MD3 OSCE Recall

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2014	1. PP fever	2. Pelvic pain (endometriosis) 3. HMB	4. Asthma counselling 5. Abdo exam	3. Eating disorder (BN) 4. Guy going crazy (OCD)	3. Carer distress (burns) 3. Commencing Warfarin	4. Back pain mets from breast ca. (Hx) 5. Explain the OCP
2013	1. Headache (PET)	1. 1st pap smear (explain, do)	2. Cardiac murmur 3. Epilepsy, alcohol, teenager 4. Anxiety 5. Asthma Rx	1. Social withdrawal (Hx) 2. Heart attack = panic attack	1. Confirm death + explain to daughter 2. Elderly man trouble sleeping (depression in elderly)	1. Explain results of OGTT + Lipids 2. Fever in returned traveller (Malaria)
2012	1. Advice on twin's preg 2. Fundus less than dates	1. Amenorrhoea 2. Urinary incontinence 3. How to take the pill	1. Neonatal Jaundice 2. Resp Sitress Exam 3. Asthma Rx	1. First manic episode (Hx) 2. OCD (Hx)	1. Urge Incontinence 2. Pt about to die (address concerns – POA, living)	
2011	1. Headache (PET) 2. Post dates Mx (Hx + IOL) 3. PPH (Hx) 4. First antenatal visit 5. PP fever (Hx)	1. Menorrhagia + dysmenorrhoea 2. Infertility 3. Pelvic mass (Hx) 4. Menopause (Hx) 5. Pap smear procedure	1. Neonatal Jaundice (x2) 2. Neonatal pics 3. Asthma Rx 4. Breath holding spells	1. PP depression 2. Social withdrawal – schizo	1. Depression in elderly	
2010	1. 1st antenatal visit 2. 40+2 - no progress, CTG/partograter 3. HG vommy 4. Headache EPT 5.	1. Explain Cin II/III + 2. Dysmneorrhoea (Hx – endometriosis vs adenomysosi) 3. Pelvic Pain – ectopic 4. PM incontinence	1. Neonatal Jaundice (x2) 2. Neonatal pics	1. Social withdrawal 2. child who's 'not himself' 3. 25 yo bit 'going mad' - Manic 4. PP depression	1. Rehab post stroke (neuro exam + higher function) 2. Confirm death + explain to daughter 3. Carer distress (burns) 4. Falls risk history	1. PP fatigue 2. Counsel on OCP 3. Fever in returned traveller (Malaria) 4. OA (exam)
2009	1. Early preg bleed 2. IP Rx of failure to progress 3.	1. Amenorrhoea (prolactinoma) 2. Pap test (explain/do)	1. Neonatal pics 2. Breathholding spells	1. Eating disorder	1. Palliative Care issues at home 2. Falls examination 3. Memory history from son	1. History from woman on many meds
2008	1. Post dates Mx + counselling 2. Explain partogram	1. Pap test (explain/do) 2. Pelvic mass (		1. Social withdrawal (Hx) – shizo/1st psychosis 2.	1. Depression Hx (old man) 2. Back pain with METS 4. MS history	1. Back pain mets (Hx) + ll Neuro, PR/Back 2. Counselling on MS 3. Erectile dysfunction 4. Teenager w epilepsy 2. Full Social History
2007	1. PP fever (mastitis) 2. Obstructed labour (CTG + Mx) 3. RIF pain in preg (ectopic)	1. Explain CIN II 2. Pelvic Pain - ectopic 3.	1. Neonatal jaundice 2. Asthma Rx		1. Hx from NUM – delirium/BPSD history 2. Gait + Balance assessment	1. Migraine 2. Anaemia 3. Give lipid results 4. OA DM CRECS
2006	1. 1st antenatal visit (Ixs) 2. Twin pregnancy (Risks etc)	1. Menorrhagia 2. Incontinence in PM woman	1. Neonatal derm		1. Urinary incontinence 2. Breaking bad news to relative	1. Smoking cessation 2. Explain lipids 3. Back pain and Mets
2005					1. Urinary incontinence 2. Falls examination 3. Carer distress (Hx) 4. MS history 5. Confirming death and break bad news	

2004		1. Menorrhagia 3. CIN III	2. Neonate pictures		1. Falls assessment (ex) 2. Depression in elderly 3. LT pain mx	1. Pain management in Prostate Cancer

2017 OSCEs

Women's Health

Station 1

Caesarean Counselling

- Women 37wk GA with Placenta praevia
- Questions
    - Explain C/S procedure
    - Why might the baby need to be taken after the birth? Respiratory issues / special care nursery
    - What if I bleed afterwards? Explain normal amount of bleeding, PPH management
    - Will I be able to breastfeed? Breastfeeding strategies after C/S

Station 2

Heavy Menstrual Bleeding

- Recently stopped breastfeeding
- Question
    - What investigations would you like to do and why?

CAH

Station 1

Surgical Abdominal Examination

- Generalised abdominal pain & vomiting in primary school aged child
- Questions
    - List 4 differentials for the presentation and justify your answers

Station 2

12mo immunisation – take brief medical history and counsel

- Previous febrile convulsions
- Worried immunisation will cause further convulsions
- Febrile convulsion management
- Side effects of vaccines
- Vaccines and autism

GP

Station 1

Iron Deficiency anaemia history

- 65yo woman
- Diagnosed via blood test after 6mo lethargy
- Hx: unintentional weight loss, infrequent FOBT, change bowel habits - no blood in stool, family hx bowel cancer – father 55yo
- Question

    - What is the most important diagnosis to rule out and why

Station 2

Back Examination + Lower limb reflexes

- Schober's test and Hip Examination not required
- What is the most likely diagnosis and why? Non-specific / musculoskeletal pain

Aged Care

Station 1

Falls History

- 70yo woman, recent fall due to trip, resulting in humerus fracture
- 2 previous falls – 1 slip on wet tiles, 1 turned suddenly
- No previous fractures
- Falls risk Fx: inappropriate footwear/dressing gown, house obstacles, cataracts, benzodiazepines
- Question
    - Falls prevention management
    - Injury prevention management

Station 2

End of Life care counselling

- Women with terminal lung cancer
- Questions
    - Can I die at home?
    - I don't want to suffer
    - I don't want a feeding tube
    - ?

Psych

Station 1

Post-MI Depression

- 65yo man 6wk post-MI decreased energy
- No other features of depression except sleeping more – approx. 8h/night
- Question
    - Do you think this is depression and why?

Station 2

Bulimia History

- 24yo student, lives at home with parents
- Binge-purge, used diuretics once, normal BMI
- No changes in menstruation, dentition issues from purging
- Parents overweight
- Question
    - What is the most likely diagnosis and why

2016 OSCEs

Women's Health

Station 1

Stress Incontinence: post-menopausal woman who has been leaking

- Basic station; go through all urinary symptoms
- She did not have a prolapse and had complicated vaginal deliveries

Station 2

Pre-Eclampsia: Headache in 32 week pregnant woman

- Headache, no other symptoms except RUQ pain (liver capsule haematoma) → needed to specifically ask about that location; patient said no to pain in general throughout the pregnancy or now to me!
- Questions:
    - What do you think the diagnosis is?
    - What would be your management?

CAH

Station 1

Asthma Station: 8yo who had an asthma attack 5 hours ago

- Respiratory Exam
- Question: Are they clinically stable to leave the hospital?
- Explain how to use an asthma puffer (put spacer together, 4 x 4 x 4 rule)
- Question:
    - What do you want to tell the child and mother before they leave?
    - ction plan, follow up with gp etc.

Station 2

HEADS Screen: 15yo no longer going to school. Parent already told to leave the room

- Explain confidentiality
- New school, bullying, peer pressure; party ~ got drunk → drunken photos taken etc.
- Question:
    - What will you say to the mother when they come back in the room? Keep in mind confidentiality

Mental Health

Station 1

Personality Disorder: Girl in hospital for attempted suicide (panadol) following a fight with boyfriend

- Tough station; the actor acted very strangely though
- She had a history of multiple self-harm episodes, many short sharp relationships
- No psychotic, depressive or anxiety symptoms

Station 2

Post-Partum Depression: post-partum woman not coping

- Quick history of pregnancy
- She had all key depression symptoms; some anxiety; no suicidal ideation
- Some help form husband but mostly on her own; first child

General Practice

Station 1

Lipid Results and Checkup: Explain results of test (hyperlipidaemia) + Brief medical history

- SNAP (smoking, exercise, alcohol, physical activity)
- General Medical & Surgical History
- Questions: how would you manage ~ reasonably healthy young, no lipid lowering agents, but some lifestyle changes possible, reassess in 6 months

Station 2

Diabetes Examination

- Manual BP
- Height + Weight → calculate BMI
- Main focus was on the feet/legs
- Question: Fundoscopy picture

Aged Care

Station 1

Falls

- 3 previous falls; recent fall broke humerus
- Poor shoes, benzos for sleeping, cataracts
- Question:
    - How would you manage? Osteoporosis management (bisphosphonates, weight bearing exercise)

Station 2

Faecal Incontinence: 25yo spinal cord injury

- Who knows what they wanted in this station?! It was a bit of a surprise for all of us.
- Function Before ~ physically, work, social etc.
- About the accident

- Current impairments, participation limitation, activity restriction etc
- Medications, Context (recent change = left hospital)
- Systems Review: Lower GIT, urinary symptoms, sensation/ motor of legs
- Question:
    - What do you think is going on? Overflow diarrhoea from constipation/faecal impaction
    - Management? Enema, laxative, fibre etc.

