MRCP(UK) PACES

Station 5: BRIEF CLINICAL CONSULTATION

Patient details:	Mrs XX aged 72.
Your role:	You are the doctor in the medical admissions unit.

You have 10 minutes with each patient. The examiners will alert you when 6 minutes have elapsed and will stop you after 8 minutes. In the remaining 2 minutes, one examiner will ask you to **report on any abnormal physical signs** elicited, your **diagnosis or differential diagnoses**, and your **plan for management** (if not already clear from your discussion with the patient).

Referral text:

Clinical problem: This woman has been referred by her family doctor with severe back pain. She lives on her own and is struggling to cope at home. She is known to have osteoporosis and her family doctor is concerned that she may have had another vertebral fracture.

Physiological observations for the patient above	**Reading on arrival**
Respiratory rate (respirations per minute)	18
Pulse rate (beats per minute)	90
Systolic blood pressure (mm Hg)	110
Diastolic blood pressure (mm Hg)	55
Oxygen saturations (%)	98 on air
Temperature ^{0}C	38.0
Other relevant observation data (units if applicable)	N/A

Your task is to:

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

Any notes you make may be taken into the examination room for your reference, but must be handed to the examiners at the end of the station.

NOT TO BE SEEN BY CANDIDATES

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Candidates will have a very limited time (8 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 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 as you will have the opportunity at that point to raise any questions or concerns you may have.

You are: Mrs XX aged 72.
You are in: the medical admissions unit.

History of current problem

Information to be volunteered at the start of the consultation
One week ago, you noticed a dull pain in the middle of your back which has not gone away and is getting steadily worse. It is now there all the time and any movement is now painful. You just don't feel right in yourself and as you live on your own, daily activities such as washing and dressing are becoming increasingly difficult. You have had a fracture in your back in the past and are concerned that this may be related.

Information to be given *if asked*
You have not fallen recently.

The back pain started gradually around one week ago and is now present constantly. It wakens you from sleep at night.

You have also been feeling feverish and sweaty and a bit shaky at times. You feel washed out, tired and just not right. You haven't felt like eating much over the past week and you think you may have lost a little weight (a few pounds) over that time but you haven't noticed a significant loss of weight.

You did have a small cut on your toe about one month ago which oozed pus. The family doctor gave you a course of antibiotics but you didn't complete the course as they made you feel sick. Your toe improved in a few days and is now back to normal.

You have no cough, breathlessness or sputum. You have not coughed up any blood.

Your bowels are working fine with no change in habit or blood from the back passage / in the stool. You are not going to the toilet more frequently and have not had any episodes of bowel or urinary incontinence.

Background information

Past medical and surgical history
You have osteoporosis and have had a fracture of a bone in your back as a result of this.

Relevant family history
Your mother broke her hip after a minor fall in her early seventies.

Medication record

Current medications (Please bring a list of your treatment with you and show it to the doctor if asked.)
Alendronate 70 mg once weekly.
Calcium carbonate (Calcichew D3 Forte) two tablets daily.

Personal history

Relevant personal, social or travel history
You are widowed. You have never smoked but enjoy the occasional glass of sherry.

Occupational history
You are a retired primary school teacher.

Physical Examination

The doctor will want to examine your back. If they press down the middle of your spine, please tell them that it is painful just over your spine in the middle of your back. They may wish to examine the power in your legs and test your reflexes. You have normal power in your legs and normal sensation.

You have one or two specific questions / concerns for the doctor at this consultation.

Please note them down on a small card to remind you during the exam.

1. Why am I feeling so unwell?

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DATE	CYCLE

Station 5: BRIEF CLINICAL CONSULTATION

Examiners should advise candidates after 6 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 anything else they would like to ask or examine. If they have finished, please remain silent and allow the candidate that time for reflection.

The examiner should ask the candidate to describe any abnormal physical findings that have been identified. The examiner should also ask the candidate to give the preferred diagnosis and any differential diagnoses that are being considered. Any remaining areas of uncertainty, eg regarding the plan for investigation or management of the problem may be addressed in any time that remains.

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 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.

Continued on next page…

Problem:	Osteoporosis and vertebral fracture with back pain and fever preceded by cutaneous infection.
Candidate's role:	The doctor in the medical admissions unit.
Patient details:	Mrs XX aged 72.
Patient or surrogate:	Surrogate.
Clinical setting:	The medical admissions unit.

Examiners are reminded that the boxes 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.

Clinical skill	Key issues
Clinical Communication Skills (C)	Establishes symptoms of gradual onset constant back pain with fever, not in keeping with osteoporotic fracture. Establishes risk factors for discitis in history (preceding soft tissue infection, failure to complete antibiotics and probable bacteraemia with seeding in previously fractured vertebrae). Establishes no symptoms suggestive of acute cord compression.
Physical Examination (A)	Looks at the observations to assess for septic shock. Palpates spine looking for spinal tenderness, conducts focal neurological examination of lower limbs, assessing tone, power and reflexes. Indicates the wish to formally check sensation and perform rectal exam to assess anal tone and perianal sensation. Indicates the need to look for signs of endocarditis (skin lesions, murmur etc).
Clinical Judgment (E)	Immediate management – close observation, assess for signs of sepsis syndrome, fluid balance. Commence empirical antibiotics eg IV flucloxacillin based on likely staphylococcal infection after several sets of blood cultures. Immediate tests: x-ray of spine, MR scan of spine looking for evidence of discitis, cord compression. Blood cultures, FBC, U&Es, CRP. Discusses the need for discussion with senior on call and liaison with microbiology. Recognises that abnormal bone eg previous fracture acts as a nidus for infection.
Managing Patients' Concerns (F)	Addresses the patient's questions and concerns in an appropriate manner.
Identifying Physical Signs (B)	Identifies pyrexia, hypotension and sepsis. Identifies spinal tenderness and establishes no signs of acute cord compression.

Differential Diagnosis (D)	**Probable Diagnosis:** Infective discitis presumed secondary to bacteraemia following incompletely treated soft tissue infection. **Plausible alternative diagnoses:** Osteoporotic fracture with an alternative source of sepsis.
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.