Clinical challenge

Using *AJGP* for your CPD

Each issue of the *Australian Journal of General Practice* (*AJGP*) focuses 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.

Below you will find various ways you can use *AJGP* as part of 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 Educational Activities (EA) and Reviewing Performance (RP) CPD time.

Clinical challenge

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 EA and RP. This CPD allocation includes reading time for the Focus articles.

MO companion activity

The 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.

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

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 your practice manager or PHN quality improvement team.

Consider evaluating your practice setting's approach to supporting women who are experiencing menopause symptoms, using Spencer and Newman's article as a guide. Explore your role as a team in providing evidence-based advice and support to patients as well as routine screening for other risk factors such as cardiovascular health and bone density.

A simple evaluation might be recorded for several MO hours, while a more comprehensive PDSA approach would provide at least 10 hours of MO CPD. Evaluating and implementing 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.

AI declaration: The Editors advise that artificial intelligence (AI)-assisted technology was used in the writing and/or editing of the April 2026 *AJGP* Clinical challenge and accept full responsibility for all content.

April 2026 Multiple-choice questions

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

QUESTION 1

The average length that a woman will experience bothersome menopausal symptoms is:

- **A.** 5–6 years
- **B.** Less than 12 months
- **C.** 7–8 years
- **D.** 10–11 years

CASE 1

Zuri, a woman aged 34 years, presents with 8 months of irregular periods and hot flushes. Her pregnancy test is negative. Initial blood tests show follicle-stimulating hormone (FSH) 29 IU/L and oestradiol 85 pmol/L.

QUESTION 2

According to the 2024 international premature ovarian insufficiency (POI) guideline, which next step is **most** appropriate for confirming the diagnosis of POI in general practice?

- **A.** Arrange anti-Müllerian hormone (AMH) testing to confirm the diagnosis of POI
- **B.** Repeat measurement of FSH level after 4–6 weeks to confirm the diagnosis of POI
- **C.** Repeat measurement of FSH level after 4–6 weeks only if diagnostic uncertainty remains
- **D.** Request pelvic ultrasonography to exclude polycystic ovarian syndrome as the cause

CASE 2

Tayla, an accounts manager aged 30 years, presents with secondary amenorrhoea for 3 months. She has smoked a packet of cigarettes daily since the age of 18 years. Tayla used the combined oral contraceptive pill for 4–5 years between the ages of 16 and 21 years. Her body mass index is 27.4 kg/m^2. Tayla currently engages in low levels of physical activity.

QUESTION 3

Which of the following is a recognised lifestyle-related risk factor for developing premature ovarian insufficiency?

- **A.** Body mass index of >25 kg/m^2
- **B.** Cigarette smoking
- **C.** Low physical activity levels
- **D.** Using combined oral contraceptives

CASE 3

Ngaire, a woman aged 29 years, is diagnosed with spontaneous premature ovarian insufficiency (POI). Her uterus is intact. She has no contraindications to hormone therapy, is concerned about her bone health and is experiencing significant vasomotor symptoms.

QUESTION 4

According to the 2024 international POI guideline, which menopause hormone therapy regimen would be the most appropriate?

- **A.** A 20 mcg ethinyl oestradiol contraceptive pill, taken continuously (to avoid withdrawal bleeding) until age 51 years
- **B.** Oral oestradiol 1 mg daily combined with cyclical oral progestogens (on days 14–28) and continued until age 51 years
- **C.** Transdermal oestradiol 100 mcg patch combined with the Kyleena intrauterine device (IUD), changed every 5 years, continued until age 51 years
- **D.** Transdermal oestradiol 100 mcg patch combined with the Mirena IUD, changed every 5 years, continued until age 51 years

CASE 4

Lucy, a woman aged 52 years with a history of breast cancer, is experiencing severe hot flushes. She is currently taking tamoxifen.

QUESTION 5

Which antidepressant should not be prescribed to manage her vasomotor symptoms because of drug interactions that may reduce the efficacy of tamoxifen?