2015

Women's Health

Station 1

Station 2

CAH

Station 1

Station 2

Mental Health

Station 1

Station 2

Aged Care

Station 1

Station 2

General Practice

Station 1

Station 2

2014

Women's Health

Station 1

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CAH

Station 1

Station 2

Mental Health

Station 1

OCD

Mr X is a 40 year old who has been very worried that he is 'going mad'. He has already been investigated and no medical cause has been found. Please take a history with a view to establishing a diagnosis.

OCD patient, worried about developing Ebola and needed to wash hands to stop getting sick. Other than obsessions/compulsions, no significant history (risk assessment normal, no substance abuse etc.). Patient was instructed to not respond to the first question for at least 15-20 seconds (ie he sits there waiting/humming, you should patiently wait).

Question

1. What is the most likely diagnosis and why?

Station 2

Eating disorder

Ms X is a 24-year old who has been referred from her GP with hypokalaemia and lethargy. Her GP also has concerns over whether or not she has an eating disorder. Please take a history with a view to establishing a diagnosis. You do not need to evaluate the hypokalaemia.

Diagnosis was bulimia, station was reasonable and straightforward
Weighed 70kg, was 175cm tall, was desperate to lose 5kg, binged/purged, used mother's diuretics to attempt to lose weight, had no suicidal ideation or other psychiatric features etc.

Question

1. What is the most likely diagnosis and why?

Aged Care

Station 1

Neuro exam for spinal cord compression

Middle-aged lady with a history of breast cancer presents with back pain. You will be asked to state you most immediate concern at the beginning of the station (strictly spinal cord

compression – pathological fracture, compression fracture, bony metastases not accepted). Given that spinal cord compression is the main concern, perform a lower limb neurological examination (full motor and sensory examination is expected and is definitely possible to complete).

Questions

1. Based on your examination findings (normal), are you still concerned about spinal cord compression at this stage?
2. What else would you like perform to complete your examination? (full upper limb neuro exam, PR)

Station 2

Carer stress

Lady presents to the GP clinic with a burn on the hand. Your GP noticed that she looks down and worn out. After the burn has been dressed by the nurse, she says that she needs to leave the clinic quickly. Speak to the patient and address her concerns. (On further questioning, you realise that the patient accidentally burnt her hand with the iron at home. She needs to go home quickly as she is the full-time carer of her father who has Alzheimer's Disease and her friend who is helping her care for him at the moment needs to leave soon. She then tells you that she is finding taking care of her father increasingly difficult, but also made a promise to her father not to send him to a nursing home)

Questions

1. What is the greatest concern in this scenario?
2. Do you think that the patient should keep her promise of not sending her father to a nursing home and justify why.

General Practice

Station 1

Contraception in young woman

17 year old female present to the GP clinic for a repeat prescription of the oral contraceptive pill, which she has run out of 2 days ago. Assess her with appropriate management. You do not have to assess the patient's risk of sexually transmitted infections.

Questions

1. What is a more suitable method of contraception for this patient? LARC

Station 2

Warfarin advice and CHADS2

Elderly patient with atrial fibrillation has been assessed by your GP to require anticoagulation based on her CHADS2 score. Your GP would like to start the patient on warfarin. Assess the bleeding risk in this patient and provide appropriate advice regarding warfarin. You do not have to manage the patient's atrial fibrillation itself.

Questions

1. What is your assessment of the bleeding risk in this patient and why

2013

Women's Health

Station 1

Station 2

CAH

Station 1

Station 2

Aged Care

Station 1

You have been called in by the nurses on the palliative care unit to examine Ms P. Stebbing.
Her recent biochemistry results are also found on the door, and inside the room.
Na: 138mmol/L
K: 8.2mmol/L
Cr: 340
Urea 14

This is a modified repeat of previous MBBS stations.
Mrs. Stebbing was admitted 2 weeks ago for renal cancer but her death has occurred sooner than expected. Her daughter is in the room and you have not met her before; she believes her mother is still alive but is "not breathing the same" since the last hour. Please perform an examination and explain to Mrs Stebbing's daughter what has happened. (N.B. The patient was a Little Anne dummy with stuffed newspaper arms and body).

CERTIFYING DEATH – (adapted from OSCE A-Team recall)
Introduce yourself to daughter Claire, who tells you she is the daughter
Explain what you are going to examine this person

a) "Would you like to stay, or would you prefer to leave the room?" She wants to know what happened to her mum

Approach:

A) Ask the time of death and if someone was present – if it's a staff person who was there
B) B) Ask for the notes
    a. In this station, you can ask the examiner for the notes but there are none, and no one has said anything about Mrs. Stebbing being dead before you got there. If you ask the daughter about her mother's death she will react with surprise and shock – DON'T unless the stem specifically tells you to confirm death!

C) Would observe patient first

1. Wash hands
2. Confirm patient name – notes and wristband

a. Newspaper arms had no wristband and there were no notes – examiner said "this is Mrs. Stebbing"

RESPONSES

3. Attempt to rouse patient verbally
4. Attempt to rouse with response to pain – supra-orbital pressure
5. Talk to the patient (if family member is there), e.g. Mrs Stebbing, I am going to shine light into your eyes, etc…

Pupils

6. See if pupils fixed
7. See if pupils dilated
    a. You shine a light into the dummy's eyes and the examiner asks: what do you expect to see?
8. Can ask for opthalmoscope for fundi examination
    a. I asked for this. The examiner actually said "why would you want that? There isn't one"

Heart

9. No central pulse – carotid or femoral for a FULL MINUTE
    a. Examiner: "Absent pulse. How long would you have checked for?"
10. No heart sounds on auscultation for a FULL MINUTE
    a. Examiner: "Absent heart sounds. How long would you have listened for?"

Lungs

11. No breath sounds for a FULL MINUTE
    a. Etc.
12. Respectfully tuck the patient back in – do not leave chest exposed

Document

13. Notes on these absent features
14. DATE AND TIME
15. Name and DESIGNATION
16. Signed
    a. There was no documentation at this station. Proceed directly to wash hands
17. Wash Hands

C) Counselling the daughter
    a. You sit down in a triangle with the daughter and the examiner
    b. SPIKES for delivering bad news – would they like another room, company, do they know what has happened
    c. Make sure you have personally certified that the patient is dead.
    d. Break the news – be direct and upfront about it
        i. "are you sure? But she was breathing fine just an hour ago"
    e. Try to engage the patient. Assess how distress they are
        i. "My Dad will be so upset, he wanted to stay over last night but I sent

him home..and my brother is still flying back home from interstate, he will be so upset"

f. Ask if anyone they'd like you to contact
    i. "no thank you, I think I should do it myself"
g. Ask for cultural wishes, e.g. religious considerations – remind the patient they have social work and pastoral care services available to her for her mother
h. Explain what is going to happen next – "I am going to discuss this with her treating team and document my findings. A death certificate will be prepared etc"
    i. "what will happen to my mother's body?"

D) There are no examiner questions for this station.
E) P.S.: The patient has died from an AMI (see biochem). Being considerate and reassuring the patient that you will follow up with your treating team for this and other questions will get you style points even if you didn't know this.

Mental Health

Station 1

You are asked to see Mr. Robinson, a 45 yo gentleman who presented to ED a few days ago with a ?heart attack. Investigations revealed no organic cause, and he was advised in ED to present to his GP. Please take a history.

He has an office job and been stressed by the interactions he has had with some of his co-workers as they have a high-stakes project underway. His father is in ill health. He does not have a significant PMHx, has never smoked and drinks beer socially (<4/wk). He has never had anything like this happen to him before, and no significant FHx (cardiovasc or psych). He has a supportive wife and children. He has not been abnormally worried it will happen again (panic attack disorder, also <1mo) but is reassured when you tell him it's not likely to have been a heart attack.

