SHORT CASE MBBS 2008/2013

examiners: prof external O&G, prof ks tan, prof surgery (dunno name), prof Lee WS
o&g: uterine fibroid 18 week size with laparotomy scar. what ddx of ur finding. ix u want to do? what type of ovarian tumour u know and what possible type of ovarian tumour in young pt? other than abd ultrasound waht ix to exclude ovarian tumour? mx of uterine fibroid other than myomectomy in young pt?
medicine: intrepret ur finding; bilat symmetrical muscle wasting, weakness 3/5, areflexia and loss of pain sensation in glove n stocking distribution n loss proprioception. no Q from prof KS Tan dt limited time.
surgery: thyroid mass, diffuse involving the right lef n midline neck. nodular surface, heterogenous inconsistency. what your ddx in this age and why? other dx than thyroid ca? what type of thyroid cancer u know? what ix u want to do? which type of thyroid cancer will show normal cyto and FNAC cannot dx?

azlan
Examiners: Prof kamarul(ortho), Prof Asma Omar(paeds), Prof Kong(O&G)Case 1: O&GQ:examine patient abdomenA:singleton pregnancy with transverse lieDiscussion on unstable lie.Case 2: PaedsQ: please do DA on this childA: do gross motor n fine motor only. child is atleast 18moOnly do DA with Prof AO. she is very very nice. prompt everything on DA.Case 3: OrthoQ: this patient complaint of discomfort at the posterior chess wall.please examine the back.A: got lump there. straight away examine lump. Benign bone tumor arise from lateral site of spine of scapula. DD: osteochondroma. mx on that lump etc. kring.... 10 minutes very fast guys. my advise is please do running commentary as time running tooo fast. gud luck guys!

Ss
1) paeds - examine the abdominal system
just pallor, needle mark at abdomen... prompt by examiner tu percuss trhrobe space again... dull.. Differential - Xpress shortcase ... Ix u want to do. bla bla bla. . if pt Hb 9, wbc 6 pt 300 what do you think... bla bla bla kringgg!
2) ortho - lump at right arm..... you differential - lipoma, cyst, rhabdomyoma... how u want Ix - u/s, xray, mri, biopsy... type of biopsy - 2, histo cyto bla bla... size of needle use? sorry xknow. kringg!
3 - obs - external examiner cannot understand sgt... start with peripheral, wat need to do, what is this what i that explain everythng about examination technique, transverse lie, how u manage...

QH
1) Prof Ong (Urology): This gentleman complains of inguinal swelling, please examine.
Examined on standing, described swelling site size shape etc. cough impulse positive, then palpation, pt requested for me to reduce the hernia. fail to reduce on standing, Prof Ong prompted me what should I do? Lie patient on the bed, and with the patient's guidance, the hernia was reduced. Occlusion test positive, Dx indirect inguinal hernia. What other things to check?

Abdominal masses, respi system (in case patient has chronic cough), and (on prompting) BPH on per rectal examination. What's the treatment? Hernioraphy and hernioplasty. Krriiinggg.

2) Dr Choo YM: Observe the child, and proceed.
Young boy, around 3-4 y/o, with characteristic Down Syndrome facies (upslanting palpebral fissure, hypertelorism, flat nasal bridge, single palmar crease etc.)
What would you like to examine? Cardiovascular system.
Nvm, examine the abdomen.
Child open the shirt, appears to have a transverse scar over the R hypochondrium.
What do you think it's for? Duodenal atresia. What else? I answered liver (Dr Choo said no because not common in DS, what else? Hirschsprung? he accepted, but he wanted something else), figured its probably Pyloric stenosis after only. . Then what is your observation on the patient's development so far? Me: "I wasn't paying attention to that...." Just simply blabber about the child is playing , responsive to surroundings, not speaking words then kringgg... " (completely failed this station)

3) Dr YB Chong (Nephro): Examine this lady's hands. (Rheum Arthritis hands) Describe standard RA stuff, left out a few things in inspection, got stuck for a long time thinking what I left out (palmar erythema, muscle wasting etc). Then proceed to palpation and check for function, then rheumatoid nodules, then before I know it, Kringgg... Dr continue asking, what else would you like to check? Eyes for anemia, abdomen for splenomegaly, skin for rashes, etc.) what's your diagnosis? RA. Differential? Psoriasis? How to differentiate? Rashes, loss of hair? Nail changes etc. (He wanted me to say psoriatic plaque I think) Followed him all the way to the examiner room, until he stopped me from entering. LOL. (Did badly overall for this station as well, Arrgh)

Advice: Don't panic!!!! Everything went down from the point I started to panic from 2nd station. Keep calm and think properly. All the best!!

Melvin
Prof Azlina (Ortho), External (Surg), Internal (Med), Prof Ong (Paeds - observer)

RA Hands (Med)
Examine the hand: All typical features of RA with rheumatoid nodules
What other examinations you wish to perform? Name as much as you can…
What would you do if you see her in clinic?
How do you monitor her condition?
Name other differential diagnosis? SLE with Jaccoud Arthropathy, Psoriatic arthropathy, Primary osteoarthritis
If this RF -ve, could it still be RA? Yes, pt has typical features of RA, & RF only positive in 80% of cases
What lesion did you see in the eye? No idea, thought it was pterygium, I was wrong.
Describe the lesion. There's a whitish growth over the sclera encroaching onto the cornea with visible blood vessel seen.

