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SAMSON CLINICAL COURSES

PLAB 2 COURSE

LONDON

By Dr. Samson

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DAY 1:

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Top tips from PLAB examiner

1. **Be yourself – just be a doctor, try not to think of this as an exam, but a busy clinic day.**

You have 18 consultations on your clinic list, you have time to have a look over the patient's notes before each one, and there may be some test results to check too.

You could be seeing a patient or perhaps a relative – this could be the first time they have come in. You may be asked to provide advice for an ongoing condition or you could be asked to speak to a relative about a patient's care.

Whatever you are faced with, you have eight minutes to complete the task and you will be marked on three areas:

- **Domain 1 – Data gathering, technical and assessment skills**: covers history taking, physical examination, practical procedures, investigations leading to a diagnosis.
- **Domain 2 – Clinical management skills**: covers diagnosis, explaining something to the patient, formulating a management plan.
- **Domain 3 – Interpersonal skills:** covers how the candidate approaches the station – whether they establish a rapport with the patient, how they use open and closed questions, involving the patient in their care and how they demonstrate their professionalism and understanding of ethical principles

2. Communication is key

In my experience, one of the biggest factors to a candidate's ability to perform well in the test is their communication skills. This typically comes down to verbal English language skills. There is a requirement to demonstrate English language skills before applying to take the PLAB test. However, some candidates struggle to communicate clearly in the test environment.

3. Take the time to read the task

It's really important to take the time to read the task and understand what is expected of you.

Make sure you think of how to approach the scenario in terms of the three domains you will be marked on and make sure you cover all three elements for each station.

Read the scenario carefully, including who you are and where you are working, along with the patient, relative or colleague's details.

4. Keep up to date with any changes to the PLAB test

In September 2016, there were a number of changes to PLAB 2. For example, we extended the number of scenarios (from 14 to 18) and the time for each scenario (from five to eight minutes). The scenarios are more reflective of a patient consultation, rather than just asking a doctor to carry out a procedure. We also now have a stronger focus on the professional values and behaviours expected of doctors working in the UK, across both parts of the PLAB test

What do you like about being a PLAB examiner?

I find it very interesting. I get to meet a diverse range of doctors from all over the world and with that, I get to see varying standards of medical practice. Some are of an exceptionally high quality and others can be poor, with the majority in between. I feel that I am doing a duty to my profession, by assessing the standards of doctors coming to practice in the UK.

The feedback statements

The ten feedback statements are listed below.

Descriptions of the feedback statements you'll receive for each station and what they mean	
Feedback statement	Description
Consultation	Disorganised / unstructured consultation. Includes illogical and disordered approach to questioning. You did not demonstrate sufficiently the ability to follow a logical structure in your consultation. For example, your history taking may have appeared disjointed, with your line of questioning erratic and not following reasoned thinking. You may have undertaken practical tasks or examination in an illogical order that suggested you did not have a full grasp of the reason for completing them or a plan for the consultation.
Issues	Does not recognise the issues or priorities in the consultation (for example, the patient's key problem or the immediate management of an acutely ill patient). You did not recognise the key element of importance in the station. For example, giving health and lifestyle advice to an acutely ill patient.
Time	Shows poor time management. You showed poor time management, probably taking too long over some elements of the encounter at the expense of other, perhaps more important areas.
Findings	Does not identify abnormal findings or results or fails to recognise their implications. You did not identify or recognise significant findings in the history, examination or data interpretation.
Examination	Does not undertake physical examination competently, or use instruments proficiently.
Diagnosis	Does not make the correct working diagnosis or identify an appropriate range of differential possibilities.

Management	Does not develop a management plan reflecting current best practice, including follow up and safety netting.
Rapport	Does not appear to develop rapport or show sensitivity to the patient's feelings and concerns, including use of stock phrases. You did not demonstrate sufficiently the ability to conduct a patient centred consultation. Perhaps you did not show appropriate empathy or sympathy, or understanding of the patient's concerns. You may have used stock phrases that show that you were not sensitive to the patient as an individual, or failed to seek agreement to your management plan.
Listening	Does not make adequate use of verbal & non-verbal cues. Poor active listening skills. You did not demonstrate sufficiently that you were paying full attention to the patient's agenda, beliefs and preferences. For example, you may have asked a series of questions but not listened to the answers and acted on them.
Language	Does not use language or explanations that are relevant and understandable to the patient, including not checking understanding. The examiner may have felt, for example, that you used medical jargon, or spoken too quickly for the patient to take

Introduction to data gathering:

1. The **P3MAFTOSA**
    - Presenting complaint
    - Past medical history
    - Family history
    - Travel history
    - Occupational social history
    - Social history
    - Anything else

2. **Urology history**
3. **Rheumatology history**
4. **Paediatric history**
5. **Surgical history**

6. **Communication tools**
    - The **Initial** approach
    - Systemic review
    - Effects of symptoms on patient's life
    - **ICE**
    - Sign posting
    - Summarising
    - Finish a consultation

7. **Responding to the patient's emotions**

- EVE protocol
- PEARLS protocol
- Patient cantered consultation (bio-psycho-socio-module presentation)
- Building rapport with the patient (approach or presentation)

HISTORY TAKING PROFORMA:

P3MAFTOSA

P – Presenting complaint (SOCRATES/ODPARA)

P – Past Medical History

P – Personal History

M – Medication History

A – Allergy History

F – Family History

T – Travel History

O – Occupational History

S – Social History

A – Anything else you would like to tell me?

1.**PRESENTING COMPLAINT:**

• **SOCRATES** (only for pain) or **ODPARA** (for other symptoms)

• Differential diagnoses

S – Site: Where is the pain, can you show me with one finger?

O – Onset: How did it start? Suddenly or gradually?

C – Character: What type of pain is it? Dull ache/compressing/sharp?

R – Radiation: Does the pain go/move anywhere?

A – Associated: Differential diagnoses

T – Timing: Is there any specific time you experience the pain or when is it worse? Is it always there or does it come and go?

E – Exacerbating and relieving factors: Is there anything that makes the pain worse? Is there anything that makes the pain better?

S – Severity/Score: On a scale of 0 – 10, 0 being no pain and 10 being the worst, how would you score your pain?

O – Onset: How did it start? Suddenly or gradually?

D – Duration: When did it start? or How long have you had these symptoms for?

P – Progression: Is it becoming worse, improving or is it the same?

A – Aggravating factors: Anything which makes it worse or anything which brings it on (if intermittent symptoms)?

R – Relieving factors: Anything which makes it better?

A – Associated symptoms: Differential diagnoses

2. PAST MEDICAL HISTORY:

- Do you have any medical conditions?
- Have you ever been admitted to hospital for any reason?
- Have you ever had any operations performed on you?
- Do you have any medical conditions like asthma, high blood sugar / high blood pressure / heart problems /epilepsy/stroke?

3. PERSONAL HISTORY:

Sexual history: (You should be non judgemental and comfortable with sexual history)

I need to ask you a few personal questions, if you find it a little bit a little too much, please let me know and I will stop.

Sexual practices:

- Are you sexually active?
- Is your partner male or female?
- Do you practice safe sex? By this, I mean do you use condoms?
- What kind of sexual intercourse do you usually practice? Oral, vaginal, anal ?
- When was your last sexual intercourse?
- Have you ever had sexual intercourse for casual purposes?
- How many sexual partners have you had in the 6 months?
- Have you travelled abroad? Did you have sexual intercourse with anyone when you while you were abroad?

Relationship

- Are you in a stable relationship?
- Are you married?

Previous infections and testing:

- Have you ever had a sexually transmitted infection before?
- Have you ever been tested for STI such HIV, chlamydia or gonorrhoea?

Symptoms:

- Are you experiencing any discharge from your penis or vagina?
- Any burning sensation when passing urine?
- Any ulcers or lumps around your genital areas?
- Are running any temperature?

DPSUT (Discharge / Burning / ulcers, temp.)

STI

Partners

- Is there any chance you could have any other partner ?
- How many partners did you have in the past 6 months?

Symptoms in partner:

- Is your partner experiencing symptoms such as discharge from the private parts, pain or lumps anywhere?

Tracing contact: (This is where there has been exposure)

- Did you have sexual intercourse with your **partner** or your wife after that?
- What kind of sexual intercourse did you have with your partner? **oral , anal or vaginal?**
- Did you have sexual intercourse with anyone else after that ?

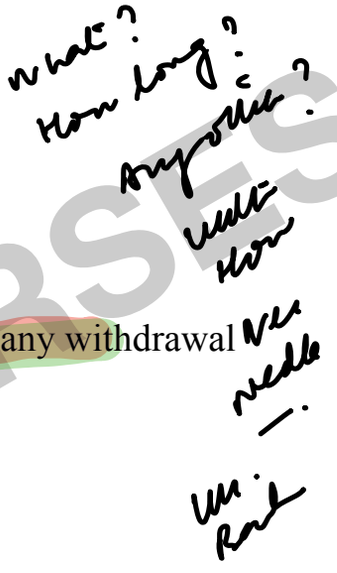
Menstrual History:

- When was your last menstrual period?
- Are your periods normally regular?
- How many days do you bleed?
- How many days is your menstrual cycle?
- Do you pass any clots?
- Are your periods painful?
- Are your periods heavy?
- When was your last cervical smear?
- What were the results of your last cervical smear? (Ask only if patient had a previous cervical smear.)
- Do you use any type of contraception? (If yes, you need to ask further. Which contraception are you using?)

Drug Abuse History

- Use of recreational drugs:
- Is there any chance you use recreational drugs?

- **Type of drugs** - What kind of drugs do you use?
- **Route** - How do you take these drugs?
- **Duration** - For how long have you been taking them?
- **Other drugs** - Do you use any other drugs?
- **With whom?** Who do you do drugs with?
- **Withdrawal -** If you stop taking these drugs, do you develop any withdrawal symptoms? What kind of symptoms do you usually develop?
- **Previous attempts:**
  - Have you ever attempted to stop using recreational drugs?
- **Needle:**
  - Do you use needles?
  - Do you share needles with other people?



Needle Exchange Program

- Do you know about needle exchange program?
- Do you use the needle exchange program?
- Is there any particular reason you do not use the needle exchange program?

Safe guarding issues

- Who else is at home?
- Do you use drugs at home?
- Are there any children at home?
- Do you ever take drugs in front of your children?

Social services

- Have safe guarding issues ever been raised about your children?
- Have the child protection services ever been involved?

Social history:

- Where do you get drugs from?
- What do you do for your living?
- How to you get money to buy drugs?
- Have you ever been in problems with the law?
- Do you have any siblings ?
- Are you parent around?
- Do they know you use recreational drugs?
- How do your family feel about you using drugs?
- Would your family or partner be supportive of you while trying to stop using recreational drugs?
- Does your partner use recreational drugs?

4. MEDICATION HISTORY:

- Are you taking any regular medication?
- Are you taking any over the counter (OTC) medication?
- Are you on any type of contraception (for females of reproductive age only)?

5. ALLERGY HISTORY:

- Are you allergic to anything?
- Are you allergic to any medication?
- If yes: What happens when you take it?

Just say I'm sorry to hear that.

6. FAMILY HISTORY:

• Anyone in the family with similar conditions or problems?

• Anyone in the family with heart problems, high blood pressure, high blood sugar levels or asthma?

7. TRAVEL HISTORY:

• Have you travelled abroad recently?

• If yes, where did you travel?

8. OCCUPATION HISTORY:

• What do you do for a living?

• Are you retired? What did you use to do for a living?

9. SOCIAL HISTORY:

• Who do you live with?

• Do you live in a house or a bungalow?

• Do you walk independently? (For elderly patients or patients with disabilities)

• Is there anything that is causing you stress in your life?

• Are you married? Do you have any children?

• Do you smoke? If the patient says no, ask if he/she has ever smoked.

• Do you drink alcohol?

• Has this affected you at home or at work?

DESA.

10. ANYTHING ELSE:

Is there anything else you would like to tell me about your condition?

NB: Ask these questions after taking a full history of the presenting complaint

Psychological Issues: ICE

effects of symptoms?

Have you lost pleasure in doing things?

mood?

1. RED EYE - 168

ODPARA of Red eye

O – Onset: How did it start? Suddenly or gradually?

D – Duration: When did it start? Or How long have you had these symptoms for?

P – Progression: Is it becoming worse, improving or is it the same?

A – Aggravating factors: Anything which makes it worse or anything which brings it on (if intermittent symptoms)?

R – Relieving factors: Anything which makes it better?

A – Associated symptoms: Differential diagnoses

Differential Diagnosis:

- **Bacterial conjunctivitis** (purulent discharge, red eyes, stickiness of the eyelids, especially in the morning, vision is usually not affected)
- **Viral conjunctivitis** (watery discharge, red eyes, foreign body sensation in the eyes)
- **Cluster headache** (severe unilateral headache in a middle-aged man, headache occurs in clusters, associated with lacrimation of red eye)
- **Acute closed-angle glaucoma** (acute pain in the eye, reduced vision, red eye, nausea and vomiting)
- **Sub-conjunctival haemorrhage** (spontaneous blood shot eye, no pain, vision not affected, usually occurs after patient has been rubbing the eye or in elderly patients with hypertension)
- **Trauma**

- **Rheumatoid arthritis (iritis):** (symmetrical polyarthritis, especially of the small joints, red eye is due to anterior uveitis)
- **Iritis/Anterior uveitis** (ankylosing spondylitis, usually a young man with back pain, plus or minus family history of similar complaints or a family history of back pain in young males)
- **SLE** (iritis, polyarthritis, young female, butterfly rash on the face)
- **Inflammatory bowel disease** (iritis, can be unilateral or bilateral, chronic diarrhoea, abdominal pains)
- **Reiter's syndrome** (conjunctivitis, arthritis and urethritis, positive sexual history)
- **Foreign body** (foreign body sensation in the eye, patients usually remember an episode when they felt something entered their eye)

Questions for differential diagnosis

- **Bacterial conjunctivitis**
  - Any discharge from your eyes?
  - Is it a clear discharge or thick pus-like discharge?
  - Any matting of your eyes in the morning?
- **Viral conjunctivitis**
  - Is the discharge watery?
- **Cluster headache**
  - Is it associated with headaches? If yes, is this the first time? Does the headache come at a particular time of the day?
- **Acute closed-angle glaucoma**
  - Any pain in your eye?
  - Is your vision affected?

- **Sub-conjunctival haemorrhage**
    - Are you taking any medication like aspirin or warfarin?
- **Trauma**
    - Did you sustain an injury to your eye?
- **Rheumatoid arthritis**
    - Is there any joint pains?
- **Iritis/Anterior uveitis (ankylosing spondylitis)**
    - Any back pains?
    - Anyone else in the family with similar complaints?
- **SLE**
    - Any fever, joint pain, swollen joints?
    - Butterfly rash?
- **Inflammatory bowel disease**
    - Are you experiencing any diarrhoea? Have you noticed any blood in your stool?
- **Reiter's syndrome**
    - Any discharge from your penis/vagina?
- **Foreign body**
    - Any gritty sensation in your eye?

Scenario 184

You are FY 2 in GP surgery. A 50-year-old male has made an urgent appointment to see you. Take a focused history and discuss management.

Patient Information:

You are a 50-year-old man who woke up this morning with a red eye. It is very red but no pain. You do not have any other symptoms; no vomiting or headache. You are normally fit and well and not on any medication. You are worried that you could lose your vision.

Questions:

What do you think is happening doctor?

Will I lose my vision?

Is it something serious?

Is there any treatment?

Emotions:

You look worried and are sitting on chair.

Examiners Prompt:

Fundoscopy is normal and provide a photograph

Approach to scenario 184

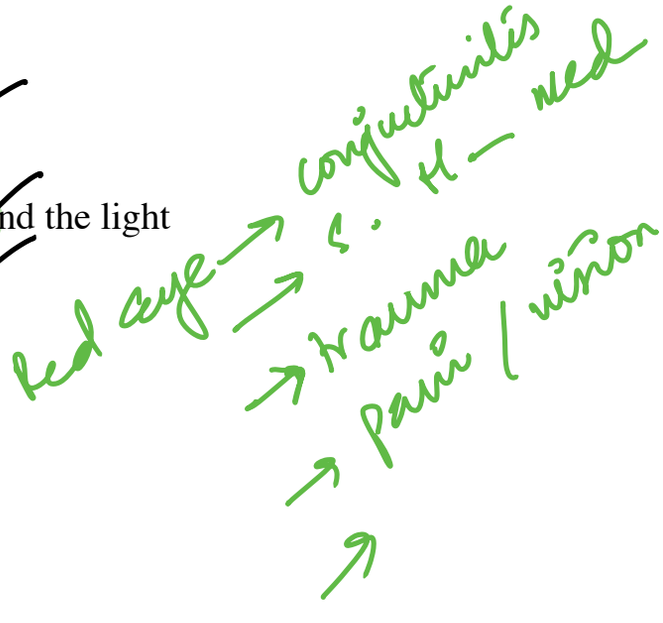
- Initial Approach or GRIPS
- ODPARA
- Differential Diagnosis
- Red Flags
- MAFTOSA
- ICE
- Summarise

- **Examination**
    - Observations
    - Examination of the eye, including the back chamber (fundoscopy)
    - Check pressure in the eye
- Explain the findings
- **Diagnosis**
- Sub-conjunctival haemorrhage. It is caused by bursting of small blood vessels in the eye.
- **Management:**
    - Check BP as sometimes if the BP goes up it can cause small blood vessels to burst.
    - Artificial tears to reduce irritation if it causes discomfort in the eye.
    - Advise not to use aspirin or NSAIDs.
    - Reassure that it is a self-limiting condition.
    - Resolves within 12-14 days.
    - Leaflets

- **<u>Safety Netting</u>**:

Advise patient to come back if any of the following happen:

- Visual loss
- Severe pain
- Photophobia
- Coloured haloes around the light
- Pain in the eye



Practical Scenario

69

2. DIZZINESS

Description of Dizziness

Can you tell me what you mean with dizziness?

Do you have an experience of buildings rotating around you?

FODPARA of Dizziness:

F – Frequency: How often do you experience dizziness?

O – Onset: How did the dizziness start? Suddenly or gradually?

D – Duration:

- When did it start?
- How long have you had the dizziness for?
- How long does the dizziness last? A few seconds, minutes, hours or days?
- Have you ever experienced dizziness before?

P – Progression: Is it becoming worse, improving or is it the same?

A – Aggravating factors:

- Is there anything that triggers the dizziness?
- Does head or neck movement trigger your dizziness?
- Does coughing, sneezing and straining trigger your dizziness?
- Did you recently have any viral illness – cough, runny nose, sneezing?
- Does standing from sitting or lying down provoke your dizziness?
- Does standing for a long time make you dizzy? If you don't eat on time, do you experience dizziness?

R – Relieving factors:

- Is there anything that makes the dizziness better?
- Does your dizziness improve when you sit down?

- Does it become better if you don't move your head?
- Does vomiting makes it better?
- Does closing the eyes makes it better?
- Does lying down makes it better?

A – Associated symptoms: Differential diagnoses

Differential Diagnosis:

- **Panic attack** (SOB, feeling of impending doom, peri-oral paresthesia, butterflies in the stomach)
- **Trauma** (there will be history of trauma).
- **Acute otitis media** (earache, ear discharge, fever, history of recent upper respiratory tract infection)
- **Labyrinthitis** (recent history of flu-like illness, dizziness)
- **Benign positional vertigo** (symptoms worse in the morning when waking up, especially when changing posture e.g. turning in bed or rising from a supine to a sitting position in bed)
- **Stroke** (usually in an elderly patient, weakness of the legs, speech or swallowing difficulty, any weakness on the face)
- **Anaemia** (light-headedness, weakness, fatigue, tiredness, history of use of NSAIDs or aspirin)
- **Acoustic neuroma** (hearing loss, dizziness, progressive headaches, family history of similar complaints)
- **Meniere's disease** (intermittent deafness, dizziness, tinnitus)
- **Brain tumours** (weight loss, headache, vomiting, weakness in the limbs, any other focal neurological symptoms)

- **Postural hypotension** (side effects of drugs especially thiazides, typical presentation is a hypertensive patient on anti-hypertensive medication)
- **Hypoglycaemia** (usually in a diabetic patient)
- **Medications** - ototoxicity (e.g. gentamicin)

Questions for differential diagnosis

- **Panic attack**
    - Do you ever experience shortness of breath or chest pain together with the dizziness?
- **Trauma**
    - Is there any chance you could have hurt your ear?
    - Did you sustain a head injury?
- **Acute otitis media**
    - Are you running a temperature?
- **Labyrinthitis**
    - Any nausea?
    - Any problems with the balance?
    - Have you recently had any flu like illnesses?
- **Benign positional vertigo**
    - Is the dizziness worse in any particular position?
- **Stroke**
    - Any weakness in the legs or arms?
    - Any speech problems?
- **Acoustic neuroma**
    - Have you lost weight recently? If so, quantify.
    - Do you feel tired all the time?
    - Any hearing problems? Was it gradual?

- **Meniere's disease**
    - Any ringing in the ears?
    - Any hearing problems?
    - Do you also feel sick with the onset of dizziness?
    - Any feeling of fullness in the ear?
- **Postural hypotension**
    - Does the dizziness start on sitting up from lying position or standing up from sitting position or standing for long period of time?
- **Hypoglycaemia**
    - Have you been told your blood sugar levels are low?
- **Medications**
    - Are you on any medication for your symptoms?

Scenario 102

You are FY 2 in in A&E. A 25 years old lady presented with dizziness. Please take a focused history, assess and discuss management with the patient.

Patient Information:

You are having dizziness. You feel like the building is spinning around. You went to the marker shipping and you suddenly felt dizzy when you turned your head to look at your friend. Your symptoms started 3 hours ago. You could not stand. You felt sick but did not vomit. You felt this until the ambulance came. 2 weeks ago you had a flue (cough, fever, running nose and sore throat). Your ears feels blocked. The flue symptoms are completely gone now.

Questions:

Q. What is wrong with me doctor?

Q. What are you going to do for me?

Q. Is it something serious?

Q. Can it be stroke?

Q. Do you think it can be stroke?

You are sitting on a chair with a bucket in your hands as if you are about to vomit.

Approach to scenario 102

- Initial Approach or GRIPS
- ODPARA
- Differential Diagnosis
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise

- **Examination**
    a. Observations
    b. Eye examination
    c. Neurological examination
    d. Cranial nerve examination
    e. Gait, rombus test.
- Explain the findings

- **Diagnosis**

Summarise the findings and give diagnosis.

So you have told me that you developed sudden onset of dizziness today while you were shopping when you turned your heard

You mentioned that about 2 weeks ago (10 days ago) you had flu like symptoms like flu, sneezing, cough, runny nose

Is there anything else i have missed. Now from this information, I feel that you have a condition called Vestibular Neuritis, it is an inflammation of the nerves responsible for balance.

MB: If a task says perform relevant examination, such as assess the patient, then you must examine the patient unless stopped by examiner.

Management

- Bloods (FBC, GS, inflammatory markers)
- Opinion from seniors

- Reassure that it normally resolves on its own within a few days. But we will make sure that there is nothing else causing your symptoms other than infection of the nerve.
- Admit under medical team
- If there is repeated vomiting give iv fluids
- Leaflets

3. HAEMATEMESIS Vomiting in Blood

Nature of Haematemesis

- What is the colour of your vomit?
- How many times did you throw up?
- Did you see blood in it?

ODPARA of haematemesis

O – Onset: How did you vomiting start? Suddenly or gradually?

D – Duration: When did it start? Or How long have you had these symptoms for?

P – Progression: Is it becoming worse, improving or is it the same?

A – Aggravating factors: Anything which makes it worse or anything which brings it on ()?

R – Relieving factors: Anything that makes it better?

A – Associated symptoms: Differential diagnoses

<u>Differential Diagnosis:</u>

- **Peptic ulcer** (upper abdominal pain worse with meals)
- **Gastric erosions** (aspirin, NSAIDS, clopidogrel, warfarin)
- **Oesophagitis** (GERD - reflux symptoms e.g. heartburn, sour taste in the mouth, ± recurrent chest infections)
- **Mallory–Weiss tear** (usually follows binge drinking, patient vomits small amount of blood, retching before vomiting starts)
- **Gastric carcinoma** (weight loss, epigastric pain, anaemia, weakness, elderly patient, early satiety)

- **Oesophageal carcinoma** (progressive dysphagia for solids, initially for solids only and then liquids as well, weight loss, elderly patient)
- **Bleeding diathesis** (check for a family history of bleeding disorders)
- **Oesophageal varices** (history of alcohol abuse or any chronic liver disease)
- **Instrumentation** (recent endoscopy or any other instrumentation)

Questions for differential diagnosis

- **Peptic ulcer disease**
  - Any abdominal pain?
  - Does the pain changes with food intake?
- **Gastric erosions**
  - Are you taking any regular medications?
  - Any over the counter medications, like aspirin, naproxen, ibuprofen?
- **Oesophagitis**
  - Any heartburn or sour taste in mouth?
  - Any recurrent chest infections?
- **Mallory-Weiss tear**
  - Were you retching before you started vomiting blood?
  - Do you drink alcohol? If yes, were you drinking just before you started vomiting?
- **Gastric carcinoma**
  - Have you lost weight recently? If yes, quantify.
  - Do you feel tired all the time?
  - Do you feel satisfied after eating small meals?

- **Oesophageal carcinoma**
    - Have you lost weight recently, If yes, quantify.
    - Do you feel tired all the time?
    - Do you ever experience difficulty in swallowing?
- **Bleeding diathesis**
    - Anyone in the family with bleeding problems?
- **Oesophageal varices**
    - Do you drink alcohol? If yes, how much?
    - Any liver issues?
- **Instrumentation**
    - Any recent endoscopy or any other instrumentation?

Red Flags

- Tachycardia
- Melena (Any Blackstools)
- Dysphagia (Problems swallowing)
- Epigastria mass
- Jaundice (Fiaues)
- Weight loss

Scenario 116

You are FY 2 in A&E. A 32 years old female presented with vomiting blood.

BP 100/80 HR 110 RR 18 O2 sat 96%

Take a focused history, discuss differential diagnosis with the patient and inform him of your next management plan

Patient Information:

You have been vomiting dark blood (coffee ground) since 3 hours ago. You have vomited twice; once before coming to the hospital and once in the hospital. The amount was about three small cups full. No abdominal pain/abdominal pain. Abdominal pain started after vomiting. It started suddenly. You drink one bottle of wine everyday and smoke 15 cigarette per day for past 10 years/does not smoke. You have been taking ibuprofen (at least 5 times a week), diclofenac (400mg three times a day) and aspirin for past 6 months. You are feeling weak and dizzy, no blood in stools. You take ibuprofen for hangover due to alcohol. You have No colour changes in stool.

Questions:

Q. What is wrong with me?

Q. What are you going to do for me?

Q. Will I go home today?

Q. What has caused this?

Q. When the doctor tells you about endoscopy you ask: "will it be painful?"

Examiner's prompt:

PR: normal

Abdominal pain-tenderness in epigastrium/no findings

Observations (verbally) BP 100/70 HR 110 and everything else is normal

Approach to scenario 116

- Initial Approach or GRIPS
- ODPARA
- Differential Diagnosis

- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise
- **Examination**
    a. Observations
    b. Abdominal exam
    c. Per rectal exam
- Explain the findings
- **Diagnosis**

Explain possible causes (medication Ibuprofen, diclofenac, aspirin)

1. It could be due to the medication you have been taking. Because diclofenac/Aspirin/Ibuprofen can all cause damage to the lining of the stomach. This could be the most likely cause
2. Bleeding due to Alcoholic Liver Disease.

Management

- Admit
- Monitors
- IV fluids.
- Bloods – FBC, U&E, LFT, clotting, glucose, group & save
- Emergency Endoscopy (to go and see where the he is bleeding from)
- Advice to stop smoking.
- If he needs blood transfusion, does he have any restrictions to blood transfusions.
- Give leaflets about blood loss.

4. CHEST PAIN

SOCRATES for chest pain

S – Site: Where is the pain, can you show me with one finger?

O – Onset: How did it start? Suddenly or gradually?

C – Character: What type of pain is it? Dull ache/compressing/sharp?

R – Radiation: Does the pain move/go anywhere?

A – Associated: Differential diagnoses

T – Timing: Is there any specific time you experience the pain or when is it worse? Is it always there or does it come and go?

E – Exacerbating and relieving factors: Is there anything that makes the pain worse? Is there anything that makes the pain better?

S – Severity/Score: On a scale of 0 – 10, 0 being no pain and 10 being the worst, what would be the score of your pain?

Differential Diagnosis:

- **Myocardial infarction** (central crushing chest pain radiating to the left arm or throat, lasting >20 minutes, nausea, sweating in palms, middle-aged or elderly patient)
- **Angina** (chest pain lasts < 20 minute, may be difficult to differentiate from MI)
- **Thoracic aneurysm** (chest pain radiating to the back)
- **Pulmonary embolism** (haemoptysis, chest pain, SOB, positive risk factors e.g. long flight, postoperative, immobility)
- **Pericarditis** (pleurisy chest pain, relieved by leaning forward, mild grade fever)

- **Pneumonia** (fever, cough with sputum, SOB, chest pain)
- **Tension pneumothorax** (sudden onset SOB, chest pain, usually in a tall, thin young man)
- **Trauma**
- **Musculoskeletal pain** (usually after strenuous exercise e.g. after gym, there is usually tenderness on palpation of the chest)
- **GERD** (heart burn, sour taste in the mouth ± recurring chest infections)
- **Costochondritis** (pain along the ribs)
- **Shingles** (rash, usually starts from the back to the front along the intercostal spaces, usually in immunocompromised patients e.g. elderly patients, patients on steroid, patients with cancer)
- **Fractured rib** (history of trauma, localised tenderness)
- **Oesophageal spasm** (retrosternal chest pains)
- **Pleurisy** (pain on inspiration, usually after URTI)

Questions for differential diagnosis

- **Myocardial infarction**
  - Do you have central chest pain? Does it radiate?
  - How long have you had this pain?
  - Do you have nausea or sweating?
- **Angina**
  - Is the pain less than 20 minutes?
  - Have you ever been diagnosed with angina?
  - Have you had these pains before?
- **Thoracic aneurysm**
  - Does the pain radiate to the back?

- **Pulmonary embolism**
  - Do you have blood in your sputum?
  - Is there any shortness of breath?
  - Have you been on long flight or had operation recently or been immobile recently?
- **Pericarditis**
  - Have you been feeling feverish?
  - Does the pain improve on leaning forward?
- **Pneumonia**
  - Do you have any fever?
  - Do you have cough? Any discharge in sputum?
  - Any shortness of breath?
- **Tension pneumothorax**
  - Do you have any shortness of breath? Did it start suddenly?
- **Trauma**
  - Did you injure yourself recently?
- **Musculoskeletal pain**
  - Have you recently done a lot exercise?
  - Does it hurt to touch?
- **GERD**
  - Do you have sour taste in mouth or burning in throat?
  - Do you have recurring chest infection?
- **Costochondritis**
  - Do you have pain along your ribs?
- **Shingles**
  - Did you notice any rash, particularly in the back coming to the front?

    - Are you on any medicines like steroids?
- **Fractured rib**
    - Have you recently fractured your rib?
    - Does it hurt to touch?
- **Oesophageal spasm**
    - Is your pain on and off?
- **Pleurisy**
    - Do you have any pain during breathing in?
    - Have you recently had cough, runny nose or sore throat?

Red Flags

Pain not relieved with nitrates, pain on exercise or nausea, vomiting or sweating.

Scenario 33

You are FY 2 in A&E. A 57 years old man presented with chest pain. An electrocardiogram has been done. Take a focused history, perform relevant examination and discuss management with the patient.

Patient Information:

You have presented with central crushing chest pain that radiates to the neck and left arm. The severity of pain is 7/10. Nothing makes it better or worse. You smoke 20 cigarettes per day for the last 20 years. You drink 2-3 units of alcohol per week and take a well balanced diet. Your brother who is 47 years of age had a heart attack 2 years ago. You are worried you could have a heart attack. You developed severe chest pain 3 hours ago while you were making breakfast, the pain radiates to left arm and to the jaw.

Questions:

Q. Will I go home today?

Q. What is wrong with me?

Q. How long will I stay in the hospital? (only if candidate says you need admission)

Q. Which blood thinning tablets will you give me?

Q. What if it is a heart attack, what will you do?

Q. What is an electrocardiogram?

Q. What are there zig zag lines on this paper?

Approach to scenario 33

- Initial Approach or GRIPS
- SOCRATES
- Differential Diagnosis
- Risk factors for MI: DM, hypertension, family history, smoking, previous IHD and high cholesterol)
- Red Flags
- MAFTOSA
- ICE

DM
HTN
Family Hx
Smoking
Previous IHD
High Cholesterol

- Effects of Symptoms
- Summarise
- **Examination**
  a. Observations
  b. CVS exam
  c. RES exam

Heart, lungs. ECG Vitals

- Explain the findings

Diagnosis

You have told me that You had a sudden onset of chest pain which started 4 hours ago.

You mentioned that the pain is crushing in nature and it radiates to the throat. The pain made you sick but you did not vomit. You also mentioned that your brother and father had a heart attack. Is there anything i missed?

Explain the diagnosis:

Explain that from what you have told me unfortunately, I feel that your chest pain is coming from the heart. And unfortunately, it could be a heart attack. But it could also be a simple Angina attack. So we need to perform some investigations and blood tests to make sure that you have not suffered a heart attack.

SOB / Chestpain / Cough / Fever / trauma

Management

- GTN
- We need to connect you to the monitors just to check that your oxygen levels in your blood are normal
- Give blood thinner tablets: Aspirin, clopidogrel,

F L A W S.
fever cough rash vomit WL sweating.

- Take bloods (FBC, U&E, cardiac enzymes, cholesterol, clotting profile) and give morphine and metochlopramide (anti sickness medication)
- Explain that you need to perform an ECG. Once the examiner has given you the ECG then explain whether it is normal or has a heart attack .This is bad news.
- Give you also a blood thinner injection (LMWH subcutaneously)
- Take a second opinion from my senior colleague
- Refer to Cardiologist
- Admit you to the Coronary Care Unit (CCU)- this is the ward where we admit anyone suspected of a heart attack.
- When you go to the coronary care unit the cardiologist might need to perform what we call an angioplasty.
- Angioplasty is a procedure where a catheter is inserted through the groin all the way to the heart. A dye is injected which maps out the blood vessels.
- Blocked blood vessels become visible and a stent is inserted.
- If there are too many blocked blood vessels, you might need a different operation which we call bypass operation.
- It is a big operation so it is usually done on a separate day.

Complications

- Anaphylaxis: if it happens we will give you a medication to treat it
- Pain on the site: can take analgesia.
- Bleeding at the site: we will be keeping a close eye on it.
- Can affect the kidneys but we will give you fluids to prevent that from happening.

Scenario 178

You are an FY2 in A&E. A 25 years old man has presented with chest pain. Take a focused history, assess the patient and discuss management.
You fell 3 days ago and now have chest pain on the left side. The pain is on lower ribs. You thought the pain would go away but it didn't go away.
Q. What is wrong with me?
Q. What are you going to do for me?
Q. Is it a heart attack?
Q. I heard that other people have their heart on the right? Do I?

Approach to scenario 178

- Initial Approach or GRIPS
- ODPARA
- Differential Diagnosis
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise
- **Examination**
    a. Observations
    b. Chest exam
    c. Palpation of chest for tenderness
- Explain the findings

- **Diagnosis**

    Explain that it is most likely to be musculoskeletal pain

- **Management**
    a. Analgesia-ibuprofen
    b. Chest X ray
    c. Blood tests
    d. ECG
    e. Leaflets
    f. Warning signs: chest pain radiating to neck, back or throat, palpitations and shortness of breath

Scenario 156

You are an FY2 in A&E. A 25 years old man presents with chest pain. Take a focused history, assess the patient and discuss management.

Patient information

You have chest pains for last 2 days. 10 days ago you had viral illness. You have a dull central chest pain, relieved by leaning forward and worse on inspiration.

Questions:

Q. What is wrong with me?

Q. What are you going to do for me?

Q. What does ECG show?

Examiners Prompt:

Observations chart and ECG in the cubicle

Approach to scenario 156

- Initial Approach or GRIPS
- ODPARA
- Differential Diagnosis
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise
- **Examination**
    a. Observations
    b. Chest exam
- Explain the findings

- **Diagnosis**

From what you have told me and from the examination that I have performed, it looks like you unfortunately have pericarditis. It is inflammation of the layer surrounding the heart.

- **Management**
  a. Routine bloods
  b. Chest X ray
  c. ECG
  d. Admit
  e. Analgesia (NSAIDS)

Practical scenarios

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5. SORE THROAT

FODPARA of sore throat

F – Frequency: How frequently do you get the sore throat?

O – Onset: How did it start? Suddenly or gradually?

D – Duration: When did it start? Or How long have you had these symptoms for?

P – Progression: Is it becoming worse, improving or is it the same?

A – Aggravating factors: Anything which makes it worse or anything which brings it on (if intermittent symptoms)?

R – Relieving factors: Anything which makes it better?

A – Associated symptoms: Differential diagnoses

Differential Diagnosis:

- **Tonsillitis** (fever, difficulty in swallowing, sore throat, cough, sneezing)
- **Upper respiratory tract** infection (cough, sneezing, runny nose, fever)
- **Instrumentation** (recent history of procedure carried out in the throat)
- **Laryngeal carcinoma** (weight loss, progressive symptoms, hoarseness of voice, smoker, elderly patient)
- **Laryngitis** (cough, sneezing, ±fever)
- **Foreign body** (history of foreign body ingestion)
- **Trauma**
- **Voice abuse** (over-shouting e.g. football supporters)
- **Glandular fever or infectious mononucleosis** (coryza, symptoms like cough, runny nose, sneezing, low-grade fever, sore throat, rash, cervical lymphadenopathy)

- **HIV** (Prodrome period of HIV can present with glandular fever-like illness i.e. fever, myalgia, pharyngitis, headaches, diarrhoea, lymphadenopathy, neuralgia, maculo-papular rash).

Questions for differential diagnosis

- **Tonsillitis**
  - Do you have any fevers?
  - Did you experience any difficulty in swallowing?
  - Do you have any cough?
- **Upper respiratory tract infection**
  - Do you have any cough, fever, runny nose or sneezing?
- **Instrumentation**
  - Have you recently had a procedure carried out in the throat?
- **Laryngeal carcinoma**
  - Have you recently lost weight? If yes, quantify.
  - Are the symptoms getting worse with time?
  - Have you noticed your voice becoming hoarse?
  - Do you smoke? If yes, how much and for how long?
- **Laryngitis**
  - Do you have a cough?
  - Have you been sneezing?
  - Do you have a fever?
- **Foreign body**
  - Is there a history of foreign body ingestion?
  - Possibility of unintentional foreign body ingestion?
- **Trauma**
  - Have you recently sustained any trauma?

- **Voice abuse**
  - Are you a teacher or singer?
  - Have you excessively used your voice recently?
- **Glandular fever or infection**
  - Do you have runny nose, sneezing and low-grade fever recently?
  - Have you noticed a rash on your body?
  - Do you feel your neck glands are increasing in size?
- **HIV**
  - Do you have fever, myalgia, headaches, diarrhoea or rash on your body?
  - Did you notice any lumps and bumps on your body?
  - Do you use recreational drugs, have unprotected sex or have multiple blood transfusions in the past?

Typical approach:

- Initial Approach or GRIPS
- ODPARA
- Differential Diagnosis
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise
- Examination
- Explain the findings
- Diagnosis
- Management

tonsillitis
URTI
laryngitis
Voice abuse
HIV
IM
Laryngeal cancer
Trauma
Intubation

Practical scenarios

289 → Statin
→ allergic to penicillin
→ sore throat, runny nose.
→ No travelling HK.
Patient concerned.

Temp 38°
RR 18.
HR 90
Sat 98%
ear, throat examination.

6. MUSCULOSKELETAL PAINS + swelling + stiffness.

The Nature of the pains

- Where are the pains?
- Is it one joint or more?
- Are they most painful first thing in the morning or later in the day?

SOCRATES

S – Site: Where is the pain? Can you show me with one finger?

O – Onset: How did it start? Suddenly or gradually?

C – Character: What type of pain is it? Dull ache/compressing/sharp?

R – Radiation: Does the pain move/go anywhere?

A – Associated: Differential diagnoses

T – Timing: Is there any specific time you experience the pain or when is it worse? Is it always there or does it come and go?

E – Exacerbating and relieving factors: Is there anything that makes the pain worse? Is there anything that makes the pain better?

S – Severity/Score: On a scale of 0 – 10, 0 being no pain and 10 being the worst, what would be the score of your pain?

Swelling:

- Do your joints swell?

Stiffness:

- Are your joints stiff when you wake up in the morning?
- Do you experience stiffness in your joints when you wake up in the morning?

- How long does it take you to get the joints going?

Differential Diagnosis:

- **Fibromyalgia** (memory loss, muscle pains, fatigue, extreme exhaustion lasting more than 24 hours after physical exercise)
- **Malignancy** (weight loss, loss of appetite, anorexia, weakness, fatigue)
- **Polymyalgia rheumatica** (muscle pains and stiffness often occur in the shoulders, neck, arms and hips, usually associated with GCA)
- **Drug side effects** e.g. statins (statin induced myalgia)
- **Chronic fatigue syndrome** > 6 M
- **Dermatomyositis** (body rash, muscle weakness, especially of the hips, thighs, upper arms, shoulders etc.)
- **Polymyositis**
- **SLE** (butterfly rash on the face, joint pains)
- **Rheumatoid arthritis** (multiple symmetrical joint pains, red eye may suggest iritis, episcleritis or scleritis)
- **Rhabdomyolysis**
- **Myofascial pain syndrome**
- **Porphyria**

Questions for differential diagnosis

- **Fibromyalgia**
  - Have you noticed any problems with memory?
  - Do you have muscle pains and fatigue?
  - Do you have exhaustion lasting more than 24 hours after exertion?

- **Malignancy**
    - Any history of weight loss? If yes, quantify?
    - Do you have weakness, fatigue and are generally unwell?
- **Polymyalgia rheumatic**
    - Do you have stiffness in muscles especially shoulders, neck, arms and hips.
    - Have you every been diagnosed with giant cell arteritis?
- **Drug side effect**
    - Are you taking any regular medication?
    - Are you on statins?
- **Chronic fatigue syndrome**
- **Dermatomyositis**
    - Have you noticed any body rash?
    - Do you experience muscle weakness, especially in hips, thighs, upper arms and shoulders?
- **Polymyositis**
- **SLE**
    - Any fever, joint pain, swollen joints?
    - Butterfly rash?
- **Rheumatoid arthritis –** maybe caused by gastroenteritis or urethritis. Gastroenteritis usually caused by campylobacter, salmonella, clostridium etc. and urethritis usually by chlamydia trachomatis.
    - Do you have pain in multiple joints?
    - At what time of day is the pain worst?
    - Does the pain improve on movement?

- **Rhabdomyolysis**
    - Have you recently worked out excessively?
    - What is the colour of your urine?
    - Any local tenderness?
- **Myofascial pain syndrome**
    - Does the pain feel to be deep in the muscle?
    - How has your sleep been recently?
- **Porphyria**
    - Do you have chest/abdominal/leg or back pain?
    - What is the colour of your urine?
    - Do you feel more confused or find it difficult to concentrate?
    - Do you have any nausea or vomiting?

msk pain — DDs

1. fibromyalgia
2. RA
3. PMR
4. LFS
5. malignancy
6. Drugs
7. myofascial

Scenario 191

You are an FY2 in GP surgery. A 40 years old lady presented with pain in her hands. She is a smoker. Take history, assess the patient and discuss management with the patient.

Patient Information:

You have pains in hands on both sides. You have gradual onset of pain for past 3-4 weeks. Work as a secretary in a hospital and find that pain is worse when typing. You also have morning stiffness in both hands. You live with your husband and smoke 10 cigarettes per day for past 20 years. You have tried to use paracetamol but it did not help.

Questions:

Q. What could be the cause of the pain?

Q. Can I use ibuprofen?

Approach to scenario 191

- Initial Approach or GRIPS
- ODPARA
- Differential Diagnosis
- Systemic Review
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise
- **Examination**
    a. Observations
    b. Exam of hands
    c. Functional assessment

- Explain the findings

- **Diagnosis**

Explain that it is most likely rheumatoid arthritis but we would need to investigate to confirm it.

- **Management**
  - Routine bloods tests
  - Rheumatoid factor.
  - Inflammatory markers
  - Ibuprofen and PPI.
  - Refer to rheumatologist: they may assess again and may start you on some medication called disease modifying agents: DMARDs
  - Refer to occupational therapist and physiotherapist for advice on how to manage work and to advice about exercises to help pain and mobility respectively.
  - Warning signs: Return to hospital in case of fever and redness of joint

Practical scenarios

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DAY 2:

History Taking Part 1

1. Palpitations (108)

2. Hyperthyroidism:
- Weight loss - (44)
- Tremors and sweaty hands (98)

3. Benign prostatic hypertrophy with UTI (8)

4. Back pain:
- Back sprain (204)
- Back pain - prostate cancer pain management (1)
- Traumatic back pain (161)
- Back pain (renal colic) (19)

5. Constipation:
- Post hemiarthroplasty constipation (53)
- Constipation with nurse (106)

6. Shortness of breath:
- Pulmonary embolism scenario A (168)
- Pulmonary embolism scenario B (238)
- Pneumonia in elderly (179)
- Pneumocystis Carinii pneumonia scenario B (263)
- Acute COPD (212)

7. Headache:
- Migraine (235)
- Subarachnoid haemorrhage (72)
- Giant cell arteritis (132)
- Tension headache (193)

8. Hypothyroidism:
- Weight gain (147)
- Tiredness (128

9. Wheeze:
- Asthma first presentation - (scenario A and scenario B) (74)

10. Cough:
- Pneumocystis Carinii pneumonia scenario A (66)
- Tuberculosis (119)
- Pneumonia
- Mesothelioma / Tuberculosis (56)
- Pneumonia in 72 year old (276)
- Pneumonia from a nursing home (275)
- Pneumonia in a traveller (107)

11. Anaemia:
- Iron deficiency anaemia with weight loss (187)
- Iron deficiency anaemia in a vegetarian
- Vitamin B12 deficiency (177)
- Thalassemia (199)

DAY 2

1.PALPITATIONS

Nature of Palpitations

- Can you tell me what you mean by palpitations?
- Do you have an awareness of your heart racing?
- Can you tell me what you mean by fluttering feeling?
- Do you have an experience of thumping in the chest?
- Are the palpitations fast or slow?
- Do you have an experience of pounding in the chest?
- Do you have an experience like you're skipping some beats?
- Did you have a feeling that everything stopped for a moment?
- Can you tap for me on this table how fast your palpitations are?

FODPARA of Palpitations

F – Frequency:

- How often do you experience palpitations?

O – Onset:

- How did the palpitations start the first time? Suddenly or gradually?

D – Duration:

- When did the palpitations start?
- How long have you had the palpitations for?
- How long do the palpitations last? How do the palpitations stop?

P – Progression:

- Are the palpitations becoming more frequent?

A – Aggravating factors:

- Anything which makes it worse or anything which brings it on (if intermittent symptoms)?
- Does exercise make it worse?
- Does stress make it worse?
- Does drinking alcohol make it worse?
- Does drinking coffee or tea make it worse?

