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/Aug26CCMO 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 approach towards women's sexual health during menopause. Use the article by Whitburn as a guide and consider how you navigate the stigma and lack of awareness associated with the anatomical and functional changes that can take place due to oestrogen deficiency. Explore with others what an effective trauma informed, and culturally safe approach would look like in your role and scope of practice.

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

August 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

A woman aged 54 years using continuous combined transdermal menopause hormone therapy (MHT) (estradiol + norethisterone acetate) reports persistent fluid retention and breast tenderness. Her vasomotor symptoms are well controlled. According to the article by Spencer, which is the most appropriate next step?

A. Add a lowdose of furosemide to alleviate her symptoms of fluid retention
B. Increase the oestrogen dose in her MHT to achieve an improved hormonal balance
C. Switch to a drospirenone-containing MHT formulation
D. Trial a short break from MHT before re-trialling the same regimen

QUESTION 2

A woman aged 51 years has been using continuous combined transdermal MHT for 5 months. She reports increasingly heavy, unpredictable vaginal bleeding. According to the article by Spencer, what is the most appropriate next step?

A. Arrange a pelvic examination and refer for transvaginal ultrasound to assess the endometrium
B. Increase the progestogen dose to stabilise the endometrium and review her in 3 months
C. Reassure her that irregular bleeding is normal up to 12 months after starting continuous combined MHT
D. Switch to a higher-dose oestrogen patch for better control of her bleeding and review her in 6 weeks

QUESTION 3

A woman aged 57 years has been using transdermal MHT for vasomotor symptoms for 12 months. Her hot flushes have improved, but she continues to experience significant genitourinary symptoms of menopause (GSM), including dyspareunia, vaginal dryness and urinary urgency. According to the article by Whitburn, which is the most appropriate next step?

A. Add vaginal oestrogen therapy either as a cream or tablet
B. Increase the systemic oestrogen dose in her patch

C. Stop systemic MHT and add a vaginal lubricant
D. Trial vaginal laser therapy as a first-line option for persistent GSM

QUESTION 4

A woman aged 62 years with a history of oestrogen-receptor–positive breast cancer (treated 7 years ago) presents with severe GSM symptoms. Non-hormonal vaginal moisturisers have provided minimal relief. She asks whether she can use topical vaginal oestrogen. According to the article by Whitburn, what is the most appropriate advice?

A. Avoid vaginal oestrogens completely because any exogenous hormonal exposure is unsafe for her
B. Consider vaginal oestrogen after discussion with her oncology team because of its minimal systemic absorption
C. Consider prasterone (dehydroepiandrosterone [DHEA]) as first-line therapy because evidence supports its routine use post-breast cancer treatment
D. Trial vaginal laser therapy as a safer and more effective initial option

QUESTION 5

A woman aged 42 years experienced menopause aged 38 years. She asks whether this has any long-term health implications. According to the article by Crump et al, which statement best reflects the cardiovascular risk associated with premature menopause?

A. Her cardiovascular risk is unchanged because early menopause does not affect long-term physical health outcomes
B. Her cardiovascular risk is reduced because earlier menopause lowers lifetime oestrogen exposure
C. Her cardiovascular risk is substantially increased due to the loss of endogenous oestrogen's cardioprotective effects
D. Her cardiovascular risk is only elevated if she develops severe vasomotor symptoms during the menopause transition

QUESTION 6

A woman aged 52 years reports frequent, severe hot flushes occurring most days. She asks whether these flushes have any implications for her long-term cardiovascular health. According to the article by Crump et al, which statement best reflects the relationship between vasomotor symptoms (VMS) and cardiovascular risk?

A. Frequent VMS are associated with a higher risk of CVD events, especially when symptoms are persistent over many years
B. VMS only increase CVD risk when accompanied by significant weight gain during the menopause transition
C. VMS are not linked to CVD risk because they reflect thermoregulatory changes rather than vascular dysfunction
D. VMS reduce CVD risk because they indicate lower lifetime exposure to endogenous oestrogen

QUESTION 7

A healthy, non-smoking woman aged 59 years presents with persistent vasomotor symptoms. She reached menopause aged 51 years (8 years ago). She has no past medical history of note. Her blood pressure is 118/78 mmHg, body mass index 21.6 kg/m^2, total cholesterol 5.3 mmol/L and low-density lipoprotein-cholesterol (LDLC) 2.8 mmol/L. She is considering transdermal menopause hormone therapy (MHT). According to the article, which statement best reflects the cardiovascular implications of initiating MHT at this time?

