

check

Independent learning program for GPs

Unit 561
June 2019

Preventive health for Australia's First Peoples

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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.








Preventive health for Australia's First Peoples

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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

About this activity

The Vision of The Royal Australian College of General Practitioners' (RACGP's) Aboriginal and Torres Strait Islander Health faculty is that 'all Aboriginal and Torres Strait Islander peoples receive optimal primary care from general practitioners and are able to enjoy long and healthy lives'.¹

In 2010–12, life expectancy for Aboriginal and Torres Strait Islander peoples was approximately 10 years less than that of non-Indigenous Australians.² Hospital admission rates are also higher in Aboriginal and Torres Strait Islander peoples for almost all health problems, compared with non-Indigenous Australians.³

In the past decade there has been a syphilis outbreak in Aboriginal and Torres Strait Islander peoples in northern Australia.⁴ This outbreak has resulted in six congenital syphilis deaths,⁵ emphasising the specific importance of appropriately treating syphilis in pregnancy.

Research has shown that clusters of suicides are common in Aboriginal and Torres Strait Islander communities.⁶ Consequently, mental healthcare is crucial in these populations, particularly after a tragedy occurs in the community.⁷

In 2012–13, rates of chronic obstructive pulmonary disease were 2.5 times higher in Aboriginal and Torres Strait Islander peoples than in non-Indigenous Australians, at a prevalence of 4%.⁸

Although Aboriginal and Torres Strait Islander peoples are more likely to abstain from alcohol than non-Indigenous Australians (31% versus 23%), almost 20% of Aboriginal and Torres Strait Islander peoples consume ≥11 drinks per occasion at least once per month,⁹ resulting in an increased risk of alcohol-related harm.

This edition of *check* considers preventive health for Australia's First Peoples.

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Learning outcomes

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

- discuss the approach to mental health assessment for Aboriginal and Torres Strait Islander peoples
- summarise the management of syphilis in a pregnant Aboriginal woman

- identify the key features of alcohol withdrawal and outline the appropriate measures to prevent alcohol-related harm in Aboriginal and Torres Strait Islander peoples
- describe the follow-up care of Aboriginal patients with chronic obstructive pulmonary disease.

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Special thanks to Ada Parry FRACGP (Hons), Cultural and Education Advisor for RACGP Aboriginal and Torres Strait Islander Health, for reviewing the cases for cultural sensitivity.

Abbreviations

ACAT	Aged Care Assessment Team
ACCHO	Aboriginal Community Controlled Health Organisation
AHW	Aboriginal Health Worker

COPD	chronic obstructive pulmonary disease
CXR	chest X-ray
FEV₁	forced expiratory volume in one second
FVC	forced vital capacity
GEM	Growth and Empowerment Measure
GP	general practitioner
HANAA	Here and Now Aboriginal Assessment
HIV	human immunodeficiency virus
K-10	Kessler 10
KICA-Dep	Kimberley Indigenous Cognitive Assessment of Depression
MBS	Medicare Benefits Schedule
PCR	polymerase chain reaction
PHQ-9	Patient Health Questionnaire
RPR	rapid plasma reagin
SSRI	selective serotonin reuptake inhibitor
STI	sexually transmissible infection
UTI	urinary tract infection

CASE

1 Victoria is here for a health check

Victoria is an Aboriginal woman, aged 38 years, who comes in to see you requesting a health check. You see from her medical record that she has been to your practice a few times in the previous year for minor illnesses and work certificates, but you have not seen her before.

Victoria works for a local disability service provider as their Aboriginal Liaison Officer. You ask her if there is anything in particular that she is worried about. She tells you that a young man in her community killed himself last month, and it has affected everyone.

Question 1

How would you assess Victoria's mental health? What are the most important features of the history you need to elicit?

Question 2

Are there any questionnaires that might help your assessment?

Further information

You ask Victoria more about what is happening and how it is affecting her, as well as how long these symptoms have been occurring.

She tells you that she has a close relationship with the family of the young man who killed himself, and they are all devastated. She had known him since he was a child, and was friends with his older sister, and knew the parents well. She was not involved in the discovery of his body, and had not been aware that he had been going through any difficulties. Now she is trying her best to support the family, but she is also struggling to sleep and has lost her appetite, only picking at her food.

Victoria is finding it difficult to concentrate at work, as she keeps thinking about the man and his family. She is worried she might lose her job because of this. She is feeling a bit torn because of the expectations placed on her to cope at work with a busy caseload, but also to provide support for the family and others in the community. Victoria is in a supportive same-sex relationship, with two children at home. She is feeling tired and a bit irritable. She does not smoke or drink and is not taking any medication. She had not had any of these feelings or symptoms before the suicide.

Question 3

What is your differential diagnosis at this point?

Question 4

What would be your management plan at this point?

Question 5 

What cultural considerations might you need to consider?

Further information

Victoria is referred to the social and emotional wellbeing team at the local Aboriginal Community Controlled Health Service. They keep in contact with her, and she is able to talk to a local Elder informally and join in some of the social groups. You see her for her planned reviews, and at the second one, she tells you she is feeling much better and is continuing her work. She is still supporting the family of the young man who killed himself. They remain very upset, and Victoria is still worried about them and some of the other young people in the community. 'What can I do to help?' she asks you.

Question 6 

What do you say to her?

CASE 1 **Answers****Answer 1**

Mental health assessment forms an important part of the health assessment of Aboriginal and Torres Strait Islander peoples. While universal screening – asking everyone coming into contact with the service a set of screening questions – is not recommended, clinicians should be alert to cues from those who might be at higher risk of depression and ask about their mental health. Features putting people at higher risk of depression (Box 1) are not unusual in Aboriginal and Torres Strait Islander patients.¹

Box 1. People in whom depression risk is greater¹

- Exposure to adverse psychosocial events, such as unemployment, divorce or poverty
- A previous history of depression or suicide attempts
- A history of physical or sexual abuse
- A history of substance misuse
- Presence of other chronic diseases, including chronic pain
- Multiple presentations to health services may also be an indicator of depression

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Victoria has raised the issue herself, which gives you the opportunity to open up a conversation with her to explore this.

In many circumstances, all that is required is a conversation that allows the patient to raise their concerns with the doctor, and tell their story of what is happening for them and how it affects their mood. This will allow a detailed picture of the patient's situation to emerge, together with what they think is happening and what they think might help. Sometimes the patient's mood is so low that they cannot imagine anything that will help or improve their situation, but they can usually still talk about what is happening for them. Allowing the patient to tell their own story and listening attentively will also help to develop rapport and trust. This will be crucial for managing Victoria's mental health in the future. You can then explore particular details of the patient's history, asking about how it is affecting their appetite; their sleep; and their work, family and community life. Asking about the patient's alcohol, smoking and medication use in this context will also be important.

Suicides can cluster in some communities, and this is more common in Aboriginal and Torres Strait Islander communities.² This is when more than one related suicide occurs in an area over a short period of time, and it will be crucial to ask Victoria about thoughts of self-harm and assess her suicide risk.

It is also important to find out about protective features, such as relationships with family and friends, and activities she would normally enjoy. There is often a strong background of strength and resilience to draw on.

