# PATIENT CASE 1

**Patient**

66 yrs old female,  98 kg, 168 cm
Smoking 20 cigarettes daily

Patient comes to regular visit to GP. She is diagnosed for DM II 15 years ago andhypertension for 20 years ago. She also has complained back pain for 1 month (diclophenac prescribed during last visit).

**Medication**

Gliclazide tab 80 mg 1daily
Hydrochlorothiazide tab 25 mg 1daily
Ramipril 2,5mg 1x daily
Amitriptylline 25 mg 1 x daily
Diclophenac 100mg 1x in the evening (complains back pain)
Some herbal medicines to improve memory and strenght (cannot remember name of the products)

**Lab values**

| | |
|---|---|
| Gluc | 7,8 mmol/l |
| HbA1c | 8,9% |
| Creatinine | 151 µmol/L |
| Blood pressure (measured during the visit | 165/95 mm/Hg |

## PATIENT CASE 2

79 years old female
163 cm, 72 kg
The patient came to visit GP for renewing her prescriptions. She complains dizziness, sleep disorders (wakes up very early, needs to go to the toilet, cannot fall asleep again). She also complains constipation. The patient asks if she can take „Heart vitamines“ recommended by her daughter who works in the hospital as a nurse.
Medical history: hypertension (diagnosed 15 years ago)
Drug history: T. Enalapril 10mg once daily (in the morning), T.Co-Prenessa (perindopril/indapamid) 8mg/2,5mg once daily (in the evening), T.Retafer (ferrous sulphate) 100mg twice daily, T.Diazepam 5mg once daily (in the evening)
Blood pressure measured by GP 135/75 mmHg
Lab values:

| | | Ref value |
|---|---|---|
| $Na^+$ | 138 | 135..145 mmol/L |
| $K^+$ | 4,7 | 3,5..5,0 mmol/L |
| Glc | 4,2 | |
| Creatinine | 110 | 59..104 µmol/L |
| Urea | 7,9 | <8,1 mmol/L |
| Chol | 6,5 | < 5 mmol/L |

The doctor renews all current prescriptions and prescribes additionally T.Betahistidini 24mg twice daily ja T.Zopiclone 7,5mg once daily (in the evening) as required. The GP suggest to buy some laxatives from the pharmacy (f.ex senna). The GP encourages to take the „Heart vitamines“ without any additional questions.

**PATIENT CASE 3**

86 years old female

168 cm, 61 kg

Admitted to the hospital to assess her status. Patient complains pain, vertigo and balance symptoms.

Medical history: hypertension, gastric ulcer, osteoporosis, glaucoma.

Patient has been hospitalized several times due to fractures (caused by falls). The total hip replacement was performed 3 years ago.

She lives alone, social worker visits her once a week, brings food and sets up her medication (dosette box) for next week.

Drug history: C.Omeprazole 20 mg x 1, T.Atorvastatin 20 mg x 1, T.Ramipril 5 mg x 1, Gtt. Latanoprost 1 gtt to right eye, C. Duloxetine 60 mg x 1, T. Ketoprofen 50 mg x 2, T.Alprazolam 1 mg x 1 (night), T. Paracetamol 1g as needed, T.Alendronic acid 70 mg 1x weekly.

Lab values

| | |
|---|---|
| K+ | 5,2 |
| Na+ | 135 |
| Crea | 99 |
| ASAT | 55 |
| ALAT | 61 |
| RR | 151/92 mmHg |

**PATIENT CASE 4**

Patient data and social history:
Female, 82 years. 55 kg, 161 cm
Widow, husband died 3 months ago.
Complains restlessness, anxiety, sleeping disorders, feels unwell.
Antidepressant prescribed after husband's death, no mood improvement.
Visits regularly GP and other doctors, but no significant help.

Medical history:
Hypertension,
depression
constipation
dry cough

Drug history:
- Enalapril 10mg 1 daily
- Felodipin 10mg 1 daily
- Verapamil 40mg 2 daily
- Nortriptyline 75mg 1 daily
- Sertraline 100mg 1 daily
- Senna at nights as required
- Codeine at nights as required