

OSCEs for Medical Students, Volume 2 Second Edition



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Chapter 1

Gastroenterology

Gastroenterology and Hepatobiliary Disease – History

Diarrhoea

- **Age of the patient:**
Under 40 – think irritable bowel disease, infective, irritable bowel
Over 40 – think carcinoma
- **Duration of the illness** – ‘when were you last well?’

What does the patient mean by diarrhoea?

Increased frequency

Increased volume of stool

- **Frequency**
How many times in a 24 hour period is the patient opening their bowels?
Do they have to get up at night to defecate?
- **Consistency of the stools**
Watery/clear/frothy
Fluid/brown
Semiformed
Solid
Presence or absence of blood
Presence or absence of mucus
Steatorrhoea-like stool
Pale, offensive, porridge-like stools which float in the toilet water and are difficult to flush away

Features associated with diarrhoea

- Systemic signs and symptoms: anaemia pyrexia, arthritis, sacroiliitis, uveitis, erythema nodosum
- Nausea and vomiting; dehydration
- Abdominal pain: character, site, radiation, relief, exacerbation
- Weight loss, loss of appetite (anorexia)
- Recent foreign travel, particularly to epi/endemic areas
- Family history of inflammatory bowel disease, bowel polyps/cancer

Differential diagnoses

The main causes of diarrhoea are colonic. Small bowel causes are rare

- **Colonic causes**

Inflammatory bowel disease

Infective colitis

Bacterial:

E. Coli, *Salmonella typhi* and *paratyphi*

Campylobacter, *Shigella*, *Yersinia*, *Vibrio cholerae*,

Clostridium difficile

Viral: rotavirus, adenovirus, astrovirus

Protozoal: *Giardia lamblia*, *Entamoeba histolytica*, *Cryptosporidium* (in the immunosuppressed)

Left-sided colonic malignancy

Ischaemic colitis

Overflow diarrhoea secondary to constipation

- **Small bowel causes**

Coeliac disease

Secretory or high output diarrhoea, eg post small bowel resection

VIPoma

Terminal ileitis, eg TB or Crohn's disease

Bleeding per rectum

History

- 'Spotting' and fresh blood stains on toilet tissue during or following bowel action: found in haemorrhoids or fissure
- Fresh and/or profuse bleeding (egg cupful or more): found in diverticular disease, inflammatory bowel disease, arterio-venous malformation or carcinoma
- Dark/altered blood: usually from lesions in the proximal colon (diverticular disease or carcinoma) or rarely small bowel
- 'Red currant jelly' stool: intussusception in children
- Mucoïd bloody diarrhoea: in enteric infections such as typhoid and amoebiasis

Associated features

- Altered bowel habits: loose motions alternating with constipation
- Mucus in stool
- Abdominal pain/discomfort, abdominal mass
- Tenesmus
- Weight loss

Causes

- Piles and fissures: commonest cause in adults (may present as a 'red herring' masking a bowel tumour)
- Diverticular disease: commonest cause in middle age and the elderly
- Colonic carcinoma: must be excluded by colonoscopy or bowel imaging
- Anal carcinoma: uncommon, palpable on digital examination

Upper GI bleed*History*

- Haematemesis: fresh blood, altered blood or coffee grounds
- Volume of vomitus and amount of blood
- How many episodes/volume of each episode at this presentation
- Passage of melaena
- Previous episodes/causes if known

Associated features

- Epigastric pain – acute/chronic, character, radiation, relief, exacerbation
- Epigastric fullness, weight loss, anorexia
- Dyspepsia
- Features of chronic liver disease

Risk factors

- Use of NSAIDs – duration
- Other medications: steroids, anticoagulants
- Known or previous peptic ulcer disease, varices or hiatus hernia
- Alcohol excess: duration, amount, type of alcohol
- Chronic liver disease
- Familial blood dyscrasia

Causes

In anatomical sequence:

- Oesophageal: oesophagitis, carcinoma, varices, Mallory–Weiss tear, trauma, hiatus hernia
- Gastric: gastritis, peptic ulcer, benign and malignant tumours, eg leiomyoma, adenocarcinoma
- Duodenal: duodenitis, peptic ulcer

Dysphagia

- Level of the dysphagia: oropharynx; high, mid or lower oesophagus
- Degree of dysphagia: solids, semi-solids, liquids
- Progression: insidious, intermittent onset signifies benign disease; a rapidly progressive course implies malignancy
- Pain: suggests local inflammatory process or infection, eg candidiasis
'Impaction pain' is typical of benign stricturing
- Regurgitation: immediate/delayed

Associated features

- Weight loss, anorexia
- Features of systemic diseases:
Raynaud's (systemic sclerosis)
Muscle weakness and wasting (motor neurone disease)
Ptosis (myasthenia gravis)
- Change in bowel habit
- Coughing/recurrent chest infection – implies aspiration

Causes

- Oropharynx
Bulbar palsy, eg motor neurone disease, myasthenia gravis
tonsillitis, pharyngeal pouch
- Oesophageal
Benign stricture: gastro-oesophageal reflux; corrosives
Malignant stricture: upper oesophagus – squamous carcinoma;
lower oesophagus – adenocarcinoma
- Hiatus hernia
- Infective: candidiasis, CMV, HSV (particularly in HIV disease)
- Chagas' disease (South American trypanosomiasis)
- Oesophageal web (Plummer–Vinson or Paterson–Brown Kelly syndrome)
- Extrinsic compression eg bronchial carcinoma, left atrial hypertrophy, retrosternal goitre, mediastinal lymphadenopathy

Risk factors for oesophageal carcinoma:

- Smoking
- Alcohol excess
- Possible dietary factors (nitrosamines in diet)
- Achalasia of the cardia
- Plummer–Vinson syndrome
- Tylosis

Jaundice

Causes

- Pre-hepatic – haemolysis
- Hepatic – cirrhosis, infective hepatitis, drugs
- Obstructive – gallstones, carcinoma of the gall bladder, pancreas, ampulla of Vater, pancreatitis, biliary stricture

