Student Reports on Finals: Gastroenterology

Written by students for students
Students attending the ADC revision courses are asked each year to give feedback on their experiences in the clinical part of their exams and for comments about the courses. This helps keep the courses up to date and as relevant as possible and also helps to give subsequent cohorts of students a flavour of what’s expected. Please note that any answers suggested by students have not been checked for accuracy. By providing real exam scenarios, our hope is that students will be able to gauge the range of questions which most often appear in clinical exams and that this will help guide them to practise their clinical skills in the areas most relevant both to their exams and to their roles as junior doctors.

Students from the following Universities have contributed to these reports: Aberdeen, Birmingham, Bristol, BSMS, Cardiff, Cambridge, Cork, Dundee, Edinburgh, Glasgow, HYMS, Imperial, Keele, Leicester, Limerick, Liverpool, Manchester, Newcastle, Nottingham, NUIG, QMUL, RCSI, SGUL, Sheffield, Southampton, Swansea, Trinity College, UEA, UCL, UCD, Warwick

Patient confidentiality: new GMC guidance 2013
New guidance from the GMC was issued in 2013 and recommended extreme caution when using patient related information on the internet. As a result, where patient details have been provided in student reports, these have been carefully anonymised. Furthermore, the cases have been organised by clinical subject area rather than by medical school which provides further anonymisation of data.

Health warning: Reports can be misleading
Writing down what happened in the exam can be quite cathartic- a particularly useful way of off-loading all the stress- and so may not always give a balanced account, as people tend to emphasise the bits they found tricky.

Student report: “Take all the cases that people write about here with a pinch of salt. They seem like nightmares when you read them but in the actual exam you just deal with it and get on with it. I looked at the past questions before my exams and freaked myself out. Just look at these things to get an idea about stuff to include in your revision. I advise AGAINST looking at these things the day before your exam”.

Health warning: Remember the standard that’s expected
Student report: “In terms of the clinical exams I thought I’d done ok but really didn’t feel I’d done enough to do any more than pass. It turned out that I got As. I think the lesson is don’t get caught up in the Finals circus. They want safe junior doctors who can examine patients and elicit signs, not their next registrar.”

Health warning: Trust your own judgement
Student report: “My biggest advice is not to listen to students who went before you or to let people freak you out. You always know more than you think you do and will be amazed with what comes out!”

If you find these reports helpful, please email your own experiences of the clinical exams: support@askdoctorclarke.com
**Report: explain colonoscopy**
This patient has had a positive FOB, discuss colonoscopy and gain consent. Nice patient who was obviously anxious about colonoscopy and what it was. I explained everything easily and discussed risk factors (I have a very good friend who has Crohn's and she gave me the unedited version of what it's actually like to have a colonoscopy!). The patient was worried about transport so I told her about Patient Transport as well, she seemed pleased and the examiner was smiling at the end.

**Report: rectal examination and document findings**
Thanks for the fantastic course, I will be recommending it to future final years... This station provided a disembodied bottom that you had to speak to like a patient then perform a PR. Obvious polyp. The bulk of the station seemed to revolve around documenting your findings in an appropriate manner after completing the exam e.g. name, date, time, role, procedure performed, indication, consent, chaperone (name), findings (external, internal) etc. etc. Pretty easy station

**Report: haematemesis and alcohol problem**
I'm very pleased I went to the revision courses, they proved helpful in giving me the kick up the arse I needed to start revision! And they gave me a good initial overall base to build my revision upon... We had a man presenting with haematemesis, he has a drink problem: he is really an ex-soldier who has returned from Iraq & is suffering from PTSD!
How do you treat the alcoholism? How do you treat his PTSD? What is his risk? The examiner asked about differentials and how you would manage drinking excess (MDTs, groups, CBT, self help etc) and PTSD, and whether we thought he was at risk. Asked about acute management of alcohol abuse.

**Report: chronic liver disease**
A chronic liver disease patient and asked to do a full examination of his gastrointestinal system.

**Report: chronic liver disease with liver transplant**
I attended both the medicine/surgery and obstetrics/Gynaecology and paediatrics courses that you ran this year at BMA house. I found that them to be really useful specifically for the OSCEs.

This patient was for GI exam. He had a large scar which I guessed was for liver transplant and it seemed I was right. Got asked why do you think liver transplant (patient wasn't jaundiced but had yellow discolourtion over mucous membranes in the mouth - the examiners didn't like when other students referred to this as jaundice because patient wasn't jaundiced -and he did have duyputren's contracture and gynaeecomastia. Asked to demonstrate shifting dullness.

