# 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 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.

### Self-directed Measuring Outcomes options

You can also do self-directed Measuring Outcomes (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 as a practice team how you approach your care provision for transgender and gender diverse people. Using Ruhl's article 'The longitudinal primary care of transgender and gender diverse people' as a guide, evaluate your ability to provide holistic support to address a patient's broader health needs beyond gender affirmation. This can include cardiovascular disease risk, mental health, bone health, sexual health and overall wellbeing.

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

Throughout this Focus issue, the acronym LGBTQIA+ (lesbian, gay, bisexual, transgender, queer/questioning, intersex, aromantic/asexual, with the + representing other gender identities/sexualities that are part of the community) is often used, alongside other acronyms such as TGD (transgender and gender diverse). We acknowledge that the LGBTQIA+ acronym does not encompass all culturally specific gender identities and sexualities. We also acknowledge that the LGBTQIA+ community is diverse and heterogeneous, and that this heterogeneity and diversity is not always reflected in the statistics, data and research literature.

## October 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**

Which statement best reflects current evidence regarding meningioma and prolactinoma risk in transgender women taking cyproterone acetate as part of gender-affirming hormone therapy (GAHT)?

**A.** Cyproterone acetate is associated with a higher incidence of meningioma. Therefore, routine, biennial MRI-brain (MRI-B) screening is recommended for all long-term users

**B.** Cyproterone acetate is associated with increased rates of meningioma and prolactinoma, but no specific tumour screening is recommended, with clinicians and patients advised to monitor for symptoms

**C.** Cyproterone acetate is associated with increased rates of hyperprolactinaemia, but the prolactinoma risk is similar to that of cisgender women, so routine MRI-B imaging is not recommended

**D.** Cyproterone acetate is associated with a small increased risk of meningioma, but the prolactinoma risk is not increased, and routine MRI-B imaging is not recommended

**QUESTION 2**

What is the approximate annual incidence rate of anal cancer in men living with HIV who have sex with men compared to the general population?

**A.** 6 times

**B.** 16 times

**C.** 60 times

**D.** Rates are broadly similar

© The Royal Australian College of General Practitioners 2026

**QUESTION 3**

A patient aged 25 years asks you about anal cancer screening. They are a transgender woman who lives with HIV, and they have sexual partners that identify as male. In your region of Australia, you do not have access to high resolution anoscopy. What are the current recommendations for anal cancer screening in this patient?

**A.** Annual assessment of anal cancer symptoms, annual examination of the perianal region and annual digital rectal examination.
**B.** Annual digital rectal examination and annual ano-rectal human papillomavirus (HPV) swab
**C.** Annual digital rectal examination and annual ano-rectal HPV swab only if they have symptoms suggestive of anal cancer
**D.** The patient can be reassured that anal cancer screening does not need to start until they are 45 years old

**QUESTION 4**

Which statement best reflects the effects of gender-affirming hormone therapy (GAHT) on lipid homeostasis?

**A.** Feminising GAHT typically lowers high-density lipoprotein (HDL) cholesterol and increases non-HDL cholesterol
**B.** Feminising GAHT is associated with increased HDL cholesterol and decreased non-HDL cholesterol
**C.** Masculinising GAHT generally lowers non-HDL cholesterol, HDL-cholesterol and triglycerides
**D.** Masculinising GAHT is associated with decreased non-HDL cholesterol and increased HDL cholesterol

**QUESTION 5**

According to the article by Ruhl regarding the provision of longitudinal care to transgender and gender diverse (TGD) people, which statement best reflects current evidence regarding pregnancy risk in transgender men using testosterone?

**A.** Amenorrhoea in transgender men using testosterone indicates anovulation, making pregnancy risk negligible
**B.** Higher doses of testosterone provide effective contraception, with ovulation occurring only in those using lower doses
**C.** Unplanned pregnancy rates are high in transgender men, and approximately one-third of amenorrhoeic testosterone users may still ovulate
**D.** Testosterone is not teratogenic, and contraception is only required if transgender men continue to menstruate after 3 months of use

**QUESTION 6**

In the article by Russell, a recent Australian study is referenced which examined all-cause mortality in transgender and gender diverse (TGD) individuals aged 15 years and older. Which statement best reflects its findings regarding suicide-related mortality?

**A.** Hazard ratios for suicide were similar across all TGD people, with no significant difference from the general population
**B.** Suicide-related mortality was increased in TGD people, with higher hazard ratios in those presumed female at birth compared to those presumed male at birth
**C.** Suicide-related mortality was increased in TGD people, but hazard ratios were higher in those presumed male at birth than those presumed female at birth
**D.** Suicide-related mortality was not increased in TGD people once adjusted for age, with hazard ratios approximating population averages

**QUESTION 7**

Which statement best reflects the evidence regarding polycythaemia in people treated with testosterone-based gender-affirming hormone therapy (GAHT)?

