

Abd.pain 1

Time: 7 minutes
Student Copy

Station : History taking

This station is designed to test your ability to take a comprehensive history.

You are about to interview a mother who brought her 10 - year old daughter complaining of Abdominal pain.

You have 7 minutes to complete this task.

Student Name:

Final Mark: /30

Examiner's Copy

Case : a 10- year old girl with abdominal pain.

Observe that the student asks the following:

Asking about characteristics of abdominal pain			
Ask about location of pain, and radiation	0	1	2
Ask about onset	0	1	
Ask about nature of pain	0	1	
Ask about pain frequency and duration	0	1	2
Ask about pain severity (crying from pain, awakening from sleep,score)	0	1	
Ask about relieving factors (posture ,bowel movement, drugs)	0	1	
Ask about exaggerating factors (food ,drugs, anxiety)	0	1	
Ask about associated other GIT symptoms			
Ask about vomiting	0	1	
Ask about bowel movements	0	1	
Ask about stool character (consistency, color change ,presence of blood)	0	1	
Ask about jaundice	0	1	
Ask about urinary symptoms (dysuria,frequency etc...)	0	1	
Ask about respiratory symptoms (cough)	0	1	
Ask about constitutional symptoms			
Ask about fever	0	1	
Ask about appetite/activity	0	1	
Ask about weight loss	0	1	
Ask about rheumatological symptoms			
Ask about oral ulcers	0	1	
Ask about joint swelling,skin rash	0	1	
Past History			
Ask about Past history of similar abdominal pain episodes	0	1	
Ask about past surgeries	0	1	
Family History			
Ask about family history of diseases as (celiac, IBD, CF,FMF)	0	1	
Drug history of NSAIDS,PPI ,OTHERS	0	1	
social history of travel , social changes at home,school	0	1	
Ask the student: What is your most likely diagnosis ?	0	2	
Functional abdominal Pain			
Over all Organization and communication	0	1	2 3

Examiner name and signature

Abdominal pain OSCE case

You are a mother of a 10 year old female, previously healthy, and her name is Salwa. You brought her to the clinic because she has been complaining of abdominal pain for the past three months. She always points to her umbilicus and says it hurts there.

Needs more details

Freq

Associated

Increase with drinking tea and coffe

Stressed at school

.....etc

Time: 10 minutes
Student Copy

Abd.pain2

You are a fifth year medical student. You are about to interview a mother who brought her 4 year old daughter complaining of Abdominal pain..

Please perform a focused history, and once you are done, perform ABDOMINAL examination.

You have 10 minutes to complete this task.

Student Name:

Final Mark:

--

Examiner's Copy

History and abdominal examination of 4 year old with abdominal pain.

Observe that the student performed the following:

1) Introduce self	0	1
2) Ask about duration of abdominal pain	0	1
Ask about nature of pain	0	1
Ask about location of pain, and radiation	0	1
Ask about fever	0	1
Ask about vomiting	0	1
Ask about bowel movements	0	1
Ask about jaundice	0	1
Ask about change of color of stool and urine	0	1
Ask about urination (amount or frequency)	0	1
Ask about dysurea	0	1
Ask about possibility of food poisoning	0	1
Ask about appetite	0	1
Ask about cough or difficulty breathing	0	1
Ask about sore throat	0	1
4) Past history		
Ask about past history of urinary tract infections	0	1
Ask about past history of constipation	0	1
Ask about past history of abdominal pain	0	1
5) Family History		
Ask about sick contacts	0	1
6) Physical examination Observe the student do the following:		
Abdominal inspection with adequate exposure (ask student not to expose genitalia)	0	1
Correct abdominal palpation of liver edge	0	1
Correct technique of liver span	0	1
Auscultation of the abdomen for bowel sounds	0	1
7) Overall performance		
Organization	0	1
Communication	0	1

Abdominal pain OSCE case

You are a mother of a 4 year old female, previously healthy, and her name is Salwa. You brought her to the clinic because she has been complaining of abdominal pain for the past three days. She always points to her umbilicus and says it hurts there. The pain doesn't seem to travel anywhere else. She doesn't cry when she complains. You felt that she was warm to touch today but you have not measured her temperature. She vomited once two days ago but has not vomited again. There was a normal bowel movement two days ago but since then she didn't have any bowel movement. There was no change in skin color. Her appetite is less than usual. She drinks liquids and water normally. You have not checked her urine color or smell because she goes to the bathroom by her self. She is potty trained and has no enuresis for the past one year except last night when she wet her bed which was unusual for her. There has been no cough and no respiratory symptoms.

There are no sick contacts in the family and Salwa does not go to school yet. She is previously healthy with no hospitalization. She had constipation twice in the past year and you have given her Glycerin suppository for that which helped her.



Anaphylaxis

Examiner copy (time 10 minutes)

Student Name -----

Mark -----/

A 7 year old boy presented to the emergency room with hoarsness of voice , difficulty in breathing , and diffuse skin rash . The mother said he ate fish 30 minutes ago

<p>What is the most likely diagnosis</p> <p>Anaphylaxis mostly due to fish</p>	0	3
<p>What type of anaphylaxis is this</p> <p>Immeadiate type 1 hypersensitivity 0 1</p>	0	1
<p>The patient became relatively stable , what do you want to do now</p> <p>Admit the patient to Pediatric ICU</p>	0	2
<p>You admitted the patient to the PICU what management should be done there</p> <p>Cardiac monitor</p>	0	1
<p>Pulse oxymeter</p>	0	1
<p>Frequent vital signs</p>	0	1
<p>Iv fluids</p>	0	1
<p>Drugs (antihistamine , salbutamol , steroids)</p>	0	1

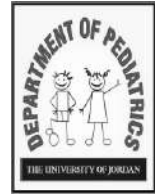
After 6 hours the nurse called you , the patient developed cyanosis and difficulty in breathing , what is your differential diagnosis :		
Late type anaphylaxis	0	2
Laryngeal edema / bronchospasm	0	1
Aspiration pneumonia	0	1
The patient was managed properly and now you want to discharge him home what instructions should you give to the mother for the future		
1- inform all surroundings that he has allergy to fish (family members , friends , school)	0	2
2-cross reaction with other food (peanuts , seafood , eggs)	0	1 2
3- Epipen	0	2

Overall performance 0 1 2 3



The University of Jordan /Pediatric Final OSCE
2013

TIME: 7 minutes



SP copy

My daughter Samar is 7 years old.

She is having joint pain since 2 days. It started in her right ankle, it was swollen and the skin was red in color, but her pain was much worse than you would expect from the way her ankle looked.

She could not move without limping because of the pain, and when I touch it she starts crying.

Today her ankle is better but the same thing is happening to her right knee.

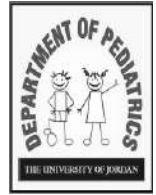
She was ok before this apart from sore throat about 2 weeks back. She got sick with sore throat many times before, but never had this joint issue.

She did not have any skin rashes, or diarrhea, or urinary symptoms, she also did not have fever.

I do not recall any falling downs or trauma.

My other kids are healthy, nobody in the family has joint problem

I did not give her any medication , I was afraid it might harm her , 2 weeks back when she got sick ,she did not finish her antibiotics ,she did not like the way it tastes



Skill: History taking & Problem solving

Arthritis 1

You are about to interview a parent of a **7 years old** girl complaining of Joint pain.

Please take focused history, and then answer the examiner's questions



The University of Jordan /Pediatric Final OSCE
2013
TIME: 7 minutes



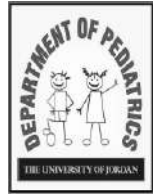
Student Name:

Mark /22

Please observe the student taking detailed history about joint pain in a 7 years old girl, and note that he/she asks about the following:

Analyzing the chief complaint				
Onset /duration	0	1		
Joint/s involved	0	1		
Course/progression :migratory /additive	0	1		
Limitation of movement	0	1		
Aggravating factors	0	1		
Relieving factors	0	1		
Analyzing associated symptoms :				
Joint swelling /hotness /redness	0	1		
Fever	0	1		
Rash/eye redness	0	1		
Symptoms of viral illness : Diarrhea ,vomiting	0	1		
Urinary symptoms: red urine/dysuria	0	1		
Generalized symptoms :weight loss ,decreased appetite ,fatigability	0	1		
Respiratory symptoms preceding current illness/ duration in between	0	1		
Past history of similar problem	0	1		
Family history /any rheumatological diseases/similar problem	0	1		
Medication History	0	1		
Nutrition : Raw milk ingestion	0	1		
After 6 minutes stop the student and ask the following questions				
If this girl had upper respiratory tract infection 4 weeks ago , for which no treatment was given ,now presenting with migratory arthritis .what are the most important relative things in the physical exam you should look for :				
Cardiac exam				
Rash/subcutaneous nodules /Chorea	0	1	2	
Overall (organization, systematic, polite, good communications skills..	0	1	2	3

Examiners' name and signature:



Arthritis 2

Student Name:

Mark

/25

A mother brings her four year old boy complaining of left knee swelling. Observe the student asking the mother about the following:

Asking symptoms of acute monoarthritis			
History: onset, duration and course	0	1	2
History of other affected joints	0	1	
History of pain	0	1	
History of limping, unusual gait	0	1	
History of redness	0	1	
History of trauma	0	1	
History of fever	0	1	
History of skin rash	0	1	
Past history			
Similar previous attacks	0	1	
Recurrent abdominal or chest pain	0	1	
Tonsillitis or pharyngitis	0	1	
Bleeding from other sites	0	1	
Drug exposure	0	1	
Family history			
Bleeding disorder/rheumatologic disorder/FMF	0	1	2
<i>After 5 minutes Stop the student to ask the following :What is your differential diagnosis based on the history:any two of the following.</i>	0	1	2
1.septic arthritis 2.rheumatic fever 3.reactive arthritis (this is an acute problem,so chronic rheumatological illnesses as FMF,JRA, aren't accepted)			
<i>: In this child you suspected Rheumatic fever, name two investigations that would support this diagnosis? And why?</i>			
1. Echocardiogram for carditis 2. Electrocardiogram for prolonged PR interval 3. Antistreptolysin O titer for recent streptococcal infection 4. Acute phase reactants (ESR and CRP) for inflammation	0	2	4
Overall (organization, systematic, polite, good communications skills...	0	1	2 3

Examiners' name and signature:

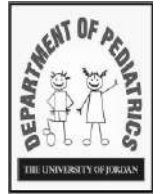


Time: 7 minutes

Station: History taking

A mother brings her four year old boy complaining of left knee swelling.

Please take a focused history, and answer the examiner's question.

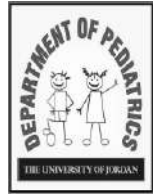


SP copy

My four years old boy is complaining of left knee swelling of two days duration. I discovered it suddenly two days ago and today it is better. I did not see any other swollen joints. He complained that it is painful and he tries not to bear weight on it and so he is limping. When I looked at it, it seems red. There is fever, but there is no rash and he is telling me that there is no trauma.

This is the first time he complains of joint swelling. He never complains of abdominal or chest pain. He never had any bleeding from any site. He had tonsillitis two weeks ago but there is no history of taking any drugs.

There is no history in the family of similar conditions, bleeding disorders, FMF, or rheumatologic disorder.



Broncholitis

Student Name:

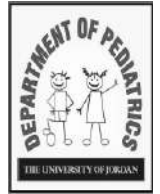
Mark

/30

The mother of a 6 months old baby brings her child complaining of fever and cough . Please take a focused history, and answer the examiner's questions.

Analyzing the fever,asking about			
Onset, duration	0	1	
Amplitude, documented or not?	0	1	
Relieving factors (antipyretics, cold compressors...)	0	1	
Analyzing cough,asking about			
Duration,onset	0	1	
Course/diurnal variation	0	1	
Nature of cough (dry,wet)	0	1	
Postussive vomiting	0	1	
Aggrevationg symptoms as smoke,pets,after food, Relieving factors as nebulisers,drugs	0	1	2
Associated symptoms,asking about			
Rapid breathing	0	1	
Audible sounds as wheezes	0	1	
ENT symptoms as ruuny nose,ear pulling	0	1	
History of cyanosis	0	1	
Activity, feeding	0	1	
Other important questions			
Past History of previous attacks	0	1	
Vaccination history	0	1	
Contact with sick people	0	1	
Medication history	0	1	
Family history of asthma in family	0	1	
<i>After 6 minutes Stop the student to ask the following; .O/E: RR 60, pulse Ox 88 %,with subcostal retractions,there is expiratory wheezes.What is your differential diagnosis.(name two)</i>			
Bronchiolitis	0	2	4
pneumonia			
The baby has bronchiolitis.what is your management			
Oxygen	0	2	4
Maintaince fluids			
Nebulised salbutamol/adrenaline			
Overall (organization, systematic, polite, good communications skills...	0	1	2 3

Examiners' name and signature:

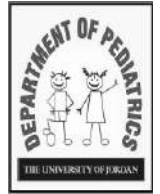


Time: 7 minutes

Station: History taking

A mother of a 6 months old child brought him, to the emergency room with fever and cough .

Please take a focused history, and answer the examiner's questions.

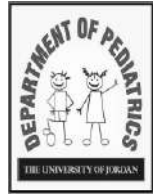


SP copy

My 6 months old child is complaining of fever that is undocumented of two days duration. It is relieved by paracetamol and cold compressors. His cough started two days ago, is more at night, is wet in nature. He does not vomit. I did not give him anything to relieve the cough and there are no aggravating factors.

There is a history of rapid breathing and I hear a musical sound in his breath. There is a history of runny nose but no ear pulling. No history of cyanosis. He has good activity when afebrile but his feeding has decreased.

This is the first time for my child with these complaints. He is fully vaccinated. He is not on any drugs. There is no history of asthma in his cousins. His older sister has cough and fever.



Chronic cough

Student Name:

Mark

/25

The mother of a 12 month old baby brings her child complaining of cough for the last three weeks. Observe the student asking the mother about the following:

Analyzing cough,asking about				
Course/diurnal variation	0	1		
Nature of cough (dry,wet),	0	1		
Postussive vomiting/severity	0	1		
Aggrevationg symptoms as smoke,pets,after food, Relieving factors as nebulisers,drugs	0	1	2	
Associated symptoms,asking about				
History of fever	0	1		
Rapid breathing	0	1		
Audible sounds as wheezes,noisy breathing	0	1		
ENT symptoms as ruuny nose,ear pulling	0	1		
History of cyanosis	0	1		
Asking about constitutional symptoms as Activity, feeding	0	1		
Asking about Past history of respiratory infections,other infections,previous admission	0	1		
Other important questions to know cause of recurrent chest infections				
History of choking	0	1		
History of vomiting after feed	0	1		
History of chronic diarrhea (ask about duration,frequency)	0	1	2	
History of poor weight gain	0	1		
Vaccination history	0	1		
Neonatal history (meconium ileus,prolonged jaundice)	0	1		
Family history of similar cases in family as asthma,cystic fibrosis,	0	1		
<i>After 6 minutes Stop the student to ask the following; this child was diagnosed with cystic fibrosis,what nutritional deficiencies would you expect?</i>				
<i>Fat malabsorption</i>	0	1	2	
<i>Fat soluable vitamin malabsorption</i>				
Overall (organization, systematic, polite, good communications skills...	0	1	2	3

Examiners' name and signature:

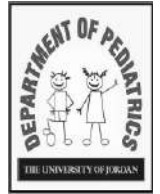


Time: 7 minutes

Station: History taking

A mother of a 12 month old child brought him, to the emergency room with cough for the last three weeks

Please take a focused history, and answer the examiner's questions.



SP copy

My 12 month old child is complaining of cough for the last 3 weeks. The cough is the same for the last three weeks. Cough is more at night, is wet in nature. He does not vomit after cough. There are no aggravating factors for the cough. He wasn't given any nebulizer. He was given two weeks of antibiotics without marked improvement.

There is a history of rapid breathing with the cough and I hear a noisy breathing. He was having fever for the last three weeks, that decreased with antipyretics and antibiotics use, but recurs after stopping antibiotics, so the fever is on and off. There is history of runny nose but no ear pulling. No cyanosis. He has good activity when afebrile but his feeding has decreased.

