Over 100 SCA cases aligned to the RCGP Blueprint areas

FOURTH EDITION

4

CASES WORKBOOK FOR THE MRCGP

ELLEN WELCH

JENNIFER LYALL

FOURTH EDITION

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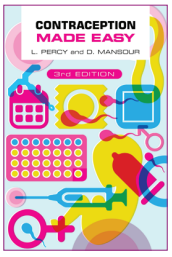

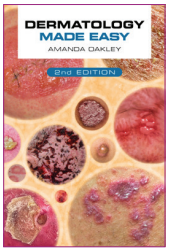

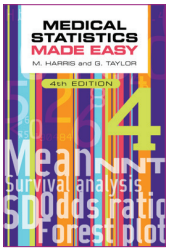

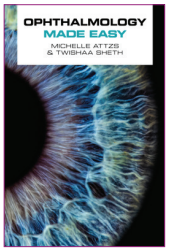

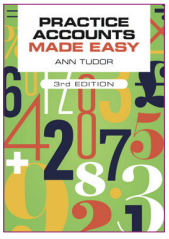

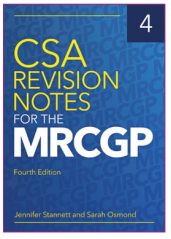

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CASES WORKBOOK FOR THE MRCGP

Ellen Welch (MBChB, MRCGP (2013), MRCEM, BA (Hons), DTMH, DFSRH)
GP, Carlisle, Cumbria

and Jennifer Lyall (MBBS, MRCGP (2013), DRCOG, DFSRH)
GP, Workington, Cumbria

With contributions from:
Irina Zacharcenkova and George Bardsley

Scion

ISBN 9781914961571 (hardback ring-bound version)
ISBN 9781914961441 (loose-leaf version)

Fourth edition first published 2024
Third edition published 2019
Second edition published 2017
First edition published 2014

A CIP catalogue record for this book is available from the British Library.

Scion Publishing Limited
The Old Hayloft, Vantage Business Park, Bloxham Road, Banbury OX16 9UX, UK
www.scionpublishing.com

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Typeset by Evolution Design & Digital Ltd (Kent)
Printed in the UK
Last digit is the print number: 10 9 8 7 6 5 4 3 2 1

Contents

Preface to the fourth edition

The first edition of this workbook was written in 2013 when we were all still GP Registrars preparing for the CSA ourselves. We struggled to find the resources we needed at the time to revise in a meaningful way for the exam, so decided to create our own. *Cases Workbook for the MRCGP* presents a practical and organised approach to the exam, allowing candidates to access SCA role-play scenarios aligned to the RCGP Curriculum and Blueprint areas, alongside a logical structure to exam preparation and revision.

The Workbook has been enthusiastically received and we have been delighted to read positive feedback from GP Registrars who have gone on to pass the exam using our book. We were delighted to win the Young Author Award at the BMA Book Awards, as well as being highly commended in the General Practice category. We've also taken on the criticisms – the main one being that this book doesn't provide 'the answers'. Our response to this is that every consultation in general practice is unique; what works for one clinician may not work for another. The purpose of this workbook is not to provide a script with all the answers, but to allow you to practise clinical scenarios and find your own consultation style. What we do provide is up-to-date links to the clinical information you need, and a basic structure to your revision that follows what the SCA examiners are looking for.

Our fourth edition presents over 100 remote consultation scenarios, alongside QR codes, accessible by smartphone, to help keep abreast of ever-changing guidelines. You will find the QR codes throughout the book and they take you to hyperlinked PDFs for every Curriculum area and every Blueprint area (and there's one at the start that takes you to a single PDF that covers all the weblinks in the entire book), so that during a revision session, any clinical queries can be addressed using the most up-to-date resources available.

We hope this newest edition will continue to provide a valuable resource for registrars applying to sit their SCA.

All the best – you can do it!

Ellen Welch
Jenny Lyall

Acknowledgements

Huge thanks need to go firstly to Jonathan Ray at Scion Publishing, for bringing this workbook into its 4th edition, more than 10 years after the first one came out. Thank you for sticking with us and always being patient with the deadlines being missed, and always hugely supportive of our ideas. Clare Boomer also deserves big thanks for her painstaking checking of case numbers and the finer details. The 4th edition needed a huge re-do since the structure of the exam has changed over recent years, but we did keep some of the original cases that Irina and George Bardsley wrote – thanks to you both for your time on these. Thank you to Elissa Abi-Raad for your suggestions about the structure of the book, as one of the first cohorts of registrars to sit the new exam. And thank you to Dr Sarah Jacques and Dr Lizzie Toberty for proofreading the book. Thanks to our own revision group who helped us get through our own exam, and finally to you the reader – thanks for buying this book and we hope it helps you.

