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## Station Number FIVE: SCBD

### Candidate instructions

*This is a 7-minute standardised case base discussion.*

You will be interacting directly with an examiner. You will be asked to outline your assessment and management to the following clinical situation. Further information will be provided as the case evolves. The examiner will be assessing your medical knowledge, as well as the reasoning and rationale to your approach and decisions. Please be as specific as possible when answering. For example, when discussing drugs describe doses, when discussing investigation or management provide reasons why you chose that approach.

#### **Case information:**

You are the ED consultant in charge in a regional centre on a Monday evening shift.

The Emergency mental health clinician has asked you to review a pt they have seen prior to any medical staff reviewing the patient.

A 40-year-old female was brought to the department by a concerned friend. She has recently gone through a relationship breakdown. Her friend was concerned as she has become increasingly withdrawn and seemed very depressed.

The mental health clinician attempted to review her primarily but found her to be drowsy and a confused. The pt then divulged she had taken “ a lot of paracetamol over the weekend”

#### Current vitals are:

- RR 20
  - Sats 96% ra
  - HR 110
  - BP 110/70
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**Your task is to:**

- Outline your initial assessment of the patient
- Answer any further questions from the examiner as the scenario evolves

**This OSCE will assess the following Domains:**

- Medical expertise 50%
  - Prioritisation and decision making 50%
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## Examiner Instructions

The questions are to be delivered in the same manner to all candidates. If a candidate's response lacks clarity– then the lead examiner may probe further or ask the candidate to justify their decision-making process.

### Section 1 – Initial assessment - allow 2 mins

***“Please outline your initial assessment of the patient”***

This is a patient with a delayed presentation of potentially massive overdose and signs suggestive of liver toxicity.

Initial assessment should consist of:

#### History

- Accurate timing of ingestion
- Dose taken
- Pt weight if known
- Co – ingestants/ Illicit drugs/ ETOH
- Pmhx – liver disease
- Meds
- Allergies
- Prev attempts
- Social hx – Kids

#### Symptoms of toxicity

- N+V, abdominal pain

#### Examination

- RUQ tenderness
  - Jaundice, Liver flap, Confusion, encephalopathy, GCS
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### Initial investigations

- BSL
- ECG
- VBG

### Prompts

*“What details in the history would you want to clarify?”*

*“What specific examination findings would you look for?”*

*“What bedside investigations would you perform?”*

### Section 2 – further management 2-4 minutes:

*“The pt reports taking most of a box of 100 tablets on Saturday morning. She felt nauseated most of the weekend. Today she has some upper abdominal pain. She is confused.*

*What further investigations and management will you initiate?”*

Candidate is expected to identify that that this is a massive ingestion with delayed presentation, significant risk of toxicity.

Delayed presentation requires **immediate commencement of NAC** (prior to waiting for blood results)

Candidates should be able to give doses for a NAC regime - 2 bag as per below

- Standard - 200mg/kg in 500ml of 5% dextrose 4/24 then 100 mg/kg in 1l 5% dextrose 16/24
- Or double dose for massive ingestion - 2nd bag 200mg/kg over 16 hours

3 bag regimen is also acceptable

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Investigations should occur to risk stratify

- LFTs, particularly ALT > 50
- Paracetamol level which is still detectable
- INR
- BSL
- VBG
- ECG

Plan to repeat bloods 2 hours prior to end of NAC infusion

### **SECTION 3 – 4-6 minutes**

***“Here are the patient's blood results. (Give candidate bloods, see attached sheet)***

***Interpret these results.***

***What are your next steps in managing this patient?”***

- Very elevated transaminases
- Raised INR indicating impaired synthetic function
- Raised ammonia in conjunction with confusion indicative of encephalopathy.
- Raised lactate but nil resus as yet
- Renal function currently maintained.
- Overall impression of fulminant hepatic failure secondary to paracetamol overdose
- Risk of developing renal failure, hypoglycaemia
- NAC needs to be continued
- IVT and repeat lactate

**MUST consult with a liver unit for transfer** for ongoing management in an ICU setting

D/w retrieval services to organise t/f to liver centre

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***"What (other) clinical/biochemical features should prompt discussion with a Liver unit?"***

Referral for liver transplantation

- INR >3.0 at 48 hours or >4.5 at any time.
- Oliguria or creatinine > 200 micromol/L
- Acidosis with pH < 7.3 after resuscitation
- Systolic hypotension with BP < 80mmHg
- Hypoglycaemia
- Severe thrombocytopenia
- Encephalopathy of any degree

**Section 4 – 6-7 minutes:**

***"The patient was successfully transferred to a tertiary Liver centre. On review it is noted that the patient had presented the day before but did not wait to be seen.***

***What ED specific measures can be implemented to manage the risk of patients who do not wait to be seen?"***

- Aim for staff member to speak with any pt who wishes to leave before seen, explain risks of leaving prior to being formally assessed, encourage to stay, enlist family
  - Provide info re alternative follow up, return advice, safety net
  - Doctor at triage/WR nurse or similar to aide early reviews
  - F/u phone calls for pts who DNW with high risk features
  - Streaming of pts
  - Adequate staffing
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## Ref range

|         |       |           |
|---------|-------|-----------|
| Na      | 140   | (135-145) |
| K       | 4     | (3.5-5.2) |
| Cl      | 107   | (95-110)  |
| Ur      | 9.4   | (3.5-8)   |
| Cr      | 82    | (45-90)   |
| egfr    | 72    | (> 59)    |
| Alb     | 37    |           |
| ALP     | 143   | (30-120)  |
| Bili    | 37    | (< 25)    |
| GGT     | 51    | (< 50)    |
| AST     | 14132 | (< 41)    |
| ALT     | 18191 | (<41)     |
| INR     | 3.1   | (0.8-1.2) |
| Ammonia | 66    | (11 - 35) |
| Gluc    | 6.2   | (3-6.9)   |
| Lactate | 2.9   | (< 1.5)   |

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OSCE Station:

## COMPONENT ASSESSMENT

For each domain below select the **ONE** option which best represents this candidates performance. The option '**Minimum level of competency displayed**' represents the minimum level of safe independent practice as a junior FACEM in Australasia.

A horizontal bar chart with seven bars of increasing length and decreasing height, colored in a gradient from light blue to dark blue. Each bar contains a text label representing a response category. The bars are arranged from left to right, with the shortest bar on the left and the longest bar on the right.

| Response Category           | Percentage |
|-----------------------------|------------|
| Very poor                   | 1%         |
| Well below minimum standard | 1%         |
| Below minimum standard      | 1%         |
| At minimum standard         | 1%         |
| Above minimum standard      | 1%         |
| High standard               | 1%         |
| Very High standard          | 1%         |

**Please rate all the following domains:**

[illegible]

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### GLOBAL ASSESSMENT RATING

Please rate this candidate's OVERALL performance in this OSCE:

In terms of a **safely practising junior emergency physician** please select the ONE option which best reflects this candidate's performance in this station

**Well  
Below  
Standard**

☐

**Below  
Standard**

☐

**Just at  
Standard**

☐

**Above  
Standard**

☐

**Well  
Above  
Standard**

☐

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