

PATIENT DETAILS

Name	Margaret / Michael Ashby
Presenting complaint	Dysphagia — oesophageal carcinoma

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FACILITATOR INFORMATION- MARGARET/ MICHAEL ASHBY

This case has 2 parts 1. the initial history taking with a discussion of next steps in the management (this discussion should be with the patient but then expanded on with the whole group/ discussion led by the facilitator) 2. Review of hospital letter and second consultation with the patient where they come to discuss the results Interviewing/History Taking Clarification of the presenting complaints and associated symptoms will suggest probable

DIAGNOSIS. EXPLORATION OF PATIENT'S IDEAS, CONCERNS AND EXPECTATIONS IMPORTANT FOR

management. Elicitation of social history necessary to erect the triple diagnosis.

PHYSICAL EXAMINATION

(Not undertaken in PCB scenarios) General examination to look for anaemia (pallor), localised lymphadenopathy (lymph nodes) and weight loss: specific examination would include only an abdominal examination to look for a gastric mass or liver enlargement.

Patient Management This presents the most challenging aspect of the consultation. Reassurance is not appropriate: explanation will need to include the possibility of a serious diagnosis with sensitivity and honesty if patient probes for information. Referral for endoscopy essential. Follow-up obligatory. The management of the follow-up consultation involves the difficult challenge of breaking bad news.

Problem Solving Must include the possibility of malignancy as well as a benign stricture of the lower end of the oesophagus.

Behaviour A good doctor/patient relationship will be important. Empathic understanding and ability to cope with patient's distress and anger essential for management.

DIAGNOSIS

Most likely: Carcinoma of the oesophagus.

The long history of oesophagitis (inflammation of oesophagus) often precedes malignant change. The symptom of dysphagia (difficulty swallowing) although not clearly described as food "sticking" plus history of weight loss and appetite strongly suggest a malignant lesion.

Less likely: Benign stricture following long-standing oesophagitis. Patient is looking forward to their spouse's retirement in the near future & the opportunity to travel widely. The diagnosis will seriously affect these plans.

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Management (1st Consultation) Reassurance: Reassurance is not appropriate. Explanation: the negative physical examination (except for confirming probable weight loss) can be mentioned but in the context that this does not exclude the possibility of a serious problem. Patient will be surprised at the mention of a serious problem and will want to know more. Further explanation should include possibility of an obstruction at the lower end of the gullet which may be related to long-standing heartburn. Patient will be shocked if cancer mentioned without being prepared for this and doctor will need to discuss this possibility fully with patient if asked directly.

Advice: Softer food to be chewed well. Fluids increased particularly milky drinks to provide nutrients.

Prescription: None applicable at present.

Referral: 2ww referral – dysphagia – initial investigations usually go via Gastroenterologists, sometimes via ENT, sometimes via upper GI surgeons depending on 2ww set up at hospital.

Investigation: See referral. Blood tests for FBC, CRP & LFTs will be agreed to.

Observation: Follow-up after result of endoscopy.

Management (2nd Consultation)

Patient returns after 10 days having had the endoscopy (see letter attached for consultant report). He/she volunteers they feel much better and swallowing appears to have improved following the endoscopy.

Reassurance: Reassurance is not appropriate. Explanation: The principles to be applied in breaking bad news need to be employed. Find out what he/she has been told at the hospital. For the purposes of this scenario they did have a discussion with the consultant but didn't take anything in, so cannot remember the detail. He/she recalls the consultant saying that he needed to wait for the results of the biopsy. Indicate his letter does not contain good news and wait for response. Patient will be surprised at the mention of a serious problem again as he/she had tended to dismiss this possibility as feels better. Further explanation by the doctor should clearly indicate an obstruction at the lower end of the gullet as the cause of the problem due to a growth. Patient should be given the opportunity to explain what he/she understands by a growth. If he/she mentions "cancer" the doctor can affirm that this is the cause. Important to decide how much patient wants to know/needs to know at this consultation. He/she will still be unready to accept the diagnosis and may demand to see the consultant's letter. Doctor should acknowledge their distress empathetically, recognising denial and anger as a natural response. Patient should be given time to come to terms with the diagnosis and the implication for their future plans when spouse retires. Offers to continue to support both of them in the immediate and long-term are important particularly to see them both together soon if he/she would like this, the same day and at their

home if necessary. Realistic discussion about possible outcomes. Cancers in the lower third of the oesophagus have a poor prognosis

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Treatment: The hospital will convene a multidisciplinary team (MDT) meeting which includes surgeons & oncologists. They may suggest the following treatment options: • placement of a stent if swallowing becomes difficult. • Radical surgery will be considered by Upper GI surgeons. • Adenocarcinomas are resistant to radiotherapy. More active treatment available includes chemotherapy. This may involve intravenous infusions at intervals. Side effects would be mainly some nausea & vomiting but these symptoms can now be controlled with medication, but no alopecia.