My child was admitted twice with similar complaints and was found to have a chest infection and was given antibiotics. His stools are loose around 8 times a day since he was a baby. He is not gaining weight as his siblings. No history of choking, vomiting after feeds. No contact with sick people. He is fully vaccinated. There is no family history of asthma, cystic fibrosis or similar cases. His neonatal history was unremarkable.



The University of Jordan /Pediatric OSCE
2016
TIME: 7 minutes



Student name: _____

Time: 7 minutes

History taking

Cough + fever 1

Examiner copy

Instructions to the student: please take a short and to the point history from this mother of a 3 year old boy; she brought him to the ER because he has cough

Mark :(/ 24)

Ask about cough history				
Analyze cough				
duration	0	1		
Onset	0	1		
Severity (cannot talk, post tussive vomiting awake at night)	0	1		
Character (whooping , barking,recurrent, etc)	0	1		
Aggravating factors (day/night, exercise, smoke, pets, URTI,)	0	1		
Reliving factor (ventulin, medication, humidity)	0	1		
Ask about difficulty breathing	0	1		
Ask about associated symptoms				
Wheezes (or noisy breathing)	0	1		
Stridor/noisy breath/hoarseness	0	1		
Cyanosis (turned blue)	0	1		
Ask about previous similar episode	0	1		
Ask about constitutional symptoms				
Fever, activity, feeding	0	1	2	
Ask about upper respiratory symptoms				
Runny nose	0	1		
Ask about FB	0	1		
Ask about Allergy (recurrent runny nose, itching, nasal obstruction,any symptoms suggest AR) or Seasonal variation History suggesting eczema ll limbs	0	1		
Ask the student about the to summaries the problem (acute history of fever with stridor and cough	0	1	2	
Ask what is your differential diagnosis in this baby ?				
Acute larungeotracheobronchitis (croup),give 1and for Epiglottitis or Trachitis give1	0	1	2	
Communication skills introduce him/herself, explain purpose of interview, organization ,type of questions open vs. close end questions ,appropriate body language.(eye contact)	0	1	2	3 4



Cough + fever 2

TIME :7 minutes
OSCE(history taking)
Examiner copy

Mark /25

The mother of a 2 year old boy brought him to you because of fever and cough. Please take a focused history, and answer the examiner's questions.

Observe the student asking the mother about the following:

Analysing the fever		
Onset	0	1
Amplitude, documented or not?	0	1
Relieving factors (antipyretics, cold compressors..)	0	1
Analysing cough		
Onset	0	1
dry or wet	0	1
specific type (repetitive, barking, episodic or continuous)	0	1
aggravating factors (smell/ smoke..)	0	1
relieving factors (any intervention, nebulizers..)	0	1
course	0	1
Asking about associated symptoms		
Runny nose/ or ear pain	0	1
Difficulty breathing/ rapid breathing	0	1
Noisy breathing (wheezing, stridor..)	0	1
Cyanosis	0	1
Vomiting (post tussive)	0	1
Decreased appetite/activity	0	1
Other important questions		
Contact with sick individuals	0	1
History of choking or aspiration	0	1
Vaccination history	0	1
Past history of similar conditions , hospital admissions	0	1
Medication history, ever required nebulizer treatment in the past	0	1

Stop the student after 6 minutes to ask the following questions

Q: if the physical examination showed a child with temperature of 38, and audible stridor and suprasternal retractions. What is your differential diagnosis ? name at least 2

1- Laryngotracheobronchitis (croup)	0	1	2	
2- epiglottitis				
3- Foreign body aspiration				
4- Tracheitis				
Overall performance	0	1	2	3

Time: 7 minutes

Station: History taking

The mother of a 2 year old boy brought him to you because of fever and cough

Please take a focused history, and answer the examiner's questions.

SP copy

My child is a 2 year old boy who is not known to have any previous illness, started to have fever two days ago. It measured 38 degrees axillary. I gave him Revanin and the fever improved. He has several episodes of cough, dry and similar to the dog barking. He also had noisy breathing, he has a harsh noise when he takes a breath, his voice changes He had no exposure to smoke or dust, and no other medications were given.

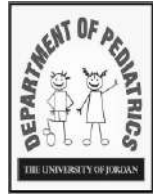
2 days ago he had runny nose.

He has no cyanosis, but seems to have more difficulty breathing than normal. He had no vomiting and no drooling or pain when swallowing. But his appetite this morning is not as usual, he didn't want to finish his breakfast and he is less active than usual.

There is nobody else sick at home, and there was no history of choking or aspiration.

He is not known to have any chronic illness, never admitted and never required nebulization treatment.

His vaccinations are up to date.



Group

Student Name:

Mark

/31

The mother of a two year old baby brings her child complaining of abnormal audible breathing sound .Observe the student asking the mother about the following:

Analysing the sound			
Onset, duration	0	1	
Course (worsening,improving)	0	1	
Character(inspiratory,expiratory,musical,harsh, diurnal variation)	0	1	
Relieving factors ,aggrevating factors	0	1	
Asking about associated symptoms			
History of cyanosis	0	2	
History of rapid/difficulty breathing	0	2	
History of fever	0	1	
History of cough and character of cough	0	1	2
History of hoarseness	0	1	
History of drooling	0	1	
Other important questions			
Activity, feeding	0	1	
History of choking	0	2	
Family history of similar cases in family	0	1	
Vaccination history	0	1	
Past history of similar attacks	0	1	
<i>After 6 minutes Stop the student to ask the following What is your most likely diagnosis?</i>			
Laryotracheobronchitis	0	3	
<i>If diagnosis was croup and on exam:child was in respiratory distress,hypoxic,with suprasternal retractions.What are your main lines of management</i>			
Oxygen,hydration	0	2	4
Nebulised adrenaline			6
Steroids			
Overall (organization, systematic, polite, good communications skills...	0	1	2
			3

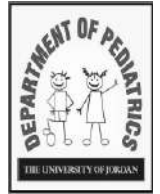
Examiners' name and signature:



Time: 7 minutes

Station: History taking

The mother of a two year old baby brings her child to emergency room complaining of abnormal breathing sound .Please take a focused history, and answer the examiner's questions.



SP copy

My two year old boy woke up at midnight with abnormal breathing sound (describe sound, ,harsh) when he is taking a breath.The sound got better when he sat out of bed and increased with crying.The sound improved on our way to hospital.My child was having difficulty breathing and he turned blue.No history of drooling.For the last two days he was having low grade fever measured 38.4 axillary along with runny nose.He was having also a barking cough.His voice turned hoarse.He was active and feeding well yesterday.

No history of choking or of similar episodes.My child isn't known to have any medical problem.He is fully vaccinated and hasn't received any drugs.His brother was having URT symptoms before one week

His perinatal history is unremarkable.



The University of Jordan /Pediatric Final OSCE
2013
TIME: 7 minutes
Examiner copy



CF

Student Name:

Mark

/24

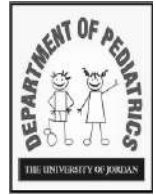
Please observe the student taking detailed history about chronic cough in a 2 years old boy, and note that he/she asks about the following:

Analyzing Cough				
Course of cough(episodic or continuous)	0	1		
Nature of cough (dry or wet)	0	1		
Diurnal (day and night) or seasonal variation	0	1	2	
Aggravating factors as dust,perfumes,pets,URTI,exercise	0	1		
Relieving factors as nebulizers use, medications	0	1		
Analyzing associated symptoms :				
History of fever	0	1		
History of chronic runny nose, snoring	0	1		
History of shortness of breath	0	1		
History of cyanosis	0	1		
Frequency and consistency of bowel habits	0	1	2	
History of inadequate weight gain	0	1		
History of vomiting, or regurgitation	0	1		
History of foreign body aspiration, choking	0	1		
History of contact with similar cases	0	1		
Past History of hospital admissions, recurrent E/R visits	0	1		
Family history of cystic fibrosis,asthma,similar cases in family	0	1		
<i>After 6 minutes stop the student and ask the following questions;</i>				
If this child with chronic cough was found to have chronic diarrhea and failure to thrive, what are the 2 most important diagnostic investigations that you would like to perform				
CXR	0	1	2	
Sweat chloride Test				
Overall (organization, systematic, polite, good communications skills..	0	1	2	3

Examiners' name and signature:



The University of Jordan /Pediatric Final OSCE
2013
TIME: 7 minutes
Examiner copy



Skill: History taking & Problem solving

Time: 7 minutes

You are about to interview the parent of a **2 years old** boy complaining of cough of 6 months duration.

Please take focused history, and then answer the examiner's questions



The University of Jordan /Pediatric Final OSCE

2013

TIME: 7 minutes

Examiner copy



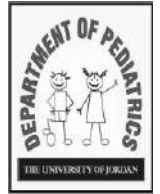
SP copy

My 2 years old boy is complaining of chronic cough for the last 6 months. Cough is continuous but gets worse with infections. It is wet .There is no diurnal or seasonal variation. It is aggravated with infections only. There is no use of nebulisers.No history of fever, runny nose, and cyanosis. There is shortness of breath with the infections. He was admitted multiple times to the hospital due to chest infection and was given intravenous antibiotics.

My child is not adding weight well as other children. He goes to the toilet 6 times a day and I find his stool to be soft in consistency. And it smells really bad.

No history of choking, recurrent vomiting, foreign body aspiration. No history of contact with similar cases.

I and my husband are cousins, there is a history of the same problem in her cousin but the cause is not known



Edema

Student Name:

Mark

/22

A mother brings her five years old boy complaining of periorbital swelling of five days duration. Observe the student asking the mother about the following:

Analyzing complaints				
Course of swelling,diurnal variation	0	1		
History of tearing,redness in eyes	0	1		
History of swelling in other places as tummy,legs, back (sacral), scrotal	0	1	2	
History of increase in weight	0	1		
History of decreased urine output,change in urine color	0	1	2	
History of previous URTI	0	1		
History of skin rash	0	1		
History of insect bites,new food or drug ingestion	0	1		
Other important questions				
History of S.OB,cough other heart failure symptoms	0	1		
History of chronic diarrhae	0	1		
History of jaundice,abdominal pain	0	1		
History of previous attacks	0	1		
Family history of similar case	0	1		
<i>After 6 minutes Stop the student to ask the following;O/E child had ascitis and lower limb edema,based on your history and exam name two important investigation</i>				
1.serum albumin	0	2	4	
2.urine analysis				
3.urea,creat,electrolytes				
Overall (organization, systematic, polite, good communications skills...	0	1	2	3

Examiners' name and signature:

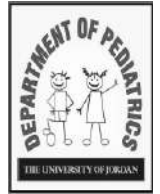


The University of Jordan /Pediatric Final OSCE

2018

TIME: 7 minutes

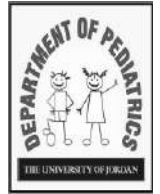
Time: 7 minutes



Station: History taking

A mother of a five years old child brought him to the emergency room of periorbital swelling of five days duration.

Please take a focused history, and answer the examiner's questions.



SP copy

My five years old boy is complaining of swelling around eyes of five days duration. The swelling is gradually increasing and is more in the morning. I noticed his tummy and legs are swollen. His clothes can not fit him well, I think he is gaining weight. His eyes are not red. He was having runny nose and fever few days ago. He is not going to the toilet as frequently as before and his urine color is dark a bit.

This is the first time he complains of this, one of his cousins used to complain of swelling in his body and was given a medication for that. There is no history of renal failure in the family. My child has not received any medication or new food.

He does not complain of shortness of breath or diarrhea or change in his body color, or skin rash.

Time: 10 minutes

Student Copy

You are a fifth year medical student. You are about to interview a mother who brought her 3 year old daughter complaining of Nose bleed.

Please perform a detailed history.

You have 12 minutes to complete this task.

The examiner will then ask you a few questions about this patient

Student Name:

Final Mark:

--

Examiner's Copy

History taking of 3 year old with epistaxis. Observe that the student performed the following:

1) <i>History</i>		
Ask about time and duration of epistaxis	0	1
Ask about amount of blood/ blood clots	0	1
Ask about frequency of epistaxis	0	1
Ask about history of trauma to the nose	0	1
Ask about nose picking/ foreign body introduction to the nose	0	1
Ask about loss of consciousness	0	1
Ask about pallor or change in color	0	1
Ask about skin rash	0	1
Ask about change of color of stool and urine	0	1
Ask about vomiting blood or coffee-ground	0	1
Ask about possibility of drug ingestion or presence of anticoagulants at home	0	1
2) <i>Past history</i>		
Ask about history of infections in the past several weeks	0	1
Ask about past history of bleeding or epistaxis	0	1
3) <i>Family History</i>		
Ask about family history of bleeding tendency	0	1
4) Ask the student: What do you think the mechanism of this child's bleeding		
Thrombocytopenia, or low platelets, or platelet dysfunction	0	1
5) Ask the student: If this child has platelet count of 12,000, what are the possible causes?		
Immune thrombocytopenia, or ITP, or platelet destruction	0	1
Decreased platelet production, bone marrow failure, or aplastic crisis	0	1
6) <i>Overall</i>		
Introduces self	0	1
Organization	0	1
Communication	0	1

Epistaxis OSCE case

You are a mother of a 3 year old female, previously healthy, and her name is hana. She has been doing well until about two days ago when she started having epistaxis. The first time she had epistaxis was 2 days ago and lasted for 15 minutes, the bleeding was from one side of the nose and stopped after a long period of local pressure on the nose.

Yesterday and today she had two more episodes of bleeding from the nose, and it seems it happened from the different nostril these times, she bled a lot for about 20 minutes each time, with some clots as well. The bleeding stopped a few minutes before arriving to the emergency room.

You have not noticed any nose picking by your child, and she usually does not pick her nose, and never saw her putting any foreign bodies in it. There is also no history of trauma. Epistaxis happened only once in the past year and was very trivial for a few minutes after a minor trauma to the face.

There is no history of bleeding from any other orifice, There is no change in stool or urine color. You don't remember any problem with easy bruisability or excessive bleeding before. There is no pallor or loss of consciousness.

Today you noticed fine reddish skin rash over her face and trunk.

There is no history of fever or infections in the past few weeks, but she did have some runny nose two months ago when she started going to the day care center.

There is no family history of bleeding tendency.

No history of drug ingestions, no body in the family takes anticoagulants.

OPENNING statement:

“My child is having nose bleed”

FTT

Station: History taking

Time: 7 minutes

You will interview the parent of a 4 month old male infant brought in because he is not growing well.

Please take a detailed history.

The examiner will ask you a few questions after you're done.

Name:

Total score:

/20

Observe the student doing the following :

Observe the student asking about the following:		
Current weight	0	1
Ask whether there was poor weight gain or there is loss of weight	0	1
perinatal history questions, Asks about:		
• Gestational age	0	1
• Birth weight	0	1
• Exposure to illnesses during pregnancy	0	1
• Exposure to medications or smoking during pregnancy	0	1
• When did the child pass meconium	0	1
• Was the child admitted to NICU	0	1
Nutritional history questions		
• Breast feeding or formula	0	1
• Frequency of feeding (or number of feedings in 24 hours)	0	1
Adequacy of breast feeding, student should ask about the following		
• Duration of feeding on each breast	0	1
• Does the child get satisfied after the meal (or keeps crying), sleeps?	0	1
• Does the mother feel her breast is less full after feeding	0	1
• Urine output (number of wet diapers)	0	1

Other questions		
• Chocking during feeding	0	1
• Vomiting, regurgitation	0	1
• Diarrhea or stool consistency	0	1
• Recurrent infections or admission to the hospital	0	1
• Respiratory symptoms (tachypnea, respiratory distress)	0	1
• Pallor, cold extremities, sweating	0	1
• Activity (smiles, plays, or excessive sleeping)	0	1
Developmental history questions		
• Social development: e.g (When did the child smile, interaction with mother... etc)	0	1
• Motor development: e.g (Does the child turn his head from side to side, follows faces.. etc)	0	1

After 7 minutes hand the student growth chart for this patient and ask him to give you three more likely differential diagnosis for this patient's failure to thrive (give only three)

Cystic fibrosis	0	1	2
Malabsorption			
Immune deficiency			

Overall performance	0	1	2
---------------------	---	---	---

Score : /30

SP copy

My son is 4 months old, I am concerned that his weight is only 4 Kg. He was born normally at 40 weeks gestation. His birth weight was 3 Kg. I had no problem during pregnancy, did not take any medications and was not smoking or exposed to smoking. I am 30 year old and this is my first baby. I am a housewife and the only caretaker of this baby.

