OSCE History Taking – Notes for Actor

Patient demographics:
You are Elijah Woods, a 60-year-old Caucasian male. You have come to the GP because you have seen Blood in your Stool

Presenting Complaint: Haematochezia

History of Presenting Complaint:
- Quality: Normal Texture + Colour of stool, Small amounts of Blood
- Time: Started 1 week ago, 5 movements a day
- Aggravating Factors: None
- Relieving Factors: Noticed less movements and less blood in stool after Smoking

Other symptoms + Negative History (ONLY IF ASKED)
- Wakes at night to go to toilet
- Red Gritty Eye
- Red Rash on Shins
- No recent changes in Diet/ Exercise, No Pain, No Weight Loss, No Fever, No Jaundice, No Abdominal distension, No Tenesmus, No Urinary/ Respiratory/ Cardiovascular changes

ICE
I: None
C: Worried about a bleed somewhere
E: To know diagnosis

PMH + Surgical History:
- None

Drug History
- None, No allergies

Family History
- Father has Primary Sclerosing Cholangitis

Social History
- Started smoking a few days ago. Doesn't drink. Healthy diet, gets 5-a-day.
- Lives with wife and daughter. Retired. No Caffeine intake. No travel history. No drug use.

Diagnosis: Ulcerative Colitis

OSCE History Taking – Notes for Candidate

Role: GP Trainee
Presenting complaint: Headache

This is Elijah Woods, a 60-year-old Caucasian Male who has presented to the GP with Blood in his Stool.

Please take a history in 8 minutes
There will be 2-minute further questions from examiner at the end

OSCE History Taking- Examiner Marksheet

Opening:

- Introduces themselves
- Confirms Patient demographics
- Explains and gains consent from patient about consultation
- ***Demonstrates relevant and spontaneous empathy at APPROPRIATE times***

Presenting complaint and History of presenting complaint:

- Open questioning to begin
- Structured approach
- Red flags: Weight loss, Abdominal distension (Cancer),
- Asks about Pain, Fever
- ICE
- Uses clear language and avoids jargon

Systemic enquiry:

- Screens for relevant symptoms in other body systems

PMH/Surgical history:

- Asks about any Medical Conditions or Surgical Procedures

Drug History, Social and Family History:

- Asks about both prescribed and over the counter medication
- Allergies and what happens during allergy
- Substance misuse, Alcohol and Smoking history, Caffeine intake
- Occupation, Relevant Family History

Ending consultation:

- Summarises and clarifies any points
- Thanks Patient
- Signposting

EXAMINER FOLLOW UP QUESTIONS:

Q1: What is your top differential diagnosis and why?
Moderate Ulcerative Colitis Exacerbation: Painless GI Bleed, Waking at night, Family History, Smoking alleviates symptoms

Q2: What initial investigations/examinations would you order for this patient?

- FBC, ESR, CRP, U&Es, LFTs, B12, Folate, Albumin, Clotting screen
- Faecal Calprotectin, Stool culture, AXR, CT Colonography
- Haemoglobin, Observations

Q3: What would you expect to see on Biopsy and Colonoscopy?
Crypt abscess/ Distortion, Neutrophilic infiltrates, Continuous Superficial inflammation, No Granulomas

Q4: What is your management plan to induce Remission?

- Topical Aminosalicylate for 4 weeks. If fails, progress to Oral.

Global Impression:

- Excellent
- Good
- Pass
- Borderline
- Fail

Patient Impression/comments: