MSSBU OSCE PRACTICE CASE 3_03_02

Station Vignette

You are a third-year student at a GP practice.

The GP has asked you to take a brief history from Jeremiah/Jemimah Thompson, a 23-year-old regarding their child. James/Jamie Thompson, a 12-month-old has presented with a seizure.

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 allocated time, you will have **1 minutes** to answer the examiner's questions.

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

PATIENT INSTRUCTIONS

History of presenting complaint (/3)
Onset: 3 hours ago
Character: bilateral synchronised twitching noted in both arms and legs. Unresponsive over duration of seizure.
Associated symptoms: (see below)
Time course/duration: 3-4 minutes
Exacerbating/relieving factors: nil
Beliefs: Could they have epilepsy?
Impact on patient: Drowsy for half an hour after seizure but regained normal alertness after
Concerns: Any brain damage after the seizure?
Previous episodes: Nil

Systems review/associated symptoms (at least 2 per differential = 1 mark)
*The symptoms **BOLDED** are indicative of positive answers, other answers are suggestions of what is required in terms of questioning to ensure a comprehensive history.*

Febrile convulsions
- **Concurrent URTI symptoms inclusive of runny nose, dry cough with COVID PCR negative**
- Sick contacts from brother with similar symptoms
- **Fever of 38.5 degrees Celsius.** Felt a little warm this morning but didn't recheck temperature again.
    - Paracetamol and ibuprofen relieved symptoms
- No recent travel

Meningitis/Encephalitis
- No obvious photophobia
- No non-blanching rash
- Nil headache
- Nil nuchal rigidity
- Nil irritability
- Nil reduced LOC after the incident

Epilepsy e.g. West syndrome, Lennox-Gastaut Syndrome
- No abnormal behaviours or past history of seizures
- Development involved no delays
- No family history suggestive of epilepsy syndromes

Traumatic Brain Injury/Non-Accidental Injury
- RFs: Low SES, unemployed, single parent, substance abuse, stepchildren, disability, history of parental abuse
- Bruises around trunk, ears and neck

- Broken frenulum, cheek, retinal haemorrhages, cuts, bites, drowsiness due to subdural haematoma, fractures

Paediatric history (5 marks)

BINDS

Birth history: born at term, spontaneous vaginal delivery, 40 weeks. No problems noted following birth or in the antenatal period.
Immunisations: Up to date
Nutrition: switched to solid foods 3 months ago from breastfeeding. Mashed and soft foods are taken with no assistance required. Weight, height and head circumference are tracking along the same percentile.
Developmental milestones: normal, can stand, drinks from a cup and eats from a spoon
Social history: second born, older brother is 5 years old, lives with father and mother

Past medical history (2 marks)

No previous surgeries
No current or previous medical conditions

Medications (2 marks if general but 1 if asks individual categories)

Prescription: none
Recreational: none
Over the counter: Paracetamol and ibuprofen for fever
Vitamins/supplements: none

Allergies (1 mark)

No known allergies

Family history (1 mark)

Mother: nil
Father: nil
Siblings: brother has asthma, salbutamol provided prn

EXAMINER QUESTIONS

1. What is the **most likely** diagnosis?

2. What **age group** is typically affected?

3. What are the **categorisations** of febrile seizures?

Extra question

4. What are some of the differences between simple and complex febrile seizures? (3 marks; 1 for each difference)

MARKING CRITERIA – Case 3_03_02

Item	Criteria	Mark
Introduction	☐ Hand hygiene ☐ Appropriate introduction ☐ Confirms patient name and age ☐ Explains personal role and gains consent	/2
Presenting complaint	☐ Leads with open question	/1
History of presenting complaint	☐ Site ☐ Onset ☐ Character ☐ Associated symptoms ☐ Time course/duration ☐ Exacerbating/relieving factors ☐ Beliefs ☐ Impact on patient/concerns	/4 (0.5 for each)
Systems review	☐ At least 2 symptoms per differential = 1 mark, up to 4 differentials. See differential list and riskfactors in patient information.	/4
Paediatric history	☐ Birth – type and how many weeks, any complications, special care nursery ☐ Immunisations ☐ Nutrition – e.g. breastfeeding or formula, latching on, solids	/4
Constitutional history	☐ Weight changes ☐ Appetite ☐ Diet ☐ Exercise ☐ Energy levels ☐ Sleep ☐ Night sweats ☐ Chills ☐ Fever ☐ Rashes	/5 (0.5 points for each one)
Past medical history	☐ Past medical/surgical history ☐ Asks over the counter, prescription, and herbal remedies ☐ Allergies ☐ Immunisations	/4
Family history	☐ Asks relevant family history	/1
Social history	☐ Occupation ☐ Living situation ☐ Asks all of smoking, alcohol and recreational drug use	/3
Questions	☐ **Diagnosis** – febrile seizure ☐ **Age group -** 6 months – 5 years (some say 6 years) ☐ **Categorizations** - simple, complex, and afebrile ☐ **Simple vs. complex seizures** – see table below	/8
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	/45

Source: https://www.youtube.com/watch?v=_1VV7qRB-gY