This station was a double combined station - 16min station of APLS scenario. 6 month old child - respiratory difiiculty, then went onto have an EMD arrest.

2. Shoulder examination. Young lad with deltoid wasting and scapular winging post injury 5months before.

3. Neurologocal examination of lower limbs of 65yr old man who developed actue weakness in legs. Real pt. Probably had a spinal cord tumor or spinal mets from prostate CA (pt had had urinary symptoms)

4. Manic pt. HAd to take history for 5 mins and do psychiatric assessment. Then 3 mins talking to exmainer about findings and management.

5. Airway management in 6yr old pt given too much rectal diazepam by paramedics for a seizure.
Essentially you had to go through all the airway equipement then do basic airway manouevres all the way upto intubation.
Also further pt Mx.

6. HAd to do a dorsal backslab on Charlie Farlie with Shirley McTrusty has the glamorous assistant.
You got alot of points for interacting with the pt and your staff nurse.

7. Actor in this station who had a pneumothorax after falling down stairs. HAd to speak to him, show the landmarks to the examiners and then put in a chest drain in a carcass.

8. 14yr old with PV bleed. Didn't want mum to know. Probably pregnant. HAd to get a history and discuss management plan. Also I think Gillick's competence needed to be assessed.

9. Pt in dept complaining that SHO treating him for back pain was rude and abrput. HAd to talk to SHO involved.
She had had a difficult week of nights with a locum reg who was useless. HAd just finished last night and was stressed +++.

10. Respiratory examination. Pt had Di George's syndrome which I didn't get. I thought it was Cystic Fibrosis

11. Old pt in dept with chest pain, complete Heart block, Hx of lung Ca. HAd a living will - signed by GP, Pt and daughter.
Had to speak to daughter. Daughter was keen for full resus. Essentially had to talk her around it.

That's your merry lot. So 10 single stations and a double combined one.

FCEM OSCE (what I remember of it)

1) package for transfer an unidentified 12 year old head injury- GCS 3 – large extradural for neurosurgical transfer and refer to neurosurgeons. You are not going

with. Difficulties with this was that there was a nurse giving you handover- it wasn't obvious there were notes available and although I asked about the ct scans I was shown a packet and told they were as reported. The neurosurgeon wants to know if you have looked at the scans and basic details.

2) 25 year old unrestrained RTA GCS 3- to run as team leader- hands off. Guedel in rr- 20's, anaesthetist not available- you are not allowed to intubate, central steering wheel chest injury. Abdo soft but GCS 3, no obvious other injuries, tachy 130. trauma series not available. FAST is inconclusive and not allowed to DPL. Surgeon not available. Tachy comes down eventually with fluids and blood but bp still low??? ECG shows inferior st elevation which is a cardiac contusion- I thought this should be V leads but whatever. So I put central line in still low so still bleeding. Not sure if point was not to ct or just to realise that still bleeding and not due to contusion. Needs theatre.

3) Teach an ENP to interpret Cspine films.

4) Man with known mechanical valve with pyrexia and malaise on warfarin examine. Has cracking systolic mechanical valve I thought loudest aortic.

5) Suture a mans arm wound – no neurovascular problem. I found this difficult as very artificial- had to ask nurse for everything sutures would not lock on foam used to simulate wound. Things like should I have checked the lignocaine bur no bottles no needles and I forgot to aspirate as injecting. Needs to give post care instructions.

6) Young man previous dislocation patella 15 years ago- history of ? repeat incident. Examine knee (remember apprehension test and gait) discuss management and treatment.

7) SVT in 15 month old- no response to cold water or adenosine- crashes needs shocking (no anaesthetist available no sedation) shock it- it recovers- mum present throughout. Double station

8) History of a child with a spiral tib and fib fingermark bruising previous HI, underweight slow on milestones- convince A+E sister who knows family and doesn't agree its an NAI to call paeds and social services- clinical reasoning for NAI and conflict resolution- busy department early hours.

9) Loin pain female- take a history explain investigation plan and management- remember analgesia.

10) PID new partner- I think on OCP and lmp 1 week- examine- tender R groin mild pyrexia and tachy- I took swabs first then bimanual. Remember chaperone, privacy, empathy, watch face, be nice explain PID and FU. ? admission or not?

11) Cranial nerves except 2 and 8 apparently had 6th nerve palsy, which I wasn't convinced of as patient only had diplopia when specs off, ? also had 4th, certainly left eye position was not normal.

12) Explain bm machine and importance of bm's to mother of a 3 year old recently diagnosed diabetic who has come in with a hypo and further management- no gp. A lot to do in 8 minutes if try to do 4 part teaching method.

13) Back pain lady 18 months, ortho state not operable. Pt is overweight and probably a bit depressed discuss pain management and other coping methods. I found this difficult to know what they wanted. Went through home circs on disability- not getting out weight loss issues pain clinic alternative therapies- physio yoga????????

14) Overdose medically cleared, obviously depressed- well acted. Suicide intent- high risk patient short discussion on what if he left.

Although have a pie chart outside demonstrating what the station is testing it was difficult to know what was expected. Nothing killer difficult lots of communication skills.

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