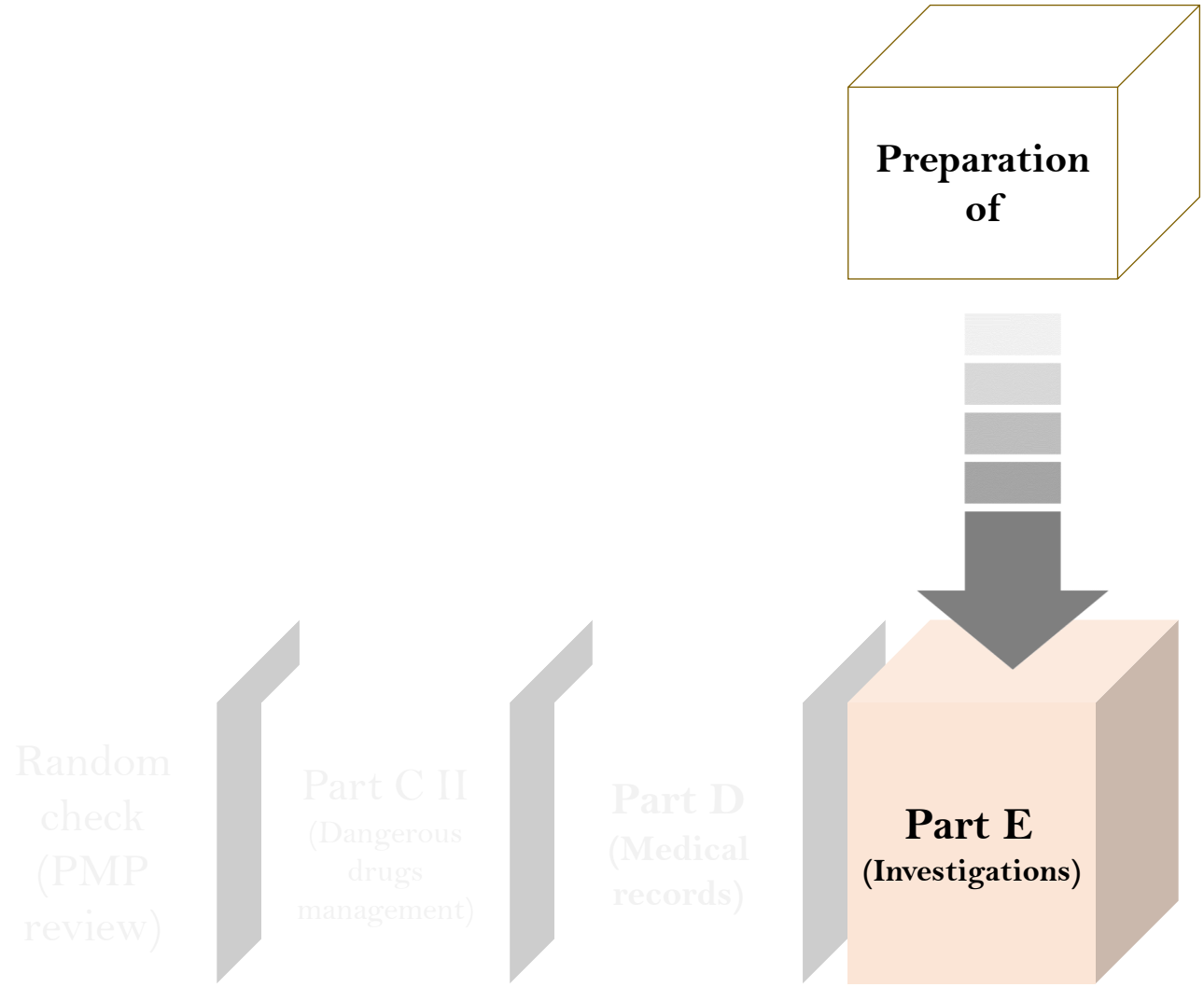
Prepare for Part E (investigation) Practice Assessment Exit Exam

3 March 2023

Practice Assessment consists of 4 Parts

- **Random check (PMP review)**
- **Part C II** (Dangerous drugs management)
- **Part D** (Medical records)
- **Part E** (Investigations)


Preparation of
Part E
(Investigations)
Part D
(Medical records)
Part C II
(Dangerous drugs management)
Random check
(PMP review)

Process of PA

1. Prepare for the examination
2. Submit required PA Document at Exam Application
3. Examiners will visit the candidate on a designated **exam date**

   to conduct PA –which consist of:

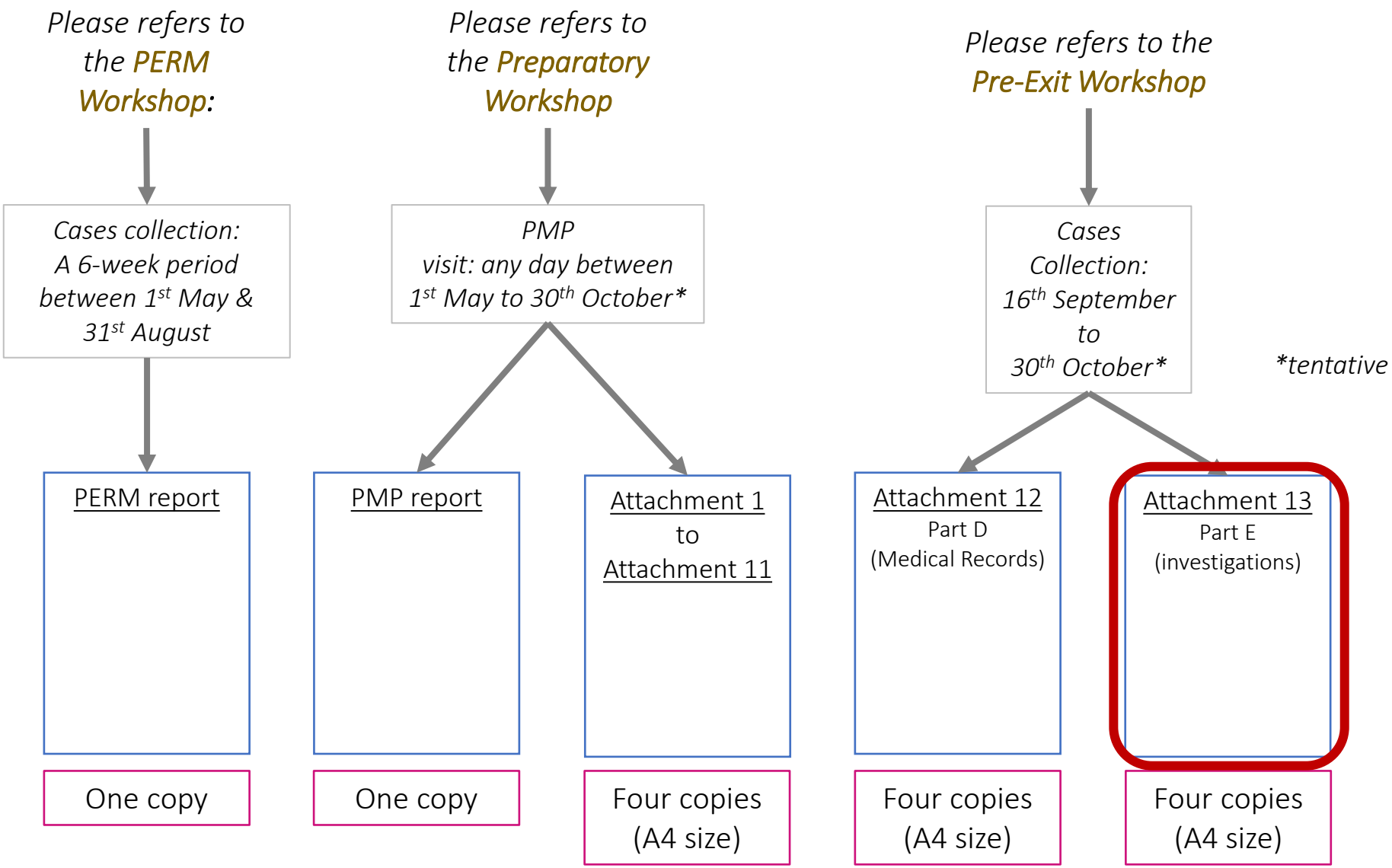
   Random check (on PMP)

