Case One
High Risk Breast Cancer Screening

A healthy 38 year old woman presents to your office for an annual. Her 46 year old sister was recently diagnosed with breast cancer. She wonders, “Should I have an MRI?”

- Past Medical History: benign breast biopsy at 28, 2 normal pregnancies at 32 and 34. Menarche at age 11. Regular periods.
- Medications: IUD
- Family history: sister as above, mother with post menopausal breast cancer at 65, maternal aunt with ovarian cancer. CAD on the paternal side, and thyroid disease in a 3rd sibling.

- Social Hx: She’s married with 2 kids, works as a teacher, active in her synagogue. No dv, alcohol, or street drugs. No tobacco.
- Her physical exam is completely normal.
What is her lifetime risk of breast cancer?
A. 8%
B. 15%
C. 20%
D. 35%
E. 40%

Risk Assessment
- While in the office, you go to www.cancer.org/bcrisktool and answer the following questions

NCI Risk Model
Gail Model
- Race/Ethnicity: White
- History of breast cancer, DCIS, LCIS: No
- Age: 38
- Age at Menarche: 7-11
- Age at first live birth: >30
- First Degree relatives: >1
- Biopsies?
  - How many: 1
  - Any with atypical hyperplasia: No

Caveats
- Underestimates risk for people who are gene positive.
- Developed for populations, not individuals
- Does not factor in other risks

What is the recommended screening for our patient?
Annual clinical breast exam and:
A. Annual mammogram starting at 35?
B. Mammograms every 6 months starting at 35?
C. Mammogram one year; MRI the next?
D. Both MRI and mammogram every 6 months
E. Annual mammogram and annual MRI, 6 months apart?

Key Points
- Newer recommendations are mammogram and MRI for women with a lifetime risk of breast cancer of 20% or more.
- Consider referring for genetic counseling for people at high risk.
- New USPSTF recommendations would not apply to her because of her high risk.
Case Two
Smoking Cessation

“I’m smoking…Again”
45 year old manager of a retail outlet presents with the above complaint. She smokes a pack per day. She doesn’t smoke at home. She has tried nicotine replacement, groups, wellbutrin (which helped, but caused her to be very anxious), and even hypnotism.

“I saw an ad in People”
Can I try the new medicine?

You review the risks and benefits of varenicline. You start with .5 mg daily for 3 days, increase it to bid for 4 more days and then 1 mg bid for 12 weeks. She understands that if it works after the first 12 weeks, it is probably reasonable for her to continue another 12 weeks.

What is the likelihood that she will quit during the first 12 weeks?
A. 23%
B. 28%
C. 44%
D. 48%
E. 51%

Varenicline
- Initial studies showed that the likelihood of sustained quitting between weeks 9-12 were:
  - Varenicline 44%
  - Bupropion 30%
  - Placebo 18%
After the first 12 weeks

- Patients who benefited had a sustained benefit with 12 more weeks of treatment.
- Likelihood of sustained quitting up to a year after treatment is only fair:
  - Varenicline 23%
  - Bupropion 16%
  - Placebo 9%

Most Common Adverse Effects

- Nausea
- Abnormal dreams
- As of July 2009, new black box warning regarding neuropsych symptoms with both wellbutrin and varenicline
- New data about increased CV disease

How much weight can I expect to gain?

A. 1-2 kg in the first two weeks followed by 2-3 kg over the next 4-5 months.
B. 0-1 kg in the first two weeks followed by 3-5 kg in the next 4-5 months.
C. 2-3 kg in the first two weeks followed by 3-5 kg in the next 4-5 months.
D. 1-2 kg in the first two weeks only.
E. 1-2 kg in the first two weeks, followed by up to 5 kg in the next 4-5 months?

Weight Gain After Quitting

- It’s a reality.
- One of the most common reasons for relapse
- Benefits usually outweigh the downside
- Average is about 11 lbs

Case 3

50 year old man comes in with a huge red area in his eye. He is in good health and recently carried many boxes to the attic. No pain in the eye. Vision is 20/20. He’s worried that this occurred because he’s missed his antihypertensive meds over the last few days.

Cases 3 and 4

Red Eyes
Case 4

50 year old woman with RA comes in to see you. Her disease has been active lately and she is not feeling well. Since yesterday, she has had photophobia and two painful, red eyes.

On Exam

- She’s clearly in pain, worse with pressure to the eye
- Photophobia on exam
- ESR is 100
- Phenylephrine drops don’t clear it.

What is Your Diagnosis?