**A.** Intramuscular testosterone is associated with a higher risk of polycythaemia than transdermal formulations
**B.** Polycythaemia risk is negligible in testosterone-based GAHT when haematocrit is monitored annually
**C.** Transdermal testosterone carries a higher risk of polycythaemia than intramuscular preparations of testosterone
**D.** Testosterone-based GAHT is not associated with polycythaemia in otherwise healthy individuals who are non-smokers

## October 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.*

**QUESTION 1**

Drawing on the article by Ruhl about cervical cancer screening in transgender and gender diverse (TGD) people with a cervix, outline three key barriers to cervical screening participation in this population and describe three patient-centred strategies general practitioners can use to improve screening uptake and comfort.

**QUESTION 2**

Drawing on the article by Ruhl on providing longitudinal care to transgender and gender diverse (TGD) people, describe:

1. The overall patterns of physical activity observed among TGD people when compared to the broader population
2. The factors that may contribute to these observations
3. What approach may help clinicians to explore barriers to exercise and physical activity.

**QUESTION 3**

Drawing on the article by McNair and Wynne, describe:

1. The emerging evidence regarding cognitive impairment and Alzheimer's disease risk in older transgender and gender diverse (TGD) people
2. At least two unique challenges that older TGD people living with cognitive decline may face.

**QUESTION 4**

Drawing on the article by Russell, regarding mental healthcare for LGBTQIA+ people, define and describe the minority stress models mentioned


© The Royal Australian College of General Practitioners 2026

in the article and how they may account for the observed disparities in mental health disorders seen in the LGBTQIA+ population.

## September 2026 Clinical challenge answers

**ANSWER 1: B**

When there is insufficient duration of action rather than overall medication failure, the first step is to extend coverage with an afternoon short-acting dose before declaring stimulant failure.

**ANSWER 2: C**

Revenge bedtime procrastination is a recognised pattern in attention deficit hyperactivity disorder (ADHD) related to executive dysfunction, emotional regulation difficulties and impaired self-boundary setting. It creates a vicious cycle of sleep deprivation that exacerbates core ADHD symptoms the next day.

**ANSWER 3**

Two evidence-based non-pharmacological strategies that would be particularly helpful for James include the Pomodoro technique with body doubling for task initiation, and energy budgeting framework with sensory regulation strategies (eg short walk, music or breathing exercises) during low-energy ('red') states to reduce impulsive dopamine-seeking behaviours such as binge eating.

**ANSWER 4: B**

Australian Family Law presumes shared parental responsibility, but either parent can provide consent independently. Treatment can proceed with one parent's consent, but careful documentation and medical defence advice are essential in disputed cases.

**ANSWER 5: B**

From 1 December 2025, Queensland general practitioners can initiate psychostimulants in patients aged 4 years and older without prior paediatrician or psychiatrist approval, provided daily dose limits are observed.

**ANSWER 6**

The civil liability medicolegal standard that applies to general practitioners (GPs) prescribing stimulants for attention deficit hyperactivity disorder (ADHD) is the standard of a reasonable professional peer, with strong emphasis on adherence to Australasian ADHD Professionals Association and The Royal Australian College of General Practitioners guidelines and thorough documentation. Some of the potential medicolegal risks for GPs may include: providing repeat prescriptions without adequate review; failing to adequately assess treatment response, adverse effects or functional outcomes; and failing to reassess the ongoing clinical need for psychostimulants.

**ANSWER 7: D**

Both guanfacine and atomoxetine require a diagnosis prior to the age of 18 years for Pharmaceutical Benefits Scheme–subsidised initiation when treated by a paediatrician or a psychiatrist.

**ANSWER 8**

For a patient with attention deficit hyperactivity disorder, the key physical parameters that should be monitored at every medication review are blood pressure and heart rate. Weight (and height in children) should be reviewed at least every 6 months.

**ANSWER 9: B**

The Pomodoro technique (structured work intervals) and body doubling directly target executive dysfunction and task initiation difficulties in cognitive behavioural therapy for attention deficit hyperactivity disorder.

**ANSWER 10**

Energy budgeting helps patients recognise fluctuations in cognitive and emotional resources (green = high capacity, orange = moderate, red = fatigue/depletion). In a red state, use gentle sensory regulation strategies such as listening to music, a short walk or brief breathing exercises to avoid impulsive behaviours.

**ANSWER 11**

Telehealth prescribing of S8 medications requires verification of identity, genuine therapeutic need and compliance with the laws of both the prescriber's and patient's jurisdictions.

**ANSWER 12: A**

In the Poulton study, only 5 of 207 children (2.4%) required referral to non–general practitioner (GP) specialists, supporting that GPs trained in attention deficit hyperactivity disorder (ADHD) management/diagnosis can safely manage most uncomplicated ADHD cases.

**ANSWER 13**

'Uncomplicated attention deficit hyperactivity disorder (ADHD)' is ADHD without severe psychiatric comorbidity, severe tic disorders or medical contraindications to stimulants (oppositional defiant disorder was not considered complicated).

**ANSWER 14**

Two important limitations of the study by Poulton et al are incomplete teacher rating scale data and absence of a non–general practitioner specialist comparator group.

**ANSWER 15**

In multimodal attention deficit hyperactivity disorder management, the general practitioner provides psychoeducation and lifestyle counselling (sleep, exercise and nutrition), coordinates psychology and school supports, optimises medication with a focus on functional outcomes, and ensures regular monitoring and review.

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

© The Royal Australian College of General Practitioners 2026