Clinical challenge

These questions are based on the Focus articles in this issue. Please choose the single best answer for each question.

CASE 1

Emily, a woman aged 38 years, wants to discuss how to make lifestyle changes to help her lose weight.

QUESTION 1

Emily has heard of the ketogenic diet and asks what she would need to keep her daily carbohydrate intake below. You advise her that most ketogenic diets limit total carbohydrate intake to less than:

A. 30 g
B. 50 g
C. 80 g
D. 100 g

QUESTION 2

To understand what a ketogenic diet means to her, Emily asks what the average Australian daily carbohydrate intake is. You explain that the average daily carbohydrate intake is:

A. Less than 100 g
B. 100–175 g
C. 175–250 g
D. More than 250 g

QUESTION 3

Side effects of a ketogenic diet can include ketone breath, increased risk of kidney stones and:

A. diarrhoea
B. B vitamin deficiencies
C. hyperkalaemia
D. vitamin C overdose

CASE 2

Barry, a man aged 45 years, has a body mass index of 33 kg/m^2 and wants to explore pharmacological management of his weight.

QUESTION 4

Which medication is subsidised under the Pharmaceutical Benefits Scheme for the management of obesity?

A. Semaglutide (Wegovy)
B. Tirzepatide (Mounjaro)
C. Orlistat
D. None

Continued on page 209.

How to use *AJGP* for your CPD

Each issue of the *Australian Journal of General Practice* (*AJGP*) focusses on a specific clinical or health topic. Many GPs find the entire issue of interest and relevance to their practice and others explore the issue more selectively.

However you prefer to engage with the issue, you can use *AJGP* for your CPD. If you want to use the entire issue for CPD, carefully and critically work your way through each focus article, considering how you might adjust your practice in response to what you have learnt, then complete the Clinical challenge.

Your CPD will be automatically recorded for you
When you complete the *AJGP* Clinical challenge and/or Measuring Outcomes (MO) companion activity through *gplearning* your CPD hours will be automatically recorded on myCPD Home within 12 hours.

Self-recorded reading
If you prefer to read and reflect on specific articles without completing the Clinical challenge, record this via quick log on myCPD Home. As guidance, each article in *AJGP* can be recorded for up to two CPD hours, split evenly between EA and RP CPD time. CPD for this issue will enable you to meet your Program-Level Requirements of Addressing Health Inequities.

Self-directed MO options
You can also do self-directed MO CPD related to this issue of *AJGP*. Choose any topic area from within the issue and undertake a quality improvement activity. This can be done on your own, with a colleague, in a group, or perhaps with the assistance of our practice manager or PHN quality improvement team.

Consider reviewing your practice data and examine your recent experiences with patients. Use the article by Munindradasa and Douglas to explore some of the systemic issues that prevent your patients from accessing treatment, and how as a team, you can do a targeted campaign to raise awareness and offer care without further compounding stigma patients experience.

Evaluate and implement your strategy with five patients could provide at least 10 hours MO CPD. Log in to myCPD Home (https://bit.ly/myCPDhome) for guides and templates to complete your self-directed quality improvement activities and record your MO hours.

The **Clinical challenge** consists of multiple-choice and short answer questions based on the focus articles in this issue of *AJGP*. Complete the Clinical challenge to earn 10 CPD hours, split evenly between Educational Activities (EA) and Reviewing Performance (RP). This CPD allocation includes reading time for the focus article.

The **Measuring Outcomes (MO) companion activity** assists you to implement and evaluate changes in your practice in line with the guidance provided in a specific article in this issue of *AJGP*. Complete the companion activity to earn five MO hours.

Important notice: The AJGP Clinical Challenge will be moving to **digital-only** soon. From July 2025, you can access your CPD activity through the AJGP website (www1.racgp.org.au/ajgp/home) or on *gplearning*.

Visit https://bit.ly/AprilCCMO and select the 'Register' button to find both the Clinical challenge and Measuring Outcomes companion activity.

Scan the QR code for a custom quick log when you read the whole issue without completing the Clinical challenge.

QUESTION 5

Obesity is a chronic disease affecting nearly what proportion of Australian adults?

