GK'S NOTES 3.0

MARCH 2026 EDITION

VOLUME 2

GK's Notes 3.0 - Volume 2
March 2026 Edition
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All cases, scenarios, clinical discussions, and teaching content in this book are **entirely original works** created independently by the author(s). They are:

- Based on common UK clinical practice scenarios and consultation structures
- Informed by publicly available NHS, NICE, BNF, and GMC Good Medical Practice guidelines
- Designed to teach clinical reasoning, communication skills, and management planning in a UK healthcare context
- Written using original phrasing and independently constructed case designs

No actual PLAB 2 examination stations, candidate instructions, examiner scripts, actor scripts, marking schemes, checklists, proprietary case scenarios, or any other confidential or copyrighted GMC examination materials have been used, quoted, reproduced, referenced, or reverse-engineered in the creation of this resource.

This resource does not claim to predict, replicate, or substitute for the real PLAB 2 examination. Any similarity between the clinical scenarios in this book and actual examination content is coincidental and attributable to the shared underlying clinical guidelines (NICE, NHS, GMC) that inform both this resource and the examination itself.

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While every effort has been made to ensure clinical accuracy and alignment with current UK guidelines at the time of writing, this material is for revision and educational purposes only. It does not substitute formal clinical training, supervised practice, professional medical judgment, or official medical advice. The author(s) and publisher accept no liability for clinical outcomes or decisions arising from the use of this content.
Users are strongly encouraged to consult official NHS, NICE, and BNF guidelines regularly, as clinical recommendations evolve over time.

Patient Scenarios
All patient cases are entirely fictional. Any resemblance to real persons, living or deceased, is purely coincidental. No real patient data or identifiable clinical encounters have been used.

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

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This textbook gives you the consultation scripts, the frameworks, and the exact words to say in every PLAB 2 station.

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- **OSCE Practice Stations** - Full exam-format stations with candidate briefs, marking schemes, actor scripts, and case notes that show you exactly where marks are won and lost. Practise each one as many times as you want.

Free access to Practice Lounge - A Partner in 30 Seconds, Not 3 Days

You know the drill. You post in the WhatsApp group: "Anyone free to practise tonight?" Three people say yes. One cancels. One doesn't show. The third wants to do a different system. By the time you actually practise, you've wasted a week.

The **Practice Lounge** fixes this permanently.

Open the app. Pick your role - Doctor or Patient. Choose a system. You're matched with another candidate and connected over live audio within seconds. No scheduling. No chasing. No group politics.

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Free accounts get 9 sessions per day - 3 as Doctor, 6 as Patient. That's more daily practice than most candidates do in a week. Resets at midnight UK time, every day.

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12 essential tools - from £12.

PREPARE - Walk Into Every Station With Confidence

1. **Clinical Concept Refreshers**
   Guidelines change between editions. Examiners don't tell you which ones. These refreshers keep your clinical knowledge aligned with current best practice for every system - so you never lose marks on something you could have looked up the night before.

   Read the chapter in this textbook for how to consult. Use the refresher to make sure the clinical facts behind your consultation are still correct.

2. **Summary Notes - 500+ Cases On Your Phone**
   The entire PLAB 2 syllabus condensed into high-yield notes across all 18 systems. Each one pulls the essentials from the corresponding GK's Notes chapter into something you can revise on the bus, in a queue, or in bed at midnight.

   Not a replacement for reading. A replacement for flipping back through 1500 pages trying to find that one management step you can't quite remember.

PRACTICE - Because Reading About Consultations Doesn't Pass the Exam

3. **Practice Hub with 560+ OSCE Stations and patient scripts -**
   Every station built to mirror the real PLAB 2 format. Candidate brief. Actor script. Case notes explaining precisely where marks are gained and where they're lost.

   Stop wondering if you're ready. **Start knowing.**

4. **OSCE Evaluation Checklists - See Exactly Where Your Marks Go**
   This isn't vague "practice questions." This is you sitting down, reading the brief, doing the case, then checking the marking scheme to see whether you'd have passed. Across all systems. Mapped directly to the cases in this textbook.

5. **AI Patient - An Examiner Who Never Sleeps***
   You speak. The AI listens. It responds - naturally, in character, based on the clinical scenario. You have 8 minutes. The clock is running. There's no pause button, no hint, no "show me the answer." Just you, consulting, exactly like the real exam.

   When time runs out, you get a **detailed feedback report** across all three PLAB 2 marking domains. Not generic encouragement - specific, actionable feedback on what you said, what you missed, and what you should have done differently.

   Practise at 2 AM. The AI doesn't care. **Practise the same case six times.** It won't get tired of you. **Practise on the bus with earphones.** Nobody needs to know.

   Your subscription includes 3 sessions.
   Less than a cup of coffee per session. For feedback that used to require booking a tutor.
   *Tech Preview - Full AI Practice packs and mocks coming soon.

6. **Unlimited Practice Partners - No Caps, No Excuses**
   Premium removes the daily limit entirely. Practise 5 times. Practise 20 times. Morning, afternoon, midnight - as many sessions as you want, in any role, across any system.

   The week before your exam, this is what makes the difference. The ability to just keep going.

7. **8-Minute Timer - Every System, Every Case**
   The exam clock, available everywhere. Warning bell at 6 minutes. End bell at 8. Use it on every single case until you stop thinking about time - because the candidates who run out of time aren't the ones who know less. They're the ones who didn't train under the clock.

REVISE - The Part Where Everything Finally Sticks

8. **Rapid Review Notes - What You Actually Need to Remember**
   You've read the chapter. You've practised the case. Now strip away everything except what you need to walk into the station knowing. Key points. Critical differentials. Management steps. Nothing else.

   Open these the night before your exam. Refresh an entire system in minutes. This is the revision tool you'll wish you'd had for every exam you've ever taken.

9. **Visual Mindmaps - One Glance, One Entire System**
   Every clinical system laid out as a single connected map - cases, differentials, management plans, all linked together. Scan it. Find the branch you can't recall. That's your revision target for the next hour.

   Perfect for:
   Refreshing an entire system in one sitting
   Seeing how similar presentations differ (migraine vs. cluster vs. tension)
   Discovering gaps you didn't know existed

10. **Management Flashcards - 570+ Cards That Refuse to Let You Forget**
    Spaced repetition, done properly. Every major management plan in the PLAB 2 syllabus, tracked by an algorithm that learns what you know and what you don't. Cards you struggle with come back sooner. Cards you've mastered space out further.

    This isn't re-reading your notes and hoping it sticks. This is **active recall** - the single most effective study technique research has ever identified - applied to every management plan you need to know. The app does the scheduling. You just show up and answer.

11. **AI Learning Trends - See What the Crowd Is Doing**
    Which cases are trending this week? Which systems are getting the most practice? What are other candidates focusing on right now? Use real-time platform data to make sure you're not ignoring the topics everyone else is drilling.

12. **Medical Image Library - Train Your Eyes, Not Just Your Ears**
    Clinical images - dermatological findings, clinical photographs - for the visual diagnoses that appear in PLAB 2 stations.

    Use it until you can glance at an image and know. That's the standard.

The exam doesn't wait. Neither should you.
gksplab2.com

A Note Before You Begin

To every doctor reading this,

You already did something remarkable. You studied medicine, you qualified, and you chose one of the hardest paths a doctor can take - proving yourself all over again in a system that wasn't built with you in mind.

I won't sugarcoat what 2026 looks like for international medical graduates. The exam has changed - realigned to the MLA content map, demanding sharper clinical reasoning and deeper UK-specific thinking. PLAB 2 pass rates sit below 66%. Fees have risen. The validity window has tightened. And beyond the exam, the landscape has shifted dramatically. Over 47,000 doctors are now competing for roughly 13,000 specialty training posts. The UK Government has fast-tracked the Medical Training (Prioritisation) Bill - legislation that explicitly prioritises UK graduates for foundation and specialty training offers ahead of IMGs.

These are facts. You deserve to know them clearly.

But here's the other side of that story: over 138,000 internationally trained doctors are currently licensed and working in the UK - 42% of the entire medical workforce. The NHS doesn't just welcome international doctors. It depends on them. That hasn't changed, and it won't.

What sets you apart isn't where your degree is from. It's how you show up. The way you think through a consultation. The way you communicate with a patient. The way you safety-net, share decisions, and manage uncertainty. That's what this exam tests. And that's exactly what this book is built to teach you.

GK's Notes 3.0 is a complete rebuild from the ground up - every case, framework, and clinical discussion independently created, rooted in NHS, NICE, and GMC guidance, and designed to help you think the way this exam demands.

In the past eight months, over 4,000 candidates have used GK's PLAB 2 Study Centre to prepare - and passed. What started as a small project has grown into a community that spans countries, time zones, and exam cohorts. Doctors helping doctors. Strangers becoming study partners. People celebrating each other's passes like their own.

That community is you. And I owe you more than I can say.

To everyone who sent a message after passing, who recommended us to a friend, who showed up again after a setback - thank you. You built something far bigger than a set of notes.

Take your time with this edition. Read slowly. Think deeply. Practise out loud. And after every attempt, pause - not to judge yourself, but to learn.

The system may not be fair. But you can still be exceptional.

Trust the work. Trust yourself.

- GK

How to Use This Book

Let's get one thing out of the way.

DO NOT MEMORISE THESE NOTES.

If your plan is to highlight every line, cram fifty cases in a weekend, and walk into your station reciting someone else's words - this book isn't going to help you. Not because the content isn't good enough, but because that's not how PLAB 2 works.

This exam doesn't reward memory. It rewards thinking. It rewards doctors who can listen, respond, explain, and make decisions in real time - clearly, calmly, and with empathy. That's what this book is designed to train.

Every case is written in a natural, conversational style - not so you can repeat it word for word, but so you can absorb the rhythm of a safe, structured UK consultation and learn to speak in your own voice with confidence.

What This Book Is

This is a structured, station-by-station guide to PLAB 2. Every case is built around realistic clinical scenarios, aligned with current NHS, NICE, and GMC guidance, and designed to help you develop three things: clinical reasoning, consultation structure, and the language to tie them together. It's a resource that trains your logic, sharpens your communication, and prepares you to make sound decisions under time pressure.

What This Book Is Not

It is not a script bank. It is not a shortcut. It is not a rehash of academy slides or lecture transcripts. And it is not something to read cover to cover in silence the night before your exam.

How to Get the Most Out of It

1. Speak it out loud. Every single time. Set a timer. Record yourself. Practise with a partner or solo - but never just read silently and move on. PLAB 2 is a spoken exam. Your preparation should be too.

2. Learn the structure, not the sentences. Every case follows a logical consultation flow - opening, history, screening, ICE, explanation, plan, safety netting. These are your anchor points, not your script. Understand the steps, then express them in your own words.

3. Don't try to say everything. The cases here are written in detail so you can understand the full picture. You are not expected to cover every point in an eight-minute station. In the exam, clear and focused communication will always beat trying to say it all. If you need a quicker revision pass before your exam, the **summary notes and rapid review notes on gksplab2.com** are built for exactly that - distilling each case down to what matters most.

4. Don't be overwhelmed by the size. This is a comprehensive book - deliberately so. The detail exists to deepen your understanding, not to burden your memory. Take it one case at a time. Quality over quantity, always.

5. Repeat before you move on. Master a few cases deeply. Then come back to them. Repetition builds fluency. Your goal isn't to finish the book - it's to learn from it.

6. Pair it with active revision tools. Reading alone isn't enough. The most successful candidates combine spoken practice with visual and active recall methods. The **management flashcards, mind maps, and image library on gksplab2.com** are designed to work alongside this book - reinforcing key decisions, counselling phrases, and clinical patterns so they stick under exam pressure.

7. Test yourself with real station practice. Once you're comfortable with a case, try it under timed conditions. The **companion OSCE cases on gksplab2.com** give you a chance to simulate the exam experience - complete with candidate briefs and marking guidance - so you can identify gaps before exam day does it for you.

8. Use it however you study best. Whether you're attending a course, working with a study group, or preparing independently, these notes are built to give you a clean, solid foundation. They'll help you cut through the noise and focus on what actually matters in a station.

Staying Up to Date

PLAB 2 is a constantly evolving exam. Core stations reappear frequently, but new scenarios are introduced regularly - often with different angles, emotional tones, or ethical dimensions.

GK's Notes 3.0 is built to evolve with it.

This resource is updated multiple times a year, incorporating new case patterns, refined phrasing, and structural improvements. Always ensure you are working from the latest version. All updates, new cases, and the full suite of revision tools - including summary notes, rapid reviews, flashcards, mind maps, OSCE companions, and the image library - are available at **www.gksplab2.com**.

A Note on Accuracy

This book is the product of considerable time, care, and clinical attention - with the goal of helping as many candidates as possible prepare with confidence. Every case has been written with close attention to accuracy and alignment with current guidance.

That said, medicine evolves. Guidelines are updated. And despite every effort, no resource is immune to the occasional error.

If something seems unclear, outdated, or inconsistent - please verify it against trusted sources such as NICE, NHS CKS, or BNF. These should always be your primary reference for clinical reasoning and management decisions.

And if you do spot an error, I'd be genuinely grateful if you let me know directly. Every correction strengthens the next edition - and helps every candidate who comes after you. Email at gksplab2@gmail.com

Thank you for being part of making this resource better.

Table of Contents

CHAPTER 12: EAR, NOSE AND THROAT 6

Structure for Ear-Related Presentations 7
Acute Otitis Media (AOM) 9
Impacted Ear Wax 12
Earwax Follow-Up with Ongoing Hearing Loss 14
Acoustic Neuroma (Vestibular Schwannoma) 16
Acoustic Neuroma (Vestibular Schwannoma) in an Elderly Patient 18
Cholesteatoma 20
Malignant (Necrotising) Otitis Externa 22
Benign Tinnitus 24
Unilateral Hearing Loss - SNHL 27
Introduction to Dizziness Stations 29
Vestibular Neuritis 30
Benign Paroxysmal Positional Vertigo (BPPV) 32
Ménière's Disease 34
Epistaxis 36
Recurrent Nosebleeds While on Apixaban 39
Neck Lump – Suspected Cancer 41
Allergic Rhinitis 43
Unilateral Nasal Polyp – Suspected Cancer 46
Suspected Laryngeal Cancer 48
Infectious Mononucleosis (Glandular Fever) 50
Acute Tonsillitis 52

CHAPTER 13: OPHTHALMOLOGY 56

Introduction to Eye Stations 57
General History and Examination Structure for Eye Stations 58
Retinal Detachment 60
Diabetic Retinopathy 63
Hypertensive Retinopathy 65
Toxoplasmosis 69
Ocular Herpes (Herpes Simplex Keratitis) 71
Age-Related Macular Degeneration (ARMD) 73
Acute Angle-Closure Glaucoma 76
Chronic Open-Angle Glaucoma 78
Cataract 80
Optic Neuritis 83
Subconjunctival Haemorrhage 85
Conjunctivitis 87
Contact Lens-Associated Keratitis 89
Scleritis 92
Blepharitis 94
Hordeolum on a background of Blepharitis 97
Arcus Senilis 100
Giant Cell Arteritis (GCA) with Vision Loss 102
Pituitary Adenoma (Bitemporal Hemianopia) 105

CHAPTER 14: DERMATOLOGY 109

Dermatology - General Structure 110
Suspected Basal Cell Carcinoma (BCC) 112
Suspected Squamous Cell Carcinoma (SCC) 114
Suspected Melanoma 116
Suspected Melanoma (Mimicking Verruca) 118

Talon Noir (Black Heel) 120
Seborrheic Keratosis 126
Cholinergic Urticaria 127
Acne Vulgaris 129
Impetigo 131
Herpes Labialis (Cold Sore) 133
Measles 134
Cellulitis 136
Chickenpox (Varicella) 138
Paronychia 140
Psoriasis 142
Erythema Nodosum 144
Lyme Disease (Erythema Migrans) 146
Folliculitis 148
Intertrigo 149
Cherry Angiomas 150
Haemangioma 151
Molluscum Contagiosum 152
Herpetic Whitlow 153
Tinea Manuum 154
Tinea Capitis 156
Tinea Pedis 157
Oral Candidiasis (Child) 158
Oral Candidiasis (Older Adult) 160
Scabies 161
Scabies in Child 162
Mole - Requesting Removal 163
Mole - Worried About Cancer 164
Cradle Cap (Infantile Seborrheic Dermatitis) 166
Head Lice (Pediculosis Capitis) 167
Primary Focal Hyperhidrosis 168
Contact Dermatitis 170
Eczema (Atopic Dermatitis) 171
Venous Ulcer 173
Non-Healing Venous Ulcer 175
Onychomycosis 175
Erythema ab igne 178

CHAPTER 15: PAEDIATRICS 181

Paediatric History-Taking Structure 182
Intussusception 183
Constipation Follow-Up 186
Diarrhoea in a One-Year-Old 188
Foreign Body Ingestion 191
Infant on Triage Call 193
Viral Illness with Dehydration Concern 196
Suspected Appendicitis 197
Antibiotic Request for Viral Infection 199
Scarlet Fever 201
Kawasaki Disease 205
Chickenpox 209
Tonsillitis in a 5-Year-Old 212
Teething 215
UTI in a Child 217
Resistant UTI - Test Result Discussion 219
Bronchiolitis 222
Asthma Counselling 225

Exacerbation of Asthma 228
Febrile Seizure 229
Autism Spectrum Disorder 232
Follow-Up: Autism Spectrum Disorder 235
Developmental Delay in Walking 238
Night Terrors 240
Temper Tantrums 242
Primary Nocturnal Enuresis 244
Nocturnal Enuresis in Older Child 246
Head Injury 249
Type 1 Diabetes Mellitus 252
Needlestick Injury in a Child 254
Bilateral Congenital Cataract 257

CHAPTER 16: WOMEN'S HEALTH 262

Structure of an Obstetric & Gynaecological History 263
Missed Miscarriage 264
Incomplete Abortion 267
Teenage Pregnancy with Vomiting 268
Hyperemesis Gravidarum 270
Pre-eclampsia 273
Pre-eclampsia (24-week Primi with Headache and Proteinuria) 276
Ectopic Pregnancy 280
Ectopic Pregnancy in EPU 281
Chronic Anal Fissure in Pregnancy 282
Low-Lying Placenta – Test Result Discussion 285
Urinary Tract Infection (UTI) in Pregnancy 286
Chickenpox Exposure at 36 Weeks 289
Genital Herpes in Pregnancy 291
First Antenatal Care Visit 294
Antenatal Checkup - Lifestyle Risks 296
Antenatal Checkup – Rubella Non-Immune & Rhesus Negative (14 Weeks Pregnant) 299
Breech Presentation (34 Weeks) 300
Breech Presentation at 36 Weeks 303
Endometritis 305
Variation: Late Postpartum Presentation (e.g., 3 weeks post C-section) 308
Emergency Contraception Request – Learning Disability 308
Emergency Contraception Request – Epilepsy Patient 311
Minor Requesting Contraception 314
Minor Requesting Oral Contraceptive – Safeguarding 316
Requesting COCP Repeat for Period Delay 318
Retained Tampon 321
Vulvovaginal Candidiasis 322
Bacterial Vaginosis 324
Persistent Dysuria 326
Pelvic Inflammatory Disease (PID) 328
PID Presentation in GP Setting (Mild to Moderate) 331
PID Presentation in A&E Setting (Severe) 331
Gonorrhoea Positive Test Result 332
Breast Lump 334
Breast Engorgement 336
Mastitis 338
Mastitis - Alternate Scenario 341
Heavy Menstrual Bleeding (Menorrhagia) 342
Primary Dysmenorrhoea 344
Uterine Fibroids 346
Endometriosis 348

Premenstrual Syndrome (PMS) 351
Premature Ovarian Insufficiency (POI) 352
Perimenopause / Menopause 355
Atrophic Vaginitis 357
Atrophic Vaginitis WITH Bleeding/Pain After Intercourse *359*
Uterine Prolapse 361
Stress Incontinence 363
Stress Incontinence with Uterine Prolapse 366
Urge Incontinence (Overactive Bladder Syndrome) 368
Mixed Urinary Incontinence 371
Postmenopausal Bleeding 373
Suspected Endometrial Cancer 375
Suspected Ovarian Cancer 378
Suspected Vulval Carcinoma 381
Genital Warts in a Minor (Safeguarding) 383
Missed Cervical Screening 385
Cervical Screening Result - HPV Positive with Normal Cytology 387
Variation: Mild Dyskaryosis *390*
Antenatal Visit — HIV-Positive Woman 393
Dyspareunia 396
Post-Lumpectomy Lump 399
Red Flag Pitfalls Section - Women's Health 401

CHAPTER 17: PSYCHIATRY 403

Schizophrenia 406
Depression 410
Case 1: Mild Depression *412*
Case 2: Mild Depression *413*
Case 3: Mild Depression *413*
Case 4: Moderate Depression *414*
Case 5: Moderate Depression - Post-MI *415*
Case 6: Severe Depression *415*
Case 7: Moderate Depression - Relapse After Stopping Sertraline *416*
Case 8: Depression Follow-up - CBT Not Working *417*
Case 9: Postnatal Depression *419*
Work-Related Stress 421
FGM Safeguarding Concern — Low Mood in Teenager 423
Self-Harm 426
Case 1: Wrist Cutting + OCP Overdose *426*
Case 2: Paracetamol Overdose *428*
Case 3: Paracetamol Overdose (20 Tablets, Recent Ingestion) *429*
Drug Addiction 430
Alcohol Misuse 433
Case 1: Incidental Finding During OBG Consultation *433*
Case 2: Alcohol Withdrawal - Self-Referred Patient *435*
Insomnia 436
Case 1: Insomnia - Bereavement *436*
Case 2: Requesting Sleeping Pills *438*
Case 3: Insomnia with Tiredness *438*
Anorexia Nervosa 441
Bulimia Nervosa 444
Health Anxiety 446
Somatic Symptom Disorder 448
Attention Deficit Hyperactivity Disorder (ADHD) 450
Obsessive-Compulsive Disorder (OCD) 453
Post-Traumatic Stress Disorder (PTSD) 456
Generalized Anxiety Disorder (GAD) 459

Erectile Dysfunction in a Patient with Depression 463
Performance Anxiety 464
Psychiatry - Red Flags, Pitfalls, and Exam Cautions 467

Chapter 12: Ear, Nose and Throat

A Note to Learners

The cases in this resource are written in a conversational style to help you become familiar with the natural flow of clinical consultations and the language commonly used in UK healthcare settings.

These dialogues are intended as a learning guide, not a script. Please do not attempt to memorise them verbatim. Examiners assess your ability to think and communicate authentically - not to recite rehearsed phrases.

Use this material to understand the underlying clinical reasoning, then practise in your own words until the consultation feels natural to you.

For Companion OSCE Cases, Practice Scripts, Evaluation Checklists, Summary Notes, Rapid Review Notes, Mindmaps, Management Flashcards and Image Library including Otoscope findings - visit https://www.gksplab2.com

Disclaimer
This material is independent educational content created to help candidates develop clinical reasoning and communication skills for UK medical practice.

All cases and clinical scenarios are based on common presentations encountered in UK primary care and emergency medicine, drawn from publicly available sources including NICE Clinical Knowledge Summaries (CKS), BNF, and other official NHS/UK healthcare guidelines.

No content in this resource is derived from, represents, or claims to replicate actual GMC PLAB 2 examination material.

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

- **P**ast medical conditions – recurrent infections, eczema, diabetes, immunosuppression
- **M**edications – ototoxic drugs (aminoglycosides, loop diuretics)
- **A**llergies – especially to ear drops
- **F**amily history – hearing problems, Meniere's
- **T**obacco – smoking (risk for infections and malignancy)
- **O**ccupation – noisy environments, water exposure, scaffolder
- **S**ocial – alcohol, swimming, earphone habits, hygiene
- **A**lcohol – 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?"

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?"

General Observations Look for fever, facial asymmetry, distress, walking instability

Inspection of the Ears Look for:
- Redness or swelling
- Discharge
- Deformity or scars
- Skin rashes or eczema
- Behind the ear for mastoid swelling

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

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.

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

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

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?"

Acute Otitis Media (AOM)

Scenario: Primary Care Setting | Patient with Acute Ear Pain | Variable Duration | Consider Discharge, Perforation, Allergy Variants

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

Diagnosis	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

PMAFTOSA

- **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?"

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

Inspection

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

Palpation "Let me know if this feels tender."

- Tragus
- Pinna
- Mastoid area

If tragus or pinna is tender → likely otitis externa

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)

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
- Consider **phenazone with lidocaine ear drops** (e.g., Otigo) for pain relief if no immediate antibiotic is given and there's no eardrum perforation or discharge.

5 or more days of symptoms → *Give antibiotics*

- **Amoxicillin 500 mg TDS, 5-7 days**
- **If allergic** → Clarithromycin 500 mg BD, 5-7 days

If symptoms worsen after 2-3 days on amoxicillin → switch to **co-amoxiclav** for 5-7 days.

Note: *Most cases of AOM are self-limiting. NICE recommends a no-antibiotic or* ***back-up (delayed) antibiotic*** *strategy for most patients. Offer immediate antibiotics if the patient is systemically very unwell, has signs of serious illness, or is at high risk of complications. Review after 3 days if not improving.*

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*

Children under 2 years with bilateral AOM → *Offer immediate 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)

"I know it's worrying when your child is in pain. Most ear infections in children are caused by viruses, which means antibiotics won't help and could actually cause side effects like diarrhoea or tummy upset. 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. Sometimes the pain can feel a bit worse over the next day or two before it starts to settle – that's normal and doesn't mean anything's wrong."
"Does that make sense so far? Any questions before I continue?"

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 or redness **behind** the ear (which could indicate mastoiditis)."

Follow-Up & Leaflet
- GP review in 2–3 days if no improvement
- Leaflet on AOM (explanation + pain management)

Impacted Ear Wax

Scenario: Primary Care Setting | Adult with Unilateral Hearing Difficulty | Gradual Onset | Consider Lifestyle Factors and Removal Options

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?"

PMAFTOSA, Impact
- **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

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: "I know it seems like cotton buds should help, but they actually tend to push the wax deeper in – a bit like trying to clean a tube with something that's bigger than the opening."
If swimmer: "Water can get trapped behind wax and cause it to swell, worsening the blockage."

Management Plan
Step 1 – Softening Drops "I know you'd probably like it sorted today, but we've found that softening the wax first makes removal much safer and more comfortable. You can use either:
- **Sodium bicarbonate 5% drops** - 3–4 drops, twice daily for 3–5 days, or
- **Olive or almond oil** - 2–3 drops, twice daily for 3–5 days. Use for 3–5 days before review.

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 **electronic water irrigation** or **microsuction**, either at the surgery or with a specialist."
Note: Electronic water irrigation is the appropriate method – not manual syringing (which is no longer recommended).

Absolute Contraindications to Ear Irrigation:
- **Cleft palate** (repaired or not)
- **Previous mastoid surgery** or mastoid cavity
- Current or recent **tympanic membrane perforation**
- **Grommets** in place
- Active ear infection (otitis externa or media)
- History of ear surgery (e.g., stapedectomy)

Important: For patients with **diabetes** or **weakened immune systems**, irrigation should be avoided due to increased infection risk. Microsuction is safer in these patients.

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

Scenario: Primary Care Setting | Follow-Up Visit | Adult with Persistent Hearing Difficulty Despite Initial Treatment | Consider Residual Obstruction vs Sensorineural Cause

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?"

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 **electronic water 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."
"In rare cases, there can be a small growth near the hearing nerve called a **vestibular schwannoma** – it's almost always benign, meaning not cancer, but we do want to check to rule it out."
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:
If hearing loss developed **suddenly within the last 30 days** (over 72 hours or less), this is a **medical emergency** – refer immediately to be seen within **24 hours**.

- Rapidly progressive hearing loss (4-90 days) → **Urgent ENT within 2 weeks**
- Gradual unilateral hearing loss → **Routine ENT referral** (not 2WW unless red flags)

Investigations ENT may arrange:

- Urgent audiometry (hearing test)
- **MRI scan** to rule out vestibular schwannoma
- **If SNHL diagnosed early** → oral **steroids** may improve recovery
- **If vestibular schwannoma 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 (Vestibular Schwannoma)

Scenario: Primary Care Setting | Middle-Aged Adult | Gradual Unilateral Hearing Difficulty | Occupational Context Involving Prolonged Telephone Use | Family History of Relevant Genetic Condition

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 – (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?" *If yes:* "Is the sound like a constant tone, or does it pulse like a heartbeat?" (Pulsatile tinnitus suggests vascular cause – different workup needed) "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?"

PMAFTOSA + 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

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
Vestibular schwannoma (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 possibility we want to check for is something called a **vestibular schwannoma** – sometimes called an acoustic neuroma. It's a **benign growth**, which means it's not cancer, but it can affect hearing and balance if it grows."
"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."

Note for student: *If family history of NF2, bilateral vestibular schwannomas are possible.*

Management
ENT Referral "I'll arrange an ENT referral to get this looked at thoroughly. Given your symptoms and family history, we want this assessed promptly."

Note: *Vestibular schwannoma is* ***benign****. The 2-week wait pathway is reserved for* ***suspected malignancy****. Routine ENT referral is appropriate unless there are features suggesting malignancy (e.g., cranial nerve involvement, rapid progression).*

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 a vestibular schwannoma, 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 **vestibular schwannoma (acoustic neuroma)**
"Do you feel okay with the plan? Any other questions before we finish?"

Acoustic Neuroma (Vestibular Schwannoma) in an Elderly Patient

Scenario: Primary Care Setting | Older Adult | Unilateral Tinnitus with Associated Hearing Change | Family History of Relevant Genetic Condition

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 – (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

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
Vestibular schwannoma (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 **vestibular schwannoma** (sometimes 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 to have this properly assessed. Given your symptoms, we want to make sure we don't miss anything important."

Note: *Vestibular schwannoma is* ***benign****. Routine ENT referral is appropriate – the 2-week wait pathway is reserved for* ***suspected malignancy****, not benign tumours.*

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 a vestibular schwannoma, ENT may recommend **monitoring**, **surgical removal**, or other treatments based on its size and effects."

If vestibular schwannoma 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 **vestibular schwannoma (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: Primary Care Setting | Older Adult | Chronic Ear Discharge with Reduced Hearing | History of Previous Ear Pathology

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 – (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."

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**."

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."

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Management
ENT Referral "I'll arrange an urgent referral to an ENT specialist. This isn't cancer, but it does need to be dealt with sooner rather than later to prevent complications."

Note: *Cholesteatoma is* ***not malignant*** *– it should be referred as* ***urgent ENT*** *but not via the 2-week wait cancer pathway.*

Investigations "They'll likely order:
- A **hearing test**
- **High-resolution CT (HRCT)** of the temporal bone to assess disease extent and plan surgery– and possibly an **MRI** if they need more detail about the soft tissues"

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 (Necrotising) Otitis Externa

Scenario: Primary Care/A&E Setting | Adult with Severe Ear Pain and Swelling | Immunocompromised with Diabetes and Immunosuppressive Medication | Consider Invasive Infection

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
"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."

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)

Otoscopy Stabilize, pull pinna up and back → **Findings (given by examiner)**:
- External canal: **swollen with pus**
- Tympanic membrane: **red, inflamed**

Differential Diagnosis

Diagnosis	Supporting Features
Necrotising (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 **necrotising otitis externa** (sometimes called 'malignant otitis externa')."
"The word 'malignant' can sound scary, but I want to reassure you this doesn't mean cancer. In this context, it's an older term that means the infection is aggressive and needs proper treatment to stop it spreading."
"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."

Note: *The modern preferred terminology is* ***necrotising otitis externa*** *rather than "malignant" to avoid confusion with cancer.*

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 **ciprofloxacin** 750 mg twice daily. Treatment is prolonged — typically up to 3 months, guided by clinical and radiological response. **IV antibiotics (e.g., ceftazidime)** if oral therapy not tolerated or disease is severe.
- They may also **clean and dress your ear**, which is called toileting"

Note: *Fluoroquinolones (e.g., ciprofloxacin) carry MHRA warnings about tendon damage and other serious side effects. However, in necrotising otitis externa, the benefits outweigh these risks. Necrotising OE is most commonly caused by Pseudomonas aeruginosa (80–90% of cases).*

"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: Primary Care Setting | Middle-Aged Adult | Unilateral Tinnitus | Occupational Noise Exposure History

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, occupational noise, no red flags
Earwax	Blocked sensation, otoscopy shows wax
Ménière's disease	Episodic vertigo + hearing loss + tinnitus
Vestibular schwannoma	Unilateral SNHL + tinnitus + imbalance
Ototoxicity	Recent ototoxic medications

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
Because your tinnitus is only on one side, I'd like to arrange an **ENT referral** to rule out any underlying causes. One-sided tinnitus can sometimes – rarely – be a sign of something that needs investigation, so we want to be thorough.

Lifestyle Advice "In the meantime, 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."

Cognitive Behavioural Therapy (CBT) "If tinnitus persists and affects your quality of life, **cognitive behavioural therapy (CBT)** can be very helpful – it teaches techniques to manage the impact of tinnitus on daily life."

Note: The recommended psychological intervention for tinnitus-related distress is: (1) digital CBT (preferred where available), (2) group CBT, (3) individual CBT. No pharmacological treatment is recommended by NICE for tinnitus.

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."

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: ENT referral given unilateral nature; lifestyle adjustments in meantime 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: Primary Care Setting | Older Adult | Progressive Unilateral Hearing Loss Over One Year | Occupational Noise History

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?"

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?"

General Observations: No fever, facial asymmetry, or signs of distress
Otoscopy (performed): Both tympanic membranes intact, no wax, no discharge, no redness or swelling

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**

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 a **vestibular schwannoma** (acoustic neuroma)."

Management Plan
ENT Referral – Routine Pathway "I'll arrange an ENT referral so we can investigate this properly. One-sided hearing loss does need looking into, though I want to reassure you this doesn't mean we're worried about anything serious – we just want to find the cause."
Note for student: NICE NG98 states unilateral/asymmetric hearing loss warrants **routine referral** to ENT. The 2WW cancer pathway is only indicated for adults of Chinese or South-East Asian origin with hearing loss AND a unilateral middle ear effusion (nasopharyngeal carcinoma risk).

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

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

Treatment Options (Based on Results) "If the cause is benign but permanent, hearing aids may improve hearing." "In rare cases like a vestibular schwannoma, ENT may recommend **surgical treatment**." "Most causes are slow-growing and manageable if caught early."

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."

Introduction to Dizziness Stations

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	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

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Vestibular Neuritis

Setting: Emergency Department | **Presentation:** Adult Patient with Acute Continuous Vertigo and Systemic Symptoms | Ambulance Attendance

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*

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*

Note: In A&E, if a trained clinician is available, a **HINTS test** (Head-Impulse, Nystagmus, Test-of-Skew) may be performed to help differentiate peripheral from central causes of acute vestibular syndrome.

PMAFTOSA

- **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 one of the nerves deep inside your ear – the one responsible for balance. Think of it like your balance sensor sending confused signals temporarily. Usually this happens 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 feel significantly better within 2–4 weeks, though some mild unsteadiness can linger a bit longer."

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 (50 mg IM) or** Prochlorperazine **5–10 mg IM/IV** 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. Corticosteroids "Corticosteroids are **not routinely recommended** for vestibular neuritis. Current evidence (including Cochrane reviews) shows they do not significantly improve symptoms or long-term recovery."

D. Driving & Safety "Please don't drive or operate heavy machinery until the dizziness has fully resolved."
"You may need to notify the DVLA if your symptoms are sudden, disabling, or likely to recur – I can give you guidance on that."

E. Recovery & Prognosis "Vestibular neuritis usually improves gradually over **2–6 weeks**. You may feel a bit unsteady for some time even after the spinning stops."

F. Follow-Up Plan "If symptoms don't start improving after **1 week**, or haven't resolved by **6 weeks**, referral for **vestibular rehabilitation therapy** should be arranged. 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: Primary Care | **Presentation:** Middle-Aged Adult with Episodic Positional Vertigo | Occupational Safety Considerations

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?"

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*

PMAFTOSA + 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."
"Because this is a mechanical problem – tiny crystals in the wrong place – medication won't fix it. The good news is, a simple repositioning manoeuvre usually works really well."

Management
A. Epley Manoeuvre "The treatment for BPPV is a simple head movement procedure called the **Epley manoeuvre**. We can do this today, or if needed, I can refer you to ENT or a vestibular physiotherapist."
[Note for candidate: NICE CKS states Epley manoeuvre can be performed immediately if Dix-Hallpike is positive, provided the clinician is trained. If you are not trained, refer appropriately.]

B. 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"

C. Home Exercises "I can also show you some exercises you can do at home (Brandt-Daroff exercises) which may help between appointments."

D. 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."

E. Recurrence Information "BPPV can sometimes come back – if it does, the same treatment works again."

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

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: Primary Care | **Presentation:** Middle-Aged Adult with Episodic Vertigo and Fluctuating Auditory Symptoms | Impact on Work and Driving

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*

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 your ears?" → *Yes, during attacks* "Any pressure or fullness in the ear?" → *Yes, before episodes* "Any nausea or vomiting during the attacks?" → *Yes*
P – Progression "Are the attacks becoming more frequent or severe?"
A – Aggravating factors "Is there anything that seems to trigger the attacks?"
R – Relieving factors "Anything that helps during an episode?"
A – Associated impact "How have the attacks been affecting your work and daily life?"

PMAFTOSA

- **P**: No significant past medical history
- **M**: No regular medications
- **A**: No known allergies
- **F**: No family history of ear conditions
- **T**: No smoking; occasional alcohol
- **O**: Works in off-license shop, on feet all day
- **S**: Concerned about unpredictable attacks affecting work

ICE
Idea: "I thought it might be something with my ear" *Concern*: "Worried I won't be able to work if this continues" *Expectation*: "Hoping for something to stop the attacks"

Examination
"I'd like to examine your ears and check your balance."
Otoscopy: Normal bilaterally **Dix-Hallpike**: Negative (rules out BPPV) **Hearing assessment**: May show fluctuating low-frequency hearing loss

Diagnosis
"Based on your symptoms-the episodic vertigo lasting hours, fluctuating hearing, ringing in the ear, and fullness before attacks-this sounds like **Ménière's disease**."

Explanation
"I know it must be frustrating – not being able to work and not knowing when the next attack might come. The condition itself isn't dangerous, but I completely understand how disruptive it is."
"Ménière's disease is caused by a build-up of fluid in the inner ear, which affects both your balance and hearing. It causes episodes of spinning (vertigo) that can last from 20 minutes to several hours, often with hearing changes, ringing, and a feeling of pressure in the ear."
"The good news is that for most people – around two-thirds – the attacks become less frequent and less severe over time. Some people go months or even years between episodes."

Management
A. Acute Attack Management "For an acute attack, we can prescribe **prochlorperazine** (buccal tablet) which helps control the nausea and dizziness."

B. Preventive Medication "To try to reduce the frequency and severity of attacks, I'll prescribe **betahistine 16mg three times daily**."

Note: Betahistine should be trialled for at least 3 months (and up to 6 months) before assessing effectiveness. If no improvement or ongoing significant impairment, we will explore vestibular rehabilitation therapy.

C. Lifestyle Modifications "There are also some lifestyle changes that may help reduce attacks:

- **Reduce salt intake** – this may help with fluid balance in the inner ear
- **Cut back on caffeine** (coffee, tea, energy drinks)
- **Stay well hydrated** – aim for about 2 litres of water per day
- **Manage stress** where possible, as this can trigger attacks"

D. ENT Referral "I'll also refer you urgently to an **ENT specialist** to confirm the diagnosis and arrange a formal hearing test. They can also discuss other treatment options if the medications don't help."

E. Driving Advice "Unfortunately, because of the sudden nature of the vertigo attacks, you **must stop driving** for now. You'll also need to **inform the DVLA**. They'll guide you on when it's safe to return."

F. 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."

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?"

Epistaxis

Setting: Primary Care
Patient: Older Adult
Presenting Complaint: Recurrent epistaxis

1. Introduction & Consent
- Greet, confirm name and DOB.
- "I understand you've come in today because you've been having nosebleeds. I'll ask you some questions to figure out what's causing it and how we can manage it. Is that okay?"

2. History of Presenting Complaint
A. Details of Nosebleeds:
- "When did the nosebleeds start?" *(Expected: about a week ago)*
- "How many times has it happened since then?" *(Expected: 3-4 times – once last week, twice yesterday, once today)*
- "How long does each episode last?" *(Seconds to minutes)*
- "Does it start suddenly?" *(Expected: Yes)*
- "Does anything seem to trigger it? Like blowing your nose, sneezing, or trauma?" *(Expected: No – spontaneous)*
- "Is it a lot of blood, or just a small amount?"

- "How do you usually stop the bleeding? What do you do when it happens?" *(Check if incorrect methods like tilting head back are used)*
- "Have you needed to go to hospital or get any medical help for this?"

B. Associated Symptoms / Red Flags:

- "Apart from the nose, have you noticed any other bleeding?"
  - "Any blood in urine, stools, or when coughing?"
  - "Any new bruises or marks on your skin?"
- "Any headaches, particularly in the morning?" *(Screen for hypertension or raised ICP)*
- "Any vision problems, ear pain, or blocked sensation?"
- "Have you felt unusually tired or fatigued lately?" *(Screen for possible anaemia or malignancy)*

3. Medical History Review

- "Have you ever been told you have high blood pressure?" *(Important in elderly epistaxis)*
- "Any previous problems with your nose — like nasal polyps, infections, or surgery?"
- "Do you have any bleeding disorders diagnosed in the past?"
- "Any history of blood vessel problems or frequent bleeding before?"

4. Family History

- "Any family history of bleeding problems, clotting disorders, or nose issues?"

5. Medications Review

- "Are you taking any medications that might affect bleeding, like aspirin, clopidogrel, warfarin, rivaroxaban, or apixaban?"
- "Any recent changes in your medications?" *(Check especially for anticoagulants or antiplatelets.)*

6. Lifestyle and Environmental Triggers

- "Do you notice if it happens more in dry, hot, or cold weather?"
- "Any recent travel or exposure to dry air or heating?" *(Dry air can irritate nasal mucosa.)*
- "Do you use nasal sprays or decongestants?" *(These can cause mucosal dryness.)*

7. ICE — Ideas, Concerns, Expectations

- **Ideas:** "What do you think might be causing these nosebleeds?" *(Likely: 'I have no idea', 'Maybe my age')*
- **Concerns:** "Is there anything you're particularly worried about today?" *(May say: 'Worried it's something serious or cancer')*
- **Expectations:** "What were you hoping I could help you with today?" *(Likely: 'Stop this from happening again')*

8. Focused Examination

- "I'd like to check you over to help figure this out. I'll check your blood pressure, have a look at your nose for any visible bleeding points or crusting, and may check your ears and throat as well."

What we examine:

- **Vitals:** BP (Check for hypertension — important to emphasise this as hypertension is a common association), HR, oxygen, temperature.
- **Nose:** Visible active bleed, crusting, signs of trauma, nasal septum (Little's area).
- **Ears & Throat:** Check for concurrent infection or blood tracking.
- **General:** Look for bruises, pallor (anaemia), or any signs of systemic bleeding.

9. Diagnosis with Explanation

- **Provisional Diagnosis:** Recurrent spontaneous epistaxis — likely from fragile blood vessels in the front of the nose (Little's area).

- **Explanation:**

"Inside everyone's nose — right at the front of the dividing wall — there's an area packed with tiny blood vessels. In some people, especially as we get older, these can become quite fragile and prone to bleeding. This area is called Little's area, though there's nothing 'little' about the problems it can cause!
It's common, especially in elderly people, and usually not serious but we do need to manage it to stop it from recurring."

10. Management Plan

A. Immediate Advice — How to Manage an Episode:

- "When the bleeding starts, sit upright and lean slightly forward."
- "Pinch the soft part of your nose (just below the bone) firmly for 10-15 minutes without letting go." *(Demonstrate)*
- "Breathe through your mouth while doing this."
- "Do not tilt your head back — that can make the blood go to your throat and cause coughing or vomiting."
- "If it doesn't stop after 15 minutes, you should go to A&E immediately."

B. Prevention Advice:

- "Avoid blowing or picking your nose."
- "Keep your nails trimmed short to avoid scratching inside the nose."
- "Apply Vaseline or use saline nasal sprays regularly to keep the inside of your nose moist, especially in dry weather."
- "Avoid very hot or cold environments."
- "Avoid lifting heavy weights or straining."
- "Avoid alcohol, and do not take NSAIDs like ibuprofen or aspirin unless prescribed." *(If on blood thinners, discuss whether GP review is needed.)*

C. Medication:

ALLERGY CHECK — CRITICAL SAFETY POINT: Before prescribing Naseptin, you MUST ask: "Do you have any allergies to peanuts or soya?" This is a classic exam "red herring" — failure to verbalise this check can fail the Safety domain.

- Prescribe **Naseptin nasal cream** (antibiotic with moisturizing effect). Apply inside the nose 2–4 times a day for 7–10 days.
- **If allergic to peanuts/soya (Naseptin contraindicated), use Mupirocin nasal ointment or plain Vaseline instead.**

D. Tranexamic Acid Option :

- For significant bleeding while awaiting hospital transfer, **oral tranexamic acid 1g** can be considered to help control bleeding.

Important context: In a GP setting with active bleeding that won't stop after 15-20 minutes of proper pressure technique, the priority is transfer to A&E rather than waiting for oral medications to work. Use TXA primarily if:

- Hospital transfer will be significantly delayed
- Bleeding is troublesome but not severe enough for immediate A&E
- Patient has recurrent problematic epistaxis (prophylactic use)

E. When to Go to Hospital:

- "If the bleeding is heavy and doesn't stop after 15–20 minutes of pinching, or if it happens multiple times a day, please go directly to A&E."
- "In the hospital, they might use nasal packing (gauze or special balloon) or a procedure called cauterization to seal the blood vessels."

F. Cautery in Primary Care:

- Nasal cautery can be performed in primary care if appropriate expertise and facilities are available, and a bleeding point is visible. Important: never cauterise both sides of the nasal septum at the same time as this increases the risk of septal perforation.

FY2 Note: *Nasal cautery should only be performed if you have been trained and are supervised. If uncertain, refer to ENT rather than attempting cautery.*

11. Safety Net Advice

- "If you notice any other unusual bleeding like in your urine, stool, when coughing, or unusual bruising, please contact us immediately."
- "Also come back if the nosebleeds become more frequent, heavier, or last longer than before."
- "If you feel faint, dizzy, or weak during an episode, sit down and call for help."

12. Follow-Up Plan

- Book a follow-up appointment in **2 weeks** to review how things are progressing.
- If no improvement or worsening, refer to **ENT for further evaluation and possible nasal cauterization.**
- Provide a **patient information leaflet** on nosebleeds with first aid steps clearly shown.
- Check blood pressure today, and if high, arrange follow-up or initiate BP management.

Recurrent Nosebleeds While on Apixaban

Setting: Primary Care | **Presentation:** Adult on Anticoagulation Presenting with Recurrent Epistaxis | History of Nasal Trauma

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
"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)
- **Blood pressure and pulse** – essential in all epistaxis patients, especially those on anticoagulants

Important: Uncontrolled hypertension is a major cause of recurrent epistaxis. Do not discharge a patient without checking and addressing elevated BP.

Provisional Diagnosis: Recurrent anterior epistaxis (nosebleed) likely caused by nasal trauma while on apixaban.

Explanation
"I know it can be quite alarming to see that much blood, but the good news is there's no need for urgent tests or hospital treatment right now."
"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: "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."

Anticoagulation Review: "Since you've been on apixaban for a long time without problems, we won't change it based on two local nosebleeds. However, if you continue to have frequent bleeds, we may need to review your anticoagulation with a senior colleague or specialist."

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, four times a day, for around 10 days."
(Avoid if allergic to peanut or soy products - clarify first.)

Alternative to Naseptin: "If you're allergic to peanuts or soya, we'll use an alternative cream called **mupirocin** instead."

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."

Cautery Option: "If the bleeding keeps happening despite the cream, we may refer you to ENT for a procedure called **cautery** – where they seal off the small blood vessels causing the problem."
"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 & Leaflet

- GP review if recurrent despite Naseptin
- ENT referral if conservative management fails or posterior bleed suspected
- Provide epistaxis first-aid leaflet

Neck Lump – Suspected Cancer

Setting: Primary Care | **Presentation:** Young to Middle-Aged Adult with Persistent Unexplained Neck Lump | Significant Smoking History | Family History of Haematological Malignancy

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 prefer me to address you?"
"I understand you've come in about a lump in your neck. Would it be okay if I ask you some questions about it and then examine it?"

Presenting Complaint – History of Lump
Duration: "When did you first notice the lump?"
Onset: "Did it come on suddenly or gradually?"
Size change: "Has it stayed the same size, grown, or shrunk?"

Pain: "Is it painful or tender to touch?"
Other lumps: "Have you noticed any other lumps anywhere else in your body?"

Associated Symptoms (B-symptoms and Red Flags)
"Have you had any:
- Unexplained weight loss?
- Night sweats?
- Persistent fever?
- Fatigue or feeling generally unwell?
- Changes in your voice or hoarseness?
- Difficulty swallowing?
- Ear pain on that side?
- Bleeding from the mouth or nose?"

Risk Factor Screening
Smoking: "Do you smoke? How many per day and for how long?"
Alcohol: "How much alcohol do you drink?"
Sun exposure: "Any history of skin cancers or significant sun exposure?"
Previous cancers: "Have you ever been diagnosed with cancer before?"
HPV-related: "Any history of oral HPV or related conditions?"

PMAFTOSA
- **P**: Generally fit and well; history of anxiety
- **M**: No regular medications
- **A**: No known allergies
- **F**: Father and mother both had leukaemia
- **T**: Smoker for more than 10 years
- **O**: Works in office
- **S**: Concerned, anxious about the lump

ICE
Idea: "I thought it might just go away" *Concern*: "Now I'm worried it could be cancer" *Expectation*: "I need to know what it is"

Examination
"I'd like to examine the lump now and also check some other areas."
Examine:
- Location, size, shape, consistency of the lump
- Mobility (fixed vs mobile)
- Tenderness
- Overlying skin changes
- Check all other lymph node groups (cervical chain, supraclavicular, axillary, inguinal)
- Check for hepatosplenomegaly
- Examine oral cavity and oropharynx if possible

→ **Findings**: Firm, non-tender, fixed lump in the neck, present for more than 3 weeks

Diagnosis Discussion
Breaking News with Empathy:
Pause and signal seriousness: "I've finished examining you, and I'd like to talk to you about what I've found. Is that okay?"
Allow time: "I can see this lump has been there for a few weeks, and it has some features that concern me."

Explain findings: "The lump is firm and doesn't move easily, which can sometimes indicate something more serious. Given that it's been there for more than three weeks, and considering your smoking history, I think we need to get this checked further."
Address concern directly: "You mentioned you've been a smoker for quite some time. I'm not saying this to make you feel bad – but it's important context because smoking does increase the risk of cancers in this area."
Be honest but supportive: "I want to be open with you - I can't tell you exactly what this is without further tests, but I am concerned enough that I'd like to refer you urgently to a specialist."

Management
2-Week Wait Referral "I'm going to refer you to the **Head and Neck/ENT team** on an **urgent two-week wait pathway**. This means you should be seen within two weeks."
"This pathway is used when we want to rule out cancer. It doesn't mean you definitely have cancer - but it's the right thing to do to get answers quickly."

Investigations the Specialist May Do:
- Ultrasound of the neck
- Fine needle aspiration (FNA) or biopsy
- CT or MRI scan
- Examination of throat with a camera (nasendoscopy)

What Happens Next: "If the lump turns out to be benign, we'll let you know and arrange appropriate follow-up. But it's important we don't delay in getting this checked."

Support
"I understand this is a lot to take in. Do you have someone at home you can talk to about this?" "Would you like me to write anything down for you?" "Here's some information about the referral process."

Safety Netting
"If you haven't received an appointment within two weeks, please contact the surgery."
"In the meantime, if you notice:
- The lump growing rapidly
- Difficulty breathing or swallowing
- Coughing up blood
- Any new lumps

Please come back or go to A&E."

Follow-Up & Leaflet
- Urgent 2WW referral to Head & Neck/ENT
- Provide written information about the referral
- Offer support resources
- GP to follow up after specialist appointment

"Is there anything else I can help with today, or any questions about what we've discussed?"

Allergic Rhinitis

Setting: Primary Care | **Presentation:** Middle-Aged Adult with Persistent Nasal Symptoms and Impact on Work | Atopic History

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 prefer me to address you?"

"I understand you've been having some trouble with your nose and it's been affecting your daily life. Would it be okay if I asked you some questions about it?"

Presenting Complaint
D – Duration "How long have you been experiencing these symptoms?"

O – Onset "Did they start suddenly or gradually?" "Can you identify when they first started - was it a particular season or after any changes?"

O – Other symptoms "Which symptoms are bothering you most?"
- Sneezing?
- Runny nose?
- Blocked nose?
- Itchy nose, eyes, or throat?
- Cough?
- Watery or red eyes?

P – Progression "Are the symptoms getting worse, staying the same, or improving?" "Are there times of year when they're worse?"

A – Aggravating factors "Have you noticed anything that makes symptoms worse?"
- Pollen, grass, dust?
- Pets?
- Certain environments (indoors vs outdoors)?

R – Relieving factors "Does anything seem to help?" "Have you tried any treatments already?"

A – Associated impact "How are these symptoms affecting your work, sleep, or concentration?"

Atopic History
"Do you have any history of:
- Eczema?
- Asthma?
- Food allergies?
- Hay fever as a child?"

"Does anyone in your family have similar problems?"

PMAFTOSA
- **P**: History of eczema as a child
- **M**: No regular medications
- **A**: No known drug allergies
- **F**: Mother has asthma
- **T**: Non-smoker
- **O**: Office worker; symptoms affect concentration
- **S**: Symptoms affecting sleep quality and work performance

ICE
Idea: "I think it might be an allergy" *Concern*: "It's really affecting my work and sleep" *Expectation*: "I was hoping for something to help with the symptoms"

Examination
"I'd like to have a quick look at your nose and check a few other things."

Examine:
- Nasal mucosa (pale, boggy, swollen in allergic rhinitis)
- Nasal discharge (clear and watery suggests allergy)
- Check for nasal polyps
- Examine eyes for conjunctival injection
- Listen to chest if any respiratory symptoms

→ **Findings**: Pale, swollen nasal mucosa with clear discharge; mild conjunctival redness

Diagnosis
"Based on your symptoms - the sneezing, runny and blocked nose, itchy eyes, and the pattern of when they occur - this sounds like **allergic rhinitis**. It's also sometimes called hay fever, though it can be triggered by things other than pollen."

Explanation
"Your immune system is reacting to something in the environment - like pollen, dust mites, or pet dander - as if it were harmful. This causes inflammation in your nose and sometimes your eyes, leading to the symptoms you're experiencing."
"The tricky thing with allergic rhinitis is that it's not always obvious what sets it off. Keeping a symptom diary for a week or two can help us spot patterns – like whether it's worse outdoors, at certain times of year, or around pets."

Management
A. Trigger Avoidance "While we can't always avoid triggers completely, there are some things that may help:
- Keep windows closed during high pollen days
- Shower and change clothes after being outdoors
- Use allergen-proof covers on bedding
- Vacuum regularly with a HEPA filter
- Avoid drying clothes outside during pollen season
- Consider an air purifier for your bedroom"

B. First-Line Treatment
For nasal symptoms (especially congestion): "For your blocked nose, I'd recommend a **nasal steroid spray** such as **beclometasone** or **fluticasone** – these are often more effective than tablets for nasal congestion. You'll need to use it regularly for a week or two before it works fully."
For general symptoms: "A **non-sedating antihistamine** like **loratadine** or **cetirizine** (one tablet daily) can help with sneezing, itching, and runny nose."

C. Combination Therapy "For moderate-to-severe symptoms not controlled by monotherapy, a combination intranasal corticosteroid + intranasal antihistamine spray (e.g., Dymista — azelastine 137 mcg + fluticasone 50 mcg per spray) is the most effective option"

D. Eye Symptoms "For your itchy, watery eyes, we can add **antihistamine eye drops** like **sodium cromoglicate** - use them twice daily."

E. Referral Criteria "If your symptoms don't improve with these treatments, or if we're unsure what's triggering them, we can arrange:
- Allergy testing to identify specific triggers
- Referral to an allergy specialist
- Consider if there might be an occupational cause"

Technique for Nasal Spray
"Let me quickly explain how to use the nasal spray properly:
- Shake the bottle
- Tilt your head slightly forward
- Put the nozzle just inside your nostril, pointing away from the septum
- Spray while breathing in gently
- Don't sniff hard or blow your nose immediately after"

Safety Netting
"Please come back if:
- Symptoms don't improve after 2-4 weeks of treatment
- You develop nosebleeds (rare side effect of nasal sprays)
- You notice one-sided symptoms only (we'd want to check for other causes)
- You develop breathing difficulties or wheeze"

Follow-Up & Leaflet
- Review in 4 weeks to assess response
- Consider stepping up treatment or referral if inadequate response
- Provide leaflet on allergic rhinitis management

"Here's some information about managing allergic rhinitis. Do you have any questions?"

Unilateral Nasal Polyp – Suspected Cancer

Setting: Primary Care | **Presentation:** Older Adult with Unilateral Nasal Obstruction, Blood-Stained Discharge, and Visible Mass | History of Seasonal Allergies

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 prefer me to address you?"
"I understand you've been having some problems with your nose. Would it be okay if I asked you some questions and then had a look?"

Presenting Complaint
Duration: "How long have you noticed a problem with your nose?"
Main symptoms: "What's been bothering you most?"
- Blocked nose?
- Discharge?
- Bleeding?
- Loss of smell?

Side affected: "Is it one side or both?" → *One side*
Discharge characteristics: "What does the discharge look like?"
- Clear, mucus, or blood-stained? "How often do you get it?"

Red Flag Symptoms
"Have you noticed:
- Blood in the discharge?
- A lump or swelling inside your nose?
- Facial pain or numbness?
- Change in vision or double vision?
- Loose teeth or swelling in the roof of your mouth?
- Unexplained weight loss?
- Any lumps in your neck?"

PMAFTOSA

- **P**: History of seasonal allergies (hay fever)
- **M**: Occasional antihistamines
- **A**: No known drug allergies
- **F**: No significant family history
- **T**: Non-smoker
- **O**: Retired
- **S**: Symptoms bothering him when trying to read

ICE

Idea: "I thought it was just allergies or a polyp"
Concern: "The blood is worrying me"
Expectation: "I'd like to know what's causing it"

Examination

"I'd like to look inside your nose using a small light and also feel your neck for any lumps."
Examine:

- Anterior rhinoscopy (looking into nostrils)
- Palpate neck for lymphadenopathy
- Check for facial swelling or asymmetry
- Examine oral cavity

→ **Findings**: Visible polyp/mass in one nostril; blood-stained discharge

Key Teaching Point

"Unilateral nasal polyp in an adult (especially over 60) is a RED FLAG and should be treated as cancer until proven otherwise."
Bilateral polyps are usually benign and associated with conditions like asthma or aspirin sensitivity. But a **one-sided polyp**, especially with bleeding, needs urgent investigation.

Explanation (Breaking Difficult News)

Prepare the patient: "I've had a look inside your nose, and I'd like to talk to you about what I've found. Is that okay?"
Explain findings: "I can see there's a growth on one side of your nose, and there's some blood mixed with the discharge."
Be honest: "When we see a growth on just one side, especially with bleeding, we need to take it seriously. In some cases, this can be a sign of something more concerning, and I think we need to get this checked by a specialist as soon as possible."
Pause and check understanding: "I know that's difficult to hear. Do you have any questions so far?"
Offer support: "I want to reassure you that we're going to get you seen quickly so we can find out exactly what this is."

Management

2-Week Wait Referral "I'm referring you urgently to the **ENT team** under the **two-week wait pathway**. This is the fast-track route we use when we want to rule out cancer."
"This doesn't mean you definitely have cancer - but it's the right thing to do to get answers quickly."

What the Specialist Will Do:

- **Nasal endoscopy** - a closer look with a camera
- **Biopsy** - taking a small sample to examine under a microscope
- **CT scan** - to see how far the growth extends

Safety Netting
"If you haven't received an appointment within two weeks, please call the surgery."
"In the meantime, if you notice:

- Heavy bleeding from the nose
- Facial swelling or numbness
- Vision changes
- Difficulty breathing through your nose

Please come back or seek urgent help."

