MSSBU OSCE PRACTICE CASE 4_03_01

Station Vignette

You are a resident working at the Emergency Department.

John Huynh, a 58-year-old man, has presented with severe abdominal pain which is slightly relieved by IV morphine given by the intern.

VITALS

- **HR:** 80 bpm
- **BP:** 105/81 mmHg
- **RR:** 16
- **O_2 Sats:** 98% RA
- **Temp:** 37.7°C

TASK

You have a total of **5 minutes** to take a history.

This includes:

- History of presenting complaint
- Constitutional history
- Past medical history
- Medications history
- Social history
- Family history
- Focussed systems review

At the end of the allotted time, you will have **3 minutes** to answer the examiner's questions.

Do **NOT** perform a physical examination.

PATIENT INSTRUCTIONS

You are John Huynh, a 58-year-old male who has presented to the Emergency Department due to abdominal pain. You were in excruciating pain which was slightly relieved by IV Morphine.

Be rapid with your responses as the student will only have 5 minutes to complete the history.

PC	• Severe "stomach" pain

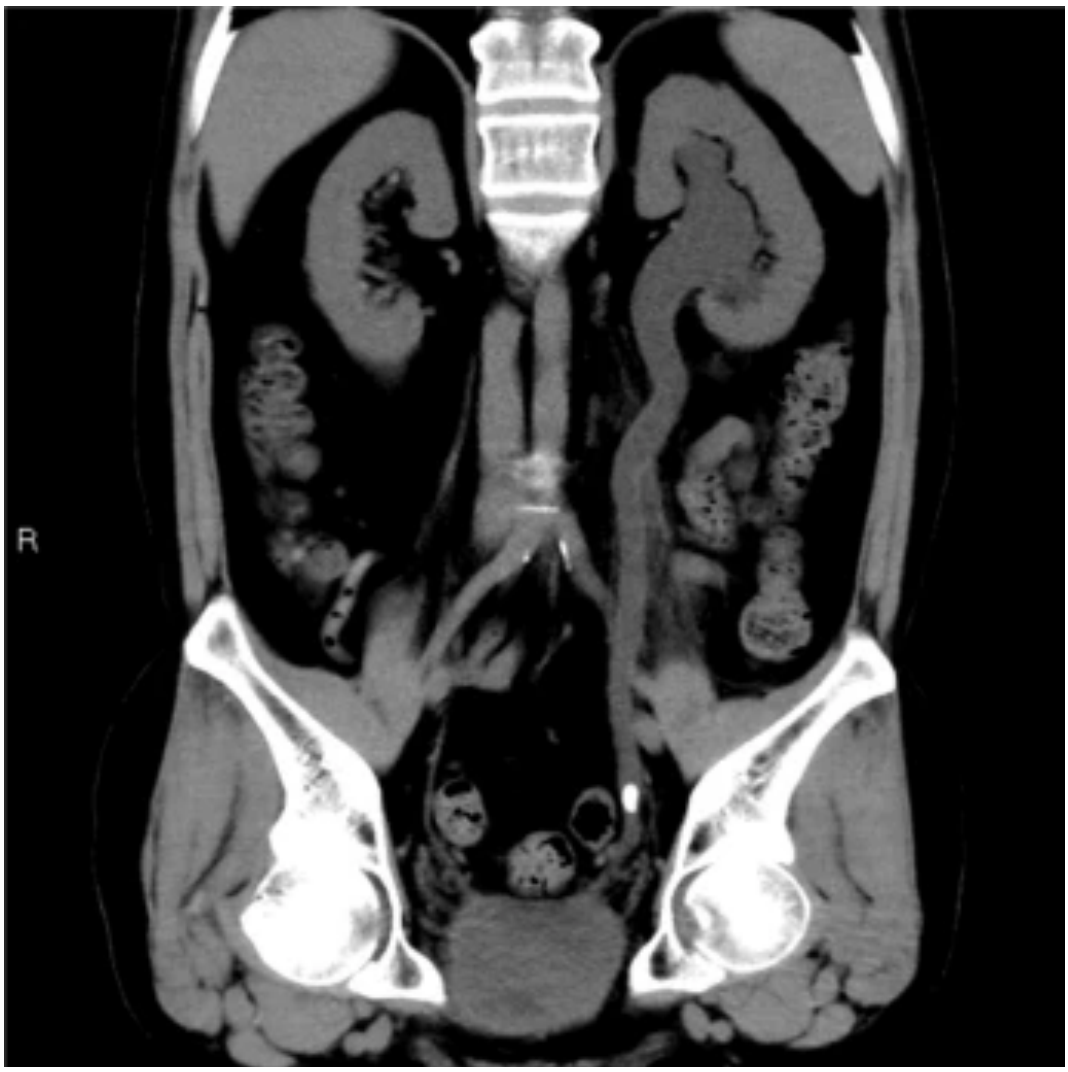
HOPC	Crampy pain started from left side/flank this morning (8 hours ago)
	• Radiates to left lower abdomen
	• No triggers - occurred when watching TV
	• Intermittent, lasting 1-2mins with ~5 minutes rest
	• Progressively worsening pain
	• Was 10/10 pain "worst pain of my life" - was rolling in bed in pain
	  o But since given Morphine 30 minutes ago, pain is now 5/10
	• Pain aggravated by void attempt 3 hours ago
	  o Was able to pass "some" urine
	• No other relieving or aggravating factors
	• Had less painful previous episode 2 months ago which settled within a few days