A. One-quarter
B. One-third
C. One-half
D. Two-thirds

QUESTION 6

Semaglutide is administered by subcutaneous injection at what frequency of dosing?

A. Once daily
B. Twice daily
C. Once weekly
D. Once monthly

QUESTION 7

All pharmacotherapy options for the treatment of obesity are contraindicated during pregnancy and lactation. When should these medications be ceased before trying to conceive?

A. Two weeks
B. One month
C. Two months
D. Four months

CASE 3

Ameer, a man aged 29 years, wishes to be referred to a bariatric surgeon due to his difficulty losing weight and a body mass index of 39 kg/m^2.

QUESTION 8

Bariatric surgery typically results in a typical weight loss of 30% initially, which long term stabilises to:

A. 20%
B. 25%
C. 30%
D. 35%

QUESTION 9

Which is the most common bariatric surgical procedure?

A. Sleeve gastrectomy
B. One-anastomosis gastric bypass
C. Roux-en-Y gastric bypass
D. Vertical banded gastroplasty

CASE 4

Dr Craig, a general practitioner colleague in your practice, wishes to discuss the challenges of managing patients with obesity.

QUESTION 10

How long does it take on average, for Australians to present to their general practitioner for weight management?

A. 6 months
B. 12 months
C. 3 years
D. 9 years

These questions are based on the Focus articles in this issue. Please write a concise and focused response to each question.

CASE 1

Emily, a woman aged 38 years, wants to discuss how to make lifestyle changes to help her lose weight.

QUESTION 1

Discuss the potential concerns related to intermittent fasting.

QUESTION 2

State six chronic health conditions that a Mediterranean diet has been shown to improve.

QUESTION 3

Describe the patient groups and health conditions that should avoid ketogenic diets, or only follow them under medical supervision.

CASE 2

Barry, a man aged 45 years, has a body mass index of 33 kg/m^2 and wants to explore pharmacological management of his weight.

QUESTION 4

Discuss the indications for pharmacological management of adults with overweight and obesity.

QUESTION 5

Explain the mechanism of action of glucagon-like peptide-1 receptor agonists.

QUESTION 6

State three obesity-related comorbidities that Tirzepatide has been shown to improve.

QUESTION 7

What features of medical and psychological history are important to discuss when considering pharmacological management of obesity?

CASE 3

Ameer, a man aged 29 years, wishes to be referred to a bariatric surgeon due to his difficulty losing weight and a body mass index of 39 kg/m^2.

QUESTION 8

Discuss the indications for bariatric surgery.

QUESTION 9

Describe briefly the sleeve gastrectomy procedure and its benefits.

CASE 4

Dr Craig, a general practitioner colleague in your practice, wishes to discuss the challenges of managing patients with obesity.

QUESTION 10

Discuss the barriers to success cited by general practitioners in the literature related to managing obesity using standard consults.

March 2025 Multiple-choice question answers

ANSWER 1: C

The current recommendation of antidepressant therapy for the first episode of moderate-severity depression is 9–12 months. For recurrent depression of two or more episodes, the recommended duration of antidepressant therapy is two years – indefinitely.

ANSWER 2: C

In the ANTidepressants to prevent reLapse in dEpRession randomised controlled trial (ANTLER-RCT), the relapse rate in those who discontinued antidepressants was 56%. In those who continued antidepressant therapy, it was 39%.

ANSWER 3: D

Typical withdrawal phenomena include rapid onset of symptoms after an antidepressant dose reduction, a rapid resolution of symptoms if the antidepressant dose is increased, and might include nausea, dizziness and 'brain zaps'.

ANSWER 4: D

Statements A, B and C are all correct. For people living with borderline personality disorder (BPD), psychotropic medications may be prescribed in the short term in very small quantities to assist with mental health crises.

ANSWER 5: C

The frequency of non-suicidal self-injury (NSSI) in people living with BPD is around 85%. Statements A, B and D are all correct.

ANSWER 6: D

Sexual abuse, increasing substance use and previous high-lethality suicide attempts are all associated with an increased risk of suicide. Chronic suicidality is characteristic of BPD and helps the person communicate their distress. It is not usually intended to result in death.