Differentiating questions

- | | |
|---------------------------|---|
| • Alcohol consumption | • Previous blood transfusions |
| • Travel abroad | • Recent contacts |
| • Family history | • Sexual contacts |
| • Recreational drug use | • Medications |
| • Previous jaundice/cause | • Fever/viral prodrome |
| • Weight loss | • Dark urine/pale stools – signs of obstructive disease |
| • Food Poisoning | |

Differentiating acute and chronic liver disease

- On examination of jaundiced patients it is important to differentiate between acute and acute on chronic liver disease. One must therefore look for signs of chronic liver disease
- Hands: clubbing, leuconychia, palmar erythema, Dupuytren's contracture
- Upper limbs: scratch marks, bruising
- Chest: gynaecomastia, loss of male distribution of hair, spider naevi
- Abdomen: hepatosplenomegaly, ascites, caput medusae, gonadal atrophy
- Confusion, hepatic fetor and liver flap are signs of hepatic encephalopathy

Gastroenterology and Hepatobiliary Disease – Examination

Introduction

Many patients with abdominal pathology present with abdominal pain. The characteristics of the pain including site, character, radiation, exacerbating and relieving factors and associated features such as jaundice, dysphagia, diarrhoea, constipation and abdominal distention all help in the differential diagnoses and direct the clinical examination and subsequent investigations. Abdominal pain may be acute or chronic and in the acute cases, severity of the pain and the accompanying peritonism, are important factors in determining the need for urgent surgical or other intervention. Such emergencies require the patient to remain nil by mouth with passage of a nasogastric tube if there is nausea or distention, and intravenous fluids in the presence of dehydration, shock or suspected blood loss.

Examination

As with all clinical examinations introduce yourself and explain the examination, gaining verbal consent to proceed. The patient traditionally is exposed from 'nipples to knees' – which implies the whole of the abdomen from above the xiphisternum to below the genitalia and inguinal regions. In clinical exams it is sufficient to expose the patient from the xiphisternum to the pubis, the inguinal region and external genitalia being examined at the end of the examination if the examiner wishes. Examination of the groins is important to identify inguinal and femoral herniae and exclude inguinal lymphadenopathy. This part of the examination should be carried out without embarrassment to patient or attendees.

Once the patient is comfortably positioned and correctly exposed:

1 Observation

At the end of the bed – look for and comment on the presence or absence of:

- Distress; well or unwell; jaundice; signs of chronic liver disease
- Abdominal distension; asymmetry; scars; masses; organomegaly

You may ask the patient to:

- draw their knees up to relax the abdomen
- take a deep inspiration observing for equal painless movement, and hepatosplenomegaly and masses

Return to the right-hand side of the patient

From the hands – look for:

Hands (clubbing, leuconychia, koilonychia, palmar erythema, Dupuytren's contracture, hepatic flap)



Upper limbs (tattoos, bruising, purpura, spider naevi)



Face (jaundice, xanthelasma, hepatic fetor, anaemia, dentition and ulceration of the buccal mucosa)



Neck (supraclavicular lymphadenopathy – particularly a left-sided supraclavicular fossa node: Virchow's node/Trossier's sign)



Chest (spider naevi, gynaecomastia, loss of male distribution of hair)



Abdomen (asymmetry, scars, distention, masses, organomegaly)

2 Palpation

Always check if patient has any pain and if it is localised to any particular area of the abdomen. Try to start on the opposite side of the abdomen.

- Kneel on the right side of the patient so that you are level with the abdomen; this also stops you placing too much downwards pressure while palpating (which one tends to do if standing). Shorter people should use their common sense!
- Always warm your hands prior to placing them on the abdomen
- Throughout the examination observe the patient's face for distress
- If the patient has signs of peritonism one should check for **rebound tenderness** and **guarding**

