MODUL

PROBLEM BASED LEARNING
KELAS REGULER
SISTEM INDRA KHUSUS

- Modul Gangguan Pendengaran

- Modul Gangguan Penciuman

Diberikan Pada Mahasiswa Semester V
Fakultas Kedokteran Unhas

Fakultas Kedokteran
Universitas Hasanuddin
2016

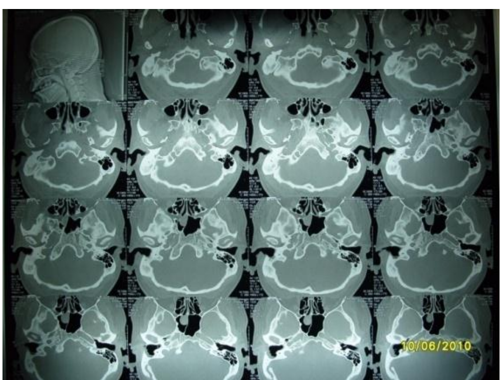
FACULTY OF MEDICINE HASANUDDIN UNIVERSITY
OBJECTIVE STRUCTURED ORAL CASE ANALYSIS
SPECIAL SENSE SYSTEM
OTORHINOLARYNGOLOGY
ACADEMIC YEAR 2016-2017

CASE 1

Women, A, 25 years came to the clinic with chief complaints of hearing loss in right ear since 1 year ago accompanied by a purulent ear charged, smells, sometimes pain and itching and headache. No complaints of vertigo. History of frequent ear probe, a history of the same disease is often recurrent, a family history of atopy denied.

Physical examinations:

General conditions: Good, not anemic. Height: 160 cm, Weight: 60 kg.
Vital signs are within normal limit.
Inspection : Auricel normal
Palpation : No edema and no tenderness of tragus and retroauricel
Otoskopi : Right external acoustic meatus and right tympanic membrane hyperemic, subtotal central perforation of right tympanic membrane, mucoid secretions in right tympanic cavity and the external acoustic meatus
Left acoustic meatus and left tympanic membrane normal
Faringoscopy : Within normal limits
Anterior Rhinoscopy : Nasal cavity, nasal septum and nasal turbinate normal
Laboratory examination: Hb 14 g / dl, leukocytes 12,600 g%, LED 45 / 1 hour
Pure Tone Audiometry Examination :
Ear artery: Mild-Severe Hearing Loss Conductive (60 dB)
Ear Sinistra: Normal Hearing (20 dB)
Examination of vestibular function: no canal paresis
Chest X-Ray : Normal
Mastoid CT-Scan :



Diagnosis : Right Chronic Supurative Otitis Media

Therapy : Antibiotics, antiinflammation, nasal dekongestan dan mucolitic

<u>EACH STUDENTS ARE ASSIGNED TO :</u>

1. **MAKE A MIND MAP OF CHRONIC SUPURATIVE OTITIS MEDIS:**
2. **SYMPTOMS AND SIGNS OF HEARING DISTURBANCE**
3. **EXPLAIN THE ETIOLOGY AND PATOFISIOLOGY CHRONIC SUPURATIVE OTITIS MEDIS.**
4. **EXPLAIN THE CLINICAL MANIFESTATION CHRONIC SUPURATIVE OTITIS MEDIS, INCLUDE THE SIGN AND SIMPTOMS.**
5. **EXPLAIN THE TREATMENT, COMPLICATION AND PROGNOSIS.**
6. **PRESENT AND DISCUSS IN CLASS**

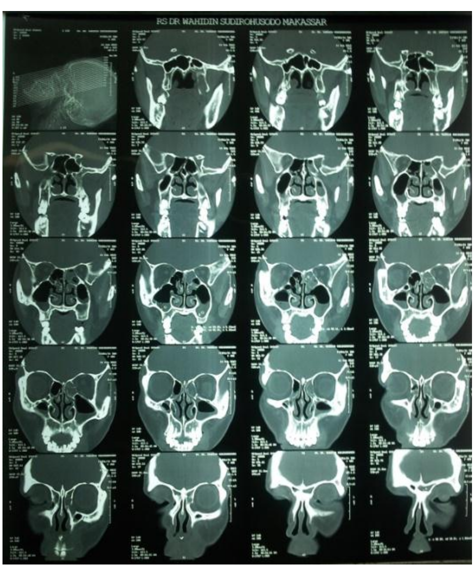
FACULTY OF MEDICINE HASANUDDIN UNIVERSITY
OBJECTIVE STRUCTURED ORAL CASE ANALYSIS
SPECIAL SENSE SYSTEM
OTORHINOLARYNGOLOGY

CASE 2

Male, 18 years came to the clinic with complaints of smelling reduced from six months ago accompanied by nasal congestion, thick mucus that are ingested into the throat, sometimes smells and headache. No complaints of serial sneezing and nasal itching. Previous history of the same disease and a family history of atopy denied.

