Case 1: Unsafe Driving

Mr. Dent is a pleasant 91 year-old male with a history of cognitive impairment, living independently with PMH of IDDM, HTN, GERD and prior TIA who is presenting to the office at the request of the patient's daughter. The patient's daughter accompanies him to the visit and reports that she has concerns about the patient's driving. She states that she drove with him for the first time in several years this past weekend, and there was a near miss. The patient was driving in the left lane and came close to hitting a car next to him in the right lane when changing lanes. She also notices some scratches on the fender, but is unsure when these occurred. The patient states that they must have been other vehicles and he has no trouble driving. He does not have any history of visual complaints and had a normal eye exam within the last year. Vitals are normal. On examination, the patient appears comfortable. His hearing is intact to voice and visual testing is within normal limits. He has a normal gait and get up and go time of 10 seconds. There is normal muscle strength, range of motion and muscle tone. You perform cognitive testing showing MoCA of 22/30 (lost 5 points for visuospatial testing, 1 point for verbal fluency and two points for abstraction). When asked what his concerns would be if he were driving and a ball rolled in front of the car he replies that he would not want to pop the ball or wreck his car. The patient is completely unable to perform a Trails B test. He requests to go home and becomes anxious after the testing. He agrees to share his medical information with his daughter.

After seeing the patient and his daughter, you are concerned about his ability to drive safely. His cognitive testing is notable for impaired executive function (as evidenced by his MoCA testing and impaired Trails B) and impaired judgment. An abnormal Trails B test confers a two-fold increase in risk of failing a formal DMV driving evaluation.

In this exercise, you need to discuss the abnormal testing with the patient and his daughter and share your concerns about his ability to drive safely. Your goal is to deliver the information using SPIKES and to recommend that the patient go for a formal driving evaluation at the DMV.

For those receiving this information, imagine that you are the patient. You enjoy driving daily to interact with friends and family and to run necessary errands. You would never want to burden your family with needing to take you places if you were unable to drive yourself. You see no reason why you shouldn't be able to drive, after all, you have been driving for over 70 years!

Case 2: Diagnosis of Dementia

Mrs. Frooget is an 86 year-old with PMH of cognitive impairment, breast cancer s/p lumpectomy with adjuvant chemotherapy and completion of 5 years of hormonal therapy and HTN who is presenting to clinic accompanied by her spouse for evaluation of cognitive impairment. During her last visit one year ago, MoCA was 18/30 and she needed assistance with medications, transportation and cooking. Her spouse is concerned that her memory is worse. She now also needs to be prompted to bathe and will occasionally choose clothing that is not appropriate for the season. She denies any concerns about memory. Vitals are normal and examination is unremarkable. Repeat testing notable for MoCA of 14/30. Laboratory testing is notable for normal TSH, B12, folic acid. MRI shows hippocampal atrophy bilaterally. Her spouse asks what can be done to improve her memory or prevent it from getting worse.

Based on this patient's cognitive impairment and functional impairment, you correctly identify that this patient has dementia. The advanced age and hippocampal atrophy in the absence of reversible etiologies raises your suspicion for Alzheimer's dementia. You recall that the natural history of Alzheimer's is such that the patient will likely decline cognition and function slowly over time. The average life expectancy for patients from time of diagnosis to death is 10 years. Medication options at this time given the patient's functional decline include acetylcholinesterase inhibitors. The main side effects of these medications are GI upset, nighttime hallucinations and small risk of GI bleeding.

In this exercise, you need to discuss your diagnosis with the patient and spouse and provide them with the information above. Your goals of the conversation are to deliver the information with SPIKES and to counsel the family regarding potential treatment options.

For those receiving the information, imagine that you are the patient's spouse of 60 years. You and your spouse do everything together and enjoy spending time with your family (4 children and 9 grandchildren). You have had a wonderful retirement and love to travel whenever you can. You greatly fear that your spouse has Alzheimer's dementia and that she will forget you and your family.

Case 3: Failure to thrive:

Ms. Confoose 86yo lady with dementia, coronary artery disease and osteoporosis presents to your office for routine follow up. You have known this patient for 10 years and know that her family is her primary source of support and are responsible for all her IADLs. Her dementia has been treated in the past with donepezil but she was unable to tolerate it due to nighttime hallucinations and bradycardia. She requires help with most ADLs but is still able to feed herself. She continues to be calm and confused at home but her family is concerned about her diet. They note that over the last 3 months she has had a significant reduction in her dietary intake and has to be reminded to take bites of her food. When prompted the patient just states that she is not hungry. She has no abdominal pain or change in bowel movements. She has baseline incontinence without changes to urine color or odor. She continued with routine cancer screening per guideline recommendation and has no family history of cancer. Her vitals are T 96.9F, BP152/76, P74, RR14, 99% on RA. Her weight is 90lbs (last known weight 108lbs 12mo ago). The remainder of her exam is significant for well-maintained dentures, normal cardiovascular and respiratory exam, and a non-tender abdomen. She has a slow but steady gait with a get up and go of 25 seconds. She has no rigidity and her muscle strength is 4/5 in all extremities and is new from her last exam. Labs done prior to the visit come back with mild hypernatremia, LDL 51 and microcytic anemia.

You prescribe ensure to take with every meal and ask the family to be present at every meal to encourage more intake. You also remind them of the importance of hydration. In 1 month, the patient returns to your office and now weighs 88lbs and her labs are unchanged. Her diet continues to be poor and the family turns to you for help.

You are concerned that this patient's dementia or, possibly, a new cancer is the cause of her failure to thrive, as she has no other evidence of respiratory, abdominal, cardiac or renal disease that you have identified. Failure to thrive is associated with functional loss and increased risk of medical illness and compromised wound healing due to impaired immunity. Patients with failure to thrive have higher rates of social isolation and depression.

In this exercise, you need to discuss this diagnosis with the family. Your goals of the conversation are to deliver the information using SPIKES, identify what the family's next steps are for their loved one and offer to discuss advanced care planning with the family.

For those receiving the information, you are the grandchild of this elderly woman. You live with her and have cared for his for the last 5 years, having to quit your own job to take care of her.

Case 4: New Cancer Diagnosis:

Mr. Marlboro is a 78yo gentleman with a PMH mild COPD, diabetes and long time smoking history. On your last visit with him you ordered a CT scan of his chest for lung cancer screening due to his 50-pack year smoking history. At the time of your last visit with him, his COPD was well controlled on Symbicort and albuterol PRN and other than a chronic cough, which was unchanged in character from previous visits, and a 30lb intentional weight loss, he had no other positive findings on review of systems. His CT results come back identifying a 3cm, speculated lung mass in the right lower lobe with multiple enlarged mediastinal lymph nodes. He is also noted to have multiple nodules of varying sizes in his liver consistent with metastatic cancer.

He is coming in today to review the results of his CT scan.

You need to disclose to him of the results of his CT scan and that there is a very high chance that he has metastatic cancer. Because he has yet to have a biopsy of the lesions, you cannot tell him what kind of cancer he has or what the treatment would be but know that it will not be cured.

Your goal of this exercise is to disclose the results and interpretation of the CT scan using SPIKES, focus on the patient's emotional and verbal cues, avoid awkward wording (anything, everything, nothing, what would you like to do), and work on empathic curiosity.

For those receiving the information, fast forward to 50 years to an office visit with your primary care physician. You are a current smoker but otherwise feel healthy and very excited about losing the weight you have been trying to lose for 10 years. You are coming into the office for the results of your CT scan and your physician provides you with the news. When receiving the news, you should be shocked and silent for at least 30 seconds while you gather your thoughts.