

## **BSIR ADVANCED PRACTICE COURSE 2022 – PATIENT SCENARIOS**

### **DAY 1: PATIENT RED**

Room: Exchange 1 Stand A

Clinical scenario: Consent for elective EVAR

#### **Description of scenario for Actor/Actress – Mr Jones**

You are a 68 year-old male retired gardener. Presenting complaint & history of presenting complaint. You were invited to have an Ultrasound scan of your abdomen as part of the National Abdominal aneurysm screening program. You understand that it has shown a swelling of a blood vessel in your abdomen which measures 7cm.

Past medical history. You have previously had an operation to remove a bowel cancer via a large cut in your abdomen and as a result you have been told by the Vascular surgeon that an open operation is too risky in your case. This procedure (EVAR) has been suggested as an alternative to the open operation, however you are unclear about some details of the procedure.

Relevant drug, occupation and social history. Nil relevant

Previous treatment or experience. Bowel cancer operation. The ends of the bowel were joined back up and you do not have a stoma bag.

Proposed treatment.

Suggested questions for delegates (the doctors):

1. How long will I be in hospital/ how long will it take to recover
2. Will I need any follow up treatment or scans
3. Is this procedure better than the open operation that you have been told is too risky in you?
4. Am I likely to die from this procedure and what happens if I choose not to do anything?

#### **Intro for Delegate - Day 1 Patient Red 1- Mr Jones**

Mr Jones is 68 and has a screen detected 7cm AAA. MDT decision is for EVAR although you were not present on the day of MDT. The anatomy is suitable for conventional EVAR with long iliacs and a uniform proximal sealing zone of 3cm below the renal arteries. You have been asked to consent the patient on the day of procedure.

## **DAY 1: PATIENT CONSULTATION – RED 2**

Room: Exchange 1 Stand B

Clinical scenario: Consent for pre-EVAR internal iliac artery embolisation

### **Description of scenario for Actor – Mr Flasheart**

You are a 70 year-old male ex-footballer. Presenting complaint & history of presenting complaint. You have been told you need repair of a swollen aneurysm measuring 6.5cm in your stomach. As an additional procedure the day before the main procedure you have been told you need an additional procedure to block off one of the blood vessels to help facilitate the main operation.

Past medical history. None relevant

Relevant drug, occupation and social history. You have a much younger partner who is in her late 20s – you would like to consider the option of becoming a father again and are concerned about any impact this procedure may have on your ability to do so.

Previous treatment or experience. None

Proposed treatment.

### **Suggested questions for delegates (the doctors):**

1. Why do I need this additional procedure?
2. What are the side effects of the procedure?
3. Will it have any impact in terms of erectile dysfunction?

### **Intro for Delegate – Day 1 Patient Red 2 – Mr Flasheart**

You have been asked to consent a 70-year-old man for right internal iliac artery embolization today prior to elective EVAR tomorrow. The EVAR is for a 6.5cm aortic abdominal aneurysm. There is no suitable landing zone in the right common iliac artery and so the plan is for right internal iliac artery embolization today with a view to landing the right limb of the EVAR in the right external iliac artery. The remainder of the arterial anatomy is normal with a patent left internal iliac.

## **DAY 1: PATIENT CONSULTATION – BLUE 1**

Room: Exchange 2 Stand A

Clinical scenario: Consent for treatment for endoleak detected on EVAR

Surveillance

### **Description of scenario for Actor/Actress – Mrs Brown**

You are a 69 year-old female librarian. Presenting complaint & history of presenting complaint. You have had a previous EVAR operation to repair a swollen blood vessel in your abdomen. You have received a letter saying that a follow up scan has shown a “leak” of the repair and that you require a further procedure to treat this. You are very unsure of what this involves.

Past medical history. Nil relevant

Relevant drug, occupation and social history. Keen to get back to work as soon as possible. Have a cat at home and nobody to care for it so keen to make sure you will spend as little time in hospital as possible.

Previous treatment or experience. Previous EVAR operation to repair a swelling in a blood vessel.

Proposed treatment.

### **Suggested questions for delegates (the doctors):**

1. What is this sort of leak? Did they not do the repair properly? And why did they not see it at the time of the main operation?
2. Is this leak dangerous? Do I really need to have something done about this?
3. What are the side effects and risks of this procedure?

### **Intro for Delegate - Day 1 Blue 1 - Mrs Brown**

You have been asked to consent Mrs. Brown who had an elective EVAR 4 years ago. Sac size at time of repair was 7cm. After the uneventful repair the sac size did not regress but remained stable on Duplex surveillance until recently. In the last year the sac has grown and is now 9cm – Duplex and CT identify a type 2 endoleak filling from the SMA via the IMA into the sac. No other endoleak is seen. MDT decision is for endoleak embolisation.