Answer 2

Standardised questionnaires to assess mood have become increasingly popular, but these sometimes need to be used cautiously in Aboriginal or Torres Strait Islander communities, as they were often developed in European or American settings, and have not been validated or assessed for their cultural appropriateness in these communities. This work has started, and adapted or new questionnaires that are more culturally appropriate are starting to be published. A five-question adaptation of the Kessler 10 (K-10) called the K-5 has been developed by the Australian Bureau of Statistics with Aboriginal community representatives.³ The Patient

Health Questionnaire (PHQ-9) has been adapted for use in Aboriginal men,⁴ and the Pearlin Mastery Scale has been adapted for use with Yolngu people of Arnhem Land.⁵ The Here and Now Aboriginal Assessment⁶ is a tool that promotes a conversation about an Aboriginal person's social and emotional wellbeing more broadly. The Kimberley Indigenous Cognitive Assessment of Depression (KICA-Dep) was developed in town in remote north Western Australia, and may be useful in people older than Victoria.⁷ The Growth and Empowerment Measure (GEM) has been developed to try to assess wellbeing and connectedness to people and country.⁸ Refer to Table 1 for information about these tools.

Table 1. Specific tools that may be useful in assessing mental health in Aboriginal and Torres Strait Islander peoples

Name of tool	Notes
Kessler 5 (K-5) ³	Adapted from K-10 by Australian Bureau of Statistics with original developers of tool and Indigenous representatives
Patient Health Questionnaire 9 ⁴	Copy of final questionnaire in published paper
Pearlin Mastery Scale adapted for Yolngu people ⁵	For use with Yolngu people in Northern Territory
Here and Now Aboriginal Assessment (HANAA) ⁶	Has been used quite widely in Queensland
Kimberley Assessment of Depression in older Indigenous Australians (KICA-Dep) ⁷	For use with older people, developed in Kimberley
Growth and Empowerment Measure (GEM) ⁸	Developed to try to assess wellbeing and connectedness to people and country

Some of these tools may be useful to help practitioners have a conversation with their patients about mental health and social and emotional wellbeing, and monitor their mental health diagnosis.

It is important to recognise that mental health is a narrow Western medical concept of disease related to individual psychological diagnosis or pathology, which may not be adequate in this context. Aboriginal and Torres Strait Islander concepts of health tend to be more holistic, concerned with not only the individual but also the social, emotional and cultural wellbeing of the whole community and country. This is often referred to under the umbrella of social and emotional wellbeing.

Answer 3

At this point the main diagnoses to consider would be:

- adjustment disorder – the main features of this are emotional and behavioural symptoms that are related to the onset of one or more stressful life events⁹

- acute stress reaction – this is characterised by anxiety symptoms and dissociative symptoms, such as detachment, reduced awareness of surroundings and depersonalisation, soon after the onset of a traumatic event
- depression – this is characterised by low mood, with anhedonia (lack of pleasure in usual activities), withdrawing from friends and family, thoughts of suicide, crying all the time without reason, and feelings of worthlessness for two weeks or more
- normal emotional response to a stressful situation.

The most likely diagnoses would be adjustment disorder, as there is a clear trigger for Victoria's symptoms, and she does not appear to have the dissociative aspects of an acute stress reaction.

Adjustment disorder diagnostic criteria require that there is functional impairment and a perception that the distress is 'out of proportion to the severity or intensity of the stressor'.¹⁰ This diagnostic criterion has been criticised, as the concept of what is normal is vague and highly variable across social and cultural groups.⁹

However, depression cannot be excluded at this point either. It is important to note that further history now, or development of her symptoms over time, may warrant a change in diagnosis.

This could, of course, be a normal emotional response to a terrible event. If this is the case, she may not be eligible for a Mental Health Care Plan under the Medicare Benefits Schedule (MBS), but would also probably not need to see a psychologist. This diagnosis will become clearer with the passage of time.

Answer 4

At this point, the most important thing is to discuss with Victoria what she thinks will help and what she wants to do. It may be that, having talked about what is happening, she feels better and more optimistic about being able to continue. This would be a reasonable plan, provided the risk of self-harm is low and adequate follow-up and safety netting is arranged. Good practice for follow-up in this situation would be to see Victoria again in two weeks to assess her mood and symptoms for any changes. This would be consistent with, for example, the guidelines for mild depressive symptoms.¹¹

It is more likely that she has come in to ask for help. Facilitating this through referral to a psychologist would be the most appropriate plan at this stage, if Victoria agrees. If eligible, this could be done through the use of an MBS Mental Health Care Plan and referral to a psychologist. Alternatively, she may be eligible for a local program or may have psychology available through private health insurance or through her employer. If she has had an Aboriginal and Torres Strait Islander Peoples Health Assessment, she can access MBS funding for up to five additional allied health sessions per year, which can include psychologists or mental health workers.

It would also be important to consider whether she may get more appropriate care through an Aboriginal Social

and Emotional Wellbeing program, where available, often run through a local Aboriginal Community Controlled Health Service. These programs usually offer broader support than can be provided by a psychologist alone, and may include an Aboriginal Health Worker (AHW), a social worker and/or a mental health nurse. These professionals are often aware of, and can navigate, cultural considerations and obligations.

Antidepressant medication, particularly a selective serotonin reuptake inhibitor (SSRI), would be a therapeutic option here, but it is more likely that, given the diagnosis, the use of an SSRI would be limited in this scenario. Antidepressants are more likely to be helpful if Victoria's symptoms are prolonged or severe. This could change as the nature of the symptoms changes, or if psychological treatment does not help. Sleeping tablets are likely to have more harms than benefits in this situation.¹²

Increasingly, online and mobile phone applications are being used to manage mental health. These may be useful in management, though many have not been evaluated for clinical efficacy or cultural acceptability.

A crucial part of the management will be ongoing follow-up, with specific arrangements and safety netting with plans made should a crisis arise.

Answer 5

The most direct cultural considerations that might be having an impact on Victoria's mental health right now are her obligations to others in her community and family, and she may have extended family caring responsibilities. In her work, she may be feeling that she is the sole Aboriginal representative in her organisation, which can stretch her between a non-Indigenous worldview of work responsibilities and implicit internal community representation in her workplace.

More broadly, she may have obligations to, and draw strength from, her connection to her own country, which may not be where she lives and works.

Aboriginal and Torres Strait Islander peoples have often experienced adverse events in their lives,¹³ including experience of racism, and she may have also experienced discrimination related to her sexuality, including in health services. However, it is important not to assume this and stereotype her.

Though it may not come up in the consultation, Victoria is in the age group that is most likely to be a descendant of someone who was forcibly removed from their parents due to government policy (the Stolen Generation). This group has a significantly increased prevalence of experiencing adverse events and significantly poorer health outcomes.¹⁴

For this reason, a patient-centred approach, allowing Victoria to make decisions for herself, will allow her to guide you about her cultural preferences. It will be important to refer to mental health services that are familiar with local Aboriginal cultural practices, engaged with the community and culturally safe.

Answer 6

The time after a suicide in a community is recognised as being crucial for intervention. There is evidence that intervening at this moment – sometimes called postvention – is effective at preventing further suicides.¹⁵

Your first suggestion would be for Victoria to ensure she is well and does not put herself at undue risk/pressure. It would also be appropriate to tell Victoria that you recognise this is a very difficult time for young people in the community, and that you would encourage them to see a general practitioner (GP), AHW or Elder that they respect. You would be happy to see them.

You may want to make sure the rest of the practice staff are aware, so that they can take steps to ensure the practice is culturally safe and they have the capacity to see these young people.

It is also important to recognise that well-intentioned suicide prevention activities that do not have the active engagement and leadership of the local Aboriginal or Torres Strait Islander community can do more harm than good – so much so that the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project recommended that if the community was not leading the process, the project should not proceed.⁶

Advice to Victoria should be that the local community, perhaps through an Aboriginal Community Controlled Health Service, needs to lead any suicide prevention project, but that you would be happy to support that as a GP.