A. Initiating transdermal MHT now increases all-cause mortality because she is more than 5 years past her final menstrual period
B. Initiating transdermal MHT now is associated with neutral or beneficial cardiovascular outcomes because she is within 10 years of menopause onset
C. Initiating transdermal MHT now substantially increases coronary artery disease risk because she is outside the recommended age range for initiating MHT
D. Initiating transdermal MHT now is contraindicated because stroke risk is universally elevated in women aged 59 years

QUESTION 8

A woman aged 58 years presents with severe vasomotor symptoms. She is 7 years post-menopause and has well-controlled hypertension and hyperlipidaemia. She has no history of coronary or peripheral artery disease, venous thromboembolic disease, diabetes or stroke. She is a non-smoker. Her Australian CVD risk calculator (AusCVDRisk) score is 6%. She wants to discuss whether she can have MHT. According to the article by Crump et al, which statement best reflects appropriate management?

A. Avoid systemic MHT because any cardiovascular risk factors are an absolute contraindication to using MHT
B. Consider transdermal MHT as acceptable, using shared decision-making, because she is at intermediate risk of CVD and it is <10 years since menopause onset
C. Recommend oral MHT because it has been better studied in cardiovascular outcome trials than transdermal formulations
D. Recommend transdermal MHT only if her AusCVDRisk score falls below 5% after further optimisation of her risk factors

QUESTION 9

A postmenopausal woman aged 67 years undergoes bone densitometry (DXA) scanning. Her femoral neck T-score is –2.6 and her Z-score is –2.3. According to the article by Sztal-Mazer and Goeltom, which interpretation is most appropriate?

A. The T-score confirms osteoporosis, and the low Z-score suggests that evaluation for secondary causes should take place
B. The T-score is unreliable in women over 65 years, so the Z-score should be used to diagnose osteoporosis
C. The Z-score alone confirms osteoporosis because it is below –2.0 for her age group

D. The Z-score indicates normal bone density because age-matched comparisons account for expected decline in bone density

QUESTION 10

A woman aged 74 years with established osteoporosis has been receiving denosumab every 6 months for the past 3 years. She is otherwise well and adherent to her therapy. Her next injection is due when she is travelling interstate, and she asks whether she can delay it by 8 weeks. According to the article by Sztal-Mazer and Goeltom, what is the most appropriate advice?

A. Delaying the injection by 3 months is safe because denosumab has a long duration of action

B. Delaying the injection by 8–10 weeks is safe, but she should take calcium supplements to offset any rebound bone loss

C. Delaying the injection beyond 4–6 weeks is not safe because rebound bone loss can occur, leading to vertebral fractures

D. She should undergo bone densitometry testing to establish if she can take a 'drug holiday' from denosumab while she is travelling

August 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

A woman aged 52 years presents urgently because her usual continuous combined menopause hormone therapy (MHT) patch is unavailable because of a supply shortage. She is concerned about symptom recurrence and asks what alternative options she can use. Using the article by Spencer as a guide, outline the key questions and clinical considerations to consider when selecting an appropriate substitute MHT product during supply disruptions.

QUESTION 2

A woman aged 57 years has been using transdermal MHT for vasomotor symptoms for 12 months. Her hot flushes have improved, but she continues to experience significant genitourinary symptoms, including dyspareunia, vaginal dryness and urinary urgency.

Using the article by Whitburn, describe the key vulvovaginal and lower urinary tract examination findings that support a diagnosis of genitourinary syndrome of menopause (GSM). Include changes to the vulva, vagina, urethra and pelvic floor that might be seen on physical examination.

QUESTION 3

List at least three important differential diagnoses to consider when a woman presents with symptoms suggestive of genitourinary symptoms of menopause (GSM). Briefly outline the clinical features or examination findings that might prompt consideration of each using the article by Whitburn as a guide.

QUESTION 4

A woman aged 54 years presents for a midlife health review. She reached menopause 18 months ago. She reports increasing central weight gain despite no major lifestyle changes, new-onset snoring and daytime fatigue, and occasional palpitations. Her blood pressure today is 148/98 mmHg (previously normal). Her lipid profile shows a rise in low-density lipoprotein-cholesterol (LDLC) and total cholesterol compared with 2 years ago. She asks whether these changes are 'just ageing' or whether menopause could be contributing to her cardiovascular risk.

Using your understanding of physiological changes across the menopause transition and the article by Crump et al, explain three ways in which menopause might be contributing to her current cardiometabolic profile and outline the mechanisms by which these changes increase cardiovascular disease (CVD) risk.

QUESTION 5

A woman aged 49 years presents for a health assessment. She reached menopause 2 years ago and reports worsening vasomotor symptoms, poor sleep, low mood and increased appetite. She has gained 6 kg, mostly centrally, and feels too fatigued to exercise regularly. She drinks 2 glasses of wine most nights and smokes 5–10 cigarettes at the weekend. Her blood pressure today is 142/86 mmHg. Her lipid profile shows rising low-density lipoprotein-cholesterol (LDLC) and total cholesterol compared with 3 years ago. Her fasting glucose is in the impaired range. She asks what she can do to 'get her health back on track' and if menopause is to blame.

