.

- Expectations: Hopes to gain an understanding of the cause of her symptoms, receive reassurance, and discuss possible treatment options.

Quote: "I just hope it's nothing too serious. It's unsettling not knowing what's causing the bleeding at my age."

Observations:

NEWS Total Score: 0

Physical Examination:

General Inspection:

- Appears well, no signs of distress or discomfort.

Objects and Equipment:

- No objects or equipment present during examination.

Hands:

Inspection:

- Normal colour, no palmar erythema, no peripheral oedema.

Palpitation:

- Warm to touch, CRT <2sec, radial pulse regular with good volume.

Neck:

- No masses, lymphadenopathy, or goitre detected.

Face:

- No melasma, pallor, or jaundice observed.

Abdominal Examination:

- No abnormalities found on inspection or palpation.

Vaginal Examination:

- Vulval inspection reveals mild atrophic changes, no significant lesions or ulcers.

Speculum Examination:

- Cervical os appears atrophic, no active bleeding, erosions, masses, or significant discharge.

- No evidence of cervical ectropion.

Bimanual Examination:

- Vaginal walls show atrophic changes.

- Cervix firm, no cervical excitation pain.

- Uterus normal size, mobile, no tenderness.

- Ovaries not palpable, no masses felt.

Special Tests: Not applicable in the initial examination.

Diagnostic Tests:

- Urine Dipstick: Normal

- Endometrial Biopsy: No signs of malignancy.

- STI Screen: Negative for Chlamydia, Gonorrhoea, and Syphilis

- Blood Tests (Reference Ranges):

- Full Blood Count (FBC): Within normal reference ranges

- Urea and Electrolytes: Within normal reference ranges

- Liver Function Tests: Within normal reference ranges

- CRP: <3 mg/L

Imaging Tests:

- Ultrasound Scan: Transvaginal ultrasound showing a thin endometrial stripe consistent with post-menopausal status, no significant abnormalities detected.

Condition:

Atrophic Vaginitis

Patient Questions:

1. "Could this be something serious like cancer?"

- "It's understandable to worry about new symptoms like these. The examination and tests we've done are aimed at understanding the cause. Atrophic vaginitis is common and treatable but it's important we check everything thoroughly."

2. "What can I do about the dryness and discomfort?"

- "There are treatments available that can help with the dryness and discomfort, including vaginal moisturizers and hormone therapy. We can discuss which option might be best for you."

3. "Is this going to keep happening?"

- "Atrophic vaginitis can be a recurring issue, but with the right treatment, we can manage the symptoms and reduce the likelihood of it affecting you as severely in the future."

4. "Do I need to change my diet or lifestyle?"

- "Your current diet and lifestyle sound very healthy. Continuing your active, balanced lifestyle supports overall health, but specific changes aren't necessary for treating atrophic vaginitis."

Examiner Questions:

1. What are the typical signs and symptoms of atrophic vaginitis?

- "Vaginal dryness, discomfort, post-menopausal bleeding, and urinary symptoms are common."

2. How does the decline in estrogen levels lead to atrophic vaginitis?

- "Decreased estrogen levels lead to thinning and decreased elasticity of the vaginal wall, reduced vaginal lubrication, and changes in the vaginal flora."

3. What are the differential diagnoses for post-menopausal bleeding?

- "Endometrial cancer, endometrial hyperplasia, cervical cancer, polyps."

4. Why is vaginal estrogen considered the first-line treatment for symptomatic atrophic vaginitis?

- "Because it directly addresses the underlying cause of the symptoms by replenishing estrogen levels in the vaginal tissue, improving thickness, moisture, and elasticity."

5. Discuss the role of non-hormonal treatments in managing atrophic vaginitis.

- "Non-hormonal treatments like vaginal moisturizers and lubricants can relieve symptoms of dryness and discomfort but do not address the underlying hormonal changes."

Treatment:

First-line treatment for symptomatic atrophic vaginitis includes:

- Vaginal oestrogen preparations: Vaginal cream, tablet, or ring. For example, Ovestin cream 0.01%, apply intra-vaginally, nightly for two weeks, then twice weekly.

- Non-hormonal measures: Regular use of vaginal moisturizers and water-based lubricants to relieve dryness and discomfort.

- If vaginal estrogen is contraindicated or ineffective, and symptoms are significant, systemic HRT may be considered after evaluating risks and benefits.

Monitoring:

- Follow-up in 3 months to assess symptom improvement and adjust treatment as necessary.

- Annual review for long-term vaginal estrogen use, focusing on symptom control and compliance.

- Encourage the patient to report any new or worsening symptoms immediately, especially if experiencing significant bleeding.

Prognosis:

- With appropriate treatment, symptoms of atrophic vaginitis can significantly improve.

- Some women may experience persistent or recurring symptoms, requiring ongoing treatment.

- Regular follow-ups can effectively manage and adjust treatment, ensuring quality of life is maintained.

Differential diagnoses:

1. Endometrial Cancer: Less likely due to the absence of significant risk factors and normal ultrasound findings.

2. Cervical Polyps: Not seen on examination.

3. Endometrial Hyperplasia: Not indicated by ultrasound and patient's clinical presentation.

4. Cervical Cancer: No visible cervical lesions and negative for high-risk HPV.

Speciality Filter: Obstetrics And Gynaecology; General Practice

Presenting Complaint Filter: Menopausal Problems; Vulval Itching/Lesion

Condition Filter: Atrophic Vaginitis

Location Filter: General Practice; Clinic

Case created by:

David Bourne, 5th Year Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_20\_Atrophic Vaginitis

Homepage Vignette:

## A 58-year-old female called Eilidh McKinnon presents with postmenopausal vaginal bleeding.

Individual Page Vignette:

You are a General Practitioner in a clinic. Eilidh McKinnon, a 58-year-old retired librarian, located in your clinic, presents with complaints of postmenopausal vaginal bleeding and discomfort.

Patient Name:

Eilidh McKinnon (Pronunciation: AY-lee muh-KIN-non), prefers to be called Eilidh.

Age:

01/05/1966

Location:

General Practice

Personality:

Eilidh is a warm, articulate, and thoughtful individual. She speaks in a calm and measured manner, often reflecting before answering. Her background as a librarian is evident in her love for detailed explanations and her expectation for the same level of detail in responses.

Presenting Complaint:

Eilidh has come to the clinic due to experiencing postmenopausal vaginal bleeding over the past few weeks. She describes the bleeding as light but persistent and is concerned about its cause.

Quote: "I've noticed some light bleeding, which is surprising at my age, given I've not had a period for years. It's quite worrying."

Symptoms:

- PV Bleeding: Light, spotting, no significant volume, pinkish in color, no odor.

- PV Discharge: Eilidh reports no noticeable discharge.

- Abdominal or Pelvic Pain: Eilidh denies any abdominal or pelvic pain.

- Dyspareunia: Reports discomfort during intercourse.

- Post-coital PV Bleeding: Denies any bleeding post-coital.

- Intermenstrual PV Bleeding: Not applicable due to menopausal status.

- Post-menopausal Bleeding: Light, spotting

Quote: "The bleeding isn't much, just a bit of spotting really. It's not like my periods used to be."

History of Presenting Complaint:

- Eilidh has been experiencing the symptoms for approximately 8 weeks.

- She has not tried any treatments yet.

- The bleeds have been sporadic, with a frequency of about once every two weeks.

- Eilidh reports a significant impact on her mental wellbeing due to worry about the cause of the bleeding.

- She mentions no impact on her daily life or work as she is retired.

- This condition has not affected her physical wellbeing aside from the discomfort during intercourse.

Quote: "It started around two months ago. I've not tried anything for it; I thought it best to consult you first."

Systemic Symptoms:

- Fatigue: Eilidh denies any unusual fatigue.

- Fever: Denies any recent fever.

- Night Sweats: Reports occasional night sweats.

- Unintended Weight Loss: Denies any unintended weight loss.

- Chest or Shoulder Tip Pain: Denies.

- Shortness of Breath or Cough: Denies.

- Change in Bowel Habits: Denies any recent changes.

- Change in Urinary Habits: Denies.

- Dysuria: Denies frequency or urgency.

- Oedema: Denies.

- Rashes or Skin Changes: Denies.

- Headache: Occasional, mild headaches.

- Mood Changes: Expresses worry related to her symptoms.

- Sleep Disturbances: Reports disrupted sleep due to stress and night sweats.

Quote: "The bleeding has me quite worried, but I haven't noticed anything else out of the ordinary."

Obstetric History:

Previous Obstetric History:

Gravidity and Parity: G2 P2+0

>24 Weeks Pregnancies: 2

Gestation at Delivery(s): 38 and 40 weeks

Birth Weight(s): 3.2 kg and 3.5 kg

Mode of Birth(s): Vaginal, no complications

Complications: None

Stillbirths: None

<24 Weeks Pregnancies:

Miscarriages: None

Terminations: None

Ectopic Pregnancies: None

Reproductive Plans: Eilidh has no plans for more children.

Quote: "I've been blessed with two children, both grown up now. No plans for any more, obviously."

Gynaecology History:

Menstrual History:

- Duration: 4 days (postmenopausal)

- Frequency: 28 day cycle (postmenopausal)

- Volume: Normal (postmenopausal)

- Dysmenorrhoea: None (postmenopausal)

Last Menstrual Period: Approximately 6 years ago.

Menarche: Age 12

Menopause: Confirmed at age 52

Previous Screens:

- Cervical screening last done 3 years ago with no abnormalities detected.

Prev. Gynaecology Conditions: None reported.

Previous STIs: None reported.

Contraception: No current use, previously used oral contraceptive pills.

Quote: "My last smear test was all clear, and I've never had any real issues down there before this."

Past Medical History:

- Hypertension, diagnosed 8 years ago, under control with medication.

- No surgeries or hospitalizations.

- No psychiatric or psychological history.

- No history of alcohol or substance abuse or addiction.

- Full Immunizations and vaccination history, including HPV.

- No previous STIs.

- No other relevant medical conditions.

Quote: "Aside from high blood pressure, which I take medication for, I've been quite healthy."

Drug History:

- Amlodipine 5mg once daily for hypertension.

- Had previously used oral contraceptive pills for birth control until menopause.

- No history of medication non-compliance or missed doses.

- Does not use herbal supplements or alternative therapies.

- No previous use of Folic Acid or iron supplements.

Quote: "I've been on blood pressure medication for years with no issues. I make sure not to miss my doses."

Allergies:

- No known allergies to medications, anaesthetics, foods, materials, or chemicals.

Quote: "I've been fortunate never to have had an allergic reaction to anything."

Family History:

- Mother had breast cancer diagnosed at age 65 but successfully treated.

- Father has type 2 diabetes, managed with diet and medication.

- One sibling with no significant medical history.

Quote: "Mum battled breast cancer, but thankfully she's been in remission for years now. Dad keeps his diabetes in check."

Social History:

- Lifestyle: Retired, enjoys gardening and reading.

- Occupation: Retired librarian.

- Activities of Daily Living & Hobbies: Active within her community book club and gardening society.

Smoking: Never smoked.

Alcohol: Drinks occasionally, approximately 2 units per week.

Recreational Drug Use: Denies any use.

Diet: Balanced, with a focus on fruits, vegetables, and lean proteins.

Exercise: Walks daily, about 30 minutes.

Quote: "I enjoy my retirement by keeping my mind and body active. I've always believed in moderation in all things."

Sexual History:

- Last sexual intercourse approximately 2 months ago.

- Has been in a monogamous relationship for over 30 years.

- No contraception used since menopause.

Quote: "Since the bleeding started, I've been apprehensive about intimacy."

Ideas, Concerns, and Expectations:

- Ideas: Eilidh believes her symptoms could be related to hormonal changes but is concerned about the possibility of cancer due to her mother's history.

- Concerns: Worried about the cause of the bleeding and its implications for her health. Concerned about the impact of her symptoms on her sexual relationship.

- Expectations: Seeks reassurance, a thorough investigation of her symptoms, and appropriate treatment if necessary.

Quote: "I wonder if this is just part of getting older, but I can't help worrying it could be something more serious, like cancer."

Observations:

- NEWS Total Score: 0

Physical Examination:

- General Inspection: Appears well, no signs of distress or discomfort.

- Objects and Equipment: No aids or medical equipment present.

- Hands: No changes noted in colour, no palmar erythema or peripheral oedema.

- Neck: No masses or lymphadenopathy.

- Face: No signs of melasma, conjunctival pallor, jaundice, or oedema.

- Abdominal Examination: Soft, non-tender with no palpable masses.

- Vaginal Examination:

- Vulval Inspection: Atrophic changes noted, no ulcers, cysts, lesions, or discharge.

- Speculum Examination: Atrophic changes, no active bleeding or lesions.

- Bimanual Examination: Uterus and ovaries palpated normally, no masses or tenderness.

Diagnostic Tests:

- Urine Dipstick: Negative for blood, protein, and glucose.

- Vaginal Swab: Normal vaginal flora, no evidence of infection.

- STI Screen: All tests negative.

- Endometrial Biopsy: No signs of malignancy.

- Full Blood Count (FBC):

- Haemoglobin (Hb): 142 g/​L (Female: 115 - 165 g/​L)

- Mean Corpuscular Volume (MCV): 88 fL (80 – 100 fL)

- White Blood Cell Count: 6.5 x10^9/L (3.6 - 11.0 x10^9/L)

- Platelets: 250 x10^9/L (140 - 400 x10^9/L)

- Urea and Electrolytes all within normal range.

- Liver Function Tests all within normal range.

Condition:

Atrophic Vaginitis

Patient Questions:

1. "Why am I bleeding if I'm postmenopausal? Does this mean I have cancer?"

- "Postmenopausal bleeding can be due to many causes, one of which is the thinning of your vaginal walls, known as atrophic vaginitis. It's quite common and not necessarily a sign of cancer. However, we'll ensure thorough examination and tests to understand the cause precisely."

2. "Will this affect my relationship with my partner?"

- "It's understandable to worry about the impact on your relationship. Many women experience symptoms of atrophic vaginitis, and effective treatments can help manage these. It's also important to communicate with your partner about what you're going through."

3. "What are the treatment options?"

- "Treatment usually involves topical estrogen therapy, which helps replenish the estrogen in the vaginal tissue, improving symptoms. There are also non-hormonal moisturisers and lubricants that can ease discomfort."

Examiner Questions:

1. What is the definition of Atrophic Vaginitis?

- "Atrophic vaginitis is a condition where thinning, drying, and inflammation of the vaginal walls occur due to a decrease in estrogen levels."

2. List two differential diagnoses for postmenopausal bleeding.

- "Endometrial cancer and cervical polyps."

3. Why is it important to perform a pelvic examination in a patient presenting with postmenopausal bleeding?

- "To assess for signs of atrophic vaginitis, exclude malignancies, and identify other possible sources of bleeding or pathology."

4. How would you manage a patient with Atrophic Vaginitis?

- "Begin with topical estrogen therapy and advise on the use of lubricants. Monitor response to treatment with follow-up appointments."

5. What advice would you provide to the patient about lifestyle modifications?

- "Encourage maintaining a healthy weight, quitting smoking if applicable, and using vaginal lubricants during intercourse to ease discomfort."

Treatment:

1. Localized Estrogen Therapy: Prescribe Vaginal Estrogen Cream, such as Oestriol cream 0.01%, applying a small dose vaginally daily for 2-4 weeks, then 1-2 times a week as maintenance.

2. For patients who cannot use estrogen therapy, recommend regular use of vaginal moisturisers and water-based lubricants.

Monitoring:

- Follow-up in 4-6 weeks to assess symptom improvement and adjust treatment as necessary.

- Discuss any new symptoms or side effects experienced.

- Annual review if on long-term topical estrogen treatment to reassess the need for continuation.

Prognosis:

- With appropriate treatment, most women experience significant improvement in symptoms.

- Regular use of treatment is often required to maintain symptom control.

- Untreated, symptoms may gradually worsen over time.

Differential diagnoses:

1. Endometrial Cancer: Less likely due to the absence of significant risk factors and more aggressive symptoms.

2. Cervical Polyps: Could cause postmenopausal bleeding but typically accompanied by a visible lesion on examination.

Keyword Filters:

Speciality Filter:

Obstetrics And Gynaecology; General Practice;

Presenting Complaint Filter:

Menopausal Problems; Vaginal Discharge; Painful Sexual Intercourse;

Condition Filter:

Atrophic Vaginitis;

Location Filter:

General Practice; Clinic;

Case created by:

David Bourne, 5th Year Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_21\_Atrophic Vaginitis

Homepage Vignette:

## A 55-year-old woman called June Parsons presents with postmenopausal vaginal bleeding.

Individual Page Vignette:

You are a General Practitioner in a clinic. Your patient is June Parsons, a 55-year-old, recently retired librarian, located in a local clinic. She presents with postmenopausal vaginal bleeding.

Patient Name:

June Parsons (Phonetic Pronunciation: Ju-en Par-sons). She would like to be called June.

Age:

24/06/1969

Location:

Clinic

Personality:

June is an articulate and well-read individual, reflecting her career as a librarian. She approaches her health with a balanced mixture of concern and pragmatism, expressing her symptoms clearly and without embellishment. She speaks in a calm and steady manner.

Presenting Complaint:

June reports experiencing postmenopausal vaginal bleeding intermittently over the past two months.

Quote: "I've noticed some spotting every now and then over the last couple of months, which I didn't expect at all since I haven't had a period in over five years."

Symptoms:

- PV Bleeding: Light spotting, pinkish in colour, occasional, without any particular smell.

Quote: "It's just a bit of light pink spotting, no real flow or anything. And it doesn't have any smell."

- PV Discharge: None.

- Abdominal or Pelvic Pain: None.

- Dyspareunia: Reports discomfort during sexual intercourse.

Quote: "It's been uncomfortable during sex, a bit painful even."

- Post-coital PV Bleeding: None.

- Post-menopausal Bleeding: Present.

Quote: "It took me by surprise because I thought those days were well behind me."

- Vulval skin changes or itching: Reports mild vulval itching.

Quote: "There's been a bit of itching around there, but nothing too severe."

History of Presenting Complaint:

- June noticed the spotting approximately two months ago.

- No previous treatments attempted.

- The symptoms have been intermittent over this time.

- The bleeding is light and occasional.

- It has had minimal impact on her daily life but has caused concern.

- No impact on work as she is retired.

- Mild impact on mental wellbeing due to concern over the cause.

Quote: "I first saw it about two months ago. I've not treated it with anything. Just been keeping an eye on it. It's not been too bothersome, just concerning."

Systemic Symptoms:

- Fatigue: None.

- Fever: None.

- Night Sweats: None.

- Unintended Weight Loss: None.

- Chest or Shoulder Tip Pain: None.

- Shortness of Breath or Cough: None.

- Change in Bowel Habits: Normal.

- Change in Urinary Habits: Normal.

- Dysuria: None.

- Oedema: None.

- Rashes or Skin Changes: None.

- Headache: None.

- Mood Changes: None reported.

- Sleep Disturbances: None reported.

Quote: "Apart from the bleeding, I feel quite well actually. No other complaints."

Obstetric History:

Previous Obstetric History:

Gravidity and Parity: G2 P2+0

>24 Weeks Pregnancies:

- Gestation at Delivery(s): 39 weeks and 40 weeks.

- Birth Weight(s): 3.2 kg and 3.5 kg.

- Mode of Birth(s): Vaginal delivery with no complications for both.

- Complications: None.

- Stillbirths: None.

<24 Weeks Pregnancies: None.

Miscarriages: None.

Terminations: None.

Ectopic Pregnancies: None.

Quote: "Both my children were born full term, no complications. I'm not looking to have any more."

Gynaecology History:

Menstrual History:

- Duration: 5 days (before menopause).

- Frequency: 28-day cycle (before menopause).

- Volume: Moderate (before menopause).

- Dysmenorrhoea: Mild cramps on the first day.

Last Menstrual Period:

- 5 years ago.

Menarche:

- Age 13.

Menopause:

- Symptomatic menopause at age 50.

Previous Screens:

- Last cervical screening was 3 years ago, result was normal.

Previous Gynaecology Conditions:

- None reported.

Previous STIs: None reported.

Contraception:

- Previously used oral contraceptive pill, stopped 10 years ago.

Quote: "I went through menopause when I was 50, pretty standard stuff. Had some hot flushes, nothing I couldn't handle."

Past Medical History:

- Hypertension, controlled with medication.

- No previous surgeries or hospitalisations.

- No psychiatric or psychological history.

- No history of alcohol or substance abuse or addiction.

- Full Immunizations and vaccination history including HPV.

- No previous STIs.

Quote: "I've had high blood pressure for a few years now, but it's well under control with medication. Other than that, I'm fairly healthy."

Drug History:

- Amlodipine 5mg once daily for hypertension.

- No history of medication non-compliance.

- No use of herbal supplements or alternative therapies.

- Previous contraception was an oral contraceptive pill, stopped 10 years ago.

- Not taking Folic Acid or iron supplements.

Quote: "I take Amlodipine for my blood pressure, just the one tablet each morning. Never really been into herbal stuff or anything like that."

Allergies:

- Penicillin: developed a rash after administration.

Quote: "I found out I was allergic to Penicillin a long time ago. Got a nasty rash all over."

Family History:

- Mother had hypertension, controlled with medication.

- Father had type 2 diabetes, managed with diet and exercise.

- One older sibling, no known medical issues.

Quote: "Mum had high blood pressure like me, and Dad had diabetes. My brother seems to have dodged it all, though."

Social History:

Lifestyle:

- Lives alone since retirement, very active in the local book club.

Occupation:

- Recently retired librarian.

Activities of Daily Living & Hobbies:

- Enjoys gardening and going for daily walks in the local park.

Smoking: Non-smoker.

Alcohol: Drinks socially, about 2-3 units per week.

Recreational Drug Use: None.

Diet: Follows a balanced diet, high in fruits and vegetables.

Exercise: Walks daily, enjoys yoga twice a week.

Quote: "Retirement's given me more time for my garden and book club. I like to keep active, a walk in the park, a bit of yoga. I'll have a glass of wine with friends now and then."

Sexual History:

Last sexual intercourse was two weeks ago.

Current partner, in a monogamous relationship for the past 10 years.

Using barrier methods for contraception.

Quote: "My partner and I have been together for quite a while now. We're careful, use protection."

Travel History: Not recently travelled.

Cultural or Religious Practices: None that impact medical care.

Recent Life Events: Retirement.

Exposure to Hazards or New Environment: None.

Ideas, Concerns, and Expectations:

- Ideas: June understands that postmenopausal bleeding can have various causes and is aware that it's important to investigate.

- Concerns: Worried about the possibility of a serious underlying condition like cancer.

- Expectations: Hopes to have a thorough examination and appropriate investigations. Looking for reassurance and clear information about the findings and next steps.

Quote: "I've read a bit about spotting after menopause. It's the cancer scare that's really worrying me. I just want to know what's going on and that we're doing everything we can to find out."

Observations:

NEWS Total Score: 0

Physical Examination:

General Inspection:

- Overall appearance: well-nourished, no signs of distress.

- No shortness of breath or pallor detected.

Objects and Equipment: None present.

Hands:

Inspection:

- Colour normal, no palmar erythema or peripheral oedema noted.

Palpation:

- Temperature normal, CRT less than 2 seconds, radial pulse regular rate and rhythm, no peripheral oedema.

Neck:

- No masses, no visible JVP, no lymphadenopathy detected.

Face:

- No significant findings like melasma, conjunctival pallor, or jaundice.

Abdominal Examination:

Inspection: Normal contour, no visible scars or masses.

Palpation: Soft, non-tender, no masses palpable.

Vaginal Examination:

Vulval Inspection: Mild atrophic changes noted, no ulcers, cysts, rashes, discharge, or lesions.

Speculum Examination:

- Atrophic changes, no bleeding, erosions, masses or discharge. Cervical os closed and appears normal.

Bimanual Examination:

- Vaginal walls show signs of atrophy. Cervix firm and in mid-position, no cervical excitation.

- Uterus normal in size and non-tender. Ovaries not palpable, no masses.

Diagnostic Tests:

Urine Dipstick:

- Normal, no signs of infection or glucose.

Vaginal Swab:

- No signs of infection and cellular changes.

Endometrial Biopsy:

* No signs of malignancy.

STI Screen:

- Chlamydia: Negative.

- Gonorrhoea: Negative.

- Syphilis (blood test): Negative.

- HIV (blood test): Negative.

MSU: Not indicated.

Blood Tests (Reference Ranges):

Full Blood Count (FBC):

- Haemoglobin (Hb): 145 g/​L (Female: 115 - 165 g/​L)

- Mean Corpuscular Volume (MCV): 90 fL (80 – 100 fL)

- White Blood Cell Count: 5.2 x10^9/L (3.6 - 11.0 x10^9/L)

- Platelets: 250 x10^9/L (140 - 400 x10^9/L)

Urea and Electrolytes:

- Sodium: 140 mmol/L (133–146 mmol/L)

- Potassium: 4.2 mmol/L (3.5–5.3 mmol/L)

- Calcium (adjusted): 2.4 mmol/L (2.2-2.6 mmol/L)

- Magnesium: 0.9 mmol/L (0.7–1.0 mmol/L)

Imaging Tests:

Ultrasound Scan:

- Pelvic ultrasound demonstrates normal uterine size and endometrial thickness for post-menopausal woman, ovaries not visualized due to postmenopausal status, no masses or abnormalities detected.

Condition:

Atrophic Vaginitis

Patient Questions:

1. "Is this something serious, like cancer?"

- Answer: "Based on your symptoms and initial investigations, we're looking at atrophic vaginitis, which isn't cancerous. It's quite common and treatable."

2. "How could we treat this condition?"

- Answer: "Treatment involves moisturisers or hormonal treatments like topical oestrogen, which can alleviate symptoms effectively."

3. "Will this affect my sexual life?"

- Answer: "We can manage the symptoms to make sexual intercourse more comfortable. Many women find relief with treatment and can maintain an active sexual life."

4. "Do I need to make any lifestyle changes?"

- Answer: "Maintaining a healthy lifestyle can help, but specific treatments for atrophic vaginitis will directly tackle your symptoms."

Examiner Questions:

1. What are the key diagnostic criteria for atrophic vaginitis?

- Answer: Postmenopausal status, vaginal symptoms such as dryness and dyspareunia, and physical examination findings of thinning and dryness of the vaginal mucosa.

2. What differential diagnoses should be considered in a postmenopausal woman with vaginal bleeding?

- Answer: Endometrial cancer, endometrial atrophy, endometrial polyp, and cervical cancer.

3. How does topical estrogen therapy work for atrophic vaginitis?

- Answer: Replenishes local oestrogen levels, improving blood flow and tissue integrity of the vagina and vulva, alleviating symptoms.

4. What are the considerations and contra-indications for the use of topical oestrogens?

- Answer: Consideration of a patient's history of hormone-sensitive cancers, unexplained vaginal bleeding, or history of thromboembolic disease. Always individualise therapy.

5. Describe the non-hormonal treatments for atrophic vaginitis.

- Answer: Vaginal moisturisers, lubricants, and practices to maintain vaginal health such as avoiding irritative soaps and douches.

Treatment:

- Initial treatment involves non-hormonal vaginal moisturisers and lubricants for symptomatic relief.

- If symptoms persist or significantly impact quality of life, consider prescribing topical oestrogen therapy. For example, Oestriol cream 0.01%, applied daily for two weeks, then twice weekly.

- Ensure to discuss the benefits and potential risks of oestrogen therapy with the patient.

- Review in three months to assess response to treatment and adjust as necessary.

Monitoring:

- Schedule a follow-up appointment in three months to assess treatment efficacy and patient comfort.

- Monitor for any adverse reactions to treatment, particularly with hormonal therapy.

- Regularly reassess to determine if the chosen treatment continues to be appropriate or needs adjustment.

- Consider referral to a gynaecologist if symptoms persist despite treatment or if any abnormalities are detected during examinations.

Prognosis:

- Atrophic vaginitis is a chronic condition, but symptoms can usually be effectively managed with treatment.

- Women may experience fluctuating symptoms, which require adjustments in treatment.

- Long-term prognosis is good, with most women achieving symptomatic relief.

Differential diagnoses:

1. Endometrial cancer - less likely due to the absence of significant risk factors and normal ultrasound findings.

2. Endometrial polyps - considered but not supported by ultrasound findings.

3. Uterine fibroids - less likely due to the absence of symptoms such as increased menstrual bleeding or pelvic pain, and normal ultrasound.

4. Cervical cancer - not supported by the lack of visible cervical lesions and negative cytology.

Keyword Filters:

Speciality Filter:

Obstetrics And Gynaecology; General Practice;

Presenting Complaint Filter:

Vaginal Discharge; Menopausal Problems; Painful Sexual Intercourse; Vulval Itching/Lesion;

Condition Filter:

Atrophic Vaginitis

Location Filter:

Clinic

Case created by:

David Bourne, 5th Year Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

### Case Code:

# DWZHB\_22\_Syphilis

### Homepage Vignette:

## A 29-year-old female called Elara presents with a genital lesion.

### Individual Page Vignette:

You are a General Practitioner, tasked with assessing Elara, a 29-year-old marketing executive, based in a Clinic. She presents primarily with concerns about a genital ulcer discovered a week ago and a body rash that developed over the past few days.

### Patient Name:

Elara Zhang (Phonetic Pronunciation: E-lah-rah Jang) - Prefers to be called Elara.

### Age:

DOB: 14/02/1995

### Location:

Clinic

### Personality:

Elara is articulate and precise in her communication. She exhibits a calm demeanor despite her underlying anxiety about her symptoms. She values clear information and direct answers.

### Presenting Complaint:

Elara reports noticing a "strange, sore-less ulcer" on her genitals last week, which she dismisses initially, thinking it would heal. Recently, she observed a rash covering her body, which prompted her to seek medical advice.

Quote: "I first thought it was just some harmless spot, but then this rash started appearing out of nowhere. It's quite worrying."

### Symptoms:

\*\*Site\*\*: Ulcer located on the vulva. Rash spread across torso and limbs.

- Quote: "The ulcer is right down there, and the rash is pretty much all over my torso and limbs."

\*\*Onset\*\*: Ulcer noticed one week ago, rash developed over the past few days.

- Quote: "That ulcer popped up about a week ago, and the rash just a few days back."

\*\*Character\*\*: Ulcer is painless, rash is non-itchy.

- Quote: "The strange thing is that the ulcer doesn’t hurt, and the rash doesn't itch."

\*\*Radiation\*\*: No radiation of symptoms.

- Quote: "No, the discomfort is pretty much localised, nothing spreading or moving around."

\*\*Associated Symptoms\*\*: None reported with the ulcer. Rash is widespread.

- Quote: "Aside from the rash showing up, nothing else really came along with the ulcer."

\*\*Timing\*\*: Ulcer persists for over a week; rash present for a few days without change.

- Quote: "The ulcer's been the same since it showed up, and the rash hasn't really changed since it appeared."

\*\*Exacerbating and Relieving Factors\*\*: No known factors that worsen or alleviate symptoms.

- Quote: "Nothing I do seems to make it better or worse."

\*\*Severity\*\*: Ulcer and rash are mild in appearance but causing significant anxiety.

- Quote: "It doesn't hurt, but it's really stressing me out."

PV Bleeding: None.

PV Discharge: None.

Abdominal or Pelvic Pain: None.

Chance of Pregnancy: Not pregnant.

Dyspareunia: None.

Post-coital PV Bleeding: None.

Intermenstrual PV Bleeding: None.

Vulval skin changes or itching: Painless ulcer noted; no itching.

History of Presenting Complaint:

- Symptoms noticed over the past week, no prior similar episodes.

- No treatments attempted.

- Symptoms have remained constant without progression.

- Symptoms have caused significant anxiety.

- Impact on daily life due to concern about the nature of the symptoms.

- No impact on work or ADLs reported yet, but Elara is worried about the potential health implications.

Quote: "This is the first time anything like this has happened to me. I've not tried treating it because I hoped it would just go away on its own. But here we are."

### Systemic Symptoms:

- Fatigue: Normal.

- Fever: None.

- Night Sweats: None.

- Unintended Weight Loss: None.

- Chest or Shoulder Tip Pain: None.

- Shortness of Breath or Cough: None.

- Change in Bowel Habits: None.

- Change in Urinary Habits: Normal.

- Dysuria: None.

- Oedema: None.

- Rashes or Skin Changes: Rash present across torso and limbs, as described.

- Headache: None.

- Mood Changes: Increased anxiety due to symptoms.

- Sleep Disturbances: None reported.

Quote: "Apart from this rash and the ulcer, I've been feeling pretty normal, just really anxious about what this might mean."

### Obstetric History:

Previous Obstetric History: G0 P0+0

>24 Weeks Pregnancies: None.

<24 Weeks Pregnancies: None reported.

Reproductive Plans: Interested in having children in the future but not currently trying.

Quote: "I've always thought I'd have kids someday, just not right now. This whole situation is concerning, though."

### Gynaecology History:

Menstrual History: Regular, every 28 days, lasting about 5 days, with moderate flow. No dysmenorrhoea.

Last Menstrual Period: 2 weeks ago.

Menarche: Age 13.

Previous Screens: Normal cervical screening 1 year ago.

Previous Gynaecology Conditions: None reported.

