# Module 4 - Case study

## 1. Untitled Scene

### 1.1 Overview



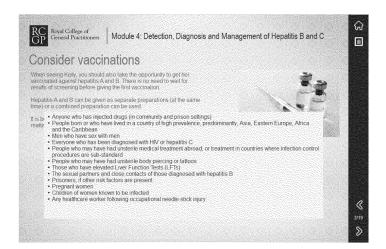### 1.2 Reflection questions

**Untitled Layer 1 (Slide Layer)**



## 1.3 Reflection questions

## Untitled Layer 1 (Slide Layer)
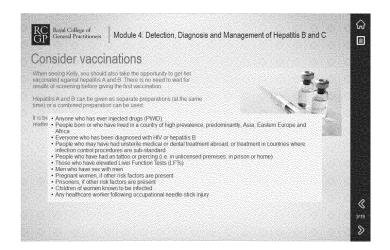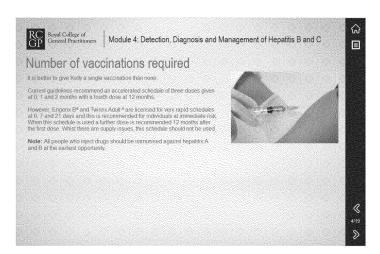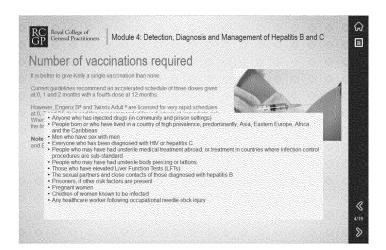


## Untitled Layer 2 (Slide Layer)

## 1.4 Reflection questions



## Untitled Layer 1 (Slide Layer)

**Untitled Layer 2 (Slide Layer)**



## 1.5 Reflection questions

*(Essay, 0 points, 1 attempt permitted)*

## Thank You (Slide Layer)



## 1.6 Reflection questions



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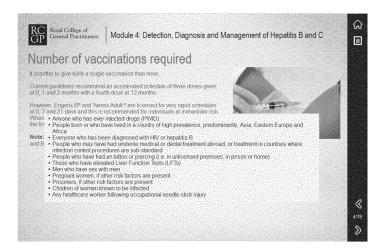
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## *1.7 Reflection questions*

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## 1.8 Cluster of symptoms

## Untitled Layer 1 (Slide Layer)



| HBsAg<br>anti-HBc<br>anti-HBs | negative<br>negative<br>negative | Susceptible |
|---|---|---|
| HBsAg<br>anti-HBc<br>anti-HBs | negative<br>positive<br>positive | Immune due to natural infection |
| HBsAg<br>anti-HBc<br>anti-HBs | negative<br>negative<br>positive | Immune due to hepatitis B vaccination |
| HBsAg<br>anti-HBc<br>IgM anti-HBc<br>anti-HBs | positive<br>positive<br>positive<br>negative | Acutely infected |
| HBsAg<br>anti-HBc<br>IgM anti-HBc<br>anti-HBs | positive<br>positive<br>negative<br>negative | Chronically infected |
| HBsAg<br>anti-HBc<br>anti-HBs | negative<br>positive<br>negative | Interpretation unclear; four possibilities:<br>1. Resolved infection (most common)<br>2. False-positive anti-HBc, thus susceptible<br>3. "Low level" chronic infection<br>4. Resolving acute infection |

## 1.9 Reflection questions

## hbv (Slide Layer)



## hvc (Slide Layer)



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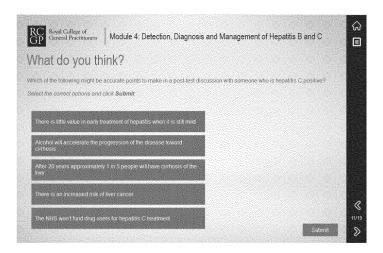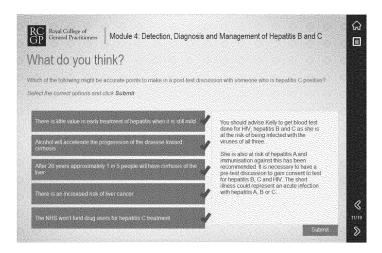
## 1.10 Cluster of symptoms



## 1.11 Reflection questions



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**Untitled Layer 1 (Slide Layer)**
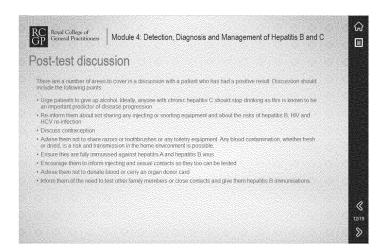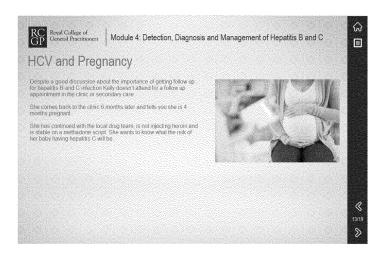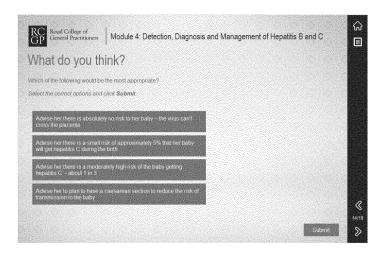


## *1.12 Cluster of symptoms*

## 1.13 Cluster of symptoms



RCGP Royal College of General Practitioners | Module 4: Detection, Diagnosis and Management of Hepatitis B and C

**HCV and Pregnancy**

Despite a good discussion about the importance of getting follow up for hepatitis B and C infection Kelly doesn't attend for a follow up appointment in the clinic or secondary care.

