

Simulated Patient Brief — MARTIN (First Seizure) • Week 5

PATIENT DETAILS

Name	David / Dotty Martin
Presenting complaint	First seizure

ORIGINAL SCRIPT PAGE 1

FACILITATOR NOTES

Name: David/Dotty Martin

DIAGNOSIS

Most likely: Single fit - sudden preceded by flash of light (aura), drowsy afterwards. Less likely: Syncope - common, but should have recovered faster. This case is in 2 parts: 1. History taking of straightforward clinical presentation of a seizure. Students should be able to recognise from this history that this patient had a seizure not a faint. The student should suggest the next steps (onward referral/ imaging/ EEG) and potentially broach the initial no driving conversation with the patient.

2. Students should review the hospital letter and discuss the official diagnosis with the patient this should be done in the form of breaking bad news.

Epilepsy | Health topics A to Z | CKS | NICE Epilepsy and driving - GOV.UK (www.gov.uk)
Neurological disorders: assessing fitness to drive - GOV.UK (www.gov.uk) Breaking Bad News - OSCE Guide | Communication | Geeky Medics

ORIGINAL SCRIPT PAGE 2

Name: David/Dotty Martin Age: 40

OPENING STATEMENT: ' I FAINTED AT HOME AND MY PARTNER MADE ME COME'

Information to be given away after further open questioning: 3 days prior to this consultation you were at home with your partner one evening. Your partner was upstairs in the bath when they heard you drop some crockery. Hearing nothing afterwards, they got out the bath and went downstairs where they found you lying on the kitchen floor, initially unconscious but slowly coming round. Information to only divulge on direct questioning: You remained drowsy for some 20 minutes afterwards, but was able to insist that you would be alright and that your partner should not call an ambulance. You were able to recall seeing a sudden flash of light, but nothing else until your partner found you. The next day you felt fine and attributed the previous night's events to the fact that you had fainted, probably because you had been extremely busy and had not had time to eat anything since breakfast that morning, been out jogging, followed by a 'pint' and was now preparing for visitors to come around. However, you agreed to go and see the GP (for his partner's

sake)- Just for a 'check up'. There were not other associated symptoms or outward signs, other than recalling seeing a sudden flash of light you did not have any feelings/ pain or symptoms before you collapsed. No fevers, no weight loss, no headaches, no visual changes, No gastrointestinal symptoms, no residual symptoms. You realised when you woke that the side of your tongue was painful and think you must have bitten it as you fell. You will admit to having wet yourself during the event and you are very embarrassed by this but you feel this can be normal when you faint as you 'lose control of everything', you don't think this is worrying because you think that you must have needed the toilet before you collapsed. You do drive and it is very important that you can continue to do so as there is no other way for you to get to work. If the student mentions that you are not able to drive then you become very worried that you will end up losing your job which ultimately means you can't pay your bills. If you are told an underlying cause needs to be excluded you will become extremely concerned. If the doctor is insensitive, you will strongly deny the possibility of something serious and lose confidence in the doctor. If discussed sensitively you will want to know as much as possible showing increasing concern and worry. Ideas: You think you fainted because you were hot and had skipped breakfast Concerns: You are not worried about it being anything serious, you just need to get back to work. Expectations: You think the doctor will agree with you that it was a faint and send you on your way. Feelings: You are not particularly worried or anxious but do start to put up walls if they suggest further tests. If they advise you can't drive you become very anxious. Past medical history: Age 20 admitted to hospital with viral meningitis. Made a slow but uncomplicated recovery. No other significant illnesses. General health good. Medication- Nil – No known allergies

ORIGINAL SCRIPT PAGE 3

FAMILY HISTORY- NIL – BOTH PARENTS AND SETS OF GRANDPARENTS STILL ALIVE AND DOING WELL. NO SIBLINGS.

SOCIAL HISTORY – COMPUTER PROGRAMMER- RECOMMENDED RECENTLY TO APPLY FOR A HEAD OF DEPARTMENT

post. Live in terraced house. Regular partner for last 10 months Divorced 5 years ago- 2 children : 12 and 10 years Smoking- Non smoker Alcohol – 20units/ week (Beer/ wine)

IMPORTANT SOCIAL, CULTURAL OR BEHAVIOURAL CHARACTERISTICS

At the first consult you need to get back to work as you have a busy job and have been asked to think about stepping up to management. You would like to take on a management role but recognise you need to keep up with the workload you currently have or your potential promotion will be put at risk. Patient initially dismissive of others' (partner, GP) concerns. Unreasonably confident in their predilections and expecting to be told everything is alright. You will gladly accept the explanation of a 'faint' due to stress or having not eaten properly. On being told epilepsy - initial denial saying no tests have been done to confirm this and that you feel fine now. If this part is handled badly turns to anger -against partner and GP . At the second consult you are reluctant to accept the diagnosis but if done in a sensitive way and you are persuaded to accept diagnosis you have several questions: regarding treatment, confirmation of

DIAGNOSIS EFFECT ON JOB, DRIVING, HOBBIES AND EFFECT ON YOUR RELATIONSHIP.

A degree of acceptance of advice will depend on how the diagnosis has been explained to you.

Demeanour: Casually dressed - is planning on going straight to work after this appointment.

Assertive, articulate. Rather feels that this is all a waste of time - partner worrying unnecessarily and GP jumping to wrong

DIAGNOSIS.

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PHYSICAL EXAMINATION

PATIENT NAME: D MARTIN

Normal Peripheral and CNS exam HS normal PERLA

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Patient Record (to be given to student) Name: D Martin Age: 40

Past Medical History: Age 20 admitted to hospital with viral meningitis. Made a slow but uncomplicated recovery. No other significant illnesses. General health good.

Last 3 consultations: 3 years ago: ankle sprain 6 years ago: flu 8 years ago: URTI

Medication None

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To be given to student after initial consult Hospital letter: Dear Dr Aram Thank you for referring this pleasant computer programmer who unfortunately had what sounds like a first grand mal epilepsy attack. Examination is normal and I have arranged an EEG and CT scan, the latter to exclude any underlying pathology relating to a first fit at this stage. They are obviously very reluctant to accept the idea that he may have epilepsy but for the time being I have advised them against driving, dangerous sports and to avoid prolonged viewing of TV screens/monitors especially in the dark or sitting close to such. I have suggested they use an LCD type display as much as possible. Yours sincerely Dr Pye

PS: I now have the EEG and Scan results:

EEG: abnormal activity compatible with epilepsy focus. CT Scan: Normal.