Abbreviations

AAA	Abdominal aortic aneurysm
A&E	Accident and Emergency department
ABPI	Ankle brachial pressure index
ACEi	ACE inhibitor
ACL	Anterior cruciate ligament
ACR	Albumin–creatinine ratio
ACS	Acute coronary syndrome
ADHD	Attention deficit hyperactivity disorder
ADL	Activities of daily living
AF	Atrial fibrillation
AiT	Associate in training
AKT	Applied knowledge test
ALP	Alkaline phosphatase
ALT	Alanine aminotransferase
AS	Ankylosing spondylitis
ASD	Atrial septal defect
BCC	Basal cell carcinoma
BMD	Bone mineral density
BMI	Body mass index
BMJ	*British Medical Journal*
BNF	*British National Formulary*
BNP	Brain natriuretic peptide
BP	Blood pressure
BS	Bowel sounds
BTS	British Thoracic Society
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive behavioural therapy
CCF	Congestive cardiac failure
CCT	Certificate of completion of training
CFU	Colony-forming units
CHD	Chronic heart disease
CI	Contraindication
COCP	Combined oral contraceptive pill (or COC)
COPD	Chronic obstructive pulmonary disease
COT	Consultation observation tools
CKD	Chronic kidney disease
Cr	Creatinine
CRF	Chronic renal failure
CRP	C-reactive protein
CSA	Clinical Skills Assessment
CVD	Cardiovascular disease
CVS	Chorionic villus sampling
CXR	Chest X-ray
DEXA	Dual-energy X-ray absorptiometry
DH	Drug history
DM	Diabetes mellitus
DNAR	Do not attempt resuscitation
DRE	Digital rectal examination
DSH	Deliberate self-harm
DVLA	Driver and Vehicle Licensing Agency
DVT	Deep vein thrombosis
ECG	Electrocardiogram
eGFR	Estimated glomerular filtration rate
ENT	Ear, nose and throat (Otorhinolaryngology)
ESR	Erythrocyte sedimentation rate
ET	Exercise tolerance
FBC	Full blood count
FEV_1	Forced expiratory volume in 1 second
FGM	Female genital mutilation
FSH	Follicle-stimulating hormone
FVC	Forced vital capacity
GCS	Glasgow Coma Scale
GFR	Glomerular filtration rate
GGT	Gamma-glutamyl transferase
GI	Gastro-intestinal
GMC	General Medical Council
GORD	Gastro-oesophageal reflux disease
GTN	Glyceryl trinitrate
GUM	Genito-urinary medicine
Hb	Haemoglobin
HbA1c	Glycated haemoglobin
HIV	Human immunodeficiency virus
HOCM	Hypertrophic cardiomyopathy
HPV	Human papillomavirus
HR	Heart rate
HRT	Hormone replacement therapy
HS	Heart sounds
HTN	Hypertension
I&D	Incision and drainage
IBD	Inflammatory bowel disease
IBS	Irritable bowel syndrome
ICE	Ideas, concerns and expectations
ICP	Intracranial pressure
IELTS	International English Language Testing System
IM	Intramuscular
IMB	Inter-menstrual bleeding
IMG	International medical graduates
IUD	Intrauterine device (e.g. copper coil)
IUS	Intrauterine system (e.g. Mirena)