- **A.** Citalopram
- **B.** Escitalopram
- **C.** Fluoxetine
- **D.** Sertraline

CASE 5

Jo, a non-binary individual aged 53 years who was assigned female at birth, presents with severe hot flushes but cannot take menopause hormone therapy (MHT) because of a history of breast cancer. They are interested in new pharmacological options.

QUESTION 6

Which of the following statements about NK3 receptor antagonists (eg fezolinetant) is correct?

- **A.** Fezolinetant can be safely combined with MHT in selected patients to enhance symptom relief
- **B.** Fezolinetant is effective in reducing hot flushes and sweating within the first week of treatment
- **C.** Fezolinetant is also licensed for the treatment of mood disorders associated with menopause
- **D.** Fezolinetant requires routine liver function tests to be monitored on a 3-monthly basis indefinitely

CASE 6

Fatima, a woman aged 54 years with severe vasomotor symptoms, asks about starting menopause hormone therapy (MHT). Her last menstrual period was 3 years ago.

QUESTION 7

Which of the following is an **absolute contraindication** to initiating MHT?

- **A.** Current venous thromboembolic disease
- **B.** Migraine with aura
- **C.** Past history of venous thromboembolism
- **D.** The final menstrual period having been 5 years ago

QUESTION 8

Fatima asks about the duration of menopause hormone therapy (MHT), should you decide that it is appropriate for her. Which statement about the duration of MHT is correct?

- **A.** It should be ceased after 3 years because of the increased risk of breast cancer
- **B.** It should be ceased after 5 years because of the increased risk of breast cancer
- **C.** It should be ceased before she reaches the age of 60 years because of the increased stroke risk
- **D.** It should be reviewed annually, and the duration of treatment should be individualised

CASE 7

Georgie, a trans-male aged 50 years who was assigned female at birth, reports irritability, poor sleep and increased anxiety over the past 6 months. Georgie has not been using gender-affirming hormone therapy or menopause hormone therapy.

QUESTION 9

Which statement relating to perimenopausal hormonal changes and psychological symptoms is true?

- **A.** Fluctuating progesterone levels during perimenopause can reduce the usual calming influence of progesterone and allopregnanolone on the brain, contributing to anxiety, irritability and sleep disturbance
- **B.** Fluctuating oestradiol levels during perimenopause and menopause cause vasomotor symptoms but have little impact on cognition or emotional regulation, and they do not contribute to other psychological symptoms
- **C.** Serotonin regulation, unlike dopamine regulation, is largely unaffected by fluctuating oestradiol, testosterone or progesterone levels during perimenopause and menopause
- **D.** Testosterone levels are not significantly affected by perimenopause and menopause and thus do not underlie any mood changes or cognitive changes that Georgie may be experiencing

CASE 8

Nicole, a woman aged 45 years who also has a diagnosis of attention deficit hyperactivity disorder (ADHD), presents with low mood, irritability, sleep disturbance and decreased sexual interest. You use the Meno-D scale to assess her for perimenopausal depression, on which she scores 30.

QUESTION 10

How should her perimenopausal depression be categorised and subsequently managed?

- **A.** Mild perimenopausal depression – treatment optional, ongoing monitoring required
- **B.** Moderate perimenopausal depression – treatment indicated, ongoing monitoring required

C. Normal symptoms that are to be expected during perimenopause – no treatment needed

D. Severe perimenopausal depression – urgent treatment required and ongoing monitoring required

April 2026 Short answer questions

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

CASE 1

Ngaire, a woman aged 29 years, presents with 5 months of secondary amenorrhoea. She experienced menarche at age 10 years and had a regular 26-day cycle until about 8 months ago, when her periods became less regular. She has also been tearful, feels hot all the time and is not sleeping well. A home pregnancy test is negative.

QUESTION 1

List two genetic and two autoimmune causes of premature ovarian insufficiency.