RAPPORT: Introduce, Explain, Confidentiality, safe place
History Details: Name, Age, Occupation
Chief Complaint: Their words
Symptoms: Nature, detail, why now? Reason for presenting?
Panics: Panic Attacks – peak within 10 minutes – how long does it happen – symptoms of – palps, sweats, racing heart, shaking, sob, chest tight or pain, abdo distress, nausea, dizzy, unsteady, derealisation, going to die, going to go crazy, paraesthesias
Worry about panics: worry about having extra, worried about what would happen if you did, change in behavior related to attacks **- what happens between attacks?**
Anxiety: Anxiety or worry – 6 months difficult to control those worries, - symptoms of restlessness, keyed up , on edge, easily fatigued, irritable, muscle tension, blanking out, hard to concentrate sleep disturbance
Symptom details: T/O SSRQ AR

Associated Features: Any other anxiety related symptoms, physical symptoms, fears phobias,
Mood: depression, mania
Anxiety: – worries, obsessions, compulsions, panics, phobias – fear
Psychosis: delusions or hallucinations –
Suicide Risk?: Harm to others or self
Organics and Substances and Stress: Phaeo, hyperthyroid, Drugs, alcohol, marijuana, poor social indicators or stress
OTHER HISTORY
Functioning: Self, Work, Social/Relationships – affected?
Evaluate factors: Premorbid personality –
SUPPORT NETWORK – FRIENDS FAMILY
Medical/Surgical History/Psychiatric History – symptoms of illness, conditions, treatment, admissions to hospital, side effects, drugs, adherence
Personal History and Family Hx: Developmental history – perinatal, child, schooling, adolescence, transition to adult- work, educatio, Schooling, Family history of depression
Premorbid Personality:
Social: Living arrangements – people- place, work, diet exercise, smoking, insight
Most likely Dx? – panic disorder without agoraphobia

S weating
T remor
U nsteadiness
D epersonalisation, Dissociation
E xcessive heart rate
N ausea
T ingling
S hortness of breath
FEAR of dying/going crazy/ losing control
C hest pain
C hills
C hoking

check for above somatic symptoms of panic attacks
frequency, duration
context
inter-panic symptoms > 1month
worry about when the next attack will be
worry about consequences
change in behavioural
ask about agoraphobia
are you worried when you are in a crowded place and worried about not being to escape or avoid such situations

specific phobias
screen depression
psychosis!
substance abuse hx
EFFECTS ON LIFE!
RISK ASSESSMENT

Questions:
What is the most likely diagnosis? Panic attack

What are three non-pharmalocial Mx for this condition?

- Relaxation – breathing and muscle
- CBT
- Lowering things like caffeine and alcohol
- Sleep hygiene

Station 2

Please see Jeremy Connor, 21yo, who has been brought in by his parents for social withdrawal. He has been examined and no medical cause has been found.

His past medical history is provided on the door – nothing of note. This is the same station as recalled by MBBS students. He is a 2nd year Arts student and has been avoiding study or leaving the house. He describes the tv sending him messages to protect his family and hearing 2-3 voices for 6-7 months. There are men coming for his family, and he stays at home because he is the only one who can protect them. When prompted, he would not hurt himself or anyone else, even the bad men – he would call the police on them. He has a very flattened affect and is slow to start speaking (wait for him to respond).
(From OSCE A-Team):
RAPPORT: Introduce, Explain, Confidentiality, safe place
History Details: Name, Age, Occupation
Chief Complaint: Their words
Symptoms: Nature, detail, why now? Reason for presenting?
Positive: Delusions, hallucinations – nature - persecution, auditory,
Negative: flattened affect, alogia- cant speak, avolition – cant do goal directed activities
Disorganisation: disorganised speech, catatonic behavior - flight of ideas, loose association, echolalia (repeating what others say), word salad (meaningless speech
Symptom details: T/O SSRQ AR
Associated Features:
Mood: depressed manic,
Anxiety: – worries, obsessions, compulsions, panics, phobias – fear
Psychosis: see above
Suicide: Harm to others or self, and Suicide
Organics and Substances and Stress: Drugs, alcohol, marijuana, poor social indicators or stress

OTHER HISTORY
Functioning: Self, Work, Social/Relationships – affected?
Evaluate factors: Marijuana Smoker, FHx of schizo
Medical/Surgical History/Psychiatric History – symptoms of illness, conditions, treatment, admissions to hospital, side effects, drugs, adherence
Personal History and Family Hx: Developmental history – perinatal, child, schooling, adolescence, transition to adult- work, education– Specifically Pervasive Developmental Disorder, Schooling, Family history of schizo
Premorbid Personality: Cluster A – Paranoid, Shizotypal, Schizoid – evaluate –
Social: Living arrangements – people- place, work, diet exercise, smoking, insight

Questions:
What is your diagnosis and why?
First Episode Psychosis/ Brief Psychotic Disorder/ Schizophreniform/Schizophrenia/Schizoaffective/Mood disorder with Psychotic features/Delusional Disorder/ Substance induced Psychosis/Organic - tumor

What two things would you do to manage this patient?
Assessment and Management – Evaluate risks to self and others – choose whether admission required – Community Treatment Order vs Involuntary Treatment Order vs Outpatient care

Pharmacological: Anti-psychotics – Atypical vs Typical – e.g olanzapine, quetiapine, respiredone, haloperidol, clozapine for refractory – agranulocytosis, myocarditis – ensure to explain about side effects and length of treatment to take effect – possibility of changing – needing medications permanently even if feel well – watch out for NMS

General Practice

Station 1

You are a student at the local Medical Clinic. Mrs. Maureen McConnel is a 58 year old woman who has come back for results of her fasting glucose and her cholesterol tests.
You have been asked to discuss these results with her by the GP. A lot of information is provided on the door prompt:

- Past medical history (none),
- Social history (one 32 year old son who does not live at home, lives with husband) including her smoking (does not smoke), drinking (2-3 glasses of wine/evening, more on weekends), and no illicit drug use.
- She weighs 70kg and her hip-waist ratio is 0.8.

The GP has asked you to a) explain the results to Mrs. McConnell, and b) negotiate a management plan for these results.
This is a modification of a previous examination for MBBS sem 9's found in the OSCE pack.
She has high cholesterol and triglycerides but normal blood glucose (4.4).

Examiners Marking Sheet

1. Tell the patient the diagnosis Appropriate explanation of total cholesterol, LDL/HDL, triglycerides Appropriate language	 1 1
2. Check patient's current knowledge and attitude What he understands about cholesterol His fears, expectations,beliefs about causes and consequences	 2
3. Cardiovascular risk factors Opportunistic health promotion / illness prevention Significance if lipids as one of several cardiac risk factors. - unalterable- family history, age, sex, past smoking - alterable – body build- explains significance of waist/hip ratio and BMI, exercise level, diet - address positive factors – BP, alcohol intake, ceased smoking, glucose	 5
4. Negotiate a short and long term management plan **a) Diet** - current diet- 24-hour recall or average weekly diet, who cooks - short term – food diary, gives brief understanding of aims - long term – possible dietician referral **b) Exercise** - establishes current exercise level - sets clear goal with patient eg daily walking **c) Weight/ body build** - sets goal with reasonable time frame- ie long term- 6 to 12 months **d) Lipids** - Set target lipid levels with reasonable timeframe - Plan repeat fasting lipid level no earlier than 6 weeks - Long term- potential for lipid-lowering medication- not immediate option	 3 2 1 3
5. Communication of Management Plan Check this information with the patient, allow time for him to ask questions, be sensitive to any cues from the patient Correct any misconceptions- 'tablets for lipids can replace diet and exercise'	 3 1
6. Use of a negotiating approach Take into account patient's context and response, and the implications of the management plan for them, helping them explore options. Check if patient had any other ideas or expectations regarding management outcomes.	 4
7. Reinforce the management plan Simplified summary	 2
8. Arrange follow-up Realistic review time based on natural history eg. 3 mth	 2
TOTAL MARKS (out of 30)	

Strengths / weaknesses / comments

Mrs. McConnell has recently joined the gym and goes walking with a friend and their dog. She says she has really felt the benefits and current exercise easily is at least 30 mins x 5/wk. She is the one who cooks at home but only for herself and husband. She eats eggs and sometimes bacon in the morning with toast, take-away food for lunch most days, and meat and 3 veg at home unless she comes home late – then more take-away food. She looks hesitant about the food diary but is reassured by the fact that "it gives a picture of what you're eating and has suggestions on foods to avoid and foods to swap".

Question: If this patient had a high atherosclerotic risk, what two ways would that change your management?

a. lipid lowering drugs
b. investigations into her risk e.g. stress echo

Station 2

James Thompson, 24, has presented to his GP feeling feverish and unwell. Please take a history (8 minutes) and you will be asked some questions.