   Part CII (Dangerous drugs management)

   Part D (Medical records)

   Part E (Investigations)
4. Results announcement
5. Post Examination evaluation

PA Document


Please refers to the PERM Workshop:
Cases collection: A 6-week period between 1st May & 31st August
PERM report
One copy
Please refers to the Preparatory Workshop
PMP visit: any day between 1st May to 30th October*
PMP report
One copy
Attachment 1 to Attachment 11
Four copies (A4 size)
Please refers to the Pre-Exit Workshop
Cases Collection: 16th September to 30th October*
*tentative
Attachment 12 Part D (Medical Records)
Four copies (A4 size)
Attachment 13 Part E (investigations)
Four copies (A4 size)

Attachment 13

Case summaries & a summary Table of medical records of ten patients

2023 Exit Exam

The patients

- **Had investigations ordered and followed up by you** during the **cases collection period** **(six-week; mid-September to end of October)**
- Can come from more than one clinic; however, all the medical records must be available at the Exam venue on the Exam day

The date you first see the patient and order investigations

Can be

- before OR within the cases collection period

Follow up of the investigations

Must

- **Occur within the cases collection period**
- be **documented by the candidate** on the medical records

Can be

in the form of:

- Face to face consultations ; *if not feasible*,
- Telephone / electronic communications

Types of cases submitted for PA (Part E)

For individual case

Can be

- Patient's complaint(s) in episodic/ regular visit
- Monitoring of existing / chronic medical condition

Cannot be, solely, for following situation:

- Health screening / Medical assessment
- Monitoring of potential side effects of medication / treatment in asymptomatic patients,
  e.g. RFT after using ACEI; Blood liver enzymes after statins; CBP to screen neutropenia on carbimazole
- where consensus existed among assessors (PA Examiners) that investigation is not necessary, **the only current example**:
  Urine routine microscopy / culture in female uncomplicated cystitis

Types of cases submitted for PA (Part E)

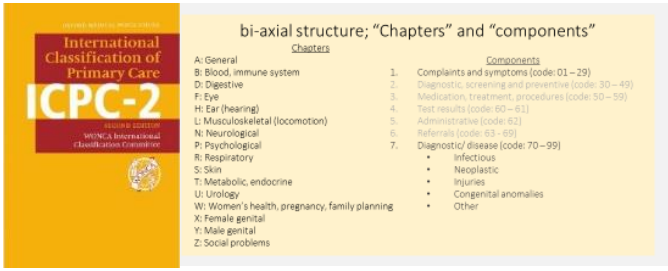
Cases must be a mix of clinical problems (i)

Must

follow the regulations listed below:

For each case

- give **one** ICPC-2 code to the Provisional diagnosis / main condition that necessitate the investigation(s); e.g. T90, R74
- show the code on your Case Summaries and the Summary Table (Attachment 13)



Suggest:
code according to the 'body / system' as possible

Types of cases submitted for PA (Part E)

Cases must be a mix of clinical problems (ii)

Must

follow the regulations listed below:

Among the ten cases

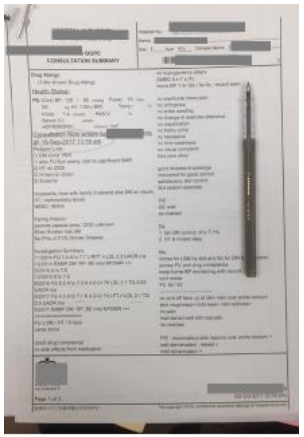
- No more than two cases should be the same **ICPC - 2 "Chapter" (the alphabet)**
- No more than one T-90 (type II diabetes mellitus) is allowed
- No more than one K-86 (uncomplicated hypertension) is allowed

For 2023 Exit Exam;
These regulations are under review
Please refer to Pre-Exit Workshop in August for updates

The medical records listed in Attachment 13 (i)

The format

paper



Print-out from computer system

or / with

Handwritten records

on the computer screen

The medical records listed in Attachment 13 (ii)

The content of each medical record for assessment should at least include:

Consultation note
Dr. Candidate

Patient: XXX
M/72
No: GK 123984

1 Sep 2019

- Retired seafarer With wife.
  C/O: progressive poor memory 6/12 .....
- e.g. confused on date/ events...
- .....ADL independent, went out for lunch / market by self...
- Quitted smoking / drinking since retired age 60
- Exercise: nil regularly
- PE: GC sat, normal gait BP 129/78 P 89 euthyroid....
- --- AMT 6/10
- Imp: cognitive impairment/ ? Dementia or MCI
- Mx:
- Brief explain cogn. Impairment with pamphlet
- Bld test (CBC, L/RFT, FBS, Lipids, TFT, Vit B12,folate, VDRL)
- FU 3/52

The first consultation: investigation initiated / ordered

Lab report
Date: 4 Sep 2019

COPY

Consultation note
Dr. Candidate

Patient: XXX
M/72
No: GK 123984

21 Sep 2019

- with wife and daughter today
- Consult. 1/9/ 2019 refers;
- Dementia bld work up (4 Sep 2019):
  CBC, L. RFT, TFT, Vit B12, folate: N; VDRL: no-reactive
- Daughter concerned ....
- Imp: cognitive impairment/ likely MCI
- Mx:
- Suggest SFI CT brain; relatives need time to think about
- Encourage regular social activities / exercise. : e.g. visit nearby elderly community center
- Refer:
- Occ therapist (assessment and training)
- Geri SOPC
- FU 12/52

The follow up: key investigation findings documented; management offered

Referral letter
To: Geriatrics SOPC
Date: 21 Sep 2019

COPY

As applicable according to the follow up management offered

Please note: the consultation notes content are simulated and not implying a standard of pass or fail in the Exam

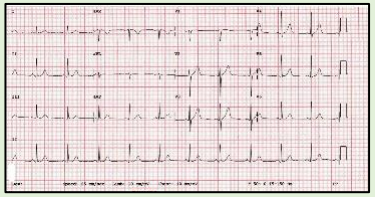
The medical records listed in Attachment 13 (iii)

