Instructions

- **Review** the patient record summary, clinical examination findings, and investigation results.
- **Your examiner** will ask you a series of questions based on this information.
- **You have 15 minutes** to complete this case.

Patient Record Summary

- **Name:** Amelia Dawson
- **Age:** 48 years
- **Gender:** Female
- **Indigenous Status:** Not Aboriginal or Torres Strait Islander
- **Allergies and Adverse Reactions:** Nil known
- **Medications:**
    - Amitriptyline 25 mg at night (for chronic tension-type headaches)
    - Atorvastatin 10 mg daily (for hyperlipidaemia)
- **Past History:**
    - Tension-type headaches, on amitriptyline for the past 6 months with good control until recently.
    - Hyperlipidaemia, diagnosed 2 years ago.
- **Social History:**
    - Works as a librarian.
    - Non-smoker, occasional glass of wine with dinner.
    - Lives with her partner, no children.
- **Family History:**
    - Mother: Migraines
    - Father: Deceased from stroke at 68 years old.
- **Vaccination and Preventative Activities:**
    - Up to date with all routine vaccinations
    - Last GP check-up 6 months ago.

Scenario

Amelia Dawson, a 48-year-old librarian, presents to your clinic with a **2-week history of worsening headaches** and **blurred vision**. She describes the headaches as a dull, constant ache that is centred around her temples and worsens throughout the day. She has been waking up with headaches and mentions that her **vision has become blurry**, especially when reading or focusing on nearby objects.

Amelia reveals that she has been using a new herbal supplement she purchased online about a month ago. It was advertised as a "natural brain booster" with ingredients like ginkgo biloba and unknown herbal blends. She was convinced by the positive online reviews and thought it might help her stay focused and alert at work.

She has been on amitriptyline for tension-type headaches, which initially worked well, but she feels it is no longer effective. Amelia is worried that her symptoms might be related to something serious like a brain tumour, given her family history of stroke.

She denies nausea, vomiting, fever, or recent infections, and has no history of head trauma. However, she mentions feeling more anxious about her health recently and is looking for reassurance.

Clinical Examination Findings

- **General Appearance:** Appears slightly anxious but is otherwise well.
- **Vital Signs:**
    - BP: 130/85 mmHg
    - HR: 78 bpm, regular
    - Temp: 36.9°C
    - RR: 14/min
    - SpO2: 98% on room air
- **Neurological Examination:**
    - Cranial Nerves: Pupils equal and reactive to light, no papilledema, mild difficulty with accommodation on the right.
    - Motor: Normal tone, power 5/5 in all limbs.
    - Sensory: No sensory deficits.
    - Reflexes: Normal reflexes bilaterally.

    - Coordination: Normal finger-nose test and heel-shin test.
- **Fundoscopy:** No papilledema or haemorrhages noted.

Investigation Results

- **Blood Tests:**
    - Full Blood Examination: Normal
    - CRP: Normal
    - ESR: 20 mm/hr (slightly elevated)
    - Electrolytes: Normal
- **CT Brain (non-contrast):** No intracranial masses or signs of haemorrhage.