

CONSULTATION STATION

EXAMINER INSTRUCTIONS

Candidates should be advised after 10 **minutes** have elapsed that “You have 5 **minutes** remaining with your patient”.

If the candidate finishes early, you may begin the 1-minute clarification. The candidate should leave the room at the end of the 1 minute.

Key Issues:

1. Abdominal pain secondary to constipation colic
2. Background of metastatic colorectal cancer defaulted treatment and follow up
3. Palliative care and end of life discussion

Clinical Summary:

Name: Mr Andy Lee

Age: 72

Gender: Male

Summary of main medical problem

Mr Lee comes in with 3 months of intermittent abdominal pain likely secondary to constipation colic. He has a background of stage IV metastatic colorectal cancer but declined palliative chemotherapy and medical oncology follow up. The candidate is expected to address the patient's concerns empathetically, provide symptomatic relief for his symptoms and consider engaging palliative referral to provide holistic end-of-life care for him.

Presenting complaint

Abdominal pain x 3 months

- happens daily but intermittently, comes and goes
- central in location. no radiation
- squeezing and colicky characteristics
- pain score 6-7/10
- Took paracetamol but not better
- unsure of exacerbating factors, not related to food
- better with defecation
- passing flatus

Associated with constipation x more than 6 months

- last year baseline BO once a day, soft stools
- now BO once in 3-4 days of hard lumpy stools

- last BO yesterday, normal amount but hard stools
- no PR bleed or change in stool caliber or tenesmus
- no nausea vomiting

Associated with loss of appetite for more than 6 months

- with loss of weight of 3kg over past year
- used to take 3 full meals, mix of outside food and home-cooked food by wife
- but now feels less hungry, can barely finish half portions
- still tries to take vegetables and fruits 1-2 portions a day
- drinks to thirst, at least 1.5 L/ day
- not early satiety
- no dysphagia or odynophagia
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Systemic review otherwise unremarkable

No fever

No urinary symptoms

No chest pain

No joint pain or rashes

No falls

Memory nil issues

Oncological History

Went for colonoscopy in view of change in bowel habits in April 2024

told by doctors he has a growth in his sigmoid colon "S-shape part of the large intestine", did biopsy and told was CA

also went for staging scans and was told the cancer has spread to involve his lungs (multiple lesions involving both sides of the lungs - not amenable for metastasectomy)

No metastasis to liver, bones, brain

Discussed with surgeons and medical oncologist doctors

- not amenable for curative surgery: multiple lesions involving both lungs
- Stenting: option to relieve any obstruction but patient not keen due to discomfort during colonoscopy
- offered palliative chemotherapy at last medical oncology TCU 3 months ago

Patient thought about it and is not keen to go for palliative chemotherapy as the doctors told him it is not curative.

- worried about side effects of chemotherapy
- stopped going for follow ups after then as felt that there was nothing else that can be done for him - "no hope already"

Told prognosis without any treatment: 6 months to a year

No concrete thoughts with regards to end of life and legacy planning e.g.

- Site of treatment and site of demise (home vs medical facility)
- Funeral arrangements
- Financial arrangements e.g. living will

Wishes to be comfortable at the last days of his life

Mood

- Shocked by his diagnosis
- Feels troubled but getting to terms with his diagnosis
- Initially sad and unable to accept the diagnosis
- Family have been supportive
- Has some worries regarding pain and end-of-life planning
- Takes a little more time to fall asleep due to rumination but able to maintain sleep
- PHQ-2: 0, GAD-2: 0
- No suicidal/homicidal ideation

Past Medical History

1. Type 2 Diabetes Mellitus
 - a. Diagnosed 8 years ago
 - b. on metformin 250mg BD
 - c. HbA1c latest March 2024: 6.4%
 - d. SMBG once a week: pre-breakfast 4.8-5.6mmol/L
2. Hypertension
 - a. On lisinopril 5mg OM
 - b. HBPM 110-150/68-74mmHg

