MRCP(UK) PACES

CONSULTATION

Patient details:	Mr Joseph CRUISE, a 66-year-old man
Your role:	You are the core medical trainee in the medical assessment unit

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 patient has had a blackout but now seems fully recovered. Routine blood tests (full blood count and renal function) are normal. Please advise regarding his diagnosis and management.

Physiological observations for the patient above	**Reading on arrival**
Respiratory rate (respirations per minute)	12
Pulse rate (beats per minute)	88
Systolic blood pressure (mm Hg)	118
Diastolic blood pressure (mm Hg)	74
Oxygen saturations (%)	98
Temperature ^{0}C	36
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 Joseph CRUISE, a 66-year-old man
You are in: The medical assessment unit

History of current problem

Information to be volunteered at the start of the consultation
Yesterday you had an episode of collapse.
You were sitting reading a book, felt a bit odd for a few seconds and then passed out.
You ended up on the floor. You think you were 'out' for about 3 minutes.
'Could I have had a stroke doctor?'

Information to be given *if asked*
No one saw this episode.
You had not bitten your tongue or lost control of your bladder.
When you came round you were not confused, there was no slurring of speech or deviation of the mouth, and you had no weakness of one side of your body.
You had no palpitations preceding or following the episode.
You rang your family doctor who advised you to attend hospital.

Eight weeks ago, you had a similar blackout. You had played golf for 3 hours in the morning. You went home, had some lunch and while sitting on a chair in the kitchen, you felt hot and flushed, couldn't focus your eyes then blacked out quite suddenly.
Your wife who saw the episode said your eyes rolled up, you slid to the floor looking very pale. You were not rousable and were sweating profusely. Your wife says your limbs twitched a little for a short time. You did not bite your tongue and had no urine incontinence.
She thought you were dying but apparently you came round within a few minutes. By the time the ambulance came you felt fully recovered and declined the offer to be taken to the hospital.

Background information

Past medical and surgical history
You have arthritis of your hips and knees.
You have very infrequent episodes of an irregular heartbeat. You have never required long-term treatment for this as the episodes are so infrequent. If questioned further or prompted, you recall a diagnosis of atrial fibrillation.
You have to pass urine more often than before, and have to rush to get to the lavatory in time. You suspect it is from your prostate gland – your father had the same trouble. You therefore don't drink much fluid so that you don't get 'caught short'.

Medication record

Current medications (Please bring a list of your treatment with you and show it to the doctor if asked.)
aspirin 75 mg once daily. If asked, you just take this for general health reasons.
paracetamol 500 mg as needed for aches and pains.
Allergies, adverse reactions and previous relevant medications
None known.

Personal history

Relevant social, lifestyle and travel history
You enjoy playing golf, although your arthritis is making this more difficult.
You stopped smoking 20 years ago. You smoked 20 cigarettes daily for 20 years.
You drink a glass of wine occasionally.
You drive. You live with your wife who does not drive.
Family history
Your father and mother died in their seventies. You think they might have had heart problems but you are not sure.

Occupational history
You are a retired accountant.

Physical Examination

The doctor will check your pulse and your heart sounds. They may look at your tongue. They may examine your limbs for strength and coordination and ask you to walk a few steps.

Concerns, expectations and wishes

You are eager to know the cause of these symptoms and whether they will happen again. You are very worried about whether you can continue driving – you and your wife are very dependent on the car.
You are planning a long trip to Australia in the next 4 months.

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. Why am I having these attacks? Are they mini-strokes?
2. Do I need some tests?
3. Is there anything that can be done to stop them? Can I carry on with aspirin?
4. Can I carry on driving?
5. Will I have to cancel my trip to Australia?

NOT TO BE SEEN BY CANDIDATES

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DATE	CYCLE

CONSULTATION

Examiners should advise candidates after 13 minutes have elapsed that "You have 2 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.

Continued on next page…

Problem:	Episode of collapse probably vasovagal or dysrhythmia
Candidate's role:	The core medical trainee in the medical assessment unit
Patient details:	Mr Joseph Cruise, a 66-year-old man
Patient or surrogate:	Patient
Clinical setting:	The medical assessment unit

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. • Takes details of the episode, the events before, during and after the patient regains consciousness. • Asks about palpitation, jerky activity, tongue biting, incontinence, loss of consciousness and confusion • Establishes witness account. • Establishes the patient's history of paroxysmal atrial fibrillation.
Physical Examination (A)	Note physiological observations (relative hypotension / tachycardia). Focused cardiovascular & neurological examination. Checks tongue for bite marks.
Identifying Physical Signs (B)	None.
Differential Diagnosis (D)	**Probable Diagnosis:** Vasovagal syncope Arrhythmia **Plausible alternative diagnoses:** Seizure
Clinical Judgment (E)	Arranges urgent ECG, additional blood tests to exclude diabetes, liver disease etc Further investigations including 24/72-hour tape, tilt-table test, CT scan of head or MR scan of brain (EEG unlikely to be diagnostic) Referral to the cardiology team if appropriate. Discusses implications for driving in light of attacks while seated with little warning Discusses the possibility of anticoagulation if atrial fibrillation is confirmed.
Managing Patients' Concerns (F)	Addresses the patient'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.