Self-Assessment in Family Practice

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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.

Directions

Choose the one best answer (A, B, C, D, or E).

Case 1

Barbara K., a 17-year-old-unmarried patient whom you have known for two years, has become pregnant. She is a heavy smoker, supporting herself on a part-time job. Her decision is to have the baby, and she wants your help.

1. In counseling this teenager, the physician should point out that
   A. smoking has no effect on pregnancy
   B. her protein requirement is higher than that of a mature pregnant woman
   C. chances of anemia, toxemia, and low-birth-weight children are lower than those of a mature woman
   D. nausea and vomiting may be limited by decreasing the frequency of meals
   E. diarrhea is frequent
2. In this case it is likely that
   A. the pregnancy may cause diminished gratification and self-esteem
   B. the physician should strongly advise the patient to undergo an abortion
   C. the father and his parents should have extensive counseling
   D. an early abortion will be less emotionally traumatizing than one late in pregnancy
   E. the patient can clearly distinguish external reality from her perceived reality and fantasies.

After completion of this pregnancy your patient asks for help in choosing a method for family planning.

3. In your counseling, you should be aware that
   A. questions concerning failure rates and safety of different programs of birth control can be answered easily
   B. patients choosing oral contraception should initially be placed on "progestogen only" tablets
   C. initial intrauterine contraception can be offered within one week after delivery
   D. diaphragm or condoms carry the lowest risk of side effects to the users
   E. postcoital contraception can be accomplished by a single "morning-after" pill.

Case 2

Mrs. C. Smith is a 22-year-old white female. She is the daughter of an engineer and has been married for 18 months to an accountant. She is impeccably groomed and seems unhappy about being in the doctor's office. Her problem is secondary amenorrhea of eight months' duration. She also reports erratic eating habits and frequent laxative use. Physical examination reveals a woman 165 cm in height with a weight of 40 kg. She has a pulse rate of 56 beats per minute and a diastolic pressure of 65 mmHg. Otherwise no other physical abnormalities are noted.

4. The following diagnostic test result would be expected:
   A. normal BUN
   B. increase in serum cholesterol
   C. normal ECG
   D. decrease in plasma protein
   E. anemia more frequently than leukopenia
5. The therapeutic prognosis for Mrs. Smith involves all the following *except*:
   A. progress can be monitored by weight gain
   B. mortality rate is less than 1 percent
   C. a better prognosis exists if onset is before age 15
   D. a poorer prognosis exists if patient has depressive and/or obsessional traits
   E. psychotherapy is usually helpful

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Answers and Discussion

1. B. Smoking has been demonstrated to cause premature births and low birth weight children. Teenage pregnant women have a higher risk of anemia and toxemia than more mature women. Nausea and vomiting are limited to early pregnancy and can be relieved by small meals every three hours consisting primarily of easily digestible carbohydrates. Constipation is common in the latter half of pregnancy because of pressure on the gastrointestinal tract by the developing fetus, decreased motility, limited exercise, and inadequate fiber and fluid intake. Pregnant teenagers require at least 1.25 gm of protein per kilogram of body weight while mature women require 1.0–1.1 gm.[1]

2. D. Pregnancy in the teenager often signals underlying emotional stress. Unless the girl is psychotic or significantly retarded, the decision concerning an abortion should be left to her. However, the physician should point out that more significant emotional complications are often seen when an abortion is elected later in pregnancy. This is most likely due to both the physical trauma of the procedure and the intense psychologic investment in a fetus that is active prior to removal.[2]

3. D. The choice of a contraceptive technique is highly personal, and the patient should have access to as much information as is needed to make an informed selection. "Progestogen only" oral contraceptives have limited usefulness since there is a higher pregnancy rate and a slightly increased incidence of bleeding difficulties in users. Intrauterine devices should not be inserted earlier than four weeks following delivery to allow the uterus to shrink to its normal size. Some other contraceptive should be used if desired during this period. Postcoital contraception requires multiple day courses of oral medication (eg, conjugated estrogens [Premarin] 30 mg daily for five days, or ethinyl estradiol 5 mg, once daily for five days).[3]

4. B. Mrs. Smith shows several diagnostic criteria of anorexia nervosa. Onset of illness began prior to age 25, an irregular eating pattern, no medical cause for her being so thin, amenorrhea, bradycardia, use of cathartics, and a low diastolic blood pressure are all appropriate diagnostic criteria. Laboratory tests and ECG offer additional diagnostic support. The BUN is generally elevated, the ECG shows low voltage and nonspecific T wave changes, and anemia is rarely noted. Hypercholesterolemia is frequent probably because weight loss increases the transfer of cholesterol from tissues into the plasma. Triglycerides are normal.[4]

5. B. The objective in therapy of anorexia nervosa is weight gain, but the elements of the process to effect that gain are multiple and complex. The literature cites a mortality rate of 6 to 15 percent. Autopsies provide no clues to cause of death.[4]

References

1. Taylor RB (ed): Family Medicine: Principles and Practice. New York, Springer-Verlag, 1978, pp 286-289
2. Cooper JC: Pregnancy in adolescents: Helping the patient and her family. Postgrad Med 64(6):60, 1978
3. Swartz DP, Henriques ES: Choosing methods for family planning. Am Fam Physician 13(4):139, 1975
4. Reece RM: Anorexia nervosa. Am Fam Physician 13(4):121, 1975