ANSWER 7: B

A systematic review and meta-analysis of numerous studies of dose-related risk of unintentional opioid overdose concluded that the threshold dose for an unintentional overdose is 20 mg morphine equivalents (MME)/day, with higher risks with larger doses.

ANSWER 8: D

Having multiple providers of high-risk opiates can cause an increase in the risk of uncoordinated care, opiate overdose, opiate misuse and opiate diversion.

ANSWER 9: D

Both statements B and C apply. Prescribers must apply to the Special Access Scheme (SAS-B) or become authorised prescribers (AP) through the Therapeutic Goods Administration (TGA). The SAS-B requires healthcare practitioners to apply for each patient to be able to access each category of medical cannabis products. The AP scheme allows healthcare practitioners to prescribe medical cannabis products without the need to seek approval for individual patients.

ANSWER 10: C

Serious psychiatric conditions – major depressive episodes, mania, delirium and psychotic disorders – develop in approximately 6% of patients who receive oral glucocorticoids.

March 2025 Short answer question answers

ANSWER 1

Common side effects of antidepressants which might affect a patient's quality of life include sexual side effects, weight gain, gastrointestinal side effects and sleep disturbances. Rarer side effects, for which confounders might exist, include falls, hyponatraemia, upper gastrointestinal tract bleeding and stroke.

ANSWER 2

Three areas within Sadiya's agenda (ie her request for antidepressant discontinuation) that are important to explore are her ideas, concerns and expectations about antidepressant discontinuation. This might include exploring if she has concerns about long-term side effects and if she is experiencing stigma from taking anti-depressants. It is also important to explore her ideas and concerns about discontinuation; her knowledge about the process of discontinuation and discontinuation symptoms, as well as her knowledge of the benefits of continuing the therapy for longer (which is recommended). In terms of her expectations, you might explore what is she hoping for from the discussion with you today, and what she wants the discontinuation process to look like.

ANSWER 3

Three predictors of depression relapse that should ideally be explored with Sadiya include previous psychosocial precipitants, ongoing psychosocial precipitants and comorbid conditions.

ANSWER 4

Clinical features of borderline personality disorder (BPD) include the following:

- Identity disturbances with fragile, unstable sense of self and chronic sense of emptiness.
- Pervasive unstable relationships that are characterised by switching from idealisation to devaluation, usually in reaction to feeling criticised or rejected.
- Intense fear of abandonment or rejection by others.
- Emotional instability with intense and changeable emotions that are poorly regulated.
- Intense anger and difficulty controlling it.
- Impulsive behaviours and recurrent self-harm using multiple means including non-suicidal self-injury (NSSI), substance use, disordered eating, unsafe sex and other risk-taking behaviours.
- Chronic suicidal thoughts, often accompanied by suicidal threats or behaviour.
- Stress-related paranoid ideation and dissociative symptoms.

ANSWER 5

Important principles in the provision of primary care to people living with BPD include the following:

- Diagnosis: Identify patterns of unstable relationships, self-image and affect and reflect on expectations of challenging encounters to flag need for further assessment. McLean and BPQ are useful screening tools, to create a starting point for psychoeducation if a high likelihood of BPD is identified.
- Psychoeducation: Educate patients about their diagnosis with emphasis on effective treatments. Recommend resources such as the factsheets from Sane and Project Air.
- Safe space: Ensure a validating, empathetic and trauma-informed environment with clear communication about therapeutic boundaries.
- Regulation of emotions: Help patients to become aware of intense emotions,

identify triggers and strategies to reduce acting on them.

- Focused brief psychological interventions: These can be used to deal with current problems as identified by the patient.
- Prescribing caution: Be wary of prescribing psychotropics and sedatives, given the overdose risk. Medications should not be used as primary treatment as there is no evidence of efficacy but might play these roles:
  - management of crisis with short term and low dose quetiapine or olanzapine, noting that this would typically be a non-Pharmaceutical Benefits Scheme prescription
  - treatment of co-occurring psychiatric conditions (depression not responsive to psychotherapy or with psychotic features and bipolar disorders)
  - targeting specific symptoms (eg significant anger or aggression, micro-psychosis triggered by stress)
  - the use of omega-3 fatty acids to reduce aggression and improve depressive symptoms per evidence from some small studies.

