2021 PsySOM OSCE Night Station 6

*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 an intern working in the emergency department of a busy metropolitan hospital.

Emma Johnson is a 75-year-old retired teacher who has been brought into the hospital by her son, Michael. Earlier today, Emma was brought home by police officers, who found her wandering the streets in the morning and not knowing where she was or where she needed to go.

She currently looks disoriented, dazed, unkempt, and unable to recognise Michael. She also has disorganised speech. She is otherwise well with stable vitals.

Emma does not identify as Aboriginal or Torres Strait Islander.

In 8 minutes, your tasks are as follows:

1. Take a collateral history from her son Michael to be able to arrive at a diagnosis and differential diagnosis. (5 minutes)
2. Present your diagnosis and differential diagnosis to the examiner and outline what your short term management including investigation is in ED. (3 minutes)

ROLE PLAYER INSTRUCTIONS

You are Michael Johnson, the son of Emma Johnson who was found wandering on the streets in the morning by police officers. The police informed you that she seems rather confused. You have brought your mother to the hospital because you are worried about what is happening. This is very unusual for your mother, although you have noticed that your mother has been quite different since your father's demise. Your mother has lived alone since your father passed. Since his passing, Emma has felt lost without him. You live with your family about 10 minutes away from her. You visit her frequently to look after her. You have also noticed a progressive change to her behaviour, which began last year.

Unless stated, assume Michael does not know the answer to the question.	
Opening Statement	"I am so shocked and worried that she wandered out and got lost. This has never happened before." If asked to elaborate on her recent state: "I got a call from the police at 3am telling me that they found my mother wandering the streets looking lost and not knowing where she is and why she is out at that time. She has been having issues with her memory, but I always thought it is due to her age, but this is so unlike her. I spoke to her before her dinner last night, and she wasn't dazed."
Cognitive Function Assessment	All symptoms started about 1 year ago and gradually worsened since. ● **Apraxia:** she has been increasingly finding it difficult to dress herself, and I often find her clothes buttoned incorrectly ● **Agnosia:** I have 2 other siblings (sisters) who are married and living in Queensland, and she increasingly is unable to recognise them when they video call. We think it could be due to old age and did not suspect anything sinister. ● **Anomia:** she is able to correctly identify objects and has no trouble comprehending objects/images. ● **Aphasia:** we have no trouble communicating with her, she speaks English fluently and can understand each other well.
Medical Symptoms	● No fever, recent illness, weight loss ● No complaints of recurrent UTIs ● No thyroid, cardiovascular or stroke history ● No sudden changes in personality
Psychiatric Review	**Psychosis symptoms**: ● No auditory or visual hallucinations; she does not report 'seeing' her husband after his death but does miss him a lot. **Mania symptoms**:

	● Denies any euphoric mood, abnormal expenditure, or promiscuity **Depressive symptoms:** ● Felt lost when her husband passed away ● Does not have low mood and/or lack of energy ● Was not yearning to join her husband ● No noticeable changes in weight **Anxiety symptoms:** ● She is anxious for husband to come and get her ● She does not understand why she is in the hospital ● Never exhibited anxious symptoms

Risk Assessment	● No self-harm/suicidal thoughts and/or to harm others
	● <u>Mild cognitive impairment (memory)</u>
	● Unsure about mother's family history
	● <u>Independent with most ADLs :</u>
	  ● Cooking, cleaning, self-hygiene
	  ● Son does groceries for her

Personal History	
Social History	Ex-smoker: 1 pack for 30 years. Quit about 5 years ago. Alcohol: 1 glass of red wine a night. Does not binge drink. Lives alone in an apartment
Medical History	Type 2 Diabetes Mellitus - on metformin Hypertension - on cardopril Hypercholesterolaemia - on rosuvastatin Depression - on sertraline

MARKING GUIDE († denotes pertinent points)

S6: ALZHEIMER'S DISEASE	**Needs Improvement**	**Proficient**	**Excellent**
History Taking and Risk Assessment			
Introduces self and confirms patient details. Sets context for the interview. Uses open and closed questions appropriately. Establishes good rapport.			
† Explores HOPC including duration and onset, evolution of Sx and events leading up to the presentation.			
† Conducts a cognitive assessment: Discusses ≥ 3 cognitive domains (executive function, language, learning & memory, social cognition, complex attention, perceptual-motor function).			
† Excludes ≥ 4 of the following causes: organic Sx, manic Sx, psychotic Sx, anxiety Sx.			
† Conducts a basic risk assessment of ≥ 4 of domains: presence of suicidal intent/harm/plan, recent/past substance use, other harm to self or others, current living situation/finances, support from family/friends, exercise/diet.			
Assesses a patient's past psychiatric and medical Hx (i.e. meds, allergies and FHx)			
Diagnosis and Differential Diagnosis			
† Correctly diagnoses patient with mild neurocognitive disorder, specifically Alzheimer's disease.			

† Provides justification by stating presence of some cognitive decline from a previous level of performance in ≥ 1 cognitive domain (memory), gradual loss of memory, difficulty dressing but otherwise is able to function independently with some accommodation.			
† Considers other differential diagnoses such as delirium, depression or other dementia types and provides clear justification for ruling in/out.			
Management in ED			
† Investigates for possible medical/organic causes using ≥ 5 of the following: physical examination, MMSE/MoCA/RUDAS, full blood panel (FBE/UEC/TFT/LFT), urine drug screen, urine MCS, blood alcohol levels, ECG.			
† Refers patient to On-Call Psychiatry registrar to review patient and considers ≥ 3 of the following: conducting a mental state examination, risk assessment, location of care/admission status, use of Mental Health Act (MHA)			
Considers orienting patient to place, time, date and year using appropriate tools (clock, presence of familiar faces)			
Considers the possibility of a disoriented patient requiring de-escalation and recommends use of sedation (benzodiazepine or atypical antipsychotics).			
General comments:			

KEY LEARNING POINTS FROM OSCE NIGHT

- Do not forget to discuss ≥3 cognitive domains, in particular, assessing social cognition, complex attention and executive function. For example, questions such as 'is she able to shop for herself?' or 'who is responsible for her banking?' could indicate executive function.
- Ensure that you clearly differentiate between delirium, dementia and depression. Important questions to ask would be the timeline of functional loss and how rapid the onset of current symptoms are. For example, it is unlikely to be delirium if it has been progressively worsening over a year as delirium, by definition, is acute, fluctuating and reversible (as compared to dementia).
- Remember to justify your primary differential, in this case, Alzheimer's disease, by ruling out other forms of dementia. In the history it is useful to screen for each type of dementia - Lewy Body dementia (Parkinsonism/visual hallucinations), frontotemporal (changes in personality), vascular (stepwise decline, CVD risk factors), and Alzheimer's (short term memory loss, very common).
- When managing most elderly patients, it is good practice to do an MMSE or MoCA (for frontal function) to establish a patient's baseline cognitive function. Once organic causes have been ruled out with relevant bloods and imaging, it is also important to refer the patient to the psychiatry team.