

PACES Station 2: HISTORY TAKING

Patient details:	Miss Lily Kwan, a 28-year-old woman
Your role:	You are the doctor in the general medical outpatient clinic
Presenting complaint:	Diarrhoea and weight loss

Please read the letter printed below. When the bell sounds, enter the room. You have 14 minutes to take a history from the patient, 1 minute to collect your thoughts and 5 minutes for discussion. You may make notes if you wish.

Referral text:

Dear Doctor,

Thank you for seeing this patient who presented to my general practice health centre complaining of a 1-month history of diarrhoea and weight loss.

On examination, she had a soft and non-tender abdomen. Rectal examination was normal. I have taken routine blood tests including full blood count, urea and electrolytes and glucose, which have all been normal. Furthermore, urine culture showed no growth.

She is otherwise well with no past medical history and is not taking any regular medication. She works as an IT consultant.

I would be grateful for any advice on the possible diagnosis and immediate management.

Yours faithfully,

Your task is to interview the patient and, based on the history you obtain, construct a differential diagnosis and plan for investigation. You should explain these to the patient and answer any questions they may have.

DO NOT EXAMINE THE PATIENT

Any notes you make must be handed to the examiners at the end of the station.

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Your role: You are the patient, Miss Lily Kwan, a 28-year-old woman
Location: The general medial outpatient clinic

History of presenting symptoms

Information to be volunteered at the start of the consultation

You have been feeling generally unwell for about 3 months. Over the past month you have developed diarrhoea, which is loose but formed stool, with no blood or mucus. If asked, the stool does not float in the pan and is not offensive smelling.

You open your bowels approximately 5–6 times per day and occasionally need to open your bowels once at night. You have no urinary symptoms of any sort.

You have also noticed that you have lost weight unintentionally, having dropped from a UK size 12 to a size 10 in the past 3 months. You do not weigh yourself so you cannot comment on the exact weight loss.

Your appetite has not been affected and, in fact, you feel that, if anything, you seem to be eating more than usual.

Information to be given *if asked*

Your periods have become erratic over the last 6 months with only occasional, scanty blood loss. You feel warm and sweaty a lot of the time and have not enjoyed the recent warm weather, which is unusual for you. Recently, your hands feel somewhat 'shaky', and sometimes your writing has been difficult to read. You have not noticed any problems with your eyes and have not developed any skin rashes. You wonder if your neck has become a little swollen.

Background information

Past medical and surgical history

You have otherwise always been well. You have only been to hospital once before, for a termination of pregnancy at the age of 19. You do not take any prescribed medication, but have been taking vitamin supplements recently. You have no allergies.

Medication record

Current medications

None.

Personal history

Lifestyle

You smoke 5–10 cigarettes a day. If asked, admit to occasionally smoking cannabis. You drink about two gins and tonic a day (if asked, you pour yourself a generous measure).

Social and personal circumstances

You live with your partner and have been trying to start a family recently.

NOT TO BE SEEN BY CANDIDATES
INFORMATION FOR THE SURROGATE

Scenario No: Sample 10

Occupational history

You work as an IT consultant.

Family history

Both your parents died in their eighties. Your father had a heart attack, and your mother had colon cancer. There is no family history of inflammatory bowel disease or coeliac disease.

Patient's concerns, expectations and wishes

You are concerned that you may have cancer because your mother had diarrhoea and lost weight before she was diagnosed with cancer. You also have concerns about your fertility, which is causing some friction between you and your partner.

NOT TO BE USED IN THE EXAM

PACES Station 2: HISTORY TAKING

DATE	CYCLE

Examiners should advise candidates when there are 2 minutes remaining (i.e. after 12 minutes). If the candidate appears to have finished early remind them how long is left at the station and enquire if there is anything else they would like to ask, or whether they have finished. If they have finished, please remain silent and allow the candidate that time for reflection. The surrogate should remain until the end of the 14-minute period.

A good candidate would be expected to take a history which includes a detailed social history and activities of daily living; and to particularly focus on the questions raised in the referral letter. At the end of the consultation the candidate should have discussed solutions to the problems posed by the case. A good candidate would also give the patient the opportunity to ask any further questions before closure. It is not necessary for candidates to agree a summary with the patient during their interview.

Examiners are encouraged to make a rough record of the candidate's consultation with the patient as it progresses. This may highlight omissions in history taking, ambiguities that remain unresolved, and additional points that were not 'in the script'.

The examiner is expected to ask the candidate whether they have formed a problem list or preferred diagnosis and answer the questions in the family doctor's letter. Following discussion of the answer to these questions the discussion should explore the issues raised.

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

Examiners are reminded that, during the calibration process, the surrogate should be rehearsed and specific aspects of the scenario that require clarification or emphasis should be discussed. The boxes on the next page indicate areas of potential interest in this case which both examiners should consider, along with any other areas they feel appropriate. Examiners must agree the issues that a candidate should address to achieve a Satisfactory award for each skill and record these on the calibration sheet provided. Examiners should also agree the criteria for an Unsatisfactory award at each skill.

NOT TO BE SEEN BY CANDIDATES

INFORMATION FOR EXAMINERS

Scenario No: Sample 10

Problem:	Diarrhoea and weight loss
Candidate's role:	The doctor in the general medical outpatient clinic
Surrogate's role:	The patient, Miss Lily Kwan, a 28-year-old woman

Examiners are reminded the areas below indicate areas of potential interest, but are not intended as absolute determiners of Satisfactory performance. It is for the examiners to agree and record the specific criteria they will assess the candidate on during the calibration process.

Differential Diagnosis (Clinical Skill D)

Probable diagnosis:

- Thyrotoxicosis

Clinical Communication Skills (Clinical Skill C)

- Collects information regarding the nature of the diarrhoea, specifically history consistent with fast transit and not with inflammatory change or malabsorption
- Elucidates weight loss in the context of increased appetite and neck swelling
- Clarifies diagnosis, noting:
 - Tremor
 - Heat intolerance
 - Oligomenorrhoea
 - Neck swelling
 - Eye problems
 - Skin rashes

Managing Patients' Concerns (Clinical Skill F)

- Explores and addresses the patient's concerns

Clinical Judgement (Clinical Skill E)

- Plans investigations that must include thyroid function tests
- Discusses likely initial management plan: block (carbimazole) and replace (with levothyroxine when euthyroid); β -adrenoceptor blockers for temporary symptomatic relief

Maintaining Patient Welfare (Clinical Skill G)

See marksheet