

This section of the Journal is designed to present clinical problems which focus on patient management, problem-solving, and other elements integral to family medicine. The intent of this section is aimed more at teaching and learning than self-assessment as an evaluation or scoring device. Reinforcement of major teaching points is therefore included through the further discussion and supplemental references which appear on the following pages. Critical comments relating to these self-assessment materials are invited and should be submitted as Letters to the Editor.

Self-Assessment in Family Practice

These materials have been prepared by members of the Self-Assessment Panel of *The Journal of Family Practice*. Membership: R. Neil Chisholm, MD, Chairman (University of Colorado, Denver), B. Lewis Barnett, MD (Medical University of South Carolina, Charleston), Leland B. Blanchard, MD (San Jose, California), Paul C. Brucker, MD (Thomas Jefferson University Hospital, Philadelphia, Pennsylvania), Laurel G. Case, MD (University of Oregon Medical School, Portland), Silas W. Grant, MD (University of Alabama, Huntsville), Ian R. Hill, MD (Plains Health Centre, Regina, Saskatchewan), Kenneth F. Kessell, MD (MacNeal Memorial Hospital, Berwyn, Illinois), John A. Lincoln, MD (University of Washington, Seattle), James G. Price, MD (Brush, Colorado), Richard C. Reynolds, MD (University of Florida, Gainesville), Gabriel Smilkstein, MD (University of Washington, Seattle), William L. Stewart, MD (Southern Illinois University, Springfield).

Question A

A 40-year-old married man whom you have not previously seen complains of being exhausted. He is scheduled for a 15-minute appointment. His answers to your preliminary questions reveal that he has felt unusually tired for about six months and he expects you to prescribe some "pep pills" or a potent vitamin to give him more energy. Further interrogation reveals no obvious cause for his fatigue, and it becomes apparent you will be unable to resolve his problem in the remaining five minutes allotted for this initial visit. Which of the following three approaches to the solution of the problem would be the most desirable?

- A. Briefly describe several diseases which could produce his fatigue and how you will proceed determining which one he has. Schedule him for a number of laboratory and x-ray procedures prior to his next visit.
- B. Tell him fatigue is nearly always due to "nerves." Prescribe a tran-

quilizer and advise him there is no point in wasting a great deal of time and money having laboratory and x-ray procedures done.

- C. Explain to him one prevalent cause of fatigue is the emotional distress incidental to everyday living. Schedule him for a complete examination with adequate time for a history and physical examination. Tell him you intend to "rule out" organic disease by use of appropriate laboratory and x-ray procedures.

Question B

One or more answers may be correct. A 42-year-old woman reports to you that her urine "just turned dark" and she has had no appetite for the last seven to ten days. Physical examination reveals mild icterus and a slightly tender liver palpable 2 cm below her right costal margin. In arriving at a diagnosis, you would question her

carefully relative to:

- A. Ingestion of contraceptive pills.
- B. Ingestion of chlorpromazine (Thorazine).
- C. Alcohol ingestion.
- D. Ingestion of raw shell fish.
- E. All of above.

Question C

The answers are true or false.

In mycoplasmal (or primary atypical) pneumonia:

- A. Diagnosis is easily and promptly achieved by blood count and sputum cultures.
- B. The organism is susceptible to nearly all antibiotics.
- C. Patients usually appear seriously ill.
- D. All cases should be treated with an antibiotic.
- E. The onset is rapid with an initial high fever and severe cough.
- F. This type of pneumonia is common after the age of 40.
- G. Occurrence is usually in only one of the upper lobes.

Question A

Approach C is the most desirable. If history, physical examination, and laboratory or x-ray procedures reveal an organic disease of such severity to explain the degree of fatigue, he will readily accept this diagnosis. Minimal laboratory procedures would be a complete blood count, urinalysis, chemistry panel including blood glucose, and kidney, liver, and thyroid function studies. (An x-ray of the lungs and an ECG would also seem appropriate as part of a complete examination.)

Approach A provides the patient with the fixed idea that fatigue other than physiological is due to a disease process. If you are unable to uncover a disease to explain his symptom, he will go elsewhere seeking a wiser physician.

Approach B is undesirable for obvious reasons. In fact, many tranquilizers will increase the symptom of fatigue.

Fatigue due to emotional distress is undoubtedly more prevalent than that due to organic disease. Management of this type of patient is eloquently outlined by Rockwell and Burr.¹

Reference

1. Rockwell DA, Burr BD: The tired patient. *J Fam Pract* 1(2):62, 1974, reprinted 5(5):853, 1977

Question B

E. All of these have been demonstrated to be associated with jaundice and hepatomegaly. Contraceptive pills and thiorazine may cause cholestatic jaundice. Alcoholic hepatitis usually occurs after years of excessive drinking, but may appear in a few individuals within a year. Contaminates in raw shell fish have been a source of viral hepatitis in man.

Suggested Reading

Krupp MA, Chatton MJ: *Current Medical Diagnosis and Treatment*. Los Altos, Calif, Lange Medical Publications, 1977, pp 376-380, 447

Question C

A. False. The white blood count is usually within normal limits or only slightly elevated and sputum cultures usually show only normal flora.

B. False. The organism is not susceptible to penicillin. Tetracycline and erythromycin are the only antibiotics recommended.

C. False. Patients usually do not appear seriously ill. It has been called "walking pneumonia" be-

cause patients often do not feel ill enough to go to bed.

D. False. In mild or moderate cases antimicrobial drugs are not indicated.

E. False. There is a gradual onset of lassitude, respiratory symptoms, headache, myalgia with slowly rising fever, and increasing cough.

F. False. This type of pneumonia is rare beyond the age of 40.

G. False. Studies on the distribution of the pneumonia in one large series showed more than one half of the cases were multilobar and slightly less than half were bilateral. The lower lobes were appreciably more frequently involved than the upper lobes.

Suggested Reading

Knight V: Mycoplasmal diseases. In Thorn GW, Adams RD, Braunwald E, et al (eds): *Harrison's Principles of Internal Medicine*, ed 8. New York, McGraw-Hill, 1977, p 968

Krupp MA, Chatton MJ: *Current Medical Diagnosis and Treatment*. Los Altos, Calif, Lange Medical Publications, 1977, p 122