check

RACGP CPD solution

Unit 602
March 2023

Veterans' health

RACGP

www.racgp.org.au/check

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

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The five domains of general practice

- Communication skills and the patient–doctor relationship
- Applied professional knowledge and skills
- Population health and the context of general practice
- Professional and ethical role
- Organisational and legal dimensions

RACGP

ACTIVITY ID **422410**

Veterans' health

This unit of *check* is approved for 10 hours of CPD Activity (two hours per case). The 10 hours, when completed, including the online questions, comprise five hours' Education and five hours' Reviewing Performance.

To complete this unit as a CPD Activity, you should carefully read all cases, complete the questions for each case (hard copy or online), answer the linked multiple-choice questions online and score >80%, and complete the evaluation form online.

All doctors also need to do a minimum five hours' Measuring Outcomes CPD each year, and you can do this by completing one Mini-Audit each year. You can do a Mini-Audit based on this unit, or any other unit of *check*, or on any topic that is relevant to your practice.

To do a Mini-Audit on this unit's topic, select the last five relevant patients you managed. Review their records, summarise your management and findings, and indicate in writing (for yourself) where your management and patient outcomes could have been improved, based on what you have learned following your completion of this *check* unit.

You can access all online resources here: https://mycpd.racgp.org.au

For any technical issues, including guides and templates for a Mini-Audit, contact us on 1800 284 789. To purchase this unit if you are not an RACGP member, please call 1800 284 789.

About this activity

There are more than 600,000 ex-serving members of the Australian Defence Force (ADF).[1] The ABS 2014–15 National Health Survey estimated that 90% of those who have served in the ADF had consulted a general practitioner (GP) in the last 12 months.[2] Australian GPs are therefore ideally placed to help veterans and those transitioning out of the ADF to fully re-engage with the civilian primary healthcare system and Department of Veterans' Affairs (DVA) services, and are more likely to achieve better healthcare outcomes.

In 2017–18, 48% of male veterans considered themselves to be in excellent or very good health compared with 56% of those who had never served in the ADF.[3] Twenty-two per cent of males who had served in the ADF had a mental or behavioural condition compared with 18% of those who had never served.[3]

Specific health and wellbeing issues affecting the veteran and ex-service community following transition from the ADF include:[4–6]

- risk of social isolation
- reduced employment opportunities
- risk of weight gain
- a higher prevalence of mental health conditions, such as depression and post-traumatic stress disorder (PTSD)
- a higher prevalence of alcohol dependence disorder
- comorbidity with other mental illnesses
- a higher prevalence of smoking while serving.

The 2015 Mental Health and Wellbeing Transition Study identified patterns of healthcare among current serving and recently transitioned ADF personnel and estimated that 64% of recently transitioned and 52% of serving ADF members had had mental health concerns during their lifetime.[7] Of these members, around three in four (both transitioned and current serving) received assistance for their mental health.

Of the recently transitioned members who were concerned about their mental health and sought assistance, 38% had consulted a GP in the last 12 months.

This edition of *check* considers the role of GPs in caring for the physical and mental health and wellbeing of veterans to ensure they and their families/carers have the appropriate healthcare support following service in the ADF.

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Learning outcomes

At the end of this activity, participants will be able to:

- help veterans to fully re-engage with the primary healthcare system following service discharge
- carry out a structured veterans' physical and mental health check
- use appropriate screening tools to evaluate depression, anxiety and

stress

- support veterans and their families/carers to obtain resources and healthcare provisions, including onward referral.

Author

Cases 1–5

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Abbreviations

ACAT	aged care assessment team
ACL	anterior cruciate ligament
ADF	Australian Defence Force
AOD	alcohol and other drugs
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
AUDIT	Alcohol Use Disorders Identification Test
CBT	cognitive behavioural therapy
CBT-I/CBTI	CBT for insomnia
CNS	central nervous system
CPT	cognitive processing therapy
CT	computed tomography
CVC	Coordinated Veterans' Care
DASS-21	Depression Anxiety Stress Scale – 21 items
DMMR	domiciliary medication management review
DSM-5	*Diagnostic and statistical manual of mental disorders*, 5th edition
DVA	Department of Veterans' Affairs
ECOG	Eastern Cooperative Oncology Group
EMDR	eye movement desensitisation and reprocessing
eTG	electronic therapeutic guidelines
FBE	full blood examination
FOBT	faecal occult blood test
GP	general practitioner
GPCOG	General Practitioner assessment of Cognition
HbA1c	glycated haemoglobin
HIV	human immunodeficiency virus
IBS	irritable bowel syndrome
MBS	Medicare Benefits Schedule
MDD	major depressive disorder
MDMA	3,4-methylenedioxy methamphetamine
MMSE	Mini-Mental State Examination
MSE	Mental State Examination
MTSS	medial tibial stress syndrome
NLHC	non-liability health care
NSAIDs	non-steroidal anti-inflammatory drugs
PAMT	provisional access to medical treatment
PCL-5	PTSD checklist for DSM-5
PE	prolonged exposure
PTSD	post-traumatic stress disorder
RAP	Rehabilitation Appliances Program
REM	rapid eye movement
RPBS	Repatriation Pharmaceutical Benefits Scheme
SNRI	serotonin and norepinephrine reuptake inhibitor
SRDP	Special Rate Disability Pension
SSRIs	selective serotonin reuptake inhibitors
TF-CT	trauma-focused cognitive therapy
UACR	urinary albumin creatinine ratio
VAPAC	Veterans' Affairs Pharmaceutical Advisory Centre
VHC	Veterans' Home Care
VSMR	Veteran's Six Monthly Review
VVCS	Veterans and Veterans' Family Counselling
WHO	World Health Organization

CASE

1 Dakota is worried about his drinking

Dakota, aged 22 years, presents to your clinic requesting a referral for residential rehabilitation to address his drinking. You have seen him once before as a teenager at the local emergency department for stitches after he stood on broken glass.

Dakota was medically discharged from the army because of 'shin splints' (medial tibial stress syndrome [MTSS]) and he has had this accepted by the Department of Veterans' Affairs (DVA) as related to his service.

Since medically discharging from the army, Dakota has started using alcohol and cannabis to help get to sleep.

Question 1

What further history would you seek from Dakota?

Further information

Dakota drinks 6–12 full-size (375 mL) cans of full-strength beer (9–18 standard drinks) every night. If he cannot find beer, he drinks boxed wine or raids his father's drink cabinet. He occasionally lacks recall of what happens in the late parts of the evenings when he drinks. He does not drink in the mornings and has never had a seizure. He does admit to getting shaky when he does not drink for a few days.

Dakota's dress and hygiene are fair; he usually has bare feet, despite the cold. Dakota looks his stated age and is calm and cooperative. He makes good eye contact. There is no psychomotor agitation or retardation. His speech is normal, with no pressure of speech. He has no thought disorder, and his thoughts are goal directed. Dakota's affect is euthymic and appropriate. He has no emotional blunting. Dakota notes he does not experience any hallucinations and no delusions. His insight, judgement and impulse control are fair. Dakota is cognitively intact.

Dakota occasionally smokes cannabis using a water bong, amounting to approximately $120 a week. He notes that he has not used prescribed or over-the-counter medications other than as prescribed. He smokes two packs of cigarettes a week.