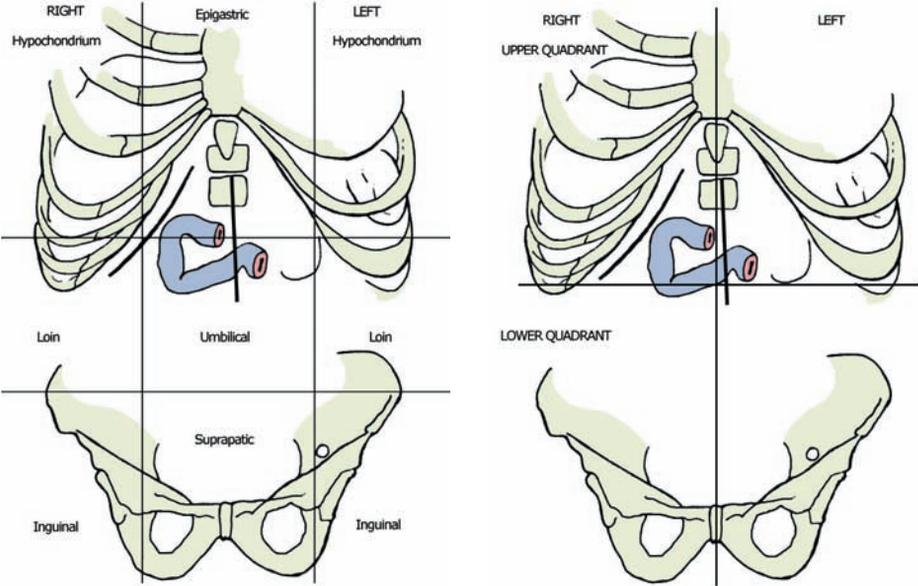


fig 1a the four quadrants of the abdomen

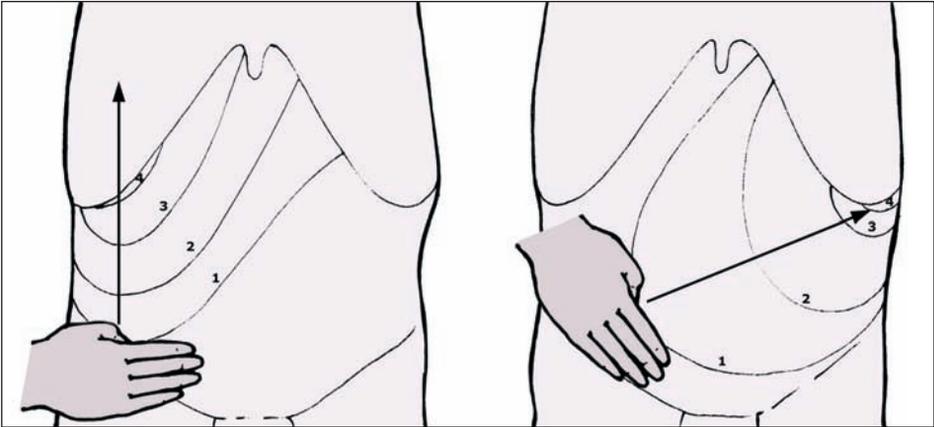


fig 1b

When examining the abdomen you should:

- 1 Start in the diagonally opposite side area if there is any localised area of pain**
- 2 Examine from your MCP joints (not bending the IP joints) of the fingers**
- 3 Examine all four quadrants of all nine areas – ie thoroughly cover the whole surface in a systematic manner**

(a) Examine for the enlarged liver – see fig 1a

- Start in the right iliac fossa. At position (1) ask patient to take a deep breath in and move your hand 'up' to meet the 'descending' liver edge.
- As the patient breathes out – take your hand off and replace in position (2) – repeat process as for (1)
- Repeat in positions (3) and (4)
- Percuss and define the upper and lower borders of the liver

Positions (1)–(4) are not randomly chosen, they represent the four clinical 'enlargements' of the liver and equally in the description below the spleen, ie (1) 'giant', (2) grossly enlarged, (3) enlarged, and (4) just palpable below the costal margin. It is traditional to describe the enlargement of both liver and spleen in terms of 'finger breadths' below the costal margins, one finger breadth being approximately equal to one centimetre.

(b) Examine for the enlarged spleen – see fig 1b

Start in the right iliac fossa

- Ask the patient to take a deep breath in. Move your hand 'up' (across diagonally up towards the left costal margin) with the left hand supporting the left costal margin
- As the patient breathes out – take your hand off and replace in position (2) – then repeat (1)
- Repeat in positions (3) and (4)
- Percuss and define the upper and lower borders of the spleen

The five characteristics of splenomegaly – differentiating it from other left upper quadrant mass, such as a large renal mass are:

- 1 You cannot get above or over it**
- 2 It descends downwards and then across towards the right iliac fossa with inspiration**
- 3 It is dull to percussion**
- 4 It has an anterior notch**
- 5 It is not bi-manually ballotable**

Remember: a spleen just palpable below the left costal margin is at least two or three times its normal size

(c) Examine for enlarged kidneys

Over the left and right loins, 'ballot' for the left and right kidneys.

The kidneys are retroperitoneal so they normally have the following characteristics (as compared to the spleen):

- They are ballotable
- They don't move with respiration
- They are resonant to percussion
- You can get above them on palpation

However large eg polycystic kidneys may break many of these 'rules'.

(d) Examine for ascites

With planted hand facing in a head to toe direction, percuss away from yourself towards the left loin.

If an area of dullness is elicited, ask the patient to move onto their right side ie towards you, with planted hand still over area of dullness.

Wait for 5–10 seconds – then re-percuss over the area – if ascites is present, the area will now be resonant, demonstrating 'shifting dullness'. (At this point you could also re-palpate for splenomegaly.)

(e) Define a mass

As with any other mass, if you palpate an intra-abdominal mass you should define the:

- **Site**
- **External features** – size (defining upper and lower borders), shape, surface, colour, temperature, mobility, tenderness
- **Internal features** – consistency, compressibility, reducibility, fluctuation, fluid thrill, expansile, pulsatile, cough impulse, discharge, transillumination, presence of a bruit
- **Surrounding features** – attachments to superficial and deep structures, invasion of local structures, related lymphadenopathy

(f) Palpate for inguinal lymph nodes

(g) Examine for inguinal hernia

A hernia is a protrusion of the abdominal contents through a deficit in the wall (internal hernias occur when a loop of gut passes through a deficit in the mesentery and the term is also used for hiatus hernia, when the stomach slides or rolls through the oesophageal opening in the diaphragm). With an external hernia, a patient usually complains of a lump, which may or may not be painful. Complications arise from a narrowed neck of the hernia contents; bulging out may become irreducible (incarcerated), producing intestinal destruction (colic, abdominal pain, vomiting, constipation and distention) and the blood supply may be compressed at the neck and contents become ischaemic (strangulation).

Hernias are common and therefore appropriate and often available for examination. It is essential that the anatomy and the technique of examination are perfected. Although it is not ideal for a single patient to be examined repeatedly in an OSCE, a number of patients can be used in series.

If the candidate has to confirm that there is a lump, one needs to define:

- Where it is situated, ie site
- Whether it is tender
- Whether it is reducible

In all hernias, ie including ones that are difficult to find or when checking the normal side, the examination is best undertaken with the patient standing as gravity tends to extrude the abdominal contents. However, if there is a large hernia or if the patient is already lying down, the initial examination is carried out in this position.

A key feature is an understanding of the anatomy of the inguinal canal, so that you can put your finger on the right spot and feel a cough impulse. Reduce the lump, then find if you can control the cough impulse by imposing pressure over the suspected neck of the sac. Figs 1c and 1d indicates the anatomy of direct and indirect inguinal and femoral herniae.