Conclusion

Victoria thanks you for the care you have provided and your advice. She is grateful that you were able to provide care that used her strengths as an Aboriginal woman, taking account of her culture, without stereotyping or making assumptions about her. This was a marked contrast to some of her previous experiences.

'I'm glad there are good GPs out there for our people,' she says as she closes the door.

Resources for doctors

- National Aboriginal Community Controlled Health Organisation and The Royal Australian College of General Practitioners, *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people*, 3rd edn, www.naccho.org.au/wp-content/uploads/National-guide-3rd-ed-web-final.pdf
- Telethon Kids Institute – Working together: Aboriginal and Torres Strait Islander Mental health and wellbeing principles and practice, www.telethonkids.org.au/our-research/early-environment/developmental-origins-of-child-health/aboriginal-maternal-health-and-child-development/working-together-second-edition/
- Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) – Solutions that work: What the evidence and our people tell us, www.atsispep.sis.uwa.edu.au/

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Medicare Benefits Schedule. You give her a Closing the Gap annotated script and instructions for oral iron, iodine and folate replacement according to the *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people*, 3rd edition, recommendations for antenatal care.¹ As Jayla feels safe at Zia's and is planning to stay for now, you add a record reminder to follow up safety in her community at her next appointment. You organise a dental appointment for her. With Jayla's consent, you talk to Zia about the pregnancy, the tests Jayla needs, and the importance of returning for her results and further antenatal checks.

Question 3 

What is the sexually transmissible infection (STI) you are concerned Jayla may have? Are there any other point-of-care tests that may be helpful in this setting?

Further information

Jayla's antenatal STI tests return as below.

- Syphilis enzyme immunoassay: positive
- Rapid plasma reagin (RPR): 1:128
- *Treponema pallidum* particle agglutination assay: positive
- Human immunodeficiency virus (HIV): negative
- Hepatitis C antibody: negative
- Hepatitis B: immune by vaccination
- First-void urine:
 - chlamydia polymerase chain reaction (PCR): positive
 - gonorrhoea PCR: negative
 - trichomonas PCR: negative.

Question 4 

How would you manage Jayla now?

Further information

You call the clinic in Jayla's home community and ask them to perform an STI screen and treat her partner for syphilis and chlamydia. You pass on his name and age, but you do not give Jayla's details. Given Jayla is pregnant, you talk to her about the infections and treatment, the importance of treatment not only for her but for her baby, ask her to return for a repeat syphilis test in four weeks, and give her condoms.

Jayla is treated with benzathine penicillin for syphilis and azithromycin for chlamydia. With the support of her aunt, she decides to stay with Zia for the duration of her pregnancy. You manage her with shared care with the local hospital, and they are aware of her treatment. Within a week the rash has disappeared, and on retesting in one month her RPR has fallen to 1:16. As this is more than a two-fold drop in RPR titre from 1:128, this is consistent with adequate treatment. Her pregnancy is closely monitored with serial growth scans by the local hospital obstetric team and is progressing well. Her RPR is retested according to local antenatal protocols, if at continued risk, at 28 weeks, 36 weeks and delivery.

The aim is to achieve a two-titre RPR drop as early in pregnancy and before delivery as possible. If this is not achieved, then sexual history should be retaken, and the neonate needs careful examination and consideration for treatment.

On her fourth visit to you, when you have established a good relationship with her, Jayla discloses that she had had unprotected sex with another casual partner about three months before leaving her community, which was the source of trouble that required her to leave. You discuss this and together agree on a plan to ensure her safety should she return to her community. More information on this can be found in the *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people*, 3rd edition, in the chapter on family abuse and violence.¹

You are unsure how to follow up this contact as Jayla cannot remember his name and is not sure where he is, as he was from out of town.

Question 5 

What resources do you have to try to perform effective contact tracing in these circumstances?

CASE 2 Answers**Answer 1**

First, try to establish rapport with Jayla. You could start by asking some general questions to initiate conversation and encourage her to talk. For example:

- Where are you from?
- How many families are there in your community?
- Who else lives in your house?
- How long have you been living with Auntie Zia?

You can confirm and explain confidentiality in simple terms, for example, 'Anything you say to me here we can keep in this room, unless something is happening that is dangerous to you'.

Then ask specific questions about the vomiting:

- When does it occur and how often?
- Do you have any other symptoms of pregnancy (eg nausea, tiredness, sore breasts)?
- Do you have any other related symptoms of concern (eg fevers, headache, abdominal pain, haematemesis)?

Gently exploring the relationship Jayla has with Zia can be helpful to prepare them for your request to see Jayla on her own for more personal questions. Explain that it would help to understand more about Jayla's health if you can ask about what might be causing the vomiting and explicitly seek permission to do this, for example, 'In order to understand more, would it be OK if I asked some more questions about what's been going on with you?'

It is then an easier transition to ask about seeing Jayla by herself, for example, 'Some of the questions I need to ask you are quite personal. Would you like to see me by yourself or would you prefer Auntie Zia to stay with you?'

Answer 2

At this point, it is helpful to observe Jayla's general appearance (including ears, mouth, teeth and skin) and check her heart rate, temperature and blood pressure. A focused examination comprises a check of Jayla's cardiorespiratory system and abdomen. Vulval examination, with Jayla's consent, is important to check for a chancre (painless, punched-out wet ulcer, can be single or multiple) and condylomata lata (multiple small firm lumps similar to warts but with a wet shiny surface). At this point it is also important to conduct a urine pregnancy test, urine dipstick test, and haemoglobin point-of-care test.

Answer 3

It is likely that Jayla has secondary syphilis. Syphilis is caused by *Treponema pallidum*, a spirochaete infection transmitted usually by sex, but also via vertical transmission (from a mother across the placenta to her unborn baby) or by blood-to-blood transmission. Most infections are detected by serologic testing, as the symptoms of early syphilis within the first two years of infection maybe painless, internal or fleeting. Primary syphilis is rarely symptomatic and is characterised by a painless, firm genital ulcer that disappears without

treatment and appears 10–90 days after infection. Secondary syphilis, if symptomatic, occurs 2–24 weeks after infection. It can manifest as a non-itchy rash on palms and soles, at times involving the whole trunk. There may be mucous patches in the mouth and/or condylomata lata (shiny lumps on the genitals that are occasionally mistaken for genital warts). The term 'early latent syphilis' is used to describe patients with positive syphilis serology within two years of a negative test, with no symptoms. Early syphilis is infectious to sexual partners within the first two years of infection. Beyond two years, asymptomatic syphilis is termed 'late latent' and is no longer transmissible to sexual partners but may still be passed on to an unborn child, resulting in congenital syphilis.²

Syphilis in pregnancy can result in higher rates of prematurity, low birthweight, stillbirth, perinatal mortality and neonatal infection. Infants affected by congenital syphilis may have a diverse range of complications including deafness, bone deformity and neurological sequelae, which may not all be apparent at birth.³

Conversely, the risk of congenital syphilis is low if the mother is adequately treated more than four weeks before delivery, partner treatment has been simultaneously completed and there has been no reinfection.⁴ The earlier the infection is detected, the earlier the treatment in pregnancy, and the better the outcome; therefore, testing early in pregnancy, and repeat testing at 28 weeks, is important.

