MED435.

OSCE TEAM

OBJECTIVE STRUCTURED CLINICAL EXAMINATION

Endocrine Block.

Done by:
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Thyroid: history taking

Simulated Patient Case Script:

Weight loss due to hyperthyroidism.

Hyperthyroidism is a condition wherein the thyroid gland produces excessive thyroid hormones resulting to an accelerated body metabolism.

Personal and Social History:
Single, living with parents. No tobacco use.
present complaint:
1- When these complaints started? It started four months ago.
2- How much weight did you lose? I had lost about 10 kilos.
3- Was there any change in your appetite? Not really. My food intake is the same as before.
4- Is there any other symptoms? I noticed that I get tired easily even when I am doing light activity. I also sweat a lot more than before and cannot tolerate heat well. Sometimes I feel pounding on my chest and my heart beats faster.
5- Did you experience this condition before? No, this is the first time.
6- Do you have any medical problems or condition in the past? No, I believe I was perfectly healthy before this.
7- Does anyone in your family with similar condition? No.
8- Are you on any medication? No.Past medical history: Nothing specific, No important disease history, No operation, No current medication, No allergy.Family history: Parents are healthy and alive, no major history of disease.

Thyroid: history taking

	Step/Task	D	PD	ND
	Preparation			
1.	Greet the patient and introduce yourself.			
2.	Explain the procedure, reassure the patient and get patient's consent.			
3.	Make sure the patient is in a comfortable position sitting or lying down.			
4.	Maintain good eye contact and establish rapport with the patient.			
	History			
1.	**Personal information:** Ask for the patient's Name, Age, Gender, Occupation, Nationality, and Address.			
2.	**Presenting Complaint:** Ask the patient about the main problem/s that made him/her went to see the doctor.			
3.	**History of Present Illness:** ● Allow the patient to provide an account of recent events in his/her own words without interruption. ● Ask the patient when the condition started. Ask how much weight was lost. ● Ask any associated signs and symptoms like increased appetite, nervousness, weakness, difficulty in sleeping, hair loss, shortness of breath, diarrhea etc.			
4.	**Past medical history:** ● Ask about any similar episodes in the past. ● Ask about any previous history of goiter or thyroid problems. ● Ask about other medical conditions or congenital problems. ● Ask about any history of surgery particularly in thyroid, parathyroid, or pituitary. ● Ask about any history of radiation. ● Ask about previous hospitalizations, allergy, blood transfusion, and trauma history.			
5.	**Family History:** Ask about significant illness in the family (like Marfan's or Diabetes Mellitus). Similar illness in the family.			

Thyroid: history taking

6.	**Personal and Social History:** ● Ask about use of alcoholic beverages, cigarette smoking or illicit drugs. ● Ask politely about emotional problems at home or at work.			
7.	**Obstetric and Gynecologic History (if patient is female):** ● Ask about the LMP (last menstrual period), regularity and quality of menstruation. ● Ask age of menopause if patient is elderly. ● Ask about number of pregnancy, number of children, and history of complications during pregnancy.			
8.	**Systematic Review (inquiry about all the cardinal symptoms in each of the major systems):** ● **Cardio-respiratory symptoms** Ask about having cough, shortness of breath, chest pain, ankle swelling, etc. ● **GIT symptoms** 1. Ask about having weight loss or weight gain, nausea or vomiting, diarrhea or constipation, abdominal pain, excessive thirst etc. 2. Ask about having loss or increase of appetite. ● **Neurological symptoms** 1. Ask about having nervousness, irritability, fatigue, or seizures. 2. Ask about having headache, dizziness, ringing in the ears, changes in hearing, vision, smell or taste, etc. ● **Urinary and Reproductive symptoms** 1. Ask about having increased frequency of urination. Ask about having burning on passing urine, frequency of urination, blood in the urine, etc. 2. Ask about having penile or vaginal discharge, hesitancy or urgency of urination, poor urine stream or dribbling, etc. ● **Dermatologic symptoms** 1. Ask about having skin rashes, redness, or itchiness, etc. 2. Ask about having skin pigmentation, dryness, or sweating. ● **Musculoskeletal symptoms** 1. Ask about having joint pain or stiffness, muscle pain or weakness, etc. 2. Ask about having overgrowth or shorter stature.			
	Closing			
1.	Make explanations to the patient, answer questions and discuss management plan. If appropriate, order diagnostic investigations (e.g. ultrasound scan, CBC, LFTs, etc.).			
2.	Ensure that the patient is comfortable.			
3.	Thank the patient. Wash hands and document the procedure.			