This baby was not admitted to the NICU, and he was discharged home with me on his second day of life. He had no jaundice, he passed meconium on the first day of life.

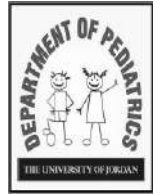
I breast feed the baby since birth. He feeds every 3-4 hours and stays 10 minutes on each breast, he empties the breast, and often sleeps after feeding. He has no vomiting, ut occasionally spits up with burping. He has 5-6 wet diapers every 24 hours. He passes stools 6-7 times daily, his stool is soft and smells bad, and often becomes watery like diarrhea. There is no mucous or blood in his stool.

He was admitted to the hospital twice when he was 2 months and 3 months old, each for 2 days because of cough, they told me he had lung infection. He is gaining weight slowly. Not taking medication.

There is no history of sweating during feeding, no palor, no cold extremities.

No family history of CF, or other chronic illnesses.

He smiled at one month of age, and now he turns head from side to side. (developmentally normal)



Student Name:

Mark

/24

A mother of a three year old child presents to the emergency room with fever and seizures. Observe the student asking the mother about the following:

Analyzing the fever				
Onset, duration	0	1		
Amplitude, documented or not?	0	1		
Relieving factors (antipyretics, cold compressors...)	0	1		
Analyzing seizures				
Duration	0	1		
Type (Tonic /Clonic)	0	1		
Focality symptoms	0	1		
Loss of consciousness	0	1		
Asking questions to determine focus of fever				
Headache /Photophobia	0	1		
Vomiting, nausea/Diarrhea	0	1		
Skin rash	0	1		
Cough /runny nose /sore throat	0	1		
Urinary symptoms: dysuria ...	0	1		
Other important questions				
Activity, appetite, level of consciousness	0	1		
Contact with sick individuals	0	1		
Vaccination history	0	1		
Past history of similar conditions , hospital admissions	0	1		
Medication history (received antibiotics?)	0	1		
Travelling history (people returning from Hajj or Omra)	0	1		
After 6 minutes Stop the student to ask the following;				
<i>If CSF analysis showed cell count of 900,neutrophils 90 %,Glucose of 30 mg/dl,serum Glucose 75 mg/dl.what is your treatment plan</i>				
Antibiotics (should say Vancomycin & Cefotaxime)	0	1	2	
Steroids (Dexamethazone)	0	1		
Overall (organization, systematic, polite, good communications skills...	0	1	2	3

Examiners' name and signature:



The University of Jordan /Pediatric Final OSCE
2013
TIME: 7 minutes
Examiner copy



Time: 7 minutes

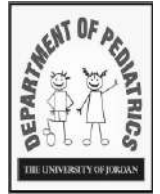
Station: History taking

A mother of a three year old child brought him to the emergency room with fever and seizures of a few minutes duration.

Please take a focused history, and answer the examiner's questions.



The University of Jordan /Pediatric Final OSCE
2013
TIME: 7 minutes
Examiner copy



SP copy

My child is a 7 year old girl who is not known to have any previous illness, started to have fever last night. It measured 39 degrees axillary. I gave her Revanin and the fever improved. She also complains of headache all night, she had difficulty in sleeping last night until I gave her the Paracetamol when headache improved she was able to sleep. She says her headache is worse when she leans forward, and it is throbbing in nature. This morning she was crying with headache, mainly frontal. She vomited once this morning. She does complain that her throat hurts. No photophobia, skin rash, or abnormal movements or chills. She had poor appetite this morning and less active than usual.

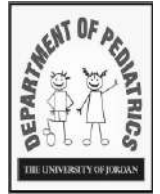
No URTI symptoms. No travel, No sick contacts.



**The University of Jordan /Pediatric Final OSCE
2013
TIME: 7 minutes
Examiner copy**



Vaccination complete. No previous hospitalizations. No trauma. No medication



Headache and fever 1

Student Name:

Mark

/28

The mother of a 7 year old girl brought her to you because of fever and headache. Please take a focused history, and answer the examiner's questions.

Analyzing the fever,asking about			
Onset, duration	0	1	
Amplitude,route, documented or not?	0	1	
Relieving factors (antipyretics, cold compressors...)	0	1	
Analyzing headache			
Onset, duration	0	1	
Course (intermittent,continuous)	0	1	
Site (frontal, retro-orbital....)	0	1	
Severity (Could sleep, watch TV, cries with pain...)	0	1	
Character (throbbing, constant...)	0	1	
Relieving factors as analgesia	0	1	
Aggrevating factors as noise,position	0	1	
Associated symptoms,asking about			
vomiting	0	1	
Photophobia,back pain	0	1	
Ask about CNS symptoms			
Abnormal movements	0	1	
Altered level of consciousness	0	1	
Focal neurological deficiets (weakness etc)	0	1	
Skin rash	0	1	
Ask about ENT symptoms (Runny nose,sore throat,ear pain)	0	1	
Other important questions			
Activity, appetite,	0	1	
Contact with sick individuals /travel abroad	0	1	
Vaccination history	0	1	
Past history of similar conditions , hospital admissions	0	1	
Medication history (received antibiotics,drugs?)	0	1	
History of trauma	0	1	
ASK the student give you two differential diagnosis ?			
meningitis	0	1	
Sinosis /pharyngitis	0	1	
Overall (organization, systematic, polite, good communications skills...	0	1	2 3

Examiners' name and signature:



*The University of Jordan /Pediatric Final OSCE
2016
TIME: 7 minutes*



Time: 7 minutes

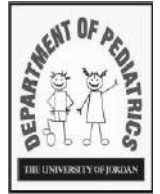
Station: History taking

**The mother of a 7 year old girl brought her
to you because of fever and headache**

Please take a focused history



*The University of Jordan /Pediatric Final OSCE
2016
TIME: 7 minutes*



SP copy

My child is a 7 year old girl who is not known to have any previous illness, started to have fever last night. It measured 39 degrees axillary. I gave her Revanin and the fever improved. She also complains of headache all night, she had difficulty in sleeping last night until I gave her the paracetamol when headache improved she was able to sleep. She says her headache is worse when she leans forward, and it is throbbing in nature. This morning she was crying with headache, mainly frontal. She vomited once this morning. She does complain that her throat hurts. No photophobia, skin rash, or abnormal movements or chills. She had poor appetite this morning and less active than usual.

No URTI symptoms. No travel, No sick contacts.

Vaccination complete.

No previous hospitalizations.



**The University of Jordan /Pediatric Final OSCE
2016
TIME: 7 minutes**



No trauma.

No medications.

Headache and fever 2



TIME :7 minutes
OSCE(history taking)
Examiner copy

Mark /30

The mother of a 7 year old girl brought her to you because of fever and headache. Please take a focused history, and answer the examiner's questions.

Observe the student asking the mother about the following:

Analysing the fever		
Onset, duration	0	1
Amplitude, documented or not?	0	1
Relieving factors (antipyretics, cold compressors..)	0	1
Chills, rigors		
Analyzing headache		
Onset, duration	0	1
Site (frontal, retro-orbital...)	0	1
Severity (Could sleep, watch TV, cries with pain...)	0	1
Nature (throbbing, constant...)	0	1
Relieving factors (analgesia...)	0	1
Aggravating factors (noise, position..)	0	1
Asking about associated symptoms		
Sore throat	0	1
Vomiting, nausea	0	1
Skin rash	0	1
Photophobia	0	1
Abnormal movements	0	1
Previous URTI (recent), Trauma	0	1
Other important questions		
Activity, appetite, level of consciousness	0	1
Contact with sick individuals	0	1
Vaccination history	0	1 2
Past history of similar conditions , hospital admissions	0	1
Medication history (received antibiotics ?)	0	1 2
Travelling history (people returning from Hajj or Omra)	0	1

Stop the student after 6 minutes to ask about the most likely differential diagnosis based on the history: (3 differentials)

Meningitis	0	2
Sinusitis	0	1
Pharyngitis	0	1

Overall performance	0	1	2	3
---------------------	---	---	---	---

Time: 7 minutes

Station: History taking

The mother of a 7 year old girl brought her to you because of fever and headache.

Please take a focused history, and answer the examiner's questions.

SP copy

My child is a 7 year old girl who is not known to have any previous illness, started to have fever last night. It measured 39 degrees axillary. I gave her Revanin and the fever improved. She also complains of headache all night, she had difficulty in sleeping last night until I gave her the paracetamol when headache improved she was able to sleep. She says her headache is worse when she leans forward, and it is throbbing in nature. This morning she was crying with headache, mainly frontal. She vomited once this morning. She does complain that her throat hurts. No photophobia, skin rash, or abnormal movements or chills. She had poor appetite this morning and less active than usual.

No URTI symptoms. No travel, No sick contacts.

Vaccination complete.

No previous hospitalizations.

No trauma.

No medications.



Fever + knee pain

TIME: 7 minutes
OSCE (history taking)
Examiners' copy

Mark /30

The mother of a 9 year old girl brought her to you because of fever and knee pain. Please take a focused history, and answer the examiner's questions.

Observe the student asking the mother about the following:

Analyzing the fever	
Onset	0 1
Documented or not?	0 1
Relieving factors (antipyretics, cold compressors..)	0 1
Chills/ rigors	0 1
Analyzing knee pain	
Onset	0 1
Severity (cries of pain, can or cant walk, limping..)	0 1
progression/ course	0 1
Relieving factors (position, pain medications..)	0 1
Aggravating factors (movement/ walking...)	0 1
Asking about other symptoms	
Pain in other joints	0 1
redness of the knee	0 1
swelling of the knee	0 1
limitation of knee movement	0 1
skin rash	0 1
chest pain , difficulty breathing, fatigability	0 1
abdominal pain	0 1
GI symptoms: Diarrhea/ constipation/ or vomiting	0 1
Other important questions	
trauma	0 1
history of pharyngitis in the last few weeks	0 1
use of medications	0 1
Past history of similar conditions , hospital admissions	0 1
recent ingestion of unpasteurized milk	0 1
family history of joint problems, FMF, rheumatological disorders	0 1

Stop the student after 4 minutes to ask the following questions
If the physical examination showed temperature of 38, swollen right knee, severe tenderness and redness, with limitation of movement due to pain. Auscultation of the chest showed a loud systolic murmur at the apex. What is your next step in the evaluation? (Give me only three important investigations)

(Any three of the following)

(ASO titer or throat cx), (ESR or CRP), (ECG or echocardiography) , CBC, chest X-ray	0	1	2	3
--	---	---	---	---

Overall performance	0	1	2	3	4
---------------------	---	---	---	---	---

Time: 5 minutes

Station: History taking

The mother of a 9 year old girl brought her to you because of fever and knee pain

Please take a focused history, and answer the examiner's questions.

SP copy

My 9 year old girl has been complaining of left knee pain for the last week. She also has fever which I measured to be 38.5 yesterday.

Knee pain started 7 days ago, has been worsening over the last few days, constant in nature, and it is more when she walks or move her knee. I gave her revanin which helped only slightly to decrease the pain. Today she is unable to walk on her knee.

I noted some swelling of the knee, but no redness.

The fever happened daily mainly in the afternoon, I only measured it yesterday and it was 38.5 orally, no chills or rigors, Revanin helped decrease the temperature.

She has no other joint pains, no skin rash, no chest pain or difficulty breathing. And no abnormal movements. No diarrhea, sore throat, runny nose. No body in the family has joint or chronic diseases. No ingestion of raw milk or any medications other than revanin.

No trauma or pin pricks, no travel, no past history of similar episode

She had pharyngitis 2 months ago, no treatment was given because she did not complain much.

Fever + noisy breathing



TIME :7 minutes
OSCE(history taking)
Examiner copy

Mark /27

The mother of a 3 year old boy brought him to you because of fever and noisy breathing. Please take a focused history, and answer the examiner's questions.

Observe the student asking the mother about the following:

Analysing the fever			
Onset	0	1	
Amplitude, documented or not?	0	1	
Relieving factors (antipyretics, cold compressors..)	0	1	
Analyzing noisy breathing			
Onset	0	1	
What type of noise (inspiratory, wheezing, snoring.. etc)	0	1	2
Aggravating or relieving factors (smells, smoking..)	0	1	
Asking about associated symptoms			
Runny nose	0	1	
Cough	0	1	
Analyzing type of cough (dry, paroxysmal, barking... etc)	0	1	2
Difficulty breathing	0	1	
Cyanosis	0	1	
Vomiting (post tussive)	0	1	
Drooling, dysphagia	0	1	
Decreased appetite	0	1	
Decreased activity	0	1	
Other important questions			
Contact with sick individuals	0	1	
History of choking or aspiration	0	1	
Vaccination history	0	1	
Past history of similar conditions , hospital admissions	0	1	
Medication history, ever required nebulizer treatment	0	1	

Stop the student after 6 minutes to ask the following questions

Q: Ask the student, if the physical examination showed a well appearing child with temperature of 38, and audible stridor and mild suprasternal retractions. What is the most likely diagnosis based on your history and these findings? (give me one answer)

Laryngotracheobronchitis (croup)	0	2	
----------------------------------	---	---	--

Overall performance	0	1	2	3
---------------------	---	---	---	---

Time: 7 minutes

Station: History taking

The mother of a 3 year old boy brought him to you because of fever and noisy breathing.

Please take a focused history, and answer the examiner's questions.

SP copy

My child is a 3 year old boy who is not known to have any previous illness, started to have fever last night. It measured 38 degrees axillary. I gave him Revanin and the fever improved. He also had noisy breathing, he has a harsh noise when he takes a breath, his voice changes and has several episodes of cough, dry and similar to the dog barking. He had no exposure to smoke or dust, and no other medications were given.

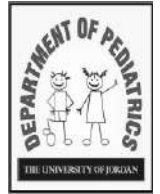
2 days ago he had runny nose.

He has no cyanosis, but seems to have more difficulty breathing than normal. He had no vomiting and no drooling or pain when swallowing. But his appetite this morning is not as usual, he didn't want to finish his breakfast and he is less active than usual.

There is nobody else sick at home, and there was no history of choking or aspiration.

He is not known to have any chronic illness, never admitted and never required nebulization treatment.

His vaccinations are up to date.



Fever + rash

Student Name:

Mark

/27

A 3 years old child came to E/R complaining of skin rash. Observe the student asking the mother about the following:

Analyzing rash				
onset	0	1		
Site or distribution	0	1		
Course of the rash(face then trunk ,or all over same time,if comes and goes as flares)	0	1		
Description (if raised or not),color of rash,presence of fluid in rash,swollen skin around lesion	0	1		
If itchy or not	0	1		
Ask about mucus membranes involvement	0	1		
Associated symptoms				
History of vomiting	0	1		
History of fever	0	1		
Headache/ irritability/ photophobia	0	1		
History of abnormal movement				
Cough,runny nose,conjunctivitis,diarrhea (viral illness)	0	1		
Joint pain or swelling	0	1		
History of abdominal pain	0	1		
History of red urine	0	1		
Other important questions				
Activity, feeding	0	1		
History of previous episodes	0	1		
History of allergy in child/food	0	1		
Contact with individuals with same complaint, Family history of similar cases	0	1		
Drug history	0	1		
Vaccination history	0	1		
<i>After 6 minutes Stop the student to ask the following;O/E the child has raised nonblanching skin lesions.what is your diagnosis and what are the main investigations that you will perform apart from CBC,ESR,KFT (mention two)</i>				
<i>Henoch Schonlein Purpura</i>	0	2		
MAIN INVESTIGATIONS				
<i>1.urine analysis</i>	0	2	4	
<i>2.stool for heme occult</i>				
Overall (organization, systematic, polite, good communications skills...	0	1	2	3

Examiners' name and signature:



*The University of Jordan /Pediatric Final OSCE
2015
TIME: 7 minutes*

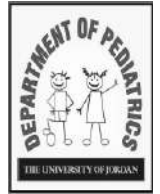


Time: 7 minutes

Station: History taking

**A 3 years old child came to E/R
complaining of skin rash**

**Please take a focused history, and answer
the examiner's questions.**



SP copy

My three years old baby has a skin rash of three days duration. It started on the foot and over the three days the rash went up to cover thighs. The rash is red, raised and not itchy.