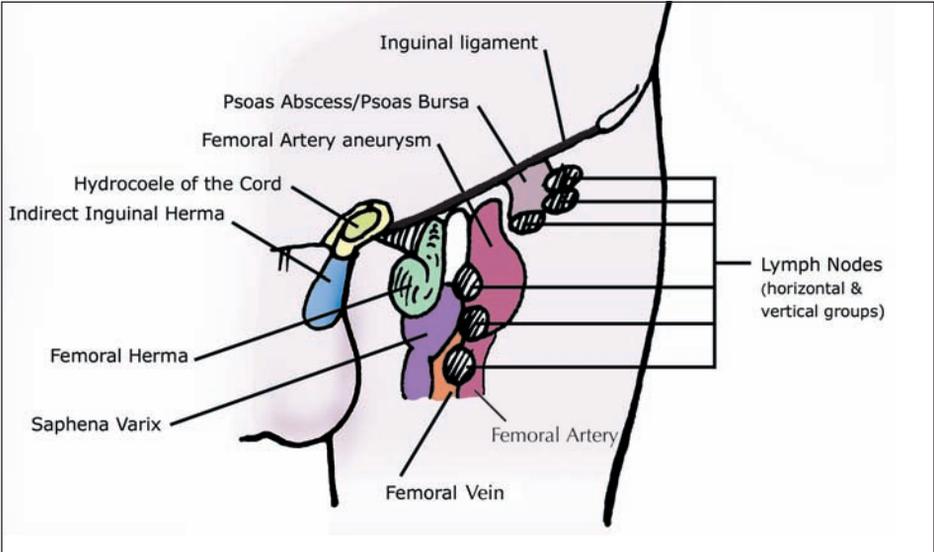


fig 1c Examining for hepatomegaly

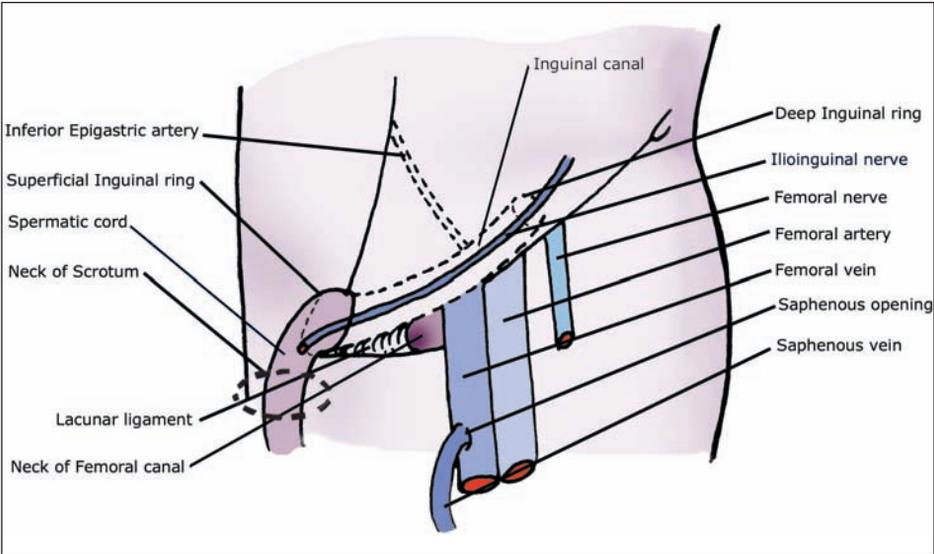


fig 1d Examining for splenomegaly

3 Auscultation

Listen for bowel sounds and bruits. Palpate femoral pulses; define abdominal aortic aneurysm (if present).

4 To complete your examination

- 'I would like to perform a per rectal (PR) examination' to assess and comment on:
 - peri-anal disease
 - rectal disease
 - prostate assessment (in men)
 - stool colour/melaena
- Examine the external genitalia
- Record temperature, BP and pulse
- Urinalysis:
 - urobilinogen
 - leucocytes; nitrites
 - haematuria
 - proteinuria

Abdominal extras

1 Inspection

Observe the shape of the abdomen, whether it is symmetrical, obese, distended, full in certain areas, the presence of any cutaneous lesions and operation or other scars. The abdominal wall should move freely and symmetrically with respiration; this can be further tested and pain noted by asking the patient to draw the abdomen in and then blow it out, followed by a cough.

Scars indicate previous problems and you should recognise the common ones as indicated in fig 00. Know the surface markings of abdominal viscera, namely:

- The upper border of the liver, in the right 4th intercostal space in the midclavicular line
- The anterior border of the spleen, beneath the 9th, 10th and 11th ribs, reaching the posterior axillary line
- The pylorus, just to the right of the midline in the transpyloric plane (midway between the suprasternal notch and the symphysis pubis)
- The gallbladder, beneath the tip of the 9th costal cartilage
- The duodenojejunal flexure, just to the left of the midline and just below the transpyloric plane
- The base of the appendix, at the junction of the middle and lateral thirds of the line joining the umbilicus and the right anterior superior iliac spine
- The hilum of each kidney, approximately in the transpyloric plane 10 cm from the midline (the left slightly higher than the right)
- The deep inguinal ring, just above the midpoint of the inguinal ligament (passing from the anterior superior iliac spine to the pubic tubercle)

2 Palpation

Palpation determines the presence of tenderness, guarding and rigidity. Ask the patient to indicate the area of tenderness and leave examination of this area till last.

Other useful techniques for demonstrating tenderness while producing minimal discomfort are percussion rebound (see below) and asking the patient to palpate their own abdomen, to see how carefully they press in certain areas. In children, further confidence may be gained by using the child's hand underneath your own in the abdominal palpation.

Palpation commences with gentle pressure in the four quadrants, leaving the tender area till last. Once the degree of tenderness is established, deeper palpation can be undertaken, to look for abdominal masses in these areas, and up and down the midline, particularly looking for neoplasms of the stomach and pancreas, retroperitoneal masses and nodes, and aorto-iliac aneurysms.

Next palpate the liver, spleen and kidneys. For the liver, commence in the right iliac fossa, with the index finger placed transversely, moving cranially in stages. See if the edge can be palpated on deep inspiration, proceeding in four or five steps to the right costal margin. The spleen is similarly assessed from the right iliac fossa across the umbilicus to the left subcostal margin, then rolling the patient slightly onto the right side to deeply palpate beneath the costal margin in the midaxillary line, where the tip of the spleen is first felt.

