

OSCE

Candidate information

Your RMO has been seeing Amanda, a 34 year old female who presented with sudden onset of dyspnoea today. She is very anxious and seems to be hyperventilating.

Your RMO has taken a history from Amanda and has some questions for you as to how to manage her.

Domain	%
Medical expertise	40
Prioritisation and decision making	20
Communication	
Teamwork and collaboration	
Leadership and management	
Health advocacy	
Scholarship and teaching	40
Professionalism	

PE on apixaban

Actor (RMO) information

You have been seeing Amanda, a 34 year old female who presented with acute dyspnoea for the past four hours.

Amanda was diagnosed with a left below-knee DVT 4 days ago by her GP (ultrasound) and commenced on apixaban. She has been compliant with her medication, but today developed acute dyspnoea.

You are unsure what investigations to do for Amanda and how to manage her dyspnoea. You have ordered a D-dimer (result: 0.4) and are thinking of ordering a CTPA. Amanda is currently stable, but you want to discuss her case with your consultant.

Prompts:

- What could be causing her dyspnoea?
- Does she need a CTPA if her D dimer is negative?
- If a PE is found, how should she be managed?
- Does she need lifelong anticoagulation?

Marking:

	Mark
Identifies need for CTPA to exclude PE	2
Explores possible anticoagulation options – heparin, clexane, warfarin, etc	2
Explains D dimer relevance in this patient – not a low risk pt!	1
Checks if patient could be pregnant	1
Suggests tests for clotting disorder (outpatient acceptable)	1
Admits patient under Respiratory team for management	1
Discusses risk stratification tests- ECHO for right heart strain, troponin, etc	1
Approach to RMO – teaching method, organisation of thoughts	1

Three possibilities can account for early diagnosis of PE in patients on treatment for a DVT:

1. Mechanical break-off of some of the leg thrombus: PE comes from proximal DVT – anticoagulation stops further thrombus growth within a short time, but some of the DVT can still break off and cause symptomatic PE in the few days after starting treatment.
2. Fragmentation of a PE that was already there when anticoagulation started. Remember that about half of patients with a proximal DVT already have a silent PE – some of these will fragment and then produce symptoms in the few days after starting treatment.
3. True failure of anticoagulation and development of new or worsening of DVT leading to new PE. This is most likely to occur in patients with very thrombogenic cancers (such as non-small cell lung cancer [NSCLC]) or in patients with really active antiphospholipid antibody syndrome (APLAS).