History taking:

General points: Marks for everything

Introducing yourself, confirming the name of the patient/surgery/side of surgery etc., allergy, smoking, alcohol etc. Have a drill for your history taking

You should be able to finish routine anaesthetic history taking in less than 1 minute

Almost always, there is a hidden agenda within the history

Explore patient’s previous medical history, especially post anaesthetic in the past. For example, explore one week stay following LSCs as opposed to 3 days — may be post LSCs patient had DVT/PE etc. — often if you miss that, you may miss a chunk of the marks.

Always listen to the patient, especially one with follow on station, as sometimes you will be asked simple questions like which region of Africa the patient is from? (Key is to keep a note of things that patient says involuntarily but you may think as not important)

General medical disease that often appears in history taking station (Oxford handbook)

Respiratory
   Asthma
   COPD
   OSA

Cardiovascular
   Hypertension
   Angina/IHD

Surgery specific history – you may need to make the decision after history taking

There is often a task mentioned in both history taking and communication skills station. You have to address the task otherwise you will not score higher marks in the station.

Always end the station with a summary and an open question like: Is there anything else you want add? Have I missed anything? See common examples below:

TURP – often with AF on warfarin regional may be contraindicated. GA vs Spinal – do a risk/benefit analysis

Carotid endarterectomy – often arteriopath and DM explore micro and macrovascular complications

Cataract surgery and unstable angina – may be on elective list - planned to be done under GA. You are asked to preassess – Patient may be unsuitable for GA and you may need to make decision in favour of LA (yes, yes, yes! you will always discuss any problem with your consultant)

Aortic stenosis and DHS – establish the severity from history? The question is likely to be - Does the patient need further medical evaluation or not?

You must know your differential diagnosis for the following conditions:
   Anaemia
Jaundice
Hematuria

Airway related symptoms/disease
Reflux – yes, yes! you will do an RSI if in doubt only thio and sux (Roc vs Sux = 2+ performance remember sugammadex)

Rheumatoid arthritis – not only Atlanto-occipital dislocation but also systemic involvement should be explored in the history, remember severe arthritis and not being able to use patient controlled analgesia

Ankylosing spondylitis – you may think about GA/airway but remember central neuroaxial blockade may be difficult as well very important in pregnant patient (senior involvement)

Subtotal thyroidectomies – clearly focussed on airway, but remember to elicit history suggestive of retrosternal extension, other local compression – difficulty in swallowing, hoarseness of voice etc, and also establish euthyroid status in history

Baseline for any medical disease
   Establish whether the disease is controlled or uncontrolled
   If uncontrolled, assess whether patient can be optimized further medically
   If that’s the best shape that can be achieved, if surgery is emergency – speak to senior/postop hdu +/- ICU care
   Think as you would normally do in those clinical situations

Daycase
   Don’t forget the social criteria for discharge of patients (often we dont deal with it personally, but certainly will lose if you forget in preassessment)

Communication skills:
   Common classical exam stations.
   Suxamethonium apnoea – speak to the parents
   Malignant hyperpyrexia – first degree relative, patient worried
   Mask phobia – need RSI
   Needle phobia – needs epidural
   Explain RSI to a trainee ODP
   Explain Difficult airway plan to an ODP
   PCA vs Epidural – for a patient worried about chronic back pain/paraplegia
   Awareness and PONV – anxious patient
   Jehovah’s witness – establish whether patient would die rather than having blood products
   Dental loss – for a boxer often
   Drug addict on Methadone – worried about opioid addiction
   Emergency AAA – critical in theatre - speak to the daughter

   Might be worth knowing incidence of common complications following anaesthesia like PONV, sorethroat, dental injury, awareness, allergy, etc

NEVER GO TO THE OSCE WITHOUT KNOWING YOUR ANATOMY – AS OFTEN 3 STATIONS ARE BASED ON ANATOMY. IF YOU DONT PREPARE YOUR ANATOMY YOU WILL LOSE 60 MARKS OUT OF 320. THAT LEAVES 260 MARKS. OFTEN 1 OR 2 DIFFICULT STATIONS WILL APPEAR IN THE EXAM. SO THE FINAL TALLY IS 225 OUT OF 240 TO PASS THE OSCE WHICH IS NEARLY IMPOSSIBLE.