There has been a syphilis outbreak in Aboriginal and Torres Strait Islander peoples in northern Australia over the past decade⁵ resulting in six congenital syphilis deaths.⁶

If available, a syphilis point-of-care test is a fingerprick test similar to a urine dipstick strip, with excellent sensitivity and specificity. It does not differentiate between treated or current infection, so it is important to ask about any history of syphilis and past treatments. All positive point-of-care tests should be followed up by formal syphilis laboratory testing. Your local sexual health clinic, or Aboriginal Medical Service if in northern Australia, may offer the syphilis point-of-care test. Urine point-of-care testing machines for chlamydia and gonorrhoea are also available in some rural and remote areas in Australia, with a test turnaround time of approximately 90 minutes.

STIs often travel in pairs or groups, so it is good practice to offer testing both for blood-borne infections (HIV, hepatitis B and C, and syphilis) as well as first-void urine or self-obtained vaginal swab PCR for chlamydia. In high-risk settings, such as regional/rural communities, PCR urine should also include tests for gonorrhoea and trichomonas.⁷

Answer 4

Management of early syphilis and chlamydia, and STIs in general, requires five steps:

1. Education about the infection and offering condoms where appropriate
2. Treatment: for early syphilis, 1.8 g intramuscular benzathine penicillin stat, and for chlamydia, azithromycin 1 g oral stat
3. Notification to the local Department of Health, as syphilis and chlamydia are notifiable conditions

4. Contact tracing and empiric partner treatment
5. Follow-up with repeat history and STI testing to ensure treatment has been effective and no reinfection has occurred in one month for syphilis and three months for syphilis and chlamydia.

Additional considerations in pregnancy include:

- specialist consultation – although antibiotic therapy is as for non-pregnant women, specialist advice is recommended for management of syphilis in pregnancy²
- repeat STI screening – recommended at 28 weeks' gestation and at time of delivery for syphilis for all pregnant women in high-prevalence communities⁴ – see point 5 above
- neonatal assessment – required to assess for congenital syphilis. Thorough clinical examination, serology and PCR of placental tissue are suggested, with specialist consultation if congenital syphilis is identified.⁵

It is important to discuss with the patient the risk of a possible Jarisch–Herxheimer reaction (Box 1). In pregnant women this reaction can bring on premature labour or fetal distress, especially during the second half of pregnancy. Therefore, women should be advised to seek urgent review if they notice fever, contractions or reduced fetal movements following antibiotic therapy.⁴

Arrangements can then be made for repeat syphilis testing ± serial obstetric ultrasounds according to local protocols for high-risk pregnancies.

Box 1. Jarisch–Herxheimer reaction²

The Jarisch–Herxheimer reaction is a common reaction to treatment in patients with primary and secondary syphilis. It occurs 6–12 hours after commencing treatment and is an unpleasant reaction of varying severity with fever, headache, malaise, rigors and joint pains, and lasts for several hours. Symptoms are controlled with analgesics and rest. Patients should be alerted to the possibility of this reaction and reassured accordingly.

Reproduced with permission from Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine. Australian STI management guidelines for use in primary care: Syphilis. Surry Hills, NSW: ASHM, 2018.

Answer 5

Partner notification, or contact tracing, is a skill requiring patience, tact and diplomacy. There are two major types – patient-initiated and health service-initiated. Sometimes a mix of both can be helpful.

If there is a risk that patient-initiated partner notification is likely to result in violence, it is important to offer anonymous, service-initiated contact tracing.

An Aboriginal Health Worker who is not family to Jayla may be able to help with getting details about who her former partner might be, based on appearance, timing of visit to community, and who he was staying with. Some states employ dedicated contact tracing services available via health departments.

Queensland Health runs the state-wide syphilis register, which has a free call number (1800 032 238) for results of past serology to assist with determining early or late infection, and offers phone advice on testing, treatment and follow-up. The website www.LetThemKnow.org.au was developed by the Melbourne Sexual Health Centre and offers an anonymous SMS service to message partners to get tested. The Australian Federation of AIDS Organisations maintains a contact tracing site for all STIs (<http://bettertoknow.org.au/index.html>), which provides an easy-to-use, anonymous SMS service to partners. Refer to Australasian Contact Tracing Manual for further options.

Resources for doctors

- Australian STI management guidelines for use in primary care, www.sti.guidelines.org.au/sexually-transmissible-infections
- National Aboriginal Community Controlled Health Organisation and The Royal Australian College of General Practitioners, *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people*, 3rd edn, www.naccho.org.au/wp-content/uploads/National-guide-3rd-ed-web-final.pdf
- Australasian Contact Tracing Manual, Melbourne Sexual Health Centre, www.mshc.org.au/HealthProfessional/AustralasianContactTracing/tabid/456/Default.aspx#.XHH423duKUK
- SMS contact tracing service, <https://letthemknow.org.au/>
- An introduction to Aboriginal and Torres Strait Islander cultural protocols and perspectives, www.racgp.org.au/the-racgp/faculties/atsi/guides/an-introduction-to-cultural-protocols

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CASE**3 Peter is a new admission to an aged care facility**

Peter, an Aboriginal man aged 65 years, was admitted two days ago to Sunny Oaks Aged Care Facility, which is located in Far North Queensland approximately 30 km from the closest regional city. Peter has lived most of his life in this area. English is his primary language. He agreed to placement in the facility but did take some persuading from his family.

You are new to the Aboriginal Community Controlled Health Organisation (ACCHO) you work for and have never met Peter, but the other doctors at the ACCHO are well acquainted with his family, having assisted with care of his wife, Helen, in the final years of her life. Peter is a retired tradesman and has two adult children, Robert (aged 45 years) and Lisa (aged 39 years). You are aware that both his children married local Aboriginal people. Robert has four children aged between 15 and 25 years, and Lisa has three children aged between 10 and 19 years. Peter also has one surviving sibling, a sister named Paula, who is 62 years of age. Until recently, Paula resided locally but since the death of her husband has moved away to family living in the Northern Territory. Peter's non-Indigenous wife, Helen, passed away 10 years ago; prior to this he was her carer. Notes indicate she had dementia.

Peter has a history of functional decline and falls. The most recent fall, three months ago, resulted in a hospital stay owing to a head injury. On discharge from hospital, he returned home, but his children, on visiting, found Peter unkempt and soiled, with no food in his kitchen. After assessment it was determined he should be admitted to a care home. Peter's assessment for admission into aged care states that he suffers from mild short-term memory loss and instability on his feet. There is mention that he consumes large amounts of alcohol, but this is not quantified.

Peter has a Webster pack but he has refused to take medication since arriving at the facility. The medications in the Webster pack are listed as digoxin, sertraline and paracetamol. The staff at the facility have asked you to see him as he has become 'agitated' over the past 24 hours.

Question 1 

How would you go about obtaining a history from this agitated patient and what key questions would you ask?

Question 2 

What are the potential causes for Peter's agitation?

Further information

You attempt to obtain a history from Peter but find his answers incoherent. He is mildly verbally aggressive. You note a tremor of the hands. You are unable to contact Robert, Peter's next-of-kin, so instead you talk to Lisa to discuss Peter's history and uncover salient information to accompany the information in his medical records.

From Lisa:

- Since his wife passed 10 years ago, Peter has been drinking heavily. This has been the source of many family arguments. Lisa is unable to quantify his alcohol intake but states his falls were largely owing to intoxication.
- Lisa states the reason for his heavy drinking is depression following death of his wife; before her death he would drink socially but not every day.
- Peter's other child, Robert, does not agree Peter has a problem with alcohol. Robert is a heavy drinker himself.
- Peter was found on the floor of his kitchen three months ago and diagnosed with a concussive head injury. He was given 'medicine' for alcohol withdrawal in hospital and discharged with carer support (Robert, who is unemployed) and advice to abstain from drinking.