James has felt hot for the last 4 days, tired, and generally unwell within himself. He had vomiting and diarrhoea (loose stools, normal colour) the two days before presenting which is why he's come to see the GP but they've stopped today. He has recently (5 days) returned from a trip through SE Asia, including Thailand and Vietnam. While there, he visited jungles (+/- elephant rides), swam in rivers and ate what he thought was fairly clean food and drank bottled water. He had all the normal high school vaccinations growing up in Aus, and Hep A and Japanese Encephalitis prior to travelling. He was prescribed doxycycline for the trip and was compliant but lost them after a month and thought that with mosquito repellent (which he sometimes forgot to use) and mosquito nets *most* of the time he would be fine. Despite this he got bitten by mosquitos "a lot". He travelled with a group sometimes, with a friend for a bit, then alone. No sexual partners or unwell contacts. His bowels and liver/skin colour were fine during the trip. He is a student who lives in a share house.
(From Austin MOSCE MBBS group 2013):

Fever in Returned Traveller – Mark Sheet (Pg 2)

TASK		**Max Marks**	
HOPC	Time course	1	
	Fatigue	1	
	Nausea/vomiting	1	
	Jaundice	1	
	Abdominal cramps or RIF pain	1	
	Change in bowels	1	
	Headache	1	
	Rigors	1	
	Drenching sweats	1	
Travel History	Duration	1	
	Area	1	
	Style of travel/activities (backpacking/local activities)	0.5	
	Accommodation (budget/home stay)	0.5	
	Meals (local food)	1	
	Animal contact	1	
	Specifically mosquito bites	1	
	Sexual intercourse? # of partners/ protection?/ gender of partners	4	
	Travel companions sick?	1	

Specifically	Well during trip?	1	
	Time course if unwell?	1	
	Medications	1	
Travel Meds	Hep A vaccination	1	
	Malarial prophylaxis pills prescribed?	1	
	Compliance	1	
PMHx	Any past medical issues	1	
Social	Smoking, Alcohol	2	
Questions	What are 3 differential diagnoses (Malaria, dengue fever, typhoid, TB)	3	
	What are three tests you would order to investigate Jane's PUO? (FBE, LFT, Blood culture, thick and thin blood films, CXR, stool culture) (1 each to max 3 marks)	3	
Discretionary Mark	Introduction systematic questioning listened to patient appropriately closed interview patient's impression	5	
		TOTAL	/40

Questions

- What is the diagnosis? Malaria
- What are two differential diagnoses? Dengue fever, typhoid, TB

Mental Health OSCE Overview

Year	Station	Notes
2017		
2016	**1) Personality Disorder: Girl in hospital for attempted suicide (panadol) following a fight with boyfriend** **2) Post-Partum Depression: post-partum woman not coping**	• Tough station; the actor acted very strangely though • She had a history of multiple self-harm episodes, many short sharp relationships • No psychotic, depressive or anxiety symptoms • Quick history of pregnancy • She had all key depression symptoms; some anxiety; no suicidal ideation • Some help form husband but mostly on her own; first child
2015		
2014	**1) OCD** Mr X is a 40 year old who has been very worried that he is 'going mad'. He has already been investigated and no medical cause has been found. Please take a history with a view to establishing a diagnosis. **2) Eating disorder** Ms X is a 24 year old who has been referred from her GP with hypokalaemia and lethargy. Her GP also has concerns over whether or not she has an eating disorder. Please take a history with a view to establishing a diagnosis. You do not need to evaluate the hypokalaemia.	*OCD patient, worried about developing Ebola and needed to wash hands to stop getting sick. Other than obsessions/compulsions, no significant history (risk assessment normal, no substance abuse etc.). Patient was instructed to not respond to the first question for at least 15-20 seconds (ie he sits there waiting/humming, you should patiently wait).* *Question: What is the most likely diagnosis and why?* Diagnosis was bulimia, station was reasonable and straightforward. Weighed 70kg, was 175cm tall, was desperate to lose 5kg, binged/purged, used mother's diuretics to attempt to lose weight, had no suicidal ideation or other psychiatric features etc. Question: What is the most likely diagnosis and why?
2013	**1) Psychosis** Please see Jeremy Connor, 21yo, who has been brought in by his parents for social withdrawal. He has been examined and no medical cause has been found. His past medical history is provided on the door – nothing of note. • What is your diagnosis and why?	This is the same station as recalled by MBBS students. He is a 2nd year Arts student and has been avoiding study or leaving the house. He describes the tv sending him messages to protect his family and hearing 2-3 voices for 6-7 months. There are men coming for his family, and he stays at home

	• What two things would you do to manage this patient? **2) Panic attack** You are asked to see Mr. Robinson, a 45 yo gentleman who presented to ED a few days ago with a ?heart attack. Investigations revealed no organic cause, and he was advised in ED to present to his GP. Please take a history. • What is the most likely diagnosis? • What are three non-pharmalocial Mx for this condition?	because he is the only one who can protect them. When prompted, he would not hurt himself or anyone else, even the bad men – he would call the police on them. He has a very flattened affect and is slow to start speaking (wait for him to respond).
2012	**1) First Manic episode** 1 station was a 25 M PhD student having first manic episode of bipolar disorder. Asked 4 reasons why it was mania (know your DSM-IV definitions. I didn't) **2) OCD** The other station was 25 F who has OCD of handwashing because of fear of getting H1N1 after her aunt died (see past year papers). Was asked elements of CBT that were important to her treatment.	
2011	**Depression History** 1. 72yo presents with insomnia 2. 35 year old male who has recently been in the 'dumps'	
2010	**Post Natal Depression History** • Mrs Jacintha Harris, a 38 year old woman 12 weeks post partum has presented to your general practice feeling tired and run down. Her FBE, iron studies and thyroid tests have come back normal. Please take a history and assess her. You do not need to perform any examinations. After 7 minutes you will be asked some questions. **Psychosis** • **You are asked to see Mr Jordon Cartwell, a 21 year old gentleman who has presented for psychiatric assessment with symptoms of social withdrawal, referred by his GP. Please take a history. After 8 minutes you will be asked questions.** ◦ Schizophrenia/first episode psychosis (no substance abuse) ◦ What is the most likely Dx? Schizophrenia ◦ Mr X's social withdrawal could also be due to a severe depression though it is unlikely. What 2 features on Hx would make you think depression is unlikely? ◦ What are 3 treatment strategies for Mr X **OCD**	What is the most likely diagnosis? What are 6 RFs or symptoms on Hx for the Dx of PND?

	You are at a Mental Health First clinic. A 25yo girl is referred there by her university GP, and presents because she feels she's "going mad". (OCD?) **You have EIGHT minutes to take a history.** You will then be asked TWO questions: ◦ What is the most likely diagnosis? ◦ Name two features of CBT that could be used in her treatment. **Mr. John Day, a 25yo man, has come in because his parents are worried. They say that he hasn't slept in three weeks and he's not himself.** You have EIGHT minutes to take a history. You will then be asked TWO questions: a. What's the most likely diagnosis? b. Name two classes of drug used for ongoing management and an example of each.	
2010	Hypomania History -?? (not recalled)	
2009	**Panic Disorder History** • Middle-aged man presented to ED a few days ago with ?heart attack. Investigations revealed no organic cause. Advised by ED to visit GP. Now presents to GP. Take a history.	2 Medications to treat?
2010, 2009	**OCD History** • 2009 – Man in 20s presenting to GP because he thinks he's "going crazy". Take a history	What features on history support your diagnosis? What psychological treatments can be used to manage?
2009	**Eating Disorder History** – Distinguish between anorexia and bulimia	
2009	Subclinical Depression History **50 year old is coming in for follow up 6 weeks post discharge for AMI. He has query major depression. Take a focused history to determine if he has major depression** 1. Does he have major depression? (No) 2. What makes you think this (doesn't fulfil 5 / 9 criteria) 3. What features on MSE support your answer	
2011, 2010, 2008	**Psychosis History** • 2008 - 21 year old man has been brought in by his parents due to social withdrawal. Take a history in view for a diagnosis • 2010 - You are asked to see Mr Jordon Cartwell, a 21 year old gentleman who has presented for psychiatric assessment with symptoms of social withdrawal, referred by his GP. Please take a history. After 8 minutes you will be asked questions. – Schizophrenia/First Episode Psychosis • 2011 – Presents with social withdrawal	What's the most likely diagnosis? What 3 things can you use to manage him? 2010 Questions: • Schizophrenia/first episode psychosis (no substance abuse) • What is the most likely Dx? Schizophrenia • Mr X's social withdrawal could also be due to a severe depression though

		it is unlikely. What 2 features on Hx would make you think depression is unlikely? • What are 3 treatment strategies for Mr X – anti-psychotics, behavioural therapy, family therapy
??	Bulimia History • Take a history from a 22 year old female with query Bulimia who is coming in to the doctor to review her blood results which show hypokalaemia. Take a detailed history about the Bulimia, you do not need to take any history regarding the hypokalaemia. What are some immediate treatments?	