R – Relieving factors:

- Anything which makes it better?
- Does sitting help with the palpitations?
- Does holding your breath help with the palpitations?

A – Associations = Differential Diagnosis

Note: Ventricular ectopic beats disappear with exercise whereas AF remains the same.

Differential Diagnosis:

- Hyperthyroidism (oligomenorrhoea, heat intolerance, palpitations, weight loss, diarrhoea, tremors, palpitations)
- Medications (salbutamol inhalers)
- Hypoglycaemia (history of diabetes)
- Anxiety/panic attack (shortness of breath, chest pain, perioral paraesthesia, generalised chest pains, previous episodes of similar symptoms)
- Arrhythmia (history of angina or myocardial infarction, hypertension or heart failure)
- Pheochromocytoma (intermittent abdominal pain, diarrhoea, episodic symptoms of headaches, high blood pressure, panic attacks)
- Anaemia (light-headedness, weakness, tiredness, patient could be on aspirin or NSAIDs for a long period of time)
- Drug abuse (IV drug abuse)
- Excess intake of coffee / tea (common in people who drink excess amounts of coffee or tea)
- Ventricular ectopics (can occur in previously healthy person)

- Anorexia nervosa (amenorrhoea, weight loss, BMI <17.5, over- exercising, poor dietary habits)

Questions for differential diagnosis

- Hyperthyroidism
  - Do you feel hot when others are comfortable?
  - Do you have diarrhoea?
  - Have you lost weight? If yes, quantify.
  - Do you experience any tremors?
  - How is you appetite?
- Medications
  - Are you taking any inhalers (salbutamol)?
- Hypoglycaemia
  - Do you have any medical problems like diabetes mellitus, high pressure?
- Anxiety/panic attack
  - When you are having palpitations, do you experience shortness of breath as well?
  - Do you experience any tingling around your lips?
  - Do you get the feeling that you are going to die?
- Arrhythmia
  - Do you have any heart problems like angina?
  - Any heart attacks in the past?
- Pheochromocytoma
  - Do you experience headaches or tummy aches at the same time as the palpitations?
  - Have you noticed that your urine is turning dark in colour?
- Excess intake of tea or coffee?
  - Do you drink a lot of coffee or tea?
- Anaemia
  - Do you suffer from light-headedness, weakness or tiredness?
- Drugs
  - Is there any chance that you could be using recreational drugs?

Red Flags

- Shortness of breath?
- Chest pain?
- Syncope?

Fever
Chest pain
Palpitations
SOB
Trauma

Scenario 10

SUPRAVENTRICULAR TACHYCARDIA.

You are working as FY2 in GP practice. A 55 year old male James Brown presented with some concerns. Take a history, assess the patient and discuss initial management with the patient.

Patient Information

You are a 55 year of age. You have a fluttering feeling in the chest. If the doctor ask what do you mean, tell them it's a thumping in the chest. "I feel like my heart is pumping in a very weird way". You do not have palpitations at the moment. You have got hypertension and you are on Enalapril 10mg once a day. You visit your GP every 6 months and take your medications regularly. You smoke 10 cigs/day for the past 15 years, drink 8-10 units/ day of alcohol and drink 7-8 cups of coffee each day. You father had a stroke and died from it and you brother had heart attack at the age of 60.

Approach to Scenario 108

- Initial Approach or GRIPS
- FODPARA
- Differential Diagnosis
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Signpost
- Summarise
- **Examination:**
    a. Observations
    b. Pulse
    c. CVS- listen to heart
    d. RES- listen to lungs

cardio vs obs. [ECG. ~~FBC~~ urine dipstick pregnancy test

- glands in your neck.
- BMI
- ECG.

- **Explain the findings**
- **Diagnosis:**

I think you got some palpitations; It could be an irregular heartbeat which we call Supra-ventricular Tachycardia (if it is a younger individual, then AF). But there can be other causes as well, so we are going to run some blood tests to make sure there is nothing else going on. You do have a risk factor for Atrial Fibrillation, which is your high blood pressure.

But sometimes if you drink too much tea or coffee you can develop an irregular heart beat called an Ectopic Beat, where you can have an experience where by your heart is skipping some beats.

Is there anything you are worried about?

- **Management**
    a. ECG now
    b. 24 hour Ambulatory ECG
    c. CXR
    d. Routine bloods including TFT's

To make sure there are no thyroid problems like hypernatraemia as they can cause some palpitations as well.

    a. Advice to cut down on coffee or tea.
    b. Follow up in a 1 weeks to discuss the results once
    c. Refer to the medical team immediately if at present patient is experiencing dizziness, shortness of ~~breath and chest pain~~
    d. **Safety netting:** If chest pain, dizziness, syncope, unwell or if chest discomfort/ feeling are sustained please go to the hospital immediately.
    e. Referral to the cardiologist.

Practical scenarios

108 – scenario B

2. HYPERTHYROIDSM

Nature of weight loss

- How much weight have you lost?
- Over what period of time have you lost such amount of weight?
- Have you noticed your clothes becoming looser or hanging off you?
- Have you been trying to lose weight?
- Have you changed your lifestyle recently?
- Have you changed your eating habits recently?
- How is your appetite?
- Do you still feel hungry?

Alarm symptoms

- **Dysphagia:** Do you have problems swallowing or does the food ever get stuck?
- **Early Satiety:** Are you able to manage a meal or have you been getting full quickly?
- A**bdominal Pain:** Do you ever experience any pain in your stomach or abdomen? Do you experience pain after eating?
- **Change in bowel habits:** Have you noticed any change in your bowels? Any diarrhoea or constipation?
- **Melena:** What colour are the stools? Have you noticed any blood in your stools?
- **Haemoptysis:** Do you cough out any blood?
- **Bone Pains:** Do you experience any bone pains?
- **Diabetes:** Have you been unusually thirsty or passing a lot of urine?
- **Hyperthyroidism:** Have you been experiencing tremors in your hands? Any sweating or palpitations?

Differential Diagnosis:

- Malignancy (weight loss, anorexia, tiredness, mild grade fever, loss of appetite)

- Tuberculosis (haemoptysis, cough with sputum, fever, patients are usually from Asia or Africa)
- Anorexia nervosa (weight loss, young female, amenorrhoea)
- Depression (low mood, loss of appetite, anhedonia, insomnia, poor sleep)
- HIV (common in IV drug abuse or homosexuals, weight loss, generally unwell)
- Malabsorption (diarrhoea, tummy pains)
- Systemic autoimmune disease (SLE or Rheumatoid arthritis polyarthritis)
- Inflammatory bowel disease (usually common in young patients with chronic diarrhoea with or without bleeding per rectal, abdominal pain)
- Irritable bowel syndrome (bloating, diarrhoea, abdominal pain relieved by defecation)
- Hyperthyroidism (diarrhoea, palpitations, tremors, weight loss, menstrual irregularities)
- Diabetes mellitus (polyuria, polydipsia, weight loss)
- Bulimia nervosa (binge eating, laxative abuse, fluctuations in weight)
- Malnutrition

Questions of differential diagnosis:

- **Malignancy**
    - Any weight loss? How much weight have you lost?
    - Do you feel weak and tired?
    - Any loss of appetite?
- **Tuberculosis**
    - Do you have fever with night sweats?
    - Do you have cough? If yes, is there any sputum?
    - Have you recently travelled to Asia or Africa?
- **Anorexia nervosa**
    - Have you recently lost weight? If yes, how much?
    - Is your menstrual cycle regular?
- **Depression**
    - Have you recently been in low mood?
    - Do you enjoy doing any particular activity?
    - How has your appetite been?

- How is your sleep?

- **HIV**
  - Do you have fever, muscles, headaches, diarrhoea or rash on your body?
  - Did you notice any lumps and bumps on your body?
  - Do you use recreational drugs, have unprotected sex or have multiple blood transfusions in the past?

    NOTE: in this setting history taking is crucial!
- **Malabsorption**
  - Do you have any diarrhoea?
  - Do you have any abdominal pain?
- **Systemic autoimmune disease (SLE or Rheumatoid arthritis/ polyarthritis)**
  - Any fever, joint pain, swollen joints?
  - Any rashes on your body?
- **Inflammatory bowel disease**
  - Any pain in the tummy?
  - Do you feel tired all the time?
  - Is there any blood in your stools? If yes, what colour?
  - Have you lost any weight recently? If yes, quantify.
  - Do you experience these symptoms at night?
- **Irritable bowel disease**
  - Any pain in the tummy?
  - Do you have alternating diarrhoea with constipation?
  - Do you feel bloated and gassy?
- **Hyperthyroidism**
  - Do you feel hot when others are comfortable?
  - Do you have diarrhoea?
  - Have you lost weight? If yes, quantify.
  - Do you experience any tremors?
- **Diabetes mellitus**
  - Do you have increased urination? Increased thirst?
  - Have you ever been told that your blood sugar levels are high?
- **Bulimia nervosa**
  - Do you have periods of binge eating and starvation?

    - Do you use laxatives?
    - Does your weight vary?
- **Malnutrition**
    - What kind of food do you eat?
    - How is your diet?

Scenario 98

You are an FY in GP surgery. A 27 years old female Sarah Jones has presented with sweating and shaking in her hands. One week ago, she had come to the GP and had blood tests done: TSH – 0.6 (0.5-4.5ug/dl); T4 – 22 (4.6-12ug/dl); T3 – 235 (80-180ng/dl). Please take a focused history and discuss initial management with the patient.

Patient Information

You have had tremors and sweating of your hands for the past 2 months. You have lost 3kgs in weight, your periods have become irregular and your mother has thyroid problems.

Questions:

Q. What is wrong with me?

Q. How will you manage it?

Q. What medication will you give me?

Q. What is radio-iodine doctor?

Examiner's Prompt:

If the candidate says he would like to perform thyroid function tests, give him the results of the thyroid function test

Observations:

Pulse 90/min and BP 130/80.

Rest of the examinations is normal

Approach to scenario 98

- Initial Approach or GRIPS
- ODPARA
- Differential Diagnosis
- Red Flags
- Systemic review
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise

- **Examination:**
    a. Observations
    b. Hands for tremors
    c. Thyroid gland in your neck
    d. CVS - listen to heart
    e. Check for reflexes
- **Explain the findings**
- **Diagnosis:**

Explain most likely diagnosis (most likely you have an over active thyroid) and any symptoms. To confirm the diagnosis I will need to perform some examinations + investigations)

- **Management**
    a. Refer to endocrinologist
    b. Medicine to suppress over activity: Carbimazole, B-blockers, radio-iodine, operation (complete removal of thyroid gland and put you on replacement medication.
    c. Specialist may also do specific blood test and an ultrasound
    d. Leaflets
    e. Is there anything in particular you are worried about?

Patient is worried that the weight loss is due to cancer. Reassure her that weight loss is due to overactive thyroid gland.

Practical scenarios

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3. DYSURIA

SOCRATES

Differential Diagnosis:

- Urinary tract infection (dysuria, fever, frequency, supra pubic pain)
- Pyelonephritis
- Bladder stones (pain on urination, supra pubic pain)
- Sexually transmitted infections (history of unprotected sex, multiple partners, discharge)

Risk factors of UTI

- **Benign prostatic hypertrophy**
  - Do you pass urine more frequently than usual?
  - How many times do you wake up during the night to urinate?
  - Do you feel as though you have to wait a while when trying to initiate urination?
- **Prostatic carcinoma**
  - Did you notice any blood in your urine?
  - Do you have any back pain?
  - How many times do you wake up to pass urine at night?
  - Is there any dribbling at the end of passing urine?
- **Bladder carcinoma**
  - Have you lost any weight recently? If yes, quantify.
  - How has your appetite been recently?
  - Did you notice any blood in your urine?
- **Faecal impaction**
  - Do you suffer from any constipation or diarrhoea?
  - Is there any pain in your tummy?

Questions for Differential Diagnosis

- **Urinary tract infection**
  - Do you have any fever?
  - Any burning when you pass wee?
  - Do you have pain in your lower tummy?
- **Pyelonephritis**
  - Do you have swinging fever?
  - Any rigors or sweating?
  - Any vomiting?
  - Is there any pain in your back?
- **Urinary bladder calculi**
  - Have you noticed blood in urine?
  - Have you ever passed small stones in urine?
  - Have you ever developed inability to pass urine?
  - Do you have any pain? If so, where? Does it radiate anywhere?
- **Sexually transmitted infection**
  - Any urethral discharge?
  - Any history of unprotected sex?
  - Did you notice any rash?

Terminal dribbling
BPH - urgency, frequency, urinary incontinence
PC - WL, Backpain, blood in urine, frequency
BC - WL, Blood in urine
PI - constipation, diarrhea

Red Flags

- Urinary obstruction
- Symptoms of cancer (tiredness & weight loss)
- Haematuria
- Pyelonephritis
- Recurrent UTI.

Scenario A

You are FY 2 in Urology Unit. A 75 years old gentleman has presented with dysuria. Take a focused history, perform relevant examination and discuss initial management with the patient.

Patient information:

You have presented with burning micturition. You have had hesitancy, frequency of micturition, burning sensation, passing urine at night very frequently (you have to wake up 2-3 times every night, dribbling of urine and very slow flow of urine).

You have had these symptoms for the past one year. In the last 2 days you have been experiencing burning sensation when passing urine and felt hot but you did not check the temperature.

You work as a clerk in the office. Because of your frequency you have to sit near the door so that you can go to the toilet easily. You can't concentrate at work easily. Your wife complains that there is too much smell of urine. You strain a lot when passing urine. You are allergic to amoxicillin. You are worried it could be cancer.

Questions:

Q. Since I am allergic to amoxicillin, what antibiotics are you going to give me?

Q. What caused the water works infection?

Q. What treatment options are there?

Q. If doctor wants to examine the back passage ask "Why do you need to examine it. Is it a very uncomfortable procedure?"

Q. Do you really need to perform this examination?

Examiner's prompt:

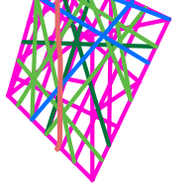
Abdominal exam: There is supra-pubic tenderness

Per rectal exam: Enlarged prostrate with deep median sulcus but smooth

Observations: normal.

Approach to scenario A

- **Initial Approach or GRIPS**
- **ODPARA**
- **Differential Diagnosis**
- **Red Flags**
- **MAFTOSA**
- **ICE**
- **Effects of Symptoms**
- **Sign post**
- **Summarise**
- **Examination:**
    - Observations
    - Abdominal examination
    - Per-rectal examination
- **Explain the findings**
- **Diagnosis:** Urinary tract infection with benign prostatic hyperplasia
- **Management:**
        - Perform urine dipstick.
        - Antibiotics (Trimethoprim)
        - Arrange a bladder scan to check the amount of the residual urine. If too much urine is in your bladder after urination, then we can catheterise you.
        - Admit under urology.
        - Blood test: FBC, U&E, LFT, blood glucose.
        - Explain what the specialist would do.
            - Medication (Tamsulosin) to help the sphincter relax
            - Operation :TURP- Remove part of the enlarged prostate.
            - In 90% of the cases, people get relieved of their symptoms
- Offer a leaflet about water works infection and BPH.



4. BACK PAIN

SOCRATES

Differential Diagnosis:

- Prostate cancer (usually a middle-aged or elderly patient, weight loss, frequency, haematuria).
- Intervertebral disc prolapse (sudden onset of pain while lifting heavy things).
- Spinal metastasis (weight loss, tiredness, weakness, middle-aged or elderly patient, +/- symptoms of primary tumour).
- Trauma (history of trauma or fall).
- Tuberculosis (weight loss, night sweats, patient from Africa / Asia, alcoholic).
- Ankylosing spondylitis (young man, +/- family history of back pain, morning stiffness, red eye due to anterior uveitis).
- Osteoporosis (elderly patient, usually due to compression or wedge fracture).
- Abdominal aortic aneurysm (middle-aged or elderly, abdominal pain radiates to the back, presence of other markers of atherosclerosis, intermittent claudication).
- Multiple myeloma (chronic back pain, elderly patient, proteinuria).
- Cauda equina (constipation, urinary incontinence or retention, weakness or sensory loss in the lower limbs).
- Osteoarthritis (elderly patient, +/- involvement of other joint like knee or hip).

Questions of differential diagnosis

- **Prostrate cancer**
  - Have you lost weight? If yes, quantify.
  - Do you pass urine more frequently than usual? How many times do you wake up at night for urination?
  - Have you noticed any blood in your urine?
- **Intervertebral disc prolapse**
  - Did the pain start suddenly on lifting heavy object?
- **Spinal metastasis**

- Do you feel tired and lethargic?
- Have you lost weight?
- Have you been diagnosed with cancer?
- Primary cancer symptoms/any other symptoms?

- **Trauma**
  - Have you recently sustained a trauma?
- **Tuberculosis**
  - Have you lost weight? If yes, quantify
  - Do you have fever or night sweats?
  - Have you recently travelled to Asia or Africa?
  - Do you drink alcohol? (if did not travel outside UK)
- **Ankylosing spondylitis**
  - Do you have a family history of back pain?
  - Do you feel stiff in the morning or after work?
  - Do you have redness in your eye?
- **Osteoporosis**
  - When was your last menstrual period?
  - Have you had fractures in the past?
- **Abdominal aortic aneurysm**
  - Does the pain start in tummy and radiate to back?
  - Have you been diagnosed with high blood pressure?
  - Do you feel pain in your legs, after exercise, that is relieved by resting?
- **Multiple Myeloma**
  - Is the back pain new or have you had it for long?
  - Do you have any kidney issues?
  - Do you have a history of repeated infections?
- **Cauda equina**
  - Do you have constipation or urinary retention?
  - Have you lost control of bowel or bladder?
  - Do you have loss of sensation in your legs?
  - Is there weakness or sensory changes in your limbs?

Red Flags

- Symptoms of spinal cord compression.

Scenario 204

You are FY 2 in Urology Unit. A 75 years old gentleman has presented with dysuria. Take a focused history, perform relevant examination and discuss initial management with the patient.

Patient information:

You have presented with burning micturition. You have had hesitancy, frequency of micturition, burning sensation, passing urine at night very frequently (you have to wake up 2-3 times every night, dribbling of urine and very slow flow of urine.

You have had these symptoms for the past one year. In the last 2 days you have been experiencing burning sensation when passing urine and felt hot but you did not check the temperature.

You work as a clerk in the office. Because of your frequency you have to sit near the door so that you can go to toilet easily. You can't concentrate at work easily. Your wife complains that there is too much small of urine. You strain a lot when passing urine. You are allergic to amoxicillin. You are worried it could be cancer.

Questions:

Q. Since I am allergic to amoxicillin, what antibiotics are you going to give me?

Q. What caused the water works infection?

Q. What treatment options are there?

Q. If doctor wants to examine back passage ask "Why do you need to examine it. It is a very uncomfortable procedure?"

Q. Do you really need to perform this examination?

Examiner's prompt:

Abdominal exam: There is supra-pubic tenderness

Per rectal exam: Enlarged prostrate with deep median sulcus but smooth

Approach to scenario A

- Initial Approach or GRIPS
- SOCRATES
- Differential Diagnosis
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Sign post
- Summarise
- **Examination:**
    - Observations
    - Back examination
    - Neurological examination
    - Per rectal examination
- **Diagnosis:** Back sprain - it is caused by over-stretching of ligaments in the back.
- **Management**
- Pain killers, go home with analgesia
- Refer patient to physiotherapy. Advise to start exercise gradually.
- X-ray.
- Offer leaflets about back sprain.

Scenario 19

You are FY 2 in A&E. A 45 years old man has presented with back pain. The nurse has given him 1 tablet of diclofenac. Take a focused history and discuss management with the patient.

Patient information:

As soon as the doctor walks in say: "Oh! doctor, I'm in pain!!"

You are in severe pain now, which started 4 hours ago. You have been given diclofenac by the nurse 45 minutes ago. You should keep saying "Doctor I'm in pain" continuously until the doctor reassures you that the analgesia would take some time to work or he would offer you another analgesia. Your pain was initially 10/10, now it is 8/10. The pain made you vomit 4 times. You are sweating on your forehead. You are sitting on the chair. You have loin pain, radiating to the groin. You have not travelled abroad. You had pain when passing urine.

Q. What are you going to do for me now?

Q. What do think is wrong with me Doctor?

Q. If the Doctor mentioned that he will do any investigations, ask him/her what is that? (CT KUB/ X-ray)

Q. What caused the renal stones?

SET UP: Holding a bowl in your hands as if about to vomit.

Examiners prompt: Blood on urine dipstick.

If they mention they would like to check the vital signs give them vital charts with the BP 110/70, HR 110, RR 14, Sats 100% on air.

If they mention urine dipstick give them a urine dipstick that is positive for blood.

Examination: Tenderness in right loin.

Approach to scenario B

- Initial Approach or GRIPS
- SOCRATES
- Differential Diagnosis
- Red Flags
- MAFTOSA
- ICE

- Effects of Symptoms
- Summarise
- **Examination:**
    - Observations
    - Abdominal examination
- **Diagnosis**: Renal Colic - Stone in the tube connecting the kidney to the bladder. Pain and blood in urine dipstick test both show renal colic.
- Explanation of diagnosis
- Diagnostic Investigations
- **Management**

Investigations

- Urine dipstick and MC&S
- Routine blood tests
- CT Kidney Ureter Bladder

Treatment: will depend on size of stones.

- If small: a lot of fluid. Advise to drink plenty of fluid.
- If the pain settles, refer to discharge with a follow up with the GP in one week's time.
- Bigger stones need ECSWL to break down the stone in to small pieces that can pass in the urine.
- If pain does not subside, we can refer to urology unit for pain control. In any case we will admit you and they will see you within 7 week.
- Big: Surgery, shock waves, key holes.
- If still in pain, will give morphine I/M or I/V according to patient pain because diclofenac is every 8 hours. Offer anti-emetics.
- Wait for painkillers to try to control the pain
- Follow up

Practical Scenarios

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6. CONSTIPATION

Nature of Constipation

- How many times a week do you usually open your bowels?
- At the moment, how many times a week do you open your bowels?
- How often do you open your bowels in an average week?
- What do you pass?
- Is the stool hard or soft?
- Does it hurt or do you strain when you pass stool?
- Have you noticed any blood in the toilet or in your stool?
- When you finish, do you ever have the feeling that you still need to open your valves?

ODPARA

O – Onset: How did your constipation start? Suddenly or gradually?

D – Duration: When did you start experiencing constipation?

P – Progression: Is it becoming worse, improving or is it the same?

A – Aggravating factors: Anything which makes it worse or anything which brings it on (if intermittent symptoms)?

R – Relieving factors: Anything which makes it better?

A – Associated symptoms: Differential diagnoses

→ How's your stool? Detail

→ Can you tell me abt diet? Detail

→ fibre?

→ water?

Differential Diagnosis:

RED FLAGS

- Hypercalcaemia (polyuria, polydipsia, confusion, abdominal pain)
- Hypothyroidism (cold intolerance, weight gain, constipation, menorrhagia)
- Malignancy (weight loss, change in bowel habits, middle-aged or elderly patient, abdominal pain)
- Dietary (absence of fruit or vegetables, not drinking enough water)
- Medication (morphine, codeine, tramadol)
- Pregnancy (ask about LMP)
- Irritable bowel syndrome (abdominal pain, abdominal bloating, diarrhoea)
- Immobility (bed-bound or hospital admission)

→ Nausea

→ vomiting

→ pain in tummy.

→ fluid, fruit, food

- Post-operative (this is secondary to paralytic ileus, there is usually no pain)
- Anal fissures (history of constipation)
- Faecal impaction (history of constipation, overflow diarrhoea)
- Intestinal obstruction (vomiting, abdominal pain, absolute constipation, abdominal distension)
- Diabetic neuropathy (positive history of diabetes for a long time)
- Spinal cord compression (urinary symptoms, weakness or sensory loss in the lower limbs, ± back pain)

Questions of differential diagnosis

- **Hypercalcaemia**
  - Do you feel thirsty all the time?
  - Do you have any pain in your tummy?
  - Are you passing urine more frequently than normal?
- **Hypothyroidism**
  - Do you feel cold when others are comfortable?
  - Have you gained weight recently?
- **Malignancy**
  - How are your bowel habits? Any recent changes?
  - Have you lost weight recently? Over what period of time have you gained this weight?
- **Dietary**
  - How many glasses of water do you drink everyday?
  - Do you eat enough fruits and vegetables?
- **Medication**
  - Are you taking any medication for pain relief?
  - Are you taking any other medication?
- **Pregnancy**
  - Is there a chance you could be pregnant?
- **Irritable bowel syndrome**
  - Do you have tummy pain with diarrhoea? If yes, is the pain better at night?
- **Immobility**

- Do you have a problem walking?

- **Post-operative**
  - Have you had any operations recently or in the past?
- **Anal fissures**
  - Any pain when opening your bowels?
- **Faecal impaction**
  - Have you experienced excessive diarrhoea after constipation in past?
- **Intestinal obstruction**
  - Do you have abdominal pain?
  - When was the last time you passed bowel?
  - When was the last time you passed gas?
  - Do you feel that your tummy is distended?
- **Diabetic neuropathy**
  - Do you have diabetes?
- **Spinal chord compression**
  - Do you feel any weakness or sensory loss in the lower limbs?
  - Do you have control of your bladder and bowels?
  - Do you have any back pain?

Red Flags

- Systemic symptoms (e.g. unexplained and progressive weight loss, fatigue, sweats, fever, malaise)
- New onset of constipation in older people
- Tenesmus
- Rectal bleeding
- Anaemia

Tenesmus Rectal Bleeding Anaemia.

Stools : How many times you pass stool everyday?
When was the last time you passed stool.
Is it hard or soft stool?
Does it hurt when you pass stool.
Any blood?
Do you still feel like you need to open your bowels.

Scenario 53

You are FY 2 in orthopaedics and trauma department. A 70 years old female has been admitted to the hospital. Patient had hemiarthroplasty 4 days ago because of fracture of the neck of femur. She hasn't passed any stools since she was admitted. Patient is taking co-codamol for pain. Her pain is controlled now and she is stable. Please talk to the patient, take history, assess the patient's condition, perform any relevant examinations and discuss management plan with the patient.

Patient Information:

You had a fall 1 week ago when you slipped on the toilet and broke your femur. You were admitted to the hospital for hip surgery and had an operation 4 days ago. Your operation went well and your pain is controlled well. You had no constipation before the admission and now have not been able to open your bowels for 7 days. Before the fracture you used to open your bowels daily. You were fully mobile before the fall. You are taking co-co-damol for pain but are not on any other medication. You are able to pass wind. You have no abdominal pain. You eat a lot of fibre in your diet and drink plenty of fluid. No past medical history or allergy.

Questions:

Q. What are you going to do for me?

Q. If you stop this medication, will I not be in pain again? (ask this question only if the doctor suggests to stop the medication)

Q. What are laxatives?

Q. "I am amazed how you guys are addressing. I was in so much pain and now I am completely fine."

Q.What are you going to do for me?

Q.When will I go home?

Examiner's prompts: If the candidate mentions he wants to perform abdominal examination give findings verbally.

Abdominal Examination: There is a mass in the left iliac fossa.

Per Rectal Examination: Loaded with faecal impaction.

Observation charts should have the following vitals and should be given to candidates who **mention observations:** T 37ºC BP 120/80 HR 80

Approach to scenario 53

- Initial Approach or GRIPS
- ODPARA DDs
- Red Flag (absolute constipation, vomiting abdominal pain)
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise
- Examination:
    - Observations
    - Abdominal examination
    - PR examination
- Diagnosis: Explain it is constipation due to the medication co-codamol. This medicine has paracetamol and codeine. The other reason for constipation is decreased mobility.
- Explanation of diagnosis
- Diagnostic Investigation
- Management
    - FBC, U&E, Abdominal x-ray
    - Paracetamol only and if required ibuprofen
    - Increase mobility and occupational therapy
    - Continue follow-up with physiotherapy
    - High fibre diet
    - Take plenty of fluids
    - Phosphate enema (Strong laxatives passed through your rectum to clear your bowels)

Practical scenarios

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7. SHORTNESS OF BREATH

FODPARA of shortness of breath

O – Onset: How did it start? Suddenly or gradually?

D – Duration: When did it start? Or How long have you had these symptoms for?

P – Progression: Is it becoming worse, improving or is it the same?

A – Aggravating factors: Anything which makes it worse or anything which brings it on (if intermittent symptoms)?

R – Relieving factors: Anything which makes it better?

A – Associated symptoms: Differential diagnoses

Differential Diagnoses:

- **COPD** (history of smoking, chronic shortness of breath and cough)
- **Asthma** (wheeze, dry cough, shortness of breath, history of atopy, or allergies, family history of asthma)
- **Pulmonary embolism** (common in young females, risk factors e.g. history of long flight, haemoptysis, recent operation, taking OCP, chest pain, SOB)
- **Pneumonia** (fever, cough, shortness of breath, sputum, chest pain)
- **Pulmonary oedema** (shortness of breath, history of IHD, shortness of breath on lying down)
- **Pleural effusion** (SOB, presence of a disease causing heart failure, malignancy, renal failure)
- **Sepsis** (fever, systemically unwell patient)
- **Anaemia** (light-headedness, weakness, tiredness, history of using NSAIDs or aspirin, menorrhagia)
- **Myocardial infarction** (chest pain radiating to the left arm, nausea, sweating in palms, risk factors e.g. hypertension, diabetes, family history)
- **Pneumothorax** (common in young tall men with sudden onset of SOB and chest pain)
- **Anxiety/panic attack** (young female, SOB, hyperventilation, feeling of impending doom, generalised chest pains, patient has a feeling that he is having a heart attack).

Questions for differential diagnosis

- **COPD**
    - Have you been diagnosed with any lung conditions like asthma/COPD?
    - Do you smoke? If yes, what do you smoke?
    - How long have you been smoking? How many cigarettes per day?
- **Asthma**
    - Do you have asthma?
    - Anyone in the family with asthma?
- **Pulmonary Embolism**
    - Any pain in the legs, especially in the calf?
    - Have you travelled by plane recently?
    - Have you ever been diagnosed with clots in the legs or lungs?
- **Pulmonary Edema**
    - Do you have a history of heart disease?
    - Does shortness of breath get worse on lying down?
- **Sepsis**
    - Are you running a temperature?
    - Any cough?
    - Are you bringing up any phlegm?
- **Anaemia**
    - Have you ever been told you have anaemia?
    - Do you suffer from light-headedness, weakness or tiredness?
- **MI**
    - Any chest pain?
    - Do you have heart problems?
    - Have you had a heart attack in the past?
- **Pneumothorax**
    - Did the shortness of breath start suddenly?
    - Any recent trauma?
    - History of lung collapse in past?
- **Anxiety/Panic attack**
    - When you are short of breath, do you experience palpitations as well?
    - Do you experience any tingling around your lips?
    - Do you get the feeling that you are going to die?

Red Flags

- Tachypnea
- Tachycardia
- Tracheal deviation
- Stridor
- Cyanosis
- Hypoxia
- Hypotension
- Confusion
- Use of an accessory muscle
- Effortful breathing without effective air movement (‘silent chest’)

Scenario 179

You are an FY2 in A&E. A 70 years old male has presented with shortness of breath. Assess the patient and discuss initial management with the patient.

You have had shortness of breath for the last 2-3 days, no fever. You live in a nursing home because you have got some memory problems. But you are generally okay. As you sit on the couch you are short of breath. Students should offer you oxygen, otherwise you continue being short of breath. You are fit and well and not on any medications and have no allergies.

You are lying on the couch and you are very short of breath. You are speaking with difficulty. There is an observation chart available with oxygen saturation of 92% on air but the rest of the observations are normal.

CXR should be available-given to those who mention it

Urea	38mmol/L	(2.5 to 7.1 mmol/L)
Creatinine	300 umol/l	(60–110 μmol/L)
K+	4.5	(3.6 to 5.2 mmol/L)
Na	137	(135-145 mmol/L)

Chest Examination-If mentioned is normal

Approach to scenario 179

- Initial Approach or GRIPS
- ABCDE assessment
- Differential Diagnosis
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise
- **Examination**
    a. Observations
    b. CVS-listen to heart
    c. RES examination
- Explain the findings
- **Diagnosis**

It is likely to be chest infection as you are short of breath. We need to confirm it by doing some investigations.

- Management
    a. Admit
    b. Routine blood tests including CRP/inflammatory markers
    c. CXR
    d. Antibiotic co-amoxiclav (pneumonia from nursing home: + clarithromycin)

Curb-65 score
C = confusion
U = urea > 7mmol/l
R = respiratory rate > 30
B = BP; systolic < 90, diastolic < 60
65 = age more than 65 years
Score
0 = low
1 – 2 = is intermediate (less than 1% mortality risk)
3 – 4 = high risk (1-10% mortality risk)

Scenario 263

You are an FY2 in A&E. A 50 years old male has presented with shortness of breath. Assess the patient and discuss initial management with the patient.

You are a 50 year old male who has presented to A&E with shortness of breath. You have been experiencing shortness of breath for the last 2 days which was sudden in onset. You also have dry cough and chest pain on the left side. The pain does not radiate and is not aggravated by anything. The pain does not get better by leaning forward. You had flu like symptoms 2 weeks ago. You do not drink significant amount of alcohol and you do not smoke. You are not on any medication and there is no past medical history. You are taking Methadone. You have been injecting yourself with heroin. You have taken the last dose of heroin recently.

Q. What do I need to be admitted?

Q. Will I be able to continue injecting myself in the hospital?

You want to get your medicine and go home. You are not willing to stay in the hospital because of your addiction. But if you find the doctor convincing enough, then you are willing to be admitted.

Blood pressure: 126/75

Temperature: 38.5ºC

O2 Saturation: 94%

Heart rate: 95 bpm

Respiratory rate: 20 breaths per minute

On Chest examination: Decreased breath sounds on left side. Pleural friction rub on left side. No added sounds

Approach to scenario 263

- Initial Approach or GRIPS
- ODPARA
- Differential Diagnosis
- Systemic review
- Red Flags
- MAFTOSA
- ICE

- Effects of Symptoms
- Summarise
- **Examination**
    a. Observations
    b. Chest examination
    c. Lymph node examination
- Explain the findings
- **Diagnosis**

Most likely you have some chest infections called Pneumocystic Carinii. But we need to perform investigations to know the cause of the chest infection.

- **Management**
    a. Routine blood tests including inflammatory markers
    b. ABGs
    c. Chest X-ray
    d. Blood culture
    e. Sputum culture
    f. We might need to a test called Broncho-alveolar lavage (BAL). This is when we take secretions from your lungs and send it to the lab in order to know what bug caused the infection.
    g. Admit
    h. Give high flow 15L oxygen
    i. IV fluids: normal saline 0.9%
    j. Take second opinion from seniors
    k. Antibiotics

Will speak to the microbiologist who is the infection specialist before starting you on any antibiotics, because the infection we are suspecting is one of the rare bugs that usually cause chest infection in people who are immunocompromised.

After speaking to the specialist we may start you on IV antibiotics called Co-Trimoxazole (Trimethoprim-Sulfamethoxazole).

NOTE: If the patient is short of breath from the start you need to review observations earlier using the ABCDE approach.

Practical scenarios

168, 212, 238

10. HEADACHE

SOCRATES for Headache

S – Site: Where is the pain? Can you show me with one finger?

O – Onset: How did it start? Suddenly or gradually?

C – Character: What type of pain is it? Dull ache/compressing/sharp?

R – Radiation: Does the pain move/go anywhere?

A – Associated: Differential diagnoses

T – Timing: Is there any specific time you experience the pain or when it becomes worse? Is it always there or does it come and go?

E – Exacerbating and relieving factors: Is there anything that makes the pain worse? Is there anything that makes the pain better?

S – Severity/Score: On a scale of 0 – 10, 0 being no pain and 10 being the worst, what would be the score of your pain?

Differential Diagnosis:

- **Subarachnoid haemorrhage** (photophobia, sudden onset of headache, very severe, worst headache of his / her life)
- **Giant cell arteritis** (elderly patient, unilateral temporal headache worse with combing and chewing, weight loss, weakness)
- **Cluster headache** (common in middle-aged men, unilateral headache, red eye on the same side as headache, headaches occurs in clusters)
- **Acute closed-angle glaucoma** (sudden onset of eye pain, causing same-sided headache, red eye, visual impairment, plus or minus a history of similar episodes in the past)
- **Migraine** (young female patient, unilateral headaches, preceded by short-lived visual fortification, nausea and vomiting, previous episodes)
- **Brain tumours or space occupying lesions** (middle-aged or elderly patient, progressive headaches, weight loss, vomiting, focal neurological signs)
- **Meningitis** (headache, fever, neck stiffness, rash, photophobia)
- **Carbon monoxide poisoning** (problems with cookers or leaking gas in the house)

- **Sinusitis** (frontal headaches or between the eyes which is worse when leaning forward, recent history or presence of coryza symptoms)
- **Trauma** (history of head injury)
- **Tension headache** (band-like headache, usually precipitated by stress)
- **Weak eyesight** (history of prolonged use of bright screens like computer or TV monitors)

Questions for differential diagnosis

- **Subarachnoid haemorrhage**
    - Did the headache start suddenly?
    - Would you call it worse headache of your life?
    - Do you feel uncomfortable in light?
- **Giant Cell arteritis**
    - Is headache one sided?
    - Is it worse on chewing or combing hair?
    - Have you recently lost weight? If so, quantify.
    - Is there any weakness of any part of body?
- **Cluster headache**
    - Is it one sided headache?
    - Do you feel your eye has become red?
    - Is it the first time or have you had it before?
- **Acute closed-angle glaucoma**
    - Is there any eye pain? If so, did it start suddenly?
    - Is there any new problem with vision?
    - Have you have similar episodes before?
- **Migraine**
    - Is the headache one sided?
    - Any visual symptoms just before or during headache?
    - Any nausea or vomiting?
    - Have you had similar headache before?
- **Brain tumours**
    - Is the headache becoming worse with time?
    - Any weight loss? If yes, quantify.

    - Any vomiting?
    - Any focal neurological signs / any change in sensations or new weakness in any part of body?
- **Meningitis**
    - Do you have a fever with the headache?
    - Any neck stiffness?
    - Did you notice any rash on body?
    - Do you feel uncomfortable in light?
- **Carbon monoxide poising**
    - Any problems with cookers or leaking gas in the house?
    - Any paint jobs recently in the house?
- **Sinusitis**
    - Where exactly is the headache? (Frontal or between eyes?)
    - Is there any change in intensity on leaning forward?
    - Any recent cough, runny nose or sneezing?

- **Trauma**
    - Any history of head injury?
- **Tension Headaches**
    - Where exactly does it hurt? (Band like pain around head)
    - Any increased stress in work or personal life?
- **Weak eyesight**
    - What work do you do? (Office workers using computer)
    - Are you using a screen like computers or TV monitors for long time?

Red Flags

- Severe persistent headache of acute onset
- Sudden change in previously stable headache
- Early morning headache
- Thunderclap headache
- Presence of fever and non-blanching rash
- Recent head trauma

- Retro bulbar pain
- Jaw claudication
- Neurological signs, such as hemiparesis, cranial nerve abnormalities or hemianesthesia, drowsiness
- Cough headache or headache when bending over, laughing or straining

Scenarios 72

You are FY 2 in A&E. A 66 years old female has come to the hospital with a headache. Please take a history, perform relevant examinations and discuss management with the examiner.

Patient Information:

You are sitting on the chair/lying on the bed holding the back of your head and facing down with your eyes closed. The severity of pain is 9/10. You are not comfortable until the doctor gives you analgesia. You would like to take painkillers. You have had migraine whole your life but you have never had a headache as bad as this. Light is bothering your eyes. You take Sumatriptan for your migraine. If the doctor asks you if this is the worse headache of your life you reply as "I am not sure/yes it is the worse headache of my life" You also have neck pain but you do not have a rash.

Questions:

Q. What is wrong with me?

Q. What are you going to do for me?

Set up: Low GCS, holding the back of your neck.

Examiner's prompt:

Candidates who want to perform exam, tell them it is normal.

In the last 2 minutes, asks the candidate: "How would you manage the patient?"

If candidate wants to give painkillers to the patient ask "which painkillers?"

Approach to scenario 72

- Initial Approach or GRIPS
- ODPARA
- Differential Diagnosis
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise
- **Examination**

a. Observations
b. Fundoscopy
c. Neurological examination of arms, legs and nerves of face

- Explain the findings
- **Diagnosis**

Unfortunately from what you have told me so far, most likely you could have suffered a bleed in the brain which is called SAH

- **Management**

Overall initial management

- Keep monitoring
- Analgesia
- If CT confirms SAH then refer to neurosurgeons.
- Inform seniors

Specific Management (examiner)

- ABC
- I will keep the patient on the monitors.
- CT head
- Analgesia (Paracetamol, Ibuprofen)
- If there is any bleeding, refer to the neurosurgeons
- If the CT scan come back normal, I will arrange a lumbar puncture
- What are you looking for on a LP?
- Ans: Xanthochromia
- When are you going to do a LP?
- Ans: At least 12 hours from the onset of the headache.
- Admit the patient under the medical team
- Take a second opinion from my seniors.

Scenario 132

You are FY 2 in Rheumatology department. A 60 years old female has been referred to the hospital by the GP with a headache. Take a focused history, perform relevant examination and discuss management with the patient.

Patient Information:

You have presented with 3 weeks history of one sided headache (on left side without any radiation, you feel it mostly as scalp tenderness). You have been taking paracetamol but with no relief. You are also unable to see properly with your right eye for 1 week/your vision is normal. You also have pain in the jaw every time you ear or when you open your mouth and combing hair. You have no weight loss, do nausea, no weakness in your legs. You have muscle pains on your shoulders and thighs. If the doctor asks: "is this the worst headache of your life", say yes.

Questions:

Q. What are you going to do for me?

Q. How are you going to treat me?

Q. If the doctor mentions biopsy ask: "What is a biopsy and how is it done?"

Q. How long will I take steroids? What are the side effects?

Q. When the doctor says they will admit you say: "Oh! I did not expect that"

Q. Why won't you just give me medication and then I can go home?

Q. If the candidate says they will perform blood tests ask: "Which blood tests?"

Approach to scenario 132

- Initial Approach or GRIPS
- SOCRATES
- Differential Diagnosis
- Cancer symptoms
- Red Flags (loss of vision, worse headache)
- MAFTOSA

- ICE
- Effects of Symptoms
- Summarise
- **Examination**
    a. Observations
    b. Scalp tenderness
    c. Lift your arms above your head
    d. Stand up from chair without using support from arms
    e. Open your mouth - Does it hurt?
    f. Palpation of shoulder, hips and thigh - for tenderness
    g. Eye assessment: examiner would say they are normal
        i. Visual acuity
        ii. Light reflex
        iii. Red reflex
        iv. Fundoscopy
        v. Eye movements in a form of H
- Explain the findings
- **Diagnosis**

GCA –This is an inflammation of the arteries. Temporal arteritis is when the arteries, particularly those at the side of the head (the temples), become inflamed. It's a serious condition, if not treated promptly it leads to loss of vision.

- **Management**
    a. Blood test (inflammatory markers ESR, Kidney Function test).
    b. USS
    c. Confirmation by biopsy: explain biopsy to the patient
    d. Admit the patient
    e. Offer analgesia (paracetamol or codeine)
    f. Treatment - steroid 40-60 mg and PPI cover
    g. Leaflets

Note:

Side effects of steroid with solution

- Hypertension - monitoring (blood pressure)
- Diabetes Mellitus - high blood sugar but we will monitor and if you develop diabetes we will treat you with insulin
- Osteoporosis - Bisphosphonate to prevent osteoporosis
- Damage to lining of the stomach - we will give some medication to prevent that from happening

Practical scenarios

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11. WEIGHT GAIN

Nature of weight gain

- How much weight have you put on?
- Over what period of time have you put on this weight?
- Where have you put on the weight? Abdomen, trunk, hip, legs, face or ankles?
- Is the weight gain evenly distributed?

Differential Diagnosis:

- **Hypothyroidism** (weight gain, constipation, menorrhagia, cold intolerance)
- **Obesity** (familial)
- **Cushing's syndrome** (weight gain, central obesity, bruises)
- **Polycystic ovarian syndrome** (weight gain, acne, hirsutism, infertility)
- **Acromegaly** (increased shoe and ring size, spaced teeth)
- **Depression** (low mood, loss of interest in daily activity, poor sleep, low energy levels, loss of appetite)
- **Medication** (side effects of any medications like steroids, contraceptive pills)
- **Pregnancy** (history of amenorrhoea, take sexual history)

Questions for differential diagnosis

- **Hypothyroidism**
    - Do you feel cold when others are comfortable?
    - Do you suffer from constipation?
- **Obesity**
    - Have you changed your diet recently?
    - What type of food do you normally eat?
    - Anyone in the family who has increased weight on the higher side?
- **Cushing's syndrome**
    - Is the weight gain more at any part of body? (Central)
    - Have you noticed bluish marks on your tummy?
- **Polycystic ovarian syndrome**
    - Have you noticed excess hair growth on your face?

    - Have you tried to have children? If yes, have you had any problems with that?
    - Noticed any recent development of acne?
- **Acromegaly**
    - Have you noticed a change in size of your shoes or ring size?
- **Depression**
    - How is your mood normally?
    - Are you on any medication like steroids?
    - How has your energy level been recently?
- **Medication**
    - Are you taking any medications?
    - Do you use oral contraceptive pills or steroids?
- **Pregnancy**
    - When was your last menstrual period?
    - Are your periods usually regular?
    - Is there a chance you could be pregnant?

Red Flags

- Morbid obesity
- Severely reduced mobility
- Suicidal ideation
- Poor self-image
- Diabetes
- Cardiovascular complications

Scenarios 147

You are FY 2 in GP surgery. A 46 years old female presented with come concerns. Take a focused history and discuss initial management plan with the patient.

You came to practice as a follow up. You had come to practice last week and the doctor did some investigations. You have been experiencing weight gain for the last 1-year and now are feeling tired most of the time. Sometimes you feel cold when others are comfortable.

Q. What is wrong with me?

Q. What are you going to do for me?

Q. What medications will you give me?

You are calm; just want to know why you have been experiencing your symptoms.

All examinations are normal

If the candidate mentions that he need to perform thyroid function tests, please give them TFT results

Thyroid	**Function**	**Tests**
	TEST	NORMAL RANGE
TSH	10	0.5-4.5 ug/dl
T4	2ug/dl	4.6-12 ug/dl
T3	40	80-180 ng/dl

Approach for scenario 147

- Initial Approach or GRIPS
- ODPARA
- Differential Diagnosis
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms

- Summarise
- **Examination**
    a. Observations
    b. Thyroid examination
- **Explain the findings**
- **Diagnosis**

Hypothyroidism: Thyroid is a gland in body that takes care of metabolism by producing a hormone called thyroxine. Your body is not currently producing enough thyroxine leading to your weight gain.

- **Management**
    a. Bloods
    b. Levothyroxine
    c. Refer to endocrinologist
    d. Leaflets

Scenario 128

You are an FY2 in GP surgery. A 45 years old female has presented with tiredness. Take a focused history and discuss management with the patient.

