Instructions to Candidates – Aim for 8 minutes

You are a Foundation doctor in General Practise.

Neil Dermet has made an appointment to see you regarding her toilet habits.

You have 6 minutes to take a history from Neil, you will then have 2 minutes to answer questions.

Patient Name: Neil Dermet

Age: 34 years

PC & HPC

"Doctor, you need to help me. I can't stop going to the toilet, its driving me crazy. I can't go out and it just won't stop."

You have been frequently opening your bowels – the consistency is loose and watery. You have noticed fresh red blood in your stools, no mucous or difficulty flushing.

This current episode has been going on for the last 3 weeks and increasingly getting worse:

- Currently you open your bowels every 3-4 hours during the day, eating does not stimulate your bowels to open.
- At night you have to wake up every 2 hours to open your bowels.
- Initially (3 weeks ago) you were opening your bowels once every 4-5 hours, but this never woke you up at night
- You have noticed the blood over the last 10 days, you see blood at least 3 times in a day and are now very worried.

You have been experiencing cramping pain in the lower left quadrant of your abdomen; the pain is there even after opening your bowels – you rate the pain 8/10 at its worst.

Pain does not radiate anywhere.

<u>Associating symptoms:</u>

- Unintentional weight loss over the last 7 weeks – approximately 1.5kg.
- Reduced appetite – home cook food for the last 2 months
- No vomiting or reflux symptoms.
- No fever.

Nothing specifically exacerbates the symptoms.

<u>If asked whether you have had these symptoms before 3 weeks ago:</u> You have been experiencing diarrhoea for the past 7/8 months, with blood occasionally seen.

<u>If asked about travel history:</u> About 10-12 months ago you went to Tenerife and Malaga for a 2 week holiday.

<u>ICE:</u> "Initially, I was worried this might be a bad case of food poisoning, but I think this could be much worse than right, right?", "I just want to find out what's going on and what can be done to fix this."

PMH

- None

DH

- Over the counter vitamin supplements – You have been taking these supplements for over 5 years.
- Penicillin allergy – causes tongue swelling.

FH

- Father has multiple sclerosis.
- Mother has polycystic ovarian syndrome.

SH

You work as a maths teacher in a secondary school, the work can sometimes get stressful but you enjoy the work. You live with your partner, never-smoker, little alcohol consumption (approximately 4 units per week), and no recreational drug use.

Questions

What are your differentials?

Traveller's diarrhoea, Ulcerative Colitis, Chron's Disease.

What infectious organisms are likely to cause Traveller's diarrhoea in this patient's case?

Ameoba, Shigella

What investigations would you do?

- Bloods (CRP, ESR, FBC, U&Es, LFT)
- Stool Culture – including parasite studies
- Urgent sigmoidoscopy/colonoscopy with biopsies
- Urgent referral to Gastroenterology
- Referral for *H. pylori* breath test

Is there anything else you would want to do?

Given the frequent bowel habits of the patient and 10 day history of blood being in the stool it would be best to discuss the case with any on-call gastroenterologist at the local Trust to have the patient admitted.

Feedback

Area	Clear Fail	Fail	Satisfactory	Good	Excellent
PC & HPC: Good range of open and closed questions asked.					
PMH & DH					
SH					
FH					
ICE					
Differential dx					
Investigations					
Rapport/communication skill					
Overall					

Feedback

Invasive intestinal infections, typically due to *Entamoeba histolytica* – cases in Europe involving international travel or immigration, can cause amoebic colitis. Patients may experience mild to severe symptoms; such as abdominal pain, watery and/or bloody diarrhoea, and weight loss. Both IBD and amoebic colitis can cause subacute diarrhoea, therefore, for any patient where IBD is considered a differential, make sure to include all diagnostic methods (including parasite studies) as it can be difficult to differentiate between pathological features of IBD and amoebic colitis from colonic biopsies. A firm diagnosis should be considered before starting the patient on first-line treatment for IBD.