Contraception: Currently using oral contraceptive pills for the past 3 years.

Quote: "My periods have always been pretty regular, and I've been on the pill for a while now without any issues."

### Past Medical History:

- Asthma managed with salbutamol inhaler as needed. No recent exacerbations.

- No previous surgeries, trauma or hospitalizations.

- No history of alcohol or substance abuse.

- HPV vaccination received at age 14.

- No previous STIs reported.

Quote: "Apart from my asthma, which I’ve had since I was a kid, I’ve been pretty healthy. Never been hospitalized or had any serious health scares."

### Drug History:

- Salbutamol inhaler, 100 mcg, use as needed for asthma.

- Oral contraceptive pill, combined ethinylestradiol and levonorgestrel, daily.

- No history of medication non-compliance.

- No use of herbal supplements or alternative therapies.

Quote: "I just have my inhaler for asthma, which I rarely need, and my contraceptive pill, which I take every day without fail."

### Allergies:

- Allergic to penicillin: Causes rash and swelling.

Quote: "I found out I was allergic to penicillin the hard way – ended up with a horrible rash and my face swelled up."

### Family History:

- Mother has hypertension, managed with medication.

- Father has type 2 diabetes, also managed with medication.

- No known family history of genetic conditions or sexually transmitted infections.

Quote: "Both my parents have their own health issues – my mum with her blood pressure and dad with his sugar. But they’re managing well."

### Social History:

Lifestyle: Leads an active lifestyle, enjoys hiking and yoga.

Occupation: Marketing Executive.

Activities of Daily Living & Hobbies: Independent, enjoys cooking and reading in her spare time.

Smoking: Non-smoker.

Alcohol: Occasional social drinker, 1-2 units per week.

Recreational Drug Use: None.

Diet: Follows a balanced diet, includes fruits and vegetables.

Exercise: Regular exercises, attends yoga classes three times a week.

Quote: "I try to stay active and healthy. Yoga is my go-to for stress relief, and I love getting out into nature when I can."

Sexual History:

- Last sexual intercourse was 3 weeks ago.

- Has had a total of three partners in the past year.

- Always uses contraception (oral contraceptive pill).

Quote: "I’m careful about using protection and have been with a few partners this past year."

Travel History:

- Recent travel to Southeast Asia 6 months ago.

Cultural or Religious Practices:

- Does not follow any specific religious practices but considers herself spiritual.

Recent Life Events:

- Recently received a promotion at work, which has increased her stress levels slightly.

### Ideas, Concerns, and Expectations:

- \*\*Ideas\*\*: Worries that the symptoms could indicate a sexually transmitted infection or a more serious underlying condition.

- \*\*Concerns\*\*: Anxious about the impact this could have on her ability to have children in the future.

- \*\*Expectations\*\*: Looking for a thorough investigation of her symptoms, a clear diagnosis, and treatment plan.

Quote: "I’m really hoping this isn’t anything serious that could affect my health long-term. I just want to know what’s going on and that it can be treated."

### Observations:

Respirations: 16 Breaths/min.

Oxygen Saturation: 98% on room air.

Blood Pressure: 120/75 mmHg.

Pulse: 72 Beats/min.

Consciousness: Alert and oriented (AVPU: Alert).

Temperature: 37.0°C.

NEWS Total Score: 0

The observations have been scored as follows: All parameters fall within normal ranges, resulting in a NEWS total score of 0, indicating the patient is currently stable.

### Physical Examination:

\*\*General Inspection\*\*: Appears well, no signs of distress.

\*\*Objects and Equipment\*\*: None observed.

\*\*Hands\*\*: Normal colour, no palmar erythema, or peripheral oedema.

\*\*Neck\*\*: No palpable lymphadenopathy or thyroid enlargement.

\*\*Face\*\*: No abnormal findings.

\*\*Abdominal Examination\*\*: Soft, non-tender, no palpable masses. Visible diffuse maculopapular rash present.

\*\*Vaginal Examination\*\*:

- \*\*Vulval Inspection\*\*: Painless ulcer noted on vulva, approximately 1 cm in diameter, round, with a clean base and indurated border. No discharge, scarring, or other lesions noted.

\*\*Speculum Examination\*\*:

- Cervical os normal, no bleeding or discharge. No cervical ectropion or masses noted.

### Diagnostic Tests:

\*\*Urine Dipstick\*\*: Negative.

\*\*STI Screen\*\*:

- Chlamydia: Negative.

- Gonorrhoea: Negative.

- Syphilis (blood test): Positive.

- HIV (blood test): Negative.

\*\*Blood Tests (Reference Ranges)\*\*:

- Haemoglobin (Hb): 140 g/L (Female: 115 - 165 g/L)

- White Blood Cell Count: 7.0 x10^9/L (3.6 - 11.0 x10^9/L)

- Platelets: 250 x10^9/L (140 - 400 x10^9/L)

### Treatment:

Based on the Clinical Knowledge Summaries (CKS) and British National Formulary (BNF), the primary treatment for syphilis is:

- Benzathine penicillin G, 2.4 million units intramuscularly, single dose for early syphilis.

HOWEVER, Since the patient is allergic to penicillin, an alternative regimen per guidelines would be:

- Doxycycline 100 mg orally, twice daily for 14 days.

If doxycycline is contraindicated or not tolerated:

- Azithromycin 2 g orally as a single dose might be considered, but resistance issues should be taken into account.

### Monitoring:

- Follow-up blood tests for syphilis titres at 3, 6, and 12 months to monitor treatment response.

- A repeat STI screen in 3 months to ensure no other infections were acquired or missed.

- If symptoms persist or recur, further assessment and possibly alternative treatments may be needed.

- Refer to a specialist in infectious diseases or genitourinary medicine if treatment fails or if there are complications.

### Prognosis:

- With appropriate treatment, the prognosis for early-stage syphilis is excellent.

- Without treatment, syphilis can progress to later stages, leading to more serious health issues.

- Regular monitoring of titres is essential to confirm cure and detect any recurrence.

- Early treatment minimizes the risk of transmission and long-term health effects.

### Differential Diagnoses:

1. \*\*Herpes Simplex Virus (HSV)\*\* - Less likely due to the non-painful nature of the ulcer and the absence of vesicles.

2. \*\*Chancroid\*\* - Less likely given the ulcer's characteristics and negative Haemophilus ducreyi culture.

3. \*\*Lymphogranuloma Venereum (LGV)\*\* - Less probable in the absence of significant inguinal lymphadenopathy.

### Patient Questions:

1. "Is syphilis curable?"

- "Yes, with the appropriate treatment, syphilis can be completely cured. We'll start with antibiotics to treat the infection."

2. "Will this affect my chances of having children?"

- "Early treatment greatly reduces any risk of complications that could affect fertility. It's also important to treat any STIs early to prevent complications."

3. "Can I have sex?"

- "It's important to avoid sexual contact until you have finished the treatment and we confirm the infection has cleared to prevent spreading it to partners."

4. "Should my partners be tested?"

- "Yes, it's important to inform recent sexual partners so they can be tested and treated if necessary to prevent the spread of the infection."

### Examiner Questions:

1. What is the first-line treatment for syphilis in a patient not allergic to penicillin?

- Benzathine penicillin G, 2.4 million units IM, as a single dose is the first-line treatment.

2. How would you manage a patient with a penicillin allergy, like in this case?

- For patients with a penicillin allergy, alternatives like doxycycline or azithromycin can be considered, taking into account the patient's specific health profile and potential resistance issues.

3. What are the stages of syphilis, and how do they present?

- Discuss the primary, secondary, latent, and tertiary stages of syphilis, noting characteristic presentations such as chancre in primary syphilis and rash in secondary syphilis.

4. Why is it important to monitor syphilis titres after treatment?

- To ensure effective treatment, check for cure, and monitor for any recurrence of the infection.

5. What advice would you give a patient about informing sexual partners?

- Stress the importance of notifying all recent sexual partners so they can be tested and treated if necessary to prevent further transmission of syphilis.

### Keyword Filters:

Speciality Filter:

Infection; Sexual Health; General Practice; Obstetrics And Gynaecology

Presenting Complaint Filter:

Urethral Discharge and Genital Ulcers/Warts; Pelvic Pain; Menstrual Problems

Condition Filter:

Syphilis

Location Filter:

Clinic

Case created by:

David Bourne, 5th Year Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_23\_Syphilis

Homepage Vignette:

## A 27-year-old woman called Priya Banerjee presents with genital rash.

Individual Page Vignette:

You are tasked as a General Practitioner to assess Priya Banerjee, a 27-year-old, office administrator, living in an urban area, presenting with symptoms of a genital rash.

Patient Name:

Priya Banerjee (Pri-ya Ban-er-jee), prefers to be called Priya.

Age:

15/07/1996

Location:

General Practice

Personality:

Priya is thoughtful and articulate, presenting her symptoms and concerns with clarity. She displays a level of anxiety about her symptoms but remains hopeful for a diagnosis and treatment plan. She engages in conversation with direct eye contact and answers questions coherently and succinctly.

Presenting Complaint:

Priya visited the clinic concerned about a noticeable rash around her genital area accompanied by an unusual-smelling vaginal discharge.

Quote: "I first noticed this rash a few weeks ago, followed by a weird-smelling discharge. It's been quite worrying."

Symptoms:

- Site: Genital region. Quote: "The rash is just around my private area."

- Onset: Approximately 3 weeks ago. Quote: "About three, maybe four weeks back is when I first saw the rash."

- Character: Rash is reddish and patchy. Discharge is yellowish. Quote: "The rash is these red patches, and the discharge... it's kind of yellow."

- Radiation: Symptoms are localized to the genital area. Quote: "No, it's just in that area."

- Associated Symptoms: Mild itching around the rash. Quote: "Yeah, it itches sometimes."

- Timing: Symptoms have been persistent for the past 3 weeks. Quote: "It's been like this for a few weeks now, not getting any better."

- Exacerbating and Relieving Factors: None identified. Quote: "Nothing seems to make it worse or better."

- Severity: Mild to moderate discomfort. Quote: "It's uncomfortable, more worrying than painful."

PV Bleeding: Negative for any additional bleeding.

PV Discharge: Yellowish discharge, medium volume, unpleasant smell.

Abdominal or Pelvic Pain: None reported.

Chance of Pregnancy: Low, using contraception.

Dyspareunia: Not reported.

Post-coital PV Bleeding: Negative.

Intermenstrual PV Bleeding: Negative.

Post-menopausal Bleeding: Not applicable.

Vulval skin changes or itching: Reddish rash with mild itching noted.

“It’s like a red itchy rash down there, It’s very concerning!”

History of Presenting Complaint:

- Duration of symptoms: Approximately 3 weeks.

- Previous treatments: None tried.

- Progression: Symptoms have remained consistent with no improvement.

- Frequency: Symptoms are persistent.

- Impact on daily life: Causes distress and affects confidence.

- Impact on work: Distraction due to concern about symptoms.

- Impact on physical and mental wellbeing: Increased anxiety.

Quote: "It's been on my mind constantly since I noticed it. Hasn't gotten worse, but it's not getting any better either."

Systemic Symptoms:

- Fatigue: No unusual fatigue reported.

- Fever: No fever reported.

- Night Sweats: None reported.

- Unintended Weight Loss: None reported.

- Chest or Shoulder Tip Pain: None reported.

- Shortness of Breath or Cough: None reported.

- Change in Bowel Habits: Normal.

- Change in Urinary Habits: Normal.

- Dysuria: Normal.

- Frequency: Normal.

- Urgency: Normal.

- Oedema: None reported.

- Rashes or Skin Changes: Only as noted in the genital region.

- Headache: None reported.

- Mood Changes: Increased anxiety due to symptoms.

- Sleep Disturbances: Normal sleep patterns.

Quote: "Aside from what's going on down there, I feel quite normal, just worried."

Obstetric History:

- Previous Obstetric History: G0 P0+0

- Reproductive Plans: Desires children in the future.

Quote: "I've not had any pregnancies. I do hope to have children someday."

Gynaecology History:

- Menstrual History: Regular, every 28 days, lasting 5 days, moderate flow, no dysmenorrhoea.

- Last Menstrual Period: 2 weeks ago.

- Menarche: Age 13.

- Previous Screens: Up to date with cervical screenings, last one 1 year ago, no abnormalities.

- Previous Gynaecology Conditions: None reported.

- Previous STIs: None reported.

- Contraception: Currently using oral contraceptives for the past 2 years.

Quote: "My periods have always been pretty regular, and I make sure to keep up with my health checks."

Drug History:

- Current medications: Oral contraceptive pills taken daily.

- Past medications: No significant past medications reported.

- Folic Acid or iron supplements: None taken currently.

- History of medication non-compliance: None reported.

- Herbal supplements or alternative therapies: Occasionally uses over-the-counter multivitamins.

- Use of contraception: Oral contraceptives for the past 2 years.

Quote: "I'm pretty consistent with my pill; haven't missed a day. Also, take some vitamins when I remember."

Allergies:

- No known drug allergies.

- Food allergies: None reported.

- Environmental allergies: Sensitive to pollen, causes sneezing and itchy eyes in spring.

Quote: "Just the usual sneezes when everything starts blooming, no serious allergies."

Family History:

- Mother: Hypertension, treated with medication.

- Father: Type 2 Diabetes Mellitus, on diet control and metformin.

- Siblings: No significant medical history.

- Paternal grandparents: Grandfather had prostate cancer. Grandmother has osteoporosis.

- Maternal grandparents: Both had a history of cardiovascular diseases.

Quote: "Mum takes her blood pressure pills, and dad's watching his sugar. But nah, nothing like what I'm worried about."

Social History:

- Lifestyle: Leads an active lifestyle, enjoys hiking and swimming.

- Occupation: Office administrator.

- Activities of Daily Living & Hobbies: Socialises with friends, attends book clubs, and practices yoga.

- Smoking: Non-smoker.

- Alcohol: Drinks socially, approximately 4 units on weekends.

- Recreational Drug Use: None reported.

- Diet: Vegetarian, tries to maintain a balanced diet.

- Exercise: Regularly attends yoga classes and occasional swimming.

Quote: "I like keeping active, and I'm careful with what I eat. Weekends are for a bit of fun, though, never anything too heavy."

Sexual History:

- Last sexual intercourse: About 1 month ago.

- Current and previous partners: In a monogamous relationship for the past 3 years.

- Contraception used: Oral contraceptive pills.

Quote: "I've been with my partner for a bit now; we're pretty steady."

Ideas, Concerns, and Expectations:

- Ideas: "I didn't think much of it at first, but now I'm worried it could be an STI or something."

- Concerns: "What if it's something serious? Could it affect me having kids in the future?"

- Expectations: "I'm hoping for some answers today, maybe a cream or something to clear it up."

Quote: "I really just want to know what's going on and get it sorted."

Observations:

- NEWS Total Score: 0

Physical Examination:

- General Inspection: Appears well, no signs of distress or discomfort.

- Objects and Equipment: No personal or medical equipment observed.

- Hands: Normal colour, no palmar erythema, no peripheral oedema.

- Palpitation: Warm, CRT <2 seconds, radial pulse regular and of normal volume.

- Neck: No goitres, lymphadenopathy, or JVP elevation.

- Face: No melasma, conjunctival pallor, or jaundice.

- Abdominal Examination: Soft, non-tender with no palpable masses.

- Vaginal Examination:

- Vulval Inspection: Erythematous rash, no ulcers or cysts.

- Speculum Examination: Cervical os normal, no evident lesions or masses.

- Bimanual Examination: Normal findings, no tenderness or masses.

Diagnostic Tests:

- STI Screen: Indicated due to symptoms and sexual history.

- Chlamydia: Negative

- Gonorrhoea: Negative

- Syphilis (blood test): Positive

- HIV (blood test): Negative

- Full Blood Count (FBC): Within normal limits.

- Urine Dipstick: No abnormalities detected.

Condition

Syphillis

\*\*Patient Questions:\*\*

1. "Is syphilis curable? I'm really worried about what this means for my future."

- \*\*Answer:\*\* "Yes, syphilis is curable with appropriate antibiotics. Early treatment is quite effective, and most people recover completely without any long-term problems. It's important to follow the treatment plan and attend all follow-up appointments to ensure the infection is fully cleared."

2. "Could I have given syphilis to my partner? What should I do?"

- \*\*Answer:\*\* "It's possible to transmit syphilis through sexual contact, so it's important that your partner gets tested even if they don't have symptoms. Everyone diagnosed with syphilis is advised to notify their sexual partners so they can also get tested and treated if necessary."

3. "Can I have sex while I'm being treated for syphilis?"

- \*\*Answer:\*\* "To prevent spreading the infection, it's recommended to avoid all sexual contact until you and any sexual partners have completed treatment and follow-up tests confirm the infection is cleared."

4. "Will having syphilis affect my chances of having children in the future?"

- \*\*Answer:\*\* "Syphilis can be fully treated with antibiotics. If treated early, it shouldn't affect your ability to have children in the future. However, untreated syphilis can lead to complications, so it's important to complete your treatment."

\*\*Examiner Questions:\*\*

1. "How would you differentiate between primary and secondary syphilis based on clinical findings?"

- \*\*Answer:\*\* "Primary syphilis is typically marked by a painless chancre at the infection site, while secondary syphilis can present with a rash that may affect the palms of the hands and soles of the feet, mucosal lesions, and lymphadenopathy."

2. "What are the indications for a lumbar puncture in a patient with syphilis?"

- \*\*Answer:\*\* "A lumbar puncture is indicated in patients with neurologic or ophthalmic signs suggestive of neurosyphilis, audiological symptoms, or other symptoms indicating potential central nervous system involvement."

3. "Why is penicillin considered the first-line treatment for syphilis, and what are the alternatives for penicillin-allergic patients?"

- \*\*Answer:\*\* "Penicillin is the first-line treatment due to its effectiveness in all stages of syphilis. For those allergic to penicillin, options include doxycycline or tetracycline for non-pregnant patients. Pregnant women require desensitization to penicillin."

4. "Discuss the importance of partner notification and management in the treatment of syphilis."

- \*\*Answer:\*\* "Partner notification is crucial to prevent the spread and re-infection of syphilis. Sexual partners should be informed, tested, and treated if necessary, to break the chain of transmission."

5. "Describe the typical serological response to successful treatment for syphilis."

- \*\*Answer:\*\* "Successful treatment is typically followed by a decline in quantitative nontreponemal test titers, ideally to nonreactive levels. However, some individuals may experience a slower decline or remain serofast without evidence of treatment failure or reinfection."

6. "What are the consequences of untreated syphilis?"

- \*\*Answer:\*\* "Untreated syphilis can progress to tertiary syphilis, leading to severe complications such as cardiovascular syphilis, neurosyphilis, gummatous lesions, and increased risk for HIV transmission."

Treatment:

The management of syphilis is primarily with antibiotic therapy, as per guidelines from the British Association for Sexual Health and HIV (BASHH), which aligns closely with the information sourced from the NICE CKS, BMJ Best Practice, and BNF:

1. Primary, Secondary, and Early Latent Syphilis (less than 2 years duration):

- \*\*Benzathine penicillin G\*\*:

- Dosage: 2.4 million units administered intramuscularly (IM) as a single dose.

- If \*Penicillin allergy\* is present: Consider \*\*Doxycycline 100mg orally twice daily for 14 days\*\* or \*\*Tetracycline 500mg orally four times daily for 14 days\*\*. For pregnant women allergic to penicillin, desensitization and then treatment with penicillin is recommended.

2. Late Latent Syphilis or Syphilis of Unknown Duration:

- Increased dosage frequency of Benzathine penicillin G:

- Dosage: 2.4 million units administered intramuscularly (IM) once weekly for three weeks.

- Penicillin allergy management remains similar to that of early syphilis, with adjusted durations as per clinical guidance.

3. Neurosyphilis or Ocular Syphilis:

- Penicillin G administered intravenously (IV):

- Dosage: 10-24 million units per day, given as 3-4 million units every 4 hours or by continuous infusion, for 10-14 days.

- Alternative treatment options are limited and should be discussed with a specialist.

Note: It's crucial to conduct a thorough allergic history before initiating treatment with penicillin or its alternatives.

\*\*Monitoring:\*\*

- Follow-up blood tests for syphilis serology should be conducted at 3, 6, and 12 months for early syphilis and more frequently for late or complicated cases.

- Clinical symptoms should resolve within a few weeks of treatment commencement. Any persistent or worsening symptoms require further evaluation.

- Patients with neurosyphilis should have a more intensive follow-up, which includes repeated lumbar punctures to ensure therapeutic efficacy.

- Sexual partners should be notified, tested, and treated as appropriate to prevent reinfection and further transmission.

\*\*Prognosis:\*\*

- With appropriate and timely treatment, the prognosis for primary and secondary syphilis is excellent.

- The response to treatment is monitored through serial serological testing, and a decline in titres is expected.

- Latent or tertiary syphilis may have a more guarded prognosis depending on the extent of irreversible damage before treatment initiation.

- Failure to treat syphilis can lead to serious complications, including neurosyphilis, cardiovascular involvement, and gummatous lesions.

\*\*Differential Diagnoses:\*\*

1. Genital Herpes: Characterised by painful ulcers, often with systemic symptoms. A viral culture or PCR test can confirm the diagnosis.

2. Chancroid: Presents with painful genital ulcers and inguinal lymphadenopathy. Caused by \*Haemophilus ducreyi\*, and diagnosed with culture.

3. Lymphogranuloma Venereum: Caused by \*Chlamydia trachomatis\*, presenting as transient genital ulceration followed by inguinal lymphadenopathy.

4. Genital Warts: Caused by human papillomavirus (HPV), presenting with painless lesions that do not resemble the rash seen in syphilis.

5. Bacterial Vaginosis: Presents with vaginal discharge and odour but lacks the systemic features of syphilis.

Syphilis is considered the most likely diagnosis due to the positive blood test and the characteristic rash and discharge, which are not typical for the other differentials mentioned.

Created by David

Filters as per last

Case Code:

# DWZHB\_24\_Syphilis

Homepage Vignette:

## A 29-year-old woman named Catherine Willows presents with a genital ulcer.

Individual Page Vignette:

You are a General Practice doctor. Catherine Willows, a 29-year-old accountant, comes to your clinic from her home location, primarily concerned with a recently noticed genital ulcer.

Patient Name:

Catherine Willows (Pronunciation: Kath-er-in Wil-loes). She prefers to be called Catherine.

Age:

Date of birth: 13/08/1995

Location:

Clinic

Personality:

Catherine is articulate and detailed in her communication. She exhibits a proactive attitude towards her health, seeking information and expressing concerns succinctly. She talks calmly but with a sense of urgency about her recent symptoms, reflecting her analytical nature.

Presenting Complaint:

Catherine reports noticing a "strange, painless sore around my genital area" about a week ago.

Quote: "I've discovered this unusual sore down there; it doesn't hurt, but it's got me worried."

Symptoms:

- Site: The sore is located on the external genitalia. Quote: "The sore is right on my vulva."

- Onset: Noticed 1 week ago. Quote: "I first saw the sore last week."

- Character: Painless. Quote: "It's odd, it really doesn’t hurt."

- Radiation: No radiation. Quote: "The sore is just in that one spot; it hasn’t spread or anything."

- Associated Symptoms: None reported. Quote: "Just the sore, nothing else really."

- Timing: Constant since noticing. Quote: "It's been there, just the same, since last week."

- Exacerbating and Relieving Factors: None identified. Quote: "Nothing seems to make it worse or better; it just stays the same."

- Severity: The patient does not report pain.

PV Bleeding: Normal menstrual cycle reported, no abnormalities in volume, colour, consistency, or smell.

PV Discharge: No abnormal vaginal discharge reported.

Abdominal or Pelvic Pa in: Patient reports no abdominal or pelvic pain.

Chance of Pregnancy: Patient denies any chance of pregnancy.

Dyspareunia: Not present.

Post-coital PV Bleeding: Not present.

Intermenstrual PV Bleeding: Not present.

Post-menopausal Bleeding: Not applicable.

Vulval skin changes or itching: Aside from the reported ulcer, no other skin changes or itching.

Additional Symptoms: Negative for abdominal distension, breast lumps, missed periods, infertility, shoulder tip pain, etc.

History of Presenting Complaint:

- Noticed the genital ulcer approximately 1 week ago without preceding injury or irritation.

- No previous occurrence of similar symptoms.

- The symptom has been constant without progression.

- No impact on daily life as the lesion is painless.

- Currently no treatment sought until today's visit.

- No effect on work or mental wellbeing reported.

Quote: "This is the first time something like this has happened to me; it just appeared out of nowhere."

Systemic Symptoms:

Fatigue: None reported.

Fever: None reported.

Night Sweats: None reported.

Unintended Weight Loss: None reported.

Chest or Shoulder Tip Pain: None reported.

Shortness of Breath or Cough: None reported.

Change in Bowel Habits: None reported.

Change in Urinary Habits: None reported.

Dysuria: Not present.

Oedema: Not present.

Rashes or Skin Changes: Not present.

Headache: Not present.

Mood Changes: Not present.

Sleep Disturbances: Not present.

Quote: "Apart from the sore, I've been feeling perfectly normal."

Obstetric History:

Gravidity and Parity: G0 P0

No previous pregnancies.

Reproductive Plans: Expresses a desire to have children in the future but not currently trying.

Quote: "I do want kids, just not right now."

Gynaecology History:

Menstrual History:

Duration: 5 days

Frequency: Every 28 days

Volume: Moderate

Dysmenorrhea: Mild and controlled with over-the-counter analgesics

Last Menstrual Period: 2 weeks ago

Menarche: Age 13

Contraception: Currently using oral contraceptive pills for the past year. Menstrual history similar before and during contraception use.

Previous Screens: Last cervical screening 2 years ago, result was normal.

Previous Gynaecology Conditions: None reported.

Previous STIs: None reported.

Quote: "My periods have always been pretty regular, and the pill hasn’t changed that."

Past Medical History:

- No previous medical conditions of note.

- No previous surgeries or hospitalisations.

- No psychiatric or psychological history.

- No history of alcohol or substance abuse.

- Fully vaccinated, including HPV vaccine.

- No trauma or injuries.

Quote: "I’ve been lucky, health-wise; never really had to deal with anything serious."

Drug History:

- Oral contraceptives: Combined oral contraceptive pill, one tablet daily.

- Occasional use of ibuprofen for menstrual cramps: 400mg as needed, not more than three times a day during menstruation.

- No history of medication non-compliance.

- No use of herbal supplements or alternative therapies.

- Previous contraception methods included condoms before transitioning to oral contraceptives.

Quote: "I've been on the pill for a year now, and it's been fine. I sometimes take ibuprofen for period cramps, but that's about it."

Allergies:

- No known allergies to medications, anaesthetics, foods, allergens, materials, chemicals, vaccinations, or animals.

Quote: "I've never had any allergic reactions, thankfully."

Family History:

- Mother diagnosed with breast cancer at age 50, currently in remission.

- Father has hypertension, managed with medication.

- No known genetic disorders or significant health events in extended family.

Quote: "My mum had a scare with breast cancer, but she’s doing well now. Dad’s on blood pressure pills."

Social History:

Lifestyle: Leads a moderately active lifestyle.

Occupation: Works as an accountant, mostly a desk job but tries to stand and move around every hour.

Activities of Daily Living & Hobbies: Enjoys hiking on weekends, reading, and painting.

Smoking: Non-smoker.

Alcohol: Consumes alcohol socially, approximately 4 units per week.

Recreational Drug Use: Denies any recreational drug use.

Diet: Follows a balanced diet with a focus on fruits, vegetables, and lean proteins.

Exercise: Attends a yoga class twice a week and goes for hikes on weekends.

Quote: "I like my job, though I try not to sit still for too long. Hiking gets me out and moving, and I love my quiet time with books and my paintings."

Sexual History:

- Last sexual intercourse was 2 weeks ago.

- Has had 3 sexual partners in the past year.

- Currently in a monogamous relationship.

- Uses oral contraceptive pills as her primary form of contraception.

Quote: "I've been careful with my sexual health, always using protection with new partners until I was sure."

Travel History: Recently travelled to a popular coastal resort for a holiday, within the country.

Cultural or Religious Practices: Identifies as Anglican but is not strictly observant.

Recent Life Events: Started a new role within her company 3 months ago, which has been a positive change.

Exposure to Hazards or New Environment: Denies any unusual exposures.

Ideas, Concerns, and Expectations:

- Ideas: Catherine believes the sore might be related to an STI, despite using protection.

- Concerns: Worries about the implications of an STI on her relationship and future fertility.

- Expectations: Hopes for a thorough examination and appropriate testing to determine the cause of her symptoms. She expects clear communication about potential diagnoses and treatment options.

Quote: "I can't help but think this might be an STI. I'm worried about what this means for me and my partner. I just want to know what's going on and how we can treat it."

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98% on room air

Air or Oxygen?: On room air

Blood Pressure (mmHg): 122/76

Pulse (Beats/min): 72

Consciousness (AVPU): Alert

Temperature (Celsius): 36.8

NEWS Total Score: 0

Physical Examination:

General Inspection:

- Well-nourished and well-hydrated with no signs of distress.

- No visible rashes or skin changes.

- No signs of oedema.

Objects and Equipment: None present.

Hands:

Inspection: Normal colour, no palmar erythema, no peripheral oedema.

Palpation: Warm to touch, CRT < 2 seconds, radial pulse normal rate, rhythm, and volume, no peripheral oedema.

Neck: No masses, no visible JVP, no lymphadenopathy noticed.

Face: No melasma, conjunctival pallor, jaundice, oedema, exophthalmos, corneal arcus, xanthelasma, or Kayser-Fleischer rings.

Abdominal Examination:

Inspection: Abdomen flat, no visible scars or masses.

Palpation: Soft, non-tender, no masses or organomegaly palpable.

Vaginal Examination:

Vulval Inspection: A single, well-defined, painless ulcer noted on the labia majora. No other ulcers, cysts, rashes, discharge, scarring, atrophy, lesions, masses, or signs of prolapse observed.

Speculum Examination: Cervical os normal, no bleeding, erosions, masses, discharge, or ectropion observed.

Bimanual Examination: Vaginal walls intact, cervix in a normal position with a smooth consistency, no cervical excitation. Uterus and ovaries normal in size and consistency, no masses or tenderness.

Diagnostic Tests:

Urine Dipstick: Negative for nitrites, leucocytes, and blood.

Vaginal Swab: To assess for bacterial vaginosis, candidiasis, and trichomoniasis.

STI Screen: Negative for chlamydia and gonorrhoea.

Blood Tests (Reference Ranges):

Full Blood Count (FBC):

Haemoglobin (Hb): 128 g/L (Female: 115 - 165 g/​L)

Mean Corpuscular Volume (MCV): 92 fL (80 – 100 fL)

White Blood Cell Count: 5.8 x10^9/L (3.6 - 11.0 x10^9/L)

Platelets: 250 x10^9/L (140 - 400 x10^9/L)

Urea and Electrolytes:

Sodium: 140 mmol/L (133–146 mmol/L)

Potassium: 4.2 mmol/L (3.5–5.3 mmol/L)

Calcium (adjusted): 2.4 mmol/L (2.2-2.6 mmol/L)

Magnesium: 0.9 mmol/L (0.7–1.0 mmol/L)

Urea: 4.4 mmol/L (2.5 – 7.8 mmol/L)

Creatinine: 60 μmol/ L (Female: 45–84 μmol/ L)

Estimated Glomerular Filtration Rate (eGFR): >90ml/min/1.73m3

Syphilis (blood test): Positive result indicating current infection.

HIV (blood test): Negative.

Further tests as indicated by the clinical picture and diagnostic algorithms.

Condition

Syphillis

Treatment:

The treatment of syphilis in line with guidelines from the British Association for Sexual Health and HIV (BASHH) and NICE includes:

1. \*\*Primary, Secondary, and Early Latent Syphilis:\*\*

- \*Benzathine penicillin G 2.4 million units IM, single dose.\*

- For patients allergic to penicillin: \*Doxycycline 100mg orally twice a day for 14 days\* or \*Tetracycline 500mg orally four times a day for 14 days.\*

2. \*\*Late Latent or Unknown Duration Syphilis:\*\*

- \*Benzathine penicillin G, 2.4 million units IM, once weekly for 3 weeks.\*

- For penicillin-allergic patients: \*Doxycycline or Tetracycline regimen as above,\* but extended to \*\*28 days.\*\*

3. \*\*Close Contacts and Sexual Partners:\*\*

- Evaluation, testing, and treatment as appropriate, following current guidelines.

4. \*\*Pregnant Women:\*\*

- Penicillin is the only recommended treatment during pregnancy. Penicillin-allergic patients should be desensitized and then treated with penicillin according to the syphilis stage.

5. \*\*Follow-up:\*\*

- Patients treated for early syphilis should have \*\*quantitative nontreponemal serologic tests\*\* at 6, 12, and 24 months.

- For late latent or tertiary syphilis, additional follow-up at \*\*36 months\*\* is recommended, along with CSF examination if neurosyphilis is suspected.

- Azithromycin has been considered as an alternative in some cases of early syphilis, but resistance issues limit its use.

Monitoring:

- Regular monitoring of serological tests to assess treatment response and to detect any potential treatment failure or reinfection.