You have had tiredness for the last 2/6 months. You feel cold most of the times when others are comfortable. You have gained 5kg weight, your appetite is poor, have constipation and your sleep is poor. Your mood is 3/6 out of 10. Otherwise you are fit and well. No past medical history and you are not on any regular medication. You live alone and your husband passed away 18 months ago.

Q. What is wrong with me?

Q. What are you going to do?

Approach to scenario 128

- Initial Approach or GRIPS
- ODPARA
- Differential Diagnosis
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise
- **Examination**
    a. Observations
    b. Thyroid examination
    c. CVS - listen to heart
- Explain the findings
- **Diagnosis**

Use the summarisation technique

You have told me that you have been feeling tired for the past 6 months, you have become constipated in the last 2 months or so, you have gained 5kg in weight and you feel cold most of the time. Is there anything else that I have missed?

From what you have told me you most likely you have a condition called hypothyroidism. Which is also called under-active thyroid.

A thyroid gland usually produces a hormone called thyroxine. If it does not work properly, it causes a deficiency of this hormone in your body.

- **Management**
    a. Routine bloods
    b. Thyroid function test
    c. Refer to endocrinologist: Once confirmed I will refer you to the specialist, the endocrinologist, and they will give you medication called thyroxine.
    d. Leaflets
    e. Follow up in 1 week time

NOTE: Do not make a routine referral to the patient if experiencing:

Side effects of thyroxine

Abnormal structure of the thyroid gland

Persistent symptoms despite treatment

12. WHEEZE

FODPARA of wheeze

O – Onset: How did it start? Suddenly or gradually?

D – Duration: When did it start? Or How long have you had these symptoms for?

P – Progression: Is it becoming worse, improving or is it the same?

A – Aggravating factors: Anything which makes it worse or anything which brings it on (if intermittent symptoms)?

R – Relieving factors: Anything which makes it better?

A – Associated symptoms: Differential diagnoses

Precipitating factors:

- **Viral illness** – Did you have any fever, cough, runny nose or sore throat recently?
- **Cigarette smoke** – Do you smoke? Is there anyone in your family who smokes?
- **Pollen** – Are you handling flowers or plants?
- **House dust mite** – Is there any dust in the house?
- **Animal dander** – Do you have any pets at home?
- **Cold air and pollutants** – Do cold air make your symptoms worse?
- **Exercise** – Are your symptoms worse when you exercise?
- **Emotional stress** – Does stress make your symptoms worse?

Control of Symptoms:

Have you had difficulty sleeping because of your asthma symptoms (including cough)?

Have you had your usual asthma symptoms during the day (cough, wheeze, chest tightness, or breathlessness)?

Assessing severity:

- Do you get symptoms on exercise?
- What is your best peak expiratory flow rate reading? Has this changed recently?
- What treatment are you on? Inhalers? Oral treatment? Home nebulisers? Have you needed the salbutamol inhaler more than usual?

- How many times in the last year have you had an asthma attack? Have you previously been admitted to ITU because of asthma?

Ask about drugs that induce bronchoconstriction:

Aspirin

NSAIDS

Beta Blockers

Effects of symptoms on patient:

Does it affect your day to day activities?

Do you wake up in the middle of the night due to wheezes or shortness of breath?

Have you had to take time off from work because of your symptoms?

Differential Diagnosis:

- **Asthma** (young patient, history of allergies, family history of asthma, intermittent symptoms of shortness of breath, wheeze and dry cough)
- **COPD** (middle-aged man, long-standing history of smoking, chronic shortness of breath)
- **Foreign body** (this is usually in children, acute onset, while a child was playing with toys, or if it is in an adult, while eating)
- **Anaphylaxis** (rash, history of allergy or previous episodes, similar complaints, swelling of face and neck)
- **Allergy** (rash)
- **Cardiac asthma** (elderly patient, chronic shortness of breath, symptoms worse when patient lies flat)

Questions for differential diagnosis

- **Asthma**
    - Is there anyone in the family with asthma or eczema?
    - Any particular time when your wheeze is worse?
    - Do you experience wheeze while doing exercise?

- **COPD**
    - Do you smoke?
    - Do you usually feel short of breath?
    - Do you have a cough? If yes, for how long have you had this cough?
- **Foreign Body**
    - Was the child playing with toys right before it started?
    - Did it start right after eating?
- **Anaphylaxis**
    - Have you noticed any rash?
    - Has this happened before in a similar situation?
    - Noticed any swelling of the neck and face?
- **Allergy**
    - Are you allergic to anything?
    - Anyone on the family with allergies?
- **Cardiac Asthma**
    - Is there any shortness of breath?
    - Is it something new or is it long standing?
    - Does it change when lying flat on your back?
- **Chest Infection**
    - Do you have a cough?
    - Do you bring up phlegm? If yes, what colour?
    - Are you running a temperature?

Red Flags

- Unable to talk in full sentences
- Tachycardia
- Tachypnea
- <50% peak flow
- Cyanosis
- Silent chest
- Hypotension
- Bradycardia
- Confusion

Scenario 74

You are FY 2 in A&E. A 33 years old make presented with chest tightness. The nurse has examined him and there is a wheeze on auscultation of the chest. Take a focused history, perform relevant examination and discuss initial management with the patient.

Scenario A

You were playing football when you got an attack of chest tightness and wheeze. You say: "I heard myself whistling". You have had asthma since childhood but for 15 years you have not had any symptoms. You used inhalers in the past. Both of your parents have asthma. You have been seen by someone who said you could have asthma. You have had shortness of breath, wheeze and chest tightness when playing football and exercise for the past 2-3 months. You do not smoke or drink. You have not had a fever. You are currently using NSAID for pain relief. You feel cold weather makes it worse. There is a carpet in your house. The nurse gave you inhalers. You feel better now. You blow 650L/min on PEFR.

Scenario B

You have never used inhalers before. You have not been diagnosed with asthma but you do have eczema. You are taking Ibuprofen for pain relief. One of the nurses mentioned to you that you could have asthma.

Q. What is wrong with me doctor?

Q. What are you going to do for me?

Q. Are you going to admit me?

Q Will I still be able to play football?

Q. Is it asthma again?

Set up:

PEFR

Approach to scenario 74

- Initial Approach or GRIPS
- FODPARA
- Differential Diagnosis
- Precipitating factors of asthma

    a. Cold weather
    b. NSAID
    c. Pets
    d. Dust
    e. Smoking
    f. Carpet
    g. Occupation
    h. Family history of asthma
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise
- **Examination**
    a. Observations
    b. Respiratory examination
    c. PEFR
- Explain the findings
- **Diagnosis**

Asthma

- **Management**

Depends on PEFR value.

PERF normal:

    a. Follow up in 2 days to GP
    b. Send summary to GP
    c. Blue inhaler
    d. Explain how to use it-before any activity
    e. Oral Prednisolone 30mg once daily for 3 days
    f. PPI cover
    g. Avoid NSAID and take paracetamol instead
    h. Asthma diary
    i. Leaflets

j. **Safety netting**: come to hospital if not better with inhaler, shortness of breath, chest tightness or generally unwell

If PERF low:

a. Admit
b. Oxygen
c. Nebulisation with salbutamol
d. IV steroids or oral prednisolone
e. Chest X-ray
f. Bloods
g. ECG
h. Discuss with seniors

13. COUGH

Characteristics of Cough

FODPARA of cough

F – Frequency: How often do you cough?

O – Onset: How did it start? Suddenly or gradually?

D – Duration:

When did your cough start?

Or how long have you had a cough for?

Is there any particular time in the day when the cough is worse?

Is your cough worse in the morning?

Do you experience any cough at night?

P – Progression: Is it becoming worse, improving or is it the same?

A – Aggravating factors: Anything which makes it worse or anything which brings it on (if intermittent symptoms)? Does food or drink make it worse?

R – Relieving factors: Anything that makes it better?

A – Associated symptoms: Differential diagnoses

Sputum

Do you bring up any phlegm with your cough?

Is there any blood with it?

Can you estimate the amount of phlegm? A teaspoon, a tablespoon or a cupful?

What is the colour of the sputum? (Clear of grey sputum suggests Chronic Bronchitis) (Pinky frothy sputum suggests Left Ventricular failure)

Differential Diagnosis:

- **Pneumocystis jirovecii pneumonia** (Usually in an HIV patient with a dry cough, shortness of breath, weight loss, positive history of unprotected sexual intercourse or history of visiting endemic areas like Africa)
- **Asthma** (acute dry cough, history of atopy, presence of other allergies, family history of allergy or atopy)
- **Tuberculosis** (usually patient from Africa or Asia or homeless, alcoholic, presenting with weight loss, night sweats, haemoptysis)
- **COPD** (middle-aged man with chronic history of smoking, chronic cough)
- **Post-nasal drip** (presence of coryza symptoms-running nose, sneezing cough and sore throat. Usually it is due to dribbling of secretions at the back of the throat which triggers a cough)
- **Cardiac asthma** (history of heart failure or ischaemic heart disease)
- **Drugs** (ACEI causes a dry cough)
- **Laryngeal carcinoma** (weight loss, haemoptysis, smoking history, middle aged or elderly patient, weakness, tiredness, fatigue)
- **Smoker's cough** (active heavy smoker)
- **Pneumonia** (fever, cough, shortness of breath, chest pain, sputum)
- **Atypical pneumonias** will cause a dry cough. A dry cough with recent history of being on holiday or staying in a hotel will suggest Legionella. A dry cough with a history of contact with pets is likely to be Chlamydia psittaci)
- **Allergy** (sudden onset of symptoms, rash, itching)
- **Interstitial lung disease** (occupational history is important e.g. exposure to asbestos, coal mining)
- **Bronchiectasis** (chronic cough with sputum)
- **Bronchogenic carcinoma** (middle-aged or elderly patient, weight loss, weakness, tiredness, smoking history)
- **Chronic bronchitis**

Questions for differential diagnosis

- **Pneumocystis jirovecii pneumonia**
    - What kind of cough is it? Is it dry?

    - Sexual history?
    - Do you use recreational drugs?
- **Asthma**
    - Do you have a medical condition called asthma?
- **Tuberculosis**
    - Have you travelled abroad recently?
    - Any night sweats?
- **COPD**
    - Do you smoke? If yes, how many per day and for how long?
    - Any shortness of breath or cough?
- **Post-nasal drip**
    - Any runny nose or sneezing?
- **Cardiac asthma**
    - Do you have any heart problems?
- **Drugs**
    - Are you taking any regular medication?
- **Laryngeal carcinoma**
    - Have you lost weight recently? If yes, quantify.
    - Any changes in your voice?
    - Do you feel tired all the time?
- **Smoker's cough**
    - Long history of smoking?
- **Pneumonia**
    - Are you running a temperature?
    - Are you bringing up any phlegm?
- **Atypical pneumonias**
    - Are you running a temperature?
- **Allergy**
    - Any runny nose or sneezing?
    - Do you have any allergies?
- **Interstitial lung disease**
    - Do you feel short of breath, especially after exercise?

    - Do you feel tired all the time?
    - Any weight loss? If yes, quantify.
    - Clubbing
- **Bronchiectasis**
    - Any discharge in sputum? Is it purulent?
- **Bronchogenic carcinoma**
    - Any weight loss? If yes, quantify.
    - Any tiredness or fatigue?
    - Any cough or shortness of breath?
    - History of smoking?
    - Have you noticed any lumps and bumps on your body?

Red Flags

- Shortness of breath at rest or with minimal exertion
- Haemoptysis
- Weight loss
- Raised JVO
- Hypoxia
- Confusion
- Hypotension

Scenario 66

You are FY 2 in Medicine department. A 30 years old man has come to the hospital with shortness of breath. Take a focused history, perform relevant examination and discuss management with the patient.

Patient Information:

You have had shortness of breath and cough with white sputum for the last 3 weeks. You have had weight loss, have been feeling feverish but you did not check the temperature. There is no blood in the sputum. You came GP once a week where you were given amoxicillin for 1 week but the cough has not resolved. You smoke 40 cigarettes a day since your school days. You are homeless, have multiple male partners. You also use recreational drugs - you do not know about the needle exchange program as a result you share needles. You are short of breath at rest. One of your sexual male partner has got HIV infection.

Questions:

Q. What do you think is wrong with me?

Q. What are you going to do for me?

Examiner's prompts:

Observations: Temp 38ºC, RR 34, O2 sats 91%, BP 110/70 and HR 102

Chest examination: Bilateral crackles

X-ray: An X-ray showing bilateral hilar infiltration

Approach to scenario 66

- Initial Approach or GRIPS
- ODPARA
- Differential Diagnosis
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Sign posting
- Summarise
- **Examination**

a. Observation
b. Chest examination
c. Lymph node examination

- Explain the findings
- **Diagnosis**

Explain the diagnosis: Most likely you have some chest infections.

But we need to perform investigations to know the cause of the chest infection.

- **Management**

The investigations we need to perform are:

1. Blood tests: FBC, U&E, LFT, Glucose, inflammatory markers, ABGs, a blood test to check for oxygen levels in blood
2. CXR
3. Blood culture
4. Paracetamol to reduce the temperature
5. Urine test
6. Inflammatory markers (CRP, ESR)
7. Sputum culture
8. Advice the patient to undergo HIV and Hepatitis tests (blood borne infections)
9. We might need to do a test called Broncho-alveolar lavage (BAL)
10. This is when we take secretions from your lungs to send it to the lab in order to know what bug has caused the infection.

Treatment

1. Admit
2. Give oxygen high flow
3. IV Fluids
4, IV antibiotics
5. Take a second opinion from the senior.

NOTE: If the patient is short of breath from the start you need to review observations earlier (i.e. If patient is Short of breath)

Scenario 276

You are FY 2 in A&E. A 72 years old man was referred by his GP with cough. He has had a cough for about a week for which his GP sent him for a chest X-ray. He was then referred to A&E. You will find the X-ray film and MEWS chart in the cubicle. Assess the patient and discuss the management with the patient.

Patient Information:

You have had cough for the past 1 week and have productive cough with greenish sputum. You are a known hypertensive and diabetic for 6 years for which you take amlodipine and metformin. Both are well controlled. You smoke 20 cigarettes/day for past 18 years. You do not drink alcohol. Your GP told you that you are allergic to metronidazole. You are otherwise fit and well.

Questions:

Q. Can I go home?

Examiner's prompts:

Observations: RR 26, BP 110/70, HR 92, T 39 and O2 sats 91%

Approach to scenario 276

- Initial Approach or GRIPS
- ODPARA
- Differential Diagnosis
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise
- **Examination**
    a. Observations
    b. Chest exam
    c. Lymph nodes
- Explain the findings
- **Diagnosis**

Explain oxygen levels are low and temperature is high. From what you have told me and from the examination, it looks like you have a chest infection called Pneumonia. I would like to confirm it with investigations.

- **Management**

Investigations:

a. Blood tests including inflammatory markers
b. Blood culture
c. Chest X ray

Treatment:

- Admit
- IV fluids
- Antibiotics (clarithromycin plus co-amoxiclav - do not explain the details of the medication to the patient unless he or she asks "Which antibiotics will you give me?")
- Refer to the medical team.
- Offer leaflets about chest infection

Scenario 107

You are an FY 2 in A&E. A 65 years old male presented with cough. Take a focused history, perform relevant examination and discuss management with patient.

Patient Information :

Scenario A :

You are a 65-year-old man. You had a cough for the past 3 days. You returned from Spain 3 days ago. You have got a cough and shortness of breath. You went to Spain but you were not staying in the hotel. You have got a family in Spain (your cousin) and you stayed at his place. You have got white sputum. You smoke 20 cigs a day for the last 30 years.

Examiner's prompts:

Temp 38ºC, Sats 92%, HR 110, BP 120/80, RR 22

Scenario B:

You have had cough for 3 weeks. GP gave you Amoxicillin antibiotics 2 weeks ago but no relief. You have also got chest pain which is worse with inspiration.

Examiner's prompts:

Observations: Sats: 91%, T: 38.7ºC, BP: 110/70, HR: 108, RR: 20

CXR was provided to those who asked for it.

Approach to scenario 107

- Initial Approach or GRIPS
- ODPARA
- Differential Diagnosis
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise

- **Examination**
    a. Observations
    b. Chest exam
- Explain the findings
- **Diagnosis**

Explain oxygen levels are low and temperature is high. From what you have told me and the examination, it looks like you have chest infection called Pneumonia. I would like to confirm it with investigations.

- **Management**
    a. Routine bloods including inflammatory markers
    b. Chest X ray
    c. Admit
    d. IV fluids
    e. Antibiotics - amoxicillin (if suspected Legionella pneumonia then prescribe erythromycin)
    f. Discuss with seniors
    g. Leaflets

Practical scenarios

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ANAEMIA

ODPARA of tiredness

Differential Diagnosis:

- Anaemia (light-headedness, weakness, fatigue, tiredness, history of use of NSAIDs or aspirin)
- Chronic fatigue syndrome
- Malnutrition
- Malabsorption
- Malignancy
- Rheumatoid arthritis
- Drugs
- Anaemia of chronic disease
- Haemolytic anaemia
- Celiac disease
- Inflammatory bowel disease
- Anaemia:
    - Do you feel weak and tired all the time?
    - Has a doctor ever told you that your blood levels are low?
    - Do you feel tired on mild exertion?
    - Do you feel light headed
- **Chronic fatigue syndrome**
- **Malnutrition**
    - What kind of food do you eat?
    - What is your diet like?
- **Malabsorption**
    - Do you have any diarrhoea?
    - Have you been having any tummy pains?
- **Malignancy**
    - Have you lost any weight recently? If yes, quantify.
    - Have you been feeling lethargic and fatigued?
    - Primary tumour symptoms?

- Any lumps and bumps on your body?

- **Rheumatoid arthritis**
    - Have you had any fevers recently?
    - Do you have pain in your joints?
    - Did you notice any swelling in your joints?
    - Did you notice a rash on your face recently?
- **Drugs**
    - Are you using any pain killers like Asprin and Nsaid?
    - Are you on antidepressant citalopram?
- **Anaemia of chronic disease**
    - Have you been diagnosed with any medical condition?
    - Haemolytic anaemia
    - Have you felt you have become pale?
    - Have you been feeling confused lately?
    - Do you feel fatigued and dizzy?
- **Celiac disease**
    - Any diarrhoea or constipation?
    - Any feeling of bloatedness?
    - Do you have an itchy rash?
    - Have you lost weight? If yes, quantify.
- **Inflammatory bowel disease**
    - Any pain in the tummy?
    - Do you feel tired all the time?
    - Is there any blood in your stools? If yes, what colour?
    - Have you lost any weight recently? If yes, quantify.
    - Do you have these symptoms at night?

Red Flags

Constitutional symptoms such as weight loss, loss of appetite, fevers, night sweats and lymphadenopathy, depression, abnormal physical exam, pain anywhere in the body, disabling tiredness, polyuria and polydipsia.

Scenario B (177)

You are FY 2 in GP surgery. A 30 years old lady has come for review of her blood tests. She had presented with tiredness and she was seen by a local doctor. She had Hb of 10.1g/dL and MCV was 120. The local doctor did the following tests:

Her results		**Normal range**
-Ferritin	30ng/mL	(12 to 150 ng/mL)
-Iron	13g/dL	(12.0 to 15.5 g/dL)
-Folic acid	12 ng/ml	(2-20 ng/mL)
-B12	100 pg/mL	(200- 500 pg/mL)
-Calcium		(2.15-2.55 mmol/L)
-Thyroxin		(8-22 pmol/L)
-TSH		(0.35-5.5mLu/L)

Explain the results, take a focused history and discuss initial management with the patient.

Patient information

You decided to be a vegetarian 2 years ago for religious reasons. You do not eat meat or eggs. Not willing to change your diet due to religious reasons. You feel tired most of the times and it is affecting your daily activities. You have tiredness for the past 4 months. You work as an accountant and it is affecting your work. You have 2 children and you're finding it difficult in coping with them. The other doctor mentioned you are anaemic. You do not like injections so you make faces when the doctor mentions you need injections. Last week you came for follow-up for the blood test results, they told you that you are anaemic and they requested another blood tests.

Q. Will the medication be life long?
Q. Is there anything causing it?
Q. If the doctor mentions injections - ask why not tablets.
Q. If the doctor mentions he/she will refer you to a specialist, ask: "what will the specialist do?"
Q. Is there any other possible causes for this?

Approach to scenario B

- Initial Approach or GRIPS
- ODPARA
- History of B12 deficiency (tiredness, tingling or numbness in legs, gait problems, balance problems, anyone in family with anaemia, thyroid problems)
- Causes of B12 deficiency (diet, what kinds of food do you not eat?)

- Symptoms of Anaemia
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise
- **Examination**
    a. Observations
    b. General physical
- **Explain the findings**
- **Diagnosis and management**

Explain the blood tests are all normal but Vitamin B12 is low.

- B12 is found in meat, eggs and dairy products
- Treatment is local vitamin B12, but will check for intrinsic factor to make sure that vitamin B12 can be absorbed.
- Initially injections twice weekly for 4 weeks as a loading dose
- Then one injection of B12 every 3 months
- You will perform other blood tests to rule out other possible causes.
- Follow up blood tests in 4 weeks time.
- Refer to the haematologist.
- Leaflets

Scenario C (Iron deficiency anaemia in a vegetarian)

Approach to scenario A

- Initial Approach or GRIPS
- ODPARA
- Differential Diagnosis
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise

- **Examination**
- Explain the findings
- **Diagnosis**
- **Management**

DAY 3

History Taking Part 2

1. Falls in elderly:
- Falls in elderly (253)
- Postural hypotension (99)
- Collapse with hip fracture (142)
- Fall on the ward (355)

2. Tiredness:
- Chronic fatigue syndrome (76)

3. GERD (172)

4. Hyperparathyroidism (266)

5. Loss of vision:
- Age related macular degeneration (286)
- Cataract (293)

6. Head injury in adult (5)

7. UTI with confusion (145)

8. Hyponatremia
- Confusion – due to hyponatremia (166)
- Tiredness secondary to Citalopram (194)
- Hyponatremia in COPD (233)

PSYCHIATRY STATIONS

Depression:
First go through approach to "Psychiatric History" then go through "A Depression Talk"
- Depression scenario A (255)
- Depression scenario B (269)
- Low mood in a 37 year old (313)
- Depression follow up (314)
- Depression in a young man (317)

Cognitive Impairement
- Schizophrenia (59)
- MMSE (39)
- Concerns about dementia in a 65 year old (335)

First go through approach to "**Suicide Risk Assessment**"
1. OCP overdose in a young woman (28)
2. Paracetamol overdose in a young man - (126)

3. Drug dependence-heroin (64)
4. Anorexia nervosa
    - Anorexia nervosa scenario A (140)
    - Anorexia nervosa scenario B (292)

INSOMNIA

First go through **Insomnia Talk**

- Insomnia scenario A (12)
- Insomnia scenario B (273)
- Insomnia scenario C (261)

DAY 3

1. COLLAPSE

Nature of collapse (before - during - after)

Can you describe what happened?

Before Collapse:

- How did you feel just before the collapse?
- Did you experience any warning symptoms prior to the collapse?
- Did you experience any nausea or abdominal pain?
- Did you experience any light-headedness?
- Any blurred vision?
- Did you experience any strange sensation just before the collapse?
- Did you experience any headache?
- Any chest pain, any shortness of breath or any palpitations before the episode?

Precipitants:

- What were you doing just before the collapse?
- Is there anything that triggers the episode?
- Did you change your posture from sitting or lying to standing? (Postural hypotension)
- Were you standing for a long period of time? (Vasovagal)
- Was the environment very hot before you collapsed? (Vasovagal)
- Were you coughing or sneezing? (Situational syncope)
- Were you drinking alcohol?

During Collapse:

- Did you lose consciousness?
- Do you remember falling to the floor?
- Do you remember what happened during the collapse?
- How long did you lose consciousness for?

Rule out Epilepsy:

- Did you/he experience any jerking of the limbs?
- Did you/he bite your tongue?
- Did you/he experience frothing of the mouth?
- Did you/he experience rolling of the eyes?
- Was there any stiffness of the body?

After Collapse:

- How long did it take for you to feel you/he were back to normal?
- Was/Were he/you confused after the seizure?
- Any headache after gaining consciousness?
- Any weakness of the limb after gaining consciousness?

Number of previous episodes:

- How many times has this happened before?
- Did you experience the same symptoms every time?
- What were you doing on those occasions?

Differential Diagnosis:

- **Hypoglycaemia** (history of diabetes, missing meals, common in patients who are on insulin)
- **Stroke / TIA** (sudden onset of symptoms, facial or limb weakness, dysphasia, elderly patient)
- **Epilepsy** (seizure, faecal or urinary incontinence, tongue biting)
- **Drug toxicity** (agitation, delusion, usually in young patients)
- **Subarachnoid haemorrhage** (sudden severe headache, photophobia, fever, vomiting)
- **Intracerebral bleed** (history of chronic uncontrolled hypertension, severe headache prior to collapse)
- **Aortic aneurysm** (chest or abdominal pain radiating to the back, signs of generalised hypertension e.g. IHD, intermittent claudication)
- **Pulmonary embolism** (chest pain, haemoptysis, SOB, risk factors e.g. pregnancy, post-operative, long flight, common in young females)

- **Cardiac arrhythmia** (palpitations, history of IHD)
- **Myocardial infarction** (central crushing chest pain radiating to the left arm, nausea, sweating in the palms)
- **Alcohol** (alcohol may cause hypoglycaemia, patient needs to have a history of drinking prior to collapse or you can smell alcohol on his breath)
- **Situational syncope** (collapse while using the toilet, when coughing, or sneezing)
- **Meningitis** (headache, vomiting, rash, fever, photophobia)
- **Sepsis** (fever, non-specifically unwell)
- **Head injury** (patient could have got involved in a brawl, history of a fall)
- **Postural hypotension** (collapse while trying to stand up from a sitting position, usually elderly patient with hypertension and on anti-hypertensive medication)
- **Diabetic ketoacidosis** (polyuria, polydipsia, weight loss, usually in a young patient)
- **Valvular heart disease** (dizziness or collapse on exercise is usually due to aortic stenosis, there could be a history of valvular heart disease)
- **Congenital heart disease** (e.g. Hypertrophic obstructive cardiomyopathy usually there is a family history of sudden death and it is common in young males)
- **Hyperglycaemia hyperosmolar non-ketotic coma**: HONK (usually elderly patient, progressive drowsiness, polyuria, polydipsia, obesity)

Questions for differential diagnosis

- **Hypoglycaemia**
    - Did you feel hungry, sweaty or shaky before fainting?
- **Stroke/TIA**
    - Do you have any weakness in any part of your body?
    - Did you notice any change in your voice?
- **Epilepsy**
    - Did anyone around tell you that you had a fit?
    - Did you loose bowel or bladder control during the episode?
    - Were you very sleepy once you came to your consciousness?
- **Drug toxicity**
    - Are you on any medication?

- **Subarachnoid haemorrhage**
    - Did you experience any headache? Any vomiting? Any neck pain?
- **Intracerebral bleed**
    - Have you been diagnosed with high blood pressure? Is it controlled?
    - Did you have severe headache right before fall?
- **Aortic aneurysm**
    - Did you experience sudden chest or abdominal pain radiating to back before fainting?
    - Have you experienced intermittent pain in legs?
    - Do you have a history of heart problems?
- **Pulmonary embolism**
    - Did you experience chest pain or shortness of breath right before the fall?
    - Did you have any blood in sputum?
    - Is there a chance you could be pregnant or have you had operations recently or taken long flights or been immobile recently?
- **Cardiac arrhythmia**
    - Do you have a history of heart problems?
    - Did you feel racing of the heart beat before fall?
- **Myocardial infarction**
    - Did you experience central crushing chest pain radiating to left side of neck or arm?
    - Did you experience nausea and sweating of your palms right before collapse?
- **Alcohol**
    - Do you drink? How much?
- **Situational syncope**
    - What were you doing at the time of collapse?
    - Were you using toilet or coughing or sneezing?
- **Meningitis**
    - Do you have a headache?
    - Did you notice any rash on your body?
    - Does light make you uncomfortable?
- **Sepsis**

- Do you have any fever?
- Do you feel you are generally unwell?

- **Head injury**
  - Have you sustained a head injury recently?
- **Postural hypotension**
  - Have you been diagnosed with high blood pressure? If yes, do you use medication? If yes, which one?
  - Has your medication been changed recently?
- **Diabetic ketoacidosis**
  - Did you experience polyuria, polydipsia or unintentional weight loss?
  - Any history or family history of diabetes?
- **Valvular heart disease**
  - Were you exercising when you collapsed?
- **Congenital heart disease**
  - Is there family history of sudden deaths?
- **HONK**
  - Have you been diagnosed with high blood sugar?
  - Have you experienced polyuria or polydipsia?
  - Have you been becoming more and more drowsy?

Red Flags

- Severe headache with photophobia and vomiting
- Non blanching rash
- Weakness of any part of the body
- Central chest pain
- Shortness of breath with hypoxia
- Blood in sputum.

Scenario 99

You are FY 2 in Orthopaedic unit. A 72 years old female presented to the hospital 5 day ago with hip fracture and had a hemiarthroplasty. She is fine now. The consultant has asked you to go and find out the cause of falls. Please assess the patient and discuss initial management plan with her.

Patient information

You prefer to be called Jane. You take antihypertensive medication but do not remember the name. There has been a change in your medications or dose. You have had 3 falls in the last 6 months. At this time you were standing in the kitchen making breakfast when you suddenly fell. Your husband was also at home but he was in the sitting room. You lost consciousness for a few minutes. Your husband called an ambulance and you were brought to the hospital 5 days ago. You did not get any feeling that you were going to fall. It just happened suddenly and on this occasion you broke your hip. No hearing problems, ringing in ears or headache. You are hypertensive but otherwise fit and well. You did not shift from sitting to a standing position.

Approach to scenario A

- Initial Approach or GRIPS
- ODPARA
- Differential Diagnosis
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise
- **Examination**
    a. Observations including lying and standing blood pressure
    b. Chest examination
    c. Abdominal examination
    d. Neurological examination
    e. Fundoscopy

- Explain the findings

- **Diagnosis**

The cause is not clear but we need to check that it is not a heart problem. Explain that you will need to run some investigations.

- **Management**
    a. ECG
    b. Routine bloods
    c. Chest X-ray
    d. Urine test
    e. Blood pressure monitoring (including when lying and standing)
    f. Echocardiogram
    g. Admit

Other scenarios

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2.TIREDNESS/FATIGUE in adults

FODPARA of tiredness

F – Frequency: Does your tiredness come and go in waves?

O – Onset: How did it start? Suddenly or gradually?

D – Duration: When did you start experiencing tiredness?

P – Progression: Is it becoming worse, improving or is it the same?

A – Aggravating factors: Anything which makes it worse or anything which brings it on (if intermittent symptoms)?

R – Relieving factors: Anything which makes it better?

A – Associated symptoms: Differential diagnoses

Differential Diagnosis:

- **Chronic fatigue syndrome**
    - Persistent fatigue for 4 months or more
    - New or had a specific onset of symptoms
    - Had resulted in substantial reduction in activity level
    - Patient has post exertional malaise and/or fatigue
    - General malaise or flu like symptoms
    - Sleeping disturbance
    - Chronic pain
    - Cognitive dysfunction such as difficulty to concentrate, impairment of short term memory
    - Worsening of symptoms upon physical exercise
- **Medications** (Antihistamines, sedatives, antidepressants, opioids, antihypertensive medication)
- **Malignancy**
    - Rule out malignancy
- **Anaemia**
- **Chronic renal failure**
- **SLE**
- **RA**

- **Viral illness**
- **Depression**
- **Infections such as HIV, Hepatitis B, Hepatitis C or Tuberculosis**

Other questions to consider:

- Effects of exercise – Does your weakness improve with exercise?
- Effects of rest – Does your tiredness improve with rest?
- Effects on sleep – Does your tiredness improve after sleep?

🚩 Red flags:

- Weight loss
- Lymphadenopathy
- Fever or night sweats

Scenario 76

Where you are: You are FY2 in General Practice

Who the patient is: Ben Lewis 40-year old man has come to your GP practice complaining of tiredness

Other information you have about your patient: The IT system of your GP practice is down at the moment, so you can not get access to records.

What you must do

Take a focused history and discuss initial management with the patient

Patient information

Opening sentence: Dr I am tired again, So I came back"

You are a 40-year old man

You had come to your GP surgery 6 month ago due to constant tiredness.

You came to the hospital 6 months ago and they suggested the cause is not clear.

The doctor had suggested to perform some blood tests.

You had the blood tests done but you are not sure which blood tests were done and you are here today to find out the results from the blood test.

You are still experiencing tiredness.

You are not able to practice sexual intercourse with your wife and do your normal daily activities due to fatigue.

You work as a lawyer.

First time you had tiredness you had a flu-like illness.

2 weeks ago you had another viral illness with flu-like illness.

Questions:

- What are you going to do for me?
- What do you think is wrong with me?
- Are you going to prescribe me some supplements?

Approach to Scenario 76

- **GRIPS** (loud, confident, nice, smile, know the name of the patient)

How can I help you?

- **History**
- **FODPARA of tiredness**
    - O/S this is the first time you are seeking medical advice for your tiredness
    - What did they tell you was wrong and did they perform any investigations?

Differential Diagnosis

- Anaemia
- Chronic renal failure
- SLE
- RA
- Chronic fatigue syndrome
- Malignancy
- Viral illness
- Depression
- Infections such as HIV, Hepatitis B, Hepatitis C or Tuberculosis

Systemic review (GIT, CVS, CNS, GU, RS, MSK)

Take a sleep history

- Quality of sleep
- Quantity of sleep
- Sleep hygiene measures
- Snoring
- Nocturia

Effects of symptoms on patients life

- On sleep
- Daily activities
- Occupation

Take a lifestyle history

- Stress at home or work
- Use of recreational drugs

- Alcohol consumption
- Personal relationships

Screen for depression or anxiety disorder

- Depression: Suicidal thoughts, loss of interests in daily activities and feeling hopeless
- Anxiety: Palpitations, shortness of breath

MAFTOSA

Examinations

- Systemic examinations: Chest, cardiac, abdominal
- Lymph node examination
- Body Mass Index (BMI)

- **Explain that the diagnosis is Chronic Fatigue Syndrome:**

  It is a functional disorder where the body becomes upset and you start experiencing symptoms of tiredness or fatigue. You have no structural abnormalities and the cause of this condition is not known.

- **Perform blood test:** FBC, U&Es, LFTs, Glucose, TSH, Random blood glucose, IgA tissue transglutaminase

- **Inflammatory Markers:** CRP and ESR

- **If tiredness or fatigue has persisted for 3 months or longer, add the following investigation:**
  - Urinalysis for protein and blood
  - Bone biochemistry (calcium, phosphates)

- **Refer to a specialist chronic fatigue syndrome service:**
  - Within 6 months of presentation if the symptoms are mild
  - Within 3 – 4 months if symptoms are moderate
  - Immediately if symptoms are severe

- **Offer symptomatic advice e.g.** Sleep hygiene, balance between exercise and rest, balanced diet

- **Offer sleep hygiene**
  - Establish fixed times for going to bed and waking up (and avoid sleeping in after a poor night's sleep)
  - Try to relax before going to bed.
  - Maintain a comfortable sleeping environment: not too hot, cold, noisy, or bright.
  - Avoid napping during the day.
  - Avoid caffeine, nicotine, and alcohol within 6 hours of going to bed.
  - Consider complete elimination of caffeine from the diet.
  - Avoid exercise within 4 hours of bedtime (although exercise earlier in the day is beneficial).
  - Avoid eating a heavy meal late at night.
  - Avoid watching or checking the clock throughout the night
  - Only use the bedroom for sleep and sexual activity.

- **Advice on sleep**
  - Discourage excessive sleep and daytime sleeping or naps
- **Exercise**
  - Advice to limit the length of resting to 30 minutes at a time
  - Avoid vigorous exercise
- **Diet**
  - Advice balanced diet
- **Offer leaflet**
- **Apologise for the fact that the computer system is not working:**
  Explain that we would need to wait until the computer system starts working to see the results of his blood tests. Once the computer is working, you will be able to make an appointment again to discuss the results.

Practical scenarios

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8. GERD

Scenario 172

You are FY2 in GP Surgery

Who the patient is:

40-year-old Tom Wilkinson who has made an appointment to see you. Please talk to the patient and address the concerns

Patient information:

You have had heart burn for more than five years

Initially you used to get heart burn when you eat spicy food but now you get heart burn when you eat any food

You been taking Rennie for a long time

You also take over the counter anti acid syrup

You smoke 20 cigarettes a day for the past 20 years

You drink five kinds of beer everyday

If the doctor asks you to stop smoking tell them, you are not interested to stop.

Questions:

Why do I keep getting the heart burn?

So what are you going to do for me?

Examination:

Examiner will say all examinations are normal

Approach:

- GRIPS
- How can I help you?
- History of presenting complaint i.e. history of heart burn

- **FODPARA**

F- Frequency: How often do you experience heartburn?

O – Onset: How did it start? Suddenly or gradually?

D – Duration: When did it start? Or How long have you had these symptoms for?

P – Progression: Is it becoming worse, improving or is it the same?

A – Aggravating factors: Anything which makes it worse or anything which brings it on (if intermittent symptoms)?

R – Relieving factors: Anything which makes it better?

A – Associated symptoms: Differential diagnose

Risk factors

- Stress and anxiety
- Smoking and alcohol
- Trigger foods such as coffee and chocolate
- Obesity
- Drugs that decrease LOS pressure
- Pregnancy
- Hiatus hernia
- Family history

Differential Diagnosis

- Angina
- GORD
- Pericarditis
- Medication (Benzodiazepine, alpha blockers, beta blockers, steroids, diphosphonates, TCA)
- Oesophageal spasm
- Peptic ulcer disease
- Oesophagitis

ALARM55 symptoms

A – Anaemia

L – Loss of weight

A – Anorexia

R – Recent onset of symptoms

M – Melena

55 – Age

Rule out complications of gastro oesophageal reflex disease

- Oesophagitis
- Anaemia
- Oesophageal stricture
- Barrett's Oesophagus

Assess for stress and anxiety

- Any stress at work?
- Any stress at home?

Ideas, Concerns and Expectations (ICE)

ICE: Effects of symptoms on patient's life

- Occupation
- Job
- Sleep

Treatment history

- What medication has been tried?
- Does it help or not?
- If they tried the medication, when did the medication stop working?
- Ask about use of over-the-counter medication

- **Systemic review** (CVS, RS, CNS, GIT, GU, MSK)

- MAFTOSA

- **Examinations**
  - Observations
  - Abdominal
  - Per-rectal

- **Diagnosis**

Explain that the most likely diagnosis is Gastro-oesophageal Reflux Disease.

It is a chronic condition where there is a reflux of gastric contents, particularly acid, back into the oesophagus or food pipe which causes heartburn and acid regurgitation.

Management

- **Explain that the heart burn needs to be investigated further**
  - Endoscopy
  - Routine investigations (FBC, LFT, U&E, CRP, Glucose)
  - Follow up after endoscopy in 1-month time

- **Offer advice on lifestyle measures that may improve symptoms.**

  Encourage the person to:
  - Lose weight if they are overweight or obese.
  - Avoid any trigger foods, such as coffee, chocolate, tomatoes, fatty or spicy foods.
  - Eat smaller meals and eat their evening meal 3–4 hours before going to bed, if possible.
  - Stop smoking, if appropriate.
  - Reduce alcohol consumption to recommended limits, if appropriate.
- **Sleep with the head of the bed raised** (for example by placing wood or bricks under the bed head to raise it by 10–20 cm, if practical).

  People not to use additional pillows, as this may increase intra-abdominal pressure and worsen symptoms.

- **Safety netting**
  - Vomiting blood
  - Tummy pain
  - Dark stools
  - Weight loss
  - Symptoms not responding to treatment

- **Offer leaflets on GERD**

- **Follow up:**
  - Follow up in one month time to discuss endoscopy and assess response to the antibiotics

Practical scenarios

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12. HYPERPARATHYROIDSM

ODPARA

1. **Differential Diagnosis:**

- Drugs: vitamin D, calcium, lithium, thiazide
- Malignancy
- Granulomatous disease: sarcoidosis or tuberculosis
- Chronic kidney disease
- Primary hyperparathyroidism
- Familial hypercalcaemia
- Non-parathyroid endocrine disease: Thyrotoxicosis, Addison's disease, Pheochromocytoma

Questions for differential diagnosis

- **Drugs**
  - Are you taking any supplements like calcium or vitamin D?
  - Are you taking anti-epileptic lithium?
  - Are you taking blood pressure medication?
- **Malignancy**
  - Have you lost weight? If yes, quantify.
  - Do you feel tired and lethargic all the time and that it doesn't improve?
  - Any lumps and bumps on your body?
- **Granulomatous disease: sarcoidosis or tuberculosis**
  - Have you lost weight recently? Any night sweats with shivering? Any cough? Blood in sputum?
- **Chronic kidney disease**
  - Have you been told you have any problems with your kidney?
- **Primary hyperparathyroidism**
  - Have you had fractures in past?
  - Any abdominal pain?
  - Increased frequency of urination?

- Any bone or joint pain?
- Any forgetfulness?

- **Familial Hypercalcaemia**
  - Anybody in family with the same problem?
- **Hyperthyroidism**
  - Do you feel hot when others are comfortable?
  - Any racing of the heart beat?
  - Any tremors of hands?
  - Any diarrhoea?

Red Flags

Constitutional symptoms: weight loss, anaemia, and tiredness. Seizures, fever, depression, suicidal ideation, abnormal physical examination.

Scenario A (266)

You are FY 2 in GP surgery. A 30 years old woman has come for followup. Last week she had blood tests done and results are as follow:

FBC		Normal
Corrected Ca:	3.3	(2.25- 2.65 mmol/L)
Na	139	(135-145 mmol/L)
K	4.2	(3.5-5 mmol/L)
Urea	4	(2.5- 6.7 mmol/L)
Creatinine	120	(70-150 umol/L)
PTH:	7.3	(1.6- 6.9)

Assess the patient and discuss management.

Patient information:

You were feeling tired that is why you came last week. No other complaints. Your tiredness started 3 months ago. No significant incident. Your mood is 7/10, normal sleep, no loss of interest. You get better with rest however your tiredness does not get better towards the end of the day. You have polyuria and polydipsia. You have muscle weakness and joint pain. Nurse found your blood glucose was normal, you take a lot of milk. You do not smoke and drink alcohol occasionally. There is no family history of any illness.

Q. Is it the milk I drink that caused it?
Q. What will you do for me?

Approach to scenario A

- Initial Approach or GRIPS
- Explain the results: High calcium and high parathyroid hormone
- What prompted you to get these investigations?
- Symptoms of hyper parathyroid: thirst, weakness, polyuria
- Differential Diagnosis
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise
- **Examination**
    a. Observations
    b. Thyroid examination
    c. CVS examination
- Explain the findings
- **Diagnosis**

Hyperparathyroidism. A benign tumour in the parathyroid gland may produce excess amount of parathyroid hormone leading to high calcium in the blood. High calcium in the blood can cause symptoms such as passing urine in excess and very frequently, nausea, vomiting, thirst, abdominal pain and sometimes it can cause confusion.

- Commonly it is produced from a benign tumour in the gland, which produces this hormone.
- Other things that could have contributed are: calcium and vitamin D tablets, plus drinking too much milk.
- **Management**

Note: Assess the severity of the symptoms: if the patient is unable to cope at home, send to hospital for admission.

- Refer to the endocrinologist.
- The specialist will do further investigation to determine the exact cause such as US of the thyroid gland.
- If it is benign swelling in the neck, it can be removed by the surgeons.

- Advise to stop:

a. Drinking too muck milk
b. Stop taking vitamin D
c. Stop taking calcium tablets

14. LOSS OF VISION

ODPARA of loss of vision

Differential Diagnosis:

- Age related macular degeneration
- Glaucoma
- Refractory errors
- Trauma
- Cerebrovascular accident
- Brain tumour
- Diabetic retinopathy
- Retinal detachment

Questions for differential diagnosis

- **Age related macular degeneration**
  - When you look at the window, for example, have you noticed that straight lines appear wavy?
  - Have you ever bumped into things which are directly in front of you?
  - Do you have any problems reading? Is it small or large print?
  - Are you able to see things which are on the sides?
  - Do you have grey or black patches in your visual areas where you cannot see?
- **Glaucoma**
  - Haloes around the light?
  - Pain and redness in the eye?
- **Refractory errors**
  - Do you wear glasses?
- **Trauma**
  - Have you hurt yourself?
- **Cerebrovascular accident**
  - Face - asymmetry on the face
  - Arm - weakness on the arm

- Speech - Slurred speech

- **Brain tumour**
  - Headache worse in the morning?
  - Worse on bending down?
- **Diabetic Retinopathy**
  - Have you been diagnosed with diabetes?
- **Retinal detachment**
  - Any flashing lights?
  - Do you see any floaters?

Red Flags

Bilateral loss of vision, rapid deterioration, suspected serious pathology, loss of independence, neurological symptoms, visual field defects and HIV infection.

Scenario A (286)

You are FY 2 in GP surgery. A 69 years old woman has been referred by the optician. Talk to the patient and address her concerns.

Patient information:

You cannot see and find it difficult to read. You went to the optician because you wanted to change your glasses as you thought it might help. You have been having problems with your vision for the last one year. You have been using glasses for the past one-year. Lines appear wavy to you and it gets blurry – this has been going on for the past 3 - 4 months. You have no pain, redness or discharge in your eyes. It started gradually and is getting worse but maybe is the same – not too sure. You are worried as you can't read now. You are eating a normal balanced diet. There is no history of high cholesterol, no HTN, no DM. No dizziness. You do not see halos around light. You do not have any headache, no jaw claudication. Nothing like curtain falling down. No smoking, no alcohol, not stressed at all. Optician told you that you have 'some degeneration'. You have no idea about the cause

Q. How can you help me read again?
Q. Will it get better?
Q. Will I go blind?

Examination

"Patient has bilateral retinal drusen"

Approach to scenario A

- Initial Approach or GRIPS
- Reason for visiting option
- ODPARA of loss of vision
- Differential Diagnosis
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise
- **Examination**
    a. Observations
    b. Fundoscopy
    c. Visual acuity
    d. Visual field examination: Check your central and peripheral vision, i.e., how well you see things which are directly in front of you as well as things which are on your sides.
- Explain the findings
- **Diagnosis**

Explain to the patient:

- You have got degenerative changes of the macula in both eyes.
- The macula is part of the back chamber of your eye
- It is responsible for central vision; that is seeing things which are directly in front of you.
- If it has been affected - you may find it difficult to see things which are directly in front of you or to read.

- **Management**

- Refer urgently to ophthalmologist if:

i. Metamorphopsia
ii. Visual loss that is rapid onset

- Explain what the specialist would do:

i. Examine your eyes again

ii. Use special movement to examine your retina (back chamber of the eye)

- Support and help:

i. Once you have been referred to the ophthalmologist.

ii. You can be offered:

- Magnifying glasses to help you read.
- Use bright lights.

- Lifestyle advices:

i. Stop smoking

ii. Eat balanced diet

iii. Exercise regularly

- **Driving:**
  i. Advice to avoid driving
  ii. Inform the DVLA
- **Medications:**

Sometimes, there are medications that can be offered but the specialist will review you to see if you are suitable.

- **Safety netting:**

Advice that if there is a delay of more than one week or the symptoms become worse, he/she should go to ophthalmology eye clinic.

