Osce *and* *paces* *recalls* *for* *national* .May 2021

1, Mr Tobias a 35 yr old rice farmer who lives at ore ile sagamu presented with 5 days history of passage of bloody urine. Take a focused history.

ANS

G – GREET MY PATIENT
R – RAPPORT
I – INTRODUCE MYSELF
P – CONFIRM PURPOSE OF VISIT
S – ENSURE THE SETTING IS CONDUCIVE AND OBTAIN CONSENT
BIODATA

PC – BLOODY URINE

HPC - Onset and duration of bloody urine

- Progression or worsening of the symptom
- Clarifies color of urine (bright red blood) Microscopic or macroscopic, If blood is initial, terminal or gross
- Ask for Urinary frequency, Pain on urination , Urgency, Nocturia, Incomplete voiding, Hesitancy
- Ask for patients location, occupation, source of drinking water, type of sewage disposal used, any hx of swimming in water recently, if there are similar cases among people in his community
- Occupational history – especially exposure to exogenous toxins

Ask for Penile tip pain, Flank Pain, Abdominal discomfort/fullness

Systemic Symptoms – weight loss, fever, night sweats, any mass in any part of his body

Personal history of bleeding diathesis, renal stones, his genotype, CONSUPTION OF BEETROOT, FAVA BEANS, BLUEBERRIES, ARTIFICIAL FOOD COLOURINGS

Any Past history of renal disease, past history of UTI, PAST HISTORY OF UROGENITAL CANCER

PMSH – HTN, DM, ASTHMA, SEIZURES, PREVIOUS HOSPITALIZATIONS, BLOOD TRANSFUSION, PREVIOUS SURGERIES

- FSH - MARITAL STATUS, NO OF ROOMS IN HIS HOUSE, NO OF CHILDREN . Smoking history (quantity in pack-years), ALCOHOL USE

DRUG HX – ASK FOR Current medications, INCLUDING USEOF DRUGS SUCH AS RIFAMPICIN, NITROFURANTOIN, CYCLOPHOSPHAMIDE, WARFARIN

Review of sys

FIFE – His Concerns as to what is causing the hematuria,

are there things he is scared of concerning his symptom,

what he expects from his visit to the facility

ASSESSMENT- DISCUSS THE POSSIBLE DIAGNOSES, INVESTIGATIONS AND POSSIBLE TREATMENT PLANS

ASK IF PATIENT HAS ANY QUESTION

RESCHEDULE FOLLOW UP VISIT

THANK PATIENT

2) follow up station,

A, His name and Age – Mr Tobias , 35years
B, Address

C, Causative organism and Vector.
Ans – Schistosoma Haematobium
Vector – Bulinus Snails

D ,How will you manage him

Ans – AFTER TAKING HISTORY AND EXAMINING THE PATIENT
INVESTIGATIONS WILL BE REQUESTED FOR TO CONFIRM DIAGNOSIS, THEY INCLUDE FBC, MP, URINALYSIS/MCS, STOOL MCS FOR PARASITES AND EGGS, CLOTTING PROFILE, PSA, EUCR, abdominopelvic uss
Treatment with Tab Praziquantel at 20mg/kg twice daily x 1/7 or a Single dose of 40mg/kg stat

E, Recommendations you would give to the community in terms on management.

Prevention and Control

1) ELIMINATION OF THE RESERVOIR - PREVENTIVE CHEMOTHERAPY
2) ELIMINATION OF THE VECTOR - SNAIL CONTROL USING MOLLUSCICIDE EG NICLOSAMIDE PRODUCTS, PHYSCICAL CONTROL BY ALTERATION OF THE HABITAT EG DRAINAGE OF SWAMPS
3) HEALTH EDUCATION WITH EMPHASIS ON GOOD SANITATION, IDENTIFYING THE MAJOR GROUPS AT RISK AND SOCIAL MOBILIZATION
4) COMMUNITY PARTICIPATION - TO ENSURE THAT THE COMMUNITY IS AWRE OF THE RISK AND CONSEQUENCES OF THE DISEASE. AND TO ALL MAKE SURE THAT THE MECHANISS OF CONTROL BEING PUT IN PLACE ARE ACCEPTABLE TO THE COMMUNITY

5) AVOIDANCE OF CONTAMINATION WITH SURFACE WATER - ENVIRONMENTAL MANAGEMENT WITH PROPER WASTE DISPOSAL SYSTEM
6) PREVENTION OF HUMAN CONTACT WITH INFECTED WATER - ACCESS TO CLEAN WATER

3, Take a focused history from a 24yr old student who presented with bleeding per vaginam.