The kidneys are examined by bimanual palpation. The left hand is placed behind each lumbar region in turn, either across the bed for the left side or leaning over the patient and placing the left hand behind the left flank. The right hand is placed anteriorly and the patient asked to take a deep breath; the kidney can be felt moving in a cranial-caudal direction between the two hands.

3 Percussion

The value of percussion in identifying tenderness has been already mentioned. It is also valuable in looking for the edge of the liver and spleen, an enlarged bladder and fluid in the flank; the patient is then asked to roll in each direction to see if this fluid level moves (shifting dullness).

Examination is completed by exposing the groins, to look for inguinal and femoral herniae (page 15). In clinical practice, rectal examination is essential to find pelvic lesions. Although this is not expected in the qualifying examination, it is important to tell the examiner that you would usually undertake this procedure. After abdominal examination it is essential to reposition the patient and ensure they are well covered and comfortable.

Abdominal pain

Abdominal pain may be acute or chronic and in the acute case, the severity of the pain and the accompanying peritonism are important factors in determining the need for urgent surgical or other intervention. Such emergencies require nil by mouth with passage of a nasogastric tube if there is nausea or distention, and intravenous fluids if there is dehydration. The position and type of pain and accompanying jaundice, vomiting, dysphagia, diarrhoea, constipation and abdominal distention all help in the differential diagnoses, and direct a clinical examination and subsequent investigations.

Clinical examination includes general features starting with the hands for pulse rate, volume and dryness, and laxity of the dorsal skin to identify dehydration. Pallor and deformity of nails are found in anaemia, and palmar flush and Dupuytren's, and telangiectasia in liver disease.

Specific examinations of the head and neck are of the conjunctiva over the sclera, for jaundice, and under the lower lid for the pallor of anaemia, and palpation of the root of the neck for malignant nodes.

Abdominal examination must be accompanied by appropriate exposure including of the groin to identify inguinal and femoral hernia carried out without embarrassment to patient or attendees.

Examination follows the usual inspection, palpation, percussion, auscultation, but, in severe tenderness, percussion rebound is a key manoeuvre to identify maximum points of tenderness; severe tenderness prevents even superficial palpation particularly in children. Painless gentle percussion also rules out any severe tenderness in unsuspecting malingerers, who over-react to palpation, making interpretation difficult.

STATION 1.1 (*Answers – page 167*)

History

A 24-year-old man presents to the Emergency Department with a history of bloody diarrhoea. You are the student on call with the medical team. Please take a history of the presenting complaint with a view to making a diagnosis.

(5 minute station)

STATION 1.2

History

You are a GP, new to this practice. Your next patient is a 42-year-old woman who has just returned from a foreign holiday with a 10-day history of diarrhoea. Please take a history of the presenting complaint, explaining to the patient the likely diagnosis and the investigations you wish carry out.

(10 minute station)

STATION 1.3

History

You are the medical student attached to a gastroenterology firm. You have been asked to take a history from a 24-year-old woman, who has been referred to the outpatient department by her GP with a 3- to 4-month history of 'diarrhoea'. Please take a history of her presenting complaint with a view to making a diagnosis. (You should be able to give a differential diagnosis at the end of the station.)

(5 minute station)

STATION 1.4

History

You are the medical student attached to the general medical firm on call. You have been asked by the registrar to clerk a 36-year-old woman who has just arrived in the Emergency Department after vomiting some blood. She is haemodynamically stable. Please take a history of the presenting complaint and any other relevant history with a view to making a diagnosis.

(5 minute station)

STATION 1.5

History

You are the medical student attached to a gastroenterology firm. You have been asked to take a history from a patient who has been referred to the outpatient department with epigastric pain and a proven microcytic anaemia. Please take a history of the presenting complaint and any other relevant history with a view to making a diagnosis.

(5 minute station)

STATION 1.6

History

Please answer the following questions, which are associated with the history you have just taken from the stockbroker in Station 1.5, indicating whether the statements are **True** or **False**.

(10 minute station)

	True	False
1 This patient should have an oesophago-gastroduodenoscopy	<input type="checkbox"/>	<input type="checkbox"/>
2 This patient will have a high plasma ferritin	<input type="checkbox"/>	<input type="checkbox"/>
3 This patient may have koilonychia	<input type="checkbox"/>	<input type="checkbox"/>
4 This patient will have a raised MCV	<input type="checkbox"/>	<input type="checkbox"/>
5 This patient should have a CLO test	<input type="checkbox"/>	<input type="checkbox"/>
6 This patient may require triple therapy	<input type="checkbox"/>	<input type="checkbox"/>
7 Triple therapy is given for 3 to 4 weeks	<input type="checkbox"/>	<input type="checkbox"/>
8 Clarithromycin is commonly used in triple therapy	<input type="checkbox"/>	<input type="checkbox"/>
9 Cimetidine is a proton pump inhibitor used in triple therapy	<input type="checkbox"/>	<input type="checkbox"/>
10 This patient will need to be on routine omeprazole for life	<input type="checkbox"/>	<input type="checkbox"/>

STATION 1.7

History

You are a GP. The next patient is a 47-year-old man who has come to see you with 'swallowing problems'. Please take a history of the presenting complaint and any other relevant history with a view to making a diagnosis.

(10 minute station)

STATION 1.8

History

You are the medical student attached to the medical team on call. You have been asked by the registrar to take a history from a 33-year-old man who has presented in the Emergency Department with jaundice. Please take a history of the presenting complaint and any other relevant history with a view to making a diagnosis.

(10 minute station)

STATION 1.9

History

You are a medical student attached to a surgical firm. A 65-year-old woman is referred to the surgical clinic by her GP complaining of abdominal symptoms and an alteration in her bowel habit. The consultant has asked you to take a history from this patient.

(5 minute station)

STATION 1.10

History

A 53-year-old man was referred to the surgical clinic complaining of intermittent bleeding per rectum and a fleshy lesion protruding through the anus. You are a medical student and the registrar has asked you to take a history from this patient.

