GK'S NOTES 2.0

JUNE 2025 EDITION

VOLUME – 2

GK's Notes 2.0 – Volume 2
June 2025 Edition

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Guideline references are based on public domain standards such as NICE, NHS CKS, and GMC Good Medical Practice. Every effort has been made to ensure the accuracy of information at the time of writing. Users are encouraged to consult official NHS and NICE guidelines regularly, as clinical recommendations may evolve over time.

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For updates, revision tools, and additional resources, visit:
www.gksplab2.com

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All cases in this book are entirely original and have been created for teaching purposes. They are:

- Based on common UK clinical practice scenarios
- Informed by recurring themes and trends described by candidates
- Fully aligned with NHS, NICE, and GMC guidance
- Written using original phrasing, with no reproduction of official exam content

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This resource does not claim to predict, replicate, or substitute for the real PLAB 2 exam. It is intended to help candidates build confidence in consultation structure, communication skills, clinical reasoning, and management planning in a UK healthcare context.

Unlock the Full GK's PLAB 2 Toolkit – Beyond the Book. Made to Pass.

GK's Notes 2.0 isn't just a book. It's the core of a smarter, leaner, and fully structured exam prep system—designed to help you pass PLAB 2 without wasting months or thousands on academies, travel and stay.

If you were led to believe that the only way to pass this exam is by relocating to the UK for expensive courses and group practice, you've been misled.

You don't need to memorise lectures or scripts.
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What's Included:

- **Flashcard Set**
  → Quick-reference cards **for every core case**
  → Covers: Management, DVLA advice, and Referral criteria
  → Aligned with GK's Notes 2.0 and based on NICE/NHS CKS guidance

- **One-Page Revision Sheets**
  → Covers **all major PLAB 2 case types**
  → Each includes:
    - Top differential diagnoses
    - Key red flag symptoms
    - Natural lay explanations
    - Stepwise management
    - Safety netting guidance

- **Case Hotlist**
  → A prioritised list of commonly reported station themes and **AI-generated predictions**
  → Created using general trends and recurring clinical topics reported by candidates

- **Mock Exam Generator**
  → Randomised mock station lists **simulating full exam rounds** (16 stations)
  → Structured for solo or paired practice
  → Balances systems, consultation types, and case difficulty

Ideal for final-month revision, crash review sessions, and structured mock simulations.

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Build exam-ready confidence with structured, simulation-based tools.

What's Included:

- **Audio Case Library**
  → Realistic 7–8 minute consultations voiced in natural tone
  → Covers common case categories: SimMan, angry patients, psychiatry, ethics, and more
  → Ideal for passive revision or active speaking drills

- **Exam-Style Question Bank**
  → Structured clinical and scenario-based questions
  → Includes prompts based on patient presentations, concerns, and management decisions

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  → Patient-side dialogue scripts to use with peers
  → Includes emotional cues and realistic responses to help simulate live stations

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  → Day-by-day structured prep plan
  → Balances systems, case types, repeat exposure, and speaking drills
  → Designed for solo or partner-based practice

- **Study Group Access & Partner Matching**
  → Join curated practice groups with others preparing for the same exam window
  → Gain access to peer mocks, speaking drills, and community-based accountability

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BONUS: Weekly Live Recall Webinars

Join regular, structured breakdowns of real-world case patterns, updates on recurring themes, and strategy sessions—open to all premium users.

**These sessions are for educational discussion only and do not reproduce or distribute confidential exam material.*

What Makes This Different?

- Every tool aligns directly with GK's Notes 2.0
- No duplication, no confusion—just clarity
- Practice what you revise, revise what you practise

All of these and more are coming your way very soon.
To access the packs or ask questions, contact me directly.

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Welcome to Volume 2 of GK's Notes 2.0!

This volume picks up where Volume 1 left off—and takes you deeper into some of the most essential (and often most misunderstood) areas of PLAB 2:
Eye, ENT, Dermatology, Paediatrics, Women's Health, and Psychiatry.

These systems require more than just medical knowledge—they demand **clarity, empathy, sensitivity, and structure**. The notes in this volume are designed to help you navigate these high-yield stations with confidence and calm, whether it's counselling a worried parent, explaining a rash, or managing a safeguarding concern. Before you dive in, here are a few pointers to help you get the most out of this book:

Don't Memorise – Understand

These notes are here to train your structure, reasoning, and natural phrasing. You're not expected to memorise every line. Instead, focus on why each question or explanation matters—and how you can apply it in real conversations.

Use the Notes with Active Practice

Don't passively read. Speak aloud. Use a timer. Practice with a partner, record yourself, or use AI roleplays. The structure in each case mirrors exam conditions—use it to simulate the real thing.

Refer Back When in Doubt

Every case includes diagnostic clues and NICE/NHS-aligned plans. When a topic feels unclear—revisit it. These notes are designed to support, not overwhelm you.

Use Explanations to Build Clinical Confidence

The lay explanations aren't exam tricks—they're patient-friendly, safety-focused habits of good doctors. Use them to sharpen your language and build your ability to explain, not just recite.

Link Across Volumes

If you need a refresher on consultation structure, ICE, or key examination phrases—jump back to Volume 1. These books are built to work together, and each volume strengthens the other.

Stay Updated & Stay in Touch

Clinical guidance evolves. If you notice anything that feels out of date—or unclear—please reach out. I'd be grateful for your feedback, and always aim to keep these notes exam-relevant and accurate.

This isn't about chasing perfect phrasing.
It's about **thinking clearly, speaking naturally, and managing stations like a real doctor would.**
Let's keep going—one case at a time.

You've got this.
– GK

Staying Up to Date – New Cases & Evolving Stations

PLAB 2 is constantly evolving. While many core stations are repeated frequently, new scenarios continue to appear, and familiar ones are often presented with different angles, emotional tones, or ethical twists.
To reflect this, GK's Notes 2.0 is not a static book—it's a living resource.

- The notes will be updated multiple times each year, incorporating new recalls, evolving phrasing trends, and structural refinements.
- Make sure you're always using the latest version to stay aligned with current exam patterns.
- Join the weekly live webinars where new or modified cases are broken down, explained, and discussed in real time.

PLAB 2 isn't just about having the right notes—it's about staying current, adapting, and practising with the most relevant material available.
To receive updates and webinar links, stay connected through the main study group or contact me directly.

A Note on Accuracy and Errors

This book is the result of a lot of time, care, and effort—put together by one person, with the goal of helping as many PLAB 2 candidates as possible. Every case has been written with maximum attention to accuracy, clinical alignment, and the most up-to-date guidance available at the time of writing.
That said, medicine evolves. Guidelines change. And despite best efforts, mistakes can slip through.
If you ever come across something that seems unclear, outdated, or incorrect—please don't hesitate to double-check it yourself using trusted sources like NICE or NHS CKS. These should always guide your clinical reasoning and management.

And if you do spot an error, I'd be genuinely grateful if you message me directly with the details. I'll make sure it's reviewed and corrected in the next version. Your feedback not only improves the book—it helps everyone who uses it.

Thank you for helping make this resource better for the whole community.

IMPORTANT!!!

These notes are meant to guide your understanding,

NOT TO BE MEMORISED.

Learn the presentation, consultation structure, and management thoroughly.

In the exam, you must adapt naturally — NOT RECITE A SCRIPT.

Chapter 12: Ear, Nose and Throat

Structure for Ear-Related Presentations

Covers: Pain, Deafness, Dizziness, Tinnitus, Discharge, Infection, TM perforation, BPPV, Meniere's, Vestibular Neuritis

Introduction

"Hi, my name is Dr. [Name], one of the junior doctors here today. Can I confirm your full name and age, please?"
"Thank you. How would you prefer me to address you?"
"Nice to meet you, [Name]. What's brought you in today?"

Presenting Complaint (Clarify Terminology)

Never assume "ear pain", "dizziness", or "hearing issues" mean the same to everyone.
If dizziness:
"Just to understand better—when you say dizzy, do you mean:
the room spinning (vertigo)?
feeling faint or blacking out?
a sensation that you yourself are spinning?"
If hearing loss:
"Is it blocked, reduced, or completely gone?"
"Has it come on suddenly or gradually?"

If pain:
Use **SOCRATES**
Site: One ear or both?
Onset: Sudden or gradual?
Character: Sharp, dull, throbbing?
Radiation: Does it go anywhere?
Associated: Fever, discharge, balance issues?
Timing: Constant or intermittent?
Exacerbating: Cold, water, movement?
Severity: 1–10 scale

DOOPARA Symptom History

D – Duration
"When did this start?"
"Has it been constant or does it come and go?"
O – Onset
"Did it start suddenly or gradually?"
O – Other symptoms
"Any fever, discharge, blocked sensation, or nausea?"
P – Progression
"Getting better, worse, or staying the same?"

A – Aggravating factors

"Does anything bring it on or make it worse?"

"Does turning your head or lying down worsen it?" (BPPV)

"Does water, cold air, or loud sounds make it worse?"

R – Relieving factors

"Anything that makes it better?"

Rest, lying still, avoiding noise, medication

A – Associated symptoms

"Any nausea, headaches, facial weakness, or unsteadiness?"

"Any changes in hearing, ringing, or pressure sensation?"

Focused ENT Symptom Screen (DVTF)

Ask all four:

"Have you noticed any of the following in your ears:

Deafness or hearing changes?

Vertigo – a spinning feeling?

Tinnitus – ringing or buzzing sounds?

A feeling of pressure or fullness?"

Explore Red Flags & Associated Clues

"Any fever or recent infections like cold or flu?"

"Any ear discharge? What did it look like—clear, yellow, or bloody?"

"Any trauma to the ear or recent air travel/swimming?"

"Any pain behind the ear or swelling?"

"Any facial drooping, weakness, or trouble with speech?"

"Have you ever had similar problems in the past?"

"Any vision changes or headaches?"

PMAFTOSA Screening

Past medical conditions – recurrent infections, eczema, diabetes, immunosuppression

Medications – ototoxic drugs (aminoglycosides, loop diuretics)

Allergies – especially to ear drops

Family history – hearing problems, Meniere's

Tobacco – smoking (risk for infections and malignancy)

Occupation – noisy environments, water exposure, scaffolder

Social – alcohol, swimming, earphone habits, hygiene

Alcohol – falls or risky behaviours

ICE (Ideas, Concerns, Expectations)

"What do you think might be going on?"

"Is there anything specific you're worried about?"

"What were you hoping I could do for you today?"

Differentials with Quick Clues

Likely Diagnosis	*Clues*
Wax impaction	Sudden muffled hearing, no pain, worse after water exposure
Otitis externa	Pain on pinna/tragus movement, discharge, itching, swimming history
Otitis media	Children, fever, bulging red TM, tugging ear, crying
TM perforation	Sudden pain relief + watery/bloody discharge, trauma, pressure
BPPV	Short-lasting vertigo with positional change
Meniere's disease	Vertigo + tinnitus + hearing loss (episodic, <24h)
Vestibular neuritis	Vertigo for days post-viral, unidirectional nystagmus
Acoustic neuroma	Progressive unilateral hearing loss + tinnitus
Stroke/TIA	Dizziness + neuro signs (weakness, diplopia, speech issues)

Examination – ENT and Neurology

Pre-exam Consent and Setup

"Thank you for answering my questions. I'd now like to examine your ears and assess your hearing to help find the cause of your symptoms. This won't be painful, but may be a little uncomfortable. You'll remain seated. A chaperone will be present, and I'll ensure your privacy.
Is that okay with you?"

1. General Observations

Look for fever, facial asymmetry, distress, walking instability

2. Inspection of the Ears

Look for:

- Redness or swelling
- Discharge
- Deformity or scars
- Skin rashes or eczema
- Behind the ear for mastoid swelling

3. Palpation

"Let me know if anything is tender."

Tragus: pain = otitis externa
Pinna movement: pain = otitis externa
Mastoid: pain/swelling = mastoiditis
Compare warmth to cheek

4. Otoscopy (Perform if safe)

"I'll now gently look inside your ear using a small lighted scope."

Use **right hand for right ear, left hand for left ear**
Stabilize 2 fingers on cheek
Pull pinna up and back
Look at:

External canal (wax, discharge, swelling)

Tympanic membrane (colour, perforation, cone of light)

Normal: pearly grey TM with cone of light

Avoid if tragus/pinna is tender.

5. Tuning Fork Tests (Rinne + Weber)

Only if hearing loss reported.

Rinne Test

"I'll place a vibrating fork behind your ear—let me know when you can't hear it anymore. Then I'll move it in front of your ear—tell me if you still hear it."

Normal / SNHL: Air > Bone

CHL: Bone > Air

Weber Test

"I'll place this on your forehead—tell me if you hear it in the middle or more on one side."

CHL: Sound localizes to affected ear

SNHL: Sound localizes to good ear

6. Balance and Cranial Nerve Testing (if vertigo/imbalance)

Gait observation

Romberg's test

HINTS exam (Head-Impulse, Nystagmus, Test of Skew)

CN exam (especially 7 and 8)

Dix-Hallpike if BPPV suspected

Diagnosis & Management

Always tailor based on likely cause.

Example Managements:

Condition	*FY2 Plan*
Wax impaction	Olive oil drops 3–5 days → ENT if not resolved
Otitis externa	Topical ciprofloxacin/steroid drops; keep ear dry
Otitis media	Mild = safety net; systemic = amoxicillin 5 days
TM perforation	ENT referral; no drops unless instructed; keep dry
BPPV	Epley manoeuvre; avoid driving until resolved
Vestibular neuritis	Prochlorperazine short course; safety net for neuro signs
Meniere's disease	ENT referral; lifestyle advice; betahistine if recurrent
Acoustic neuroma	ENT & MRI referral

Safety Netting

"If you notice worsening symptoms, sudden hearing loss, high fever, or trouble with your balance or walking—please come back immediately or seek urgent care."

Follow-Up and Leaflet

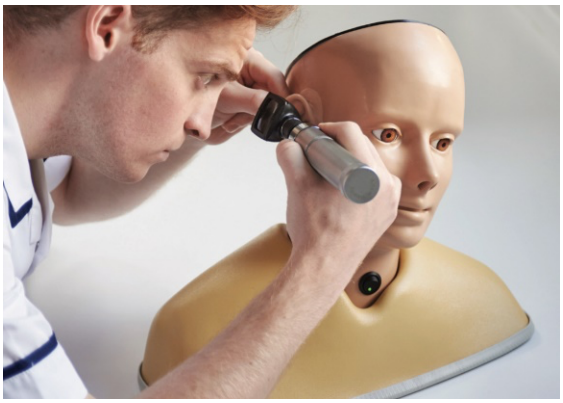
ENT referral if symptoms persist

GP review if trial of treatment

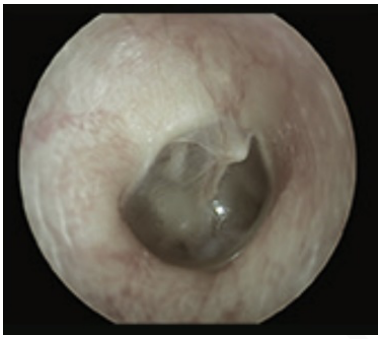
Leaflet for self-care and wax management if relevant

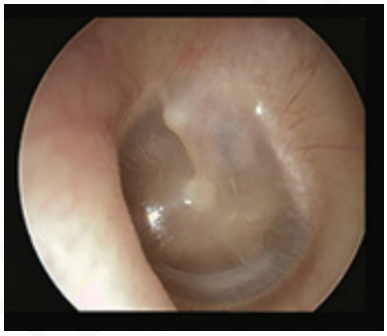
"Would it help if I shared a leaflet on how to manage this at home?"

Otoscope findings

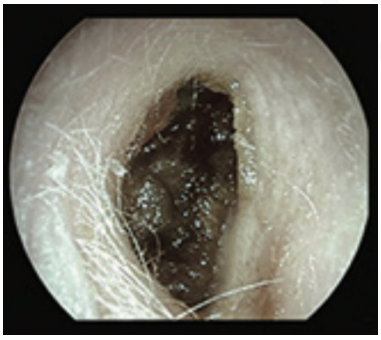


Normal

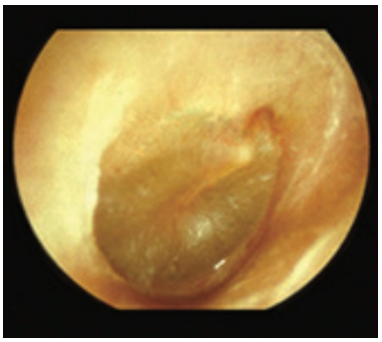


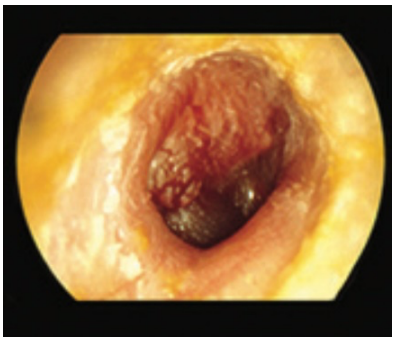


Ear Wax

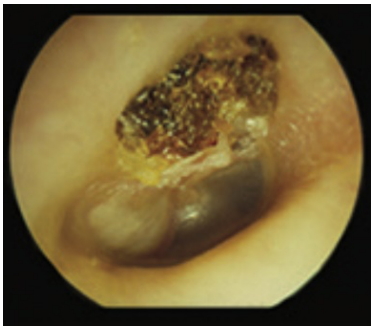


AOM





Cholesteatoma



Acute Otitis Media (AOM)

Scenarios Covered:

- Adult or child with ear pain (1-day, 5-day)
- Otorrhoea
- Perforation
- Penicillin allergy
- ENT referral

Introduction

"Hi, I'm Dr. [Name], one of the junior doctors here today. Can I confirm your full name and age?"
"Thank you. How would you like me to address you?"
"Nice to meet you, [Name]. What's brought you in today?"

Presenting Complaint – Clarify the Symptom

Use **SOCRATES** when the complaint is clearly pain.
If the patient says "discomfort" or "blocked," then use DOOPARA.
"Just to clarify—when you say you've got ear pain, do you mean it's a throbbing or sharp type of pain?"
Then explore with:

- **Site** – Is it one ear or both?
- **Onset** – Did it come on suddenly or gradually?
- **Character** – Throbbing, dull, stabbing?
- **Radiation** – Does the pain spread to the jaw or neck?

Associated – Fever, hearing loss, discharge, sore throat, cold?
Timing – Constant or comes and goes?
Exacerbating – Worse at night? When lying down?
Severity – On a scale of 1 to 10, how bad is it?

In paediatric cases, explore parent observations instead of symptom descriptors: "Have they been pulling at the ear? Trouble sleeping? Crying more than usual?"

DVTF Symptom Screen

"Along with the pain, have you noticed any of the following?"

Deafness or hearing changes?
Vertigo or spinning feeling?
Tinnitus – buzzing or ringing sounds?
Feeling of pressure or fullness?

Differentials

Condition	*Key Clues*
Acute Otitis Media	Ear pain, fever, history of flu/cold, red or bulging tympanic membrane
Otitis Externa	Pain on tragus/pinna movement, itchy ear, recent water exposure
TM Perforation	Pain followed by sudden relief, discharge, visible perforation
Wax impaction	Hearing loss, blocked feeling, worse after bathing
Tonsillitis (referred)	Sore throat, no ear signs on exam, pain radiates to ear
Mastoiditis	Pain behind ear, swelling over mastoid, fever

Red Flags & Escalation Criteria

Otorrhoea (discharge) → Requires antibiotics
Visible TM perforation → ENT same-day referral
Severe ear pain + mastoid tenderness → Mastoiditis → urgent ENT
Facial drooping or cranial nerve signs → possible complication
Children:
- Age <3 months → refer to hospital
- Age <2 years + bilateral AOM → consider admission
- Comorbidities (e.g., CP, immunocompromised) → consider referral

PMAFTO-SA

Past Medical History – recurrent AOM, eczema, immunosuppression
Medications – already tried paracetamol/ibuprofen? Allergy to penicillin?
Allergies – check for drug allergies (especially to penicillin)
Family history – hearing problems, glue ear
Tobacco – passive smoke exposure in children
Occupation – cold exposure, headphone use

Social – childcare exposure, swimming, hygiene, impact on sleep
Alcohol – balance issues, adult risk behaviour

ICE

Ideas: "Do you have any thoughts on what's causing this?"
Concerns: "Are you worried this might be serious or affect hearing?"
Expectations: "Were you hoping for any specific treatment today?"

Examination
Consent
"I'd now like to examine your ear. It won't be painful, but may feel a bit uncomfortable. I'll ensure your privacy and have a chaperone present. Is that okay?"

1. General Observation

Fever, signs of distress or crying child
Ear tugging (child), facial drooping (adult), hearing difficulty

2. Inspection

Ear redness/swelling
Otorrhoea (discharge)
Post-auricular swelling (mastoiditis)
Skin issues (eczema)

3. Palpation

"Let me know if this feels tender."

Tragus
Pinna
Mastoid area

If tragus or pinna is tender → likely otitis externa

4. Otoscopy

"I'm going to gently look inside your ear with a small lighted scope."

Right hand for right ear, left for left
Pull ear up and back
Look for:

Redness, bulging, or dull TM
Fluid level or bubbles
Perforation or discharge
Cone of light (lost or distorted)

5. Tuning Fork Tests (if hearing loss)

Rinne Test: Bone vs air
Weber Test: Localisation

Management Plan

In Adults:

1–4 days of mild pain, no discharge → *No antibiotics*

Paracetamol + ibuprofen

Explain viral causes

5 or more days of symptoms → *Give antibiotics*

Amoxicillin 500 mg TDS, 5 days

If allergic → Clarithromycin 500 mg BD, 5 days

In Children:

<3 days of pain, no discharge → *No antibiotics*

Paracetamol every 4 hrs (max 4x/day)

Reassurance: viral, self-limiting

Otorrhoea present at any point → *Give antibiotics*

TM perforation → ENT referral

Still unwell after 3 days → Start antibiotics

Meets red flag criteria (e.g., under 3 months, bilateral AOM <2 yrs) → Refer to paediatrics

Referral to ENT (if TM perforation or persistent discharge): They may clean the ear, prescribe ear drops, take a swab, and consider surgery like tympanoplasty if needed.

How to Explain to Parents (Paediatric Case)

"Most ear infections in children are caused by viruses. Antibiotics won't help those and may cause side effects. But if your child doesn't improve in 3 days, or develops discharge, we may need to start antibiotics. Continue giving regular paracetamol for pain. It might get worse before it gets better — that's expected."

Safety Netting

"Please come back if:

Pain or fever worsen

Discharge starts or increases

Hearing worsens

Your child becomes unusually drowsy, develops balance problems, or you notice any swelling behind the ear."

Follow-Up & Leaflet

GP review in 2–3 days if no improvement

Leaflet on AOM (explanation + pain management)

Impacted Ear Wax

Covers: Adult patient with hearing loss due to cerumen impaction, cotton bud use, swimmer, requests irrigation

Introduction

"Hi, I'm Dr. [Name], one of the junior doctors here today. Can I confirm your full name and age please?"

"Thank you. And how would you prefer me to address you?"

"Lovely to meet you, [Name]. I understand you've come in today because you've been having some trouble with your hearing in your [left/right] ear. Is that right?"

Presenting Complaint Clarification

"Could you tell me a bit more about the hearing problem?"

When did it start?

Is it constant or does it come and go?

Has it been getting worse or staying the same?

Do you notice anything that makes it better or worse?"

Detailed History – DOOPARA + ENT Symptom Screen

D – Duration

"When did you first notice the hearing issue?"

O – Onset

"Did it start suddenly or gradually?"

O – Other symptoms

"Any pain or discomfort in the ear?"

"Any itching or irritation?"

"Any fluid or discharge coming out?"

"Any ringing or buzzing sound (tinnitus)?"

"Do you feel a sense of pressure or fullness in the ear?"

"Any dizziness or balance problems?"

P – Progression

"Has your hearing changed over time or stayed the same?"

A – Aggravating factors

"Does anything make the hearing worse?"

(e.g., after showers, headphones, swimming)

R – Relieving factors

"Anything that improves it—moving your jaw, lying down?"

A – Associated symptoms

Cold symptoms, sore throat, history of eczema/skin problems

Recent water exposure, trauma, or noise exposure

Risk Factor Screening

"Do you use cotton buds to clean your ears?"

"Do you regularly use headphones, earbuds, or hearing aids?"

"Do you swim often?"

"Have you had earwax problems before or ever had your ears cleaned out?"

PMAFTO-SA, Impact, ICE

Past Medical History – eczema, skin conditions, diabetes

Medications – especially topical drops or steroid creams

Allergies – to olive oil or drops

Family History – hearing loss

Tobacco/Alcohol – general screen

Occupation – exposure to noise or headset use

Psychosocial – "Has this been affecting your work, conversations, or daily life?"

ICE

"What are your thoughts about what might be going on?"

"Is there anything specific you're worried about?"

"Were you hoping for any particular treatment today—like ear syringing?"

Examination

"Thanks for sharing that. I'd now like to examine your ears to check what might be causing the problem. This won't be painful, but might be a little uncomfortable. I'll ensure your privacy and have a chaperone present. Would that be okay?"

Use PPECC – Permission, Position, Exposure, Comfort, Chaperone

Otoscopy

Use correct technique:

Stabilize fingers

Pull ear up and back

Use correct side hand

Findings (as given by examiner): Impacted wax seen

Verbalise:

"I'd also like to quickly assess your hearing, and based on what I can see, there's a build-up of wax that's likely causing the problem."

Diagnosis and Lay Explanation

"So, based on everything you've told me and what I've seen on examination, it looks like you have a build-up of **ear wax** in your [left/right] ear.

Earwax is a natural substance that protects the ear canal. But in some people, especially those who use cotton buds, headphones, or swim often, it can build up and block the canal—leading to hearing loss or a blocked feeling."

Tailored Advice Based on Patient-Specific Triggers

If cotton buds used:

"While it may feel like you're cleaning the ear, cotton buds often push the wax deeper and make things worse."

If swimmer:

"Water can get trapped behind wax and cause it to swell, worsening the blockage."

Management Plan

Step 1 – Softening Drops

"We'll start with **ear drops** to soften the wax. You can use either:

Sodium bicarbonate 5% drops or

Olive or almond oil

Put 2–3 drops into the affected ear **3–4 times a day for 3–5 days**."

Anchor line: "The drops help loosen and soften the wax so it can come out naturally or be removed more easily later."

Step 2 – Avoid Inserting Anything

"Please don't use cotton buds or try to clean the ear yourself, as that can push the wax in deeper or cause injury."

Step 3 – If No Improvement

"If you don't notice improvement after 5–7 days, we can consider removing it using **ear irrigation** or **microsuction**, either at the surgery or with a specialist."

Step 4 – If Pain Present

"You can take simple pain relief like paracetamol or ibuprofen if the ear feels sore."

Strong Advice Against Harmful Methods

"Please don't use **ear candles**—they're not effective and can even burn the ear or cause further damage."

Safety Netting

"Please come back if:

The ear becomes painful

You develop fever or discharge

The itching gets worse

Your hearing doesn't improve after a week of drops"

Follow-Up & Leaflet

Follow up: GP or nurse review if no improvement in 5–7 days

ENT referral: Only if very hard wax or failed irrigation

Leaflet: Give ear wax management info

Common Patient Questions

"Why do I have wax build-up?"

"Everyone produces wax—it's protective. But some people's ears make more, or their canals are shaped in a way that makes it harder for wax to clear naturally."

"How can I prevent this in future?"

"Avoid putting anything in the ears. If you're prone to wax build-up, using olive oil drops once in a while might help keep things soft."

"Can I get it removed today?"

"We usually recommend softening the wax first—this reduces the risk of damaging the ear drum during irrigation. Once it's soft, removal is much safer and more effective."

Final Reassurance

"This is a very common and easily managed condition. We'll start with the drops, and I'm confident you'll feel the difference soon. If things don't improve, we'll see you again and take the next step."

Earwax Follow-Up with Ongoing Hearing Loss

Possible Outcomes:

Wax still impacted → Recommend private irrigation

Wax cleared, but hearing still reduced → Sudden SNHL → ENT/Audiology referral

Introduction & Consent

"Hi, I'm Dr. [Your Name], one of the junior doctors here today. Can I confirm your full name and age?"
"Thank you. And how would you prefer me to address you?"
"I understand you're here for a follow-up after your last visit for a blocked ear. Would it be okay if we go through how things have been since your last appointment and then examine the ear again?"
Speak slightly louder, clearly, and face the patient—especially if they appear hard of hearing.

Focused History & Context

"Could you tell me when you first noticed the problem with your hearing?"
"When you came in last week, what symptoms were you having then?"
"Do you recall what the doctor explained to you at that time?"
"Were you prescribed any treatment or drops?"
"Have you been using the ear drops as advised?"
"Have you noticed any improvement at all in your hearing?"
"Do you still feel that blocked sensation?"
"Any new symptoms like pain, discharge, dizziness, or ringing since we last saw you?"
"Do you remember any particular trigger—like water entering the ear, recent travel, or loud noise exposure?"
Optional context: Patient swam in Spain and developed sudden ear blockage after.

Explore ICE

Ideas: "What do you think might be causing the hearing issue now?"

Concerns: "Are you worried it could be something more serious?"

Expectations: "Were you hoping it could be cleared or removed today?"

If patient requests irrigation today:
"I'll explain exactly what we can do next once we examine the ear."

Otoscopy & Hearing Assessment – Examination

"Thanks for sharing all that. I'd now like to re-examine your ear to check whether the wax has cleared and whether your eardrum is visible. Is that okay?"

Steps:

Use right hand for right ear, left for left

Stabilize with two fingers

Pull pinna upwards and backwards

Otoscope visualisation

"I'm also going to do a quick hearing test by speaking and assessing how well you can hear at different distances."
(Optional tuning fork tests if hearing deficit persists and you're asked to interpret)

Result Disclosure – Two Possible Outcomes

Outcome A: Wax Still Present

"I've had a look at your ear, and I can still see impacted wax in the canal, which is likely why your hearing hasn't improved."

"It looks like the drops have helped a little but haven't cleared the blockage completely."

Outcome B: Eardrum Now Visible, Wax Cleared

"I've had a good look inside the ear and I can now clearly see your eardrum, which means the wax has cleared. That's great."

"But since your hearing is still reduced, this suggests there may be a different cause that we need to investigate further."

Explanation

If Wax Still Present:

"Earwax is produced naturally to protect the canal, but sometimes it can build up and block sound. That's what's happened here."

"We usually start with softening drops, which you've already used. When that's not enough, the next step is **ear irrigation**—a flushing procedure to safely remove the wax."

"It's a very safe and common procedure, especially once the wax has already been softened."

If Wax Cleared but Hearing Still Reduced:

"Now that the wax has cleared and you're still having trouble hearing, we need to **take this seriously** and investigate further."

"One possibility is **sudden sensorineural hearing loss**, which happens due to inflammation or nerve involvement. This is often treated with steroids if caught early."

"Another less common cause is a **growth near the hearing nerve**, called an **acoustic neuroma**. These are usually non-cancerous, but need to be assessed."

Anchor line: "We never ignore unexplained sudden hearing loss. Acting quickly gives you the best chance of recovery."

Management Plan

If Wax Still Present:

- **Continue softening drops** until procedure
- **Refer to private ear care clinic** or a local service for irrigation
- **Advise** against cotton buds, ear candles, or self-cleaning
- **Offer leaflet** explaining how irrigation works
- **Only refer to ENT if**:
  - No improvement after irrigation
  - Severe symptoms, discharge, pain, or wax too hard to remove safely

If Wax Cleared but Hearing Loss Persists:

- **Urgent audiometry** (hearing test)
- **Same-day ENT referral** (if sudden sensorineural hearing loss suspected)
- **ENT may request MRI** to rule out acoustic neuroma

If SNHL diagnosed early → oral **steroids** may improve recovery
If acoustic neuroma found → ENT may suggest surgery or monitoring
Offer leaflet about sudden hearing loss
"If we act early, there's a high chance of partial or even full hearing recovery."

Safety Netting
"Please come back or go to A&E urgently if:
Your hearing suddenly worsens further
You notice pain, discharge, or fever
You experience dizziness or imbalance
You notice any facial weakness or numbness"

Follow-Up Plan
If wax: Patient to arrange irrigation. GP review in 1 week if unresolved
If SNHL suspected:
Treatment initiated based on ENT findings

Offer Leaflet & Final Check
"Would you like a leaflet that explains ear wax management or sudden hearing loss, depending on today's findings?"
"Is there anything you'd like me to go over again or any other concern I can help with today?"
End with:
"Thank you for coming in. You've done the right thing by following this up. Let's get you seen quickly so we can get your hearing back on track."

Acoustic Neuroma in a Young Patient

Scenario: 40–45-year-old working in a call centre, trouble hearing on the right side.

Introduction
"Hi, I'm Dr. [Name], one of the junior doctors here today. Can I confirm your full name and age?"
"Thanks. And how would you prefer I address you?"
"I understand you've come in with hearing trouble in your right ear. Would it be alright if I ask some questions to understand it better, and then examine your ears?"

Presenting Complaint – DOOPARA Structured (Unilateral Hearing Loss)
"Let me ask a few focused questions to understand your hearing concern better."
D – Duration
"When did you first notice the hearing loss?"
"Roughly how long has it been going on?"
O – Onset
"Did it come on suddenly or gradually?"
O – Other symptoms
"Any ringing or buzzing in the affected ear?"

"Any dizziness, unsteadiness, or balance issues?"
"Any ear pain, pressure, or discharge?"
"Any numbness or weakness in your face?"

P – Progression
"Has it stayed the same or been gradually getting worse?"

A – Aggravating factors
"Is it harder to hear in noisy settings?"
"Do you struggle to hear people on the phone or at work?"

R – Relieving factors
"Is there anything that improves your hearing, even temporarily?"

A – Associated impact
"Has it affected your work or daily activities?"

Risk Factor & ENT Screening
"I'll just ask a few quick questions to rule out other causes."
"Any recent ear infections, sore throat, or flu-like symptoms?"
"Any loud noise exposure—at concerts, work, or while using headphones?"
"Any recent travel involving air pressure changes?"
"Do you use cotton buds or had water enter your ear recently?"
"Have you had earwax problems in the past?"

PMAFTO-SA + ICE
P: No long-term conditions
M: No regular medications
A: No known allergies
F: Brother has **neurofibromatosis**
T: No smoking, occasional alcohol
O: Call centre job – headset use all day
S: Difficulty at work, misses customer conversations
Idea: "Thought it might be wax"
Concern: "Worried it's something serious now"
Expectation: "I was hoping you could tell me what's wrong or help clear it"

ENT Examination
A. Otoscopy
"I'll have a look inside both ears with this scope—it shouldn't be painful."
Pull ear up and back, stabilize with fingers
→ **Findings**: Ear canals and tympanic membranes are normal bilaterally

B. Tuning Fork Tests
Rinne
"I'll place this behind your ear, then in front—tell me when the sound stops and whether you still hear it."
→ **Result**: Air conduction > bone conduction = Rinne positive both sides

Weber

"I'll place this tuning fork on the middle of your forehead. Tell me which ear hears the sound louder."

→ **Result**: Lateralises to **left**

Interpretation: Sensorineural hearing loss on **right**

Differential Diagnosis

Diagnosis	*Supporting Features*
Acoustic Neuroma	Unilateral SNHL, tinnitus, imbalance, family hx (NF)
Idiopathic SNHL	Could be sudden but patient had gradual onset
Wax / Otitis Media	Ruled out by normal otoscopy
Noise-induced	Less likely—no noise trauma, controlled headset environment

Explanation

"From your history and examination, it looks like you have **sensorineural hearing loss** in your right ear. That means the issue is likely affecting the nerve that transmits sound from the inner ear to the brain."

"One condition that can cause this is called an **acoustic neuroma**—a **non-cancerous growth** on the hearing and balance nerve."

"It grows slowly, and often the first symptom is one-sided hearing loss or ringing. Your family history of **neurofibromatosis** also increases the chance slightly, so we want to rule this out properly."

Management

ENT Referral

"I'll refer you to an **ENT specialist** on the **urgent two-week pathway**. You should be seen within 14 days."

Investigations

"The ENT team will likely do:

A full **hearing test (audiometry)**

An **MRI scan** to get a detailed view of the nerve behind the ear"

Treatment (if confirmed)

"If it turns out to be an acoustic neuroma, treatment depends on its size and symptoms.

Options include **monitoring**, **surgery**, or **radiotherapy**, and the ENT team will guide you based on what's safest and most effective."

Safety Netting

"Please return sooner or go to A&E if:

Your hearing gets worse suddenly

You develop **severe imbalance**

You notice **numbness or weakness in your face**"

Follow-Up & Leaflet

Provide leaflet on **unilateral hearing loss** and **acoustic neuroma**

Do you feel okay with the plan? Any other questions before we finish?"

Acoustic Neuroma in an Elderly Patient

Scenario: 65–69-year-old journalist, reports new-onset right-sided ringing sensation.

Introduction

"Hi, I'm Dr. [Name], one of the junior doctors here today. Can I confirm your full name and age?"
"Thank you. And how would you prefer me to address you?"
"I understand you've been experiencing some ringing in your ear. Would it be alright if I ask you a few questions and then examine your ears?"

Presenting Complaint – DOOPARA Structured (Tinnitus)

"Let me ask you a few focused questions to better understand the ringing sensation."

D – Duration

"When did you first notice the ringing?"
"Roughly how long has it been going on—days, weeks, or months?"

O – Onset

"Did it come on suddenly or gradually?"

O – Other symptoms

"Have you noticed any hearing loss on that side?"
"Any dizziness or unsteadiness?"
"Any ear pain, pressure, or discharge?"
"Any numbness or weakness in your face?"

P – Progression

"Has the ringing stayed the same or been worsening?"
"Has it become more noticeable or louder over time?"

A – Aggravating factors

"Does anything make it worse—such as noise, caffeine, or stress?"
"Is it more noticeable at night or in silence?"

R – Relieving factors

"Have you found anything that seems to reduce the ringing?"

A – Associated impact

"Has it affected your sleep, mood, or ability to focus on work or reading?"

ENT Screening & Risk Factors

"Just to check for other causes…"
"Have you had any recent cold, flu, or sinus infections?"
"Any loud noise exposure—concerts, machinery, headphones?"
"Have you been on any medications like aspirin, antibiotics, or chemotherapy?"
"Do you use cotton buds or had water enter your ears recently?"
"Any prior history of ear problems, wax build-up, or surgeries?"

PMAFTOSA

P: No chronic illnesses reported, no prior ear disease
M: Takes antihypertensives; no ototoxic drugs

A: None
F: Brother diagnosed with **neurofibromatosis**
T: No smoking; occasional alcohol
O: Retired journalist, no current loud noise exposure
S: Tinnitus affecting sleep and quiet reading

ICE

Idea: "I thought it might be just age-related."
Concern: "It's only in one ear, which worries me."
Expectation: "I'd like to know what's causing it and if it can be treated."

ENT Examination

A. Otoscopy

"I'll have a look inside both ears using a small light—it won't be painful."
→ **Findings**: Normal canals and tympanic membranes bilaterally

B. Tuning Fork Tests

Rinne Test (both ears)

"I'll place this vibrating fork behind your ear, then in front—let me know when the sound stops and if you hear it again."
→ **Result**: Air > bone = Rinne positive both ears

Weber Test

"I'm placing this on the middle of your forehead—let me know if the sound is louder in one ear or equal on both sides."
→ **Result**: Lateralises to **left**
Interpretation: Sensorineural hearing loss on **right**

Differential Diagnosis

Diagnosis	*Supporting Features*
Acoustic Neuroma	Unilateral tinnitus + SNHL + family hx (NF)
Age-related hearing loss (presbycusis)	Usually bilateral, slow and symmetrical
Ototoxicity	Consider if recent ototoxic meds (none in this case)
Noise-induced SNHL	Less likely—no ongoing loud noise exposure

Explanation

"From your symptoms and the hearing test, it seems you have **sensorineural hearing loss** in your right ear, along with a persistent ringing sound—this is known as **tinnitus**."
"One possible cause is a condition called **acoustic neuroma**, which is a slow-growing, non-cancerous growth on the nerve that connects your ear to your brain."
"It's uncommon, but we take it seriously—especially with your brother's history of **neurofibromatosis**, which can increase the risk."

Management

ENT Referral

"I'll refer you to an **ENT specialist** under the **urgent two-week pathway** to have this looked at in more detail."

Investigations

"They'll likely arrange:

A full **hearing test (audiometry)**

An **MRI scan** to examine the hearing nerve and surrounding structures"

Treatment (if confirmed)

"If this is an acoustic neuroma, ENT may recommend **monitoring**, **surgical removal**, or other treatments based on its size and effects."

If acoustic neuroma is ruled out

"If no growth is found, ENT may help with **tinnitus management**—which can include sound therapy, hearing aids, or coping strategies."

Safety Netting

"Please come back sooner or seek urgent help if:

The ringing suddenly worsens

You develop any new imbalance or spinning sensation

You notice **weakness or numbness** in your face"

Follow-Up & Leaflet

Provide leaflet on **tinnitus** and **acoustic neuroma**

"Here's some written information about tinnitus and what we've discussed.

Do you have any questions or concerns before we finish?"

Cholesteatoma

Scenario: 70-year-old with right ear discharge for 2 weeks, known past ear problems.

Introduction

"Hi, I'm Dr. [Name], one of the junior doctors here today. Can I confirm your full name and age please?"

"Thank you. And how would you prefer I address you?"

"I understand you've come in today because of some discharge from your ear—is that right?"

"Let me ask a few focused questions and then I'll examine your ears."

Presenting Complaint – DOOPARA Structured (Ear Discharge)

"Let's go through your ear symptoms in detail."

D – Duration

"How long have you had the discharge?" → "About two weeks."

O – Onset

"Did it start suddenly or gradually?"

O – Other symptoms (Discharge MEDS)

M – Morphology

"What does the discharge look like—clear, pus-like, or bloody?"

"Does it have any smell?"

"Is it a small amount or a lot?"

E – Evolution

"Has the discharge changed since it started?"

"Is it constant or does it come and go?"

S – Symptoms

"Is it painful?"

"Any itchiness, pressure, or fullness in the ear?"

P – Progression

"Has it been getting better or worse?"

A – Aggravating factors

"Does it worsen with water or after showering?"

R – Relieving factors

"Anything that seems to help?"

A – Associated symptoms

"Any changes in your hearing—like needing to increase the TV volume?"

"Any ringing or buzzing in your ear?"

"Any dizziness or loss of balance?"

"Any facial numbness or weakness?"

ENT Screening & Risk Factors

"Let me check for any contributing factors."

"Have you had any previous ear problems or surgeries?"

Patient may recall an ear issue 20 years ago ("glue ear")

"Do you use cotton buds or had water enter your ear recently?"

"Any recent cold, sinus issues, or trauma to the ear?"

"Have you been on any new medications?"

"Do you have any family history of ear problems?"

PMAFTOSA

P: Glue ear in 50s

M: Antihypertensives

A: No drug allergies

F: No known family history of cholesteatoma

T: Non-smoker, occasional alcohol

O: Retired, spends time reading/listening to TV

S: TV volume has gone up; hearing conversations harder

ICE

Idea: "I thought it was just another infection."

Concern: "Worried it might affect my hearing permanently."

Expectation: "I hoped you could tell me what it is and how to treat it."

ENT Examination

"I'd like to examine your ears using a small lighted instrument called an otoscope—it won't be painful."

A. Otoscopy

Right hand for right ear, left for left

Pull pinna up and back

Stabilize fingers on cheek

→ **Findings (given by examiner)**: Damaged tympanic membrane with visible abnormal growth behind

"This may indicate a **cholesteatoma**."

B. Tuning Fork Tests (if hearing loss suspected)

Rinne

→ Positive both ears (AC > BC)

Weber

→ Lateralises to opposite ear → Suggests sensorineural hearing loss on affected side

Could also be conductive if lateralises to affected side

Differential Diagnosis

Diagnosis	*Supporting Features*
Cholesteatoma	Chronic smelly discharge, hearing loss, previous glue ear
Chronic Otitis Media	Painless discharge, no visible growth
Fungal Otitis Externa	Itching + discharge, more superficial, otoscopy differs
Malignancy	Rare, more likely with blood-stained discharge in older pt

Explanation

"From the history and what I can see in your ear, you may have a condition called **cholesteatoma**. It's an abnormal growth of skin cells inside the ear. Normally, ear skin sheds outwards, but here, it's grown inwards and built up as a pocket."

"It often causes **long-term discharge**, and if left untreated, it can damage the small bones that help with hearing—and in rare cases, spread deeper toward the skull base."

"That's likely what's causing your current discharge and hearing difficulty."

Management

ENT Referral

"I'll refer you to an **ENT specialist** on the **two-week urgent pathway**. You should be seen within 14 days."

Investigations

"They'll likely order:

A **hearing test**

An **MRI scan** to look at the extent of the growth"

Treatment

"Treatment usually involves **surgery to remove the cholesteatoma**, and if the small bones are damaged, they may be replaced with artificial ones."

"The goal is to remove the growth and **prevent complications or recurrence**."

Safety Netting

"Until your ENT appointment:

Please keep your ear dry—avoid swimming or letting water in during showers

Avoid inserting anything into the ear

If you develop **worsening discharge, severe pain, dizziness**, or **fever**, please come back or seek urgent care."

Follow-Up & Leaflet

Provide leaflet on **cholesteatoma and ear discharge**

Malignant Otitis Externa

Scenario: Piano teacher with painful swollen ear, hearing loss, immunocompromised due to diabetes and methotrexate.

Introduction

"Hi, I'm Dr. [Name], one of the junior doctors here today. Can I confirm your full name and age?"

"Thank you. And how would you prefer me to address you?"

"I understand you're here because of some ear pain and swelling—would it be alright if I ask you a few questions to understand more, and then examine your ear?"

Presenting Complaint – DOOPARA Structured

"Let me ask a few focused questions about your ear symptoms."

D – Duration

"When did the ear pain and swelling start?"

O – Onset

"Did it begin suddenly or gradually?"

O – Other symptoms

"Is the pain on the inside or the outer part of your ear?"

"Any discharge from the ear?"

"Any redness or pressure sensation?"

"Any fever or recent illness like a cold or sore throat?"

P – Progression

"Has the pain or swelling been getting worse over time?"

"Is your hearing on that side also getting worse?"

A – Aggravating factors

"Does touching or pulling on the ear make it worse?"

"Has water entered your ear recently?"

R – Relieving factors

"Have you tried anything for the pain? Did it help?"

A – Associated impact

"Has this affected your ability to teach piano or concentrate at work?"

"Have you had any balance issues or dizziness?"

Risk Factor & Differential Screening

"Just to check for any underlying risks…"

"Do you have any medical conditions?" → **Diabetes and rheumatoid arthritis**

"What medications are you on currently?" → **Methotrexate**

"Have you had any recent trauma or scratching to the ear?"

"Any history of ear infections or wax buildup?"

PMAFTOSA

P: Diabetes and rheumatoid arthritis

M: Methotrexate (immunosuppressant), possibly metformin or steroids

A: None reported

F: No family history of ear disease

T: No smoking, minimal alcohol

O: Piano teacher, relies heavily on hearing acuity

S: Ear pain affects work, hearing impaired

ICE

Idea: "I thought it might be a regular infection"

Concern: "Worried it could be something serious—it's getting worse"

Expectation: "I'd like to know what's going on and get something to help"

ENT Examination

"I'd like to examine your ear now. First, I'll check if there's tenderness around the ear, then I'll use an otoscope to look inside."

A. Tragus Test

"I'm going to gently press on the small cartilage at the front of your ear. Please tell me if it's painful."

→ **Positive Tragus Sign** (pain on palpation)

B. Otoscopy

Stabilize, pull pinna up and back

→ **Findings (given by examiner)**:

External canal: **swollen with pus**

Tympanic membrane: **red, inflamed**

Differential Diagnosis

Diagnosis	*Supporting Clues*
Malignant Otitis Externa	Painful tragus, discharge, canal swelling, diabetes, methotrexate use
Simple Otitis Externa	No systemic risk, less severe, often itchy rather than painful
Otitis Media	TM bulging or infection, usually without tragal tenderness
Furuncle / Abscess	Localized, more fluctuant swelling

Explanation

"Based on your symptoms and what I can see on examination, this looks like a condition called **malignant otitis externa**."

"The word 'malignant' here doesn't mean cancer—it just means that it can spread and become serious, especially in people with a weakened immune system."
"Because of your **diabetes** and the **medication you take for arthritis**, your body's ability to fight infections is a bit lower. That's why this has become more severe."
"It affects the outer ear canal and can cause pain, swelling, hearing loss, and in rare cases, spread deeper if untreated."

Management
Setting-Based Referral
If in **GP setting**:
"This needs hospital management, so I'll arrange for you to go to **A&E straight away**."
If already in **A&E**:
"I'm referring you to the **ENT specialist** here in the hospital."

Investigations at Hospital
"In hospital, they'll likely:
Do **blood tests** to check for infection or spread
Swab the discharge to identify the specific bacteria
Examine the ear more closely
Possibly arrange a **CT or MRI scan** if deeper infection is suspected"

Treatment Plan
"They will likely start you on:
Antibiotic ear drops
Oral or intravenous antibiotics—often something like **Ciprofloxacin**
They may also **clean and dress your ear**, which is called toileting"
"If the infection has spread or doesn't improve quickly, you may need to be admitted for stronger antibiotics."

Safety Netting
"Please don't delay going to hospital, as this infection can spread and cause more serious complications if not treated early. If you notice worsening pain, swelling, facial weakness, dizziness, or fever—seek urgent medical care immediately."

Follow-Up & Leaflet
Provide ENT infection care leaflet if in GP setting
"Once treated, the ENT team will arrange further follow-up to make sure the infection has fully cleared. Do you have any questions or concerns I can answer before we proceed?"

Benign Tinnitus

Scenario: 45–50-year-old factory worker with one-sided ringing in the ear for 1 month.

Introduction "Hi, I'm Dr. [Name], one of the junior doctors here today. Can I confirm your full name and age?"
"Thanks. And how would you prefer me to address you?"

"I understand you've been experiencing some ringing in your ear—is that right?"
"If it's alright with you, I'll ask a few questions to understand more and then examine your ears."

Presenting Complaint – DOOPARA Structured (Tinnitus)

"Let's talk through the ringing sensation in your ear."

D – Duration

"When did the ringing first start?"
"Has it been going on every day?"

O – Onset

"Did it start suddenly or gradually?"
"Can you remember anything that triggered it?"

O – Other symptoms

"Which ear is affected—right or left?"
"Can you describe the sound—ringing, buzzing, sizzling, hissing, or humming?"
"Is it constant or does it come and go?"
"How long do the episodes last when they happen?"
"How often do you experience it—daily, occasional?"
"Has it been getting better, worse, or staying the same?"

P – Progression

"Do you feel it's becoming more noticeable?"

A – Aggravating factors

"Is it worse when it's quiet—like at night or when watching TV?"
"Does stress or lack of sleep make it worse?"

R – Relieving factors

"Does background noise help—like music or talking to someone?"

A – Associated impact

"How has this been affecting your daily activities or sleep?"
"Has it affected your focus at work or ability to relax?"

ENT Symptom Screen & Risk Factors

"Let me check for any related symptoms or possible causes."

Ear-Related

"Any changes in your hearing—muffled sounds or loss?"
"Any ear pain, discharge, or pressure feeling?"
"Any dizziness or imbalance?"
"Any numbness or weakness in your face?"

Infections, Inflammation & Wax

"Have you had any recent colds, flu, or ear infections?"
"Any history of wax build-up or cleaning with cotton buds?"

Trauma or Noise Exposure

"Have you had any recent head injuries or ear trauma?"
"Do you work in a noisy environment?"

Yes – factory

"How long have you worked there?"

"Do you use hearing protection at work?"

Follow-up: "Do you still find it noisy even with ear protection?"

PMAFTOSA

P: No chronic illness

M: No regular medications

A: No known allergies

F: No family history of ear conditions

T: No smoking; drinks coffee daily

O: Factory worker, 20+ years in loud environment

S: Tinnitus worsens at night; affects focus and sleep

ICE

Idea: "Maybe it's due to work noise?"

Concern: "Worried it might be permanent or get worse."

Expectation: "Looking for a solution or relief—especially for sleep."

ENT Examination

"I'd like to take a quick look inside your ears now."

Use correct otoscopy technique: stabilize, pull pinna up/back

→ **Findings**: Ear canal and tympanic membrane normal bilaterally

"I don't see anything abnormal like infection, wax, or fluid behind the ear drum."

Differential Diagnosis

Diagnosis	*Clues*
Benign noise-induced tinnitus	Unilateral, chronic, noisy job, no red flags
Earwax	Ruled out on otoscopy
Ménière's disease	Unlikely—no vertigo, fullness, or fluctuating hearing
Acoustic neuroma	Always consider if unilateral, but no red flags in this case
Ototoxicity	No meds (e.g. aspirin, antibiotics) linked to tinnitus reported

Explanation

"What you're experiencing is called **tinnitus**—it means hearing a sound like ringing or buzzing without any external source. It's not dangerous in itself, but it can be bothersome."

"In your case, the most likely cause is long-term **noise exposure** at work. This can affect the hearing nerve over time and lead to tinnitus."

"It's important to know that tinnitus is **not a disease**, but a **symptom**. It's a bit like a flickering light in a circuit—it's the system's way of reacting to previous damage or overstimulation."

Management Plan

Lifestyle Advice

"There are a few things you can do that may help reduce the impact of tinnitus:

Take **regular breaks from noise**

Get **good sleep and reduce stress**

Stay hydrated and eat a balanced diet

Reduce **caffeine, smoking, and alcohol**

Try **relaxation exercises** like deep breathing or light yoga"

Sound Therapy (White Noise Techniques)

"You can try:

Soft background music

White noise machines or apps (e.g. rain sounds, fan sounds)

Leaving a radio on low volume, especially at night

These can help mask the tinnitus and make it less noticeable."

Work-Related Advice

"You should **always wear hearing protection** at work—even if you've been doing it for years. If the factory is still too loud despite protection, speak with your manager—your hearing is a priority."

Follow-Up

"If the tinnitus doesn't improve within **6 weeks**, please come back.

At that point, we may consider:

Referral to ENT

Hearing test (audiometry)

In rare cases, an **MRI** if symptoms are persistent or one-sided with hearing loss."

Safety Netting

"If you notice:

Worsening tinnitus

New hearing loss

Facial numbness

Dizziness or imbalance

Please come back straight away."

Leaflet

Reassure: **No urgent red flags found**

Plan: Monitor for 6 weeks with lifestyle adjustments

Leaflet: Offer **tinnitus management advice sheet**

"I'll give you a leaflet with some tips on managing tinnitus.

Do you feel clear about everything we discussed—or would you like me to go over any part again?"

Unilateral Hearing Loss - SNHL

Scenario: 65-year-old woman with progressive hearing loss in the left ear
Setting: General Practice
Role: FY2 Doctor

Introduction
"Hi, my name is Dr [Name], one of the junior doctors here today. Can I confirm your full name and age, please?"
"Thank you. How would you prefer me to address you?"
"Nice to meet you, [Name]. What's brought you in today?"

Presenting Complaint – Clarify Hearing Loss
"You mentioned trouble with your hearing — is it a blocked sensation, reduced hearing, or completely gone?"
"Has it come on suddenly or gradually?"
"Is it only in one ear or both?"

DOOPARA Symptom History
Duration: "When did you first notice this change?" *(1 year ago)*
Onset: "Did it come on suddenly or gradually?" *(Gradual)*
Other symptoms: "Any ear pain, discharge, ringing in the ears (tinnitus), or spinning sensations (vertigo)?" *(All negative)*
Progression: "Has it been getting worse, staying the same, or improving?" *(Getting worse recently)*
Aggravating: "Does anything seem to make it worse — like noise, cold air, or water exposure?" *(No)*
Relieving: "Anything that helps?" *(No)*
Associated: "Any facial weakness, headaches, balance issues, or blurred vision?" *(No)*

Focused ENT Symptom Screen (DVTF)
"Have you noticed any of the following in your ears?"
"Deafness or hearing changes?"
"Vertigo or spinning sensation?"
"Tinnitus or buzzing sounds?"
"Feeling of pressure or blockage?"
Only deafness

Explore Red Flags & Exclude Differentials
"Any recent infections like cold or sinus problems?"
"Any discharge from the ear?"
"Any history of trauma, air travel, or swimming?"
"Any pain behind the ear or swelling?"
"Any visual changes, headaches, or dizziness?"
"Have you had similar symptoms before?"
"Any family history of hearing loss or neurofibromatosis?"
No red flags

PMAFTOSA Screening
P: "Any long-term medical problems like diabetes or autoimmune conditions?"
M: "Are you on any regular medications?"

A: "Do you have any known allergies, especially to ear drops?"
F: "Any family history of hearing conditions?"
T: "Do you smoke or drink alcohol?"
O: "What kind of work did you do?" *(Telephone company – possible noise exposure)*
S: "Any recent stress, trouble sleeping, or social impact from hearing loss?"
A: "Do you live alone or have someone to support you at home?"

No other risk factors

ICE

Ideas: "What do you think might be causing the hearing loss?" *("Maybe wax")*
Concerns: "Are you worried this might be permanent?"
Expectations: "Were you hoping we could clear the ear or prescribe something today?"

Effect on Life

"Has this affected your ability to work, communicate, or enjoy social situations?"
"Any impact on your sleep or mood?"
"Are you driving or operating machinery?"

Examination (Verbalised)

"Thanks for sharing all that. I'd now like to examine your ears and assess your hearing to help understand the cause. This won't be painful, but you may feel slight pressure. You'll remain seated, and I'll ensure your comfort throughout. Is that okay with you?"

A. General Observations:

No fever, facial asymmetry, or signs of distress

B. Otoscopy (performed):

Both tympanic membranes intact, no wax, no discharge, no redness or swelling

C. Tuning Fork Tests *(must verbalise to receive results)*:

Rinne's Test: Air > Bone (bilaterally)
Weber's Test: Lateralised to right
→ Indicates **left-sided sensorineural hearing loss**

D. Cranial Nerve Examination:

Normal CN VII and VIII function
No focal neurological deficits
No gait abnormalities

Diagnosis: **Unilateral Sensorineural Hearing Loss – likely cochlear or retrocochlear cause**

Lay Explanation:

"From the assessment and hearing tests, it seems you have hearing loss in your **left ear**. This type is called **sensorineural hearing loss**, which means the issue is likely with the **inner ear** or the nerve that carries sound to the brain. It's not caused by wax, infection, or a blockage.

Since it's been getting worse over time and only affects one ear, we need to investigate further to rule out more serious but treatable conditions — such as a rare growth near the hearing nerve, called an **acoustic neuroma**."

Management Plan

A. Urgent ENT Referral – 2-Week Wait

"I'll arrange an urgent referral to an **ENT specialist**, who'll assess your hearing in more detail. This is a 2-week fast-track referral due to the one-sided nature of your symptoms."

B. Investigations Likely to Be Done by ENT

MRI scan of the brain and internal auditory canal

Audiometry to formally measure the extent of hearing loss

C. Audiology Referral

"You'll also be referred to an **audiologist**, who can help with treatment like **hearing aids** if needed."

D. Treatment Options (Based on Results)

"If the cause is benign but permanent, hearing aids may improve hearing."

"In rare cases like an acoustic neuroma, ENT may recommend **surgical treatment**."

"Most causes are slow-growing and manageable if caught early."

E. Lifestyle Advice

"Avoid loud noise exposure."

"Don't insert anything into your ears, including cotton buds or drops, unless advised."

"Keep your ears dry and protected from water during showers or swimming."

Safety Netting, Follow-Up, and Leaflet

"Please return urgently if you notice:

Worsening of hearing

Ringing in the ears

Facial weakness

Visual changes, dizziness, or unsteadiness"

"We'll review things again after you've seen ENT and had the scan."

"Here's a leaflet explaining sensorineural hearing loss and how we investigate it."

Note to Student: How the Diagnosis Was Made

Diagnosis of **unilateral sensorineural hearing loss** was based on:

Gradual onset progressive hearing loss over 1 year

No ear pain, discharge, tinnitus, or vertigo

Normal otoscopy

Tuning fork tests: **Rinne positive**, **Weber lateralised to right** → confirms **left SNHL**

Occupational exposure and age are background risk factors

NICE recommends **2-week referral for persistent unilateral SNHL** to exclude **acoustic neuroma**

Introduction to Dizziness Stations in PLAB 2

Dizziness is a common but **clinically vague complaint**, so your first task is to **clarify what the patient means**—spinning (vertigo), presyncope, or imbalance. In PLAB 2, **only three vertigo conditions are typically tested**:

BPPV (Benign Paroxysmal Positional Vertigo)

Ménière's Disease

Vestibular Neuritis

All are inner ear conditions but differ in **duration, triggers, hearing involvement**, and **urgency of referral**.

Your structure should include:

DOOPARA for symptom history

DVTF screening (Deafness, Vertigo, Tinnitus, Fullness)
Rule out central red flags
Clear diagnosis explanation
NICE/NHS-aligned management with safety netting

Comparison Table – BPPV vs Ménière's vs Vestibular Neuritis

Feature	*BPPV*	*Ménière's Disease*	*Vestibular Neuritis*
Setting	GP	GP	A&E
Onset	Sudden, positional	Recurrent attacks over weeks	Sudden onset
Duration of Episode	Seconds to 1 minute	20 min to 24 hours	Continuous for days
Pattern	Episodic, triggered by head movement	Episodic attacks, spontaneous	Continuous dizziness
Trigger	Turning in bed, looking up/down	No specific trigger	Often post-viral (recent cold/flu)
Vertigo Present During Consult?	No (between attacks)	No (between attacks)	Yes (ongoing vertigo at consultation)
Hearing loss?	No	Fluctuating hearing loss	No
Tinnitus?	No	Yes	No
Fullness in Ear?	No	Yes	No
Dix-Hallpike	Positive	Negative	Negative
ENT Referral?	If no response after 4 weeks	Yes (urgent)	Not usually needed unless prolonged
Medication	Not recommended	Betahistine + Prochlorperazine	Cyclizine or Prochlorperazine (short-term)
Definitive Treatment	Epley manoeuvre	Symptom control only	Self-limiting + vestibular rehab if persistent
Driving Advice	Avoid during symptomatic phase	Stop driving + inform DVLA	Stop driving until symptoms resolve
Follow-Up Plan	GP review in 4 weeks	GP review in 1 week	A&E discharge + follow-up if no recovery in 6 wks
Prognosis	Resolves with manoeuvre or time	Chronic, may relapse	Good, full recovery expected in weeks

Vestibular Neuritis

Setting: FY2 in A&E
Patient: Adult male brought in by ambulance with acute continuous vertigo, nausea, and vomiting.

Introduction

"Hi, I'm Dr. [Name], one of the junior doctors here in A&E. Could I confirm your full name and age, please?"
"Thanks. I understand you're feeling very dizzy today. Would it be okay if I asked a few questions to understand what's going on, then we'll see how best to help?"

Clarify Nature of Dizziness

"When you say dizzy, do you mean:
The room is spinning around you? (vertigo)
Feeling faint or like you'll pass out?
Or like you're off-balance or swaying?"
"Are you still feeling dizzy right now?" → *Yes*

DOOPARA Structured Vertigo History

D – Duration

"When did this dizziness start?"
"Has it been continuous since then?" → *Yes, ongoing for days*

O – Onset

"Did it start suddenly or build up gradually?" → *Sudden onset while turning to look at friend*

O – Other symptoms

"Any recent cold, sore throat, or fever before this started?" → *Likely yes*
"Have you vomited?"
"Roughly how many times?"
"Are you currently able to eat or drink anything?"
"Can you keep tablets down?"

P – Progression

"Is it getting better, worse, or staying the same?"

A – Aggravating factors

"Does movement—like turning your head or getting up—make it worse?"

R – Relieving factors

"Does lying still help?"

A – Associated impact

"Has this stopped you from walking or caring for yourself?"
"Do you drive?" → *Driving must be avoided until symptoms resolve*

DVTF Screening

"Just checking for other symptoms in the ears:
Any hearing loss? (D) → *No*
Spinning sensation? (V) → *Yes*
Ringing or buzzing? (T) → *No*
Feeling of fullness or pressure in the ear? (F) → *No*"
This supports **vestibular neuritis** and helps rule out Ménière's.

Red Flag Screening for Central Causes

Weakness or numbness in face, arms, or legs?

Trouble speaking, seeing, or swallowing?
Unsteady walking or collapsing?
New, severe headache?
→ *If all absent → peripheral cause likely*

PMAFTO-SA

P: No prior episodes, no known stroke/TIA
M: No regular medications, not on ototoxic drugs
A: No allergies
F: No family history of neurological illness
T: No smoking, no alcohol
O: Employed, able-bodied until episode
S: Lives with partner, brought in by friend
Context: No red flag features, full ADLs affected, likely post-viral

Examination

"I would check your vital signs, assess your balance and coordination, and look inside your ears."
In this station, no abnormal findings are provided.

Diagnosis

"From your symptoms and the absence of other concerning signs, this is most likely **vestibular neuritis**."

Explanation:

"It's an inflammation of the balance nerve in the inner ear, usually after a mild viral infection. It causes a sudden, intense spinning sensation, often with nausea or vomiting—but without affecting your hearing. Although it feels alarming, it's not dangerous, and most people get better gradually over a few weeks."

Management Plan

A. Initial Stabilisation & Assessment

"First, we'll assess whether you can tolerate food, fluids, or tablets. If not, we'll give medication through a drip and may keep you in hospital temporarily."

B. Symptomatic Relief

NICE recommends short-term vestibular suppressants only in acute phase.

"To reduce your dizziness and nausea, we'll give you:
A single dose of **Cyclizine injection (IM)** now
If you're able to take tablets, we'll send you home with a short course (maximum 3 days) of **oral prochlorperazine or an antihistamine**."

"It's important **not to take these for longer than 3 days**, as long-term use can delay recovery."

C. Driving & Safety

"Please don't drive or operate heavy machinery until the dizziness has fully resolved."

D. Recovery & Prognosis

"Vestibular neuritis usually improves gradually over **4–6 weeks**. You may feel a bit unsteady for some time even after the spinning stops."

E. Follow-Up Plan

"If your symptoms don't improve after 6 weeks, or if they return, we'll refer you to **vestibular rehabilitation therapy**. It's a physiotherapy program that retrains your balance."

"If anything changes—like new hearing loss, facial weakness, or difficulty walking—come back immediately."

Safety Netting

"Please return or call 999 if you develop:

Sudden hearing loss

Severe imbalance or falls

Trouble speaking or walking

Weakness or numbness in your face or limbs"

Discharge Plan & Leaflet

Discharge if stable and tolerating oral meds

Leaflet provided: Vestibular neuritis + vertigo care

"Here's a written leaflet explaining your condition and what to expect. Do you feel okay with the plan, or is there anything you'd like me to go over again?"

Benign Paroxysmal Positional Vertigo (BPPV)

Setting: FY2 in General Practice

Patient: 40–50-year-old male, presenting with episodic dizziness when turning in bed

Introduction

"Hi, I'm Dr. [Name], one of the junior doctors here in the practice. Can I confirm your full name and age, please?"

"Thank you. And how would you prefer I address you?"

"I understand you've been feeling dizzy for some time—is that right?"

"Would it be alright if I asked a few questions to understand what's happening, and then we'll talk about how to manage it?"

Clarify Nature of Dizziness

"When you say dizzy, do you mean:

– the room is spinning around you? (Vertigo)

– you feel faint or lightheaded?

– or like you're off balance or swaying?"

"When do these episodes usually happen?" → "When turning in bed"

"How long does each episode last?" → "Less than a minute"

"Do they happen every time you move in that position?"

"Are you feeling dizzy right now?"

DOOPARA Structured History

D – Duration

"When did these episodes start?" → *Two weeks to one month ago*

O – Onset

"Did they start suddenly or build up gradually?"

"Can you recall what triggered it the first time?"

O – Other symptoms

"Any nausea or vomiting?"

"Do you feel unsteady when standing up or walking?"

P – Progression

"Are the episodes becoming more frequent or severe?"

A – Aggravating factors

"Which movements trigger it most—turning in bed, looking up, bending forward?"

R – Relieving factors

"Does staying still make it better?"

"How long does it take to settle down after an episode?"

A – Associated impact

"Has this been affecting your work or day-to-day activities?"

"Do you drive or work at heights?"

DVTF – Symptom Screen

"Have you noticed any of the following?"

– **D**: Hearing loss?

– **V**: Sensation of spinning? → *Yes*

– **T**: Ringing or buzzing?

– **F**: Pressure or fullness in the ear?

Helps rule out Ménière's disease.

Red Flag Screening

"Just to be thorough…"

"Any weakness or numbness in your face or limbs?"

"Difficulty speaking, walking, or vision problems?"

→ *If all absent → consistent with peripheral cause*

PMAFTO-SA + Work Impact

P: No long-term illnesses

M: Not on ototoxic drugs

A: No allergies

F: No family history of vertigo

T: No smoking, occasional alcohol

O: Works on scaffolding at height

S: Concerned about safety while working

This is a **critical red flag** for occupation-based safety.

Examination
"I'd like to examine you with a quick positional test called the **Dix-Hallpike manoeuvre**."
→ **Positive** (examiner will confirm this)
"The test shows typical signs of a balance issue in the inner ear."
No other findings required in this case. ENT exam otherwise normal.

Diagnosis
"Based on your symptoms and the results of our test, this appears to be a condition called **Benign Paroxysmal Positional Vertigo—or BPPV**."

Explanation
"It's caused by tiny crystals in your inner ear that move when they shouldn't. These movements confuse the balance nerve and make you feel like the room is spinning whenever you turn your head or roll over. We call it *benign* because it's not dangerous, and *positional* because it's triggered by certain movements. It's a mechanical issue—so **medication won't help much**—but lifestyle changes usually work very well."

Management
A. Lifestyle Advice (NHS-guided)
"To help reduce symptoms, try the following:
Move your head and neck slowly and deliberately
When turning in bed, do so gently—avoid sudden movements
When getting up, sit on the edge of the bed for a minute before standing
Use a soft nightlight to reduce disorientation if you wake up dizzy
Avoid bending your neck to pick objects—bring things to your level instead
If dizzy during the day, fix your gaze on a stable object and sit down immediately
Stay hydrated, and having a small sugary snack may help during episodes"

B. Safety & Occupational Advice
"Because you work at heights, this poses a safety concern. You may be at risk of falling if dizziness comes on suddenly."
"It's important to avoid working at height until your symptoms resolve."
"Please speak to your employer to explore alternate duties. If that's not possible, I recommend you contact the **Job Centre** or **Citizens Advice Bureau**—they can help you explore safer work alternatives."

C. Follow-Up
"We'll see how you respond to lifestyle adjustments. Most people feel better within **4 weeks**."
"If you're still having symptoms after that, I'll refer you to ENT for a procedure called the **Epley manoeuvre**."

Safety Netting
"Please come back sooner if:
The symptoms worsen
You develop hearing loss
You experience imbalance while walking

You develop any weakness or changes in vision or speech"

Leaflet

Offer NHS leaflet on **BPPV self-management**

"Here's a leaflet explaining everything we talked about. Do you have any concerns or would you like me to go over any part again?"

Ménière's Disease

Setting: FY2 in General Practice
Patient: 55-year-old woman, dizzy with episodic hearing symptoms

Introduction

"Hi, I'm Dr. [Name], one of the junior doctors here at the practice. Can I confirm your full name and age?"
"Thank you. And how would you like me to address you?"
"I understand you've been feeling dizzy—would it be okay if I asked you a few questions to understand more, and then we'll talk about what may be going on?"

Clarify Nature of Dizziness

"When you say dizzy, do you mean:
– the room is spinning? (vertigo)
– you feel faint or like you might pass out?
– or more like unsteady or off-balance?"
"Are you feeling dizzy right now?" → *No*
"Since when have you been experiencing this?" → *Two weeks*
"Is it continuous or comes and goes?" → *On and off*
"How many episodes have you had?" → *Two attacks*
"Roughly how long does each episode last?" → *Around 24 hours*

DOOPARA Structured History

D – Duration

Two-week history, episodic

O – Onset

Gradual worsening; brought to clinic today as it's worsening

O – Other symptoms

"Have you had any hearing changes?" → *Yes, fluctuating*
"Any ringing or buzzing in the ears?" → *Yes*
"Any sense of fullness or blocked ear?" → *Yes*
"Any nausea or vomiting during episodes?"
"Do you notice which ear is worse?"

P – Progression

"Are the episodes getting worse or more frequent?"

A – Aggravating factors

"Do head movements or standing worsen it during an attack?"

R – Relieving factors

"Does rest or lying down help during an episode?"

A – Associated impact

"Has this stopped you from working or daily activities?"

→ *Has been unable to work in off-license shop for 2 weeks*

"Do you drive?" → *Yes*

DVTF –Symptom Screen

"Let me quickly check some related symptoms you may have noticed."

– **D**: Hearing loss → *Fluctuating*

– **V**: Vertigo → *Yes, during attacks*

– **T**: Tinnitus → *Yes*

– **F**: Ear fullness → *Yes*

Typical DVTF profile for Ménière's disease.

Red Flag Screening

"Any of the following?"

– Weakness or numbness in your face or limbs?

– Trouble speaking, seeing, or walking?

– Severe headaches?"

→ *None reported*

Always screen for central causes.

PMAFTOSA + Lifestyle Context

P: No previous neurological illness

M: No regular meds currently

A: No allergies

F: No family history of vertigo

T: Non-smoker, occasional alcohol

O: Works in an off-license shop, unable to work due to symptoms

S: Lives alone; no recent travel

Examination

"I'd like to assess your balance and do a quick hearing check."

→ **Findings provided on paper**:

Hearing test: **Normal**

Dix-Hallpike: **Negative**

"Your hearing test is currently normal, which we often see in between episodes."

Diagnosis

"From your symptoms, this seems to be a condition called **Ménière's disease**."

Explanation

"It's a condition of the inner ear where a build-up of fluid affects your **balance and hearing**. You may feel a sudden spinning sensation (vertigo), notice ringing in your ears, and feel like your ear is full or blocked."

"These symptoms come in attacks and you feel fine between them. It's not dangerous, but it can be very disruptive."

"We call it **Ménière's disease**, and although it's a long-term condition, we can help reduce how often these attacks happen and how severe they feel."

Management

A. Medication

"We'll start you on:

Prochlorperazine: to help with nausea and dizziness during an attack

Betahistine: a medication to reduce how often attacks occur"

Note: These are NICE CKS-supported for acute Ménière's

B. ENT Referral

"I'll refer you to an **ENT specialist** for:

A **hearing test (audiometry)**

Possibly an **MRI scan**, just to rule out any other causes like nerve issues or growths"

→ *Urgent referral due to ongoing symptoms affecting life*

C. Driving & DVLA

"Because this condition affects your balance and can come on without warning, it's unsafe to drive until you're stable."

"We advise you to **stop driving** for now and **inform the DVLA**. They'll guide you on when it's safe to return."

D. Work Advice

"Since your work involves standing and interacting with people, we can provide a medical letter explaining your condition if needed. Avoid working until your attacks are under control."

E. Follow-Up Plan

"Please try the medications for now and see how you get on."

"If things don't improve after **1 week**, come back—we'll explore **vestibular rehabilitation therapy**, which includes special balance exercises to help you recover more quickly."

Safety Netting

"Please come back or seek help urgently if:

The dizziness becomes continuous

You notice weakness in your face or limbs

You lose hearing suddenly

You collapse or can't walk without support"

Leaflet

Provide leaflet on **Ménière's disease** and info on **Ménière's Society**

"This leaflet explains the condition and where to get extra support.

Do you have any questions or would you like me to go over anything again?"

Recurrent nosebleeds while on apixaban

Station Type: Primary Care – Medical Consultation
Role: FY2 GP seeing a patient with recurrent nosebleeds while on apixaban

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Introduction

"Hello, I'm one of the doctors here today. Thanks for coming in. Could I confirm your full name and age, please? Thank you. What brought you in today?"

Presenting Complaint – Structured History (ODIPARA)

Onset: "Can you tell me how the nosebleed started?"
Duration: "Roughly how long did the bleeding last each time?"
Intensity: "Was it just a small trickle or quite a lot of blood?"
Progression: "Have your nosebleeds been getting worse over time?"
Aggravating/Relieving: "Did anything seem to make it worse or help stop it?"
Radiation: Not applicable
Associated Symptoms:

"Did you feel dizzy or light-headed during the bleed?"
"Did your heart race?"
"Did you faint or feel like you might faint?"
"Did you vomit or swallow any blood?"
"Any headaches, visual changes, or other bleeding elsewhere?"

Differential Diagnosis Screening

Local trauma: "Have you been picking your nose or had any knocks or injury to the nose recently?"
Cold or infection: "Have you had any recent colds, sinus infections, or sore throats?"
Foreign body or lesion: "Have you noticed any lumps or blocked sensation inside your nose?"
Substance use: "Do you use any nasal sprays or sniff any substances?"
Medication: "Are you taking any blood thinners or anti-inflammatories?"
Other bleeding: "Any bleeding from gums, blood in stool or urine, or bruising?"
Anaemia signs: "Have you felt more tired than usual, breathless, or had palpitations?"

Targeted Risk Factor + PMAFTOSA Combined

Past Medical History: "Any history of blood disorders like haemophilia, leukaemia, or anaemia?"
Medications: "I understand you've been on apixaban for 10 years — are you on any other medications, like aspirin or NSAIDs?"
Allergies: "Do you have any known allergies to medications or creams?"
Family History: "Anyone in your family with bleeding disorders like haemophilia?"
Social History: "Do you smoke, drink alcohol, or use recreational drugs?"
Trauma: "Have you had any injuries to your nose or face recently?"
Operations: "Any history of nasal surgery or cautery in the past?"
Systemic: General screen for weight loss, fevers, or night sweats

ICE

Ideas: "What do you think might be causing the nosebleeds?"
Concerns: "Are you worried that it could be something serious?"
Expectations: "Is there anything you were hoping I could do today?"

Effect on Life

"Have the nosebleeds been affecting your sleep, work, or daily activities?"
"Are you feeling anxious or afraid it might happen again?"

Examination (Verbalised)

"I'd like to examine your nose to look for any obvious bleeding point or damage, particularly in an area called Little's area, where lots of blood vessels sit close to the surface."

Examine:

Front of nasal septum (especially Little's area) for crusting, scars, bleeding points
Any nasal masses or foreign bodies
Signs of systemic illness (pallor, bruising, lymphadenopathy)
Check blood pressure and pulse if significant blood loss was reported

Provisional Diagnosis + Explanation

Provisional Diagnosis: Recurrent anterior epistaxis (nosebleed) likely caused by nasal trauma while on apixaban.
Explanation:
"It looks like your nosebleeds are coming from a small, delicate area inside the front of your nose called Little's area. This area has many tiny blood vessels close to the surface. Picking your nose can easily damage these, especially since you're on apixaban — a blood thinner — which means you bleed more easily and for longer. These two factors together are likely causing the repeated bleeding episodes."

Management Plan

Immediate Advice:

"There's no need for urgent tests or hospital treatment right now, because you've had only two episodes and they settled with first aid."
"You've been on apixaban for many years without other bleeding issues, so this seems to be a local problem, not a systemic one."

Topical Treatment:

Naseptin Cream:

"I'll prescribe a cream called Naseptin, which contains an antibiotic to prevent infection and an agent to promote healing. You'll need to apply it gently just inside your nose, two to three times a day, for around 7 days."
(Avoid if allergic to peanut or soy products — clarify first.)

Preventive Advice:

"Avoid picking your nose or blowing it forcefully."
"Keep your nasal passages moist — using a saline spray can help."

First Aid Instructions:

"If you get another nosebleed:
Sit upright and lean forward slightly — don't tilt your head back.
Pinch the soft part of your nose, just above your nostrils.
Hold it firmly for 15 minutes without letting go.

You can breathe through your mouth.
Spit out any blood that drips into your mouth — don't swallow it."

Escalation Advice:

"If the bleeding doesn't stop after 15 minutes, or if it recurs very frequently, please come back or go to the hospital."

"If you have any new symptoms like coughing up blood, persistent bruising, or bleeding elsewhere — let us know urgently."

Safety Netting

"Please come back if you have:
Nosebleeds that last more than 15 minutes,
Any new or frequent bleeding elsewhere,
Dizziness or fainting,
Or if the cream doesn't help after a week."

Follow-Up

"No routine follow-up is needed if the bleeding stops. But do come back for review if the symptoms persist or if you feel unsure."

Leaflet & Final Check

"I'll also give you an information leaflet on managing nosebleeds at home."
"Before we finish, do you feel everything was explained clearly today?"
"Is there anything else on your mind or anything I can help with?"

Note to Student: How the Diagnosis Was Made

The diagnosis of anterior epistaxis was based on:

Bleeding starting from nasal trauma (picking),
Ongoing anticoagulant use (apixaban),
Localized and self-limiting episodes without systemic signs,
No red flags such as persistent bleeding, systemic bruising, or masses.

No further investigations were warranted due to clear cause, known anticoagulant, and reassuring systemic history.

Neck lump– Suspected Cancer

Scenario: 30–40-year-old male presents with a persistent neck lump. Known smoker. History of anxiety. No fever. Father and mother had leukaemia.

Introduction

"Hello, I'm one of the doctors here at the practice. Thanks for coming in today. Could I confirm your full name and age, please? Thank you. How can I help you today?"

Presenting Complaint – MES History Structure

Morphology

"Which side of your neck is the lump on?"
"Roughly how big is it — would you say it's the size of a pea, a grape, or something else?"
"Does it feel soft or hard? Would you say it's smooth or irregular?"
"Is it fixed in place or can it be moved around under the skin?"

Evolution

"When did you first notice it?"
"Since then, has it stayed the same size or changed — getting bigger or smaller?"
"Does it change size when you lie down, eat, or swallow?"
"Does it move when you turn your head or move your tongue?"

Symptoms

"Is the lump painful or causing any discomfort?"
"Have you had any numbness, tingling, redness, or swelling around the lump?"
"Any ulcers or wounds inside your mouth or on your lips?"
"Any sore throat, voice changes, or difficulty swallowing?"
"Have you noticed any change in your smell or bleeding from your nose?"
"Any recent cough, shortness of breath, or nasal blockage?"
"Any fevers or night sweats?"
"Have you been feeling more tired than usual, or lost weight unintentionally?"
"Any bruising or gum bleeding?"
"Any long-standing dental issues or tongue ulcers?"

Targeted Risk Factor + PMAFTOSA

"Do you smoke? How many cigarettes a day, and for how many years?"
"Have you had any previous problems with your nose, throat, or thyroid?"
"Any past surgeries or operations in this area?"
"Are you currently taking any regular medications?"
"Any known allergies?"
"Do you have any chronic medical conditions?"
"Do you have any recent infections or tooth abscesses?"
"Do you live with anyone else, and do you work in a dusty or smoky environment?"

ICE

Ideas: "What do you think this lump might be?"
Concerns: "Is there anything specific you're worried about?"
Expectations: "Is there anything you were hoping we could do or find out today?"

Effect on Life

"Has this lump affected your eating, sleeping, or speaking in any way?"
"Is it making you feel anxious or distracted during the day?"

Examination (Verbalised)

"I'd like to examine your neck and the lump to better understand its size, shape, and whether it's fixed or mobile. I'll also check inside your mouth and throat."
(Assume mannequin exam: fixed, hard 1 cm neck lump on one side; no mouth ulcers)

Provisional Diagnosis + Explanation

Start by expressing concern:
"Mr. [Patient's Last Name], we are a little bit concerned about this lump in your neck."

Explain the reason for concern:
"It's been present for several weeks now, and on examination, it feels firm and fixed. It hasn't gone down on its own, and you haven't had any recent infections that might explain it."
Mention the risk factors clearly:
"Also, you've mentioned that you've been smoking for more than 10 years. Smoking increases the risk of certain cancers in the mouth, throat, and nose areas — what we call the head and neck region."
Deliver the cancer possibility directly and with empathy:
"Unfortunately, I'm sorry to tell you this, but one of the possibilities we're concerned about is cancer. Cancers in the back of the nose/throat — known as nasopharyngeal/oropharyngeal cancers — can sometimes present like this: a painless lump in the neck without many other symptoms."
Pause (give the patient a moment to absorb)

Handling Likely Patient Responses
If the patient asks, "Are you sure, doctor?"
"Well, it could still be something else, like a benign lump. But we are more worried because it hasn't gone away, it feels fixed on examination, and with your smoking history, this puts you in a higher risk category. That's why we don't want to delay — we need to investigate this properly."
If the patient seems scared or unsure
"I completely understand how concerning this sounds. Please know that we're taking this very seriously, and we're here to support you through the next steps. We're going to make sure you're seen quickly and get the right tests and care."

Management Plan
Immediate Next Steps:
- "I'll refer you to an ENT (Ear, Nose, and Throat) or Head and Neck specialist through what's called the two-week wait pathway."
- "You should get an appointment within two weeks. If you don't hear from them by then, please call us."

Investigations likely to be done by the specialist:
- "They'll probably do a scan like an ultrasound or CT to locate where the lump is coming from."
- "They may also do a needle biopsy — where a small sample is taken from the lump using a fine needle to look at under the microscope."
- "They may check your nose, mouth, and throat in more detail using a camera."

Potential Treatments:
- "If it turns out to be cancer, there are various treatment options, depending on the type and stage. These could include surgery, radiotherapy, chemotherapy, or newer treatments like immunotherapy. But that's a discussion for later — first, we need a clear diagnosis."

Safety Netting
- "If the lump grows bigger, becomes painful, or you notice any new symptoms like bleeding, ulcers, weight loss, or difficulty swallowing, please let us know urgently."
- "Also, if you don't get an appointment within 2 weeks, call the clinic or let us know and we'll follow up."

Follow-Up Plan
- "Once the specialist assesses you and the tests are done, we'll get a report and you'll either be followed up here or directly by the specialist, depending on the results."

"If you have any concerns in the meantime, you can always reach out to us."

Final Check & Leaflet

"I know this is a lot to take in — do you have any questions about what we've discussed today?"
"Would you like me to give you an information leaflet about the referral process and what to expect?"

Support instructions:

"When you attend the appointment, you can take a family member or friend with you for support."
"And if you don't hear about your appointment in 2 weeks, please contact us so we can follow up."

Note to Student: How the Diagnosis Was Made

The suspicion of nasopharyngeal cancer was based on:

Unilateral, persistent neck lump >3 weeks
No signs of infection or recent trauma
Firm, fixed nature of the lump
Strong smoking history
No fever or generalised lymphadenopathy
Red flag NICE criteria for **urgent two-week wait referral for suspected head and neck cancer**

Feature	*Nasopharyngeal Carcinoma*	*Oropharyngeal Carcinoma*
Location	Behind the nose (nasopharynx)	Middle throat (tonsils, tongue base)
Virus	EBV	HPV (especially HPV-16)
Symptoms	Neck lump, nasal blockage, ear fullness	Sore throat, dysphagia, voice change
Common in	Southeast Asians, North Africans	Western populations, men > women
Referral	ENT 2-week wait pathway	ENT 2-week wait pathway

Allergic Rhinitis

Scenario: 40–45-year-old man presents with persistent sneezing, nasal congestion, and mild cough affecting daily life and work.

Introduction

"Hello, I'm one of the doctors here at the practice. Thanks for coming in today. Could I confirm your full name and age, please? Great, thank you. How can I help you today?"

Presenting Complaint – ODIPARA

Onset: "When did these symptoms first start?"
Duration: "How long have they been going on for?"
Intensity: "Are they there all day or worse at specific times of day?"
Progression: "Have the symptoms changed or worsened recently?"
Aggravating/Relieving: "Do you notice what makes it worse or better — like dust, pollen, or going outdoors?"
Radiation: Not applicable
Associated:

"Do you get itchy or watery eyes?"
"Any nasal congestion or blocked nose?"
"Any coughing, wheezing, or shortness of breath?"
"Have you noticed a change in your smell?"

"Any postnasal drip or sore throat?"

Differential Diagnosis Screening

"Have you had any recent cold or flu symptoms — fever, sore throat, or body aches?"
"Any nasal lumps or growths?"
"Do you smoke or use any substances that might irritate your nose?"
"Any nasal injuries or surgeries in the past?"
"Have you been around any pets or new environmental changes recently?"

Targeted Risk Factor + PMAFTOSA

Past Medical History: "Any history of asthma, eczema, or allergies yourself?"
Medications: "Are you taking any medications, including nasal sprays or antihistamines?"
Allergies: "Do you know of anything you're allergic to?"
Family History: "Anyone in your family with asthma, eczema, or other allergic problems?"
Trauma/Operations: "Have you had any surgery on your nose or sinuses?"
Occupation: "What kind of work do you do?" (Patient says IT work)
Social History: "Do you smoke or live with anyone who does?"
Associated Systems: "Any eye symptoms, chest tightness, or skin issues recently?"

ICE

Ideas: "What do you think might be causing all this sneezing?"
Concerns: "Is there anything about this that's worrying you?"
Expectations: "Were you hoping for a medication or something to help relieve this?"

Effect on Life

"Has this been affecting your concentration or performance at work?"
"Are you able to sleep well at night?"
"Has it affected your confidence or social life?"

Examination (Verbalised)

"I'd like to examine your nose and check the lining inside to see if there's any inflammation or swelling."
You are told:
There is visible inflammation of the nasal mucosa lining.

Provisional Diagnosis Explanation

"Based on your symptoms and the findings from the examination, it looks like you have a condition called allergic rhinitis. This happens when your body overreacts to harmless things like dust, pollen, or animal dander — causing swelling and irritation inside the nose. It's very similar to hay fever, and people who have a family history of asthma, eczema, or allergies — like you mentioned — are more likely to get it. That's why you're having so much sneezing, a blocked nose, and difficulty focusing at work."

Management Plan

A. Medication – Non-sedating antihistamines

"I'll prescribe you a once-daily antihistamine such as **loratadine** or **cetirizine**."
"These help control the allergic reaction and reduce sneezing, itchiness, and congestion."

"You mentioned being concerned about drowsiness — both of these are **non-drowsy** options, so you can take them while working."

B. Lifestyle and Trigger Avoidance Advice

"Try to identify and avoid the things that trigger your symptoms. Common ones include dust, pollen, animal fur, or strong smells."
"Keep windows closed, especially in the early morning when pollen counts are high."
"Avoid air-drying clothes outside during pollen season."
"Try not to work outdoors around plants, trees, or flowers if possible."
"Close car windows when driving."
"Vacuum your home regularly and consider using an air purifier if symptoms persist."
"Make a note of any food items or places that seem to make symptoms worse."

C. Optional Add-ons if symptoms persist

"If symptoms continue despite antihistamines, we may consider:
A **nasal steroid spray** to reduce inflammation,
Or refer you for allergy testing or specialist input."

Safety Netting

"Please come back if:
The antihistamines don't help after 1–2 weeks,
Your symptoms worsen significantly,
You develop other symptoms like wheezing, chest tightness, or severe sleep disturbance."

Follow-Up

"No routine follow-up is needed for now — but let's review things in 2 weeks if you feel no improvement."

Leaflet & Final Check

"I'll also give you a leaflet about allergic rhinitis and how to manage it at home."
"Do you feel everything was explained clearly today?"
"Is there anything else you'd like to ask before we finish?"

Note to Student: How the Diagnosis Was Made

Diagnosis of allergic rhinitis was based on:

Classic symptoms: sneezing, nasal irritation, congestion
No fever, systemic illness, or infective signs
Family history of atopy (asthma, eczema)
Inflamed nasal mucosa on examination
Symptoms worsened by environmental exposure, not infection

No red flags or need for urgent referral.

Unilateral Nasal Polyp - Suspected Cancer

Setting: GP Clinic
Patient: 62-year-old man
Presenting Behaviour: Sitting in the waiting room repeatedly wiping his nose with a tissue
Opening Line: "Doctor, I think it's just my hay fever again. But this time the nose is constantly running, and nothing seems to be helping."

Background Clues:

History of seasonal allergic rhinitis
Took antihistamines: eye symptoms improved, **but nasal symptoms persist**
Slight blood-stained discharge noticed twice in the past 2 weeks
No history of recent infection or trauma
No known nasal surgeries
Complains of **nasal blockage on one side only**
Clothing feels "loose" recently (optional weight loss clue)

Introduction

"Hello, I'm one of the doctors here at the practice. Thanks for coming in today. Could I confirm your full name and age, please? Thank you. How can I help you today?"

Presenting Complaint – ODIPARA

Onset: "When did the nose symptoms begin?"
Duration: "How long have you been having the runny nose or blockage?"
Intensity: "Is it constant or comes and goes?"
Progression: "Has it been getting worse over time?"
Aggravating/Relieving: "Do any situations or environments make it better or worse?"
Radiation: Not applicable
Associated:

"Have you noticed any nosebleeds — even just drops of blood?"
"Any change in your sense of smell?"
"Do you feel any pressure or pain in the face or head?"
"Any ear blockage or hearing loss on the same side?"
"Have you unintentionally lost any weight recently — such as clothes feeling loose?"

Differential Diagnosis Screening

"Have you had any recent cold, flu, or sinus infection?"
"Any history of hay fever or allergies?"
"Do you smoke or have any long-term exposure to dust or chemicals?"
"Any nasal surgeries or trauma in the past?"
"Have you used any nasal sprays recently?"

Targeted Risk Factor + PMAFTOSA

Past Medical History: "Any history of asthma, eczema, or nasal polyps?"
Medications: "Have you taken anything for this — like antihistamines or nasal sprays?"
Allergies: "Are you allergic to anything?"
Family History: "Does anyone in your family have asthma, eczema, or nasal issues?"
Trauma/Operations: "Have you ever had surgery on your nose?"
Occupation: "What kind of work do you do?"
Social History: "Do you smoke or drink alcohol?"
Effect on Life: "Is this affecting your sleep, your work, or your daily comfort?"

ICE

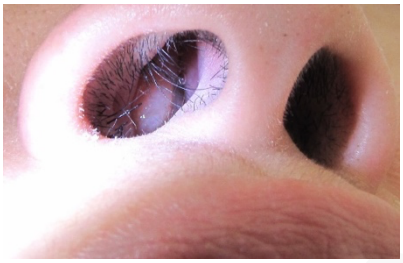
Ideas: "What do you think is causing these symptoms?"
Concerns: "Is there anything about this that worries you?"

Expectations: "Is there something specific you were hoping for today — medication, or a test?"

Examination (Verbalised)

"I'd like to examine your nose now to see what's going on inside."

There is a visible unilateral nasal polyp on the left side.



Provisional Diagnosis + Explanation

Express concern:

"Mr [Patient's Name], I'm a bit concerned about what I've found during your examination today."

Explain the red flags:

"You've had ongoing one-sided nasal symptoms despite medication, and you also mentioned seeing a bit of blood from time to time. On examination, I can see a growth inside your left nostril."

Mention the risk factor:

"Given your age, and because this isn't a typical allergy picture, we're more concerned."

Use empathy + clearly state cancer possibility:

"Unfortunately, I'm sorry to tell you — one possibility is that this growth could be cancer. Cancer of the nasal area can sometimes show up with one-sided blockage, bleeding, and a polyp like this. So we don't want to take any chances."

Pause briefly to let the patient respond

Handling Likely Patient Responses

If patient asks, "Are you sure it's cancer?"

"We're not saying it definitely is cancer. It could still be something else, like a non-cancerous polyp. But because of your age and the presence of blood, we have to treat this seriously until we've ruled it out."

If patient seems scared or silent

"I completely understand this is concerning. The important thing is, we're acting early, and we'll get you seen by a specialist quickly to find out what it is and what needs to be done."

Management Plan

A. Two-Week Wait Referral

"I'll be referring you to an ENT specialist — that's a doctor who deals with the ear, nose, and throat."

"This will be done through a fast-track cancer referral system, which means you'll be seen within 2 weeks."

B. ENT Investigations

"At the hospital, they'll likely perform a **nasal endoscopy** — that's a test using a small camera to look deeper into your nasal cavity."

"They may take a **biopsy** — a small tissue sample — to check under the microscope."

"Depending on what they find, they may do a **scan** like a CT to look for deeper involvement."

C. Treatment (if confirmed)

"If it turns out to be cancer, treatment options may include:

Surgery to remove the tumour,

Radiotherapy,

Chemotherapy,

Or newer treatments, depending on what they find.

The specialist will go through this in detail with you."

Safety Netting

"Please let us know immediately if:
You haven't heard from the ENT clinic within 2 weeks,
You start having more frequent nosebleeds,
You develop double vision, severe facial pain, or a blocked ear on the same side."

Follow-Up

"Once you've had your hospital appointment, we'll get a report from the specialist, and I'll be happy to discuss the next steps with you."
"You can also contact us anytime if you need support while you wait."

Leaflet & Final Check

"I'll also give you a leaflet about what to expect during an ENT referral."
"Do you feel everything was explained clearly today?"
"Is there anything you'd like to ask or anything you're unsure about before we finish?"

Note to Student: How the Diagnosis Was Made

Diagnosis of **suspected nasal cancer** was based on:

Unilateral nasal polyp (always red flag in over-60s)
Presence of intermittent bleeding
No systemic infection signs
Family history, allergy history, or "hay fever" symptoms can be misleading — one-sided polyp is always treated as **cancer until proven otherwise**
NICE recommends **2-week wait referral** for any **unilateral nasal mass** in adults, especially with bleeding or weight loss.

Suspected Laryngeal Cancer

Scenario: 51-year-old man with intermittent hoarseness for two weeks, smoker with diesel fume exposure

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Introduction

"Hello, I'm one of the doctors here at the practice. Thank you for coming in today. Could I confirm your full name and age, please? Great — thank you. What brings you in today?"

Presenting Complaint – Voice Change History (ODIPARA)

Onset: "When exactly did the hoarseness begin?"
Duration: "Has it been ongoing for two weeks straight, or coming and going?"
Intensity: "How bad is the voice change — are people struggling to hear you, or is it just rough-sounding?"
Progression: "Is it getting worse or staying about the same?"
Aggravating/Relieving: "Does anything make it better or worse — like resting your voice, drinking fluids, or talking a lot?"
Radiation: Not applicable
Associated:
"Is it painful when you speak?"
"Have you noticed any sore throat, neck discomfort, or pain?"

Red Flag Screening – Laryngeal Cancer Features

"Any **pain or lump in the neck**?"
"Have you had any **difficulty swallowing food or liquids**?"
"Have you had any **earache or blocked sensation in your ears**?"
"Any **weight loss** you've noticed, like clothes becoming loose?"
"Have you coughed up blood or noticed any blood when clearing your throat?"

Targeted Risk Factors + PMAFTOSA

Past Medical History: "Any history of chronic throat infections, allergies, or reflux?"
Medications: "Are you on any medications or inhalers?"
Allergies: "Any known drug or environmental allergies?"
Family History: "Anyone in your family had cancers or other serious health conditions?"
Toxins/Occupational Exposure:
"What kind of work do you do?" (Patient: garage mechanic)
"You mentioned fumes — do you get exposed to diesel or other chemical fumes regularly?"
"Have you ever worked around asbestos or paint dust?"
Smoking History: "Do you smoke? How many a day, and for how many years?"
(Patient smokes for 35 years – major risk factor)
Social Impact: "Has this voice issue affected your work or daily life?"

ICE

Ideas: "Do you have any thoughts on what could be causing your voice changes?"
Concerns: "Is there anything in particular you're worried about today?"
Expectations: "Were you hoping for a prescription, or were you expecting some tests?"

Effect on Life

"Is it affecting your work at the garage — are you struggling to speak to customers or colleagues?"
"Any impact on your confidence, social interactions, or sleep?"

Examination (Verbalised)

"I'd like to examine your throat and neck to check for any visible inflammation or lumps. I'll also feel for any swellings in your neck area."
You are told: *Throat appears normal. No lymphadenopathy visible externally. No fever.*

Provisional Diagnosis + Lay Explanation (Using Suspected Cancer Communication Format)

Express concern:
"Mr [Patient], I'm a little concerned about what you've described."

Explain the red flags:
"Your hoarseness has lasted for over two weeks, and though it's intermittent, it hasn't fully resolved. Normally, voice changes caused by infections settle within a week. But when it lasts longer — especially without signs of infection — we take it more seriously."

Mention the risk factors:
"You've mentioned smoking for over 30 years and working around diesel fumes every day — both are known to increase the risk of voice box problems, including more serious conditions."

Use empathy + clearly state suspicion:
"Unfortunately, I'm sorry to tell you this, but one of the possibilities we're concerned about is a condition affecting the voice box — the larynx — such as **laryngeal cancer**. We don't want to assume the worst, but we do need to investigate this urgently to rule it out."

(Pause for patient reaction)

Handling Patient Reactions
If patient says, "Are you sure it's cancer?"
"We're not saying it definitely is — it could still be due to a minor issue like acid reflux or chronic irritation. But because of the duration and your background risk, we want to make sure we're not missing something serious."
If patient is scared or overwhelmed
"I completely understand how difficult this is to hear. But you've come in at the right time, and if anything is found, early detection gives us the best chance of managing it successfully."
Management Plan (NICE Two-Week Wait Pathway)
Urgent ENT Referral:
"I'll be referring you to an ENT specialist — a doctor who looks after the ears, nose, and throat. You'll be seen within **two weeks** under a fast-track cancer referral system."
Likely Investigations:
"They'll do a test called **nasendoscopy** — using a small camera to look at your voice box."
"If they see anything unusual, they might take a small tissue sample — called a **biopsy** — to be sure."
"Sometimes a scan like a CT is also done to assess the deeper structures."
Treatment Possibilities (if confirmed):
"If anything is found, early-stage conditions can often be treated with **radiotherapy** and sometimes **chemotherapy**."
"Surgery is usually only needed in advanced cases, but that's something the specialist will explain if necessary."
Safety Netting
"Please let us know if:
You don't hear from the hospital in the next two weeks,
You notice worsening symptoms like difficulty breathing, swallowing, or coughing blood."
"If you feel overwhelmed at any point, you can always contact us — we're here to support you."

Follow-Up and Leaflet
"Once you've seen the specialist, we'll get a report and can discuss the next steps here in the clinic if needed."
"Would you like a leaflet on voice changes and ENT referrals for your reference?"
"Do you feel everything was explained clearly? Is there anything you'd like to go over again?"

Note to Student: How the Diagnosis Was Made
Diagnosis of **suspected laryngeal carcinoma** was based on:
Persistent hoarseness lasting over 2 weeks
No infective symptoms
Significant risk factors: long-term smoking and occupational diesel fume exposure
NICE guidelines recommend **2-week ENT referral for hoarseness >3 weeks**, but earlier referral is justified due to high-risk profile

Infectious Mononucleosis (Glandular Fever)

Scenario: 22-year-old male presents with persistent sore throat and fatigue
Setting: GP Surgery
Role: FY2 Doctor

Introduction
"Hello, I'm one of the doctors here at the practice. Thanks for coming in today. Could I confirm your full name and age, please? Thank you. How can I help you today?"

Presenting Complaint – Sore Throat (ODIPARA)

Onset: "When did your sore throat start?"
Duration: "How long has it been going on?"
Intermittent or Constant: "Is the pain constant or does it come and go?"
Progression:
"Has it been getting better, worse, or the same?"
"Did your doctor prescribe antibiotics?"
"Did the antibiotics help at all?"
Aggravating/Relieving: "What makes it worse?" "Anything that helps – like warm fluids or rest?"
Radiation: "Does the pain spread to your ears or jaw?"
Associated Symptoms:
"Any fever or chills?"
"Is swallowing painful?"
"Any changes in your voice?"
"Cough or blocked nose?"
"Any lumps or swelling in your neck?"
"Rash?"
"Feeling more tired than usual?"
"Any abdominal pain or discomfort?"
"Loss of appetite or weight?"
"Any night sweats?"

Differential Diagnosis Screening

"Have you had cold or flu symptoms like sneezing or congestion?"
"Any cough with phlegm or chest pain?"
"Any vomiting, diarrhoea, or urinary discomfort?"
"Any recent travel, insect bites, or animal contact?"
"Anyone around you unwell recently?"
"Did you get a rash after taking antibiotics?"
"Have you had glandular fever before?"
"Do you play contact sports like rugby or football?"

Targeted Risk Factors (Specific to IM)

"Have you ever had something like this before?"
"Are you on any long-term medications or steroids?"
"Any known immune problems?"
"Do you drink alcohol regularly?"

"Have you had poor sleep or been under stress recently?"

PMAFTOSA

P: "Any long-term medical conditions?"
M: "Are you on any regular medications?"
A: "Any known allergies, especially to antibiotics?"
F: "Any family history of immune problems or infections?"
T: "Do you smoke?"
O: "Do you drink alcohol?"
S: "Do you use any recreational drugs?"
A: "Who do you live with? Do you have support at home?"

ICE

Ideas: "What do you think this might be?"
Concerns: "Is there anything you're particularly worried about?"
Expectations: "What were you hoping I could do for you today?"

Effect on Life

"Has this affected your work, studies, or ability to manage daily tasks?"
"Are you able to keep up with meals, hygiene, and rest?"
"Have you had to stop exercising or playing sports?"

Examination (Verbalised)

"I'd like to examine your throat, feel your neck for any swollen glands, and check your tummy to feel for any swelling in your liver or spleen. I'll also check your temperature and general vital signs."

Findings Given:

Bilateral tonsillar exudates
Tender bilateral cervical lymphadenopathy
Temperature 38.5°C
Mild left upper quadrant tenderness (splenic area)

Provisional Diagnosis + Explanation

Provisional Diagnosis: Infectious Mononucleosis (Glandular Fever)

Lay Explanation:

"From your symptoms and examination findings, this looks like **glandular fever**, also known as **infectious mononucleosis**. It's caused by a common virus called **Epstein-Barr virus**, which spreads through saliva — sometimes called the 'kissing disease'. It often affects young adults like yourself and causes a sore throat, swollen glands in the neck, fever, and extreme tiredness.
You mentioned that antibiotics didn't help — that makes sense, because this is a virus, and antibiotics don't work against viruses. It usually clears on its own, but the tiredness can linger for a few weeks."

Management Plan

Investigations (only if required for confirmation or atypical course):

Full Blood Count (FBC) – may show raised white cells and atypical lymphocytes
Liver Function Tests (LFTs) – to check for mild liver involvement
Throat swab – to rule out strep throat

Monospot test or **EBV serology** – confirmatory if diagnosis is unclear

Supportive Management:

Rest and good hydration
Paracetamol or ibuprofen for fever and throat pain
Warm fluids, soft foods, **saltwater gargles**
Avoid alcohol until fully recovered to protect the liver
Issue a fit note if needed for absence from university/work

Specific Advice:

Avoid **contact sports** and **heavy lifting** for 4–6 weeks to prevent **splenic rupture**
Avoid further **antibiotics** unless there is confirmed bacterial co-infection
Avoid **amoxicillin or penicillin** unless essential — can trigger a widespread rash in glandular fever

Safety Netting

"Please come back or seek urgent help if you notice:
Difficulty breathing or swallowing,
Severe abdominal pain,
Yellowing of the eyes or dark urine,
Rash or worsening fatigue,
Or if your symptoms last more than 3 weeks."

Follow-Up and Leaflet

"We'll review your blood test results in 3–5 days if done."
"I'd recommend a GP review in 2–3 weeks to check your recovery."
"Here's a **leaflet on glandular fever** with self-care tips, return-to-activity guidance, and warning signs."

Note to Student: How the Diagnosis Was Made

Diagnosis of **Infectious Mononucleosis** was based on:

Persistent sore throat, fatigue, cervical lymphadenopathy
Lack of response to penicillin
Systemic signs (fever, splenomegaly) without signs of bacterial infection
Confirmatory signs: bilateral tonsillar exudates, tender lymph nodes, fever
No cough, coryza, or short symptom duration → bacterial/viral URTI less likely
Young adult, high index of suspicion — no routine antibiotics given

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Acute Tonsillitis

Scenario: 35-year-old man presents with sore throat
Setting: GP Surgery
Role: FY2 Doctor

Introduction

"Hello, I'm one of the doctors here at the practice. Thanks for coming in. Could I confirm your full name and age, please? Great, thank you. I understand you've been having a sore throat?"

Presenting Complaint – ODIPARA

Onset: "When did the sore throat start?" *(3 days ago)*
Duration: "Has it been constant since it started, or does it come and go?"

Intensity: "Would you say it's mild, moderate, or severe?"
Progression: "Has it been getting worse, better, or staying the same?"
Aggravating/Relieving: "Does eating, drinking, or speaking make it worse?" "Have you tried anything for relief?"
Radiation: "Does the pain spread to your ears or neck?"
Associated Symptoms:
"Any difficulty or pain when swallowing?" *(Yes)*
"Any fever, chills, or night sweats?" *(Fever uncertain – but temp is 38.5°C)*
"Any cough or blocked nose?" *(Cough absent, runny nose present)*
"Any change in your voice?" "Any rash?" "Any neck stiffness or ear pain?"

Differential Screening
"Have you had any recent cold or flu symptoms?"
"Any chest pain or productive cough?"
"Any vomiting or diarrhoea?"
"Any urinary symptoms?"
"Any recent travel, animal contact, or insect bites?"
"Have you ever had glandular fever before?"
"Anyone around you been sick recently?"

Risk Factor + PMAFTOSA
Past Medical History: "Do you have any chronic conditions like diabetes or asthma?" *(None)*
Medications: "Are you taking any regular medications?"
Allergies: "Any known allergies to medications?" *(Yes – allergic to penicillin)*
Family History: "Any family history of immune conditions or infections?"
Toxins: "Do you smoke or drink alcohol?"
Occupation: "What kind of work do you do?"
Social Support: "Who do you live with? Do you have help at home if needed?"

ICE
Ideas: "What do you think this might be?"
Concerns: "Is there anything you're particularly worried about?"
Expectations: "What were you hoping we could do today — check your throat or give something for the pain?"

Effect on Life
"Has this affected your ability to eat, sleep, or go to work?"
"Are you able to stay hydrated and keep food down?"

Examination (Verbalised)
"I'd like to check your vital signs and examine your throat, neck, and overall appearance."
Findings Provided:
Temperature: 38.5°C
Throat: Bilateral enlarged tonsils with pus
Lymph nodes: Tender bilateral cervical lymphadenopathy
No airway distress, muffled voice, or stridor
Vitals otherwise normal

Provisional Diagnosis + Explanation

Provisional Diagnosis: Acute Tonsillitis

Lay Explanation:

"Based on your symptoms and examination, it looks like you have **acute tonsillitis**. This means the tonsils at the back of your throat are inflamed — often due to a viral or bacterial infection.

Since your throat is very sore, your tonsils are swollen and covered with pus, and your temperature is raised, this may be a bacterial infection — possibly caused by a germ called Group A Streptococcus.

You've also had tonsillitis before, so you may be more prone to it. We'll manage this with appropriate treatment."

Management Plan

Centor Criteria Assessment (For Reference – Do not tell)

Tonsillar exudates
Tender cervical lymph nodes
Fever >38°C
No cough
→ Score: 4/4 → **Bacterial cause likely → antibiotics appropriate**

A. Antibiotics (penicillin allergy):

"Since you're allergic to penicillin, I'll prescribe **Clarithromycin 500 mg**, twice a day for **7 days**. It's safe and effective in treating this infection."

"Do let us know if you experience diarrhoea, rash, or any side effects."

B. Symptomatic Treatment:

Paracetamol and/or ibuprofen for pain and fever
Lozenges or sprays for throat pain relief
Warm salt water gargles
Soft, cool fluids to soothe the throat

C. Self-Care Advice:

"Get plenty of rest and stay well hydrated."
"Avoid smoking, alcohol, and spicy or hot food for now."
"Avoid sharing cups or utensils while you're unwell."
"Wash your hands often to prevent spreading it to others."

Safety Netting

"Please seek urgent care if you notice any of the following:
Difficulty breathing or swallowing saliva,
Severe neck swelling,
High fever not coming down with medication,
Muffled voice or difficulty opening your mouth,
Or if the pain becomes unbearable."

Follow-Up

"You should start feeling better within **2–3 days** of starting antibiotics. If there's no improvement after **3–4 days**, please come back for reassessment."

"We don't routinely need to do blood tests or a throat swab unless symptoms are unusual or persistent."

Leaflet & Final Check

"I'll give you an information leaflet on **tonsillitis** – it includes advice on what to do at home, when to seek help, and how to avoid spreading it to others."
"Do you feel everything was explained clearly today?"
"Is there anything else you'd like to ask before we finish?"

Note to Student: How the Diagnosis Was Made

Diagnosis of **acute tonsillitis** was based on:

Sore throat with painful swallowing
Fever (38.5°C)
Bilateral tender cervical lymphadenopathy
Tonsillar exudates on examination
Absence of cough, which supports a bacterial rather than viral cause
→ Centor score = 4 → meets criteria for antibiotic treatment

Chapter 13: Ophthalmology

Introduction to Eye Stations in PLAB 2

Eye stations in PLAB 2 are a mix of clinical reasoning, safe communication, and structured examination. They may be **mannequin-based** or **non-mannequin**, but the expectations remain the same: assess the complaint safely, think aloud with structure, and make appropriate decisions based on findings.
You are not expected to act like an ophthalmologist – but you must function confidently as an **FY2 doctor** who knows when to **reassure**, when to **refer**, and when to **act quickly** to protect a patient's vision.

What Are Eye Stations Testing?

Focused history-taking (pain, blurring, photophobia, flashes/floaters)
Screening red flags that need urgent escalation
Safe and professional **verbalisation of eye examination**
Ability to **communicate findings clearly and empathetically**
Understanding of **when to refer urgently** vs when to reassure
Familiarity with common NHS pathways, DVLA advice, and safety netting

Common Types of Eye Stations

Category	Examples	What's Expected
Vision changes	Cataract, ARMD, Diabetic Retinopathy	History, visual function, refer vs reassure
Sudden vision loss	Retinal detachment, GCA, CRAO	Urgent recognition, immediate referral ± steroids
Red eye	Glaucoma, Keratitis, Conjunctivitis, Scleritis	Differentiate serious from benign, determine urgency
Painful eye	Optic neuritis, Ocular herpes, Contact lens cases	Recognise systemic links (e.g. MS, HSV), explain clearly
Appearance concern	Arcus senilis, subconjunctival haemorrhage	Reassure, explain benign findings, advise follow-up if needed

Eye Examination in PLAB 2

In PLAB 2, **some eye stations have mannequins** where you're expected to perform fundoscopy. In others, findings may be provided on **paper**. Your job is to:

Always verbalise each step confidently
Perform fundoscopy if equipment or mannequin is provided
Interpret findings accurately when provided by the examiner

Fundoscopy is expected to be physically performed if a mannequin or direct ophthalmoscope is present.
Politely say:
"I would examine the back of the eye using a direct ophthalmoscope in a dimly lit room. I'd ask the patient to fix their gaze on a point ahead, and inspect the optic disc, vessels, and macula one eye at a time."
Avoid saying: *"I'm looking for diabetic retinopathy or papilledema" – this sounds like a diagnosis before assessment.*

Top Tips for Eye Stations

Always check if the vision loss is **sudden or gradual**, **painful or painless**, **central or peripheral**
In red eye cases, ask about **contact lens use**, **photophobia**, and **trauma**
Keep your explanations **simple and confident** – use terms like "pressure in the eye", "cloudy lens", "blocked blood supply"
Never guess findings – if fundoscopy is not performed, explain what you'd do instead
Know which cases need **immediate referral**, **DVLA notification**, or **oral steroids** (e.g. GCA)

General History and Examination Structure for Eye Stations

INTRODUCTION

"Hello, my name is Dr [Name], one of the junior doctors here today. Can I confirm your full name and age, please?"
"Thank you. Just to let you know, everything we discuss will remain confidential, and I'll explain each step clearly before we proceed. Is that okay?"
"What brought you in today?" (Let the patient describe the symptom in their own words.)

