MRCP(UK) PACES

Station 5: BRIEF CLINICAL CONSULTATION

Patient details:	Mr JS aged 70.
Your role:	You are the doctor in the medical assessment 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 man has developed pain and swelling in his finger. He has a history of controlled heart failure, hypertension, mild stable renal impairment and type 2 diabetes.

Physiological observations for the patient above	**Reading on arrival**
Respiratory rate (respirations per minute)	12
Pulse rate (beats per minute)	68
Systolic blood pressure (mm Hg)	136
Diastolic blood pressure (mm Hg)	80
Oxygen saturations (%)	98
Temperature ^{0}C	37.1
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 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 e.g. 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 before the exam to run through the scenario with you. Please read through the history carefully beforehand and you will have the opportunity at that point to answer any questions or concerns you may have.

You are: Mr JS aged 70.
You are in: the medical assessment unit.

History of current problem

Please note that your medical details have been modified for the purposes of the examination.

Information to be volunteered at the start of the consultation
You have developed pain and swelling in your finger. The pain has not been relieved by paracetamol so you went to see your doctor who has sent you to hospital for further assessment.

Information to be given *if asked*
The pain in your finger started two days ago. The joints in your finger have become swollen. Your finger is so swollen and tender that you cannot bear to use that hand or let anything touch it. You do not recall any injury to your hand or finger.

You vaguely remember something similar some years ago but had forgotten about it until this latest episode. The episode settled after taken ibuprofen for a week.

You have discomfort in your hips and knees which you have put down to arthritis. The doctor has told you it is due to ‘wear and tear’. You take paracetamol as required and this usually helps.

Background information

Past medical and surgical history
You were diagnosed with type 2 diabetes 10 years ago, which you control by diet and medication (metformin).

Six years ago, you had a heart attack which was treated with angioplasty and a stent followed by medication. You were told there was moderate damage to the heart muscle. You currently experience mild breathlessness if you push yourself but you don't experience angina.

You have high blood pressure which was diagnosed at the same time as diabetes. It has been a bit higher over the last few months so your doctor added some more medication.

The doctor has advised you that your kidneys are not working 100% but they are stable. You haven't had a blood test to check your kidneys for about three months.

You used to have indigestion but this is now controlled by medication.

Relevant family history
None of your family have experienced anything similar.

Medication record

Current medications (Please bring a list of your treatment and show it to the doctor if asked.)
Amlodipine 5 mg once daily,
Aspirin 75 mg once daily,
Atorvastatin 40 mg at night,
Bendroflumethiazide 2.5 mg once daily,
Bisoprolol 2.5 mg twice a day,
Eplerenone 25 mg once daily,
Lansoprazole 15 mg once daily,
Metformin 500 mg three times a day,
Paracetamol 1 g up to four times a day as required,
Ramipril 5 mg twice a day.

If asked, say that the bendroflumethiazide was started four weeks ago for your blood pressure.

Personal history

Relevant personal, social or travel history
You stopped smoking at the time of your heart attack. You do not drink alcohol.

Occupational history
You are a retired teacher.

Physical Examination

The doctor will examine your hands. They may also wish to examine your other joints, such as knees and feet. They may check the appearance of your ears.

You have a few 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 are my fingers so painful?

2. What tests and treatment do I need?

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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 e.g. 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 mark sheet.

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:	Acute gout in a patient with IHD, DM, HF and CKD.
Candidate's role:	The doctor in the medical assessment unit.
Patient details:	Mr JS aged 70.
Patient or surrogate:	Patient with modified history.
Clinical setting:	The medical assessment 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)	Focused history of joint pain and swelling, including the previous episode. Explores all likely causes of joint symptoms, noting pre-existing O/A. Establishes PMH and treatment. Notes drug history and establishes new treatment with diuretic in relation to onset of symptoms.
Physical Examination (A)	Notes physiological observation, including borderline pyrexia. Examines hands & knees, offers to examine other joints. Checks ears for gouty tophi.
Clinical Judgment (E)	Investigates: FBC, WCC, CRP/ESR. Renal function & urate level. Checks diabetes and cholesterol control. Joint x-ray may be required. Joint aspiration if there is significant fluid / suggestion of infection. Treats: NSAID or colchicine with appropriate advice, aware of preventative treatment with allopurinol. Advises: role of diuretics, alternative BP control.
Managing Patients' Concerns (F)	Addresses the patient's questions and concerns in an appropriate manner.
Identifying Physical Signs (B)	Right index finger is swollen over the pip and dip joints. Skin redness and tenderness. No significant fluid collection.
Differential Diagnosis (D)	**Probable Diagnosis:** Acute gout precipitated by introduction of diuretic. **Plausible alternative diagnoses:** Infected joint.
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.