1. **Diabetes Mellitus Type 2**

45 year old lady in your GP clinic presenting with feeling tired for a month. She has been feeling tired for some weeks and running down. She also has urinary symptoms and feeling more thirsty than before.

Brief History

Physical examination to be asked from examiner

Order Investigations

Explain to your patient about your Management plan

She had been suffering from vague tiredness for a month associated with weight loss about 3 kg. She also noticed increased frequency of urination but denied any burning pain, change in urine color, incontinence, urgency or loin pain. It is associated with feeling more thirsty than usual.

There were no other signs and symptoms apart from that. Not depressed.

No previous relevant medical history, family history, not on any GI upset.

Physical Examination reveals- BMI 31, BP -135/85 mmHg, others – unremarkable

Urine dipstick- sugar +++ but no ketones

BSL – 16 mmol/L

Order investigations whatever you can think of – everything will be pending except High BSL and Urine positive for sugar.

While explaining the patient about DM type II and management including life style modifications and referral, role player's expression was somewhat confused about treatment.

Questions from role player- what is the cause? – "It is a metabolic disorder; we can't point out single cause. But there is high BSL because impaired control by insulin hormone. Cause is multi factorial. That means it involves life style, diet, weight, genetic and other factors.

It can be well controlled by life style modifications and medications. So don't worry. There are many diabetic patients living out there enjoying life with very limited restrictions.

I organized a numbers of blood tests and investigations because there can be associated conditions like heart disease.

What is the immediate management?

"Adoption of healthy life style, weight reduction to healthy level, regular exercise, diet control. I m gonna refer you to dietitian and specialist for assessment. You also need to see specialist for eye check up and podiatrist for foot care. These check-ups should be done annually or two yearly. And I will also follow u up when the other lab tests are available and to monitor your BSL control. If its not controlled by the mentioned measures then you will need to have insulin injection as treatment.

Does my son can have it in the future? – I answered that "it is possible so I'd like to suggest to test his BSL as well if there is any suspicious symptoms. But don't worry. With healthy life style, exercise and diet program the onset can be delayed or conditions can be controlled well."

I didn't have time to talk about complications but still passed.

2. Perforated PU

You are a HMO in ED of hospital. A man came to ED for Acute severe abdominal pain which is worsening over 2-3 hours. He is a chronic heavy smoker and drinks 4-5 wine a day. Since 2 weeks ago, he has been taking Diclofenac as his GP described it for joint pain and swelling.

Take a Brief History

Perform focus abdominal examination

Manage the patient

A patient was lying on the bed, softly groaning. Haemodynamically stable.

Offer pain killer and he said it's ok.

No previous history of PU. No other relevant history apart from NSAID usage, smoking and drinking.

Wash the hands before examination and ask for consent.

Tell the examiner that exposure should be to mid thigh level.

Abdominal examination – abdomen is not extended and moved with respiration. No visible peristalsis or mass. No scar.

Ask examiner for hernia orifices – NAD

Light palpation revealed guarding and role player said its painful all over the abdomen though the most painful area was at epigastrium.

I told the examiner that the condition is most likely to be acute PU perforation secondary to NSAID use and associated with chronic smoking and drinking. So I ordered plain X ray abdomen to look for gas under diaphragm.

The examiner gave me a X ray obviously showing GUD.

Examiner's question- how will you manage it?

I will call the surgical team to review his condition, prepare for surgery and admit him to hospital.

Immediate Management includes-

Nil by mouth

IV assess with wide bore cannula and give IV fluid

Take Blood for investigations – FBE, Inflammatory markers, Urea and electrolytes, Liver function tests, Coagulation profile, Blood for Grouping and cross match.

His vital signs has to be monitored and the surgical team will review him soon.

He will need to be undergone surgical operation.

I finished so early that examiner told me to explain the conditions and management to the patient.

I reassured him that he will be treated by skilled and experienced surgical team and all the members will give him the best possible care.

I also offered to contact to next of kin or other family members if he wished me to inform and explain to them about his condition.

Passed

3. Infant with poor weight gain

9 month old baby is brought to your GP by her mother. There is a list of her weight for months and also a weight chart. The weight for early months was already plotted in the chart. Only one left is weight in 9 month. Head circumference for age is 50th percentile.

Plot the weight chart.

Ask history from mother.

Management

I performed badly and poorly in that case. So please read other recalls for reference.

I was so clumsy and did not plot the weight chart due to misunderstanding that there were marks for previous month's weight. Examiner warned me to plot the chart but I still did not do it. ☹ Instead I drew a line connecting the markings and showed the mother that weight gain is not satisfactory.

Anyway weight at 7th month was touching 10th centile and at 9th month it decreased to 3rd centile.

Mother knew nothing about her child. Probably it was according to instruction. She said that her baby is well and she never had concern about the baby's health. Uneventful pregnancy and born by vacuum delivery. No problem after delivery. Breast fed up to 6 month and then weaned and introduced solid foods. Not a food fad and ate cereals. Immunization up to date and there is no other sibling.

