



MSSBU OSCE PRACTICE CASE 3_02_01

Station Vignette

You are a third-year medical student at the ED

The ED registrar has asked you to take a history from Lily Homes, a 32-year-old female who has presented with abdominal pain.

TASK

You have a total of **7 minutes** to take a full 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 INSTRUCTIONS

Presenting Complaint: Abdominal Pain

Hx of Presenting Complaint:

- Abdominal pain started 60 mins ago and it hurts in the middle, right under my ribs. It was sudden and felt sharp. I can feel it towards my back.
- It's been constant and is getting worse. Panadol hasn't helped but leaning forward does. It gets worse when I take deep breaths or moving around.
- I have never had this before.
- 10/10 pain

Associated Symptoms:

- I have felt nauseous since the pain came on but nil vomits
- I've been feeling breathless since this all started too, even when sitting down.
- I opened my bowels this morning with no issues
- No jaundice/pruritis
- No dysphagia/odynophagia
- No reflux
- No change in bowel habits/haematochezia/melaena
- No dysuria
- No confusion

Constitutional Symptoms:

- Weight: 3kg lost last 5 weeks (intentional – new fitness regime)
- Fever: present
- Chills: present
- Night sweats: nil
- Diet: normal
- Appetite: decreased today
- Sleep: nil affected, 7hrs a day

Past Medical and Surgical Hx:

- **Medical Conditions:**
 - Gallstones
 - Gestational diabetes (**with both my children**)
- **Surgeries:** Nil
- **Medications:** COCP
- **Allergies:** Nil food or drug

Social Hx:

- Lives with husband and two children, aged 4 and 1 years old
- Full-time mother
- Non-smoker
- Alcohol: 2 bottles of wine on the weekend
- Recreational drugs: none
- Exercise and diet: started a new fitness regime due to being overweight
- Travel: Nil recent

Family Hx:

- Mother had **gallstones** and Type 2 DM
- No other relevant family history

EXAMINER QUESTIONS

1. Please provide **two (2)** differential diagnoses based on the findings of your history.
2. List **three (3)** appropriate investigations.

MARKING CRITERIA – Case 3_02_01

Item	Criteria	Mark
Introduction	<input type="checkbox"/> Hand hygiene <input type="checkbox"/> Appropriate introduction <input type="checkbox"/> Explains personal role and gains consent	/ 2
Presenting complaint	<input type="checkbox"/> Leads with open question <input type="checkbox"/> Follows with another open question	/ 2
History of presenting complaint	<input type="checkbox"/> Site of pain <input type="checkbox"/> Radiation of pain <input type="checkbox"/> Onset of pain <input type="checkbox"/> Time course of pain <input type="checkbox"/> Character of pain <input type="checkbox"/> Relieving and exacerbating factors <input type="checkbox"/> Severity of pain	/8
Constitutional history	<input type="checkbox"/> 0.5 points for each of the following: diet, appetite, weight loss, sleep, energy, exercise <input type="checkbox"/> 0.5 points for each of the following systemic symptoms: fevers, chills, night sweats, rash <input type="checkbox"/> Travel <input type="checkbox"/> Recent trauma <input type="checkbox"/> Recent illness	/5
Past medical history	<input type="checkbox"/> Past medical/surgical history <input type="checkbox"/> Screen for relevant conditions/risk factors (e.g., diabetes, hypertension, hypothyroidism, cholesterol, depression, spinal injury, Peyronie's, gynaecomastia etc.)	/2
Medications history	<input type="checkbox"/> Asks over the counter, prescription, and herbal remedies <input type="checkbox"/> Allergies <input type="checkbox"/> Immunisations	/4
Social history	<input type="checkbox"/> Occupation <input type="checkbox"/> Living situation <input type="checkbox"/> Asks all of smoking, alcohol and recreational drugs	/3
Family history	<input type="checkbox"/> Asks relevant family history	/1
Systems review	<input type="checkbox"/> GIT: Nausea and Vomiting, Constipation, Bloating, Blood in Stools, Diarrhoea <input type="checkbox"/> Cardioresp: Palpitations, SOB, Chest pain, Syncope	/4
Questions	<input type="checkbox"/> Differentials – 2 of: Acute pancreatitis, Cholecystitis, Choledocholithiasis, AAA, MI, Ectopic Pregnancy <input type="checkbox"/> Investigations – 3 of: <ul style="list-style-type: none"> • Bedside: ECG, Urinalysis and B-HCG • Bloods: FBC, U&Es, LFTs, CRP, ABG, Amylase • Imaging: Abdo US, Abdo CT 	/5
Communication skills	<input type="checkbox"/> Appropriate questioning style <input type="checkbox"/> Actively listens to patient <input type="checkbox"/> Systematic approach to history taking <input type="checkbox"/> Appropriate conclusion and summary	/4
Global score	Overall impression of candidate based on warmth, clarity and competence: 1 = fail 2 = borderline 3 = pass/expected	/5

	4 = good 5 = excellent	
	Total	/45