PRESENTING COMPLAINT: Structured History Taking (ODIPARA + Add-ons)

"I'd like to ask a few more questions about your eye symptoms to understand better."
Use ODIPARA (Onset, Duration, Intensity, Progression, Associated, Relieving/Aggravating, Anything else)
Onset – "Did it come on suddenly or gradually?"
Duration – "How long has this been going on?"
Intensity – "On a scale of 1–10, how bothersome or painful is it?"
Progression – "Has it been getting better, worse, or staying the same?"
Associated symptoms – (Ask these explicitly):
"Any redness, discharge, itchiness or swelling?"
"Any pain – is it dull or sharp?"
"Any blurriness, double vision, floaters, or flashes of light?"
"Any sensitivity to light or feeling like the eye is full or tight?"
"Do you feel any pressure in or around the eye?"
"Have you had headaches or recent trauma?"
Relieving/aggravating – "Anything that makes it better or worse – like light, movement, rest, drops?"
Any other symptoms?

DIFFERENTIAL DIAGNOSIS SCREENING (Ask selectively based on symptoms)

Question	*Differential it screens for*
"Do you see any flashing lights or floaters?"	Retinal detachment, posterior vitreous detachment
"Is your vision cloudy like a curtain or shadow?"	Retinal detachment
"Is the eye red with discharge?"	Infective conjunctivitis
"Is it red but with pain and light sensitivity, no discharge?"	Uveitis
"Are you seeing coloured haloes around lights?"	Acute angle-closure glaucoma
"Do you get eye pain when moving your eyes?"	Optic neuritis
"Do you have recent severe headaches or scalp tenderness?"	GCA (if over 50)
"Is it itchy in both eyes, especially with watery discharge?"	Allergic conjunctivitis

PAST HISTORY + SYSTEM REVIEW

"Now I'll ask a few general questions to see if anything else could be related."

PMAFTOSA:

Past medical history: Diabetes, hypertension, migraines, autoimmune disease, eye surgeries, thyroid issues
Medications: Especially steroids, anticoagulants, eye drops
Allergies
Family history: Glaucoma, macular degeneration, diabetes
Trauma: Any recent injuries to the head or eye?
Occupation: Screen time, chemical exposure, manual work, driving?
Social: Smoking (linked with macular degeneration), alcohol, drugs
Activities: Impacts on reading, working, mobility, screens, hobbies

ICE (Ideas, Concerns, Expectations)

"What do you think might be causing this?"
"Is there anything you're particularly worried about?"
"What were you hoping we could do for you today?"

EXAMINATION

"Thanks for sharing that with me. I'd now like to examine your eyes to better understand what might be going on."
Say: "This examination won't be painful, though it may feel slightly uncomfortable at times. I'll be checking your vision, colour vision, visual fields, how your pupils react to light, and looking at the back of your eye using a lighted device called a fundoscope.
You'll remain seated. Please remove your glasses or contact lenses if wearing any.
A chaperone will be present and I'll ensure your privacy. Do I have your consent to proceed?"

Eye Examination: Step-by-Step

1. General Inspection

Inspect the **face and orbits** for asymmetry, swelling, redness, drooping eyelid
Ask patient to **look in all directions**: "Can you follow my finger without moving your head?"
Look for **nystagmus, restriction of movement, diplopia**

*The following steps are rarely performed, but **always verbalised**. It shows the examiner that you have a structured, safe clinical approach.*
*"I would begin by assessing **visual acuity** using a Snellen chart at 6 metres, checking each eye individually, with and without glasses. Next, I would check **visual fields** using confrontation in four quadrants per eye. I would assess **pupil size, symmetry, and reactivity**, including the **swinging light test** to check for a relative afferent pupillary defect."*

2. Visual Acuity

"I would now assess your visual acuity using a Snellen chart placed 6 metres away. I would ask you to cover one eye at a time and read the smallest line you can. Then I'd record your vision as 6/x for each eye."

(Verbalise result if provided)

3. Colour Vision

"I would now use an Ishihara colour plate book and ask you to identify numbers from a few coloured dot patterns, one eye at a time."

(State: 'normal colour vision' or 'reduced')

4. Visual Fields (Confrontation)

"I'd sit facing you at arm's length. I'd ask you to cover your right eye while I cover my left eye to test one side at a time."

"I'd move my finger from the corners of your vision toward the centre and ask you to say when you see it."

(Upper/lower temporal and nasal fields – both eyes)

5. Pupillary Reflexes

"Using a pen torch, I'd shine a light into each eye to assess the **direct and consensual response**."

"Then I would perform the **swinging light test** to detect any relative afferent pupillary defect."

6. Accommodation Reflex

"I would ask you to look at a distant object, and then at my finger as I bring it closer to your nose, observing for pupil constriction and convergence."

7. Red Reflex

"I would stand about 30cm away and shine the ophthalmoscope into each eye from directly in front, looking for a red glow. Absence may indicate cataract or retinal pathology."

8. Fundoscopy (Ophthalmoscopy) – to be performed on mannequin

"I'm now going to examine the back of your eye using a lighted magnifying tool called an ophthalmoscope. Normally, I'd dim the room lights to help me see clearly"

Fundus Exam Approach:

Use **right eye & hand** to examine right eye, and **left for left**

Ask patient to **fix gaze at a point on the wall**

Approach from about 15 degrees laterally and look for the following:

Area	*What to Look For*
Optic Disc	Margins (sharp/blurry), colour (pale = atrophy), cupping
Vessels	AV ratio, nipping, haemorrhages, neovascularisation
Macula	Appears darker, use dimmer light, look slightly lateral
General Retina	Cotton wool spots, hard exudates, detachment, bleeding

Repeat this on the other eye.

END OF EXAMINATION

"Thank you for cooperating. I've completed the eye examination."

"I would also like to perform a basic neurological assessment including cranial nerves and reflexes, especially if your symptoms suggest a nerve-related issue."

Retinal Detachment

Category: Eye – Vision Loss
Setting: GP Surgery
Role: FY2 Doctor
Patient: Male, 60 years old

INTRODUCTION

"Hello, my name is Dr [Name], one of the junior doctors here. Can I confirm your full name and age, please?"
"Thanks, Mr. X. I understand you've come in today with some concerns about your vision—do you mind if I ask a few questions to understand more and then examine your eyes?"

PRESENTING COMPLAINT – Sudden Visual Loss

"Let me ask a few questions to understand the problem better."

ODIPARA

Onset: "When did you first notice the problem?"
→ *"2 days ago"*
Duration: "Has it been constant since it started, or did it come and go?"
→ *Constant*
Intensity: "Would you describe this as a complete loss of vision, or partial?"
→ *"Can't see on the sides but centre vision is okay"*
Progression: "Has it improved, worsened or stayed the same?"
→ *"Stayed the same"*
Associated symptoms:
"Any pain in the eye?"
"Any flashes of light or floaters?"
"Any redness, itchiness, discharge?"
→ *Flashes and floaters; no pain or discharge*
Relieving/Aggravating: "Has anything helped or made it worse?"
→ *No effect*

DIFFERENTIAL SCREENING QUESTIONS

"I'd like to quickly check a few other things to rule out serious causes."

Screening Question	*Condition Screened*
"Are you seeing flashes of light or floaters?"	Retinal detachment or vitreous detachment
"Is your vision dark like a curtain from the side?"	Retinal detachment
"Do you have any eye pain or headache?"	Optic neuritis, glaucoma
"Any recent trauma to the head or eye?"	Retinal detachment or vitreous haemorrhage
"Is it red and painful with blurring?"	Uveitis, glaucoma
"Do you see haloes around lights?"	Acute glaucoma

PMAFTOSA & SYSTEMS REVIEW

Past Medical History: Hypertension
Medications: Ramipril
Allergies: Not stated (ask)
Family History: Ask about glaucoma, retinal disorders
Trauma: None
Occupation: Not specified (ask about visual demands)

Social: Driving status? Alcohol/smoking?
Activities: **E**ffect on Function:
"Has this affected your ability to read, drive, use screens, or move around confidently?"
→ *Difficulty moving due to peripheral loss*
"Have you had any eye surgeries in the past?"
→ *"Yes, cataract surgery a few months ago"*

ICE
"What do you think is going on?"
→ *"Will I go blind?"*
"Is there anything specific you were hoping we could do for you today?"

EYE EXAMINATION
"Thanks, Mr. X. I'd now like to examine your eyes to understand this better. This won't be painful, though it might be a little uncomfortable. I'll be checking your vision, peripheral fields, pupil responses, and then looking into the back of your eye using a tool with a light and magnifier. Please remain seated and remove your glasses. A chaperone will be present and I'll maintain your privacy. Is that okay?"

VERBALISED EXAM STEPS
"I would begin by assessing **visual acuity** using a Snellen chart at 6 metres, checking each eye individually, with and without glasses."
"Next, I would check **visual fields** using confrontation in four quadrants per eye."
"I would assess **pupil size, symmetry, and reactivity**, including the **swinging light test** to check for a relative afferent pupillary defect."

Fundoscopy
"I'm now going to look into the back of your eye."
Explain again: "Normally we dim the lights to see more clearly."
Using right eye/right hand for right eye and vice versa:
Observe:
Optic disc – margin, cupping, pallor
Retinal vessels – haemorrhages, AV changes
Macula – central clarity
Peripheral retina – look for grey, folded retina or areas of elevation (classic RD sign)
In retinal detachment, the retina appears elevated, grey and may have folds.

SYSTEMIC & NEURO EXAM
"Since this is a visual complaint, I'd also check your cranial nerves, balance, and coordination, particularly if there are any neurological signs."

MANAGEMENT
"Thanks for allowing me to examine your eyes. Based on everything you've told me—and what I observed during the eye examination—I'm concerned that you may have a condition called **retinal detachment**. Inside the eye, there's a thin, delicate layer called the **retina**—this is like the film in a camera, capturing what you see. In your case, it seems that this layer has peeled away from the back of the eye, which is why you're experiencing the shadow and floaters. The central vision is still preserved, which is a positive sign—but the outer layer being affected explains why you're missing parts of your side vision. This condition is considered an **eye emergency** because if not treated quickly, it could progress and affect the central vision as well."

"I'm going to arrange an **immediate referral to the eye hospital** so a specialist can assess you today."
"You'll likely need **surgery**, which could involve using a laser or a small gas bubble to push the retina back into place."

How the patient is getting to hospital:
"Since this needs urgent assessment, we will help arrange **transport to the hospital directly**—you **should not drive** yourself. Do you have someone who could take you, or should I ask the receptionist to help arrange a medical transport service?"

"The fact that your central vision is still intact is a good sign. Most patients do **not go completely blind** if treated quickly. But the sooner it's repaired, the better the chances of preserving full vision."

SAFETY NETTING
"Until you get to hospital, try to **keep your head still and slightly reclined**, and **avoid any sudden movements**. If you notice changes in the other eye—such as floaters, flashes, or blurring—go straight to A&E. Also, please **avoid driving until you are cleared by the ophthalmologist**, and check with the **DVLA** before resuming."

FOLLOW-UP PLAN
Follow up with ophthalmology team after surgical treatment

Diabetic Retinopathy

Category: Eye – Vision loss
Setting: GP Surgery
Role: FY2 Doctor
Patient: 56-year-old man referred by optician/blurred vision post cataract surgery

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INTRODUCTION
"Hello, my name is Dr [Name], one of the junior doctors here at the GP surgery. Could I confirm your full name and age, please?"
"Thanks for confirming. I understand you were referred here by your optician—is that right? Could you tell me what led you to visit the optician in the first place?"

PRESENTING COMPLAINT – Blurred Vision
"Let me ask you a few more focused questions to understand your vision concerns better."
ODIPARA:
Onset: "When did you first start noticing the blurred vision?"
Duration: "Has it been continuous or does it come and go?"
Intensity: "Has it been mild or quite noticeable?"
Progression: "Is it worsening over time?"
Associated features:
"Is it one eye or both?"
"Any floaters, flashes, pain, redness, or double vision?"
Relieving/Aggravating: "Anything that improves or worsens it?"

DIFFERENTIAL SCREENING & COMPLICATIONS OF DIABETES
"Let me ask a few questions to rule out other problems linked to diabetes."
"Any numbness, tingling, or burning in your feet or hands?"

"Any foot ulcers, colour changes, or changes in sensation?"
"Any chest pain or breathlessness when walking?"
"Any history of stroke or mini-stroke?"
"Do you often feel tired, very thirsty, or pass urine frequently?"

DIABETES HISTORY + MAFTOSA + LIFESTYLE

"I'll now ask a few background questions about your diabetes and general health."

Type of diabetes: "Was it type 1 or type 2?"
Duration: "How long have you had it?" → 3 years
Control: "How is your diabetes currently managed?" → Diet only
Compliance: "Have you been attending your diabetes follow-ups?"
Specialist care: "Have you had annual diabetic eye checks? What happened to the last appointment?" → Missed due to caring for mum
Foot check: "Have you had your feet checked in the last year?"

MAFTOSA:

Medications: Diet-controlled diabetes (consider escalation)
Allergies
Family history: Any diabetes complications or eye problems?
Trauma/surgery: None
Occupation: Self-employed
Social history: Smoking (20/day, 10 years), Alcohol (30 units/week)
Activities: Struggles to cook or exercise due to caregiving responsibilities

"How has this vision issue affected your day-to-day life or work?"

ICE

Ideas: "What do you think might be causing the problem?"
Concerns: "Are you worried it could be serious or permanent?" → "Will I lose my vision?"
Expectations: "Is there anything specific you were hoping I could do for you today?"

EXAMINATION

"Thanks for sharing that. I'd now like to examine your eyes, which won't be painful but might feel slightly uncomfortable. I'll check your vision, peripheral vision, pupils, and use a small light to examine the back of your eye. I'd also like to check your feet and blood pressure since you have diabetes. We'll ensure privacy and a chaperone will be present. Do I have your consent to proceed?"

VERBALISED EXAM STEPS

"I would begin by assessing **visual acuity** using a Snellen chart at 6 metres, checking each eye individually, with and without glasses."
"Next, I would check **visual fields** using confrontation in four quadrants per eye."
"I would assess **pupil size, symmetry, and reactivity**, including the **swinging light test** to check for a relative afferent pupillary defect."

Fundoscopy:

"I will be using a magnifying light to look at the retina. I would look for signs like small bleeds, microaneurysms, or leaking vessels typical of diabetic retinopathy."

Additional:

Feet Examination: "I would inspect the feet, check for ulcers, and assess sensation using monofilament testing."

Blood Pressure: Measure to check for hypertensive contribution.

MANAGEMENT PLAN
"Thanks for allowing me to examine you. Based on everything you've told me—and what I can see in the eye examination—it's likely that you've developed a condition called **diabetic retinopathy**. Diabetic retinopathy is a condition where high blood sugar damages the small blood vessels in the back of the eye, causing them to leak, swell, or bleed. Over time, this affects your vision—particularly if the sugar has been uncontrolled. The early changes are not usually painful, but if untreated, they can progress and affect your sight more seriously."

What We'll Do:

Immediate Actions:
"I'll refer you to the **ophthalmology team** for a more detailed eye assessment."
"They may suggest treatments like **eye injections or laser therapy** depending on how advanced the damage is."

Blood Sugar Management:
"Your diabetes is currently diet-controlled, but now that you've developed complications, we need better control."
"We'll start you on **Metformin**, which helps lower your blood sugar and reduce further damage."

Monitoring and Blood Tests:
"We'll do a blood test called **HbA1c** to assess your sugar control over the past 3 months."
"We'll also check your **kidney function** and general health."

Address Missed Follow-ups:
"I understand you've been looking after your mother, but your health matters too."
"Would you be open to discussing help at home—such as a carer—so you can attend your appointments regularly?"

Lifestyle Intervention:
"I'll support you to reduce smoking and alcohol, and help improve your diet."
"Would you be willing to meet with a **dietician** or join a local diabetes support group?"

DVLA Notification:
"Since this affects your vision, you need to inform the **DVLA**, and avoid driving until you're cleared."

SAFETY NETTING
"If you notice any sudden changes like worsening vision, pain, floaters, or flashes of light, please go to A&E or call us immediately."
"I'll also follow up to make sure you've been seen by the eye specialist."

Hypertensive Retinopathy

Category: Eye – Gradual Blurred Vision
Setting: GP Surgery or Eye Clinic
Role: FY2 Doctor
Patient: Middle-aged patient with a history of uncontrolled hypertension, presenting for routine eye check or blurred vision

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INTRODUCTION
"Hello, my name is Dr [Name], one of the junior doctors here. Could I confirm your full name and age, please?"
"Thanks for confirming that. I understand you're here today for a routine eye check—or was there anything specific that brought you in?"

PRESENTING COMPLAINT – Gradual Blurred Vision

"Let me ask a few focused questions about your vision."

ODIPARA:

Onset: "When did you first notice the change in your vision?"
Duration: "Has it been continuous or coming and going?"
Intensity: "Is the blurring mild or quite noticeable?"
Progression: "Has it been getting worse over time?"
Associated symptoms:
"Do you see floaters, flashing lights, or haloes?"
"Any eye pain, redness, or discharge?"
Relieving/aggravating: "Any pattern—worse in mornings or evenings?"

DIFFERENTIAL DIAGNOSIS SCREENING

"I'd like to ask a few questions to rule out other causes."

Screening Question	*Rule Out*
"Do you get flashes or floaters?"	Retinal detachment or PVD
"Is there central or peripheral loss?"	Macular vs retinal conditions
"Any headache or nausea?"	Papilledema, glaucoma
"Any pain when moving the eyes?"	Optic neuritis
"Is the blurring worse when lying down or first thing in the morning?"	Raised ICP
"Have you had recent eye surgeries or trauma?"	Cataract, RD, vitreous haemorrhage

PMAFTO-SA & SYSTEMIC HISTORY

"Now I'll ask a few questions about your general health."

Past medical history: Hypertension
"How long have you had high blood pressure?"
"Do you monitor it regularly? Do you know your usual readings?"
Medications: Confirm antihypertensives and compliance
"Do you take your BP medications regularly?"
Allergies
Family history: Hypertension, heart disease, stroke, or vision issues
Trauma/surgery: Any previous eye trauma or surgery?
Occupation: Screen-heavy? Visually demanding tasks?
Social history:
"Do you smoke or drink alcohol?"
"How is your diet and exercise routine?"
Activities/ADLs: Impact on reading, driving, hobbies, mobility?

ICE

Ideas: "Do you have any thoughts on what might be causing this?"
Concerns: "Are you worried this could affect your vision permanently?"
Expectations: "Is there anything you were hoping we could do today?"

EXAMINATION

"Thanks for that. I'd now like to examine your eyes. It won't be painful, but may feel slightly uncomfortable."
"I'll check your visual sharpness, peripheral vision, pupil response, and examine the back of your eye using a lighted tool. I'd also like to check your blood pressure and general health."

"We'll ensure your privacy and a chaperone will be present. Do I have your consent to proceed?"

VERBALISED EXAM STEPS

"I would begin by assessing **visual acuity** using a Snellen chart at 6 metres, checking each eye individually, with and without glasses."

"Next, I would check **visual fields** using confrontation in four quadrants per eye."

"I would assess **pupil size, symmetry, and reactivity**, including the **swinging light test** to check for a relative afferent pupillary defect."

Fundoscopy (Focus of station):

"I'd use a direct ophthalmoscope to inspect the back of the eye. Although I can't dim the lights here, I'd look for typical signs of hypertensive retinopathy such as:"

Finding	*Explanation*
Arteriovenous (AV) nipping	Thickened arteries compressing veins
Cotton wool spots	Micro-infarctions
Flame haemorrhages	Leaking from retinal vessels
Hard exudates	Lipid deposits
Papilloedema	If malignant hypertension or raised ICP

MANAGEMENT PLAN

"Thanks for letting me examine your eyes. Based on what you've described and what I saw on examination, it looks like you have a condition called **hypertensive retinopathy**."

Explanation of Diagnosis:

"This condition happens when **high blood pressure** causes damage to the small blood vessels at the back of your eye. Over time, the pressure can make the vessels stiff, narrow, or even leak. That's likely what's affecting your vision now."

"These changes don't usually cause pain, so they often go unnoticed until they begin to affect your eyesight or are spotted during routine checks."

What We'll Do:

Review Your Blood Pressure Control:

"Your current blood pressure may not be fully controlled, so we'll review your readings, medications, and lifestyle."

"I'll perform a full set of bloods, including kidney function and cholesterol."

Medication Review:

"We may need to adjust your antihypertensive medication or add another if your pressure remains high."

Referral:

"I'll refer you to the ophthalmology team for formal grading and assessment. They'll decide whether treatment such as laser therapy is required."

Lifestyle Support:

"Reducing salt intake, exercising regularly, and stopping smoking can make a huge difference in protecting your vision and overall health."

"Would you be open to meeting a practice nurse or health advisor?"

DVLA Advice:

"Since this affects your vision, I'd advise you to **check the DVLA guidance** or avoid driving until the eye specialist gives you clearance."

Monitoring Plan:

"We'll follow you up closely—both from the eye side and to ensure your blood pressure is tightly managed."

SAFETY NETTING

"If you experience any sudden vision loss, flashes, floaters, or pain in the eye—please go straight to A&E."
"And if you notice a persistent headache or feel unwell with visual changes, those may be signs of dangerously high blood pressure—seek help immediately."

FOLLOW-UP PLAN

Monitor vision and blood pressure long-term in primary care

Referral in Hypertensive Retinopathy

When to Refer

You should **refer to ophthalmology** when:

- Retinal signs are visible during fundoscopy (e.g., AV nipping, flame haemorrhages, exudates, papilledema)
- There is **any visual disturbance**
- There is **uncertainty** about the cause or grade of retinopathy
- There is **evidence of malignant or accelerated hypertension** (e.g., grade 3 or 4 hypertensive retinopathy)

In PLAB 2, **refer routinely** to ophthalmology for grading and further assessment unless it's a red flag case, in which case escalate urgently.

Type of Referral

Clinical Finding	*Type of Referral*
Mild/moderate retinopathy with controlled BP	**Routine** referral to ophthalmology
Moderate retinopathy with uncontrolled BP	**Urgent** ophthalmology referral + review antihypertensives
Papilloedema or signs of malignant hypertension	**Same-day referral to A&E or emergency eye service**
No visual symptoms but changes on screening	**Routine** ophthalmology referral for formal grading

DVLA Guidance – Hypertensive Retinopathy

Do Patients Need to Notify DVLA?

According to DVLA and **GOV.UK "At a glance" guidance**:

- Patients **do not need to notify the DVLA** for hypertensive retinopathy **unless** it affects visual acuity or visual fields significantly.
- If vision is impaired to the extent that it falls **below the driving standard** (worse than 6/12 with both eyes open or visual field loss), then **they must stop driving and notify the DVLA**.

What to Say in PLAB 2

For **mild/moderate hypertensive retinopathy with preserved vision**:
"There's no need to notify the DVLA at this point, but I'd still advise avoiding driving until your vision has been fully assessed by the ophthalmologist."
For **visual impairment affecting driving standard**:
"Because your vision is affected, you'll need to **stop driving for now** and notify the **DVLA**. They'll guide you based on your specialist's report."

Toxoplasmosis

Category: Eye – Infectious/Blurred Vision
Setting: GP Clinic
Role: FY2 Doctor
Patient: 58-year-old woman with blurred vision and systemic symptoms, PMR on steroids, works with cats

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INTRODUCTION

"Hello, my name is Dr [Name], one of the junior doctors here today. Could I confirm your full name and age, please?"
"Thanks. I understand you've been experiencing some visual changes—is that right? Would it be alright if I asked you a few questions and examined your eyes to understand more?"

PRESENTING COMPLAINT – Gradual Visual Blurring

"Let's talk through the vision problem first."
ODIPARA:

Onset: "When did this start?" → "About 2 months ago"
Duration: "Has the blurring been constant or does it come and go?"
Intensity: "Is it mild or affecting your day-to-day activities?"
Progression: "Has it been getting worse over time?"
Associated symptoms:
"Any floaters, flashes of light, eye redness, or pain?"
"Any double vision, fever, body aches, or headaches?" → "Yes, flu-like symptoms"
Relieving/aggravating: "Does anything improve or worsen your vision?"

DIFFERENTIAL DIAGNOSIS SCREENING

"I'd like to ask a few extra questions to consider other causes of blurred vision."

Question	*Screens For*
"Any pain when moving the eyes?"	Optic neuritis
"Do you see haloes or flashes of light?"	Retinal detachment, glaucoma
"Is it worse in bright light or at night?"	Cataract
"Have you had eye surgery, trauma, or infections before?"	Cataract/retinal disease
"Any new weakness, slurred speech, or difficulty swallowing?"	CNS spread
"Are you still taking steroids regularly?"	Cataract vs immunosuppression effects

SYSTEMIC & RISK HISTORY

"Now I'd like to ask about your general health and any risks that could be relevant."
PMR on long-term steroids → Immunosuppressed
Pets: "I understand you work in an animal shelter and have several cats at home—how do you handle their litter?"
Infection risk: "Any recent illnesses, travel, or contact with sick animals?"
Immunisation: "Have you had recent vaccinations or immune system conditions?"

PMAFTOSA:

Past medical: PMR, on steroids
Medications: Corticosteroids → ask about dose and duration
Allergies
Family history: Eye problems or immune conditions

Trauma: None
Occupation: Works in an animal shelter
Social: Any impact on driving, reading, or mobility
Activities: Direct contact with cat litter at home

ICE

Ideas: "Have you had any thoughts about what this might be?"
Concerns: "Are you worried this might be related to your steroid use or your cats?"
→ "Should I stop steroids?"
→ "Do I have to get rid of my cats?"
Expectations: "Is there anything specific you were hoping I could do today?"

EXAMINATION

"I'd like to perform an eye examination now. It won't be painful but may feel a bit uncomfortable."
"I'll assess your visual sharpness, peripheral vision, and examine the back of your eye using a magnifying light. I'll also check your general health and blood pressure. Is that okay?"
"We'll ensure your privacy and a chaperone will be present."

Verbalise Eye Examination:

Visual Acuity: "I would use a Snellen chart to assess vision in each eye."
Colour Vision: "I would use Ishihara plates to check colour perception."
Visual Fields: "I would assess peripheral vision using confrontation testing."
Pupillary Reflexes: "I would check the light response in each eye and look for a relative afferent pupillary defect."
Fundoscopy: White retinal lesions, scars, and vitritis (cloudy vitreous fluid) suggestive of toxoplasmosis.

MANAGEMENT PLAN

"Thanks for letting me examine you. Based on what you've told me and what I've seen during the eye examination, I'm concerned that you may have an **eye infection called toxoplasmosis**. Toxoplasmosis is an infection caused by a parasite that's commonly found in cat faeces. In people with weakened immune systems—like those on long-term steroids—it can reactivate or cause complications, including inflammation and scarring in the back of the eye, which can affect your vision."

What We'll Do:

Urgent Referral:

"I'm going to refer you **urgently to the hospital** to be seen by the **eye specialist (ophthalmology)** and **infectious disease team** today."
"They may perform blood tests (including **Toxoplasma IgG, IgM, and PCR**) and possibly a **CT scan** of your brain to ensure it hasn't spread."

Rheumatology Review:

"Because you're on steroids, we'll also ask **rheumatology to review** your treatment."
"Please **do not stop the steroids on your own**—stopping them suddenly could be dangerous. A specialist will advise on any adjustments."

Treatment:

"If confirmed, treatment usually includes a combination of **antibiotics like pyrimethamine and sulfadiazine**, possibly alongside folinic acid to reduce side effects."

Addressing Your Concerns:

"You **don't need to get rid of your cats**, but you should avoid cleaning litter trays yourself if possible. If you do, wear gloves and wash hands thoroughly."

"Also consider **taking your cats to the vet** to ensure they are healthy and treated if needed."

Prognosis:

"The outcome depends on how early treatment begins and where the infection is in the eye. That's why we're acting quickly to avoid permanent damage."

6. **DVLA**: If visual acuity or field loss confirmed → must stop driving and notify DVLA

SAFETY NETTING

"If your vision gets worse, or if you develop new symptoms like slurred speech, difficulty swallowing, or confusion, go straight to A&E."

FOLLOW-UP PLAN

Follow-up with patient's regular GP to monitor immune suppression and visual status

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Ocular Herpes (Herpes Simplex Keratitis)

Category: Eye – Painful Red Eye / Blurred Vision
Setting: GP Surgery
Role: FY2 Doctor
Patient: Adult with eye discomfort, blurred vision, and history of cold sores

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INTRODUCTION

"Hello, my name is Dr [Name], one of the junior doctors here. Could I confirm your full name and age, please?"
"Thanks. I understand you're here with some eye discomfort or vision changes—is that right? Would it be okay if I asked you a few questions and then examined your eyes?"

PRESENTING COMPLAINT – Eye Discomfort / Blurred Vision

"Let me ask a few questions to better understand your eye symptoms."

ODIPARA:

Onset: "When did you first notice the discomfort or blurring?"
Duration: "Has this been constant or does it come and go?"
Intensity: "Is the pain or irritation mild, moderate, or severe?"
Progression: "Has it worsened over time?"
Associated symptoms:
"Any redness, gritty sensation, or tearing?"
"Any discharge—watery or sticky?"
"Is there any sensitivity to light (photophobia)?"
"Any blurred vision or seeing haloes?"
Relieving/aggravating: "Anything that makes it better or worse?"

DIFFERENTIAL SCREENING – Red Eye / Blurred Vision

"Can I ask a few more questions to rule out other eye issues?"

Question	*Screens For*
"Is your eye red and itchy, especially in both eyes?"	Allergic conjunctivitis
"Is there sticky yellow discharge?"	Bacterial conjunctivitis
"Is the pain deep and associated with nausea?"	Acute glaucoma
"Do you have floaters, flashes, or a curtain in vision?"	Retinal detachment
"Do you wear contact lenses?"	Contact lens-related keratitis

"Any history of uveitis, autoimmune diseases?"	Recurrent uveitis
"Have you had this eye problem before?"	Herpes keratitis recurrence

SYSTEMIC & RISK HISTORY

"Now I'll ask a few questions about your health and background."

Cold sores history: "Have you ever had cold sores around your lips or nose?" → Yes, a few times
Immunity: "Do you have any medical conditions or take medications that lower your immunity?"
Eye trauma/surgery: "Have you had any injuries or surgeries to this eye in the past?"
Other infections: "Any recent flu-like illnesses, fever, or swollen lymph nodes?"

PMAFTOSA:

Past medical history: Ask about autoimmune disease, immunosuppression
Medications: Any steroids, antivirals, immune modulators
Allergies
Family history: Eye conditions, HSV
Trauma: None reported
Occupation: Screen time? Outdoor work?
Social: Contact lenses? Recent travel?
Activities: Difficulty reading, using screens, driving?

ICE

Ideas: "Do you have any thoughts on what might be causing the issue?"
Concerns: "Are you worried it's something serious or permanent?"
Expectations: "Were you hoping I could treat it here or arrange a specialist?"

EXAMINATION

"Thanks for sharing all that. I'd now like to examine your eyes to help us understand more."
"It won't be painful but may feel slightly uncomfortable. I'll assess your vision, check your pupils, and use a lighted device to look at the back and front of your eye. A chaperone will be present and I'll maintain your privacy throughout. Is that okay?"

Verbalise Eye Examination:

Visual Acuity: "I would check visual acuity in each eye using a Snellen chart."
Colour Vision: "I'd assess colour vision using Ishihara plates."
Visual Fields: "I'd assess peripheral vision using confrontation."
Pupillary Reflexes: "I'd check for light response and RAPD."
Red Reflex: "I'd assess for red reflex to rule out lens opacity or media opacity."
Fundoscopy: Signs of corneal ulceration, particularly dendritic patterns typical of herpes simplex infection.

MANAGEMENT PLAN

"Thank you for allowing me to examine you. Based on your history of recurrent cold sores, the eye symptoms, and findings on examination, I'm concerned that this may be a case of **ocular herpes**, also called **herpes simplex keratitis**."
"This is a condition where a virus—usually the same one that causes cold sores—reactivates and causes inflammation on the surface of the eye, particularly the cornea."
"It can cause pain, redness, watering, blurred vision, and light sensitivity. If left untreated, it may cause scarring, which can affect vision long-term."

What We'll Do:

Immediate Referral to Eye Clinic:

"I'll refer you to the **eye specialist urgently** so they can confirm the diagnosis using specialist equipment and start treatment promptly."

Treatment Plan:

"Treatment typically involves **antiviral eye drops** or oral antivirals like **aciclovir**, prescribed by the eye clinic."

"Steroid drops are sometimes used, but **only under ophthalmologist supervision**, as using steroids at the wrong time could worsen the infection."

Avoid Self-Treatment:

"Please do not use any over-the-counter eye drops until seen by the specialist."

SAFETY NETTING

"If your vision worsens suddenly, if the eye becomes very painful, or if you develop severe light sensitivity or headaches, please go straight to A&E."

"This condition can come back in the future—if you notice similar symptoms again, seek help early."

FOLLOW-UP PLAN

If vision impaired: **Avoid driving until cleared by ophthalmology**

"If your vision is significantly affected, you may need to inform the **DVLA**, especially if both eyes are involved. Your eye doctor will guide you based on their findings."

Offer written leaflet on eye infections and hygiene precautions

GP follow-up to confirm ophthalmology management and recurrence prevention if needed

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Age-Related Macular Degeneration (ARMD)

Category: Eye – Central Vision Loss
Setting: GP Surgery
Role: FY2 Doctor
Patient: 82-year-old woman referred by optician due to progressive vision loss

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INTRODUCTION

"Hello, my name is Dr [Name], one of the junior doctors here. Can I confirm your full name and age, please?"

"Thank you. I understand you've been referred by your optician due to some changes in your eyesight—would it be alright if I asked you a few questions and then examined your eyes?"

PRESENTING COMPLAINT – Gradual Central Vision Loss

"Let's go through your vision concerns together."

ODIPARA:

Onset: "When did you first notice a change in your vision?" → Several weeks ago

Duration: "Has it been continuous or does it come and go?" → Continuous

Intensity: "How much is it affecting your daily life—like reading or watching TV?"

Progression: "Has it been gradually worsening?" → Yes

Associated features:

"Do straight lines appear wavy?" → Yes

"Is there a grey patch in the centre of your vision?" → Yes

"Any pain, redness, itchiness, discharge, or eye trauma?" → No

Relieving/aggravating: "Does it change with lighting or eye movement?"

DIFFERENTIAL DIAGNOSIS SCREENING

"I'd like to ask a few more questions to rule out other possible causes."

Question	*Rule Out*
"Do you see haloes or coloured rings around lights?"	Acute glaucoma
"Any flashes, floaters, or shadow in the vision?"	Retinal detachment
"Any pain when moving your eyes or colour vision loss?"	Optic neuritis
"Any jaw pain, scalp tenderness, or severe headaches?"	GCA
"Any recent infections or viral illnesses?"	Infectious retinitis
"Any double vision?"	Cranial nerve palsy

SYSTEMIC, SOCIAL, AND RISK HISTORY

"Now I'll ask a few questions about your overall health."

Past medical history: "Any previous eye conditions, diabetes, hypertension, stroke, or autoimmune problems?" → None

Family history: "Any family members with vision problems, especially macular degeneration?" → No

Smoking/alcohol: "Do you smoke or drink alcohol?"

Medication: "Are you on any eye drops, steroids, or other medication?"

Allergies: Confirm

Living situation and function: "Do you live alone or with someone? Are you managing household tasks, okay?"

Driving: "Are you still driving currently?"

Pets, trauma, infections: No relevant history

Impact on ADLs: Difficulty reading, recognising faces, watching TV, considering audiobooks

ICE

Ideas: "Do you have any thoughts about what might be causing this?"

Concerns: "Are you worried this might be permanent or affect your independence?" → "Am I going blind?"

Expectations: "Is there anything you were hoping I could do for you today?" → "What's happening to my eyes?"

EXAMINATION

"Thanks for sharing that with me. I'd now like to examine your eyes—it won't be painful but may feel slightly uncomfortable."

"I'll check your vision, peripheral fields, how your pupils respond to light, and finally, use a lighted tool to look at the back of your eyes."

"A chaperone will be present and I'll ensure your privacy. Do I have your consent to proceed?"

Verbalised Eye Examination:

Visual Acuity: "I'd assess vision in each eye using a Snellen chart at 6 metres."

Visual Fields: "I'd test peripheral vision using confrontation."

Colour Vision: "I'd use Ishihara plates to assess colour perception."

Pupillary Reflexes: "I'd check for normal direct and consensual response and rule out RAPD."

Fundoscopy:

Drusen (yellow deposits under the retina)
Pigmentary changes or scarring
Subretinal fluid or haemorrhage (in wet AMD)"

MANAGEMENT PLAN

"Thanks for letting me examine you. Based on your symptoms and the eye findings, I'm concerned that you may have a condition called **Age-Related Macular Degeneration**, or AMD. AMD is a condition that affects the **macula**, the central part of your retina that helps you see fine details—like when you're reading or recognising faces. As we age, the macula can become damaged. That's likely why straight lines are appearing wavy and your central vision feels grey or distorted."

"The good news is that it **doesn't cause total blindness**, because your **peripheral (side) vision stays intact**."

What We'll Do:

Urgent Ophthalmology Referral (within 1 week):

"I'll arrange for you to be seen by an **eye specialist within the next week** to confirm the diagnosis and begin management."

"They may do tests like:

OCT scan – a detailed scan of the retina

Dye angiography – to look for leaking blood vessels

Slit-lamp exam – to examine the back of the eye."

Management Based on Type:

Dry AMD: "There's no direct treatment, but magnifiers, large print, and low vision aids can really help."

Wet AMD: "This type can be treated with **regular injections** into the eye to slow down the damage, and sometimes with **laser therapy**."

Driving & DVLA Advice:

"Since this affects your central vision, you should **stop driving immediately** and **notify the DVLA**. They'll guide you further based on your specialist's report."

Lifestyle & DESA Advice:

"Stop smoking if applicable, eat a diet rich in green leafy vegetables and omega-3s, and protect your eyes from UV light."

"Staying on top of blood pressure and cholesterol can also help slow progression."

Support Services:

"If this is confirmed, I'll give you information about the **Macular Society** and other support groups."

"We can explore vision aids and audiobooks to help you stay independent."

SAFETY NETTING

"If your vision worsens suddenly, you start seeing flashes, or your appointment is delayed more than a week, please go straight to your local **eye casualty clinic** or call 111."

"If your other eye starts developing symptoms, don't wait—get reviewed again."

FOLLOW-UP PLAN

Offer information leaflet + refer to local **low vision services**

Book follow-up to discuss long-term management options

Acute Angle-Closure Glaucoma

Category: Eye – Sudden Painful Vision Loss
Setting: A&E
Role: FY2 Doctor
Patient: 45-year-old patient with sudden painful red eye, blurred vision, nausea

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INTRODUCTION

"Hello, my name is Dr [Name], one of the junior doctors here in A&E. Could I confirm your full name and age, please?"

"Thank you. I understand you've come in with sudden eye pain and some other symptoms. If it's alright with you, I'd like to ask a few more questions and then examine your eyes."

PRESENTING COMPLAINT – Sudden Painful Red Eye

"Let's go through your eye symptoms first."

ODIPARA:

Onset: "When did the pain begin?" → Suddenly, while reading in a dim room
Duration: "Has the pain been constant since it started?" → Yes
Intensity: "On a scale of 1–10, how painful is it?" → 9 or 10
Progression: "Has it worsened with time?"
Associated features:
"Is your vision blurry?" → Yes
"Do you see coloured haloes around lights?" → Yes
"Any headache, nausea, or vomiting?" → Yes
Relieving/aggravating: "Did it start after being in low light or feeling stressed?"

DIFFERENTIAL SCREENING & RED FLAGS

"Let me quickly check for other possible causes."

Question	*Screens for*
"Any history of trauma or eye injury?"	Orbital fracture, traumatic uveitis
"Do you see flashes or floaters?"	Retinal detachment
"Do you have any jaw pain, scalp tenderness, or fever?"	GCA
"Any double vision or difficulty with speech or swallowing?"	CNS involvement
"Have you experienced this before?"	Recurrent angle closure

SYSTEMIC & RISK FACTORS

"Now I'll ask about your general health and risks."

Past medical history: Hypertension (controlled)
Medications: Any recent use of:
Antihistamines, decongestants, or antidepressants? → May precipitate attack
Family history: Glaucoma or other eye conditions?
Lifestyle:
"What is your occupation? Any recent stress, screen time, or travel?"
Allergies: Confirm

ICE

Ideas: "Do you have any idea what might be going on?"
Concerns: "Are you worried this could affect your vision permanently?"
Expectations: "Were you hoping for any particular treatment or investigation today?"

EXAMINATION

"Thanks for sharing that. I'd like to examine your eyes and take some basic observations. It won't be painful, but might feel uncomfortable. A chaperone will be present and I'll make sure your privacy is maintained."

Verbalised Eye Examination:

Vitals:

Blood pressure and pulse → Assess systemic response

Inspection:

"I'd check for a red eye, hazy cornea, tearing, and eyelid swelling."

Pupils:

"I'd check for a mid-dilated, fixed, and non-reactive pupil in the affected eye."

Palpation (gently):

"The affected eye may feel **hard or tense** on palpation, suggesting raised intraocular pressure."

Visual Acuity:

"I'd test vision in each eye using a Snellen chart—likely reduced in the affected eye."

Visual Fields:

"I'd check peripheral vision using confrontation testing."

Fundoscopy:

Contraindicated at this stage

*Fundoscopy is **not advised at this point** due to likely corneal oedema and patient discomfort. A detailed assessment will be done by the eye specialist after initial pressure is controlled.*

MANAGEMENT PLAN

"Thanks for allowing me to examine you. Based on your symptoms and the findings, I'm concerned that this could be a case of **acute angle-closure glaucoma**."

Explanation:

"This is a **medical emergency** where the drainage inside the eye becomes blocked. That causes a sudden build-up of pressure, which leads to the pain, blurred vision, and nausea you're experiencing."

"If left untreated, it can cause permanent damage to the nerve that connects your eye to the brain, so it's important we act quickly."

Immediate A&E Management

Urgent Ophthalmology Referral:

"I'll contact the on-call ophthalmology team for **immediate review**—this needs to be treated today."

Lower Intraocular Pressure:

IV **Acetazolamide 500 mg stat**

Topical **beta-blocker** (e.g. **Timolol**)

Topical **alpha agonist** (e.g. **Apraclonidine**)

Pilocarpine eye drops only **after pressure begins to drop**

Pain and Nausea Relief:

Paracetamol or stronger analgesia

Ondansetron or **metoclopramide** for nausea

Definitive Treatment (by ophthalmologist):

Likely to undergo **laser peripheral iridotomy** (create a new drainage hole in the iris)

May need **surgical trabeculectomy** in some cases

SAFETY NETTING

"This can sometimes happen again, and your **other eye is also at risk**, so we'll arrange preventative treatment for it as well."

"If you notice similar symptoms in your other eye, or worsening of vision, **go straight to A&E**."

"Avoid dark rooms or over-the-counter cold/flu tablets unless cleared by your GP, as some can trigger this."

FOLLOW-UP PLAN

DVLA: "Since this condition affects your vision, you must **stop driving immediately** and **notify the DVLA**. They will assess your suitability to drive based on specialist input."

Document episode and inform GP of outcome and follow-up needs

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Cataract

Category: Eye – Gradual Vision Loss
Setting: GP Surgery
Role: FY2 Doctor
Patient: 60-year-old woman, referred by optician with bilateral cataracts

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INTRODUCTION

"Hello, my name is Dr [Name], one of the junior doctors here at the surgery. Could I confirm your full name and age, please?"

"Thank you. I understand you were told by the optician that you have cataracts and that it's affecting your vision—is that right? Would it be alright if I ask you a few questions and then examine your eyes?"

PRESENTING COMPLAINT – Blurred Vision

"Let's talk through your symptoms in more detail."

ODIPARA:

Onset: "When did you first notice your vision becoming blurry?" → 1 year ago

Duration: "Has it been persistent or does it come and go?" → Gradually worsening

Intensity: "How much is it interfering with your daily life—like reading or driving?"

Progression: "Is it affecting both eyes equally or is one worse than the other?" → Left worse than right

Associated features:

"Any pain, redness, discharge, itchiness, watering?" → No

"Any sensitivity to light or glare, especially at night?" → Yes

"Do objects seem misty, foggy, or like your lenses are dirty?" → Yes

Relieving/aggravating: "Any difference in daylight vs low light?"

DIFFERENTIAL DIAGNOSIS SCREENING & RED FLAGS

"I'd like to rule out other possible causes."

Question	*Rule Out*
"Any double vision or blind spots?"	Macular degeneration, neurological
"Any flashing lights or floaters?"	Retinal detachment
"Any pain during chewing or hair brushing?"	Giant cell arteritis
"Any headache worse in the morning or on bending?"	Raised ICP
"Any jaw pain, slurred speech, or weakness in limbs?"	Neurological causes
"Any sudden vision loss?"	Vascular causes
"Have you had trauma to the eyes recently?"	Post-traumatic cataract

SYSTEMIC & FUNCTIONAL HISTORY

"Now I'll ask about your general health and lifestyle."

Medical:
Hypertension – controlled
PMR – on steroids
Diagnosed with cataract 3 years ago but no treatment yet
Medications:
Antihypertensives
Steroids for PMR
MAFTOSA:
Medications: Confirm adherence
Allergies: Check for pre-op prep
Family history: Any family eye problems?
Trauma/surgery: No trauma
Occupation: Any vision-dependent tasks?
Social: No alcohol, DESA negative
Activities: Can't read or drive comfortably, struggling with independence

Driving:
"You mentioned driving—are you still currently driving?"
"Has your optician told you to stop driving due to vision?"
→ Yes, optician advised against driving.

ICE
Ideas: "Do you think it's just aging or something else?"
Concerns: "Are you worried you may go blind or lose your independence?"
Expectations: "Were you hoping for surgery or to regain your ability to drive?"

EXAMINATION
"Thanks for sharing all of that. I'd now like to examine your eyes. It won't be painful, and a chaperone will be present."
Verbalised Eye Examination:
Visual Acuity: "I'd check vision in both eyes using a Snellen chart." → Likely reduced
Colour Vision: "I'd use Ishihara plates to assess colour perception."
Visual Fields (Confrontation): "I'd check peripheral vision quadrant by quadrant."
Pupillary Reflexes: "I'd assess direct and consensual response to light."
Fundoscopy:
"I would use an ophthalmoscope to check the back of the eye.
In cataract, the lens may appear cloudy and limit my view of the retina.

PROVISIONAL DIAGNOSIS
"Based on your history, symptoms, and examination, it's likely that your blurred vision is due to **bilateral cataracts**—which is when the natural lens inside the eye becomes cloudy over time. A cataract is like a cloudy patch forming in the lens inside your eye. It's a common part of aging and can make vision foggy, especially in bright lights or at night. Cataracts usually develop slowly, and treatment becomes necessary when they start to affect daily life—like reading, working, or driving."

MANAGEMENT PLAN
Referral:
"I'll refer you to an **ophthalmologist** who will confirm the diagnosis and discuss treatment options."

Treatment:

"The main treatment is **cataract surgery**, which is a short day-case procedure."

"It usually takes **15–20 minutes**, and involves removing the cloudy lens and replacing it with a clear, plastic lens."

"It's done under local anaesthetic, and recovery is quick for most people."

Medical Advice:

"Please continue your current **blood pressure and PMR medications**."

"We'll ensure you're medically fit for surgery during pre-op assessment."

Lifestyle:

Eat a balanced diet, manage your chronic conditions well, avoid smoking.

Driving & DVLA:

"Since your vision is affected and you've been advised by the optician, you should **stop driving immediately** and **contact the DVLA**. After surgery, your ophthalmologist will reassess your vision and guide you on when you can drive again."

SAFETY NETTING

"If your vision gets worse before the appointment, or you don't hear back within **one week**, please return to the surgery or go to an **emergency eye clinic**."

"Also, if you notice sudden loss of vision, flashes, or new floaters, don't wait—go to A&E."

FOLLOW-UP PLAN

GP follow-up post-surgery for medication review and visual recovery

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Optic Neuritis

Category: Eye – Sudden Painful Vision Loss
Setting: GP Clinic
Role: FY2 Doctor
Patient: 25-year-old woman, sudden painful right eye vision loss

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INTRODUCTION

"Hello, my name is Dr [Name], one of the doctors here at the GP clinic. Could I confirm your full name and age, please?"

"Thanks. I understand you've been having some sudden eye symptoms—is that right? Would it be alright if I ask you a few questions and examine your eyes?"

PRESENTING COMPLAINT – Sudden Painful Vision Loss

"Let's start with the pain in your right eye."

SOCRATES (Pain-Focused History):

Site: "Is the pain only in your right eye?" → Yes

Onset: "When did it start?" → 4 hours ago

Character: "Is it dull, sharp, or throbbing?"

Radiation: "Does the pain spread to other areas, like your forehead or cheek?"

Associated symptoms:

"Any blurring of vision?" → Yes

"Any redness, discharge, or itchiness?" → No

"Any double vision or haloes around lights?"

"Any pain when moving the eye?" → Ask explicitly – common in optic neuritis

Timing: "Has it been constant or does it come and go?"
Exacerbating/Relieving: "Anything that makes it better or worse?"
Severity: "How would you rate it out of 10?"

DIFFERENTIAL DIAGNOSIS SCREENING
"Let me ask a few quick questions to rule out other causes."

Question	*Screens for*
"Any recent trauma or injury to the eye?"	Orbital trauma
"Any gritty sensation, sticky discharge, or burning?"	Conjunctivitis
"Any haloes around lights or intense eye pain?"	Acute glaucoma
"Any history of joint pain, painful urination, or ulcers?"	Reiter's syndrome
"Any new tingling, numbness, muscle stiffness or spasms?"	MS
"Any difficulty with balance, speech, or swallowing?"	MS

SYSTEMIC & RISK HISTORY
"Now I'd like to ask a bit more about your general health and family background."
Past medical history: No chronic illnesses
Medications: Any medications like antidepressants or steroids? → Check amitriptyline use
Family history: "You mentioned your mother had multiple sclerosis—thank you for sharing that. Do you know how her MS was diagnosed or started?"
DESA: No smoking, alcohol, or drug use
Impact on function: Any difficulty reading, walking, or driving?
PMAFTOSA Summary:
Past: Nil
Meds: None or check amitriptyline
Allergies: Ask explicitly
Family: Mother has MS
Trauma: No
Occupation: Ask about impact on work/screen time
Social: Lives independently, mood and stress levels
Activities: Any recent illnesses, viral infections?

ICE
Ideas: "What do you think might be causing this?"
Concerns: "Are you worried this could be something serious?"
→ "Am I going to lose my vision?"
Expectations: "Is there anything you were hoping I could do for you today?"
"It must be really worrying to have sudden vision changes, especially with your family history. I'll explain everything and make sure we take the next steps quickly."

EXAMINATION
"Thanks for explaining that. I'd now like to examine your eyes—it won't be painful, and I'll ensure your privacy. A chaperone will be present. Is that okay?"

Observations:
Check vitals – especially blood pressure and temperature
Eye Examination (Verbalised):
Visual Acuity: "I'd test each eye using a Snellen chart." → ↓ acuity in right eye

Visual Fields: "I'd assess peripheral vision by confrontation testing." → ↓ field in right eye
Colour Vision: "I'd test using Ishihara plates." → ↓ colour in right eye
Pupillary Reflexes:
"I'd check for a relative afferent pupillary defect (RAPD) using the swinging light test."
→ Common in optic neuritis
Fundoscopy:
In optic neuritis the optic disc may appear normal (retrobulbar) or swollen (papillitis).

PROVISIONAL DIAGNOSIS

"Based on your symptoms and examination findings, I suspect this is a case of **optic neuritis**—inflammation of the nerve that connects your eye to your brain."
The optic nerve is like a cable that carries visual signals from your eye to your brain. In your case, that nerve appears to be inflamed, which is why you're experiencing pain and blurred vision. Sometimes this happens after an infection, but in some people—especially with a family history like yours—it can be an early sign of a condition called **multiple sclerosis**, which affects how nerves in the brain and spine communicate. That doesn't mean you have MS, but it's something we'd need to rule out."

MANAGEMENT PLAN

Immediate Actions:
"I'll refer you **urgently to the hospital to be seen by an ophthalmologist** today."
Investigations likely to be arranged:
MRI brain and orbits – to assess demyelination
Lumbar puncture – to analyse cerebrospinal fluid for MS markers
Blood tests – FBC, U&E, LFTs
Optical Coherence Tomography (OCT) – in specialist care
Treatment:
"If the diagnosis is confirmed, treatment usually involves **IV methylprednisolone for 3 days**, which can help speed up recovery."
"This won't affect the long-term outcome, but it may help symptoms improve faster."
Neurology Referral:
"Depending on the findings, you may also be referred to a **neurologist** to discuss long-term management or whether disease-modifying treatments are needed."

SAFETY NETTING

"If your vision worsens, the pain increases, or you start noticing new symptoms like:
Weakness or numbness in your limbs
Muscle stiffness or spasms
Balance problems
Difficulty speaking or swallowing
Bladder or bowel changes
Please come back or go straight to A&E."

FOLLOW-UP PLAN

DVLA: "Since this affects your vision, you should **stop driving for now** and **notify the DVLA**. They will advise based on the outcome of your hospital assessment."
Offer written information on optic neuritis and MS
Arrange GP follow-up after hospital review to support continuity of care

Subconjunctival Haemorrhage

Category: Eye – Red Eye
Setting: GP Surgery
Role: FY2 Doctor
Patient: 65-year-old man presenting with red left eye for 3 days

INTRODUCTION
"Hello, my name is Dr [Name], one of the doctors here at the GP surgery. Could I confirm your full name and age, please?"
"Thank you. I understand you've come in with some redness in your eye—would it be alright if I asked you a few questions and then examined your eyes?"

PRESENTING COMPLAINT – Red Eye (Unilateral, Painless)
"Let's talk about your red eye in more detail."
ODIPARA:
Onset: "When did you first notice the redness?" → 3 days ago
Duration: "Has it been getting better, worse, or staying the same?"
Intensity: "Any discomfort or irritation?" → No pain
Progression: "Has it spread or changed in appearance?"
Associated features:
"Any discharge, itchiness, or tearing?" → No
"Any sensitivity to light?"
Relieving/aggravating: "Have you used anything like eye drops or rubbed your eye?"

DIFFERENTIAL DIAGNOSIS SCREENING
"Let me ask a few questions to rule out other causes of red eye."

Question	*Screens for*
"Any sticky discharge or recent cold symptoms?"	Bacterial/viral conjunctivitis
"Any eye trauma, rubbing, or foreign body?"	Traumatic haemorrhage
"Are you taking blood thinners like aspirin or warfarin?"	Drug-related bleeding
"Any nosebleeds, gum bleeding, or easy bruising?"	Bleeding disorders
"Any joint pain or back stiffness?"	Autoimmune uveitis
"Any recent headaches, fever, or vomiting?"	Raised ICP, GCA
"Is this the first time this has happened?"	Recurrent or systemic cause

SYSTEMIC & SOCIAL HISTORY
"Now a few background questions."
Past medical history: None reported
Medications: None (important: not on anticoagulants)
Allergies: Check
Family history: Any clotting or autoimmune conditions?
DESA: Occasionally drinks alcohol, no smoking or drug use
MAFTOSA: No trauma, surgery, allergies, or social issues
ICE
Ideas: "Do you know what this could be?"
Concerns: "Are you worried it might be something serious or affect your vision?" → "Am I going to lose my vision?"

Expectations: "Is there anything you were hoping I could do today?"
"I completely understand how worrying red eyes can look, but I'll explain exactly what's going on and what to expect."

EXAMINATION
"I'd now like to examine your eyes. This won't be painful, and I'll make sure your privacy is respected. A chaperone will be present. Is that okay?"

Verbalised Eye Examination:
Observations: Temperature, BP, pulse → All normal
Inspection (external):
"I'd inspect for conjunctival swelling, haemorrhage location, absence of discharge, and check for trauma."
Likely finding: **Bright red patch on sclera, no conjunctival swelling or discharge**
Visual Acuity: "I'd test each eye with a Snellen chart." → Normal
Visual Fields (Confrontation): Normal
Colour Vision: Preserved
Pupillary Reflexes: Normal direct and consensual light response
Fundoscopy: Normal

PROVISIONAL DIAGNOSIS
"This looks like a case of **subconjunctival haemorrhage**, which is when a tiny blood vessel bursts under the clear surface of the eye."

Explanation of Subconjunctival Haemorrhage:
"The white part of your eye is covered by a thin layer called the conjunctiva. Sometimes, one of the small blood vessels in this layer bursts and causes a bright red patch. It looks dramatic, but it's usually **harmless and painless**."
"It's similar to a bruise on the skin and **doesn't affect your vision**. It often happens after straining, coughing, or rubbing the eye, though in your case there may not be a clear cause."

MANAGEMENT PLAN
Reassurance:
"It typically clears up on its own within **one to two weeks**, just like a bruise."
Advice:
"Avoid rubbing the eyes."
"Wear **protective eyewear during sports or activities** where trauma could occur."
"Artificial tears may help if there's any irritation or dryness."
No Treatment Needed:
No antibiotics or eye drops unless there's secondary irritation
Lifestyle:
"Continue your normal activities, but if it happens again, we may do further blood tests."
Driving:
"This won't affect your ability to drive or perform daily tasks, as long as your vision remains clear."

SAFETY NETTING
"If you notice **repeated episodes**, or bleeding from other areas like your gums, nose, or easy bruising—please come back."
"Also, if you develop **eye pain, reduced vision, or headaches**, come back or go to A&E."

FOLLOW-UP PLAN

No immediate follow-up needed
Provide **leaflet** on subconjunctival haemorrhage
Return if recurrence or systemic symptoms arise
Ensure reassurance and emotional closure:
"It's completely understandable to be concerned, but this is a common and harmless issue that should clear on its own."

Conjunctivitis

Category: Eye – Red Eye with Discharge
Setting: GP Clinic
Role: FY2 Doctor
Patient: Adult presenting with bilateral red eyes, no vision loss

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INTRODUCTION

"Hello, my name is Dr [Name], one of the junior doctors here. Could I confirm your full name and age, please?"
"Thank you. I understand you've come in with red eyes. Would it be okay if I asked you a few questions and then examined your eyes?"

PRESENTING COMPLAINT – Bilateral Red Eye

"Let's talk about your eye symptoms first."
ODIPARA:

Onset: "When did the redness start?"
Duration: "Has it been constant or coming and going?"
Intensity: "Has it been mild or quite irritating?"
Progression: "Is it worsening or improving?"
Associated features:
"Any itching, watery or sticky discharge?"
"Any pain or foreign body sensation?"
"Any sensitivity to light (photophobia)?"
"Any blurred or reduced vision?" → No
Relieving/aggravating: "Anything that seems to trigger or relieve it?"

DIFFERENTIAL SCREENING

"Let me ask some questions to rule out more serious causes."

Question	*Rules out*
"Is your vision reduced?"	Red flag for keratitis, uveitis, glaucoma
"Is there any severe pain or headache?"	Uveitis, glaucoma
"Any pain on light exposure or pupil reaction?"	Iritis
"Do you wear contact lenses?"	High risk for keratitis
"Any trauma or chemical exposure?"	Trauma-related injury
"Is this the first time or has it happened before?"	Allergic recurrence
"Any joint pain, ulcers, or urinary problems?"	Reiter's syndrome

SYSTEMIC & FUNCTIONAL HISTORY

"Now a few background questions."

Past medical history: Any allergies, asthma, atopy, autoimmune disease?
Medications: Any recent eye drops or systemic medication?
Allergies: Any known triggers?
Family history: Eye conditions or allergies?
DESA: Smoking/alcohol – minimal impact here
MAFTOSA: No recent trauma, surgeries, foreign travel, or systemic illness

ICE

Ideas: "Do you think this could be an infection or something more serious?"
Concerns: "Are you worried it might affect your sight or spread to others?"
Expectations: "Were you hoping for some treatment or eye drops?"

EXAMINATION

"I'd now like to examine your eyes. This won't be painful and I'll ensure your privacy. A chaperone will be present. Is that alright?"

Eye Examination (Verbalised):

External Inspection:
"I'd look at the eyelids, conjunctiva, and surrounding skin for swelling or irritation."
Findings in conjunctivitis: **diffuse conjunctival redness**, possible **sticky or watery discharge**

Visual Acuity:
"I'd check both eyes using a Snellen chart." → Normal in conjunctivitis

Colour Vision & Fields:
"I'd test colour perception and peripheral fields." → Preserved

Pupillary Reflexes:
"I'd assess for normal light reflex and rule out any afferent pupillary defect." → Normal

Fundoscopy:
Normal

Cornea Check (verbalised):
"I'd look for corneal clarity—if cloudy or ulcerated, that would suggest keratitis, not conjunctivitis."

PROVISIONAL DIAGNOSIS

"Your symptoms and examination findings suggest **conjunctivitis**, which is an inflammation of the thin layer covering the white of your eyes and inside of your eyelids."

Explanation of Conjunctivitis:

"Conjunctivitis can be caused by infections—either **viral or bacterial**—or by **allergies** like pollen or dust. In your case, it sounds more like [allergic/infective] conjunctivitis, as your vision is clear and there's no serious pain."
"It's **not dangerous** and should settle on its own, but we'll take some steps to help you feel better."

MANAGEMENT PLAN

If Viral or Mild Bacterial Suspected:

"This is usually self-limiting and should improve in **5–7 days**."

Advice:

Wash hands regularly
Avoid touching or rubbing eyes
Use clean tissues to wipe discharge
Avoid contact lenses until symptoms resolve
Cold compress and lubricating drops (artificial tears)

Antibiotics:

"In case of sticky discharge, we can issue a **delayed prescription** for **chloramphenicol** drops. Start it only if symptoms haven't improved after 3 days."

If Allergic Conjunctivitis:

Avoid allergen exposure (e.g. dust, pollen)
Apply cold compresses
Use **lubricating eye drops**
Consider **topical antihistamines** if needed
Follow up in 1 week if no improvement

Driving & DVLA:

There's no need to notify the DVLA unless vision is affected.

SAFETY NETTING

"If you notice any **blurred vision, severe pain, sensitivity to light, or if things get worse after a few days**, please come back or go to the eye clinic."
"If you wear **contact lenses** and develop eye pain or vision changes, go straight to A&E, as that can be more serious."

FOLLOW-UP PLAN

No urgent follow-up needed unless symptoms worsen
Review in 1 week if allergic conjunctivitis and no relief
Provide patient **leaflet on conjunctivitis care**
Escalate if any red flags emerge

Differentiating Conjunctivitis Types

Feature	Allergic	Viral	Bacterial
Onset	Sudden or recurrent	Often follows a cold/flu	Acute
Laterality	Usually both eyes	Often starts in one eye → spreads	Often starts in one eye → may spread
Discharge	Watery, stringy, no crusting	Watery or mucoid	Thick, yellow/green, lashes may stick
Itching	**Prominent**	Mild or absent	Absent or mild
Redness	Mild to moderate	Moderate	Moderate to severe
Other Symptoms	Sneezing, nasal allergy, eczema	Recent URTI, preauricular lymphadenopathy	No systemic signs usually
Contagious?	No	Yes	Yes
Typical Triggers	Dust, pollen, pets	Viral illness (e.g. adenovirus)	Direct contact or autoinoculation
Treatment	Cool compresses, antihistamine drops	Supportive: hygiene, lubricants	Usually self-limiting; chloramphenicol if needed
Referral Needed?	No	No	No (unless not resolving after 3–5 days)

Contact Lens–Associated Keratitis

Category: Eye – Painful Red Eye

Patient: 20-year-old woman with 2-day history of painful red eyes, contact lens user

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INTRODUCTION

"Hello, my name is Dr [Name], one of the junior doctors here today. Could I confirm your full name and age, please?"

"Thank you. I understand you've come in with pain and redness in both eyes. If it's alright with you, I'd like to ask some questions and then examine your eyes."

PRESENTING COMPLAINT – Bilateral Eye Pain

ODIPARA:

Onset: "When did the pain start?" → 2 days ago

Duration: "Has it been constant or coming and going?"

Intensity: "Would you describe it as mild, moderate, or severe?"

Progression: "Is it worsening or staying the same?"

Associated features:

"Are your eyes red?" → Yes

"Any discharge or watering?" → Yes

"Any blurring of vision?" → Yes

"Any photophobia (light sensitivity)?"

"Any itchiness?"

Relieving/aggravating: "Does anything make it worse or relieve it?"

DIFFERENTIAL DIAGNOSIS & RED FLAG SCREENING

"Let me ask a few more questions to rule out other possible causes."

Question	*Screens For*
"Any severe headache or nausea?"	Acute glaucoma, GCA
"Any foreign body sensation or trauma?"	Corneal abrasion
"Any ulcers or eye injuries in the past?"	Recurrent erosions
"Do you wear contact lenses regularly?"	Risk factor for microbial keratitis
"Did you sleep with your contact lenses in?" → Yes	Major risk factor for microbial keratitis
"Any pain on looking at bright light?"	Suggestive of corneal involvement
"Any joint pain, oral ulcers, or urinary issues?"	Reiter's/autoimmune uveitis
"Have you used any new eye drops recently?"	Allergic reactions

SYSTEMIC & RISK HISTORY

PMAFTOSA:

Past: No chronic illness

Meds: None

Allergies: Ask specifically about eye drop reactions

Family history: Autoimmune or visual conditions
Trauma: No direct injury
Occupation: Vision-related impact?
Social: Uni student? Lifestyle habits?
Activities: Contact lens use—daily wear, sleeping with lenses

DESA:

Diet, exercise, smoking, alcohol – no significant findings

ICE

Ideas: "Do you think this is just irritation from contact lenses or something more serious?"
Concerns: "Are you worried this could affect your eyesight?"
Expectations: "Were you hoping for some drops or specialist review?"

EXAMINATION

"Thanks for sharing that. I'd now like to examine your eyes—it won't be painful, and I'll maintain your privacy. A chaperone will be present. Is that alright?"

Eye Examination:

Observations: Normal vital signs
Visual Acuity (Snellen):
Right: 6/18
Left: 6/36
Inspection:
Conjunctival redness
Watery or mucopurulent discharge
No periorbital swelling
Pupillary Reflexes:
Direct and consensual responses preserved
No RAPD
Visual Fields: Confrontation – normal
Colour Vision: Ask – likely unaffected
Fundoscopy: Normal

PROVISIONAL DIAGNOSIS: "Your symptoms and findings are suggestive of **contact lens–related keratitis**, which is inflammation or infection of the front part of your eye (the cornea), most likely due to sleeping with lenses in. The **cornea** is the clear front part of your eye that focuses light. In your case, the contact lens has likely caused a breakdown in the surface of the cornea, allowing bacteria to enter and cause inflammation or even infection. This is called **keratitis**, and it can become serious quickly if not treated—so we'll take action immediately."

MANAGEMENT PLAN

Urgent Ophthalmology Referral:

"You need to be seen **urgently by an eye specialist today**, ideally at the hospital eye clinic. They'll do a **slit-lamp exam** and may take a **corneal scrape** to identify the organism."

Treatment:

Likely **topical antibiotics** (hospital initiated):

Broad-spectrum such as **gentamicin** or **vancomycin** eye drops

Analgesia for eye pain (oral paracetamol/ibuprofen)

May require **admission** if ulceration or worsening vision

Contact Lens Advice:

"Avoid wearing contact lenses until your eye is completely healed."

Educate on lens hygiene:

Never sleep in single-use lenses

Reusable lenses must be **cleaned, disinfected**, and stored properly

Always use **fresh lens solution**

Never re-use old solution or water

Driving & DVLA:

"Since your vision is affected and you're being referred urgently, please **avoid driving until your ophthalmologist confirms your vision is safe**."

SAFETY NETTING

"If the pain worsens, your vision becomes more blurry, or you develop any new symptoms like eye swelling or discharge, please return to A&E immediately."

"We'll ensure you're seen today by ophthalmology for rapid treatment."

FOLLOW-UP PLAN

Provide **leaflet** on keratitis and contact lens hygiene

GP follow-up after discharge to ensure healing and discuss contact lens safety

13. Scleritis

Category: Eye – Painful Red Eye
Setting: GP Surgery
Role: FY2 Doctor
Patient: 70-year-old woman with right eye pain for 1 week

INTRODUCTION

"Hello, my name is Dr [Name], one of the doctors here today. Could I confirm your full name and age, please?"
"Thank you. I understand you've been experiencing some discomfort in your right eye—if it's alright, I'll ask you a few questions and then examine your eyes."

PRESENTING COMPLAINT – Right Eye Pain

"Let's start with your eye symptoms."

SOCRATES:

Site: "Where exactly is the pain?" → Right eye

Onset: "When did it begin?" → 1 week ago
Character: "Is the pain dull, deep, sharp, or throbbing?" → Deep ache
Radiation: "Does the pain spread to your forehead, cheek, or temple?"
Associated symptoms:
"Any photophobia?" → Yes
"Any redness or discharge?" → Redness, no discharge
"Any watering or itchiness?" → No
"Any vision changes like blurring, floaters, or double vision?" → Some blurring
Timing: "Has it been constant or worsening?"
Exacerbating/relieving: "Does it get worse with eye movement?" → Yes
Severity: "How bad is it on a scale from 1 to 10?"

DIFFERENTIAL DIAGNOSIS SCREENING

"Let me rule out some other causes of eye pain."

Question	*Screens for*
"Any gritty sensation or feeling like something's in your eye?"	Conjunctivitis, foreign body
"Have you used contact lenses recently?"	Keratitis
"Do you see halos around lights?"	Glaucoma
"Any recent eye trauma or injury?"	Traumatic scleritis
"Any headaches or jaw pain?"	GCA
"Any rashes or cold sores?"	Herpes simplex/zoster keratitis

SYSTEMIC & RISK HISTORY

"Now I'll ask about your general health and background."
"Do you have any joint conditions like rheumatoid arthritis or autoimmune disease?" → Yes
"Have you been diagnosed with RA or take medications like methotrexate?" → Yes, on methotrexate
"Any joint stiffness in the morning or swelling?"
Past medical history: Confirm RA
Medications: Methotrexate (weekly)
Allergies: Ask
Family history: Autoimmune or eye disease?
Trauma: None
DESA: No smoking, occasional alcohol
Impact: "Has this affected your ability to read, watch TV, or go outside?" → Yes
Driving: "Are you still driving safely?"
ICE: "Are you worried this could affect your vision?"
"Would you like to know more about what's causing the pain?"

EXAMINATION

"I'd now like to examine your eye. Please let me know if anything feels uncomfortable. A chaperone will be present."

A. General Observations:
Temperature, BP, HR, O2 sats → Normal

B. Eye Examination (Verbalised):
Inspection:
"I'd examine the eye for redness over the sclera."
Likely finding: **Deep violaceous redness** without discharge

Visual Acuity:
"I'd check both eyes with a Snellen chart." → 6/6 in both eyes
Pupils:
Equal, reactive to light; no RAPD
Eye Movements:
"I'd assess 6 directions of gaze—pain worsens on movement." → Positive
Fundoscopy: Not possible due to severe photophobia.
Visual Fields (Confrontation):
Grossly full

PROVISIONAL DIAGNOSIS
"Based on your history and the examination, I suspect this is **scleritis**—inflammation of the white part of your eye. It's often related to immune system conditions like rheumatoid arthritis. The white layer of your eye is called the **sclera**. In your case, that layer has become **inflamed**, which is why you're experiencing this deep pain and light sensitivity. This isn't an infection, but rather an immune-related reaction."
"It's considered a **serious condition** because if left untreated, it can damage the eye's structure and affect vision. Fortunately, we're catching it early."
"Since you have **rheumatoid arthritis**, this inflammation may be a sign that your immune condition is not fully controlled, even if you're on methotrexate."

MANAGEMENT PLAN
Urgent Specialist Referral:
"I'll refer you **urgently to the ophthalmology team today or within 24 hours.** They'll use specialist equipment to confirm the diagnosis and start treatment right away."
Initial Medical Plan:
Start oral NSAIDs (e.g., ibuprofen) for pain control, if no contraindications
"This helps reduce inflammation and pain while you wait to see the specialist."
Do not prescribe topical steroids or immunosuppressants in GP
Requires slit-lamp assessment
Rheumatology Involvement:
"I'll also notify your **rheumatology team**, as this may indicate your RA isn't fully controlled."
Investigations (if requested or diagnosis is new):
FBC, ESR, CRP
Rheumatoid factor, anti-CCP, ANA
Syphilis serology
Chest X-ray (to rule out systemic causes)
Urine dipstick
Driving & DVLA:
"Until your vision is confirmed to be safe by the eye specialist, I'd recommend **avoiding driving**."

SAFETY NETTING
"If you notice **worsening pain**, your eye becomes **more red or swollen**, or you experience **vision loss**, please return immediately or go to A&E."

FOLLOW-UP PLAN
Provide **leaflet on scleritis and RA-related eye disease**
GP follow-up after ophthalmology review to coordinate long-term care

Final Reassurance
"You asked if this is serious—it is something that needs treatment, but we're acting early to protect your eyesight. Most people with scleritis do well when managed quickly. The eye team may adjust your treatment depending on what they find. You're in safe hands."

Blepharitis

Category: Eye – Irritated Eyelid Margin
Setting: GP Surgery
Role: FY2 Doctor
Patient: Adult presenting with sore, itchy eyelids

INTRODUCTION
"Hello, I'm Dr [Name], one of the junior doctors here today. Could I confirm your full name and age, please?"
"Thank you. I understand you've been having some irritation around your eyes. I'm sorry to hear it's been bothering you—let me ask a few questions so we can find out what's going on and how best to help."

PRESENTING COMPLAINT – Sore, Itchy Eyelids
"Let's talk about the symptoms you're experiencing."
ODIPARA-like Eyelid History:
Onset: "When did the symptoms first start?"
Duration: "Has it been constant or coming and going?"
Laterality: "Are both eyes affected, or just one?"
Intensity/Character:
"Are the eyelids itchy, sore, or burning?"
"Is there any swelling or redness around the eyelids?"
Pattern: "Have you noticed crusting or flakes around the lashes?"
"Do your eyelids feel stuck in the morning?"
"Any gritty or foreign body sensation in the eyes?"

DIFFERENTIAL DIAGNOSIS & RED FLAGS
"Let me ask a few more questions to rule out other conditions."

Question	*Screens For*
"Any sticky discharge from the eyes?"	Conjunctivitis
"Any change in vision or blurring?"	Corneal involvement
"Any sensitivity to light (photophobia)?"	Keratitis
"Is this the first time, or have you had similar problems before?"	Chronic blepharitis
"Do certain things like smoke, dust, or makeup make it worse?"	Allergic or irritant triggers
"Have you tried anything at home like warm compresses or drops?"	Response to conservative treatment

SYSTEMIC & RISK HISTORY (PMAFTOSA + DESA)

Medical Risk Factors:

Contact lens use?
Makeup use?
Skin conditions like eczema, rosacea, or seborrheic dermatitis?
History of dry eyes or artificial tear use?

PMAFTO-SA:

Past: Any recent eye infections, trauma, or allergies?
Medications: Any eye drops or new medications?
Allergies: Medications, eye products, cosmetics?
Family: Dry eyes, rosacea, or other skin/eye conditions?
Travel/Illness: Recent illness or travel?
Occupation: Dry or dusty workplace, prolonged screen time?
Social: Smoking or alcohol use? Home remedies tried?

ICE:

Ideas: "What do you think is causing the irritation?"
Concerns: "Are you worried it could be something serious?"
Expectations: "Were you hoping for treatment today, or just reassurance?"
Effect on life:

"Is this affecting your ability to read, work, or watch TV?"
"Is it disturbing your sleep or mood?"
"Are you feeling self-conscious about how your eyes look?"

EXAMINATION

"Thanks for explaining that. I'd now like to examine your eyes. A chaperone will be present, and I'll ensure your privacy."

A. General Observations:

Vitals: Temp, BP, HR → All normal
Overall appearance: Mild local irritation, no systemic signs of infection

B. External Eye Examination:

Redness around **eyelid margin**
Crusting/flakes at **base of eyelashes**
No visible swelling or pus
No signs of conjunctivitis or deeper infection
Pupils equal and reactive to light
Vision normal (6/6)
Cornea: Clear, no ulceration or infiltrate

PROVISIONAL DIAGNOSIS

"From the history and examination, this looks like a condition called **blepharitis** — inflammation of the eyelid margins. The **edges of your eyelids** have tiny oil glands that can get blocked or inflamed. This leads to **redness,**

flakes, and irritation. It's not contagious and not dangerous, but it can cause long-term discomfort if not managed properly. It's a bit like **dandruff of the eyelids**. With regular cleaning and care, most people find relief."

MANAGEMENT PLAN

First-Line: Eyelid Hygiene

"The most important part of treatment is regular cleaning of the eyelids."

Warm Compresses:

Use a clean flannel soaked in warm water over closed eyes for 5–10 minutes, once or twice daily

Eyelid Massage:

Gently massage lid margins to help unblock glands

Lid Cleaning:

Use cotton buds with cooled boiled water, **diluted baby shampoo**, or a commercial lid-cleaning solution to clean at the base of the lashes

Maintenance:

Continue cleaning even after symptoms improve (once daily)

Supportive Measures:

- Use **preservative-free artificial tears** for dryness
- Avoid **eye makeup** during flares, especially mascara and eyeliner
- Avoid **contact lenses** during flare-ups
- Consider tea tree facial products if mites or rosacea suspected

Medications (if hygiene fails after 2–4 weeks):

- **Topical chloramphenicol 1%** ointment to the lid margin twice daily for 6 weeks
- In persistent or severe cases: **oral tetracyclines (e.g. doxycycline)** → if appropriate, specialist advised

Do not prescribe steroid creams/drops unless recommended by an eye specialist

Referral Indications:

- No improvement with hygiene or antibiotics
- Recurrent **chalazia** or **meibomian gland dysfunction**
- Suspected **rosacea**
- Any **corneal involvement** (e.g. blurred vision, photophobia)
- Diagnostic uncertainty

Driving: *This condition doesn't affect vision, so no restrictions*

SAFETY NETTING

"If you develop **severe eye pain**, **blurred or reduced vision**, or sudden **swelling/redness** of the eye, please return immediately or go to A&E."

FOLLOW-UP PLAN

- Provide **NHS leaflet on blepharitis and lid care**
- **No routine follow-up** if symptoms settle

Review in **4–6 weeks** if symptoms persist despite regular care

Arcus Senilis

Category: Eye – Patient Concern About Appearance
Setting: GP Surgery
Role: FY2 Doctor
Patient: Older adult female presenting with concern about a ring around the eye

INTRODUCTION
"Hello, I'm Dr [Name], one of the doctors here today. Could I confirm your full name and age, please?"
"Thanks. I understand you've come in after noticing a ring or growth around your eye. If it's alright, I'll ask a few questions about your eyes and vision, and then examine them."

PRESENTING COMPLAINT – Ring Around Eye
"Let's go through what you've noticed recently."
ODIPARA-like History for Visual Changes:
Onset: "When did you first notice the ring?"
Duration/Progression: "Has it changed in size or colour since you first noticed it?"
Associated symptoms:
"Have you had any blurred vision recently?"
"How is your vision at night or in dim light?"
"Any floaters, flashes, or patches of vision missing?"
"Any trouble recognising faces, reading, or watching TV?"
"Has the blurriness you mentioned resolved with the new glasses?" → Yes

DIFFERENTIAL DIAGNOSIS SCREENING
"Let me ask a few more questions to rule out other causes of vision changes."

Question	*Screens For*
"Do you feel your vision is worse at night or when it's dim?"	Cataracts
"Do you see any patches or blind spots in your vision?"	ARMD
"Any flashing lights or sudden vision loss?"	Retinal detachment
"Have you seen an eye specialist recently?"	Existing diagnosis
"Do you have any known eye conditions?"	Past history
"Do you have high cholesterol or heart problems?"	Risk factor evaluation

SYSTEMIC & RISK HISTORY
PMAFTOSA:
Past: No chronic eye disease
Medications: On no current eye medications
Allergies: None reported
Family: Any family history of early vision loss or eye conditions?
Travel/illness: No recent illness
Occupation: Retired or home-based
Social: No smoking, no excessive alcohol
DESA:
No diabetes, epilepsy, stroke, or autoimmune disease

ICE:

Ideas: "Do you have any idea what it might be?"

Concerns: "Are you worried this could be something growing or dangerous?"

→ "Will I go blind?"

Expectations: "Were you hoping for treatment, or just to understand what this might be?"

"Thanks for explaining that. I understand this has made you feel a bit unsure, so I'll do my best to clarify everything for you."

EXAMINATION

"I'll now examine your eyes—it won't be painful, and I'll ensure your comfort and privacy."

General Observations:

Patient appears well, no systemic illness

Eye Examination (Verbalised):

Visual Acuity:

"I would assess using a Snellen chart." → Normal vision with new glasses

Inspection:

A **characteristic white-grey ring** around the cornea is visible

No redness, swelling, or discharge

Pupillary Reflexes:

Normal direct and consensual reflexes

Cornea and Lens:

Cornea clear centrally, peripheral white arc observed → **Arcus senilis**

Visual Fields (Confrontation):

Grossly full

Fundoscopy:

Clear view to fundus, no signs of ARMD or diabetic changes

PROVISIONAL DIAGNOSIS

"This appears to be a case of **arcus senilis**, a common age-related change in the eye that causes a pale ring to form around the cornea."

Explanation of Arcus Senilis

"The ring you're seeing is called **arcus senilis**. It starts as a half-moon arc and usually becomes a full ring over time. It's very common in older adults."

"It's caused by **fat deposits in the tiny blood vessels** around the outer edge of the clear part of your eye called the cornea. These deposits don't affect the center of the eye and **don't interfere with your vision**."

"To give you an idea of how common it is – about 60% of people over 60 have it, and by the time we're 80, nearly everyone has some form of it."

"In younger people under 40, we call it arcus juvenilis and it may warrant a cholesterol check. But in your case, it's just part of normal ageing."

MANAGEMENT PLAN

No Treatment Required:

"Arcus senilis doesn't need any treatment. It's **benign**, and it doesn't affect your vision."

Reassurance:

"It won't grow into the eye or harm your sight. Most people live with it without even noticing it after a while."

Lifestyle Advice:

"You don't need to do anything about it. But if you're due for a cholesterol check or general health review, we can include that."

Cosmetic Discussion:

"There's no surgical option to remove it because it isn't dangerous or treatable.

If it ever makes you feel self-conscious, you could use **coloured contact lenses** for special occasions like weddings or photos."

SAFETY NETTING

"If at any point your vision changes again, you develop sudden blurring, floaters, pain, or light flashes—please come back or go to an eye clinic straight away."

FOLLOW-UP PLAN

No formal follow-up required for arcus senilis
Provide **leaflet** on arcus senilis
Offer cholesterol and BP check if clinically indicated
GP review if any vision changes in future

Common Patient Questions & Responses

Q: Do I need any treatment for this?

"No, arcus senilis doesn't require any treatment. It's harmless."

Q: Will this affect my vision over time?

"No, it stays on the edge of the eye and doesn't interfere with how you see."

Q: Can I get it removed for cosmetic reasons?

"There's no recommended surgery to remove it, but coloured contact lenses can help cover it cosmetically if it bothers you."

Giant Cell Arteritis (GCA) with Vision Loss

Category: Eye – Sudden Monocular Vision Loss
Setting: GP Surgery
Role: FY2 Doctor
Patient: Male, aged 50+, presenting with sudden vision loss and scalp tenderness

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INTRODUCTION

"Hello, I'm Dr [Name], one of the doctors here today. Could I confirm your full name and age, please?"
"Thanks. I understand you've come in with some concerns about your eye—let me ask a few questions and then we'll discuss what to do next."

PRESENTING COMPLAINT – Sudden Vision Loss

"Let's talk through your eye symptoms."

ODIPARA-based History:

Onset: "When did the vision problem begin?" → Sudden onset
Duration: "Has it lasted continuously or come and gone?"
Intensity: "Is your vision completely gone or just reduced?" → No vision on right side
Progression: "Did it start with any blurring or shadowing before it worsened?"
Associated symptoms:

"Does it feel like something is falling or covering your eye?" → Yes, curtain-like shadow

Relieving/aggravating factors: None

DIFFERENTIAL DIAGNOSIS SCREENING

"I'll ask a few more questions to rule out possible causes."

Question	*Screens for*
*"Have you had any **headaches**, especially around your temples?"*	GCA
"Any pain when chewing, particularly in your jaw?"	Jaw claudication – GCA
"Any tenderness or sensitivity when touching your scalp?"	Temporal arteritis
"Any weakness, facial drooping, or slurred speech?"	Stroke or TIA
"Any recent flashing lights or floaters?"	Retinal detachment
*"Do you have **high blood pressure or diabetes**?"*	Vascular risk
"Any episodes like this in the past?"	CRAO, amaurosis fugax
"Have you recently lost weight, had night sweats, or general fatigue?"	Systemic vasculitis

SYSTEMIC & FUNCTIONAL HISTORY

PMAFTOSA:

Past medical history: Check for known hypertension, diabetes, GCA
Medications: Any steroid use, blood thinners?
Allergies: Confirm before prescribing steroids
Family history: Any vascular, eye, or autoimmune conditions?
Trauma: None
Occupation: Any driving or visual-reliant work
Social: Smoking/alcohol history
Activities: ADL impact due to sudden loss of sight

DESA: No known diabetes, epilepsy, stroke, or autoimmune disease

ICE:

Ideas: "Do you have any idea what might be causing this?"
Concerns: "Are you worried this could be permanent?"
→ "Will I get my vision back?"
Expectations: "What were you hoping I could do for you today?"

EXAMINATION (Paper findings provided – verbalise interpretation)

General Observations:

Patient is alert, no facial asymmetry or stroke signs
No limb weakness

Eye Examination (Paper findings):

Visual acuity: No perception of light in right eye
Scalp tenderness: Present over temporal region
Pupillary reflexes: Likely RAPD in affected eye
Fundoscopy: if given, might show pale retina, cherry-red spot
Visual fields: Right-sided complete vision loss

PROVISIONAL DIAGNOSIS

"Based on the sudden loss of vision, the curtain-like description, and scalp tenderness, I'm highly concerned this is **Giant Cell Arteritis**, also known as **Temporal Arteritis**."

Explanation of GCA:
"The symptoms and findings suggest a condition called **Giant Cell Arteritis**. It's when the immune system causes inflammation in the blood vessels that supply the eyes and head. It's sometimes called a 'stroke of the eye' because it cuts off blood flow to the optic nerve, which is why the vision was lost so suddenly."
"This condition is a **medical emergency**—not because of the affected eye, but because the **other eye is at risk**. We must act fast to protect your remaining vision."

MANAGEMENT PLAN
Immediate Actions:
"I need you to go **straight to the eye hospital** now for urgent evaluation."
Do not drive:
"It's not safe for you to drive right now. Could someone take you there, or should I help arrange transport?"
Urgent referral to eye casualty and rheumatology (same-day)
"You'll be seen by the eye specialist and a rheumatologist who'll confirm the diagnosis and arrange any imaging and long-term treatment."
Emergency Treatment:
Start high-dose steroids immediately (before referral):
"I'll give you a high dose of steroids today to reduce inflammation and protect your other eye—even before we confirm the diagnosis."
Prednisolone 60–80 mg orally (or IV methylprednisolone if advised)
Investigations (likely coordinated by secondary care):
FBC, ESR, CRP → will likely be elevated
Temporal artery ultrasound or biopsy → diagnostic
Consider visual field mapping (specialist level)

Driving & DVLA:
"You must **stop driving immediately** until cleared by ophthalmology, especially as your vision is affected in one eye."

SAFETY NETTING
"If your vision worsens in the other eye, you develop a severe headache, jaw pain, or become drowsy—go straight to A&E."

FOLLOW-UP PLAN
Arrange for **transport** if needed
Provide **leaflet on GCA** and explain recurrence risk
GP to follow up within 48 hours to review symptoms and blood tests

Common Patient Questions & Responses
Q: Will I get my vision back?
"Unfortunately, once the damage has occurred, it's often not reversible. But we're acting quickly to protect your other eye."
Q: Is this going to keep happening?
"With the right treatment, we can usually keep it under control and prevent further episodes."
Q: Will I need long-term treatment?
"Yes, treatment usually continues for several months, and we'll monitor you closely."

Pituitary Adenoma (Bitemporal Hemianopia)

Setting: GP consultation
Role: FY2 GP doctor
Patient: Adult male presenting with subtle visual complaints noticed by wife

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Introduction
"Hello, I'm one of the doctors at the surgery today. Thanks for coming in.
I understand you've come in because your wife has been concerned about your eyesight — is that right?
Before we begin, could I confirm your full name and age please?
And how can I help you today?"

Presenting Complaint – ODIPARA for Visual Symptoms
"Could you tell me a bit more about what made your wife think something's wrong with your eyesight?"
→ "She says I've been bumping into things — I broke my side mirror."
Follow-up:
"Was this a one-time thing or has it happened more than once?" → "There are a few scratches on the side of my car, but I didn't notice how they happened."
Clarify further:
"How is your vision generally?"
"Do you notice any **dark patches**, **blind spots**, or **areas you can't see**?"
"Are you having trouble **seeing objects to your side**?"
"Can you still read, recognise faces, and see things directly in front?"
"Any trouble seeing in dim light or at night?"

Differential Diagnosis Screening (Vision Loss Causes)
Neuro/Endocrine Symptoms
"Any recent **headaches**, especially in the mornings or behind the eyes?"
"Any changes in your **weight**, facial appearance, or shoe size?"
"Have you experienced any **weakness, numbness, or balance issues**?"
"I know this might be a bit sensitive, but have you noticed any **discharge from your chest** or nipples?" *(Ask with sensitivity; essential for prolactin-secreting tumours)*

General Red Flags
"Any recent memory problems, fatigue, or mood changes?"
"Do you feel more tired or unwell than usual?"

PMAFTOSA
Past Medical History: Any known eye or neurological conditions? → No
Medications: Any regular medications? → None
Allergies: Any known drug or food allergies? → None
Family History: Any family history of hormone disorders, vision problems, or tumours?
Travel/Occupation: Any driving or safety-critical work?
Smoking/Alcohol: Relevant for general risk profile
Activity/Function: "Have these vision issues affected your daily life or driving confidence?"

ICE
Ideas: "Do you have any thoughts on what might be causing these vision changes?"

Concerns: "Is there anything you're particularly worried about today?"
Expectations: "What were you hoping I could do or check today?"

Effect on Life
"How have these changes affected your daily routine, work, or driving?"
→ "My wife drives me now — I'm not confident anymore."

Examination Findings
Visual Field Test: Bitemporal hemianopia
No papilloedema, cranial nerve palsy, or acute vision loss reported

Provisional Diagnosis
"Based on your history and the examination results, the pattern of vision loss — where you can't see well on the sides — is called **bitemporal hemianopia**.
This suggests there may be pressure on the nerves responsible for your peripheral vision. The most common cause of this is something called a **pituitary adenoma**."

Explanation
"At the base of your brain, there's a small but very important gland called the **pituitary gland**. It helps regulate hormones and controls several body functions.
Sometimes, a **non-cancerous growth** can develop in this gland. If it grows large enough, it can press on the **optic chiasm**, which is where your left and right eye nerves cross — that's why you may not be seeing things from the sides.
This condition is called a **pituitary adenoma**, and we need to investigate this further right away."

Management Plan
Urgent 2-week referral to **endocrinology**
→ "I'll refer you to a hormone specialist — you'll be seen within 2 weeks."
Further Investigations (arranged by specialist):
MRI brain and pituitary
Hormone blood panel: Prolactin, GH, TSH, ACTH, cortisol, FSH/LH
If confirmed, referral to **neurosurgery**
Most tumours are benign
Common treatment:
→ **Surgery through the nose (transsphenoidal)**
→ **Medical therapy** if prolactinoma (e.g., cabergoline)
Driving advice:
→ "Unfortunately, based on your visual field loss, you'll need to **stop driving immediately** and **inform the DVLA** — this is a legal requirement. They will assess your eligibility once treatment is complete."

Safety Netting
"If you develop **sudden vision loss**, **severe headache**, **vomiting**, or **confusion**, go to A&E immediately — these can be signs of pressure in the brain."
"If you notice worsening of peripheral vision, hormone-related symptoms, or anything unusual, please call the surgery."

Follow-Up
"We'll send the referral today, and the hospital should contact you within the next two weeks.

You'll likely have an MRI and blood tests there.
Once they confirm the diagnosis, they'll decide on the best treatment, which is usually very effective."

Diagnostic Note for Student
The diagnosis was based on **subtle history** of side accidents and confirmed by **bitemporal hemianopia**, which strongly suggests **optic chiasm compression** — most often caused by a **pituitary adenoma**.
Prompt recognition, **urgent referral**, and **driving advice** are critical exam points.
Always ask about endocrine features and explain the anatomy in **simple terms**.

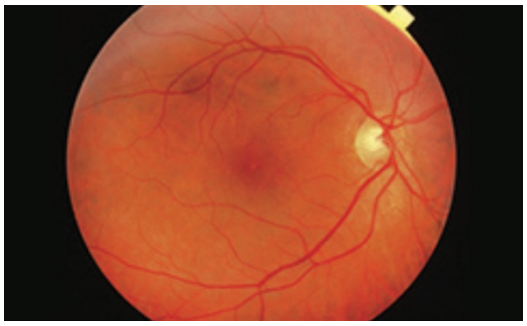
PLAB 2 Eye Case Diagnosis – Simplified Table

#	*Condition*	*Presenting Symptoms*	*Examination Findings*	*Fundoscopy Findings*
1	Retinal Detachment	Sudden visual loss with "curtain" over vision, flashes, floaters	Severely reduced acuity, possible RAPD, no redness	Pale, folded detached retina may be visible
2	Diabetic Retinopathy	Gradual blurry vision, known diabetic, missed eye checks	Reduced visual acuity, no pain, no redness	Tiny bleeds, yellow exudates, cotton wool spots
3	Hypertensive Retinopathy	Gradual vision change, known hypertension	May have reduced acuity, normal pupil reaction	Thin arteries, flame-shaped haemorrhages, swollen disc
4	Toxoplasmosis	Unilateral blurred vision, floaters, PMR on steroids, cat exposure	Reduced acuity, photophobia	White patch or scar in retina with surrounding inflammation
5	Ocular Herpes (HSV Keratitis)	Painful red eye, recurrent, history of cold sores	Red eye, photophobia, reduced acuity	Not usually done; slit lamp shows branching corneal ulcer
6	Age-Related Macular Degeneration (ARMD)	Gradual central vision loss, straight lines wavy	Central acuity reduced; peripheral vision spared	Yellow-white drusen spots in macula
7	Acute Angle-Closure Glaucoma	Sudden painful red eye, nausea, seeing halos around lights	Mid-dilated fixed pupil, hazy cornea, very high IOP, reduced vision	Disc not clearly visible; may show cupping if seen late
8	Cataract	Gradual blurry vision, glare, trouble recognising faces	Reduced acuity, poor red reflex, clear cornea	Cloudy lens blocks view of retina
9	Optic Neuritis	Sudden painful vision loss, worse with eye movement, young adult	Reduced visual acuity, poor colour vision, RAPD	Swollen optic disc or may be normal if retrobulbar
10	Subconjunctival Haemorrhage	Painless red patch in eye, normal vision, no trauma	Normal acuity, no tenderness, localised redness	Fundus normal

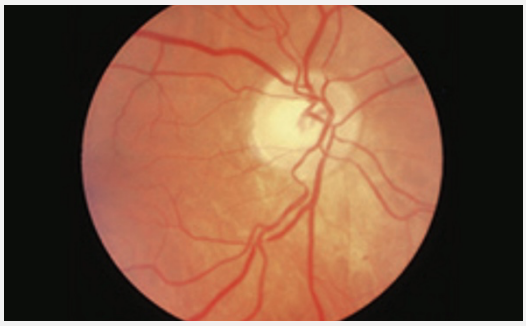
11	Conjunctivitis	Red eye with discharge; may be itchy or watery; depends on type (bacterial, viral, allergic)	Red conjunctiva, no corneal involvement, visual acuity usually normal; no photophobia or severe pain	Normal fundus; not affected as conjunctiva is external
11	Contact Lens–Associated Keratitis	Painful red eye, contact lens use, photophobia, blurred vision	Red eye, photophobia, corneal opacity, reduced acuity	Usually not visible; corneal ulcer prevents view
12	Scleritis	Deep boring eye pain, worse with movement, photophobia, RA history	Red sclera with violet hue, photophobia, normal or reduced acuity	Fundus usually normal unless posterior scleritis
13	Blepharitis	Itchy, gritty eyelids, crusting at lashes, morning stickiness	Normal acuity, inflamed lid margins, flakes around lashes	Fundus normal
14	Arcus Senilis	Asymptomatic ring around iris, noticed by patient	Normal acuity, visible grey-white ring at corneal edge	Fundus normal
15	Giant Cell Arteritis (GCA)	Sudden complete vision loss, scalp tenderness, jaw pain in person >50	No light perception, scalp tenderness, high ESR/CRP if given	Pale, swollen optic disc (AION – ischaemic optic neuropathy)

Fundoscopy images for reference

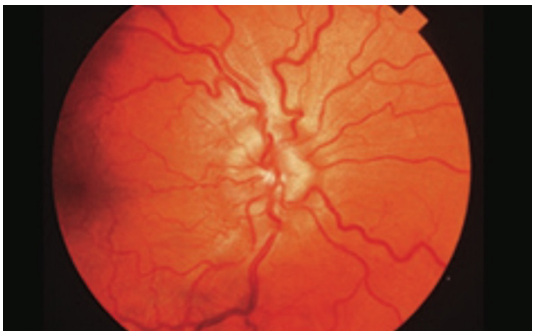
Normal fundus



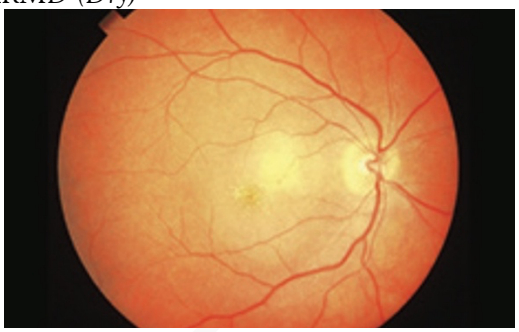
Hypertensive retinopathy



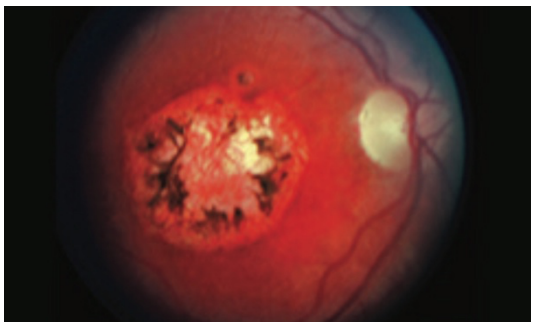
Papilloedema



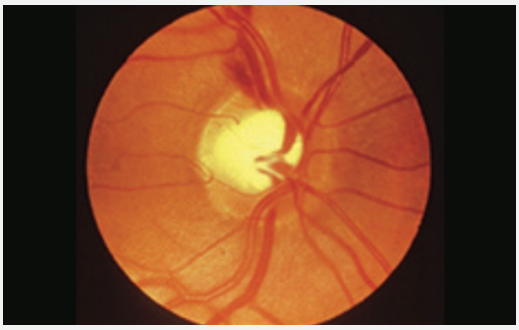
ARMD (Dry)



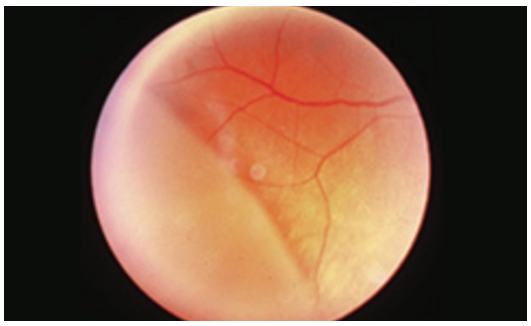
Toxoplasmosis



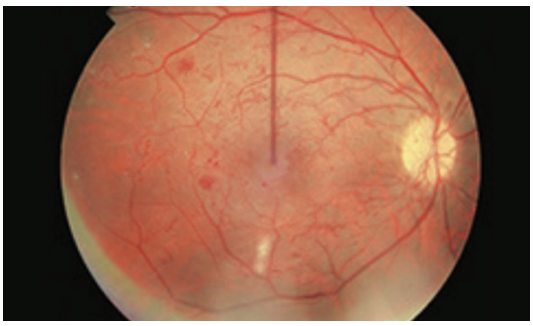
Glaucoma



Retinal Detachment



Diabetic Retinopathy (pre-proliferative)



Chapter 14: Dermatology

Introduction to Dermatology in PLAB 2

Dermatology cases in PLAB 2 can seem straightforward but often test your ability to take a **structured history**, explain clearly in **layman terms**, and respond to the patient's **emotional concerns**. These stations are highly scoreable — but only if approached with the right clinical reasoning and IPS skills.

Consultation Skills in Dermatology – IPS Focus

Dermatology cases are full of **patient emotion** — embarrassment, anxiety about cancer, or fear of contagion. Many cases mention school, work, relationships, or appearance.

You must demonstrate:

- **Sensitivity and warmth** – never rush or label it as "nothing serious" too early
- **Permission-based phrasing** – especially if examining intimate areas
- **Validating concerns** – even if it's benign, the concern is still real

Examples:

"I can imagine this must be quite frustrating, especially if it's been affecting your confidence."

"I understand this feels embarrassing — please know you're not alone. This is something we see and treat regularly."

"There's absolutely no need to feel uncomfortable — let's figure this out together."

Important: How to Use This Chapter

At the beginning of this dermatology section, we've provided a **complete and structured history format** that includes:

- **MES** – Morphology, Evolution, Symptoms
- **PMAFTOSA** – Past medical, medications, family history, travel, etc.
- **Red Flag Screening** – Especially for cancer, infection, or immunosuppression
- **Infection/Allergy Risk** – Including fever, flu symptoms, or recent exposures
- **ICE & Social Impact** – Understand fears (e.g. cancer), stigma, and school/work effects

You must learn and practise this full structure early.

It forms the core of all dermatology consultations in PLAB 2.

Reminder

You don't get points in PLAB 2 for naming a skin condition early — but you do get points for:

- **Explaining clearly what it is**
- **Offering the correct management**
- **Giving confident, kind reassurance**
- **Knowing when to refer or escalate**

Let the patient lead the case. Don't assume "rash" or "lump" until you hear it from them.

Dermatology – General Structure

Introduction

"Hello! I'm one of the doctors here at the practice.

Could I confirm your full name and age, please?

Nice to meet you today. What brought you in?"

(Let the patient describe the issue before assuming rash or lump.)

Presenting Complaint –

Morphology

(*If lesion is visible already, no need to ask about appearance—observe directly instead.*)

Location – "Where on your body is the lump or rash?"
Type – "Is it flat against your skin or raised like a bump?"
Size – "Roughly how big is it? Would you compare it to a coin or something else?"
Colour – "What colour is it?"
Pigmentation – "Any black, brown or darker colours within or around it?"
Shape – "Does it look round, or is the shape irregular?"
Surface/Texture – "Is it dry, flaky, or scaly?"
Distribution – "Have you seen similar spots or rashes elsewhere on your body?"

Evolution

Duration – "When did this start?"
Reason for visit – "Why did you decide to get it checked now?"
First noticed – "How did you first notice it? Where did it first appear?"
Progression –
"Has it changed in size, colour, or shape?"
"How has it spread?"
"Roughly how long did it take to spread?"
Triggers/modifiers –
"Does anything make it better or worse — like weather, heat, creams, or any medicines?"

Symptoms

Ask the following clearly and systematically:

"Is it **itchy**?"
"Any **pain** or discomfort?"
"Any **tingling** or unusual feeling?"
"Has it ever **bled**?"
"Any **blisters** or fluid-filled bumps?"
"Any **pus or discharge**?"
"Have you noticed **open sores or ulcers**?"
"Has it left behind any **marks or scars**?"

Additional Assessment

Surrounding area – "How does the skin around the rash look — any redness, swelling, or other bumps?"
Contact/exposure –
"Anyone close to you with a similar rash?"
"Have you had any insect bites or skin injuries recently?"
Sun exposure –
"Do you spend time outdoors regularly?"
"Any outdoor hobbies or activities involving sun or chemicals?"
"Do you use tanning beds?"

Infection or Allergy Screening (if rash)

"Have you had any **fever**, runny nose, wheezing or sneezing recently?"
"Any **swelling** around the lips, eyes, or face?"
"Have you had any **breathing difficulty**?"
"Have you ever **fainted or collapsed** recently?"

Paediatric-specific (if child)

(Only ask if appropriate and rash is in a child)

"Has your child been pulling at their ears?"
"Any crying while passing urine?"
"Any diarrhoea?"

Cancer Red Flag Symptoms

"Any unexplained **weight loss**?"
"Have you been feeling more **tired** than usual?"
"Any unusual or **persistent pain** elsewhere?"

Examination (done before PMAFTOSA) – In case of a rash (Not a strict requirement)

Say: "Thanks for the information. Would it be okay if I have a look at the rash now?"
Perform:

Look for:
- Size, colour, shape, border
- Surface: dry, moist, scaly, crusted
- Distribution: localised, symmetrical, widespread
- Surrounding inflammation or satellite lesions

Palpate gently if needed
Check nearby lymph nodes

Say: "Thanks. Based on what I can see, it looks like a [flat/raised] patch, around [size], with [scaling/redness]. The shape is [regular/irregular], and the skin around it looks [normal/inflamed]. I'll ask a few more questions now."
Important: For **telephone consultations**, do **not say "I can see" or "on examination"** unless you've an image attached with the case scenario (e.g. photo already sent in advance — and even then, interpret with care).

PMAFTOSA

Ask systematically:

P – "Have you had something like this before?"
M – "Any long-term conditions, especially immune-related ones?"
A – "Any known allergies — especially to creams or medications?"
F – "Any skin conditions or skin cancer running in the family?"
T – "Any recent travel, especially to tropical or foreign places?"
O – "What do you do for work? Does it involve sun or chemicals?"
S – "Do you smoke or drink alcohol?"
A – "Any medications you're currently taking — particularly for joint or immune issues?"

ICE

"Do you have any idea what might be causing it?"
"Is there anything you're particularly worried about?"
"What were you hoping we could do for you today?"

Effect on Life

"Is this rash affecting your sleep, work, or daily life?"
"Has it impacted your confidence or how you feel socially?"

For Skin Lumps (e.g. mole, cyst, lipoma)
Keep the same structure **but move Examination to after PMAFTOSA**, since:

- These lesions are **not urgent** unless suspicious.
- You'll want to complete risk history (e.g. cancer family history, travel, sun exposure) **before examining**.

Structural Change:
Correct order:

- Introduction
- Morphology
- Evolution
- Symptoms
- Red flags
- PMAFTOSA
- ICE
- Effect on Life
- **Examination comes last before summary/diagnosis**

Note: if the initial presentation is unclear, the MES questions will help decide if it's a lump or a rash.

Diagnosis to Leaflets – Final Steps
After history and examination, you must confidently lead the patient through the final steps of the consultation. This is where many PLAB 2 candidates lose marks by rushing or skipping over key IPS elements.

Use the "T-A-E-C" communication model once you've decided on a diagnosis:

Step	*What to Say*	*Example*
Tell	State your diagnosis confidently	"Based on what I've seen, this appears to be a fungal infection called tinea."
Ask	Invite the patient's perspective	"Have you heard of this before?"
Explain	Give a lay explanation (cause, course, contagiousness, safety)	"It's caused by a fungus, not poor hygiene. It's common and treatable…"
Check	Make sure they understand & feel heard	"Does that explanation make sense? Would you like me to go over any part again?"

Management Structure
Every case should include:

- **Immediate management**
  - Prescription or over-the-counter treatment
  - Duration, frequency, method of application
  - Practical tips to maximise success
- **Preventive advice**
  - Trigger avoidance
  - Hygiene advice
  - Clothing/environment adjustments

Household considerations

Should family members be treated?
Decontamination advice (if relevant)

What to expect

When it should improve
What is normal (e.g. itch may persist)
When to worry

Safety Netting

Always say:

"If the rash/lump doesn't improve in X days…"
"If it gets worse…"
"If you develop fever/spreading/redness/pain…"
→ Please come back to see us or seek urgent medical attention.

Leaflet & Closing the Consultation

Offer a leaflet

"I'll also give you a leaflet that explains this condition in simple terms and shows how to apply the cream properly."

Final check for concerns

"Does everything I've explained make sense?"
"Would you like me to go over anything again?"
"Do you feel comfortable managing this at home?"

Encouragement & Support

"You've done the right thing getting it checked."
"This is very treatable, and I'll be here if you need any help later."

IMPORTANT!!!

From This Point On:

The following cases in this chapter use a shortened history for efficiency — assuming you already know the full MES-based structure.

Additional questions that are important to ask are provided in each case. Use them logically.

In actual consultations, you must use a full dermatological history and adapt your questioning to the patient — never follow a script blindly.

In every case, consistently use IPS cues — especially the TAEC flow (Tell, Ask, Explain, Check) — to guide the patient.

DO NOT LEARN THESE NOTES BY-HEART. USE IT ONLY AS A GUIDE.

Red Flag Pitfalls – Dermatology

Essential Clinical and Communication Guidance for PLAB 2 Dermatology Stations

Dermatology stations in PLAB 2 test more than pattern recognition. Examiners assess your ability to take a structured history, interpret findings cautiously, explain clearly, and deliver appropriate management. This summary outlines common traps to avoid and key principles to follow.

1. Communication and Explanation

- Always describe what you see, even if unsure of the diagnosis. Avoid silence after examination.
- Do not use technical terms like "maculopapular rash" or "melanotic" when speaking to patients. Translate findings into plain language.
- Be clear and specific when offering a diagnosis. Avoid using vague or general terms.
- Do not create hypothetical scenarios such as "best case" or "worst case." Stick to the likely diagnosis.
- Explain the diagnosis in a way the patient can understand and confirm their understanding before moving forward.

2. History and Assessment Structure

- Use the MES approach consistently: Morphology, Evolution, Symptoms.
- Always ask about duration, change in appearance, and associated symptoms such as pain, itching, or discharge.
- Enquire about exposure risks: sun exposure, recent travel, hygiene practices, allergies, medications, and contact with others.
- Don't skip occupational or lifestyle risks, especially for skin cancers or infections.
- Ask about family history when relevant, especially in suspicious lesions or genetic conditions.

3. Management and Safety Netting

- Provide a specific plan: whether it is reassurance, treatment, referral, or monitoring.
- For benign conditions, explain why no intervention is needed but offer safety-net advice if things change.
- Be cautious with treatments. Use guideline-first options and avoid alternatives unless clearly justified.
- Reassure for conditions like seborrheic keratosis, but acknowledge cosmetic concerns sensitively.
- For suspected malignancies, arrange appropriate urgent referrals without alarming the patient unnecessarily.

4. Diagnostic Confidence and Clinical Safety

- Never suggest a diagnosis without an examination if a physical lesion is involved.
- Do not confuse similar conditions without clear clinical reasoning (e.g., ringworm vs Lyme rash).
- For rashes or lesions that appear infectious or atypical, arrange follow-up or specialist referral as needed.
- Always consider the patient's age, location of the lesion, and clinical context to guide your diagnosis and level of concern.
- Don't forget to advise decontamination measures when managing contagious conditions (e.g., scabies, tinea, impetigo).

5. Scenario-Specific Considerations

Seborrheic Keratosis:

- Reassure about benign nature but validate cosmetic concerns.
- Do not suggest unnecessary medical removal. Offer private options only if asked.

Mastitis and Breast Rashes:

- Differentiate clearly between engorgement and mastitis.

Always encourage continued breastfeeding and provide safety netting.

Scabies:

Identify characteristic linear lesions in typical sites.
Treat patient and close contacts. Emphasize hygiene and bedding decontamination.

Acne:

Do not blame hygiene or diet. Reassure and provide guideline-based treatment.
Address psychological impact and bullying where relevant.

Psoriasis and Chronic Conditions:

Avoid rushing. Explain chronicity, flare-ups, and medication side effects.
Always provide a safety net and offer support for emotional wellbeing.

Genital Dermatoses and STIs:

Maintain patient dignity. Avoid judgment.
Always take a complete sexual history.
Refer to GUM or gynaecology when required.
Provide clear information about treatment, partner notification, and follow-up.

Oral Candidiasis:

In children, consider feeding impact and inhaler use.
In elderly patients, check for drug interactions (e.g., with warfarin).

Lyme Disease:

Ask about tick exposure. Identify the characteristic bullseye rash.
Do not confuse it with fungal infections.
Treat with doxycycline and refer if systemic involvement is suspected.

Vulval Lesions:

Take any genital growth seriously, especially in older patients.
Refer urgently if malignancy is suspected, particularly in cases with lichen sclerosus history.

6. General Clinical Judgment

Avoid overconfidence with visual diagnosis. Combine history with findings.
Acknowledge cosmetic concerns with sensitivity, particularly in older adults.
Do not dismiss conditions that appear minor to you; patients may be distressed or embarrassed.
Always document examination findings and follow-up plans clearly in simulated scenarios.

Suspected Basal Cell Carcinoma (BCC)

Scenario: GP consultation. Adult with skin lesion noticed by wife or causing irritation.
Role: FY2 GP — assess, explain, and refer appropriately.

Introduction

"Hello, I'm one of the doctors here at the practice.
Could I confirm your full name and age, please?
Thanks — how can I help you today?"
(*Patient: "There's a growth here – my wife noticed it." OR "It's bleeding when I brush my hair." OR "It's affecting my glasses."*)

History – Follow dermatology lump structure (Examination after PMAFTOSA)
Diagnostic pivots for BCC:

Location: sun-exposed areas (face, scalp, forehead, nose)
Pearly/shiny/rolled edge
Bleeding with minor trauma
Non-healing sore
Grows slowly
Often asymptomatic
No rapid change or systemic symptoms

Ask specifically:

"When did you first notice it?"
"Has it changed at all in shape, size, or colour?"
"Has it ever bled, oozed, or crusted?"
"Has anyone in your family had skin cancer?"
"Do you spend a lot of time in the sun — for work or travel?"