About the investigation reports:

Lab report
Date: 4 Sep 2019

COPY

Copy of investigation reports can be:

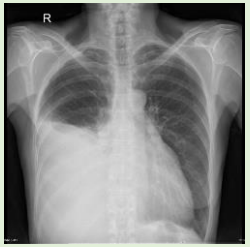


CT scan Report

Ultrasound scan report

X-ray report

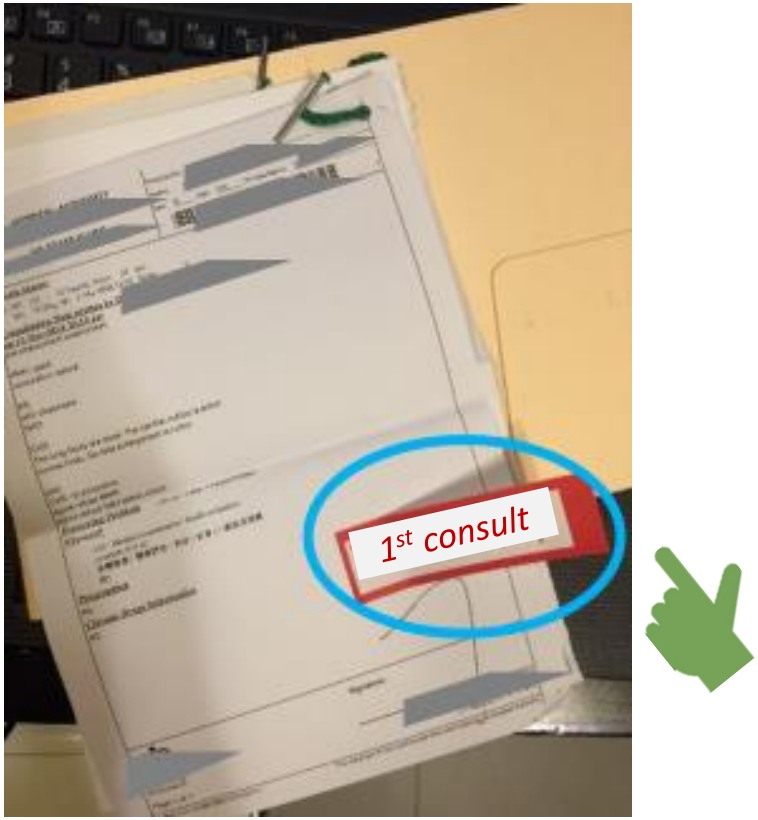
For plain X-Ray: if report not available



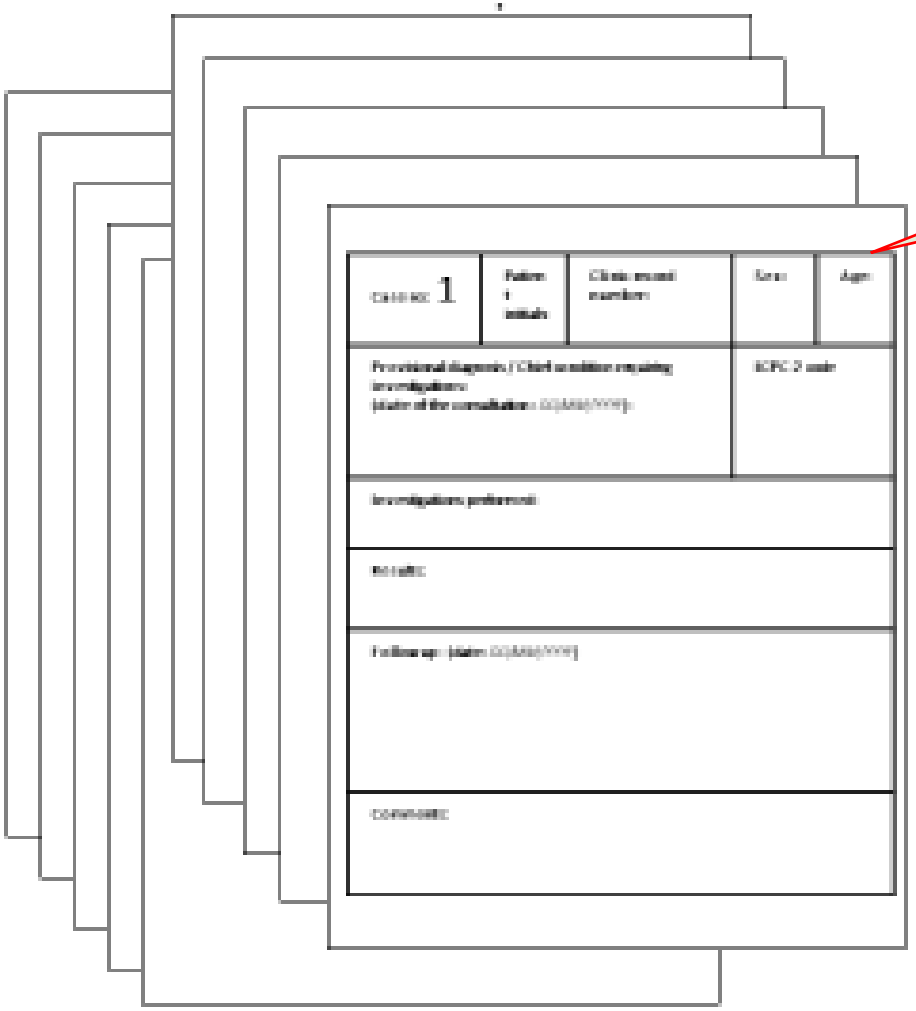
OR

The medical records listed in Attachment 13 (iv)

Suggestions paper flags the pages for Examiners



Attachment 13: Case summary



Standard format

Confidentiality:
Do not include
patient's name, HKID

sample

Sample Case Summary for each patient (Attachment 13)

Case No: *6*	Patient initials: *LKH*	Clinic record number: *GOSY 1810XY21*	Sex: *M*	Age: *83*

Provisional diagnosis / Chief condition requiring investigations:
(date of the consultation: *DD/MM/YYYY*):
Weight loss, ? Bowel pathology
C/O Weight loss 6 to 7 Ib in last 3/12
B O change from daily to once every 3/7
PE GC sat, mild pallor, abd soft non-tender / no mass….PR: empty no mass felt

- Concise summary from the medical record
- Less than 300 words #

ICPC-2 code
T08 (weight loss)

- Appropriate coding
- Also put down description of the code

Investigations performed:
CBC, CEA, thyroid function (TSH), stool Occult blood X 3

Results:
CBC: Hb 9.8 (low), WBC 4.8, Platelet count 345, CEA 2.0 (ref < 3.0), TSH normal, Stool OB +ve X 1

Section(s) grossly exceed the words limit may be blocked and cannot be seen by Examiners

