

OSCE 1

Candidate Instructions

This is a **7 minute** history taking station.

You are a consultant in a tertiary Emergency Department. Kate is a 30 year old woman who presents with a collapse.

Observations:

Afebrile

HR 72 bpm

BP 110/65 mmHg

O2sats. 99% room air

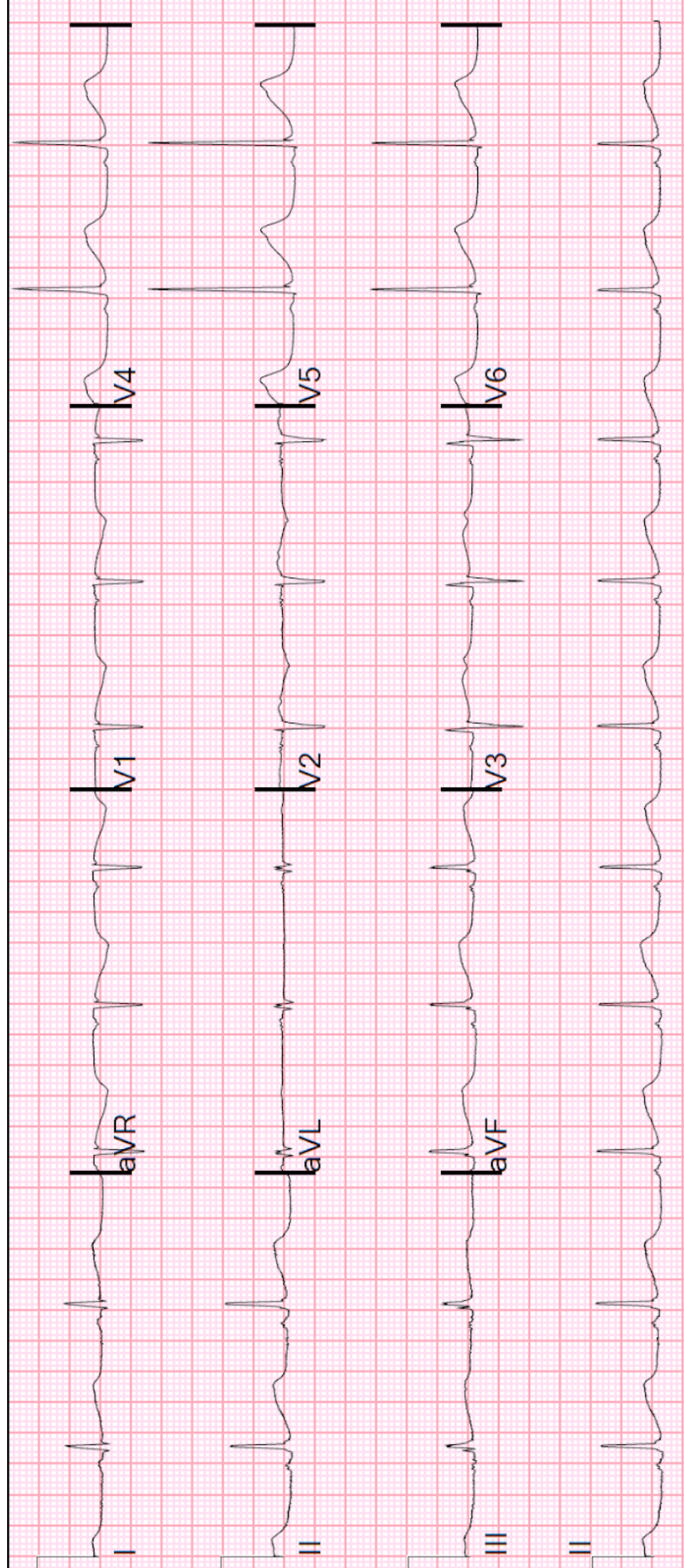
You will be interacting directly with Kate who is in an ED cubicle.

Your tasks are to:

- Take a focused history from Kate, then
- To the examiner directly:
 - present a provisional/differential diagnosis, and
 - present an approach to investigation

This OSCE will assess the following domains:

- Medical expertise
 - Relevant history (40%)
 - Provisional diagnosis and investigations (40%)
- Communication
 - History-taking technique (40%)



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Role-player Instructions

Role-player requirements: Female, 25-35.