(*Patient: "I worked in Dubai outdoors for years."*)

PMAFTOSA (Summarised)

No similar previous lesions
No major chronic illness
No allergies
Family history unclear or negative
Lived/worked in sunny climates (e.g., Dubai)
Retired/working in office now
Non-smoker
No regular meds

ICE

"Is it skin cancer?"
"Is it because of my time in Dubai?"
"Will I need time off work? Is this dangerous?"

Effect on Life

"Has it made wearing glasses, combing your hair, or daily tasks uncomfortable?"
"Is the bleeding or appearance bothering you or your partner?"

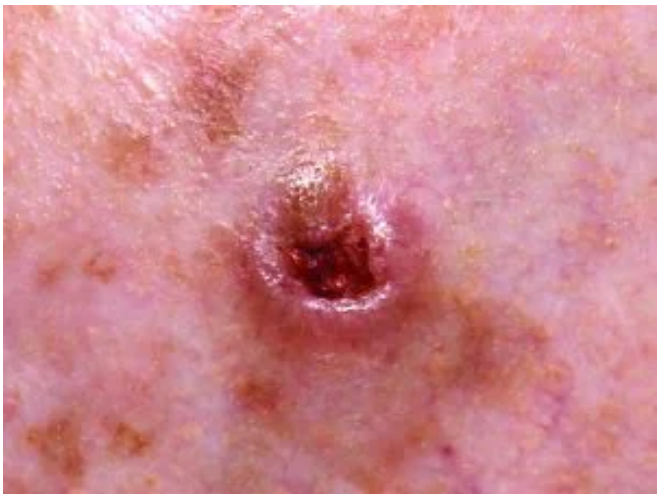
Examination (done after PMAFTOSA)

"Thanks. Would it be alright if I take a closer look at the area now?"

Findings (examples by site):

Back of head: Pearly lesion, slightly raised, shiny surface, telangiectasia, small area of crust
Nose: Dome-shaped nodule, translucent centre, interfering with glasses
Forehead: New nodule at hairline, shiny appearance, bleeds easily

"I can see a small, shiny, raised lesion here. It has a pearly surface and a slightly rolled border, with a small area that looks like it could bleed. There's no redness or swelling around it."



Provisional Diagnosis
"Based on what you've described and what I can see, this looks like a **basal cell carcinoma** — a very common form of skin cancer."

Explanation
"I want to reassure you — although this is a type of skin cancer, it's the most treatable kind.
It usually grows very slowly, stays localised, and almost never spreads elsewhere."
"It develops over time in sun-exposed areas. Working outdoors in Dubai likely played a part — sun exposure is one of the biggest risk factors."
"It's also very common in the UK — especially in older adults, or people with fair skin who've had a lot of sun."

Management Plan (By Site)

Site	*Referral*	*Reason*
Back of head	**Routine dermatology referral**	Not in a high-risk site, no urgent features
Nose or hairline	**Urgent 2-week skin cancer pathway**	Facial lesions are referred urgently regardless of appearance

"I'll refer you to a skin specialist — a dermatologist — who will assess it in more detail.
If it's on your face or close to the eyes or nose, we'll do this as an **urgent referral**. It's not because it's dangerous right now — it's just to avoid any risk of complications later."
"For areas like the back of the head, if there's no sign it's aggressive, we do a **routine referral** — the treatment is still the same."

What the dermatologist may do:
Examine the lesion under magnification
Possibly take a **biopsy** or remove it under local anaesthetic
Recommend treatment:
Surgical excision (most common)
Cryotherapy (freezing)
Topical treatments (for small superficial lesions)
Mohs micrographic surgery (if near sensitive areas like the nose or eyes)

Safety Netting
"Please come back if the lesion changes in colour or size, bleeds more often, becomes painful, or if any new patches appear elsewhere."
"Also, let us know if you don't hear from the hospital within 2 weeks if I'm sending this as an urgent referral."

Follow-Up + Leaflet
"I'll give you a leaflet about BCC and skin protection.
No need for follow-up with me unless it changes — the dermatologist will take over the next steps.
You can carry on with work as normal — though if you have minor surgery, you might need a day or two off to heal."

Suspected Squamous Cell Carcinoma (SCC)

Scenario: GP | Female, ~60 years old | Forearm lesion present for 1–3 months
Your Role: FY2 GP — assess, examine, explain, and arrange referral.

Introduction
"Hello, I'm one of the doctors here at the practice.
Could I confirm your full name and age, please?
Thanks. What brings you in today?"
(*Patient: "I thought it was an infection, but it's still there. Looks like it's not healing."*)

History – Follow standard dermatology lump structure
Examination will follow PMAFTOSA.
Diagnostic pivots for SCC:

- Location: sun-exposed (face, scalp, forearms, hands)
- Lesion often **scaly, crusted, ulcerated, or firm**
- Bleeds or doesn't heal over weeks
- May start as red patch or wart-like lump
- Growth over 1–3 months
- Often misinterpreted as an abscess or infected spot
- Risk factors: age, chronic sun exposure, fair skin, immunosuppression

Ask specifically:

- "When did you first notice this lesion?"
- "Has it changed recently — in size, colour, or shape?"
- "Has it ever bled, crusted, or felt painful?"
- "Any swelling around it or in nearby glands?"
- "Any past similar lesions or history of skin problems?"
- "Have you spent a lot of time in the sun over the years?"

PMAFTOSA

- No previous skin cancers
- No systemic illnesses reported
- No allergies
- Family history negative for melanoma/SCC
- Retired — worked as gardener

Smoked in past, no alcohol
No current medications

ICE

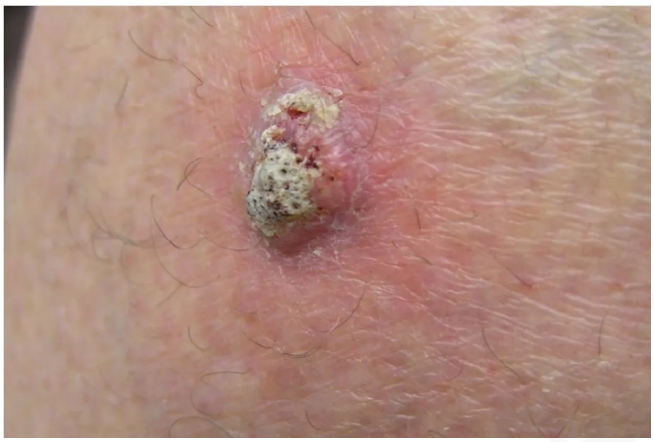
I: "I thought it might be a boil or infection, but it's not going away."
C: "Is it serious? Could it be cancer?"
E: "I just want to know what's going on and get it sorted."

Effect on Life

"Does it affect your ability to do tasks like gardening, dressing, or sleeping?"
"Is the appearance bothering you at all?"

Examination

"Thanks for all that. Would it be alright if I have a look at the lesion now?"



Findings:

"I can see a slightly raised lesion on your forearm. It's around [size], firm to touch, with a crusted surface. The border appears slightly irregular, and the colour is reddish-brown with some scaling. There's no major swelling in the surrounding skin, but it does look like it could bleed or ulcerate."

Provisional Diagnosis

"Based on what I can see and what you've told me, this could be a type of skin cancer called **squamous cell carcinoma** — or SCC."

Explanation

"I know that sounds scary, but let me explain clearly.
Squamous cell carcinoma is a **common type of skin cancer**, and the good news is that it's **very treatable** when caught early.
It often develops after years of sun exposure — especially on the face, arms, or scalp."
"It may have started looking like a patch or sore and then slowly thickened or crusted. Because it's not healing and may be changing, we need to get it checked properly."

Management Plan
"I'll be referring you to a skin specialist — a **dermatologist** — through what's called a **Two-Week Wait Cancer Pathway**. That just means we want you to be seen quickly — within two weeks."
"The dermatologist will likely take a **small sample (biopsy)** to confirm what it is.
If it's SCC, the most common treatment is to **surgically remove it** under local anaesthetic."
"In some cases, especially if it's large or has spread a little, they may recommend **additional treatment** like radiotherapy — but that's not common when we catch it early."
"Most people recover fully after treatment.
However, around **5 in 100 cases** can spread if left untreated — so it's good that you came in now."

Patient Concern Handling
(*Patient: "Could this be serious?"*)
"It can be if left untreated, but from what I see now, we've caught it early.
This is why we're getting you referred quickly."

(*Patient: "Will I need time off?"*)
"The treatment is usually done as a day procedure, so if it's a simple removal, you may only need a day or two off to recover."
(*Patient: "Is this because I worked in the sun a lot?"*)
"Yes, long-term sun exposure is the biggest risk factor — and working outdoors definitely adds to that.
We'll also give you advice on protecting your skin going forward."

Safety Netting
"If this lesion starts bleeding, growing rapidly, or becomes painful — or if you notice any new patches elsewhere — please come back immediately."
"If you haven't heard from the hospital within 2 weeks, give us a call so we can follow it up."

Follow-Up + Leaflet
"I'll give you a leaflet about squamous cell carcinoma and sun safety.
We don't need to book another GP visit now — the specialist will take it from here — but you're always welcome to come back if you're unsure about anything."

Suspected Melanoma

Scenario: GP | Older male (60s), gardener | Pigmented lesion on shoulder or behind ear with recent changes
Your Role: FY2 GP – assess, explain, and refer appropriately

Introduction
"Hello, I'm one of the doctors here at the practice.
Could I confirm your full name and age, please?
Thanks. How can I help you today?"
(Patient: "My wife noticed this spot recently" OR "This mole has been changing lately.")

History – Follow standard dermatology lump structure
Melanoma-specific diagnostic pivots:

Long-standing mole or new lesion
Recent changes: darker, larger, bleeding, itching, irregular border
Location: sun-exposed areas (shoulders, face, scalp, ears, back)
Risk factors: outdoor occupation, fair skin, past sunburns
Family history of melanoma or previous skin cancers

Ask specifically:

When did you first notice this mole or spot?
What changes have you observed? (size, shape, colour, itching, bleeding)
Any discomfort or irritation?
Has anyone in your family had skin cancer?
Have you worked outdoors or had significant sun exposure over the years?

PMAFTOSA

No previous lesions removed
Otherwise fit and well, no chronic illness
No medication
Worked as a gardener for 30+ years
Non-smoker
No allergies
No relevant family history

ICE

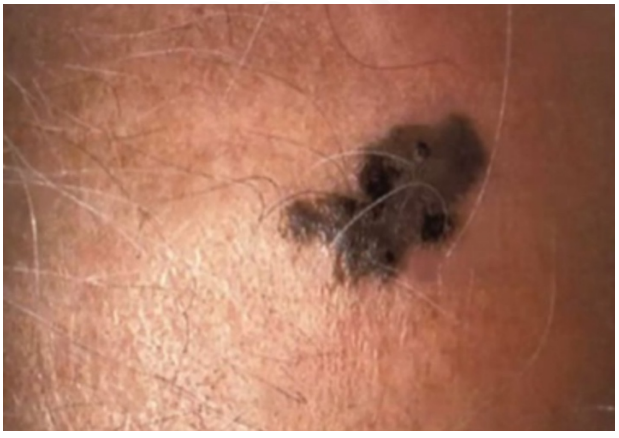
Idea: "I thought it was a mole I've always had."
Concern: "It's started bleeding. Could it be something serious?"
Expectation: "I'd like it checked properly and know what to do next."

Effect on Life

Mild irritation from clothing or grooming
Appearance has made family members worried
Anxiety about what it might be

Examination (done after PMAFTOSA)

"Thanks. Would it be alright if I have a look at the area now?"



Findings:

"I can see a slightly raised pigmented lesion with irregular borders. It's approximately [size], and the colour varies

— there are areas of dark brown, black, lighter brown, and even a touch of pink. It's asymmetrical and looks like it has recently changed. There's a small area that looks like it may bleed or ulcerate."

Provisional Diagnosis
"Based on what you've told me and what I can see, this could be a type of skin cancer called melanoma."

Explanation
"Melanoma is a serious type of skin cancer that can develop from an existing mole or as a new growth. It happens when pigment cells in the skin start growing in an uncontrolled way."
"What makes me concerned is that this lesion has changed in colour, shape, and size — and that it's started to bleed or itch. Those are signs we take seriously."
"I want to reassure you — catching it early makes a big difference. The changes you've noticed and acted on are very important, and you've done the right thing by coming in now."

Management Plan
"I'll be referring you to a dermatologist urgently through what we call the Two-Week Cancer Pathway. That means you'll be seen within two weeks."
"The specialist will examine the lesion closely and likely take a small sample — a biopsy — to confirm what it is."
"If it turns out to be melanoma, the main treatment is surgery to remove it completely. They may also perform a test called a sentinel lymph node biopsy, which checks if any nearby glands are involved."
"Depending on the findings, additional treatments like chemotherapy, radiotherapy, or newer treatments like immunotherapy might be used — but that's decided based on how early we've caught it."

Patient Concerns
"Is this because I worked in the sun a lot?"
"Yes — long-term sun exposure is one of the most important risk factors. Your work outdoors may have increased that risk, especially if there was little skin protection."

"Does this mean it's spread?"
"Not necessarily. In many cases, it's still local when caught at this stage. The referral is just to act fast and get all the information we need."

"Will it be removed quickly?"
"Yes — once the specialist confirms the diagnosis, treatment typically starts without much delay."

Safety Netting
"If you notice that the lesion grows further, bleeds more, or new patches appear anywhere else — please let us know straight away."
"If you haven't heard from the hospital in two weeks, do contact us so we can follow up the referral."
"While waiting, please avoid direct sun exposure on that area and don't apply any creams or try to remove it yourself."

Follow-Up and Leaflet
"I'll give you a leaflet about melanoma, signs to look out for, and what to expect from the referral.
You don't need to come back unless the lesion changes further or you haven't been contacted.
We'll be here for any support you need."

Seborrhoeic Keratosis

Scenario: GP setting. Older adult presents with a long-standing skin growth.
Your Role: FY2 GP – assess, explain, and manage accordingly.

Introduction
"Hello, I'm one of the doctors here at the practice.
Could I confirm your full name and age, please?
Thanks. What brings you in today?"
(Patient: "I've had this growth for a while and just wanted to get it checked.")

History – Follow dermatology lump structure
Examination will follow PMAFTOSA.
Diagnostic pivots:

- Slow-growing, often present for years
- Waxy, stuck-on appearance
- Usually painless and not inflamed
- Common in older adults
- No bleeding, ulceration, or colour change
- Not associated with systemic symptoms
- Risk concerns mainly when location is unusual (e.g., breast) or patient has family history of melanoma

Ask specifically:

- "How long have you noticed this?"
- "Has it changed in size, colour, or feel?"
- "Has it ever bled, crusted, or itched?"
- "Has anyone in your family had skin cancer?"
- "Is the appearance something that's bothering you?"

PMAFTOSA

- No history of previous skin lesions or removals
- Fit and well, no comorbidities
- No medications
- Occupation: retired, past outdoor work (gardener)
- Non-smoker, occasional alcohol
- Family history:
  - **Female case:** Positive for melanoma
  - **Male case:** No relevant family history

ICE

- Idea: "I thought it might be a wart or a skin cancer."

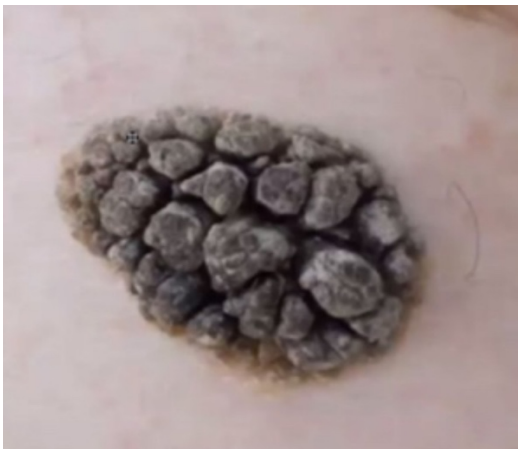
Concern: "Is it something dangerous?"
Expectation: "I'd like to know if it needs removing."

Effect on Life

"Does it bother you physically — for example, when dressing?"
"Or are you more concerned about the appearance of it?"

Examination

"Thanks for explaining all that. Would it be alright if I take a closer look?"



Findings:

"I can see a waxy, raised growth with a stuck-on appearance. It's roughly [size] and has a brown, slightly crusty surface. The shape is oval, the borders are well-defined, and there's no surrounding redness or swelling."

Provisional Diagnosis

"Based on what I've seen and what you've described, this appears to be a **seborrhoeic keratosis** — which is a harmless skin growth."

Explanation

"A seborrhoeic keratosis is a common, non-cancerous skin growth. It can look a bit odd or warty, but it's completely harmless.
It tends to appear with age, and it often looks like it's stuck onto the surface of the skin — like a small piece of wax or crust."
"There's no sign of infection or cancer here. It's not dangerous and doesn't need to be removed unless it causes irritation or cosmetic concerns."

Management Plan

A. For patients without family history of melanoma:

"As this is clearly a benign growth and not causing you any problems, we don't need to do anything further medically."
"But if at any point it changes — gets darker, starts to bleed, or becomes painful — do come back so we can reassess it."
"If you'd like it removed for cosmetic reasons, that's not something the NHS covers, but I can guide you to local private dermatology clinics."

B. For patients with family history of melanoma:
"Although this growth looks harmless, because of your family history of melanoma, I'd like you to be seen by a **dermatologist** – not because I think this is cancer, but as a precaution."
"I'll refer you through an **urgent 2-week skin cancer pathway** so the specialist can do a full skin check, possibly take a photo for future comparison, and decide if any follow-up is needed."
"They may use a tool called a dermascope to look more closely, and sometimes they take a tiny skin sample to confirm what it is."
"This is more about your **risk profile**, not because we're worried about this particular lesion."

Patient Concern
"Why are you referring me if it's not cancer?"
"That's a great question. It's really about caution due to your family history. A dermatologist can establish a baseline and make sure everything is safe going forward."

"Can I get it removed for cosmetic reasons?"
"Yes, that's completely understandable. Cosmetic removal isn't funded on the NHS, but I can give you contact details for private clinics that offer this. They'll discuss procedure options and costs with you directly."

Safety Netting
"If this or any other skin lesion changes – for example, if it gets bigger, darker, painful, starts bleeding, or looks very different – please come back right away."
"And if you haven't heard from the hospital within two weeks after the referral, contact us to follow up."

Follow-Up and Leaflet
"I'll give you a leaflet that explains seborrhoeic keratosis and how to monitor your skin.
If we're referring you, the specialist will take over from here.
If not, no routine follow-up is needed unless something changes."

Cholinergic Urticaria

Scenario: GP | Child aged 3–4 | Rash not present at the time of exam
Role: FY2 GP – assess, reassure, and advise parent appropriately

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Introduction
"Hello, I'm one of the doctors here at the practice.
I understand that you brought your child today.
And just to be sure, could I confirm your child's full name and age?
Thank you. How can I help you both today?"
(*Parent: "He sometimes gets a rash that comes and goes."*)

Presenting Complaint – Morphology, Evolution, Symptoms
(Follow standard paediatric rash structure)
Diagnostic pivots for cholinergic urticaria:
Transient itchy rash

Triggered by heat or exertion
Lasts minutes to an hour
Appears as small pink bumps or patches
Often described as "heat rash" or "tiny red spots"
Non-infectious and no systemic symptoms

Ask:

"What does the rash look like when it appears?"
"How long does it usually last?"
"Does it happen after exercise, bath time, or in warm weather?"
"Does it itch or bother your child?"
"Does your child seem otherwise well during the rash — any fever, pain, or vomiting?"

Red Flags – Rule Out Infection

"Has your child had high fever, vomiting, stiff neck, or been unusually sleepy?"
"Has the rash ever looked like dark purple spots that don't go away when you press on them?"

PMAFTOSA (Paediatric-Adapted)

No past medical issues
No medications or known allergies
No recent infections or immunisations
No family history of autoimmune or skin conditions
Child is active and well
No relevant travel history
Lives in warm climate (or exposed to warm environments)

ICE

Idea: "Could this be something serious?"
Concern: "Is it meningitis or some kind of infection?"
Expectation: "I want to make sure it's not dangerous or contagious."

Effect on Life

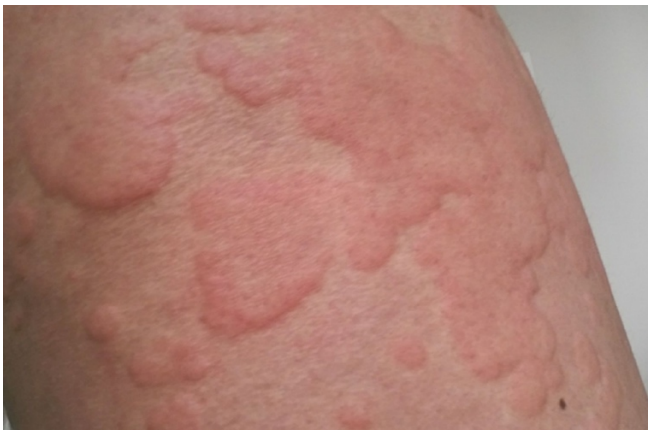
"Does the rash disturb your child's play or sleep?"
"Does your child become irritable or uncomfortable when it happens?"

Examination

"I understand the rash isn't present right now, but if it's okay with you, I'd still like to examine your child."

Perform general inspection:

Normal skin appearance during consultation
No current rash, no signs of distress, child alert and playful
No fever, no lymphadenopathy, normal vitals



Provisional Diagnosis
"From what you've described and what I've seen today, this sounds like a condition called **cholinergic urticaria** — also known as heat rash."

Explanation
"Cholinergic urticaria is a harmless skin condition that happens when your child's body heats up — for example, after running around, bathing in hot water, or being out in the sun."
"What happens is that a chemical in the skin called acetylcholine gets triggered by heat, which causes small itchy bumps or redness to appear — but they come and go quickly."
"It's not an allergy, not dangerous, and not something that can spread to other children."

Management Plan
"We usually treat this with **antihistamine medication** — these are safe and available over the counter. You can give it to your child when the rash appears or even before known triggers — like before showering or going outside on a hot day."
"You don't need a prescription for this, but if you prefer, I can also write one for you. Make sure to always have some at home or when travelling."

Advice (Prevention Tips)
Keep showers **lukewarm**, not hot
Avoid **overdressing** the child in warm weather
Adjust indoor **room temperature** if it's too hot
Pre-dose with antihistamines before **playing outdoors** on hot days
Carry antihistamines when **travelling to hot countries**

Safety Netting
"This condition is generally mild and self-limiting. But in **very rare cases**, it could trigger a more severe reaction. Please seek emergency help if you ever notice any of these:
Swelling of lips, face, or around the eyes
Trouble breathing or wheezing
Fainting or dizziness"
"Call an ambulance immediately if any of those occur — but again, this is extremely rare."

Follow-Up
"If the rash starts to get worse, doesn't respond to antihistamines, or if you feel something's just not right — please bring your child back in."
"Otherwise, this is something you can manage at home using what we've discussed."

Leaflet
"I'll print a leaflet for you that explains cholinergic urticaria and how to manage it safely. It also includes a checklist of when to seek further help."

Acne Vulgaris

Scenario: Telephone call. 17-year-old male. Mild acne on forehead. Shared image sent prior.
Your Role: FY2 GP – assess, counsel, and initiate treatment remotely.

Introduction
"Hello. Am I speaking to [patient name]?
This is Dr [Your Name], calling from the GP surgery. Is now a good time to speak?"
"Before we begin, can I just confirm a couple of quick details to make sure I've got the right person? Could you please confirm your age and the first line of your home address?"
"Thanks. I've seen the photo of your skin that you sent us. How can I help you today?"
(*Patient hesitates to talk; you pick up on it.*)
"You sound a bit hesitant — is there anything about this that's been particularly difficult to talk about?"
(*Patient: "I've been getting bullied at school. They say it's because I'm not clean enough."*)
"I'm really sorry to hear that — that must be incredibly upsetting.
I want you to know clearly that acne is **not** caused by poor hygiene. Let's go through what's happening and how we can help you feel better."

History – Follow standard dermatology rash structure (adapted for photo review)
Since this is a remote consultation, ask for specific acne pivots:

"When did the acne first appear?"
"Has it been spreading or getting worse?"
"Have you noticed whiteheads or anything oozing?"
"Do you ever pick or scratch at the spots?"
"Have you used anything to treat it so far — creams, scrubs, face washes?"
"Are you using anything now — over-the-counter or prescribed?"
"Any past use of antibiotics or medicated creams?"

No systemic symptoms or red flags. No history of severe nodulocystic acne or scarring. No signs of hormonal triggers like hirsutism or irregular periods (if female).

ICE

Idea: "I thought it was a scar, but it's been there for a while."
Concern: "I'm worried people think I'm dirty or unhygienic."
Expectation: "I just want to fix it. I'm getting bullied and it's really affecting my confidence."

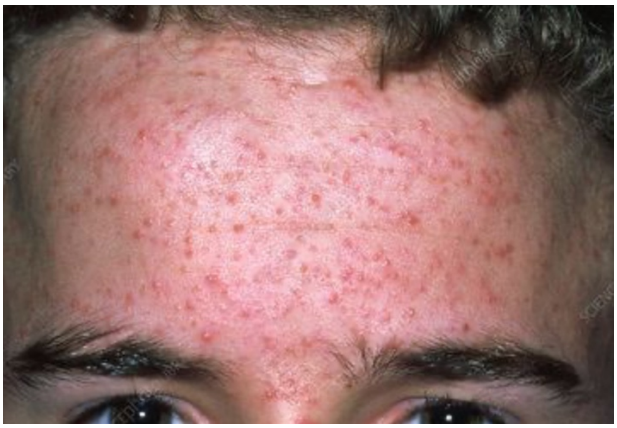
Effect on Life

"Has this been affecting your mood, confidence, or social life?"

"Are you avoiding certain things — like photos, sports, or school events?"
"Is it interfering with your sleep or making you feel isolated?"

Examination (via photo review)

"I've reviewed the picture you sent. I can see small bumps and whiteheads around your forehead. There are no signs of infection, inflammation, or scarring at the moment."



Provisional Diagnosis

"From what I can see and what you've told me, this condition is called **acne vulgaris** — a common skin condition, especially in teenagers."

Explanation

"Acne happens when small glands in your skin get blocked with oil and dead skin. This leads to whiteheads, blackheads, and sometimes red bumps.
It's linked to **hormones**, not hygiene. Washing more doesn't prevent acne — in fact, **over washing can make it worse**."
"What you're experiencing is really common — and it's not your fault. Many people your age go through it."

Management Plan

"To treat this, I'd recommend starting with a cream called **benzoyl peroxide**. It helps to reduce inflammation and clear blocked pores."
Instructions:

- Apply a thin layer **once daily**, ideally at night
- Use on **clean, dry skin**, but **not immediately after washing**
- It may cause **mild irritation** or dryness in the first 1–2 weeks — this usually settles
- Avoid contact with **eyes, lips, and broken skin**
- **Bleaches fabrics** — use white towels/pillowcases

Skincare & Lifestyle Advice

"Some important tips that really help with acne:"

- Wash your face **no more than twice a day** using a **gentle, non-alkaline cleanser**
- Avoid scrubbing or exfoliating — it worsens inflammation
- Don't pick or squeeze spots — it can **cause scarring**
- Use non-comedogenic (non-oily) moisturisers
- Avoid tight caps or helmets on acne-prone areas

"And I really want to emphasise again — **this is not about being dirty**. Over washing can actually damage your skin barrier and make acne worse."

Emotional Support (Bullying)
"I'm really sorry you're going through bullying. That's never okay.
You don't have to deal with this alone — I'd encourage you to speak to a teacher, school counsellor, or trusted adult."
"We're also here to support you — whether it's for your skin or your mental health."

Safety Netting
"The treatment usually takes a few weeks to start working. It may get slightly worse before it improves — that's normal.
If your acne doesn't improve in **8 to 12 weeks**, or if it starts to scar or flare up badly, we may add a **topical antibiotic**, or refer you to a **dermatologist**."
"If your mood is ever really low, or you feel overwhelmed by what's happening at school, please call us or reach out immediately."

Follow-Up
"Let's book a **follow-up in 3 months** to check your progress. If needed, we can adjust the treatment."

Leaflet
"I'll email you a leaflet about acne and how to use benzoyl peroxide safely. It also covers some self-care tips and myths about acne."

Impetigo

Scenario: GP | Breastfeeding woman presents with spreading rash on face. Upset due to perceived pharmacy error.
Your Role: FY2 GP – assess, manage, and counsel.

Introduction
"Hello, I'm one of the doctors here at the practice.
Could I confirm your full name and age, please?
Thanks. I understand you're here because of a facial rash?"
(*Patient: "They gave me the wrong medication and now it's spread everywhere!"*)
"I'm really sorry to hear that you had a difficult experience. That must be very frustrating.
If it's alright with you, could I have a quick look at the rash first, and then ask you a few questions?"

History – Follow standard dermatology rash structure
Diagnostic pivots for **impetigo**:

- Rapid onset
- Itchy or painful
- **Golden crusts** or oozing patches
- May start as a small sore or blister
- Spreads by touch or close contact

Recent minor trauma, shaving, or other skin conditions as entry points

Ask:

"When did this rash first start?"
"How has it changed since then?"
"Did it begin as a small sore, spot, or blister?"
"Is it itchy or painful?"
"Have you noticed similar areas anywhere else on your body?"
"Has anyone around you had something similar?"

Red flags:

"Any fever or feeling generally unwell?"
"Any swelling of the face, or red streaks near the rash?"

Special considerations:

"Are you currently breastfeeding?"
"I know this may be a bit personal, but have you or your partner had oral contact with the area recently?" (*Used gently: "The reason I ask is because certain types of contact can sometimes introduce skin bacteria that trigger this kind of rash."*)
"Do you have any allergies — especially to antibiotics like penicillin?"
"Do you recall what medication the pharmacy gave you?"

ICE

Idea: "I thought it was a skin allergy, but it just got worse."
Concern: "I'm angry — they gave me the wrong thing at the pharmacy and it's all over my face now."
Expectation: "I need this sorted quickly. I'm breastfeeding, and I don't want to pass this to my baby."

Effect on Life

"Has it affected your sleep or feeding routine?"
"Has it been affecting your confidence or making you avoid going out?"

Examination

"I can see some **golden-yellow crusts** over red patches on your face, especially around the nose and cheek area. There's no visible swelling or heat, and no signs of deeper infection."

Provisional Diagnosis
"From what you've told me and what I can see, this looks like a bacterial skin condition called **impetigo**."

Explanation
"Impetigo is a **bacterial skin infection** — usually caused by a bacteria called *Staphylococcus aureus*.
It often starts when bacteria enter through a small break in the skin — like a spot, cut, or even dry skin — and it spreads easily by touch."
"It's **not your fault**, and it has nothing to do with hygiene or how you've looked after yourself. It's very common and can happen to anyone — including children and adults."

Management Plan
"I'll prescribe a cream called **fusidic acid**, which is an antibiotic.
You'll need to apply a small amount to the affected areas **2 to 3 times a day**, covering the entire visible rash — not just the centre."
"It's safe to use even if you have a **penicillin allergy**, and it's considered safe in breastfeeding, as long as it's not applied near the breast."

Contagion Advice (48-hour rule)
"Impetigo is **contagious** — mainly for the first **48 hours after starting treatment**. During that time, please take the following precautions:"

- Avoid close face-to-face contact
- Don't kiss anyone, especially your baby
- **Avoid breastfeeding for 48 hours** – use expressed milk or formula temporarily
- Cover the rash with a clean dressing if going out
- Don't share towels, clothes, or bedding
- Wash hands frequently and avoid touching or scratching the area
- Avoid going to work or nursery drop-offs during this period

Hygiene & Prevention Tips
"It's important to keep the skin clean, but avoid **excessive washing**, which can make things worse. Use warm water and gentle cleansing once or twice a day.
Dry gently with a clean towel — and don't share that towel with anyone else."

Patient Concerns
"Why do I have to stop breastfeeding?"
"That's just for the first 48 hours. We want to avoid accidental transfer through skin contact — especially if your baby touches the rash during feeding."

"Can this leave a scar?"
"Not usually, especially if treated early. Just try not to scratch, and let the cream work."

"Can I complain about the pharmacy?"
"If you'd like to, I can help direct you to the complaints process. But first let's get this under control — and I'll make sure we document everything accurately."

Safety Netting
"If the rash gets worse, spreads, becomes painful, or if you develop fever, please contact us immediately. Also return if it doesn't improve within **3–5 days** of treatment."

Follow-Up
"If there's no improvement after 5 days, or if the rash recurs, we may need to switch to **oral antibiotics** or refer to dermatology. But most cases respond very well to cream alone."

Leaflet
"I'll give you a leaflet that explains more about **impetigo**, how to treat it, and when to seek help. There's also guidance for breastfeeding mothers and how to avoid spreading it."

Herpes Labialis (Cold Sore)

Scenario: GP | Adult male model presents with painful blisters around lips
Your Role: FY2 GP – assess, explain, and advise with empathy and professionalism

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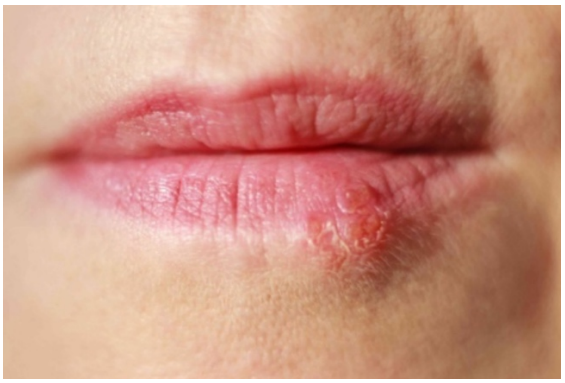
Introduction
"Hello, I'm one of the doctors here at the practice.
Could I confirm your full name and age, please?
Thanks. What brings you in today?"
(*Patient: "I've developed these blisters on my lips, and it's affecting my work as a model."*)

History – Follow dermatology rash structure
(Examination comes before PMAFTOSA)
Diagnostic pivots for herpes labialis:
- Tingling/burning sensation before blisters
- Painful vesicles or crusts near vermilion border
- May recur, especially during stress or illness
- Highly contagious during outbreak

Ask:
- "When did the symptoms first start?"
- "Did you feel any tingling or burning before the blisters appeared?"
- "Have you had anything like this before?"
- "Are the blisters painful or itchy?"
- "Have your partner or child had similar symptoms recently?"
- "Are you taking any medications or have any long-term conditions?"

Red Flag Screening
- "Have the blisters spread to your eyes or other parts of the face?"
- "Any fever, fatigue, or difficulty eating or drinking?"

Examination
"Thanks. I'm going to examine your lips now, especially where the skin meets the inner part of the lip — the vermilion border."



Findings:
"I can see multiple small fluid-filled blisters with some crusting around the edge of the lip, mostly near the vermilion border. There's mild redness, but no swelling or signs of deeper infection."

PMAFTOSA

No chronic illness
No regular medication
Married with one child
Works as a model (cosmetic impact important)
No history of immunosuppression
No known allergies
Generally well otherwise

ICE

Idea: "Is this a cold sore? It looks familiar."
Concern: "I'm worried it'll affect my modelling job."
Expectation: "Can I get something to make it go away quicker?"

Effect on Life

"Is this affecting your confidence or ability to work?"
"Have you had to cancel any photo shoots or events?"

Provisional Diagnosis

"From what you've told me and what I can see, this is a condition called **herpes labialis**, commonly known as a cold sore."

Explanation

"Cold sores are caused by a **virus called herpes simplex**, which stays in the body and can reactivate from time to time.
It's not dangerous, but it can be painful and contagious."
"People usually notice **tingling or burning** first, followed by small blisters, and then a scab forms as it heals. It usually settles on its own in about **7 to 10 days**."
"Outbreaks can be triggered by things like stress, sunlight, illness, or fatigue."

Management Plan

"Cold sores often **go away on their own**, but to help relieve symptoms and speed up healing, you can:"

Use **over-the-counter antiviral cream** (like aciclovir), ideally **at the tingling stage**
Take **paracetamol** or **ibuprofen** for discomfort
Keep the area **clean and dry**
Avoid squeezing or picking at the blister

"If started early, antiviral creams can reduce severity and duration.
If symptoms persist or worsen, we can consider prescribing a short course of **oral antivirals**."

Contagion & Prevention Advice

"This condition is **highly contagious** while blisters are present. For the next **7–10 days**, I recommend:"

Avoid kissing or close contact, especially with your daughter
No oral sex or sharing utensils, cups, or towels
Cover the lesion if possible and **wash your hands** after touching your face
Wear a mask in public or professional settings if you feel more comfortable

Occupational Advice

"You can still go to work if you feel well, but considering your profession involves modelling, you may want to **inform your agent or employer** so they're aware.
It's a visible condition, but not medically limiting unless symptoms are severe."

Safety Netting

"Please come back if:"

The cold sore **lasts longer than 10 days**
It **spreads to your eye** or **becomes very painful**
You develop **frequent or severe outbreaks**
You feel generally unwell or develop fever or swollen glands

Follow-Up

"If things don't improve in a few days, or if you'd like to explore **preventative treatment** due to your profession, we can discuss **oral antiviral tablets** or **dermatology referral**."

Leaflet

"I'll print a leaflet for you that explains herpes labialis, how to manage it, and how to prevent spreading it to others."

Measles

Scenario: University health service | 19-year-old male | Rash and viral symptoms | Telephone consultation with image available
Your Role: FY2 GP – assess, explain, and advise with public health responsibilities

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Introduction

"Hello, am I speaking to [patient's name]?
This is Dr [Your Name], calling from the student health centre.
I've got the photo of your rash in front of me. Is now a good time to talk?"
"Could you start by telling me more about what's been going on?"

History – Follow adapted rash structure for remote consultation
Diagnostic pivots for measles:

Rash: maculopapular, starts on face, spreads downwards
Fever, cough, runny nose, conjunctivitis
Koplik spots before rash (white spots in mouth)
Systemic symptoms: fatigue, malaise
Incubation: 10–12 days from exposure
Infectious from 4 days **before** and **after** rash onset

Ask:

"Did you feel unwell before the rash — fever, sore throat, red eyes, or a dry cough?"
"Did you notice any **white spots in your mouth** before the rash appeared?"
"Have you had the **MMR vaccine** before?"
"Have you been around anyone with a similar rash or diagnosed with measles?"
"Do you live in shared accommodation or attend group lectures?"
"Any history of **immune suppression**, asthma, or other chronic illness?"

Red Flag Screening

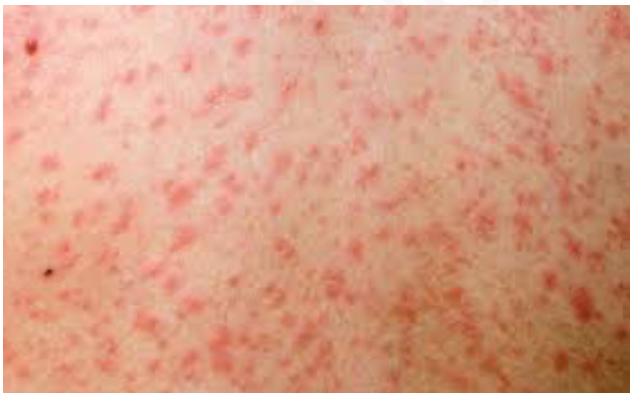
"Just to be safe, have you had any of the following?"

Shortness of breath
Confusion or drowsiness
Severe headache or neck stiffness
Seizures or fits
High fever not settling with paracetamol

(*Patient: "No, just the fever, tiredness, and rash."*)

Examination (Photo Review)

"Thanks for sending the photo. I can see a red, blotchy rash that's spread from the face to the upper body — it's consistent with a viral rash pattern



PMAFTOSA

No chronic conditions
No medication
Lives in student housing

One dose of MMR, missed second
No recent travel
Rash started 2 days ago
No known allergies

ICE

Idea: "I wasn't sure if it was a heat rash or something viral."
Concern: "Will I miss my exam? Can I visit my family this weekend?"
Expectation: "Just want to know what to do next and stop it getting worse."

Effect on Life

Fatigue interfering with concentration
Concerned about academic performance and family contact
Mild anxiety about infecting others

Provisional Diagnosis

"Based on your symptoms and the photo, this looks like **measles** — a viral infection that can spread quite easily, especially in group settings."

Explanation

"Measles is caused by a virus. It usually begins with a fever, cough, red eyes, and then a red rash that spreads across the body.
It can make you feel very tired and unwell, but most people recover with rest and fluids."
"It spreads through droplets when we cough or sneeze — which is why we ask people to stay isolated for a short time."

Management Plan – Symptom Control

"There's no specific medicine for measles itself, but we treat the symptoms and monitor for any complications."

Take **paracetamol** to control fever and aches
Drink **plenty of fluids** — aim for at least 2 litres/day
Get **plenty of rest**
Keep the room well-ventilated and avoid bright light if eyes are sore

Public Health Advice – Self-Isolation

"You'll need to **self-isolate for 4 days from the day the rash began** — so in your case, another 2 days."

No attending university, lectures, or exams
Avoid contact with housemates if possible
No contact with **young children**, **pregnant women**, or anyone **immunocompromised**
Keep shared areas clean, wash hands regularly

Legal Requirement – Notifiable Disease

"Just so you're aware — **measles is a notifiable condition**, which means we are required by law to report your case to the local public health team.
They may contact you to discuss who you've been in contact with."
"This will involve sharing limited information, such as your name and contact details, to help with **contact tracing**. Your clinical care remains confidential otherwise."

Addressing Patient Concerns
Patient: "Can I attend my exam next week?"
"The rash began 2 days ago, so by the time of your exam, you'll be **past the infectious period**. That said, you may still be tired — I recommend informing your university, and they may offer alternative arrangements."
Patient: "Can I visit my parents this weekend?"
"As long as they're generally healthy and your symptoms are improving, it's **okay to visit after your 4-day isolation ends**.
But if possible, consider waiting until next week to give your body a chance to recover fully."

Safety Netting
"Please seek urgent medical attention if:"
- You develop **difficulty breathing**
- Your fever doesn't settle with paracetamol
- You feel **confused or drowsy**
- You experience **convulsions or seizures**

Follow-Up
"Once you've recovered, we'll arrange for you to receive your **second dose of the MMR vaccine** to prevent this happening again.
Let's book that once you're fully well."

Leaflet
"I'll email you a leaflet that explains measles, how to isolate, and how to prevent further spread."

Cellulitis

Scenario: GP | ~60-year-old woman | Painful rash on left leg | Recent insect bite |Penicillin Allergy
Your Role: FY2 GP – assess, explain, prescribe appropriate antibiotics, and safety net

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Introduction
"Hello, I'm one of the doctors here at the practice.
Could I confirm your full name and age, please?
Thanks. What brings you in today?"
(*Patient: "There's a red, painful patch on my leg. I got bitten yesterday, and now it's getting worse."*)

History – Follow dermatology rash structure
Diagnostic pivots for cellulitis:
- Red, swollen, warm, tender area
- Often unilateral (commonly lower limb)
- Trigger: minor trauma, insect bite, wound
- Fever, malaise, headache may occur
- Risk factors: diabetes, lymphoedema, poor circulation

Ask:
- "When did you first notice the redness or swelling?"
- "Has the area changed in size or intensity since then?"
- "Have you had any insect bites, injuries, or breaks in the skin recently?"

"Have you checked your temperature or felt feverish?"

Systemic red flag screening:

"Have you felt very unwell, dizzy, or faint?"
"Any shortness of breath or fast breathing?"
"Any confusion or trouble focusing?"
"Any nausea, vomiting, or chills?"

Allergy and antibiotic history:

"Are you allergic to any medications — especially antibiotics like penicillin?"
"Have you taken antibiotics for cellulitis before?"

PMAFTOSA

History of mild hypertension
No immunosuppression or diabetes
Allergic to **penicillin** (rash and swelling previously)
No regular antibiotics
Lives alone, good mobility
Not on immunosuppressants

ICE

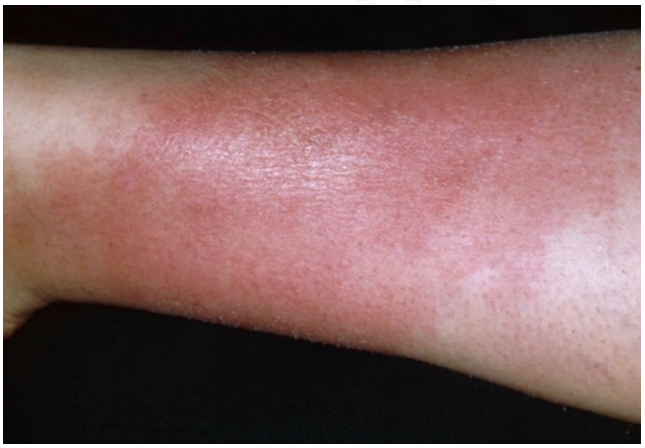
Idea: "I think it started from a bug bite yesterday."
Concern: "Is this spreading? Could it be serious?"
Expectation: "I want something to stop it from getting worse."

Effect on Life

Pain on walking
Disturbed sleep due to discomfort
Mild anxiety about infection

Examination

"Let me take a look at your leg now."



Findings:
"Your left lower leg appears red, warm, and swollen. There's no discharge, no ulceration, and no signs of necrosis.
Your temperature is 38°C.
Blood pressure, pulse, and oxygen levels are normal."

Provisional Diagnosis
"From what you've told me and what I can see, this appears to be **cellulitis** — an infection of the **deeper layers of skin**."

Explanation
"Cellulitis is usually caused by **bacteria** getting in through a small break in the skin — in your case, very likely through that **insect bite**.
It causes the skin to become **red, hot, swollen, and painful**, and can sometimes come with a fever."
"It's important we treat it early to prevent the infection from spreading or becoming severe."

Management Plan
"Since you're allergic to penicillin, I'll prescribe **doxycycline** instead, which is an effective antibiotic for cellulitis."
Prescription:

- **Doxycycline 200mg on day 1**, then **100mg once daily** for **5–7 days**
- Take with food and plenty of water
- Avoid direct sunlight exposure while on doxycycline (photosensitivity risk)
- Finish the full course even if you feel better early

"You can also take **paracetamol** for pain or fever, and try to **elevate your leg** when resting to reduce swelling."

Advice
"To aid recovery and prevent worsening:"

- Avoid standing or walking for long periods
- Keep the leg **clean and uncovered** (no dressings unless skin is broken)
- Avoid scratching or massaging the area
- Don't apply creams unless advised

Safety Netting
"If you feel **worse** at any point, or if the redness starts to **spread quickly**, go to the nearest hospital.
Specifically, please seek help immediately if:"

- You become **very unwell or confused**
- Develop **shortness of breath or dizziness**
- Your **fever gets higher** or doesn't settle with paracetamol
- The rash becomes **dark, blistered, or oozing**

"If there's **no improvement within 48 hours**, please come back — we might need blood tests or hospital antibiotics."

Follow-Up
"Let's schedule a **follow-up appointment in 3 to 4 days** to check how the leg is responding.
If things improve before then, that's great — but please don't hesitate to return sooner if needed."

Leaflet
"I'll give you a leaflet that explains **cellulitis**, its treatment, and when to seek help."

Chickenpox (Varicella)

Scenario: GP | Child with widespread rash, fever, and drowsiness
Your Role: FY2 GP – assess, confirm diagnosis, advise on symptom relief, and provide safety netting

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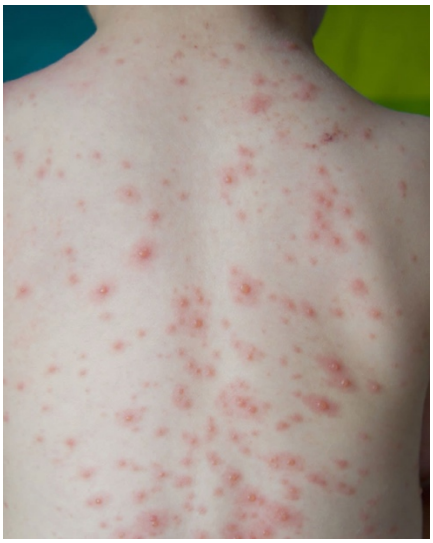
Introduction
"Hello, I'm one of the doctors here at the practice.
Are you the child's parent?
Could I confirm your child's full name and age, please?"
(*Parent: "My child has a rash all over and is feeling quite unwell."*)
"I'm really sorry to hear that. Could you tell me more about what's been going on?"

History – Morphology, Evolution, Symptoms
Diagnostic pivots for chickenpox:
- Rash begins as red spots → fluid-filled blisters → crust over
- Often starts on torso, spreads to face and limbs
- Fever, tiredness, poor appetite often precede rash
- Known contact or exposure is common
- Vaccination history may be missing in UK-born children (as not routinely offered)

Ask:
- "When did the rash first appear?"
- "Has your child had a fever, headache, or seemed sleepier than usual?"
- "Are they still drinking and eating normally?"
- "Have you noticed them scratching the spots?"
- "Has your child been in contact with anyone who's had chickenpox recently?"
- "Have they ever had the **chickenpox vaccine**?"

Red Flag Screening
"I just want to check for any warning signs. Have you noticed:"
- Dry mouth or dark urine?
- Trouble breathing or rapid breathing?
- Redness, swelling, or pus in any of the blisters?
- Very high fever not settling with paracetamol?
- Your child being unusually drowsy or not responsive?

Examination
"Thanks for sharing that. I'd like to have a quick look at your child's skin now."



Findings:
"I can see small, **fluid-filled blisters on red skin**, scattered across the body. Some have already started to scab. These are typical of **a viral rash**. There are no signs of skin infection or severe inflammation."

PMAFTOSA

No major past medical issues
Up to date on other vaccines
Not on medication
No recent travel
Lives at home with parents and siblings
No one else currently unwell
Mild fever and decreased appetite

ICE

Idea: "I think it's chickenpox."
Concern: "I'm worried about the fever and sleepiness."
Expectation: "What can I do to help them feel better and avoid complications?"

Effect on Life

Child is more tired and clingy
Parent is worried about infecting siblings or vulnerable contacts
Difficulty managing symptoms at home

Provisional Diagnosis
"From what you've told me and what I've seen, this is most likely **chickenpox** — a common viral infection caused by the **varicella-zoster virus**."

Lay Explanation
"Chickenpox usually starts with a **fever or feeling unwell**, followed by a rash made up of **small, red, itchy blisters** that eventually scab over."
"It spreads easily through droplets or contact with the fluid in the blisters. Most children recover well without complications, but we keep an eye out for certain warning signs."

Management Plan – Symptom Control

"There's no specific cure, but we manage the symptoms and make your child comfortable:"

- **Paracetamol** for fever and pain (avoid aspirin — risk of Reye's syndrome)
- Keep your child well-hydrated — offer **small sips often**
- Allow them to **rest as much as needed**
- To ease **itching**:
  - Apply **calamine lotion**
  - Use **age-appropriate antihistamines** (available at pharmacy)
  - Dress in **loose, cotton clothes**
  - Keep **nails short and clean**
  - Consider soft mittens or socks over hands at night

Infection Control Advice

"Chickenpox is **contagious from 2 days before the rash** until **all blisters have scabbed over** — usually about **5–7 days** from rash onset."

- Keep your child home from **nursery or school** until all spots are crusted and they feel better
- Avoid contact with:
  - Pregnant women
  - Newborns
  - People with weakened immune systems
- Clean surfaces and avoid sharing towels or clothing

Safety Netting

"Please contact us or seek help urgently if you notice:"

- **Trouble breathing**
- **Very high fever not settling** with paracetamol
- Blisters becoming **red, swollen, or oozing pus**
- Signs of **dehydration**: dry mouth, reduced urine, dark urine
- If your child becomes **very drowsy, confused, or unresponsive**

Follow-Up

"Chickenpox usually clears within **7 to 10 days**.
If you're worried or new symptoms appear, please get in touch. Otherwise, no specific follow-up is needed."

Leaflet

"I'll give you a leaflet that explains **chickenpox**, what to expect, and when to seek help.
If you have other children, we can talk about protecting them or what to watch out for."

Paronychia

Scenario: GP | 20-year-old male | Pain and swelling in big toe after trauma
Your Role: FY2 GP – assess, explain, differentiate from gout, manage conservatively, and safety net

---

Introduction

"Hello, I'm one of the doctors here at the practice.
Could I confirm your full name and age, please?
Thanks. What brought you in today?"
(*Patient: "I think I might have gout. My grandfather had it, and my big toe really hurts after I hit it on the tea table."*)
"Thanks for sharing that. I understand your concern — but let's not jump to conclusions just yet. Gout is quite rare in someone your age, and a direct injury can cause similar pain. Let's explore this a bit more."

Presenting Complaint – SOCRATES & Targeted History

"Can I ask a few questions to understand the pain better?"

SOCRATES:

- **Site:** "Where exactly is the pain located — near the nail or the joint?"
- **Onset:** "Did it come on immediately after hitting the table?"
- **Character:** "Is it sharp, throbbing, or dull?"
- **Radiation:** "Does the pain go anywhere else?"
- **Associated symptoms:**
  - "Any redness around the nail?"
  - "Swelling or tenderness?"
  - "Any discharge, pus, or warmth?"
  - "Any numbness, tingling, or colour changes?"
- **Timing:** "Is it constant or comes and goes?"
- **Exacerbating factors:** "Does it get worse with shoes or walking?"
- **Severity:** "On a scale of 1 to 10, how bad is the pain?"

Additional:

- "What kind of shoes do you usually wear?"
- "Do you often wear tight shoes or closed footwear for long hours?"
- "How do you usually cut your toenails — straight across or curved?"

PMAFTOSA

- No known medical conditions
- No current medications
- No allergies reported
- No diabetes
- No smoking
- Well otherwise
- Injury was blunt trauma from furniture

ICE

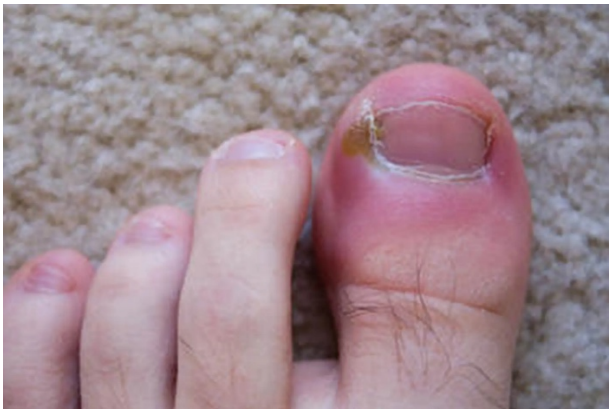
- **Idea:** "Could this be gout like my grandfather had?"
- **Concern:** "Worried it might get worse or be infected"
- **Expectation:** "Looking for pain relief and to know what's going on"

Effect on Life

- Difficulty walking long distances
- Pain when wearing shoes
- Mild interference with daily activities

Examination

"Let me take a closer look at your toe now."



Findings:

"I can see **redness and swelling around the nail fold** of your big toe. There's **no visible pus or drainage**, but the skin looks inflamed and tender."

Provisional Diagnosis

"From what you've described and what I can see, this is a case of **paronychia** – which is an **inflammation or minor infection of the skin around the nail**, often triggered by trauma or an ingrown nail."

Explanation

"It's **not gout** – that usually affects the joint and comes on suddenly in people with risk factors like obesity or long-standing illness.

In your case, this pain started **after hitting the toe**, and the redness is **focused around the nail**, not the joint."

"Paronychia happens when bacteria enter through a small break in the skin near the nail – often from trauma, tight shoes, or improper nail trimming."

Management Plan

"There's **no pus or abscess**, so we can manage this conservatively for now."

Fusidic acid cream: Apply **2–3 times a day** around the nail
Ibuprofen or paracetamol: For pain and inflammation
Continue monitoring the toe daily

"If you start to notice any **pus**, increasing pain, or the swelling worsens, we might need to prescribe **oral antibiotics** or perform a **small drainage procedure**.

If you're allergic to penicillin, please let the next doctor know – we'd use something like **doxycycline** instead."

Self-Care Advice

"To help it heal and prevent it happening again:"

Soak your foot in **warm salt water** for 15 minutes, **3–4 times a day**
Let the nail grow out naturally – **don't cut it too short**
Avoid picking or digging around the nail
You can gently place **cotton wool or floss under the nail edge** to guide it outward
Wear **wider shoes** with room for your toes
Keep feet clean and dry

Safety Netting

"Please come back if:"

Pain **worsens or becomes severe**
You see **pus or yellow discharge**
The redness **spreads beyond the toe**
You develop **fever or feel generally unwell**

Follow-Up

"If things don't improve in about **a week**, we'll reassess.
And if needed, we can refer you to a **podiatrist** for a minor nail procedure to remove part of the nail if it's persistently ingrown."

Leaflet

"I'll give you a leaflet that explains **paronychia**, how to treat it, and when to seek help."

Gout vs Paronychia (Exam-focused)

Feature	*Gout*	*Paronychia*
Age	>40 yrs, rare in teens	Any age, incl. teens
Onset	Sudden, overnight	Gradual or post-trauma
Site	Big toe joint (MTP)	Nail margin (toe/finger)
Pain	Severe, throbbing	Localised tenderness
Swelling	Whole joint	Nail fold only
Skin	Shiny, red, tense	Red, may show pus
Triggers	Alcohol, red meat, CKD	Trauma, ingrown nail, tight shoes
Systemic signs	Possible fever	Rare

Psoriasis

Scenario: GP | Young adult | Red, scaly rash on elbows
Your Role: FY2 GP – assess, explain, treat, and safety net for joint/systemic features

---

Introduction

"Hello, I'm one of the doctors here at the practice.
Could I confirm your full name and age, please?
Thank you. What brought you in today?"
(*Patient: "I've had this red, itchy rash on my elbows for a while now."*)

History – Morphology, Evolution, Symptoms

Diagnostic pivots for psoriasis:

Well-defined, red, scaly plaques
Often bilateral – elbows, knees, scalp
May have associated **nail pitting, thickening**
May have **joint stiffness or pain**, especially in the morning
Common triggers: stress, illness, skin injury, alcohol, medication

Ask:

"When did the rash first appear?"
"Has it spread to any other areas — like the scalp, knees, or nails?"
"Do you have any **itching**, pain, or scaling?"
"Have you noticed any **changes in your nails** — like pitting, lifting, or thickening?"
"Any **joint pain or stiffness**, especially in the mornings?"
"Any **diarrhoea**, **stomach pain**, or weight loss?"
"Any **redness or irritation in your eyes**?"

Family & Risk History

"Has anyone in your family had **psoriasis**, **arthritis**, or conditions like **Crohn's** or **ulcerative colitis**?"
"Do you have any known autoimmune conditions?"
"Any recent infections, new medications, or stressful events?"

PMAFTOSA

No major long-term conditions
No regular medications
No known allergies
Lives with family, generally well
Works in retail – dry environments and hand irritation common
Occasionally smokes
No current stressors mentioned

ICE

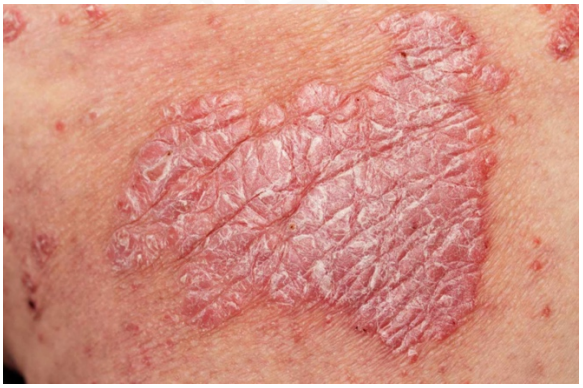
Idea: "Could this be eczema or something like that?"
Concern: "It's not going away. I'm worried it's something serious."
Expectation: "Looking for something to clear this up and stop the itching."

Effect on Life

Embarrassed by visible rash
Avoids short sleeves
Scratching at night disrupts sleep
Social discomfort and occasional teasing

Examination

"Let me have a look at your elbows and any other areas you're concerned about."



Findings:
"There are **well-defined, red plaques with silvery scales** over the elbows.
Some similar plaques are present in the **scalp margin**. There's **nail pitting** but no signs of infection or ulceration."

Provisional Diagnosis
"From what you've described and what I can see, this appears to be **plaque psoriasis**."

Explanation
"Psoriasis is a **long-term skin condition** caused by the body's immune system **mistakenly attacking the skin**, which speeds up skin cell turnover.
This leads to **thick, red, scaly patches** — often on the elbows, knees, scalp, and back."
"It's **not contagious**, but it is **chronic**, which means it tends to come and go in flare-ups.
It can also affect the **nails, joints, and sometimes even the gut or eyes**, so we'll keep an eye on that."

Management Plan
"For now, we'll start with **prescription creams** to reduce the inflammation and scaling."
Dermovate (clobetasol): Potent steroid cream
Apply **thinly, twice daily** to affected areas for up to **4 weeks**
Vitamin D analogue cream (e.g., calcipotriol): Use **alongside** Dermovate
Dermovate scalp application: For affected scalp areas
Part hair and apply directly to plaques
"Apply gently, only to the plaques — avoid using it on your face unless told otherwise."

Lifestyle Advice
"Psoriasis can't be cured, but you can manage it well with treatment and lifestyle changes:"
Stop **smoking**, as it worsens flare-ups
Keep skin **moisturised** — use **fragrance-free emollients** regularly
Identify and avoid **personal triggers**: stress, skin injury, harsh soaps
Consider **omega-3-rich diet**, **stress management** (e.g. yoga, meditation), and regular exercise
Avoid excessive alcohol and maintain a healthy weight
Use **mild, non-perfumed skincare** products

Safety Netting
"Psoriasis can affect more than just your skin. Please come back if you notice:"
Joint stiffness or pain, especially in the morning
Worsening rash or new areas
Eye redness, pain, or blurred vision
Mood changes or if it starts to impact your daily life

Follow-Up
"Let's review you in **4 weeks** to see how your skin is responding.
If the plaques haven't improved, we may need to **refer you to a dermatologist**."
"Specialists may consider:"
UV light therapy
Stronger tablets (like methotrexate or ciclosporin)

Biologics – targeted injections for moderate to severe psoriasis
"Some patients also find it helpful to **join support groups**."

Leaflet
"I'll give you a leaflet that explains **psoriasis**, how to manage it, and when to seek help."

Erythema Nodosum

Scenario: GP | 40-year-old female airport worker | Painful rash on both legs | Recent flu-like illness
Your Role: FY2 GP – assess, explain, rule out underlying causes, and manage symptoms

---

Introduction
"Hello, I'm one of the doctors here at the practice.
Could I confirm your full name and age, please?"
"Thanks. What's brought you in today?"
(*Patient: "I've developed a painful rash on both my legs."*)

History – Morphology, Evolution, Symptoms
Diagnostic pivots for erythema nodosum:
Red, **tender nodules**, commonly over **shins**
Often **bilateral**
Preceded by **recent infection** or associated with systemic conditions
No surface breakdown or blistering
Can be linked with **TB, sarcoidosis, IBD, HIV, or medications**
Ask:
"When did this rash first appear?"
"Is it painful or itchy?"
"Has it been getting better or worse?"
"Did anything happen before this started — illness, new medications, travel?"
"Have you had this before?"

Red Flag Screening
"I need to ask a few questions to check for any related conditions:"
"Any **persistent cough, breathlessness, or wheeze**?"
"Have you had any **unexplained weight loss**, **night sweats**, or prolonged fever?"
"Any recent **changes in vision**?"
"Any **joint pain, stiffness, or swelling**?"
"Any ongoing **abdominal pain or diarrhoea**?"
"Have you ever been diagnosed with **TB, HIV**, or any **autoimmune condition** like lupus or sarcoidosis?"

PMAFTOSA
Generally healthy, no known autoimmune conditions
Works at airport, recent exposure to crowds
Had a **flu-like illness last week**
No new medications
No history of TB or immunosuppression

Premenopausal, not pregnant
No smoking or alcohol
No recent travel

ICE

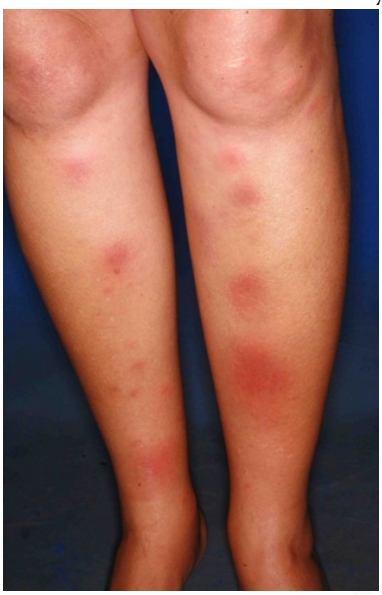
Idea: "Could it be something linked to my flu?"
Concern: "Is this serious? I'm worried it might be an infection."
Expectation: "I'd like to know what this is and whether I need time off work."

Effect on Life

Painful while walking
Discomfort standing for long hours at work
Mild fatigue

Examination

"Let me have a closer look at your legs."



Findings:

"I can see multiple **red, tender nodules** beneath the skin, mostly over both shins.
There's no open wound, discharge, or ulceration."

Provisional Diagnosis

"From what you've told me and what I've seen, this appears to be a condition called **erythema nodosum**."

Explanation

"Erythema nodosum is an **inflammation of the fat layer** under the skin. It often appears as **painful red lumps**, most commonly on the legs."
"It's usually **not dangerous**, but it can be linked to other conditions — such as recent infections (like the **flu** you mentioned), certain medications, or more rarely things like **tuberculosis or inflammatory bowel disease**."

Management Plan
"In most cases, erythema nodosum improves on its own in a few weeks. But we'll help with symptom relief and run tests to rule out any underlying causes."
Symptom relief:

Ibuprofen for pain/swelling – take with food
If itching present, consider **cetirizine** or another antihistamine
Elevate your legs when sitting or resting
Apply **cool compresses** for comfort

Investigations
"I'd like to arrange some **blood tests** and screening to check for possible causes:"

Inflammatory markers (**ESR, CRP**)
Full blood count, LFTs, U&Es
TB screening
HIV test (with your consent)
Autoimmune markers (e.g. ANA, ENA if indicated)
Consider chest X-ray (for sarcoidosis) if respiratory symptoms or TB risk

Work Advice
"Erythema nodosum itself is **not infectious**, so you can **continue working** if you feel up to it.
However, if the pain is affecting your mobility, I'd be happy to provide a **fit note** so you can take a few days to rest."

Safety Netting
"Please come back or seek urgent help if:"

You develop a **fever** or feel very unwell
The rash spreads rapidly or starts to ulcerate
You develop **chest pain, cough, or breathlessness**
Joint or abdominal pain becomes severe

Follow-Up
"Let's schedule a **follow-up in 7 days** to go over your test results and see how the rash is progressing.
Of course, come in sooner if you feel worse before then."

Leaflet
"I'll give you a leaflet that explains **erythema nodosum**, what causes it, and how to manage it at home."

Lyme Disease (Erythema Migrans Rash)

Scenario: GP | Adult patient | Rash on arm | Tick bite 1 month ago during bush walk
Your Role: FY2 GP – assess, recognize typical rash, start early treatment, refer and safety net

---

Introduction
"Hello, I'm one of the doctors here at the practice.
Could I confirm your full name and age, please?"
"Thanks. What brings you in today?"

(*Patient: "There's this weird rash on my arm. I think it might be from a tick I pulled off a month ago after walking through some bushes."*)

History – Morphology, Evolution, Symptoms

Diagnostic pivots for Lyme disease:

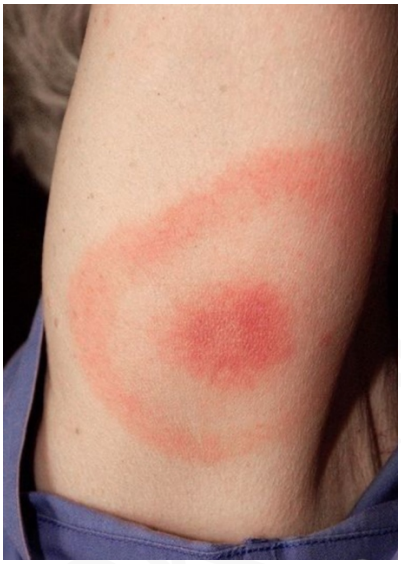
Tick bite history (within 30 days)
Target or bull's-eye rash (erythema migrans)
Non-itchy, expanding rash
Systemic symptoms: fatigue, joint pain, fever, headaches, nerve symptoms

Ask:

"Can you tell me when you first noticed the rash?"
"Did you have a **tick bite** recently — and how long was the tick attached?"
"Has the rash changed in size or shape since you first saw it?"
"Any **fever**, chills, or **night sweats**?"
"Have you felt **very tired**, or noticed any **swollen glands**?"
"Any **muscle aches**, **joint pain**, or **headaches**?"
"Any **numbness**, **tingling**, or trouble concentrating?"
"Any changes to your **vision** or **heart rhythm**?"
"Do you regularly go walking, hiking, or spend time in wooded or grassy areas?"

Examination

"Let's take a look at the rash now."



Findings:

"There is a circular red rash on your arm with a slightly paler centre — forming a **bull's-eye or target-like appearance**.
There's no crusting, discharge, or signs of trauma. No lymphadenopathy noted."

PMAFTOSA

No long-term medical conditions
No current medications

No known drug allergies
No family history of autoimmune or neurological disorders
Works indoors, but enjoys outdoor walking on weekends
No recent travel abroad

ICE

Idea: "I looked online and saw something about Lyme disease."
Concern: "I'm worried it might affect my brain or joints."
Expectation: "I'd like to know if this needs treatment or testing."

Effect on Life

Rash is painless but worrying
Mild fatigue past few days
Not affecting work yet, but wants to act early

Provisional Diagnosis

"Based on your tick exposure history and this characteristic rash, this is likely to be **Lyme disease** — a bacterial infection from tick bites."

Explanation

"Lyme disease is caused by a bacteria called **Borrelia**, which is transmitted through **tick bites**. It often starts with a circular rash at the site of the bite and can later affect other parts of the body — like the **joints**, **nervous system**, or **heart** — if not treated."
"You don't need to remember the tick being attached for long — **a single bite is enough** to cause infection, even weeks later."

Management Plan

"It's important to treat this early. I'm starting you today on an antibiotic called **doxycycline**, which kills the bacteria."
Prescription:

Doxycycline 200mg on day 1, then **100mg once daily** for **6 more days**
Take with food and a full glass of water
Avoid prolonged sun exposure — doxycycline can make your skin more sensitive to light

"Please complete the full 7-day course, even if you start feeling better."

Referral Plan

"I'll also arrange an **urgent referral to the infectious diseases team**. They'll confirm the diagnosis with a blood test called **ELISA**, and may check inflammation levels like **ESR**. They may continue or modify your treatment depending on test results and symptoms."

Prevention Advice

"For future bush walks or outdoor trips:"

Wear **long sleeves and trousers**
Use **insect repellent containing DEET** (diethyltoluamide)
After walking, check your skin for ticks, especially behind the knees and around the ankles

If you find a tick, **remove it promptly with tweezers** close to the skin

Safety Netting
"If you develop any new or worsening symptoms, please come back or seek urgent help.
Watch for:"

Fever or night sweats
Facial droop, weakness, or balance problems
Joint swelling or severe headaches
Palpitations or chest pain
Vision changes or mental fog

Follow-Up
"The infectious diseases team will monitor your progress and guide long-term care.
If anything changes before your appointment with them, please return to see me."

Leaflet
"I'll give you a leaflet about **Lyme disease**, including symptoms to watch for, treatment, and prevention."

Folliculitis

Scenario: GP | 18-year-old female | Red bumpy rash in pubic area after Brazilian wax
Your Role: FY2 GP – assess sensitively, explain, reassure, and manage conservatively

---

Introduction
"Hello, I'm one of the doctors here at the practice.
Thanks for coming in. Could I confirm your full name and age, please?"
(*Patient: "I've developed a rash... um, down below."*)
"Thanks for letting me know — and no worries, I'll handle this sensitively. Could you tell me more about where exactly you've noticed the rash?"

History – Morphology, Evolution, Symptoms
Diagnostic pivots for folliculitis:

Small red bumps, often with a hair in the centre
Painful, itchy, or tender
Often occurs after shaving or waxing
May be triggered by friction or tight clothing

Ask:

"When did this rash first appear?"
"Is it **itchy, painful**, or just red?"
"Are the bumps **all the same size**, or are some larger?"
"Have you noticed any **discharge**, crusting, or change in colour?"
"Did you have any **hair removal or waxing** recently?"
"Have you changed any **products** you use on the area — like soaps or creams?"
"What type of **underwear** do you usually wear — cotton or synthetic?"
"Have you been sweating more than usual, or started new workouts?"

PMAFTOSA

Healthy, no past skin conditions
Not on any regular medications
No allergies
No previous similar episodes
Recently had a **Brazilian wax** about a week ago
No new hygiene or cosmetic products
Wears **tight, synthetic underwear**
Exercises regularly

ICE

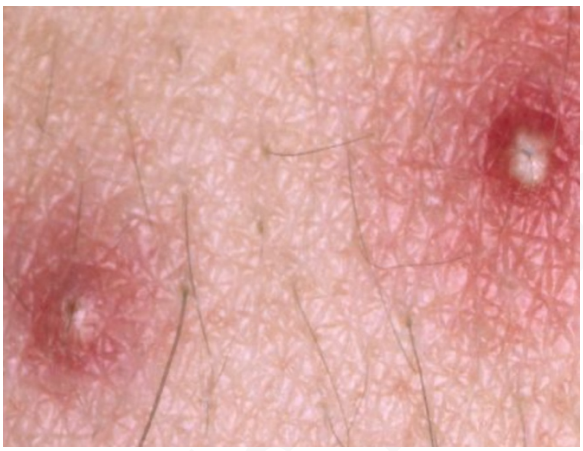
Idea: "Could this be an infection?"
Concern: "I'm embarrassed and worried it might get worse."
Expectation: "I'd like to know if it's something serious and how to treat it."

Effect on Life

Mild discomfort with tight clothing
Avoiding gym due to irritation
Feels self-conscious, anxious about it getting infected

Examination

"Would it be alright if I examine the area? I'll keep it quick and professional."



Findings:

"There are **multiple small, red bumps** clustered around the hair follicles in the lower pubic and suprapubic area. No pus, crusting, or ulceration."

Provisional Diagnosis

"This looks like a mild case of **folliculitis**, which is an **inflammation of the hair follicles**, often triggered by **waxing or shaving**."

Explanation

"Folliculitis happens when hair follicles become **irritated or slightly infected** — often from friction, blocked pores, or skin trauma.

In your case, the recent **Brazilian wax** likely caused some minor irritation, leading to this rash.
It's **not sexually transmitted** and usually clears up on its own."

Management Plan
"This should settle down without prescription medication, but here's what you can do to help it resolve more quickly and feel more comfortable:"

- Use a **chlorhexidine skin wash** (available over the counter) – 2–3 times daily
- If **itchy**, try an **oral antihistamine** like cetirizine
- Apply **warm compresses** for pain or tenderness
- You can take **paracetamol or ibuprofen** if needed
- Keep the area **clean, dry, and cool**
- **Avoid tight or synthetic underwear** – switch to breathable **cotton**
- Shower soon after exercising and pat dry instead of rubbing

Advice – Prevention & Self-Care
"To avoid this in the future:"

- Choose **less irritating hair removal** methods
- If waxing again, ensure it's done by a **trained professional**
- Follow all **aftercare instructions** strictly
- Avoid picking or squeezing the bumps
- Don't apply thick moisturisers, perfumes, or scented washes to the area

Safety Netting
"Most cases resolve in a **week or two**.
But please come back if:"

- The rash becomes **painful, hot, or spreads**
- You notice **pus**, swelling, or fever
- It doesn't improve in **7–10 days**

Follow-Up
"No routine follow-up is needed — but if anything worsens, you're always welcome to return.
If this keeps coming back, we can explore other treatments or see a dermatologist."

Leaflet
"I'll give you a leaflet that explains **folliculitis**, how to care for the skin, and what to watch out for."

Intertrigo

Scenario: GP | 65–70-year-old woman | Itchy, red rash under breast
Your Role: FY2 GP – assess, explain, manage with topical treatment, and advise on prevention

---

Introduction
"Hello, I'm one of the doctors here at the practice.
Could I confirm your full name and age, please?"
"Thanks. What brings you in today?"
(*Patient: "I've had this red, itchy rash under my breast for a few days now."*)

History – Morphology, Evolution, Symptoms

Diagnostic pivots for intertrigo:

Rash located in **skin folds** (under breasts, groin, armpits)
Red, itchy, **moist**, sometimes raw appearance
Can be complicated by **fungal** or **bacterial infection**
Aggravated by **heat, sweating, friction**

Ask:

"When did you first notice the rash?"
"Has it been **itchy, painful, or burning**?"
"Have you noticed any **discharge, oozing**, or odour?"
"Do you sweat a lot or have difficulty keeping the area dry?"
"Has this happened before in the same area?"
"What type of bras or undergarments do you usually wear?"
"Do you use powders, creams, or soaps in that area?"
"Have you noticed any other areas of skin with similar issues?"

PMAFTOSA

No diabetes or immunosuppressive conditions
No regular steroid use
Wears non-cotton bras for long periods
Rash worsens with heat and sweating
Lives with spouse, independent in hygiene
No known allergies or regular medications

ICE

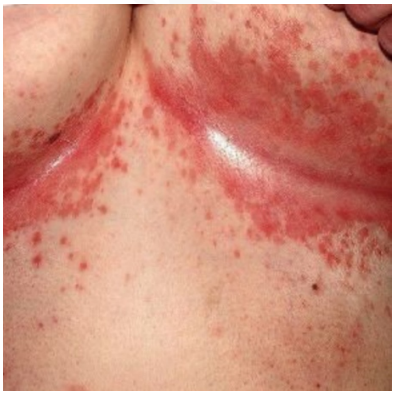
Idea: "It feels like a heat rash."
Concern: "I'm worried it could be a skin infection."
Expectation: "Hoping for a cream to get rid of the itching and redness."

Effect on Life

Irritating during daily movement and at night
Avoiding certain clothes due to discomfort
Slight embarrassment in social situations

Examination

"Let me have a look under the breast to assess the rash."



Findings:
"There is a **red, moist, slightly scaly rash** in the fold beneath the left breast. No ulceration or pus. Margins are irregular with satellite lesions."

Provisional Diagnosis
"From what you've described and what I can see, this appears to be **intertrigo** — an irritation and inflammation of the skin in folds, often complicated by **fungal overgrowth**."

Explanation
"Intertrigo happens when the skin in warm, moist areas — like under the breasts — becomes irritated by **friction and trapped sweat**.
Bacteria or fungi can then multiply in that environment and worsen the rash."
"It's very common, especially in hot weather or if the area stays moist for long periods. But the good news is — we can treat this effectively."

Management Plan
"We'll use a **combination of mild steroid and antifungal creams** to settle the inflammation and treat the infection."
Topical treatment:
Hydrocortisone 1% cream: Apply **once daily** for up to **7 days** (anti-inflammatory)
Clotrimazole cream: Apply **2–3 times daily** for **2 weeks** (antifungal)
"Apply a **thin layer**, and continue the antifungal cream even after the itching improves to fully clear the infection."

Self-Care Advice
"To help it heal faster and prevent it coming back:"
Wash the area **twice daily**, pat gently dry — avoid rubbing
Avoid talcum powder or perfumed products
Wear **supportive, breathable cotton bras**
Avoid tight-fitting clothes or synthetic materials
Once the rash clears, use a **barrier cream** like **zinc oxide** or **castor oil** if sweating or friction returns

Safety Netting
"Please come back if:"
The rash **doesn't improve within 2 weeks**
You notice **oozing, spreading, or intense pain**
You develop **fever, chills, or general unwellness**

Follow-Up
"We'll keep this under review. You don't need a routine follow-up, but if it doesn't improve or recurs frequently, we can explore longer-term options like **antifungal powders** or specialist referral."

Leaflet
"I'll give you a leaflet that explains **intertrigo**, what causes it, and how to care for the skin going forward."

Cherry Angiomas

Scenario: GP | 65-year-old male | Multiple red spots on torso | Present for 5–6 years, now increasing
Your Role: FY2 GP – assess, reassure, educate, and provide safety netting

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Introduction
"Hello, I'm one of the doctors here at the practice.
Could I confirm your full name and age, please?"
"Thanks. What brought you in today?"
(*Patient: "I've had these small red bumps on my body for a few years, but they seem to be spreading now."*)

History – Morphology, Evolution, Symptoms
Diagnostic pivots for cherry angiomas:
- Small, bright red/purple, dome-shaped lesions
- Often appear on **trunk**, **arms**, **scalp**
- No itching, pain, or discharge
- Appear **with age**, usually harmless
- May increase in number over time

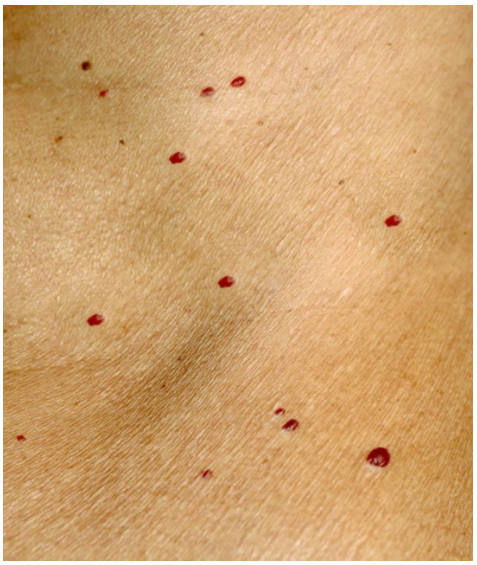
Ask:
- "When did you first notice these spots?"
- "Have they changed in **size**, **shape**, or **colour**?"
- "Any **pain, itching, or bleeding** from them?"
- "Have you noticed similar spots anywhere else on your body?"
- "Do you regularly use any skin products or creams on this area?"
- "Have you had **any weight loss, fevers, or other rashes**?"

PMAFTOSA
- No history of skin cancer
- No regular medications
- No known allergies
- Retired firefighter, worked outdoors for many years
- No family history of melanoma or vascular skin conditions
- Healthy lifestyle, no smoking
- No recent travel or new products used

ICE
- **Idea:** "Are these blood clots or some type of skin condition?"
- **Concern:** "I'm worried they might be a sign of something serious."
- **Expectation:** "I'd like to know if I need any tests or treatment."

Effect on Life
- Not painful or disabling
- Mild cosmetic concern as they're now more visible
- No recent trauma to the skin

Examination
"Let me have a look at the areas you're worried about."



Findings:
"I can see multiple **small, bright red, dome-shaped lesions** on the chest and upper back. They are **non-tender**, **non-itchy**, and show no signs of crusting, ulceration, or irregular borders."

Provisional Diagnosis
"From what you've described and what I've seen, these are called **cherry angiomas**."

Explanation
"Cherry angiomas are small **overgrowths of blood vessels** in the skin. That's what gives them their bright red appearance."
"They're **very common as we get older**, especially from the age of 40 onwards.
They are **completely benign** – which means they don't turn into cancer or spread internally."

Management Plan
"They don't need treatment, but we usually advise just to **leave them alone** unless they're causing problems."
- Avoid **scratching or scrubbing** the area
- Wear **loose, breathable clothing** to reduce irritation
- Use a **gentle skin moisturiser** if dryness or friction is an issue

"If you ever want them removed for cosmetic reasons, we can refer you to a **private dermatologist**, as the NHS doesn't cover cosmetic removal."

Advice
"These won't disappear on their own, but they usually **stay harmless**.
It's quite common for new ones to appear slowly over time."

Safety Netting
"Let us know **immediately** if you notice:"
- Any lesion that starts **bleeding, growing rapidly**, or changing shape
- Any associated **pain or ulceration**
- Any sudden increase in **number or size** within a short period

"While this isn't worrying now, we always take skin changes seriously if they evolve."

Follow-Up
"You don't need a routine follow-up, but please feel free to book in if there's any **concern about changes** in the future."

Leaflet
"I'll give you a leaflet that explains **cherry angiomas**, what causes them, and when to seek advice."

Haemangioma

Scenario: GP | 2-week-old baby | Lump on abdomen | Premature birth
Your Role: FY2 GP – assess, reassure, and advise the parent

Introduction
"Hello, I'm one of the doctors here at the practice.
Are you [baby's name]'s mother?
Thank you. Could I confirm your baby's full name and age, please?"
"Lovely. What brought you both in today?"
(*Parent: "There's a red lump on my baby's tummy."*)

Presenting Complaint – History
Ask:

"When did you first notice this lump?"
"Has it changed in size, shape, or colour since then?"
"Have you noticed anything like this elsewhere on your baby's body?"
"Does your baby cry or seem uncomfortable when you touch it?"
"Has the skin ever looked broken or bled at any point?"

PMAFTOSA

P – No past health issues since birth
M – Born prematurely at **34 weeks**
A – Not on any medications
F – Feeding well, no weight concerns
T – No travel or NICU-acquired infections
O – Lives with both parents, no risk exposures
S – Non-smoker household, no pets
A – No family history of skin conditions or birthmarks

ICE

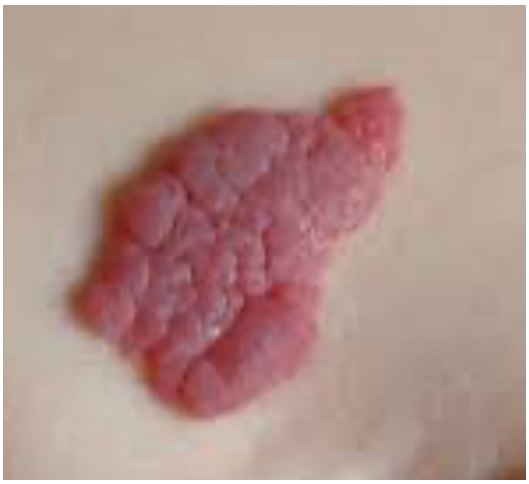
Idea: "I thought it might be a birthmark or bruise."
Concern: "Could it be something dangerous or permanent?"
Expectation: "I'd like to know what it is and what we should do."

Effect on Life

No signs of discomfort

Mother is mainly concerned about what it is and if it needs treatment

Examination
"Thanks for answering those questions. If it's alright with you, I'd like to take a gentle look now."



Findings:
"I can see a **bright red, raised, round lesion** on your baby's abdomen. It's about [size], soft to touch, and not tender. There's **no ulceration, bleeding, or skin breakdown**. The skin surrounding it looks healthy."

Provisional Diagnosis
"From what you've told me and what I've seen, this appears to be a **haemangioma** — a common and usually harmless overgrowth of tiny blood vessels in the skin."

Explanation
"Haemangiomas are sometimes called **'strawberry birthmarks.'** They're not cancerous and aren't caused by anything you did.
They're more likely to appear in **premature babies**, and they usually show up in the first few weeks of life."
"It may grow a little bigger over the next few months, but most of these lumps **shrink on their own** and disappear by the time your child is about **5 to 7 years old**."

Management Plan
"This doesn't need any medication or removal — we'll just monitor it. But we want to take **good care of the skin** so it doesn't break or bleed."
Advice:

Avoid harsh soaps, bubble baths, or scrubbing the area
Use a **fragrance-free moisturiser** to keep the skin soft
Once your baby is older, apply **sunscreen** to protect the area in sunlight

Preventive Advice
"To avoid accidental scratching or injury:"

Trim your baby's nails daily
Consider using **cotton mittens** if needed

Safety Netting

"If the skin starts to **bleed**, here's what to do:"

Apply **firm pressure** with clean cloth or gauze for **5 minutes**
If it soaks through, **replace without lifting pressure**
If bleeding **hasn't stopped after 5 minutes**, go to the **nearest hospital immediately**

"Please also come back if:"

It grows suddenly or becomes painful
The skin looks broken or infected
You notice other unusual lumps or rashes

Follow-Up

"Let's book a **follow-up in a month** to monitor how it's growing.
Of course, come in sooner if you notice any significant changes or if you're worried at any point."

Leaflet

"I'll give you a leaflet that explains haemangiomas, what to expect, and how to care for the skin gently."

Quick Reference: Cherry Angioma vs Haemangioma

Feature	*Cherry Angioma*	*Haemangioma*
Who gets it?	Adults, especially >30 years	Infants, especially premature babies
Appearance	Small, red or purple dome-shaped spots	Raised, red/blue lump (can be large)
Cause	Age-related capillary overgrowth	Developmental blood vessel overgrowth
Location	Trunk, upper limbs	Head, neck, scalp, trunk
Growth	Slow, lifelong	Rapid growth in infancy, then gradual fading
Risk	Benign, cosmetic concern only	May ulcerate, bleed, or affect vision/breathing
Management	Reassure or remove for cosmetic reasons	Usually self-resolving; treat if complicated

In short:

Cherry angioma = adult, age-related, static
Haemangioma = infant, congenital, dynamic (grows then fades)

Molluscum Contagiosum

Scenario: GP | 4–5-year-old child | Localized rash on one side of chest/shoulder | 2–3 days duration
Your Role: FY2 GP – assess rash, explain diagnosis, reassure, and advise mother (who is pregnant)

Introduction

"Hello, I'm one of the doctors here at the practice.
Are you the child's mother?
Could I confirm your child's full name and age, please?"
"Thank you. What's brought you both in today?"
(*Parent: "There's a strange rash on his chest, only on one side. I'm also pregnant, so I'm a bit worried."*)

History – Morphology, Evolution, Symptoms

Diagnostic pivots for molluscum contagiosum:

Small, shiny **flesh-coloured or pink bumps**
Central dimple or pit (umbilicated)

Usually in clusters, **asymmetrical**
No pain or itching in most cases
Typically appears in **children under 10**

Ask:

"When did you first notice the rash?"
"Has it been growing or spreading?"
"Does it seem to be bothering your child — is it itchy or painful?"
"Has your child been unwell recently or had any other skin rashes?"
"Any recent contact with children with similar spots?"
"Has he scratched or picked at the bumps?"
"Has anyone else in the house developed similar lesions?"

To mother:

"Can I ask how far along you are in your pregnancy?"
"Have you noticed any skin changes yourself recently?"
"Are there other young children at home?"

PMAFTOSA

No chronic conditions
No recent illnesses
Child not on medications
Up-to-date with vaccinations
No previous skin issues
Family otherwise healthy

ICE

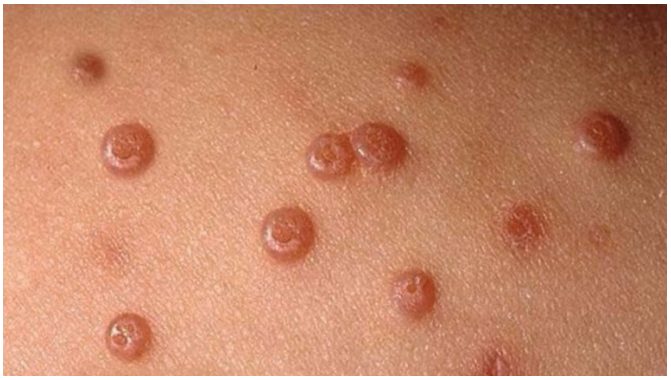
Idea: "Could this be chickenpox?"
Concern: "I'm pregnant — I don't want to catch anything from him."
Expectation: "I want to know if he needs treatment or if it's contagious."

Effect on Life

Child is playful and otherwise well
No discomfort or sleep issues
Parents anxious about transmission to mother and others

Examination

"Let's take a closer look at the rash on your son's shoulder and chest."



Findings:
"There are several **small, pink, dome-shaped bumps** with a clear **dimple in the centre**.
They are clustered on one side of the chest and shoulder. No surrounding redness, swelling, or signs of infection."

Provisional Diagnosis
"From what you've told me and what I can see, this condition is called **molluscum contagiosum**."

Explanation
"It's caused by a **virus** from the **poxvirus family**. It's very common in young children and causes **harmless bumps** that can spread locally or to others.
It's **not dangerous** and usually clears up on its own, but this can take **several months to even 12–18 months**."
"It spreads through **skin-to-skin contact** or shared towels and clothing — but the risk is low if good hygiene is followed."

Management Plan
"We generally don't need to treat it. But here's what you can do:"
- **No scratching** – keep nails short to prevent bacterial infection
- Use **fragrance-free moisturiser** to reduce irritation
- If desired, you may try **Molludab cream** (available over the counter) — but results are mixed
- Specialist options (if worsening or persistent):
  - **Cryotherapy** (freezing)
  - **Curettage** (removal under local anaesthesia)
  - **Topical irritants** — offered in dermatology

"We only consider treatment if the rash is **painful, infected, or spreading rapidly**."

Prevention Advice – Family & Pregnancy
"For prevention at home:"
- Don't share **towels, sponges, or clothing**
- Encourage **handwashing**, especially if he touches the bumps
- Cover lesions during contact play if needed
- Avoid public swimming until lesions are gone

To the pregnant mother:
"The virus itself is not known to **cause complications in pregnancy**, and transmission to adults is **rare**.
However, good hand hygiene and not sharing personal items is advised.
If you notice any new spots or skin changes yourself, do let us know."

Safety Netting
"Please come back if:"
- The bumps become **red, painful, or ooze pus**
- He develops **fever, rash elsewhere**, or seems unwell
- It's **not improving in a few months** or you have concerns about spread

Follow-Up
"There's **no need for routine follow-up**, but you're always welcome to return if it worsens or persists beyond 6–12 months."

Leaflet
"I'll give you a leaflet that explains **molluscum contagiosum**, how it spreads, and what to look out for."

Herpetic Whitlow

Scenario: GP | Adult male typist | Painful thumb blister | Recent cold sore
Your Role: FY2 GP – assess, confirm viral blistering lesion, initiate treatment, manage work impact

---

Introduction
"Hello, I'm one of the doctors here at the practice.
Could I confirm your full name and age, please?"
"Thanks. What brought you in today?"
(*Patient: "I've got this painful blister on my thumb – I work as a typist and it's making things difficult."*)

History – Morphology, Evolution, Symptoms
Diagnostic pivots for herpetic whitlow:
- **Painful, fluid-filled blister**
- Affects **fingers or thumbs**, often with swelling
- Typically one lesion or small cluster
- Often preceded by **cold sore** or contact with HSV
- May have **tingling, burning**, or **fever** early on

Ask:
- "When did the blister appear?"
- "Is it painful or itchy?"
- "Have you had any tingling or burning before it came up?"
- "Do you get cold sores regularly?"
- "Have you had any recent contact between your thumb and a cold sore or someone else's?"
- "Have you had this before?"
- "Any other blisters or symptoms anywhere else on your body?"
- "Any fever, swollen glands, or flu-like symptoms?"

PMAFTOSA
- Healthy otherwise
- No history of eczema or immunosuppression
- Known history of **recurrent oral HSV**
- No regular medications
- Works full time as a **data entry typist**
- No recent trauma or nail injury
- No high-risk exposures

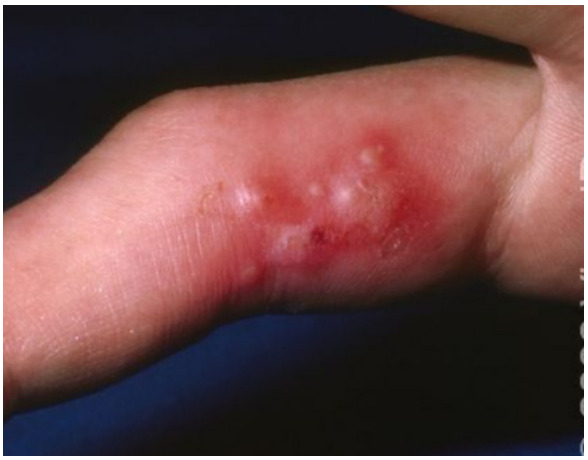
ICE
- **Idea:** "I thought it might be an infection — maybe something serious."
- **Concern:** "I use my hands all day for work and I'm worried it'll get worse or spread."
- **Expectation:** "I'd like to know what it is and get something to treat it quickly."

Effect on Life

Thumb pain is affecting typing ability
Slight embarrassment about appearance of blister
Worried about infecting others at work or home

Examination

"Let me take a closer look at your thumb."



Findings:

"There is a **single, tense, fluid-filled blister** on the lateral aspect of the thumb. The area is **tender**, with surrounding redness but no signs of bacterial pus or tracking.
You also have a healing **cold sore on your lip**, which matches recent HSV exposure.
No regional lymphadenopathy or systemic features."

Provisional Diagnosis

"This appears to be a condition called **herpetic whitlow** — a localised **viral infection** caused by the same virus that causes cold sores."

Explanation

"Herpetic whitlow is caused by the **herpes simplex virus** — the same one that gives you **cold sores**.
Sometimes, the virus gets into the skin through a small cut, especially on the fingers, causing a **painful blister**.
It's **not dangerous**, but it is contagious until it heals."

Management Plan

"Since your blister started recently, we can start **antiviral treatment** to shorten the illness and reduce symptoms."

Acyclovir 400mg, 5 times a day for **5–7 days**
Paracetamol or ibuprofen for pain
Apply **dry, non-stick dressing** to cover the area
Keep it **clean and dry**
Avoid touching your mouth or eyes

"The blister will likely heal within **10–14 days**, and may scab before going down."

Work Advice

"Since you're a typist, we've got a few options depending on your preference:"

"If the pain is too distracting, I can give you a **fit note** for a few days of rest."

"Or, if you'd prefer to work, we can provide **stronger painkillers** and even a mild **numbing cream** to help you manage typing."

"Either way, the key is to keep the blister **covered and clean** to avoid spreading the virus to others or other parts of your body."

Safety Netting

"Come back immediately if:"

The blister becomes **filled with pus** or very swollen

You develop **fever, chills**, or feel generally unwell

You notice **spreading redness** or can't use your thumb at all

Follow-Up

"No routine follow-up is needed, but if it's not improving in a week or gets worse, come back and we'll reassess."

Leaflet

"I'll provide you with a leaflet that explains **herpetic whitlow**, including treatment, how to prevent spread, and when to seek help."

Tinea Manuum

Scenario: GP | Male with hand rash for 2 weeks | Wife is pregnant

Your Role: FY2 GP – assess, diagnose, and manage with appropriate counselling

---

Introduction

"Hello, I'm one of the doctors here at the practice.

Could I confirm your full name and age, please?

Thanks. What brings you in today?"

(*Patient: "I've had this rash on my hand for a couple of weeks now."*)

History – Follow standard dermatology rash structure

(Examination done **before** PMAFTOSA)

Diagnostic pivots for tinea manuum:

Circular, well-demarcated rash

Central clearing, scaly edges

Often itchy or dry

May have mild redness

May have history of athlete's foot or contact with infected items

Ask:

"When did you first notice the rash?"

"Has it spread or changed in appearance?"

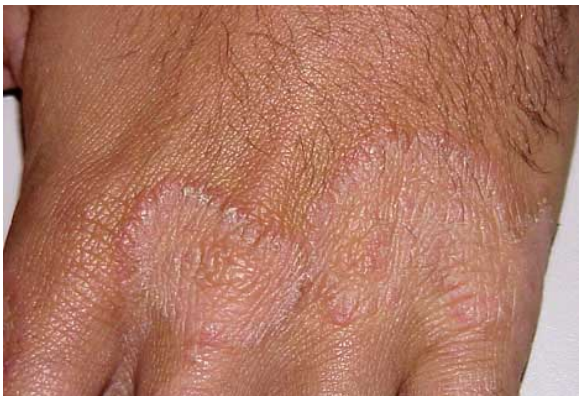
"Is it itchy or painful?"

"Have you had athlete's foot or a similar rash before?"

"Has anyone else in your household had a skin rash recently?"

"Have you tried any creams or home remedies?"

Examination
"Would it be okay if I take a closer look at the affected area now?"



Findings:
"I can see a round, well-defined lesion with **scaling around the edges**, about [size], on the back of your hand. It has a slightly red border and appears dry in the centre."

PMAFTOSA

No long-term conditions
No current medications
Wife is **pregnant**
No history of allergies
Works in an office (minimal occupational exposure)
Recently returned from gym/locker room use
No travel or animal contact
No systemic symptoms

ICE

Idea: "I thought it might be eczema or something from the gym."
Concern: "My wife is pregnant — I'm worried I might pass this to her."
Expectation: "Can I get something to stop it spreading?"

Effect on Life

"Is it affecting your ability to use your hand at work?"
"Is it bothering you at night or while washing?"

Provisional Diagnosis
"From what you've told me and what I can see, this appears to be a fungal skin infection called **tinea manuum** — also known as **ringworm of the hand**."

Explanation
"Tinea is a common fungal infection. Despite the name 'ringworm,' it has nothing to do with worms — the rash just forms a ring-like shape."

"The fungus affects the **outer layer of skin**, often causing dry, scaly patches.
It's typically picked up from contact with infected towels, gym equipment, or from athlete's foot."
"It's **not dangerous**, and it's very treatable with antifungal cream."

Management Plan
"I'll prescribe a cream called **clotrimazole 1%**, which treats fungal skin infections.
Here's how to use it:"

- Apply a **thin layer** to the entire affected area **two to three times a day**
- Continue applying for **4 full weeks**, even if it looks better earlier
- Use **about half a centimetre of cream** to cover the palm-sized area
- Always **wash your hands before and after** applying the cream
- Do not apply to broken skin or near eyes

"It's important to treat fungal infections fully — stopping early may cause the rash to return."

Hygiene & Prevention Advice
"To prevent spreading the infection to your wife or others:"

- Avoid sharing **towels, clothes, or bedding**
- **Keep the hand clean and dry**, but avoid over washing
- **Change towels and pillowcases daily** until the rash settles
- Wash clothes and linen in **hot water** if possible
- Wear gloves if applying cream to other body parts
- If you use the gym or sauna, avoid direct skin contact with surfaces

Addressing Pregnancy Concerns
"Could this affect my wife or the baby?"
"You can pass this infection to your wife through skin contact or shared items, but **it's very unlikely to affect the pregnancy directly**. If she develops symptoms, she should see her doctor to get safe treatment."
"The cream I've prescribed is **topical and safe** for use around pregnant family members.
If oral tablets were needed — those wouldn't be suitable during pregnancy, so that's why it's important we manage your case well now."

Safety Netting
"Please return if:"

- The rash **doesn't improve in 4 weeks**
- It spreads, becomes painful, or starts to ooze
- Your wife or any household contact develops similar symptoms

"In that case, we may consider a **stronger antifungal** or check for other conditions."

Follow-Up
"Let's plan a follow-up if there's no improvement after the full course.
For now, you should be able to manage it at home with the cream."

Leaflet
"I'll give you a leaflet explaining **tinea manuum**, how to apply the cream, and how to prevent spreading it."

Tinea Capitis

Scenario: GP | Adult male | Persistent dandruff | Farm worker | Scaling + hair loss
Your Role: FY2 GP – identify fungal scalp infection, start oral antifungal, counsel on prevention

---

Introduction
"Hello, I'm one of the doctors here at the practice.
Could I confirm your full name and age, please?"
"Thanks. What brings you in today?"
(*Patient: "I've had really bad dandruff for a while. I've tried washing and even ketoconazole shampoo, but nothing works."*)

History – Morphology, Evolution, Symptoms
Diagnostic pivots for tinea capitis:
- Scaling of scalp, **often patchy**
- Associated **redness, inflammation**
- May have **broken hairs or bald patches**
- Often **resistant to dandruff treatment**
- Occupational exposure to **animals or livestock** is a risk factor

Ask:
- "When did this problem first start?"
- "Has the rash changed or spread since then?"
- "Have you noticed any **hair loss** or breakage?"
- "Is the area **itchy or painful**?"
- "Do you notice any **redness or swelling**?"
- "Do you work with animals or wear head coverings at work?"
- "How often do you wash your hair, and how have you been using the ketoconazole shampoo?"
- "Have you noticed any similar symptoms elsewhere on your body?"
- "Do you live with anyone who has similar symptoms?"

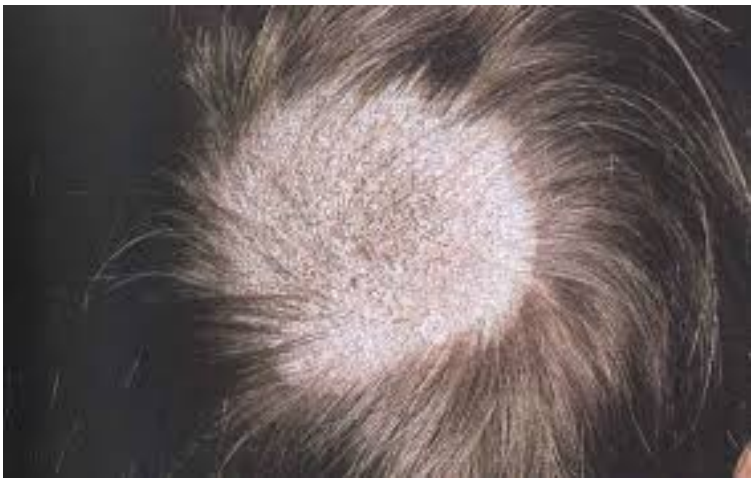
PMAFTOSA
- No chronic illness
- Works full-time on a **farm**
- No regular medications
- No known allergies
- Wears caps while working
- Previously tried antifungal shampoo with no improvement
- Lives alone

ICE
- **Idea:** "Thought it was bad dandruff."
- **Concern:** "I'm worried I'm losing hair and nothing seems to help."
- **Expectation:** "Looking for a treatment that actually works."

Effect on Life
- Embarrassed about visible flakes and patches
- Avoiding hats due to irritation
- Discomfort at work and around others

Mild anxiety about permanent hair loss

Examination
"Let me take a closer look at your scalp."



Findings:
"There are **scaly, red patches** with areas of **hair thinning and breakage**. The broken hairs are close to the scalp, and there are multiple well-defined, circular lesions."

Provisional Diagnosis
"From what you've told me and what I can see, this appears to be **tinea capitis**, also known as **scalp ringworm**."

Explanation
"This isn't regular dandruff. It's caused by a **fungus that infects the scalp and hair follicles**.
That's why shampoos haven't worked — because the infection is deeper in the skin and hair roots.
This condition is **not dangerous**, but it won't go away without the right treatment."

Management Plan
"We'll start you on **oral antifungal medication** to treat this properly."
Treatment:
Griseofulvin, taken **orally for 4–8 weeks** (standard first-line in adults and children)
Continue **ketoconazole shampoo 2–3 times/week** during treatment (to reduce surface fungus)
Ensure full course completion to prevent recurrence
"It may take a few weeks to see visible improvement. Hair may take time to regrow, but it usually returns as the scalp heals."

Self-Care and Prevention Advice
"To prevent reinfection and protect others:"
Wash or replace **hats, scarves, pillowcases, and combs** in **hot water**
Don't share **towels, combs, or headgear**
Wear **breathable, clean head coverings** at work
Shower and shampoo after working with animals

If you see animals with **bald patches**, report them to your supervisor — some farm animals carry the fungus
Consider using **antifungal spray or powder** in hats if reused

Safety Netting
"Please come back sooner if:"

You develop **pus, oozing, or spreading inflammation**
You have **allergic reaction or side effects** from medication
The condition **worsens** or doesn't improve within **6–8 weeks**

Follow-Up
"I'd like to see you again in **4–8 weeks** to check how you're responding.
We'll reassess your scalp and adjust the treatment if needed."

Leaflet
"I'll give you a leaflet that explains **tinea capitis**, treatment steps, and how to avoid reinfection."

Tinea Pedis

Scenario: GP | Adult marathon runner | Itchy rash between toes and soles
Your Role: FY2 GP – diagnose, treat with antifungal + advice, and counsel on prevention

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Introduction
"Hello, I'm one of the doctors here at the practice.
Could I confirm your full name and age, please?"
"Thanks. What brings you in today?"
(*Patient: "My feet are constantly itchy – mostly between the toes. I'm a long-distance runner and thought it was just from sweat, but it's not going away."*)

History – Morphology, Evolution, Symptoms
Diagnostic pivots for tinea pedis:

Interdigital scaling, redness, **itching or burning**
Associated with **sweaty feet or damp footwear**
May extend to soles (moccasin type)
Worse in humid conditions or post-exercise
Household exposure possible

Ask:

"When did the itching and rash first start?"
"Is it mainly between your toes, or has it spread to the rest of the foot?"
"Do you notice any cracking, oozing, or burning sensation?"
"How often do you run, and how long do your shoes stay damp afterward?"
"Do you rotate your shoes or wear the same pair daily?"
"Do you wear cotton or synthetic socks?"
"Does anyone in your household have a similar rash or itchy feet?"
"Any history of fungal nail infections or rash in the groin area?"

PMAFTOSA

No chronic conditions
Marathon runner, 4–5 days/week
Regular use of same trainers
Wears cotton socks but often keeps shoes on for hours post-run
No other skin or nail involvement
No regular medications
Lives alone

ICE

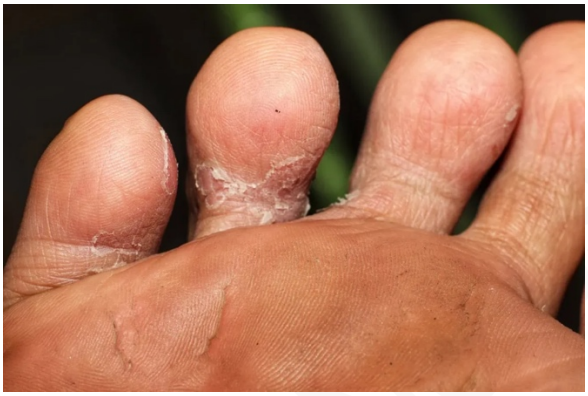
Idea: "I thought it was just sweat rash."
Concern: "I'm training for a race and worried it'll get worse."
Expectation: "Looking for something to stop the itching and prevent it coming back."

Effect on Life

Itchy at work and during runs
Avoiding shared showers at the gym
Mild anxiety about worsening or embarrassment

Examination

"Let me take a look at your feet."



Findings:

"There's **redness and scaling** between the 3rd, 4th, and 5th toes, extending slightly to the lateral sole.
No pus or ulceration. The skin is macerated and cracked in places — classic signs of **tinea pedis**."

Provisional Diagnosis

"From what you've told me and what I can see, this looks like **tinea pedis**, commonly known as **athlete's foot**."

Lay Explanation

"It's a **fungal infection** that grows in **warm, moist environments**, especially between the toes. Because you run frequently and keep your shoes on for long periods, it's likely the fungus has had a chance to grow and spread."
"It's very common — and treatable — but does need both **medicine and lifestyle changes** to go away completely."

Management Plan
"We'll treat this with two creams — one for the fungus, and one to reduce inflammation and itching."
Treatment:
Clotrimazole cream, applied **twice daily** for **at least 2 weeks after the rash clears**
Hydrocortisone 1% cream, applied **once daily for no more than 7 days**, 20–30 minutes **after** the antifungal
"You should start feeling relief within a few days, but complete the course to prevent it returning."

Footwear & Prevention Advice
"To help treatment and prevent reinfection:"
Dry your feet thoroughly after washing — especially **between the toes**
Consider using a **hair dryer on cool setting** for full dryness
Change socks daily — cotton is best
Rotate shoes and let them dry completely between uses
Use **antifungal powder** inside shoes during training
Spray your trainers with **disinfectant** and air them fully
Avoid walking barefoot in **public showers or locker rooms**
Don't share towels, socks, or footwear

Safety Netting
"Please come back if:"
The rash doesn't improve within **2 weeks**
You notice **spreading, pus, or worsening cracks**
You develop signs of **bacterial infection** or **nail involvement**
Follow-Up
"You likely won't need a routine review, but if you're still having trouble or preparing for your race, I'm happy to reassess or refer to a skin specialist if needed."

Leaflet
"I'll give you a leaflet that explains **athlete's foot**, treatment, and tips to stop it coming back."

Oral Candidiasis

Scenario: GP | 4–5-year-old child | White rash in mouth, poor feeding | On inhalers
Your Role: FY2 GP – assess oral lesions, manage fungal infection, counsel parent on inhaler hygiene

---

Introduction
"Hello, I'm one of the doctors here at the practice.
Could I confirm your son's full name and age, please?"
"Thank you. And are you his father? What's brought you both in today?"
(*Father: "He hasn't been eating well and there's a white rash on his tongue."*)

History – Morphology, Evolution, Symptoms
Diagnostic pivots for oral candidiasis:
White plaques on tongue, inner cheeks or lips
Can be **wiped off**, leaving red/bleeding base
Common in **inhaler users**, antibiotic users, or immunosuppressed

Symptoms: **Pain on eating**, poor feeding, **dry mouth**

Ask:

"When did you first notice the white patches?"
"Has your child had any pain while eating or drinking?"
"Is he drinking fluids okay?"
"Has he had any fever, cough, or recent illness?"
"Has he taken any antibiotics recently?"
"What kind of inhalers does he use — do you know the colours?"
"Does he rinse his mouth after inhaler use?"
"Any tiredness, rashes, or other symptoms?"

PMAFTOSA

No chronic medical conditions
On blue (salbutamol) and brown (beclomethasone) inhalers for asthma
No known allergies
Not on regular antibiotics
Doesn't always rinse mouth after inhaler use
Lives with both parents; no recent illness in household

ICE

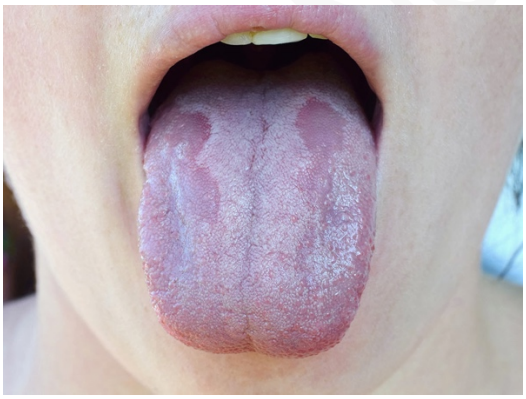
Idea: "Is this some kind of infection?"
Concern: "He hasn't eaten much, and I'm worried it'll get worse."
Expectation: "I'd like something that clears it quickly and safely."

Effect on Life

Not eating solids properly
Waking at night due to mouth discomfort
Slight weight loss due to reduced intake

Examination

"Let me have a gentle look inside his mouth."



Findings:
"There are **white, patchy plaques** on the tongue and inner cheeks.
They can be **gently wiped off**, revealing **red, raw-looking tissue** underneath.
No ulcers, no signs of dehydration or systemic illness."

Provisional Diagnosis
"This is a condition called **oral thrush**, or **oral candidiasis** — a **fungal infection** in the mouth."

Explanation
"It's caused by a type of yeast called **Candida**, which normally lives in small amounts in the mouth.
Steroid inhalers can sometimes allow this yeast to grow more than usual, especially if the mouth isn't rinsed after use."
"It's **not dangerous** and usually clears with the right treatment."