She comes back to the clinic 6 months later and tells you she is 4 months pregnant.

She has continued with the local drug team, is not injecting heroin and is stable on a methadone script. She wants to know what the risk of her baby having hepatitis C will be.

13/19

## 1.14 Reflection questions



RCGP Royal College of General Practitioners | Module 4: Detection, Diagnosis and Management of Hepatitis B and C

**What do you think?**

Which of the following would be the most appropriate?

*Select the correct options and click Submit.*

Advise her there is absolutely no risk to her baby – the virus can't cross the placenta

Advise her there is a small risk of approximately 5% that her baby will get hepatitis C during the birth

Advise her there is a moderately high risk of the baby getting hepatitis C – about 1 in 3

Advise her to plan to have a caesarean section to reduce the risk of transmission to the baby

Submit

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**Untitled Layer 1 (Slide Layer)**



## 1.15 Cluster of symptoms

## Untitled Layer 1 (Slide Layer)



## *1.16 Cluster of symptoms*

**Untitled Layer 1 (Slide Layer)**



*1.17 Cluster of symptoms*

## 1.18 Case study 4 - Gordon



## 1.19 Download answers

*(Results Slide, 0 points, 1 attempt permitted)*



| Results for |
| --- |
| 1.5 Reflection questions |

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# 1.20 resources



**Course Resources**

**Harm Reduction Works**
They have an excellent range of resources for health professionals and users around hepatitis B and C including leaflets, posters, DVDs.
Weblink

**Health Protection Agency**
Shooting Up: Infections among injecting drugs users in the United Kingdom 2009. An update: November 2010
Weblink

**Public Health England (2017) - Hepatitis B vaccination in adults and children:temporary recommendations from 21 August 2017.**
This document indicates the priority groups for vaccination and how to manage the global shortage of hepatitis B monovalent vaccine.
Weblink

**Public Health England (2018) Plan for phased re-introduction of hepatitis B vaccine for lower priority groups in 2018.**
This document describes how vaccinations with hepatitis B monovalent vaccine should be reintroduced for lower priority groups during 2018. It should be noted that these initial reintroductions exclude vaccination for the purpose of travel.
Weblink

**University of Liverpool- Interaction Checker**

## Untitled Layer 1 (Slide Layer)



**List of specialist centres that manage GSD**
(H=Hepatic GSD, M=Muscle GSD, P=Pompe Disease)

**Children's Services**
South West Regional Metabolic Department (H)
Division of Women's and Children's services
Bristol Royal Hospital for Children
Bristol

Inherited Metabolic Disorders (P H)
Birmingham Children's Hospital

Metabolic Medicine (P H)
Great Ormond Street Hospital NHS Trust
London

Willink Unit (P H)
St Mary's Hospital
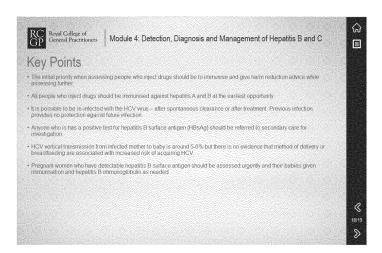Manchester University NHS Foundation Trust

Endocrinology and Metabolic Medicine (H)
Sheffield Children's NHS Foundation Trust

Metabolic Medicine (Paediatric and Adult) (P H)
The Inherited Metabolic and Lysosomal Disease Service
University Hospital of Wales

Royal Hospital for Sick Children (P H)
Edinburgh

Royal Hospital for Sick Children (P H)
Yorkhill
Glasgow

Department of Genetic Medicine
Belfast City Hospital

The National Centre for Inherited Metabolic Disorders
Children's University Hospital
Dublin

**Adult Services**
MRC Centre for Neuromuscular Diseases (M)
National Hospital for Neurology and Neurosurgery
London

Birmingham Inherited Metabolic Diseases Unit (P H)
University Hospitals Birmingham NHS Foundation Trust
Queen Elizabeth Hospital
Birmingham

Lysosomal Disorders Unit (P)
Addenbrookes Hospital
Cambridge University Hospital NHS Foundation

Charles Dent Metabolic Unit (P H)
The National Hospital for Neurology and Neurosurgery
Queen Square
London

Lysosomal Storage Disorders Unit (P)
The Royal Free NHS Trust
Pond Street
London

Neuromuscular Services (P M)
Robert Jones and Agnes Hunt Orthopaedic Hospital
Oswestry

The Mark Holland Metabolic Unit (P H)
Salford Royal NHS Foundation Trust
Salford

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