Case number: **3R9605** Disease: **Asthma**

Situation: **primary health care centre** Position: **doctor-assistant general medicine**

General patient information			
Name: **Josefien Amsterdam**	*	Profession:	*
Age: **6**		Intoxications:	
Sex: **female**		Allergy: **cephalosporin**	
Civil status: **-**		Pregnancy/lactation:	
Children (age): **-**		Other:	
Summary previous diseases and (current) treatment			
'99: uncomplicated partus			*
'99: atopic dermatitis			
'01: pneumonia: ther.:cefradine 7 days. Skin erythema after four days; ther.: clarithromycine			
'02: atopic dermatitis: ther.: hydrocortisone ointment 1%, apply twice daily.			
'04: viral bronchitis; ther.: conservative			
'06: Salbutamol 100 microgram/dose if necessary.			
Eight days ago: severe recurrent atopic dermatitis; ther.: triamcinolone ointment 1% apply twice daily for fourteen days.			

* tick off (v) essential pat. data!

Essence present findings *)

You have just talked to Mr. Amsterdam, the father of Josefien. Now he is at your surgery with his daughter because Josefien complains increasingly more about dyspnoea the last three weeks. In the past Josefien used salbutamol about once a week. The last three weeks she uses this medication three times a week. During the acute asthma Josefien has to cough a lot and she almost suffocates from it. The most severe attack lasted for about five minutes and responds adequately to medication. After a couple of hours the breathing became normal. Josefien is using triamcinolone ointment for eight days to cure her atopic dermatitis.

After focussed history-taking increased asthma seemed to be the most likely cause of the complaints.

You have just performed a physical/ additional examination:

- percussion and auscultation of the lungs: no signs of (broncho) pneumonia
- auscultation: little prolonged expirium, some expiratory wheezes, normal breath sounds.
- percussion of the lungs: no abnormal findings
- peak flow rate: 80% of normal for this age (not reliable)
- weight 23 kilos.

You make the working diagnosis (preliminary diagnosis): **increased asthma.**

Assignment:
Before the consultation (5 minutes):

1. Draw up your management/treatment plan.

During the consultation (10 minutes):

2a. Inform the patient about your findings of history and examination;
2b. Discuss your management/treatment plan with the patient;
2c. Execute the management/treatment on the patient.

***)** Only deviating findings are mentioned; other (non-mentioned) data are normal.

Case number: **1T9056** Disease: **Diabetes Mellitus 2**

Situation: **primary health care centre** Position: **doctor-assistant general medicine**

General patient information			
Name: **Mr. O. Den Haag**	*	Profession: **teacher**	*
Age (date of birth): **63**		Intoxications: **-**	
Sex: **male**		Allergy: **-**	
Civil status: **married**		Pregnancy/lactation: -	
Children (age): **-**		Other: **-**	
Summary previous diseases and (current) treatment			
'98: Came to surgery. History: '88: HNP left L5-S1, treated conservatively. '96: femur-fracture left after a fall from a stepladder at work. Post-operative physiotherapy; total recovery.			*
'02: sleeping problems due to imminent dismissal: temazepam 14 days (monitoring!)			

* tick off (v) essential pat. data!

Essence present findings *)

You just talked to Mr. Den Haag. He came to your surgery, because last month he became increasingly thirsty and had to go to the toilet 2 – 3 times at night. Moreover, lately he often feels very tired.

After focussed history taking, diabetes mellitus type 2 seemed to be the most likely cause of his complaints.

You have just performed a physical/additional examination:
- the blood glucose is 12.6 mmol/l (non-fasting) (reference value fasting: 5.6 mmol/l);
- the weight is 97 kg at a height of 1.80 m (QI: 30);
- the blood pressure is 150/85 mm Hg.

You make the working diagnosis **diabetes mellitus type 2**.