You do not need an appointment.

Other scenarios

15. HEAD INJURY IN AN ADULT

History of fall: before - during - after

- Can you tell me about the fall?
- When, where, how the fall took place.
- Did anyone tell you how you fell down?
- Were there any witnesses?
- Did you trip?
- LOC?
- Any seizure or biting of the tongue?

- **Before the fall:**
  - Activities before the fall.
  - Symptoms before the fall.
  - Did he trip?
  - What made you fall down?
  - Were there any witnesses?
  - Any headache, CP/palpitations, fever, alcohol, drug abuse, palpitations, dizziness)
- **During the fall:** LOC, seizures, incontinence, tongue biting
- **After the fall:** headache, drowsy, vomits

Head injury Symptoms:

a. Loss of consciousness
b. Drowsiness
c. Nausea or vomiting
d. Discharge from ear or nose

Systemic Review

Red Flags

Reduced GCS <13, GCS <15, 2 hours after initial assessment, open or depressed skull fracture, sign of basal skull fracture, seizures, focal neurological deficit, persistent vomiting, retrograde amnesia of more than 30 minutes, dangerous mechanism of injury, alcohol or drug intake and signs of physical trauma to the head or neck.

Scenario 5

You are FY 2 in A&E. A 40 years old gentleman was brought to the hospital after a fall. Take a focused history, assess the patient, perform relevant examination and discuss initial management with the patient.

Patient information:

You went out to the restaurant with your wife/ family (wife and 2 children). You do not remember what happened but according to your wife after eating, when coming out of the restaurant/pub you tripped on the door and fell down. You did not drink alcohol (or you drink 2-3 units of beer). No use of recreational drugs. You did not have headache before the fall. The next thing you remember is waking up in the ambulance. You do not remember what happened after the fall. You vomited once in the ambulance / no vomiting. There were no weakness anywhere in the body. It was projectile vomiting. At the moment you are experiencing generalised headache. You are not very keen to stay in hospital you just want to go home. You are sitting on a chair/ lying on the bed and wearing a hospital gown. Mild headache. You want to go home. You do not think it is something serious.

Q. What is wrong with me?
Q. What are you going to do?
Q. Why can't you just treat me so I can go home?

Examination

Temp 37ºC, BP 120/80, HR 80
No neck stiffness
Colourless discharge from right ear
Normal power, tone and reflexes
Pupils equal & reactive to light
Normal fundoscopy

Approach to scenario 5

- Initial Approach or GRIPS
- History of fall
- Head injury symptoms
- Systemic review

- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise
- **Examination**
    a. Observations
    b. Fundoscopy
    c. Neurological examination
    d. Cranial Nerves examination
    e. Ear examination
    f. Pupils

N.B: Examiner will tell you that all the examinations are normal.

- Explain the findings

- **Diagnosis**
    a. Most likely/unfortunately you have a severe head injury
    b. You could have suffered a bleed in the brain because of the symptoms that you have told me like vomiting/ headache/ drowsiness/ not remembering things.
    c. PAUSE and allow patient to understand the diagnosis and ask questions.

- **Management**

    a. **Observe:** Keep a close eye on you monitoring your BP and pulse.
    b. **CT scan :** If a CT scan shows a bleed refer to neurosurgeon for further management which is usually performed, if CT scan normal he can go home and you will leaflet with head injury instructions

        If there is a bleed, we might need to refer you to the neurosurgeons.

        If CT scan is normal patient can go home and explain that you gave them head injury leaflet. When they need to look for seizures, LOC, drowsiness and persistent vomiting.
    c. **Painkillers** - Paracetamol, Ibuprofen (ask if analgesia is given)

16. Hyponatremia

FODPARA

F - Frequency : Does he get confused frequently?

O - Onset : Did he get confused suddenly or gradually?

D - Duration : How long has he been confused?

P - Progression : Do you feel that he is getting worse?

A - Aggravating factors : Is there anything that makes his confusion worse?

R - Relieving factors : Anything makes his confusion better?

A - Associated symptoms.

Differential Diagnosis:

- Trauma
- Infection
- Hypernatraemia
- Dementia

Questions for differential diagnosis

- **Trauma**
  - Is there any chance he could have had a fall?
- **Infection**
  - Any recent illness?
  - Fever?
- **Hypernatraemia**
  - Any problems with kidneys?
  - Any seizures?
- **Dementia**
  - Is he normally confused?
  - Has it happened before?
  - Is he forgetful?
- **Drugs**
  - Is he taking any regular medications?

- **Cerebrovascular event**
  - Any weakness in any part of body
  - History of strokes/mini strokes in past
  - Does he have any medical conditions such as heart problems, high blood pressure or stroke?

Red Flags

Head injury, reduced GCS, signs of brain bleeding, drop in GCS, systemically unwell.

Scenario 145

You are FY 2 in A&E. A 70 years old man has presented with confusion. Please talk to the wife and address her concerns.

Patient information:

You are Mr Ian Hayes's wife. Today you have come to the hospital with your husband because he is very confused. You came to the hospital with him 24 hrs ago and he was prescribed trimethoprim oral tablets. Yesterday you were able to have normal conversation with your husband but today he keeps saying random words. Even though he was given medication, he is getting worse now. You are not happy with the whole situation.

Q. What is wrong with him?
Q. Why has he become more confused?
Q. Why did you send him home when you knew that he would get even more confused?
Q. What are you going to do now?

Approach to scenario 145

- Initial Approach or GRIPS
- ODPARA
- History of previous visit
  a. What was wrong?
  b. What was the diagnosis?
  c. What treatment was given?
- Differential diagnosis
- Systemic Review
- Red Flags
- MAFTOSA

- ICE
- Effects of Symptoms
- Summarise
- **Examination**
    a. Observations
    b. Systemic exam
- Explain the findings
- **Diagnosis**

Explain that UTI is the likely diagnosis and can cause confusion in elderly patients.

- **Management**
    a. Admit
    b. Routine blood tests
    c. Bladder scan for retention
    d. IV Antibiotics (co-amoxiclav 1.2gm)
    e. IV fluids
    f. Urine dipstick and MC&S

Practical scenarios

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PSYCHIATRY

Introduction

Psychiatry is one of the most difficult subjects for the majority of PLAB 2 candidates. This is mainly due to the high demand of emotions and non-verbal communication skills required to communicate with psychiatric patients.

Here are the main points, which you will require in most of psychiatry stations.

Know how to start the station:

There are the two ways you can start the stations:
A. If the patient was brought to the hospital by a relative (e.g. mother) or by the police:
In this type of situation avoid starting like: "May I know what brings you to the hospital?"

Rather, start like this: "I understand that you have been brought to the hospital by your boyfriend (or relative/police) who is concerned about you. Why do you feel that he/she has good reasons to be worried about your health?"

B: If the patient comes to the hospital alone:
In this case it is better to start like "May I know what brings you to the hospital?" or "How may I help you today?"

This can be applicable in certain scenarios only e.g. when taking history from an anxious patient.

Take a history of the presenting complaint:

Here, it is important to allow the patient to think about the possible cause of his/her symptoms.

How to start:

- "I understand that you have been feeling a little bit anxious recently.
- Can you tell me a little bit more about it?
- When did you start feeling like this?
- What do you think makes you feel like that?
- Did anything happen just before you started feeling like this or experiencing this?
- Is there anything you think could be the cause of this?
- Is there anything in your life that could be causing stress at the moment?
- Do you think there is anything that can be done to help relieve these feelings you are going through?
- When you started experiencing this, would you say you were under stress in your life?
- If the patient says he was stressed or he/she had a bad experience, express empathy e.g "I am really sorry to hear that" or "I am really sorry you went through/you are going through this"
- How do you feel now about all of this?
- Is there anything you normally do to help yourself feel better?
- Have you talked to anyone about this? Or is there anyone in your life you feel free to share these feelings with?
- Has this affected your life in any way (like going to work or meeting up with friends or carrying out your daily activities)?
- What were you hoping to get from us today?
- What would you like us to do for you?"

Rule out possible differential diagnoses:

Even if the diagnosis is quite clear, it is important to rule out other possible diagnoses e.g. for depression, rule out hypothyroidism, post traumatic-stress disorder, postnatal depression etc.

Ask specific questions about the diagnosis:

From the history of the presenting complaint and questions about the differential diagnoses, you will have reached a diagnosis by now. You then need to ask specific questions about that diagnosis: e.g. specific questions of depression, obsessive-compulsive disorder, post-traumatic stress disorder or anorexia nervosa.

Rule out suicide:

"Some people, when they are going through such difficult times, sometimes they tend to have thoughts of harming themselves or taking their own lives. Has such a thought ever crossed your mind? Have you ever tried to harm yourself in anyway in the past?" If patient says yes, then you ask follow up questions: "How did you do that?"

Now apply FAMISH for background information and to complete the remaining history:

F - Family, friends, finances, forensic

A - Alcohol, smoking, drugs

M - Medical history, medications, hospitalisation, operations

I - Insight, interest in life

S - Stress, sleep, appetite

H - Hallucinations and psychosis

Psychosis:

Delusion: "James, do you have any firm beliefs which other people strongly disagree with?"

Note: For patients with psychosis (e.g. hallucinations or delusions) you need to rule out danger to society. Rule out Danger to society.

"Mr Taylor, you mentioned that you hear these voices," or "You see these people who are following you…." or "Now that you believe that these people are against you/ want to take you to jail, ... do you generally feel safe? Is there anything that you do to protect yourself?"

This type of patient might be carrying a knife or a weapon with them to protect themselves from the people/voices they are afraid of. If a patient carries a weapon to protect himself, he/she is regarded as a danger to society or family as he may attack at any time.

This particular type of patient may have depression due to constant fear of being followed by the police or MI5. It is therefore important that you rule out depression and suicidal ideation.

1- Beliefs
2- Danger to Society
3- effects of symptoms -

Ask about the effects of the symptoms on the patient:

Patients may stop eating and drinking, or even going out of the house, due to fear that once they leave their house, the police will arrest them.

Therefore it is important that you find out how much the patient has been affected by their problem.

- Since the police are waiting to arrest you or are following you, are you able to carry out your daily activities?
- Are you still able to go to work or meet up with your friends and relatives?

- **Thought broadcasting:** "Have you ever had an experience whereby you feel that people know what you are thinking despite the fact that you haven't told anyone about it?"
- **Thought withdrawal:** "What about another type of experience whereby you feel that other people are taking your thoughts out of your mind?"
- **Thought insertion:** "Some people also tend to experience a feeling as if other people are putting thoughts into their mind? Have you ever experienced such a thing?"
- **Hallucinations:** "What about another types of experience where you hear voices when there is no one around you, or see things which other people cannot see? Have you ever had such an experience?"

Orientation

NB: If the patient has hallucinations, you need to find out more about the type of hallucinations and find out if there are also visual hallucinations i.e. visual, auditory, 2nd person or third person hallucinations etc.

For example:

"Mr Robert, you mentioned that you can hear voices; how many voices can you hear? Do these voices speak to you? Are they telling you to do something? Or do they discuss something amongst themselves? What are they talking about? Do you see these people or do you just hear them talking?"

Insight:

Insight is the ability of a patient to recognise that he/she has got a problem, which needs some sort of help.
For instance, a patient may clearly say she is sorry for her actions; for example a patient after a paracetamol overdose who recognises herself that it was a silly action and regrets doing it.

Such a patient clearly has insight into the problem and it is therefore inappropriate to ask them: "Do you think you have a problem?"

How to ask about insight: "Do you feel that you have a problem that might need medical attention or treatment?"

Social history:

- It is important to organise information by using signposts: "I just need to ask a few things about your social life."
- Do you drink alcohol?
- Do you smoke?
- I'm sorry to ask you this, but is there any chance you use recreational drugs? If the patient says yes, then you have to ask what drug, for how long and route of administration.
- Do you have a family? If yes, then ask further about who is in their life and do they feel free to talk to them about their problem.
- What do you do for a living? If the patient is not working, ask further. Is there a reason why you are not working?
- How are your finances? How do you finance yourself?
- Would you say that you are generally stressed in life?
- Have you ever been in trouble with the law?
- Do you have friends?
- How has this affected your life? Are you able to go on with your daily activities?
- Do you have any problems with your housing?

Past medical history:

- Use a sign-post: "Now, I just need to ask a few questions about your health."
- Do you have any medical conditions such as high blood pressure or high blood sugar?

- Do you have any mental health problems?
- Is there anyone in your family with mental health problems?
- Do you take any regular medication?
- Have you ever had any operations?

Diagnosis:

Usually you will have to tell the patient what is wrong with them.

For example:

"From what you are telling me, most likely you have a condition called... but I need to consult my seniors for a second opinion. Then I will get back to you. Is that alright?"

Management:

Usually they will be referred to a specialist called a psychiatrist who will offer patients either Cognitive Behavioural Therapy (talking therapy) or medication. Offer lifestyle advice and modification.

"I will refer you to the psychiatrist who will either offer you talking therapy or some medications."

NB: It is important to check which department you are working in. If the question says "You are a junior doctor in the Psychiatry department", DO NOT say, "We will refer you to the psychiatrist". The patient is already in the Psychiatry department and you are the junior doctor who represents the Psychiatric team.

The above format can be adopted in all other psychiatry stations with minor modifications.

Emotions:

Above all in psychiatry, it is important to have appropriate body language, especially when talking to certain groups of patients e.g. depressed, anxious, psychotic or patients with suicidal ideation.

Depressed patients or those with suicidal ideation:

You might need to lean forward slightly when speaking to this type of patient and speak slowly, with a low tone of voice. Your body language should show that you empathise with the patient.

If you talk to such patients as if you are taking a history about chest pain, you will find it difficult to build a rapport.

Psychotic patients:

Try to be friendly but do not sit very close to the patient. Maintain a good distance, as mentally disturbed patients may attack you. Although in the exam this is definitely not going to happen, you need to show the examiner that in real life that is how you will conduct your consultation.

At the same time, you need to show that you understand what they are going through. Do not show that you are afraid of the patient. Such behaviour may cause the patient not to co-operate during the consultation.

DEPRESSION:

1. History of presenting complaint

(Generally feeling unwell, weight loss, tiredness, insomnia)

2. Differential diagnosis

- Depression
- Grief
- Bipolar disorder
- Hypothyroidism
- Cushing's syndrome
- Addison's disease
- Drug induced
- Post-traumatic stress disorder
- Post-natal depression
- Seasonal affective disorder

3. Questions on differential diagnosis:

Depression:

Ask about the two co-symptoms of depression:

1. During the last month, have you often been bothered by feeling down, depressed or hopeless?
2. Do you have little interest or pleasure in doing things?

Note: If a person answers yes to one or both questions, you should take a detailed history of depression.

Depression Symptoms:

- Weight loss
- Decreased appetite
- Decreased energy levels
- Decreased sleep

- Fatigue
- Inappropriate or excessive guilt/worthlessness
- Recurrent thoughts of death
- Suicidal thoughts or actual suicidal attempt
- Lack of concentration/diminished ability to think
- Psychomotor agitation/retardation

Risk factors of Depression:

- Relationship problems
- Divorce
- Loss of job/unemployment
- Loss of beloved ones
- Chronic co-morbidities: Diabetes, COPD, Rheumatoid arthritis, etc
- Poverty
- Personal history of depression
- Family history of depression

Grief:

- Have you lost somebody/ something important to you recently?
- Do you feel shocked, numb or guilty?
- Do you find it difficult to concentrate on your daily activities?

Grief vs Depression:

- In depression, patient feels hopeless, worthless and guilty but in grief the patient feels numb.
- Distress related to a particular loss is grief, while in depression, distress is generalised to everything.
- In grief, the person retains the capacity for pleasure. While in depression, the person enjoys nothing.
- Grief comes in waves while depression is constant and unremitting.
- In grief, the person may express a passive wish for life to end, while in depression, a person expresses suicidal ideation.

→ PTSD

→ Postnatal.

- In grief, the person is able to look forward to the future while in depression, there is no sense of a positive future.

Bipolar Disorder:

- Do you feel more energetic than usual? energetic at times?
- Do you feel like you have a lot of ideas to make things around you work differently?
- Do you feel that you have got special powers?

Hypothyroidism:

- Do you feel cold when others are comfortable?
- Do you suffer from constipation? cold when others not?
- Have you gained weight recently?

Cushing's Syndrome:

- Have you noticed any bruises?
- Have you gained weight recently?
- Do you have weakness in your limbs?

Addison's disease:

- Do you have any muscle or joint pains?
- Have you lost weight recently?
- Have you noticed any darkening of your skin?

Drug induced:

Corticosteroids, beta-blockers, etc

Post-Traumatic Stress Disorder:

Specific symptoms of PTSD – DREAMS:

- D – Disinterest in life; detached and emotionally numb;
- R – Reliving the incident through intrusive flashbacks, nightmares or vivid memories
- E – Extreme nature of the event
- A – Avoidance of similar circumstances (avoid watching TV, war movies, avoidance of vehicles, avoid certain routes)

- M – Months (= or > 6 months). It starts within a few weeks after exposure to trauma. If < 6months, it is Acute Stress Disorder.
- S – Sympathetic hyper-arousal; like hyper-vigilance, on the edge etc. (High profile, fugitive, irritable, agitated.)

How to ask:

- **D:** Do you feel that you have lost interest in life? Do you feel detached, numb?
- **R:** Do you get flashbacks about what happened? Do you get nightmares about what happened?
- **E:** Exaggerated response? Do you feel your response to what happened is exaggerated?
- **A:** Do you try to avoid similar situations?
- **M:** When did it happen? Did you have a prolonged distress after what happened?
- **S:** Do you feel on the edge all the time?

Post-natal depression:

- How many children do you have?
- Have you been feeling this low mood since the birth of your baby?
- Was it a planned pregnancy?
- How do you feel about the baby?
- Do you have any thoughts of harming yourself or the baby?

Seasonal affective disorder:

Do you think that your feelings come and go in a seasonal pattern?

4.Red flags:

- Risk of suicide
- Feeling of hopelessness
- Chronic pain
- Disabling symptoms
- Severe and prolonged symptoms

Scenario 255

You are an FY2 doctor in GP surgery. A 30-year-old lady has made an appointment to see you. Talk to the patient, address her concerns and discuss management with her.

Patient information:

Opening sentence "Doctor I am not feeling well" or tell them you have been losing weight. You are struggling to eat and you have lost one stone in the last 2-3months. Also, your energy level is low. Your mood is low 5/10 and your sleep is poor. You go to bed around 10:00 pm and fall asleep around 02:00 am and you wake up early in the morning around 05:00 am and sometimes 04:30 am. These symptoms started 4 months ago. One year ago you split up with your partner. You have one child who you live alone with. At the moment you are not employed as you quit your job to look after your son. You are normally fit and well and you have no allergies.

You used to go out with your friends but now you do not feel like it plus you are looking after your son most of the time. You used to play squash but you have not been playing recently because you don't feel like it. You do not smoke and you drink alcohol occasionally.

Questions:

1. What is wrong with me?
2. What are you going to do for me?

appetite ↓
sleep ↓
energy ↓
interest ↓ lost
low mood
guilty
suicidal thoughts.

Approach:

- **GRIPS**
- **History of presenting complaint (not feeling well, sleeping problems)**
  - Onset
  - Duration
  - Relieving and exacerbating factors
- **Differentials diagnosis**
- **Questions on differential diagnosis**
- **ICE**

Bipolar
Hypothyroid
Sleep Apnea.
Anemia
PTSD.

- **Effects of symptoms on patient's life**

Assess for suicide

1. Directly ask about suicidal thoughts. Do not avoid the word suicide.
2. Do you feel life is hopeless and not worth living?
3. Do you ever think about suicide?
4. Have you made any plans for ending your life?
5. Do you have means of doing it if this available to you? If the patient answers not really, ask them 'does that mean yes or no'.
6. What has kept you from acting on these thoughts?

FAMISH.

- **MAFTOSA**
- **Summarise**
- **Examinations:**
  - Observations
  - Thyroid examination
  - Systemic examinations

Explain the diagnosis is depression.

Diagnosis of depression:

- If a person has at least 5 out of the 9 symptoms listed above, with at least one of the co-symptoms, then you can make a diagnosis of depression.

Classification of Depression:

1. Sub-threshold depression - less than 5 symptoms required to make a diagnosis of major depression.
2. Mild depression - few, if any symptoms, in excess of 5 required to make a diagnosis of depression and only minor function impairment.
3. Moderate depression - there is mild to severe functional impairment but marked symptoms.
4. Severe depression - excessive symptoms plus severe function impairment.

Management:

1. Contact crisis resolution and home treatment team.
2. Manage other co-morbidities associated with depression such as anxiety or alcohol misuse.
3. Discuss with the patient what might be contributing to the stress and suggest ways of avoiding the contributing factors.
4. For sub-threshold or mild-moderate depression, consider cognitive behavioural therapy.
5. Moderate - severe depression: CBT + anti-depressants.
6. Advise people with moderate - severe depression to inform DVLA if they drive.
7. Ask about sleeping problems and offer sleep hygiene advice.
8. Arrange follow up within 1 week for people less than 30 years old, and within 2 weeks for others. After that, arrange follow-up every 2-4 weeks.
9. Provide information such as leaflets.
10. Explain treatment is cognitive behavioural therapy and sometimes anti-depressants.

Medical Treatment:

- SSRI is the 1st choice: citalopram, fluoxetine, sertraline, etc
- Manage social issues:
    - How is she coping at home?
    - Any children?

At the end summarise the main points of management.

ANOREXIA NERVOSA:

1. **History of presenting compliant (weight loss)**

2. **Differential Diagnosis:**

- **Anorexia nervosa** (weight loss, young female, amenorrhoea)
- **Malignancy** (weight loss, anorexia, tiredness, mild grade fever, loss of appetite)
- **Tuberculosis** (haemoptysis, cough with sputum, fever, patients are usually from Asia or Africa)
- **Depression** (low mood, loss of appetite, anhedonia, insomnia, poor sleep)
- **HIV** (common in IV drug abuse or homosexuals, weight loss, generally unwell)
- **Malabsorption** (diarrhoea, tummy pains)
- **Systemic autoimmune disease** (SLE or Rheumatoid arthritis polyarthritis)
- **Inflammatory bowel disease** (usually common in young patients with chronic diarrhoea with or without bleeding per rectal, abdominal pain)
- **Irritable bowel syndrome** (bloating, diarrhoea, abdominal pain relieved by defecation)
- **Hyperthyroidism** (diarrhoea, palpitations, tremors, weight loss, menstrual irregularities)
- **Diabetes mellitus** (polyuria, polydipsia, weight loss)
- **Bulimia nervosa** (binge eating, laxative abuse, fluctuations in weight)
- **Malnutrition**

3. Questions on differential diagnosis:

Anorexia Nervosa:

- **Diet:**
  - How is your appetite?
  - What do you eat for breakfast, lunch and dinner?
  - Do you have a habit of binge eating?

- **Exercise:**
    - Do you exercise? How frequent?

- **Medications:**
    - Do you take any medications to lose weight or reduce your hunger?
- **Weight:**
    - Do you know how much weight you have lost?
    - What was your weight before?
    - How much is your weight now?
- **Body image:**
    - How do you see yourself in the mirror?
    - What do your family and friend say about your weight?
- **Role models:**
    - Who are your role models?
- **Clothes:**
    - What type of clothes do you wear?

Screening questions for Anorexia Nervosa SCOFF:

S: Do you make yourself sick because you feel uncomfortably full?

C: Do you worry that you have lost control over how much you eat?

O: Have you recently lost more than one stone in a three-month period?

F: Do you believe yourself to be fat when others say you are too thin?

F: Would you say that food dominates your life?

- **Menstrual History:**
    - When was your last menstrual period?
    - Are your periods usually regular?
    - How many days do you bleed?
    - Are your periods painful?
    - When was your last cervical smear done? Was it normal?

- **Rule out depression:**
    - How is your appetite?
    - How is your mood? Can you rate it on a scale from 1 to 10?
    - How is your sleep?
    - How are your energy levels?
    - Do you feel that you have lost interest in life and daily activities?
    - How do you see your future?
    - How long have you been feeling like this? (Ask if the patient reports positive symptoms of depression)

- **Rule out suicide:**
    - Have you ever had thoughts of harming yourself?
    - Have you ever visited a psychiatrist before?
    - Any history of mental illness in the family?

Differential Diagnoses:

- **Malignancy:**
    - Have you noticed any weight loss?
    - Have you noticed any lumps or bumps anywhere in your body?
    - Do you suffer from light-headedness, weakness or tiredness?

- **Tuberculosis:**
    - Do you have chest pain?
    - Have you been coughing? If yes, is it dry or productive?
    - Have you ever coughed up blood?
    - Do you have night sweats?
    - Have you lost weight recently?

- **HIV:**
    - Do you use any recreational drugs? If yes, do you inject yourself?
    - Are you sexually active? What kind of sex do you practice (oral, vaginal, anal)?
    - Is your partner male or female?

- Do you feel generally unwell?
- Do you practice casual sex?
- How long have you been with your current partner?
- Do you have multiple partners?

- **Malabsorption:**
  - Are you suffering from diarrhoea?
  - How are your stools? Fatty? Offensive smell? Difficult to flush?
  - Do you have tummy pains?
  - Have you been losing weight?
  - Any similar conditions in the family?

- **Systemic autoimmune disease (SLE, RA.etc)**
  - Do you have any joint pains?
  - Have you noticed any skin rashes?
  - Do you feel generally unwell and tired?
  - Have you noticed any swelling or redness?
  - Any muscle spasm?
  - Do you have diarrhoea? Any bleeding?
  - Any tummy pains? Cramps?

- **Inflammatory bowel disease:**
  - Are you suffering from diarrhoea?
  - Have you noticed any bleeding from your back passage?
  - Do you have tummy pain? Urgent bowel movements?
  - Any weight loss?
  - **Irritable bowel syndrome:**
  - Do you feel bloated?
  - Any diarrhoea?
  - Do you have tummy pain?
  - Is your tummy pain relieved by defecation?

- **Hyperthyroidism:**
- Do you experience any tremors?
- Do you feel hot when others are feeling comfortable?
- Do you have diarrhoea?
- Have you ever had any palpitations/ irregular heartbeats?
- Any mood swings?
- How are your periods?
- Do you feel anxious, irritated most of the time?

- **Diabetes Mellitus:**
    - Have you ever been told that you have high blood sugar?
    - Do you feel thirsty more than usual?
    - Have you noticed that you need to urinate more frequently?

- **Bulimia Nervosa:**
    - Have you noticed that your weight is fluctuating?
    - Do you feel you are always occupied by your weight and body shape?
    - Do you feel that you do not have control over your eating?
    - Do you induce vomiting after eating?
    - Do you use laxatives to reduce your weight?
    - Do you exercise? How many hours a week/ a day?

- **Malnutrition:**
    - How is your diet? Appetite?
    - Have you been losing weight?
    - Do you feel tired most of the time?
    - Have you noticed that your wounds take long time to heal?
    - How is your mood?
    - Do you feel that you lack concentration?

4.Red flags:

- BMI < 18 Kg/m2
- Speed of weight loss > 0.5 kg/week, or losing >10% of body weight
- Obsessive feeling about body image and food
- Physical, emotional and sexual abuse
- Dysfunctional family and parental problems
- Bereavement and major life events
- Self-harm

Scenario 140

You are an FY2 doctor in Psychiatric department. An 18-year-old girl has been brought to the hospital by her mother. Take a focused history and discuss initial management with the patient.

Patient Information:

You have been referred by the GP because your BMI is 17. Your mum has brought you today to the hospital as she is also concerned about your weight but you cannot see a reason why your mum is worried. Your weight was 39kg, now it is 35kg.You are on a special diet, it contains smoothies, grilled chicken, fish, vegetables and fruits but no carbohydrates. You may be on a water diet which means you drink more than you eat. You exercise 3 hours a day. You haven't had your period for the last 4 months. You study economics at university and your studying is suffering as you spend most of your time reading about diet. You do not like what you see in the mirror and your role model is your friend (classmate), who all the boys are after, because she is skinny. You have been smoking for the last 6 weeks, 4-6 cigarettes a day in order to lose weight.

APPROACH:

GRIPS

Paraphrase scenario and ask if she knows why the GP has referred her.

"Do you feel like your mum has got reasons to be concerned about your weight?"

- **Take history**
- **Differential Diagnosis**
- **Systemic review**
- **MAFTOSA**
- **ICE**
- **Effects of symptoms on patient's life**
- **Summarise**

Normal BMI 18.5 – 24.9
Yours is 17.

Explain the diagnosis is Anorexia Nervosa.

Explanation of Anorexia nervosa: This is a condition in which someone perceives herself as being obese or overweight when in the actual sense they are actually underweight.

Explain that the BMI is a ratio between height and weight. The normal is 18.5 and yours is 17. This suggests that the amount of weight you have lost is significant and can cause problems to your health.

below Healthy weights are to your height.
Your weight is likely to cause you health problems. so I'd like to refer you.

Examinations:

- Observations
- Weight and height (BMI)
- Systemic examination

Management:

- Blood, U&E, LFT, TFT
- Refer to eating disorder clinic → CBT
- Cognitive behavioural therapy → Supervised Weight Gain Programs.
- Dietary counselling - dietician
- Refer to the gym instructor and dietician
- Regular physical monitoring - height and weight
- Multivitamins
- Food diary
- Offer books about diet
- Offer leaflet about Anorexia Nervosa

They can teach how you can eat well & exercise well so you have a body that looks Beautiful.

<u>Admit</u>

- Risk of suicide
- Home environment problematic
- Severe deterioration
- <17.5 BMI
- Rapid weight loss

W/ PC
↙ DD.

sick
lost control
one tone
fat
food.

↑ MACRO

- Urgent referral if BMI <15

Medical complications:

- Arrhythmia
- Hypoglycaemia
- Electrolyte imbalance

(2) Girl. F42 15 y old Came with mother to surgery.
No previous records. of surgery. Concerns.
mother is shocked when you tell her she has anorexia. Daughter doesn't measure her weight frequently. She doesn't look in the mirror. She has exercise plan & Diet plan
Diet includes. wkly in morning. salad in lunch.
& one slice in dinner . 2 hrs of exercise everyday.
when you refer her she will what is eating disorder unit? BMI : 17 ↓ mother also here.
Involve Both in the scenario.
well somebody suffering from anorexia which might not

INSOMNIA

1.History of presenting complaint (sleep problems)

2.Differential Diagnosis:

- Shift worker
- Living environment (noisy)
- Depression
- Mania/anxiety
- Grief
- Nocturia (BPH, DM)
- Nocturnal cough (asthma)
- Medication
- Pain (joint problems)
- Obsessive compulsive disorder
- Post-traumatic stress disorder
- Coffee/tea.

3.Questions on differential Diagnosis:

- **Shift worker:**
  - What type of job do you have?
  - Do you do night shifts at work?
  - How many hours do you work?
- **Living environment:**
  - Where do you live?
  - Are you surrounded by noisy environment?
- **Depression:**
  - Who is your appetite, sleep, energy level, mood?
- **Mania/ anxiety:**
  - Do you feel anxious?
  - Do you feel like you have special powers?
  - Do you feel over energetic at times?

- **Grief:**
  - Have you lost somebody/ something important to you recently?
  - Do you feel shocked, numb or guilty?
  - Do you find it difficult to concentrate on daily activities?
- **Nocturia:**
  - Have you been going to the toilet to pass urine more frequently at night?
- **Nocturnal cough:**
  - Have you been coughing lately?
  - Do you experience the cough more at night?
- **Medication:**
  - SSIs, Steroids, Diuretics, etc
- **Pain:**
  - Do you have any pain anywhere in your body?
  - Any joint or muscle pains?

- **Obsessive Compulsory Disorder: RIPSOUR**
  - **R- Repetitive:** Do you feel that you need to carry out a certain activity or behaviour repeatedly? Do you have any thought, image or worry that repeatedly enters your mind?
  - **I- Intrusive:** Do these thoughts intrude upon your normal flow of thoughts and hamper your daily activities?
  - **P: Persistent:** Are these thoughts persistent and cause you anxiety?
  - **S- Senseless:** Do you feel they are senseless?
  - **O-Derived from one's own thought:** Do you think these thoughts are your own?
  - **UR-Unable to resist:** Have you tried resisting them? Do you get anxious when resisting them?

- **Post-traumatic stress syndrome: DREAMS**
    - **D:** Do you feel that you have lost interest in life? Do you feel detached, numb?
    - **R:** Do you get flashbacks about what happened? Do you get nightmares about what happened?
    - **E:** Exaggerated response?
    - **A:** Do you avoid similar situations?
    - **M:** When did it happen? Did you have a prolonged distress after what happened?
    - **S:** Do you feel on the edge all the time?

- **Coffee/tea:**
    - Do you drink a lot of coffee/ tea during the day or before going to sleep?

4.Red flags:

- Physical signs and symptoms
- Depression
- Suicidal ideation
- Alcohol or substance misuse

Scenario 12

You are an FY2 doctor in GP surgery. A 60-year-old lady has made a non-urgent appointment to see you. She has had Rheumatoid Arthritis for 5 years and she is on Methotrexate 7.5 mg weekly, Paracetamol 8 tablets daily and Folic acid 0.4 mg once a day. Assess the patient and discuss management with her.

Patient Information:

You have had difficulty in sleeping for the last 3 months. You go to bed at 10pm but you do not fall asleep until 3 am and you usually wake up 9am if you manage to sleep on time. Your husband died 6 months ago, you miss your husband and you feel that maybe you can't sleep because you can't sleep alone. You have tried different things to help you sleep like reading a book, listening to music and taking a cup of milk mixed with Brandy before going to sleep. However, none of these helped. You drink 1 coffee or tea at 1pm in the afternoon and then you take a nap. You are not in pain; you just don't understand why you are unable to sleep. You live alone. You have got 2 daughters who live in Manchester and Birmingham, they visit you regularly. You have no financial problems, as your husband left you a lot of money. You are coping very well making your way around, you do shopping on your own and you continue with your daily activities and you go to a book club every day. You are on methotrexate 7.5mg weekly, paracetamol 8 tablets a day, folic acid once a day

Questions:

1. Your opening sentence: "Doctor, I cannot sleep!"
2. "Doctor, can't you prescribe me sleeping tablets?" (ask only if the candidate does not offer)
3. "Which medication are you going to give me doctor?"
4. If the doctor mentions benzodiazepine, ask him/her "are benzodiazepines safe?"
5. "How long will I need to take these medications for?"

Approach:

GRIPS

History of insomnia

- How long have you not been sleeping well?
- Anything you think could be the cause of this?
- Has it happened before?
- When you go to bed, after how many minutes do you normally fall asleep?
- How many hours do you sleep continuously?
- When you wake up in the morning do you feel well rested and refreshed?
- What have you tried so far to help you fall asleep?
- When do you usually wake up?
- Any naps during the day?

History of Rheumatoid Arthritis

- Which joint is affected?
- Any medications? For how long?
- **Social History:** smoking, alcohol, family?

Rule out depression

Assess mood (1-10)

Differential Diagnosis

MAFTOSA, hobbies

ICE

Effects of insomnia on daily life

- Has this lack of sleep affected your quality of life?
- How is your concentration during the day?
- Has your performance during the day been affected?
- Has this affected relationship with your partner (if married)?

Examinations:

- Observations
- Examinations of the hand (Rheumatoid hand arthritis)

Management:

<u>Principles of sleep hygiene</u>

The few things you can improve on are:

- Do not go to bed until you feel sleepy
- Don't stay in bed if you are not sleepy
- Avoid daytime naps
- Establish a regular bedtime routine
- Reserve a room for sleep only (if possible). Do not eat, read, work or watch TV in it
- Make sure the bedroom and bed are comfortable and avoid extreme of noise and temperature
- Avoid caffeine, alcohol and nicotine
- Have a warm bath and a warm milky drink at bedtime
- Take regular exercise, but avoid late night exercise
- Monitor your sleep with a sleep diary (record both times of your sleep and quality)

<u>Drug treatment</u>

Benzodiazepines – temazepam or zopiclone for a short period of time and to be used on alternative days

Side effects:

1. Drowsiness / confusion
2. Falls
3. Amnesia
4. Dependence

MINI MENTAL STATE EXAMINATION:

History of presenting complaint

Differential Diagnosis:

- Dementia
- Normal age-related memory changes
- Mild cognitive impairment
- Depression
- Delirium
- Vitamin deficiency
- Hypothyroidism
- Adverse drug effects
- Normal pressure hydrocephalus
- Sensory deficits

Questions on differential diagnosis:

Dementia:

- **Suspect dementia if any of the following are reported by the person and/or their family/carer:**
    - **Cognitive impairment, including:**
        - Memory problems, have difficulty learning new information or remembering recent events or people's names, be vague with dates, and/or miss appointments.
        - Receptive or expressive dysphasia.
        - Difficulty in carrying out coordinated movements such as dressing.
        - Disorientation and unawareness of the time and place.
        - Impairment of executive function, such as difficulties with planning and problem solving.

    - **Behavioural and psychological symptoms of dementia (BPSD) tend to fluctuate, may last for 6 months or more and include:**

- Psychosis — the person may have delusions (which may be persecutory) and/or hallucinations (visual and auditory).
- Agitation and emotional lability — the person may be easily upset, argumentative, shout, have mood swings, and/or be physically and verbally aggressive.
- Depression and anxiety — the person may follow their carer around. The onset of depression in later life is a warning sign of dementia.
- Withdrawal or apathy.
- Disinhibition — the person may exhibit social or sexually inappropriate behaviour.
- Motor disturbance — wandering, restlessness, pacing, and repetitive activity may be reported.
- Sleep cycle disturbance or insomnia.
- Tendency to repeat phrases or questions.

- **Difficulties with activities of daily living (ADLs):**
  - In the early stages of dementia this may lead to neglect of household tasks, nutrition (causing weight loss), personal hygiene, and grooming. People with dementia who are in employment may find that they are increasingly making mistakes at work.
  - In the later stages, basic ADLs such as dressing, eating, and walking become affected.

- **Symptoms related to specific subtypes of dementia include**:

  -For Alzheimer's disease:

  - Early impairment of episodic memory — this may include memory loss for recent events, repeated questioning, and difficulty learning new information.

-For vascular dementia:

- Stepwise increases in the severity of symptoms — subcortical ischaemic vascular dementia may present insidiously with gait & attention problems and changes in personality.
- Focal neurological signs (such as hemiparesis or visual field defects) may be present.

-For dementia with Lewy bodies:

- Repeated falls, syncope or transient loss of consciousness, severe sensitivity to antipsychotics, delusions, and hallucinations may be present. Memory impairment may not be apparent in early stages.
- Parkinsonian motor features (such as shuffling gait, rigidity, slow movement [bradykinesia], and loss of spontaneous movement) and autonomic dysfunction (such as postural hypotension, difficulty in swallowing, and incontinence or constipation) may be present.

-For frontotemporal dementia (FTD):

- Personality change and behavioural disturbance (such as apathy or social/sexual disinhibition) may develop insidiously.
- Other cognitive functions (such as memory and perception) may be relatively preserved.

To assess a person with suspected dementia:

- **Take a history from the person (and, if possible, a close informant) asking about:**
  - **Cognitive symptoms:**
    - Do you have problems remembering things, places, names?
    - Do you have difficulty learning new information?
    - Do you tend to miss appointments?
    - Do you have difficulty putting words together to make meaning?
    - Do you have difficulty dressing?
    - Are you always oriented to time and place?
    - Do you feel that your judgment has been affected?
    - Do you have difficulty planning, solving problems?
  - **Behavioural and Psychological symptoms:**

- Do you believe in ideas that other people do not agree with?
- Do you hear voices or see things which others cannot hear or see?
- How is your mood? Do you easily get upset or irritated?
- Have you ever become aggressive towards others, physically or verbally?
- Do you feel that you have lost interest in life and daily activities?
- Any inappropriate sexual behaviour in front of others?
- Any restlessness, wandering or pacing?
- How is your sleep? Do you sleep well? Enough hours?
- Do you tend to repeat phrases?

- **Impacts on daily activities:**
- Are you able to carry out your daily activities such as dressing, eating, cleaning and shopping?
- Do you work? Are you able to continue your work as usual?
- Any signs of neglect? Personal hygiene or household tasks?
- Safety at home?
- Driving?

- **Ask about factors which may trigger or exacerbate behavioural or psychological symptoms of dementia:**
- Comorbidities such as stroke, depression and epilepsy.
- Acute illnesses such as UTI, constipation, dehydration, anaemia and delirium.

UT
Pneumonia
Constipation.

- **Risk factors:**
- Cardiovascular risk factors
- Family history of genetic causes of dementia
- Learning difficulties
- Neurological conditions such as stroke and Parkinson's disease.

- **Drugs** — Benzodiazepines, anticholinergic drugs and analgesics.

- **Discuss the possibility of dementia:**

- Explain why a more detailed assessment is advisable, and ask the person if they would like to know the diagnosis and who else they would like to be involved and informed.

- **Assess cognition:**
- Use a standardised tool such as the Mini-Mental State Examination (MMSE), see below.

DDs:

Normal age-related memory changes:

- Do you occasionally forget where you put your regular things like keys, glasses?
- Do you pause sometimes to remember directions but you can still find your way?
- Are you still able to carry on your daily activities?
- Do you experience difficulty finding the words but no trouble holding a conversation?

Normal age-related memory changes	Symptoms that may indicate dementia
Able to function independently and pursue normal activities, despite occasional memory lapses	Difficulty performing simple tasks (paying bills, dressing appropriately, washing up); forgetting how to do things you've done many times
Able to recall and describe incidents of forgetfulness	Unable to recall or describe specific instances where memory loss caused problems
May pause to remember directions, but doesn't get lost in familiar places	Gets lost or disoriented even in familiar places; unable to follow directions
Occasional difficulty finding the right word, but no trouble holding a conversation	Words are frequently forgotten, misused, or garbled; Repeats phrases and stories in same conversation

Judgment and decision-making ability the same as always	Trouble making choices; May show poor judgment or behave in socially inappropriate ways

Do you feel that your judgment and decision making has been affected?

Mild cognitive impairment:

- Do you frequently lose or misplace things?
- Do you often forget events, appointments or conversations?

Depression:

- Have you been through difficult times recently?
- How is your mood, sleep, appetite, energy level?
- Do you feel like you have lost interest in life or hobbies you used to like?

Delirium:

- Do you have any memory problems?
- Do you have difficulty concentrating?
- Do you feel distracted and unable to follow a conversation?
- Do you hear or see things which others cannot hear or see?
- How is your mood? Do you feel angry, agitated?
- Do you feel drowsy? How is your sleep?

Vitamin B12 deficiency:

- Have you been experiencing any loss of sensation?
- Any muscle weakness?
- Do you have any headaches?
- Any palpitations?
- Have you been having any problems with your vision?

Hypothyroidism:

- Do you have any constipation?
- Have you been gaining weight?
- Do you feel cold when others are comfortable?

Adverse drug effects:

- Sleeping pills, antihistamines, muscle relaxants, anticholinergic drugs, antidepressants and anti-anxiety medications

Normal pressure hydrocephalus:

(Progressively worsening memory lapses, personality and mood disturbances, difficulty walking, dementia, urinary incontinence.)

- Do you have any difficulty walking?
- Do you feel that you do not have control over your bladder or bowels?
- Do you have any memory problems?
- How is your mood?

Sensory deficits:

- Have you been having any difficulty hearing?
- Do you have any problems with your vision?

Red flags:

- Falls
- Head injury
- Bereavement
- History of cancer
- Rapidly progressing symptoms
- Severe disability and risk to independence
- Confusional state
- Systemic symptoms, such as fever, night sweats or weight loss

Scenario A: 42 GP 65 lady concerns: falls and address · mixing up Dates & App. Forgets things from time to time · But she's never got lost on the street. She says I'm fine - I'm just busy. I'm fine doc · my daughter asked me to come. She denies but didn't drink today. Family Hx of Alzheimer. Diabetic failed self-admin. Mother is a retired judge Patient: annoyed · saying I'm fine. MMSE 26/30.

26/30 is abnormal for highly educated. So referral to memory Clinic. MMSE can miss cognitive impairment in highly educated.

Take Hx of forgetfulness — Cognitive changes.

Take Social, Behavioural changes, emotions mood.

Have you been acting strange.

→ Depression / Anxiety

→ IMAFTUSA.

Exam: Neurological: exam including gait, Hearing & MMSE.

I'll also like to listen to heart & lungs just to be on the safe side. In most situations 26/30 is normal but in your case its borderline since you're highly educated: this may I'll advise a detailed assessment. I was hoping if i could refer you to a memory clinic. I do need to ask you if a suspicion becomes a reality & do you want me know - as you do have the right not to know. I can imagine how alarming it might be.

Scenario B: Not a judge. No fam Hx. MMSE 22/30. Done by Nurse. Refer to memory clinic.

Mini Mental State Examination:

ORIENTATION (accept only the exact answer):

A. Time

- Year: What year is it?
- Season: What season is it?
- Month: What month of the year is it?
- Date: What is today's date?
- Day: What day of the week is it?

NB: Allow 10 seconds for each answer. Score one point for each correct answer.

A. Place:

- Country: What country are we in?
- County: What county are we in?
- City: What city are we in?
- Building: What is the name of the building we are in?
- Floor: Which floor of the building are we on?

NB: Allow 10 seconds for each answer. Score one point for each correct answer.

REGISTRATION:

- I am going to name three objects. After I have said all three objects, I would like you to repeat them. Please remember them because I am going to ask you to name them again in a few minutes.
- Can you please say, APPLE, PENNY, TABLE?

NB: You need to say the three words to the patient very slowly, at the rate of one word per second.

Score one point for each correct reply ONLY on the first attempt. (Total of three points.) Allow 20 seconds to reply.

If the patient did not repeat all three objects correctly, repeat them until they have learned it, or for a maximum of five times. But remember you are scoring the patient for the first attempt only. The reason we are repeating up to five times is because the patient needs to learn the words so that you can ask him to repeat them after a few minutes.

ATTENTION:

Firstly, spell the word WORLD.

You can help the patient spell the word correctly. If the patient cannot spell the word WORLD forwards, there is no point asking him to spell it backwards.

Once they have managed to spell it correctly, then say, "Now can you spell it backwards please?"

If the patient failed to spell WORLD then score 0. There is no point in asking them to spell it backwards if they can't spell it forwards. Allow 30 seconds to spell it backwards.

Score 1 point for each correct letter, until the order is lost. For example, if they say 'D, L, O, R, W' then the score is 2.

RECALL:

Ask for the names of the three objects the patient learned earlier.

Say, "Now what were those three objects that I asked you to remember?"

Allow 10 seconds for the answer. Score one point for each correct answer.

LANGUAGE:

A. Object identification:

Show the patient a piece of paper and say, "What is this called?"

Show the patient another object e.g. a pen "What is this called?"

Score one for each correct answer.

B. Repeat a phrase:

I would like you to repeat a phrase after me: "No ifs, ands or buts"

Accept the exact answer only. Allow 10 seconds for the answer. Score 1 for the correct answer.

C. Reading:

Write down a phrase in capital letters – CLOSE YOUR EYES.

Then say, "Read the words on this paper and then do what it says."

Score one point only if the patient closes his eyes, not just for reading. Allow 10 seconds to do it.

D. Write a sentence:

Give the patient a piece of paper and pen.

Then say, "Can you please write a full sentence on this piece of paper?"