When I asked about bowel motion, mother said she noticed anything unusual but while asked more, the baby defecated 6 times a day. Mother couldn't provide any more info.

Regarding management, I told mother that I concerned about baby weight as she is failure to thrive. So I need to refer her to child specialist and will have to organize a number of tests as well including stool examination, Blood tests and if required I will refer her to child gastroenterologist to diagnose condition like Celiac disease.

Examiners are probably more kind in re-test exam! I missed task no. 1 but still passed.

4. Cardiac arrest in the setting of AMI

A patient came to ED where you are working as HMO for chest pain for 2 hours.

Ask history

Management.

Ask for hemodynamic status and offer O2 and pain killer.

The chest pain is typical of AMI, with referred pain on jaw and tip of the shoulder.

He had previous history of similar, chest pain while climbing stairs which was settled itself by resting for a while. This time the pain was brought by heavy meal and not relieved after resting and still there. He has never been diagnosed of heart disease or other relevant medical conditions. Non smoker, non drinker. No recent travel.

Not on any medication.

Again I finished early as I didn't ask much. So I told the examiner that its most likely to be acute myocardial infarction. The differential diagnoses are Angina Pectoris, Aortic Dissection, Acute Pulmonary Embolism, Acute Pericarditis but they are less likely than AMI. And I gave him O2, morphine, Aspirin, order blood test and ECG and give IV assess and call the cardiac team.

Then alarm on the examiner's desk rang and she said "your patient lost consciousness now. So what will you do?"

I checked DR ABC. Call for help.

When I checked the mouth the patient opened his mouth for me. I tried not to smile :D

He was very kind and nice role player.

The patient was breathing and pulse present. So I ordered ECG and examiner gave me ECG strip showing VF. And asked me what will you do next?

I said "Defibrillation" and acted as if I am actually giving defib to the patients, remove the clothes, shouting to stay clear and give him shock. It's funny but I couldn't think of anything in the exam room.

The examiner said "he is still unconscious and what will you do?"

"I will give second shock".

Then the patient regained consciousness and I ordered ECG again.

The second ECG shows antero-laterat infarct.

I admitted him to the cardiac ward and explained to the patient about his condition and management.

The examiner asked me "what is the next step of management? " but the bell rang and I didn't answer it but passed again!

5. Placental Abruption

34 weeks pregnant, primigravida comes to hospital ED for vaginal bleeding. FHS (+). Her blood group is Rh negative.

History, Examination, Management.

I first asked about the hemodynamic status of my patient. It is stable.

Bleeding starts suddenly without any trauma or sexual intercourse, bright red in colour and no mucus or no water leakage, the amount is less than menstruation and not that much. Not painful and she can feel the fetal movements as usual. The pregnancy is uneventful until now and all the ante natal tests are normal including USG. I particularly asked about placental position in USG and anti D injection for Rh negative. She said "I was told that the placenta is in the normal position and I'd received anti D injection once.

No high blood pressure before and during pregnancy. No previous pregnancy, miscarriage and blood transfusion.

There is no other associated medical condition.

Physical Examination

Patient is stable and vital signs are normal.

Fundal height appropriate for gestational age. No tenderness. Fetal heart rate normal.

"I will perform the USG examination first to make sure placenta is in normal position although its said that in normal position in previous USG, before doing VE".

Management - your condition is known as Ante partum hemorrhage, bleeding during pregnancy. There are two possibilities, abruption of placenta and placenta previa. As you said

the placenta position is told to be normal in previous USG it is most probably due to abruption of placenta. I drew the picture to explain it- this is your womb and the placenta is attached to its wall and when it is detached from the wall there is bleeding. It could be serious if the blood loss is massive and if there is hidden bleeding.

So I will admit you to hospital, insert IV lines and take blood for grouping and cross matching, Kleihauer test and Indirect Coombs test as you are Rh negative. you may need to receive the anti D injection again.

The baby's condition will be monitored by CTG.

The Obstetric reg will review your condition and if there is massive blood lost, you might need to undergo CS delivery. If it is mild one, we will keep you in the hospital for some days to observe you and your baby.

The Obstetrician will decide whether steroid injection is to be given to prevent lungs immaturity in baby.

Only concern is the premature delivery. I assured her that it's not like you will definitely need to deliver the baby. The management will depend on severity confirmed by USG test, your condition and baby's condition. If it is mild one we can wait until baby is mature enough to be delivered.

Please ask me if there is anything unclear and if there is any concerns.

Passed.

6. Binge Drinking

That one is modified book case.

The patient is the old patient in your GP clinic. He is single father with history of binge drinking and occasional injury. You previously discussed him about his binge drinking and he agreed to reduce amount. He is now presenting to your GP for follow up visit of his child's ankle sprain that was sustained during playing in playground. Now you have examined his child and about to talk about his drinking habit.

Counsel the patient.

I asked him how is he doing, told him I understand that single parenting is not easy task so how he coping with it, and any help required.

And then ask about his drinking habit and other drug use, social life, job and stress, financial problem.