**Report: alcoholic liver disease**
Jaundiced man with alcoholic liver with encephalopathy (and flap)- asked about causes of jaundice, management of alcoholic liver disease and other complications of alcohol abuse. I was asked about the other causes of liver failure, and causes of ascites.
Report: chronic liver disease with transplant
Patient had distended abdo, tattoos, xanthelasma, z-scars from dupuytrens surgery, and upper midline lap scar with a transverse scar halfway down. Examiner made me repeat the shifting dullness coz I said it was positive, and I still thought it was positive when I repeated, but he said he wasn't convinced :( He asked causes of CLD in this pt, I said hepatitis or NAFLD; causes of scar, I said liver resection or transplant. He asked indications of transplant, and how would u check up on pts that have recently had a transplant. What would u worry about?

Report: liver transplant secondary due to autoimmune hepatitis; treatment of encephalopathy
Questions on causes on CLD, Ix- specifically what you’re looking for with each Ix, antibodies associated with AIH, management of encephalopathy (i said what i knew, but he was after one specific drug that they use- rifaximin- a poorly absorbed antibiotic related to rifampicin). I was also asked about hepatitis serology- which one test would u run for hep B and C.

Report: Rutherford Morrison scar
Abdo – obese lady who couldn't manoeuvre due to hip pain. Only sign I found was a midline lap and drain scars. Couldn't palpate for organomegaly or distinguish any masses. I presented this and the examiner revealed a Rutherford-Morrison scar I had missed and then could only recognise as an appendicectomy or Crohns stricturoplasty. We discussed RIF masses and what medicines Crohns patients may be on (steroids) … who else may take steroids … penny drops … shouted RENAL TRANSPLANT just as the bell went and stayed to reel off as much info as I could regarding transplants to try and rescue the situation.

Report: splenomegaly
Patient had a chemotherapy book on his bedside, it said he was on Chlorambucil. He also had splenomegaly. I presented the patient and the examiner interrupted me midway through. I got to cervical lymphadenopathy and he asked “Where else might you feel lymphadenopathy?” I said cervical chain and inguinal region. He asked, “Why is that relevant?” I replied, he has splenomegally. He asked “why do you think he has it?” I said, most common cause of splenomegaly in this country are myeloproliferative diseases such as CML or Myelofibrosis. He asked “Any other causes?” I said world wide the most common cause is Malaria, so I would like to take a travel history. He asked “How about in the UK?” So I rattled off my causes of non-massive splenomegaly (Budd chiari, Haematological from sickle cell, Infective like EBV CMV and Hepatitis, Neoplastic lymphoma, Rheumatoid arthritis - Felty syndrome, and SLE). He said “How about non-myelopathic haematological diseases” I said lymphoma. “Any others?” he asked. What he was getting at was CLL. Then he asked me what investigation would I do. I said blood film. “Anything else?” Ummmm CT. Bell rang.

Report: hepatosplenomegaly
Abdomen - young black female with a distended abdomen, linea nigra, and hepatosplenomegaly?? with a well healed cesarean scar. She was pregnant! The examiner asked me the common causes of hepatosplenomegaly
Report: jaundice and splenomegaly
The patient had jaundice in the eyes and mouth. No scars, but had splenomegaly. I wasn’t asked about the causes, but asked about investigations. Started out with bloods, I mentioned FBC as CML/myelofibrosis can cause splenomegaly. Asked: What exactly would you see in the bloods? Would you do any genetic testing? Any other investigations? Mentioned CT, asked what I would see there.

Report: hepatomegaly
Abdo Ex: Patient has no gross signs and slightly distended stomach (but then again, I too have a slightly distended stomach). I thought there was some hepatomegaly but I’m not sure. The examiner seemed fair and quizzed me on causes of hepatomegaly.

Report: abdominal pain
Take a history of a patient presenting with abdominal pain and perform an abdominal examination. The examiner then asked for a differential diagnosis and what two investigations you would like to perform. Based on the answers the examiner presented the results of the investigations requested and asked for a definitive diagnosis. I chose Abdominal USS and serum amylase. The results were given and it was an acute pancreatitis patient. We had to give about 5-6 differentials though.