3. Hyperlipidaemia

- a. On atorvastatin 20mg OM
- b. Last LDL 2.35mmol/L

4. Osteoarthritis of left knee

- a. X-ray done in Aug 2023: mild OA knee
- b. Given glucosamine 500mg TDS and Calcium Carbonate 450mg/Vit D 200IU 2 tablets/day

Medications

Lisinopril 5mg OM

Metformin 250mg BD

Atorvastatin 20mg OM

Glucosamine 500mg TDS

Calcium Carbonate 1250mg OM

Colecalciferol 1000U OM

Adherent to medications

Previously given

- Lactulose 10ml BD PRN: not keen to take as worried it may worsen his diabetes
- Senna 2 tablets ON PRN

No other supplements or OTC medications

Social

Retired. previously works as an engineer. No financial difficulties.

married with 2 children who stays apart

Staying with elderly wife

- cordial relationship, sad but coping with patient's diagnosis
- 4 room HDB flat, lift-landing, EASE completed
- Patient unsure if family is aware what to do if his situation gets worse

Non-smoker

No alcohol intake

Goes for daily walks in the morning with wife: still enjoys doing so

Examination

Vitals (Given in CI)

Temperature 36.4°C

Blood pressure 145/84mmHg

Heart Rate 102/min

Height 1.67m

Weight 55kg

BMI 19.72kg/m²

Alert, comfortable

Not in respiratory distress

No

pallor

Anicteric

not cachetic

Mucosa moist

Small left supraclavicular lymph node palpable

Heart S1S2, regular, no murmurs

Lungs clear

Abdomen soft, non-tender

Bowel sounds present, normal, not tinkling

Digital Rectal examination (examiner to ask what candidate is looking for specifically and answer directly)

- Anal tone intact
- Empty rectum: brown stool stains, no masses, no bleeding
- Prostate 2 finger breadths, not tender, no nodules

No masses

No organomegaly

Bowel sounds present

No ascites

No pedal oedema

Gait normal

Left knee:

No effusion, no deformity
Medial joint line tenderness
ACL, PCL, MCL, LCL intact

Investigations

As attached

Issues and management:

1. Abdominal pain secondary to constipation colic b/g metastatic sigmoid cancer
 - a. Patient declines ED referral, demonstrates mental capacity when conveying his decision. He values time with his family and is not keen to be warded for treatment in view of his limited prognosis.
 - b. Laxatives: reaffirm patient lactulose does not affect diabetes, advise to take regularly together with sufficient fluids. can offer dulcolax PRN
 - c. Stop Calcium carbonate
 - d. Patient would enquire re stronger analgesia: inform risk of constipation with opioids, patient will understand and agree to hold off first
 - e. Red flag advice
2. Metastatic sigmoid cancer
 - a. End-of-life care: offer palliative medicine referral (initially not keen to see hospital as thought there was nothing else that can be done for him; agreeable after candidate explains rationale)
 - b. Highlight legacy planning: Offer/refer for Preferred Plan of Care, Lasting Power of Attorney, Living Will
3. Polypharmacy b/g well-controlled cardiovascular risk factors and life-limiting illness
 - a. DM: Stop metformin (good glycaemic control and patient already has poor appetite)
 - b. HLD: KIV stop atorvastatin
 - c. Osteoarthritis: Stop glucosamine and Calcium/Vit D tablets

NOT TO BE SEEN BY CANDIDATES

FINALISED REPORT CT THORAX, ABDOMEN & PELVIS of 02-MAY-2024

FINDINGS: Contrast enhanced scans acquired. 70 ml of IV Omnipaque 350mg/ml administered.