General Practice OSCE Overview

	Station
2014	1. 17 year old female present to the GP clinic for a repeat prescription of the oral contraceptive pill, which she has run out of 2 days ago. Assess her with appropriate management. You do not have to assess the patient's risk of sexually transmitted infections. a. What is a more suitable method of contraception for this patient? 2. Elderly patient with atrial fibrillation has been assessed by your GP to require anticoagulation based on her $CHADS_2$ score. Your GP would like to start the patient on warfarin. Assess the bleeding risk in this patient and provide appropriate advice regarding warfarin. You do not have to manage the patient's atrial fibrillation itself. a. What is your assessment of the bleeding risk in this patient and why?
2013	3. 45 year old woman comes to GP to get lipid results. Results are provided inside the room. Brief history is provided on the door → don't need to take one in the OSCE. You must explain the results to the patient and come up with a management plan. Examiner asks questions a. How would your management plan change if this woman had a personal history of heart disease? 4. 25 year old man comes to the GP "feeling unwell". Take a history to get a diagnosis. (He only had fever, muscle aches and some nausea as symptoms. Recent travel history to Thailand). Examiner asks questions a. What do you need to rule out? (Malaria) b. What are your other DDx? c. What tests would you do to diagnose malaria?
2012	
2011	
2010	
2009	
2009	

Cholesterol counseling

- Introduction
- Patient name, age and occupation
- As I understand, you are here for the results of your cholesterol tests. Is that correct?
- Before we discuss that I would like to learn about your health if that's ok?
    - SNAP
        - May I ask if you smoke?
            - Characterize
        - What is your diet like?
            - Do you get plenty of fruit + vegetable?
            - Have you ever had problems with your weight?
        - Do you drink alcohol?
            - Characterize
        - Are you physically active?
            - Characterize
    - Past medical history
        - Any problems
        - Medications
        - Allergies
        - Blood pressure
        - Diabetes
        - Past history of stroke, heart attack or kidney problems?

    - FHx
        - Is there a family history of stroke, heart attacks or kidney problems?
- Giving results:
    - Now, may I ask what you understand about why you had the test?
    - Could you tell me what you know about cholesterol?
    - Excellent, that is correct but why don't we go over it in a little more detail. Please interrupt me at any time if you have questions or concerns, though I will leave time for this at the end.
- What is cholesterol + implications
    - Cholesterol is a substance used in our body to transport fat.
    - However, when cholesterol levels get too high, the cholesterol will deposit itself in the walls of blood vessels and this can adversely affect the blood flow to organs. Particularly the BRAIN, HEART and KIDNEY.
    - When it is bad enough, the blood vessels can become completely blocked and people can have heart attacks and strokes.
- Why do we monitor cholesterol?
    - It is important we monitor cholesterol because of this risk of these events.
    - Generally people with high cholesterol will feel fine until one of these events occurs.
- What determines your level of cholesterol?
    - There are 3 main factors that determine a persons cholesterol level, namely their weight, diet and genetic background.
- Does all of that make sense? I understand that it is a lot to take in.
- Ok well why don't we go over your cholesterol results then…
    - As you can see cholesterol is divided into three categories
        - The good cholesterol or HDL – we like this to be high
        - The bad cholesterol or LDL – we want this to be low
        - The total cholesterol which is a combination
        - And the other category down the bottom here is your triglycerides, which is a type of fat in the body. It is not relevant for the moment.
        - So as we can see…
- Does that make sense?
    - I would like to give you some pamphlets and other information on this subject if you are interested?

What management would you recommend to this patient?

- Initially I would recommend lifestyle interventions to reduce her cholesterol levels.
    - Smoking cessation (if applicable)
    - Diet change
        - More fruit + veg
        - Less fast food, animal fat, foods like prawns and butter
        - Use of margerines like flora pro-activ
    - Increased physical activity
        - Ideally we would be aiming for you to be engaging in a mild-moderate intensity activity of 30 minutes duration around 5 times a week.
    - Weight loss
        - Any weight you lose, whether it be 2 kg or 27kg, will have a significantly positive impact on your health
        - Not only will you feel better, but you are likely to have more energy as well.
    - Alcohol consumption in moderation
        - For lady the recommended serving of alcohol daily is 1 standard drink of alcohol per day.
        - This is about 1 standard glass of wine.
- I would follow the patient up and ideally re-test their cholesterol levels in 3 months time.

Name 2 ways her management would be different if she had a past history of ischaemic heart disease?

- Start on a statin irregardless of her cholesterol results
- Aim for a lower cholesterol target – (4-2-1-2 rule)

- i.e. Total = 4, LDL = 2, HDL > 1, and TG =2
- They may ask for values.

Diabetes + weight loss:

LOW/tiredness in 20-year-old female (diagnosis is TIDM, have to ask TIDM, thyroid, cancer, depression, IBD, Coeliac, diet/exercise, stress questions)

- Introduction
- Patient name, age and occupation
- HOPC:
  - Can I ask what has brought you in today?
    - Can you tell me anything else?
  - Quality
    - Have you been trying to lose weight at all?
    - Have there been any changes to your diet?
    - Have there been any changes to the amount of exercise that you do?
      - How much exercise do you do at the moment?
  - Severity
    - Can I ask how much weight you have lost?
  - Time course
    - When did you first notice this change in your weight?
    - Has your weight fluctuated at all over that period?
  - Context
    - Can you think of anything that might be responsible for this change in your weight?
  - Agg/Rel
    - Not relevant in my opinion
  - Associated;
    - Aside from this loss of weight, have you noticed anything else at all?
    - General:
      - Have you noticed any changes in your energy levels?
      - Have you had a fever?
      - Have you had any night sweats?
    - Thyroid
      - Do you ever find that you are particularly sensitive to hot weather?
      - Have you noticed that you are particularly sweaty or that you have a tremor?
    - GIT
      - Have you been feeling nauseated or vomited?
      - Do you ever feel bloated?
      - Do you have any abdominal pain?
      - Have you noticed any change in your bowels?
        - Blood?
        - Mucus?
        - Incomplete emptying?
        - Flatulence?
      - Do you ever experience pain with defecation?
      - Are there any foods that don't sit well with you?
    - Depression:
      - How have you been feeling in your spirits recently?
      - Do you ever feel down or depressed?
      - Are you stressed out at the moment?
    - Anorexia
      - How do you feel about your current weight?
      - Are you worried about gaining weight?
    - Diabetes
      - Have you noticed that you are particularly thirsty?

        - Soft drinks?
        - How much?
    - Have you been going to the toilet more often?
        - How frequently?
        - Are you passing small amounts or urine when you go to the toilet, or is it a large amount?
    - Have you ever had thrush?
    - Have you had any urinary tract infections recently?
- Past medical history:
    - Illnesses?
    - Medications
    - Allergies
- Family history
    - Illnesses?
    - Diabetes?
    - Coeliacs disease?
    - Thyroid disease?
- Social history
    - Where do you live at the moment?
    - Do you smoke?
    - Do you drink alcohol?

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<u>Rheumatoid flare up – similarly could be flare up of Crohn's disease, COAD, or epilepsy.</u>

A 34-year-old female with acute flare up of rheumatoid arthritis. Previously well controlled on methotrexate and paracetamol. Stopped methotrexate 10 months ago when trying to be pregnant, had baby 1 month ago. Methotrexate has not been restarted. Hands are flaring up now. New extra articular symptoms included carpal tunnel in right hand. Social issues - husband is really busy with work, mum is in hospital, no other support at

home, difficult taking care of baby, really worried of dropping baby. Should also ask about her mood and post natal depression.

- Introduction
- Patient name, age and occupation
- HOPC:
    - Reason for coming in today? → Brief rheumatoid history
        - Ok, well lets begin by getting an understanding of your rheumatoid arthritis?
        - When were you diagnosed?
        - How are you being treated?
        - When did you stop taking medication?
        - Was there a particular reason why?
        - You haven't taken medication since then?
    - Site:
        - Where is the flare up?
    - Quality:
        - Pain?
        - Reduce mobility?
    - Severity:
        - How is this affecting your life?
        - Is there anything that you find yourself unable to do?
        - Is there anything that you are worried about?
        - Acknowledge emotion – I can understand that that must be very difficult for you at the present time.
    - Time course
        - When did this start?
        - Is it getting worse?
    - Context – brief rheumatoid history
        - Can you think of anything else that might have caused this?
    - Agg/Rel
        - Is it worse in the morning?
    - Associated:
        - Have you had any other symptoms?
        - General:
            - Weight loss
            - Fatigue?
            - Fever?
            - Night sweats?
        - Post natal depression:
            - It can be a very trying time for people in the period immediately after having a baby, how are you coping?
            - Do you ever feel depressed or sad?
            - Symptoms of depression:
                - Loss of interest/pleasure in activities
                - Affect on sleep + energy levels
                - Concentration
                - Memory
                - Appetite + weight loss
                - Feeling hopeless?
                - Guilt?
                - Lack of self-esteem?
- Risk assessment:
    - Suicide
        - Some people when they have these sort of feelings can feel that life is no longer worth living? Have you ever thought that?
        - Have you ever considered ending your life?
        - Have you made any plans to this effect?