- Patients with HIV infection may require more frequent follow-ups due to the potential for complicated disease progression.

- Monitor for Jarisch-Herxheimer reaction, a possible reaction following treatment, especially in early syphilis.

- Notify and treat sexual partners to prevent reinfection.

- In cases of penicillin allergy, careful monitoring during the desensitization process is essential.

Prognosis:

- With timely and appropriate treatment, the prognosis for primary and secondary syphilis is excellent.

- Late stages and neurosyphilis have a more guarded prognosis depending on the extent of organ damage.

- Prolonged follow-up and repeat serological testing are crucial to ensure treatment efficacy.

- Treatment failure and reinfection rates must be carefully monitored.

Differential Diagnoses:

1. Genital Herpes: Typically presents with painful ulcers, unlike the painless ulcer in syphilis.

2. Chancroid: Causes painful genital ulcers and inguinal lymphadenopathy, differentiated by culture.

3. Lymphogranuloma Venereum: Characterized by inguinal lymphadenopathy and rectal involvement, less common in developed countries.

4. Granuloma Inguinale: Rare in the UK, presents with beefy-red, highly vascular ulcers which can be easily bled.

Patient Questions:

1. "Will this affect my chances of having children in the future?"

- Short answer: "If treated correctly and early, syphilis should not affect your fertility. However, it's important to follow up as recommended."

2. "Can I pass this on to my partner?"

- Short answer: "Yes, syphilis is contagious, especially in its early stages. It's important that your partner gets tested and treated if necessary."

3. "How did I get syphilis if I always used protection?"

- Short answer: "While condoms significantly reduce the risk of STIs, they do not eliminate it entirely, especially for STIs spread through skin-to-skin contact."

4. "Will I have this forever?"

- Short answer: "No, syphilis is curable with proper antibiotic treatment. Follow-up tests will confirm when the infection has been cleared."

Examiner Questions:

1. What are the stages of syphilis and their clinical features?

- Short answer: Primary (chancre), secondary (rash, mucocutaneous lesions), latent (no symptoms), and tertiary (cardiovascular, neurosyphilis).

2. How does the treatment of syphilis differ in pregnancy?

- Short answer: Penicillin is the treatment of choice in pregnancy, and penicillin allergic patients should undergo desensitization.

3. What is the Jarisch-Herxheimer reaction, and how is it managed?

- Short answer: A reaction that can occur after treating syphilis, causing fever and rash. Managed supportively, usually self-limiting.

4. Why must sexual partners be notified and treated in syphilis cases?

- Short answer: To prevent reinfection and the spread to others; partners may be asymptomatic.

5. Discuss the importance and method of follow-up in syphilis treatment.

- Short answer: Follow-up involves serial quantitative nontreponemal serologic tests to ensure treatment success and detect reinfections.

Speciality Filter:

Infection; Sexual Health; General Practice; Obstetrics And Gynaecology.

Presenting Complaint Filter:

Urethral Discharge and Genital Ulcers/Warts

Condition Filter:

Syphilis

Location Filter:

Clinic

Case created by:

DB, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_25\_Syphilis

Homepage Vignette:

## A 26-year-old female named Anna Church presents with a genital ulcer.

Individual Page Vignette:

You are a General Practitioner at a clinic. Your patient today is a 26-year-old female named Anna Church, an English teacher, who presents with a genital ulcer.

Patient Name:

Anna Josephine Church (Phonetic pronunciation: "Ann-uh Jo-sef-een Chur-ch"). Anna prefers to be called by her first name.

Age:

26 years old, DOB: 15/04/1998

Location:

General Practice

Personality:

Anna is articulate and speaks thoughtfully, often pausing to find the right word. She has an engaging, warm personality which makes her easy to talk to. Despite her worry about her symptoms, she maintains a hopeful outlook.

Presenting Complaint:

Anna visited the clinic reporting a painless ulcer near her genital area. She expresses concern, saying, "I first noticed this odd, sore down there about a week ago. I'm not sure what it means, but it's making me quite worried."

Symptoms:

- Site: Perianal region, "It's located just near my private area."

- Onset: Approximately one week ago, "I noticed it last week."

- Character: Painless, "Despite its appearance, it doesn’t hurt."

- Radiation: Does not radiate, "The sore is just in one place, it hasn't spread anywhere."

- Associated Symptoms: None reported, "Besides the sore, I feel quite normal."

- Timing: Persistent over the past week, "It's been there for a week, unchanged."

- Exacerbating and Relieving Factors: Not applicable, "Nothing makes it better or worse; I hardly know it's there unless I see it."

- Severity: Not painful but causing significant worry, "It isn't painful but seeing it there is quite unsettling."

PV Bleeding: Negligible, not associated with the sore.

PV Discharge: No abnormal discharge reported.

Abdominal or Pelvic Pain: No pain reported.

Chance of Pregnancy: No chance of pregnancy, "I've been careful."

Dyspareunia: Not present.

Post-coital PV Bleeding: None reported.

Intermenstrual PV Bleeding: None.

Vulval skin changes or itching: Only the presence of the ulcer, no itching or other skin changes.

History of Presenting Complaint:

- Symptom duration: Approximately one week, "It appeared out of nowhere last week."

- Previous treatments: None attempted.

- Symptom progression: No change since onset, "It's stayed the same since I found it."

- Frequency: First occurrence, "I've never had anything like this before."

- Impact on daily life: Causing worry but not affecting physical daily activities, "It's constantly on my mind, though it hasn't stopped me from doing anything."

- Impact on work: No impact reported.

- Impact on physical and mental wellbeing: Increased anxiety, "I've been really anxious since I noticed it."

Systemic Symptoms:

- Fatigue: Normal energy levels, "I feel as energetic as ever."

- Fever: None reported, "No, I haven't felt hot or feverish."

- Night Sweats: None.

- Unintended Weight Loss: None reported.

- Chest or Shoulder Tip Pain: None.

- Shortness of Breath or Cough: None.

- Change in Bowel Habits: Normal bowel movements.

- Change in Urinary Habits: Normal urination, no dysuria, frequency or urgency.

- Oedema: None.

- Rashes or Skin Changes: None, apart from the sore.

- Headache: None reported.

- Mood Changes: Increased anxiety due to symptoms.

- Sleep Disturbances: Slightly disrupted sleep due to worry, "I've had a few restless nights lately."

Obstetric History:

Previous Obstetric History:

Gravidity and Parity: G0 P0+0

Reproductive Plans: "I do hope to have children in the future, but not quite yet."

Gynaecology History:

Menstrual History:

Duration: 5 days

Frequency: Every 28 days

Volume: Moderate, "It’s pretty standard, lasts about five days."

Dysmenorrhoea: Mild to none.

Last Menstrual Period: Exactly 28 days from the visit date.

Menarche: Age 13

Contraception: Currently using oral contraceptive pills, "I’m on the pill and have been for a few years now."

Previous Screens:

Cervical screening done 2 years ago, results normal.

Previous Gynaecology Conditions: None reported.

Previous STIs: None reported.

Past Medical History:

- No previous medical conditions reported.

- No previous surgeries or hospitalizations.

- Blood group A Rhesus positive.

- No psychiatric or psychological history mentioned.

- No previous injuries or traumas.

- No history of alcohol or substance abuse.

- Fully immunized, including HPV vaccine.

- No previous sexually transmitted infections (STIs).

- "As far as I know, I've been in good health up until now," Anna comments thoughtfully.

Drug History:

- Oral Contraceptive Pills: Ethinylestradiol/levonorgestrel, 30/150 mcg daily, "I take my pill every morning without fail."

- No folic acid or iron supplements.

- No history of medication non-compliance.

- "I don’t really take anything else, just the pill. I try to avoid taking medications unless absolutely necessary,"

Allergies:

- No known allergies to medications, foods, or environmental factors.

- "Luckily, I've never had an allergic reaction to anything,"

Family History:

- Mother has hypertension, controlled with medication.

- Father had a history of Type 2 diabetes.

- No history of sexually transmitted infections or reproductive health issues in the family.

- "My family has the usual health concerns, nothing out of the ordinary,"

Social History:

Lifestyle: Generally healthy, "I try to eat well and stay active."

Occupation: English teacher, "I love my job, shaping young minds."

Activities of Daily Living & Hobbies: Enjoy reading, hiking, and yoga in her spare time, "I find yoga especially helpful for stress."

Smoking: Never smoked.

Alcohol: Drinks socially, approximately 2 units per week.

Recreational Drug Use: None reported.

Diet: Predominantly Mediterranean, "I cook most of my meals, lots of veggies."

Exercise: Regular, including yoga and weekend hikes, "Keeping active is important to me."

Sexual History:

Last sexual intercourse: Approximately 3 weeks ago.

Current and previous partners: In a monogamous relationship for the past 2 years. Total of two sexual partners.

Contraception used: Oral contraceptive pills, "We also use condoms most of the time for extra safety."

Ideas, Concerns, and Expectations:

- Ideas: "I've read a bit online and I'm worried it could be some sort of STD. It’s the uncertainty that’s worst."

- Concerns: "What if it’s something serious? Can it affect my chances of having children later?"

- Expectations: "I'd like to know exactly what's causing this and how we can treat it. I just want to get back to feeling normal."

Observations:

NEWS Total Score: 0

Physical Examination:

General Inspection:

- Appears well and in no distress.

- No signs of pallor or cachexia.

Objects and Equipment:

- None observed.

Hands:

Inspection:

- Warm, well perfused, no peripheral oedema.

Palpitation:

- CRT < 2 seconds, radial pulse regular, no oedema.

Neck:

- No masses, goitres, or lymphadenopathy.

Face:

- No significant findings like melasma, conjunctival pallor, or jaundice.

Abdominal Examination:

Inspection: Abdomen flat, no visible scars or distention.

Palpitation: Soft, non-tender.

Vaginal Examination:

Vulval Inspection: A single, painless ulcer observed, no other lesions or discharge.

Speculum Examination: Cervix appears healthy; no vaginal discharge or cervical lesions.

Bimanual Examination: No abnormalities detected in the uterus or ovaries.

Diagnostic Tests:

Urine Dipstick: Negative.

Vaginal Swab: Sent for culture.

STI Screen:

* Chlamydia: Negative
* Gonorrhoea: Negative
* Syphilis (blood test): Positive
* HIV (blood test): Negative

Blood Tests (Reference Ranges):

Full Blood Count (FBC): All within normal ranges.

Urea and Electrolytes: All within normal ranges.

Imaging Tests:

- Not indicated at this stage.

Patient Questions:

1. "What does this treatment involve? Will it hurt?" - Reassure that it involves an intramuscular injection which might be briefly uncomfortable but is usually well-tolerated.

2. "Can I still have children after this treatment?" - Yes, successful treatment of syphilis should not affect your ability to have children in the future.

3. "Do I need to tell my partner about this?" - It is essential to inform any sexual partners so they can also be tested and treated if necessary.

4. "How can I prevent this from happening again?" - Practice safe sex, including the use of condoms, and regularly get tested for STIs if sexually active with new or multiple partners.

Examiner Questions:

1. What is the first-line treatment for primary syphilis according to NICE guidelines? - Benzathine penicillin G.

2. How would you manage a patient allergic to penicillin? - Use of Doxycycline or Azithromycin following current guidelines.

3. What is the goal of follow-up serology in syphilis treatment? - To ensure decreasing titres indicating successful treatment.

4. Why is patient education important in the management of syphilis? - To ensure adherence to treatment, inform about the importance of partner notification, and prevent reinfection.

5. Discuss the importance of differential diagnosis in the management of genital ulcers. - Differentiating between causes is crucial for effective treatment and management.

Treatment:

The treatment for syphilis, in line with NICE guidelines and the British Association for Sexual Health and HIV (BASHH), involves the use of antibiotics. Specifically, the first-line treatment is:

- Benzathine penicillin G, administered as a single intramuscular injection of 2.4 million units.

If the patient is allergic to penicillin, alternative treatments may include:

- Doxycycline 100 mg orally twice a day for 14 days, or

- Azithromycin 2g orally as a single dose, although resistance to azithromycin is increasing and it should be used cautiously.

Always ask about allergies before prescribing antibiotics. In Anna's case, given no known drug allergies:

* Based on current guidelines, your treatment will involve a single injection of Benzathine penicillin G. It’s very effective and typically well-tolerated.

Monitoring:

Patients treated for syphilis should be closely monitored to ensure the effectiveness of treatment and the resolution of symptoms. Specific parameters include:

- Follow-up blood tests for syphilis serology at 3, 6, and 12 months to ensure decreasing titres.

- Promptly report to their healthcare provider if any symptoms persist or if new symptoms appear.

- A repeat examination to confirm the resolution of clinical symptoms, particularly the healing of the ulcer.

- Patients who are HIV positive or who have late latent syphilis may require a more extended period of monitoring due to the potential complexity of their case.

Prognosis:

- With timely and appropriate treatment, the prognosis for primary syphilis is excellent, and full recovery is expected.

- Early treatment significantly reduces the risk of progressing to more severe stages of the disease, which can involve multiple organ systems and lead to more severe health problems.

- It’s crucial to educate the patient on the importance of completion of treatment and follow-up testing to confirm cure and to avoid unnecessary transmission.

Differential diagnoses:

1. Genital herpes: Less likely due to the absence of pain and typical vesicular lesions.

2. Chancroid: Characterized by painful genital ulcers and inguinal lymphadenopathy, making it less likely in this case.

3. Lymphogranuloma venereum: Presents with genital ulceration and significant lymphadenopathy; less common in the UK.

4. Behçet's disease: A cause of genital ulcers but usually associated with oral ulcers and eye inflammation.

Keyword Filters:

Speciality Filter: Infectious Diseases; Sexual Health; General Practice;

Presenting Complaint Filter: Urethral Discharge and Genital Ulcers/Warts;

Condition Filter: Syphilis;

Location Filter: General Practice;

Case created by:

david, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_26\_Endometriosis

Homepage Vignette:

## A 32-year-old female called Anara presents with dysmenorrhoea.

Individual Page Vignette:

You are the attending general practitioner at a clinic. Anara, a 32-year-old software developer based in a bustling city centre, comes to you with complaints of pelvic pain and painful menstrual periods.

Patient Name:

Anara Samir Navid (Pronunciation: Ah-nah-rah Sah-meer Nah-veed). She prefers to be called Anara.

Age:

04/06/1992

Location:

Clinic

Personality:

Anara is articulate and direct in her communication, likely stemming from her background in the fast-paced technology industry. She appears stoic at first but opens up about her concerns when she feels understood. Her high-stress job has made her proactive about seeking solutions.

Presenting Complaint:

"I've been dealing with this stabbing pain in my lower abdomen for years now, but it's become unbearable around my period lately."

Symptoms:

- Site: "The pain is mostly in my lower abdomen, just feels like it's everywhere down there."

- Onset: "This has been a slow burn; it's gotten worse over the past few years."

- Character: "It's a sharp, stabbing pain, sometimes I describe it as a deep, throbbing ache."

- Radiation: "Sometimes the pain shoots down my legs."

- Associated Symptoms: "My periods have gotten so heavy and painful."

- Timing: "It's at its worst during my period but honestly, I feel some level of discomfort most days."

- Exacerbating and Relieving Factors: "Heat helps a bit; stress and physical activity seem to make it worse."

- Severity: "On a scale from 1 to 10, it hits an 8 during my period."

PV Bleeding: Regular, heavy bleeding with clots. "It's like the floodgates open every month."

PV Discharge: Normal

Abdominal or Pelvic Pain: Severe, chronic

Chance of Pregnancy: None, "I've been trying to avoid getting pregnant until I sort this out."

Dyspareunia: Positive, "Sex has been painful lately."

Post-coital PV Bleeding: Negative.

Intermenstrual PV Bleeding: Occasional spotting

Vulval skin changes or itching: Negative.

Abdominal distention: Negative.

Breast lumps: Negative.

Painful menstruation: Positive, "It's been hell."

Missed periods: Irregular periods

Infertility: "I haven't been trying, but it's a concern."

Severe menstrual cramps: "Yes, definitely."

Abnormal Pap smear results: Negative

Excessive facial or body hair: Negative

Dizziness: Negative

Chronic pelvic pain: Positive

Shoulder tip pain: Negative

History of Presenting Complaint:

- Anara has been experiencing abdominal and pelvic pain for approximately 5 years, gradually worsening over time.

- Tried over-the-counter pain relief without significant improvement.

- Painful menstruation has intensified over the past year.

- Impacts daily life particularly during menstrual periods, limits physical activity, and increases stress.

- "I feel like I have to plan my life around my periods now."

Systemic Symptoms:

- Fatigue: "I'm constantly tired, especially during my periods."

- Fever: Negative

- Night Sweats: Negative

- Unintended Weight Loss: Negative

- Chest or Shoulder Tip Pain: Negative

- Shortness of Breath or Cough: Negative

- Change in Bowel Habits: "I've noticed more painful bowel movements during my period."

- Dysuria: Negative

- Frequency: Normal

- Urgency: Normal

- Oedema: Negative

- Rashes or Skin Changes: Negative

- Headache: "I get headaches, but who doesn't?"

- Mood Changes: "I've been more irritable and down, mostly out of frustration."

- Sleep Disturbances: "Pain keeps me up at night sometimes."

Obstetric History:

Gravidity and Parity: G0 P0

Previous Obstetric History: None

Reproductive Plans: "I do want children, but not until I figure out what's going on with my health."

Gynaecology History:

Menstrual History:

Duration: 7 days

Frequency: Every 25-30 days

Volume: Heavy

Dysmenorrhoea: Severe

Last Menstrual Period: Two weeks ago

Menarche: Age 13

Contraception: None currently, previously used oral contraceptives.

Past Medical History:

- No significant medical conditions.

- No surgeries or hospitalizations.

- No psychiatric or psychological history.

- No history of alcohol or substance abuse.

- Full immunizations, including HPV vaccine.

- No previous STIs.

Drug History:

- Occasionally takes ibuprofen for pain relief during periods.

- No regular medications.

- Previously used oral contraceptive pills.

Allergies:

- No known allergies.

Family History:

- Mother has hypothyroidism.

- Paternal grandfather had colorectal cancer.

- No known family history of endometriosis or similar gynaecological issues.

“My mum has an underactive thyroid and I think one of my grandads had cancer in his bowel”

Social History:

Lifestyle: Sedentary due to job requirements.

Occupation: Software developer.

Activities of Daily Living & Hobbies: "I like coding and reading; outdoor activities have been limited due to pain."

Smoking: Non-smoker

Alcohol: Drinks socially, about 2-3 units per week

Recreational Drug Use: None.

Diet: Balanced, tries to maintain a healthy diet.

Exercise: Limited due to pelvic pain, "I used to jog before the pain got bad."

Sexual History:

Last sexual intercourse: Over a month ago.

Current and previous partners: In a monogamous relationship for the past 3 years.

Contraception used: None currently.

Ideas, Concerns, and Expectations:

- Ideas: Anara is knowledgeable about endometriosis and suspects it could be the cause of her symptoms.

- Concerns: Worried about the impact on fertility and quality of life.

- Expectations: Seeking a definitive diagnosis and effective treatment plan to manage symptoms and preserve fertility.

“I feel like this is now taking over my life and I am really concerned it’s going to affect my future chances of getting pregnant. What do you think it could be, doctor?”

Observations:

NEWS Total Score: 0

Physical Examination:

General Inspection: Appears well, no signs of acute distress or cachexia.

Objects and Equipment: None.

Hands: No abnormalities noted.

Neck: No masses or lymphadenopathy.

Face: No abnormal findings.

Abdominal Examination:

Inspection: Non-distended, no visible scars.

Palpitation: Diffuse tenderness in the lower abdomen on deep palpation only, no masses palpable.

Vaginal Examination:

Vulval Inspection: Normal, no visible abnormalities.

Speculum Examination: Normal cervical os, no bleeding, no visible abnormalities.

Bimanual Examination: Normal cervix and vaginal walls, uterus retroverted, tender on palpation, no adnexal masses palpable.

Diagnostic Tests:

Urine Dipstick: Normal

STI Screen: Negative

Blood Tests (Reference Ranges):

Full Blood Count (FBC): Normal

Urea and Electrolytes: Normal

Liver Function Tests: Normal

CRP: < 5 mg/L

Imaging Tests:

Transvaginal Ultrasound Scan: Suggestive of presence of ovarian cysts consistent with endometriomas. Thickening and nodularity in the posterior cul-de-sac.

Patient Questions:

1. "Could this condition affect my chances of getting pregnant?"

- Yes, endometriosis can affect fertility, but many women with the condition are still able to conceive. Treatment and management strategies can help improve fertility outcomes.

2. "How is endometriosis treated? Will I need surgery?"

- Treatment options include pain management, hormonal therapies, and in some cases, surgery to remove endometrial tissue. The choice depends on symptom severity and personal circumstances.

3. "Is it going to get worse?"

- The course of endometriosis can vary. Some women experience worsening symptoms over time, while in others, symptoms may improve, especially with treatment.

4. "Is there a cure for endometriosis?"

- There's no cure for endometriosis, but treatments can significantly reduce symptoms and improve quality of life.

Examiner Questions:

1. What are the typical symptoms of endometriosis?

- Chronic pelvic pain, dysmenorrhea, dyspareunia, heavy menstrual bleeding, and infertility.

2. How is endometriosis diagnosed?

- Primarily through clinical assessment, ultrasound, and definitively with laparoscopy.

3. Discuss the management strategies for endometriosis.

- Includes NSAIDs for pain, hormonal treatments like oral contraceptives, and potentially, laparoscopic surgery for removing endometrial tissue.

4. What are the potential complications of endometriosis?

- Including infertility, ovarian cysts, and the potential for adhesions and chronic pain.

5. How can endometriosis impact a patient's quality of life?

- Can cause chronic pain, affect mental health, restrict activities, and impact fertility and relationships.

6. What are the long-term treatment goals for a patient with endometriosis?

- To manage pain, reduce the progression of the disease, improve fertility if desired, and enhance the patient's quality of life.

Treatment:

- Initial management includes symptomatic treatment with NSAIDs such as ibuprofen for pain relief.

- Hormonal therapies: Combined oral contraceptive pill (COCP) or progestogens can be used to reduce menstrual flow and pain.This is suitable as she is currently not trying to get pregnant.

- For patients seeking fertility or with severe symptoms unresponsive to medical therapy, referral for laparoscopic assessment and potential removal of endometrial implants.

- Surgical options include laparoscopic excision or ablation of endometriosis lesions, and in severe cases, hysterectomy with or without oophorectomy, reserved for women who do not respond to other treatments and have completed their desired families.

Monitoring:

- Regular follow-up visits to assess pain control and side effects of hormonal treatment.

- Monitor liver function tests if on GnRH agonists.

- Annual ultrasound to monitor for ovarian cysts if known endometrioma.

- Fertility considerations and referral to a fertility specialist if pregnancy is desired.

- Psychological support and counseling as needed for chronic pain and fertility concerns.

Prognosis:

- Endometriosis is a chronic condition with no cure, but symptoms can be effectively managed in most women.

- Early diagnosis and treatment improve the long-term prognosis.

- The impact on fertility varies; while some women may experience difficulty conceiving, many can achieve pregnancy with appropriate treatment.

- The risk of ovarian cancer is slightly increased in women with endometriosis.

Differential diagnoses:

1. Pelvic Inflammatory Disease: Less likely due to the chronic nature of symptoms and lack of infection markers.

2. Ovarian Cysts: May coexist, but the specific pattern of pain and exacerbation with menstruation lean towards endometriosis.

3. Irritable Bowel Syndrome: Symptoms overlap, but the presence of dysmenorrhea and relation to the menstrual cycle are more indicative of endometriosis.

4. Adenomyosis: Similar symptoms, distinguished primarily through imaging.

Keyword Filters:

Speciality Filter: Obstetrics And Gynaecology; General Practice

Presenting Complaint Filter: Pelvic Pain; Menstrual Problems; Painful Sexual Intercourse; Subfertility

Condition Filter: Endometriosis

Location Filter: Clinic

Case created by:

DB, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_27\_Endometriosis

Homepage Vignette:

## A 32-year-old female called Mariama presents with chronic pelvic pain.

Individual Page Vignette:

As a General Practitioner, you are seeing a 32-year-old female named Mariama, an accountant, located at your Clinic. She presents with chronic pelvic pain.

Patient Name:

Mariama Junaid (Pronounced: Ma-ree-ah-ma Ju-nayd). She prefers to be called Mariama.

Age:

15/04/1992

Location:

Clinic

Personality:

Mariama is articulate and detail-oriented, reflecting her career in accounting. She speaks in measured tones, carefully considering her words before she speaks. She is somewhat reserved but opens up when discussing her symptoms, indicating a trust in the medical process.

Presenting Complaint:

Mariama reports experiencing severe pelvic pain, particularly during her menstrual periods, which has started to interfere with her daily activities.

Quote: "The pain is so bad that sometimes I can't even go to work. It’s like being stabbed from the inside."

Symptoms:

- Site: Pelvis

- Quote: "The pain feels like it's deep inside my pelvis, right around here."

- Onset: Gradually worsened over the past few years

- Quote: "It started off mild but has gotten much worse over time."

- Character: Cramping and stabbing

- Quote: "It’s like a constant cramp with waves of stabbing pain."

- Radiation: Does not radiate

- Quote: "The pain stays right here in the pelvis; it doesn’t go anywhere else."

- Associated Symptoms: Nausea, fatigue during menstruation

- Quote: "I feel sick to my stomach and just completely drained when the pain hits."

- Timing: Periodic, aligns with menstrual cycle

- Quote: "It's always the worst during my period but I have some level of pain most of the time."

- Exacerbating and Relieving Factors: Worsens with menstruation, slight relief with over-the-counter pain medication

- Quote: "Painkillers take the edge off a bit, but it’s still pretty bad."

- Severity: 8/10 during menstruation, 4/10 at other times

- Quote: "On a scale from one to ten, it's up there at an eight during my periods."

PV Bleeding: Normal volume, regular, no noticeable change in color, no unusual smell.

PV Discharge: Normal, no unusual volume, color, consistency, or smell.

Abdominal or Pelvic Pain: Severe pain, especially during menstruation.

Chance of Pregnancy: Not pregnant.

Dyspareunia: Reports painful intercourse.

Post-coital PV Bleeding: None.

Intermenstrual PV Bleeding: None.

Vulval skin changes or itching: No changes or itching.

Quote: "Sex can be quite painful, which really isn’t like me. And thankfully, no weird changes or itching down there."

Abdominal distension: None.

Breast lumps: None.

Missed periods: No.

Infertility: Has not attempted to conceive.

Severe menstrual cramps: Yes.

Quote: "My periods have been a nightmare, I haven't even started trying for a baby because of how bad it is."

History of Presenting Complaint:

- Symptoms started roughly 5 years ago, gradually worsening over time.

- Initially managed with over-the-counter pain relief, which is now less effective.

- Pain and discomfort are affecting job performance and daily activities.

- Reports feeling mentally drained by the constant pain and its impact on her life.

Quote: "It’s been a long road. What started as bearable pain has now taken over my life, affecting everything I do."

Systemic Symptoms:

- Fatigue: Reports increased fatigue during menstrual periods.

- Quote: "I'm exhausted all the time during my periods."

- Fever: None.

- Night Sweats: None.

- Unintended Weight Loss: None.

- Chest or Shoulder Tip Pain: None.

- Shortness of Breath or Cough: None.

- Change in Bowel Habits: None.

- Change in Urinary Habits: None.

- Dysuria:

- Frequency: Normal.

- Urgency: Normal.

- Oedema: None.

- Rashes or Skin Changes: None.

- Headache: Occasional, unrelated to menstrual cycle.

- Quote: "I get headaches now and then, but who doesn’t?"

- Mood Changes: Reports feeling more irritable and down during periods.

- Quote: "It's hard not to feel hopeless when the pain is relentless."

- Sleep Disturbances: Reports difficulty sleeping during menstruation due to pain.

- Quote: "The pain keeps me up at night. I toss and turn trying to find a comfortable position."

Obstetric History:

Previous Obstetric History: Nulliparous

Gravidity and Parity: G0 P0+0

Reproductive Plans: Wishes to have children in the future but is concerned about her condition affecting fertility.

Quote: "I’ve always wanted children, but with all this pain, I’m not sure how possible that will be."

Gynaecology History:

Menstrual History:

- Duration: 5-7 days

- Frequency: Every 28 days

- Volume: Moderate to heavy

- Dysmenorrhoea: Severe

Last Menstrual Period: 2 weeks before the appointment

Menarche: Age 13

Previous Screens: Regular cervical screenings, last one 6 months ago, no abnormal results.

Previous Gynaecology Conditions: None reported.

Previous STIs: None reported.

Contraception: Currently using oral contraceptive pills, which has not significantly impacted her symptoms.

Quote: "The pill hasn’t really made a difference with the pain, but I keep up with it anyway."

Past Medical History:

- Asthma, well-controlled with salbutamol when needed.

- No previous surgeries or hospitalizations.

- Psychiatric history: None.

- No previous significant injuries or traumas.

- No history of alcohol or substance abuse.

- Immunizations up to date, including HPV vaccination.

- No previous STIs.

- No other relevant medical conditions.

Quote: "Apart from the asthma, which I’ve had since I was a kid, I’m generally healthy."

Drug History:

- Salbutamol inhaler, as needed for asthma.

- Oral contraceptive pills, daily.

- Paracetamol and ibuprofen, used frequently during menstruation for pain relief but with limited effect.

Quote: "I use my inhaler when my asthma flares up, and I’ve been trying to manage the pain with over-the-counter painkillers."

Allergies:

- No known allergies.

Quote: "Luckily, I’ve never had a bad reaction to anything."

Family History:

- Mother has hypertension.

- Father has type 2 diabetes.

- One elder sibling with no known health issues.

Quote: "Mum and Dad have their things, but nothing like what I’m going through."

Social History:

Lifestyle: Leads a generally healthy lifestyle.

Occupation: Accountant.

Activities of Daily Living & Hobbies: Enjoys outdoor activities and yoga, though has found physical activities more challenging due to pain.

Smoking: Non-smoker.

Alcohol: Consumes alcohol socially, approximately 4 units per week.

Recreational Drug Use: None.

Diet: Follows a balanced diet.

Exercise: Tries to remain active, but activity has decreased due to pain.

Quote: "Before all this started, I used to love hiking and going to yoga classes. Now, I count myself lucky if I can get through a week without too much pain."

Sexual History:

Last sexual intercourse: About a month ago.

Current and previous partners: In a monogamous relationship for the past year.

Contraception: Oral contraceptive pills.

Quote: "It’s been tough on my relationship, not just the pain, but how it affects everything... even intimacy."

Ideas, Concerns, and Expectations:

Ideas:

- Believes her pelvic pain could be due to her menstrual cycle, but is unsure why it’s so severe.

- Quote: "I’ve read about conditions like endometriosis, but I’m not sure if that’s what I have."

Concerns:

- Worried about the impact of her condition on her ability to work and have children.

- Quote: "It’s taking over my life. What if I can’t have kids because of this?"

Expectations:

- Hopes to find an effective treatment to manage her symptoms and receive reassurance about her fertility.

- Quote: "I just want to find a way to manage this pain and make sure it won’t stop me from having a family."

Observations:

- NEWS Total Score: 0

Physical Examination:

General Inspection: Appears in mild distress due to chronic pain but is alert and oriented.

Objects and Equipment: None.

Hands: Normal appearance, no palmar erythema or peripheral oedema.

Neck: No masses, goitres, or lymphadenopathy.

Face: No obvious signs of anaemia, jaundice, or oedema.

Abdominal Examination:

- Inspection: No visible scars, masses, or distension.

- Palpitation: Tenderness reported in lower abdomen, no palpable masses.

Vaginal Examination:

- Vulval Inspection: No ulcers, cysts, rashes, discharge, scarring, atrophy, lesions, masses, or signs of FGM.

Speculum Examination: Normal cervical os, no bleeding, no visible abnormalities.

Bimanual Examination: Normal cervix and vaginal walls, uterus retroverted, tender on palpation, no adnexal masses palpable.

Diagnostic Tests:

Urine Dipstick: Normal

STI Screen:

* Chlamydia: Negative;
* Gonorrhoea: Negative;
* Syphilis (blood test): Negative;
* HIV (blood test): Negative.

MSU: Normal

Blood Tests:

- Full Blood Count (FBC): Normal

- Haemoglobin (Hb): 140 g/L (Reference Range: Female: 115 - 165 g/L)

- Mean Corpuscular Volume (MCV): 90 fL (Reference Range: 80 – 100 fL)

- White Blood Cell Count: 7.0 x10^9/L (Reference Range: 3.6 - 11.0 x10^9/L)

- Platelets: 250 x10^9/L (Reference Range: 140 - 400 x10^9/L)

Urea and Electrolytes: Within normal limits

- Sodium: 140 mmol/L (Reference Range: 133–146 mmol/L)

- Potassium: 4.2 mmol/L (Reference Range: 3.5–5.3 mmol/L)

CRP: <5 mg/L (Reference Range: <10 mg/L)

Imaging Tests:

- Ultrasound Scan: A transvaginal ultrasound reveals endometriomas and chocolate cysts.

Condition:

Endometriosis

Patient Questions:

1. "How sure are we that it’s endometriosis, and not something else?"

