

General Internal Medicine Cases and Questions

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- Nothing to declare
- No conflicts of interest



Case One

High Risk Breast Cancer
Screening

A healthy 38 year old woman presents to your office for an annual. Her 46 year old sister was recently diagnosed with breast cancer. She wonders, “Should I have an MRI?”

- Past Medical History: benign breast biopsy at 28, 2 normal pregnancies at 32 and 34. Menarche at age 11. Regular periods.
- Medications: IUD
- Family history: sister as above, mother with post menopausal breast cancer at 65, maternal aunt with ovarian cancer.

- Social Hx: Eastern European descent. She's married with 2 kids, works as a teacher, active in her synagogue. No dv, alcohol, or street drugs. No tobacco.
- Her physical exam is completely normal.

What is her lifetime risk of breast cancer?

- A. 8%
- B. 15%
- C. 20%
- D. 35%
- E. 40%

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E. 40%

Risk Assessment

While in the office, you go to www.cancer.gov/bcrisktool and answer the following questions

NCI Risk Model

Gail Model

- Race/Ethnicity White
- History of breast cancer, DCIS, LCIS No
- Age 38
- Age at Menarche 7-11
- Age at first live birth >30
- First Degree relatives >1
- Biopsies? Yes
 - How many 1
 - Any with atypical hyperplasia No

Caveats

Underestimates risk for people who are gene positive.

Developed for populations, not individuals

Does not factor in other risks, including breast density, chest wall radiation.

What is the recommended screening for our patient?

Annual clinical breast exam and:

- A. Annual mammogram starting at 35?
- B. Mammograms every 6 months starting at 35?
- C. Mammogram one year; MRI the next?
- D. Both MRI and mammogram every 6 months
- E. Mammogram and MRI every year.

What is the recommended screening for our patient?

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- C. Mammogram one year; MRI the next?
- D. Both MRI and mammogram every 6 months
- E. Annual mammogram *and annual* MRI, 6 months apart

Key Points

These recommendations are mammogram *and* MRI for women with a lifetime risk of breast cancer of 20% or more.

Consider referring for genetic counseling for people at high risk.

USPSTF recommendations would not apply to her because of her high risk.

Keep your eyes on data around breast density and new risk calculators, e.g. <https://tools.bccsc-scc.org/BC5yearRisk/calculator.htm> (not lifetime risk)

My Mother-in-Law

On her way out of the office, she stops to ask you about whether her mother-in-law, now 86 with progressive dementia and Parkinson's Disease should still have breast cancer screening. The mother-in-law's mobility and comprehension are severely limited, and she's been living in a skilled nursing facility.

Screen Mother-in-Law?

- 1.It's up to the family and her mom
- 2.It's up to the family and her mom,
but I recommend it!
- 3.It's up to the family and her mom,
but I really suggest that it's not
necessary

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When to Stop Screening?

There is no good evidence for screening after the age of 74.

What is the woman's overall health status?

What is her preference?

Does she have a 5-10 year life expectancy?

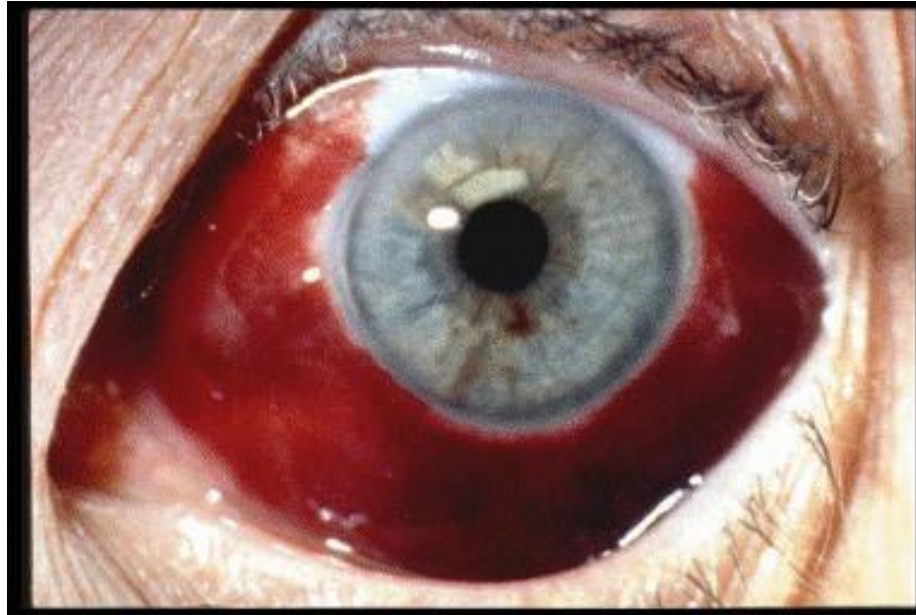
How would she act upon a cancer diagnosis?

Cases 2 and 3

Red Eyes

Case 3

A 50-year-old man comes in with a huge red area in his eye. He is in good health and recently carried many boxes to the attic. No pain in his eye. Vision is 20/20. He's worried that this occurred because he's missed his antihypertensive meds over the last few days.