Physical examinations:

General conditions: Good, not anemic. Height: 160 cm, Weight: 60 kg.
Vital signs are within normal limit.
Inspection : The external nose normal
Palpation : No edema and crepitation, tenderness in the left and rightcheek tenderness on the left and right orbital roof
Otoscopy : Within normal limits
Faringoscopy : Within normal limits
Anterior Rhinoscopy : hyperemicof nasal mucosa, congestion of nasal turbinate, there is secret in bilateral of the middle nasal meatus and nasal cavity
Laboratory examination : Hb 14 g / dl, leukocytes 12,600 g%
Chest X-Ray :Normal
CT scan :



Diagnosis : Bilateral anterior ethmoidalsinusitis, Left posterior ethmoidal sinusitis, Bilateral frontal sinusitis and Bilateral maxillary sinusitis chronic

<u>BASED ON THE ABOVE CASE, EACH STUDENTS ARE ASSIGNED TO:</u>

1. **MAKE A MIND MAP OF CHRONIC SINUSITIS**
2. **ETIOLOGY OF CHRONIC SINUSITIS**
3. **SYMPTOMS AND SIGNS OF SMELLING DISTURBANCE**
4. **SYMPTOMS AND SIGNS OF CHRONIC SINUSITIS.**
5. **PATHOGENESIS OF CHRONIC SINUSITIS.**
6. **PATHOPHYSIOLOGY OF SYMPTOMS AND SIGNS OF CHRONIC SINUSITIS.**
7. **PRINCIPLES OF MANAGEMENT THREATENED CHRONIC SINUSITIS**
8. **PROGNOSIS OF THREATENED CHRONIC SINUSITIS.**
9. **CATEGORIES OF CHRONIC SINUSITIS.**
10. **DIFFERENTIAL DIAGNOSIS OF CHRONIC SINUSITIS**

MODUL
PROBLEM BASED LEARNING
KELAS REGULER
SISTEM INDRA KHUSUS

Modul Ilmu Kesehatan Kulit &Kelamin

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Universitas Hasanuddin
2015

MODUL KULIT (Tutorial 3 &4)

MEDICAL FACULTY HASANUDDIN UNIVERSITY
SPECIAL SENSE SYSTEM
DERMATOVENEROLOGY MODULE

CASE 1:

A man, 30 years old diagnosed with seborroic dermatitis, based on :

- **History Taking** :

A man, 30 years old came to the hospital with the chief complained red spot,with yellow scale on scalp, face, nasolabial folds and chest since one week ago and getting more itch if sweating and eat spicy food. There is no Family history with the same disease. There is no allergic history and no drug consumption before.

- **Physical examination** : status present : mild pain/ good level of nutrition/ compos mentis
- **Vital Sign :** T = 120/80mmHg; N = 80 x/minute, P= 20x/minute; S= 36,7^{o} C
- **Dermatology status** :
  - Regio scalp, facialis, nasolabial fold, trunk
  - Effloresensi : mild scale, papule, makule eritematous, yellow crusts
  - Another examination : KOH (-)
- **Diagnose :** seborroic dermatitis
  - (seborrheic erythroderma).
- **Prognosis** : dubia.

BASED ON THE ABOVE CASE, EACH STUDENTS ARE ASSIGNED TO :

1. **MAKE A MIND MAP OF SEBORROIC DERMATITIS**
2. **EXPLAIN THE ETIOLOGY AND PATOFISIOLOGY, CLASSIFICATION.**
3. **EXPLAIN THE CLINICAL MANIFESTATION OF SEBORROIC DERMATITIS, INCLUDE THE SIGN AND SIMPTOMS.**
4. **EXPLAIN THE TREATMENT, COMPLICATION AND PRODGNOSIS.**
5. **PRESENT AND DISCUSS IN CLASS**

MEDICAL FACULTY HASANUDDIN UNIVERSITY
SPECIAL SENSE SYSTEM
DERMATOVENEROLOGY MODULE

CASE 2:

A woman, 28 years old diagnose with pityriasis rosea, based on :

- **History taking :**

  A woman, 28 years old came to the hospital with chief complain redness on chest and back area since 1 week ago after cleaning the house. Firstly there are only 2 wide lesion with thin scale on the margin then spread into some small lesion on the back with a mild itchiness. There is no family history of the same complain, no history of allergy and no history of medication.