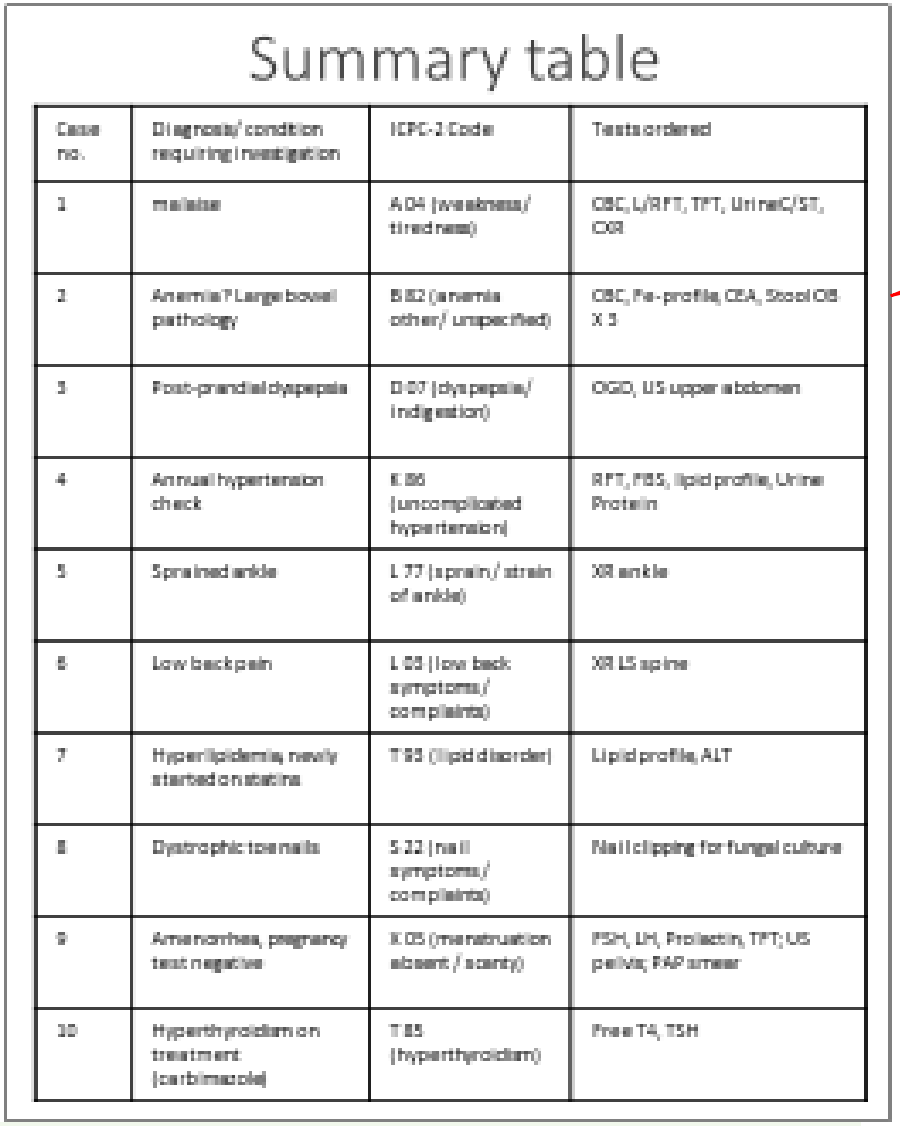
Follow up: (date: *DD/MM/YYYY*)
Results informed
Discussed with patient and daughter…
Mx: referral to Surgical SOPC (seek early appointment)

- Concise summary from the medical record
- Less than 300 words #

Comments:

- Optional; marks will not be deducted for leaving this section blank
- For discussion on investigation justification, limitations of the performance, area of improvement, possible remedial actions
- *clinic protocols, departmental guidelines, literature references, expert opinions; or general summary from the medical record*: to be avoided here
- Less than 300 words #

Attachment 13: Summary Table



Summary table

Case no.	Diagnosis/ condition requiring investigation	ICPC-2 Code	Tests ordered
1	malaise	A04 (weakness/ tiredness)	CBC, L/RFT, TPT, UrineC/ST, CXR
2	Anaemia? Large bowel pathology	B82 (anaemia other/ unspecified)	CBC, Fe-profile, CEA, Stool OB X 3
3	Post-prandial dyspepsia	D07 (dyspepsia/ indigestion)	OGD, US upper abdomen
4	Annual hypertension check	K86 (uncomplicated hypertension)	RFT, FBS, lipid profile, Urine Protein
5	Sprained ankle	L77 (sprain/ strain of ankle)	XR ankle
6	Low back pain	L03 (low back symptoms/ complaints)	XR LS spine
7	Hyperlipidemia, newly started on statins	T93 (lipid disorder)	Lipid profile, ALT
8	Dystrophic toenails	S22 (nail symptoms/ complaints)	Nail clipping for fungal culture
9	Amenorrhea, pregnancy test negative	X05 (menstruation absent / scanty)	FSH, LH, Prolactin, TPT; US pelvis; PAP smear
10	Hyperthyroidism on treatment (carbimazole)	T85 (hyperthyroidism)	Free T4, TSH

Standard format

Confidentiality:
Do not include
patient's name, HKID

sample

Sample Summary table (Attachment 13)

Summary table

Case no.	Diagnosis/ condition requiring investigation	ICPC-2 Code	Tests ordered
1	malaise	A 04 (weakness / tiredness)	CBC, L/RFT, TFT, Urine C/ST, CXR
2	Anemia ? Large bowel pathology	B 82 (anemia other/ unspecified)	CBC, Fe-profile, CEA, Stool OB X 3
3	Post-prandial dyspepsia	D 07 (dyspepsia / indigestion)	OGD, US upper abdomen
4	Annual hypertension check	K 86 (uncomplicated hypertension)	RFT, FBS, lipid profile, Urine Protein
5	Sprained ankle	L 77 (sprain / strain of ankle)	XR ankle
6	Low back pain	L 03 (low back symptoms / complaints)	XR LS spine
7	Hyperlipidemia, newly started on statins	T 93 (lipid disorder)	Lipid profile , ALT
8	Dystrophic toe nails	S 22 (nail symptoms / complaints)	Nail clipping for fungal culture
9	Amenorrhea, pregnancy test negative	X 05 (menstruation absent / scanty)	FSH, LH, Prolactin, TFT; US pelvis; PAP smear
10	Hyperthyroidism on treatment (carbimazole)	T 85 (hyperthyroidism)	Free T4, TSH

Monitoring of possible side effects of medication/ treatment in asymptomatic patients **added**

OK

Health screening **added**

OK

Attachment 13 will be reviewed by the Examiners before the Exam Day

Attachment 13 serves to assist the Examiners

- to have some basic understanding on the ten cases
- to note if the candidate has, if any, special consideration about the investigation ordering and management of the cases

The content of Attachment 13 have to be consistent with the respective medical records

The actual marking will be based on the medical records presented

Carefully choose the cases

Choose cases that show your competency , not weakness

Not sure if the case on hand is good to be presented for Exam?