IVDU	Intravenous drug user
K	Potassium
LARC	Long-acting reversible contraception
LD	Learning disability
LFTs	Liver function tests
LGV	Lymphogranuloma venereum
LMP	Last menstrual period
LOC	Loss of consciousness
LRTI	Lower respiratory tract infection
LTOT	Long-term oxygen therapy
LUTS	Lower urinary tract symptoms
MCS	Microscopy, culture and sensitivities
MCV	Mean corpuscular volume
MDT	Multi-disciplinary team
ME/CFS	Myalgic encephalomyelitis / chronic fatigue syndrome
MI	Myocardial infarction
MMR	Measles, mumps, rubella vaccination
MRCGP	Member of the Royal College of General Practitioners
MS	Multiple sclerosis
MSU	Mid-stream urine
Na	Sodium
NAD	Nothing abnormal detected
NAI	Non-accidental injury
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NIV	Non-invasive ventilation
NRT	Nicotine replacement therapy
NSAID	Non-steroidal anti-inflammatory drug
NTDs	Neural tube defects
NVD	Normal vaginal delivery
OCP	Ova, cysts and parasites
OE	On examination
OOH	Out of hours
OSA	Obstructive sleep apnoea
OSCE	Objective structured clinical examination
OTC	Over-the-counter
PCB	Post-coital bleeding
PCOS	Polycystic ovary syndrome
PE	Pulmonary embolism
PEFR	Peak expiratory flow rate
PERL	Pupils equal and reactive to light
PID	Pelvic inflammatory disease
PIL	Patient information leaflet
PLAB	Professional and linguistic assessment board exam
Plt	Platelets
PND	Paroxysmal nocturnal dyspnoea
PO	*Per orum* (orally)
POP	Progesterone-only contraceptive pill
PPI	Proton pump inhibitor
PR	Per rectum (examination)
prn	Pro re nata (as needed)
PSA	Prostate-specific antigen
PTSD	Post-traumatic stress disorder
PVD	Peripheral vascular disease
RA	Rheumatoid arthritis
RCA	Recorded Consultation Assessment
RCGP	Royal College of General Practitioners
RCOG	Royal College of Obstetricians and Gynaecologists
RhF	Rheumatoid factor
RICE	Rest, ice, compression, elevation
RR	Respiratory rate
Rx	Treatment
SCA	Simulated Consultation Assessment
SCBU	Special care baby unit
SCC	Squamous cell carcinoma
SI	Sacroiliac
SIGN	Scottish Intercollegiate Guidelines Network
SLE	Systemic lupus erythematosus
SOB	Shortness of breath
SpO_2	Pulse oximetry measurement
SSRI	Selective serotonin reuptake inhibitor
ST3	Specialist trainee year 3
STD	Sexually transmitted disease
STI	Sexually transmitted infection
SVC	Superior vena cava
SVT	Supraventricular tachycardia
T	Temperature
T2DM	Type 2 diabetes mellitus
TATT	Tired all the time
TB	Tuberculosis
TCA	Tricyclic antidepressant
TFTs	Thyroid function tests
TIA	Transient ischaemic attack
TSH	Thyroid-stimulating hormone
U&Es	Urea and electrolytes
UPSI	Unprotected sexual intercourse
Ur	Urea
URTI	Upper respiratory tract infection
USS	Ultrasound scan
UTI	Urinary tract infection
VA	Visual acuity
VTE	Venous thromboembolism
WCC	White cell count
WPBA	Workplace-based assessments

C1 Allergy and immunology

Cases provided in *Workbook*: B1.4, B3.6, B9.17, B10.2

Possible cases

- Allergy testing request
- Anaphylaxis
- Angioedema
- Atopy – asthma, eczema, hay fever
- Autoimmune conditions
- Chickenpox in pregnancy
- Drug reactions / allergies
- Food allergies
- Gastrointestinal symptoms of allergy
- Immune deficiency states (inherited and acquired, e.g. HIV, chemotherapy)
- Immunisation
- Needlestick injury and bloodborne disease
- Occupational allergies (contact allergies – latex / hair dye / metals / plants)
- Pollen food syndrome
- Transplantation patients in primary care
- Urticaria and rashes

Emergency cases

- Acute management of anaphylaxis
- Emergency treatment of venom allergy

Special cases

- Discussing allergy tests – skin patch plus specific IgE testing
- Discussing indications / contraindications to routine immunisation in an immunosuppressed child

Revision notes

Applicable guidelines and useful resources

Relevant NICE guidelines and pathways:

- cks.nice.org.uk/specialities/allergies
- cks.nice.org.uk/specialities/immunizations

The British Society for Allergy & Clinical Immunology: www.bsaci.org
British Society for Immunology: www.immunology.org
British HIV Association: www.bhiva.org
British Transplantation Society: bts.org.uk
Resuscitation Council UK – emergency treatment of anaphylaxis: www.resus.org.uk/library/additional-guidance/guidance-anaphylaxis
RCEM Learning – management of needlestick injury: www.rcemlearning.co.uk/reference/needlestick-injury

Vaccine Knowledge (University of Oxford): vaccineknowledge.ox.ac.uk/home
UK immunisation schedule: www.gov.uk/government/publications/the-complete-routine-immunisation-schedule
Guidance on allergy and specific IgE testing: www.coventryrugbygpgateway.nhs.uk/pages/guidance-on-allergy-and-specific-ige-testing

Material for patient

Allergy UK: www.allergyuk.org
ASCIA info leaflets: www.allergy.org.au/patients
Immunodeficiency UK: www.immunodeficiencyuk.org
Patient leaflets from BSACI: www.bsaci.org/professional-resources/patient-information-leaflets-2
Transplant patient information: www.nhsbt.nhs.uk/organ-transplantation
UK PIPS (Primary immune deficiency patient support): ukpips.org.uk

