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/July26CCMO 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 how you approach fitness to drive as outlined by Moshegov et al ('Assessing fitness to drive'). Discuss with colleagues in your practice how they approach assessment of a patient's physical, visual and cognitive abilities against the Austroads standards. Approaching fitness to drive by considering any visual impairment can be a gentle entry point into a wider evaluation of this important and often-complex professional requirement of a GP. 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 July 2026 *AJGP* Clinical challenge and accept full responsibility for all content.

July 2026 Multiple-choice questions

These questions are based on the Focus articles provided. Please choose the single best answer for each multiple-choice question.

CASE 1

A man aged 76 years with a private car licence attends for his annual review. He reports increasing glare at night and has noticed bumping into objects on his left side. Visual acuity is 6/18 right (corrected) and 6/24 left (corrected). You wonder about his fitness to drive.

QUESTION 1

According to national visual standards, what is the minimum visual acuity required for an unconditional private (non-commercial) licence?

- **A.** 6/9 in the better eye
- **B.** 6/12 in one eye or both eyes together
- **C.** 6/18 in the better eye
- **D.** 6/24 in one eye with corrective lenses

QUESTION 2

Which visual field result on binocular Esterman testing would fail the unconditional private licence standard?

- **A.** 110° horizontal field with no scotoma within the central 20°
- **B.** Three adjoining missed points within the central 20° of fixation
- **C.** 140° horizontal field with no defects
- **D.** Horizontal field of 105° with no central defects

CASE 2

A woman aged 68 years with a 40-pack-year smoking history reports gradual central blur and wavy lines when reading. Fundoscopy shows visible drusen deposits.

QUESTION 3

Which modifiable risk factor is most strongly associated with progression of age-related macular degeneration?

- **A.** Hypertension
- **B.** Smoking
- **C.** Diabetes
- **D.** Hypercholesterolaemia

QUESTION 4

A patient with intermediate age-related macular degeneration reports new sudden central distortion (ie in her field of vision). What is the most appropriate next step?

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A. Routine optometry review in 6 months
B. Urgent same-day ophthalmology referral
C. Prescribe evidence-based supplements (vitamins C and E, zinc, copper plus lutein/zeaxanthin replacing β-carotene) and review in 4 weeks
D. Reassure and monitor with Amsler grid only

CASE 3

A man aged 32 years presents 2 hours after a workplace chemical splash to the right eye. He reports severe pain and blurred vision.

QUESTION 5

What is the immediate management?

A. Instil topical anaesthetic and check pH
B. Commence copious irrigation
C. Apply an eye pad and refer to ophthalmology urgently
D. Perform fluorescein staining to assess epithelial defect

CASE 4

A woman aged 58 years with type 2 diabetes reports a 3-day history of severe unilateral eye pain, haloes around lights, and nausea.

QUESTION 6

Which clinical sign is most suggestive of acute angle-closure glaucoma?

A. Mid-dilated fixed pupil with corneal oedema
B. Normal pupil reaction with conjunctival injection
C. Relative afferent pupillary defect with clear cornea
D. Normal visual acuity with posterior synechiae

QUESTION 7

Apart from arranging for same-day ophthalmology review, what is the most appropriate immediate action for the management of acute angle-closure glaucoma?

A. Prescribe oral acetazolamide and topical timolol
B. Instil pilocarpine 2% immediately
C. Prescribe oral analgesia
D. Perform tonometry and document intra-ocular pressure

CASE 5

A man aged 55 years with high myopia describes a sudden onset of flashes and floaters followed by a curtain-like shadow in the temporal field of his right eye.

QUESTION 8

Which symptom combination is most concerning for rhegmatogenous retinal detachment?

A. Flashes, floaters and a field defect
B. Gradual blurred vision without floaters
C. Isolated floaters for 6 months
D. Mild photophobia with normal acuity

CASE 6

A woman aged 42 years with recently diagnosed Graves' disease reports bilateral gritty eyes, lid swelling worse in the morning, and mild proptosis.

QUESTION 9

Which single modifiable risk factor has the greatest impact on both development and progression of thyroid eye disease?

A. Poor glycaemic control
B. Smoking
C. Vitamin D deficiency
D. Hypercholesterolaemia

July 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

A man aged 76 years with a private car licence attends for his annual review. He reports increasing glare at night and has noticed bumping into objects on his left side. Visual acuity is 6/18 right (corrected) and 6/24 left (corrected). You wonder about his fitness to drive.

QUESTION 1

Name two practical screening questions relating to his vision that can be used to assess driving safety.

CASE 2

A woman aged 68 years with a 40-pack-year smoking history reports gradual central blur and wavy lines when reading. Fundoscopy shows visible drusen deposits.

QUESTION 2

Name two evidence-based lifestyle interventions that reduce progression risk in early/intermediate age-related macular degeneration.

CASE 3

A man aged 32 years presents 2 hours after a workplace chemical splash to the right eye. He reports severe pain and blurred vision.

QUESTION 3

After irrigation for a chemical eye injury, what finding is considered a red flag requiring urgent ophthalmology referral?

CASE 4

A woman aged 58 years with type 2 diabetes reports a 3-day history of severe unilateral eye pain, haloes around lights, and nausea.

QUESTION 4

Name two patient risk factors that increase the likelihood of acute angle-closure glaucoma.

CASE 5

A man aged 55 years with high myopia describes a sudden onset of flashes and floaters followed by a curtain-like shadow in the temporal field of his right eye.

QUESTION 5

What is the single most important prognostic factor once a retinal detachment is diagnosed?

QUESTION 6

List two high-risk groups for retinal detachment that warrant a lower threshold for urgent referral.