Support
"Do you have someone who can come with you to the appointment?" "Would you like me to write down what we've discussed?"

Follow-Up

- Urgent 2WW referral to ENT
- GP to follow up after specialist review
- Provide information about the referral process

Suspected Laryngeal Cancer

Setting: Primary Care | **Presentation:** Middle-Aged Adult with Persistent Hoarseness | Significant Smoking History and Occupational Exposure | No Infective Features

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 prefer me to address you?"
"I understand you've been having some trouble with your voice. Would it be okay if I asked you some questions about it?"

Presenting Complaint
Duration: "How long has your voice been hoarse?"
Onset: "Did it start suddenly or gradually?"
Progression: "Is it getting worse, staying the same, or improving?"
Pattern: "Is it there all the time or does it come and go?"
Associated Symptoms (Red Flags)
"Have you noticed:

- Difficulty swallowing?
- Pain when swallowing?
- A lump in your neck?
- Ear pain (especially on one side)?
- Unexplained weight loss?
- Coughing up blood?
- Shortness of breath?"

Rule Out Infective Cause
"Have you had:

- Recent cold or sore throat?
- Fever?
- Cough?"

→ *All negative*

Risk Factor Assessment

Smoking: "Do you smoke? How many per day and for how long?" → *35-year history*
Alcohol: "How much alcohol do you drink?"
Occupational: "What work do you do?" → *Garage mechanic* "Are you exposed to any fumes, dust, or chemicals?" → *Diesel fumes*
Reflux: "Do you get heartburn or acid coming up into your throat?"

PMAFTOSA
- **P**: Generally well
- **M**: No regular medications
- **A**: No known allergies
- **F**: No family history of cancer
- **T**: Heavy smoker, 35 years
- **O**: Garage mechanic with diesel fume exposure
- **S**: Voice change affecting communication at work

ICE
Idea: "I thought it might be a chest infection" *Concern*: "But it's been going on too long now" *Expectation*: "I need to find out what's wrong"

Examination
"I'd like to examine your throat and neck."
Examine:
- Inspect oral cavity and oropharynx
- Palpate neck for lymphadenopathy
- Check for stridor (noisy breathing)
- General appearance (weight loss, cachexia)

→ **Findings**: No visible abnormality on inspection; may have palpable cervical lymph node

Clinical Reasoning
Concerning features:
- Hoarseness lasting more than 2 weeks
- Heavy smoking history (35 years)
- Occupational exposure to carcinogens (diesel fumes)
- No infective symptoms
- No improvement

Note for student: *NICE NG12 recommends considering a 2WW referral for adults aged 45+ with persistent unexplained hoarseness (commonly interpreted as lasting 3 weeks or more). However, earlier referral is appropriate when there are significant risk factors (heavy smoking, occupational carcinogen exposure), as in this case.*

Explanation (Breaking Difficult News)
Prepare: "I've finished examining you, and I'd like to discuss what I think we should do next. Is that okay?"
Explain the concern: "Your voice has been hoarse for more than two weeks, and it doesn't seem to be getting better. Given that you've been smoking for many years and you're exposed to diesel fumes at work - both of which can affect the voice box - I think we need to get this properly checked."
Be honest but compassionate: "I want to be upfront with you. When someone has hoarseness that doesn't go away, especially with a smoking history, we need to make sure it's nothing serious. That includes ruling out any growths on the voice box."
Pause for reaction: "I know that's a lot to take in. How are you feeling about what I've said?"

Management
2-Week Wait Referral "I'm going to refer you urgently to the **ENT team** under the **two-week wait pathway**. This means you should be seen within two weeks."
What the Specialist Will Do:

- **Laryngoscopy** - looking at your voice box with a camera
- Possibly **biopsy** if anything abnormal is seen
- **CT or MRI scan** if needed

Differential Diagnosis to Mention: "There are other things that can cause hoarseness, like acid reflux affecting the voice box (laryngopharyngeal reflux), or benign growths. But given your history, we need to rule out anything more serious first."

Smoking Cessation
"I know you've been smoking for a long time, and this isn't about judging you. But if you'd like support to stop, we can help - whether that's nicotine replacement, medication, or a referral to a stop smoking service."

Safety Netting
"If you notice before your appointment:

- Difficulty breathing
- Difficulty swallowing
- Coughing up blood
- Any new lumps in your neck

Please seek urgent medical attention."

Follow-Up

- Urgent 2WW referral to ENT
- Offer smoking cessation support
- GP follow-up after specialist review

Infectious Mononucleosis (Glandular Fever)

Setting: Primary Care | **Presentation:** Young Adult with Persistent Sore Throat, Fatigue, and Lymphadenopathy | Failure to Respond to Antibiotics

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 prefer me to address you?"
"I understand you've been feeling unwell with a sore throat that isn't getting better. Would it be okay if I asked you some questions?"

Presenting Complaint
Duration: "How long have you had the sore throat?"
Onset: "Did it start suddenly or gradually?"
Severity: "How bad is the pain - can you eat and drink?"
Previous treatment: "Have you already seen a doctor or taken any treatment?" "Were you given antibiotics? Did they help?" → *Given antibiotics but no improvement*
Associated Symptoms
"Have you noticed:

- Fever?
- Extreme tiredness or fatigue?
- Swollen glands in your neck?

- Any rash?
- Headache?
- Loss of appetite?
- Tummy pain?" (hepatosplenomegaly)

Transmission/Exposure History
"Have you been in close contact with anyone who's been unwell?" "Any recent kissing or sharing drinks with someone new?"

PMAFTOSA
- **P**: Previously fit and well
- **M**: Recently prescribed antibiotics (no improvement)
- **A**: No known allergies
- **F**: No significant family history
- **T**: Non-smoker, occasional alcohol
- **O**: Student/young professional
- **S**: Fatigue affecting studies/work

ICE
Idea: "I thought the antibiotics would help" *Concern*: "I'm worried because I'm still so tired" *Expectation*: "I need to know what's wrong and how long this will last"

Examination
"I'd like to examine your throat and feel for any swollen glands."
Examine:
- Throat: Look for tonsillar enlargement, exudates, petechiae on palate
- Lymph nodes: Cervical (especially posterior), axillary
- Abdomen: Check for hepatosplenomegaly
- Skin: Look for any rash

→ **Findings**: Enlarged tonsils with white exudate; tender cervical lymphadenopathy; may have splenomegaly

Diagnosis
"Based on your symptoms - the persistent sore throat that didn't respond to antibiotics, the extreme tiredness, and the swollen glands - I think you may have **infectious mononucleosis**, which is also called **glandular fever** or sometimes the 'kissing disease' because it's spread through saliva."

Explanation
"Glandular fever is caused by a virus called Epstein-Barr virus. It's very common in young adults and is spread through saliva - from kissing, sharing drinks, or coughs and sneezes."
"The infection itself usually clears within 2-4 weeks, but I have to be honest – the tiredness can hang around for several weeks, sometimes even months. It's frustrating, but it does get better with time."
"Antibiotics don't help because it's a virus, not a bacterial infection. In fact, certain antibiotics like amoxicillin can cause a rash in people with glandular fever - that might explain why you didn't improve."

Investigations
"I'd like to do some blood tests to confirm the diagnosis:
- A **Monospot test** (or heterophile antibody test) - this checks for antibodies your body makes against this virus
- A **full blood count** - may show characteristic changes
- **Liver function tests** - the liver can sometimes be affected"

Note: The Monospot test can be negative in the first week of illness. If it's negative but we still suspect glandular fever, we may repeat it in a week or arrange EBV-specific serology.

Management
Symptomatic Treatment: "Since this is a viral infection, we focus on managing symptoms:

- **Rest** is important - listen to your body
- **Paracetamol and ibuprofen** for pain and fever
- **Drink plenty of fluids** - warm drinks can be soothing
- **Salt water gargles** may help the sore throat"

Important Warnings:
Avoid contact sports: "Your spleen may be slightly enlarged, which puts it at risk of rupture if you have any impact to your tummy. Please **avoid contact sports and heavy lifting for at least 4 weeks**. If your symptoms are ongoing or if splenomegaly is confirmed, this may need to be extended to **6-8 weeks**. Splenic rupture, although rare, can be life-threatening."

Avoid alcohol: "The virus can affect your liver temporarily, so please **avoid alcohol** until you're fully recovered."

Avoid spreading: "Avoid kissing or sharing cups and cutlery while you're unwell."

Corticosteroids: "We don't routinely use steroids, but if your tonsils are very swollen and affecting breathing or swallowing, a short course of steroids may be considered."

Fitness to Work/Study: "You may need time off work or study. I can provide a fit note if needed."

Safety Netting
"Please come back or seek urgent help if you notice:

- Difficulty breathing or swallowing
- Severe tummy pain (especially on the left side)
- Yellowing of your skin or eyes (jaundice)
- Increasing weakness or dizziness
- Symptoms not improving after 2-3 weeks"

Follow-Up

- Blood test results review
- Reassess in 2 weeks if not improving
- Provide information leaflet on glandular fever

"Do you have any questions about what we've discussed?"

Acute Tonsillitis

Setting: Primary Care | **Presentation:** Adult with Acute Sore Throat, Fever, and Tonsillar Exudates | Penicillin Allergy

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 prefer me to address you?"
"I understand you've come in with a sore throat. Would it be okay if I asked you some questions?"

Presenting Complaint
Duration: "How long have you had the sore throat?"

Onset: "Did it start suddenly or gradually?"
Severity: "How bad is the pain - on a scale of 1 to 10?" "Can you eat and drink?" "Is it painful to swallow?"

Associated Symptoms
"Have you noticed:
- Fever?
- Feeling generally unwell?
- Headache?
- Cough?
- Runny nose?
- Swollen glands in your neck?
- Any rash?
- Ear pain?"

Centor/FeverPAIN Criteria Assessment
"Let me ask a few specific questions to help decide about treatment:"
Centor Criteria:
1. Fever (temperature >38°C)?
2. Tonsillar exudates (pus on tonsils)?
3. Tender anterior cervical lymph nodes?
4. Absence of cough?

FeverPAIN Criteria:
1. Fever in past 24 hours?
2. Purulence (pus on tonsils)?
3. Attended rapidly (within 3 days of symptom onset)?
4. Inflamed tonsils?
5. No cough or coryza?

PMAFTOSA
- **P**: Generally well
- **M**: No regular medications
- **A**: **Allergic to penicillin** - what happens when you take it?
- **F**: No significant history
- **T**: Non-smoker
- **O**: Working, taking time off due to symptoms
- **S**: Struggling to eat due to pain

ICE
Idea: "I think I need antibiotics" *Concern*: "The pain is really affecting me" *Expectation*: "I was hoping for something to help"

Examination
"I'd like to have a look at your throat and feel your neck."
Examine:
- Tonsils: Size, redness, exudates
- Uvula: Central or deviated
- Palate: Any swelling or asymmetry
- Lymph nodes: Anterior cervical
- General: Temperature, hydration status

→ **Findings**: Enlarged, red tonsils with white exudates; tender cervical lymph nodes; fever; no cough

Clinical Scoring
Centor Score: 4/4

- Fever ✓
- Tonsillar exudates ✓
- Tender anterior cervical nodes ✓
- Absence of cough ✓

Interpretation: Score of 4 suggests ~50-60% likelihood of bacterial infection. Antibiotics are appropriate.
"We use scoring systems like FeverPAIN or Centor to help decide about antibiotics. Your score suggests a bacterial cause is likely, so antibiotics are appropriate here."

Diagnosis and Explanation
"I can see from examining you – and I'm sorry, I know this is really uncomfortable – that your tonsils are quite swollen and infected. This is what we call **acute tonsillitis**."
"The pus on your tonsils and your high fever suggest this is likely a bacterial infection. That's why antibiotics will help in your case - unlike viral sore throats where they wouldn't make a difference."

Management
Antibiotics: "Because you're allergic to penicillin, I'll prescribe **Clarithromycin 250 mg**, twice a day for **5 days**." *(Increase to 500 mg BD only if infection is severe.)*

"It's really important to complete the full course, even if you start feeling better."

Note: *First-line antibiotic for acute bacterial tonsillitis: Phenoxymethylpenicillin (Pen V) 500 mg four times daily (or 1000 mg twice daily) for 5–10 days. Amoxicillin is equally effective but must be AVOIDED if glandular fever is suspected (rash risk 70–100%).*

Important – Pregnancy: If a macrolide is needed in pregnancy, **erythromycin is preferred** over clarithromycin. This is because there is more documented experience of erythromycin use in pregnancy. Discuss the potential benefits and harms with the patient.

Symptomatic Relief: "For the pain and fever:

- **Paracetamol** regularly (up to 4 times daily)
- **Ibuprofen** can also help with pain and inflammation
- **Throat lozenges** or sprays may give temporary relief
- **Warm drinks with honey** can be soothing
- **Salt water gargles** - half a teaspoon of salt in warm water, gargle and spit"

Hydration: "Keep drinking plenty of fluids, even if swallowing is uncomfortable. Cold drinks or ice lollies can help numb the pain."

Rest: "Rest at home while you have a fever. You should start to feel better within 2-3 days of starting antibiotics."

Red Flags for Quinsy (Peritonsillar Abscess)
"I want you to watch out for signs that things might be getting worse:

- **Difficulty opening your mouth** (trismus)
- **Muffled or 'hot potato' voice**
- **One-sided throat swelling**
- **Severe one-sided pain**
- **Drooling or difficulty swallowing your own saliva**

If any of these happen, please come back urgently or go to A&E - it could mean an abscess is forming."

Safety Netting
"Please come back if:

- Symptoms aren't improving after 2-3 days of antibiotics
- You develop any of the red flag symptoms I mentioned
- You can't swallow fluids
- You're getting worse rather than better
- You develop a rash (rarely, the infection can spread)"

Follow-Up & Leaflet

- No routine follow-up needed if improving
- Return if symptoms persist beyond antibiotic course
- Provide sore throat advice leaflet

"Is there anything else you'd like to ask before you go?"

Chapter 13: Ophthalmology

A Note to Learners

The cases in this resource are written in a conversational style to help you become familiar with the natural flow of clinical consultations and the language commonly used in UK healthcare settings.

These dialogues are intended as a learning guide, not a script. Please do not attempt to memorise them verbatim. Examiners assess your ability to think and communicate authentically - not to recite rehearsed phrases.

Use this material to understand the underlying clinical reasoning, then practise in your own words until the consultation feels natural to you.

For Companion OSCE Cases, Practice Scripts, Evaluation Checklists, Summary Notes, Rapid Review Notes, Mindmaps, Management Flashcards and Image Library including Ophthalmoscope images- visit https://www.gksplab2.com

Disclaimer
This material is independent educational content created to help candidates develop clinical reasoning and communication skills for UK medical practice.

All cases and clinical scenarios are based on common presentations encountered in UK primary care and emergency medicine, drawn from publicly available sources including NICE Clinical Knowledge Summaries (CKS), BNF, and other official NHS/UK healthcare guidelines.

No content in this resource is derived from, represents, or claims to replicate actual GMC PLAB 2 examination material.

Introduction to Eye Stations

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 a **junior 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

- **First question: Monocular or Binocular?** This is the single most important discriminator. Monocular = local eye pathology (retinal, corneal, lens). Binocular = neurological or systemic cause.
- 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**
- **Use the pinhole test:** If vision is reduced, offer a pinhole. Improvement with pinhole = refractive error (needs glasses). No improvement = pathology.

- 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)
- **Always ask about driving:** "Do you drive a car, or do you drive a lorry or bus for a living?" (Group 2 drivers have stricter DVLA rules)
- **Exam tip:** Modern PLAB 2 stations may use digital tablets or high-fidelity simulators for fundoscopy findings instead of paper—be prepared for either format.

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."

- **O**nset – "Did it come on suddenly or gradually?"
- **D**uration – "How long has this been going on?"
- **I**ntensity – "On a scale of 1–10, how bothersome or painful is it?"
- **P**rogression – "Has it been getting better, worse, or staying the same?"
- **A**ssociated 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?"
- **R**elieving/aggravating – "Anything that makes it better or worse – like light, movement, rest, drops?"
- **A**ny 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:

- **P**ast medical history: Diabetes, hypertension, migraines, autoimmune disease, eye surgeries, thyroid issues
- **M**edications: Especially steroids, anticoagulants, eye drops
- **A**llergies
- **F**amily history: Glaucoma, macular degeneration, diabetes
- **T**rauma: Any recent injuries to the head or eye?
- **O**ccupation: Screen time, chemical exposure, manual work, driving?
- **S**ocial: Smoking (linked with macular degeneration), alcohol, drugs
- **A**ctivities: 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."*

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)

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')

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)

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."

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."

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."

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:

Structure	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

Setting: Primary Care
Role: Junior Doctor
Patient: Older Adult Male with Sudden Visual Disturbance and Recent Eye Surgery

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."

Question	Screens for
"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) **S**ocial: Driving status? Alcohol/smoking?
Activities:
Effect 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 what you've described and what I found during the examination, I think you may have something called a **retinal detachment**. I know that sounds worrying, so let me explain what that means."
"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."

Urgency - Surgical Emergency
"This is a **surgical emergency**. Because your central vision is still intact—we call this 'macula-on'—we have a window of opportunity to save your sight. But this window is very short, typically hours rather than days. I'm arranging **same-day transfer to a vitreoretinal surgery unit** right now."
"You'll likely need **urgent surgery**, which could involve using a laser, a freezing probe, or a small gas bubble to push the retina back into place."

Pre-Operative Advice (NBM):
"Because you may need surgery very soon, I need to ask you **not to eat or drink anything** from now until you've been seen by the eye surgeon. This is called being 'nil by mouth' and it's important in case you need an anaesthetic."

How the patient is getting to hospital:
"It's really important that you **don't drive yourself** today—both because of your vision and because you may need surgery. Do you have someone who could take you straight away, or should I arrange emergency transport?"
"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, **keep your head as still as possible and avoid any sudden movements or bending down**. If you notice any worsening—more shadow, more floaters, or changes in the other eye—that's even more urgent."

Driving & DVLA:
"Please **do not drive** until you've been assessed by the ophthalmologist and your vision meets the driving standard. You'll need to check with the DVLA—if this affects both eyes or your vision falls below the standard, you must notify them. Do you drive a car, or do you drive a lorry or bus for work? The rules are stricter for professional drivers."

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

Diabetic Retinopathy

Setting: Primary Care
Role: Junior Doctor
Patient: Middle-Aged Male with Type 2 Diabetes, Gradual Visual Changes, and Missed Screening Appointments

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. The ophthalmology team will do detailed imaging of your retina, which may include a type of scan called OCT that gives very detailed pictures."
"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 to get your blood sugar levels under tighter control."
"If your HbA1c is above target, and your kidney function allows it, we'll start you on **Metformin**, typically 500 mg once or twice daily, gradually increasing.

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 (eGFR)** and general health—this is important both to monitor diabetes effects and to ensure any medications we prescribe are safe."

Address Missed Follow-ups:
"I understand you've been looking after your mother, but your health matters too."
"I wonder if there's any way we could arrange some support at home for your mother, so you have time to look after yourself too?"

Lifestyle Intervention:
"I'll support you to reduce smoking and alcohol, and help improve your diet."
"Regular physical activity can also help with blood sugar control—even a daily 30-minute walk can make a difference."
"Would you be willing to meet with a **dietician** or join a local diabetes support group?"

DVLA Notification:
"If your vision is significantly affected — for example, if it falls below 6/12 or you have field loss — you'll need to inform the DVLA. Your eye specialist will advise."

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

Setting: Primary Care
Role: Junior Doctor
Patient: Adult with Poorly Controlled Hypertension Presenting with Gradual Visual Changes

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."

Question	Screens for
"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	Significance
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. Think of it like a garden hose under too much pressure—over time, the walls can become stiff, narrow, or even spring small leaks. 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."
"We're aiming to get your blood pressure below 140/90, or below 130/80 if you have other risk factors."
"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 keep a close eye on you—no pun intended—to make sure things improve, 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)

Grading and Urgency

Grade	Findings	Urgency
Grade 1	Mild arteriolar narrowing, silver/copper wiring	Routine ophthalmology referral
Grade 2	AV nipping, more marked narrowing	Routine to Urgent referral
Grade 3	Flame haemorrhages, cotton wool spots, hard exudates	**SAME-DAY ADMISSION** - Accelerated hypertension
Grade 4	Papilloedema (optic disc swelling)	**EMERGENCY ADMISSION** - Malignant hypertension

CRITICAL POINT: Grade 3 and Grade 4 hypertensive retinopathy indicate **accelerated or malignant hypertension**. This is a **medical emergency**, NOT a routine referral.

If you see Grade 3/4 findings:

1. Check BP immediately
2. If BP is severely elevated (e.g., >180/120), this is a **hypertensive emergency**
3. Arrange **same-day admission** to medical assessment unit or A&E
4. The patient needs urgent evaluation to rule out:
    - Stroke/TIA
    - Acute kidney injury
    - Cardiac complications
    - Encephalopathy

Type of Referral Summary:

Clinical Finding	Type of Referral
Grade 1-2 retinopathy with controlled BP	**Routine** referral to ophthalmology
Grade 1-2 retinopathy with uncontrolled BP	**Urgent** ophthalmology referral + review antihypertensives
Grade 3 (haemorrhages/cotton wool spots)	**SAME-DAY medical admission** - accelerated HTN
Grade 4 (papilloedema)	**EMERGENCY admission** - malignant HTN
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

Setting: Primary Care
Role: Junior Doctor
Patient: Immunosuppressed Adult with Gradual Visual Changes, Systemic Symptoms, and Occupational Animal Exposure

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 **S**ocial: Any impact on driving, reading, or mobility **A**ctivities: 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 caused by a tiny parasite that can sometimes be found in cat droppings. It's actually quite common, and most people's immune systems deal with it easily—but because you're on steroids, your immune system isn't as strong, which can allow it to cause problems. In people with weakened immune systems, 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 **antiparasitics like pyrimethamine and sulfadiazine**, possibly alongside folinic acid to reduce side effects."

Addressing 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."

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)

Setting: Primary Care
Role: Junior Doctor
Patient: Adult with Painful Red Eye, Photophobia, and History of Recurrent Oral Herpes

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?"	Uveitis

"Have you had this eye problem before?"	Recurrent HSV

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 caused by the same virus that gives you cold sores. Once you catch it, the virus stays in your body and can occasionally 'wake up' and cause problems—in this case, affecting your eye."
"It can cause pain, redness, watering, blurred vision, and light sensitivity. The good news is that with the right treatment, most people recover well. But it's important we treat it quickly to prevent any scarring that could affect your 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 gel**—the most commonly used is **ganciclovir 0.15% gel** (Virgan), which is applied to the eye 5 times daily until healed. The eye specialist will prescribe this. In some cases, oral antivirals like **aciclovir** (400 mg five times daily for 7 days) may also be used."

CRITICAL - No Steroids Without Specialist Supervision:
If asked about steroids drops - "I want to be very clear about one thing: **I will NOT give you steroid eye drops today**. Using steroids on this type of infection is like adding fuel to a fire—it can cause the virus to spread rapidly and could permanently damage your sight. The eye specialist will assess whether steroids might ever be appropriate after they've confirmed exactly what's happening with their specialist equipment."

Contact Lens Advice:
"If you wear contact lenses, don't use them until the infection has fully cleared and your eye specialist says it's safe."

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)

Setting: Primary Care
Role: Junior Doctor
Patient: Older Adult with Gradual Central Vision Loss, Metamorphopsia, and Optician Referral

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 Referral to Macula Service (within 1 working day): "I'll arrange for you to be seen by the **macula service tomorrow or the next working day**. Wet AMD can progress quickly, so we don't want to delay—but this is urgent rather than an emergency, so you don't need to go to A&E."
"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 is treated with regular injections into the eye (anti-VEGF therapy) to slow down the damage."

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:
"If you're a smoker, stopping is one of the most important things you can do—it's one of the biggest risk factors for this condition getting worse."
"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."

Charles Bonnet Syndrome:
"Some people with macular degeneration experience something called Charles Bonnet syndrome—seeing things that aren't really there, like patterns or shapes. This is caused by the brain adjusting to reduced vision, not a mental health problem. If this happens, please let us know."

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

Setting: Emergency Department
Role: Junior Doctor
Patient: Adult with Acute Painful Red Eye, Visual Disturbance, Systemic Symptoms, and Precipitating Factors

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: Fundoscopy is usually deferred until the pressure has been reduced and the cornea clears—the specialist will do this once initial treatment has worked.
*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- 2 agonist** (e.g. **Apraclonidine 1%**)
- **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**."
"Try to stay in well-lit areas—dim lighting can make the pupil dilate, which can trigger another episode."
"Be careful with over-the-counter cold and flu medicines, hay fever tablets, or some antidepressants—if you're ever prescribed a new medication, mention that you've had this eye condition."

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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Chronic Open-Angle Glaucoma

Setting: Primary Care
Presenting Complaint: Review following optometry referral for raised intraocular pressure

1. Introduction & Consent

- Greet and confirm identity
- "I understand you were recently referred by your optician because they found raised pressure in your eyes. Is it okay if I ask you a few questions and explain what this could mean?"

2. Focused History
Symptom Inquiry (Visual Function)

- "Have you noticed any changes in your vision at all?"
- "Do you have any difficulty seeing things from the sides (peripheral vision)?"
- "Have you noticed bumping into objects, misjudging steps or doorways?"
- "Any difficulty seeing at night?"
- "Is your central vision (for reading or recognising faces) okay?"
- "Do you see any halos around lights or blurred areas?"
- "Have you experienced sudden vision loss, flashing lights, or floaters?"
- "Any pain, redness, or pressure sensation in the eyes?"
  → **Commonly asymptomatic; may have mild peripheral vision changes**
  → **No eye pain or central vision loss** unless coexistent pathology

Associated Systemic History

- "Any headaches or migraines?"
- "Any nausea, vomiting, or eye strain?"
- "Any jaw pain, scalp tenderness, or chewing discomfort?" (→ GCA screen)
- "Any neurological symptoms — weakness, numbness, slurred speech?"
  → Screens for GCA, CVA, raised ICP, retinal detachment, optic neuritis

Ophthalmic History

- "Do you use glasses or contact lenses?"
- "Any previous eye conditions, surgeries, or injuries?"
- "When was your last eye test before this?"
- "Have you ever used steroid eye drops or taken steroids long-term?"

Risk Factor Screening

- "Any family history of glaucoma or blindness?"
- "Do you have diabetes, high blood pressure, or high cholesterol?"
- "Do you use medications like inhalers, steroids, or antidepressants?"
  → Risk factors: Age >40, family history, steroid use, Afro-Caribbean descent, myopia, diabetes

Functional Impact

- "Are your symptoms affecting reading, working, or driving?"
- "Have you had difficulty with hobbies, mobility, or stairs?"

3. Explore ICE

- **Ideas**: "Do you have any idea why the optician was concerned?"
- **Concerns**: "Are you worried this might lead to blindness?"
- **Expectations**: "Were you expecting any treatment today?"

4. Examination

In ED, perform basic visual and external eye exam; full glaucoma workup is done by ophthalmology.

- Visual acuity (Snellen, if available)
- General inspection: symmetry, conjunctival redness, discharge, ptosis
- Pupil reaction and light reflex
- Intraocular pressure (IOP) or fundoscopy can be attempted

"A full glaucoma assessment will be done by the eye specialist, including nerve scans and field tests."

5. Explanation of Diagnosis

"From what you've described and what your optician found, this could be **open-angle glaucoma**, which is the most common type of glaucoma."

- "This happens when the fluid inside your eye doesn't drain properly, causing a slow rise in pressure."
- "Over time, that pressure can damage the **optic nerve**, which is the connection between your eye and brain."
- "It usually affects your **side vision first**, and it doesn't cause pain — so many people don't notice until picked up during routine tests."
- "The type you have is the slow-developing kind, not an emergency. But treating it now is really important because — while we can't reverse any damage that's already happened — we can stop it from getting worse and protect the vision you have."

6. Management

Referral

- **Routine referral to ophthalmology** within a few weeks for full glaucoma assessment → Not an emergency unless acute angle-closure suspected
- However, if the IOP is ≥32 mmHg or the referral letter notes significant optic disc damage, consider urgent or same-day referral.

Specialist Investigations

- **Gonioscopy**: checks whether the drainage angle is open or closed
- **Visual field testing**: to identify any early peripheral vision loss
- **Optic nerve imaging** (e.g. OCT)
- **Pupil-dilating drops** may be used — patient should **avoid driving after the test**

Treatment (if confirmed)

- First-line: **360° Selective Laser Trabeculoplasty (SLT)** — offered to all patients with newly diagnosed OHT (IOP ≥24 mmHg) or COAG
- If patient **prefers not to have SLT** or SLT is **unsuitable** (e.g. pigment dispersion syndrome): offer **generic prostaglandin analogue eye drops** (e.g. latanoprost)
- PGA drops also offered while **waiting for SLT** or if SLT alone insufficient
- May require **combination therapy** (beta-blocker, carbonic anhydrase inhibitor, sympathomimetic) if IOP not controlled
- A **second SLT** may be needed if the effect of the first reduces over timeTreatment is **lifelong**; **adherence to daily eye drops is crucial — missing doses can lead to progression even if you feel fine**
- NICE recommends **IOP reduction by at least 20% from baseline**

Driving Advice
- Patients should not drive until vision is assessed
- **DVLA notification required if visual field is impaired**
- Patients with confirmed glaucoma in both eyes require visual field testing to retain driving licence

7. Safety Netting
- "If you develop **sudden eye pain, redness, blurred vision**, or see halos around lights, come to hospital immediately — it could be a rare emergency type called **acute angle-closure glaucoma**."
- "If you don't hear from the eye clinic within 2 weeks, contact your GP to follow up the referral."
- "It's very important to **attend every follow-up** — missing appointments can lead to irreversible vision loss."

8. Follow-Up
- Routine referral to ophthalmology
- GP follow-up if there's a delay
- Long-term ophthalmology-led monitoring (typically every 6–12 months once stable)

9. Leaflet & Visual Aids
- Offer NHS leaflet on glaucoma
- "Would you like me to print some information about glaucoma for you to take home?"

10. Address Common Patient Questions
Q: "Will this get better on its own?"
→ "No — but we can stop it from getting worse with treatment if we act early."

Q: "Will I go blind?"
→ "If untreated, glaucoma can cause permanent vision loss. But if caught early and treated properly, most people retain good vision for life."

Q: "What happens next?"
→ "You'll be seen by a specialist within a few weeks. They'll confirm the diagnosis and discuss treatment options — the first choice is usually a quick laser procedure called SLT, or daily eye drops if you prefer.''

Q: "Will I need surgery?"
→ "Most people are treated with a laser procedure or eye drops. More invasive surgery is only used if pressure isn't well controlled with these options."

Q: "What is SLT?"
→ "SLT stands for Selective Laser Trabeculoplasty. It's a quick, painless outpatient procedure where a laser helps the fluid in your eye drain better. It can delay or reduce the need for daily eye drops."

Cataract

Setting: Primary Care
Role: Junior Doctor
Patient: Older Adult with Gradual Bilateral Visual Decline, Glare Symptoms, and Optician-Detected Lens Opacity

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	Screens for
"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 extremely common—by 80, more than half of people either have a cataract or have had surgery for one. So you're definitely not alone in this. It 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."

Note: The decision to refer for cataract surgery is based on how much it affects quality of life – not just the eye test result. Since this is clearly affecting reading and driving, referral is appropriate.

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, which is usually very successful, your eye doctor will check your vision has improved enough to drive again. Most people can get back to driving within a few weeks."

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: Primary Care
Role: Junior Doctor
Patient: Young Adult with Acute Painful Monocular Vision Loss and Family History of Neurological Disease

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?

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—many people have optic neuritis and never develop it. But given your family history, it's something we'd want to check for, just to be safe."

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 1g daily 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: "You should **stop driving** until your vision has been reassessed and meets the driving standard. Check DVLA rules—if this persists or affects both eyes, you must notify them. Do you drive for work, like a lorry or bus? The rules are stricter for professional drivers."
Offer written information on optic neuritis and MS
Arrange GP follow-up after hospital review to support continuity of care

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Subconjunctival Haemorrhage

Setting: Primary Care
Role: Junior Doctor
Patient: Older Adult with Unilateral Painless Red Eye and Normal Vision

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?"
I'd also like to check your blood pressure today, as sometimes a subconjunctival haemorrhage can be the first sign of raised blood pressure.

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 can happen after coughing, sneezing, straining, or even rubbing your eyes—sometimes there's no obvious cause at all, which is perfectly normal too."

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

Setting: Primary Care
Role: Junior Doctor
Patient: Adult with Bilateral Red Eye and Discharge

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	Screens for
"Is your vision reduced?"	Red flag for keratitis, uveitis, glaucoma
"Is there any severe pain or headache?"	Red flag for keratitis, uveitis, glaucoma
"Any pain on light exposure or pupil reaction?"	Uveitis, glaucoma
"Do you wear contact lenses?"	Iritis
"Any trauma or chemical exposure?"	High risk for keratitis
"Is this the first time or has it happened before?"	Trauma-related injury
"Any joint pain, ulcers, or urinary problems?"	Allergic recurrence

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: Not typically affected (conjunctivitis is external)

PROVISIONAL DIAGNOSIS
"Based on what you've told me and the examination findings, this looks like **conjunctivitis**—inflammation of the clear layer over the white of your eye."

Explanation of Conjunctivitis
"Conjunctivitis can be caused by infections—either viral or bacterial—or by allergies like pollen or dust. The good news is this isn't serious and should clear up on its own."

MANAGEMENT PLAN
Type of Conjunctivitis & Treatment:

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)

Treatment Advice:
First-line: Self-care and hygiene measures
- "Most cases of conjunctivitis resolve on their own within 5–7 days."
- "Clean your eyes regularly with cooled boiled water and cotton wool."
- "Wash your hands frequently to prevent spreading."

Delayed Antibiotic Prescription (if bacterial features):
- "I'll give you a prescription for **chloramphenicol eye drops** (one drop every 2 to 3 hours while awake) that you can start only if not improved after 3 days."

Allergic conjunctivitis:
- "Antihistamine eye drops can help reduce the itching."
- "Try to avoid known triggers like dust or pollen."

Work/School Advice:
"You don't need to take time off work or keep your child off school for this, but do wash your hands regularly to stop it spreading."

Contact Lens Advice:
"Avoid wearing contact lenses until your symptoms have completely resolved."

SAFETY NETTING
"If your vision becomes blurry, you develop severe pain, or your symptoms aren't improving after a week, please come back or go to an eye clinic."
"If you develop photophobia (sensitivity to light) or the redness spreads significantly, seek urgent review."

FOLLOW-UP PLAN
No routine follow-up needed if symptoms resolve
Return if symptoms persist beyond 7–10 days or worsen

Contact Lens-Associated Keratitis

Setting: Primary Care or Emergency
Role: Junior Doctor
Patient: Young Adult Contact Lens Wearer with Acute Painful Red Eye and Reduced Vision

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 **microbial keratitis**—this is an infection of the front part of your eye (the cornea), most likely caused by bacteria that got in while sleeping with your contact lenses."
"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—most commonly **Pseudomonas**—to enter and cause infection. This is called **microbial keratitis**, and it's a **sight-threatening emergency**."
"I know this sounds alarming, but I need to be direct with you: a delay of even 24 hours in treating this can lead to serious corneal damage or even perforation. That's why we need to act immediately. The good news is we've caught this early, and with quick treatment, most people make a full recovery."

MANAGEMENT PLAN
Emergency Same-Day Referral:
"You need to be seen **urgently by an eye specialist today**—this is an **emergency referral**, not just an urgent one. They'll do a **slit-lamp exam** and may take a **corneal scrape** to identify exactly which organism is causing the infection."

Treatment:
"Treatment involves **intensive antibiotic eye drops**—these are given **every hour, day and night** initially. I want you to understand that this means waking up through the night to put drops in. This intensive schedule is necessary to save your sight."
Likely **topical antibiotics** (hospital initiated):
- **Ofloxacin** or dual therapy with **cefuroxime + gentamicin** 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
- **Avoid swimming or showering with contact lenses** (risk of Acanthamoeba infection)

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

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Scleritis

Setting: Primary Care
Role: Junior Doctor
Patient: Older Adult Female with Deep Eye Pain, Photophobia, and Known Rheumatoid Arthritis

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."
General Observations:
Temperature, BP, HR, O2 sats → Normal
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."

Clinical Pearl: Scleritis vs Episcleritis

Feature	Scleritis (EMERGENCY)	Episcleritis (Routine/Self-limiting)
Pain	**Severe, boring, deep**	Mild discomfort
Sleep	**Wakes patient from sleep**	Does not disturb sleep
Tenderness	**Eye tender to touch**	Not tender
Appearance	Deep violaceous (purple-red)	Bright red, sectoral
Vision	May be affected	Normal
Urgency	**Emergency referral**	Routine or self-limiting

"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. The fact that the pain is severe enough to wake you and the eye is tender to touch tells me this is true scleritis, not the milder condition episcleritis. 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'm going to arrange for you to see an eye specialist very urgently—ideally today or first thing tomorrow. I know that might sound a bit concerning, but it's because we want to start treatment quickly to protect your vision."

Initial Medical Plan:
Start oral NSAIDs (e.g., naproxen or 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, ANCA (PR3 and MPO)
- 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

Setting: Primary Care
Role: Junior Doctor
Patient: Adult with Chronic Eyelid Irritation, Crusting, and Gritty Sensation

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?

PMAFTOSA:
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."

General Observations:

Vitals: Temp, BP, HR → All normal **Overall appearance:** Mild local irritation, no systemic signs of infection

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."

"I know it can be frustrating because this tends to be an ongoing condition that needs regular management—a bit like looking after your skin if you have eczema. But the good news is that with regular care, most people can keep it well controlled."

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)

"Think of it like brushing your teeth—once you get into the habit of doing it every day, it becomes second nature, and it really does make a difference."

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 2-4 times 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

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Hordeolum on a background of Blepharitis

- **Setting:** Primary Care
- **Patient:** Adult
- **Presenting:** Acute eyelid lump on background of recent eye condition

1. Introduction & Consent
- Wash hands, introduce self, confirm patient's name & age.
- Take consent for consultation and examination.
- Ask: "How can I help you today?" (Allow patient to describe symptoms in their own words).

2. Focused History
a. History of Presenting Complaint
- **Onset:** "When did you first notice the lump?"
- **Progression:** "Has it increased in size or changed in any way since you first noticed it?"
- **Pain:** "Do you have any pain or tenderness over the lump?"
- **Discharge:** "Have you noticed any pus, discharge or crusting?"
- **Vision:** "Any blurring of vision or change in vision?"
- **Lid swelling:** "Any swelling spreading around the eyelid or face?"
- **Similar lumps:** "Have you had similar lumps or styes in the past?"
- **Associated symptoms:** "Any itchiness, irritation, or foreign body sensation?"
- **Background:** "You mentioned blepharitis was diagnosed recently — how has that been since starting the lid hygiene?"

b. Differential Diagnosis Questions
To help distinguish:
- **Chalazion:** "Has the lump become firm, painless, or stayed after the pain subsided?"
- **Cyst / Dermoid / Skin lesion:** "Has it been there for a long time, or is it slowly growing without pain?"
- **Preseptal / Orbital cellulitis:** "Any redness spreading to surrounding areas, eye pain with movement, fever, feeling generally unwell?"
- **Allergic swelling:** "Any recent exposure to allergens, itching in both eyes, runny nose?"
- **Sebaceous cyst / Meibomian cyst:** persistent painless nodule away from lash line.

c. Systemic / Red Flag Screening
(Important to exclude serious complications like preseptal/orbital cellulitis)

- "Any pain when you move your eyes?"
- "Any double vision or loss of vision?"
- "Any fever or feeling generally unwell?"
- "Is the swelling spreading rapidly or affecting both eyelids?"
- "Any trauma to the eye?"

d. Past Medical / Risk Factors

- **Past ocular history:** recurrent blepharitis, previous styes, chalazion, eyelid conditions.
- **Contact lens use** (risk factor for infection).
- **Immunocompromised state:** diabetes, immunosuppressants, skin conditions (e.g. rosacea).
- **Allergies & medications** (esp. topical eye meds).
- **Occupation / exposure:** dusty environments, eye make-up use.

3. ICE (Ideas, Concerns, Expectations)

- **Ideas:** "What do you think this lump might be?"
- **Concerns:** "Is there anything in particular that worries you about it?" (e.g., cancer, loss of vision, spreading infection).
- **Expectations:** "What were you hoping I could do for you today?" (e.g., antibiotics, drainage, reassurance).

4. Examination

- **General inspection:** swelling, erythema, tenderness, pustule at lid margin.
- **Palpation:** localised tender nodule (external hordeolum), no diffuse warmth spreading beyond lid.
- **Vision:** visual acuity normal.
- **Eye movements:** full, painless.
- **Pre-auricular lymph nodes:** check for enlargement or tenderness — tenderness may indicate a more significant or spreading infection.
- **No discharge or conjunctival injection** unless associated blepharitis.

(In exam, describe findings if they provide an image – here, classic external hordeolum on upper eyelid.)

5. Diagnosis

Likely Diagnosis: *External hordeolum (stye)* — an acute bacterial infection (commonly *Staphylococcus aureus*) of an eyelash follicle or associated Zeis gland, on a background of chronic blepharitis.

6. Explanation

- "From what you've told me and what I can see, this is a **stye** — a small infection at the base of an eyelash gland. It causes a painful, red swelling which often forms a small spot filled with pus.
- You mentioned you were diagnosed with **blepharitis** recently. Think of the blepharitis as creating a *fertile ground* for this to happen. Because the glands along your eyelids are already a bit inflamed and blocked, it's much easier for a small infection like a stye to take hold. That's why continuing with **good lid hygiene** is so important — it not only helps this one settle, but it also prevents new ones from popping up.
- It's a **very common and harmless** condition. Most styes burst or drain naturally within **a week or two**, and get better with simple measures.
- It doesn't usually affect vision, and it's not contagious in the way conjunctivitis is, but good hygiene helps prevent spread."

7. Management Plan

a. Conservative (First Line)

- **Warm compresses:**

    - Apply a clean warm (not hot) flannel to the closed eyelid for **5–10 minutes, 2–3 times daily** to encourage drainage.
- **Eyelid hygiene:**
    - Continue daily cleaning of eyelid margins with warm water and diluted baby shampoo or commercial lid wipes.
    - This helps control the underlying blepharitis and prevents recurrence.
- **Avoid squeezing** or rubbing the stye, as this can worsen infection.

b. Additional Nuance

- If there is a **clearly visible eyelash emerging from the centre of the hordeolum**, gentle **epilation (plucking)** of that eyelash can be done by a trained clinician. This often facilitates drainage and hastens resolution.

c. Symptomatic Relief

- Simple analgesia (paracetamol or ibuprofen) if painful.
- Lubricating drops can help if irritation is significant.

d. Topical Antibiotics

- **Not routinely required** for uncomplicated hordeolum.
- **Consider topical chloramphenicol ointment** if there is discharge or associated conjunctivitis. Apply to lid margin 2–4 times daily for 5 days.

e. Escalation / Referral Criteria

- If the lesion **persists >2 weeks**, becomes **firm and painless**, is recurrent, or appears atypical → may have become a **chalazion** or other lesion → **consider routine ophthalmology referral** if not settling with conservative measures.
- **Preseptal cellulitis** (infection anterior to orbital septum): May be managed with **oral antibiotics** (e.g., co-amoxiclav — follow local antimicrobial guidelines and check allergy status) in adults if mild and vision/eye movements are normal. Urgent ophthalmology review same day.
- **Immediate hospital/A&E referral** if:
    - Visual changes, diplopia
    - Pain with eye movement **(suggests orbital cellulitis)**
    - Proptosis, restricted eye movements **(orbital cellulitis — IV antibiotics required)**
    - Spreading erythema with systemic unwellness or fever.
    - Orbital cellulitis is a **medical emergency** requiring IV antibiotics.

f. Addressing Blepharitis

- Reinforce **long-term lid hygiene** to prevent recurrences.
- If blepharitis remains troublesome, consider topical antibiotics or oral doxycycline (if recurrent posterior blepharitis — long-term management, not acute).

8. Safety Netting

- "Come back urgently if you notice your **vision changes**, the **swelling spreads rapidly**, you develop **pain with eye movements**, or you feel **unwell** with fever."
- "If the lump hasn't improved in about 2 weeks, or if it becomes a firm painless nodule, we may refer you to eye specialists to have it drained."

9. Follow-Up Plan

- Review in **1–2 weeks** if not resolving.
- Earlier review if red flag symptoms appear.

10. Leaflets & Resources
- Offer NHS leaflet on **styes and blepharitis** for self-care guidance.
- Direct to NHS website for eyelid hygiene techniques.

11. Patient Final Check
- "Do you have any questions or concerns?"
- "Are you happy with the plan we've discussed?"
- Ensure they understand home care, when to return, and red flags.

Arcus Senilis

Setting: Primary Care
Role: Junior Doctor
Patient: Older Adult with Cosmetic Concern About Eye Appearance (Ring Around Iris)

INTRODUCTION
"Hello, I'm Dr [Name], one of the doctors here today. Could I confirm your full name and age, please?"
"Thanks for coming in. I can see why something new appearing around your eye would be concerning—let's have a good look and I'll explain what I find."

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?"
"I can completely understand why you were worried when you first noticed it, but I want to reassure you—this is absolutely harmless and won't affect your vision at all."

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 people under 50, corneal arcus warrants a lipid profile check, as it may indicate dyslipidaemia. In younger people under 40, it is called arcus juvenilis and is strongly associated with abnormal lipid levels."

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: Primary Care
Role: Junior Doctor
Patient: Older Adult with Sudden Monocular Vision Loss, Headache, and Scalp Tenderness

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. You'll be seen by the eye specialist and a rheumatologist who'll confirm the diagnosis and arrange any imaging and long-term treatment."
Urgent referral to eye casualty and rheumatology (same-day)

Emergency Treatment:
Start high-dose steroids immediately (before referral):
"I'll give you a high dose of steroids right now to reduce inflammation and protect your other eye—even before we confirm the diagnosis. We never wait for test results before starting treatment in suspected GCA."

Steroid Dosing:

Clinical Scenario	Treatment
Established visual loss (chronic)	Prednisolone **60mg orally** immediately to protect the other eye
Acute/evolving visual loss or amaurosis fugax	**IV Methylprednisolone 500mg-1g daily for 3 days** BEFORE oral steroids
Uncomplicated GCA (no visual symptoms)	Prednisolone 40-60mg orally

"Because you've recently lost vision in one eye and there's a risk to your other eye, I'm going to arrange for you to receive **intravenous (IV) methylprednisolone** — a very high dose of steroid given through a drip — for three days to give the best possible protection to your remaining vision. This will be followed by oral prednisolone 60 mg daily."

PPI/gastroprotection should be co-prescribed with high-dose steroids (e.g., omeprazole 20mg)
Bone protection should also be started: calcium and vitamin D supplementation, plus a bisphosphonate such as alendronate 70 mg weekly, to protect against steroid-induced osteoporosis.

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? "I wish I could give you better news about the eye that's already affected—when the blood supply is cut off, the damage is usually permanent. But what we can do—and why we're acting so quickly—is 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: Primary Care
Role: Junior Doctor
Patient: Adult with Gradually Progressive Peripheral Vision Loss and Driving Difficulties Noticed by Family

INTRODUCTION
"Hello, I'm one of the doctors at the surgery today. Thanks for coming in. Could I confirm your full name and age, please?"
"I understand your wife noticed some changes in your vision—could you tell me a bit more about what's been happening?"

PRESENTING COMPLAINT – Subtle Visual Loss
"Let's go through your symptoms in more detail."

ODIPARA-based History:
Onset: "When did you first start noticing changes in your vision?"
Duration: "Has it been getting worse over time?"
Progression: "Have you noticed anything different about your side vision?"
Pattern:
- "Have you been bumping into things on your left or right?"
- "Any difficulty noticing cars coming from the side while driving?"

Associated features:
- "Any double vision or blurriness?"
- "Any headaches, especially in the morning?"

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
I'm going to arrange an **urgent MRI** of your brain — this should happen **within two weeks**. I'll also **refer you to both the endocrinology and neurosurgery teams**, as this type of condition is best managed by a multidisciplinary team.

Ophthalmology referral should also be arranged for formal visual field monitoring

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:
"I know this is difficult news, especially with everything else I've just told you. But because your side vision is affected, it's not safe for you to drive—and the law requires you to let the DVLA know. Your wife can help with driving for now, and once treatment is complete, we can reassess."

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**.

Eye Case Diagnosis

#	Condition	Key History	Examination Clues	Fundoscopy
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;	Red conjunctiva, no corneal involvement,	Normal fundus; not affected as

		depends on type (bacterial, viral, allergic)	visual acuity usually normal; no photophobia or severe pain	conjunctiva is external
12	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
13	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
14	Blepharitis	Itchy, gritty eyelids, crusting at lashes, morning stickiness	Normal acuity, inflamed lid margins, flakes around lashes	Fundus normal
15	Arcus Senilis	Asymptomatic ring around iris, noticed by patient	Normal acuity, visible grey-white ring at corneal edge	Fundus normal
16	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)
17	Pituitary Adenoma	Gradual peripheral vision loss, bumping into things, driving difficulties	Bitemporal hemianopia on visual field testing	Usually normal unless optic atrophy

For Ophthalmoscope images visit https://www.gksplab2.com

Chapter 14: Dermatology

A Note to Learners

The cases in this resource are written in a conversational style to help you become familiar with the natural flow of clinical consultations and the language commonly used in UK healthcare settings.

These dialogues are intended as a learning guide, not a script. Please do not attempt to memorise them verbatim. Examiners assess your ability to think and communicate authentically - not to recite rehearsed phrases.

Use this material to understand the underlying clinical reasoning, then practise in your own words until the consultation feels natural to you.

For Companion OSCE Cases, Practice Scripts, Evaluation Checklists, Summary Notes, Rapid Review Notes, Mindmaps, Management Flashcards and **Image Library including Dermatology images**- visit https://www.gksplab2.com

Note: Images are not included in this text due to copyright reasons. You can access them at https://www.gksplab2.com

Disclaimer
This material is independent educational content created to help candidates develop clinical reasoning and communication skills for UK medical practice.

All cases and clinical scenarios are based on common presentations encountered in UK primary care and emergency medicine, drawn from publicly available sources including NICE Clinical Knowledge Summaries (CKS), BNF, and other official NHS/UK healthcare guidelines.

No content in this resource is derived from, represents, or claims to replicate actual GMC PLAB 2 examination material.

Introduction
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?"

Topic-Specific Tips
Skin Cancer: Always screen for sun exposure and family history of skin cancer. Use dermoscopy where appropriate. Refer urgently through the Two-Week Wait pathway when indicated.

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.

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: Primary Care Setting | Adult Patient | Skin Lesion - Partner-Noted or Symptomatic
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."
"I can see why you wanted this checked - you've absolutely done the right thing."

Explanation
"I know hearing 'skin cancer' can be worrying, but I want to reassure you - this is the most treatable kind."
"It grows very slowly - think of it like a slow leak rather than something aggressive - and it almost never spreads to other parts of the body."
"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	Management
Back of head	**Routine** dermatology referral - Not in a high-risk site, no urgent features
Nose or hairline	**Urgent** - 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.
For a lesion in this location, I'll arrange an **urgent routine referral** to dermatology. This isn't the same as a cancer emergency pathway - it's just to make sure it's dealt with promptly given the location near your [eyes/nose]."

"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)
- **Photodynamic therapy** (PDT)
- **Topical treatments** (for small superficial lesions- **imiquimod 5% cream** and **5-fluorouracil (5-FU) cream**)
- **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."

Sun Protection Advice
"I'd also recommend using SPF 30+ sunscreen and wearing a hat when outdoors to protect your skin going forward."

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: Primary Care Setting | Older Adult | Non-Healing Skin Lesion - Several Months Duration
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 you've done exactly the right thing by coming in when you noticed this."

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."
"I know this is a lot to process. Is there anything you'd like me to go over again?"

Suspected Melanoma

Scenario: Primary Care Setting | Older Adult | Changing Pigmented Skin Lesion - Sun-Exposed Area
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 skin cancers
- No serious chronic illnesses
- No known drug allergies
- Family history: check melanoma, other skin cancers
- Occupational sun exposure (e.g., gardening, outdoor work)
- Non-smoker/light alcohol
- No regular medications

ICE
I: "My wife said it looks different - I wasn't sure." **C:** "Could it be melanoma? I've read about it online." **E:** "I just want to know if it's serious and what happens next."

Effect on Life
"Has it been affecting you day to day - any discomfort or worry?"

Examination
"Thanks. Would it be alright if I take a close look at the lesion now? I'll use a dermatoscope - it's a special magnifying tool that lets me see the structure of the mole in detail."

Findings (example):
"I can see a pigmented lesion on your shoulder. It's about [size] and has irregular borders, uneven colouring with shades of brown and darker areas, and what looks like some asymmetry. There's no bleeding or ulceration visible at the moment."

7-Point Weighted Checklist for Melanoma Referral
Major features (2 points each):
- Change in size
- Irregular shape
- Irregular colour

Minor features (1 point each):
- Diameter ≥7mm
- Inflammation
- Oozing
- Change in sensation

Score ≥3 = Refer via suspected cancer pathway

Provisional Diagnosis
"Based on what I can see and what you've told me, I'm concerned this could be a type of skin cancer called **melanoma**."
"The changes you've noticed and acted on are very important, and you've done the right thing by coming in now."

Explanation
"Melanoma is a more serious type of skin cancer, but catching it early - like we're doing now - makes a real difference to outcomes."
"Pigment cells are like the cells that give your skin its colour - when they start growing abnormally, that's melanoma."
"It can develop from an existing mole that changes, or it can appear as a completely new spot."
"Long-term sun exposure is a major risk factor, especially if there were sunburns in the past."

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."
"Before I make this referral, I need to check - are you available for the next two weeks? Do you have any holidays or commitments that might affect attending an urgent appointment? This is important because if you're not available, the referral may be delayed."
"The specialist will examine the lesion closely 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 immunotherapy, targeted therapy (for certain gene mutations), or radiotherapy might be used - but that's decided based on how early we've caught it."

Patient Concerns
(*Patient: "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."
(Patient: "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."
(Patient: "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. Try not to irritate or scratch the lesion."

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."

Suspected Melanoma (Mimicking Verruca)

Setting: Primary Care
Patient: Middle-aged Adult
Presenting Complaint: Persistent foot lesion initially thought to be benign
Role: FY2 GP

1. Introduction & Consent
"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?"
(Patient: "There's a verruca on my foot that I've had for a while.")

2. History
Morphology (What it looks like now)
- "Could you describe what the lesion looks like?"
  → *"It looks like a verruca – but it's more of a dark spot now."*
- "Is it raised or flat?"
- "What colour is it?"
- "Is the border smooth or irregular?"
- "Is there any bleeding or discharge?"
- "Does it have any crusting, ulceration, or broken skin?"

Evolution (How it's changed over time)
- "How long has it been there?" → *"About 3 months."*
- "Has it changed since you first noticed it?"
  → *"Yes – it's getting bigger."*
- "Was it always shaped or coloured like this?"
- "Have you ever had anything similar before?"

Symptoms (Sensory, systemic, spreading)
- "Is it painful, itchy, or sore?"
- "Is it affecting your ability to walk or wear shoes?"
- "Have you noticed any similar lesions anywhere else?"

- "Any fevers, weight loss, or feeling generally unwell?"

3. Focused Risk Factor History
Sun Exposure & Skin Cancer Risk
- "Do you spend much time in the sun?" → *"Yes, I enjoy sunbathing."*
- "Do you use sunscreen or protective clothing when outside?"
- "Have you ever had blistering sunburns?"
- "Any history of tanning beds?"

Occupational Risk
- "Do you work outdoors?"
  → *Yes*

Family & Personal History
- "Have you ever had any moles removed or biopsied?"
- "Any personal history of skin cancer?"
- "Anyone in your family diagnosed with skin cancer?"

4. PMAFTOSA
- **P**: No previous skin lesions removed
- **M**: Not on regular medications
- **A**: No known allergies
- **F**: No smoking or alcohol mentioned
- **T**: Otherwise healthy, no comorbidities

5. ICE
- **Idea:** "I thought it was just a verruca."
- **Concern:** "But now it's getting bigger and there's some bleeding."
- **Expectation:** "I want to know if it's something serious and what to do next."

6. Effect on Life
- No pain or functional limitation
- Prompted to attend as lesion continued changing despite 3 months passing

7. Examination
"Would it be alright if I examine the lesion now?"
Findings:
- **Location:** Outer lateral side of the foot
- **Appearance:** Pigmented lesion, visibly larger than previously
- **Colour:** Darkening noted
- **Surface:** Small bleeding spot noted on one edge

Weighted 7-Point Checklist for Melanoma:
- Major features (2 points each): Change in size, Irregular shape, Irregular colour
- Minor features (1 point each): Largest diameter ≥7mm, Inflammation, Oozing, Change in sensation
- **Score ≥3 → Suspected cancer pathway referral**

8. Provisional Diagnosis
"Based on what you've described and what I can see, this lesion raises concern for a type of skin cancer called **melanoma**.
It is not confirmed yet, but the **changes in colour, size, and bleeding** make it important to get it assessed urgently."

9. Explanation

"I know melanoma is a word that can feel frightening. The important thing is that you've come in — catching these things early makes a real difference, and that's exactly what you're doing.
Melanoma starts when pigment-producing cells in the skin grow in an abnormal way.
It can develop from an existing mole or appear as a new lesion.
Be aware that nodular melanoma may present as a non-pigmented lesion — a rapidly growing, firm, red or skin-coloured nodule. If suspected, refer via suspected cancer pathway even without typical pigmented features."

10. Management
Urgent suspected cancer pathway referral to dermatology — suspected melanoma (meets criteria: colour change, size increase, bleeding)
Do NOT treat, biopsy or freeze — any pigmented lesion suspected of melanoma should not be managed in primary care
Dermoscopy may be used by the specialist — this is a special magnifying device that helps examine skin lesions more closely
Advice:

- Don't apply creams or try to self-treat
- Avoid further sun exposure on the lesion
- Do not pick or rub it

Information leaflet — on melanoma and what to expect from the referral
Timeline: You should be seen by the specialist team within 2 weeks and have a diagnosis within 28 days

11. Addressing Concerns
"Is this because of sun exposure?"
→ "Yes — long-term sun exposure without protection is a known risk factor for developing skin cancer, especially in fair-skinned individuals."

"Does this mean it has spread?"
→ "We don't know yet — many melanomas are caught before spreading, which is why we act fast."

"Will it be removed soon?"
→ "Once the dermatologist sees it, they'll assess and if needed, remove it promptly."

12. Safety Netting & Follow-Up
"If you notice it grows further, bleeds more, or any new patches appear elsewhere, please come back urgently.
If you don't hear from the hospital within **2 weeks**, contact us so we can follow up.
Please don't treat the lesion yourself or expose it to the sun."

Final check:
"I'll give you a leaflet with information.
You don't need to return unless the lesion changes or you don't hear from the hospital.
But we're always here if you need any support."

Talon Noir (Black Heel)

Scenario: 50-year-old male. Dark mark was noticed on his left foot during a pedicure session. Known diabetic (well controlled).

Introduction
"Hello, I'm Dr. [Your Name], one of the doctors here today." "Can I confirm your full name and date of birth, please?" "Nice to meet you today. What brought you in?"

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?" *In this case: posterior aspect of the left foot/heel*
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?" *In this case: noticed incidentally during a pedicure*

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?"

Cancer Red Flag Symptoms

- "Any unexplained **weight loss**?"
- "Have you been feeling more **tired** than usual?"
- "Any unusual or **persistent pain** elsewhere?"
- "Any new **lumps** — for example in the groin area?"

Closed Questions — Differentials & Red Flags
Rule Out Melanoma — ABCDE

- **A**symmetry — "Is one side of the mark different from the other?"
- **B**order — "Are the edges smooth and well-defined, or irregular and jagged?"
- **C**olour — "Is it one colour throughout, or are there different colours within it?"
- **D**iameter — "Is it bigger than the size of a pencil eraser — roughly 6mm?"
- **E**volution — "Has it changed in size, shape, or colour over time?"