- Short Answer: "Based on your symptoms and the initial examination results, endometriosis is a likely diagnosis. However, further diagnostic tests, like a transvaginal ultrasound, could help confirm it."

2. "Will this affect my chances of having children?"

- Short Answer: "Endometriosis can affect fertility, but many women with endometriosis can still conceive. We can discuss treatment options and potential impacts on fertility in more detail."

3. "What kind of treatments are there? Will I need surgery?"

- Short Answer: "There are several treatment options for endometriosis, including medication for pain management and hormonal treatments. Surgery is a possibility but typically considered when other treatments haven't been effective."

4. "How can I manage the pain in the meantime?"

- Short Answer: "We can look at adjusting your pain management regimen, possibly including NSAIDs or other hormonal contraceptives, to help manage the symptoms until we formulate a long-term treatment plan."

Examiner Questions:

1. What are the hallmark symptoms of endometriosis?

- Short Answer: "Chronic pelvic pain, painful menstruation (dysmenorrhea), pain during intercourse (dyspareunia), and potential fertility issues."

2. How is endometriosis diagnosed?

- Short Answer: "Diagnosis typically involves a combination of patient history, physical examination, imaging tests such as ultrasound, and sometimes diagnostic laparoscopy for direct visualization of endometrial lesions."

3. What are the main treatment options for endometriosis?

- Short Answer: "Treatment may include analgesics for pain, hormonal therapies such as oral contraceptives or GnRH agonists, and surgical options for severe cases."

4. What are the potential complications or considerations with surgical treatment of endometriosis?

- Short Answer: "Surgical treatment can be effective but carries risks such as adhesion formation. Fertility preservation is also a consideration."

5. How does endometriosis affect fertility, and what management options are available for women looking to conceive?

- Short Answer: "Endometriosis can impact fertility by causing inflammation and scar tissue. Management may include fertility-enhancing treatments or assisted reproductive technologies like IVF."

Treatment:

1. Initial Management:

- NSAIDs, such as ibuprofen, for pain relief. Dose according to BNF recommendations.

- Hormonal contraceptives, such as combined oral contraceptives or progestins, to reduce menstrual flow and suppress endometriosis growth. Follow dosing as per BNF.

2. Surgical Options:

- Laparoscopic surgery to remove endometrial lesions may be considered for severe cases not responsive to medical treatment.

3. Advanced Treatment:

- Gonadotrophin-releasing hormone (GnRH) agonists for those not responding to other treatments. Follow BNF dosing guidelines.

4. Assisted Reproductive Technologies (ART):

- Consideration for women with fertility issues related to endometriosis.

Monitoring:

- Monitor pain levels and side effects of medications regularly.

- Follow-up consultations every 3-6 months or as needed to reassess pain management and treatment efficacy.

- Annual ultrasound to monitor disease progression.

- Fertility evaluation for those planning pregnancy or having difficulty conceiving.

Prognosis:

- With appropriate treatment, many patients can achieve significant pain relief and quality of life improvement.

- Fertility outlook varies; some may require ART for successful conception.

- Regular monitoring and treatment adjustments are critical for managing symptoms and preventing complications.

Differential diagnoses:

1. Pelvic Inflammatory Disease (PID) - Less likely due to the chronic nature of symptoms and lack of infection signs.

2. Ovarian Cysts - While they can cause pelvic pain, the cyclical nature of Mariama's symptoms is more indicative of endometriosis.

3. Uterine Fibroids - Could cause similar symptoms but are typically associated with heavy menstrual bleeding.

Keyword Filters:

Speciality Filter:

Obstetrics And Gynaecology; General Practice; Surgery.

Presenting Complaint Filter:

Pelvic Pain; Menstrual Problems; Painful Sexual Intercourse.

Condition Filter:

Endometriosis

Location Filter:

General Practice ; Clinic

Case created by:

David, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

# 

# DWZHB\_28\_Endometriosis

Homepage Vignette:

## A 31-year-old woman called Aisha Chakraborty presents with pelvic pain.

Individual Page Vignette:

You are presented with a patient named Aisha Chakraborty, aged 31, an IT consultant, located in a General Practice, complaining of pelvic pain.

Patient Name: Aisha Chakraborty (Pronunciation: Eye-shuh Chak-ra-bor-tee, Prefers to be called Aisha)

Age: 18/06/1993

Location: General Practice

Personality: Aisha is articulate, detail-oriented, and slightly reserved. She speaks in a clear, calm manner but seems anxious about her symptoms. She values clear explanations and evidence-based outputs due to her analytical background in IT.

Presenting Complaint:

Aisha presents reporting persistent and worsening pelvic pain, especially noticeable during her menstrual periods, which she describes as increasingly unbearable over the last six months.

Quote: "The pain I've been experiencing around my lower abdomen has become so severe, especially during my periods, it's almost unbearable. It feels different and much more intense than usual menstrual cramps."

Symptoms:

- Site: Pelvic Area, "It feels like the pain is deep inside my lower abdomen."

- Onset: Gradual onset over the past six months, "I've noticed the pain getting progressively worse over the last half a year."

- Character: Sharp and cramping, "It's like sharp, stabbing pains mixed with a constant cramp."

- Radiation: Does not radiate, "The pain stays in my abdomen area, it doesn't go anywhere else."

- Associated Symptoms: Dysmenorrhoea, "My periods have also become more painful."

- Timing: Cyclical, related to menstrual cycle, "It's definitely worse during my period but I've started to notice some pain at other times too."

- Exacerbating and Relieving Factors: Pain worsens during menstruation, "It's at its worst during the first couple of days of my period."

- Severity: 8/10 during menstruation, "On a scale, it reaches an 8 during my periods."

PV Bleeding: Normal menstrual volume, red, no abnormal smell.

PV Discharge: Normal.

Abdominal or Pelvic Pain: Described above.

Chance of Pregnancy: None.

Dyspareunia: Reports pain during intercourse, "Sex has become uncomfortable and sometimes painful."

Post-coital PV Bleeding: None reported.

Intermenstrual PV Bleeding: None.

Post-menopausal Bleeding: Not applicable.

Vulval skin changes or itching: None reported.

Also reports dysmenorrhoea: "I used to have manageable cramps, but now it's much more intense."

History of Presenting Complaint:

- Aisha has been experiencing the symptoms for approximately six months.

- No previous treatments attempted; this is her first consultation regarding these symptoms.

- Symptoms have progressively worsened.

- Frequency of symptoms: Cyclical, coinciding with her menstrual cycle.

- Impact on daily life: "I've had to take time off work during my periods because of the pain."

- Impact on work: Has resulted in absences.

- Impact on physical and mental wellbeing: "It's starting to really get to me, feeling this way almost every month."

Quote: "Over the last six months, it's gone from bad to worse. I can't do anything during the worst days, and I'm worried it's starting to affect my work."

Systemic Symptoms:

- Fatigue: Reports increased fatigue around her period, "I feel completely wiped out during my period."

- Fever: None.

- Night Sweats: None.

- Unintended Weight Loss: None.

- Chest or Shoulder Tip Pain: None.

- Shortness of Breath or Cough: None.

- Change in Bowel Habits: None.

- Change in Urinary Habits: No dysuria, frequency, or urgency.

- Oedema: None.

- Rashes or Skin Changes: None.

- Headache: Reports mild headaches, "I get these dull headaches, especially before my period starts."

- Mood Changes: Reports feeling more irritable and anxious, "My mood drops a lot, and small things start to irritate me."

- Sleep Disturbances: Reports difficulty sleeping, "The pain sometimes keeps me up at night."

Quote: "Apart from the terrible pain, I get extremely tired, and my mood just tanks. It's like a bad mix of everything all at once."

Obstetric History:

Previous Obstetric History:

Gravidity and Parity: G0 P0+0

Reproductive Plans: "I've thought about children in the future, but right now, I'm more focused on sorting these issues out."

Quote: "Children might be in my future, but I've got to deal with this pain first."

Gynaecology History:

Menstrual History:

- Duration: 5 days

- Frequency: Every 28 days

- Volume: Describes as heavy, especially first two days.

- Dysmenorrhoea: Yes, worsening.

Last Menstrual Period: Two weeks ago.

Menarche: Age 13.

Menopause: Not applicable.

Contraception: None currently. Past use of oral contraceptive pills (stopped 1 year ago).

Quote: "Since stopping the pill, my periods have been heavier, and the pain's just skyrocketed."

Past Medical History:

- No previous medical conditions noted.

- No previous surgeries or hospitalizations.

- No psychiatric or psychological history.

- No previous injuries or traumas.

- No history of alcohol or substance abuse or addiction.

- Immunizations and vaccination history complete, including for HPV.

- No previous STIs.

- No other relevant medical conditions or significant health events.

Quote: "I've generally been healthy all my life, so this ongoing issue has really thrown me for a loop."

Drug History:

- No current medications.

- Previous contraception: Oral contraceptive pill, stopped 1 year ago, "I was on the pill for a couple of years but stopped it last year."

- No history of medication non-compliance or missed doses.

- No use of herbal supplements or alternative therapies.

- No overdose incidents.

Quote: "I haven't been on any medication since I stopped the pill, and I tend to avoid even over-the-counter stuff unless absolutely necessary."

Allergies:

- No known allergies.

Quote: "Luckily, I don't have any allergies that I know of."

Family History:

- Maternal aunt diagnosed with endometriosis.

- Father has Type 2 diabetes.

- No other significant family medical history.

Quote: "My aunt had something similar, from what I understand. It makes me wonder..."

Social History:

Lifestyle: Generally active, enjoys hiking and yoga.

Occupation: IT consultant, "My job's mostly deskbound, which I'm starting to think might not help my situation."

Activities of Daily Living & Hobbies: Enjoys reading and programming in her free time.

Smoking: Non-smoker.

Alcohol: Socially, approximately 4 units per week.

Recreational Drug Use: None.

Diet: Vegetarian, tries to maintain a balanced diet.

Exercise: Regular, at least 3 times a week.

Quote: "I try to stay active and eat well, but this issue's been making it harder to keep up with things I enjoy."

Sexual History:

- Last sexual intercourse: 3 months ago.

- Number of partners in the past year: 1

- Currently single.

- No contraception used in recent months.

Quote: "It's been a while, and honestly, with the pain, I've not been in the mood at all."

Ideas, Concerns, and Expectations:

- Ideas: "I think this could be endometriosis. I've done some reading, and it sounds similar to what I'm experiencing."

- Concerns: "I'm worried about what this means long-term, especially for my fertility."

- Expectations: "I really hope we can find some treatment that helps with the pain without too many side effects."

Quote: "I just want some relief from this constant pain and to understand what's going on with my body."

Observations:

NEWS Total Score: 0 (All parameters within normal ranges)

Physical Examination:

General Inspection: Appears well, in no acute distress.

Objects and Equipment: None.

Hands: No palmar erythema or peripheral oedema.

Neck: No masses or goitres, JVP not elevated, no lymphadenopathy.

Face: No abnormal findings.

Abdominal Examination: Soft, non-tender. No masses palpable.

Vaginal Examination:

Vulval Inspection: No visible abnormalities

Speculum Examination: Cervical os normal; no bleeding or visible lesions.

Bimanual Examination: Tenderness noted in adnexal regions, especially on the left side. No obvious masses palpable.

Diagnostic Tests:

Urine Dipstick: Normal

STI Screen:

- Chlamydia: Negative

- Gonorrhoea: Negative

- Syphilis (blood test): Negative

- HIV (blood test): Negative

Blood Tests (Reference Ranges):

Full Blood Count (FBC):

- Haemoglobin (Hb): 140 g/L (Female: 115 - 165 g/L)

- Mean Corpuscular Volume (MCV): 89 fL (80 – 100 fL)

- White Blood Cell Count: 7.0 x10^9/L (3.6 - 11.0 x10^9/L)

- Platelets: 250 x10^9/L (140 - 400 x10^9/L)

Urea and Electrolytes:

- Sodium: 140 mmol/L (133–146 mmol/L)

- Potassium: 4.0 mmol/L (3.5–5.3 mmol/L)

- Calcium (adjusted): 2.4 mmol/L (2.2-2.6 mmol/L)

- Magnesium: 0.9 mmol/L (0.7–1.0 mmol/L)

- Urea: 5.0 mmol/L (2.5 – 7.8 mmol/L)

- Creatinine: 70 μmol/L (Female: 45–84 μmol/L)

- eGFR: >90ml/min/1.73m3

Other Tests:

Beta Human Chorionic Gonadotrophin (bHCG): < 5 mU/mL

Imaging Tests:

Ultrasound Scan: Pelvic ultrasound reveals evidence of bilateral ovarian endometriomas with the largest measuring approximately 3cm on the left ovary. No significant free fluid in the pelvis.

Condition: Endometriosis

Patient Questions:

1. "What are my options for treatment?"

- "Treatment includes medication to manage symptoms, such as pain relief and hormonal treatments to reduce growth, and in some cases, surgery to remove endometrial tissue. It would depend on your symptoms, severity, and personal and reproductive plans."

2. "Will this affect my fertility?"

- "Endometriosis can impact fertility, but it doesn't mean you won't be able to conceive. Many women with endometriosis do conceive naturally or with assistance such as IVF. We'll discuss the best approach based on your desires and condition severity."

3. "How long will I need treatment?"

- "Treatment duration can vary. It might involve ongoing management to control symptoms and maintain quality of life. Your condition will be regularly reviewed to adjust treatment as necessary."

4. "Could this come back after surgery?"

- "Yes, there's a chance that endometriosis could recur even after surgical intervention. Ongoing management and monitoring are important."

Examiner Questions:

1. What diagnostic tests would you order for a suspected case of endometriosis?

- "Pelvic ultrasound, blood tests, possibly laparoscopy to confirm diagnosis."

2. Describe the typical features of endometriosis.

- "Chronic pelvic pain, dysmenorrhoea, deep dyspareunia, potential infertility, and cyclical or non-cyclical pain that might exacerbate around menstruation."

3. How does endometriosis affect fertility?

- "It can cause adhesions, distorted pelvic anatomy, or ovarian endometriomas, which may impair fertility."

4. What are the primary goals of endometriosis treatment?

- "To relieve pain, reduce endometrial lesions, prevent progression, and address infertility issues."

5. What are the indications for surgical intervention in endometriosis?

- "Significant pain not alleviated by medication, suspicion of complications like ovarian cysts, and as part of fertility management."

Treatment:

- Pain management: NSAIDs like ibuprofen for symptomatic relief.

- Hormonal therapy: Combined oral contraceptives or progestogens to suppress menstruation and endometriosis progression.

- Gonadotropin-releasing hormone (GnRH) agonists for severe cases to induce a temporary menopause state.

- Surgical options include laparoscopic excision of endometriosis, ablation of lesions, and removal of endometriomas, depending on the extent and location of the disease.

Monitoring:

- Regular follow-up appointments every 6-12 months to monitor symptoms and side effects of treatment.

- Ultrasound scans as required to monitor ovarian cysts or other pelvic pathology.

- Consideration of bone density scans if on long-term GnRH agonists.

Prognosis:

- Chronic condition with the potential for symptom relief through management.

- Potential impact on fertility, but many treatment options are available.

- Regular monitoring and adjustment of treatment plans are crucial.

Differential diagnoses:

1. Pelvic inflammatory disease - less cyclical symptom pattern and usually associated with an STI.

2. Ovarian cysts - may cause pelvic pain but not typically associated with menstrual cycle.

3. Irritable bowel syndrome - can cause abdominal pain but lacks menstrual correlation.

Speciality Filter: General Practice; Obstetrics And Gynaecology

Presenting Complaint Filter: Pelvic Pain; Menstrual Problems

Condition Filter: Endometriosis

Location Filter: General Practice

Case created by:

David , XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_29\_Endometriosis

Homepage Vignette:

## A 32-year-old woman named Elspeth MacQuarrie presents with dysmenorrhoea.

Individual Page Vignette:

You are a General Practitioner. Elspeth MacQuarrie, a 32-year-old, HR Manager, from your local area, comes to your clinic complaining of painful menstrual periods.

Patient Name:

Elspeth MacQuarrie (Pronunciation: Els-peth Mac-Kwah-ree); prefers to be called Elspeth.

Age:

Date of Birth: 15/06/1992

Location:

General Practice

Personality:

Elspeth is articulate and exudes a calm demeanor. She communicates her concerns clearly and appears well-informed about her health. She exhibits a high level of patience and listens attentively.

Presenting Complaint:

Elspeth is seeking medical attention for her recent exacerbations of pelvic pain, particularly around her menstrual periods, which she describes as "debilitating".

Quote: "It feels like there's a constant, unbearable pressure in my lower abdomen during my periods. It's been getting worse."

Symptoms:

- Site: Pelvic region; "It's mainly around my lower abdomen."

- Onset: Gradually worsening over the past year; "I've always had painful periods but nothing like this year."

- Character: Cramping, sharp; "It's like a stabbing pain mixed with intense cramps."

- Radiation: Does not radiate; "It stays pretty much in the same area."

- Associated Symptoms: Dysmenorrhoea; "My periods have become a nightmare."

- Timing: Primarily pre-menstrual and menstrual; "It kicks in a day or two before my period and doesn't let up."

- Exacerbating and Relieving Factors: Worsens with menstruation; "It's at its worst during my period." Relieved by heat and NSAIDs; "A hot water bottle and ibuprofen provide some relief, but not much."

- Severity: 8/10 during menstruation; "It's around 8 out of 10, unbearable at times."

PV Bleeding: Normal menstrual volume; "It's the usual amount."

PV Discharge: None.

Abdominal or Pelvic Pain: Present as described.

Chance of Pregnancy: Not pregnant; "There's zero chance I'm pregnant as I just took a test."

Dyspareunia: Yes; "Sex has become painful."

Post-coital PV Bleeding: No.

Intermenstrual PV Bleeding: No.

Vulval skin changes or itching: No.

Abdominal distention: No.

Breast changes: No.

Missed periods: No; "My periods are regular but just very painful."

Infertility: Not tried to conceive yet; "Haven't started trying for a baby."

Severe menstrual cramps: Yes, as described.

Chronic pelvic pain: Yes, has been ongoing for the past year.

History of Presenting Complaint:

- Elspeth has been experiencing severe pelvic pain for the past 12 months.

- She initially managed her symptoms with over-the-counter NSAIDs, but they have become less effective.

- Her symptoms have gradually worsened, particularly in relation to her menstrual cycle.

- The pain occurs consistently every month, associated with her menstrual period.

- The severity of her symptoms significantly impacts her daily life, making it difficult to work or stay active during her menstrual periods.

- Elspeth reports that her quality of life has declined, experiencing mood disturbances and occasional insomnia due to the pain.

Quote: "It's like my whole life is disrupted once a month. It's exhausting and frustrating."

Systemic Symptoms:

- Fatigue: Yes, "I'm always tired, especially when the pain peaks."

- Fever: No.

- Night Sweats: No.

- Unintended Weight Loss: No.

- Chest or Shoulder Tip Pain: No.

- Shortness of Breath or Cough: No.

- Change in Bowel Habits: "I've noticed more cramping with bowel movements during my periods."

- Change in Urinary Habits: No.

- Dysuria: No.

- Frequency: Normal.

- Urgency: Normal.

- Oedema: No.

- Rashes or Skin Changes: No.

- Headache: Occasionally; "I get headaches, but I think they're linked to stress."

- Mood Changes: "The constant pain and discomfort make me feel down."

- Sleep Disturbances: "The pain keeps me up at night."

Obstetric History:

Previous Obstetric History: G0 P0+0

Reproductive Plans: "I might want children in the future, but not right now."

Gynaecology History:

Menstrual History:

Duration: 5-7 days.

Frequency: Every 28 days.

Volume: Moderate.

Dysmenorrhoea: Severe.

Last Menstrual Period: "About two weeks ago."

Menarche: Age 13.

If on contraception: Not currently using contraception.

Previous Screens: Normal cervical screening 2 years ago.

Previous Gynaecology Conditions: No history of STIs or other gynecological conditions.

Contraception: Used oral contraceptive pills in the past; currently not using any form of contraception.

Past Medical History:

- No previous significant medical conditions.

- No previous surgeries or hospitalizations.

- No psychiatric or psychological history.

- Fully vaccinated, including HPV vaccine.

- No previous STIs.

- No other relevant medical conditions or significant health events.

“No medical of sorts, thankfully, until now by the looks of it.”

Allergies:

- No known allergies.

- “I don’t think I have any allergies.”

Family History:

- Mother has hypertension.

- Father was diagnosed with Type 2 diabetes.

- No known genetic conditions or cancers in the family.

“Just the usual blood pressure and blood sugar problems with my parents.”

Social History:

Lifestyle: "I try to stay active and eat healthily."

Occupation: HR Manager.

Activities of Daily Living & Hobbies: Enjoys hiking and reading.

Smoking: Non-smoker.

Alcohol: Drinks socially, approximately 4 units per week.

Recreational Drug Use: No.

Diet: Balanced diet, rich in fruits and vegetables.

Exercise: Regular, 3-4 times per week.

Sexual History:

Last sexual intercourse: "A month ago."

Current and previous partners: In a monogamous relationship for 5 years.

Any contraception used: None recently.

Ideas, Concerns, and Expectations:

- Ideas: "I've read about endometriosis and wonder if that's what I have."

- Concerns: "I'm worried about my fertility and the impact of this pain on my life."

- Expectations: "I'm hoping for a plan to manage this pain better and understand what's causing it."

Observations:

NEWS Total Score: 0

\*\*Physical Examination:\*\*

General Inspection:

- Overall appearance: Appears well-nourished and appropriately anxious due to discomfort.

- Signs of distress: Pain-related discomfort observed.

- Level of consciousness: Fully alert and oriented.

Objects and Equipment: None observed.

Hands:

Inspection:

- Colour: Normal.

- Peripheral oedema: None noted.

Palpitation:

- Temperature: Warm to touch.

- Capillary refill time (CRT): Less than 2 seconds.

- Radial pulse: Rate 72 beats/min, rhythm regular, volume normal.

Neck:

- No masses or goitres observed.

- JVP not elevated.

- No lymphadenopathy noted.

Face:

- No significant findings such as melasma, conjunctival pallor, or jaundice.

Abdominal Examination:

Inspection: No scars or visible masses.

Palpitation: Mild tenderness noted in the lower abdomen, no palpable masses.

Vaginal Examination:

Vulval Inspection: No ulcers, cysts, rashes, discharge, scarring, atrophy, lesions, masses, prolapses, or signs of lichen sclerosus noted.

Speculum Examination: Normal cervical os, no bleeding, erosions, masses, ulcers, or discharge observed. No cervical ectropion noted.

Bimanual Examination:

- Vaginal Walls: Normal

- Cervix: Anterior, firm, no cervical excitation pain.

- Uterus: Normal size, shape, and position; no masses, nodules, or tenderness.

- Ovaries: Not palpable, no masses.

Special Tests: None indicated at this point.

\*\*Diagnostic Tests:\*\*

Urine Dipstick: Negative for protien, blood, and glucose.

STI Screen: Negative results for Chlamydia, Gonorrhoea, Syphilis (blood test), and HIV (blood test).

Blood Tests (Reference Ranges):

- Full Blood Count (FBC): Within normal limits.

- Haemoglobin (Hb): 142 g/L (Female: 115 - 165 g/L)

- Mean Corpuscular Volume (MCV): 89 fL (80 – 100 fL)

- White Blood Cell Count: 7.2 x10^9/L (3.6 - 11.0 x10^9/L)

- Platelets: 250 x10^9/L (140 - 400 x10^9/L)

Urea and Electrolytes within normal limits.

- Sodium: 140 mmol/L (133–146 mmol/L)

- Potassium: 4.2 mmol/L (3.5–5.3 mmol/L)

Imaging Tests:

- Ultrasound Scan: Transvaginal ultrasound shows signs of endometriosis and associated cysts and adhesions.

\*\*Condition\*\*:

Endometriosis

\*\*Patient Questions\*\*:

1. "Is there a cure for this condition?"

- "Currently, there is no cure for endometriosis, but there are effective treatments to manage symptoms and improve your quality of life."

2. "Will this affect my chances of having children?"

- "Endometriosis can impact fertility in some women. However, many women with endometriosis do successfully conceive. It's important to discuss your personal risk and options with a fertility specialist."

3. "What are the treatment options available?"

- "Treatment options include pain relief medications, hormonal therapies to reduce or stop menstrual flow, and, in some cases, surgical interventions to remove endometrial tissue."

4. "How long will I need to be on treatment?"

- "The duration of treatment can vary widely depending on how well you respond and your personal circumstances, such as if you're planning for pregnancy. We will tailor the treatment plan to your needs and monitor your response."

\*\*Examiner Questions\*\*:

1. What are the clinical features of endometriosis?

- "Pelvic pain, dysmenorrhoea, dyspareunia, and sometimes infertility are classic symptoms of endometriosis."

2. How is endometriosis diagnosed?

- "Diagnosis is suspected based on clinical history and physical examination but can be confirmed by ultrasound or laparoscopy, which allows direct visualization of endometrial implants."

3. Describe the management plan for a patient with endometriosis.

- "Management includes NSAIDs for pain, hormonal contraceptives to suppress the menstrual cycle, GnRH agonists, and potentially surgical options for diagnosis and removing endometrial lesions."

4. What are the potential complications of untreated endometriosis?

- "Complications can include chronic pain, infertility, ovarian cysts, and potential complications from adhesions, such as bowel obstruction."

5. How does endometriosis affect fertility?

- "Endometriosis can lead to infertility by causing adhesions, ovarian cysts, and inflammation, all of which can impair the function of the ovaries, fallopian tubes, and uterus."

\*\*Treatment\*\*:

The treatment approach will be tailored based on Elspeth's symptoms, severity, and fertility considerations. Options include:

1. \*\*Pain management\*\*: Starting with NSAIDs like ibuprofen for pain relief during periods.

2. \*\*Hormonal Therapies\*\*: Combined oral contraceptives or progestogens to suppress ovulation and menstrual bleeding, reducing the growth of endometrial tissue.

3. \*\*GnRH agonists\*\*: Such as leuprorelin, for cases not responding to other therapies, understanding the potential side effects and use of add-back therapy to minimize bone density loss.

4. \*\*Surgical interventions\*\*: Considered for diagnosis, removal of endometrial tissue, and relief from symptoms, particularly in those not responding to medical management or with significant anatomy distortion.

\*\*Monitoring\*\*:

- Regular follow-up appointments every 3-6 months to monitor symptoms and treatment side effects.

- Annual ultrasound imaging if endometriomas or significant adhesions are present.

- Bone density scans if on long-term GnRH agonists.

- Fertility consultation if pregnancy is desired.

\*\*Prognosis\*\*:

- Endometriosis is a chronic condition with symptoms persisting over many years.

- Symptom relief and quality of life can significantly improve with appropriate management.

- Fertility may be affected, though many women with endometriosis can conceive naturally or with assistance.

- Regular monitoring and adjustments to treatment are often required to manage symptoms effectively.

\*\*Differential diagnoses\*\*:

1. Pelvic Inflammatory Disease - less likely due to lack of fever or elevated inflammatory markers.

2. Ovarian cysts - consideration given pelvic pain; ultrasound will help differentiate.

3. Irritable Bowel Syndrome - may coexist; however, the pattern of pain correlated with menstruation points more towards endometriosis.

4. Fibroids - can cause similar symptoms but usually associated with heavy menstrual bleeding.

\*\*Keyword Filters\*\*:

Speciality Filter:

Obstetrics and Gynaecology; General Practice.

Presenting Complaint Filter: Menstrual Problems; Pelvic Pain; Painful Sexual Intercourse.

Condition Filter: Endometriosis.

Location Filter: General Practice.

Case created by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_30\_Endometriosis

Homepage Vignette:

## A 27-year-old female called Eleanor presents with menstrual irregularities.

Individual Page Vignette:

You are a General Practitioner at a clinic evaluating Eleanor, a 27-year-old office manager. She presents with menstrual irregularities.

Patient Name:

Eleanor Maeving (Pronunciation: El-eh-nor May-ving). Eleanor prefers to be called 'Ela'.

Age:

27/06/1997

Location:

Clinic

Personality:

Eleanor has a calm and optimistic personality but exhibits signs of distress when discussing her symptoms. She speaks articulately and prefers to address issues directly.

Presenting Complaint:

Eleanor reports experiencing debilitating pelvic pain that worsens during menstruation. She also mentions irregular menstrual periods.

Quote:

"The pain I feel down there just before and during my period is unbearable at times. And my cycles? They're all over the place, really making planning anything a nightmare."

Symptoms:

- Site: Pelvic region, "It's mainly in my lower belly, sort of all over."

- Onset: Chronic, "I've had mild discomfort for years, but it's gotten much worse in the past few months."

- Character: Cramping and sharp, "It's like a constant cramping, but there are sharp pains that come and go too."

- Radiation: Does not radiate, "No, it pretty much stays in that one area."

- Associated Symptoms: Menstrual irregularities, "My periods are so unpredictable now."

- Timing: Cyclic, related to menstrual cycle, "It's worst around my period, but I also have some level of pain most days."

- Exacerbating and Relieving Factors: Exacerbated by menstruation, "The pain ramps up right before my period starts." Relief with over-the-counter pain medication, "I take painkillers, which dull it a bit, but it's still there."

- Severity: Severe pain, "On a scale from one to ten, it's often at an eight during my period."

PV Bleeding: Normal volume but increased pain.

PV Discharge: Normal volume, no unusual colour or smell.

Abdominal or Pelvic Pain: Severe, as described above.

Chance of Pregnancy: Low, "I've been careful, and with my irregular periods, it's tricky but I highly doubt it."

Dyspareunia: Present but not severe, "Yes, it's uncomfortable."

Post-coital PV Bleeding: None.

Intermenstrual PV Bleeding: Present, "I sometimes get spotting here and there."

Vulval skin changes or itching: None reported.

Abdominal distention, severe menstrual cramps, missed periods, dizziness during periods, and chronic pelvic pain are present.

Quote:

"My stomach does seem a bit bloated at times, especially before my period. And sometimes, I feel so dizzy during my periods; it's scary."

History of Presenting Complaint:

- Over two years experiencing symptoms, with a significant increase in severity over the past six months.

- Attempted using NSAIDs and heat packs with minimal relief.

- Symptoms have progressively worsened, affecting her work and daily activities.

- Irregular menstrual cycles with increased pain and occasional spotting.

- Pain intensity has escalated, leading to missed workdays and reduced participation in social activities.

Quote:

"It started off as just annoying period pain, but over the last six months, it's been a nightmare. I've missed work and had to cancel so many plans."

Systemic Symptoms:

- Fatigue: Present, "I'm always tired, no matter how much I sleep."

- Fever: None.

- Night Sweats: None.

- Unintended Weight Loss: None.

- Chest or Shoulder Tip Pain: None.

- Shortness of Breath or Cough: None.

- Change in Bowel Habits: Normal.

- Change in Urinary Habits: Normal.

- Dysuria:

- Frequency: Normal.

- Urgency: Normal.

- Oedema: None.

- Rashes or Skin Changes: None.

- Headache: Occasional, not severe, "I get headaches now and then, nothing crazy."

- Mood Changes: Present, related to pain and lifestyle impact, "It's hard to stay positive with all this going on."

- Sleep Disturbances: Mild difficulty falling asleep due to pain, "The pain makes it hard to find a comfortable position to sleep."

Quote:

"I just feel worn out all the time, and preparing for another sleepless night is dreadful."

Obstetric History:

Previous Obstetric History:

Gravidity and Parity: G0 P0+0

Reproductive Plans:

Hopes to have children in the future but concerned about current health issues.

Quote:

"I've always imagined being a mum one day, but with all these issues, it feels like that dream is slipping away."

Gynaecology History:

Menstrual History:

Duration: 5-7 days.

Frequency: Irregular, approximately 21-45 days apart.

Volume: Moderate to heavy.

Dysmenorrhoea: Severe.

Last Menstrual Period: Irregular, cannot accurately recall.

Menarche: 13 years old.

Contraception: Currently using oral contraceptive pills. Previous use of condoms.

Quote:

"I thought the pill would help regulate things, but it's been a bit of a hit and miss."

Past Medical History:

- Asthma, controlled with Salbutamol Inhaler.

- No previous surgeries or hospitalizations.

- No psychiatric or psychological history.

- Fully vaccinated, including HPV.

- No previous STIs.

- No significant injuries or traumas.

Quote:

"Yeah, I have asthma but it's well controlled. Aside from that, I've been relatively healthy, until now."

Drug History:

- Salbutamol Inhaler as needed: "I use it before exercise or whenever I feel wheezy."

- Oral contraceptive pills: "I'm currently on the pill for birth control and to try and manage my symptoms, though I'm not sure how much it's helping."

Quote:

"I stick to my asthma plan and take my pill regularly. I try to avoid taking too much pain medication, but some days it's necessary."

Allergies:

- Penicillin: Causes rash and swelling. "I had a bad reaction to penicillin when I was younger, scared me a bit."

Quote:

"It's just penicillin that I know of. I avoid it like the plague now."

Family History:

- Mother has hypertension.

- Father had a history of asthma, similar to the patient.

- No known family history of endometriosis or other significant gynaecological conditions.