I thought that your course was succinct and covered most aspects that could not be taken from books. Unfortunately, I had no opportunities to use "Lub-de-burr" in this years OSCE but nonetheless, it was a well-presented course and it has received positive feedback all around from my peers.

Report: gastroscope
Examine this patient’s abdomen. Patient had a gastroscope but could not remember the name of it! When asked by the examiner I said “well it’s a tube... and it’s coming from the stomach...”. The examiner just laughed and moved on. The patient had lots of other scars and I was asked what they might all be for.

Report: GI bleed
History and communication station: A middle-aged woman who had had a single episode of malaena this morning and was worried that she had gastric cancer (which her father died from). This was unlikely and she had a background of excess alcohol and NSAID use for osteoarthritis. There was a discussion with the examiners about the differential diagnosis, the investigations she’d require and the protocol for managing an upper GI bleed in hospital. I was asked to tell the patient what the next stage in her management would be and to assuage her fears regarding gastric cancer.

Report: Crohn’s
History taking on a man with Crohn’s disease.

Report: splenomegaly
Next was a bloke in his late 50’s with what i think was myelofibrosis or CML. Luckily a friend had been round the evening before and done lots of haematological examinations with me, so I know the examiner was impressed when I checked tonsils etc as well. There was a discussion on bone marrow failure, investigations, differing haematological diseases.
Report: examination of the abdominal system  
Diagnosis: Renal transplant following polycystic kidney disease

I loved this examination having made the diagnosis from the elbows (bilateral AV fistulae, one of which was buzzing without any puncture marks)! The patient had a transverse scar at the neck, which I pointed out to the examiner and stated that this may be due to surgical treatment for secondary parathyroidism due to renal failure, to which he agreed heartily! A mass was palpated in the abdomen beneath a classic Rutherford-Morrison scar.

The only difficulty the case gave me was that I gave the likely causes that would lead to replacement, but had not felt any enlarged kidneys – apparently they had atrophied and were no longer palpable.

Report: Crohn’s disease  
History: change in bowel habit  
Diagnosis: Crohn’s disease

This history was actually quite hard to take in an examination setting as the patient began by stating she had Crohn’s. I asked her to go through the various stages to her diagnosis starting with the onset of symptoms to investigations and to present. The only thing the examiner seemed to want to ensure I knew in his questions was that colorectal cancer was in my differential.

Report: history ulcerative colitis  
Ulcerative Colitis History - Woman had only been diagnosed 2 weeks ago, not much history asked about all the obvious symptoms PR bleeding, weight loss etc - examiner kept asking me what else I wanted to ask I wasn’t sure but he was getting at Joint Pains - asked me about link between smoking and the 2 IBDs.

Report: abdominal examination  
Abdo Exam - Weird Examiner, kept stopping me, when I was checking for liver flap (beginning of the exam) he said why are you doing this I said chronic liver disease, he then made me list all the other signs I would look for in CLD. Then didn’t really want me to do full exam - just bombarded me with questions - ‘tell me all the hernias’ 'difference in direct and indirect' 'anatomy of inguinal canal' ‘tell me the different inflam bowel diseases - I said UC and crohns, he said what else, but I didn’t know' I got all the other questions right so he was nice after this

Report: rectal examination  
Intimate examination - “Patient bleeding per rectum”. Normal exam on simulated patient. Asked for chaperone, talked to the patient throughout the procedure. There have been no questions at the end, however I talked about what I would like to do to complete the examination: full history, abdominal examination, stool culture, etc.

Report: history of haematemesis and explain investigations and management  
Focussed history. I explained common causes (mallory weiss, liver, oesophageal varices, ulcers and some more severe cause) and that the causes can range from common things to slightly more severe things. I told him that I would like to do perform a thorough abdo exam, take some bloods and do a camera test and then I would like to make him an appointment and come back when we have more info so that we can discuss.
Report: jaundice and splenectomy
Abdominal: man with yellow sclera, but no peripheral stigmata of liver disease, subcostal scar. Q’s – what surgery may this have been? Splenectomy. What disease links jaundice with a splenectomy – haemolytic anaemias

Report: Crohn’s history
History from a patient with Crohn’s disease who was 40 years old. The patient had major complications from his disease. He had two bowel resections. He also had a colovesical fistula 10 years ago. Currently he was suffering from major joint problems and was recently diagnosed with ankylosing spondylitis. He was afraid he was going to end up with a stoma. I forgot to ask what investigations the patient had when he was first diagnosed. The examiner then asked me about differentials and investigations for Crohn’s at the end.