Risk Factors — Skin Cancer

- "What is your skin type? Do you burn easily?"
- "Have you ever used sunbeds?"
- "Do you have lots of moles on your body?"
- "Has anyone in your family had skin cancer or melanoma?"

Diabetes-Specific (Relevant to This Case)

- "You mentioned you have diabetes — how well is it controlled?"
- "Do you check your feet regularly?"
- "Any numbness, tingling, or loss of feeling in your feet?" *(Neuropathy screen)*
- "Any wounds that have been slow to heal?"

Background History — PMAFTOSA
P — Past Medical History

- "Do you have any other medical conditions apart from the diabetes?"
- "Any history of skin problems?"
- "Have you ever had anything similar before?"

M — Medications

- "What medications are you currently taking?"
- "Are you on any blood thinners like aspirin or warfarin?"

A — Allergies

- "Do you have any allergies to medications or anything else?"

F — Family History

- "Has anyone in your family had skin cancer, melanoma, or any other cancer?"

T — Travel / Tan

- "Have you travelled anywhere hot or sunny recently?"

O — Occupation

- "What do you do for work? Are you on your feet a lot?"
- "Any outdoor work with sun exposure?"

S — Smoking / Alcohol

- "Do you smoke?"
- "How much alcohol do you drink?"

A — Activity / Sports

- "Do you play any sports — like running, football, tennis, gym?"
- "Do you do a lot of walking or spend long hours on your feet?"
- *(KEY question — talon noir is strongly linked to sports and repetitive trauma/friction)*

ICE — Ideas, Concerns, Expectations
Ideas

- "What do you think might be causing this mark?"
- "Have you looked it up or has anyone suggested what it could be?"

Concerns

- "I can see you're worried — is there anything specific you're concerned about?"
- "Are you worried this could be something serious, like cancer?"

Acknowledge directly: "I completely understand your concern. Any new dark mark on the skin can be worrying, especially when you hear about things like melanoma. Let me reassure you — we're going to look at this carefully together."

Expectations

- "What were you hoping we could do for you today?"

Impact on Life

- "Has this been affecting your day-to-day life?"
- "Has it stopped you from doing any activities or sports?"
- "Has it been playing on your mind or causing you anxiety?"
- "Has it affected your work?"

Examination

"Thank you for telling me all of that. I'd like to have a close look at your foot now if that's okay."

Verbalise

- **Inspect the foot** — Look at the posterior/posterolateral aspect of the heel
- **Describe the lesion** — Site, size, shape, colour, borders, surface
- **Check skin lines** — Are the normal skin markings (dermatoglyphics) preserved?
    - **Preserved** in talon noir
    - **Interrupted/destroyed** in melanoma
- **Paring test** (if doubt exists) — Gently scraping the surface with a #15 blade can help confirm the diagnosis
    - Talon noir → dark pigment **comes off** in the shavings
    - Melanoma → pigment is **deeper** and does NOT scrape away

Dermoscopy is not routinely available at FY2 level. If there is clinical doubt and dermoscopy is not available in the practice, refer to dermatology where further assessment including dermoscopy can be carried out.

Expected Findings in This Case:

- Dark/black-brown mark on posterior aspect of the heel
- Flat, well-defined, speckled appearance
- Made up of tiny black pinpoint dots grouped together
- **Skin lines preserved**
- Painless
- No ulceration, bleeding, or irregular borders

Diagnosis

"Based on what you've told me and what I can see, I'm pleased to tell you that this looks like a condition called **talon noir**, which is also known as a **black heel**."

"Have you heard of that before?"

Explain Simply

"Talon noir is a completely harmless condition. What happens is that the tiny blood vessels under the thick skin of your heel leak a very small amount of blood due to pressure and friction — usually from walking, sports, or certain types of footwear. It's essentially a small bruise trapped in the skin."

"It's **not skin cancer**, and it's **not caused by cancer cells** at all. I want to reassure you about that."

"It will eventually grow out and disappear on its own as your skin naturally renews itself. This usually takes a few weeks."

"Does that make sense? Do you have any questions about what I've just explained?"

Management

1. Conservative / Self-Management Advice

- **Reassurance** — This will disappear on its own. No treatment is needed.
- **Reduce pressure and friction** on the area
- **Wear well-fitting, cushioned footwear** — avoid shoes that are too tight or loose
- **Avoid high-impact activity temporarily** if related to sports
- **Regular diabetic foot checks** — continue monitoring feet for any new marks, wounds, or changes

2. Offer

- **Clinical photography** — take a photo of the mark and keep it on file for comparison
- **Paring test** — if there is any clinical uncertainty, the GP can gently scrape the surface to confirm the diagnosis
- **Referral to dermatology** if the appearance changes, does not resolve, or there is any diagnostic doubt — where further assessment including dermoscopy can be carried out

Addressing Patient Concerns — Common Questions
"Is this skin cancer?" "No, this is not cancer. Talon noir is caused by trapped blood from pressure and friction — it has nothing to do with cancer cells."

"Do I need a biopsy?" "Not if the features are typical, which they are in your case. We only investigate further if there's any uncertainty."

"How long will it take to go away?" "It usually fades over a few weeks as the skin naturally renews itself. Think of it like a bruise working its way out."

"Can it come back?" "Yes, if the same pressure or friction happens again. But it can be prevented with better footwear and cushioning."

"Does my diabetes make this worse?" "Your diabetes is well controlled, which is great. Since you don't have any neuropathy or circulation problems, this shouldn't be a concern. But it is important to keep checking your feet regularly."

3. Safety Net / Follow-Up / Leaflet
Safety Net — Come Back If:

- The mark changes in **size, shape, or colour**
- It becomes **raised, bleeds, or ulcerates**
- **New similar marks** appear elsewhere
- It **doesn't fade** within a few weeks
- You develop any **new lumps** (especially in the groin)
- Any other new skin changes that concern you

Follow-Up:

- Routine review in **4–6 weeks** to check it's fading as expected
- "If anything changes before then, don't wait — come straight back."

Leaflet:

- Offer NHS information leaflet on talon noir / benign skin conditions
- Direct to NHS website for further reading

Note: Referral Pathway (If Doubt Exists)
If at any point the lesion does **NOT** look typical of talon noir, or if there are features raising suspicion of melanoma:

7-Point Weighted Checklist for Melanoma

Major Features (2 points each):
1. Change in size
2. Irregular shape
3. Irregular colour

Minor Features (1 point each): 4. Diameter ≥ 7mm 5. Inflammation 6. Oozing / crusting 7. Change in sensation (itch/pain)

Score ≥ 3 → Refer via 2-Week Wait Suspected Cancer Pathway
Also refer urgently (2WW) if:
- Dermoscopy suggests melanoma
- Lesion suggests nodular melanoma (pigmented or non-pigmented)

In this case: The lesion scores 0 on the 7-point checklist. No red flags. Features are entirely consistent with talon noir. No referral needed — reassure and safety net.

Note: Key Differentials at a Glance
Talon Noir (Black Heel)
- Intra-epidermal dried blood
- **Painless**
- Flat and speckled
- Well-defined borders
- **Skin lines preserved**
- Caused by repeated trauma/friction
- Pigment **scrapes off** with paring

Verruca (Wart)
- Rough, papillomatous papule
- **Pain on pressure** (lateral squeeze test positive)
- Tiny black dots (thrombosed capillaries)
- **Interrupts skin lines**
- Caused by HPV infection

Acral Melanoma
- Irregular, uneven surface
- Ulceration, bleeding possible
- Brown/black pigmentation — may have multiple colours
- **Interrupts or DESTROYS skin lines**
- Asymmetry, bleeding, change = **THINK CANCER**
- Pigment does **NOT** scrape off

Golden Rule: Irregular pigment on the sole = **Think melanoma until proven otherwise.**

Skin Cancer: Always screen for sun exposure and family history of skin cancer. If there is any clinical doubt about a pigmented lesion, refer — do not delay. Use the NICE NG12 7-point weighted checklist. Refer urgently through the Two-Week Wait pathway when indicated.

Diabetic Foot: In any patient with diabetes presenting with a foot lesion, always screen for neuropathy and peripheral vascular disease. Reinforce the importance of regular foot checks and appropriate footwear. Ensure the patient is engaged with diabetic foot screening services.

Seborrheic Keratosis

Scenario: Primary Care Setting | Older Adult | Long-Standing Skin Lesion - Routine Presentation
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 for Seborrheic Keratosis:
- Long-standing, stable lesion
- Waxy, "stuck-on" appearance
- Brown, tan, or black colour
- Well-defined borders
- Often multiple lesions
- Common in older adults
- No pain, bleeding, or rapid change

Ask specifically:
"How long has this been there?" "Has it changed at all - in size, colour, or shape?" "Does it itch, hurt, or bleed?" "Do you have any similar spots elsewhere?" "Has anyone in your family had skin cancer?"

PMAFTOSA
- No previous skin cancers
- No systemic illness
- No allergies
- Family history: check for melanoma (if positive, increases caution)
- Retired
- Non-smoker
- No regular medications

ICE
I: "I wasn't sure if it was a wart or something else."
C: "Could this be skin cancer?"
E: "I just want reassurance - or treatment if needed."

Effect on Life
"Does it catch on clothing or cause any discomfort?" "Is the appearance bothering you?"

Examination
"Thanks. Would it be alright if I take a closer look?"

Findings:
"I can see a raised, waxy-looking lesion. It's brown in colour, has a well-defined border, and looks like it's stuck onto the surface of the skin - like a small piece of wax. There's no bleeding, ulceration, or surrounding redness."

Provisional Diagnosis
Version 1 - No family history of melanoma:

"This looks like a **seborrhoeic keratosis** - sometimes called an 'age spot' or 'seborrhoeic wart'. It's a completely harmless, benign skin growth."

Version 2 - With family history of melanoma:
"Given your family history of melanoma, I'd like to refer you for a skin check with the dermatology team - just to be on the safe side. This is an **urgent two-week referral**."

Explanation
"Seborrhoeic keratoses are very common, especially as we get older. They're not caused by sun exposure and they're not contagious."
"It can look a bit unusual or warty, which understandably makes people want to get it checked - and I'm glad you did."
"They don't turn into skin cancer and don't need treatment unless they're causing symptoms or you'd like them removed for cosmetic reasons."

Management Plan
If benign and no concerns:
"There's no medical need to remove it. However, if it's catching on clothing or bothering you, removal is possible - but it's considered a cosmetic procedure and isn't available on the NHS."
"If you'd like it removed, I can refer you to a private dermatologist or cosmetic clinic. They'll discuss procedure options and costs with you directly."

If family history of melanoma:
"Because of your family history, I'll arrange an urgent referral for a full skin check. This is just to be thorough."

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: Primary Care Setting | Young Child | Intermittent Rash - Not Present at Consultation
Role: FY2 GP - assess, reassure, and advise parent appropriately

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 when your child gets warm, the skin releases a natural chemical that causes these temporary bumps - but they come and go quickly."
"It isn't an allergy to food or pollen, but your child's skin is releasing the same chemical (histamine) that causes allergies, just triggered by heat. That's why allergy tablets work well for this."

Management Plan
"We usually treat this with **antihistamine medication** - such as cetirizine or loratadine, which are suitable from age 2. 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 Consultation | Adolescent | Mild Facial Acne - Image Available
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
Since this is a remote consultation, ask for specific acne pivots:

"When did the acne first appear?" "Is it mainly on your forehead, cheeks, or elsewhere?" "Do you get blackheads, whiteheads, or red inflamed spots?" "Any painful cysts or lumps under the skin?" "Have you tried any treatments so far - creams, washes, or anything from the pharmacy?"

PMAFTOSA

- No significant past medical history
- No allergies
- No regular medications
- Family history of acne (often positive)
- Non-smoker
- Good diet (reassure diet is not the cause)

ICE

I: "I think it's because I'm dirty or eating too much chocolate."
C: "Will it scar? Will it ever go away?"
E: "I just want something that works."

Effect on Life

"How is this affecting you at school or with friends?" "Is it affecting your confidence or mood?" "I know it's tough to ask, but has the bullying or the way you feel about your skin ever made you feel really low or hopeless?"

Provisional Diagnosis

"From the photo and what you've told me, this looks like **mild acne vulgaris** - a very common skin condition, especially during teenage years."

Explanation

"Acne happens because of a combination of things: your skin produces more oil during puberty, dead skin cells can block pores, and bacteria can cause inflammation."
"It's **not** caused by being dirty, eating chocolate, or anything you're doing wrong. It's just part of how your skin responds to hormonal changes."
"The good news is that it's very treatable, and most people see real improvement with the right approach."

Management Plan

Important safety check (for females of childbearing age): "Before I prescribe treatment, I need to ask - are you pregnant or planning to become pregnant? Some acne treatments can't be used during pregnancy."
"To treat this, the most effective approach is using a combination cream that tackles multiple causes of acne at once.
I'd recommend starting with a cream called **Epiduo** - it contains two active ingredients: **adapalene** (which helps unblock pores) and **benzoyl peroxide** (which reduces bacteria and inflammation).
[Note: Alternative options per NICE]

- Tretinoin + clindamycin combination (e.g., Treclin)
- Benzoyl peroxide + clindamycin combination (e.g., Duac)

Apply a thin layer once daily at night, on clean dry skin. Wait 20-30 minutes after washing before applying - this reduces irritation. It may cause some mild irritation or dryness at first - this usually settles after 1-2 weeks.

"If you'd prefer something simpler, benzoyl peroxide alone can also help, though combination treatments tend to work better."

If these are contraindicated or patient prefers to avoid retinoids/antibiotics:

"Benzoyl peroxide gel on its own is also an option - apply once or twice daily. Start with a lower strength (2.5% or 5%) to reduce irritation."

General Advice
- Wash face twice daily with a gentle cleanser
- Avoid picking or squeezing spots (causes scarring)
- Use non-comedogenic (oil-free) moisturisers if skin is dry
- Be patient - it can take 8-12 weeks to see full improvement

Safety Netting
"If the acne gets worse, becomes very painful, or you develop deep cysts, please get back in touch - we may need to add an oral antibiotic alongside your topical treatment or refer you to a dermatologist."
"Also, if you're feeling really low about this, please talk to someone - we can help with that too."

Follow-Up
"Let's review in about 12 weeks to see how things are going. You can send another photo or book an appointment."

Leaflet
"I'll arrange for a leaflet to be sent to you about acne and skincare. Remember - this is not your fault, and with the right treatment, it will get better."

Impetigo

Scenario: Primary Care Setting | Breastfeeding Adult | Facial Rash - Spreading | Concerns About Previous Treatment
Your Role: FY2 GP - assess, explain, and prescribe appropriately.

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 got this rash on my face that keeps spreading. I went to the pharmacy but the cream they gave me didn't work. I'm really frustrated.")
"I'm really sorry to hear that you had a difficult experience. Let's take a fresh look and see how we can help."

History - Follow standard dermatology rash structure
Diagnostic pivots for impetigo:
- Golden, honey-coloured crusts
- Often starts around nose or mouth
- Spreads with scratching
- Highly contagious
- Common in children but can affect adults
- May follow minor skin trauma

Ask specifically:
"When did the rash first appear?" "Where did it start and how has it spread?" "Is it itchy or painful?" "Has anyone else in your household developed a similar rash?" "Are you currently breastfeeding?"

PMAFTOSA
- Currently breastfeeding
- No significant past medical history
- No allergies

- No regular medications
- No recent travel

ICE
I: "I thought it was just a cold sore at first."
C: "Is it contagious? Can I pass it to my baby?"
E: "I need something that actually works this time."

Effect on Life
"Is this affecting your ability to care for your baby?" "Are you worried about passing it on?"

Examination
"Would it be alright if I take a closer look at the rash?"

Findings:
"I can see clusters of small blisters around your nose and mouth, some of which have burst and formed golden, honey-coloured crusts. The surrounding skin is slightly red. There's no swelling of the lymph nodes."

Provisional Diagnosis
"This looks like **impetigo** - a common bacterial skin infection."

Explanation
"Impetigo is caused by bacteria that get into the skin, often through a small cut or scratch. It's not your fault, and it has nothing to do with hygiene."
"It's very contagious, so it's important to treat it promptly and take some precautions to stop it spreading."

Management Plan
"For localised impetigo, the first treatment we try is hydrogen peroxide 1% cream - apply two to three times daily for 5 days. However, since the impetigo is very close to your eyes/nose, I'll prescribe **fusidic acid 2% cream** instead, as hydrogen peroxide could cause irritation in this sensitive area. Apply it three times a day for 5 days. It's safe to use while breastfeeding, as long as you don't apply it directly on or near the breast."

Hygiene Advice
- Wash hands frequently
- Avoid touching or scratching the affected area
- Use separate towels and flannels
- Wash bedding and towels regularly
- Don't share items with others
- You can continue breastfeeding - just wash hands thoroughly before handling your baby and avoid kissing near the affected areas

Safety Netting
"If the rash spreads despite treatment, becomes very red or swollen, or you develop a fever, please come back - you may need oral antibiotics."
"The infection usually clears within 7-10 days with treatment. You're no longer contagious 48 hours after starting treatment, or once the sores have crusted and healed."

Follow-Up
"You shouldn't need routine follow-up, but if things aren't improving after 5 days, please get back in touch."

Leaflet
"I'll give you a leaflet about impetigo, including how to prevent it spreading to your baby."

Herpes Labialis (Cold Sore)

Scenario: Primary Care Setting | Working Adult | Painful Lip Blisters - Occupational Concern
Your Role: FY2 GP - assess, explain, and advise appropriately.

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 got these painful blisters on my lip. They keep coming back and it's really affecting my work.")

History - Follow standard dermatology rash structure
Diagnostic pivots for herpes labialis:

- Recurrent painful blisters on or around lips
- Preceded by tingling or burning sensation
- Crusts over after a few days
- Triggered by stress, illness, sun exposure
- History of previous cold sores

Ask specifically:
"When did this episode start?" "Did you notice any tingling before the blisters appeared?" "How often do you get cold sores?" "What seems to trigger them?" "How is this affecting your work?"

PMAFTOSA

- History of recurrent cold sores
- No significant past medical history
- No allergies
- No regular medications
- Works in client-facing role

ICE
I: "I know it's a cold sore but I need it to go away quickly."
C: "Will I keep getting these forever?"
E: "I need something stronger than the pharmacy cream."

Effect on Life
"I understand this is particularly concerning given your profession. How is it affecting your confidence at work?"

Examination
"Would it be alright if I take a look?"

Findings:
"I can see a cluster of small blisters on your lower lip, some of which are starting to crust over. There's some redness and swelling around the area."

Provisional Diagnosis
"This is a **cold sore** - caused by the herpes simplex virus."

Explanation
"Cold sores are caused by a virus that stays dormant in your body and can reactivate from time to time - especially when you're stressed, run down, or have had a lot of sun exposure."
"Once you have the virus, it stays with you, but the good news is that outbreaks usually become less frequent over time, and we can help manage them."

Management Plan
"The key is to apply antiviral cream like aciclovir as early as possible - ideally at the first tingle, before the blisters even appear."
"Since this outbreak has already started, I can prescribe oral antiviral tablets to help it heal faster."

Oral antiviral treatment:
- Aciclovir 200mg five times daily for 5 days (start within 48 hours for best effect)
- Alternative: Valaciclovir 2g twice in a single day

"For future outbreaks, keeping antiviral cream at home and applying it at the first tingle can often stop the cold sore from fully developing."

Advice
- Avoid kissing or close contact while you have active blisters
- Don't share lip balm, cups, or towels
- Wash hands after touching the area
- Use SPF lip balm to protect against sun-triggered outbreaks
- Manage stress where possible

Safety Netting
"If the cold sores become very frequent (more than 6 times a year), we can discuss preventive treatment."
"If you develop cold sores near your eyes, or if they spread to other parts of your body, please seek medical attention urgently."

Follow-Up
"You shouldn't need routine follow-up, but if the outbreaks are bothering you significantly, we can discuss long-term options."

Leaflet
"I'll give you a leaflet about cold sores and how to manage them."

Measles

Scenario: Student Health Service | Young Adult | Viral Rash with Systemic Symptoms | Telephone Consultation
Your Role: FY2 GP - assess, advise, and ensure public health measures.

Introduction
"Hello, am I speaking to [patient name]?
This is Dr [Your Name] calling from the health service. Is now a good time to talk?"
"Before we begin, can I confirm your date of birth and address?"
"Thanks. I understand you're not feeling well. Can you tell me what's been going on?"
(Patient: "I've got a rash all over and I feel terrible - fever, cough, really tired.")

History - Follow standard infectious rash structure
Diagnostic pivots for measles:
- Prodrome: fever, cough, runny nose, conjunctivitis (3 Cs: cough, coryza, conjunctivitis)

- Koplik spots (white spots inside cheeks) - pathognomonic
- Rash: starts on face/behind ears, spreads downwards
- Maculopapular rash that may become confluent
- Very unwell - systemic symptoms
- Vaccination status important

Ask specifically:
"When did you first feel unwell?" "When did the rash appear and where did it start?" "Have you had a cough, runny nose, or red eyes?" "Have you had your MMR vaccinations?" "Have you been in contact with anyone who's been unwell?"

PMAFTOSA
- Check vaccination history (may be incomplete)
- No significant past medical history
- No allergies
- No regular medications
- University student - communal living

ICE
I: "I thought it was just the flu but then this rash appeared."
C: "Is it serious? I have exams coming up."
E: "I just want to know what it is and how long I'll be ill."

Effect on Life
"I know this is really inconvenient timing. How are you managing with your studies and living situation?"

Clinical Assessment (telephone)
"Based on what you've described - the fever, cough, red eyes, and the rash starting on your face and spreading down - this is very likely to be **measles**."

Explanation
"Measles is a viral infection that causes the symptoms you're experiencing. It's spread through coughs and sneezes and is very contagious."
"I have a legal duty to notify the Health Protection Team immediately, even before test results are back. This helps protect others in your community and is a statutory requirement for measles."
"The good news is that most people recover fully with rest and supportive care, though it can take 7-10 days to feel better."

Management Plan
"There's no specific treatment for measles - it's a viral infection, so antibiotics won't help. Treatment is supportive:"
- **Paracetamol** for fever and discomfort (avoid ibuprofen as NSAIDs may mask symptoms or potentially worsen complications)
- **Plenty of fluids** - stay well hydrated
- **Rest** - your body needs energy to fight the infection
- **Dim lighting** may help if your eyes are sensitive

Isolation Advice
"You need to stay isolated for **4 days from when the rash first appeared**. This means:
- Stay at home - don't go to lectures or communal areas
- Avoid contact with others, especially pregnant women, babies, and anyone with a weakened immune system

- If you need to see someone, wear a mask"

Vaccination
"Once you've recovered, we should discuss catching up on your MMR vaccination if you haven't had both doses. This will protect you from future infections."

Safety Netting
"While most people recover without problems, measles can occasionally cause complications like ear infections, pneumonia, or very rarely, inflammation of the brain (encephalitis).
Please seek urgent medical help if you experience:

- Difficulty breathing or chest pain
- Severe headache or neck stiffness
- Confusion or drowsiness
- Fits or seizures
- Symptoms getting worse instead of better after a few days"

Follow-Up
"You don't need routine follow-up, but please contact us if you're not improving after 7-10 days or if you develop any of the warning signs I mentioned."

Notification
"I'll be notifying public health about your case. They may contact you for some additional information about your contacts."

Cellulitis

Scenario: Primary Care Setting | Older Adult | Painful Lower Limb Rash | Recent Skin Break | Drug Allergy
Your Role: FY2 GP - assess, examine, and initiate treatment.

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 leg has become really red and painful. I think it started after an insect bite.")

History - Follow standard dermatology structure
Diagnostic pivots for cellulitis:

- Rapidly spreading redness
- Warmth, swelling, tenderness
- Often follows skin break (bite, wound, eczema)
- Systemic symptoms possible (fever, malaise)
- Usually unilateral
- Risk factors: diabetes, obesity, lymphoedema, previous cellulitis

Ask specifically:
"When did you first notice the redness?" "Has it been spreading?" "Is there any pain, warmth, or swelling?" "Did you have any injury, bite, or break in the skin before this started?" "Have you had any fever or felt unwell?" "Have you had cellulitis before?" "Do you have any allergies to medications?"
(Patient: "Yes, I'm allergic to penicillin.")

PMAFTOSA

- Penicillin allergy (important for antibiotic choice)
- No diabetes

- No lymphoedema
- Previous insect bite on leg
- Otherwise well
- No regular medications

ICE
I: "I thought the bite was getting infected."
C: "Will it spread further? Do I need to go to hospital?"
E: "I just want it treated before it gets worse."

Effect on Life
"Is the pain affecting your mobility or sleep?"

Examination
"Would it be alright if I examine your leg?"

Findings:
"I can see an area of redness on your lower leg, roughly [size]. The skin is warm to touch, slightly swollen, and tender. The borders are slightly irregular. There's no pus or abscess visible. I can see what looks like a healing insect bite in the centre."
"I'd like to draw a line around the edge of the redness with a marker pen - this helps us see if the infection is spreading or improving over the next few days."

Vital Signs
- Check temperature
- Check for tachycardia
- Assess for systemic illness

Provisional Diagnosis
"This looks like **cellulitis** - a bacterial skin infection that's spread into the deeper layers of your skin."

Explanation
"Cellulitis happens when bacteria get through a break in the skin - in your case, likely through the insect bite - and cause an infection in the skin and tissue underneath."
"It's important we treat it early to prevent the infection from spreading deeper or becoming more severe - and the good news is that antibiotics are very effective for this."

Management Plan
Since patient has penicillin allergy:
"Because you're allergic to penicillin, I'll prescribe **doxycycline** instead."
Prescription:
- Doxycycline 200mg on day 1, then 100mg once daily (total 5-7 days including loading day)

OR (alternative):
- Clarithromycin 500mg twice daily for 5-7 days

"Take the doxycycline with plenty of water and food to avoid stomach upset. Avoid lying down for 30 minutes after taking it, as it can cause irritation to the gullet."

Important advice:
- "Doxycycline can make your skin more sensitive to sunlight - so avoid prolonged sun exposure and use sunscreen while taking it."

General Advice
- Rest and elevate the leg when possible
- Take paracetamol for pain relief
- Keep the skin clean and moisturised
- Complete the full course of antibiotics

Marking the Area
"I've drawn a line around the redness. If the redness spreads beyond this line, that's a sign we may need to change treatment or consider hospital admission."

Safety Netting
"Please come back or seek urgent help if:
- The redness spreads beyond the line I've drawn
- You develop a high fever or feel very unwell
- You develop blistering or dark patches on the skin
- You're not improving within 48-72 hours"

"If you haven't started to improve within 2-3 days, please contact us so we can review and consider whether you need different treatment."

Follow-Up
"I'd like to see you again in 48 hours to check how things are progressing. We can see if the redness has reduced and whether the antibiotics are working."

Leaflet
"I'll give you a leaflet about cellulitis and what to look out for."

Chickenpox (Varicella)

Scenario: Primary Care Setting | Paediatric Patient | Widespread Vesicular Rash with Systemic Symptoms
Your Role: FY2 GP - assess, advise, and ensure appropriate isolation.

Introduction
"Hello, I'm one of the doctors here at the practice. I understand you've brought your child in today. Could I confirm your child's full name and age, please?
Thanks. What's been going on?"
(Parent: "They've got spots all over and a fever. I'm worried it might be chickenpox.")

History - Follow standard paediatric rash structure
Diagnostic pivots for chickenpox:
- Vesicular rash ("dew drops on a rose petal")
- Different stages present simultaneously (papules, vesicles, crusts)
- Starts on trunk, spreads to face and limbs
- Intensely itchy
- Prodrome: fever, malaise
- Incubation period 10-21 days
- Contact history important

Ask specifically:
"When did the spots first appear?" "Where did they start and how have they spread?" "Are the spots itchy?" "Has your child had a fever or felt unwell before the spots appeared?" "Has your child been in contact with anyone with chickenpox recently?" "Has your child had the chickenpox vaccine?"

PMAFTOSA (Paediatric-Adapted)

- Vaccination history
- No significant past medical history
- No immunosuppression
- No allergies
- Not on any regular medications
- Otherwise healthy child

ICE

I: "I think it's chickenpox but I wanted to make sure."
C: "Is it serious? Will it scar? I have other children at home."
E: "I need to know how to manage it and when they can go back to school."

Effect on Life

"How is your child coping with the itching?" "Is the fever affecting their eating or drinking?"

Examination

"Would it be alright if I examine your child?"

Findings:

"I can see a widespread rash with spots at different stages - some are red bumps, some are fluid-filled blisters, and some have already crusted over. The rash is present on the face, trunk, and limbs. Your child has a mild fever but is otherwise alert and responsive."

Provisional Diagnosis

"This is **chickenpox** - a common viral infection caused by the varicella-zoster virus."

Explanation

"Chickenpox is very common in childhood and is usually mild in otherwise healthy children. The spots will continue to appear for a few days and will then crust over and heal."
"Most children feel much better within a week, and it's usually just a case of keeping them comfortable while their body fights it off."
"The virus is spread through direct contact and through the air when an infected person coughs or sneezes."

Management Plan

"There's no specific treatment for chickenpox - it's a viral infection, so antibiotics won't help. Treatment is about managing symptoms:"

Fever and discomfort:

- **Paracetamol** regularly if needed
- **Avoid aspirin** - risk of Reye's syndrome in children
- **Avoid ibuprofen** - NHS advises against its use in chickenpox due to potential risk of more severe skin reactions

Itching:

- **Calamine lotion** - apply to spots to soothe itching
- If the itching is really bothering them, the pharmacist can recommend an antihistamine suitable for their age - something like Piriton syrup (chlorphenamine)
- Keep fingernails short to prevent scratching
- Cool baths may help
- Loose cotton clothing is more comfortable

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Hydration:
- Encourage plenty of fluids

School Exclusion
"Your child needs to stay off school until **all the spots have crusted over** - this usually takes about 5-6 days from when the rash first appeared."

Protecting Others
"Chickenpox is very contagious. Please keep your child away from:
- Pregnant women (especially those who haven't had chickenpox)
- Newborn babies
- Anyone with a weakened immune system

If any of these people have been in contact with your child, they should speak to their doctor."

Safety Netting
"Most children recover without any problems, but please seek urgent medical help if your child:
- Develops difficulty breathing
- Becomes very drowsy or difficult to wake
- Develops a high fever that doesn't respond to paracetamol
- Has spots that become very red, hot, or painful (possible secondary infection)
- Seems to be getting worse rather than better after a few days
- Has any fits or seizures"

Follow-Up
"You shouldn't need routine follow-up, but please contact us if you're concerned about how your child is recovering."

Leaflet
"I'll give you an NHS leaflet about chickenpox with information on caring for your child at home."

Paronychia

Scenario: Primary Care Setting | Young Adult | Painful Swelling Around Toenail Following Minor Injury
Your Role: FY2 GP - assess, examine, and initiate treatment.

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 toe has been really painful and swollen. I stubbed it a couple of weeks ago.")

History - Follow standard dermatology structure
Diagnostic pivots for paronychia:
- Pain, swelling, redness around nail fold
- Often follows trauma or nail biting
- May have pus collection
- Acute vs chronic presentation
- Risk factors: nail biting, manicures, ingrown nails

Ask specifically:
"When did the pain and swelling start?" "Did you injure your toe before this started?" "Is there any pus or discharge?" "Have you had this problem before?" "Do you bite your nails or pick at the skin around them?"
(Patient mentions concern about gout)

"Thanks for sharing that. I understand your concern - but let's not jump to conclusions just yet."

PMAFTOSA
- Recent minor trauma to toe
- No significant past medical history
- No allergies
- No regular medications
- No family history of gout

ICE
I: "I'm worried it might be gout - my dad has it."
C: "Will I need surgery?"
E: "I just want the pain to go away."

Effect on Life
"Is the pain affecting your ability to walk or wear shoes?"

Examination
"Would it be alright if I take a look at your toe?"

Findings:
"I can see swelling and redness around the nail fold of your big toe. The area is tender to touch. There's no obvious pus collection visible, but the skin looks quite inflamed."

Provisional Diagnosis
"This is **paronychia** - an infection of the skin around the nail."

Explanation
"Paronychia happens when bacteria get into the skin around the nail, often through a small injury like the one you described. It's very common and very treatable."
"Gout would be really unusual at your age - it typically affects people later in life, and usually those with specific risk factors. The location and appearance of your toe is much more consistent with a nail infection."

Management Plan
Topical treatment (mild cases):
- **Fusidic acid 2% cream** - apply 2-3 times daily to the affected area

Plus:
- **Warm salt water soaks** - 15 minutes, 3-4 times daily. This helps draw out infection and reduce swelling.

If worsening or spreading:
- Oral antibiotics may be needed
- If penicillin allergic: clarithromycin/erythromycin/doxycycline

If abscess present:
- May need incision and drainage

Advice
- Keep the area clean and dry
- Avoid picking at the skin or nail
- Wear comfortable, well-fitting shoes
- If you have an ingrown toenail contributing to this, we may need to address that

Safety Netting
"Please come back if:

- The swelling and redness spreads up your toe or foot
- You develop a fever
- Pus starts collecting under the skin
- It's not improving after a few days of treatment"

"If an abscess forms, you may need a minor procedure to drain it."

Follow-Up
"If things aren't settling within 5-7 days, please come back. If the problem keeps recurring, we might need to consider a podiatry referral to address any underlying nail issues."

Leaflet
"I'll give you some information about caring for nail infections at home."

Differential Diagnosis Reference Table

Condition	Key Features
Paronychia	Swelling/redness at nail fold, follows trauma, localized
Gout	Extremely painful, red, hot joint; often big toe MTP joint; older patient; elevated uric acid
Ingrown toenail	Nail growing into skin, chronic pain, may have granulation tissue
Cellulitis	Spreading redness, systemic symptoms, not localized to nail fold

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Psoriasis

Scenario: Primary Care Setting | Young Adult | Chronic Symmetrical Scaly Rash on Extensor Surfaces
Your Role: FY2 GP - assess, explain, and initiate treatment.

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, scaly rash on my elbows for a while now. It's getting worse and I'm embarrassed about it.")

History - Follow standard dermatology structure
Diagnostic pivots for psoriasis:

- Well-demarcated, raised red plaques
- Silver-white scales
- Symmetrical distribution
- Extensor surfaces (elbows, knees, scalp)
- Nail changes (pitting, onycholysis)
- Family history often positive
- Chronic/relapsing course
- May have joint symptoms

Ask specifically:
"When did you first notice the rash?" "Has it spread or changed over time?" "Does it itch or cause any discomfort?" "Have you noticed any changes to your nails?" "Do you have any stiffness or pain in your joints, especially in the mornings?" "Has anyone in your family had psoriasis or similar skin conditions?" "Have you noticed any triggers - stress, infections, certain medications?"

PMAFTOSA

- No significant past medical history
- Family history of psoriasis (often positive)
- No allergies
- No regular medications
- Smoker/non-smoker (smoking worsens psoriasis)
- Alcohol intake (can affect treatment choices and worsen psoriasis)

ICE

I: "I've heard of psoriasis but I'm not sure what it is."
C: "Is it contagious? Will I have it forever?"
E: "I want something that will make it go away."

Effect on Life

"How is this affecting your confidence and daily life?" "Is it affecting your sleep or work?" "Is the appearance bothering you in social situations?"

Examination

"Would it be alright if I examine your skin?"

Findings:

"I can see well-defined, raised red patches with silvery-white scaling on both elbows. The plaques are symmetrical. There are also some smaller patches on your knees. Your nails show some small pits. There's no joint swelling visible."

Screening Questions for Psoriatic Arthritis

"Do you experience any joint stiffness or pain, especially in the mornings?" "Do your fingers or toes ever feel swollen like 'sausages'?" "Have you noticed any eye redness, pain, or blurred vision?"

Provisional Diagnosis

"This is **psoriasis** - a common, long-term skin condition."

Explanation

"Psoriasis is caused by your immune system making skin cells renew much faster than normal - instead of the usual 3-4 weeks, it happens in just a few days. This causes the build-up of scales and redness you can see."
"First, I want to reassure you - psoriasis isn't contagious at all. You can't catch it from someone or pass it on."
"It is a long-term condition that tends to come and go, but we have very good treatments to control it and keep it in remission."
"Stress, skin injuries, infections, and certain medications can trigger flare-ups."

Management Plan

First-line for trunk and limbs:

"I'm going to prescribe a combination of two treatments that work well together:"

1. **Betamethasone 0.1% cream (e.g., Betnovate)** - a potent steroid
    - Apply thinly **ONCE daily in the morning** to affected areas
    - Use for up to 4 weeks, then review
2. **Calcipotriol cream** - a vitamin D-based treatment
    - Apply **ONCE daily in the evening** (at a different time to the steroid)
    - Can be used longer-term
    - Apply these at different times of day for best effect."

3. Alternatively, there is a combination cream/ointment called Dovobet which contains both ingredients in one - you apply it once daily, which some patients find easier.

For scalp psoriasis:
- Betamethasone scalp application
- Coal tar shampoo (alongside betamethasone scalp application)

If resistant plaques (not first-line):
- Dermovate (clobetasol) - very potent steroid for short courses only (up to 4 weeks) after other strategies have failed

General Advice
- Use **emollients** regularly to keep skin moisturised
- Avoid picking or scratching plaques
- **Stop smoking** if applicable - this can significantly improve psoriasis
- Limit alcohol intake
- Manage stress where possible

The Psoriasis Association
"The Psoriasis Association has some really helpful resources and support groups if you'd find it useful to connect with others."

Safety Netting
"Please come back if:
- The psoriasis spreads significantly or doesn't respond to treatment
- You develop joint pain or stiffness
- You notice any eye problems
- You're feeling very low about this - we can discuss additional support"

Follow-Up
"I'd like to review you in 4-6 weeks to see how you're responding to treatment. If topical treatments aren't controlling it, we can discuss other options including referral to dermatology."

Leaflet
"I'll give you a leaflet about psoriasis and how to manage it."

Erythema Nodosum

Scenario: Primary Care Setting | Middle-Aged Adult | Bilateral Painful Nodular Rash on Lower Limbs with Recent Viral Prodrome
Your Role: FY2 GP - assess, investigate, and manage appropriately.

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 painful lumps on my shins. They appeared a week after I had a flu-like illness.")

History - Follow standard dermatology structure
Diagnostic pivots for erythema nodosum:
- Painful, tender nodules on shins
- Bilateral distribution

- Red initially, then bruise-like colour changes
- Associated with recent infection or underlying condition
- May have systemic symptoms (fever, malaise, joint pain)

Ask specifically:
"When did the lumps first appear?" "Are they painful?" "Did you have any illness before they appeared - sore throat, cough, flu-like symptoms?" "Have you had any joint pain or stiffness?" "Any recent medications or changes to medication?" "Any bowel symptoms - diarrhoea, blood, abdominal pain?" "Any recent travel?"

PMAFTOSA
- Recent flu-like illness
- No significant past medical history
- No inflammatory bowel disease
- No allergies
- No recent new medications
- Non-smoker
- Works at airport (for context)

ICE
I: "I don't know what these lumps are."
C: "Could it be something serious like a blood clot?"
E: "I want to know what's causing it and how to treat it."

Effect on Life
"Is the pain affecting your ability to work or walk?"

Examination
"Would it be alright if I examine your legs?"

Findings:
"I can see several raised, tender nodules on both shins. They're red and feel warm. Some of the older ones look more purple-brown, like bruises. There's no ulceration and no swelling of the ankles or calves."

Provisional Diagnosis
"This is **erythema nodosum** - inflammation of the fat layer under the skin."
Explanation
"Erythema nodosum is a reaction pattern where the fat under your skin becomes inflamed, causing these painful lumps. It's often triggered by an infection - like the flu-like illness you had - or sometimes by medications or underlying conditions."
"In most cases, it's caused by a viral or bacterial infection and improves on its own in a few weeks. But I'd like to do some tests to check for any underlying causes."

Investigations
"I'd like to arrange some blood tests and possibly a chest X-ray:"
- FBC, ESR, CRP (inflammation markers)
- LFTs, U&Es
- TB screening (if risk factors or chest symptoms)
- Consider: ASOT titre, stool culture, HIV testing, autoimmune markers
- Chest X-ray (to look for sarcoidosis or TB)

Common Causes to Consider

Cause	Features
Post-viral/bacterial	Recent URTI, streptococcal infection

Sarcoidosis	Bilateral hilar lymphadenopathy on CXR
Inflammatory bowel disease	GI symptoms
Medications	Recent antibiotics, oral contraceptives
TB	Risk factors, systemic symptoms, CXR changes

Management Plan
Symptomatic treatment:
- **Ibuprofen** or other NSAIDs for pain and inflammation
- **Leg elevation** when resting
- **Cool compresses** for comfort
- **Rest** - avoid prolonged standing

"The nodules usually improve on their own within 3-6 weeks and don't usually leave any scars."

Work Advice
"This isn't infectious, so you can continue working. However, if the pain is significant, you might benefit from a few days off to rest your legs. I can provide a fit note if needed."

Safety Netting
"Please come back if:
- The nodules spread or don't improve after a few weeks
- You develop new symptoms - joint pain, breathing problems, bowel symptoms, weight loss
- The results of your tests show anything that needs further investigation"

Follow-Up
"I'll contact you with your blood test and X-ray results. We'll review to discuss findings and next steps."

Leaflet
"I'll give you some information about erythema nodosum."

Lyme Disease (Erythema Migrans)

Scenario: Primary Care Setting | Adult Patient | Expanding Circular Rash Following Outdoor Exposure and Tick Bite
Your Role: FY2 GP - assess, diagnose, and treat appropriately.

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 got this strange rash on my arm. I remember being bitten by a tick about a month ago when I was hiking.")

History - Follow standard dermatology structure
Diagnostic pivots for Lyme disease:
- Expanding circular or "target/bullseye" rash
- Central clearing with red ring
- History of tick bite (may not recall being bitten)
- Outdoor activities in endemic areas
- May have flu-like symptoms
- Gradual expansion over days to weeks

Ask specifically:

"When did you first notice the rash?" "Has it been getting bigger?" "Do you remember being bitten by a tick?" "Where were you when you might have been exposed?" "Have you had any other symptoms - fever, headache, fatigue, muscle aches, joint pain?"

PMAFTOSA
- Recent outdoor activities (hiking, camping)
- No significant past medical history
- No allergies
- No regular medications
- Check pregnancy status if relevant (affects antibiotic choice)

ICE
I: "I looked it up online and I'm worried it's Lyme disease."
C: "Can it cause serious problems if it's not treated?"
E: "I want to make sure it's treated properly."

Effect on Life
"How are you feeling generally? Any symptoms affecting your daily activities?"

Examination
"Would it be alright if I take a look at the rash?"

Findings:
"I can see a circular rash on your arm, about [size] cm in diameter. It has a characteristic 'bullseye' appearance with a red outer ring and central clearing. The rash is flat and not itchy."

Provisional Diagnosis
"This is **erythema migrans** - the characteristic rash of early Lyme disease."

Explanation
"Lyme disease is a bacterial infection transmitted by tick bites. The bacteria is called Borrelia burgdorferi."
"The rash you have - called erythema migrans - is the hallmark sign of early Lyme disease. You don't need the tick to have been attached for long - and many people don't remember being bitten at all."
"The good news is that when caught early like this, Lyme disease is very treatable with antibiotics."

Management Plan
"I'm prescribing a course of antibiotics to treat the infection:"
First-line:
- **Doxycycline 100mg TWICE daily for 21 days**
- OR Doxycycline 200mg ONCE daily for 21 days

"Take with food and a full glass of water. Avoid lying down for 30 minutes after taking. Avoid prolonged sun exposure while taking doxycycline as it can make your skin more sensitive to sunlight."

If doxycycline is contraindicated (e.g., pregnancy, allergy):
- **Amoxicillin 1g THREE times daily for 21 days**

"Please complete the full 21-day course, even if you feel completely better. Stopping early can allow the bacteria to survive and cause problems later."

Prevention Advice for Future
- Use DEET-based insect repellent when outdoors
- Wear long sleeves and trousers in tick-prone areas
- Check your skin for ticks after outdoor activities

- Remove ticks promptly using fine-tipped tweezers

Safety Netting
"If you develop any of the following symptoms during or after treatment, please seek medical attention urgently:
- Facial weakness or drooping (facial palsy)
- Severe headache or neck stiffness
- Palpitations or chest pain
- Joint swelling, especially large joints like the knee
- Numbness or tingling in limbs

These could indicate the infection has spread, and you may need different treatment."

Follow-Up
"I'll refer you to infectious diseases if you develop any complications or if the rash doesn't improve after starting antibiotics."
"If you complete the course and make a full recovery, routine follow-up isn't usually needed."

Leaflet
"I'll give you information about Lyme disease and tick bite prevention."

Folliculitis

Scenario: Primary Care Setting | Young Adult | Follicular Rash in Sensitive Area Following Hair Removal
Your Role: FY2 GP - assess, reassure, and advise appropriately.

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 seems hesitant)
"Take your time - there's no rush. Whatever it is, I'm here to help."
(Patient: "I've got this rash in a private area. I had a wax recently and now there are these red bumps.")
"Thanks for letting me know - and no worries, I'll handle this sensitively. This is something we see regularly, so please don't feel embarrassed."

History - - Follow standard dermatology structure
Diagnostic pivots for folliculitis:
- Small red bumps centred on hair follicles
- May have pustules
- Often follows hair removal (shaving, waxing)
- Can be itchy or tender
- Usually not associated with systemic symptoms

Ask specifically:
"When did the rash appear?" "Did you have any hair removal before it started?" "Are the bumps itchy or painful?" "Is there any discharge or pus?" "Have you had any new sexual partners recently?"

ICE
I: "I wasn't sure if it was an allergic reaction or something else."
C: "Could this be an STI? I'm really worried."
E: "I just want it to go away and know what caused it."

Examination

Findings:
"I can see multiple small red bumps, some with tiny white heads, centred on the hair follicles. There's some surrounding redness but no spreading cellulitis or ulceration."

Provisional Diagnosis
"This is **folliculitis** - inflammation of the hair follicles."

Explanation
"Folliculitis happens when hair follicles become irritated or infected, usually by bacteria. After waxing, the follicles are more vulnerable to this."
"I want to reassure you - this is **not** sexually transmitted. It's a common skin reaction."

Management Plan
Conservative treatment:
- **Chlorhexidine wash** - use when showering
- **Warm compresses** - can help soothe the area
- **Antihistamines** - if itching is bothersome

Note: For more significant cases, topical antibiotics (fusidic acid or mupirocin) may be needed.

General advice:
- Wear loose, breathable cotton underwear
- Shower after exercise
- Avoid tight clothing that causes friction

"Most cases settle within a week or two."

Safety Netting
"Please come back if the rash spreads, becomes very painful, you develop a fever, or it doesn't improve within 1-2 weeks."

Intertrigo

Scenario: Primary Care Setting | Older Adult | Itchy Erythematous Rash in Skin Fold
Your Role: FY2 GP - assess, examine, and treat appropriately.

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 got this itchy rash under my breast. It's been bothering me for a few weeks.")

History - Follow standard dermatology structure
Diagnostic pivots for intertrigo:
- Rash in skin folds
- Red, moist, sometimes macerated
- May have satellite lesions (suggests candida)
- Itchy and sometimes sore
- Aggravated by heat, moisture, friction

Ask specifically:
"When did the rash first appear?" "Is it itchy, sore, or both?" "Does it have any smell?" "Do you have similar rashes in other skin folds?" "Do you have diabetes?"

Examination

Findings:
"I can see a red, moist rash in the skin fold under your breast. The area is slightly macerated with some satellite spots around the edges."

Provisional Diagnosis
"This is **intertrigo** - a rash that develops in skin folds due to moisture, friction, and warmth. It's very common."

Management Plan
Combination treatment:
1. **Hydrocortisone 1% cream** - Apply once or twice daily for **7 days only**
2. **Clotrimazole 1% cream** - Apply twice daily for **2-4 weeks**

Self-care advice:
- Keep the area clean and **dry** - pat dry thoroughly after washing
- Wear a **well-fitting, supportive cotton bra**
- Avoid talcum powder

Once healed - prevention:
- Apply a **barrier cream** (zinc oxide or castor oil-based)

Safety Netting
"Please come back if the rash spreads, you develop a fever, or it doesn't improve after 2 weeks."

Cherry Angiomas

Scenario: Primary Care Setting | Older Adult | Multiple Small Red Vascular Lesions on Trunk
Your Role: FY2 GP - assess, reassure, and explain appropriately.

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 noticed I'm getting more of these little red spots. I'm worried about what they are.")

History- Follow standard dermatology structure
Diagnostic pivots for cherry angiomas:
- Small, bright red papules
- Round, well-defined
- 1-5mm typically
- Increase in number with age
- Usually on trunk
- Completely benign

Examination Findings:
"I can see multiple small, round, bright red spots on your chest and abdomen. They're smooth and slightly raised. They don't blanch with pressure."

Provisional Diagnosis
"These are **cherry angiomas** - also called Campbell de Morgan spots."

Explanation
"Cherry angiomas are small overgrowths of blood vessels. They're extremely common, especially as we get older."

"They're **completely benign**. They don't turn into cancer and they're not a sign of any underlying problem."

Management Plan
"There's no medical need to treat them."
"If any bother you cosmetically, removal is possible privately but isn't available on the NHS."

Safety Netting
"Please come back if any spots grow rapidly, bleed repeatedly, become painful, or change colour to dark brown or black."

Haemangioma

Scenario: Primary Care Setting | Neonate | Soft Vascular Lesion | History of Prematurity
Your Role: FY2 GP - assess, reassure parents, and arrange appropriate follow-up.

Introduction
"Hello, I'm one of the doctors here at the practice. I understand you've brought your baby in today. Could I confirm your baby's name and date of birth, please?
Thanks. What's been worrying you?"
(Parent: "There's this bump on the baby's tummy. It appeared a few days after birth and seems to be getting bigger.")

History- Follow standard dermatology structure
Diagnostic pivots for infantile haemangioma:
- Appears in first few weeks of life
- Grows rapidly in first months
- Bright red, raised, rubbery ("strawberry")
- More common in premature babies
- Usually involutes by age 5-10 years

Ask specifically:
"When did you first notice this?" "Has it been growing?" "Was your baby born prematurely?" "Is there any bleeding or broken skin?"

Examination Findings:
"I can see a raised, soft, bright red lesion on the abdomen. It's rubbery. There's no ulceration or bleeding."

Provisional Diagnosis
"This is an **infantile haemangioma** - sometimes called a 'strawberry birthmark'."

Explanation
"Haemangiomas are benign overgrowths of blood vessels. They're more common in premature babies."
"I want to reassure you - this is **not caused by anything you did**."
"They typically grow for the first few months, then shrink on their own. Most are completely or almost completely gone by age 5-10 years."

Management Plan
For uncomplicated haemangiomas:
"This doesn't need medication or removal - just monitoring."
"If it ever bleeds, apply firm pressure for about 5 minutes with a clean cloth."

If complicated (near eye, airway, ulcerating):

"If the haemangioma is near the eye, airway, or causing problems, I would refer urgently to a paediatrician or paediatric dermatologist. There are specialist treatments available - such as a medicine called propranolol - that can help shrink it faster, but that would be started and monitored by the specialist team."

Follow-Up
"I'd like to see you again in 4 weeks to check progress."

Safety Netting
"Please come back if it bleeds and you can't stop it, the skin breaks down, it grows very rapidly, or affects feeding, breathing, or vision."

Molluscum Contagiosum

Scenario: Primary Care Setting | Young Child | Asymmetric Cluster of Umbilicated Papules | Concerned Pregnant Parent
Your Role: FY2 GP - assess, reassure, and advise appropriately.

Introduction
"Hello, I'm one of the doctors here at the practice. I understand you've brought your child in today.
Could I confirm your child's name and age, please?
Thanks. What's been worrying you?"
(Parent: "They've got these little bumps that have appeared on their chest. And I'm pregnant - I'm worried it might affect the baby.")

History- Follow standard dermatology structure
Diagnostic pivots for molluscum contagiosum:
- Small, pearly, dome-shaped papules
- Central umbilication (dimple)
- Usually clustered
- Spread by direct contact
- Common in children
- Self-limiting (12-18 months)

Ask specifically:
"When did you first notice the bumps?" "Have they spread?" "Are they itchy?" "Has anyone else in the household developed similar bumps?"

Examination Findings:
"I can see several small, round, pearly bumps on your child's chest and shoulder. They have a characteristic dimple in the centre. There's no redness or infection around them."

Provisional Diagnosis
"This is **molluscum contagiosum** - a common viral skin infection caused by a poxvirus."

Explanation
"Molluscum is very common in children. The bumps are caused by a virus and will eventually clear up on their own - usually within 12-18 months."
"The good news for you is that molluscum is **not known to cause any complications in pregnancy**. It doesn't affect unborn babies, so there's no need to worry about your pregnancy."

Management Plan
"No treatment is usually needed - we recommend watchful waiting."

"The bumps will eventually disappear on their own as your child's immune system clears the virus."

To prevent spread:
- Don't share towels or flannels
- Wash hands after touching the bumps
- Avoid swimming pools during active infection (though schools vary on this)
- Avoid scratching - this can spread the spots

Optional treatment:
"Some parents try a solution called Molludab from the pharmacy, but honestly, the evidence for it is mixed. Most doctors recommend just waiting it out."
"If spots become very numerous, infected, or are in cosmetically sensitive areas, we can discuss specialist referral for treatments like cryotherapy."

Safety Netting
"Please come back if the spots become red, swollen, or painful - this could indicate secondary infection. Also return if they spread rapidly or if you have any other concerns."

Follow-Up
"Routine follow-up isn't needed, but we're here if you have any questions."

Herpetic Whitlow

Scenario: Primary Care Setting | Adult Male | Painful Digit Blister with History of Recurrent Oral HSV
Your Role: FY2 GP - assess, explain, and treat appropriately.

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 got this painful blister on my thumb. It's really sore and affecting my work - I do a lot of typing.")

History- Follow standard dermatology structure
Diagnostic pivots for herpetic whitlow:
- Painful vesicles/blisters on finger
- Often preceded by tingling
- History of cold sores or HSV exposure
- May be recurrent
- Can be mistaken for bacterial paronychia

Ask specifically:
"When did the blister first appear?" "Did you notice any tingling before it started?" "Do you get cold sores?" "Have you had similar finger blisters before?" "How is this affecting your work?"

PMAFTOSA
- History of recurrent cold sores
- Works in office (typing affected)
- No allergies
- No regular medications

ICE
I: "I thought it was an infection at first."
C: "Is it related to my cold sores?"
E: "I need it to heal quickly so I can work."

Examination Findings:
"I can see a cluster of small, fluid-filled blisters on your thumb. The area is red, swollen, and tender. There's no pus or bacterial infection visible."

Provisional Diagnosis
"This is **herpetic whitlow** - an infection of the finger caused by the herpes simplex virus - the same one that gives you cold sores."

Explanation
"The virus has spread from your mouth to your finger, probably through touch. This can happen if you touched a cold sore and then your finger, or if you bite your nails."
"Like cold sores, herpetic whitlow tends to heal on its own within 2-3 weeks, but we can use antiviral medication to speed things up."

Management Plan
"Since your blister started within the last day or two, we can start antiviral treatment. Antivirals work best when started within 48 hours of symptoms appearing."

Prescription:
- **Aciclovir 200mg, five times a day for 5 days**

"Take the tablets spread throughout the day."
Alternative (if preferred - fewer daily doses):
- Valaciclovir 500mg twice daily for 5 days

For future recurrent episodes:
- Aciclovir 400mg twice daily during prodrome may abort recurrence, OR
- Aciclovir 200mg five times daily at the first sign of recurrence (prodromal symptoms)

Advice
- Keep the area clean and covered to prevent spreading
- Avoid touching your eyes or other people's skin
- Don't bite your nails
- Wash hands frequently
- The blister will crust over and heal within 2-3 weeks

Safety Netting
"Please come back if the infection spreads, you develop a fever, or if the blisters become very red and painful - this could indicate a secondary bacterial infection."
"If you get frequent recurrences, we can discuss preventive treatment."

Follow-Up
"Routine follow-up isn't usually needed, but do come back if you're concerned."

Tinea Manuum

Scenario: Primary Care Setting | Adult Male | Persistent Hand Rash | Partner Pregnant
Your Role: FY2 GP - assess, explain, and treat appropriately.

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. It's not going away. My partner is pregnant and I'm worried about passing something to her.")

History- Follow standard dermatology structure
Diagnostic pivots for tinea manuum:

- Scaly, red, annular (ring-shaped) rash
- Usually one hand affected
- May have associated tinea pedis ("two feet, one hand syndrome")
- Itchy
- Slowly spreading

Ask specifically:
"When did the rash first appear?" "Has it been spreading?" "Is it itchy?" "Do you have any similar rash on your feet?" "Have you been in contact with animals?"

Examination Findings:
"I can see a red, scaly rash on your palm with a slightly raised, ring-shaped border. The edges are more pronounced than the centre."

Provisional Diagnosis
"This is **tinea manuum** - a fungal infection of the hand, commonly called 'ringworm'."

Explanation
"Despite the name 'ringworm,' it has nothing to do with worms - it's a fungal infection. It's the same type of fungus that causes athlete's foot."
"Regarding your partner - fungal infections can spread through close contact, but they're not harmful during pregnancy. Simple precautions like not sharing towels and treating the infection promptly will minimise any risk."

Management Plan
"I'll prescribe antifungal cream. You have two options:"

1. **Terbinafine 1% cream** - Apply twice daily for **one week**
    - More effective, shorter course
2. **Clotrimazole 1% cream** - Apply twice daily for **four weeks**
    - Longer course but equally effective

"Terbinafine is slightly more effective with a shorter course. Would you prefer that option?"

General advice:

- Apply to the entire affected area and slightly beyond
- Continue for the full course even if it looks better
- Wash hands after application
- Don't share towels

If extensive or not responding:

- Oral terbinafine 250mg daily for 2-4 weeks may be needed

Safety Netting
"Please come back if the rash spreads significantly, doesn't improve after completing treatment, or if you develop any new symptoms. If the rash is very extensive or involves your palm, we may need to consider tablets instead of cream."

Tinea Capitis

Scenario: Primary Care Setting | Adult Male | Scalp Scaling with Hair Loss | Occupational Animal Exposure
Your Role: FY2 GP - assess, investigate, and treat appropriately.

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 flaky scalp for months. The shampoos aren't working and I'm losing hair in patches. I work on a farm.")

History- Follow standard dermatology structure
Diagnostic pivots for tinea capitis:

- Scaly patches on scalp
- Hair loss in affected areas
- May have broken hairs ("black dots")
- Lymphadenopathy possible
- Contact with animals (cattle, pets)
- More common in children but can affect adults

Ask specifically:
"When did you first notice the scalp changes?" "Have you noticed hair loss?" "Do you work with animals?" "Has anyone else in your household had similar problems?" "Have you tried any treatments?"

Examination Findings:
"I can see patches of scaling on your scalp with some hair loss in those areas. Some hairs appear broken off at the surface. There's mild redness but no pus or significant inflammation. I can feel some slightly enlarged lymph nodes at the back of your neck."

Provisional Diagnosis
"This is **tinea capitis** - a fungal infection of the scalp."

Explanation
"Tinea capitis is a fungal infection that affects the scalp and hair roots. This explains why the anti-dandruff shampoos haven't worked - the infection is too deep for surface treatments to reach."
"Your work with animals may be relevant - certain types of fungus that cause this infection can be picked up from cattle and other animals."
"I know hair loss can be worrying. The good news is that once the infection clears, hair usually grows back normally in the affected areas."

Investigation
"We should send a scalp sample to the laboratory to confirm the diagnosis and identify the fungus type, which helps guide treatment choice."

Scalp scraping/brushing for:

- Microscopy
- Fungal culture

Management Plan
"For scalp fungal infections, we need oral antifungal tablets because the infection is too deep for creams to reach."

"Since you work with animals, the infection is likely caused by a type called Microsporum. The best treatment for this is:"

Prescription:
- **Griseofulvin 500mg-1g daily for 8-12 weeks** (for Microsporum species)

OR if Trichophyton species confirmed:
- **Terbinafine 250mg daily for 4 weeks** (more effective for Trichophyton)

Monitoring: "Before starting treatment, I'll arrange a blood test to check your liver function. These antifungal tablets can occasionally affect the liver, so we need to make sure it's safe to proceed. If you develop any symptoms like nausea, yellowing of the skin or eyes, or abdominal pain during treatment, please stop the medication and contact us immediately."
[Note: For adult tinea capitis requiring prolonged oral treatment, dermatology input is recommended]
"I'd also like to arrange a dermatology review to help monitor your progress with this treatment. They may want to see you during or after the course to ensure the infection has fully cleared."