- **Physical examination :** General status : Mild illness/ Well-nourished / Conscious.
- **Status Vital :**BP = 120/80; HR = 80 x/m, RR= 20x/menit; Tax= 36,7^{o} C
- **Dermatology status :**

  Trunk & vertebrae region

  Efflorescence : herald patch, erythematous papule, thin scale

- **Laboratory test** : KOH (-), wood lamp (-)
- **Differential Diagnosis :**
  - Nummular dermatitis
  - Tinea corporis
  - Guttate psoriasis

- **Treatment :**
  - Self limiting disease :
    - Education about the clinical course of the disease
  - salycil talc plus menthol 0,-1% for topical agent and mild topical corticosteroid
- **Prognosis** : bonam

STUDENT ASSESSMENT :

1. **MAKE A MIND MAP FOR THE CASE ABOVE**
2. **EXPLAIN THE ETIOLOGY AND PATOPHYSIOLOGY OF THIS CASE**
3. **EXPLAIN THE CLINICAL MANIFESTATION OF PITYRIASIS ROSEA, INCLUDING THE SIGN AND SYMPTOMS.**
4. **EXPLAIN THE MANAGEMENT AND THE PROGNOSIS**
5. **PRESENT AND DISCUSS IN CLASS**

MEDICAL FACULTY HASANUDDIN UNIVERSITY
SPECIAL SENSE SYSTEM
DERMATOVENEROLOGY MODULE

CASE 3:

A woman, 30 years old, diagnosed with vitiligo, based on:

- **History taking :**

A woman, 30 years old came to the hospital with the complaint of whitish spot like white milk, well-defined border in the face since 2 months ago. There is no history of injury. She has a family history of the same complaint and no history of atopic and medication.

- **Physical examination :** General status : Mild illness/ Well-nourished/ Conscious
- **Vital sign :**BP = 120/80; HR = 80 x/menit, RR= 20x/menit; Tax= 36,7^{o} C
- **Dermatology status :**

  Location: Face region

  Efflorecensce :Hypopigmented macules
- **Laboratory test** : KOH (-), wood lamp (-)
- **Differential Diagnosis :**
  - Post-inflammation hypopigmentation
  - Pityriasis versicolor
  - Pityriasis alba
- **Treatment** : a high-potency fluorinated corticosteroid for 1 to 2 months, after which prudence dictates that therapy is gradually tapered to a lower-potency corticosteroid
- **prognosis** : dubia

STUDENT ASSESSMENT :

1. **MAKE A MIND MAP OF VITILIGO.**
2. **EXPLAIN THE ETIOLOGY AND PATHOPHYSIOLOGY, CLASSIFICATION**
3. **EXPLAIN THE CLINICAL MANIFESTATION OF VITILIGO, INCLUDING THE SYMPTOMS AND SIGNS.**
4. **EXPLAIN THE MANAGEMENT, COMPLICATIONS, AND PROGNOSIS.**
5. **PRESENT AND DISCUSS IN THE CLASS.**

MODUL
PROBLEM BASED LEARNING
KELAS REGULER
SISTEM INDRA KHUSUS

- **Modul Gangguan Penglihatan**
- **Modul Mata Merah**

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MODUL MATA (Tutorial 5&6)

SPECIAL SENSE SYSTEM
OPHTHALMOLOGY MODULE

CASE 1

A 66 year old man was diagnosed as Senile Cataract + Diabetic Retinopathy (ODS), based on these findings :

History: A chief complain of decreased vision on both eyes, aware since ± 8 months ago and worsened for the past 4 weeks. Vision appears to be white, hazy smoke-like and seems to be clearer during night time. There was no history of using spectacles for distant vision, and neither of red eyes or trauma of the eye balls. There is a history of hypertension for about 10 years with improper treatment, diabetic mellitus is not known and neither in family history.