Dakota was medically discharged after failing to complete all his army training. He developed MTSS. Despite rest, every time he returned to marching, he was reinjured. He was subsequently medically discharged from the Australian Defence Force (ADF), serving less than one year.

Since returning home 13 months ago, Dakota has been doing odd labouring jobs for cash and surfing a lot. He lives with his father, who often travels interstate for work. Dakota's father has expressed concern regarding 'his partying'. Dakota is single although he has had girlfriends in the past.

Question 2

What else would you include in your initial assessment of Dakota?

Further information

Dakota experienced no traumatic events (no *Diagnostic and statistical manual of mental disorders,* 5th edition [DSM-5] post-traumatic stress disorder [PTSD] Criterion A stressors) during his time in ADF service.[8] His results for the post-traumatic stress disorder (PTSD) checklist for DSM-5 (PCL-5) are below the cutoff for treatment or onwards referral/specialist review.

Dakota reports that he has never injected drugs. His human immunodeficiency virus (HIV) and hepatitis C serology results are negative.

Dakota notes he does not have any health, social or legal problems. He sometimes struggles to afford food and pay his mobile phone bill. Dakota finished his schooling at Year 12 and was not strong academically.

Dakota's Depression Anxiety Stress – 21 items (DASS-21) score is 20 in total (D = 0, A = 7, S = 13).

Dakota has a DVA White Card with a single accepted condition of 'MTSS' and he is not sure if he is covered for non-liability health care (NLHC) for mental health.

Question 3

What would be your initial treatment approach for Dakota?

Further information

You give Dakota verbal and printed information on reducing his alcohol, tobacco and cannabis use. You arrange follow up in 2–4 weeks.

You prescribe Dakota thiamine and discuss his willingness to change. Dakota has 'had enough' of his drinking and is keen to be admitted to a facility soon while his father is away.

Dakota has already contacted Open Arms (formerly Veterans and Veterans' Family Counselling [VVCS]), which provides phone counselling services. Open Arms has suggested that he seek alcohol and drug (AOD) treatment and see his general practitioner (GP).

Question 4

What additional DVA support is Dakota entitled to that enable his clinical treatment?

CASE 1 Answers

Answer 1

It is important to ask about the quantity of alcohol Dakota is drinking, including how often he drinks.

Other important points to consider and assess are:

- Is the patient alert, oriented and appropriate?
- What is the standard of his dress and hygiene?
- Does the patient look their stated age?
- Are they calm and cooperative?
- Do they make good eye contact?
- Are there signs of psychomotor agitation or retardation?
- Is their speech normal or pressured?
- Does the patient show thought disorder, or are thoughts goal directed?
- Is affect appropriate or is there evidence of emotional blunting?
- Does the patient report hallucinations or delusions?
- Is the patient's level of insight, judgement and impulse control fair?
- Is the patient cognitively intact?

The mode of ADF transition (voluntary or involuntary) can predict outcomes.[1] Given his involuntary (medical) discharge, Dakota is at statistically higher risk for substance abuse,[1,2] chronic pain, unemployment and suicide. It is also worth asking about which service the patient served in, the length and role of service, postings, deployments and rank. Those enlisted are more at risk of unemployment than officers and those involuntarily transitioned before four years of service and aged <30 years are at highest risk of suicide.[3] His accepted condition of MTSS would not cover him for AOD treatment; instead, treatment eligibility is conferred under NLHC for mental health.

While Dakota is a veteran, it is also important to ask directly about trauma outside the military setting.

Answer 2

Mental State Examination

The Mental Health Examination (MSE) is a structured way of observing and describing a patient's current state of mind, under the domains of appearance, attitude, behaviour, mood, affect, speech, thought process, thought content, perception, cognition, insight and judgement.[4]

DASS-21

The DASS-21 is a self-reporting scale for measuring the emotional states of depression, anxiety and stress:[5]

- Depression (D): Comprises subscales to assess dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/involvement, lack of joy and inertia.
- Anxiety (A): Assesses symptoms of arousal, muscular tension, situational anxiety and subjective experience of anxiety.
- Stress (S): Comprises subscales to assess the levels of non-chronic arousal through difficulty relaxing, nervous arousal, and being easily agitated, irritable and exhibiting a lack of patience.

The World Health Organization's Alcohol, Smoking and Substance Involvement Screening Test

The World Health Organization's (WHO's) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) demonstrates moderate tobacco risk, high alcohol risk and moderate cannabis use.[6]

The ASSIST is a questionnaire that screens for all levels of problematic or risky substance use. The ASSIST consists of eight questions covering drugs: tobacco, alcohol, cannabis, cocaine, stimulants (including 3,4-methylenedioxy methamphetamine [MDMA]), inhalants, sedatives, hallucinogens, opioids and other drugs.

A risk score is provided for each substance class. Scores are clustered into low, moderate, high or very high risk. The risk score links to the level of intervention recommended (brief intervention or brief intervention plus referral for specialist treatment). The WHO ASSIST has been validated in an Australian population.[7]

It is recommended to ask the patient explicitly about readiness to change and screen for AOD-related harms.

Answer 3

Provide feedback and brief advice on reducing drinking to lower risk levels based on the national drinking guidelines. Providing Dakota with printed materials that can be read later might also be helpful.

Thiamine is required to reduce the risk of alcohol-related dementia. Dakota is at increased risk of withdrawal seizures due to his drinking frequency and consumption levels.

Confirm that Dakota has NLHC for mental healthcare accepted on his White Card either by asking him to log onto MyService and confirming his card details, or calling the DVA Providers Line (1800 550 457). If Dakota transitioned since July 2019, this will be automatically added when the White Card is issued on transition.

An admission to a facility or referral to an outpatient service would be clinically appropriate. Given his heavy alcohol intake,[9] current social situation and his request, an AOD admission might be a viable alternative versus referring to community-based services. A short AOD admission would also facilitate a range of supports to be put in place prior to discharge.

Answer 4

Mental health treatment

The DVA provides veterans with NLHC for mental health conditions, including substance use disorder. Mental health treatment must be provided by a mental health professional for a mental health condition that can be diagnosed in the DSM-5.

AOD treatment

The DVA has contractual arrangements with private hospitals. A veteran can receive AOD treatment at any community-based service, but the provider will need to seek prior financial approval.

Veterans' Health Check

GPs can claim for providing a comprehensive physical and mental health check for all veterans aimed at supporting early intervention and better outcomes for transitioning service personnel (www.dva.gov.au/health-and-treatment/veterans-health-check).

Veterans who transitioned before 30 June 2019 are entitled to a one-off Veterans' Health Check, which should be billed using Medicare Benefits Schedule (MBS) item numbers 701–707, depending on how long the assessment lasts, and MBS item code 10991, plus the bulk-billing incentive relevant to your MMM area. Veterans who transitioned after 1 July 2019 are entitled to an annual Veterans' Health Check for five years and should be billed using DVA item numbers MT701–MT707, depending on how long the assessment lasts, and MBS item code 10991, plus the bulk-billing incentive relevant to your MMM area. The DVA encourages an extensive health assessment.

Travel for treatment

The DVA funds clinically necessary travel for approved treatment in Australia. Veteran Gold Card holders have access to treatment for all conditions, while White Card holders have access to treatment for an accepted service-related condition or for the treatment of a specific condition covered under NLHC.