Management Plan
"We'll treat this with a gel that directly targets the fungus."
Prescriptions:

Miconazole oral gel: Apply **2–3 times daily** after meals for **2–3 weeks**

Wash hands
Apply with clean finger inside the mouth, gently rub on patches
Avoid food or drink for **30 minutes after** each dose
Continue **for at least 7 days after symptoms clear**

Self-Care and Prevention Advice
"To reduce recurrence and help recovery:"

Rinse mouth with **water after every inhaler use**
Use a **spacer** with the steroid inhaler if not already doing so
Give inhaler just before meals — chewing and swallowing helps clear the mouth
Avoid sugary snacks and drinks during treatment
Ensure good oral hygiene with gentle brushing
Replace toothbrush at end of treatment

Safety Netting
"Please come back if:"

There's **no improvement in a week**
He develops **fever, trouble swallowing**, or seems unwell
New symptoms develop or it worsens

Follow-Up
"I'll arrange a review in **1 week** to check how he's responding.
If it clears before that, you're still welcome to attend just to confirm full resolution."

Leaflet
"I'll give you a leaflet that explains **oral thrush**, treatment instructions, and how to prevent it coming back."

Why *examination comes later* in **oral candidiasis**, even though it's a rash:

Unlike most rashes, the patient doesn't typically come saying "I have a rash in my mouth."

Instead, they usually present with **difficulty eating**, **burning sensation**, **white patches**, or a general complaint like "mouth pain" or "sore tongue".

So, this behaves more like an internal/systemic condition, **not a visual rash-led consultation**.

Case Variation: Management in a 5-month-old baby with oral thrush:

First-line treatment:

Miconazole oral gel is the preferred option for babies over 4 months of age.

→ Apply **a small pea-sized amount** to the affected area using a clean finger, ideally after feeding.

→ This should be done **2 to 4 times per day**, as advised.

→ Take extra care not to place the gel near the back of the throat, as this increases the risk of **choking or aspiration**.

Alternative option:

If there is any concern about the baby's swallowing reflex, or if the baby is under 4 months, use **Nystatin oral suspension**.

→ Administer **4 times daily after feeds**, directing the suspension around the sides of the mouth using a dropper or syringe.

Parental Advice:

Feeding:

Continue breastfeeding as normal. However, if **nipple thrush is suspected** in the mother (painful, red, shiny nipples), both **mother and baby should be treated** to prevent reinfection. Miconazole cream is commonly used for the mother.

Hygiene Measures:

Sterilise all feeding equipment, bottles, teats, and dummies daily.

Clean toys that the baby frequently puts in their mouth using hot soapy water or a baby-safe sterilising solution.

After each feed, gently **wipe away milk residue** from the baby's mouth and lips using a soft damp cloth — this reduces the chance of yeast build-up.

Monitoring:

You should see improvement within **a few days**, but continue treatment for **at least 2 days after symptoms resolve**.

If symptoms persist beyond **7 days**, or worsen, follow-up may be needed for reassessment or to consider underlying causes (e.g., immunodeficiency or antibiotic use).

Oral Candidiasis in Older Adult

Scenario: GP | 80-year-old male | Complaining of pain and white patches in mouth, difficulty eating
Your Role: FY2 doctor in GP | Assess, diagnose, and manage oral thrush in elderly

Introduction

"Hello, I'm one of the doctors here at the practice. Could I confirm your full name and age, please? Thank you. How can I help you today?"

(He reports pain and white patches in his mouth, making it hard to eat.)

"I'm sorry to hear that. Let me ask a few more questions to understand better."

History Taking

Symptom Exploration:

"When did the symptoms start?"
"Are the patches painful or itchy?"
"Do they come off when you try to remove them?"
"Any change in taste, burning sensation, or dryness in your mouth?"

Eating & Drinking:

"Has this affected your ability to eat or drink?"

Associated Symptoms:

"Any recent fever, sore throat, or trouble swallowing?"

Risk Factors:

"Do you wear dentures? How often do you clean them? Do you sleep with them on?"
"Have you recently taken any antibiotics or steroid tablets/inhalers?"
"Do you have diabetes or dry mouth (xerostomia)?"
"Any known immune-related conditions (like cancer treatments, immunosuppressants)?"

Medication History:

Check for: inhaled steroids, recent antibiotics, or immunosuppressants

PMAFTOSA:

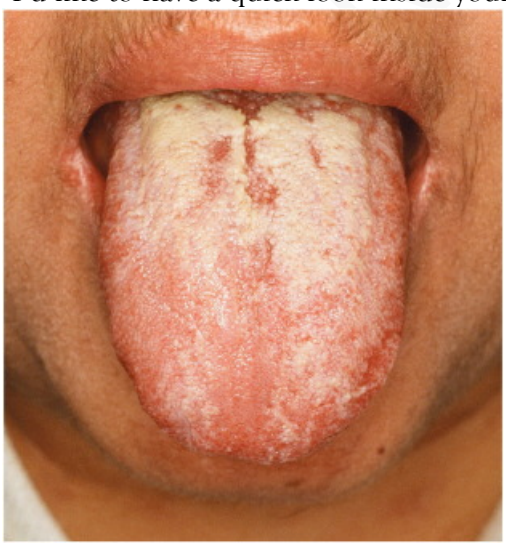
PMH: Diabetes, COPD, cancer, dry mouth
Medications: Especially steroids, inhalers, antibiotics
Allergies, Family History, Travel, Occupation, Smoking, Alcohol

ICE:

Idea: "Do you have any idea what this might be?"
Concern: "Is there anything in particular you're worried about?"
Expectation: "What were you hoping I could help with today?"

Examination

"I'd like to have a quick look inside your mouth, if that's okay."



Findings:
- White plaques on tongue, cheeks, or palate
- Can be scraped off, leaving red raw area beneath
- Possible denture stomatitis (redness under dentures)
- No signs of deep ulceration or systemic infection

Provisional Diagnosis
"Based on what you've told me and what I can see, this looks like oral thrush, or oral candidiasis."

Explanation
"Oral thrush is a fungal infection caused by a yeast called *Candida*, which normally lives in the mouth in small amounts. But sometimes it grows more than usual, especially in older adults, denture wearers, or after antibiotics. It's not dangerous, but can cause soreness or affect eating."

Management Plan

Medication:
- Miconazole oral gel (apply 4 times daily after meals, hold in mouth for as long as possible before swallowing)
- Avoid in patients on warfarin – check drug interactions
- If unable to use gel: nystatin suspension
- If extensive or recurrent: Fluconazole oral tablet (contraindicated in liver disease)

Denture Hygiene Advice:
- Remove dentures at night
- Clean thoroughly daily using toothbrush and denture cleaner
- Leave out for at least 6 hours overnight

Oral Care:
- Avoid mouthwashes containing alcohol
- Rinse mouth after using steroid inhalers
- Stay hydrated

Safety Netting
"Please come back if you notice any bleeding, ulceration, fever, difficulty swallowing, or if symptoms don't improve in 7-10 days."

Follow-Up
"Let's review in 7-10 days to check response to treatment. If it doesn't improve, we may need to do a swab or consider an oral tablet."

Leaflet
"I'll provide a leaflet that explains more about oral thrush and denture care."

Scabies

Scenario: GP. Patient presents with itchy rash on hands. 19-year-old male, recently returned from travel (e.g. Cambodia, Tanzania, India)
Your Role: FY2 GP – assess, examine, explain, and manage accordingly

---

Introduction

"Hello, I'm one of the doctors here at the practice.
Could I confirm your full name and age, please?
Thanks. What brings you in today?"
(*Patient or parent: "It's this rash. It's really itchy – especially at night."*)

History – Follow standard dermatology rash structure

(Examination will follow before PMAFTOSA)

Diagnostic pivots for scabies:

- **Itchy rash**, often between fingers, wrists, groin
- **Worse at night**
- Presence of **burrow lines** or bumps
- Recent **travel** or **crowded accommodation**
- **Close contact** with others (household, tents, hostel)
- Others around also itchy

Ask additionally:

- "Where exactly did the rash start?"
- "Have you noticed any tiny lines or tracks under your skin?"
- "Have any of your friends or housemates had similar symptoms?"
- "Did you stay in hostels or shared tents?"
- "Is the itch keeping you up at night?"

Red Flag Screening

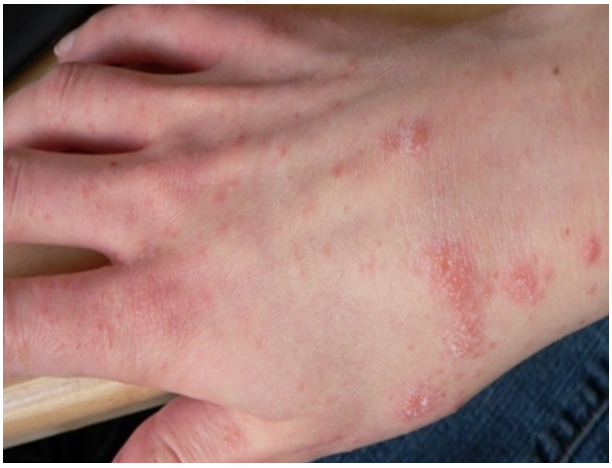
- "Any fever or general illness?"
- "Any signs of infected skin – redness, pus, or pain?"
- "Is the itch spreading quickly?"

Examination

"Thanks. Would it be alright if I take a look at your skin now?"

Focus areas:

- Between fingers, wrists, armpits, groin, waistline, buttocks
- In children: also scalp, face, soles, and palms



Findings:
"I can see some small raised bumps and fine lines between your fingers and on your wrists. There's also some mild redness from scratching."

PMAFTOSA

No other skin conditions
No chronic illness
Not on regular meds
No relevant family history
Recent travel/stay in shared accommodation (hostel/tent)
In contact with others now showing similar symptoms
No known allergies

ICE

I: "I thought it was just an allergic rash."
C: "Is it contagious?" / "Do I have to stay off work?"
E: "I want to stop the itch and not pass it to anyone else."

Effect on Life

"Is the itch disturbing your sleep?"
"Has it affected your ability to concentrate or do daily tasks?"
"Have you been avoiding others because of the rash?"

Provisional Diagnosis
"Based on what you've told me and what I've seen, this appears to be **scabies** — a common skin infestation."

Explanation
"Scabies is caused by tiny mites that burrow into the skin, triggering a strong itch.
It spreads through close skin contact or shared bedding, which is why it's common in places like hostels, dorms, or tents."
"It's not dangerous, but it's very uncomfortable and can easily pass from person to person."
"The good news is — it's very treatable."

Management Plan
"We treat scabies with a cream called **permethrin 5%**.
Here's how you should use it:"

Apply to the **entire body from the neck down** (including soles and under nails)
In **children under 2**, also apply to **scalp and face** (avoiding eyes and mouth)
Leave it on for **8–12 hours**, then wash off
Repeat treatment exactly 7 days later, even if itching improves
Antihistamines can help with the itching in the meantime

"It's very important to treat **everyone in your household** and **close contacts**, even if they don't have symptoms — because scabies spreads before the rash appears."

Decontamination Advice
"To prevent reinfection:"
Wash all **clothing, bedding, and towels** in hot water and dry on high heat
Items that can't be washed should be **sealed in a plastic bag for 72 hours**
Avoid **skin-to-skin contact** until after treatment is completed
"Please also inform your travel friends or classmates to check with their GP."

Patient Concern Handling
"Will I need to take time off work or school?"
"No formal isolation is required, but you might want to **start treatment in the evening**, like on a Friday, so you have the weekend to wash bedding and manage the itching."

"Will the itch go away immediately?"
"The itch can **continue for a few weeks**, even after the mites are gone. That's a normal immune reaction. Antihistamines can help with that."

Safety Netting
"Please come back if:"
The rash **doesn't improve after both treatments**
The itch **gets worse**, or you notice **redness or pus**, which could mean infection
Others in your household start showing symptoms

Follow-Up + Leaflet
"I'll give you a leaflet that explains how to treat scabies, who else needs to be treated, and how to clean your home.
If things don't settle after the second treatment, please come back and we'll reassess."

Variation - Scabies in Child

Scenario: GP | Telephone consult with father of 3-year-old | Rash & itching | Crowded nursery
Your Role: FY2 GP – assess rash over phone, counsel parent, arrange treatment

---

Introduction
"Hello, I'm one of the doctors here at the practice.
Am I speaking with [Father's name]?
Thank you — could I confirm your child's full name and age, please?"
"Thanks. I understand you've noticed a rash on your child's leg. Could you tell me more about that?"

History – Morphology, Evolution, Symptoms
Ask:
"When did you first notice the rash?"
"Where on the body did it first appear?"
"Has it spread since then? Where else have you noticed it?"
"What does the rash look like — flat, raised, blistered, or crusty?"
"Is your child scratching it a lot?"
"Is it worse at night or at any specific time?"

"Has your child been generally well otherwise — any fever, tiredness, or other skin problems?"
"Any changes in appetite or behaviour?"
"Are there any other children at nursery with rashes?"
"Do you or your partner or anyone else at home have a similar rash?"

Summary of Key Findings from History:

Rash **started in finger webs**, now also on **leg**
Red, itchy, slightly **crusted appearance** in places
Child is **otherwise well**
Crowded nursery setting
No antibiotics or other medications
No known allergies
No family history of skin conditions
Father and partner **have started feeling itchy** recently

PMAFTOSA

No regular medications
Fully vaccinated
Healthy 3-year-old attending nursery
Two-father household; both caregivers present
No immunosuppression or recent illness

ICE

Idea: "I thought it might be impetigo, but the rash isn't weeping."
Concern: "We're worried it's spreading — and he's really uncomfortable."
Expectation: "We'd like to know what it is and how to stop it from getting worse."

Effect on Life

Disrupting child's sleep due to itching
Father and partner beginning to experience symptoms
Worry about spread at nursery and home

Provisional Diagnosis

"From what you've described — especially the itching between the fingers and spread to the legs — this strongly suggests scabies."

Explanation

"Scabies is caused by **tiny mites** that burrow into the skin and cause intense **itching**.
It's **not dangerous**, but it **spreads easily**, especially in **crowded places** like nurseries.
The itching is often **worse at night**, and the rash commonly starts between the fingers before spreading."

Management Plan

"We'll start treatment for your child and the rest of the household at the same time."
Treatment for child:

Permethrin 5% cream

Apply to **entire body from neck down** (including soles and under nails)

Leave on overnight (8–12 hours), then wash off
Repeat the treatment **after 7 days**

Other advice:

Treat **all household members** at the same time — even if they don't have symptoms
Do not use in mouth or eyes; for children, avoid lips and eyes carefully
Avoid eating or drinking while cream is applied to hands

Environmental Measures

"To prevent reinfection:"

Wash all **bedding, towels, clothing** used in last 72 hours in **hot water** and dry on **high heat**
Seal unwashable items (e.g. stuffed toys) in a **plastic bag for 72 hours**
Vacuum carpets and upholstery

Safety Netting

"Itching may **continue for 2–3 weeks** even after successful treatment — that's normal.
What we expect is for the **rash to stop spreading** and begin to improve."
"Please call us if:"

The rash or itching gets **worse**
New spots appear **after the second treatment**
The skin becomes **red, swollen, or oozing**, suggesting infection

Follow-Up

"We'll arrange a **follow-up call in one week** to see how your child is doing.
If the symptoms don't start improving after the second application, we may refer to dermatology."

Leaflet

"I'll email you a leaflet that explains **scabies**, how to use the treatment, and the steps to stop it spreading."

Mole – Requesting Removal

Scenario: Young adult in GP surgery. Requests mole removal for wedding.
Role: FY2 in General Practice

Introduction

"Hello, I'm one of the doctors here today.
Could I confirm your full name and age, please?
That's lovely — congratulations on your upcoming wedding! What brings you in today?"
(*Patient says: "I want to get this mole removed – I'm getting married soon and don't want it visible in the dress."*)

History – Follow standard dermatology structure for lumps

Examination will follow PMAFTOSA in this case.

Diagnostic pivots to clarify:

Duration: Long-standing vs new
Changes: Size, shape, colour, bleeding, crusting
Symptoms: Pain, irritation, catching on clothing

Impact: Practical vs cosmetic vs emotional

Ask specifically:

"Has the mole changed at all recently — in colour, size, or shape?"
"Does it bleed, get sore, or catch on anything?"
"Do you have any others like this?"
"Have you ever had one checked before?"
"Any family history of skin cancer?"

If not bothering the patient physically, confirm:

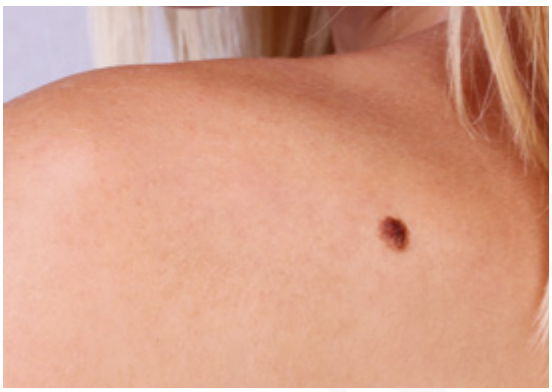
"Apart from the wedding, does it cause you any day-to-day discomfort?"

PMAFTOSA

Previous similar issues or removals
No major medical issues or immune conditions
No allergies relevant
Family history: no skin cancer
No recent travel
Office job, not outdoors
Non-smoker, occasional alcohol
No current medications

Examination

"Thanks for that. Would it be alright if I take a look at the mole now?"



Findings:

"What I can see is a slightly raised, evenly pigmented mole on your upper shoulder. It's about the size of a pencil rubber, light brown in colour, with a smooth surface and regular borders. There are no signs of bleeding, crusting, or inflammation. The skin around it looks healthy too."

Provisional Diagnosis

"From everything you've said and how it looks, this appears to be a completely harmless mole — what we call a benign naevus."

Explanation
"A mole is just a collection of pigmented cells in the skin. Most people have them, and the vast majority are completely safe. Yours has no signs of anything concerning — the shape, colour, and border all look normal, and it's not changing or causing symptoms."
"So from a medical perspective, this is not something that needs removing. That said, I understand that you're getting married and would prefer not to have it visible in photos — and that's a very reasonable concern."

Management Plan
"Let me explain the options, and also what we can and can't do on the NHS."

NHS Policy:
"The NHS usually only removes moles when they cause medical problems — for example, if the mole bleeds repeatedly, causes daily pain, keeps getting infected, or looks suspicious for skin cancer. Yours isn't doing any of that, so the NHS wouldn't be able to fund removal in this case."

(*Patient asks: "What if I really want it gone?"*)
Private Options:
"You can still have it removed privately, and I'm happy to guide you. There are a few common ways:"

Surgical removal – quick and very effective, but may leave a visible scar
Laser removal – minimal scarring, but often needs several sessions and can be more expensive
Freezing with liquid nitrogen – not typically used for moles, more for warts or sun spots
Topical creams – rarely effective for moles and not commonly recommended

(*Patient asks: "Will it leave a scar?"*)
"That's a very fair concern. Any method could leave a scar — even laser. Surgical removal gives the most visible scar, but is usually one-and-done. Laser tends to leave a lighter mark, but results vary depending on your skin."

Shared Plan & Reassurance
"So right now, there's no need to worry medically. But if you choose to go ahead with private removal, I can give you information on dermatology clinics that offer these procedures."
"Also, please do keep an eye on this mole in the future. If it ever changes — gets bigger, darker, uneven, starts to bleed or itch — do come back in right away."

Safety Netting
"Just to be safe — if the mole starts to change in any way, or if you develop others that look different or odd, please don't wait. Book back in with us so we can check it again."

Follow-Up + Leaflet
"I'll send you a leaflet about moles and what signs to watch for, plus some private options for removal. There's no need for follow-up unless anything changes — but I'm glad you came in to get it checked."

Mole – Worried About Cancer

Scenario: GP | Young female | Long-standing mole on arm | Concerned due to colleague comments
Your Role: FY2 GP – assess mole, rule out concerning features, reassure, educate, and address anxiety

Introduction

"Hello, I'm one of the doctors here at the practice.
Could I confirm your full name and age, please?"
"Thanks. What brings you in today?"
(*Patient: "I have a mole on my arm that I've had for a while, but someone at work said it could be cancer."*)

History – Morphology, Evolution, Symptoms

Ask:

"How long have you had this mole?"
"Have you noticed any change in **size, shape, or colour**?"
"Has it ever **itched, bled, become painful**, or oozed anything?"
"Do you have any other similar moles or spots that concern you?"
"Has anyone in your family had **skin cancer**?"
"Do you spend a lot of time in the sun or use tanning beds?"
"You mentioned being anxious — do you have a history of anxiety, or is this more recent due to what was said at work?"

Findings from History:

Mole has been present for **2–3 years**
No changes in size, shape, or colour
No pain, bleeding, or itching
Anxiety triggered by **colleague comments**, not by changes in the lesion itself
Patient has a known **history of anxiety** but has not sought support recently

PMAFTOSA

No chronic skin conditions
No personal or family history of melanoma or skin cancer
Non-smoker
Office-based job with occasional sun exposure during travel
No regular medications
Moderate anxiety background, no ongoing counselling

ICE

Idea: "Could this be something serious, like cancer?"
Concern: "My colleague said it looked suspicious, and that made me nervous."
Expectation: "I just want to know if I should be worried or if anything needs to be done."

Effect on Life

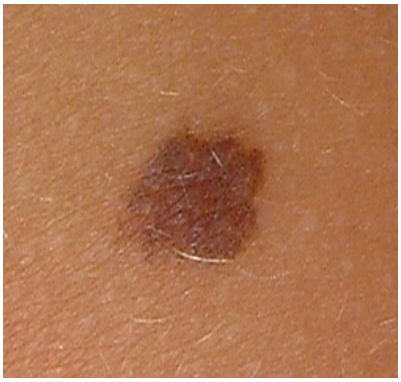
Frequently checking the mole at home
Mild sleep disturbance from overthinking
Avoiding sleeveless clothes due to embarrassment and uncertainty

Examination

"Let me take a close look at the mole using a."
ABCDE screening findings:

- **Asymmetry** – Mole is symmetrical
- **Border** – Smooth and regular
- **Colour** – Uniform, light brown pigmentation
- **Diameter** – Less than 6mm
- **Evolution** – No change over 2–3 years

No ulceration, bleeding, inflammation, or satellite lesions noted.



Provisional Diagnosis
"This appears to be a **benign mole** — what we also call a **naevus**."

Lay Explanation
"A mole is a common cluster of skin cells that produce pigment.
Yours looks perfectly normal — it's **small, evenly coloured**, and **hasn't changed** over time, which is a good sign."
"The most important thing we look for in moles that could become cancerous is **evolution** — any change in size, shape, colour, or symptoms like bleeding.
Since none of those are present, it's very **unlikely to be dangerous**."

Management Plan
"We don't need to remove this mole or refer you at the moment. However, I'll give you some simple tips on how to monitor it yourself."

Self-monitoring advice – "ABCDE" rule:

Asymmetry
Border irregularity
Colour variation
Diameter >6mm
Evolution or any change

"If you ever notice any of these, especially if it starts changing or bleeding, please come back."
"Wear sunscreen when outdoors, avoid sunbeds, and check your skin regularly, including hard-to-see areas like your back."

Anxiety Reassurance
"I understand why you were alarmed, especially after your colleague's comment.
It's completely natural to feel anxious, especially when health is involved."

"Based on my clinical findings, there is **no indication of cancer**, and you don't need to worry.
But if this anxiety is affecting your day-to-day life or keeps coming up, I'm happy to discuss support options like counselling or stress-relief techniques."

Safety Netting
"Come back sooner if:"
- You notice **any change** in the mole's appearance
- It becomes **painful, itchy, or starts bleeding**
- You develop other moles that concern you

"Even though everything looks fine now, we encourage people to keep an eye on their skin and seek advice if needed."

Follow-Up
"No routine follow-up is needed, but if you'd feel more at ease, you're welcome to book a **skin check once a year** or sooner if anything changes."

Leaflet
"I'll give you a leaflet with the **ABCDE guide**, how to monitor your moles, and when to seek help."

Cradle Cap

Scenario: GP Surgery | 2-month-old baby | Rash on scalp | Concerned parent (mother)
Your Role: FY2 GP – assess rash, rule out infection or systemic illness, reassure and educate

---

Introduction
"Hello, I'm one of the doctors here at the practice.
Could I confirm — are you the baby's mother? And may I check your baby's full name and age?"
"Thanks. How can I help you both today?"
(*Parent: "There's this yellow patchy rash on the baby's head. I'm worried it might be something serious."*)

History – Presenting Complaint
Diagnostic pivots:
- Yellow, greasy, adherent scales
- Non-itchy, non-infective appearance
- Localised to scalp, possibly ears or eyebrows

Ask:
- "When did you first notice the rash?"
- "Has it changed — like getting worse, spreading, or flaking more?"
- "Is it only on the scalp, or do you see it on the ears, eyebrows, or body?"
- "Is the baby scratching or showing discomfort when you touch it?"
- "Have you tried anything at home — like baby shampoo, oils, or brushing?"

Systemic Review (Red Flag Screening)
- "Any fever or episodes of excessive crying?"
- "Any change in your baby's sleep pattern or feeding?"
- "Is your baby generally alert and responsive?"

"How many wet nappies per day?"
"Normal bowel movements?"

PMAFTOSA

Birth: Full-term, vaginal delivery, no complications
Medical: Healthy 2-month-old, no skin conditions
Allergies: None known
Feeding: Breastfed, latching well, no vomiting or reflux
Toileting: 6–8 wet nappies/day, normal stool
Sleep: Age-appropriate pattern
Activity: Alert and responsive when awake

ICE

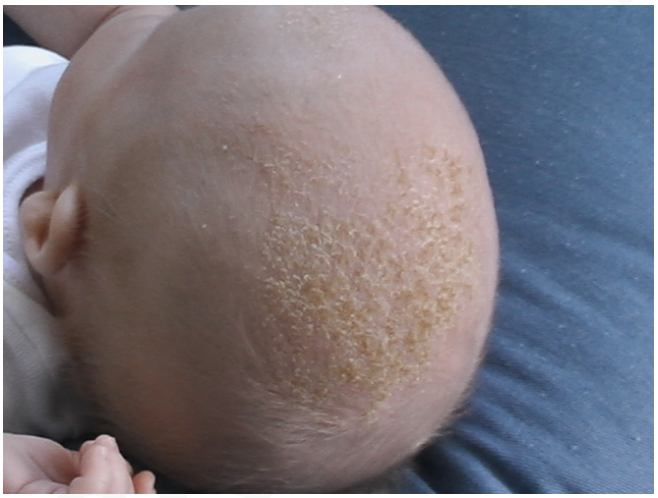
Idea: "Could this be an infection?"
Concern: "Someone said it looks yellow and crusty — I'm scared it's serious."
Expectation: "I was hoping to get it checked and know how to treat it safely."

Effect on Life

No effect on feeding, sleep, or routine
Mum feels anxious and checks rash multiple times a day
Concerned it may spread or indicate something wrong

Examination

"Let me check your baby's overall appearance, hydration, and take a close look at the scalp."



Findings:

Well-appearing, hydrated baby
Scalp shows **adherent yellow, greasy scales**
No erythema, swelling, oozing, or tenderness
No signs of infection or systemic illness
Rash confined to scalp with minimal involvement of eyebrows

Provisional Diagnosis
"This appears to be a case of **cradle cap**, or what we call **infantile seborrhoeic dermatitis**."

Explanation
"Cradle cap is a very **common, harmless skin condition** in babies. It causes **greasy, yellow, scaly patches** on the scalp. It's caused by a mix of **mild skin oil overproduction** and a **natural skin yeast** — not because of poor hygiene or infection."
"It doesn't hurt or itch, and it usually **goes away on its own** over the next few months. It's not contagious and doesn't mean anything is wrong with your baby."

Management Plan
"Here's what you can do at home to help it settle:"
Home care:
Apply **baby oil**, **olive oil**, or **petroleum jelly** to scalp 15–30 mins before washing to soften the scales
Wash gently with **mild baby shampoo**
Use a **soft baby brush** or your fingertips to gently loosen flakes after washing
Do this **once daily or every other day**
What to avoid:
Don't **scratch or pick** at the scales
Avoid harsh soaps, **medicated shampoos**, or **excessive washing**
"It usually clears by **6–12 months of age** without medical treatment."

Safety Netting
"Please come back or call us if:"
The rash becomes **red, swollen, or oozing**
The baby becomes **irritable, feeds poorly, or develops a fever**
There's **no improvement** after a few weeks of home care

Follow-Up
"We don't need a routine follow-up, but I'm happy to review if anything worsens or doesn't improve."

Leaflet
"I'll give you a leaflet from the NHS about **cradle cap** and how to care for it at home."

Head Lice

Scenario: GP Clinic | Father of 6-year-old girl calls regarding recurrent lice
Role: FY2 GP – Assess, clarify recurrence, address concerns, educate, and arrange plan

---

Introduction
"Hello, this is one of the doctors calling from the GP surgery. Am I speaking with [Father's name]? Thank you — could I confirm your child's full name and age, please?"
"Lovely. How can I help you today?"
(*Parent: "She had lice again. We treated her a few weeks ago and thought it was gone, but now it's back."*)

Presenting Concern – History

"Thanks for letting me know. Just a few questions to understand it better, if that's okay?"

"When did you first notice them this time?"
"Is she scratching her head again, or feeling uncomfortable?"
"Have you seen actual lice moving, or just the white eggs (nits) stuck to the hair?"
"Has she had any sores or irritation on the scalp?"

Exposure & Treatment History

"What treatment did you use last time — was it a shampoo or a combing method?"
"Did you repeat the treatment a week later?"
"Did you treat any other family members at the same time?"
"Has she had close contact with other children — for example, at school or a sleepover?"

PMAFTOSA

Otherwise healthy 6-year-old
No medications, no skin conditions like eczema
Up-to-date with vaccinations
Eats and sleeps normally
Lives with both parents and a younger sibling
Attends primary school

ICE

Idea: "We're sure it's head lice — we saw them again."
Concern: "She's being blamed at school, and I'm worried it keeps spreading."
Expectation: "We've done treatments before. Can we get something stronger this time — maybe an oral medication? I'd prefer not to bring her in."

Effect on Life

Daisy is embarrassed at school and scratching in class
Father reports stress at home — multiple treatments, washing everything
Social tension due to other parents blaming Daisy for recurrence

Invitation for In-Person Review

"I completely understand your frustration, and you've done the right thing by treating her.
However, I'd really recommend that you bring her in for a quick face-to-face appointment."
(*If parent hesitates)*

"Sometimes, conditions like **seborrhoeic dermatitis** or even scalp eczema can look similar, and we want to confirm it's truly lice before moving to another treatment. Also, some lice may be resistant, so it's important we check properly."
"Would you be happy to bring her in tomorrow or the day after so we can have a look?"
(*Parent hesitates but then agrees: "Alright… I see your point. We'll come in tomorrow morning."*)

Provisional Diagnosis

"From your description — repeated episodes, presence of live lice, and itching — this sounds like a **recurrent head lice infestation**, also known as **pediculosis capitis**."

Explanation

"Head lice are tiny insects that live on the scalp and feed on blood. They spread easily through close head-to-head contact — very common in children at school or nursery."

"It's not related to hygiene, and it happens to many children. Lice lay eggs (nits) which stick to the hair. If not all lice and eggs are removed, or if another child reinfects her, it can keep coming back."

Management Plan

Step 1 – Wet Combing Protocol (First-line)

"The first option — and still one of the best — is **wet combing**. You wash her hair, apply conditioner, and comb through using a special fine-toothed lice comb. You'll need to do this on **Days 1, 5, 9, and 13**, each session for about 20–30 minutes."

"The idea is to remove both the lice and any newly hatched eggs before they can mature."

Continue until the hair is lice-free for 17 days

Use a **Bug Buster Kit** if available

Step 2 – If Wet Combing Fails

"If lice are still present after that full cycle, we'll prescribe a **medicated lotion**, like **dimeticone 4%**.

It works by suffocating the lice and is very effective. You'd apply it to dry hair, leave it overnight, and repeat after 7 days."

"We avoid permethrin-based shampoos or electric combs now, as they're not very effective anymore."

Step 3 – Household & School Advice

Treat only those household members who have live lice

Wash hats, pillowcases, and combs in hot water

No need for full home cleaning

Avoid sharing hair brushes or clips

There's **no need to keep her off school** once treatment is started. We can give you a note to explain that to the teacher if needed.

Safety Netting

"If she still has lice after two full rounds of treatment, or if you notice scalp redness, infection, or worsening irritation, please come back straight away."

"Also, if any other family member develops symptoms, only treat them if you actually see **live lice**."

Follow-Up

"Let's plan to see her in person tomorrow to confirm the diagnosis. Then we can decide whether to start with wet combing or go directly to medicated treatment."

"We'll book a review around Day 17 to make sure she's lice-free. And of course, contact us earlier if anything changes."

Leaflet

"I'll text you the NHS Head Lice page and give you a printed leaflet when you come in. It includes photos, combing instructions, and what to look for during follow-up."

Primary Focal Hyperhidrosis

Scenario: GP | Young adult (20s) presents with ongoing excessive sweating, socially distressing
Role: FY2 GP – Reassure, assess severity, rule out secondary causes, advise non-invasive management

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Introduction & Rapport
"Hi, I'm one of the doctors here at the practice. Thanks for coming in today."
"You mentioned there's something that's been bothering you — I understand it might feel a little awkward to talk about, but please know this is a very common concern, and we deal with things like this all the time. You can feel free to speak openly."

Presenting Complaint
"Can you tell me more about the issue that's been bothering you?"
→ Patient reports: excessive sweating in armpits (± groin), has a smell, feels embarrassed, present for months or longer.

History – Duration, Distribution, Evolution
"When did you first notice this problem starting?"
"Has it been getting worse over time?"
"Do you sweat in any particular areas — armpits, groin, hands, feet, scalp?"
"Is it constant, or does it come and go?"
"Any sweating while you're sleeping?" (→ *No = suggests primary*)
"Has anyone in your family had similar symptoms?"
Symptoms for >6 months, starting before age 25, no night sweats = fits NICE criteria for primary focal hyperhidrosis

Screening for Secondary Causes
"To be safe, I'd like to ask a few more questions to make sure it isn't linked to something else."
"Any fever, weight loss, or night sweats?"
"Any new lumps or swellings?"
"Do you feel hot all the time, or notice a racing heartbeat?" (*Hyperthyroidism*)
"Do you feel thirsty more often or urinate frequently?" (*Diabetes*)
"Have you been on any new medications?"
"Do you have any long-term illnesses?"
No systemic features, no medications = primary cause likely

Trigger Exploration
"Do you find it gets worse with heat or certain foods — like spicy meals, caffeine, or alcohol?"
"Any link with stress or emotional situations?"
"Do you smoke?"

ICE – Ideas, Concerns, Expectations
"Do you have any idea what this might be?"
"Is there anything specific you're worried about?"
→ *"I'm scared it's not normal... What if this never goes away?"*
"What were you hoping I could help with today?"
Patient wants explanation and discreet treatment options, unsure if they need to live with it forever

Effect on Life

"How much is this affecting your day-to-day life?"
"Has it impacted your work, confidence, or social situations?"
"Do you avoid certain clothes or activities?"

Patient avoids dark clothing, struggles with social confidence, skips exercise

Examination

"I understand the concern is in your underarms. If you're okay with it, I'd like to examine the area briefly — I can arrange a chaperone if that makes you feel more comfortable."

→ *Findings often normal, no infection, no rash*

Provisional Diagnosis & Explanation

"Based on what you've told me, this sounds like a condition called **primary focal hyperhidrosis**. That means your body produces excess sweat in specific areas — most commonly armpits, hands, feet, or groin — without an underlying medical cause."
"It's not dangerous or a sign of illness, but I completely understand how frustrating and embarrassing it can be. The good news is — it's manageable, and we have a few treatment options."

Management Plan

Step 1 – Identify and Avoid Triggers

"Try to avoid spicy food, caffeine, smoking, and stressful situations if you notice they make it worse."

Step 2 – Over-the-Counter Antiperspirants

"Unlike deodorants, **antiperspirants** actually reduce sweating. Look for ones with **aluminium chloride** — they're stronger than regular options and available at most pharmacies."

Step 3 – Prescription-Strength Options

"There are stronger prescription antiperspirants we can offer, which you apply at night and wash off in the morning. These are often used for a few nights a week to control symptoms."

Step 4 – Clothing Advice

"Wearing **loose-fitting cotton clothes**, light colours, or using **underarm pads** can help hide visible sweat marks."

Optional Step 5 – If Symptoms Persist

"If these measures don't help enough, we can explore other options like **botulinum toxin (Botox) injections**, which block the nerves that trigger sweat glands. These are done in hospital clinics."
"Some people are also referred to dermatology or consider oral medications, but those are for more severe cases."

Safety Netting

"If you ever start developing **new symptoms** — like night sweats, fever, weight loss, or rapid heartbeat — please let us know, as we'd want to investigate further."
"And if this continues to affect your mental health or confidence despite treatment, we can discuss supportive counselling too."

Follow-Up & Leaflet

"Let's try with the aluminium-based antiperspirant for now and review in 4 weeks. If it's not working well enough, we'll consider prescription treatment or dermatology referral."

"I'll also send you an **NHS leaflet** on hyperhidrosis with some helpful tips and support links."

Contact Dermatitis

Scenario: GP | Adult florist | Sore, itchy finger rash | Chemical exposure, no gloves

Your Role: FY2 GP – assess for allergic skin reaction, educate on avoidance, initiate topical management

---

Introduction

"Hello, I'm one of the doctors here at the practice.

Could I confirm your full name and age, please?"

"Thanks. What's brought you in today?"

(*Patient: "I've developed a rash on my finger – it's sore and itchy, and it's been getting worse."*)

History – Morphology, Evolution, Symptoms

Diagnostic pivots for contact dermatitis:

Red, itchy, and inflamed skin over **area of contact**

May be **painful or dry**

Improves with **avoiding exposure**

Often **occupational or hobby-related**

Ask:

"Which finger is affected, and how long has it been there?"

"Has the rash spread anywhere else?"

"What does it feel like — itching, burning, or tenderness?"

"Have you tried anything that helped or worsened it?"

"Does it get worse during or after work?"

"Do you wear gloves while working with flowers or chemicals?"

"Have you been using new sprays, fertilizers, or other products?"

"Do you know if you have any known skin allergies?"

"Have you started using any new skincare products or hand sanitizers?"

"Is anyone else at work affected?"

PMAFTOSA

No known allergies prior

No chronic skin conditions

Works as a **florist**, handling **plants and pesticides**

No regular medication

New job started 1–2 months ago

No other rashes or systemic symptoms

Rash improves slightly on weekends or days off

ICE

Idea: "Could it be eczema or an allergy?"

Concern: "I'm worried it'll get worse and affect my work."

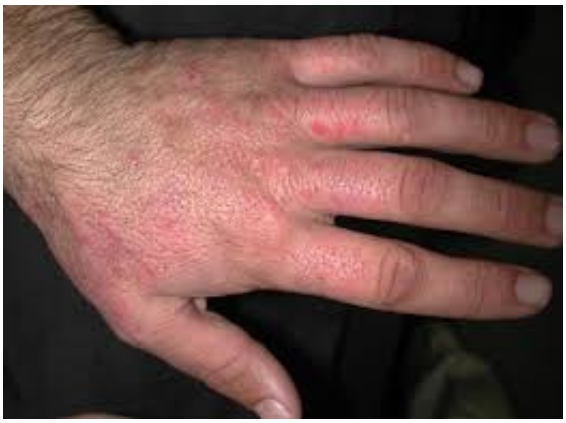
Expectation: "Hoping for something to stop it and help it heal."

Effect on Life

Difficulty using hand tools at work
Avoiding wet work or certain plants
Skin sore to touch when washing hands or using soaps

Examination

"Let me take a look at your finger."



Findings:

"There is **a red, scaly, inflamed patch** over the dorsal aspect of the right index finger.
It is **slightly swollen** and tender to touch with **no signs of pus or infection**.
No other body areas are affected."

Provisional Diagnosis

"This appears to be a condition called **allergic contact dermatitis**."

Lay Explanation

"It's a type of **skin reaction** caused by **direct contact with certain substances**, often chemicals like pesticides or plant-based compounds.
The body reacts to the chemical with **inflammation and redness**, which is why it's sore and itchy."
"There's another similar condition called **irritant contact dermatitis**, but that usually happens with repeated friction or wet work.
In your case, the timing, appearance, and exposure all suggest an **allergic cause**."

Management Plan

"The good news is this is treatable. Here's what I recommend:"

Topical Treatment:

Emollient cream (moisturizer) to protect and hydrate the skin
Hydrocortisone 1% cream, applied sparingly once or twice a day for **up to 7 days** to reduce inflammation

"Apply the steroid **first**, wait 15–20 minutes, then apply the moisturizer."

Exposure Reduction Advice

"To help prevent flare-ups and protect your skin:"

Always wear **nitrile gloves** or **barrier protection** when handling flowers or chemicals
Wash hands with **fragrance-free soap**, then moisturize
Avoid direct contact with **sprays, pesticides, or unknown plant matter**
Reduce use of hand sanitizers or scented lotions if possible
If full avoidance isn't feasible, reduce frequency of contact and take breaks
Gently cleanse and dry the skin after any accidental exposure

Safety Netting
"If you notice:"
The rash **spreading**, **worsening**, or becoming **oozy or painful**
Any signs of **infection** (pus, warmth, fever)
Or if **no improvement in 2–3 weeks**
"Please come back — we may need to try a **stronger steroid**, consider patch testing, or refer you to dermatology."

Follow-Up
"Let's review this in about **2–3 weeks** to check your progress.
If symptoms resolve with treatment and avoidance, no further steps may be needed."

Leaflet
"I'll provide you with a leaflet that explains **contact dermatitis**, treatment instructions, and how to avoid future flare-ups."

Eczema (Atopic Dermatitis)

Scenario: GP | 15-year-old boy with itchy rash behind knees, presented by mother
Your Role: FY2 GP – assess, confirm diagnosis, explain eczema, reassure and manage appropriately

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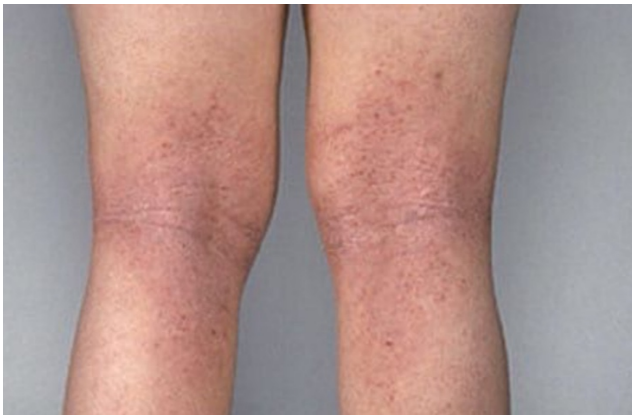
Introduction
"Hello, I'm one of the doctors here at the practice. Are you the child's mother? Thank you for coming in today. Could I confirm his full name and age, please?"
"I understand you're concerned about a rash James has developed. Could you tell me more about what's been happening?"

History – Morphology, Evolution, Symptoms (MES)
Diagnostic pivots for eczema:
Chronic itchy rash
Flexural areas (elbows/knees)
Recurrent episodes
Dry, red, cracked skin; may have lichenification
Ask:
"Where did you first notice the rash?"
"Has it changed in size, spread, or severity?"
"Is it itchy or painful?"
"Have you tried any creams or treatments before coming in?"
"Have you noticed any oozing, bleeding or infection in the area?"

Red Flag Screening
"Has he had any high fever or feeling unwell recently? Any crusting or yellow discharge from the rash? Is he scratching at night and unable to sleep?"

Examination
"Thank you for sharing that. Would it be okay if I have a look at the rash now?"



Findings:
Dry, erythematous patches with some excoriation behind both knees
No signs of infection or systemic illness

PMAFTOSA
P: Born full term, normal delivery
M: Has asthma (well-controlled with blue inhaler)
A: No known allergies
F: Strong family history of atopy (father and sister with asthma)
T: No recent travel
O: Attends school, no recent illness outbreaks
S: No smoking at home
A: Not on any regular medications except salbutamol

ICE
Idea: "Is it because of his asthma?"
Concern: "I don't want him to be given steroids. I've heard they cause side effects."
Expectation: "I just want something to help him sleep and concentrate better."

Effect on Life
Scratching at night, poor sleep
School performance affected
Child embarrassed by appearance of rash

Provisional Diagnosis
"From what you've told me and what I can see, this looks like a flare-up of **atopic eczema**, which is common in children with asthma."

Explanation
"Eczema is a condition where the skin becomes inflamed, dry, and very itchy. In children with asthma or allergies, the immune system tends to overreact to everyday triggers like soaps, weather changes, or even sweat. The skin becomes irritated and itchy, and scratching can make it worse or even lead to infections."

Management Plan

Emollients:
Use fragrance-free emollient (e.g. Dermol) frequently (2–3x/day)
Use as soap substitute and moisturiser
Apply in direction of hair growth, especially after bathing

Topical Steroids:
"For the face and skin folds: **Hydrocortisone 1% once daily for up to 7 days**."
"For the body: **Clobetasone (Eumovate) or Betamethasone 0.025%**, if needed — applied once daily during flare-ups."
"Always apply the moisturiser first, wait 20–30 minutes, then apply the steroid sparingly."
Reassure: "Used correctly, mild steroids are very safe, especially for short periods."

Avoid triggers:
Avoid perfumed products, bubble baths
Use cotton clothes
Keep fingernails short to prevent damage

Antihistamine:
Short-term cetirizine for night-time itching

School advice:
Inform teachers so they're aware of symptoms and impact on focus

Safety Netting
"Please come back if the rash doesn't improve within 1–2 weeks, or if it gets red, swollen, or starts to ooze, which may mean infection. If the itching becomes unbearable or James seems very tired or unwell, please contact us."

Follow-Up
"Let's review him in 2–3 weeks to see how he's responding to treatment."

Leaflet
"I'll give you an NHS leaflet about eczema with instructions on using creams and spotting complications."

Note: If the patient is a **baby**, adapt the ICE and history to reflect **parental observations and concerns**. Use the full MES history but gather information from the **parent**, not the child. The examination, diagnosis, and management remain similar, but phrasing and reassurance should be tailored to address **parental worries**, feeding, sleep disruption, and risk of infection.

Note on Management in Babies:
When managing eczema in infants:
• **Emollients:** Use fragrance-free, paraffin-based emollients suitable for babies (e.g. *Hydromol*, *Diprobase*, or *Epaderm*). Apply generously at every nappy change and after bathing. These can also be used as soap substitutes.

• **Topical Steroids:** If needed, use only **mild steroids** such as **hydrocortisone 1%**. Apply once daily for up to **7 days** to the affected areas. **Avoid the face unless specifically instructed**, and **never use moderate or potent steroids without paediatric review**.
• **Bathing:** Recommend using emollient bath additives or plain water only. Avoid bubble baths or soap-based cleansers, which can worsen dryness.
• **Clothing and Environment:** Encourage parents to dress the baby in **soft, breathable cotton** clothing. Keep the baby's nails short and consider mittens to reduce scratching. Maintain a cool room temperature to prevent overheating, which may worsen itching.
• **Parental Reassurance:** Explain that **infantile eczema is common** and often improves with age. Emphasise regular emollient use even when the skin appears clear to help prevent flare-ups.
• **Safety Netting:** Advise parents to seek review if the rash worsens, starts oozing, becomes red and hot (suggesting infection), or doesn't improve within 1–2 weeks.

Venous Ulcer: Follow-Up Consultation

Scenario: GP | 80-year-old male | Ongoing venous leg ulcer with poor response to stockings
Your Role: FY2 in GP Surgery | Follow-up after ABPI | Address patient concerns, improve compliance, plan next steps

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Introduction & Identity Confirmation "Hello, I'm one of the doctors here at the practice. Thank you for coming in today. Before we begin, could I confirm your full name and age, please?"
"I understand you've been having ongoing discomfort in your legs and previously had a leg ulcer diagnosed. I also see that the nurse did a test called ABPI recently. Let's go through how things have been and discuss a clear plan together."

Focused History & Current Update "Can I ask how your legs have been since your last visit?"
Patient: Discomfort continues. Was advised to use compression stockings but unable to tolerate them. Ulcer not healing. No pus. Still mobile.

How would you describe the discomfort? Is it painful, itchy, or heavy?
Have the symptoms worsened or stayed the same?
Any swelling, change in skin colour, or new discharge?
Any previous episodes of ulcers in the past?
Do you still move around or spend most time sitting/standing?
Any issues with walking or circulation?

Venous Risk Factor Screen

Prolonged standing at work (previous occupation)
Family history of varicose veins
Any history of DVT or clots in the legs?

General Risk Factors / PMAFTOSA

Medical history: Diabetes, rheumatoid arthritis, poor mobility?
Medications: Blood thinners, NSAIDs, corticosteroids?
Allergies: Latex or dressings?
Family and social context: Living with someone? Support at home?
Smoking and alcohol history?

ICE

Idea: "Do you have any thoughts about why it hasn't healed yet?"
Concern: "I'm worried it hasn't improved and want to know if I need a specialist."

Expectation: "I would prefer to be seen by a doctor rather than the nurse."

Examination Summary (already done by nurse)

ABPI performed – result was normal (between 0.9 and 1.3) → indicates adequate arterial supply and safe for compression therapy.

No signs of cellulitis or systemic infection.

"The nurse performed a test called the Ankle Brachial Pressure Index. It checks the blood flow to your legs. Your result was within the normal range, which is reassuring. This means the arteries in your legs are working well, and we can safely continue compression therapy."

Provisional Diagnosis "From what you've shared and the results we have, this is still a venous leg ulcer. It hasn't worsened, but it hasn't improved either, likely due to the difficulty using compression therapy."

Explanation in Simple Terms "Venous ulcers happen when blood has trouble flowing back up the leg. Over time, this causes pressure to build up and leads to skin breakdown, especially if you spend a lot of time standing or sitting still. Compression stockings are the main treatment because they help improve circulation and allow the skin to heal."

Management Plan

A. Re-introduce Compression Therapy

"I understand the stocking was uncomfortable. Let's try a different size or type with better fit. There are softer options available."

"The nurse plays a key role in monitoring and dressing ulcers — but I'll stay involved too. I'll personally review your progress."

B. Investigations

Order blood tests to rule out factors delaying healing:

FBC, ESR, CRP
U&E, HbA1c
Albumin

C. Pain Management

Paracetamol as needed for discomfort

D. Lifestyle Advice

Keep active with light walking
Elevate your leg when sitting
Avoid prolonged sitting/standing without movement
Maintain healthy diet and hydration
Avoid injury to the skin

E. Specialist Referral (Conditional) – If the patient insists

When the patient says "I want to be seen by a specialist," don't say no outright.

Say: "I completely understand why you'd want that. From what I can see today, there's no sign of infection or arterial problems, and your scan results were reassuring. What we'd usually do is try a full course of compression first — if that still doesn't help after 2–4 weeks, then I'll absolutely refer you on. Would you be open to giving it another go, with a review in a couple of weeks?"

Safety Netting "Please let us know immediately if you notice:
Increased pain, redness, swelling or pus
Fever or feeling generally unwell
Any new ulcers or difficulty walking"

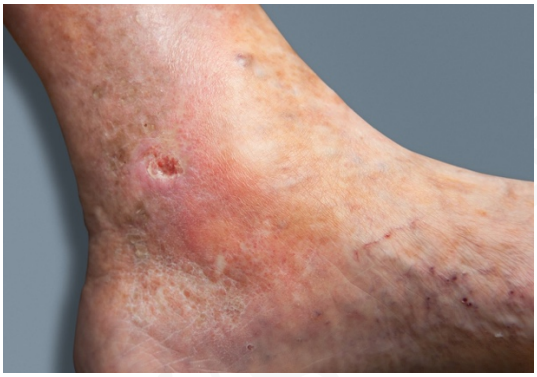
Follow-Up Plan
Nurse review in 2 days to ensure better stocking fit
GP follow-up in 2 weeks to assess healing

Leaflet
"I'll give you a leaflet about venous ulcers and compression stockings, with tips on how to manage symptoms at home."

Case Variation – Non-Healing Venous Ulcer (Follow-Up Presentation)

Patient Profile: 50-year-old male returns for follow-up 2 months after being diagnosed with a venous ulcer.
He was advised to wear compression stockings but reports poor healing despite regular use.
He now says:
"I've been using the bandages but nothing's working. I don't want to wear them anymore. Can I stop? Can you refer me to someone?"

Approach Summary (Follow-Up Format):
Presenting Concern: Persistent leg wound despite compression therapy
Compliance: Good compliance with compression but no significant improvement
Examination: No signs of infection, ABPI previously normal
Impact: Ongoing discomfort, reluctant to continue current treatment



Diagnosis: *Non-healing venous ulcer despite adequate compression for over 6 weeks.*

Management Plan:
Referral:
Tissue Viability Nurse for specialist dressing and wound care
Vascular Team to evaluate for potential venous surgery or advanced interventions
NICE CKS: Refer **if no healing after 4–6 weeks of compression** despite ABPI > 0.8
Continue Compression:
Explain that stopping now would worsen healing
Explore alternative compression options (e.g., different wrap systems)

Adjunct Treatment:
Consider **Pentoxifylline** (unless contraindicated) to promote healing
Wound swab if signs of **secondary infection** develop
Lifestyle & Education:
Leg elevation, regular movement, weight loss if overweight
Avoid trauma to the affected leg
Provide **leaflet** and safety net: signs of infection, worsening pain, new swelling

Chapter 15: Paediatrics

Paediatric History-Taking Structure

1. INTRODUCTION & IDENTITY CHECK
"Hi, I'm Dr. [Name], one of the junior doctors here today."
Confirm: Child's **full name** and **age**
Parent/carer's **relationship** to the child
(If a newborn): "Was this a planned pregnancy?"
"Congratulations – how have things been going since birth?"

2. PRESENTING COMPLAINT
Use this structure to explore the concern fully:
Onset
Duration
Interval (on and off?)
Progression (better, worse, same?)
Associated symptoms (fever, rash, vomiting?)
Relieving/worsening factors
Activity – "Is your child eating, playing, or sleeping differently than usual?"
Ask: "Is there anything else you've noticed?"

3. SYSTEMATIC HEAD-TO-TOE CHECK (If needed)
Important Note:
A **brief head-to-toe systems screen** is **recommended in most PLAB 2 paediatric cases**, especially when:
The presenting complaint is **vague** (e.g., fever, crying, not feeding)
The child is **under 5** or **non-verbal**
There are **safeguarding concerns** (e.g., suspected NAI)
If focused and clear, **you can shorten** it to:
"Any concerns with breathing, feeding, stools, or urine?"

System	*Ask 1–2 questions*
Neuro	Drowsiness? Seizures? Crying when held? Light sensitivity?
Ears	Pulling ears? Discharge?
Nose	Runny nose? (TRAC: Timing, Relation, Amount, Colour)
Eyes	Sticky or red eyes? Difficulty opening in the morning?
Lungs	Cough? Breathing difficulty or wheezing?

GI	Vomiting? Diarrhoea? Constipation? Feeding issues?
Urinary	Crying while passing urine? Smelly urine? Wetting nappies normally?
Hydration	Crying without tears? Dry mouth? Less playful than usual?
Injuries	Any recent falls or injuries?

4. RELEVANT PAST HISTORY – Use BIRDS-MAF Mnemonic

Code	*Topic*	*Key Questions*
B	**Birth**	"Was your child full-term?" "Vaginal or C-section delivery?" "Any complications during or after birth?"
I	**Immunisations**	"Are their vaccines up to date?" "When was the last one?"
R	**Red Book**	"Any concerns ever raised in their red book?"
D	**Development**	"Are they walking, talking, and playing like other kids their age?" "Any delays you've noticed?"
S	**Safeguarding**	"Who's at home with the child?" "Do you have enough support?" "Any social worker ever involved?" *(ask gently)*
M	**Medications**	"Any current or recent medications?" "Any antibiotics recently?"
A	**Allergies**	"Any allergies to food, medication, or anything else?"
F	**Family History**	"Any conditions like asthma, eczema, seizures in the family?"

5. GENERAL WELLBEING CHECK

"Is your child active and playful today?"

"How has their sleep been recently?"

(This can also double as a hydration/sickness screen in young children)

6. ICE – Ask After Full History

I – Ideas: "Do you have any thoughts about what might be causing this?"

C – Concerns: "Is there anything you're particularly worried about?"

E – Expectations: "What were you hoping we could do today?"

7. WRAP-UP & SIGNPOST

"I'd now like to [examine your child / explain what I think / discuss what we can do next]. Does that sound okay?"

Final Flow to Memorise:

Intro → ODIPARA → Systems Check (if needed) → BIRDS-MAF → Wellbeing → ICE → Wrap-Up

Intussusception

Setting: FY2 in Paediatrics | Child referred by GP with vomiting and irritability

Task: Focused history from parent + discuss likely diagnosis and management

1. INTRODUCTION & IDENTITY

"Hello, I'm one of the junior doctors in the paediatric team."
"To make sure I have the right details — could you please tell me your child's full name and age?"
"And may I check your relationship to them?"
"I understand you were sent here by your GP — do you happen to have a referral letter with you?" *(Read if given)*
"Before we proceed, I'd like to ask you a few questions to understand what's been going on — is that alright?"

2. PRESENTING COMPLAINT – ODIPARA for crying/irritability

O (Onset): "When did the crying or discomfort first start?"
D (Duration): "Has it been constant or on and off?"
I (Interval): "Roughly how long do these episodes last each time?"
P (Progression): "Has it been getting worse or staying the same?"
A (Associated symptoms):
"Has your child been feeding as usual?"
"Have they vomited?" → *Ask colour and content*
"Any changes in the stools?" → *Ask about blood or jelly-like appearance*
"Have they had any fever?"
R (Relieving/Aggravating): "Does anything seem to make it better or worse?"
A (Activity): "Are they still playful and alert, or more tired than usual?"

3. Systematic Screen (Focused Head-to-Toe)

(Because child is non-verbal and unwell)

Neuro: "Has he seemed unusually sleepy or floppy?" – "Yes."
Ears: "Any ear pulling or discharge?" – "No."
Nose/URTI: "Runny nose, sneezing?" – "No."
Cough/Resp: "Any cough or difficulty breathing?" – "No."
Urinary: "Any crying while peeing or smelly urine?" – "No."
Testicular torsion: "Any swelling in the groin or private parts?" – "No."
Skin: "Any unusual rashes or bruises?" – "No."
Injury: "Any recent falls or injuries?" – "No."
Feeding: "Any feeding difficulty earlier?" – "Yes, reduced feeds."

4. STRUCTURED BACKGROUND HISTORY – BIRDS-MAF

Code	*Topic*	*Ask*
B	**Birth**	"Was your child born full-term?" "Any complications during or after delivery?"
I	**Immunisations**	"Are all vaccinations up to date?"
R	**Red Book**	"Has the red book ever shown anything concerning during check-ups?"
D	**Development**	"Are you happy with their growth and development so far?"
S	**Safeguarding**	"Who else lives with you at home?" "Do you feel well supported with childcare?" *(Ask gently)*
M	**Medications**	"Is your child on any regular medications?"
A	**Allergies**	"Any known allergies to food or medicine?"
F	**Family History**	"Any family history of digestive problems or surgeries in early childhood?"

5. WELLBEING & HYDRATION CHECK

"Have you noticed fewer wet nappies today?"
"Any dry lips or crying without tears?"
"Do they seem unusually drowsy or less responsive?"

6. ICE – Ideas, Concerns, Expectations

Ideas: "Do you have any thoughts about what this could be?"
Concerns: "Is there anything in particular you're worried about?"
Expectations: "What were you hoping we could do today?"

Examination

"As part of the assessment, I would like to check your child's vital signs including temperature, heart rate, respiratory rate, oxygen saturation, and hydration status. I'd also like to weigh your child."
"I will then examine the tummy to check for any tenderness, swelling, or abnormal masses."
Findings (from referral or examiner cue):

Right upper quadrant **palpable mass** (described as sausage-shaped)
Possible **abdominal distension**
Signs of **dehydration**: reduced skin turgor, dry mucosa, lethargy
No rashes, bruising, or signs of trauma noted

"On abdominal examination, I can feel a soft, elongated mass in the upper part of the abdomen, and the tummy appears a little bloated. These findings support the possibility of a bowel blockage."

7. PROVISIONAL DIAGNOSIS

"Based on what you've described — especially the episodes of intense crying, the green vomiting, and the jelly-like blood-stained stool — this could be a condition called **intussusception**."

8. EXPLAIN THE DIAGNOSIS

"Intussusception is when one part of the intestine slides into another, a bit like how a telescope folds into itself. This can block the passage of food and blood through the bowel. That's why your child is in pain and unable to feed properly — and it explains the vomiting and the unusual stool."
"It's a serious condition, but with the right treatment, most children recover well."

9. MANAGEMENT PLAN

"We'll need to act quickly but carefully to treat this. Here's what we'll do:"
Immediate care

Admit to paediatric ward
Keep the child **nil by mouth (NBM)**
Start **intravenous fluids** to prevent dehydration
Insert a **nasogastric (NG) tube** to decompress the bowel and reduce vomiting
Monitor observations closely

Investigations

Blood tests: FBC, CRP, U&Es, glucose, group & save
Urine and stool samples

Abdominal ultrasound (first-line diagnostic tool – NICE recommended)
X-ray if concerns about perforation or unclear diagnosis

Definitive treatment
"Most cases can be treated with a procedure called an **air enema**. This involves gently passing air through the back passage to release the part of the bowel that has folded in. It's done by a specialist and usually avoids surgery."
"If that doesn't work — or if the bowel looks damaged — then **surgery may be needed** to fix the problem and prevent complications."

10. SAFETY NETTING
"We'll be monitoring your child very closely, but please alert us straight away if they become more floppy, pale, have further vomiting, or stop responding."

11. FOLLOW-UP
"After treatment, your child will be observed on the ward. If all goes well with the air enema, they may be discharged within 24–48 hours, followed by outpatient review if needed."
12. LEAFLET & FINAL CHECK
"We'll give you an NHS leaflet that explains intussusception and its treatment in simple terms."
"Do you feel everything we've discussed makes sense so far?"
"Is there anything else you'd like to ask before we proceed?"

Note to the Student – How Was the Diagnosis Made?
The diagnosis of **intussusception** is made by **linking the focused history with the physical findings**. Key diagnostic pivots:

Intermittent, severe abdominal pain with leg-drawing posture → classic for colicky obstruction
Green vomit → suggests obstruction distal to the stomach
Currant jelly stools → hallmark of intussusception
Palpable mass in RUQ → sausage-shaped mass = diagnostic clue
Dehydration & lethargy → late systemic features of obstruction
Age group (3 months to 2 years) → most common window for intussusception

Put together, this symptom cluster **rules in intussusception** as the most likely diagnosis and justifies urgent imaging and surgical referral.

Constipation Follow-Up

Setting: FY2 in GP Surgery
Task: Follow up a 2-year-old child previously seen for constipation. Address the parent's concerns and discuss diagnosis and management.

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1. INTRODUCTION & CONSENT
"Hello, I'm one of the doctors working in the surgery today."
"I understand you're here to follow up regarding your child's constipation — thank you for coming in."
"Would it be okay if I asked you a few questions about how things have been since your last visit?"

2. FOCUSED HISTORY & CONTEXT REVIEW

"Last time, your child was seen for constipation, and I believe dietary advice was given. Could you tell me what you were advised and how things have been since?"

Explore:

"Have there been any improvements in their bowel movements?"
"How often are they opening their bowels now?"
"Has there been any change in the consistency or appearance of the stool?"
"Any straining, pain, or blood while passing stool?"
"Any episodes of soiling or passing small amounts of liquid stool?"
"Any vomiting or tummy swelling?"

3. SYSTEM SCREEN (Shortened, as it's a follow-up)

"Just to check for anything new or concerning…"

Fever, ear pulling, nasal discharge?
Any urinary symptoms or difficulty peeing?
Change in activity, appetite, sleep, or hydration?
New rash or bruises?
Any developmental regression or walking difficulty?

4. BIRDS-MAF REVIEW (Condensed for Follow-Up)

CODE	ASK
B	"Any concerns about birth or developmental delays?"
I	"Vaccinations still up to date?"
R	"Any concerns ever raised in the red book?"
D	"Is your child walking and talking appropriately for their age?"
S	"Any changes in family situation or routines lately?"
M	"Any new medications or changes in diet?"
A	"Any allergies to medication or food?"
F	"Any family history of constipation, coeliac, or thyroid issues?"

5. WELLBEING CHECK

"Have they been otherwise active and playful?"
"Are they feeding and drinking normally?"

6. ICE (Ideas – Concerns – Expectations)

Ideas: "Do you have any idea what might be causing the constipation?"
Concerns: "Is there anything specific you're worried about?"
Expectations: "What would you like us to do today?"

7. EXAMINATION (Verbalised)

"As part of the review, I'd like to check your child's weight, hydration, and general wellbeing."
Verbalise:

Abdominal exam – soft or distended, any tenderness or masses
Per rectal exam – previously done, no faecal impaction found

Neurological check – normal tone and reflexes
Growth and weight chart – within expected range

8. PROVISIONAL DIAGNOSIS
"From the history and examination, this appears to be **functional constipation**, meaning constipation without an underlying medical cause."

9. EXPLAIN THE DIAGNOSIS
"Sometimes after an illness or a change in diet, children can develop a pattern where they hold in their stool. Over time, this can make the bowel sluggish. The longer stool stays inside, the harder and more painful it becomes to pass — so they hold it in even more. That creates a cycle of constipation."
"It's common in toddlers and is called **idiopathic or functional constipation** — it doesn't mean anything serious is wrong, and we can treat it."

10. MANAGEMENT PLAN
General Advice
"Make sure your child drinks plenty of water."
"Encourage more fruits, vegetables, and fibre in meals."
"Set a toilet routine — sit them on the potty at the same time daily, preferably after meals."
"Stay calm and supportive — avoid punishment or pressure around toilet use."

Medical Treatment
"Since dietary advice alone hasn't helped, we'll now start a **gentle laxative** to help soften the stool and get things moving again."
"We usually use **movicol paediatric plain**, and we'll adjust the dose depending on response."
"This might cause looser stools at first — that's okay. It shows it's working."
"Laxatives are safe in children and may be needed for **several months** to retrain the bowel."
If stool withholding or hard stools continue, and faecal impaction develops, NICE recommends a disimpaction regimen with higher-dose movicol.

Investigations ***(if red flags, failure to respond, or prolonged delay):***
"We may consider a stool sample, abdominal X-ray, blood tests (FBC, TFT, coeliac screen) — but not routinely unless needed."

11. SAFETY NETTING
"Please come back earlier if your child develops vomiting, bloated tummy, fever, or if they stop eating or drinking."

12. FOLLOW-UP PLAN
"Let's review progress in **two weeks**. If things are improving, we'll continue. If not, we'll escalate as needed."

13. LEAFLET
"We'll also give you an NHS leaflet about childhood constipation with tips and reminders."

Note to the Student – How Was the Diagnosis Made?
This is a **follow-up case of functional constipation**, diagnosed clinically. Red flags (e.g. vomiting, weight loss, rectal bleeding, neurological signs) were absent, and the child had a **clear pattern of infrequent hard stools, poor fluid/fibre intake, and withholding behaviour**. No faecal impaction was found on initial exam, and there's been **no systemic deterioration**. this confirms **idiopathic (functional) constipation**, managed with education, lifestyle changes, and a structured laxative plan.

Diarrhoea in a One-Year-Old

Setting: FY2 in General Practice
Mode: Telephone Consultation
Task: Assess a 1-year-old child with diarrhoea over the phone and provide advice

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1. INTRODUCTION & IDENTIFICATION
"Hello, my name is Dr [Name], one of the doctors here at the GP surgery. I understand you're calling today about your child — is that right?"
"Before we go further, could I just confirm who I'm speaking to and your relationship to the child?"
"And can I check that you're in a safe and quiet place to talk for a few minutes?"
"Thank you — let's go through what's been happening so I can give you the best advice possible."

2. FOCUSED HISTORY – ODIPARA for Diarrhoea

O: "When did the diarrhoea start?" – "Today"
D: "How many episodes so far?" – "Four"
I: "Is it ongoing or has it slowed down?"
P: "Has it been getting better or worse through the day?"
A: "Any vomiting? Fever? Blood or mucus in stool?"
R: "Is the child feeding well?"
A (Activity): "Is your child still playful and alert?"

3. DIFFERENTIAL & RED FLAG SCREEN
"I'd like to ask a few quick questions to rule out anything serious:"
Dehydration screen:

"How many wet nappies has your child had today?"
"Is their mouth moist or dry?"
"Do they cry with tears?"
"Does their skin feel dry or clammy?"
"Do they seem unusually sleepy or drowsy?"
"Any fast breathing or very rapid heartbeat?"

Other red flags:

"Any signs of rash?"
"Any recent travel abroad or contact with others who are unwell?"
"Any signs of severe tummy pain?"
"Has your child been refusing feeds completely?"

4. BIRDS-MAF SNAPSHOT (Brief via phone)

Code	*Ask*
B	"Was your child born full term and healthy?"
I	"Are all vaccinations up to date, including the rotavirus vaccine?"
R	"Any previous concerns in their red book?"
D	"Are you happy with their development so far?"
S	"Any recent changes in environment — starting nursery, new contacts?"
M	"Is your child on any medication currently?"
A	"Any known allergies?"
F	"Any family history of digestive issues or intolerances?"

5. ICE – Ideas, Concerns, Expectations

I: "Do you have any thoughts on what might be causing this?"

C: "Is there anything in particular you're worried about?"

E: "Is there something specific you were hoping we could help with today?"

6. PROVISIONAL DIAGNOSIS

"From what you've described — sudden onset of loose stools, no vomiting, your child being alert and feeding, and no signs of dehydration — this sounds like a **viral gastroenteritis**, most likely caused by **rotavirus**, which is very common in children."

7. EXPLAIN IN SIMPLE TERMS

"Rotavirus is one of the most common viruses that causes diarrhoea in young children. It spreads easily, but the good news is that most children recover well at home with simple care."

8. MANAGEMENT PLAN

Home management

"The main treatment is keeping your child **well hydrated**."

"Offer small sips of water or oral rehydration solution regularly — even if your child doesn't seem very thirsty."

"Continue feeding as normal. If you're breastfeeding or formula feeding, please continue."

"Avoid fruit juice or sugary drinks, as these can worsen diarrhoea."

Infection control

"Keep your child at home and away from other children for now."

"Wash your hands thoroughly after changing nappies, and clean any contaminated surfaces well."

"Try to ensure that everyone in the house is also practising good hand hygiene, especially before eating or preparing food."

9. SAFETY NETTING

"Please seek urgent care if you notice any of the following:"

Your child becomes **drowsy, very irritable, or floppy**

They have **no wet nappies for 12 hours**

They **refuse feeds** or are **vomiting repeatedly**

They become **pale, cold, or their breathing becomes rapid**

You pinch the skin on their tummy and it **stays up instead of bouncing back**
Any blood in stool or the diarrhoea **lasts more than 7 days**

10. FOLLOW-UP PLAN
"Most viral diarrhoea settles within about **5 to 7 days**. If the diarrhoea continues beyond that, or if you become worried at any point, please call us back or bring your child in for review."

11. OFFER LEAFLET
"If you have internet access, I'll send you an NHS leaflet about caring for children with diarrhoea, which includes tips on hydration and signs to watch for. Would that be helpful?"

Note to the Student – How Was the Diagnosis Made?
This diagnosis of **viral gastroenteritis (likely rotavirus)** is based on:
Sudden onset of diarrhoea in a previously well child
No vomiting, no fever, no red flags
Child is still **active, feeding, and passing urine**
No signs of **dehydration**, systemic illness, or other serious pathology

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Foreign Body Ingestion

Setting: FY2 in A&E
Task: A parent brings in a child after suspected ingestion of a foreign object. The metal detector was inconclusive; an X-ray has now been done.

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1. INTRODUCTION & IDENTITY
"Hello, I'm one of the junior doctors in the emergency team. Thanks for bringing your child in."
"Could I confirm their age and your relationship to them?"
"Before I explain the results of the scan, I'd like to ask you a few quick questions about what happened, if that's alright?"

2. HISTORY OF INGESTION
"Could you tell me what happened?"
"Did you see your child swallow something, or did someone tell you?"
"Roughly when did it happen?"
"Do you know what it was — a coin, button battery, toy part?"
"Any chance it was sharp or pointed?"

3. SYMPTOM SCREEN – GI and RESPIRATORY
GI symptoms:
"Any vomiting or stomach pain?"
"Any difficulty swallowing or excessive drooling?"
"Are they eating and drinking as normal?"
Respiratory symptoms:
"Any coughing, choking, or wheezing?"
"Any noisy breathing or change in their voice?"

These questions screen for **oesophageal impaction**, **airway involvement**, or early **perforation risk**.

4. CLARIFY PRIOR EVALUATION (If seen previously)

"Has your child been seen by a doctor earlier for this?"
"Were any treatments started at that time, like antibiotics or vaccines?"
"Were any previous X-rays done?"
(If this is the first contact, you may skip this.)

5. CONDENSED BIRDS-MAF

Code	*Ask*
B	"Were they born full-term and healthy?"
I	"Are all their vaccinations up to date?"
R	"Any concerns ever raised in their red book?"
D	"Are they meeting their milestones?"
S	"Anyone else at home? Any supervision concerns today?" *(ask gently)*
M	"Any regular medications?"
A	"Any allergies to medication or food?"
F	"Any history of reflux, strictures, or similar issues in the family?"

6. ICE – Ideas, Concerns, Expectations

Ideas: "Did you have any thoughts on whether it's passed yet?"
Concerns: "Is there anything you're particularly worried about?"
Expectations: "Were you hoping for reassurance, or to have something removed today?"

7. EXPLAINING THE X-RAY FINDINGS

"Thanks for your patience. We've now reviewed the X-ray. I'd like to explain what we've found and what happens next."

SCENARIO A: Coin in the Stomach

"The scan shows that the object is a coin, and it's already passed into the stomach — well below the food pipe. That's reassuring."

MANAGEMENT:

No urgent intervention needed
Child can eat and drink normally
Coin should pass naturally in 48–72 hours
No need to inspect stool unless parents wish
Follow-up in 3 days via paediatric clinic (or GP if no symptoms)
Return if pain, vomiting, or fever develops

"We'll check again in a few days to make sure it's passed, but it usually comes out naturally in the stool."

SCENARIO B: Button Battery in Upper Oesophagus

"The scan shows a round object that appears to be a **button battery**, and it's sitting in the upper part of the food pipe, above the collarbone."
"Batteries can be harmful if they stay there — they can cause chemical burns to the surrounding tissue. That's why we need to act quickly."

MANAGEMENT:

Nothing to eat or drink (NIL BY MOUTH)
Urgent referral to paediatric surgical team
Endoscopic removal planned under general anaesthesia
Close monitoring for airway risk
Admit for observation and further management

"The surgical team will use a small camera to safely remove it under specialist care."

8. SAFETY NETTING

"If at any point your child has vomiting, stomach pain, fever, or seems sleepy or unwell, please come back immediately or call 999."
"For future reference, please keep batteries, magnets, and small objects well out of reach. These are among the most common childhood emergencies we see."

9. FOLLOW-UP PLAN

Coin: Review in 72 hours or sooner if symptoms develop
Battery: Inpatient care under surgical team

"We'll keep you informed every step of the way."

10. LEAFLET

"We'll give you an NHS leaflet about swallowed objects — it explains what to watch for and how we manage it."

Note to the Student – How Was the Diagnosis Made?

The diagnosis was based on:

History of witnessed ingestion
Type and timing of object (coin vs button battery)
Absence or presence of red flag symptoms (e.g., drooling, pain, vomiting, airway compromise)
X-ray confirmation:
Coin in **stomach** = conservative management
Battery in **upper oesophagus** = emergency referral

This station tests your ability to make safe decisions based on **object type**, **location**, and **clinical stability**, as per **NICE emergency paediatrics guidance**.

Infant on Triage Call

Setting: GP telephone consultation
Role: FY2 triaging urgent paediatric calls

INTRODUCTION & IDENTITY CHECK

"Hello, I'm one of the doctors at the surgery. Thanks for calling today.
Just to confirm — may I check your child's full name and age, please?
And you're his mother, right?
Could I also confirm your current address and contact number in case we get disconnected?"

PRESENTING COMPLAINT (ODIPARA)

"Could you tell me what's been happening?"

Onset: When did the fever start? → Around 24 hours ago
Duration: Has it been constant or coming and going? → Persistent
Interval: Any breaks in symptoms? → No improvement despite medication
Progression: Is it getting better, worse, or the same? → Getting worse
Associated symptoms: Any cough, runny nose, rash, vomiting? → Cough and runny nose
Relieving/Worsening: Have you tried anything? → Gave ibuprofen but no improvement
Activity: "Has he been eating, sleeping, or playing differently?" → Poor feeding, lethargic

Ask: "Is there anything else you've noticed?" → No wet nappies for 24 hours

SYSTEMATIC HEAD-TO-TOE CHECK

Neuro: Any seizures? Drowsiness? Crying when held? → Lethargic
Ears: Any ear pulling or discharge? → No
Nose: Runny nose – how long, what colour, how much? → Watery, started yesterday
Eyes: Any redness or discharge? Difficulty opening them? → No
Lungs: Any breathing difficulty or wheeze? → No
GI: Vomiting or diarrhoea? Constipation? → No
Urinary: Crying during urination? Smelly urine? Any wet nappies? → No urine at all
Hydration: Dry mouth? Crying without tears? Less playful? → Yes to all
Injuries: Any recent falls or injuries? → No

RELEVANT PAST HISTORY – BIRDS-MAF

Birth: Was he full-term? Any issues at birth? → Full-term, no problems
Immunisations: Are all vaccinations up to date? → Yes
Red Book: Any past health concerns or monitoring issues? → None
Development: Has he been meeting milestones? → Not yet sitting up at 10 months
Safeguarding: Who lives with the child? Any social worker ever involved? → Lives with parents, no concerns raised
Medications: Any current or recent medications? → No
Allergies: Any known allergies? → None
Family history: Any health conditions like asthma or epilepsy in the family? → No

GENERAL WELLBEING CHECK

"Has he been alert and playful today?" → No, seems drowsy
"How has he been sleeping?" → Not sleeping well due to fever

ICE

Ideas: "Do you have any thoughts on what could be causing this?" → "I thought it might be just a cold."

Concerns: "Is there anything in particular that's worrying you?" → "He's not peed and he's just lying there."
Expectations: "What were you hoping we could do today?" → "Can someone visit us or can I bring him in?"

WRAP-UP & SIGNPOST

"Thanks for sharing all of that — I understand this must be very stressful.
I'd now like to explain what we think is going on and what needs to happen next — is that okay?"

Diagnosis & Explanation

"Based on what you've told me — especially the **high fever**, **not feeding**, and **no urine for over 24 hours** — I'm concerned that your baby may be getting **dehydrated**. While many fevers in children are due to viral infections, this combination of symptoms means we **cannot safely assess or treat him over the phone** or even in a GP clinic. He needs to be seen in **hospital straight away**, where they can check his hydration, do tests like a **urine sample**, and possibly give fluids through a drip if needed."

Management Plan

Immediate Actions:

"You mentioned you don't have transport — I will now arrange for an ambulance to come to your home."
"While waiting, please:
- Keep offering **small sips of water**
- Give **paracetamol** if due
- **Stay with him at all times**, even if he's sleeping
- Don't wrap him up too warm — keep him in light clothing to help the fever come down"

Antibiotics:

"At this point, we don't know what's causing the fever. **Antibiotics won't help if it's viral**, and without seeing him in person, it wouldn't be safe to prescribe anything blindly. The hospital will decide after examination."

Addressing Parent's Requests

"Can I bring him to the surgery instead?"
→ "I understand that may seem easier, but the GP surgery isn't equipped for unwell babies. We don't have drips or emergency equipment here — the safest place for him is hospital."

"Can you prescribe antibiotics?"
→ "Right now, we're not sure if it's a virus or something else — antibiotics can cause more harm if not needed. The hospital team will examine him and give whatever treatment is necessary."

Safety Netting

"If he becomes more drowsy, stops responding, develops a rash, or starts breathing rapidly — call 999 immediately."
"I will also call you back in **10–15 minutes** to make sure the ambulance has arrived and things are okay."

Follow-Up Plan

Seen in **hospital today**
Will likely receive:
- Clinical assessment
- Blood/urine tests
- Fluids if dehydrated

Once improved, he'll be discharged and reviewed by your regular GP as needed

Final Wrap-Up
"You've done the right thing by calling today — you've acted early, and that's exactly what we want parents to do. We'll make sure your baby gets the care he needs right away. Is there anything else you'd like to ask before I arrange the ambulance?"

Diagnostic Note
The child has **high fever**, **poor feeding**, **no urine output for 24 hours**, and is **lethargic** — all red flags for **dehydration** or **serious bacterial infection**.
Although symptoms suggest a viral illness, the **risk of deterioration** is high.
Hospital referral is based on **clinical risk**, not confirmed diagnosis.

Viral Illness with Dehydration Concern

Setting: FY2 in General Practice
Mode: Telephone consultation
Scenario: Parent calls concerned about their child's viral illness and possible dehydration

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1. INTRODUCTION & VERIFICATION
"Hello, this is Dr [Name], one of the GPs at the practice. Am I speaking with the child's parent or guardian?"
"Can I confirm your child's age and that you're somewhere safe and quiet to talk for a few minutes?"
"Thanks — let's go through what's been happening so I can help you best."

2. PRESENTING COMPLAINT
"Could you tell me what made you decide to call today?"
"What symptoms has your child had so far?"
"Roughly when did it all start?"
"Have they had any fever? If yes, how high and for how long?"
"Any sore throat, cough, or runny nose?"
"Have they had any vomiting or diarrhoea?"

3. HYDRATION STATUS
"Has your child been drinking fluids? Roughly how much today?"
"Have they been eating anything at all, or completely refusing food?"
"How many wet nappies have you changed in the last 24 hours?"
"Have you noticed any dry lips or mouth, sunken eyes, or if the skin stays raised when you pinch it?"
"Do they seem tired or sleepier than usual?"
"Are they still active and responding to you like normal, or more irritable or drowsy?"

4. ICE – Ideas, Concerns, Expectations
Ideas: "Do you think this could be something more than just a viral illness?"
Concerns: "Is there anything specific you're particularly worried about right now?"
Expectations: "Were you hoping to speak about any medications or tests today?"

5. PROVISIONAL DIAGNOSIS

"From what you've described, it sounds like your child has a **viral infection**, likely something like the flu. These infections can cause fever, cough, sore throat, and tiredness. It's also common for children to eat and drink less when they're unwell, which can lead to signs of mild dehydration."
"At the moment, your child doesn't appear to have red flags, and you're doing the right thing by monitoring their fluids and energy levels."

6. EXPLAIN IN SIMPLE TERMS
What is likely happening?
"These types of viral illnesses usually get worse in the first 2–3 days, then slowly start to improve over the next few. However, symptoms like cough can last a couple of weeks even after the child starts feeling better."

Why we're not using antibiotics
"Antibiotics only work against bacteria — not viruses. Using them when they're not needed can actually do more harm, like causing side effects or making bacteria harder to treat in the future."
7. MANAGEMENT – At Home
"The most important thing now is keeping your child **well hydrated**."
Hydration tips
"Offer small sips of water or oral fluids frequently, even if they don't feel like drinking."
"Ice lollies, diluted juice, or rehydration sachets can help — especially if they're refusing plain water."
"Don't worry too much about solid food for now — fluids are more important."

Fever relief
"You can give **paracetamol** to bring down the fever and ease discomfort."
"The usual dose is every 4–6 hours, up to 4 times a day — please follow the instructions based on your child's weight."
"Avoid giving medications like chlorpheniramine or decongestants unless advised by a pharmacist — they're not recommended for very young children."
"If your child is over 1 year old, **a spoon of honey** can sometimes soothe a cough."

8. SAFETY NETTING
"Please bring your child to the GP or hospital if you notice any of the following:"
Fast or difficult breathing
Very high fever that doesn't go down with paracetamol
Vomiting that doesn't stop
Diarrhoea lasting more than a few days
No wet nappies for over 12 hours
Sunken eyes, **dry mouth**, or skin that stays pinched
Your child becomes **very drowsy**, **unresponsive**, or you just feel something's not right

9. FOLLOW-UP PLAN
"Viral symptoms usually settle in **5–7 days**, though the cough may last longer. If things don't start improving in the next few days — or if you're worried at any point — please don't hesitate to call us or come in."

10. OFFER NHS LEAFLET

"I'll send you a link to the NHS leaflet on caring for unwell children at home — it includes tips on hydration, when to seek help, and managing fever safely."

Note to the Student – How Was the Diagnosis Made?

The diagnosis of **mild viral illness with early dehydration risk** was made based on:

Recent onset of viral symptoms (cough, fever, sore throat)
No red flags (no respiratory distress, no altered consciousness, no persistent vomiting)
Mild decrease in fluid intake but child is **still alert and passing urine**
No systemic deterioration
Classic features of viral upper respiratory tract infection and mild illness course

This is a **reassurance and home-management station**, focused on **hydration, safe symptom control, parent education, and knowing when to escalate**. Avoiding antibiotics while safety-netting well scores highly.

Suspected Appendicitis

Setting: FY2 in General Practice / Hospital
Patient: 12-year-old child
Scenario: Parent is contacted with blood test results after inconclusive A&E visit the previous day

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1. TELEPHONE INTRODUCTION & VERIFICATION

"Hello, this is Dr [Name], one of the doctors following up from the hospital. Am I speaking with [Parent's Name]?"
"I'm calling about your son's visit to us yesterday for tummy pain — is this still a good time to talk?"
"Before we continue, could I quickly confirm his age and how he's been since yesterday?"

2. HISTORY – Review of Yesterday's Visit

"Could you tell me a bit about what happened yesterday? What were his symptoms like at the time?"
"Were any tests done — do you recall if blood tests or any scans were performed?"
"What were you told before you left the hospital?"
Parent is likely to report:
– Pain started near the belly button and moved to the right side
– Bloods were taken, no scan done
– Child was sent home with safety-netting

3. CURRENT STATUS – Reassessment Over Phone

"And how is he doing today?"
"Is he still having tummy pain?"
"Where is the pain now, and has it changed or worsened?"
"Any nausea or vomiting?"
"Any diarrhoea or constipation?"
"Has he passed urine and stool normally since yesterday?"
"Does he have a fever?"
"Is he eating or drinking at all today?"
"Has he been drowsy or less responsive than usual?"
Likely reply: child still has pain, not responding to paracetamol, seems lethargic, no fever.

4. CONDENSED MAFTOSA (Child History)

Code	*Ask*
M	"Any known medical conditions or allergies?"
A	"Any regular medications?"
F	"Any previous tummy problems or surgeries?"
T	"Any trauma or injury recently?"
O	"Any other children at home? Any family history of similar issues?"
S	"How's he been growing and developing overall?"
A	"Any recent infections or illnesses before this pain started?"

5. DISCUSSING BLOOD TEST RESULTS

"Thank you for sharing that. I've had a look at his blood test results from yesterday. They show an **elevated white blood cell count** — that usually means the body is fighting off an infection."

6. EXPLAINING PROVISIONAL DIAGNOSIS – Suspected Appendicitis

"With the worsening abdominal pain, particularly if it's moved to the lower right side, and now with this elevated white count, I'm concerned he may have **appendicitis**."

"That's an inflammation of the appendix, a small pouch in the lower part of the bowel. The pain often starts around the belly button and shifts lower right. Children may also have nausea, loss of appetite, vomiting, or fever."

7. MANAGEMENT PLAN – Immediate Referral

"We'd like you to bring your son back to the hospital **as soon as possible**. He needs to be assessed again and likely kept in for observation and further tests."

Investigations likely include:

Repeat blood tests

Abdominal ultrasound or CT scan

Close monitoring of pain and vital signs

Possible Treatment:

Appendectomy (removal of the appendix)

IV fluids and antibiotics to stabilise any infection before surgery

"This is something we need to manage promptly — the earlier we treat appendicitis, the better the outcome. It can become serious if left too long."

8. CONFIRM UNDERSTANDING & ESCALATION

"Are you able to bring him in now?"

"I know this might feel sudden, but unfortunately appendicitis can progress quickly and needs to be ruled out properly."

"There's no alternative here — this needs hospital review today."

9. SAFETY NETTING (In Case of Delay)

"If at any point he becomes more drowsy, has severe vomiting, is unable to move due to pain, or develops a high fever, please call 999 or come straight to the emergency department."

10. WRAP-UP & FINAL CHECK
"I'll inform our team so they're expecting you when you arrive."
"Is there anything you'd like me to explain again or anything you're unsure about?"

Note to the Student – How Was the Diagnosis Made?
This is a **clinical red flag telephone station**. The diagnosis of **suspected appendicitis** is based on:

- **Progressive abdominal pain**, now localising to right iliac fossa
- **Elevated white cell count**
- Systemic signs (lethargy, poor feeding, worsening pain)
- No evidence of gastroenteritis or alternative diagnosis

In children, appendicitis can be subtle — NICE recommends **early reassessment** and **immediate referral** when symptoms worsen and bloods support infection.
This station tests your ability to:
Communicate urgency without panic
Explain reasoning clearly to a parent
Make **safe, non-negotiable decisions** based on evolving clinical evidence

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Antibiotic Request for Viral Infection

Setting: FY2 in General Practice
Mode: Telephone
Patient: 3-year-old child
Task: Assess child's symptoms, address parental concern, and explain why antibiotics and an X-ray are not needed

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1. INTRODUCTION & VERIFICATION
"Hello, this is Dr [Name], one of the GPs at the surgery. Am I speaking with [Parent's Name]?"
"I understand you're calling about your 3-year-old child — is that right?"
"Are you in a quiet and safe place to talk for a few minutes?"
"Thanks — let's go through everything and make sure your child gets the care they need."

2. PRESENTING COMPLAINT – SYMPTOM EXPLORATION
Fever

- "When did the fever start?"
- "What was the highest temperature you recorded?"
- "How did you measure it?"
- "Has it come down with paracetamol or ibuprofen?"
- "Is the fever gone now?"

"Have you given any medications so far — like paracetamol or ibuprofen?"

Respiratory symptoms

- "Is there a cough? Is it dry or chesty?"
- "Any noisy breathing, wheezing, or shortness of breath?"

"Has your child said anything about chest pain or discomfort?"

General wellbeing

"Are they still playing, smiling, or interacting normally?"
"Have they been eating and drinking as usual?"
"Any change in their sleep?"

Sepsis / red flag screen

"Have they been unusually drowsy or difficult to wake?"
"Any vomiting or diarrhoea?"
"Any rashes — especially one that doesn't fade when you press on it?"
"Any fewer wet nappies than usual, or signs of dry lips or sunken eyes?"

3. EXPOSURE HISTORY

"I understand you visited your mother recently who had pneumonia. When did you visit her?"
"Did your child have close contact with her — like hugging or sitting close for long periods?"
"Has anyone else at home been unwell recently?"

4. MEDICAL BACKGROUND

"Does your child have any long-term conditions — like asthma or frequent infections?"
"Are all vaccinations up to date?"

5. ICE – Ideas, Concerns, Expectations

Ideas: "Do you think this could be more than a regular viral illness?"
Concerns: "What are you most worried about today?"
Expectations: "You mentioned antibiotics and an X-ray — could you tell me what made you feel those might help?"

6. CLINICAL IMPRESSION – Viral Upper Respiratory Tract Infection

"Thank you for sharing all that. Based on everything you've said — the mild symptoms, short duration of illness, the fact that the fever has now gone down and your child is active and eating — this sounds very much like a **common viral infection**."
"These are extremely common in young children, especially after mixing with others or visiting family. Coughs, sore throat, mild fever — all very typical."

7. EXPLAINING WHY ANTIBIOTICS AREN'T NEEDED

"Antibiotics are used for bacterial infections — but they don't work on viruses. And in this case, there are no signs of a bacterial infection."
"In fact, using antibiotics when they're not needed can lead to problems like side effects (rashes, diarrhoea) and **antibiotic resistance**, which makes future infections harder to treat."

8. WHY AN X-RAY ISN'T NEEDED

"X-rays are typically used if a child looks very unwell or we suspect pneumonia — things like rapid breathing, high persistent fever, or being unable to eat or drink."

"Your child doesn't have any of these signs, so there's no indication for an X-ray right now. We also try to avoid exposing young children to radiation unless truly necessary."

9. HOME CARE ADVICE

"The good news is, most viral illnesses settle with time and supportive care."

What to do now:

- Encourage plenty of fluids (water, soups, ice lollies)
- Continue giving **paracetamol or ibuprofen** for fever or discomfort, as needed
- Rest is important — but don't worry if they still want to play
- Use a thermometer to check for fever once or twice a day

"A spoon of honey can help with cough if your child is over one year old."

10. SAFETY NETTING

"If any of the following happen, please call us back or seek urgent help:"

- Breathing becomes rapid or difficult
- Child is **too sleepy, floppy, or unresponsive**
- **Fever persists beyond 5 days** or doesn't respond to medication
- Child **stops drinking**, or has **no wet nappies for 12+ hours**
- A rash appears that doesn't fade when pressed

11. FOLLOW-UP PLAN

"If things don't improve in the next few days, or if anything new develops, just give us a call back and we'll reassess."

"We're here for you, and it's absolutely okay to call again if you feel worried."

Scarlet Fever

Setting: FY2 in GP Surgery
Patient: 6-year-old child
Accompanied by: Parent
Presenting Complaint: Fever, sore throat, and rash

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1. INTRODUCTION & CONSENT

"Hello, I'm one of the doctors here today."

"You've brought your child in — could I confirm their full name and age?"

"And you are their parent, is that right?"

"I understand they've had a **fever, sore throat, and now a rash** — let's talk through everything that's been happening."

2. HISTORY – PRESENTING COMPLAINT

Fever

- "When did the fever start?"
- "What was the highest temperature you recorded?"
- "Is it coming and going, or staying high?"
- "Did you give Calpol or ibuprofen — and did it help?"

"How many days has the fever lasted so far?"
(Scarlet Fever typically lasts 3–5 days and improves with antibiotics.)

Sore Throat
"Have they complained of a sore throat?"
"Any difficulty swallowing or speaking?"
"Any bad breath or white patches in the throat?"

Rash
"When did the rash first appear?"
"Where on the body did you notice it first?"
"Is the skin red and bumpy — kind of like sandpaper?"
"Have you noticed flushed cheeks with a pale area around the mouth?"
"Has the rash spread anywhere else?"

Tongue/Mouth Changes
"Have you noticed any redness or small bumps on the tongue — like a strawberry texture?"

Lymph Nodes
"Any swelling in the neck?"
"Is it on one side or both sides?"
"Is it painful to touch?"

Other Symptoms
"Any sneezing, cough, or runny nose?"
"Any ear pain or signs of an ear infection?"
"Any tummy pain, nausea, or vomiting?"
"Any issues with passing urine or stools?"

3. BACKGROUND HISTORY – BIRDS-MAF

Code	*Ask*
B	"Was your child born full term, and without any complications?"
I	"Are their vaccinations up to date?"
R	"Any issues after previous vaccines — any reactions or side effects?"
D	"Are they developing normally — walking, talking, playing like others their age?"
D (Diet)	"Any feeding issues or food allergies?" "Has their appetite changed recently?"
D (Diseases)	"Any long-term conditions like asthma, eczema, or frequent infections?" "Any past episodes of tonsillitis or strep throat?"
S (School)	"Do they go to school or nursery?" "Anyone unwell in school recently?"
M (Medications)	"Are they on any regular medication?"
A (Allergies)	"Any known allergies — especially to antibiotics like penicillin?"

F (Family/Social)	"Anyone else at home currently unwell?" "Who normally looks after them day to day?"

4. ICE + EFFECT ON LIFE

Ideas: "Do you have any thoughts on what this could be?"
Concerns: "Is there anything in particular you're worried about?"
Expectations: "Were you hoping for any tests or treatment today?"
Effect on life: "Has this affected school, sleep, or day-to-day activities?"

5. FOCUSED EXAMINATION

"With your permission, I'd like to check your child's vitals and do a quick examination."

General appearance

Flushed cheeks, tired but alert
Pale ring around the mouth (perioral pallor)

Vitals

Temperature
HR, RR, O2 saturation
Capillary refill

Skin

Generalised red rash with sandpaper texture (trunk, axillae, neck, thighs)
Pastia's lines in skin folds

Throat and Tongue

Erythematous oropharynx ± tonsillar exudate
Strawberry tongue

Neck

Bilateral tender cervical lymphadenopathy

ENT + Chest + Abdomen

No ear discharge or signs of otitis
Clear chest, no crepitations
Abdomen soft, no tenderness

6. PROVISIONAL DIAGNOSIS

"From everything you've told me — the sore throat, the flushed face with pale area around the mouth, the sandpapery rash, and the fever — this is most likely a condition called **Scarlet Fever**."

7. EXPLAINING SCARLET FEVER TO THE PARENT

"Scarlet Fever is a contagious infection caused by **Group A Streptococcus**, a type of bacteria that often starts with a **sore throat and fever**, and is followed by a red, rough-feeling rash — which your child has described perfectly."
"It's very common in children between 5 and 15 years of age, and it spreads easily in schools and nurseries."
"The good news is — it responds **very well to antibiotics**, and children usually start feeling better within a couple of days once we start treatment."

8. MANAGEMENT PLAN

Investigations

Throat swab (if needed for confirmation, but not required if clinically classic)
Bloods not required unless systemically unwell

Antibiotic Treatment

First-line:

Phenoxymethylpenicillin (Penicillin V) — 250 mg QDS for 10 days (weight-adjusted)

If allergic to penicillin:

Azithromycin or clarithromycin for 5 days

"We'll start antibiotics today — you don't need to wait for swab results. These reduce the symptoms, help prevent complications, and stop the spread to others."

Supportive Care

Continue **paracetamol or ibuprofen** for fever and sore throat
Encourage **plenty of fluids and rest**
Stay home from school for 24 hours after starting antibiotics
Promote good hand hygiene at home to reduce spread

Complications to Watch For (rare)

"Most children recover quickly, but please seek help if you notice:"

Fever lasting more than **48 hours after starting antibiotics**
Difficulty swallowing or breathing
Child becomes **drowsy or very tired**
Ear pain or signs of worsening infection
Rash that changes significantly or spreads rapidly

9. FOLLOW-UP PLAN

No routine follow-up if improving
Consider 48-hour review if:
- No improvement
- Recurrent tonsillitis
- Parent unsure about compliance or absorption

10. LEAFLET + PARENT EDUCATION

"We'll give you an **NHS leaflet on Scarlet Fever**, which explains more about the condition and how to manage it at home."
"Please avoid close contact with others until your child has completed at least 24 hours of antibiotics."
"You can also find more information at the NHS Scarlet Fever website."

Note to the Student – How Was the Diagnosis Made?

This case is diagnosed clinically based on:

Fever + sore throat
Sandpaper rash, starting on trunk and spreading
Flushed cheeks, pale mouth area (perioral pallor)
Strawberry tongue

Bilateral tender cervical nodes

No cough or wheeze, differentiating it from viral URTI

In PLAB 2, this is a **classic bacterial infection case** where antibiotics **must** be prescribed — the key is recognising the clinical triad and acting promptly to explain and treat while safety-netting thoroughly.

Kawasaki Disease

Setting: FY2 in GP Surgery
Patient: 3-year-old child
Accompanied by: Father
Presenting Complaint: Persistent fever (5 days), rash, swollen neck gland

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1. INTRODUCTION & CONSENT

"Hello, I'm one of the doctors in the practice today."
"Could I confirm your child's name and age, and you're their father, is that right?"
"I understand your child has had a fever for the last few days and hasn't been feeling well — I'd like to ask some questions to better understand what's going on."

2. HISTORY – PRESENTING COMPLAINT

Fever

"When did the fever begin?"
"Has it been continuous or coming and going?"
"What's the highest temperature you've recorded?"
"Have you given Calpol or ibuprofen — has it helped?"
"Does the fever return after medication wears off?"

(Fever ≥5 days is key diagnostic criteria)

Rash

"When did the rash appear — before or after the fever?"
"Where did it start, and has it spread?"
"Is it flat or raised? Is it itchy?"

(Diffuse maculopapular rash typical – not itchy, often starts on trunk)

Lymph Nodes

"Any swelling in the neck?"
"Is it on one side or both?"
"Does it feel firm or tender?"

(Unilateral node >1.5 cm = diagnostic criteria for Kawasaki)

Eyes

"Have the eyes looked red or bloodshot?"
"Any sticky discharge?"
"Any light sensitivity?"

(Bilateral conjunctival injection without discharge is classic)

Mouth & Tongue

"Any redness, swelling, or cracking around the lips?"
"Have you noticed the tongue looking red and bumpy — like a strawberry?"
"Any complaints of sore throat?"

Hands & Feet

"Any redness or swelling in the hands or feet?"
"Any peeling of skin around the fingers or toes?"
(Late finding, but ask early for planning follow-up)

GI & General Symptoms

"Is your child eating and drinking normally?"
"Any vomiting, diarrhoea, or tummy pain?"
"Any change in urine — frequency, colour, smell?"
"Any irritability, tiredness, or drowsiness?"

3. BACKGROUND HISTORY – BIRDS-MAF

Code	*Ask*
B	"Was the pregnancy and birth full term and without complications?"
I	"Are all vaccinations up to date?"
R	"Any reactions to previous vaccines?"
D	"How's your child doing with milestones — walking, talking, interacting?"
D (Diet)	"Any issues with eating or drinking in general?"
D (Diseases)	"Any past serious illnesses or hospital admissions?"
	"Any allergies?"
S (School)	"Do they go to nursery or daycare?"
	"Anyone there recently unwell?"
M	"Is your child on any regular medications?"
A	"Anyone else at home unwell?"
	"Who looks after your child day to day?"
F	"Any family history of autoimmune or heart conditions?"

4. ICE + EFFECT ON LIFE

Ideas: "What do you think might be causing this?"
Concerns: "Is there anything you're particularly worried about?"
Expectations: "Were you hoping we could do any tests or start treatment today?"
Effect on Life: "Has this affected sleep, appetite, or nursery?"

5. FOCUSED EXAMINATION

General appearance:

Tired, irritable, possibly drowsy

Vitals:

Temperature, HR, RR, oxygen saturation

Skin:
Diffuse maculopapular rash
Eyes:
Bilateral conjunctival redness
No discharge
Mouth:
Red cracked lips
Strawberry tongue
Pharyngeal erythema ± no pus
Neck:
Unilateral firm cervical node >1.5 cm

6. PROVISIONAL DIAGNOSIS
"From the history and what I've found on examination, this is strongly suggestive of a condition called **Kawasaki Disease**."

7. EXPLAINING THE CONDITION TO THE PARENT
"Kawasaki Disease is a rare condition where the immune system becomes overactive and causes **inflammation of blood vessels** throughout the body."
"It's not contagious, and we're not entirely sure what causes it, but we do know that it needs **early treatment** to reduce the risk of complications — especially those affecting the heart."
"It typically starts with a fever that doesn't settle, followed by a rash, **red eyes**, **red cracked lips or tongue**, **swollen hands or feet**, and **a large neck gland** — which matches what your child is experiencing."

8. MANAGEMENT PLAN – URGENT HOSPITAL REFERRAL
"This condition **requires treatment in hospital**. I'm going to arrange for you and your child to go to hospital **today** so they can run tests and start treatment promptly."
Hospital Investigations (on admission):
FBC, CRP, ESR
U&E, LFTs
Urinalysis
Throat swab
Echocardiogram (ECHO) – baseline and repeat at 2, 6, and 8 weeks

Hospital Treatment:
IV Immunoglobulin (IVIG) — ideally within **10 days** of symptom onset
High-dose aspirin — anti-inflammatory dose initially, followed by low-dose antiplatelet
Steroids — if not responding to IVIG

Specialist Follow-up
Paediatric cardiologist
Serial ECHOs for coronary artery monitoring
Long-term low-dose aspirin if coronary artery dilation detected

9. PARENTAL REASSURANCE

"Most children recover completely with early treatment. We're acting quickly to minimise any risk."
"The hospital team will monitor your child closely, especially their heart, and start treatment straightaway."
"We'll stay involved and ensure everything is followed up properly."

10. SAFETY NETTING

"While waiting for admission or if there are delays, seek urgent help if your child:"

- Becomes drowsy or confused
- Develops breathing difficulty or chest pain
- Has **persistent fever after starting treatment**

"Once admitted, the team will keep a close eye for these issues."

11. LEAFLET & RESOURCES

"We'll give you a leaflet from the **NHS** about Kawasaki Disease."
"It also has advice on what to watch for and how follow-up will work."
"You can find more information on the NHS or RCPCH websites."

Note to the Student – How Was the Diagnosis Made?

Diagnosis was based on **clinical criteria**:

- Fever > 5 days
- Bilateral conjunctivitis (non-purulent)
- Cracked lips, strawberry tongue
- Unilateral cervical lymphadenopathy
- Generalised rash
- Swelling/redness of hands/feet

Kawasaki Disease is a **clinical diagnosis**, not ruled in by bloods. Early recognition and urgent **referral for IVIG** are the priorities. PLAB 2 examiners will expect **confident decision-making**, **parental reassurance**, and **clear escalation**.

Scarlet Fever vs Viral Tonsillitis vs Kawasaki Disease (PLAB 2 Comparison)

Feature	*Scarlet Fever*	*Viral Tonsillitis*	*Kawasaki Disease*
Age group	5–15 years (school-age)	Any age (common in children)	<5 years (peak at 1–4 years)
Fever	High, sudden onset	Mild to moderate	Persistent ≥5 days (unresponsive to antipyretics)
Throat	Very sore, may have tonsillar exudate, strawberry tongue	Mild to severe sore throat ± red tonsils, no exudate	Red, cracked lips ± strawberry tongue (less sore)
Rash	Sandpaper-like, starts on neck/chest, spreads, flushed cheeks, perioral pallor	No rash (or mild viral exanthem)	Polymorphous rash (not itchy), may involve trunk/extremities

Lymph nodes	Bilateral small, tender anterior cervical nodes	Mild bilateral enlargement	Unilateral cervical node >1.5 cm (firm)
Eyes	Normal	Normal or slightly red	Bilateral conjunctival injection (no discharge)
Extremities	Normal	Normal	Swollen/red hands/feet, later peeling (periungual)
Tongue	Strawberry tongue (with red rash)	Normal or red	Strawberry tongue (with cracked lips, no exudate)
Course	Improves with antibiotics in 2–3 days	Self-limiting, resolves in 5–7 days	May lead to coronary artery aneurysms if untreated
Causative agent	Group A Streptococcus (bacterial)	Mostly viral (adenovirus, EBV, etc.)	Autoimmune/inflammatory (not infectious)
Contagious?	Yes – droplet spread	Yes – viral spread	**No** – not contagious
Treatment	**Penicillin V** for 10 days (or azithro if allergic)	Supportive only (paracetamol, fluids)	**Urgent hospital referral**, IVIG + aspirin
Complications	Otitis media, glomerulonephritis, rheumatic fever	Rare (can trigger bacterial infection)	Coronary artery aneurysms, myocarditis
Return to school	24h after antibiotics start	Once fever settles	After hospital treatment and clearance

Chickenpox

Setting: FY2 in GP Surgery
Patient: Child
Accompanied by: Mother
Presenting Complaint: Rash all over body, fever, and tiredness

1. INTRODUCTION & CONSENT
"Hello, I'm one of the doctors here today."
"Can I confirm your child's name and age?"
"And you're their mother, is that right?"
"I understand your child has developed a rash and isn't feeling well — let's talk through what's been going on."

2. HISTORY – PRESENTING COMPLAINT
Rash
"When did you first notice the rash?"
"Where did it first appear?" *(→ typically starts behind ears or on face)*
"How has it spread since then?"
"What does it look like — are they small red spots or fluid-filled blisters?"
"Do the spots look like they're at different stages?"

"Is the rash itchy?"

Fever + General Symptoms

"When did the fever start?"
"What was the highest temperature you recorded?"
"Did you give paracetamol or ibuprofen — did it help?"
"Has your child seemed sleepier or more tired than usual?"
"Have they been eating and drinking normally?"

3. BACKGROUND HISTORY – BIRDS-MAF

Code	*Ask*
B	"Were they born full term without any complications?"
I	"Are all vaccinations up to date?" *(Note: chickenpox vaccine not routine in UK)*
R	"Any previous reactions to vaccines?"
D	"How's their development — talking, walking, playing?"
D (Diet)	"Any feeding difficulties or known allergies?"
D (Diseases)	"Any long-term health conditions like asthma or eczema?"
S (School)	"Do they go to nursery or school?"
	"Anyone else unwell recently?"
M	"Any regular medications?"
A	"Any medication or food allergies?"
F	"Who looks after them day to day?"
	"Anyone at home unwell recently or immune compromised?"

4. ICE + EFFECT ON LIFE

Ideas: "What do you think might be causing the rash?"
Concerns: "Is there anything in particular that's worrying you?"
Expectations: "Were you hoping for any tests or treatment today?"
Effect on Life: "How has this affected sleep, eating, or school?"

5. FOCUSED EXAMINATION (Verbalised or Performed)

General appearance: Mildly irritable, sleepy, febrile
Vitals: Temp, HR, RR, O2 sat (if available)
Skin: Classic vesicular rash – fluid-filled spots at **different stages**, on face, scalp, chest, limbs
ENT: Mild pharyngeal erythema
Chest & Abdomen: Normal

"The rash is consistent with chickenpox — fluid-filled spots on red skin, at different stages, with some crusting starting to appear."

6. PROVISIONAL DIAGNOSIS

"From the rash and symptoms you've described — and what I can see — this is very likely **chickenpox**."

7. EXPLAINING THE CONDITION TO THE PARENT

"Chickenpox is a common viral illness in children caused by the **varicella-zoster virus**. It usually starts with a fever and tiredness, followed by a **rash that spreads**, often starting on the face and chest."

"The rash turns into **fluid-filled spots**, which later scab over. These appear in batches — that's why some look new while others are crusting."

"It's **very contagious** but usually a mild illness in otherwise healthy children. Most recover in about 7–10 days."

8. MANAGEMENT PLAN – Symptom Control

FFR Management

Fever: Paracetamol regularly if needed *(avoid aspirin)*

Fluids: Encourage small, frequent sips of water or juice

Rest: Allow them to sleep as much as needed — this helps the immune system

Itching Relief

Calamine lotion or cooling gels

Dress in **loose cotton clothing**

Keep **nails short and clean** to avoid scratching

Use **antihistamines** (age-appropriate, e.g. chlorphenamine for children over 1 year)

Soft gloves or mittens at night if scratching

9. SAFETY NETTING – When to Seek Help

"Please contact us urgently or go to A&E if your child:"

Has **trouble breathing** or chest pain

Shows signs of **dehydration** — dry mouth, fewer wet nappies, or dark urine

Becomes **very drowsy** or hard to wake

Has a **fever that doesn't settle** with paracetamol

Has **rash areas that become very red, painful, or have pus** (→ sign of bacterial infection)

10. INFECTIVITY & RETURN TO SCHOOL

"Chickenpox is contagious from **2 days before the rash** until **all spots have crusted over** — usually about **5 days after the rash starts**."

"Your child can return to nursery or school once the spots are crusted and they're feeling well enough to take part in normal activities."

"Try to **avoid contact with pregnant women, newborns, and anyone with a weak immune system** until the spots have crusted over."

11. FOLLOW-UP

No need for routine review if improving

Contact GP if: rash worsens, no improvement after 7–10 days, or complications suspected

12. LEAFLET & EDUCATION

"We'll give you an **NHS leaflet on chickenpox**, with tips on symptom control, rash care, and when to seek help."

"There's also guidance on preventing the spread, and a section explaining when to return to school."

Note to the Student – How Was the Diagnosis Made?

Diagnosis was based on:

- History of **fever**, **malaise**, and **rash starting behind ears or face**
- Characteristic **vesicular rash at different stages**
- Itching, tiredness, and mild fever
- No signs suggesting measles, scarlet fever, or drug rash

Chickenpox is a **clinical diagnosis**. No tests are needed in healthy children. The mainstay is **symptom relief**, **infection control**, and safety-netting.

Tonsillitis in a 5-Year-Old

Role: FY2 in A&E
Setting: Paediatric emergency – child next door with nurse, parent present

Introduction

"Hello, I'm one of the doctors looking after children in the emergency department today. Thank you for coming in. You're his mum, is that right? May I just confirm your son's full name and age please?
Great – while the nurse is finishing up the checks next door, I'd like to understand what's been going on from your side so we can plan what to do next. Could you tell me what brought you both in today?"

Presenting Complaint

Mother says: "He has tonsillitis."
Use open elaboration:
"I'm really sorry to hear he's been unwell – when did the symptoms start?"
Onset: "When did you first notice his symptoms?" → 4 days ago
Duration/Progression: "Has it been getting better or worse since then?" → Worsening
Intensity: "How high has the fever been?" → 39°C
Precipitating/Aggravating: "Anything that seems to make it worse?"
Alleviating: "Any medicines helped?" → No response to paracetamol
Radiation: N/A
Associated symptoms:

- "Has he had any cough, runny nose, or rash?" → Cough (+), Coryza (+)
- "Any swelling around his neck?" → No
- "Any difficulty breathing or noisy breathing?" → No
- "Any vomiting, diarrhoea, or tummy pain?" → No
- "Has he complained of pain when swallowing?"
- "Is he eating or drinking at all?" → Unable to eat/drink
- "Any change in urine output – has he been passing less urine?" → Mother unsure
- "Has he been lethargic or less active than usual?" → Yes

Red Flags and Safety Screening

- Unable to maintain oral hydration
- Fever 39°C
- Appears lethargic
- No signs of airway obstruction, neck stiffness, or stridor

PMAFTOSA

Pregnancy/Birth history: Full-term, no complications
Milestones: Normal
Allergies: None known
Family history: Non-contributory
Temperature tolerance: High fever reported
Others at home unwell? → No
School: Attends nursery
Attendance: First visit for this issue

ICE

Ideas: "You mentioned tonsillitis — did someone say that before or is that your own thought?" → "He's had fever and a sore throat. I think it's that."
Concerns: "What are you most worried about today?" → "He's not eating or drinking anything at all. He just lies around."
Expectations: "What were you hoping we could do for him today?" → "Make sure he's okay and get him better."

Effect on Life

"He's been refusing food and not playing. He just lies down."

Examination Summary

General Condition: Lethargic but alert
Temperature: 39.0°C
ENT Exam: Inflamed, red tonsils with no pus
No stridor or respiratory distress
Mildly dry mucous membranes, child appears fatigued

Diagnosis

"Thank you for sharing that with me. Based on everything you've told me, and the findings from the nurse's assessment, this looks like **acute tonsillitis** — an infection and inflammation of the tonsils at the back of the throat.
While this is common in children and often settles with rest, your child is currently **not able to drink or eat**, which puts him at risk of **dehydration**. That's why we'd recommend **admitting him to the hospital** for treatment and monitoring."