CASE 6

A woman aged 42 years with recently diagnosed Graves' disease reports bilateral gritty eyes, lid swelling worse in the morning, and mild proptosis.

QUESTION 7

Name two first-line measures a general practitioner can initiate while awaiting ophthalmology review.

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QUESTION 8

List two indications for urgent ophthalmology referral in a patient with known thyroid eye disease.

QUESTION 9

What legal obligation should be discussed with a driver who has active thyroid eye disease and new diplopia?

June 2026 Multiple-choice question answers

ANSWER 1: E

Overdiagnosis can occur in a variety of ways, including through the increased sensitivity of more advanced tests, widening of disease definitions and labelling of risk factors as diseases, and it can also result from participation in population screening.

ANSWER 2: D

ANSWER 3: D

ANSWER 4: D

ANSWER 5: B

ANSWER 6: C

ANSWER 7: A

ANSWER 8: B

ANSWER 9: B

June 2026 Short answer questions answers

ANSWER 1

The five Choosing Wisely questions are:

1. Do I really need this test?
2. What are the risks?
3. Are there simpler, safer options?
4. What happens if I don't do anything?
5. What are the costs?

ANSWER 2

Any three of the following tests that may have potential for overtesting and overdiagnosis:

- Coronary artery calcium scoring in people without indications
- Methylenetetrahydrofolate reductase (*MTHFR*) gene testing in asymptomatic, healthy patients
- Vitamin D testing in patients with no risk factors for vitamin D deficiency
- Anti-Müllerian hormone testing for predicting natural conception or perimenopause
- Gut microbiome testing as a diagnostic tool
- Ultrasonography for uncomplicated shoulder pain
- Routine periodic tests (eg full blood count, liver function tests, thyroid function tests) in asymptomatic patients

ANSWER 3

Any four of the following opportunities for reviewing medicines, which may then lead to deprescribing:

- New patient
- Recent medical event (eg hospital admission, acute illness, change in condition/prognosis)
- Recent transition of care (eg movement from hospital to residential aged care or between healthcare providers)
- Frailty
- High HOSPITAL Risk Score (HRS), which predicts risk of 30-day hospital readmissions
- Change in goals of care
- 75+ health assessments for all patients over the age of 75 years
- 715 health checks for Aboriginal and Torres Strait Islander peoples of all ages
- GP chronic condition management plans for care planning and medication management reviews
- Reported adverse effects or suspected medicine-related harm
- Practice prescribing software safety alerts (eg medication safety alerts for low HbA1c, low estimated glomerular filtration rate)

ANSWER 4

Any two of the following barriers to deprescribing, with an appropriate strategy to overcome each:

POSSIBLE BARRIERS

- **Automated repeat prescribing** through dose administration aids in residential aged care, potentially leading to minimal reviews of ongoing need for medication.
- **Limited appointment time** and **competing priorities**, especially when older patients attend only for specific issues.
- **Fragmented care and increasing complexity of the prescribing landscape**, including expanded prescribing rights for nurses and pharmacists.
- **Transport or access difficulties** reducing opportunities for comprehensive medication review.
- **Profession-specific barriers** related to differing roles, workflows or prescribing responsibilities.

POSSIBLE STRATEGIES TO OVERCOME BARRIERS

- Implementing **structured medication reviews** (eg during chronic disease management plans, 75+ health assessments or after hospital transitions).
- Using **practice-level systems**, such as prompts or recall processes, to ensure regular review of long-term medicines.
- Improving **communication and information sharing** between healthcare providers to reduce fragmentation.
- Encouraging **multidisciplinary collaboration**, including pharmacists, nurses and general practitioners, to support deprescribing.
- Advocating for **system-level reforms** that reduce administrative barriers and support safer prescribing practices.

ANSWER 5

The three-talk model includes:

- team talk – establishing that a decision needs to be made, exploring who should be involved and emphasising partnership between clinician and patient
- option talk – outlining the available options, including benefits, risks and supporting evidence, to help the patient understand their choices
- decision talk – supporting the patient to reach a decision that reflects their preferences and values, informed by the evidence and guided by the clinician.

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ANSWER 6

Any two of the following patient typologies within the Patient Deprescribing Typology, with an appropriate explanation of how each might influence a general practitioner's approach to deprescribing discussions:

- 'Attached to medicines' – patients have positive attitudes toward medicines, have high trust in their doctor and are resistant to deprescribing. General practitioners (GPs) may need to provide reassurance, emphasise safety and revisit the conversation over time.
- 'Would consider deprescribing' – patients hold ambivalent attitudes toward their medicines and prefer a proactive role in decision making. They may be receptive to deprescribing when benefits are unclear or harms emerge, so GPs can use shared decision making and present options clearly.
- 'Deferred decision making to others' – patients give medicines little thought and defer decisions to their doctor or a companion. They may be unaware that deprescribing is possible, so GPs may need to initiate the discussion, involve carers and provide simple explanations.

ANSWER 7

One narrative metaphor you could use to validate the patient's experience is the **'unknown vs imaginary'** narrative. This metaphor directly addresses the patient's fear that their symptoms are 'all in their head' by distinguishing between conditions that are *real but not yet understood* and those that are fictional. Explaining that their illness is 'like the giant squid – real, but not yet fully explained' helps validate their experience and reinforces that medically unexplained symptoms are not equivalent to imagined symptoms.

This narrative is appropriate because it normalises uncertainty without dismissing the patient's experience. It reframes the lack of diagnostic clarity as a limitation of current medical knowledge rather than a personal failing or psychological weakness. Using this metaphor can strengthen trust, reduce self-blame and support ongoing engagement with management strategies despite diagnostic uncertainty.

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