Practise explaining

Practise explaining the following to a patient in less than 2 minutes:

- Exclusion and reintroduction in non-IgE disease
- How to effectively administer nasal steroids
- Signposting patients to pharmacy for over-the-counter hay fever treatments
- Benefits and risks of different vaccinations (try: MMR; influenza for a 2-year old and for a 65-year old)
- The role of immunotherapy for chronic allergic disorders

Practise examining

Ensure that you can undertake the following procedures confidently and efficiently:

- How to administer adrenaline

Case B2.5 Information for the doctor

You are a newly qualified GP in surgery taking video calls.	
Name:	Anita Singh
Age:	31
Past medical history:	Marsupialisation for Bartholin's cyst (2011); eczema
Current medication:	Naproxen 250 mg prn, Zeroderm ointment
Telephone consultation (4 months ago):	GP Dr S: phone call from patient (not known to me), enquiring about swab and USS results – all reported as normal, reassured. Previous consult noted. Manages well with naproxen during periods. No new issues. Review as needed.
Previous consultation (6 months ago):	GP Dr K: complaining of dyspareunia in certain positions, occasional abdo ache, worse when on her period (previously seen with abdo pain in OOHs, ongoing issue), took tramadol from a friend for a few days 3 months ago as the pain was unbearable. Discouraged to do so in the future, reasons discussed in detail. Usually manages well with naproxen during periods. Admits stress at work / lack of sleep. Anxious, unable to conceive, only been trying for 6 months so reassured at this stage. Minimal PV discharge, clear – ?physiological. No urinary symptoms. Married, no problems at home. No postcoital / intermenstrual bleeding. Smear – normal last year. Examination: normal vital signs; abdo soft, normal pelvic exam, self vaginal swabs sent for reassurance, urine NAD. Imp - ?cause for abdo pain / ?stress related / ?anxiety around conceiving. Plan – arrange USS, swabs and review with results. Counselling discussed – declined at this stage.
Consultation in Out Of Hours Centre (9 months ago):	Presented with her husband with severe abdo pain for 2 days. On her period at present. Haemodynamically stable, vitals all normal. Naproxen not working. Had some loose stools. No fever. Examination – min discomfort in lower abdomen. BS normal. Urine – NAD, pregnancy test negative. Imp – menstrual cramps Plan – add short-term co-codamol, continue naproxen. See GP if not better.

Case B2.5 Information for the patient

You are Anita Singh, a 31-year old woman. You are worried there might be something wrong as you are unable to get pregnant. You have been trying for less than a year, but you are concerned and would like to get a referral to a fertility clinic. You wish to start a family as soon as possible and the fact that everyone around you seems to be getting pregnant is making you more stressed.

ICE

- You start by saying: "Sorry to bother you again but I think I need to be referred to fertility clinic".
- You've done your research and are aware that you might not qualify under the NHS criteria so are happy with a private referral.

Background

- You work as a designer and do a lot of travelling around the country.
- You love your job but recently decided to drop your hours because you are desperately trying to get pregnant.
- Your husband is a rental agent and works full time.
- You have 2 older sisters who both got pregnant in their early 20s.
- Your parents live in London, you see them every couple of months. They keep asking you if you have decided not to have children. It really affects you because you are trying to get pregnant. You and your husband haven't told them you've been trying for a while because you don't want them to worry (your mum has had 2 heart attacks in her 60s).

Information divulged freely

- You are usually well, only suffering from mild eczema in winter.
- Your mum has had 3 daughters. Your two older sisters (they are both in their 40s) were born when your mum was in her early 20s. You are not aware of any fertility problems in your family but it did take 10 years for your mum to get pregnant with you after your two sisters were born.
- One of your sisters has 2 children who are now teenagers and your second sister has a child in their early 20s.
- You don't smoke. You have the occasional Martini every few weeks.
- Your husband has asthma, otherwise he is pretty healthy. He smokes the occasional shisha when you are on holiday, otherwise he doesn't smoke. He enjoys a couple of beers at the weekend.
- Your periods are regular, your cycle is 26 days. They've always been painful for as long as you can remember. In the past ibuprofen would sort your pain but over the past year or so, you've noticed that it's simply not enough. You were given naproxen which was initially effective during your painful periods but it didn't help a few months ago, so you took some tramadol from a friend. You know it was silly but you were in agony and needed to prepare a presentation for work.
- Your periods usually last 7 days and are quite heavy.
- If the GP offers an appointment for internal examination you decline as the GP you saw last time carried this out and you are currently menstruating and don't feel comfortable doing this while you are.