Quote:

"My family's pretty healthy for the most part, though my dad and I share the asthma thing."

Social History:

Lifestyle: Leads a generally active lifestyle, walks to work, engages in light physical activities on weekends.

Occupation: Office manager.

Activities of Daily Living & Hobbies: Enjoys reading, cooking, and weekend hiking.

Smoking: Non-smoker.

Alcohol: Drinks socially, approximately 4 units per week.

Recreational Drug Use: None.

Diet: Tries to maintain a balanced diet, including plenty of fruits, vegetables, and whole grains.

Exercise: Light exercise routine, mainly walking and occasional yoga.

Quote:

"I try to stay active and healthy. It helps take my mind off the pain, even if just for a little while."

Sexual History:

Last sexual intercourse: Approximately 3 weeks ago.

Current Partner: In a monogamous relationship for 2 years.

Contraception Used: Oral contraceptive pills and condoms occasionally.

Quote:

"My partner is really understanding about everything. We're careful, especially with my irregular cycles."

---

\*\*Ideas, Concerns, and Expectations:\*\*

- Ideas: Eleanor understands that her symptoms might indicate a gynecological issue, possibly endometriosis, given her research on her symptoms. "I've read that my symptoms might be endometriosis, but I'm not sure."

- Concerns: Worried about her fertility and the impact of her condition on her future plans to have children. "I'm really scared this might mean I can't have kids."

- Expectations: Hopes to get a diagnosis and effective treatment to manage her symptoms. Eager for information on how this condition might affect her life and fertility. "I just want to know what's wrong and what we can do about it."

\*\*Observations:\*\*

- NEWS Total Score: 0

\*\*Physical Examination:\*\*

General Inspection: Appears in mild distress due to pain. No pallor or cachexia noted. No signs of oedema.

Objects and Equipment: None.

Hands:

Inspection: Normal color, no palmar erythema, no peripheral oedema.

Palpitation: Normal temperature, CRT <2 seconds, Radial pulse regular, rate normal, no peripheral oedema.

Neck:

No masses, goitres, JVP not elevated, no lymphadenopathy noted.

Face:

No melasma, conjunctival pallor, or signs of jaundice. No oedema or exophthalmos.

Abdominal Examination:

Inspection: Mildly distended, no visible scars.

Palpitation: Tender in the lower abdomen but no masses palpated.

Vaginal Examination:

- Vulval Inspection: No abnormalities detected.

- Speculum Examination: No cervical lesions or unusual discharge seen.

- Bimanual Examination: Tenderness in the adnexal regions, no palpable masses.

Diagnostic Tests:

- \*\*Urine Dipstick:\*\* Normal.

- \*\*STI Screen:\*\* Negative for full panel results.

- \*\*Blood Tests:\*\*

- \*\*Full Blood Count:\*\* Within normal ranges.

- \*\*CRP:\*\* <5 mg/L - within normal limits.

* Ultrasound Scan: Pelvic ultrasound reveals evidence of bilateral ovarian endometriomas with the largest measuring approximately 2cm on the left ovary. No significant free fluid in the pelvis.

Condition: Endometriosis

\*\*Patient Questions:\*\*

1. "What exactly is endometriosis and what causes it?"

- "Endometriosis is a condition where tissue similar to the lining inside the uterus is found outside the uterus, causing pain and other symptoms. The exact cause isn't known, but hormonal factors play a key role."

2. "Can endometriosis affect my fertility?"

- "It can in some cases, but many women with endometriosis do go on to have successful pregnancies. We'll manage your symptoms and monitor your condition closely."

3. "What are my treatment options?"

- "Treatment can include medications to manage pain and hormonal treatments to suppress endometriosis growth. In some cases, surgery might be necessary to remove the endometriosis tissue."

\*\*Examiner Questions:\*\*

1. How would you differentiate endometriosis from other causes of pelvic pain in a clinical assessment?

- "Through a combination of patient history, physical examination, imaging like ultrasound, and sometimes diagnostic laparoscopy."

2. What are potential complications of untreated endometriosis?

- "Complications can include severe chronic pain, ovarian cysts, infertility, and adhesions/scarring."

3. How does hormonal treatment help manage endometriosis symptoms?

- "Hormonal treatments aim to reduce or eliminate menstruation, limiting the growth of endometrial tissue and reducing symptoms."

4. Discuss the role of surgery in endometriosis management.

- "Surgery, primarily laparoscopic, is used to remove endometrial tissue, which can help alleviate pain and improve fertility prospects for some women."

\*\*Treatment:\*\*

1. \*\*First-line Treatment:\*\* NSAIDs for pain relief and combined oral contraceptives to manage symptoms.

2. \*\*Second-line Treatment:\*\* Consider gonadotropin-releasing hormone agonists if symptoms persist or for those not planning pregnancy soon.

3. \*\*Surgical Options:\*\* Laparoscopy for diagnosis and removal of endometriosis tissue is recommended in cases not responding to medical therapy or if fertility is a concern.

\*\*Monitoring:\*\*

- Regular follow-up appointments to monitor symptom control and side effects of medication.

- Adjust treatment based on response and patient preferences.

- Consider referral to a gynaecologist for further management or surgery if indicated.

\*\*Prognosis:\*\*

- While incurable, endometriosis symptoms can be managed effectively with a combination of medical and surgical treatments.

- Fertility may be affected, but early and aggressive management can improve outcomes.

- Periodic monitoring and changes in treatment approach may be necessary based on symptom progression and patient goals.

\*\*Differential Diagnoses:\*\*

1. Pelvic Inflammatory Disease - Less likely due to lack of severe infectious symptoms or evidence of an STI.

2. Ovarian Cysts - Could present similarly but typically with distinctive findings on ultrasound.

3. Irritable Bowel Syndrome - Overlaps with abdominal pain and discomfort but lacks menstrual correlation and other gynaecologic symptoms.

\*\*Keyword Filters:\*\*

Speciality Filter: Obstetrics And Gynaecology; General Practice;

Presenting Complaint Filter: Pelvic Pain; Menstrual Problems;

Condition Filter: Endometriosis;

Location Filter: Clinic;

Case created by:

David, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_31\_Fibroids

Homepage Vignette:

## A 32-year-old woman called Amelia presents with menstrual irregularities.

Individual Page Vignette:

You are a GP in a clinic, and your patient today is Amelia, a 32-year-old primary school teacher from the local area, presenting with menstrual irregularities and pelvic pain.

Patient Name:

Amelia Blythe Thompson (Pronunciation: A-meel-ya Bl-eye-th Thomp-sun). She prefers to be called Amelia.

Age:

17/06/1992

Location:

General Practice

Personality:

Amelia is articulate and expresses her concerns clearly. She has a calm demeanour but becomes visibly anxious when discussing her symptoms and their impact on her life.

Presenting Complaint:

Amelia has come in due to experiencing increasingly heavy and painful periods over the past six months, coupled with intermittent pelvic pain that seems unrelated to her menstrual cycle.

Quote: "My periods have just been out of control lately, and sometimes the pain in my lower belly just comes out of nowhere, even when I'm not on my period."

Symptoms:

- Site: Pelvic area. "It feels like the pain and heaviness are right in my lower stomach."

- Onset: Gradual over six months. "This all started slowly but it's just getting worse."

- Character: Cramping. "It’s like really bad cramps, even when I don’t have my period."

- Radiation: Does not radiate. "The pain stays in my lower belly, doesn’t really go anywhere else."

- Associated Symptoms: Menorrhagia. "My periods have been so heavy; it’s like I can't keep up."

- Timing: Intermittent. "There doesn’t seem to be a pattern, it can be anytime."

- Exacerbating and Relieving Factors: Noticed increase with periods. "When I’m on my period it’s like the floodgates open and the pain is worse."

- Severity: 7/10 during menstruation, 4/10 intermittent pain. "It's sometimes just bearable, but during my periods, it's just too much."

PV Bleeding: Heavy menstrual bleeding, darker red without unusual smell.

PV Discharge: Normal.

Abdominal or Pelvic Pain: Intermittent, severe during menstruation.

Chance of Pregnancy: None, using contraception.

Dyspareunia: Not present.

Post-coital PV Bleeding: Not present.

Intermenstrual PV Bleeding: Not present.

Vulval skin changes or itching: Not present.

Associated Symptoms Quote: "Sometimes I feel so bloated, and my periods have been nightmarish."

History of Presenting Complaint:

- Experiencing symptoms for around six months.

- No previous treatments attempted.

- Symptoms have progressively worsened over time.

- Frequency of symptoms has increased, particularly noted with menstrual cycle.

- Significant impact on daily life due to the unpredictability and severity of symptoms.

- Has had to take time off work during particularly bad periods.

- Describes a decline in mental wellbeing due to stress and discomfort.

Quote: "It's been half a year of just trying to deal with it, but it's getting to the point where I can't ignore it anymore. It's affecting my work and, honestly, my mood as well."

Systemic Symptoms:

- Fatigue: Reports feeling more tired than usual. "I just feel drained all the time now."

- Fever: None reported.

- Night Sweats: None reported.

- Unintended Weight Loss: None reported.

- Chest or Shoulder Tip Pain: None.

- Shortness of Breath or Cough: None.

- Change in Bowel Habits: Reports occasional constipation. "Sometimes I just can't seem to go, which isn’t normal for me."

- Change in Urinary Habits: Increased frequency but no dysuria. "I’ve been needing to pee more often, but it doesn’t hurt or anything."

- Oedema: None.

- Rashes or Skin Changes: None.

- Headache: Occasional mild headaches. "I’ve gotten a few headaches here and there, nothing too bad though."

- Mood Changes: Reports feeling more anxious and stressed. "All this has really been getting to me, making me feel quite anxious."

- Sleep Disturbances: Occasional difficulty sleeping. "Sometimes it's hard to get to sleep, with the pain and all."

Quote for Systemic Symptoms: "Apart from feeling tired and a bit stressed, I don’t think there’s anything else going on that I’ve noticed."

Obstetric History:

Previous Obstetric History:

Gravidity and Parity: G0 P0

Reproductive Plans:

"Right now, I'm not sure about having children, but maybe in the future. It's not off the table."

Gynaecology History:

Menstrual History:

Duration: 7 days.

Frequency: Every 28-30 days.

Volume: Heavy, especially in the first 3 days.

Dysmenorrhoea: Yes, severe.

Last Menstrual Period: 2 weeks ago.

Menarche: Age 13.

Previous Screens:

Cervical screening up-to-date, last done 12 months ago with no abnormalities detected.

Previous Gynaecology Conditions: None reported.

Previous STIs: None reported.

Contraception: Currently using oral contraceptive pills, no change in the menstrual pattern since starting.

Quote: "The pain during my period is just unbearable sometimes. And no, I’ve not noticed any difference since I started taking the pill."

Past Medical History:

- Asthma, managed with Salbutamol inhaler as needed.

- No previous surgeries or hospitalizations.

- No significant injuries or traumas.

- No history of alcohol or substance abuse.

- Vaccinations up-to-date, including HPV.

- No previous STIs.

- No other significant medical conditions or health events.

Quote: "Aside from my asthma, which I've had since I was a kid, I'm generally pretty healthy, I think."

Drug History:

- Salbutamol inhaler, as needed for asthma.

- Oral contraceptive pills, taken as prescribed.

- No history of non-compliance or overdose incidents.

- No use of herbal supplements or alternative therapies mentioned.

Quote: "I use my inhaler when I need it, and I'm pretty diligent with my contraceptive pill."

Allergies:

- Penicillin: Causes hives.

Quote: "I found out I was allergic to Penicillin the hard way, ended up covered in itchy hives."

Family History:

- Mother has hypertension, managed with medication.

- Father has type 2 diabetes.

- No known family history of gynaecological conditions.

Quote: "My mum has high blood pressure, and my dad's diabetic, but that's about it for family health issues."

Social History:

Lifestyle:

Occupation: Primary school teacher.

Activities of Daily Living & Hobbies: Enjoys outdoor activities and reading.

Smoking: None.

Alcohol: Social drinker, approximately 4 units per week.

Recreational Drug Use: None.

Diet: Balanced diet, tries to eat healthily.

Exercise: Goes for runs 3 times a week.

Quote: "I try to stay active and healthy; teaching kids all day keeps me on my toes, and I enjoy a run to clear my head."

Sexual History:

Last sexual intercourse: 1 month ago.

Current and previous partners: In a monogamous relationship for the past 3 years.

Contraception used: Oral contraceptive pills.

Quote: "I've been with my partner for three years, and we're pretty careful with contraception."

Ideas, Concerns, and Expectations:

- Ideas: Suspects her symptoms might be due to hormonal issues.

- Concerns: Worried about her symptoms affecting her ability to work and about the possibility of fertility issues in the future.

- Expectations: Hopes to get a diagnosis and effective treatment to manage her symptoms.

Quote: "I'm worried there's something really wrong that could affect me having kids later on. I just want to know what's going on and how to fix it."

Observations:

NEWS Total Score: 0

Physical Examination:

General Inspection:

- Overall appearance: Well-nourished and well-hydrated.

- No signs of distress, cachexia, or oedema.

- No obvious scars or abnormal findings.

Objects and Equipment:

- No mobility aids or equipment present.

Hands:

- Inspection: Normal colour, no palmar erythema or peripheral oedema.

- Palpation: Warm to touch, CRT < 2 seconds, radial pulse regular in rate and volume.

Neck:

- No masses, goitres, lymphadenopathy, or abnormalities in JVP noted.

Face:

- No melasma, conjunctival pallor, jaundice, oedema, exophthalmos, corneal arcus, xanthelasma, or Kayser-Fleischer rings noted.

Abdominal Examination:

- Inspection: Abdomen appears normal, no distention or visible abnormalities.

- Palpation: Soft, non-tender, no masses palpated.

Vaginal Examination:

- Vulval Inspection: No ulcers, cysts, rashes, discharge, scarring, atrophy, lesions, masses, evidence of FGM, prolapses, or lichen sclerosis noted.

- Speculum Examination: Cervical os appears normal, no bleeding, erosions, masses, ulcers, discharge, or cervical ectropion observed.

- Bimanual Examination: Uterus of normal size, shape, and position with no masses, nodules or tenderness. Ovaries not palpable, no masses noted.

Special Tests:

- No additional specific special tests conducted during the initial physical examination.

Diagnostic Tests:

- Urine Dipstick: Normal

- STI Screen: Results negative

Blood Tests (Reference Ranges):

- Full Blood Count (FBC):

- Haemoglobin (Hb): Result within range (Female: 115 - 165 g/​L)

- Mean Corpuscular Volume (MCV): Result within range (80 – 100 fL)

- White Blood Cell Count: Result within range (3.6 - 11.0 x10^9/L)

- Platelets: Result within range (140 - 400 x10^9/L)

- Urea and Electrolytes:

- Sodium, Potassium, Urea, Creatinine: All results within normal ranges.

Imaging Tests:

- Ultrasound Scan: Submucosal Uterine fibroids present and visible.

Treatment:

The treatment for Fibroids is multifaceted and based on symptom severity, desire for fertility, and fibroid characteristics. Following NICE guidelines:

1. Pharmacological Treatments:

- For pain management and heavy menstrual bleeding, non-steroidal anti-inflammatory drugs (NSAIDs) like ibuprofen may be used.

- Gonadotropin-releasing hormone (GnRH) analogues like Leuprorelin may be considered for short-term use to reduce fibroid size and blood loss. However, they are not a long-term solution due to potential bone density loss with prolonged use.

- Tranexamic acid may also be recommended during menstruation to reduce bleeding.

2. Surgical Interventions: If symptoms are severe and medical management is insufficient or if there's a desire for fertility preservation:

- Hysteroscopic resection for submucosal fibroids.

- Myomectomy for removal of fibroids, preserving the uterus.

- Uterine Artery Embolization (UAE) can be an option, especially for women who wish to avoid surgery.

3. Monitoring and Follow-Up: Patients should be monitored for symptom relief and potential side effects of treatments. Regular follow-ups are essential to assess the need for treatment adjustments or additional interventions.

Prognosis:

- Many women with fibroids experience significant improvement with proper treatment.

- The chance of symptom recurrence exists, especially if not all fibroids are removed or if new ones develop.

- Fertility can be affected but many women with fibroids can still conceive and carry a pregnancy to term.

Differential diagnoses:

1. Endometriosis: Similar symptoms but often associated with more extensive menstrual pain. Less likely without a history of painful intercourse or cyclical symptoms besides menstruation.

2. Adenomyosis: Presents similarly but typically in a slightly older age group. Characterized by the presence of endometrial tissue within the uterine muscle.

3. Ovarian cysts: Might cause irregular periods and pelvic pain but often have pain more localized to one side.

4. Pelvic Inflammatory Disease (PID): Similar pelvic discomfort and menstrual irregularities. More likely if there are risk factors such as new sexual partners without a consistent use of barrier contraception.

Keyword Filters:

Speciality Filter: Obstetrics And Gynaecology; General Practice;

Presenting Complaint Filter: Menstrual Problems; Pelvic Pain;

Condition Filter: Fibroids;

Location Filter: General Practice ;

Case created by:

David, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_32\_Fibroids

Homepage Vignette:

## A 45-year-old female called Georgina Scattergood presents with excessive menstrual bleeding.

Individual Page Vignette:

As a General Practitioner, you are seeing a 45-year-old patient called Georgina, a secondary school teacher from a local clinic. Georgina presents with complaints of excessive menstrual bleeding and ongoing pelvic pain.

Patient Name:

Georgina Scattergood (Pronunciation: Jor-JEE-nah Scatter-good), prefers to be called Georgina.

Age:

Date of Birth: 14/02/1979

Location:

Clinic

Personality:

Georgina is articulate and has a warm demeanour despite her discomfort. She speaks clearly and concisely about her symptoms, expressing her concerns with a certain composed urgency. She demonstrates a high level of self-awareness and is proactive about seeking medical care.

Presenting Complaint:

Georgina has come to the clinic concerned about her recent experiences of excessive menstrual bleeding and persistent lower abdominal pain.

Quote: "I've always had slightly heavier periods, but now, it’s like a tap that I can’t turn off. And the pain, it’s always there, nagging at me."

Symptoms:

- Site: Pelvic area. "It feels like it's all over my lower belly."

- Onset: Gradual worsening over the past 6 months. "It's been getting worse for half a year, I’d say."

- Character: Aching and heavy. "It feels like a constant heavy ache."

- Radiation: Does not radiate. "No, it doesn’t move, just stays put right there."

- Associated Symptoms: Excessive menstrual bleeding. "It’s a lot, much more than usual."

- Timing: Symptoms are constant with worsening during menstruation. "It’s always there, but turns unbearable during my periods."

- Exacerbating and Relieving Factors: Relief with over-the-counter pain medication; exacerbated by physical exertion. "Taking ibuprofen helps a bit, but if I do too much, it gets worse."

- Severity: Moderate to severe. "On a scale of 1 to 10, it oscillates between 6 and 8."

Negative Findings:

- PV Bleeding: Heavy menstrual bleeding, no other bleed.

- PV Discharge: No abnormal discharge.

- Abdominal or Pelvic Pain: Consistent lower pelvic pain as described.

- Chance of Pregnancy: Negligible, currently on contraception.

Positive Findings:

- Dysmenorrhoea: Severe menstrual cramps.

- Missed Periods: Irregular.

Quote: "The cramps feel like they’re tearing me apart, and sometimes my periods just skip a month without any warning."

History of Presenting Complaint:

- Symptoms have been progressively worsening over the past 6 months.

- Over-the-counter pain relievers provide some relief; however, no specific treatments for fibroids have been attempted.

- Symptoms have fluctuated in frequency - with menstrual periods being heavier and more painful.

- Georgina reports a significant impact on her daily activities, particularly during her menstrual cycle.

- Experiences limitations at work due to pain and excessive bleeding.

- Expresses concerns about the growing impact on her mental wellbeing and quality of life.

Quote: "It feels like I’m constantly battling my body. It's wearing me down, both physically and mentally."

Systemic Symptoms:

- Fatigue: Reports feeling unusually tired. "I feel wiped out most days."

- All other systemic symptoms are normal.

Quote for each systemic symptom:

- "Yes, I feel tired, but no, no fever or anything else really."

Obstetric History:

Previous Obstetric History: G2 P2+0

- >24 Weeks Pregnancies: Two full-term pregnancies.

- Gestation at Delivery(s): 38 weeks and 39 weeks.

- Birth Weight(s): 3.2kg and 3.4kg.

- Mode of Birth(s): Natural, no complications.

- Complications: None.

- Stillbirths: None.

- <24 Weeks Pregnancies: None.

- Miscarriages: None.

- Terminations: None.

- Ectopic Pregnancies: None.

Reproductive Plans:

- Not planning to have more children.

Quote: "My family is complete, and I’m not planning to add more to it."

Gynaecology History:

Menstrual History:

- Duration: 7-8 days.

- Frequency: Every 28-32 days, but has been irregular lately.

- Volume: Heavy, increased significantly.

- Dysmenorrhoea: Severe.

Last Menstrual Period:

- Approximately 3 weeks ago.

Menarche:

- Age 13.

Menopause:

- Not yet menopausal.

Contraception:

- Currently using oral contraceptives.

Quote: "My periods have become a nightmare, really heavy and painful."

Past Medical History:

- Asthma, well-controlled.

- No previous surgeries or hospitalisations.

- No history of substance abuse.

- Vaccinations up to date, including HPV vaccine.

- No previous STIs.

- No other significant medical conditions.

Quote: "Apart from my asthma, I’ve been generally healthy."

Drug History:

- Salbutamol inhaler as needed for asthma.

- Oral contraceptive pills.

- Ibuprofen during menstruation for pain relief.

Quote: "I use my inhaler occasionally and take ibuprofen to manage the period pain."

Allergies:

- Penicillin: Causes rash and swelling.

Quote: "Penicillin doesn’t agree with me, last time it made me all swollen and itchy."

Family History:

- Mother had hypertension.

- Father had type 2 diabetes.

- No history of fibroids or similar conditions in the family.

Quote: "Mum has blood pressure issues and Dad’s sugar levels are a bit of a concern."

Social History:

Lifestyle:

- Non-smoker.

- Alcohol: Drinks socially, approximately 3 units per week.

- Does not use recreational drugs.

- Balanced diet.

- Moderate exercise, including yoga and walking.

Occupation:

- Secondary school teacher.

Activities of Daily Living & Hobbies:

- Enjoys reading and gardening.

Quote: "I try to keep active and engaged, it’s my way of coping."

Sexual History:

- Last sexual intercourse was two weeks ago.

- Married, monogamous relationship.

- Uses oral contraception.

Quote: "My husband and I have a healthy relationship, but my symptoms do affect our intimacy at times."

Ideas, Concerns, and Expectations:

- Ideas: Suspects her symptoms might be due to hormonal issues.

- Concerns: Worried about her symptoms affecting her ability to work and about the possibility of fertility issues in the future.

- Expectations: Hopes to get a diagnosis and effective treatment to manage her symptoms.

Quote: "I'm worried there's something really wrong that could affect me having kids later on. I just want to know what's going on and how to fix it."

Observations:

NEWS Total Score: 0

Physical Examination:

General Inspection:

- Overall appearance: Well-nourished and well-hydrated.

- No signs of distress, cachexia, or oedema.

- No obvious scars or abnormal findings.

Objects and Equipment:

- No mobility aids or equipment present.

Hands:

- Inspection: Normal colour, no palmar erythema or peripheral oedema.

- Palpation: Warm to touch, CRT < 2 seconds, radial pulse regular in rate and volume.

Neck:

- No masses, goitres, lymphadenopathy, or abnormalities in JVP noted.

Face:

- No melasma, conjunctival pallor, jaundice, oedema, exophthalmos, corneal arcus, xanthelasma, or Kayser-Fleischer rings noted.

Abdominal Examination:

- Inspection: Abdomen appears normal, no distention or visible abnormalities.

- Palpation: Soft, non-tender, no masses palpated.

Vaginal Examination:

- Vulval Inspection: No ulcers, cysts, rashes, discharge, scarring, atrophy, lesions, masses, evidence of FGM, prolapses, or lichen sclerosis noted.

- Speculum Examination: Cervical os appears normal, no bleeding, erosions, masses, ulcers, discharge, or cervical ectropion observed.

- Bimanual Examination: Uterus of normal size, shape, and position with no masses, nodules or tenderness. Ovaries not palpable, no masses noted.

Special Tests:

- No additional specific special tests conducted during the initial physical examination.

Diagnostic Tests:

- Urine Dipstick: Normal

- STI Screen: Results negative

Blood Tests (Reference Ranges):

- Full Blood Count (FBC):

- Haemoglobin (Hb): Result within range (Female: 115 - 165 g/​L)

- Mean Corpuscular Volume (MCV): Result within range (80 – 100 fL)

- White Blood Cell Count: Result within range (3.6 - 11.0 x10^9/L)

- Platelets: Result within range (140 - 400 x10^9/L)

- Urea and Electrolytes:

- Sodium, Potassium, Urea, Creatinine: All results within normal ranges.

Imaging Tests:

- Ultrasound Scan: Submucosal Uterine fibroids present and visible.

Patient Questions:

1. "Can I still have children after treatment for fibroids?"

- Yes, treatments like myomectomy are specifically designed to remove fibroids while preserving fertility. However, the impact on future pregnancies can vary depending on the treatment chosen and the severity of the fibroids.

2. "Will I need to have surgery?"

- Surgery is one of several treatment options, depending on the size and location of your fibroids, your symptoms, and your personal and reproductive goals. We can explore medical management and minimally invasive procedures as well.

3. "Are fibroids cancerous?"

- No, fibroids are benign (non-cancerous) tumours of the uterus. However, they can cause symptoms that significantly impact your quality of life, which is why treatment is recommended.

4. "Do fibroids come back after treatment?"

- Fibroids can recur, especially with medical management alone. That's why we closely monitor your symptoms and the size of any remaining fibroids after treatment.

Examiner Questions:

1. What are the first-line pharmacological treatments for managing fibroids-related heavy menstrual bleeding?

- Tranexamic acid and NSAIDs are considered first-line treatments for heavy menstrual bleeding associated with fibroids.

2. Describe the differences between a myomectomy and hysterectomy in the management of fibroids.

- Myomectomy involves the surgical removal of fibroids while preserving the uterus, suitable for women wishing to maintain fertility. Hysterectomy is the removal of the uterus, offering definitive treatment but eliminating fertility.

3. How does the levonorgestrel-releasing IUD work in managing fibroids symptoms?

- The levonorgestrel-releasing IUD works by thinning the endometrial lining, reducing menstrual bleeding, and decreasing fibroid symptoms.

4. What considerations should be made when prescribing GnRH analogues for fibroids?

- GnRH analogues induce a temporary menopause-like state, reducing fibroid size and symptoms, but are usually prescribed for a limited duration due to side effects like osteoporosis risk.

Treatment:

The management of fibroids primarily depends on the severity of symptoms, the patient's age, and her reproductive plans. Georgina Scattergood's treatment plan would be formulated based on the guidelines from NICE and BMJ Best Practice:

1. Pharmacological Management:

- Tranexamic acid 1 g three times daily during menstruation, if heavy menstrual bleeding is the main symptom.

- Non-steroidal anti-inflammatory drugs (NSAIDs) like ibuprofen 400 mg three times daily during menstruation for pain.

- Consideration of Gonadotropin-releasing hormone (GnRH) analogues, like Leuprorelin, for short-term use to reduce fibroid size and symptoms, especially if surgery is planned.

2. Intrauterine Devices (IUD):

- Levonorgestrel-releasing intrauterine system (LNG-IUS) can be considered as it reduces menstrual blood loss and improves symptoms.

3. Surgical Options:

- Myomectomy for women who wish to retain their uterus and fertility.

- Hysterectomy for definitive treatment in patients with no desire for future pregnancies, considering the patient's age and symptom severity.

- Uterine artery embolization (UAE) as a non-surgical option for symptom relief.

4. Other:

- Iron supplements should be prescribed if there's evidence of anaemia due to heavy menstrual bleeding.

Dosages and frequencies are as per British National Formulary guidelines.

Monitoring:

- Regular follow-up appointments every 6 to 12 months to monitor symptoms and treatment efficacy.

- Annual pelvic examination and ultrasound to monitor fibroid size and uterine health.

- Haemoglobin levels should be checked annually to monitor for anaemia.

- Check-in on patient's mental wellbeing and quality of life at each appointment.

- If undergoing GnRH analogue therapy, bone density should be monitored due to the risk of osteoporosis with long-term use.

Prognosis:

- Symptom relief is usually achieved with appropriate medical management; however, fibroids may recur, needing further intervention.

- Surgical interventions like hysterectomy provide definitive relief from symptoms but come with their risks and the consideration of the patient’s fertility desires.

- Myomectomy and UAE are effective in symptom reduction but may not prevent the recurrence of fibroids.

- Long-term prognosis is generally good, with a significant improvement in the quality of life post-treatment.

Differential diagnoses:

1. Adenomyosis - Presents similarly but often diffusely enlarges the uterus.

2. Endometrial Cancer - More common in postmenopausal women, often presents with postmenopausal bleeding.

3. Pelvic Inflammatory Disease - Typically presents with fever and pelvic pain, often with a history of STIs.

4. Ovarian Cysts - Can cause pain and menstrual irregularities but are typically identified via ultrasound.

5. Endometrial Polyps - Can cause heavy menstrual bleeding but often are smaller and localized to the endometrial cavity.

Keyword Filters:

Speciality Filter: Obstetrics And Gynaecology; General Practice; Clinical Imaging

Presenting Complaint Filter: Menstrual Problems; Pelvic Pain; Abnormal Menstrual Bleeding

Condition Filter: Fibroids

Location Filter: Clinic

Treatment, monitoring, prognosis, differential diagnoses, and further instructions provide a comprehensive approach to managing a complex case like Georgina Scattergood's fibroids situation. It incorporates current guidelines and practices, focusing on patient-centred care and considering the patient's future reproductive plans.

Case created by:

David, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Given the complexity and multitude of sections required for this detailed patient case simulation, let's start with the first half of the case, focusing on creating a comprehensive narrative for our patient with Fibroids.

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\*\*Case Code:\*\*

# DWZHB\_33\_Fibroids

\*\*Homepage Vignette:\*\*

## A 34-year-old female called Elizabeth McEwan presents with heavy menstrual bleeding.

\*\*Individual Page Vignette:\*\*

You are a GP in a clinic. Elizabeth McEwan, a 34-year-old office manager, comes to you presenting with heavy menstrual bleeding.

\*\*Patient Name:\*\*

Elizabeth McEwan (El-lis-a-beth Mac-you-wen); prefers to be called Elizabeth.

\*\*Age:\*\*

15/07/1989

\*\*Location:\*\*

Clinic

\*\*Personality:\*\*

Elizabeth is articulate, expressing her concerns with clarity and precision. She maintains eye contact and articulates her thoughts coherently, indicating a high level of education and a reflective personality.

\*\*Presenting Complaint:\*\*

"I've been experiencing really heavy menstrual flows for the past six months, and the pain in my lower abdomen is becoming hard to ignore."

\*\*Symptoms:\*\*

- \*\*Site:\*\* Pelvic region

- "The pain's mostly in my lower belly, just below my belly button."

- \*\*Onset:\*\* 6 months ago

- "This began around six months back."

- \*\*Character:\*\* Crampy

- "It feels like a very bad cramp."

- \*\*Radiation:\*\* Does not radiate

- "The pain stays right there in my belly."

- \*\*Associated Symptoms:\*\* Menorrhagia

- "My periods have gotten so heavy, it's alarming."

- \*\*Timing:\*\* Cyclic, coinciding with menstrual cycle

- "It's worst during my period but I feel dull pain through the month as well."

- \*\*Exacerbating Factors:\*\* Menstruation

- "It gets really bad during my periods."

- \*\*Relieving Factors:\*\* NSAIDs

- "Taking painkillers does offer some relief."

- \*\*Severity:\*\* 7/10

- "On a scale from one to ten, it's around a seven."

\*\*PV Bleeding:\*\*

- Volume: Increased

- Colour: Bright red

- Consistency: Clots present

- Smell: Normal

- "My period is much heavier than it used to be, with clots."

\*\*PV Discharge:\*\* Negative

\*\*Abdominal or Pelvic Pain:\*\*

- Result: Described as described in symptoms

\*\*Chance of Pregnancy:\*\* Negative

\*\*Dyspareunia:\*\* Mild discomfort

- "It's been slightly uncomfortable during sex lately."

\*\*Post-coital PV Bleeding:\*\* Negative

\*\*Intermenstrual PV Bleeding:\*\* Occasional spotting

- "I've noticed light spotting between periods as well."

\*\*Post-menopausal Bleeding:\*\* Not applicable

\*\*Vulval skin changes or itching:\*\* Negative

\*\*Other Symptoms:\*\*

- \*\*Abdominal distention:\*\* Mild

- "I've noticed my belly seems a bit swollen."

- \*\*Breast lumps:\*\* Negative

- \*\*Painful menstruation:\*\* Positive

- "My periods are painfully heavy."

- \*\*Missed periods:\*\* Negative

- \*\*Infertility:\*\* Not trying for pregnancy

- \*\*Severe menstrual cramps:\*\* Positive

- "The cramps during my period are getting worse."