Choose another case

Exam Day

Part E (Investigations) Rating Form

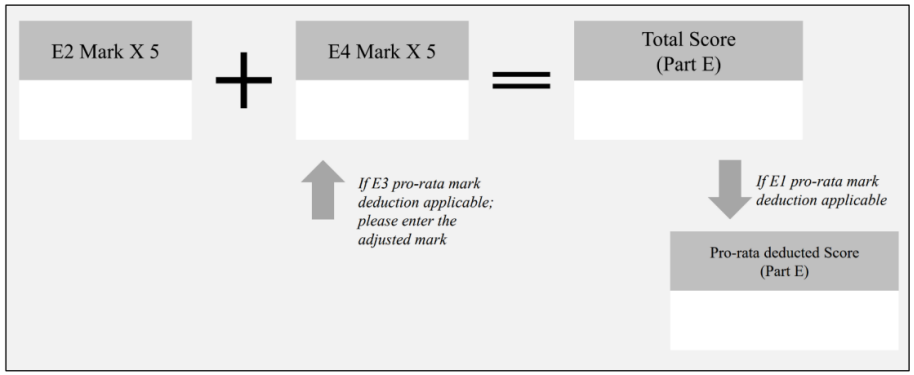
Candidate Number: EE XXXXX

Part E (Investigations)

Case number	1	2	3	4	5	6	7	8	9	10
E1 Investigation indication documentation										
E2 Justification										
E3. Results documentation										
E4. Follow up										

E2 score *(circle one)*	*4*	*4.5*	*5*	*5.5*	*6*	*6.5*	*7*	*7.5*	*8*	*8.5*	*9*	*9.5*
E4 score *(circle one)*	*4*	*4.5*	*5*	*5.5*	*6*	*6.5*	*7*	*7.5*	*8*	*8.5*	*9*	*9.5*

Part E (Investigations)

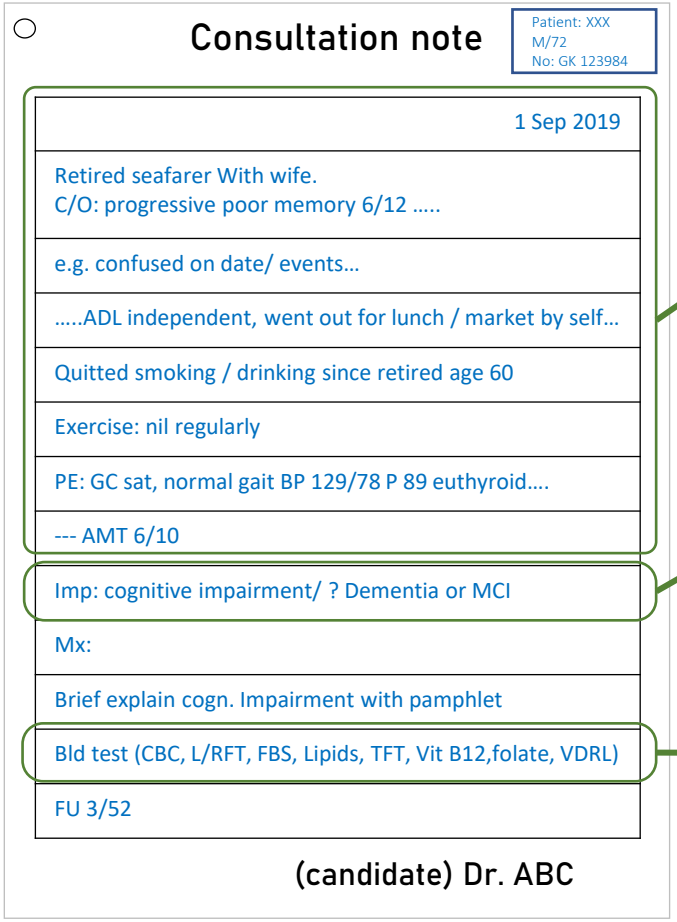


Please note:

- E1 (Investigation indication documentation): IF NOT shown in the record → cross the box; no need to mark the concerned case, apply pro-rata deduction to 'total score in Part E'
- E3 (Results documentation): IF report copy NOT available OR result NOT recorded in the 'follow up' medical notes → cross the box; no need to mark E4 of the concerned case; apply pro-rata deduction to 'E4 score'
- Assessment should be based on the medical records; but can consider score adjustment if the candidate offers appropriate additional information in the 'Comment' section, Attachment 13.

Updated August 2022

E1 (Investigation indication documentation)



Clinical information

Present in record

ICPC coded in Attachment 13

Provisional diagnosis / Chief condition requiring investigations

Present in record

Test(s) ordered

Present in record

Indication of the investigation documented (E1)

Please note: the consultation note content are simulated and not implying a standard of pass or fail in the Exam

E1 (Investigation indication documentation): marking

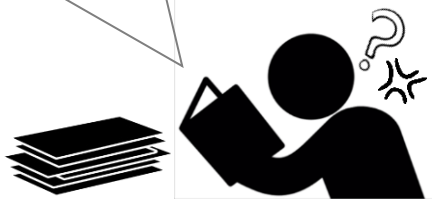
Indication(s) of the investigation documented in record

Part E (Investigations)

Case number	1	2	3	4	5	6	7	8	9	10
E1 Investigation indication documentation	✓									
E2 Justification										
E3. Results documentation										
E4. Follow up										

→ Examiners proceed to assess the record

Indication(s) of the investigation **cannot be found** in the record



Part E (Investigations)

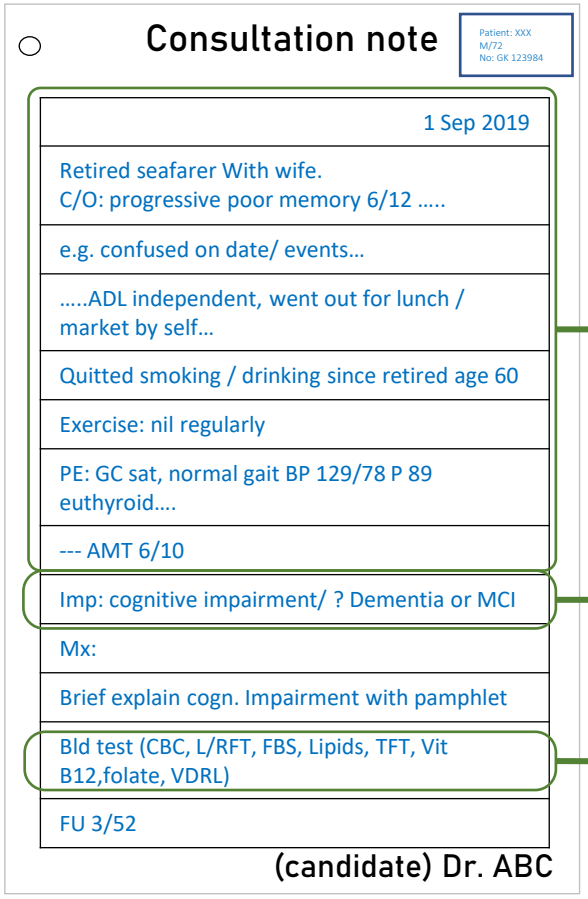
Case number	1	2	3	4	5	6	7	8	9	10
E1 Investigation indication documentation	X									
E2 Justification	X									
E3. Results documentation	X									
E4. Follow up	X									

Penalty!

