Multi-morbidity and Polypharmacy 1 – Notes for Candidate

Multi-morbidity and Polypharmacy Station 10 minutes
Patient: Jane Smith (68F)
DOB: 20/01/1955
Setting: GP clinic review

You are working as a foundation doctor in a local GP surgery.

You are about to see Jane Smith, a 68-year-old who has recently been discharged from hospital after an infective exacerbation of COPD.

She is known to have COPD with recurrent hospital admissions and has also recently been diagnosed with type 2 diabetes. A copy of the discharge letter is provided.

You are expected to:
Take a brief focused history and discuss and rationalise the patient's medication.

You will be given the hospital discharge letter during the 2 minutes reading time and will have a copy to refer to throughout the station

Discharge Letter

Patient Name: Jane Smith DOB: **20/01/1955** Hospital number: E1237545	Admitted: 05/03/2024 Discharged: 12/03/2024 Ward: A2 Destination: Home

Height: 167cm Weight: 105kg

History of presenting complaint: SOB

PMH: COPD, ILD, OA knee, hypertension, depression, new T2DM

Clinical Treatment summary: Jane a 68-year-old female was brought in by ambulance for shortness of breath. She is a known recurrent attender for COPD exacerbations, last attendance 9 weeks prior.

Presented after rescue pack failed to resolve symptoms after 3 days use. Desaturations at home to 84% breathing room air. Chest X-ray demonstrated chronic fibrotic changes with overlying right lower zone consolidation. Producing green sputum with a severe cough responsive to nebulisers, chest physiotherapy and escalated antibiotic and steroid treatment.

Discovered to have raised BMs on this admission and diagnosed with T2DM.
Jane is not a candidate for LTOT, due to being a current smoker.

Notes for GP: Please note new diagnosis T2DM

Medication changes: weaning steroid regime, commenced on metformin and linagliptin

Follow-up arrangements:
Follow up CXR in 6 weeks time
DSN review 2-4 weeks post discharge in community

Medication:

Allergies: Nil known drug allergies

Medication	Route	Dose	Frequency	Duration
Salbutamol inhaler	Inhalation of aerosol	2 puffs	QDS	PRN
Trimbow inhaler (beclometasone dipropionate, formoterol fumarate dihydrate, glycopyrronium bromide)	Inhalation of aerosol	2 puffs	BD	Regular
Azathioprine	PO	100mg	Every morning	Regular
Amlodipine	PO	10mg	Every morning	Regular
Metformin	PO	1g	BD	Regular
Linagliptin	PO	5mg	Every morning	Regular
Atorvastatin	PO	20 mg	Every night	Regular
ibuprofen	PO	400mg	QDS	Regular
naproxen	PO	500mg	BD	Regular
paracetamol	PO	1g	QDS	Regular
Sertraline	PO	50mg	Every night	Regular
Prednisolone	PO	Weaning regime (40mg-0mg)	Every morning	4 weeks. Reduce by 5mg/5 days. Discharged on Day 2 of 35mg

Multi-morbidity and Polypharmacy 1 – Notes for Actor

Patient demographics:

Jane Smith, 68F, being seen today in the GP practice post discharge for IECOPD. New diagnosis T2DM.

History of Presenting Complaint:

- Admitted to hospital for 7 days due to IECOPD with right lower zone consolidation. Treated with regular antibiotics, steroids, nebulisers and chest physiotherapy.
- She is aware of the new diagnosis of diabetes.
- She has been invited for a clinical and medication review post discharge.

New symptom:

- Epigastric pain worse on eating with associated new acid reflux. Started 3 days post discharge
- New ankle swelling – never had it before. Been on amlodipine for 10 years.

PMH + Surgical History

- Hypertension (controlled)
- COPD (**If asked: attend hospital almost every 3 months for the last 4 years**)
- ILD
- OA knee
- Depression
- New T2DM

Drug History

- As per discharge summary. You understand your regular prescriptions and steroid weaning regime.
- The metformin and linagliptin are new to you. You are concerned about 'hypos' if asked

Family History

- Nil

Social History

- You live alone, no support network
- Current smoker 30 pack year
- Struggle to prepare meals.
- Mobility is fine
- Mood: depressed

Diagnosis

Steroid induced dyspepsia

Multi-morbidity and Polypharmacy 1 – Examiner marksheet

<table>
<tr><th>MARKING RUBRIC</th><th>✓</th></tr>
<tr><td>Opening:
Introduces themselves.
Confirms Patient demographics.
Explains and gains consent from patient about consultation.</td><td></td></tr>
<tr><td>Exploration of history
Clarifies details of event requiring hospitalisation and subsequent problems
Brief and focussed history is sufficient and preferable (HPC to hospital, symptoms now, PMH, DHx, SHx)
Confirms with discharge summary to speed things up.</td><td></td></tr>
<tr><td>Explores patients views / Communication
Discusses each medication and actively involves the patient in discussion
Establishes patients views and willingness to continue
Deals with discussion/challenge sensitively and respectfully</td><td></td></tr>
<tr><td>Discussion of medication
Accurate discussion of relevant interactions/side effects
Accurate assessment of need for each medication
Rationale for continuing/stopping medication fully explained</td><td></td></tr>
<tr><td>Medication change
Suggests appropriate changes to medication
Successfully negotiates and agrees acceptable management plan with patient</td><td></td></tr>
<tr><td>Ending consultation:
Summaries and clarifies any points
Thanks Patient</td><td></td></tr>
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Global Impression:

- Excellent
- Good
- Pass
- Borderline
- Fail

Patient Impression/comments:

Station key notes:

- Identify recurrent steroid use related side effects: New DM, dyspepsia, peripheral oedema
- Identify potential DDIs: peptic ulcers (steroid+ NSAIDs), ankle swelling (steroid+ amlodipine),
- Identify potential changes to medication
    - Stop: NSAIDs (make PRN or stop altogether); sertraline short term while on steroids; consider holding amlodipine short-term with re-review to follow. Suggest stopping amlodipine in preference for ACEi/ARB due to new diabetes.
    - Start: alginate raft-forming liquid (Gaviscon), PPI, alternative analgesia as per WHO ladder. Suggest commencing ACEi/ARB

- Suggest lifestyle changes: smoking cessation, COPD management advice to prevent future steroid needs
- Suggested follow up: repeat BP check if holding amlodipine, regular BM monitoring for new DM