Thyroid (Surg) – External: MNG goitre, euthyroid status
Perform neck examination, then to proceed with assessment of thyroid status in running commentary with multiple interruption in btw!! ><
As you are palpating the lymph nodes, name them as you proceed.
What are you looking for at the hands?
What pulse character do you anticipate?
Describe AF.
Diagnosis & reasoning

Lump (Ortho)
Examine the lump
[Huge multiloculated lump over midshaft of right humerus extending on the distal humeral shaft, >5cm, encircling the arm, etc, no other cutaneous signs to suggest malignancy, etc]
What are the features of malignancy?
Where is the origin of the lesion? Benign soft tissue tumour, give differentials….
What else would you like to examine? ROM, neurovascular examination of UL
Show me the ROM? Is it limited? Is there extension into the elbow joint?
Comparing with the normal side, it is limited by the mass effect
What nerve would you like to examine? Radial nerve
Demonstrate radial nerve examination? Normal finding
Where to assess radial nerve sensation? Were you not taught to examine the sensation over the 1st digital web space? Stunned! Just said I was taught to assess over the anatomical snuffbox
How to differentiate lipoma and liposarcoma?
How would you manage him if you see him in the clinic? Surgery in view of the size >5cm, with mass effect
What if he insisted not to do surgery?

<u>Su-Ann.</u>
Examiners : Prof Adeeba. Prof Ng wai ming, Dr Si lay. external examiner Medicine. Prof Adeeba. Question : This gentleman has progressive SOB, please examine his respiratory system. Peripheral examinations revealed no significant findings (although I think he has sclerodatyly but I did not commit and later on forget bout this, examiner also did not prompt). On chest examination, very loud crepitations can be heard bibasally up till the middle zone. I said it was coarse, and give diagnosis of bronchiectasis. Prof asked what are the peripheral findings for bronchiectasis. I said clubbing, cyanosis and plethora, and should have sputum cup filled with sputum, and not present in this patient. Then Prof asked again, what would like to offer as differentials? Then I said pulmonary fibrosis. Was asked cause of pulmonary fibrosis, investigation for it, and any other differentials.

Surgery. External examiner (Indian). Question : please examine the pt's scrotum. Inguinal hernia. Question : Perform ring occlusion test. What other clinical examination would you like to do. (do PR for BPH, abdominal examination for mass, respi exam forchronic cough). Complication of this condition. (strangulation, IO) What would you do for this patient. (Refer to surgeon, most likely do a hernioplasty due to his age) What pre-op preparation would you like to do. (basic blood ix, CXR, ECG).

Ortho. (Prof Ng Way Ming). Question : Inspect the back and proceed. I inspected and commented a lot until he said please inspect this area properly, pointing at the scapular area. Then I saw a swelling. Describe the lump and I concluded it is a osteochondroma and asked permission to look for other swellings. Prof : Tell me about osteochondroma. What is the malignant percentage? (not sure, just told it has high risk due to the position and could have been gone unnoticed for a long time). When would you suspect malignancy (increasing pain, increasing size, continue to grow even after skeletal maturity, bulky cap and invasion into soft tissue) Only ONE investigation (MRI)

Vincent - Prof Phillip poi, Prof Fatimah, external gynae, prof azalina

Case1 – APCKD
Inspect this gentleman and proceed. Tell me what are your findings. Did general inspection then mentioned the abdomen appeared to be distended, got one catheter attached to RIF !!! Did not see the catheter b4 !! Asked by prof what catheter is that, I was like shit, what is that.. luckily after saw distended tortuous veins on pt left forearm--AVF, tembak it is a tenchkoff catheter. Luckily tembak correct (examiners were nodding). Lesson of the story pls go and check a tenchkoff catheter looks like in UMMC like, very different with the one in Klang! Examine abdomen: ballotable kidneys, described it (TESCO-tenderness, edge, surface, consistency, aus bruit), no hepatomegaly (11cm) and splenomegaly (traube space resonant). No ascites. Prof asked why patient on both AVF and tenchkoff?? I said because probably the AVF malfunctioning, he accepted. So what advice would you give the patient – genetic counseling AD blabla.. then kringg..

Case2 – gynae mass
40 + yo Malay lady P3+1. Inspect the abdomen and proceed. Fibroid or ovarian mass?? Why do you say so? I committed into saying fibroid in the end. How you going to ix & manage etc

Case 3 – DEVELOPMENTAL ASSESSMENT
Aihh.. basically a one year old child. Do the usual fine motor, gross motor, speech and language, personal social assessment then come to a range of 10-12 mo. No delay after confirm with the mother.