- Peter had been determined to go home following hospital admission and was supported by Robert. Cleaners were scheduled to attend to his house weekly.
- Almost immediately upon discharge, Peter had commenced drinking again, often with his son, Robert.
- Other than increasing frailty and unsteadiness, Peter is in reasonably good physical health. His memory has been declining slowly, but he has been assisted by family, who check on him twice a day. Robert lives locally.
- He has had a number of falls over the past 12 months, most of them minor, until three months ago when he suffered a head injury.

Salient Aged Care Assessment Team (ACAT) assessment details are as follows:

- lives in a single-storey two-bedroom home; there is access to running water, electricity and adequate food storage
- increasing problems with short-term memory
- unable to complete daily tasks such as washing, dressing and eating without prompting and reminding
- alcohol intake is above recommended levels
- family are local but do not live at home with Peter
- high falls risk, very unsteady on feet, forgets to use walking aids.

From your records:

- infrequent attender
- diagnosed atrial fibrillation 12 months ago, prescription filling has been inconsistent
- diagnosed osteoarthritis in 2004, managed with standard dose paracetamol
- diagnosed with depression in 2003, consistent with the timing of his wife's diagnosis of Alzheimer's dementia.
- medication history:
 - current
 - digoxin 0.125 mg daily
 - sertraline 50 mg daily
 - paracetamol 1 g four times a day
 - previous
 - warfarin (discontinued 18 months ago owing to falls risk, following a fall at home)
 - citalopram (switched to sertraline owing to ineffectiveness in 2010)
- alcohol history:
 - infrequent attender to clinic, most recent documentation on alcohol is from most recent visit >1 year ago

- Feedback, Listen, Advice, Goals, Strategies (FLAGS) brief intervention was performed to address drinking
- drinking recorded as eight cans of beer daily, occasionally drinks rum and cask wine in addition
- no previous admissions to hospital for alcohol withdrawal
- no alcoholic seizures noted previously
- blood test results:
 - most recent blood tests noted from one year ago at time of atrial fibrillation diagnosis
 - full blood count
 - haemoglobin 120 g/L (male reference range: 135–175 g/L)
 - white cell count $7.9 \times 10^9/L$ (reference range: $4.0\text{--}11.0 \times 10^9/L$)
 - platelets $160 \times 10^9/L$ (reference range: $150\text{--}400 \times 10^9/L$)
 - mean corpuscular volume 111 fL (reference range: 80–100 fL)
 - haematocrit 40% (male reference range: 40–54%)
 - liver function tests:
 - gamma-glutamyl transferase 85 U/L (male reference range: 5–50 U/L)
 - alanine aminotransferase 90 U/L (male reference range: 5–40 U/L)
 - aspartate transaminase 60 U/L (male reference range: 5–35 U/L)
 - alkaline phosphatase 100 U/L (reference range: 30–110 U/L)
 - bilirubin 17 $\mu\text{mol/L}$ (reference range: 3–20 $\mu\text{mol/L}$)
 - albumin 28 g/L (reference range: 35–55 g/L)
 - magnesium 0.6 mmol/L (reference range: 0.7–1.10 mmol/L)
 - urea and electrolytes:
 - estimated glomerular filtration rate 70 mL/min/1.73 m² (reference range: >90 mL/min/1.73 m²)
 - creatinine 170 $\mu\text{mol/L}$ (male reference range: 60–110 $\mu\text{mol/L}$)
 - urea 9 mmol/L (reference range: 3–8 mmol/L)
 - potassium 3.9 mmol/L (reference range: 3.5–5.2 mmol/L)
 - sodium 133 mmol/L (reference range: 135–145 mmol/L).

Examination findings

Cardiovascular system:

- atrial fibrillation (clinically, not confirmed by electrocardiogram), heart rate 110 bpm
- no murmurs
- blood pressure 150/95 mmHg
- slightly diaphoretic
- temperature: 38.5°C, tympanic thermometer.

Respiratory system, gastrointestinal system:

- no abnormalities detected
- no stigmata of chronic liver disease apparent
- liver edge palpable with normal apparent size and texture, no splenomegaly
- no asterix or hepatic fetor.

Neurological:

- bilateral tremor
- confused, unable to co-operate with mental state examination
- speech is slurred, incoherent
- no evidence of recent head injury
- pupils equal and reactive to light, no nystagmus
- response to visual hallucinations
- moving all four limbs spontaneously, normal facial symmetry, no obvious spatial neglect.

General appearance:

- bilateral skin tears and bruising on his legs; thin, dry skin on legs
- dirt under fingernails
- vague smell of body odour, alcohol and urine
- poor dentition.

Question 3 

What are your differential diagnoses? Are there any tests you can do now?

Question 4 

How would you like to proceed?

Further information

Using a convene and a bit of patience, you manage to obtain a urine sample from Peter. You find the following:

- protein ++
- blood ++
- leucocytes ++
- nitrites +
- blood glucose 3.6 mmol/L (reference range 3.9–5.5 mmol/L)
- oxygen saturation 97% on air.

These findings indicate a urinary tract infection (UTI). A UTI is very common in people with heavy alcohol misuse and thus, although an important finding, does not rule out alcohol withdrawal as another cause for Peter's symptoms.¹

Question 5 

What are the key presenting features of alcohol withdrawal? What symptoms warrant hospital management and why?

Question 6

What is your immediate management for Peter?

Further information

Peter's son, Robert, is also your patient, whom you see regularly about his back pain. Following his father's hospitalisation, Robert comes to see you to discuss his alcohol intake. 'I don't want to go through that, like my old man ... but I don't know how to stop.'

Question 7

How will you assess Robert's alcohol intake and support him in reducing this?

CASE 3 Answers

Answer 1

First seek to obtain history directly from the patient. If you are uncertain about their mental state or orientation, consider using a tool such as the Mini Mental State Examination – further guidance can be found in The Royal Australian College of General Practitioners' (RACGP's) *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people*, 3rd edition, in the chapter focusing on dementia.²

If this is problematic or unobtainable, seek collateral history from other sources, such as:

- family members or next of kin
- medical records
- the discharging team from his recent discharge
- staff at the facility
- ACAT assessment notes.

It would be prudent to discuss with an appropriate Aboriginal Health Worker (AHW) to advise further on obtaining a collateral history. When engaging with AHWs it is important to recognise their central role in the primary healthcare workforce. AHWs can act as communicators on the behalf of clients and healthcare workers.³ AHWs are generally employed by ACCHOs to act as 'cultural brokers' and community educators.⁴ In addition to medical history, a psychosocial history will be important.

In seeking further history about Peter, you may wish to consider the reasons for admission to an aged care facility. It will also be helpful to understand more about the nature of the falls, as well as any evidence of preceding decline in memory and cognition, or drug and alcohol use.

Answer 2

When assessing agitation, it is important to consider a broad range of medical, social-environmental and psychiatric causes.

Consider the following causes:

- psychological distress
 - a reaction to distressing circumstances (eg dislocation, lack of cultural safety, negative associations with institutionalisation)
 - psychological illness (eg depression, post-traumatic stress disorder)
- delirium – possible triggers might include:
 - infection, including sepsis
 - pain (eg urinary retention), medication or substance use (initiation, interactions, withdrawal)
 - change in routine and environment
 - lack of sensory aids (hearing aids, glasses)
- metabolic derangement
 - electrolyte imbalance
 - abnormal blood glucose
 - acute kidney injury
 - hepatic encephalopathy or Wernicke's encephalopathy
 - alcohol poisoning/withdrawal
 - carbon monoxide poisoning
 - hypoxia

- neurological insult
 - stroke/transient ischaemic attack
 - traumatic brain injury
- behavioural and psychological symptoms of dementia.

