MRCP(UK) PACES

CONSULTATION

Patient details:	Mr H Smith aged 75 assisted by his son
Your role:	You are the core medical trainee in the general medical outpatient clinic

Please read the referral letter below. You may make notes and bring these into the consultation, making further notes during the consultation if you wish. When the bell sounds, enter the room.

Your task is to:

- Assess the problem by means of a focused clinical history and a relevant physical examination. You do not need to complete the history before commencing the physical examination.
- Advise the patient of your probable diagnosis (or differential diagnoses), and discuss your plan for investigation and treatment, where appropriate.
- Respond directly to any specific questions / concerns which the patient may have.

You have 15 minutes with the patient. The examiners will alert you when 13 minutes have elapsed, leaving you 2 minutes to finalise the consultation. In the remaining 5 minutes, one examiner will ask you to **report on any abnormal physical signs** elicited, your **diagnosis or differential diagnoses**, and your **plan for management**.

Any notes you make must be left in the examination room.

Clinical referral

This man attended the surgery with his son with a two-month history of tiredness and lethargy. They reported a vague history of loss of balance, but neurological examination was normal. I could not find any other abnormalities, but initial investigations revealed a low sodium of 120mmol/L (133-146). Potassium was 4.8mmol/L (3.5-5.3), creatinine 93umol/L (60-120), urea 4.8mmol/L (2.5-7.8), eGFR 69mL/min/1.73 (>90).

I would be most grateful for further assessment and investigations as appropriate.

Physiological observations for the patient above	**Reading on arrival**
Respiratory rate (respirations per minute)	12
Pulse rate (beats per minute)	86
Systolic blood pressure (mm Hg)	116
Diastolic blood pressure (mm Hg)	80
Oxygen saturations (%)	98
Temperature ^{0}C	36.4
Other relevant observation data (units if applicable)	

NOT TO BE SEEN BY CANDIDATES

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Candidates will have 15 minutes with you to gather all the information they require, perform an examination and explain what further tests or treatments they would like to arrange, as well as answer your questions. The scenario below may be based upon your case, however, some aspects of your medical history may have been simplified or left out from the scenario for the purpose of the exam, for example your current diagnosis, other health problems, previous tests and treatments. It is very important that you stick to the history given below and do not deviate from it. This is essential to ensure that the exam is fair for all candidates. Those organising the exam will contact you beforehand to run through the scenario with you. Please read through the history carefully so that you can raise any questions or concerns you may have.

You are: Mr H Smith aged 75
You are in: the medical outpatient clinic

History of current problem

Information to be volunteered at the start of the consultation
You have come to the clinic because for the last couple of months your father has been feeling tired and lethargic with poor concentration.
He has been feeling somewhat unsteady and listless.
His GP arranged some initial blood tests and you received a call back to say that there is an abnormality and a hospital appointment was required. She did not mention exactly what the problem was.

Information to be given *if asked*
You feel that his memory is fading.
He has lost a kilogram in weight over this length of time.
Bowel and bladder function are normal.
There has been no cough or shortness of breath.
He suffers from indigestion – this consists of heartburn and acid reflux particularly if he eats a big meal, certain foods or eats late.

Background information

Past medical and surgical history
Three years ago he had seen some blood in his stools and this was investigated by an endoscopy.
Diverticular disease and a polyp were diagnosed; the latter was removed.

Medication record

Current medications (Please bring a list of your treatment with you and show it to the doctor if asked.)
Omeprazole 15mg daily
Allergies, adverse reactions and previous relevant medications
none known

Personal history

Relevant social, lifestyle and travel history
He is a non-smoker and a social drinker. If asked, his alcohol intake amounts to several bottles of beer per week.
His spouse is well. His children have grown up and left home.
Family history
There are no major illnesses in the family.

Occupational history
He is a retired teacher.

Physical Examination

The doctor will examine your legs for swelling. They will also check your neck veins and examine your neck, under your arms and your groin for lymph node enlargement. They may also check your thyroid in your neck.