Tharisinidevi kunasekaran
examiner : prof ong, prof eugene, dr yb chong and dr choo
case 1: mass at neck near clavicle ; not thyroid, not lipoma, not LN....not everything else.....i ve no idea.....T.T
case 2 : hernia at right groin, positive cough impulse....then ask patient to lie on bed.....kringgggggggggggggggggg
case 3: examine this 23 years old lady's abdomen blurrrrrrrrr.....dont know gynae or obs.....abdomen distended up to umbilica with linea nigra .....confuse so did superficial and deep palpation then straight do fundal lateral and pelvic grip.....look at prof eugene eyes and say i cant feel any fetal poles.....panic.....then he said its ok...proceed ...basicly deal like fibroid lepas tu.....but blurrrrr T.T
case 4 : patient has difficulty in breathing check his respiratory system.....this is the worst station....cause i dah give up..... deal it like

right lung patholgy (fullnes at supraclavicular region) differential LN and pancoast tumour but guess bukan kut sebab Dr YB chong stress...mostly stress with my anotomical approach....
p/s : i left my brain outside the exam hall.....:|

Lee Kar yin
Examiner: DR shanker
Short case 1: peads (down syndrome facies)
S: This young 'man' has language delay. Please proceed.
M: okok. Go and intro to pt's mother.ask for pt's name and also his age..(opps,,den oni I realize I should not have asked the age???aha..take a quick peep at Dr shanker but he jz show me his kind smile J. Proceed to pt…take a quick inspection.called out his name and he is responsive to it..den I said boleh tengok tengok sikit tangan tak?…luckily he understands and is very cooperative with me!!! Quickly look for all da features for Down and comment on it. Den the special boy open up his shirt for me without me asking for it!! Aha..again I smiled and look at Dr shanker. Then he said proceed. There is a obvious tansverse scar at right lower quadrant of his abdomen. So jz comment on the scar.
S: what do u tink is the most likely cause?
M: Err..in this special kid..they would have GIT problem like duodenal atresia and Hirsprung dx.err..since the scar is at Right..so duodenal atresia??
S: ok..so what else do u wana look at???
M: erm…check his cvs?? no findings at cvs..bothS! and S2 heard with no murmur.
S: ok..good..now why don't u proceed with fine motor assessment.
M: Pt got tripod grip…but jz scribble..cant imitate straight line or circle. He can do till train with chimney but not the bridge. Peep at Dr shanker again..haha..err…thought block for a while..den Dr shanker said do u want to show him da book??okok..quickly show him da book. But the child push away my book.><
S: ok..so what else can u do??
M: thought block for awhile..den ask him to show his body parts?? Pt can oni point to nose not others. so conclude his fine motor and language less than 2 years old.
S: so now what do u tink is the cause for his language delayed?
M: err..child with Down's will have learning difficulties? He obviously has no sensorinural deafness.
Apparently Dr shanker want recurrence otitis media as its common in DS><

Case 2: surg(Dr Ng char hong) Goitre
N: please examine her neck.
M: so jz inspect da mass on the neck lor(swallowing, protrude tongue..palpate..percuss..auscultate.
Present da findings as a diffuse mass.
N: do u want to palpate again??
M: err…quickly palpate again (me gave Dr ng a doubtful glance..aha..den he asked me focus on the right side..so nice of him!!.ohh..got 2 small nodular lumps on the right..so say mutinodular goiter lor. Tell da differentials and how to investigate and manage the pt. since still have time left, he jz asked me to tell him what features special in hyper and hypothyroid. Bell ringsss…

Case 3: obs (prof PC tan)
P: please examine pt's abdomen.
Me: intro, expose and inspect. Obvios linea nigra and striae gravidarum and a LSCS. Den prof said are u sure it's a LSCS???den quickly change to suprapubic transverse scar>< So jz present as gravid uterus lor..proceed with all those palpation and grip thgy…forget to check for fetal heart rate..but there is no pinard available..so Dr asked how to determine fetus well being by bedside if no pinard?? Me thought block awile then look at shanker but he dint hint me anythg>< look back at prof PC tan…then he raised his eyebrows and look at the patient. Then oni I blurt out loudly..ask the mother baby ada gerak tak?? Then they all LOL…. Phew><"
P: asked all those scans and specific thgs u wana look for in each trimester and how to monitor mother and baby in each trimester.
Last Q :what are ur concerns in this mother? Me mode of delivery since pt got a LCSC? Den he said one more thing?? Bell rings..and he actuali wants mode and time of delivery.
*that's it..time flies..u'll be nervous and have thought block but examiners will hint u;) good luck!

<u>tan wee how</u>
prof anna(paeds) , prof adeeba(med) , dr hari (neuro surgeon), dr aizura (ortho)
1st case - turner syndrome (paeds)
prof anna : this 11 yo gal presented with short stature...plz examine her
- so i ask her to stand...inspect.....genu varus...then i proceed to check for widening of metaphysis....rickety rosery...then run out of idea..i said check cranio tabes but not in this age group...
- ok...ur ddx?...i say ricket...vit d def....blount dz....
- ok...what can cause ricket?...i said reduced sun exposure...familial...malnutrition...
- do u think malnutrition common in this country?...wats other cause which is more common?....then i said malabsorption....
- yes....so wat symptoms u wan to ask if u suspect malabsorption?....i said steathorrhoea...
-yes....ok...if i tell u this gal is born with something (forgot how she ask this question...sry ya..XD) that cause her to have short stature...wat u think it is?....i said turner syndrome...
-yes...so if u think she has turner syndrome...wat else u wan to check?....then i proceed to check for wide carrying angle...webbed neck...but thr was none in this gal..
-ok...tell me how u counsel her parents about her illnes....i said reassure them that she can have normal intelligent....but she will have infertility...
-why u say she will have infertility?...i said primary ovarian failure....
-ok..other that that...wat cx can occur in turner syndrome....i said they might have cvs problem....thyroid.....
-wat kind of cvs cx?....i said coarctation of aorta...
-ok...how about other system?...then i say they also more prone to have hypothyroidism...
ok...lets go to next station :)

