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 8 CPD hours, split evenly between EA and RP. This CPD allocation includes reading time for the Focus articles.

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 as a practice team how you and others in your practice setting are navigating some of various medicolegal risks and considerations for patients diagnosed with attention deficit hyperactivity disorder, using Bradfield and Fernando's article as a guide.

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 September 2026 *AJGP* Clinical challenge and accept full responsibility for all content.

September 2026

These questions are based on the Focus articles provided. Please choose the single best answer for each multiple-choice question. For the short answer questions, please write a concise and focused response to each question.

CASE 1

James, aged 41 years, is an accountant who was diagnosed with attention deficit hyperactivity disorder (ADHD) combined type 6 months ago by a psychiatrist. He was commenced on immediate-release methylphenidate 10 mg twice daily. He reports excellent morning focus but significant difficulty concentrating during late-afternoon client calls. He describes poor sleep due to late bedtimes, skipped meals during hyperfocus periods, and evening binge eating.

QUESTION 1

When optimising James's methylphenidate because of insufficient afternoon coverage, the most appropriate next step is:

- **A.** Immediate change of stimulant medication to lisdexamfetamine
- **B.** Addition of a low-dose short-acting methylphenidate in the afternoon
- **C.** Addition of atomoxetine as an adjunct to improve impulse control
- **D.** Reduction of the morning dose and change of the evening dose to dexamfetamine

QUESTION 2

James's pattern of delaying sleep because evenings feel like his only personal time can be best explained as:

- **A.** Volitional behaviour unrelated to ADHD
- **B.** A feature of comorbid depression
- **C.** Revenge bedtime procrastination
- **D.** A consequence of stimulant therapy

QUESTION 3

Name two evidence-based non-pharmacological strategies that would be particularly helpful for James's task-initiation difficulties and evening binge eating.

CASE 2

Maya, aged 9 years, is a girl you have diagnosed with ADHD inattentive type using *Diagnostic and statistical manual for mental disorders*, 5th edition (DSM-5) criteria and multi-informant rating scales. You are a general practitioner (GP) with a specific interest in ADHD in Queensland. Maya's parents are separated. Her mother consents to a medication trial, but her father subsequently telephones the practice to withdraw consent.

QUESTION 4

Under Australian Family Law (no existing parenting orders), the correct approach is:

- **A.** Cease treatment until both parents provide written consent

B. Treatment may lawfully continue with the consent of one parent
C. A court order is required before continuing
D. Referral to a paediatrician is recommended

QUESTION 5

As of December 2025, a Queensland GP initiating methylphenidate in a child aged 9 years:

A. Must obtain prior paediatrician approval for all children under 12 years
B. May initiate without prior approval provided the daily dose does not exceed 80 mg
C. May only prescribe if continuing treatment already started by a paediatrician
D. Requires real-time monitoring check but no formal authority

CASE 3

You are a GP in regional NSW considering initiating stimulant treatment for a woman aged 35 years newly diagnosed with ADHD.

QUESTION 6

What civil liability medicolegal standard applies to GPs prescribing stimulants for ADHD? What are some potential medicolegal pitfalls regarding ADHD management?

QUESTION 7

Which of the following non-stimulant medications cannot be initiated by a GP under the Pharmaceutical Benefits Scheme for ADHD?

A. Clonidine
B. Guanfacine
C. Atomoxetine
D. Both B and C

QUESTION 8

For a patient with ADHD, list the key physical parameters that should be monitored at every medication review and the minimum frequency for weight and height checks in children.

CASE 4

Thomas, a software developer aged 35 years, discontinued methylphenidate because of anxiety and appetite suppression but is still struggling with attention and task initiation. He is interested in non-pharmacological approaches.

QUESTION 9

Along with body doubling, which strategy is mentioned by Nowinska and Savage that could be useful for addressing Thomas's difficulty with task initiation?

A. Systematic desensitisation
B. Pomodoro technique
C. Progressive muscle relaxation
D. Motivational interviewing

QUESTION 10

Explain the 'energy budgeting' framework and provide one practical strategy for a patient in a 'red' (low energy) state.

CASE 5

Dr Nguyen, a GP in Sydney, receives a telehealth request from a patient who has moved to Victoria for a repeat lisdexamfetamine prescription.

QUESTION 11

What are some medicolegal considerations when prescribing Schedule 8 medication via telehealth across state borders?

CASE 6

You are reviewing the prospective cohort study by Poulton et al on GP-led ADHD management.