Thyroid Examination

	Step/Task	D	PD	ND
	Preparation			
1.	Introduce yourself to the patient.			
2.	Confirm patient's ID.			
3.	Explain the procedure and reassure the patient and get consent.			
4.	Wash your hand and prepare the necessary material.			
5.	Position the patient in a sitting position and uncover his/her neck and upper body.			
	Examination			
1.	**Inspection:** ● Inspect patient's neck.(Asymmetry, surgical scars, prominent veins, redness, swelling or evident masses). ● Ask the patient to take a sip of water and watch the neck. (Thyroid gland, thyroid cartilage, cricoid cartilage, thyroglossal cyst, lymph nodes are moved upon swallowing).			
2.	**Palpation:** ● Put one hand on either side of his neck and examine the anterior and posterior triangles of the neck with fingertips. ● .Palpate the neck for any masses. (If any; determine its location, size, shape, mobility, tenderness, surface features etc.) ● Palpate the thyroid gland. (If palpable; determine its size, shape, symmetry, consistency, tenderness and mobility). ● Palpate for cervical lymph nodes and describe. ● Palpate for tracheal deviation in the suprasternal notch.			
3.	**Percussion:** Percuss the manubrium sterni from one side to the other.(A change from resonant to dullness indicates possible retrosternal goitre).			
4.	**Auscultation:** Auscultate the thyroid over each lobe for bruits.			
	After examination			
1.	Ensure that the patient is comfortable			
2.	Make explanations to the patient, answer his/her questions and discuss management plan.			
3.	Dispose waste material according to infection control standards, Wash hands then Document the procedure.			

Adrenal: history taking

Simulated Patient Case Script:

Weight gain due to cushing's disease.

Cushing's syndrome is a condition wherein the adrenal glands produces excessive hormones (cortisol) due to drugs or abnormal glands/ tumors.

Personal and Social History:
Single, living with parents. No tobacco use.

present complaint:

1- When these complaints started? It started 8 months ago.
2- How much weight did you ? I have gained about 6-8 kilos.
3- Was there any change in your appetite? I tried controlling my diet but I am tired easily so I eat to feel relaxed.
4- Is there any other symptoms? I noticed that I have difficulty lifting things at work, I used to think maybe I am getting old or just tired.
5- Did you experience this condition before? No, this is the first time.
6- Do you have any medical problems or condition in the past? No, I believe I was perfectly healthy before this.
7- Does anyone in your family with similar condition? No.
8- Are you on any medication? No.

Past medical history:
Nothing specific, No important disease history, No operation, No current medication, No allergy.

Personal and Social History:
I play tennis and usually go to the gym for work-outs, I like to feel fit and healthy that's why this weight gain is bothering me so much.

Family history:
Parents are both hypertensive, and live a healthy lifestyle, no major history of other disease.

Adrenal: history taking

	Step/Task	D	PD	ND
	Preparation			
1.	Greet the patient and introduce yourself.			
2.	Explain the procedure, reassure the patient and get patient's consent.			
3.	Make sure the patient is in a comfortable position sitting or lying down.			
4.	Maintain good eye contact and establish rapport with the patient.			
	History			
1.	**Personal information:** Ask for the patient's Name, Age, Gender, Occupation, Nationality, and Address.			
2.	**Presenting Complaint:** Ask the patient about the main problem/s that made him/her went to see the doctor.			
3.	**History of Present Illness:** ● Allow the patient to provide an account of recent events in his/her own words without interruption. ● Ask the patient when the condition started. Ask how much weight was lost or gained. ● Ask any associated signs and symptoms like increased appetite, nervousness or irritability, weakness, difficulty in sleeping, hair loss, shortness of breath,changes in menstruation for women, skin changes like bruising etc.			
4.	**Past medical history:** ● Ask about any similar episodes in the past ● Ask about any previous history endocrine problems. ● Ask about other medical conditions or congenital problems. ● Ask about any history of surgery particularly in thyroid, parathyroid, pituitary, kidneys/ adrenal.\Ask about any history of radiation. ● Ask about previous hospitalizations, allergy, blood transfusion, and trauma history.			
5.	**Family History:** Ask about significant illness in the family (like Marfan's or Diabetes Mellitus). Similar illness in the family.			

Adrenal: history taking

6.	**Personal and Social History:** ● Ask about use of alcoholic beverages, cigarette smoking or illicit drugs. ● Ask about use of drugs to improve physical appearance, exercise or workout. ● Ask politely about emotional problems at home or at work.			
7.	**Obstetric and Gynecologic History (if patient is female):** ● Ask about the LMP (last menstrual period), regularity and quality of menstruation, Ask age of menopause if patient is elderly. ● Ask about number of pregnancy, number of children, and history of complications during pregnancy.			
8.	**Systematic Review (inquiry about all the cardinal symptoms in each of the major systems):** ● **Cardio-respiratory symptoms:** Ask about having cough, shortness of breath, chest pain, ankle swelling, etc. ● **GIT symptoms:** 1. Ask about having weight loss or weight gain, nausea or vomiting, diarrhea or constipation, abdominal pain, excessive thirst etc. 2. Ask about having loss or increase of appetite. ● **Neurological symptoms:** 1. Ask about having nervousness, irritability, fatigue, or seizures. 2. Ask about having headache, dizziness, ringing in the ears, changes in hearing, vision, smell or taste, etc. ● **Urinary and Reproductive symptoms:** 1. Ask about having increased frequency of urination. Ask about having burning on passing urine, frequency of urination, blood in the urine, etc. 2. Ask about having penile or vaginal discharge, hesitancy or urgency of urination, poor urine stream or dribbling, etc. ● **Dermatologic symptoms:** 1. Ask about having skin rashes, redness, or itchiness, etc. 2. Ask about changes in skin color, darkness or lightness 3. Ask about having skin pigmentation, dryness, or sweating. ● **Musculoskeletal symptoms:** 1. Ask about having joint pain or stiffness, muscle pain or weakness, etc. 2. Ask about having overgrowth or shorter stature.			
	Closing			
1.	Make explanations to the patient, answer questions and discuss management plan. If appropriate, order diagnostic investigations (e.g. ultrasound scan, CBC, LFTs, etc.).			
2.	Ensure that the patient is comfortable.			
3.	Thank the patient. Wash hands and document the procedure.			