No history of fever or vomiting. No history of headache, photophobia or irritability. No history of cough, runny nose.

There is a history of abdominal pain around the umbilicus. No diarrhea or vomiting. There is a history of joint swelling in both knees and there is limping. There is history of red urine. No dysuria or frequency. No change in color of stool

There is good activity and feeding. There is no similar cases in the family or contact with sick people. He did not take new drugs

The child is vaccinated.



Foreign body aspiration



TIME: 7 minutes
OSCE (history taking)
Examiner copy

Mark /21

The mother of a 1.5 year old boy brought him to you because of noisy breathing. Please take a focused history, and answer the examiner's questions.

Observe the student asking the mother about the following:

Analyzing noisy breathing				
Onset	0	1		
What type of noise (inspiratory, wheezing, snoring.. etc)	0	1		
Aggravating or relieving factors (smells, smoking..)	0	1	2	
Asking about associated symptoms				
fever	0	1		
Runny nose	0	1		
Cough	0	1		
Difficulty breathing	0	1		
Cyanosis	0	1		
Drooling, dysphagia	0	1		
Decreased appetite	0	1		
Decreased activity	0	1		
Other important questions				
History of choking or aspiration	0	1		
Vaccination history	0	1		
Past history of similar conditions , hospital admissions	0	1		
Medication history, ever required nebulizer treatment	0	1		
After 5 minutes stop the student and ask the following question :				
If this child has a history of witnessed choking, he is afebrile and has no runny nose, what do you expect to see on the chest X-ray? Answer: unilateral hyperinflation ,complete collapse , the foreign body if radiopaque	0	1		
Overall performance :eye to eye contact, introduce him/herself, using appropriate words and questions , compassionate and considerate	0	1	2	3 4

Examiner's name and signature



Time: 7 minutes

Station: History taking

The mother of a 1.5 year old boy brought him to you because of noisy breathing.

Please take a focused history, and answer the examiner's questions.



SP copy

My child is a 1.5-year-old boy who is not known to have any previous illness, started to have noisy breathing, he has a harsh noise when he takes a breath in, he had cough only this afternoon for about 10 minutes, he was in the other room with his siblings playing with their new toy, I heard him coughing so I went to see what happened, he was blue and coughing, then it resolved but he has difficulty in breathing and he has this noise I mentioned. He had no exposure to smoke or dust, and no medications were given.

He had no vomiting and no drooling or pain when swallowing. No change in activity and feeding. There is anybody else sick at home.

He is not known to have any chronic illness, never admitted and never required nebulization treatment.

His vaccinations are up to date.



Fever

TIME :7 minutes
OSCE(history taking)

Examiner copy

Mark /30

**The mother of a 1.5 year old girl brought her to you because of “fever”.
Please take a focused history, and answer the examiner’s questions.**

Observe the student asking the mother about the following:

Analyzing the fever		
Onset	0	1
Documented or not?	0	1
Amplitude	0	1
Route : oral, rectal, axillary	0	1
Pattern :Intermittent or continuous	0	1
Relieving factors (antipyretics, cold compressors..)	0	1
Asking about associated symptoms		
GI system :		
-Vomiting	0	1
- diarrhea	0	1
- Jaundice	0	1
Respiratory symptoms :		
- runny nose, Cough, Difficulty breathing	0	1
- Ear pulling	0	1
CNS symptoms :		
-Abnormal movements (seizures)	0	1
-Excessive sleepiness , impaired consciousness/activity	0	1
-Irritability/ excessive crying	0	1
Skin rash	0	1
Cyanosis	0	1
Urinary symptoms : color, odor, frequency	0	1
Decreased feeding	0	1
Other important questions- risks factors		
Contact with sick individuals at home	0	1
History of Day care attendance	0	1
Vaccination history	0	1
Any given Medications other than antipyretics (antibiotics)	0	1
Similar history in the past	0	1
History of medical illness or condition in this patient	0	1

Stop the student after 6 minutes to ask the following question:

If the patient has high grade fever, with negative meningeal signs, what basic work up labs would you like to obtain ? The answer should include :

CBC, Blood culture, urine analysis, and urine culture

0	1	2	3
---	---	---	---

Overall performance	0	1	2	3
---------------------	---	---	---	---

Examiner name and signature

Student's copy

Time: 7 minutes

This station tests your ability to take
and analyze history

**The mother of a 1.5 year old girl
brought her to you because of
“fever”.**

**Please take a focused history, and
answer the examiner's question**

SP

My 1.5 year old girl is having fever for two days duration. I am measuring it axillary as 39. I am giving her regranin suppositories and cold compressors and the fever is going down but it comes after hours again.

The baby is hypoactive even when the fever goes away. she is sleeping more than usual and is not feeding well

No history of cough, runny nose, ear pulling, difficulty breathing. No diarrhea. No history of abnormal movement. No history of vomiting or irritability or skin rash

The urine smells as usual and no change in color.

My baby doesn't go to a day care and there is no family history of similar cases and my baby was not exposed to sick children

Vaccines are up to date.

No antibiotics were given

The infant is previously healthy

Negative family history of immune diseases/ immune deficiency

Frequent falls

Station : history delayed walking and frequent falls

Examiner copy (time 10 minutes)

Student Name -----

Mark -----/28

This station examines the ability of student to take a history to differentiate if the weakness is related to upper motor or lower motor neuron disorder in addition to his ability to understand the causes of lower motor neurone disorders

A mother brought her 3 years boy to your clinic because he has frequent falls while walking which is worsening for the last 6 months. He had no trauma, no joint swelling and no fever

- 1- Take a focused history from his mother
- 2- the examiner will stop you after 7 minutes to ask you about the differential diagnosis

Ask about antenatal history : medical problems in mother (DM, hypertension , drugs , fetal activity , infections , fever)	0	1	2
Ask about birth history :GA , mode of delivery , BW , jaundice ,NICU,cried at birth	0	1	2
Ask about vaccine history	0	1	
<i>Ask about developmental history</i>			
<i>Gross motor</i> : when did he start walking , and if he goes upstairs and downstairs now	0	1	2
<i>Fine motor</i> : if he draws a circle	0	1	
<i>Social</i> : if h plays with peers	0	1	
<i>Language</i> : if he forms 3 word sentences and knows 1-2 colors	0	1	
Ask about regression or not and when did it start	0	1	2
<i>Any other weaknesses elsewhere</i>			
Upper limbs	0	1	
Chocking	0	1	
Ptosis	0	1	
Squint (ophthalmoplegia)	0	1	
Tired more at the end of day	0	1	
<i>Family history of</i> Consanguinity	0	1	

Similar cases in the family (or early deaths)	0	1	
<i>What is your differential diagnosis</i>			
<i>Muscle disease</i> :Progressive muscle dystrophy (+/- mostly duchenne)	0	2	
<i>Anterior horn cell</i> :Polio	0	1	
<i>Neuromuscular junction or nerve</i> :Myasthenia gravis or neuropathy	0	1	
<hr/>			
<i>Tell the student that upon physical examination the child was noticed to have decrease tone and Deep tendon reflexes in addition <u>to calf hypertrophy</u></i>			
<i>Mention 2 tests to help in reaching towards the correct diagnosis (<u>any 2</u>)</i>			
CPK , muscle biopsy , dystrophin gene	0	1	2
Communication Skill :			
Introduce him /herself . Explain purpose of interview,organization,type of questioning open versus close end question,appropriate body language (eye contact.etc)	1	2	3



Examiner's copy



Student name:

Score /32

Please observe the student taking detailed history about vomiting and diarrhea in a 1 year old infant, and note that he/she asks about the following:

Analyzing vomiting					
Asking about onset	0	1			
Asking about frequency (or number)	0	1			
Asking about Character (forceful, projectile)	0	1			
Asking about content of vomitus/ bile or blood in vomitus	0	1			
Asking about relation to meals	0	1			
Analyzing diarrhea					
Asking about onset	0	1			
Asking about frequency (or number)	0	1			
Asking about amount of stool (large stools, watery, bulky)	0	1			
Asking about the presence of mucous	0	1			
Asking about the presence of blood	0	1			
Asking about associated symptoms					
Appetite/ food intake	0	1			
Activity	0	1			
Fever	0	1			
Irritability	0	1			
Jaundice	0	1			
Respiratory/ viral symptoms (cough, runny nose)	0	1			
Seizure or abnormal movements	0	1			
Change of urine color or smell	0	1			
Asking about symptoms of dehydration					
Thirst	0	1			
Urinary amount and frequency	0	1			
Past history questions					
Previous history of vomiting and diarrhea	0	1			
Ask about family history					
Asking about contact with sick family member	0	1			
Asking about exposure to contaminated water or food					
Asking about going to day care or not	0	1			
Drug history (antibiotics)					
0					
<i>After 6 min ,stop the student and ask what are things in physical exam that will help in assessing degree of dehydration</i>					
Answer:					
1- Signs of dehydration :dry mucus membranes ,decreased skin turgor, sunken fontanel , crying without tears, cap refill (the student should mention at least 3 of them)	0	1	2	3	4
2- Vital signs : blood pressure , heart rate					
Overall (organization, systematic, polite, good communications skills...)	0	1	2	3	4

Examiner's Name & signature:

Student Copy

Station: History taking

Time: 7 minutes

You are about to interview the parent of
a **ONE** year old male child who
presented with history of **vomiting and
diarrhea**

**Please take focused history, and then
answer the examiners question**

SP copy

My son Omar is a one year old, previously healthy

Has vomiting and diarrhea since yesterday

He started vomiting yesterday morning and since then he vomited 3 times. He vomits after drinking milk within few minutes of feeding. He has no mucous, blood or bile in his vomitus.

He developed diarrhea last night and since then he had 7 episodes of watery stool, with mucous but no blood, the stool is large that he spoils his clothes (soaks the diaper and the clothes). He has no abdominal pain.

He has been less active than usual since yesterday; he had a fever that I measured at 38.5 rectally. He has poor appetite but only wants to drink a lot of water. He had no seizures or loss of consciousness. He didn't eat from outside the house. He is on formula milk and table food. I use filtered water to prepare his milk. He stays with me at home and has a 3year old brother who had diarrhea last week but was very mild.

Last urine output was yesterday morning, but I can't tell if he had urine mixed with the stool.

He has no runny nose, and no cough.

Gastroenteritis 2



Examiner's copy



Student name:

Score /34

Please observe the student taking detailed history about vomiting/diarrhea in a 6 month old girl, and note that he/she asks about the following:

Analyzing chief complaint / HOP				
Diarrhea :				
Onset / duration	0	1		
Frequency	0	1		
Consistency /	0	1		
Usual bowel habit	0	1		
Presence of blood or mucus	0	1		
Vomiting :				
Onset/duration	0	1		
Frequency /volume	0	1		
Consistency/content	0	1		
Relation to food (tolerance)	0	1		
Fever :	0	2		
Feeding History :				
Type of milk	0	1		
Preparation/sterilization technique	0	1		
demand on feeds (thirst)	0	1		
Analyzing symptoms of dehydration :				
Urine output	0	1		
Activity : hypoactivity or irritability	0	1		
History of similar contact / Day care attendance				
	0	1		
Past medical : previous episodes				
	0	1		
Drug history : antipyretic , anti emetics, Herbal , etc				
	0	1		
Immunization				
	0	1		
<i>After Six minutes, ask the student the following questions :</i>				
1-Based on the history that you took What is your Diagnosis? (acute viral gastroenteritis)				
	0	1		2
3-If this child was in the ER and looked lethargic , had signs of dehydration with delayed capillary refill , what is your initial management in the ER : IV Bolus of Normal Saline 0.9% 20 ml / kg				
4-After stabilization, this infant was admitted to the hospital as GE with dehydration, what are the important labs you would you do (name only three)				
Serum for electrolytes and Sugar : Electrolytes (Na , K ,Cl) ,	0	1		
VBG KFT (Creatinine and BUN).	0	1		
Stool Analysis ,CBC, blood gas ,urine work up	0	1		
5) Serum Sodium came back 160 meq /l, what are the expected complications (seizures, Intracranial hemorrhage	0	1		2
what are the general rehydration roles you have to follow in this case (Avoid hypotonic solution and rehydration over long time, serial Na follow up)	0	1		2
Overall (organization, systematic, polite, good communications skills..	0	1	2	3 4

Examiner's name & signature:

Student's copy/ History taking

You are about to interview the parent of a **6 month old** baby girl .who presented with history of **vomiting and Diarrhea**

Please take focused history, and then answer the examiners questions

SP copy

My daughter Sara is 6 month old.

She was well until 5 days ago when she started to have Diarrhea , 5 times a day .Her stool was watery , clear ,with no mucus nor blood .Her usual bowel habit was one to two motions a day .

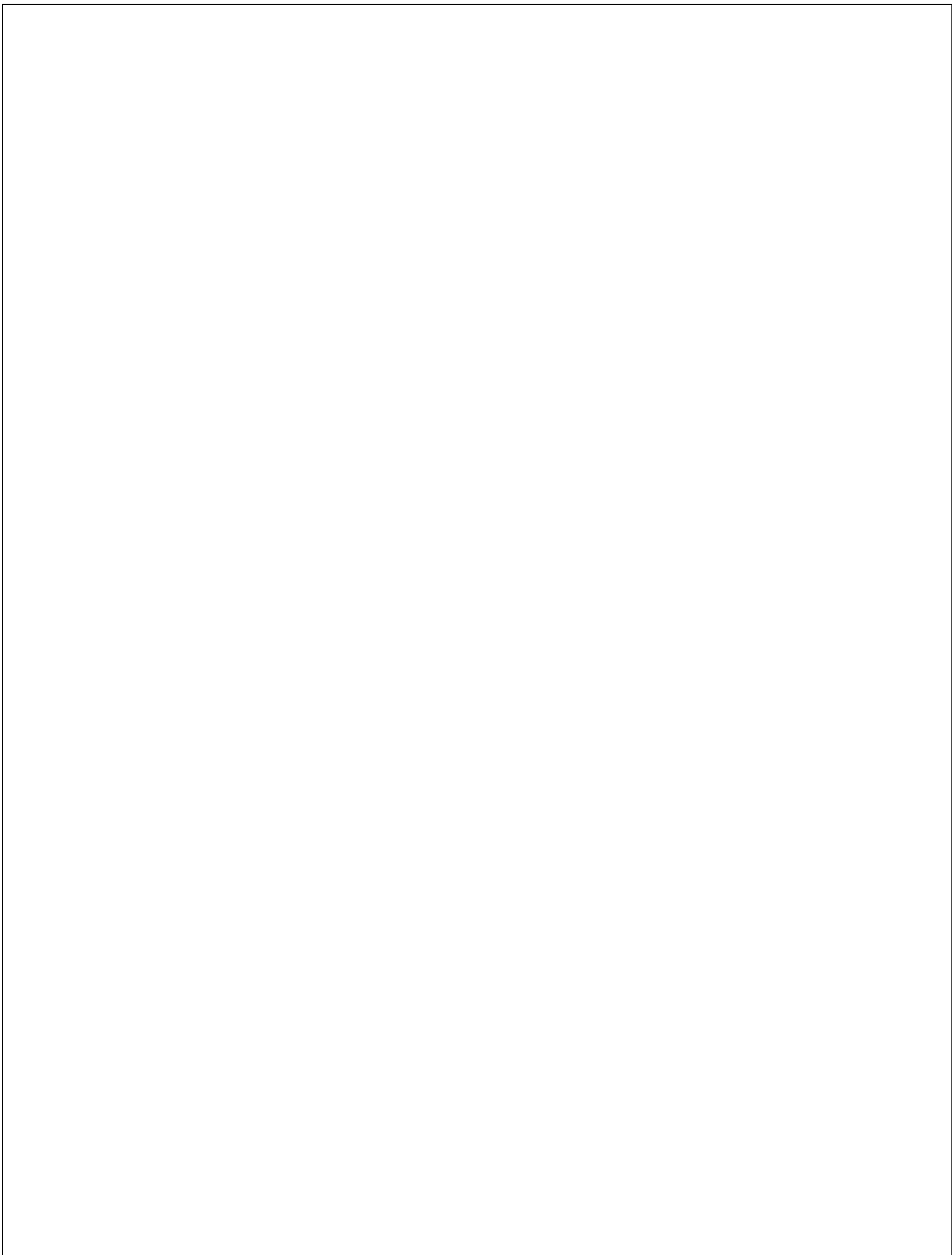
Vomiting started two days later , 4 to 5 times a day but last day she vomited all her feeds . Vomitus non- bilious with usual milk content.