What is Your Diagnosis?

- A. Severe Conjunctivitis
- B. Subconjunctival Hemorrhage
- C. Herpes Keratitis
- D. Hypertensive Urgency
- E. Acute Angle Closure Glaucoma

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Case 4

A 50-year-old woman with RA comes in to see you. Her disease has been active lately and she is not feeling well. Since yesterday, she has had photophobia and two painful, red eyes.

On Exam



She's clearly in pain, worse with pressure to the eye

Photophobia on exam

ESR is 100

Phenylephrine drops don't clear it.

What is Your Diagnosis?

- A. Herpes Keratitis
- B. Acute Angle Closure Glaucoma
- C. Scleritis
- D. Episcleritis
- E. Rheumatoid Eye

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Episcleritis vs. Scleritis

- Acute in onset, may be local or diffuse
- Resolves without treatment
- Vision is not affected
- Phenylephrine drops leads to transient resolution. Sclera normal underneath

- Striking, highly symptomatic course
- Associated with rheumatologic disease in 50% of patients
- Painful, photophobia
- Threatens vision
- Ophthalmologic and systemic treatment warranted urgently

Case 4

Geriatrics: Falls in the Elderly

Case 5

A 92-year-old community dwelling elderly woman brought by her 73-year-old daughter because she fell – Again.

Quickly ascertaining that her only injuries are wounded pride and a sore bottom, you review her history. The fall occurred at home when she got up from the chair and headed for the bathroom. She lives alone, doesn't drive, ignores her walker. She takes multiple meds including atenolol, hctz, lisinopril, insulin, and metformin.

At night she takes amitryptiline
for her diabetic neuropathy.
She also drinks, though she's
never admitted this to you
and you've learned this from
her daughter.

On a Limited Physical Exam, Which is Most Helpful?

- A. Full Neurological Exam
- B. Functional Exam
- C. Vital Signs
- D. Cardiac Exam
- E. Joint Exam

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Functional Evaluation: The Get Up and Go Test

Record the time that it takes for a patient at risk to get up from a chair, walk 10 feet, and return to the chair. If this takes more than 30 seconds, they have impaired mobility and are at greater risk for a fall.

Results

You do the “get up and go” test and she scores 21 seconds, a marker of impaired mobility. She also fails to draw a clock correctly on her mini-cog.

You send the visiting nurses in to do a home safety assessment, stress the importance of always using her walker, stop the amitriptyline and try something else for her neuropathy. You address the alcohol again as well.

What percentage of ED visits non-fatal injuries in people over 65 come from falls each year?

- A. 42%
- B. 48%
- C. 56%
- D. 62%
- E. 80%

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- Fell in her bathtub and sustained subdural. Age 88.



- Died from traumatic brain injury after a fall at his Manhattan home. Age 85

Falls in the Elderly

Are responsible for 70% of accidental deaths in people 75 and over.

Increases with age and transcends ethnic groups

Cause significant morbidity, including decline of functional status, risk for hospitalization, admission to long term care

Cause serious injuries in 5-15% of falls. Hip fracture occurs in 1-2% of falls.

Risk Factors

Intrinsic

- Muscle weakness
- Gait and balance dysfunction
- Visual impairment
- Cognitive impairment (even mild)
- Orthostatic hypotension
- Meds
- Substance use

Extrinsic

- Poor lighting
- Clutter
- Environmental obstacles
- Bad shoes

Drinking in Elderly Patients in the ED

Lifetime alcohol abuse was 24%

14% had a drinking problem in the last year.

Elderly patients with GI complaints had a much higher rate of alcohol issues (22%) than those who fell.

Physicians detected only 21% of the cases of current abuse of alcohol.

Cases 6 & 7

Workplace Related Medicine

The patient following JM

Fell in her work at a local discount store about 7-8 weeks ago. She has been complaining of pain in her lower back ever since then.

Treatment with NSAIDS and muscle relaxants did not help. Imaging was negative and PT, likewise, did not make a difference. Her symptoms are out of proportion to her injury and to your exam.

“I don’t think I can go back to work yet, doctor,” she says tearfully. “I’m just not ready.”

What do you tell her now?

- A. Tell her to stop malingering and get back to work.
- B. Screen for and treat depression
- C. Work with her and her company to come up with a transition back to work plan.
- D. Inquire about pending litigation
- E. B, C, and D

What Do You Tell Her Now?

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Returning to Work after an Injury

Vast majority of people get better, go back to work.

Patient factors include perception of pain, injury, depression, lawsuits pending, other secondary gain

Returning to Work after an Injury

Work factors include inability to provide transitional employment.

MD factors include our own discomfort with when patients are stable to return to work, desire to help a bad situation

Only 50% of workers ever return to work if they have been out >6 months.

Lead Astray?

A patient who has lead exposure in his work as an instructor in the police academy firing range comes in to follow up after a hospitalization department for a left sided facial droop and a right-sided hemiparesis.