## **DAY 1: PATIENT BLUE 2**

Room: Exchange 2 Stand B

Clinical scenario: Consent for TEVAR for subacute aortic dissection

### **Description of scenario for - Ms Smith**

You are a 55 year-old female writer. Presenting complaint & history of presenting complaint. You presented to the emergency department with chest pain 1 year ago – the pain was tearing in nature and spreading to your back at that stage. You spent a week in hospital with medication to control your blood pressure and after that were discharged home. You have now been called by the surgical team to tell you that you will require a procedure because the latest scan shows that the torn blood vessel is now enlarging.

Past medical history. History of aortic dissection (tearing of the aorta). High blood pressure.

Relevant drug, occupation and social history. Strong family history of similar aortic dissection cases – mother died at a young age from this and brother and one sister also have had similar chest pains. No genetic testing has been performed.

Previous treatment or experience. Nil relevant other than that described

Proposed treatment. TEVAR

### **Suggested questions for delegates (the doctors):**

1. What is this procedure and how does it help me? My chest pain has got better so why do I need anything doing?
2. What are the risks of this procedure?
3. Will my daughter also get a similar problem?
4. I have read there is a chance of being paralysed after this procedure – how likely is that to happen?

### **Intro for Delegate - Day 1 Patient Blue 2 - Ms Smith**

You have been asked to consent Ms Smith for TEVAR. She had an acute type B dissection 1 year ago which was managed with blood pressure control. The dissection extended from 3cm distal to the left subclavian artery to the low descending thoracic aorta a few cm above the coeliac. The abdominal visceral vessels were not involved. Follow up imaging now shows sequential aneurysmal dilation of the false lumen. MDT decision is for TEVAR from just beyond the left subclavian to the low thoracic aorta.

## **DAY 2: PATIENT 1**

Room: Exchange 9a

Clinical scenario: Consent for femoral-popliteal vein graft thrombolysis

### **Description of scenario for Actor/Actress - Mr/Mrs Furley**

You are a 67 year-old male/female. Occupation: Landlord/lady. Presenting complaint & history of presenting complaint: Intermittent pains in right leg for the past few weeks making work difficult. (similar pains to those prior to the bypass surgery: calf aching, precipitated by walking, going up stairs, resolved when at rest). Suddenly became much worse 3/7 ago whilst working at the pub. No idea why, haven't been doing anything out of the ordinary. Unbearable at rest. Strong pain killers given intravenously in hospital have been the only thing to help.

Past medical history: Right leg bypass graft 1 year ago. Open heart surgery 4 years ago. High blood pressure.

Relevant drug history: Blood pressure tablets, blood thinners (aspirin and clopidogrel). Been overwhelmed in last few weeks so haven't been remembering to take medications.

Relevant social and occupational history: Smoking 10-20/day. No alcohol. Runs pub with husband who is currently in hospital with a stroke.

Previous treatment or experience: Need to get back to the pub as no-one else able to step in. Worried as on feet all day and the pains are making work impossible. Just want it to be better like it was after the surgery.

Proposed treatment: Unblock the bypass graft with a tube in to the artery, a medication to break down the clot and/or removal of the clot, and then over 24-48 hours an ongoing infusion to prevent further clot forming. Imaging of the leg arteries and bypass graft to identify underlying narrowing's which can be treated with balloon stretching (angioplasty) and/or stenting to hold narrowing open.

### **Suggested questions for delegates (the doctors):**

1. What happens if I don't go ahead with it?
2. Can't I just have a new bypass graft?
3. Will I be asleep for the procedure?
4. How long will it take?
5. When can I get back to work?
6. Why has it happened? Will it happen again

### **Intro for Delegate - Day 2 Patient 1 - Mr/Ms Furley**

67M BG: CABG, PVD. Right fem-pop vein bypass graft 1 year ago. Admitted acute limb ischaemia. ABPI 0.27. Cold discoloured foot. Fontaine III/ Rutherford IIA Duplex USS: occluded bypass graft. CT angio: Occluded bypass graft confirmed.

### **DAY 2: PATIENT 2**

Room: Exchange 9b

Clinical scenario: Consent for infrapopliteal angioplasty

### **Description of scenario for Actor/Actress - Mr/Ms McKay**

You are a retired 82 year-old male/female. Presenting complaint & history of presenting complaint: Podiatrist is worried about the toes on your right foot – a 'sore' doesn't seem to be healing.

Past medical history: Diabetes, ischaemic heart disease, new heart valve, stroke (5 years ago), high blood pressure, renal impairment.