No fever was documented .No medications given

She had good appetite with increased demand on her feeds ,she is on Formula milk ,mom uses boiled then cooled tap water for preparation and uses good sterilization technique .

Baby was active but today noticed to be lethargic ,with decreased urine amount in her diapers .

She attends a day – care centre on daily basis ,no similar complaints in her siblings .No previous similar episodes .Vaccination up to age .



Gastroenteritis 3



Examiner's copy



Student name:

Score /32

Please observe the student taking detailed history about vomiting and diarrhea in a 9 month old infant, and note that he/she asks about the following:

Analysing vomiting				
Asking about onset	0	1		
Asking about frequency (or number)	0	1		
Asking about Character (forceful, projectile)	0	1		
Asking about content of vomitus/ bile or blood in vomitus	0	1		
Asking about relation to meals	0	1		
Analysing diarrhea				
Asking about onset	0	1		
Asking about frequency (or number)	0	1		
Asking about amount of stool (large stools, watery, bulky)	0	1		
Asking about the presence of mucous	0	1		
Asking about the presence of blood	0	1		
Asking about associated symptoms				
Appetite/ food intake	0	1		
Activity	0	1		
Fever	0	1		
Abdominal pain/ colic/ crying episodes	0	1		
Asking about exposure to contaminated water or food	0	1		
Jaundice	0	1		
Respiratory/ viral symptoms (cough, runny nose)	0	1		
Seizure or abnormal movements	0	1		
Change of urine color or smell	0	1		
Asking about symptoms of dehydration				
Thirst	0	1		
Urinary amount and frequency	0	1		
Past history questions				
Previous history of vomiting and diarrhea	0	1		
Ask about family history				
Asking about contact with sick family members	0	1		
Asking about going to day care or not	0	1		
Drug history (antibiotics)				
0 1				
<i>After 6 minutes of history taking, please stop the student and ask: If this infants examination was normal, what diagnostic investigations on the stool sample would you like to obtain?</i>				
Answer: Stool for Rotavirus, ova and parasite, and culture	0	1	2	3
Overall (organization, systematic, polite, good communications skills..)	0	1	2	3 4

Station: History taking

Time: 7 minutes

You are about to interview the parent of a **1 year old** female infant who presented with history of **vomiting and diarrhea**

Please take focused history, then answer the examiners question

SP copy

My daughter lina is 1 year old girl, previously healthy

Has vomiting and diarrhea since yesterday

She started vomited yesterday morning and since then she vomited 3 times. She vomits after drinking milk within few minutes of feeding. She has no mucous, blood or bile in his vomitus.

She developed diarrhea last night and since then had 7 episodes of watery stool, with mucous but no blood, the stool is large that she spoils her clothes (soaks the diaper and the clothes). She has no abdominal pain.

She has been less active than usual since yesterday; she had a fever that I measured at 38.5 rectally. She has poor appetite but only wants to drink a lot of water. She had no seizures or loss of consciousness. She didn't eat from outside the house. She is on formula milk and table food. I use filtered water to prepare her milk. She stays with me at home and has a 3year old brother who had diarrhea last week but was very mild.

Last urine output was yesterday morning, but I can't tell if she had urine mixed with the stool.

She has no runny nose, and no cough.

Time: 7 minutes
Student Copy

You are a fifth year medical student. You are about to interview a mother who brought her 3 month old daughter complaining of fast breathing.

Please perform a focused history.

You have 7 minutes to complete this task.

The examiner will then ask you a few questions about this patient

Student Name:

Final Mark:

/ 26

History taking of 3 month old with tachypnea. Observe that the student performed the following:

1) Analysing tachypnea				
Ask about duration of tachypnea	0	1		
Ask about course of tachypnea (progressive, episodic, day and night etc)	0	1		
Ask about predisposing and relieving factors (feeding, sleeping, positioning..etc)	0	1		
2) Ask about associated symptoms				
cough	0	1		
fever	0	1		
choking or aspiration history	0	1		
noisy breathing, grunting	0	1		
cyanosis	0	1		
edema (swelling of face or extremities)	0	1		
urination (amount or frequency)	0	1		
Activity, oral intake, feeding difficulties	0	1		
excessive sweating	0	1		
Pallor, or cold extremities	0	1		
Weight gain	0	1		
4) Past history				
Ask about past history of infections (previous URTI)	0	1		
Ask about past history of hospitalizations	0	1		
Ask about perinatal complications	0	1		
5) Family History Ask about family history of cardiac disease, or tachypnea, or similar conditions..... etc	0	1		
6) Tell the student "If I told you that this child has tachycardia, tachypnea, cool extremities, and gallop rhythm" . What is your diagnosis at this point				
Heart failure	0	2		
7) Tell me three possible common causes of heart failure in this child (any three of the following)				
Large VSD, PDA, COA, Aortic stenosis, Truncus arteriosus, Cardiomyopathy, myocarditis. (note, cyanotic heart disease other than truncus arteriosus is not a correct answer)	0	1	2	3
9) Overall performance (introduces self, communication skill, organization)	0	1	2	3

Examiner name and signature

Heart failure OSCE case

You are a mother of a 3 month old female, previously healthy, and her name is Layan. She has been doing well until about one month ago when you started noticing that her breathing is fast. You did not count the rate, but compared to the first 2 months of life it is faster. The fast breathing seems to be more significant now than a month ago. It is more prominent after she feeds but also fast while she is asleep.

There is no fever, and no cough. She has breathing difficulty with noisy breathing (grunting) after feeding, but not wheezing and not stridor. There is no vomiting or choking episodes, and no history of aspiration. You also noted that she sweats a lot during feeding in the past 2 weeks, and her feeding is less than before. She breast feeds exclusively, and she used to feed for 15 minutes but now gets tired after only 5 minutes of feeding. She also looks pale and with cold feet in the past week.

She has normal bowel movements, she has 3 wet diapers per day, no change in urine color or odor.

She cries a lot because she is hungry but gets tired quickly when I tried to feed her.

Pregnancy was normal, full term, NVD, 39 weeks, b wt 3.4 kg. now her weight is 4.5 kg. Last month her weight was also 4.5 kg, so she has no weight gain for the last month. No NICU admission, no previous hospitalization.

She has one brother, 3 year old healthy. No family history of similar conditions, no heart disease, no consanguinity.

There is no history of exposure to any other illnesses, her father smokes occasionally at home. He is a teacher, and I am a house wife.

OPENING statement:

“My child is breathing faster than normal in the past month”

Time: 10 minutes

Student Copy

Heart failure 2

You are a fifth year medical student. You are about to interview a mother who brought her 2 year old daughter complaining of fast breathing.

Please perform a focused history.

You have 7 minutes to complete this task.

The examiner will then ask you a few questions about this patient

Student Name:

Final Mark:

--

Examiner's Copy

History taking of 2 year old with tachypnea. Observe that the student performed the following:

1) Introduce self	0	1
2) Ask about duration of tachypnea	0	1
Ask about cough	0	1
Ask about fever	0	1
Ask about choking history	0	1
Ask about activity	0	1
Ask about wheezing or noisy breathing	0	1
Ask about cyanosis	0	1
Ask about edema (swelling of face or extremities)	0	1
Ask about urination (amount or frequency)	0	1
Ask about appetite (or oral intake)	0	1
Ask about excessive sweating	0	1
Ask about pallor	0	1
Ask about GI symptoms (vomiting or diarrhea)	0	1
4) Past history		
Ask about past history of infections	0	1
Ask about past history of hospitalizations	0	1
5) Family History		
Ask about family history of cardiac disease, or tachypnea, or wheezing..... etc	0	1
6) Tell the student "If I told you that this child has tachycardia, tachypnea, cool extremities, and gallop rhythm". What investigations would you do for this child (give the students three attempts before showing him/her a chest X-ray)		
If he orders Chest X-ray	0	2
7) Interpret this chest Xray:		
Cardiomegally	0	1
Pulmonary edema	0	1
8) Ask student: What do you think the most likely explanation of this child's illness		
Cardiomyopathy, or congestive heart failure, or myocarditis, or pericardial effusion or tamponade (Cardiac etiology)	0	2
9) Overall performance		
Organization	0	1
Communication	0	1

Heart failure OSCE case

You are a mother of a 2 year old female, previously healthy, and her name is Suha. She has been doing well until about one week ago when your sister told you that she is breathing a little fast, you have not noticed this before and you thought this was not important at that time. But for the past 2 days you noticed that she is breathing faster even while she is asleep, and her activity decreased. You checked her temperature by a thermometer under her arm several times in the past week but she had no fever. Today you brought her to the clinic because you were concerned that there is something wrong with her.

Normally your child is playful; she can walk very well and runs normally. Usually she takes one hour nap every day in the afternoon but for the last 3 days she sleeps at least twice for 2 hours, and seems to be more tired than usual and less playful, and she cries and whines more than her usual state. In the last few days she likes to be carried more. There was no cough, no cyanosis and no history of choking. No vomiting or diarrhea, no loss of consciousness.

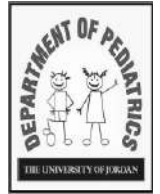
Her breathing is not noisy, just fast. There is also some fullness around her eyes, and her abdomen is a little bigger than usual. She looks a little pale to you as well.

There is no significant past medical history. She had some runny nose a month ago when the whole family had it as well. There is no history of hospitalizations or surgeries done. Family history is completely unremarkable. Your husband is your first degree cousin.

There is no history of exposure to any other illnesses, her father smokes occasionally at home.

OPENNING statement:

“My child is breathing faster than normal in the past week”



Student Name:

Mark

/23

A mother brings her 7 month old baby with vomiting and decreased activity for the last 24 hours

Analysing symptoms			
Asking about Frequency of vomiting(number)	0	1	
Asking about content(blood or bile in vomitus)	0	1	
asking about character (forceful,projectile)	0	1	
History of fever	0	1	
History of diarrhea	0	1	
Asking about frequency (number of bowel habits)	0	1	
Presence of blood or mucus in stool	0	1	
Amount ,consistency of stool	0	1	
History of irritability	0	1	
History of skin rash	0	1	
Seizure or abnormal movement	0	1	
History of change in urine color,smell	0	1	
Activity and feeding	0	1	
Asking symptoms of dehydration			
Crying without tears, History of decreased urine output,	0	1	2
Other important questions			
History of contact with similar cases, day care attendance,exposure to contaminated water	0	1	
<i>After 6 minutes Stop the student to ask the following:O/E the child was febrile,irritable and dehydrated and had bloody stools..give me two most likely differential diagnosis and labs test for diagnosis of each?</i>			
1. Invasive gastroenteritis (amebic,shigella),diagnosed by stool analysis and culture	0	1	2
2.Intussusceptions diagnosed by abdominal ultrasound/barium or pneumatic enema	0	1	2
Overall (organization, systematic, polite, good communications skills...	0	1	2 3

Examiners' name and signature:



*The University of Jordan /Pediatric Final OSCE
2014
TIME: 7 minutes*

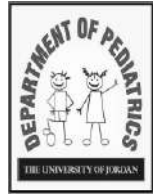


Time: 7 minutes

Station: History taking

**A mother brings her 7 months old baby
with vomiting and decreased activity for the
last 24 hours**

**Please take a focused history, and answer
the examiner's questions.**



SP copy

My 7-month-old boy is complaining of 12 episodes of vomiting. The vomitus has only food, with no blood in it or yellowish fluid. It was not forceful. He was febrile. I measured his temperature and it was 38.5°C axillary. He had decreased activity for the past 24 hours and was not feeding well. He had five loose motions with small amounts of stool and they were soft, the last one was mainly blood with little stool. No mucus in stool was seen. My child was very irritable with recurrent bouts of crying and he kept flexing his legs as if someone is having a colic. There was no abnormal movement and no change in color or smell of urine. My child was crying without tears and his diapers were not as heavy as before. There was no crying upon urination. This is the first time my child complains of this. There is no contact with sick people or exposure to contaminated food. I send my child to day care

LOC

Time: 7 minutes

Student Copy

You are a fifth year medical student in the emergency room. You are about to interview a mother who brought her 2 year old daughter who was unconscious.

Please take a focused history.

Student Name:

Examiner's Copy

Final Mark:

History taking of 2.5 year old found unconscious. Observe that the student performed the following:

Ask about duration of LOC	0	1
Ask about Seizure-like activity	0	1
Ask about color during LOC	0	1
Ask about post-ictal state	0	1
Ask about Trauma or fall	0	1
Ask about breathing pattern	0	1
Ask about Fever	0	1
Ask about recent illness	0	1
Ask about medication history	0	1
Ask about vomiting	0	1
Ask about intoxication (drugs, organophosphate, or pesticides)	0	1
Ask about diabetes symptoms (polyurea, polydipsia)	0	1
3) Asks about developmental history	0	1
4) Past history		
Ask about past history of LOC	0	1
Ask about past history of seizures	0	1
Ask about vaccinations	0	1
5) Family History		
Ask about similar condition in the family	0	1
Ask about family history of febrile seizure	0	1
Ask about family history of epilepsy	0	1
6) Please ask the student to think for a few moments and provide the most likely five diagnoses based on the history, he/she gets a score for each of the following		
Febrile seizure	0	1
Epilepsy	0	1
Meningitis or CNS infection	0	1
7) Overall performance		
Organization	0	1
Communication/ coherence	0	1

LOC OSCE case

You are a mother of a 2.5 year old female, previously healthy, and her name is Sara. Your son (Ibrahim) who is 10 year old called you to see her at 3pm today afternoon. He told you that she was lying on the floor in the back yard for sometime. You rushed out to see her and found her on the floor, breathing normally, with her eyes closed. She didn't answer you when you called her name, and didn't wake up when you moved her. Her color was normal, she was floppy. You carried her immediately and came to the hospital by a taxi. You live about 10 minutes from the hospital. She woke up while you were in the car, she cried a little, but was very sleepy. At that time you noticed that she felt very hot. You arrived to the hospital 30 minutes before the interview with the medical student. During these thirty minutes she was given a dose of Rivanin because her temperature was 39 C and her temperature came down, she became more alert, and was asking you to go home. Now she is asleep. You are still concerned about what happened to her.

You remember that in the past 2 days she had runny nose, her brother has runny nose too, She had no vomiting, and was acting normally otherwise. You didn't notice the fever before coming to the hospital. Today she had her lunch normally at around 2:30 pm, and she asked if she can go out to play in the backyard, she went out around 2:45p. You were in the kitchen when her brother came in and told you that she was lying on the floor.

She is not taking any medications for her cold or any other reason. There were no bruises on her body when you saw her but you are not sure if she fell down. There was no urinary incontinence, and there was nothing in her mouth when you saw her. Her father is hypertensive and takes medications but they are kept away in the parents' bedroom so children can't reach them, but you didn't check if any medication is missing. In the backyard, you have not used any pesticides or insecticides for the past six months.

Sara has no past history of any significant illness, and no hospitalization, she never lost her consciousness, and never had seizures. Her vaccinations are up to date, last one was about a year ago. She had normal delivery and normal development. She walked at age 14 months and she is talking very well. She can use a pencil to mimic a circle, and she plays well with Lego and cubes.

There is no family history of seizure disorder, or loss of consciousness. Her father works at the university library and he has HTN for which he takes two medications that you don't know their names his age is 45yrs, and your age is 38. Parents are cousins. Sara doesn't go to day care. And mom is a housewife. You have a son (Ibrahim) and a daughter (Sara).

After you daughter woke up, and her fever came down with rivanin you felt a little relieved, but you still are concerned about her, and want to know what she had.