Open Arms

Open Arms counselling offers all current and former service personnel and their families free, confidential face-to-face and/or telehealth counselling, group programs and peer support.[10] GPs can refer by calling 1800 011 046 or veterans can self refer on the same number. Open Arms is available 24 hours a day, seven days a week.

Conclusion

You ask Dakota to call the DVA on 1800 VETERAN (1800 838 372) to apply for NLHC for mental health.

Under NLHC for mental health, Dakota is eligible for inpatient treatment at a panel of approved DVA community-based services and hospitals through prior approval.[11]

DVA prior approval is required for AOD providers.[12] Local access might still be difficult in regional and rural areas.

You arrange admission to a DVA contracted private hospital. Given that the local AOD facility is a distance away, the DVA will fund transport to and from the facility, as well as travel for subsequent outpatient follow up.

Dakota engages a DVA advocate at his local ex-serviceman's club. As Dakota sustained several minor orthopaedic injuries that were not addressed in his initial claim submission, they assist him to prepare and submit other DVA claims.

Dakota is admitted to a DVA-contracted inpatient AOD facility for alcohol withdrawal treatment. He does well during his stay, but relapse would not be surprising.[9]

The veteran's liaison coordinator at the hospital helps him access supporting DVA services.

Several of Dakota's other musculoskeletal injuries are covered under DVA's provisional access to medical treatment (PAMT) provisions (www.dva.gov.au/financial-support/compensation-claims/get-treatment-while-you-wait-claim-pamt). This allows him to access treatment being assessed.

The DVA accepts liability for these other conditions, enabling Dakota to access income support,[13] rehabilitation, and medical and allied health treatment in the future. Two years later, Dakota books an appointment, and you are delighted by the patient that enters the consultation room; he has found full-time employment as an electrician's apprentice.

Resources

- The Royal Australian College of General Practitioners. AOD resource listing. www.racgp.org.au/alcohol-and-other-drugs/aod-resource-listing DVA veterans' health check providers

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CASE

2 Ellie wants to stay at home

Ellie, aged 92 years, is a long-term patient of your practice. She typically saw your colleague, but you have taken over her general practice care since your colleague retired. Ellie is a sprightly and active war widow. Her husband, Bert, a Korean war veteran, died many years ago, and since then, Ellie has held a Department of Veterans' Affairs (DVA) Gold Card.

Ellie typically arrives early, takes notes in her personal diary and is dressed immaculately. You have noticed a pattern of subtle decline in recent years. She has slowly been losing weight and has several persistent lower limb ulcers, despite the efforts of your practice nurse to manage this condition. More recently, Ellie requires a reminder phone call one hour prior to her appointment, but even with a reminder she sometimes forgets to attend or arrives late.

Question 1

What further history would you seek from and about Ellie?

Further information

Ellie is oriented to person, place and time. She reports no focal or systemic symptoms. Of note, she does not report urinary frequency, dysuria, dysphagia, bowel habit change, chest pain, cough or fever.

Ellie has type 2 diabetes, mild hypertension, a chronic right pre-tibial ulcer, dyslipidaemia, osteoporosis, rhinosinusitis and recurrent skin tears. Her glycated haemoglobin (HbA1c) when last checked nine months ago was 54 mmol/mol. Her diabetes has always been well controlled.

Ellie's medications include metformin, gliclazide, ramipril, paracetamol, vitamin D and alendronate.

Ellie is from a family with a history of longevity. She has never smoked and has always been teetotal. There is a remote family history of dementia.

Question 2

What else would you include in your initial assessment of Ellie?

Further information

You undertake the Mini-Mental State Examination (MMSE) and her result is 25/30. You arrange further testing, including a full blood examination; electrolytes, urea and creatinine; liver function tests, thyroid function tests, C-reactive protein, human immunodeficiency virus (HIV), HbA1c, calcium, phosphate, magnesium and a plain computed tomography (CT) scan of the brain.

Other test results include:

- venereal disease laboratory test – no abnormality detected
- urine dipstick – no abnormality detected
- midstream specimen of urine – epithelial cells detected, nil else
- body mass index – 18.1 kg/m^2 (height 165 cm, weight 51 kg)
- blood pressure – 127/65 mmHg
- heart rate – 78 beats per minute, regular
- a wound swab of lower limb ulcers shows copious growth of *Staphylococcus aureus*, with resistance to amoxicillin.

Ellie's daughter, Sarah, lives in a city several hundred kilometres away. You have met Sarah at least once before and are aware that she manages some of Ellie's household matters.

Ellie has no active enduring power of attorney or advance care directive.

Question 3

What would be your initial treatment approach for Ellie?

Further information

You write a referral for Ellie to a wound clinic for a review of her lower limb ulcers.

A geriatrics review is scheduled, but Ellie's review is currently categorised as low urgency.

Ellie's HbA1c result of 54 mmol/mol shows good current diabetes control.

Ellie's spot urinary albumin creatinine ratio (UACR) is unremarkable.

CT of the brain shows generalised cerebral atrophy in keeping with Ellie's age. There is nil midline shift, and no masses, infarcts, collections or haemorrhages are seen. An incidental finding of nasal polyps on the left side is made.

You refer Ellie for a home occupational therapy assessment (DVA form D0904).

You also arrange a domiciliary medication management review (DMMR)/home medications review (Item 900). After six months, you can assess and review Veteran's Six Monthly Review (VSMR) via case conference and bill Item CP42. You pre-emptively arrange for Ellie to get a Webster pack. You arrange an aged care assessment team (ACAT) referral for Ellie.

You notice Ellie has not completed her diabetic cycle of care. You refer her (DVA form D0904) for an overdue ophthalmologic and podiatric review.

You arrange for an outpatient hearing review and an eye check. The reports received indicate that Ellie would benefit from updated hearing aids and a new script for her eyeglasses. There is no evidence of diabetic eye disease following her examination.

You refer Ellie to a dietitian (DVA form D0904), who recommends some high-calorie, low-preparation snacks, and provides general education regarding appropriate caloric intake. The dietitian recommends some community meal support.

Question 4

What additional help and services does the DVA offer to support war widows such as Ellie?

Further information

Ellie already has a DVA Gold Card and receives a pension from the DVA. She is therefore eligible for a number of services to support her to live independently for as long as possible.

You refer Ellie to DVA community nursing (1800 838 372) for daily wound dressings.

Question 5

What support is available if Ellie's future care needs increase?

CASE 2 Answers

Answer 1

With Ellie's history of progressive cognitive decline, it is recommended that questions should initially be aimed at determining whether there is any delirium (and, if so, whether this is of short duration), dementia, depression or degrees of all. Depression, delirium and dementia often coexist.[1]

Answer 2

Diagnosing depression involves ruling out treatable causes via screening,[2] and requires a physical examination, pathology, medical history and medication review, as well as a clinical or mental health interview.

Delirium has an acute onset, which normally manifests as a sudden change of cognitive behaviour. Most common deliriums are caused by urinary tract infections and wound infections; it is important not to overlook mouth ulcers, which might often be missed.

Ellie has lost weight and her dentures might now be loose, which can cause mouth ulcers and potentially additional weight loss through lower oral intake.

Due to Ellie's persistent lower limb ulcers, it would be advised to take a wound swab to rule out an infection.

Assessment tools

Conduct additional cognitive assessments, as they might indicate that Ellie has mild dementia.