→ the whole case will not be assessed

→ pro-rata mark deduction in Part E total score

E2 (Justification)



Consultation note

Patient: XXX
M/72
No: GK 123984

1 Sep 2019
Retired seafarer With wife. C/O: progressive poor memory 6/12 …..
e.g. confused on date/ events…
…..ADL independent, went out for lunch / market by self…
Quitted smoking / drinking since retired age 60
Exercise: nil regularly
PE: GC sat, normal gait BP 129/78 P 89 euthyroid….
--- AMT 6/10
Imp: cognitive impairment/ ? Dementia or MCI
Mx:
Brief explain cogn. Impairment with pamphlet
Bld test (CBC, L/RFT, FBS, Lipids, TFT, Vit B12,folate, VDRL)
FU 3/52

(candidate) Dr. ABC

Marking of E2 (Justification)
is the **Examiner's judgement** on the record's :

- Clinical information
- Provisional diagnosis / Chief condition requiring investigations
- Test(s) ordered

Please note: the consultation note content are simulated and not implying a standard of pass or fail in the Exam

Marking Scale for E2 (Justification)

Examiner marks all the eligible medical records
Then give a global mark in Part E2 (justification)

4	4.5	5	5.5	6	6.5	7	7.5	8	8.5	9

Reference for marking D2. Basic Information and D3. Consultation notes	
Mark (Please circle one)	General description
9	Consistently demonstrates outstanding performance in all components; criterion performance (outstanding)
8.5	
8	Consistently demonstrates mastery of most components and capability in all (Very Good)
7.5	
7	Consistently demonstrates capability in most components to a professional standard. (Average to good) *(minor omissions / defects that can be tolerated)*
6.5	
6	Demonstrates capability in some components to a satisfactory standard; but with omissions and/ or defects in other components that have impact on patient care *(Such omissions/ defects were seen in two or more of the Cases assessed)*
5.5	
5	Demonstrates inadequacies in several components with major omissions or defects
4.5	
4	Demonstrates serious defects; clearly unacceptable standard overall

E3 (Results documentation)

Consultation note

Patient: XXX
M/72
No: GK 123984

21 Sep 2019
with wife and daughter today
Consult. 1/9/ 2019 refers;
Dementia bld work up (4 Sep 2019): CBC, L. RFT, TFT, Vit B12, folate: N; VDRL: no-reactive
Daughter concerned ….
Imp: cognitive impairment/ likely MCI
Mx:
Suggest SFI CT brain; relatives need time to think about
Encourage regular social activities / exercise. : e.g. visit nearby elderly community center
Refer:
Occ therapist (assessment and training)
Geri SOPC
FU 12/52

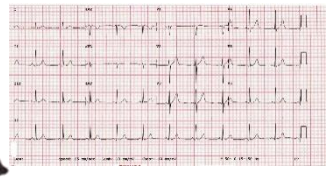
(candidate) Dr. ABC

Investigation results/ findings

documented in record

+

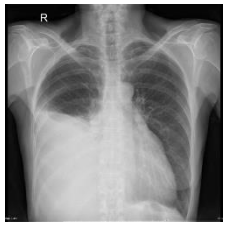
Copy of the investigation reports, e.g.



CT scan

Ultrasound scan

For plain X-Ray: : if report not available



film

OR

Present for Examiner's inspection

Results documented (E3)

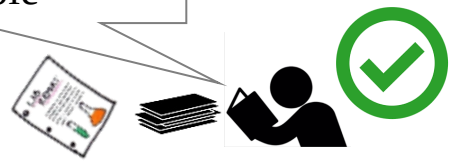
Please note: the consultation note content are simulated and not implying a standard of pass or fail in the Exam

E3 (Results documentation): marking

- The investigation results documented in the medical record
  AND
- The investigation/ laboratory report (copy) available

E3. Results documentation	✓									
E4. Follow up	↓									

→ Examiners proceed to assess the record, E4 (follow up)



- The investigation results **NOT** documented in the medical record
  OR
- The investigation/ laboratory report (copy) **NOT** available

E3. Results documentation	X									
E4. Follow up	X									

Penalty!

→ "Follow up" of the case will not be assessed
→ pro-rata mark deduction in E4 (follow up) score

E4 (follow up)

Consultation note

Patient: XXX
M/72
No: GK 123984

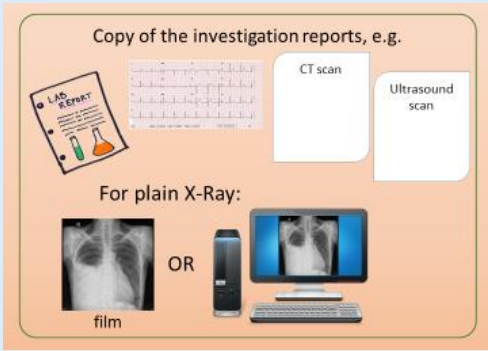
21 Sep 2019
with wife and daughter today
Consult. 1/9/ 2019 refers;
Dementia bld work up (4 Sep 2019): CBC, L. RFT, TFT, Vit B12, folate: N; VDRL: no-reactive
Daughter concerned ….
Imp: cognitive impairment/ likely MCI
Mx:
Suggest SFI CT brain; relatives need time to think about
Encourage regular social activities / exercise. : e.g. visit nearby elderly community center
Refer:
Occ therapist (assessment and training)
Geri SOPC
FU 12/52

(candidate) Dr. ABC

Marking of E4 (follow up)
is the **Examiner's judgement** on the record's:

Investigation results/ findings:

In the Medical record *and*



Further clinical information elicited (if any)

Diagnosis

Management

Please note: the consultation note content are simulated and not implying a standard of pass or fail in the Exam

Marking Scale for E4 (follow up)

Examiner marks all the eligible medical records
Then give a global mark in Part E4 (follow up)

4	4.5	5	5.5	6	6.5	7	7.5	8	8.5	9

Reference for marking D2. Basic Information and D3. Consultation notes	
Mark (Please circle one)	General description
9	Consistently demonstrates outstanding performance in all components; criterion performance (outstanding)
8.5	
8	Consistently demonstrates mastery of most components and capability in all (Very Good)
7.5	
7	Consistently demonstrates capability in most components to a professional standard. (Average to good) *(minor omissions / defects that can be tolerated)*
6.5	
6	Demonstrates capability in some components to a satisfactory standard; but with omissions and/ or defects in other components that have impact on patient care *(Such omissions/ defects were seen in two or more of the Cases assessed)*
5.5	
5	Demonstrates inadequacies in several components with major omissions or defects
4.5	
4	Demonstrates serious defects; clearly unacceptable standard overall