2nd case - PCKD (med)
prof adeeba : this is mr wong a xx year old gentleman with hx of

hypertension...plz examine his abdomen..
-so do full set git system...start from inspection till auscultation...i did running commentary...
-my finding was bilateral flank mass, nodular surface...and it is ballotable...
-tell me why u say this is kidney but not spleen or liver?...standard answer lo...kidney move inferior when inspire....resonant percussion...no notch...traub space resonant...ballotable...bla bla bla...
-ok...wats ur ddx for bilateral ballotable kidney?..i said pckd...then hydronephrosis...and RCC...
-ok...one question u would lk to ask the patient.....i ask is thr any other family members with similar problem...the pt say yes...
-ok...why u ask so?...i said its an inheritance dz....
-wat kind of inheritance dz?...autosomal dominant lo....
-ok...wat other system u would lk to check?....cvs for mitral valve prolase...liver spleen pancreas cysts..berry aneurysm..bla bla bla...standard answer lk in X press book :)
-ok...this pt come to ur clinic...how u mx him?...i said f/u regularly and check bp....then they more prone renal stone..encourage them drink more water(this answer quite stupid actually...definitely not the answer she want, but thought block so i say this XD)....then in the end i said they usually will go into renal failure...so monitor renal profile regulary...she satisfy with it...
-thats all, next station :)

3rd station - L irreducible indirect inguinal hernia
dr hari : this is a xx year old gentleman with scrotal swelling...plz examine him...
-so i stand the patient up...inspect...palpate..percuss...cough impulse...do everything...wear glove...
-then follow by all the standard q for hernia....boundary of inguinal canal...how to dif btw indirect and direct....
-dif of inguinal and femoral hernia....
-direct inguinal hernia common in female....femoral also common in female....so...if compare direct inguinal hernia and femoral hernia...which is more common in female?....answer is direct inguinal hernia...
-wats the length of ingunal canal?...i guess 5cm..he said almost thr...
-how would u mx this gentleman hernia....i said herniorplasty...
-wat other component u would lk to consider before u do surgery...basically he wan risk factor for hernia...so standard answer again....copd...increase abd pressure eg. ascites...obesity...constipation BPH....
-ddx for scrotal swelling....i said hernia...hydrocele....saphena varix (he say ok..i hardly see one b4 XD)...then orchitis and testicular CA
-ok..last q for u....whr does testicular CA drain into?....i said i dunno...
-nvm...giv a wild guess?...either transverse or longitudinal?...i said transverse...the answer is longitudinal XD (? para aortic LN)
-thats all....thank you and u may leave :)

so lucky to get 4 angels :) all the best for those taking exam tml....hope we all pass together!!!

Kong Sik Thien
Prof Mary Marret (Paeds), Dr.Sia(Neurosurgery), Dr Azura (Ortho), External (O&G)

Station 1(Paeds-PDA in failure)Look at this child n auscultate the heart.She is about 6-7 months old i guess as prof din tell the age. I forgot to introduce myself n proceed straight to the baby n she cried right after i tried to open her clothes...Q:What u heard?I said grade 4 pansystolic murmur all over the 4 areas.Q:So u think this is a pansystolic murmur?Then why would u said it's grade 4?Tell me the diff btw Grade 3 n 4...I mixed up the 2 murmurs n told her the opposite one n then only realized it..=.="Q: So what do u want to palpate?Then i said i want to plapate for thrill which is present in this baby n apex beat which is displaced to 5th intercostal space btw midclavicular n ant axillary line (show properly how u locate the apex beat)..Q: What else can u see on her chest? Hyperactive precordium, use of accessory muscle evidenced by subcostal recession.Q:Then what u want to do next, i said i want to check for hepatomegaly.No need,but this child's liver is a bit enlarged. Q:What is yr differential? I said VSD, then the 2nd one i put PDA (since she was not satisfied with pansystolic murmur,then i think it might be a continuous murmur).Then she seemed satisfied and asked me how to differentiate btw these 2, so i said PDA will radiate to the backQ: Check the back n tell me what u listen?murmur is radiated to the back, so i confirm my diagnosis which is PDAQ: Is she in failure?Yes,coz pt has cardiomegaly, respiratory distress...Q: What other features of heart failure?tachycardia, gallop rythm, hepatomegaly...Q:if u are a doctor in periphery, what ix would u like to do? I 1st gv the ans of echo cardiogram,then dr was like...errrr,then only i mentioned CXR n i can see cardiomegalyQ:define cardiomegaly in CXR, what else u can see?Bell rings!!!Prof Mary was so nice....