- If the GP suggests that you and your husband should have some more investigations first, you'd insist on a private referral to a local fertility centre. If the GP clearly explains what tests could be done first and why, you'd be happy to have these tests first.
- If the doctor is unsure if you could be referred to a fertility clinic on the NHS but is willing to find out about current criteria, you'd be grateful if a follow-up telephone call could be arranged.
- If the GP suspects you might have endometriosis, you'd get really worried and will need more answers about what it is and how it's diagnosed. If the GP remains confident and empathetic and offers a gynaecology referral for a second opinion you'd be very happy that the doctor takes your concerns seriously.
- If the GP has some general fertility advice for you and tells you that all your tests so far (swabs and USS) are normal and you should just keep trying and give it a bit longer, you'd start crying and will keep asking about private referral to fertility clinic until the doctor agrees to arrange one.

Information only divulged if specifically asked:

- You'd admit certain sexual positions are uncomfortable. You are embarrassed to talk about it.
- If specifically asked about your bowel symptoms, you'd admit your bowel movements are usually more painful and looser during your periods but it's always been this way, so you are not sure if it's getting any worse.
- You have no urinary symptoms.
- You've never had any sexually transmitted infections.
- If specifically asked about intercourse you'd confirm you have vaginal intercourse regularly, usually three times a week unless you are on your period.
- You've been married for 5 years and have never been on any contraception; you were using the 'withdrawal method'.
- You've never been pregnant and never had any miscarriages or abortions.
- You are already taking folic acid supplements.

Case B2.5 Marking scheme for the observer

The NICE guidelines on Endometriosis: diagnosis and management and Fertility problems: assessment and treatment can be read in conjunction with this case:
www.nice.org.uk/guidance/ng73
www.nice.org.uk/guidance/cg156

Data gathering and diagnosis			
☐	☐	☐	• Identifies reason for attendance and desire for referral
☐	☐	☐	• Takes a fertility history including: length of time trying to conceive; regularity of intercourse and any difficulties experienced; gynae history (pattern of menstrual cycle / pain / prior pregnancies or procedures / smear history); previous STIs; partners and family history
☐	☐	☐	• Checks for red flag symptoms such as postcoital bleeding, rectal bleeding, abdominal masses and enquires about general health / presence of any systemic disease
☐	☐	☐	• Considers following up with an examination and to check BMI, BP
Clinical management and medical complexity			
☐	☐	☐	• Suspects possible endometriosis (cyclical pelvic pain, dyspareunia, heavy menstrual bleeding, painful bowel movements during periods) and takes appropriate steps to diagnose or exclude it. Referral to gynae clinic would be appropriate in this case. The candidate should be aware that a normal USS and examination does not rule out endometriosis and should be able to explain that diagnostic laparoscopy is the gold standard in the diagnosis of endometriosis
☐	☐	☐	• Is able to give general fertility advice (lifestyle – smoking cessation, avoidance of alcohol / illicit drugs, folic acid supplementation, having unprotected intercourse 2–3x weekly)
☐	☐	☐	• Can discuss investigations available (NICE advises against a 'blind screen' for everything and different localities will vary on what GPs can offer in primary care). The following pathway may be useful: www.ouh.nhs.uk/services/referrals/womens/fertility-clinic.aspx
☐	☐	☐	• Arranges follow-up with results / offers to see husband and explains need for semen analysis and consulting with him too
☐	☐	☐	• Explains options with regards to fertility / checks criteria for NHS referral if unsure (may differ between areas)
☐	☐	☐	• Discusses pain symptoms and analgesic options. Discusses NSAIDs being contraindicated in pregnancy. Shares with the patient that hormonal methods (such as the combined oral contraceptive pill) can be used to reduce pain, but acknowledges at present when trying to get pregnant this may not be an option

Relating to others			
☐	☐	☐	• Addresses ICE, empathetic towards patient concerns about fertility
☐	☐	☐	• Builds rapport and is able to question patient openly but sensitively about intercourse and any problems she is experiencing
☐	☐	☐	• Appropriately refers / arranges follow-up and safety-netting
☐	☐	☐	• Offers written information on both endometriosis (patient.info/health/pelvic-pain-in-women/endometriosis) and fertility (patient.info/health/infertility-leaflet).

APPENDIX

Case list by subject

Subject	Relevant case(s)	Page reference
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Subject	Relevant case(s)	Page reference
Third party consultation	B1.1, B1.2, B4.1, B4.6, B5.3, B7.1, B7.2, B7.3, B7.5, B7.6, B9.1	75, 81, 225, 255, 285, 357, 363, 369, 381, 387, 429
TIA	B4.8	267
Tinnitus	B3.5	207
Tiredness	B9.11	489
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Weight loss	B10.1	543