Allow 10 seconds to write the sentence. Score 1 point if the sentence makes sense (ignore any spelling errors).

E. Three part task:

"Can you please pick up this piece of paper in your right hand, fold it into two and place it back on the table?"

Allow 30 seconds to complete this task. Score one point for each instruction that is correctly executed.

COPYING:

Ask the patient to copy intersecting pentagons. Say, "Please can you copy this design."

Allow several tries until the patient is finished, maximum one minute.

Score one point for a correctly copied diagram. The patient must draw two five-sided pentagons which are intersecting at two points.

Score	MMSE
Mild Alzheimer's disease	21-26
Moderate Alzheimer's disease	10-20
Moderately severe Alzheimer's disease	10-14
Severe Alzheimer's disease	Less than 1

Exam tip: Do not fight with the patient if he grabs the scoring paper from you.

Scenario 39

You are an FY2 doctor in Acute Medical Unit. A 70-year-old man was found wandering in the park and was brought to the hospital by 2 policemen. Assess the patient's confusion and discuss management with the examiner after 6 minutes.

Patient Information:

- Which floor are we on? This floor -- use your leg to demonstrate
- Which country are we in? France
- Which county are we in? Yorkshire
- Apple, Penny, Table: repeat after each word unless the doctor stops you from doing so
- When asked to spell the word WORLD backwards say it as "DAWARD"
- Tell the patient and spell it for him like. W for whisky, O for Oscar, R for Rose, L for Lima, D for Delta.
- Recall: When asked to recall the three words respond "Which words did you tell me?"
- When the doctor asks you to name 2 objects, you are able to name 1 object but on the second object reply "I know this but I've forgotten the name"
- When asked to repeat "no ifs, ands or buts" reply as "no ifs, buts, buts"
- If the doctor asks you to read a sentence CLOSE YOUR EYES and do what it says correctly, do it correctly but keep your eyes closed until the doctor asks you to open your eyes.
- When the candidate asks you to write something during assessment write: "Good luck in your exam"
- When asked to take a piece of paper, fold it into two and give back, follow the first two instructions correctly but do not give the paper back.
- When asked to draw two pentagons that intersect with each other on two points draw the two pentagons but do not intersect them. If the doctor asks you to try again tell them you are tired you don't want to do it.

Comments and Questions:

During the interview, you get distracted easily and you make comments:

"Very nice weather today"

"Doctor why are you asking these questions?"

Approach:

- **GRIPS**
- Assess patient and discuss management with examiner.
- Prepare the patient, ask the following before you start:

  Can I just check, do you have any…?
  - Hearing problem.
  - Visual problems.
  - Are you able to read and write?
- Complete the assessment

- **Management with the Examiner:**

What is your assessment? (Patient has cognition impairment)

How will you manage this patient? (I will perform dementia screening)

- Full Blood Count (anaemia, acute infection)
- TFT, LFTs, U&Es
- Infection screening (Syphilis, HIV, Hepatitis)
- CT scan head looking for atrophic changes or subdural hematomas
- Blood Glucose
- Investigate for UTI
- CXR
- Iron, Folate levels, B12, Ferritin
- Urine Dipstick
- Ceruloplasmin (for Wilson's disease)
- CJD Disease (check for prion)
- Refer the patient to the memory clinic

NB:

1. Use piece of paper and pen to record your marks.
2. Be ready to repeat information e.g. Who are you? Where are we? Thank you very much. Are you ready for the first question? Speak slow and clear.
3. Please ensure to use a pen and piece of paper to mark his score. Ask patient to repeat the information.

Self-harm / overdose:

- **Undertake a risk assessment in all people presenting following an act of self-harm.**
    - Ensure that a sensitive and compassionate approach is used to minimize the person's distress.
    - Where possible, the person should initially be seen alone, to maintain confidentiality
    - Assess risks after any subsequent episode of self-harm because risks associated with each episode may change significantly.
- **Assess the physical risks from the act of self-harm**, such as acute bleeding following self-cutting, or risk of acute liver failure following paracetamol ingestion.
- **Assess for the risk of psychological harm and the risk of further self-harm or suicide** by exploring the person's feelings including hopelessness, continuing suicidal intent, understanding of their own self-harm, level of emotional distress, mental state, and the possible presence of an associated mental health disorder, such as depression or schizophrenia.
- **Assess for any safeguarding concerns in children, young people, or vulnerable adults.**

The purpose of a suicide risk assessment is to;

- Establish the patient's intent
- Assess the seriousness and perceived seriousness of their attempt
- Assess how they feel about the attempt at the time of assessment

<u>Key questions to ask about the current episode of self-harm</u>

It's best to think about this in terms of before, during, and after…

<u>Before</u>

- Was there a precipitant? (e.g. argument with spouse/recent bereavement)

Would you like to tell me more about what happened?

- Was it planned, or impulsive?
- Did you carry out any final acts like writing a note or leaving a will?

- Have you terminated any contracts (e.g. mobile phone, gas and electricity)
- Were any precautions taken against discovery?
- Did you close the curtains?
- Did you lock the door?
- Were you alone at home? Did you wait for everybody to leave the house?

<u>During</u>

- What method of self-harm was involved?
- Where were you when you self-harmed?
- What was going through your mind at the time?
- What were your intentions when you self-harmed/ took the tablets?
- Did you think this self-harm would kill you?
- What did you do straight after the self-harm?

<u>After</u>

- Did you call anyone? How did you get to the A&E? Who were you found by?
- How did you feel when help arrived?
- How do you feel about the attempt now? Do they regret it?
- How is your current mood?
- Do you still feel suicidal?
- If you were to go home today what would you do? (make sure you cover the next few days)
- If you were to feel like this again, what might you do differently?
- What might prevent you from doing this again in the future? Is there anything to live for? (protective factors)
- Are you willing to accept treatment?

Specific questions to ask about overdose

- What medication did you take?
- Where did you get the medication from?
- How much of the medication did you take?
- What did you take the medication with?
- What did you think that amount of medication that you took would do?

- What made you decide to take the medication/how long have you been thinking about taking an overdose for?
- What did you do after taking the medication?
- How did you get to hospital?

Specific questions to ask about cutting:

- Where are the cuts?
- Number of cuts?
- How deep are the cuts?
- Can you describe how you felt whilst cutting?
- How did you feel when you saw your blood?
- What were you hoping the cutting would do?

Risk factors:

- **Intake of alcohol at the time of overdose:** Did you drink any alcohol just before you took the tablets?
- **Any use of drug abuse:** Is there any chance you use recreational drugs?
- **Any previous low mood (depression):** Have you ever been diagnosed with depression? Have you ever had any symptoms of low mood, poor sleep or waking up in the morning very early? How are your energy levels? How is your appetite? How long have you had these symptoms?
- **Any mental health problems:** Have you ever been diagnosed with any mental health problems?
- **Any regular medications:** Do you take any regular medications?
- **Previous self-harm and methods used:** Have you ever tried to harm yourself in the past? What did you do?
- **Any other relationship:** Do you have any brothers or sisters? Are they supportive? Are you very close to your family? Is there anyone you feel free to speak to about your problems?
- **Employed or not, any financial or housing problems:** What do you do for a living? Do you have any financial or housing problems?

- **Family history of suicide or self-harm:** Sorry to ask you this question. Is there anyone in the family who ever suffered self-harm? Is there anyone in your family with mental health problems?
- Do you think you need help with this?
- Do you hear voices when there is nobody around you?
- Do you have beliefs, which other people disagree with?
- Do you think other people are putting thoughts into your head?
- Do have a family?
- Who do you live with? (FAMISH)

Screen for other mental health disorders which increase the risk of suicide

Depression:

- Check for the cardinal symptoms
- Anhedonia
- Low mood
- Fatigue

Psychosis:

- Do you ever feel like there are voices that you can hear telling you to harm yourself, that no one else can hear?

Alcohol dependency (particularly if used during self-harm episode)

Anorexia

Scenario 28

You are an FY2 doctor in the Psychiatric department. A 16-year-old girl took an overdose of oral contraceptive pills last night and cut her wrists this morning. She has been seen by A&E doctors who declared her fit for discharge. Assess the patient and address her concerns.

Patient information:

- You took an overdose of OCPs (16 tablets of your mum's OCP) because you thought you were pregnant and you wanted to get rid of the pregnancy as your period was one week late.
- You told your boyfriend, who is 16 year old, that you could be pregnant but he acted angrily and was not interested in your pregnancy, that annoyed you and you cut your wrists.
- You came to the hospital on your own, you regret your action and you feel stupid about it.
- You live with your mum and you did not tell her as you don't think she would understand but you are sure she will find out soon once she starts looking for her pills.
- You are normally fit and well and not on any medications.

Questions:

1. "Doctor, I feel stupid about what I have done"
2. I just freaked out when I found out that my period was late by 1 week.
3. If the doctor suggests that you should talk to your parents or friends tell him/her that you will think about it.
4. Can I go home now?
5. Will I be pregnant?
6. When can I go home?

e what made you take OCPs?

questions about the during overdose & cutting after.

APPROACH: (negotiating approach)

→ FANISH omit age inappropriate questions.

1. GRIPS

- Avoid shaking hands

2. Questions about the overdose

3. Questions about wrist cutting

4. Suicidal risk assessment

5. Assess for risk factors

5. Screen for other mental health disorders depression, alcohol.

6. Pregnancy history:

- When was your LMP?
- Did you perform a pregnancy test at home?
- Did the A & E doctors perform a pregnancy test?
- When did you have unprotected sexual intercourse?

7. MAFTOSA

8. ICE

- Do your parents know that you are in a sexual relationship?
- Ask if there is any particular reason she didn't tell her parents?
- Explain that the parents were also of her age and they may understand

9. Management (this patient has low suicide risk)

1. Arrange a pregnancy test now.
2. Explain that there is no contraception which is recommended because of your late periods. Contraception can prevent pregnancy but they would not get rid of the pregnancy.
3. Because if you were already pregnant, none of the contraceptions would work.
4. Allow discharge home, after taking a second opinion, from a senior colleague.
5. Arrange community psychiatry follow up.
6. Advice to see the GP to discuss long term contraception in oder to avoid similar situations in the future.
7. Explain that you will take a second opinion before she goes home.
8. And that you will give her a crisis card
   - It has the name and telephone number of someone you can call if you feel low and you feel like talking to someone.

I understand that sometimes when we're distracted we do stuff that we dont want to do but there are some important aspects you need to know about contraception.
I feel strongly you are ok & I'm happy to go home.
Just so you can check how you're doing in a few weeks time.
Arrange community psychiatrics follow up.

Drug abuse:

Aims of assessment

- Treating any emergency problem.
- Confirming the patient is taking drugs (history, examination, drug testing).
- Assessing the degree of dependence.
- Identifying physical and mental health problems.
- Identifying social problems: housing, employment, domestic violence, offending.
- Assessing risk behaviour.
- Determining expectations of treatment and desire to change.
- Determining the need for substitute medication.
- Assessing competency of young people to consent to treatment and involving those with parental responsibility as appropriate.
- Assessing any risk to dependent children of drug-misusing parents.
- In private practice, ensuring the patient is able to pay for treatment by legitimate means.
- Providing access to sterile injecting equipment and safe needle disposal as needed.
- Providing testing for hepatitis and HIV.
- Providing immunisation against hepatitis B.
- Determining the most appropriate level of expertise to manage the patient. Referral or liaison with specialist services may be needed.
- Notification of the patient to the relevant national drug monitoring system.

DRUG ABUSE

Assessment of current drug and alcohol use:

History:

Types of drugs used: which one have you been using?

- Which recreational drugs have you been using?

Quantity, frequency and pattern of use:

- How much do you use in a day? How often do you use these recreational drugs?
- How did you start using these drugs? Was there anything that forced you into it?

Route of administration:

- How do you take these drugs? Do you smoke them or do you inject yourself? If injecting, do you share needles?

Symptoms of dependence:

- Do you think you have to increase the amount of drug to achieve the same effect?
- What happens if you do not use these drugs for a day or two? Do you experience any problems? If yes, what exactly happens?

Source of drug (including preparation):

- Where do you get these drugs from?
- Do you take them on your own or with your friends?

Prescribed medication:

- Do you have any medical problems? Do you use any regular medications?

Tobacco use:

- Do you smoke? If yes, what do you smoke and for how long?

Alcohol use, including quantity, frequency and pattern of use:

- Do you drink alcohol? How much do you drink and how often?

Assessment of social functioning:

Issues covered should include:

- **Partners, family and support:** Do you have any family, friends? If you were to stop, do you think your family or friend will support you?
- **Housing:** Where do you live? Who do you live with? Do you have any problems with housing?
- **Education:** What do you do? What qualifications do you have?
- **Employment:** What do you do for a living?
- **Domestic violence.**
- **Benefits and financial problems:** How do you finance yourself? How do you get the money to buy drugs?
- **Childcare issues - pregnancy, parenting, child protection:** Do you have any children? Do you take these drugs in their presence?

Assessment of criminal involvement and offending:

- Have you ever been arrested for any offence?
- Have you ever had any problems with the law?
- Have you received any warrants?
- Have you ever been accused of any criminal activities?

🚩 **Red flags:**

- Sharing of needles or other equipment
- High drug use
- Using cocktails of drugs or polydrug use
- Suicidal ideation
- Hepatitis B or C infection
- HIV infection
- Opioid users who have been abstinent (increased risk of overdose-related death)

Assessment of physical and psychological health:

History taking should cover the following:

- Presenting symptoms and perceptions as to why this consultation is taking place.
- Past medical history.
- Psychiatric history and any current symptoms.
- Drug-related complications: abscesses, venous thromboses, septicaemia, endocarditis, constipation.
- History of accidental/deliberate overdose.
- Current or past infection with blood-borne viruses.
- Cervical screening, menstrual and pregnancy history in women.
- Sexual health and sexually transmitted infection history and contraceptive use.
- Oral health.
- Current prescribed and non-prescribed medication.
- Allergies and sensitivities.

for Drug Dependance DOB Name, Address, Phone.
Phone Consultation: Identity.
Is it a good time to talk?
Fortunately, I have some Pmp news to tell you.
As you came for your blood tests in the morning. Unfortunately,
I mislabelled your blood tests. Dependson tone of your voice.

Scenario 64

You are an FY2 doctor in Alcohol and Substance Misuse Clinic. A 32-year-old man, who has been using drugs for a while, has come to your clinic with the intention to stop using recreational drugs. Assess the patient for drug dependency and address his concerns.

Patient Information:

You have been using recreational drugs (LSD, Sorbent and Heroin) for 4 years and in the last 2 years you have been injecting yourself with heroin.You live with your girlfriend who has asked you to come to the clinic to seek help regarding your use of recreational drugs. She also uses drugs but not regularly. You have never tried to give up before and you know about the needle exchange program but you do not always use it. You are not working at the moment and sometimes your girlfriend helps you financially. Your family (parents) is not talking to you due to drug problems. You smoke 40 cigarettes a day for the last 15 years and you drink 20- 30 units of Alcohol per week. If you don't use drugs for 3 to 4 days you develop runny nose, headaches, difficulty in sleeping, muscle cramps, and agitation. You last used drugs 4 days ago. You are developing withdrawal symptoms at the moment (you are shivering, look agitated, not making eye contact).

Questions:

1. If the doctor says he will give you some medications, ask him "which medication are you going to give me?
2. How long would I be taking this medication you are suggesting for?"

Approach:

- **GRIPS**
- **History:**
  - Assess current drug and alcohol use
  - Assess social functioning
  - Assess criminal involvement
  - Red flags
  - Assess the mood

which.
How much.
Since when
Where do you get it from?
Do you do with friends.
How do you inject it?
Do you share needles.
Do you feel you have to use
symptoms when you don't take it.

family
friends
job
employment.
forensic

- On a scale of 1-10, how would you rate your mood?
- MAFTOSA

- **Examinations:**
  - Observations
  - Assessment of injection sites if injecting/injected in the past: limbs, groins, etc
  - General assessment of respiratory, cardiovascular and other systems depending on history/presenting symptoms.
- **Management:**

- Explain that a urine test will be required to confirm which drug is in your body.
- Explain that a blood test (FBC, U&Es will be done to check the general health and suggest to test for HIV and Hepatitis infection.
- ECG.
- Assess the desire to quit drugs - "Have you made up your mind to stop using drugs?" "What has motivated you?" "What happens if you do not use drugs for one or two days?" I feel you have withdrawal symptoms.
- Ask if he knows about the needle exchange program, if not explain that should he never inject himself with drugs, it's better to use the needle exchange program in order to prevent infection.
- Explain that the medication (Methadone) will be prescribed to him to stop the withdrawal symptoms. But it may take a few weeks before we can control the symptoms completely. So the first few days you may have mild symptoms of withdrawal.
- Comment on the behaviour:
- I can see that you are anxious and unsettled. That can be a withdrawal effect of the opiates.
- Explain that he is likely to remain on this medication for one to two years in order to increase his chance of stopping the use of drugs.
- Refer to self-help group. (Where you can talk to others)
- Smoking - Advise to stop
- Alcohol - Advise him to cut down the amount of alcohol he is taking. Explain that people who drink too much are more likely to go back to use of recreational drugs. Would you consider cutting down on alcohol to less than 40 units per week?
- We will arrange a regular follow up and monitor your progress.

- Take a second opinion from your seniors and if there is anything else that needs to be done, you will inform him.
- NOTE: Methadone is given as a syrup (liquid form of medication) and it is initially given by the pharmacist. It should be taken in front of doctor or pharmacist.

Alcohol Dependence

Details of alcohol intake:

- When did you have your first drink? – Was it a good/bad experience?
- When did you notice your alcohol intake increase?
- "Did your drinking gradually increase, or was the increase sudden?"
- "Is there anything in your life you feel caused your intake to increase?" (think adverse life events)

Current drinking pattern:

- Every day or weekends?
- Time of day – mornings / evenings / all day

Quantify and clarify intake:

- "How much do you drink, in an average day?"
- "What do you drink? When?"
- "How much do you drink at that time?"
- "Where do you tend to drink?"
- "Who do you drink with?"
- "What do you drink in a week?"
- "Is there anything that makes you drink more/less in a day?"
- "How much do you spend on alcohol?"

Assess Alcohol Dependence using CAGETW or TWEAK:

C – Cut down

A – Annoyed

G – Guilty about drinking

E – Eye-opener

T – Tolerance

W - Withdrawal

C – Have you ever felt that you need to cut down on your drinking?

A – Have you ever got annoyed because other people are concerned about your drinking?

G – Have you ever felt guilty because of the way you drink?

E - Have you ever used alcohol as an eye-opener in the morning?

T – Do you feel that you have to increase the amount of alcohol you drink to achieve the same effect?

W – What happens if you do not drink for a day or two?

OR

Tolerance - Do you have an increased tolerance to alcohol?

Worried - Do you worry about your drinking habit?

Eye opener - Have you ever had alcohol as an eye-opener in the morning?

Amnesia - Do you ever get amnesia after drinking alcohol?

K Cut (K) Down - Do you sometimes feel the need to cut down on your drinking?

<u>Effects on daily living:</u>

Diet – adequate intake? / type of food (balanced?) / eating pattern?

Occupation – Are you working? / what is your job? / is it impacted by drinking?

Relationships – has alcohol impacted your friendships/relationships?

Alcohol-related crime? – particularly aggression, drunk and disorderly, drink driving

"Have you been in contact with the police as a result of alcohol-related incidents?"

Living situation? – where do you live / who do you live with?

Previous attempts at abstinence:

"Have you ever tried to stop drinking before? Why?"

"Why do you think it was unsuccessful? "

If not already revealed, assess desire to stop drinking

Psychological assessment

"Lastly, I'm just going to ask some questions about your mood. These may seem a little strange, but we ask them to everyone who comes in with issues like this."

Assess risk

Assess risk to self:

- "How has your mood been?"
- "How is your appetite?"
- "What is your sleeping pattern like?"
- "Are there things you enjoy in life? What?"
- "How is your concentration?"
- "Have you had any thoughts of hurting yourself?"
- "Have you ever thought of ending it all? If so, any plans?"

Assess risk to others:

- "Do you ever have thoughts of harming others?"
- Note who is at home – if any dependents etc

Red flags:

- Lack of control
- Concern about alcohol intake expressed by the patients or others
- Signs of liver disease
- Gastrointestinal problems in conjunction with depression
- Alcohol dependency
- Suicidal ideas
- Loss of employment
- Mental health problems, including depression, anxiety and insomnia

Scenario 30

You are an FY2 doctor in the Gynaecology department. A 55 year-old-lady came to the hospital with per vaginal bleed, she had hysterectomy done and now she is ready to be discharged. One of the nurses has asked you to see the patient because she overheard the patient talking about drinking excessive amounts of alcohol. Assess the patient for alcohol dependency and address her concerns.

Patient information:

You work at a bar and you drink as a matter of habit with your friends and customers. You have been drinking since the age of 18 and you have never had a day without alcohol. Sometimes you take whisky in the morning as an eye opener. You usually drink 2 units per day but a bit more over the weekend. Lately you have increased the amount of your intake and you do not want to cut down but you may think about it. You get annoyed when someone asks about your drinking habits and If the doctor says "Have you ever got annoyed if someone asks about your drinking habit?" you should reply as follows: "Doctor, I am getting annoyed right now with your questions about my drinking habits".

Questions:

- If the doctor refers you to the alcohol anonymous team, ask him: What will happen if I go there?
- Do I need to cut down completely? Or I can just reduce the amount of alcohol I take?

Approach:

GRIPS

Take history:

Questions about hysterectomy

Take details of alcohol intake

Assess alcohol dependence

- Do you know the normal recommended alcohol units per week?

- The number of units you are drinking depends on the strength and size of your drink. Some of them maybe 9%, 11%, 12% up to 15%. Do you know what is the alcohol % of the wine you usually drink?
    - If the patient says a glass, explain that there are different sizes of glasses.
- How are you with mathematics? You can actually calculate the number of alcohol units you take and we will give you a leaflet that can show you how to find out exactly how much you drink.
- In your situation you may be just within the normal limits as mentioned above. What do you think of yourself? Do you feel that you need to cut down?
- I think it may be a good idea for you t

125 ml glass	1.4 – 1.8 units
175 ml glass	1.9 – 2.4 units
250 ml glass	2.8 – 3.5 units
750 ml glass	8.2 – 10.5 units

o just keep a dairy of your alcohol consumption.

Effects on daily living

Risk assessment

Red flags

PMH & Drug History

Explanation:

- From what you have told me: you do get annoyed when people sometimes ask you about your drinking habits and you have had to increase the amount of alcohol that you take in order to have the same effects and you also you don't feel too well if you do not drink for a few days. These are signs that your body is becoming dependent on alcohol without you knowing about it.
- As you may already know the amount of alcohol you drink is above the recommended amount which is:
    - 14 units/week for Women
    - 14 units/week for Men

- Have you ever thought about cutting down the amount of alcohol you drink?

- Explain the effects of excessive alcohol.
- Drinking this much of alcohol sometimes can cause damage to the liver and other organs in your brain. It can also have an impact on your personal and family life.
- We are concerned about the long-term effects of your habits
- Your body may become dependent on alcohol which will make it difficult to stop drinking.
- Do you think it is something you can try and cut down?

MANAGEMENT:

- If the patient agrees to cut down the alcohol intake then ask them: should I tell you the help that is available for you?
- Who do you normally drink with? If you were to stop drinking or cut down your consumption, do you think that your friends/customers would be okay with that? Do you feel that they would be happy for you?
- We have different ways in which we can help:
- Do you think you would need an AA team to help you cut down on alcohol?
- We can refer to the AA team if you feel that you need motivation in trying to stop.
- Alcohol Anonymous groups – Is a support group for people who are alcoholics or with drinking problems. The only requirement for someone to go there is the desire to quit drinking.
- What usually happens there is that people usually sit in a group and share their experience about what type of things have helped them cut down or quit alcohol.

(i) AA Meetings

There 2 types of AA meetings:

- **Open Meeting**

- In open meetings, if you have a family member or a friend who want to support you, they can come along as well.

- **Closed Meeting**

- Only alcoholics or people with alcohol problems can attend.

Anonymity is treated seriously and things which are discussed there are usually kept confidential.

(ii) Other forms of support:

1. Cognitive behavioural therapy "This is talking therapy". It helps identify thoughts or beliefs that may contribute to alcohol dependence.
   - For example
     - Some people feel or think that they cannot relax without alcohol
     - Fear of losing friends if they stop drinking alcohol
     - Drinking just a few pints of beer cannot hurt

Do you have any thoughts that may be preventing you from cutting down?
The amount of alcohol you take at the moment, talking therapy can help.

(iii) Family Therapy:

- Are you married?
- What does your husband think about your alcohol consumption?
- We do provide support for families as well.
- If your husband is supportive, he can accompany you to AA

ADVICE

(iv) Diary:

1. Advise them to keep a diary of their alcohol consumption
2. Please record on the daily habits, all the alcoholic drinks you have every day.
3. Record:
   - Type of drinks
   - What time of alcoholic drinks?
   - Where you have your drinks?
   - How many units?

You may not need all of this; it is just to let you know what help is available. Is it something you would be interested in?

For patients who are dependent on alcohol:

- Have you ever tried to cut down before?
- If yes - why did it fail? If it was due to withdrawal symptoms reassure the patient that she would first go through what we call a detoxification program during which the symptoms of withdrawal will be treated.
- Medication for detoxification: Chlordiazepoxide - only if patient has withdrawal symptoms.
- Medication to stop cravings: Acamprosate (only if the patient has cravings)
- Follow up to be made with the GP
- Offer leaflets about alcohol consumpti

Amount of alcohol in units	
Standard glass of wine	2.3U
Large glass of wine	3.3U
Small glass of wine	1.3U

on recommendations.This usually involves admission in a rehab centre for weeks. During this time patient will not be able to drink and symptoms would be managed if he develops any.

NB:

1. Assess desire to stop or cut down on alcohol intake, then refer to AA.
2. Also advise patient to make arrangements with the GP to check how far you have managed.
3. If the patient says she is getting annoyed right now because you are asking about her drinking habits, apologise "I am sorry, I did not mean to offend you. I just wanted to see if we can help you. Are you ok to continue?"
4. Some people find it helpful if they substitute the alcoholic drink with non-alcoholic one.

DAY 4:

History Taking Stations (Part 3)

- **Guillian-Barre syndrome (224)**
- **Obstructive sleep apnoea (188)**
- **Rheumatoid arthritis (191)**
- **Post-herpetic neuralgia (280)**
- **UTI**
  - UTI in a young woman (85)
  - UTI in a young woman (237)
- **Gout (247)**
- **Seizure:**
  - Seizure in a middle aged man (262)
  - Viral encephalitis (117)
- **Jaundice:**
  - Abnormal LFT scenario A – Hepatitis A (55)
  - Abnormal LFT scenario B – Gilbert syndrome (245)
  - Abnormal LFT scenario C – Alcoholic hepatitis (250)
  - Abnormal LFT scenario D – Alcohol misuse (327)
- **Polycystic ovarian syndrome (257)**
- **Analgesic nephropathy (290)**
- **Nose Bleeding in a 40 year old (340)**

Suspected Cancer

First go through approach to Suspected Cancer → Any old patient.

- Cough with haemoptysis (lung cancer) (46)
- Multiple myeloma (268)
- Leukaemia 1 (201)
- Leukaemia 2 (281)
- Dysphagia and upper GI endoscopy explanation (43)
- Haematuria and cystoscopy explanation (77)

back passage.

CANCER.

PMAFTOSA

1. effect of symptoms
2. occupation
3. Do you live alone? so see if anyone to support

Always ask about ICE

Dermatology:

- Basal cell carcinoma (54a)
- Melanoma (54b)
- Squamous cell carcinoma (54c)
- Lipoma (54d)
- Papilloma (54e)
- In rheumatoid arthritis patient (232)
- Seborrhoeic Keratosis (352)

whenever they have any concern, always ask why? then proceed.

Q I want Xray. (we don't to expose you for extra radiation)

examination : lymph nodes + PE (leg)

Examine every DD asked. Hypo – BMI. Bad language. abdomen. urine dipstick. Always start best to worst case scenario. for suspected cancer.

Other skin lesions:
- Acne (183)
- Herpes Labialis (283)
- Infective rash (ringworm) (197)
- Urticaria in a 5 year old (329)
- Scabies (343)
- Cellulitis (353)

Dermatology: Skin lesions / Rash.
Hx of lesions
- How many?
- In any other parts of body?
- Size
- Is it all the same color or gradient in color?
- Is it regular or irregular?
- Is it painful?
- bleeding? (BOPI) Always ask about bleeding in (Derma station)
- oozing?
- itchy?
- Is it increasing in size

Risk Factors.
→ Family Hx
→ Skin Baking
→ Tanning
→ moles.

→ DDs of Derma.
Basal cell carcinoma
melanoma
Squamous cell.
lipoma (mobile)
papilloma
Seborrheic keratosis (itchy or scaly)

Always Ask Abt Self Esteem.
Ask if this lesion is annoying or not making confident.
Exam: obs. Head to toe lymphnodes.

DAY 4

WEAKNESS - GUILLIAN - BARRE SYNDROME (224)

FODPARA

F - Frequency : Does he get the weakness frequently?

O - Onset : Did he get the weakness suddenly or gradually?

D - Duration : For how long?

P - Progression : Do you feel that he is getting worse?

A - Aggravating factors : Is there anything that makes his weakness worse?

R - Relieving factors : Anything makes it better?

A - Associated symptoms.

Differential Diagnosis:

- Multiple sclerosis
- Guillain barre syndrome
- Stroke
- Spinal cord lesion
- Myasthenia gravis

Questions for differential diagnosis

Red Flags

Scenario 224

You are FY 2 in GP surgery. A 45 years old lade has presented with weakness. She had upper respiratory tract infection 2 weeks ago. No antibiotics had been prescribed and the infection has resolved on its own. Assess the patient and discuss initial management with the patient.

Patient information:

You have presented with weakness. You had a viral illness 3 weeks ago which gave you the symptoms of sneezing , cough, fever and sore throat. For the past week you have developed weakness on both of your legs which has been getting worse. In the last few days you have developed weakness of both upper limbs. You are finding it difficult to do things like reaching fot the spoon forks and plates. You work as a taxi driver. You came to hospital today driving. It has been difficult for you to brake or press on the clutch. Your mother is at work; she works as an admin in the hospital. If required, you can call her to come and pick you up and take you to hospital. No past medical history, no regular medications and no allergies.

Q. What is wrong with me?
Q. What will you do for me?
Q. Can I call my mum to come?
Q. What test will you do in the hospital?
Q. Why do I need to go to the hospital right now?

Examiner prompt:

Lower limb:

Gait: Waddling Gait

Inspection: Normal

Power: 3/5

Sensation: Loss of sensation up to the mid-thigh Bilaterally

Reflex: Reduced bilaterally

Tone: Reduced bilaterally

Upper Limb:

Inspection: normal

Power 4/5: bilaterally

Tone: reduced

Sensation: affected up to elbows bilaterally

Reflexes: reduced

Cranial nerves: normal

Fundoscopy: normal

Approach

- Initial Approach or GRIPS
- FODPARA
- Differential Diagnosis
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise
- **Examination**

- Observations
- Neurological examination of upper and lower limbs
- Cranial Nerve exam
- Fundoscopy

- Explain the findings
- **Diagnosis**

This is a condition in which there is damage to nerves in your body. Especially nerves in your feet, limbs and hands causing numbness, weakness and pain.
It can be treated and most people will eventually make a full recovery.
Guillian barre Syndrome is an autoimmune condition, which means the immune system which usually protects us from infections is affected itself.
The nerves in our body are like electrical cables. They are usually covered by insulation.
When the immune system itself is affected, it makes the nerve loses the insulation leading to weakness, loss of sensation and pain.
Initially it affects the legs and then it affects the arms.

- **Management**
    - Admit
    - Refer to Neurologist
    - Offer Leaflets about Guillian Barre Syndrome

1. **Investigations:**
    - Blood tests (FBC, U&E, CRP, ESR, LFT)
    - Lumbar puncture
    - Spirometry, Respiratory Function Tests
    - Nerve conduction studies
    - ECG
    - Specific Antibodies
2. **Treatment:**
    - Plasma exchange (Exchange part of the blood)
    - Intravenous Immunoglobulin (Give you a medication called immunoglobulin)
    - Steroid medication

SOCRATES of abdominal pain

S: Where is exactly the discomfort**?**

O: Did it start gradually or suddenly?

C: Can you describe the pain to me?

R: Is the pain just in one place or has it moved anywhere else?

A: Does anything else happen while you have the pain?

T: Time course

E: Exacerbating/relieving factors

S: Severity

Differential Diagnosis:

- Ectopic pregnancy (missed periods, presence of risk factors: PID/IUCD)
- Pyelonephritis (swinging fever, abdominal pain, pus or blood in urine, generally un-well, vomiting)
- Pelvic inflammatory disease (history of unprotected sexual intercourse or history of change in sexual partners, fever, PV discharge, lower abdominal pain)
- Urinary tract infection (dysuria, frequency, fever, lower abdominal pain)
- Colonic carcinoma (weight loss, change in bowel habits, abdominal pain, per rectal bleeding)
- Gastroenteritis (diarrhoea, vomiting, abdominal pain, history of travel abroad in case of traveller's diarrhoea)
- Bladder stones (pain on urination)
- Ovarian tumour (abdominal bloating, family history, weight loss, pelvic pain)
- Miscarriage

- **Questions for differential diagnosis:**
- **Ectopic pregnancy:**

- When was your last normal menstrual period?
- Have you ever been diagnosed with a condition called Pelvic Inflammatory Disease?
- Do you use any form of contraception?
- Do you use IUCD or have you used IUCD in the past?

- **Pelvic inflammatory disease:**
  - Do you have any PV discharge?
  - Any fevers?
- **Urinary tract infection:**
  - Any burning while passing urine?
  - Are you passing urine more often?
  - Is there blood in the urine?
  - Any fever?
- **Colonic carcinoma:**
  - Have you lost weight?
  - Do you feel tired and lethargic?
  - Any diarrhoea or constipation?
- **Gastroenteritis:**
  - Any fever?
  - Any nausea or vomiting?
  - Do you have diarrhoea?
- **Ureteric stones:**
  - Do you have a history of passing small stones?
  - Does the pain go from flank to groin or from groin to the loin area?
  - Any blood in urine?
- **Ovarian tumour:**
  - Do you have any weight loss?
  - Do you feel bloated?
  - Is there anyone in your family that has been diagnosed with ovarian cancer?

 **Red Flags:**

Swinging fever, persistent fever, back pain, blood in urine, worsening abdominal pain, vomiting

Scenario 85

You are FY 2 in GP surgery. A 25 years old lady presented with lower abdominal discomfort. Take a focused history, make a diagnosis and prescribe the medication to the patient.

Patient information:

- You are a 25-year-old lady who has come to the hospital with abdominal discomfort.
- For the past 5 days you have had lower abdominal (suprapubic) Pain.
- Burning sensation when passing urine, fever and increased frequency of passing urine.
- All the symptoms started 3 days ago.
- Last menstrual period was 2 weeks ago.
- You are worried and planning to have a baby
- You are on folic acid.
- You did the pregnancy test yesterday and it was negative. You have been trying to get pregnant for the past 2 months.
- No allergies
- Otherwise fit and well.

Questions:

Q. What is wrong with me?

Q. What treatment will you give me?

Q. Can I have sex during treatment?

Q. Will this medication affect my pregnancy because I am planning to have a baby.

Approach:

- Initial Approach or GRIPS
- ODPARA
- Differential Diagnosis
-  Red Flags
- Menstrual history
- Sexual History
- MAFTOSA
- ICE
- Effects of Symptoms

- Summarise
- **Examination:**
    - Observations
    - Abdominal exam
- Explain the findings
- **Diagnosis:**

  Explain that it is likely urinary tract infection.
- **Management:**

- Routine bloods (FBC, U&E, LFT, GLUCOSE, CRP)
- Urine dipstick & MC&S
- Urine pregnancy test
- Antibiotics: Nitrofurantoin 50mg BD or Amoxicillin 500mg TDS.

  Otherwise it would be Trimethoprim 200mg D for 3 days.
- Advise to drink plenty of water
- Follow up with GP in 5 days time
- Leaflets

- **Safety netting**

  Return to the hospital in case of back pain, vomiting or generally feeling unwell.

Practical scenarios

237

SEIZURES

Incident history: before - during - after

Systemic Review

Differential Diagnosis:

- Diabetes Mellitus
- Meningitis
- Head Injury
- Encephalitis
- Drug abuse
- Alcohol
- Brain tumour

Questions for differential diagnosis:

- **Diabetes Mellitus:**
  - Has there been a diagnosis of diabetes mellitus?
  - Any increased thirst?
  - Any increased urination?
- **Meningitis:**
  - Any headache or neck stiffness?
  - Any rash on body?
  - Any nausea or vomiting?
  - Any fever?
  - Dose the light make you uncomfortable
- **Head Injury:**
  - Is there any chance of head injury recently?
- **Encephalitis:**
  - Any recent illness?
  - Review of systems?
  - Any drowsiness?

- Any changes in behaviours?

- **Stroke:**

  - Weakness in legs?

  - speech disturbance?

  - Difficulties in swallowing?

- **Drug abuse:**

  - Any use of recreational drugs?

- **Alcohol:**

  - Alcohol intake in units per week?

  - What kind?

- **Brain tumour**

  - Any headaches? If yes, what time of the day are they worst?

  - Does the headache increase with bending head forward?

Red Flags:

Drop in GCS, neurological signs like weakness in any part of the body, Non-blanching rash, neck stiffness, acute confusion and drug overdose

Management:

- Blood tests: FBC, LFT, GLUCOSE.
- ECG
- MRI scan is the investigation of choice in adult onset seizure
- EEG
- CT scan if you need to exclude space occupying lesion

Scenario 117:

You are FY 2 in A&E. A 22 years old man has been unwell for the past 3 days. He was sitting with his father when he suddenly felt drowsy and started making inappropriate conversation and then had a fit. After the fit he was drowsy and confused. His father brought him to the hospital.

Talk to the father, take a focused history, explain the investigations and examinations. Discuss provisional diagnosis and initial management with the father.

You will find the examination findings and test results inside the room.

Patient information:

You are the father and your son has been feeling unwell for the past 3 days. He has been coughing, sneezing and having other flu symptoms. While watching a football match suddenly he became unwell. Started saying inappropriate things. He was hearing sounds, which you could not hear. It was like he had some hallucinations. You felt like he was hallucinating. Lost consciousness for 2-3 minutes. Normally fit and well and not on any regular medications. Lives with parents. He is a student studying computer engineering. No smoking. He has got a couple of friends and you are not sure if he uses recreational drugs or not. You are not aware of his sexual history.

Examination:

Temp: 37.8, HR: 112, BP: 100/70, SaPO2: 95%

GCS: 14/15

CT scan head: Normal

LP: CSF Clear,

Lymphocytes: 90%

Glucose: 5 mmol/L (2.5 – 4.5 mmol/L)

Protein: 0.6g/L (0.2 – 0.45 g/L)

O/E:

- He has brisk reflexes
- Still drowsy and confused
- Mild generalised lymphadenopathy

Questions:

Q. What do you think is happening?

Q. What are you going to do for him?

Q. What kind of infection?

Q. Will he be okay after the treatment?

Q. Is there any vaccination for this infection?

Q. Is he going to die?

Q. Is it a serious infection?

Approach

- Initial Approach or GRIPS
- Confirm relationship
- Incident history: before, during, after
- Differential Diagnosis
- Systemic Review
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise
- **Examination:**
    a. Observations
    b. Neurological exam
    c. Fundoscopy
- Explain the findings
- **Diagnosis:**

Explain likely infections of the brain which we call viral encephalitis. Commonly caused by a virus. It is an inflammation of the brain.

- **Management:**

Further investigations:

- Admit
- Fluids through the veins
- Blood tests (FBC, U&E, LFT, Glucose, blood culture)
- Urine tests
- EEG - abnormal waves may be visible which usually occur in encephalitis
- Take a second opinion from seniors
- Start on anti-viral medication
- Leaflets

- **Only if a patient asks explain complications that may occur:**
    - Can cause brain damage leading to weakness on one part of the body

- Speech problems

Practical scenarios

262

JAUNDICE

Rise in ALP in middle aged women with Itching. Primary Biliary Cirhosis.

ODPARA of jaundice

Differential Diagnosis:

- Alcohol
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Malaria
- Hepatobiliary carcinoma
- Gallstones
- Pancreatic tumour
- Haemolytic Anaemia
- Drugs
- Metastasis

Pt: Info. You came to well woman clinic your accountant. You live with your husband. You have alot of complaints because of your eating habits. You drink one bottle every weekend. Drinking for past 15 years. You are ready to accept help from Doc to cut down. mood is 9/10. If doc ask you did you try to harm yourself. Say why would I harm myself. normal Healthy Diet. Ah Idk how many alcohol units I drink. You've never tried to stop dinking before. You think that it's difficult to quit smoking.

Questions for differential diagnosis:

- **Alcohol**
  - How many units per week?
  - What do you drink?
  - When do you drink?
- **Hepatitis A**
  - Does your pain radiate to your shoulder blades?
  - Do you have any fever?
  - Any vomiting?
- **Hepatitis B**
- **Hepatitis C**
- **Hepatobiliary or pancreatic cancer**
  - Any weight loss? If yes, quantify

mild alcoholic damage of liver. Council abt Alcohol Repeat LFTs. Council about Alcohol.

- Do you feel tired and lethargic?
- Have you noticed any lumps or bumps on your body?

- **Gallstones**
  - Have you had these symptoms before?
  - Is there any particular kind of food that brings out the pain?
- **Cholestatic Jaundice**
  - Have you had gallstones in the past?
  - Have you had any surgery to your liver/gall bladder
  - Do you have any blood cell problem?
- **Haemolytic Anaemia**
  - Have you been diagnosed with any blood problems?
- **Drugs**
  - Are you taking any painkillers or cold remedies containing paracetamol?
  - Do you drink herbal tea or herbal remedies?
  - Are you under treatment for TB or epilepsy?

Red Flags:

Constitutional symptoms, weight loss, pain not controlled by medication, abnormal physical examination.

how to manage.

- If slightly abnormal rise in LFTs. repeat LFT again. viral serology & USS. If the test remain abnormal, refer to specialist for further Ix. meanwhile. tell about lifestyle especially if drinking alcohol. If patient is not good at all → refer urgently.
- If double upper limit of normal — refer to specialist directly. If old age & suspecting cancer.
- severe jaundice
  sepsis
  Hematemesis (coffee ground vomiting) } Hosp admission
  rapid deterioration.
  Hepatic encephalopathy (confusion)

Scenario A 55

You are FY 2 in GP surgery. A 33 years old woman had presented to your practice I week ago and her blood tests were done.

ALT – 530 (5-35)

AST – 110 (5-35)

ALP – 83 (30-150)

Bilirubin – 35 (3-17)

GGT : Normal

Explain the results, take a focused history and discuss initial management with the patient.

You had come to see GP last week because you have been feeling tired and lethargic for past 3 weeks. You have also been experiencing dull achy pain on the right upper side of your tummy which is 4/10 in severity. You have also noticed some yellowish discolouration of your eye. You felt sick but did not vomit. You are sexually active with your husband of 10 years. You do not use condoms. You eat out about 3 times a week and your favourite dish is seafood oyesters and sheel fish and you ate them prior to the onset of your symptoms. You husband does not have any of these symptoms and he does not like to eat seafood.

Q. Why are my liver enzymes high?

Q. What is bilirubin?

Q. What is wrong with me?

Q. Why do I have this infection?

Q. How did I get this infection?

Q. What are you going to do for me?

Q. Was it the shell fish that caused this?

Q. I wont go to that restaurant again.

Q. Is “hepatitis A” a serious condition?

Approach

- Initial Approach or GRIPS
- Any particular reason for blood tests?
- ODPARA
- **Symptoms of hepatitis:** fever, nausea, vomiting, pale stools, diarrhoea, jaundice, abdominal pain, dark urine, pale stools
- Systemic review
-  Red Flags
- MAFTOSA (sexual history)
- **Dietary history:**
    a. What kind of diet do you like?
    b. What do you normally eat?
    c. Do you normally wash fruit before eating?
    d. Do you normally eat out?
    e. Who do you normally go out with?
    f. Does he eat the same food as you?
    g. Have you travelled abroad recently?
- **Differential Diagnosis:**
    a. Hepatitis A
    b. Hepatitis B
    c. Hepatitis C
- ICE
- Effects of Symptoms
- Summarise
- **Examination**
    a. Observations
    b. General physical
    c. Abdominal exam

- Explain the findings and test results
- **Diagnosis**

Explain that blood tests were done to check if the liver is functioning properly. The test result show that there is a little bit damage to your liver.

One of the possible changes in the blood test could be because of an infection, in particular Hepatitis A infection. It is usually contracted by eating sea foods like sea shells. Very commonly if you have been eating in restaurants. It usually clears up itself in 1 week.

- **Management**
    a. Hepatitis screen
    b. Avoid using alcohol if patient drinks
    c. Analgesia, anti emetic and avoid paracetamol
    d. Repeat LFT in 1 month
    e. If after 1 month results are not normal then will do an ultrasound and refer to specialist - gastroenterologist

COUGH WITH HAEMOPTYSIS

ODPARA of the cough

Differential Diagnosis:

- Lung abscess (cough with sputum, swinging fever, chest pain, SOB, haemoptysis)
- Tuberculosis (weight loss, night sweats, fever, patient usually from Africa or Asia or, if living in the UK, then likely to be an alcoholic)
- Bronchogenic carcinoma (elderly patient, weight loss, haemoptysis, cough, tiredness, shortness of breath)
- Goodpasture's syndrome (haemoptysis, kidney problems like haematuria or proteinuria)
- Medication (warfarin)
- Trauma (there will be a history of trauma)
- Pulmonary embolism (haemoptysis, chest pain, SOB, young female, or any patients with risk factors like recent operation, long flights, calf pain)
- Left ventricular failure (history of IHD or previous MI)
- Wegener's granulomatosis (haematuria, haemoptysis, rhinorrhoea, weight loss, tiredness)
- Bronchiectasis (middle-aged man, chronic purulent sputum, cough)
- Upper respiratory tract infection (sneezing, cold, flu-like symptoms, runny nose)
- Pneumonia (fever, cough, SOB, chest pain, sputum production)
- Cystic fibrosis (history of recurrent chest infection and failure to thrive as a child)
- Bleeding disorders (Haemophilia, Von Willebrand disease)
- Instrumentation (e.g. bronchoscopy)
- Pulmonary oedema (pink frothy sputum, shortness of breath when lying flat, history of myocardial infarction)

Questions for differential diagnosis:

- **Lung abscess**

- Do you have any cough with sputum?
- Do you have fever? If yes, is it swinging?
- Any chest pain or shortness of breath?