Station 2 (Surgery-MNG)Kindly introduce yrself to the pt n examine the pt's neck!She is a middle aged Malay lady who is sitting comfortably on a chair, generalized diffuse swelling of the ant neck with a prominent mass noted above the sternal notch.No prominent veins, no skin changes n no discharge noted.Then asked the pt to swallow n protrude the tongue. it moves with swallowing but not tongue protrusion.Q:y u ask pt to protrude the tongue? TRO thyroglossal cystThen proceed to palpation, do running commentary.Multiple mass (4) noted at the left n right lateral aspect of the neck.Sizes ranged from 2x2cm to 3x5cm, smooth in surface, firm in consistency, well defined margin, non tender n no increased in warmth.No lymph node is palpable, no retrosternal expansion (Dr wanted me to percuss from bottom)..Then i thought block...Dr: Dont u want to auscultate? yes yes,but no bruit..Q: what is the differential diagnosis of a euthyroid MNG?i mentioned smooth non-toxic MNG, drug-induced..then he prompted me any autoimmune ds that u know of that can cause it, then i mention Graves...Then i forgot what happened ady n how tis Q ended..Q: What ix would u like to do? TFT, FBC,US of the thyroid gland, FNACQ: let's say FNAC result came back to be adenoma,how would u like to manage tis pt? FNac could not differentiate whether it is follicular adenoma or carcinoma,so i would perform a hemithyroidectomy on pt n send the tissue sample for HPE.If the result comes back to be malignant,i will perform a total thyroidectomy n if it's adenoma, i wiill be happy to do hemi onlyQ:what sturcture tat u are worrying when u do hemithyroidectomy n y?recurrent larnygeal nerve n it will cause vocal cord palsy n pt would not be able to breathe if it bilateral involvement...Bell rings!!!Dr. Sia kept encouraging me by saying good, well done...made u feel more confident!!

Station 3 (O&G- fibroid)This is a 23 year-old Malay lady..Inspect the

abdomen..The external examiner insisted me to do a running commentary n want me to tell the landmark for proper exposure in abd examination, n rmbr to inspect AT THE END of the bed...The abd is distended up to umbilical level which is corresponding to a 22 weeks size of the uterus.The mass is more prominent on the right side but it's centrally located.The umbilicus is inverted n linea nigra is present.No surgical scar noted. Was hesitating whether this is an OBS case or Gyne case coz the examiner didnt tell anything.But then usually in OBS,they wont send such a small gravid uterus as u cant palpate the fetal part oso,so i examine using the gynae way..Q:Tell me yr finding. The mass is firm in consistency(R u sure?),couldnt get below,mobile horizontallyQ: differential diagnosis? Fibroid (definition of fibroid), gravid uterus, finally he wanted me to say ovarian mass then i said usually ovarian mass we can get below right then he said not necessary.. Q:What ix u would like to do to differentiate btw ovarian mass n uterine mass?US of the pelvic(E:not always,sometimes hard),hysteroscopy??i dunno what to ans ady then examiner said hysteroscopy can only visualize uterine mass but not ovary...Q: How would u like to manage fibroid?When to give intervention? In this case,it's as large as a size of 22 weeks uterus,so i said must treat regardless of symptoms(E: what symptoms?blah the standard ans). Can treat medically by giving POP,OCP...surgically, myomectomy, EUA(E: not a surgery...ME:oh yea,it's a radiological intervention), finally he wanted hysterectomy then i said i wont do on this pt becoz she is till young...The end....Good external also,feel like having a WR with him rather than exam...Dr.Azura also nice,keep hinting me when i was having thought block!! Good luck!!!

Lee Yin Yee

Prof Azlina 1) Pt had an accident pls do a right knee examination. (PCLtear- Posterior sagging, loss of medial step off)Q: do u think there is ACL tear as well? PCL tear usuallyassociated with MCL or LCL tear? Y need to do stress test in 0 and 30 degree?What investigations? Can arthroscopy be diagnostic and therapeutic tools inthis case? (yes) Do u wan to do mri first or arthroscopy first? How u wan tomanage the pt? (physioT) If physioT did not work, what u wan to do? (repair)

Prof Fatimah2) Please assess this child growth (13 yo)-When wan measurept height and weight, notice she has bow leg and short stature.Q: what do u think the causes of bow leg? What else u wan tocheck if pt got rickets? (Rickety rosary, widened wrist) do u think pt gotwiden wrist? Blaunt dz cause unilateral or bilateral bow leg? what ur bonecontain other than calcium? (Phosphorus) What causes rickets? (actually she wanthe genetic x linked hypophosphatemia I think) What investigations to do in rickets?(serum calcium, vit D, phosphorus, PTH, ALP) what is the fxn of PTH? ALP levelincrease or decrease? What other causes of short stature? (I mention Turner) dou think this girl has turner? (no web neck, no widely space nipple, no 2ndsexual characteristic) what u wan to check for 2nd characteristic?(pubic hair, breast development et) pt had breast tissue, do u think the dx ofturner fit? (no) what else u wan to check for turner? (cubital valgus)- andprof F relieve

