SUBJECT AND CURRICULUM REFERENCE

Clinical Discussion with Intern: Should I perform a D Dimer?

- *Prioritisation and decision making*
- *Communication*
- *Scholarship and teaching*
- *Medical expertise*

Length: 10 minutes

CLINICAL SCENARIO STEM:

INSTRUCTIONS:

Candidate: You are in charge of the shift. Your intern has asked to present a patient to you that he/she has just seen. Could you please discuss the case with your intern?

Role player – intern: Candidate is presented a case by an intern who has a patient Mrs Farrugia who he thinks might have a PE. He approaches the candidate with the question of whether he should perform a D Dimer. The actor only provides some of the information required to allow the candidate to form an opinion on whether to perform a D dimer. The station is to assess the candidates ability to gather the correct information, risk stratify the patient with the intern, educate the intern on the pros and cons of performing a d dimer, and to educate the doctor on how to present patients in the future to ensure that a comprehensive history and exam is taken.

Your request will be 'should I perform a D-dimer? Whatever the answer, make sure that the question "why?" has been answered.

Make sure that every question is answered to discourage the candidate from saying "let's go and see the patient together". If the candidate does ask to do this, acknowledge that this is good practice, but patient not available at present (eg still in x-ray)

Examiner: Observe the conversation. Candidate must gather enough of the missing history to give sensible, logical and clear advice.

Script:

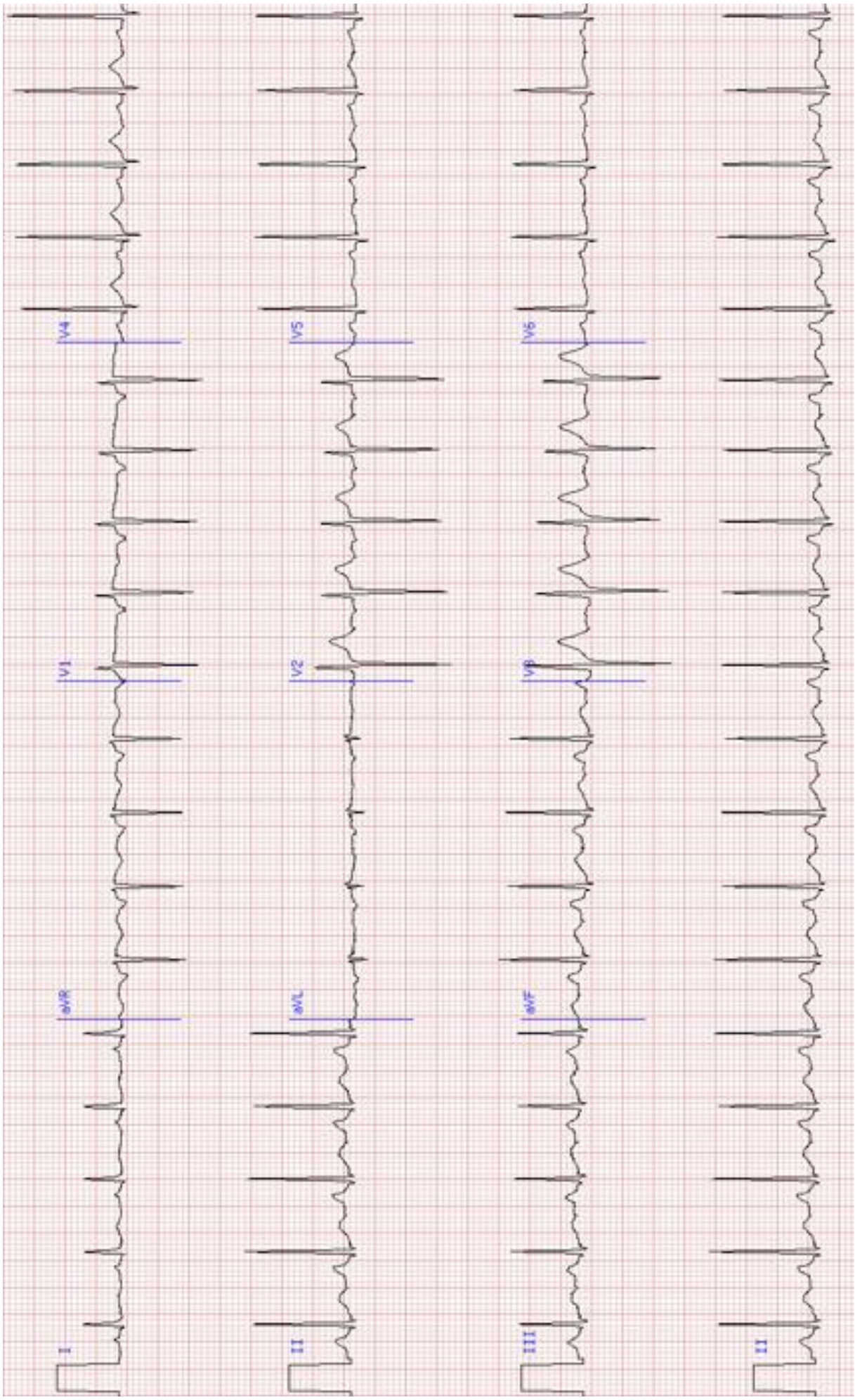
"I have just seen Mrs Farrugia, a 52 year old lady with a pat history of anxiety and depression, who has presented with left sided pleuritic chest pain for the past 24 hours, with no relief from paracetamol. She has a past history of anxiety and depression and takes Alprazolam and Venlafaxine. She is not SOB, has not had any recent respiratory infective symptoms. No haemoptysis, no previous history of these symptoms in the past. Her ECG shows sinus rhythm with a rate of 110 (provided) and looks pretty good otherwise. She has had a CXR which has been reported by the

consultant radiologist as normal. Her clinical examination, including a full cardiac, respiratory and lower limb examination is all normal. I'm wondering whether she has a PE and whether I should add a d-dimer to her bloods."

Other history to provide if asked:

- SpO2 96% on air
- No haempotysis
- No back pain, or any other signs or symptoms to suggest alternate pathologies: aortic dissection. No signs or symptoms to suggest gallstones, pancreatitis or gastrointestinal pathology (reflux, PUD etc), chest infection
- No family history of PE. No history of PE/DVT in the past
- No unilateral leg swelling
- Not on the pill, no recent surgery, no recent flights or travel >6 hours duration, no limb immobilisation

Candidate must acknowledge that patient is not PERC negative, so PE cannot be ruled out conclusively. Wells criteria discussion – probably falls into moderate risk – resting HR >100, and no other more likely diagnosis. Discussion will then need to entertain D-dimer vs definitive testing (CTPA vs V/Q)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