He said he is coping well with that and because I told him to reduce amount of alcohol he now cutting it down to 38 drinks and he only drinks during weekend with his mates, not on weekdays and he thinks it s good enough.

I tried to relate his child injury and his drinking but he said “Dr it was happened in playground and I didn’t drink on that day. I drink only on weekend.

His mum always takes care of the child during weekend and he said its ok and no need any help for that.

I told him that – I know you are cutting down drinking but 38 drinks is still binge drinking and need to reduce to safe level. As you had visited to my clinic before for injuries and trauma associated with binge drinking it indicated that it is dangerous for your health and your life. Although your mother helps you to look after your child on weekend you are responsible for your child well being. So it is better to change the drinking habit and reduce it to safe level.

When I mentioned about alcoholic anonymous and drug abuse treatment centre, he said “I am not alcoholic Dr, and I am cutting down now”. I asked cage questions and he denied everything.

Ok then I will regularly follow u up for progress and if you need any help regarding it please don’t hesitate.

At that time I didn’t know what to say more and started repeating things as I ran out of idea and still left more than 2 min. The examiner told me to leave the room if I had finished the task. I asked the role player for any concern but he replied no.

I was worried standing outside the exam room for about 2 min but managed to forget it as its already over.

I didn’t tell much, didn’t feel satisfied with my performance but passed it.

So, put a smile during counseling and don’t argue with role player. Follow the flow and you will also pass it.

7. Post op Fever

You are HMO in surgical ward. The patient is in her forties, operated for cholecystitis yesterday by laproscopy. There is a chart showing her temperature, going upward after operation, above 38.5 degree, increased HR and RR as well. She is a chronic smoker, had had bouts of bronchitis in the past. No other medical conditions.

Manage the patient.

As I entered the room the examiner handed me the vital signs chart and asked me to explain it to him.

"The temperature, HR and RR are showed to be increased in post op day 1. The temperature is more than 38.5 degree and HR is more than 100. RR is also faster than normal. So it is post of fever. I have to find out the underlying cause. As it is day 1 post op and the patient is chronic smoker with history of bouts of bronchitis the most probably cause is Pulmonary atelectatsis.

However I have to exclude other causes such as superficial thrombophlebitis, DVT, UTI, wound infection although they are less likely.

Then I asked patient about her present condition, cough, shortness of breath, any pain from wound site, urinary symptoms, previous DVT, leg swelling.

When I asked her "Are you still smoking?" she smiled and "yes doctor but I haven't smoke since the day before surgery."

In physical examination, I asked –

General appearance

Chest signs – there are few crackles at the base

Check the IV cannula site, any drainage tube, Urinary catheter if present.

Surgical wound for any sign of inflammation. Abdomen for tenderness, guarding.

Leg swelling and pain for DVT.

Urine dipstick

Everything is good except lung signs.

Examiner question- what do you think and what is your management?

I believe that it is due to pulmonary atelectasis as it is the most common cause for post op day 1 fever especially in heavy smoker patients with previous history of bronchitis.

I won't prescribe any antibiotics as it is not necessary at this stage. X ray is not essential.

Active breathing exercise, postural drainage, physiotherapy and early mobilization will be enough for first line management. I will review the patient later for progress.

Explain to the patient and reassure her and to discuss about smoking later.

Examiner was so nice and helpful in this station.

Passed

8. Inflammatory Bowel Disease

A chef, 50 year old comes to your clinic for GI symptoms.

History,

Ask for Physical Examination,

Order Investigations.

This is the third time having the symptoms, including discomfort, diarrhea within 2 years.

This time he notices blood and mucus in his stool. There is slight weight loss over 2 years.

No other medical conditions or surgery before. Not on any medication.

Her uncle living overseas known to have a GI condition but she doesn't know what exactly

it is. No known family history of Colon cancer.

She went to Thailand 2 months ago but denied consuming street food and she thought it is unrelated to her symptoms.

Physical Examination

Slightly pale

Vital signs are stable.

Vauge abdominal pain all over the abdomen.

No organomegaly.

Hernia orifices- NAD.

Rectal Examination reveals blood and mucus.

I explained to her that blood and mucus were seen on RE. I have to order investigations including blood tests and colonoscopies to confirm the diagnosis. I have to exclude CA colon first and inflammatory bowel disease is also a possible condition. Infection shouldn't also be omitted.

Investigations

Stool examination to exclude infestation and infection.

FBE

Hb%

Inflammatory markers

LFT,

coagulation profile

Urea and Electrolytes

Tumor markers

Sigmoidoscopy, colonoscopy and biopsy

Refer to gastroenterologist.

Passed

It was a tough and long journey for me but finally I did it.

Big thanks to my family for supporting me in every aspect, vmpf tutors and study partners, Dr Wenzel for continuous support and his efforts for all the IMGs including me, the last but not the least- the examiners and the role players!

One useful tip – Don't discuss about cases while you are waiting before exam starts. Instead eat something sweet (me? I ate a lot of colorful, sweet jellies while waiting.)

Try it if you are not diabetic.

Best of luck !