Neonatal fever

TIME :7 minutes
OSCE(history taking)
Examiner copy

Mark /28

The mother of 15 day old infant brought him to you because of fever. Please take a focused history, and answer the examiner's questions.

Observe the student asking the mother about the following:

Analysing the fever	
Onset	0 1
Amplitude, documented or not?	0 1
Intermittent or continuous	0 1
Relieving factors (antipyretics, cold compressors..)	0 1
Asking about associated symptoms	
Vomiting	0 1
diarrhea	0 1
Jaundice	0 1
Skin rash	0 1
Cyanosis	0 1
Cough, or Difficulty breathing	0 1
Abnormal movements (seizures)	0 1
Excessive sleep, impaired consciousness, activity	0 1
Irritability/ excessive crying	0 1
Urinary changes: color, odor	0 1
Decreased feeding	0 1
Other important questions- risks of sepsis	
Contact with sick individuals	0 1
Admission to NICU	0 1
Gestational age	0 1
Perinatal fever/ infections in the mother	0 1
Premature rupture of membranes	0 1
Mode of delivery	0 1

Stop the student after 6 minutes to ask the following questions

Q: Ask the student, if the physical examination showed a well appearing infant with temperature of 38.8 rectally, mild jaundice, normal moro and other primitive reflexes, no respiratory distress, and no skin rash. Respiratory and cardiac exams are normal. In addition to CBC and CRP what other workup would you do?

Obtain sepsis workup: including blood culture, urine and CSF work up	0 1 2 3
--	------------------

Overall performance	0 1 2 3
---------------------	------------------

Time: 7 minutes

Station: History taking

The mother of a 15 day old infant brought him to you because of fever.

Please take a focused history, and answer the examiner's questions.

SP copy

My child is only 15 day old. I noticed him to be hot to touch since last night. I did not measure his temperature. The fever recurred this morning. I did not give him anything to treat the fever.

He was born vaginally, he is my first child. I had no issues during pregnancy and did not have fever during birth. No premature rupture of membranes. His father has a cold, but no other sick contacts.

He is feeding breast milk and I give one bottle at night.

His feeding did not change and he is active as usual. Sleeps a lot but that has not changed. He is not crying more than usual.

No cough, runny nose, rash, convulsions, vomiting, diarrhea. NO change in urine smell or color. He had jaundice that appeared on day 3 but now is better.

He stayed in the hospital for one day after birth and came home with me. I was told that the pediatrician examined him and he was normal.

Birth weight was 3.2 kg.

Neonatal jaundice

SP copy

My daughter Sara is 5 days old.

She has yellowish discoloration of her eyes and skin since the second day of her life ,I feel its increasing but this is my first visit to a pediatrician , she is breast fed , 8-10 times per day, 30 minutes each time , she is very comfortable after she is fed , she passes stools 6 times , yellowish in color , she passes urine also around six times , yellowish in color as well, she is active and has no fever .

Sara is my 3rd child, her siblings had jaundice, did not need anything, I was just told to increase the frequency of breast feeding.

My pregnancy was very smooth, I had regular visits to my Ob .I had her at my due date, vaginally. Her weight at birth was 3 kgs. Her weight today is 2.95 kg

We do not have any blood disorder running in the family, nobody gets regular blood transfusion or had surgeries

Station: History taking

Time: 7 minutes

You are about to interview the parent of a **5 days old** newborn girl .who presented with history of **yellowish discoloration of her eyes and skin .**

Please take focused history, and then answer the examiners question



Examiner's copy



Student name:

Score /25

Please observe the student taking detailed history about jaundice in a 5 days old newborn girl, and note that he/she asks about the following:

Analyzing Jaundice and perinatal history				
Gestational age	0	1		
Birth weight	0	1		
Pregnancy complications/infections /rashes	0	1		
Mode of delivery/ vacuum for cephalhematoma	0	1		
Age of onset	0	1		
Previous bilirubin measurement /coarse	0	1		
Analyzing potential causes :				
Type of milk	0	1		
Frequency of feeds / amount / Adequacy : less irritable after feeding , suckling sounds	0	1	2	
Frequency of bowel motion and urination	0	1	2	
Asking about stool and urine color (yellow –green/pale stools /dark urine)	0	1	2	
Mother blood group/if known	0	1		
Fever /Irritability /decreased feeding /hypoactivity	0	1		
Skin rash	0	1		
Abnormal movements	0	1		
Ask about family history				
Previous siblings ,if they had jaundice , what did they need as a treatment (photo/admission/exchange) /highest level	0	1	2	
Family history of blood disorder (G6PD) , recurrent blood transfusion/ cholecystectomy	0	1		
<i>After 6 minutes of history taking, please stop the student and ask:</i>				
<i>1-What is the most likely cause of this newborn jaundice (answer : physiological)</i>	0	1		
<i>2-what is the most important investigation you would like to order Total serum bilirubin</i>	0	1		
Overall (organization, systematic, polite, good communications skills..	0	1	2	3 4

Neonatal sepsis

SP copy

My son Ahmad is **8 days** old.

He has not been feeding well **since yesterday**. He is breast fed and he was feeding every 2 hours, I could hear his suckling sounds and I could see the milk drooling out of his mouth, Ahmad is my **third child** and I could tell he was feeding very well previously. After feeding he would sleep until the next feed. Yesterday **he is sleepy** and whatever I do to wake him up to feed, he is not responding very well, he would wake up sometimes and I would try to feed him, but his **sucking is very weak**, he was passing urine and stool 6 times a day, **since yesterday he passed 2 times, non since the last 12 hours**. His hands and feet felt cold, the color of his urine is dark yellow, no stool since yesterday. **His skin is pale to me**, not yellowish. **I didn't notice any abnormal movement**, no cough or runny nose, no urine abnormal smell, no excessive crying, no cyanosis, my pregnancy was very smooth, no infections, no vaginal swabs were done for me. I had regular visits to my Ob .I had Ahmad at my due date, vaginally. His weight at birth was 3 kg. His **weight today is 2.700 kg**.

My previous siblings did not need NICU admissions. I did not give him any drugs; I don't take any regular drugs

PM

Student's copy/ History taking

You are about to interview the parent of
an **8 days old** newborn boy .who
presented with history of **decreased**
feeding.

**Please take focused history, and then
answer the examiner's question**



Examiner's copy



Student name:

Score /38

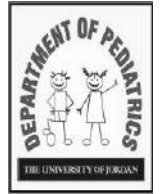
Please observe the student taking detailed history about decreased feeding in a an 8 days old newborn boy, and note that he/she asks about the following:

Analyzing decreased feeding and perinatal history			
Gestational age	0	1	
Birth weight	0	1	
Primigravida/number of siblings	0	1	
Pregnancy complications/infections /UTI/vaginal discharge /maternal fever	0	1	
GBS status /vaginal swab results	0	1	
Mode of delivery	0	1	
Age of onset of the current complaint	0	1	
Establishment of the baseline feeding pattern and the change			
Type of milk	0	1	
Frequency of feeds / amount Before & after	0	1	2
Frequency of bowel motion and urination Before & after	0	1	2
Previous siblings were breast fed	0	1	
Associated symptoms of sepsis			
Fever / felt cold	0	1	
Vomiting	0	1	
Rapid breathing, noisy breathing	0	1	
Irritability /hypo activity/sleepy	0	1	
cough	0	1	
Skin rash	0	1	
Abnormal movements	0	1	
Asking about stool (bloody) and urine color	0	1	
Crying upon micturition /smelly urine	0	1	
Color / pallor /Jaundice/ mottling	0	1	
Cyanosis/apnea	0	1	
Ask about family history of similar cases at neonatal period/ immune deficiency/etc	0	1	
Sick contacts	0	1	
Previous siblings admission to NICU /Cause /duration	0	1	2
Drug history / baby or mother	0	1	
<i>After 9 minutes of history taking, please stop the student and ask:</i>			
<i>1-What is the most likely cause of this newborn condition</i> <i>(answer : Sepsis)</i>	0	2	
<i>2- work up</i> <i>Non specific : CBC , CRP, Urine analysis (1 mark)</i> <i>Diagnostic :Blood , urine, CSF (cultures)(2 marks)</i>	0	1	2
Overall (organization, systematic, polite, good communications skills..	0	1	2

PM

Examiner's name & signature:

PM



Student Name:

Mark

/24

The mother of a 3 year old boy brought him to you because of fever and cough. Please take a focused history, and answer the examiner's questions

Analysing the fever				
Onset/course	0	1		
Amplitude,documented or not?	0	1		
Relieving factors (antipyretics,cold compressors..)	0	1		
Analysing cough				
Onset/course	0	1		
Wet/dry	0	1		
Character (repetitive,barking,episodic or continous)	0	1		
Aggrevating factors (odor/smoke/diurnal...)	0	1		
Relieving factors (any intervention,nebulisers..)	0	1		
Severity (vomiting posttussive)	0	1		
Asking about associated symptoms				
Runny nose/ear pain	0	1		
Difficulty breathing/rapid breathing	0	1		
Noisy breathing.audible sounds	0	1		
Cyanosis	0	1		
Constitutional				
Decreased appetite and activity	0	1		
Other important questions				
Contact with sick individuals	0	1		
History of choking or aspiration	0	1		
Vaccination history	0	1		
Medication history	0	1		
Past history of similar conditions, hospital admissions	0	1		
<i>After 5 minutes Stop the student to ask the following: if the physical examination showed fever of 39 degrees orally, respiratory rate of 55 per minute, intercostal retractions, and fine crepitations on the right lung field?</i>				
What is the most important diagnostic investigation you would order? (Allow one answer only)				
Chest X ray	0		2	
Overall (organization, systematic, polite, good communications skills...	0	1	2	3

Examiners' name and signature:



*The University of Jordan /Pediatric Final OSCE
2018
TIME: 7 minutes*



Time: 7 minutes

Station: History taking

The mother of a 3 year old boy brought him to you because of fever and cough

Please take a focused history, and answer the examiner's questions.

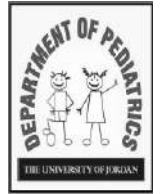


The University of Jordan /Pediatric Final OSCE

2018

TIME: 7 minutes

SP copy



My child is a 3 year old boy who is not known to have any previous illness, started to have fever three days ago. It measured 39.5 degrees axillary. I gave him Revanin and the fever improved. He has several episodes of cough, which sounded wet but he can't expectorate the sputum. He also has difficulty breathing, he had runny nose for a few days before fever started. There is no exposure to smoke or dust, and no other medications were given.

He has no cyanosis, but seems to have more difficulty breathing than normal. He had no vomiting and no drooling or pain when swallowing. But his appetite this morning is not as usual, he didn't want to finish his breakfast and he is less active than usual.

There is nobody else sick at home, and there was no history of choking or aspiration.

He is not known to have any chronic illness, never admitted and never required nebulization treatment.

His vaccinations are up to date.

SP copy

My son is 8-week- old, previously healthy

Has been vomiting over the last week. No previous similar episode.

He vomits almost after each feed (within few minutes of feeding). Projectile, no mucous, blood or bile in his vomitus. He is breast fed. course is the same static

No history of diarrhea, fever, irritability or hypoactivity. Good sucking.

No abdominal distention. No cyanosis or apnea.

Last urine output was yesterday afternoon. Change diaper 2-3 times/day. No change in urine smell or colour.

I feel he doesn't gain weight.

Station: History taking

Time: 7 minutes

You are about to interview the parent of a **8-week-old** male infant who presented with history of **vomiting**

Please take focused history, then answer the examiner's questions



Examiner's copy

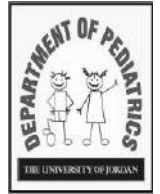


Student name: _____

Score / 28

Please observe the student taking detailed history about vomiting in an 8-week-old infant, and note that he/she asks about the following:

Analysing vomiting				
Asking about onset	0	1		
Asking about frequency (or number)	0	1		
Asking about Character (forceful, projectile)	0	1		
Asking about content of vomitus/ bile or blood in vomitus	0	1		
Asking about relation to meals /cough	0	1	2	
Asking about course	0	1		
Asking about associated symptoms				
Asking about diarrhea/constipation	0	1		
Asking about fever	0	2		
Asking about abdominal distention	0	1		
Asking about irritability/ activity	0	1		
Asking about feeding (type of milk, frequency)	0	1		
Asking about urinary symptoms (change in urine colour, smell)	0	1		
Asking about weight change	0	1		
Asking about episodes of apnea or cyanosis	0	1		
Asking about CNS symptoms (seizures/change in level of consciousness)	0	1		
Asking about symptoms of dehydration				
Urinary amount and frequency	0	2		
Other important questions				
Drug history	0	1		
Family history of metabolic disease	0	1		
<i>After 6 minutes of history taking, please stop the student and ask student: If this infant has non-bilious vomitus, projectile, almost immediately or after 5 minutes of feeds, is afebrile, what would be the most likely differential diagnosis</i>				
1. Pyloric stenosis, malrotation	0	2	4	
2. GERD				
Overall (organization, systematic, polite, good communications skills..)	0	1	2	3



Student Name:

Mark

/22

A mother brings her five year old boy complaining of red urine of two days duration. She had a urine analysis showing hematuria.

Observe the student asking the mother about the following:

Asking symptoms of UTI,stones			
Course of Red urine (at the end or although)	0	1	
color of urine, presense of clots	0	1	
History of fever	0	1	
History of decreased feeding/activity	0	1	
Symptoms of UTI,as dysuria,frequency,wetting,urgency,	0	1	
History of loin or abdominal pain	0	1	
Asking symptoms of glomerulonephritis			
History of edema,periorbital swelling	0	1	
History of decreased urine output	0	1	
History of previous tonsillitis	0	1	
History of previous attacks	0	1	
Other important questions			
Family history of renal failure,deafness ,stones,hematuria	0	1	
History of trauma	0	1	
History of bleeding from other sites	0	1	
History of joint pain,skin rash	0	1	
Drug history	0	1	
<i>After 6 minutes Stop the student to ask the following ;In this child you suspected glomerulonephritis. What other findings on urine analysis would support your diagnosis?</i>			
1 .high grade proteinuria	0	2	4
2.RBC casts			
Overall (organization, systematic, polite, good communications skills...	0	1	2 3

Examiners' name and signature:



Time: 7 minutes

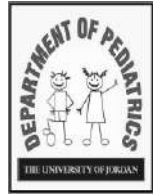
Station: History taking

A mother of a five year old child brought him to the emergency room with red urine of two days duration.She had a urine analysis done outside showing microscopic hematuria.

Please take a focused history, and answer the examiner's questions.



*The University of Jordan /Pediatric Final OSCE
2016
TIME: 7 minutes*



SP copy

My three years old boy is complaining of red urine of two days duration. The color is dark red with no clots and it is all through the urination. There is no abdominal or flank pain. No fever, dysuria, frequency, wetting or urgency. I noticed his eyes puffy in the morning and he is not going to the toilet as frequently as before. This is the first time he complains of this. He had tonsillitis one month ago.

There is no history of trauma, no problems in the family. No bleeding from other sites. No history of skin rash or joint pain. He didn't take any drugs

Station number

Student copy

This is the mother of a 10 year old boy who presented with a history of red urine.

- 1-Take up to the point history from the mother
- 2-What are the most important things you want to do in the physical examination
- 3-You will be given lab tests for interpretation to give the diagnosis

Station number.....

Examiner copy

Student name.....

Final mark.....

Stop the student from taking the history **after 5** minutes

Introduce himself to mother and explain	0	1
---	---	---

Urine color	0	1
-------------	---	---

Urine amount	0	2
--------------	---	---

Dysuria	0	1
---------	---	---

Urgency/frequency	0	1
-------------------	---	---

Fever	0	1
-------	---	---

Previous episode	0	2
------------------	---	---

Preceding upper respiratory infection	0	2
---------------------------------------	---	---

Dyspnea	0	1
---------	---	---

Skin rash	0	1
-----------	---	---

Joint pain	0	1
------------	---	---

Drugs	0	1
-------	---	---

Abdominal pain	0	1
----------------	---	---

Family history	0	1
----------------	---	---

Stop the student after 5 minutes

What to examine (1 minute)

Blood pressure	0	2
----------------	---	---

Edema	0	2
-------	---	---

Name 3 investigations that will help to reach diagnosis(4 minutes)

ASO titer	0	1
-----------	---	---

Complement	0	1
------------	---	---

Urine routine and microscopy	0	1
------------------------------	---	---

<i>What is the diagnosis</i>	0	1
------------------------------	---	---

Station number.....

