Station Vignette

You are a fourth-year student on GP rotation.

The GP has asked you to take a brief history from Margaret Johnson concerning her 3-year-old son Ben. You just need to talk to Margaret – you do not need to talk to the son.

TASK

You have a total of **7 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 **1 minute** to answer the examiner's questions.

You do **NOT** need to complete a physical examination.

PATIENT INFORMATION

Presenting complaint:
- Recently my son has started getting pain in his right hip which started 2 days ago.

History of presenting complaint:
- 2 days ago, son complaining of hip/groin pain
- Yesterday started to have a bit of a limp
- Mother is quite concerned as never seen child limp before

Systems review:
- MSK
  - Some limited range of motion on abduction and internal rotation
  - Pain on palpation of the right hip
  - Refusing to weight bear
  - No obvious bruising around the site
  - No trauma (hasn't fell or anything)
  - Was perfectly walking before this started
  - Ask what position is comfortable for the child
- Neuro
  - Can ask if mother can tell if he has lost sensation
  - Can ask if they lose power
- Developmental hx
  - Fine, child reach all milestones as required
  - No DDH
- Delivery
  - Fine delivered 37 weeks, nil complications

Constitutional history:
- Has had a recent URTI 2 weeks ago, but has now resolved
- Weight fine
- Sleeping well post illness
- Still eating well (much better since the previous illness)

Medications history:
- Nil

Past medical history:
- Has had some viral infections in the past, but nothing abnormal

Social history:
- Nil

Family history:
- Nil

EXAMINER QUESTIONS

1. Please provide **three (3)** differential diagnoses based on the findings of your history.

2. What is the **most probable** differential diagnosis?

3. What is the first line **management** for this child?

Marking Criteria – 4_01_02

Item	Criteria	Mark
Introduction	☐ Hand hygiene ☐ Appropriate introduction ☐ Explains personal role and gains consent	/ 2
Presenting complaint	☐ Leads with open question ☐ Follows with another open question	/ 2
History of presenting complaint	☐ Determine onset and progression ☐ Determine severity of pain ☐ Screen for any other symptoms ☐ Screens for any additional concerns/patient worry	/8
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 history	☐ Past medical/surgical history ☐ Screen for genetic abnormalities	/2
Medications history	☐ Checking if on any medications	/1
Social history	☐ Occupation of mother ☐ Living situation (how is the child usually act when home) ☐ Asks all of smoking, alcohol and recreational drugs in the household	/3
Family history	☐ Asks relevant family history	/1
Systems review	☐ MSK- Relevant questions (SOCRATES, stiffness, guarding / weight bearing, deformities) ☐ Delivery Hx ☐ Developmental Hx ☐ Neuro- general screening	/4
Questions	☐ Differentials - legs-calve-perthes disease, transient synovitis, SCFE (slipped capital femoral epiphysis) ☐ Main differential - transient synovitis ☐ Management – supportive (pain management)	/3
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	/40