- **Tuberculosis**
  - Any weight loss? If yes, quantify?
  - Any night sweats?
  - Recent travel from Africa or Asia?
  - Any contact with a patient of TB?
- **Bronchogenic carcinoma**
  - Any weight loss? If yes, quantify.
  - Any tiredness or fatigue?
  - Any cough or shortness of breath?
  - History of smoking?
  - Have you noticed any lumps or bumps on your body?
- **Goodpastures's syndrome**
  - Any kidney problems like haematuria or proteinuria?
  - Burning or difficulty while urinating?
  - Any swelling of legs?
- **Medications**
  - Are you on warfarin or any other blood thinners?
- **Trauma**
  - Any recent trauma?
- **Pulmonary embolism**
  - Any cough or chest pain or shortness of breath?
  - Any recent risk factors like operations, long flights?
- **Left ventricular failure**
  - History of IHD?
  - History of MI?
- **Wegner's granulamatosis**
  - Any haematuria or rhinorrhea?
  - Have you lost weight? If yes, quantify?
  - Have you been feeling more tired recently?
- **Bronchiectasis**

- Any discharge in sputum? Is it purulent?

- **Upper respiratory tract infection**
  - Have you recently had cold, flu-like symptoms, runny nose or sneezing?
- **Pneumonia**
  - Do you have a fever?
  - Do you have any chest pain or shortness of breath?
  - Do you have sputum with cough? If yes, what colour?
- **Cystic fibrosis**
  - Have you had recurrent chest infection?
  - Any history of failure to thrive as a child?
- **Bleeding disorders**
  - Have you been diagnosed with any medical conditions like haemophilia or Von Willebrand disease?
- **Instrumentation**
  - Have you recently had bronchoscopy done?
- **Pulmonary edema**
  - Do you have pink frothy sputum?
  - Do you experience shortness of breath on lying flat?
  - Any history of MI?

🚩 **Red Flags:**

Severe blood loss, tachycardia, postural hypotension, systemic features; such as weight loss, fever and sweats and features suggestive of cancer.

cough with hemoptysis
1- PE
2. Lung cancer
3- Pneumonia
4- Instrumentation
5. Trauma
6- TB

Scenario 46

You are FY 2 in GP surgery. A 70 years old man has presented with cough. Take a focused history, perform relevant examination and discuss initial management with the patient.

Patient Information:

You presented with cough and haemoptysis. You had productive cough with blood. You lost some weight but you are not sure exactly how much. You have been smoking 40 cigarettes/day since you were at the university. You did not travel abroad recently. You work as a teacher and have no medical problems or family history of cancer.

Questions:

Q. What are you going to do for me?

If the candidate says he will perform CT scan or bronchoscopy then ask them: What is CT scan doctor?

Q. What is bronchoscopy?

Q. Doctor, what is wrong with me?

Q. You asked me about family history of cancer, do you think it could be cancer?

Examination:

Chest exam is normal but there is a lymph node enlargement in the right supraclavicular area.

If the candidate says he/she will perform blood tests ask them which blood test will you do and what will you be looking for in these blood tests?

Approach

- Initial Approach or GRIPS
- ODPARA
- Differential Diagnosis
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise
- **Examination:**
    a. Observations
    b. Chest exam
    c. Lymph node exam
- Explain the findings
- **Diagnosis: Suspected Lung Cancer**

It is difficult to know the exact cause. We will need to do further investigations.

- **Management**
    a. We will refer you to the Chest Clinic Specialist within 2 weeks.
    b. The Specialist will decide what tests will be required but usually a CT scan of the chest and Bronchoscopy of the lungs is required.
    c. A CT scan is just a special scan which takes special X rays and transmits it to the computer.
    d. Leaflets

ODPARA of dysphagia (Difficulty in swallowing) – ODPARA Any meds.

Differential Diagnosis:

- Achalasia cardia (Difficulty in swallowing solids and liquids from the onset)
- Oesophageal carcinoma (initially difficulty in swallowing solids, then liquids, weight loss, progressive dysphagia, usually elderly patient)
- Oesophageal stricture (ingestion of corrosives)
- Pharyngeal pouch (history of regurgitation of undigested food particles-patient may notice food particles on the pillow, neck swelling)
- Myasthenia gravis (dysphagia worse by the end of the day)
- Globus hystericus (sensation of a lump in the throat)
- Post procedural (e.g. after endoscopy)
- Systemic sclerosis (CREST syndrome, joint problems, body rash)
- Sore throat (fever, cough, coryza symptoms, any rash)
- Esophagitis (history of GERD)
- Oesophageal candida (common in immunocompromised patients i.e. patients on steroids, with cancer, elderly etc.)
- Plummer-Vinson-Syndrome (anaemia, painless dysphagia for solids and oesophageal web).

Questions of differential diagnosis:

- **Achalasia cardia**
  - Did you have difficulty in swallowing solids and liquids from the same time?
- **Oesophageal carcinoma**
  - Have you lost weight? If yes, quantify.
  - Any swelling in the neck?
  - Did you have difficulty in swallowing solids or liquids more?
  - Is it becoming progressively worse?
- **Oesophageal stricture**
  - Have you ingested corrosive substance?
- **Myasthenia gravis**

- Is there any particular time of the day when the difficulty is worse?

- **Globus hystericus**
  - Do you have a sensation of a lump in your throat?
- **Post procedure**
  - Have you recently had any procedures done where instrument was put down your throat?
- **Systemic sclerosis**
  - Do you have joint problems?
  - Have you noticed a rash on your body?
- **Sore throat**
  - Do you have any fever, cough, runny nose or rash?
- **Esophagitis**
  - Have you been diagnosed with GERD?
  - Do you have sour taste in your mouth?
  - Any burning in the throat?
- **Oesophageal candida**
  - Are you on steroids?
  - Have you been diagnosed with cancer?
- **Plummer-Vinson-Syndrome**
  - Do you feel tired and short of breath?
  - Any problems with swallowing liquids?

Red Flags:

Constitutional symptoms: weight loss and weakness in any part of body. Progressive dysphagia, stomach ulcer and sort out my evidence.

Scenario 43

You are FY 2 in GP surgery. A 58 years old man came with complaint of difficulty in swallowing. Please talk to the patient, assess the patient and discuss initial management plan with the patient.

Patient information:

You have dysphagia for 2 months. Initially it was for solids only then progressed to liquids too. Not sure how much weight you have lost. You feel your clothes have gotten loose. You smoke 20 cigarettes/day for the past 20 years. You have no family history of any cancer. You have tiredness, weakness, fatigue. You want to eat but you cannot swallow. You are worried that the cause could be cancer?

Questions:

Q. What is wrong with me?

Q. You asked me if I have family history of cancer, is it cancer?

Q. What are the things that can cause this problem?

Q. What is a barium meal?

Q. What is an endoscopy?

Q. Do you think it can be cancer?

→ There's a lot of conditions that can cause these symptoms but I'm worried about is cancer.

Approach

Examination:

Observations, Chest & abdomen exam and Lymph node exam.

Diagnosis:

It is not clear yet. Explain that further examinations and investigations would be required in order to get to the bottom of the problem. Explain it is difficult to say what is going

Management:

- Routine blood tests
- Chest X-ray

- **Barium swallow:** This is when you are given some contrast to swallow. Then chest X-ray is done. This would show the lining of the food pipe and demonstrate where there is an obstruction.
- **Endoscopy:** Camera test to visualise the food pipe from inside and would allow us to take samples from the gut and take to the lab for detail examination.

Could it be cancer doctor?

- Unfortunately, cancer is one of those things that can cause difficulty in swallowing, but there are a few more things that could cause this.
- I would suggest you go the hospital, so that you can undergo some investigations.
- In your situation, what concerns us is that you have lost weight and your difficulties in swallowing are getting worse.
- With these types of symptoms, it is important that we do not miss out cancer of the food pipe se we would need to do a camera test to make sure that we rule out cancer of the food pipe.
- We also need to refer you urgently to a specialist surgeon.

• We will refer to Hosp Rn if patient is unstable. If stable cancer pathway within 2 weeks. (immediately)

'we'll do further Ix, you'll be seen' we words like these make it general.

(MULTIPLE MYELOMA)

Q Pt2 GP. 70y lady for follow up came with Backpain & tiredness. Blood tests Hb. 10.2 MCV 69 ESR 85 LFT N Na 137 K 4.2 urea 2.6 creat 60. Nitrates -ve. leucocytes -ve protein +++ Hence jones test. explain results. take Hx.

Pt: 70y lady. Back pain 3M. chest Inf 2 times in the last 3 months. treated with Antibiotics & now recovered. BP ↑ taking amlodipine. takecare of grand children. but now can't takecare due to Back pain & tiredness. OTC paracetamol. came to GP had Blood tests done. living alone.

Are you able to take care of yourself. We can refer them offer social services.

HAEMATURIA AND CYSTOSCOPY EXAMINATION

I have your results with me & I'll explain everything to you. but before that can we be on same page. why did you come? what did they do for you? Did anyone explain to you abt your condition. Did they give you any meds? I have your

results & ICE explain in a while. treatment
If patient is in pain su— ask if comfortable. Always if PATIENT IN PAIN.
→ Admit only if calcium 73.4.
Go NORMAL. Go NATURAL Can't take Ibuprofen bcz NM-NSAIDS
Problem with kidney
continue with paracetamol until you see specialist.

ODPARA of haematuria

Differential Diagnosis:

- Renal calculi (loin pain, colic pain and haematuria)
- Ureteric calculi (flank pain radiating to the groins, haematuria)
- Bladder calculi (suprapubic pain when passing urine)
- Renal carcinoma (loin pain, weight loss, haematuria, weakness, tiredness)
- Urinary tract infection (dysuria, frequency of micturition)
- Drug-induced
- Post procedural
- Post-surgery
- Schistosomiasis (travel history to tropical areas and swimming in rivers)
- Trauma
- Bladder carcinoma (occupation = dye industry, painless haematuria)
- Prostate carcinoma
- Bleeding disorders

BD ③ Stones
② Instrumentation
① RCC.
④ UTI
⑤ Trauma
⑥ Bleeding disorders.

Questions of differential diagnosis

- **Renal calculi**
  - Do you have pain in your genital region?
  - What is the character of the pain?
  - Have you ever been told that you have stones in your kidney?

pain inside of your tummy.?
pain while urinating?

- **Ureteric calculi**
  - Do you have any pain in your tummy or your pelvis?
  - Does it move down to your thigh or groin?
- **Bladder calculi**
  - Do you have any pain in your lower tummy?
  - Do you have any pain on passing urine?
- **Renal carcinoma**
  - Have you lost weight? If yes, quantify.
  - Have you been feeling weak and tired?

patient with tiredness- always rule out depression. hypothyroidism. they can try to confuse you. I know it's v. hard to cope with new situations, sometimes ppl tend to behaviour of their

character. so did you have any trouble with law.

- Do you have any loin pain?

- **Urinary Tract Infection**

  - Do you have burning micturition, increased frequency of urination or fever?

Do you have to go to toilet more frequently?

- **Drug-induced**

  - Are you taking any blood thinning tablets like warfarin?

- **Post procedural**

  - Have you had any procedure done through your urine passage? (or down below if woman?)

- **Schistosomiasis**

  - Have you travelled to tropical areas recently? Did you go for swimming in rivers?

- **Trauma**

  - Have you sustained any trauma recently?

- **Bladder carcinoma**

  - Have you lost weight? If yes, quantify.
  - Do you feel tired and lethargic?
  - Any family history of cancer?

- **Prostrate carcinoma**

  - Do you have any back pain?
  - Have you lost weight?
  - Have you ever been unable to pass urine?

- **Bleeding disorders**

  - Have you ever been diagnosed with any bleeding or problems?

in results, always start telling you about normal results first. let me assure you. sugar is normal.

I can understand that it came as unexpected sorry to alarm you.

Red Flags:

Bleeding, risk of infection, blood disorders,

When - amount ↓ since when? how long?

to see if

Scenario 77

You are FY 2 in A&E. A 40 years old man has come with a complaint of haematuria. Take a focused history, perform relevant examination and discuss initial management with the patient.

Patient information:

You are a 40 year old man, you have presented to your GP because you have noticed blood in your urine throughout the stream for the past 10 days. You are normally fit and well and not on any regular medications. You do not have any urgency, frequency or pain on micturition. You are otherwise fit and well. You have been smoking 20 cigarettes per day for the past 30 years, work as a clerk and there is no family history of cancer.

Scenario A:

- You are feeling tired and weak most of the time
- You do not pass clots
- You are worried it could be cancer

Scenario B:

- You have palpations and light headedness.
- Q. What is wrong with me?
- Q. What are you going to do for me?
- Q. If the candidate mentioned that he would like to do some investigations, ask him: When?

Examination:

- Abdominal examination is normal
- Per rectal examination: Prostrate gland is slightly enlarged but smooth

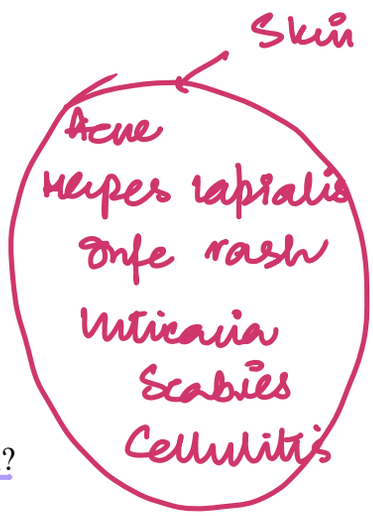
Approach

- Initial Approach or GRIPS
- ODPARA
- Differential Diagnosis
- Red Flags
- MAFTOSA

- ICE
- Effects of Symptoms
- Summarise
- **Examination**
    a. Observations
    b. Abdominal exam
    c. Per rectal e exam
- Explain the findings
- **Diagnosis**

Explain that diagnosis is not clear and you will need some examinations and investigations to confirm the diagnosis

- **Management**
    a. Urgent referral to the urologist within 2 weeks
    b. Investigations: urine test, blood tests (FBC, U&E, LFT, clotting screen
    c. Cystoscopy may be required. But you will need to speak to your seniors about it. Cystoscopy will help visualise your bladder and determine where the bleeding is coming from.
    d. I will also consult my seniors, if they suggest a different plan and I will inform you.



LIPOMA

History of ulcer/swelling

- Where is it located?
- How would you describe the lesion?
- How long has it been there?
- What is the size?
- Is it increasing in size?
- What is the colour?
- Is the colour regular or irregular?
- Has it changed in colour or shape over time?
- Does it have an irregular edge?
- Does it bleed or has a discharge?
- Is it painful?
- Do you sunbathe a lot?

Differential Diagnosis:

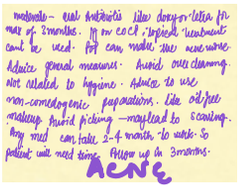
- Basal cell carcinoma
- Melanoma
- Squamous cell carcinoma
- Lipoma
- Papilloma

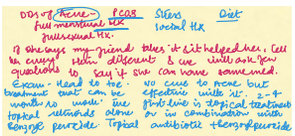
Red Flags:

Increase in swelling, rate of swelling, weight loss, sun exposure, other symptoms signifying haematuria.

Se of topical acne:

Burning sensation
Erythema/redness
Edge irritation
Blistering of skin.





Scenario 54 D

You are FY 2 in out patient surgical unit. A 25 years old man has presented with skin lesion. He has been referred by GP. Take a focused history, take consent for the procedure to be done.

Patient information:

Q. What do you think it is?

Q. What are you going to do for me?

Q. What are the options of removal?

Q. Which option will you recommend me?

Q. Can I just leave the swelling?

Q. Will it leave a scar?

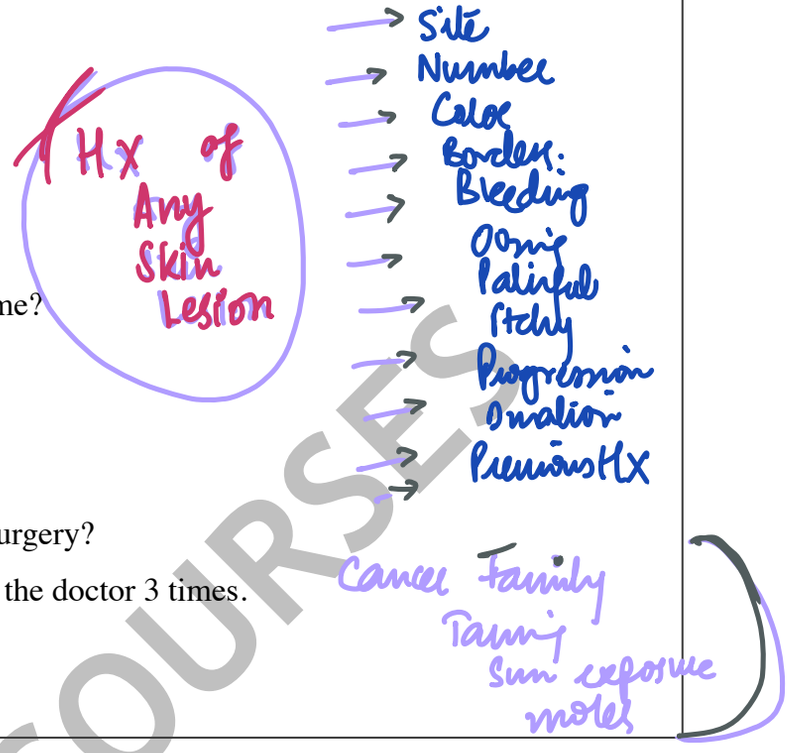
Q. Will it recur?

Q. Are there any complications of the surgery?

Q. Doctor, what do you think it is? Ask the doctor 3 times.

Q. When will the results come out?

Q. Will I have a scar?



Approach

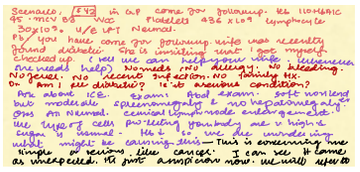
- Initial Approach or GRIPS
- Ulcer history + ODPARA
- Cancer symptoms
- Systemic Review
- Red Flags
- MAFTOSA
- ICE
- Effects of Symptoms
- Summarise
- **Examination:** Observation, Lymph node examination and systemic examination
- **Diagnosis: Lipoma**

Most likely it is a lipoma; which is collection of fat tissue. From examination it doesn't look like cancer. We can only say it is not cancer after we see it in the lab.

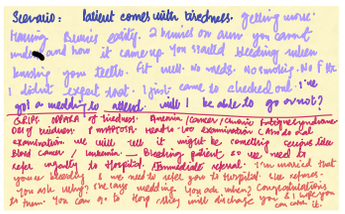
- **Management:**

It can be removed under a local anaesthesia. The scar left behind would be very small. If you are anxious, a sedative can be given to relax you. Discharge can be arranged after discussing with the surgeons. What would you like us to do?

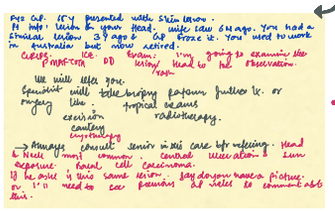
N.B: Ask your consultant to help you have a look at it.



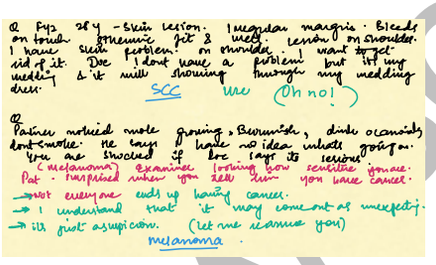
multiple myeloma/ cancer

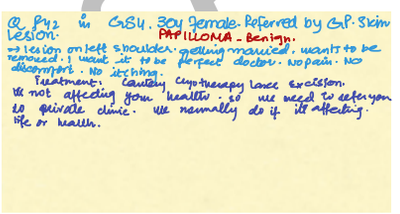


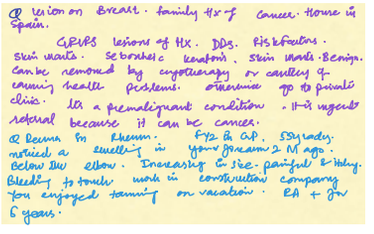
leukemia / cancer.



- BCC







Derma:

Q B12 def cap. Swelling on lip. Blisters on margin of lower lip & on the corners of mouth. 2W ago we went to pharmacy & was given topical creams but didn't help at all. Rash is not painful. No Bleeding. No itching. Married for 3y. 6M old Baby. Oral sex as well. You are a teacher. You have not noticed patient developing any rash. will my baby / husband get the rash. Can I continue going to work? Will it leave a scar. — could be allergy or Impetigo. Its a bacterial infection. Spreading by skin contact. Topic fusidic acid. Antibiotic. To apply 2-3 times a day. If allergic to penicillin, prescribe clarithromycin. Avoid school until the rash has crusted. Avoid touching the region. Wash hands immediately after touching the lesion Avoid oral sex until all lesions have healed. Unfortunately you can pass to family so avoid kissing or Breast feeding.

DAY 5:

Paediatrics scenarios:

First go through approach to Paediatric History

1. Constipation in a child (254)
2. Nightmare in a child (243)
3. Pyloric stenosis (96)
4. Breast milk jaundice (160)
5. Bronchiolitis (148)
6. AOM in a child (135)
7. Febrile Convulsions (45)
8. Head injury in a child (35)
9. Intussusception (7)
10. Recurrent tonsillitis in a child (284)
11. Chlamydia eye infection in a child (271)
12. Fever in an infant – telephone conversation (228)
13. Eczema in a 15 year old (318)
14. Urticaria in a 5 year old (329)
15. Enuresis in a 4 year old (341)

Asthma in a child:

1. Asthma in a child (258)
2. Exacerbation of Asthma in a child (115)
3. Asthma in a child – telephone conversation (260)

Milestones:

1. Child Development – Scenario A (244)
2. Child development – Scenario B (288)
3. Child Development – Scenario C (337)

Autism:

st

1. Autism 1 presentation (272)
2. Autism follow up (277)

Vaccination:

1. Vaccination in a 5 week old baby (299)
2. MMR Vaccination (52)
3. Influenza Vaccination in a child (176)

DAY 5

NIGHTMARE IN A CHILD (243)

- History of presenting complaint:

  - How long?

  - How many times a day?

  - Any particular time of the sleep e.g. is it when he is about to fall asleep? Or when he is about to wake up? Or just in the middle of the sleep?

  - Has the child been watching some violent movies?

- **Differential Diagnosis:**

  - Night terrors.

  - Underlying organic-brain disorder: delirium, mental impairment.

  - PTSD

  - Medication or withdrawal from medication

  - Recurrent febrile illness

  - Seizures

  - Depressive illness

  - REM sleep behaviour disorder

  - Obstructive sleep apnea

- **Questions on differential diagnosis:**

  - Have you witnessed your child having an episode of screaming or thrashing around?

  - Does your child remember what happened in the morning?

  - Did you try and comfort him/her? (If so) Did your child recognise you? Were his/her eyes open?

Scenario 243

You are FY 2 in GP Surgery. A 30-year-old mother has taken an appointment to meet you. Talk to the mother and address her concerns accordingly.

Patient information

Your son has been waking up in the middle of the night screaming. He wakes up 2 to 3 times in the night for the past 4 months. His father had told you that he had similar episodes in the childhood. You are worried that it could be something serious.

Questions

- What is wrong with him?
- Is there anything I should do?
- Do you think he is having nightmares?

Approach

- **GRIPS**
- ODPARA
- Differential Diagnosis
- MAFTOSA
- ICE
- Effects of symptoms
- Summarise
- **DIAGNOSIS**
- **Explanation:**

  -Usually nothing needs to be done, it will resolve on its own

  -Offer leaflets

  -Arrange a follow up

PYLORIC STENOSIS (96)

- **ODPARA** of vomiting

- **Differential Diagnosis**
  - AOM
  - Meningitis
  - Intussusception
  - UTI
  - URTI
  - Gastroenteritis
  - GERD

- **Rule out Dehydration**
  - Lethargy?
  - No. of nappies changed
  - Crying with tears

- 🚩 **Red Flags**
  - Meningitis, pneumonia, URTI
  - Drowsiness
  - Headache
  - Rash

Scenario 96

You are FY2 in the paediatric department. A 6 week old baby has been vomiting for the past 2 days and the nurses have taken observations which are as follows Temperature: 36.8

- Blood pressure: 99/66
- RR 42
- HR 115
- Weight 7.6kg
- Skin color: slight dry

Take a focused history and discuss the initial management with the mother.

Patient information

You have a 6-week old baby who has been vomiting for the past 2 days. The vomiting is like a fountain, goes very far (projectile) and looks like fresh milk. The child is constantly asking for milk.

Your child is otherwise fit and well and not on any other medications. Everything was normal during the pregnancy and child has been gaining weight normally.

Questions

- What is wrong with my child?
- What are you going to do for her?
- Do we need to stay in hospital?
- If the doctor mentions that you have a pyloric stenosis, ask them" what is pyloric stenosis?
- What is pylorotomy?

Approach:

- **GRIPS**
- ODPARA of vomiting
- **Differential Diagnosis**

  -Meningitis

-Upper respiratory tract infection

- Ear infection

- Gastroenteritis

- Dietary intolerance

- Over feeding

- Bronchiolitis

- Increased intracranial pressure

- Pyloric stenosis

- Intussusception

- Urinary tract infection

- GERD

- Duodenal ulcer

- **Rule out Dehydration**

  - Lethargy?

  - No. of nappies changed

  - Crying with tears

- 🚩 **Red Flags**

- **Paediatric questions**

  -During pregnancy and after pregnancy

  -MAFTOSA

- **Examination**

  - Abdominal examination

  - Feed test

- **Explain the findings** – Examination of the child's tummy while the child is feeding, a palpable mass may be felt

- **Investigations**

  -Abdominal USS

  -Blood test - FBC, U&E, ABG and make sure that he has not lost too much salts from the body

- **Diagnosis**

  likely to be pyloric stenosis

- **Explanation of the Diagnosis**

Pyloric stenosis is the narrowing of the outlet of the stomach. The food your child takes, it goes to the stomach, but as the outlet of the stomach is obstructed, the food doesn't go to the bowels. But you would need examinations the tummy of the child especially while the child is feeding and preform some investigations to confirm it.

- **Management**

  - Admit
  - Intravenous fluids
  - Consult the seniors.
  - **Explain that once confirmed** the condition usually traded with an operation. This operation is called a small pyloromyotomy. It is done under general anesthesia. An incision would be made at the narrowed part of the outlet of the stomach.
  - I will take as second opinion from my seniors and if they suggest a different treatment I would inform you.

BRONCHIOLITIS (148)

History of presenting complaint:

- ODPARA

- **Differential diagnosis:**

  - Viral-induced wheeze. Consider if there is wheeze but no crackles, a history of episodic wheeze, and/or a family or personal history of atopy.

  - Pneumonia. Consider if temperature is above 39°C and there are persistent focal crackles.

  - Asthma.

  - Bronchitis.

- **Questions on differentials**

  - Any shortness of breath?

  - Any high temperature?

  - Any wheeze?

  - Any family history of atopy?

  - Any allergies?

- 🚩 **Red flags:**

  - Inconsolable cry

  - Rash

  - Photophobia

  - Persistent high fever

  - Apnea

  - Central cyanosis

  - Intercostal recession

Scenario 148

FY2 in the Paediatric department.

Mrs. Sofia Black is 30 years old lady who brought her 8 months baby Michelle with breathing difficulty.

Child is currently with the triage nurse.

Observation:

O2 Sat: 94%

RR: 26

BP: 99/77

HR: 110

Take a history from the mother and address her concerns.

Patient Information:

- You brought your child to the hospital with breathing problems.
- She has had difficulty in breathing, fever, cough and running nose.
- Michelle had similar attack when he was 3 months
- From last night the shortness of breath and wheeze has got worse.
- She could not sleep at night.
- Last time he had similar problems, she was admitted and given oxygen and nebulisers.
- Child was admitted for a day and then discharge home.
- Child was discharged home on nebulisers
- Once the baby was fine, you stopped giving her the medication.
- You were as well given a spacer device.
- Offer a leaflet about bronchiolitis
- Follow up in one week time

- **Warning sign:**
  - High temp
  - Rash
  - Drowsiness
  - If you are ever worried bring the child

Approach:

- **GRIPS:** Be confident, speak loud, maintain eye contact, and smile.
- **History of presenting complaint.**
  - SOB
  - Fever
  - Cough
  - Difficulty in feeding
  - Runny nose
- ODPARA
- **MAFTOSA**
- **Paediatric History**
- **Birth history**
- Immunisation
- Child Immunisation
- Problem in pregnancy
- **Examination**
- Chest examination
- Ear, nose and throat examination
- **Management**
  - Oxygen
  - Nasal gastric tube
  - Admit
  - May need to stay in hospital for two days (2-3 days)
- **Investigations**
  - Bloods
  - Nose Swabs – to confirm that whether the respiratory syncytial virus is responsible for the infection.
  - CXR
- Take a second opinion

- **Advice:**

- Keep your child away from other children.
- Paracetamol and ibuprofen to relieve the temperature.
- Drink plenty of fluids – to prevent dehydration.
- Keep your child upright – this may make his breathing easier and may be useful in trying to feed.
- Keep child away from smoke inhalation.

FEBRILE CONVULSION (45)

- **History of seizure:**
  - How long did the seizure last?
  - Did you witness the seizure?
- **Before the fit:**
  - Fever
  - Unwell
- **During the fit:**
  - Any tongue biting?
  - Any urinary incontinence?
  - Fecal incontinences?
  - Did he hit the head to anything?
- **After the seizure:**
  - Was he drowsy?
  - Any vomiting?

- **Differential Diagnosis:**
  - Hypoglycaemia
  - Epilepsy
  - Febrile convulsions
  - Family history of febrile convulsions

- **Questions on differential diagnosis:**
  - Does he have any medical conditions such high blood sugar?

- 🚩 **Red flags:**
  - Drowsiness
  - Non blanching rash

Scenario 45

You are a FY 2 doctor in the Paediatric department. Mrs. Melanie Carl has brought her 2-year-old child, Jenny Carl. Jenny had a fit at home, which lasted 2 minutes. Her temperature is 38.5 C. On examination, there is redness over the left the eardrum. The rest of nose and throat are normal. Please talk to the mum, take a focused history, discuss management of the child and address her concerns.

Patient Information

- You are Mrs. Melanie Carl; you have brought your 2-year-old child because the child had a fit at home 2 hours ago.
- This is the first time it has happened
- You have got 2 children at home. You were in the kitchen and the 2 children were in the living room. Then the older child who is 6 years old called you to say that John was having a fit. Jenny is years old.
- After the seizure the child went floppy and pale.
- On the last 24 hours Jenny has been touching the ear vividly and there has been discharge from the ear.
- The child is up to date with all immunisation
- Child was pulling and touching the ear but not crying.
- No other past medical history, no allergies, no regular medications
- You are worried about meningitis because your neighbour child had meningitis OR you read in the news that there are many children now getting meningitis.

Scenario B

The child had a seizure when you were walking in the garden

The child never had any immunisation, because you did not know that you are supposed to take him for immunisation.

- The fit lasted less than 30 seconds.
- The child was running a temperature but you did not measure
- You gave paracetamol to the child
- The child has been pulling the ear in the last 24 hours.
- The child was able to eat and drink
- Child is allergic to amoxicillin

Scenario C:

- The child woke up this morning pulling the ear.
- The child was on the mum's lap when she had a fit.
- Child is feeding and developing well.
- Child is with the nurse at the moment.

T: 39.4

Approach:

- **GRIPS**
  - Shake hand
  - Smile
  - How can I help?
- **History of fits**
- **Differential Diagnosis**
- **Paediatric history**
- **Rule out dehydration**
- **Explain examinations:**
  - He has red ear drum
  - High fever
- **Explain Diagnosis**
  - Febrile convulsions. This is a condition in which children develop a fit when they have high temperatures.
  - Seizure usually develops with a temperature of 38 degree or more.
  - The cause is known
  - Due to ear infection. It usually develops between 6 months and 6 years.
  - It may happen again
  - Child is likely to be free of having febrile convulsion after the age of 6 years.

- Febrile convulsion is not epilepsy, but unfortunately it has been linked with an increased risk of temperature.

- **Acute management:**
  - Ask if she is eating and drinking?
  - Assess dehydration
  - Child is able to eat or drink so need for admission.
  - Give antibiotics for acute otitis media (Amoxicillin for 5 days if no allergy)
- **Advice:**
  - Paracetamol and ibuprofen to reduce temperature
  - Light clothing
  - Tepid sponging or excessive cooling is not recommended

- **What to do when child is having seizure:**
  - Remove dangerous things away from the child
  - Put him in the recovery position
  - Do not put anything in the mouth
  - Call an ambulance if the seizure lasts more than 5 min.
  - Always take child to the doctor for assessment

- **Safety warning:**
  - Non blanching rash
  - Drowsiness
  - Persistent crying
  - Child is unwell
  - Or if you are worried about your child
- **Offer leaflet** about febrile convulsion and ear infection.

HEAD INJURY IN A CHILD (35)

Scenario 35

You are working in the Paediatric Department as a Foundation Year 2 doctor. Your next patient is Jenny, a 9-month-old baby who fell down at home. She has a bruise on her head. At the moment, the child is well and actively playing in the department. Please talk to her mum, Lucy. Take a history and discuss management.

PATIENT INFORMATION:

You are Mrs Lucy Lopez, a 31 year old lady. You have brought your 9 month old child Jenny to the hospital who has had a fall.

- You were changing the nappy of a 2 year old child when Jenny, 9 months fell down from the sofa.
- It happened one hour ago
- Jane is up to date with all vaccinations
- No past medical history
- The child goes to the nursery
- Jane vomited once

Questions:

- Are u sure everything is okay doctor?
- Yes i Know there is a Bruise on the Head
- You are very distressed
- What should I do next?
- Doctor, you will not perform a CT scan now?
- Why not CT Scan? how will you know she will be fine?
- What should be done about it?

Approach:

- **GRIPS :**

  - How can I help?

  - History about the fall; when, where, how, who witnessed the fall.

- **History of Incident**

  - Before

  - During (LOC, vomit, seizure)

  - After

- **Rule out NAI**
- **P3MAFTOSA**
- **Paediatric questions**
- **ICE**
-  **Red flags**

  - Slept and couldn't wake up; drowsy

  - CSF from nose or ear

  - Loss of consciousness

  - Vomited

  - Seizure

  - Bruise, laceration, swelling > 5cm (CT Scan)

- **Examination**

  - Observation

  - Examine the ears, nose and throat.

  - **Explain the diagnosis to the mother:** Child has mild head injury

- **Management**

  - CT Scan is not required because it's a mild head injury and will expose the child to unnecessary radiations.

  - Observe for 4 hours in the department, if ok then can go home.

EXACERBATION OF ASTHMA IN A CHILD (115)

Scenario 115

You are FY2 in Paediatric department. A 4 years old child George who was admitted with an exacerbation of acute asthma.George is a 4 years old child who is known to have asthma. He has had recurrent exacerbation of asthma. Talk to mum and determine the cause of exacerbations of asthma. Explain to the mother how to use the spacer device.

Patient information:

- You are Lesley white
- A 30 years old lady
- Your child George was diagnosed with asthma one year ago.
- For the 1 year he has had to come to the hospital with acute exacerbation every month, so 6 times in the last 1 year.
- When you are giving inhalers to your child but he is not always cooperative. He fights a lot and he does not like the spacer.
- You feel that you have done everything you have been asked to do but still he keeps getting the attack of asthma.
- You have removed the carpet at home.
- You do not smoke.
- You do use perfume at home.
- You do fry food in the kitchen from time to time.
- You had to give your pet (cat) to your neighbours because you thought it could be the cause.
- You have got another child 7 years' old who is fit and well.
- You use yellow spacer and you have got 6 of them at home
- You scrub the spacer to clean it
- Too many puffs

QUESTIONS:

Why is he keep getting the exacerbations of asthma?

Approach:

- **GRIPS**
  - Smile
  - Shake hands
  - Be loud and confident
  - Maintain eye contact
  - Know the name of the patient
  - What would you like me to call you?
- **Confirm relationship to the child.** 'May I know how are you related to George/ Emmy?'
- **Paraphrase the scenario:** "I understand that George was brought to the hospital because he was unwell."
- **Check their understanding:** "What have you been told about George condition?"
- **Explain that he has an exacerbation of asthma and you were wondering what could be the cause of his exacerbation.**
- **History taking**
  - Can I ask you some questions?
  - How long has he had asthma for?
  - What medications is he taking?
  - Since he has been diagnosed with asthma how many times has he been to the hospital due to exacerbations of asthma? Let's say in the last one-year.
  - Is there anything you think could be the cause of these exacerbations?
- **Triggers of asthma:**
  - Any pets at home (like cats and dogs)
  - Is there anyone who smokes at home?
  - Do you have any carpet at home?
- In the last one-year how many times did you have to come to the hospital?
- Does the child get recurrent chest infections?
- Which medications is he taking?
- Is he taking the inhaler?
- Do you use a spacer?

- Which type of spacer is he using?
- Is he cooperative while taking the medication?
- How do you give him the brown inhaler?
- Is he taking the brown inhaler regularly?
- Do you face any problems while giving the inhalers?
- Does he tolerate the spacers well?

- **MAFTOSA:** Past Medical History, Drug History, Allergies.

- **Paediatric questions**

  - Any problems during the delivery?
  - Any problems during development?
  - Did you have any complications/ problems with the pregnancy?
  - Is he/she up to date with vaccinations?

- **Management:**

  - From what you have told me I feel like he is not taking all the medications in.
  - Explain that she needs to use the correct spacer device according to the age of the child and needs to use a mask (Only say this if the mother is not using the correct spacer)
  - Red spacer 0-1 year
  - Yellow spacer 1-5 years
  - Blue spacer with or without a mask – 5 years and above.
  - Explain some of the reasons why someone could have some exacerbations of asthma.
  - If the feeding is not good, the child may not take the appropriate dose of medications.
  - Or maybe the dose is not adequate, it needs to be revised or a new medication might need to be prescribed.
  - Demonstrate how to use an inhaler.

- **Explain how to use a spacer:**

- Ask which spacer do you use?
- Apply a tight seal around the mouth.
- Give one puff and place it around mouth and nose for 5-6 seconds.
- Give a 30 seconds break.
- And then give another puff.

- **Taking care of spacers:**
  - How often do you wash?
  - Wash it 2-3 times a week or if it is visibly dirty.
  - When washing it, use soap and water, but just under running water.
  - You do not need to scrub.
  - Please also do not remove the mask when washing the spacer.

- **Helpful tips:**
  - Put it tight around the mouth and nose
  - What does he like to watch on the TV?
  - Try to distract the child by putting TV on channel which he/she likes
  - Use the rewarding technique approach by telling your child that if you take the medication we will give you something
  - Turn on his favourite programme
  - Also you can decorate the spacer so that it is attractive to him/her
  - So try to make it as playful as possible.

- **Explain the importance of a preventer inhaler.**
  - Address any triggers of asthma in the station
  - Arrange follow-ups in 2 weeks time

-  **Red flags:**
  - If symptoms not improving needs to bring the child to hospital

- Give leaflets about exacerbations

ASTHMA IN A CHILD - TELEPHONE CONVERSATION (260)

Approach

- **History of the presenting complaint:**
  - Ask what is wrong with the child?
  - Is the child breathing?
  - Is the child sitting up?
  - Is he drowsy?

- **History of SOB:**
  - Onset
  - Duration
  - Exacerbating and relieving factors

- **Long term treatment for asthma:**
  - What medications is the child on?
  - Does he take inhalers?
  - Does he take any steroid tablets?

- **Treatment of acute episode:**
  - Have you given him salbutamol?
  - Have you used spacer?
  - How many puffs did you give him?

- **Differential Diagnosis:**
  - URTI
  - Pneumonia
  - Asthma

- **Questions on differential diagnosis:**

  - Cough, runny nose, fever, sneezes

  - Sputum, chest pain, SOB

  - Wheeze, SOB, cough, chest pain (tightness)

-  **Red Flags:**

  - Child is drowsy

  - Not eating much

  - Short of breath

  - He is not very active

  - He is sleeping on the sofa

Scenario 260

You are FY 2 in a GP Surgery. The father of a 9 year old has telephoned the practice and would like to talk to a doctor, as his son has not been well. Talk to the father over the phone and address his concerns.

Patient information

- Your child has had cough, fever and cold for the last 3 days and is running a temperature. You have given him paracetamol but the temperature is still high.
- In the last 24 hours, he has developed shortness of birth and you have given salbutamol, inhaled steroid and montelucast but he is still short of breath.
- Your child was diagnosed with asthma 4 years ago and is on salbutamol regular inhaled steroid (brown inhaler) and Montelucast.
- At the moment, he is drowsy, not eating much, short of birth, not very active and is sleeping on the sofa.
- Child is up to date with all vaccinations and there were no problems during pregnancy or after delivery.
- He doesn't have any known allergies.

Questions

- What should I do?
- Can you prescribe him some oral steroid may be he will improve?

I will come and collect the steroid as the last time (6 months ago) he had similar problem, the doctor prescribed him steroids

Approach

- **GRIPS**
- **SOCRATES**
- **Differential Diagnosis**
- **Red Flags**

- **MAFTOSA**
- **ICE**
- **Effects of Symptoms**
- **Summarise**
- **Explanation of the Diagnosis -**

  - Infective exacerbation of asthma - Likely to have viral infection which has made his asthma worse
- **Management**

  - Please remove all the objects from around the child

  - Place the child in a sitting position but reclining backwards, it will help with breathing

  - Check airway patency

  - Stay with the child

  - Keep giving him salbutamol via spacer and we will call the ambulance for you

  - If he loses consciousness please lay him on the left side.

CHLAMYDIA EYE INFECTION IN A CHILD (271)

Scenario 271

You are a FY2 in a GP Surgery. A 18 year old lady who delivered 10 days ago has made an appointment to see you. When the child was 7 days old, he was found to have eye infection and the eye swab taken showed chlamydia infection. Child was treated with chloramphenicol eye drops and is now fine. Take a history and address her concerns.

Patient Information :

- You have been with your partner for the last 2 years.
- You never had PID infections.
- Your partner never complained of any STI symptoms.
- You do not have any symptoms of PID.
- You have been in this stable relationship for the last 2 years.
- You do not have any other partners.
- Your child was diagnosed with chlamydia eye infection but he is now fine.

Questions:

- How did the child get the eye infection?
- Did I get this infection from my partner?
- Do you think he is cheating on me?

Approach

- **GRIPS**
- **History**
  - How can I help you?
  - Ask about how the child is doing.
  - Any eye discharge in the child?
  - Any redness, fever?
- **Sexual history**
  - Married or stable relationship?

- Practice safe sex?
- Any symptoms like discharge or lower abdominal pain?
- Any STIs in the past?
- Any symptoms in the partner?
- Has her partner ever been diagnosed with sexually transmitted infection?
- How long has she been with the partner?
- Is there any chance you could have any other partners?

- **MAFTOSA**
- **SUMMARIZE**
-  **Red Flags**
- **Examination:**
  - Abdominal examination
  - PV exam
  - Observations
- **Explain the findings and diagnosis :**
  - Child is likely to have contract chlamydia infection from the mother during delivery.
  - Explain that sexually transmitted infections in women can be silent which means you can have these infections without having any symptoms.
  - It is a sexually transmitted infection which means you got it from your partner but what I cannot say is whether you got it from the current partner or not.
  - "But doctor I have had 1 partner for the last 2 years."
  - I think any one in your situation would ask the same question but I think it is something that you can discuss with your partner.
  - In terms of going forward, we can arrange some swabs for STIs from you and start some treatment.
  - Sometimes, even if you have got a PID, the swabs can still come back negative. So as soon as we take the swabs, we can start you on treatment anyway.
  - Do you think you can discuss with your partner? If you can talk to your partner and have a discussion, he can also come and get treated.

- **Management**
  - Refer them to the GUM clinic.

- Explain that it is important to screen for other sexually transmitted infections such as Hepatitis B and HIV.
- Explain that she needs to use a barrier method of contraception such as condoms until both herself and the partner have completed treatment.
- Explain that future use of barrier method of contraception with greatly reduce the risk of reinfection and other STIs.
- Explain that it is important to complete the treatment once it has been started to prevent long term complications such as PID, infertility, ectopic pregnancy and chronic pelvic pain.
- Advise to use contraception.
- Offer leaflet about sexually transmitted infection

CHILD DEVELOPMENT MILESTONES

- History of concern
- Milestone history
- Smile
- Walk
- Following with eyes
- Laughing with other people
- Talking
- Crawling
- Walking with support
- Does he cry ok?
- Paediatric History
- Pregnancy - any problems?
- Birth - any problems?
- Up to date with vaccinations?
- Social History

Differential Diagnosis :

- Constitutional delay (never started walking, family history)
- Trauma
- Cerebral palsy (difficult birth, breathing problems after birth)
- Duchenne muscular dystrophy (walked since birth but then stopped, climbs on him-self, increase in the size of calf muscles)
- Congenital hip dysplasia (clicking sound from hip while changing nappies)
- Infections e.g. septic arthritis (fever, swelling, redness, tenderness)
- Perthes disease (avascular necrosis of the femoral head; pain, limping, age 3-14)
- Irritable hip (history of infection a few days back)
- Non accidental injury (bruises of different ages)
- Polio (not up to date with his vaccinations)
- Rickets (bowing of legs, knock knees, malnutrition)

Questions on differential diagnosis

- After how many days did you go home after delivery?
- Did the child need any special care after delivery (cerebral palsy)?
- Has he ever suffered from any infections?
- Is there anyone in your family who had delayed walking (familial)?

Child Development – Scenario A (244)

You are FY 2 in GP Surgery. A 30-year female has made an appointment to see you. Talk to her and address her concerns accordingly.

Patient information

You have a 14-month old son who has not yet started to walk independently. He can walk with support around the table but cannot walk independently whereas his friends of the same age group are already walking. Your child can say few words, laugh, smile, interact with other siblings and can follow with his eyes. He plays well with toys and you have no other concerns in terms of other developments.

Questions

1. Why can't he walk doctor?
2. Do we need to see the specialist?
3. Does he need any investigations?

Approach

- **GRIPS**
- SOCRATES
- Differential Diagnosis
- Red Flags
- MAFTOSA
- Effects of Symptoms
- Summarise
- **Explanation**

  - Explain that it is normal for a child still not to walk at 14 months of age.
  - Reassure he will walk
  - Arrange a follow up in 2 months' time
  - If not walking by then, we will send you to a specialist.
  - Offer information in terms of what a child can do and what he cannot do at certain age

MMR VACCINATION (52)

You are working as a Foundation Year 2 doctor in the general Practice.

An 11 months old girl is due for Immunisation next week.

Please talk to her mum Jane and address her concerns

Patient's information

- You are Mrs. Jane Jones, a 30-year-old lady. You have an 11-month-old girl, Rachel, who is due for her MMR vaccination next week.
- You are worried that MMR vaccination is not safe.
- Opening statement: " Doctor I read in the news paper /magazine/ article that MMR vaccination can cause autism and it is linked
- One of your nephews has got autism and you are concerned that MMR vaccine can cause autism in your child. Your child is well, able to eat and drink. She has got no allergies. At the end of the day you do not agree to the vaccination, you say that you want to think about it.
- You do not know much about MMR Vaccination.
- You are happy to receive a leaflet about MMR Vaccination.

Questions

- Is there a link between MMR and autism?
- Can you tell me about the MMR vaccine?
- Is it given in one go or can I take it separately? mumps, rubella and measles?
- Tell me what does MMR stand for?
- Why do you give it?
- When do you normally give it?
- I read there is connection between MMR and autism.
- Is it linked to a bowel condition? Which condition is it?
- Why is there a still rubella infection if you are giving vaccine?
- When MMR is usually given?
- Is there any alternative to MMR vaccination?
- Are there cases of these infections in the UK?
- Do you think it is really important to do this vaccination?
- Are there any complications of MMR vaccination?
- Are there any side effects of this vaccination?