Physical findings: General state : Mild / Good nutrition / Conscious

- **Vital signs :BP** = 180/90 mmHg; **Pulse** = 80 x/mnt, **Breathe**= 20x/mnt; **Temp** = 36,7^{o} C
- **Ophthalmology findings :**
  VOD = 3/60; could not be corrected   VOS= 1/60; could not be corrected
- Anterior Segment :

Eye	OD	OS
Palpebra	Normal	Normal
Cilia	Normal	Normal
Bulbar conjunctiva / Palpebral conjunctiva	Normal/ Hyperemic(-)	Normal/ Hyperemic(-)
Cnea	Clear	Clear
COA	Normal	Normal
Iris	Dark brown, crypt(+)	Dark brown, crypt(+)
Pupil	Round, central, light reflex (+)	Round, central, light reflex (+)
Lens	Opaque	Opaque, dense

- Posterior Segment :
    - FOD : fundus reflex (+), Optic nerve : fine edge, CDR 0,3, A/V : 1/3, Macula : fovea reflex(+), peripheral retinal : dot-blot hemorrhage 4 quadrant
    - FOS : fundus reflex (+), Optic nerve : fine edge, CDR 0,3, other details are difficult to evaluate due to dense cataract.
- Lab findings, biometry

Diagnose :ODS Mature Senile Cataract + Diabetic retinopathy

- Treatment plan :
    - Cataract extraction + IOL implant (Intra Ocular Lens) ODS
    - control blood glucose and pressure

EACH STUDENTS ARE ASSIGNED TO :

1. **OUTLINE A MIND MAP OF SENILE CATARACT.**
2. **DESCRIBE RISK FACTORS, PATHOPHYSIOLOGY OF SENILE CATARACT**
3. **DESCRIBE CLINICAL MANIFESTATION OF CATARACT, INCLUDING SIGNS AND SYMPTOMS**
4. **DESCRIBE TREATMENTS, POSSIBLE COMPLICATIONS AND ITS PROGNOSIS**
5. **PRESENT AND DISCUSS THIS CASE IN CLASS**

PROBLEM BASED LEARNING MODULE
SHORT OBJECTIVE ORAL CASE ANALYSIS EXAM
SPECIAL SENSE SYSTEM

CASE 2

A 20 year old woman was diagnosed with anterior uveitis, due to:

History taking :

Major complaint was red and painful right eye, which since 1 week prior to visit, first symptom was mild pain which developed progressively until admitted. She also complaint of excessive tearing, glare and blurred vision on her right eye. No previous history of trauma, systemic illness nor ocular surgery. No history of spectacle uses and other ocular diseases.

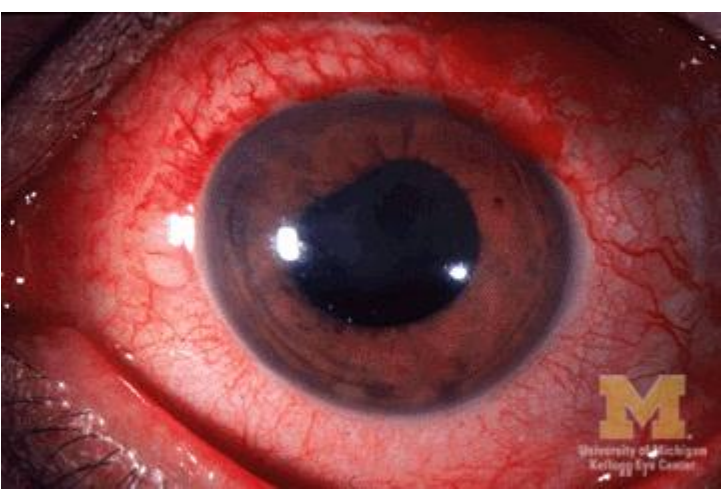
Pemeriksaan Fisik : Keadaan Umum : Sakit sedang / Gizi baik/ sadar

- o Vital sign : TD = 120/80; Nadi = 80x/mnt; Pernapasan= 20x/mnt; Suhu= 37,1^{o}C

- Pemeriksaan Oftalmologi :
    - o Visual Acuity :
        - OD : 3/60 Counting finger
        - OS : 20/20
    - o Intraocular Pressure : OD : Tn OS : Tn
    - o Segmen Anterior :

Structures of the eye	**OD**	**OS**
Palpebra	Normal	Normal
Cilia	Normal	Normal
Konjungtiva bulbi/ Konjungtiva palpebral	Hyperemis, conjunctival injection (+), pericorneal injection (+)	Normal/ normal
Cornea	Slightly hazy,diffuse Keratic Precipitate (+)	Clear

COA	AC (+), flare grade (+2)	Normal
Iris	Bombae Segmental posterior synechiae	Brown, crypte(+)
Pupil	Irregular shape	Round, light reflex(+)
Lens	Clear	Clear



Posterior segment :

FOD : Due to unclear media, posterior segment could not being evaluated

FOS : red reflex (+), fine edges of optic nerve, CDR normal, fovea reflex (+).