QUESTION 12

The rate of referral to non-GP specialists (paediatrics or psychiatry) in the Poulton study was:

A. 2.4%
B. 8.4%
C. 15.4%
D. 25.4%

QUESTION 13

Define 'uncomplicated ADHD' as used in the study by Poulton et al.

QUESTION 14

Name two important limitations of the study by Poulton et al.

QUESTION 15

Describe the central coordinating role of the GP in multimodal ADHD management.

August 2026 Multiple-choice question answers

ANSWER 1: C

Drospirenone has mild anti-mineralocorticoid properties that might help with fluid retention.

ANSWER 2: A

Although this bleeding is occurring within the first 6 months of continuous combined menopausal hormone therapy (MHT), it is becoming increasingly heavy and needs clinical assessment with a pelvic examination, consideration of a cervical co-test, and transvaginal ultrasonography.

ANSWER 3: A

The article by Whitburn notes that up to 25% of individuals on systemic menopausal hormone therapy (MHT) still experience genitourinary symptoms of menopause (GSM), and that vaginal oestrogen can be safely added for further symptom relief. Local estriol or oestradiol has minimal systemic absorption, does not require additional progestogen and improves moisture, elasticity, epithelial integrity and urinary tract infection risk. Increasing systemic oestrogen, ceasing MHT or using vaginal laser therapy are not recommended first-line approaches.

ANSWER 4: B

ANSWER 5: C

The article by Crump et al states that women with premature menopause (aged <40 years) have a 55% higher risk of cardiovascular disease (CVD), those with early menopause (aged 40–44 years) have a 30% higher risk, and incident CVD rises by ~3% for each year menopause occurs earlier. This increased risk spans coronary artery disease, heart failure and

atrial fibrillation, and it is associated with a 19% increase in CVD mortality.

ANSWER 6: A

The article by Crump et al notes that frequent vasomotor symptoms (VMS; ≥6 days per 2 weeks) increase cardiovascular disease events by 51%, and persistent VMS over many years increase risk by 77%. VMS are associated with autonomic dysfunction, lipid derangement, insulin resistance, hypertension and coronary artery calcification, all contributing to elevated cardiovascular risk.

ANSWER 7: B

ANSWER 8: B

The article by Crump et al states that established coronary or peripheral artery disease is a contraindication to MHT, but this woman has no known coronary or peripheral arterial disease. With an Australian CVD risk calculator (AusCVDRisk) score of 6%, she falls into the intermediate-risk category, where menopausal hormone therapy (MHT) is acceptable, especially transdermal formulations in the presence of cardiovascular risk factors. She is also within 10 years of menopause onset, which aligns with the timing hypothesis supporting safer initiation. Oral MHT is not preferred in this context, and requiring a risk score <5% is not supported by the decision tool.

ANSWER 9: A

T-scores compare bone mineral density (BMD) with the young adult mean and are used to diagnose osteoporosis in postmenopausal women, and men ≥50 years. A T-score ≤–2.5 = osteoporosis.

Z-scores compare BMD with age-matched norms and are used in premenopausal women, in adults aged <50 years and when secondary osteoporosis is suspected. A Z-score ≤–2 at any age should prompt evaluation for secondary causes.

Therefore, this woman has osteoporosis (T-score –2.6), and her Z-score –2.3 appropriately raises concern for secondary contributors.

ANSWER 10: C

Denosumab must be given strictly every 6 months, and the interval should not be delayed by more than 4–6 weeks, as delays can trigger rapid rebound bone loss and increased vertebral fracture risk. It should only be used in patients who can remain fully adherent to ongoing therapy. If denosumab is stopped, a bisphosphonate must be commenced immediately to prevent rebound loss. Increasing calcium intake or intermittently stopping therapy does not prevent the rebound effect.

