CLINICAL CASES
Case 1: Mr. OA
Mr. OA: Case Presentation

- 62-year-old lawyer
- Mild left knee pain for 3 months, but became worse 1 week ago
- No swelling
- 1 week earlier: 2-hour walk in the countryside 2 days in a row
- Walks 3–4 times a week
- No current medications
Mr. OA: Discussion Question

WHAT ARE SOME POSSIBLE CAUSES OF MR. OA’S JOINT PAIN?
WHAT ADDITIONAL INFORMATION WOULD YOU LIKE TO KNOW?
Mr. OA: Pain History

- Where is the pain?
  - Diffuse but more pronounced medially

- Trigger:
  - Walk in the country, 2 hours, 2 days in a row
  - Morning stiffness that disappears after 30 minutes

- Swelling:
  - Not this time, but appears when he is more active
  - No locking or buckling

- Old surgery or deformation:
  - Medial meniscectomy of left knee 37 years ago
Mr. OA: Discussion Question

Based on the information collected, what would you look for on the physical exam?
Mr. OA: Targeted Examination

• Inspection:
  – Slight limp
  – Overweight
  – Mild genu varum
  – No swelling, atrophy or redness

• Mr. OA locates his pain with his hand in the anterior medial area of the knee

• Incomplete flexion on the affected side
Mr. OA: Targeted Examination (cont’d)

- **Range of motion:**
  - Incomplete flexion on the affected side
  - Normal extension

- **Swelling:**
  - Patellar tap: negative
  - Therefore, no effusion

- **Palpation:**
  - Medial joint-line tenderness, no pain elsewhere
  - Crepitus was detected in the left knee

- **Hip examination:** normal
WOULD YOU CONDUCT ANY FURTHER INVESTIGATIONS SUCH AS LABORATORY TESTS OR IMAGING?
Mr. OA: Investigation

• X-ray of knee shows:
  – Multiple moderate osteophytes
  – Definite medial joint space narrowing
  – Some sclerosis
Mr. OA: Discussion Question

WHAT WOULD BE YOUR DIAGNOSIS?
Mr. OA: Diagnosis

- Osteoarthritis of the knee (medial compartment)
Mr. OA: Discussion Question

WHAT WOULD BE YOUR TREATMENT PLAN?
Mr. OA: Treatment Plan

• Apply heat on local pain area
• Physiotherapy or therapeutic exercise
• Possibility of joint injection
• Acetaminophen
• nsNSAIDs/coxibs

Coxib = COX-2-specific inhibitor; nsNSAID = non-specific non-steroidal anti-inflammatory drug
Case 2: Mrs. RA
Mrs. RA: Case Presentation

- 55-year-old legal secretary
- Complains that she has had pain and swelling of several hand joints for about 2 years, but these have become worse in the last 3 months
- Her joint pain and swelling is more severe in the morning and she has difficulty typing, but her symptoms get better in the afternoon
- She asks to be put on same medication as her husband who has osteoarthritis
WHAT ADDITIONAL INFORMATION WOULD YOU LIKE TO KNOW?
Physical Examination

• Her hand joints are swollen and tender, involving PIP and MCP
• Slight swelling and tender in both wrist
• Symmetrical in both hands

MCP = metacarpophalangeal; PIP = proximal interphalangeal
WOULD YOU CONDUCT ANY FURTHER INVESTIGATIONS SUCH AS LABORATORY TESTS OR IMAGING?
X-ray and Abnormal Lab Findings

- Osteoporosis around PIP joints and erosion of some PIP joints
- Her blood ESR and CRP were elevated
- Her RF and anti-CCP antibody are positive

CCP = cyclic citrullinated peptide; CRP = C-reactive protein; ESR = erythrocyte sedimentation rate; PIP = proximal interphalangeal; RF = rheumatoid factor
Mrs. RA: Discussion Question

WHAT WOULD YOU TELL MRS. RA?
What Mrs. RA’s diagnosis?

- Her diagnosis is rheumatoid arthritis
Mrs. RA: Discussion Questions

WHAT WOULD BE YOUR GOALS FOR MRS. RA?

WHAT WOULD BE YOUR TREATMENT PLAN?
Mrs. RA: Treatment Plan

- You prescribe nsNSAID/coxib to manage the pain from the acute flare
- Refer Mrs. RA to rheumatologist to confirm diagnosis and initiate disease-modifying treatment

Coxib = COX-2-specific inhibitor; nsNSAID = non-specific non-steroidal anti-inflammatory drug
Case Template
Patient Profile

• Gender: male/female
• Age: # years
• Occupation: *Enter occupation*
• Current symptoms: *Describe current symptoms*
Medical History

**Comorbidities**
- List comorbidities

**Measurements**
- BMI: # kg/m²
- BP: #/# mmHg
- List other notable results of physical examination and laboratory tests

**Social and Work History**
- Describe any relevant social and/or work history

**Current medications**
- List current medications
Discussion Questions

Based on the case presentation, what would you consider in your differential diagnosis?
What further history would you like to know?
What tests or examinations would you conduct?
Pain History

- Duration: *When did pain begin?*
- Frequency: *How frequent is pain?*
- Quality: *List descriptors of pain*
- Intensity: *Using VAS or other tool*
- Distribution and location of pain: *Where does it hurt?*
- Extent of interference with daily activities: *How does pain affect function?*
Clinical Examination

- List results of clinical examination
Results of Further Tests and Examinations

- *List test results, if applicable*
WHAT WOULD BE YOUR DIAGNOSIS FOR THIS PATIENT?
Diagnosis

• *Describe diagnosis*
Discussion Question

WHAT TREATMENT STRATEGY WOULD YOU RECOMMEND?
Treatment Plan

• List both pharmacologic and non-pharmacologic components of management strategy
Follow-up and Response to Treatment(s)

- Describe pain, function, adverse effects, etc. at next visit
Case Template: Discussion Question

WOULD YOU MAKE ANY CHANGES TO THERAPY OR CONDUCT FURTHER INVESTIGATIONS?
Other Investigations

• List results of further investigations, if applicable
Changes to Treatment

- Outline changes to therapy, if applicable
Conclusion

• *Describe pain, function, adverse effects, etc. at next visit*
What If Scenarios

- How would your diagnosis/treatment strategy change if...
  - List what if scenarios