Ten warning signs (www.dementia.org.au/information/diagnosing-dementia) is an easy checklist that clinicians, clients and carers can use to assess common symptoms of dementia.[3]

The General Practitioner assessment of Cognition is a screening tool for cognitive impairment.[4] It has been designed for use by GPs.

Answer 3

When a person has been diagnosed with dementia, adequate support is required for the person, their carers and family. Counselling and education are important. Management priorities will vary from patient to patient, but there might be a need to consider medical management of dementia, behaviour and comorbidity, legal and financial planning, current work situation, driving and advance care planning.

Medications

If Ellie has been referred to a geriatrician, it would be recommended to increase the urgency of Ellie's appointment. Cholinergic and memantine medications are indicated for dementia and are particularly effective at slowing the progression of the effects of the condition if commenced earlier in the disease process. These medications are now available in Australia. A non-GP specialist, such as neurologist, psychogeriatrician, geriatrician or psychiatrist, will usually be involved in the prescription of these medications. Once the initial script is authorised, the GP can write the ongoing scripts.

It would be recommended to schedule regular (monthly) GP appointments and involve Sarah via teleconference. Ensure the practice nurse continues to call Ellie and her daughter to remind them of the appointments.

A local dementia support group, such as those provided by Dementia Australia (www.dementia.org.au/support/programs), can also provide support and educational resources that Ellie and Sarah can access.

Answer 4

A range of services aimed at supporting Ellie to live at home for as long as possible are available.[5] The DVA's community nursing program funds clinically required nursing/personal care in a client's home. Its aim is to improve health outcomes and quality of life, and avoid early admission to hospital or residential care by meeting a client's assessed nursing needs.

GPs, non-GP specialists and nurse practitioners specialising in a community nursing field can refer patients to community nursing.[6]

The Coordinated Veterans' Care program (CVC) allows a GP and care coordinator (typically a practice nurse) to work with community-based patients to manage the patient's chronic condition(s) and reduce unplanned hospitalisation. Practices receive payments for CVC enrolments and ongoing care. The DVA provides a CVC toolkit to access eligibility and assist with the billing via the Ready Reckoner for all Gold and White Card holders who have an accepted mental health condition.

Veterans' Home Care (VHC) funds small amounts of practical help so eligible clients can continue to live at home. Services include social and domestic assistance, personal care, home and garden maintenance, and respite care. These services require a small contribution co-payment by the veteran or the card holder.

Social assistance might be supportive in keeping Ellie connected with her community and social activities. Social isolation is a known risk factor for dementia.[7]

The DVA funds travel for approved treatment in Australia. Gold Card holders have access for the treatment of all conditions, while White Card holders have access for treatment of an accepted service-related condition or for treatment of a specific condition covered under non-liability health care (NLHC).

The DVA's booked car with driver service uses a local contracted taxi provider.[8] Given Ellie's advanced age, this might be the most appropriate service for her.

There is a wide range of dressings available on prescription through DVA programs (eg Rehabilitation Appliances Program [RAP]) (www.dva.gov.au/providers/rehabilitation-appliances-program-rap/rap-schedule). While you cannot bulk order these for the practice, you can reasonably replace those already used. Dressings can also be accessed through Repatriation Pharmaceutical Benefits Scheme (RPBS) with some on the schedule and others available through discussion with Veterans' Affairs Pharmaceutical Advisory Centre (VAPAC) for special requests or increased quantities. Dressing packs, dressings and other consumables required for veteran care of excisions/wounds can also be obtained via prescription through the RPBS.

Answer 5

For Ellie's future care, the 'exceptional case status' can be accessed by the community nursing provider via the DVA. This can be implemented when Ellie needs increased personal or clinical care that is above the Medicare Benefits Schedule of fees.[9]

You can also enrol Ellie in your practice's CVC program, which funds care coordination. The practice nurse can assist with CVC planning (item numbers UP01, UP02, UP03 and UP04). This allows a reviewed care plan every 90 days.

To determine her care needs, you can refer Ellie for an ACAT assessment,[10] an occupational therapy assessment (DVA form D0904) and a home medicines (aka Domiciliary Medication Management Review [DMMR]) review.[11]

The community occupational therapist might recommend a range of home modifications aimed at keeping Ellie safe in her home. These might include modifications to the bathroom (eg addition of handrails) and the kitchen (eg installation of an electric hot plate and disconnection of the mains gas).

A podiatric review is also advised. Special footwear and regular nail trims might be recommended to avoid placing pressure on Ellie's feet.[12]

Conclusion

Ellie remains at home in the short term while extra services are put in place. Her daughter Sarah is appointed an enduring power of attorney, and an advance care directive has been completed (this will ensure that any medical interventions are in place; for example, not for resuscitation and what types of active treatment should be instigated). A copy is uploaded to My Aged Care and provided to Sarah, who joins Ellie's future consultations by teleconference. Ellie moves into a spare room at her daughter's house interstate, and her care is changed to local providers.

Resources

- DVA
  - Aids, equipment and modifications through the Rehabilitation Appliances Program (RAP). www.dva.gov.au/health-and-treatment/care-home-or-aged-care/services-support-you-home/aids-equipment-and
  - Welcome to the CVC toolbox. https://cvctoolbox.dva.gov.au/
  - Coordinated Veterans' Care (CVC) Program. www.dva.gov.au/providers/health-programs-and-services-our-clients/coordinated-veterans-care/coordinated-veterans-0
  - CVC claiming process. cvctoolbox.dva.gov.au/Claim-Calculator
- Open Arms
  - Family. www.openarms.gov.au/who-we-help/family
  - Partners. www.openarms.gov.au/who-we-help/partners
- Dementia Australia
  - Clinical practice guidelines. www.dementia.org.au/resources/clinical-practice-guidelines

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CASE

3 Trinh has knee pain

Trinh, aged 48 years, presents with right knee pain, with worse pain at night and in cold weather. His knee pain is dull and aching. He has had sharp pain in his right knee when going down stairs, along with occasional spontaneous swelling of the knee.

Trinh served as a combat engineer in the army and discharged voluntarily 10 years ago. He was deployed several times to Afghanistan. He currently works in information technology and has two teenage sons.

Question 1

What further history would you seek from Trinh?

Further information

Trinh notes no other symptoms, specifically small joint arthritis, urogenital, eye or skin symptoms. He has previously injured his right knee when playing rugby.

Trinh ruptured his anterior cruciate ligament (ACL) and 'bruised the cartilage' in the early 2000s when a rugby scrum gave way under him while he was representing the army. He says he 'heard a snap, couldn't walk and his knee blew up like a blue and black balloon'. Trinh got a 'green whistle' for pain relief. Trinh underwent a 'knee reconstruction' at the time and it 'seemed to go pretty well for a bunch of years' following that. He was able to return to a fully deployable status.

Trinh says he has sharp focal pain in the front of his right knee when going up or down stairs. He says he gets spontaneous knee swelling following intense physical activity. He does not report his right knee locking or giving way. He says he avoids walking long distances, carrying a backpack or carrying his kids on his shoulders, as this can make him 'sore for a few days'. He used to enjoy multi-day hikes; this has stopped. He is frustrated as he can no longer exercise, and his weight has crept up.

Trinh occasionally takes paracetamol when 'it gets really bad', but he 'hates tablets'. Trinh admits he is sometimes short tempered with the kids when they are noisy and his knee is sore. He does not report self-medicating with alcohol. He has also tried glucosamine tablets that his friend suggested, but they have made no difference to the pain.