G – GREET MY PATIENT
R – RAPPORT
I – INTRODUCE MYSELF
P – CONFIRM PURPOSE OF VISIT
S – ENSURE THE SETTING IS CONDUCIVE AND OBTAIN CONSENT AND ASSURE HER OF CONFIDENTIALITY
BIODATA
PC – BLEEDING PV
HPC - LMP
Onset
Constant/intermittent
Progression, Frequency
Exact amount of bleeding - pads used per day.
Any Precipitating events, ANY Previous episode
Alleviating factor/ Aggravating factors

Associated symptoms -
Trauma (to the pelvis), Swelling of the ankles
Fever/chills, Night sweats, Fatigue
Urinary problems
Bowel problems - Abdominal pain.
Appetite, Weight changes
Hx of bleeding diasthesis, genotype

Ask for patients location, occupation, source of drinking water, type of sewage disposal used, any hx of swimming in water recently, if there are similar cases among people in her community

Sexual history, OB/Gyn

menarche, cycle length, any menstrual abnormalities like dysmenorrhea, intermenstrual bleeding
Vagina discharge
Sexually transmitted infection
chlamydia, HPV infection
Previous Pregnancies - Abortions/miscarriage (VTOP)
Knowledge of Pap smear and if she has done any
Knowledge of contraceptive and if she uses any

Past medical & Surgical history - HTN, DM (HEADS) Hospitalizations, blood transfusion, previous surgeries

family history & social history
Marital status
Work, Home
Alcohol, Tobacco

Drug & Allergy hx - current medications, Recreational drugs, any allergy

FIFE – Her Concerns as to what is causing the bleeding

are there things she is scared of concerning her symptom,

what she expects from his visit to the facility

ASSESSMENT- DISCUSS THE POSSIBLE DIAGNOSES, INVESTIGATIONS AND POSSIBLE TREATMENT PLANS

ASK IF PATIENT HAS ANY QUESTION

RESCHEDULE FOLLOW UP VISIT

THANK PATIENT

4,urethral catheter

a, 10 indications

1) T O COLLECT STERILE URINE SAMPLE
2) TO MONITOR URINE OUTPUT
3) TO FACILITATE IMAGING OF THE URINARY TRACT
4) TO MANAGE ACUTE URINARY RETENTION
5) FOR CONTINOUS BLADDER IRIGATION IN GROSS HEMATURIA
6) FOR HYGENIC CARE OF BEDRIDDEN PATIENTS
7) FOR INTERMITTENT DECOMPRESSION OF NEUROGENIC BLADDER
8) FOR CERVICAL RIPENING
9) FOR MAINTAINING HEAMOSTASIS AFTER MYOMECTOMY
10) PATIENT COMFORT AT END OF LIFE
11) FOR INTRAOPERATIVE ASSESSMENT OF FLUID STATUS DURING MAJOR SURGERIES
12) FOR PHARMACOLOGIC INFUSIONS EG BCG IN BLADDER CA

b, 6 UNIQUE FEATURES that aids its function

ANS

1) **IT** IS FLEXIBLE
2) EASY TO USE
3) IT IS SELF RETAINING WITH AN INFLATABLE BALLON
4) IT HAS A DRAINING LUMEN
5) IT HAS A BIFURCATION POINT (Y- JUNCTION) SERVING AS A GUIDE BEFORE INFLATING THE BALLOON
6) ITS MADE OF LATEX/SILICONE WHICH CAUSES LESS IRRITATION
7) IT HAS A BALLOON PORT AND A DRAINAGE PORT WHICH CAN BE SPIGORTED FOR BLADDER TRAINING
8) THE TIP HAS 2 BLADDER OPENINGS TO ALLOW FREE FLOW OF URINE INTO THE CATHETER

C, six steps in catheterization.