APPROACH:

- **GRIPS**

  - How can I help you?

- **History taking:**

  - Do you have any other concerns regarding other vaccinations?
  - Have you been able to take your child to other vaccinations?
  - Do you feel you will be able to take your child for vaccinations?
  - Summarise for the mother
  - Explain to mother that MMR IS safe.

- **MMR stands for mumps, measles and rubella:**

  - 1st dose is offered between 12 to 13 months.
  - 2nd dose 4 to 5 years old.
  - These are highly infectious condition that can cause serious complications such as meningitis, encephalitis and deafness.
  - No option for separate dose (3 in 1).
  - Not linked to autism.
  - Not associated with any bowel condition.

- **Why is rubella still in the UK?**

  - Not everyone is vaccinated.
  - Go to other countries and get infected.

- **Alternative:**

  - There are no alternative forms of MMR vaccine.

- **Side Effect of MMR:**

  - Pain, swelling and reddening at the site of an injection.
  - Fever - mild fever may develop a few days after immunisation.

- Parotid swelling (swelling of gland in face).

- **Advice:**

  To do:

  - Protect you and your child from many serious and potential deadly diseases
  - Protect other people in your community – by helping to stop diseases spreading to people who cannot have vaccines
  - Get safety tested for years before being introduced – they're also monitored for any side affects
  - Sometimes cause mild side effects that won't last long – some children may feel a bit unwell and have a sore arm for 2 to 3 days
  - Reduce or even get rid of some diseases - if enough people are vaccinated.

  Not to do:

  - Do not cause autism – studies have found no evidence of a link between the MMR vaccine an autism
  - Do not overload or weaken the immune system – it's safe to give children several vaccines at a time and this reduces the amount of injections they need

Immunisation schedule:

Note:

- 2nd month: DPT + Pneumonia + H. influenza + Polio
- 3rd month: 5 + Rotavirus+meningococcal
- 4th month: 5 + Rotavirus+ meningococcal
- 12 months: Rotavirus and MMR

- Complications
- Contra-indications:
  - Acute illness e.g. URTI, otitis media
  - Allergy to neomycin

Patients with egg allergy CAN be given MMR vaccination

DAY 6:

SURGERY COUNSELLING
Approach to communication - The **CLASS** protocol

1. Pain management
    - Prostate cancer (189)
    - Breast cancer (120)
2. Hemiarthroplasty – post operative management (29)
3. Barrett's oesophagus (225)
4. Patient requesting for PSA (303)

OPERATIONS:
Dermoid cyst removal (138)

First go "Approach to scopes"
- Endoscopy in Celiac Disease (322)
- Cystoscopy
- Bronchoscopy
- Colonoscopy scenario A (195)

MOTIVATION STATIONS
1. Smoking Cessation (first go through to smoking cessation)
    1. COPD (129)
    2. Angioplasty (18)
2. Alcohol counselling (30) (first go through to alcohol counselling)
3. Obesity (150)

PREGNANCY
First go through approaches to **Obstetric history**
AND then approach to **Menstrual history.**
1. 1st antenatal visit (149)
2. Pre-conception wants male child (181)
3. Pre-conception with HTN (236)
4. Pre-eclampsia at 36 weeks (13)
5. Pre-eclampsia at 38 weeks (267)
6. Chickenpox exposure in pregnancy (311)

SEXUAL HEALTH AND CONTRACEPTION
First go through approaches to "Sexual A History"

STI SCENARIOS
1. Dysuria in a 26 year old (246)
2. Gonorrhoea in a man (206)
3. Gonorrhoea in a woman (40)
4. PID with IUCD (65)
5. HIV - HIV scenario A (226)
6. HIV scenario B (265)
7. HIV scenario C (251)
8. Syphilis (319)
9. Cervical smear invitation in a 25 year old (304)

CONTRACEPTION
First go through approaches to "**Contraception in Minors"**
1. Contraception in 30 year old (2)
2. Repeated OCP prescription (302)

DAY 6

Pain management.

PAIN MANAGEMENT (chronic pain)		
RUNG 1	Non-opioid	Paracetamol, Ibuprofen etc…
RUNG 2	Weak opiates	codeine, tramadol, Dihydrocodeine etc…
RUNG 3	Strong opiates	Morphine, Fentanyl, oxycodone etc…

Breast cancer

Scenario 120

You are FY2 in pain clinic. Joana Hutchinson is an 80-year old lady who has been admitted from the oncology department directly to the pain clinic. Joana had Mastectomy for breast cancer 5 years ago.

Please talk to patient and advise her on the painkillers you need to give her.

PATIENT INFORMATION:

Scenario A

- Your name is Joana Hutchinson, an 80 year old lady who had breast cancer 5 years ago and you had mastectomy done.
- You are currently taking paracetamol but your pain is not well controlled.
- You have had this pain for the past 4 months and it is 5/10.
- You are okay to carry on the conversation without taking painkillers.
- You were given morphine/codeine before but you stopped it because it caused constipation.
- This back pain was investigated, you just want something stronger so you are hoping that the doctor can give you different medications.
- Any medications the doctor offers you, you want to know the side effects and how can it be taken.
- You have your grand child‘s wedding to attend in a weeks' time and you worried that you might not go the wedding due to the pain.
- The back pain was investigated and they told you that the cancer has spread to the back. You know about this and you were placed on palliative therapy.
- You are interested in knowing all the side effects of the medications being offered by the doctors and ways to alleviate them.

Scenario B

You are worried about drowsiness. You look after your grandchildren and you do no want drowsiness as this may prevent you from looking after your grand children.

Questions

1. Are there any other painkillers?
2. Do you think I will be able to go to my grand daughters wedding?
3. Are there any side effects to this medications?
4. Will they cause any drowsiness?
5. Will I still be able to look after my grand children If I take Morphine?
6. When you are mentioned PCA, you ask ‘Doctor, you mean I can give myself the injection?’

APPROACH:

1. GRIPS (loud, confident, eye contact, smile), offer analgesia (if in pain)
2. How can I help you?
3. SOCRATES of the back pain
    - What painkillers have you tried so far?
    - Why did they top those painkillers?
4. D/Ds (spinal cord compression, trauma, weight loss, hypercalcaemia, thirst, polyuria symptoms, last follow up by the surgeons in regard to the breast cancer she had)
5. Ask if the back pain has ever been investigated in order to find the causes
6. PMH, DH, Allergies
7. What medications are you taking currently?
8. **Ask warning Signs (spinal cord compression)**
    - Constipation
    - Urinary symptoms
    - Weakness and sensory loss in the legs

9. **Discuss pain management:**

- Ibuprofen(S/E- indigestion- can cause damage to stomach but if we are to place you on this medication we will give you another medication to prevent your stomach).
- Weak opiates like codeine ,tramadol but use laxatives like senna, as the pain is not severe this would ok.
- Morphine with laxatives to prevent constipation she developed last time. What do you think about that?
- Discuss with seniors
- Advice that patient can still go ahead with the normal life when she is on this medication.
- Advice that if it will cause severe drowsiness, You would stop the morphine medications and try some other medications.
- Explain that you would take the second opinion from your senior.
- Explain that you would try and control the pain as soon as possible so that she can go for her wedding.

NOTE: SIDE EFFECTS OF OPIATES

- Nausea and vomiting (use anti emetics)
- **Constipatio**n (use laxatives)
- **Drowsiness** – usually a problem in the Initial stage of taking the medication but with time gradually wears off)
    - If drowsiness becomes a big problem then we can try to change it to a different type of opiate
- **Dry mouth** (use a chewing gum or take sips of water)
- **Tolerance:** If you have been taking opioids for a long time ,the dose might need to increased in order to control the pain.This is called tolerance.
- **Dependence**: if you take the opioids medications your body may become dependent on it.It means that if you miss the dose or stop the opioid suddenly you may experience withdrawal symptoms.
    - In this situation ,if you need to stop the medication, the dose needs to be gradually reduced.

Withdrawal symptoms:

- Feeling anxious
- Difficulty falling asleep
- Muscle pain
- Sweating
- Yawning
- Diarrhoea and vomiting

ADDICTION:

Addiction is an excessive craving for the opioid .It is unusual for the people who are prescribed opioids for pain to become addicted to opioids

Barrett's oesophagus:

Scenario 225

You are FY2 in the outpatient department. Peter Smith, 52-year-old man who had an endoscopy with biopsy done. The patient has a past history of GERD and is on omeprazole 20 mg daily.

A copy of the biopsy results from the histopathology department is available in the cubicle.

Talk to the patient, explain the results and discuss management with the patient.

Patient information :

- You are 52 years old.
- You had GERD for years.
- Your symptoms are getting worse.
- The symptoms are not being controlled by Omeprazole anymore, that's why you had the endoscopy done.
- You have night symptoms which wake you up from sleep.
- You have been smoking 20 cigarettes per day for 20 years.
- You drink a lot of alcohol.
- Your diet is poor.
- You work as a pizza delivery man.

Questions:

1. Why can't you cut it out?
2. Why can't you just do an endoscopy now?

Approach:

1. Initial approach

2. Explain the purpose of consultation

3. Paraphrase the scenario and ask: "I understand that you had endoscopy done". Did they tell you reasons why an endoscopy was performed?

4. **Explain the results of endoscopy.** Endoscopy shows that you have a condition called Barrett's oesophagus. Barrett's oesophagus is formed by repeated damage from stomach acid to the oesophagus. Over years the damage can lead to changes in the cell lining of the oesophagus. Unfortunately, these abnormal cells are at increased risk of becoming cancerous in future, but the risk is small.

   Because of the increased risk, it is recommended that we perform an endoscopy every 3 years. If the abnormal cells become cancer cells, then they will be discovered at an early stage and treatment such as operation may be offered.

   At this stage, we just need to stop anything that may contribute to the development of any cancer. At the moment, these abnormal cells are not cancerous.

5. Alcohol:

- Drinking too much alcohol causes irritation and inflammation in the lining of the oesophagus.

6. Smoking:

- Tobacco smoke contains many harmful toxins and chemicals. These substances irritate the cells that make up the lining of the oesophagus, which increases the likelihood that they will become cancerous.
- The longer you smoke, the greater the risk of developing cancer of the oesophagus.

7. Obesity:

- If you are overweight or obese, your risk of developing cancer of the oesophagus is higher that people of healthy weight.

8. Diet:

- Not eating enough fruit and vegetables may increase the risk of getting oesophageal cancer.

Dermoid cyst removal

Scenario 138

You are FY2 in the obstetric and gynaecology department. Mrs Jenny Thompson is a 30-year-old lady who has been scheduled for a dermoid cyst removal. The cyst is 8cm x 8cm in size. The dermoid cyst will be removed via laparotomy with an incision on the bikini line. She is planned to stay in the hospital after the procedure for at least 48 hours. The surgeon will be using absorbable sutures. Consent has been taken from the patient. Patient has some concerns. Please talk to the patient.

Patient information:

- You are Mrs. Jenny Thompson
- You have been told that you have a cyst in one of your ovaries
- You know that you are going to undergo an operation
- You are normally fit and well and not on any medications

Questions:

- How will you do the operation?
- Will I be able to have children?
- Are there any complications?
- Do I need to make any preparation?
- What can I expect after the operation?

Approach…

Colonoscopy

Scenario 195

You are working as an FY2 in GP surgery.
Lisa Atkinson a 65-year-old who has made an appointment to see you. You had referred her to the hospital for per rectal bleeding. She had sigmoidoscopy done which showed bleeding polyp. Histology was done which confirmed Benign adenoma and some dysplastic changes.The specialist would like to perform a colonoscopy. The patient would like to talk to you about it. Please talk to patient and address her concerns.

Patient Information:

- You had presented to your GP a few weeks ago following 2 episodes of blood in the stools.
- You GP referred you to the specialist who performed a sigmoidoscopy.
- They found out that you have polyps.
- They removed the polyps, sent it to the lab and the biopsy results showed that it is benign.
- You know all the results of your sigmoidoscopy and biopsy.
- You were quite happy that all was good.
- You has some discomfort while having a sigmoidoscopy, this is why you are not very keen to go through this process again.
- Since the polyp was removed you had no bleeding from the back passage.
- You are not happy that the specialist wants to do another procedure.
- The first time you had a sigmoidoscopy you were offered a laxative.
- You live with your husband, and he can come and get you. It is not a problem.
- You are normally fit and well and not on any medication.
- You have one brother and one sister, but they never had any similar problems.
- Last time you had colonoscopy it was very embarrassing for you.
- This is why you do not want to go through it again.
- You also had severe discomfort. They did not offer sedatives initially until half way through the procedure.

Questions:

- Why do I need to do another investigation when you said that it was benign?
- Is the previous sigmoidoscopy not enough to do that?
- Do you think it could be cancer?

Approach:

1. **GRIPS**
2. **Establishes reason for visit**
3. **Takes concerns**
4. **Checks that patient understands the results of sigmoidoscope (Benign polyp)**
5. **Explains the need of colonoscopy**
    - You have been invited to have a colonoscopy because a growth called polyps were found when you had a sigmoidoscopy.
    - This means there is a chance you have polyps further up the bowel.
    - Some polyps are benign growths but they might turn into bowel cancer if not removed.
    - So we need to check that there are no more polyps further up the bowel and that there is nothing else going on.
    - Unfortunately, polyps are one of the risk factors of developing lung cancer
    - So you need to check the whole colon (large bowel)
6. **P3MAFTOSA**
7. **Takes risk factors of colonic cancer:**
    - Smoking
    - Family history of lung cancer
    - Family history of polyps
    - Does she have brothers and sisters
    - Do any of the brothers and sisters have any bowel problems of polyps
    - Symptoms of cancer:
    - Weight loss
    - Diarrhoea
    - Constipation
    - Tiredness
    - Weakness
    - Systemic review

Concerns: Is there anything you are worried about?

Colonoscopy – This is a procedure to look at the inside of the large bowel (colon) with a long flexible camera (endoscope) and it also allows us to take a biopsy.

- Patient needs to take bowel preparations
- Will be given special laxatives at least 24hours before a colonoscopy.
- This will give you diarrhoea and we will advise you to stay at home during this day.
- 12 hours before the procedure to drink clear fluids only.

Explain the procedure:

- The camera is in a flexible thin tube (about the thickness of your little finger) You will be offered sedatives to make you relax. The tube is inserted through your back passage in the bowel. A colonoscopy can visualise the whole large bowel and you can also take a sample called biopsy. Procedure will last 30 -45 minutes. The doctor will insert the colonoscope (thin flexible tube) into your large bowel through your anus and look inside using the tiny camera. He will gently pump some gas inside the bowel, to inflate them so that he can see the lining of the bowels properly.

Complications:

- Perforation of the bowels (but this is very rare)
- Infection
- Allergic reaction to sedative
- Abdominal discomfort or bloating

Post- Procedure:

- Few hours of monitoring are required until sedation wears off.
- Needs someone to pick her up.
- The effects of the sedative may last up to 24 hours, we therefore advise you not to:
    - Drive or ride any type of bicycle for at least 24 hours.
    - Operate any type of electrical or mechanical equipment/ machinery for at least 24 hours.
    - Sign any legally binding documents for at least 48 hours
    - Drink any alcohol for at least 24 hours.
    - Not be responsible for young children, disabled or dependent relatives for at least 24 hours.

- You can eat as you normally would.
- Rest quietly for the remainder of the day and if possible have someone stay with you overnight.

Safety Netting: if any of the following happens, patient needs to come back.

- Abdominal pain
- Rectal bleeding
- Fever

Smoking cessation

Scenario 129

You are FY2 in general medicine. Lewis Williams is a 70-year old man who was admitted to hospital with chest infection. He is known to have Chronic Obstructive Pulmonary Disease. He does get chest infection from time to time. On this occasion his chest infection has been treated and he is stable.

The nurses have been advising him to stop smoking but he has been reluctant. So they have requested you to talk to him.

Please talk to Mr Lewis Williams and advise him about smoking cessation.

PATIENT INFORMATION:

Scenario A:

- You are Mr Lewis William, a 70 year old man.
- You are known to have Chronic Obstructive Pulmonary Disease.
- You do get chest infection from time to time. On this occasion your chest infection now been treated and you are well.
- The nurses have been advising you to stop smoking but you have been reluctant. So they have requested the doctor to talk to him.
- You do not want to quit.
- You smoke 30 cigarettes a day since you were in college.
- You enjoy smoking.
- You have a friend of yours who died of lung cancer and you believe that it was due to his smoking.
- You are on the following medications:
  Salbutamol, Dexamethasone, Ipratropium.
- You have no home oxygen or nebulisers.
- You get admitted into the hospital every 2-3 months.

Scenario B:

If the doctor is nice with you, tell him/her at the end of conversation: I am motivated with the conversations we have had. I will now go and think about it.

But if the doctor is not being nice and supportive, insist to say I do not want to quit.

Questions:

- If the doctor talks about nicotine replacement ask him/her "How will the nicotine replacement help me?"
- If doctor asks to explain options of smoking cessation, tell him "the nurses have already done that" but if doctor wants to explain, he can go ahead.
- "Why do I need to cut? I love my smoking."

Comments

"Doctor, I have been smoking for a long period of time and the whole idea of stopping smoking completely scares me"

APPROACH:

1. **GRIPS** (Be nice to the patient, speak loudly and smile)

2. PARAPHRASE the scenario:

- "I understand that you were admitted to the hospital with chest infection. How are you doing now from the chest infection point of view? What symptoms did you have when you came into the hospital? I have been asked to come and talk to you about your condition and discuss what type of lifestyle changes can help with your condition. In particular, I want to talk about smoking. I understand that you do smoke, is that right?" Or "I also understand that you do smoke? Is it ok if we have a chat about your smoking habit?"
- **Take history of smoking:**
    - How many cigarettes a day do you smoke?
    - How long have you been smoking?
    - Have you ever thought of stopping smoking?
    - Have you ever tried to stop smoking?

3. Discuss about COPD

- How much do you understand about COPD in terms of its cause and prognosis?
- How long have you had COPD?
- What treatment are you on?
- What do you understand about the causes of COPD and its prognosis?
- How frequent do you get admitted to hospital as a result of your COP, let's say in the last year?

4. Explain that the commonest cause of COPD is smoking

- Because smoking causes damage to the lungs.
- You have told me that you have been smoking for a long time, since you were in college, so the most likely cause of your COPD is smoking.

5. Explain the course and prognosis of COPD.

- Usually COPD is caused by longstanding smoking.
- Chest infections tend to become more frequent as time goes by.
- If the condition becomes severe it may lead to heart failure.
- There are rare cases where it runs in the family but most of the time COPD it is due to smoking.
- In your case the COPD is most likely due to smoking because you have been smoking for many years.
- Do you have any liver problems? (There is a type of COPD where it runs in the family, but then it would also give you liver problems in childhood.)
- What do you understand about the prognosis of the disease? The progression of COPD can be reduced if you can stop smoking.
- Usually COPD leads to respiratory failure and unfortunately, it usually occurs at an early stage and eventually people die from respiratory failure if someone with COPD continues to smoke.

6. **Explain that the most important treatment is to stop smoking.**

7. **Benefits of quitting smoking (Management)**

Stopping smoking is the single most important factor:

- It will reduce damage to the lungs
- It will reduce the number of times you get admitted to hospital
- Reduce the progression of the disease.
- Decrease the risk of lung cancer
- Decrease risk of IHD and heart failure.

Respiratory failure is the final stage of COPD.

- Check his opinion: "What do you think about what we have discussed?"

8. **Explain that there is a smoking cessation clinic which can help you quit smoking.**

"Would you like me to tell you what they can do for you in case you decide to quit?"

9. **Choose a quitting date**

We can give you nicotine replacement treatment.

1. Nicotinic replacement therapy (NRI)

There are different preparations available, in the form of a tablet. They reduce the desire to smoke

2. **Bupropion:** You start taking this medication 1-2 weeks before you quit a day

3. Agree a quit day to a patient. IF they agree to choose a stop date, then explain that you can prescribe then a medication for 1-2 week.

4. Offer a leaflet

1st antenatal visit

Scenario 149

You are a FY2 doctor in obstetric and gynaecology department. Mrs Audrey Jones is a 25 year old lady who came for routine antenatal follow up. Mrs Audrey Jones had her last menstrual period 6 weeks ago. This is her first antenatal visit. Please assess the patient and discuss further management plan.

Patient information

You are Mrs Audrey Brown, 25 year old lady.

You had 2 previous miscarriages at 8 weeks.

The miscarriage was 2 years ago.

You are taking folic acid at the moment.

You smoked for 5 years but then stopped last year.

This is your 3rd pregnancy.

You did a pregnancy tests and you know you are 2 weeks pregnant.

This is why you have come for routine antenatal follow up.

You are fit and well and not on any regular medications.

After the 2 miscarriages, you went to see the GP but nothing was found.

The GP simply said that you should try again.

Questions:

1. Do you think everything will be fine?
2. Is it going to happen again?
3. What are going to do for me?
4. Will I be able to have a baby?
5. How can I make sure that I do not have another miscarriage?

Approach:

→ first pregnancy?
→ planned / not
→ Congratulate How is it going?
→ Symps of pregnancy?
tummy pain
discharge
Headache
Vomiting
Swelling in leg?

1) GRIPS

- Nice
- Friendly
- Eye contact
- Smile

→ How did you confirm pregnancy?
→ How many babies are you expecting?

- Know the name

2) **Paraphrase the scenario:**

I understand you have come for routine antenatal follow up.

- How are you?
- Is this your first pregnancy? Ok, you have been pregnant before and you know what happens on your first antenatal visit.
- Usually it involves asking you some questions, doing some examinations and arranging some investigations.

3) **History taking phase:**

Shall I start by asking you some questions?

- Is this your first pregnancy or you mentioned this is not your first pregnancy. How many times have you been pregnant before?
- Can you please tell me how did your previous pregnancies ended?
- I am sorry to hear that
- How many weeks was your first pregnancy when did you have a miscarriage? What about your second pregnancy, how many weeks was it?
- Do you have any medical problems?
- Have you ever suffered from clots in your legs or lungs?
- Is there anyone in your family who has ever suffered from clots in lungs or legs?
- Is there anyone in your family who has ever had a miscarriage?
- Are you taking any regular medication?
- Are you married? Are you related to your partner in any other way?
- Did you attend antenatal follow ups in your previous pregnancies?
- Did you have any problems like infections?
- Did you have any investigations done on your previous pregnancies?
- Is there any chance you use recreational drugs?
- Do you smoke?
- Do you drink alcohol?
- Have you ever been diagnosed with any sexually transmitted infections?

] social hmp.

- What do you do for your living?
- Is there anything that could be causing stress in your life?

Now I need to ask you about your menstrual history:

- When was your LMP?
- Are your periods usually regular? How many days do you normally bleed?
- Do you experience any pains during your period?
- Do you have any thyroid problems?
- Do you have any medical problems like diabetes or high blood sugar?
- Have you ever had any operations done on you?

Examinations:

- I will need to examine you.
- Observations: Temperature, BP, HR, Pulse, Oxygen
- Abdominal examinations
- ~~PV examination~~ contraindicated in pregnancy.

Diagnosis:

You have had two miscarriages before, so we need to check that this is no medical condition like anti-phospholipid syndrome which is one of the common causes of miscarriages. bfr 12 w.

Investigations:

1. FBC, UTE, CFR
2. Urine test for infection
3. Infection screen (Syphilis, Hepatitis, HW, Rubella, Chlamydia)
4. USS of the abdomen Imp.

Management:

- More test of after a 3rd Miscarriage
- You have got an equal; chance of having a normal pregnancy like every other woman because you had only 2 miscarriages. The chances of having another miscarriage increases after 3 consecutive miscarriages. (tone empathic)
- Give antenatal care information e.g "The Pregnancy Book" (remain ideal)

- Advice lifestyle:
    - Exercise; continue moderate exercises
    - Alcohol; High consumption may result in fatal alcohol syndrome
    - Smoking; is associated with miscarriage, intra-uterine deaths, premature delivery
    - Place of birth
    - Diet
    - Folic acid supplement
    - Vitamin D

Notes:

- A miscarriage is defined as loss of pregnancy before 24 weeks
- Recurrent miscarriage is defined as loss of 3 or more consecutive miscarriages

Risk factors:

- Endocrine cause (PM, thyroid disease, PCOS)
- Inherited through syphilis
- Infections
- Structured anomalies (e.g. Uterine septum)
- Genetic abnormalities

Practice obs/gynae. It's very tricky.

Pre-Eclampsia at 36 week: Scenario 13

You are a foundation year two doctor in the Maternity Assessment unit. 30 year old lady, Alice Smith who has come for routine antenatal follow-up. She is 36 weeks pregnant and she has been seen by the midwife who has made the following note:
Her Blood pressure today is 160/110.
Urine Dipstick shows protein +++
Her booking antenatal blood pressure: 110/70.
Take a focused history and discuss management with the patient.

SCENARIO A:

You are Alice Smith a 30 year old lady who is 36 weeks pregnant.
You have come for a routine antenatal follow up. You have been having headache for two hours and leg swelling of your legs bilaterally.
- The midwife examined and checked your blood pressure and sent you to the obstetrics ward.
  - The doctor will be here to talk to you. The midwife in the antenatal clinic found your BP to be high but she did not explain this to you.
  - You have noticed swelling of your feet in the last 2 weeks and you have headaches during the same period.
  - You have attended all the antenatal follow up.
  - Your booking blood pressure was 110/70.

Does she understand what booking BP is?
  - You are really hoping all will be fine today
  - This is your 2nd pregnancy; the previous pregnancies all went fine and it was normal vaginal delivery. Your children are 2 and 5 years.
  - Your pregnancy was OK, no problems in current pregnancy
  - You are able to feel the kicks of the baby

SCENARIO B:

  - 1st pregnancy
  - Swelling of the ankle
  - Attended all antenatal clinics
  - Works as a secretary; in 3 days time you will be having maternity leave. You will call them and inform them.
  - No visual problems.

You have been trying for 2-3 years to get pregnant a dn you really wanted a water birth.
Your husband and yourself have been planning to have water birth.
You have also discussed with the midwife about water birth.

QUESTIONS:

  - What caused it?
  - Is it serious doctor?
  - what will happen if i don't get admitted?
  - what are the complications?
  - How will i be treated?
  - What medications will be given to me?
  - Doctor can I have a water birth?
  - If water birth is not possible, please doctor try to make it a normal delivery as much as possible.
  - The midwife and I had planned a water birth.

1. I do not want to be admitted, I do not think it's serious.
2. Can you give me the medication and I will take them at home.

Water birth is not recommended in the following situations:

- Hypertensive
- Pre-eclampsia
- Epilepsy
- Foetus Distressed
- Induced Labour

Approach: (nice approach)

- **GRIPS:**

Paraphrase the scenario.

I understand that you have come for routine antenatal follow up. And i understand that the midwife has checked your BP and tested your urine. Has she explained the results of the BP and urine test. I will explain the results of these tests before that can i just ask you a few questions?

- **Take a history**
    - Is this your first pregnancy?
    - How has pregnancy been so far?
    - Any problems so far (bleeding, Hypertension, high blood sugar, vomiting)?
    - What was your BP the first time you went for your antenatals?
    - Anybody in the family had problems during pregnancies like increased BP or increased Blood Sugar?
    - Do you know how many babies are you expecting?

- **Red flags**
    - Tummy pain
    - Vision problems
    - Headaches
    - Fits

- **MAFTOSA**
    - Are you feeling the kicks of the baby?
    - Ask about symptoms of Pre-eclampsia: Headache, abdominal pain, swelling of the legs, blurry vision.

Booking Blood pressure

- Explain the results of BP and urine dipstick .
- Break news of the diagnosis: pre-eclampsia
- Common complications of pregnancy if not treated e.g. seizures,
- Pre-eclampsia is a potentially dangerous condition

- **Management**
    - Admit
    - Give medication (Labetalol) control BP less than 150mmhg
    - Examine the baby-Antenatal examination (presentation, lie, position)
    - CTG machine (To check that the baby is not in distress. If the baby is in distress we might suggest a cesarian section)
    - Check urine
    - USS to check that the baby has been growing well.
    - Continue monitoring vitals i.e. BP, temp, pulse
    - Blood tests especially LFTs to rule out HELLP syndrome as well as FBC and U&Es and LFTs.
    - Negotiate the management with patient (Are you okay with it) and address concerns
    - Explain that water-birth would not be advised due to close monitoring required in labour as a result of pre-eclampsia, CTG and BP need to be monitored.
    - MgSO4 to prevent a seizure, if the BP is above 160/110.
    - C-section if the monitoring during labour suggests baby is in distress.
    - Offer leaflets for more information about pre-eclampsia

Gonorrhoea in a woman

Scenario 40

You are FY2 doctor in Genito-Urinary Medicine Clinic. A 24 year old lady came to the GUM clinic 1 week ago to be tested for sexually transmitted infection. The results are back from the laboratory and shows that the patient is positive for gonorrhoea infection. Take a sexual history and discuss management with the patient.

PATIENTS INFORMATION:

You are a 24-year-old lady who came for STI testing 1 week ago.

SCENARIO A:

She saw a TV advert about STIs.

She is in a new sexual relationship for 3 weeks

2 or 3 sexual partner in the last 6 months

She is married

SCENARIO B:

She had symptoms(PV discharge, lower abdominal pain) New partner in the last 3 weeks. She was in a relationship for 5 years before and broke up 1 year ago. She is not married now

SCENARIO C: Was reading a newspaper and read about STI infections

SCENARIO D:

You are reading on the internet about STI and you decided to come for a check up.

Your partner does not have any symptoms.

Questions

- Did I get it from my partner?
- Where did I get it?
- Is it curable?
- "I do not have a problem in telling my partner about the diagnosis, I can tell him"
- Are there any complications?
- Which antibiotics will you give me?
- What treatment will you give me?
- How long do i need to take the antibiotics?
- Are there any complications?
- How common are these complications?

Approach:

1. **GRIPS**

2. **Paraphrase the scenario:** You came to the hospital to be tested for STI 1 week ago. Has anyone explained the results to you?

3. **Break bad news:** Unfortunately the results include bad news – the test shows that you have a sexually transmitted infection called Gonorrhoea

Pause to allow the news to sink before proceeding.

4. **Reassure that Gonorrhoea is a curable condition.** There are some antibiotics that can be given.

5. **Take a focused History**
    - Can I ask some questions to see if there is anything you need to do to prevent this infection in the future?
    - Some of the questions may be personal but if you find it too much, please let me know and we can stop.
    - Questions:
        - Are you in a stable relationship?
        - How long have you been with your current partner?
        - Do you practice safe sex i.e. use condoms?
        - Are you experiencing any symptoms like discharge, tummy pain, fever?
        - What made you come to the clinic to get tested for STI?
        - Have you ever been diagnosed with STI before?
        - Is your partner experiencing any symptoms?
        - Are you using any form of contraception?
        - How long ago was your previous relationship?
        - Have you ever had sexual intercourse for casual purposes?
        - Other than your current partner do you have any other sexual partners?

What medications will you give me?

- A single dose (Ceftriaxone 500mg IM in 1 dose and Azithromycin 1g orally in 1 dose)
- We also need to treat your sexual partners

Did I get it from my partner?

- Unfortunately, it is a sexually transmitted infection, which means you could have gotten it from your partner.
- But you have had more than one partner in the past. So it could be from any of your partners in the past 6 months.

- Is it ok if you can discuss this situation your current partner and ask your partner for testing and treatment?
- This bug can live in our body for a very long time without showing any symptoms so we need to treat all sexual partners in the last six months.

- Is it ok if you can give us the contact details of you previous partners so that we can contact them, invite them for testing and treatment. We will not reveal that we got the details from you.

Are there any complications?

- Infertility: (there is a solution)
- Ectopic pregnancy: if you notice any tummy pains or miss a period, come back to the hospital
- Dysmenorrhea: analgesia
- Dyspareunia
- Chronic infection (PID): that can flare up from time to time and present with PV discharge and lower abdominal pain, fever then you need to go to the hospital.

But with treatment all complications can be avoided.

No sexual intercourse when on treatment.

6. Explain what will happen next:

- Advise to use barrier methods
- Follow up in 2 weeks for repeat swab to make sure that the infection has cleared.

- Avoid having sex until we have repeated the tests and show that you do not have the infection.
- Watch out for warning signs:
    - lower abdominal pain
    - fever
    - vaginal discharge
- If you have any of these symptoms please come back.

7. Advice to get tested for other STI's like HIV and Hepatitis.

8. Refer to GUM clinic if there is need for contact tracing.

- Change of partners in the last 6 months.

Prevention:

- Explain that STI can be prevented by using condoms.

Acute pelvic inflammatory disease:

Scenario 65

You are a foundation year two doctor in the Emergency Department. A 30-year old lady who has presented with right lower abdominal pain. Take a focused history, perform relevant examination and discuss management with the patient.

Patient Information:

- You are Ms Nicola Addison a 30-year-old lady who presented to the emergency department with lower tummy pain.
- You have had right sided lower tummy pain for 3 days.
- It's 8/10 severity.
- You felt sick but you did not vomit.
- You have also noticed foul, smelly, greenish vaginal discharge for the past 5 days.
- You are sexually active and you use IUCD as a form of contraception.
- You are in a new relationship with your new male partner for the last 3 weeks ago.
- You have had 3 partners in the last 6 months.
- Your partner has no symptoms.
- Your IUCD was inserted 1 year ago.
- You are normally fit and well, not on any medication.
- LMP 4 weeks ago.
- You feel hot generally, but you did not check the temperature.
- You have never been diagnosed with any sexually transmitted infection before.

QUESTIONS:

1. What is wrong with me?
2. Will I be treated here?
3. Where did I get it from?
4. Did I get it from my partner?
5. Is it something you can cure?
6. Are there any complications?
7. Will I be able to get pregnant?

Observations:

- Temperature - 38ºC
- Pulse - 98
- BP - 110/70
- RR - 14
- Sats - 98%

- **Per vaginal examination:** cervical excitation is positive and greenish discharge on the gloves.
- **Abdominal examination:** right iliac fossa tenderness, no rebound or guarding and no adnexal masses.

Approach:

GRIPS: Smile, be loud, confident, shake hands

History taking phase: How can I help you?

Empathy - Are you comfortable? Do you need any pain killers?

1. SOCRATES (can you tell me more about the pain?)

- Any PV bleeding or discharge?
- If any discharge, then is there any colour or smell?

2. Differential Diagnosis (endometritis, ectopic pregnancy, ovarian cyst, appendicitis, PID, miscarriage, UTI, pyelonephritis, renal stones)

3. P3MAFTOSA (Personal - Sexual and Menstrual)

- How to check the IUCD/When was it inserted?
- Do you know how to check if the IUCD is on place? And when was the last time she got checked?

Examination:

Explain what examinations you would like to perform.

1. Observations (Temp, Respiratory rate, Heart Rate, BP, Pulses, Oxygen levels)
2. Explain that you need to perform abdominal examination or examination of the tummy.
3. Vaginal examination to check for any bleeding or discharge.

Explain the findings to the patient:

From what you have told me most likely you have a condition called Pelvic Inflammatory Disease. This is an infection of the womb, tubes, and the ovaries. It is usually caused by sexually transmitted infections. The common infections are chlamydia and gonorrhoea infections Explain the differential diagnosis: Infection of the wombs and tubes: Pelvic inflammatory disease (uterus ovaries and tubes).

Management:

- Admission
- Blood test: Inflammatory markers - to see how severe the infection is?
- FBC, U& E, LFTs, CRP, ESR
- Blood cultures: To look for any infection in the blood.
- Take swabs: Take some swab
- IV antibiotics
- Refer to the Gynaecologist
- Pregnancy test - Is it possible for you to give us urine, so that we can perform a pregnancy test?

You need to rule out pregnancy, explain why:

- No contraception is 100% safe
- IUCD is a risk to infection/ectopic pregnancy.

Q1: Where did I get the infection from?

It is a sexually transmitted infection which means you got it from one of your partners.

You mentioned that you have been in a new sexual relationship in the last 3 weeks and also you had other partners in the last 6 months

So it could be from your current partner or previous partners unfortunately.

Q2: Can it be cured?

Yes, it is a curable condition. There are antibiotics which we can give you and they can cure the infection.

Q3: Are there any complications?

Unfortunately, there are some complications that may occur

- Infertility - difficulty getting pregnant
- Ectopic pregnancy - when you get pregnant, the pregnancy could be outside your womb
- Solution: So if you miss your periods and you develop any sort of abdominal pain, you need to seek medical help. But if that were to happen, there is a solution to that as well.
- Dysmennorhoea: Which is painful periods.But you can always take painkillers if that happens
- Dyspareunia: This is pain during intercourse.

Patient: so what are you going to do for me?

Refer to the hospital to the gynaecologist for assessment.

- Explain that sometimes they might remove an IUCD after 3 days if there is no improvement of the infection.
- Admit under gynaecologist.
- Ask if she knows about how to check that an IUCD is in place.
- USS will need to be done in order to assess that there is no collection of pus anywhere in the tubes or anywhere in the body and also to check that the IUCD is in place.
- Advise to bring partners to get screened for STI in order to treat this infection effectively. We will need to treat your partner as well
- Are you comfortable to discuss this with your partner?

- Offer leaflets to the patient.

Contraception in a 30 Year old

Scenario 2

You are an FY2 in GP surgery. Sue Hale, aged 30, has made a routine appointment to see you. Please talk to the patient and address her concerns.

PATIENT INFORMATION

Opening sentence: Doctor I want to know about the contraception pill. You are a 30 year old lady Sue Hale. You have come to see the GP to request for contraception. You traveled to Australia 1 year ago by flight, a journey which took about 12 hours. You developed swelling in the legs. You were admitted and given blood thinner tablets (Warfarin) for about 6 months.

- You have tried diaphragm and condoms in the past but you got pregnant with your second child so you are very keen to know about the failure rate of each contraception
- You have 2 children
- You like the idea of combined pills but if the doctor advices you it is not appropriate for you, you are okay with it and you accept his/her opinion
- You are a nonsmoker
- Stable partner
- No medical history, no allergies, no medications
- Your friend recommended you a pill.

Questions

- So what options are there for me?
- What is the failure rate? (ask failure rate for each and every type of contraception)
- Are there any side effects?
- Are there any complications?
- Which is the best?

SCENARIO B.

Your boyfriend used condoms and you have tried diaphragm as well. You had DVT 2 years ago and you were treated with warfarin. Last smear was one year ago and it was normal. Your last menstrual period was 5 days ago.

1. Doctor can you tell me which one is the most effective?
2. Do the COCP and POP have the same failure rate?
3. Are there any risks for a coil?

Candidate should be able to explain the following types of contraception:

- **COCP**
    - Daily
    - 21 days cycle
    - Failure: 3:1000
    - Contraindicated in this patient

- **POP**
    - Daily
    - Failure 3:1000
    - Side effect: intermenstrual bleed

- **Patches**
    - Weekly
    - Failure: 3: 1000
    - Side effect: intermenstrual bleed

- **Depo Provera**
    - Intramuscular injection
    - Have to go to GP
    - 3 months once
    - Failure 2:1000
    - S/E: intermenstrual bleed

- **Implant**
    - Device inserted under the skin of the inner arm under LA
    - Protection up to 3 years
    - Failure: 1:2000
    - S/E: intermenstrual bleed

- **Mirena Coil**
    - Intrauterine device
    - Mechanical and hormonal block
    - Helps with dysmenorrhea, fibroids
    - S/E: ectopic, PID
    - Protection up to 5 years
    - Failure: 2:1000

- **IUCD** Best one.
    - Copper T
    - Intrauterine device
    - Mechanical block
    - S/E: ectopic, PID, dysmenorrhea, uterine perforation, menorrhagia
    - Protection up to 5 years
    - Failure: 8:1000

- **Permanent contraception**
    - Female sterilisation
    - 1:200

For each and every contraception, the candidate should give the failure rate, advantages and disadvantages.

Approach:

- GRIPS
- How can I help?
- Is there any particular contraception you want to know or you just want to know the available options?

- Take a history to assess the suitability for contraception
  - PMH
  - Previous contraception used
  - DVT
  - Migraine
  - Medications
  - Allergies
  - Menstrual Hx (LMP, irregular cycle, dysmenorrhea)
  - Any children?
  - Finished family?
  - Have you tried any other contraception? How long are you planning to use the contraception for?

- Counselling
- Explain each contraception giving advantage and disadvantage of each one
- Tell the failure rates

- **Recommend contraception according to her history**

Contraception in a 15 year old.

Scenario 252

FY2 in the GP surgery. Heather Watson is a 15-year old female who has made an appointment to see you. Talk to the patient and address her concerns.

Patient information:

You are 15 year old Heather Watson and you suffer from migraines with aura. The aura begins about an hour before the migraine and you experience visual problems where you see zigzag lines. You also experience associated nausea and sometimes vomit.

The headache is usually left sided. You take paracetamol for the headaches. You are otherwise fit and well. You have a 15 year old boyfriend and you are sexually active. Up till now you have been using condoms but your boyfriend doesn't like them so you want to see the GP to discuss what other options you have for contraception.

Questions:

1. Can it be kept confidential?
2. How will I be taking POP?
3. What are the side effects?
4. What is the failure rate?

Approach

1. GRIPS

- May I know what brought you to the practice today?
- Can I ask some questions to understand your situation better?
- Usually it is a practice policy that any one under 16 years of age should attend the practice with their parents.
    - Have you come on your own?
    - And do you parents know that you are here?
    - Ok, It's ok I will see you, now that you are already here.
    - And do your parents know about your sexual relationship?
    - Is there any particular reason you have not told your parents about your relationship?

Reassure that we can definitely help with contraception.

2. **Offer confidentiality:** Reassure that whatever is discussed will be kept confidential .

3. **Ask about her sexual relationship and assess for abuse.**

Can I ask you about your sexual life:

- Are you in a stable relationship ?
- How long have you been together with your partner?
- How old is your partner?
- How has everything been going with your partner?
- Has your partner ever been aggressive towards you?
- Has he ever forced you to have sexual intercourse when you didn't want to?

4. **History of contraindications -** Now I need to ask you few question to assess your suitability of contraception?
    - Diabetes , hypertension , heart problems. , fibroids, precious ectopic , epilepsy , headache, migraine , CVS risk , breast feeding .

5. **Menstrual history-menorrhagia**
    - Last menstrual period?
    - How many days do you bleed?
    - How many days is your cycle?
    - Are your periods regular?
    - Are your periods heavy?
    - Do you experience any pain during your periods?

6. **Previous contraception:**
    - What contraception have you tried in the past?
    - What about condoms - have you tried them?
    - How does your partner feel about using condoms?

7. **Assess for Gillick competence :**

- I need to ask you some questions to check that you understand why you need contraception
- Can you explain to me why do you need contraception?
- What would happen if you do not use contraception ?
- And do you know some of the risks of being in a sexual relationship ?

8. **Assess for Fraser criteria:**

- Do you think you can try and talk to your parens about your relationship?
- Your parents were of your age at one point - they may understand .
- How would you feel if you not prescribed contraception today?
- If you are not prescribed contraception, do you think that would stop from being in sexual relationship?
- Would you consider using condoms - they would also protect you from sexually transmitted infections.
- Contraception does not protect from STI.

DISCUSSION - Fraser criteria :

Prescribe contraception only if the following criteria are met:

- The young person understands the practitioner's advice.
- The young person cannot be persuaded to inform their parents or will not allow the practitioner to inform their parents.
- The young person is likely to begin or continue to have sexual intercourse with or without protection.
- The young person's best interest requires the practitioner to give contraceptive advice or treatment without parental consent.
- Unless he or she receives contraceptive advice or treatment, the young person's physical or mental health is likely to suffer.

9. **RULE OUT PREGNANCY :**

- Last menstrual period
- Last sexual intercourse

10. **Examinations:**

- Abdominal
- Blood pressure
- BMI

11. **Explain different options of contraception**
    - Combined contraception (vaginal ring, transdermal patch and pills)
    - POP
    - IUCD
    - Levonorgestrel (IUS)
    - Barrier methods (condoms)

12. **Screening for STIs:** If she has had unprotected sexual intercourse, explain that sometimes it can be symptomatic

13. **Prescribe the contraception** if you have reached an agreement with the patient and offer leaflets about contraception

Note:

This patient has got migraines so COCP can worsen headaches.

We should advice POP.

DAY 7:

MEDICINE COUNCELLING
First go through approach to communication **– CLASS** protocol
1. Post mortem (60)
2. URTI - wants antibiotics (82)
3. Coeliac disease and endoscopy (169)
4. Food poisoning (202)
5. Heart failure (first presentation – shortness of breath) (306)
6. Worried about meningitis (330)

LIVING HEALTHY
First go through cardiovascular risk assessment (**Q risk score)**
AND then approach to "**Lifestyle advice"**
1. High BMI and Statins (146)
2. High BMI with low QRISK score (282)
3. HTN worried about stroke (31)
4. High BMI - patient worried about vascular dementia (158)
5. HTN with high Q score (214)

TRANSIENT ISCHAEMIC ATTACK
First go through "TIA talk"
1. TIA scenario A (14)
2. TIA scenario B (14)
3. TIA scenario C (291)
4. TIA in a taxi driver (285)

DISCHARGE DISCUSSION WITH PATIENTS
First go through approach to "Discharge"
1. Asthma (26)
2. Epilepsy in a 13 year old child (101)
3. Post MI advice (86)
4. Discharge Medication (198)

WARFARIN TREATMENT:
First go through "Warfarin Talk"
AND the " Oral anticoagulants talk"
1. Warfarin (6)
2. Warfarin follow up - patient with learning disability (153)
3. High INR on warfarin (203)

FOLLOW UP SCENARIOS
First go through approach to "**Follow up"**
1. Epilepsy in an adult (57)
2. Osteoporosis (97)
3. Post MI heart failure (123)
4. Microscopic Haematuria (208)
5. Colonoscopy scenario B (239)
6. Polymyalgia Rheumatica follow up (323)
7. Hypothyroidism follow up (333)

HYPERTENSION FOLLOW UP
First go through "Hypertension Talk"
1. Hypertension follow up scenario A (67)
2. Hypertension follow up scenario B (163)
3. Hypertension follow up scenario C (213)

DAY 7

MEDICINE COUNCELLING

1. POST MORTEM

Scenario

You are the FY2 doctors in acute medical ward. Mr. Adam Jones a 65 year old man who was admitted 4 days ago with shortness of breath.

Unfortunately patient died yesterday.

The cause of death has been found to be acute respiratory failure secondary to chest infection.

Death certificate can be issued with a diagnosis of acute respiratory failure but has not yet been issued.

Talk to his wife Mrs. Elena Jones and address her concerns

Patient information:

You are Mrs. Elena Jones. Your husband Mr. Adam Jones presented 4 days ago with shortness of breath and was treated in the acute medical ward. He died last night. The cause of death was found to be respiratory failure secondary to a chest infection.

You would like to request for a postmortem because you want to be sure of cause of death.

You have no issues regarding the treatment offered to your husband.

You live with your nephew whom you are happy to discuss the situation with if the doctor asks you to discuss it with someone.

You want a postmortem because everything happened so quickly.

You watch the criminal investigation films or movies where they chop people's bodies apart during a post mortem.