\*\*History of Presenting Complaint:\*\*

- \*\*Duration of symptoms:\*\* 6 months

- \*\*Previous treatments:\*\* NSAIDs for pain relief

- \*\*Symptoms progression:\*\* Gradual increase in severity and discomfort

- \*\*Frequency of symptoms:\*\* Cyclic, worsens during menstruation

- \*\*Impact on daily life:\*\* Significant, impairs ability to work effectively during periods

- \*\*Impact on work:\*\* Has to take leave during heavy days

- \*\*Impact on physical and mental wellbeing:\*\* Increasingly stressed and anxious about her health

- "I'm just not myself anymore. The constant worrying and discomfort take a toll on me."

\*\*Systemic Symptoms:\*\*

- \*\*Fatigue:\*\* Moderate

- "I've been feeling more tired than usual."

- \*\*Fever:\*\* Negative

- \*\*Night Sweats:\*\* Negative

- \*\*Unintended Weight Loss:\*\* Negative

---

\*\*Obstetric History:\*\*

\*\*Previous Obstetric History:\*\* G0 P0

\*\*Reproductive Plans:\*\* "I'm not sure about children right now, but it's something I might consider in the future."

\*\*Gynaecology History:\*\*

\*\*Menstrual History:\*\*

- Duration: 7 days

- Frequency: Every 28 days

- Volume: Increased in the last 6 months

- Dysmenorrhoea: Yes, severe

\*\*Last Menstrual Period:\*\* Accurate date one week ago reflecting regular cycles

\*\*Menarche:\*\* Age 12

\*\*Contraception:\*\* "I've been on the combined oral contraceptive pill for the past 10 years."

\*\*Previous Screens:\*\* Negative for abnormalities

\*\*Previous Gynaecology Conditions:\*\* Negative

\*\*Previous STIs:\*\* Negative

\*\*Past Medical History:\*\*

- Asthma, well-controlled with inhalers.

- No surgeries or hospitalisations.

- Fully vaccinated, including HPV vaccine.

- "I keep my vaccinations up to date."

\*\*Drug History:\*\*

- Combined Oral Contraceptive Pills, as prescribed.

- Salbutamol inhaler, 100mcg, use as needed for asthma.

- "I'm very diligent about taking my medications as prescribed."

\*\*Allergies:\*\*

- Penicillin causes a rash.

- "Penicillin makes me come out in a rash."

\*\*Family History:\*\*

- Mother has hypertension.

- Father had prostate cancer.

- "Mum has high blood pressure, and Dad had cancer a few years back."

\*\*Social History:\*\*

\*\*Lifestyle:\*\* Active social life

\*\*Occupation:\*\* Office Manager

\*\*Activities of Daily Living & Hobbies:\*\* Enjoys hiking and painting

\*\*Smoking:\*\* 0 pack years

\*\*Alcohol:\*\* Consumes 5 units per week

\*\*Recreational Drug Use:\*\* Negative

\*\*Diet:\*\* Balanced, vegetarian.

\*\*Exercise:\*\* Regular, 3 times a week gym sessions.

"I make sure to keep active and eat well. It's important to me."

\*\*Sexual History:\*\*

- Last sexual intercourse: 2 weeks ago

- Current and previous partners: In a monogamous relationship for 3 years.

- Contraception used: Combined oral contraceptive pill.

"We've been together for a while now, and we're careful about protection."

\*\*Ideas, Concerns, and Expectations:\*\*

- Worried about the cause of her symptoms and the potential impact on her fertility.

- Hopes to find a treatment that can manage her symptoms without significant side effects.

- "I'm really worried this could affect my ability to have children in the future."

\*\*Observations:\*\*

- \*\*NEWS Total Score:\*\* 0

\*\*Physical Examination:\*\*

\*\*General Inspection:\*\* Well-looking, no obvious distress

\*\*Abdominal Examination:\*\* Mild enlargement palpable

\*\*Vaginal Examination:\*\*

- \*\*Vulval Inspection:\*\* Normal

- \*\*Speculum Examination:\*\* Cervix appears normal, no visible lesions

- \*\*Bimanual Examination:\*\* Uterus mildly enlarged, no adnexal masses palpable

\*\*Diagnostic Tests:\*\*

- \*\*Urine Dipstick:\*\* Normal

- \*\*Vaginal Swab:\*\* Negative for infection

- \*\*STI Screen:\*\* Negative

\*\*Blood Tests (Reference Ranges):\*\*

- \*\*Full Blood Count (FBC):\*\* Within normal limits

- \*\*Urea and Electrolytes:\*\* Within normal range

\*\*Imaging Tests:\*\*

- \*\*Ultrasound Scan:\*\* Shows multiple fibroids with the largest measuring 4cm in the anterior wall of the uterus.

\*\*Condition:\*\*

Fibroids

\*\*Patient Questions:\*\*

- "Could this affect my chances of having a baby?"

(Reassure that many women with fibroids conceive and carry a pregnancy to term. The impact on fertility can depend on the size and location of the fibroids.)

- "What treatment options are available?"

(Discuss medical management, such as GnRH agonists to reduce size/prep for surgery, and surgical options like myomectomy for fertility preservation.)

- "Will I need surgery?"

(Explain that it depends on symptom severity, fibroid size/location, and patient's reproductive plans.)

\*\*Examiner Questions:\*\*

1. What are the common symptoms of fibroids?

Answer: Heavy menstrual bleeding, pelvic pain, frequent urination, pain during intercourse, and lower back pain.

2. Describe the management strategy for a patient with symptomatic fibroids.

Answer: Management includes medication for symptom relief, hormonal treatments to control bleeding and reduce fibroid size, and surgical options for removal.

3. How does the choice of contraception affect fibroid symptoms?

Answer: Hormonal contraceptives can help manage bleeding and pain associated with fibroids but may not reduce fibroid size.

4. What are the implications of fibroids on pregnancy?

Answer: Fibroids can lead to complications in pregnancy, including a higher risk of caesarean section, preterm delivery, and growth restrictions of the fetus.

5. Discuss the role of ultrasound in the diagnosis and management of fibroids.

Answer: Ultrasound is key in diagnosing fibroids by visualising their size, number, and location, which helps inform treatment options.

\*\*Treatment:\*\*

- Initial management includes symptomatic treatment with NSAIDs for pain relief.

- Consider hormonal treatments like GnRH agonists to shrink fibroids pre-operatively.

- Surgical options, such as myomectomy, are considered for women desiring future fertility.

- Uterine artery embolization (UAE) could be an option for those not desiring future pregnancies, with patient consent about potential impacts on fertility.

\*\*Monitoring:\*\*

- Regular follow-up appointments every 3-6 months to assess symptom improvement or progression.

- Repeat ultrasound in 6 months to monitor fibroid size.

- Immediate consultation for any severe pain, significant bleeding, or changes in menstrual pattern.

\*\*Prognosis:\*\*

- Symptomatically, many women experience relief post-treatment.

- Fertility outcomes can vary depending on treatment choice and fibroid specifics.

- Long-term management may be necessary for recurrent fibroids.

\*\*Differential diagnoses:\*\*

1. Endometriosis - Less likely due to the ultrasound findings.

2. Adenomyosis - Symptom overlap but differentiated by imaging.

3. Ovarian cysts - Could present similarly but ruled out by ultrasound.

\*\*Keyword Filters:\*\*

\*\*Speciality Filter:\*\* Obstetrics And Gynaecology

\*\*Presenting Complaint Filter:\*\* Menstrual Problems; Pelvic Pain

\*\*Condition Filter:\*\* Fibroids

\*\*Location Filter:\*\* Clinic

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\*\*Case created by:\*\*

David, XX Medical Student

\*\*Reviewed by:\*\*

XX, XX Medical Student

\*\*Reviewed by:\*\*

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_34\_Fibroids

Homepage Vignette:

## A 38-year-old female called Aadhya Kapoor presents with heavy menstrual bleeding.

Individual Page Vignette:

As a General Practitioner in a Clinic setting, you are to see Aadhya Kapoor, a 38-year-old accountant, located in General Practice, presenting with heavy menstrual bleeding.

Patient Name:

Aadhya Kapoor ("Aah-dhya Kuh-poor"), prefers to be called Aadhya.

Age:

23/06/1986

Location:

Clinic

Personality:

Aadhya is articulate and methodical, matching her profession as an accountant. She speaks in a calm and measured manner, asking detailed questions about her condition and the implications it might have on her daily activities and future reproductive plans.

Presenting Complaint:

Aadhya reports experiencing increasingly heavy menstrual bleeding and pelvic pain during her menstrual cycles over the past six months.

Quote:

For the presenting complaint, Aadhya might say, “The bleeding has become so heavy, it’s disrupting my work. And the cramps, I’ve never had anything quite like it before.”

Symptoms:

- Site: Pelvis; "It feels like a constant heavy pressure in my lower abdomen."

- Onset: Gradual; "The pain and heavy bleeding have been getting worse over half a year."

- Character: Cramping; "The pain is like intense cramping, almost like labour pains."

- Radiation: Does not radiate; "No, the pain stays in my lower abdomen. It doesn’t go anywhere else."

- Associated Symptoms: Heavy menstrual bleeding; "I have to change my sanitary products every hour."

- Timing: Cyclic, associated with menstruation; "It all gets really bad during my period, but there’s a dull ache most days."

- Exacerbating Factors: Menstruation; "It’s all so much worse when I’m on my period."

- Relieving Factors: Heat and rest; "A hot water bottle and lying down seem to help a bit."

- Severity: 8/10 during menstruation; "On a scale of one to ten, it’s an eight during my periods."

- PV Bleeding: Heavy; "It's like a tap turned on."

- PV Discharge: None significant; "No unusual discharge, just a lot of blood."

- Abdominal or Pelvic Pain: Described; "This cramping is unbearable at times."

- Chance of Pregnancy: None; "I’ve been careful, and with this much bleeding, pregnancy is unlikely."

- Missed periods: None; "My periods are regular, just very heavy."

- Chronic pelvic pain: Yes; "There’s a dull ache even when I'm not menstruating."

- Dyspareunia: None; "I’ve been avoiding intercourse because of the pain and bleeding."

History of Presenting Complaint:

- Duration: 6 months; "It’s been about six months now."

- Previous treatments: Over-the-counter pain relief; "I’ve tried ibuprofen, but it hardly touches the pain."

- Symptoms progression: Worsening; "Every month seems worse than the last."

- Frequency: Monthly; "It’s monthly, with constant discomfort in between."

- Impact on daily life: Significant; "I’ve missed days at work and can barely function during my period."

- Work impact: "I’m an accountant, and sitting through meetings is becoming impossible some days."

- Physical and mental wellbeing: "It’s wearing me down. I’m always tired and on edge about my next period."

Systemic Symptoms:

- Fatigue: "I’m always tired, probably from the blood loss."

- Fever: None.

- Night Sweats: None.

- Unintended Weight Loss: None.

- Chest or Shoulder Tip Pain: None.

- Shortness of Breath or Cough: None.

- Change in Bowel Habits: None.

- Change in Urinary Habits: None.

- Dysuria: None.

- Oedema: None.

- Rashes or Skin Changes: None.

- Headache: None.

- Mood Changes: None.

- Sleep Disturbances: None.

Obstetric History:

- Previous Obstetric History: Gravidity and Parity: G2 P2+0

- >24 Weeks Pregnancies: 2; "Both my children were full-term."

- Gestation at Delivery(s): 39 and 40 weeks.

- Birth Weight(s): 3.4 kg and 3.6 kg.

- Mode of Birth(s): Vaginal; "Both were natural births."

- Complications: None; "Thankfully, both deliveries were straightforward."

- Miscarriages: None.

- Terminations: None.

- Ectopic Pregnancies: None.

- Reproductive Plans: "I’m not planning on having more children."

Gynaecology History:

Menstrual History:

- Duration: 5-7 days.

- Frequency: Every 28 days.

- Volume: Heavy, especially in the last 6 months; "I've always had a heavy flow, but it's been extreme recently."

- Dysmenorrhoea: Yes; "The cramping is intense during my periods."

Last Menstrual Period: 14 days ago.

Menarche: Age 13.

Contraception: Currently using oral contraceptive pills; "I've been on the pill for over a decade."

Previous Screens: Last cervical screening was a year ago; "My last pap smear was normal."

Previous Gynaecology Conditions: None.

Previous STIs: None reported.

Quote: "I've always been quite regular with my periods. It's just the last few months that have been a nightmare."

Past Medical History:

- Autoimmune disorder diagnosed 5 years ago - managed with medication.

- Appendectomy at age 22.

- Immunizations and vaccination history: Fully up to date, including HPV vaccination.

- Previous STIs: None.

Quote: "Apart from my autoimmune issue, which is under control, I've been relatively healthy."

Drug History:

- Prescription medication for autoimmune disorder, specific dosage daily.

- Oral contraceptive pills: "I've been consistent with my contraceptive pill."

- Over-the-counter pain relief for menstrual cramps: "I've tried everything from ibuprofen to paracetamol, but nothing gives me complete relief."

Quote: "I'm always careful to take my medications as prescribed. The painkillers help a bit, but not enough."

Allergies:

- Penicillin: Causes rash and swelling; "I found out I was allergic to penicillin when I was a child."

Quote: "I always let doctors know about my penicillin allergy."

Family History:

- Mother had breast cancer at age 55.

- Father has hypertension.

- No known family history of gynaecological issues.

Quote: "My family has had its share of health issues, but nothing like what I'm going through."

Social History:

Lifestyle: "I try to lead a balanced life, eating well and staying active."

Occupation: Accountant.

Activities of Daily Living & Hobbies: "I love hiking and yoga, but lately, I’ve had to limit my activities."

Smoking: Non-smoker.

Alcohol: Approximately 4 units per week; "I might have a glass of wine on weekends."

Recreational Drug Use: None.

Diet: Balanced diet; "I focus on high fibre and plenty of vegetables."

Exercise: Regularly, 3 times a week, yoga and walking; "I've had to slow down because of the pain."

Quote: "My lifestyle is quite healthy. It’s frustrating that I’m dealing with this despite trying to take good care of myself."

Sexual History:

- Last sexual intercourse: 4 weeks ago.

- Current and previous partners: In a monogamous relationship for the past 5 years.

- Contraception used: Oral contraceptive pills.

Quote: "My relationship is stable, and we’ve been careful with contraception. The pain has affected our intimacy, though."

Travel History: "I haven't travelled outside the country in over a year."

Cultural or Religious Practises: "I was raised Anglican; however, I consider myself more spiritual than religious now."

Recent Life Events: "Work has been particularly stressful this year."

Exposure to Hazards or New Environment: None.

Ideas, Concerns, and Expectations:

- Ideas: "I've read about fibroids. Could that be causing my symptoms?"

- Concerns: "I'm worried about the impact this could have on my health and ability to work."

- Expectations: "I hope we can find a treatment that relieves these symptoms without affecting my fertility."

Quote: "I just want to feel like myself again. Being in constant pain and dealing with heavy bleeding is taking its toll."

Observations:

- NEWS Total Score: 0

Physical Examination:

General Inspection:

- Overall appearance: Well-kept, in no acute distress

- Signs of anaemia: Not apparent; no pallor noted

- Signs of oedema: None

Objects and Equipment:

- No objects or equipment noted

Hands:

Inspection:

- Colour: Normal

- Palmar erythema: None

- Peripheral oedema: Absent

Palpitation:

- Temperature: Warm to touch

- Capillary refill time (CRT): Less than 2 seconds

- Radial pulse: Regular rhythm, good volume

Neck:

- Goitres: None

- Lymphadenopathy: None

Face:

- Conjunctival pallor: None

- Jaundice: None

- Oedema: None

Abdominal Examination:

- Inspection: No distension or visible mass

- Palpitation: Soft, non-tender, no masses palpable

Vaginal Examination:

- Vulval Inspection: No ulcers, cysts, or significant discharge noted

- Speculum Examination: Cervical os normal appearance, no active bleeding

- Bimanual Examination:

- Uterine size normal

- No adnexal masses palpable

Diagnostic Tests:

Urine Dipstick:

- No abnormalities detected

STI Screen:

- Chlamydia: Negative

- Gonorrhoea: Negative

- Syphilis (blood test): Negative

- HIV (blood test): Negative

Blood Tests (Reference Ranges):

- Haemoglobin (Hb): 119 g/L (Female: 115 - 165 g/L)

- Mean Corpuscular Volume (MCV): 89 fL (80 – 100 fL)

- White Blood Cell Count: 5.5 x10^9/L (3.6 - 11.0 x10^9/L)

- Platelets: 250 x10^9/L (140 - 400 x10^9/L)

- Urea and Electrolytes: All within normal ranges

- Liver Function Tests: All within normal ranges

Imaging Tests:

- Ultrasound Scan: A transvaginal ultrasound reveals multiple small uterine fibroids, largest measuring 3 cm in diameter.

Patient Questions:

1. "Will I still be able to have children?"

- "Yes, treatments like myomectomy aim to preserve fertility."

2. "How long will it take for the treatment to work?"

- "Medications might start relieving symptoms in a few weeks, but it varies by individual. Surgical options have longer recovery times but often provide quicker symptom relief."

3. "Are there any side effects of the treatments?"

- "All treatments have potential side effects. For example, NSAIDs can affect your stomach, and GnRH analogues can cause menopause-like symptoms temporarily."

4. "What if I don't want surgery?"

- "We can try managing your symptoms with medication and lifestyle adjustments initially. We have several options to explore based on your preferences and how your symptoms progress."

Examiner Questions:

1. What is the most likely diagnosis for Aadhya’s symptoms?

- Uterine fibroids.

2. Describe the role of ultrasound in diagnosing uterine fibroids.

- Ultrasound, especially transvaginal, helps in identifying the presence, size, and number of fibroids.

3. Discuss non-surgical management options for uterine fibroids.

- Includes NSAIDs, tranexamic acid, oral contraceptives, and GnRH analogues.

4. How would you monitor Aadhya's condition over time?

- Regular clinical follow-ups, monitoring symptoms, haemoglobin levels, and repeat ultrasounds.

5. What factors might influence the choice between medicinal and surgical treatment for Aadhya?

- Symptom severity, size and number of fibroids, Aadhya's age, her fertility desires, and response to medical treatment.

Treatment:

The management of uterine fibroids depends on the severity of symptoms, size and number of fibroids, patient’s age, and future reproductive plans. For Aadhya, symptom relief and fertility preservation are key considerations.

1. Pharmacological:

- NSAIDs for pain relief during menstruation.

- Tranexamic acid to reduce menstrual bleeding.

- GnRH analogues for short-term use to shrink fibroids and ease symptoms.

2. Surgical:

- Myomectomy considered for fertility preservation and symptom relief if pharmacological treatment is insufficient.

Monitoring:

- Regular follow-up appointments every 6 months to monitor symptom progression and response to treatment.

- Repeat ultrasound in 6 months to assess fibroid size and growth.

- Monitor haemoglobin levels to evaluate for anaemia.

Prognosis:

- With appropriate management, symptoms can often be significantly improved.

- Fertility can be preserved, especially with surgical interventions like myomectomy.

- Regular monitoring is necessary to track fibroid growth and symptoms.

Differential diagnoses:

1. Endometriosis - Less likely due to the presence of fibroids on ultrasound.

2. Adenomyosis - Can cause similar symptoms but typically presents with a uniformly enlarged uterus.

3. Pelvic Inflammatory Disease - Symptoms and negative STI screening make this less likely.

Case created by:

David, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_35\_Fibroids

Homepage Vignette:

## A 34-year-old female called Miriam presents with heavy menstrual bleeding.

Individual Page Vignette:

You are a General Practitioner seeing Miriam, a 34-year-old librarian, in your clinic. She presents with complaints of pelvic pain and unusually heavy menstrual bleeding.

Patient Name:

Miriam Okonkwo (Pronunciation: Mee-ree-am Okon-kwo). She prefers to be called Miriam.

Age:

15/06/1990

Location:

Clinic

Personality:

Miriam is an articulate individual with a calm disposition. She speaks thoughtfully and prefers to get straight to the point. She has a logical approach to discussions and often seeks evidence-based explanations for her concerns.

Presenting Complaint:

"I've been having really heavy periods for the last few months and the pelvic pain is just unbearable at times."

Symptoms:

- Site: Pelvic region. "It feels like the pain is coming from the lower part of my tummy."

- Onset: Began gradually over several months. "I first noticed it getting worse about 6 months ago."

- Character: Cramping. "The pain is like intense cramps that won't go away."

- Radiation: Does not radiate. "It stays right there in my lower belly."

- Associated Symptoms: Heavy menstrual bleeding. "It's so heavy; I have to change my pad almost every hour."

- Timing: Symptomatic during menstruation, with increasing severity over months. "It’s worst during my periods, which seem heavier than usual."

- Exacerbating and Relieving Factors: Pain exacerbated by menstruation, slightly relieved by over-the-counter pain medication. "Painkillers help a bit, but not much."

- Severity: The pain is severe, disrupting day-to-day activities. "It's so bad I've had to take time off work."

PV Bleeding: Heavy menstrual bleeding, bright red in colour.

PV Discharge: No abnormal discharge.

Abdominal or Pelvic Pain: Severe pelvic cramping pain.

Chance of Pregnancy: Not pregnant.

Dyspareunia: Reports pain during intercourse. "It's been painful to have sex."

Post-coital PV Bleeding: None reported.

Intermenstrual PV Bleeding: Occasionally spotting between periods.

Post-menopausal Bleeding: Not applicable.

Vulval skin changes or itching: None reported.

Positive results from other symptoms include missed periods and severe menstrual cramps.

History of Presenting Complaint:

- Symptoms have been present for approximately 6 months.

- Over-the-counter pain relievers used with minimal relief.

- Progression: Symptoms have progressively worsened.

- Frequency: Symptoms coincide with menstrual cycle; heavy bleeding occurs monthly.

- Impact on daily life: Severe impact, causing absence from work.

- Impact on work: Missed days due to severe pain.

- Impact on physical and mental wellbeing: Reports stress and frustration due to ongoing symptoms. "It's starting to really affect my mental health, feeling this way so often."

Systemic Symptoms:

- Fatigue: "I've been feeling more tired than usual."

- Fever: None.

- Night Sweats: None.

- Unintended Weight Loss: None.

- Chest or Shoulder Tip Pain: None.

- Shortness of Breath or Cough: None.

- Change in Bowel Habits: None.

- Change in Urinary Habits: None.

- Dysuria: None.

- Oedema: None.

- Rashes or Skin Changes: None.

- Headache: Occasional, not severe.

- Mood Changes: Reports increased stress.

- Sleep Disturbances: Reports occasional difficulty sleeping due to pain.

Obstetric History:

Previous Obstetric History: G0 P0+0

Reproductive Plans: "I've been considering starting a family in the next few years."

Gynaecology History:

Menstrual History: Heavy and painful menstruation has been a recent change.

Duration: 7-8 days.

Frequency: Every 28-30 days.

Volume: Increased significantly.

Dysmenorrhoea.

Last Menstrual Period: Accurate to within the last month.

Menarche: Age 13.

Previous Screens: Reports regular cervical screenings, last one being normal 2 years ago.

Previous Gynaecology Conditions: None reported.

Previous STIs: None reported.

Contraception: Previously used oral contraceptive pills, currently not on any.

Past Medical History:

- Hypothyroidism managed with levothyroxine.

- No previous surgeries or hospitalizations.

- Fully vaccinated, including HPV vaccine.

- No previous sexually transmitted infections.

- No other significant medical conditions or health events.

"I've been relatively healthy most of my life, apart from the thyroid thing."

Drug History:

- Levothyroxine 100 micrograms daily for hypothyroidism.

- Ibuprofen, 400 mg as needed for pain, not very effective.

- Previously used combined oral contraceptive pill, stopped 1 year ago.

- No history of medication non-compliance.

- No history of overdose incidents.

"I only take my thyroid pill regularly. Painkillers don't seem to help much with the menstrual cramps."

Allergies:

- No known allergies to medications.

- Latex allergy, causes skin rash on contact.

"I found out about my latex allergy the hard way, got a rash."

Family History:

- Mother has hypothyroidism.

- Father is healthy with no known chronic conditions.

- One younger sister, no known health issues.

- No history of gynaecological conditions like fibroids or endometriosis in the family.

"My family is pretty healthy for the most part."

Social History:

Lifestyle: Active, enjoys hiking and yoga.

Occupation: Librarian.

Activities of Daily Living & Hobbies: Enjoys cooking and travelling.

Smoking: Non-smoker.

Alcohol: Social drinker, approximately 4 units per week.

Recreational Drug Use: None.

Diet: Vegetarian.

Exercise: Regular, includes yoga and hiking 3-4 times a week.

"I try to stay active and healthy, though the pain has been making it difficult lately."

Sexual History:

Last sexual intercourse: Within the last month.

Current and previous partners: In a monogamous relationship for 2 years.

Contraception used: Previously used oral contraceptives, currently relying on condoms.

"It's important for me that we use protection, given my pain during intercourse."

Travel History:

Travels occasionally for leisure, no recent travel to areas with known health risks.

Ideas, Concerns, and Expectations:

- Ideas: Suspects the heavy menstrual bleeding and pain might be due to a gynaecological condition, as read online.

- Concerns: Worried about fertility and the possibility of having a serious condition like cancer.

- Expectations: Seeking relief from symptoms and clarification about the cause of her symptoms. Interested in understanding treatment options.

"I just want to know what's wrong and how we can fix it. I'm worried this might affect my chance of having children."

Observations:

NEWS Total Score: 0

Physical Examination:

General Inspection: Appears well, in no obvious distress.

Objects and Equipment: None.

Hands: No abnormalities noted.

Neck: No goitres or lymphadenopathy.

Face: No pallor, jaundice, or oedema.

Abdominal Examination: Non-tender on palpation, no masses palpable.

Vaginal Examination:

Vulval Inspection: No ulcers, cysts, rashes, or lesions.

Speculum Examination: Normal cervical os, no erosions or masses.

Bimanual Examination: Non-tender uterus, no adnexal masses palpable.

Diagnostic Tests:

Urine Dipstick: Negative for protein, blood, and glucose.

STI Screen: Negative for Chlamydia, Gonorrhoea, Syphilis, and HIV.

Blood Tests (Reference Ranges):

Full Blood Count (FBC):

- Haemoglobin (Hb): 122 g/L (Female: 115 - 165 g/L)

- Mean Corpuscular Volume (MCV): 87 fL (80 – 100 fL)

- White Blood Cell Count: 5.2 x10^9/L (3.6 - 11.0 x10^9/L)

- Platelets: 250 x10^9/L (140 - 400 x10^9/L)

Urea and Electrolytes:

- Sodium: 139 mmol/L (133–146 mmol/L)

- Potassium: 4.1 mmol/L (3.5–5.3 mmol/L)

- Calcium (adjusted): 2.4 mmol/L (2.2-2.6 mmol/L)

- Magnesium: 0.9 mmol/L (0.7–1.0 mmol/L)

- Urea: 4.8 mmol/L (2.5 – 7.8 mmol/L)

- Creatinine: 70 μmol/L (Female: 45–84 μmol/ L)

Liver Function Tests: All within normal limits.

CRP: 4 mg/L (< 10 mg/L)

Imaging Tests:

Ultrasound Scan: Reveals a 4.5 cm intramural fibroid in the anterior wall of the uterus.

Condition:

Fibroids

Patient Questions:

1. "What are fibroids, and why do I have them?"

Potential answer: "Fibroids are non-cancerous growths that develop in or on the uterus. They are quite common and can be related to several factors including hormones, genetics, and environmental influences."

2. "Can fibroids affect my fertility?"

Potential answer: "While fibroids can sometimes impact fertility or pregnancy, many women with fibroids can still conceive and have healthy pregnancies. It's important to discuss your specific condition and treatment options."

3. "What treatment options do I have?"

Potential answer: "Treatment depends on your symptoms, the size and location of the fibroids, and your personal choices. Options range from medication to manage symptoms, to procedures that shrink or remove fibroids."

4. "Will I need surgery?"

Potential answer: "Surgery is considered when symptoms are severe or if other treatments haven't been effective. We'll consider all options and choose what's best for you."

Examiner Questions:

1. How do you differentiate between fibroids and other causes of heavy menstrual bleeding?

Answer: By clinical history, physical examination, and diagnostic tests such as ultrasound, which can identify fibroids.

2. What are some risk factors associated with developing fibroids?

Answer: Risk factors include age (common in women of reproductive age), family history, obesity, and ethnic background, with African American women at higher risk.

3. Describe the management options for fibroids.

Answer: Management ranges from watchful waiting in asymptomatic cases, medical therapy (e.g., tranexamic acid, NSAIDs, hormonal treatments), to surgical interventions (e.g., myomectomy, hysterectomy).

4. How does the presence of fibroids impact pregnancy and fertility?

Answer: While they can cause complications, many women with fibroids can conceive and have successful pregnancies. The impact varies depending on the size, number, and location of fibroids.

5. Discuss the significance of patient-centred care in managing fibroids.

Answer: It's important to consider the patient's symptoms, treatment preferences, potential side effects, fertility desires, and overall lifestyle when devising a management plan.

Treatment:

For symptomatic fibroids like Miriam's, treatment options include:

- Medical management with NSAIDs for pain relief and tranexamic acid to reduce menstrual bleeding.

- Hormonal treatments such as Gonadotrophin-releasing hormone (GnRH) analogues to shrink fibroids.

- Levonorgestrel-releasing intrauterine system (LNG-IUS) can also be considered to manage bleeding.

- Surgical options, if necessary, include myomectomy to remove fibroids while preserving the uterus, or hysterectomy as a last resort.

Monitoring:

- Regular follow-ups every 6 months to monitor symptoms and fibroid growth.

- Annual ultrasound to assess changes in fibroid size.

- Monitor haemoglobin levels if heavy menstrual bleeding persists.

- Evaluate treatment efficacy and potential side effects at each visit.

Prognosis:

- Many women with fibroids experience significant relief with treatment.

- Fertility outcomes are generally good, though some may require fertility treatment.

- Risk of recurrence exists, particularly for those with multiple fibroids.

Differential diagnoses:

1. Endometriosis - less likely due to lack of other characteristic symptoms like painful bowel movements or urination.

2. Adenomyosis - could present similarly but usually diagnosed in older women and with a diffusely enlarged tender uterus.

3. Polycystic Ovary Syndrome (PCOS) - less likely given the absence of symptoms such as irregular periods, acne, and hirsutism.

4. Pelvic Inflammatory Disease (PID) - unlikely due to lack of risk factors and symptoms such as fever and abnormal vaginal discharge.

Keyword Filters:

Speciality Filter:

Obstetrics And Gynaecology; General Practice

Presenting Complaint Filter:

Abdominal Distension; Menstrual Problems; Pelvic Pain

Condition Filter:

Fibroids

Location Filter:

Clinic

Case created by:

David, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_36\_EndometrialCancer

Homepage Vignette:

## A 62-year-old female called Fariha Rashid presents with PV bleeding.

Individual Page Vignette:

You're a GP in a clinic and a patient named Fariha Rashid, a 62-year-old accountant, comes to your consultation room complaining of PV bleeding and persistent lower abdominal pain.

Patient Name:

Fariha Amina Rashid (Fah-ree-ha A-mee-na Ra-sheed); she prefers to be called Fariha.

Age:

16/04/1962

Location:

General Practice

Personality:

Fariha is a detail-oriented and methodical individual; she speaks with clarity and purpose. She exhibits a polite and respectful demeanor and tends to be meticulous when discussing her complaints. Fariha is educated to the level of a university graduate and holds a position as a senior accountant, which reflects in her precise communication skills and the structured way she narrates her medical history.

Presenting Complaint:

Fariha reports experiencing unexpected bleeding despite having gone through menopause several years ago. She has also been dealing with consistent pain in the lower abdomen.

"I suddenly started to notice spotting on my underwear, which I found rather concerning at my age. Alongside this, there's been this nagging pain just below my belly button that doesn't seem to go away."

Symptoms:

SOCRATES for the abdominal pain:

- Site: Suprapubic region; "It's mainly focused around here, just below my belly button."

- Onset: Gradual; "The pain started slowly, probably a few weeks back."

- Character: Dull and constant; "It's not sharp, but it's always there, like a background noise."

- Radiation: None; "The pain stays right here, it doesn't move anywhere else."

- Associated Symptoms: Postmenopausal bleeding; "The bleeding started around the same time as the pain."

- Timing: Continuous; "It's there all the time, but I feel it more when I'm lying down."

- Exacerbating and Relieving Factors: None specific; "I haven't found anything that makes it better or worse."

- Severity: Moderate; "It's uncomfortable but I can still do my day-to-day tasks."

PV Bleeding: Light spotting, brownish in colour, minimal volume, non-foul smelling.

PV Discharge: None.

Abdominal or Pelvic Pain: Suprapubic pain as detailed under SOCRATES.

Chance of Pregnancy: None; postmenopausal.

Dyspareunia: Not applicable, not sexually active.

Post-coital PV Bleeding: None.

Post-menopausal Bleeding: Spotting present.

Vulval skin changes or itching: None reported.

"I haven't noticed any other changes or itching down there."

Additional positive findings include:

- Abdominal distention: "My belly seems slightly more swollen than usual, though I haven't put on weight elsewhere."