ANS –

1) IT IS AN ASEPTIC PROCEDURE DONE WITH AN ASSISTANT
2) INTRODUCE YOURSELF TO THE PATIENT

3) GET INFORMED CONSENT FROM THE PATIENT, AFTER EXPLAINING THE PROCEDURE

4) PREPARE THE CATHERISATION TRAY (On a clean trolley, gather:

- A catheterisation pack.
- Saline solution.
- Sterile gloves.
- A10 ml pre-filled syringe containing 2% lignocaine gel.
- A catheter bag.
- A 10 ml syringe containing sterile water.
- Adhesive tape.

5) PLACE PATIENT IN SUPINE POSITION WITH LEGS EXTENDED AND FLAT ON THE BED (SCREEN PATIENT)
6) EXPOSE THE GROIN AREA
7) Check the expiry date of the catheter, A 12-16 french Folev catheter.
8) Open the catheter pack aseptically, and pour saline solution into the receiver.
9) If pre-filled syringes are not provided with the pack, draw up 10 ml sterile water and 10 ml lignocaine gel into separate syringes.
10) Wash and dry your hands, Put on sterile gloves.
11) Drape the patient.
12) With your non-dominant hand, hold the penis just below the glans and hold upright (in between your thumb and index finger)
13) With your dominant hand, retract the foreskin and clean the area around the urethral meatus with saline-soaked swabs.
14) Instill about 5 -10 ml of lignocaine gel into the urethra while letting the patient know that it may create a stinging sensation. Hold the urethral meatus closed. Indicate that the anaesthetic needs about 2-5 minutes to work.
15) Hold the penis so that it is vertical, ask your assistant to open the catheter aseptically for you and Coat the end of the catheter with lignocaine gel
16) Holding the catheter by its sleeve, gently and progressively insert the lubricated tip of catheter into the urethra meatus
17) Once a stream of urine is obtained, continue to advance the catheter completely to the bifurcation and then inject 10 ml of sterile water to inflate the catheter's balloon, while continually ensuring that this does not cause the patient pain
18) Attach the urine bag and Gently retract the catheter until a resistance is felt ie until the ballon engages the bladder neck
19) Remove drape, clean up patient and cover patient up
20) Ensure drainage bag is anchored to the bed frame and can Tape the catheter to the thighmif indicated for certain patients
21) ENSURE THAT YOUR PATIENT IS COMFORTABLE AND THANK YOUR PATIENT
22) Remove your gloves, Discard any rubbish and wash your hands
23) After the procedure - Record the date and time of catheterisation, type and size of catheter used. volume of water used to inflate the balloon, and volume of urine in the catheter bag

FOR FEMALES

BASICALLY THE SAME STEPS WITH JUST THE TECHNIQUE DIFFERENCE OF

- USING THE THUMB, MIDDLE AND INDEX FINGERS OF THE NON-DOMINANAT HAND TO SEPARATE THE LABIA MAJORA AND LABIA MINORA
- PULL SLIGHTLY UPWARDS TO LOCATE THE URINARY MEATUS AND MAINTAIN THIS POSITION TO AVOID CONTAMINATION OF THE PROCEDURE

5, A boy ON CLUTCHES

a, SIX DIFFERENTIALS

1) PARALYTIC POLIOMYELITIS
2) TRAUMATIC PARAPLEGIA
3) GULLIAN BARRE SYNDROME
4) SPINAL CORD COMPRESSION
5) TRANSVERSE MYELITIS
6) MYASTHENIA GRAVIS
7) ENCEPHALITIS
8) SPINAL DYSRAPHISM
9) SPACE OCCUPYING LESION
10) POLYMYOSITIS

b, HOW TO PREVENT MOST LIKELY DIAGNOSIS

ANS – 1) Provision of clean water
2) improved hygienic practices – Safe disposal of faeces
3) sanitation is important for reducing the risk of transmission
4) Immunisation is the cornerstone of **polio eradication**, 2 types of vaccines are available: an inactivated poliovirus vaccine (IPV) and a live attenuated OPV
5) Surveillance of acute flacid paralysis – Notification and isolation of individual cases

C) Most likely diagnosis
ANS – POLIOMYELITIS (ACUTE FACCID PARALYSIS)

D) What are the three forms of the diagnosis
types of p**oliovirus** (WPV) WILD POLIO VIRUS – **type** 1, **type** 2, and **type** 3.