Using your understanding of cardiovascular prevention in midlife women and the article by Crump et al, outline an evidence-based management plan to reduce her cardiovascular risk. Include lifestyle interventions, screening and risk assessment, and indications for pharmacotherapy.

July 2026 Multiple-choice question answers

ANSWER 1: B

An unconditional private (non-commercial) licence requires at least 6/12 in one eye or both eyes together.

ANSWER 2: B

Any significant scotoma within the central 20° radius from fixation fails the unconditional private standard.

ANSWER 3: B

Smoking is the strongest modifiable risk factor (pooled odds ratio 1.86) for age-related macular degeneration and accelerates progression to bilateral disease.

ANSWER 4: B

Sudden distortion suggests possible neovascular ('wet') age-related macular degeneration and is an ophthalmic emergency, warranting urgent review (within 24 hours).

ANSWER 5: B

Irrigation must begin immediately and continue until pH normalises (7.0–7.4); do not delay for pH testing.

ANSWER 6: A

Mid-dilated fixed pupil plus corneal oedema is characteristic of acute angle-closure glaucoma.

ANSWER 7: A

Topical β-blocker and oral acetazolamide can be given (if no contraindication) while transferring the patient for ophthalmology review. Although tonometry to measure intra-ocular pressure is useful, it is not widely available in general practice, and treatment should not be delayed if acute glaucoma is suspected.

ANSWER 8: A

The '4 Fs' (flashes, floaters, field defect, failing vision) are hallmark symptoms of retinal detachment.

ANSWER 9: B

Smoking is the strongest modifiable risk factor for development and progression of thyroid eye disease.

July 2026 Short answer question answers

ANSWER 1

Practical screening questions relating to vision that can be used to assess driving safety include:

- Do you ever have trouble seeing road signs, especially at night or in rain when it is darker?
- Do you feel your vision is not as sharp as before?
- Do you bump into objects or have falls?
- Do you struggle with glare from oncoming headlights?
- Do you avoid driving at night, in the rain or in unfamiliar areas?
- Have you had any near misses or car accidents?

ANSWER 2

Smoking cessation and adherence to a Mediterranean-style diet have been shown to be protective against progression. Additionally, in at-risk eyes, Age-Related Eye Disease Study 2 (AREDS2) formulations (vitamins C, E, zinc, copper plus lutein/zeaxanthin replacing β-carotene) were shown to reduce the 5-year risk of progressing from intermediate to late age-related macular degeneration by approximately 25%.

ANSWER 3

Any limbal ischaemia (vascular blanching at the border between the cornea and the conjunctiva) is considered a red flag requiring urgent ophthalmology referral. This indicates severity – limbal stem cell loss carries poorer prognosis.

ANSWER 4

Risk factors that increase the likelihood of acute angle-closure glaucoma include:

- female sex
- high myopia
- marked hypermetropia
- increasing age
- family history
- Asian or African ancestry
- diabetes mellitus
- chronic corticosteroid use
- previous ocular trauma.

ANSWER 5

The single most important prognostic factor once a retinal detachment is diagnosed is whether the macula is attached ('macula-on') or detached (macula-off') at the time of surgery (macula-on has far better visual prognosis).

ANSWER 6

High-risk groups for retinal detachment that warrant a lower threshold for urgent referral include patients with:

- high myopia (>–3 diopter)
- previous retinal detachment in the fellow eye
- age >50 years
- family history of retinal detachment
- recent ocular surgery
- diabetic retinopathy
- uveitis.

ANSWER 7

First-line measures a general practitioner can initiate and support while awaiting ophthalmology review include:

- Smoking cessation through behavioural modification and pharmacotherapy
- Restoration of euthyroid status (suggest co-management with endocrinologist)
- Lubricating eye drops for dry eyes, ointment at night
- Wearing dark sunglasses for photophobia relief
- Head elevation when sleeping to reduce oedema
- Patching of one eye for diplopia, if present
- Selenium supplementation (100 mcg twice daily for 6 months) in active cases
- Correct vitamin D deficiency with vitamin D supplement, if any
- Treat hypercholesterolaemia, if present, with a statin.

ANSWER 8

Indications for urgent ophthalmology referral in a patient with known thyroid eye disease include suspected dysthyroid optic neuropathy (reduced vision, colour desaturation, relative afferent pupillary defect), rapidly progressive proptosis/globe subluxation or corneal ulceration due to exposure.

ANSWER 9

Drivers with thyroid eye disease and diplopia should be informed of their responsibility to notify the driver licensing authority, with input from ophthalmologists in assessing visual acuity and formal visual fields. Generally, drivers with diplopia are not fit to drive; however, a conditional licence may be considered if diplopia is managed with corrective lenses or an occluder (after a 3-month non-driving period for adaptation). Medical practitioners in South Australia and Northern Territory have a mandatory reporting obligation. Meanwhile, mandatory reporting obligations in the Australian Capital Territory only apply if the driver holds a heavy vehicle licence.

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