Trinh has tried taping and a neoprene knee brace, which did not do much. He finds keeping his right knee warm during exercise helps; after 20 minutes or so his pain fades. His pain is worse in the mornings, especially in cold and rainy weather. He struggles to get in and out of low cars and chairs.

Trinh has not seen a physiotherapist.

Trinh has a Department of Veterans' Affairs (DVA) White Card, with an accepted condition of 'right knee ACL rupture'.

Trinh does not report any mental health symptoms as a result of his service. He does not drink alcohol.

Question 2

What would you include in your initial assessment of Trinh?

Further information

You note Trinh gets up from the chair in a laboured manner, sparing his right knee. He does not walk with an obvious limp. Trinh has no visible wasting, fasciculations or muscle spasms. He has a moderate warm effusion and joint line tenderness on the medial side of his knee. You can feel and hear gross crepitus in that joint. A patella grind test is positive. There is no ligamentous laxity. Power is 5/5 bilaterally. He has full range of motion in both knees and hips but is somewhat stiff. He grimaces silently when lowering himself into a chair and uses the arms on the chair to stand up.

Trinh has a stocky build (height 176 cm, weight 95 kg, body mass index [BMI] 30.7 kg/m^2). His neck circumference is 41 cm.

You send Trinh for bilateral weight-bearing knee X-rays, which clearly demonstrate moderate osteoarthritis in his right knee's medial compartment, as well as the signs of prior ACL repair.

Question 3

What would be your initial treatment approach for Trinh?

Further information

You commence Trinh on regular paracetamol and meloxicam. Trinh has been taking fish oil and glucosamine for some months. You recommend taking up bicycling and low-impact weights to improve his physical fitness, reduce his weight and improve his knee symptoms.

Trinh thinks that his knee osteoarthritis is a result of his army sports injury. You agree and recommend that he lodges a DVA claim for knee osteoarthritis subsequent to his traumatic injury. He should submit the X-ray report to support his claim.

Question 4

What additional DVA supports is Trinh entitled to that enable his clinical treatment?

CASE 3 Answers

Answer 1

It would be useful to explore if Trinh has other symptoms, such as small joint arthritis, urogenital, and eye and skin symptoms. Previous injuries to the same knee might also be relevant.

A locking or giving way of the knee signals a mechanical problem and is an indication for imaging and onwards referral.

Symptoms in the same single, large weight-bearing joint, with a prior history of sports injury, decreases the likelihood of autoimmune arthritis.

Answer 2

Given Trinh's prior injury and single joint involvement, a plain X-ray is sufficient to establish a diagnosis of osteoarthritis. Weight-bearing knee X-rays are better at showing joint space narrowing and lower limb alignment than non-weight-bearing films.[1] X-rays do not correlate with the severity of arthritis symptoms or show chondromalacia. X-rays have decreasing utility with advancing patient age.[2]

It is advised to screen for an autoimmune arthritis or rheumatologic causes if the diagnosis is in doubt.

Answer 3

Physiotherapy treatments aim to dissipate knee joint load, alter lower limb alignment, improve range of motion and restore normal neuromuscular function.

Multimodal analgesia (paracetamol +/– non-steroidal anti-inflammatory drugs +/– an antidepressant) is preferred over opiate analgesics.[2]

Australian guidelines strongly recommend against surgery (such as arthroscopic debridement, meniscectomy and cartilage repair) for patients with knee osteoarthritis, unless the person also has signs and symptoms of a 'locked knee' (www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/knee-and-hip-osteoarthritis).

Answer 4

Eligible veterans awaiting the outcome of a DVA claim can receive medical and allied health care on a provisional basis (provisional access to medical treatment [PAMT]) for any of the 20 most commonly accepted diagnoses (www.dva.gov.au/financial-support/compensation-claims/get-treatment-while-you-wait-claim-pamt). Most of these diagnoses are for orthopaedic conditions, and include:

- Achilles tendinopathy and bursitis
- chondromalacia patella
- cut, stab, abrasion and laceration
- dislocation

- fracture
- internal derangement of the knee
- intervertebral disc prolapse
- joint instability
- labral tear
- lumbar spondylosis
- non-melanotic malignant neoplasm of the skin
- osteoarthritis
- plantar fasciitis
- rotator cuff syndrome
- sensorineural hearing loss
- shin splints
- solar keratosis
- sprain and strain
- thoracic spondylosis
- tinnitus.

Conclusion

Trinh uses the MyService portal to lodge a DVA claim for right knee osteoarthritis. He later brings in PAMT DVA paperwork to be signed.

You confirm a diagnosis of right knee osteoarthritis, and tick the osteoarthritis box on the PAMT paperwork (right knee).[3] You print his previous knee imaging. Trinh submits this paperwork, which confers temporary healthcare funding for this condition while his DVA claim is being assessed.

You refer Trinh for physiotherapy (DVA form D0904) for both knee/quadriceps strengthening and weight loss, listing knee osteoarthritis as his treated condition. Noting his raised BMI and neck circumference, you refer Trinh to a dietitian for nutritional education and lifestyle modification. You explain that this dietitian referral will be private, as his obesity is not linked to his military service. Trinh is keen to drop some weight off his 'dad bod' and get a 'new rig for summer'.

Eventually, Trinh's knee is so painful it begins to wake him while sleeping. He begins to struggle with the pain, and a trial of duloxetine and opiate analgesia is unhelpful. Frustrated, he buys a walking stick from the pharmacy. He stops enjoying walking with his dog, as the dog's pulling on the lead makes his knee sore.

You refer Trinh to an orthopaedic surgeon, who schedules him for an elective knee replacement. Trinh is eligible for the surgery under his PAMT condition of osteoarthritis of the right knee.

Trinh will not be able to work following his surgery and initial intensive rehabilitation phase. He brings in incapacity paperwork (DVA form D1360), which will provide income support payments while he is unable to work. The DVA will also cover the costs of his surgery and prosthesis.

Trinh does well with surgery and his postoperative rehabilitation; his physiotherapist remarks that he is a motivated patient. He is able to return to bushwalks (without a heavy backpack), but retires from Masters Rugby.

Trinh hears that his claim for osteoarthritis of the right knee has been accepted. This entitles him to free lifetime clinical treatment for his knee, and likely compensation in the future, for which he will need to submit a D2020 claim for rehabilitation and compensation form. This will result in a medical impairment assessment being issued and must be completed by his doctor, usually his GP.

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CASE

4 Nikola is having panic attacks

Nikola, aged 32 years, presents to your general practice clinic complaining of suicidal thoughts, tiredness, insomnia and being 'at the end of her tether'. She has episodes of palpitations and panic attacks.

Nikola struggles with sleep. Alcohol helps her to fall asleep, but she wakes up unrefreshed. She wakes up partly because of pain in her right hip, but mainly because of distressing and graphic nightmares.

Nikola previously served in the Australian Defence Force (ADF) as a drone pilot. She discharged to spend time with her young family.

Question 1

What further history would you seek from Nikola?

Further information

Nikola reveals that, since the Ukraine war began, she has become increasingly withdrawn and emotionally distant, with low-volume, low-quality and highly disrupted sleep. She struggles to get to sleep due to 'ringing in her ears' – she sleeps well when it rains.