E) IF there is to be a re-emergence of this from the North East, what type would it be.
ANS - WILD POLIO VIRUS I AND 3 (WPV1 and WPV3)

6)A woman presented with burning sensation at micturation and a doctor requested for a lab work up.
(the lab is a chem path lab and he filled the wrong name, wrong pxt no, wrong duration , wrong department,etc)

A) Criticize the doctors write up.
ANS – INCORRECT FILLING OF LABORATORY INVESTIGATION FORM

b, what is the diagnosis.
ANS - ?UTI BASED ON ASSUMPTION COS THE LAB RESULT VALUES WERE NOT GIVEN)

c, two ways you can correct the doctor.
ANS - 1) APPROACH THE DOCTOR DIRECTLY & TALK ABOUT IT WITHOUT INVOLVING ANY OTHER PERSON
2) ASK QUESTIONS ON WHAT LEAD TO THE WRONG FILLING OF THE LAB FORMS

7, A fashion designer who presented with (a picture of alopecia) noticed that her hair pulls out on combing.
a, five differentials
ANS – 1) TAENIA CAPITIS
SECONDARY SYPHILLIS
SLE

CHEMOTHERAPY
TRAUMA (BURNS)
TRACTION ALOPECIA
LICHEN PLANUS
HEAVY METAL POISOING
IRON DEF
HYPOTHYROIDISM

B) DIAGNOSIS IF IT SHOWS COMMA SIGN

ANS – TINEA CAPITIS

C) 3 ways to treat

ANS – 1) USE OF ANTIFUNGAL SHAMPOO TO DECREASE TRANSMISSIBILITY OF INFECTION (SELENIUM SHAMPOO)
2) 1ST LINE DRUG Tab GRISEOFULVIN which disrupts fungal microtubule formation
Newer antifungal agents such as terbinafine, itraconazole, and fluconazole are at least as effective as griseofulvin effective
3) All members of the household should be screened for tinea capitis and treated simultaneously if found to be affected.
4) Sharing of potential fomites such as hairbrushes, hats, and pillows should be discouraged, and these should be properly cleaned.

D, 5 Risk factors for the diagnosis.

ANS – 1) Living in warm climate.
2) Have close contact with an infected person or animal.
3) Share clothing, bedding or towels with someone who has a fungal infection.
4) Participate in sports that feature skin-to-skin contact, such as wrestling.
5) Wearing tight or restrictive clothing.
6) Having a weak immune system.

8, A picture of cystic hygroma,spinal bifida and cleft lip/ palate
a, list the diagnosis

ANS – CYSTIC HYGROMA
SPINAL BIFIDA
CLEFT LIP/ PALATE

b, 2 COMPLICATIONS OF EACH

ANS - CYSTIC HYGROMA

1) RESPIRATORY DISTRESS FROM AIRWAY OBSTRUCTION
2) BLEEDING INTO THE CYST
3) INFECTION OF THE CYST
4) Insinuation into major structures
5) Before delivery may cause obstructed labour
6) Recurring growths

SPINAL BIFIDA

1) Traumatic birth and difficult delivery of the baby
2) Frequent urinary tract infections
3) Hydrocephalus (Fluid buildup on the brain)
4) Loss of bowel or bladder control

5) Meningitis
6) Permanent weakness or paralysis of legs

CLEFT LIP/ PALATE

1) FEEDING DIFFICULTIES
2) HEARING LOSS
3) SPEECH & LANGUAGE DELAY
4) RECURRENT EAR INFECTIONS - URTI, Chronic otitis media
5) DENTAL PROBLEMS - Altered dentition, Hypoplasia of the maxilla
6) Respiratory obstruction
7) COSMETIC PROBLEM

D) OTHER PARTS WHERE HYGROMA CAN OCCUR

ANS – 1) ORALcavity (BUCCALMUCOSA, TONGUE)
2) Axilla,
3) Mediastinum,
4) POSTERIOR TRIANGLE
5) Abdominal cavity,
6) Retroperitoneum,
7) GROIN (scrotum)
8) SKELETON

E) WHEN to repair cleft lip and palate , and why that time?