I was expecting the examiners to be standing there like robots, and to be quite expressionless! After one of my stations, I had examined and presented (no questions!) and was walking to the next one when the examiner ran after me, tapped me on the shoulder and said "just a friendly comment, when you are presenting, don't put your hands in your pockets, some people don't like that". That comment gave me a confidence boost, I realised this examiner really wanted me to do the best I could, and was human after all! I was also reminded of how I should be standing presenting, so made a conscious effort in the following stations to put my hands behind my back, stand tall and look confident!

Report: hepatosplenomegaly
A full abdominal examination. The woman had lots of scars as well as hepatosplenomegaly. She also had scars under her breast and I thought that she had breast cancer with metastasis. The others who got this patient thought the same. It was otherwise just an abdominal examination.

Your course was brilliant. A lot of the stuff you covered came up in the written paper. It really provided a good foundation of knowledge.

Report: inflammatory bowel disease
Next was a chronic diarrhoea history. Patient had IBD. Again, present back, diagnosis and differentials and further investigation.

All examination stations essentially asked:
1: what are your significant examination findings?
2. what is your differential diagnosis?
3. how would you investigate this patient?
4. how would you initially manage the patient? (not always asked)

Report: normal abdomen
This was really hard! Couldn’t find any signs – the instructions to the scenario were that this patient has a history of diarrhoea. Couldn’t find any signs but I think because I covered all bases when asked what I would do, I pulled through.

Report: explain about a nasogastric tube
GI: explain NG tube to a patient with autism who has already been assessed as having capacity.
Student Reports on Finals: Gastroenterology

Report: abdominal examination
You were an FY1 on gastro outpatient and had been asked to examine the next patient. You were asked to report your findings as you went along. The patient had no signs except a stoma in the RIF. I explained that I thought what type of stoma this was and that I would like to remove the bag to be certain of this (we weren’t allowed to do that). We also had to examine for hernias and then summarise our findings at the end. Asked about position/site and perhaps indications for surgery. Used Dr Clarke notes a lot in this station!

Report: normal abdominal examination
Abdominal exam – standard abdo exam testing our technique. I had a normal patient, no signs. We were asked to present our findings at the end… Thanks for the revision courses. I attended Medicine, Surgery and Paediatrics and they were all really useful!

Report: abdominal examination/ Osler Weber Rendu
Abdo exam: just asked to perform abdo exam on a woman. I went through it systematically reporting findings as I went. She had telangiectasia on her face and a large laparotomy scar on her abdomen. The examiner looked excited when I said this and said “and putting your findings together, what do you think the diagnosis is?” I had no idea and said I didn’t know. In retrospect I wonder if it was Osler-Weber Rendu?!

Report: ascites
I got to examine a patient with ascites, was asked about the treatment and when was TIPSS indicated (transjugular intrahepatic porta-systemic shunt).

Report: long case UC
The long case was a new diagnosis of UC. The patient was wary about giving me his new diagnosis until half way through my history but I once I had it, I asked a few more targeted questions and prepared my baseline and definitive investigations before the examiners came in. He had few signs on examination except clubbing. Following my history I was asked questions by the bedside, it felt like it went on forever. The questions start off as easy (investigations for bloody diarrhoea) and onto more difficult topics (what lung problems do UC patients get - bronchiectasis I think and tell me about autoimmune pancreatitis in IBD patients and new stool testing for IBD) Some I knew some I didn't but that’s the way it goes I suppose. I used your book from the course from cover to cover and really enjoyed learning it. This website is fantastic. I would recommend it to anyone!

Report: long case: hepatitis A
Hepatitis A in a previously well 34 yo
Measure liver span

Report: chronic liver disease with ascites
Last case was a man with a big liver with jaundice and ascites, spider naevi. They had me do shifting dullness and feel his hepatomegaly.

Report: chronic liver disease
Perform a GI exam: the patient was a young woman who was jaundiced and had hepatomegaly. I was asked the potential causes of her hepatomegaly in this age group… Thank you very much for all the work you put into your courses. They were very helpful- it was reassuring and also gave us a bit of motivation to keep going.
Report: splenomegaly
Abdominal exam - massive splenomegaly was nervous here as knew the examiner and was terrified of him in tutorials. Asked the causes of splenomegaly I blurted out a list and he stopped me with hold on I want likely causes!! was fine though just asked a bit about myelofibrosis

Report: chronic liver disease
A man with hepatomegaly and small volume ascites. Just palpated and percussed the liver borders and gave differentials and they just asked me to list the sequelae of chronic liver disease. One I'd the examiners made reference to the fact that when we came into the bay the patient had been on the phone selling shares (apparently) and asked if I thought he should be allowed to do that...for the life of me I just didn't get what they wanted me to say and was kicking myself afterwards for not getting the answer without a prompt, but they were referring to hepatic encephalopathy, and once I made the connection they left it there.