(5 minute station)

Chapter 1

Gastroenterology Answers

STATION 1.1

Patient history

I am a 24-year-old engineering student who is normally fit and well. I have been revising hard for my final exams and have been very stressed. During the last three weeks I have had bloody diarrhoea. My bowels are open once or twice an hour and I am passing semiformed/loose stools with blood and mucus, mixed and separate to the stools. I have lost 5 kg in weight and have been too tired to play squash, which I normally do twice a week. I have tried eating normally but have felt too unwell most of the time to manage anything. There seems to be no relationship between my dietary intake and the diarrhoea.

In the last week I have developed red, painful lesions on my shins, and have been feverish. I have had no recent foreign travel and no-one in my family has ever had anything similar. I have no risk factors for 'food poisoning'. I am not on any medication and do not drink alcohol. I smoke ten cigarettes per day. No-one in my family has bowel disease. I am really worried about what might be wrong and about my exams. I do not feel well enough to go out.

Assessment	Good	Adequate	Poor/not done
1 Appropriate introduction (full name and role)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Explains purpose of interview	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Establishes duration of the illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Establishes the normal bowel habit of the patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Establishes what the patient means by diarrhoea, ie frequency and volume of stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Establishes how often the patient is opening their bowel in a 24 h period	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Establishes the consistency of the motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8	Establishes the presence of blood and mucus in the stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Establishes/excludes weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Establishes associated gastrointestinal symptoms – vomiting and abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Asks about systemic features	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Establishes any other risk factors for diarrhoea, eg foreign travel/recent contacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Establishes/excludes family history of bowel disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Elicits patient's concerns and responds sensitively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Uses an appropriate questioning technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Avoids or explains jargon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Summarises history back to the patient, including concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	Systematic, organised approach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	Makes a reasonable attempt at the diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Diagnosis

Inflammatory bowel disease.

STATION 1.2

Patient history

I have just returned from a two month trekking holiday in Nepal. I am normally fit and well and have never had any bowel problems before. In the last 10 days I have had bloody, watery diarrhoea, with urgency. I am opening my bowels every 2–3 hours, and immediately after eating or drinking anything. I have had no vomiting, but have had intense cramping abdominal pains, particularly after food. In this period I have had a couple of episodes of fever and chills. I think I may have picked up a bug after a village feast I attended. I am not very keen on any investigations but would take medication if it was necessary.

A couple of other people on the trek were similarly unwell with fever and diarrhoea but my husband has been well. I am on no medications other than HRT after a premature menopause and drink no alcohol. I do not smoke.

I work as a librarian and these problems are really affecting my work. They are embarrassing too.

Assessment	Good	Adequate	Poor/not done
1 Appropriate introduction (full name and role)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Establishes reason for patient's visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Establishes duration of present illness and excludes similar episodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Establishes where the patient went on holiday and contact history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Establishes how often the patient is opening their bowels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Establishes the consistency of the stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Establishes the presence of blood in the stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Asks about the presence of mucus in the stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Establishes associated features, ie pain, vomiting, fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Establishes/excludes weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Answers	11 Asks about the likely source of the infection – water, dairy products, shell fish, meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	12 Elicits patient's concerns and responds sensitively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	13 Uses an appropriate questioning technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	14 Summarises history back to the patient, including concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	15 Explains the diagnosis to the patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	16 Explains the need for blood tests, stool culture and possible sigmoidoscopy and biopsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	17 Gives clear, jargon-free explanation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	18 Checks patient's understanding of information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	19 Invites questions and addresses any concerns the patient may have	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	20 Systematic, organised approach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Diagnosis

Infective diarrhoea. Among other organisms amoebiasis and giardiasis should be excluded in this case.

STATION 1.3

Patient history

I am a 24-year-old legal secretary, who was previously fit and well with a normal bowel habit until four months ago. Since then I have been passing offensive, pale, porridge-like stools up to eight to ten times per day. The stools float and are difficult to flush away.

During my illness I have lost 10 kg in weight, have lost my appetite and feel extremely tired, to the point where I am now missing a lot of time from work. I have no abdominal pain, nausea or vomiting and have not passed any blood or mucus rectally. I have had no fever or systemic upset. I am really concerned about the weight loss – doesn't this mean that it could be something serious?

I have never been abroad and have had no recent contacts with anyone with similar symptoms. There is no family history of bowel problems. I drink 5–10 units of alcohol per week (mainly white wine) and smoke 20 cigarettes per day. I am on no medications other than the OCP.

Assessment	Good	Adequate	Poor/not done
1 Appropriate introduction (full name and role)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Explains purpose of interview	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Establishes the duration and nature of the presenting complaint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Establishes the normal bowel habit of the patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Establishes the frequency and volume of diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Establishes stools have the characteristics of steatorrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Establishes/excludes the presence of blood and mucous PR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Establishes the associated features of anorexia, weight loss and lethargy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Establishes/excludes recent foreign travel or contacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10	Establishes/excludes family history of bowel disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Elicits patient's concerns and responds sensitively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Uses an appropriate questioning technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Avoids or explains jargon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Summarises history back to the patient, including concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Establishes the diagnosis of malabsorption and makes a reasonable attempt at the differential diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Systematic approach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SP to mark				
17	The student was empathic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Diagnosis

Malabsorption secondary to coeliac disease.

Comment

Differential diagnosis:

- Coeliac disease and dermatitis herpetiformis
- Infective – tropical sprue, bacterial overgrowth, Whipple's disease
- Giardia, cryptosporidium
- Small bowel lymphoma
- Pancreatic insufficiency
- Small bowel resection – short bowel syndrome, blind loop syndrome
- Iatrogenic – radiation enteritis, drugs, eg cholestyramine

STATION 1.4

Patient history

I am a 36-year-old chronic alcohol abuser with repeated admissions with upper GI bleeds secondary to oesophageal varices. I have had an endoscopy, and on two or three occasions the varices have been injected. I have been out on a large alcoholic binge and started vomiting fresh blood about an hour ago. I have vomited twice, each time bringing up about a cup or two of blood. I have some retrosternal and epigastric pain and feel nauseated. I have not had any melaena or blood PR. I do not take any NSAIDs and do not have any other risk factors for GI bleeding. I am healthy apart from the varices but I do smoke moderately.

