***Sheet 1***

**College of Medicine**

**Department of Medical Education**

**Objective Structured Clinical Examination**

**(Information for student)**

**Patient Brief Record / Brief Scenario:**

**Patient Name: Ahmad**

**Age: 50 years**

**Occupation Teacher, Primary School.**

**No frequent visit to clinic**

**Ahmad is a 50-year old, came with complaint of abdominal pain and indigestion.**

**TASK: (What is expected from a student)**

* **Take a focus history, to reach a probable diagnosis.**
* **Explain to the patient possible diagnoses and the management plan.**

**No need of physical examination.**

***Sheet 2***

**College of Medicine**

**Department of Medical Education**

**Objective Structured Clinical Examination**

**Patient’s Scenario/ Instructions to Patient**

**A 50-year-old man, who works as a teacher for long time, has presented to the clinic today with the complaint of indigestion and upper abdominal pain.**

**These complaints initiated for last 3 months. Pain and indigestion are usually felt after heavy meals.**

**Bowel movements are normal.**

**He uses paracetamol and Brufen for aches and pain.**

**He is smoker, 10-20 cigarettes per day.**

**No history of hematemesis or melena.**

**No history recent weight loss or generalized weakness.**

**He is not known to have any other chronic illness.**

**Initially, he could manage this problem taking antacid brought over the counter.**

**During the last week he could not get relief by the antacid and has vomited 2-3 times.**

**Idea: could be some serious problem.**

**Concern: not specific**

**Expectation: Relief of symptoms.**

***Sheet3***

**College of Medicine**

**Department of Medical Education**

**Objective Structured Clinical Examination**

**Candidates Name:**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Professional behavior (for all cases)** | **0** | **1** | **2** |
| 1. **Data Gathering (If Hx Taking to be tested)** |  |  |  |
| 1. **Examination (If Clinical examination to be tested)** |  |  |  |
| 1. **Management ((If Mgx plan to be tested)** |  |  |  |
| **Total**  **Grades %** |  |  |  |
| **Passed Borderline Failed** |  |  |  |

**College of Medicine**

**Department of Medical Education**

**Objective Structured Clinical Examination**

**Candidates Name:**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Professional behavior (for all cases)**   Introduces himself, and get the permission to take history  Starts with open ended question.  Develops the rapport with patient. | **0** | **1** | **2**  **10** |
| 1. **Data Gathering (If Hx Taking to be tested)**   Onset, duration, character of pain, relieving and aggravating factors………..  Bowel movement, character of stool  ALARM symptoms (recent wt loss, hematemesis, malena,….)  Smoking  Medications (NSAID, or other gastric irritant medication)  Social history (home or work stree…)  Ongoing problem  **Summarizes to the patient about the history taken from him.**  Differentiating symptoms for GERD.and other causes of dyspepsia.  Patient idea, concern and expectation |  |  | **60** |
| 1. **Examination (If Clinical examination to be tested)**   **NOT NEEDED** |  |  |  |
| 1. **Management ((If Mgx plan to be tested)**   Explains the problem to the patient in simple way.  Informs that could be NUD or GERD  Dietary advice and other non-pharmacological advice.  PPI medication / H2 blocker  Follow up advised  Possibility of Urea Breath test request.  Arrive at shared understanding.  **Summarize at the end of consultation**  **Invite questions from patient** |  |  | **30** |
| **Total**  **Grades %** |  |  |  |
| **Passed Borderline Failed** |  |  |  |