2021 PsySOM OSCE Night Station 5

*You have been provided with the following candidate instructions. You have **4 minutes** to read and prepare for your station. Please read the instructions carefully.*

CANDIDATE INSTRUCTIONS

You are a junior doctor completing your community psychiatry rotation.

Katie Jones is a 19-year-old single woman living with her parents. She is studying to become an engineer at a university. Today, Katie was referred to your community clinic by her General Practitioner. Her mother expressed concerns about Katie's eating habits. This is on a background of three-month deterioration in weight and eating habits.

Katie has no prior psychiatric or medical history and has no history of substance misuse. She is a social drinker, and has 4-5 alcoholic drinks over the weekend.

You have the following notes from a physical examination conducted earlier today:

- ➔ Previous weight: 58kg
- ➔ Current weight: 40kg
- ➔ Height: 175cm
- ➔ BMI: 13.1 kg/m^2

This patient does not identify as being Aboriginial or Torres Strait Islander.

In 8 minutes, your tasks are as follows:

1. Take a brief history about her presenting complaint and conduct a risk assessment. (4 minutes)
2. To the examiner, state and justify your most likely diagnosis. (1 minute)
3. To the examiner, describe your short and long-term management based on the results shown on the next page. (3 minutes)

TESTS FOR KATIE JONES (DOB: 05/09/2001)

TEST	RESULT	REFERENCE RANGE
White Blood Cell Count	4100 WBCs/mCL	4000 - 10000 WBCs/mcL
Red Blood Cell Count	**3.8**	4.2 - 5.7
Haemoglobin	**10.1**	13.2 - 16.9
Haematocrit	**36%**	38.5 - 49 %
Mean Corpuscular Volume	**70**	80 - 97
Serum Iron	**50**	60 - 170 mcg/dL
Platelet	169000	150000 - 450000
Glucose	5.0 mmol/L	4.0 - 7.8 mmol/L
Total Protein	7.0	6.0 - 8.3
Albumin	**3.3 g/dL**	3.5 - 5.4 g/dL
Total Calcium	9.1 mg/dL	9.0 - 10.5 mg/dL
Sodium	**124 mEq/L**	135 - 145 mEq/L
Potassium	**2.8 mEq/L**	3.5 - 5.0 mEq/L
Bicarbonate	24 mmol/L	22 - 30 mmol/L
Chloride	100 mmol/L	98 - 108 mmol/L
Magnesium	1.8 mg/dL	1.7 - 2.2 mg/dL
Phosphate		
Kidney Function	Normal	-
Liver Function	Normal	-
Lipid Profile	Normal	-
ECG	Decreased heart rate Bradycardia Prolonged QTc	-
Full vital signs	Tachycardic Hypotensive Postural BP drop >20mmHg	-

ROLE PLAYER INSTRUCTIONS

You are Katie Jones, a 19-year-old Engineering university student. You live with your parents, and your mother has been worried about your eating habits. You have been referred to the community psychiatrist by your General Practitioner. In the interview, you are guarded and convey the impression that you don't want to be here. You don't feel much like talking, and are initially a little hostile.

Unless stated, assume Katie does not know the answer to the question.	
Opening statement	**"I'm here because my mum thinks there's something wrong with my eating, but there's not. I'm absolutely fine."**
Current presentation	**"Well, I have been slightly reducing my food intake for the past few months."** *If asked to elaborate on your current eating pattern:* Current diet: ○ Breakfast: Cereal (one tbsp), Banana (one bite) ○ Dinner: Porkchop (two bites), Salad (handful) ○ Skips lunch Used to eat 3 full "balanced" meals a day. Do not snack between meals or binge eat. Do not feel full after meals.
Body image perceptions	Attitude towards food and weight loss: "**I am not unwell. I only avoid food so that I don't gain weight. I am happy with my recent weight loss. It makes me feel good about myself!"** *If asked to elaborate on your weight loss, use the following:* ▪ Desired weight: 38kg ▪ Used to exercise a lot, but now often feel tired ▪ Never consumed slimming tablets or laxatives but thought about it ▪ Never purged after eating ▪ Drink lots of water throughout the day ▪ Weighs self twice a day
Physical symptoms	● Regular periods stopped abruptly 3-4 months ago. ● Have been feeling constipated and have stomach cramps. ● Often feel dizzy if you get up too quickly.
Psychiatric symptoms	*Psychosis:* No auditory or visual hallucinations. *Mania:* No euphoric mood, abnormal expenditure or promiscuity. *Depression:* Mood is okay, not tearful but irritable. Poor concentration. Low motivation and reduced energy levels **but able to enjoy activities with friends.** *Anxiety:* Worries around weight. No other symptoms of anxiety.
Risk assessment	Nil suicidal ideation or deliberate self-harm, maintains personal hygiene and financially well-supported by parents

MARKING GUIDE († denotes pertinent points)

S5: ANOREXIA NERVOSA	**Needs Improvement**	**Proficient**	**Excellent**
History Taking and Risk Assessment			
Introduces self and confirms patient details. Sets context for the interview including consent. Uses open and closed questions appropriately. Establishes good rapport.			
† Explores history of presenting complaint including duration and onset, evolution of past and present eating patterns.			
† Explores patient's perception of their body image including current perceptions of body image, desired weight, frequency of attempts to achieve desired body, efforts to reduce weight (e.g. use of laxative, exercise or purging).			
† Excludes at least 3 of the following organic causes: gynaecological symptoms (menstrual), gastrointestinal symptoms, cardiovascular symptoms, endocrine symptoms, neurological symptoms, constitutional B symptoms, dermatological symptoms			
Excludes depressive symptoms, manic symptoms, psychotic symptoms, anxiety symptoms.			
† Conducts a basic risk assessment of at least 4 of the following domains: past psychiatric/medical history, family history, presence of suicidal intent/harm/plan, recent/past substance use, other harm to self or others, current living situation/financial status, support from family/friends, exercise.			

Diagnosis and Justification			
† Correctly diagnoses patient with anorexia nervosa.			
† Provides justification by stating patient's low Body Mass Index (BMI), current body image perception and compensatory behaviours.			
Short and Long Term Management Plan			
† In the short-term, shows understanding that investigation results show deranged electrolytes, anaemia and severely underweight BMI which requires a medical admission.			
In the short-term, considers the need/role of Mental Health Act and discuss the need for Consultant Liaison psychiatry input.			
† In the long-term, considers need for family based psychotherapy and psychoeducation for both patient and family.			
In the long-term, considers need for multidisciplinary approach in a community with the involvement of psychiatrist, psychologist, dietician and general practitioner. Understands the need for a long-term and regular follow up to prevent relapse.			
† Utilises Bio-Psycho-Social model to approach short-term and long-term management.			
General feedback:			

KEY LEARNING POINTS FROM OSCE NIGHT

HISTORY TAKING:

- In patients with a suspected eating disorder, it is important to ascertain objective eating behaviours (e.g. can you please list what you would normally eat in a day?) as well as their own perceptions and insight into their eating behaviours and weight (e.g. do you think this is a healthy amount to eat/weight to be?).
- Do not forget to ask about any binging and purging behaviours - this includes manual or medication-induced vomiting, use of laxatives, diuretics or enemas. Importantly, binging and/or purging can fall under anorexia nervosa (binge/purging type) OR bulimia nervosa - the only difference being that patients with bulimia nervosa are a normal weight or above (BMI>18) whereas in anorexia nervosa, BMI<18.
- It is also important to think medically as well! Does your patient have food intolerance, Crohn's disease or even coeliac disease? Such conditions need to be addressed by appropriate medical input and can often be missed.

MANAGEMENT:

- Eating disorders have the highest mortality rate of any psychiatric illness and are complex to manage due to the risk of refeeding syndrome. Short-term work up of EDs should include an ECG (long QT, bradycardia) and comprehensive blood investigations, in particular a full electrolyte panel - UECs & CMP (calcium, magnesium, phosphate), as well as FBE, LFTs, TFTs, lipid studies, glucose, thiamine & VBG.
- Be very wary of electrolyte derangement in the acute setting, in particular **hypokalaemia** and **hypophosphataemia** (which has neurological and cardiovascular complications!), and ensure that this is corrected before refeeding/acute management is started.
- Long term, family based therapy and/or cognitive behavioural therapy are the most useful psychotherapies for EDs. Family based therapy is most appropriate for those aged <18 with a supportive family environment. Otherwise, cognitive behavioural therapy would be deemed more appropriate for those aged >18 and lacking support from family or independent.