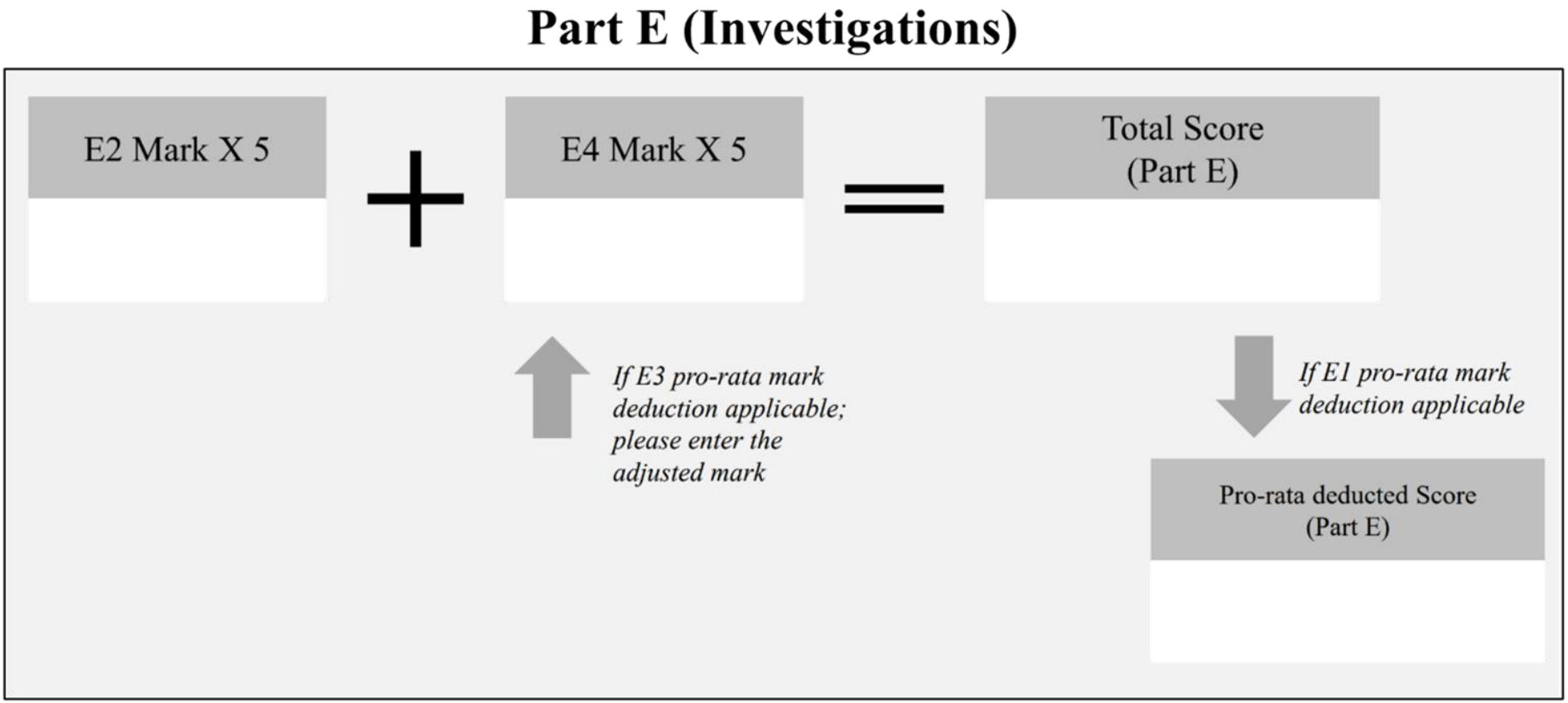
Part E (Investigation): total score calculation

Mark distribution:

E2 (Justification): 50%

E4 (Follow up): 50%

Passing mark Total score ≥ 65%



Some practice tips in preparing Attachment 13 and Part E (Investigations)

E2 (Justification): some tips on practice

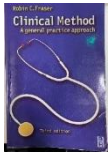
- Choose **test(s)** that are **recognized** and **accepted** in our **local primary care** setting
- Perform the test(s) at an **appropriate time / interval** (e.g. for disease monitoring)
- Test(s) are in line with the patient's problem(s), beware of
  - ***under-investigations***: omit test(s) that help to solve the problem
  - ***over-investigations***: order irrelevant / redundant test(s)
- Consider the **patient's needs**, ***but not just because*** patient wishes or requests to have the test
- Consider **availability of the test** in your practice setting
- **Unnecessary to put down explicit explanation in the medical record to support your choice of investigations in most cases.**

E2 (Justification): some tips on practice

Investigation can be performed for a number of reasons, some diagnostic, others therapeutic (House, 1983):

- To confirm or to make more precise a diagnosis suspected …
- To exclude an unlikely but important and treatable disease, …
- To monitor the effect or side effect of medicine, ….
- To screen asymptomatic patients, e.g. cervical cytology …
- To reassure an anxious patient that nothing is seriously wrong, …
- To convince a sceptical patient that something is wrong and that lifestyle amendments should be made, e.g. liver function in a heavy drinker.

But please note: These two groups of cases should not be submitted for the exam



From:
Robin C. Fraser. Clinical Method: A general practice approach. 3rd edition

E2 (Justification): some tips on practice

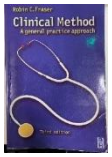
The decision to investigate a patient …is based on clinical judgement,

which is influenced by many factors –

- the clinical findings on history and examination (including social and psychological factors),
- the doctor's temperament and attitudes,
- the doctor-patient relationship, and
- organizational factors such as the availability of diagnostic services,
- the time of the day or night, etc.

such decisions are often finely balanced.

In public setting, consider self-finance basis as appropriate



From:
Robin C. Fraser. Clinical Method: A general practice approach. 3rd edition

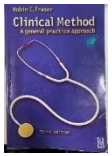
E2 (Justification): some tips on practice

…clinicians should ask themselves before requesting an investigation…

- Why am I ordering this test?
- What am I going to look for in the result?
- If I find it, will it affect my diagnosis?
- How will this affect my management of the case?
- Will this ultimately benefit the patient?

In general, investigations should be performed only when the following criteria are satisfied:

- The consequence of the result of the investigation could not be obtained by a cheaper, less intrusive method, e.g. taking a more focused history or using time
- The risks of the investigations should relate to the value of the information likely to be gained
- The result will directly assist in the diagnosis or have an effect on subsequent management



From:
Robin C. Fraser. Clinical Method: A general practice approach. 3rd edition

E4 (follow up): some tips on practice

In the follow up visit:

- Distinguish **normal** vs **abnormal results**
- If necessary, **elicit further clinical information** e.g.
  - to help interpret certain incidental findings in the investigation
  - refine the diagnosis
  - to help planning the management
- Inform the patient on the **significance** and **implication** of the investigation results
- Management: according to the tests **results** and the **clinical context;** if needed:
  - **order further investigations** *(such investigations will not be assessed in the Exam)*
  - **Referrals**: but beware of the **potential long waiting time** for non-urgent / usual priority cases **in the public settings** → consider interim follow up(s)
- Also take care of **other significant health issues**, though apparently not related to the problem investigated. Examples: smoking, obesity, comorbidities

Some observations, comments and recommendations
in previous PA
(Part E)

Part E (Investigations) (i)

Issue noted	Comments / recommendations
Performing Urine R/M, C/ST in uncomplicated lower urinary tract infection (cystitis) in female patients: • PA Examiners come to a consensus that this type of cases do not have adequate justification (E2)	• Not to be submitted for PA

Part E (Investigations) (ii)