ANS -

Cleft lip Repair should be after 10weeks of age to ensure good muscle approximation /attachment

This age appears to be advantageous because healing times are fast, the patient's memory of the recovery process is short, and the area around the cleft hasn't had much of a chance to develop surrounding tissues in an abnormal manner.

For cleft lip
The rule of 10 -
Child must be up 10weeks old
10pounds/ 4.5kg wt
10g/dl of HB
Wbc shld not be > 10,000

Cleft palate is not repaired before 10 months of age because at that age bony structures are not well formed . if repaired before this age, it will heal by fibrosis and cause fixation of the maxillary area

The rest of the face continues to develop except the repaired area which will lead to a " Dish face" ie Retarded maxillary growth

The rule of 10 -
Child must be up 10 mnths old
10kg wt
10g/dl of HB
Wbc shld not be >10,000

9, Chest xray showing opacity of almost all the right lung Field.

a, what is the diagnosis

ANS - MASSIVE PLEURAL EFFUSION

b, six features
ANS – 1) HOMOGENOUS RADIO OPACITY
2) BLUNTING OF COSTOPHRENIC ANGLE
3)) BLUNTING OF CARDIOPHRENIC ANGLE
4) MENISCUS SIGN
5) LOSS OF DIAPHRAGMATIC DOME
6) MEDIASTINAL SHIFT TO THE OPPOSITE SIDE

c, most common cause in our environment.
ANS - PULMONARY TB

10, A Woman came at term because she couldn't feel her baby's movement, first time she is carrying pregnancy to term. Your colleague requested for a scan but stepped out.
Explain the scan to the woman which showed no cardiac activity. (breaking bad news)
ANS
Getting started
PREPARE AND ENSURE YOU HAVE ALL THE NECESSARY INFORMATION READY
G – GREET PATIENT
R – RAPPORT
I – INTRODUCE MYSELF, STATING THAT AM STANDING IN FOR MY COLLEAGUE
P – CONFIRM PURPOSE OF VISIT AND ASK IF THERE IS ANYONE ELSE THAT SHE WANTS TO JOIN US
S – ENSURE THE SETTING IS CONDUCIVE , OBTAIN CONSENT AND ASSURE OF CONFIDENTIALITY
BIODATA

Indicate conversation will be two-way
PERCEPTION – 1) Find out how much she already knows
2.Ask what she has already been told about her bAby
3.Assess her state of mind

INVITATION - Find out how much more she wants to know
1.Ask what detail you should cover-every medical detail or only the big picture

KNOWLEDGE - Sharing the information
1.Give the information in small chunks
2. Fire a warning shot (Am afraid madam , the scan report is not looking good)
3.Stop between each chunk to ask if she understands
4. Translate medical terms into English, sorry to let you know that the scan report says the baby"s heart is no longer beating
This means that the baby is no longer alive
5.Don't try to teach pathophysiology

EMPATHY - Respond to her feelings
1.Identify and acknowledge her reaction
2.Ask how she is feeling
3.If she cries, simply wait for her to stop
4.Offer tissue paper or clean handkerchief
5.Be attentive and answer her questions

SUMMARY - Planning and follow-through

1.Synthesise her concerns and medical issues into a concrete plan to be carried out.
2.Outline a step-by-step plan and explain it to her
3.Be clear about next contact with her
4.Give her a phone number to reach you
5. Ensure she does not leave the hospital alone without someone going with her
6.thank patient