Adjunctive treatment:
- **Ketoconazole 2% shampoo** - use 2-3 times per week to reduce spore shedding

"We'll start treatment now and adjust if needed once the lab results come back."

Advice
- The infection can spread to others - avoid sharing combs, brushes, hats, towels
- Wash bedding and towels regularly
- Your close contacts should be checked if they develop symptoms

Safety Netting
"Please come back if the scalp becomes very inflamed, painful, or develops pus - this could indicate a more severe reaction. Also return if you're not improving after several weeks of treatment."

Follow-Up
"I'd like to see you in 4-6 weeks to check progress. The full course may take 8-12 weeks."

Tinea Pedis

Scenario: Primary Care Setting | Active Adult | Interdigital Foot Rash with Pruritus
Your Role: FY2 GP - assess, explain, and treat appropriately.

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 got this itchy rash between my toes and on the soles of my feet. I do a lot of running.")

History- Follow standard dermatology structure
Diagnostic pivots for tinea pedis:
- Itchy, scaly rash
- Between toes (interdigital) or on soles (moccasin-type)
- May have blisters or fissures
- Worse in warm, moist conditions
- Associated with athletic activities, communal showers
- May spread to nails

Ask specifically:

"When did the rash first appear?" "Is it itchy?" "Do you use communal showers at the gym?" "Have you noticed any changes to your toenails?" "Have you tried any treatments?"

Examination Findings:
"I can see red, scaly skin between your toes, particularly the 4th and 5th toe web spaces. There's also some scaling on the soles. The skin is slightly macerated between the toes."

Provisional Diagnosis
"This is **tinea pedis** - commonly known as 'athlete's foot'."

Explanation
"Athlete's foot is a fungal infection that thrives in warm, moist environments - which is why it's common in people who exercise regularly and use shared changing rooms."
"Because you've been running regularly, the fungus has had a chance to grow and spread in the warm, sweaty environment inside your trainers."

Management Plan
"I'll prescribe antifungal cream. You have options:"

1. **Terbinafine 1% cream** - Apply twice daily for **one week**
    - More effective, shorter course (fungicidal)
2. **Clotrimazole cream** - Apply twice daily for **four weeks**
    - Longer course needed

"Terbinafine is slightly more effective with a shorter course. Would you prefer that?"

If significant inflammation:

- **Hydrocortisone 1% cream** - Apply once daily for up to 7 days (apply 20-30 minutes after antifungal)

General advice:

- Dry feet thoroughly after washing, especially between toes
- Consider using a hair dryer on cool setting for full dryness
- Wear cotton socks and change them daily
- Alternate shoes to allow them to dry out
- Wear flip-flops in communal showers
- Apply antifungal powder to shoes

Safety Netting
"Please come back if the rash spreads, becomes very red or painful, or doesn't improve after completing the full course. If creams don't work, we can try antifungal tablets."

Oral Candidiasis (Child)

Scenario: Primary Care Setting | Young Child | Oral White Patches with Reduced Feeding | Inhaler Use
Your Role: FY2 GP - assess, explain, and treat appropriately.

Introduction
"Hello, I'm one of the doctors here at the practice. I understand you've brought your child in today. Could I confirm your child's name and age, please?
Thanks. What's been worrying you?"
(Parent: "They've got white patches in their mouth and they don't want to eat properly. They use an inhaler for asthma.")

History- Follow standard dermatology structure
Diagnostic pivots for oral candidiasis:

- White patches in mouth (can be scraped off, leaving red base)
- May affect feeding
- Common with inhaled steroid use
- May have cracked corners of mouth (angular cheilitis)

Ask specifically:
"When did you first notice the white patches?" "Has your child been eating and drinking normally?" "Does your child use an inhaler? Which type?" "Do they use a spacer device?" "Do they rinse their mouth after using the inhaler?"

Examination Findings:
"I can see white patches on the inside of your child's cheeks and tongue. When gently wiped, they reveal a red base underneath. The rest of the mouth looks healthy."

Provisional Diagnosis
"This is **oral thrush** - a fungal infection caused by Candida yeast."

Explanation
"Oral thrush is very common in children, especially those who use steroid inhalers. The steroid can reduce the natural defences in the mouth, allowing the yeast to overgrow."
"It's not serious and is very treatable."

Management Plan

- **If under 4 months:** Miconazole gel is **contraindicated** (choking risk). Prescribe **Nystatin oral suspension** 1ml four times after feed, daily instead.
- **If 4-6 months:** Use miconazole with caution, apply small amounts carefully.
- **If over 6 months:** Miconazole gel is appropriate.

Prescription (if over 4 months):

- **Miconazole oral gel** - Apply **four times daily** (after meals and at bedtime)
- Continue for at least **7 days** and for **2 days after symptoms have cleared**

Application technique: "Apply with a clean finger to the affected areas inside the mouth. Take care not to put it near the back of the throat as this can cause choking in young children. Let your child keep it in their mouth as long as possible before swallowing."

Prevention of recurrence:

- Always use a **spacer device** with the steroid inhaler
- **Rinse mouth** or have a drink/snack after using the inhaler
- Clean the spacer regularly

Safety Netting
"Please come back if the thrush doesn't improve within a week, spreads, or if your child stops eating and drinking."

Follow-Up
"You shouldn't need routine follow-up, but do come back if it keeps recurring - we may need to review the inhaler technique."

Oral Candidiasis (Older Adult)

Scenario: Primary Care Setting | Older Adult Male | Oral Pain with White Patches and Eating Difficulty
Your Role: FY2 GP - assess, investigate underlying causes, and treat.

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 got a sore mouth with white patches. It's painful to eat.")

History- Follow standard dermatology structure
Diagnostic pivots for oral candidiasis in adults:

- White patches (can be scraped off)
- Sore mouth, difficulty eating
- Consider underlying causes: diabetes, immunosuppression, antibiotics, steroids, dentures
- May indicate undiagnosed systemic condition

Ask specifically:
"When did you first notice the patches?" "Is eating or drinking painful?" "Do you wear dentures?" "Do you have diabetes or any other medical conditions?" "Are you on any medications - antibiotics, steroids, inhalers?" "Do you take dentures out at night?"

PMAFTOSA

- Check for denture use
- Diabetes status
- Medications (especially antibiotics, steroids, immunosuppressants)
- Check if on warfarin (important drug interaction)

Examination Findings:
"I can see white patches on your tongue and inner cheeks. They wipe off to reveal a red, raw base. There's some redness at the corners of your mouth as well."

Provisional Diagnosis
"This is **oral thrush** - a fungal infection in the mouth."

Explanation
"Oral thrush in adults is less common than in children, and it's worth thinking about why it's happened." "Because oral thrush in adults can sometimes be a sign of other conditions, we should also check things like your blood sugar levels. Would that be okay?"

Investigation
Consider checking:

- HbA1c or fasting glucose (diabetes screening)
- FBC (anaemia, immune issues)
- In unexplained adult oral thrush, consider HIV testing

Management Plan
Prescription:

- **Miconazole oral gel** - Apply four times daily after meals
- Hold in mouth for as long as possible before swallowing
- Continue for 7 days after symptoms resolve

IMPORTANT - Drug interaction: "Are you taking warfarin? Miconazole can interact with warfarin and increase bleeding risk. If you're on warfarin, we'll use **nystatin suspension** instead."

If on warfarin:
- Nystatin oral suspension 100,000 units/ml - 1ml four times daily

Denture advice: "It's really important to take your dentures out at night - this gives your mouth a chance to recover and helps prevent the thrush coming back."
- Clean dentures thoroughly
- Soak dentures overnight in dilute bleach solution or denture cleaner
- Apply antifungal gel to fitting surface of dentures

Safety Netting
"Please come back if the thrush doesn't improve with treatment, keeps coming back, or you develop new symptoms."

Follow-Up
"I'll arrange blood tests to check for any underlying causes. Let's review once we have those results."

Scabies

Scenario: Primary Care Setting | Young Adult Male | Intensely Pruritic Hand Rash | Recent Travel History with Shared Accommodation
Your Role: FY2 GP - assess, explain, and treat appropriately.

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 got this really itchy rash on my hands. It's driving me crazy, especially at night. I just got back from travelling.")

History- Follow standard dermatology structure
Diagnostic pivots for scabies:
- Intense itching, worse at night
- Burrows (linear tracks) between fingers, wrists
- May have papules in warm areas (armpits, groin)
- Contact history - close contacts, shared accommodation
- Recent travel to endemic areas
- May take 4-6 weeks after exposure to become symptomatic

Ask specifically:
"When did the itching start?" "Is it worse at night?" "Where is the rash - hands, wrists, between fingers?" "Have you been travelling recently? Where did you stay?" "Has anyone you've been in close contact with had similar symptoms?"

Examination Findings:
"I can see small papules between your fingers and on your wrists. Looking closely, I can see some linear burrows. The itching has caused some scratch marks."

Provisional Diagnosis
"This is **scabies** - an infestation caused by tiny mites that burrow into the skin."

Explanation

"Scabies is caused by tiny mites that burrow into your skin and lay eggs. It's spread through close skin-to-skin contact, which is why it's common in shared accommodation during travel."
"I want to reassure you - this is nothing to do with personal hygiene. Anyone can catch scabies through close contact."

Allergy Check
IMPORTANT - Before prescribing permethrin:
"Before I prescribe the cream, I need to check - are you allergic to chrysanthemums or any insect repellent sprays? The cream contains a related ingredient."

Management Plan
First-line treatment:
- **Permethrin 5% cream**

Application instructions:
- Apply to the **whole body from the neck down**
- Include between fingers and toes, under nails, wrists, armpits, groin, buttocks
- Leave on for **8-12 hours** (overnight), then wash off
- **Repeat after 7 days**

"Everyone in your household needs to be treated at the same time - even if they don't have symptoms yet."

Decontamination:
- Wash all bedding, towels, and clothing at **60°C or higher**
- Items that can't be washed - seal in plastic bag for 72 hours

If permethrin allergic or contraindicated:
- **Malathion 0.5% aqueous liquid** - apply for 24 hours, repeat after 7 days

Third-line (treatment-resistant cases):
- **Ivermectin** tablets may be considered if two courses of topical treatment fail

Important Information About Post-Treatment Itch
"The itch can continue for **up to 6 weeks** after successful treatment - this is normal and doesn't mean the treatment hasn't worked. It's a reaction to the dead mites and their droppings in your skin."
"You can use antihistamines to help with the itching during this time."

Safety Netting
"Please come back if the itching is getting worse after 2-3 weeks (not just persisting), if new burrows appear, or if close contacts develop symptoms."

Follow-Up
"You shouldn't need routine follow-up, but do come back if the symptoms haven't improved after completing both treatments."

Scabies in Child

Scenario: Primary Care Telephone Consultation | Parent of Young Child | Intensely Pruritic Rash | Close Contact Setting History
Your Role: FY2 GP - assess, explain, and manage via telephone.

Introduction
"Hello, am I speaking to [parent name]?

This is Dr [Your Name] from the surgery. I understand you called about your child's rash. Is now a good time to talk?"
(Parent: "Yes, they've been scratching constantly and not sleeping. They go to nursery.")

Telephone Assessment
"Let me ask some questions to understand what's going on."
"When did the itching start?" "Is it worse at night?" "Where is the rash - hands, wrists, body?" "Has anyone else in the family or at nursery had similar itching?" "Can you see any small lines or tracks between the fingers?"

Assessment
"From what you're describing - the intense itching that's worse at night, the distribution, and the nursery contact - this sounds like it could be **scabies**."

Management Plan
Prescription:
- **Permethrin 5% cream**

Application in children:
- Apply from **neck to toes** (in children under 2 and elderly, also apply to face, scalp, and behind ears - but this child is older so neck-down is appropriate)
- Include all skin creases, between fingers and toes, under nails
- Leave on overnight (**8-12 hours**), then wash off
- **Repeat in 7 days**

"All household members need treatment at the same time."

Decontamination:
- Wash bedding and clothes at high temperature
- Soft toys - either wash or seal in bag for 72 hours

Post-Treatment Itch
"Itching may continue for **up to 4-6 weeks** after successful treatment - this doesn't mean it hasn't worked."

Nursery Advice
"Please let the nursery know so they can alert other parents. Your child can return to nursery after the first treatment has been applied."

Safety Netting
"Call back if your child develops any skin infection - very red, hot, or weeping skin - or if new rash appears after completing both treatments."

Mole - Requesting Removal

Scenario: Primary Care Setting | Young Adult | Requests Mole Removal for Cosmetic Reasons
Your Role: FY2 GP - assess, explain NHS policy, and advise on options.

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 got this mole on my face and I'm getting married soon. I'd really like it removed.")

History

"I understand that you're getting married and would prefer not to have it visible in photos - and that's a very reasonable concern."
"Let me first ask a few questions to make sure the mole doesn't need medical attention."

Questions to assess the mole: "How long have you had this mole?" "Has it changed at all - in size, colour, or shape?" "Does it itch, bleed, or cause any discomfort?" "Has anyone in your family had melanoma or skin cancer?"

Examination
"Would it be alright if I take a look at the mole?"

Findings:
"I can see a small, round, evenly-coloured mole. The borders are regular, and it's symmetrical. There are no concerning features."

Explanation
"I'm pleased to say this looks like a completely benign, normal mole. There's no medical concern here."

NHS Policy Explanation
"I need to explain how this works on the NHS. Because this mole is benign and not causing any medical problems, removal would be considered a cosmetic procedure. Unfortunately, the NHS doesn't fund cosmetic mole removal."
"This means if you'd like it removed, you'd need to see a private dermatologist or cosmetic clinic."

Private Options
"If you decide to pursue private removal, there are several options:

- **Surgical excision** - the mole is cut out and the wound stitched
- **Shave excision** - for raised moles, they can be shaved flat
- **Laser** - for some superficial moles

"A private clinic can discuss the best option for your specific mole and its location on your face."
"Costs vary but typically range from £100-500 depending on the method and clinic."

Self-Monitoring Advice
"Even though this mole is benign, it's good practice to keep an eye on all your moles. Watch out for any changes using the **ABCDE rule**:

- **A**symmetry - one half doesn't match the other
- **B**order irregularity - edges are ragged or blurred
- **C**olour variation - different shades or colours
- **D**iameter over 6mm - larger than a pencil eraser
- **E**volution - any change over time

If you notice any of these changes in any mole, please come back."

Safety Netting
"Please come back if this or any other mole starts to change, bleed, itch, or look different."

Mole - Worried About Cancer

Scenario: Primary Care Setting | Young Adult Female | Long-Standing Pigmented Lesion | Health Anxiety Triggered by External Comments
Your Role: FY2 GP - assess, reassure appropriately, 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've had this mole on my arm for years, but someone at work said it looks suspicious and now I'm really worried it might be cancer.")

Acknowledging Concern
"I understand why you were alarmed, especially after your colleague's comment. It's completely natural to feel anxious."
"You've done exactly the right thing by coming to get it checked. Let me ask some questions and then examine it properly."

History
"How long have you had this mole?" "Has it changed at all - in size, colour, or shape?" "Does it itch, bleed, or cause any discomfort?" "Has anyone in your family had melanoma or skin cancer?"

Examination
"Would it be alright if I take a close look at the mole? I'll use a dermatoscope - it's a special magnifying tool that lets me see the structure of the mole in detail."

Findings:
"I can see a mole that's [size], with regular borders, even colour throughout, and symmetrical shape. Looking with the dermatoscope, the pattern is consistent with a normal, benign mole."

ABCDE Assessment (Explain to Patient)
"When we assess moles, we use something called the ABCDE criteria:

- **A**symmetry - this mole is symmetrical ✓
- **B**order - the edges are smooth and regular ✓
- **C**olour - the colour is even throughout ✓
- **D**iameter - it's less than 6mm ✓
- **E**volution - you've said it hasn't changed ✓

Based on all of this, I'm confident this is a benign mole."

Reassurance
"I can see why your colleague's comment worried you. However, I've looked at the structure of the mole under magnification, and it doesn't show the chaotic patterns we see in cancer. The pattern is very organised and healthy - even colour, smooth borders, and symmetrical shape. This is what we expect to see in a completely benign mole."

Self-Monitoring
"Moving forward, it's good practice to keep an eye on your moles. If you ever notice any changes - using the ABCDE criteria I mentioned - please come back."
"Taking photos of your moles every few months can help you track any changes."

Sun Protection
"Regardless of mole concerns, it's always a good idea to protect your skin from the sun:

- Use SPF 30+ sunscreen
- Wear protective clothing
- Avoid sunbeds"

Addressing Anxiety

"I can see this has been quite worrying for you. If you find yourself becoming very anxious about your health, please do talk to us - we can support you with that too."
"Is there anything else I can help clarify today?"

Safety Netting
"Please come back if this mole or any others change in any way. But based on today's examination, there's no cause for concern."

Follow-Up
"You don't need routine follow-up for this, but our door is always open if you're worried."

Cradle Cap (Infantile Seborrheic Dermatitis)

Scenario: Primary Care Setting | Infant | Scalp Rash | Concerned Parent
Your Role: FY2 GP - assess, reassure, and advise appropriately.

Introduction
"Hello, I'm one of the doctors here at the practice. I understand you've brought your baby in today. Could I confirm your baby's name and date of birth, please?
Thanks. What's been worrying you?"
(Parent: "There's all this crusty, flaky stuff on my baby's scalp. It looks terrible.")

History- Follow standard dermatology structure
Diagnostic pivots for cradle cap:
- Yellow, greasy, scaly patches on scalp
- May extend to face, behind ears, nappy area
- Not itchy or uncomfortable for baby
- Usually appears in first few weeks of life
- Self-limiting

Ask specifically:
"When did you first notice this?" "Does it seem to bother your baby at all?" "Is your baby feeding and sleeping normally?" "Have you tried any treatments?"

Examination
"Would it be alright if I take a look at your baby's scalp?"

Findings:
"I can see yellow, greasy scales on your baby's scalp. The skin underneath looks healthy. Your baby doesn't seem bothered by it at all, which is reassuring."

Provisional Diagnosis
"This is **cradle cap** - a very common and completely harmless condition in babies."

Explanation
"Cradle cap is caused by a mild overproduction of oil in the skin, combined with a natural yeast that lives on everyone's skin. It's very common in young babies."
"I want to reassure you - it doesn't cause your baby any discomfort. It doesn't hurt or itch. And it's definitely not caused by poor hygiene or anything you're doing wrong."
"It almost always clears up completely on its own within a few months - usually by 6-12 months of age."

Management Plan
Home care:

"You can help loosen the scales with these steps:"

1. **Apply baby oil or petroleum jelly** to the scalp (note: olive oil is no longer recommended as it has been found to damage the skin barrier. Also, do not use peanut-based oils due to allergy risk)
2. Leave for **30 minutes to overnight** to soften the scales
3. **Gently brush** with a soft baby brush or fine-toothed comb to loosen flakes
4. **Wash with mild baby shampoo** to remove the loosened scales

"You don't need medicated shampoos - these aren't usually necessary and aren't routinely prescribed on the NHS for cradle cap."

Fire Safety Note
"If you're using any paraffin-based emollients or petroleum jelly, be aware that these can be a fire hazard if they get onto clothing or bedding. Keep away from flames and cigarettes."

Safety Netting
"Please come back if:

- The cradle cap spreads to other parts of the body
- The skin becomes red, weepy, or looks infected
- Your baby seems bothered or uncomfortable
- It's not improving after several weeks of home treatment"

Follow-Up
"You don't need routine follow-up - this will resolve on its own."
Reassurance
"Try not to worry - this looks worse than it is! It's one of those things that bothers parents more than babies."

Head Lice (Pediculosis Capitis)

Scenario: Telephone Consultation | Parent of School-Age Child | Recurrent Head Lice
Your Role: FY2 GP - assess, advise, and support frustrated parent.

Introduction
"Hello, am I speaking to [parent name]?
This is Dr [Your Name] from the surgery. Thanks for calling - I can hear this has been frustrating. How can I help?"
(Parent: "My daughter keeps getting head lice. We've tried everything. I'm at my wit's end and there's tension with other parents at school.")

Empathy and Validation
"I'm really sorry you're dealing with this - recurrent head lice can be incredibly frustrating, and I know it causes a lot of stress for families."
"I want to reassure you first that head lice are **not related to hygiene** - they actually prefer clean hair. This is nothing you're doing wrong."

History
"Let me ask a few questions to help us find the best approach."
"How are you currently detecting and treating the lice?" "Are you finding live lice, or just eggs (nits)?" "Is everyone in the household being checked and treated?" "What treatments have you tried?"

Management Options
Option 1: Wet Combing (Detection Comb Method)
"The most reliable method is systematic wet combing with a fine-toothed detection comb."

"Here's how to do it properly:
- Wash hair and apply lots of conditioner
- Using a detection comb, comb through sections of wet, conditioned hair
- Wipe the comb on white tissue after each stroke to check for lice
- Do this on **Days 1, 5, 9, and 13**
- Continue until no lice are found for 17 days

The Bug Buster Kit from pharmacies has everything you need and comes with clear instructions."

Option 2: Physical Insecticide Lotions
"If wet combing isn't working or isn't practical, there are effective lotions:"

Dimeticone 4% lotion (Hedrin):
- Apply to dry hair
- Leave on **overnight (8 hours)** or use the spray gel version for **15 minutes**
- Comb through to remove dead lice
- **Repeat after 7 days**

"These treatments are available without prescription from pharmacies - head lice treatments are not routinely prescribed on the NHS. Your pharmacist can advise on the most suitable product."

Why Permethrin Is No Longer Recommended
"Older treatments like permethrin-based products aren't very effective anymore because lice have developed resistance to them. Physical treatments like dimeticone work better."

What Doesn't Work
"Just so you know - electric combs and repellent sprays are not very effective."

Managing School Situation
"Regarding school - there is no medical requirement to exclude your daughter from school. Once treatment has been started, she can attend as normal. Some schools have outdated policies on this."
"If it would help, I can provide a letter for the school explaining the current guidance."

Household Management
"Make sure to check everyone in the household with the detection comb. Only treat those who have live lice - you don't need to treat everyone 'just in case'."

Safety Netting
"Please call back if the infestation continues despite properly following these methods, or if your daughter's scalp becomes very itchy, red, or looks infected."

Primary Focal Hyperhidrosis

Scenario: Primary Care Setting | Young Adult | Excessive Sweating Causing Social Distress
Your Role: FY2 GP - assess, explain, and initiate treatment.

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 seems uncomfortable)
"Take your time - whatever it is, I'm here to help."
(Patient: "I sweat excessively, especially from my hands and underarms. It's really affecting my confidence.")

Empathy

"Thank you for sharing that - I can imagine this is difficult to talk about. This is much more common than you might think, and you're definitely not alone in this."

History- Follow standard dermatology structure
Diagnostic criteria for primary focal hyperhidrosis:

- Excessive sweating for ≥6 months
- Affecting palms, soles, axillae, or face
- Started before age 25
- Bilateral and symmetrical
- No night sweats (distinguishes from secondary causes)
- Often positive family history

Ask specifically:
"How long have you had excessive sweating?" "Where do you sweat the most?" "Does it happen at night while you're sleeping?" "Did it start before you were 25?" "Does anyone in your family have similar problems?" "How is it affecting your daily life?"

Ruling Out Secondary Causes
"Do you have any other symptoms - weight changes, palpitations, feeling very hot?" "Are you taking any medications?"

ICE
I: "I thought it was just nerves but it happens all the time."
C: "Will I have this forever? Is something wrong with me?"
E: "I just want something that helps."

Effect on Life
"How is this affecting your work, relationships, and social life?"

Provisional Diagnosis
"This sounds like **primary focal hyperhidrosis** - a condition where certain areas of the body produce more sweat than needed."

Explanation
"In primary hyperhidrosis, the sweat glands are overactive. It's not caused by another medical condition and it's not related to hygiene or anything you're doing. It often runs in families."
"The good news is there are several treatment options that can really help."

Management Plan - Stepwise Approach
Step 1: Stronger Antiperspirants
"Regular antiperspirants probably haven't worked for you. Look for ones containing **20% aluminium chloride hexahydrate** - brand names include **Driclor** or **Anhydrol Forte**. These are available from pharmacies without prescription."

Application:

- Apply to **dry skin** at night
- Wash off in the morning
- Use every 1-2 days initially, then reduce frequency as symptoms improve

Managing irritation: "Skin irritation is common when starting treatment. If this happens, you can:

- Use a soap substitute instead of regular soap
- Reduce how often you apply it
- Use a mild hydrocortisone 1% cream for up to two weeks if needed"

Step 2: If antiperspirants aren't enough
"If stronger antiperspirants don't help enough, we can refer you to dermatology for other options:

- **Iontophoresis** - using electrical current to reduce sweating (for hands/feet)
- **Botox injections** - very effective for underarm sweating
- **Medications** - anticholinergic tablets in some cases"

Lifestyle Advice

- Wear loose, breathable clothing
- Cotton or moisture-wicking fabrics help
- Carry spare clothing if needed
- Avoid known triggers (spicy food, alcohol) if relevant

Mental Health Support
"If this is significantly affecting your mood or confidence, please let us know. We can offer support for the emotional impact too."
"Hyperhidrosis UK (www.hyperhidrosisuk.org) is a useful resource with information and support."

Follow-Up
"Let's review in about 4-6 weeks to see how you're getting on with the antiperspirant. If it's not helping enough, we'll discuss the next steps."

Contact Dermatitis

Scenario: Primary Care Setting | Working Adult | Localised Hand Rash with Occupational Exposure History
Your Role: FY2 GP - assess, explain, and treat appropriately.

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 got this itchy, sore rash on my fingers. I work with flowers and chemicals without gloves.")

History- Follow standard dermatology structure
Diagnostic pivots for contact dermatitis:

- Localised rash in area of contact
- Itchy, red, may have vesicles
- Clear exposure history
- Irritant vs allergic patterns

Ask specifically:
"When did the rash first appear?" "What substances do you come into contact with at work?" "Do you wear gloves?" "Does the rash improve when you're away from work - on holiday, for example?" "Have you had this before?"

Examination Findings:
"I can see a red, itchy rash on your fingers with some small blisters. The distribution matches where you would handle materials at work."

Provisional Diagnosis
"This is **contact dermatitis** - a skin reaction caused by contact with an irritating or allergenic substance."

Explanation

"Your skin has developed a sensitivity to something you've been in contact with - it's like an allergic reaction localised to that area."
"There are two types: irritant dermatitis (direct damage from chemicals) and allergic dermatitis (immune reaction). Either can occur with occupational exposures."

Management Plan
Treatment:

1. **Emollient (moisturiser):**
    - Apply frequently to repair the skin barrier
    - Use as a soap substitute
2. **Topical steroid:**
    - For hand dermatitis, where the skin is thicker, we usually need a more potent steroid. I'll prescribe **betamethasone valerate 0.1% cream (Betnovate)** - apply thinly once or twice daily for up to 2 weeks, then step down to a milder steroid like **Clobetasone butyrate (Eumovate)**, for maintenance

Application order:
Apply one product at a time. You can apply either the steroid or emollient first - what matters is leaving about 20-30 minutes between them so each has time to absorb properly.

Prevention:

- Wear **nitrile gloves** when handling chemicals or irritants
- Use barrier creams before work
- Wash hands gently and pat dry (don't rub)
- Avoid known irritants where possible

Safety Netting
"Please come back if:

- The rash spreads or doesn't improve within 2 weeks
- You develop a secondary infection (very red, weeping, painful)
- You're having frequent flare-ups despite precautions"

"If this continues, we may refer you for **patch testing** with a dermatologist to identify the specific allergen."

Follow-Up
"Let's review in 2-3 weeks if it's not settling."

Occupational Health
"If this is clearly work-related and keeps recurring, you may benefit from an occupational health referral to help adapt your workplace."

Eczema (Atopic Dermatitis)

Scenario: Primary Care Setting | Adolescent with Parent | Flexural Eczema Flare
Your Role: FY2 GP - assess, explain, and manage flare-up.

Introduction
"Hello, I'm one of the doctors here at the practice. I understand you've both come in today.
Could I confirm the patient's name and age, please?
Thanks. What's been going on?"
(Parent: "Their eczema has flared up really badly behind the knees. They're not sleeping and it's affecting school.")

History- Follow standard dermatology structure

Diagnostic pivots for atopic eczema:

- Itchy, dry, red patches
- Flexural distribution (elbows, behind knees)
- Personal/family history of atopy (asthma, hay fever)
- Chronic/relapsing course
- Triggered by irritants, stress, infections

Ask specifically:
"When did this flare start?" "What do you think triggered it?" "How is the itching affecting sleep?" "What treatments are you currently using?" "Does your child have asthma or hay fever?"

PMAFTOSA

- History of atopic conditions
- Current treatments
- Check for steroid concerns from parent

ICE
Parent's concerns: "I've heard steroids thin the skin. I'm worried about using them."

Examination Findings:
"I can see red, inflamed patches behind both knees. The skin is dry and there are scratch marks. There's no sign of infection - no weeping or crusting."

Provisional Diagnosis
"This is a flare-up of **atopic eczema**."

Explanation
"Eczema is a condition where the skin's barrier isn't as strong as it should be, making it more easily irritated. In children with asthma or allergies, this is even more common. The skin becomes irritated and itchy, and scratching can make it worse or even lead to infections."

Management Plan
1. Emollients - the foundation of treatment:
"Use fragrance-free emollient generously and frequently - ideally **at least 3-4 times daily**, even when the skin looks clear. Apply all over the body, not just to affected areas."

- Use as soap substitute and moisturiser
- Apply in direction of hair growth (reduces folliculitis)
- Generous amounts - 250-500g per week for a child

2. Topical Steroids:
"For the face and skin folds: **Hydrocortisone 1%** - apply once daily for up to 7 days."
"For the body (behind knees): Start with hydrocortisone 1% applied once daily, as the skin behind the knees is thinner and more sensitive. If this doesn't control the flare after 7-14 days, we can step up to a moderate strength like Clobetasone butyrate (Eumovate)."

Application order: Apply one product at a time. You can apply either the steroid or emollient first - what matters is leaving about 20-30 minutes between them so each has time to absorb properly.

Addressing steroid concerns: "Used correctly, mild to moderate steroids are very safe, especially for short periods. The key is using them appropriately - the right strength for the right area, for limited time during flares. Undertreating eczema actually causes more problems than appropriate steroid use."

3. Avoiding triggers:

- Avoid perfumed products, bubble baths

- Use cotton clothing
- Keep fingernails short

4. Antihistamines:
"If itching is severely affecting sleep, consider a **short course (7-14 days maximum) of a sedating antihistamine** such as chlorphenamine at night."
"Non-sedating antihistamines like cetirizine are only recommended if there is severe itching or urticaria alongside eczema."

School Advice
"Please let teachers know so they're aware of the symptoms and impact on concentration."

Safety Netting
"Please come back if:
- The rash doesn't improve within 1-2 weeks
- It gets red, swollen, or starts to ooze - this may mean infection
- The itching becomes unbearable or your child seems very tired or unwell"

Follow-Up
"Let's review in 2-3 weeks to see how they're responding to treatment."

Leaflet
"I'll give you an NHS leaflet about eczema with instructions on using creams and spotting complications."

Venous Ulcer

Scenario: Primary Care Setting | Older Adult | Venous Leg Ulcer Follow-Up | Poor Compression Compliance
Your Role: FY2 GP - assess progress, address barriers to compression, and plan ongoing care.

Introduction
"Hello, I'm one of the doctors here at the practice. Could I confirm your full name and age, please? Thanks. It's good to see you again. How have things been since your last appointment?"
(Patient: "The ulcer isn't healing like I hoped. I've been struggling with the compression stockings - they're uncomfortable.")

History of Current Situation
"I'm sorry to hear you've been struggling. Let me understand what's been happening."
"How often have you been wearing the compression?" "What specifically makes them uncomfortable?" "Have you been able to keep your leg elevated?" "Any increase in pain, discharge, or smell from the ulcer?"

PMAFTOSA Review
- Previous venous disease
- Diabetes status
- Smoking
- Mobility
- Social support

Examination
"Would it be alright if I examine the ulcer today?"

Findings:
"The ulcer is [size] cm, located on the lower leg near the ankle. The wound bed is [describe]. There's some surrounding skin changes consistent with venous disease but no signs of active infection."

Reviewing ABPI
"Let me check your previous ABPI result. I can see it was within the normal range (between 0.8 and 1.3). This confirms adequate arterial supply and means compression therapy is safe."

ABPI interpretation:
- ≥0.8: Safe for full compression
- 0.5-0.8: Reduced compression at 20mmHg may be appropriate
- <0.5: Compression contraindicated - urgent vascular referral

Explanation
"Venous ulcers happen when the valves in your leg veins don't work properly, causing blood to pool in the lower legs. This increased pressure damages the skin over time."
"Compression therapy is the most important treatment - it helps the blood flow back up your leg properly. Without compression, these ulcers are very slow to heal."

Addressing Compression Barriers
"I understand the compression has been difficult. Let's see if we can find a solution."

Options:
- Different stocking type (two-layer systems may be more comfortable)
- Compression wraps instead of stockings
- Timing of application (easier in the morning when less swelling)
- Support from district nurse for application

"I'll personally oversee your care and make sure we're making progress. Let's try a different approach this time - we have other compression options that might be more comfortable."

Management Plan
1. Compression - essential: "I'll refer you to the tissue viability nurse to review your compression. They can fit you for a system that works better for you."
2. Wound care: "Regular dressing changes as per current plan."
3. Lifestyle:
- Elevate legs when sitting
- Avoid prolonged standing
- Stay mobile - walking helps the calf muscle pump blood back

4. If not healing after 4-6 weeks of compression: Consider referral to vascular/tissue viability team who may:
- Assess for surgical venous intervention
- Perform additional investigations
- Consider medications such as **Pentoxifylline 400mg three times daily** *[Note: Specialist-initiated; evidence supports improved healing rates]*

Safety Netting
"Please contact us urgently if:
- The ulcer becomes more painful, red, swollen, or smelly
- You develop a fever
- You notice the ulcer rapidly increasing in size"

Follow-Up
"I'd like to see you again in 2 weeks to check progress. The tissue viability nurse will also be involved in your care."
"I'll stay involved too - we'll work together to get this healed."

Non-Healing Venous Ulcer

Scenario: Middle-aged adult returns for follow-up with non-healing ulcer despite treatment.

Additional Management:
If ulcer not healing after adequate compression trial:

1. **Vascular referral** - assess for underlying arterial disease or venous surgery options
2. **Investigations:**
    - Repeat ABPI
    - Venous duplex ultrasound
    - Consider biopsy if suspicious features
3. **Pentoxifylline:**
    - 400mg three times daily
    - Improves microcirculation
    - Evidence supports improved healing rates
4. **Consider:**
    - Wound debridement
    - Advanced wound care products
    - Skin grafting in specialist centre

Onychomycosis

Setting: Primary Care
Patient: Middle-aged Adult
Presenting Complaint: Nail changes and discomfort over several months

1. INTRODUCTION & CONSENT

- Greet, introduce self, confirm patient's name and age
- "What brings you in today?"

2. HISTORY

A. Onset, Site & Course

- "When did the nail changes start?" → **"About 6 months ago."**
- "Which nail is affected?" → **"Big toe on the right foot."**
- "How has it changed over time?" → **"It's become thick, yellow, and crumbly."**
- "Is it spreading to other nails?"
- "Any nail lifting or detachment?" → **"Yes, it's lifting at the edge a bit."**

B. Symptoms

- "Do you have any itching, pain, or redness?" → **"There is itching, but no pain."**
- "Where is the itching — around the nail or elsewhere?"
- "Any discharge, odour, or swelling?"
- "Any trouble walking or pressure from shoes?"

C. Treatment History

- "Have you used anything to treat this?" → **antifungal spray for 3 months.**
- "Was there any improvement?" → **No**
- "Any previous tablet treatment?"

D. Medical History

- "Any recent trauma to the toe?" → **"No trauma."**
- "Any conditions like diabetes or poor circulation?"
- "Are you taking any regular medication?"
- "Any liver problems or allergies?"

E. Occupational & Lifestyle Risk Factors

- "What do you do for work?" → **scaffolder**
- "Do you wear enclosed shoes for long periods?" → **Implied yes**
- "Do your feet sweat a lot?" → **"Yes, I have sweating as well."**

F. ICE

- If asked:
  - **Ideas:** "I'm not sure, just want to know what it is."
  - **Concerns:** "It's not going away."
  - **Expectations:** "Would like proper treatment."

3. EXAMINATION

Right great toenail shows:

- **Yellow discoloration**, **thickened nail plate**, **subungual debris**, and **distal onycholysis**
- Mild **dry scaling** seen between toes
- No swelling, redness, or discharge
- No signs of cellulitis or secondary infection

4. DIFFERENTIAL DIAGNOSES

- **Onychomycosis** (fungal nail infection — most likely)
- Psoriatic nail disease
- Traumatic nail dystrophy (unlikely — no trauma)
- Chronic paronychia
- Lichen planus (rare)

5. DIAGNOSIS & EXPLANATION

Likely diagnosis: Fungal nail infection (onychomycosis)

Lay Explanation:

"This looks like a fungal infection affecting your nail. This is really common, especially in people who work on their feet — it's not about cleanliness at all, just the conditions the feet are in. These infections often happen when feet are in warm, moist conditions for long hours — like wearing boots during work. You've tried the spray, which was worth a go, but once the fungus gets under the nail, topical treatments struggle to penetrate — that's why we usually need tablets for this.

We'll confirm it with a simple nail test, and if it's positive, we can start an antifungal tablet that works from inside the body. It takes a few months, but it usually clears it up well."

Important: Advise the patient that treatment is not essential if they are not troubled by the appearance and there are no symptoms. Many people choose to live with fungal nail infections. Treatment is an option, not a necessity.

6. MANAGEMENT

A. Investigations

Nail clippings for fungal microscopy and culture — must confirm before oral antifungal
Baseline LFTs — if starting oral terbinafine, then repeat at 4–6 weeks into treatment (local policy may vary)

Optional:

- Skin scraping (if tinea pedis)
- HbA1c — if signs of undiagnosed diabetes (not suspected here)

B. Treatment

OTC option first: In the first instance, patients may wish to try amorolfine 5% nail lacquer (available OTC) before committing to oral treatment.

First-line (if confirmed dermatophyte infection)

- **Oral Terbinafine 250 mg once daily for 12 weeks**
  - LFTs at baseline AND at 4–6 weeks into treatment (check local policy)
  - Urgent LFTs if symptomatic at any time
  - Discontinue if ALT/AST >3x upper limit of normal or if patient develops symptoms of hepatotoxicity
  - Educate on full course adherence
  - Common side effects: rash, taste changes, GI upset
  - Rare: liver dysfunction — advise to report yellowing of skin, dark urine, or persistent abdominal pain

DRUG INTERACTION WARNING — CYP2D6 Inhibition: Terbinafine is a potent CYP2D6 inhibitor. Check medication history for:

- **Tricyclic antidepressants** (amitriptyline, nortriptyline) — can increase plasma levels significantly
- **Beta-blockers metabolised by CYP2D6** (metoprolol, propranolol) — risk of bradycardia
- **SSRIs** (paroxetine, fluoxetine)
- **Antipsychotics** (risperidone, aripiprazole)

If patient is on these medications, consider dose adjustment or closer monitoring. The interaction can persist for months after terbinafine is stopped due to its long half-life.

Patient Warning Signs for Hepatotoxicity: "If you develop any of these symptoms while on treatment, stop the tablets immediately and contact us urgently:

- Unexplained nausea, loss of appetite, or fatigue
- Dark urine or pale stools
- Yellowing of skin or eyes
- Persistent abdominal pain"

If unsuitable or declined

- **Topical Amorolfine 5% nail lacquer**, once or twice weekly for 6–12 months
  - Slower results, suitable only if superficial or ≤2 nails

Treat tinea pedis (if present)

- **Topical terbinafine/clotrimazole cream** between toes for 4 weeks
- Dry feet thoroughly, especially between toes

C. Lifestyle & Prevention

- Change socks twice daily
- Let boots air and dry after work
- Use antifungal foot powder inside shoes
- Avoid barefoot walking in communal showers
- Don't share towels or nail clippers
- Trim nails straight across

7. SAFETY NETTING

- "Please come back if it worsens, spreads, or becomes painful."
- "If you develop rash, yellowing of your eyes, or dark urine while on treatment, stop and see us urgently."
- "It may take 6–12 months for the nail to grow back fully even after treatment — that's normal."

8. FOLLOW-UP

- Review in **3–4 weeks** for test result
- Start treatment only if fungal infection confirmed
- Recheck LFTs at 1 month if on terbinafine
- If no improvement after 6 months or if recurrent → consider referral to dermatology or podiatry

9. CLOSING

- Offer NHS leaflet on fungal nail infections
- "Is there anything else you'd like to ask?"

Erythema ab igne

- **Setting:** Primary Care
- **Patient:** Young adult female
- **Presenting complaint:** Abdominal skin changes with cyclical pain

1. Introduction & Consent

- Greet and introduce yourself as the doctor.
- Confirm patient's name and age.
- Gain consent: "I understand you've noticed a rash and also have period pains. Would it be alright if I ask you some questions to better understand your concerns?"
- Offer chaperone if examination required.

2. Presenting Complaint & History of Rash
Open question:

- "Could you tell me more about this rash you've noticed?"

Focused questions:

- Onset: When did you first notice it?
- Duration: Is it constant or does it appear only at certain times?
- Timing: Any relation to your menstrual cycle?
- Progression: Has it spread or changed over time?
- Symptoms: Itch, pain, burning, tenderness?
- Exposures: Do you apply anything hot (e.g. hot water bottle, heating pad, laptop)?
- Severity: Any effect on daily life?
- Previous episodes?
- Treatments tried (creams, lotions, etc.)?

Red flag screening for other causes:

- Any blistering, open sores, bleeding, non-healing areas?
- Any unintentional weight loss, night sweats, fevers?
- Family/personal history of skin cancers?

3. Menstrual & Pain History

- Cycle: Regular or irregular? Length?
- Flow: Normal / heavy / clotting?
- Pain: Duration, timing (before, during, after period), severity (1–10 scale).
- Associated symptoms: Nausea, vomiting, headaches, back pain, mood changes.
- Medications tried: Ibuprofen, paracetamol, mefenamic acid, naproxen. Effectiveness?
- Previous use of hormonal contraception (COCP, progestin-only pill, IUS)? Concerns or side effects?
- Impact on life: School, work, relationships.

4. Past Medical, Surgical, and Family History

- PMH: Any other chronic illnesses?
- PSH: Any abdominal/gynaecological surgery?
- Family history: Gynaecological cancers, skin conditions?
- Medications and allergies.

5. Social History

- Smoking, alcohol, recreational drugs.
- Occupation and lifestyle.
- Impact on quality of life — missing work/school due to period pain.

6. Explore ICE (Ideas, Concerns, Expectations)

- **Ideas:** What do you think this rash might be?
- **Concerns:** "You mentioned concerns about hormonal treatment and cancer risk — can you tell me more?"
- **Expectations:** What would you like help with today — the rash, the period pain, or both?

7. Examination (if time allows)

- Inspection of rash: Reticulated, reddish-brown pigmentation over lower abdomen.
- No tenderness, no ulceration, no induration.
- Abdominal exam: soft, non-tender.
- (Pelvic exam not immediately required unless other concerns.)

8. Diagnosis & Explanation

Likely Diagnosis:

- The rash is most consistent with **Erythema ab igne** — "toasted skin syndrome."

Explanation:

- "This rash is caused by frequent use of very hot objects like hot water bottles. The heat damages the tiny blood vessels in the skin and causes this net-like red to brown discoloration. It's not an infection, and it's not contagious."
- "If you stop using direct heat, the rash usually fades gradually over months. Sometimes it can leave some permanent marks, especially if it's been there for a long time."
- "In rare cases, long-term repeated heat damage can increase the risk of skin changes, so it's best to avoid direct strong heat."

9. Management Plan

For the Rash (Erythema ab igne):

- Stop prolonged direct hot water bottle use.
- If heat is needed, keep it warm but not hot, and wrap in a towel/cover.
- No specific creams required; simple emollients can help.
- If rash persists, worsens, ulcerates, or doesn't fade after months → refer to dermatology.

For Dysmenorrhea (Period Pain):

- **First-line:** Offer a trial of mefenamic acid or naproxen (more effective than ibuprofen). Take with food.
- **If associated heavy menstrual bleeding (HMB):** Consider **tranexamic acid** (antifibrinolytic) — can be used alongside NSAIDs if bleeding is the main issue (NICE NG88).
- **Second-line / adjuncts:** Consider combined oral contraceptive pill (COCP) or levonorgestrel IUS if pain severe and not controlled — provide balanced counselling:

    - "Modern low-dose contraceptive pills are actually protective against some cancers — they reduce your risk of ovarian and womb cancer. There is a very small temporary increase in breast cancer risk while taking it, but this returns to normal after stopping."
- Non-pharmacological: Regular exercise, hot compresses (safe), TENS machine, relaxation techniques.
- If symptoms remain severe or there is suspicion of secondary cause (e.g. endometriosis) → refer to gynaecology.

10. Safety Netting

- "If the rash changes rapidly, becomes painful, ulcerates, or you notice new lumps or sores, please come back immediately."
- "If your periods suddenly change — become much heavier, irregular, or associated with severe pelvic pain outside of your period — let us know, as further tests may be needed."

11. Follow-up & Leaflet

- Arrange follow-up in a few months to review rash and pain control.
- Provide patient information leaflet on:
    - Dysmenorrhea self-care and medical management (NHS leaflets).
    - Erythema ab igne and skin care.
- Confirm understanding: "Does this plan make sense to you? Do you have any other questions or concerns?"

Chapter 15: Paediatrics

A Note to Learners

The cases in this resource are written in a conversational style to help you become familiar with the natural flow of clinical consultations and the language commonly used in UK healthcare settings.

These dialogues are intended as a learning guide, not a script. Please do not attempt to memorise them verbatim. Examiners assess your ability to think and communicate authentically - not to recite rehearsed phrases.

Use this material to understand the underlying clinical reasoning, then practise in your own words until the consultation feels natural to you.

For Companion OSCE Cases, Practice Scripts, Evaluation Checklists, Summary Notes, Rapid Review Notes, Mindmaps, Management Flashcards and Image Library - visit https://www.gksplab2.com

Disclaimer
This material is independent educational content created to help candidates develop clinical reasoning and communication skills for UK medical practice.

All cases and clinical scenarios are based on common presentations encountered in UK primary care and emergency medicine, drawn from publicly available sources including NICE Clinical Knowledge Summaries (CKS), BNF, and other official NHS/UK healthcare guidelines.

No content in this resource is derived from, represents, or claims to replicate actual GMC PLAB 2 examination material.

Paediatric History-Taking Structure

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): "Congratulations - how have things been going since birth?"
Note: "Was this a planned pregnancy?" should only be asked in specific contexts such as safeguarding stations or detailed developmental history for congenital conditions - not as a routine opening question.

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?"

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?"

PLAB 2 Tip: In an 8-minute station, perform a **targeted systems review relevant to the presenting complaint** (e.g., ENT/Resp/Hydration for fever) rather than a full head-to-toe check.

The table below is for reference - use clinical judgement to select relevant questions.

System	Ask 1–2 questions
Neuro	Any seizures, drowsiness, floppiness?
Ears	Any ear pulling, discharge?
Nose	Runny nose, sneezing?
Eyes	Redness, discharge?
Lungs	Cough, wheeze, difficulty breathing?
GI	Vomiting? Diarrhoea? Constipation? Feeding issues?
Urinary	Crying while peeing? Smelly urine? Wet nappies?
Hydration	Crying without tears? Dry mouth? Less playful than usual?
Injuries	Any recent falls or injuries?

RELEVANT PAST HISTORY - Use BIRDS-MAF Mnemonic

Code	Category	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?"

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)

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?"

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

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Intussusception

Setting: Paediatric Assessment Unit | Infant/Toddler | GP Referral for Acute Abdominal Symptoms and Irritability
Task: Focused history from parent + discuss likely diagnosis and management

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?"

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?"

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."

STRUCTURED BACKGROUND HISTORY

Code	Category	Question
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?"

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?"

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."

PROVISIONAL DIAGNOSIS
"I understand this must be very worrying for you. 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**."

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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."
"I know hearing 'serious condition' is scary, but I want to reassure you that with prompt treatment, the vast majority of children make a full recovery."

MANAGEMENT PLAN
"We've caught this at a good time, and we're going to take care of [child's name] quickly but thoroughly. Here's what we'll do:"
Immediate care

- **Admit** to paediatric ward
- Keep the child **nil by mouth (NBM)**
- **If signs of shock:** administer 10 ml/kg 0.9% NaCl bolus over <10 minutes. Repeat as needed.
- Insert a **nasogastric (NG) tube** to decompress the bowel and reduce vomiting
- Monitor observations closely
- Antibiotics are not routinely indicated before air enema but should be given if there are signs of peritonitis, sepsis, or systemic illness.

Investigations

- **Blood tests**: FBC, CRP, U&Es, glucose, group & save
- Urine and stool samples
- **Abdominal X-ray** - often first-line to rule out perforation/free gas
- **Abdominal ultrasound** - diagnostic gold standard (sensitivity >95% per GOSH/RCPCH)

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."

Critical: Air enema is **contraindicated** if there are signs of **peritonitis** (hard/rigid abdomen, guarding) or **perforation** (free air on X-ray). These patients require **immediate surgical referral**.
"If that doesn't work - or if the bowel looks damaged - then **surgery may be needed** to fix the problem and prevent complications."

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."
"There is a small chance (around 5%) that intussusception can recur in the first few days after treatment - if you notice similar symptoms, return immediately."

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."

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: Primary Care | Toddler | Follow-Up Appointment for Bowel Concerns
Task: Follow up a child previously seen for constipation. Address the parent's concerns and discuss diagnosis and management.

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?"

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?"

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?

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?"

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WELLBEING CHECK
"Have they been otherwise active and playful?"
"Are they feeding and drinking normally?"

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?"

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

PROVISIONAL DIAGNOSIS
"From the history and examination, this appears to be **functional constipation**, meaning constipation without an underlying medical cause."

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."

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."
"Children often pick up on our stress, so try to keep toilet time relaxed and pressure-free. Reward attempts, not just success."
"Using a small stool under their feet when on the toilet can help - it puts the body in a better position for bowel movements."

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** (starting dose for children aged 1–6 years: 1 sachet daily, adjustable up to 4 sachets/day)"
"This might cause looser stools at first, which can be a bit messy - but that's actually a good sign. It means the medicine is doing its job."
"Laxatives are safe in children and may be needed for **several months to years** to retrain the bowel."
"Please continue the laxative even when things seem better - stopping too early is a common reason for symptoms to return."
For children under 2, we use this medication with parental consent as it's the recommended treatment despite licensing limitations.

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."

When to Refer to Paediatrics
Refer to paediatric gastroenterology or general paediatrics if:

- **Constipation from birth or first few weeks of life** (suspect Hirschsprung's disease)
- **Ribbon-like stools** or **failure to pass meconium within 48 hours of birth**
- **Abdominal distension with vomiting** (possible obstruction)
- **Faltering growth** or weight loss
- **Neurological signs** (lower limb weakness, abnormal reflexes, sacral dimple/tuft)
- **Failed disimpaction regimen** despite adequate dose escalation
- **Faecal incontinence persisting beyond 1 year** of treatment
- **Suspected safeguarding concerns** (e.g., anal fissure without clear cause in older child)

As an FY2: You can initiate first-line management (Movicol, lifestyle advice) and manage uncomplicated functional constipation. Seek senior advice if red flags present or if no improvement after 3 months of optimised treatment.

SAFETY NETTING
"Please come back earlier if your child develops vomiting, bloated tummy, fever, or if they stop eating or drinking."

FOLLOW-UP PLAN
"Let's review progress in **two weeks**. If things are improving, we'll continue. If not, we'll escalate as needed."

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: Primary Care Telephone Consultation | Infant | Parent Calling About Acute Gastrointestinal Symptoms
Mode: Telephone Consultation
Task: Assess a child with diarrhoea over the phone and provide advice

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."

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?"

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?"

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?"

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?"

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."

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."

MANAGEMENT PLAN

Home management

"The main treatment is keeping your child **well hydrated**."
"Offer small sips of water or oral rehydration solution (such as Dioralyte) 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."
"Avoid anti-diarrhoeal medications like loperamide - they're not recommended for young children."

Infection control

"Keep your child at home and away from other children for now."
Important: Children must be excluded from nursery/school for **48 hours after the last episode of diarrhoea or vomiting**. This is a mandatory Public Health requirement.
"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."

Note: Zinc supplementation is recommended by WHO for diarrhoea in developing countries, but is **not routinely recommended in UK guidelines** (NICE) unless there is specific evidence of zinc deficiency.

When to Refer to Hospital

Arrange SAME-DAY hospital assessment if:

- **Clinical dehydration** (reduced skin turgor, sunken eyes, dry mucous membranes, tachycardia)
- **Shock suspected** (prolonged CRT, mottled skin, altered consciousness, tachypnoea)
- **Bloody diarrhoea** - consider HUS (haemolytic uraemic syndrome), especially if recent E. coli O157 exposure or after antibiotics
- **Bilious (green) vomiting** - surgical cause until proven otherwise
- **Severe abdominal pain or distension**
- **Child appears systemically unwell** or parent has significant concern
- **Infant <3 months with fever and diarrhoea**
- **High-risk child** (immunocompromised, comorbidities)

As an FY2: You can manage mild gastroenteritis over the phone with safety netting. If any red flags above, arrange urgent face-to-face assessment or direct hospital referral. If bloody diarrhoea: advise hospital, request stool culture for E. coli O157, and warn about HUS symptoms (pallor, reduced urine, bruising).

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**
- If you gently pinch the skin on their tummy and it stays 'tented' rather than springing back - that's a sign of dehydration
- **Any blood in stool** or the diarrhoea **lasts more than 7 days**

"Please don't hesitate to call us back or bring your child in - it's always better to check if you're worried."

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."

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: Emergency Department | Young Child | Witnessed/Suspected Foreign Object Ingestion
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.

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?"

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?"

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**.

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.)

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?"

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?"

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 within **2-4 weeks** in most cases
- Most parents don't check the nappy - but if you'd like to know for certain it's passed, you can look for it over the next few days. It's not essential though.

Follow-up: Watch stools for 2-4 weeks. Re-imaging only if coin fails to pass or symptoms develop (pain, vomiting, fever).
Return if pain, vomiting, or fever develops
"We'll advise you to watch for it in the stool, but it usually comes out naturally. Only come back if symptoms develop."

SCENARIO B: Button Battery in 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."
"Button batteries are a **medical emergency** when stuck in the food pipe. They can cause severe burns within **2 hours** and life-threatening injury. We need to remove it **urgently**."

MANAGEMENT:
If the child is **>1 year old** and ingestion was **<12 hours ago**, give **honey 10ml every 10 minutes** (up to 6 doses) immediately while awaiting endoscopy. This coats the battery and reduces mucosal injury.
For children under 1 year old: Give sucralfate 1g every 20 minutes for up to 3 doses in hospital (instead of honey, which carries botulism risk in this age group).
- **Nothing else to eat or drink (NIL BY MOUTH)** except honey as above
- **Emergency** referral to paediatric surgical team - this cannot wait
- **Endoscopic removal** planned under general anaesthesia (ideally within 2 hours)
- Close monitoring for airway risk
- Admit for observation and further management

"The surgical team will use a tiny camera to safely guide the removal - your child will be asleep for this and won't feel anything."

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."
"If you ever suspect a child has swallowed a button battery, this is always an emergency - even if they seem fine. Call 999 or go straight to A&E."
"Small batteries, magnets, and button cells should be stored securely out of children's reach - and battery compartments on toys should be screwed shut."

FOLLOW-UP PLAN
Coin in stomach: Most pass spontaneously in 2–4 weeks. Review if symptoms develop (pain, vomiting, fever). Re-imaging if coin not passed after 2–4 weeks.
Battery: Inpatient care under surgical team
"We'll keep you informed every step of the way."
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**.
Note: While foreign body ingestion is common and usually accidental, unexplained repeated presentations should prompt safeguarding consideration.

Infant on Triage Call

Setting: Primary Care Urgent Telephone Triage | Infant | Parent Reporting Fever and Reduced Wet Nappies
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
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
Note: Inability to sit independently at 10 months warrants developmental assessment once acute illness resolved.
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**, and with the combination of high fever and no wet nappies, we need to rule out a more serious infection."
"Whenever I see a baby with these symptoms, I always ask myself: 'Could this be sepsis?' - that's an infection in the blood that needs urgent treatment."

Note: *An infant with "no urine for 24 hours" and "lethargy" is Amber/Red Flag for Sepsis. Must assess for signs of shock to determine ambulance category.*

Additional shock assessment questions:
- "Is his skin looking mottled or blotchy?"
- "Do his hands and feet feel cold even though he has a fever?"
- "If you press on his chest, does the colour come back quickly or slowly?"

If signs of shock present (mottled skin, cold peripheries, prolonged capillary refill) → **Category 1/2 (Blue Light) ambulance transfer**.

"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:
"We cannot rule out a serious bacterial infection like sepsis over the phone. We need to see him immediately to decide if antibiotics are needed to save his life. The hospital will examine him and start treatment straight away if needed."

Addressing Parent's Requests
"Can I bring him to the surgery instead?"
→ "I understand that may seem easier, but the GP surgery isn't set up for very unwell babies - we don't have the drips or monitoring equipment that your baby might need. The safest place for him is hospital, where they can do everything under one roof."
"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 that doesn't fade when you press a glass to it, or if he becomes very floppy or difficult to wake - call 999 immediately."
"I will also call you back in about **15 minutes** to check the ambulance has arrived and make sure you're 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: Primary Care Telephone Consultation | Young Child | Parent Concerned About Ongoing Viral Symptoms and Fluid Intake
Mode: Telephone consultation

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."

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?"

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?"

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?"

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 already doing exactly what I would recommend - keeping a close eye on their fluids and energy levels. That's really good parenting."

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 antibiotics when they're not needed can actually do more harm than good - they can cause side effects like diarrhoea or rashes, and they can make bacteria harder to treat when we really need them in the future."

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 squash, 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** or ibuprofen (for children over 3 months) 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."

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

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."

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: Telephone Follow-Up (GP/Hospital) | School-Age Child | Callback with Blood Results Following ED Assessment for Abdominal Pain

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?"

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

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.

CONDENSED MAFTOSA

Code	Ask
M	"Any regular medications?"
A	"Any allergies?"
F	"Any family history of similar problems?"
T	"Any recent travel?"
O	"Any operations in the past?"
S	"Who's at home with him? Any safeguarding concerns?"
A	"Any ongoing illnesses or hospital admissions?"

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."

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, this points strongly towards a condition called **appendicitis** - inflammation of a small finger-shaped pouch attached to 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."

MANAGEMENT PLAN - Immediate Referral
"I know this might feel like a lot to take in, but there really isn't a safe alternative here - we need the hospital team to assess him today."

Investigations likely include:

- Repeat blood tests
- Abdominal ultrasound (first-line imaging in children; CT only if ultrasound is inconclusive)
- 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."
"If it is appendicitis, surgery is usually done by keyhole, and most children go home within a day or two."

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."

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."

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: Primary Care Telephone Consultation | Young Child | Parent Requesting Antibiotics After Recent Illness Contact
Mode: Telephone
Task: Assess child's symptoms, address parental concern, and explain why antibiotics and an X-ray are not needed

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 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."

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?"

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?"

MEDICAL BACKGROUND
"Does your child have any long-term conditions - like asthma or frequent infections?"
"Are all vaccinations up to date?"

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?"

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."

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."

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."

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."

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

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."

Note to the Student
This case is an **exemplar for antimicrobial stewardship communication**. The key is recognising a viral illness, explaining clearly why antibiotics aren't needed, and maintaining a supportive relationship with the parent while safety-netting thoroughly.

Scarlet Fever

Setting: Primary Care | School-Age Child | Acute Febrile Illness with Pharyngitis and Rash
Accompanied by: Parent
Presenting Complaint: Fever, sore throat, and rash

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."