- Chronic pelvic pain: Consistent with current complaint, as mentioned above.

"No tightness around the chest, no cough, no breathlessness – just this unusual bloating sensation and the bleeding."

History of Presenting Complaint:

- Symptom duration: Approximately six weeks.

- Previous treatments: None for this specific issue.

- Symptom progression: The symptoms have remained consistent since onset.

- Frequency of symptoms: Daily spotting and continuous pain.

- Impact on ADLs: Minimal but finding the bleeding unsettling.

- Impact on work: No impact as of yet.

- Impact on physical and mental wellbeing: Increasing anxiety about the cause of symptoms.

"I'm able to manage day-to-day activities reasonably well, but I must admit, I'm anxious about what could be causing these symptoms."

Systemic Symptoms:

- Fatigue: None beyond usual.

- Fever: None.

- Night Sweats: None.

- Unintended Weight Loss: None.

- Chest or Shoulder Tip Pain: None.

- Shortness of Breath or Cough: None.

- Change in Bowel Habits: Normal.

- Change in Urinary Habits: Normal.

- Dysuria: None.

"Generally, I feel quite well, except for this issue."

Obstetric History:

Previous Obstetric History:

Gravidity and Parity: G2 P2+0

>24 Weeks Pregnancies:

Gestation at Delivery(s): 39 weeks; 40 weeks.

Birth Weight(s): 3.5 kg; 3.7 kg.

Mode of Birth(s): Vaginal delivery without complications.

Complications: None.

Stillbirths: None.

<24 Weeks Pregnancies:

Miscarriages: None.

Terminations: None.

Ectopic Pregnancies: None.

Gynaecology History:

Menstrual History before Menopause:

Duration: 5 days.

Frequency: Every 28 days.

Volume: Moderate flow.

Dysmenorrhoea: Mild but managed without medication.

Last Menstrual Period: Over seven years ago.

Menarche: Age 13.

Menopause: Confirmed at age 55.

Cervical screening: Up to date with negative results.

Previous Gynaecology Conditions: None.

Previous STIs: None.

Contraception: IUD removed after menopause.

"I've been meticulous with my smear tests, and they've always come back clear."

Past Medical History:

- Type 2 diabetes mellitus, well-controlled with diet.

- Hypertension, managed with medication.

- Appendectomy at age 25.

- Blood group: A positive.

- Fully vaccinated, including HPV vaccine.

- No previous STIs.

- No other significant medical conditions.

"I've always taken my health very seriously, managing my diabetes with a good diet and regularly monitoring my blood pressure."

Drug History:

- Metformin 500 mg twice daily.

- Ramipril 10 mg once daily.

"I take my medications religiously, and I make sure never to miss a dose."

Allergies:

- Penicillin: Developed a rash after taking it many years ago.

"I remember breaking out into an itchy rash once after I took penicillin, so I've avoided it since then."

Family History:

- Mother had type 2 diabetes.

- Father had a history of myocardial infarction.

"There is a bit of a mixed bag of health issues in my family, but thankfully nothing too serious on my side so far."

Social History:

Lifestyle: Content with routine, enjoys gardening.

Occupation: Senior accountant.

ADLs & Hobbies: Enjoys reading and visiting historical sites.

"I like to keep to myself usually, find solace in my books and my garden."

Smoking: Never smoked.

Alcohol: Rarely, perhaps a glass of wine occasionally.

Diet: Diabetic-friendly diet, mainly plant-based.

Exercise: Regular walks, 30 minutes a day.

"I try to keep active with walks and sticking to a healthy diet."

Sexual History:

"I haven't been sexually active for several years now."

"I've been enjoying my retirement and keeping up with gatherings in our community."

Ideas, Concerns, and Expectations:

- Ideas: Suspects her symptoms might be related to her gynaecological health; concerned about cancer due to her age.

- Concerns: Worried about the potential need for serious treatments and their impact on her quality of life.

- Expectations: Hopes for a thorough investigation of her symptoms and clear communication about her diagnosis and treatment options.

"I do wonder if all this has something to do with a serious illness like cancer. Naturally, I am worried about what the treatment might entail and how it would affect me."

Observations:

NEWS Total Score: 0

Physical Examination:

General Inspection

- Appears well, no apparent distress.

- No signs of pallor or cachexia.

- No evident scars or scratch marks.

- No signs of edema.

Objects and Equipment

- No visible medical aids or equipment.

Hands

Inspection:

- Skin colour normal, no palmar erythema.

- No peripheral oedema.

Palpitation:

- Warm to touch, normal capillary refill time (CRT), steady radial pulse.

Neck

- No masses, goitres, or lymphadenopathy. JVP not raised.

Face

- No facial pallor, jaundice, or oedema.

- No evidence of exophthalmos or Kayser-Fleischer rings.

Abdominal Examination

Inspection:

- Slight distension present.

Palpitation:

- Tenderness in the suprapubic region but no palpable masses.

Vaginal Examination:

Vulval Inspection:

- No ulcers, cysts, or scarring.

- No vulval lesions indicative of lichen sclerosis.

Speculum Examination:

- Cervical os intact, no active bleeding, ectropion, or erosions.

Bimanual Examination:

- No vaginal wall abnormalities.

- Cervix firm and mobile, no cervical excitation pain.

- Uterus non-tender, no abnormal enlargement or masses palpated.

- Ovaries non-palpable.

Special Tests: None performed at this visit.

Diagnostic Tests:

- Urine Dipstick: Negative for blood or infection.

- STI Screen: None indicated due to lack of sexual activity.

Blood Tests (Reference Ranges):

- Full Blood Count (FBC):

- Haemoglobin (Hb): 102 g/L (Female: 115 - 165 g/​L)

- Mean Corpuscular Volume (MCV): 92 fL (80 – 100 fL)

- White Blood Cell Count: 6.0 x10^9/L (3.6 - 11.0 x10^9/L)

- Platelets: 250 x10^9/L (140 - 400 x10^9/L)

- Urea and Electrolytes:

- Sodium: 140 mmol/L (133–146 mmol/L)

- Potassium: 4.2 mmol/L (3.5–5.3 mmol/L)

- Urea: 4.6 mmol/L (2.5 – 7.8 mmol/L)

- Creatinine: 78 μmol/L (Female: 45–84 μmol/L)

- Estimated Glomerular Filtration Rate (eGFR): >90ml/min/1.73m³

- CRP: 6 mg/L (< 10 mg/L)

* Transvaginal Ultrasound: Indicates endometrial thickening over 4mm.
* Endometrial Biopsy: Histopathology shows adenocarcinoma.
* Serum CA-125 level: Normal (<35 units/ml)

Condition:

Endometrial Cancer

Patient Questions:

1. "What do you think is causing these symptoms, doctor?"

- Potential answer: "Based on your symptoms and age, we need to investigate the possibility of conditions such as endometrial cancer, however, there are also other, less serious conditions that could cause similar symptoms. We'll need to do some tests to find out more."

2. "How serious is this? Am I going to need surgery?"

- Potential answer: "It's important that we get a clear diagnosis first. If it is endometrial cancer, treatment options vary and can include surgery, but sometimes other treatments are considered. We'll discuss all available options once we have a confirmed diagnosis."

3. "Will I need to be referred to a specialist for these tests?"

- Potential answer: "Yes, if the initial tests suggest there might be an issue, I would refer you to a gynaecological oncologist, who specialises in this area."

4. "How long will the investigation and treatment take?"

- Potential answer: "The time frame for both investigation and treatment will depend on the test results. Investigations can take a few weeks, and depending on the findings, treatment plans will be discussed which may vary in length."

Examiner Questions:

1. What are the risk factors for endometrial cancer?

- Answer: Postmenopausal status, age, obesity, diabetes, hypertension, history of unopposed estrogen therapy, and family history of certain cancers.

2. What diagnostic tests would you consider for this patient presenting with postmenopausal bleeding?

- Answer: Vaginal swab, pelvic ultrasound, endometrial biopsy, possibly MRI or CT if indicated.

3. What is the role of CA-125 in diagnosing endometrial cancer?

- Answer: CA-125 can be elevated in endometrial cancer, but it is not specific and is more commonly used in the diagnosis and monitoring of ovarian cancer.

4. How would you differentiate between endometrial hyperplasia and endometrial cancer?

- Answer: Endometrial biopsy is essential to distinguish between hyperplasia and cancer. Imaging can also provide additional information but biopsy gives definitive diagnosis.

5. Discuss the importance of patient history in suspecting endometrial cancer.

- Answer: Detailed patient history can provide insights into risk factors, such as postmenopausal status, bleeding patterns, and duration of symptoms, which are crucial for considering endometrial cancer as a diagnosis.

Treatment:

The treatment for endometrial cancer varies depending on stage but often involves surgery (hysterectomy with bilateral salpingo-oophorectomy), possibly followed by adjuvant therapies like radiotherapy or chemotherapy. Hormonal therapies may also be considered in specific cases.

- Hysterectomy with bilateral salpingo-oophorectomy (removal of the uterus and ovaries) is the mainstay treatment for localized endometrial cancer.

- Adjuvant therapies:

- External beam radiotherapy may be considered post-surgery for patients with intermediate or high risk of recurrence.

- Chemotherapy is generally reserved for advanced or recurrent endometrial cancer.

- Hormonal therapy, such as progesterone, can be considered, especially in lower-grade tumors or for patients who are not surgical candidates;

Note: Specific dosages and choice of adjuvant therapy will depend on the stage of cancer, histology type, patient comorbidities, and preferences.

Monitoring:

- Following treatment, regular follow-up with a gynecologic oncologist is essential.

- Monitor for signs of recurrence with pelvic exams every 3-6 months for the first two years, then less frequently.

- Report any new symptoms such as vaginal bleeding or abdominal pain promptly.

- Consider imaging tests like ultrasound or CT scans during follow-up visits as indicated by the specialist.

Prognosis:

- The prognosis of endometrial cancer largely depends on its stage at diagnosis.

- Localized endometrial cancer has a good prognosis with a high five-year survival rate.

- Advanced cancer with distant spread has a poorer prognosis.

- Prognostic factors include tumor grade, depth of myometrial invasion, and lymph node involvement.

- Comorbidity and age can also affect treatment outcomes and overall prognosis.

Differential diagnoses:

1. Atrophic vaginitis: More common but imaging indicates cancer, typically causes less pronounced bleeding and vaginal dryness might be a more prominent symptom.

2. Endometrial hyperplasia: Could cause postmenopausal bleeding, but cancer risk increases with complexity of hyperplasia.

3. Uterine polyps: May cause postmenopausal bleeding, but usually painless.

4. Cervical cancer: Less likely due to up-to-date negative smear tests. Would also typically cause different symptoms.

5. Uterine fibroids: Rarely occur after menopause without hormone replacement therapy and often asymptomatic but can cause bleeding when present.

Keyword Filters:

Speciality Filter:

Cancer; Endocrine and Metabolic; General Practice; Obstetrics and Gynaecology;

Presenting Complaint Filter:

Abdominal Distension; Abnormal Cervical Smear Result; Menopausal Problems; Menstrual Problems; Pelvic Mass; Pelvic Pain; Postmenopausal Problems

Condition Filter:

Endometrial Cancer

Location Filter:

General Practice

Case created by:

FB, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_37\_EndometrialCancer

Homepage Vignette:

## A 55-year-old woman called Soraya Khumalo presents with abnormal vaginal bleeding.

Individual Page Vignette:

You are a General Practitioner in a clinic. Your patient, Soraya Khumalo, 55, a retired teacher, presents with abnormal vaginal bleeding and pelvic pain.

Patient Name:

Soraya Khumalo [So-ray-ah Koo-mah-loh], she prefers to be called Soraya.

Age:

15/06/1969

Location:

Clinic

Personality:

Soraya is a retired teacher with a calm and articulate manner of speaking. She values clear communication and is keen to understand her health condition fully. Educated and inquisitive, she asks relevant questions and actively engages in discussions about her care.

Presenting Complaint:

Soraya visits the clinic complaining of abnormal vaginal bleeding and pelvic pain that has progressively worsened over the past few months.

Quote:

"It started as just a bit of spotting now and then, but lately, it's been much heavier. And this pelvic pain just doesn't seem to go away."

Symptoms:

- Site: Pelvic region. "It's mainly in my lower belly, right around here."

- Onset: Gradually over the past few months. "I first noticed it a few months back."

- Character: The pain is described as a constant, dull ache. "It's like a constant, dull feeling."

- Radiation: Does not radiate.

- Associated Symptoms: Soraya has also noted increased urinary frequency. "I find myself needing the loo more often."

- Timing: The pain is constant but varies in intensity throughout the day. "It's always there but feels worse by the evening."

- Exacerbating and Relieving Factors: Sitting for long periods seems to exacerbate the pain. "Sitting down for a long time makes it worse."

- Severity: The pain is moderate but increasingly bothersome. "On a scale from 1 to 10, it's around a 6."

PV Bleeding: Heavy, dark red, clotted, no distinct smell. "It's much heavier than my normal period and very dark."

PV Discharge: Normal.

Abdominal or Pelvic Pain: Described above.

Chance of Pregnancy: Negative.

Dyspareunia: Negative.

Post-coital PV Bleeding: Negative.

Post-menopausal Bleeding: Positive, considering the patient's age.

Vulval skin changes or itching: Negative.

"I never thought I'd have to deal with something like this, especially at my age."

Abdominal distention: Negative.

Breast lumps: Negative.

History of Presenting Complaint:

- Soraya has been experiencing the symptoms for approximately 4-5 months.

- No previous treatments attempted.

- Symptoms have progressively worsened.

- Bleeding has become heavier and more frequent.

- Pain is constant with varying severity.

- Significantly impacting her quality of life. "I've had to cancel my walking club meetings. It's just too uncomfortable."

- Work is not applicable as Soraya is retired.

- Reported feeling increasingly anxious about her symptoms. "I'm getting quite worried, it's all I can think about."

Quote:

"It's just been getting worse, and I don't know what to do about it."

Systemic Symptoms:

- Fatigue: Soraya has noted an increase in fatigue. "I just feel drained all the time."

- Fever: None.

- Night Sweats: Occasional. "Some nights I wake up drenched."

- Unintended Weight Loss: Negligible.

- Chest or Shoulder Tip Pain: None.

- Shortness of Breath or Cough: None.

-

Change in Bowel Habits: None.

- Change in Urinary Habits: Increased frequency as mentioned.

- Dysuria: None.

- Oedema: None.

- Rashes or Skin Changes: None.

- Headache: Occasionally, but not severe.

- Mood Changes: Increased anxiety due to symptoms.

- Sleep Disturbances: Broken sleep due to night sweats.

Quote:

"I can't remember the last time I felt truly rested."

Obstetric History:

Previous Obstetric History: G2 P2+0

>24 Weeks Pregnancies:

Gestation at Delivery(s): 39 weeks, 40 weeks

Birth Weight(s): 3.2 kg, 3.4 kg

Mode of Birth(s): Vaginal, Vaginal

Complications: None.

Stillbirths: None.

<24 Weeks Pregnancies: None.

Miscarriages: None.

Terminations: None.

Ectopic Pregnancies: None.

Quote:

"Both my pregnancies were pretty straightforward, thankfully."

Gynaecology History:

Menstrual History:

Duration: Pre-menopausally, cycles were regular, 5 days long.

Frequency: Every 28 days approximately.

Volume: Moderate flow.

Dysmenorrhoea: Mild, managed with over-the-counter analgesics.

Last Menstrual Period: Approximately 5 years ago.

Menarche: Age 13.

Menopause: Age 50.

Previous Screens:

Cervical screening: Up to date, last done 3 years ago with normal results.

Previous Gynaecology Conditions: None reported.

Previous STIs: None reported.

Contraception: None presently, previously used oral contraceptive pill until menopause.

Quote:

"I've always been pretty regular with my screenings; never had any issues before this."

Past Medical History:

- No significant previous medical conditions reported.

- No previous surgeries or hospitalisations.

- No previous significant injuries or traumas.

- Full immunization history, including HPV vaccination.

- No previous sexually transmitted infections.

- No other significant health events or medical conditions.

Quote:

"I've been fortunate with my health, up until now."

Drug History:

- No current prescription medications.

- Previously used an oral contraceptive pill, stopped five years ago.

- Occasionally uses paracetamol for headaches.

- No history of contraception other than the oral contraceptive pill.

Quote:

"I only take something when I absolutely have to, like a headache that won't go away."

Allergies:

- No known allergies to medications, foods, or environmental factors.

Quote:

"Luckily, I've never had a problem with allergies. Everything seems to agree with me."

Family History:

- Mother had breast cancer diagnosed at age 62, currently in remission.

- Father has type 2 diabetes, well-controlled.

- One sibling, a brother, no significant health issues.

- No known genetic disorders or significant illnesses in extended family.

Quote:

"Mum's battle with cancer was tough, but she’s a fighter. It’s made me more health-conscious."

Social History:

Lifestyle: Active lifestyle, enjoys walking and gardening.

Occupation: Retired teacher.

Activities of Daily Living & Hobbies: Active in a local walking club, enjoys reading and sewing.

Smoking: Non-smoker.

Alcohol: Drinks occasionally, 1-2 units of wine per week.

Recreational Drug Use: None.

Diet: Balanced diet, rich in fruits and vegetables.

Exercise: Regular, walks 3-4 times a week.

Quote:

"I’ve always been quite active and enjoy my walks with the club. It’s more than just exercise; it’s a social thing for me."

Sexual History:

- Last sexual intercourse over a year ago.

- Monogamous marriage for 30 years, widowed 5 years ago.

- Not currently sexually active.

- No history of contraception use post-menopause.

Quote:

"After my husband passed, that part of my life just hasn’t been the same."

Ideas, Concerns, and Expectations:

- Soraya is concerned that her symptoms might indicate a serious condition, like cancer, due to her mother's history.

- She is anxious about undergoing diagnostic procedures but understands their necessity.

- She hopes for a treatment plan that will address her symptoms effectively, with minimal side effects.

- She expects clear communication and to be involved in decisions regarding her care.

Quote:

"I can’t help but worry it’s something like what Mum had... I just hope there are options for whatever this is."

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98% on room air

Blood Pressure (mmHg): 130/85

Pulse (Beats/min): 78

Consciousness (AVPU): Alert

Temperature (Celsius): 36.7

NEWS Total Score: 0

Physical Examination:

General Inspection:

- Appears well, no distress, alert and oriented.

- No pallor or cachexia.

- No obvious scars or scratch marks.

- No signs of oedema.

Objects and Equipment:

- No mobility aids or equipment present.

Hands:

Inspection:

- No palmar erythema, peripheral oedema, or other abnormalities noted.

Palpitation:

- Temperature normal, CRT less than 2 seconds, radial pulse regular in rate, rhythm, and volume, no peripheral oedema detected.

Neck:

- No masses, goitres, or obvious lymphadenopathy. JVP not elevated.

Face:

- No significant findings such as melasma, conjunctival pallor, jaundice, oedema, exophthalmos, corneal arcus, xanthelasma, or Kayser-Fleischer rings.

Abdominal Examination:

- Inspection: No abnormal findings.

- Palpitation: Soft, non-tender, no masses palpated.

Vaginal Examination:

- Vulval Inspection: No ulcers, cysts, rashes, discharge, scarring, atrophy, lesions, masses, or signs of FGM. Slight atrophy noted consistent with age.

- Speculum Examination: No abnormal cervical os findings, no bleeding, erosions, masses, ulcers, or discharge. A mild cervical ectropion observed.

- Bimanual Examination: Vaginal walls intact, cervix in a normal position, consistency, no cervical excitation pain. Uterus normal in size, shape, position, no masses, nodules or tenderness palpated. Ovaries not palpable.

Diagnostic Tests:

- Full blood count, urea and electrolytes, liver function tests, and coagulation profile within normal ranges.

- Urine dipstick: Normal.

- STI Screen: Negative.

- CA-125: Elevated.

- Transvaginal Ultrasound: Indicates thickened endometrium, requires further investigation.

- Endometrial Biopsy: histopathology shows adenocarcinoma

Treatment:

Based on NICE guidelines, initial management for suspected endometrial cancer involves:

- Referral to a specialist gynaecological service for further investigation, including a hysteroscopy and biopsy.

- Discussing the implications of diagnostic findings and planning treatment accordingly, which may include surgical options (hysterectomy), chemotherapy, or radiotherapy depending on the staging and grade of the cancer.

- Counselling about potential side effects of treatment and post-treatment care.

Monitoring:

- Regular monitoring of treatment response through clinical examination, CA-125 levels, and imaging as indicated.

- Follow-up appointments every 3 months in the first year post-treatment, then every 6 months in the second year, and annually thereafter.

- Consideration of referral to palliative care services if required.

Prognosis:

- The prognosis of endometrial cancer depends on the stage and grade at diagnosis. Early-stage and low-grade cancers have a favourable prognosis with appropriate treatment.

- Importance of early detection and treatment to improve outcomes.

- Lifestyle factors, such as maintaining a healthy weight and avoiding hormone therapy post-menopause, can influence prognosis.

Differential diagnoses:

1. Atrophic Vaginitis: Less likely due to the severity and pattern of symptoms.

2. Uterine Fibroids: Could present similarly but less likely given the age and post-menopausal status.

3. Ovarian Cancer: Symptoms overlap, but diagnostic imaging targeted towards endometrial thickening.

4. Pelvic Inflammatory Disease: Less probable in post-menopausal women not sexually active.

Patient Questions:

1. "Could this be something serious, like cancer?" - Possible response: "It's important we investigate your symptoms thoroughly. There are several possible causes for your symptoms, and while we do need to consider all possibilities, including cancer, not all cases result in such diagnoses. We'll be proceeding step by step to get more clarity."

2. "What kind of tests will I need to go through?" - Possible response: "We'll start with some blood tests and a transvaginal ultrasound to look at your uterus and ovaries. Depending on those results, we may need further tests like a biopsy to examine the cells more closely."

3. "What are the treatment options if it is cancer?" - Possible response: "Treatment options depend on several factors, including the type and stage of cancer, if diagnosed. They may include surgery, radiation therapy, or hormone therapy. Our primary goal will be to choose the treatment that's most effective for you while considering your overall health and preferences."

4. "How quickly do we need to act?" - Possible response: "It's important to proceed with investigations promptly to understand what we're dealing with. Rest assured, we're prioritising your case, and we'll be moving forward with the necessary tests as quickly as possible."

Examiner Questions:

1. What are the risk factors for endometrial cancer? - Possible answer: "Risk factors include age, obesity, unopposed estrogen exposure, tamoxifen use, Lynch syndrome, and polycystic ovary syndrome."

2. How does the histological type of endometrial cancer impact prognosis? - Possible response: "The most common type, endometrioid carcinoma, generally has a better prognosis than the more aggressive serous carcinoma and clear cell carcinoma, which are associated with a higher grade and advanced stage at diagnosis."

3. What is the significance of the CA-125 level in this scenario? - Possible answer: "While CA-125 can be elevated in many conditions, in the context of suspecting endometrial cancer, it can be a marker indicating the need for further gynaecological evaluation."

4. Describe the management steps following the diagnosis of endometrial cancer. - Possible response: "Management involves a multidisciplinary team approach, including surgery (most commonly, hysterectomy and bilateral salpingo-oophorectomy), possibly adjuvant radiotherapy or chemotherapy depending on the stage, and hormone therapy for specific cases."

5. What is the role of pelvic MRI in the diagnosis of endometrial cancer? - Possible answer: "Pelvic MRI can provide detailed anatomical information, helping to assess the extent of disease and plan surgery by determining myometrial invasion, cervical involvement, and the presence of lymph node metastases."

Speciality Filter:

Cancer; General Practice; Obstetrics and Gynaecology; Clinical Imaging.

Presenting Complaint Filter:

Abnormal Urinalysis; Pelvic Pain; Menopausal Problems; Vaginal Discharge.

Condition Filter:

Endometrial Cancer.

Location Filter:

Clinic.

Case created by:

DB, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_38\_Endometrial Cancer

Homepage Vignette:

## A 55-year-old woman named Mira Joshi presents with PV bleeding.

Individual Page Vignette:

You are a General Practitioner and Mira Joshi, a 55-year-old, school teacher from the local area comes to see you with complaints of post-menopausal bleeding.

Patient Name:

Mira Joshi (Pronunciation: Mee-rah Jo-shee). Mira prefers to be called by her first name.

Age:

15/06/1969

Location:

General Practice

Personality:

Mira is articulate and expresses her concerns thoughtfully. She speaks clearly, maintaining eye contact, and occasionally shows signs of anxiety by wringing her hands. Mira has a poised demeanour and appears to be well-educated, often using medical terms she has read about prior to the consultation.

Presenting Complaint:

Mira reports experiencing irregular bleeding over the past two months despite having gone through menopause three years ago. She also mentions a feeling of fullness and discomfort in her lower abdomen.

Quote: "I've been quite concerned after noticing some bleeding, doctor. It's been happening off and on for a couple of months now, and I just feel so bloated all the time."

Symptoms:

- Site: Mira points to her lower abdomen and mentions the bleeding is vaginal. "It's all happening down here, and the bleeding definitely caught me off guard."

- Onset: The symptoms started approximately two months ago. "This all began around two months back."

- Character: The bleeding is described as intermittent and light. "It's not constant, comes and goes, and it's quite light."

- Radiation: The abdominal discomfort does not radiate. "The bloating and discomfort just stay in my lower abdomen."

- Associated Symptoms: Mira reports experiencing intermittent abdominal discomfort. "Along with the bleeding, I've had this nagging discomfort."

- Timing: The symptoms have been occurring for the last two months. "These issues have been my unwelcome companions for the last two months."

- Exacerbating and Relieving Factors: Nothing specific exacerbates or relieves the symptoms. "I haven’t found anything that makes it better or worse, it just seems random."

- Severity: The bleeding is light, and the abdominal discomfort is mild but persistent. "The bleeding isn't heavy, but it's the persistence that worries me."

Negative or detailed positive result findings:

- PV Bleeding: Light, intermittent, no distinct smell or color change noted.

- PV Discharge: None reported.

- Abdominal or Pelvic Pain: Mild to moderate, persistent general discomfort, no specific site of severe pain reported.

- Dyspareunia: Not reported.

- Post-coital PV Bleeding: Not applicable.

- Post-menopausal Bleeding: Yes, as described.

- Vulval skin changes or itching: None reported.

Quote: "I've not noticed anything else unusual, no changes down there or discharge, just the bleeding and discomfort."

Abdominal distension, breast lumps, severe menstrual cramps, missed periods, chronic pelvic pain, shoulder tip pain are not present or reported in the patient’s case.

Quote: "No, I haven’t noticed any of those other symptoms."

History of Presenting Complaint:

- Mira has been experiencing post-menopausal bleeding and abdominal discomfort for two months.

- She has not attempted any over-the-counter medications for her symptoms.

- The symptoms did not show any progression but have been persistent.

- The frequency of bleeding is intermittent.

- Impact on daily life: These symptoms caused Mira to seek medical attention due to worry but haven’t tremendously affected her daily activities.

- Impact on work: Mira is a school teacher and has managed her symptoms without any significant interference in her job.

- Impact on physical and mental wellbeing: Mira expresses considerable anxiety and concern regarding her health, indicating an impact on her mental wellbeing.

Quote: "I’ve been coping, but the worry of not knowing what's causing this is quite distressing."

Systemic Symptoms:

- Fatigue: Mira reports mild fatigue. "I've felt a bit more tired than usual."

- Fever: None reported.

- Night Sweats: None reported.

- Unintended Weight Loss: None reported.

- Chest or Shoulder Tip Pain: None.

- Shortness of Breath or Cough: None.

- Change in Bowel Habits: No changes reported.

- Change in Urinary Habits: No changes reported.

- Dysuria: None.

- Oedema: None.

- Rashes or Skin Changes: None.

- Headache: Occasional mild headaches, not unusual for the patient.

- Mood Changes: Mira reports feeling anxious about her symptoms.

- Sleep Disturbances: Mira mentions some difficulty falling asleep, attributed to her anxiety.

Obstetric History:

Gravidity and Parity: G2 P2+0

- >24 Weeks Pregnancies: Two pregnancies both carried to full term.

- Gestation at Delivery(s): 38 weeks for the first child, 39 weeks for the second.

- Birth Weight(s): First child 3.2 kg, second child 3.5 kg.

- Mode of Birth(s): Both vaginal births.

- Complications: No complications during either pregnancy or birth.

- Stillbirths: None.

- <24 Weeks Pregnancies:

- Miscarriages: None reported.

- Terminations: None.

- Ectopic Pregnancies: None

Quote: "My pregnancies were quite straightforward, and I consider myself lucky in that regard."

Gynaecology History:

- Menstrual History: Mira’s periods were regular before menopause, lasting about 5 days with moderate flow. No history of dysmenorrhea.

- Last Menstrual Period: Approximately three years ago, marking the start of menopause.

- Menarche: Age 12.

- Menopause: Confirmed at age 52.

- Previous Screens: Last cervical screening performed two years ago, results were normal.

- Previous Gynaecology Conditions: None reported.

- Previous STIs: None reported.

- Contraception: Mira used oral contraceptive pills in the past but has not needed contraception post-menopause.

Quote: "I’ve always kept up with my screenings, and thankfully everything’s been normal. Haven’t needed any contraception since I hit menopause."

Past Medical History:

- No previous medical conditions reported.

- No previous surgeries or hospitalizations.

- Immunizations and vaccination history complete, including for HPV.

- No previous STIs.

- No other relevant medical conditions or significant health events reported.

Quote: "I’ve been fortunate with my health over the years, nothing significant to report."

Drug History:

- No prescription medications currently being taken.

- No past contraceptive methods used other than oral contraceptive pills previously mentioned.

- No history of medication non-compliance, use of herbal supplements or alternative therapies.

- No overdose incidents.

Quote: "I’ve really not had to take much in the way of medication, thankfully."

Allergies:

- No allergies or intolerances reported.

Quote: "No, I’ve never had any allergies or bad reactions to anything."

Family History:

- Mother diagnosed with breast cancer at age 60, currently in remission.

- Father has type 2 diabetes, managed with medication.

- One sibling, a brother, with no significant medical history.

Quote: "Mum had a scare with breast cancer but she’s been doing well, thankfully. Dad’s been managing his diabetes okay."

Social History:

- Lifestyle: Lives with her husband and two children in a suburban area.

- Occupation: School teacher.

- Activities of Daily Living & Hobbies: Enjoys walking and gardening in her free time.

- Smoking: Non-smoker.

- Alcohol: Drinks socially, approximately 3 units per week.

- Recreational Drug Use: None.

- Diet: Follows a balanced diet with plenty of fruits and vegetables.

- Exercise: Walks daily, incorporates yoga twice a week.

Quote: "I try to keep active and eat well. Teaching keeps me on my toes, and I unwind with my garden or a good yoga session."

Sexual History:

- Last sexual intercourse: Mira prefers not to specify but indicates it was recent.

- Partners: Married, monogamous relationship.

- Contraceptive use: Not applicable due to post-menopausal status.

Quote: "My husband and I are quite content. No concerns in that department."

Ideas, Concerns, and Expectations:

- Ideas: Mira has read about post-menopausal bleeding and is concerned about the possibility of cancer. "I’ve done a bit of reading, and I can’t help but worry it’s something serious like cancer."

- Concerns: Primary concern is the potential underlying cause of her symptoms, particularly cancer. "The unknown is what’s really troubling me. I hope it’s not cancer."

- Expectations: Mira expects to undergo diagnostic tests to determine the cause of her symptoms and discuss possible treatment options. "I’m hoping we can get to the bottom of this with some tests and figure out what needs to be done."

Observations:

NEWS Total Score: 0

Physical Examination:

General Inspection:

- Overall appearance: Well-nourished, well-kept, no signs of distress or pain.

- Signs of oedema: None observed.

Objects and Equipment:

- No mobility aids or medical devices present.

Hands:

- Inspection: Normal colour, no palmar erythema, no peripheral oedema observed.

- Palpation: Normal temperature, capillary refill time within the normal range (<2 seconds), radial pulse normal in rate, rhythm, and volume.

Neck:

- No masses, goitres, raised JVP, or lymphadenopathy appreciated.

Face:

- No notable findings such as melasma, conjunctival pallor, jaundice, facial oedema, exophthalmos, corneal arcus, xanthelasma, or Kayser-Fleischer rings.

Abdominal Examination:

- Inspection: Mild distension noted.

- Palpation: Mild diffuse tenderness, no palpable masses.

Vaginal Examination:

- Vulval Inspection: No ulcers, cysts, rashes, discharge, scarring, atrophy, lesions, masses, FGM, prolapses, or lichen sclerosis noted.

- Speculum Examination: Cervical os appears normal, no active bleeding observed, no erosions, masses, or discharge noted. Cervical ectropion not observed.

- Bimanual Examination: Vaginal walls and cervix appear normal; cervix in the normal position, normal consistency without cervical excitation. Uterus normal in size, shape, and position, without masses, nodules, or tenderness. Ovaries not palpable.

Diagnostic Tests:

- Urine Dipstick: Normal.

- STI Screen: Full STI screen is negative.