11,An obese woman whose hubby complained about her snoring habit presented to the clinic for solution.
Counsel her.
ANS
G – GREET MY PATIENT
R – RAPPORT
I – INTRODUCE MYSELF
P – CONFIRM PURPOSE OF VISIT
S – ENSURE THE SETTING IS CONDUCIVE AND OBTAIN CONSENT
BIODATA
COUNSELLING WILL FOCUS ON Behavioural modification, diet and exercise

- Assess readiness to change (u can use The 5As or transtheoritical model)

Ask - Discuss weight with the patient (the positives and negatives)
Confirm her Bmi as a baseline
Assess her health status, comorbidities if any and causes of her weight gain

Advise: Advice on management options such as eating high fibre diets, cut down on junk, moderate intensity exercise of at least 30mins per at least 3times a week, lots of water

Assess : Assess patient's willingness to accept the informations given and the willingness to make a positive change

Assist : Agree on weight loss expectations and treatment plan
Encourage her that its acheivable

Arrange: Schedule follow-up to assist patient in the continuous process of weight management
Give out phamphlets she can go through at home
Thank patient

- Help px set SMART goals
Specific,
Measurable,
Attainable,
Relevant,
Time-Based.
- Follow up

12, A man who got a job, conduct an exam for him
ANS

G – GREET PATIENT
R – RAPPORT
I – INTRODUCE MYSELF
P – CONFIRM PURPOSE OF VISIT
S – ENSURE THE SETTING IS CONDUCIVE AND OBTAIN CONSENT
BIODATA

Take measurements, weight, height, vitals signs
Occupation details – job Title/ appointment, dept, expected date of resumption,previous working experience
History - Current & Past medical including immunization hx, Surgical and musculoskeletal hx
FSH (lifestyle smoking, alcohol) , hx of psychiatry diagnosis, drug (recreational drug use) and allergy hx
General Physical Examination
Systemic examination
- Respiratory, Cardiovascular
- MSS - general body contour gait; range of body movements
- Mental health assessement
- Visual acuity using Snellen chart
- Hearing test (weber/rinne tests)
- Screening tests- Base line tests will be carried out such as
PCV, FBS, URINALYSIS, CHEST XRAY, BLOOD GROUP, GENOTYPE
Further tests will be based on the job specification for the patient – eg
Caterring staff must have stool & Sputum microscopy, Serology included in their investigations.
All drivers require thorough eye examination: pupillary light reflex,
lens for opacification, eye tension, opthalmoscopic examination, visual fields, proprioception and visual fields.

Pilots must have thorough eye screening, as above. Pilots are expected to have perfect visual acuity.
Chemists – should have good olfaction
ALLRESULTS OF INVESTIGATIONS MUST BE DULY ENTERED & REVIEWED BEFORE WRITING THE MEDICAL REPORT TO BE SENT TO THE PATIENT'S EMPLOYER
THANK PATIENT

13, follow up
write a referral (itemize)to an ophthalmologist if you noticed a severe eye problem.
Ans

Composition of the referral letter will include
• Doctors name
• Address/clinic
• Greetings
• Socio-demographic data of the patient e.g.Name of patient, age, sex, occupation e.t.c.
• History (pre employment)
• Physical & systemic examination findings (A SEVERE EYE PROBLEM)
• Investigations done so far
• Treatment offered so far
• Thank you for the feedback
• Doctor's signature and date

14, PICTURE of a mans foot with history of severe itching worse at night with serpentine features.

a, list five differentials
ANS – 1) CUTANEOUS LARVA MIGRAN (ANCYLOSTOMA BRAZILIENSE & CANIUM)
2) ALLERGIC CONTACT DERMATITIS
3) SCABIES
4) LARVA CURRENS CAUSED BY STRONGYLOIDES STERCORALIS
5) EPIDERMAL dermatophyte infection
6) Phytophotodermatitis

b ,diagnosis if it is worse at night.
ANS – CUTANEOUS LARVA MIGRANS BY ANCYLOSTOMA BRAZILINESE & CANIUM)

c, name other part of the body it can occur.
ANS – 1) Feet,
2) Spaces between the toes,
3) Hands,
3) Knees
4) Buttocks.

d, How will you treat him
ANS - For cutaneous larva migrans:

Ivermectin 200 mcg/kg orally once OR

Albendazole 400 mg orally 3-7 days

e**,what is the name of the severe form of this disease**.