Examiner copy

A 10 years old boy came to your clinic with a history of red urine for the last 3 days.

Two weeks ago he had fever and sore throat and he did not go to school for 2 days.

1-Take up to the point history

2-What do you want to examine

3-What investigation to help in diagnosis

After finishing the history, examination and investigation tell the student that **the following data will help him in diagnosis:**

Patient has blood pressure 135/90, periorbital edema and urine analysis showed: specific gravity 1.035

Blood +2

Protein +2

RBC cast

Blood: low complement

4-Ask the student what is the diagnosis



Name:

Score: /25

Case 2: Red urine

A 7 year old previously healthy girl has red colored urine of 1 day duration.

Q What are the important questions you ask by history to reach at a differential diagnosis?

History of URTI	0	1
Ingestion of certain coloring foods or medications	0	1
History of skin infection, or rash	0	1
Peri-orbital swelling	0	1
Urine output	0	1
Flank pain	0	1
Dysuria, frequency, urgency or dribbling	0	1
Family history of renal problems	0	1
History of trauma	0	1

On examination the child was found to have high blood pressure, tachypnia, and generalized edema.

Q List the most likely differential diagnosis for his red urine?

glomerulonephritis	0	1
--------------------	---	---

Q Tell me the important investigations that will help you in the diagnosis of this child:

Urine analysis	0	1
Serum electrolytes	0	1
Kidney function test	0	1
ASO titer	0	1
C3, C4 levels and/or ANA	0	1
CBC and blood film	0	1
Albumen	0	1

Q If you suspect glomerular disease in this child, what are you looking for on urinalysis to support your suspicion?

RBC cast	0	1
----------	---	---

What are the important steps in the management of acute post-streptococcal Glomerulonephritis?

Q	Fluid and salt restriction	0	1
	Treatment of hypertension	0	1
	Treatment and observation for electrolyte imbalance	0	1

Q Would you give prophylaxis antibiotics for this child?

No	0	1
----	---	---

Overall performance	0	1	2	3
---------------------	---	---	---	---

Note: The overall performance marks depends on how fluent the student was in giving the correct answers (Not hesitant, not needing a lot of leading questions by the examining committee)

Refusing feeding

Examiner copy (time 10 minutes)

Student Name -----

Mark -----/30

18 month old infant is brought to the outpatient department with history of vomiting and refusal to eat

- 1- Take a focused history from his mother
- 2- the examiner will give the result of his positive finding in his physical exam
 - a. give differential diagnosis
- 3- the examiner will ask you then on the management

Ask about vomiting Duration	0	1
Course and number	0	1
Character (color , amount)	0	1
Timing and relation to food (relation food)	0	1
Ask about associated GI symptoms		
Bowel motion (Diarrhea, constipation)	0	1
Abdominal pain	0	1
Jaundice	0	1
Ask about urinary symptoms		
Dysuria or burning upon micturition	0	1
Urine color, amount	0	1
Ask about Constitutional Symptoms		
Fever	0	1
Rash	0	1
Activity	0	1
Ask about CNS symptoms		
Drowsiness, Level of consciousness	0	1
Seizures	0	1
Tell the student that upon physical examination the child was febrile, irritable, crying all the time and skin rash all over his body		
What is your differential Diagnosis		
Meningitis/meningoencephalitis	0	1
Viral Exanthema (measles,etc)	0	1
Bacterial sepsis , meningococemia	0	1
Ask the student the following		
What is (Next step) answer is to admit	0	1
Ask the student what are the necessary investigation		
Blood culture	0	1
Lumbar puncture	0	1
Electrolytes	0	1
CBC (WBC,HB)	0	1

Platelet count	0	1	
PT/PTT	0	1	
Urine analysis	0	1	
CSF analysis revealed WBC 900 Neutrophils 90% Glucose 30/dl mg (blood glucose 120mg/dl) Protein 100 mg/dl			
What is the diagnosis Bacterial meningitis (0 if did not define type of meningitis)	0	1	
What antibiotics would you give Rocephen / Claforan + Vancomycin (0 if incomplete answer)	0	1	
Communication Skill : Introduce him /herself . Explain purpose of interview,organization,type of questioning open virusesclose end question,appropriate body language (eye contact.etc)	1	2	3

Student copy

Time 10 minutes

18 month old infant is brought to the outpatient department with history of vomiting and refusal to eat

- 1- Take a focused history from his mother
- 2- the examiner will give the result of his positive finding in his physical exam
 - a. give differential diagnosis
- 3- the examiner will ask you then on the management

This is Hytham

he is 18 month old child he was vomiting for the last 2 days yesterday he vomit twice at night and to day he vomits 4 times which once it was after lunch the he did at all but continue to vomit of yellowish watery vomituous with no blood, he was irritable change all night today morning I have noticed this skin rash on his trunk, face upper and lower limbs which was not itchy

He is hypo active all through yesterday and to day, refuses to play.

He did not take any medication apart from the reivanin

He did not have any diarrhea or change in color of his skin as pallor or yellow discoloration; he does not have abdominal pain

He does not have pain upon micturation and I have changed hi diaper 4 times which contain the same amount of urine as usual with no change in urine color

I noticed that he is drowsy this morning because I brought him to you

Communication skill Introduce him her self. explain purpose of interview, Organization, type of questioning open viruses close end question, appropriate body language (eye contact.etc)	0 1 2 3



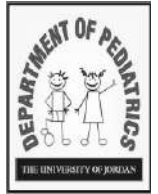
Student Name:

Mark /33

A 3 year old child is brought to ER by his parents after having an attack of abnormal movements of his limbs. Observe the student asking the mother about the following:

Analyzing the attack			
Onset (what was the patient doing before the attack: crying, sleeping, aura...)	0	1	
Which limbs involved (unilateral, bilateral)	0	1	
Nature of movements (tonic, clonic,etc)	0	1	
duration	0	1	
Eye up rolling, cyanosis	0	1	
Level of consciousness and responsiveness during AND after the attack,postictal weakness	0	1	2
How the attack aborted (spontaneous, medication)	0	1	
Is this the first attack or has it happened before	0	1	
Associated symptoms			
History of vomiting, irritability,decreased activity, skin rash	0	1	2
History of fever	0	2	
History of headache	0	2	
History of trauma	0	2	
History of drug ingestion	0	1	
History of exposure to enviromental toxin	0	1	
Other important questions			
Perinatal history	0	1	
Developmental history	0	1	
Known chronic diseases (diabetes, metabolic...)	0	1	
Vaccination history	0	1	
Family history of similar condition	0	1	
<i>After 6 minutes Stop the student to ask the following;What is the differential regarding etiology of this seizure (name three)</i>			
1. Trauma in garden causing hemmhrage	0	2	4
2. Meningitis			6
3. First attack of epilepsy			
4. Poisoning (drugs at home,pesticides)			
Overall (organization, systematic, polite, good communications skills...	0	1	2
			3

Examiners' name and signature:

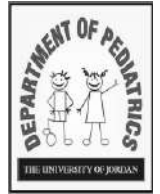


Time: 7 minutes

Station: History taking

A 3 year old child is brought to ER by his parents after having an attack of abnormal movements of his limbs

Please take a focused history, and answer the examiner's questions.



SP copy

My child was playing outside in our garden when I came to find him having extension movements of his upper and lower limbs. His eyes were uprolled and he wasn't blue. I don't know what my child was doing when this happened. He wasn't awake and I brought him directly to E/R. He is been having these movement for 15 min from the time I saw him.

In the E/R he was given medications and the attack aborted. After it stopped he slept for two hour and there was no weakness.

This is the first time my child is having these movements.

Today in the morning he was having runny nose and decreased activity and undocumented feeling of hotness.

I don't know if the child fell in the garden. there is no vomiting or skin rash, no history of headache . No hx of known drug ingestion but his grandmother who is diabetic lives with us in our home.

Perinatal history is unremarkable

Past history: No known medical problems

Developmental history: normal

Vaccination: up to age

Family history: His older brother has seizures and is on medications



Seizure 2



SP copy

My boy Ahmad is 6 year old, he was playing with his toys when I heard a scream. I was next room , I came in , he was shivering hands and legs and he was so blue , his eyes were looking up and his tongue was out , he peed in his pants .He wasn't awake .I did put him on his side , it was so scary but thank God it lasts for about 2 minutes only . And he was just a little bit sleepy after wards.

Those days he is perfectly well, no issues of any kind.No fever.

There is no family history of seizures,before few months he had abnormal movements that lasted for a shorter time,but I didn't seek medical attention. Ahmad has been always healthy , he is smart boy , telling stories and recently riding his red tricycle that he loves so much , he doesn't take any medication .never had any head trauma before .

My pregnancy was so smooth, it was vaginal delivery, his weight was 3 kgs he went home with me, had no jaundice.



Skill: History taking

Time: 7 minutes

You are about to interview the parent of
a **6 year old** boy complaining of
abnormal movement

Please take a focused history



Examiner's copy

Student name:

Score

/ 26

Please observe the student taking detailed history about abnormal movement in a 6 year old boy, note that he/she asks about the following:

Analyzing abnormal movement :					
Pre-ictal					
Onset (<i>what was the child doing when it happened, any abnormal sensation, visual aura</i>)	0	1			
Ictal					
Ask about duration	0	1			
Analysis of movement(tonic,clonic)	0	1			
Ask about focal or generalized	0	1			
Ask about loss of consciousness	0	1			
Ask about cyanosis	0	1			
Ask about loss of sphincteric control	0	1			
Post Ictal : sleeping ,lethargy / weakness	0	1	2		
Past History : similar attacks	0	1			
History of fever (looking for infection)	0	2			
History of lethargy,headache,hypoactivity (CNS infection)	0	1			
History of Head trauma	0	2			
Medication History	0	2			
Family History : Seizure disorder (epilepsy/febrile seizures)	0	1			
Perinatal History :, gestational age , mode of delivery ,birth weight , NICU Admission	0	1			
Developmental History	0	2			
<i>After 6 minutes ask the following :what are the basic investigations for recurrent seizure without fever :</i>	0	1	2		
EEG					
Imaging studies					
Overall Performance : Introduce him/her self, organized thoughts , appropriate questions and comments	0	1	2	3	

examiners' Name and Signature:

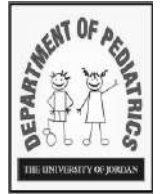


The University of Jordan /Pediatric Final OSCE
2015

TIME: 7 minutes

Short stature 1

بعراف انه سيمنار لسادسة



Student Name:

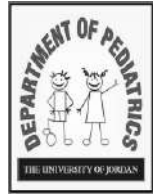
Mark

/24

A mother brings her 7 year old boy to the clinic complaining of short stature which was confirmed in your clinic, what are the important points in history that you need to ask to assess in this child?

Ask about Onset (when mother started to notice the short stature)	0	1		
Ask about History of growth pattern (previous measurements)	0	1		
Ask about weight,if appropriate or not	0	1		
Ask about CNS symptoms (History of headache / visual disturbances (central causes of GH deficiency)	0	1		
Ask about endocrine symptoms (History of weight gain/constipation/cold intolerance (hypothyroidism)	0	1		
Associated symptoms				
Ask about GIT symptoms :History of recurrent diarrhea, abdominal pain, bloating(celiac disease)	0	1		
Ask about Respiratory symptoms: History of recurrent sino-pulmonary infections, recurrent nebulizers	0	1		
Ask about History of recurrent urinary tract infections, edema, renal disease in the family	0	1		
Ask about cardiac symptoms (History of cyanosis, syncope)	0	1		
Nutritional history	0	1		
Develpemental histoty	0	1		
Family history				
Parental heights	0	1		
Pattern of puberty in parents (if father was a late bloomer, mother's menarche)	0	1		
Siblings heights/known severe short stature in family	0	1		
Neonatal/perinatal history				
Birth weight/gestational age	0	1		
History of hypoglycemia/jaundice/micropenis	0	1		
Other important questions				
Drug history	0	1		
Psychosocial status (divorced parents, conflicts at home, abuse : physical, emotional or neglect)	0	1		
<i>After 5 minutes Stop the student to ask the following; O/E apart from having short stature, the child has normal physical exam, his mother's height is 150cm, and his father's height is 163. What is his mid-parental height and target range of end height?</i>				
1. 163 cm	0	2	4	
2. target range 153-173, some will say (154.5-171.5) (mother's height+13+father's height)/2 +/- 10cm(8.5 cm)				
Overall (organization, systematic, polite, good communications skills...	0	1	2	3

Examiners' name and signature:

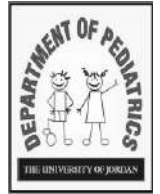


Time: 7 minutes

Station: History taking

**A 7 years old child came to clinic
complaining of short stature**

**Please take a focused history, and answer
the examiner's questions.**



SP copy

My seven years old boy has a short stature noticed since he started to go to kindergarten (4 years).I have no previous measurements.

No history of headache or visual disturbances.

No history of excessive weight gain, cold intolerance or constipation.

No known chronic disease.

Eats like his siblings.

Review of systems is free.

Father's height 163cm, mother's height 150 cm, father had delayed puberty. Mother's menarche 13 years.

He has an older brother who has normal height.

No family history of severe short stature.

Product of full term vaginal delivery, birth weight 3 kg.

No history of neonatal hypoglycemia, prolonged jaundice or micropenis.

No history of drug use.

Adequate psychosocial status.

Short stature 2



TIME :5 minutes
OSCE(history taking- short stature)

Examiner copy

Mark

/22

A mother came to see you in the clinic, she thinks that her 2 year old son is short compared to children his age. His height is 80cm (<5th%tile)

Take a focused history from the mother.

Observe the student asking the mother about the following:

Onset of problem/ birth history		
Length at birth/ previous height measurements	0	1
Birth weight	0	1
Gestational age	0	1
Any neonatal problems (NICU admissions)	0	1
Asking about developmental history (one milestone about each domain)		
Gross motor: if the child runs well, jumps, or upstairs downstairs.....	0	1
Fine motor: if the child scribbles, builds 7 cubes.....	0	1
Language: if the child speaks 2-3 word sentences	0	1
Social history: handles spoon, listens to stories, helps to undress.....	0	1
Asking about symptoms chronic illnesses		
Asking about weight or weight gain	0	1
Asking about activity	0	1
Chronic diarrhea, or vomiting, or constipation (any one)	0	1
Appetite, and feeding	0	1
Asking about teeth	0	1
Asking about use of medications	0	1
Family history		
Asking about maternal and paternal height	0	1
Asking about family history of short stature	0	1
Asking about family history of genetic disorders/ chronic illnesses	0	1

Stop the student after 4 minutes to ask the following question

Q: If the physical examination of this child showed normal weight for age, short stature, and large umbilical hernia, what is the most likely diagnosis? (allow one diagnosis only)

Hypothyroidism	0	2
----------------	---	---

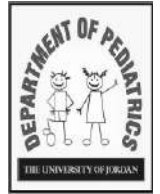
Overall performance	0	1	2	3
---------------------	---	---	---	---

Time: 5 minutes

Station: History taking

A mother came to see you in the clinic; she thinks that her 2 year old son is short compared to children his age. His height is 80cm (<5th%tile)

Take a focused history from the mother. Then answer the examiner's question



Student Name:

Mark /25

A 3 years old child came to E/R complaining of skin rash. Observe the student asking the mother about the following:

Analyzing rash				
onset	0	1		
Site or distribution	0	1		
Course of the rash(face then trunk ,or all over same time,if comes and goes as flares)	0	1		
Description (if raised or not),color of rash,presence of fluid in rash,swollen skin around lesion	0	1		
If itchy or not	0	1		
Ask about mucus membranes involvement (mouth/ eyes)	0	1		
Associated symptoms				
History of vomiting/ diarrhea	0	1		
History of fever	0	1		
Headache/ irritability/ photophobia	0	1		
History of abnormal movement	0	1		
Cough,runny nose,conjunctivitis,diarrhea (viral illness)	0	1		
Joint pain or swelling	0	1		
History of abdominal pain	0	1		
History of bleeding (red urine/ blood in stool/ epistaxis)	0	1		
Other important questions				
Activity, feeding	0	1		
History of previous episodes	0	1		
History of allergy in child/food	0	1		
Contact with individuals with same complaint, Family history of similar cases	0	1		
Drug history	0	1		
Vaccination history	0	1		
<i>After 6 minutes Stop the student to ask the following;O/E the child has purpuric rash on the legs and buttocks.what is your most likely diagnosis</i>				
<i>Henoch Schonlein Purpura</i>	0	2		
Overall (organization, systematic, polite, good communications skills...	0	1	2	3

Examiners' name and signature:



*The University of Jordan /Pediatric Final OSCE
2018
TIME: 7 minutes*

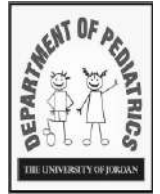


Time: 7 minutes

Station: History taking

**A 3 years old child came to E/R
complaining of skin rash**

**Please take a focused history, and answer
the examiner's questions.**



SP copy

My three years old baby has skin rash of three days duration. It started on the foot and over the three days the rash went up to cover thighs. The rash is red, raised and not itchy.

