# Contents

*Contributors* vi  
*Acknowledgements* vii  
*Preface* viii  
*Preface to the Second Edition* ix  
*Introduction* x  
*How to Use this Book* xv  
*Glossary* xvii  
*Normal Values* xxv  
*Generic Approach to Examinations* xxvii

## OSCE Stations

- Chapter 1: Gastroenterology 1  
- Chapter 2: Neurology and Psychiatry 59  
- Chapter 3: Ophthalmology and Otolaryngology 109  
- Chapter 4: Urology and Renal Medicine 135

## Answers with Explanations and Comments

- Chapter 1: Gastroenterology Answers 167  
- Chapter 2: Neurology and Psychiatry Answers 221  
- Chapter 3: Ophthalmology and Otolaryngology Answers 313  
- Chapter 4: Urology and Renal Medicine Answers 327

*Mock Examinations* 357  
*The OSCE Marking Scheme* 358  
*Revision Checklist* 360  
*Recommended Reading List* 362  
*Index*
Chapter 1: Gastroenterology
Contents

Gastroenterology and Hepatobiliary Disease – History

Gastroenterology and Hepatobiliary Disease – Examination

1.1 – History of bloody diarrhoea
1.2 – History of diarrhoea
1.3 – History of diarrhoea
1.4 – History of haemetemesis
1.5 – History of epigastric pain and anaemia
1.6 – MCQs regarding the patient with epigastric pain and anaemia
1.7 – History of dysphagia
1.8 – History of jaundice
1.9 – History of abdominal pain and change in bowel habit
1.10 – History of bleeding PR
1.11 – Full abdominal examination
1.12 – Limited abdominal examination
1.13 – Examination of the jaundiced patient
1.14 – Examination of a child with RIF pain
1.15 – Examination of a patient with left lower abdominal pain
1.16 – Examination of the post-operative patient
1.17 – Examination of a patient with a 'lump in the groin'
1.18 – Identification of tongue lesions
1.19 – Identification of lesions seen on OGD
1.20 – Identification of lesions seen on Colonoscopy
1.21 – Data interpretation – abdominal disease
1.22 – Data interpretation – weight loss
1.23 – Data interpretation – deranged LFTs
1.24 – Data interpretation – Hepatitis serology
1.25 – Data interpretation – Diarrhoea
1.26 – Radiology interpretation
1.27 – Radiology interpretation
1.28 – Radiology interpretation
1.29 – Radiology interpretation
1.30 – Radiology interpretation
1.31 – Radiology interpretation
1.32 – Radiology interpretation
1.33 – Radiology interpretation
1.34 – Prescribing triple therapy
1.35 – Total Parenteral Nutrition (TPN)
1.36 – Abdominal Instruments
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
- Mucoid 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, e.g. 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
tonsilitis, 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
- Travel abroad
- Family history
- Recreational drug use
- Previous jaundice/cause
- Weight loss
- Food Poisoning
- Previous blood transfusions
- Recent contacts
- Sexual contacts
- Medications
- Fever/viral prodrome
- Dark urine/pale stools – signs of obstructive disease

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, Dupytren’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 nae v i, 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 repercuss 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
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.
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 telangectasia 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)

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

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Good</th>
<th>Adequate</th>
<th>Poor/not done</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Appropriate introduction</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(full name and role)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2  Explains purpose of interview</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3  Establishes duration of the illness</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4  Establishes the normal bowel habit of the patient</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5  Establishes what the patient means by diarrhoea, ie frequency and volume of stool</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6  Establishes how often the patient is opening their bowel in a 24 h period</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7  Establishes the consistency of the motion</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Establishes the presence of blood and mucus in the stool

Establishes/excludes weight loss

Establishes associated gastrointestinal symptoms – vomiting and abdominal pain

Asks about systemic features

Establishes any other risk factors for diarrhoea, eg foreign travel/recent contacts

Establishes/excludes family history of bowel disease

Elicits patient’s concerns and responds sensitively

Uses an appropriate questioning technique

Avoids or explains jargon

Summarises history back to the patient, including concerns

Systematic, organised approach

Makes a reasonable attempt at the diagnosis

**Diagnosis**

Inflammatory bowel disease.
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.

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Good</th>
<th>Adequate</th>
<th>Poor/not done</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Appropriate introduction (full name and role)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Establishes reason for patient’s visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Establishes duration of present illness and excludes similar episodes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Establishes where the patient went on holiday and contact history</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Establishes how often the patient is opening their bowels</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Establishes the consistency of the stool</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Establishes the presence of blood in the stool</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Asks about the presence of mucus in the stool</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Establishes associated features, ie pain, vomiting, fever</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Establishes/excludes weight loss</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
11 Asks about the likely source of the infection – water, dairy products, shell fish, meat
12 Elicits patient’s concerns and responds sensitively
13 Uses an appropriate questioning technique
14 Summarises history back to the patient, including concerns
15 Explains the diagnosis to the patient
16 Explains the need for blood tests, stool culture and possible sigmoidoscopy and biopsy
17 Gives clear, jargon-free explanation
18 Checks patient’s understanding of information
19 Invites questions and addresses any concerns the patient may have
20 Systematic, organised approach

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.