QUESTION 2

Using Vincent and Ee's article on the European Society of Human Reproduction and Embryology 2024 premature ovarian insufficiency guidelines, describe the initial investigations for a woman aged <40 years presenting with secondary amenorrhoea for 5 months. Explain how these investigations assist clinical reasoning.

QUESTION 3

According to Vincent and Ee's article, describe two genetic tests (after genetic counselling) and two autoimmune tests that may help ascertain the underlying cause of premature ovarian insufficiency.

CASE 2

Nicole, a woman aged 45 years who also has a diagnosis of attention deficit hyperactivity disorder (ADHD), presents with low mood, irritability, sleep disturbance and decreased sexual interest. She has no other relevant medical history, takes no prescribed or over-the-counter medications and has no allergies. She is a lifelong non-smoker. Alcohol intake is approximately 12 standard drinks per week. There is no history of substance use in the past 20 years. Family history includes her mother diagnosed with breast cancer at age 72 years.

On the Meno-D scale, Nicole scores 30.
Blood pressure: 138/81 mmHg.
Body mass index: 22.6 kg/m^2.
Waist circumference: 72 cm.

QUESTION 4

Using Kulkarni et al's article, list three risk factors for perimenopausal depression.

QUESTION 5

Using Kulkarni et al's article, suggest three differential diagnoses for perimenopausal depression.

QUESTION 6

Using Kulkarni et al's article, outline an initial management plan for Nicole's perimenopausal depression.

March 2026 Multiple-choice question answers

ANSWER 1: B

Ongoing self-reflection and addressing power differentials are central to cultural safety when providing healthcare for Aboriginal and Torres Strait Islander peoples. Cultural safety requires ongoing reflective practice, action to address power imbalances, and awareness of how practitioner attitudes affect care delivery. It shifts from providing care regardless of difference to providing care that meets unique needs, grounded in self-awareness rather than studying others' cultures.

ANSWER 2: A

Dismantling settler-colonial systems is required to eradicate racism against Aboriginal and Torres Strait Islander peoples. Eradicating racism requires structural change, ongoing resistance and ceding power by non-Indigenous peoples to enable cultural safety.

ANSWER 3: B

The key action under 'Advise' for all people who smoke is to provide brief, clear, non-confrontational advice to quit at every visit. General practitioners are encouraged to advise all smokers to quit (eg 'The best thing you can do for your health is to quit the smokes') in a non-confrontational way, as brief as 30 seconds, without first assessing readiness. This increases quit attempts.

ANSWER 4: A

Nicotine dependence is assessed by three questions: time to first cigarette after waking, number of daily cigarettes and difficulty refraining in no-smoking areas.

ANSWER 5: C

For smoking cessation pharmacotherapy in pregnant Aboriginal and Torres Strait Islander women, oral nicotine replacement therapy (NRT) is appropriate to use if counselling alone has not been effective.

There is insufficient evidence that NRT is effective in increasing smoking cessation in pregnancy from a review of only five placebo-controlled trials, in contrast to the effectiveness of behavioural interventions in pregnancy (97 trials). However, if counselling has not been successful, it is reasonable to consider using oral NRT after explanation of risks and benefits. Varenicline or bupropion should not be used in women who are pregnant or breastfeeding.

ANSWER 6: C

As a result of increasing syphilis rates since 2011 in both Aboriginal and Torres Strait Islander and non-Indigenous populations, more frequent testing is recommended. Consider up to five tests for those at ongoing risk per jurisdictional guidelines.

ANSWER 7: B

The Which Way? study found women want non-pharmaceutical, culturally appropriate support, especially during pregnancy, facilitated face to face by Aboriginal and Torres Strait Islander health workers.

ANSWER 8: B

Respiratory syncytial virus vaccine is administered at 28–36 weeks; if not,

nirsevimab can be given to newborns. COVID-19 vaccine is considered for high-risk cases.

March 2026 Short answer question answers

ANSWER 1

Cultural safety describes a state where people are enabled and feel they can access healthcare that suits their needs, are able to challenge personal or institutional racism (when they experience it), establish trust in services and expect effective, quality care.