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?"

BACKGROUND HISTORY - BIRDS-MAF

Code	Ask
B	"Was the pregnancy and birth without complications?"
I	"Are all vaccinations up to date?"
R	"Any concerns raised in the red book?"
D	"Is development on track - walking, talking?"
D (Diet)	"Any issues with eating?"
D (Diseases)	"Any past serious illnesses?"
S (School)	"Does anyone at school have similar symptoms?"
M	"Any regular medications?"
A	"Any allergies - especially to penicillin?"
F	"Anyone else at home currently unwell? Who normally looks after them day to day?"

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?"

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

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**."

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 really common in school-age children and spreads easily - there's often a cluster of cases at school around the same time."
"The good news is - it responds **very well to antibiotics**, and most children start to feel much better within a day or two once we start treatment."

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)* – typically 250 mg 2-4 times daily for **10 days** (weight-adjusted)
- For children unable to swallow tablets, liquid penicillin V is available

If allergic to penicillin:
- If your child has a **severe** penicillin allergy (previous anaphylaxis), clarithromycin is the preferred option
- *Clarithromycin* for **10 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)

"Very rarely, untreated strep infections can lead to complications like rheumatic fever or kidney problems - but with antibiotics, this is extremely unlikely."
"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

When to Refer to Hospital

Arrange URGENT hospital assessment if:

- **Signs of invasive Group A Strep (iGAS):**
  - Rapidly deteriorating condition despite antibiotics
  - Spreading erythema or skin necrosis (necrotising fasciitis)
  - Severe muscle pain out of proportion to examination
  - Hypotension, tachycardia, or signs of sepsis
- **Peritonsillar abscess (quinsy):**
  - Severe unilateral throat pain, trismus (difficulty opening mouth)
  - "Hot potato" voice, drooling, uvula deviation
- **Airway compromise** - stridor, drooling, severe difficulty swallowing
- **Systemically unwell child** - lethargic, not responding to treatment
- **Very young infant** (<3 months) with suspected GAS infection

As an FY2: You can diagnose and initiate antibiotics for uncomplicated scarlet fever. If features of iGAS, quinsy, or systemic toxicity - this is a **medical emergency**. Call for senior review and arrange immediate transfer. Complete the notifiable disease form in all cases.

Notification Requirement

"Scarlet fever is a **notifiable disease** - I will inform public health, which helps track outbreaks in the community."

FOLLOW-UP PLAN

- No routine follow-up if improving
- Consider 48-hour review if:
  - No improvement
  - Recurrent tonsillitis
  - Parent unsure about compliance or absorption

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."

"Your child can go back to school once they've had **24 hours** of antibiotics **AND** are feeling well enough - both conditions must be met. The infection stops being contagious quite quickly once treatment starts."
"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: Primary Care | Young Child | Prolonged Fever with Mucocutaneous Features
Accompanied by: Father
Presenting Complaint: Persistent fever (5 days), rash, swollen neck gland

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."

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?"

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?"

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?"

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

PROVISIONAL DIAGNOSIS
"From the history and what I've found on examination, this is strongly suggestive of a condition called **Kawasaki Disease**."

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 - your child didn't catch it from anyone, and they can't pass it on. We don't know exactly what triggers it, but it's not caused by anything you did or didn't do."
"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."
"We do know that it needs **early treatment** to reduce the risk of complications - especially those affecting the heart."

MANAGEMENT PLAN - URGENT HOSPITAL REFERRAL
CRITICAL: SAME-DAY PAEDIATRIC REFERRAL REQUIRED
Kawasaki Disease is a **paediatric emergency**. Treatment with IVIG within 10 days of fever onset significantly reduces coronary artery complications from ~25% to <5%.
As an FY2:

- **Do not delay** - if clinical features are suggestive, refer immediately
- You do not need to confirm the diagnosis before referring
- Call the paediatric registrar directly and arrange same-day transfer
- If in GP setting: Do not attempt to manage in the community
- If in ED: Discuss with paediatrics and admit under their care

Incomplete Kawasaki: Children with prolonged fever (≥5 days) and only 2-3 clinical features should still be discussed with paediatrics, as "incomplete" Kawasaki carries the same coronary risk.
"I know this is a lot to take in. I need to arrange for [child's name] to go to hospital **today** - but I want you to know that by catching this early and acting quickly, we're giving them the best possible chance of a full recovery."

Hospital Investigations (on admission):

- FBC, CRP, ESR
- U&E, LFTs
- Urinalysis
- Throat swab
- **Echocardiogram (ECHO)** - baseline and repeat at 2 and 6 weeks

Hospital Treatment:

- **IV Immunoglobulin (IVIG)** - ideally within **10 days** of symptom onset
- **High-dose aspirin** - 30–50 mg/kg/day in divided doses (anti-inflammatory) until afebrile for 48–72 hours, then low-dose aspirin: 3–5 mg/kg/day (antiplatelet) for at least 6–8 weeks.
- **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

Important Vaccination and Safety Information

"Because of the aspirin, your child should have their **flu vaccine** each year. They should receive the **inactivated (injectable) flu vaccine** rather than the nasal spray, as a precaution to reduce Reye's syndrome risk."

Note: Children on long-term aspirin should receive the **inactivated influenza vaccine** (injection), not the live attenuated nasal spray (LAIV), due to theoretical Reye syndrome risk with live vaccine and aspirin.
"If your child develops chickenpox while on aspirin, contact us immediately."
"Live vaccines (like MMR) should be delayed for at least **3 months** after IVIG treatment, as the immunoglobulin can interfere with vaccine response. Discuss timing with the paediatric team."

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."

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."

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 (white coating early → red "strawberry" appearance later after desquamation)
- 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**.

Comparison Table: Scarlet Fever vs Viral Tonsillitis vs Kawasaki Disease

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	Red, cracked lips ± strawberry tongue (less sore)
Rash	Sandpaper-texture rash, flushed cheeks, perioral pallor	Usually no rash	Diffuse maculopapular, not sandpaper

Eyes	Usually normal	Usually normal	Bilateral non-purulent conjunctivitis
Lymph nodes	Bilateral tender cervical	May have bilateral nodes	Unilateral cervical node >1.5 cm
Hands/Feet	Usually normal	Usually normal	Erythema, oedema, later desquamation
Treatment	Antibiotics (Penicillin V)	Supportive care	Urgent hospital: IVIG + aspirin
Contagious	Yes	Yes	No

Chickenpox

Setting: Primary Care | Patient: Preschool-aged Child | Accompanied by: Parent | Presenting Complaint: Acute Generalised Vesicular Rash with Systemic Symptoms

INTRODUCTION & CONSENT
"Hello, I'm one of the doctors here today."
"Can I confirm your child's name and age?"
"And you're their parent, 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."

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 any paracetamol - did it help?" *(Note: avoid ibuprofen in chickenpox)*
"Has your child seemed sleepier or more tired than usual?"
"Have they been eating and drinking normally?"

BACKGROUND HISTORY - BIRDS-MAF

Code	Ask
B	"Were they born full term without any complications?"
I	"Are all vaccinations up to date?" *(Note: From September 2024, chickenpox/MMRV vaccine is being added to the routine UK childhood immunisation schedule)*
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?"

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?"

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."

PROVISIONAL DIAGNOSIS
"From the rash and symptoms you've described - and what I can see - this is very likely **chickenpox**."

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 small **blisters filled with clear fluid**, which later scab over. New spots keep appearing over several days - that's why you'll see some that look fresh while others are already scabbing over."
"It's **very contagious** but usually a mild illness in otherwise healthy children. Most recover in about 7–10 days."

MANAGEMENT PLAN - Symptom Control
Fever: Paracetamol regularly if needed *(avoid aspirin)*
Important: Do not give ibuprofen - NHS and NICE advise against its use in chickenpox due to potential risk of more severe skin reactions.
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

Note: Aciclovir is not indicated in healthy children with uncomplicated chickenpox. However, consider IV aciclovir for immunocompromised children (any age ≥1 year), severe varicella, or ongoing new lesions beyond day 5. Most effective if started within 48 hours of rash onset.

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)

When to Refer to Hospital
Arrange URGENT hospital assessment if:
- **Secondary bacterial infection** - spreading cellulitis, increasing pain, pus, fever not settling
- **Respiratory symptoms** - varicella pneumonia (cough, breathlessness, hypoxia)
- **Neurological symptoms** - encephalitis (confusion, seizures, ataxia), meningism
- **Severe systemic illness** - sepsis, prolonged high fever despite treatment
- **Haemorrhagic chickenpox** - bleeding into spots (petechiae/purpura)
- **Immunocompromised child** - on steroids, chemotherapy, or known immunodeficiency
- **Neonate** (<4 weeks) - high risk of severe disease

Contacts requiring urgent action:
- **Pregnant women exposed** → Contact midwife/GP urgently. Post-exposure prophylaxis is now aciclovir 800 mg QDS or valaciclovir 1g TDS for days 7–14 post-exposure (first-line). VZIg is no longer first-line for pregnant women.
- **Immunocompromised contacts** → Aciclovir prophylaxis is preferred; urgent VZV antibody testing if immune status uncertain.
- **Neonates** of mothers with peripartum chickenpox → Paediatric review for VZIg (VZIg is still indicated for neonates, particularly <4 weeks old).

As an FY2: You can manage uncomplicated chickenpox with supportive care and safety netting. If any red flags above, arrange same-day hospital review. For high-risk contacts, seek senior advice regarding post-exposure prophylaxis.

INFECTIVITY & RETURN TO SCHOOL
"Chickenpox is contagious from **2 days before the rash** until **all spots have crusted over** - the crusting is the definitive endpoint, usually about 5 days after the rash starts."
"Your child can return to nursery or school once **all spots are crusted over** (not just a set number of days) 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."
Critical Safety Netting for Pregnant Contacts: "If your child has already been in contact with a pregnant woman during the infectious period (which starts 2 days before the rash appeared), she must inform her midwife or GP immediately so they can check her immunity and consider treatment if needed."

FOLLOW-UP
- No need for routine review if improving
- Contact GP if: rash worsens, no improvement after 7–10 days, or complications suspected

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

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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

Setting: Paediatric Emergency Department | Patient: Young Child | Accompanied by: Parent | Presenting Complaint: Sore Throat with Fever and Reduced Oral Intake

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 5–10 days (per NICE NG84)
- 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."

When to Escalate/Refer

Arrange URGENT ENT/senior review if suspected:

Peritonsillar abscess (Quinsy):

- Severe **unilateral** throat pain
- **Trismus** (difficulty opening mouth)
- "Hot potato" or muffled voice
- **Uvula deviation** to opposite side
- Drooling, dysphagia
- Systemic toxicity

Retropharyngeal abscess:

- Neck stiffness or pain on extension
- Drooling, stridor
- "Cock-robin" position (neck extended, tilted)

Epiglottitis (rare but life-threatening):

- Stridor, tripod positioning, drooling
- **Do NOT examine throat** - call anaesthetics/ENT immediately

Lemierre syndrome (internal jugular vein thrombophlebitis):

- Persistent fever despite antibiotics
- Neck swelling, tenderness along sternocleidomastoid
- Consider if septic emboli suspected

As an FY2: You can manage uncomplicated tonsillitis with supportive care and admit for IV hydration if needed. If any red flags above - this requires **immediate senior review**. Quinsy may need needle aspiration

or incision and drainage. For epiglottitis, do not examine the throat and call for emergency airway support.

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 most children start to feel much better within a day or two. 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: Primary Care Telephone Consultation | Patient: Infant (6-12 months) | Caller: Parent | Presenting Complaint: Behavioural Changes - Irritability and Clinginess

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?"

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?"

BACKGROUND HISTORY - Relevant BIRDS-MAF (Brief)

Code		Ask
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?"

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?"

ASSESSMENT & PROVISIONAL DIAGNOSIS
"Thanks for sharing all of that. From everything you've said - the clinginess, the biting and chewing, extra drooling, and those swollen gums you've described, along with 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."

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."

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."

Note:

- *Teething gels are no longer routinely recommended due to limited evidence and safety concerns. Gels containing choline salicylate (e.g., Bonjela) are contraindicated in children under 16 years (Reye's syndrome risk). Lidocaine-based gels carry risks of seizures and should only be used under pharmacist supervision. If parents wish to try a gel, advise them to discuss with a pharmacist first.*
- *Amber teething necklaces are not recommended. They carry risks of choking (if beads break off) and strangulation. There is no evidence they relieve teething symptoms.*

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."

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."

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?"

UTI in a Child

Setting: Paediatric Emergency Department | Patient: Preschool-aged Female Child | Accompanied by: Parent | Presenting Complaint: Urinary Symptoms with Behavioural Changes

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?"

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?"

BACKGROUND HISTORY - BIRDS-MAF

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?"

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?"

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**
"Positive for nitrites is highly suggestive of UTI. Leukocytes alone are less specific but supportive. We're sending a sample to the lab to confirm and check which antibiotic will work best."

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."

PROVISIONAL DIAGNOSIS
"Based on her symptoms and the urine test result, your daughter has a **urinary tract infection**, or UTI."

EXPLAINING THE CONDITION TO THE PARENT
"UTIs happen when germs - usually bacteria from the skin or bowel - find their way into the bladder. 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."

MANAGEMENT PLAN -
Infants **under 3 months** with suspected UTI must be **immediately referred to a paediatric specialist** for IV antibiotics. They cannot be managed with oral antibiotics in the community.

Antibiotic Treatment
"We'll start her on a **3-day course of an antibiotic called Trimethoprim/Nitrofurantoin**, which is very effective against urine infections in children."
Note: Nitrofurantoin is increasingly preferred as first-line for lower UTI in children >3 months due to rising trimethoprim resistance. Check local guidelines.
"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

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."

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: Primary Care | Patient: School-aged Female Child | Scenario: Follow-up Consultation - Urine Culture Results and Ongoing UTI Symptoms
Task: Explain urine culture result showing resistance to trimethoprim, discuss ongoing symptoms, reassure parent, explain recurrent UTI plan, and initiate correct follow-up

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 bacteria 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 - this is called **vesicoureteric reflux**, where urine flows the wrong way - back up towards the kidneys instead of down towards the bladder. That's why we recommend doing a simple ultrasound scan now - just to check that everything looks normal inside."

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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

When to Refer to Paediatric Nephrology/Urology
Refer to specialist services if:
Recurrent UTIs:

- **≥2 upper UTIs** (febrile/pyelonephritis)
- **≥3 lower UTIs** (cystitis)
- **≥1 upper UTI + ≥1 lower UTI**

Imaging abnormalities:
- Hydronephrosis, scarring, or structural abnormality on USS
- VUR (vesicoureteric reflux) on MCUG
- DMSA showing renal scarring

Atypical UTI features:
- Seriously ill or septic presentation
- Poor urine flow or abdominal/bladder mass
- Raised creatinine
- Failure to respond to antibiotics within 48 hours
- Infection with non-E.coli organism

Other indications:
- Family history of VUR or renal disease
- Hypertension
- Poor growth

As an FY2: You can manage first/second uncomplicated UTI with antibiotics and arrange initial USS. For recurrent UTIs, atypical features, or imaging abnormalities - discuss with paediatrics and arrange nephrology/urology referral. Always send urine for culture before starting antibiotics.

Bronchiolitis

Setting: Paediatric Emergency Department | Patient: Infant (Under 12 months) | Accompanied by: Parent | Presenting Complaint: Acute Respiratory Distress with Viral Prodrome

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?"

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?"

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?

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?"

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?"

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?"

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

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."

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 typically starts like a normal cold, then the breathing gets a bit worse around days 3–5 before it starts to improve. Most children recover fully in 1–2 weeks."
"I know it can be really frightening to see your baby struggle to breathe - but you've done exactly the right thing bringing her in."

MANAGEMENT PLAN
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."

Recommend admission if:
- Oxygen saturation is persistently below **90%** (or below **92%** for babies <6 weeks or those with underlying conditions)

- Respiratory rate is above 70 breaths per minute
- The baby is taking less than half their normal feeds (less than 50% usual intake)
- There have been any pauses in breathing (apnoea)

Note: The 2021 NICE update lowered admission thresholds to <90% for most children ≥6 weeks, but retains <92% for high-risk groups (under 6 weeks, underlying conditions). Referral threshold remains <92% for all.

2. **Oxygen support if needed**

"We'll give extra oxygen if her oxygen levels stay below 90% (or 92% given she's a young infant). If her oxygen levels stay low, we'll start her on **extra oxygen** using soft tubes near her nose - that's a tiny soft feeding tube to help her get milk without getting tired, so she can save her energy for breathing."

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 (O2 sat ≥90% on air for 4 hours including period of sleep - or ≥92% if under 6 weeks or has underlying conditions)
- Feeding well
- And otherwise stable

This could take 2–3 days, but we'll keep you updated."

7. **RSV Prophylaxis Information**

"You may hear about a new RSV prophylaxis called nirsevimab - this is a preventive injection now available that can help protect vulnerable babies from severe RSV infection. We can discuss this further at follow-up if relevant."

Note: Nirsevimab provides approximately 6 months of protection against severe RSV infection with a single dose. It is currently offered to premature infants (<32 weeks) and high-risk babies.

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."

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"

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 (NG9).

Asthma Counselling

Setting: Primary Care Telephone Consultation | Patient: Young Child with Known Asthma | Caller: Parent | Presenting Concern: Suboptimal Asthma Control Despite Reliever Inhaler Use

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

Note: In children under 5, asthma diagnosis is primarily clinical. **FeNO testing and spirometry are not reliable** in this age group as young children cannot perform the required manoeuvres. Diagnosis is based on symptom pattern, response to trial of treatment, and clinical judgement.

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."

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 his blue inhaler more than three times a week (outside of exercise), or he's going through more than one inhaler in a few months, that's a sign his asthma isn't well controlled and we need to step up treatment."

MART Information

"For children with uncontrolled asthma despite regular preventer use, there's an approach called MART - Maintenance and Reliever Therapy - where a single combination inhaler is used both daily and for relief. This may be considered if he can manage the regimen. This is not suitable for children under 6 years."

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."

Cleaning Advice

"Clean the spacer about once a month with washing-up liquid."
"Rinse with warm soapy water and **leave to air dry or drip dry** - do NOT towel dry, as this creates static charge that makes the medicine stick to the sides instead of reaching the lungs."

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."

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."

When to Refer to Respiratory Paediatrician
Refer to specialist respiratory services if:
Diagnostic uncertainty:

- Symptoms not responding to standard asthma treatment
- Atypical features (persistent wet cough, failure to thrive, finger clubbing)
- Suspected alternative diagnosis (CF, PCD, bronchiectasis, inhaled foreign body)

Poor control despite optimised treatment:

- Frequent exacerbations (≥2 requiring oral steroids in 12 months)
- Requiring high-dose ICS + add-on therapy without control
- Persistent symptoms affecting school attendance or sleep
- Previous PICU admission for asthma

Severe/life-threatening asthma history:

- Previous ventilation or ICU admission
- Brittle asthma pattern

Complex management needs:

- Considering biologic therapy (e.g., omalizumab)
- Severe allergic component requiring allergy input
- Significant psychosocial factors affecting management

As an FY2: You can manage most childhood asthma in primary care - optimise inhaler technique, ensure preventer adherence, provide action plans. If control remains poor despite step 3-4 treatment (ICS + LABA or montelukast), or if there are red flags suggesting alternative diagnoses, arrange respiratory paediatrics referral. Discuss with seniors if uncertain.

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: Primary Care Telephone Consultation (Urgent) | Patient: School-aged Child with Known Asthma | Caller: Parent | Presenting Concern: Acute Respiratory Symptoms with Fever Not Responding to Usual Medications

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

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:
"Give him up to 10 puffs of his blue inhaler through the spacer - one puff at a time, taking a few breaths after each puff. You can repeat this every 20 minutes if needed while waiting for help."
"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."

"Note: Oral prednisolone can be started in primary care for moderate exacerbations if safe to do so (Prednisolone 20 mg/day age 2–5; 30–40 mg/day age >5 for 3 days) but in this case with drowsiness and poor response, hospital assessment is essential."

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: Paediatric Emergency Department | Patient: Toddler (1-3 years) | Accompanied by: Parent | Presenting Complaint: First Seizure Associated with Fever

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
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.
This is not epilepsy - it's a febrile seizure, which happens when a child's temperature rises quickly. The vast majority of children who have a febrile seizure grow out of them and don't develop epilepsy.
Simple febrile seizures last less than 15 minutes (yours was under 5 minutes, which is very reassuring), involve the whole body, don't recur within 24 hours, and children recover fully within an hour.
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."
Note: Children under 18 months should always be assessed in hospital after a first febrile seizure, as signs of serious illness can be harder to spot.

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 <15 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 (for infants under 1 year) or appropriate weight-based dose)
- Paracetamol or ibuprofen for fever and pain

Important clarification: "Paracetamol or ibuprofen won't prevent future febrile seizures, but they will help her feel more comfortable if she's in pain or distressed from the fever."

- 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

Setting: Primary Care | Patient: Young Child | Scenario: Parental Concerns About Developmental and Behavioural Differences

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 - some of what you're describing does fit with features we sometimes see in children with autism. The good news is we can refer for a specialist assessment to understand exactly what's going on and get the right support in place."

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."

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."
"Once we make the referral, the specialist team should aim to start the assessment within 3 months - though waiting times can vary."

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."
"The **National Autistic Society** has excellent resources, and you may also be eligible for **Disability Living Allowance (DLA)** to help with additional care needs."

11. **Safety Netting**

"Parenting any child is challenging, and raising a child with autism can bring extra questions. If you ever feel overwhelmed or unsure how to support them, please contact us immediately."
"If your child is having meltdowns that risk their safety, showing self-harming behaviours, or if you're struggling to cope, please let us know 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."
School and Education
"Some children with autism do well in mainstream schools with support, while others benefit from specialist settings. We can explore which might work best for your child. An **Education, Health and Care Plan (EHCP)** may be helpful to ensure they get appropriate support."

Follow-Up Plan
- Referral made to specialist autism team
- Schedule follow-up after initial assessment
- GP review in 4–6 weeks to check progress and provide ongoing support

When to Refer and Pathway Guidance
Referral to Developmental Paediatrics/Autism Pathway: Any child with concerns about autism features should be referred - you do not need to confirm the diagnosis before referring.
Key triggers for referral:
- Parental concern about social communication or behaviour
- Nursery/school concerns about interaction or development
- Delayed speech with reduced social engagement
- Repetitive behaviours, restricted interests, sensory sensitivities
- Regression of previously acquired skills (urgent)

NICE recommends assessment should start within 3 months of referral.

Urgent/priority referral if:
- **Developmental regression** (loss of speech, social skills) - may indicate rare conditions requiring urgent investigation
- Safeguarding concerns
- Severe challenging behaviour affecting safety
- Parental mental health crisis related to child's needs

What to do while waiting:
- Arrange hearing test (rule out hearing loss)
- Refer to Speech and Language Therapy
- Signpost to early support services and parent groups
- Consider Early Years SENCO involvement

As an FY2: You can recognise features suggestive of autism and initiate referral to the local neurodevelopmental pathway. You don't need to diagnose autism - that's for the specialist team. Ensure hearing assessment is arranged and provide supportive information to families. Escalate urgently if developmental regression.

Follow-Up: Autism Spectrum Disorder

Setting: Primary Care | Young Child with Confirmed Developmental Condition | Follow-Up Consultation
Purpose: Discuss confirmed ASD diagnosis and support plan with parent

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:
"Some children with autism do well in mainstream schools with support, while others benefit from specialist settings. We can explore which might work best for your child. 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."
"Parenting any child is challenging, and raising a child with autism can bring extra questions. If you ever feel overwhelmed or unsure how to support them, 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: Primary Care Telephone Consultation | Toddler with Parental Concern About Motor Milestones
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, and it's reassuring that his other milestones are on track."

"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:

"This is most likely within the normal range, and it's reassuring that his other milestones are on track."

"We usually give children up to 18 months before investigating walking delays further. If still not walking by 17–18 months, we'll arrange referral to the child development team."

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 floor play to help strengthen his leg muscles - safe supervised tummy time is great for this."

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

Setting: Primary Care | Preschool Child with Nocturnal Behavioural Episodes | Parent Concerned About Sleep Disturbance

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 8. 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."
"Night terrors don't harm your child's brain or affect their development in any way."

9. Management Plan

Reassurance
"These episodes usually settle as children grow older."
Supportive Advice
Track the pattern: "If it's happening at a regular time, gently wake him up about 15–30 minutes before the usual time for 7 nights - 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 regularly last longer than 10–15 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 **The Sleep 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."

When to Refer
Refer to Paediatrics or Paediatric Neurology if:
Features suggesting epilepsy rather than night terrors:

- Episodes occurring during **daytime** or from wakefulness
- **Multiple episodes per night** or occurring at unpredictable times
- **Stereotyped motor movements** (rhythmic jerking, tonic posturing)
- **Tongue biting**, urinary incontinence during episode
- **Prolonged post-ictal confusion** (>30 minutes)
- Episodes **not responsive** to scheduled awakening after 4 weeks

Other indications for referral:

- **Frequent or severe episodes** affecting daytime functioning

- Episodes lasting **>15 minutes** regularly
- **Sleep-disordered breathing** suspected (snoring, apnoeas)
- **Injury risk** during episodes
- Parental anxiety not managed by reassurance
- **Atypical features** not fitting typical parasomnia pattern

Consider sleep study referral if:
- Suspected obstructive sleep apnoea contributing to parasomnias
- Frequent night wakings with daytime somnolence

As an FY2: Most night terrors can be managed with reassurance and sleep hygiene advice. If red flags for epilepsy are present, discuss urgently with paediatrics. For persistent parasomnias not responding to first-line management, consider referral to paediatric sleep services.

Temper Tantrums

Setting: Primary Care Telephone Consultation | Toddler with Behavioural Concerns | Parent Seeking Advice
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."

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

Aspect	Question
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

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:
"Once he's starting to calm down, try gently redirecting his attention to something else - distraction works best after the peak of the tantrum, not during."

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

Setting: Primary Care Telephone Consultation | Young Child with Nocturnal Enuresis | Parent Seeking Advice
Role: FY2 Doctor in GP Practice
Scenario: Father of a 5-year-old boy calls concerned about night-time bedwetting.

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**

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**

Active treatment for bedwetting isn't usually offered until children are around 5–7 years old, and only if it's bothering them or affecting their quality of life.

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: "Reward charts can help - focus rewards on the behaviours your child can control, like using the toilet before bed, rather than dry nights which they can't control."
No Blame or Shame: "Avoid any punishment - it's not something within his control."

Active Treatment Options (if lifestyle measures insufficient):
Enuresis Alarm: "If the bedwetting continues and becomes distressing, we can discuss options like an enuresis alarm, which helps train the brain to wake up when the bladder is full. It's often the most effective long-term treatment."
Desmopressin: "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."

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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 Older Child

Setting: Primary Care | Older Child with Persistent Nocturnal Enuresis | Parent Consultation (Child Not Present)
Consultation Type: Face-to-face with father only
Role: FY2 Doctor

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

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 often the most effective long-term treatment and works better than medication for lasting results."
"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 Desmotabs 200 micrograms at bedtime OR DesmoMelt (sublingual lyophilisate) 120 micrograms at bedtime.
- Can increase to Desmotabs 400 mcg or DesmoMelt 240 mcg if partial response after 1–2 weeks.
- Review response at 4 weeks

Important requirements:

- If effective, continue for 3 months before attempting withdrawal
- To withdraw: gradually reduce dose rather than stopping abruptly
- 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:

Aspect	5-Year-Old	8-Year-Old
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: Paediatric Emergency Department | Toddler with Minor Trauma | Parent Concerned About Head Injury
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 NG232 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)

Note on dangerous mechanism in children: A fall from a height greater than 3 metres (or greater than 5 stairs) is considered a dangerous mechanism in children under 1 year. For older children, the threshold is also 3 metres.

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 significant 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 if the child has **more than one risk factor** from a specific list, which includes:

- Loss of consciousness lasting more than 5 minutes
- Vomiting 3 or more times
- Dangerous mechanism (fall >3 metres in children)

- A large bruise or swelling more than 5 cm (especially in children under 1 year)
- Post-traumatic seizures
- Signs of a skull fracture
- Abnormal drowsiness or behaviour
- GCS less than 15"

"Since your child has none of these concerning features, doing a CT would only expose him to unnecessary radiation 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. **Discharge Criteria**

Important: Children can only be discharged home if:

- A **responsible adult** is available to supervise them for the next 24-48 hours
- The family has **access to a telephone** to call for help if needed
- The family understands the warning signs and when to return

"Before we let you go home, I need to make sure someone can keep a close eye on him for the next day or so, and that you can contact us or emergency services if needed."

13. **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
CT head scan is indicated if the child has more than one of the following risk factors:

Assessment	Criteria/Threshold for CT Scan
GCS (Glasgow Coma Scale)	GCS <15 at 2 hours post-injury, or GCS <14 at any time
Loss of Consciousness	>5 minutes witnessed LOC
Vomiting	≥3 discrete episodes
Post-traumatic seizure	Any seizure after the injury
Suspected skull fracture	Clinical signs of fracture or base of skull fracture (panda eyes, Battle's sign, CSF leak)
Large scalp haematoma	>5cm (especially concerning in children <1 year)
Dangerous mechanism	Fall >3 metres for children, high-speed RTA, projectile injury
Amnesia	Amnesia for events >5 minutes before or after injury

Important: The 2023 NICE update emphasises that CT is recommended when **more than one risk factor** is present, rather than any single factor in isolation (except for certain high-risk features like GCS <14 or signs of skull fracture).

Type 1 Diabetes Mellitus

- **Setting:** Primary Care
- **Patient:** Young child with parent
- **Presenting complaint:** Constitutional symptoms with nocturnal disturbance

1. Introduction & Consent

- Greet parent, confirm child's name and age.
- Introduce self as GP.
- Gain consent: "I'll ask some questions about your child's health, then explain what may be happening and what we need to do next."
- Clarify confidentiality: "Everything we discuss will be kept private, but if I find something serious, I may need to involve a specialist team straight away to help your child."

2. Presenting Complaint Exploration

Questions

- "When did you first notice your child was more tired than usual?"
- "How does the tiredness affect their play, school, or daily activities?"
- "When did you start noticing weight loss? How much do you think they have lost? Have their clothes become looser?"
- "Has the tiredness or weight loss been getting worse or staying the same?"

3. Detailed History

A. Diabetes Symptom Screening

- **Fluid intake**: "Has your child been asking for water more often, especially at night?"
- **Urine output**: "Any change in how often they pass urine? Any bedwetting, which wasn't happening before?"
- **Night waking**: "Has your child ever woken at night because of thirst or to use the toilet?"
- **Appetite**: "Have you noticed your child eating more or less than usual?"
- **Infections**: "Any mouth thrush, urine infections, boils, or skin rashes?"
- **Acute symptoms**: "Any tummy pain, vomiting, fast or deep breathing, unusual drowsiness or confusion?" (→ screen for DKA).
    - **Additional DKA warning signs to ask about:**
        - **Kussmaul breathing**: "Is their breathing unusually deep and laboured, like sighing?" (deep, gasping respirations — compensating for acidosis)
        - **Fruity/pear-drop breath**: "Have you noticed any unusual smell on their breath, like nail polish or pear drops?" (acetone — pathognomonic)

B. Malignancy / Chronic Illness Screen

- "Any unexplained fevers, night sweats, or chills?"
- "Any easy bruising or bleeding, like from gums or nosebleeds?"
- "Any swellings or lumps around the neck, armpits, or groin?"
- "Any bone pains, joint pains, or limp?"
- "Any cough lasting more than 2 weeks, or weight loss in the family (TB contact)?"

C. Background & Risk Factors

- Pregnancy/birth history: "Any problems during pregnancy or delivery?"
- Developmental history: milestones reached?
- Past medical history: "Any long-term conditions or previous hospital admissions?"
- Medications and allergies.
- Family history: diabetes, thyroid disease, coeliac disease, cancers.
- Diet: "What kind of food does your child usually eat?"

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- Social: school attendance, any recent stressors.

4. ICE (Ideas, Concerns, Expectations)

- **Ideas**: "What do you think might be causing the tiredness and weight loss?"
- **Concerns**: "Is there anything in particular you are worried about — like diabetes, cancer, or infection?"
- **Expectations**: "What were you hoping we would do today? Check blood sugar, arrange tests, or give advice?"

5. Focused Examination (if child present — verbalize)

Look

- General appearance: pale, thin, tired.
- Growth centiles (weight and height).
- Hydration: dry lips, sunken eyes, cap refill.
- Respiratory effort (Kussmaul breathing).

Feel

- Abdomen: organomegaly (liver, spleen).
- Lymph nodes: cervical/axillary/groin.

Other signs

- Bruising, rashes, thrush.
- Vital signs: temperature, HR, RR, BP, oxygen sats.

6. Differential Diagnosis

1. **Type 1 Diabetes Mellitus** — most likely with weight loss, tiredness, polydipsia/nocturia.
2. **Leukaemia/lymphoma** — systemic features: weight loss, bruising, night sweats, bone pain.
3. **Chronic infection** — e.g. TB, recurrent UTIs.
4. **Endocrine disorders** — hypothyroidism, Addison's.
5. **Coeliac disease / malabsorption.**

7. Explanation to Parent

- "You've done exactly the right thing by bringing them in today. Catching this early makes a real difference.
- One important condition we must rule out is **diabetes**. This happens when the body cannot make enough insulin, the hormone that helps sugar get into cells for energy. Without insulin, sugar stays in the blood, making the child lose weight, feel tired, and sometimes wake at night to drink or pass urine."
- "We also consider other causes like blood problems, long-term infections, or issues with the gut absorbing food, but diabetes is the most urgent to check today because it can become dangerous very quickly if missed."

8. Investigations

Immediate (same day)

- Capillary blood glucose (finger prick).
- Urine dipstick for glucose and ketones.
- **Blood ketone testing** (point-of-care β-hydroxybutyrate meter if available) — more accurate and faster than urine ketones for DKA detection (NICE NG18).
- If abnormal → urgent referral to hospital paediatrics.

Hospital baseline

- Plasma glucose, HbA1c.
- Blood gas, electrolytes (rule out DKA).
- FBC, TFT, coeliac serology, chest X-ray depending on differential.

9. Management

If diabetes suspected/confirmed

- **Urgent same-day admission** under paediatrics (mandatory).
- Paediatric team will:
  - Start insulin injections.
  - Monitor glucose/ketones.
  - Correct dehydration and electrolyte imbalance.
- **Family education** by diabetes specialist nurse, dietician, and paediatrician on:
  - Insulin use.
  - Finger-prick glucose monitoring.
  - Sick-day rules.
  - Balanced diet.
- Ongoing follow-up in paediatric diabetes clinic.

If diabetes ruled out

- Investigate for malignancy, infections, endocrine or coeliac disease depending on symptoms.
- Arrange appropriate blood tests and referrals.

10. Safety Netting

- "If your child develops vomiting, severe tummy pain, **deep laboured breathing** (like sighing or gasping), **fruity-smelling breath**, or becomes unusually drowsy or difficult to wake — call 999 immediately, as this can mean a serious diabetic emergency called ketoacidosis."
- "These warning signs often appear **before** drowsiness, so don't wait for your child to become sleepy."
- "If you notice worsening weight loss, persistent fevers, bruising, or lumps — please bring your child back immediately."

11. Follow-Up

- If diabetes suspected → **immediate hospital referral today**.
- If investigations pending → review within 1–2 weeks.
- Long-term shared care between GP, paediatric team, and diabetes nurse if diagnosis confirmed.

12. Leaflets & Final Check

- Provide leaflet: "4 T's of Diabetes" (Toilet, Thirsty, Tired, Thinner).
- Signpost to Diabetes UK family support groups.
- Final check: "Do you feel I've answered your questions? Is there anything you'd like me to explain again?"

Needlestick Injury in a Child

- **Setting:** Primary Care/Urgent Care
- **Patient:** Young Child (brought by carer)
- **Presenting:** Community Needlestick Injury

1. Introduction & Consent

- "Hello, I'm Dr ____, one of the doctors here. I understand [child's name] had a small injury at the park today?"
- Confirm name and age of the child, and relationship of the adult present ("Are you her carer?").
- Gain verbal consent: "Is it okay if I ask you some questions about what happened and examine her hand afterward?"
- Smile, use a gentle tone, make the environment child-friendly.

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- Offer chaperone: "A nurse will be present during examination."

2. Focused History
Event Details
- "Could you please tell me exactly what happened?"
- "Where was this — a public park, or somewhere else?"
- "What was she doing at the time?"
- "Did you actually see the needle?"
- "Was it attached to a syringe, or just lying on the ground?"
- "Did it look clean or dirty, any visible blood?"
- "Was it a deep prick or just a small scratch?"
- "Did she cry or bleed at the site?"
- "Did you clean it immediately, and how?"

Timing & Immediate Action
- "When did this happen?"
- "Was the area washed or covered at the time?"
- "Any first aid or medical attention before coming here?"

Child's Health Background
- "Has she been otherwise well recently?"
- "Is she fully immunised for her age — including hepatitis B and tetanus?"
- "Any chronic illness, medications, or allergies?"

Carer & Family Background (Safeguarding screening)
- "How long have you been her carer?"
- "How are things between you and the parents?"
- "Any concerns about your work load or stress lately?"
- "Do you smoke or take alcohol or other substances?" (Already known: 4 months as carer, no mental-health issues, no relationship problems, no recent stressors.)

Social Circumstances
- "Where are her parents now?" (Parents away at time of incident.)
- "Does she usually play in that park?"
- "Was anyone else present or supervising?"
- "Any delay in bringing her here?"

Explore ICE
- "What's worrying you most about this?"
- "Are you worried she could catch something from the needle?"
- "What were you hoping we could do today?"

3. Physical Examination
Explain gently before proceeding.
- **Inspection:** small puncture or scratch, redness, bleeding, swelling, foreign material.
- **Palpation:** tenderness, warmth, fluctuance.
- **Check vitals** — temperature, pulse, respiratory rate.
- **General appearance:** alert, consolable, interactive.
- **Systemic check** — no other bruising, marks, or concerning signs. (*Comment that full body check is part of safeguarding evaluation.)*

4. Differential Diagnoses

1. **Superficial needlestick injury** (most likely)
2. **Minor abrasion or puncture wound**
3. **Possible exposure to blood-borne infection (HBV, HCV, HIV)**
4. **Non-accidental injury / safeguarding concern** (must always consider)

5. Explanation
"I completely understand your concern — anyone would worry hearing the word *needle*. The good news is that in public places, the risk of catching infections like HIV or hepatitis from such an injury is **extremely low**.
These viruses are fragile outside the body and don't survive for long on discarded needles, especially in sunlight or warm conditions. A quick prick on the hand rarely causes deep exposure.
What we'll do today is clean the area properly, check her vaccination record, and make sure she's protected against infections like **hepatitis B and tetanus**.
We'll also take a small blood sample to have a record of her baseline results, and arrange follow-up tests just to be absolutely safe."

6. Management
Immediate Wound Care
- Encourage **washing the area under running water for several minutes** with soap.
- **Do not squeeze, scrub, or suck** the wound.
- Apply clean dressing.

Assess Immunisation
- **Tetanus:** give booster if incomplete or uncertain.
- **Hepatitis B:**
  - If **fully vaccinated** — no further dose needed.
  - If **unvaccinated or status uncertain** — start **hepatitis B vaccine course** today (0, 1, 2, 12 months).
  - If **source known or suspected high risk (e.g. visible blood, drug paraphernalia)** — add **hepatitis B immunoglobulin (HBIG)** as per local protocol.

HIV / Hepatitis C Risk
- **HIV PEP:** not routinely indicated for community needle injuries.
  - Only consider if **known high-risk source** and **significant deep injury**.
  - **Time-critical:** If PEP is considered, it must be started **as soon as possible, ideally within hours, and no later than 72 hours** after exposure.
  - Discuss with **infectious disease / paediatric ID** consultant within 1–2 hours if suspected.
- **Hepatitis C:** no vaccine; baseline bloods and follow-up monitoring.

Investigations
- Baseline serology: HIV Ag/Ab, HBsAg, anti-HBs, anti-HCV.
- **Baseline blood samples for storage are not routinely required in children with community needlestick injuries, as the pre-existing infection risk is negligible. However, local protocols may vary.**
- Document wound site and description carefully.
- Report incident to local **public health / environmental health** for safe needle disposal.

Safeguarding
- Evaluate consistency of history, timing, and injury pattern.
- Record detailed notes on carer, parental absence, and social background.
- Inform safeguarding lead or health visitor if there's any doubt about supervision or neglect.

7. Reassurance & Shared Plan
"This kind of accident can be upsetting, but you did the right thing by bringing her straight away. We'll clean and dress the wound, give any vaccines she needs, and arrange simple follow-up blood tests. I'll also inform our public-health team so they can check that area of the park for any discarded needles."

8. Safety-Netting
- "Please bring her back urgently if you notice redness, swelling, pus, fever, or if she becomes generally unwell."
- "If you ever see signs such as yellowing of eyes, dark urine, or pale stools, seek review immediately."
- "Otherwise, we'll see her again in about two weeks to review results."

9. Follow-Up Plan
- **1–2 weeks:** wound review and confirm vaccine status.
- **6 weeks, 3 months, 6 months:** repeat serology for HIV, HBV, HCV.
- Document and communicate plan to parents on their return.
- Ensure completion of vaccine schedule.

10. Leaflet & Information
- Provide NHS leaflet: *"Needlestick Injuries in the Community – Advice for Parents and Carers."*
- Give contact details for local **sexual health / infectious disease service** if any later concern.
- Encourage carer to report unsafe park environment to council.

Bilateral Congenital Cataract

- **Setting:** Neonatal Ward / Postnatal Ward
- **Patient:** Mother of 1-day-old newborn (Day 1 post-delivery)
- **Task:** Perform neonatal examination (NIPE), interpret findings, counsel parent, and manage appropriately

1. Introduction & Consent
- Greet the mother warmly, introduce yourself by first name.
- "Hello, I'm **[First Name]**, one of the doctors on the ward today. I'm here to do your baby's newborn check — this is a routine examination we offer to all babies before they go home."
- Confirm baby's name and date of birth.
- "Is it alright if I ask a few questions about your pregnancy and then examine your baby? I'll explain everything as we go."

2. Focused Neonatal History
Antenatal History
- "How did the pregnancy go overall? Were there any complications?"
- "Did you have any infections during pregnancy — such as rubella, chickenpox, or any other viral illness?"
- "Were all your antenatal scans normal?"
- "Did you take any medications during pregnancy, including herbal or over-the-counter remedies?"
- "Do you have any medical conditions — diabetes, thyroid problems, or anything else?"

Birth History
- "How was the delivery — was it vaginal or by caesarean?"
- "Did the baby cry straight away? Were there any concerns at birth?"
- "How is baby feeding — breast or bottle? Any concerns with feeding?"
- "Has baby passed urine and stool since birth?"

Family History (Critical for Eye Pathology)

- "Is there any family history of childhood eye problems — such as cataracts, glaucoma, or any need for early eye surgery?"
- "Has anyone in the family had retinoblastoma — a type of eye tumour in children?"
- "Is there any family history of genetic conditions or syndromes?"
- "Are you and the baby's father related by blood?"

3. Newborn Infant Physical Examination (NIPE)

General Inspection

- Activity, tone, colour (central cyanosis, jaundice, pallor)
- Breathing pattern, any respiratory distress
- Any dysmorphic features

Head & Fontanelles

- Anterior fontanelle soft, flat, and pulsatile
- No caput, cephalhaematoma, or cranial abnormalities

Eyes (KEY COMPONENT)

Red Reflex Examination:

"I'm going to check your baby's eyes using a special light called an ophthalmoscope. This helps me see whether light is passing through normally."

Technique:

1. Dim the room lights
2. Hold ophthalmoscope at arm's length (~30 cm / 12 inches)
3. Shine light into both pupils simultaneously
4. Observe the reflected glow from each pupil

Normal Finding:

- Bright, symmetrical, orange-red reflex in Caucasian babies
- May appear yellow-brown or less bright in babies of Black, Asian, or mixed ethnicity
- *Tip: If uncertain, compare with parents' red reflexes*

Abnormal Finding (This Case):

- **Bilateral white reflex (leukocoria)** — absent or white reflection instead of red

Cardiovascular

- Heart sounds, murmurs, femoral pulses

Hips

- Barlow and Ortolani manoeuvres
- Any click, clunk, or instability

Testes (if male)

- Both descended into scrotum

Spine & Skin

- No sacral dimple, tuft, or neural tube defects
- Mongolian blue spots, birthmarks

4. Interpreting the Finding: Bilateral White Reflex

What It Means

Leukocoria (White Pupil) — Abnormal white reflection seen instead of normal red reflex.

Bilateral involvement raises specific concerns:

Cause	Key Features

Congenital Cataracts (Most Likely)	Lens opacity — may be hereditary, metabolic, or infective
Galactosaemia	Metabolic emergency — "oil droplet" cataract; baby becomes unwell with feeding
Congenital Rubella Syndrome	Triad: cataracts + deafness + heart defects
Retinoblastoma	Rare in newborns; more common at 3–6 months; usually unilateral initially
Retinopathy of Prematurity	Only in premature babies (<32 weeks or <1500g)

5. Explanation to Mother
Acknowledge and Empathise
"Thank you for letting me examine your baby. I've finished the check, and I'd like to talk to you about something I noticed with the eyes. I know this might feel worrying, so please let me explain everything carefully."

Explain the Finding
"When I shone a light into your baby's eyes, I should have seen a red glow — this is called the **red reflex**, and it tells us that light is passing through the eye normally.
In your baby, I noticed a **white reflection in both eyes** instead of the normal red. This is called **leukocoria**, which literally means 'white pupil.'
This can happen when something is blocking the light from getting through — the most common cause in newborns is a **congenital cataract**, which means cloudiness in the lens of the eye that was present from birth."

Reassure (Without False Promises)
"I want to reassure you that this is something we pick up specifically so we can act quickly. Most causes are treatable, and the earlier we get a specialist involved, the better the outcome for your baby's vision."

6. Differential Diagnosis to Consider
If the examiner asks: "What are the possible causes?"
"The main causes of bilateral white reflex in a newborn include:

1. **Congenital cataracts** — the most common cause; may be hereditary or linked to infections or metabolic conditions
2. **Galactosaemia** — a metabolic disorder where the body cannot process galactose in milk; can cause a characteristic 'oil droplet' cataract and is life-threatening if not treated early
3. **Congenital rubella syndrome** — if the mother had rubella in pregnancy; classically causes cataracts, deafness, and heart defects
4. **Retinoblastoma** — a rare eye cancer; more common after 3–6 months and usually starts in one eye, but can be bilateral in familial cases
5. **Other metabolic or genetic syndromes** — such as Down syndrome, Lowe syndrome, or hypocalcaemia"

7. Management Plan
Immediate Actions (Do NOT Discharge)

Action	Rationale
Do NOT discharge the baby	Must exclude galactosaemia and confirm diagnosis
Urgent ophthalmology referral	NIPE standard: screen-positive babies must be seen by ophthalmologist within **2 weeks** of NIPE — but for bilateral white reflex, aim for **same day or next day**

Discuss with senior paediatrician	To coordinate workup and exclude systemic causes
Consider holding breastfeeding temporarily	If galactosaemia is suspected, pending urgent metabolic screen

Investigations
Urgent Metabolic Screen: If galactosaemia is suspected (bilateral cataracts + feeding difficulties + jaundice), urgently check urine reducing substances and discuss with the metabolic team. Do not wait for routine blood spot results — galactosaemia requires immediate investigation and may necessitate stopping milk feeds pending results.

Additional Investigations (May Be Arranged by Ophthalmology/Paediatrics):
- Genetics referral and chromosomal analysis (if syndromic features)
- TORCH screen (toxoplasmosis, rubella, CMV, herpes, syphilis)
- Calcium, glucose, blood cultures if sepsis suspected
- Echocardiogram if congenital rubella suspected

Referral Pathway (Per NIPE Standards)
Babies with a screen-positive eye result must be seen by an ophthalmologist **within 2 weeks** of the NIPE newborn examination.
For bilateral leukocoria: Clinical urgency is higher — ideally **same day** or **within 24–48 hours**.

8. Why Early Referral Matters
"The reason we act quickly is because of something called **amblyopia**, or 'lazy eye.' The brain learns to see in the first few weeks and months of life. If light cannot get through to the back of the eye, the brain doesn't develop the connections for vision properly.
For congenital cataracts, **surgery is ideally performed by 6–8 weeks of age** for bilateral cataracts to give the best chance of normal vision. The earlier we act, the better the outcome."

9. Addressing Parent Concerns (ICE)
"Is my baby blind?"
"At this stage, we cannot say exactly how much your baby can see. What I can say is that your baby's eyes responded to light, which is a good sign. The specialist will do detailed tests to assess the vision and decide the best treatment. Many babies with early treatment go on to see well."

"Did I do something wrong during pregnancy?"
"No — please don't blame yourself. Most congenital cataracts happen by chance or are inherited. Sometimes they are linked to infections, but you had your routine antenatal care and there's no reason to think you did anything wrong."

"Will my baby need surgery?"
"That depends on what the eye specialist finds. If the cataract is significantly affecting vision, surgery is usually recommended — and it's very successful when done early. The specialist will explain all the options and what to expect."

"Can this affect my future children?"
"That's an important question. If there's a genetic cause, we may offer genetic counselling and testing for future pregnancies. The paediatrician and genetics team can discuss this with you."

10. Safety Netting
"Before you go home, I want to make sure you know what to look out for:

- **Feeding problems** — if your baby becomes very sleepy, vomits a lot, or refuses feeds, come back urgently. This could be a sign of a metabolic condition like galactosaemia.
- **Jaundice** — if your baby becomes very yellow, especially in the first few days, let us know.
- **Not responding to faces or light** — if you notice your baby is not looking at you or tracking objects as they grow, mention this at your follow-up.
- **White spot in the pupil** — if you notice a visible white area in the pupil, especially in photos, bring it to our attention.

You'll be given an urgent appointment with the eye specialist within the next day or two."

11. Follow-Up Plan

Timeframe	Action
Before discharge	Confirm galactosaemia screen result; urgent ophthalmology referral made
Within 24–48 hours	Ophthalmology review for detailed examination under dilation
6–8 week check	Repeat NIPE; GP to confirm eye follow-up in progress
If surgery needed	Aim for cataract extraction by 6–8 weeks of age for bilateral cases
Long-term	Visual rehabilitation, refraction, patching if needed; genetic counselling if hereditary

12. Closing the Consultation

"I know this is a lot to take in, and it's natural to feel worried. But you've done exactly the right thing by having your baby's check done — this is why we do these examinations.
We will stay with you every step of the way. The eye specialist will see your baby very soon, and the team here will make sure all the tests are arranged.
Do you have any questions right now? Is there anyone you'd like me to call to support you?"

Note: Red Reflex Summary

Finding	Interpretation	Action
Normal bilateral red reflex	Screen negative	Routine 6–8 week check
Unilateral absent/white reflex	Screen positive	Urgent ophthalmology within 2 weeks
Bilateral absent/white reflex	Screen positive — HIGH CONCERN	Urgent ophthalmology within 24–48 hours; do NOT discharge; exclude galactosaemia
Asymmetric reflex	Screen positive	Urgent ophthalmology within 2 weeks

Clinical Pearls

1. **Bilateral leukocoria = Do NOT discharge.** Always exclude galactosaemia before sending home.
2. **Red reflex varies by ethnicity.** Compare with parents if unsure. Yellow-brown is normal in non-Caucasian babies.
3. **Galactosaemia is a metabolic emergency.** Baby can deteriorate rapidly with milk feeds — classic triad: cataracts, hepatomegaly, and E. coli sepsis.
4. **Surgery timing matters.** For dense bilateral cataracts, surgery by 6–8 weeks gives the best visual outcome.
5. **Family history is critical.** Always ask about childhood cataracts, retinoblastoma, consanguinity, and genetic conditions.
6. **NIPE standards:** Screen-positive eye findings → ophthalmology within 2 weeks. For bilateral leukocoria, treat as more urgent (24–48 hours).

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Chapter 16: Women's Health

A Note to Learners

The cases in this resource are written in a conversational style to help you become familiar with the natural flow of clinical consultations and the language commonly used in UK healthcare settings.

These dialogues are intended as a learning guide, not a script. Please do not attempt to memorise them verbatim. Examiners assess your ability to think and communicate authentically - not to recite rehearsed phrases.

Use this material to understand the underlying clinical reasoning, then practise in your own words until the consultation feels natural to you.

For Companion OSCE Cases, Practice Scripts, Evaluation Checklists, Summary Notes, Rapid Review Notes, Mindmaps, Management Flashcards and Image Library including Ophthalmoscope images- visit https://www.gksplab2.com

Disclaimer
This material is independent educational content created to help candidates develop clinical reasoning and communication skills for UK medical practice.

All cases and clinical scenarios are based on common presentations encountered in UK primary care and emergency medicine, drawn from publicly available sources including NICE Clinical Knowledge Summaries (CKS), BNF, and other official NHS/UK healthcare guidelines.

No content in this resource is derived from, represents, or claims to replicate actual GMC PLAB 2 examination material.

Introduction

Obstetrics and Gynaecology (O&G) stations in PLAB 2 assess your ability to manage situations involving pregnancy, reproductive health, and women's health concerns safely and sensitively. 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, 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

Role: FY2 Doctor
Patient: Woman of Reproductive Age
Context: Follow-up after transvaginal ultrasound
Findings: Early pregnancy with no detectable heartbeat
Concerns: Long-awaited pregnancy, loss of pregnancy symptoms

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?"

Focused History & Contextual Clarification
Pregnancy History
"How many weeks pregnant are you?"
"Can you tell me a little about your journey so far? I understand you've been trying to conceive for quite some time." *(Acknowledge the emotional context)*
"How have you been feeling physically in the past few days?" "Have you noticed any changes - like breast tenderness going away, or less nausea?"

Symptom Check
"Any vaginal bleeding or spotting?" "Any cramping or abdominal pain?" "Any fever or unusual discharge?"

Medical & Obstetric Background
"Is this your first pregnancy?"
"Do you have any long-term health conditions?"
"Have you taken folic acid or any other supplements during this pregnancy?"

ICE
"What's been going through your mind since the scan?" "Were there any specific concerns you wanted to talk about today?" "What were you hoping we could help with?"

Result Disclosure
"Thank you for sharing all of that. I want to speak to you now about the scan results - and I know this might be difficult to hear, so please take your time.
The scan we did showed that while the pregnancy has developed to about 7 weeks, sadly, there was no heartbeat detected. We call this a **missed miscarriage**."
Pause. Allow time for reaction.
"I'm really sorry to tell you this. I know this is not the news you were hoping for - especially after trying for so long."

Explanation
"A missed miscarriage is when the pregnancy stops developing, but your body hasn't recognised this yet. That's why many women, like yourself, don't have any symptoms like bleeding or pain at this stage.
I also want to reassure you that **nothing you've done has caused this**. It's completely understandable to feel shocked or confused right now. Most early miscarriages happen because of something that went wrong with how the pregnancy develops in the very early stages - often due to genetic reasons that can't be predicted or prevented."

Detailed Management Plan
A. **Immediate Plan**
"We will arrange a **repeat scan in a minimum of 7 days**. If that also shows no heartbeat and no growth, we can then confirm a missed miscarriage."

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 two medications over two days:
Day 1: You'll take a tablet called **Mifepristone (200mg)** by mouth. This prepares your body for the miscarriage.

Day 2 (48 hours later): You'll take **Misoprostol (800mcg)** - this can be given vaginally, under the tongue, or by mouth. This helps your womb contract and pass the pregnancy tissue.
You may experience pain and bleeding within a few hours of taking the misoprostol. 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 anti-sickness medication, and explain what to expect. If bleeding hasn't started within 48 hours after misoprostol, please contact us. We usually check after a week or so to confirm that the miscarriage is complete."
Clinical Note: The combination of mifepristone + misoprostol is more effective than misoprostol alone (83% vs 76% success rate) and reduces the need for surgical intervention.

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."

Note on Anti-D

Anti-D immunoglobulin is **only required for surgical management** (MVA/ERPC) of miscarriage.
Do NOT offer anti-D for:

- Medical management of miscarriage
- Expectant management of miscarriage
- Threatened miscarriage
- Complete miscarriage

This applies regardless of gestation. If you are Rhesus negative AND opt for **surgical management**, anti-D immunoglobulin (250 IU) will be offered.

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."

Follow-Up Plan

Book a repeat ultrasound in **minimum 7 days**
Consultant review following confirmation

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Offer Leaflet & Final Check
"I'll give you a leaflet to take away - please don't feel you need to read it today if you're not ready. It explains what a missed miscarriage is, along with all the treatment options we've discussed.
The **Miscarriage Association** also has a helpline and support groups if you'd find that helpful.
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. We'll also offer you emotional support and information about the Miscarriage Association if you'd like."

Incomplete Abortion

Setting: Gynaecology Clinic / Early Pregnancy Unit
Role: FY2 Doctor
Patient: Young Adult Woman
Context: Post-termination complications with vaginal discharge
Scan Result: Retained products of conception

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?"

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?"

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?"

Clear Result Disclosure
"Thanks for sharing all that. I've reviewed your ultrasound, and it shows that **a small amount of tissue remains in the womb** - this is quite common and treatable. 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."

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."

Structured Management Plan
"We have three main management options. All are safe, and we'll support you with whichever feels right."

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."

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."

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."

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**, or co-amoxiclav 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."

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."

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
Patient: Adolescent Female
Presenting Complaint: Acute vomiting with undisclosed pregnancy

CRITICAL SAFEGUARDING NOTE - Age Matters
Immediately establish the patient's age:

- **Under 13 years:** Sexual activity is **statutory rape** regardless of apparent consent. **Mandatory referral** to Social Services/Police. Fraser Guidelines do NOT apply.
- **13-15 years:** Fraser/Gillick competence assessment applies. Assess capacity and any safeguarding concerns.
- **16-17 years:** Can consent but still assess for exploitation/coercion.

1. Introduction & Consent

Greet the patient politely. **Confirm name and age immediately.**
"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 medicine that's safe in early pregnancy. The first options we use are **Cyclizine** or **Prochlorperazine**."
Clinical Note: Ondansetron is generally avoided in the first trimester where possible due to an MHRA 2020 warning about a small increased risk of cleft lip/palate. If first-line antiemetics are ineffective, ondansetron may be considered with appropriate counselling.
"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: Pregnant Woman
Presentation: Persistent vomiting for 2–3 weeks during early pregnancy

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?"

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?"

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. The PUQE (Pregnancy-Unique Quantification of Emesis) scoring system can help objectively assess severity.

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?"

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?"

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.

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."

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 get this under control and help you feel much better."

Management Plan
A. **If Mild to Moderate – Outpatient**
"We can try managing this at home if you're not severely dehydrated."
Antiemetics (in order of preference per current guidelines):

1. **First-line: Cyclizine** or **Prochlorperazine or doxylamine/pyridoxine combination** – "These are safe and effective anti-sickness medications."

2. **Second-line: Ondansetron** – "If the first medications aren't working well enough, we may try ondansetron. There's a small theoretical risk in the first trimester that we'll discuss with you."
3. **Third-line: Metoclopramide** – "This is usually limited to a maximum of 5 days due to a small risk of movement side effects."

"Eat small, frequent meals - crackers, dry toast. Avoid fatty or spicy foods."

B. **If Severe – Admission Required**
"You'll need to be admitted for fluids and monitoring."

IV Fluids – Normal saline or Hartmann's to correct dehydration and electrolytes.
[CRITICAL for candidates: IV Thiamine MUST be given BEFORE or WITH any dextrose-containing fluids to prevent Wernicke's encephalopathy in malnourished patients.]

IV Thiamine (Vitamin B1) – "We'll also give you a vitamin injection to protect your brain while we give fluids."
[Note: VTE Risk Assessment (RCOG) - Admission for hyperemesis automatically scores ≥3 points (Pregnancy + Dehydration + Immobility). Thromboprophylaxis is required.]

IV Antiemetics – "To control the vomiting - options include cyclizine first, then ondansetron or metoclopramide if needed."

Steroids (e.g. prednisolone) – Corticosteroids should only be used after 10 weeks' gestation due to a possible increased risk of cleft palate if used in the first trimester.