August 2026 Short answer question answers

ANSWER 1

1. Can she safely use oral menopausal hormone therapy (MHT)?
   - Assess contraindications to oral oestrogen, including:
     - history of migraine with aura
     - cardiovascular disease (CVD)
     - venous thromboembolism (VTE) risk factors, including body mass index >30 kg/m^2.
   - If oral oestrogen is unsuitable, choose a transdermal oestrogen alternative.
   - Consider tibolone only if appropriate: it does not increase VTE risk but slightly increases stroke risk, especially in women aged >60 years, and should be avoided in migraine with aura or CVD.
2. Is the oestrogen dose equivalent?
   - Use the Australian Menopause Society equivalency table to match doses.
   - Typical equivalences:
     - 2 mg oral estradiol ≈ 50 mcg patch ≈ 2 pumps estradiol 0.06% gel ≈ 1 sachet estradiol 0.1% gel
   - Ensure the replacement product provides a comparable oestrogen dose to maintain symptom control and endometrial protection.
3. Does the progestogen need to change?
   - If she uses a separate progestogen, it can usually continue unchanged as long as the oestrogen dose remains equivalent.
   - If switching from a combined product, she will require a new progestogen (eg micronised progesterone, norethisterone, medroxyprogesterone acetate) in an appropriate regimen (continuous vs cyclic).
   - Confirm that the progestogen dose matches the oestrogen strength to ensure adequate endometrial protection.
4. Are there suitable Therapeutic Goods Administration (TGA)-approved alternatives or imported substitutes?
   - Check the TGA shortages database for:
     - expected resupply dates
     - unregistered but TGA-approved imported products.
   - Consider whether the patient is comfortable switching to an imported equivalent if no local product is available.
5. What is the patient's preference and ability to use the alternative formulation?
   - Patch, gel, oral tablet or combination regimen.
   - Consider ease of use, adherence, skin sensitivity (for patches) and lifestyle factors.
6. How soon should follow-up occur?
   - Arrange review to assess symptom control, bleeding patterns and tolerability after switching.
   - Provide safety-netting advice regarding unexpected bleeding or adverse effects.

ANSWER 2

The key vulvovaginal and lower urinary tract examination findings that support a diagnosis of genitourinary syndrome of menopause are:

- vulval changes: loss of labial and vulval fullness; reduction in labia majora and clitoral hood; sparser/coarser pubic hair; pallor or thinning of vulval skin; fissures or petechiae; signs of irritation or dermatitis from irritants
- vaginal changes: narrowing of the introitus; vaginal shortening;

loss of rugae; thin, dry, pale epithelium; reduced elasticity, especially at the posterior fourchette; discomfort on speculum insertion (might require small/paediatric speculum)
- urethral changes: urethral meatal prominence or caruncle; thinning of urethral epithelium; possible mucosal prolapse
- pelvic floor: pelvic floor muscle spasm or tenderness; evidence of pelvic floor weakening or prolapse
- general features: reduced lubrication; contact bleeding; altered sensation; pain on touch or stretch.

ANSWER 3

Possible differential diagnoses to genitourinary symptoms of menopause include:

- dermatological conditions:
  - lichen sclerosus – pale, thickened, sclerotic plaques; fissures; architectural change
  - lichen planus – erosions, erythema, Wickham striae
  - eczema/psoriasis/contact dermatitis – erythema, scaling, excoriation, clear irritant triggers.
- vulvodynia: pain on light touch, normal or near-normal appearance
- vaginismus: pelvic floor hypertonicity, difficulty tolerating examination
- vaginal/vulval malignancy: persistent ulcers, erosions, raised lesions, atypical pigmentation or texture
- chronic pelvic pain syndromes: pain disproportionate to local findings
- trauma or foreign body: localised injury, discharge, bleeding
- autoimmune or inflammatory disease: examples include lupus, Crohn's disease causing vulval fissures, or oedema
- infective causes: candidiasis (thick discharge, erythema), bacterial vaginosis (odour, pH >4.5), sexually transmitted infections
- endocrine/metabolic conditions: diabetes (recurrent infections, irritation)
- urinary tract pathology: recurrent urinary tract infections, urethral lesions, bladder pain syndrome

ANSWER 4

The patient's new central adiposity, dyslipidaemia, impaired glucose tolerance, hypertension and possible sleep apnoea are all consistent with menopause-related physiological changes, not simply ageing. These changes collectively create a more atherogenic and cardiometabolic environment, increasing her long-term cardiovascular disease (CVD) risk.

Ways in which menopause might be contributing to her cardiometabolic profile:

Dyslipidaemia:

- Menopause is associated with a marked rise in total cholesterol, low-density lipoprotein cholesterol (LDL-C) and apolipoprotein B in the year before and after the final menstrual period (FMP).
- High-density lipoprotein cholesterol (HDL-C) becomes less anti-atherogenic, contributing to accelerated atherosclerosis.

Fat redistribution:

- Central adiposity increases significantly across the menopause transition (visceral fat increases 8.2% annually before FMP and increases 5.8% annually post FMP).
- Visceral fat promotes inflammation, insulin resistance and subclinical atherosclerosis.