While you discuss his recovery from what appears to be a CVA, his wife tells you that she is sure that lead poisoning caused his MCA stroke.

Which is the Correct Response?

- A. She's probably right. Check a lead level immediately.
- B. She's probably wrong. Lead exposure only causes peripheral neuropathies.
- C. She's probably wrong. It is uncommon for occupational exposures to cause focal neurological problems such as strokes.
- D. She's right. Lead can cause encephalopathy, why not strokes?

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And, yet it's worth noting

Prevalence of CHD and stroke in adults younger than 55 is highest in those with service and blue collar jobs, particularly accommodation and food service. (Nat'l Health Interview Survey).

Risks may include stress, shift work, exposures to second hand smoke and other particulates.



Case 8

After Gastric Bypass
Surgery

A 45-year-old female patient

Presents to your clinic to establish care. She is new to you. Past medical history is notable for diabetes, which she proudly tells you is “in remission” after gastric bypass surgery 5 years ago.

- She followed up with her surgeon for a year or two, but since then has not really been seen by a physician. She has maintained her weight loss.

- She currently takes no medicines, no herbal supplements, and no vitamins.
- The remainder of her history and exam are unremarkable.

Long term, she's at risk for:

- A. Nothing , she's fine
- B. Late Weight Regain
- C. Metabolic and Nutritional derangements
- D. B & C

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- D. B & C

Late Complications of Gastric Bypass

Most common are anemia and b12 deficiency (30%) if not replaced.

Incisional hernia in 10%

Depression/Emotional disturbance (5-10%)

Rare ulcers at the anastomosis site (1-2%)

Very rare electrolyte abnormalities, sbo,

Cholelithiasis

Case 9

Unilateral Hearing Loss

Can You Talk to My Good Ear?

A 36-year-old man calls your office with a complaint that he woke up and can't hear out of his left ear very well. He has no history of ear problems, no recent infections. He did travel recently on an airplane and wonders if it's because of the plane trip. Your astute triage nurse had him hum and the hum sound did not lateralize. He has no vertigo, but he has tinnitus and a little bit of ear pain.

What Do You Do Now?

- A. Don't worry. It's the plane, take a decongestant and call me in the morning if you're not better.
- B. Don't worry. See if you can come in this week and we'll take out the wax.
- C. Worry a little. Maybe he has an otitis. Add him on later or tomorrow.
- D. Worry. See him today or refer to ENT.

What do you do now?

- A. Don't worry. It's the plane, take a decongestant and let me know if not better.
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Sudden Sensorineural Hearing Loss

Rapid hearing loss. Usually noted over 12 hours or on awakening in the morning.

Usually (but not always) unilateral

More than 90% of patients have tinnitus

Often patients have a sense of ear fullness

Etiologies for SSNHL

Myriad, but most commonly autoimmune, microvascular, or viral cochleitis.

Depending on the series, tumor ranges from 3-30%. MRI to evaluate the retrocochlear space is indicated.

Treatment

No agreement on the best protocols.

Most ENT will treat with high dose glucocorticoids (60-80mg/day) for 10 days. Some studies suggest faster healing.

Some data about intratympanic steroids as well.

Subset of patients may improve with antivirals.

Prognosis

Generally, the prognosis is good.

- Better if it is high or low frequency loss and not across the board.
- Better for younger patients

May take up to 4 months and not be complete

May be worse in people with vertigo

Case 12: Primary Care of Transgender Individuals



You have a new patient coming to see you. She is a transwoman, meaning she was assigned male at birth (AMAB), but has chosen to live as a woman since her early adulthood. She has been taking estrogen and testosterone blockers since her late teens and is now in her 40's. She has not undergone gender affirmation surgery.

What cancer screening is most appropriate for this 53-year-old woman?

- A. Breast exam, mammogram, pap, PSA
- B. Breast exam, mammogram,
- C. Breast exam, mammogram, colon cancer screening, PSA
- D. Breast exam, PSA

What Cancer Screening is Most Appropriate for this woman?

A. Breast exam, mammogram, pap,

B. Breast exam, mammogram

C. Breast exam, mammogram, colon cancer screening, DRE, and PSA

D. Breast exam, PSA

I've never seen a transgender patient

A phone survey in MA found a self-reported prevalence of .5%

Provide sensitive care

Empathic, non judgmental, don't assume sexuality based on gender

Honor the patients gender identity (pronouns)

Provide care for the anatomy that is present.

Beyond the PHQ-2

Don't assume that your patient is depressed, but DO be aware that depression, anxiety, substance abuse, and trauma are more common in the transgender population. No clear recommendations, but be aware:

16% have h/o Substance use disorder

Over 50% meet criteria for depression

May be increased risk of suicidal ideation

Resources for Transgender Care

- https://oi.mgh.harvard.edu/pcoi/primary_care_guidelines/Transgender.asp#surg
- UCSF Center of Excellence for Transgender Health
- National LGBT Health Education Center

Best of Luck on the Boards!

- Nothing to declare
- No conflicts of interest