Nikola's distress has manifested as family discord; she 'flips out when stressed', especially if she has been drinking. She notes that her school-aged children are a little distant from her and try and be on their best behaviour. Her anger is also becoming problematic in day-to-day interactions, and she notes that she yells at people on the phone when she is frustrated and not able to articulate what she needs.

Nikola drinks a few glasses of wine while scrolling through social media after her two children go to bed. She falls asleep on the couch on most nights, waking up when it is cold, at which point she goes to bed. Her husband is reluctant to wake her up once she is asleep as she can lash out violently.

The war in Ukraine is simultaneously distressing and fascinating to Nikola, and she religiously 'doom scrolls' every evening. Nikola has family ties to both Ukraine and Russia. Her mother spoke Ukrainian as her first language.

She occasionally takes a 'couple of paracetamol' for her hip, which used to hurt a lot after marching but settled down for a while following her transition out of the ADF.

Nikola recounts several terrifying episodes of 'being rocketed' while deployed in Afghanistan. Her role as a surveillance drone pilot routinely exposed her to graphic war violence and considerable human misery.

She has thoughts about suicide occasionally, but has not made plans. Thinking of what this will do to her children keeps her grounded. At this point, she has decided that she needs to see someone.

Nikola has a Department of Veterans' Affairs (DVA) White Card that covers her non-liability mental health care. She has not yet submitted any claims as she feels daunted by the process.

You wonder if Nikola has post-traumatic stress disorder (PTSD).

Question 2

What else would you include in your assessment?

Further information

Nikola is neatly presented, wearing gym activewear. She maintains good eye contact. Her mood is mildly anxious. Her speech is normal in rate and rhythm but low in volume. Her mood and affect are dysthymic. She does not have any homicidal ideation, psychotic symptoms or obsession, compulsion or phobia. She is alert and oriented. Her insight and judgement are fair. She has an exaggerated startle reflex (a slamming door) and wipes her sweaty palms on her thighs several times during the consultation.

Nikola drinks 4–5 standard drinks every weekday, mostly white wine. Her initial Alcohol Use Disorders Identification Test (AUDIT) score indicates moderate risk.[4]

Nikola's PTSD checklist for the *Diagnostic and statistical manual for mental disorders*, 5th edition (PCL-5) score is significantly elevated (63/80), indicating a probable diagnosis of PTSD.

Nikola says she had a 'good childhood' and denies a history of childhood trauma, including domestic violence or sexual assault.

Question 3

What would be your initial treatment approach to Nikola?

Further information

You think Nikola might have PTSD and comorbid depression. Several treatments for PTSD are available, including psychological and pharmaceutical approaches.

The Australian guidelines for the treatment of PTSD provide an evidence-based treatment guide for general practitioners (GPs).[9]

Given that Nikola has not had any treatment, psychotherapy should be the first-line treatment and options include trauma-focused cognitive behavioural therapy (CBT), prolonged exposure (PE), cognitive processing therapy (CPT), trauma-focused cognitive therapy (TF-CT) or eye movement desensitisation and reprocessing (EMDR).

If Nikola does not want to or cannot access psychological treatment, has comorbid conditions that need to be treated first or she is not stable enough, medication options are reasonable. They include selective serotonin reuptake inhibitors (SSRIs; sertraline, paroxetine, fluoxetine) or an serotonin and norepinephrine reuptake inhibitor (SNRI; (venlafaxine).

Any comorbid conditions such as depression, alcohol misuse and suicidal ideation need to be treated.

Sequencing of treatment will largely, depend on the patient, their motivation and comfort with treatment options. The ability to build trust and a good working relationship will be beneficial to acceptance of evidence-based treatments, including referral options.

Given insomnia is a prime symptom, sleep hygiene, minimisation of stimulants after lunchtime, avoidance of triggers and a trial of sleeping medication might provide symptomatic relief. Sleep can also be worsened by tinnitus or pain, especially when nocturnal analgesics have worn off.

A trial of paracetamol and a non-steroidal anti-inflammatory drug is a good first step. Most musculoskeletal pain is improved by exercise, and a referral for exercise physiology or physiotherapy might be appropriate.

You counsel Nikola on healthy alcohol consumption. You reflect that she might be self-medicating her distress caused by her social media intake.

Psychiatric review can initially be reserved for patients at high risk and those with medically complex conditions, an uncertain diagnosis, dual diagnoses, medico-legal concerns or those who are unresponsive to initial standard therapies. A psychiatrist referral will be required for a formal diagnosis for the DVA claim and impairment assessment.

Question 4

What additional treatment options are available for Nikola?

CASE 4 Answers

Answer 1

It is recommended to ask the patient specifically about suicidality. Also consider the co-existence of PTSD, major depressive disorder (MDD) and chronic pain. Alcohol abuse disorder, already common among the Australian population, is also common in veterans, who might 'self-medicate' with alcohol.[1]

Answer 2

The PCL-5 can be used to screen for or aid a provisional PTSD diagnosis and monitor symptom changes.[2] The PCL-5 is a self-reporting measure of the 20 DSM-5 symptoms of PTSD. The PCL-5 domains correspond with the four DSM-5 criteria of PTSD: re-experiencing (B), avoidance (C), negative cognition and mood (D) and arousal (E). A higher score indicates more severe symptomatology.

Optimal PCL-5 cutoffs vary by clinical setting, but PTSD is considered likely in primary care patients who have a total PCL-5 score >38.

It is recommended that every mental health consultation should include a Mental State Examination.[3]

The World Health Organization's Alcohol Use Disorders Identification Test (AUDIT) is the most widely tested instrument for screening in primary healthcare.

Answer 3

Australian treatment guidelines recommend psychological therapies as the first-line PTSD treatment.[1] CBTs, such as PE, CPT and EMDR, have greater effects on relieving PTSD symptoms than medications.[5]

Even with the most effective psychological treatments, non-response and drop-out rates are high, and many veterans continue to experience significant symptoms. The picture is similar with medication-based treatment of PTSD.

The overall role of pharmacotherapy for PTSD is still unclear. Pharmaceutical treatment options for PTSD primarily start with antidepressants; medications are also useful as treatment adjuncts for the varied physiological manifestations of PTSD.

Medications might be appealing in resource-constrained settings, as they are not subject to the same access constraints as psychotherapy.

A wide range of antidepressant medications is used worldwide. Choice can also be led by availability and side effect profile. Australian guidelines recommend three SSRIs (sertraline, paroxetine and fluoxetine) and one SNRI (venlafaxine).[1]

Prazosin is an alpha-adrenergic antagonist. It crosses the blood–brain barrier, antagonises the alpha receptors in the central nervous system (CNS), and partially blocks a stress response. Higher than normal nocturnal CNS adrenergic activity disrupts normal rapid eye movement (REM) sleep. Prazosin reduces this adrenergic activity and therefore can aid sleep disturbances and nightmares. Start with a low dose and titrate up over weeks and watch for postural hypotension. There is evidence that prazosin can help in the treatment of nightmares, night terrors and poor sleep associated with PTSD. Medicine Plus advises this in the 'other uses for prazosin'.[6] The electronic therapeutic guidelines (eTG) recommend prazosin as first-line treatment for PTSD-associated nightmares in young people.[7]

Beta blockers have no current preventive benefit for patients with PTSD.[8] However, they can be useful in acute anxiety-provoking circumstances (eg airplane flights, court appearances, crowded shopping centres, public speaking) and are preferable to alcohol.