Answer 3

From your examination you note that Peter is febrile and diaphoretic, with evidence of poor self-care. He has a tremor and appears to be hallucinating. He is in atrial fibrillation as expected from his history.

In combination with the history acquired, these examination findings suggest the most likely causes for Peter's presentation would include:

- alcohol withdrawal/delirium tremens – Peter is suffering from confusion, agitation and other symptoms observed in alcohol withdrawal (this is discussed in detail later in the case study)
- delirium secondary to infection – Peter has signs of a possible UTI and mild fever. It is possible Peter has a UTI superimposed on alcohol withdrawal, or as an independent cause of confusion
- metabolic disturbance secondary to dehydration/malnutrition – If Peter is not hydrating adequately owing to confusion (possibly from alcohol withdrawal or infection), it is possible dehydration and subsequent metabolic disturbance is adding to his clinical picture
- stroke/transient ischaemic attack – Given Peter's age, it would be prudent to consider a neurological assessment for signs of stroke, particularly in the setting of known atrial fibrillation
- subacute head injury (subdural haematoma) – Peter has a history of falls, so it is possible he has had another witnessed or unwitnessed fall and sustained a head injury.

Peter is at high risk of misdiagnosis as an Aboriginal male with a history of alcohol misuse. It is imperative to consider all possible diagnoses and rule out other causes for his confusion and agitation, while still considering that alcohol withdrawal is a likely diagnosis.

Answer 4

A urine dip, blood glucose test and pulse oximetry are easy bedside tests to gain more information and help assess some of the causes of confusion, such as low blood glucose, UTI and pneumonia/other causes of low oxygen saturations. Blood tests should also be requested; however, these will not assist with immediate diagnosis, and you should consider if Peter will require hospital admission where further tests will be performed.

Answer 5

Symptoms of alcohol withdrawal include:^{5,6}

- restlessness

- anxiety
- panic attacks
- tachycardia
- diaphoresis
- dilated pupils
- nausea and vomiting
- tremor
- delirium tremens
 - agitation, inattention, disorientation
 - hallucinations
 - gross tremors and incoordination
 - seizures.

Minor alcohol withdrawal occurs 6–12 hours after the most recent alcoholic drink and presents with anxiety, tremor, insomnia, nausea and vomiting.⁷ This may progress to major alcohol withdrawal, or 'alcoholic hallucinosis', which can include visual and auditory hallucinations, hypertension and diaphoresis.⁷

Alcohol withdrawal seizures may occur 6–48 hours after the most recent alcoholic drink; they are usually generalised and brief and in 50% of cases will be a single seizure only.^{6,7} Alcohol withdrawal seizures require admission to hospital for immediate high-level medical care.

Alcohol withdrawal delirium or 'delirium tremens' is the most severe form of alcohol withdrawal. Onset is usually 72–96 hours after the most recent alcoholic drink.⁶

Management of alcohol withdrawal requires admission to hospital. It is a medical emergency; the mortality rate is high (5–15%) and early recognition and management is vital as alcohol withdrawal is rarely uncomplicated. In this case, suspicion of alcohol withdrawal-related delirium warrants further investigation and admission to hospital for management of withdrawal concurrently with management of UTI and assessment regarding the significant past medical history of atrial fibrillation and recurrent falls. Alcohol withdrawal is frequently associated with infection, metabolic disturbances and encephalopathies.⁶ The most common causes of mortality are cardiac arrhythmias and respiratory failure.⁸

Answer 6

Your history and examination findings lead you to suspect Peter is suffering from alcohol withdrawal with possible delirium tremens, which is likely exacerbated by UTI and hypoglycaemia.

You recognise that delirium tremens is a life-threatening condition that should always be managed in a hospital setting, and arrange an ambulance transfer. You could consider writing a letter for the hospital doctors including the results from the urinary analysis, to alert them to the possibility of a UTI.

While awaiting retrieval, you may wish to treat Peter's hypoglycaemia – remembering to administer thiamine (for example, 300 mg thiamine intramuscular) prior to any glucose to avoid precipitating acute Wernicke's encephalopathy.⁶

It would also be prudent to contact an addiction specialist for advice on immediate management while awaiting Peter's transfer to the emergency department.

Answer 7

The first step will be to assess whether Robert may have alcohol dependence, as well as any complications or comorbidities. Take a full alcohol history, including asking:

- How often do you drink?
- How much do you drink?
- Who are you with when you drink?
- Where do you drink?
- What age did you start drinking?
- Have you had previous treatments for alcohol use?

In addition, it is important to assess whether there is a history of problems related to alcohol consumption, such as:

- acute intoxication – driving offences, victim/perpetrator of violence
- medical complications
- withdrawal complications
- signs of alcohol dependence.

Alcohol dependence is defined as craving, preoccupation with and tolerance of drinking alcohol despite knowledge or existence of harmful consequences.⁷ Criteria for diagnosis of alcohol dependence are given in Box 1. Patients with moderate and severe dependence require medical assistance with alcohol withdrawal, in a hospital setting for those showing signs of severe dependence.⁷

Box 1: Criteria for alcohol dependence¹⁴

Three or more of the following:

- a strong desire or sense of compulsion to drink
- difficulties in controlling alcohol intake
- a physiological withdrawal state when substance use has ceased or been reduced
- evidence of tolerance
- progressive neglect of alternative pleasures or interests
- persisting with substance use despite clear evidence of overtly harmful consequences.

Reproduced with permission from World Health Organization. The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines. Geneva: WHO, 1992; p. 70. Available at www.who.int/classifications/icd/en/bluebook.pdf [Accessed 16 May 2019].

For Robert, it may be useful to engage in some motivational interviewing and brief interventions. Explore his motivations and barriers for change and enquire as to what supports he would feel comfortable accessing. Consider the need for medically supervised withdrawal. Robert may wish to engage with an AHW or mental health worker. For further, detailed information, refer to the *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people*, 3rd edition.¹

Assessment

The salient points in assessing someone for alcohol withdrawal include:^{7,9}

- a thorough assessment of alcohol intake as well as any other substance use
- previous withdrawal symptoms, including complications such as seizures, confusion, delirium
- full medical and psychiatric history, as well as mental state examination including assessment of risk and suicidality
- physical examination, looking for signs of acute alcohol withdrawal or complications such as chronic liver disease
- laboratory investigations, such as full blood evaluation; urea, electrolytes and creatinine; liver function tests and urine drug screen where indicated
- psychosocial assessment.

Where alcohol dependence is identified, consideration needs to be given to whether it is safe for the patient to attempt withdrawal at home. Features indicating a person may not be suitable for withdrawal management at home include:^{10,11}

- history of alcohol-related seizures or delirium tremens
- risk of suicide
- inadequate availability of social support such as lack of family or friends or any requirement for daily care or supervision
- polypharmacy misuse or dependence on benzodiazepines or other substances
- severe liver disease
- advanced age.

Management at home commonly includes use of benzodiazepines in tapering doses over 5–7 days, administered with close supervision in case of relapse. Supplementation of thiamine is routine. Post-withdrawal care plans are essential to reduce the risk of relapse and may include both medication and non-medical therapies.^{9–11} It is important that any home management is discussed with an addiction specialist.

Non-medical therapies may include: local support groups (via the Aboriginal Medical Service), Men's Shed for Aboriginal men, Alcoholics Anonymous and one-on-one counselling.