  If prescribing, consider a low dose of a single medication in small quantities only for limited periods of time. If ongoing medication is prescribed, psychiatric review is strongly encouraged.
- Advocacy: Advocate for access to appropriate therapeutic services and for psychiatric opinions where there is diagnostic uncertainty, complexity or concern regarding risk.
- Collaborative planning: Establish a joint treatment and crisis plan and communicate regularly with health providers and other supports to avoid splitting. Involve family members and/or carers identified by the individual. Consider supports and resources that carers might need.
- Continuity of holistic care: Prioritise chronic disease prevention and age-risk-based screening.
- Self-reflection and self-care: Recognise signs of vicarious trauma, burnout, and compassion fatigue in yourself, particularly when managing chronic suicidality. Agree on clear limits for disruptive behaviours and about treatment boundaries. Seek mentoring, consider a Balint group and prioritise self-care.

ANSWER 6

These are four important principles when providing care to people living with BPD who have undertaken non-suicidal self-injury (NSSI):

- Identify triggers: understand the event and the underlying emotional cause, whether it's rejection, loss or failure.
- Empathy: address and validate the distress without fixating on the self-injury act.
- Encourage self-management: if feasible, teach the individual to care for their injuries and recognise when they need to seek medical attention.
- Psychotherapy: can significantly diminish NSSI episodes.

ANSWER 7

Examples of how to reframe the feelings you might experience with a patient who has BPD include focusing on the patient's mind and affect rather than their behaviour, validating the distress that the patient is experiencing or recognising your own symptoms of compassion fatigue or burnout.

ANSWER 8

1. The potential benefits for patients of introducing a real-time prescribing system for schedule 8 (S8) medications:

   The Coroners Court of Victoria identifies there has been a decreasing number of overdose deaths involving benzodiazepines, pharmaceutical opioids and quetiapine since the introduction of SafeScript. Many practitioners find SafeScript extremely useful in obtaining a more complete assessment of their patients' use of monitored medicines, particularly where patients had been accessing them from multiple providers. Descriptions from prescribers to the SafeScript team include reports that patients suspected of misusing monitored medicines had not been. Other prescribers found that SafeScript information encouraged them to review prescribing for individual patients and plan for safer supply.

2. Unintended consequences of introducing a real-time prescribing system for S8 medications that might be harmful to patients:

   There has been an increase in the use of the stigmatising term 'doctor shopping' to describe drug seeking for psychoactive medicines such as opioid analgesics and benzodiazepines. This term prejudges the reason for attending multiple providers and triggers a policing response and discharge from care instead of providing professional assessment and support. Other concerns included that those patients prevented from accessing medicines on which they were dependent would be forced onto the illicit drug market to use illicit drugs, and that drug-seeking individuals would move across state/territory borders to obtain medicines. These latter two concerns might be unfounded.

ANSWER 9

'Dimensions of accessibility' that might be barriers for patients trying to access medicinal cannabis in Australia include the following:

- Approachability: limited GP knowledge of medical cannabis can form an approachability barrier for patients, as many GPs feel uncomfortable discussing medical cannabis with patients.
- Acceptability: acceptability is a barrier for both patients and GPs. Medicinal cannabis prescription is polarising, where prescribers and non-prescribers both describe facing stigmatisation in different areas.
- Availability and accommodation: geographical location plays a significant role in access.
- Affordability: the cost of the clinic attendance, travel and the prescription was a barrier for both patients and GPs.

- Appropriateness: the appropriateness of medical cannabis prescription was a concern for GPs due to the lengthy prescription process, potential harm, and the paucity of high-quality evidence for safety and efficacy.

ANSWER 10

The first therapeutic intervention for people who develop psychosis as a result of oral glucocorticoids is reducing and, if possible, ceasing the corticosteroids. The second intervention is the use of second-generation antipsychotic medications. Most published cases report the use of olanzapine 2.5–20 mg daily. This is best administered at night as it has a sedative effect.

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