PRIMARY CARE BLOCK

Simulated Patient Brief — LOVETT (Multiple Sclerosis) · Week 5

PCB

PATIENT DETAILS

Name	Georgie Lovett
Presenting complaint	Neurological symptoms — multiple sclerosis

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FACILITATOR NOTES

Name: Georgie Lovett This simulation is in 2 parts: 1. Initial consultation 2. Explanation of diagnosis (Breaking bad news)

DIAGNOSIS

Most likely: The history and examination findings are strongly suggestive of multiple sclerosis because of remitting/relapsing nature; sensory and motor modalities involved; examination findings suggesting a central nervous system pathology. If correctly elicited there are no other plausible provisional diagnoses. Less likely: Diagnoses that may appropriately be considered during the interview are: spinal lesions causing nerve root entrapment (less likely because of absence of pain, timing of the episodes, quality of sensory changes); Syringomyelia (very unlikely as this is not a remitting/relapsing condition & is rare ++). The history is easily obtained with only a limited amount of non-volunteered information. The

DIAGNOSIS IS MADE READILY BY CORRECT INTERPRETATION OF INFORMATION, PROVIDED THIS HAS BEEN

gathered accurately. Initially the doctor has to decide how much information to share with the patient, particularly as urgent hospital investigation of the problem is required. At a second consultation, when confirmation of the diagnosis is available, the doctor will be strongly challenged to bring the patient to a shared understanding of the problem. The doctor will have to show sensitivity/empathy. Key communication skills will be required for the task of breaking the bad news. A good relationship will have to be established for the longer term care. Management: Reassurance/ Explanation: An explanation that the problem lies with the nervous system is essential. The degree to which the doctor shares their understanding at this stage is a critical issue in this scenario and is a major teaching point. Advice: The patient can be advised to rest at home with appropriate social support. They should be advised not to drive. Referral: Urgent referral to neurology outpatient clinic for further investigation is essential. Observation: Urgent GP review if there is a significant worsening of his symptoms. Otherwise after his hospital appointment.

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Actor Script Name: Georgie Lovett Age: 42

OPENING STATEMENT: ' I HAVE BEEN HAVING SOME PINS AND NEEDLES IN MY FOOT'

Information to be given away after further open questioning: For one week: pins and needles in the left foot and leg, accompanied by weakness of the same leg. The symptoms are constant, nothing makes it better or worse. Over the past two days you have become unsteady when walking, with a tendency to go to the left. Your whole leg is feeling 'weak' Information to only divulge on direct questioning: This is his fifth such attack in the past six months, although the previous episodes eased after a few hours. The first episode was six months ago, whilst abroad. The weather was hot and you had been on a long walk; the left leg became weak and you had to be helped back to your hotel. Your symptoms improved over two hours. You did not seek help or medical review after this. You think the problem is probably caused by a trapped nerve and you have no other underlying concern. You are expecting the doctor to confirm your self-diagnosis. You have been off work for the last two days because of feeling unsteady. No trauma or injury, no head injury. Neuro- no headaches, no visual changes, no colour vision changes, no slurred speech, no facial droop, no word finding difficulties, no issues with the upper limbs. GI/ GU- no bladder or bowel trouble, all normal for you Resp- No respiratory symptoms Cardio- no cardio Sx, no palpitations, no changes to heart rate etc No weight loss, no fever, no night sweats, no skin changes.

Ideas: You think this is probably caused by a trapped nerve Concerns: No underlying concern Expectations: You are expecting the doctor to confirm your self-diagnosis.

Past medical history: no significant past medical history Medication- Nil No known allergies

FAMILY HISTORY

Dad= hypertension (well controlled) Mum= Breast cancer, in remission (developed age 70).