Overall it was fine and I came away thinking it was a fair assessment. If I was to prepare for my finals again, I think the most important thing is exposure on the wards as an FY1. By the time 5th year comes round there is very little the books can teach you about being a junior doctor and its just about getting experience.

Report: polycystic kidney disease
Abdo exam - we were told not to examine peripherally and just focus on the abdomen. He had a scar in the right iliac fossa. I asked him if he'd had his appendix removed but he wasn't allowed to tell me. I felt a mass in the left flank which I thought was a big spleen. I left that station feeling happy about it. Then I heard, from behind the curtain, another student saying he had polycystic kidneys and a renal transplant!! I had failed to put the two together.

Report: long case- haemachromatosis.
I felt that this chap was a bit of a gift. The opening statement was "this gentleman has arthritis and has recently been found to have altered liver function tests; please find out more". I thought initially it may have been drug-induced, so I went down the avenue of his arthritis first. He then pretty much steered me and said it wasn't a drug causing the LFT derangement, as a Dr had thought, and was happy to tell me all about his haemachromatosis. I asked him what other tests he had had, and he proceeded to tell me about his pituitary and lack of testosterone, how his heart was fine and he didn't have diabetes. I hadn't even remembered that it affects all these organs! This really helped with the questioning...which was mainly about which organs haemachromatosis affects and other causes of liver cirrhosis.

Report: long case Crohn's
Quite a lot to cover in history as patient had a diagnosis of Crohn's but initial presentation was obstruction, so had to try to cover both sets of symptoms. Abdo exam - finished that one early and examiners suggested I use the remaining minute to continue history - which made me think I must have left something important out and threw me off completely!
Questioning on investigations, anaemia, why the patient had developed osteoporosis, differences between Crohn's and UC on presentation/ imaging/ endoscopy/ treatment. Had to explain diagnosis/management - but for when she initially presented which I wasn't prepared for and again ran out of time after my first couple of sentences! Thank you so very much for the excellent courses. They really were very helpful and picked out the sorts of things I needed to learn.
Report: eradication of helicobacter pylori
Prescribing station – we had to prescribe the eradication therapy for helicobacter pylori. We were given the local guidelines and a BNF. The key was to notice the guy was penicillin allergic and therefore prescribe the right therapy. We had to cross off NSAID and paracetamol for OA and switch to co-codamol.

Report: GORD
My long case had GORD. They wanted to discuss GORD, then benign oesophageal disease such as achalasia, corkscrew and nutcracker oesophagus and different investigations (manometry / barium swallows)
The patient was on bisphosphonates, they wanted to know mechanisms of action and long term s/e. Finally they wanted to know other treatment options of osteoporosis.

Report: ascending cholangitis
Prescribing- unmanned station. Given a short history of a patient with ascending cholangitis. Had to review the drug chart and prescribe as appropriate. The antibiotic guidelines where there, a BNF and a calculator. I gave antibiotics, fluids, paracetamol and cyclizine and made sure VTE prophylaxis was written up.

Report: primary biliary cirrhosis
History. A lady who has been diagnosed with PBC. Tests and investigations for PBC, antibodies to look for and complications. Causes of Liver Cirrhosis and complications (e.g. hepatic encephalopathy and management)

Report: inflammatory bowel disease
History of patient with IBD Basic history of blood in stool, pain, altered bowel habit. Asked about systemic features of IBD. Examiner seemed impressed that I knew these, Other questions on causes of bloody diarrhoea, treatment options for IBD, link between RA and IBD.

Report: inflammatory bowel disease
GI history - preparation time told us to take a HPC, family history and PMH from a patient with a 'change in bowel habit - diarrhoea' and also gave us a medication list on which was listed 'Azathioprine'. It was a nice station, remembered to ask about the bigger impact that IBD had on the patient’s life. Questions included; differentials, investigations and management.

What cases will you be examined on?
Do let us know after your exams so that we can add to these reports: support@askdoctorclarke.com