ANSWER 2

Racism affects health and wellbeing through multiple pathways. These can include exposure to physical, psychosocial, socioeconomic and legal stressors, which can interact and compound over life courses and generations. Racism creates negative determinants of health including stress, trauma and risk of physical injury and death through exposure to racially motivated violence and substandard care. Racism also impedes access to protective social, cultural, environmental and economic determinants of health, and it can give rise to coping mechanisms that are not supportive of health. Racism contributes to inequitable access to healthcare and legal services, which exacerbates poor health outcomes and creates vicious cycles that entrench poor health and wellbeing.

A direct path between racism and health is via chronic stress. Experiencing or anticipating racism triggers the fight-or-flight response, activating the sympathetic nervous system and hypothalamic–pituitary–adrenal axis, producing elevated heart rate, blood pressure, blood glucose and inflammation. The cumulative physiological burden of repeated or chronic activation of stress pathways (allostatic load) can lead to changes in cardiovascular, gastrointestinal, endocrine, metabolic, neurological and immune systems, with long-term immunosuppressive effects. Higher allostatic load is associated with all-cause mortality, cardiovascular disease, diabetes, cancer, psychological distress and periodontal disease.

ANSWER 3

Behavioural support elements that could lead to successful cessation of smoking in Aboriginal and Torres Strait Islander peoples include providing or referring to multi-session behavioural support using individual or group counselling, Quitline, text messaging (eg QuitTxt), internet programs (eg QuitCoach or iCanQuit) or incentives for cessation support. Quitline (phone 137848 or 13QUIT) offers cessation counselling from trained Aboriginal and Torres Strait Islander counsellors who will call the person who smokes following referral from a health practitioner (www.quit.org.au/referral-form) or self-referral.

More sessions of counselling and advice increase successful cessation. Four or more sessions have been recommended. Agree on a quit day, provide strategies for managing smoking triggers, mobilise support from family and friends and at follow-up visits provide encouragement and support, reviewing progress and problems. A meta-analysis of 194 studies showed that counselling increased cessation. Similarly, two randomised controlled trials at Aboriginal Community Controlled Health Services demonstrated that patients who were allocated to more intensive multi-session face-to-face counselling and support were more likely to successfully quit.

ANSWER 4

Advise all people who smoke to quit in a clear, non-confrontational way – for example, 'The best thing you can do for your health is to quit the smokes'. This advice can be as brief as 30 seconds, and it should be given at every visit and followed by offers of assistance to quit. Provide brief advice to all people who smoke whether they want to quit or not; there is no need to first assess 'stage of change'. Aboriginal and Torres Strait Islander people who recall being advised to quit are two times more likely to have made a quit attempt in the past year than those who did not.

ANSWER 5

It is important to ask all parents and carers of children if they smoke and, if so, if they smoke inside the home or car. It is important to advise them to quit to protect their children, as not smoking inside reduces exposure to second-hand smoke but does not provide complete protection.

ANSWER 6

Preconception and pregnancy represents a time when women and their partners may be more receptive to health promotion messages and experience increased motivation to make behaviour changes. Healthcare professionals need to be confident in delivering health promotion and interventions to women and their families during the antenatal period. This should be supported with the availability of culturally appropriate resources. Care should be taken to space the timing and frequency of antenatal health promotion messaging to ensure women are not overwhelmed or experience shame if they are not able to achieve the desired change.

ANSWER 7

Research has found that some Aboriginal and Torres Strait Islander men would like more opportunities to engage with pregnancy healthcare to help support their partner and unborn child, but many found the clinical environment unwelcoming. Creating systems that support family functioning while respecting the agency and, if applicable, safety of a pregnant woman is central to the delivery of culturally appropriate and contextually tailored pregnancy care.

ANSWER 8

This should be a personal reflection, tailored to your own circumstances and practically based on the content of this issue.

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