



Year 4 Formative OSCE #1 (July) 2019

Reading for Station 5

Candidate Instructions

Clinical Scenario

You are an intern in the Gold Coast University Hospital Emergency Department. Maria Wattleberry is a 60 year-old woman who has presented with an acutely painful red left eye. Your registrar has asked you to take a history. Her vitals are stable.

Task

In a total of eight (8) minutes:

- **Take a history** within the first 5 minutes
- The examiner will interrupt you at 5 minutes and ask you what physical examinations you will like to perform **in the ED setting**. You will then be presented with the physical examination findings.
- Provide the examiner with your provisional diagnosis and initial management

You do not need to examine the patient

[The examiner in the room will assume the role of the registrar]

Simulated Patient Information

The candidate has the following scenario and task

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- Take a history within the first 5 minutes
- Your examiner will interrupt you at 5 minutes and ask you what physical examinations you will like to perform **in the ED setting**. You will then be presented with the physical examination findings.
- Provide the examiner with the principal (one) diagnosis and your initial management before the end of the station

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[The examiner in the room will assume the role of the registrar]

Instructions for simulated patient

- Your name is Maria Wattleberry and your DOB is 05/05/1959 (60 years old)
- You are dressed normally and sitting on a chair in front of a table.

Presenting complaint:

- State that you came straight to ED after sudden onset of left eye pain and blurring of vision after watching a movie at home

Only give more of the following information if asked specifically about it:

- Have not received any analgesia yet – Nil known drug allergies
- SOCRATES PP:
 - Left eye only, Sudden (30 minutes ago), Feels deep in eye, No radiation, Constant pain, Light seems to make pain worse, Nothing makes it better, Severe (8/10)
 - Never had this before
 - Pain came on suddenly at home when watching a movie. Was feeling well up until then
- Associated sx: Red eye
 - Vomited once (20 minutes ago), Feels nauseated
 - Has frontal headache
 - No preceding ocular trauma
 - No ocular discharge
- Associated sx: Visual loss/disturbance
 - Sudden blurry vision
 - Can see halos around light
 - Photophobia

- Teary eyes
- No preceding visual disturbance
- No floaters

Past medical history

- Ocular
 - Mildly far sighted – has reading glasses for past 10 years
 - No other known issues with vision/ ocular diseases
 - Maria does not wear contact lenses
- Hypertension diagnosed 10 years ago – well controlled on perindopril
- Type 2 diabetes mellitus – diet controlled

Family history

- Mother had glaucoma
- Nil other

Social history

- Non-smoker
- Red wine with dinner once a week
- No recreational drugs
- Retired happily for past 5 years. Previously worked with husband as his secretary in a newspaper company
- Lives with husband and pet birds
- Enjoys gardening and playing table tennis
- Nil recent overseas travel/ long distance travel
- Nil current stressors in life

Medication

- Perindopril for HTN
- Nil current medications
- Nil known drug allergies

Surgical

- Nil ocular surgeries
- Tubal ligation 20 years ago
- Appendix removed when teenager

Examiner Instructions

Please verify that you are examining the correct student by checking the name on the student's ID card against the name on the score sheet, as the student enters the room.

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You do not need to examine the patient

[The examiner in the room will assume the role of the registrar]

Instructions

- The examiner has a busy role in this station as they must prompt the student and mark them at the same time. Examiners must perform their tasks at the set time to allow students to progress through the station and finish on time. **Please read the following instructions carefully.**
- You are playing the role of the registrar in this exam. Please address the student as a registrar would, after you have checked ID. Please do not provide prompts on the station content.
- Please start your stopwatch at the start of the station. The station is planned as follows:
 - **Student takes history = 0-5 mins**
 - **Examiner asks student what examinations in ED they would like to perform = 5-6 mins**
 - **Examiner provides 'Physical examination findings [Student Copy]' and 'Photo of Eyes' to student = 6-7 mins**
 - **Examiner asks what primary diagnosis is and management = 7-8 mins**
- Stay out of the line of sight between the candidate and the patient during the physical exam. Do not provide any positive or negative feedback to the candidate
- Please record your observations on the scoresheet **as you go**, as discussed in the briefing.
- At around the **5 minute mark**, ask the student what physical examinations in the ED setting they would like to perform.
 - Stop the student if they begin examining the patient. This is not an examination station.