Laboratory findings : Leucocytosis (14.000 /ul), elevated ESR/LED

Diagnose : Anterior Uveitis

STUDENTS ARE ASSIGNED TO :

1. **OUTLINE A MIND MAP FOR THE CASE ABOVE**
2. **DESCRIBE THE ETHIOLOGY AND PATHOPHYSIOLOGY OF THE CASE**
3. **DESCRIBE CLINICAL MANIFESTATION OF ANTERIOR UVEITIS, INCLUDING ITS SIGNS AND SYMPTOMS**
4. **DESCRIBE THE DIFFERENTIAL DIAGNOSE OF ANTERIOR UVEITIS**
5. **DESCRIBE ITS MANAGEMENT AND PROGNOSIS**
6. **PRESENT AND DISCUSS THIS CASE IN A GROUP**

SPECIAL SENSE SYSTEM
OPHTHALMOLOGY MODULE

CASE 3 :

Seorang Wanita 60 tahun didiagnosis dengan Glaukoma absolut berdasarkan :

Anamnesis :

Kedua mata tidak bisa melihat yang dialami sejak 6 bulan yang lalu, awalnya pasien sering merasa sakit kepala sejak 2 tahun yang lalu, kemudian penglihatan kabur pada kedua mata dan perlahan – lahan tidak bisa melihat, riwayat mata merah (+), gatal (-), berair (+), kotoran mata berlebih (-), nyeri (-), silau (-), berair (+). Riwayat berobat (-), Riwayat operasi (-), Riwayat penyakit yang sama dalam keluarga(-), Riwayat HT (-), Riwayat DM (-).

Pemeriksaan Fisik :

A. Visus

VOD : 0

VOS : 1/-

Tonometri :

TOD = 0/5,5 = 0/7,5 = 2/10 = 59,1 mmHg

TOS = 0/5,5 = 0/7,5 = 2/10 = 59,1 mmHg

PEMERIKSAAN	OD	OS
Palpebra	Edema (-)	Edema (-)
Apparatus Lakrimalis	Lakrimasi (+)	Lakrimasi (+)
Silia	Normal	Normal
Konjungtiva	Hiperemis (-)	Hiperemis (-)
Bola mata	Normal	Normal

Mekanisme muskular	Normal ke segala arah :	Normal ke segala arah :
Kornea	Jernih	Jernih
Bilik Mata Depan	Dangkal	Dangkal
Iris	Coklat, kripte (+)	Coklat, kripte (+)
Pupil	Bulat,middilatasi (-), RC (-)	Bulat, sentral, mid dilatasi RC (-)
Lensa	Keruh	Keruh

A. Oftalmoskopi

FOD : refleks fundus (+), papil N.II batas tegas, CDR 1,0, a/v = 2/3, nasalisasi (+), makula refleks fovea (+) kesan normal, retina perifer kesan tipis.

FOS : refleks fundus (+), papil N.II batas tegas, CDR 1,0, a/v = 2/3, nasalisasi (+), makula refleks fovea (+) kesan normal, retina perifer kesan tipis.

STUDENTS ARE ASSIGNED TO :

1. **OUTLINE A MIND MAP FOR THE CASE ABOVE**
2. **DESCRIBE THE ETHIOLOGY AND PATHOPHYSIOLOGY OF THE CASE**
3. **DESCRIBE CLINICAL MANIFESTATION OF ABSOLUTE GLAUCOMA, INCLUDING ITS SIGNS AND SYMPTOMS**
4. **DESCRIBE THE DIFFERENTIAL DIAGNOSE OF ABSOLUTE GLAUCOMA**
5. **DESCRIBE ITS MANAGEMENT AND PROGNOSIS**
6. **PRESENT AND DISCUSS THIS CASE IN A GROUP**