External - not really understand his language, bt our profs arehappy to help translate (Prof Phillip)3) Examine this woman (G2P1 @ 38 weeks POA), start

fromperipheralQ: what do u think the scar is due to? The abd is more fullon maternal right, do u think is normal? how many types of striae gravidarum? (I answer 2 because during LC, chiew yen got him as examiner and he told her got2 types, however I only able to name one type- striae gravidarum albica, theother forgot what he told me liao) how do u listen for fetal heart sound? (hegot his own method @@) how do u want to manage this pt?Profs ll guide u if u got thought block… good luck

Brendan Jonathan Chin Chien Chou

1st station.. (kena stunned by dr choo ym)1. examine this 12 yo boy abd.totally cant feel hepatomegaly or splenomegaly but got few injection scarsi can percuss hepatomegaly just 1-2cm below subcostal but x feel..so i reconfirm 4 times.traube space dullno other findings.10 mins jux gone like dat, dr choo ask me can u is there hepatomegaly i say yes(hesitation)show me the border then i tell dr choo i can percuss but i cant feel it.Just tell me yes or no. prof azad come and tell me if no just say no. so i said no. if the boy got 2cm hepatomegaly wat ur ddx? i say Bthal and portal hypertension and ringggg..... dr choo tap my shoulder say its okay. cause i very sad that time.Angel Prof Azad hold my hand and smile at me.. say is ok.

den we go to 2nd pt inguinal hernia old uncle.check and present.i got auscultate the hernia and heard bowel sound. Prof azad ask y is a hernia. i say reducible and cough impulse +ve.so wat ur finding i said is diret hernia and he ask y ? i say cause i do occlusion test and the hernia still come out. he say ok. wat is the content ? i say bowel. so? i say large gi he say are u sure? i say small gi. then his angel smile shine and say actually large also can but small more common.what is the history u want to ask?i say heavy lifting , chronic cough, any bowel habit changes , any hematuria? y ? i say bph .. he straight away say issit the 1st thing u ask in bph den i say no.. i say WISE, FUN (weak stream, intermittent strangulation end dribbling.. then he nodded. what mplications can happen? io, stangulation, perforation, peritonitis. what they usually present? acute pain and io symptoms and irreducible if previously reducible. uncle 78 yo. how u want manage? i say cant conservaative coz uncle too old d, ask unlce dont do heavy lifting , if there is symptoms of io or strangulations come to hospital immediately, besides that can do surgery suchas hernioplasty and rrhapy. but b4 surgery i want to must sure uncle is fit for surgery. Do u noe how the surgery be done?? is a mesh put inside den ring.....

3rd case - uterine fibroid 24 weeks sizei started to do fundal grip bcx so young den i feel something wrong as no striae gravidarum. Prof Eugene. (he want abdomen straight away, no peripheral) then d momment i want to measure the sfh i kneel down and palpate the abdomen and the lump then awhile he stopped me and ask my ddx. after i fin palpate he palpate like palpate pregnant woman in front of me.. i so so so confused.ddx: i say pregnancy in very soft tone and the nurse behind dr yb chong tell me fibroids, den i say fibroids and ovarian mass. What u want to do next, pelvic examination and bimanual. ok. Prof eugene: do u straight away do that, den i say no, i will do speculum first. what u look for, i say the normal things we want to look for during speculum.then i say ultrasound. ok tell me more. den i answer to differentiate either is ovarian or fibroud or to rule out pregnancy, fibroid can see either is subserosa, intramural or pedunculated and can see

features of ovarian mass either is benign or maglinant.\then he asked the age of pt and say she just married young and no kids what u want to do? i say surgery intervention such as myomectomy or can do HIFU . do u advise her to undergo UAE? do you know what is UAE?i say yes i know, i will be hesitate to advise her bcx there is a risk that can cause uterus necrosis.he nodded and if she rejected the options what u want to do. i say i will advise her for GNrh, can reduce pain and bleeding. What is the disadvantage? can rebound back if stop. what else? do u know how much GNRH cause. i say vl expensive , How much? i am sorry prof i unaware of the price. Based on YOUR EXPERIENCE, how much the fibroid will shrink?? i donnoe la.. he say give me a figure? 99.3% i say no prof, less than 50% then he say ok, is far more less than that. what blood test u want do? i say hb, iron profile watelse?? cant think of, maybe he want ca 125. tell me the size of the fibroid? i say i would like to measure. NO, just tell me i say 24 weeks , he say ok fair enough. if u r the HO oneday b4 surgery what will u advise her, i say the indications and the complications, tell me the cx, so i say GA cmplication and he want what the worse scenario , i say if bleeding non stop dr may need to hysterectomy, he nodded and ring and finish..good luck everyone... pass pass pass...

