This new edition has been comprehensively updated to include new information on the latest clinical evidence, national guidelines, and from the recent medical literature:

• all existing cases have been revised
• many new cases have been added, including telephone consultation, home visit, dealing with a patient with a hearing impairment, and a consultation with more than one person
• the key national guidelines have been summarised within the appropriate case

The first two editions have helped thousands of candidates through the CSA exam in the last 6 years. The original approach has therefore been retained so the book continues to offer readers a concise ‘need-to-know’ guide to passing the CSA, with the emphasis on successfully completing a case in the allotted ten minutes using a structured consultation framework that works.

The aim of the book is to leave exam candidates with more time to concentrate on passing the CSA exam itself.

COMMENTS ON PREVIOUS EDITION

“Very useful for CSA exam, I think it is a must for anyone appearing for CSA. One of the best in market.”

“Great book in combination with revision notes! Lots of useful information that can be used to enhance knowledge and communication skills.”

“Nicely written book with a lot of cases emphasising the information that you need to incorporate into the consultation in order to pass the CSA exam.”

“This is a great book for anyone preparing for their MRCGP or even for those already practicing who are looking to keep up to date. It is concise, well written, practical and current. I love the way it is focussed on symptoms rather than disease types.”
ALSO OF INTEREST

For more details see www.scionpublishing.com
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Diabetic review

Data gathering

**Symptoms**  “How have you been?”
1. Energy levels
2. Polydipsia/polyuria
3. Recurrent infections – skin, genito-urinary, respiratory

**Diabetic complications**
- Vision
- Sensory disturbance, weakness
- Sexual functioning
- Chest pain, SOB

**Monitoring**
- Home blood sugar measurements
- Medication review: compliance with treatment

**Social history**
- Smoking, alcohol, drugs, diet, exercise
- Depression and anxiety screen
- Driving
- Occupation

**Red flags**
- DKA: vomiting, confusion, DIB
- HONK: extreme thirst, polyuria, drowsiness, nausea, high/low blood sugars

**Examination**
- BMI, BP, waist circumference, urine dip
- Visual acuity and retinal screening
- Peripheral neuropathy – reflexes, sensation
- Peripheral pulses
- Foot care – infections, ulceration, footwear

**Interpersonal skills**

**ICE**  Systematic exploration of patient's symptoms; ICE early in consultation
- Medication compliance – if not, why not?
- Depression and anxiety screen
- Consider checking patient understands difference between blood glucose and HbA1c

**For patient**  “Everyone has small amount of sugar in their blood. In diabetes blood sugar (glucose) is too high. This is due to lack of effectiveness of a hormone called insulin which is made by the pancreas”
“Whenever you eat, it causes your blood sugar to go up. This is because sugar from the food you eat goes into your digestive system and is absorbed into the bloodstream”
“How well do you think your diabetes is being controlled?”
“How well do you think prevents you from better controlling your diabetes?”
“Stopping smoking, regular exercise and a healthy diet can stop diabetes getting worse, and prevent its complications”
“The HbA1c allows us to see how well your diabetes is being controlled over a 3–4 month period”
“Long term high blood sugar can cause damage to kidneys and eyes and can cause heart disease”

Management

Investigations
Urine – microalbuminuria, ACR, ketones
Bloods – FBC, U&Es, glucose, HbA1c, lipids
Screening – retinal screening, foot ulcers

Management
Conservative
Structured education programmes, support groups
Diet, weight optimisation, smoking cessation
Exercise – aim for 30 mins five times a week
Patient may need to inform DVLA, free prescriptions

Medical
Metformin/sulphonylureas: start if HbA1c >48 mmol/mol (6.5%) despite lifestyle advice
Warn regarding hypoglycaemia if starting sulphonylurea
Prevention of complications
Cardiovascular: statin, control BP, aspirin
Renal: ACE inhibitor if microalbuminuria
Foot: annual podiatry if at risk
Depression screen
Immunisations: flu, pneumococcal

Safety net
Refer to A&E if HONK or DKA
Repeat HbA1c and regular review 2–6 monthly
Consider referring to DM clinic for insulin therapy initiation if HbA1c >7.5% despite treatments in primary care
Type 2 diabetes mellitus


Diagnosis (WHO criteria)
Based on symptoms and biochemistry:
- Symptoms: polyuria, polydipsia, weight loss
- Biochemistry:
  - fasting glucose ≥7.0 or
  - OGTT: glucose ≥11.1 2 hours after 75 g oral glucose load

If patient has no symptoms, repeat biochemistry tests to confirm diagnosis.

Do not use HbA1c to test for diabetes in these patients:
- with symptoms < 2 months
- pregnancy or childhood/young people
- if suspecting type 1 diabetes.