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

11 Elicits patient’s concerns and responds sensitively

12 Uses an appropriate questioning technique

13 Avoids or explains jargon

14 Summarises history back to the patient, including concerns

15 Establishes the diagnosis of malabsorption and makes a reasonable attempt at the differential diagnosis

16 Systematic approach

**SP to mark**

17 The student was empathic

**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.

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Good</th>
<th>Adequate</th>
<th>Poor/not done</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Appropriate introduction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(full name and role)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Explains purpose of interview</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Establishes the nature of the haematemesis, ie fresh blood or coffee grounds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Establishes the present number of haemetemeses and the volume of each haematemesis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Establishes the absence of melaena stool and fresh blood PR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Establishes previous episodes of haematemesis and hospital admissions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Asks about associated symptoms, eg epigastric pain recent weight loss, anorexia, dyspepsia</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8 Establishes or excludes the risk factors for upper GI bleed:

- *Use of NSAIDs*  
- *Alcohol excess*  
- *Previous peptic ulcer disease*  
- *Known oesophageal varices*  
- *Medications – eg warfarin*

9 Uses an appropriate questioning technique

10 Avoids or explains jargon

11 Makes a reasonable attempt at the diagnosis

12 Systematic and organised approach

**SP to mark**

13 The student was non-judgemental

**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 painkillers 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.

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Good</th>
<th>Adequate</th>
<th>Poor/not done</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate introduction (full name and role)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains purpose of interview</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establishes onset of symptoms</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establishes characteristics of the abdominal pain:</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Site and radiation</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Exacerbating factors</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Relieving factors</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establishes/excludes haematemesis, melaena or fresh blood PR</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establishes/excludes dyspepsia, retrosternal burning and water brash</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
7 Establishes associated GI symptoms, eg weight loss, anorexia, nausea and vomiting

8 Establishes risk factors for peptic ulcer disease and upper GI inflammation:
   - Use of pain killers
   - Alcohol excess
   - Smoker
   - Previous ulcer
   - Known hiatus hernia
   - GI inflammation, eg gastritis

9 Establishes/excludes symptoms of anaemia

10 Elicits patient’s concerns and responds sensitively

11 Uses an appropriate questioning technique

12 Avoids or explains jargon

13 Summarises history back to the patient, including concerns

14 Makes a reasonable attempt at the diagnosis

15 Systematic, organised approach

**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.
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.

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

12 Establishes any associated features of systemic diseases or relevant previous medical history

13 Elicits patient’s concerns and responds sensitively

14 Uses an appropriate questioning technique

15 Avoids or explains jargon

16 Summarises history back to the patient, including concerns

17 Makes a reasonable attempt at the diagnosis

18 Systematic, organised approach

**SP to mark**

19 The doctor was empathic

*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.

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Good</th>
<th>Adequate</th>
<th>Poor/not done</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Appropriate introduction (full name and role)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2 Explains purpose of interview and gains consent</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3 Establishes reason for coming to the Emergency Department</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4 Establishes the duration and nature of the presenting symptoms</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5 Establishes previous episodes of jaundice and cause</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
6 Establishes risk/symptoms of infective hepatitis:

- Prodromal symptoms/fever
- Foreign travel
- Sexual contacts
- Recent contacts
- Intravenous drug abuse
- Previous transfusions

7 Establishes alcohol consumption and duration

8 Establishes colour and consistency of stools and urine

9 Establishes medications

10 Establishes systemic symptoms – weight loss, abdominal pain, diarrhoea, steatorrhoea

11 Elicits patient’s concerns and responds sensitively

12 Uses an appropriate questioning technique

13 Avoids or explains jargon

14 Summarises history back to the patient, including concerns

15 Makes a reasonable attempt at the diagnosis

16 Systematic, organised approach

**SP to mark**

17 The student was non-judgemental

**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.

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Good</th>
<th>Adequate</th>
<th>Poor/not done</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Appropriate introduction (full name and role)</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>2 Explains purpose of interview</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>3 Establishes presenting complaint:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Passage of blood/slime/melaena</em></td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td><em>Constipation alternating with diarrhoea</em></td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td><em>Tenesmus, pruritus, piles</em></td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>4 Asks about poor appetite/weight loss</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>5 Asks about abdominal cramps and bloating</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>6 Establishes past history of bowel problems and outcome</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>7 Establishes current dietary habits and lifestyle</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>8 Elicits patient’s concerns and responds sensitively</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>9 Uses an appropriate questioning technique</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
</tr>
<tr>
<td>10 Avoids or explains jargon</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
</tr>
</tbody>
</table>
Summarises history back to the patient, including concerns

Makes a reasonable attempt at the diagnosis

Systematic, organised approach

SP to mark

It was easy for me to talk to this student

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.

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Good</th>
<th>Adequate</th>
<th>Poor/not done</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Appropriate introduction (full name and role)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2 Explains purpose of interview</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3 Establishes presenting complaint</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4 Establishes the duration of symptoms and treatment</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5 Establishes dietary and bowel habits: excludes passage of blood and mucus</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6 Establishes general lifestyle</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7 Uses an appropriate questioning technique</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8 Avoids or explains jargon</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9 Summarises history back to the patient, including concerns</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10 Makes a reasonable attempt at the diagnosis</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>11 Systematic, organised approach</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

SP to mark

12 I felt comfortable talking to this student ☐ ☐ ☐