Explanation to Parent

Use natural, calm phrasing while still sounding knowledgeable.
"Tonsillitis means the tonsils, which sit at the back of the throat, have become infected and inflamed. This can happen due to **viruses** — like the common cold — or sometimes **bacteria** like *Streptococcus*.
In your son's case, his **fever**, **sore throat**, and inability to drink suggest he's struggling to stay hydrated. Even though he doesn't have pus on the tonsils — which often points toward a viral cause — his body still needs help recovering.
The main concern right now is **hydration**, not just the infection itself. That's why we'll need to **admit him for fluids through a drip**, and for close observation."

Management Plan

Admission

Due to:

Inability to tolerate fluids
Fever > 38.5°C
Lethargy
Parental concern
Signs of early dehydration

Supportive Care

IV fluids to maintain hydration
Paracetamol and/or ibuprofen to reduce fever and help throat pain
→ Use weight-based dosing
→ Alternate only if necessary, not routinely

Antibiotics?

We will review bloods and signs before starting antibiotics.
If signs suggest **bacterial tonsillitis** (see FeverPAIN or Centor criteria), we may start:
Phenoxymethylpenicillin (Penicillin V) for 10 days
If allergic: **Clarithromycin**
Note: No antibiotics unless strong bacterial signs

Investigations

FBC, CRP
U&Es to check hydration
No need for throat swab unless recurrent or unusual presentation
Consider rapid strep test if 3+ Centor criteria (not mandatory)

Monitoring

Nursing observations: fluid balance, vitals, input/output
Medical review if symptoms worsen or child deteriorates

Involve Senior Early *– to confirm admission and treatment*

Safety Netting

"While in hospital, we'll be keeping a close watch to make sure he stays hydrated and comfortable. If he starts showing any of the following signs, we'll act immediately:
Breathing becomes noisy or difficult
Very high or persistent fever
Becomes confused or unresponsive
Develops a new rash or becomes floppy
Please don't hesitate to call for the nurse at any time — even if it seems small."

Follow-Up Plan

Discharge when:
Oral fluids tolerated
Symptoms improving
GP follow-up if not improving within a week
If this occurs frequently (≥7 episodes in a year), referral to ENT may be considered for further evaluation (NHS criteria for tonsillectomy)

Leaflet Offer

"We'll give you a leaflet on managing sore throats in children and explain what to watch out for after discharge as well."

Final Reassurance & Check

"You've done the right thing bringing him in today. We'll make sure he's well cared for in the hospital and aim to get him back to eating and drinking soon. Do you have any questions before I arrange the next steps?"

Diagnostic Reasoning

No pus, presence of cough → Viral tonsillitis likely

But red flags (not drinking, lethargy) require **hospital admission for hydration**, regardless of viral/bacterial cause

Antibiotics are not indicated unless features align with Centor or FeverPAIN criteria

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Teething

Setting: FY2 in GP (Telephone Consultation)

Patient: 7-month-old baby

Accompanied by: Parent (via phone)

Presenting Complaint: Child is clingy, irritable, wants cuddles, "not quite right"

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1. TELEPHONE INTRODUCTION

"Good morning, you're speaking with Dr [Your Name], one of the GPs here at the surgery."

"Could I confirm — am I speaking with the parent or guardian of the child?"

"And may I ask your child's age, please?"

"Thank you. How can I help you both today?"

2. HISTORY – PRESENTING COMPLAINT

Behavioural Changes

"You mentioned your child is clingy — can you tell me more about what you mean by that?"

"Has your baby been crying more than usual or needing to be held constantly?"

"Have they been feeding and sleeping as usual?"

Teething-Related Clues

"Have you noticed your baby **biting objects** or putting hands or toys in their mouth more than usual?"

"Any **drooling or dribbling** recently?"

"Do the gums look **red or swollen**, especially near the front?"

"Has there been any **flushing of the cheeks**?"

"Do you think your baby is in discomfort or pain?"

General Wellbeing

"Has your baby had a **temperature**? Are you able to check it now?"

"Any **diarrhoea**, vomiting, or other new symptoms?"

"Have they had a **cold, cough**, or signs of illness recently?"

"Have they had any recent vaccinations or medications?"

3. BACKGROUND HISTORY – Relevant BIRDS-MAF (Brief)

Ask

Code	
B	"Was your baby born full-term without complications?"
I	"Are vaccinations up to date so far?"
D	"Is your baby generally meeting milestones — e.g., reaching for toys, responding to your voice?"
M	"Any regular medications or allergies?"

4. ICE – IDEAS, CONCERNS, EXPECTATIONS

Ideas: "Did you have any thoughts on what might be causing this?"
Concerns: "Is there anything you're particularly worried about?"
Expectations: "Were you hoping for any medicine or advice today?"

5. ASSESSMENT & PROVISIONAL DIAGNOSIS

"Thanks for sharing all of that. From everything you've said — the clinginess, biting behaviour, drooling, gum swelling, and the age — this all sounds like **teething**, which is very common around 6 to 9 months."
"Some babies get a bit of mild fever or loose stools while teething, but they shouldn't seem very unwell — so it's important to keep an eye on that."

6. EXPLAINING TEETHING TO THE PARENT

"Teething is when your baby's first teeth start breaking through the gums. It can make them feel a bit uncomfortable or unsettled — they might drool more, chew on everything, or seem clingy and irritable."
"It's completely normal and happens to every baby — though some go through it more smoothly than others."

7. MANAGEMENT PLAN

Pain Relief

"You can give **paracetamol (Calpol)** if your baby seems in discomfort — follow the age-based dosing on the packaging."
"Don't give ibuprofen on an empty stomach."

Soothing Remedies

"Offer a **clean, chilled teething ring** — you can find these in most pharmacies."
"Some parents find that **cold washed cucumber sticks** or **chilled carrots** help — just supervise closely if offering solids."
"Gently **massage the gums with a clean finger** if your baby allows."

Dental Registration

"If you haven't already, it's a good idea to **register your baby with a dentist** — NHS dental care is free for children and the dentist can give teething guidance too."

8. SAFETY NETTING – When to Worry

"Please get in touch again or seek help if your baby:"

Has a **fever above 38°C for more than 48 hours**
Develops **diarrhoea or vomiting that doesn't settle**
Seems **drowsy, very irritable**, or **not feeding or drinking at all**
Has a **rash**, is **hard to wake**, or **breathing fast**
Has **signs of dehydration** — such as dry mouth or fewer wet nappies

"If anything doesn't feel right, you can always call us or ring 111 for advice."

9. CLOSING THE CALL & FOLLOW-UP

"Thanks for speaking with me today. It sounds like this is likely teething, but if anything changes or you're not sure, feel free to call us again."

"Would it be helpful if I sent over an **NHS leaflet on teething** to your email or through the app?"

Urinary Tract Infection (UTI) in a Child

Setting: FY2 in A&E
Patient: 3-year-old girl
Accompanied by: Mother
Presenting Complaint: Crying while urinating, smelly urine, reduced fluid intake

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1. INTRODUCTION & CONSENT

"Hello, I'm one of the doctors here in the emergency department."

"Could I confirm — are you her mother?"

"And may I check your child's full name and age, please?"

"Thank you. What's been going on today with your little one?"

2. HISTORY – PRESENTING COMPLAINT

Urinary Symptoms

"When did you first notice the symptoms?"

"You mentioned she's crying when passing urine — does that happen every time?"

"Have you noticed any changes in the **smell** or **colour** of the urine?"

"Any blood in the urine?"

"Is she trying to avoid going to the toilet?"

Fluid Intake

"Is she drinking less than usual today?"

"Is she refusing to drink anything completely or just drinking small sips?"

Associated Symptoms

"Any fever, vomiting, tummy pain, or back pain?"

"Any diarrhoea or recent illness?"

"Any rashes or new symptoms?"

3. BACKGROUND HISTORY – BIRDS-MAF (Paediatrics)

Code	*Ask*
B	"Was she born full-term without complications?"
I	"Are all her vaccinations up to date?"
R	"Any reactions to previous medications or vaccines?"
D	"Has she been meeting developmental milestones?"
S	"Does she go to nursery or stay at home?"
M	"Any regular medications — including inhalers, creams, etc.?"
A	"Any known allergies to antibiotics or other medications?"
F	"Anyone in the family with a history of urinary or kidney problems?"

4. ICE + EFFECT ON LIFE

Ideas: "Did you have any idea what this could be?"
Concerns: "Is there anything you're particularly worried about right now?"
Expectations: "Were you hoping for a treatment or further tests today?"
Effect: "Has this affected her play, sleep, or eating at all?"

5. FOCUSED EXAMINATION

"I'd now like to do a quick check to make sure she's well overall."

Urinary Dipstick Test

Positive for **nitrites and leukocytes** → confirms UTI

Observations:

Temperature, heart rate, respiratory rate
Capillary refill <2 seconds
Active, alert, responsive
No signs of dehydration (eyes moist, tongue not dry, normal urine output)

"She's well hydrated, alert, and generally playful — which is reassuring."

6. PROVISIONAL DIAGNOSIS

"Based on her symptoms and the urine test result, your daughter has a **urinary tract infection**, or UTI."

7. EXPLAINING THE CONDITION TO THE PARENT

"UTIs are caused by **bacteria entering the bladder**, usually from the skin or bowel. They're more common in young girls due to their **shorter urethra**, which makes it easier for bacteria to travel into the bladder."
"The symptoms — crying when passing urine, strong-smelling urine, and reduced drinking — all match what we commonly see in young children with UTIs."

8. MANAGEMENT PLAN – NHS/NICE ALIGNED

Antibiotic Treatment

"We'll start her on a **3-day course of an antibiotic called Trimethoprim**, which is very effective against urine infections in children."
"You might be wondering why only 3 days — and that's a great question. Urine infections are caused by different bacteria than chest infections, and most children respond very well to **3 days of targeted treatment**."
"If her symptoms don't improve in 48 hours, we'll review and possibly switch antibiotics based on lab results."

Urine Sample for Culture

"We'll also send her urine sample to the lab, just to confirm the bacteria and make sure the antibiotic we've started is the right one."
"If anything needs to be changed, we'll contact you."

Regarding Admission

"Because she's alert, playful, and not showing signs of dehydration or systemic illness, she doesn't need to stay in hospital right now."
"But if things worsen or she stops drinking altogether, please bring her straight back."

Symptom Relief & Fluids

Encourage extra fluids
Monitor temperature
Give paracetamol if needed for fever or discomfort

9. SAFETY NETTING

"Please bring her back or call us if:"

She develops **fever or vomiting**
Pain gets worse or she cries constantly during urination
She **refuses to drink completely** or passes no urine for 8–10 hours
She becomes **drowsy, floppy**, or you're just not sure

"We're here to help — even if you're just unsure, always feel free to call."

10. FOLLOW-UP & ADVICE

Continue antibiotics for full 3 days
GP review if symptoms not improving in 48 hours
Reinforce need for hygiene (wiping front to back)
Discuss prevention if recurrent UTIs

Resistant UTI –Test Result Discussion

Setting: GP clinic
Role: FY2 doctor
Actor: Parent (father or mother) of 7-year-old girl
Task: Explain urine culture result showing resistance to trimethoprim, discuss ongoing symptoms, reassure parent, explain recurrent UTI plan, and initiate correct follow-up

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Introduction

"Hello, I'm one of the doctors here at the practice. Thank you for coming in today.
"May I know your name, please?"
I understand you're related to the young girl we're seeing today — could I just confirm how you're related to her?
And just to be sure, could I confirm her full name and age as well?
We've received the results of her urine test. Is it okay if we go through that together now and talk about what we'll do next?"

Focused History & Context

"Before I explain the results, I'd like to understand a bit more about how she's been doing."

Symptom Progression

"How has she been feeling since we started the antibiotic?"
"Did her fever go down at any point?"
"Is she still having any pain while passing urine?"
"Any tummy pain, nausea, or vomiting?"
"Has she been eating and drinking as usual?"
"Any back pain or pain in her sides?"

Red Flags Screening

"Has she been drowsy or difficult to wake?"
"Is she passing less urine than usual?"
"Any signs of blood in the urine?"
"Does she complain of pain in her lower back, just under the ribs?"

Infection Background

"Has she had urinary infections before?"
→ Confirm this is her **second UTI**
"Roughly how long ago was the first one?"
"Was a scan or any other tests done after the first UTI?"

Contributing Factors

"Any history of constipation or difficulty with bowel movements?"
"Do you know if she holds her urine when she needs to go?"
"How is her fluid intake — is she drinking enough during the day?"
"When she uses the toilet, does she wipe front to back?"
"Has she been dry at night, or any recent bedwetting?"

Explore ICE

Ideas: "Do you have any thoughts about why this keeps happening?"
Concerns: "What's been worrying you the most right now?"
→ "Why is she getting UTIs again?"
→ "Will this cause long-term damage?"
→ "Is the infection serious?"
Expectations: "What were you hoping we could do today?"
→ Likely: Better treatment, further tests, prevent future UTIs

Clear Result Disclosure

"We received the results of the urine culture we sent last time. It shows that the infection is caused by a germ that isn't responding to the antibiotic we initially started — trimethoprim. So that explains why she's still unwell. But the good news is that the bacteria are sensitive to other antibiotics — particularly **amoxicillin** and **nitrofurantoin** — which means we can now switch to one that will work more effectively."

Explanation of the Condition

"UTIs happen when bacteria travel up into the bladder, causing inflammation and infection.
They are more common in young girls because the urethra — the tube where urine comes out — is shorter, which makes it easier for bacteria to reach the bladder."
"In her case, it looks like the infection didn't fully respond to the first antibiotic. This can happen because some bacteria are now resistant — meaning they've adapted to survive certain medications. That's why we always send the urine for testing — so we can pick an antibiotic that works."
Since your child has now had more than one urine infection — and this latest one involved a high fever, which tells us it may have affected the kidneys — we classify it as a recurrent urinary tract infection. That doesn't always mean something serious, but in some children, repeated infections can be linked to things like the bladder not emptying properly, or urine flowing the wrong way towards the kidneys. That's why we recommend doing a simple ultrasound scan now — just to check that everything looks normal inside.

Management Plan

A. Immediate Treatment

Switch antibiotic based on sensitivity:

First-line:

→ If oral route appropriate and child is not vomiting:

Nitrofurantoin (if sensitive, and child >3 months) – 3 days

or

Amoxicillin (if sensitive) – 3 days

If vomiting or signs of upper UTI (e.g., fever >38°C + flank pain) → Consider admission for IV antibiotics

Paracetamol or ibuprofen for fever/discomfort

Encourage **fluid intake** and **frequent voiding**

Addressing Recurrent UTI

"As this is her second confirmed UTI, guidance recommends we arrange an **ultrasound scan** of her kidneys and bladder. This is to check for any structural problems — for example, if the bladder isn't fully emptying, or if there's a condition called reflux where urine flows backwards towards the kidneys. This scan is painless and non-invasive. It's done using gel and a probe on the tummy. We'll send the referral today and aim to get it done soon."

Addressing Concerns:

"Why is she getting recurrent UTIs?"

"That's a valid concern. UTIs are quite common in young girls due to the shorter urinary tract, which makes it easier for bacteria to reach the bladder. Sometimes, things like not drinking enough water, holding in urine, or even constipation can increase the risk. But if infections happen repeatedly, we start thinking about possible underlying causes — like a blockage or reflux — which is why we'll arrange a scan to check everything looks normal."

"What do I do to prevent this from happening again?"

"That's a great question — and there are definitely some simple things you can do at home that make a real difference. Encourage her to drink plenty of water through the day, and make sure she doesn't hold in her urine for too long — regular toilet trips really help.

If she's constipated or has trouble with bowel movements, let us know, because that can also contribute. And when she uses the toilet, wiping from front to back is important to prevent bacteria from spreading. If she ever seems unwell again — like if she has a fever, tummy pain, or says it hurts to wee — just bring her in straightaway so we can treat it early."

Safety Netting

"If she gets more unwell — such as having very high fever, being drowsy, not drinking, being sick repeatedly, or complains of pain in the sides or back — please don't wait. Either call us immediately or go to the emergency department, as those might be signs of a more serious kidney infection."

Follow-Up Plan

Review in **2–3 days** to check symptom improvement after switching antibiotics

If she remains unwell or fever continues → consider escalation and admission

Ultrasound referral sent today

If she has a **third UTI in the future**, especially if febrile → paediatric nephrology referral may be required

Offer Leaflet & Final Check

"I'll also print a leaflet for you on UTIs in children — it goes through causes, signs to watch for, and prevention tips."

"Before we finish, was there anything else you were worried about or anything you'd like me to explain again?"

Student Note

This is a **confirmed resistant UTI** in a 7-year-old girl with fever and persistent symptoms after trimethoprim. NICE CKS recommends **amoxicillin or nitrofurantoin** based on culture sensitivity. Recurrent UTI (≥2 confirmed episodes) warrants **renal and bladder ultrasound** to rule out structural anomalies. Safety net for escalation is essential, especially with flank pain, vomiting, or persistent fever. Ensure thorough parental explanation, address anxiety about recurrence, and document referral. Avoid co-amoxiclav unless specified by sensitivities or severe presentation.

Bronchiolitis

Setting: Emergency Department
Patient: 8-month-old child
Accompanying: Parent
Presenting Complaint: Difficulty in breathing, cough, fever, nasal congestion

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1. INTRODUCTION & CONSENT

"Hello, I'm one of the doctors in the emergency department today. Thank you for bringing your child in. Just to confirm — may I check your child's age, please? And you're their parent, is that right? What's been going on that brought you here today?"

2. PRESENTING COMPLAINT – DOOPARA for Shortness of Breath

Duration: "When did the breathing difficulty start?"
Onset: "Was it sudden or gradual?"
Order: "What were the first symptoms you noticed?"
Progression: "Has it been getting worse, or staying the same?"
Associated symptoms: "Any fever, cough, wheezing, or nasal congestion?"
"Is your child feeding less than usual?"
"Any vomiting after feeds or irritability?"
"Did they sleep poorly last night?"
Relieving/Aggravating: "Does sitting up help? Any worsening when lying down?"
Additional episode: "Has something like this happened before?"

3. DIFFERENTIAL DIAGNOSIS SCREENING

Upper Respiratory Infection: Sneezing? Runny nose?
Pneumonia: Fast breathing? Chest in-drawing?
Viral-induced wheeze: Any previous similar attacks? Family history of asthma, eczema?
Otitis media: Ear pulling or discharge?
UTI: Pain during urination? Foul-smelling urine?

Gastroenteritis: Diarrhoea or vomiting?
Sepsis/Meningitis: Rash? Extreme drowsiness? Unresponsive?

4. TARGETED RISK FACTORS

Birth: "Was your child born full-term? Any complications at birth?"
Immunisation: "Are vaccinations up to date?"
Red Flags: "Any dusky lips, apnoeic episodes, or drowsiness?"
Development: "Is your child meeting milestones – like sitting or responding to sound?"
Medications: "Is your child on any medications currently? Have you used any nebulisers recently?"
Allergies: "Any known drug or food allergies?"
Feeding: "How is feeding going now? Are nappies still wet regularly?"

5. ICE

Ideas: "What do you think might be causing this?"
Concerns: "Is there anything you're particularly worried about?"
Expectations: "What were you hoping we could do today?"

6. EFFECT ON LIFE

"How has this affected your routine or your child's sleep and feeding?"
"Were you able to give any paracetamol or use the spacer device at home?"

7. EXAMINATION

General Observation: Alertness, signs of respiratory distress, colour (cyanosis), irritability
Vitals: Respiratory rate, oxygen saturation, heart rate, temperature
Chest Examination: Subcostal recession, nasal flaring, bilateral wheeze, crepitations
ENT: Check for congestion, ear inflammation
Hydration: Dry mucous membranes, reduced tears, capillary refill time
Abdomen: Soft, non-distended

8. PROVISIONAL DIAGNOSIS

"From what you've described and on examination, this is most likely **bronchiolitis**, a common viral chest infection in infants caused by respiratory syncytial virus (RSV). It tends to peak around this age, especially during winter months."

9. LAY EXPLANATION TO PARENT

"Bronchiolitis causes swelling and mucus in the small airways of the lungs, which leads to wheezing, coughing, and difficulty breathing.
It usually starts like a common cold, then gets worse over the next 2–3 days before improving. Most children recover fully in 1–2 weeks."

10. MANAGEMENT PLAN (Based on NICE & NHS CKS)

1. **Admission to the ward**

"Given her difficulty breathing, refusal to feed, and your previous history of needing oxygen and nebulisers — we will **admit her to the children's ward** today.

That way, we can **monitor her breathing and oxygen levels** closely, and give her the right supportive care to help her recover safely."

2. Oxygen support if needed
"If her oxygen levels stay low, we'll start her on **extra oxygen** using soft tubes near her nose — nothing painful, but just enough to help her breathe more comfortably."

3. Help with feeding and fluids
"Because she's not feeding well at the moment, we'll **keep a close watch on her fluid levels**.
If she struggles to drink enough by mouth, we might give her fluids through a **nasogastric tube** — that's a soft tube through the nose into the stomach — or possibly through a drip in the hand, if needed."

4. No nebulisers or inhalers – let me explain why
"Although I know she's had nebulisers in the past, we don't routinely give inhalers or nebulisers for bronchiolitis.
That's because this isn't like asthma — bronchiolitis is **caused by a virus**, and these treatments **don't tend to help** unless there's a strong family history of asthma or allergies.
We'll keep assessing her regularly, and if there's any indication that she'd benefit from a trial of inhalers, we'll consider that — but only if there's a clear reason."

5. No antibiotics
"Because this is a **viral infection**, **antibiotics won't help**.
But if we notice any signs of a secondary bacterial infection, like pneumonia, we will start antibiotics right away."

6. How long will she need to stay?
"Most babies start improving within a few days.
We'll usually discharge her when:
- She's breathing comfortably without oxygen,
- Feeding well,
- And otherwise stable.

This could take 2–3 days, but we'll keep you updated."

What you can do at home in the future:
"Once she's better and goes home:
- Keep her away from other children who are unwell, especially during winter.
- Keep her upright while feeding to help her breathe better.
- You can give **paracetamol or ibuprofen** if she's uncomfortable or has fever — just follow the age-appropriate dosing.
- Avoid any exposure to **smoke or dusty environments**, as that can worsen her breathing."

11. SAFETY NETTING
"Please let us know immediately if your child:
- Becomes unusually drowsy or unresponsive
- Develops blue lips or pauses in breathing
- Refuses all feeds or has significantly fewer wet nappies
- Has a high fever that does not settle with medication"

12. FOLLOW-UP PLAN

"We'll monitor her progress here in hospital for the next 24–72 hours.
If she improves and maintains feeding with normal oxygen levels, she can go home.
We will provide advice on home care and what to watch out for.
We'll also give a leaflet before discharge to guide you."

Note to Student – Diagnostic Reasoning:
Bronchiolitis should be suspected in infants <1 year with cough, tachypnoea, chest recession, and wheeze or crackles. The diagnosis is clinical. Admission is indicated if feeding is poor, oxygen saturation is low, or the child has apnoeas, as per NICE bronchiolitis guidelines.

Asthma Counselling – Telephone Call

Setting: GP (Telephone Consultation)
Role: FY2 Doctor
Patient: 5-year-old child
Caller: Mother
Presenting Concern: Ongoing wheeze despite using blue inhaler

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1. INTRODUCTION & IDENTITY CONFIRMATION

"Hello, you're through to the GP practice. My name is Dr [Name], one of the doctors here today.
Could I please confirm your child's name and age? And are you their mother?
Thanks — how can I help you today?"

2. PRESENTING COMPLAINT

"I understand you're worried that your child's asthma doesn't seem to be improving. Could you tell me more about what's been happening?"

"What sort of symptoms is he having — wheezing, coughing, breathlessness, or chest tightness?"
"When do these symptoms usually occur — during the day, at night, or with exercise or cold air?"
"How long has this been going on? Have the symptoms worsened recently?"
"When was he diagnosed with asthma?"

3. DIFFERENTIAL SCREENING

To rule out other possibilities and assess severity:

"Has he had any fever or signs of infection recently?"
"Is there any family history of asthma, hay fever, or eczema?"
"Does he have any allergies — to dust, pets, foods, or pollen?"
"Has he ever been admitted to hospital for asthma or breathing problems?"
"Any emergency visits or need for oxygen or steroids in the past?"
"Does anyone in the household smoke?"
"Is there a pet at home or carpet flooring?"

4. MAFTOSA + Compliance Check

Medications: "What inhalers or medications is he currently on?"

"Does he have a blue inhaler only, or has he ever used a brown preventer inhaler?"
"How often do you give the blue inhaler? Does it help?"
"Has anyone shown you or your child how to use the inhaler correctly?"
"Do you use a spacer device?"
"How does your child respond — is he cooperative, or does he struggle with it?"
Adherence: "Would you say he's taking it regularly when he has symptoms?"
"How confident are you that the technique is correct?"

5. ICE

Ideas: "What do you think might be going on?"
Concerns: "What are you most worried about?"
Expectations: "Were you hoping we'd review his medication or arrange a visit?"

6. EXPLANATION & EDUCATION

"Thank you — from what you've told me, it sounds like your son's asthma symptoms are likely continuing because the reliever inhaler (blue) isn't being used correctly or consistently.
This is quite common, especially at this age — many children struggle with the inhaler unless the spacer is the right size and the technique is demonstrated properly."

7. MANAGEMENT PLAN

A. Technique + Compliance

"We need to ensure the inhaler technique is correct. I'll book you in for a face-to-face asthma review where a nurse can walk you through the proper method."
"Always use a spacer. For children under 6, a mask attachment is usually better than a mouthpiece."
"Shake the inhaler, insert it into the spacer, press one puff, and let him take 5–6 slow breaths in."
"This makes sure the medicine actually gets to the lungs."

B. How and When to Use the Blue Inhaler

"It's a reliever — use it only when he has symptoms like wheezing, coughing, or tight chest."
"Usual dose is 1 or 2 puffs, up to 4 times a day if needed — not routinely."
"If he needs it more than twice a week or four times in 24 hours — that's a sign we need to step up treatment."

C. Making It Child-Friendly

"Children sometimes resist using the inhaler. You can make it more fun — decorate the spacer with stickers, or turn it into a game. Praise and rewards help too."

D. Cleaning Advice

"Clean the spacer about 2–3 times a week — not daily."
"Rinse with warm water only and let it air dry — don't scrub it or use soap. Don't remove the mask if it's attached."

E. Trigger Control

"Try to minimise triggers like dust, cold air, smoke, and pet fur."
"If possible, avoid carpets or keep them well vacuumed. Keep pets out of the child's bedroom."

F. Asthma Action Plan

"We'll prepare a written asthma plan for you. It explains when to use the inhaler, what symptoms to watch for, and when to call us."

8. SAFETY NETTING

"Please call us or go to A&E if you notice any of the following:

If he needs the inhaler more than 4 times in 24 hours

If symptoms are waking him at night or stopping him from playing

If he has difficulty talking due to breathlessness, or if you see his chest pulling in when he breathes

If his lips look blue, or he's very tired or drowsy."

9. FOLLOW-UP PLAN

"I'll arrange an asthma review with the nurse in the next few days."

"If there's still poor control, we'll consider stepping up treatment, such as adding a preventer (brown inhaler)."

"We'll also reassess regularly to make sure the plan is working for him."

10. LEAFLET & CLOSE

"I'll send you an NHS asthma leaflet and a copy of the personalised asthma action plan."

"Please don't hesitate to reach out again if anything worries you."

"You're doing the right thing by calling — we'll work together to help manage his asthma better."

Exacerbation of Asthma

Setting: GP Surgery – Telephone Consultation
Doctor: FY2
Patient: 9-year-old child, known asthmatic
Caller: Father
Concern: Child is unwell with cough, fever, and now shortness of breath despite medication

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1. INTRODUCTION & IDENTITY CHECK

"Hello, this is Dr [Name], one of the doctors at the practice. May I confirm who I'm speaking with please?"
[Wait for confirmation of father's identity.]
"Thank you, and can I just confirm your child's full name and age?"
"How can I help you today?"

2. PRESENTING COMPLAINT – Focused History of Current Illness

"So, your child has had a cough, fever, and cold for 3 days, and you're worried his asthma is getting worse — let's go through this carefully."

Key questions:

"Has the fever responded to paracetamol at all?"

"Is he coughing more than usual? Any wheezing or chest tightness?"

"Is he managing to speak in full sentences?"

"How's his breathing now — is he breathless at rest or only when moving?"

"Is he eating and drinking anything?"
"Is he alert and responsive, or is he drowsy or sleeping more?"
"Is he still using his inhalers? How many puffs of the blue inhaler has he needed in the last 24 hours?"

Red Flag Screening:
"Have you noticed his lips turning blue?"
"Any signs of chest sucking in while breathing?"
"Is he able to sit upright, or is he slumping over?"
"Have you seen a rash, vomiting, or headache?"

3. BACKGROUND HISTORY

B – Birth History
"Was your child born full-term, and were there any complications at birth?"
I – Immunisations
"Is he up to date with all his vaccinations?"
R – Recurrent Illnesses
"Has he had similar asthma flare-ups before? How often does this happen?"
D – Development
"Has his growth and development been normal for his age?"
M – Medication History
"Could you remind me what medications he's currently on?"
(→ Salbutamol, Inhaled steroid, Montelukast)
A – Allergies
"Any known allergies to medicines or anything else?"
F – Family/Social History
"Is there anyone at home who smokes?"
"Has he been around anyone else who's unwell recently?"

4. ICE – Ideas, Concerns, Expectations

I – "What do you think might be going on?"
C – "What are you most worried about right now?"
E – "What were you hoping I could help you with today?"

5. EFFECT ON DAILY LIFE

"Is he able to go about his usual activities today?"
"Has he been sleeping well, or is the breathlessness disturbing him?"
"You mentioned he's drowsy — does he respond normally when you talk to him?"

6. ASSESSMENT SUMMARY & PROVISIONAL DIAGNOSIS

"Thanks for going through everything with me. From what you've told me — fever, cold symptoms, and now shortness of breath that's not settling with his usual medication — it sounds like he has a viral infection that has triggered a flare-up of his asthma. We call this an infective exacerbation of asthma."
"But because he's now becoming drowsy, less responsive, and still struggling to breathe despite his inhalers, I'm concerned that he may need urgent hospital assessment."

7. MANAGEMENT PLAN – NHS/NICE Aligned (Explained to Parent)

Emergency Plan – Prioritise Safety:

"I'm arranging for him to be seen at the hospital immediately. He's not responding to inhalers and seems to be drowsy and not eating — these are signs that he needs close monitoring and stronger treatments, such as oxygen and possibly nebulisers."

"We can call an ambulance for you right now — or if you feel you can bring him straight in safely, I'll let the hospital know to expect you."

"At the hospital, they'll assess him and give him stronger medications — possibly oxygen, nebulised bronchodilators, and oral steroids. They'll monitor his breathing, hydration, and oxygen levels closely. He may also have a chest X-ray or a viral swab to check for infection. Most children recover well with early treatment."

Continue Home Support While Waiting:

"Keep giving him 2 puffs of his blue inhaler every 20 minutes if needed, through the spacer."

"Keep him sitting upright — it'll help his breathing."

"Stay with him and keep him awake if possible."

"If he becomes very sleepy, unresponsive, or you notice his lips turning blue — don't wait. Call 999 immediately."

Regarding Your Request for Steroids:

"I completely understand why you're asking — and yes, steroids are often part of the treatment plan. But because of how unwell he is right now, it wouldn't be safe to start oral steroids at home without seeing him first."

"The hospital will assess him, and if steroids are needed, they'll be given there under supervision."

8. SAFETY NETTING

"Please don't delay — he needs to be seen urgently. If you're unable to bring him in yourself, I can arrange an ambulance right away."

"While waiting, keep giving the blue inhaler, monitor his breathing, and stay close to him."

"Call back if his condition changes in any way."

9. LEAFLET & FINAL CHECK

"The hospital team will give you an asthma leaflet and help you understand how to prevent future flare-ups."

"Before we end the call, is there anything else you wanted to ask or that I can clarify?"

Febrile Seizure

Setting: Emergency Department
Patient: 2-year-old girl
Role: FY2 Doctor

Introduction

"Hello, I'm one of the doctors here in the emergency department. Thank you for coming in with your daughter today.

And can I double-check her full name and age, please?

I understand she had a seizure this morning — that must've been very distressing to witness. I'll ask you a few questions to understand what happened, then examine her to see how she's doing now."

History – Data Gathering

A. Seizure History – Before / During / After

Before:

"How was she doing in the past couple of days?"
"Has she had a fever?"
"Any runny nose, cough, or cold-like symptoms?"
"Any ear pulling, irritability when lying down, or reduced hearing?"
"Any vomiting, diarrhoea, or rash?"

During:

"Can you describe exactly what you saw when the seizure happened?"
"How long did it last, roughly?" (Confirmed <5 minutes)
"Was the whole body shaking, or just part of it?"
"Did she lose consciousness or go floppy?"
"Did she bite her tongue, roll her eyes back, or wet herself during the fit?"

After:

"What was she like after the seizure ended?"
"Was she drowsy or confused?"
"Has she returned to her usual self now?"

Systemic Review and Red Flags

"Has she had any sensitivity to light or stiffness in her neck?"
"Is she feeding and drinking normally now?"
"Any breathing difficulty or fast breathing?"
"Any unusual rash or cold limbs?"

Paediatric Background – BIRD-MAF

Birth: "Was she born full term? Any problems during or after delivery?"
Immunisations: "Are all her childhood vaccines up to date?"
Reactions: "Any unusual responses to vaccines or illnesses in the past?"
Development: "Is she walking, talking, and playing like other kids her age?"
Medications: "Is she on any regular medication?"
Allergies: "Any allergies to food or medicine?"
Feeding & Toileting: "How is her appetite? Any change in urine or stool?"

ICE

"Do you have any idea what may have caused the fit?"
"Is there anything specific you're worried about today?"
"What were you hoping we could do for her now?"

Examination

General: Child is alert, responsive, and well-perfused
Vitals: Temp 38.5°C, HR 128, RR 28, SpO_2 98% on air
ENT: Right tympanic membrane red and bulging; no discharge
Neuro: Normal tone, reflexes, good interaction

No signs of CNS infection: No neck stiffness, photophobia, or rash

Provisional Diagnosis
Simple febrile seizure, most likely triggered by **acute otitis media**

Explanation
"From what you've told me, and based on the findings today, it looks like your daughter had a **febrile seizure** — a short fit that some children have when their body temperature rises quickly. These are quite common between 6 months and 5 years.
It's not epilepsy, and it doesn't usually lead to long-term problems.
The fit lasted less than 5 minutes, involved her whole body, and she's back to normal now — all of which is reassuring."
"When I examined her ears, I noticed signs of a **middle ear infection**, which likely caused her fever and triggered the seizure."

Management Plan
A. In the Emergency Department
Monitor for 4–6 hours
Ensure she's feeding, afebrile, and neurologically normal
Discussed with ED senior
Since this is her **first seizure**, she will need to be **seen by the paediatrics team today** for further assessment before discharge
"Even though she looks well now and the infection is clear, we'll still arrange for her to be assessed by the children's doctors today. This is standard practice after a first-time seizure, just to make sure there's nothing else going on."

B. If Already Referred to and Seen in the Paediatric Department
Reconfirm seizure history and full recovery
Reassess for any red flags or signs of serious illness
If she is alert, well, and stable → **discharge is appropriate** after parental education
No need for admission if:
Seizure was <5 minutes
Child is >18 months
Full recovery
No focal signs or recurrence
No ongoing clinical concern
"As she's now fully back to normal and the seizure was short and generalised, we don't need to keep her in hospital. We'll give you all the information you need on what to do if it happens again, and when to come back."

Treating the Infection
"Although many ear infections get better on their own, in your daughter's case, we're starting antibiotics.
Her eardrum is bulging — a sign of significant inflammation — and the fever has already caused a seizure. Treating the infection will help settle the fever and reduce the risk of further complications."
Start Amoxicillin (125 mg TDS for 5 days or appropriate weight-based dose)
Paracetamol or ibuprofen for fever and pain (avoid routine combination)

Encourage fluids and rest
Provide full safety-netting and instructions for home monitoring

What to Do if Another Seizure Happens
"If she ever has another seizure at home:
Stay calm, and **note the time**
Lay her on her side on a soft surface
Don't put anything in her mouth
Don't try to hold her still
Call **999** if the seizure lasts more than 5 minutes, if she doesn't wake up afterwards, or if you're at all concerned"

Safety Netting
"Please bring her back if:
Her fever doesn't improve in 2–3 days
She becomes more sleepy, confused, or has breathing trouble
You see any new symptoms like a rash or vomiting
She has another seizure
Or even if you're simply unsure or worried — we'd rather you came in early."

Follow-Up Plan
Assessment by **paediatrician today** before discharge
GP review in 48–72 hours to check on the ear infection
Delayed antibiotics may be considered if symptoms persist
If any further seizures occur → refer to **paediatric neurology**
Provide written information on febrile seizures and ear infections

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Clinical Reasoning Note
2-year-old with short (<5 min), generalised seizure + complete recovery = **Simple febrile seizure**
Fever + ear-pulling + irritability + red tympanic membrane → **acute otitis media**, explaining the fever trigger
No signs of meningitis or systemic illness
Seizure is **first presentation**, so **paediatric assessment required** before discharge
NICE recommends **antibiotics** for:
Children **under 2 with bilateral AOM**
Any age with **otorrhoea** or **severe symptoms**
Or when there are **systemic signs**, such as in this case: febrile seizure

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Autism Spectrum Disorder

Role: FY2 in GP Surgery
Presenting Situation: Parents concerned about their child's development — possibly autistic behaviours

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1. Introduction

"Hello, I'm one of the doctors here at the practice. Thank you for coming in today. Could I confirm — are you [child's] mother/father? And just to be sure, may I check your child's full name and age? Great, thank you. How can I help you both today?"

2. Presenting Complaint *(Clarify development concerns)*

"Could you tell me what exactly you've been noticing that made you worried about your child's development?"
"Has anyone else — like nursery staff or family — noticed similar behaviours?"

Explore Key Autism Features (Social, Communication, Repetitive Patterns, Sensory)

Social interaction:
"How does your child interact with other children or adults?"
"Do they maintain eye contact? Respond to their name?"

Speech & communication:
"How many words can they currently say?"
"Do they point to objects or bring things to show you?"
"Do they understand simple instructions?"

Repetitive behaviour:
"Do they repeat the same actions or phrases often?"
"Are there any routines they insist on following very strictly?"

Sensory sensitivities:
"Do they react strongly to certain sounds, lights, or textures?"
"Any unusual interests — like spinning objects or lining up toys?"

3. Differential Screening Questions

To rule out other causes of developmental or behavioural concerns:
"Has your child had any high fevers or recent infections?"
"Do they ever lose awareness of their surroundings or stare into space for long periods?"
"Have they had any seizures or unusual movements?"
"Do you feel they are extremely hyperactive or inattentive beyond what's normal for their age?"

4. Paediatric History

B – Birth
"Was it a normal delivery?"
"Any complications during pregnancy or after birth?"
"Did your child need special care or NICU admission?"

I – Immunisation
"Are their vaccinations up to date?"
"Any reactions to previous vaccines?"

R – Red Book
"Have you been using the red book to track your child's growth and development?"

D – Developmental Milestones
"Are they walking, running, and climbing stairs like other children their age?"
"How is their fine motor coordination — like picking up small objects or using crayons?"
"Do they make eye contact, respond to facial expressions, and show affection?"
"Are you happy with their overall development?"

5. PMAFTOSA Review

Past medical history – "Has your child had any chronic illnesses or hospitalisations?"
Medications – "Are they on any regular medications?"

Allergies – "Any known allergies to medicines or food?"
Feeding – "Any concerns with their appetite or feeding habits?"
Toileting – "Are they toilet trained? Any issues with bowel or bladder habits?"
Sleep – "Do they sleep well at night or wake frequently?"
Activity – "Are they generally active and playful when well?"

6. Family & Social History

"Any family history of autism, delayed speech, or learning difficulties?"
"Does your child attend nursery? How do they interact there?"
"Are there siblings, and how do they interact with each other?"

7. ICE (Ideas, Concerns, Expectations)

Ideas – "What do you think might be going on?"
Concerns – "Is there anything you're especially worried about?"
Expectations – "What were you hoping we could do or help with today?"

8. Examination Summary

(In exam setting, state what you would examine verbally)

General physical examination
Neurological observation (eye contact, behaviour, tone)
ENT check (to rule out hearing loss)
Developmental observation: speech, play, interaction

9. Provisional Diagnosis

"Based on what you've shared — especially the concerns around delayed speech, social interaction, and repetitive behaviours — your child may have features suggestive of **Autism Spectrum Disorder (ASD)**. But we'll need a formal assessment to confirm this."

10. Explanation to Parent

"Autism is a developmental condition that affects how a child sees the world and communicates with others. Some children may develop speech later, struggle to connect socially, or focus on certain routines or objects more than usual.
It's not caused by parenting or anything you've done. It's something children are born with, but with the right support, many go on to thrive."

11. Management Plan

Specialist Referral

"I'll refer your child to the **local child development team** or **paediatric autism pathway**. This team includes a paediatrician, psychologist, speech and language therapist, and occupational therapist."

Hearing Check

"We'll also arrange a hearing assessment, just to be sure speech delay isn't due to hearing problems."

Support and Leaflets

"I'll give you leaflets about autism and explain what to expect from the referral process. You'll also get a link to NHS information on ASD."

Community Resources

"There are support groups and parenting resources that can help guide you. I'll note some for you, or we can get a social prescriber involved."

12. Safety Netting

"If you ever feel that your child is self-harming, having meltdowns that risk their safety, or if you're overwhelmed, please contact us immediately or attend A&E."

"You're not alone — we're here to support you through this journey."

Common Concern: MMR Vaccine and Autism

"There's a common myth about the MMR vaccine causing autism, but this has been **thoroughly disproven** by research.

The original study was discredited and withdrawn.

Autism symptoms often appear around the same age as the MMR is given — but that's just a coincidence, not a cause."

Follow-Up Plan

Referral made to specialist autism team

Schedule follow-up after referral outcome

Check-in call in 2–4 weeks if needed

Follow-Up: Autism Spectrum Disorder

Scenario ID: Follow-up Consultation – GP
Setting: GP Surgery
Patient: 3-year-old child
Role: FY2 Doctor
Purpose: Discuss confirmed ASD diagnosis and support plan with parent

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1. Introduction & Identity Check

"Hello, I'm one of the doctors here at the practice. Thank you for coming in today. Could I confirm — are you the child's mother? And just to be sure, may I check your child's full name and age? Great, thank you. I understand you were referred to the autism team recently and now you're here for a follow-up. How can I help today?"

2. Focused History & Context

Paraphrase:

"I understand your child was referred due to concerns around delayed speech and social development, and the autism team has confirmed a diagnosis of autism spectrum disorder. You've come in today to understand what happens next — is that right?"

Explore current functioning:

Speech: "Has he started saying any words yet?"

Social Interaction: "How does he interact with you or others at home or daycare?"

Behaviour: "Does he show any repetitive behaviours or intense interest in certain toys or routines?"

Daycare feedback: "How has he been coping in the daycare setting?"

Reactions: "Any extreme responses to noise, light, or changes in routine?"

Assess development (BIRD-MAF):

Birth: "Was it a normal delivery?" Any complications?

Immunisation: "Is he up to date with all his vaccinations?"

Red Book / Growth: "Have you been using the red book to track his milestones?"

Development:

Gross Motor: Can he walk, run, climb stairs?

Fine Motor: Can he feed himself? Build towers?

Social: Does he smile, make eye contact, show affection?

Communication: Does he respond to his name? Can he express needs (pointing, sounds)?

Medical History: Any previous diagnoses or hospital admissions?

Allergies: Any known allergies to food, medication, vaccines?

Feeding / Toileting / Sleep: Any concerns with appetite, toilet habits, or sleep?

Activity Level: Does he play actively?

Family History: Any relatives with similar challenges, speech delays, autism, or learning difficulties?

3. Explore ICE

Ideas: "What are your thoughts about what might be going on with your child?"

Concerns: "Is there anything in particular that you're really worried about?"

Expectations: "What were you hoping to get from today's visit?"

4. Clear Disclosure of Diagnosis

"Thank you for sharing that. From what you've told me and the assessment results from the autism team, the diagnosis of Autism Spectrum Disorder — or ASD — has been confirmed. This means that your child has a different way of experiencing and interacting with the world, which affects how they communicate, behave, and relate to others."

5. Explanation of ASD

"ASD is a neurodevelopmental condition — it means that the brain processes information in a different way. Some children with autism may struggle with things like speech, eye contact, playing with other children, and managing changes in routine. You may also notice repetitive behaviours, very specific interests, or unusual sensitivity to noise, light, or textures."

"This is not your fault. Autism is not caused by poor parenting, vaccinations, or anything you did or didn't do. It often runs in families, and many children with autism grow up to live meaningful and independent lives — especially when supported early."

6. Structured Management Plan

Referrals and Interventions:

Speech and Language Therapy: To support communication and language development

Occupational Therapy: To assess sensory needs and help with coordination, feeding, or self-care tasks

Educational Support: Referral to Early Years SEN support and assessment for a suitable learning environment

Behavioural Therapy: For repetitive behaviours or emotional regulation

Psychologist or CAMHS: If signs of anxiety or emotional distress arise later

Home Adaptation Advice:

"Create a calm, predictable environment at home — avoid bright lights or noisy areas if he is sensitive."
"Use simple language and visual routines — some children benefit from using picture charts for daily tasks."
"Avoid overstimulating him; instead, give space and support gently."

Support Organisations and Social Help:

Charities & Community: National Autistic Society, Autism Alliance, local parent groups
Financial Support: You may be eligible for Disability Living Allowance (DLA) or carer support
Keyworker Role: You may be offered a family support worker through community paediatrics

School Planning:

"He might not thrive in a mainstream setting just yet. With your consent, we'll begin the process for an EHCP (Education, Health, and Care Plan) assessment to access special educational support."

Vaccination Concern – Addressing the MMR Myth:

"There is no link between the MMR vaccine and autism. That theory came from a discredited study that's been proven false. Autism signs usually appear around the same age that the MMR is given, but that's just a coincidence."
"MMR protects against serious diseases — measles, mumps, and rubella — and it's important that your child gets the full course."

7. Safety Netting

"Please let us know if you notice sudden changes in his behaviour — like severe meltdowns, self-harming behaviour, or loss of skills."
"If you ever feel overwhelmed or unsure how to support him, we can connect you with specialist services quickly."

8. Follow-Up Plan

"We'll schedule a follow-up in 6–8 weeks to see how you're doing and make sure referrals have been processed."
"You can also call the surgery anytime if you need to speak to a GP, health visitor, or support worker in the meantime."

9. Offer Leaflet & Final Check

"I'll print a leaflet for you with information about autism, the local support system, and practical strategies to help at home."
"Does everything we discussed today make sense so far?"
"How are you feeling now after going through all this?"
"Is there anything else I can answer for you before we finish?"

Developmental Delay in Walking

Setting: GP Telephone Consultation
Role: FY2 Doctor
Concern: Child not walking at 14 months — parental worry

1. Introduction & Identity Check

"Hello, I'm one of the doctors here at the practice. Thank you for calling today. Could I please confirm — are you the mother of the child? And just to be sure, may I check your child's full name and age? Thank you. How can I help today?"

2. Presenting Complaint

Mother: "My son is 14 months old and still can't walk. I see other children his age in daycare already walking, and I'm worried something is wrong."

"When did you first notice he wasn't walking like the others?"
"Can he pull himself to stand or move around with support?"
"Has he ever taken a step independently?"
"Any falls or leg injuries that you're aware of?"

3. Developmental Screening – **BIRD-MAF**

B – Birth history

"Was the pregnancy and delivery normal?"
"Any complications at birth?"

I – Immunisations

"Is he up to date with all his vaccinations?"

R – Red Book / Routine growth checks

"Have his height and weight checks been normal so far?"
"Have you noticed any concerns flagged in the red book?"

D – Developmental Milestones

Gross Motor:

"Can he stand holding furniture?"
"Can he crawl, shuffle, or cruise around with support?"
"Any stiff or floppy movements?"

Fine Motor:

"Can he pick up small objects, like bits of food?"
"Does he pass objects between hands?"

Hearing:

"Does he respond to his name?"
"Does he react to loud sounds?"

Social/Emotional:

"Does he smile at you or other people?"
"Does he try to get your attention or point at things?"
"Does he enjoy interaction with others?"

4. *M – Medical history*

"Has your child had any major illnesses or hospital admissions before?"
"Any concerns raised in previous check-ups?"

A – Allergies & Medications

"Is your child on any regular medications?"

"Do they have any known allergies — to medications, food, or anything else?"

F – Family & Feeding

"Is there anyone in the family with developmental delay, autism, or epilepsy?"

"How is your child's feeding – are they eating and drinking normally for their age?"

5. ICE

Ideas: "Do you have any thoughts about why he might not be walking yet?"

Concerns: "What worries you most about this?"

Expectations: "Were you hoping we'd refer you to a specialist today?"

6. Examination (Telephonic Limitation)

"As this is a telephone consultation, I'm unable to assess his physical movements or muscle tone right now. I'd recommend booking an in-person appointment in 2–4 weeks so we can examine him more closely if there's no improvement."

7. Provisional Diagnosis & Explanation

Provisional Impression: Normal variant of gross motor delay

Explanation

"At 14 months, many children are still learning to walk. Some start walking as early as 9 months, others closer to 18 months. Since your child can stand with support and there are no red flags in his overall development, this is most likely within the normal range."

"Each child develops at their own pace, and a delay in walking alone—if other milestones are met—is usually not concerning at this stage."

8. Management Plan

Reassurance:

"There's nothing to worry about just yet. His overall development is on track."

"We usually give children up to 18 months before investigating walking delays further."

Practical Advice:

"Encourage walking by letting him hold your hands and cruise around furniture."

"Avoid baby walkers as they can delay walking."

"Give him plenty of tummy time and floor play to strengthen his legs."

Follow-up:

"Let's arrange a face-to-face review in 4 weeks to check on progress."

"If there's still no improvement, we can assess further and consider referrals."

Referral Threshold:

Referral to a paediatrician or child development team would be considered if:

No signs of walking by 18 months

Regression in any milestones

Concerns about tone (stiff/floppy), social interaction, or suspected autism

Leaflet and Safety Netting:

Offer NHS leaflet on gross motor development

"If you notice any changes — such as regression, floppiness, stiffness, or issues with interaction — please contact us sooner."

9. Final Check

"Do you feel a bit more reassured now?"
"Would it be okay if I booked you for a review in 4 weeks?"
"Is there anything else you'd like to ask or talk about today?"

Night Terrors

Scenario: FY2 GP | Mother brings 4-year-old with screaming episodes at night
Type: Face-to-face consultation
Exam Focus: Reassurance, Red Flags, Differentials, and Supportive Advice

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1. Introduction & Rapport

"Hi, I'm one of the doctors here at the practice. Thanks for coming in today.
Could I just confirm — are you his mum? And to be sure, may I check your child's full name and age?"
"Thank you. I understand you're concerned about what's been happening during his sleep — would you like to tell me a bit more?"

2. Presenting Complaint – Clarify the Problem

Symptom Clarification:

"When did these episodes start?"
"How often does it happen in a week?"
"What exactly happens — does he scream, sweat, thrash about?"
"Is he awake or responsive when you go to him?"
"Does he recognise you during the event?"
"Does he remember anything about it in the morning?"

Current State:

"Is he otherwise well during the day?"
"Any problems with his mood, eating, or playing?"

3. Red Flag Screening & Differentials

To rule out seizures, trauma, or infection:

"Have you seen any jerky or stiff body movements?"
"Has he ever gone blue or stopped breathing?"
"Any tongue biting, incontinence, or twitching during episodes?"
"Has he had a recent fever, rash, vomiting, or neck stiffness?"
"Any recent head injury?"

To rule out nightmares or psychological distress:

"Does he seem scared or upset before going to sleep?"
"Any scary shows, movies, or games recently?"
"Has anything changed at home — new school, sibling, or stress?"

4. Developmental History

B – Birth: "Was it a normal pregnancy and delivery?"
I – Immunisation: "Is he up to date with his vaccines?"

R – Red Book: "Have his growth and milestones been okay so far?"
D – Development: "Is he walking, talking, and interacting normally?"
M – Medications: "Is he on any regular medication?"
A – Allergies: "Any allergies you're aware of?"
F – Feeding, Toileting, Sleep, Activity:
"Is he eating and drinking well?"
"Is he generally active and playful?"
"How's his sleep routine overall?"

5. ICE – Ideas, Concerns, Expectations

Ideas: "What do you think is going on?"
Concerns: "What's worrying you the most — are you worried about seizures or something else?"
Expectations: "What were you hoping we could do today?"

6. Effect on Life

"How is this affecting his daytime behaviour?"
"Is it affecting your sleep or causing stress at home?"

7. Suggested Examination

"I'd like to bring him in for a basic head-to-toe check, especially a neurological and ENT exam, just to be sure we're not missing anything medical."

8. Provisional Diagnosis & Lay Explanation

"From what you've described — the screaming at night, not being fully awake, not remembering it in the morning — this sounds like something called **night terrors**."
"It's quite common in children aged 3 to 12. It happens during the deepest part of sleep, usually in the first few hours. They may look awake or scream, but they're not conscious or dreaming. It's not harmful and isn't linked to epilepsy or mental health conditions."

9. Management Plan (NHS/NICE CKS Aligned)

Reassurance

"These episodes usually settle as children grow older."
"They don't cause harm to the brain and aren't related to learning difficulties."

Supportive Advice

Track the pattern: "If it's happening at a regular time, gently wake him up about 15 minutes before the usual time for 7 days — this often breaks the cycle."
Sleep routine: "Stick to a relaxing bedtime — warm bath, quiet time, no screens before bed."
Sleep environment: "Keep the room dim and calm — soft lights, minimal noise."
Avoid approaching: "Try not to wake him or comfort him during the event. Just stay nearby and let it pass."
Toileting: "Make sure he uses the toilet before bed — a full bladder can sometimes trigger episodes."

Red Flag Safety Netting

"Please come back or seek help if:"
"Episodes become more frequent or happen during the day."

"They last longer than 5 minutes."
"You see signs like jerky movements, limb stiffness, or unresponsiveness."
"He's not returning to normal after the episodes."

10. Leaflet & Support

Provide a parent-friendly **NHS leaflet on Night Terrors**.
Signpost to NHS.uk sleep resources and **ERIC (The Children's Bowel & Bladder Charity)** for sleep support.

11. Follow-Up

"I'd like to review him again in 2 months just to see how he's getting on.
If the episodes change in any way or you're concerned sooner, feel free to contact us anytime."

Temper Tantrums

Setting: GP Practice – Telephone Call
Role: FY2 Doctor
Patient: 3-year-old boy
Caller: Mother
Presenting Concern: "I'm concerned about his behaviour – he's not obeying and has been throwing food."

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1. Introduction & Identity Confirmation

"Hello, you've reached the GP surgery. You're speaking to one of the doctors here. May I confirm — are you the mother of the child? Could I confirm your child's full name and age please? Thank you. How can I help you both today?"

2. Presenting Complaint

Element	*Questions*
Onset	"When did you first start noticing these behaviour changes?"
Duration	"How long does a tantrum usually last?"
Intervals	"How often does it happen in a week?"
Progression	"Is it getting better, worse, or staying the same?"
Aggravating	"Any specific triggers like hunger, tiredness, or certain activities?"
Relieving	"Is there anything you've found that helps calm him down?"
Associated	"Any signs like crying, screaming, throwing things, or hitting?"

3. Red Flag Screening & Differentials

To rule out serious underlying conditions:

Autism Features:
"Does he avoid eye contact?" → *No*
"Does he repeat specific movements or fixate on certain objects?" → *No*

ADHD:
"Is he constantly hyperactive, impulsive, or struggling to focus for even short periods?" → *No*

Mental/Neurological concerns:
"Any recent falls, injuries to the head, or fever?" → *No*

4. Developmental Screening

Domain	*Questions*
Birth	"Was the delivery normal? Any complications?" → *Normal*
Immunisations	"Are his vaccinations up to date?" → *Yes*
Red Book	"Have you been tracking his growth or milestones in the red book?"
Development	"Is he able to speak, feed himself, play, and follow instructions?" → *Yes, but throws food sometimes*
Medical Hx	"Has he had any medical conditions in the past?" → *No*
Allergies	"Is he allergic to any foods or medications?" → *No*
Family	"Any family history of developmental or behavioural issues?" → *No*

5. ICE – Ideas, Concerns, Expectations

I: "What do you think might be going on?"

→ *"Maybe something is wrong at daycare or with us at home."*

C: "What are you most worried about?"

→ *"Could this be something serious or long-term?"*

E: "What were you hoping we could do today?"

→ *"I wanted to understand if this is normal and if anything can help."*

6. Diagnosis & Explanation

"It sounds like your child is experiencing what we call **temper tantrums**, which are actually quite common in children between 1 to 4 years of age. At this age, they are still learning how to express emotions, deal with frustration, and communicate effectively. When they get overwhelmed or can't express themselves, they may scream, cry, or throw things — and that's their way of reacting. It can seem worrying, but it's part of their emotional development and not a sign of a long-term problem."

7. Management Plan (NHS/NICE-Aligned)

Reassurance

"This is very common in toddlers and doesn't mean something is wrong. Most children grow out of this phase with time."

Supportive Advice

Calm, Consistent Response:

"Stay calm during an episode — avoid yelling or reacting angrily. This helps de-escalate the situation."

Consistency:

"Try to keep routines consistent so he feels secure. Toddlers thrive on structure."

Distraction & Redirection:

"Gently distract him with another activity or toy once he's calmer."

Positive Reinforcement:

"Praise him when he expresses himself well or follows instructions."

Ignore Minor Tantrums:

"If the tantrum is safe and not harming anyone, sometimes ignoring it calmly helps it pass."

Promote Emotional Regulation

"Talk to him when he's calm — name the emotions he may be feeling like 'Are you upset because...?'"

"Model how to express anger or frustration using words."

Avoid Triggers

"Make sure he's not hungry or tired — many tantrums are linked to basic needs being unmet."

8. Safety Netting & Follow-Up

Red flags:

"If the behaviour becomes aggressive, constant, affects eating or sleeping badly, or you see signs of emotional withdrawal or regression, please call us immediately."

Follow-up:

"Let's review in a month. If things haven't improved, we can explore behavioural support or child psychology if needed."

9. Leaflet & Resources

Offer NHS parenting advice leaflets

Suggest parenting support groups or local child behaviour workshops if available.

End the Call Warmly

"Thank you for reaching out. You're doing a great job by being proactive. Let's keep in touch — and feel free to call us if things don't improve or you feel something isn't right."

Primary Nocturnal Enuresis

Role: FY2 Doctor in GP Practice

Scenario: Father of a 5-year-old boy calls concerned about night-time bedwetting.

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1. Introduction & Identity Check

"Hello, this is Dr [Your Name], one of the doctors here at the practice. Am I speaking with [Father's Full Name]?"

"Could I just confirm your child's full name and age as well, please?"

"Thanks for confirming that. I understand you're calling today about your son's bedwetting — would you like to tell me a bit more about what's been happening?"

2. Presenting Complaint & Clarification

Onset: "When did you first notice he was wetting the bed at night?"

Duration: "Has it always been like this, or did he ever have a dry period?"

Intensity: "How often does it happen — every night or a few times a week?"

Pattern: "Does it tend to happen around the same time every night?"

Aggravating: "Does it seem worse after busy or stressful days, or after drinking more before bed?"

Relieving: "Have you tried anything that seems to help?"

Associated: "Any other issues like pain when passing urine or wetting during the day?"

3. Exclude Red Flags & Rule Out Differentials

"Has he had any daytime accidents, urgency, or difficulty holding urine?"

"Any pain when he passes urine, strong-smelling urine, or fevers?"
"Is he constipated or passing hard stools?"
"Any previous urine infections or recent stressful events like starting school or a family change?"

These screen for UTI, diabetes, constipation, child stress, or emotional triggers

4. Background History – BIRD–MAF

B – Birth: "Was he born full term and were there any complications at birth?"
I – Immunisations: "Are his vaccinations up to date?"
R – Red Book & Development: "Has his development otherwise been normal?"
D – Diet & Digestion: "Does he eat well and have regular bowel movements?"

M – Medical Conditions: "Any known medical issues or past hospital visits?"
A – Allergies / Medications: "Any allergies or regular medications?"
F – Family History: "Has anyone in the family had similar issues growing up?"

5. Sleep Pattern & Impact

"Does he sleep deeply or wake up easily?"
"Is he aware that he's wet the bed in the morning?"
"How is this affecting him emotionally? Does he seem upset or embarrassed?"
"How are you and the rest of the family coping with this?"

6. ICE – Ideas, Concerns, Expectations

Ideas: "Do you have any idea what might be causing this?"
Concerns: "Is there anything in particular you're worried about — maybe something you've heard or read?"
Expectations: "What were you hoping we could do for him today?"

7. Provisional Diagnosis & Explanation

Diagnosis: *Primary Nocturnal Enuresis*
"This means your child has never consistently been dry at night. It's actually very common at this age — up to 1 in 6 children are still wetting the bed at 5 years old."

Explanation:
"There are a few reasons this can happen — sometimes the body produces more urine at night than the bladder can hold, or the brain hasn't yet learned to wake the child up when the bladder is full. It's not your fault, and it's not something the child is doing deliberately."

8. Management Plan

First-Line: Lifestyle & Behavioural Advice

Fluid Intake: "Encourage plenty of fluids during the day, but reduce drinks 1–2 hours before bed. Avoid fizzy or sugary drinks in the evening."
Toileting Routine: "Remind him to use the toilet regularly during the day and always just before bed."
Reward System: "Use positive reinforcement like a reward chart — not for staying dry, but for trying, like using the toilet before bed."
No Blame or Shame: "Avoid any punishment — it's not something within his control."

Medical Options (if needed)

"If the bedwetting becomes very distressing or impacts social activities like sleepovers, we can consider a short course of a medication called *desmopressin*, which reduces urine production at night."

"It's safe when used properly, and we'd usually try this only if lifestyle measures alone aren't enough."

9. Addressing the Father's Concerns

"I understand you're worried this might happen at school — but because this only happens at night, it's very unlikely to affect his school life."

"The fact that he's otherwise happy and healthy is very reassuring."

10. Safety Netting & Follow-Up

"Let us know if he starts wetting during the day, gets pain when peeing, or becomes more distressed."

"If lifestyle changes haven't helped after a few months, we'll review again to consider next steps."

11. Leaflet & Resources

"I'll send you a leaflet with all the key points we discussed and tips to try at home."

"You can also find more advice on the *ERIC* (Enuresis Resource and Information Centre) website and NHS online."

12. Final Wrap-Up

"How are you feeling about everything we've discussed today?"

"Would you be happy to try some of the suggestions we talked about and keep in touch?"

"We'll plan a review in 2–3 months if things don't improve — and feel free to contact us sooner if you're worried."

Nocturnal Enuresis in an 8-Year-Old

Setting: GP Practice
Consultation Type: Face-to-face with father only
Role: FY2 Doctor

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1. Introduction

"Hello, I'm one of the doctors here at the practice. Thank you for coming in today. Could I confirm — you're the father of an 8-year-old boy? And just to clarify, is he with you today? [No] Alright — I'll do my best to understand what's going on and support you both."

2. Presenting Complaint

"Could you tell me what's been happening with his bedwetting? How often is it happening currently?"

Bedwetting only at night
Around 3 nights per week
Occasionally has dry nights
No daytime symptoms
No incontinence at school
Father is now requesting medication due to ongoing concern

3. Differential Diagnosis Screening

"Before we go further, can I check a few things to make sure nothing else is contributing?"

Exclude daytime urinary symptoms or red flags:

Any dribbling, urgency, or daytime wetting?
Any pain when passing urine or signs of infection?
Any constipation or soiling issues?
Any new behavioural issues or regression?
Any signs of diabetes (thirst, weight loss, increased urination)?

4. Risk Factors (BIRD-MAF)

B – Birth & Background

"Were there any complications during pregnancy or birth?" → Normal
"Has he been dry in the past for a long period?" → No (never consistently dry)

I – Immunisation

"Are his vaccinations up to date?" → Yes

R – Red Book & Development

"Has his development been normal otherwise?" → Yes
"Any concerns about learning or social milestones?" → No

D – Diet, Daycare, and Daily habits

"How is his diet and fluid intake — especially in the evening?"
→ Drinks normal amounts, but sometimes fluids close to bedtime
"Is he in school? Any stressors there?" → No concerns
"Any recent changes at home?" → No new stressors

M – Medical History

Any history of UTIs, chronic illness, diabetes, neurological conditions? → No
Any medications? → None
Allergies? → None

A – Activity, Sleep & Toileting

"Does he have deep sleep?" → Yes, very deep sleeper
"Does he wake up to use the toilet?" → No
"Regular toilet use in the day?" → Yes
"Has he been toilet trained well? Any accidents during the day?" → Fully trained, no accidents

F – Family History

"Did anyone else in the family have bedwetting?" → Yes, father had similar issues as a child

5. ICE

Ideas: "I think maybe something is wrong with his bladder."
Concerns: "I'm worried he's falling behind other kids… and I don't want him to be embarrassed at sleepovers."
Expectations: "We want to try medication now if that's an option."

6. Effect on Life

Child is becoming more aware and embarrassed
Reluctant to attend sleepovers

Parents becoming frustrated but trying to stay supportive

7. Examination Summary (not performed)

"I'd ideally like to bring your son in next time to examine him and check a urine sample."
No signs today to suggest UTI, constipation, diabetes, or developmental delay

8. Provisional Diagnosis

Primary Nocturnal Enuresis

Child has never been consistently dry at night
No daytime symptoms
Likely multifactorial: delayed bladder–brain signalling, deep sleep, possible genetic tendency

9. Explanation

"Bedwetting at this age, while less common than in younger children, is still very treatable. It often happens because the bladder fills at night, but the brain doesn't yet fully wake the child up to respond. In some children, this connection develops later than others. It's not due to laziness or poor training — and it's not the child's fault. Many children outgrow it, but we can support and speed up the process."

10. Management Plan

1. Reassurance

"You're not alone — many children still wet the bed at 7 or 8. And the fact that he has dry nights is a great sign."
"He doesn't need any invasive tests right now, and there are things we can do to help."

2. First-Line: Behavioural & Lifestyle

Fluid Advice: "Encourage fluid intake in the morning and early afternoon, but reduce fluids 1–2 hours before bed."
Toileting Advice: "Regular toilet use during the day and always before bed."
Environment: "Make sure the toilet is easily accessible — maybe with a nightlight."
Reinforcement: "Try reward charts for dry nights — no punishment for wet ones."
Mattress protection for practical support

3. Enuresis Alarm – Discussed

"We can try an enuresis alarm, which wakes the child as soon as bedwetting starts. It's a good long-term solution if you and your son are both committed."
"It can take a few weeks to show results — we assess at 4 weeks and continue if it helps."

4. Desmopressin – Now an Option

"Since your son is 8 and you've already tried other strategies, we can consider Desmopressin, especially for immediate relief — like school trips or social events."
Mechanism: "It reduces urine production at night."
Safety: "It's safe when used properly, but we must limit fluids 1 hour before and 8 hours after taking it."
Dosage: Start with one dose before bed. Can increase if partial response.
Pause during illness (vomiting or diarrhoea).
Avoid NSAIDs during use (e.g., ibuprofen) due to hyponatremia risk.

Provide NHS leaflet.

11. Safety Netting

"Please let us know immediately if:

He starts having daytime wetting, pain when passing urine, or any behavioural changes

You notice signs of UTI

The medication doesn't work after a few weeks"

12. Follow-Up

"Let's review progress in 4 weeks if you start Desmopressin, or sooner if needed."

"If symptoms persist long-term or worsen, we'll consider referral to a continence specialist."

Comparing the Two Enuresis Cases

In **both cases**, the child presents with **nocturnal enuresis** — but the approach differs slightly based on the **child's age**, **parental expectations**, and **clinical urgency**.

*Case 1: **5-Year-Old with Primary Enuresis (Phone Call)***

Age-appropriate reassurance is the focus.

First-line management involves **conservative behavioural strategies** only.

Medication **not typically considered** at this age.

Parents often need **normalisation and education**, as bedwetting is still within expected developmental limits under age 7.

*Case 2: **8-Year-Old with Nocturnal Enuresis – Father Requests Medication***

By age 8, **fewer children have persistent enuresis**, so further intervention is more reasonable.

The child has **some dry nights**, which is a good prognostic sign.

Since the father **requests medication**, the doctor must:

Acknowledge the request empathetically,

Ensure **non-pharmacological steps** have been tried or explained,

Then discuss **Desmopressin** as a second-line option, with proper fluid restriction and safety netting.

Key Differences:

Feature	***Case 1 (Age 5)***	***Case 2 (Age 8)***
Age	5 years	8 years
Parental Request	General concern	Specific request for medication
Management Focus	Conservative only	Conservative + Medication if appropriate
Use of Desmopressin	Not typically offered	Can be considered
Follow-up	Delayed (monitor progress)	More proactive (4-week review)

Head Injury

Setting: FY2 in A&E

Scenario: Child fell from sofa, now alert and active (GCS 15/15). Small bruise noted.

1. Introduction & Identity Check

"Hello, I'm one of the doctors in the A&E department. Thank you for coming in."

"Can I confirm, are you [child's] mother?"
"And could I confirm your child's full name and age, please?"
"Thanks — how can I help you both today?"

2. Presenting Complaint (ODIPARA)

Onset: "When did this happen?"
Duration: "How long ago did the fall occur?"
Intensity/Impact: "Did you notice any change in his behaviour right after the fall?"
Progress: "Has he been back to normal since then?"
Aggravating/Relieving: "Is anything making it worse?"
Associated Symptoms: Covered below
Response/Action Taken: "What did you do immediately after the fall?"

3. Mechanism & Red Flag Screening

Ask about the following clearly (as per NICE head injury criteria):

Mechanism of Injury:

"Can you tell me exactly how the fall happened?"
"How high was the sofa he fell from?"
(Low-height fall, typically <1 metre – unlikely to cause significant injury)

Immediate Symptoms:

"Was he conscious right after the fall?"
"Did he lose consciousness at any point?"
"Did you notice any jerky movements or a seizure?"
"Was there any bleeding from the head, ears, nose, or mouth?"
"Any clear watery discharge from ears or nose?" *(CSF leak)*

Post-Injury Symptoms:

"Has he vomited at all?" → "How many times?" *(Only one episode = not concerning)*
"Any unusual drowsiness or change in alertness since then?"
"Is he behaving normally now?" → "Has he been eating, playing, and interacting as usual?"

4. Risk Factor History

Birth: "Was his birth full-term and without complications?"
Immunisation: "Are his vaccines up to date?"
Red Book / Development: "Is he meeting his developmental milestones normally?"
Diet: "Is he eating and drinking well recently?"
Medical History: "Has he had any significant medical problems before?"
Allergies: "Does he have any allergies?"
Family History: "Any history of seizures, bleeding disorders, or developmental conditions?"

5. ICE

Ideas: "What do you think might be wrong?"
Concerns: "Is there anything in particular you're worried about?"

Expectations: "Were you hoping for a scan or any specific check today?"

6. Examination Summary

"On examination, your child appears well, alert, and active."
"He is currently playing and interacting normally."
"Vital signs are within the normal range."
"The only external sign of injury is a small bruise on the forehead, less than 5cm in size."
"There are no signs of serious injury like multiple vomiting episodes, seizures, or altered consciousness."

7. Provisional Diagnosis

Minor head injury with low-risk features.
No red flags suggesting intracranial injury.
CT scan not indicated as per NICE guidance.

8. Explanation in Lay Terms

"Your child has had what we call a minor head injury."
"These are very common in toddlers, especially from low falls like from a sofa."
"At the moment, everything about your child's behaviour and examination is reassuring."
"He's alert, playful, and has no signs of serious internal injury."

9. Addressing the CT Request

"I understand you're worried and were hoping for a scan."
"CT scans involve a large dose of radiation to the head, and we only use them if there's a strong reason."
"Based on NICE guidelines, a scan is considered only if:
They lose consciousness
Vomit more than 3 times
Have a large swelling or bruise more than 5 cm
Seizures, confusion, or signs of brain injury"
"Since none of those are present in your child, doing a CT would only expose him to unnecessary risk without benefit."

10. Management Plan

Observation: "We'll observe him here for about 4 hours to be absolutely sure he remains well."
Pain Relief: "You can give paracetamol if he seems to have a headache or is uncomfortable."
No need for antibiotics or scans.

11. Safety Netting

"Please bring him back or seek urgent help if any of the following occur at home:
Vomiting more than 3 times
Becomes unusually sleepy or hard to wake
Has a fit or jerky movement
Starts behaving abnormally or is very irritable
You see any watery fluid coming from his nose or ears"

12. Follow-Up & Leaflet

"In most cases, children recover completely without any issues."
"You're welcome to call us or your GP if you have further concerns."
"Here's a leaflet on minor head injuries in children with all this information summarised."

Criteria for **CT scan in paediatric head injury** :

Assessment Criteria	*Threshold for CT Scan*
GCS (Glasgow Coma Scale)	<15 at presentation or <14 at any time (age ≥1 year)
Loss of Consciousness	Yes, any loss of consciousness
Vomiting	≥3 episodes after head injury
Post-traumatic seizure	Yes
Suspected skull fracture or base of skull signs	Yes (e.g. raccoon eyes, CSF leak, bruising behind ears)
Large scalp haematoma (age <1 year)	>5cm (especially occipital or parietal)
Dangerous mechanism of injury	High-speed RTA, fall from ≥1m (age <2), ≥1.5m (age ≥2)

Chapter 16: Women's Health

Introduction to Obstetrics & Gynaecology in PLAB 2

Obstetrics and Gynaecology (O&G) stations in PLAB 2 assess your ability to safely and sensitively manage situations involving pregnancy, reproductive health, and women's health concerns. These scenarios test not just your clinical knowledge, but your ability to communicate with empathy, protect patient dignity, and navigate sensitive topics under pressure.

What You're Expected to Be in O&G Stations

In PLAB 2, you're acting as an **FY2 doctor**. That means:

You're **not delivering babies**, managing labour wards, or performing surgery.
But you **do**:

- Take structured antenatal or gynaecology histories
- Counsel patients based on scan or test results (e.g. low-lying placenta, HSV in pregnancy)
- Recognize red flags and refer appropriately
- Offer first-line advice on contraception, fertility, or symptom management
- Escalate to maternity units or obstetric teams when needed

What Makes O&G Cases Unique in PLAB 2?

Challenge	*How to Tackle It*
Multiple timelines *– current pregnancy, past obstetrics, menstrual history*	Use a **structured framework** to stay on track
Sensitive topics *(STIs, sexual history, miscarriage)*	Offer **confidentiality** and seek consent before asking
Dual focus *– mother and foetus*	Always consider **safety for both** in your plan
High emotional tone	Acknowledge emotion, **don't rush into facts**
Referral is often key	Know when to escalate to: GUM, obstetric consultant, MAU, EPAU

Structure of an Obstetric & Gynaecological history

1. Presenting Complaint

Always start with what brings the patient in.

"What's brought you in today?"
"How long has this been going on?"
"Have you had anything similar before?"
Follow-up with tailored questions depending on presenting symptom (pain, discharge, rash, scan concern, bleeding, missed periods, etc.)

2. Gestational Status / Pregnancy Context

*If the patient is **pregnant**:*

"How many weeks pregnant are you?"
"Was the pregnancy planned or a surprise?"
"Was it a natural or assisted conception?"
"How was the pregnancy confirmed?"
"Is this your first pregnancy?"

*If the patient is **not currently pregnant**:*

"When was your last menstrual period (LMP)?"
"Are your periods usually regular?"
"Is there a chance you could be pregnant now?"
"Have you ever been pregnant before?"

This section orients you clearly toward an antenatal vs gynaecological path.

3. Medical, Menstrual & Medication History

Medical Conditions

"Do you have any long-term medical problems like diabetes, high blood pressure, thyroid issues, epilepsy, or clotting disorders?"

Menstrual Cycle

"Are your periods regular?"
"What's your average cycle length and bleeding duration?"
"Any history of painful or heavy periods?"
"Any spotting between periods or post-coital bleeding?"
"Have you ever been diagnosed with PCOS, fibroids, or endometriosis?"

Medications & Allergies

"Are you on any prescribed medications, supplements, or over-the-counter remedies?"
"Do you have any allergies, especially to medications?"

4. Antenatal Care (If Pregnant)

Ask this **only if the patient is currently pregnant**

"Have you been attending your antenatal appointments regularly?"
"When was your last scan? Did everything look okay?"
"Have you had your booking bloods and infection screens (HIV, hepatitis B/C, rubella, syphilis)?"

"Have any concerns been raised so far?"
"Are you feeling your baby move?" (after 16–20 weeks)
"Any bleeding, pain, or contractions?"
"Any new symptoms like headaches, swelling, visual changes, or reduced movements?"

5. Past Obstetric History (G/P)

Ask **after** current pregnancy details, or earlier in infertility/fertility-related cases

"Have you been pregnant before?"
"How many total pregnancies have you had?" **(Gravida)**
"How many births beyond 24 weeks?" **(Parity)**
"Any miscarriages, ectopic pregnancies, or terminations?"
"Any complications in previous pregnancies like high blood pressure, diabetes, bleeding, or PPH?"
"Were the deliveries vaginal or by caesarean?"
"Any instrumental deliveries?"
"NICU admissions?"
"How are your previous children doing?"

For **non-pregnant patients** (e.g. fertility concerns, recurrent miscarriage):
→ Move this section earlier after menstrual history.

6. Family & Genetic History

"Any family history of pregnancy-related conditions — like preeclampsia, gestational diabetes, or blood clotting problems?"
"Any known inherited or genetic conditions?"
"Any multiple pregnancies in your family?"

7. Social & Lifestyle History

"Do you smoke or drink alcohol?"
"Do you use recreational drugs?"
"How is your diet and activity level?"
"Do you feel emotionally supported at home?"
"Do you feel safe in your relationship and household?" *(gentle safeguarding if concerns present)*

8. Sexual History (If Relevant)

Include only if clinically appropriate: infection, bleeding, fertility, vaginal symptoms.

"Are you sexually active?"
"Do you use contraception?"
"Any recent change in partners?"
"Any pain during sex or after?"
"Any past or recent STIs in you or your partner?"

Omit if irrelevant – don't force this into every case.

9. ICE – Ideas, Concerns, Expectations

"What do you think might be going on?"
"Is there anything that's been particularly worrying you?"
"What were you hoping we could do today?"

Missed Miscarriage

Setting: Early Pregnancy Assessment Unit (EPAU)
Role: FY2 Doctor
Patient: 32-year-old woman
Context: Follow-up after a transvaginal ultrasound scan
Findings: Scan shows a 7-week gestation with foetal pole but no heartbeat
Concerns: First pregnancy, conceived after 6 years of trying, recent loss of pregnancy symptoms, worried it may not be viable

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1. Introduction & Consent
"Hello, I'm Dr [Your Name], one of the doctors here in the Early Pregnancy Unit. I understand you're here today to discuss the results of your recent scan. Before we go through them together, would it be alright if I ask you a few questions first to understand how things have been for you recently?"

2. Focused History & Contextual Clarification
Pregnancy History

"Can I check—how far along do you think you are?"
"You mentioned you did a test 9 weeks ago—have you had any other scans?"
"Have you had any bleeding or pain?"
"Any signs of pregnancy—like nausea, breast tenderness, tiredness?"
"Have those symptoms changed recently?"

Past History & Risk Factors

"Is this your first pregnancy?"
"Have you ever been pregnant before—naturally or via fertility treatment?"
"Any medical issues such as diabetes, thyroid problems, clotting disorders?"
"Are you taking any medication or supplements at the moment?"
"Have you had any procedures through the front passage before?"
"Do you smoke or drink alcohol?"
"Any family history of miscarriages or blood clotting issues?"

3. Explore ICE

"Have you had any thoughts about what the scan might show today?"
"Is there anything specific that's been worrying you?"
"What were you hoping we could talk about or achieve in today's visit?"

4. Clear Result Disclosure
"Thank you for sharing that. I've reviewed your scan results with our team. It shows that there is a foetal pole, which indicates early pregnancy development, but unfortunately, there is **no detectable heartbeat** at the moment. The pregnancy is measuring around 7 weeks.
Because the pregnancy test was positive 9 weeks ago, we would normally expect to see a heartbeat by now. Right now, we can't confirm anything for certain—we need to repeat the scan in 7 to 10 days to see if anything changes. But I do want to be honest with you—**this may represent a missed miscarriage**, which means the pregnancy has stopped growing without any of the usual signs like bleeding or pain."

5. Explanation of Missed Miscarriage

"A missed miscarriage is when the baby stops developing, but the body hasn't recognised the loss yet. That's why many women, like yourself, may stop feeling pregnancy symptoms but don't have any bleeding or pain.
It's completely understandable to feel shocked or confused. I also want to reassure you that nothing you've done has caused this. Most early miscarriages happen because of problems with how the baby develops in the very early stages—often due to genetic reasons that can't be predicted or prevented."

6. Detailed Management Plan

A. Immediate Plan

"We will arrange a **repeat scan in 7 to 10 days**. If that also shows no heartbeat and no growth, we can then confirm a missed miscarriage."

B. If a Missed Miscarriage is Confirmed: Three Main Options

1. Expectant Management – *Waiting naturally*

"You can wait for the miscarriage to happen naturally.
In many cases, your body will start the process on its own within 1–2 weeks.
This usually involves cramping and bleeding, similar to a heavy period."

"It's a completely safe approach, but we'll monitor you. If it doesn't happen on its own, you can change your decision anytime and opt for medication or surgery."

2. Medical Management – *Tablets to help complete the miscarriage*

"This involves taking medication, usually Misoprostol, to help your womb empty itself.
You may experience pain and bleeding within a few hours. This can be done at home or in the hospital depending on your comfort and the unit's guidance."

"We'll give you pain relief and explain what to expect. We usually check after a week or so to confirm that the miscarriage is complete."

3. Surgical Management – *Procedure to remove pregnancy tissue*

"This is a short procedure done under local or general anaesthetic, called **Manual Vacuum Aspiration** or **Surgical Evacuation**.
It gently removes the pregnancy tissue from the womb.
It's quick and effective, and most women go home the same day."

"Some women prefer this to have things resolved quickly, especially when emotions are high or if other methods haven't worked."

"All three options are equally safe and you'll be supported no matter which you choose. You don't have to decide now. Once the repeat scan confirms things, we'll talk through your preferences again."

7. Safety Netting

"If you experience any heavy bleeding, severe pain, fever, or if you feel faint at any point, please come back to the unit straight away or attend A&E.
We'll also give you contact numbers in case you need urgent support before the next appointment."

8. Follow-Up Plan

Book a repeat ultrasound in **7–10 days**
Consultant review following confirmation

9. Offer Leaflet & Final Check
"I'll give you a leaflet that explains what a missed miscarriage is, along with all the treatment options we've discussed today. Would you like me to go over anything again? I know this is a lot to take in—and I'm here to support you."

Incomplete Abortion

Setting: Gynaecology Clinic or Early Pregnancy Unit
Role: FY2 Doctor
Patient: 30-year-old woman
Context: Vaginal discharge and mild discomfort following a recent medical abortion
Scan Result: Retained products of conception (RPOC)

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1. Introduction & Consent
"Hello, I'm Dr [Your Name], one of the doctors in the clinic today. I understand you've recently had a medical abortion and have been experiencing some vaginal discharge and discomfort. I'd like to go over the results of your ultrasound and talk through next steps, if that's alright?"

2. Focused History & Context
- "Can you tell me more about the discharge you've had? Any smell, colour, or change in amount?"
- "Have you noticed any bleeding—how heavy has it been?"
- "Any clots or tissue passing since the abortion?"
- "Do you have any pain or cramping in your lower tummy?"
- "Any fever, chills, or feeling generally unwell?"
- "When did you take the abortion medication?"
- "Was it given through a clinic? Do you remember the names—was it mifepristone and misoprostol?"
- "Since the procedure, have you noticed a reduction in symptoms or change in bleeding pattern?"
- "Do you have any long-term conditions—such as anaemia, clotting disorders, or infections?"
- "Have you ever had any gynaecological procedures in the past?"

3. Explore ICE
- "Have you had any thoughts about what might be going on?"
- "Is there anything specific you're concerned about today?"
- "What were you hoping we could do for you?"

4. Clear Result Disclosure
"Thanks for sharing all that. I've reviewed your ultrasound, and it shows that **some pregnancy tissue is still present in the womb**. We call this an **incomplete abortion**.
This means that while most of the tissue has passed, a small amount remains inside the uterus. It's not uncommon, especially after medical abortion in early pregnancy. It's something we can treat safely, and I'll talk you through the options."

5. Explanation of the Diagnosis
"During a medical abortion, medications are used to help the womb contract and pass all the pregnancy tissue. Sometimes, though, **a small portion remains**, which can lead to ongoing symptoms like discharge, bleeding, or mild pain.
It's important to manage this carefully to avoid complications like infection or prolonged bleeding—but I want to reassure you this is treatable and not your fault. It's simply a known outcome in some cases."

6. Structured Management Plan

"We have three main management options. All are safe, and we'll support you with whichever feels right."

A. Expectant Management – Waiting Naturally

"We can wait and let your body try to pass the remaining tissue naturally.
This is called **expectant management**, and it often works within 1–2 weeks.
You'd be monitored and given safety advice, and we'd review you again to confirm completion."

B. Medical Management – Repeat Misoprostol

"We can give you **another dose of misoprostol**, the same medication used earlier.
This helps the womb contract and pass the remaining tissue.
It's taken either as a tablet or inserted vaginally, and it may cause bleeding, cramping, and tissue passage within hours.
We'll offer pain relief and clear instructions on what to expect."

C. Surgical Management – Manual Vacuum Aspiration (MVA)

"We can perform a **minor procedure** where we remove the tissue using a gentle suction method.
It's called **manual vacuum aspiration**, usually done under local or general anaesthetic.
It's quick, safe, and effective—some women prefer this option for faster resolution, especially if they're emotionally or physically tired."

"There's no single right choice—just what feels best for you. Some women prefer to wait and avoid intervention; others want to move on quickly. You can take some time to think about it."

7. Additional Steps

Infection Screening

"We'll take a **vaginal swab** today to check for any infection. This is standard."

Antibiotics (If infection is confirmed)

"If infection is detected, we'll treat it with **doxycycline and metronidazole**, which are commonly used antibiotics."

Pain Relief

"We'll also provide **painkillers** like paracetamol or ibuprofen, and stronger options if needed."

Follow-Up

"You'll be seen again in clinic or contacted by phone to confirm everything has resolved. If symptoms continue or worsen, we can repeat the scan or change the plan."

8. Safety Netting

"If you develop **heavy bleeding** (soaking a pad per hour), **severe pain**, **fever**, or **foul-smelling discharge**, please come back immediately or go to A&E. These could be signs of infection or heavy blood loss, and we'd want to act early."

9. Offer Leaflet & Final Check

"I'll give you a leaflet that explains what incomplete abortion is and details each treatment option.
Would you like me to go over anything again, or is there anything else on your mind right now?"

Teenage Pregnancy with Vomiting

Setting: Emergency Department (A&E)
Patient: 15-year-old girl
Presenting Complaint: Vomiting for one day

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1. Introduction & Consent

Greet the patient politely.
Confirm name and age.
"Would it be alright if we speak privately for a few minutes?" *(You may ask parents to wait outside, depending on context. This is appropriate for contraception and pregnancy-related conversations, even in minors.)*

2. Presenting Complaint

"I understand you've been feeling sick today. Can you tell me more about the vomiting?"
Duration: "When did it start?"
Frequency: "How many times have you vomited?"
Description: "Was there anything unusual in the vomit? Any blood?"
Severity: "Has it stopped you from eating or drinking today?"
Triggers: "Anything that made it worse or better?"

3. Red Flag Screening

Head/Neuro: "Any headaches, dizziness, or changes in your vision?"
ENT: "Any earache, ringing, or feeling off-balance?"
GI: "Any tummy pain, diarrhoea, or changes in bowel habits?"
GU: "Any pain or burning when you pee? Any unusual smell or colour?"
Pregnancy Symptoms:
"When was your last period?"
"Do you think there's any chance you could be pregnant?"
If hesitant: "Are you sexually active?"

If she hesitates or becomes worried, reassure again:
"Whatever you tell me stays between us. I'm only asking to make sure we can give you the right care."

4. Sexual and Relationship History (Only if she consents)

"Are you currently in a relationship?"
"How long have you been with your boyfriend?"
"How old is he?" *(Safeguarding relevance)*
"Do you use any protection like condoms?"
"Do your parents know about your relationship?"
"Has your partner ever been aggressive or made you feel unsafe?"

5. ICE

Ideas: "What do you think is causing the vomiting?"
Concerns: "Is there anything in particular that you're worried about right now?"
Expectations: "What were you hoping would happen during this visit?"

6. Examination

BP, HR, Temp, RR, SpO_2
General appearance: hydration, distress
Abdominal exam if pain is reported

Urine pregnancy test

Result Disclosure

"We've done a pregnancy test, and it's come back positive. That means you're pregnant."

Pause, check how she reacts

"I can see this might come as a surprise — take your time, and I'll support you through this."

Explanation

"What you're experiencing — the vomiting — is likely a symptom called **morning sickness**, which happens in early pregnancy. In some women, it can become more severe. You've come in early, and we can help you feel better."

Management Plan

1. Treat the Vomiting

"We'll give you an anti-sickness (e.g., Prochlorperazine, Cyclizine, or Ondansetron) medicine that's safe in early pregnancy."

"We'll also monitor you here briefly to make sure you can keep down some fluids."

2. Emotional Support & Next Steps

"You don't have to make any decisions today — but we do recommend that you book an appointment with your **GP in the next few days**."

"Your GP will help you access pregnancy care and talk through your options if needed."

"There's also a service called **NUPAS** — the National Unplanned Pregnancy Advisory Service. They offer free, confidential support and will go through all options like continuing the pregnancy, adoption, or ending the pregnancy."

If she asks about abortion, you can say:

"That's something you can discuss in full with the clinic or your GP. They'll make sure you have all the information, and the decision is completely yours."

3. Safeguarding (if relevant)

If concerns about coercion, abuse, or unsafe home arise → escalate quietly to senior/safeguarding lead

If no safeguarding concerns and the patient is Gillick competent → maintain confidentiality

Safety Netting

"If the vomiting worsens — for example, if you can't eat or drink anything, feel dizzy, or start losing weight — please come back straight away or call 111."

"If you feel unsafe or are not sure who to talk to, come see your GP or return to A&E. You'll always be taken seriously."

Closing

"You've done the right thing by coming in today. You're not alone — there are people who will support you whatever you choose."

"Would you like written information about NUPAS or where to get more help?"

"Is there anything else on your mind right now?"

Hyperemesis gravidarum

Setting: Antenatal Assessment Unit or GP Surgery
Role: FY2 Doctor
Patient: 25-year-old woman
Presentation: Persistent vomiting for 2–3 weeks during early pregnancy (now 12 weeks gestation)

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1. Introduction & Consent
"Hi, I'm Dr [Name], one of the doctors here today. I understand you've been having persistent vomiting during your pregnancy. I'd like to ask you a few questions to understand more about what's going on and how we can help—would that be alright?"

2. Presenting Complaint
"How long have you been vomiting?"
"How often do you vomit each day?"
"What does the vomit look like—any blood or bile?"
"Are there specific times or triggers, like mornings or after eating?"
"Are you keeping any food or fluids down?"

3. Dehydration & Severity Assessment
"Have you noticed any dizziness or light-headedness, especially when standing?"
"Any dry mouth, cracked lips, or reduced urination?"
"Do you know if you've lost weight since this started?"
Note: Weight loss >5% of pre-pregnancy weight suggests hyperemesis

4. Risk Factor Screening
"Is this your first pregnancy?"
"Are you carrying twins or just one baby?"
"Has anyone in your family—like your mum or sister—had severe vomiting during pregnancy?"
"Do you know what your weight or BMI was before the pregnancy?"
"Do you have any long-term conditions like asthma or thyroid problems?"

5. Functional & Life Impact
"Have you been able to eat or drink anything at all?"
"Is this affecting your ability to work, rest, or do daily activities?"

6. Examination Findings to Request
(For exam setting, summarise findings)
Weight loss: Confirm percentage change from booking weight.
Urine dipstick: Request ketones (presence indicates starvation).
Vital signs: Check pulse, BP, temperature (signs of dehydration).
Check hydration status: Capillary refill, mucous membranes.

7. Provisional Diagnosis
"Based on your symptoms—frequent vomiting, difficulty eating or drinking, and weight loss—it looks like you're experiencing **hyperemesis gravidarum**.
This is a more severe form of nausea and vomiting in pregnancy, and it can lead to dehydration and nutritional deficiencies if not managed properly."

8. Explanation
"Hyperemesis gravidarum is a condition where the hormonal changes in early pregnancy cause excessive nausea and vomiting.
It's more intense than usual morning sickness and can affect your ability to stay hydrated or nourished.
This isn't harmful to the baby in most cases—but **if it continues untreated**, it may increase the chance of **low birth weight**. The good news is that with prompt treatment, we can reduce these risks."

9. Management Plan
A. Admission to Maternity Unit
"Because you're struggling to eat and may be dehydrated, I'd recommend we admit you to the hospital for supportive treatment."

B. In-Hospital Management
IV Fluids – "To rehydrate you and replace electrolytes."
IV Thiamine (Vitamin B1) – "To prevent deficiencies like Wernicke's encephalopathy."
IV Antiemetics – "To control the vomiting—options include cyclizine, ondansetron, or metoclopramide."
Steroids (e.g. prednisolone) – "If anti-sickness medications aren't working well."
Lansoprazole or omeprazole – "To reduce stomach acid and prevent further irritation."
LMWH (e.g. dalteparin) – "A blood thinner to prevent clots, which can form more easily if you're dehydrated and less mobile."

C. Investigations & Monitoring
FBC, U&E, LFTs, CRP – rule out other causes of vomiting and monitor electrolytes
Early pregnancy **ultrasound scan** – confirm gestation, exclude molar pregnancy or twins
Monitor input/output and daily weight

D. Discharge & Follow-Up
"Once you're able to keep food and fluids down and feel stronger, we'll discharge you with oral antiemetics and a follow-up plan."
GP or midwife review to monitor progress, weight gain, and recurrence
Dietician referral if prolonged nutritional concern

10. Reassurance & Support
"I know this has been exhausting, but please know this is a **recognised medical condition**, and many women recover fully after the early pregnancy stage.
Our goal is to support you, reduce the vomiting, and make sure both you and the baby stay healthy. You're not alone—and we'll help you through this."

11. Safety Netting
"If you notice worsening vomiting, dizziness, very dark urine, or you're unable to drink again after discharge, please come back to A&E or call your midwife urgently. We'd rather see you early than risk further dehydration."

12. Offer Leaflet & Final Check
"I'll give you a leaflet that explains hyperemesis gravidarum, what to expect, and where to get help. Would you like me to go over anything again or answer any questions before we get started?"

Pre-eclampsia

Setting: Antenatal Clinic or Maternity Unit
Role: FY2 Doctor
Patient: 28-year-old woman, 36 weeks pregnant
Reason for Review: Routine antenatal follow-up; midwife noted high BP and proteinuria

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1. Introduction & Consent
"Hello, I'm Dr [Name], one of the doctors working here in the maternity unit. I understand you're here for your routine antenatal check-up today.
Before we continue, can I confirm your full name and how many weeks along you are?"
"I'd just like to ask you a few questions about how you've been feeling lately, and then I'll explain what we'll do next. Is that alright?"

2. Focused History – Data Gathering
A. Symptom Screening for Pre-eclampsia
"Have you noticed any of the following recently?"
- Headaches (especially front of head)?
- Visual changes—like blurred vision or flashing lights?
- Pain in your upper tummy or under your ribs?
- Feeling sick, dizzy, or generally unwell?
- Swelling in your hands, face, or feet?
- Chest tightness or shortness of breath?
- Any changes in your baby's movement?

B. Obstetric History
- "Is this your first pregnancy?"
- "Have you had any complications in this or any previous pregnancies?"
- "Have all your antenatal appointments been normal until now?"

C. Medical & Family History
- "Do you have any long-term conditions like diabetes, thyroid problems, or kidney issues?"
- "Any family history of high blood pressure in pregnancy?"

D. Medications & Allergies
- "Are you taking any regular medications, like aspirin or vitamins?"
- "Do you have any allergies?"

E. ICE – Ideas, Concerns, Expectations
- "Has anyone explained what today's check-up might involve?"
- "Is there anything that's been worrying you lately?"
- "What were you hoping we'd do for you today?"

3. Examination
"I'd now like to check a few things to understand how you and your baby are doing.
I'll recheck your blood pressure, listen to your baby's heartbeat, and look for signs of swelling in your hands or feet.
I'll also check your reflexes, which helps us assess if the blood pressure is affecting your nervous system."

(Assume BP remains ≥140/90 and protein is confirmed in urine)

4. Provisional Diagnosis
"Thanks for going through all of that.
Based on your blood pressure and the protein we found in your urine, along with how far along you are in your pregnancy, we're concerned that you may have a condition called **pre-eclampsia**."

5. Explanation of Pre-eclampsia
"Pre-eclampsia is a pregnancy-related condition where your blood pressure becomes high and starts affecting other parts of the body—like your **kidneys, liver, and even the placenta**. That's why we see protein leaking into your urine.
If left unmanaged, pre-eclampsia can lead to serious complications for both you and your baby, including **seizures** (called eclampsia), **organ damage**, or **reduced oxygen supply to the baby**.
But the good news is: we've picked it up early, and with the right monitoring and treatment, we can manage it safely."

6. Structured Management Plan
A. Admission for Monitoring
"We'd like to admit you to the maternity ward to keep a closer eye on both you and the baby."
- Monitor BP regularly (4-hourly)
- Track urine output
- Monitor for any worsening symptoms (headache, vision, pain, foetal movement)

B. Investigations
"We'll do some **blood tests** to check how your liver, kidneys, and clotting system are coping."
- FBC, U&E, LFTs, platelets
- Confirm proteinuria (24-hour collection or protein/creatinine ratio)

C. Medication – Blood Pressure Control
"We'll start you on a medication called **labetalol** to help lower your blood pressure. It's safe during pregnancy and helps protect your organs and the baby."
- Alternatives if contraindicated: nifedipine, methyldopa

D. Seizure Prevention (If Severe)
"If your blood pressure rises further or we see signs that your condition is worsening, we may give a medicine called **magnesium sulphate** to reduce the risk of seizures.
This is only used when really needed, and we'll explain everything clearly if that point comes."

E. Foetal Monitoring
"We'll monitor your baby using a machine called a CTG to make sure the baby's heart rate and movements remain healthy."
- Consider Doppler scan for foetal blood flow
- Growth scan to check amniotic fluid and foetal weight

F. Planning Delivery
"At 36 weeks, your baby is considered almost full-term. Depending on how your condition progresses, we may plan to **induce labour** soon."

"If there are urgent concerns, a **C-section** might be the safest option."
"This decision will be made together with the senior obstetric team after reviewing your condition daily."

7. Responding to Concerns
If Patient Refuses Admission
"I understand this may be unexpected or inconvenient. Can I explain why it's important?"
"Without treatment, pre-eclampsia can progress rapidly and lead to seizures or serious complications.
We can only monitor and treat it safely if you're in hospital. The aim is to keep both you and the baby safe, and to act early if anything changes."

If Patient Requests Water Birth
"That's a very good question—and I know you may have had preferences around your birth plan. But with pre-eclampsia, a **water birth is not considered safe**. Here's why:
We need to monitor your baby's heartbeat and your blood pressure closely.
There's a small risk of seizures, and we'd need to act quickly if that happens.
Water delivery would delay emergency care if complications occur."
"We'll still do our best to accommodate your preferences in other ways—but your safety is our first priority."

8. Safety Netting
"Please let us know immediately if you feel worse—especially if you get new headaches, visual changes, tummy pain, or feel that your baby isn't moving as much.
You're in the right place, and we'll be keeping a close watch."

9. Reassurance & Closing
"You've done the right thing by coming in. Pre-eclampsia can sound scary, but with close monitoring and treatment, most women and babies do very well.
We'll support you every step of the way.
Do you have any questions you'd like me to go over again?"

Student Note: Pre-eclampsia Management by Gestational Age

At 28 Weeks – Very Preterm
Goal: Delay delivery safely to allow fetal maturation
Admission: Yes – **mandatory**
Monitoring:
Maternal: BP every 4 hours, urine output, bloods (FBC, U&E, LFTs, clotting)
Fetal: CTG, growth scan, umbilical artery Doppler, amniotic fluid assessment
Treatment:
Antihypertensives: Labetalol (1st-line), nifedipine or methyldopa as alternatives
Magnesium sulfate: For seizure prophylaxis if severe features present
Steroids: **Yes** — Give corticosteroids to enhance fetal lung maturity
Delivery?: **Only if severe** (e.g., uncontrolled BP, HELLP, eclampsia, fetal compromise)
Referral: To maternal-fetal medicine specialist
Plan: Monitor closely, aim to continue pregnancy until 32–34 weeks if stable

At 34 Weeks – Late Preterm
Goal: Monitor and plan delivery depending on maternal and fetal status
Admission: Usually yes — especially if BP >140/90 or complications
Monitoring:

Same maternal and fetal surveillance as above
Twice-weekly assessments often required

Treatment:
Antihypertensives and **magnesium sulfate** if indicated
Steroids: **Yes** — administer if delivery is anticipated within 7 days
Delivery?: Consider **planned delivery** if:
Severe disease
Worsening bloods or symptoms
Fetal growth restriction or distress
Otherwise aim to delay to **37 weeks**

At 36 Weeks – Early Term
Goal: Plan for delivery, balance risk of progression with prematurity
Admission: May be outpatient if mild and monitored
Monitoring:
Daily BP if outpatient; regular labs and fetal monitoring
Treatment:
Antihypertensives continued
Steroids: **Not routinely needed** at this stage
Delivery?:
Offer **planned delivery at 37 weeks**
Consider **earlier delivery** if disease worsening or fetal concerns

At 38 Weeks – Full Term
Goal: **Deliver** — avoid further maternal and fetal risk
Admission: Usually for induction
Monitoring:
Routine intrapartum monitoring
Treatment:
Antihypertensives continued
Magnesium sulfate **only if severe disease or eclampsia risk**
Delivery?: Yes — **plan induction of labour or C-section** depending on obstetric factors

Ectopic Pregnancy

Condition: Suspected Ectopic Pregnancy
Structure: Counselling + Test Result Discussion
Scenarios:
- GP Setting – Urgent Referral + Ambulance Refusal
- Hospital (EPAU) Setting – Overnight Admission Refusal

Scenario : GP SETTING

Setting: General Practice
Role: FY2 GP
Patient: 21-year-old woman
Presenting Complaint: Lower abdominal pain, LMP 6 weeks ago
Findings: Positive pregnancy test

1. Introduction & Consent
"Hi, I'm Dr [Name], one of the doctors here today. I understand you've been having some lower tummy pain—thank you for coming in.
Before we go further, could I confirm your name and age?"
"I'd like to ask a few questions, check a couple of things, and then we'll discuss what could be causing your symptoms and how to move forward. Is that alright?"

2. History – Data Gathering
A. Presenting Complaint
"When did the pain start?"
"Where exactly is it? Is it one-sided?"
"Does it come and go or stay constant?"
"Any vaginal bleeding or spotting?"
"Have you had any shoulder tip pain or felt dizzy or faint?"

B. Menstrual & Pregnancy History
"When was your last period?" *(6 weeks ago)*
"Are your cycles usually regular?"
"Have you done a pregnancy test?" *(Positive)*
"Have you been pregnant before?"

C. Sexual & Contraceptive History
"Are you in a relationship?"
"Do you use contraception?" *(Condoms, inconsistently)*
"Any past pelvic infections or gynaecological surgeries?"

D. ICE
"What's been going through your mind about this pain?"
"Are you worried it could be something serious?"
"What were you hoping I could do for you today?"

3. Examination
"I'd like to check your blood pressure, pulse, and temperature.
I'll also gently examine your tummy to see where the pain is, and we'll do a urine dipstick. I'd also like to confirm your pregnancy test."
(Vitals stable, mild tenderness, pregnancy confirmed)

4. Explanation of Findings & Working Diagnosis
"Thanks for letting me examine you. Based on your symptoms—a missed period, one-sided abdominal pain, and a positive pregnancy test—we are concerned that this could be an **ectopic pregnancy**."
"That means the pregnancy may be growing **outside the womb**, usually in a fallopian tube. Unfortunately, this type of pregnancy **cannot survive**, and if left untreated, it can cause **internal bleeding**—which can be **life-threatening**."

5. Management Plan – Urgent Referral
"We need to send you to the hospital **immediately** for further assessment. They will:
– Do a **blood test** to check pregnancy hormone levels (β-hCG)

– Perform an **ultrasound scan** to locate the pregnancy
– Confirm whether it is ectopic and decide on treatment."

6. Addressing Ambulance Refusal
Patient: "I don't want an ambulance—it's too dramatic. I came with my boyfriend."
"I understand this feels overwhelming—but may I explain why this is urgent?"
"Ectopic pregnancy can **rupture suddenly**, even without warning.
If that happens on the way to hospital, you could **collapse** or go into **shock** from internal bleeding."
"In a private car, no one can monitor your condition or start emergency treatment.
With an ambulance, we can:
– Monitor your blood pressure
– Start fluids if needed
– Call ahead so the hospital team is ready when you arrive"
"This isn't about drama—it's about giving you the **safest possible journey** to the care you need."

7. Reassurance & Safety Netting
"You've done the right thing by coming in early, and we'll respect your privacy.
We won't contact anyone without your consent. You're in control of the decisions, but we're here to protect your health."

Red flags before transfer:
– Sudden severe pain
– Heavy vaginal bleeding
– Feeling faint or collapse
– Shoulder tip pain

8. Closing
"Can I call the ambulance now and inform the hospital you're coming? We'll make sure everything is arranged discreetly and safely."

Scenario: HOSPITAL (EPAU) SETTING

Setting: Early Pregnancy Unit
Role: FY2 Doctor
Patient: 21-year-old woman
Status: Awaiting scan (booked for next morning), refusing admission

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1. Introduction & Rapport
"Hi, I'm Dr [Name], one of the doctors on the unit. I understand you've come in with some tummy pain and are waiting for a scan tomorrow.
Is now a good time to have a chat about your symptoms and the next steps?"

2. Clarify Current Condition
"Are you still having pain?"
"Any bleeding or spotting now?"
"Any dizziness or faintness since arriving?"
"How are you feeling emotionally right now?"
Continue history and examination as in the first scenario

3. Explanation of Likely Diagnosis
"We're concerned this may be an **ectopic pregnancy**.
That means the pregnancy may have implanted **outside the womb**, usually in the fallopian tube.
These pregnancies are not viable and can **burst at any time**, causing **sudden, severe internal bleeding**."

4. Justification for Overnight Admission
"Your scan is booked for **tomorrow morning**, but we're asking you to **stay in hospital overnight** so we can monitor you."
"Even though you're stable now, an ectopic pregnancy can **rupture without warning**.
If that happens while you're at home, the bleeding could be so fast and severe that you might not make it back in time for emergency treatment."
"Here in the hospital, we can monitor your vitals, check your symptoms, and act **immediately** if anything changes.
It's about **protecting your life**."

5. Addressing Refusal to Stay
Patient: "I can't stay. My parents will find out. They'll be so angry."
"I'm really sorry you're feeling that way. I want to reassure you that **we won't tell anyone** without your permission.
Your care is confidential—even from your parents."
"Right now, the risk to your health is significant. If something happens overnight, being at home could delay the treatment you need and lead to life-threatening complications."

6. Treatment Options (Once Confirmed)
"If the scan confirms an ectopic pregnancy, we'll consider two possible treatments:"
A. Surgical Management (most common)
"Usually done via **keyhole surgery** under general anaesthesia"
"The affected fallopian tube is either repaired or removed"
"You'd be monitored afterwards, with pain relief and support"

B. Medical Management (if stable and criteria met)
"A medication called **Methotrexate**, which stops the pregnancy from growing"
"Given as an injection, followed by serial blood tests over 2–3 weeks"
"Only used if you're clinically stable, early in pregnancy, and no rupture has occurred"

7. Safety Netting & Red Flags
"If you feel worse at any time—more pain, bleeding, dizziness, shoulder tip pain, or feel faint—press the call bell or tell a nurse **immediately**."

8. Reassurance & Closing
"You're not alone, and I know this is a lot to take in. But please know that we're here to **protect your life**, not to judge you or disclose anything.
Staying overnight gives us the chance to act early, if needed, and gives you the best chance of staying safe."
"Can I speak with the team and arrange for your stay tonight?"

Chronic Anal Fissure in Pregnancy

Setting: GP Surgery
Role: FY2 Doctor

Patient: Pregnant woman (late 2nd or 3rd trimester)
Presenting Complaint: "Bleeding down below"
Diagnosis: Chronic Anal Fissure

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1. Introduction
"Hi, I'm Dr [Name], one of the doctors here today. It's nice to meet you.
Can I check your full name and age, please?"
"What's brought you in today?"
Patient: "I've had some bleeding down below."
"Thanks for sharing that. Just to understand a bit more—is the bleeding coming from the front passage or the back passage?"
Patient: "It's from the back passage."
"Alright, thank you for clarifying. Let's talk through it and figure out what's going on."

2. Focused History – Rectal Bleeding
"When did you first notice the bleeding?"
"Does it happen every time you go to the toilet or just occasionally?"
"Would you say it's a small amount or more than that?"
"Is the blood bright red? Is it mixed with the stool or separate?"
"Do you notice pain—especially sharp or burning pain—when passing stools?"
"Any clots, mucus, or dripping afterwards?"

3. Screening for Contributing Factors
A. Bowel & GI
"Have you had constipation or been straining recently?"
"Any diarrhoea or frequent loose motions?"
"Any changes in appetite, weight, or energy levels?"

B. Previous Issues
"Have you had piles or similar bleeding in the past—maybe in a previous pregnancy?"
"Any history of anal tears, fissures, or surgeries?"

C. Other Medical Considerations
"Are you on any medications that could increase bleeding, like aspirin or blood thinners?"
"Any recent infections or testing for STIs?"

D. Anaemia Screening
"Have you been feeling unusually tired, dizzy, or lightheaded lately?"

4. Pregnancy-Specific Context
"How many weeks pregnant are you?"
"Have there been any complications so far?"
"Any issues with constipation or haemorrhoids earlier in this pregnancy?"

5. Full History – MAFTOSA
Medications: Folic acid, iron, laxatives?
Allergies: Any medication allergies?
Past medical issues: Anaemia, IBS, thyroid?

Drugs/alcohol/smoking: Lifestyle screening
Occupation: Sedentary work?
Support: Home and partner support?

ICE

Ideas: "What do you think might be causing the bleeding?"
Concerns: "Is there anything you're worried this could be?" (e.g. cancer, harm to baby)
Expectations: "What were you hoping I could do for you today?"

Effect on Life

"Has the pain made you avoid going to the toilet or change your diet?"
"Is it affecting your sleep or daily routine?"
"Has it caused any anxiety or fear around passing stool?"

6. Examination

"To confirm what might be causing the bleeding, I'd like to examine the area gently.
This would involve having a quick external look at the back passage to check for any tears, swelling, or signs of inflammation. Would that be okay with you?"
(Findings: small posterior midline tear, possible skin tag, no haemorrhoids or swelling)

7. Diagnosis

"Based on everything you've told me and what I saw on examination, this looks like a **chronic anal fissure**. That's a small split in the skin just inside your back passage.
It often happens when someone passes hard stool or strains—and in pregnancy, it's quite common due to hormonal changes slowing digestion and causing constipation."
"The bleeding is usually bright red, and the pain can be sharp or burning during bowel movements."

8. Management Plan

First-Line: Conservative (FFE)

"We'll start with simple but effective steps to soften your stools and reduce straining."

Fluids: "Drink at least 2 litres of water a day—more if you're active or it's hot."
Fibre: "Include fruits, vegetables, oats, and wholegrains."
Exercise: "Even gentle walking daily helps with bowel movement."

Second-Line: Pregnancy-Safe Stool Softeners

"If that's not enough, we can add a stool softener to make things easier."

Lactulose: Safe in pregnancy, draws water into the bowel
Fybogel: Natural fibre supplement to bulk and soften stool

Patient concern: "Is it safe during pregnancy?"
"Yes—both are commonly used and considered safe for pregnant women."

Note: For a *chronic* anal fissure, if conservative measures are insufficient, **topical treatments** are typically considered before or alongside the mentioned second-line options (egs. topical glyceryl trinitrate (GTN) ointment).

9. Self-Care & Practical Tips

"Try to go to the toilet when the urge comes—don't delay it."
"Avoid sitting too long or straining on the toilet."

"Use soft toilet paper or moist wipes—pat gently rather than rubbing."
"You can take a warm bath after bowel movements—it helps soothe the area and encourages healing."
"Avoid strong soaps or perfumed wipes which might irritate the skin."

10. Safety Netting
"Please come back or call us if you notice any of the following:"
Pain becomes severe or unmanageable
Bleeding becomes heavy or persistent
Signs of infection: swelling, pus, fever, or chills
No improvement in 7–10 days, even after using stool softeners

11. Follow-Up Plan
"Let's give this a week or so with diet and fluids.
If it's still painful or hasn't healed, we'll try medication or discuss a referral after pregnancy if needed."
"Most fissures heal with these measures, but if it doesn't, we have more options after delivery."

12. Reassurance & Closing
"I know it's not an easy thing to talk about, so thank you for sharing it.
Anal fissures in pregnancy are common, and most heal with simple measures like these.
You've taken the right step by coming in early—and we'll keep supporting you throughout."
"Would you like me to write these points down for you?
Is there anything you'd like me to go over again?"

Low-Lying Placenta – Test Result Discussion

Setting: Antenatal Clinic
Role: FY2 Doctor
Patient: 29 years old
Gestation: 20 weeks
Scenario Type: Test Result Discussion + Reassurance + Pregnancy Counselling
Scan Result: Transvaginal scan shows placenta edge <20 mm from cervix

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1. Introduction & Consent
"Hi, I'm Dr [Name], one of the doctors in the antenatal team. I understand you're here for your routine check-up.
Before we go through your results, is it okay if I ask a few quick questions to check how things have been going?"

2. Focused History & Context
"Can I check how many weeks along you are now?" *(20 weeks)*
"Have there been any concerns in this pregnancy so far?"
"Any bleeding, spotting, abdominal pain, or contractions?"
"Any issues with blood pressure, blood sugar, or severe vomiting?"
"Have you had any scans or tests before this one?" *(This was routine anomaly scan)*

3. Screening for Risk Factors of Placenta Previa
"Have you had any previous pregnancies, caesarean sections, or uterine surgeries?"
"Any past abortions or IVF/conception assistance?"
"Do you smoke or use any recreational drugs?" *(e.g., cocaine)*
"Any painless vaginal bleeding so far?"