A. Severe Conjunctivitis
B. Subconjunctival Hemorrhage
C. Herpes Keratitis
D. Hypertensive Urgency
E. Acute Angle Closure Glaucoma

Episcleritis vs. Scleritis

- Acute in onset, may be local or diffuse
- Resolves without treatment
- Vision is not affected
- Phenylephrine drops leads to transient resolution. Sclera normal underneath
- Striking, highly symptomatic course
- Associated with rheumatologic disease in 50% of patients
- Painful, photophobia
- Threatens vision
- Ophthalmologic and systemic treatment warranted urgently

What is Your Diagnosis?

A. Herpes Keratitis
B. Acute Angle Closure Glaucoma
C. Scleritis
D. Episcleritis
E. Rheumatoid Eye
Case 5
Geriatrics: Falls in the Elderly

92 year old community dwelling elderly woman brought by her 73 year old daughter because she fell – Again.

Quickly ascertaining that her only injuries are wounded pride and a sore bottom, you review her history. The fall occurred at home when she got up from the chair and headed for the bathroom. She lives alone, doesn’t drive, ignores her walker. She takes multiple meds including atenolol, hctz, lisinopril, insulin, and metformin.

At night she takes elavil for her diabetic neuropathy. She also drinks, though she’s never admitted this to you and you’ve learned this from her daughter.

On a Limited Physical Exam, Which is Most Helpful?
A. Full Neurological Exam
B. Functional Exam
C. Vital Signs
D. Cardiac Exam
E. Joint Exam

Functional Evaluation: The Up and Go Test
Record the time that it takes for a patient at risk to get up from a chair, walk 10 feet, and return to the chair. If this takes more than 30 seconds, they have impaired mobility and are at greater risk for a fall.
Results
You do the “up and go” test and she scores 31 seconds, a marker of impaired mobility. You send the visiting nurses in to do a home safety assessment, stress the importance of using her walker at all times, stop the elavil and try something else for her neuropathy. You address the alcohol again as well.

What is the Likelihood of Recurrent Falls?
Of the 1/3 of elderly people who fall every year,
A. 20%
B. 30%
C. 40%
D. 50%
E. 60%
have multiple falls.

Falls in the Elderly
- Are responsible for 70% of accidental deaths in people 75 and over.
- Increases with age and transcends ethnic groups
- Cause significant morbidity, including decline of functional status, risk for hospitalization
- Cause serious injuries in 5-15% of falls. Hip fracture occurs in 1-2% of falls.

Risk Factors
- **Intrinsic**
  - Muscle weakness
  - Gait and balance dysfunction
  - Visual impairment
  - Cognitive impairment
  - Orthostatic hypotension
  - Meds
- **Extrinsic**
  - Poor lighting
  - Clutter
  - Environmental obstacles
  - Bad shoes
Drinking in Elderly Patients in the ED
- Lifetime alcohol abuse was 24%
- 14% had a drinking problem in the last year.
- Elderly patients with GI complaints had a much higher rate of alcohol issues (22%) than those who fell.
- Physicians detected only 21% of the cases of current abuse of alcohol.

Case 6
Chronic Pain

A 69 Year Old Man with Back Pain
JM is a 69 year old man with back pain. He has had many studies which show minimal reversible problems. He has tried multiple treatment modalities and adjunctive therapy. He gets some relief, but still suffers.

PMH: HTN and gout
Social: No tob, 3 drinks/week, married, well-supported by family. No history of substance abuse.

Trial of Narcotics?
You’ve been burned in the past by people seeking narcotics. What questions will be most helpful in determining whether he has a high risk of developing problematic behavior around these meds?

Opioid Risk
A. Family history of Substance Abuse
B. Personal History of Substance Abuse
C. Preadolescent Sexual Abuse
D. A&B
E. All of the above.
Opioid Risk
- Family history of substance abuse
- Greatest for prescription drugs
- Personal history of substance abuse
- Greatest for prescription drugs
- Age between 16 and 45
- Preadolescent sexual abuse (women)
- Certain Psychiatric Diseases

Opioid Addiction
- Low incidence of iatrogenic addiction in low risk groups
- About 10% of the general population is at risk for addictive disorders
- Ask about risk factors!

Addiction Problem?
Our patient has been on a stable dose of long and short-acting narcotics. One day, he comes in, obviously in pain, telling you he strained his back helping his grandson learn to swim, used up all his breakthrough meds, borrowed some from his wife, and needs more (of a specific medicine).

What should you do?
A. His behavior is worrisome. Consider weaning all narcotics.
B. He’s in violation of his contract. No more meds.
C. Refill the meds, just this one time. Make it clear to him that he’s violating his contract.
D. Refill the meds, he’s clearly in pain and has been up front with you.

