

NATUROPATHIC PRESCRIBING COURSE

ORAL ASSESSMENT PREPARATION

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Instructions:

- 1) Below are 2 PRACTICE cases (1 page each) to help you prepare for the oral exams.
- 2) Upon reviewing these 2 cases below, you may use any of your books and materials when reviewing the cases and preparing your treatment plans (excluding any electronic based references). Be efficient with your time. During the live oral assessment session, you only have 25 min per case (75 min total for all 3 cases). So for these 2 cases, try to prepare for both of sessions in 60 min or less.
- 3) Note: you are allowed to bring in ONLY 1 (8x10) piece of paper/case to the online/oral session (not allowed to use any of your texts/refs during the face to face oral exam). So use your prep time to put useful information on the 1 pager to help you best prep for the oral exam. **This piece of paper should contain your written prescription with drug name, dose and interval.** It does not need to contain all the elements of a proper prescription, like name, address etc.). You will hand this paper in at the end of your session. So for this online preparation session, try to just use one piece of paper. Feel free to create and use a template sheet that helps guide your preparation time.
- 4) When you are reviewing the cases and preparing for the oral assessment, please be prepared to:
 - A. List 5 goals (or targets) of treatment.
 - B. Design a PICO question for the case (if needed).
 - C. List 5 reasonable/viable treatment options (1 of these can be a non-drug measure), and two potential advantages and two disadvantages for each of these options.
 - D. Describe roughly the magnitude of the benefit and the harms associated with a particular treatment option.
 - E. Discuss any contraindications, precautions (general or patient specific) or drug interactions to any of your treatment options.
 - F. Identify which of the 5 treatment options you would try first and why you picked this choice versus the other options.
 - G. Describe the dose you would start with and how you would titrate it to effect. Please write the prescription out (*in the live session you would be handing this to the assessor*).
 - H. Describe 3-5 efficacy and toxicity monitoring parameters. For each parameter, list when these parameters should be monitored, how often and by whom.
 - I. Describe if and how any medications the patient is taking should be stopped.
 - J. Outline if there is anything else you would do in this case.


Case 1: Depression

MT is a 29-year old female patient who you have just diagnosed with depression.

She has been feeling “down and out” for about six months and states that she has no energy. She struggles to get out of bed in the morning and she goes to bed early (around 7pm) for most evenings. She wants to eat all the time but has no energy to prepare anything at home. As a result, she is eating a lot of junk fast food and gaining weight, which upsets her even more. She expresses feelings of guilt, indifference and irritability as prominent during her last week. Also, over the last 4 days, she also is complaining of having “a cold”. Her symptoms include: runny nose, dry cough and headaches.

She has missed 8 shifts in the last month from her cashier job at Costco due to her depressive symptoms. She started taking St. John’s wort and B-complex vitamins about two (3) months ago because her sister told her those things helped her and there was information on the internet about these treatments.

Current drug therapy:

Medical Condition	Drug Therapy	Duration of Therapy	Response
Birth control	Alesse 21-day	5 years	N/A
Cold symptoms	Tylenol cold and flu (contains acetaminophen, dextromethorphan, guaifenesin and phenylephrine) 	4 days	Improved cold symptoms
Depression	St. John’s wort 300mg 3 times daily	3 months	30% reduction in symptoms
Depression	B-Complex 100mg once daily	3 month	30% reduction in symptoms

Allergies and intolerances: **Aspirin hurts her stomach**

Diet: **Typically, balanced with lots of fruits and vegetables**
Recently, high fat, high calorie junk food

Vaccinations: **All up to date**

Tobacco: **1 ppd for 10 years**

Caffeine: **3x 12 oz coffees daily plus a cola**

Alcohol: **occasional wine and beer (4-6 drinks/week)**

Exercise: **used to be very active but now is quite sedentary.**

Vital signs: **Temperature: 36.8°C**

Blood pressure: 124/85

Heart rate: 73 bpm

Respiratory rate: 14

General appearance: **rumpled, untidy, slightly nonresponsive**

CNS: **headaches**

Lab values: **All normal**

Create a PICO question for this case.

Design a treatment plan for MT’s depression.

Case 2: Hypertension

KN is a 55-year old female patient. You have been noticing a steady increase in her blood pressure for the past few months, though it was normal when she first became your patient 6 months ago. At present her blood pressure is around 155/95 on repeated measurements. Her other medical conditions include psoriasis and gout. For gout, KN has had 3 episodes in the last 2 years and her family physician started her on allopurinol 9 months ago. She hasn't had any acute gouty attacks in the last 9 months.

KN's dermatologist has been treating her psoriasis for the last 5 years with various topical agents including various types of steroid creams, calcineurin inhibitors (tacrolimus), coal tar, vitamin D derivatives. About 6 months ago, her dermatologist started her on oral cyclosporine and changed all her topical agents back to betamethasone.

She gets occasional heartburn, particularly in the evening, but finds that taking some Maalox Plus is enough to control it. She also uses ibuprofen a few times a week for occasional low back pain or when she has pain in her joints attributed to gout. She states she's under stress at work these days and isn't as active as she used to be.

Current drug therapy:

Medical Condition	Drug Therapy	Duration of Therapy	Response
Psoriasis	Betamethasone valerate ointment applied daily to psoriatic areas	5 years	Partial control
Psoriasis	Cyclosporine 150 mg po bid	6 months	50% improvement in the last 6 months
Gout	Allopurinol 200 mg daily	9 months ago	No attacks since it started
Intermittent low back pain and painful joints	Ibuprofen 200-400 mg PRN	3 years	Helps somewhat
Heartburn	Maalox Plus susp 15ml pc PRN	Several years	Controlled

Allergies and intolerances: **None**

Diet: Relatively balanced diet with fruits and vegetables. Still has a high red meat intake despite your previous advise

Vaccinations: All up to date

Tobacco: ½ ppd x 30 years – she plans to try to stop cold turkey in the next few weeks

Caffeine: 3-4 12 oz coffees daily

Alcohol: 2 or 3 glasses of wine daily

Exercise: little exercise except for gardening

Vital signs: Temperature: 36.8°C
 Blood pressure: 155/95 – multiple measurements – assume properly done
 Heart rate: 80 bpm
 BMI: 28.5
 Respiratory rate: 17

General appearance: unfit, perhaps 15kg overweight, carrying weight around waist

CNS: No unusual CNS findings

Lab values: From a few months ago

Total cholesterol: 6.6 mmol/L (Normal = <5.2 mmol/L)
 HDL-C: 1.1 mmol/L (Normal = > 0.9 mmol/L)
 LDL-C: 4.5 mmol/L (Normal = < 3.4 mmol/L)
 HbA1C: 6% (Normal = 4-6%)
 Serum urate levels: 410 micromol/L (Normal = < 360 micromol/L for females)

- 1) What is KN's risk for having a clinically significant cardiovascular event in the next 5 years? Please consider how much your treatments would decrease this risk.
- 2) Design a treatment plan for reducing this patient's cardiovascular risk, focussing on blood pressure control.