History related to Diabetes mellitus

Simulated Patient Case Script:

Frequent urination.

Cushing's syndrome is a condition wherein the adrenal glands produces excessive hormones (cortisol) due to drugs or abnormal glands/ tumors.

Personal and Social History:
Single, living with parents. No tobacco use.

present complaint:

1- When these complaints started? It started 8 months ago.
2- How much weight did you ? I have gained about 6-8 kilos.
3- Was there any change in your appetite? I tried controlling my diet but I am tired easily so I eat to feel relaxed.
4- Is there any other symptoms? I noticed that I have difficulty lifting things at work, I used to think maybe I am getting old or just tired.
5- Did you experience this condition before? No, this is the first time.
6- Do you have any medical problems or condition in the past? No, I believe I was perfectly healthy before this.
7- Does anyone in your family with similar condition? No.
8- Are you on any medication? No.

Past medical history:
Nothing specific, No important disease history, No operation, No current medication, No allergy.

Personal and Social History:
I play tennis and usually go to the gym for work-outs, I like to feel fit and healthy that's why this weight gain is bothering me so much.

Family history:
Parents are both hypertensive, and live a healthy lifestyle, no major history of other disease.

History related to Diabetes mellitus

	Step/Task	D	PD	ND
	Preparation			
1.	Greet the patient and introduce yourself.			
2.	Explain the procedure, reassure the patient and get patient's consent.			
3.	Make sure the patient is in a comfortable position sitting or lying down.			
4.	Maintain good eye contact and establish rapport with the patient.			
	History			
1.	**Personal information:** Ask for the patient's Name, Age, Gender, Occupation, Nationality, and Address.			
2.	**Presenting Complaint:** Ask the patient about the main problem/s that made him/her went to see the doctor.			
3.	**History of Present Illness:** ● Allow the patient to provide an account of recent events in his/her own words without interruption. ● Ask the patient when the condition started. ● Ask the patient how many times he/she urinates in a day. Ask the amount or volume in comparison before. ● Ask to describe the urine's appearance. (Color, texture, and smell) ● Ask any associated signs and symptoms like increased appetite/hunger, increased thirst, weight loss, fatigue, blurred vision, headache, dry mouth, etc.			
4.	**Past medical history:** ● Ask about any similar episodes in the past. ● Ask about other medical conditions or congenital problems. ● Ask about history of surgery, previous hospitalizations, allergy, blood transfusion, and trauma.			
5.	**Family History:** Ask about significant illness in the family like Diabetes Mellitus, Hypertension, etc..			
6.	**Personal and Social History:** ● Ask about use of alcoholic beverages, cigarette smoking or illicit drugs. ● Ask politely about emotional problems at home or at work.			

History related to Diabetes mellitus

7. Obstetric and Gynecologic History (if patient is female):

- Ask about the LMP (last menstrual period), regularity and quality of menstruation, Ask age of menopause if patient is elderly.
- Ask about number of pregnancy, number of children, and history of complications during pregnancy like Gestational Diabetes

8. Systematic Review (inquiry about all the cardinal symptoms in each of the major systems):

- **Cardio-respiratory symptoms:**

Ask about having cough, shortness of breath, chest pain, ankle swelling, etc.

- **GIT symptoms:**

1. Ask about having weight loss or weight gain, nausea or vomiting, diarrhea or constipation, abdominal pain, excessive thirst etc.
2. Ask about having loss or increase of appetite.

- **Neurological symptoms:**

1. Ask about having nervousness, irritability, fatigue, or seizures.
2. Ask about having headache, dizziness, ringing in the ears, changes in hearing, vision, smell or taste, etc.

- **Urinary and Reproductive symptoms:**

1. Ask about having increased frequency of urination.
2. Ask about having burning on passing urine, frequency of urination, blood in the urine, etc.
3. Ask about having penile or vaginal discharge, hesitancy or urgency of urination, poor urine stream or dribbling, etc.

- **Dermatologic symptoms:**

1. Ask about having skin rashes, redness, or itchiness, etc.
2. Ask about having skin pigmentation, dryness, or sweating.

- **Musculoskeletal symptoms:**

1. Ask about having joint pain or stiffness, muscle pain or weakness, etc.
2. Ask about having overgrowth or shorter stature.

Closing

1. Make explanations to the patient, answer questions and discuss management plan. If appropriate, order diagnostic investigations (e.g. ultrasound scan, CBC, LFTs, etc.).

2. Ensure that the patient is comfortable.

3. Thank the patient. Wash hands and document the procedure.