Issue noted	Comments / recommendations
Discrepancy in the Attachment 13 and the medical record: Attachment 13: • Problem: deranged LFT (D97) • Investigation ordered: Ultrasound of hepatobiliary system ○ In **the case summary** of Attachment 13: ➢ (follow up): *"**After discussion, patient was reluctant for invasive diagnostic test** or other imaging such as Fibroscan as latest private blood test for liver function was normal"* ○ In **the consultation notes**: ➢ (1st visit / when the Ix ordered): *"**concern the need for other investigation as patient had read online about liver biopsy**"* ➢ (follow up): *"explained that **liver biopsy is the gold standard diagnostic test however due to its invasive nature, it is only considered in complicated and severe cases, therefore it is not recommended in his case**"*	• The Attachment 13: seems that the candidate had suggested patient to have invasive diagnostic test • From the Medical Record: actually patient raised a concern if liver biopsy is needed in the 1st visit; candidate not recommend in his case a the follow up • Confusing information in the examination material, pose a risk of misunderstanding by the Examiners in the marking process

Part E (Investigations) (iii)

Part E: issue noted	Comments / recommendations
Candidates claimed he is part time work in clinic only. • Case A, B, C, not followed up by candidate at all. • Case D, not ordered by candidate.	• Non-compliance to examination guideline; pro-rata mark deduction
Presented a different/ amended version of medical record print-out to the 3rd examiner	• Should present the same version seen by the previous PA examiner • If amendment had been necessary; indicate to the 3rd examiner on the area(s) amended
ECG not available	• → mark deduction pro-rata in E4
Laboratory reports on ANA and RF not present	• → mark deduction pro-rata in E4

Part E (Investigations) (iv)

Part E: issue noted	Comments / recommendations
Clinically diagnosed lipoma left upper back had already been made; ordering ultrasound of the mass not justifiable	
Not justifiable for ultrasound scan of shoulder as all the clinical findings already indicated tendinitis	
Should not repeated blood x lipid at 21/6/2016 as just done by medical 6/2016 in which the result is normal. The duration of Ix is not appropriate	
(knee) If worry about ligament injury, should suggest MRI rather than XR	
Baseline ECG should be sought for all HT patients if not done before	
Rt wrist pain. Mechanism / severity of the sprain & contusion not clearly documented to assess if there was significant trauma justifying the XR. Contusion was documented as minor.	
M/65. Recurrent Renal stone. Had ESWL Rt renal stone in 2015. Ix: MSU, KUB	• Should check blood calcium, urate (underlying cause?) • Can consider US kidneys or SFI CT Urogram

Part E (Investigations) (v)

Part E: issue noted	Comments / recommendations
PV itch and discharge, hx not point to STD, 1st episode, not recurrent, single partner, PE Speculum → curd like discharge ; point to candidiasis. No strong indication for endocervical swab which is usually more useful for STD. If STD is suspected , endocervical swab X chlamydia should be performed as well.	
RUQ abd pain X 1/52. Bld check should include CBC for WBC , to assess any infection	
For fatty liver, it is better to order USG rather than LFT only, should explain why not refer USG	
For hep B carrier, we need to consider whether antiviral Tx is needed. So we need to check HBV DNA as well and order CBC/ASZ to calculate APRI score / Fibrosan and see any chance of cirrhosis. Although GOPC might not have HBV DNA/Fibrosan, we need to discuss with patient (similar to provide Ultrasound order by the candidate)	

Part E (Investigations) (vi)

Part E: issue noted	Comments / recommendations
Patient with HT, IFG, H-lipid & Gout since 2002. Ordered blood test for patient. Results (5/17): Urate came back 0.61 mmol/L vs Hx 7/16 Urate 569 mmol/L & 8/15 Urate 550 mmol/L Increasing trend of urate level with on & off gouty attack. Still emphasis on low purine diet only but no dietitian referral. Should emphasis the patient to put on allopurinol to lower the uric level & prevent recurrent gouty attack	
Patient with history of cough x 1/52 with nasal secretion. Only travel to Eastern China. No other TOCC. Clinically look like URI. Why so early to order CXR when just the vague recommendation suggested by TCM. Then the CXR come back to be normal for the lung but incidentally finding of ? Calcified gallstone, patient been FU Surgical before; but no further documentation of FU action to patient & when to seek help if needed.	
It is better to see the case as a whole (dizziness + elevated blood pressure) rather than separate the case to 2 issues at FU	

Part E (Investigations) (vii)

Part E: issue noted	Comments / recommendations
F/54. 1st episode of ↑ clinic BP. No home BP → immediate refer for ABPM. What is the evidence of early ABPM? ABPM result : mild HT. At follow up: clinic BP 137 / 88. started Norvasc 2.5 mg QD. What is the evidence of using anti-HT? most guideline recommend trial of life style modification 6 months first rather than put on Rx after 1 months of BP monitoring	
Referred from Surgical for A1c 6.7% X 1, ? DM. No random bld sugar nor FBS value. DM not confirmed. Not indicated for urine ACR.	
M/68. SOB & chest discomfort → refer to have CXR and SFI CT coronary angiogram. CXR revealed massive Rt pleural effusion ← immediately referred to AED by Chest Clinic (where the patient had the XR taken) Diagnosis: malignant mesothelioma Only telephone consultation with the patient Why advocate patient to SFI CT Coro so early at GOPC setting and not wait for CXR first?	

Part E (Investigations) (viii)

Part E: issue noted	Comments / recommendations
All along stable thyroid case. Hx and Physical examination didn't indicate any hypo/hyperthyroid symptoms. No strong reason to follow up the case in 2 weeks' time to see the result.	
Post-RAI on thyroxine. Increased thyroxine for ↑ TSH and normal T4 level. Bld check at 3 wk and FU 4/52 → not much change for lab result finding for TSH.	
Thyrotoxicosis since Dec 2021. Poor Rx compliance FT4: 73 (Apr 2022) , 40.8 (May 2022) , 54 (July 2022) Pulse 108 / min Dx: 'mild rebound' Candidate had seen the patient 2 episodes and did not adjust the CMZ dosage; now increased from 10 mg QD to 15 mg QD	• Should address and well document the issue of compliance

Part E (Investigations) (ix)

Part E: issue noted	Comments / recommendations
Patient PT +ve / pregnancy case. Folate not prescribed.	In GOPCs: • Folate of appropriate dose may not be available in the clinics • Should encourage the patient to self purchase (till seen by antenatal clinic)
Toe nail clippings fungal culture +ve, patient declined SFI topical treatment or oral antifugal Rx, referred to Skin Clinic which the waiting time is long	can consider • Podiatry referral, or • trial of Canestan cream
X-ray R/o rib fracture patient (ordered) on 21/9/2021 FU on 20/10/2021. X ray report available on 26/10/2021. Did candidate see wet film earlier?	

Carefully choose the cases

Choose cases that show your competency , not weakness

Not sure if the case on hand is good to be presented for Exam?

Choose another case

Prepare for Part E (Investigations): what you can do now

1. Look for cases that may be used in the preparation Part E of PA
2. Familiarize with ICPC-2 coding (Attachment 13)
3. Practice write up short cases summaries (Attachment 13)
4. Every day:
    a) Practice rational use of investigations (justification)
    b) Provide appropriate follow up on the investigation results

Enquiry

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