Clinical support via guidelines as well as remote collaboration with Addiction Medicine Specialists is available in several

states via the Drug and Alcohol Clinical Advisory Service (www.dacas.org.au).

Cultural sensitivity when managing alcohol dependence with Aboriginal and Torres Strait Islander peoples

The *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people*, 3rd edition, provides information on cultural sensitivity when managing alcohol dependence in Aboriginal and Torres Strait Islander populations.¹ It should be noted that Aboriginal and Torres Strait Islander peoples are less likely to drink alcohol than the non-Indigenous population, but the prevalence of harmful drinking is greater.¹² Alcohol use is closely linked with poverty and disadvantage; Aboriginal and Torres Strait Islander incomes are on average significantly lower than those of non-Indigenous Australians. Additionally, the stress linked with over-crowding and childhood adversity is also associated with an increased likelihood of risky drinking. Finally, racism and mental health problems further increase risk, and all must be considered when addressing alcohol intake in Aboriginal and Torres Strait Islander peoples. These can be considered in three streams: social and cultural support, psychological therapy and medical treatment.¹³ The social, cultural and historical factors are important to remember when assessing and treating risky drinking in Aboriginal and Torres Strait Islander peoples.

Social and cultural support is provided by Aboriginal and Torres Strait Islander health workers, care managers and social workers. Support includes: advocacy, social/cultural support, brief interventions and case management. Psychological therapy is provided by psychologists and mental health-accredited social workers and can include cognitive behavioural therapy, brief interventions and motivational interviewing.¹³

Resources for doctors

- National Aboriginal Community Controlled Health Organisation and The Royal Australian College of General Practitioners, *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people*, 3rd edn, www.naccho.org.au/wp-content/uploads/National-guide-3rd-ed-web-final.pdf
- The Royal Australian College of General Practitioners, *Prescribing of drugs in general practice, part B – Benzodiazepines*. East Melbourne: RACGP, 2015.
- The Royal Australian College of General Practitioners, *Alcohol withdrawal*, www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/prescribing-drugs-of-dependence/prescribing-drugs-of-dependence-part-b/evidence-based-guidance-for-benzodiazepines/alcohol-withdrawal
- Drug and Alcohol Clinical Advisory Service, www.dacas.org.au

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CASE

4 | Maria feels more short of breath than usual

Maria, aged 40 years, has been feeling more breathless and coughing a lot recently. Maria is an Aboriginal woman, originally from northern NSW, who tells you she has been living in the area of your outer metropolitan practice for 10 years. Although you have not seen her personally, you note she has attended your practice a couple of times previously. She works in administration at a local hospital and lives with her partner and teenage son.

Maria tells you she bought a salbutamol inhaler from the pharmacy on her friend's recommendation and has been using it several times per day in the past three months. She reports coughing most days, sometimes bringing up phlegm. She has not worried too much about that, as she believes it to be expected given her smoking history. She tells you she has had a persistent cough for more than a year and has smoked approximately 20 cigarettes per day since she was approximately 13 years of age. In the past she smoked marijuana as well as tobacco, but now smokes only tobacco. She describes getting more puffed than her friends when walking up stairs and hills.

You review Maria's file and reread the discharge summary from her emergency department presentation with chest pain three months ago. You note that she was then seen in the Rapid Access Cardiology Clinic and went on to have a normal chest X-ray (CXR) and stress echocardiogram. The cardiology team advised that she did not need follow-up with them, but she needed to modify her lifestyle and give up smoking. She reports that she has managed to cut back her smoking a bit, but observes her breathlessness and coughing makes exercise difficult.

Question 1

What is the likely diagnosis? What further assessment would you consider at this point?

Further information

Physical examination is normal. The spirometry test confirms that Maria has airflow limitation because the ratio of the forced expiratory volume in one second (FEV₁) to the forced vital capacity (FVC) is <0.7, and the FEV₁ <80% predicted, and this persists post-bronchodilator. You diagnose chronic obstructive pulmonary disease (COPD), of mild severity. You discuss treatment options. Given she has mild COPD with ongoing symptoms despite use of a short-acting bronchodilator, you provide Maria with a script for tiotropium 18 mcg via inhaler. You ensure she knows how to correctly use this and her salbutamol inhaler. You also ensure she is aware of her eligibility for Closing the Gap Pharmaceutical Benefits Scheme scripts, to increase the affordability of her medications.

Question 2

Maria asks whether this medication will stop her condition from getting worse. How will you answer Maria?

Further information

Maria says she is surprised that you did not do routine spirometry at the Aboriginal health assessment she had a couple of years ago, considering she is a smoker.

Question 3

How do you respond to Maria? What are the screening recommendations for COPD?

Question 4 

You decide to review Maria's immunisation status, given her new diagnosis. What immunisations are recommended for Maria?

CASE 4 **Answers****Answer 1**

Exertional dyspnoea can be due to several causes, with poor fitness (often associated with obesity), heart and lung disease all common causes. You are concerned that Maria may have lung disease, especially asthma or COPD, as the cause of her dyspnoea. Given Maria's smoking history, cough and sputum, normal CXR and stress echocardiogram, this is a likely diagnosis. Other less common lung conditions to consider would include bronchiectasis, chronic infections (including tuberculosis), interstitial lung disease and lung cancer.

Your assessment will include further history. In particular, given the frequent co-existence of heart and lung disease, it is important to review the result of the stress echocardiogram in detail to ensure it is indeed normal. Given the increased risk of lung cancer in Aboriginal and Torres Strait Islander people,¹ it would also be important to enquire about haemoptysis and weight loss.

The first step in assessment is to undertake a physical examination followed by spirometry. Spirometry is used to diagnose COPD by determining the presence of airflow limitation that is not fully reversible.² A ratio of the FEV₁/FVC <0.7 with an FEV₁ <80% predicted is consistent with airflow limitation. The FEV₁ in comparison with the predicted value also provides a measure of the severity of airflow limitation. If this airflow limitation is not fully reversible following the use of a short-acting bronchodilator (eg salbutamol), this is consistent with a diagnosis of COPD.² If it is partially, but not fully, reversed, consider a combination of COPD and asthma (termed asthma/COPD overlap). There is no need to perform a computed tomography scan of the lungs.

As well as heart disease and lung cancer, COPD is commonly associated with other diseases, including obstructive sleep apnoea, stroke, anxiety and depression.

These conditions should also be actively identified and carefully managed.¹ It will be important to organise follow-up with Maria to undertake mental health screening and a preventive health check.

Answer 2

You advise Maria that inhaled medications provide symptom relief, an initial increase in lung function, improvement in quality of life and prevention of exacerbations of COPD.²⁻⁵ Unfortunately, they have not been shown to modify the steady decline of lung function (the hallmark of COPD) despite their valuable role in improving function and decreasing complications.

It is important to discuss with Maria that she can reduce the progression of COPD by giving up smoking. General practitioners (GPs) have a crucial role in providing brief interventions, motivational interviewing and medications to assist patients to quit smoking. Furthermore, as her GP, you are ideally placed to explore with her the resources available to assist her to quit.² These include support services (ie Aboriginal Quitline in Victoria, which can also be accessed from outside Victoria) as well as referral for individually targeted allied health services. Medicare Benefit Schedule funding is available for up to five allied health services per year following a health assessment for people of Aboriginal and Torres Strait Islander descent; this is in addition to services available through chronic disease management plans.⁶

It is also important to consider Maria's exposure to environmental risk factors for COPD – such as passive smoking, fumes, gases, occupational dusts and chemicals, and indoor and outdoor air pollutants – and discuss the importance of minimising this.³

Answer 3

In Maria's case, spirometry was indicated today because she had symptoms of COPD.