Assignment:
Before the consultation (5 minutes):

1. Draw up your management/treatment plan.

During the consultation (10 minutes):

2a. Inform the patient about your findings of history and examination;
2b. Discuss your management/treatment plan with the patient;
2c. Execute the management/treatment on the patient.

*) Only deviating findings are mentioned; other (non-mentioned) data are normal.

Case number: **2L9053** Disease: **Asthma**

Situation: **primary health care centre** Position: **doctor-assistant general medicine**

General patient information			
Name: **Anne-Loes Utrecht**	*	Profession:	*
Age: **5**		Intoxications:	
Sex: **female**		Allergy:	
Civil status: **-**		Pregnancy/lactation:	
Children (age): **-**		Other:	
Summary previous diseases and (current) treatment			
'01: uncomplicated partus			*
'01: atopic dermatitis			
'03: viral bronchitis			
'05 (march): relapse viral bronchitis			
4 months ago: attack of dyspnoea: Phys. Exam.: lungs: little prolonged experium and some expiratory wheezes, normal breath sounds. Peak flow measures not reliable. Diagnosis: asthma. Ther.: salbutamol 100 microgram inhaler with holding chamber.			

* tick off (v) essential pat. data!

Essence present findings *)

You have just talked to Mr. Utrecht, the father of Anne-Loes. Four months ago you diagnosed asthma and you gave her a prescription for salbutamol inhalation (see history). Now he is at your surgery because there are some problems with the use of salbutamol. The last couple of months Anne-Loes complains increasingly about an irritated mouth and throat after inhalation. On average she has acute asthma once every three weeks, mostly at night. She needs two-three puffs of salbutamol to dock the acute asthma.

After focussed history-taking asthma, adequately responding to salbutamol seemed to be the most likely cause of the complaints. The inhalation technique is well preformed.

You have just performed a physical/ additional examination:

- percussion and auscultation of the lungs: no signs of (broncho) pneumonia
- auscultation: little prolonged expirium, further no abnormal findings
- peak flow rate before medication: 80%, after medication 90%
- inspection mouth-throat: no abnormal findings

You make the working diagnosis (preliminary diagnosis): **asthma, adequately responding to salbutamol inhalation and salbutamol related complaints**

Assignment:
Before the consultation (5 minutes):

1. Draw up your management/treatment plan.

During the consultation (10 minutes):

2a. Inform the patient about your findings of history and examination;
2b. Discuss your management/treatment plan with the patient;
2c. Execute the management/treatment on the patient.

***)** Only deviating findings are mentioned; other (non-mentioned) data are normal.

Case number: **2T9065** Disease: **Diabetes Mellitus 2**

Situation: **primary health care centre** Position: **doctor-assistant general medicine**

General patient information			
Name: **Mr JH Rotterdam**	*	Profession: **retired porter**	*****
Age (date of birth): **67**		Intoxications: **-**	
Sex: **male**		Allergy: **-**	
Civil status: **married**		Pregnancy/lactation: **-**	
Children (age): **3**		Other: **-**	
Summary previous diseases and (current) treatment			
'96: Came to surgery. History: '89: sleeping problems (advice, temazepam 10 days, monitoring!) '95: diverticulosis sigmoid: lactulose syrup 0,5g/g during 4 weeks, motor advice			*
'98: light distortion left knee after fall with bicycle: prescribed rest, if necessary ibuprofen for 10 days			
'03: spastic colon: mebeverine suspension during 14 days; motor advice.			
Four weeks ago: Diab.mellitus 2; bl.gluc. non-fasting: 13 mmol/l; fasting: 9 mmol/l (normal value fasting: 5.6 mmol/l); weight 86kg, height 1.76m (QI:28), RR: 150/90 mm Hg; ther.: dietician advice.			

* tick off (v) essential pat. data!

Essence present findings *)

You have just talked to Mr. Rotterdam. Four weeks ago you diagnosed diabetes mellitus and referred him to a dietician for advice about his life-style and nutrition (see summary above). He is now visiting you for a check-up of his blood glucose.
According to the patient, he sticks to the diet. The complaints, however, remain more or less the same (increasingly thirsty, having to go to the toilet 2 – 3 times at night, getting tired more often). The patient didn't lose any weight.