MZL

Examiner: Prof CHee (cardio), external Prof WIlliam, Prof MT Koh (paeds)1st case- Bilateral PCKD with renal failurePlease do a quick peripheral examination & examine the abdomen.I did runnign commentary: No clubbing, no... (stopped and asked to do sth simpler)I straight focus on the AVF, said it was dilated blood vessels and commtied myself to AVF as eveidenced by presence of thrill. Inspection of abd: tenchkoff catheter present. no other findingsPalpation: bilateral ballotable kidneys. Left kidney was cystic. (both easily balloted) I straight away tell it was kidney by saying out the points supporting it was kidney when i was doing the manouvres (able to get above bla bla bla)gave the complete diagnosis: bilatteral PCKD in renal failure.what else u wan to check? I said Proctoscopy... to check for increase abd pressure for increase abd pressure.Asked the relevance to autosomal recessive or dominant. I answered dominant but he doubted me so I said i dont know (T_T) WHat is the most common presentation in PCKD? Hypertension. what else? Late stage: mass in abdomenI want early stage. hematuria. Ended 1st case.

2nd case- lipomatosis. Prof William (external)Q: ask the patient to show you the lesions.generalized swellings on abdomen, thighs and the back.FIndings:mutiple soft, mobile round mass which is non-tender, superficial to muscle, attached to skin and slip sign is actually positive (but i kept saying it was negative... now only i realise) I examined 4 lumps & gave simialr findings but was not stopped... (haiz)Finally he ask for diagnosis and I answered based on extensive generalized distribution I said neurofibromas. He accepted and asked what is the German name of the Neurofibromatosis.(they say the name was von Recklinghausen disease) I said I dont know. then erm, he asked what are the structures in subcutaneous tissue so I realized the diagnosis was lipomas... So I said it was more likely to be lipomas. =p So he asked how would you advise the patient now? benign condition, so reassure the patient and can cont with daily life. Then also can do surgical resection if complication arise... (I realized I dig my own grave)The following question is does it invade the vessels... is it

a true tumor and does it have a sac... I answered No and somehow he is not encouraging in the sense of givign answer =(ended as prof chee showed him time ran out.

3rd case screwed =(Prof MT KOhInstrcution:11 yo boy well & jaundiced. examine the hand.gross finger clubbingNo further instruction given. Asked about causes... I was stucked as he didnt gv further instruction.I said respi causes was denied in this patient and I said cyanotic HD also not in this patient and I answered GI system and he said yes. So now allowed to examine the abd,Findings: massive splenomegaly with no hepatomegaly.Discussed the causes: I said lymphoproliferative d/o & infection but not accepted. =(bell ringsAccordingly, jaundice + finger clubbing = liver cause. Examiner was kinda cruel, luckily not 1st case if not will continue to be in shock for the rest of the stations...

Tan Pei Wen
Med(handsome Prof SY Lim), O&G(Prof Khong), Paed(Prof Asma), Ortho aka observer(Prof Karmarul)
case 1: young malay gentleman, high BMI, sallor appearance, leukonychia, multiple incisional scar at bilateral UL only 1 is functional AVF, multiple incision mark at neck bilaterally for IJC insertion previously, super vague balloatable kidney at left lumbar.
Q1: why is the mass is kidney
Q2: formulate your diagnosis. ADPCKD on renal replacement therapy
case2: young malay lady, examine abdomen
gravid uterus with linea nigra, striae gravidarum and Fetal movement seen. SFH 30cm, longitudinal lie, cephalic presentation, 4fifth palpable not engage, liquo volume adequate, EFW 2.5kg.
Q1: if her EDD is confirmed, now at 34 POG, discuss...
smaller for date causes.
Q2: 1investigation to order
transabdominal us and ustify your answer la
Q3: if in clinic SBP 160mmHg, Proteinuria 2+, management?
Admit, monitor BP 4hourly, urine protein, 24hr urine protein, impending eclampsia symptom list out, baseline blood(FBC,LFT,RP,Uric acid),
Q4: you want to manage it alone?
refer to obstetrician
Q5: you are the obstetrician! everyone laugh....
then i would call paediatrician to stand by and blar blar....Prof Asma delighted and say yes! Paediatrician is very important you know! hahaha everyone laugh again
case3: 5yo malay boy, obese, come to clinic because of snoring at night, do relevant examination(dont worry i will guide you along the way)
-comment increase BMI, confirm by plotting at BMI chart, more than 95th centile is obese,
-got acanthosis nigricans at neck and axilla, obesity associate with insulin resistance
-do BP, cause high risk of HPT
-check for hypotonia in Prader Wille(she say he dont have)
-check tonsillar enlargement(this boy abit difficult to visulise so prof ask me to skip)
-check CVS for palpable P2(she want me to put the whole palm on the pulmonary area), loud P2, parasternal heave(put heel of hand at

xiphisternum or sternum also can). this patient has parasternal heave only
- check GIT for hepatomegaly for fatty liver(she say nonid cause he dont have)
- look at the aerochamber and inhaler, Patient has bronchial asthma with ventolin and fluticarsone, tell which is controller, rescue inhaler.

