

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 Impairment

- 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)

SAMSON COURSES

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 lose 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

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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

SAMSON COURSES

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 reflux 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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SAMSON COURSES

12. HYPERPARATHYROIDISM

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 much milk
 - b. Stop taking vitamin D
 - c. Stop taking calcium tablets

SAMSON COURSES

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

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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 37°C, 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.

“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.

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?”

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.

- 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?
- 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?
- 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 < 6 months, 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?

Approach:

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

- **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?

- **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 complaint (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

SAMSON COURSES

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**

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.

Examinations:

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

Management:

- Blood, U&E, LFT, TFT
- Refer to eating disorder clinic
- Cognitive behavioural therapy
- 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

Admit

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

- Urgent referral if BMI <15

Medical complications:

- Arrhythmia
- Hypoglycaemia
- Electrolyte imbalance

SAMSON COURSES

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:**Principles of sleep hygiene**

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)

Drug treatment

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.

- **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
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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

SAMSON COURSES

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

Key questions to ask about the current episode of self-harm

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

Before

- 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?

During

- 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?

After

- 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?

APPROACH: (negotiating approach)

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

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 order 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.

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.

Assessment of current drug and alcohol use:

History:

Types of drugs used:

- 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.

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:

- 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.

SAMSON COURSES

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?

Effects on daily living:

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 to

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 consumption

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.