        - Have you ever made an attempt on your life?
        - Do you have any weapons or meds that you would use?
        - Have you ever made any final arrangements?
    - Infanticide
        - How do you feel about the baby?
        - Are you ever worried when you are alone with the baby?
        - Do you ever worry that you will not be able to look after the baby
        - Have you ever thought of harming the baby?
- Social:
    - Who is at home at present?
    - Do you have any supports or people to help you out?

Summarize and present the key issues about the patient and what is her main concern?

- Jane is a 34 year old female with an acute flare up of her rheumatoid arthritis, following the birth of her child …
- The main concerns here are…
    - Her ability to take care and look after her child. It is also important to consider the risk of the baby being dropped and suffering serious trauma.
    - Controlling this flare up of rheumatoid and referral to a rheumatologist
    - Her lack of support presently with her mother in hospital and her husband constantly working
    - Providing her with adequate social and psychological support given the affect this has had on her mood.

3 investigations to monitor the progress of this flare up?

- FBE – platelets
- ESR
- CRP

<u>Claudication – monitoring of progress +screening for other diseases.</u>

- Introduction
- Patient name, age and occupation
- HOPC:
    - Site
        - Where is the pain
        - Does it radiate anywhere else?
    - Quality:
        - What does the pain feel like?
    - Severity:
        - How far can you walk before this pain makes you stop?
        - What impact is this having on your life?
        - Is there anything that you find yourself unable to do?
    - Time course
        - When did this problem begin?
        - Did it come on suddenly or gradually?
        - Has it been getting worse?
        - Has it been there constantly since coming on?
    - Context
        - Can you think of anything that might have caused this?
        - Trauma?
    - Agg/Rel
        - Aside from rest, does anything else seem to make it better?
            - Think neurological claudication – relived by forward flexion of the spine, i.e. not painful when riding a bike, or climbing upstairs.
        - Does anything make it worse?
    - Associated: have you noticed anything else?

        - General
            - Fever
            - Weight loss
            - Lethargy/fatigue
        - PVD systems:
            - Any ulcers
            - Any change in sensation
            - Any change in the appearance of your feet – loss of hair etc.
            - Erectile dysfunction
        - Cardiovascular systems review
            - Chest pain
            - Shortness of breath
            - Palpiation
            - Shortness of breath when lying flat
            - Ever wake up at night feeling short of breath
            - Any swelling in legs?
        - Neurological:
            - Have you ever-experienced migraines?
            - Have you ever noticed weakness in your arms, legs or face?
            - Have you ever had an episode where you vision changed?
- Past medical history:
    - Illnesses
    - Medications
    - Allergies
    - Vascular risk factors:
        - Smoking
        - Weight
        - Level of activity – sedentary lifestyle
        - Blood pressure
        - Cholesterol
        - Diabetes
        - Heart attack
        - Stroke
        - Kidney problems
        - FHx
- FHx
    - Illnesses
- Social history
    - Where are you living at present?
    - How has your mood been?

<u>Crohn's Flare Up</u>
A 28-year-old woman with 18/12 history of Crohn's Disease. Do not take social history.
Chronic disease history, she doesn't have any active disease. Ask about how long she's had it, treatments, and flare-ups.

What blood test would you like to do if she has terminal ileitis?

What other medications would you try her on if mesalamine and prednisolone fails? (Discuss Mx options).

<u>Epilepsy:</u>
A 30-year-old lady with temporal lobe epilepsy. Still driving (works as commercial driver). Take a Hx (confidentiality, other substances).

How do you treat epilepsy not responding to medications?
Check medication levels, increase dose, change medication, surgery

Could she have her license?
Conditions with epilepsy. Compliance with meds. Whether she's having seizures/control

Pap smear

Introduction

Patients name, age and occupation

Explain to actor why we do pap smears

- Interrupt me at any time, but will leave time for questions at the end.
- Do you understand what a pap smear is and why it is performed?
- Structure interview
- The pap test is a quick and simple screening test that checks for particular changes to the cells of a woman's cervix (the neck of the womb). These changes may lead to cervical cancer if left untreated.
- We can catch early changes in the make up of cells and this allows for early and simple treatment.
- Its important to get regular screening so we can pick up these early changes, and

Explain procedure;

- What the test involves…
- I will insert an instrument called a speculum into the vagina, So that I can see your cervix. Then I will use a small spatula or tiny brush to collect cells from the cervix.
- I'll then send it to the laboratory for analysis. The results should be available within a week.
- The pap smear can be uncomfortable, but is generally well tolerated. Some people may experience some mild cramping and spotting for few hours after the exam.

Get consent

- Do you have any questions about the procedure?
- Are you ready to proceed with the test?
- Please let me know if you feel uncomfortable or you would like to stop for whatever reason. Just say stop.

Perform Pap smear on the model whilst talking it through with the actor

- Prepare patient – as I am preparing the equipment can I ask you to…
  - Empty bladder
  - Private area to change
  - Cushion or fists to place under bottom
  - Offer mirror
- Prepare equipment
  - Speculum
  - Lube / Warm water
  - Slides – labeled with name, UR, DOB (pencil) – confirm with patient.
  - Wash hands
  - Gloves
- Check speculum is working
- Insertion of speculum
  - Tell patient to bring their knees up and put their heels together, then when there ready move their knees apart
  - When your ready if you would like to lift the sheet up.
  - Inspect genitalia/introitus
  - Place speculum at introitus (say aloud)
  - Take a big breathe in and as you breathe out I will insert the speculum
  - Insert speculum
  - Use broom to take cervical sample, spin 360 degrees inside the cervix
- Smear on slides and fix with cytospray
- Remove speculum
- Indicate to the examiner that generally at this point in time a bimanual examination is performed.

- Conclude examination
    - Patient can get dressed when ready.
    - And then we can discuss results of examination
    - Explain when and how to obtain results
    - Positive reinforcement for undertaking a Pap smear
    - Tell her about Pap smear registry – this is a registry which all women are automatically listed in, and it will notify you if you are to miss a schedule pap test.
    - Warn about complications – spotting and cramping for the next few hours.

COCP

Lady comes in requesting the oral contraceptive pill (no CIs). Counsel her regarding its use.

- Patient name, age and occupation
- Should ask CIs
- Reason for visit
    - Reason for interest in the pill
    - Current contraceptive method and efficacy
    - Contraindications to the pill
        - Clots
        - Vasc RFs – HTN, cholesterol, DM, smoking, FHx etc.
        - Potentially pregnant?
        - FHx of breast cancer
- Ask for their understanding
- Structure – give time for questions
- Inform them that you will give them hand outs + follow up
- How it works?
    - The pill works by stopping the release of an egg each cycle, and preventing sperm entering the womb and makes the womb unsuitable for pregnancy.
- How to take it?
    - 1 pill once a day
    - Same time every day
        - Best to get in a rhythm such as taking it with toothbrush or app on iphone to assist you in remembering
    - Can start at any time of your cycle
        - Not essential to start on your period
        - 7 days of active pills are required for contraception to be effective
    - Each pack contains 7 sugar pills
        - If you take this, this is when you will have your period or a withdrawal bleed.
    - Note; it is not essential to have this withdrawal bleed
        - Can run packs together if you wish
        - If you do this, you may have some breakthrough bleeding however.
            - At this point some people opt to take the sugar pills and have a withdrawal bleed.
- Missed pills and what to do?
    - What does this include
        - Forgotten pills, vomiting after pill, taking the pill when you have diarrhoea, when you are taking antibiotics
    - What to do if any of these things happen…
        - If it is < 12 hours since pill was meant to be taken
            - For example the pill was meant to be taken with your breakfast, but you don't remember to take it till lunch, then don't stress, simply take the missed pill immediately, and take the subsequent pill at its usual time.
        - If it is > 12 hours
            - For example the pill was meant to be taken with your breakfast, but you do not think to take it, til the next morning, then the efficacy of the pill will be impaired.

- What this means is that you have to use an alternative method of contraception (i.e. condoms) until you have had 7 active pills
- Once you have had 7 active pills you will be covered again
- This may mean you have to skip the sugar pills.
- If you have had unprotected sex since the last pill, you may require emergency contraception and should see a doctor.