ANS - **Visceral larva migrans** (VLM) or **TOXOCARIASIS ,** is a zoonotic infection usually **caused** by dog or cat ascarids of the Toxocara genus.

15, A man involved on RTA , assess his level Gcs.
ANS
FIRST IS TO FIND OUT IF THERE IS ANY INFORMANT AROUND THE PATIENT AND GET A BRIEF HX
THEN PROCEED TO ACCESS HIS LEVEL OF CONSCIOUSNESS
GCS measures the following functions:

Eye Opening (E)

4 = spontaneous
3 = to sound
2 = to pressure
1 = none

Verbal Response (V)

5 = orientated
4 = confused
3 = inappropriate

2 = Incomprehensible
1 = none

Motor Response (M)

6 = obeys command
5 = localizing
4 = normal flexion
3 = abnormal flexion
2 = extension
1 = none

SCORING FOR SEVERITY OF BRAIN INJURY
GCS OF 8 OR LESS – SEVERE INJURY
GCS 9 – 12 – MODERATE BRAIN INJURY
GCS 13-15 – MILD BRAIN INJURY

PACES
An **overseas based man that returned for burial, collapsed with severe respiratory embarrassment, was brought to you, how will you manage him?**
One of the examiners claim to be patients relative.
(a laryngoscope, ett tube , gloves, a model for CPR, a stylet,)

ANS – CALL FOR HELP (SENIOR COLLEAGUES, NURSES ETC)
Nurse please call the other members of the emergency response team, bring the defibrillator, bring the emergency equipment and tray then inform ICU that we might be transferring a patient to their unit

GREET AND INTRODUCE MYSELF TO THE PATIENT RELATIVE
QUICKLY GET A BRIEF HISTORY FROM THE RELATIVE OF WHAT HAPPENED AND IF THERE ARE OTHER CO-MORBID CONDITIONS
WHILE WAITING FOR HELP TO ARRIVE, I WILL START ASSESSING THE PATIENT

Call out patient's name
Mr James! Mr James! Can u hear me? (Shake the patients shoulder as u call)

I will quickly ensure privacy while I expose the patient's chest by removing his shirt

I will start with ABC sequence of Basic life support
I willCheck for any airway obstruction , checking the mouth
Check if patient is breathing, look at the chest for expansion
I will check for the carotid pulse for 10secs. (look@ur watch while u do so)

No carotid pulse is palpable in 10secs, commence chest compressions
Ensure patient is well laid on a flat bed

Pls i need an assistant. thank u. Pls come and stand on the other side of patient, u are going to be my assistant
Assistant pls start the stop watch as soon as I begin compressions, when 2mins has elapsed u and I will change positions. Pls count my compressions aloud as I give them.

I am interlocking my hands and placing the Palm over the lower 1/2 of his sternum

I am giving 30 chest compressions allowing for recoil in between compressions

I am looking(@chest wall for breathing movement,there is no movement), listening(over patients nose for breath sounds, there is none)& open up his airways, I am doing the head thrust & chin lift

My assistant pls give 2 breaths with the ambu bag while observing his chest for chest rise

The defibrillator is available now

I am attaching the leads, pls assistant continue chest compressions

I am checking the reading...it is shockable rhythm

Pls stand clear!

I am applying the shock

Patient is now responsive; but breathing is apneic and oxygenation saturation is not adequate

I will transfer to the Icu , intubate
Intubation Steps

Before intubation, the patient is given muscle relaxants , , allowing the mouth and airway to relax
While standing at the patient's head

The patient's mouth is gently opened. Using the laryngoscope to lift the tongue and illuminate the throat
, the endotracheal tube is steered into the throat and advanced into the airway.

The balloon around the tube is inflated to keep the tube in place and prevent air from escaping.
Once the balloon is inflated, the tube is taped in place around the mouth.

Successful placement is checked by listening to the lungs with a stethoscope and can be further verified through a chest X-ray.

And then connect to a mechanical ventilator

Further detailed secondary survey and appropriate management