Lansoprazole or omeprazole – "To reduce stomach acid and prevent further irritation."

LMWH (e.g. dalteparin) – "A blood thinner to prevent clots - this is essential because dehydration and immobility significantly increase clot risk in pregnancy."

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

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

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."

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."

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: Pregnant Woman (Third Trimester)
Reason for Review: Routine antenatal follow-up; midwife noted high BP and proteinuria

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?"

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?

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?"

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?"

Medications & Allergies
"Are you taking any regular medications, like aspirin or vitamins?" "Do you have any allergies?"

Important Aspirin Prophylaxis Screen: "Were you advised to take aspirin from 12 weeks of pregnancy? Did you take it?" *(This helps understand if prophylaxis was missed, which is relevant for future pregnancy planning)*

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?"

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)

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**."

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."

Structured Management Plan
[FY2 Note: You can initiate admission, investigations, and first-line antihypertensive (labetalol). All further management decisions - including magnesium sulfate, delivery timing, and mode of delivery - should be discussed with the obstetric registrar/consultant.]

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)

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)
PlGF-based Testing: For suspected preterm pre-eclampsia (20-36+6 weeks), PlGF-based testing is now **recommended as standard** alongside clinical assessment to help rule in or rule out pre-eclampsia. Tests include:

- Elecsys immunoassay sFlt-1/PlGF ratio
- Triage PlGF Test
- DELFIA Xpress PlGF 1-2-3

This is particularly beneficial for groups at higher risk of severe adverse pregnancy outcomes.

Note: PlGF testing helps diagnose/rule out pre-eclampsia but should NOT be used to make decisions about planned early birth.

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. Our target is to keep your blood pressure below 135/85."
Alternatives if contraindicated: nifedipine, methyldopa

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."

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

Planning Delivery
"At this stage of pregnancy, 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."

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."

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."

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

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Pre-eclampsia (24-week Primi with Headache and Proteinuria)

- **Setting:** Primary Care
- **Patient:** Mid-trimester Primigravida
- **Presenting:** Headache with Elevated Blood Pressure

1. Introduction & Consent

- "Hello, I'm Dr ..., one of the doctors here today. How are you feeling?"
- "I understand the pharmacy asked you to see a doctor because of your headache — is that right?"
- "Before we continue, may I ask a few questions to understand what's going on and then check your observations?"

2. Focused History
A. Clarify the Main Concern

- "Can you tell me more about your headache — when did it start?"
- "Where exactly is the pain — front, sides, or back of the head?"
- "How would you rate it from 1–10?"
- "Have you taken any medicines for it?"
- "Did anything trigger it — stress, tiredness, dehydration?"
- "Do you have any blurring of vision, flashing lights, or seeing spots?"
- "Any pain just below your ribs, nausea, or vomiting?"

- "Any swelling — in your feet, hands, or around the eyes?"
- "Any ringing in ears or sudden weight gain recently?"

(These are targeted for pre-eclampsia red flags: visual symptoms, RUQ pain, oedema, rapid weight gain.)

B. Obstetric Background

- "How many weeks pregnant are you now?"
- "Is this your first pregnancy?"
- "Any previous pregnancies, miscarriages, or complications?"
- "Have your antenatal check-ups been going smoothly so far?"
- "Any previous record of raised blood pressure or protein in urine?"
- "Have you had your blood pressure checked recently?"

C. Medical & Medication History

- "Do you have any long-term illnesses like hypertension, kidney disease, diabetes, or autoimmune problems such as lupus?"
- "Are you taking any regular medications apart from antenatal vitamins?"
- "Any allergies to medicines?"

D. Social History

- "How has your sleep and rest been recently?"
- "Do you work at the moment? Is it stressful or physically demanding?"
- "Do you smoke or take alcohol?" *(should be none, but still ask)*
- "Do you have support at home — family or partner?"

E. Review of Systems

- "Any changes in your urine — colour, frequency, burning?"
- "Any abdominal pain, vaginal bleeding, or fluid leakage?"
- "Have you noticed your baby's movements yet?" *(at 24 weeks)*
- "Any fever or signs of infection?"

F. Explore ICE (Ideas, Concerns, Expectations)

Ideas

- "What do you think might be causing this headache?" *(She may say stress or lack of sleep.)*

Concerns

- "Is there anything in particular you're worried about — maybe the baby or your health?" *(Allows exploration of hidden fear or unawareness.)*

Expectations

- "What were you hoping would happen today — just to get some pain relief or to have things checked more thoroughly?"

(This reveals she came for painkillers, unaware of underlying risk – perfect entry to counselling.)

3. Examination Findings (Given)

- BP 150/90 mm Hg
- Urine dipstick: Protein ++
- Bilateral ankle oedema
- Otherwise systemically stable

4. Diagnosis

Likely diagnosis: *Pre-eclampsia*

Hypertension (greater than or equal to 140/90 mm Hg) after 20 weeks + proteinuria (greater than or equal to 1+) with or without oedema. Pathophysiology: The placenta doesn't implant properly, releasing substances that affect maternal blood vessels, causing raised BP and kidney leak of protein.

5. Explanation to Patient
"I know this must feel worrying, especially when you're here with a headache. I'd like to explain what we've found and what we're going to do to look after both you and your baby.
Your blood pressure today is higher than we'd expect in pregnancy, and there's protein leaking into your urine. This suggests a condition called **pre-eclampsia**, which can happen in some pregnancies because the placenta — the organ that supplies your baby — isn't working perfectly.
This can cause strain on your body, especially your blood vessels, kidneys and liver. Most women feel fine at first, but if untreated it can become serious — for example causing very high blood pressure, fits, or problems with the baby's growth."

6. Assessment of Severity / Baseline Work-Up
Immediate investigations:
- Full Blood Count (for haemoconcentration, platelets)
- Liver function tests (ALT, AST for HELLP)
- Renal profile (urea, creatinine, uric acid)
- Coagulation profile
- Urine protein:creatinine ratio (PCR) or 24-hr protein
- Fetal assessment: Ultrasound for growth, amniotic fluid, Doppler, CTG (if greater than 26 weeks)
- Baseline reflexes, weight, fluid balance
- The obstetric team may arrange **PlGF-based testing** (placental growth factor) to help confirm or rule out pre-eclampsia in women presenting between 20 and 36+6 weeks with suspected pre-eclampsia.

7. Management Plan
FY2 Role: Recognise pre-eclampsia, arrange urgent admission, explain the condition to the patient, and safety-net. Once admitted, the **obstetric team manages** all treatment decisions.

A. Admission
- **Admit to hospital (antenatal ward / maternity assessment unit).** Reason: She's 24 weeks with new hypertension and protein ++, risk of progression to severe disease or eclampsia. In-hospital monitoring allows close observation and early treatment.
- **VTE prophylaxis:** Consider **LMWH (e.g., enoxaparin)** as pre-eclampsia with hospital admission is a significant VTE risk factor in pregnancy (per RCOG Green-top Guidelines).

Inpatient Management (Obstetric team — for candidate knowledge)
The following treatments are initiated and managed by the **obstetric/maternity team**, not independently by FY2:

B. Antihypertensive Therapy
- **First-line:** Labetalol (oral or IV)
- Second-line: Nifedipine (modified-release)
- Third-line: Methyldopa (use only short-term; avoid post-delivery due to depression risk)

Target BP: **135/85 mm Hg**

C. Seizure Prophylaxis
- **Magnesium sulfate** if severe features or imminent eclampsia (headache, visual symptoms, epigastric pain, BP greater than 160/110).

D. Fluid Management
- Strict fluid input/output monitoring (risk of pulmonary oedema).

- Fluid balance is carefully monitored in pre-eclampsia to avoid both dehydration and fluid overload.

E. Fetal Monitoring
- Daily fetal movements review.
- Regular ultrasound growth scans every 2 weeks if stable.

F. Corticosteroids
- **Betamethasone** if delivery anticipated before 34 weeks to aid fetal lung maturity.

G. Definitive Treatment
- **Delivery of the baby and placenta** — the only cure.
- Timing based on severity and maternal–fetal condition (usually greater than or equal to 37 weeks if mild and controlled; earlier if severe or complications).

8. Counselling and Reassurance
"We'll keep you in hospital so we can check your blood pressure, urine, and your baby's wellbeing regularly. You might need tablets to keep your BP under control. Most women with pre-eclampsia recover well once monitored and treated. The aim is to keep both you and your baby safe until it's time for delivery."

Explain potential complications gently:
- Maternal: fits (eclampsia), liver/kidney problems, bleeding
- Fetal: growth restriction, premature delivery, stillbirth (rare with proper care)

Empower her:
"By staying in hospital and taking treatment, we can prevent these problems."
Note on pulse oximetry:
- Overestimation of oxygen saturation has been reported in people with darker skin tones when using pulse oximetry — clinical correlation is important.

9. Safety Netting & Red Flags
- Come immediately if:
  - Severe headache or visual disturbance
  - Pain below ribs / vomiting
  - Sudden swelling of hands, face
  - Reduced baby movements
  - Shortness of breath or chest pain
  - Any vaginal bleeding or fluid leakage

10. Follow-Up Plan
- If stable after few days then discharge with:
  - Home BP monitoring / daily urine dipsticks
  - Weekly review at antenatal clinic
  - Continued antihypertensive as per results
- **Post-partum review at 6–8 weeks:** repeat BP and urine; counsel about recurrence in future pregnancies and long-term CV risk.

11. Leaflet & Support
- Provide **NHS "Pre-eclampsia" leaflet**.
- Offer contact numbers for **Maternity Assessment Unit** for emergencies.

12. Closure

- "Do you have any questions or worries about what I've explained?"
- "We'll look after you closely here, and most women with pre-eclampsia go on to have healthy babies."

Ectopic Pregnancy

Setting: General Practice
Role: FY2 GP
Patient: Young Adult Woman
Presenting Complaint: Lower abdominal pain, LMP 6 weeks ago
Findings: Positive pregnancy test

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?"

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?"

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?"

Sexual & Contraceptive History
"Are you in a relationship?"
"Do you use contraception?" *(Condoms, inconsistently)*
"Any past pelvic infections or gynaecological surgeries?"

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?"

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)

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**."

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."

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."

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

Closing
"Can I call the ambulance now and inform the hospital you're coming? We'll make sure everything is arranged discreetly and safely."

Ectopic Pregnancy in EPU

Setting: Early Pregnancy Unit
Role: FY2 Doctor
Patient: Young Adult Woman
Status: Awaiting scan (booked for next morning), refusing admission

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?"

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

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**."

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**."

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."

Treatment Options (Once Confirmed)
[FY2 Note: The specific treatment approach will be determined by the gynaecology registrar/consultant once investigations confirm the diagnosis. Your role is to counsel the patient on the likely options and ensure she understands the importance of staying for monitoring.]
"If the scan confirms an ectopic pregnancy, we'll consider two possible treatments:"

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"

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"

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**."

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"

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."

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?"

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?"

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?"

Other Medical Considerations
"Are you on any medications that could increase bleeding, like aspirin or blood thinners?" "Any recent infections or testing for STIs?"

Anaemia Screening
"Have you been feeling unusually tired, dizzy, or lightheaded lately?"

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?"

1. **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?"

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)

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."

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 (e.g. topical glyceryl trinitrate (GTN) 0.4% ointment).

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."

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

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."

Reassurance & Closing
"I know it's not an easy thing to talk about, so thank you for sharing it. This is actually quite a common thing to happen, so please don't feel embarrassed.
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: Pregnant Woman (Mid-Pregnancy)
Scenario Type: Test Result Discussion + Reassurance + Pregnancy Counselling
Scan Result: Low-lying placenta identified on routine anomaly scan

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?"

Focused History & Context
"Can I check how many weeks along you are now?" "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)*

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?"

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?"

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."

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**."

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."

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**."
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."

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."

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

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."

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: Pregnant Woman (Third Trimester)
Presentation: Lower urinary tract symptoms suggestive of infection

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."

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

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?"
Pregnancy History
"How far along are you now?" → *Third trimester*
"How has the pregnancy been so far?"
"Any history of high BP or gestational diabetes?"
"Have you been attending your antenatal visits regularly?"

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

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?"

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

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."

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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."

Management Plan
"To manage this safely, we'll do the following:"

Investigations
Send urine sample for **culture and sensitivity**
If systemic signs: consider FBC, U&Es

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

Clarification on antibiotic choice: "Nitrofurantoin is normally first-line for UTI in pregnancy, but because you're in your third trimester, we'll use cefalexin instead - nitrofurantoin is avoided closer to delivery due to a small risk to the baby's blood cells (neonatal haemolysis). Trimethoprim is avoided throughout pregnancy because it interferes with folic acid."

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"

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."

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

Follow-Up
"I'd like to review you in **5 days** to make sure symptoms are settling. We'll also repeat a urine sample after treatment to make sure the infection has cleared - this is called a 'test of cure'."

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	Nitrofurantoin or Cefalexin	Trimethoprim (folate antagonist)

2nd Trimester	Nitrofurantoin (preferred) or Cefalexin	Trimethoprim
3rd Trimester	Cefalexin or Amoxicillin (if susceptible)	Nitrofurantoin (risk of neonatal haemolysis at term)

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: Pregnant Woman (Third Trimester)
Presenting Concern: Household contact with chickenpox

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 son has just been diagnosed with chickenpox. I'm 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?" → *Third trimester*
"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 has almost certainly developed **lifelong 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 this stage, 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 needed
- **If not immune (IgG negative)**: Post-exposure prophylaxis is required

Oral Aciclovir is FIRST-LINE for ALL pregnant women (regardless of gestation):

Situation	Management
Non-immune pregnant woman exposed to chickenpox	**Oral Aciclovir 800mg FOUR times daily from days 7-14 after exposure**
Alternative	Oral Valaciclovir 1000mg THREE times daily (days 7-14)
If oral antivirals contraindicated	IV Immunoglobulin (IVIG) may be considered

Key Points:

- Aciclovir has been shown to be as effective as VZIG in preventing maternal chickenpox
- Start prophylaxis 7 days after exposure (or 7 days after rash onset in index case if continuous exposure)
- Aciclovir is safe in pregnancy - extensive safety data from >1,200 pregnancies

If a second exposure occurs: Repeat risk assessment and another course of antivirals if needed (start 7 days after subsequent exposure)

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

Setting: GP Surgery / GUM Clinic
Role: FY2 Doctor
Patient: Pregnant Woman
Presenting Complaint: Painful genital rash during pregnancy

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."
"I know finding out you have herpes can be distressing, but it's a very common infection and we can manage it well during pregnancy."

2. Focused History
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?"

Associated Systemic Symptoms
"Have you experienced any fever, body aches, or flu-like symptoms recently?"

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?"

Pregnancy Status
"How many weeks pregnant are you?"
"Have there been any complications during this pregnancy?"
"Are you receiving regular antenatal care?"

Medical, Medication, Allergy History
"Any known medical conditions?"
"Any medications you are taking currently?"
"Any allergies?"

Lifestyle History
"Do you smoke or drink alcohol?"

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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?"

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
[FY2 Note: You can diagnose genital herpes, initiate acute treatment (aciclovir 400mg TDS × 5 days), and arrange referrals. Decisions about suppressive therapy timing and delivery mode are made by the obstetric/GUM consultant in collaboration with the patient.]

IMPORTANT: Management depends on timing of episode

Scenario A: First Episode in 1st or 2nd Trimester
Immediate Treatment (Acute Episode)
Start **Acyclovir** antiviral tablets - **400mg three times daily for 5 days**:
"We'll start you on acyclovir tablets - 400mg three times a day for 5 days. It's safe to use during pregnancy."

Suppressive Therapy from 36 Weeks
"We'll start you on suppressive acyclovir at **36 weeks - 400mg three times daily** - to continue until you deliver. This helps reduce the risk of a recurrence at the time of birth and helps protect your baby."
Note: The higher dose (TDS rather than BD) is used in late pregnancy due to increased plasma volume.

Scenario B: First Episode in 3rd Trimester (≥28 weeks)
This scenario carries the HIGHEST RISK of neonatal transmission

"Since this is your first herpes infection and you're already in your third trimester, we need to manage this more intensively.
We'll start acyclovir **400mg three times daily NOW** and **continue until delivery** - this is longer than we would normally treat because your body hasn't had time to develop full antibodies to protect the baby."

Delivery Recommendation
"Because this is a new infection late in pregnancy, we strongly recommend a **planned caesarean section**, especially if the infection occurred within 6 weeks of your due date. This is because:

- There's a higher risk of passing the virus to the baby
- You haven't had enough time to develop protective antibodies
- Viral shedding can last longer with first infections"

Scenario C: Recurrent Genital Herpes (History of herpes BEFORE pregnancy)
"Since you've had herpes before pregnancy, your body already has protective antibodies. This means the risk to your baby is much lower.
We don't usually need to treat recurrent episodes in early pregnancy unless symptoms are severe - simple measures like saline bathing and paracetamol are usually enough.
From **36 weeks**, we'll start suppressive acyclovir **400mg three times daily** until delivery to reduce the chance of an outbreak at the time of birth."

Delivery with Recurrent Herpes
"With recurrent herpes:

- If there are **NO active lesions** at delivery → vaginal delivery is safe
- If there **ARE active lesions** at delivery → we will discuss options, but caesarean is not routinely required for recurrent herpes (unlike first episodes)"

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."

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"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."

Summary Table: Genital Herpes in Pregnancy

Scenario	Acute Treatment	Suppressive Timing	Delivery Mode
First episode: 1st/2nd trimester	Acyclovir 400mg TDS × 5 days	Start 36 weeks, continue until delivery	Plan vaginal if no lesions at delivery
First episode: 3rd trimester	Acyclovir 400mg TDS immediately	**Continue until delivery**	**Recommend Caesarean** (especially if <6 weeks from delivery)
Recurrent herpes	Supportive care (treat if severe)	Start 36 weeks, continue until delivery	Vaginal delivery usually safe

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First Antenatal Care Visit

Setting: GP Surgery
Role: FY2 Doctor
Patient: Pregnant Woman
Context: First antenatal visit/booking

Greet and Confirm
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

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"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 **10 to 14 weeks** to confirm dates and offer early screening."
"Your next major scan is at **18 to 21 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 micrograms daily** is the standard dose."

"**If you have diabetes, take epilepsy medications, or have had a previous pregnancy affected by neural tube defect, you'll need the higher dose of 5mg** - let me know if any of those apply to you." (Note: BMI >30 alone is no longer an indication for 5mg folic acid)

"We also recommend **vitamin D - 10 micrograms (400 units) daily** throughout pregnancy and while breastfeeding."
"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: Pregnant Woman (First Trimester)
Task: Conduct antenatal check-up, review results, identify lifestyle risks, explain risks, and counsel patient

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."

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

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."

B. 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 (34 Weeks)

Setting: Antenatal Clinic
Role: FY2 Doctor
Patient: Pregnant Woman (34 Weeks Gestation)
Referral: Midwife noted baby is in breech position during routine palpation

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 over 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."

Additional notes on ECV:

- **Tocolysis** (medication to relax the uterus) may be given before ECV to increase success rates
- **If you are Rhesus negative**, anti-D immunoglobulin will be offered after ECV

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: Antenatal Clinic
Role: FY2 Doctor
Patient: Multiparous Woman (G2P1, 36 Weeks Gestation)
Task: Focused history, examination, and management discussion

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
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?"

Previous Pregnancy History
"You mentioned this is your second pregnancy. How was your previous delivery?"

"Any complications like prolonged labour, pre-eclampsia, or caesarean?"

Antenatal Care Review
"Have you been attending regular antenatal appointments?"
"Any concerns raised in previous scans or blood tests?"

Past Medical, Surgical, Drug History
"Any ongoing medical problems or surgeries?"
"Any medications you are currently taking?"
"Any allergies?"

Social History
- Smoking, alcohol, recreational drugs
- Support at home

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.

Observations:
Blood pressure, HR, temperature, respiratory rate, oxygen saturations.
General Inspection:
Look for pallor, jaundice, distress.

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
ECV Counselling (for after 37w)	If breech is still confirmed, offer **External Cephalic Version (ECV)** after counselling
ECV Details	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
Additional ECV Notes	Tocolysis (medication to relax the uterus) may be given before ECV to increase success rates. If you are Rhesus negative, anti-D immunoglobulin will be offered after ECV
If ECV unsuccessful or declined	Discuss **birth planning**: Planned caesarean delivery is usually advised; vaginal breech birth possible but requires experienced team and risk discussion

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	Watchful waiting - most babies turn spontaneously
At 36+0 to 36+6 weeks	Confirm presentation with scan; plan intervention timing based on parity
After 37+0 weeks	Offer ECV (with tocolysis and anti-D if needed); if unsuccessful, plan delivery mode

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Endometritis

Setting: A&E or GP Surgery
Role: FY2 Doctor
Patient: Woman (Recently Postnatal)
Presentation: 2 days post-Caesarean section, lower abdominal pain, foul-smelling vaginal bleeding

1. Introduction and Confirm Identity
Greet warmly:
"Hello, my name is Dr [Name], one of the doctors here today."
Confirm identity (name, DOB).
Acknowledge the new mother context:
"Congratulations on your new baby. I understand you've been feeling unwell - that must be really difficult when you're trying to recover and care for your little one."

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 **7 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**.

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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: GP Surgery
Role: FY2 Doctor
Patient: Young Adult Woman with Mild Learning Disability
Context: Attending alone, requesting emergency contraception after unprotected sex

Introduction
Greet and confirm identity.
"Hello, I'm Dr [Name]. 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?"

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.)

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?

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)?

Past Medical History (PMH)
Ask simple:
"Do you have any health problems?"
Chronic illnesses? (Epilepsy, diabetes, etc.)
Drug History (DH)
Current medications:
Taking any daily medicines?
Allergies:
Any allergies to medicines?
Specifically check no allergy to Levonorgestrel.

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).

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.

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?

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 Options
Explain the most effective option first - Copper IUD:
"The most effective option is a copper coil - would you like me to explain how that works?"
"It's a small device, like a T-shape, that goes inside the womb to stop pregnancy. It can be put in up to 5 days after unprotected sex and works very well."
"It can cause period-like cramps and some bleeding, but it's very effective."
If interested, refer to local sexual health clinic or GP surgery with fitting facility.

If Copper IUD declined or unavailable - Oral options:
Option 1: Ulipristal acetate (ellaOne)
- Effective up to 120 hours (5 days) after unprotected sex
- May be more effective than levonorgestrel
- "This is a tablet you take once today."

Option 2: Levonorgestrel (Levonelle)
- Effective within 72 hours (3 days)
- "You will take one pill today. It helps to stop pregnancy happening."

Weight/BMI considerations (FSRH 2023):
If weight >70kg or BMI >26:
- Cu-IUD is preferred option
- If not suitable, ulipristal may be better than levonorgestrel
- If neither available, consider double-dose levonorgestrel (3mg)

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 within 2 hours if levonorgestrel / 3 hours if ulipristal** - 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

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Emergency Contraception Request – Epilepsy Patient

Setting: GP Surgery
Role: FY2 Doctor
Patient: Young Adult Woman on Enzyme-Inducing Antiepileptic
Context: Emergency contraception request

Introduction
Greet and confirm identity:
"Hello, I'm Dr [Name]. 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?"

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?"

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?

Past Medical History (PMH)
Epilepsy:
- How long diagnosed? (15 years)
- Last seizure? (1 year ago)
- Well controlled?

Other conditions:
Any other health problems?
Drug History (DH)
Carbamazepine use:
Confirm regular use.
Other medications:
Any additional medications? (Especially enzyme inducers.)
Allergies:
Allergic to any medicines?

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.

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?

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):
The copper coil is the best option because your epilepsy medication doesn't affect how well it works.
- 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.

If Copper IUD is Declined or Unavailable
Important - Ulipristal NOT recommended:
"We don't recommend ulipristal (ellaOne) when you're taking carbamazepine because your medication reduces how well it works."

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

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.

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.
Note: Other enzyme inducers include phenytoin, phenobarbital, primidone, rifampicin, and St John's Wort. The enzyme induction effect persists for 28 days after stopping the drug.

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: GP Surgery
Role: FY2 Doctor
Patient: Adolescent Female
Context: Contraception request – Fraser Guidelines assessment required

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?"

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?

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.) - This doesn't affect which pill you can use, but we encourage healthy eating and activity for overall health.

Blood pressure:
Normal (assume no high-risk finding unless otherwise prompted.)

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.

Management
Explain contraception options clearly:
Combined pill (COCP):
Not suitable due to migraine with aura (↑ stroke risk). (NICE CKS, FSRH 2022.)
"The combined pill isn't safe for you because of your migraines with visual symptoms - it would increase your risk of stroke."

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

Long-acting methods:
"There are also longer-acting options like implants or injections that you wouldn't need to remember daily - we can discuss these if you're interested."

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 – Safeguarding

Setting: GP Surgery
Role: FY2 Doctor
Patient: Adolescent Female (Under 16)
Context: Contraception request with safeguarding concerns identified during consultation

1. Introduction
Greet warmly:
"Hello, I'm Dr [Name]. 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 this is "Abuse of Position of Trust" under Sexual Offences Act 2003 - a criminal offence regardless of apparent consent**

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
A. Safeguarding Action - MANDATORY REPORTING
Legal Context: Under the Sexual Offences Act 2003 (Sections 16-19), it is a criminal offence for a person in a "position of trust" (including teachers) to engage in sexual activity with a person under 18 in their care. This is **automatically abusive** regardless of the young person's apparent consent.

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."
"I'm really glad you felt comfortable sharing this with me."
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. This is actually against the law."

Explain mandatory reporting:
"Because of what you've told me, I am **required by law** to refer this to the safeguarding team. This will be reported to either:

- **LADO** (Local Authority Designated Officer) - who deals with allegations against professionals, OR
- **MASH** (Multi-Agency Safeguarding Hub)"

"The safeguarding team will ensure you are safe and supported, and they will also need to investigate the teacher's conduct."
Reassure confidentiality and emotional safety:
"We will handle this carefully. You are not alone. Your parents will be informed by the safeguarding team - this is part of the process to protect you."
Note: You cannot simply "involve parents carefully" - this must go through proper safeguarding channels. The LADO/MASH will coordinate how and when parents are informed.
Firm but gentle advice:
"Please try not to contact him from now on. This is for your safety."

B. 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.

C. 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."

D. Written Support
Provide leaflets:

- Emergency contraception
- STI screening information
- Young person's safeguarding support services

Requesting COCP Repeat for Period Delay

Setting: GP Surgery
Role: FY2 Doctor

Patient: Young Adult Woman
Context: COCP repeat prescription and advice on period delay for travel

1. Introduction
Greet and confirm identity:
"Hello, I'm Dr [Name]. 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)
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."

"You can safely take packs back-to-back for longer periods if needed. If you get breakthrough bleeding, you can take a **4-day break** (not 7 days) and then restart. Modern guidance supports flexible extended regimens - many women take continuous pills for several months at a time."

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 (5mg TDS), 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 packs back-to-back. With modern guidance, you can do this for longer than two packs if needed - just take a short 4-day break if you get any breakthrough bleeding."

Safety Netting
Breakthrough bleeding:
"If you notice spotting or bleeding while taking continuous pills, it's safe - you can either carry on or take a 4-day 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."

Leaflet
Provide patient leaflet on COCP use, continuous pill taking, and safe contraception abroad.

Retained Tampon

Setting: GP Surgery / ED
Role: FY2 Doctor
Patient: Adult Woman
Presenting Complaint: Offensive vaginal discharge

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?"
"This is actually quite a common thing to happen, so please don't feel embarrassed."

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?"

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?"

Sexual History
"Are you currently sexually active?" "Any new partners recently?" "Do you use contraception? If so, which type?"

Past Medical History
"Any previous vaginal infections or STIs?" "Any allergies or regular medications?"

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?"

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."

Provisional Diagnosis
"Based on the examination, it appears you have a retained tampon, which is causing the symptoms."

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."

Management Plan
Symptomatic Relief

Independent educational content based on publicly available UK clinical guidelines.
Not affiliated with or derived from GMC PLAB 2 examination material.
GK's PLAB 2 Preparation WhatsApp Channel - https://tinyurl.com/gksplab2

Removal of tampon carefully using forceps during speculum exam. Clean the area gently if needed. Offer mild painkillers (paracetamol) if patient experiences minor discomfort.

Investigations
Vaginal swab for culture and sensitivity to rule out secondary infection. Blood tests only if systemic signs of infection (not routinely needed here).

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

Advice and Education
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

Toxic Shock Syndrome (TSS) Awareness
"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."

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."

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."

Follow-Up
Review swab results in 48–72 hours. Contact patient if infection confirmed; arrange antibiotics if necessary.

Vulvovaginal Candidiasis

Setting: GP Surgery
Role: FY2 Doctor
Patient: Adult Woman
Presenting Complaint: 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. How can I help you today?"

Presenting Complaint Clarification
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
"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?"

Examination (Verbalised)
"To understand better, I'd like to check a few things, if that's okay."
"I'd like to check your vital signs (BP, pulse, temperature)." "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
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	**Clotrimazole 500mg pessary** (single dose intravaginally) OR **Fluconazole 150mg oral** (single dose) Topical external cream (clotrimazole 1%) can be added for vulval symptoms. Avoid fluconazole in pregnancy — use topical azoles instead.
Swabs	Consider if diagnosis uncertain or recurrent
Hygiene Advice	Avoid scented products, wear cotton underwear
Sexual Activity	Can continue but may be uncomfortable; not an STI

Partner treatment	Only if partner is symptomatic
Follow-Up	Review if symptoms persist beyond 7–14 days
Safety Netting	Return if worsening symptoms, fever, or new symptoms

Recurrent Candidiasis (≥4 episodes per year):
- Consider checking for underlying conditions (diabetes, immunosuppression)
- May need extended treatment course
- Consider referral if not responding

Addressing Patient Concerns
"Will this affect my fertility?" → No, uncomplicated thrush does not affect fertility. **"Can this be passed to my partner?"** → Only if symptomatic; partner treatment can be discussed. **"Will it come back?"** → Some people are prone to recurrent thrush; we can discuss longer-term management.

Leaflet
Offer a leaflet on **vaginal thrush** from NHS website.

Bacterial Vaginosis

Setting: GP Surgery
Role: FY2 Doctor
Patient: Adult Woman
Presenting Complaint: 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. I understand you made an appointment today because you've been having some discharge - is that correct?"

Presenting Complaint Clarification
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?"

ICE
"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?"

Examination (Verbalised)
"I'd like to examine you to better understand the cause, if that's alright."
"I would check your vital signs - blood pressure, pulse, temperature." "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
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	**Metronidazole 400mg BD for 5–7 days** (oral) OR Metronidazole gel intravaginally for 5 nights OR intravaginal clindamycin 2% cream once daily for 7 days
Swabs	Send for microscopy and culture to confirm diagnosis
Self-Care Advice	Avoid douching, scented products, bubble baths
Sexual Activity Advice	BV is not an STI; can continue sexual activity
Smoking Cessation	Smoking increases BV recurrence - offer cessation support
Follow-Up	Review if symptoms persist after treatment
Safety Netting	Return if worsening symptoms, fever, or pelvic pain

Addressing Specific Concerns
"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."

Note: Historically partner treatment was NOT recommended, but a 2024 NEJM trial showed concurrent male partner treatment may reduce recurrence – discuss with patients.

Leaflet
Provide an NHS leaflet on **Bacterial Vaginosis**.

Vaginal Discharge Comparison Table

Feature	Thrush (Candida)	BV	Trichomoniasis
Discharge	White, cottage cheese	Grey/white, thin	Green/yellow, frothy
Smell	None	Fishy (worse after sex)	Offensive
Itching	Marked	Minimal	Variable
Pain	Dyspareunia common	Rare	Dysuria common
pH	Normal (<4.5)	Raised (>4.5)	Raised (>4.5)

Treatment	Antifungals	Metronidazole	Metronidazole
Partner treatment?	Only if symptomatic	Not required	Yes - contact tracing

Persistent Dysuria

Setting: GP Surgery
Role: FY2 Doctor
Patient: Adult Woman
Context: 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 date of birth, 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
Summarise 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."

4. 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.)

5. 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?

6. 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.)

7. 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
Take swabs FIRST before considering treatment:
"We will take the swabs today. If you are in significant discomfort, we can discuss starting antibiotics now, but often it is better to wait for the result to ensure we treat the right infection."
If empirical treatment indicated (e.g., high-risk contact, symptomatic contact, significant discomfort):
Doxycycline 100mg BD for 7 days (standard for uncomplicated chlamydia)

Important clinical note: Empirical treatment without confirmed swab results is debatable in General Practice. BASHH guidelines generally recommend testing first unless the patient is a symptomatic contact of a confirmed case or has high-risk factors. Over-treating contributes to antibiotic resistance.
If dysuria persists despite Doxycycline: Consider **Mycoplasma genitalium** - this requires specialist input and may need Moxifloxacin treatment.

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 (PID)

Setting: GP Surgery
Role: FY2 Doctor
Patient: Young Adult Woman

Presenting Complaint: Lower abdominal pain with vaginal discharge

1. Introduction
"Good morning, I'm Dr [Name], one of the doctors working today."
"Could I confirm your full name and date of birth, 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.

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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 me, 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."
Add fertility reassurance for mild cases:
"The good news is that when PID is caught early and treated promptly, the risk of long-term problems like fertility issues is very low."

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."
Consider adding: "We may also test for Mycoplasma genitalium, which can cause similar symptoms."

Treatment:
"Even before we get all the results back, we usually start treatment to cover common infections."
"You would be given:"

- **Ceftriaxone 1g IM injection (one time)** +
- **Doxycycline 100mg tablet twice a day for 14 days** +
- **Metronidazole 400mg tablet twice a day for 14 days**

(We remember it as 'PID = C + 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."

PID Presentation in GP Setting (Mild to Moderate)

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 & Management	Suspected **Pelvic Inflammatory Disease (PID)** (mild/moderate).
	Start empirical **oral antibiotic treatment immediately**:
	• Ceftriaxone 1g IM single dose
	• Doxycycline 100mg BD for 14 days
	• Metronidazole 400mg 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:

- Young adult 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 & Management	Severe PID with likely **tubo-ovarian abscess** (complication).
	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.

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	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

Setting: GP Surgery / GUM Clinic
Role: FY2 Doctor
Patient: Adult
Context: Discussion of positive gonorrhoea 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 date of birth, 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."
"Please remember this is a common infection, easily treated."

7. Management Plan
Immediate Treatment:
"We recommend starting treatment today with:"
Ceftriaxone 1g IM injection (intramuscular)
Check allergies before prescribing.

Partner Notification
Correct look-back periods for gonorrhoea:

- **Male with urethral symptoms:** All partners since, and in the **2 weeks prior** to symptom onset
- **All others (females, asymptomatic males, non-urethral sites):** All partners in the **3 months prior** to diagnosis

(Note: Do NOT confuse with chlamydia which uses 4 weeks/6 months)
"It's important to inform any sexual partners 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 know that this is a very common infection and you've done the right thing by getting tested."
"Is there anything else you'd like to ask or talk about?"
"Do you have support at home, or would you like us to arrange any additional support?"

Breast Lump

Setting: GP Surgery
Role: FY2 Doctor
Patient: Woman (Post-Menopausal Age)
Presenting Complaint: Self-detected breast lump

1. Introduction
Greet warmly and confirm identity:
"Hello, I'm Dr ___. Could I confirm your full name and date of birth, please?"
"I understand you've come in because you've noticed something in your breast. Could you tell me more about what you've found?"

2. History of Presenting Complaint
Lump characteristics:
"When did you first notice the lump?"
"Where exactly is it? Which breast and which part?"
"Has it changed in size since you noticed it?"
"Is it painful or tender?"
"Does it move when you touch it, or does it feel fixed?"

Associated features:
"Have you noticed any changes to the skin over the lump - like dimpling, redness, or thickening?"
"Any changes to the nipple - like it pulling inwards, or any discharge?"
"Any lumps under your arm?"

Cyclical changes:
"Does the lump change with your periods?" *(If still menstruating)*

3. Risk Factor Assessment
Menstrual and reproductive history:
"At what age did you start your periods?"
"At what age did your periods stop?" *(If post-menopausal)*
"Have you ever been pregnant? Did you breastfeed?"

Hormonal factors:
"Have you ever used hormone replacement therapy (HRT)?"
"Have you used the oral contraceptive pill?"

Family history:
"Has anyone in your family had breast cancer or ovarian cancer?"
"If so, who was affected and at what age were they diagnosed?"
(Patient reveals: Mother and sister affected - high-risk family history)

Lifestyle:

"Do you smoke or drink alcohol?"
"Have you noticed any unexplained weight loss recently?"

4. Systemic Review (Red Flags)
"Any bone pain, especially in your back or hips?"
"Any shortness of breath or persistent cough?"
"Any loss of appetite or feeling generally unwell?"

5. ICE
Ideas: "What do you think this lump might be?"
Concerns: "Is there anything in particular you're worried about?"
Expectations: "What were you hoping we could do today?"

6. Clinical Examination
"I would like to examine your breasts today, if that's okay with you."
"I'll explain everything I'm doing, and a chaperone will be present."

Examination includes:
- Inspection: symmetry, skin changes, nipple changes
- Palpation: both breasts, all quadrants, nipple expression
- Axillary examination: lymph nodes

Findings (given):
- Palpable lump in [location]
- No palpable axillary lymphadenopathy

7. Acknowledge Anxiety and Reassure
"I can imagine finding a lump must have been quite worrying. You've done absolutely the right thing coming in to get it checked."

8. Diagnosis and Explanation
"I have felt a lump during the examination today, and I understand this can feel worrying."
"Most breast lumps are not cancer, and there are many other possible causes like cysts or benign changes. However, because you have a lump, especially given your family history, we need to investigate it properly to be sure."

9. Management Plan - 2-Week Wait Referral
"I'd like to refer you to the breast clinic where they can do some more detailed tests. This is a precaution - it doesn't mean I think it's cancer, but with any new lump we want to make sure."
"This is an **urgent referral** - you should be seen **within 2 weeks**."

What will happen at breast clinic (Triple Assessment):
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."

10. Reassurance and Support
"You can take a family member or a friend with you to the appointment for support if you wish."

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"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."

11. 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."

12. Breast Awareness Advice
"Continue to check your breasts regularly - get to know how they normally look and feel, so you can notice any new changes."

13. Leaflet
Provide:
- Breast clinic 2WW referral information leaflet
- Breast lump awareness leaflet

Breast Engorgement

Setting: GP Surgery
Role: FY2 Doctor
Patient: Postpartum Woman
Presenting Complaint: Bilateral breast pain and fullness

1. Introduction
Greet warmly and confirm identity:
"Hello, I'm Dr ___. Could I please confirm your full name and date of birth?"
Open the consultation:
"I understand you've come in today with some breast discomfort. Could you tell me a little more about it?"

2. Focused History Taking
Symptom analysis:
"Could you describe the discomfort - is it in one breast or both?"
"When did it start?"
"Is it a constant feeling, or does it come and go?"
"Would you describe it as heaviness, tightness, or pain?"

Breastfeeding history:
"Are you currently breastfeeding?"
"How often are you feeding your baby?"
"How has breastfeeding been going generally?"
"Any difficulties with the baby latching on?"

Associated symptoms:
"Have you noticed any fever or feeling unwell?"
"Any redness or warmth over the breasts?"
"Any nipple discharge - is it milk, or anything else like blood or pus?"
"Any cracked or sore nipples?"

General postnatal wellbeing:
"How are you feeling in yourself since the birth?"

"Any concerns about how your baby is feeding or gaining weight?"

3. Brief Background Check
Past medical history: "Any previous breast problems or infections?"
Medications: "Are you taking any medications currently?"
Allergies: "Any known allergies to medications?"

4. 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 help you with today?"

5. 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."
"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."
"Would it be alright to proceed?"

Examination Technique:

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)

6. 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."

7. 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."

8. 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."

9. Follow-up Advice
"If you don't improve within 24–48 hours despite these measures, please return for reassessment."

10. Leaflets and Closing
Provide:
- 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."

Mastitis

Setting: GP Surgery
Role: FY2 Doctor
Patient: Postpartum Woman (Breastfeeding)
Presenting Complaint: Unilateral breast pain with fever and systemic symptoms

1. Introduction
Greet and confirm identity:
"Hello, I'm Dr ___. Could I please confirm your full name and date of birth?"
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):
"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?"

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?"

3. 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 if relevant)*
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?"

4. ICE
Ideas: "What do you think might be causing the problem?"
Concerns: "Is there anything you're particularly worried about?" *(Patient may ask: "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?"

5. 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?"
Verbalise 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.

6. 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?"

7. 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:
If no penicillin allergy: "I'll prescribe **flucloxacillin 500mg four times a day for 7 days. Extend to 10–14 days** if symptoms not resolving. This is the best antibiotic for this type of infection and is safe to use while breastfeeding."
If penicillin allergy: "Because you are allergic to penicillin, I'll prescribe you **erythromycin** (or clarithromycin) - 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."
Summarise: "With this approach, most women feel a lot better within 24–48 hours."

8. 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."

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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."

9. 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."

Mastitis - Alternate Scenario

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: **500mg 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 - Comparison Table

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

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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

Heavy Menstrual Bleeding (Menorrhagia)

Setting: GP Surgery
Role: FY2 Doctor
Patient: Adult Woman
Presenting Complaint: Heavy menstrual bleeding affecting quality of life

1. Introduction
Greet and confirm identity:
"Hello, I'm Dr ___. Could I confirm your full name and date of birth, please?"
"I understand you've come in because of problems with your periods. Could you tell me more about what's been happening?"

2. History of Presenting Complaint
Characterise the bleeding:
"How heavy would you say your periods are?"
"How many days does your period typically last?"
"How often do you need to change your pads or tampons?"
"Do you ever need to use double protection - like a pad and a tampon together?"
"Do you pass any clots? How big are they?"
"Have you ever had flooding - where blood soaks through to your clothes or bedding?"
"Do you need to wake at night to change protection?"

Impact on life:
"How is this affecting your daily life - work, activities, relationships?"
"I can hear that this is really affecting your daily life, and that's something we want to help you with."

Associated symptoms:
"Any pain with your periods?"
"Any bleeding between periods or after sex?"
"Any symptoms of anaemia - tiredness, dizziness, shortness of breath, palpitations?"

3. Menstrual and Reproductive History
"When did you start your periods?"
"Are your cycles regular?"
"When was your last period?"
"Any chance you could be pregnant?"
"Have you been pregnant before? Any children?"
"Are you currently using any contraception?"

4. Risk Factor and Red Flag Screening

Thyroid: "Any weight changes, feeling hotter or colder than usual, changes in energy levels?"
Bleeding disorders: "Do you bruise easily? Any history of prolonged bleeding after cuts or dental procedures?"
Family history: "Any family history of heavy periods, bleeding disorders, or gynaecological problems?"
Red flags: "Any unexplained weight loss?"
"Any postmenopausal bleeding?" *(if applicable)*

5. PMAFTOSA
Past medical history: "Any previous medical conditions - especially thyroid problems, PCOS, fibroids?"
Medications: "Are you on any medications currently, including blood thinners?"
Allergies: "Any known drug allergies?"
Family history: "Any family history of fibroids, cancer, or bleeding disorders?"
Social: "Do you smoke or drink alcohol?"

6. ICE
Ideas: "Do you have any thoughts about what might be causing the heavy bleeding?"
Concerns: "Is there anything particular you're worried about?"
Expectations: "What were you hoping we could do to help?"

7. Examination
"I'd like to do a brief examination - checking your tummy and possibly doing an internal examination if appropriate."
Findings may include:
- General observations (pallor suggesting anaemia)
- Abdominal examination (any masses)
- Speculum/bimanual examination if appropriate

8. Investigations
"I'd like to arrange some tests to understand the cause better:"
- **Full blood count (FBC)** - to check for anaemia
- **Thyroid function tests (TFTs)** - thyroid problems can affect periods
- **Ferritin** - to check your iron stores
- **Pelvic ultrasound** - to look at the womb and ovaries

An endometrial biopsy may be considered at hysteroscopy if there are additional risk factors for endometrial pathology such as intermenstrual bleeding, obesity, or PCOS.

9. Diagnosis and Explanation
"Heavy menstrual bleeding is very common and can have several causes, including hormonal imbalances, fibroids, or sometimes no specific cause at all. We'll do some tests to find out more, and there are very effective treatments available."

10. Management Plan
First-line treatment:
"The most effective treatment we have is a small hormone-releasing coil called the **Mirena (LNG-IUS)**. It sits inside the womb and most women find their bleeding reduces significantly within a few months."

Second-line options if Mirena declined or unsuitable:
- **Tranexamic acid** - "This is a tablet you take during your period to reduce bleeding."
- **NSAIDs (mefenamic acid)** - "This can help with both bleeding and period pain."
- **Combined oral contraceptive pill (COCP)** - "This can make periods lighter and more regular."
- **Cyclical progestogens** - "Tablets taken for part of your cycle."

Iron supplementation: "If your blood tests show anaemia, we'll start you on iron tablets."

Referral criteria: "We would refer you to gynaecology if medical treatments don't work, if you have large fibroids (over 3cm), endometrial polyps, or if you're planning pregnancy."

11. Safety Netting
"Please come back if your symptoms worsen, if you develop severe pain, or if you're soaking through a pad or tampon every hour for several hours - that would need urgent attention."

12. Follow-up
"I'll arrange a review in a few weeks once we have the test results, and we can discuss the best treatment options for you."

Primary Dysmenorrhoea

Setting: GP Surgery
Role: FY2 Doctor
Patient: Young Adult Woman
Presenting Complaint: Painful periods with no underlying pelvic pathology

1. Introduction
Greet and confirm identity:
"Hello, I'm Dr ___. Could I confirm your full name and date of birth, please?"
"What brings you in today?"
(Patient describes painful periods)
"I'm sorry to hear your periods have been causing you so much discomfort. Let's go through this together and see how we can help."

2. History of Presenting Complaint
Characterise the pain (SOCRATES):
"When does the pain start in relation to your period?"
"Where exactly do you feel the pain?"
"What does it feel like - cramping, stabbing, constant?"
"Does it spread anywhere - to your back or thighs?"
"How bad is it on a scale of 1–10?"
"How long does it last?"
"Does anything make it better or worse?"

Associated symptoms:
"Any nausea, vomiting, or diarrhoea with your periods?"
"Any headaches or fatigue?"
"Any pain during or after sex?"
"Any pain when opening your bowels or passing urine during your period?"

Impact on life:
"How is this affecting your daily life - school, work, activities?"
"Do you ever have to stay off work or school because of the pain?"

3. Menstrual History
"When did you start your periods?"
"Are your cycles regular?"
"How long do your periods last?"

"Are your periods heavy?"
"When did the painful periods start - from the beginning, or more recently?"

4. Red Flag Screening (to exclude secondary causes)
"Any bleeding between periods?"
"Any bleeding after sex?"
"Any unusual vaginal discharge?"
"Any difficulty getting pregnant?" *(if relevant)*
**If pain started later in life or is worsening, consider secondary dysmenorrhoea (endometriosis, adenomyosis, fibroids).*

5. Brief Background
Past medical history: "Any previous medical conditions?"
Medications: "What have you tried so far for the pain?"
Allergies: "Any known drug allergies?"
Sexual history: "Are you sexually active? Any current contraception?"

6. ICE
Ideas: "Do you have any thoughts about what might be causing the pain?"
Concerns: "Is there anything you're particularly worried about?"
Expectations: "What were you hoping we could do today?"

7. Examination
"If you're happy, I'd like to do a gentle tummy examination. An internal examination isn't usually needed for straightforward period pain in young women, but we can discuss that if needed."

8. Diagnosis and Explanation
"Based on what you've told me, this sounds like **primary dysmenorrhoea** - that's the medical term for painful periods without any underlying problem in the womb or ovaries."

Explain the mechanism in simple terms:
"During your period, your womb contracts to shed its lining. These contractions are caused by chemicals called prostaglandins. In some women, there are higher levels of these chemicals, which causes stronger, more painful contractions. The good news is that we have very effective treatments."

9. Management Plan
First-line treatment:
NSAIDs (e.g., ibuprofen, mefenamic acid): "Anti-inflammatory painkillers like ibuprofen work really well because they reduce the prostaglandins causing the pain. Take them as soon as your period starts or just before, and continue for the first 2–3 days."
"Mefenamic acid is another option that's specifically helpful for period pain."

Paracetamol: "You can add paracetamol alongside ibuprofen if needed."

Heat therapy: "A hot water bottle or heat pad on your lower tummy can really help relax the muscles."

Second-line treatment (if NSAIDs not enough):
Combined oral contraceptive pill (COCP): "The pill can be very effective because it thins the womb lining and reduces prostaglandin production. Many women find their periods become lighter and less painful."

Other hormonal options:
- Progestogen-only pill

- Hormonal IUS (Mirena)
- Contraceptive patch or ring

10. Safety Netting
"If your symptoms don't improve with these treatments, or if the pain changes - for example, if it starts earlier in your cycle, becomes constant, or you develop pain during sex - please come back. We may need to investigate for other causes like endometriosis."

11. Follow-up
"Let's try these treatments for a few months and see how you get on. If there's no improvement, we can consider other options or refer you for further investigation."

12. Leaflets
Provide:
- Period pain information leaflet
- Contraception options leaflet *(if considering hormonal treatment)*

Uterine Fibroids

Setting: GP Surgery
Role: FY2 Doctor
Patient: Adult Woman
Context: Follow-up to discuss pelvic ultrasound findings showing uterine fibroids

1. 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?"

2. 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?"

Impact:
"How is the bleeding affecting your daily life - work, activities, mood?"

Associated Symptoms:
"Any pelvic pain or pressure?"
"Any difficulty passing urine or needing to go frequently?"
"Any constipation or difficulty with bowel movements?"
"Any lower back pain?"

Reproductive History:
"Have you had any children? Any plans for future pregnancy?"
"What contraception are you currently using, if any?"

Red Flags:
"Any unexplained weight loss?"

"Any new lumps or swelling in your tummy?"

3. Brief Background
Past medical history: "Any previous medical conditions?"
Medications: "Any regular medications?"
Allergies: "Any known drug allergies?"
Family history: "Any family history of fibroids or gynaecological problems?"

4. ICE
Ideas: "Do you have any thoughts about what might be causing your symptoms?"
Concerns: "Is there anything you're particularly worried about?"
Expectations: "What were you hoping we could discuss or arrange today?"

5. Result Disclosure
"Thank you for sharing all of that. I now have the results of your ultrasound scan, and I'd like to go through them with you."
"The scan has found two growths in your womb called **fibroids**. One is on the front wall of the womb and measures about 17cm, and the other is on the side and back, measuring around 14cm."
Pause and check: "How are you feeling hearing this?"

6. Explanation of Fibroids
"Fibroids are very common - they're non-cancerous growths made of muscle and fibrous tissue that develop in or around the womb."
"They can vary in size - from very small to quite large, like yours. They're often discovered when investigating heavy periods or other symptoms."
"The good news is that **fibroids are not cancer** and they don't turn into cancer. However, when they're large like yours, they can cause symptoms like heavy bleeding, pressure on the bladder or bowel, and sometimes pain."

7. Management Plan
CRITICAL CLINICAL NOTE: A 17cm fibroid is **massive** - equivalent to approximately 20 weeks pregnancy. This is NOT suitable for routine medical management or Mirena discussion in GP. This patient requires **urgent gynaecology referral**.

Urgent Referral to Gynaecology:
"Because your fibroids are very large - particularly the 17cm one - I need to refer you urgently to a gynaecologist. Fibroids of this size can cause significant pressure on nearby organs like your bladder and kidneys, and they need specialist assessment."

While awaiting urgent specialist review (symptomatic management only):
Tranexamic Acid:
- "Taken during your period"
- "Helps reduce bleeding by stabilising 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"

NOT appropriate for this patient:

- **Mirena coil (LNG-IUS):** NOT suitable - the uterine cavity will be severely distorted by fibroids of this size
- **"Watch and wait" / GP follow-up only:** NOT appropriate for fibroids of this size

Surgical and Interventional Management (Specialist-Led):
Given the size of these fibroids, the specialist will likely discuss:
Uterine Artery Embolisation (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"

GnRH Analogues (e.g., Goserelin):

- "Injections that shrink fibroids by lowering oestrogen levels"
- "Usually used short term (e.g., pre-surgery) to reduce fibroid size and bleeding"
- "Fibroids often regrow after stopping"

8. 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."

9. Follow-Up Plan
"We'll arrange GP follow-up after your gynaecology review, or sooner if symptoms change."

10. 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

Setting: GP Surgery / Gynaecology Clinic
Role: FY2 Doctor
Patient: Young Adult Woman
Presenting Complaint: Chronic pelvic pain with cyclical pattern and dyspareunia

1. Introduction
"Good morning. I am Dr [Name], one of the doctors here today. Could you kindly confirm your full name and date of birth 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 describe symptoms: "I have been having lower tummy pain, painful periods" etc.)

2. Clarify Presenting Complaint
"Thank you for sharing that. I'd like to understand a bit more about your symptoms."
Pain history (SOCRATES):
"Where exactly do you feel the pain?"
"When did it first start?"
"Is it there all the time, or does it come and go?"
"Does the pain relate to your menstrual cycle - is it worse before or during your period?"
"How severe is the pain on a scale of 1–10?"
"Does anything make it better or worse?"
"Does the pain spread anywhere - to your back, thighs, or bowel?"

Associated symptoms:
"Do you have pain during or after sex?" *(Dyspareunia)*
"Any pain when opening your bowels, especially during your period?" *(Dyschezia)*
"Any pain or difficulty passing urine?"
"Any blood in your stools or urine during your period?"
"Any difficulty getting pregnant?"

Validate patient experience: "It sounds like these symptoms have been really affecting your quality of life. I want you to know that we take this seriously and there is help available."

3. Menstrual History
"When did you start your periods?"
"Are they regular?"
"How heavy are they?"
"How long do they last?"

4. Background
Past medical history: "Any previous surgeries, especially gynaecological?"
Medications: "What have you tried for the pain so far?"
Allergies: "Any known drug allergies?"
Family history: "Any family history of endometriosis or other gynaecological conditions?"

5. ICE
Ideas: "What do you think might be causing your symptoms?"
Concerns: "Is there anything particular you're worried about?"
Expectations: "What were you hoping we could do for you today?"

6. Examination
"I'd like to do a gentle examination if that's okay - checking your tummy and possibly doing an internal examination."
Findings may include:

- Tenderness on abdominal examination
- Fixed, retroverted uterus
- Tenderness in the pouch of Douglas
- Nodularity on rectovaginal examination

7. Diagnosis and Explanation
"Based on your symptoms, I suspect you may have a condition called **endometriosis**."

Explain simply:
"Endometriosis happens when tissue similar to the lining of the womb grows outside the womb - in places like the ovaries, the area around the womb, or the bowel. This tissue still responds to your hormones each month, which causes inflammation, pain, and sometimes scarring."
"It can cause painful periods, pain during sex, pain when opening your bowels, and can sometimes affect fertility."
"It's a common condition - affecting about 1 in 10 women - but it often takes a long time to diagnose because the symptoms can be similar to other conditions."

8. Investigations
"To investigate further, we may arrange:"

- **Pelvic ultrasound** - "This can sometimes show endometriosis cysts (endometriomas) on the ovaries."
- **MRI** - "May be helpful if deeper endometriosis is suspected."
- **Laparoscopy** - "A keyhole operation is the only way to definitively diagnose endometriosis. This would be arranged by a specialist."

9. Management Plan
Pain Management:
"For pain relief, we can use:"

- **NSAIDs (e.g., ibuprofen, naproxen)** - "Best started 1–2 days before your period is due."
- **Paracetamol** - "Can be used alongside."
- **Heat therapy** - "A hot water bottle can help relax the muscles."

Hormonal Treatment (to suppress the cycle):
"Hormonal treatments work by suppressing your menstrual cycle, which reduces the stimulation of the endometrial tissue:"

- **Combined oral contraceptive pill** - "Can be taken continuously to skip periods."
- **Progestogen-only pill or injection (Depo-Provera)**
- **Mirena (LNG-IUS)** - "Can reduce symptoms and bleeding."
- **GnRH analogues** - "Used for more severe cases, usually with add-back HRT to prevent menopausal side effects."

Surgical Options (Specialist-Led):

- **Diagnostic laparoscopy with excision/ablation** - "Removing or destroying the endometrial deposits."
- **More extensive surgery** - "For severe cases involving bowel or bladder."

Fertility:
"If you're trying to conceive, we would refer you to a fertility specialist. Some women with endometriosis may benefit from assisted conception."

10. Support
"Endometriosis can be a challenging condition to live with, both physically and emotionally. There are support groups like **Endometriosis UK** that many women find helpful."
"We're here to support you through this."

11. Safety Netting
"Please come back if your symptoms worsen, if you develop new symptoms like significant changes in your bowel or bladder habits, or if the treatments aren't helping."

12. Follow-Up

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"I'll arrange a referral to gynaecology for further assessment. We can also review you here in a few weeks to see how you're getting on with the initial treatment."

Premenstrual Syndrome (PMS)

Setting: GP Surgery
Role: FY2 Doctor
Patient: Adult Woman
Presenting Complaint: Cyclical mood and physical symptoms in luteal phase

1. Introduction
"Good morning. I am Dr [Name], one of the doctors here today. Could you please confirm your full name and date of birth for me?"
"What brings you in today?"
(Patient describes mood changes, irritability, bloating before periods)

2. Clarify Presenting Complaint
"Thank you for sharing that. Let me ask a few more questions to understand this better."

Symptom pattern:
"When do you notice these symptoms starting in relation to your period?"
"Do they go away once your period starts or shortly after?"
"How many days do they typically last?"
"Are they the same every month?"

Physical symptoms:
"Do you experience any bloating, breast tenderness, or headaches?"
"Any changes in appetite or food cravings?"
"Any tiredness or difficulty sleeping?"

Mood symptoms:
"Do you feel more irritable, anxious, or low during this time?"
"Any difficulty concentrating?"
"Have the symptoms affected your relationships or work?"

3. Screening for PMDD
"For some women, these symptoms can be severe enough to significantly affect daily life. This is sometimes called **Premenstrual Dysphoric Disorder (PMDD)**."
"Would you say these symptoms are severely impacting your ability to function - at work, at home, or in relationships?"

4. Background
Menstrual history: "Are your periods regular? Any changes recently?"
Past medical history: "Any history of depression, anxiety, or other mental health conditions?"
Medications: "Any current medications?"
Social: "How is your sleep? Any major stressors at the moment?"

5. ICE
Ideas: "What do you think might be causing these symptoms?"
Concerns: "Is there anything you're particularly worried about?"
Expectations: "What were you hoping we could do to help?"

6. Diagnosis and Explanation
"From what you've described, it sounds like you're experiencing **premenstrual syndrome**, or PMS."
Explain:
"PMS is caused by the hormonal changes that happen in the second half of your menstrual cycle - after ovulation and before your period. These changes affect brain chemicals like serotonin, which can cause mood swings, irritability, and physical symptoms like bloating."
"It's very common - affecting around 3 in 4 women to some degree - and there's a lot we can do to help."

7. Management Plan
Symptom Diary:
"I'd recommend keeping a symptom diary for 2–3 cycles. This helps us confirm the pattern and measure how well treatments are working."
First-Line: Lifestyle Changes:
"Lifestyle measures can make a real difference:"

- **Regular exercise** - "Helps with mood and physical symptoms."
- **Healthy diet** - "Reduce salt (helps bloating), caffeine, and alcohol."
- **Good sleep hygiene**
- **Stress management** - "Relaxation techniques, mindfulness."

Second-Line: Cognitive Behavioural Therapy (CBT):
"CBT specifically designed for PMS can be very helpful, especially for the mood symptoms. It teaches techniques to manage the emotional changes."

Third-Line: Medical Treatment:
Combined oral contraceptive pill (COCP): "Taken continuously can suppress the cycle and reduce symptoms."
SSRIs (e.g., sertraline, fluoxetine): "Reserved for severe PMS or PMDD. Can be taken continuously or just during the luteal phase."

Other options:

- Vitamin B6 supplements (up to 100mg daily)
- Evening primrose oil - "Some women try this, though the evidence isn't strong."

8. Safety Netting
"If your symptoms are severe, affecting your relationships or ability to work, or if you're having thoughts of self-harm, please come back urgently or seek immediate help."
"If your symptoms don't improve with these measures, we can consider referral to a specialist."