- Benefits
    - Effective, convenient, reversible, unobtrusive and simple means of contraception
    - Periods
        - Predictable
        - Less painful
        - Less heavy
    - Other good things
        - Has been shown to reduce the risk of uterine and ovarian cancer
        - Can treat other conditions such as endometriosis and PCOS
        - Can reduce acne
        - Can treat PMDD
- Risks:
    - "There are number of serious side effects to do with clots and thrombosis, but looking at you a 19year old, non smoker, otherwise healthy the risks are negligible"
    - There are a few common minor SEs that some women may notice initially…
        - Breast tenderness
        - Headache
        - Nausea
        - Breakthrough bleeding – can change pill type if this is bothersome
    - Serious SEs:
        - Arterial atherosclerosis
            - For someone likeyourself with no risk factors I am not concerned at all
            - However some people can be at increased risk of heart attacks and strokes.
        - Venous thrombosis
            - Small risk of clots in your legs which can secondarily travel to the lung and cause chest pain and shortness of breath
            - Increased rate from 4/10,000 to 15/10,000, which is less of an increase than is expected during pregnancy
        - Hormone dependent cancers
            - Slight increase in the risk of breast Ca, this will normalise some years after you cease the pill
- STIs
    - Does not provide protection from STIs
    - You need to use barrier methods of contraception to prevent this.
    - Even when in a stable relationship, some people can remain asymptomatic for many years and still pass be able to pass on STIs. Thus we still recommend using condoms.
- Preventative health
    - Pap smear last done?
- Types of pills available
    - Low oestrogen pill
        - Older people, people with higher atherosclerotic risks, people with other pathology like endometriosis
    - High oestrogen pill
        - For people with irritating breakthrough bleeding

PMB:

- HOPC:
- Oestrogen exposure
    - Cycles regular + irregular

    - HRT + COCP + tamoxifene
    - Weight
        - Pregnancies
    - Breast feeding
    - Menarche + menopause dates
- Gynaecology
    - Menopause
    - STIs
    - Paps

Smoking cessation

- Patient name, age, occupation
- Intro + "I understand that you were…"
- Characterize smoking
    - Mode of smoking
    - Number per day
    - When behaviour began
    - Periods of increased/decreased use
    - Situations associated with smoking
    - Past attempts to quit
        - How
        - Length of abstinence
    - Withdrawal symptoms
        - Movies / planes
        - 1st thing in the morning
- Motivating = DARN – C
    - D = desire
        - "If you could wake up tomorrow and have any change, would you still be a smoker"
        - "In an ideal world would you still be a smoker"
        - Where do you see yourself in 5 years
    - A = Ability
        - How confident do you feel in your ability to stop smoking?
        - How would you scale it out of 10?
            - You said you were a 5, why is that?
            - What would it take to make you a 10?
        - How would you do it?
            - Is there anything that you are worried about that might make this more difficult?
            - How do we fix that?
    - R = reasons
        - Give me your 3 biggest reasons to make a change?
            - i.e. health, money; you say you smoke a pack a day, how much does a pack cost these days?
        - What things are really important to you in your life, do you think that this will have an impact on them?
    - N = need
        - One a scale of 0-10 how much do you need to make this change in your life?
        - Why are you a 5?
        - What would it take to make you a 10?
    - C = commitment
        - What is the first step?
        - What are you going to do as soon as you leave this room?
- NB: throughout the interview you should be…
    - Reframing self deprecating comments
    - Reinforcing good points
    - Tie back into history already given

- Smoking MGMT:
    - 1. Reinforce decision + counselling
    - 2. NRT → patches + gum or vapour cigs
    - 3. Champix (varenicline) or Bupropion
    - Other: quitline, support groups, avoiding situations, relaxation treatment, CBT/hypnotherapy

<u>Alcohol cessation</u>

More or less identical to above – simply change the characterization and emphasize different points throughout the history as appropriate.

- Patient name, age, occupation
- Intro + "I understand that you were…"
- Characterize alcohol consumption
    - Type of alcohol
    - Amount per day
    - When behaviour began
    - Periods of increased/decreased use
    - Situations associated with alcohol consumption
    - Past attempts to quit
        - How
        - Length of abstinence
    - Withdrawal symptoms
        - Tremors, shakes, nausea/vomiting etc.
- Motivating = DARN – C
    - D = desire
        - "If you could wake up tomorrow and have any change, would you still be drinking this much?"
        - Where do you see yourself in 5 years
    - A = Ability
        - How confident do you feel in your ability to give up alcohol?
        - How would you do it?
            - Is there anything that you are worried about that might make this more difficult?
            - How do we fix that?
    - R = reasons
        - Give me your 3 biggest reasons to make a change?
            - i.e. health, money, family
        - What things are really important to you in your life, do you think that this will have an impact on them?
    - N = need
        - One a scale of 0-10 how much do you need to make this change in your life?
        - Why are you a 5?
        - What would it take to make you a 10?
    - C = commitment
        - What is the first step?
        - What are you going to do as soon as you leave this room?
- NB: throughout the interview you should be…
    - Reframing self deprecating comments
    - Reinforcing good points
    - Tie back into history already given

History of the alcoholic train driver brought in by his wife

- Patient name, age and occupation
- Symptoms of withdrawal + HOPC:
    - Autonomic – sweating, tachycardia, tremor
    - Psychological – hallucinations, mood, sleep
    - GI – N/V, anorexia

    - Neuro – fatigue, convulsions, coma, lethargy, drowsiness
- CAGE screen:
    - Have you ever attempted to cut down your drinking?
    - Have you ever been annoyed when someone criticised you for your drinking?
    - Have you ever felt guily about your drinking
    - Have you ever need an eye opener in the morning to get you going?
- Substance abuse:
    - Have you ever had any legal problems because of your drinking – i.e. fines, arrests etc.
    - Have any personal relationships suffered because of your drinking?
    - Have you ever failed to carry out your job or had any trouble with employment because of your drinking?
    - Have you ever been in a fight or driven under the influence of alcohol?
        - Have you ever been to hospital or had any problems with your health because of your drinking?
- Substance dependence:
    - Do you need more alcohol to feel the same way?
    - Have you ever felt strange or different when you haven't drunk for extended period of time?
    - Have you tried to quit or cut down on your drinking in the past?
    - Have you given up or stopped participating in any activities because of your drinking
    - Do you spend more time drinking now than previously?
    - Do you find it difficult to control yourself once you begin drinking?
    - You continue to drink knowing of all the problems that it has caused you?
- Risk assessment:
    - Other substances?
    - Suicide
    - Homicide
    - Job
    - Finances
    - Social
- Past Psych
- Past Med
- FHx
- SHx

What is the MGMT for alcohol withdrawal – both short and long term?

- Immediate:
    - Consider need for admission
    - Monitoring
    - Provide them with a low stimulation and reassuring environment.
    - Administer thiamine
    - Diazepam prn
        - Haloperidol if hallucinating
- Long term:
    - Biological:
        - Naltrexone
        - Disulfiram
        - Acamprosate
    - Psychological:
        - Supportive therapy
        - Psychodynaimic therapy
        - CBT
        - Support groups
        - Assess for Axis I disorder previously masked by alcohol consumption
    - Social:
        - Engage supports
        - Time off work

        - Financial supports and assistance

What are the confidentiality issues for this person?

- Risk of harm to others
    - Train driving – statutory body
    - Driving car – VIC roads
- Risk of harm to self
    - Continued use
    - Drink driving – VIC roads
- Reputation
- Employment/livelihood