Answer 4

Insomnia

A variety of sleep disorders has been associated with PTSD; 70–91% of individuals have difficulty falling or staying asleep, and 19–71% experience nightmares.[10] It is recommended that GPs have a very low threshold for screening and onwards referral,[8,11] as well as active management[12] It is advised to ask the patient specifically about initial and terminal insomnia, restless legs, night terrors and the content of the nightmares.

CBT for insomnia (CBT-I or CBTI) is a short, structured and evidence-based approach to combating the frustrating symptoms of insomnia.

Tinnitus

Sound maskers (eg blowing fan, a white noise machine or smartphone noise apps) might aid individuals with getting to sleep and staying asleep. Noise has a tinnitus suppressing effect and might also obscure sounds that would trigger a hyperaroused CNS.

Hearing loss and tinnitus are the two most common ear, nose and throat conditions experienced by veterans. Screening for both hearing loss and tinnitus (Hearing Handicap Inventory and Tinnitus Functional Index) should be routine clinical practice.[13] Tinnitus symptoms worsen with distress.[14]

Hearing devices

The DVA funds hearing devices and services for Gold Card holders regardless of cause, and for White Card holders with conditions of hearing loss and tinnitus accepted by the DVA as linked to their service.[15,16]

Moral injury

Issues such as moral injury might complicate treatment for veterans, and further research is required into appropriate treatments. Moral injury is the distressing psychological, behavioural, social and sometimes spiritual aftermath of exposure to traumatic events. A moral injury can occur in response to acting or witnessing behaviours that go against an individual's innate values and moral belief systems.

Although presenting similar to PTSD, moral injury is different and often will not respond to PTSD first-line treatments. Moral injury has an increased risk of suicide.[17]

Veterans' Health Check

GPs can claim for providing a comprehensive physical and mental health check for all veterans, aimed at supporting early intervention and better outcomes for transitioning service personnel.

Travel for treatment

Gold Card holders have access to travel for approved treatment in Australia for all conditions, while White Card holders have access to treatment of an accepted service-related condition or for treatment of a specific condition covered under non-liability health care.

Open Arms counselling

Free, confidential face-to-face and/or telehealth counselling, group programs and peer support is available from Open Arms (formerly Veterans and Veterans' Family Counselling) 24 hours a day, seven days a week. Counselling services are available for all current and former service personnel and their families. No GP referral is needed. Access to Open Arms can be especially helpful for those who reside in regional, rural or remote locations.

Trauma recovery: PTSD

The DVA funds group programs at DVA-contracted hospitals and some community programs for eligible veterans. No referral is needed for DVA-contracted hospitals. Prior approval is required for non-contracted programs.

Income support

The DVA provides income support (the veteran payment) if a mental health claim has been accepted as service-caused or has been lodged (and eligibility is still being determined).

DVA psychiatric assistance dogs for veterans receiving treatment for PTSD

Psychiatric assistance dogs provide a popular adjunct to PTSD treatments.[18] They can detect signs of handler distress and perform routine tasks to help alleviate symptoms.

Conclusion

You help Nikola to download the CBT-Insomnia Coach app to her smart phone.

You discuss avoiding predictable psychological triggers and develop a healthy coping plan for when she is acutely distressed. She commences a slowly escalating dose of nocturnal prazosin. She is keeping a routine pain, activity, alcohol and sleep journal, which allows her to quantify her symptoms and gauge response to treatments.

Nikola attends her psychologist appointments and develops a strong rapport. After a few treatment cycles of therapy, she has been able to process and reassess traumatic memories and learns a variety of strategies that can ground her when she becomes emotionally elevated. She also learns what her specific triggers are, and how to deal with the discomfort, knowing the distress will pass and that she is okay.

She is referred to a psychiatrist to make/confirm a formal diagnosis, and submit a claim to the DVA. The DVA will ask the psychiatrist for a report for liability and compensation purposes. The DVA requests a psychiatric review to finalise her DVA claims. The psychiatrist formally confirms diagnoses of alcohol use disorder, PTSD and major depression. They suggest no major change to her treatment plan.

Nikola's hip pain is eventually diagnosed as femoral acetabular impingement syndrome, with early osteoarthritis.

After a period, her improvements plateau, and she commences an SNRI for her chronic pain and remaining depression, which also slightly improves her PTSD symptoms.

The DVA accepts liability for her hip osteoarthritis, PTSD, depression and tinnitus.

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CASE

5 Sandy is feeling tired and short of breath

Sandy, aged 76 years, is a Department of Veterans' Affairs (DVA) Gold Card holder and receives a Special Rate Disability Pension (SRDP). He has previously been diagnosed with post-traumatic stress disorder (PTSD). He presents to your regional general practice clinic reporting an altered bowel habit, having noticed his stool is dark black. He says he feels short of breath, tired and 'washed out'. He 'doesn't normally bother much with doctors', but he is 'feeling really crook'. He is getting short of breath when walking up stairs and chopping firewood.

Question 1

What further questions would you ask Sandy?

Further information

Sandy denies cough, palpitations, chest pain, easy bruising or ankle swelling.

He says he is not depressed, and that his PTSD is under control.

Sandy has had altered bowel habits and intermittent melena for the past six months. Several distant relatives have had bowel cancer.

Sandy has never had a faecal occult blood test (FOBT) or gastroscopy/colonoscopy. His last blood tests were two years ago, which showed only mild dyslipidaemia and hyperuricaemia.

Question 2

What else would you include in your initial assessment of Sandy?

Further information

Sandy has had intermittent abdominal pain associated with appetite loss, rectal bleeding, weight loss and a change in bowel habit.

Sandy has a history of hypertension (last blood pressure 134/71 mmHg), gout, squamous cell carcinoma (excised), right inguinal hernia (open surgical repair in 1973) and tinea pedis.

As a result of his prior military service (Infantry) in Vietnam he has PTSD, which is in clinical remission. He drinks 3–4 standard drinks every Friday evening at the local diggers' club. He says he keeps a 'good lid on his drinking' these days.

His current medications are ramipril, esomeprazole and allopurinol.

On examination, Sandy looks thinner than when you last saw him approximately 12 months ago (height 174 cm, weight 71 kg, body mass index [BMI] 23.5 kg/m^2) and pale. His abdominal examination is unremarkable. On per rectum examination you note external haemorrhoids and a craggy rectal mass, with melena on your glove.

Question 3

What would be your initial treatment approach for Sandy?

Further information

You order an urgent full blood examination (FBE), which shows Sandy is newly anaemic. However, Sandy's haemoglobin level is high enough that no blood transfusion is indicated. You refer Sandy for an urgent surgical review. Because of his symptoms, he is seen quickly. His rectal mass is biopsied and demonstrates malignancy (adenocarcinoma).

Sandy is referred to a local oncology centre. He also sees a colorectal surgeon who orders preoperative work-up to stage disease and inform surgical options. Sandy is physically active and performs all his own cares, therefore has a good functional status.

The Eastern Cooperative Oncology (ECOG) performance level is a functional scale that grades patients in terms of their physical activity.

The diagnosis comes as 'quite a shock' to Sandy. He seeks solace with some friends who are cancer survivors at the diggers' club. You suggest to Sandy that he can call Open Arms (formerly Veterans and Veterans' Family Counselling [VVCS]) to talk to a counsellor. He happily accepts this, and Open Arms also arranges counselling for his wife.

