



# MSSBU OSCE PRACTICE CASE 3\_02\_02

## Station Vignette

You are a third-year medical student at the ED.

The registrar has asked you to take a history from Thomas Bing, a 24-year-old man who has presented with her friend.

### **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:** Took some paracetamol tablets for a headache

### **Hx of Presenting Complaint:**

- About 6 hrs ago you ingested 30 paracetamol tablets, all at once with ½ a bottle of vodka. If asked about the tablet's strength, it is 500 mg and immediate release, you did not take any other medications with it.
- If asked why, say that you have been feeling depressed for the last 2 weeks, as you lost your close friend to suicide. You had been thinking about attempting for the last couple of days due to the insurmountable guilt you were feeling.
- This was your first attempt, and you haven't self-harmed before. Mention you are annoyed with your housemate because they found you. You cannot say for sure that you will not do this again. You haven't had any symptoms and you don't feel sick.

### **Associated Symptoms:**

- Nil nausea and vomiting
- Nil confusion
- Nil visual or auditory hallucinations

### **Constitutional Symptoms:**

- Weight: nil changes
- Fever, chills, night sweats: nil
- Diet: vegan
- Appetite: decreased today
- Sleep: nil affected, 7hrs a day

### **Past Medical and Surgical Hx:**

- **Medical Conditions:** Nil
- **Surgeries:** Nil
- **Medications:**
  - COCP
  - OTC: paracetamol for headaches
- **Allergies:** Nil food or drug

### **Social Hx:**

- Lives with flat mate
- Full-time university student
- Non-smoker
- Alcohol: 2 bottles of vodka every weekend but not during the week
- Recreational drugs: weed once a fortnight

**Family Hx:**

- Mother has **depression**
- No other relevant family history

**EXAMINER QUESTIONS**

1. Please provide **two (2)** appropriate investigations.
2. Describe how you would **manage** this patient.

## MARKING CRITERIA – Case 3\_02\_02

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"/> Asks when and where the patient took the medication <input type="checkbox"/> Asks what medication the patient took and how <input type="checkbox"/> Clarifies how much of the medication the patient took <input type="checkbox"/> Asks if the patient co-ingested any other substances at the time <input type="checkbox"/> Asks what the patient did after taking the medication <input type="checkbox"/> Asks how the patient got to hospital <input type="checkbox"/> Clarifies ongoing suicidal intent (what was the purpose of the overdose) <input type="checkbox"/> Asks if the patient has ever self-harmed or attempted suicide in the past <input type="checkbox"/> Asks if the patient has any psychiatric diagnoses or if they have ever been admitted to a psychiatric hospital	/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., psychiatric conditions)	/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"/> Cardioresp: Palpitations, Pre-syncope and Syncope <input type="checkbox"/> Neuro: Confusion, Headache, Hallucinations <input type="checkbox"/> GIT: Nausea, Vomiting, Abdominal pain	/3
Questions	<input type="checkbox"/> <b>Investigations</b> – 2 of: ECG, FBC, Serum Paracetamol Level, UEC <input type="checkbox"/> <b>Management</b> – 0.5 for each of: Discuss with senior doctor, NAC infusion, IV fluids, organise visit with mental health team	/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:	/5

	1 = fail 2 = borderline 3 = pass/expected 4 = good 5 = excellent	
	<b>Total</b>	<b>/44</b>