Prescription: None applicable immediately Referral: See above to multidisciplinary team

Investigation: Further investigations will be organised by the MDT Observation: Follow-up soon if offer of a further consultation today with spouse is not taken up.

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ACTOR INFORMATION

Name: Margaret/ Michael Ashby Age: 60 years old

OPENING STATEMENT: 'I HAVE COME TODAY BECAUSE I HAVE BEEN HAVING TROUBLE WHEN EATING. I CAN

feel everything as it goes down' Information to be given away after further open questioning: For the last 1 month you have been able to feel your food go down your food pipe, it does not actually stick but you can feel it as it goes down. The usual medication you take for your heartburn has not helped. You have also noticed you have a reduction in energy and your appetite is poor, this has also been ongoing for the last month or so. The discomfort you have been experiencing is not like your usual heartburn. You have had your heartburn for a long time (around 30 years) and when you do experience it you describe it as a burning pain which is generally relived by antacids. Information to only divulge on direct questioning: You are not sure if you have lost weight but would not be surprised if you had as your appetite is poor. No acid reflux into mouth. Heartburn used to be worse on bending forward and lying down and at night. Less obvious now for few months. If further clarification sought by student about sensation of swallowing then point to area in lower throat and explain that you can feel odd sensation when food reaches that point although not actually sticking. Fluids do not cause the same sensation. Ideas: You think this is all related to your longstanding heartburn Concerns: You are not really worried about it being anything serious Expectations: You would like the doctor to prescribe a stronger antacid. Feelings: You tend to play things down, not overly worried at all.

Past medical history: Indigestion- 12 years ago : Prescribed antacid (Omeprazole 20mg) Heartburn - 8 years ago : Prescribed Gaviscon Cough/ URTI- 3 years ago : Reassured Medication Omeprazole 20mg

FAMILY HISTORY

Nil of note that you know about as you were adopted.

SOCIAL HISTORY

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2 grown up daughters who are living away from home. Smoking- Non-smoker (never smoked)
Alcohol – occasional alcohol on special occasions, never to excess.

IMPORTANT SOCIAL, CULTURAL OR BEHAVIOURAL CHARACTERISTICS: TEND TO MAKE LIGHT OF ANY PHYSICAL

problems as you do not like being ill. Your partner is retiring from their teaching role next year and you are eagerly awaiting this as you have plans to travel extensively afterwards. You are keen ramblers and help run a club for elderly people at your local church. Demeanour: Intelligent, cheerful, slightly worried but tends to play down symptoms.

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PHYSICAL EXAMINATION

PATIENT NAME: MARGARET/ MICHAEL ASHBY

3Kg weight loss No other abnormal physical signs

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Patient Record (to be given to student) Name: Margaret/ Michael Ashby Age: 60 years old Past Medical History: Indigestion- 12 years ago : Rx Omeprazole 20mg Heartburn – 8 years ago : Rx Gaviscon Cough/ URTI- 3 years ago : Reassured Medication Omeprazole 20mg

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Hospital letter Dear Dr X

RE: MRS MARGARET / MR MICHAEL ASHBY, AGE 60 YEARS

Thank you for referring this patient for endoscopy. I found an extensive tumour at the lower one third of the oesophagus and histology has now confirmed an adenocarcinoma. Unfortunately, liver function tests are grossly abnormal strongly suggesting hepatic secondaries.

Radical excision may not be possible, the next step would be to organize an MRI and refer him/her to the multi -disciplinary team which includes myself and the oncologists to discuss the treatment options. This may include placing a stent to improve swallowing. However, the oncologists are likely to recommend a more aggressive approach with chemotherapy which may improve the prognosis somewhat.

I have not fully discussed these findings with the patient as I had not had the confirmation of the histology at the time of endoscopy. I told him/her I would be writing to you, however, so he/she may well come to see you in the near future.

With kind regards

Yours sincerely

Mr A Plummer Macclesfield General Hospital