Question 4

Does Sandy's veteran status alter your management approach?

Further information

Sandy's physical status is assessed as ECOG 1.[9] Sandy is scheduled for chemotherapy and surgery at a local DVA-contracted private hospital. He does well with neo-adjuvant chemotherapy and radiotherapy and only experiences tiredness, lethargy, mild nausea and some oral lesions.

His surgery removes a sizable portion of bowel with surrounding tissues, and he has a planned stoma. His postoperative course is uneventful.

Question 5

What support can Sandy access following discharge?

CASE 5 Answers

Answer 1

New-onset shortness of breath has a wide differential diagnosis. Likely culprits could include cardiovascular, respiratory, haematological, renal or oncological disease. Psychiatric illness can also cause subjective shortness of breath. Open-ended questioning can help to narrow the cause.

Sandy has a diagnosis of PTSD and is at increased risk of depression; both these mental health conditions increase the odds of irritable bowel syndrome (IBS).[1,2] However, melena is a worrying development that is not seen in IBS, and bowel cancer would be high on your list of differentials because of Sandy's age.[3] It is important to ask Sandy whether he has had an FOBT or colonoscopy.[4]

Answer 2

A targeted physical examination will likely reveal the system involved. Blood screening examinations in a symptomatic patient can aid the diagnosis, and guide treatment choices. Palmar and scleral pallor become more likely with lower haemoglobin levels (ie 70 g/L).

Checking for mental health symptoms with the PTSD checklist for the *Diagnostic and statistical manual of mental disorders*, 5th edition (DSM-5) and tools such as the Depression Anxiety Stress Scale-21 (DASS-21) or Beck's Depression Inventory might be of use in overall management.[6,7]

Answer 3

The history and examinations indicate Sandy has a rectal carcinoma. Urgent referral is required.[8]

Answer 4

Sandy has a DVA Gold Card, which covers clinically necessary treatment, including for any malignancy. He can use all public hospitals and many private hospitals, provided they are contracted to the DVA.

Sandy is able to use a local private hospital (DVA-contracted facilities; www.dva.gov.au/providers/health-programs-and-services-our-clients/hospitals-and-day-procedure-centres/delivering) and surgeon and oncologist private rooms for his specialist appointments. Sandy might also be eligible for travel funding.

Treatment of colorectal cancer might include combinations of surgery, chemotherapy or radiotherapy.

Answer 5

Prior to discharge, Sandy can be enrolled to receive community nursing by the hospital discharge planner (DVA form D9389), who can make the referral to a local DVA-contracted community nursing provider.[10] This would allow Sandy to be discharged and return home earlier.

The DVA funds membership of stoma associations and the delivery of stoma consumables.[11] Sandy accesses colostomy supplies through the DVA Rehabilitation Appliances Program (RAP).[12] He masters care of the stoma and adjusts to its impact on his lifestyle. Referral to an occupational therapist (DVA form D0904) would allow Sandy to be assessed for home appliances during recovery (eg shower chair, commode chair).

Conclusion

After his treatment, Sandy enters active surveillance. The DVA funds his travel to and from his oncologist and funds his medical imaging.

Five years after treatment, Sandy presents with new-onset ascites. You arrange a diagnostic/therapeutic ascetic tap, which confirms a recurrence of his malignancy.

After a long discussion Sandy declines further interventions and chooses to focus on his quality of life. You document his wishes in a region-specific advanced care directive,[13] and Sandy appoints a substitute decision maker.[14]

You refer to your local palliative care service, who contacts Sandy promptly. The palliative care team liaises directly with DVA community nursing to provide care in Sandy's home.[10] Sandy starts to arrange his personal affairs.[15] Sandy passes away peacefully at home four months later.

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Multiple choice questions

Question 1

In veterans, chronic post-traumatic stress disorder (PTSD) is commonly associated with which of the following? Select all that apply.

A. Depression

B. Anxiety

C. Alcohol use disorder

D. Chronic musculoskeletal pain

E. Osteoarthritis

F. Sensory neural hearing loss

G. Tinnitus

H. Solar keratosis

I. Inflammatory bowel disease

J. Chronic kidney disease

K. Psychogenic non-epileptic seizures

L. All of the above

Question 2

Which of the following groups are able to access Department of Veterans' Affairs (DVA) services? Select all that apply.

A. Veterans who have served at least one day in the Australian Defence Force

B. Some Australian federal police officers

C. All current emergency services personnel

Question 3

DVA's provisional access to medical treatment (PAMT) scheme aims to (select all that apply):

A. Provide treatment funding while the DVA is determining initial liability

B. Cover treatment costs for common medical conditions in Australian veterans

C. Gather additional medical evidence to help prove veterans' liability and compensation claims

Question 4

Which of the following are guideline-based first-line treatments for PTSD?

A. Psychological therapies (eg trauma-focused cognitive behavioural therapy, eye movement desensitisation and reprocessing)

B. Sertraline, paroxetine, fluoxetine or venlafaxine

C. Adjunct prazosin and/or melatonin

D. Anti-psychotics and/or benzodiazepines for agitation

E. Ketamine or esketamine therapy

F. Recurrent transcranial magnetic stimulation

Question 5

The DVA issues veterans' cards with differing levels of coverage. Which of the following are used? Select all that apply.

A. White Card

B. Gold Card

C. Orange Card

D. Pink Card

E. Green Card

F. Black Card

Question 6

With regards to charging veterans gap fees (co-payments), which of the following statements are correct?

A. It is permitted, but only if the co-payment is in cash

B. Charging gap fees is contrary to the Health Insurance Act (1973)

C. If the veteran agrees, they can make a voluntary contribution

Question 7

The DVA funds the items found in the Medical Benefits Scheme, and the products listed in the Pharmaceutical Benefits Scheme, along with a number of other useful clinical items. Which of the following are DVA programs that fund clinical treatment? Select all that apply.

A. Repatriation Medical Fee Schedule

B. Repatriation Pharmaceutical Benefits Scheme

C. Prior approval

D. Medical expenses previously incurred

E. All of the above

Question 8

Reception staff should be encouraged to ask patients if they have served in the Australian Defence Force at patient enrolment. Asking every new patient 'have you served in the Australian Defence Force?' is important because (select all that apply):

A. This aids the practice in identifying their veteran patient base and those eligible for veteran-specific services, such as the Veterans' Health Check and Coordinated Veterans' Care

B. Many veterans do not know the wide range of clinical services and support services they are eligible for

C. A growing proportion of Australian veterans do not conform to common stereotypes (eg Caucasian, male, heterosexual and elderly)

D. Asking every patient normalises the question

E. All of the above

Question 9

The DVA scheme that supplies rehabilitation appliances and devices aimed at letting eligible persons live independently is called:

A. Rehabilitation Appliances Program

B. Repatriation Benefits Scheme

C. Repatriation Application Products

Question 10

The DVA has a program titled Coordinated Veterans' Care that provides for regular case coordination by a general practitioner (aided by a practice nurse). This program is open to (select all that apply):

A. All Australian Defence Force veterans

B. All Australian Defence Force veterans who have been deployed on peacekeeping operations

C. Members of the Australian regular army only

D. All Gold Card holders

E. All White Card holders with a mental health claim-accepted condition

check

RACGP CPD solution