4. ICE – Ideas, Concerns, Expectations
"Has anyone explained the scan results to you yet?" *(Patient: "No, just said they'll explain today.")*
"Is there anything in particular you were worried this might mean?"
"What were you hoping we'd talk about today?"

5. Clear Result Disclosure
"Thanks for your patience. I've reviewed the scan, and I can see that the **placenta is lying a bit low**, and its edge is currently **less than 20 mm from the cervix**. This is what we call a **low-lying placenta** at this stage."

6. Explanation of the Condition
"The placenta is the organ that provides nutrients to your baby, and it's attached to the wall of the womb. In your case, it's a little closer to the opening of the womb (the cervix) than we'd normally expect."
"This isn't uncommon—especially at 20 weeks. In fact, in **9 out of 10 women**, the placenta naturally moves upward as the uterus grows."
"So right now, we're not too concerned, but we do need to **keep an eye on it**."

7. Structured Management Plan
A. Monitoring and Follow-Up
"We'll repeat a **transvaginal scan around 32 weeks** to check if the placenta has moved away from the cervix."
"If it still looks low at that point, we'll check again at **36 weeks** to help us plan your delivery safely."

B. Delivery Planning
"If the placenta has moved up by then—which it usually does—you'll be able to have a **normal vaginal delivery** if you want one."
"But if it's still within 20 mm of the cervix at 36 weeks, the safest option may be a **planned caesarean delivery**."

C. Activity Advice
"We recommend **avoiding vaginal intercourse** or anything that could put pressure on the cervix for now."
"There's no need for bed rest or restrictions on walking or gentle activity, unless advised otherwise."

8. Addressing Common Concerns
"Is my baby okay?"
"Yes, everything else on your scan looks healthy. A low-lying placenta does not usually affect the baby's growth or development."

"Do I have to deliver by C-section?"
"Not necessarily. Most cases resolve by 32 weeks. We'll only suggest a caesarean if the placenta is still covering or too close to the cervix near your due date."

"Can I have sex?"
"Until we reassess at 32 weeks, we advise **avoiding sexual intercourse** or anything that may disturb the cervix, just to minimise the risk of bleeding."

10. Safety Netting
"If you experience any of the following, please contact your midwife or come to the hospital straight away:"
Any vaginal bleeding or spotting

Abdominal pain or tightness
Contractions or pressure in the pelvis
Reduced baby movements later on

11. Follow-Up Plan
"We'll arrange the next scan at 32 weeks to reassess the placenta's position. Based on that, we'll decide if further scans or delivery planning are needed."

12. Offer Leaflet & Final Check
"We have a leaflet about low-lying placenta that goes over everything we discussed. I'll give you a copy before you leave so you can read it in your own time."
"Do you have any other questions or anything you'd like me to go through again?"

Urinary Tract Infection (UTI) in Pregnancy

Setting: GP Surgery
Role: FY2 Doctor
Patient: 30 years old, 29 weeks pregnant
Presentation: Suprapubic pain, dysuria, urinary frequency

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1. Introduction
"Hi, I'm Dr [Name], one of the doctors here today. It's nice to meet you. Could you tell me what's brought you in today?"
Patient: "I've been having some lower tummy pain."
"Thanks for letting me know. Let's explore that together — I'll ask a few questions to understand what might be going on."

2. Presenting Complaint – Pain Clarification (SOCRATES)
Site: Suprapubic
Onset: Gradual onset
Character: Dull
Radiation: None
Associated: Dysuria, frequency
Timing: Persistent
Exacerbating: Worse during urination
Severity: 5/10

3. Red Flag & Differential Screening
Urinary Tract Infection
"Any burning when you pass urine?" → *Yes*
"Going more frequently?" → *Yes*
"Any change in smell or colour?"
"Any blood in the urine?"
Renal Colic
"Any pain in the back or sides?"
"History of kidney stones?"
Obstetric / Preterm
"Any contractions, tightening, or bleeding?"
"Any fluid leaking or reduced baby movements?"

4. Pregnancy History

"How far along are you now?" → *29 weeks*
"How has the pregnancy been so far?"
"Any history of high BP or gestational diabetes?"
"Have you been attending your antenatal visits regularly?"

5. PMAFTOSA

Past Medical History: No known issues
Medications: None
Allergies: To penicillin? → *None*
Family History: Any kidney disease, diabetes?
Treatment History: Previous UTIs?
Obstetric: First pregnancy
Social: No smoking, no alcohol
Appetite/Sleep: Well
Support: Partner at home

6. ICE – Ideas, Concerns, Expectations

"What do you think might be causing the pain?"
"Are you worried this might affect your baby?"
"What were you hoping I could do for you today?"

7. Examination

"With your consent, I'd like to check your vital signs, gently examine your tummy, and test your urine."

Vitals: BP, HR, Temp, O2
Abdomen: Soft, mild suprapubic tenderness
Urine dipstick: Nitrites and leukocytes positive → suggestive of UTI

8. Provisional Diagnosis

"From what you've told me — and based on the findings — it looks like you've developed a **urinary tract infection**, which is common in pregnancy."

9. Explanation of Diagnosis

"A UTI is an infection in your bladder or urinary tract. In pregnancy, hormonal changes and pressure from the growing womb can make these infections more likely.
Common symptoms include pain while urinating, going more frequently, and discomfort in the lower tummy.
The good news is: it's easily treatable and we've caught it early."

10. Management Plan

"To manage this safely, we'll do the following:"

A. Investigations

Send urine sample for **culture and sensitivity**
If systemic signs: consider FBC, U&Es

B. Antibiotics – Empirical

"We'll start you on **Cefalexin**, which is safe in pregnancy and effective against common bacteria."

Cefalexin 500 mg BD for 7 days (empirical first choice in late pregnancy)
Modify based on culture results if needed

"We'll avoid options like Nitrofurantoin at this stage of pregnancy, and Trimethoprim is avoided earlier in pregnancy."

C. Supportive Advice

"Drink plenty of fluids to help flush the infection"
"Take paracetamol if needed for discomfort"
"Try to urinate regularly — don't hold it in"

11. Patient Concerns

"Is this dangerous for my baby?"

"No — if treated promptly, it's very unlikely to cause any problems. Untreated UTIs can sometimes lead to more serious infections, so we treat early to avoid that."

"Is the antibiotic safe?"

"Yes. Cefalexin is one of the most commonly used antibiotics in pregnancy. It won't harm your baby."

12. Safety Netting

"Please contact us or come in urgently if you develop:"

Fever or chills
Vomiting
Pain in your flanks or back
Worsening symptoms or no improvement in 48–72 hours

13. Follow-Up

"I'd like to review you in **5 days** to make sure symptoms are settling.
We'll also check your urine culture and change antibiotics if needed."

14. Leaflet & Closing

"Before you go, I'll give you an NHS leaflet about UTIs in pregnancy that explains everything we discussed."
"Is there anything you'd like me to go over again?"

Recommended Antibiotics for UTI in Pregnancy – By Trimester

Trimester	*Recommended Antibiotics*	*Avoid*
1st Trimester	**Cefalexin** (safe) **Amoxicillin** (if culture sensitive)	**Trimethoprim** (teratogenic, folate antagonist)
2nd Trimester	**Cefalexin** **Nitrofurantoin** (safe up to 36 weeks)	**Trimethoprim** (unless folate 5 mg given)
3rd Trimester	**Cefalexin** **Amoxicillin** (if appropriate)	**Nitrofurantoin** (risk of neonatal haemolysis) **Trimethoprim**

Clinical note: While some sources (BNF, UKTIS) permit nitrofurantoin up to 36 weeks, **NICE CKS currently advises avoiding nitrofurantoin in the third trimester** due to risk of neonatal haemolysis. This book follows the stricter NICE wording for PLAB 2 alignment.

Chickenpox Exposure at 36 Weeks

Setting: GP Clinic
Role: FY2 Doctor
Patient: 28-year-old, 36 weeks pregnant
Presenting Concern: (Discovered during consultation: Son diagnosed with chickenpox)

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1. Clarify the Concern

Greet warmly, confirm identity, and open neutrally:
"Hi, I'm Dr [Name], one of the doctors here today. How can I help you today?"
Let the patient explain her concern:

"My 3-year-old son has just been diagnosed with chickenpox. I'm 36 weeks pregnant and worried."

Gently reflect and clarify:
"I see — thank you for sharing that. Just to clarify, has your son had a formal diagnosis from a GP?" "And is your main concern whether this might affect your pregnancy?"

2. Assess the Background

Chickenpox Exposure History

"When did his rash start?"
"Any fever or other symptoms before that?"
"Is he at home with you now?"
"Do you know if he's been started on any medication or cream?"

Patient's History

"Have you ever had chickenpox yourself?"
→ *(She says yes – had it in childhood)*
"Have you had any recent symptoms — like rash, fever, aches, or feeling unwell?"
→ *(No symptoms currently)*

Pregnancy History

"How far along are you now?" → *36 weeks*
"Have there been any problems so far in your pregnancy?" → *No*
"Have you been attending your antenatal appointments?" → *Yes, all fine*

PMH/Meds/Allergies

"Any other medical conditions?"
"Any medications or supplements?"
"Any allergies?"

ICE

"What are you most worried about today?"
"Is there anything in particular that you're expecting from today's visit?"

3. Respond with Explanation

"Thanks for sharing all that. Based on what you've told me, I can reassure you about a few things."

Explanation

"Because you've had chickenpox before, your body is likely to have developed **natural immunity** to the virus."
"That means the risk of you catching it again is **extremely low**, and it's **very unlikely to harm your pregnancy**."

"At 36 weeks, your baby is already **fully developed** in terms of organs — so the risk of complications is also **extremely small**, even if you were to be exposed."

If She Was Uncertain About Her Chickenpox History:

"If someone isn't sure whether they've had chickenpox, we can do a simple **blood test** to check for immunity — it's called a VZV IgG test."

If immune (IgG positive): No action

If not immune (IgG negative): Consider **VZIG (immunoglobulin)** within 10 days of exposure → *Escalate to obstetrics*

4. Empower with a Plan + Prevention + Safety Netting

Reassurance:

"You don't need to isolate yourself from your son — it's absolutely fine for you to continue caring for him."

Safety-Netting:

"If you notice **any symptoms** in yourself like a rash, fever, or generally feeling unwell — please contact your midwife or GP immediately."

"Make sure to mention your son's chickenpox diagnosis in case you need urgent assessment."

Next Steps:

"There's no need for any extra tests or scans at the moment."

"Just continue your regular antenatal care as planned."

Offer an **NHS leaflet**: *Chickenpox and Pregnancy*

Closing Statement

"You've done exactly the right thing by coming in today. Thankfully, because of your past immunity and the stage of pregnancy, the risk to you and your baby is very low."

"If anything changes or you feel unwell, don't hesitate to get in touch. Do you have any other questions or concerns I can help with?"

Genital Herpes in Pregnancy

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1. Introduction

Greet the patient:

"Good morning, my name is Dr. [Name], one of the doctors here today."

Confirm identity:

"Could I confirm your full name and your age, please?"

Build rapport and open:

"How can I help you today?"

Patient says:

"Doctor, I have a painful rash down below. I'm pregnant and I'm worried."

Reassure:

"Thank you for sharing this. Please don't worry — you've done the right thing by coming in, and I'll do my best to help you today."

2. Focused History

A. Explore Presenting Complaint (Morphology, Evolution, Symptoms)

"Can you describe the rash for me? What does it look like?"
"Is it painful, itchy, or causing any discharge?"
"Are the blisters fluid-filled or dry?"
"When did you first notice it?"
"Has the rash changed since you first saw it?"

B. Associated Systemic Symptoms

"Have you experienced any fever, body aches, or flu-like symptoms recently?"

C. Sexual History (Ask sensitively)

"Would it be alright if I asked you a few questions about your sexual health? It may help us understand the cause better."
"Have you had any new partners recently?"
"Have you or your partner had a history of cold sores, genital sores, or herpes before?"
"Do you use condoms during intercourse?"

D. Pregnancy Status

"How many weeks pregnant are you?"
"Have there been any complications during this pregnancy?"
"Are you receiving regular antenatal care?"

E. Medical, Medication, Allergy History

"Any known medical conditions?"
"Any medications you are taking currently?"
"Any allergies?"

F. Lifestyle History

"Do you smoke or drink alcohol?"

G. ICE (Ideas, Concerns, Expectations)

"Is there anything you are particularly worried about regarding this rash?"
"What were you hoping we could do for you today?"

H. Effect on Life

"Has this rash been affecting your day-to-day activities or comfort?"

3. Examination (Explain verbally if not allowed to actually examine)

Thank the patient for answering.
Explain examination plan:

"I'd now like to examine the area if that's okay with you. It shouldn't be painful, but may be a little uncomfortable. A female chaperone will be present, and I will maintain your dignity at all times. May I proceed?"

Exposure: lower body exposed appropriately while maintaining dignity.

Perform:

Visual inspection of the external genitalia:
Multiple small, painful vesicles or ulcers noted.
Check for inguinal lymphadenopathy if allowed.

Verbalise:

"On examination, there are multiple small fluid-filled blisters with surrounding redness, typical of genital herpes."

4. Provisional Diagnosis

"Based on your symptoms and what I can see, this is likely a **genital herpes infection**. It's caused by a virus known as herpes simplex."

5. Explanation

"This virus causes small painful blisters or sores around the genital area. It's quite common, and the virus stays dormant in the body, sometimes flaring up later.
Since you're pregnant, it's important we treat it promptly to protect both you and your baby."

6. Management Plan

Immediate Treatment

Start **Acyclovir** antiviral tablets:

"We'll start you on a course of acyclovir tablets. It's safe to use during pregnancy. You'll take it now for about 5-7 days."

Plan to restart suppressive Acyclovir at 36 weeks of pregnancy:

"We'll start you on another course of acyclovir at 36 weeks to continue until you deliver. This helps reduce the risk of a recurrence at the time of birth and helps protect your baby."

Symptom Relief

Pain management:

"You can take **paracetamol** safely for pain."

Prescribe **lidocaine cream** for local application to relieve soreness.

Specialist Referrals

GUM Clinic (Genitourinary Medicine):

"You'll be referred for confirmation of the diagnosis and partner notification if needed."

Maternity Assessment Unit (MAU):

"You'll also be seen by an obstetric consultant to ensure the pregnancy is monitored closely."

Delivery Planning

"Closer to delivery, the team will reassess. If there are active lesions near delivery time, they may recommend a **caesarean section** to protect the baby."

Partner Management

"It's important your partner also gets assessed and treated if needed, even if they don't have symptoms."

Education and Prevention

Avoid sexual activity during active outbreaks.
Use condoms even when asymptomatic.
Wash hands thoroughly after touching the area.

7. Safety Netting

"If the rash worsens, if you develop fever, strong pain, trouble passing urine, or any other concerns, please seek medical help urgently."

"Also, if you notice new lesions closer to your due date, inform your obstetric team immediately."

8. Follow-up

Follow-up arranged with:

GUM clinic

Obstetrician

Review after completion of antiviral course or earlier if any concerns.

9. Leaflet

Provide information leaflet on genital herpes in pregnancy.

10. Final Check

Ask:

"Is there anything else you would like to ask before we finish?"

Reassure:

"You've done exactly the right thing by coming in early. With prompt treatment and monitoring, most women with genital herpes in pregnancy have healthy deliveries."

Management Adjustment if Patient >28 Weeks Pregnant

Context:

If a patient presents with **genital herpes** after **28 weeks of pregnancy**, the management slightly changes from the early pregnancy approach.

Explanation to Patient

"Since you are currently 26 weeks pregnant, we can treat this episode now with a short course of antivirals, and we'll monitor you closely.

However, if you were further along — beyond 28 weeks — we would manage it slightly differently.

After 28 weeks, the focus becomes preventing reactivation of herpes closer to delivery, because active infection at the time of labour could pass the virus to the baby.

In that case, we would start you on a continuous daily dose of **acyclovir** or similar antiviral medication all the way until delivery.

This suppressive treatment reduces the chance of a recurrence during labour.

And if any active lesions were present when you go into labour, we would usually recommend a **caesarean section** to protect your baby from infection."

Medical Management Plan:

After 28 weeks:

Continuous Acyclovir (or Valacyclovir) daily until delivery

If active lesions at delivery:

Elective Caesarean Section is offered

If no active lesions at delivery:

Vaginal delivery may still be possible safely

First Antenatal Care Visit

Setting: GP clinic

Role: FY2 Doctor

Patient: Pregnant woman attending for first pregnancy checkup

---

Greet and C

Confirm patient identity.

"I understand you've come for your first pregnancy visit — congratulations. I'd like to ask a few questions about your health and pregnancy so far, then explain what happens next. Does that sound okay?"

Present Pregnancy Details

"Have you done a pregnancy test?" (Home or clinic?)

"Do you have any idea how far along you might be?"

→ Ask for first day of last menstrual period (LMP)

→ Check for cycle regularity

"Any symptoms so far?" (Ask specifically about nausea, vomiting, cramps, bleeding)

"Any concerns about the pregnancy so far?"

Past Obstetric History

"Have you been pregnant before?"

If yes:

Number of pregnancies (gravida/parity)

Miscarriages / terminations / ectopics

Mode of previous delivery

Any complications (e.g. GDM, preeclampsia, IUGR, bleeding)

Neonatal outcomes

Medical & Mental Health History

Chronic conditions: "Any known medical problems like diabetes, thyroid issues, high blood pressure, epilepsy?"

Previous mental health history, especially:

Postnatal depression

Anxiety or trauma

Severe mental illness (e.g. bipolar, psychosis)

Medications (especially valproate, methotrexate, lithium, ACE inhibitors)

Allergies

Supplement use (folic acid, vitamin D)

Surgical History

Previous abdominal or gynaecological surgery

Cervical procedures

Family History

"Any inherited conditions in your family or the baby's father's side?" (e.g. thalassaemia, sickle cell, cystic fibrosis)

"Any history of twins or multiple pregnancies?"

Gynae & Sexual Health

Menstrual history: "Were your cycles regular before pregnancy?"

Smear test history

STI history

Previous contraception use

Social History & Lifestyle

Living situation and support: "Who's at home with you?"
Partner support?
Occupation – risks (lifting, chemicals, infections, long hours)
Diet: "How is your appetite? Are you eating well?"
Exercise routine
Smoking, alcohol, or recreational drug use
Domestic safety: "Do you feel safe at home?" (Gently screen for domestic abuse)

ICE + Effect on Life

"How are you feeling emotionally about the pregnancy?"
"Is there anything you're particularly worried about?"
"How has this been affecting your daily life or work so far?"

Examination

"We'll check your blood pressure and weight today."
"We'll also test your urine for protein and sugar."

Management Plan & Explanation

"So let me walk you through the plan from here:"

Appointments:

"You'll be booked in with the midwife for a booking visit ideally before 10 weeks — that's a longer appointment to go over your health in detail and arrange initial blood tests."
"You'll then have your first scan around 12 weeks to confirm dates and offer early screening."
"Your next major scan is at 20 weeks to check how the baby is developing."

Blood Tests:

"At your booking visit, they'll offer blood tests to check your blood count, blood group, and screen for things like hepatitis B, HIV, and syphilis."
"If your background or family origin suggests it, they'll also check for thalassaemia or sickle cell."
"You can choose to have Down's syndrome screening too — we'll explain that closer to your scan."

Supplements & Lifestyle:

"Keep taking folic acid — 400 mcg is perfect unless you're in a high-risk group, which you're not."
"We also recommend vitamin D — especially during pregnancy."
"Avoid certain foods like unpasteurised cheeses, raw fish, or liver. And continue eating well and staying active unless advised otherwise."
"If you're ever unsure what's safe, just ask — or use the NHS Pregnancy app."

Red Flags:

"Please come back immediately if you notice bleeding, severe abdominal pain, fever, vomiting, or if you just feel something isn't right."

Referral & Support

Midwife booking referral
Perinatal mental health team if mood concerns, trauma, or history
Social services/domestic safety team if abuse suspected
Genetic counselling if family history of inherited conditions

Closing

"We'll arrange your booking appointment now, and you'll be contacted with scan details."
"Do you have any questions or anything you'd like me to go over again?"
"We're here throughout your pregnancy — feel free to contact us anytime if you're unsure about anything."

Antenatal Checkup - Lifestyle Risks

Setting: GP Surgery
Role: FY2 Doctor
Patient: 26 years old
Gestation: 14 weeks pregnant
Task: Conduct antenatal check-up, review results, identify lifestyle risks, explain risks, and counsel patient

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1. Introduction & Consent

Greet warmly, confirm identity and reason for visit.
"Hi, I'm Dr [Name], one of the doctors here. I understand you've come to review your antenatal reports. Would it be alright if I first ask you a few questions about how the pregnancy has been going so far?"

2. Clarify the Concern

"How have you been feeling in general?"
"Are there any symptoms or concerns you've noticed recently?"
"How do you feel about the pregnancy overall?"

3. Assess Relevant History (Structured Antenatal History)

Gestation & Booking

"How many weeks pregnant are you now?" → 14 weeks
"Is this your first pregnancy?" → Yes
"How was the pregnancy confirmed?" → Home test
"Have you had any scans or booking appointments yet?" → Yes, 12-week dating scan

Symptom Screening

"Have you had any nausea, vomiting, tummy pain, or bleeding?" → No symptoms reported

Medical & Lifestyle History

PMH: No chronic conditions
Allergies: Not mentioned
Medications: None
Tobacco: 15 cigarettes/day
Alcohol: 1–2 bottles of wine/week
Cannabis: Smokes 3–4 times/week
Social: Lives alone, no partner or immediate support
Occupation: Not specified (ask if time permits)

4. ICE – Ideas, Concerns, Expectations

"Do you have any thoughts about how the pregnancy is progressing so far?"
"Any worries about the lifestyle or habits you've mentioned?"
"What were you hoping for from today's visit?"

How has all of this been affecting you so far — your daily life or emotional wellbeing?

5. Examination Summary (Verbalised)

"At this point in pregnancy, we check your blood pressure, urine, and overall well-being."
"Today I've reviewed your earlier test results:
Bloods and urine are normal
Baby appears to be doing well."

6. Explanation of Risks

"It's really encouraging that everything looks good so far.
But I'd like to talk about a few lifestyle factors that may affect your baby's development going forward. The earlier we address them, the better the outcomes for both you and your baby."

7. Management Plan – Lifestyle Risk Counselling

A. Smoking in Pregnancy

Risks:

Increased chance of miscarriage and ectopic pregnancy
Higher risk of premature birth and low birth weight
Increased risk of stillbirth and neonatal breathing problems
Long-term effects like asthma or developmental delay

Advice:

"Stopping smoking completely during pregnancy greatly reduces these risks."
"Even cutting down helps, but the biggest benefit is from quitting entirely."

Support:

Refer to NHS Stop Smoking Services (free programme with nicotine replacement, counselling)
Offer leaflets on quitting in pregnancy
Explain that support can begin immediately, including non-judgemental phone support lines
"Would you be open to a referral to a smoking cessation team today?"

B. Alcohol in Pregnancy

Risks:

Foetal Alcohol Spectrum Disorder (FASD) — causes lifelong learning, behavioural and physical problems
Risk of miscarriage, poor foetal growth, and premature delivery

NICE Advice:

"There is no known safe level of alcohol in pregnancy."
"Even occasional drinking can increase risk, especially in early pregnancy."

Support:

Signpost to local alcohol counselling services
Discuss NHS online help or specialist support if dependence suspected
"You don't have to do this alone. We can refer you today or give you support resources to take home."

C. Cannabis in Pregnancy

Risks:

Associated with poor foetal growth

Possible impact on baby's brain development, behaviour, and attention later in life
Increases risk of stillbirth and developmental delays

Advice:
"Cannabis is not safe during pregnancy, even in small amounts."
"Its effects may not show immediately, but it can affect your baby's brain and long-term wellbeing."

Support:
Offer referral to substance misuse team or drug support counselling
Reassure that help is confidential and non-punitive
Encourage gradual reduction if stopping all at once is difficult

8. Follow-Up Plan
"We'll continue routine antenatal care with regular check-ups, blood pressure monitoring, and scans."
"You'll be due for your 20-week anomaly scan soon."
"At each visit, we'll keep checking how both you and the baby are doing — and we'll continue supporting you with the lifestyle changes."

9. Safety Netting
"Please contact the maternity team or your GP urgently if you experience bleeding, severe pain, reduced movements (after 24 weeks), or anything unusual."
"And if you ever feel unsure or overwhelmed about quitting smoking, drinking, or cannabis, reach out — we're here to help without judgment."

10. Closing
"It's good that you're coming for your antenatal appointments, and the baby is doing well so far."
"Making changes now can have a huge positive impact, and there's a whole team to help you do that."

Variation: Antenatal Checkup – Rubella Non-Immune & Rhesus Negative (14 Weeks Pregnant)

You are: FY2 doctor in antenatal clinic
Task: Explain rubella non-immunity and rhesus-negative status, risks, precautions, and support

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Clarify the Concern
"Thanks for waiting while I reviewed your results. I can see you've already had some routine antenatal blood tests and your ultrasound, and I'd like to go through them with you and explain what they mean."

Assess Relevant Background
First pregnancy, 14 weeks gestation
Normal ultrasound
Rubella: non-immune
Blood group: A Rh-negative
STI screen: negative
No comorbidities
Not in a stable relationship, multiple partners
Recreational drug and alcohol use covered separately

Reassure & Explain

A. Rubella – Non-Immune

Risk:

"Your blood test shows you're not immune to rubella — that's a virus also called German measles. It's usually mild in most people, but it can be dangerous during early pregnancy."

Why it matters in pregnancy:

"If a pregnant woman catches rubella in the first 16 weeks, there's a high chance — up to 9 in 10 — that the baby can develop serious problems like hearing loss, eye defects, heart issues, or even brain development concerns. This is called congenital rubella syndrome."

Why we don't give vaccine now:

"Unfortunately, we can't offer the rubella vaccine during pregnancy — it's a live vaccine, and there's a small risk it might harm the baby."

Advice & Support:

"So it's really important to avoid contact with anyone who has a rash, fever, or known rubella infection."

"If you ever develop symptoms like a rash, fever, sore throat, or notice people around you with these symptoms, please contact us immediately — we may need to do urgent blood tests."

"After the pregnancy, we will offer you the MMR vaccine so you're protected in the future."

Rhesus Negative Blood Group

Risk:

"Your blood group is A negative, which means your red cells don't have a certain protein called the rhesus factor. That's not a problem for you — but if your baby has a different blood type (rhesus positive), your body might see those cells as 'foreign' and produce antibodies against them."

Why it matters:

"These antibodies won't usually cause issues in this pregnancy, but they can affect future pregnancies — they can cross the placenta and attack a future baby's blood cells, causing a serious condition called haemolytic disease of the newborn."

Prevention:

"To prevent this, we routinely give you an injection called *Anti-D immunoglobulin*. It works by clearing out any baby's blood cells that might enter your system before your body reacts to them."

When we give Anti-D:

At **28 weeks** (routine dose)

Any time there's a risk of baby's blood mixing with yours (e.g., fall, bleed, procedure, or miscarriage)

After birth, if the baby is confirmed to be rhesus-positive

Support Offered:

"We'll keep a close eye on your blood throughout the pregnancy — if we ever detect signs of antibody production, we'll involve a specialist early."

"And just so you know, we'll check the baby's blood group after delivery to see if Anti-D is needed again."

Engage in Shared Plan + Specific Management

What happens now:

"No treatment is needed right now, but we will arrange your Anti-D injection for around 28 weeks."

"We'll also make a note to offer you the MMR vaccine after your delivery."

"I'll document everything in your maternity record so the team can follow up appropriately."

Safety Netting:

"Please return or call us urgently if you experience: rash, fever, bleeding, abdominal pain, trauma (like a fall), or if you're ever unsure about a contact with someone who's unwell."

Leaflet:

"I'll also give you the NHS 'Screening Tests for You and Your Baby' leaflet and some information about rubella and rhesus status so you can read more at home."

Final Check:

"That's quite a lot of information – would you like me to go over anything again or clarify anything for you?"

Breech Presentation

Setting: Antenatal Clinic
Role: FY2 Doctor
Patient: Mrs. X, 32 years old
Gestation: 34 weeks
Referral: Midwife noted baby is in breech position during routine palpation

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1. Introduction & Identity Confirmation

"Good morning, my name is Dr [Name], I'm one of the junior doctors here in the antenatal clinic. I understand you've come in today for your routine check-up and the midwife noticed something about the baby's position — is that correct?"

"Would it be alright if I ask you a few questions and then carry out an examination to check how both you and the baby are doing today?"

2. Focused Antenatal History

A. Pregnancy Overview

"How many weeks pregnant are you now?" → 34 weeks
"Is this your first pregnancy?"
"Have you had any scans recently?" (E.g. dating scan, anomaly scan)
"Has this pregnancy been going smoothly so far?"

B. Symptom Check (Screen for complications)

"Any vaginal bleeding or spotting?"
"Any persistent abdominal pain or contractions?"
"Have you noticed swelling in your hands or ankles?"
"Any blurred vision, headache, or epigastric pain?"
"Any unusual discharge or itching?"
"Have you noticed your baby moving as usual?"

C. Medical and Psychosocial History

Past obstetric history (if multiparous): number and outcomes of previous pregnancies
Medical problems (hypertension, diabetes, thyroid, epilepsy, etc.)
Current medications and allergies
Smoking, alcohol, recreational drug use
Home situation/support system

D. ICE

Ideas: "Do you know what might be going on with the baby's position?"
Concerns: "Is there anything specific you're worried about today?"

Expectations: "What were you hoping to find out or have done today?"

3. Verbal Examination Introduction (Before you touch the patient)

"Thank you for answering those questions. I'd now like to perform an examination to assess how your baby is positioned, how it's growing, and listen to the heartbeat."

Explain step by step:

"This involves looking at and gently feeling your tummy, measuring your bump, and listening to your baby's heartbeat."

"It shouldn't be painful but might be a little uncomfortable."

"It's best if you empty your bladder before we begin — that will make the examination easier."

"Would it be okay for you to lie flat on the couch with your tummy exposed from just below the breast to your mid-thighs? Your undergarments can remain on."

"A chaperone will be present, and I'll ensure your privacy at all times."

"Do I have your consent to proceed?"

4. Antenatal Examination – Detailed Sequence

A. General Observations (Do first)

Check BP, HR, RR, O_2 sats, temperature

Observe for pallor, ankle oedema, discomfort, or distress

B. Abdominal Examination (5 key components)

(Stand on the patient's right side, facing her abdomen.)

1. **Inspection**

Look at abdomen from above and both sides

Check for:

- Size and shape of bump (symmetric/asymmetric)
- Scars (previous caesarean or surgeries)
- Skin changes: striae, Linea nigra
- Visible foetal movements or distension

2. **Superficial Palpation**

Temperature: Use the back of your hand to compare abdominal skin temperature to patient's thighs

Tenderness: Gently palpate each quadrant, observe facial expression

"Let me know if anything feels uncomfortable."

3. **Deep Palpation – Leopold's Manoeuvres**

Fundal Grip (1st manoeuvre):

- Stand facing the patient's head
- Use flat fingers of both hands to palpate the uterine fundus
- In breech: feel hard, round, ballotable head
- In cephalic: feel soft, broad, irregular buttocks

Lateral Grip (2nd manoeuvre):

- Stand to the side
- One hand stabilises one side, the other palpates opposite side
- Feel for back (long, curved) vs. limbs (knobbly)

Pelvic Grip (3rd manoeuvre – Pawlik's):

Place both hands just above the pubic symphysis
Palpate gently to identify presenting part
In breech: soft and irregular (buttocks)
In cephalic: hard, round (head)

4. Fundal Height Measurement

Use a non-stretch tape, numbers facing down
Place one end at top of symphysis pubis
Extend tape along the curve of the bump to the fundus
Expected: within 2 cm of gestational age (i.e., 32–36 cm at 34 weeks)

5. Foetal Heart Auscultation

Locate foetal back from lateral grip
Place Pinard stethoscope shoulder area
Listen for 110–160 bpm
Confirm presence and regularity
Hold device gently with ear pressure

5. Provisional Diagnosis

"Thank you for letting me examine you. Based on what I've felt, it seems like your baby's head is currently pointing upwards instead of downwards — we call this a **breech presentation**."
"At 34 weeks, this isn't uncommon — and many babies still turn by themselves. But we'll need to follow up and plan next steps."

6. Management Plan

A. Confirm the Presentation

"I'll arrange a **presentation scan** (ultrasound) to confirm the position."

B. Reassessment

If **first pregnancy** → Reassess at **36 weeks**
If **multiparous** → Reassess at **37 weeks**
"If the baby has turned by then — that's perfect, no further action needed."

C. External Cephalic Version (ECV)

"If the baby is still breech at that point, we'll consider a procedure called **External Cephalic Version (ECV)**."
Explain in lay terms:

"It's a safe procedure done by a senior doctor who uses gentle pressure on your tummy to try and help turn the baby head-down."
"You'll be monitored closely with continuous scans and heartbeat checks."
"In some cases, the baby may not turn or may flip back — and in rare cases, it may cause contractions or affect the baby's heart rate. But you'll be in hospital with a team ready to help if needed."

D. Delivery Planning

"If the baby remains breech closer to term, we will likely recommend a **planned caesarean section**, which is safer for both you and the baby."
"In some cases, depending on baby's position and your previous history, vaginal delivery may still be considered — but this decision would be made by your consultant."

7. Safety Netting

"Please let us know straight away if you notice any of the following:
Vaginal bleeding
Painful contractions
Blurred vision, swelling, headaches
Reduced baby movements
Leaking of fluid or unusual discharge"

8. Closing the Consultation

"You've done absolutely the right thing by coming in. Most breech babies turn naturally, but we're going to keep a close eye, confirm with a scan, and support you through the rest of your pregnancy safely."
"Do you have any questions or anything you'd like me to go over again?"

Breech Presentation at 36 Weeks

Setting: FY2 Doctor in Antenatal Clinic
Patient: 32-year-old woman, G2P1, 36 weeks pregnant
Task: Focused history, examination, and management discussion

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Introduction

Greet warmly, confirm full name and age.
Confirm pregnancy weeks: "You're 36 weeks today, correct?"
Briefly set agenda: "I understand you've come for your routine antenatal check. Let's go through a few questions first."

Focused History

A. Current Pregnancy History

"How has your pregnancy been so far?"
"Any bleeding, spotting, or discharge?"
"Any tummy pain, pressure symptoms, or leaking of fluid?"
"Any recent headaches, visual changes, or swelling of hands/feet?"
"Have you been feeling your baby move as usual?"

B. Previous Pregnancy History

"You mentioned this is your second pregnancy. How was your previous delivery?"
"Any complications like prolonged labour, pre-eclampsia, or caesarean?"

C. Antenatal Care Review

"Have you been attending regular antenatal appointments?"
"Any concerns raised in previous scans or blood tests?"

D. Past Medical, Surgical, Drug History

"Any ongoing medical problems or surgeries?"
"Any medications you are currently taking?"
"Any allergies?"

E. Social History

Smoking, alcohol, recreational drugs.

Support at home.

F. ICE

Ideas: "Did you have any concerns about today's visit?"
Concerns: "Is there anything particular worrying you?"
Expectations: "What were you hoping we could do today?"

Examination

Before starting:

Thank for answering questions.
"I'd now like to check your vitals and examine your tummy if that's okay?"
Explain procedure:
"This will involve checking your blood pressure, feeling your abdomen to assess the baby's position, measuring the growth, and listening to the baby's heartbeat."
Privacy, dignity, and chaperone offered.
Request bladder to be emptied.
Position: Supine, exposed from below the chest to mid-thigh (undergarments stay on).
Gain formal consent.

1. Observations:

Blood pressure, HR, temperature, respiratory rate, oxygen saturations.

2. General Inspection:

Look for pallor, jaundice, distress.

3. Abdominal Examination:

Inspection: Scars, striae gravidarum, Linea nigra, shape and symmetry.
Palpation:
Temperature with back of hand.
Tenderness.
Fundal grip (identify presenting part).
Lateral grip (feel foetal back).
Pelvic grip (assess engagement).
Fundal Height Measurement: Symphysis pubis to fundus (in cm ≈ weeks).
Auscultation: Foetal heart over the back using fetoscope.

Findings

Baby found in breech presentation (head palpable at fundus, buttocks down).
Fundal height appropriate for gestational age.
No tenderness, bleeding, or fluid leakage.

Management

Step	*Action*
Confirm	Arrange **ultrasound scan** to confirm breech presentation officially.
Follow-Up Timing	Since you've had a previous delivery (G2P1), **we'll wait until 37+0 weeks** before offering any interventions.
Plan if breech persists after 37 weeks	If breech is still confirmed, offer **External Cephalic Version (ECV)** after counselling.
ECV Counselling (for after 37w)	- Performed by a trained obstetrician. - Attempt to gently turn the baby manually. - Success rate around 50%. - Risks include discomfort, transient foetal heart changes, rare chance of emergency c-section.
If ECV unsuccessful or declined	Discuss **birth planning**: ➔ Planned caesarean delivery is usually advised. ➔ Vaginal breech birth possible but requires experienced team, risk discussion needed.

Safety Netting

"Please contact us urgently if you have any bleeding, leaking fluid, reduced foetal movements, severe pain, or if you feel unwell."

Patient's Concerns

"Why is my baby in breech?" ➔ "Sometimes babies stay breech for no clear reason. Factors like uterine shape or fibroids may contribute, but many cases happen without any cause."

"Is it my fault?" ➔ "Absolutely not. Nothing you have done has caused this."

"Is my baby okay?" ➔ "At the moment, everything else looks fine. We'll continue monitoring carefully."

"Will I need a caesarean?" ➔ "If ECV works and the baby turns, you can have a vaginal delivery. If not, we'll discuss planned caesarean birth for safety."

Breech Management by Gestational Age

Gestational Age	*Action*
Before 36 weeks	No intervention. Breech is common. Monitor normally.
At 36+0 to 36+6 weeks	**Confirm** breech presentation with ultrasound. **Discuss options** (ECV, vaginal breech, planned caesarean). If **nulliparous (first baby)** ➔ **Offer ECV** from 36 weeks. If **multiparous (previous births)** ➔ **Wait till 37+0 weeks** for ECV.
After 37+0 weeks	**Offer ECV** for both nulliparous and multiparous women if breech persists. If ECV unsuccessful/declined ➔ Discuss planned caesarean vs vaginal breech birth (case-by-case basis).

Endometritis

Setting: FY2 in A&E or GP Surgery
Patient: 32 years old
Presentation: 2 days post-Caesarean section, lower abdominal pain, foul-smelling vaginal bleeding

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1. Introduction and Confirm Identity

Greet warmly:
"Hello, my name is Dr [Name], one of the doctors here today."
Confirm identity (name, DOB).
Clarify agenda:
"I understand you've been feeling unwell with some tummy pain and bleeding. Is it okay if I ask you a few questions, examine you, and explain the next steps?"

2. Focused History – Data Gathering

Presenting Complaint

"Could you describe the pain you're having?"
SOCRATES: dull, suprapubic, 7/10, non-radiating.
"What makes it better or worse?"
"When did it start?"
"Have you tried anything for the pain?" (Paracetamol ineffective.)

Obstetric History

"When did you deliver?" (2 days ago.)
"Was it a vaginal or Caesarean birth?" (C-section after 30-hour labour.)
"Were there any delivery complications?"
"Since delivery, how has your bleeding been? Fresh blood, clots, bad smell?"
"Are you breastfeeding?"

Infection Symptoms

"Have you had any fever, chills, or feeling generally unwell?"
"Any nausea or vomiting?"
"Any burning or discomfort when passing urine?"

Past Medical, Medication, Allergy History

"Do you have any chronic medical conditions?"
"Are you taking any medications?"
"Any known allergies?"

ICE – Ideas, Concerns, Expectations

"What do you think could be causing this?"
"Is there anything you're particularly worried about?"
"What were you hoping we could help you with today?"

3. Examination

"I'd like to check your vital signs: temperature, blood pressure, heart rate, respiratory rate, and oxygen levels."
General inspection: pallor, clamminess, confusion.
"I'd like to gently examine your abdomen for tenderness."

"If needed, I will check your urine with a dipstick."

4. Provisional Diagnosis

"Based on your symptoms and examination findings, it seems likely you have **Endometritis** — an infection of the lining of the womb, commonly seen after a Caesarean section, especially after a prolonged labour."

5. Management Plan

If Patient is Well (Stable):

Treatment:

Start **oral Co-amoxiclav 625 mg TDS** for **10–14 days**.

Or **Metronidazole** (400 mg TDS) **plus either Doxycycline** (100 mg BD) *or* **Clindamycin** (300 mg QDS)

Safe pain relief: **Paracetamol** and/or **Ibuprofen** (both safe during breastfeeding).

Encourage oral hydration and rest.

Monitoring:

Symptoms should start improving within **48 hours**.

Investigations:

Urine culture to rule out concurrent UTI.

Pelvic ultrasound only if symptoms worsen or persist after 48 hours.

If Patient is Unwell (Fever, Tachycardia, Low BP, Looks Ill):

Emergency Admission:

Immediate referral to **Obstetrics and Gynaecology team**.

IV broad-spectrum antibiotics **(Clindamycin + Gentamicin)**.

IV fluids to correct dehydration and maintain BP.

Continuous vital monitoring.

Further Investigations:

Full blood count, CRP, blood cultures.

Urine analysis and cultures.

Pelvic ultrasound.

Chest X-ray if systemic signs or to rule out chest sepsis.

Treatment Adjustment:

Tailor antibiotics once culture results available.

Step down to oral antibiotics once improving.

6. Breastfeeding Advice

Continue breastfeeding during both oral and IV antibiotic treatment.

Co-Amoxiclav, Paracetamol, Ibuprofen, Clindamycin, and Gentamicin are considered **safe in breastfeeding** according to NICE and NHS CKS.

7. Reassurance

"You've done the right thing by coming early.

Mild infections like this usually respond very well to antibiotics if caught early.

If treated properly now, it shouldn't cause any long-term problems or affect your ability to have future pregnancies."

8. Safety Netting

"Please seek urgent medical attention if you experience:
- Worsening tummy pain
- Heavy vaginal bleeding with large clots
- High fever
- Feeling faint, dizzy, or unable to keep fluids down."

"If symptoms don't start improving within **48 hours** of starting treatment, return immediately."

9. Follow-up Plan

GP or midwife review within **48–72 hours** to check symptom improvement.
Additional follow-up if ultrasound or specialist input is required.

10. Final Closing

Summarise briefly:
"You have a likely infection of the womb lining. If mild, we'll treat you with oral antibiotics and monitor. If you show signs of sepsis or become more unwell, we'll escalate care immediately."

Offer leaflet on **postnatal infections** if available.
Final check:
"Is there anything else you would like me to explain or any questions you have?"

Variation: Late Postpartum Presentation (e.g., 3 weeks post C-section)

Presentation Differences:

Patient may appear relatively **well** but has persistent bleeding, mild to moderate lower abdominal pain, and intermittent fever.
Still at risk of serious infection, but less fulminant compared to early sepsis cases.

Assessment Adjustments:

Rule out **retained products of conception** (RPOC) with a pelvic ultrasound.
Consider wider differential (e.g., secondary postpartum haemorrhage).

Management Adaptations:

If stable (no sepsis signs)	*If unwell (fever, tachycardia, tenderness)*
*Trial **oral antibiotics** (e.g., Co-Amoxiclav) with close follow-up*	Immediate **hospital admission**, start **IV Clindamycin + Gentamicin**
*Arrange **urgent scan** to check uterine involution*	Full sepsis screen + supportive care

Specialist Referral:

Still under **obstetric team** urgently.
Radiology involvement earlier for imaging.

Follow-up:

GP or midwife within 3–5 days.
Obstetric team follow-up for recovery and future pregnancy advice.

Emergency Contraception Request – Learning Disability

Setting

FY2 in GP surgery
23–25-year-old female with mild learning disability
Attending alone, requesting emergency contraception (morning after pill) after unprotected sex

---

1. Introduction

Greet and confirm identity.
➔ "Hello, I'm Dr. __. *Could I confirm your full name and age, please?*"
Acknowledge learning disability sensitively.
➔ *"I also understand from my notes that you sometimes find health information tricky. Shall I check in with you while we talk, to make sure everything is clear?"*
Paraphrase presenting concern simply.
➔ *"I understand you have come today because you want help to stop pregnancy after having sex without protection last night. Is that right?"*
Confirm capacity (observe alertness, communication ability).
Offer confidentiality (if needed).
➔ *"Before we start, everything we talk about will stay private unless I think you are at serious risk. Is that okay?"*

2. History of Presenting Complaint

Timing of unprotected sex:
- When did it happen? (confirm within 72 hours)

Circumstances:
- With a regular partner/boyfriend?
- How long have they been seeing each other?
- Was the sex voluntary? (Safeguarding check: "Did you want to have sex or did someone make you?")

Contraception:
- Any contraception used?
- Reason for not using condom? ("Did you talk about using any protection?")

Understanding:
- Ask if she understands why she needs the pill.
- Confirm she knows unprotected sex can cause pregnancy.

Previous emergency contraception use:
- First time using morning after pill?

Partner details:
- Similar age? (Check safeguarding — older partners.)

3. Menstrual History

LMP:
- When did your last period start?
- Was it normal?

Menstrual cycle regularity:
- Are periods regular?

Past pregnancy history:
- Ever been pregnant before?

Pregnancy symptoms:
- Any nausea, breast tenderness, or unusual symptoms now?

4. Sexual Health History
STI risk:
Has she had unprotected sex before?
Ever been tested for infections before?
Contraception use:
Any regular contraception (pill, injection, implant)?

5. Past Medical History (PMH)
Ask simple:
➔ *"Do you have any health problems?"*
Chronic illnesses? (Epilepsy, diabetes, etc.)

6. Drug History (DH)
Current medications:
Taking any daily medicines?
Allergies:
Any allergies to medicines?
Specifically check no allergy to Levonorgestrel.

7. Learning Disability History
Check:
"Do you find it easy to understand what doctors say, or do you sometimes find it tricky?"
"Is there someone who helps you at home with your medicines?"
Assess:
Does she appear able to make health decisions independently?
Check functional understanding (about pregnancy, pill purpose, basic side effects).

8. Psychosocial History (MAFTOSA)
Home support:
Living with mother?
Daily help available?
Financial status and safety if needed (only if concerns arise).
Confirm general safety and wellbeing.

9. ICE (Ideas, Concerns, Expectations)
Ideas:
What does she believe the pill will do?
Concerns:
Fear about pregnancy?
Fear about taking medication?
Expectations:
Wants to get the pill today?
Open to advice about safer sex?

10. Examination
General Physical Examination (GPE):
Conscious, alert, oriented?

Looks well, able to engage?

Pregnancy test:

Only if LMP uncertain, irregular, or suspicion of earlier risk.

Management Plan

Emergency Contraception

Prescribe **Levonelle** (Levonorgestrel).

Explain simply:

➔ *"You will take one pill today. It helps to stop pregnancy happening."*

Warn about vomiting:

➔ *"If you are sick (vomit) within 2 hours after taking it, you need to take another one. Come back if that happens."*

Side effects explained clearly:

- Feeling sick (nausea)
- Headache
- Stomach pain
- Period may come early, late, lighter, or heavier

STI Screening

Offer STI screening politely:

➔ *"Would you like a check-up to make sure you don't have any infections from sex?"*

Safe Sex Advice

Simple message:

➔ *"Condoms help stop both pregnancy and infections."*

Offer brief discussion on future contraception options:

- Daily pill
- Injections
- Implant

Safety Netting

Vomiting after 2 hours – Return immediately.

No period within 3 weeks – Return for pregnancy test.

Heavy bleeding or severe pain – Return urgently.

Provide Written Information

Simple written instruction on:

- When and how to take pill
- When to seek help
- Condom use leaflet if appropriate

Offer Final Support

"You can always come back and see us if you have any more worries."

Key Adjustments for Learning Disability

Speak slowly and clearly.

Avoid complicated terms (no "ovulation", "emergency contraception" – say "pill to stop pregnancy").

Double comprehension checks:

➔ *"Is that clear so far?"* ➔ *"Would you like me to explain again?"*
Encourage throughout:
➔ *"You are doing really well."*
Written reinforcement.
Respect autonomy — if patient shows understanding, treat accordingly.

Emergency Contraception Request – Epilepsy Patient

Setting

FY2 doctor in GP clinic
24–30-year-old woman
Taking **Carbamazepine** for epilepsy
Presents after **unprotected sex 2–3 days ago**, requesting morning after pill

---

1. Introduction
Greet and confirm identity:
➔ "Hello, I'm Dr. __. *Could I confirm your full name and age please?"*
Paraphrase concern:
➔ *"I understand you are here because you had unprotected sex recently and would like to discuss emergency contraception. Is that right?"*
Offer support and reassurance.
Offer confidentiality in simple words if sounds hesitant:
➔ *"Everything we discuss will stay private unless there's a serious danger to you or someone else. Is that alright?"*

2. History of Presenting Complaint
Timing and details of unprotected sex:
When did it happen? (Confirm: 2 or 3 days ago — inside 72- or 120-hours limit for different methods.)
With partner or stranger? (Voluntary? Confirm no coercion.)

Sexual history:
Any other sexual partners recently?
Any previous history of STIs?

Protection use:
Regular use of contraception?
Why was contraception not used this time?
Previous emergency contraception use:
Has she taken morning after pill before?
Pregnancy risk understanding:
➔ *"Do you know what might happen after unprotected sex?"*

3. Menstrual History
Last Menstrual Period (LMP):
When did last period start?
Was it normal in flow and timing?
Menstrual regularity:
Are cycles regular?
Pregnancy symptoms:

Any symptoms suggesting pregnancy?
Obstetric history:
Ever been pregnant before?

4. Past Medical History (PMH)
Epilepsy:
How long diagnosed? (15 years)
Last seizure? (1 year ago)
Well controlled?
Other conditions:
Any other health problems?

5. Drug History (DH)
Carbamazepine use:
Confirm regular use.
Other medications:
Any additional medications? (Especially enzyme inducers.)
Allergies:
Allergic to any medicines?

6. Psychosocial History (MAFTOSA)
Living situation:
Living alone or with family?
Occupation:
Working/studying?
Support system:
Any daily help or independent?
Alcohol/drug use:
Any alcohol, recreational drugs?
Smoking:
Smoking habits?
Abuse screening:
No history of forced sex confirmed, no safeguarding issues.

7. ICE (Ideas, Concerns, Expectations)
Ideas:
What does she think the pill will do?
Concerns:
Worried about side effects? Pregnancy? Impact on epilepsy?
Expectations:
Wants the pill today?
Open to alternative options like IUD?

8. Examination
General physical examination (GPE):
Well-looking, alert, oriented.
Observations:
Blood pressure, pulse if indicated.

Abdominal examination:
No tenderness, no signs of ectopic.
Pregnancy test:
Consider if uncertain LMP, or multiple episodes of unprotected sex.

Management Plan
1. Explain Best Emergency Contraception Option
Copper IUD (preferred):
Most effective even with Carbamazepine.
Can be fitted up to 5 days after unprotected sex.
Explain simply:
➔ *"A small device, like a T-shape, will be placed inside the womb to prevent pregnancy. It's a one-time procedure."*
➔ *"It can cause period-like cramps, some bleeding, very rarely injury or slipping out, but it's very effective."*
Refer to local sexual health clinic or GP surgery with fitting facility.

2. If Copper IUD is Declined or Unavailable
Offer Double Dose Levonorgestrel (Levonelle):
Standard dose = 1.5mg.
Double dose = 3mg (due to enzyme induction by Carbamazepine reducing efficacy).
Must be taken within 72 hours.
Explain simply:
➔ *"You will need to take two tablets together today. It is safe but slightly less effective than the device."*
Warn about vomiting:
➔ *"If you vomit within 2 hours of taking it, you may need another dose. Please come back if that happens."*
Common side effects:
Headache
Feeling sick
Tummy cramps
Changes in next period timing

3. STI Screening
Offer simple STI check:
➔ *"Since you had sex without protection, would you like to be checked for infections as well?"*
Especially if multiple partners or any risk factors present.

4. Safe Sex and Future Contraception Advice
Discuss safe sex:
➔ *"Condoms help protect from both pregnancy and infections."*
Discuss long-term contraception options:
Pills
Injections (Depot)
Implant
IUS (coil)
Reminder:
Daily contraceptive pill may interact with epilepsy medications.
Progestogen-only injection or copper coil preferred for future.

5. Safety Netting

For Copper IUD:

If bleeding heavily, pain, device falls out → Urgent review.

For Levonorgestrel:

Vomiting within 2 hours → Return immediately.

No period within 3–4 weeks → Pregnancy test.

Heavy pain/bleeding → Seek urgent care.

Written Information:

Provide leaflet on emergency contraception options.

Simple explanation of what to watch for.

Final encouragement:

➔ *"You did the right thing by coming today. Please feel free to return if you need any help or have any worries."*

Minor Requesting Contraception

Setting

FY2 in GP surgery

15-year-old girl, attending alone, requesting contraception advice

---

1. Introduction

Greet and confirm ID

Acknowledge she came alone:

"We normally encourage young people to bring a parent or trusted adult, but since you're already here, I'm happy to see you."

Offer confidentiality if sounding hesitant:

"Everything we talk about today is private, unless I am seriously worried about your safety. Is that okay?"

2. Clarify Key Background

Sexual relationship:

In stable relationship? (Yes)

Age of partner? (Same age — confirm)

How long together?

Confirm no force/coercion/abuse

Condom use history:

Using condoms till now?

Reason for changing? (Partner dislikes condoms.)

Last intercourse:

When was it? (Recent.)

LMP:

When was your last period?

Was it normal?

Pregnancy suspicion:

Unlikely (if periods regular, no symptoms, recent protected sex).

STIs:

Ever tested for infections?

3. Focused Medical Screening

Migraine history:

Type: Migraine **with aura** confirmed
(visual symptoms before headache = aura)
No epilepsy or severe chronic disease.
Contraception contraindications quick check:
History of blood clots?
Family history of early stroke/DVT/heart attack?
Smoking status:
Smoker or non-smoker? (Ask briefly.)
Current medications:
Paracetamol for headaches.
BMI:
BMI = 32 (Given.)
Blood pressure:
Normal (assume no high-risk finding unless otherwise prompted.)

4. Fraser and Gillick Competence Check
Confirm understanding:
"Can you tell me why you need contraception?"
"What could happen if you don't use contraception?"
Encourage parental involvement (but not mandatory):
"Do you think you could talk to your parents about this?"
Confirm:
She understands risks.
Likely to continue sexual activity regardless.
Best interest to provide contraception without parental consent.
Fraser guidelines satisfied → You can prescribe safely.

5. Management
Explain contraception options clearly:
Combined pill (COCP):
Not suitable due to migraine with aura (↑ stroke risk).
(NICE CKS, FSRH 2022.)
Best option: **Progestogen-Only Pill (POP)**
Explain POP simply:
"You take one small pill every day at the same time. No breaks between packets."
"It is over 99% effective if taken properly."
Side Effects of POP:
Irregular bleeding
Periods may stop
Mood changes (rare)
Headaches possible
STI advice:
"Condoms are still important to protect against infections, even if you're using the pill."
Offer STI screening:
"Would you like to get tested for infections as well? They sometimes don't cause symptoms."
Provide written leaflet:
Pill information
Contraception options

STI awareness

Safety Net:

"If you have vomiting or severe headaches, or problems with periods, or any worries, please come back immediately."

Minor Requesting Oral Contraceptive – Teacher Relationship

Setting

FY2 doctor in GP Surgery

14-year-old girl attending consultation

1. Introduction

Greet warmly:

"Hello, I'm Dr. __. *Nice to meet you."*

Confirm identity and age:

"Could you tell me your full name please?"

"And how old are you?"

Open the conversation naturally:

"How can I help you today?"

Set clear but kind confidentiality boundaries if needed:

" I just want to let you know that everything we talk about will stay private, unless I'm very concerned about your safety. If that happens, I would need to involve other people to help protect you. Is that alright?"

2. Clarify the Presenting Concern

Explore reason for visit:

"Can you tell me a little more about why you're thinking about starting contraception today?"

"Have you used any contraception before?"

Explore sexual activity gently:

"Are you currently sexually active?"

"Have you always used protection like condoms?"

"You mentioned condoms – has there ever been a time they weren't used?"

Menstrual history:

"When was your last period?"

"Are your periods regular for you?"

Symptoms check:

"Have you noticed any unusual discharge, bleeding, or discomfort recently?"

"Any burning or pain when passing urine?"

Understanding about pregnancy risk:

"Do you know what could happen if contraception isn't used properly?"

"Have you ever used the morning after pill before?"

3. Safeguarding Focus

Explore about partner:

"Would it be okay if I asked about your partner?"

"How old is your partner?" (→ 30 years old → safeguarding alarm)

Explore relationship details gently:

"How long have you been seeing each other?"

"How did the relationship start?"

"Did you feel he encouraged it, or was it your idea?"

"Has he ever pressured you or forced you into anything?"
"Has he ever made you feel unsafe or threatened you?"
Support system check:
"Are you living with your parents?"
"Have you spoken to anyone else – family, friends – about this relationship?"
Confirm:
- No threats
- No visible coercion
- But relationship **automatically abusive** because of **age** and **position of trust**.

4. Emotional Safety Step
Check how she's feeling:
"How are you feeling about talking about this today?"
"Is it okay if I explain what we need to do to help keep you safe?"
Pause, allow patient to nod/agree.

5. Management Plan
5.1 Safeguarding Action
Explain concern gently:
"I want you to know that you've done nothing wrong. You've trusted me with something very important, and I really respect that."
Then, explain position of trust violation:
"The problem here is that when an adult – especially a teacher – starts a relationship with someone your age, it is never appropriate. Adults have a responsibility to protect young people, not have relationships with them, even if you agreed."
Explain need to involve safeguarding:
"Because of this, I have to share the information with a team that specializes in protecting young people. They are called the safeguarding team. They will make sure you are safe and supported."
Reassure confidentiality and emotional safety:
"We will handle this carefully. You are not alone. We will involve your parents carefully and with support from the safeguarding team."
Firm but gentle advice:
"Please try not to contact him from now on. This is for your safety."

5.2 Medical Care – Immediate Needs
Emergency contraception:
- Offer **Levonorgestrel (Levonelle)** now.
- Simple explanation:

"This is a tablet you take once today. It helps prevent pregnancy if there was unprotected sex in the last 3 days."

- Vomiting advice:

"If you vomit within 2 hours, you need another dose."

- Side effects:
  - Nausea
  - Headache
  - Tummy cramps
  - Next period might be a bit earlier or later

STI screening:
"Because even with condoms, infections can sometimes happen without symptoms, we recommend a simple health check too. It's very quick and private."

Offer referral to GUM clinic for full STI screening.

5.3 Safety Netting

Warnings:

"If you notice any severe pain, heavy bleeding, fever, or if you feel unsafe in any way, please come back immediately or call emergency services."

Emotional safety:

"If you feel upset, confused, or just want to talk more, we can arrange emotional support too."

5.4 Written Support

Provide leaflets:

- Emergency contraception
- STI screening information
- Young person's safeguarding support services

Requesting COCP Repeat

Setting

- FY2 doctor in GP surgery
- 26-year-old female patient requesting repeat contraception prescription and period delay advice

---

1. Introduction

Greet and confirm identity:

"Hello, I'm Dr. __. *Could I confirm your full name and age please?"*

"How can I help you today?"

2. Clarify Presenting Concern

Reason for visit:

"You're here for a repeat of your contraceptive pill, and to ask about managing your periods, is that right?"

Gather detailed contraceptive history:

"Which type of contraception pill are you currently taking?" (Combined oral contraceptive pill – COCP)

Pill-taking habits:

"How do you take your pill currently? Do you usually take it for 21 days and then have a break?"

"Have you been taking any dummy pills after the active pills?"

Reason for period delay:

"Is there any specific reason you would like to delay your period – for example travel, an event?"

Confirm upcoming travel:

"I understand you're travelling – when are you leaving and for how long?"

Current experience with pill:

"Have you had any issues with the pill so far, like tummy pains, nausea, spotting, or feeling unwell?"

Confirm she is happy with current method.

3. Safety Screening (PMAFTOSA)

Past Medical History:

"Have you ever had any blood clots in your legs or lungs?"

"Any personal history of stroke, heart conditions, or migraines with aura?"

"Have you ever been diagnosed with breast cancer or epilepsy?"
"Any other significant medical conditions?"
Allergies:
"Do you have any known drug allergies?"
Family and Social History:
"Anyone in your immediate family had clots or early strokes?"
Menstrual History:
"Are your periods normally regular when you're off the pill?"
Sexual Health:
"Are you currently sexually active?"
"Is your contraception mainly for pregnancy prevention or for managing periods too?"

4. ICE (Ideas, Concerns, Expectations) (Brief)

Ideas:
"What were you hoping for today – just a repeat or also advice on safely managing the timing of your periods?"
Concerns:
"Any particular worries about taking the pill continuously?"
Expectations:
"Would you like me to explain all your options for delaying your period safely?"

Management Plan

1. Confirm prescription:
"You've been doing well on your pill, and there are no issues from what you've told me. I'll be happy to issue a repeat prescription for three months to cover your time abroad."

2. Explain period delay options:
If already on **COCP** (Monophasic 21-day pill):
"You can safely delay your period by taking two packs of active pills back-to-back, without taking a break or the dummy pills. After finishing two packs, you can then take your usual 7-day break."
Important warning:
"It's best not to take more than two packs continuously, because you might experience breakthrough bleeding or feel slightly sick or bloated."
If on **everyday (ED) pill**:
"You just skip the 7 dummy pills and immediately start the next pack of active pills."
Reinforce:
"Taking pills back-to-back like this is safe short-term, and many women do it when travelling or for special occasions."

3. Alternative option (if not on pill OR can't continue COCP):
Norethisterone explanation:
"If someone wasn't already on a pill, or if COCP isn't suitable, we can prescribe another medication called norethisterone. It's a hormone tablet you take three times a day, starting 3–4 days before your expected period. You continue it while you want to delay your period, but it's generally not used for more than 20 days."
"Periods will usually come back 2–3 days after stopping it. However, norethisterone isn't a contraceptive, so you would still need condoms or other protection."
Norethisterone side effects:
- Nausea
- Headaches
- Breast tenderness

Mood changes

Contraindications for norethisterone:

History of clots

4. Summary

"Because you're already doing well on the combined pill, it's easiest and safest for you to just continue two packs back-to-back."

5. Safety Netting

Breakthrough bleeding:

"If you notice spotting or bleeding while taking continuous pills, it's safe – you can either carry on or take your usual break if needed."

Feeling unwell:

"If you experience severe headaches, chest pain, swelling in your legs, or sudden breathlessness, seek urgent medical help."

Emergency contraception:

"If you miss more than two pills, you might need extra precautions. Please seek advice if that happens."

6. Leaflet

Provide patient leaflet on COCP use, continuous pill taking, and safe contraception abroad.

Retained Tampon

Setting: GP Surgery or Emergency Department
Role: FY2 Doctor
Patient: Woman in her 30s
Presenting Complaint: Smelly vaginal discharge for 2 weeks

1. Introduction

Greet the patient warmly and confirm identity.

"I understand you've noticed some unusual discharge — is it okay if I ask a few questions to understand it better?"

2. History Taking

A. Presenting Complaint Clarification

Onset: "When did the discharge start?"

Duration: "Has it been constant or coming and going?"

Intensity: "How much discharge are you noticing?"

Progression: "Is it getting worse or better?"

Associated Symptoms:

"Any pain during urination?"

"Any itching, burning, or fever?"

"Any lower abdominal pain or discomfort?"

Appearance: "What colour is the discharge? Any unusual smell?"

B. Menstrual and Hygiene History

"When was your last period?"

"Is your menstrual cycle usually regular?"

"Do you use tampons or sanitary pads?"

"If tampons — how often do you change them?"

"Have you used any douches, scented wipes, or bubble baths recently?"

C. Sexual History

"Are you currently sexually active?"
"Any new partners recently?"
"Do you use contraception? If so, which type?"

D. Past Medical History

"Any previous vaginal infections or STIs?"
"Any allergies or regular medications?"

E. ICE (Ideas, Concerns, Expectations)

Ideas: "Have you had any thoughts about what might be causing this?"
Concerns: "Is there anything in particular you're worried about?"
Expectations: "What were you hoping we could do for you today?"

3. Examination

"I'd like to perform a general check including your vital signs and a focused examination of your lower tummy and a speculum examination to check for any possible cause of the discharge."

4. Provisional Diagnosis

"Based on the examination, it appears you have a retained tampon, which is causing the symptoms."
Short Lay Explanation:
"Sometimes if a tampon is left inside for a long time, it can cause irritation, bad-smelling discharge, and discomfort. The good news is it's usually straightforward to treat once we remove it."

5. Management Plan

S — Symptomatic Relief

Removal of tampon carefully using forceps during speculum exam.
Clean the area gently if needed.
Offer mild painkillers (paracetamol) if patient experiences minor discomfort.

I — Investigations

Vaginal swab for culture and sensitivity to rule out secondary infection.
Blood tests only if systemic signs of infection (not routinely needed here).

S — Specialist Involvement

No referral needed unless:

Symptoms persist after removal
Swab shows significant infection needing specialist input
Patient develops signs of Toxic Shock Syndrome (TSS) — then urgent hospital care

6. Advice and Education

A. Tampon Hygiene Education

Change tampons every 4–6 hours.
Never leave a tampon in for more than 8 hours.
Avoid sleeping overnight with a tampon if possible — use sanitary pads instead.
Wash hands before and after tampon insertion.

B. Toxic Shock Syndrome (TSS) Awareness

Explain:

"TSS is a very rare but serious infection associated with tampons. Symptoms include sudden high fever, rash, dizziness, vomiting, and feeling very unwell. It's rare but important to seek immediate help if you ever notice these symptoms."

C. Antibiotics

"At the moment, we don't need antibiotics. We will wait for the swab results. If an infection is found, we can start appropriate treatment."

7. Safety Netting

"If you experience worsening discharge, abdominal pain, fever, dizziness, or feeling generally very unwell, please come back immediately or seek emergency care."

"Otherwise, we expect the symptoms to settle quickly after removal."

8. Follow-Up

Review swab results in 48–72 hours.

Contact patient if infection confirmed; arrange antibiotics if necessary.

Vulvovaginal Candidiasis

Setting: GP Practice
Role: FY2 Doctor
Patient: 40-year-old woman presenting with vaginal discharge

Introduction

Greet warmly: "Good morning, my name is Dr. [Name], one of the doctors here today."

Confirm identity: "Could you please confirm your full name and age for me?"

Build quick rapport: "It's lovely to meet you, [First Name]. How can I help you today?"

Presenting Complaint Clarification (Morphology – Evolution – Symptoms)

Listen carefully:

Patient: "I have a discharge down there."

Acknowledge and gently encourage elaboration:

"I understand this may feel a bit embarrassing, but thank you for bringing it up. Could you please tell me a little more so I can help you better?"

Morphology (Appearance):

"Could you describe the discharge — is it watery, creamy, thick, or thin?"

"What colour is the discharge?"

"Does it have any noticeable smell?"

"Roughly how much discharge are you noticing?"

Evolution (Time Course):

"When did you first notice this discharge?"

"Is it there all the time, or does it come and go?"

"Is it getting better, worse, or staying the same?"

Associated Symptoms:

"Is there any itching, irritation, or soreness around the area?"
"Any pain during sexual intercourse?"
"Any burning sensation when passing urine?"
"Any abdominal pain or lower tummy discomfort?"
"Have you noticed any redness, lumps, or swelling in the area?"

Risk Factor Screening

"Have you started using any new hygiene products like soaps, bubble baths, or feminine washes recently?"
"Do you practice safe sex (using condoms)?"
"Have you had any new sexual partners recently?"
"Are you on any contraception?"
"When was your last sexual health screening?"

Focused History

Medical history: "Any long-term conditions like diabetes, asthma, thyroid problems?"
Allergies: "Any known allergies?"
Past history: "Have you ever had similar symptoms before?"
Drug history: "Are you currently taking any prescribed or over-the-counter medications?"
Obstetric/Gynae history: "When was your last period? Were they regular before?"
Social history:
"Do you smoke or drink alcohol?"
"What kind of work do you do?"

ICE (Ideas, Concerns, Expectations)

"Do you have any idea what might be causing this?"
"Is there anything you're particularly worried about?"
"What were you hoping we could help you with today?"

Effect on Life

"Has this discharge been affecting your daily life in any way, such as your work, sleep, or relationships?"

Examination (Verbalised)

"To understand better, I'd like to check a few things, if that's okay."
Verbalise:
"I'd like to check your vital signs (BP, pulse, temperature, respiratory rate, oxygen saturation)."
"I'd also like to examine your abdomen."
"With your consent, I'd suggest a vaginal examination using a speculum to inspect for discharge source, redness, swelling, and any foreign body."
"I would also take a swab for infection testing if needed."
Chaperone: Offer a chaperone and maintain privacy and dignity.
Gain consent.

Provisional Diagnosis

Based on history and findings:
Likely diagnosis: **Vulvovaginal Candidiasis** (yeast infection).

Explain in lay terms:

"It sounds like you might have a yeast infection, also known as thrush. It's a common fungal infection that causes white discharge, itching, and irritation. It's not a serious infection, and it's very treatable."

Management

Step	*Action*
Antifungal Treatment	"We'll treat this with a single dose of an antifungal tablet called **fluconazole**, which you take by mouth. Alternatively, a vaginal pessary could be used if you prefer."
Swabs	"I would like to send a vaginal swab to confirm the diagnosis and rule out any other infections like bacterial vaginosis or sexually transmitted infections."
Hygiene Advice	- Avoid using perfumed soaps, bubble baths, douches, or vaginal deodorants. - Stick to plain water or non-perfumed washes. - Wear cotton underwear and avoid tight clothing. - Keep the vaginal area as dry as possible.
Sexual Activity	"It's advisable to avoid sexual intercourse until symptoms completely resolve."
Partner treatment	"Usually, partners don't need treatment unless they have symptoms."
Follow-Up	"If your symptoms don't improve within 7 days, or if they come back frequently, please come back to us. We'll then consider further evaluation or alternative treatments."
Safety Netting	"If you develop severe lower abdominal pain, fever, or very heavy discharge, please contact us or seek urgent care."

Addressing Likely Patient Concerns

"Will this affect my fertility?" ➔ No, uncomplicated thrush does not affect fertility.

"Can this be passed to my partner?" ➔ Only if symptomatic, in which case partner treatment can be discussed.

"Will it come back?" ➔ Some people are prone to recurrent thrush, and we can discuss longer-term management if needed.

Leaflet

Offer a leaflet on **vaginal thrush** from NHS website.

Bacterial Vaginosis

Setting: GP Surgery
Role: FY2 Doctor
Patient: 40-year-old woman presenting with vaginal discharge

Introduction

Greet warmly: "Good morning, my name is Dr. [Name], one of the doctors here today."

Confirm identity: "Could you confirm your full name and age for me, please?"

Build rapport: "It's nice to meet you, [First Name]. I understand you made an appointment today because you've been having some discharge — is that correct?"

Presenting Complaint Clarification (Morphology – Evolution – Symptoms)

Morphology (Discharge Characteristics):

"Could you describe the discharge? Is it watery, creamy, thick, or thin?"

"What colour is it?"

"Does it have any smell?"

Evolution (Time Course):
"When did you first notice the discharge?"
"Is it continuous or comes and goes?"
"Has it been getting better, worse, or staying the same?"

Associated Symptoms:
"Is there any itching or irritation?"
"Any pain during sexual intercourse?"
"Any pain or burning sensation when passing urine?"
"Any lower abdominal pain?"
"Any redness, swelling, or lumps around the genital area?"

Risk Factor Screening
"Have you changed any hygiene products recently? (like soaps, bubble baths, vaginal douches?)"
"Have you noticed any changes in your sexual activity or new partners recently?"
"Are you using any contraception methods?"
"When was your last sexual health screening?"

Focused History
Medical history: "Any ongoing medical conditions?"
Allergies: "Any allergies to medicines?"
Past history: "Have you had similar symptoms before?"
Drug history: "Are you on any regular medications?"
Obstetric/Gynae history: "When was your last menstrual period? Were your cycles regular before?"
Social history:
"Do you smoke?"
"Do you drink alcohol?"
"What kind of work do you do?"

ICE (Ideas, Concerns, Expectations)
"Do you have any idea what might be causing these symptoms?"
"Is there anything you're particularly worried about?"
"What were you hoping we could do for you today?"

Effect on Life
"Has this discharge been affecting your daily activities, work, or personal life?"

Examination (Verbalised)
"I'd like to examine you to better understand the cause, if that's alright."
Verbalise:
"I would check your vital signs — blood pressure, pulse, temperature, oxygen saturation."
"I'd also like to perform a gentle abdominal and external genital examination."
"With your consent, I'd recommend a **speculum examination** to directly visualise the cervix and vagina, and take a swab for infection testing."
Offer a chaperone and maintain privacy.
Gain verbal consent.

Provisional Diagnosis

Based on history and examination:

Likely diagnosis: Bacterial Vaginosis (BV)

Explain in lay terms:

"It sounds like you have a very common condition called **Bacterial Vaginosis**. It's not a serious infection but happens when the normal healthy bacteria in the vagina get disrupted, allowing other types of bacteria to overgrow."

Management

Step	*Action*
Antibiotics	"I'll prescribe a course of **oral metronidazole 400mg twice daily for 7 days**." "An alternative would be a metronidazole vaginal gel if you prefer, but tablets are more commonly used."
Swabs	"I would take a swab today to confirm the diagnosis and screen for other infections like gonorrhoea and chlamydia, just to be thorough. Results usually take about 48 hours."
Self-Care Advice	- Avoid perfumed soaps, bubble baths, or vaginal douches. - Wash with plain water or non-perfumed products. - Wear cotton underwear and loose clothing. - Avoid smoking as it increases the risk of BV recurrence.
Sexual Activity Advice	"BV itself is not considered a sexually transmitted infection, but using condoms may reduce the risk of recurrence. You can continue normal sexual activity once treatment starts if comfortable."
Smoking Cessation	"Smoking is a known risk factor for BV. If you smoke, stopping can help reduce recurrences."
Follow-Up	"I'd like you to come back in about a week to see if the symptoms have improved. If things don't get better, we can review and adjust treatment if needed."
Safety Netting	"If you develop fever, severe pelvic pain, or worsening discharge, please come back to us or seek urgent care."

Addressing Specific Concerns

Patient may ask:

"Did I get this from my husband?"

➔ "BV is not considered a sexually transmitted infection. It's an imbalance of the natural bacteria inside the vagina. It can happen spontaneously, without catching it from someone."

Leaflet

Provide an NHS leaflet on **Bacterial Vaginosis** with information on hygiene, symptoms, treatment, and when to seek help.

Vaginal Discharge Types

Feature	*Thrush (Candida)*	*BV*	*Trichomoniasis*
Discharge	Thick, white, like cottage cheese	Thin, grey-white, fishy smell	Frothy, yellow-green, bad smell
Smell	No strong smell	Strong fishy smell	Strong bad smell
Itching	Yes, severe	No	Sometimes
Pain	Burning or soreness	Usually no pain	Mild soreness
pH	Normal (<4.5)	High (>4.5)	High (>4.5)

Treatment	Fluconazole	Metronidazole	Metronidazole
Partner treatment?	No	No	Yes

Persistent Dysuria

Setting

FY2 doctor in GP surgery

Follow-up consultation for unresolved urinary symptoms after two antibiotic courses

1. Introduction

Greet warmly and confirm identity:

"Hello, I'm Dr. __. *It's nice to meet you. Could I confirm your full name and age, please?"*

2. Clarify today's visit

Confirm the reason for attending:

"I see you've come back to see us today. Could you tell me what's been going on?"

(Patient says: "Still burning when passing urine despite antibiotics.")

Acknowledge gently:

"Thanks for sharing that. It sounds really uncomfortable, I'm glad you came back so we can sort this out."

3. Paraphrase the clinical background naturally

Summarize briefly:

"Just to make sure I have the full picture – you were prescribed two courses of antibiotics recently for what was thought to be a urine infection. Is that right?"

Transition naturally:

"Let's go over exactly how things have been since then, so we can plan the best next steps for you."

3. Review Progress and Reassess

Current symptom status:

"Could you describe the symptoms you're still experiencing?"

"Is it burning only when passing urine, or at other times too?"

"Has it been getting better, worse, or staying about the same?"

Associated symptoms:

"Are you passing urine more often than usual?"

"Any feeling of needing to rush to the toilet?"

"Any blood in the urine?"

"Any new lower abdominal pain or back pain?"

"Any fever, chills, or feeling generally unwell?"

Vaginal symptoms:

"Any discharge, irritation, or vaginal discomfort?" (Patient: No)

Sexual history:

"Are you sexually active at the moment?"

"Has there been any change in partners or any new sexual contacts recently?" (Only husband, married 6 months)

Relationship timing:

"When did you last have intercourse?"

Hygiene practices:

"Do you use any special soaps, douching, or feminine hygiene products?"
"Do you usually pass urine after intercourse?"
Contraception:
"I see you're on injectable contraception – how often do you get your injections?"
Red flag screening:
Unintentional weight loss?
Loss of appetite?
Persistent severe abdominal or back pain?
(Patient denies these.)

4. PMAFTOSA (Focused Quick Check)

Past Medical History:
Previous UTIs?
Kidney stones or urinary tract problems?
Chronic illnesses (e.g., diabetes)?
Allergies:
Any known allergies to medications?
Family History:
Family history of early diabetes, renal disease?
Social:
Smoking? Alcohol?

5. ICE (Ideas, Concerns, Expectations)

Explore her ideas:
"Do you have any thoughts about why the symptoms might still be there?"
Explore her concerns:
"Are you worried that this could be something more serious?"
Explore expectations:
"What were you hoping we could do today?"
(Patient worried about persistent infection, hopes for solution.)

6. Examination

Observations:
Temperature: Normal
Pulse: Normal
Blood pressure: Normal
Focused abdominal examination:
Soft abdomen
Non-tender suprapubic region
No renal angle tenderness

Management Plan

1. Explain Working Diagnosis
"Since you haven't improved after two courses of antibiotics, it's less likely this is a simple urine infection, and we need to consider other possible causes. Sometimes infections that are transmitted through sexual contact can cause symptoms like yours, even without obvious signs like discharge."
"We would take some samples today to check for any infections and make sure you get the right treatment."

"These types of infections wouldn't have responded to the usual antibiotics given for urinary infections, which is why you're still feeling the same."

2. Investigations and Immediate Actions

Take **high vaginal swabs** and **urine sample** for full STI screening (including chlamydia and gonorrhoea).

Send urine for culture and sensitivity if not done already.

"I would like to take some swabs today to check for these infections."

Referral:

Refer to GUM clinic for specialist sexual health assessment and contact tracing.

"I will also refer you to a specialist sexual health clinic. They are very supportive, and everything is kept confidential. They will help with testing and advising your partner too."

Offer Partner Testing:

"It's important that your husband also gets tested and treated if needed, even if he has no symptoms."

3. Treatment

Start **empirical treatment with Doxycycline** after taking swabs:

"We usually start a course of antibiotics today, but we will adjust the treatment if needed once we get the results."

Doxycycline 100 mg BD for 7 days (standard for uncomplicated chlamydia).

4. Advice and Preventive Measures

Urinary hygiene:

"Try to empty your bladder soon after intercourse."

"Stay well hydrated, and avoid strong soaps or perfumed products around the genital area."

Safe sex:

"Using condoms regularly helps protect against infections, even in long-term relationships."

5. Safety Netting

"If you develop a high fever, severe lower tummy pain, new back pain, or start feeling very unwell, please seek urgent medical help or attend A&E immediately."

6. Follow-Up

Review results in **1 week** or sooner if deteriorates.

Confirm resolution of symptoms and test-of-cure if needed.

7. Patient Leaflets

Provide written information about:

- STIs
- Safe sex practices
- Managing recurrent urinary symptoms
- GUM clinic referral process

Pelvic Inflammatory Disease

1. Introduction

"Good morning, I'm Dr. [Name], one of the doctors working today."
"Could I confirm your full name and age, please?"
"Nice to meet you. I understand you've come in with some tummy pain — is that right?"

2. Focused Symptom History (Abdominal Pain + Discharge)

"Could you tell me a bit more about the tummy pain — where exactly is it?"
(Belt-like lower abdomen pain noted)
"When did you first notice this pain?"
"Is the pain constant or does it come and go?"
"Is it sharp, cramping, dull… how would you describe it?"
"On a scale of 1 to 10, how severe is it?"
"Does anything make it better or worse?"
"Any pain during sexual activity?"
"Have you noticed any discharge from the vagina? What colour is it? Any smell?"
"Any pain or burning when you pass urine?"

3. Focused Risk Factor Screening

Menstrual history:
"When was your last period?"
"Have you noticed any bleeding between periods or after sex?"
"Have you missed any periods?"

Pregnancy possibility:
"Is there any chance you could be pregnant?"

Sexual history:
(Sensitive approach, signpost)
"I'm sorry if these questions feel a little personal, but they are important for your care. Is that alright?"
"Are you currently sexually active?"
"Do you use any contraception?"
"You mentioned taking the mini pill — do you use condoms as well?"
"Have you had any new or multiple partners recently?"

Past infections:
"Have you ever been diagnosed with a sexually transmitted infection before?"
"Any similar problems like this in the past?"

4. Check ICE

Ideas: "What do you think might be causing the symptoms?"
Concerns: "Is there anything specific you're worried about?"
Expectations: "Is there anything you were hoping I could do for you today?"

5. Effect on Life

"Has this pain affected your work, social activities, or sleep?"
"How are you coping emotionally with everything?"

6. Clinical Examination

"To help find the cause, I would normally examine your tummy and do a pelvic examination if appropriate."

"Today there's no mannequin, so I'll talk you through what I would check."

Vitals: Check BP, pulse, temp, oxygen saturation.

Abdominal exam: Look for tenderness, guarding.

Pelvic exam: Look for cervical motion tenderness, adnexal tenderness, abnormal discharge.

"I would also check a urine sample to rule out urine infections."

7. Diagnosis

"Based on what you've told, I'm concerned you could have a condition called **pelvic inflammatory disease (PID)**."

"This is when an infection travels upwards from the vagina into the womb and the fallopian tubes, causing inflammation."

"It's often caused by sexually transmitted infections, but sometimes even normal bacteria can cause it."

8. Explanation

"It's not your fault — it can happen even if you have few partners or use contraception."

"If untreated, PID can sometimes lead to complications like infertility, chronic pain, or pregnancy problems. That's why early treatment is really important."

9. Management Plan

Immediate steps:

"I would like to refer you to the **GUM clinic** — that's the sexual health clinic — for urgent tests and confirmation."

"You can walk in without an appointment. It's completely confidential — they won't contact anyone else unless you want them to."

"They will take swabs from the cervix and vagina and may do some blood tests."

Treatment:

"Even before we get all the results back, we usually start treatment to cover common infections."

"You would be given:"

Ceftriaxone injection (one time) +
Doxycycline tablet twice a day for 14 days +
Metronidazole tablet twice a day for 14 days
(We remember it as 'PID = D + M.')

Partner Notification:

"It's important that your current partner (and any recent partners in the last 6 months) also get tested and treated."

"The GUM clinic offers confidential services if you prefer that we don't contact them yourself."

Abstinence Advice:

"Please avoid sexual activity until both you and your partner(s) have completed treatment."

Follow-up:

"We would usually check on you in 72 hours to make sure the symptoms are improving."

"If they don't improve, we may need to arrange more investigations like an ultrasound."

10. Safety Netting

"Please seek urgent help if you notice:"

High fever
Severe lower tummy pain
Fainting
Vomiting
Worsening symptoms despite antibiotics

"In that case, you may need to go to the hospital for stronger antibiotics through a drip."

11. Leaflet and Emotional Support

"I'll give you a leaflet about PID, symptoms to watch out for, and safe sex practices."

"I know this might feel overwhelming, but you've done the right thing coming early, and we'll manage this together."

Alternate Scenarios and Key Differences in GP vs A&E

PID Presentation in GP Setting (Mild to Moderate) with mannequin

Scenario Setup	***32-year-old woman with lower abdominal (belt-like) pain.*** ***Foul-smelling discharge*** ***Casual sexual encounters, unprotected sex.*** ***Stable vitals*** ***No severe systemic features.***
Initial Action	- Build rapport. - Take focused history (pain, discharge, STI risk, sexual history). - ICE. - Verbalise general and abdominal examination.
Examination Findings	- Perform full abdominal examination Bilateral lower abdominal tenderness. - No fever or only mild (<38°C).
Diagnosis	- Suspected **Pelvic Inflammatory Disease (PID)** (mild/moderate).
Management	Start empirical **oral antibiotic treatment immediately**: - Ceftriaxone 1g IM single dose - Doxycycline 100 mg BD for 14 days - Metronidazole 400 mg BD for 14 days **Refer to GUM clinic** for full STI screen and partner notification. Advise abstaining from sex until treatment completed. Educate on condom use and safe practices. **Review after 72 hours** to check for improvement. **Safety Net:** If symptoms worsen (fever, vomiting, worsening pain), return urgently.
Key Point	- GP can manage **mild PID** outpatient with antibiotics + GUM clinic referral. - **Do not delay treatment** waiting for swab results.

PID Presentation in A&E Setting (Severe)

Scenario Setup	***25-30-year-old woman with severe belt-like abdominal pain*** ***Wincing in pain*** ***Foul-smelling discharge.*** ***Fever (>38°C)*** ***Recent high-risk sexual behaviour***

	Looks unwell.
Initial Action	- Quick assessment. - Offer IV pain relief early. - Insert IV cannula. - Keep patient NBM (anticipating surgery).
Examination Findings	- Guarding, rebound tenderness. - Examiner may provide: "Ultrasound shows tubo-ovarian abscess."
Diagnosis	- Severe PID with likely **tubo-ovarian abscess** (complication).
Management	**Immediate admission under Gynaecology**. **IV antibiotics:** - Ceftriaxone IV + Doxycycline IV + Metronidazole IV. IV fluids, monitor vitals. Prepare for **emergency laparoscopic surgery** if abscess needs drainage. Inform about risk to fertility. Pregnancy test must be checked. Notify GUM clinic later for full STI screen once stable.
Key Point	- **Severe PID is a surgical emergency**. - IV treatment mandatory. - Never discharge home. - Early escalation to senior/gynaecology team.

Gonorrhoea Positive Test Result

1. Introduction and Consent

"Good morning, I'm Dr. [Name], one of the doctors here today. Could I confirm your full name and age, please?"

"Thank you. I understand you've come in today to discuss the results of the tests you had recently. Is now a good time to talk?"

Build rapport gently — observe if patient appears anxious or reserved.

"Please feel comfortable. I'll explain everything clearly and you're free to ask any questions as we go."

2. Focused Symptom Review

"Since your last visit, have you noticed any new symptoms?"

Lower abdominal pain?

Pain when passing urine?

Any unusual vaginal discharge?

Bleeding between periods?

Fever or feeling generally unwell?

3. Focused Risk Factor History

"To make sure we're giving you the right advice, could I check a few details about your sexual health?"

Preface sensitively:

"These questions are routine for everyone and confidential — you can choose not to answer anything you're uncomfortable with."

Ask gently:

"Are you currently sexually active?"

"Is it with a regular partner or multiple partners?"
"Do you normally use protection such as condoms or dental dams?"
"Have you or your partner ever been tested or treated for any STIs before?"
"Do you or your partner use shared sex toys?"
"If yes, how do you usually clean them between uses?"

Confirm no assumptions about sexuality — **keep gender-neutral language** unless patient specifies.

4. Clarify ICE (Ideas, Concerns, Expectations)

"Did you have any thoughts about what the cause of your symptoms might be?"
"Anything in particular you were worried about?"
"Is there anything you were hoping we could do for you today?"

5. Clear Result Disclosure

Calm, clear tone:

"Your test results show that you have an infection called gonorrhoea."

Pause, give patient time to process.

Continue gently:

"It's a common bacterial infection that spreads through sexual contact, and can also spread through shared items like sex toys if not properly cleaned."

6. Explanation of Gonorrhoea

"Gonorrhoea is fully treatable with antibiotics."
"If left untreated, it could lead to complications like pelvic inflammatory disease, which can affect fertility, or increase the risk of other infections like HIV."
"It's good that we picked it up early."

7. Management Plan

Immediate Treatment:

"We recommend starting treatment today with:
Ceftriaxone injection (1 g intramuscular)

Check allergies before prescribing.

Partner Notification:

"It's important to inform any sexual partners you've had in the past 6 months so they can get tested and treated if needed."
"If you prefer, we can arrange for anonymous, confidential partner notification — we won't disclose your identity."

Abstinence Advice:

"Please avoid any sexual activity (including oral, vaginal, or anal sex) until **7 days after** you and any partners have completed treatment."

Referral to GUM Clinic:

"I'll refer you to a specialist sexual health (GUM) clinic to offer further support, check for any other STIs, and arrange a follow-up."

8. Reassurance about Confidentiality

If patient appears anxious about confidentiality:

"Please be reassured that everything you share with us is confidential.
We will not contact your family or anyone else without your consent, unless it's a serious safeguarding concern — and this situation doesn't fall under that."

9. Follow-up and Prevention

Test of Cure:

"We'll arrange a repeat test after 2 weeks to make sure the infection is fully cleared."

Retesting:

"We recommend retesting in 3 months to check for any reinfection."

Prevention Advice:

"Using condoms or dental dams during all types of sex reduces the risk of getting or passing on infections."

"If you use sex toys, it's important to clean them thoroughly between uses."

10. Emotional Support and Closure

Acknowledge emotions:

"I completely understand this might feel upsetting or overwhelming. Please remember this is a common infection, easily treated, and you are taking the right steps."

Offer emotional support:

"If you'd like, I can refer you to a sexual health counsellor if you feel talking to someone might help."

Safety net:

"Please contact us urgently if you develop worsening symptoms like fever, severe tummy pain, or persistent discharge."

Final check:

"Would you like me to go over anything again?"

"Would you like a leaflet explaining gonorrhoea and safer practices?"

Breast Lump

Setting

FY2 in GP surgery

Patient: Woman aged 50+ presenting with breast lump found during self-examination

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1. Introduction (30–40 seconds)

Greet and confirm identity:

"Hello, I'm Dr. __. *May I confirm your full name please?*"

Confirm age:

"And how old are you?"

Open question to explore reason for visit:

"I understand you made an appointment with us today – could you tell me a little more about it in your own words?"

2 Breast Lump History

1. Morphology (What is the lump like?)

Ask naturally:

Which breast is affected?

"Which breast have you noticed the lump in – your left or right?"

Where exactly is it?

"Which part of the breast? More towards the outer side, the inner side, above, or below?"

Size

"Roughly how big would you say the lump is? For example, the size of a grape, a pea, or somewhere in between?"

Consistency

"When you feel it, does the lump feel hard like a marble, or softer like a rubber ball?"

Texture/Surface

"Is the surface of the lump smooth, or are the edges irregular or uneven?"

Shape

"Does the lump feel round and regular, or does it have an uneven shape?"

Mobility

"When you press on it, does the lump move around easily, or does it feel fixed to the skin or deeper tissue?"

2. Evolution (How has it changed?)

Ask naturally:

Onset

"When did you first notice the lump?"

Progression

"Since you first found it, has it changed in size – getting bigger, smaller, or staying about the same?"

Variability

"Does the size or feel of the lump change depending on your posture – for example, when lying down or leaning forward?"

3. Symptoms (Associated symptoms)

Ask systematically:

Pain

"Is there any pain or tenderness over the lump, either when touching it or at rest?"

Skin changes

"Have you noticed any redness, dimpling, puckering, or changes to the skin over the lump?"

Nipple changes

"Any changes to the nipple – such as becoming pulled in (inverted), changing color, or leaking any fluid or blood?"

Nearby lumps

"Have you felt any lumps in the armpit or around the collarbone?"

General systemic symptoms

"Have you noticed any unintentional weight loss, unusual tiredness, or generally feeling unwell?"

3. Focused Past Medical History (PMAFTOSA)

Past Breast Conditions:

"Any previous breast lumps, cysts, surgeries, or breast infections?"

Medical History:

"Any other health issues – like immune system problems?"

Medications:

"Any current medications, especially hormonal therapies or contraceptives?"

Allergies:

"Any known allergies?"

Family History:

"Any history of breast cancer or ovarian cancer in your family?" (Mother and sister – positive history)

Travel, Occupation, Lifestyle:

"Have you travelled recently?"

"What kind of work do you do?"

"Do you smoke?"

"Do you drink alcohol?"

"Any recent changes in your weight?"

Obstetric and Gynaecological History:

"Do you have children? At what age did you have your first child?"
"Did you breastfeed?"
"At what age did you start your periods?"
"Have you reached menopause? At what age?"

4. ICE (Ideas, Concerns, Expectations)

Explore naturally:
"Do you have any thoughts about what might be causing this lump?"
"Is there anything specific you're worried about?"
"What were you hoping we could do for you today?"
(Patient likely worried about cancer)

5. Examination

1. Setup (Patient Interaction)

Thank the patient politely:
"Thank you for answering my questions so far, Mrs. __."
Explain the examination purpose:
"Now I would like to examine your breasts to better understand what may be causing your lump or discomfort."

Explain experience (pain/uncomfortable):
"The examination should not be painful, although you might feel a little uncomfortable at times. If at any point you feel discomfort, please let me know and we can pause."
Explain what examination will involve:
"I'll be looking at and gently feeling both breasts and underarm areas."

Explain position:
"I will ask you to sit, stand, and lie down during the examination."

Explain exposure:
"You'll need to be undressed from the waist up, including removing your undergarments. I will maintain your privacy throughout."

Chaperone:
"I will have a female chaperone from the medical team present throughout the examination."
Privacy:
"I'll ensure the examination is done respectfully and privately."

Gain final consent:
"Are you happy for me to proceed?"
(Wait for the patient to give clear consent before continuing.)

Mental Structure for the Exam:

INSPECTION → PALPATION (superficial → deep) → AXILLA

Step 1: Inspection (while sitting)

Patient seated upright, fully exposed chest (waist up), relaxed posture.

Inspect with hands relaxed on lap

Look for symmetry, contour, skin changes (redness, dimpling, puckering)

Nipple changes (inversion, discharge, rashes)
Swelling or visible lumps
Visible veins or oedema

Inspection with hands pressed on hips (tightens pectoral muscles)
Reveals tethering or skin dimpling more clearly

Inspection leaning forward slightly
Reveals masses that fix the breast to chest wall

Inspection with hands placed behind head
Again, stretches breast tissue to reveal subtle changes

Ask patient to gently lift each breast with their own hands
To inspect undersurface for skin tethering, inflammation

Ask patient to gently squeeze each nipple (one at a time)
Observe for any nipple discharge (note side, colour, quantity)

Throughout inspection:
Maintain patient dignity
Observe patient's facial expressions

Step 2: Palpation – Superficial (temperature and tenderness)

Patient lying at 45° angle
Breasts fully exposed

Check temperature
Use back of fingers
Compare each quadrant (right vs left)

Superficial palpation for tenderness
Lightly palpate all 4 quadrants + axillary tail
Watch the patient's face for discomfort
Palpate areola carefully with one finger (do **not** directly touch nipples yet)

Step 3: Palpation – Deep (for lumps/masses)

Still lying at 45° angle.

Palpate deeply quadrant-by-quadrant

Use systematic method:
Upper outer quadrant
Upper inner quadrant
Lower outer quadrant
Lower inner quadrant
Axillary tail of Spence

If a mass is found, assess fully:

Characteristic	*Question*
Site	Which quadrant, how far from nipple
Size	In centimetres
Shape	Round, irregular
Consistency	Hard, firm, soft
Surface	Smooth, irregular
Mobility	Freely mobile or fixed to skin/chest wall
Tenderness	Tender or non-tender

Step 4: Palpation – Axillary Lymph Nodes

Now patient **standing**, facing examiner.
Perform axilla exam systematically:

Patient's right arm rests on your left shoulder
Your left hand supports her arm
Right hand palpates her right axilla for nodes:
- Anterior group (along chest wall)
- Posterior group (along back wall)
- Medial group (along inner upper arm)
- Lateral group (deep high axilla)
- Apical group (top of axilla)

Repeat on left side.

Ask patient to cross arms over chest
Palpate posterior axilla nodes better from the back.

Examine for:

Enlarged, firm, matted, tender nodes

Findings

Scenario 1: Lump found, no palpable axillary nodes.
Scenario 2: No lump found.

Management for Breast Lump Scenarios

Scenario A: Lump Found on Examination

1. **Acknowledge finding kindly**:
"I have felt a lump during the examination today, and I understand this can feel worrying."
2. **Explain seriousness honestly but softly**:
"Most breast lumps are not cancer, and there are many other possible causes like cysts or benign (non-cancerous) changes. However, because you have a lump, especially given your family history, we need to investigate it properly to be sure."
3. **Explain referral (2WW)**:
"I would like to refer you to a specialist breast clinic today. You'll get an appointment within 2 weeks under what's called the 'urgent two-week pathway.' This is standard practice whenever a breast lump is found – it doesn't automatically mean cancer is suspected, but it's to make sure we don't miss anything."

4. **Explain what will happen at breast clinic (tests in layman terms):**
Mammogram:
"You'll likely have a mammogram, which is a special type of X-ray that takes a detailed picture of your breast tissues."
Ultrasound:
"They might also do an ultrasound scan – that's where they use sound waves to create a picture of what's inside the breast, similar to the scans used during pregnancy."
Biopsy (if needed):
"If they see anything that needs a closer look, they may take a tiny sample of tissue with a fine needle – this is called a biopsy. It helps them check the cells under a microscope."

5. **Reassure about support**:
"You can take a family member or a friend with you to the appointment for support if you wish."

6. **Safety Netting**:

"If you don't hear from the breast clinic within two weeks, please contact our surgery immediately."
"Also, if you notice any changes like the lump growing quickly, new pain, skin dimpling, nipple changes, or new lumps in the armpit, please come back straight away."

7. **Offer emotional support**:
"This can understandably feel overwhelming. If you'd like, I can arrange for you to speak to a counsellor or a breast care support service while waiting for your appointment."

8. **Leaflet**:
Provide:
Breast clinic 2WW referral information leaflet
Breast lump awareness leaflet

Scenario B: No Lump Found on Examination

1. **Reassure kindly**:
"I have carefully examined your breasts today, and I haven't found any lumps or anything concerning."
2. **Acknowledge patient's feelings**:
"It's completely normal to feel worried when you notice a change, and you've done exactly the right thing by coming in to get it checked."
3. **Breast self-awareness education**:
"It's important to continue being breast aware. That means checking your breasts regularly, about once a month, ideally after your period if you're still having them."

4. **Teach signs to watch for**:
"When you check, you're looking for things like:
New lumps
Changes in size or shape
Skin changes like dimpling or redness
Nipple changes like inversion or new discharge"

5. **Explain routine screening**:
"Because you're over 50, you're eligible for regular mammograms every three years through the national breast screening programme."
"Mammograms are like a special X-ray of the breast tissue that helps detect very small changes before they become noticeable."

6. **Safety netting**:
"If you notice any new changes in your breasts before your next routine check, please don't wait – come back and see us straight away."

7. **Leaflet**:
Provide:
Breast self-examination leaflet
Routine breast screening program leaflet

Breast Engorgement

Setting

FY2 in GP surgery
Female patient recently gave birth (about 3 weeks ago)
Presenting with breast pain

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1. Introduction

Greet warmly and confirm identity:
"Hello, I'm Dr. __. *Could I confirm your full name and age, please?*"
Open the consultation:
"I understand you've come in today with some breast discomfort. Could you tell me a little more about it?"

2. History of Presenting Complaint

Clarify the breast pain:
- *"Could you describe the pain a little more? Is it sharp, dull, constant, or comes and goes?"*
- *"Is the pain affecting one breast or both?"*
- *"When did it first start?"*
- *"Has it been getting better, worse, or staying the same?"*

Screen for red flag symptoms:
- *"Have you noticed any fever, chills, or feeling generally unwell?"*
- *"Have you noticed any redness, warmth, or swelling over your breast?"*
- *"Any lumps or areas that feel harder than usual?"*
- *"Any nipple discharge – such as milk, blood, or pus?"*

Obstetric history:
- *"Congratulations on your new baby! May I ask, how many weeks ago did you give birth?"*
- *"How has breastfeeding been going? Any difficulties like latching problems, blocked ducts, or pain while feeding?"*

Associated history:
- *"Any recent trauma or injury to the breast?"*
- *"Any rashes over the breast?"*
- *"Is the pain related to your periods returning?"*

Additional general questions:
- *"Any breathing difficulty?"*
- *"Any leg pain or swelling?"*
  (Screening for clot risk postpartum.)

PMAFTOSA:
- **P**ast medical history: *"Any past breast issues or infections?"*
- **M**edications: *"Any regular medications you're taking?"*
- **A**llergies: *"Any allergies?"*
- **F**amily history: *"Any family history of breast cancer?"*
- **T**ravel: *"Any recent long travels or flights?"*
- **O**ccupation: *"Are you currently working or on maternity leave?"*
- **S**ocial history: *"Do you smoke or drink alcohol?"*
- **A**ny other concerns: *"Anything else you feel I should know?"*

ICE:
- **Ideas:** *"What do you think might be causing the pain?"*
- **Concerns:** *"Is there anything in particular you're worried about?"*

Expectations: *"What were you hoping we could do for you today?"*

Effect on Life:

"How is the pain affecting your feeding, sleep, or daily activities?"

3. Examination

Explain clearly:

"Thank you for sharing all that with me. I'd now like to examine your breasts to better understand what's going on."

Explain procedure:

"It involves looking at and gently feeling both breasts and your underarms. It shouldn't be painful, but might feel slightly uncomfortable. I'll have a female chaperone present and ensure your privacy."

Ask for consent:

"Would it be alright to proceed?"

Examination Technique:

Step	*What to Do*
General inspection	Observe sitting up
Breast inspection	Symmetry, redness, shiny skin, nipple changes
Palpation	Temperature check, superficial and deep palpation of all quadrants
Nipple examination	Gently check for discharge
Axillary nodes	Palpate for swelling/tender nodes

Findings given:

Breasts feel **firm, full, tender**
No obvious lumps/masses
No nipple discharge
No axillary lymphadenopathy
No focal redness (early stage)

4. Diagnosis

" Based on the symptoms and examination, it looks like you're experiencing **breast engorgement**. *Have you heard of it before?"*

"No? That's okay. Let me explain:"

"Breast engorgement is very common after giving birth. It just means that your breasts are very full of milk – sometimes a little more than the baby is taking out. This extra build-up makes the breasts feel swollen, tight, heavy, and sore. It's not harmful by itself, but if it's not managed, it could lead to an infection later. So, it's really important to keep the milk moving by breastfeeding or expressing regularly. With the right steps, you should feel much better quite quickly."

5. Management Plan

Lifestyle and self-care advice:

"The most important thing is to keep the milk flowing regularly. Here are a few things that will help:"

Continue breastfeeding or expressing regularly:

"Keep feeding your baby on demand, ideally every 2–3 hours. This prevents milk from building up."

Warm compress before feeding:

"Apply a warm towel or warm flannel to the breast for about 5–10 minutes before feeding. This helps stimulate milk flow."

Breast massage during feeding:

"Gently massage your breast while feeding or expressing, starting from the outer part of the breast and moving towards the nipple."

Cold compress after feeding:
"After feeding, apply a cold pack for about 15 minutes to reduce swelling and ease the discomfort."
Supportive bra:
"Wear a well-fitting but not too tight bra to support your breasts comfortably."
Change feeding positions:
"Varying your baby's feeding positions can help drain different parts of the breast."

Safety Netting:
"If you notice any worsening pain, fever, redness, or if the breast becomes very hard or hot, it could mean an infection called mastitis. Please come back immediately if that happens – we can treat it early with antibiotics if needed."

Follow-up advice:
"If you don't improve within 24–48 hours despite these measures, please return for reassessment."

Leaflets:
Breast engorgement self-care leaflet
Breastfeeding advice leaflet

Offer final support:
"You're doing really well. This is a common issue, and with a little adjustment it usually improves quickly. Please don't hesitate to contact us if anything changes."
Thank and close politely.

Mastitis

Setting

FY2 doctor in GP surgery
28-year-old postpartum woman (~1 month postpartum)
Presenting with breast pain, swelling, fever

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1. Introduction

Greet and confirm identity:
"Hello, I'm Dr. __. *Could I please confirm your full name and age?*"
Open concern:
"I understand you've come in with breast discomfort. Could you tell me a little more about what's been happening?"

2. Focused History Taking

Symptom Analysis (SOCRATES + ODIPARA):
"Could you describe the pain – is it sharp, burning, throbbing?"
"Is it affecting one breast or both?"
"When did it start?"
"Is it getting better, worse, or staying the same?"
"Any lumps, swelling, or tenderness you've noticed?"
"Any warmth or redness over the breast?"
"Any nipple discharge – milk, pus, blood?"

Infection screen:
"Have you had any fever, chills, or feeling generally unwell?"

Breastfeeding history:
"How has breastfeeding been going?"
"Any difficulties with latching, skipping feeds, cracked nipples, or breast engorgement before?"
"Do you feel the burning sensation more when feeding?"
"Is your baby feeding well?" (Brief infant check)

Other symptoms:
"Any night sweats?"
"Any rash over the breast?"
"Any trauma or injury to the breast recently?"
"Any breathing difficulties or leg pain/swelling?" (PE/DVT screen postpartum)

FLAWS:
"Any lumps or bumps elsewhere in your body?"

PMAFTOSA:
Past medical history: *"Any previous breast problems or infections?"*
Medications: *"Any regular medications you're taking?"*
Allergies: *"Any allergies to medications?"* (→ Important: Penicillin allergy known)
Family history: *"Any family history of breast cancer?"*
Travel: *"Any recent travel?"*
Occupation: *"Are you working or on maternity leave currently?"*
Social: *"Do you smoke or drink alcohol?"*

ICE:
Ideas: *"What do you think might be causing the problem?"*
Concerns: *"Is there anything you're particularly worried about?"*
(→ Patient asks: "Can I continue breastfeeding my baby?")
Expectations: *"What were you hoping we could help you with today?"*

Effect on life:
"How is the pain affecting your ability to breastfeed or take care of your baby?"

3. Examination

Explain examination:
"I'd now like to examine your breasts carefully to understand the cause of the pain. I'll ensure your privacy, have a female chaperone present, and I'll be as gentle as possible. Would that be alright?"

Verbalize setup:
Wash hands
Proper exposure (waist up)
Chaperone present

Inspection:
Symmetry
Redness
Swelling

Skin changes (dimpling, shiny skin)
Nipple cracks or abnormalities

Palpation:
Temperature difference
Tenderness
Firm, lumpy area (wedge-shaped swelling around nipple)
Axillary nodes (palpate for swelling)

Findings:
Tender, warm, swollen area around nipple
No pus, no bloody nipple discharge
No palpable lymph nodes
Expressed pain during examination
Thank the patient and allow dressing.

4. Diagnosis

Deliver diagnosis clearly:
*"Thank you for allowing me to examine you. Based on the symptoms you described and what I found today, it looks like you're experiencing **mastitis**."*

Natural layman explanation:
"Mastitis is an infection of the breast tissue. It often happens when milk builds up and doesn't drain properly, creating pressure and allowing bacteria to enter, especially if there are small cracks around the nipple. This causes swelling, redness, pain, and sometimes fever."

Confirm understanding:
"Does that explanation make sense so far?"

5. Management Plan

Address immediate emotional concern (continue breastfeeding):
*"You absolutely **can and should continue breastfeeding**. In fact, keeping the milk flowing helps the breast heal faster. It's completely safe for your baby, even with mastitis."*
Full Management:

Pain relief:

*"You can take **ibuprofen** – it will help with both the pain and the inflammation. You can also take paracetamol if needed for fever."*

Antibiotics (penicillin allergy!):
*"Because you are allergic to penicillin, I'll prescribe you **erythromycin** (or clarithromycin if appropriate) – it's safe to use while breastfeeding and will treat the infection."*

Breastfeeding technique advice:
"Continue feeding or expressing milk regularly – ideally every 2–3 hours."
"Make sure your baby's latch and positioning are good. If needed, we can arrange support from a breastfeeding advisor."

Warm compress before feeding:
"Apply a warm towel to the breast for about 5–10 minutes before feeding to help milk flow more easily."

Cold compress after feeding:
"Apply a cold pack after feeds to reduce pain and swelling."

Expression advice:
"If it's too painful to feed, gently hand-express a little milk to relieve pressure and then try again."

Lifestyle:
"Wear a well-fitting but non-restrictive bra. Avoid pressing or massaging the breast too harshly. No need to apply oils or creams."
Summarize:
"With this approach, most women feel a lot better within 24–48 hours."

6. Safety Netting
Clear red flags:
"If you develop worsening pain, a high fever, green or bloody nipple discharge, or the breast becomes much more swollen or hot, please come back immediately."
Worsening scenario:
"If you do not start improving within 48 hours of starting the antibiotics, come back – sometimes mastitis can form a small collection of pus called an abscess, which may need different treatment."

7. Leaflets and Closing
Provide:
- Mastitis information leaflet
- Breastfeeding technique support leaflet

Offer supportive closing:
"You're doing an amazing job. Breastfeeding can be challenging at times, and you've done exactly the right thing by coming in early. I'm confident that with these steps, you'll feel much better very soon. And we're always here if you need anything."
Thank warmly.

Alternate Mastitis Scenarios:
In PLAB 2, mastitis may present with slight variations.
It is important to adapt your management based on the scenario, even though the core structure remains the same.

1. Mastitis with No Mention of Allergy
In this simpler version:
- The patient presents with breast pain, swelling, tenderness.
- Fever may or may not be present.
- There is no history of medication allergy.
- The patient **does not directly ask** whether she can continue breastfeeding.

Management Differences:

Antibiotics:

➔ Prescribe **Flucloxacillin** (unless allergy becomes known during history taking).

➔ Usual dose: 500 mg four times a day for 10–14 days.

Breastfeeding:

➔ Proactively **encourage continuation of breastfeeding** even if the patient doesn't directly ask.

➔ Say: *"It's very important to continue feeding or expressing to clear the blockage and help with healing."*

➔ No need to extensively focus on emotional reassurance unless patient appears anxious.

Pain Management:

➔ Ibuprofen and/or Paracetamol for symptom control.

General Advice:

➔ Warm compresses before feeds, cold compresses after. ➔ Proper bra fitting, gentle expression if feeds are painful. ➔ Safety net for signs of worsening.

Breast Engorgement vs Mastitis

Feature	*Breast Engorgement*	*Mastitis*
Cause	Milk overproduction; incomplete drainage	Blocked duct + bacterial infection
Pain	Fullness, heaviness, general discomfort	Sharp, throbbing, burning pain; more localised
Redness	Absent	Present (localised redness and warmth)
Fever	Absent	Present (often with chills)
Breast Feel	Both breasts firm, swollen	One breast tender, hard, wedge-shaped swelling
Feeding	Feeds continue normally, though uncomfortable	Feeds painful but must continue
Antibiotics	Not required	Required (Flucloxacillin / Erythromycin if allergic)
Management	- Frequent breastfeeding - Warm compress before feeds - Cold compress after feeds	- Frequent breastfeeding - Antibiotics - Warm/cold compress - Ibuprofen / Paracetamol for pain
Risk if untreated	Can lead to mastitis	Can lead to breast abscess (requires drainage)
Safety Netting	Seek help if redness, fever, worsening pain develops	Seek help if no improvement after 48h or worsening symptoms

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Polycystic Ovary Syndrome (PCOS)

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1. Introduction

"Good morning. I am Dr. [Name], one of the doctors here today. Could you please confirm your full name and age for me?"

"Thank you. I understand you have come to discuss the results of some blood tests we arranged. Is that right?"

2. Ask if patient knows why the test was done
"Before we go into the results, would you like me to briefly explain again why we performed these tests, or are you happy with what we discussed last time?"
(If the patient requests: explain the reason in simple terms: to investigate causes for irregular periods, acne, possible hormonal imbalance.)

3. Focused Symptom History
"I would like to check a few things about how you have been feeling before we go over the results."
"When did your periods become irregular or stop?"
"Have you noticed any unwanted hair growth on your face, chest, or back?"
"Have you noticed new or worsening acne?"
"Any darkened patches of skin under your arms or around your neck?"
"Any changes in your weight over the past year?"

4. Focused Risk Factor History
"Have you had any headaches or vision problems recently?"
"Any discharge from your nipples?"
"Have you noticed increased fat around your tummy, back, or neck?"
"Any history of diabetes, high blood pressure, or cholesterol problems in you or your family?"

5. Check ICE (Ideas, Concerns, Expectations)
"Do you have any thoughts about what might have been causing your symptoms?"
"Is there anything that you are particularly worried about?"
"Is there anything specific you were hoping we could address today?"

6. Effect on Life
"Have these symptoms affected your daily life, work, or confidence?"
"How has your mood been recently?"
"Have you lost interest in activities you usually enjoy?"

7. Clinical Examination
"I would like to check your vital signs today — your blood pressure, heart rate, oxygen levels, and temperature — and reassess your weight and BMI."
"I would also like to gently examine your abdomen if you are comfortable, to check for any tenderness or swelling."
(Offer chaperone if appropriate.)

8. Deliver the Test Results Clearly
"Thank you for sharing that information.
I have reviewed your blood tests carefully.
Your luteinising hormone (LH) is raised, your follicle-stimulating hormone (FSH) is normal, and the ratio between them is around three to one.
Your body mass index, or BMI, is measured at 32, which is above the healthy range."

9. Link the Result to Diagnosis
"These findings suggest a condition called **Polycystic Ovary Syndrome**, commonly referred to as **PCOS**."

10. Explain the Condition

"PCOS is a very common hormonal condition where small fluid-filled sacs, called cysts, develop on the ovaries. These cysts affect how the ovaries function.

This can lead to hormone imbalances, causing symptoms like irregular periods, acne, weight gain, and sometimes unwanted hair growth."

"It can also slightly increase the risk of developing long-term conditions like diabetes and heart problems if not managed properly."

Pause to check understanding:

"Is that explanation clear so far?"

11. Management Plan

"I'd like to reassure you that PCOS can be managed very effectively – and we'll tailor the treatment to your goals, whether that's regular periods, clearer skin, fertility, or long-term health."

a) Lifestyle Changes (First-Line for All)

"Losing even a small amount of weight – around 5–10% – can help regulate your periods, reduce acne, manage excess hair, and improve fertility."

"We can refer you to a dietitian or weight management programme if you'd like structured support."

"Regular physical activity and a balanced diet are key parts of this plan."

b) Menstrual Irregularity / Endometrial Protection

If contraception is acceptable:

"The combined oral contraceptive pill (COCP) is often the first option. It helps regulate your cycles, protects the womb lining, and can also help improve acne and hair growth."