After focussed history taking, the blood glucose appeared to not have declined sufficiently.

You have just performed a physical/additional examination:
- the blood glucose is 9 mmol/l (fasting; normal value fasting: 5.6 mmol/l);
- the weight is 80 kg at a height of 1.70m (QI: 28);
- the blood pressure is 160/90 mm Hg.

You make the working diagnosis **diabetes mellitus type 2, not sufficiently reacting to 4 weeks of diet**.

Assignment:
Before the consultation (5 minutes):

1. Draw up your management/treatment plan.

During the consultation (10 minutes):

2a. Inform the patient about your findings of the history and examination;
2b. Discuss your management/treatment plan with the patient;
2c. Execute the management/treatment on the patient.

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*) Only deviating findings are mentioned; other (non-mentioned) data are normal.

Case number: **3L9053** Disease: **Osteo-arthritis**

Situation: **primary health care centre** Position: **doctor-assistant general medicine**

General patient information			
Name: **B. Maastricht**	*	Profession: **salesman**	*
Age: **56**		Intoxications: **smoking (cigarettes)**	
Sex: **male**		Allergy: **NSAID**	
Civil status: **married**		Pregnancy/lactation:	
Children (age): **2**		Other:	
Summary previous diseases and (current) treatment			
'88: came into practice: history: congenital hip luxation? childhood: hay fever			*
'95: Bicycle accident: fracture of ri. hip and acetabulum, surgical treatment ineffective. Shape of the acetabulum shows congenital hip luxation.			
'98: control x-ray ri hip: cartilage narrowed; left hip: no clear abnormalities.			
'01: control x-ray ri hip: cartilage disappeared; left hip: cartilage narrowed. Mild pain; ther.: if necessary paracetamol. Hypertension: BP 180/105 mm Hg. QI: 29; dietician advice but ineffective. Also advice to stop smoking: still smokes. Ther: hydrochlorothiazide, 25 mg, tab 1 daily bloodpressure drop: BP 150/95 mm Hg			
1 week ago: increase osteo-arthritis ri. hip with pain and stiffness after inactivity; ther.: ibuprofen 400 mg, max 3 daily. Allergy NSAID; ther.: paracetamol/codeine tab 500/20 mg, max. 4 daily. Monitoring BP: 150/95 mm Hg, no complaints. Continue hydrochlorothiazide 25 mg, tab 1 daily; weight 79 kg; length 1.80 (QI: 24,4)			

* tick off (v) essential pat. data!

Essence present findings *)

You have just talked to Mr. Maastricht. He came to your surgery, because despite of the paracetamol/codeine walking is more painful. He complains about pain in both hips. Especially there is pain in the right hip when comes out of bed in the morning, when he stands up from a chair en during the first couple of passes of walking. Since a couple of weeks his right hip is painfull after five to ten minutes walking. He has to sit down for a moment. Moreover, he has not got any defecation for a couple of days.

You have just performed a physical/ additional examination:

- there is some crepitus on passive joint movement of the right hip, flexion, exo- and endorotation are limited.
- Active movements during the examination cause pain.
- Flexion of the left hip is mildly limited and painful in the end of movement;
- Hart and lungs: no abnormalities
- Weight: 79 kg at a height of 1.80 m (QI: 24,4)
- Blood pressure: 155/90 mm Hg.

You make the working diagnosis (preliminary diagnosis): **traumatic osteo-arthritis** of the right hip.

Assignment:
Before the consultation (5 minutes):

1. Draw up your management/treatment plan.

During the consultation (10 minutes):

2a. Inform the patient about your findings of history and examination;
2b. Discuss your management/treatment plan with the patient;
2c. Execute the management/treatment on the patient.

***)** Only deviating findings are mentioned; other (non-mentioned) data are normal.