Pseudoaddiction
- Evidence of Physical Distress
- Change in frequency of drug use or unsanctioned dose escalation
- Drug hoarding
- Requesting specific drugs
- Anxiety
- Openly acquiring drugs from others
- Asking for more meds or reluctance to change regime
- Behavior stops with dose/med change

Cases 7 & 8
Workplace Related Medicine
The patient following JM Fell in her work at a local discount store about 7-8 weeks ago. She has been complaining of pain in her lower back ever since then. Treatment with NSAIDS and muscle relaxants did not help. Imaging was negative and PT, likewise, did not make a difference. Her symptoms are out of proportion to her injury and to your exam.

“I don’t think I can go back to work yet, doctor,” she says tearfully. “I’m just not ready.”

What do you tell her now?
A. Tell her to stop malingering and get back to work.
B. Screen for and treat depression
C. Work with her and her company to come up with a transition back to work plan.
D. Inquire about pending litigation
E. B, C, and D

Returning to Work after an Injury
- Vast majority of people get better, go back to work.
- Patient factors include perception of pain, injury, depression, lawsuits pending, other secondary gain

Returning to Work after an Injury
- Work factors include inability to provide transitional employment.
- MD factors include our own discomfort with when patients are stable to return to work, desire to help a bad situation
- Only 50% of workers ever return to work if they have been out >6 months.
Lead Astray?
A patient who has lead exposure in his work as an instructor in the police academy firing range comes in to follow up after a hospitalization department for a left sided facial droop and a right-sided hemiparesis.

While you discuss his recovery from what appears to be a CVA, his wife tells you that she is sure that lead poisoning caused his MCA stroke.

Which is the Correct Response?
- A. She’s probably right. Check a lead level immediately.
- B. She’s probably wrong. Lead exposure only causes peripheral neuropathies.
- C. She’s probably wrong. It is uncommon for occupational exposures to cause focal neurological problems such as strokes.
- D. She’s right. Lead can cause encephalopathy, why not strokes?

Case 9
After Gastric Bypass Surgery

A 45 year old female patient
Presents to your clinic to establish care. She is new to you. Past medical history is notable for diabetes, which she proudly tells you is “in remission” after gastric bypass surgery 5 years ago.

She followed up with her surgeon for a year or two, but since then has not really been seen by a physician. She has maintained her weight loss.
She currently takes no medicines, no herbal supplements, and no vitamins. The remainder of her history and exam are unremarkable.

What Labs Would You Order?
- A. None, she’s fine
- B. B12, A1C, CBC
- C. B12, glucose, CBC, Vitamin D
- D. B12, Chem-7, A1C, CBC
- E. CBC, Chem-7, B12

Late Complications of Gastric Bypass
- Most common are anemia and b12 deficiency (30%) if not replaced.
- Incisional hernia in 10%
- Depression/Emotional disturbance (5-10%)
- Rare ulcers at the anastomosis site (1-2%)
- Very rare electrolyte abnormalities, sbo,
- Cholelithiasis

Can You Talk to My Good Ear?
A 36 year old man calls your office with a complaint that he woke up and can’t hear out of his left ear very well. He has no history of ear problems, no recent infections. He did travel recently on an airplane and wonders if it’s because of the plane trip. Your astute triage nurse had him hum and the hum sound did not lateralize. He has no vertigo, but he has tinnitus and a little bit of ear pain.

What Do You Do Now?
- A. Don’t worry. It’s the plane, take a decongestant and let me know if not better.
- B. Don’t worry. See if you can come in this week and we’ll take out the wax.
- C. Worry a little. Maybe he has an otitis. Add him on later or tomorrow.
- D. Worry. See him today or refer to ENT.

Sudden Sensorineural Hearing Loss
- Rapid hearing loss. Usually noted over 12 hours or on awakening in the morning.
- Usually (but not always) unilateral
- More than 90% of patients have tinnitus
- Often patients have a sense of ear fullness
Etiologies for SSNHL

- Myriad, but most commonly autoimmune, microvascular, or viral cochleitis.
- Depending on the series, tumor ranges from 3-30%. MRI to evaluate the retrocochlear space is indicated.

Treatment

- No agreement on the best protocols.
- Most ENT will treat with high dose glucocorticoids (60-80mg/day) for 10 days. Some studies suggest faster healing.
- Some data about intratympanic steroids as well.
- Subset of patients may improve with antivirals.

Prognosis

- Generally, the prognosis is good.
  - Better if it is high or low frequency loss and not across the board.
  - Better for younger patients
- May take up to 4 months and not be complete
- May be worse in people with vertigo