No history of fever or vomiting. No history of headache, photophobia or irritability. No history of cough, runny nose.

There is a history of abdominal pain around the umbilicus. No diarrhea or vomiting. There is a history of knee pain and there is limping. There is history of red urine. No dysuria or frequency. No change in color of stool

There is good activity and feeding. There is no similar cases in the family or contact with sick people. He did not take new drugs

The child is vaccinated.

SP copy

My daughter Salma is 6 years old.

She was well until 5 days ago when she started to have **abdominal pain** ,flank pain ,no radiation ,dull aching, not related to food nor bowel habits . it was mild then become worse over the next few days .it did not allow her to sleep well last night .Given Revanin syrup but hasn't improved .

She developed **fever** ,two days ago ,intermittent ,relieved by revanin syrup initially but yesterday was persistent and measured 39 Celsius orally .She had some chills overnight with the fever.

She **vomited** once shortly after meal .had poor appetite last two days .

She is toilet trained but she developed **urinary** incontinence during day and night about three times in the last 2 days .with some frequency of urination but no dysurea .

Not noticed to have diarrhea nor constipation .

She developed two episodes of febrile **UTI** in the past .treated with oral antibiotics ,and culture was positive (don't recall the organism) ,no admissions . I was supposed to maintain follow up for further investigations but did not do so.

No **family history** of renal failure but her older sister had reflux when younger but had resolved .She is **toilet trained** since age of three years ,encouraged to void regularly every two to three hours .

Student's copy/ History taking

You are about to interview the parent of
a 6 year old girl who presented with
history of **fever and abdominal pain** .

**Please take focused history, and then
answer the examiner's questions**



Examiner's copy

Student name:

Score / 34

Please observe the student taking detailed history about fever and abdominal pain in a 6 year old girl , and note that he/she asks about the following:

Analyzing chief complaint and HOP :			
Fever :			
Onset / duration / pattern	0	1	
Documentation	0	1	
Chills , rigors	0	1	
Relieving factors (does it respond to antipyretics, Cold compressors)	0	1	
Abdominal pain :			
Onset / Duration	0	1	
Location and radiation	0	1	
Severity and progression	0	1	
Aggravating and relieving factors	0	1	
Associated symptoms :			
Vomiting	0	1	
Urinary symptoms:			
Dysurea/urgency /frequency	0	1	
Urine color change (hematuria..)	0	1	
Enuresis/ incontinence	0	1	
Strong urine smell	0	1	
Appetite /decreased activity	0	1	
Bowel habits (Diarrhea / constipation)	0	1	
Past history :			
Previous history of UTI / admissions	0	1	
Pervious renal evaluation/Diagnosis with renal problems	0	1	
Family and Social history :			
history of VURD ,CRF , hemodialysis	0	1	
Toilet training, hygiene, and voiding habits	0	1	
<i>After 6 minutes ask the student to answer the following questions</i>			
1) Based on this history what is the most likely diagnosis? (Pyelonephritis scores 2, if says UTI only 1)	0	1	2
2) What are the important Laboratory investigations you should ask for			
Urine : Microscopic analysis : WBC , Bacteria , RBC	0	1	
Urine culture	0	1	
Blood : CBC, CRP , ESR	0	1	
Blood culture	0	1	
Creatinine and urea (KFT)	0	1	
3) This child was admitted with a diagnosis of pyelonephritis, and cultures showed gram negative bacilli with pending sensitivity. What is the imperial antibiotic and for how long? Cephalosporin 3rd (Aminoglycoside, Carbapenems (7 to 14 days)	0	1	2
4)what are the imaging studies that you would like to order and what is their significance : 1-Ultrasound(obstruction, congenital malformation, others)2- MCUG(VUR)3- DMSA(scars) (2 out of 3)	0	1	2
Overall (organization, systematic, polite, good communications skills..	0	1	2 3 4

Examiner's name & signature:

TIME: 7 minutes

Hepatitis

Student Name:

Mark

/24

A 4 year old male came to the clinic because of “yellow skin

Please take a focused history, and answer the examiner’s questions.

Analyzing complaint				
Onset of yellow skin	0	1		
Extent of the yellow color: skin only Vs skin and the eyes	0	1		
Course : progressive vs fluctuant vs resolving vs same	0	1		
Change in color of stool	0	1		
Change in color of urine	0	1		
Itching	0	1		
Appetite ,activity	0	1		
Associated symptoms				
Fever	0	1		
Abdominal pain	0	1		
Nausea , vomiting	0	1		
History of pallor	0	1		
Epistaxis, bruises, petichiae	0	1		
altered level of consciousness, abnormal movement	0	1		
History of ingestion of drugs/food (fava beans)	0	1		
Other important histories				
Similar episodes in the past	0	1		
History of Blood transfusion	0	1		
Vaccination history	0	1		
Travel history / or contact	0	1		
Family history of hemolysis or splenectomy	0	1		
After 6 minutes Stop the student to ask the following; this child who has jaundice, dark urine without fever or abdominal pain.On exam he was tachycardic ,pale and jaundiced without heptaosplenomegaly. What is the most likely differential diagnosis ?				
Acute hemolysis (as G6PD deficiency).				
The student gets one mark for acute hemolysis,two marks if he mentions G6PD.				
	0	1	2	3
Overall (organization, systematic, polite, good communications skills...	0	1	2	3

Examiners’ name and signature:

TIME: 7 minutes

Time: 7 minutes

Station: History taking

4 year old male came to the clinic because of “yellow skin”

Please take a focused history, and answer the examiner’s questions.

TIME: 7 minutes

SP copy

•

My 4 year old boy is having yellow eyes and skin of 2 days duration. The color is progressive in nature , getting darker since it started. There is no abdominal pain, no Fever, no vomiting. There is Decreased appetite and activity.

He appears pale .The urine is dark in color, the stool is normal.

No skin rash. . No Epistaxis, bruises, petichiae. No itching, no abnormal movements

PMHx : one Similar episodes at the age of 2 year, but milder and no investigations were done. no history of Blood transfusion. Vaccination history up to date. Travel history : negative.

FHX : no sick contact, his cousins has jaundice before one year

Drug History : no drugs. ate fava beans 3 days ago (only if ask specifically)

•



Vomiting blood



Name:

Score:

/27

Case : Child with vomiting of blood

A 4 year old previously healthy boy presented to the ER with one day history of vomiting several times. His last vomiting contained a tinge of blood. There is a history of epigastric abdominal pain for the last 3 days. There is no history change in bowel habits, No medications, and no past history of bleeding disorder.

Q

List the problem items?

vomiting	0	1
Abdominal pain	0	1
Upper GI bleeding	0	1

Q

During evaluation of this child in the emergency room, What are the most important items of physical examination?

Heart rate	0	1
Blood pressure	0	1
Pallor	0	1
Signs of dehydration	0	1
Abdominal examination	0	1

Q

Tell me the important investigations you would order in the emergency room setting for this child?

CBC (or Hemoglobin level)	0	1
Cross match	0	1
Serum electrolytes	0	1
Kidney function test	0	1

Q

What are the differential diagnoses of this child's bleeding?

Mallory- Weiss syndrome	0	1
Gastritis	0	1
Peptic ulcer disease	0	1
Vascular malformations	0	1

Q

While the child was in the ER, he had another episode of vomiting, now with dark (coffee ground) material in it, **What would be the next steps in the management?**

Admission to the hospital	0	1
Nasogastric drain	0	1
Intravenous fluid	0	1
Frequent checking of vital signs	0	1
Serial monitoring of Hemoglobin levels	0	1
Administration of antacids	0	1
Considering GI consult and endoscopy	0	1
Blood transfusion if necessary	0	1

Overall performance	0	1	2	3
---------------------	---	---	---	---

Note: The overall performance marks depends on how fluent the student was in giving the correct answers (Not hesitant, not needing a lot of leading questions by the examining committee)



Vomiting

TIME :5 minutes
OSCE(history taking)

Examiner copy

Mark

/26

The mother of a 2 month old baby brought him to the clinic because of vomiting, please take a focused history and then answer the question of the examiner.

Observe the student asking the mother about the following:

Analysing the vomiting		
Onset/ duration	0	1
Frequency/ number of time	0	1
Relation to feeding	0	1
Content (bilious, blood, milk)	0	1
Amount estimation	0	1
Character (projectile, spitting up)	0	1
Asking about associated symptoms		
Bowel movements (diarrhea/constipation)	0	1
Fever	0	1
Respiratory symptoms (choking, cough, rhinorrhea..)	0	1
Excessive crying, irritability	0	1
Change of urine color or odor	0	1
Asking about symptoms of dehydration		
Urine output	0	1
Poor activity	0	1
Poor feeding	0	1
Nutritional history		
Type of milk	0	1
Amount and frequency of feeding	0	1
Birth weight	0	1
Weight gain	0	2

Stop the student after 4 minutes to ask the following questions

Q: Ask the student, if the physical exam normal with no signs of dehydration, what is the most likely diagnosis?

Gastroesophageal reflux	0	1
-------------------------	---	---

Q; What would you tell the mother, if you diagnosed GER?

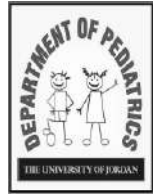
Reassurance , encourage burping of the baby after feed, positioning(not important to be mentioned)	0	1	2
No medications (if student did not mention medications, ask him: would you give medications?)	0	1	

Overall performance	0	1	2	3
---------------------	---	---	---	---

Time: 5 minutes

Station: History taking

The mother of a 2 month old baby brought him to the clinic because of vomiting, please take a focused history and then answer the question of the examiner.



Student Name:

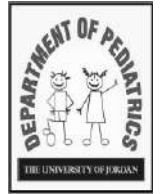
Mark

/25

A mother brings her five year old boy to the clinic because he has frequent falls while walking which is worsening for the last 6 months. Observe the student asking the mother about the following.

Analysis of problem			
History of abnormal movement,change in tone	0	1	
History of loss of consciousness	0	1	
History of fever	0	1	
History of joint pain,swelling	0	1	
History of trauma	0	1	
Ask mother to describe gait	0	1	
Age of walking	0	1	
Was the child walking normal,then he regressed	0	1	
Asking symptoms of myasthenia gravis(ptosis,squint,tired at end of day)	0	1	
History of weakness in upper limbs,choking	0	1	
Developmental history			
Gross motor: example if he goes upstairs and downstairs	0	1	
Fine motor: example if he draws a triangle	0	1	
Social:example if he plays with peers	0	1	
Language: example if he tells stories,knows colors	0	1	
Other important questions			
Antenatal history:medical problems in mother (HTN,drugs,infection)	0	1	
Birth history (GA,Birth weight,NICU admission,mode of delivery,jaundice)	0	1	2
Family history of consanguintiy	0	1	
Family history of similar cases	0	1	
Vaccination history	0	1	
<i>After 6 minutes Stop the student to ask the following If the child had calf hypertrophy,decreased tone and DTR.mention two tests to help you reach the correct diagnosis</i>	0	1	2
<i>CPK,muscle biopsy,dystrophin gene</i>			
Overall (organization, systematic, polite, good communications skills...	0	1	2 3

Examiners' name and signature:

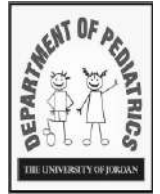


Time: 7 minutes

Station: History taking

A mother brings her five year old boy to the clinic because he has frequent falls while walking which is worsening for the last 6 months.

Please take a focused history, and answer the examiner's questions.



SP copy

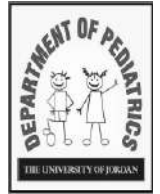
My son started walking at the age of 18 months and recently he started to have frequent falls for the last one year that became more remarkable for the last few months .

He also has difficulty of standing from sitting position .He goes upstairs and downstairs while holding the rails .Gait is like a duck

He has no problems with his hands and upper limbs , no choking or swallowing problems , no squint and no ptosis, no tremor in hands, no nystagmus and he is not ataxic and his tone is normal (if the student asks about spasticity) .No history of trauma,jont swelling,fever

He was born at term by normal vaginal delivery , BW 3 kg and no NICU admission .Me and my husband are not consanguineous and there is no similar history in the family .Antenatal history was unremarkable

Regarding his development he sat alone at 10 months , developed 2 word sentences at 2 years and currently knows 4 colors and draws a traingle .His social development is normal and he plays with children .



Student Name:

Mark

/27

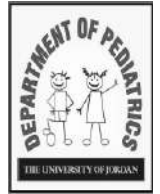
The mother of a one year old baby brings her child complaining of abnormal audible breathing sound .Observe the student asking the mother about the following:

Analysing the sound			
Onset, duration	0	1	
Course (worsening,improving)	0	1	
Character(,musical,harsh, diurnal variation, inspiratory, expiratory)	0	1	
Relieving factors ,aggrevating factors	0	1	
Asking about associated symptoms			
History of cyanosis	0	2	
History of rapid/difficulty breathing	0	2	
History of fever	0	1	
History of cough	0	1	
History of drooling/ hoarsness			
Activity, feeding	0	1	
Drug history :History of nebulisers/inhalers use/drugs	0	1	
Perinatal history			
Gestational age/NICU admission or ventilator use	0	1	
Other important questions			
History of eczema of the child	0	1	
History of recurrent vomiting/choking	0	1	
History of poor weight gain	0	1	
Past history of similar attacks	0	1	
History of hospitalization/frequent E/R visit	0	1	
Family history of similar cases in family	0	1	
Vaccination history	0	1	
<i>After 6 minutes Stop the student to ask the following .On exam the infant was tachypnic,he had intercostal retractions and diffuse wheezes .What is your differential diagnosis diagnosis?</i>			
Bronchiolitis	0	2	4
First attack of asthma			
Overall (organization, systematic, polite, good communications skills...			
	0	1	2
			3

Examiners' name and signature:



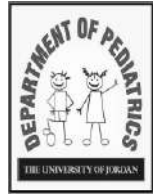
*The University of Jordan /Pediatric Final OSCE
2015
TIME: 7 minutes*



Time: 7 minutes

Station: History taking

The mother of a one year old baby brings her child to emergency room complaining of abnormal breathing sound .Please take a focused history, and answer the examiner's questions.



My one year old boy is complaining of abnormal musical sound for the last two days. He started to have low grade fever with mild runny nose before three days, then had this musical sound . The sound is getting louder with time and there are no aggravating factor. I gave him antibiotic and the sound didn't improve. He is also breathing faster than usual and with difficulty. There is a history of dry cough mainly at night along with this sound . No history of cyanosis. No change in voice, no drooling, no witnessed choking. He is not feeding well today and is less active than usual. No vomiting or diarrhea.

He had a NVD, Bwt 2 KG, GA 35 w and entered NICU for two days ,but wasn't placed on a ventilator.

His vaccines are up to age. He is growing well and gaining weight with normal development.

No previous attacks. He wasn't hospitalized before, and had no E/R visits

He has eczema, his brother has asthma and is on inhalers.