THORAX:

Two 8 x 6 mm right middle lobe, three sub 3 mm left upper lobe nodules are identified. Tiny left major fissural nodularities are also noted. No mediastinal mass is detected. The pulmonary parenchyma and the visualised vessels are normal. There is no consolidation or ground glass change. There is no pleural effusion. The visualised airways are patent with no endoluminal lesion. Multiple small volume mediastinal nodes are noted. No enlarged mediastinal, hilar or axillary lymph node is identified.

The heart and major vessels appear normal. No pericardial effusion.

Thyroid gland is unremarkable. No destructive bone lesion.

ABDOMEN & PELVIS:

Mass-like wall thickening involving the sigmoid colon with paracolic fat-stranding and tiny nodes. The rest of the imaged bowel is normal in calibre. Pericolic and perirectal lymph nodes enlarged. The liver is unremarkable. No suspicious focal lesion. The hepatic veins and the splenoportal axis are well opacified. No filling defects are noted. There is no dilatation of the biliary tree. No gallstone is present. No evidence of acute cholecystitis.

The kidneys show normal enhancement. There is no solid focal renal lesion. No urinary calculus or hydronephrosis is seen. The spleen, pancreas and adrenal glands appear unremarkable. Urinary bladder is unremarkable. No adnexal mass.

There is no intraperitoneal free air or free fluid. No destructive bone lesion is seen.

IMPRESSION:

Sigmoid colon lesion suspicious of malignancy. There is no associated intestinal obstruction.

Right middle and left upper lobe pulmonary nodules favour metastatic deposits, in the given clinical context.

Report Read By : Dr Qing Baozhong 3 MAY 2024 09:31

Report Approved By : Dr Qing Baozhong 3 MAY 2024 09:32

Investigations:

Random Capillary glucose	5.7	4.0-6.0	mmol/L
HbA1c	5.1	4.5-6.4	%

FBC			
White blood cells	9.5	4.0-9.6	$\times 10^3/\mu\text{L}$
Haemoglobin	11.5	13.6-16.6	g/dL
Haematocrit	38.2	39.3-48.7	%
Red blood cells	4.0	4.2-5.5	$\times 10^6/\mu\text{L}$
MCV	78.3	83.0-98.0	fL
MCH	26.3	28.0-34.0	pg
MCHC	30.8	33.0-35.0	g/dL
RDW	17.6	12.0-15.0	%
Platelet	359	150-360	$\times 10^3/\mu\text{L}$
MPV	9.43	7.00-10.00	fL
Neutrophil %	50	40.0-74.0	%
Neutrophil	5.7	1.90-6.60	$\times 10^3/\mu\text{L}$
Lymphocytes %	36	17.0-49.0	%
Lymphocytes	2.9	1.10-3.10	$\times 10^3/\mu\text{L}$
Monocytes %	8	4.0-10.0	%

Monocytes	0.5	0.20-0.70	x10^3/uL
Eosinophils %	5	0.00-7.00	%
Eosinophils	0.4	0.00-0.60	x10^3/uL
Basophils %	1	0.00-1.00	%
Basophils	0.10	0.00-0.10	x10^3/uL

ESR	5	2-10	mm/Hr
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Renal panel			
Sodium	138	135-145	mmol/L
Potassium	3.8	3.5-5.1	mmol/L
Creatinine	76	67-112	umol/L

