# MSSBU OSCE PRACTICE CASE 4_02_06

## ***Station Vignette***

You are the doctor working at the local general practice.

Samina Khan, a 56-year-old woman, has presented with urinary incontinence.

Samina has no past medical or surgical history.

**VITALS:**

- **HR:** 62 bpm
- **BP:** 103/78 mmHg
- **RR:** 16
- **$O_2$ sats:** 99% RA
- **Temp:** 37.3°C

**TASK**

You have a total of **6 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 **2 minutes** to perform a SBAR.

Do **NOT** perform a physical examination.

# ***PATIENT INFORMATION***

You are Samina Khan, a 56-year-old woman who has presented to the local general practice. You are having "embarrassing" issues with urinary incontinence.

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| **PC** | • "Urine leaking" |
| **HOPC** | • Started 10 months ago<br>• Has been progressively worsening with more urine leakage throughout the past few months<br>• Triggers- when exercising (does walks), lifting heavy objects, sneezing and coughing<br>• Uses 3x pads/day<br>• Usually voids 6-7x/day<br>• No previous episodes<br>• Drinks about 2 bottles of water/day<br>• Does not drink alcohol<br>• Drinks 2x cups of black tea/day |
| **Systems review** | • **Urinary:**<br>  ○ LUTS (lower urinary tract symptoms):<br>  ▪ No frequency or urgency<br>  ▪ Nocturia 1x/night<br>  ▪ No stream changes/straining, hesitancy, intermittency, incomplete emptying, or post-void dribbling<br>  ○ No UTI Sx - no dysuria or haematuria<br>• **GIT:**<br>  ○ No constipation or diarrhea<br>  ○ No fecal incontinence<br>  ○ No abdominal/pelvic pain<br>  ○ No N&V<br>• **Obstetrics:**<br>  ○ Has had 5 pregnancies before - all vaginal deliveries (last baby delivered when she was 45)<br>  ○ No C-sections<br>  ○ No miscarriages or terminations<br>  ○ No incontinence post-partum<br>• **Gynae:**<br>  ○ No prolapse Sx - no dragging/pressure/heavy sensations in groin<br>  ○ Hasn't had period since she was 54 years old<br>  ○ Did not take HRT<br>  ○ Had previous regular periods<br>  ○ No PV bleeding<br>  ○ No abnormal vaginal discharge<br>  ○ Sexually active; married to husband; some superficial dyspareunia since finishing menopause<br>  ○ No genital rashes/itching<br>  ○ Last pap smear was last year- normal results |
| **Constitutional Hx** | • No fevers, sweats or chills<br>• No weight loss<br>• No rashes<br>• Healthy diet<br>• Good energy + exercise levels |
| **PMHx** | • None |
| **PSHx** | • None |

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| **Medications** | • None |
| **Allergies** | • None |
| **FHx** | • Grandmother- MS (multiple sclerosis) |
| **SHx** | • Non-smoker<br>• Doesn't drink alcohol<br>• No recreational drug use<br>• Does not work<br>• Lives with husband and four children |
| **Ideas, concerns and/or expectations** | *Respond only if asked:*<br>• "This is a very bad problem… I can't even go on my walks without thinking of wetting myself." |

## ***EXAMINER QUESTIONS***

1. Present a **SBAR** summary of the case

**MARKING CRITERIA –** Case 4_02_06

| Item | Criteria | Mark |
|---|---|---|
| Introduction | ☐ Hand hygiene<br>☐ Appropriate introduction | /2 |
| Presenting complaint | ☐ Leads with open question<br>☐ Follows with another open question | /2 |
| History of presenting complaint | ☐ Determines onset and progression<br>☐ Triggers<br>☐ Assesses frequency of urinary incontinence<br>☐ Assesses quantity of urinary incontinence - uses 3x pads/day<br>☐ Fluid intake- includes water, alcohol, caffeine intake<br>☐ First or previous episode(s)<br>☐ Screens for any additional concerns/patient worry | /7 |
| Systems review | ☐ Urinary:<br>o Must assess for LUTS (lower urinary tract Sx):<br>▪ Storage LUTS- **FUN** (**F**requency, **U**rgency, **N**octuria)<br>▪ Obstructive LUTS- **SHED** (**S**tream changes/intermittency/straining, **H**esistancy, incomplete bladder **E**mptying, post-void **D**ribbling)<br>o Must assess for UTI Sx- dysuria, haematuria<br>☐ GIT- screening questions including constipation and fecal incontinence<br>☐ Obstetrics:<br>o Must establish gravida and parity<br>o Must establish if all vaginal deliveries<br>☐ Gynae:<br>o Must assess for prolapse Sx- e.g. dragging/pressure/heavy sensations in groin or obvious mass from vagina<br>o Must establish if postmenopausal | /4 |
| Constitutional history | ☐ 0.5 points for each of the following: diet, appetite, weight loss, sleep, energy, exercise<br>☐ 0.5 points for each of the following systemic symptoms: fevers, chills, night sweats, rash | /5 |
| Medications history | ☐ Asks over the counter, prescription, and herbal remedies<br>☐ Allergies<br>☐ Immunisations | /3 |
| Social history | ☐ Occupation<br>☐ Living situation<br>☐ Asks all of smoking, alcohol and recreational drugs | /3 |
| Family history | ☐ Asks relevant family history | /1 |
| Questions | SBAR (the following is a guide for marking):<br>☐ 1 point - Appropriate Situation<br>☐ 0.5 points- mentions age + sex<br>☐ 0.5 points- mentions gravida + parity status (G5P0)<br>☐ 1 point - Appropriate Background e.g. multiparity and post-menopausal<br>☐ 1 point - Appropriate Assessment | /7 |

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| | ▢ 0.5 points - must name provisional diagnosis of stress incontinence<br>▢ 0.5 points - mentions at least one other DDx- urge incontinence, overflow incontinence, pelvic organ prolapse, UTI, urogenital fistula, atrophic urethritis/vaginitis<br>▢ 1 point - Appropriate Recommendation<br>▢ 0.5 points - appropriate physical examination including abdominal, pelvic and speculum examination<br>▢ 0.5 points - appropriate Ix- urine dipstick, urine mcs, FBC, UECs<br>- No extra points for Mx of stress incontinence but Mx may include reducing caffeine intake, adequate fluid hydration, pelvic floor physio (least 3 months), topical vaginal estrogen (e.g. Ovestin or Vagifem), urogynae referral | |
| Communication skills | ▢ Appropriate questioning style<br>▢ Actively listens to patient<br>▢ Systematic approach to history taking<br>▢ Appropriate conclusion and summary | /4 |
| Global score | Overall impression of candidate based on warmth, clarity and competence:<br>1 = fail<br>2 = borderline<br>3 = pass/expected<br>4 = good<br>5 = excellent | /5 |
| | **Total** | /44 |