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
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
EACH STUDENTS ARE ASSIGNED TO:

1 MAKE A MIND MAP OF CHRONIC SUPURATIVE OTITIS MEDIS:
2 SYMPTOMS AND SIGNS OF HEARING DISTURBANCE
3 EXPLAIN THE ETIOLOGY AND PATHOPHYSIOLOGY CHRONIC SUPURATIVE OTITIS MEDIS.
4 EXPLAIN THE CLINICAL MANIFESTATION CHRONIC SUPURATIVE OTITIS MEDIS, INCLUDE THE SIGN AND SYMPTOMS.
5 EXPLAIN THE TREATMENT, COMPLICATION AND PROGNOSIS.
6 PRESENT AND DISCUSS IN CLASS
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 right cheek
          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
BASED ON THE ABOVE CASE, EACH STUDENTS ARE ASSIGNED TO:

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

Diberikan Pada Mahasiswa Semester V
Fakultas Kedokteran Unhas

Fakultas Kedokteran
Universitas Hasanuddin
2015
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°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 PROGNOSIS.
5. PRESENT AND DISCUSS IN CLASS
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 = 20 x/minute; Tax = 36.7°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
  
  - Salicyl 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
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 = 20 x/ menit; Tax = 36,7° C
- **Dermatology status:**

  Location: Face region
  Effluence: 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

Diberikan Pada Mahasiswa Semester V
Fakultas Kedokteran Unhas

Fakultas Kedokteran
Universitas Hasanuddin
2015
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° C

- **Ophthalmology findings:**
  - VOD = 3/60; could not be corrected  VOS= 1/60; could not be corrected
  - Anterior Segment:

<table>
<thead>
<tr>
<th>Eye</th>
<th>OD</th>
<th>OS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palpebra</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td>Cilia</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td>Bulbar conjunctiva / Palpebral conjunctiva</td>
<td>Normal/ Hyperemic(-)</td>
<td>Normal/ Hyperemic(-)</td>
</tr>
<tr>
<td>Cnea</td>
<td>Clear</td>
<td>Clear</td>
</tr>
<tr>
<td>COA</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td>Iris</td>
<td>Dark brown, crypt(+)</td>
<td>Dark brown, crypt(+)</td>
</tr>
<tr>
<td>Pupil</td>
<td>Round, central, light reflex (+)</td>
<td>Round, central, light reflex (+)</td>
</tr>
<tr>
<td>Lens</td>
<td>Opaque</td>
<td>Opaque, dense</td>
</tr>
</tbody>
</table>
- 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
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
- Vital sign: TD = 120/80; Nadi = 80x/mnt; Pernapasan= 20x/mnt; Suhu= 37,1°C
  - Pemeriksaan Oftalmologi:
    - Visual Acuity:
      - OD : 3/60 Counting finger
      - OS : 20/20
    - Intraocular Pressure : OD : Tn OS : Tn
    - Segmen Anterior:

<table>
<thead>
<tr>
<th>Structures of the eye</th>
<th>OD</th>
<th>OS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palpebra</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td>Cilia</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td>Konjungtiva bulbi/ Konjungtiva palpebral</td>
<td>Hyperemis, conjunctival injection (+), pericorneal injection (+)</td>
<td>Normal/ normal</td>
</tr>
<tr>
<td>Cornea</td>
<td>Slightly hazy, diffuse Keratic Precipitate (+)</td>
<td>Clear</td>
</tr>
<tr>
<td></td>
<td>COA</td>
<td>AC (+), flare grade (+2)</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Iris</td>
<td>Bombae Segmental</td>
<td>Posterior synechiae</td>
</tr>
<tr>
<td>Pupil</td>
<td>Irregular shape</td>
<td>Round, light reflex(+)</td>
</tr>
<tr>
<td>Lens</td>
<td>Clear</td>
<td>Clear</td>
</tr>
</tbody>
</table>

**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 ETIOLOGY 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

<table>
<thead>
<tr>
<th>PEMERIKSAAN</th>
<th>OD</th>
<th>OS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palpebra</td>
<td>Edema (-)</td>
<td>Edema (-)</td>
</tr>
<tr>
<td>Apparatus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lakrimalis</td>
<td>Lakrimasi (+)</td>
<td>Lakrimasi (+)</td>
</tr>
<tr>
<td>Silia</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td>Konjungtiva</td>
<td>Hiperemis (-)</td>
<td>Hiperemis (-)</td>
</tr>
<tr>
<td>Bola mata</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td>Mekanisme muskular</td>
<td>Normal ke segala arah :</td>
<td>Normal ke segala arah :</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Kornea</td>
<td>Jernih</td>
<td>Jernih</td>
</tr>
<tr>
<td>Bilik Mata Depan</td>
<td>Dangkal</td>
<td>Dangkal</td>
</tr>
<tr>
<td>Iris</td>
<td>Coklat, kripte (+)</td>
<td>Coklat, kripte (+)</td>
</tr>
<tr>
<td>Pupil</td>
<td>Bulat, mid dilatasi (-), RC (-)</td>
<td>Bulat, sentral, mid dilatasi RC (-)</td>
</tr>
<tr>
<td>Lensa</td>
<td>Keruh</td>
<td>Keruh</td>
</tr>
</tbody>
</table>

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 ETIOLOGY 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