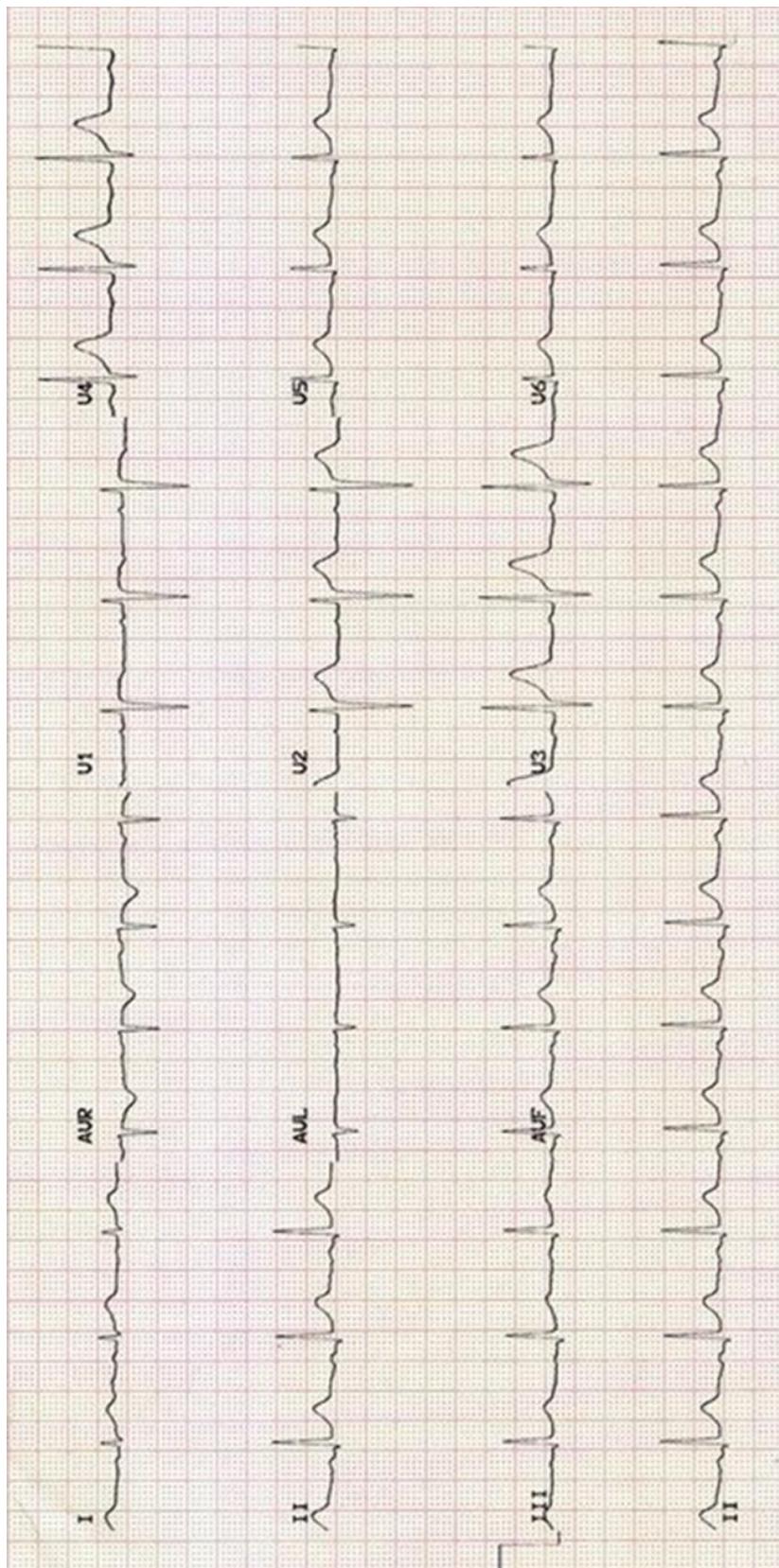
Bilirubin, total	18	2-21	umol/L
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INR	1.04