9. Follow-Up
"Let's review in 2–3 months once you've tried these approaches and kept your diary. We can then decide if any further treatment is needed."

10. Leaflet
"I'll give you a leaflet that explains PMS, self-care tips, lifestyle advice, and treatment options."

Premature Ovarian Insufficiency (POI)

Setting: Gynaecology Clinic
Role: FY2 Doctor
Patient: Young Adult Woman
Context: Follow-up to discuss hormone test results confirming premature ovarian insufficiency

1. 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?"

2. Focused History
A. Menstrual History:
"When did your periods first start?"
"When did you last have a period?"
"How long have your periods been absent?"

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:
"Has anyone in your family had early menopause or ovarian problems?" *(May reveal: Mother had menopause at 35)*
"Any autoimmune or genetic conditions?"

E. Risk Screening (Brief):
"Do you smoke?"
"How is your calcium and vitamin D intake?"
"Any family history of osteoporosis or cardiovascular disease?"

3. ICE
Idea: "Any idea what might be causing this?"
Concern: "Will I be able to have children?"
Expectation: "Can this be treated or reversed?"

4. 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."
Pause and allow time to process.

5. 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."

"I know this is a lot to take in, and I'm sorry to be giving you this news."

6. Management Plan

A. Further Investigations:

- **Pelvic ultrasound** - to assess ovaries and uterus
- **Prolactin levels** - if >1000 → refer; 500–1000 → repeat
- **TFTs** - to check thyroid function
- **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
- **Consider Daisy Network** - UK charity providing support for women with POI

C. Treatment - Hormone Replacement Therapy (HRT):

"We recommend HRT to replace the oestrogen your body is no longer producing. This will:"

- Relieve symptoms like hot flushes and vaginal dryness
- Protect your bones from osteoporosis
- Protect your heart health

"You should continue HRT at least until the average age of natural menopause - around 51."

"HRT is not a contraceptive - spontaneous ovulation can still occur in 5–10% of women with POI, so if you don't want to become pregnant, you'll need to use contraception as well."

D. Lifestyle Advice:

- Stop smoking
- Regular weight-bearing exercise
- Adequate calcium + vitamin D intake - "Vitamin D 10 micrograms (400 IU) daily is recommended."

E. Fertility Discussion:

"I know one of your main concerns is about having children."

"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."

"There is still a small chance of spontaneous pregnancy, so if you do want to become pregnant, don't give up hope - and the fertility team can advise."

7. 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."

8. Follow-Up

- Monitor response to HRT if started
- Repeat any bloods or imaging as needed under specialist guidance

9. Leaflet

"I'll give you an NHS leaflet on POI and HRT. There's also information about the Daisy Network - a charity that provides support for women with POI."

10. Closing

"I know this is difficult news. Please take your time to process it, and we're here to support you. Do you have any questions?"

Perimenopause / Menopause

Setting: GP Surgery
Role: FY2 Doctor
Patient: Middle-aged Woman
Context: Discussion of menopausal symptoms and hormone replacement therapy options

1. Introduction
"Good morning, I'm Dr [Name], one of the doctors here today. Could you please confirm your full name and date of birth 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?"
Validation: "That sounds really frustrating - these symptoms can really affect your quality of life, and I want you to know we have good options to help."

2. Clarify Presenting Complaint
"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. Explore Menopausal Symptoms
Vasomotor symptoms:
"Do you experience hot flushes - sudden feelings of heat spreading through your body?"
"Any night sweats? Do they disturb your sleep?"
Sleep and mood:
"How is your sleep overall?"
"Any changes in your mood - anxiety, low mood, difficulty concentrating?"
Urogenital symptoms:
"Any vaginal dryness or discomfort?"
"Any problems with bladder control or needing to pass urine more often?"
Menstrual changes:
"How are your periods - still regular, or becoming more irregular?"
"When was your last period?"

4. Background
Past medical history: "Any previous medical conditions - especially blood clots, breast cancer, heart disease, stroke?"
Medications: "Any regular medications?"
Family history: "Any family history of breast cancer, ovarian cancer, or blood clots?"
Social: "Do you smoke? How much alcohol do you drink?"

5. ICE
Ideas: "What do you think might be causing these symptoms?"
Concerns: "Is there anything you're particularly worried about?"
Expectations: "What were you hoping we could do to help?"

6. Diagnosis and Explanation
Perimenopause vs Menopause:

"Based on your symptoms, it sounds like you're going through the **perimenopause** - the transition phase before menopause."

	Perimenopause	Menopause
Periods	Becoming irregular	No periods for 12 months
Symptoms	Often starting	May continue or reduce
Diagnosis	Clinical (no blood test needed if >45)	Clinical

"Think of perimenopause as the transition zone - like autumn before winter arrives."

Explain the mechanism:
"During perimenopause, your ovaries produce less oestrogen. This hormonal change causes symptoms like hot flushes, night sweats, mood changes, and sleep problems."
"After menopause, your bones can gradually become weaker - this is because oestrogen helps protect bone strength."

7. Management Plan
Lifestyle Measures:
"Some things that can help include:"

- Regular exercise
- Healthy diet
- Reducing caffeine and alcohol
- Stress management
- Maintaining a healthy weight
- **Vitamin D 10 micrograms (400 IU) daily** is recommended for bone health

Cognitive Behavioural Therapy (CBT):
"Cognitive behavioural therapy (CBT) specifically designed for menopause can also help with hot flushes and night sweats - it can be used alongside HRT or instead of it if you'd prefer."

Hormone Replacement Therapy (HRT):
"The most effective treatment for your symptoms is HRT - hormone replacement therapy."
Benefits:

- Relieves hot flushes, night sweats, and mood symptoms
- Helps with vaginal dryness
- Protects your bones

Types of HRT:

- "If you still have your womb, you'll need combined HRT - oestrogen plus a progestogen to protect the womb lining."
- "If you've had a hysterectomy, you can use oestrogen-only HRT."

Routes:

- Tablets
- Patches
- Gels

"**Transdermal HRT (patches or gels)** is preferred if you have a BMI over 30 or other risk factors for blood clots, as it carries a lower clot risk than tablets."
Safety:
"HRT is unlikely to affect your life expectancy. When started around the time of menopause, the benefits usually outweigh the risks for most women."
"There's a small increased risk of breast cancer with long-term combined HRT use, but this risk is similar to other lifestyle factors like alcohol or being overweight."

Review:

"If we start you on HRT, I'll arrange a review in about **3 months** to see how you're getting on, and then we'll check in **annually** after that."
"There's no routine need to stop HRT at any particular age - we continue as long as the benefits outweigh any risks for you."

FY2 Scope Note: FY2 can initiate HRT for uncomplicated perimenopause after appropriate history-taking. For women with significant risk factors (personal/family history of VTE, breast cancer, cardiovascular disease, liver disease, or migraine with aura), discuss with senior or refer to menopause clinic before initiating.

Non-Hormonal Options:
"If HRT is not suitable AND CBT is not effective or available, non-hormonal medications like SSRIs/SNRIs (e.g., venlafaxine) may be considered for hot flushes - but they are not first-line treatment for vasomotor symptoms alone."

Emerging option (not yet NHS-funded): Fezolinetant (Veozah) is a new NK3 receptor antagonist licensed in the UK (MHRA December 2023) for moderate-severe vasomotor symptoms. Currently available on private prescription only. NICE evaluation is ongoing - as of 2025, it is NOT yet recommended for routine NHS use. Requires liver function monitoring.
"Some women try evening primrose oil, though the evidence for it isn't strong - it's unlikely to cause harm but may not help much."

Vaginal Symptoms:
"For vaginal dryness specifically, vaginal oestrogen can be used - this works locally and can be used alongside systemic HRT if needed. It can be continued long-term."

8. Safety Netting
"Please come back if your symptoms aren't improving, if you experience any unexpected vaginal bleeding, or if you have any concerns about side effects."
"If you develop any symptoms like severe headaches, chest pain, or leg swelling, seek urgent help."

9. Follow-Up
"We'll review in 3 months to see how you're getting on with treatment."

10. Leaflets and Resources
"I'll give you an NHS leaflet about menopause and HRT. The **British Menopause Society** website is also an excellent resource."

Atrophic Vaginitis

Setting: Primary Care
Role: FY2 Doctor
Patient: Postmenopausal Woman
Presenting Complaint: Vulvovaginal discomfort/itching

Introduction
Greet and confirm identity:
"Hello, I'm Dr [Name], one of the doctors here today. Could I confirm your full name and date of birth, please?"
"How can I help you today?"

History of Presenting Complaint
Clarify the main symptoms:

"Could you tell me a bit more about what's been troubling you?"
"Where exactly are you feeling the itching or discomfort - inside the vagina, or on the outside skin, or both?"
"How long have you been experiencing this?"
"Has this been affecting your daily life, like your sleep or comfort?"

Explore aggravating factors:
"Have you noticed if anything makes it worse - such as certain soaps, products, or activities?"

Associated symptoms:
- Vaginal dryness
- Burning sensation
- Bleeding or spotting
- Discharge
- Dyspareunia (pain during intercourse)

Sexual History (if relevant)
"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?"

Past Medical History
"Do you have any other health conditions, like diabetes or any immune system problems?"

Menopause details:
"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?"

Drug History
"Are you taking any regular medications at the moment?"
"Any known allergies?"

Specifically check:
- HRT use (current or previous)?
- Vaginal creams or pessaries already tried?

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?"

Examination
Verbalise findings:
- Thinned, fragile, slightly reddened vaginal skin
- No visible mass, discharge, or ulcers
- Findings consistent with **atrophic vaginitis**

Diagnosis and Explanation
"This is a very common condition - it affects around half of all postmenopausal women, and there's a lot we can do to help."
"It's not an infection or anything you've done wrong - it's simply a natural change that happens when oestrogen levels drop."
"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."
Modern terminology note: This condition is now often called **"Genitourinary Syndrome of Menopause (GSM)"** - this reflects that it can also affect the urinary system.

Management Plan
1. Lifestyle Advice
"Avoid using soaps, wipes, or any strong products in that area. Plain water is enough. Over-washing can actually make the dryness worse."
"Wear cotton underwear and avoid tight clothing that might cause irritation."

2. First-Line Treatment - Vaginal Oestrogen
"Vaginal oestrogen comes in different forms - creams, pessaries, tablets, gels, or a ring that stays in place for months. We can discuss which might suit you best."
"You can continue using vaginal oestrogen for as long as you need it - the symptoms often return if you stop, so many women use it long-term."
"Local vaginal oestrogen is very safe - very little is absorbed into the body, so it's even suitable for many women who can't take HRT tablets."

3. Non-Hormonal Alternatives (if oestrogen declined or contraindicated)
"You can also use vaginal moisturisers - products like Replens - which you apply regularly to keep the tissues hydrated."
"Water-based lubricants can help during intercourse."

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 any bleeding or new pain, please come back to see us."

6. Provide Leaflet
Information on menopause and vaginal atrophy (GSM).

7. Follow-Up
Review after **6–8 weeks** if needed.

Atrophic Vaginitis WITH Bleeding/Pain After Intercourse

Setting: Primary Care
Role: FY2 Doctor
Patient: Postmenopausal Woman
Presenting Complaint: Postcoital bleeding and dyspareunia

Introduction
Greet and confirm identity:
"Hello, I'm Dr [Name]. Could I confirm your full name and date of birth, please?"
"How can I help you today?"

History of Presenting Complaint
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?

Sexual activity context:
"Have you recently become sexually active again?"
"How long had it been before you resumed activity?"

Associated symptoms:

- Itching?
- Discharge?
- Urinary burning or frequency?

Red Flag Screening
"Have you had any bleeding not related to sex?"
"Any unexplained weight loss, appetite changes, or constant pelvic pain?"

Cervical screening check:
"When was your last cervical screening test?"

Past Medical History
Menopause:
"When did you go through menopause?"
"Did you ever take hormone replacement therapy?"

Chronic diseases:
Diabetes, cardiovascular disease?

Drug History
Current medications? Previous HRT use? Any known allergies?

ICE
"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?"

Examination
Speculum examination to inspect cervix:

- Ensure normal appearance, no suspicious lesions
- Check for contact bleeding

Vaginal atrophy signs:

- Pale, dry, fragile vaginal tissue
- Minor contact bleeding
- No visible mass

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Diagnosis and Explanation
"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."
"This is something I see regularly - you're definitely not alone."

Management Plan
1. Immediate Advice
"It might help to take a short break from intercourse to let things heal - and when you do resume, using plenty of lubricant can make a real difference."

2. Lubricants
"Using water-based or silicone-based lubricants during intercourse can help reduce dryness and friction."

3. Local Vaginal Oestrogen (if appropriate)
"We can offer a low-dose oestrogen cream or pessary if needed, to help thicken and moisturise the vaginal tissues again."
"This is very safe to use long-term."

Safety Netting - Strengthened for Postcoital Bleeding
"If the bleeding continues despite treatment, or if you notice any bleeding unrelated to intercourse, we need to arrange urgent investigations - postcoital bleeding that doesn't settle should always be checked to rule out any cervical problems."
Note: Persistent postcoital bleeding warrants consideration of referral to rule out cervical pathology.

Follow-Up
Review in **6–8 weeks** if symptoms persist.

Uterine Prolapse

Setting: Primary Care
Role: GP
Patient: Multiparous Woman
Presenting Complaint: Vaginal bulge/dragging sensation

Introduction
(Patient may say: "Doctor, it's a bit embarrassing...")
"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."

History of Presenting Complaint
Clarify the main symptom:
"Could you describe what you've been feeling? Some women describe it as a sensation of something 'coming down' - is that what you're experiencing?"

- When did you first notice this?
- Is it constant or does it come and go?
- Does it worsen with coughing, straining, or lifting?
- Does it improve when lying down?

Associated urinary symptoms:

- Stress incontinence (leaking with cough/sneeze)?
- Difficulty emptying the bladder completely?
- Urinary frequency or urgency?

Bowel symptoms:
- Constipation?
- Difficulty emptying bowels completely?
- Needing to support the vaginal wall to pass stool?

Other symptoms:
- Vaginal bleeding?
- Pain or discomfort during intercourse?

Risk Factor History
- Number of vaginal deliveries (especially prolonged labour, large babies, forceps)
- Heavy lifting (occupational or otherwise)
- Chronic cough (COPD, smoking)
- Chronic constipation
- Previous pelvic surgery
- Obesity

ICE
"What do you think might be causing this?"
"Is there anything particular that's worrying you?"
"What were you hoping we could do today?"

Examination
Verbalise findings:
- Visible prolapse at introitus
- Grade/stage of prolapse (if applicable)
- Stress test: cough and observe for incontinence

Diagnosis and Explanation
*"From what you have described and based on examination findings, this appears to be a **uterine prolapse**."*
"The muscles and tissues that act like a hammock supporting your womb have stretched or weakened over time, 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."

Management Plan
First-Line: Conservative Management
1. Pelvic Floor Muscle Training (PFMT):
*"Pelvic floor exercises need to be done for **at least 16 weeks**, ideally under supervision from a women's health physiotherapist, to see meaningful improvement."*
"I'll refer you for supervised training - they'll teach you the correct technique and monitor your progress."

2. Pessary - a supportive device:
"A pessary is a small, removable silicone ring inserted into the vagina to support the womb and vaginal walls. It can help reduce the symptoms and avoid surgery."
"If you're happy to try one, we can fit it here at the clinic and check it regularly - usually every 6 months."

3. Lifestyle Measures:
"Losing weight (if needed) can reduce pressure on the pelvic floor."
"Try to avoid heavy lifting where possible."

"Managing constipation with diet, fluids, and fibre can also help."

4. Vaginal Oestrogen:
"If there's dryness or discomfort, a local oestrogen cream can help strengthen the tissues."

Surgical Management (if conservative treatment fails)
"Surgery is an option if symptoms are severe and conservative treatments don't work."
"If surgery is ever considered, we'll discuss all the options carefully. There have been concerns about some mesh procedures, so any surgical decision would involve detailed counselling about risks and alternatives."
"Surgery may involve lifting and supporting the womb, or in some cases removing the womb (hysterectomy) if that's appropriate for you."

Safety Netting
"If you notice sudden worsening of the prolapse, the tissue becoming painful or ulcerated, difficulty passing urine, or any bleeding, please seek immediate medical attention."

Leaflet and Follow-Up
"I'll give you a leaflet explaining uterine prolapse, pelvic floor exercises, and treatment options."
"We'll plan a review in 4–6 weeks to check how you're getting on."

Stress Incontinence

Setting: Urology Outpatient / Primary Care
Role: FY2 Doctor
Patient: Middle-aged Woman (Multiparous)
Presenting Complaint: Urinary leakage on exertion and pelvic heaviness

Introduction
"Good morning, I'm Dr [Name], one of the doctors working here today. Could you please confirm your full name and date of birth?"
(Smile warmly.)
"Nice to meet you. How can I help you today?"
(Patient says: "Doctor... it's a bit embarrassing... I leak urine when I cough or sneeze.")
"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."

History of Presenting Complaint
Clarify the leakage:
"Could you tell me when you tend to leak urine - is it mostly when coughing, sneezing, laughing, or lifting?"
"Is the leakage constant, or only during those activities?"
"How long has this been happening?"
"How much do you leak - just a few drops, or more?"

Associated symptoms:
- Any urgency (sudden rush to go)?
- Any difficulty starting or stopping urine?
- Any blood in urine?
- Any burning or pain when passing urine?

Prolapse symptoms:
"Have you noticed anything coming down or bulging from below?"
"Any sensation of heaviness or dragging in the pelvis?"

Bowel symptoms:
"Any issues with constipation?"

Risk Factor History
- Number of vaginal deliveries (and any complications - forceps, prolonged labour)
- Heavy lifting (occupational)
- Chronic cough or smoking
- Previous pelvic surgery
- BMI

MAFTOSA
- Medical history: Diabetes, COPD, neurological conditions?
- Allergies
- Family history
- Travel
- Occupation
- Smoking/Alcohol
- Activity levels

Impact on Life
"How much is this leaking affecting your daily activities, work, social life, or relationships?"

ICE
"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.")

Examination
"I would like to perform a gentle physical examination to better understand what's happening. This will involve checking your abdomen and doing a pelvic examination. A female chaperone will be present to support you. Would that be okay with you?"
Observations: BP, HR, RR, temperature

Focused examination:
- General physical exam
- BMI measurement
- Abdominal palpation (rule out bladder mass or tenderness)
- Pelvic inspection (checking for prolapse)
- **Stress test:** Ask patient to cough while observing for urine leakage

Urine dipstick: Rule out infection, haematuria

Provisional Diagnosis
*"From what you've told me and based on the examination, this appears to be **stress urinary incontinence**."*

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."
"Does that explanation make sense so far?"

Management

1. Bladder Diary

"I'd like you to keep a bladder diary for 3 days - noting what you drink, how often you pass urine, and when leaks happen. This helps us understand your pattern better."

2. Investigations

- **Urine dipstick** (rule out infection) - essential
- **Urine microscopy and culture** if infection suspected
- Bladder scan for post-void residual volume (if indicated)

3. Lifestyle Changes

"Reduce caffeine intake - caffeine can irritate the bladder."
"Maintain a normal fluid intake - not too much, not too little (about 1.5–2 litres per day)."
"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."

4. Pelvic Floor Muscle Training (PFMT) - First-Line

"We will arrange a referral for supervised pelvic floor muscle training with a women's health physiotherapist."
"The exercises need to include at least 8 strong squeezes, 3 times a day, for a minimum of 3 months. They'll teach you the correct technique."

5. Medication (if conservative measures fail)

Duloxetine - Second-Line, Usually Specialist-Initiated:

"If physiotherapy does not help enough and you prefer not to have surgery, we can consider a medication called duloxetine."
"It helps tighten the muscles around the bladder - though it can cause side effects like feeling sick or a dry mouth, so we'd monitor you closely."

Important clinical notes:

- Duloxetine is NOT first-line treatment for stress incontinence
- Usually initiated in secondary care / following specialist advice
- Has high discontinuation rates due to side effects (nausea, dry mouth, dizziness)
- Should be offered as alternative to surgery only when surgery unsuitable or patient declines

FY2 Scope Note: FY2 should arrange PFMT referral and lifestyle advice as first-line. If PFMT fails after 3 months, discuss with senior or refer to urogynaecology before considering duloxetine initiation.

6. Surgical Referral (if needed)

"If exercises and other treatments don't help enough, there are surgical options - but we'd have a detailed discussion about the different procedures and their risks before making any decisions."
"I can refer you to a urogynaecologist (a women's health specialist) to discuss options."

7. Containment Products

"You can use absorbent pads temporarily, but they are not the long-term solution."

Safety Netting

"If you notice blood in urine, fever, severe pelvic pain, or sudden worsening of symptoms, please seek immediate medical attention."

Leaflet and Follow-Up

"I'll give you a leaflet about stress incontinence, pelvic floor exercises, and lifestyle changes."
"Would you like me to arrange a physiotherapist appointment for you today?"
"I'd like to review you in 4–6 weeks to check on your progress with exercises and symptom improvement."

Stress Incontinence with Uterine Prolapse

Setting: Primary Care
Role: FY2 Doctor
Patient: Middle-aged Multiparous Woman
Presenting Complaint: Combined urinary symptoms and pelvic organ prolapse

Introduction
"Good morning, I'm Dr [Name], one of the doctors working here today. Could you please confirm your full name and date of birth?"
(Smile warmly.)
"Nice to meet you. How can I help you today?"
(Patient says she has feeling of urine leakage and something coming down, feels ashamed.)
"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."

History of Presenting Complaint
Urinary symptoms:
"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?"

Prolapse symptoms:
"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 for long periods or lifting heavy things?"

Associated symptoms:
- Difficulty emptying bladder?
- Constipation or difficulty with bowels?
- Discomfort during intercourse?

Risk Factor History
- Pregnancies and deliveries (number, type, complications)
- Heavy lifting
- Chronic cough/smoking
- Constipation
- Previous pelvic surgery

Impact on Life
"How much are these symptoms affecting your daily activities, work, and relationships?"

ICE
"What do you think might be happening?"
"Is there anything particular you're worried about?"
"What were you hoping we could do today?"

Examination
"I would like to perform a gentle examination, including checking your abdomen and pelvic area. I'll have a female chaperone present. Would that be okay with you?"
Examination findings:
- Abdominal palpation
- Pelvic inspection: visible prolapse at introitus
- Stress test: cough and observe for urine leakage
- Assess degree of prolapse

Urine dipstick: Rule out infection

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**."*

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 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."
"Does that explanation make sense so far?"

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."
"Treat any constipation."

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 for the incontinence - and needs to continue for **at least 16 weeks** for the prolapse to see meaningful improvement."*

Pessary (for prolapse)
"A pessary is a supportive device - a small, removable silicone ring - that can help support the womb and reduce your symptoms."

Containment Products
"You can use absorbent pads temporarily, but they are not the long-term solution."

Medical Management (if conservative fails)
"If exercises do not improve symptoms enough, we can discuss medications:"
- Duloxetine for stress incontinence component
- Vaginal oestrogen for tissue strength

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Surgical Referral (if needed)
"If symptoms remain troublesome despite exercises and lifestyle changes, I can refer you to a urogynaecologist for further options."

Investigations
- Urine dipstick
- Urine microscopy and culture (if infection suspected)
- Bladder scan (post-void residual assessment if indicated)

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."

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."

Urge Incontinence (Overactive Bladder Syndrome)

Setting: Primary Care
Role: FY2 Doctor
Patient: Middle-aged Woman
Presenting Complaint: Urinary urgency with urge incontinence

Introduction
"Good morning, I'm Dr [Name], one of the doctors working here today. Could you kindly confirm your full name and date of birth?"
(Smile, build rapport.)
"Thank you. How can I help you today?"
(Patient says: "I have an embarrassing problem.")
"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?"

History of Presenting Complaint
(Patient says: "I need to rush to the toilet. If I don't make it in time, I leak. Please help me stop leaking.")

Clarify urgency symptoms:
"When you get the urge to pass urine, how quickly do you need to get to the toilet?"
"Do you sometimes leak before you can get there?"
"How often does this happen - once a day, several times, more?"

Pattern:
- Is it worse at certain times of day?
- Does it happen at night (nocturia)?
- Any specific triggers?

Exclude other causes:
"Do you also leak when you cough, sneeze, or laugh?" (stress component)
"Any burning or pain when you pass urine?" (infection)
"Any blood in urine?"
"Any fever?"

Fluid and Caffeine Intake
"What do you normally drink during the day - water, tea, coffee, fizzy drinks?"
"How much roughly per day?"
(Note: High caffeine intake is a common contributor)

Past Medical History
- Diabetes
- Neurological conditions (MS, stroke, Parkinson's)
- Previous pelvic surgery
- Chronic constipation

Drug History
Current medications? (Some can worsen urgency - diuretics, etc.)
Allergies?

MAFTOSA/Lifestyle
- Occupation (access to toilets?)
- Smoking
- Alcohol
- BMI

Impact on Life
"How much is this affecting your work, social life, or confidence?"

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

Examination
"I would like to perform a gentle examination, including checking your abdomen and pelvic area. I'll have a female chaperone present. Would that be okay with you?"
Observations: BP, HR, temperature, RR
Focused examination:
- General physical exam
- Abdominal palpation
- BMI calculation
- Pelvic examination (if indicated): Look for prolapse, check for stress incontinence
- **Urine dipstick:** Rule out infection (essential)

Provisional Diagnosis
*"From what you've told me and based on the examination, this appears to be **urge incontinence**, also known as **overactive bladder syndrome**."*

Explanation
"Your bladder muscle is a bit overenthusiastic - it contracts before the bladder is full, creating that sudden urgency and sometimes leaking before you can reach the toilet."
"Overactive bladder simply means your bladder is becoming a little too sensitive."
"It's a common condition and can be very successfully managed."
"Is that clear so far? Please ask me anything if you'd like."

Management Plan

1. Investigations

- Urine dipstick (essential - rule out UTI)
- Routine blood tests if indicated (FBC, U&E, glucose)

2. Bladder Diary

"I'd like you to keep a bladder diary for 3 days - noting what you drink, how often you pass urine, and when you experience urgency or leakage."

3. Lifestyle Modifications

"Gradually reduce caffeine intake - try to cut tea and 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 ideal."
"If BMI is over 30, weight loss can significantly improve symptoms."
"Avoid smoking - it can worsen bladder irritation."

4. First-Line: Bladder Training

*"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 programme usually takes **at least 6 weeks** to see improvement."*
"It's about gradually extending the time between toilet visits."
"Pelvic floor exercises can also help support your bladder better."

5. Medications (if conservative measures fail)

"If symptoms don't improve after bladder retraining, we can consider medications:"
Antimuscarinics (e.g., oxybutynin, solifenacin, tolterodine):
"These help calm the bladder muscle."
Caution for elderly patients (≥65): *"Some of these can cause confusion, memory problems, dry mouth, and constipation, especially in older patients. We need to weigh up the benefits carefully."*

FY2 Scope Note: In patients ≥65, discuss antimuscarinic choice with senior before prescribing due to cognitive side effect risk. Immediate-release oxybutynin should be avoided in the elderly. Consider mirabegron as alternative or refer to continence service.

Mirabegron:

"An alternative if antimuscarinics are unsuitable or cause side effects."
"We'll discuss side effects before starting any medication."

6. Specialist Referral (if needed)

"If needed, I can refer you to a urology or urogynaecology specialist for further assessment, including urodynamic studies."

Safety Netting

"Please seek urgent review if you develop:"

- Blood in urine
- Fever or chills
- Severe back or pelvic pain
- Numbness or weakness in the legs
- Sudden worsening of symptoms

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."

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Mixed Urinary Incontinence

Setting: Primary Care
Role: GP
Patient: Middle-aged Multiparous Woman
Presenting Complaint: Combined stress and urge urinary incontinence

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 date of birth?"
"Great - how can I help you today?"
(Patient: "I've been leaking urine for a few years now.")

History of Presenting Complaint - ODIPARA
O - Onset: *"When did this problem start?"*
D - Duration: *"Has it been ongoing continuously?"*
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
Incontinence characterisation:
"Do you leak when coughing, sneezing, laughing?" (Stress component)
"Do you leak before reaching the toilet when you get a sudden urge?" (Urge component)

Caffeine/fluid intake:
"How much water, coffee, tea, or fizzy drinks do you usually drink in a day?"

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
- Past medical history: Diabetes, neurological conditions?
- Menopausal status
- Obstetric history: Number of pregnancies, type of delivery, complications?

DESA
- Diet: Any recent changes?
- Exercise: Do you do pelvic floor exercises?
- Smoking
- Alcohol

Sexual History (if relevant)
"Are you currently sexually active?"

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
"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?"

Findings:
- Vitals: Normal
- Abdominal exam: Soft, no masses
- Pelvic exam: Normal findings / assess for prolapse
- Urine dipstick: To rule out infection

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."

Treating the Predominant Type First
"When you have both types of incontinence, we usually focus on whichever one bothers you most."
"Would you say the leaking with coughing is worse, or the sudden urgency?"

Investigations
- Urine dipstick and microscopy (rule out infection)
- Bloods: FBC, U&Es, glucose (if indicated)
- **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

Pelvic Floor Muscle Training (for stress component)
"8 contractions, 3 times per day, for at least 3 months."
"Continue if improving."

Bladder Training (for urge component)
"Delay urination slightly when urge occurs."

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"Gradually extend time between toilet visits."
"Establish 2–3 hourly toilet routine."
"This takes at least 6 weeks to see improvement."

If Conservative Measures Fail
- Refer to **continence service** or **urogynaecology**
- Consider urodynamic studies, cystoscopy if indicated

Medications
For stress incontinence: Duloxetine

For urge incontinence: Oxybutynin (immediate-release), Tolterodine, Solifenacin
(NICE recommends starting with non-drug treatment unless needed)

Safety Netting and 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 guidance on exercises and bladder training. You can also find helpful resources at the NHS website."

Student Note: Diagnostic Reasoning Summary
- Female 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 medications or referral if unresolved

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Postmenopausal Bleeding

Setting: Primary Care
Role: GP
Patient: Postmenopausal Woman (Menopause >10 years ago)
Presenting Complaint: Postmenopausal bleeding

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 date of birth, 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."

History of Presenting Complaint
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: *"What colour is the blood - bright red, brownish?"*

Focused History Taking
A. 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 go through 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 changes recently?
- Exercise: Level of daily physical activity?
- Smoking: Do you smoke?
- Alcohol: Do you consume alcohol?

F. 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?"*

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?"

Note: Postmenopausal bleeding means any vaginal bleeding that happens **more than 12 months after your periods stopped completely**.

Provisional Diagnosis and Explanation
"From what you have told me and based on your examination, my main concern is that postmenopausal bleeding must always be investigated seriously."
"One of the things we need to rule out is cancer of the womb lining - but I should reassure you that most causes of this bleeding are not cancer."
"Around 90% of cases turn out to be due to non-cancerous causes like thinning of the womb lining (atrophy) or small growths called polyps."

Management Plan
Urgent 2-Week Wait Referral to Gynaecology
"For women aged 55 and over with postmenopausal bleeding, we arrange an urgent referral to be seen within 2 weeks under a specialist fast-track pathway."
(For women under 55, we would still consider urgent referral.)

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
"If the tests do show anything concerning, the specialist team will discuss treatment options, which may include surgery, radiotherapy, chemotherapy, or hormone therapy depending on the findings."

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."

Reassurance:
"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."

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

Setting: Primary Care
Role: GP
Patient: Older Postmenopausal Woman (Long Duration Post-Menopause)
Presenting Complaint: Recurrent postmenopausal bleeding
Additional Context: Currently on HRT

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 date of birth, 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?"

History of Presenting Complaint
Open exploration:
"Can you describe the bleeding you've noticed?"
Clarify specifics:
Onset: *"When did you first notice the bleeding?"*
Frequency: *"You mentioned several 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?"*

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?"*

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."

Provisional Diagnosis - Breaking Bad News Approach
(Use BBN style: Calm, slow, kind)
"From what you have shared and considering that you had your menopause many years ago, bleeding at this stage always needs to be investigated carefully."
"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.)

HRT Consideration
"You've been on HRT for a while - depending on the type, this can slightly increase the risk of changes in the womb lining. The specialist will review your HRT regimen."

Per BMS Guidance: Bleeding on HRT beyond 6 months of initiation, or any bleeding after being well-established on HRT, warrants investigation.

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
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."

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."

Closing
Emotional reassurance:
"I can understand that this is worrying. Please remember we are acting quickly to get the right help and care for you."

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 This Case Uses Breaking Bad News Approach
Although **both previous cases present with postmenopausal bleeding**, the clinical context makes the later more suspicious for cancer:

Factor	Case 1	Case 2
Time since menopause	~10 years	15–20+ years
Bleeding pattern	Single or few episodes	Recurrent fresh episodes
HRT use	Previous	Current prolonged use
Age group	Mid-60s	Older (70+)
Clinical approach	Reassure + refer	BBN approach + refer

Key points:

- Bleeding **years** after menopause is always abnormal
- **Longer time gap** (>15 years) and **recurrent fresh episodes** strongly raise suspicion for malignancy
- **Persistent HRT exposure** without withdrawal bleeding increases risk of endometrial hyperplasia and cancer
- **Advancing age** further adds to risk - endometrial cancer is more common after age 60–65

Therefore:

- In first case: Acknowledge bleeding is abnormal but can reassure that atrophy or polyps are common
- In second case: Must gently prepare the patient that cancer is a real possibility and urgently explain next steps

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Suspected Ovarian Cancer

Setting: Primary Care
Role: FY2 Doctor
Patient: Older Woman (≥50 years)
Presenting Complaint: Persistent abdominal bloating with constitutional symptoms
Additional Context: Relative concerned about changes

Introduction
Greet and confirm full name and date of birth.
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."

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?"

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"Any recent weight loss without trying?"
"Do you feel full more quickly than you used to when eating?" (early satiety)

Systemic screening:
Fatigue? Fever? Night sweats? Loss of energy?

Focused Risk Factor History
Family history:
"Has anyone in your family had cancer? What type?"
(If mother had breast cancer - important red flag for BRCA)
"You mentioned your mother had breast cancer. This is important because some families carry genes that increase the risk of both breast and ovarian cancer. The specialist team may discuss genetic testing with you."

Gynaecological history:
"When was your last period?"
"Have you ever used HRT?"
"Any past pregnancies or miscarriages?"

Lifestyle:
Smoking? Alcohol? Activity levels?

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?"*

Effect on Life
"Is this affecting your eating, walking, sleeping, or doing daily activities?"
"Has it impacted your mood or relationships?"

Examination
Explain need for examination:
"To understand better what's causing your symptoms, I'd like to examine your abdomen."
"The examination should not be painful but might be a little uncomfortable."
"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 to the mid-thigh, keeping your undergarments on."

Positioning:
"I'll ask you to lie flat on your back, with a chaperone present."

Gain consent:
"Are you happy for me to proceed?"
Examination findings to look for:

- Abdominal distension
- Ascites (shifting dullness, fluid thrill)
- Palpable pelvic or abdominal mass
- Signs of weight loss, cachexia

Provisional Diagnosis - Breaking Bad News Approach

"Based on your symptoms, examination findings, and family history, I'm concerned about a condition that can affect the ovaries."
"I need to be honest with you - one of the things we need to rule out is ovarian cancer."
(Pause - allow patient to process)

IBS Caution
"If you're over 50 and these symptoms are new - bloating, changes in bowel habit, feeling full quickly - it's very unusual for irritable bowel syndrome to appear for the first time at your age. So we take these symptoms seriously and investigate."

Explanation
"There is a condition called ovarian cancer that can sometimes present like this - bloating, discomfort, and changes in the abdomen."
"We don't have a diagnosis yet - these tests will help us understand what's happening."
"It's important to investigate early, so that if there is anything serious, we can treat it as soon as possible."

Management Plan
Investigations - Stepwise Approach

Step 1 - Blood Test (CA-125):
"First, I'll arrange a blood test called CA-125, which can be raised with ovarian problems."

Step 2 - Ultrasound (if CA-125 ≥35 IU/ml):
"If that's elevated - above 35 - we'll arrange an ultrasound scan of your tummy and pelvis."

Other blood tests:
- Full blood count
- Renal and liver function

Urgent Referral
Two-week cancer pathway referral to Gynaecology:
- If CA-125 is raised AND ultrasound shows concerning features
- If ascites and/or pelvic/abdominal mass found on examination (immediate 2WW referral - do not wait for investigations)

What Specialists Might Do Next
- Transvaginal ultrasound
- CT scan abdomen/pelvis
- Biopsy (sample tissue test)
- MDT (multidisciplinary team) discussion

Note: Hysteroscopy is for uterine pathology, not ovarian assessment.

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."

Follow-Up Plan
- Arrange blood tests today
- Arrange ultrasound if indicated
- Book urgent 2-week referral if criteria met
- Offer review appointment once results are back

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

Setting: Primary Care
Role: GP
Patient: Older Woman with history of chronic vulval condition (e.g., lichen sclerosus)
Presenting Complaint: New vulval lump with concerning features

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 date of birth?"
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."

Focused History
Characterise the lump:
"Could you tell me more about the lump you've noticed?"
- When did you first notice it?
- Has it changed in size?
- Is it painful?
- Any itching, burning, or bleeding?
- Any discharge or ulceration?

Associated symptoms:
- Any other lumps or skin changes in the area?
- Any pain during urination or intercourse?
- Any weight loss, fatigue, or feeling unwell?

Risk factor history:
"Have you had any skin conditions affecting that area before?"
(Patient mentions lichen sclerosus - this increases vulval cancer risk)
- Smoking history?
- Any family history of cancers?
- Any previous biopsies or treatments to the vulval area?

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

Clinical Examination

"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."
"A chaperone will be present, and I'll ensure your privacy."
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 (inguinal) if appropriate

No speculum or bimanual unless explicitly instructed in the station.

Provisional Diagnosis - Breaking Bad News Approach
"Based on everything we've discussed and what I've seen, I am concerned about a serious condition called vulval cancer - this is a cancer that can develop on the skin of the genital area, especially in areas affected by conditions like lichen sclerosus."
(Pause, allow patient to process.)
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."

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 (arranged by specialist team)
- Biopsy (sample of the lump) - essential for diagnosis
- Blood tests (routine bloods)
- 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 sclerosus 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 Netting
"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.

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 (Safeguarding)

Setting: Primary Care
Role: FY2 Doctor
Patient: Adolescent Female (<16 years)
Presenting Complaint: Vulval lesion
Special Considerations: Safeguarding concerns - relationship with adult in position of trust

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 date of birth?"
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?"

Focused Symptom History
Clarify the lump:
"Could you tell me more about the lump you've noticed?"
- Appearance: colour, 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?"

Systemic symptoms:
"Any fever, general tiredness, swollen glands, or flu-like symptoms?"

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?"* (If adult - safeguarding trigger)
  - *"What is his relationship to you?"* (If position of trust e.g., teacher, counsellor - safeguarding trigger)
  - *"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:

- Partner is adult (e.g., 35 years old)
- Partner is in position of trust (e.g., school counsellor, teacher)
- Age under 16

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

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

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.)

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 - Podophyllotoxin (Warticon):

"The cream or solution is applied twice daily for 3 days, then you have 4 days off. This cycle is repeated for up to 4 weeks maximum. If warts haven't cleared by then, the GUM clinic will discuss other options."

Alternative - Imiquimod:

"If podophyllotoxin doesn't work well enough, there's another cream called imiquimod that works differently - it helps your immune system fight the virus."

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."

Hygiene advice:

"Keep the area clean and dry. Avoid using any perfumed soaps or products."

B. Safeguarding Action - MANDATORY

This relationship is illegal and must be reported.

"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?"

C. Partner Notification - Reframed for Safeguarding Context
In abuse context, the patient should NOT be made responsible for "partner notification."
"The adults involved in your care will make sure the person who had contact with you is dealt with appropriately."

D. Preventing Future Infection
"Always use condoms during sexual contact, even when symptoms are not visible. This helps protect you from future infections."

HPV Vaccine:
"The HPV vaccine can help protect you against other strains in the future. We can discuss this with you."

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."

Follow-Up
- Follow-up GP review after initial specialist assessment
- Counsellor referral if patient agrees
- Ongoing safeguarding support

Missed Cervical Screening

Setting: Primary Care
Role: FY2 Doctor
Patient: Woman of Screening Age (25-64)
Context: Opportunistic discussion about overdue cervical screening

Introduction
"Good morning, I'm Dr [Name], one of the doctors working today. Could you please confirm your full name and date of birth?"
"Lovely to meet you. I see you've come in today for your follow-up appointment."
"Before we move ahead, I noticed something in your general health record that I wanted to check with you - is that alright?"

Clarify the Issue
"I noticed it's been some time since your last cervical screening. Can I ask if there was any particular reason it's been delayed?"
(Patient reply: "I've just been very busy.")

Acknowledge and empathise:
"That's completely understandable - life gets hectic sometimes. Thank you for letting me know."

Assess Risk Factors
Health and Sexual History Assessment:
- Any past cervical screening tests?
- 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?

Explore Understanding
"Could I ask - what do you know about why we recommend cervical screening? Have you heard about what it involves?"

If limited understanding - explain in simple, reassuring language:
"Cervical screening first tests for HPV - a common virus that can cause cell changes. If HPV is found, then the cells are examined more closely."
"It helps pick up early, treatable changes long before symptoms occur."
"Almost all cervical cancers are caused by HPV, and screening helps us catch any problems long before they could ever become cancer."

NHS Cervical Screening Programme (July 2025)
Key Changes:
1. **HPV-negative women aged 25-49:** Now screened every **5 years** (previously 3 years)
2. **Women aged 50-64:** Continue every **5 years**
3. **If HPV is found:** More frequent monitoring

Eligibility Criteria for 5-Year Recall:
- Applies ONLY to tests taken **on or after 1 July 2025**
- Must test HPV-negative AND have **no HPV-positive result within the last 5 years**
- If HPV-negative NOW but had HPV+ within last 5 years → remain on **3-year recall** until confirmed negative again
- Previous test due dates are NOT changed retrospectively
- Those with ongoing colposcopy follow-up remain on their current surveillance schedule

Updated explanation:
"For women aged 25-49 who test negative for HPV from July 2025 onwards, the screening interval has been extended to 5 years. This is because the HPV test is so good at detecting risk - if you're negative, your chance of developing cervical cancer in the next 10 years is extremely low."
"However, if you've had a positive HPV result in the last 5 years, we'll keep you on more frequent screening until we're sure the virus has cleared."

Self-sampling option:
"We're also starting to offer self-sampling kits for people who find it difficult to attend - you can take the sample yourself at home or in the clinic."

Inclusive note:
"This applies to anyone who has a cervix, including trans men."

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 screening doesn't mean you're immediately at risk, but we want to catch any changes early if they ever happen."

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."

Safety Netting
"If you notice any unusual symptoms - like bleeding between periods, bleeding after sex, unusual discharge, or persistent pelvic pain - please let us know immediately, even if your last screening was normal."

Closing
"Thank you for discussing this with me today. Is there anything else you'd like me to help you with?"

Cervical Screening Result - HPV Positive with Normal Cytology

Setting: Primary Care (Telephone Consultation)
Role: FY2 Doctor
Patient: Young Woman
Context: Discussing cervical screening results - HPV positive but cytology normal
NOTE: Under NHS HPV Primary Screening (implemented December 2019), cytology is ONLY performed if the HPV test is POSITIVE. If HPV is negative, the sample is NOT examined cytologically - the report simply says "HPV Negative" and the patient returns to routine recall.

Introduction
Greet warmly.
Confirm patient's full name, date of birth, 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?"

Clarify Today's Call

"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.)

Focused History
A. Focused Symptom Review:

- Any unusual vaginal bleeding (outside of periods)?
- Any bleeding after sexual intercourse?
- Any abnormal vaginal discharge (colour, smell)?
- Any pain during or after sexual activity?
- Any lower back pain?
- Urinary symptoms: Pain while urinating? Frequency?

B. Cancer Red Flag Screening (FLAWS):

- Fever
- Lumps
- Anorexia/Weight loss
- Night Sweats

C. Sexual Health History (signpost sensitively):
"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)?
- 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, Medications, Allergies
- Family History (especially cervical, breast, ovarian cancer)
- Travel/Occupation
- Social History - Smoking, Alcohol

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?"*

Clinical Examination
(Telephone station - verbalise what would be done if face-to-face)

- Vitals: BP, Pulse, Temp, BMI (if relevant)
- General Physical Examination
- Abdominal/Pelvic Examination if symptomatic

Result Disclosure
Start gently:
"Thank you for answering my questions. Let's go through your result carefully together."

Explain the findings:
"Your cervical screening test showed that you have HPV - the human papillomavirus. This is a very common virus that most people will have at some point in their lives."
*"Because HPV was found, the laboratory also looked at the cells from your cervix. The good news is that **your cells look completely normal**."*
"This means that although you have the virus, it hasn't caused any changes to your cervix."

Explanation
"Think of HPV like a common cold - most people's immune systems will clear it naturally within 1-2 years without any problems."
"Because your cells are normal but HPV is present, we will monitor you more closely to make sure the virus clears and doesn't cause any changes."

Follow-Up Plan (per NHS Cervical Screening Pathway)
HPV Positive + Cytology Normal = 12-month recall:
*"We will invite you back for another screening test in **12 months**."*
"At that test, we will check again for HPV:"

- *"If HPV has cleared → you'll return to routine screening"*
- *"If HPV is still present but cells are still normal → we'll repeat in another 12 months"*
- *"If HPV persists for 24 months with normal cytology → you'll be referred to colposcopy for a closer look"*

Note: If HPV genotyping shows type 16 or 18, some labs may recommend earlier referral to colposcopy even with normal cytology, as these types carry higher risk.

Address Concerns
Concern 1: "Does this mean I have cancer?"
"No - this does not mean you have cancer. Your cells are completely normal. HPV is just a virus, and most people who have it never develop any problems."

Concern 2: "Should I be worried about the HPV?"
"It's natural to feel worried when you hear 'HPV', but this is an incredibly common virus. About 80% of people will have HPV at some point. Most people clear it without ever knowing they had it."

Concern 3: Family history worry
"Your grandmother's history understandably raises concern."
"But cervical cancer develops slowly, usually over 10-15 years. Because we're monitoring you carefully, if any changes did develop, we would catch them early - long before they could become cancer."

Safety Netting
"If you notice any unusual symptoms before your next screening - bleeding between periods, bleeding after sex, unusual discharge, or pelvic pain - please contact us straight away."

HPV Vaccine
"Have you had the HPV vaccine? If not, or if you only had partial doses, it may still offer some protection against strains you haven't been exposed to yet."

Closing
"I hope that's reassured you. Your result is very common and doesn't mean anything bad. We'll keep a close eye on things with the 12-month follow-up."
"Do you have any other questions about your result or what to expect next?"
"Take care, and please don't hesitate to contact us if anything concerns you."

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Variation: Mild Dyskaryosis

Patient: Young Woman Context: Discussing cervical screening results — HPV positive AND cytology shows mild dyskaryosis

Why This Scenario Is Different
Under the current NHS HPV Primary Screening Pathway (implemented December 2019):
The sample is first tested for hrHPV
Cytology is ONLY performed if HPV is positive
Therefore, mild dyskaryosis will only ever be reported alongside a positive HPV result — you cannot have mild dyskaryosis with HPV negative under the current pathway
This is a key distinction from the old notes (GK's Notes 2.0), which described a scenario of mild dyskaryosis with HPV negative — that scenario is now outdated and would not occur under current screening protocols

Key Terminology:
"Mild dyskaryosis" = "Low-grade dyskaryosis" (cytological diagnosis — what the cells look like under a microscope)
CIN 1 = Cervical Intraepithelial Neoplasia Grade 1 (histological diagnosis — what the tissue looks like on biopsy at colposcopy)
Mild dyskaryosis on cytology often correlates with CIN 1 on biopsy, but not always

Result Disclosure
Start gently:
"Thank you for answering my questions. Let's go through your result carefully together."
Explain the findings:
"Your cervical screening test showed two things. First, you have HPV — the human papillomavirus. This is a very common virus that most people will have at some point in their lives."
"Second, because HPV was found, the laboratory also looked at the cells from your cervix, and they found some mild changes. These are called mild dyskaryosis or low-grade cell changes."
"I want to reassure you — these changes are NOT cancer. They are very minor changes in the appearance of the cells, and in many cases, they go back to normal on their own."

Explanation
"Think of it this way — the HPV virus can sometimes cause small changes in the cells of the cervix. These changes are the body's reaction to the virus, and in most women, the immune system clears the virus and the cells return to normal without any treatment."
"However, because we've found both HPV and mild cell changes, we need to take a closer look to make sure there's nothing more significant going on."

Management Plan: HPV Positive + Mild Dyskaryosis = Referral to Colposcopy
"The next step is to refer you for a procedure called colposcopy."

What Is Colposcopy?
"Colposcopy is a closer examination of your cervix. It's done in an outpatient clinic — you won't need to stay overnight."
"A doctor or specialist nurse will use a special magnifying instrument called a colposcope to look at your cervix more closely. They may apply a mild vinegar-like solution to highlight any areas of abnormal cells."
"If they see anything that needs further investigation, they may take a small tissue sample — called a biopsy — to examine under a microscope. This can be slightly uncomfortable but is usually very quick."

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Timeframe
"You should receive your colposcopy appointment within 6 weeks of your referral. The referral is arranged through the screening programme — you don't need to do anything extra."
Note for candidate: Low-grade dyskaryosis and borderline changes are referred on the standard 18-week pathway (offered appointment within 6 weeks). High-grade dyskaryosis (moderate/severe), ?invasive, and ?glandular neoplasia are referred on the 2-week wait urgent pathway.

What Happens at Colposcopy — Possible Outcomes
Explain the possible findings:
1. Normal Colposcopy (No Visible Abnormality)
"If the colposcopy looks completely normal and no biopsy is needed, you will be returned to community screening and monitored from there."
Returned to routine recall in primary care

2. Low-Grade Lesion / CIN 1 Confirmed on Biopsy
"If a small area of mild changes is confirmed — called CIN 1 — this is still not cancer. CIN 1 often resolves on its own."
Management: Usually observation rather than treatment
Follow-up at 12 months in colposcopy or community
If not resolved within 2 years of referral, a biopsy should be performed
Treatment is NOT usually offered at first visit for low-grade referrals

3. High-Grade Lesion / CIN 2 or CIN 3 Found
"In a small number of cases, colposcopy may find more significant changes — CIN 2 or CIN 3. These are still pre-cancerous, not cancer, but they are more likely to need treatment."
Treatment: Usually LLETZ (Large Loop Excision of the Transformation Zone)
Done as an outpatient under local anaesthetic
Removes the area of abnormal cells
Followed by Test of Cure at 6 months post-treatment (HPV test + cytology)

4. Rarely — Cancer Detected
"It is very rare for a screening test to find actual cancer, especially in someone who has been attending regular screening. But if that were the case, you would be referred to a specialist team for further management."

Comparison Table: HPV Positive + Normal Cytology vs HPV Positive + Mild Dyskaryosis

Feature	HPV +ve, Cytology Normal	HPV +ve, Mild Dyskaryosis
What it means	Virus present, no cell changes	Virus present, mild cell changes seen
Next step	Repeat screening in 12 months	Referral to colposcopy
Referral timeframe	N/A	Within 6 weeks (standard pathway)
If HPV clears at 12 months	Return to routine screening	N/A — already referred
If HPV persists at 24 months (normal cytology pathway)	Referral to colposcopy	N/A
Most likely outcome	Virus clears, back to routine	CIN 1 found → monitored → resolves

Address Concerns

Concern 1: "Does mild dyskaryosis mean I have cancer?"
"No — mild dyskaryosis is definitely not cancer. It means there are very minor changes in the cells of your cervix, most likely caused by the HPV virus. These changes are pre-cancerous at most, and the vast majority will either resolve on their own or be caught and treated long before they could ever become cancer."

Concern 2: "Why do I need colposcopy? Can't we just wait and see?"
"Because you have both HPV and cell changes, the national guidelines recommend that we take a closer look with colposcopy rather than just waiting. This is to make sure the changes are truly mild and there's nothing more significant underneath. It's a precautionary step — not an emergency."

Concern 3: "Will I need treatment?"
"Most women with mild dyskaryosis do NOT need treatment. The colposcopy is to look more closely. If the changes are confirmed as mild (CIN 1), they are usually just monitored because they tend to resolve on their own. Treatment — such as LLETZ — is only needed if the changes are more significant, like CIN 2 or CIN 3."

Concern 4: "Will this affect my fertility?"
"If treatment is needed — for example, a LLETZ procedure — this is a very small procedure that removes a tiny area of tissue from the cervix. While there is a very small increased risk of preterm birth in future pregnancies, the risk is low, and we would monitor any future pregnancy closely. But most women with mild dyskaryosis don't even need treatment."

Concern 5: Family history worry
"Your family history understandably raises concern. But it's important to know that cervical cancer develops very slowly — usually over 10 to 15 years. Because we've detected these changes early through screening, we can monitor and manage them long before they could ever become cancer. That's exactly what screening is designed to do."

Safety Netting
"While you wait for your colposcopy appointment, please contact us if you develop any of the following:"
Unusual vaginal bleeding (between periods)
Bleeding after sexual intercourse
Unusual vaginal discharge (change in colour, smell)
Pelvic pain
Any other concerns
"You should receive your colposcopy appointment letter within a few weeks. If you haven't heard anything within 6 weeks, please contact us so we can chase this up for you."

HPV Vaccine
"Have you had the HPV vaccine? Even if you already have HPV, the vaccine may still offer protection against other strains you haven't been exposed to yet."

Closing
"I know hearing about cell changes can be worrying, but I want to reassure you — mild dyskaryosis is very common, it is not cancer, and we have a clear plan in place to make sure you're looked after."
"The colposcopy is the next step, and you'll be in expert hands. Do you have any other questions about what to expect?"
"Take care, and please don't hesitate to contact us if anything concerns you before your appointment."

NHS HPV Primary Screening Pathway Summary

HPV Result	Cytology Result	Action
HPV Negative	Not performed	Return to routine screening (5 years for ages 25-49; 5 years for ages 50-64)
HPV Positive	Normal	12-month recall for repeat HPV test
HPV Positive	Borderline/Low-grade	Refer to colposcopy
HPV Positive	High-grade or worse	Urgent colposcopy referral
HPV Positive at 24 months	Normal	Refer to colposcopy

Antenatal Visit – HIV-Positive Woman

Setting: Antenatal Clinic
Patient: Pregnant Woman at Term
Test Results:

- **Viral load: Undetectable (<50 copies/mL)**
- **Ultrasound: Breech presentation, placenta high (normal), otherwise normal pregnancy**

Task: Discuss test results, delivery planning, baby's care, and address patient's concerns

Introduction & Consent

- Greet, confirm identity:
  "Hello, I'm Dr [Name], one of the doctors in the antenatal clinic. Can I confirm your name and age?"
- Confirm purpose:
  "You've come today for your 36-week check-up, to review your scan and blood results, and to discuss the delivery plan. Is that right?"
- Gain consent to proceed.

Focused History & ICE (Ideas, Concerns, Expectations)
A. Medical and Pregnancy History

- "How are you feeling at this stage of the pregnancy?"
- "Have you been taking your HIV medications every day without missing doses?"
- "Any recent infections, fevers, or other health concerns?"
- "Any history of complications in previous pregnancies?" (if multiparous)
- "Are you still under the care of the HIV specialist?"

B. Explore ICE

- "What are your thoughts about the delivery?"
- "Any concerns or worries about how the birth will go or about the baby's health?"
- "What are you hoping or expecting from today's discussion?"

Common Expressed Concerns at 36 Weeks:

1. *"Can I have a normal delivery even though the baby is breech?"*
2. *"I really want a normal delivery – is it possible?"*
3. *"Will my baby need antiviral medicine after birth?"*
4. *"Will my baby be born with HIV?"*

Clear Result Disclosure

- "Your blood tests are very reassuring. Your **HIV viral load is undetectable**, which is excellent – it means the virus is well controlled."

- "Your ultrasound shows that the baby is still in a **breech position** — meaning bottom-down instead of head-down. The placenta is high, which is normal."

Lay Explanation of the Condition
"HIV can be passed from mother to baby during pregnancy, delivery, or breastfeeding. But when someone is on treatment and their viral load is undetectable, the risk becomes **extremely low — less than 1 in 1000.**
The breech position means the baby is not in the usual head-down position for birth. This is a common variation but affects delivery options."

Structured Management Plan
A. Delivery Plan — Breech + HIV Considerations
FY2 Note: Delivery planning for HIV-positive women requires MDT involvement (obstetrics, HIV specialist, neonatology, midwife). The discussion below outlines the options, but final decisions are made jointly with the specialist team.

- **External Cephalic Version (ECV):**
  - "At 36–37 weeks, we can offer a procedure called **ECV**, where we try to gently turn the baby to head-down from the outside.
    If successful, and with your viral load undetectable, a **normal vaginal delivery is safe and recommended.**"
- **If ECV fails or is declined, or if breech persists:**
  - "A **planned cesarean section is recommended.** This is because vaginal breech birth carries higher risks for the baby — this applies whether or not you have HIV. The HIV itself is not the reason for cesarean, but the breech position is."
- **If baby turns to head-down and VL <50:**
  - "Proceed with vaginal delivery safely."
- **If VL ≥50 (not in this case but for completeness):**
  - "A planned cesarean would be recommended to reduce HIV transmission risk."

Feeding Plan

- **Formula feeding remains the recommendation** if you want to completely eliminate any risk of HIV transmission after birth.
- **BHIVA 2025 Update:** "However, we now know that some women with undetectable viral load may safely choose to breastfeed with appropriate support and monitoring. If this is something you're considering, we can discuss it further with the specialist team."

Baby's Postnatal Care

- **Neonatal HIV Prophylaxis:**
  - "Your baby will receive a short course of HIV medication after birth. Because your viral load is undetectable and you've been taking your medication as prescribed, this is classified as VERY LOW risk, so the course is now just **2 weeks (14 days)** rather than the 4 weeks we used to recommend." *(BHIVA 2025 update)*
- **HIV Testing for Baby:**
  - "Your baby will be tested at birth, then again at around 6 weeks and 3 months, to confirm HIV-negative status."

Ongoing Monitoring and Planning

- Book ECV for 36–37 weeks if appropriate.
- Book planned cesarean date if breech persists or if ECV fails.
- Confirm involvement of the paediatric team for the baby's medication and follow-up plan.

Addressing ICE — Detailed Responses to Concerns

"Can I have a normal delivery even though the baby is breech?"
Yes, you absolutely *can have a normal vaginal delivery*, as long as your **HIV viral load stays undetectable closer to delivery — below 50 copies per millilitre.** This is because when the virus is so low that it can't be detected, the chance of passing HIV to your baby during delivery becomes *extremely small – less than 1 in 1000.*
So the HIV itself does **not stop you from having a normal delivery.** The only thing that might change this plan is if your baby stays in a breech position — which is unrelated to HIV. If breech continues after 36 weeks, we usually suggest a C-section because vaginal delivery with a breech baby can be risky for the baby.
We'll check your baby's position later in pregnancy and guide you.

"I really want a normal delivery — is that possible?"
Yes, it's not only *acceptable* — it's actually the **recommended plan** when the virus is well controlled like yours.
As long as your HIV remains undetectable and your baby is head down, there is no reason for a cesarean based purely on HIV. If the baby remains breech near the end of pregnancy, we'll try to turn the baby with a safe procedure called **ECV (External Cephalic Version)**. If that works, we go ahead with a vaginal delivery.
If ECV doesn't work and the baby remains breech, then yes — a cesarean will be safer, but that's because of the baby's position, *not because of the HIV*. So we fully support your preference for a normal delivery — if it remains safe closer to the time.

"Will my baby need antiviral medicine after birth?"
Yes, your baby will need to take a **short course of HIV medication** after birth — now just **2 weeks (14 days)** for very low risk cases like yours.
This is a **precaution**. It doesn't mean we think your baby has HIV. Even when your viral load is undetectable, there's still a tiny chance — so the medicine gives the baby extra protection while their own immune system adjusts outside the womb. This is standard care for all babies born to mothers with HIV, regardless of delivery method or how low the virus is.