Conservative management
Patient education is central to management, ideally as part of a structured, evidence-based group education programme.

Controlling cardiovascular risk factors (e.g., diet, exercise, smoking) prevents both microvascular and macrovascular conditions.

Diet
- No specialist/specific diet for diabetics – discourage foods specifically marketed for people with diabetes.
- Tailor to patient’s needs, weight loss as appropriate.
- High fibre, low fat, low glycaemic index.
- Include low fat dairy and oily fish.
- Alcohol within normal healthy limits.

Regular exercise
- Prevents onset of diabetes.
- Aim for 30 minutes exercise 5 days a week.
- Over 65s should also aim for this, being as physically active as their abilities allow.

Depression
- Higher incidence of depression in diabetics, even higher if complications present.
- Treating depression associated with improved glycaemic control.
Section 3 – Endocrinology

**Self monitoring**
- Monitor blood glucose if on insulin.
- T2DM: no routine monitoring with blood or urinary glucose.
- Consider monitoring if:
  - high risk of hypoglycaemia
  - acute illness or fasting (e.g. Ramadan)
  - planning pregnancy or pregnant
  - significant changes in medications

*Medical management*

Start medication if HbA1c > 48 mmol/mol (6.5%) despite lifestyle treatment.

Three main treatment steps:
1. Metformin; slowly increase dose to minimise side effects, monitor U&Es, LFTs.
2. Add sulphonylurea if HbA1c > 48 mmol/mol (6.5%); warn regarding hypoglycaemia.
3. Add insulin if HbA1c > 58 mmol/mol (7.5%) with metformin + sulphonylurea.

Other agents can be used if any of above three are not appropriate:
- Thiazolidinediones or DPP-4 inhibitors (gliptins) can be used if sulphonylurea inappropriate. Only continue if >0.5% reduction of HbA1c in 6 months.
- Sitagliptin or thiazolidinedione can be used instead of insulin.
- Exenatide instead of insulin together with metformin + sulphonylurea, especially if BMI > 35. Only continue if >1% HbA1c reduction and >3% weight loss in 3 months.
- Acarbose – only if other oral agents not tolerated.
- Thiazolidinediones (glitazones) – warn regarding oedema, stop if CCF.

*HbA1c*

Set individual targets, avoid lowering to less than 48 mmol/mol (6.5%).

Monitor 2–6 monthly.

**Primary prevention of cardiovascular disease**

*Blood pressure*
- Aim for BP <140/80 (or <130/80 if organ damage – CVD, eye, kidney).
- Monitor 4–6 monthly if treated stable HTN (annually if no treatment required).
- Lifestyle advice: diet, exercise, weight, low salt, etc.
- ACE inhibitor = first-line.
- CCB or thiazide diuretic = second-line.
- CCB = first-line if patient may become pregnant
- Consider starting two treatments initially if Afro-Caribbean.
- Avoid alpha and beta blockers in diabetics**.
Section 3 – Endocrinology

**Blood lipids**

- Diet and lifestyle.
- Annual review of weight and CVD risk.
- Offer simvastatin 40 mg for all T2DM patients aged over 40 regardless of baseline cholesterol**.
- Fibrate if raised triglycerides not controlled with lifestyle or statin*.
- Aim for total cholesterol <4.0 and LDL <2.0*.
- Increase simvastatin to 80 mg or another statin or ezetimibe if target not reached*.
- Do not routinely use nicotinic acid or omega-3 fish oils*.

**Aspirin**

At the time of writing there is no consensus on when aspirin should be prescribed in diabetics. Here is what NICE, SIGN and MHRA have to say:

- NICE: aspirin if >50 years or raised CVD risk and BP <145/80
- SIGN: aspirin not recommended for primary prevention of cardiovascular disease in diabetics
- MHRA: Aspirin is not licensed for primary prevention of vascular events

**Diabetic nephropathy**

Annual screening with urine ACR, serum creatinine, eGFR.

**Microalbuminuria**

- Earliest sign of DM nephropathy.
- ACR >2.5 in men or 3.5 in women.
- Predictor of mortality, CVD mortality and morbidity, end stage renal disease.

**Diabetic nephropathy**

- >300 mg albumin/day in urine.
- Stronger predictor of mortality, CVD mortality, end stage renal disease.
- May exist with normal creatinine.

**Management**

- Reduce BP as much as possible; this reduces GFR and proteinuria.
- ACEi = first-line, regardless of BP, titrate to maximum dose.
- ARB if ACEi not tolerated.
- Protein restriction diet not recommended in early renal disease.
- Screen annually for anaemia (may need erythropoietin treatment).

**Diabetic eye disease**

Annual retinal screening with digital retinal photography and visual acuity testing.