Aged Care OSCE Overview

Year	Station	Notes
2017		
2016		
2015		
2014	**Neuro exam for spinal cord compression** 1. Middle-aged lady with a history of breast cancer presents with back pain. You will be asked to state you most immediate concern at the beginning of the station (strictly spinal cord compression – pathological fracture, compression fracture, bony metastases not accepted). Given that spinal cord compression is the main concern, perform a lower limb neurological examination (full motor and sensory examination is expected and is definitely possible to complete). a. Based on your examination findings (normal), are you still concerned about spinal cord compression at this stage? b. What else would you like perform to complete your examination? (full upper limb neuro exam, PR) **Carer stress** 2. Lady presents to the GP clinic with a burn on the hand. Your GP noticed that she looks down and worn out. After the burn has been dressed by the nurse, she says that she needs to leave the clinic quickly. Speak to the patient and address her concerns. (On further questioning, you realise that the patient accidentally burnt her hand with the iron at home. She needs to go home quickly as she is the full-time carer of her father who has Alzheimer's Disease and her friend who is helping her care for him at the moment needs to leave soon. She then tells you that she is finding taking care of her father increasingly difficult, but also made a promise to her father not to send him to a nursing home) a. What is the greatest concern in this scenario? b. Do you think that the patient should keep her promise of not sending her father to a nursing home and justify why.	
2013	**Confirm death & breaking bad news** 1. You have been called to confirm the death of an 80 year old woman with terminal kidney cancer. She has died unexpectedly early. Please confirm the death and answer the daughters questions. There were UEC results on the door and in the room you had to explain. The daughter did NOT know her mother was dead so you had to break the news to her – I think they wanted you to confirm the death first. The examiner didn't ask any questions. The daughter wanted to know why her mother had died early, how long the body could stay in the room and what she was meant to do now i.e. funeral planning etc. I think! **Depression in the elderly** 2. 80 year old man presenting with tiredness. He clearly had depression – more of a psych history. They only gave you 7 minutes to take the history which wasn't enough. Examiner asks questions a. What is the most likely diagnosis? b. How would like to manage this?	
2012	**??**	
2011	**Stroke** Shown a CT scan, asked to interpret and for 4 findings: 1) right fronto-temporal-parietal lobe infarct, 2) surrounding oedema, 3) ventricle	

	compression, 4) midline shift, 5) haemorrhagic conversion Test orientation Ask for handedness Cortical: • Dressing, constructional apraxia • Sensory and visual neglect • Temporal: remember 3 objects • Frontal: Lists words starting with a particular number	
2010, 2003	**Falls History** ○ 2010 - Mr Ronald Daly, a 65 year old gentleman has presented to the Emergency Department after having a "funny turn". His BP is 115/70, PR 52, RR 16. Please take a history to assess his episode. After 6 minutes you will be asked a series of questions. ○ 2003 – Perform a verbal falls assessment of an elderly woman (history from a woman who has just presented with a fall) ○ ?? 3) Take a history from this 84 year old man with a one day history of a fall, with a view to make a diagnosis. And subsequent management. ○ An 84 year old man who resides in a nursing home was found by a nurse in the floor of his room. The nurse reportedly heard a 'crashing noise' followed by a scream. The man was on his right side with his lunch tray next to him. And spilled food items nearby. He told the nurse that he fell as he was trying to go to the toilet. He denies any PIC, SOB or altered motor control.	What is the most likely cause of his "funny turn"? (Arrhythmia). Given 2 ECG strips to interpret (1st one is Brady with prolonged PR interval, 2nd ECG shows VT). What are 2 Mx strategies for VT? (Amiodarone, Lignocaine 2003 – Don't forget to ask about OP! and do a Medications review!
2010	**Carer Assessment – Alzheimer's**	
2010	**Neurological Examination for Stroke** ○ Mrs Costella is a 60 year old woman who has just been admitted to the Rehab ward 10 days post stroke. You are asked to interpret cerebral findings on CT and perform a focussed neurological examination. You will then be asked 4 questions about stroke	CT: R sided temporal/parietal lesion Do an examination of her cortical function (not speech/language/tone/power/reflexes) • Empty clock face on table • Sensory/visual inattention • ?Apraxia • Anomia Questions: • What cortical abnormalities does she have? • How long would you estimate her recovery to take? • What is the difference between a physiotherapist and an occupational therapist?

2009	**Memory problems** You are with the ACAT team visiting the house of an elderly lady because her son is worried about her memory problems. Take a history from this lady and its impact on her social and ?smtg functioning.	What other information would you like? (collateral Hx and MMSE) MMSE results shown – interpret What do you think she has? What factors can affect MMSE – language, vision, hearing, education, physical frailty, cultural intellectual disability, isolated language impairments, inter-examiner variability
2009	**Palliative Care – Issues about dying at home** o A patient ~ 40y/o comes to see you regarding end of life care for terminal lung cancer. Take a history and answer his questions o Patient had a list of questions regarding end of life care at home, who is in charge of decision making, if partner can be involved in decision making, when happens when patient is no longer competent to make decisions etc	
2009	**Pain Management** – Take a history. Pt suffers from postural hypotension. Shown list of medications	
2009	Broad Arm Sling	
2008, 2006	**Cancer Pain** o 2008 - Young woman with history of breast cancer, which has metastasized to L humerus, and has received chemotherapy and radiotherapy. She has developed back pain, and scans showed a lesion at T10. Take a focussed history on her pain. o 2006 - History from a man with back pain, history and questions – metastases from prostate and looking at MRI –discussing pain management	What 2 things are you concerned about? Spinal cord compression, Pathological fractures. Do an appropriate examination (LL neuro)
2007, 2003	**Osteoarthritis (Rehab?)** patient w OA, thinking abt surgery. take a hx about symptoms, previous treatments, and address concerns. prescribe a walking stick, and tell the patient how to use it	
2008, 2007	ED – Patient with Diazepam OD. Do vitals, assess and record GCS, talk about how you would manage the airway	What 2 things would you do as the doctor? (After managing airway)? What unit should the patient be transferred to?
2006	**Rehab – 10 Week Post Op Amputee Review** – Pain management issues, physio, secondary risk prevention	
2006	ED – Hx of **Collapse**, put cardiac monitor on, asked about drugs for the various arrhythmias	
2006, 2005	**Urinary Incontinence History** o Lady presents with urinary frequency and urgency, take a 7-minute history and answer questions:	What investigations would you perform? Interpret bladder chart Management
2007, 2005	**Carer Distress History (BPSD or Delirium)**	What are your DDx?

	○ Incident in nursing home where a male patient has been aggressive and 'disrupting the peace'. Take a 7 minute history and answer the questions	What Ix would you perform? What is your Mx?
2009, 2005	ED – Collapse and Airway Maintenance (Procedure and Viva) ○ Elderly gentleman visiting his friend in hospital and collapsed. You are the intern at the scene. How would you respond?	Demonstrate proper airway management. Perform oximetry → O2 sats suddenly dropped to 90%. What are the possible causes?
2008, 2005	Multiple Sclerosis History	
2011, 2005	ED – Wrist fracture Viva ○ ED: colles fracture. Describe deformity in photo. Describe XR findings. Describe clinical findings. Describe how you would examine the neurovascular status of lady. Describe 4 steps of initial management. Describe how to care for arm: keep cast dry, move fingers, move arm, don't drive, get help for 1-handedness. What complication: compartment syndrome. Describe clinical findings. Describe management	
2010, 2006, 2005, 2003	**Confirming death and breaking bad news to relatives** ○ 2010 - You have been called in by the nurses on the palliative care unit to confirm the death of a patient Mr Stebbing. He has been on the ward for some weeks but his death has occurred sooner than expected. His daughter is in the room and you have not met her before. Please perform an examination and explain to Mr X's daughter what has happened. (N.B. The patient is a real actor pretending to be dead). Below are the results of recent tests: ○ Na: 138mmol/L ○ K: 8.2mmol/L ○ Cr: 340 ○ Urea 14	
2007, 2005, 2004	**Falls Assessment Examination** ○ 2005 – Lady trips over her dog and fell. Do a gait and balance assessment. Report your findings ○ 2007 - Someone presents for annual health checkup, but had a fall 6w ago. Do a gait and balance assessment (no need to do vestibular assessment), talking abt what the tests mean along the way.	Name the tests as you go and your findnigs. What are the factors leading to falls? Medical conditions leading to falls? Cardiac, Neurological, Vision, Old age etc.
2008, 2004	**Depression in Old Age History** ○ 2008 – 67 year old man has presented to doctor for the first time because his old GP died recently. Please take a history and answer questions	What is the most likely diagnosis? How would you manage him? Don't forget to ask about past psychiatric episodes, hospitalisation or treatment, precipitating event (death of wife)

2004	IV Cannulation Procedure and Viva	Selecting the correct sized needle and management
2004	**Pain Management in Metastatic Prostate Cancer**	
2003	ED: Patient comes in confused. Assess GCS and management	
??	**Delirium History** ○ You are a medical house officer. You have been asked by your registrar to obtain a history from the wife of a confused patient that he is examining. Please take a history of the presenting complaint. You should be prepared to discuss the management options.	
??	**Polypharmacy** ○ Take a focused history from ~60 y/o lady who is on many medications. You will then be asked to do a procedure ○ The patient was on multiple medications, including many pain meds (patient had a list of meds and doses). She had recently had a fall. Ask about side effects ○ Should the medications be changed? (Yes, patient wasn't in much pain anymore so can reduce pain meds) ○ **Which medication would cause: itch, 'wooziness', constipation, nausea – OPIOID?** ○ **Procedure – BP.** The stethoscope had 2 ear sets so the examiner could hear also	
??	**Breaking Bad News** ○ A 40 y. o woman and her partner awaits the results of the triple assessment of a breast lump which was found to be malignant. Inform the patient (and her partner) of the diagnosis and offer counseling. (5 minute station)	
??	**Dyspnoea in a palliative patient**	