You do not want anyone to chop your husband's body like that.

You are happy to receive bereavement offered by the hospital but you don't need any help with funeral arrangements.

You do not know when you'll be conducting the funeral at the moment. You are planning for a burial and NOT a cremation.

You have got a nephew who works as a nurse in a different hospital and she has advised you to ask for a postmortem.

Questions:

1. Will a postmortem delay the funeral? (NO)
2. Will you disfigure his body? (NO)
3. Will it delay issuing a death certificate? (NO)

Approach

- Initial Approach or GRIPS
- GRIPS It is not a smiling station, shake hand and maintain eye contact, have normal facial expressions
- Confirm relationship to the patient (know the name of the patient XYZ)

  I understand that your husband was admitted 4 ago with shortness of breath. What is your understanding about your husband condition at the moment?

- **History**
  - Is there anything from your side that you wanted us to talk about?
  - Did you manage to talk to any of the doctors while your husband was in hospital?
  - Do you have any concerns regarding the treatment your husband received while in hospital?
  - Has anyone explained to you what lead to the death of your husband? If not explain now.
  - As you know he came in with chest infection and unfortunately from the chest infection he developed respiratory problem and this is what unfortunately he died from.
  - Is there any particular reason you why you feel that a postmortem is needed?
  - Can I just ask, what is your understanding of a postmortem? In terms of how it's being done and reasons of doing it?
  - Are you planning for a burial or cremation?
  - What they know already
  - Brief medical history

- **Explanations:**
  - A postmortem is a detailed examination which is carried out by the pathologist.
  - It starts off as an external inspection and then it proceeds to internal examination.
  - During an internal examination the incisions are made but are kept to the minimum and making sure that we do not disfigure the body.
  - Full detailed postmortem examination all the organs are of the body are removed and inspected before they are returned back.

    - If we conduct a limited postmortem examination then certain organs may not be inspected. For example in his case he had breathing problems, we a limited examination may concentrate or lungs and any other organs but not all the organs of the body.
    - Will the postmortem disfigure his body?
    - A post mortem will not disfigure his body. The pathologist will open his body but after he finishes the post mortem he will nicely close up his body. Is there any particular reason why you are worried about the body being disfigured?

- **Offer Bereavement Help**
    - Ask if she has been offered any bereavement services?

- **Offer Funeral services**

2. UPPER RESPIRATORY TRACT INFECTION

Scenario

You are the FY2 doctor in General Practice.

Elizabeth Black is a 20 year-old lady who has come to your GP practice with some concerns.

Patient had come to your GP practice 2 days ago with a sneezing, cough, sore throat and blocked nose.

The nurse performed a nose and throat swab, which came back negative.

She was advised to take paracetamol and use steam inhalation.

Please talk to the patient and address her concerns.

Patient information :

Opening sentence: "Yes doctor, I came in 2 days ago, I saw a male nurse who said I have viral infection and gave me paracetamol. He advised me to take steam inhalations but I think I need antibiotics."

- You are Elizabeth Black a 20 year old lady
- You made an appointment to see the your GP because you have had cough, blocked nose, sore throat and sneezing for the past 3 days
- You came 2 days earlier to your see GP practice with the same problem.
- You were seen by a different doctor who told you it was a common cold and it would resolve in the next couple of days.
- The nurse took some swab from your throat and nose.
- You have been following all the instructions given to you i.e. taking paracetamol, resting and drinking plenty of fluids. You have tried everything but you haven't really been using inhalation steam.
- The results of the swab are back but no one has explained them to you.
- Your grandmother's birthday is in 5 days' time and you really want to be well so that you can attend her birthday. She is 95 years old and this could be her last birthday.
- You are normally fit and well and not on regular medications.
- Your symptoms: you have had them for the past 3 days
    1. Sneezing
    2. Blocked nose
    3. Cough
    4. Sore throat
- You have tried paracetamol and over the counter but it's not helping.

Questions:

1. Doctor can you give me antibiotics?
2. Paracetamol is not working, just give me antibiotics.
3. My friend was given antibiotics when she had similar symptoms and she improved.
4. Do you think it can become a bacterial infection?
5. How will I know that it is a bacterial infection?

Approach

- **Initial Approach or GRIPS**
- **History of presenting complaint**
- **History of URTI symptoms**
    - Cough
    - Fever
    - Running nose

Differential Diagnoses

- **URTI**
    - Cough
    - Sneezing
    - Running nose
    - Sore throat
    - Fever
- **Pneumonia**
    - Shortness of breath
    - Chest pain
    - Fever
    - Sputum
- **Sinusitis**
    - Facial pain when bending down
- **Red flags:**
    - Meningitis
    - Rash
    - Neck stiffness
    - Headache
    - Photophobia
- **Acute otitis media**
    - Ear pain
    - Ear discharge

- **History of previous GP surgery visit.**
    - Any change to your symptoms in the last 2 days? Explain that swabs were taken and have come back normal.
    - Do you know why we performed the swab?
    - It is to check for bacteria which are not there and from what you have told me, and the swab we did, you have a condition called Upper Respiratory Tract Infection (URTI). In other words, it is a flu which has been caused by a virus.

- **Explain that bacterial infection would usually cause**
    - Pus in throat
    - Cough and sputum
    - Difficulty in swallowing

- **Red Flags : Complications of bacterial infections**
    - Tonsillitis: difficulty in swallowing, pus on throat.
    - Otitis Media: earache and discharge
    - Meningitis: rash, neck pain, headache, high temperature.

- **MAFTOSA**
- **ICE**
- **Effects of Symptoms**
- **Daily activities and job.**
- **Summarise**

- **Examination**
    - Observations: T, P, BP, RR,O2
    - Throat: rule out signs of bacterial infection
    - Ears.
    - Chest examination

- **Explain the findings and give diagnosis**

  From what you have told me and the swab we did, you have a condition called Upper Respiratory Tract Infection (URTI). In other words, it is a flu which has been caused by a virus.

- **Explain the course of viral infection:**
  - Reassure that it will resolve
  - Explain to the patient that viral infections initially gets worse for 3-4 days, remains stable in the next 3-4 days and after 2-3 days it starts settling down and you would be fine in a week or so.
  - Continue PCM, cough syrup, drink a lot of fluids.

- **Follow-up:**
  - 1 week from now to see how she is doing

- **Management**
  - Paracetamol
  - Cough Syrup
  - Ibuprofen
  - Lemsip
  - Drink plenty of fluids and rest well
  - Antibiotics would not help because it has been caused by the virus. Antibiotics usually do not work against viruses.
  - If the swab showed bacteria, we would definitely give you antibiotics
  - The antibiotics have got side effects, like diarrhoea, rash.
  - If you take the antibiotics frequently when you do not need them, in the future when you need the antibiotics, they may not work for you.
  - So it is important that you do not take antibiotics when you do not need them. If given when they are not indicated, they can cause harm.

Other scenarios

LIVING HEALTHY

3. HIGH BMI AND STATINS

Scenario:

You are an FY2 in GP Surgery.

Mrs. Lena Brown has come to the practice for her well-woman follow up. Blood tests were taken and examination was done.

FBC, LFT, TFT and U&E are normal

BMI is 28

Cholesterol on two occasions: 6.2

Q score: 14%

She has been planned to be started on statins.

Explain exam findings and discuss management plan with the patient

Patient Information:

- You are Mrs Lena Brown, a 30-year-old lady.
- Today you have come for a well-woman clinic follow up.
- The doctors last time had done some blood tests, checked your weight and height.
- You don't what Body Mass index (BMI) is.
- You do not smoke.
- You drink wine; a glass a day.
- You like eating outside, mainly fish and chips.
- Hang out with friends.
- You do not like exercising but play golf with your husband.
- You walk around the golf course with your husband.
- The doctors are planning to start you on statin.
- You are retired.

Questions:

1. If the doctors says he will start you on statin, ask him/her "Does statin have any side effects?"
2. So how can I reduce the BMI?
3. Will I be on statin for the rest of my life?
4. Doctor, am I obese?

- **Approach to scenario**
    - Initial Approach or GRIPS
    - Explain the results
        - Explains BMI
        - Explain the high cholesterol

    a. Explain that she needs to be put on statins

    b. Side effects of statins: muscle aches, drowsiness, stomach upsets, headaches

    - **Explain the Q score** which is a score that tells us the risk of developing a heart attack or stroke in the next 10 years, ideally this score should be less than 10%. We calculate it by taking many factors into consideration for example cholesterol levels, medical conditions (such as high blood pressure and high blood sugar), ethnicity, weight.
    - Explain that she has a slight increase in the risk of developing heart problems or stroke.

- **Take history of risk factors of CVS disease:**
    - Diabetes
    - Hypertension
    - Cholesterol
    - AF
    - Exercise
    - Diet
    - Heart problems
    - Previous stroke
    - Alcohol

- **MAFTOSA**
- **ICE**
- **Summarise**
- **Explanation**
- **Lifestyle advice**

A Healthy Diet

- 5 fruits everyday
- 2 portions of fish every week – ask if the patient eats fish first of all
- Add vegetables to your diet
- Refer to dietician
- Offer diet sheet

Exercises

- 2 ½ - 5 hours per week of exercises
- Take up activities such as jogging, walking and swimming
- Join local exercises groups

Other scenarios

4. HTN WORRIED ABOUT STROKE

Scenario:

You are the FY 2 doctor in General Practice.

Your next patient is a 67-year old Mr. Zimmerman who has come to your practice to see a doctor.

The nurse has checked the patient blood pressure and its 160/90.

Please assess and manage the patient.

You do not have to perform examinations.

Patient information

SCENARIO A: (Worried about stroke)

You are Mr. Edward Hopkins, a 67 year old patient.

You have come to see the doctor because you are concerned about the risk of stroke.

The nurse has taken your BP which is 160/100.

- Why? (because your father had stroke at age of 59 and he died)
- Your brother has stroke and he is 47 years old
- You are working as the board of NHS Trust
- Job is stressful
- Difficult time to assess financial situation for the hospital
- You tend to eat whenever you can. No time to eat properly
- Not exercising. Don't have time
- Smokes 20 cigarettes/day since you were a student.
- Tried quitting once but did not receive help that time
- Drinking moderate amount of alcohol
- You want to be referred for quitting but you want to know about stroke first
- You eat mostly Indian food
- You saw an advert on the TV which said if you have got a family member with stroke you can as well develop a stroke. This is why you have come to see the doctor.
- If the doctor says use stairs or go out to exercise, tell him that you are very busy. You cannot afford to be walking up and down. But if the doctor mentions that you will have to reduce your risk, you are willing to try and exercise or walk up the stairs.
- If they ask you to cook, you tell him/her that you are too busy, you cannot find time to cook plus you do not know how to cook.

Questions

1. I heard the word 'borderline'; what does that mean?
2. How can you help me with diet doctor?
3. What is the risk that I'll have stroke?
4. What can I do to prevent stroke?.

We have to develop a risk score to assess if there is likelyhood. - Smoking cessation Diet advice. 5 fruits & 5 vegetables.

SCENARIO B: (You went to a health insurance company who asked him to see his GP)
You are Mr. Robert Green, a 67 year old patient.
You have come to see the doctor because you are concerned about the risk of stroke.

- Why? (because your father had stroke at age of 59 and he died)
- Your brother has stroke
- You are working as the board of NHS Trust
- Job is stressful
- Difficult time to assess financial situation
- You tend to eat whenever you can. No time to eat properly
- Not exercising, don't have time
- Smokes 20 cigarettes/day since you were a student.
- Tried quitting once but did not receive help that time
- Drinking a lot
- You want to be referred for quitting but you want to know about stroke first
- You do not have any past medical history; no HTN, no diabetes

Questions

I heard the word 'borderline'; what does that mean?

- How can you help me with diet doctor?
- What is the risk that I'll have stroke?
- What can i do to prevent stroke?

SCENARIO C:

This is the first attendance to your practice

Approach

- **Initial Approach or GRIPS**
  - Loud, confident, smiling, supportive, nice and friendly
  - How can I help? Is there any reason why you are worried about stoke?
  - Ask what made you come and see the doctor today (demonstrate empathy about the dad and the brother having stroke)

- Reassurance that you can help him to reduce the risk of stroke. Is it ok if I ask you a few questions to see if there is anything putting you at risk?

- **History**
    - Risk factors (IHD, high cholesterol, hypertension, stress, diet, DM, exercise)
    - Stroke increases in intermittent claudication. Explain the risks of stroke.

- MAFTOSA
- ICE
- **Management**
- **Offer lifestyle changes**
    - Offer smoking cessation
    - Advice and help in alcohol reduction
    - Increase fruits and take 5 vegetables in a day
    - Reduce salt intake, it's important for blood pressure control.
    - Reduce caffeine (ask if patient takes coffee or tea too much)
    - Encourage relaxation and stress management (advice to get counselling for his work): Have you ever thought of getting some counselling regarding your stress at work? It's something that I would try and do.
    - Check cholesterol and treat accordingly
    - Arrange follow up in one month time
    - Exercise
    - Offer diet change and diet sheet
    - Check your weight and height
    - Do you know your weight?

- **Explain normal is BP (140/90)**

His BP is 160/100. It is just on the border between when medications are indicated and when lifestyle changes can be used to lower the blood pressure.

- Confirm the blood pressure using ambulatory blood pressure measurement.
- The ambulatory blood pressure cuff measures your blood pressure every 20 minutes during the day and every 1 hour during the night.
- Ambulatory blood pressure measurement is required to confirm that your blood pressure is constantly high.

- **Further examinations;**

Hypertensive retinopathy - ask about visual problems and suggest to perform a fundoscopy.

  - Intermittent Claudication: ask about pain in the legs
  - Cardiomegaly: Perform chest x-ray
  - IHD: perform an ECG
  - Hypertensive Nephropathy: Check urine test and ask about swelling of the legs. Blood tests to check kidney function.
  - Check cholesterol levels

- Arrange a follow up in 1-week time (This is when you are going to have all the investigations with you and you can discuss with the patient the results)

Red Flags:

To go to the ER immediately or call 999 if develop any of the following:

FAST

Face - asymmetry or numbness

Arm - weakness of arm

Speech difficulty/difference

Time

⇒ safety net for stroke
⇒ council abt stroke

Other scenarios

5. HTN WITH HIGH Q SCORE

Scenario

You are FY2 in GP surgery

Richard Branson a 50-year-old man came for follow up.

He came last week and had some tests done.

He was placed on 24 hours BP monitoring and the average BP is 165/95.

Q Score 16

BMI 28

Talk to the patient, address his concerns and discuss further management with him.

Patient information

- You came one week ago for a general checkup because your wife advised you to do so.
- You and your wife watched a TV program on annual checkups which states that everyone above the age of 40 should go to their GP regularly
- You are normally fit and well and not on any medications.
- You are a businessman; you sit in an office for very long hours so you don't have time to exercise.
- You eat outside most of the time.
- Your job is very stressful.
- You have been smoking 26 cigarettes a day for the past 18 years.
- You drink 2 glasses of wine a day.
- You have two grown-up children and you live with your wife.
- When the doctor advises you on quitting smoking and cutting down on drinking, you agree.
- When the doctor advises you on diet and exercise, you say "I'll try to diet and I'll take the stairs instead of the lift, I don't want a gym instructor."

Questions:

1. What is BMI, doctor?
2. What are you going to do for me?

Approach:

- **GRIPS**
- **Explain the examination findings (BMI, BP and Q score)**
    - BMI is a ratio of your weight to your height.
    - The normal BMI is between 18.5- 25
    - If the BMI is between 25-30 we say that someone is overweight and if it is above 30 we say that someone is obese.
    - Unfortunately, your BMI falls in the category of overweight.
    - You also had your blood pressure checked. After measuring your blood pressure, we found that it is on the higher side 165/96

- **Management**
    - So we need to start you on some medications to control your blood pressure.
    - We might need to start you on some medication called Ramipril.
    - It has some side effects like cough, if that becomes a problem we can change it to a different one.
    - It can also affect your kidneys sometimes so we need to check your kidney function before we can start the medication.
- We also calculated what we call Q score.
    - -A Q score is the parameter that indicates the risk of developing heart problems or stroke.
    - -The normal Q score is less than 10
    - -Unfortunately, in your case the Q score is 16 which is high.
    - -This means that you have got an increased risk of suffering from heart problems.

Other scenarios

TRANSIENT ISCHAEMIC ATTACK

6. TIA

You are FY2 doctor in A and E.
Linda Jones, aged 69 has been brought to the hospital by her husband due to weakness on one side of body, slurred speech, dropping of angle of the mouth and difficulty in swallowing. Symptoms lasted for 15 minutes and it happened 3 hours ago.
General and neurological examinations have been done and there were no findings.
BP was measured and recorded as 150/95.
Routine blood test has been done and still awaiting results.
CT scan of the head has been done and is normal.
She has been referred to the TIA clinic tomorrow.
Take history from the husband, assume consent has been given and discuss further management.
Patient is completely fine now but she is too upset to talk and she has asked to talk to her husband.

Patient information

You are Mr. Robert Green, a 70-year-old man.
Your wife Alice Green developed loss of vision, difficulties in speaking and difficulty in moving her right arm for 2 hours. It happened 3 hours ago.
It happened while you were having breakfast.
You called an ambulance which brought her to hospital.
You have now seen your wife, she has recovered from all the symptoms and you are delighted.

- She drinks 2-3 glasses of red wine per week
- This is the first time this has happened to her
- No family history of stroke
- No medications history
- She does not do exercise
- She smokes 20 cigarettes/day
- She does not like eating vegetables and fruits
- Your wife is upset at the moment and she does not want to talk, this is why she has asked the doctor to talk to you.
- Both you and your wife are retired teachers in a secondary school.

Scenario A:

- You were watching TV at the time when your wife developed the symptoms of weakness in her arm, difficulties in speaking and dropping of the corner of her mouth.
- The symptoms lasted for about an hour.
- You have seen your wife now, she is completely fine and you are very delighted with this.

QUESTIONS:

1. Will it happen again?
2. Is there anything she can do to prevent this from happening again?
3. What caused it doctor?
4. What are you going to do for her?
5. What is TIA?

Scenario B

Patients Information:

- 57 year old lady
- You were in the kitchen with your wife when she developed difficulties in speaking and in moving her right arm for 15 minutes. It happened 3 hours ago.
- She drinks 2-3 glasses of wine per week
- Non-smoker
- Walks 30 minutes a day
- Healthy diet
- No family history
- Blood tests results are not yet back
- Presenting complaint: visual problems and facial weakness
- Patient is very careful about her diet; does not like eating vegetables and meat. Does not know the normal limit of salt
- Has been smoking 20 cigarettes/day for 20 years
- Drives and is active (walks around for more than 30 mins)
- Drinks alcohol 2-3 units/week

QUESTIONS:

You are a happy person and want to take your wife home.

1. Can I take her home?
2. What caused the problems?
3. Will it happen again?
4. What do we need to do to prevent it from happening again?

Approach

- GRIPS
- Check relationship to the patient (May I know how you are related to Mrs. XYZ?)
- Check prior understanding.
    - What have you been told about your wife's condition so far?

History

- Symptoms of TIA:
    - Unilateral weakness
    - Loss of sensation
    - Loss of coordination
    - Syncope
    - Loss of vision
    - Speech – difficulties in talking
- Risk Factors:
    - AF
    - High blood pressure
    - High blood sugar
    - Previous stroke or TIA
    - Family member with stroke of TIA
    - Heart problem
    - Smoking
    - Exercise
    - Diet
    - Alcohol
    - Passive smoking (someone smoking in the home)

- **Explain the examination findings**
    - All her examinations are normal.
    - The weakness and speech problem she had have all resolved.
- Explain that the blood pressure was high 150/100.

- **Explain the diagnosis**
    - What she had is what we call Transient Ischaemic Stroke (TIA) or a mini-stroke.
    - TIA (mini-stroke) or stroke usually develop if there is a blockage of blood supply to the brain.
    - This is usually due to blocked blood vessels that may happen due to age.
    - It is a temporary stroke.
    - Symptoms are usually resolved within 24 hours.
    - It does not usually leave any permanent damage.
    - Explain that as someone grows older he or she becomes more likely to suffer from ministroke or stroke.
    - If someone has suffered a mini-stroke, they are at high risk of developing stroke. So we need to refer her for assessment by the stroke specialist.

- **Notes:**
    - If low risk, refer to the outpatient TIA clinic
    - Avoid driving for one month after TIA.
    - When can I go home?
    - We are looking at 3-4 days staying in hospital.

3-4

- **Investigation**
    - **Blood test:** They have been sent but we are still waiting for results.
        - Blood glucose
        - Cholesterol level
    - **CT scan**
        - Explain that it is normal if it has already been done.
        - If it has not been done, explain that we will perform a CT scan of the brain to check that she does not have any sort of bleeding.
    - **ECG**
        - We will perform an ECG

- **Management**
    - Aspirin 300mg
    - Assessment within 24 hours.
    - Give family members and patients information on recognition of stroke or TIA
    - FAST Scan
    - Advise not to drive
    - Other information on stroke, TIA and risk factors.
    - Advice on lifestyle:
        - Alcohol: Drink not >14 units per week, but this must be spread over 3 days.
        - Encourage physical activities.
        - Advise smokers to stop and non-smokers to avoid passive smoking.
            - (This particular patient is not a smoker but her husband is a smoker, so she could be having passive smoke)
            - He needs to smoke away from the house.
            - Does he smoke inside the house?
    - Advice about diet.
        - 5 portions of fruits
        - Reduce salt intake
        - 2 portions of oily fish per week
- **NOTE:**
    - Generally if a patient had a stroke within one week, he or she needs to be seen in TIA clinic within 24 hours.
    - If patient had a TIA more than one week ago, can be seen in TIA within a week.

- **Explain what the specialist will do**
    - Perform further investigations such as Doppler scan of the neck to check for any blocked blood vessels in the neck that could have led to a mini-stroke.
    - They will also start her on simvastatin to reduce cholesterol further down even if it is normal.

OTHER SCENARIOS

DISCHARGE DISCUSSION WITH PATIENTS

7. EPILEPSY IN A 13 YEARS OLD CHILD

Scenario:

You are FY2 in the neurology department.

Patricia Jones a 13-year old girl who is being discharged home after being admitted with a seizure.

Patricia Jones was admitted 3 days ago with a seizure with a generalized tonic clonic seizure and electroencephalogram showed epileptic foci in the brain. She has been prescribed the medication and the medication has already been explained to the mother.

She is now ready for discharge home.

Please talk to her mum, Victoria Jones and address her concerns.

Patient information:

Your name is Victoria Jones and you are a 45 year old lady.

You brought your daughter Patricia with a seizure to the hospital 3 days ago. Patricia has been diagnosed with epilepsy and has been prescribed with anti-epileptics but this has not been communicated to you.

Patricia likes swimming, dancing and riding her bicycle. This is the first time she has had a seizure. She is otherwise fit and well. No allergies. No regular medications.

You have been prescribed sodium valproate but the medication has been explained to you.

Questions:

1. What is wrong with my daughter?
2. Can she continue dancing or swimming?
3. Are there certain things that she must not do?
4. Do I have to accompany her everywhere she goes?
5. Will the other siblings have the same condition?

Approach:

- **GRIPS:**
    - Loud confidant
    - Smile
    - Shake hands

- **Paraphrase**
    - I understand that you are going home today.
    - I have been asked to talk to you and see if you have any questions about Patricia's condition at all.
- **Check prior understanding**
    - So I understand Patricia had a fit. What have you been told about her condition so far?
    - And do you have any questions about her condition?

- **History**
    - **Social history**
        - Does she go to school?
        - How is she doing at school?
        - What does she like to do in her free time?
        - Does she plan to drive?
        - Does she ride a bicycle?
        - Does she go out for discos?
        - Riding horse?
    - **Precipitating factors:**
        - Throbbing lights
        - Alcohol
        - Stress
        - Not sleeping enough
        - Watch TV with flashing lights
        - Going to disco
        - Not sleeping enough

- **Management**
    - **Advice on activities to avoid:** There are some activities which need to be avoided
        - Avoid dangerous activities e.g. riding bicycle, mountain climbing, bungee jumping, horse riding.
        - When bathing it's better to take a shower rather than a bath.
        - If she wants to take a bath, it's better to take a shallow bath.
        - Also should avoid locking the door when bathing, so people can reach out incase she has a seizure.
        - Take medication regularly; they are there to prevent the seizures.
        - She needs to avoid cooking when alone - due to the risk of falling on fire or stove if she develops a seizure.

Doctor can she swim?

Can swim but needs supervision. She needs to inform someone so that in case she has a seizure, people should help

Doctor can she dance?

What type dancing does she do? Are there any flashing lights?

Do I need to follow her everywhere she goes?

You do not need to follow her everywhere she goes.

She can wear a bracelet which shows that she has got epilepsy and if she develops a seizure people would help. Informing her friends when she goes out can help too. As long as she is comfortable to tell them.

Note:

- This station is about addressing the concerns.
- Not to talk about epilepsy alone.
- So listen to her questions and answer her questions and then find some space in the conversation to take history about the social life of the child.
- But make sure all the concerns have been addressed.

8. POST MI ADVICE

Scenario

You are an FY2 in the medicine department.

Mr. Ellis Jones, a 60 year old man, was admitted 3 days ago with acute myocardial infarction.

He is being discharged home today and he has been prescribed the following medications: Aspirin 75mg daily, Enalapril 20mg once a day, Simvastatin 20mg once a day and Atenolol 50mg once a day. All the medications have been explained to him.

He has got some doubts about his lifestyle changes.

Talk to patient and address the concerns.

Patient information

You are Mr. Ellis Jones a 60-year-old man who was admitted 3 days ago with chest pain. You have been diagnosed with a heart attack and you have been given the appropriate medication:

- Aspirin 75mg daily
- Simvastatin 20mg once a day
- Enalapril 10 mg once a day
- Atenolol 50mg once a day

Scenario A:

You are a business man and go for different business conferences, so you do not have time to exercises or cook.

You travel most of the time.

Your next business meeting is in 3 days from today and you are planning to fly to Australia for another business meeting.

Questions:

1. Is it safe?
2. When can I go back to work?

Scenario B:

You work as a bus driver, you are wondering when you can return to work.

You are worried that you can lose your job?

Will I be able to work as a bus driver?

You eat take away most of the time.

You smoke 20 cigarette/day since you were a teenager

You heard from someone that smoking affects that heart.

Questions:

1. What lifestyle changes do I need to make?
2. I am planning to go to Australia by flight in 3 days' time, is it ok for me to travel?
3. What type of diet do I need?

Approach:

- **GRIPS:** Smile, shake hands, be loud and confident.
- **Paraphrase the scenarios:** I understand that you wanted to talk to a doctor. Is there anything you wanted us to talk about?
- **Ask if he understand what is wrong with him:** What have you been told so far regarding the reason of admission? And about how we are planning to manage you?

I have been asked to come and talk to you about your condition. But before we start, what have told so far regarding the reason of your admission? Is there anything you wanted us to discuss?

Explain that he has got a heart attack which usually occurs when the blood vessels of the heart get occluded. Reassure him that he has been treated effectively in good time and he is expected to have a good recovery.

- **History**
    - Diet: How is your diet?
        - Do you normally eat a balanced diet?
    - Alcohol
    - Smoking

- **Management**
    - **Diet:** Offer a diet sheet, 5 fruits every day, 2 portions of fish every week, reduce salt intake, add plenty vegetables to the diet, try to cook at home as much as you can. Offer diet sheet. Avoid fast/quick foods
    - **Alcohol:** Drink less than 14 units per week for both men and women
    - **Smoking:** Advice to stop, if he is not willing, tell him that in future should he needs help there is help available.
    - **Refer to cardiac rehabilitation.**

- **Exercise:** Brisk walking 20-30 minutes daily would usually help but needs to avoid strenuous exercise as it can exacerbate a heart attack.
- **Flying:** Can fly after 2 weeks if there are no other risk factors and it is first time he had a heart attack. But always safer to travel after two weeks.
- **Sexual intercourse:** Can resume as soon as he feels comfortable. It is better to rest 4-6 weeks after a heart attack.
- **Manual work:** Rest 4-6 weeks and then can return as soon as he feels comfortable.
- **Driving:** Advise him to avoid driving for 4-6 weeks. As a bus driver, he need to inform DVLA and he will need to take an exercise tolerance test before he goes back to work.

- **Follow up:**
  - You will arrange a follow up in about 6 week time in our patient

- **Red flags:**
- If he develops chest pains, dizziness, shortness of breath, nausea, vomiting which do not respond to his medications he needs to come to hospital or call 999.
  - Has he been given GTN medications?
  - If the chest pain is not responding to GTN, call an ambulance.

- **Offer leaflets.**

Other scenarios

WARFARIN TREATMENT

9. WARFARIN

Scenario A

You are an FY2 doctor in the general medicine ward.

Your next patient is Mr. Thomas Green is a 56 year old man who was admitted 4 days ago with swelling of his right calf. Please talk to the patient and address his concerns.

Patient information:

- You are a 56 year old man, Thomas Green, who was diagnosed with DVT. You presented with the complaint of calf pain and you were diagnosed with DVT. You were treated successfully and are ready to go home. You are wearing a hospital gown.
- You do not have any learning difficulties.
- You have got no other past medical history.
- You should be holding warfarin in your hand.
- You have been given medication and you have been told that the doctor will come and explain it to you. explain abt warfarin.
- You drink 2-3 units of alcohol per week.
- You love cranberry juice.
- You pronounce warfarin excellently.
- You want to know everything about warfarin.

Scenario B:

- You are wearing normal clothes.
- You are able to say warfarin.
- You watch a TV show every day.

Questions

1. Which test do I have to do?
2. Will I be coming to do the blood test?
3. What is the dose? according to INR
4. How often will I need to get my INR checked? 2-3months.
5. What time should I get the blood test done?
6. Do I have to take the medication every day? yes.
7. How long do I have to take the medication?
8. Can I take the medication with the TV show?
9. Why I should take this medicine on a particular time? at night. + compliance.

Approach:

- Check what patient knows
- Paraphrase the scenario
- Explain the diagnosis, which is: DVT (clots in the legs)
- Explain the treatment (Warfarin)
- Explain how to record in the warfarin diary chart
- Explain that he will need a blood test called INR which can be done either by the GP or anticoagulant clinic.
    - The INR blood test will tell us how thin the blood is.
    - You'll have blood tests in the morning, then in the afternoon, the blood test will be telephoned to you and the dose will be advised and you will be told what dose to take.
    - Take the medication every day at 6pm
    - If you miss the dose do not try and take a double dose
- Explain the dose, and how to use drug
- Use the BNF to check the BNF (dose, duration)
- Then review of the medication and progress routinely

- **<u>Important information!</u>**

<u>Alcohol:</u> not to be exceeded. Recommended levels:

- 1 pint of beer is 2 units
- 1 pub measure of spirit is 1 unit
- 1 glass of wine (125ml) is 1 unit

- **Side effects of Warfarin:**
    - Nose Bleed
    - Bruising
    - Vomiting
    - Dark stools
    - Blood in urine
    - Heavy menstrual bleeding
    - Inform your dentist

- Pregnancy
    - Warfarin can affect the development of the baby.
    - Try to avoid any unplanned pregnancy.
    - Inform your GP, because during pregnancy the medication will need to be changed to a different form.
- In females: periods become heavier.
- Head injury: in case of head injury, there is a risk of bleed in the head, so you must come to the hospital for assessment.
- Avoid alcohol, double dose, cranberry juice, OTC, NSAIDS, Ibuprofen
- Any other medical problems (bleeding disorder)

- **Red flags:**
    - Any blood in urine/stool.
    - Any bruises
    - Any head injury, come back to hospital so that we can assess you.

Other scenarios

FOLLOW UP SCENARIOS

10. EPILEPSY IN AN ADULT

Scenario:

You are working as a FY2 doctor in General Practice.

Mr. Sandeep Singh is a 20 year old man who has come to the practice for review.

He has been referred to your GP practice for follow up.

Explain idiopathic epilepsy to the patient and address his concerns.

Patient information:

Scenario A:

- You are Sandeep Singh, 20 year old man
- Presented with fits 21 days ago
- Today you have come for follow up
- You have had 2 seizures in the last week
- You have taken the medication twice because you thought you only had to take the medication when you had a fit
- You have come to see your GP for review after having a fit 21 days ago
- You were started on Sodium Valproate 300mg twice a day
- Not taking your medications properly
- You have a driving test in 3 weeks' time and you are keen to start driving
- You are upset that you will not be able to drive
- You like cycling
- You are planning to go for a holiday to Kenya for mountain climbing with your boyfriend
- Your weight is 70kg
- You were told you have epilepsy but you did not understand exactly what is epilepsy.

Scenario B:

- You are Samantha Jones, a 30 year old lady who has come for follow up.
- You are sexually active with your boyfriend and you are taking COCPs.
- You are thinking about having a baby in a years' time

Questions:

1. What are the side effects of sodium valproate?
2. When will I be able to drive again?
3. I am thinking of having a baby in 1 years time, will this affect this?

Post-natal depression → Always refer to specialist

Approach

- **GRIPS**
- **Paraphrase**
    - I understand that you are admitted to the hospital with a seizure and you had some investigations done. What were you told while you were in hospital in terms of the cause of your seizure and reason of admission?
    - Check how the patient has been since he was last discharged from the hospital.
    - Check that he understands his condition well and ask if he has any questions regarding his condition.
    - What did you understand by epilepsy?
    - Ask if he had any more seizures since he was discharged from the hospital.

- **History Taking**
    - If patient had a seizure ask them how many seizures they have had and what they were doing at the time when they had the seizure?
    - Try to see if there were triggers to the seizures such as alcohol, flashing lights, lack of sleep
    - Take details if there has been new symptoms or worsening of symptoms.
    - Check compliance
    - Ask if patient has been taking the medications regularly and if they have been taking the right dose.
    - If not compliant explain how they should have taken their medication and ask the reasons why they have not been taking the medication regularly. The common reason for not taking the medication is not knowing how to take it or medication is interfering with their life.
    - This particular patient was supposed to take Sodium Valproate 300mg daily but took it only when he had a seizure which is wrong.

- **Check side effects to the medication. Ask specifically about each side effect.**
    - Hair loss – a change of medication might be considered
    - Nausea and Vomiting
    - Liver damage

- Kidney damage

- Assess response to treatment e.g. seizure control, worsening of the seizures.

- **Ask about the effects of the symptoms e.g. seizure on daily functioning and quality of life.**
  - In particular ask how the condition or the symptoms are affecting work or school or leisure activities.

- **Diagnosis of epilepsy:**
  - Epilepsy is a disease of the brain defined as the following:

  At least 2 unprovoked seizures occurring more than 24 hours apart.

- **Explanations:**
- If there is a carer, make sure that the carer knows what to do in case of an emergency e.g. the carer must know what to do in case the patient has a seizure.
  - Protect person from injury by cushioning their head with hands or soft material.
  - Remove harmful objects around the person.
  - Do not put anything in the mouth.
  - Do not restrain the person.
  - When the seizure stops check their airway and place them in the recovery position.
  - Observe the person until he has recovered.
  - Call an ambulance immediately.

Explain the possible complications of the condition if the patient is not aware or the side effects of the medication.

- **Seek specialist advice if:**

1. Poor seizure control or patient does not tolerate the drug.
2. If prolonged or recurrent seizures.
3. If cognition impairment

4. If patient has been seizure free for the last 2 years and would like to withdraw or taper from the drug treatment. Make sure the patient understands that there is a risk of reoccurrence.

That they are not entitled to drive from the stop of medication and 6 months after stopping the medication.

Note:

- Women of child-bearing age with epilepsy.
- Long term enzyme inducing anti-epileptic drugs may reduce the effectiveness of COCP and POPs. Advise women to consider non-enzyme inducing contraception such as progesterone only injectable or IUCD or IUS.
- Women who are planning to get pregnant and they are taking anti-epileptic drugs
- Refer to epileptic specialist for pre-conception counselling. She should continue using contraception.
- Advise that there is increased risk of malformation and neuro-developmental delay of the child. There is possible increased risk of seizure frequency in pregnancy.
- If the woman is already pregnant and is taking anti-epileptic medication, advise to continue anti-epileptic medication and refer to epileptic specialist.
- Enzyme inducing epileptic drugs include carbamazepine, oxcarbazepine, phenobarbital, phenytoin, primidone, and topiramate.
- Sodium valproate and lamotrigine are non-enzyme inducing drugs. COCP may affect the effectiveness of lamotrigine and a high dose of lamotrigine may be required and therefore refer to specialist

- **Follow up appointment** in 1 month time

- Advice the avoid drinking, inform DVLA.

11. OSTEOPOROSIS

Scenario

You are FY2 in Orthopaedic and Trauma Department.

Deborah Jones is a 65-year old lady who has come for follow up.

She had a fracture of her right wrist 3 months ago which was treated successfully and she is now fine. She had undergone a DEXA scan while she was in hospital which showed osteoporosis.

Talk to the patient about further management and address her concerns

Patient information:

- You are Liz Jones, 65 years of age. You fell down in your back garden and sustained fracture of the right wrist
- It was a simple fall. You had a DEXA scan done but you don't know the results yet.
- LMP was 10 years ago.
- Your mum has osteoporosis and she is on medications.
- You are not sure of the name of the medications.
- You had a hysterectomy 15 years ago but the ovaries were not removed.
- You smoke 20 cigarettes a day since your university days.
- You drink a bottle of wine every day.
- You work as a school teacher.
- You don't have much time to eat so most of the time you eat takeaway food.
- You have not been told that you have osteoporosis and you do not know what osteoporosis is.

Questions:

1. Does osteoporosis run in the family?
2. How would you treat me doctor?
3. How do I take the Alendronic acid?
4. Are there any side effects of osteoporosis?
5. What is DEXA Scan?

- DEXA scan is to check the health of your bones

Approach

- **GRIPS (** Smile, Loud, Confident, Shake hands)
- **Paraphrase the scenario:** I understand that you sustained a fracture of your wrist couple of months ago?

- **Explain the results:**
    - How are you doing now? I also understand that you had a DEXA scan done. Has anyone been here to explain the results of your scan?
    - Did anyone explain to you why this scan was performed?
    - Explain what osteoporosis is. This is a condition when the bones are weak.

- **Take history:**
    - Previous operations (Gynaecological operations?)
    - Family history of osteoporosis or fractures?
    - PMHx
    - Drug Hx
    - Any other fractures in the past?
    - Questions about lifestyle habit?
    - Were the ovaries removed?
    - LMP?
    - Any menopausal symptoms? (hot flushes, irritability)
    - Smoking?
    - Alcohol?
    - Diet?
    - Exercise?
    - Living conditions / Any help required at home?

- **Management of osteoporosis**
    - **Diet:** offer a diet sheet and refer to dietician

- **Medications**:
  - Vitamin D and Calcium tablets
  - Bisphosphonates (Alendronic Acid):
    - it prevents further fractures
    - it takes a few months to work
    - it makes the bones much stronger
    - you will be taking it once a week on the same day
    - you need to take it 30ml's of water and swallow the whole tablet
    - take it on empty stomach
    - take it first thing in the morning
    - After taking the medication, wait for at least for 30minutes before eating or drinking anything. If you eat anything within the 30minutes, the medication will not get absorbed
    - Stay upright for 30minutes.
    - **Dose:** 10mg OD or 70mg Weekly
    - **Side effects:** Indigestion or heartburn: Talk to your GP

- **Exercise**
- **Reduce alcohol**
- **Stop smoking**
- **Explain** that having a family member with osteoporosis does put you at risk of osteoporosis.

12. POST MR HEART FAILURE

Scenario:

You are an FY2 doctor in the out-patient department.

Mrs. Elizabeth Wilkinson is a 68 year old lady who came for follow up.

She had a myocardial infarction 15 years ago.

Talk to the patient, assess her and address her concerns.

Special Note: There is a MEWS Chart and other information in the cubicle.

Patient Information:

Scenario A:

- You are Elizabeth Wilkinson, a 68 year old lady.
- You had a heart attack 6 weeks ago.
- You were admitted for 6 days and then discharged on Enalapril, Atenolol, Simvastatin and Aspirin.
- You have been taking all the medications as prescribed.
- 3 weeks ago you started experiencing shortness of breath while walking.
- You live on the second floor and you have to rest for about 15 minutes when you are halfway through the stairs.
- Your shortness of breath is worse when you lie flat; you prefer to sit on the couch.
- Nowadays you sleep on the couch due to cough and shortness of breath when you lie down.
- You have also noticed that your legs have started swelling up.
- Initially, you had only swelling of the ankle but now it's gone up to the knees.
- The swelling of the legs is worse by the end of the day and it also improves by elevating legs.
- You have no chest pain.
- You do not drink alcohol.
- You smoke 15 cigarettes/day since you were in high school.

Scenario B:

You were diagnosed with myocardial infarction 15 years ago.

- You have had heart failure 7 years ago.
- You are placed on some medications.
- Today you have presented for follow up.
- You have had shortness of breath and swelling of the legs for the past few weeks.
- You sleep with 6 pillows.

Questions

1. What is wrong?
2. How will you help me?

Approach:

- **GRIPS** (nice, smile, shake hands)
    - I also understand you had a heart attack 6 weeks ago.
- **Paraphrase scenario:** I understand that you have come for follow-up.

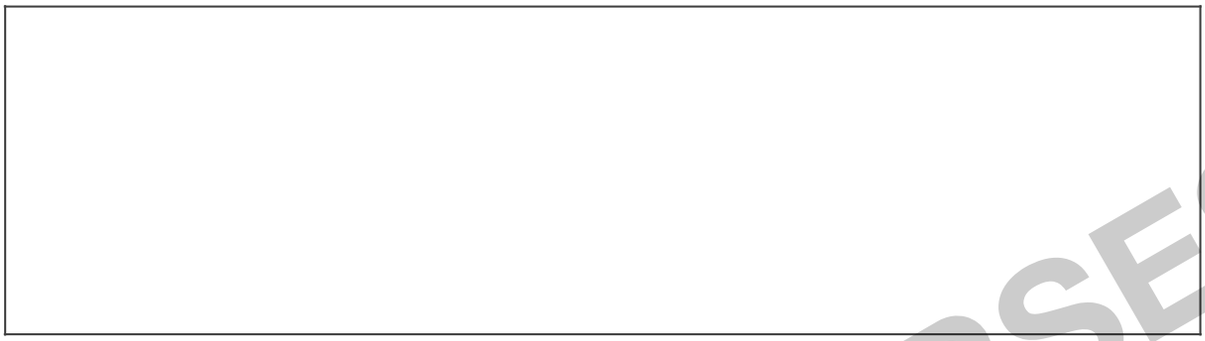
- **History:**
    - **Complications**
        - Heart failure: SOB, swelling of the legs, chest pain
        - Arrhythmias: palpitations
    - **Side effects to medications:** ask for side effects if taking any medications
    - **Compliance:** if patient is taking any medication ask whether they are regular with the medication

- **P3MAFTOSA**
- **Effects of symptoms on life:** How is this affecting your life?
- **ICE**
- **Observations**
- **Examinations -** Chest (listen to lungs), listen to heart

- **Management:**
- From what you have told me, you most likely have a condition called heart failure
    - **ECG:** Explain the diagnosis
    - **Bloods:** FBC, LFTs, U&E
    - **BP:** confirm with ambulatory BP
- Give BP medications
- CXR
- Echocardiogram
- **Admit** whenever vitals are not stable. we admit.
  we admit otherwise too bcz awaiting results.

water tablets.

- Offer diuretics (Furosemide, intravenous antibiotics)
- I will take a second opinion from my senior and if they suggest a different opinion, I will come back and let you know.
- **Other scenarios**



HYPERTENSION FOLLOW UP

13. HYPERTENSION FOLLOW UP

Scenario A

You are working as an FY2 doctor in general practice surgery.
Your next patient is Pat Jones a 53 year old man who has come for follow up.
Patient has diabetes mellitus.
Patient was admitted with cellulitis of his right leg 6 weeks ago for which he was treated with antibiotics successfully. During his hospital admission patient was diagnosed with hypertension and placed on some medications.
Please talk to the patient, take focused history, check the blood pressure and discuss initial management with the patient.
This is his first review. Do not examine the patient

Patient Information:

- You are Pat Jones, a 53 year old lady
- You have got Diabetes Mellitus Type 2 which is controlled by diet.
- 6 weeks ago you had cellulitis of the right leg for which you were admitted and treated with IV antibiotics
- During your hospital stay, the doctors found your blood pressure to be high and they arranged your follow up for today
- Your weight is on the higher side, 105kg, with a height of 165cm.
- **You were started on the following medications:**
    - Enalapril
    - Simvastatin
    - Aspirin
- You take simvastatin in the morning and aspirin in the evening.
- You do have stomach upset after taking aspirin.
- You have the boxes of these medications during the consultation with you
- The Enalapril medication has caused a severe dry cough with you and as a result you stopped taking it 2 weeks ago. As soon as you stopped taking it, the cough stopped.
- But you are still taking the other medications as follows:
    - Simvastatin you are taking it in the morning.
    - Aspirin in the evening.
- You are not able to sleep properly if you take the Enalapril medication.
- The doctor will be here to check your blood pressure and will discuss further management with you

Questions:

1. Doctor will you give me different medication? Because this one is giving me a very bad cough
2. If the doctor says he will change the medication ask him which one will you give me?
3. Ask the doctor if the new medication will have side effects.

Approach:

- **GRIPS:** shake hands, smile, confident, eye contact.
- **Go through the admission**
- **Paraphrase** - I understand you came in for follow up?
    - I also understand that you were admitted in hospital 6 weeks ago. Can you tell me what happened at the time?
    - How have you been doing in general since you were discharged?
    - Can you tell me what happened during your last hospital stay?
    - Other than the infection of your skin, were you told that you have any other medical problems at all?
    - I also understand that you were started on some medications;
    - Explain the BP
    - Explain that he was found to have high blood pressure, this is why he was started on one medication.

- **History of cough:** When did he develop the cough?
    - Does he smoke?
    - SOB?
    - Chest pain?
    - Fever?
    - Any other symptoms?
    - Do you smoke?

- Ask (Enalapril)

1. Use BNF

Give medication i.e. Losartan 50 mg OD

2. Side Effect

- Liver damage
- Headache
- Sleep problem
- Swelling of legs (rare -do not happen to everyone)
- Erectile dysfunction (rare -do not happen to everyone)

- Are you having any problem with the medication? Simvastatin
- What about aspirin? i.e. Tummy pain Bleeding.
- Check blood pressure of the patient

- **Examination and Investigation:**
  - **Hypertensive retinopathy:** ask about headaches, visual problems and suggest to perform a fundoscopy.
  - **Intermittent Claudication:** ask about pain in the legs
  - **Cardiomegaly:** perform chest x-ray
  - **IHD:** perform an ECG
  - **Hypertensive Nephropathy:** check urine test and ask about swelling of the legs
  - Lifestyle change: diet (decrease salt/fat, refer to dietician but ask if the patient is happy to do so) stop smoking, refrain from stress, coffee, tea,
  - Check the BMI (ask about his weight and his height)
  - Ask about stroke in the past
  - Blood tests to rule out renal failure (U&Es to make sure the kidneys are functioning properly)
  - Urine test to check if he is losing any proteins in his urine.
  - Talk about life style: diet - offer a diet sheet, make referral to dietician, smoke - exercise - weight

- Change the medication and review again in 2 weeks.

Other scenarios