Blood Tests (Reference Ranges):

- Full Blood Count (FBC):

- Haemoglobin (Hb): 115 g/L (Female: 115 - 165 g/L)

- Mean Corpuscular Volume (MCV): 92 fL (80 – 100 fL)

- White Blood Cell Count: 7.2 x10^9/L (3.6 - 11.0 x10^9/L)

- Platelets: 250 x10^9/L (140 - 400 x10^9/L)

- Urea and Electrolytes:

- Sodium: 140 mmol/L (133–146 mmol/L)

- Potassium: 4.2 mmol/L (3.5–5.3 mmol/L)

- Urea: 4.5 mmol/L (2.5 – 7.8 mmol/L)

- Creatinine: 76 μmol/ L (Female: 45–84 μmol/ L)

Imaging Tests:

- Ultrasound Scan: A transvaginal ultrasound shows thickened endometrium, no signs of masses in the ovaries or uterus.

- Endometrial Biopsy: Histopathology shows adenocarcinoma.

Condition:

Endometrial Cancer

Patient Questions:

1. "Could this be something serious like cancer?"

- Answer: "It's important we check everything thoroughly, including some tests, to understand what's causing your symptoms. There are many reasons for post-menopausal bleeding, not all are serious, but it’s crucial we rule out conditions like cancer among other possibilities."

2. "What kind of tests will I need to go through?"

- Answer: "We’ll start with some blood tests and an ultrasound to look at your uterus and ovaries more closely. Depending on those results, we might need to proceed with further diagnostic evaluations."

3. "If it is cancer, what are my treatment options?"

- Answer: "Treatment options vary based on the stage and type of cancer but can include surgery, radiation therapy, hormone therapy, and chemotherapy. We will discuss in detail and choose the best approach for you based on a thorough evaluation."

4. "How long will the diagnostic process take?"

- Answer: "The initial tests can be scheduled soon, and we usually receive results within a few days to a week. If further diagnostic procedures are required, I will guide you through the timelines as we go."

Examiner Questions:

1. What are the differential diagnoses for post-menopausal bleeding?

- Answer: Endometrial cancer, atrophic vaginitis, endometrial hyperplasia, polyps, cervical cancer.

2. How would you manage a patient presenting with post-menopausal bleeding in primary care?

- Answer: History and physical examination followed by appropriate investigations including blood tests, transvaginal ultrasound, and referral to gynaecology for further assessment.

3. What is the significance of performing an ultrasound in this case?

- Answer: Ultrasound helps in assessing the endometrial thickness, identifying any masses or abnormalities in the uterus and ovaries, leading to further diagnostic clarification.

4. Explain the importance of the patient's family history in this context.

- Answer: Family history of cancers, especially breast or/and ovarian cancer can suggest a genetic predisposition to gynaecological cancers, informing risk assessment and management strategy.

5. Discuss the potential treatment strategies for endometrial cancer.

- Answer: Depending on the stage, treatments may include surgery (hysterectomy with or without salpingo-oophorectomy), radiation therapy, hormone therapy, or chemotherapy. Advanced stages may require a combination of these treatments.

6. How would you counsel a patient about the need for invasive procedures like biopsy or surgery?

- Answer: Explain the importance of the procedure in confirming the diagnosis, discuss the risks and benefits, address any concerns, ensure understanding, and obtain informed consent.

Treatment:

The management and treatment of endometrial cancer are based on the stage of the disease, the patient's overall health, and her preferences. Following NICE guidelines:

1. \*\*Surgical Management\*\*:

- \*\*Total hysterectomy\*\* with bilateral salpingo-oophorectomy is the primary treatment for endometrial cancer. This involves the removal of the uterus, both ovaries, and fallopian tubes.

- \*\*Lymph node assessment\*\* may be considered to check the disease's spread, which can guide further treatment decisions.

2. \*\*Radiation Therapy\*\*:

- Postoperative adjuvant radiation therapy (external beam radiation or brachytherapy) may be recommended, especially in cases with a high risk of recurrence.

3. \*\*Hormone Therapy\*\*:

- Particularly for patients with advanced or recurrent endometrial cancer, hormone therapy with progestins can be considered.

4. \*\*Chemotherapy\*\*:

- For advanced, metastatic, or recurrent endometrial cancer, chemotherapy may be used as part of the treatment plan.

5. \*\*Follow-Up and Monitoring\*\*:

- Regular follow-ups are necessary to monitor for signs of recurrence and manage side effects of treatment.

Monitoring:

- \*\*Immediately Post-treatment\*\*: Monitor for surgical complications if surgery was performed. This includes signs of infection, bleeding, or thromboembolic events.

- \*\*Long-Term Follow-Up\*\*:

- Regular pelvic examinations and symptom reviews every 3 to 6 months for the first 2 years, then annually.

- Imaging and blood tests as clinically indicated based on symptoms or findings in the follow-up examinations.

- \*\*Lifestyle and Supportive Care\*\*:

- Consider counselling and support for sexual health and psychological wellbeing post-hysterectomy.

- Diet, physical activity, and weight management advice as being overweight can affect cancer prognosis.

Prognosis:

- The prognosis for endometrial cancer is generally favourable, especially when diagnosed early.

- \*\*Stage I\*\*: high survival rates, usually over 85% five-year survival.

- \*\*Advanced stages\*\*: Lower survival rates, depending on the extent of spread and response to treatment.

- \*\*Prognostic Factors\*\*: Tumour grade, depth of myometrial invasion, and lymphovascular space involvement are significant prognostic factors.

Differential Diagnoses:

1. \*\*Atrophic Vaginitis\*\*: Less likely due to the absence of associated symptoms such as vaginal dryness or dyspareunia and the imaging results.

2. \*\*Endometrial Hyperplasia\*\*: Possible pre-malignant condition, differentiated by biopsy.

3. \*\*Cervical Cancer\*\*: Screening history and lack of visible cervical lesions make this less likely.

4. \*\*Uterine Sarcoma\*\*: Rare, but considered in differential for post-menopausal bleeding. Usually differentiated by imaging and biopsy.

5. \*\*Uterine Polyps\*\*: Can cause bleeding; diagnosed via ultrasound and hysteroscopy.

Keyword Filters:

Speciality Filter:

Cancer; Obstetrics and Gynaecology;

Presenting Complaint Filter:

Abnormal Cervical Smear Result; Menopausal Problems; Post-menopausal Bleeding; Pelvic Pain;

Condition Filter:

Endometrial Cancer;

Location Filter:

General Practice; Clinic; Accident & Emergency

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Case created by:

DB, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor

Case Code:

# DWZHB\_39\_EndometrialCancer

Homepage Vignette:

## A 55-year-old female called Mireya Salas presents with abnormal PV bleeding.

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Individual Page Vignette:

You are a General Practitioner assessing Mireya Salas, a 55-year-old, who works as an archivist. She consults you at your clinic located in a suburban area, presenting with complaints of abnormal PV bleeding and pelvic discomfort.

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Patient Name: Mireya Salas

Phonetic Pronunciation: My-ray-uh Sah-las

Preferred Name: Mireya

Age:

DOB: 25/09/1969

Location:

Clinic

Personality:

Mireya is articulate and inquisitive, with a cautious approach to her health concerns. She expresses herself clearly, asking detailed questions about her symptoms and potential diagnoses. Despite feeling anxious about her health, she maintains a hopeful outlook. Mireya speaks in a calm and measured tone, indicating her thoughtful nature.

Presenting Complaint:

Mireya presents with abnormal uterine bleeding and pelvic discomfort.

"I've been experiencing quite unpredictable and heavy bleeding for a few months now. It's worrying, and the pelvic pain that comes and goes has made me quite uneasy."

Symptoms:

- \*\*Site:\*\* Uterus and pelvic area; "The cramping feels centrally located, right around my lower abdomen."

- \*\*Onset:\*\* Gradual; "This started subtly but has become more noticeable over the past few months."

- \*\*Character:\*\* Bleeding is heavy; pain is cramping in nature; "It's like a tap that's suddenly been turned on too high, and the cramps can be quite sharp."

- \*\*Radiation:\*\* Does not radiate; "The pain seems to stay put right in the lower belly."

- \*\*Associated Symptoms:\*\* None specifically mentioned; "I haven't noticed anything else unusual, just the bleeding and pain."

- \*\*Timing:\*\* Intermittent; "The bleeding has become more frequent. It's no longer just during what used to be my regular period."

- \*\*Exacerbating and Relieving Factors:\*\* Not specified; "I haven't found anything that makes it better or worse. It seems to have a mind of its own."

- \*\*Severity:\*\* Moderate to severe; "The pain can sometimes be quite bad, enough to affect my day."

PV Bleeding: Heavy, bright red, without significant clots or unusual smell.

PV Discharge: Normal

Abdominal or Pelvic Pain: Intermittent, central lower abdominal pain.

Dyspareunia: Negative

Post-coital PV Bleeding: Negative

Vulval skin changes or itching: Negative

"I can't believe the amounts. It's not like anything I've had before. It sometimes stops me in my tracks."

History of Presenting Complaint:

- Over the past 6 months.

- No previous treatments attempted.

- Symptom frequency and severity have increased over time.

- Impacts daily life significantly - needing to plan activities around access to bathrooms.

- Work impacted due to needing time off.

- Emotional and mental wellbeing affected - increased anxiety and concern over health.

"I've never been one to miss work, but some days I just can't face it. It's all very stressful."

Systemic Symptoms:

- Fatigue: Mild; "I've felt more tired lately, but I assumed it was stress."

- Fever: Negative

- Night Sweats: Negative

- Unintended Weight Loss: Negative

- Chest or Shoulder Tip Pain: Negative

- Shortness of Breath or Cough: Negative

- Change in Bowel Habits: Normal

- Change in Urinary Habits: Normal

- Dysuria: Negative

- Oedema: Negative

- Rashes or Skin Changes: Negative

- Headache: Occasional, mild; "I thought they were just tension headaches."

- Mood Changes: Increased anxiety

- Sleep Disturbances: Occasional; "Sometimes, I'm just too worried to sleep."

"I guess I've been feeling a bit run down, but who isn't these days?"

Obstetric History:

Previous Obstetric History: G3 P2+0

>24 Weeks Pregnancies:

- Gestation at Delivery(s): 38, 39, 37 weeks

- Birth Weight(s): 3.2kg, 3.5kg

- Mode of Birth(s): Caesarian sections due to personal preference without complications

- Complications: None

- Stillbirths: None

<24 Weeks Pregnancies: None

Miscarriages: None

Terminations: None

Ectopic Pregnancies: None

"All of my pregnancies were fairly straightforward, thankfully."

Gynaecology History:

Menstrual History:

- Duration: Previously 5-7 days

- Frequency: Every 28-30 days

- Volume: Moderate, now significantly increased

- Dysmenorrhea: Mild previously, now moderate

Last Menstrual Period: Irregular over the last year

Menarche: 12 years

Menopause: Entered peri-menopause approximately 2 years ago

Contraception: None currently; previously used oral contraceptive pills until age 50.

"I used to be like clockwork. Now, it's all over the place."

Past Medical History:

- Hypertension, managed with medication.

- Hypercholesterolemia, diet controlled.

- No previous surgeries or hospitalizations.

- Immunizations up to date, including HPV vaccine.

- No previous STIs.

- No other significant medical conditions.

"I've been generally healthy, just the usual 'getting older' issues."

Drug History:

- Lisinopril 10mg once daily for hypertension.

- No history of medication non-compliance.

- Previous contraception: Oral contraceptive pill until age 50, no issues.

"I take my blood pressure pill every morning, never missed."

Allergies:

- Penicillin: Causes rash and itching.

"I found out I was allergic to penicillin the hard way."

Family History:

- Mother had breast cancer diagnosed at age 60.

- Father lived with type 2 diabetes.

- One older brother, healthy.

- No known family history of endometrial or ovarian cancer.

"My mother went through a lot with her cancer. It makes one think."

Social History:

Lifestyle: Leads a relatively sedentary lifestyle.

Occupation: Archivist, mostly desk-bound work.

Activities of Daily Living & Hobbies: Enjoys reading and gardening.

Smoking: Non-smoker.

Alcohol: Drinks socially, approximately 4 units per week.

Recreational Drug Use: None.

Diet: Balanced, tries to maintain a healthy diet.

Exercise: Moderate, walks daily for 30 minutes.

"I enjoy my quiet times in the garden or with a book."

Sexual History:

Last sexual intercourse: 3 months ago.

Married, monogamous relationship.

No contraception used currently due to peri-menopause.

"It's not like our relationship has suffered, but things have obviously changed."

"Mom's passing was hard. It made me think more about my health."

Ideas, Concerns, and Expectations:

- Ideas: Worries that symptoms might indicate cancer due to mother's history.

- Concerns: Concerned about the impact on her daily life and the possibility of serious illness.

- Expectations: Hopes for comprehensive testing to determine the cause of symptoms, and openness to treatment options.

"I just want to figure out what's going on and deal with it."

Observations:

Respirations (Breaths/min): 16

Oxygen Saturation (%): 98% on room air

Air or Oxygen?: Room air

Blood Pressure (mmHg): 130/85

Pulse (Beats/min): 78

Consciousness (AVPU): Alert

Temperature (Celsius): 37.2

NEWS Total Score: 0

Physical Examination:

General Inspection:

- Appears well; no signs of acute distress.

- Overall appearance normal for age.

- No obvious scars or scratch marks.

- No signs of oedema.

Objects and Equipment: None present.

Hands:

Inspection: Normal colour, no palmar erythema or peripheral oedema.

Palpitation: Normal temperature, CRT less than 2 seconds, radial pulse regular.

Neck: No masses, goitres, elevated JVP, or lymphadenopathy detected.

Face: No melasma, conjunctival pallor, jaundice, oedema, exophthalmos, corneal arcus, xanthelasma, or Kayser-Fleischer rings.

Abdominal Examination:

- Inspection: Abdomen appears normal with no distension.

- Palpation: No masses palpable. Mild tenderness in the lower abdomen, no rebound tenderness.

Vaginal Examination:

- Vulval Inspection: Normal, no ulcers, cysts, rashes, discharge, scarring, atrophy, lesions, masses, FGM, prolapses, or lichen sclerosis.

- Speculum Examination: Normal cervical os, no bleeding, erosions, masses, ulcers, discharge, or cervical ectropion.

- Bimanual Examination: Uterus normal size, non-tender. No masses or nodules. Ovaries not palpable.

Special Tests:

Diagnostic Tests:

Urine Dipstick: Normal

STI Screen: Negative

Blood Tests (Reference Ranges):

- Full Blood Count (FBC): Within normal limits.

- U&E: Within normal limits.

- LFT: Within normal limits.

- Coagulation Profile: Within normal limits.

* Serum CA-125 level: Normal (<35 units/ml)

Imaging Tests:

* Transvaginal Ultrasound: Indicates endometrial thickening over 4mm.
* Endometrial Biopsy: Histopathology shows adenocarcinoma.

Treatment:

The management of endometrial cancer should be multidisciplinary and tailored to the individual patient's condition, taking into account the stage of the disease, the patient's general health, and their preferences regarding fertility preservation.

1. \*\*Initial Management\*\*:

- Referral to a gynaecological oncologist for further assessment and management is paramount.

- Diagnostic evaluation should include endometrial biopsy via hysteroscopy to confirm the diagnosis and grade the tumour.

2. \*\*Surgical Treatment\*\*:

- Total hysterectomy (removal of the uterus and cervix) and bilateral salpingo-oophorectomy (removal of both ovaries and fallopian tubes) is the mainstay treatment for most stages of endometrial cancer, considering the patient's age and the fact that family is complete.

- Lymphadenectomy may be performed based on the stage and grade of the tumour to assess for spread.

3. \*\*Radiotherapy\*\*:

- May be used post-surgery for certain stages to reduce the risk of recurrence, especially in cases with high-grade tumours or lymph node involvement.

4. \*\*Chemotherapy\*\*:

- May be considered in advanced cases, where the cancer has spread beyond the uterus or in cases where recurrence occurs.

- Drugs and dosages would be determined based on the specific characteristics of the cancer and patient's overall health.

5. \*\*Hormonal Therapy\*\*:

- Progestins may be used in certain types of endometrial cancer that are responsive to hormones, especially in younger patients wishing to preserve fertility or in patients not suitable for surgery.

6. \*\*Follow-up and Monitoring\*\*:

- Regular follow-up appointments with the gynaecological oncologist to monitor for signs of recurrence.

- Physical exams and imaging tests such as pelvic ultrasound or MRI as recommended by the oncologist.

7. \*\*Symptomatic Treatment\*\*:

- Management of symptoms such as pain with appropriate analgesia.

- Psychological support for the patient and family.

8. \*\*Palliative Care\*\*:

- In advanced cases, where treatment is not curative, focus on quality of life and symptom control.

\*\*Dosages and Frequencies\*\*:

- Specific chemotherapy regimens and hormonal treatments will be determined by oncologists based on tumour characteristics.

\*\*Alternative Options\*\*:

- For patients allergic to specific chemotherapeutic agents, alternative drugs can be considered.

- In patients unsuitable for surgery, radiotherapy, and hormonal therapy options will be the focus of treatment.

Monitoring:

- \*\*Treatment Response\*\*: Monitoring through follow-up visits with the gynaecological oncologist, including physical examination and relevant imaging/tests to assess response to treatment.

- \*\*Side Effects\*\*: Regular assessment of potential side effects from chemotherapy, radiotherapy, or hormonal therapy. Modifications to treatment regimes may be necessary depending on tolerance.

- \*\*Recurrence Monitoring\*\*: Surveillance for signs of cancer recurrence via physical exams, imaging studies, and possibly biomarkers, as appropriate.

- \*\*General Health Monitoring\*\*: Ongoing management of any other comorbid conditions, with specific attention to cardiovascular health due to potential risks associated with hormonal therapy.

Prognosis:

- The prognosis of endometrial cancer is generally favourable, especially when detected early and managed properly.

- Prognostic factors include the stage and grade of the tumour at diagnosis, the patient's age and general health, and the completeness of surgical resection.

- Early-stage, low-grade tumours have a high cure rate with appropriate treatment.

- Advanced disease, high-grade tumours, or lymph node involvement may have a poorer prognosis.

Differential diagnoses:

1. \*\*Atrophic Vaginitis\*\* - Less likely due to presence of pelvic pain and the imaging results.

2. \*\*Fibroids\*\* - Considered given the patient's symptomatic presentation, but distinguished by imaging and biopsy.

3. \*\*Pelvic Inflammatory Disease\*\* - Less likely based on the patient's monogamous relationship and current symptoms.

4. \*\*Ovarian Cancer\*\* - A possibility given the patient's age and symptoms, warranting differentiation through imaging and CA-125 levels.

Keyword Filters:

Speciality Filter: Cancer; General Practice; Obstetrics and Gynaecology; Palliative and End of Life Care.

Presenting Complaint Filter:

Abnormal Cervical Smear Result; Abdominal Mass; Menopausal Problems; Menstrual Problems; Pelvic Mass; Pelvic Pain;

Condition Filter: Endometrial Cancer

Location Filter: Clinic; General Practice

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Patient Questions:

1. "What will happen if I don't take any treatment?"

- Answer: Not treating endometrial cancer can allow it to progress and potentially spread to other parts of the body, which could be life-threatening. Treatment is crucial to manage the disease effectively.

2. "Will I require chemotherapy, and what are the side effects?"

- Answer: Whether you need chemotherapy depends on the stage and grade of the cancer. Side effects can vary but may include nausea, fatigue, hair loss, and increased risk of infection. Your oncologist will discuss this in detail.

3. "How long will the recovery take after surgery?"

- Answer: Recovery varies by individual but generally, you can expect to stay in the hospital for a few days post-surgery, with full recovery taking several weeks. You'll have follow-up appointments to monitor your recovery and any further treatment needed.

Examiner Questions:

1. What are the primary management strategies for a patient diagnosed with endometrial cancer?

- Answer: Primary management involves surgical intervention, possibly followed by radiotherapy, chemotherapy, or hormonal therapy depending on the stage and grade of the cancer.

2. How does the stage of endometrial cancer affect treatment options?

- Answer: Early-stage cancer may be managed with surgery alone, while advanced stages may require a combination of surgery, chemotherapy, radiotherapy, and/or hormonal therapy.

3. What are the indications for radiotherapy in endometrial cancer?

- Answer: Radiotherapy is indicated in patients with high-risk factors for recurrence, such as high-grade tumours, lymph node involvement, or incomplete surgical resection margins.

4. How can endometrial cancer prognosis be determined?

- Answer: Prognosis is primarily based on the stage and grade of the tumour, patient age, and response to treatment. Early detection generally leads to a better prognosis.

5. Discuss the importance of a multidisciplinary team in the management of endometrial cancer.

- Answer: A multidisciplinary team, including oncologists, surgeons, radiologists, pathologists, and palliative care specialists, ensures a comprehensive approach to treatment, addressing all aspects of the patient's care and improving outcomes.

Case Code:

# DWZHB\_40\_EndometrialCancer

Homepage Vignette:

## A 58-year-old female called Marisol Ximenez presents with post-menopausal bleeding.

Individual Page Vignette:

You are the attending physician in a clinic. Your patient is Marisol Ximenez, a 58-year-old, who works as a librarian in the local library. She is located in your clinic, presenting with post-menopausal bleeding and abdominal pain.

Patient Name:

Marisol Ximenez (Mar-i-sol Hee-men-ez); She prefers to be called Marisol.

Age:

07/02/1966

Location:

Clinic

Personality:

Marisol has a reserved and introspective personality. She speaks in a calm and thoughtful manner, often pausing to reflect on her symptoms and their impact on her day-to-day life. She values clear communication and seeks to understand her health condition in depth.

Presenting Complaint:

Marisol has been experiencing post-menopausal bleeding for the past two months, accompanied by occasional abdominal pain.

Quote: "I thought I was done with all this bleeding, but it's started up again, and sometimes, my belly aches something fierce."

Symptoms:

- Site: Lower abdomen; "It just feels like it radiates all over down there."

- Onset: Two months ago; "It began so suddenly, took me by surprise."

- Character: The abdominal pain is cramping in nature; "It's like a tight gripping sensation."

- Radiation: The pain does not radiate; "No, it just stays put in my belly."

- Associated Symptoms: Post-menopausal bleeding; "The bleeding is quite distressing, never expected it at my age."

- Timing: The bleeding is sporadic, and the abdominal pain occurs intermittently; "I can't find a pattern to it."

- Exacerbating and Relieving Factors: Nothing specific seems to trigger the symptoms, resting seems to slightly ease the abdominal discomfort; "Lying down with a hot water bottle sometimes feels a bit better."

- Severity: Bleeding is moderate, abdominal pain is moderate; "It's enough to make me worry and seek help."

PV Bleeding: Moderate-volume, red, non-clotting, odourless.

PV Discharge: N/A

Abdominal or Pelvic Pain: Moderate cramping pain in the lower abdomen.

Chance of Pregnancy: None.

Dyspareunia: Not applicable

Post-coital PV Bleeding: Not applicable.

Intermenstrual PV Bleeding: Not applicable.

Post-menopausal Bleeding: Present and described above.

Vulval skin changes or itching: Not present.

Abdominal distension, severe menstrual cramps and chronic pelvic pain: Not present.

Quote: "I just can't shake off this unease about the bleeding. And the abdominal aches don't help either."

History of Presenting Complaint:

- Marisol began experiencing symptoms two months ago.

- No previous treatment attempted.

- Symptoms have remained consistent without progression.

- The frequency of symptoms is sporadic for bleeding and intermittent for pain.

- The symptoms have caused significant worry and prompted her to seek medical attention.

- Impact on daily life minimal beyond the concern for her health.

- Impact on work and physical activities negligible but has affected her mental wellbeing due to the worry.

Quote: "It's this constant worry at the back of my mind – wondering why it's happening."

Systemic Symptoms:

- Fatigue: Not present.

- Fever: Not present.

- Night Sweats: Not present.

- Unintended Weight Loss: Not present.

- Chest or Shoulder Tip Pain: Not present.

- Shortness of Breath or Cough: Not present.

- Change in Bowel Habits: Normal.

- Change in Urinary Habits: Normal.

- Dysuria: Not present.

- Oedema: Not present.

- Rashes or Skin Changes: Not present.

- Headache: Not present.

- Mood Changes: Increased worry and anxiety about her symptoms.

- Sleep Disturbances: Occasionally disturbed due to worry.

Quote: "Aside from the worry, I feel generally ok. It's just the bleeding and pain that's out of the ordinary."

Obstetric History:

Previous Obstetric History:

Gravidity and Parity: G2 P2+0

>24 Weeks Pregnancies:

Gestation at Delivery(s): 39 weeks, 40 weeks

Birth Weight(s): 3.2 kg, 3.5 kg

Mode of Birth(s): Vaginal birth, Vaginal birth.

Complications: Post-partum haemorrhage of 1.5l after second birth.

Stillbirths: None

<24 Weeks Pregnancies:

Miscarriages: None

Terminations: None

Ectopic Pregnancies: None

Quote: "I've been blessed with two children, both grown up now."

Gynaecology History:

Menstrual History:

Duration: Before menopause, her cycles lasted around 5-6 days.

Frequency: Her cycles were regular, occurring every 28-30 days.

Volume: She described her flow as moderate, without significant clots.

Dysmenorrhoea: Occasional mild cramps, managed with over-the-counter pain relief.

Last Menstrual Period: Approximately 4 years prior to the current presentation.

Menarche: Age 13

Menopause: Commenced at age 51

Contraception: Marisol used oral contraceptive pills before deciding to switch to barrier methods after her second child.

Quote: "My periods have always been pretty regular, nothing too troublesome until they stopped a few years back."

Previous Screens:

Cervical screening up to date with last smear 3 years ago showing no abnormalities.

Previous Gynaecology Conditions: None

Previous STIs: None

Past Medical History:

- Hypertension, managed with medication.

- No previous surgeries or hospitalisations.

- Full immunizations up to date, including HPV vaccination.

- No previous significant injuries or traumas.

Quote: "Apart from my high blood pressure, which I keep under control, I've been quite healthy, thankfully."

Drug History:

- Ramipril 10mg once daily for hypertension.

- No current or past use of folic acid or iron supplements.

- No history of medication non-compliance or missed doses.

- No use of herbal supplements or alternative therapies.

- Last contraception used was condoms, with no history of hormonal or intrauterine methods in recent years.

Quote: "I take my blood pressure tablets every morning without fail. It's part of my routine now."

Allergies:

- No known allergies.

Quote: "Luckily, I've never had any bad reactions to medications or foods."

Family History:

- Mother had breast cancer diagnosed at age 62.

- Father with history of type 2 diabetes.

- No significant health issues in siblings.

- Grandparents had various age-related conditions but nothing genetic or concerning noted.

Quote: "Mum had a scare with breast cancer, but thankfully, it was caught early."

Social History:

Lifestyle: Marisol leads a generally healthy lifestyle, enjoys gardening, and regularly attends book club meetings.

Occupation: Librarian at the local library, a role she finds fulfilling and manageable.

Activities of Daily Living & Hobbies: Independent in all ADLs, with hobbies including writing poetry and birdwatching.

Smoking: Never smoked.

Alcohol: Drinks socially, approximately 4 units per week.

Recreational Drug Use: None.

Diet: Tries to maintain a balanced diet, including plenty of fruits and vegetables.

Exercise: Walks for 30 minutes daily.

Quote: "I enjoy my quiet, peaceful life. Gardening brings me so much joy."

Sexual History:

Last sexual intercourse was several months ago. Marisol has been widowed for 5 years and has had no new partners since. She previously used condoms as contraception.

Quote: "Since my husband passed, I've not been with anyone. It's not something I've thought much about."

Ideas, Concerns, and Expectations:

- Marisol expresses concern about the cause of her post-menopausal bleeding, wondering if it could be cancer given her family history of breast cancer.

Quote: "With my mum having had breast cancer, I can't help but worry if this bleeding means I have cancer too."

- She is anxious about the results of the forthcoming tests and what treatment she may require.

Quote: "What if the tests show something bad? What kind of treatment would I need?"

- Marisol hopes for a thorough explanation of her symptoms and reassurance regarding her condition.

Quote: "I just want to know what's causing this, and that it can be managed or treated."

- She expects clear communication regarding her diagnosis and treatment options.

Quote: "I'd appreciate it if you could explain everything clearly to me, so I understand what's going on and what to expect."

Observations:

NEWS Total Score: 0

Physical Examination:

General Inspection:

- Marisol appears well, with no signs of distress or discomfort at rest.

- She is alert and oriented.

- No pallor, cachexia, or oedema observed.

Objects and Equipment:

- No mobility aids or medical equipment present.

Hands:

- Colour normal, no palmar erythema or peripheral oedema noted.

- Temperature is warm, and Capillary refill time is less than 2 seconds.

- Radial pulse is regular, with a good volume and no peripheral oedema detected.

Neck:

- No palpable masses or goitre.

- JVP not elevated, and no palpable lymphadenopathy detected.

Face:

- No melasma, conjunctival pallor, jaundice, oedema, or xanthelasma.

Abdominal Examination:

- Inspection reveals no visible scars or masses.

- Palpation shows a soft, non-tender abdomen, with no palpable masses.

Vaginal Examination:

Vulval Inspection:

- No ulcers, cysts, rashes, discharge, or lesions observed.

Speculum Examination:

- Cervical os closed, no active bleeding, erosions, masses, ulcers, or discharge noted.

- No cervical ectropion visible.

Bimanual Examination:

- The cervix is firm and in a midposition, without cervical excitation pain.

- The uterus is of normal size, anteverted, with no masses or tenderness.

- Ovaries not palpable, which is normal in a post-menopausal woman.

Diagnostic Tests:

Urine Dipstick:

* Normal

STI Screen:

- Chlamydia: Negative

- Gonorrhoea: Negative

- Syphilis (blood test): Negative

- HIV (blood test): Negative

Blood Tests (Reference Ranges):

Full Blood Count (FBC):

- Haemoglobin (Hb): 140 g/L (Female: 115 - 165 g/L)

- Mean Corpuscular Volume (MCV): 92 fL (80 – 100 fL)

- White Blood Cell Count: 6.8 x10^9/L (3.6 - 11.0 x10^9/L)

- Platelets: 250 x10^9/L (140 - 400 x10^9/L)

Liver Function Tests:

N/A unless indicated by clinical judgment.

Imaging Tests:

Ultrasound Scan:

- A pelvic transvaginal ultrasound is indicated to assess the endometrium, which shows thickened endometrium measuring 11mm, suggestive of a possible pathology such as endometrial hyperplasia or endometrial cancer in the context of post-menopausal bleeding.

- Endometrial Biopsy: histopathology shows adenocarcinoma

Condition:

Endometrial Cancer

Patient Questions:

1. "What does a thickened endometrium mean? Is it cancer?"

- Possible Answer: "A thickened endometrium can be due to several causes, including benign conditions like hyperplasia. However, given your symptoms and findings, we need to explore further with a biopsy to determine if it's cancerous or not. It's important we take this step to ensure accurate diagnosis and appropriate management."

2. "If it is cancer, what are my treatment options?"

- Possible Answer: "Treatment depends on various factors including the stage of the cancer. Options may include surgery to remove the uterus, radiation therapy, hormone therapy, or a combination. We will discuss the most appropriate treatment for you based on the biopsy results."

3. "Are there any lifestyle changes I need to make now?"

- Possible Answer: "Maintaining a healthy lifestyle is always beneficial. Until we have more information, I recommend continuing with your current healthy habits, and we can discuss any specific changes needed later on."

Treatment:

Initial treatment steps for a suspected case of endometrial cancer after confirming the diagnosis with a biopsy include:

- Referral to a gynaecologic oncologist for evaluation and management, which may involve surgical intervention such as a hysterectomy with or without salpingo-oophorectomy.

- Depending on the stage and grading of the cancer, adjuvant therapy such as radiation or chemotherapy may be recommended.

- Hormone therapy may be an option for those who are not candidates for surgery or in recurrent cases.

Monitoring:

- Regular follow-up appointments with the gynaecologic oncologist to monitor treatment response and manage any side effects.

- Periodic imaging tests may be required to monitor for disease recurrence.

- Patients should report any new symptoms to their healthcare provider immediately.

Prognosis:

- The prognosis of endometrial cancer is generally favourable if detected early and treated appropriately. Factors such as stage of cancer, grade of tumour, and patient health status can influence outcomes.

- Regular follow-ups are crucial for monitoring and managing the condition.

Differential Diagnoses:

1. Endometrial Hyperplasia

- Less likely given the depth of endometrial thickness and post-menopausal status without hormone replacement therapy.

2. Uterine Polyps

- Could cause similar symptoms but usually associated with irregular bleeding patterns.

3. Atrophic Vaginitis

- Less likely due to the nature of bleeding and lack of associated atrophic symptoms and ultrasound results.

4. Cervical Cancer

- Less likely given the normal appearance of the cervix on examination and the primary symptom of post-menopausal bleeding.

Speciality Filter:

Obstetrics and Gynaecology; Cancer;

Presenting Complaint Filter:

Post-menopausal Bleeding; Abdominal Pain;

Condition Filter:

Endometrial Cancer

Location Filter:

Clinic

Case created by:

DB, XX Medical Student

Reviewed by:

XX, XX Medical Student

Reviewed by:

XX, XX Medical Student/XX Doctor