

PACES Station 2: HISTORY TAKING

Patient details:	Mrs Sarah Hay, a 33-year-old woman
Your role:	You are the doctor in the medical admissions unit
Presenting complaint:	Pleuritic chest pain and breathlessness

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,

Many thanks for admitting this patient who is experiencing pleuritic chest pain and increasing shortness of breath.

She has recently had a hernia repair and I am therefore concerned that she has had a pulmonary thromboembolism.

Your assessment of her condition and advice on management would be very much appreciated.

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 Sarah Hay, a 33-year-old woman
Location: The medical admissions unit

History of presenting symptoms

Information to be volunteered at the start of the consultation

Two weeks ago, you had a groin hernia repair performed. The operation was successful and uneventful. The only problem you had afterwards was pain around the wound site. About a week after the operation, you started to have cold-like symptoms: a sore throat, runny nose, dry cough and aching muscles. As you are asthmatic this meant that your chest became a bit tighter and wheezier over the next few days. You are used to controlling your asthma so you increased your steroid inhaler and took more frequent doses of your reliever. Things appeared to settle down for a few days. You had found it difficult to cough, however, because of the pain from your hernia wound.

Information to be given *if asked*

Two days ago, your cough increased and you started to bring up thick greenish-yellow phlegm. There has not been any blood in the sputum. Again, your chest started to become even tighter and you started to feel shorter of breath when doing your normal activities. You also felt a bit feverish and sweaty especially at night. This morning you felt short of breath even at rest and became aware of some pain in the right side of your chest. This started as a dull nagging pain but about mid-morning suddenly got a lot worse and became a sharp stabbing pain (like someone sticking a knife in your side). The pain got worse every time you took a deep breath so you had to breathe rapidly and in a shallow manner. You took some paracetamol, which only took the edge off the pain.

Background information

Past medical and surgical history

Asthma:

You have had asthma since childhood and spent quite a lot of your early childhood in and out of hospital because of breathing problems. You think you may have had to be ventilated as a child but cannot remember it. Since you were about 10 years old your asthma settled down and you have been able to manage it pretty well by yourself, with only the occasional course of steroids from your family doctor (the last course was 2 years ago). You have not been admitted because of your asthma since you were 25. However, 5 years ago, you did have to come to the emergency department for a nebuliser but you settled quickly and were discharged home within a few hours.

Eczema:

You have had eczema since childhood but this has not troubled you too much in adulthood.

Pneumothorax:

You had a collapsed left lung at the age of 25.

Other:

NOT TO BE SEEN BY CANDIDATES
INFORMATION FOR THE SURROGATE

Scenario No: Sample 5

You also had your appendix removed at the age of 11, and you fractured your left arm playing rugby as a teenager. There is no previous history of a deep venous thrombosis.

Other complaints

None.

Medication record

Current medications

- Seretide® 125 inhaler – 2 puffs twice a day
- Ventolin® inhaler – 2 puffs as required
- Betnovate® cream – topically to areas of eczema as required

Relevant previous medications

None.

Allergies and adverse reactions

You are allergic to ibuprofen; it makes your asthma worse. You have also been told by your mother not to have penicillin as you were given some as a child and it brought you out in a rash. You have been tested for various allergies (for example, dog hair) but nothing was discovered.

Personal history

Lifestyle

You do not smoke and drink only the occasional glass of wine. You like to keep fit and attend a gym regularly.

Social and personal circumstances

You are married with one son who also has asthma.

Occupational history

You work in a bank as a local branch manager. You enjoy your job and do not find it particularly stressful.

Family history

Your mother and an aunt also have asthma, and you think that your mother had a blood clot on her leg when she was young but you are not sure of the details. Your father has had angina since he was 55 and had a heart attack when he was 62.

Patient's concerns, expectations and wishes

Your current pain seems similar to the pain you had when your left lung collapsed. The doctor who treated you at that time had told you there was a chance it could happen again and if you felt a similar pain you should always see a doctor. You went to your family doctor and he sent you to hospital thinking it was a blood clot, and this had really confused you because you had wanted confirmation that it was not your lung collapsing again.

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

- Do I have another collapsed lung?
- Why might I have a clot in my lung and is this serious?

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Scenario No: Sample 5

- Will I be able to fly overseas for my holidays?

NOT TO BE USED IN THE EXAM

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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.

Problem:	Pleuritic chest pain and breathlessness
Candidate's role:	The doctor in the medical admissions unit
Surrogate's role:	The patient, Mrs Sarah Hay, a 33-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:

- Pneumonia or infective exacerbation of asthma

Plausible alternative diagnosis:

- Pulmonary embolus (to be excluded)
- (Recurrent pneumothorax is unlikely)

Clinical Communication Skills (Clinical Skill C)

- Focuses on the features of pulmonary embolism such as haemoptysis but also explores the possibility of pneumonia
- Takes a detailed history of breathlessness and explores aspects of the patient's breathlessness and its severity
- Considers possibility of both pulmonary thromboembolism and pneumonia
- Elicits past history of asthma, pneumothorax and eczema
- Takes history of current medication and allergies

Managing Patients' Concerns (Clinical Skill F)

- Elicits patient's perspective of the problem

Clinical Judgement (Clinical Skill E)

- Discusses the management of the patient and mentions appropriate investigations such as D dimer, blood gases, chest X-ray, ECG, ventilation/perfusion scan, CT pulmonary angiogram
- Discusses pulmonary embolism risk scores

Maintaining Patient Welfare (Clinical Skill G)

See marksheet