

PACES Station 2: HISTORY TAKING

Patient details: Mrs Julia Coles, a 40-year-old woman
Your role: You are the doctor in the outpatient clinic
Presenting complaint: Joint pain

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,

This patient has pain in her hands on exposure to cold. She also has paresthaesia in her hands and complains of joint pain. Her full blood count and kidney function were normal. Her serum C-reactive protein was 10 mg/L (normal range: <10)

I would be grateful if you can investigate and advise.

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, Mrs Julia Coles, a 40-year-old woman

Location: The outpatient clinic

History of presenting symptoms

Information to be volunteered at the start of the consultation

For the last 2 years, you have noticed that your hands are painful particularly in the cold weather. Over the course of the last year, your symptoms have become troublesome; for example, simply opening the freezer is triggering your symptoms.

Information to be given *if asked*

Your fingers turn white then blue then red when they are painful. You have not developed any skin damage. Your family doctor advised you to keep your hands warm by wearing gloves, which partially helped, but your symptoms are now worsening.

Over the course of the last year, you have also developed swelling in the fingers and pain in multiple joints. The joint pain started in your ankles and then your knees became painful but not swollen. Then your hands have become swollen and you had to have a new wedding ring made. You struggle to make a fist.

You have 'pins and needles' in your hands waking you up at night occasionally. Your family doctor has prescribed tablets (pregabalin).

You have shortness of breath on mild exertion, You can walk 100 m (about 100 yards) then start to be short of breath. You have no cough or chest pain. You use one pillow at night.

You have not had any sensitivity to light or sunlight, no hair loss, no mouth ulcers, no genital ulcers, no rash, no blood clots in your leg or lungs, and have not had any miscarriages and your periods are normal. You have occasional indigestion but no difficulty in swallowing.

You do not have a history of psoriasis. You have experienced no change in bowel habits, no red eyes or urinary symptoms.

You feel exhausted.

Background information

Past medical and surgical history

You previously had post-viral fatigue.

You also have depression, for which you take citalopram (see below).

Other complaints

None.

NOT TO BE SEEN BY CANDIDATES
INFORMATION FOR THE SURROGATE

Scenario No: Sample 14

Medication record

Current medications

- citalopram 20 mg once daily
- pregabalin 150 mg three times daily (for pain)

Relevant previous medications

None.

Allergies and adverse reactions

None known.

Personal history

Lifestyle

You do not smoke or drink alcohol.

Social and personal circumstances

You live with your husband and two young children.

Occupational history

You teach at a primary school.

You have been off sick for 4 weeks .

Travel history

You prefer to travel to warm places, because of your hands, and last year you went to Egypt and you enjoyed it. Your hands were good during the trip.

Family history

Your parents are well.

Patient's concerns, expectations and wishes

You want to know what is causing these symptoms and whether or not it is a serious problem.

You have some specific questions for the doctor at this consultation:

- Will the hand symptoms get worse?
- Will I be able to continue my work as a teacher?
- What is the cause of my symptoms?

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 14

Problem:	Joint pain
Candidate's role:	The doctor in the outpatient clinic
Surrogate's role:	The patient, Mrs Julia Coles, a 40-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:

- Raynaud's phenomenon

Plausible alternative diagnoses:

- Limited systemic sclerosis
- Mixed connective tissue disorder

Clinical Communication Skills (Clinical Skill C)

- Listens to the patient, and takes detailed history of the symptoms and asks about the relevant symptoms

Managing Patients' Concerns (Clinical Skill F)

- Addresses the patient's concerns

Clinical Judgement (Clinical Skill E)

- Considers the differential diagnoses
- Requests investigations including: full blood count, urea and electrolytes, liver function tests, serum C-reactive protein, antinuclear antibodies, anti-double-stranded DNA antibodies, anti-neutrophil cytoplasmic antibodies, rheumatoid factor, extractable nuclear antigen antibodies (includes anticentromere antibodies, anti-Scl-70 antibodies and anti-RNP antibodies); pulmonary function tests and echocardiography
- If the diagnosis of systemic sclerosis is proven, vasodilators can be used e.g. nifedipine can be given to alleviate the hand symptoms; considers patient referral to a rheumatologist

Maintaining Patient Welfare (Clinical Skill G)

See marksheet