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SOCIAL HISTORY – POLICE OFFICER

Married, no children (although thinking about starting family) Smoking- Non smoker Alcohol – 2-4 glasses total of wine over the weekend

IMPORTANT SOCIAL, CULTURAL OR BEHAVIOURAL CHARACTERISTICS

You are a confident, well organised person and you have a straightforward attitude to health, illness and life. You see problems and challenges to be overcome and have an expectation that solutions can always be found. You have never faced any major adversity in life up to this point. Demeanour: You are smartly dressed. There are no non-verbal cues to suggest you are anxious or depressed. You present your story in a straightforward manner. (Sim Patient can act a subtle drag of left foot when walking from waiting room- only just obvious there is a problem –ie not excessive)

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PHYSICAL EXAMINATION

PATIENT NAME: G LOVETT

Drags the left leg with a tendency to walk to the left.

Left leg: tone increased but power decreased knee and ankle reflexes brisk response extensor plantar response sensation decreased in all modalities up to the knee. Right leg: Normal.

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Patient Record (to be given to student at start of SIM) Name: G Lovett Age: 42 Past Medical History: No significant past problems reported Last 3 consultations: One year ago: seen by practice nurse for 40+ check. BP: 136/78. Lipids normal. Two years ago: flu-like illness. Medication- Nil

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SECOND CONSULTATION-: GEORGIE LOVETT ACTOR SCRIPT

You attend the GP three weeks following your referral. You were seen in outpatients the following week and admitted to hospital two days later for investigations. You were advised to see the GP one week after discharge to hear about the results of the investigations. Hospital follow-up has been arranged in four weeks. You have not been given any treatment. Things have almost totally resolved having only mild weakness of the left leg and you are expecting continued and complete recovery. You are happy and optimistic that all is well. This view has been reinforced by the fact the hospital gave you no alternative opinion or potential

DIAGNOSIS PRIOR TO DISCHARGE. YOU ASSUMED ALL IS WELL AND EXPECT TO BE GIVEN GOOD NEWS BY THE

GP . Opening statements: “You will be pleased to see I am now almost completely better, all of those tests weren’t necessary after all” . “The hospital said they would write to you, have you received the letter”? Any statement by the doctor that an abnormality was detected is greeted with disbelief, or perceived as a minor problem. However, you are inquisitive and will press the doctor to explain more. “Surely you have got the wrong patient” “The laboratory must have made a mistake, got the names mixed or something” “But I’m so well, it can’t be anything serious” “It must be a virus I picked up from abroad, its getting better now” If multiple sclerosis is mentioned abruptly, you develop denial, shock and become aggressive towards the doctor. “No that can’t be right” “Are you sure you know what you are talking about? I want to see the consultant” . If the doctor is evasive or obviously dishonest you become angry to the point of confrontation. “What exactly do the tests show”? “Come on, what are you trying to say?” “I think you’re hiding something” If the doctor shows empathy and honesty you will accept the diagnosis, but needs a lot of help to take a positive approach. To you multiple sclerosis implies a wheel chair existence and life as you knows it will end. You are too well informed to accept bland, over-optimistic reassurance. Once you have accepted the diagnosis you will enquire about the treatment possibilities, your job and plans to start a family. “Research is being done all the time, they must have found something that works by now ……”

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FURTHER INFORMATION- to be given to the student before SECOND consultation

Discharge letter from the Consultant Neurologist

Dear Dr

Re: Georgie LOVETT

Gorgie was admitted from clinic for investigation of recurrent episodes of paraesthesia and weakness of the left leg. On admission was found to have increased tone and reduced power in the left leg with hyper reflexia. We found bilateral extensor plantars and sensory deficit in the left leg and right foot. In addition there was evidence of cerebellar dysfunction. They underwent various investigations the most important of which was a brain scan. This showed multiple focal areas of demyelination. These findings and the results of his lumber puncture are fully consistent with a diagnosis of multiple sclerosis. We have arranged an outpatient appointment to see the patient back in clinic in 4 weeks time to discuss the significance of these findings. They may be a suitable candidate for treatment with monoclonal antibody therapy, and I will discuss applying for funding when I see them.

Yours faithfully

Dr B Rain