If contraception is NOT wanted:

*"We can offer a course of **cyclical progestogen tablets** – for example, medroxyprogesterone for 10–14 days every 1–3 months – to bring on regular withdrawal bleeds and protect your womb."*

Alternative long-term option:

"A Mirena (hormonal coil) is another good choice – it can reduce or stop periods safely while also protecting the womb lining. You don't need to take tablets daily."

c) Acne Management

"The COCP often helps with acne as well."

"We can also prescribe topical treatments – like benzoyl peroxide, or a retinoid cream – depending on your skin type."

"If acne is severe or doesn't improve, we can refer you to dermatology."

d) Excess Hair (Hirsutism)

"Weight loss can help reduce unwanted hair over time."

"Other options include physical methods like shaving, waxing, or laser."

"If it's particularly distressing, we can discuss prescription medications like COCP or refer to dermatology for specialist treatments."

e) Fertility

"Many women with PCOS do conceive naturally, especially with lifestyle changes."

"If you're planning to get pregnant and are having difficulty, we can refer you to a fertility clinic."

*"First-line treatment in that case is usually a tablet called **Letrozole**, which helps stimulate ovulation. This is arranged through the fertility team."*

f) Long-Term Health Monitoring

"PCOS increases your risk of diabetes, high cholesterol, and blood pressure issues – so we'll check these regularly."
"We'll also review your menstrual history and adjust treatment if periods remain absent."

g) Herbal & Alternative Treatments

"At the moment, there are no herbal treatments proven to safely and effectively treat PCOS. We recommend sticking to medically approved and evidence-based options."

12. Safety Netting

"If you notice worsening symptoms like rapid weight gain, persistent mood changes, worsening acne, or significant new health issues, please come back immediately."
"If your periods remain absent for a long period despite treatment, or if you plan pregnancy, we should review early."

13. Offer Leaflets

"I will give you a leaflet that explains PCOS in more detail, covering symptoms, treatments, and lifestyle advice."

14. Closing the Consultation

"To summarise, your blood tests suggest PCOS.
We have discussed lifestyle improvements, options to manage your symptoms, and monitoring your general health.
We will arrange an ultrasound scan and further blood tests to confirm the diagnosis properly."
"Is there anything else you would like to discuss or ask about before we finish?"
Thank the patient politely and warmly.

Menorrhagia

1. Introduction

"Good morning. I am Dr. [Name], one of the doctors in the surgery today. Could you please confirm your full name and age for me?"
"How can I help you today?" (Allow patient to say: "Doctor, I have heavy periods.")

2. Clarify Presenting Complaint

"Thank you for sharing that.
I understand your main concern is heavy menstrual bleeding. Could you tell me a little more about what has been happening?"

3. Focused Symptom History

Menstrual History

"Are your periods regular?" (Yes)
"How many days do you usually bleed for?" (7–8 days)
"How heavy is the bleeding? How many pads or tampons do you use per day?" (8–10 pads)
"Do you pass clots during your period?"
"How painful are your periods?" (Mild discomfort only)
"When was your last period?" (5 days ago)
"Do you bleed between periods?"
"Have you noticed any bleeding after sexual intercourse?"

Cervical Screening History:
"When was your last cervical smear test?"
"Was the result normal?"
Sexual History:
"Are you currently sexually active?"
"What contraception are you using?" (Condoms)
"Any new sexual partners recently?"
Obstetric History:
"Have you ever been pregnant?"
"Do you have any children?"
Previous Treatments:
"Have you had any treatment or medication for heavy periods before?"

4. Focused Differential Screening
Rule out fibroids:
"Any lower abdominal bloating or pressure?"
"Any back pain?"
"Any frequent urination or bowel problems like constipation?"
Rule out cervical cancer:
"Any intermenstrual bleeding?"
"Any postcoital bleeding?"
Anaemia Symptoms:
"Any tiredness, dizziness, breathlessness, or palpitations?"
Coagulopathy/Thyroid Disease:
"Any easy bruising, heavy bleeding elsewhere?"
"Any changes in weight, sensitivity to cold, or constipation?"
PID or Endometriosis (less likely):
"Any persistent pelvic pain?"
"Any pain during sexual intercourse?"
Family History:
"Any family history of fibroids or bleeding disorders?"

5. PMAFTOSA
Past Medical History: "Any known long-term illnesses?"
Allergies: "Any medication allergies?"
Family History: "Any family history of reproductive problems?"
Travel, Occupation, Smoking, Alcohol: brief check.

6. ICE
"What are your thoughts about what could be causing your symptoms?"
"Is there anything in particular you are worried about?"
"Is there anything you were hoping we could do for you today?"
7. Effect on Life
"How is this affecting your day-to-day life, work, or social activities?"
"Has it been causing you to feel tired, anxious, or low?"

8. Clinical Examination
"I would now like to check your vital signs and perform a focused examination if that is alright."

Observations:
- Blood pressure
- Heart rate
- Respiratory rate
- Temperature
- Oxygen saturation

Focused Examination:
- General appearance for pallor (anaemia)
- BMI measurement
- Abdominal examination: (no tenderness, no palpable mass)
- Bimanual examination (if indicated): (no pelvic mass felt)
- Speculum examination: (cervix healthy, small clot at os)

(Offer chaperone before bimanual or speculum examination.)

9. Provisional Diagnosis

"Based on your history and examination, it looks like you are experiencing **Menorrhagia**, which means heavy periods.
There are several possible causes, such as hormonal imbalances, fibroids, polyps, or sometimes no underlying cause at all."

10. Explanation

"Heavy menstrual bleeding is when periods are heavier than normal, even if they remain regular.
It can happen because of changes in hormone levels, thickening of the lining of the womb, or benign growths like fibroids or polyps.
In some women, no obvious cause is found."

11. Management Plan

Investigations First:
- Blood tests:
  - Full Blood Count (to check for anaemia)
  - Thyroid function tests (hypothyroidism can cause heavy periods)
  - Clotting screen (only if there is a personal or family bleeding tendency)
- Pelvic Ultrasound:
  - "We will arrange an ultrasound scan to check the womb and ovaries for fibroids, polyps, or other abnormalities."
- Cervical Smear:
  - "We should also arrange a cervical smear since it has been over three years."

First-Line Treatment Options (if all investigations normal):
- Offer Mirena coil:
  - "We would normally recommend a Mirena coil as first-line treatment. It slowly releases hormone inside the womb to reduce bleeding very effectively."
  - "Most women find their bleeding reduces significantly after a few months."

Alternative Options (if Mirena declined):
- Tranexamic acid (if heavy bleeding only):
  - "A medication to reduce bleeding during periods."
- NSAIDs like mefenamic acid (if pain is significant):
  - "This helps reduce both pain and bleeding."

Lifestyle Advice:
- Healthy diet to manage anaemia risk

Iron supplementation if indicated after blood tests

12. Safety Netting

"If you develop severe pain, heavy clots, breathlessness, or worsening symptoms, please come back urgently."
"If your scan or blood tests show anything unusual, we will contact you promptly."
"If at any point you feel faint, collapse, or have severe bleeding, seek immediate medical attention."

13. Offer Leaflet

Offer a patient leaflet about heavy menstrual bleeding, its causes, investigations, and treatment options.

14. Closing the Consultation

"To summarise, you are experiencing heavy menstrual bleeding.
We will arrange some blood tests and an ultrasound scan.
We have discussed treatments including the Mirena coil and other medication options depending on the results.
I will also arrange a cervical smear.
Is there anything else you would like to discuss before we finish?"
Thank the patient politely.

Primary Dysmenorrhoea

1. Introduction

"Good morning. I am Dr. [Name], one of the doctors here today. Could you please confirm your full name and age for me?"
"Nice to meet you. How can I help you today?"
(Allow patient to say: "Doctor, I have tummy pain during periods.")

2. Clarify Presenting Complaint

"Thank you for sharing that.
Could you tell me a little more about the pain?"

3. Focused Symptom History

Pain Clarification (SOCRATES):

"Where exactly do you feel the pain?" (Site)
"When does the pain usually start — before, during, or after your period?" (Onset)
"How would you describe the pain — is it cramping, sharp, or dull?" (Character)
"Does the pain travel anywhere else, like your back or thighs?" (Radiation)
"On a scale from 1 to 10, how strong would you say the pain is at its worst?" (Severity)
"Does anything make the pain better or worse?" (Alleviating/Aggravating)

Associated Symptoms:

"Do you experience nausea or vomiting during your periods?"
"Any diarrhoea or changes in bowel habits during your periods?"
"Do you feel dizzy, extremely tired, or unusually emotional during your periods?"

Menstrual History:

"When did you start your periods?"
"Are your periods regular?"
"How long do your periods usually last?"
"Is the bleeding heavy, moderate, or light?"

"Do you ever bleed between periods?"

4. Risk Factor Screening

"Has anyone in your family, like your mother or sisters, had painful periods?"
"Have you noticed any significant weight changes recently?"
"Do you smoke or have you ever smoked?" (even if unlikely, must ask)

5. Impact on Daily Life

"Has the pain affected your school attendance, sports, or social life?"
"Has it disturbed your sleep?"
"How are you coping at home, considering the emotional support after your mother's passing?"

MAFTOSA screening:

Medical conditions: "Any other known health issues?"
Allergies: "Do you have any allergies to medications?"
Family history: (already partly asked)
Travel: "Any recent travel abroad?"
Occupation: (Student)
Smoking: (asked earlier)
Alcohol: "Do you drink alcohol?"

6. ICE (Ideas, Concerns, Expectations)

"Do you have any thoughts about what might be causing this pain?"
"Is there anything in particular you are worried about?"
"What were you hoping we could do for you today?"

7. Effect on Life

"Is the pain affecting your mood, energy levels, or relationships with friends?"
"Have you felt unusually low or withdrawn during your periods?"

8. Clinical Examination (verbalise)

"I would like to do a quick general check today, if that's alright."

Vital signs: Blood pressure, heart rate, temperature, respiratory rate, oxygen saturation
General appearance for pallor or distress
Gentle abdominal palpation (only if appropriate, with consent)

(Offer chaperone if touching abdomen.)
(No need for speculum or pelvic exam unless red flags present.)

9. Provisional Diagnosis

"From the information you have shared and after the examination,
it sounds like you are experiencing a very common condition called **Primary Dysmenorrhoea**."

10. Explanation of Condition

"Primary dysmenorrhoea simply means painful periods.
It happens because the natural hormones that control your periods make the muscles of your womb contract, which can cause cramping pains.
It is very common in teenagers and young women, especially in the first few years after starting periods."
Pause to check understanding:
"Does that explanation make sense so far?"

11. Management Plan

Pain Relief (First Line):

"The most effective treatment is using a painkiller called an NSAID, like Ibuprofen or Naproxen. These medicines not only relieve pain but also reduce the hormone that causes the cramps."

"It works best if you start taking it as soon as your period starts or even just before you expect it."

Non-Medical Measures:

"Applying a warm water bottle or heat pad to your tummy during periods can help relax the muscles and ease the cramps."

"Some people also find a small machine called a TENS machine useful. It sends small electrical signals to reduce pain."

If Pain Persists:

"If things don't improve after a few months, we could consider starting a low-dose combined oral contraceptive pill.
It helps to regulate the cycle and often reduces the pain."

Lifestyle and Emotional Support:

"Getting enough rest, eating regular healthy meals, and staying active can all help.
If you ever feel overwhelmed or low, please do not hesitate to tell us."

12. Safety Netting

"If the pain becomes much worse, happens even outside your periods, or if you notice any new unusual symptoms like irregular bleeding, please come back for a review."

"If your symptoms are not improving even after trying the treatment for three to six months, we can consider a referral to a specialist."

13. Offer Leaflet

"I will give you a leaflet that explains primary dysmenorrhoea, ways to manage the symptoms, and when to seek further help."

14. Closing the Consultation

"To sum up, it sounds like you are experiencing primary period pains, which we can manage with simple and safe treatments.
We have discussed medications, self-care options, and when to seek help if needed."
"Is there anything else you would like to ask or discuss today?"
Thank the patient and her father politely.

Uterine Fibroids

Setting: GP Clinic
Role: FY2 Doctor
Patient: 40-year-old woman
Scenario: Follow-up after pelvic ultrasound
Scan Result: Two large fibroids – 17 cm (anterior wall), 14 cm (posterolateral wall)
Bloods: FBC normal

Introduction

"Hello, my name is Dr [Name], I'm one of the doctors here today. I understand you've come in to go over the results of your recent pelvic scan. Is it okay if I ask you a few questions first to get a better idea of how you've been feeling?"

Focused History & Context

Presenting Complaint & Menstrual History:

"Can I confirm—were your original symptoms related to heavy periods?"
"Are your periods still quite heavy?"
How many days do they usually last?
Do they come regularly?
Any clots or flooding?
Any bleeding in between periods or after intercourse?

Fibroid-Related Symptoms (Mass Effect):

"Do you experience lower abdominal discomfort, bloating, or pressure?"
"Any pain during sex?"
"Have you noticed going to the toilet more often, or urgently?"
"Any difficulty fully emptying your bladder?"
"Any issues with constipation or pain when opening your bowels?"

Reproductive & Gynaecological History:

"Have you ever been pregnant before?"
"Are you currently trying for pregnancy or planning to in the future?"
"Are you using any contraception at the moment?"
"When was your last cervical smear? Was it normal?"
"Have you had any infections or abnormal results in previous gynaecology visits?"

Explore ICE

"Do you have any idea about what might be causing your symptoms?"
"Is there anything in particular that's been worrying you about the scan or your health in general?"
"What were you hoping we could do for you today?"

Result Disclosure

"Thank you for sharing all of that. I've had a look at your ultrasound report. It shows that you have two fibroids—one at the front of your womb, measuring around 17 cm, and one at the back, about 14 cm in size."

Explanation of Diagnosis

"Fibroids are non-cancerous growths that develop in or around the womb. They're made of muscle and fibrous tissue and are very common in women aged 30–50. Many women don't have any symptoms, but larger fibroids like yours can cause heavy periods, discomfort, or pressure in the pelvis. The good news is that fibroids are not cancer, and having them does not increase your risk of cancer. However, they can be troublesome, especially when they grow large or cause significant bleeding."

Management Plan

Bloods & Baseline Work-up (already done):

FBC: normal
If new symptoms arise (e.g., fatigue, palpitations), repeat FBC
Consider thyroid function and clotting screen if bleeding persists despite treatment

Referral to Gynaecology:
- You're being referred to a gynaecologist, which is recommended when:
  - Fibroids are >3 cm with symptoms
  - There's significant impact on quality of life
  - Fertility is a concern
  - Medical treatment is insufficient or not appropriate

Medical Management (While Awaiting Specialist or if Surgery Not Preferred):
- Tranexamic Acid
  - Taken during your period
  - Helps reduce bleeding by stabilizing blood clots
  - Not hormonal, suitable even if you're trying for pregnancy
  - NSAIDs (e.g. Ibuprofen, Mefenamic Acid)
  - Taken with periods
  - Helps with both bleeding and cramping
  - Should be avoided if you have asthma, ulcers, or kidney problems

- Levonorgestrel Intrauterine System (LNG-IUS or Mirena Coil)
  - Small device placed in the womb
  - Slowly releases hormone to reduce bleeding
  - Also provides long-term contraception
  - May not be suitable if the womb is distorted by fibroids
  - Combined Hormonal Contraceptives (pill, patch, ring)
  - Can reduce bleeding and regulate cycles
  - Not suitable for everyone (e.g., smokers over 35, high BP)
- GnRH Analogues (e.g., Goserelin)
  - Injections that shrink fibroids by lowering oestrogen levels
  - Usually used short term (e.g. pre-surgery) due to menopausal side effects
  - Fibroids often regrow after stopping

Surgical and Interventional Management (Specialist-Led):
- Uterine Artery Embolization (UAE)
  - Minimally invasive procedure
  - Blocks blood supply to fibroids → shrinkage
  - Preserves womb
  - Not recommended if planning future pregnancy
- Myomectomy
  - Surgical removal of fibroids
  - Womb preserved → suitable if fertility desired
  - May still allow future pregnancy
- Hysterectomy
  - Removal of womb
  - Permanent solution if family complete
  - No more periods or fibroids, but ends fertility

Safety Netting

"If you notice heavier bleeding than usual, severe abdominal pain, feel faint or dizzy, or have any difficulty with urination or bowels, please contact us straight away or attend A&E. If your symptoms worsen while you're waiting to see the specialist, we can reassess and fast-track things if needed."

Follow-Up Plan

GP follow-up after gynaecology review or sooner if symptoms change

Leaflet & Final Check

"I'll give you an NHS leaflet about fibroids that explains everything we've discussed today. Would you like me to go over any part again, or is there anything else you'd like to ask before we finish?"

Endometriosis

1. Introduction

"Good morning. I am Dr. [Name], one of the doctors here today. Could you kindly confirm your full name and age for me?"

"Nice to meet you.

I understand you were referred to us by your GP. Could you tell me in your own words what brought you here today?"

(Wait for patient to say: "I have been having lower tummy pain, painful periods" etc.)

2. Clarify Presenting Complaint

"Thank you for sharing that.
Could you tell me a little more about the pain you're experiencing?"

3. Focused Symptom History

Pain Clarification (SOCRATES):

"Where exactly is the pain?"
"When did it first start?"
"Is it continuous or comes and goes?"
"How would you describe the pain — is it cramping, stabbing, or dull?"
"Does it spread anywhere, like your back or thighs?"
"Does it get worse around your periods?"
"On a scale of 1 to 10, how bad would you say it gets at its worst?"

Period-Related Questions:

"Are your periods regular?"
"How many days do they usually last?"
"Is the bleeding heavy, moderate, or light?"
"Do you experience pain before, during, or after your periods?"

Ask for associated systems (explore naturally):

"Do you experience any pain during sexual intercourse?"
"Any pain or difficulty when opening your bowels, especially during periods?"
"Have you noticed any blood in your stools?"
"Do you experience any discomfort or blood when passing urine?"
"Have you had any issues trying to conceive, or is fertility something you are thinking about?"

4. Risk Factors Screening

"At what age did you start your periods?"
"Have you had any pregnancies or children?"
"Is there anyone in your close family, like your mother or sister, who had endometriosis or similar symptoms?"
"Any history of autoimmune conditions like thyroid disease, lupus, or rheumatoid arthritis?"

5. MAFTOSA and Effect on Life

MAFTOSA:

Medical history: "Any known health problems?"
Allergies: "Any allergies to any medicines?"
Family history: (Expand if needed.)
Travel: "Any recent travel abroad?"
Occupation: "What type of work or studies are you involved in?"
Smoking and alcohol: "Do you smoke or drink alcohol?"

Effect on Life:

"Has the pain affected your daily activities like work, school, or relationships?"
"Has it impacted your mood, energy levels, or social life?"

6. ICE (Ideas, Concerns, Expectations)

"Have you heard of endometriosis before?"
"Is there anything in particular you are worried about?"
"What were you hoping we could help you with today?"

7. Clinical Examination

"I would now like to check your vital signs and perform a gentle examination if that's alright."

Observations:

Blood pressure
Heart rate
Respiratory rate
Temperature
Oxygen saturation

Focused Examination:

General appearance for signs of distress or anaemia
Abdominal inspection and palpation (check for tenderness, masses, bloating)
Pelvic examination: (only if indicated and with consent — usually not done in GP but should be mentioned)

(Offer a chaperone if suggesting pelvic exam.)

8. Provisional Diagnosis

"From what you have described and after today's examination,
your symptoms are very suggestive of a condition called **Endometriosis**."

9. Explanation of Condition

"Endometriosis is a condition where tissue similar to the lining of the womb grows outside the womb, commonly on the ovaries, fallopian tubes, or other areas in the pelvis. This tissue behaves like womb lining — it builds up and bleeds during your period, but because it is outside the womb, it can cause pain, swelling, and sometimes scar tissue."

Pause briefly: "Does that explanation make sense so far?"

10. Management Plan

Investigations:

"We will arrange a pelvic ultrasound scan.
It might show cysts related to endometriosis, but sometimes a scan can be normal even if endometriosis is present."

"The gold standard to confirm the diagnosis is a laparoscopy —
a keyhole surgery where a small camera is inserted into your abdomen to directly see any endometriosis tissue and possibly treat it at the same time."

Treatment:
Medical Management:
"We can start with medications to manage your symptoms.
These include using a combined oral contraceptive pill continuously to reduce hormonal fluctuations and suppress endometriosis."
"Painkillers like Ibuprofen or Naproxen are also very effective at controlling cramping pain."

Surgical Management (if needed):
"During laparoscopy, if endometriosis is seen, it can be removed or destroyed using a laser or heat.
This can significantly help with pain and fertility."

Lifestyle and Emotional Support:
"Exercise, stress management, and healthy eating can all help manage chronic symptoms."
"It can sometimes be emotionally draining. If you ever feel low, anxious, or isolated, please let us know.
Counselling or support groups may help."

If the patient asks about fertility:
"Endometriosis can sometimes cause fertility issues if it affects the ovaries or tubes, but many women with mild to moderate endometriosis can conceive naturally."

If the patient asks about endometriosis spreading:
"It mostly stays within the pelvis. Rarely it can be found elsewhere, but that's very uncommon."

11. Safety Netting
"If you experience worsening pain, sudden severe symptoms, or new symptoms like severe bleeding or bowel or urinary issues, please come back immediately."
"We will closely monitor your response to treatment, and if needed, refer you to an endometriosis specialist centre."

12. Offer Leaflet
"I'll provide you with a leaflet explaining endometriosis, how we manage it, and tips for self-care at home."

13. Closing the Consultation
"Is there anything else you would like to ask or discuss before we finish?"
Thank the patient warmly.

Menstrual Migraine

Setting: 17 y/o with headaches

1. Introduction
"Good morning. I am Dr. [Name], one of the doctors here today. Could you kindly confirm your full name and age for me?"

"Nice to meet you.
I understand you have come today because of headaches. Could you tell me a little more about them?"

2. Clarify Presenting Complaint

"Where exactly is the pain located?"
"When did you first start experiencing these headaches?"
"Is the headache there all the time or does it come and go?"
"How would you describe the pain — is it throbbing, pressure-like, sharp, dull?"
"Does it spread anywhere, like to your neck, face, or shoulders?"
"On a scale of 1 to 10, how bad is the pain when it's worst?"
"How long does each headache last?"
"Do you feel any warning signs before the headache starts — like seeing flashing lights, zigzag patterns, or numbness?"
"Do the headaches happen at a particular time of day or in any specific situation?"

3. Focused Differential Screening for Headaches

Screening for Red Flags and PLAB 2 Differentials:

"Do you feel nauseous or vomit during these headaches?" (Migraine)
"Do you get sensitivity to light or sounds?" (Migraine)
"Is the headache ever very sudden and extremely severe, like a thunderclap?" (SAH)
"Have you had fever, neck stiffness, or been feeling very unwell?" (Meningitis)
"Do you feel any pressure behind the eyes, changes in vision, or worsening when lying flat or straining?" (Raised ICP)
"Any recent injury to the head?" (Subdural haematoma)
"Any pain around your face or forehead that worsens with bending forward?" (Sinusitis)
"Are you feeling stressed or tense lately?" (Tension headache)
"Any drooping of eyelids, runny nose, or watery eyes on one side during headaches?" (Cluster headaches)
"Any tenderness around the temples, jaw claudication, or scalp tenderness?" (Temporal arteritis – unlikely at 17, but a good habit)

4. Discover Menstrual Link

Once other red flags are ruled out:

"Do you notice any relationship between your headaches and your periods?"
"Do the headaches start just before your periods and get better after?"

(Here, the patient says: "Yes, they happen around my periods.")

5. Menstrual History (Confirm Link)

"Are your periods regular?"
"When did you start your periods?"
"Are your periods painful?"
"How heavy is the bleeding?"
"Any mood changes or physical changes around your period?"

6. Associated Symptoms Confirmation

"Do you feel nausea, vomiting, or dizziness with these headaches?"
"Do you feel very tired or emotional around the time of headaches?"
"Any changes in sleep pattern during your periods?"

Sexual History (only if relevant for contraception options):

"Are you currently sexually active?"
"Are you using any contraception?"

7. MAFTOSA and Effect on Life
MAFTOSA:
Medical history: "Any known health problems?"
Allergies: "Any allergies to medications?"
Family history: "Any family history of migraines?"
Travel: "Any recent travel?"
Occupation: "Are you in school, college, or working?"
Smoking/Alcohol: "Do you smoke or drink alcohol?"
Effect on Life:
"How have these headaches affected your daily life, studies, or relationships?"
"Have you missed school or activities because of them?"

8. ICE (Ideas, Concerns, Expectations)
"Do you have any idea about what might be causing the headaches?"
"Is there anything you are particularly worried about?"
"What were you hoping we could help you with today?"

9. Clinical Examination
"I would like to check your vital signs and perform a brief neurological examination if that's alright."
Observations:
Blood pressure
Heart rate
Temperature
Respiratory rate
Oxygen saturation
Focused Neurological Check:
Pupils equal and reactive
Visual fields intact
Cranial nerves
Motor and coordination if needed
(Offer chaperone if examination is sensitive.)

10. Provisional Diagnosis
"From what you have told me and based on today's assessment,
your symptoms are very suggestive of a condition called **Menstrual Migraine**."

11. Layman Explanation of Condition
"Menstrual migraine is a type of headache that happens because of natural changes in hormone levels — especially a drop in oestrogen — around the time of your periods.
This trigger migraine headaches in some people."
Pause briefly: "Does that explanation make sense so far?"

12. Management Plan
Acute Management:

"For treating each migraine attack, I would recommend using a nasal spray called **Sumatriptan**. You should start using it 2 days before your period is expected and continue for 3 days after the bleeding begins."
"We avoid tablets at your age, as oral Sumatriptan is not licensed for under 18s."

Monitoring:
"I'd like you to keep a **headache diary** to track when headaches occur, how severe they are, and what helps relieve them."

Follow-Up:
"We'll arrange a review after 2–3 menstrual cycles to check how things are improving."

Long-Term Management:
"If symptoms persist, we could consider hormonal options like:"
Combined oral contraceptive pill (taken continuously)
Oestrogen patches to stabilize hormone levels

Lifestyle Advice:
"Try to maintain regular sleep, avoid skipping meals, and manage emotional stress where possible."

13. Safety Netting
"If you ever develop a very sudden, severe headache, or if your headaches change in character significantly, or if you develop any new symptoms like weakness, visual problems, or confusion, please seek medical help immediately."

14. Offer Leaflet
"I will give you a leaflet that explains menstrual migraines, how to manage them, and tips for self-care."

15. Closing the Consultation
"Is there anything else you would like to ask before we finish?"
Thank the patient warmly.

Premenstrual Syndrome (PMS)

1. Introduction
"Good morning. I am Dr. [Name], one of the doctors here today. Could you kindly confirm your full name and age for me?"
"Nice to meet you.
I understand you have come in today with some concerns. Could you tell me more about what has been troubling you?"

2. Clarify Presenting Complaint
"Could you describe how you have been feeling emotionally or physically?"
"When did you start noticing these changes?"
(Wait for the patient to reveal emotional changes around periods.)

3. Focused Symptom History (No assumptions)
Psychological Symptoms:

"Do you notice any changes in your mood or emotions around the time of your periods?"
"Could you describe what happens — for example, do you feel tearful, anxious, irritable, or angry?"

Physical Symptoms:
"Do you experience any physical symptoms like headaches, bloating, breast tenderness, palpitations, or hot flashes?"

Behavioural Symptoms:
"Have you noticed any changes in your usual behaviour, such as withdrawing from activities, difficulty concentrating, or changes in appetite or sleep?"

Period-Related Symptoms:
"How are your periods generally — are they regular?"
"When did your periods restart after stopping Depo Provera?"
"Do you experience heavy bleeding, pain, or other difficulties during your periods?"

Differential Screening:
"Have you had a diagnosis of any mood disorders in the past, such as depression or anxiety?"
"Have you noticed these emotional changes happening at other times, outside of your menstrual cycle?" (Important to rule out primary mood disorder.)

Risk Factor Screening:
"Any recent weight gain or loss?"
"Have you been under more stress lately?"
"Any significant relationship problems?"
"Do you smoke or drink alcohol?"
"Is there any family history of mood disorders?"

4. MAFTOSA and Effect on Life
MAFTOSA:
Medical history: "Any other health problems or ongoing treatments?"
Allergies: "Any allergies to medications?"
Family history: "Anyone in your family with similar problems or mental health issues?"
Travel: "Any recent travel?"
Occupation: "Are you working or studying currently?"
Smoking/Alcohol: (Already asked.)

Effect on Life:
"How are these symptoms affecting your daily life, your work or studies, and your relationships at home?"

5. ICE (Ideas, Concerns, Expectations)
"Do you have any idea what might be causing these changes?"
"Is there anything you are particularly worried about?"
"What were you hoping we could help you with today?"

6. Clinical Examination
"I would like to check your vital signs to ensure there is no physical cause contributing to your symptoms. If that's alright with you?"

Observations:
- Blood pressure
- Heart rate
- Temperature
- Respiratory rate
- Oxygen saturation
- BMI (if available)

Focused examination:
- General observation for signs of anaemia, thyroid disease, or distress.

(No physical examination of the pelvis or abdomen is needed unless indicated.)

7. Provisional Diagnosis

"From what you have described, your symptoms are very suggestive of a condition called **Premenstrual Syndrome (PMS)**."

8. Layman Explanation of Condition

"PMS happens because of natural hormonal changes that occur during your menstrual cycle.
These changes can temporarily affect brain chemicals that control your mood, leading to emotional and sometimes physical symptoms.
It usually improves once your period starts."
Pause briefly: "Does that explanation make sense so far?"

9. Management Plan

First-line Management:
- "The first steps involve simple lifestyle measures that can make a big difference."

Lifestyle Changes:
- "Eating small, regular meals that are rich in complex carbohydrates can help regulate mood swings."
- "Regular exercise, maintaining a consistent sleep pattern, and managing stress through relaxation techniques can also help."
- "If you smoke or drink alcohol, cutting down can significantly improve symptoms."

Symptom Monitoring:
- "I recommend keeping a **symptom diary** for the next 2–3 menstrual cycles.
  Note down emotional and physical symptoms daily.
  This will help confirm the timing and identify if your symptoms are truly linked to your cycle."

Symptomatic Relief:
- "For any period-related pain, simple painkillers like Ibuprofen can be taken safely."

Follow-Up:
- "We will review your symptom diary after 2–3 cycles to see how things are improving."

Second-line Management (if no improvement):
- "If lifestyle changes alone aren't enough, options we could discuss include:"
  - **Cognitive Behavioural Therapy (CBT):** to help manage emotional symptoms.
  - **Continuous use of the combined oral contraceptive pill:** to stabilize hormone fluctuations.
  - **Antidepressants (SSRIs):** for severe cases — but we only consider this if symptoms are severely affecting your life and after trying other treatments.

10. Safety Netting

"If you ever feel severely low, overwhelmed, or have any thoughts of harming yourself, it's important to seek urgent help immediately."

"If you notice symptoms becoming worse or affecting your ability to function daily, please come back for reassessment."

11. Offer Leaflet

"I will give you a leaflet that explains PMS, self-care tips, lifestyle advice, and treatment options."

12. Closing the Consultation

"Is there anything else you would like to ask or discuss before we finish?"

Thank the patient warmly.

Premature Ovarian Insufficiency (POI)

Setting: O&G Follow-up Clinic
Patient: Miss X, 25 years old
Referral: From GP for amenorrhea (20 months)
Diagnosis: POI (confirmed on repeat bloods: ↑FSH, ↑LH, ↓Estradiol)

Introduction & Consent

- Greet the patient, confirm identity
- Confirm reason for follow-up
- Gain consent to discuss results and ask a few focused questions

"You've come in to discuss the results of your hormone tests — is it okay if I go through them with you and ask a few questions to understand the full picture?"

Focused History

A. Menstrual History

What age did your periods start?"

B. Key Associated Symptoms

- "Do you get hot flushes or night sweats?"
- "Any changes in your mood, anxiety, or energy levels?"
- "Any headaches, nipple discharge, or changes in vision?" (Rule out prolactinoma)
- "Any recent weight loss, stress, or intense exercise?"
- "Any excess facial hair or acne?" (Rule out PCOS)

C. Sexual & Fertility History

- "Are you sexually active?"
- "Do you use any contraception?"
- "Have you ever been pregnant?"

D. Family History

- "Anyone in your family had early menopause or ovarian problems?" → Mother had menopause at 35
- "Any autoimmune or genetic conditions?"

E. Risk Screening (Brief)

- Smoking, calcium intake
- Family history of osteoporosis or cardiovascular disease

ICE

- Idea: "Any idea what might be causing this?"

- Concern: "Will I be able to have children?"
- Expectation: "Can this be treated or reversed?"

Result Disclosure
"We ran hormone tests twice, 6 weeks apart. Both times, your FSH and LH were very high and oestrogen was very low. This pattern confirms a condition called Premature Ovarian Insufficiency, which means your ovaries are not functioning properly and have stopped producing normal hormone levels at a much earlier age than expected."

Explanation of the Condition
"Most women go through menopause around age 50. In your case, your ovaries have reduced function well before that — which explains your missing periods and hot flushes. It's not always possible to find the exact cause, but since your mother had early menopause too, there may be a genetic link."

Management Plan
A. Further Investigations
- Pelvic ultrasound – assess ovaries and uterus
- Prolactin levels – if >1000 → refer; 500–1000 → repeat
- TFTs
- Specialist testing (e.g. karyotype, autoimmune screen) – arranged in secondary care

B. Referrals
- gynaecology – to confirm diagnosis and plan HRT
- Fertility clinic – to discuss future options
- Consider psychological support if emotionally distressed

C. Treatment
- Hormone Replacement Therapy (HRT)

o Replaces oestrogen to relieve symptoms and protect bones/heart
o Not a contraceptive but beneficial for long-term health

- Lifestyle advice:

o Stop smoking
o Regular weight-bearing exercise
o Adequate calcium + vitamin D intake

D. Fertility Discussion
"Most women with POI are not able to conceive naturally, but options like egg donation with IVF exist. We'll refer you to a fertility specialist who can go through this in more detail."

Safety Netting
- "If your symptoms worsen, or if you experience unexpected bleeding, pelvic pain, or emotional distress, please return sooner. We'll monitor your response and keep you updated once the specialist referral is in progress."

Follow-Up
- Monitor response to HRT if started
- Repeat any bloods or imaging as needed under specialist guidance

Leaflet
- Provide NHS leaflet on POI and HRT

Perimenopause / Menopause

1. Introduction

"Good morning, I'm Dr. [Name], one of the doctors here today.
Could you please confirm your full name and age for me?"

"Nice to meet you.

I understand you've come in today because you've been feeling more irritable.
Could you tell me a bit more about how you've been feeling?"

2. Clarify Presenting Complaint (Focused Open Questions)

"When did you start noticing this irritability?"
"Is it happening all the time, or only at certain times?"
"Have you noticed if it's worse during any particular part of the month?"

3. Focused Symptom History (Natural, Exam-Oriented)

Emotional Changes:

"Any other emotional changes — like feeling low, anxious, tearful, angry, or easily upset?"

Physical Symptoms:

"Have you had any hot flushes — sudden feelings of heat?"
"Any night sweats?"
"Any trouble sleeping — either falling asleep or waking up early?"
"Any palpitations — feeling your heart racing?"

Menstrual History (very important):

"Can I ask about your periods — are they still happening regularly?"
"If yes: Are they lighter, heavier, shorter, longer, or irregular?"
"If no: When was your last period?"

Urogenital Symptoms:

"Any dryness or discomfort during intimacy?"
"Any needing to pass urine more often?"

Rule out other causes:

"Any recent major stress, losses, or changes at home or work?"
"Any changes in appetite, weight, or energy?"

4. MAFTOSA and Effect on Life

MAFTOSA:

Medical history: "Any long-term health conditions like thyroid disease, diabetes, high blood pressure?"
Allergies: "Any allergies to medicines?"
Family history: "Any family history of early menopause, osteoporosis, or breast cancer?"
Travel: "Any recent travel?"
Occupation: "Are you working at the moment?"
Smoking and Alcohol: "Do you smoke or drink alcohol?"

Effect on Life:

"How have these symptoms been affecting your daily activities, relationships, or work?"

5. ICE (Ideas, Concerns, Expectations)

"Do you have any thoughts about what might be causing your symptoms?"

"Is there anything in particular you're worried about?"
"What were you hoping we could help you with today?"

6. Clinical Examination (Verbalised)

"I would like to check your basic observations to make sure there's no underlying medical reason for your symptoms.
Would that be alright?"
Observations:
- Blood pressure
- Heart rate
- Respiratory rate
- Temperature
- BMI

Focused General Look:
- Any signs of anaemia, thyroid disease, dehydration, or distress.

7. Provisional Diagnosis

"Based on your symptoms and menstrual history,
this sounds like it could be either **perimenopause/menopause**."

8. Explanation

Perimenopause:
"Perimenopause is the **transition period** leading up to menopause.
It happens when your hormone levels start fluctuating."
"Your periods may become irregular, lighter, or heavier — but you are still having periods."
"You are considered to be in perimenopause if you have **had a period within the last 12 months**."

Menopause:
"Menopause is when you have **not had any periods at all for 12 consecutive months**."
"It marks the **permanent end** of periods and fertility."
"The symptoms — like hot flushes, mood changes, night sweats — can happen during both stages, but menopause is officially confirmed after a full year without periods."

Summary:

Stage	*Periods*	*Diagnosis*
Perimenopause	Irregular, still occurring (within last 12 months)	Fluctuating hormones, still fertile
Menopause	No periods for 12 months	Permanent end of menstruation

9. Management Plan

First-line Management:
Lifestyle Measures:
"Exercise regularly — even brisk walking can help with mood and sleep."
"Eat a healthy, balanced diet rich in calcium and Vitamin D."
"Reduce triggers for hot flushes — like caffeine, alcohol, spicy foods."
"Stop smoking if applicable."
Symptom Tracking:
"I would suggest keeping a **simple symptom diary** for 2–3 months — note down when symptoms are worse."
HRT Discussion (If needed):

"If your symptoms are quite disruptive, we can consider starting **Hormone Replacement Therapy (HRT)**."
"HRT replaces the lost oestrogen and can help with hot flushes, mood swings, and bone protection."
"We will weigh the benefits and risks carefully together before making a decision."

Alternative Non-Hormonal Options:

"If HRT is not suitable, CBT (Cognitive Behavioural Therapy) or certain medications can help manage symptoms."
"Simple measures like evening primrose oil may be tried for mild cases."

Bone Health Advice:

"Menopause can weaken bones over time.
Weight-bearing exercises, a healthy diet, and monitoring bone density are important."

10. Safety Netting

"If you notice any new symptoms like heavy bleeding, sudden changes in your health, or worsening mood symptoms, please return to see us."
"If you ever feel very low, hopeless, or have thoughts of harming yourself, seek urgent help immediately."

11. Offer Leaflet

"I'll give you a leaflet that explains about perimenopause, menopause, and what you can do to feel better during this time."

12. Closing the Consultation

"Is there anything else you would like to ask before we finish?"
Thank the patient warmly.

What to Do If a Patient Refuses HRT

If a menopausal woman **declines hormone replacement therapy (HRT)**, you should follow a structured approach that ensures her safety, offers evidence-based alternatives, and respects autonomy — all while staying aligned with national guidance.

Step 1: Acknowledge & Explore the Refusal

Validate her choice:
"Thanks for sharing that — it's absolutely fine to say no to HRT. My job is to help you feel well with whichever approach you prefer."

Explore reasons for refusal (often fear of breast cancer, weight gain, mood changes, or previous negative experience):
"Is there something about HRT that worries you?"
"Would you like more information on the risks and benefits?"

Offer to clarify misconceptions but never pressure the patient.

Step 2: Tailor Alternatives Based on Primary Symptoms

A. Vasomotor Symptoms (e.g. hot flushes, night sweats)

If HRT is declined:

Offer **non-hormonal pharmacological options**:
SSRIs/SNRIs: e.g. **venlafaxine**, **fluoxetine**, **paroxetine**, **citalopram**, or **escitalopram**
Clonidine: Less effective, more side effects, but still an option

CBT: NICE recommends CBT for hot flushes/night sweats if psychological symptoms are present or HRT is declined

Avoid SSRIs like paroxetine or fluoxetine in women on tamoxifen due to CYP2D6 inhibition.

B. Urogenital Symptoms (e.g. vaginal dryness, irritation, dyspareunia)

Offer vaginal oestrogen (e.g. estriol cream, pessaries, vaginal tablets or rings)

Safe even when systemic HRT is declined

Can be continued long-term with minimal systemic absorption

Also suggest:

Non-hormonal vaginal moisturisers (used regularly)

Lubricants during intercourse

Vaginal oestrogen is usually safe even in women with a history of breast cancer – discuss with oncologist if unsure.

C. Mood Disturbance, Anxiety, or Low Motivation

Offer:

CBT (recommended by NICE even without a formal mood disorder)

Consider **antidepressants** only if depressive symptoms meet diagnostic threshold

Rule out thyroid dysfunction or other causes

Antidepressants are not recommended solely for menopause unless clinically indicated.

Step 3: Lifestyle Advice & Long-Term Health Planning

Support wellbeing and reduce long-term health risks with:

Weight-bearing exercise – protects bone and heart

Balanced diet – encourage calcium and vitamin D

Vitamin D supplement – 10 micrograms (400 IU) daily

Smoking cessation

Limit alcohol and caffeine

Good sleep hygiene

Mindfulness, relaxation techniques for anxiety or sleep disruption

Step 4: Bone Health Monitoring (HRT Alternative Protection)

Assess fracture risk using **FRAX** or **QFracture** tools (if over 65, low BMI, early menopause, steroid use, etc.)

If high risk:

Order **DEXA scan**

Consider **calcium + vitamin D supplements**

Bisphosphonates (e.g., alendronate) if osteopenia or osteoporosis confirmed

Step 5: Follow-Up and Flexible Care

Reassure the patient she can revisit the decision anytime:

"If things change down the line, we can always come back to HRT — the door is never closed."

Offer regular follow-up:

"Let's check in after a few months to see how you're doing with these options. We can tweak the plan anytime."

If Patient Refuses Vaginal Oestrogen

1. Acknowledge & Explore Concerns (non-judgementally)

Say:

"Of course — I completely respect that. Would it be alright if I ask what's made you feel unsure about it?"

Common patient concerns:

Fear of cancer

Confusion with HRT tablets

Discomfort with application

Misunderstanding that it's "hormonal"

Clarify gently:

"That's a really common worry. Just to reassure you — the oestrogen used here is at a very low dose and works locally, just in the vaginal area. It doesn't get absorbed into your bloodstream the same way as HRT tablets or patches."

"For most women, it's considered safe — even for many who can't take regular HRT. But it's completely your choice, and we can absolutely try other options."

2. Offer Non-Hormonal Alternatives

If she still refuses:

"That's absolutely fine. We can try some non-hormonal options first, and if your symptoms don't improve, we can always revisit this later."

Alternatives include:

Vaginal moisturisers (e.g. ReplensMD): used regularly to restore moisture

Water-based lubricants (e.g. Sylk, YES): during intercourse

Pelvic floor physiotherapy: may help with discomfort

CBT or psychosexual therapy: if emotional distress or relationship factors contribute

3. Reassure & Keep the Door Open

Say:

"If these non-hormonal options don't give you enough relief, we can always have another chat about vaginal oestrogen — you're in control of the decision, and we'll support you either way."

Atrophic Vaginitis

Setting

FY2 doctor in GP

65-year-old woman attending GP consultation

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1. Introduction

Greet and confirm identity:

"Hello, I'm Dr. __. *Could I confirm your full name and age, please?*"

Open with an open question:

"How can I help you today?"

2. History of Presenting Complaint (Natural Flow – 2.5 minutes)

If she mentions **itching**, explore gently:

"Could you tell me more about the itching – where exactly you feel it?"

"When did you first notice it?"

"Has it been getting worse over time, or is it about the same?"

Explore aggravating factors:

"Do you notice if anything makes it worse, like after cleaning or after using any products?"

Associated symptoms:

"Have you noticed any bleeding or spotting?"

"Any unusual discharge?"

"Any pain or discomfort when you pass urine?"

Personal hygiene practices:
"Have you been using any special soaps, washes, or doing any internal cleaning like douching?"

Impact:
"Has this been affecting your daily life, like your sleep or comfort?"

3. Screening for Other Causes

Sexual history (asked sensitively)
"Are you currently sexually active?"
"Is there any discomfort or bleeding during or after intercourse?"

Urinary symptoms:
"Have you noticed any burning when passing urine, or needing to rush more often?"

Red flag screening:
"Any bleeding that's not related to sexual activity?"
"Any unexplained weight loss, or any ongoing pelvic pain?"

4. Past Medical History (PMH)

"Do you have any other health conditions, like diabetes or any immune system problems?"

Menopause:
"Just to check, when did you have your last natural period?"
"Did you have any menopause symptoms back then, like hot flashes or mood changes?"

5. Drug History (DH)

"Are you taking any regular medications at the moment?"
"Any known allergies?"
Specifically check:
- HRT use?
- Vaginal creams or pessaries already tried?

6. ICE (Ideas, Concerns, Expectations)

"What are your thoughts about what might be causing this?"
"Is there anything in particular that's worrying you?"
"What were you hoping we could do for you today?"

7. Examination

Comment verbally:
- Thinned, fragile, slightly reddened vaginal skin.
- No visible mass, discharge, or ulcers.
- Findings consistent with **atrophic vaginitis**.

Management Plan

1. Explain Diagnosis

"From what you've described, and based on examination, this seems to be a very common condition called atrophic vaginitis. After menopause, your body makes much less oestrogen, which causes the skin inside the vagina to become thinner, drier, and more sensitive. That dryness leads to irritation and itching. It's not an infection – it's simply a natural change that happens to many women."

2. Lifestyle Advice

"It's important to avoid using soaps, wipes, or any strong products in that area. Plain water is enough. Over-washing can actually make the dryness worse."

3. Medical Treatment

Local vaginal oestrogen cream or pessary:

"We can prescribe a gentle oestrogen cream that you apply inside the vagina. It helps rebuild the skin and make it feel more comfortable again."

Vaginal moisturizers:

"You can also use moisturizers you buy at a pharmacy to help keep things hydrated even between treatments."

4. STI screening:

Only offer if sexual history suggests risk.

5. Safety Netting

"Usually, symptoms improve within a month or two. If you don't feel better after that, or if you develop bleeding or new pain, please come back to see us."

6. Provide Leaflet

Information on menopause and vaginal atrophy.

7. Follow-Up

Review after **6–8 weeks** if needed.

Bleeding/Pain After Intercourse (Atrophic Vaginitis)

Setting

FY2 doctor in GP

50–55-year-old postmenopausal woman

Recently resumed sexual activity with new partner

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1. Introduction

Greet and confirm identity:

"Hello, I'm Dr. __. *Could I confirm your full name and age, please?"*

"How can I help you today?"

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2. History of Presenting Complaint (Natural Flow – 2.5 minutes)

Clarify symptoms:

"Could you tell me a bit more about what's been happening?"

"Is it bleeding, pain, or both?"

Characterise:
- When did it start?
- Is bleeding only after sex, or at other times too?
- How heavy is the bleeding (spotting or flow)?
- Is there pain during intercourse or after?

New sexual activity:
"Have you recently become sexually active again?"
"How long had it been before you resumed activity?"

Associated symptoms:
- Itching?
- Discharge?
- Urinary burning or frequency?

3. Red Flag Screening
Cancer signs:
"Have you had any bleeding not related to sex?"
"Any unexplained weight loss, appetite changes, or constant pelvic pain?"

4. Past Medical History (PMH)
Menopause:
"When did you go through menopause?"
"Did you ever take hormone replacement therapy?"

Chronic diseases:
- Diabetes, cardiovascular disease?

5. Drug History (DH)
Medications:
- Current medications?
- Previous HRT use?

Allergies:
- Any known allergies?

6. ICE (Ideas, Concerns, Expectations)
"What are your thoughts about what might be causing this?"
"Are you worried it could be an infection or something more serious?"
"What were you hoping we could help with today?"

7. Examination
Vaginal atrophy signs:
- Pale, dry, fragile vaginal tissue
- Minor contact bleeding
- No visible mass

Management Plan

1. Explain Diagnosis

"The bleeding and pain you're experiencing is likely due to thinning and dryness of the vaginal skin after menopause. When oestrogen levels drop, the skin becomes delicate and can tear or bleed easily, especially during sex. It's very common, and you're not alone."

2. Immediate Advice

"I'd recommend stopping sexual activity for a short time to allow healing."

3. Medical Management

Lubricants:

"Using water-based or silicone-based lubricants during intercourse can help reduce dryness and friction."

Local vaginal oestrogen (if appropriate):

"We can offer a low-dose oestrogen cream if needed, to help thicken and moisturize the vaginal tissues again."

4. Safety Netting

If bleeding persists despite treatment → urgent gynaecology referral.

5. Patient Education

Leaflet about vaginal atrophy and lubricant use.

6. Follow-Up

Review in 6–8 weeks if symptoms persist.

Uterine Prolapse

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1. Introduction

"Good morning, I'm Dr. [Name], one of the doctors working today.
Could you please confirm your full name and age for me?"
(Smile warmly, natural tone.)
"Nice to meet you.
How can I help you today?"
(Patient says: "Doctor, it's a bit embarrassing...")
(Respond empathetically.)
"Thank you for sharing that with me — I completely understand.
You're in a safe space here, and I want you to feel as comfortable as possible.
Many people feel a bit shy about certain health issues, but please don't worry — I'm here to listen and help."
(Pause reassuringly.)
"When you're ready, could you please tell me a little more about what's been troubling you?"

2. Clarify Presenting Complaint

"Can you describe what exactly you have noticed?"
"When did you first notice this?"
"Does it feel like something is coming down or out?"
"Could you describe what it looks like — is it pink, rounded, smooth?"

3. Focused Symptom History

Nature of the Problem:

"Is the lump there all the time, or does it come and go?"
"Does it get worse when you cough, sneeze, strain, or lift something heavy?"
"Has it been getting bigger over time?"

Associated Urinary Symptoms:

"Any leaking of urine, especially when coughing, sneezing, or laughing?"
"Any difficulty starting or fully emptying your bladder?"
"Any urgency or needing to pass urine very frequently?"

Bowel Symptoms:

"Any constipation or feeling of incomplete bowel emptying?"
"Any difficulty passing stools?"

Bleeding or Other Symptoms:

"Any unusual bleeding from the vagina?"
"Any pain or discomfort during intercourse?"

4. Risk Factor Screening

Past Obstetric History:

"How many children have you had?"
"Were they vaginal deliveries, and were any of them assisted (like with forceps)?"
"Were the deliveries complicated — very long or very quick labours?"

Lifestyle Factors:

"Do you lift heavy objects regularly?"
"Have you had long-standing problems with constipation or chronic coughing?"

Medical History:

"Any history of pelvic surgery or hysterectomy?"

5. MAFTOSA and Effect on Life

MAFTOSA:

Medical history: "Any long-term illnesses like asthma causing coughing?"
Allergies: "Any medication allergies?"
Family history: "Any family history of prolapse?"
Travel: "Any recent travel or surgeries?"
Occupation: "What sort of work do you do — any heavy lifting?"
Smoking/Alcohol: "Do you smoke or drink alcohol?"

Effect on Life:

"How much is this affecting your daily life, activities, or relationships?"
"Is it causing you discomfort while walking, sitting, or during intimacy?"

6. ICE (Ideas, Concerns, Expectations)

"Do you have any thoughts about what this could be?"
"Is there anything you are particularly worried about?"
"What were you hoping I could help you with today?"

7. Clinical Examination

"I would like to perform a gentle examination to check the area you're worried about.
This will involve inspecting the vaginal opening while you are lying comfortably.
A female staff chaperone will be present throughout.
Would that be alright?"
Observations:

Blood pressure
Heart rate
Temperature

Focused Examination:

Visual inspection of introitus (vaginal opening).
Speculum examination
Stress test (asking the patient to cough while examining).

Typical Finding:

A pink, rounded mass seen at the vaginal opening.
Stress leak may suggest associated stress incontinence.

8. Provisional Diagnosis

"From what you have described and based on examination findings; this appears to be a **uterine prolapse**."

9. Explanation

"Uterine prolapse happens when the muscles and tissues supporting the womb become weak, allowing the womb to slip down and press into the vagina.
Sometimes it can even come partially out of the vaginal opening."

"It's quite a common problem, especially in women who have had multiple childbirths, heavy lifting, or chronic constipation."

Pause to check understanding: "Does that explanation make sense so far?"

10. Management Plan

First-line Conservative Management:
Pelvic Floor Exercises (Kegel Exercises):

"Strengthening the muscles of the pelvic floor can help improve symptoms and prevent the prolapse from worsening."
"Ideally, you would be referred to a physiotherapist specialised in women's health."

Pessary Insertion:

"A pessary is a small, removable silicone device inserted into the vagina to support the womb and vaginal walls."
"It can help reduce the symptoms and avoid surgery.
It can be fitted and checked here at the clinic."

Lifestyle Measures:
"Losing weight (if needed) can reduce pressure on the pelvic floor."
"Avoiding heavy lifting."
"Managing constipation with diet changes and fluids."

Medical Management:
"If there is vaginal dryness, a local estrogen cream might be prescribed to help strengthen tissues."

Surgical Management:
"Surgery is an option if symptoms are severe and conservative treatments don't work."
"Surgery may involve lifting and supporting the womb or removing it (hysterectomy) if appropriate."

11. Safety Netting
"If you notice sudden worsening of the prolapse, bleeding, severe urinary retention, or cannot empty your bladder properly, please seek immediate medical attention."
"We will monitor how you are responding to treatment and adjust the plan if needed."

12. Offer Leaflet and Closing
"I will give you a leaflet explaining uterine prolapse, pelvic floor exercises, and treatment options in more detail."
"Is there anything else you would like to discuss before we finish?"
Thank the patient warmly.

Stress Incontinence

FY2 working in the Urology Outpatient Department.
A 46-year-old female patient complaining of a dragging sensation in the pelvic area and urinary leakage for the past few months.
She works as a nurse aide and regularly lifts patients.
She finds the problem embarrassing and is seeking advice on how to stop leaking urine.

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1. Introduction
"Good morning, I'm Dr. [Name], one of the doctors working in the Urology department today.
Could you please confirm your full name and age for me?"
(Smile warmly.)
"Nice to meet you.
How can I help you today?"
(Patient says: "Doctor... it's a bit embarrassing... I feel like something is dragging down and I leak urine.")
(Then respond warmly and respectfully:)
"Thank you for sharing that with me.
I completely understand — many people find these topics difficult to bring up, but you're in a safe space here.
Please feel comfortable to talk freely — I'm here to help."
(Pause briefly to allow her to feel reassured.)
"Could you tell me a little bit more about what you have been experiencing?"

2. Clarify Presenting Problem
"Could you tell me a little more about when you first noticed this feeling of dragging or heaviness?"
"When do you tend to leak urine — is it mostly when coughing, sneezing, laughing, or lifting?"
"Is the leakage constant, or only during those activities?"

Prolapse-Related Symptoms:
"Have you noticed anything actually coming down or bulging out from below?"
"Does the dragging feeling worsen towards the end of the day?"

Other Urinary Symptoms:
"Any burning or pain when you pass urine?"
"Any urgency — sudden rush to go to the toilet?"
"Any difficulty starting or stopping your urine?"
"Any blood in your urine?"

Bowel Symptoms:
"Any issues with constipation?"

3. Focused Risk Factor History

"Have you had any pregnancies or deliveries?" (Confirm number of deliveries, type — in this case, 5 vaginal deliveries.)
"Does your job involve heavy lifting?" (In this case, nurse aide lifting patients.)
"Any history of chronic cough or smoking?"
"Any previous surgeries to the pelvic area?"

4. MAFTOSA and Effect on Life

MAFTOSA:
Medical history: "Any ongoing medical conditions like diabetes, COPD?"
Allergies: "Any medication allergies?"
Family history: "Any family history of urinary issues or prolapse?"
Travel: "Any recent travel?"
Occupation: "You mentioned being a nurse aide — lots of physical work?"
Smoking/Alcohol: "Do you smoke or drink alcohol?"

Effect on Life:
"How much is this leaking affecting your daily activities, work, social life, or relationships?"

5. ICE (Ideas, Concerns, Expectations)

"Have you had any thoughts about what might be causing this?"
"What worries you the most about this problem?"
"What would you like us to help you achieve today?"
(Patient says: "It's embarrassing. I just want the leaking to stop.")

6. Clinical Examination

"I would like to perform a gentle physical examination to better understand what's happening. This will involve checking your abdomen, doing a general examination, and looking at the front passage.
A female chaperone will be present to support you.
Would that be okay with you?"
Observations:
Blood pressure
Heart rate
Respiratory rate
Temperature

Focused Examination:
- General physical exam (GPE)
- Abdominal palpation (to rule out bladder mass or tenderness)
- BMI measurement
- Pelvic inspection (checking for prolapse, stress test: cough and observe leakage)

Urine Dipstick Test:
- Rule out infection, blood.

7. Provisional Diagnosis
"From what you've told me and based on the examination; this appears to be **stress urinary incontinence**."

8. Explanation
"Stress incontinence happens when the muscles and tissues that normally help keep your bladder closed become weakened.
This usually happens after multiple pregnancies, heavy lifting, or straining.
So when pressure increases inside your abdomen — like when you cough, sneeze, or lift — some urine leaks out involuntarily."
Pause and check understanding:
"Does that explanation make sense so far?"

9. Management Plan
Investigations:
- FBC, U&Es, LFTs
- Urinalysis (rule out infection)
- Bladder scan for post-void residual volume
- Pelvic ultrasound (if needed)

Lifestyle Changes:
- "Reduce caffeine intake — caffeine can irritate the bladder."
- "Maintain a normal fluid intake — not too much, not too little."
- "Weight loss if BMI is over 30 — this can significantly improve symptoms."
- "Manage constipation — straining worsens pelvic floor weakness."
- "Stop smoking if applicable — coughing worsens leakage."

Pelvic Floor Muscle Training (PFMT):
- "We will arrange a referral for supervised pelvic floor muscle training (Kegel exercises) with a women's health physiotherapist."
- "You need to perform exercises correctly and regularly for at least 3 months to see improvement."

Medication:
- "If physiotherapy does not help enough and you prefer not to have surgery,
  we can consider a medication called duloxetine.
  It strengthens the bladder closure but can have side effects like nausea and dry mouth."

Surgical Referral (If needed):
- "If exercises and medication don't help enough, we can refer you to a urogynaecologist (a women's health expert) to discuss surgical options like a sling procedure."

10. Safety Netting

"If you notice blood in urine, fever, severe pelvic pain, or sudden worsening of symptoms, please seek immediate medical attention."

11. Offer Leaflet and Closing

"I'll give you a leaflet about stress incontinence, pelvic floor exercises, and lifestyle changes."

"We'll start with conservative measures, monitor how things go over the next few months, and adjust the plan if needed."

"Would you like me to also arrange a physiotherapist appointment for you today?"

12. Follow-Up Plan

"I would like to review you in 4–6 weeks to check on your progress with exercises and symptom improvement."

Thank the patient warmly.

Stress Incontinence with Uterine Prolapse

FY2 working in General Practice.

A 50-year-old female patient with urinary frequency, urgency, and leakage that have worsened over the past two months. She also reports feeling something coming down vaginally but denies any pain, fever, or blood in urine. She is a university lecturer and feels her symptoms are affecting her daily activities and causing emotional distress. She seeks your help to understand what is happening and what can be done about it.

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1. Introduction

"Good morning, I'm Dr. [Name], one of the doctors working here today.
Could you please confirm your full name and age for me?"
(Smile warmly.)
"Nice to meet you.
How can I help you today?"
(Patient says feeling of urine leakage and something coming down, feels ashamed.)
Respond respectfully:
"Thank you for sharing that with me.
Please don't worry — you are in a safe space here, and this is more common than you might think.
Let's talk through it together and find the best way to help you."

2. Clarify Presenting Problem

"Could you tell me more about what symptoms you've been having?"

"When did you first notice these changes?"

"Is the urine leakage constant, or does it only happen when you cough, sneeze, or lift something heavy?"

"Does the leaking occur when you feel an urge to pass urine, or without any warning?"

"Have you noticed anything coming down from the vaginal area?"

"Is the bulge constant, or does it come and go?"

"Does it worsen after standing long periods or lifting heavy things?"

3. Focused Symptom History

Urinary Symptoms:

"Any pain or burning when you pass urine?"

"Any blood in the urine?"

"Any fever, chills, or feeling unwell?"

"Any need to rush to the toilet urgently?"

"Any leaking on the way to the toilet?"

Mass Protrusion Symptoms:
"What does the mass feel like — soft, hard, painful?"
"Any bleeding, ulceration, or discharge?"

Bowel Symptoms:
"Any constipation?"
"Any bowel incontinence?"

Sexual Symptoms:
"Any discomfort during intimacy?"

4. Risk Factor Screening

Obstetric History:
"How many pregnancies have you had?"
"Were they normal vaginal deliveries or assisted (forceps, ventouse)?"

Lifestyle:
"Do you often lift heavy things at work or home?"

Medical History:
"Any long-term coughing problems — like asthma, COPD?"
"Have you had pelvic surgery before?"

DESA:
Fluid intake: "How much water or fluids do you usually drink daily?"
Caffeine: "How much caffeine — coffee, tea, energy drinks — do you have daily?"
Smoking: "Do you smoke?"
Alcohol: "Do you drink alcohol?"

MAFTOSA:
Medical history: Any known medical conditions?
Allergies: Any allergies to medications?
Family history: Any family history of similar symptoms or prolapse?
Travel: Any recent travel?
Occupation: What kind of work do you do?
Smoking/alcohol habits again if needed.

5. Impact Assessment

"How is this affecting your day-to-day activities, work, relationships, or your confidence?"
"Is it affecting your sleep?"
"Are you using any pads or protection currently?"

6. ICE (Ideas, Concerns, Expectations)

"Have you had any thoughts about what might be causing these symptoms?"
"Is there anything you are particularly worried about?"
"What were you hoping I could help you with today?"

(Patient says: "Doctor, what's happening to me? Please help me stop leaking.")

7. Clinical Examination

"I would like to perform a gentle examination, including checking your abdomen and pelvic area, to better understand what's happening.
I'll have a female chaperone present to support you, and I'll maintain your privacy at all times.
Would that be okay with you?"

Vital Observations:

- Blood pressure
- Heart rate
- Temperature
- Respiratory rate

Focused Examination:

- General physical exam
- Abdominal palpation
- BMI calculation
- Pelvic examination (external and speculum):
  - Look for visible bulge at the introitus
  - Stress test: Ask patient to cough while observing for urine leakage
  - Assess degree of prolapse if visible

8. Provisional Diagnosis

"Based on what you've told me and the examination; it seems you have **stress urinary incontinence** along with some degree of **uterine prolapse**."

9. Explanation

Stress Incontinence:

- "Stress incontinence happens when there's leakage of urine when pressure inside the tummy rises — for example, when coughing, laughing, sneezing, or lifting heavy objects."
- "It happens because the pelvic floor muscles, which normally support the bladder and urethra, become weakened over time — often after multiple childbirths, aging, or heavy lifting."

Uterine Prolapse:

- "The womb (uterus) is normally supported by muscles and tissues.
  When these weaken, especially after childbirth, the womb can slip down into the vagina, leading to a feeling of heaviness or something coming down."

Check Understanding:
"Does that explanation make sense so far?"

10. Management Plan

Lifestyle Modifications:

- "Reduce caffeine — tea, coffee, fizzy drinks — as it can worsen urgency."
- "Drink normal amounts of water — not too little, not too much."
- "If your weight is above healthy levels, even modest weight loss can significantly help."
- "Avoid heavy lifting where possible."

Pelvic Floor Muscle Training (PFMT):

"I will refer you for supervised pelvic floor muscle training — specialist physiotherapists will teach you how to strengthen those muscles."
"It involves doing at least 8 squeezes, 3 times a day, for a minimum of 3 months."

Conservative Measures:
"You can use absorbent pads temporarily, but they are not the long-term solution."

Medical Management (Optional):
"If exercises do not improve symptoms enough,
we can discuss a medication called duloxetine — it can help strengthen bladder control, but it has side effects like nausea and dry mouth."

Surgical Referral:
"If symptoms remain troublesome despite exercises and lifestyle changes,
I can refer you to a urogynecologist or urologist for further options like surgical repair."

Investigations to Arrange:
Urine dipstick
Urine microscopy and culture (if infection suspected)
FBC, U&E, LFT
Bladder scan (post-void residual assessment)

11. Safety Netting
"Please come back immediately if you notice any blood in the urine, fever, severe pelvic pain, sudden worsening of leakage, or new neurological symptoms like numbness or weakness."
"Also return if the prolapse becomes painful, ulcerated, or stops you from passing urine properly."

12. Leaflet and Follow-Up
"I'll give you leaflets explaining pelvic floor exercises and more about stress incontinence and uterine prolapse."
"We'll plan a review in 4–6 weeks to check your progress with exercises and symptoms."
Thank the patient warmly.

Urge Incontinence (Overactive Bladder Syndrome)

FY2 doctor in GP surgery
Who the patient is:
48-year-old woman
Other information you have:
The patient presents with a complaint of frequent urgency to pass urine, leakage if delayed, and embarrassment due to occasional accidents.
No pain, no fever, no foul-smelling urine, and no significant past medical history.
She drinks large amounts of tea daily (8–9 cups) and works as a teacher.
She uses protective pads/diapers due to leakage.
Her concern today is, "How can I stop leaking urine?"

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1. Introduction
"Good morning, I'm Dr. [Name], one of the doctors working here today.
Could you kindly confirm your full name and age for me?"

(Smile, build rapport.)
"Thank you. How can I help you today?"
(Patient says: "I have an embarrassing problem.")
Respond supportively:
"Please don't worry — you are in a safe and confidential space. Many people feel this way, and you are not alone. Could you tell me a little more about what's been troubling you?"

2. Clarify Presenting Complaint

"You mentioned an embarrassing problem — would you be comfortable telling me a bit more?"
(Patient says: "I need to rush to the toilet. If I'm late, accident happens.")
Confirm details:
"When you say accident, do you mean leakage of urine?"
"How long has this been happening?"
"Does it happen every time you get the urge, or only sometimes?"
"Is the leakage a large amount or just a small dribble?"
"Do you feel the need to pass urine more often than usual during the day?"
"Do you have to wake up at night to pass urine?"
"Is there any burning, pain, or blood when you pass urine?"
"Have you noticed any changes in the smell or colour of the urine?"

3. Focused Differential Screening

Possible Cause	***Questions***
UTI	Fever? Chills? Burning during urination? Lethargy?
Stress Incontinence	Does leakage happen mainly when you cough, laugh, sneeze, or lift things?
Neurological	Any numbness, tingling, weakness, or back pain?
Constipation	Any bowel issues like constipation or straining?
Prolapse	Any dragging sensation or feeling of something coming down below?

(If all answers negative → pure **urge incontinence** likely.)

4. Risk Factor History (DESA + MAFTOSA)

DESA:
"How much fluid do you usually drink in a day?"
"Do you consume a lot of tea, coffee, fizzy drinks, or energy drinks?" *(Patient: 8–9 cups tea/day.)*
"Do you smoke or drink alcohol?"

MAFTOSA:
"Are you taking any regular medications?"
"Have you had any allergies diagnosed?"
"What do you do for work?" *(Patient: Teacher.)*
"How is your home situation and support?"

5. Impact on Life

"How is this affecting your daily activities, work, or confidence?"
"Are you able to go about your day normally or do you have to wear any pads or diapers?"
(Patient reports embarrassment at work.)

6. ICE (Ideas, Concerns, Expectations)

"What do you think might be causing this?"

"Is there anything you are particularly worried about?"
"What were you hoping we could help you with today?"
(Patient is worried something serious might be wrong and wants treatment to stop leakage.)

7. Examination

"I would like to perform a few checks to help us further.
This would include measuring your blood pressure, heart rate, and temperature, and examining your abdomen and bladder area.
I would also like to perform a urine dipstick test to check for infection.
Would that be, okay?"

Vitals: Normal
General Physical Exam: Normal
Abdominal exam: No tenderness, no palpable bladder
Pelvic exam: Normal (no prolapse seen)
Urine dipstick: No infection

8. Provisional Diagnosis

"From what you've shared and based on today's examination, it appears you are experiencing **urge urinary incontinence**, part of a broader condition called **overactive bladder syndrome**."

9. Explanation

"Urge incontinence means that your bladder muscle is contracting too strongly and too soon, causing a sudden need to pass urine — and sometimes leaking before you can get to a toilet."
"Overactive bladder simply means your bladder is becoming a little too sensitive."
"It's a common condition and can be very successfully managed."
Check understanding:
"Is that clear so far? Please ask me anything if you'd like."

10. Management Plan

Investigations:

Routine blood tests (FBC, U&E, Renal Function)
Urine dipstick (already done)

Lifestyle Modifications:

"Gradually reduce caffeine intake — try to cut tea/coffee down to no more than 2 cups a day."
"Avoid drinking too much or too little water — about 1.5–2 litres a day is good."
"If BMI is over 30, weight loss can significantly improve symptoms."
"Avoid smoking."

Conservative Treatment:

"I'll refer you for **bladder retraining** — this involves teaching the bladder to hold urine for longer periods. You will work with a continence nurse or specialist, and the program usually lasts for 6–8 weeks."
"Pelvic floor exercises are also helpful even in urge incontinence to support your bladder better."

Medications (If conservative fails):

"If symptoms don't improve after bladder retraining, we can consider medications:
Antimuscarinics like oxybutynin or solifenacin to calm the bladder muscle, OR

Mirabegron if antimuscarinics are unsuitable or cause side effects."
"We'll discuss side effects before starting any medication."

Specialist Referral:
"If needed, I can refer you to a urology or urogynecology specialist for further assessment like urodynamic studies."

11. Safety Netting
"Please seek urgent review if you develop:
Blood in urine
Fever, chills
Severe back or pelvic pain
Numbness or weakness in the legs
Sudden worsening of symptoms"

12. Follow-up
"We will review you in 4–6 weeks to see how things are improving."
"Meanwhile, I'll provide you with a leaflet about urge incontinence, bladder training, and fluid management."
Thank the patient warmly.

Prolapse vs Urge vs Stress Incontinence

Feature	*Prolapse*	*Urge Incontinence*	*Stress Incontinence*
Main Symptom	Feeling of something coming down from vagina	Sudden strong urge to urinate, can't reach toilet in time	Leakage when coughing, sneezing, laughing, or lifting
Patient Words	"I feel a lump," "Something is coming down," "Dragging feeling"	"I need to rush to the toilet," "If I'm late, I leak"	"I leak when I cough, laugh, or lift heavy things"
Timing	Worse after standing, lifting, coughing	Urge comes suddenly anytime, unpredictable	Leakage happens **only** during pressure activities
Associated Symptoms	Vaginal bulge, heaviness, pressure feeling	Frequency, urgency, possible bedwetting at night (nocturia)	Usually no urgency or frequency, just leak with strain
Common Risk Factors	Multiple vaginal deliveries, menopause, chronic straining	Overactive bladder, aging, bladder irritation	Pelvic floor weakness, childbirth trauma, aging
Examination Findings	Lump seen at vaginal opening on pelvic exam	Normal bladder/pelvic exam (unless other problems)	Normal pelvic exam
Management	Pelvic floor exercises, pessary, surgery if severe	Bladder training, lifestyle changes, antimuscarinic medication if needed	Pelvic floor exercises, supervised PFMT, surgery if severe

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Mixed Urinary Incontinence

Setting: GP Clinic
Patient: 40–50-year-old female
Task: History, explanation, and NICE-aligned management of mixed urinary incontinence

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Introduction

Hello, I'm one of the doctors here at the practice. Thanks for coming in today.
Could I please confirm your full name and age?
Great — how can I help you today?
(*Patient: "I've been leaking urine for a few years now."*)

Presenting Complaint (ODIPARA)

O – Onset: When did this problem start?
D – Duration: Has it been ongoing continuously over the past five years?
I – Intensity: How much does it affect your day-to-day life?
P – Progression: Has it worsened or changed over time?
A – Aggravating factors: Do coughing, laughing, sneezing, or movement worsen it?
R – Relieving factors: Anything that makes it better?
A – Associated symptoms:
Do you feel a strong urge to urinate before leakage?
Any increase in frequency, urgency, or leaking on exertion?

Focused History & Differential Screening

Caffeine/Fluid intake:
How much water, coffee, or fizzy drinks do you usually drink in a day?
Incontinence details:
Do you leak when coughing, sneezing, laughing? (Stress component)
Do you leak before reaching the toilet? (Urge component)
Other urinary symptoms:
Any pain, burning, or fever?
Any blood in urine or foul smell?
Other contributors:
Any long-standing constipation?
Any medications that increase urine output?
Any mobility or neurological problems?

PMAFTOSA:
No past illnesses or surgeries reported
Not menopausal; no symptoms suggestive

Obstetric History:
Number of pregnancies and type of delivery?
Any complications during delivery?

DESA:
Diet: Any recent changes?
Exercise: Do you do pelvic floor exercises?

Smoking: Do you smoke?
Alcohol: Any regular consumption?

Sexual history:
Not sexually active for one year

ICE:
What are your thoughts on this condition?
Any specific concerns — for example, cancer?
What are you hoping we can do today?

Impact:
How is this affecting your work, confidence, or mood?

Examination (Verbalised)

"I'd like to check a few things today, including your blood pressure, abdomen, and a pelvic exam if you're comfortable. I'd also like to do a urine dipstick. Would that be alright?"

Vitals: Normal
GPE & BMI: Not specified — assumed normal
Abdominal Exam: Soft, no masses
Pelvic Exam: Normal findings
Urine Dipstick: To rule out infection (assumed normal for this case)

Provisional Diagnosis

"You appear to have **mixed urinary incontinence** — a combination of **stress incontinence** (leakage on coughing or sneezing) and **urge incontinence** (strong urge to urinate, sometimes with leakage before reaching the toilet)."
"This can happen when the **pelvic floor muscles are weakened** and the **bladder becomes overactive or irritable**."

Investigations

Urine dipstick and microscopy (already done)
Bloods: FBC, U&Es, RFTs, random blood sugar
Maintain a **bladder diary**:
- Fluid intake (types and amounts)
- Frequency of urination
- Volume passed
- Number and timing of leaks
- Urgency episodes

Management Plan

Lifestyle Measures:
Reduce caffeine and alcohol intake
Avoid excessive fluids but stay hydrated
Treat any constipation if present

Pelvic Floor Muscle Training (Kegel Exercises):
8 contractions, 3 times/day for at least 3 months
Continue if improving

Bladder Training (for Urge):
Delay urination slightly when urge occurs
Gradually extend time between toilet visits
Establish 2–3 hourly toilet routine

If Conservative Measures Fail:
Refer to **continence service** or **urogynecology**
Further testing: Urodynamic studies, cystoscopy if indicated

Medications:
For stress incontinence: **Duloxetine**
For urge incontinence: **Oxybutynin**, **Tolterodine**, or **Darifenacin** (NICE recommends starting with non-drug treatment unless needed)

Safety Netting & Follow-Up

"If you notice any new symptoms like fever, burning urination, blood in urine, or worsening incontinence, please let us know."
"If the leaking worsens or starts affecting your mood or social life more, we may escalate treatment sooner."
"Let's arrange a follow-up in **6 weeks** to review your bladder diary, see if the exercises are helping, and decide if we need further support."
"Here's a leaflet with some guidance on exercises and bladder training. You can also find helpful resources at the NHS website."

Student Note: Diagnostic Reasoning Summary

Female in her 40s with chronic incontinence showing features of both stress and urge types
No infection, red flags, or structural abnormality
Most consistent with **Mixed Urinary Incontinence**
Initial management: conservative (pelvic floor & bladder training), followed by meds or referral if unresolved

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Postmenopausal Bleeding

65-year-old woman presents with **bleeding per vagina** for the **past one month**.
She went through menopause at the age of **55**.
She is otherwise well, was on **HRT previously**, and has **no other major medical issues**.

---

1. Introduction

Greet warmly and introduce yourself:
"Good morning, I'm Dr [Name], one of the doctors in the clinic today."
Confirm identity professionally:
"Could I confirm your full name and your age, please?"
Set a safe, empathetic tone:
"Nice to meet you. I understand you've come in with some concerns about bleeding.
Please feel comfortable — I am here to listen and help."

2. Clarify Presenting Problem

Open the conversation:
"Could you tell me more about the bleeding you've noticed?"
Key Clarification Questions:
Onset: "When did you first notice the bleeding?"

Duration: "How long does it last each time?"
Frequency: "Has it happened once or multiple times?"
Amount: "Would you say it's spotting, light bleeding, or heavier?"
Associated Clots: "Have you noticed any clots?"
Colour of Bleeding: "What colour is the blood — bright red, brownish?"

3. Focused History Taking

A) Explore Associated Symptoms:

Pain: "Have you had any lower abdominal pain or discomfort?"
Discharge: "Have you noticed any unusual vaginal discharge?"
Urinary Symptoms: "Any burning, urgency, or difficulty passing urine?"
Constitutional Symptoms: "Any weight loss, fatigue, or loss of appetite?"

B) Anaemia Symptoms:

"Have you felt more tired than usual?"
"Any palpitations, dizziness, or shortness of breath?"

C) Past Gynaecological History (P4):

Periods: "At what age did you have your menopause?"
Pregnancy: "Have you had any pregnancies in the past?"
Pills / Hormones: "Are you currently or have you previously been on hormone replacement therapy (HRT)?"
Pap smear: "When was your last cervical smear? Was it normal?"

D) Risk Factors:

Medical History: "Any history of diabetes, high blood pressure, or cancers?"
Family History: "Any family history of womb, ovarian, or breast cancer?"

E) Lifestyle History (DESA):

Diet: Any major diet changes recently?
Exercise: Level of daily physical activity?
Smoking: Do you smoke?
Alcohol: Do you consume alcohol?

F) MAFTOSA:

Medications
Allergies
Family
Travel
Occupation
Social Support
Activity Limitations

G) ICE:

Ideas: "What do you think might be causing the bleeding?"
Concerns: "Is there anything in particular you're worried about?"
Expectations: "What were you hoping we could do for you today?"

4. Examination

"I would now like to check your vital signs — blood pressure, heart rate, oxygen saturation, temperature."
"I would also recommend an abdominal and pelvic examination to assess for any abnormalities."
"I will ensure your privacy, and we'll have a female chaperone present. Would that be okay with you?"

5. Provisional Diagnosis

"From what you have told me and based on your examination, my main concern is that postmenopausal bleeding must always be investigated seriously.
One possible cause could be cancer of the lining of the womb (endometrial cancer), though there are other less serious causes as well, like thinning of the womb lining or small growths (polyps)."

6. Management Plan

Immediate 2-Week Wait Referral to Gynaecology:
"I will urgently refer you to a gynaecologist.
You should have an appointment within two weeks under a specialist fast-track pathway."

Investigations likely to be done:

Transvaginal Ultrasound Scan (TVS):
"An ultrasound through the vagina to look at the thickness and structure of your womb lining."

Hysteroscopy and Biopsy:
"If needed, they might pass a small camera into the womb to have a better look and take a sample."

Blood tests:
"We will also arrange some blood tests today — including blood counts and kidney/liver functions."
If Diagnosis Confirmed: (Explain gently)
"If anything, serious like cancer is found, the specialist team will discuss treatment options like surgery, radiotherapy, chemotherapy, or hormone therapy."

7. Safety Netting

"If you don't hear from the hospital within two weeks, please contact us immediately."
"If you develop any worsening bleeding, severe pain, dizziness, or any new worrying symptoms, please seek urgent care."

8. Closing

Offer reassurance of support:
"I know this can be an upsetting time. We are doing the right thing by investigating early, and we'll be here to support you throughout."
Offer leaflet:
"I'll give you a leaflet explaining more about postmenopausal bleeding and what to expect."
Check understanding:
"Is everything I explained clear so far? Do you have any questions or anything you would like me to go over again?"

Suspected Endometrial Cancer

A **70-year-old woman** has made an urgent appointment to discuss **some concerning symptoms**. She reports having had **four separate episodes of mild bleeding** per vagina over the **past month**.
She attained menopause **15–20 years ago**.
She is currently on **HRT** and has **no hot flashes**

1. Introduction

Greet warmly:

"Good morning, I'm Dr [Name], one of the doctors here today."

Confirm full name and age professionally:

"Could I confirm your full name and your age, please?"

Set a safe, compassionate tone:

"Nice to meet you. I understand you've come today with some concerns.
Please feel at ease — I am here to listen and support you.
Could you tell me more about what's been happening?"

2. Clarify Presenting Problem

Open exploration:

"Can you describe the bleeding you've noticed?"

Clarify specifics:

Onset: "When did you first notice the bleeding?"
Frequency: "You mentioned four episodes — were they close together or spaced out?"
Duration: "How long does each episode last?"
Amount: "Would you describe it as spotting or heavier bleeding?"
Clots: "Have you noticed any clots?"
Colour: "Was the blood bright red, brownish, or dark?"

3. Focused History Taking

A) Associated Symptoms

Pain: "Have you had any abdominal or pelvic pain?"
Discharge: "Any unusual vaginal discharge?"
Constitutional Symptoms: "Any weight loss, loss of appetite, tiredness, or feeling generally unwell?"

B) Anaemia Symptoms

"Have you been feeling more tired than usual?"
"Any dizziness, palpitations, or breathlessness?"

C) Gynaecological History (P4)

Menstrual History: "At what age did your periods stop?"
HRT History: "I understand you are on HRT — how long have you been using it?"
Pregnancy History: "Have you ever been pregnant before?"
Pap Smear: "When was your last cervical smear? Was it normal?"

D) Medical and Family History

"Any personal or family history of cancers, especially womb, ovarian, or breast cancer?"
"Any history of diabetes, hypertension?"

E) Lifestyle (DESA)

Diet
Exercise
Smoking
Alcohol intake

F) ICE

Ideas: "What are your thoughts about what might be causing this?"
Concerns: "Is there anything in particular you are worried about?"
Expectations: "Is there anything specific you were hoping we could do today?"

4. Examination

"I would now like to check your vital signs — blood pressure, heart rate, oxygen level, temperature."
"An abdominal and pelvic examination would normally be advised, but in your case, because of the bleeding and your history, it's best done by the specialist team to avoid any discomfort."

5. Provisional Diagnosis

(Use **Breaking Bad News** style: Calm, slow, kind)
"From what you have shared and considering that you had your menopause about 15 to 20 years ago, bleeding at this stage is concerning.
One of the serious possibilities we have to consider is cancer of the womb lining — endometrial cancer.
I understand this might be worrying to hear — I'm very sorry to have to mention it.
However, please remember, we still need further investigations to confirm anything."
(Pause and let the patient absorb.)

6. Management Plan

Urgent 2-Week Wait Referral to Gynaecology:
"I will arrange an urgent referral to a specialist — you should get an appointment within two weeks."

Investigations Likely:

Blood Tests:
"To check your general health — blood counts, liver and kidney function."

Transvaginal Ultrasound:
"A scan using a small probe to look closely at your womb."

Hysteroscopy + Biopsy:
"The specialist may pass a thin camera into the womb to directly look at the lining and take a small sample if needed."

CT Scan Abdomen and Pelvis:
"If necessary, to check surrounding structures."

Tumour Marker Blood Tests:
"To provide additional information."

If Cancer Confirmed:
"The gynaecologist will discuss the full treatment plan which may include surgery to remove the womb, followed by radiotherapy, chemotherapy, hormone therapy, or even immunotherapy depending on the stage and type of cancer."

7. Safety Netting

"If you do not receive a hospital appointment within 2 weeks, please contact us immediately."
"If the bleeding worsens, or you feel faint, develop severe pain, or any new symptoms, seek urgent help."

8. Closing

Offer emotional reassurance:

"I can understand that this is worrying. Please remember we are acting quickly to get the right help and care for you."

Offer leaflet:

"I'll give you an information leaflet on postmenopausal bleeding and what to expect next."

Final check:

"Is there anything else you would like me to explain or any questions you would like to ask?"

Why the 70-Year-Old Case Is Treated as a Suspected Cancer (BBN Approach)

Although **both women present with postmenopausal bleeding**, the **clinical context** makes the **70-year-old woman's case more suspicious** for cancer.

Bleeding years after menopause is always abnormal.

However, **longer time gap** (>15 years) and **recurrent fresh episodes** (not a single event) **strongly raise the suspicion** for a **malignancy**, particularly **endometrial carcinoma**.

Persistent exposure to hormones (HRT) without withdrawal bleeding increases the **risk of endometrial hyperplasia and cancer**.

Advancing age further adds to risk — endometrial cancer is more common after 60–65 years.

Thus:

In the 65-year-old, you acknowledge bleeding is abnormal but can reassure that **atrophy or polyps** are also common.

In the 70-year-old, you must gently **prepare the patient** that **cancer is a real possibility** and **urgently explain the next steps**.

Suspected Ovarian Cancer

Station ID

Where you are: FY2 in GP surgery

Who the patient is: 69-year-old lady

Presenting complaint: Bloating

Additional: Husband asked her to see GP; noticed weight loss and tummy pain.

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1. Introduction

Greet and confirm full name and age.

Build rapport:

"Nice to meet you. How can I help you today?"

Patient mentions bloating — acknowledge:

"Thank you for sharing that. Let's talk through it carefully."

2. Focused Symptom History

Clarify bloating:

"Can you describe the bloating in your own words?"

"When did it start?"

"Is it constant or does it come and go?"

"How many times a week or month do you notice it?"

(Important: >12 times/month = Red Flag)

"Is it getting worse over time?"

Associated symptoms:

"Have you noticed any tummy pain?"

"Any changes in your bowel habits?"
"Any loss of appetite, nausea, vomiting?"
"Any urinary symptoms — needing to pass urine often or urgently?"
"Any recent weight loss without trying?"

Systemic Screening:

Fatigue? Fever? Night sweats? Loss of energy?

3. Focused Risk Factor History

Family history:

"Has anyone in your family had cancer? What type?"
(Patient's mother: breast cancer – important)

Gynae history:

"When was your last period?"
"Have you ever used HRT?"
"Any past pregnancies or miscarriages?"

Lifestyle:

Smoking? Alcohol?
Activity levels?

4. ICE (Ideas, Concerns, Expectations)

Ideas: "What do you think might be causing the bloating?"
Concerns: "Is there anything you're particularly worried about?"
Expectations: "What were you hoping I could help with today?"

5. Effect on Life

"Is this affecting your eating, walking, sleeping, or doing daily activities?"
"Has it impacted your mood or relationships?"

6. Examination

Explain need for examination:
"To understand better what's causing your symptoms, I'd like to examine your abdomen."
Explain nature of procedure:
"The examination should not be painful but might be a little uncomfortable."
Explain steps:
"I'll be looking at your tummy, feeling it, tapping gently, and listening with my stethoscope."
Exposure:
"You'll need to be exposed from below the chest (nipple line) to the mid-thigh, keeping your undergarments on."
Positioning:
"I'll ask you to lie flat on your back on the bed, with a chaperone present to maintain your privacy."
Final consent:
"Are you happy for me to proceed?"

3. Observations First

Check **vital signs**:

Blood Pressure
Heart Rate
Respiratory Rate

Temperature
Oxygen Saturation

General inspection:

Assess pallor, jaundice, hydration status, signs of distress.

4. Abdominal Examination

1. Inspection

Stand at the foot of the bed and inspect the abdomen:

Skin changes (rashes, bruising, scars, striae)
Distension (generalized or localized)
Visible masses
Pulsations
Hernias
Vein engorgement (caput medusae)
Peristalsis

2. Superficial Palpation

Temperature:

Use the back of the hand across 9 quadrants, compare to thighs.

Tenderness:

Lightly palpate 9 quadrants (watch the patient's face).
Ask:
"Please let me know if you feel any discomfort."

3. Deep Palpation

Palpate deeply over all 9 quadrants:

Feel for masses, organomegaly (liver, spleen).

Special signs:

Murphy's sign (RUQ pain and inspiratory arrest → cholecystitis):

Place hand under right costal margin, ask patient to inspire.

Rebound tenderness (peritonitis):

Gently press and suddenly release in painful area.

4. Percussion

Percuss:

Start at epigastrium, move towards umbilicus and lumbar regions.
Check for:
Shifting dullness (ascites)
Liver span
Splenic dullness

Shifting Dullness:

If dullness detected:
Keep hand on abdomen.
Ask patient to turn onto side.
Percuss again at same area.
Change from dull to resonant → ascites.

Fluid Thrill Test (if ascites suspected):

Ask patient to place side of hand midline.
Tap one side, feel on the opposite side.

5. Auscultation

Listen over **right or left iliac fossa**:

Verbalise:

"Ideally, bowel sounds should be auscultated for at least 2 minutes."

Assess:

Presence of bowel sounds
Tinkling sounds (obstruction)
Absence of sounds (ileus)

5. End the Examination

Thank the patient for their cooperation.
Cover the patient properly to preserve dignity.

6. Further Examinations to Complete

(Always verbalise after main exam.)
"I would also like to complete the assessment by:"

Examining hernial orifices (umbilical, inguinal, femoral areas)
Inspecting external genitalia
Checking lower limbs for oedema
Performing a digital rectal examination (PR exam)

7. Provisional Diagnosis

"Based on your symptoms, examination findings, and family history, I am concerned about the possibility of a serious condition affecting your abdomen, possibly involving the ovaries."
*(Use soft but clear BBN tone – **do not confirm cancer** yet.)*

8. Explanation

"There is a condition called ovarian cancer that can sometimes present like this — bloating, discomfort, and changes in the abdomen."
"We are not sure yet — we need to do urgent tests to find out what's happening."
"It's important to investigate early, so that if there is anything serious, we can treat it as soon as possible."

9. Management Plan

Urgent Referral:

Two-week cancer pathway referral to Gynaecology.

Investigations:

Blood tests:

Full blood count
Renal and liver function
Tumour marker CA-125

Ultrasound abdomen and pelvis (transvaginal scan likely)
CT abdomen/pelvis (later if needed)

What specialists might do next:

Hysteroscopy (camera test if needed)

Biopsy (sample tissue test)
Further blood tests or scans.

10. Safety Netting

"If you notice worsening pain, increased swelling, vomiting, difficulty passing urine, or anything worrying, please seek help urgently."
"Please contact us if you do not get the specialist appointment within 2 weeks."

11. Follow-Up Plan

Arrange blood tests today.
Arrange ultrasound.
Book urgent 2-week referral.
Offer review appointment once results are back.

12. Leaflets and Support

Offer information leaflet on ovarian cancer symptoms and investigations.
Reassure ongoing support:
"You are not alone — we will guide you through every step, whatever happens."

Suspected Vulval Carcinoma

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1. Introduction

Greet warmly and professionally:
"Good morning, my name is Dr. [Name], one of the doctors here today."
"Could I please confirm your full name and your age?"
Quick rapport:
"Lovely to meet you. How can I help you today?"
Patient opens up:
"Doctor, I have an embarrassing problem."
"I have a lump down there."
Reassure professionally:
"Thank you for trusting me with this. Please don't worry — this is a safe space, and it's a common reason people visit us. We'll go through everything carefully."

2. Focused History

A. Clarify Presenting Problem (Lump Features)
Using **Morphology – Evolution – Symptoms** structure:
"When did you first notice this lump?"
"Where exactly is the lump — is it on the outer part, inside, or elsewhere?"
"Could you describe how it looks?"
"Has it changed in size or shape?"
"Is there any colour change?"
"Have you noticed any bleeding from it?"
"Is there any pain, itching, or discharge?"

B. Explore Associated Symptoms
"Have you noticed any new urinary symptoms — burning, urgency, blood in urine?"

"Any bowel habit changes?"
"Any fever, weight loss, or night sweats recently?"

C. Focused Past Medical History
"Have you ever had any skin conditions in the genital area, like irritation, chronic itching, or been diagnosed with anything in the past?"
(If she says "Yes, I have lichen sclerosis," **then gently explore:**)
"Are you still on any treatment for that?"
"How has it been recently?"

D. Menstrual and Sexual History
"When did you have your last period?" (To confirm menopause status)
"Are you sexually active?"
"Any discomfort or bleeding during or after sexual activity?"

E. Smoking, Alcohol, and Family History
"Do you smoke or drink alcohol?" (important because heavy smoking increases vulval cancer risk)
"Any history of cancers, especially gynaecological cancers, in the family?"

F. ICE (Ideas, Concerns, Expectations)
"Is there anything you were particularly worried this might be?"
"What were you hoping we could do today?"

G. Effect on Life
"Is this lump affecting your daily life, your comfort, or your confidence?"

3. Clinical Examination
Thank the patient for sharing.
Explain the plan:
"I would now like to examine your tummy and the area where you've noticed the lump. This will help me better understand what's going on. It shouldn't be painful, though it may feel a little uncomfortable."
Explain positioning:
Patient lying down, exposed from waist to mid-thigh while maintaining dignity. Offer chaperone.
Gain explicit consent.

Perform:
General observation (look for cachexia, pallor)
Abdominal exam (masses, tenderness)
Pelvic external inspection:
Look for lump (size, colour, surface, ulceration, discharge, bleeding)
Lymph nodes (if allowed)
No speculum or bimanual unless explicitly instructed in the station.

4. Provisional Diagnosis
Based on the history (new lump, bleeding, lichen history, weight loss) and examination findings:
"Based on everything we've discussed and what I've seen, I am concerned about a serious condition called **vulval carcinoma**, which is a type of cancer affecting the outer parts of the genital area."
(Pause, allow patient to process.)

Important to soften:
"I completely understand how difficult it is to hear this. Please know that many cases detected early are treatable, and we are taking the right steps quickly."

5. Management Plan

Immediate Action:
Urgent Two-Week Referral to gynaecology or dermatology oncology clinic:
"I'm arranging for you to be seen by a specialist urgently — within two weeks — to confirm the diagnosis and discuss the best treatment."
Investigations:
Specialist team will arrange:
Biopsy (sample of the lump)
Blood tests (routine bloods, maybe tumour markers)
Imaging (if staging needed later)

Treatment Possibilities (Explain honestly but sensitively):
"If confirmed, the most common treatment is **surgery** to remove the affected tissue."
"Sometimes, if needed, additional treatments like **radiotherapy** or **chemotherapy** are used."
"The team will explain everything based on the exact findings."
Lifestyle and Support:
Continue lichen treatment if ongoing (topical steroids).
Gentle hygiene advice: non-perfumed soap, soft toilet tissue.
Psychological support:
"Would you like me to arrange support services or counselling if you feel you would find that helpful?"
Safety Net:
"If you experience worsening symptoms — more bleeding, pain, fever, or feeling unwell — please seek urgent help."
Leaflet:
Offer a printed leaflet on vulval conditions and suspected cancer pathways.

6. Final Wrap Up

Check for any last questions:
"Is there anything else you would like to ask or talk about before we finish today?"
Reassure:
"You are not alone. We are acting quickly, and you are in good hands."
Summarise steps:
"We'll arrange the urgent referral, and you should get a specialist appointment within 2 weeks. Please don't hesitate to contact us if you need anything meanwhile."

Genital Warts in a Minor

Station Setup

Setting: FY2 doctor in GP surgery
Patient: 15-year-old female
Presenting Complaint: Lump "down below"
Underlying Concern: Potential safeguarding (adult partner, school counsellor)

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1. Introduction

Greet warmly and professionally:

"Good morning, I'm Dr. [Name], one of the doctors working here today.
Could you please confirm your full name and age for me?"

Build immediate rapport:

"Lovely to meet you. I understand you've come with a personal concern.
Please don't worry — you're in a safe and confidential space. Feel free to share whatever's bothering you. How can I help today?"

2. Focused Symptom History

Clarify the lump:

"Could you tell me more about the lump you've noticed?"

Appearance: color, texture, single or multiple lumps
Onset and evolution
Changes in size or spread
Associated symptoms:

"Is the lump causing any pain, itching, discomfort, or bleeding?" "Any unusual discharge or sores elsewhere?"

Explore systemic symptoms:

"Any fever, general tiredness, swollen glands, or flu-like symptoms?"

3. Focused STI and Sexual History

Sensitively ask about sexual history:

"I'll need to ask some personal questions about relationships to understand this better — is that alright?"

Key points:

Sexual activity: yes/no
Partner details:

"How old is your partner?" (35 years old — safeguarding trigger) "What is his relationship to you?" (school counsellor — position of trust) "How did the relationship start?" "Does anyone else know about it?" "Has he ever asked you to keep this secret or pressured you into anything?"

Red flags immediately identified.

5. Focused Medical, Psychosocial and Risk History

Medical history (other illnesses, medications)
Smoking/alcohol
Family history of cancers, STIs
Mood, emotional wellbeing
Impact on school, relationships

5. Physical Examination

Seek consent, explain fully:

"I'd like to examine the area gently to understand better. A chaperone will be present, and I'll ensure your privacy. The exam might feel a little uncomfortable but should not be painful.
Would that be alright?"

Findings:

Flesh-coloured, cauliflower-like growths — consistent with **Genital Warts (HPV infection)**
No discharge or ulceration noted

6. Diagnosis Explanation

Speak clearly and reassuringly:

"From the history you shared and the examination, these appear to be **genital warts**, caused by a common virus called **Human Papillomavirus (HPV)**.
It's something we can treat, and many people recover completely with treatment."
(Do not overwhelm — stay factual and calm.)

7. Management Plan

a. Immediate Medical Management

Specialist Referral:

"I will refer you to a **Genitourinary Medicine (GUM) clinic**, where they will confirm the diagnosis and start treatment."

Treatment Options:

"First-line treatment is a cream called **Podophyllotoxin (Warticon)**, which you apply directly onto the warts.
It can take between 1 to 6 months to fully work."

If topical treatment fails:

"Other options include freezing the warts **(cryotherapy)**, surgical removal, or using heat therapy **(electrocautery)**.
The specialists will guide you based on how your body responds."

Advise on hygiene and symptom control:

"Keep the area clean and dry. Avoid using any perfumed soaps or products."

b. Partner Notification

"It's important that your partner is tested and treated if necessary.
The GUM clinic will help you arrange this confidentially."

c. Preventing Future Infection

"Always use condoms during sexual contact, even when symptoms are not visible.
This helps protect you from future infections."

d. Safeguarding Action

This must be handled with extreme sensitivity:
"Thank you for trusting me with this information.
I'm very concerned about the age difference and the nature of your relationship, especially because your partner is someone who should protect young people, not have relationships with them."
Explain legal and ethical obligations clearly but kindly:
"Because you're under 16 and he's an adult in a position of trust, this relationship is inappropriate and illegal. I have a legal and moral duty to protect you. I will need to inform my senior doctors and the child protection team to ensure you get the right support. Your parents or guardians will also need to be informed.
The police may be involved, but everything will be handled to keep you safe."

Emphasize again:
"**This is not your fault**. You've done nothing wrong. You are not to blame in any way."

Advise:
"It's important you don't have any more contact with him for your safety."

Offer emotional support:
"I understand this must be very overwhelming.
Would you like me to arrange someone you can talk to — like a counsellor or a support worker?"

8. Safety Netting

"Please come back if you notice any worsening of symptoms — like increased pain, bleeding, or spreading of the warts.
And remember, if you feel unsafe or have any concerns while waiting for the referrals to be actioned, contact us immediately."

9. Follow-up

Follow-up GP review after initial specialist assessment
Counsellor referral if patient agrees

Missed Pap Smear

Station ID

Setting: FY2 doctor in GP surgery
Patient: 30-year-old woman
Reason: Follow-up for ankle injury, but no recent cervical screening (Pap smear)
Task: Address missed screening sensitively, assess risk factors, explain, and arrange management

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1. Introduction

"Good morning, I'm Dr. [Name], one of the doctors working today.
Could you please confirm your full name and age for me?"
"Lovely to meet you. I see you've come in today for your ankle follow-up.
Before we move ahead, I noticed something in your general health record that I wanted to check with you — is that alright?"

2. Clarify the Issue

"I noticed it's been some time since your last cervical screening (Pap smear).
Can I ask if there was any particular reason it's been delayed?"
Patient reply:
"I've just been very busy."
Acknowledge and empathize:
"That's completely understandable — life gets hectic sometimes. Thank you for letting me know."

3. Assess Risk Factors

Health and Sexual History Assessment:

Any past pap smears?
Have you ever been sexually active?
Any previous partners?
Safe sex practices (barrier methods)?
Any history of HPV infection, genital warts, or other STIs?
Smoking status (increases cervical cancer risk)
Any family history of cancer (cervical, breast, ovarian)?
Current contraception use (ask sensitively)

4. Explore Understanding (Patient's Knowledge)

"Could I ask — what do you know about why we recommend cervical screening?
Have you heard about what the Pap smear is for?"
If limited understanding:

Explain in simple, reassuring language:

A Pap smear is a screening test to detect changes in the cells of the cervix (the neck of the womb) before they can become cancerous.

It helps pick up early, treatable changes long before symptoms occur.

Most cervical cancers are preventable if changes are caught early through screening.

HPV (Human Papillomavirus) is the main cause of these cell changes — it's very common and transmitted through intimate contact.

5. Educate and Reassure

Explain why she received the reminder:

"It's a routine national program — everyone with a cervix aged 25 to 64 is invited.
Even if you're healthy and have no symptoms, regular screening is vital for prevention."

Highlight importance:

"It doesn't mean there's anything wrong — it's about keeping you safe in the future.
Missing a smear doesn't mean you're immediately at risk, but we want to catch any changes early if they ever happen."

6. Management Plan

Offer practical help:

Offer to book a convenient time around her schedule

Offer flexibility (early morning/late appointments if available)

Arrange a reminder if needed

If she agrees:

"Fantastic — I'll book it for you. It only takes about 5 minutes, and we'll ensure your privacy and comfort."

If hesitant:

"That's alright — no pressure. Would you like me to give you an information leaflet to read through first? You can always book it later when you feel ready."

7. Safety Netting

"If you notice any unusual symptoms — like bleeding between periods, after sex, unusual discharge, or persistent pelvic pain — please let us know immediately, even if your last smear was normal."

8. Closing

"Thank you for discussing this with me today. Your ankle is healing well too — keep it supported and avoid heavy strain for a few more weeks.
Is there anything else you'd like me to help you with today?"

Cervical Screening Result – Mild Dyskaryosis

Station ID

Setting: FY2 doctor in GP (Telephone Consultation)

Patient: 26-year-old woman

Scenario: Follow-up discussion of cervical screening result

Task: Explain result, assess health, address concerns sensitively

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1. Introduction

Greet warmly

Confirm patient's full name, age, and first line of address

Set the tone for call:
"I'm calling regarding your recent cervical screening test result. Is it a good time to talk?"

2. Clarify Today's Visit
"I understand you're concerned after receiving the letter about your cervical screening results.
Could you tell me a little about what's worrying you most at the moment?"
(Patient expresses fear due to family history, concern about cancer.)

3. Focused History
A. Focused Symptom Review
Any unusual vaginal bleeding (outside of periods)?
Any bleeding after sexual intercourse?
Any abnormal vaginal discharge (color, smell)?
Any pain during or after sexual activity?
Any lower back pain (concern for metastasis)?
Urinary symptoms: Pain while urinating? Frequency? Changes in urine?

B. Cancer Red Flag Screening (FLAWS)
Fever
Lumps
Anorexia/Weight loss
Night Sweats

C. Sexual Health History (Signpost)
"I'd like to ask some sensitive questions about your sexual health, just to fully assess your risk factors. Please let me know if you're uncomfortable."
Sexually active?
Stable relationship?
Use of protection (condoms)?
Any sharing of sex toys?
Previous testing or treatment for STIs?

D. Menstrual & Reproductive History
Regular periods?
Last menstrual period?
Use of contraception?
Previous pregnancies?
HPV vaccination status?

E. PMAFTOSA and DESA
Medical conditions (P)
Medications (M)
Allergies (A)
Family History (F)
Travel/Occupation (T/O)
Social History (S) – Smoking, Alcohol
Exercise and diet habits (DESA)

F. ICE

Ideas: "What do you think is happening?"
Concerns: "What's your biggest worry about this result?"
Expectations: "What were you hoping would happen after this result?"

4. Clinical Examination

(Telephone station – verbalize what would be done if face-to-face)

Vitals: BP, Pulse, Temp, BMI (if relevant)
General Physical Examination
Abdominal/Pelvic Examination if symptomatic

5. Result Disclosure

Start gently:

"Thank you for answering my questions.
Let's go through your result carefully together."

Explain the Findings:

"Your cervical screening showed mild dyskaryosis – this means there are mild, very small changes in the cells of your cervix."
"These changes are not cancer."
"Your sample was also tested for HPV – the virus that is responsible for most cases of cervical cancer – and the good news is that your HPV test was negative."
"Without HPV, the risk of developing cervical cancer from these mild changes is extremely low."

6. Explanation

"Think of mild dyskaryosis like a small warning light – not a major danger, but something we monitor carefully to ensure it doesn't develop."
"Since your immune system usually clears these changes naturally, and because you don't have HPV infection, no immediate treatment is needed."
"We follow national guidelines to simply monitor you and repeat your cervical screening in 3 years."

7. Address Concerns

Concern 1: "Why can't we start treatment now?"

"Because the changes are so mild and because there's no HPV, treating now would expose you to unnecessary procedures that carry their own risks."
"In most cases, these mild changes clear on their own without needing any treatment."

Concern 2: "Why not yearly screening?"

"Current evidence shows that re-testing earlier does not improve safety in women who have mild changes without HPV."
"If there was HPV present or if the changes were moderate or severe, we would act differently."
"Following the 3-year screening interval is the safest and most appropriate plan according to national guidelines."

Concern 3: Family history worry

"Your grandmother's history understandably raises concern.
But it's important to know that most cervical cancers today are linked to persistent HPV infection, and you've tested negative for that.
So based on today's findings, you are not considered at increased risk."

8. Management Plan

Follow-up: Repeat cervical screening in 3 years.
Lifestyle: Continue healthy habits, practice safe sex.
Vaccination: Discuss HPV vaccination if not already given.
No immediate treatment needed.
Provide reassurance:
"You're doing exactly the right thing by attending your screenings."

9. Safety Netting

Urgent review if any of the following develop:
- New or unusual vaginal bleeding
- Post-coital bleeding
- Unusual vaginal discharge
- Pelvic pain

Continue regular GP visits for general health review.

10. Offer Information Leaflet

Provide a leaflet on:
- Cervical Screening
- Mild dyskaryosis
- HPV and cervical cancer prevention

11. Closing

"Thank you for discussing this with me today.
You're doing the right thing by being proactive about your health.
Is there anything else you'd like me to explain or arrange for you before we finish?"

Red Flag Pitfalls – Women's Health

Clinical Safety and Communication Traps to Avoid in PLAB 2

This summary covers critical mistakes and communication gaps that commonly lead to lost marks in Women's Health stations—especially in scenarios involving breast symptoms, pregnancy, discharge, and sexual health. Each section highlights actions to prioritise and traps to avoid.

1. Breast Lump and Pain Scenarios

Always explore symptoms thoroughly, including nipple changes, discharge, and associated systemic symptoms.
Never assume or suggest a lump is benign without proper investigation.
Avoid rushing through history; each detail (e.g., age, family history, pain features) affects urgency and referral type.
Every breast lump requires referral. Referral urgency depends on age and cancer risk factors.
Don't offer mammography arbitrarily; consider patient age, recent imaging, and guidelines.
Mention breast awareness and teach self-examination if appropriate.
In mannequin-based exams, mention—but do not perform—axillary examination.
Distinguish clearly between engorgement and mastitis:
- Engorgement: typically bilateral, no fever.
- Mastitis: unilateral, painful, often with systemic symptoms.

In mastitis, flucloxacillin is the recommended first-line antibiotic. Paracetamol is safe for pain relief.
Encourage continued breastfeeding or expression in both mastitis and engorgement.

Be prepared for station variations (e.g., mannequin present, image shown, paper findings).

2. Early or Teenage Pregnancy

Do not express personal views or congratulate the patient; maintain neutrality.
Never initiate discussion about termination unless the patient raises it.
Maintain full confidentiality, especially with under-18s. Do not involve parents without consent.
Assess understanding and apply Gillick competence if under 16.
Be sensitive in tone and phrasing. Avoid pressuring the patient toward any option.
Explore relationship safety and potential coercion or abuse.
Offer information about confidential services and options, including continuing pregnancy, adoption, and termination.
Address the presenting complaint (e.g., vomiting) alongside the pregnancy.
Ensure time is given to process the conversation and clarify next steps.

3. Vaginal Discharge and Sexual Health

Do not assume STIs without taking a focused, risk-based sexual history.
Ask about key symptoms: itching, smell, colour, pain, bleeding, urinary symptoms.
Always perform an examination or offer swabs if the station allows it.
Use the MES approach (Morphology, Evolution, Symptoms) for discharge.
Do not prescribe without a clear diagnosis or offer non-guideline treatments.
Avoid missing lifestyle factors—e.g., hygiene practices in bacterial vaginosis.
Even in low-risk relationships, STI testing should be offered when discharge is present.
Reassure appropriately but avoid dismissing symptoms; explain diagnosis and treatment clearly.

4. Scenario Format and Flow Awareness

Breast pain scenarios may be mannequin-based, picture-based, or entirely verbal. Adapt accordingly.
Teenage pregnancy stations require emotional sensitivity and legal awareness.
Vaginal discharge scenarios follow clear diagnostic logic—no uncertainty unless explicitly presented.
Talkative patients may speak for most of the station. Don't interrupt; summarise and guide management afterward.
Be prepared for variations across the same condition (e.g., oxybutynin side effects, contraception counselling).

5. General Advice for Women's Health Stations

Avoid vague language or euphemisms. Speak clearly, with compassion and professionalism.
Be realistic in advice. Provide practical lifestyle suggestions, not generic encouragement.
Always explain why sensitive questions are being asked.
Don't calculate risk scores or refer to them during consultations unless the scenario specifically requires it.
Document appropriately, summarise actions, and offer follow-up if relevant.

Chapter 17: Psychiatry

Why Psychiatry Matters in PLAB 2

Psychiatric stations test your ability to:

- Communicate naturally and empathetically
- Explore sensitive topics without assumptions
- Screen for functional and emotional impact
- Identify risk and refer appropriately

General Consultation Tips

- Let the patient explain their concern — **don't assume**
- Explore **core symptoms** + **functional impact** (on sleep, work, relationships)
- Use **screening tools naturally** within the conversation
- Always assess **risk** — suicidal thoughts, harm, neglect, social support
- **Explain simply**, normalize the experience, and provide **hopeful next steps**

Full Screening Tools for PLAB 2 Psychiatry

Modified FAMISH – Psychiatric History Framework

Letter	*Component*	*Sample Questions / Notes*
F	**Family History & Function**	"Any family history of mental health issues?" "Who do you live with?" "What do you do for work?"
		"Any difficulties at work, school, or in relationships recently?"
A	**Alcohol and Drugs**	"Do you drink alcohol? How much and how often?" "Do you use cannabis or other recreational drugs?"
		Cannabis in teens ⟶ increased schizophrenia risk
M	**Medical Conditions & Medications**	"Any long-term illnesses?" "Have you had any mental health diagnoses in the past?" "Are you on medication?"
I	**Insight**	"Do you feel anything unusual has been happening?" "Do you think you might need help?"
		"Do you believe doctors can help you with these experiences?"
S	**Social History & Stress**	"Do you have a support network or close friends?" "Are you facing any stress right now?" "How is your sleep?"
H	**Hallucinations**	Ask directly only if not covered earlier: "Have you seen, heard, or felt things others haven't?"

Depression Screening

Start with:

"Over the last 2 weeks, have you:"

Core symptoms

✓ Felt low, down, or hopeless nearly every day?

✓ Lost interest or pleasure in things you normally enjoy?

If yes to either, follow with:

Associated symptoms

✓ Poor concentration
✓ Fatigue or low energy
✓ Sleep disturbances (too much or too little)
✓ Appetite/weight changes
✓ Feeling guilty or worthless
✓ Thoughts of death, self-harm, or feeling life isn't worth living

Use these to screen for **mild, moderate, or severe depression**

GAD Screening (Generalized Anxiety Disorder)
"Do you often feel nervous, anxious, or on edge?"
Ask about:

| ✓ Difficulty controlling worry
| ✓ Worrying about many things, not just one area
| ✓ Physical tension or restlessness
| ✓ Fatigue or feeling drained
| ✓ Poor sleep (difficulty falling/staying asleep)
| ✓ Poor concentration or irritability

Interfering symptoms lasting **>6 months** suggest GAD

SCOFF Questionnaire – *Screening for Eating Disorders*

| **S** – Do you make yourself **Sick** because you feel uncomfortably full?
| **C** – Do you worry you have lost **Control** over how much you eat?
| **O** – Have you recently lost more than **One stone** (6.5 kg) in a 3-month period?
| **F** – Do you believe yourself to be **Fat** when others say you are too thin?
| **F** – Would you say that **Food** dominates your life?

≥2 'Yes' answers suggest possible eating disorder (anorexia or bulimia)

CAGE / CAGE-TW Questionnaire – *Screening for Alcohol Misuse*

| **C** – Have you ever felt the need to **Cut down** on drinking?
| **A** – Have people **Annoyed** you by criticising your drinking?
| **G** – Have you ever felt **Guilty** about your drinking?
| **E** – Do you ever need an **Eye-opener** (morning drink) to steady yourself?

If ≥2 are positive → high suspicion for alcohol dependency
Add:

| **T** – Tolerance: Do you need more alcohol to feel the same effect?
| **W** – Withdrawal: What happens when you stop — shakes, sweating, irritability?

KHTW Tool – *Drug Addiction Screening (adapted for PLAB 2)*

| **K** – Quit: Have you ever tried to stop? What happened?
| **H** – Hurt/Guilt: Do you feel bad or guilty about using?
| **T** – Tolerance: Do you need increasing amounts?
| **W** – Withdrawal: Do you get symptoms if you stop (e.g., cramps, sweats, cravings)?

→ Also ask: "Do you inject?" "Do you share needles?" "Do you know about needle exchange?"

PTSD Symptom Cluster Screening
"Since the traumatic event, have you noticed…"
| **Re-experiencing**: Flashbacks, nightmares, intrusive thoughts?
| **Avoidance**: Avoiding places, conversations, or reminders of the event?
| **Hyperarousal**: Jumpy, irritable, poor sleep, exaggerated startle response?
| **Negative thoughts**: Guilt, detachment, loss of joy, poor concentration?
Symptoms present for **>1 month**, affecting daily life → PTSD

Psychogenic Erectile Dysfunction Screening
Used to differentiate anxiety-related ED from organic causes:
"Do you usually get erections in the morning?"
"What about during masturbation?"
"Was this your first sexual experience?"
"Did anything make you feel nervous or self-conscious in that moment?"
"Any recent stress, anxiety, or relationship issues?"
Normal erections during masturbation/mornings + sudden loss during intercourse → **performance anxiety**

Schizophrenia

Scenario Context:
You are the GP. A 20-year-old patient has been brought in by their parent due to increasingly unusual behaviour. There are 3 variants of this case, all consistent with **schizophrenia**:
Variant A: Patient believes **everyone is spying on them** (TV, neighbours, strangers)
Variant B: Patient claims **King Charles is his real father**, and he's preparing to meet the royal family
Variant C: Patient insists **the police are chasing him**, even after being cleared by them

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Introduction & Patient Identification
"Hello, I'm one of the doctors here at the practice. Thanks for coming in today. Could I confirm your full name and age, please?"
• The actor replies with a real name and confirms they are around 20 years old.