- After the student has stated what physical examinations they intend to perform (around the **6 minute mark**), provide the student with the student copy of the physical examination findings and photo of eyes found at the end of the document.
- At **7 minutes (at the latest)**, ask the student to provide a principal (one) diagnosis and a management plan
- The station will conclude at 8 minutes.
- You have two minutes between candidates to finalise your scoring and 'reset' the station.

Aim of this station:

- Identify an ophthalmological emergency: Acute angle glaucoma
- Understand basic eye examination principles
- Understand initial management of an acute angle glaucoma

Props and Sundries

- Simulated patient
- Handwash
- Photo of eyes (left is affected)

Authors – Hiroki Hayashi and Grace Low

OSCE Score Sheet

Station 5 – Red eye history (Acute angle glaucoma)

ID Check

(please tick)

Student Name/Number.....

Examiners Name:

SP:

No.	Assessment Item (details)	PLEASE MAKE ONE TICK IN EVERY ROW						
1	Infection Control and Introduces self Appropriately washes hands before, Introduces self appropriately, Appropriately washes hands after	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		0	1	2	3			
2	History of Presenting Complaint – Ocular pain Location of pain, Onset and Timeline of pain, Character of pain, Radiation, Exacerbating/Relieving factors, Severity/Pain scale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		0	1	2	3	4	5	6
3	Associated Symptoms – Red eye Ocular discharge, Headache, Nausea/Vomiting, Trauma, Dry/Watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		0	1	2	3	4	5	
4	Associated Symptoms – Visual loss/disturbance Onset, Photophobia, Blurred vision, Preceding visual disturbance, Floaters, Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		0	1	2	3	4	5	6
5	Past Medical History Previous ocular diseases, Contact lenses, Hypertension, Type 2 Diabetes, other appropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		0	1	2	3	4	5	6
6	Other history (Max. six (6)) Family history of glaucoma, Occupation, Smoking history, Medication history, Ocular surgical history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		0	1	2	3	4	5	6
7	States appropriate examinations to perform in ED (Max. six (6)) Vitals, General inspection of eye, Visual acuity, Visual fields, Pupillary reflexes, Fundoscopy, Eye movements, Staining, Slit lamp examination, Tonometry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		0	1	2	3	4	5	6
8	Provides appropriate diagnosis Acute angle glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		0	1					
9	Provides appropriate management (Max. six (6)) Urgent ophthalmology review, Eye drops (Beta blocker/ α 2 agonist), Acetazolamide (IV/Oral), Anti-emetics, Analgesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		0	1	2	3	4	5	6
10	CLARITY Organisation, appropriate confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		1	2	3	4	5	6	7
		Confused, disorganised, unclear		Below expected		Above expected		Outstanding
12	WARMTH Engagement, compassion, care for patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		1	2	3	4	5	6	7
		Cold, uncaring, brusque		Below expected		Above expected		Outstanding

Comments:

Physical examination findings

General inspection:

- Left red eye with an oedematous cornea and a semi-dilated pupil that is non-reactive to light
- Nil foreign bodies visible
- Left eye is hard on palpation
- Right eye appears normal

Visual acuity:

- 6/12 both eyes

Pupillary reflexes:

- Left pupil semi-dilated and non-reactive
- Indirect reaction to right eye intact

Fundoscopy

- Red reflexes present
- Optic nerve head appears normal with no evidence of glaucomatous optic neuropathy

Eye movements

- Normal