Assessment	Good	Adequate	Poor/not done
1 Appropriate introduction (full name and role)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Explains purpose of interview	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Establishes the nature of the haematemesis, ie fresh blood or coffee grounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Establishes the present number of haemetemeses and the volume of each haematemesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Establishes the absence of melaena stool and fresh blood PR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Establishes previous episodes of haematemesis and hospital admissions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Asks about associated symptoms, eg epigastric pain recent weight loss, anorexia, dyspepsia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8 Establishes or excludes the risk factors for upper GI bleed:			
<i>Use of NSAIDs</i>		<input type="checkbox"/>	<input type="checkbox"/>
<i>Alcohol excess</i>		<input type="checkbox"/>	<input type="checkbox"/>
<i>Previous peptic ulcer disease</i>		<input type="checkbox"/>	<input type="checkbox"/>
<i>Known oesophageal varices</i>		<input type="checkbox"/>	<input type="checkbox"/>
<i>Medications – eg warfarin</i>		<input type="checkbox"/>	<input type="checkbox"/>
9 Uses an appropriate questioning technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Avoids or explains jargon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 Makes a reasonable attempt at the diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 Systematic and organised approach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SP to mark			
13 The student was non-judgemental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Diagnosis

Alcohol-related chronic liver disease with known oesophageal varices.

STATION 1.5

Patient history

I am a 32-year-old stockbroker, and am normally fit and well. Like all stockbrokers I suppose I drink and smoke too much and live on takeaways. (When pressed admits to the exact amounts – I smoke 30 cigarettes per day, drink 30–40 units of alcohol per week in the form of lager and spirits.)

In the past six months I have had increasing upper abdominal pain, this is particularly bad when I am under stress or have been on a bit of a binge. The pain is burning in nature and radiates through to my back and occasionally behind my breast bone. It is relieved with Rennies and Alka-Seltzers. It is usually worse when I am hungry and better with meals. It makes me feel rather irritable and I'm concerned that it is more than just indigestion.

I have been otherwise well, with no other GI symptoms. My weight is stable and my appetite is fine. I have never vomited up blood but I did have some black stools one morning after a particularly bad episode a few weeks ago. I do not take any pain killers and have never had any peptic ulcers, hiatus hernias or gastritis in the past. I have had no symptoms suggestive of anaemia, eg shortness of breath, chest pain or faints, but have been feeling tired of late.

Assessment	Good	Adequate	Poor/not done
1 Appropriate introduction (full name and role)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Explains purpose of interview	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Establishes onset of symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Establishes characteristics of the abdominal pain:			
<i>Site and radiation</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Exacerbating factors</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Relieving factors</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Establishes/excludes haematemesis, melaena or fresh blood PR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Establishes/excludes dyspepsia, retrosternal burning and water brash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7 Establishes associated GI symptoms, eg weight loss, anorexia, nausea and vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Establishes risk factors for peptic ulcer disease and upper GI inflammation:			
<i>Use of pain killers</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Alcohol excess</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Smoker</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Previous ulcer</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Known hiatus hernia</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>GI inflammation, eg gastritis</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Establishes/excludes symptoms of anaemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Elicits patient's concerns and responds sensitively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 Uses an appropriate questioning technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 Avoids or explains jargon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13 Summarises history back to the patient, including concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14 Makes a reasonable attempt at the diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15 Systematic, organised approach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Diagnosis

Peptic ulcer disease.

STATION 1.6

- 1 **True** – this allows not only direct visual evidence of the cause but also the taking of biopsies and performance of a CLO test.
- 2 **False** – an iron deficiency anaemia is associated with a low plasma ferritin.
- 3 **True** – this is usually associated with chronic cases of iron deficiency.
- 4 **False** – a microcytic anaemia produces a low MCV.
- 5 **True** – CLO:campylobacter-like organism = *Helicobacter pylori*.
- 6 **True** – triple therapy is used in ulcer healing and eradication of *Helicobacter pylori*.
- 7 **False** – it is usually given for 1 week.
- 8 **True** – clarithromycin is given with amoxycillin and a proton pump inhibitor.
- 9 **False** – cimetidine is an H₂ antagonist.
- 10 **False** – he may require 3–6 months of treatment but provided he stops smoking and reduces his alcohol intake, he should avoid recurrence. Maintenance or long-term therapy with a proton pump inhibitor is only occasionally required.

STATION 1.7

Patient history

I am a 47-year-old carpet salesman with a long history of peptic ulcer disease and gastro-oesophageal reflux. I have a six-month history of intermittent difficulty in swallowing solids. I can manage most foods most of the time but occasionally foods, like bread and potatoes, seem to stick 'behind the lower part of my breast bone'. I have lost a little weight, about 2 to 3 kg, but have had no other associated gastrointestinal symptoms.

I am generally well and have had no major illness or admissions to hospital in the past. I am a non-smoker and drink 5–10 units of alcohol per week, principally in the form of red wine. I am worried that I have cancer because I have heard in the papers that this can be a symptom.

Assessment	Good	Adequate	Poor/not done
1 Appropriate introduction (full name and role)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Establishes reason for patient's visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Establishes the duration and nature of the presenting illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Establishes the level of the dysphagia, ie pharynx, upper, mid or lower oesophagus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Establishes the degree of dysphagia, ie solids/liquids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Establishes the rate and nature of progression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Establishes/excludes presence of regurgitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Establishes history of peptic ulcer disease and reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Establishes/excludes symptoms of GI bleeding – melaena, haematemesis, blood PR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Establishes/excludes associated gastrointestinal features eg abdominal pain, nausea and vomiting, weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11 Excludes risk factors for oesophageal carcinoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 Establishes any associated features of systemic diseases or relevant previous medical history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13 Elicits patient's concerns and responds sensitively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14 Uses an appropriate questioning technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15 Avoids or explains jargon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16 Summarises history back to the patient, including concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17 Makes a reasonable attempt at the diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18 Systematic, organised approach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SP to mark			
19 The doctor was empathic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Diagnosis

Benign stricture secondary to long-term gastro-oesophageal reflux disease (GORD).