Systems review	• **GIT:**
	  o Been feeling nauseous since pain started
	  o No vomit
	  o No bowel Sx - no diarrhea/constipation, no PR bleed/mucus
	  o No heartburn/reflux Sx
	• **Urinary:**
	  o No UTI Sx - no fever, dysuria, frequency, urgency
	  o No visible haematuria
	• **Cardioresp:**
	  o No chest pain, SOB, cough, mucus
	  o No palpitations

Constitutional Hx	• Had been feeling sweaty • No fever or chills, weight loss or rashes • Diet - mostly takeaway food
PMHx	• No previous kidney stones
PSHx	• Appendicectomy 20 years ago
Medications	• No meds
Allergies	• Keflex- nausea
FHx	• HTN
SHx	• Smokes 1 cig/day • EtOH- 2 beers/weekend • No recreational drug use • Woolies truck driver for interstate produce (QLD -> NSW) • Lives with wife and teenage son
Ideas, concerns and/or expectations	*Respond only if asked:* • "This was the worst pain of my life… could I still get some pain killers running?"

EXAMINER QUESTIONS

1. Interpret the **CT abdomen**



https://www.nature.com/articles/s41598-020-58805-x

2. Name **three (3)** further **investigations** required for this patient.

MARKING CRITERIA – CASE 4_03_01

Item	Criteria	Mark
Introduction	☐ Hand hygiene ☐ Appropriate introduction	/2
Presenting complaint	☐ Leads with open question ☐ Follows with another open question	/2
History of presenting complaint	☐ Determine onset and progression ☐ Cramping pain ☐ Location and radiation ☐ Intermittent/colicky pain ☐ Pain scale ☐ Triggers ☐ Aggravating factors ☐ Relieving factors ☐ First or previous episode(s) ☐ Elicits patient concerns/worries	/10
Systems review	☐ GIT – screening questions including N/V and bowel Sx ☐ Urinary – screening questions including UTI and lower urinary tract Sx (may include dysuria, frequency and haematuria) ☐ Cardioresp – screening questions including chest pain and SOB	/3
Constitutional history	☐ 0.5 points for each of the following: diet, appetite, weight loss, sleep, energy, exercise ☐ 0.5 points for each of the following systemic symptoms: fevers, chills, night sweats, rash	/5
Past medical/ surgical history	☐ Past medical/surgical history ☐ Screen for relevant conditions/risk factors (e.g. diverticulitis, kidney stones)	/2
Medications history	☐ Asks over the counter, prescription, and herbal remedies ☐ Allergies ☐ Immunisations	/3
Social history	☐ Occupation ☐ Living situation ☐ Asks all of smoking, alcohol and recreational drugs	/3
Family history	☐ Asks relevant family history	/1
Questions	☐ CT abdomen: ☐ 1 point- Confirms patient details- must include name and sex (may mention date of scan and previous imaging for comparison) ☐ 1 point- Quality of film and view- adequate exposure (e.g. lung bases to pelvis), coronal/frontal view +/- non-contrast CT ☐ 1 point- Must identify single hyperdensity/stone ☐ 1 point- Stone size ~3-5mm in maximum diameter ☐ 1 point- Stone location- distal left ureter ☐ 1 point- must identify left hydroureter AND hydronephrosis ☐ 1 point- mentions at least one of the following: looking for air in abdomen (air in large bowel, no	/11

	pneumomediastinum), calcifications in abdominal aorta/common iliac arteries, identifies no other obvious organ abnormalities (e.g. bladder, right kidney, large bowel), no external objects ▢ 1 point- Summary sentence of CT abdomen e.g. “This is a coronal non-contrast CT abdomen of John, a 58-year-old male. There is a left distal ureteric stone, ~5mm in size, with associated left hydroureter and hydronephrosis.” ▢ Further investigations – 1 point for any three of: urine dipstick, urine MCS, renal function tests (UECs), FBC o NB: eGFR is needed to assess for AKI considering there is hydroureter and hydronephrosis o NB: urine MCS is needed to assess for UTI (if there is a concurrent UTI with urolithiasis, this is an infected obstructed kidney i.e. “pus under pressure.” An urgent urological consult is required to relieve the obstruction and reduce risk of bacteremia/sepsis)	
Communication skills	▢ Appropriate questioning style ▢ Actively listens to patient ▢ Systematic approach to history taking ▢ Appropriate conclusion and summary	/4
Global score	Overall impression of candidate based on warmth, clarity and competence: 1 = fail 2 = borderline 3 = pass/expected 4 = good 5 = excellent	/5
	Total	/51