Sleep apnoea:

- Prevalence increases from 21% to 47% post menopause, contributing to hypertension, metabolic dysfunction and sympathetic activation.
- Her new snoring and fatigue might reflect this transition-related risk.

Metabolic syndrome and insulin resistance:

- Menopause increases metabolic syndrome prevalence by ~254%.
- Impaired glucose tolerance rises by ~6% per year after menopause.
- These changes increase risk of type 2 diabetes mellitus (T2DM) and CVD.

Vascular dysfunction:

- Atherosclerosis progression and arterial stiffness increase (7.5% increase within 1 year of the FMP).
- These changes contribute to rising blood pressure (BP) and endothelial dysfunction.

Cardiac remodelling:

- Increased pericardial fat and early diastolic dysfunction contribute to risk of heart failure with persevered ejection fraction.
- Palpitations might reflect autonomic shifts.

Hypertension:

- BP commonly rises after menopause, and hypertension becomes more prevalent in postmenopausal women than age-matched men.
- Sympathetic predominance contributes to this shift.

ANSWER 5

Menopause-related barriers and physiology:

- Oestrogen deficiency contributes to hyperphagia, sleep disruption, depression and reduced energy expenditure, which can undermine healthy behaviours.
- Central adiposity, dyslipidaemia, impaired glucose tolerance and rising blood pressure are common physiological changes across the menopause transition.

Lifestyle modification (core intervention):

- Emphasise that up to 82% of coronary heart disease (CHD) events in women are preventable through lifestyle change.
- Smoking cessation: strongest inverse association with cardiovascular disease (CVD) risk; offer behavioural support and pharmacotherapy.
- Alcohol reduction: aim for ≤10 standard drinks/week and ≤4 per occasion; provide counselling for risky use and behavioural support/modification as initial interventions.
- Physical activity: work towards a target of ≥2.5 hours moderate or ≥1.25 hours vigorous activity weekly; address fatigue and sleep issues that limit participation.
- Dietary modification: follow Australian Dietary Guidelines; reduce saturated fat, added salt and sugars; increase vegetables, fruit, wholegrains and healthy fats.

- Weight management: using an individualised, sensitive approach that recognises weight stigma, it might be appropriate to recommend gradual weight loss and advise that weight loss can improve vasomotor symptoms. If appropriate, discuss dietary and exercise interventions, allied health referrals and pharmacotherapy.

Screening and risk assessment:

- Perform a Heart Health Check (Medicare Benefits Schedule [MBS] item 699) or Menopause Health Assessment (MBS item 695).
- Use the Australian CVD risk calculator (AusCVDRisk) to estimate 5-year CVD risk and guide therapy.
- Consider female risk-enhancing factors (eg premature menopause, pre-eclampsia, chronic inflammatory disease, strong family history of CVD).
- If risk is borderline or intermediate, consider coronary artery calcium scoring to refine risk stratification.

Management of dyslipidaemia:

- Recommend lifestyle modification as first line.
- Initiate lipid-modifying therapy if indicated by AusCVDRisk thresholds (eg low-density lipoprotein-cholesterol [LDL-C] targets <1.4 mmol/L for very high risk; <1.8 mmol/L for high risk; <2.5 mmol/L for moderate risk; <3 mmol/L for low risk).
- Aim for ≥50% LDL-C reduction in secondary prevention and ≥35% reduction in primary prevention.
- Statins are used as first-line therapy; use additional agents if LDL-C targets are not met.

Management of hypertension:

- Encourage lifestyle modification (weight loss, exercise, reduced alcohol, dietary modification, smoking cessation).
- If blood pressure remains ≥130/85 mmHg and her calculated CVD risk warrants it, initiate stepwise antihypertensive therapy per AusCVDRisk recommendations.

Management of impaired glucose tolerance:

- Lifestyle modification is the first-line treatment.
- Monitor fasting glucose or HbA1c; consider metformin if glycaemic targets are not met after 3 months.

Sleep apnoea assessment:

- Her fatigue, weight gain and snoring warrant screening using a validated tool (eg STOP-Bang for assessing the risk of obstructive sleep apnoea [OSA] and the Epworth sleepiness scale for assessment of sleepiness).
- Refer for a sleep study if indicated; treat OSA to reduce blood pressure, metabolic dysfunction and CVD risk.

Overall approach:

- Provide reassurance that menopause-related physiological changes contribute to her symptoms and cardiometabolic profile, but risk is modifiable.
- Use a structured, supportive, behaviour-change-oriented approach with regular follow-up.

correspondence **ajgp@racgp.org.au**