STATION 1.8

Patient history

I am 33 years old and I have been unwell for about two months. Initially I thought I just had a touch of 'flu with a slight fever and aching joints and muscles. However, in the last week or so I have developed yellow skin and eyes. I feel very lethargic and generally unwell.

In response to questioning only

I drink 20 to 30 pints of beer per week and an occasional whisky. In the past I have been an intravenous drug abuser and shared needles on occasions. Currently I am off drugs. A recent HIV test I had was negative.

I have not travelled abroad and have had no sexual contacts with prostitutes. I have had no homosexual contacts, no blood transfusions and no regular medications. I remember my mother saying I was born jaundiced but I have never had any further episodes. I have no other gastric symptoms although I have lost 4 kg in the past six months. My stools and urine are normal in colour and consistency. I am working in a sorting depot of a large Post Office and smoke 10 to 20 cigarettes per day. I do not really feel up to work and I'm not able to do much with my children.

Assessment	Good	Adequate	Poor/not done
1 Appropriate introduction (full name and role)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Explains purpose of interview and gains consent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Establishes reason for coming to the Emergency Department	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Establishes the duration and nature of the presenting symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Establishes previous episodes of jaundice and cause	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6 Establishes risk/symptoms of infective hepatitis:			
<i>Prodromal symptoms/fever</i>		<input type="checkbox"/>	<input type="checkbox"/>
<i>Foreign travel</i>		<input type="checkbox"/>	<input type="checkbox"/>
<i>Sexual contacts</i>		<input type="checkbox"/>	<input type="checkbox"/>
<i>Recent contacts</i>		<input type="checkbox"/>	<input type="checkbox"/>
<i>Intravenous drug abuse</i>		<input type="checkbox"/>	<input type="checkbox"/>
<i>Previous transfusions</i>		<input type="checkbox"/>	<input type="checkbox"/>
7 Establishes alcohol consumption and duration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Establishes colour and consistency of stools and urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Establishes medications			
10 Establishes systemic symptoms – weight loss, abdominal pain, diarrhoea, steatorrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 Elicits patient's concerns and responds sensitively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 Uses an appropriate questioning technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13 Avoids or explains jargon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14 Summarises history back to the patient, including concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15 Makes a reasonable attempt at the diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16 Systematic, organised approach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SP to mark			
17 The student was non-judgemental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Diagnosis

This patient has risk factors for viral hepatitis complicated by possible alcoholic liver disease. He will need investigation to exclude viral causes including liver biopsy. He should be counselled about alcohol consumption.

STATION 1.9

Patient history

Three months ago I noticed dark blood mixed in the motions, which are hard but occasionally very loose with slime. My appetite is poor, I have lost a little weight and I am not eating well, as I feel bloated with crampy pains in the abdomen following meals. I had a severe attack of bowel cramps a few years ago. I had an X-ray of the bowels which showed I had diverticulitis. I was placed on a course of tablets but have been constipated most of my life. I had my gall bladder removed for stones many years ago and am on water and blood pressure tablets. I live alone and I manage very well. I don't drink or smoke. I am concerned that I have cancer because I have symptoms that I have read about in magazines. I don't want to tell my daughters because they will make a fuss.

Assessment	Good	Adequate	Poor/not done
1 Appropriate introduction (full name and role)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Explains purpose of interview	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Establishes presenting complaint:			
<i>Passage of blood/slime/melaena</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Constipation alternating with diarrhoea</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Tenesmus, pruritus, piles</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Asks about poor appetite/weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Asks about abdominal cramps and bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Establishes past history of bowel problems and outcome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Establishes current dietary habits and lifestyle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Elicits patient's concerns and responds sensitively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Uses an appropriate questioning technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Avoids or explains jargon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| 11 Summarises history back to the patient, including concerns | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12 Makes a reasonable attempt at the diagnosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13 Systematic, organised approach | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

SP to mark

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| 14 It was easy for me to talk to this student | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|--------------------------|
-

Diagnosis

Inflammatory bowel disease.

Comment

A long history of episodic diarrhoea with malaise and the passage of mucus is indicative of inflammatory bowel disease, although less severe symptoms may suggest an irritable bowel syndrome. Abdominal bloating and cramps point to subacute colonic obstruction, usually from a constricting tumour. This is a late presentation in tumours of the distal colon but may be the only symptom in tumours of the proximal colon. A long history of constipation and diverticular disease usually go hand-in-hand, and rectal bleeding from a focus of diverticulitis is not uncommon. Massive bleeding results from erosion of blood vessels at the base of a diverticulum, and is uncommon in an ulcerating tumour.

STATION 1.10

Patient history

I have suffered from piles on and off for the past 25 years. They now come out when I go to the toilet and sometimes I have to push them back. There is usually blood on the toilet paper and occasionally splashes of blood in the toilet bowl. I had the piles injected a few years ago and use Anusol suppositories when they become troublesome. I am a long-distance lorry driver, and as I spend days on the road, my meals are not regular, and I tend to be constipated. I am generally healthy and have had no major illnesses. I am trying to get my weight down. It is quite embarrassing to talk about this problem.

Assessment	Good	Adequate	Poor/not done
1 Appropriate introduction (full name and role)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Explains purpose of interview	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Establishes presenting complaint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Establishes the duration of symptoms and treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Establishes dietary and bowel habits: excludes passage of blood and mucus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Establishes general lifestyle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Uses an appropriate questioning technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Avoids or explains jargon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Summarises history back to the patient, including concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Makes a reasonable attempt at the diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 Systematic, organised approach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SP to mark			
12 I felt comfortable talking to this student	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>