Clarify Reason for Visit
"I understand your mum (or dad) was a bit worried and asked us to check in with you. I'd like to hear from you first — how have things been lately?"
If evasive:
"That's okay. This is a safe and confidential space — I'm just here to understand what's going on so we can help, if needed."

Open-Ended Exploration
"Is there anything that's been on your mind recently?"
"Have you noticed anything unusual happening around you?"
"Have there been any changes in how you think, feel, or experience the world?"

Explore Delusional Themes (Presentation-Specific)
Variant A – Spying/Persecutory Theme
"Have you felt like people are watching you or spying on you?"
"Where do you think the spying is coming from?"
"Do you think people on TV or online might be involved?"

Common actor cue: "Everyone's watching me. The TV presenter is sending messages."

Variant B – Grandiose Theme
"You mentioned something about King Charles?"
"Could you tell me more about how you're related to him?"
"Have you tried contacting him or planning to meet him?"
Cue: "I'm his real son. I'm going to the palace next week."

Variant C – Police Chasing
"Do you feel like the police are after you?"
"Have they said anything to you directly, or followed you physically?"
Cue: "I was in the station. They let me go, but I know they're still watching me."

Follow-up (All variants):
"How long have you had these thoughts?"
"What do you think might happen next?"
"Have these thoughts affected your daily life or relationships?"

Hallucinations Assessment
"Do you ever hear voices that others can't hear?"
"How many voices do you hear?"
"Do they speak to you directly, or to each other?"
"What do they usually say?"
"Do they ever ask you to do anything?"
If voices say harmful things:
"Have you ever followed their instructions?"
"Do you feel like acting on them now?"
"Do you ever see things others can't see?"

Thought Disorders
Insertion: "Have you ever felt that someone is placing thoughts in your mind that aren't yours?"
Withdrawal: "Do your thoughts ever just vanish or feel stolen?"
Broadcasting: "Do you feel like others can read your thoughts or know them without you speaking?"

Mood & Suicide Risk
"How has your mood been lately?"
"Do you ever feel very down or hopeless?"
"Have you ever had thoughts of harming yourself or ending your life?"
Even if mood appears stable, suicide risk must always be screened in psychotic disorders.

Safety Assessment
"Given all these experiences, do you ever feel unsafe?"
"Have you ever felt the need to carry anything to protect yourself?"

Differential Screening (Physical + Organic Causes)
"Have you had any recent illnesses like fever, headaches, or infections?"
"Any problems with sleep, appetite, or energy recently?"
"Are you taking any supplements or herbal products?"

FAMISH Screening (Adapted)

F – Family History & Functionality

"Has anyone in your family ever had a mental health condition?"
"Who do you live with at the moment?"
"Do you work, study, or have any hobbies?"
"Have these experiences affected your ability to work or keep relationships?"

Common: "I had a job, but they said I was acting weird."

A – Alcohol & Drugs

"Do you drink alcohol?"
"Do you use any recreational drugs — like cannabis or anything else?"
Cannabis is strongly associated with earlier onset schizophrenia.

M – Medical History & Medications

"Do you have any diagnosed medical conditions?"
"Have you ever been prescribed medication for your mental health?"
"Are you on any regular tablets or injections?"

I – Insight

"Do you feel there's anything unusual or different about your experiences?"
"Would you be open to some help if it could make things better?"

S – Social & Stress

"Do you have close friends or people you trust?"
"Any big stressors recently — like changes at home, study, relationships?"
"How have you been sleeping?"

H – covered above

Physical Examination

"I'd like to do a quick physical check — your blood pressure, temperature, maybe listen to your chest — just to make sure there's no physical reason for what you're experiencing."

Provisional Diagnosis

"Based on what you've shared, it sounds like you may be going through a mental health condition called **schizophrenia**."

Layman Explanation

"Schizophrenia is a condition that affects how a person thinks, feels, and experiences the world. Sometimes, people with this condition may strongly believe things that aren't quite true — like feeling they're being watched or that they have special connections. They may also hear voices or see things others can't.
These experiences can feel very real and confusing. But the good news is — this is treatable. With the right help, most people improve and are able to live a normal life."

Management Plan

Urgent Referral to Psychiatry (Non-ambulance emergency)

"This needs urgent attention from a mental health specialist today."
"Would your parent be able to take you to the hospital right now?"
"We'll call the psychiatric team ahead and let them know you're coming."

Home Treatment Team Option (Crisis Resolution)

"There's a specialist team called the Crisis or Home Treatment Team — they can come to your home and assess whether you can be managed safely there."

Hospital Plan

"In hospital, they'll have a chat with you, do a few blood tests and physical checks to rule out other causes."

"Then they'll help decide the best treatment to help you feel more settled."

Medication

"They might recommend medication like **Risperidone** or **Olanzapine**, either as tablets or a long-acting injection."

"These medicines help reduce the thoughts and voices, and help you think more clearly and feel more like yourself."

If Patient Hesitant

"The team will talk to you and decide what's best. If home treatment works, they'll support you there. If hospital is safer, they'll explain why and help you through it."

Safety Netting

"If anything changes — if you feel overwhelmed, unsafe, or the voices get worse — please go to A&E straight away or call 999. You can also call the crisis number I'm giving you."

Follow-Up Plan

"I'll write a referral now to the local mental health team, and they'll see you within a few hours. We'll also check in with your parent and offer them support too."

Leaflet & Support Resources

Offer NHS leaflet on schizophrenia and local crisis team contact info
Provide local mental health support numbers
Optionally signpost to Mind UK or Early Intervention in Psychosis services

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Diagnostic Summary

The diagnosis of **schizophrenia** is supported by:

Age (young adult),
Functional decline (not working or withdrawn),
Delusional thinking (spying/royalty/police),
Possible hallucinations,
Disorganised thought,
Poor insight,
No organic/medical cause,
Cannabis as a risk factor

This is **not** delusional disorder (functioning intact, usually older), nor brief psychosis.

Depression

General Template

This is the base structure for all depression scenarios. Tailored versions (e.g. post-MI, postnatal) will follow separately.

Introduction & Identity

"Hello, I'm one of the doctors here at the practice. Could I confirm your full name and age, please?"
"Nice to meet you. I understand your [partner/family] asked you to come in. Can I ask — what's been going on recently from your side?"

Presenting Complaint (Open History)

"How have you been feeling lately?"
"What do you mean when you say you're feeling low?"
"Did this come on suddenly or gradually?"
"Was there any trigger — like stress, a loss, or a change in your life?"

Core Symptom Assessment (NICE Criteria)

"Over the last few weeks, have you felt down, depressed, or hopeless most of the time?"
"Have you lost interest or pleasure in things you usually enjoy?"

Also ask:

"On a scale of 1 to 10 — where 1 is extremely low and 10 is very happy — how would you rate your mood today?"

"I'm sorry to hear that you've been feeling this way."

Additional Symptoms (PHQ-9 Style)

Ask the following clearly and sensitively:

"Have you been feeling tired or lacking energy?"
"Is it harder to focus or concentrate?"
"How has your sleep been — difficulty falling or staying asleep?"
"Have you been feeling more agitated or restless?"
"Any changes in appetite or weight?"
"Have you been blaming yourself or feeling guilty a lot?"
"Do you find yourself tearful more often?"
"How has your sex drive been lately?"
"Any problems with memory?"
"Have you seen or heard anything that others can't?"

Risk Assessment (Always Mandatory)

"Have you had any thoughts of harming yourself?"
"Have you ever felt like life's not worth living?"
"Have you made any plans to hurt yourself or end your life?"

If any risk is present: pause, reassure, escalate safely.

Differential Screening (As Needed)

"Have you had a baby recently?" *(Postnatal depression)*
"Have you ever had a period where you had too much energy, little sleep, and felt on top of the world?" *(Bipolar)*
"Have you been through anything traumatic — like flashbacks or nightmares?" *(PTSD)*
"Do you often feel cold, constipated, or sluggish?" *(Hypothyroidism)*

PMAFTOSA History

"Have you had depression or any mental health problems before?"
"Do you take any regular medications?"
"Any allergies to medicines?"
"Any family history of mental health conditions?"
"Do you smoke, drink alcohol, or use any drugs?"
"Do you work or study? What do you do during the day?"

"Who do you live with? Is your partner supportive?"
"Any money issues affecting you recently?"
"What do you do for fun or relaxation?"
"Do you get any regular exercise?"

ICE – Ideas, Concerns, Expectations

"What do you think might be causing this?"
"What worries you most about these symptoms?"
"What are you hoping we can do for you today?"

Effect on Life

"Has this affected your daily routine, work, or social life?"
"Has it been harder to care for your children or yourself?"

Provisional Diagnosis + Lay Explanation

"From everything you've told me — including how you've been feeling and how it's affected your daily life — it sounds like you may be experiencing what we call **clinical depression**."

What that means is this:

"Depression isn't just feeling sad or having a bad day. It's a medical condition that affects how you feel, how you think, and even how your body works."
"People with depression often feel low or empty for most of the day, nearly every day. They may lose interest in things they used to enjoy. It can affect sleep, energy levels, appetite, memory, and even how you see yourself."
"Sometimes, people feel tired all the time, or they struggle to get out of bed. Others might feel guilty, hopeless, or disconnected from those around them."
"The important thing to know is — this is **not your fault**, and **you're not alone**. Depression is common, and with the right support and treatment, people do get better."
"Does that explanation make sense so far?"

Investigations

"We'll start with a few tests to rule out physical causes. This includes:"
Full blood count
Thyroid function test
Liver and kidney tests
Blood sugar and electrolytes
ECG if indicated (especially if starting certain medications)
"Would that be alright with you?"

Management Plan

a. Lifestyle Advice (For All)

"Even small amounts of regular exercise can lift your mood — would you be open to trying a short walk each day?"
"Trying new hobbies, getting fresh air, or connecting with people can also help."

b. Talking Therapy (For All)

"We'll refer you to a **CBT therapist**. It's a structured type of counselling that helps you manage thoughts and emotions."
"Are you comfortable with us making that referral?"

c. Medication (If Moderate to Severe)

"We may start an antidepressant like **Citalopram** or **Sertraline**."
"It takes around 2–4 weeks to work. We usually continue it for 6 months after you feel better."
"Side effects can happen at first but often settle. Don't stop suddenly — always check with us first."
"Would you be okay to try this?"

d. Crisis Support

"I'll give you a **crisis contact card** — it has 24/7 numbers to call if you ever feel overwhelmed. You're not alone."

Safety Netting

"If your symptoms get worse, or you feel at risk of harming yourself, please come back immediately or go to A&E."

Follow-Up Plan

Mild symptoms or therapy only: "I'll book a review in 2 weeks."
Starting medication or safety concerns: "I'll review you in 1 week."

Leaflet

"I'll also give you a leaflet about depression, therapy, and medication to read in your own time."

Handling Concerns

Q: "Why therapy? I already talk to my sister."

"That's great — keep talking to her. But a therapist can help in a structured way, with tools to help you think and cope differently. It's a different kind of support — both are important."

Case 1: Mild Depression – Lesbian Couple After Miscarriage

Summary

Female patient presents with low mood, sleep difficulty, and guilt following a miscarriage 2–3 months ago. History of 5–6 years of trying to conceive. No suicidal thoughts or psychotic features. Functioning largely intact.

History Focus

"Can you tell me about your efforts to have a child?"
"I'm sorry to hear about the miscarriage. When did it happen?"
"How have you been feeling since then?"
"Are you managing to get out of bed, go to work, and do daily tasks?"
"How is your sleep?"
"Have you been blaming yourself or feeling guilty?"
"Do you have support from your partner or others around you?"

Diagnosis Justification

Meets diagnostic criteria for mild depression (low mood, guilt, insomnia) following a clear trigger. Symptoms <3 months, good social support, functioning preserved.

Management

Acknowledge grief and validate emotional response

Offer CBT referral (IAPT or talking therapy)
Lifestyle support (walks, reconnecting with partner, sleep hygiene)
No medication needed at this stage
Crisis card and follow-up in 2 weeks

Case 2: Mild Depression – Woman Missing Daughter

Summary

Middle-aged woman brought in by husband due to persistent low mood. She reports feeling sad, missing her daughter who recently started school. Lost interest in hobbies like shopping and volunteering. Sleep disturbance present. No suicidality or functional breakdown.

History Focus

"How do you feel about your daughter starting nursery?"
"What has your daily routine been like since she started school?"
"Are there things you used to enjoy that you've lost interest in?"
"How are you sleeping these days?"
"How are your energy and concentration levels?"

Diagnosis Justification

Mild depressive episode due to life change. Symptoms include low mood, insomnia, and anhedonia. No significant risk or loss of function. Trigger is recent and emotional.

Management

Reassure and validate feelings as common during transitions
Recommend CBT (low-intensity intervention)
Encourage daily structure and small goals (walks, social visits)
Sleep hygiene guidance
No medication at this stage
Follow-up in 2 weeks to reassess progress

Case 3: Mild Depression – Divorced Man

Summary

40-year-old man with insomnia, increased alcohol use, and reduced work performance after a divorce 4 months ago. Drinking a bottle of wine daily. Reports feeling low and anxious. Fears job loss.

History Focus

"Can you tell me about your divorce? When did it happen?"
"How long have you been having trouble sleeping?"
"What's your alcohol intake like? Daily or occasional?"
"Do you think alcohol is helping, or making things harder?"
"How is this affecting your work performance?"

Diagnosis Justification

Duration is 4–6 months. Mild to moderate symptoms, but job loss has not yet occurred. Function is beginning to decline but not yet collapsed. Currently still meets mild depression criteria.

Management

Brief intervention for alcohol (offer support and referral to alcohol services)
Suggest sleep hygiene and cut down on alcohol
Recommend CBT (focus on loss adjustment, insomnia)
Encourage gradual return to routine and work consistency
No antidepressants yet unless worsening
Follow-up in 1 week due to alcohol risk and job pressure

Case 4: Moderate Depression - Woman with Weight Loss

Summary

Middle-aged woman presents with unintentional weight loss over 3–4 months (e.g., 7–8 kg). Further questioning reveals low mood, anhedonia, insomnia, and fatigue for over 6 months. May or may not have a clear life stressor. No suicidality or psychotic symptoms.

History Focus

"How much weight have you lost and over what period?"
"Have you noticed a change in your appetite?"
"How has your mood been lately?"
"Have you felt persistently low or disinterested in things?"
"How long have you been feeling this way?"
"Any major life events recently?"
"Are you new to the country or missing family support?"

Diagnosis Justification

Symptoms (low mood, poor appetite, insomnia, fatigue) present for more than 6 months. Functional impact is moderate. Duration and symptom burden meet **moderate depression** criteria per NICE.

Management

Blood tests to rule out organic causes (FBC, TFT, LFT, HbA1c, etc.)
Start SSRI (e.g. Sertraline or Citalopram)
Refer for CBT (IAPT or equivalent)
Offer lifestyle advice: social activity, structure, mild exercise
Provide crisis card for emergency support
Follow-up in 1–2 weeks based on risk

Case 5: Moderate Depression – Post-MI with Medication Non-Compliance

Summary

49–50-year-old man referred back to GP by nurses due to non-compliance with cardiac medications after a myocardial infarction (MI) and stent placement 4 months ago. On assessment, shows signs of low mood, lack of motivation, and possible depression affecting adherence.

History Focus

"I understand the nurse referred you after noticing some issues with your medication. Can you tell me what's been going on?"
"Can you tell me what treatments you received for your heart attack?"
"Are you taking your medications like aspirin, statin, and beta-blocker regularly?"
"If not — what's made it difficult to keep up with the medications?"
"You seem a bit down today. Have you been feeling low or lacking motivation?"

"Have you lost interest in things, or been feeling tired more than usual?"
"How has your sleep been? Appetite? Energy?"
"Do you sometimes feel guilty or find it hard to concentrate?"
MAFTOSA: review overall medical history, family support, alcohol, smoking, daily functioning

Diagnosis Justification
Depressive symptoms (low mood, anhedonia, poor motivation, fatigue) following major cardiac event. Duration >1 month, impairing treatment compliance. Meets NICE criteria for **moderate depression** with functional impact.

Management
Start **Sertraline** (safe for post-MI patients, per NICE CG91 and CKS)
Refer for **CBT or counselling**
Reinforce importance of **continuing cardiac medications**: aspirin, statin, clopidogrel, beta-blocker, ACE inhibitor
Offer practical help with medication routine (e.g. dosette boxes)
Crisis card and warning signs to watch for
Follow-up in **1 week** to assess both mood and medication adherence

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Case 6: Severe Depression – 20-Year-Old with Suicidal Ideation

Summary
A 20-year-old patient previously diagnosed with severe depression presents with ongoing low mood and **active suicidal thoughts**. No psychotic symptoms, but high-risk presentation requiring urgent psychiatric input.

History Focus
"How have you been feeling lately?"
"Have you had thoughts about ending your life?"
"Have you made any plans or done anything to act on these thoughts?"
"Do you feel safe going home right now?"
Confirm support at home, compliance with any ongoing therapy or medication

Diagnosis Justification
Severe depression with **suicidal ideation**, function likely impaired, safety at risk. Needs urgent escalation. Not suitable for GP-based management.

Management
Urgent **psychiatric referral**: "You need to go to hospital today, but this is not an ambulance case. Can someone take you?"
Safety warning: "Please do not drive yourself."
Refer to **CRHT (Crisis Resolution and Home Treatment) team**
"They will assess you and decide whether treatment is needed at home or as an inpatient."
Explain treatment
- Psychosocial support and crisis plan
- Medication (typically SSRIs)
- Therapy once stable

Arrange **follow-up** after discharge to continue care at GP level

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Case 7: Moderate Depression – Relapse After Stopping Sertraline

Scenario Summary:
30-something-year-old man, previously diagnosed with depression, was on Sertraline 100 mg. His GP advised gradual tapering and discontinuation 6 months ago. Now, 4 months post-discontinuation, he presents with a relapse of depressive symptoms.

Current Symptoms:
- **2 Core Symptoms**: Low mood, anhedonia
- **4 Additional Symptoms**: Poor sleep, reduced concentration, guilt, and noticeable weight loss
- **No active suicidal thoughts**

Clinical Impression:
Meets criteria for **moderate depression** (≥2 core + ≥3 associated symptoms).

Key Points to Cover in Consultation:
- Acknowledge relapse and reassure that recurrence is common
- Explore treatment history, past response, and withdrawal pattern
- Discuss impact on daily life, work, and functioning
- Assess ICE and explore support systems
- Rule out suicidality (past/present ideation, risk)

Management Plan:
- Restart **Sertraline 50 mg**, titrate up to 100 mg if tolerated
- Offer **referral to CBT** (IAPT/self-referral pathway)
- Advise on **routine investigations**: FBC, U&E, TFTs, ECG
- Provide **crisis contact card** and safety-net (including emergency contacts)
- Plan **GP review in 2 weeks**
- Give a **leaflet on depression** and medication relapse prevention

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Case 8: Depression Follow - up– CBT Not Working

Scenario Context
You are an F2 doctor in a GP clinic. A 40-year-old man was diagnosed with depression by psychiatry 2 months ago. He was started on CBT, but now returns for follow-up saying it is not helping. He appears visibly low, may cry, and mentions difficulty functioning or attending work.

Introduction & Consent
"Hello, I'm one of the doctors here at the practice. Thank you for coming in. Can I confirm your full name and age, please?"
"I understand you were recently seen by the mental health team and have come back for a follow-up. Is it okay if I ask a few questions to understand how things have been going for you?"

Focused History & Context
- "Can you tell me what the psychiatrist explained to you at the time of diagnosis?"
- "What have you been told about depression?"
- "How did you feel when they suggested CBT?"

If the patient says: "CBT is rubbish. It's not working. I still feel the same. I can't go to work."
→ Respond empathetically:

"I'm really sorry you've been feeling this way. I know it must be frustrating. Let's go over everything together so we can figure out the next step forward."

Explore ICE

"What's been bothering you most about your situation right now?"
"Are you worried that things aren't improving?"
"What are you hoping we can help you with today?"

Therapy Review & Effectiveness

"Can I ask how long you've been attending CBT sessions?"
"How often do they happen? Are they one-on-one or in a group?"
"Roughly how long is each session?"
"Have you been able to attend them regularly, or missed any?"
"Did anything in the sessions feel useful, even slightly?"

Symptom Monitoring & Mood Check

"What kind of symptoms did you originally have when you were diagnosed?"
"Have those symptoms improved, stayed the same, or gotten worse?"
"Are you still feeling low most of the time?"
"Do you still find it hard to enjoy things you used to like?"
"How would you rate your mood today on a scale from 1 to 10?"
"Are you sleeping okay? How's your appetite? Energy? Motivation?"

Respond supportively if mood is low:
"Thank you for telling me. I can see this has been really tough for you."

Risk Assessment

"With everything that's been going on, have you had any thoughts of harming yourself or ending your life?"
"Have you made any plans or taken any steps in that direction?"

Escalate appropriately if risk is identified.

PMAFTOSA (Follow-Up Adapted)

Previous Diagnoses: "Apart from depression, have you ever had any other mental health diagnoses?"
Medications: "Have you been prescribed any antidepressants in the past?"
Allergies: "Any known allergies to medication?"
Family History: "Any history of depression or mental illness in your family?"
Travel: Not relevant in this case — omit unless new symptoms suggest an organic cause.
Occupation: "Are you still able to go to work? If not, how long have you been off?"
Social Support: "Do you live alone or with anyone? Do you feel you have support at home?"

Clear Disclosure

"From everything you've described, it seems that your symptoms of depression are still affecting your daily life. It's not uncommon for CBT alone to be insufficient in some cases — and that doesn't mean you've failed. It just means we need to support you in a different way."

Lay Explanation of the Condition

"Depression is a condition where a person feels persistently low, loses interest in normal activities, and often feels drained or hopeless. CBT is one way of helping, but sometimes, especially when symptoms continue beyond a few weeks, we also use medications to support recovery. There's no one-size-fits-all approach — and that's okay."

Structured Management Plan (Psychiatry-Aligned)
Medication

"We can start an antidepressant called **Citalopram**, which is commonly used and generally well tolerated."
"It can take 2–4 weeks to begin working, and the full effect is usually seen by around 1 month."
"We usually continue the medication for at least 6 months after you start feeling better to prevent a relapse."

Side Effects Explanation

"Like most medicines, it can cause some side effects in the beginning — things like tiredness, dry mouth, trouble sleeping, or reduced sexual desire."
"If sexual side effects are a concern, we could also consider a medication called **Reboxetine**, which tends to have a lower impact on sexual function."

CBT Continuation

"CBT can still be helpful alongside medication. The two together work better than either on their own, especially in moderate to severe depression."

Supportive Measures

"We can also discuss ways to gradually get back to a routine — even if it's just going for a short walk or making small goals each day."

Safety Netting

"If your symptoms get worse, or if you ever feel unsafe, please don't wait — contact us, go to A&E, or call the numbers I'll give you. There's always help available."

Follow-Up Plan

"Let's review you in **1 week** after starting the medication. I'll check in on how you're feeling and whether you've had any side effects."
"You don't have to go through this alone — we'll support you step by step."

Explanation to Student

This is a **psychiatric follow-up station** where the primary objective is to assess **response to treatment**, maintain empathy, and safely escalate care. The patient has **moderate depression**, diagnosed 2 months ago, and was started on **CBT only**. As he's still symptomatic and unable to work, NICE recommends **adding antidepressant medication**.

CBT alone may not be sufficient for moderate depression — combined therapy is more effective. Always re-assess symptoms, functional impact, suicide risk, and therapy compliance in psychiatric follow-ups. Medication choice should include full patient education and shared decision-making.

Case 9: Postnatal Depression

Scenario: GP clinic. A 32–33-year-old woman, 4 months postpartum, presents with difficulty sleeping and low mood for the past 5 weeks. Mood score is 3–4/10. No psychotic features at baseline. Must screen for postnatal depression and assess risk to self and baby.

Introduction & Consent

"Hello, I'm one of the doctors here at the practice. Thank you for coming in today. Can I confirm your full name and age, please?"

"Before we begin, would it be okay if I ask you a few questions to better understand what's been going on and how we can help?"

Focused History & Context
"I understand you've come in because you're struggling with sleep. Could you tell me when this started?"
"How have things been generally since your baby was born?"
"Can you take me through what a typical day looks like for you?"
If the patient says: "I don't have a day — everything is about my baby. I can't sleep, I can't eat, I can't even shower."
→ Respond:
"I'm really sorry to hear that. It sounds like this has been incredibly hard for you. Having a new baby is a huge change, and it's okay to feel overwhelmed."

Explore ICE
"Have you been worried about anything in particular?"
"What's been going through your mind when you're not able to sleep?"
"What are you hoping we can do for you today?"

Perinatal & Birth History
"How old is your baby now?"
"Was this your first child?"
"How was the pregnancy overall?"
"How did the delivery go — any complications?"
"Was your baby born at term and healthy?"

Psychiatric Symptom Screening
"How would you rate your mood these days on a scale of 1 to 10?"
"Do you often feel low or tearful?"
"Have you lost interest in things you used to enjoy?"
"Do you feel constantly tired or drained?"
"Have you been able to sleep when the baby is asleep?"
"Any changes in appetite — eating too much or too little?"
"Do you feel guilty or like you're not doing enough as a mother?"
"Do you find yourself easily irritated or anxious?"

Risk Assessment – Postpartum Psychosis
Gently preface the questions:
"I'm really sorry to ask this — I know these questions are quite personal, but they're important for your care, and I ask them to every new mother who feels this way."
"How is your bonding with the baby — do you feel emotionally connected?"
"Have you ever felt like your baby isn't yours or that you're detached?"
"Have you had any unusual thoughts or fears related to the baby?"
"Have you ever felt like harming your child — even just the thought?"
"Have you had any thoughts of harming yourself?"
If any risk is present, escalate urgently and document clearly.

PMAFTOSA (Tailored for Postnatal Case)
Previous Mental Health: "Have you had any mental health issues before, like depression or anxiety?"

Medications: "Are you currently taking any medications — including for mood or contraception?"
Allergies: "Any medication allergies?"
Family History: "Any family history of mental illness — particularly postnatal depression?"
Travel/Triggers: "Any recent stressors, life changes, or lack of support?"
Occupation: "Were you working before maternity leave? Do you plan to return?"
Social History: "Who's at home with you? Do you feel supported by your partner or family?"
Alcohol/Substance Use: "Do you drink alcohol at all? If yes, how often and how much?"

Diagnosis Disclosure
"From everything we've talked about — your low mood, sleep difficulties, and how it's been affecting your daily life — it sounds like you're experiencing **postnatal depression**."

Lay Explanation:
"This is a condition that affects some women in the first year after childbirth. It's more than just the 'baby blues' — it causes persistent feelings of sadness, tiredness, guilt, and emotional disconnection. Many mothers go through this, and it's absolutely not your fault. The good news is: with support and treatment, things do get better."

Management Plan
a. Urgent Referral to Perinatal Mental Health Team
"We'll refer you to a specialist team that looks after mental health in new mothers. They'll assess you further and help decide the best treatment."

b. Antidepressant Treatment (after psychiatry advice)
"We may start a medication called **Sertraline**, which is commonly used in postnatal depression and generally considered safe if you're breastfeeding."
"You'd usually take it once a day, ideally after a feed, and then wait a few hours before the next feed to reduce exposure to the baby."
"We'll confirm the plan with the specialist team before starting."

c. Talking Therapy
"We'll also refer you for **CBT** — a talking therapy that helps manage negative thoughts. It's been proven to work well for postnatal depression."

d. Lifestyle Support
"Try to take even 15 minutes a day for yourself — a shower, a short walk, or just rest. If others can help with the baby, don't hesitate to ask."

e. Crisis Support
"Here's a **crisis card** with 24/7 numbers you can call if you feel overwhelmed or unsafe."

Safety Netting
"If you feel your mood is getting worse, or if you ever have thoughts of harming yourself or your baby, please come back straight away or go to A&E. Help is always available."

Follow-Up Plan
"I'd like to see you again in **one week** to check in and update you after the specialist referral."

Leaflet

"I'll also give you an information leaflet about postnatal depression, including what to expect and how to manage things day to day."

Work-Related Stress

Scenario ID:

You are the GP. A 30–40-year-old patient (male or female) has booked a consultation stating they want **antidepressants** or **sleeping pills** due to poor sleep and feeling overwhelmed. They attribute this to **work stress**, a recent **promotion**, or demanding hours. Your task is to assess their symptoms, determine if they meet criteria for depression, and provide appropriate guidance and management.

Introduction & Consent

"Hello, I'm one of the doctors here today. Thank you for coming in. Could I confirm your full name and age, please?"

"I understand you've come in today because you're feeling quite stressed and are asking about antidepressants or something to help you sleep. Would it be alright if I ask you some questions to understand what's been going on and how we can best support you?"

Presenting Context

"Can I ask what made you decide to come in today?"
"Why do you feel you need antidepressants or sleeping tablets?"
"When did this start? Was there anything specific that triggered it — like a change at work or in your life?"

Functional Timeline (Before and After Trigger)

"Before this job or promotion, how was your lifestyle?"
"Were you sleeping well back then?"
"How was your appetite and energy levels before this started?"
"Did you have time for yourself, hobbies, or family?"

Explore ICE

"What are you most worried about right now?"
"Have you been feeling that you might be developing a more serious condition like depression?"
"What are you hoping I can do for you today?"

The patient may say: "I just want something to take the edge off" or "I know I'm depressed."

Depression Screening (Major and Minor Symptoms)

"Have you been feeling low or down most of the time?"
"Have you lost interest or enjoyment in the things you usually like doing?"
"How's your sleep, appetite, and energy?"
"Are you able to concentrate?"
"Have you felt tearful, guilty, or overwhelmed?"
"Have you had any thoughts of harming yourself?"

In most such cases, the patient does **not** meet the full criteria for depression — they may report one or two mild symptoms (e.g., poor sleep, feeling tired), but **not persistent low mood or anhedonia**.

PMAFTOSA (Adapted for Stress)

Previous Mental Health: "Have you ever been diagnosed with depression or anxiety before?"

Medications: "Are you on any medications currently?"
Allergies: "Any allergies to medication?"
Family History: "Any family history of mental health problems?"
Triggers: "Any other recent changes — family, finances, relationships?"
Occupation: "What do you do for work? How have things been at work recently?"
Social Support: "Do you have people around to talk to or spend time with?"
Alcohol/Substances: "Any alcohol or substance use to cope?"

Diagnosis
"Based on everything you've shared, it doesn't look like clinical depression. You're not showing the typical pattern we'd expect, like feeling low most of the day nearly every day, or losing interest in life."
"What you're describing sounds more like **occupational stress** or **early burnout**. It's very real and can affect sleep, energy, and mood — but it's different from medical depression. That's actually a good thing, because it means we can take steps to manage it early."

Explanation
"Depression is a medical condition where people feel persistently low, lose interest in everything, and often can't function in daily life. From our discussion, your symptoms seem more related to high stress and overwork, rather than depression. If left untreated, this can lead to depression, so it's important we act now — just in a different way."

Medication Request Discussion
Antidepressants:
"At this stage, I wouldn't recommend starting antidepressants. They're designed for longer-term use and come with side effects. Since this isn't clinical depression, the risks would outweigh the benefits."

Sleeping Pills:
"Sleeping tablets are also not ideal. They're highly addictive and tend to lose effectiveness very quickly. Instead, I'd like to help you address the cause of the poor sleep."

Management Plan
Lifestyle & Self-Care Advice
"What's needed is a bit of reset — your body and mind are under pressure."
"Try to take short breaks during the day, prioritise rest, and set boundaries around work."
"Exercise regularly, limit caffeine after midday, and try relaxation techniques like mindfulness or breathing apps."
"Even a short time off work or a structured evening routine can help reset your sleep."

Workplace Support
"You might want to speak to your manager or HR about temporary adjustments. Many workplaces have mental health support schemes or employee assistance programs."

Therapy if Needed
"If things don't improve in the next few weeks, we can refer you for **CBT-based talking therapy** to help you manage stress and coping patterns."

Safety Netting
"At the moment, this doesn't meet the criteria for depression — but if your symptoms continue or get worse, please come back. We'll reassess and can explore other options."

Follow-Up Plan
"I'd like to see you again in **one month** to check how you're doing. If needed, we can escalate to therapy or review again."

Explanation for Students
This is a **diagnostic judgment station**. The patient appears to have **subthreshold symptoms** triggered by work-related stress, but **does not meet the NICE criteria for depression** (no persistent low mood or anhedonia, and no functional collapse). The challenge is **assertive yet empathetic communication** — acknowledging their distress while confidently explaining that medication is not appropriate.
The candidate is expected to:

- Rule out major depressive disorder carefully
- Provide reassurance and education
- Refuse medications appropriately with clinical reasoning
- Offer lifestyle, occupational, and therapeutic alternatives
- Safety net effectively and schedule follow-up

Self-Harm

Case 1: Wrist Cutting + OCP Overdose

Scenario ID:
You are a doctor in the psychiatry department. A 16-year-old girl was referred from A&E after cutting her wrist and ingesting oral contraceptive pills (OCPs). She was medically stabilised and has been sent for a **mental health assessment**. Your task is to assess risk, understand the context, and plan further care.

Introduction & Consent
"Hello, I'm one of the doctors from the psychiatry team. I understand you were brought in last night after taking some tablets and cutting your wrist. I'm really sorry you've been going through a hard time."
"Would it be alright if I ask you some questions so I can better understand what happened and how we can support you moving forward?"

Context of Tablet Ingestion

- "Can you tell me what kind of tablets you took?"
  - (Expected: Contraceptive pills)
- "How many tablets did you take?"
- "When exactly did you take them?"
- "What made you decide to take them?"
  - (Expected: I thought I might be pregnant)
- "Did you take anything else at the same time?"
- "Were you drinking or using drugs at the time?"
- "Did you vomit or feel unwell afterwards?"
- "Where did you get the pills from?"
  - (Expected: From my mother)
- "Does your mum know what happened yet?"

Wrist Cutting Assessment

a. Pre-Attempt

"Have you ever thought about harming yourself before?"
"Was this something you planned or was it more impulsive?"
"Did you prepare for it — like writing a note, deleting messages, switching off your phone, or leaving social media groups?"
"Did you tell anyone what you were going to do?"

b. During the Attempt

"Where were you when this happened?"
"Was anyone else home?"
"Did you lock your door or try to make sure no one would interrupt you?"
"What did you use to cut your wrist?"
"What were you thinking before and during the cutting?"
"When you saw the blood, what did you feel?"

c. Post-Attempt

"How did you stop the bleeding?"
"Did you lose consciousness?"
"Did someone bring you in, or did you come on your own?"
"What happened when you got to A&E — did they give you any treatment or talk to you?"

Current Feelings and Outlook

"How do you feel about everything that happened?"
"Looking back, do you regret it?"
"If something similar happened again, do you think you'd do the same thing?"
"Why not? What would you do differently?"

Mental Health & Risk History

"Have you ever harmed yourself before — cutting, overdosing, or otherwise?"
"Do you drink alcohol or use any recreational drugs?"
"Have you ever been diagnosed with a mental health condition — like depression, anxiety, or an eating disorder?"
"Do you often feel low or find it hard to cope?"

Relationship & Social History

"Can I ask — do you have a partner or boyfriend?"
"Was this situation related to the relationship in any way?"
"Is your partner supportive?"
"Has he ever been aggressive or pressured you sexually or emotionally?"
"Who do you live with at home?"
"Do you feel supported by your family?"
"Are you still in school or college?"

Family History

"Has anyone in your family ever had depression or other mental health concerns?"
"Has anyone close to you ever attempted suicide or self-harm?"

Pregnancy Risk Assessment

"When was your last period?"
"Have you done a pregnancy test recently?"
"Did the hospital do one when you were in A&E?"
"Have you had unprotected sex since your last period?"

Physical & Allergy History

"Do you have any diagnosed medical conditions?"
"Are you on any medication regularly?"
"Any allergies to medicines?"

Provisional Summary & Explanation

"From everything you've shared, it sounds like you were feeling very overwhelmed last night and took the pills because you were scared you might be pregnant. The wrist cutting, on the other hand, sounds like a way of expressing your distress and trying to cope with painful emotions."
"I want to reassure you — these feelings are not uncommon, especially in people your age who are going through emotional pressure. What matters now is that you're here, and we're going to help you find healthier ways to cope."

Management Plan

a. Medical Clarification

"Just so you're aware — contraceptive pills are not effective at ending a pregnancy. If someone is already pregnant, taking OCPs won't change that."
"We'll arrange a **pregnancy test**, just to be sure."
"In the future, it might help to speak with your GP about **long-term contraception** that's safe and effective."

b. Risk Classification

Based on history (impulsive act, no clear intent to die, sought help, regrets actions), **this appears to be a low-risk attempt** — but this will be confirmed after senior review.
"From what you've told me, it seems unlikely that you would do something like this again."
"But before we decide anything today, I'll speak with my seniors to make sure we're all in agreement."

c. Follow-Up Plan

"If we're happy with the assessment, you'll be discharged today but referred to **community mental health services** for follow-up."
"You'll be given a **crisis card** with a number you can call if you ever feel overwhelmed or unsafe again."

Safety Netting

"If you ever feel like you're struggling again — you don't have to deal with it on your own. You can call the number on the card, go to A&E, or speak to someone you trust. We'll also follow up with you soon to make sure you're doing okay."

Student Explanation – OCP Overdose + Wrist Cutting (16-Year-Old Girl)

This is a **suicidal risk assessment** station involving two actions:

OCP ingestion: Taken impulsively due to **fear of pregnancy**, **not intended as suicide**
Wrist cutting: Act of **self-harm**, emotionally driven, not strongly suicidal

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Why This Is Low Risk

No detailed planning (no note, no deleting accounts, no isolation)

Method was **non-lethal** (minor cutting)
Came to hospital or accepted help willingly
Expresses regret and says she would not repeat it
Able to engage in conversation and reflect on actions

How to Approach

Acknowledge distress clearly: "I understand you took tablets and harmed yourself — I'm sorry you felt that way."
Assess risk **before, during, after** the attempt
Clarify the **OCP use was not a suicide attempt**
Don't say "You're low-risk" — instead say:
"From what you've told me, it seems unlikely you would repeat this."

Case 2: Paracetamol Overdose

Summary

Teenage girl presents to A&E after taking 7–8 paracetamol tablets impulsively following a fight with her boyfriend. No suicidal intent expressed. Paracetamol level is below treatment threshold. Similar incidents have occurred in the past for the same reason.

History Focus

"How many tablets did you take?" (7 or 8)
"Why did you take them?"
"Was this something you've done before?" (Yes, twice before)
"What were you thinking when you took them?"
"Do you know what a normal dose of paracetamol is?"
"Do you think you would do something like this again?"
→ Patient answers: "I'm not sure."

Why It's Low Risk (but not safe to say directly)

Impulsive act after emotional trigger
Took a **non-lethal** dose
No intent to die, more of a **cry for help**
However, due to past attempts and uncertainty about the future, **firm advice and psychiatry referral are essential**

Management Plan

Refer to **psychiatry team today** for mental health assessment
Discharge **after psychiatry review**, if safe
Arrange **community counselling** for emotional support
Do **not** tell patient it's "unlikely to happen again"

Advice to Patient

Educate: "Doctors may prescribe 8 tablets across a day, but taking 8 at once can damage your liver."
Warn: "You've been okay in the past, but there's no guarantee you'll be okay next time."
Strongly advise: "Please don't do this again — even small overdoses can be dangerous."
Address trigger: "This seems to be linked to relationship distress. Consider speaking to your GP for support or counselling about this."

Case 3: Paracetamol Overdose (20 Tablets, Recent Ingestion)

Summary
20-year-old man presents to A&E 2 hours after taking 20 paracetamol tablets impulsively following an argument with his mother after disclosing his sexual orientation. He contacted his boyfriend after the overdose and came to hospital. He expresses regret and does not intend to repeat the act.

History Focus

"How many tablets did you take, and when exactly?" (20 tablets, 2 hours ago)
"What led to this?" (Came out to mother, argument followed)
"Have you ever done something like this before?" (No previous attempts)
"Did you plan this or act on impulse?" (Impulsive)
"What made you come to hospital?" (Called boyfriend, advised to seek help)
"Do you think you would ever do something like this again?" (Says no)

Why It's Low Risk

Act was **impulsive**, not planned
Called for help (partner) immediately
No history of self-harm or suicide attempts
Expresses regret and clear desire not to repeat

Medical Management Plan

Wait 4 hours post-ingestion before blood test
→ "We need to wait a bit longer to check how your body is processing the tablets."
Check paracetamol level
→ "Once it's been 4 hours, we'll do a blood test to check if treatment is needed."

If levels are high

Start **N-acetylcysteine (NAC)** treatment (IV, over 24 hours)
Psychiatric referral after treatment

If levels are low

No NAC needed, but **still refer to psychiatry** before discharge

Patient Advice

"Even though the dose may not cause serious harm this time, any overdose carries a risk to the liver."
"Doctors prescribe a maximum of 8 tablets per day, but they must be spread out — not taken all at once."
"Just because you feel okay now doesn't mean the outcome will always be the same."

Psychiatric Plan

Refer to **psychiatry** regardless of paracetamol level
Emphasise that support is available: "This was a tough moment, but we'll make sure you're not dealing with it alone."

Drug Addiction

Role: FY2 in Psychiatry OPD
Setting: 28-Year-Old Man Wants to Quit Drugs
Task: Talk to the patient, assess his situation, and formulate a suitable management plan.

Introduction
"Hello, I'm one of the doctors here in the clinic today. Could I confirm your full name and age, please? Thank you. I understand you've come in today because you'd like help to stop taking drugs—is that right?"
"Thanks for making this appointment–it's a really positive step, and we'll do our best to support you. Would it be okay if I ask a few questions so I can understand things better and guide you appropriately?"

Presenting Concern
"Can I ask what made you decide to seek help now?"
"Is there a particular reason you feel ready to stop at this point?"
(Listen for internal motivation, family pressure, health concerns, or recent events.)

Substance Use History (Structured like a drug chart)
Drug Type:
"What sort of drugs do you take?"
"Can you name all the substances you use or have used recently?"

Route:
"How do you take it—do you swallow, smoke, sniff, or inject?"
"If inject: Do you share needles with anyone?"
"Are you familiar with needle exchange services?"
Duration and Frequency:
"How long have you been using?"
"How often do you use? Every day? More than once a day?"

Dose:
"Roughly how much do you take at a time?"
Dependence Assessment
Quit: "Have you ever tried to stop before? What happened?"
Hurt/Guilt: "Do you ever feel upset or guilty about using drugs?"
Tolerance: "Do you feel the need to take more now to get the same effect?"
Withdrawal: "If you don't use it for a day or two, do you get any symptoms?"
"What kind of symptoms?"
"How do you usually cope with them?"

Triggers & Continuation
"What was the reason you started using drugs originally?"
"What's keeping you using them now—pain, stress, habit, emotions?"

Mood & Self-Harm
"How has your mood been recently?"
"Have you ever felt so low that you've harmed yourself or considered it?"
"Have you harmed yourself when withdrawing or under the influence?"

PMAFTOSA

Past Medical History: Any long-term conditions?
Medication: Are you on any regular meds?
Allergies: Any known drug allergies?
Family History: Any history of drug use in the family?
Lifestyle:
"Where are you currently staying?"
"Any partner or children?"
"How do you manage financially?"
"Any issues with the police or legal system recently?"

ICE

Ideas: "What's your understanding of your current situation?"
Concerns: "Is there anything specific you're worried about?"
Expectations: "What are you hoping I can do for you today?"

Examination (If relevant/available)

Observe for: tremors, agitation, sweating, or withdrawal signs
Comment empathetically if visible:
"I can see you seem a bit shaky–has it been a while since you last used?"

Provisional Diagnosis

Likely diagnosis: Opiate dependence (or multi-substance misuse, if applicable)

Explanation:

"Based on what you've told me, it sounds like your body has become dependent on the drugs, and your brain has adapted to needing them regularly. But the good news is that with the right help and support, people can and do recover fully."

Management Plan

Medical:

Baseline Checks:
Physical exam: heart rate, BP, weight, injection site inspection
Blood tests: FBC, LFTs, U&Es, Hepatitis B/C, HIV
Urine drug screen
ECG (if indicated)
"These help us get a complete picture of your health and plan safely."

Medication:
Offer **Methadone substitution** (oral liquid)
"It helps reduce withdrawal symptoms and cravings. We typically continue for 1–2 years, and we'll monitor your progress carefully."

Psychosocial:

Counselling for substance misuse (1:1 and group therapy)
Support groups
"You'll meet others who've been in the same situation–some who've already recovered. It really helps to stay motivated."

Key worker/social support:

"A social worker will regularly check in on your progress and help with benefits, housing, or other support you might need."

Leaflet and Resources: Provide take-home info about substance misuse support

Safety Net & Follow-Up

"You can contact us or emergency services if you feel overwhelmed, unwell, or unsafe at any point."

Schedule follow-up in **1–2 weeks**

Offer **Crisis Card** with emergency contact and helpline

Alcohol Misuse

Case 1: Incidental Finding During OBG Consultation

Setting: Gynaecology clinic (post-hysteroscopy)
Role: FY2 doctor
Patient: Middle-aged woman, came for hysteroscopy – results are normal
Task: Deliver results, explore suspected alcohol misuse, assess dependency, and guide management

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Introduction & Rapport

"Hello, I'm one of the doctors in the team. I understand you came in recently for a hysteroscopy. Before we begin, may I confirm your name and age?"

"Thanks. I've had a look at your scan results, and the good news is that everything looks normal–there's nothing worrying on the report. Did anyone go through the results with you yet?"

"How do you feel about that?"

Transition to General Health

"Before you go, is it okay if I ask you a few general questions about your health?"

"We try to take a more holistic approach to health, and there are just a couple of things I'd like to touch on."

General Health Screening

"How has your general health been lately?"

"How's your appetite? Do you try to eat healthily?"

"Do you do any regular physical activity or walking?"

"Do you smoke or drink alcohol?"

Alcohol Use History

Opening sensitively if defensive:

"I understand this might feel a little personal, but would it be okay if we talked briefly about alcohol?"

Detailed Assessment:

"Do you drink any alcohol?"

"What type of alcohol do you usually have—wine, beer, or spirits?"

"How much would you say you drink on a typical day or week?"

(Convert into units: e.g. 1 glass wine = 3 units, 1 bottle wine = 9, 1 pint beer = 2.5, 1 shot = 1 unit)

"How long have you been drinking this amount?"

"Do you drink daily or have any alcohol-free days?"

"Do you tend to drink more on weekends or social events?"

CAGE + Extended Dependency Questions

C: "Have you ever tried to cut down?"

"How did you go about it? Did you get help or try on your own?"

A: "Do you get annoyed if others mention your drinking?"

G: "Do you sometimes feel bad or guilty about drinking?"

E: "Do you ever feel the need to drink alcohol in the morning?"

Tolerance & Withdrawal:

"Do you feel that you need more alcohol now to get the same effect?"

"If you don't drink for a day or two, do you get any symptoms?"

"What kind of symptoms?"

"How do you usually manage those symptoms?"

Psychosocial History (Modified FAMISH)

"May I ask about your living situation—who do you live with?"

"Do you work? Does your work involve alcohol, like entertaining clients?"

"Do you have a partner or children?"

"How do you usually fund your alcohol?"

"Have you ever had any legal issues because of drinking?"

"Any other health issues or medications you're on?"

"Any allergies?"

"Has anyone in your family had a history of alcohol use?"

Mood & Self-Harm

"How have you been feeling emotionally?"

"Do you feel low or depressed often?"

"Have you ever tried to hurt yourself when feeling down or while under the influence of alcohol?"

Insight & Motivation

"Do you feel that alcohol might be affecting your health or life at this point?"

"Would you be open to getting some support to reduce or stop drinking?"

Provisional Diagnosis

Likely diagnosis: Alcohol misuse with possible dependency

Explanation:

"From what you've shared, it sounds like alcohol has become a regular part of your life, and you may be drinking more than is considered safe. The recommended maximum is 14 units per week, but it sounds like you're drinking quite a bit more than that. I'd like to help you manage this before it starts affecting your health more seriously."

Management Plan

Medical Support:

"We may consider doing some blood tests and a physical check to make sure your liver, kidneys, and other organs are coping well."

Bloods: LFTs, FBC, U&Es, glucose

Consider GGT and CDT if chronic use suspected

If withdrawal symptoms present or patient motivated:

Prescribe **Chlordiazepoxide** for alcohol detox (short term)

Prescribe **Acamprosate** to reduce craving (long term support)

Psychosocial Support:

1:1 counselling and **group counselling sessions**
Alcoholics Anonymous (AA) – peer-led recovery groups
Drinkline – confidential national alcohol support line
Referral to **local alcohol liaison or addiction support service**
Offer a **key worker** or social worker if needed for ongoing support

Safety Netting

"If you ever feel unwell, have cravings, or feel low, please don't hesitate to call us or reach out to the support lines. You're not alone in this–help is available."

Follow-Up & Leaflet

"Would it be okay if we review this together in 1–2 weeks, just to see how you're getting on and arrange the right support?"
Provide alcohol advice **leaflet**
Confirm patient agrees with plan

Case 2: Alcohol Withdrawal – Self-Referred Patient

Summary:

A 50-year-old patient presents to the GP after **stopping alcohol yesterday**. They report **withdrawal symptoms** and express fear of developing **seizures**, as they had fits during a previous attempt. The patient has **requested diazepam** for home use.

Assessment:

Perform full **alcohol use history**, including:
Type, amount, frequency, duration
Calculate weekly units
Use **CAGE** and **withdrawal-specific questions** (shakes, nausea, hallucinations, seizures)
Explore **risk of self-harm**, **mood**, and **FAMISH history**

Red Flags:

History of **seizures during previous withdrawal**
Currently experiencing **withdrawal symptoms**
High risk of complications if managed at home

Immediate Safety Concern – Hospital Admission Needed

How to Say It:

"Because you've had fits before and you're already showing signs of withdrawal, it's too risky to manage this at home."
"This situation requires medical supervision–you need to be admitted to hospital today, ideally by ambulance."
*"In hospital, they'll start medications like **chlordiazepoxide or diazepam** to manage your symptoms safely and prevent seizures."*

If Patient Refuses Admission:

Emphasize medical risk and safety:
"We understand you're worried, but home detox in your case could be life-threatening. Hospital care is the safest option and gives you the best chance to recover safely."

Management Summary:

Urgent hospital referral via ambulance
Admit under psychiatry or alcohol liaison team
Supervised detox + rehabilitation plan
Plan for **post-discharge follow-up** in GP with:
Alcohol counselling
Craving-reduction meds (e.g., Acamprosate or Disulfiram)
Social services / addiction support referral

Insomnia

Case 1: Insomnia - Bereavement + RA

Setting: GP Clinic
Role: FY2
Patient: 60-year-old woman with Rheumatoid Arthritis (on Methotrexate)
Context: Difficulty sleeping since her husband passed away 6 months ago

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Introduction
"Hello, I'm one of the doctors here at the practice. Could I confirm your full name and age please? Lovely, thank you. What brings you in today?"
(Let her say it's about sleep. Mirror her concern.)
"You've been struggling with sleep lately—I'm really sorry to hear that. I'd like to ask you a few questions to understand what might be contributing, if that's okay?"

Presenting Complaint – Sleep Pattern
"Could you tell me more about how your sleep has been affected?"
"Is it falling asleep that's hard, or do you wake up frequently during the night—or wake too early?"
"Roughly how many hours of sleep are you getting now?"
"Do you feel tired or refreshed when you wake up?"
"Has this been going on since your husband passed?"

Explore Likely Contributors
"Would it be okay if I asked how you've been coping emotionally?"
"Has your arthritis pain been worse lately, especially at night?"
"Do you think your sleep got worse because of the grief, or has it always been difficult?"
"Do you often lie awake with thoughts on your mind?"

Sleep Hygiene Check
"What time do you usually go to bed and get up?"
"Do you watch TV or scroll on your phone just before bed?"
"Do you drink tea, coffee, or cola in the evenings?"
"Do you go out for walks or get some physical activity during the day?"
"Is your bedroom quiet and comfortable at night?"

Mood & Risk Screening
Can I ask you a few questions just to better understand your emotional wellbeing? We often do this when sleep is affected."
"Have you been feeling low or down nearly every day?"

"Do you find you've lost interest in things you used to enjoy?"
"How has your energy level been?"
"Any change in your appetite—eating more or less?"
"What about your concentration—do you find it hard to focus?"
"Do you feel bad about yourself, guilty, or like a burden?"
"Have you had any thoughts that life isn't worth living, or of harming yourself?"

PMAFTOSA

Past Medical History: Rheumatoid arthritis
Medication: Methotrexate
Allergies: None known?
Family History: Any psychiatric illness in family?
Tobacco/Alcohol/Caffeine: How much caffeine per day?
Occupation: Retired? Recently stopped?
Social Support: Lives alone now? Any children nearby?

ICE

"Do you have any idea what's causing this?"
"Is there anything about this that's particularly worrying you?"
"What were you hoping I could help you with today?"

Provisional Diagnosis

Likely: Secondary insomnia due to grief, possible subclinical low mood, and possibly pain from RA.

Explanation:

"It sounds like your sleep difficulties started after your husband passed, and may also be worsened by the arthritis and daily routines. This is what we call insomnia—difficulty falling or staying asleep—and it's very common in situations like yours. The good news is that it can get better with the right support."

Management Plan

Avoid Sleeping Pills

"I wouldn't recommend sleep tablets right now—and I'll explain why. They often stop working after a while, can become addictive, and in older adults, they can increase your risk of confusion, falls, or daytime sleepiness."

What We Will Do Instead:

1. Lifestyle + Sleep Hygiene Advice

Keep a consistent bedtime and wake-up time
Avoid screens, tea/coffee 2–3 hours before bed
Gentle daytime activity like walking
Reserve bed only for sleep—not TV or worrying
Try relaxation techniques like a warm bath, quiet music, or light reading

2. Emotional Support

"Would you be open to speaking to someone about your loss? We can refer you to a bereavement support service or talking therapy."

If low mood seems significant, consider **low-intensity CBT referral**

3. Address Pain Management (RA)

Review pain control with rheumatology or GP if night pain is disturbing sleep

4. Provide Leaflet
Sleep hygiene + bereavement support contacts

Safety Net
"If your sleep continues to affect your health or if you begin to feel increasingly low, please do come back. We can explore other forms of support if needed."

Follow-Up
GP review in 2–3 weeks to assess sleep pattern and mental wellbeing
May consider bloods (FBC, TSH) if symptoms persist or worsen

Closure
"Thank you for sharing all of this with me—it's not easy, especially when grief is involved. The steps we discussed can really help, and I'll be here to support you as we go along."

Case 2: 28-Year-Old Man Requesting Sleeping Pills

Context: Young man asks for pills. History shows:
Staying up till 4 a.m. playing video games
Regular **cannabis use**
High caffeine intake
Took sleeping tablets **from mother**

Diagnosis: Insomnia due to poor sleep habits and substance use

Key Points:
Acknowledge concern, but **do not prescribe sleep tablets**
"Using sleeping pills, especially without a prescription, can be risky and isn't the right solution here."
No need for CBT at this stage
Strongly recommend **lifestyle restructuring**:
Stop cannabis
Reduce caffeine (especially after 2 p.m.)
Stop screens 1 hour before bed
Fixed sleep schedule
Give **leaflet on sleep hygiene**
Offer follow-up if symptoms persist after lifestyle changes

Anorexia Nervosa

Setting: GP or Psychiatry OPD
Patient: Teenager or young adult (female usually)
Context: "My mum is worried because I've lost weight"
Role: FY2 Doctor
Task: Assess, explain, and manage the likely eating disorder

Introduction
"Hi, I'm one of the doctors here today. Could I confirm your full name and age?"
"I understand you've come in because your mum's a little concerned about your weight—is that right?"
"Thanks for being here. Is it alright if I ask you a few questions to understand things better?"

Presenting Concern – Weight Loss

"Have you noticed weight loss yourself, or is it something others have pointed out?"
"Was it intentional or did it happen without trying?"
"Roughly how much have you lost, and over what time?"
"Has your clothing become looser or have you had to change sizes?"
"Have there been any changes in your periods or energy levels?"

Daily Dietary Habits – Structured Eating History

"I'd like to ask what a typical day of eating looks like—this helps us understand nutritional balance."

"What do you usually eat for breakfast?"
"Lunch?"
"Dinner?"
"Do you snack in between meals?"
"Any foods you avoid or restrict?"
"Do you ever skip meals completely?"
"Do you do any exercise? How often and for how long?"

SCOFF Questionnaire – Screening Tool for Eating Disorders

SCOFF = validated 5-question tool (≥2 positive = likely eating disorder)
Use exact phrasing as it's acceptable in this clinical context.
"I'll ask a few specific questions we use to screen for eating difficulties. Just answer as honestly as you can."

S: "Do you make yourself *S*ick because you feel uncomfortably full?"
C: "Do you worry that you have lost *C*ontrol over how much you eat?"
O: "Have you recently lost more than *O*ne stone (about 6 kg) in a short period of time?"
F: "Do you believe yourself to be *F*at when others say you are too thin?"
F: "Would you say that *F*ood dominates your life—do you think about it a lot of the time?"

If 2 or more answers are "yes," eating disorder is highly likely.

Screen for Other Causes (Differential Rule-Out)

"Any nausea, vomiting, diarrhoea, or thyroid problems?"
"Any other long-term illnesses or medications affecting your appetite?"

Modified FAMISH – Psychosocial Assessment

Family history: "Any family history of eating disorders or mental health problems?"
Alcohol/substances: "Do you smoke, drink alcohol, or use any substances?"
Menstrual status: "Have your periods stopped or changed?"
Income/school/work: "Are you in school or working? Any stress there?"
Social life: "Do your friends talk about body image or weight?"
Home environment: "Who do you live with? How's the atmosphere at home?"

BMI & Physical Status

GP scenario: "I'd like to check your weight and height to calculate your BMI today."
Psychiatry scenario: Ask "Do you know your BMI?" *(Expected: <17)*

Mood & Depression Screening

"It's not uncommon for eating difficulties to be linked with mood. Can I ask a few questions about how you've been feeling emotionally?"

"Do you feel low or down lately?"

"Have you lost interest in things you used to enjoy?"
"How is your energy, focus, and appetite in general?"
"Any trouble sleeping?"

Self-Harm & Risk Assessment

"Have you ever felt so low that you had thoughts of harming yourself?"
"Have you ever acted on those thoughts—like cutting or overdosing?"
"Have you ever been referred to a mental health team before?"

Provisional Diagnosis

Likely diagnosis: Anorexia Nervosa (Restrictive-type Eating Disorder)

"From what you've told me—your weight loss, eating pattern, how you view yourself, and your low BMI—it sounds like you may be experiencing a condition called ***anorexia nervosa****."*

Explanation

"Anorexia is a type of eating disorder, which is actually a mental health condition. People with it often feel the need to control their eating or feel they are overweight, even if they're medically underweight. It's not something you've chosen, and it's not your fault. But with the right support, people do recover and live healthy lives again."

Management Plan – 5 Pillars (Same for Bulimia)

1. Urgent Referral

Eating Disorder Clinic (adult) or CAMHS (if <18)

"This is best handled by a specialist team who deal with eating disorders regularly."

2. Talking Therapy

Referral for CBT (Cognitive Behavioural Therapy for Eating Disorders – CBT-ED)

"This helps understand your thoughts around food and body image and slowly helps reframe them."

3. Medication (Later Step)

Consider **SSRIs** (e.g., Fluoxetine) only **if therapy is insufficient or coexisting depression is present**

"We don't usually start with medication, but it may help if your mood remains low."

4. Nutritional Support

Referral to dietitian or specialist nutritionist
Provide written advice: Healthy eating, body composition, and refeeding guidance
Consider gentle reintroduction to supervised physical activity **only when medically appropriate**

5. Peer/Group Support

Offer local support groups or charities (e.g., Beat UK)

"Many people find it helpful to hear from others who've been through something similar."

Safety Netting & Follow-Up

"If things get worse, if your weight drops more, or if you feel unsafe, please come back urgently."
Offer crisis helpline and emotional support line
GP follow-up in 1–2 weeks, or transfer to mental health team if already under psychiatry

Bulimia Nervosa

Setting: Telephone consultation (GP or mental health triage)
Role: FY2
Patient: 15-year-old girl
Context: "My mom saw me vomiting"
Task: Assess for possible eating disorder, explain, and manage appropriately

Introduction
"Hello, I'm one of the doctors working in the clinic today. Can I confirm your first name and how old you are?"
"Thanks for calling in. I understand your mum saw you being sick—is that right?"
"I really appreciate you talking to me. Would it be okay if I ask you a few questions just to understand what's going on?"

Presenting Complaint – Vomiting
"Can I check—did you vomit recently?"
"How long has this been happening?"
"Did the vomiting happen by itself, or did you make yourself vomit?"
"Can I ask—why do you make yourself vomit?"
"Are you trying to lose weight?"
"What made you want to lose weight in the first place?"

SCOFF Screening – Same Format as Anorexia
"I'd like to ask you five questions we use to screen for eating difficulties. Just answer honestly—there's no judgment at all."
SCOFF = Sick, Control, One stone, Fat, Food
(≥2 positive = likely eating disorder)
"Do you make yourself *sick* because you feel uncomfortably full?"
"Do you worry that you've lost *control* over how much you eat?"
"Have you recently lost more than *one stone* (about 6 kg) in a short time?"
"Do you believe yourself to be *fat* when others say you're too thin?"
"Would you say *food dominates* your thoughts or daily life?"

Weight Loss Methods & Eating Behaviours
"Aside from vomiting, is there anything else you do to try to lose weight?"
(e.g., skipping meals, overexercising, taking laxatives or diet pills)
"Do you ever feel like you lose control while eating?"
"Do you eat a large amount of food quickly—what we call a binge?"
"How often would you say that happens?"

BMI Discussion
"One of the things we look at when understanding eating patterns is something called BMI, which stands for body mass index. Do you know what yours is?"
(Expected reply: "It's 24")
"Okay, thank you. Just so you know, that's actually within the healthy range."
Note: In bulimia, BMI is often normal.

Modified FAMISH – Brief Version for Phone Use
"Is anyone in your family worried about you or your weight?"
"Do your friends ever talk about dieting or being thin?"
"Are you still in school? Any stress there?"
"How is home life—do you feel supported?"
"Has your period changed at all?"
"Do you drink, smoke, or take any drugs?" *(if appropriate for age)*

Mood & Risk Assessment

"Sometimes people with eating difficulties also feel low or anxious—can I ask a few things about how you've been feeling emotionally?"

"Do you feel sad or low most days?"
"Do you still enjoy things like you used to?"
"Have you ever had thoughts about harming yourself or not wanting to be here?"
"Have you ever acted on those thoughts?"

Provisional Diagnosis

Likely diagnosis: Bulimia Nervosa
"From what you've described—binging on food, making yourself vomit, and the worries about weight—it sounds like you could be experiencing a condition called **bulimia nervosa**."

Explanation

"Bulimia is an eating disorder, which is a type of mental health condition. It's where someone eats a large amount of food quickly—called a binge—and then tries to get rid of the calories through vomiting or other ways. This is called purging. Even though the person's weight might look normal, there's a lot of stress and guilt involved, and it can be dangerous for your health if it continues."

Management Plan – Same 5-Part Framework as Anorexia

1. Urgent Referral

Referral to **CAMHS Eating Disorder Team** (since age <18)
"We'll refer you to a specialist service that works with young people like yourself who are struggling with food and body image."

2. CBT / Talking Therapy

CBT-ED (Cognitive Behavioural Therapy for Eating Disorders)
"This is a structured talking therapy that helps people understand and change the thoughts and behaviours around food."

3. Medication (If Required)

SSRIs (e.g., Fluoxetine) considered if coexisting depression, anxiety, or severe bulimia
"If needed, medication can be considered later—but therapy is the main approach."

4. Nutritional Support

Involve **paediatric dietitian or CAMHS nutritionist**
"You'll also get help from a nutrition specialist who can work with you to build a healthy relationship with food."

5. Support Network

Encourage family involvement
Provide links to **Beat Eating Disorders UK** or local adolescent support groups

Safety Netting

"This isn't something to feel ashamed of—and you're not alone in this. But bulimia can lead to serious health problems if not treated. If you ever feel worse, or if you feel unsafe at any time, please call us or reach out to a trusted adult or a crisis line right away."

Follow-Up Plan

Urgent referral to CAMHS (eating disorder pathway)

Offer **routine GP follow-up in 1–2 weeks** if needed while awaiting referral
Send self-help leaflet or secure online resource (Beat UK / NHS site)

Closure
"Thanks so much for talking to me—it's not easy to open up about things like this, especially over the phone. But it's a really important first step, and I'll make sure you get the support you need."

Health Anxiety

Setting: GP Clinic
Role: FY2 Doctor
Patient: Adult (e.g., 30s–40s)
Presenting Complaint: "I think I have sickle cell anaemia"
Context: Brother diagnosed with sickle cell. Patient has tested negative (both NHS and private clinic). Still convinced he has it.

Introduction
"Hello, I'm one of the doctors here today. Could I confirm your full name and age, please?"
"Thanks. I understand you booked this appointment because you're worried you may have sickle cell disease—is that right?"
"Thanks for bringing this up. Would it be okay if I ask a few questions to understand what's been going on and how it's been affecting you?"

Presenting Complaint – Fear of Illness
"Could you tell me more about why you think you might have sickle cell?"
"What symptoms have you noticed that made you feel something's wrong?"
"Did your concern start when your brother was diagnosed?"
"Have you had similar health concerns in the past about other conditions?"

Investigation History
"Have you had any tests done already?"
"Who arranged those tests—your GP or a private clinic?"
"Do you know what the results were?" *(Confirm negative results)*
"Do you feel the tests might have been incorrect?"
"Have you been tested more than once?"
Key point: repeated negative tests but persistent belief = classic for health anxiety

Psychiatric Symptom Screening
"Just to understand this a bit better, can I ask you some questions about how this worry has affected your daily life?"
"How often do you think about having this illness—daily? hourly?"
"Do you find yourself checking your body or Googling symptoms often?"
"Do you feel reassured after tests, or does the worry come back quickly?"
"Has this fear affected your sleep, mood, work, or relationships?"
"Have you avoided certain activities because of this health worry?"

PMAFTOSA
Past Medical History: Any previous anxiety, depression, or chronic illnesses?

Medications: Any antidepressants, anxiolytics, or supplements?
Allergies: Any known allergies?
Family History: Explore emotional response to brother's diagnosis
Tobacco / Alcohol / Drugs: Any changes in use due to stress?
Occupation: "Are you currently working? Has this been affecting your performance?"
Social History: "Do you live with someone? Do you have people to talk to about your health worries?"

ICE – Ideas, Concerns, Expectations
Ideas: "What do you believe is happening in your body?"
Concerns: "What is it that worries you most?" *(e.g., misdiagnosis, dying suddenly)*
Expectations: "What were you hoping I could do today—order more tests, offer treatment, or something else?"

Physical Examination ***(Optional – if symptoms given)***
If patient reports physical complaints (e.g., fatigue, pain):
Brief clinical check to rule out red flags
Emphasize that clinical signs are normal

Provisional Diagnosis
"From what you've told me—despite clear negative results, repeated testing, and ongoing worry—it sounds like you may be experiencing something called **health anxiety**."

Explanation of Health Anxiety
"Health anxiety is a type of anxiety disorder where a person becomes very preoccupied with the idea that they have—or might develop—a serious medical condition. Even after getting normal test results, the brain remains stuck in fear mode. You may feel constant worry, scan your body for symptoms, or even feel physical sensations like pain or fatigue triggered by stress.
The condition is very real and can affect daily life, but the good news is: with the right support, it can get much better."

Management Plan
What we avoid
"I won't be recommending further testing at this point, because you've already had the appropriate checks. More tests tend to feed the anxiety rather than help it."
What we will do – NICE-aligned care plan:
1. Referral for CBT (Cognitive Behavioural Therapy)
First-line treatment for health anxiety
"CBT helps identify and challenge the patterns of worry that keep your anxiety going. Many people find it very effective."

2. Psychiatry or IAPT referral
If symptoms are severe or longstanding
"We can link you with mental health professionals who specialise in this kind of anxiety."

3. Consider SSRIs (if moderate to severe)
Fluoxetine or *Sertraline* may be started under GP or psychiatry guidance
"In some cases, medication can be used alongside therapy if anxiety is high."

4. Self-help tools

Leaflet on health anxiety

Recommend websites: *NHS Every Mind Matters*, *Mind UK*, or *Anxiety UK*

"There are resources and techniques to start practising right away, even while waiting for therapy."

5. Follow-Up Plan

Book review in **2–3 weeks**

Reassess impact, therapy engagement, and whether pharmacological support is needed

Safety Netting

"If at any point your symptoms change significantly, or you experience something genuinely new and concerning, you're always welcome to come back. But for now, our focus will be on supporting your mind and body together, without unnecessary investigations."

Closure

"Thank you for being open about your concerns. This is more common than you might think, and there is a clear path to recovery. With the right steps, things can improve a lot."

Student Note: Why This is Health Anxiety

Persistent fear of illness despite **clear negative test results**

Disproportionate concern about mild or absent symptoms

Frequent **doctor visits, repeated testing**, and **lack of reassurance**

Avoids or over-checks body

Interferes with **work, sleep, social life**

Triggered by family history (brother with sickle cell)

No red flags or physical illness confirmed

→ Diagnosis = **Health Anxiety (Hypochondriasis)** as per ICD-11 / DSM-5 criteria

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Somatic Symptom Disorder

Setting: GP Clinic
Role: FY2 Doctor
Patient: Adult (e.g. 40s–50s)
Presenting Complaint: "I think I have cancer again"
Context: Previously had a benign lump (adipoma), recently developed a rash behind the neck, convinced it's cancer. Friend recently died of cancer.

Introduction

"Hello, I'm one of the doctors in the practice. Could I confirm your full name and age, please?"
"I understand you've come in today because you're worried this rash behind your neck might be something serious, possibly cancer—is that right?"
"Thanks for sharing that. I'd like to ask a few questions to understand your concerns better. Is that okay?"

Presenting Complaint – Physical Symptom

"When did you first notice the rash?"

"Is it painful, itchy, or changing in size?"

"Have you had anything similar in the past?"

"What made you think this could be cancer?"

"Have you seen a doctor for this before?"
"Do you have any other symptoms you're worried about?"

(Note: Physical symptom is present – a requirement for diagnosis. Examiner may say: "There are scratch marks, no evidence of skin cancer.")

Previous Investigations & Medical History

"I see you previously had a lump that was biopsied. What were you told about that?"
(→ Adipose tissue; benign)
"Did that result reassure you at the time?"
"Have you ever had cancer before?"
"Have you been tested for other conditions recently?"

Key point: despite clear benign results, belief of serious disease persists

Psychiatric Symptom Screening – Somatic Focus

"Do you often worry that something serious is being missed?"
"Do you spend a lot of time researching symptoms or checking your body?"
"Has this concern affected your sleep or daily routine?"
"Do people around you think you worry more than necessary about your health?"
"Do you still feel convinced something's wrong even when doctors tell you it's not?"

Trigger Identification

"You mentioned your friend passed away from cancer—I'm sorry to hear that. Do you think that may have heightened your fear?"
"Has this loss made you more aware of changes in your own body?"

Important for context and timing of symptom preoccupation

PMAFTOSA

Past Medical History: Any history of anxiety, depression, trauma?
Medications: Any ongoing medication or supplements?
Allergies: Any known allergies?
Family History: Any cancers or mental health conditions in family?
Tobacco / Alcohol / Drugs: Any changes in use recently?
Occupation: "Are you currently working—has this worry affected your performance or attendance?"
Social: "Do you live alone or with family? Do they share your concerns?"

ICE

Ideas: "What do you think this rash is?"
Concerns: "What worries you the most about it?"
Expectations: "Were you hoping for more tests today, or a referral?"

Examination

"Would it be okay if I take a look at the rash?"
Examiner says: "You find scratch marks—no evidence of any mass or lesion suggestive of cancer."
Document normal findings, reassure, but acknowledge patient concern

Provisional Diagnosis

"From what you've told me—and based on your examination today—it doesn't appear that this is cancer. However, the way this concern is affecting you sounds like something called **Somatic Symptom Disorder**."

Explanation: Somatic Symptom Disorder
"This is a condition where someone experiences real physical symptoms—like pain, rashes, or fatigue—but the **level of worry and distress** about those symptoms becomes disproportionate to what doctors can find.
It doesn't mean you're imagining things. The physical symptoms are real—but the brain is amplifying them, especially when it's under stress or grief. It's common after a friend or relative has gone through a serious illness."
"The good news is—it's treatable. With the right psychological support, the physical symptoms often improve too."

Management Plan
What we avoid

"I wouldn't recommend more scans or tests right now, because repeated testing usually makes the anxiety worse rather than better. And based on what I've seen, there's no clinical concern for cancer today."

What we will do – NICE-aligned approach:
1. Referral for CBT or Psychological Therapy
"Talking therapy like CBT can help address the thought patterns that cause your body to react this way. Many people with similar worries benefit from it."

2. Psychiatry Referral *(if severe or long-standing)*
"If this has been affecting your life for a long time or causing a lot of distress, a mental health team can help guide your treatment more closely."

3. Medication (if co-existing depression or anxiety)
SSRIs (e.g. Sertraline or Fluoxetine) may be helpful
"Sometimes medication is useful to reduce the anxiety and improve the way your body processes stress."

4. Self-help & Resources
Leaflet on *Mind-Body symptoms / Somatic symptom disorder*
Recommend resources: *Mind UK, NHS Talking Therapies, HealthUnlocked*
Encourage structured routine: sleep, diet, and physical activity
5. Follow-Up & Relationship-Based Care
"We'll schedule a review in 2–3 weeks to check how you're doing and whether you've been linked with therapy. If needed, I'll continue supporting you regularly."

Safety Netting
"If anything changes—new symptoms, or anything that truly feels different—we'll re-assess. But I want to reassure you again that, based on today's findings, there is nothing to suggest cancer."

Closure
"I can see this has been very stressful for you, and I want you to know you're not alone. These types of symptoms are common, and with proper support, you can absolutely feel better again."

Student Note: Why This Is Somatic Symptom Disorder

Feature	*Details*
Physical Symptom Present	Rash with scratch marks – meets basic diagnostic criteria
Persistent worry despite reassurance	Continues to worry despite normal biopsy and current benign findings
Disproportionate fear	Fear of cancer triggered by friend's death, despite lack of clinical signs
Functional impact	Likely interference with emotional wellbeing, sleep, or daily focus

Red flag ruled out	No constitutional symptoms, normal exam findings

This is not malingering (faking) or delusion – the patient believes the physical symptom is serious, and the distress is real.
→ **Diagnosis**: **Somatic Symptom Disorder**, not health anxiety (because a genuine symptom exists and is the focus)

Health Anxiety vs Somatic Symptom Disorder

Feature	*Health Anxiety*	*Somatic Symptom Disorder*
Physical Symptoms Present?	No significant physical symptom	Yes – at least one real physical symptom (e.g., rash, pain, fatigue)
Main Concern	Fear of having or developing a serious illness	Excessive worry **about existing symptoms** being serious
Test Results	Normal – patient doubts or rejects the results	Normal – but patient focuses on real symptom, not test findings
Typical History	Multiple clinic visits, repeated testing, constant self-checking	Long-term concern about one or more physical symptoms
Patient Belief	"Something is wrong with me – I haven't been diagnosed yet"	"This symptom must be cancer or something serious"
Reassurance	Temporary relief or none at all after tests	Relief often short-lived, but concern returns to same symptom
Common Triggers	Family history, recent health news, personal losses	Actual mild physical illness, stress, loss, or chronic discomfort
ICE Clues	Wants more tests or scans despite reassurance	Wants explanation for ongoing symptoms; often accepts it's not cancer—but worries
Exam Findings (PLAB 2)	All normal (vitals, system exams)	Mild findings (e.g., scratch marks, muscle tension) – no red flags
BMI/Weight Loss	Usually normal, unless anxiety-induced behaviour changes	May have minor appetite or energy impact
Management	1. CBT 2. Reassurance 3. Avoid further tests 4. Optional SSRI	1. CBT 2. Validate symptom 3. Avoid over-investigation 4. Optional SSRI
Diagnosis Explanation (Lay)	"You feel very worried about having a disease, even when doctors say you're well."	"You have a real symptom, but your brain may be amplifying the distress around it."
Referral Needed?	Yes – IAPT or Psychiatry if severe	Yes – CBT via mental health team, especially if long-standing

Attention Deficit Hyperactivity Disorder (ADHD)

Setting: GP Clinic
Role: FY2 Doctor
Patient: 18-year-old student, referred by school/educational supervisor for memory and concentration difficulties

Introduction & Rapport
"Hello, I'm Dr [Your Name]. Could I confirm your full name and age, please?"
"Thank you. Would you like to have a seat?"
"How can I help you today?"

(If patient says the school nurse asked them to attend…)
"Can you tell me more about why they wanted you to see me?"

Presenting Complaint

Chief complaint: "I keep forgetting things and can't concentrate"
Onset & impact: "How long have you noticed this? How is it affecting your studies or daily life?"

Inattention Assessment

(Need ≥5 symptoms; ask for examples)

Symptom	*Suggested Question*
Forgetful in daily activities	"What sort of things do you forget—homework, appointments?"
Losing items	"Do you lose your phone, keys, or wallet often?"
Easily distracted	"Do you find your mind wandering when you try to focus on tasks?"
Careless mistakes	"Have teachers commented on careless errors in assignments?"
Poor sustained attention	"Do you struggle to concentrate when reading or playing games?"
Difficulty listening	"Do you find your mind drifts off when someone is speaking?"
Fails to follow instructions	"Do you often leave tasks incomplete because you lose track?"
Poor organization	"Is organizing schoolwork or chores challenging?"
Avoids demanding mental tasks	"Do you put off complex school projects because they feel overwhelming?"

Hyperactivity/Impulsivity Assessment

(Need ≥5 symptoms; observe and ask)

Symptom	*Suggested Question / Observation*
Fidgeting	*Observe tapping or restless movements*; "I notice you're tapping your foot—is that often?"
Leaves seat	"Do you find it hard to stay seated when you should?"
Restlessness	"Do you feel restless or on edge much of the time?"
Excessive talking	"Do people say you talk a lot, even when it's not your turn?"
Impulsive answers	"Do you blurt out answers before questions are finished?"
Difficulty waiting turn	"Is waiting in line or for your turn hard for you?"
Interrupts others	"Do you often interrupt friends or classmates?"

Duration & Setting Confirmation

Onset before age 12?
"Did you have these difficulties back in middle school or earlier?"
Present in ≥2 settings?
"Do you notice these problems both at school and at home?"
Persistence >6 months?
"Yes—consistent pattern for years."

Risk & Differential

Mood & self-harm:
"Have you felt low, anxious, or had thoughts of harming yourself?"
Sleep:
"How are you sleeping—do you feel rested?"
Substance use:
"Do you drink, smoke, or use any recreational drugs?"
Differentials:
"Have you ever been told you have anxiety or autism spectrum traits?"

Developmental & Medical History (Risk Factors)

Birth history:
"Were you born full-term? Any problems at birth?"

Brain injury:
"Have you ever had a head injury?"

Early milestones:
"Were there any delays in walking or talking?"

Family history:
"Any family members with ADHD or other mental health conditions?"

PMAFTOSA

Past Medical History: Chronic illness, head injury
Medications: None or list any
Allergies: Ask explicitly
Family History: ADHD, mood disorders
Tobacco/Alcohol/Drugs: Use patterns
Occupation/School: Year group, performance
Social: Living at home, support network
Alcohol/Caffeine: Intake levels

ICE – Ideas, Concerns, Expectations

Ideas: "What do you think is causing your memory and focus problems?"
Concerns: "What are you most worried about regarding these difficulties?"
Expectations: "What were you hoping I could do for you today?"

Provisional Diagnosis

Likely: Attention Deficit Hyperactivity Disorder (combined type)
"Based on your history of inattention and hyperactivity across multiple settings since childhood, this is consistent with ADHD."

Explanation of ADHD

"ADHD is a neurodevelopmental condition where some parts of the brain that regulate attention and impulse control work differently. It can make it hard to concentrate, stay organized, and control restlessness or impulsive actions. It's not your fault—it's how your brain is wired, and with the right strategies and support, people with ADHD do very well."

Management Plan

Immediate Actions

Referral to Adult Psychiatry / ADHD Service
"They can do a full neurodevelopmental assessment and guide treatment."

Pharmacological

Consider Stimulant Medication (e.g., Methylphenidate or Amphetamine)
Explain: "These help improve concentration and impulse control."
Driving: "Keep a record—police may ask about controlled drugs."

Non-Pharmacological

Psychoeducation

"Teach about ADHD, organizational strategies, and time management."

Talking Therapy & Coaching

"Cognitive approaches to improve planning and reduce impulsivity."

Lifestyle Advice

Sleep: 7–9 hours, consistent schedule
Exercise: Daily physical activity improves focus
Screen-Time: Limit distractions on phones/computers
Diet: Regular meals, avoid excessive caffeine

Safety Netting & Follow-Up

"If you experience mood changes, side effects from medication, or any crisis, please contact us or urgent care. We'll review you in **4–6 weeks** after starting treatment to see how you're doing and adjust as needed."

Student Note: Key ADHD Diagnostic Points

Criterion	*Detail*
Age of onset	Symptoms before 12 years old
Settings	Present at school & home
Duration	>6 months
Symptom count	≥5 inattention + ≥5 hyperactivity/impulsivity
Functional impact	Affects academic performance, daily routines, relationships
Rule out	No major mood disorder, anxiety, autism as sole explanation

Remember: Always observe for fidgeting/tapping in the station, gently probe childhood history, and focus on impact rather than just listing symptoms.

Obsessive-Compulsive Disorder (OCD)

Setting: GP Surgery
Role: FY2 Doctor
Patient: Mr. Adam Bennett, 24 years old, final-year medical student
Presenting Complaint: "I feel anxious near patients; I can't complete my work."

Introduction

"Hello, I'm Dr [Your Name], one of the GPs here today. Could I confirm your full name and age please?"
"Thanks, Adam. I see you've come in today because you're struggling with anxiety around patients and work. That sounds really tough. Would it be okay if I ask you a few questions to explore what's been going on?"

Presenting Complaint – Clarify the Anxiety

"Can you tell me more about the anxiety you experience?"
"When does it usually start — is there a trigger?"
"What goes through your mind when you're near patients or trying to study?"
Patient mentions fear of contamination in clinical settings

Obsessions – Intrusive Thoughts

"Do you have thoughts that repeat in your mind even though you don't want them to?"
"Do they feel intrusive or uncontrollable?"
"Are you able to dismiss these thoughts easily, or do they stay with you?"
Patient reports intrusive thoughts about germs and infection

Compulsions – Repetitive Behaviours

"When you feel anxious, do you feel the urge to do something to relieve the anxiety?"
"Do you wash your hands repeatedly?"
"Roughly how many times a day?"
"Do you find yourself checking things — like door locks or taps — over and over?"

Repeated handwashing and door checking reported

Functional Impact

"How much of your day is taken up by these thoughts or behaviours?"
"Is this affecting your academic work or time in placements?"

Confirmed: Interfering with clinical performance and study

Insight

"Do you feel that these thoughts or behaviours are excessive or out of proportion?"

Patient has partial insight – knows it's irrational but still feels compelled

Psychiatric Review

Mood: "Have you been feeling low, anxious, or emotionally exhausted recently?"
Sleep: "Are you sleeping well?"
Appetite/Energy: "Any changes in energy levels or appetite?"
Self-Harm Risk: "Have you had any thoughts of harming yourself or ending your life?"

No suicidal thoughts reported, but patient feels overwhelmed

Past Psychiatric / Medical / Drug / Social History

"Have you had anything like this before?"
"Any counselling or treatment in the past?"
"Do you take any regular medications or supplements?"
"Any family history of mental health conditions?"
"Do you smoke, drink alcohol, or use recreational drugs?"
"How are things at home and university?"
"Do you have support from friends or family?"

Provisional Diagnosis

"From what you've told me — the recurring intrusive thoughts about contamination, and the urge to repeatedly wash your hands or check things — this sounds like **Obsessive-Compulsive Disorder, or OCD**."

Explanation of OCD

"OCD is a mental health condition where someone experiences repeated, unwanted thoughts — called **obsessions** — that create anxiety. To reduce this anxiety, the person feels the need to carry out certain actions — called **compulsions** — like washing hands or checking things.
Even though the person often knows the thoughts aren't fully logical, the anxiety feels so intense that resisting the behaviour becomes very difficult. This is not about being 'overly clean' — it's about a pattern that causes real distress and interferes with daily life."

Management Plan

First-Line: Psychological Therapy (High-Intensity CBT with ERP)

"We'll refer you to NHS Talking Therapies for one-to-one CBT, which includes Exposure and Response Prevention. It helps you face the feared situation without acting on the compulsion, gradually reducing anxiety and the urge."

Referral: IAPT or local mental health team if severe/functional impairment present

Medication (if moderate/severe, or patient prefers)

Fluoxetine (licensed SSRI for OCD)

Start at **20 mg once daily**
May take **10–12 weeks for full effect**
Continue for **at least 12 months** post-response
Side effects: nausea, agitation, sleep disturbance
Warn: May worsen anxiety in first 1–2 weeks

Psychoeducation & Self-Help

Reassure: "OCD is **treatable** — and very common among high-achieving students."
Signpost to:

OCD-UK: support and educational resources
NHS CBT apps: e.g. *Feeling Good*, *Clear Fear*
Encourage **symptom tracking** and **setting small goals** with therapist

Follow-Up & Escalation

Review in 2–3 weeks if starting medication
If symptoms worsen, refer to **community mental health team**
If risk emerges (e.g., suicidal thoughts or loss of function), arrange **urgent MH assessment**

Safety Netting

"Please don't hesitate to come back if your symptoms get worse, if you feel overwhelmed, or if you experience any distressing new thoughts.
There's always help available — you can also contact the 24/7 mental health crisis line or Samaritans at any time."

Note: OCD Diagnostic Summary

Feature	*Finding in This Case*
Obsessions	Repetitive thoughts of contamination
Compulsions	Repeated handwashing and checking
Time-consuming	Interfering with clinical and academic responsibilities
Insight	Partial – patient knows it's irrational but can't resist
Mood Impact	Feels anxious, overwhelmed, not suicidal
DSM/NICE criteria	Obsessions and/or compulsions lasting ≥2 weeks, causing distress and functional decline

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Clarification: Why This Is OCD, Not Health Anxiety or Intern Syndrome

Why this is *not* Health Anxiety:

Although the patient is anxious in clinical settings and experiences intrusive thoughts, this is **not health anxiety**, because:

Health Anxiety	*OCD (This Case)*
The core fear is ***having or developing an illness***	The core fear is **contamination** and irrational need for cleanliness
Focus is on ***misinterpreting normal bodily sensations*** *(e.g., heartbeat, cough)*	Focus is on **intrusive thoughts** and **compulsions** (e.g., repeated handwashing)
Seeks repeated ***reassurance and medical testing***	Seeks **relief through ritualistic behaviour** (not tests)
Thoughts are ***illness-focused*** *(e.g., cancer, HIV)*	Thoughts are **contamination/cleanliness-focused**

Often ***no compulsive behaviour***	Compulsions are **central** (e.g., 20+ hand washes daily)

Conclusion:
The distress arises not from believing he is *ill*, but from an irrational **need to neutralize contamination**, followed by ritual behaviours to relieve anxiety. This pattern — **obsession → anxiety → compulsion → temporary relief** — is **diagnostic of OCD**.

Why "Intern Syndrome" is Outdated and Inappropriate:
The term **"Intern Syndrome"** (also known as *Medical Student Syndrome*) refers to a **colloquial, non-clinical label** used to describe medical students who start believing they have illnesses they are learning about.
Why it's not appropriate to use:
- It **trivializes** serious mental health concerns like OCD, health anxiety, or GAD
- It's **not a formal diagnosis** under DSM-5 or ICD-11
- It **doesn't capture the diagnostic criteria** of OCD or health anxiety
- It risks **minimizing patient distress** by reducing complex symptoms to a stereotype

Instead, in PLAB 2, always aim to provide a **structured psychiatric diagnosis** (e.g., OCD, Health Anxiety, GAD) based on **clear symptom clusters, duration, and functional impact**.

Use in PLAB 2:
- Avoid saying: *"This sounds like intern syndrome."*
- Say instead: *"This pattern of distressing, unwanted thoughts followed by repetitive behaviours fits a diagnosis of OCD."*

Post-Traumatic Stress Disorder (PTSD)

Setting: GP Surgery
Role: FY2 Doctor
Patient: 30-year-old man
Presenting Complaint: Nightmares, flashbacks, anxiety following car accident 3 months ago

Introduction
"Hello, I'm Dr [Your Name], one of the doctors here at the practice. Could I confirm your full name and age please?"
"Thanks, [First Name]. I understand things have been difficult since your accident.
If it's okay with you, I'd like to ask a few questions to understand how you've been affected and how we can support you."

Presenting Complaint – Context of Trauma
- "Can you tell me a little about what happened during the accident?"
- "Were you the driver or a passenger?"
- "Was anyone else hurt?"
- "Were you injured physically at the time?"

Patient reports a traumatic car accident 3 months ago. He was the driver, no major injuries but emotionally shaken.

Core Symptom Clusters – PTSD Screening
A. Re-Experiencing
- "Do memories of the accident suddenly come back — like flashbacks or vivid nightmares?"
- "Are there any specific triggers — like driving, certain sounds, or places?"

B. Avoidance

"Do you avoid certain places or situations — like driving or being near cars?"

C. Hyperarousal

"Do you feel more jumpy, tense, or easily startled than usual?"
"How is your sleep — trouble falling asleep or frequent waking?"
"Do you feel 'on edge' most of the time?"

D. Mood and Cognition

"How would you rate your mood lately on a scale of 1 to 10?"
"Are you still enjoying things you used to, like hobbies or spending time with friends?"
"Do you feel more irritable, withdrawn, or anxious?"

Patient reports nightmares, flashbacks, avoiding driving, poor sleep, low mood, and irritability.

Impact on Life

"How has this been affecting your work or studies?"
"What about your relationships or social life?"

Patient has taken time off work, avoids social outings.

Psychiatric & Risk History

"Have you experienced anything similar in the past?"
"Have you been diagnosed with anxiety, depression, or PTSD before?"
"Have you ever received counselling or taken medication for your mood or anxiety?"
"Do you ever feel guilty or blame yourself for the accident?"
"Do you find yourself tearful or struggling with emotions?"
"How's your concentration — at work, or when reading or watching TV?"
"Any recent changes in appetite or weight?"

Suicide Risk

"I know this can be hard to talk about, but have you had any thoughts of harming yourself or feeling that life isn't worth living?"
"Do you feel safe at home?"
"Do you have someone you trust to talk to when you feel overwhelmed?"

No suicidal thoughts reported, but patient feels emotionally drained and isolated.

PMAFTOSA

Past Medical History: Any lingering injuries from the accident?
Medications: Taking anything for mood, pain, or sleep?
Allergies: Drug or other allergies?
Family History: Mental health conditions in family?
Travel/Occupation: "Are you back at work? Any difficulties commuting or concentrating?"
Social History: "Who do you live with? Do you have support at home?"
Alcohol/Smoking/Drugs: Any recent increase to help cope?

ICE

Ideas: "What do you think is causing these symptoms?"
Concerns: "Are you worried that this might be permanent or mean something more serious?"
Expectations: "What were you hoping we could do to help today?"

Examination
"I'd like to check there's no ongoing physical issue from the accident."
Observe: **hypervigilance**, restlessness, emotional distress
Vitals: Pulse/BP (if anxious)
Musculoskeletal (if relevant): Neck/back stiffness
Mental State Exam: Appearance, affect, behaviour, speech, mood, insight
No significant physical findings; appears tense, low affect, but cooperative.

Provisional Diagnosis
"Based on what you've shared — especially the flashbacks, poor sleep, and avoidance — this sounds like a condition called **Post-Traumatic Stress Disorder**, or PTSD."

Explanation: What is PTSD?
"PTSD is a mental health condition that can develop after a frightening or traumatic event. The brain stays in a 'high alert' state, even though the danger has passed.
That's why you may be getting nightmares, sudden memories, and constantly feel on edge or emotionally numb. It's not a sign of weakness, and it's more common than you think. The good news is — there are very effective treatments."

Management Plan
a. Reassurance
"You've done the right thing by coming in. PTSD is a recognised, treatable condition — and recovery is absolutely possible."

b. Psychological Therapy Referral
Refer to **NHS Talking Therapies (IAPT)** for:
Trauma-Focused CBT or **EMDR (Eye Movement Desensitisation and Reprocessing)**
"These are evidence-based therapies designed specifically for PTSD. They help you safely process the trauma and reduce the intensity of flashbacks and anxiety."

c. Lifestyle Advice & Self-Management
Sleep hygiene: regular sleep times, screen limits, no caffeine late
Daily routine: structure, daylight exposure, exercise
Mindfulness/breathing techniques: Headspace, Calm, NHS apps
Avoid alcohol, smoking, or recreational drugs as coping mechanisms

d. Medication (if needed)
Consider **Sertraline** if:
Symptoms are severe
Waiting time for therapy is long
Patient prefers combined treatment
"This can help reduce anxiety and improve sleep. It usually takes a few weeks to work, and we'll monitor you closely."

e. Support & Education
Offer leaflets on PTSD
Signpost to:

PTSD UK, Mind, NHS mental health apps
Local support groups if open to it

Safety Netting
"If things worsen — if you feel unsafe, or if you start having thoughts of harming yourself — please don't wait. Call us, call 111, or go straight to A&E.
You can also call **Samaritans** 24/7 just to talk. Help is always available."
Follow-Up
GP review in 2–4 weeks
Confirm referral accepted
Reassess sleep, mood, safety
Consider medication if needed
Adjust plan based on progress

Student Note: Diagnostic Reasoning – PTSD

Required Criteria	*Findings in This Case*
Triggering trauma	Serious car accident 3 months ago
Re-experiencing	Flashbacks, nightmares
Avoidance	Avoiding driving or being near cars
Hyperarousal	Jumpy, poor sleep, easily startled
Mood/Cognition impact	Low mood, irritability, social withdrawal
Duration >1 month	Symptoms present for 3 months
Functional impact	Interfering with work and social life

→ Diagnosis: **Post-Traumatic Stress Disorder (PTSD)**
→ Management: **Trauma-focused CBT/EMDR**, optional **SSRI**, **lifestyle**, and **close follow-up**

Generalized Anxiety Disorder (GAD)

Setting: GP Surgery
Role: FY2 Doctor
Patient: 28–32-year-old female, single, working in IT/accounting
Presenting Complaint: "I've been feeling very anxious lately and it's affecting my work."

Introduction
"Hello, I'm Dr [Your Name], one of the doctors here today. Could I confirm your full name and age, please?"
"Thanks. How can I help you today?"
Patient says she's been feeling constantly anxious and struggling at work.

Presenting Complaint – Explore Main Concern
"Can you tell me more about how you've been feeling?"
"How long has this been going on?"
"Would you say the anxiety is constant, or does it come and go?"
"Is there anything that seems to trigger it?"
Patient reports constant low-level anxiety, worsens in work settings but also present outside.

Detailed Anxiety Symptom Assessment (GAD Screening)
"Thanks for sharing that. I'll ask you about some common symptoms people with anxiety experience. Let me know if any sound familiar or affect you regularly."

"Do you often feel nervous or on edge?"
"Do you find it hard to control your worrying?"
"Do you worry about a lot of different things — not just one issue?"
"Do you get tired easily or feel drained?"
"How is your sleep — do you struggle to fall asleep or wake up often?"
"Do you get physical symptoms like headaches, tense muscles, or stomach discomfort?"
"Has your concentration or focus changed recently?"
"Do you find yourself more irritable than usual?"
"Is it difficult to relax even in your free time?"

Screen for Depression (Important Differential/Comorbidity)
"Sometimes anxiety can come along with low mood. Can I ask a few more questions just to rule that out?"
"Over the past couple of weeks, have you been feeling low or down most of the day?"
"Have you lost interest in things you usually enjoy?"
"How has your appetite been?"
"Any feelings of worthlessness or guilt?"
"Any thoughts about harming yourself or feeling that life's not worth living?"
Patient denies low mood or suicidal ideation. Appetite and enjoyment unchanged. No features of depression.

Rule Out Other Psychiatric Causes
"Have you had any sudden episodes of panic — with a racing heart, breathlessness, or chest tightness?" *(Panic Disorder)*
"Any recent traumatic events causing flashbacks or nightmares?" *(PTSD)*
"Any obsessive thoughts or urges to repeat certain actions?" *(OCD)*
None of these are present.

Effect on Life
"How has this anxiety affected your work?"
"What about your social life or relationships?"
"Have you withdrawn from any activities or routines because of this?"
Work performance is affected (errors, missed deadlines), but social life remains intact.

Psychiatric Risk and Safety
"Have you had any thoughts of harming yourself, or thoughts that life isn't worth living?"
"Do you feel safe at home and in yourself?"
"Is there someone you can speak to when things feel overwhelming?"
No risk factors or safeguarding concerns raised.

PMAFTOSA
Past Medical History: "Any history of physical or mental health conditions?"
Medications: "Are you currently on any regular medication?"
Allergies: "Any known drug allergies?"
Family History: "Any mental health issues in the family?"
Tobacco/Alcohol/Drugs: "Do you smoke, drink alcohol, or use any recreational drugs?"
Occupation: IT/Accounting – sedentary and deadline-driven
Social: Lives alone, some support from colleagues and friends

ICE

Ideas: "What do you think is going on with you?"
Concerns: "Is there anything you're worried this might mean?"
Expectations: "What were you hoping I could do for you today?"

She believes it's stress but worries it might get worse. She wants help but prefers non-drug approaches first.

Provisional Diagnosis

"Based on what you've described — the constant worry, physical tension, poor concentration, and sleep disturbance — this fits a condition called **Generalized Anxiety Disorder**, or GAD."

Explanation

"GAD is a mental health condition where your brain stays in a high-alert state, even when there's no immediate threat. People feel tense, find it hard to relax, and often worry about many everyday things — even small ones. It's not a personal failing. It's how your system has learned to react under stress — but with the right support, it can absolutely improve."

Management Plan

a. Self-Help and Lifestyle

Offer **GAD leaflet** and NHS website/app links
Encourage:
- Daily **exercise** (e.g., 30 mins walking)
- **Sleep hygiene** (wind-down routine, no screens late)
- Mindfulness/breathing techniques: *Headspace*, *Calm*, *NHS Mind Plan*
- Reduce caffeine and alcohol
- Join anxiety **support groups** if open to it

b. Psychological Therapy Referral

Refer to **NHS Talking Therapies (IAPT-** Improving Access to Psychological Therapies) for **CBT**

"CBT is a structured therapy that helps you learn tools to manage anxious thoughts and responses. It's considered the first-line treatment for GAD."

c. Medication (If Needed)

If symptoms persist or patient prefers:
- Offer **Sertraline 50 mg** (SSRI, first-line)
- Explain: takes 2–4 weeks to work, review in 3 weeks
- Monitor side effects (GI upset, agitation, insomnia)

Patient prefers CBT and lifestyle measures first – agrees to review later if no improvement.

Follow-Up and Safety Netting

Follow-up in 3–4 weeks
- Check engagement with CBT
- Reassess symptoms
- Consider medication if no improvement

Safety Net:

"Please contact us sooner if you feel overwhelmed, your sleep worsens, or you start feeling low. Help is always available, and we can adjust the plan anytime."

Student Note: Diagnostic Reasoning for GAD

Diagnostic Feature	*Findings in This Case*

Worry present ≥6 months	Yes – ongoing for several months
Hard to control worry	Yes – can't stop overthinking, even about small things
Physical symptoms	Yes – muscle tension, poor sleep, fatigue
Functional impact	Yes – work errors, loss of focus
Other causes ruled out	No panic, PTSD, depression, OCD
No suicidal ideation	Patient is safe, low-risk

→ **Diagnosis**: Generalized Anxiety Disorder
→ **Management**: CBT ± self-help → medication if needed

GAD vs Mild Depression vs Work Stress

Feature	*GAD*	*Mild Depression*	*Work Stress*
Core Emotion	Excessive **worry** about many everyday things	Persistent **low mood, loss of interest**	Feeling **overwhelmed**, time-pressured, **burnt out**
Duration	≥6 months of near-daily symptoms	≥2 weeks of low mood or anhedonia	Usually **linked to work phase**, improves with time off
Thought Pattern	"What if…" thoughts, overthinking, catastrophizing	Hopelessness, self-criticism, guilt	Thoughts about deadlines, performance, pressure
Physical Symptoms	Muscle tension, restlessness, fatigue, sleep issues	Poor energy, appetite/sleep changes, psychomotor slowing	Headaches, sleep trouble, fatigue (improves when rested)
Mood	Anxious, tense, restless	Sad, flat, emotionally numb	Irritable, stressed but mood lifts outside work
Functioning	Impacts **multiple domains** (work, sleep, daily life)	Reduced motivation, social withdrawal	Mostly **work-related decline**, weekends usually better
Response to Rest	Symptoms **persist even with rest**	Rest helps, but not enough to restore energy/mood	**Improves significantly with rest or time off**
Treatment Approach	CBT, SSRIs, lifestyle changes	CBT, SSRIs, possible stepped-care	Time management, boundaries, occasional counselling

Tip for PLAB 2:
GAD = *persistent uncontrollable worry across topics + physical tension*
Mild Depression = *low mood + anhedonia ± fatigue*
Work Stress = *situational, improves when stressor removed*

Erectile Dysfunction in a Patient with Depression

Setting: GP Clinic
Role: FY2 Doctor
Patient: Adult male, diagnosed with depression 8 months ago
Presenting Complaint: Wants to restart medication for low mood, but concerned about erectile dysfunction previously experienced with sertraline

Introduction
"Hello, I'm Dr [Your Name], one of the doctors here in the practice. Could I confirm your full name and age, please?"
"Thanks for coming in today. I understand you wanted to talk about how you've been feeling recently and your previous treatment — is that right?"

Explore Current Concern

"Can you tell me a bit more about what's been going on lately and what made you decide to come in today?"
"Are you thinking about restarting medication, or was there something specific on your mind?"

Patient expresses he's been feeling low again and wants to restart treatment but is concerned about erectile dysfunction he experienced on sertraline.

History of Presenting Symptoms (Current Mood)

"How would you describe your mood recently?"
"What symptoms have you noticed — like changes in energy, motivation, interest in things, sleep, or concentration?"
"Have these symptoms affected your ability to work or manage daily tasks?"
"Compared to how you were when you were on sertraline — is this better, worse, or the same?"

Reports low mood, fatigue, poor concentration, and reduced motivation – similar to when initially diagnosed.

Review of Past Treatment

"You mentioned you were on sertraline before — how did that go overall?"
"Did you feel it helped with your mood at the time?"
"What side effects did you experience?"
"Was the erectile dysfunction persistent, or did it come and go?"

Patient confirms sertraline improved mood but caused persistent ED, which led to stopping it.

Psychiatric Screening

"Can I ask a few more questions to better understand your mental health overall?"
"Do you still enjoy things you used to?" *(Anhedonia)*
"How is your sleep — falling asleep or staying asleep?"
"How's your appetite?"
"Do you find yourself feeling guilty, hopeless, or tearful often?"
"Any thoughts of harming yourself or feeling that life's not worth living?"

No suicidal thoughts reported

MAFTOSA Framework

Medications: Past use of sertraline, now off all meds
Adherence: Stopped sertraline due to side effects
Family History: No known mental health history
Tobacco/Alcohol/Drugs: Drinks socially, no recreational drugs
Occupation: White-collar job, work performance affected by low motivation
Social: Lives alone, moderate support network
Activity/Diet: No exercise, irregular meals, sleep 5–6 hours broken

ICE

Ideas: "I think I'm depressed again — but I'm scared it'll affect my sex life like before."
Concerns: "I'm worried about losing intimacy with my partner again."
Expectations: "I'd like to restart something that helps without ruining my relationship."

Explanation of Diagnosis

"Based on what you've told me — the low mood, fatigue, poor focus, and how it's impacting your daily life — it sounds like your **depression may have returned**.

This happens to many people, especially after stopping treatment. The concern you've raised about the side effects is very real, and I'm glad you brought it up so we can consider better options for you."

Management Plan

a. Acknowledge and Normalize Concern

"Sexual side effects like erectile dysfunction are a known issue with some antidepressants, especially SSRIs like sertraline. But not everyone gets them, and there are other medications with a lower risk."

b. Offer Alternative Medication

Suggest **Reboxetine** *(NRI – lower risk of sexual dysfunction)*

"Reboxetine works differently and is less likely to cause sexual side effects. We can start at a low dose and monitor closely."

Monitor for other side effects (e.g., insomnia, dry mouth)

c. Offer Non-Medication Therapy

"Talking therapy, like **CBT**, is another option that works well for depression. Some people use it alongside medication, others use it on its own."

Refer to **NHS Talking Therapies (IAPT)** for CBT

Offer printed and online self-help resources

d. Lifestyle Advice

Regular physical activity

Sleep hygiene and daily routine

Reduce alcohol and caffeine

Open communication with partner about mood and intimacy

Plan and Follow-Up

"Let's start with reboxetine at a low dose and refer you to talking therapy. We'll monitor both your mood and any side effects."

Follow-up in 2–4 weeks:

Check response to medication

Ask specifically about mood and sexual function

Adjust treatment if needed

Safety Netting

"If you notice your mood worsening, or if you feel emotionally overwhelmed, please contact us immediately. You can also call 111 or the Samaritans anytime if you ever need urgent support."

Closure

"I know this hasn't been easy, and I really appreciate how openly you've talked today. We'll keep checking in and adjust things as needed so that you feel better — mentally and physically."

Feature	*Findings*
Past depression	Diagnosed 8 months ago; responded to sertraline
Current symptoms	Low mood, poor concentration, fatigue
Medication stopped	Due to sexual side effects (ED from sertraline)
Concern	Wants to restart meds but worried about recurrence of ED
Plan	Reboxetine trial + CBT referral + lifestyle support
Follow-up	2–4 weeks with review of mood and sexual function

Performance Anxiety

Setting: GP Clinic
Role: FY2 Doctor
Patient: 19-year-old male

Presenting Complaint: Concern after losing erection during a sexual encounter following a comment about penis size

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Introduction

"Hello, I'm Dr [Your Name], one of the doctors here at the practice. Could I confirm your full name and age, please?"

"Thanks. I understand you've come in today with something quite personal — and I just want to say you've done the right thing by coming in. How can I help you best today?"

Open Exploration of the Concern

"Can you tell me in your own words what happened that's been worrying you?"

"What specifically has been on your mind since the experience?"

Patient describes losing erection during an intimate moment with his girlfriend after she commented on the size of his penis.

Focused History – Erection Pattern and Context

A. Erection Health Baseline

"Do you usually get erections — like in the mornings or during masturbation?"

"Are you generally able to get and maintain an erection when you're alone?"

Yes to both – suggesting no physiological dysfunction.

B. Previous Experiences

"Have you been sexually active before?"

"If so, have you ever experienced something like this before?"

This was his first intimate encounter.

C. Incident-Specific Details

"Can you walk me through what happened during that encounter — whatever you're comfortable sharing?"

"Did you initially get an erection?"

"What was going through your mind after the comment was made?"

"Did you feel nervous or anxious?"

He felt embarrassed, his thoughts spiralled, and he lost his erection.

Relationship Context

"Was this your first time with this partner?"

"How long have you known her?"

"Would you say you felt comfortable, or were you feeling nervous overall?"

New relationship; both were nervous and unfamiliar with each other.

Relevant Background

Past Medical History: No known medical conditions
Medications: Not on any medication
Allergies: None
Family History: Not relevant to ED here
Substance Use: No alcohol or recreational drugs
Mood: No low mood, anxiety disorder, or history of trauma
Lifestyle: Sedentary but generally healthy

ICE

Ideas: "I think something's wrong with me."

Concerns: "I'm scared this will happen again or I'm not normal."
Expectations: "I just want to make sure nothing's physically wrong and know what to do next time."

Physical Examination (Testicular Model Station)
"Would it be okay if I do a brief examination just to make sure there's nothing physically abnormal?"
Penile Exam: No curvature, scarring, or anatomical abnormality
Testicular Exam: No lumps or swelling, normal size and consistency
Normal findings – reassurance provided.

Provisional Diagnosis
"From everything you've told me — your ability to get erections normally, the specific nature of what happened, and the normal exam findings — this sounds like a case of **performance anxiety**, which is a very common type of temporary erectile dysfunction, especially in younger men."
Explanation
"It's actually really common for this to happen during a first sexual experience. You're not alone at all. What often happens is that nervousness or a comment — even if not meant to hurt — causes anxiety, and that anxiety interferes with the signals that keep an erection going. It doesn't mean anything is broken or abnormal — it just means your body responded to stress. Also, I want to reassure you about your concern with penis size. There's a wide range of normal, and the size has **no impact** on the pleasure or satisfaction for either partner. Your exam was completely normal."

Management Plan
a. Reassurance
Confirm normal examination
Emphasize that this is a **common and temporary experience**
Normalize first-time anxiety: *"It gets easier with time and familiarity."*
b. Practical Advice
Go slowly with intimacy — focus on **comfort and connection**, not performance
Don't rush to intercourse — take time with foreplay
Try to set the mood: low lighting, privacy, minimal pressure
Communicate with partner: It's okay to say "I'm a bit nervous"
Practice **relaxation techniques**: breathing exercises, music, etc.
c. No Medication Needed
"At your age, and with your normal physical health, there's no need for tablets like Viagra. This is not a physical problem, and medication won't help reduce anxiety — in fact, it might make you more worried."
d. Avoid Shame
"You've done the right thing by bringing this up. This doesn't make you weak, and it doesn't define your masculinity. Confidence builds with experience."

Safety Netting
"If you notice that this becomes a regular issue, or if it starts affecting your confidence or mood long term, please come back — we can explore further support, including therapy if needed."

Follow-Up
No formal follow-up needed unless symptoms persist
Offer open-door return:
"If this happens again or starts affecting your day-to-day confidence, I'm happy to talk more anytime."

Closure

"To summarise — there's nothing physically wrong, and what you experienced is completely normal and very common at your age. It's not about size, it's about comfort and connection. Thank you for sharing it so openly — that's a really mature step to take."

Student Note: Clinical Reasoning Summary

Category	*Findings*
Erectile function baseline	Normal (morning and self-stimulated erections)
Trigger	First-time encounter + partner's comment → anxiety
Relationship context	New partner, unfamiliar setting
Physical exam	Normal penile and testicular findings
Mood history	No underlying anxiety or depression
Diagnosis	Temporary erectile dysfunction due to **performance anxiety**
Management	Reassurance, practical advice, no meds, partner communication

Note: This section includes erectile dysfunction cases with psychological or medication-related causes. For ED with organic or structural causes, refer to the Urology section.

Psychiatry – Red Flags, Pitfalls, and Exam Cautions

This guide highlights critical safety, communication, and structural points that repeatedly cause students to lose marks in PLAB 2 psychiatry stations. Use it to refine your approach and avoid the most common exam errors.

1. Communication Mistakes to Avoid

- Do not use terms like **"psychosis," "delusional disorder,"** or **"chemical imbalance"** when speaking to the patient.
- Avoid scripted or artificial rapport builders such as **"you seem like a caring parent"** — keep it natural.
- Never directly **challenge delusions** or **argue** with the patient's beliefs.
- Do not **diagnose too early** based on labels — always complete your full assessment first.
- Avoid casual language, **self-deprecating humour**, or vague reassurances (e.g., "You're in the right place").

2. Assessment Mistakes

- Don't apply FAMISH rigidly — allow flow but ensure all areas are covered, including:
  - Function
  - Alcohol/drugs
  - Medical/medication
  - Insight
  - Social support/stress
  - Hallucinations/suicidality
- Always ask about **suicidal thoughts**, **plans**, and **self-harm** — even if mood seems stable.
- Don't rely solely on the **patient's account** of symptom duration or severity — **corroborate with family** if needed.
- In overdose or suicide attempt scenarios, assess **before, during, and after** the attempt (intent, planning, isolation, regret).

3. Management Red Flags

- Always involve **psychiatry** for:
  - Suicidal ideation
  - Psychotic features

Repeat overdose
Diagnostic uncertainty

Don't discharge without **senior review** in any overdose, psychotic, or high-risk situation.
In mild cases, avoid prescribing antidepressants unless clearly indicated and follow **stepwise guidance** (e.g., low mood with functional impact ≥4 weeks).
Do not **promise urgent psychiatric referrals** or use vague phrases like "counselling will help" without specifics.

4. Scenario-Specific Pitfalls

Schizophrenia cases:
Patient may be distractible, agitated, or evasive — stay calm, adapt your pace.
Never use the word "confused" — many have long-standing fixed beliefs.

Depression:
Differentiate **mild, moderate, severe** using functional impact and symptom number.
Always explore **anhedonia**, **low mood**, **guilt**, **sleep**, **appetite**, **libido**, and **concentration**.

Overdose cases:
Never tell patient they're "low risk" — instead say, "it's unlikely based on what you've told me, but we still want to support you closely."

Substance misuse:
Be able to explain **methadone**, **NRT**, and **alcohol withdrawal protocols**.
Always calculate **alcohol units** precisely if the patient mentions intake.

Eating disorders:
Use **SCOFF** questions and check BMI: low in anorexia, normal in bulimia.
Management requires both **medical (e.g., ECG)** and **psychosocial steps**.

Dementia vs. ADHD:
Dementia has functional decline with age; ADHD in adults usually presents as underperformance or impulsivity without cognitive decline.

Health anxiety vs. somatic symptom disorder:
Both need a physical symptom, but health anxiety has persistent worry about illness despite normal investigations.

5. Follow-Up and Safety

Under 30: follow up in 1 week. Over 30: 2 weeks (for depression).
Duration for depression diagnosis: symptoms must persist for **at least 4 weeks**.
Always offer a **crisis card** with emergency contacts for suicidal patients.
Explain that **medication effects take ~4 weeks** and continue **6 months after recovery**.
Reinforce the role of **exercise**, **sleep hygiene**, and **CBT** even when prescribing medication.

Final Tips

Psychiatric cases often test your **confidence, structure, and adaptability** more than clinical knowledge alone.
Stay composed. Speak clearly. Structure your assessment logically.
Show empathy — but don't compromise clinical safety to appear sympathetic.

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