To prevent onset and progression:

- HbA1c at 53 mmol/mol (7%) = ideal
- BP <130/80
Specific treatments = laser photocoagulation, vitrectomy, cataract extraction.

If visually impaired: community support, low vision aids, maximise benefits.

Refer if maculopathy, pre-proliferative retinopathy, unexplained reduction visual acuity.

**Diabetic foot complications**

- Prompt antibiotics for infections (local policies).
- Annual foot screening and education for low risk.
- Refer to specialist diabetic foot service if active foot complications.
- Annual podiatry if previous diabetic foot disease, loss of sensation, PVD or high risk.

**Neuropathic pain (NICE 2013)**

- Offer either tricyclic (unlicensed), duloxetine, pregabalin or gabapentin.
- If one of the above 4 do not work, each of the remaining 3 can be tried.
- Short-term tramadol for breakthrough pain only.
- Capsaicin cream can be used for localised symptoms if patient does not want or cannot tolerate oral treatments.

**Gastroparesis**

- Trial of metoclopramine, domperidone, erythromycin.

**Erectile dysfunction**

- Review annually.
- Offer Viagra/Cialis if no CIs.
Gestational diabetes


Screening should be offered to all pregnant women.

Diagnosis

OGTT using different values (fasting glucose ≥5.1, 1 hr ≥10, 2 hr ≥8.5).
Do not use HbA1c for diagnosing GDM.

Risk factors

- Obesity (BMI >30).
- Previous gestational DM.
- Previous macrosomic baby (>4.5 kg).
- Family history/ethnicity (Black Caribbean, South Asian, Middle Eastern).

In T1DM

- Pregnancy should be planned with multidisciplinary team.
- Importance of contraception/family planning services.

T1DM gives increased risk of:

- DM complications: ketoacidosis, hypoglycaemia, microvascular complications
- Obstetric complications: miscarriage, infection, pre-eclampsia, premature labour
- Foetal complications: malformations, distress, hypoglycaemia, intrauterine death

Planning for pregnancy in T1DM

- Maintain normal (non-diabetic) blood glucose as much as possible.
- High dose folate up to week 12/40.
- Offer preconception HbA1c, aim for <43 mmol/mol (6.1%).
- Retinal examination: before pregnancy, during each trimester.
- Stop oral hypoglycaemic agents except metformin during pregnancy.
- Stop statins, ACEi and ARB during pregnancy.
- Consider starting insulin.

Management

- Diet, weight, exercise.
- Specialist input.
- Monitoring: blood glucose, urinary ketones (ketoacidosis).
- Early viability scan, detailed anomaly scan at 20–22/40.
- Delivery at consultant-led maternity unit.
- Early breastfeeding to avoid neonatal hypoglycaemia.
- Follow up after pregnancy to ensure no progression to T2DM.
Goitre

Data gathering

**History**  How first noticed, time-course
Recent illness, pregnancy
Effect on breathing, swallowing

**Diet**
Iodine deficiency (dairy products, iodised table salt, seaweed)

**Hyperthyroidism**: weight loss, anxiety, tremor, palpitations, menstrual disturbance

**Hypothyroidism**: weight gain, lethargy, hoarse voice, dry skin, constipation, menstrual disturbance

**Family history**
Thyroid disease, autoimmune conditions including diabetes

**Social history**  Smoking, diet

**Red flags**  Thyrotoxic crisis: fever, agitation, confusion, heart failure, unwell patient

**Examination**  Midline swelling, moves with swallowing
Retrosternal extension, thyroid bruit (moves with tongue protrusion only = thyroglossal cyst)
Neck, eyes, pulse, tremor, skin/hair
Proximal myopathy, reflexes
Mental state

Interpersonal skills

**ICE**  Effect on life

**For patient**  “Gland at base of neck that makes a hormone called thyroxine. This thyroid hormone keeps the body functioning (metabolism) at the correct rate”

Management

**Investigations**  Bloods – TFTs, thyroid auto-antibodies
USS thyroid

**Management**  **Hyperthyroidism**
Refer all cases for specialist diagnosis
Consider propranolol if tremor or tachycardia to prevent AF
Cambimazole or propylthiouracil only under specialist advice
May need radioactive iodine therapy or surgery
Hypothyroidism
Refer if young or unwell
Oral levothyroxine replacement titrated against 1–3 monthly TFTs
Ensure TSH not suppressed to avoid risk of osteoporosis

Safety net Urgent referral if thyrotoxic crisis (mortality 10%)

Carbimazole

- Should be initiated under specialist advice.
- Warn patient that they need to seek medical attention if signs of agranulocytosis, e.g. sore throat, fever.