There is a lack of evidence to support population-level screening for COPD, and screening of asymptomatic individuals is not recommended.⁷ However, early detection of COPD is beneficial, and so a targeted early case-finding approach in primary care is recommended.^{5,8} The possibility of COPD should be actively considered in all smokers and ex-smokers over the age of 35 years. If there is clinical suspicion, opportunistic checking for symptoms of COPD should be undertaken, followed by spirometry if warranted.^{2,5} Aboriginal health assessments provide a good opportunity for this.

COPD symptom questionnaires are useful for practice-led COPD case finding.⁹ The Lung Health Checklist available through the Lung Foundation Australia may assist (<https://lungfoundation.com.au/checklist/>).

Answer 4

Maria would benefit from annual influenza vaccination, as well as pneumococcal vaccination.^{2,3} There is strong evidence for the use of pneumococcal vaccine to prevent lower respiratory tract infections in people with severe COPD.³

Current immunisation guidelines for Aboriginal and Torres Strait Islander people recommend:¹⁰

- four childhood doses of pneumococcal vaccine 13vPCV (additional dose at six months of age) in certain states
- pneumococcal vaccination 23vPPV from age 50 years (compared with age 65 years for non-Indigenous Australians), with a second dose five years after the first.

Additionally, pneumococcal vaccination (polyvalent covering 23 virulent serotypes) is also recommended for all Aboriginal and Torres Strait Islander peoples over 15 years of age who are medically at risk of pneumococcal infection, which includes people with chronic lung disease as well as tobacco smokers.¹⁰

Resources for doctors and patients

- Lung Foundation Australia, <https://lungfoundation.com.au/>
- Lung Foundation Australia Indigenous COPD action plan, <https://lungfoundation.com.au/wp-content/uploads/2018/09/Information-paper-COPD-Action-Plan-Indigenous-Jul2013.pdf>
- Australian Indigenous HealthInfonet respiratory health, <https://healthinfonet.ecu.edu.au/learn/health-topics/respiratory-health/resources/>
- The COPD-X Plan: Australian and New Zealand Guidelines for the management of Chronic Obstructive Pulmonary Disease 2018, www.copdx.org.au
- Pulmonary rehabilitation toolkit: Breathe easy, walk easy, <https://healthinfonet.ecu.edu.au/key-resources/resources/21672/?title=Pulmonary%20rehabilitation%20toolkit%3A%20breathe%20easy%2C%20walk%20easy>

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ACTIVITY ID 158903**Preventive health for Australia's First Peoples**

This unit of *check* is approved for six Category 2 points in the RACGP QI&CPD program. The expected time to complete this activity is three hours and consists of:

- reading and completing the questions for each case study
 - you can do this on hard copy or by logging on to the *gplearning* website, <http://gplearning.racgp.org.au>
- answering the following multiple choice questions (MCQs) by logging on to the *gplearning* website, <http://gplearning.racgp.org.au>
 - you must score $\geq 80\%$ before you can mark the activity as 'Complete'
- completing the online evaluation form.

You can only qualify for QI&CPD points by completing the MCQs online; we cannot process hard copy answers.

If you have any technical issues accessing this activity online, please contact the *gplearning* helpdesk on 1800 284 789.

If you are not an RACGP member and would like to access the *check* program, please contact the *gplearning* helpdesk on 1800 284 789 to purchase access to the program.

Case 1 – Lyn

Lyn is an Aboriginal woman, aged 41 years, who has come to see you for a general health check. She has attended your practice previously but was seen by one of the other doctors. Lyn mentions that she has not been feeling herself lately, following the death of a close relative, who was an important Elder in her community. In addition to her general health check, you consider assessing Lyn's general mental health.

Question 1

Which one of the following resources is suitable for using with Aboriginal and Torres Strait Islander patients, to assess wellbeing and connectedness to people and country?

- A. Universal screening
- B. Patient Health Questionnaire
- C. Growth and Empowerment Measure
- D. Pearlin Mastery Scale

Further information

You determine that Lyn would benefit from referral to a psychologist, to assist with grief counselling following the death of her relative.

Question 2

Following a health assessment for people of Aboriginal and Torres Strait Islander descent, what is the maximum number of Medicare Benefit Schedule-funded allied health services per year?

- A. Two
- B. Three
- C. Four
- D. Five

Case 2 – Jenny

Jenny, an Aboriginal woman aged 25 years, comes to see you complaining of feeling tired and gaining weight. She also says she has been vomiting most mornings. You ask about Jenny's sexual history and she tells you that she does not have a boyfriend but recently met a man at a party and has had unprotected sex with him a couple of times. You suspect Jenny may be pregnant and arrange full antenatal screening. You are aware there has been an increase in cases of syphilis in the local Aboriginal community, and you are concerned Jenny may have a sexually transmissible infection.

Question 3

Primary syphilis is characterised by which one of the following symptoms?

- A. Mucous patches in the mouth
- B. Painless, firm, open sore
- C. Rash on the palms of hands
- D. Muscle pain

Further information

Antenatal screening confirms Jenny's pregnancy. Jenny is worried she may have syphilis and how this may affect her baby.

Question 4

Adequate treatment in pregnancy is defined as:

- A. rapid plasma reagin (RPR) returning to negative
- B. a two-fold titre drop in RPR four weeks before delivery
- C. a four-fold titre drop in RPR four weeks before delivery
- D. a one titre drop in RPR eight weeks before delivery.

Question 5

Which one of the following is **not** a potential outcome of syphilis in pregnancy?

- A. Perinatal mortality
- B. Neonatal infection
- C. High birthweight
- D. Premature birth

Case 3 – Bill

Bill, aged 65 years, is an Aboriginal man who has been brought into the clinic to see you by his nephew. Bill's nephew is concerned about Bill's alcohol consumption and is worried that it is contributing to Bill's poor health.

Question 6

Which one of the following is a symptom of minor alcohol withdrawal?

- A. Acute hypertension
- B. Hallucinations
- C. Insomnia
- D. Diaphoresis

Further information

You are concerned that Bill's symptoms may be an early sign of major alcohol withdrawal.

Question 7

Onset of alcohol withdrawal delirium or 'delirium tremens' usually occurs at which one of the following time points after the most recent alcoholic drink?

- A. 1-12 hours
- B. 13-23 hours
- C. 24-48 hours
- D. 72-96 hours

Question 8

Which of the following is **not** a potential cause of chronic risky alcohol consumption in Aboriginal and Torres Strait Islander people?

- A. Lack of income
- B. Genetic predisposition
- C. Parents were members of the Stolen Generation
- D. Experiencing racism at work

Case 4 – Nancy

Nancy, aged 43 years, has come to you complaining of feeling out of breath when active. Nancy is not overweight, but she is a long-term smoker, having smoked a pack of cigarettes a day since her mid-teens. Nancy coughs regularly during her appointment and says this bothers her as she often brings up phlegm when she coughs. You consider spirometry screening for Nancy to assess her lung function.

Question 9

For which of the following groups is spirometry screening recommended?

- A. All smokers
- B. Ex-smokers aged over 35 years
- C. Individuals with symptoms of COPD
- D. Asymptomatic individuals, at the discretion of their general practitioners

Question 10

What is the highest forced expiratory volume (FEV₁)/forced vital capacity (FVC) that is consistent with airflow limitation?

- A. 89%
- B. 79%
- C. 69%
- D. 59%

check

Independent learning program for GPs