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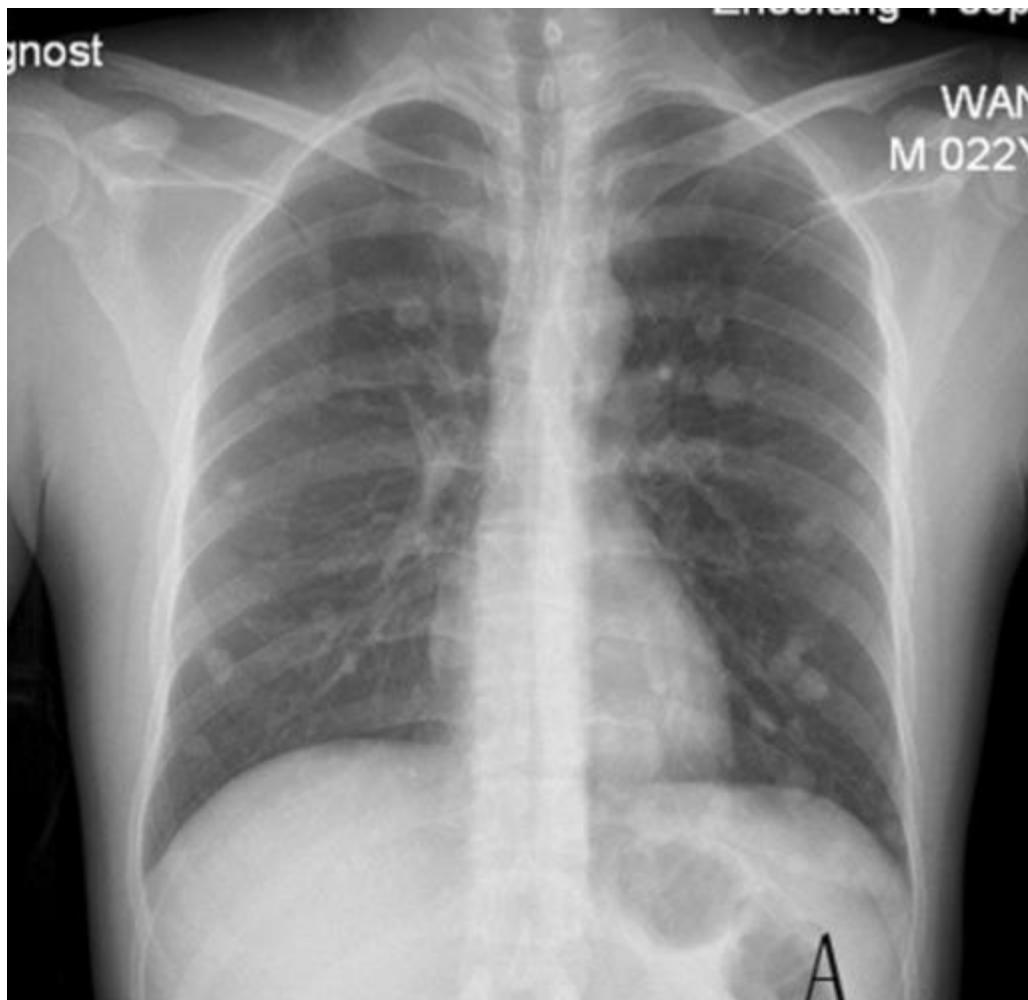
UFEME			
WBC	3	0-6	cells/uL
RBC	1	0-3	cells/uL