Concerns, expectations and wishes

You are concerned there is something serious going on, such as cancer – he had a polyp removed and although this was removed perhaps it has come back and is causing problems. Or is his indigestion something more serious? You have even worried about the possibility of dementia and kidney disease. You hope the doctor can give you a more exact diagnosis because your family doctor wasn't able to. If the doctor is a bit vague about the diagnosis and management plan, question them a bit more. You are very worried but you do not get angry.

You have specific questions for the doctor at this consultation.

Please note them down on a small card to remind you during the exam. You must ask the first two and then others as appropriate.

1. What is wrong with him?
2. What are the next steps?
3. Is this serious?

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DATE	CYCLE

CLINICAL CONSULTATION

Examiners should advise candidates after 13 minutes have elapsed that "You have two minutes remaining with your patient". If the candidate appears to have finished early remind them how long is left at the station and enquire if there is any other areas they would like to cover. If they have finished, please remain silent and allow the candidate that time for reflection. The patient / surrogate should remain until the end of the 15 minute period, and then leave if ambulant.

The examiner should ask the candidate to describe any abnormal physical findings that have been identified. The examiner should also ask the candidate about the differential diagnoses that are being considered. Any remaining areas of uncertainty, eg regarding the plan for investigation or management of the problem should be addressed before a more general discussion about any issues that the consultation raises.

Examiners should refer to the marking guidelines in the seven skill domains on the marksheet.

Examiners must fully rehearse the scenario with the patient / surrogate during calibration. The specific information given in relation to each skill should be considered by examiners in calibration, along with any other areas they feel appropriate. Examiners must agree, and each record the agreed skills on their own calibration form, the issues that a candidate should address to achieve a satisfactory award for each skill. Examiners should also agree the criteria for an unsatisfactory award at each skill. Examiners must refer to their agreed calibration record when recording marks for individual candidates.

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Problem:	New finding of hyponatraemia possibly due to omeprazole
Candidate's role:	The core medical trainee in the general medical outpatient clinic
Patient details:	Mr H Smith, aged 75
Patient or surrogate:	Surrogate
Clinical setting:	medical outpatient clinic

Examiners are reminded that the information given in the boxes below indicates areas of potential interest. These items are not intended as absolute determiners of satisfactory performance and examiners may identify additional areas during calibration to be assessed.

IMPORTANT: the candidate does not have to be perfect in order to achieve a satisfactory score.

Clinical skill	Key issues
Clinical Communication Skills (C)	The candidate must take a history which adequately explores all areas relevant to the differential diagnoses. It is not sufficient to take a history which confirms a suspected diagnosis without adequately exploring other possibilities or relevant personal history. • explores possibility of occult malignancy • considers hypothyroidism and adrenal insufficiency • relevant drug history.
Physical Examination (A)	Notes physiological observations. Assessment of volume status, general examination for lymphadenopathy or other signs of underlying malignancy, eg checks for left supraclavicular adenopathy. Checks for signs of thyroid and adrenal disease.
Identifying Physical Signs (B)	Normal physical examination Euvolaemic
Differential Diagnosis (D)	**Probable Diagnosis:** Drug related (omeprazole) Syndrome of inappropriate antidiuretic hormone secretion (SIADH) Underlying malignancy **Plausible alternative diagnoses:** Hypothyroidism or hypo-adrenalism
Clinical Judgment (E)	Attempts to categorise hyponatraemia based on volume status. Considers investigating for SIADH, hypoadrenalism and hypothyroidism. Considers drugs, recommends suspension of omeprazole, offering an alternative. Arranges appropriate review.
Managing Patients' Concerns (F)	Addresses the son's questions and concerns in an appropriate manner.
Maintaining Patient Welfare (G)	Treats the patient respectfully, sensitively and ensures comfort, safety and dignity. Does not cause physical or emotional discomfort or jeopardise safety.