"Will my baby be born with HIV?"
Because your **HIV is well controlled** and your viral load is undetectable, the chance of your baby being born with HIV is **extremely low — less than 1 in 1000.** We are doing all the right things — you are taking your medication, we are monitoring your pregnancy, and the baby will get their short course of medicine after birth. We will also test your baby after birth — usually on the first day, then again at a few weeks and months — to confirm the baby's HIV status. The vast majority of babies in your situation are born completely healthy and HIV-negative.

Safety Netting
- "If you notice reduced fetal movements, bleeding, leaking fluid, fever, or feel unwell, contact the maternity unit immediately."
- "If you miss doses of your medication, let us know quickly so we can review the plan."
- "If your viral load result were to change unexpectedly or the baby develops other issues, we may need to adjust the delivery plan."

Follow-Up Plan
- **ECV offered now at 36–37 weeks** if the baby remains breech.
- If ECV fails or breech persists → **book planned cesarean at 39 weeks.**
- If baby turns → plan for **normal vaginal delivery.**
- Confirm paediatric referral for baby's **2-week ART prophylaxis** and **HIV testing after birth.**
- Continue HIV specialist follow-up and strict ART adherence.
- Weekly or biweekly visits until delivery if needed.

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Offer Leaflet & Final Check

- "Would you like a leaflet that explains HIV in pregnancy, delivery options, and baby's care?"
- "Is there anything else you'd like to discuss or go over again?"
- "You've done an amazing job keeping your viral load undetectable — that's the best thing you can do for yourself and your baby."

Note: If Cephalic Presentation at 36 Weeks:

- With **cephalic presentation and viral load <50 copies/mL**, a **normal vaginal delivery is safe and recommended** as per **NICE and BHIVA guidelines**.
- **No need for ECV or cesarean based on HIV alone.**
- Cesarean would only be considered if **obstetric complications arise** (e.g. fetal distress, labor complications, or maternal preference).
- The rest of the plan remains the same:
    - **Formula feeding recommended** (or supported breastfeeding with specialist input per BHIVA 2025)
    - Baby to receive **2 weeks of ART prophylaxis** (BHIVA 2025 update for very low risk)
    - Baby to undergo **HIV testing after birth**
    - Continue **ART without interruption** and regular HIV specialist follow-up

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Dyspareunia

Setting: Primary Care
Patient: Middle-aged Woman
Presenting Complaint: Dyspareunia (painful intercourse)

Introduction

- "Hello, my name is Dr. ___. I'm one of the doctors here today."
- "Can I confirm your name and age, please?"
- "I understand this is something very personal. Please be assured everything you say is confidential."
- "Is it okay if I ask a few questions to understand the issue better before we discuss the plan?"

History
Opening:

- "Could you tell me a little bit about what's been going on?"

Focused Pain History:

- "When did this start?" (→ *3 months*)
- "Is the pain at the entrance, or does it feel deeper inside?" (→ *Entrance*)
- "Does it happen immediately during penetration or later on?" (→ *Immediately*)
- "Does the pain settle after intercourse, or does it continue?" (→ *Settles afterwards*)
- "Do you experience this pain during anything else — like inserting a tampon or a smear test?" (→ *Yes, painful speculum during exam*)

Infection / Malignancy / Red Flag Screening (FLAWS):

- "Have you noticed any unusual vaginal discharge — change in colour, smell, or amount?" (→ *No*)
- "Any bleeding between periods or after intercourse?" (→ *No*)
- "Any lower tummy or pelvic pain at other times?" (→ *No*)
- "Any sores, lumps, or ulcers down below?" (→ *No*)
- "Any fever, weight loss, or generally feeling unwell?" (→ *No*)

Urinary and Bowel Check:
- "Any issues passing urine — burning, going more often, or discomfort?" (→ *No*)
- "Any bowel-related problems like constipation, diarrhoea, or pain?" (→ *No*)

Menstrual History:
- "Are your periods regular as usual?" (→ *Yes*)

Contraception and Sexual Health:
- "Are you using any contraception currently?" (→ *Husband had a vasectomy*)
- "I understand that, but just to clarify — do you use condoms or protection during intercourse?" → *"No, we don't use protection."* (→ **Positive finding**)
- "Have either you or your partner ever been tested for sexually transmitted infections in the recent past?" (→ *Check patient response – likely no*)

Psychosocial / Psychological:
- "I can see you've been taking sertraline for anxiety. How have you been feeling otherwise?"
- "Any particular stress or worries that have been affecting you recently?"

Sensitive Trauma Check (Mandatory in Dyspareunia):
- "Sometimes, previous difficult experiences — whether medical procedures, childbirth, or personal — can affect how the body responds. Is there anything like that which you feel might be relevant?" (→ *No*)

Past Medical/Surgical:
- "Any past surgeries, gynaecological treatments, or medical conditions?" (→ *No*)

ICE (Ideas, Concerns, Expectations)
- **Ideas:** "I'm wondering if it might be an infection or something hormonal."
- **Concerns:** "Is this something serious? Will this affect my relationship or health?"
- **Expectations:** "I want to know what's causing it and how to fix it."

Examination Findings (Given)
- **Speculum:** Healthy cervix, normal vaginal walls, **pain during insertion.**
- **Bimanual:** Uterus normal size, no adnexal tenderness or masses; **pelvic floor muscles felt tense.**
- **External:** No lesions, ulcers, discharge, or redness.

Diagnosis
- Most likely **pelvic floor muscle dysfunction (vaginismus)** — causing pain due to involuntary tightening of vaginal muscles during penetration.
- However, given the **lack of condom use**, it is clinically appropriate to consider and rule out **asymptomatic STIs** (e.g., **chlamydia, gonorrhoea, trichomonas)** as part of safe management.

Explanation
- "Firstly, from the examination, I can reassure you that there's no sign of infection, injury, or anything serious like cancer."
- "What I've noticed is that the muscles around the entrance to the vagina seem to be holding quite a lot of tension — almost like they're bracing themselves. This isn't something you're doing deliberately; it can happen without you even realising it."
- "This condition is called **pelvic floor dysfunction**, and it's actually very common. It doesn't mean anything dangerous, and the good news is — it's very treatable."

- "That being said, because you mentioned that you don't use protection, it would be sensible to do a simple check for silent infections — some STIs don't cause noticeable symptoms but can sometimes contribute to discomfort."
- "It's just to be thorough and safe."

Management
Reassurance:
- "There's no sign of anything serious."

First-Line Treatment:
- **Referral to specialist women's health physiotherapist:**
  - Pelvic floor relaxation exercises
  - Breathing techniques
  - Stepwise training using **vaginal dilators/trainers** if needed
  - "You should hear from the women's health physiotherapy team within [local waiting time] weeks"
- **Offer psychosexual counselling** if patient agrees — helpful especially if anxiety contributes.

STI Screening (Due to No Condom Use):
- Offer **vaginal swabs for chlamydia, gonorrhoea, and trichomonas**, as per local guidelines.
- Explain: "This is just a routine check because sometimes infections can be present without symptoms."

Self-Help Advice:
- Use lubricant generously during intimacy.
- Focus on non-penetrative intimacy until pain improves.
- Practice relaxation exercises and mindfulness to help muscle relaxation.

Medication Review:
- "Sertraline isn't causing this pain directly but can sometimes reduce libido and may affect arousal and lubrication. If it's bothering you, we can review it later — but the pain seems more related to muscle tightness."

When to Refer Further:
- If no improvement after physiotherapy and counselling → refer to **gynaecology or psychosexual medicine specialist.**

Safety Net:
- "Please come back if you develop any new symptoms like bleeding, abnormal discharge, ulcers, or if the pain starts happening even without intercourse."
- "If the STI tests come back positive, we'll discuss treatment and partner notification."

Follow-Up:
- Arrange to follow up in **4–6 weeks** to review:
  - Response to physiotherapy
  - STI test results
  - Overall progress

Leaflet/Resources:
- NHS leaflet on **Painful Sex (Dyspareunia)**
- Information on pelvic floor physiotherapy and STI screening

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Closure:
- "Does everything I've explained make sense so far?"
- "Would you like me to go over anything again before we finish?"

Post-Lumpectomy Lump

- **Setting:** Primary Care (Telephone)
- **Patient:** Adult female
- **Presenting complaint:** New swelling at recent surgical site, post-breast surgery

1. Introduction & Consent
- Confirm identity, confidentiality.
- Clarify limitation of telephone consult (cannot examine).
- Gain consent to proceed.

2. Presenting Complaint
- New lump/swelling at surgical site noticed 2 days ago.

3. History of Lump
- Onset: sudden or gradual?
- Size: stable, increasing?
- Associated: pain, tenderness, bruising (suggests haematoma); heaviness/tense swelling (seroma).
- Local signs: redness, warmth, pus, wound breakdown.
- Systemic: fever, malaise.
- Other lumps in either breast/axilla?

4. Surgical History
- Exact date/type of procedure.
- Post-op course: drains used, any previous fluid collection.
- Wound healing so far.

5. Past/Family/Social History
- Past medical problems, meds, allergies.
- Family history of breast/ovarian cancer.
- Reproductive history (nulliparous, age at menarche/menopause).
- Lifestyle: smoking, alcohol.

6. Red Flags (Rule out)
- Rapidly enlarging breast lump.
- Skin tethering, dimpling, peau d'orange.
- Nipple inversion, bloody discharge.
- Weight loss, bone pain, night sweats.
- Wound breakdown, purulent discharge, spreading redness.
- **Signs of post-operative sepsis** (fever, rigors, spreading cellulitis/erythema) — requires
- **immediate A&E/admission**, not clinic review.

7. ICE
- Ideas: "Could this mean the cancer is back?"
- Concerns: Fear of recurrence, delay in results.
- Expectations: Wants reassurance, timely review.

8. Explanation

- "I can hear you're worried, and that's completely understandable given everything you're going through. I want to reassure you that what you're describing sounds much more like a normal post-surgical change than anything sinister.
- After breast surgery, it is quite common to develop a swelling. This may be a **seroma** (a collection of clear fluid) or a **haematoma** (a collection of blood)."
- "A seroma usually feels like a tense, painless swelling; a haematoma tends to cause pain and bruising. Both are benign post-surgical issues."
- "They usually settle with time, but sometimes need aspiration or drainage."
- "A new lump shortly after surgery is usually fluid or blood collecting at the site — not the cancer coming back. But we'll make absolutely sure by getting the surgical team to see you."
- "Because you have had recent surgery, and your biopsy results are still pending, it's safest that the breast surgical team examines you."

9. Management
Immediate step

- **Do NOT create a new 2-week wait referral**.
- Contact **the breast surgical team who performed the operation** → arrange urgent same-day/next-day review.
- **Safety clause:** "If you cannot get through to the breast care nurse or surgical team today, contact us back immediately so we can facilitate the referral. You must not be left unseen."
- Ensure patient is seen in person for examination ± ultrasound.

Specialist team management may include:

- Observation if small, asymptomatic seroma.
- Aspiration if large/tense or causing discomfort.
- Drainage/antibiotics if infected.
- Imaging if concern about recurrence or ongoing bleeding.
- Review pending histology results.

10. Lifestyle & Long-Term Considerations

- Breast self-awareness (not "monthly exam" but ongoing awareness).
- Healthy lifestyle: maintain weight, avoid smoking, reduce alcohol.
- Family history/genetic counselling may be considered later once histology known.

11. Safety Netting

- Contact us/seek urgent help if:
    - Lump grows rapidly,
    - Breast becomes red, hot, very painful,
    - Fever, chills, feeling unwell,
    - Wound breakdown, discharge of pus or blood.
- If severe symptoms → A&E.
- Reassure that breast team review is already arranged.

12. Follow-Up & Closure

- Arrange **urgent review with the breast surgical team**.
- Confirm histology results will be discussed with her by the same team.
- Summarise: "Most likely this is a post-op fluid collection, but we will not make assumptions — the specialist team will review you urgently. Meanwhile, keep an eye out for the warning signs we discussed."
- Offer written info on wound care and seroma.
- Check understanding and address final concerns.

Red Flag Pitfalls Section - Women's Health

General Advice

- Avoid vague language - be specific and clear
- Always explain why you're asking sensitive questions
- Document carefully and consider safeguarding at every encounter

Cervical Screening Interval Update (July 2025)

From July 2025, cervical screening intervals changed to 5 years for HPV-negative women aged 25-49.

- Previously 3-yearly for ages 25-49
- Now 5-yearly if HPV negative **AND** no HPV+ result in last 5 years
- Applies only to tests taken **on or after 1 July 2025**
- Those with recent HPV+ history remain on 3-year recall until confirmed negative
- Ensure you're using updated guidance in all cervical screening cases

Safeguarding Reminder

Any STI in a person under 16 should trigger safeguarding considerations:

- Document thoroughly
- Escalate to seniors
- Involve child protection if there's any concern about the nature of sexual contact
- Position of trust abuse is illegal regardless of apparent "consent"

Postmenopausal Bleeding Urgency

Postmenopausal bleeding = automatic 2WW referral for women ≥55.

- Do not delay for investigations
- Age <55: still consider urgent referral

Ovarian Cancer Symptom Recognition - BEAT Mnemonic

IBS-like symptoms appearing for the first time in women ≥50 should prompt ovarian cancer investigations:

BEAT Symptoms of Ovarian Cancer:

- **B**loating (persistent, not intermittent)
- **E**ating difficulty (early satiety, feeling full quickly)
- **A**bdominal pain (persistent)
- **T**oilet habits (urinary frequency/urgency)

Investigations:

- CA-125 blood test
- Abdominal/pelvic ultrasound

Key teaching point: IBS rarely presents de novo in women ≥50. Any woman over 50 presenting with new "IBS" symptoms MUST have CA-125 to rule out ovarian cancer.

Breast Lump Scenarios

- **Every lump needs referral** - don't assume benign
- **Distinguish engorgement vs mastitis:**
  - Engorgement: bilateral, no fever, no focal redness
  - Mastitis: unilateral, focal redness, fever, systemic symptoms

Teenage Pregnancy

- Maintain neutrality
- Maintain confidentiality (unless safeguarding concerns)
- Apply Gillick/Fraser competence appropriately
- Don't be judgemental

Vaginal Discharge

- Use MES approach (Microscopy, Endocervical swabs, Syndromic treatment)
- Offer STI testing to all appropriate patients
- Consider safeguarding in minors

Mastitis Antibiotic

- **First-line:** Flucloxacillin 500mg QDS for 7 days
- Penicillin allergy: Clarithromycin or Erythromycin

Chapter 17: Psychiatry

A Note to Learners

The cases in this resource are written in a conversational style to help you become familiar with the natural flow of clinical consultations and the language commonly used in UK healthcare settings.

These dialogues are intended as a learning guide, not a script. Please do not attempt to memorise them verbatim. Examiners assess your ability to think and communicate authentically - not to recite rehearsed phrases.

Use this material to understand the underlying clinical reasoning, then practise in your own words until the consultation feels natural to you.

For Companion OSCE Cases, Practice Scripts, Evaluation Checklists, Summary Notes, Rapid Review Notes, Mindmaps, Management Flashcards and Image Library - visit https://www.gksplab2.com

Disclaimer
This material is independent educational content created to help candidates develop clinical reasoning and communication skills for UK medical practice.

All cases and clinical scenarios are based on common presentations encountered in UK primary care and emergency medicine, drawn from publicly available sources including NICE Clinical Knowledge Summaries (CKS), BNF, and other official NHS/UK healthcare guidelines.

No content in this resource is derived from, represents, or claims to replicate actual GMC PLAB 2 examination material.

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

What you CAN do independently:

- *Initiate first-line SSRIs for depression, GAD, PTSD, OCD (standard doses)*
- *Provide lifestyle advice and psychoeducation*
- *Refer to NHS Talking Therapies/IAPT*
- *Recognise emergencies and refer urgently*
- *Provide safety planning and crisis contacts*
- *Arrange baseline investigations*

What requires SPECIALIST initiation:

- *Antipsychotics (first-episode psychosis → EIP referral)*
- *ADHD stimulants (→ ADHD service referral)*
- *Methadone/buprenorphine (→ addiction service referral)*
- *Community alcohol detox in high-risk patients*
- *High-dose SSRIs for OCD*

Always involve seniors/psychiatry for:

- *Suicidal ideation with plan or intent*
- *Psychotic features*
- *Self-harm/overdose (before discharge)*
- *Diagnostic uncertainty*
- *Treatment-resistant cases*

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
F	Function, Family History
A	Alcohol/Drugs
M	Medical/Medication
I	Insight
S	Social Support/Stress
H	Hallucinations/Suicidality

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 **less severe or more severe depression**

Note: NICE NG222 introduced new terminology - "less severe" (PHQ-9 <16) and "more severe" (PHQ-9 ≥16). While the traditional mild/moderate/severe terminology is still widely used clinically, either terminology is acceptable for PLAB 2.

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? |

Note: NICE CG115 recommends AUDIT-C (3 questions) or full AUDIT (10 questions) as validated screening tools. CAGE remains useful but consider adding: "We often use a questionnaire called AUDIT to help assess alcohol use - would you mind if I asked you a few questions?"

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:
Scenario: Primary Care Setting | Young Adult | New-Onset Unusual Beliefs and Behaviour | Parent-Accompanied
Three variants presenting with different delusional themes:

- Variant A: Persecutory beliefs (surveillance concerns)
- Variant B: Grandiose beliefs (special identity/connections)
- Variant C: Persecutory beliefs (authority-related concerns)

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 a young adult.

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 - Persecutory/Surveillance 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 having special connections?" "Could you tell me more about how you came to believe this?" "Have you tried contacting anyone or planning to meet them?"
Cue: "I have important connections that others don't understand."

Variant C - Authority-Related Concerns
"Do you feel like authorities are after you?" "Have they said anything to you directly, or followed you physically?"
Cue: "I was questioned. 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 experiencing a mental health condition that affects how you perceive and think about things around you."

Layman Explanation
"This is a condition that can make thoughts and experiences feel very intense and real, even when others don't share them. Sometimes people experience things that feel completely real to them but that others don't experience in the same way.
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."

Alternative explanation (Stress-Vulnerability Model): "Sometimes, when the brain is under immense stress, it starts playing tricks on us - hearing things others don't or seeing patterns that aren't there. It's the brain's way of trying to cope with overload. This doesn't mean you're 'crazy' - it means your brain needs support right now, and with the right treatment, things can get much better."

Management Plan
Urgent Referral to Psychiatry/Early Intervention in Psychosis (EIP) Services
"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 an antipsychotic medication — there are several options, and the specialist team will choose the one that's best for you based on your specific situation. Common examples include Risperidone or Olanzapine, which come as tablets, and in some cases, long-acting injections."

"These medicines help reduce the thoughts and voices, and help you think more clearly and feel more like yourself."

Physical health monitoring
(arranged by EIP/psychiatry team when initiating antipsychotics):

- Weight/BMI, waist circumference
- Blood pressure, pulse
- Fasting glucose (or HbA1c)
- Lipid profile
- Prolactin (if indicated)
- ECG (if cardiac risk or specified in SPC)

Candidate Note: These checks are arranged by the specialist team when initiating antipsychotics. Your role is urgent referral. Ongoing monitoring: weight weekly for first 6 weeks; fasting glucose/HbA1c, lipids, prolactin, pulse, and BP at 12 weeks; waist circumference at 1 year; then all annually thereafter.

Psychological Therapy
"Once you're more settled, we'll also offer you talking therapy called CBT - ithis usually involves at least 16 sessions over 6 months or more- it's been shown to help people with these experiences manage their thoughts and improve their quality of life."

Family Intervention
Offer family intervention to all families living with or in close contact with the patient
"We'd also like to offer your family some support. There's a type of family therapy that helps everyone understand what's happening and how best to support you. It reduces stress at home and helps with recovery."

- Can start during acute phase or later
- Minimum 10 sessions over 3 months to 1 year
- Includes the patient where possible

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 psychosis 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 a **first-episode psychotic disorder** is supported by:

- Age (young adult)
- Functional decline (not working or withdrawn)
- Delusional thinking (surveillance/special connections/authority concerns)
- 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.
Scenario: Primary Care Setting | Adult Patient | Presenting with Low Mood | General Depression Assessment Template

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
"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?"
Note: We sometimes use a questionnaire called PHQ-9 to help track your symptoms over time.

Risk Assessment (Always Mandatory)
Normalization bridge (softens the question): "When people are going through as much as you are, sometimes they feel like they just want to switch off or escape."
"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."
"How does that sound to you?" or "Does that fit with how you've been feeling?"

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 starting QT-prolonging medication like citalopram, or if cardiac history

"Would that be alright with you?"

Management Plan
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."

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?"

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 at least 6 months after you feel better. If you've had depression before, we may recommend continuing for longer - sometimes up to 2 years - to reduce the chance of it coming back."
"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?"

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

Summary
Scenario: Primary Care Setting | Adult Female with same sex partner | Low Mood Following Recent Pregnancy Loss | Supportive Partner Present | History of Prolonged Fertility Difficulties
Female patient presents with low mood, sleep difficulty, and guilt following a miscarriage. History of prolonged fertility difficulties. No suicidal thoughts or psychotic features. Functioning largely intact.

History Focus
"Can you tell me about your efforts to have a child?"
"I'm really sorry for your loss. What you're going through is incredibly difficult, and it's completely natural to feel this way after losing a pregnancy."
"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
- I can also put you in touch with support groups for pregnancy loss, like Tommy's or the Miscarriage Association
- Crisis card and follow-up in 2 weeks

Case 2: Mild Depression

Summary

Scenario: Primary Care Setting | Middle-Aged Female | Persistent Low Mood | Brought by Spouse | Life Transition Trigger (Child Starting Education)

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

- "Many parents feel this way when their child starts school - it's a big adjustment. The feelings you're having are completely understandable."
- 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

Summary

Scenario: Primary Care Setting | Middle-Aged Male | Insomnia and Work Difficulties | Recent Marital Breakdown | Increased Alcohol Consumption

Middle-aged man with insomnia, increased alcohol use, and reduced work performance after a recent divorce. Drinking a bottle of wine daily (approximately 9-10 units). 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?"

"I know alcohol can feel like it helps in the moment, but do you think it might actually be making your sleep and mood worse in the long run?"

"How is this affecting your work performance?"

Alcohol units clarification: "A bottle of wine contains around 9-10 units of alcohol. The recommended limit is 14 units per week spread over 3+ days, so you're currently drinking significantly more than is safe for your health."

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)
- Consider using AUDIT-C or full AUDIT for formal alcohol assessment
- 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

Summary
Scenario: Primary Care Setting | Middle-Aged Female | Unintentional Weight Loss | Prolonged Low Mood and Fatigue | Possible Social Isolation
Middle-aged woman presents with unintentional weight loss over several months. 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.)
- "We'll do some blood tests to check for other causes of weight loss. If your mood improves but the weight loss continues, we may need to do further investigations."
- 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

Note: If weight loss persists with other red flags despite psychiatric stabilisation, consider 2-week wait referral (suspected cancer pathway).

Case 5: Moderate Depression - Post-MI

Summary
Scenario: Primary Care Setting | Middle-Aged Male | Follow-up After Recent Cardiac Event | Medication Non-Compliance | Referred by Practice Nurse
Middle-aged man referred back to GP by nurses due to non-compliance with cardiac medications after a myocardial infarction (MI) and stent placement. 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)
Gastroprotection required: "Because you're taking blood thinners like aspirin and clopidogrel, and we're starting an SSRI, there's a slightly increased risk of stomach bleeding. I'll also prescribe a **stomach protector (Lansoprazole 30mg once daily)** to take alongside your other medications."
Note: Avoid omeprazole/esomeprazole with clopidogrel (interaction). Use lansoprazole or pantoprazole.
Refer for **CBT or counselling**
"I understand it's hard to keep up with so many tablets, especially when you're feeling low. But these medications are really important for protecting your heart. Let's work together to find a way to make it easier."
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

Case 6: Severe Depression

Summary
Scenario: Primary Care Setting | Young Adult | Known Depression | Presenting with Ongoing Low Mood and Suicidal Thoughts | High-Risk Presentation
A young adult 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
"I think you need to be seen by the specialist team today, and I'd like to arrange for you to go to hospital where they can support you properly. Can someone bring you, or should we arrange transport?"

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
"Before you leave, let's make a quick safety plan together - who you can call, what you can do if thoughts get worse."
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:
Scenario: Primary Care Setting | Adult Male | Known Depression | Relapse Following Discontinuation of Antidepressant | Presenting with Core Depressive Symptoms
Adult man, previously diagnosed with depression, was on Sertraline 100 mg. His GP advised gradual tapering and discontinuation. Now, several 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: "Depression can come back, especially in the first year after stopping medication. This doesn't mean you did anything wrong - it's just how the condition works for some people."
- 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)

"Because this is your second episode of depression, we'd recommend continuing the medication for at least 2 years once you're feeling better. This significantly reduces the chance of it coming back again."
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
Scenario: Primary Care Setting | Middle-Aged Adult | Known Depression | Follow-Up - Incomplete Response to Psychological Therapy | Requesting Review
You are an F2 doctor in a GP clinic. A middle-aged 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." The maximum dose of citalopram is 40mg per day for adults under 65, and 20mg per day for those 65 and over, due to effects on heart rhythm.
"We'll do an ECG before starting, as citalopram can occasionally affect heart rhythm."
"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
"Some people notice tiredness, dry mouth, or changes in sleep in the first week or two. These usually settle. Some people also notice changes in their sex drive - if that happens, we can discuss options."
"If sexual side effects are a concern, we could consider mirtazapine instead, which often has less impact in this area - though it can cause drowsiness and weight gain."

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."

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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."

Note 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: Primary Care Setting | Postpartum Female | Presenting with Sleep Difficulties and Low Mood | Several Weeks Duration
Scenario: GP clinic. A postpartum woman presents with difficulty sleeping and low mood for several weeks. 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?"
Note: We may also use a short questionnaire called the Edinburgh Scale (EPDS) to help track your symptoms.

Risk Assessment - Self-Harm AND Harm to Baby
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."

Bonding and attachment: "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?"

Thoughts about harming baby (MANDATORY SCREEN):
"Sometimes new parents have frightening thoughts about their baby - like thoughts of dropping them or hurting them. These thoughts are actually very common and don't mean you'll act on them. Have you experienced anything like this?"

If yes - distinguish intrusive thoughts from intent:
- "Do these thoughts come suddenly and feel unwanted, or do you feel you might act on them?"
- "Have you ever come close to acting on these thoughts?"

Key distinction:
- **Ego-dystonic intrusive thoughts** (common in postnatal depression/anxiety/OCD) = distressing but no intent to act
- **Ego-syntonic thoughts with intent** = urgent safeguarding concern → escalate immediately

Thoughts about harming self: "Have you had any thoughts of harming yourself?"
If any risk to self or baby 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
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."

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."

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."

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."

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: Primary Care Setting | Working-Age Adult | Requesting Medication for Sleep and Stress | Recent Occupational Changes

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:
"I can see why you'd think medication might help, but at this point, the evidence suggests it wouldn't benefit you and might cause unnecessary side effects."

Sleeping Pills:
"I understand the appeal of a quick fix for sleep, but sleeping tablets actually don't solve the underlying problem and can become habit-forming quite quickly."

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."
"Your employer may have an occupational health service that can help with workplace adjustments."

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."

FGM Safeguarding Concern — Low Mood in Teenager

Setting: Primary Care
Patient: Adolescent Female
Presenting Complaint: Mood changes with anxiety about family travel plans
Role: FY2 Doctor

Introduction
- Greet and introduce yourself
- Confirm name and age
- Begin with open-ended inquiry

"How can I help you today?"

Focused History
A. Presenting Complaint & Emotional Wellbeing
"How have you been feeling lately?"
"Can you tell me more about your mood?"
"Is this something new, or have you felt this way before?"
"Has anything in particular triggered these feelings?"

B. Explore Any Mention of Worry or Travel
If the patient vaguely mentions being worried about travel or moving:
"What is it about the trip that's making you feel uneasy?"
"Is there something specific that you're concerned might happen?"

C. Offer Confidentiality at First Clear Cue
"Just to reassure you — what you share here is confidential. The only time I would need to share it is if I'm genuinely worried about your safety or someone else's. But even then, we would talk about it together first. Is that okay?"

D. Clarify Disclosure
"Where are you planning to travel to?"
"Who are you going with and who will you stay with?"
"Are you worried someone might do something to you against your will?"
"Has anything like this happened to you before?" *(Check if FGM has already occurred.)*

If family history is disclosed (e.g. mother had FGM):
"Has anyone said something that made you think this might happen to you as well?"
"Do your parents know how you feel about the trip?"

E. Timeline and Immediacy of Risk
"When is the trip planned for?"
"Is everything booked already, or still being planned?"

F. Mental Health Screening — Depression & Anxiety
"Have you had problems sleeping?"
"Any changes in appetite or weight?"
"Do you feel tired or have low energy most days?"
"Have you lost interest in things you usually enjoy?"
"Do you feel nervous, tense, or on edge often?"
"Do you have thoughts that something bad might happen?"
"Have you had any thoughts of harming yourself or ending your life?" *(Always ask clearly and calmly in under-18s.)*

G. Explore ICE
"What do you think might happen if you go?"
"What worries you the most about this situation?"
"What kind of help were you hoping for today?"

Explanation
- "Thank you for telling me about this. It's really important that you did."
- "In the UK, female genital mutilation — sometimes called female circumcision or cutting — is illegal, even if it's done in another country."
- "It can lead to serious lifelong physical and emotional harm. Because of this, the law sees it as a form of child abuse."
- "Because you are under 18 and may be at risk, I have a legal duty to act to keep you safe."
- "That means I need to involve our safeguarding team. They are professionals trained to protect young people in situations like this."
- "I want to be really clear — you are not in any trouble at all. In fact, what you've done by telling me takes real courage, and I'm glad you trusted me with this."

Management
"Thank you for telling me this. I understand that wasn't easy. It's really important that you shared it, and I want you to know that I take it seriously."
"What you've told me — that you're worried someone might do something like what happened to your mum — is something we do not take lightly."
"In the UK, what you're describing is called Female Genital Mutilation or FGM. Some people might refer to it as female cutting or circumcision, but it's the same thing."
"FGM is illegal here — and it's also illegal to take someone abroad to have it done. That's because it causes serious long-term harm to a person's body and mind. So the law sees it as a form of child abuse."

"Because you're under 18 and we're concerned about keeping you safe, I'm going to involve some people who are specially trained to help in situations like this. You'll be part of every conversation — nothing happens behind your back."

Explain the Next Steps to the Patient

A. Safeguarding Steps

Important Clarification: The mandatory reporting duty to police applies when FGM has ALREADY OCCURRED (visual identification or verbal disclosure). For girls AT RISK of FGM (like this patient), the duty to safeguard still applies but through normal safeguarding channels — notify the safeguarding lead who will contact children's social care.

"As a doctor, I have a legal duty to report concerns like this. That means I'll be speaking with our safeguarding lead today — they're a senior member of the team who helps with situations where young people may be at risk."

"They may also contact **Children's Social Services** to support you and your family. If the risk is very urgent or if the trip is happening soon, the police safeguarding team might also get involved — but this is only to make sure you're protected."

"There's something called an **FGM Protection Order**. It's a legal order that can be used to stop anyone from taking you abroad if there's a risk of FGM. That's something the safeguarding team can help arrange if needed."

Reporting Detail: For cases where FGM has already occurred, the mandatory reporting duty requires you to report personally to the police — call 101 (non-emergency number) unless there is imminent risk, in which case call 999. You should make the report as soon as possible, ideally by close of the next working day. Make a note of the crime reference number given.

Mental Health Support

"You also mentioned that you've been feeling really low lately. I'd like to support you with that as well."

"I'm going to refer you to a team called **CAMHS** — the Child and Adolescent Mental Health Service. They can offer proper help for how you've been feeling, especially with the worry and low mood you've been going through."

"There are also youth counselling services and local charities that can support you while we get everything else sorted."

Genital Examination (Only if Relevant)

"In some cases, the safeguarding team may ask for a medical check to confirm that everything is okay. That would only be done if it's necessary, and only with your permission. You would never be forced into anything."

"If that ever comes up, we'll explain it clearly, make sure someone supportive is with you, and we'll only proceed if you're comfortable."

Travel Safety

"Right now, the most important thing is your safety. Until we've fully assessed things, the trip may need to be delayed or reconsidered. This is something the safeguarding and social care teams will help decide together with your family."

Safety Netting

"If anything changes — if anyone pressures you, or if you feel unsafe at home or about the trip — please come straight back to us or call one of the numbers I'll give you."

"There's a free and confidential helpline you can call any time: the **NSPCC FGM helpline**. They're there to help girls exactly in situations like this."

Follow-Up Plan

"Today, I'll speak to the safeguarding lead right after we finish here."
"You'll hear from either me or someone from the team in the next day or two to let you know the plan. I'll also refer you to CAMHS so someone can help with your mood and anxiety."
"And if at any point you want to talk more or you're unsure about anything, we're always here at the surgery. You're not alone in this."

Documentation: Document the disclosure verbatim where possible, your actions taken, and the police reference number if applicable.

Leaflet & Final Check
"I'll give you a leaflet that explains your rights and some contacts you can reach out to any time."

- **FGM and the law** (Home Office/NHS)
- NSPCC FGM Helpline
- Local mental health youth services

"Do you feel a bit clearer about what happens next?"
"Is there anything you want me to explain again?"

Self-Harm

Case 1: Wrist Cutting + OCP Overdose

Scenario ID:
Scenario: Psychiatry Assessment | Adolescent Female | Referred Following Self-Harm and Tablet Ingestion | Medically Stabilised

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
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?"

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?"

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
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."
"We can arrange for you to see someone about reliable contraception if that would help."

Risk Formulation
Based on the individual assessment — the impulsive nature of the act, absence of planning, help-seeking behaviour, expressed regret, and willingness to engage — the current presentation suggests a lower likelihood of repetition. However, ongoing support and safety planning remain essential.
But before we decide anything today, I'll speak with my seniors to make sure we're all in agreement.

Note: Don't say "You're low-risk" - instead say, "it's unlikely based on what you've told me, but we still want to support you closely."

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."

Safeguarding Note: If any concerns arise about the home environment, exploitation, or relationship coercion, follow local safeguarding procedures and document clearly.

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."

Note
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

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
Scenario: Emergency Department | Adolescent Female | Paracetamol Ingestion Following Relationship Conflict (7-8 tabs) | Repeat Presentation
Paracetamol level is below treatment threshold.

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."
"Were all the tablets taken at once, or spread out over more than an hour?"

CRITICAL: Staggered vs Acute Overdose
If staggered (ingested over >1 hour):

- The paracetamol nomogram **CANNOT be used**
- **Start N-Acetylcysteine (NAC) immediately** - do NOT wait for blood results
- Per MHRA guidance: all staggered overdose patients require immediate NAC
- Contact TOXBASE or National Poisons Information Service (0344 892 0111)

If acute single ingestion (<1 hour):

- Blood test for paracetamol level at least 4 hours post-ingestion
- Plot on nomogram to determine if NAC is indicated
- If taken earlier than 4 hours, levels may need repeating

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: "The safe dose of paracetamol is spread throughout the day - taking lots at once overwhelms your liver's ability to process it safely."
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
Scenario: Emergency Department | Young Adult Male | Significant Paracetamol Ingestion | Recent Family Conflict | First Presentation

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 as per **TOXBASE/local protocol**

- Licensed regimen: 3 bags IV over **21 hours** (MHRA authorised) - 150 mg/kg IV over 1 hour, then 50 mg/kg over 4 hours, then 100 mg/kg over 16 hours.
- *Note Some centres use **12-hour SNAP regimen** (TOXBASE-recognised)*
- NAC may need to be continued beyond initial course if LFTs/INR remain abnormal

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."
"What happened sounds really difficult - coming out to family can be incredibly hard, especially when it doesn't go as hoped."

Psychiatric Plan
Refer to **psychiatry** regardless of paracetamol level

Before discharge - Safety screening:
"Do you have a safe place to go tonight if you're discharged? Is it safe for you to return home given what happened with your mother?"

Red flag: Discharging a patient to "no fixed abode" or an unsafe environment is a fail. If home is not safe, involve social services or crisis team for alternative accommodation.
Emphasise that support is available: "This was a tough moment, but we'll make sure you're not dealing with it alone."
"There are also support services specifically for LGBTQ+ young people, like Switchboard or Stonewall, if that would be helpful."

Drug Addiction

Scenario: Psychiatry Outpatient Setting | Young Adult Male | Self-Referred for Substance Misuse Support
Role: FY2 in Psychiatry OPD

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
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
[Candidate Note: Your role is to assess, support, and refer to addiction services - do NOT initiate opioid substitution therapy]

Immediate Actions:
Refer to local Drug and Alcohol Service (CDAT/Addiction Service)
"I'd like to refer you to our specialist addiction service. They have expertise in helping people in your situation and can offer treatments that really work."

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 before your specialist appointment."

Specialist Treatment Options
[Candidate Note: These medications are initiated by addiction specialists, not primary care]
Opioid substitution therapy - methadone (oral liquid) or buprenorphine (sublingual tablet)
"The specialist team will discuss treatment options with you. Medications like methadone or buprenorphine help reduce withdrawal symptoms and cravings. These medications are usually continued for as long as they're helping – this could be months, years, or longer. The specialist team will review regularly to decide what's best for you."

Naloxone Provision:
"We'll also provide you with naloxone - a medication that can reverse an overdose in an emergency."

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

Scenario: Hospital Clinic Setting | Middle-Aged Female | Routine Procedure Follow-Up | Opportunity for Holistic Health Discussion

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 + AUDIT screening
"We often use a questionnaire called AUDIT to help assess alcohol use - would you mind if I asked you a few 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 limit is 14 units per week, spread over at least 3 days - and 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
[Candidate Note: Your role is brief intervention, baseline checks, and referral to addiction services]

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
Community Detox Consideration:
Important: Community alcohol detox with chlordiazepoxide is ONLY appropriate if:

- No history of withdrawal seizures or delirium tremens
- No significant comorbidities
- Adequate social support at home
- Can be monitored regularly

If ANY of the above are not met → refer for inpatient detox (see Case 2)
If community detox appropriate AND patient motivated:
Refer to **Alcohol Liaison/Addiction Service** for supervised community detox They may prescribe **Chlordiazepoxide** reducing regimen with daily monitoring **Thiamine (Pabrinex or oral)** to prevent Wernicke's
[Candidate Note: In many areas, community detox is supervised by addiction services, not primary care. Know your local pathway.]

Long-term Relapse Prevention:
[Candidate Note: These medications are typically initiated by specialists]
Acamprosate or **Naltrexone** to reduce craving

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 always 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:
Scenario: Primary Care Setting | Older Adult | Self-Presenting After Stopping Alcohol | History of Withdrawal Complications | Requesting Medication Support - DIAZEPAM

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 of what happened before with the fits, it would be unsafe for you to try to detox at home this time - you need to be somewhere with medical support."
"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."*
"In hospital, they'll also give you vitamins to protect your brain during detox."

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 to Acute Medicine (NOT psychiatry) for medically supervised detoxification
- Psychiatric wards lack resuscitation equipment and IV access for managing seizures/DTs
- Start **Chlordiazepoxide** reducing regimen
- **Pabrinex IV** (high-dose thiamine) to prevent Wernicke's encephalopathy
- **Alcohol Liaison Team** review once medically stable

Supervised detox + rehabilitation plan
Plan for **post-discharge follow-up** in GP with:

- Alcohol counselling
- Craving-reduction meds (e.g., Acamprosate for maintaining abstinence, Naltrexone for reducing consumption, or Disulfiram if the patient is motivated and adherent)
- Social services / addiction support referral

Insomnia

Case 1: Insomnia - Bereavement

Scenario: Primary Care Setting | Older Adult Female | Chronic Musculoskeletal Condition - Rheumatoid Arthritis (on Methotrexate) RA | New Sleep Difficulties Following Bereavement

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

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 your sleep problems persist, we may refer you for **CBT-I** — a structured therapy specifically designed for insomnia. It's the most effective long-term treatment

Address Pain Management (RA)
Review pain control with rheumatology or GP if night pain is disturbing sleep

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 along."

Case 2: Requesting Sleeping Pills

Scenario: Primary Care Setting | Young Adult Male | Requesting Sleeping Medication | Poor Sleep Habits and Lifestyle Factors Identified

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**
"Taking your mum's sleeping pills is something we need to discuss - it's not safe, and it won't fix the underlying problem."
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

"Cannabis can actually make sleep worse long-term. If you'd like help cutting down, we can discuss that too."
Give **leaflet on sleep hygiene**
Offer follow-up if symptoms persist after lifestyle changes

Case 3: Insomnia with Tiredness

- **Setting:** Primary Care
- **Patient:** Older adult male
- **Presenting complaint:** Chronic sleep disturbance and fatigue

1. Introduction & Consent
- Greet and confirm name/DOB.
- Ensure privacy.
- "I understand you've been having some difficulty with your sleep. If it's alright, I'll ask some questions to get a full picture, then we'll discuss what might be causing this and what we can do to help. Does that sound okay?"
- **If patient appears withdrawn/fidgeting/avoiding eye contact:** *"I can see this feels difficult to talk about. Just so you know – everything you share with me is confidential. I'd only need to share if I felt you or someone else might be at serious risk. Is it okay to continue?"*

2. Presenting Complaint
- Difficulty sleeping / feeling tired for 6 months.

3. History of Presenting Complaint

Sleep Pattern
- "When did the sleep problems start?"
- "Do you struggle to fall asleep, stay asleep, or wake too early?"
- "On average, how many hours do you get at night?"
- "Do you feel rested when you wake?"
- "Do you nap in the day?"

Associated Symptoms
- "Do you snore, or has anyone noticed pauses in your breathing at night?" (OSA screen)
- "Any restless legs, pain, or discomfort keeping you up?"
- "Any night-time passing urine?"
- "Any weight change, tremors, palpitations, heat/cold intolerance?" (thyroid screen)

Daytime Impact
- "How has this been affecting your mood, energy, or concentration?"
- "Has it affected your relationships, work, or daily activities?"
- "Do you drive — have you ever felt sleepy at the wheel?"

Lifestyle & Habits
- "Do you drink tea, coffee, cola, or energy drinks? How much, and at what times?"
- "Do you drink alcohol? How much and how often?" (check units, dependence, withdrawal)
- "Do you smoke or use recreational drugs?"
- "What is your usual bedtime routine? Do you watch TV or use your phone in bed?"
- "Do you exercise? At what time of day?"

Mood & Psychological Screening
- "How has your mood been recently?"
- "Do you still enjoy your usual hobbies or interests?"
- "Any problems with energy, motivation, or concentration?"
- "Any feelings of guilt, hopelessness, or worthlessness?"
- "Do you often feel anxious, worried, or restless?"
- "Have you had any thoughts that life isn't worth living?" (suicide risk screen)
    - *Normalize if needed:* "When people have struggled with sleep and low mood for this long, sometimes they have thoughts that life isn't worth living. Has that ever happened to you?"
- *"To help me understand this better, I'd normally use a structured set of questions in clinic that measures how much these symptoms affect you. Would you be okay if we explore this further at follow-up?"*

Past Medical & Psychiatric History
- "Any long-term health problems?"
- "Any past thyroid disease, depression, anxiety, or psychiatric illness?"
- "Any regular medications?"
- "Any allergies?"

Family & Social History
- "Who do you live with — do you feel supported at home?"
- "Any family history of depression, anxiety, or thyroid disease?"
- "Any recent stresses at home, with work, or finances?"
- "How is your relationship with your wife and children?"

4. Examination
- Physical exams normal.

5. Differential Diagnoses

1. **Primary insomnia** (lifestyle/stress related).
2. **Alcohol-related sleep disturbance.**
3. **Generalised anxiety disorder.**
4. **Depressive disorder (masked/denied).**
5. **Secondary insomnia**:
    - Obstructive sleep apnoea
    - Thyroid disease
    - Chronic pain / nocturia

6. Explanation

- "It sounds like there may be several things contributing to your sleep problems — including stress, caffeine, and alcohol. The good news is these are all things we can work on together.
- Alcohol may make you sleepy at first but it actually breaks up your natural sleep cycle, leaving you more tired."
- "Sometimes sleep problems happen alongside anxiety or low mood, even if you don't feel depressed."
- "We should also check your physical health, like thyroid function or conditions such as sleep apnoea."
- "The good news is there are effective steps we can take to improve this."

7. Management

Psychological therapy (first-line for chronic insomnia):

- **CBT-I (Cognitive Behavioural Therapy for Insomnia)** is the most effective long-term treatment for insomnia
- Refer to IAPT services or consider digital CBT-I programmes (e.g., Sleepio — NICE MTG70)
- More effective than medications for sustained improvement

Non-Drug: Sleep Hygiene & Lifestyle

- Keep regular sleep and wake times.
- Avoid daytime naps.
- Create a quiet, dark, comfortable bedroom.
- No phone, TV, or screens in bed.
- Wind down before sleep (reading, warm shower, relaxation).
- Avoid caffeine after lunchtime.
- Avoid alcohol before bed.
- Exercise regularly, but not late evening.
- Keep a sleep diary

Alcohol

- Explain harmful effect on sleep and health.
- Explore daily intake (~20+ units).
- Screen for dependence (AUDIT-C).
- **Before advising gradual reduction**: assess for physical dependence severity (consider **SADQ score** or ask about history of withdrawal seizures/delirium tremens). Unsupervised reduction in **severe dependence is dangerous** and requires specialist support.
- If dependent → gradual reduction plan, refer to alcohol support services.

Mental Health

- Address possible depression/anxiety.
- Offer referral to CBT or counselling (IAPT).
- Explore social stressors and signpost support services.

Medical Evaluation
- Order bloods: FBC (anaemia), U&Es, TFTs.
- If OSA suspected → sleep study referral.

Medication (only if severe distress and short-term)
- If sleep hygiene and CBT-I fail and patient severely distressed:
  - Offer short course (≤ 2–4 weeks) of z-drug (zopiclone) or short-acting benzo.
  - Explain risk of dependence, drowsiness, and falls.
- For severe chronic insomnia unresponsive to CBT-I, specialist may consider daridorexant (NICE TA922).
- Not first-line; temporary measure only.

8. Safety Netting
- "If you ever feel your mood gets worse, or you start to feel that life isn't worth living, please come back straight away, call NHS 111, or go to A&E."
- "If you get withdrawal symptoms from alcohol reduction (sweating, shaking, hallucinations), seek urgent medical help."
- "If you develop new symptoms like loud snoring, choking at night, weight loss, or palpitations, return sooner."

9. Follow-Up
- Review in 2–4 weeks to check progress, mood, alcohol intake, and blood results.
- Adjust plan depending on response.

10. Shared Plan
- Patient agrees to trial sleep hygiene, reduce caffeine/alcohol.
- Will attend blood tests.
- Open to referral for CBT/talking therapies.
- Follow-up arranged.

11. Leaflets & Resources
- NHS leaflet: *Better Sleep Hygiene*.
- NHS alcohol support helpline.
- IAPT/talking therapy services.

12. Closing
- Summarise plan in simple terms.
- Ask: "Does this plan sound reasonable to you? Do you have any questions or concerns?"
- End with reassurance and follow-up plan.

Anorexia Nervosa

Scenario: Primary Care or Psychiatry Setting | Young Person | Presenting with Weight Loss | Parent-Accompanied - Worried | Concerns About Eating Patterns

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 Sick because you feel uncomfortably full?"
C: "Do you worry that you have lost Control over how much you eat?"
O: "Have you recently lost more than One 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)

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*"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)
Urgent Referral
Eating Disorder Clinic (adult) or CAMHS (if <18)
"This is best handled by a specialist team who deal with eating disorders regularly."
"For younger patients, we'll also offer family-based therapy - this involves your family in supporting your recovery, which has been shown to be very effective."

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."

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."

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**

Physical Health Monitoring
"We'll also need to do some blood tests and monitor your heart, as very low weight can affect how your body functions."

- ECG monitoring
- Electrolytes (especially potassium, **phosphate**, magnesium)
- Bone health considerations (DEXA if prolonged low weight)

"If your weight is very low, we need to increase food intake gradually to avoid complications." (Refeeding syndrome awareness)

Refeeding syndrome: Monitor phosphate levels closely - hypophosphataemia is the hallmark of refeeding syndrome. Per **MEED guidance**, gradual refeeding with electrolyte monitoring is essential.

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

Scenario: Telephone Consultation | Adolescent | Self-Induced Vomiting Discovered by Parent | First Assessment

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."
"This isn't something to feel ashamed of-and you're not alone in this."

Management Plan - Same 5-Part Framework as Anorexia
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."

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."

Medication (If Required)
Fluoxetine - first-line SSRI for bulimia if medication needed
Note: The licensed dose for bulimia is **60mg daily** (higher than the standard 20mg for depression). This demonstrates specialist knowledge in PLAB 2.
"If needed, medication can be considered later-but therapy is the main approach."

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."

Physical Health Monitoring
"Frequent vomiting can affect your teeth, so we'd recommend seeing a dentist too."
"We'll check some blood tests as repeated vomiting can affect your body's salt balance." (Electrolyte monitoring)

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."

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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

Scenario: Primary Care Setting | Adult | Persistent Health Concern Despite Negative Investigations | Family Member Recently Diagnosed with Serious Condition
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?"

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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."
Note: Current terminology preference is "Illness Anxiety Disorder" (DSM-5) or "Health Anxiety" rather than the older term "Hypochondriasis."

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
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."

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."

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."

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."

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."

Somatic Symptom Disorder

Scenario: Primary Care Setting | Middle-Aged Adult | Concern About Physical Symptom | Previous Benign Investigation | Recent Bereavement

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."

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."

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

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 evidence of malignancy

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?	Minimal or absent	Yes - real physical symptom present
Main Concern	Fear of having/developing illness	Distress about existing physical symptom
Test Results	Normal, but not believed	Normal, but worry persists about symptom
Typical History	Repeated doctor visits seeking diagnosis	Focus on one or more physical symptoms
Patient Belief	"I might have a serious disease"	"This symptom must be serious"
Reassurance	Temporary, then returns	Doesn't fully resolve worry
Management	CBT, avoid further tests	CBT, relationship-based care, regular follow-up

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Attention Deficit Hyperactivity Disorder (ADHD)

Scenario: Primary Care Setting | Young Adult Student | Referred by Educational Institution | Memory and Concentration Difficulties | Possible Neurodevelopmental Assessment

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	Sample 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	Sample Question
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
[Candidate Note: Your role is to recognise, screen, and refer - do NOT initiate ADHD medication]

Immediate Actions
Refer to Adult ADHD/Psychiatry Service for formal neurodevelopmental assessment
"I'd like to refer you to our specialist ADHD service. They can do a comprehensive assessment and, if ADHD is confirmed, discuss treatment options with you."

Specialist Treatment Options

[Candidate Note: Stimulants are controlled drugs requiring specialist initiation]

Stimulant Medication (e.g., Methylphenidate or Lisdexamfetamine)
"If the specialist confirms ADHD, they may recommend medication like methylphenidate, which helps improve concentration and impulse control."
Note: For children and young people, methylphenidate is usually tried first. For adults, either methylphenidate or lisdexamfetamine can be used as the first option

Pre-treatment checks (done by specialist team):
- Cardiovascular assessment: heart rate, BP, ECG if indicated
- Height/weight baseline
- Psychiatric comorbidity screening

Driving:
"You must tell DVLA if your ADHD affects your ability to drive safely. They'll assess whether any restrictions apply, but many people with ADHD continue driving without issues."

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
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)

Scenario: Primary Care Setting | Young Adult | Medical Student | Work-Related Anxiety with Repetitive Behaviours | Contamination Concerns

Introduction
"Hello, I'm Dr [Your Name], one of the GPs here today. Could I confirm your full name and age please?"
"Thanks. 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."
"ERP stands for Exposure and Response Prevention - it involves gradually facing your fears while learning not to do the compulsions."

Referral: IAPT or local mental health team if severe/functional impairment present
"Treatment for OCD follows a stepped approach - we start with the least intensive treatment that's likely to work, and step up if needed."

Medication (if moderate/severe, or patient prefers)
Fluoxetine (licensed SSRI for OCD)
Start at **20 mg once daily**
May take **8–12 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
"Fluoxetine is the most commonly used medication for OCD, but if it doesn't work well for you or causes side effects, we can try alternatives like sertraline or fluvoxamine."
[Candidate Note: SSRI initiation for OCD is appropriate in primary care at standard doses. However, higher-dose titration (up to 60mg fluoxetine) and treatment-resistant cases should involve specialist input. Consider psychiatry referral if no response after 12 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

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DSM/NICE criteria	Obsessions and/or compulsions lasting ≥2 weeks, causing distress and functional decline

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	Compulsive behaviour is central to the condition

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)

Scenario: Primary Care Setting | Adult | Presenting with Sleep Disturbance and Anxiety | History of Recent Traumatic Event

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 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 several months ago. He was the driver, no major injuries but emotionally shaken.

Core Symptom Clusters - PTSD Screening
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?"
Avoidance
"Do you avoid certain places or situations - like driving or being near cars?"

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?"

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?"

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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."
Note: Per NICE, if symptoms are <4 weeks duration, active monitoring (watchful waiting) rather than immediate treatment may be appropriate.

Management Plan
Reassurance
"You've done the right thing by coming in. PTSD is a recognised, treatable condition - and recovery is absolutely possible."

Psychological Therapy Referral
Refer to **NHS Talking Therapies (IAPT)** for:
Trauma-Focused CBT is the first-choice treatment. An alternative is EMDR (Eye Movement Desensitisation and Reprocessing), which may be offered if CBT is unsuitable or unavailable.
"These are evidence-based therapies designed specifically for PTSD. They help you safely process the trauma and reduce the intensity of flashbacks and anxiety."

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

Medication (if needed)
Consider **Sertraline** if:
Symptoms are severe
Waiting time for therapy is long Patient prefers combined treatment
"If medication is needed and sertraline doesn't work well for you, we can try venlafaxine instead."
"This can help reduce anxiety and improve sleep. It usually takes a few weeks to work, and we'll monitor you closely."

DVLA Consideration (for driving-related trauma)
"Given the accident, you might find driving difficult for a while. If this persists, we may need to discuss whether to notify the DVLA, though this isn't always required."

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

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Student Note: Diagnostic Reasoning - PTSD

Required Criteria	Findings in This Case
Triggering trauma	Car accident
Re-experiencing	Flashbacks, nightmares
Avoidance	Avoids driving, certain places
Hyperarousal	Jumpy, poor sleep, on edge
Mood/Cognition impact	Low mood, irritable, withdrawn
Duration >1 month	Yes
Functional impact	Off work, social withdrawal

→ Diagnosis: **Post-Traumatic Stress Disorder (PTSD)**
→Management: **Trauma-focused CBT/EMDR**, optional **SSRI** (sertraline or venlafaxine), **lifestyle**, and **close follow-up**

Generalized Anxiety Disorder (GAD)

Scenario: Primary Care Setting | Working-Age Adult | Presenting with Persistent Anxiety | Occupational Impact

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?"
Note: We sometimes use a questionnaire called GAD-7 to help track your symptoms.

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
Step 1: Identification and Education
- Confirm diagnosis, provide education about GAD
- Active monitoring - may improve with education alone

Step 2: Low-Intensity Interventions (if no improvement after Step 1)
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

Step 3: High-Intensity Psychological Intervention OR Drug Treatment
Psychological Therapy Referral
Refer to **NHS Talking Therapies** for **CBT** (7-14 hours total, per NICE)
"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."
(Note: Step 3 can be CBT alone, SSRI alone, or combination depending on patient preference and severity)

Medication (If Needed or Patient Preference)
If symptoms persist or patient prefers drug treatment:
Offer **Sertraline** (SSRI, first-line - most cost-effective)
- Start 25 mg daily, increasing to 50 mg after one week, then titrate in 50 mg increments at intervals of at least one week; maximum 200 mg/day
- Note: Sertraline is off-label for GAD but widely used and NICE-recommended

If sertraline ineffective: Alternative SSRI or SNRI (venlafaxine) **If cannot tolerate SSRIs/SNRIs:** Consider pregabalin (Class C controlled substance - assess for abuse risk)
Explain: takes 2–4 weeks to work, review in 2-4 weeks Monitor side effects (GI upset, agitation, insomnia)

Do NOT offer benzodiazepines except as short-term crisis measure
Do NOT offer antipsychotics in primary care for GAD

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
Hard to control worry	Yes
Physical symptoms	Tension, fatigue, sleep issues
Functional impact	Work affected
Other causes ruled out	No depression, panic, PTSD, 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

Scenario: Primary Care Setting | Adult Male | Known Depression | 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."

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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
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."

Offer Alternative Medication
"If sexual side effects are a major concern, Mirtazapine is the main alternative, as it has less impact on sexual function, though it can cause drowsiness and weight gain. Another option, under specialist guidance, is bupropion (though it's not licensed as an antidepressant in the UK, it's sometimes used off-label)"
Monitor for other side effects

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

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 [chosen medication] 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."

Performance Anxiety

Scenario: Primary Care Setting | Young Adult Male | Sexual Concerns Following First Intimate Experience following a comment about penis size | Reassurance Sought

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.

Previous Experiences
"Have you been sexually active before?"
"If so, have you ever experienced something like this before?"
This was his first intimate encounter.

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
Reassurance
Confirm normal examination
Emphasize that this is a **common and temporary experience**
Normalize first-time anxiety: *"It gets easier with time and familiarity."*

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.

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."

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."
"If this becomes an ongoing concern, couples counselling or psychosexual therapy can be very helpful."

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 erections, masturbation)

Trigger	First sexual experience + negative comment
Relationship context	New partner, both nervous
Physical exam	Normal
Mood history	No depression or anxiety disorder
Diagnosis	Performance Anxiety (Psychogenic ED)
Management	Reassurance, practical advice, no medication

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.

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").

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).

Management Red Flags
Always involve **psychiatry** for:

- Suicidal ideation
- Psychotic features
- Repeat overdose

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.

Crisis Team vs A&E - Know the Difference
Crisis Resolution and Home Treatment Team (CRHT):

- For assessment to *prevent* admission
- Patient must be safe enough to wait at home
- Suitable for: suicidal thoughts without immediate plan, escalating symptoms, discharge support

A&E / 999:

- For **immediate safety** or medical clearance
- **Actively suicidal with plan and means** → A&E, NOT just CRHT referral
- Overdose requiring medical treatment
- Psychotic patient at risk of harm to self/others

Exam pitfall: Referring an actively suicidal patient with a plan to CRHT and sending them home is a safety fail.

Gillick Competence (Adolescent Cases)
In cases involving minors (under 16), you must assess **Gillick competence** to determine if they can consent to treatment without parental involvement.
Key phrase: "I appreciate you telling me this. Usually, we like to involve parents to support you. How would you feel about us telling them together?"
Note: In self-harm and eating disorder cases, parental involvement is almost always sought eventually, but the young person's views should be explored first.

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**.

Self-harm and Overdose cases:
Do NOT use risk assessment tools/scales to predict future suicide or self-harm repetition
Do NOT use global risk stratification (low/medium/high) to decide treatment or discharge
Instead:

- Offer **psychosocial assessment** focusing on individual needs and safety planning
- Mental health professionals should undertake a **risk formulation** (not a score)
- Focus on the person's **strengths, coping strategies, and support network**

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**, **buprenorphine**, **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, electrolytes including phosphate)** and **psychosocial steps**. Refer to **MEED guidance** (Medical Emergencies in Eating Disorders, RCPsych 2022) - replaces MARSIPAN. For bulimia medication: Fluoxetine **60mg** (higher than standard depression dose).

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:
Health anxiety (Illness Anxiety Disorder): Fear of having/developing illness, minimal physical symptoms, seeks reassurance/testing **Somatic symptom disorder:** Distress about existing physical symptom(s), symptom is present and real **OCD consideration:** If patient is repeatedly checking (e.g., pulse every 5 minutes), this is a compulsion - consider OCD spectrum rather than pure anxiety

Follow-Up and Safety
Antidepressant follow-up timing (per NICE NG222):

- **Ages 18-25** OR **suicide risk concern**: Review within **1 week** of starting/changing antidepressant
- **All others**: Review within **2 weeks** to assess response and side effects, then at intervals
- Frequency thereafter based on clinical need, not rigid age cut-offs

Duration for depression diagnosis: symptoms must persist for **at least 2 weeks**. However, NICE NG222 recommends active monitoring for approximately 2–4 weeks before starting antidepressant treatment in less severe depression.

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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Let's make PLAB 2 simpler, smarter, and more strategic - together.