EC	0		cells/uL
Casts	Not seen	Not seen	
Granular casts	Not seen	Not seen	
Mucous threads	Not seen	Not seen	
Crystals	Not seen	Not seen	
Glucose	Negative	Negative	
Protein	Negative	Negative	
Other formed element	Not seen	Not seen	

Pulse Oximetry: 98 % on room air

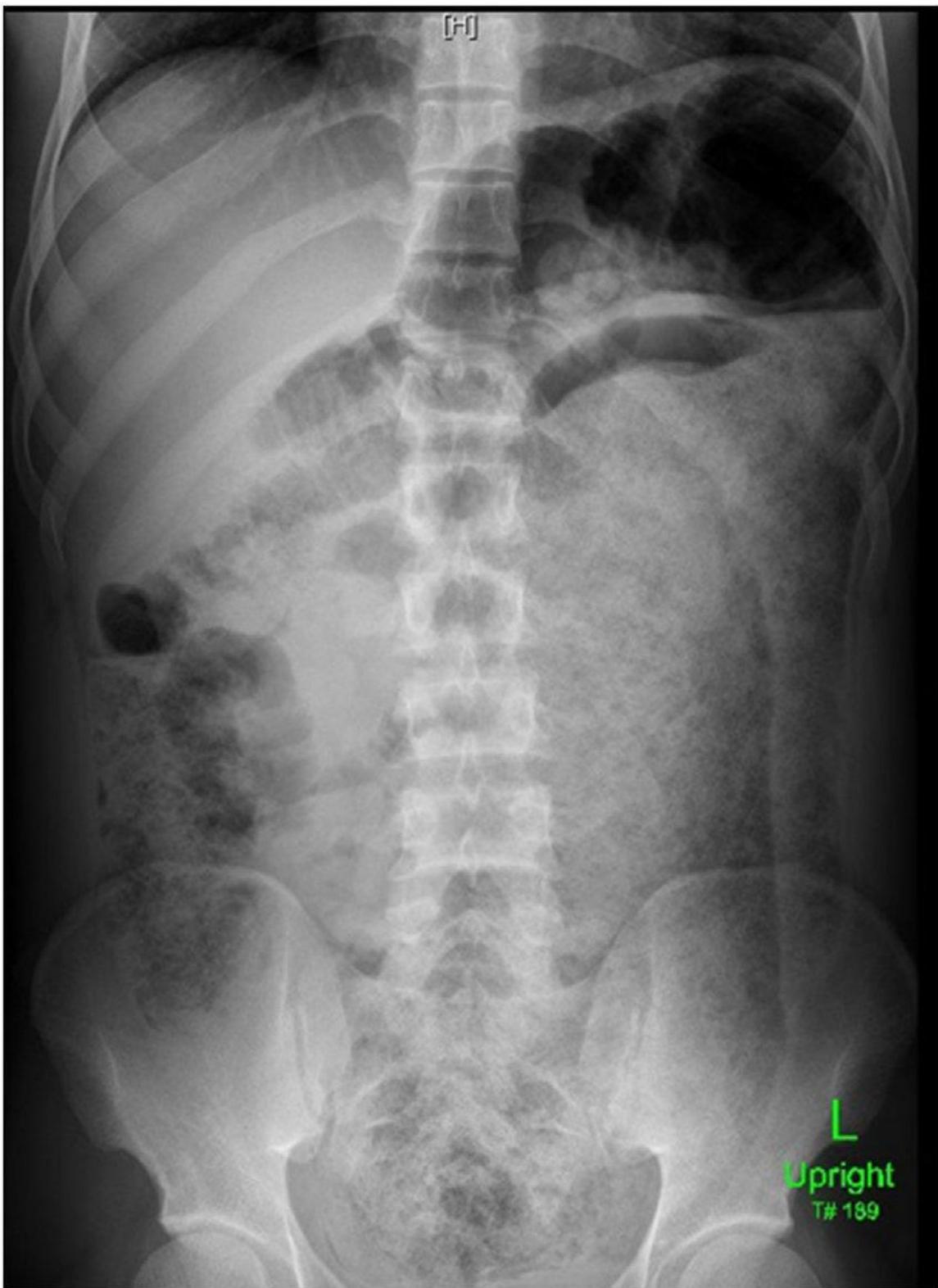


Chest X ray



Source: https://openi.nlm.nih.gov/detailedresult?img=PMC4086276_1477-7819-12-194-3&query=&req=4&simResults=PMC4405963_NJMS-5-188-g006

Abdominal x-ray



Knee x-rays



Esq



Source for abdominal x-ray: https://www.researchgate.net/figure/Plain-erect-abdominal-X-ray-showing-huge-fecal-loading-of-the-whole-colon_fig1_328144102

Source for Knee x-ray: <https://radiopaedia.org/cases/osteoarthritis-of-the-knees>

To provide PHQ-9 to candidate if candidate request for it

9. Patient Health Questionnaire-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Total Score				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
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