Relevant drug history: Warfarin, metformin, blood pressure meds

Occupation and social history: Retired. Live alone with carer coming in 3x daily. Mobility limited to walking with walking frame between rooms. Smoke 20/day. No alcohol.

Previous treatment or experience: Don't like hospitals. Stay away from them!

Proposed treatment: Tube to be placed in to artery in leg. Imaging of leg vessels performed. Attempts made to open up the vessels supplying the foot in order to help blood flow and healing of the ulcer.

### **Suggested questions for delegates (the doctors):**

1. What happens if I go home without doing anything?
2. Will the vessels block again?
3. Can I be sedated / put to sleep / given strong pain killers?
4. I'm worried about lying still for that long – my foot/leg really hurts if I have it raised up in bed

### **Intro for Delegate - Day 2 Patient 2 - Mr/Ms McKay**

82 years. IHD, AVR, HTN, Stroke, CRF.CLI with tissue loss. Non-healing ulcers right foot. Attempted angio prior to amputation.CTA: PVD. Patent iliacs, SFA. Popliteal stenosis. Calcified crural vessels? patent. Duplex – non-diagnostic due to leg swelling and raised BMI.

### **DAY 2: PATIENT 3**

Room: Exchange 10a

Clinical scenario: Consent for thrombectomy for DVT

### **Description of scenario for Actor/Actress - Mr/Ms Mertz**

You are a 21 year-old male/female dancer. Presenting complaint & history of presenting complaint: Swollen left leg associated with achey dull pain and some pins and needles. Came on slowly about 10 days ago. Unable to dance for the past week. Painful, left thigh looks twice the size of the right thigh.

Past medical history: None, fit and well.

Relevant drug, occupation and social history: Dancer – currently at dance school. Work part time bar shifts. Oral contraceptive pill. No other meds. No allergies. Minimal alcohol. Non-smoker.

Previous treatment or experience: Never been in hospital before. Hate needles – fainted last time given an injection. Terrified won't be able to dance anymore.

Proposed treatment. Place a tube in the vein and try to remove the clot with a clot-busting agent then prevent further blockage of the venous system with a infusion which may take up to two days. The veins will then be imaged again and any underlying narrowings treated with balloon with a stent.

### **Suggested questions for delegates (the doctors):**

1. What caused it? Will it happen again?
2. What if I don't have this procedure and just take the blood thinning drugs?
3. Will this affect my career as a dancer?
4. Will I have to take any medication?
5. Will you have to monitor me after I leave the hospital?
6. Can I be put to sleep for the procedure?
7. Will it hurt?

### **Intro For Delegate – Day 2 Patient 3 – Mr/Ms Metz**

21F Dancer. 10/7 hx left leg swelling and pain. Duplex left lower limb DVT. CTV confirms left iliofemoropopliteal DVT – extending to proximal left common iliac vein. OCP. No other risk factors. ? May-Thurner syndrome. For thrombectomy/thrombolysis DVT.

### **DAY 2 – PATIENT 4**

Room: Exchange 10b

Clinical scenario: Consent for difficult dialysis access

### **Description of scenario for Actor/Actress - Mr/Ms Baxter**

You are a 52 year-old male/female IT consultant. Presenting complaint & history of presenting complaint: Clotted left arm dialysis fistula. Left arm swelling which is new and hasn't happened before – getting worse over the last few weeks. 4 year old fistula, has clotted every 3 months for the last year.

Past medical history: Diabetes. Chronic renal failure.

Relevant drug, occupation and social history: Run software company. Desk based. 3 kids and a partner who is away with work a lot.

Previous treatment or experience: Previous de-clotting procedures have been lengthy and painful. Hate the times when you have had to be admitted for heparin infusion following the de-clotting procedure as involves HDU admission and hasn't even worked. Have to be in hospital enough as it is with dialysis 3x week. Also nightmare co-ordinating childcare as partner currently away and who is going to look after kids. Fed up with having this procedure multiple times and the fistula just blocking off again.

Proposed treatment: Re-attempt de-clotting procedure of fistula involving tube in to fistula, removing clot and then admission to hospital for infusion if required.

### **Suggested questions for delegates (the doctors):**

1. Is there another option?
2. Can I have a new fistula?
3. What's to say it won't block off again?
4. I've heard about stents to keep the narrowing's open – would I be eligible for one

**Intro for Delegate - Day 2 Patient 4 - Mr/Ms Baxter**

Recurrent left BC AVF thrombosis. Fistula thrombosed 2/7 ago. Confirmed on duplex. De clotted x3 in last 12 months. In-flow and out-flow lesions have responded well to balloon angioplasty. New left arm swelling. ? recurrent lesion ? central stenosis