This is a **7 minute** station.

You are 30 years old. You have presented to the ED following an unconscious collapse at home.

Case information and relevant medical history:

Collapse – occurred 2 hours ago, while you were sitting on the couch at home, watching tv.

Brief preceding symptoms – heart racing and lightheaded for a few seconds. Then you woke up on the floor. Boyfriend was in another room and came in as you were waking up. You were dazed for a couple of minutes. No incontinence or tongue biting. No injuries from falling off the couch.

No other preceding symptoms – no chest pain, sweating, headache, abdo pain.

Never had anything similar before.

No recent illness.

Your psychiatrist commenced you on risperidone for manic episode about a month ago.

No recent travel.

No sick contacts.

Normal menstrual period 2 weeks ago.

Past history

- Opioid dependency – past heroin use. Have not injected drugs for 6 months. On methadone program currently.
- Bipolar affective disorder

Meds

Methadone 100mg/day

OCP

Risperidone

Allergies

Penicillin – rash as child

Social history

Working as a shop assistant in a fruit shop. Live with boyfriend. Smokes cigarettes 20/day.

Social drinker.

Family history

Sister had a heart condition but don't know what it is. No longer in contact with her.

Scenario and script, in timed parts:

Part 1 (0-4 mins)

Opening statement:

“ Hi I’m Kate.”

The candidate should take you through the history of your presenting complaint and past history. DO NOT offer up history without being directly asked, but when asked give the history above.

Part 2 (5-7 mins) Examiner will ask the candidate for a DDx and investigation plan.

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Examiner Instructions

Station summary: 30 yr old woman with Torsades due to prolonged QT caused by combination of methadone and risperidone. Seizure is alternate possibility.

Candidates are required to:

- Take a history from the patient, then
- To the examiners directly:
 - present a provisional/differential diagnosis, and
 - present an approach to investigation

Part 1 (0-4 mins)

The candidate should take the history of presenting complaint and past history etc. Role player should NOT offer up history without being directly asked, but when asked give the history above.

Part 2 (4-5 mins – may wait till 5 minute point if still taking relevant Hx)

The examiner will ask the following questions:

What is your differential diagnosis/cause of her symptoms?

The candidate is expected to come up with a list of possible differential diagnoses:

Torsades – precipitated by prolonged QT due to methadone and risperidone.

Seizure – still a possibility given unwitnessed.

Less likely – vasovagal, other arrhythmia.

Part 3 (5 – 7mins)

What investigations would you perform and why?

ECG – most useful. Look for prolonged QT. Other: WPW, signs structural disease eg LVH, Brugada

Bloods – FBE, UEC, Mg

Check for risk factors for prolonged QT (hypoK, Mg)

CTB (in ED) or MRI (OP)

Beta-HCG (optional)

Echo – to exclude structural heart disease?

Bonus – if time permits

Please interpret her ECG – prolonged QT (660msc).

What would be the patient's further management – admit for monitoring. Replace risperidone with safer option, etc.

Marking domains:

Medical Expertise: Relevant history – 40%

- Elicits a focused, relevant history de novo
 - Details of syncopal episode – was it witnessed? Posture?
 - Pre- and post-syncopal symptoms
- Identifies important historical details (red flags) diagnostic of an important condition
 - Chest pain, palpitations, abdo pain, pregnancy, headache, exertion.
 - Seizure activity, post-event confusion
 - Family history – syncope, sudden death
 - Past history – syncope, long QT, structural heart disease/cardiomyopathy
 - Dehydration (V&D)
 - Pregnancy status (PE, haemorrhage)
- If time permits (but not essential to pass)
 - Correctly identifies prolonged QT on ECG.
 - Formulates safe management plan – admission for monitoring, replacing risperidone with safer alternative.

Medical Expertise: Provisional diagnosis and approach to investigations – 40%

- Generates a differential diagnosis, with an inherent focus on conditions requiring time critical management
- Creates a focused investigation plan that confirms or excludes time critical diagnoses

Communication: History taking technique - 20%

- Introduces self and purpose, establishes rapport, shows empathy
- Uses appropriate communication skills
- Actively listens e.g. paraphrases and clarifies what has been said
- Allows the patient to react emotionally to the situation and responds appropriately to non-verbal cues