Wong Kee Cheong
External examiner: this is a 45 years old lady with para 2 + 2 came in with menorrhagia. Please examine her abdomen
On inspection there is a localized abdominal distension over the suprapubic and periumbilical region with linea nigra but no striae gravidarum. On superficial palpation it is soft and non tender but there is fullness felt at the periumbilical region. On deep palpation there is a mass the size of 20 weeks uterus (initially mentioned 12x8cm but was corrected) with smooth surface, non tender, no increase in warmth, well defined margin and cannot get below it. It is mobile from side to side but not in vertical plane, dull on percussion and no bruit heard. Abdomen resonant on percussion (no ascites), no inguinal lymph nodes palpable.
What is the origin of this mass? Uterus because it is in the midline, cannot get below it and mobile side to side
What other examination would you like to do to confirm its origin? Bimanual examination, the mass will move with cervix (examiner: no, it's the other way round, right? Yes), there is no cleft felt between the mass and uterus.
Patient is still having menorrhagia, what else would you like to examine? Signs of anemia: palmar crease pallor, conjunctiva.
What investigation would you like to do? Ultrasound of the uterus and full blood count.
Do you think this patient will want to get pregnant anymore? Yes, probably
So how would you manage her? Reduce the bleeding by giving tranexamic acid which is an antifibrinolytic agent.
How else to shrink the fibroid? (Bell rang) GnRH agonist!

Dr KL Ng: please look at this patient's neck and proceed (thyroid surgeon for thyroid case, aih)
This is a young malay lady sitting on chair and does not appear to be cachectic or anxious (he a bit irritated I think because he just wants neck). There is a midline swelling at the base of her neck and appeared diffuse, (gives patient a cup of water) moves with swallowing but not on tongue protrusion.
Examiner: OK, continue and tell me the findings of this swelling. On palpation there is no increase in warmth or tender. There are two masses felt, one on left and another one on right, the right one being larger than the left (actually both are very vague mass; forgot to mention size). Both masses have well defined margin, can reach below it, mobile, smooth surface and moves with swallowing but not on tongue protrusion.
What else would you like to examine? No cervical lymphadenopathy, trachea not deviated. Retrosternal percussion is resonant and no bruit heard over the mass. I think this is a multinodular goiter as it has 2 distinct swellings felt.
Examiner: so what is your differential diagnosis? Multinodular goiter, carcinoma. Why do you say it is multinodular? Because there are 2 distinct swellings felt. E: where are they? One at the left and the bigger one at the right. E: how many lobes are there in thyroid gland. Two.
Can you please look at the patient's neck while she swallows and tell me

again what you see. I think there is a midline neck mass that moves with swallowing (it's vague but it's there) indicating a thyroid swelling. Examiner: yes we are convinced that it is a thyroid swelling but what else you see? Really don't know.
Examiner: okay nevermind. What investigation would you like to do now? Thyroid function test and ultrasound of the neck. E: what do you look for in ultrasound? Determine if it is benign or malignant, diffuse or multinodular. E: that's all? To guide FNAC as well. E: what else? Er, to see any infiltration to surrounding tissues… (mental block, supposed to look for cystic or solid mass)
E: so now the FNAC result is back, shows normal. Thyroid function test is also normal. So how? Stunned, then bell rang (radioiodine test??)

A/P Saw Lim Beng: examine this lady's right knee (still stunned from KL Ng's station, not sure left or right, hentam saje examine both). Do a running commentary.
This is a middle age malay lady appeared to be alert and responsive on standing position (first impression, high BMI, no athlete look – OA?)
Inspection: left popliteal fossa swelling. Prof went around to look and said nevermind. Pointed out patient's left 4th toe shorten and ask why. I said don't know (I think he's pulling my leg, implying that if it's irrelevant don't say)
E: ok nevermind continue. No muscle wasting, no scars, no deformity (was anticipating varus deformity, none seen). Gait normal. On supine position: medial malleolus aligned in same plane – no shortening. Attitude of LL normal.
Ask patient which leg pain, patient said right. (E: nevermind, do the right one) Patellar tap was normal (E: how do you do it? Explain). Negative fluid shift test. Patellar mobile side to side and left to right.
Palpate knee structures: right medial joint line tender. (E: what do you think it is due to? Could be medial meniscus tear or osteoarthritis)
Lift right leg up, don't think there is any hyperextension. Active movement: 0 to 120 degrees. Passive movement: 0 to 140 degrees. (E: what is the normal range? 0 – 140 degrees. Is it applicable to everyone? No, some may have lesser (I think he wants me to say in high BMI people the fat at thigh may reduce its range. Mental block, can't think). So is this normal in this patient? I think so because it is just slightly reduced. So how do you confirm? By checking the normal side. Did the left side and confirm right side is reduced.
E: What is extension lag? on active movement range is reduced but passive movement normal range can be produced. So does this patient has that on leg extension? Did active and passive movement again to compare, none seen.
E: does this patient have hyperextension? How to confirm? Compare both legs. Right leg has slight hyperextension of 10 degrees. Prof agrees.
Special test: saw posterior sagging and confirm by putting a card at the tibial tuberosity. E: what else you look for to confirm posterior sagging? (bell rang) (mental block couldn't answer, suppose to be medial step off)

Josephine Tiong
Examiner : Prof Siti (O&G), Prof Kwan (Ortho), Prof CT Tan (Med), Prof Kalai (neurosurgeon)

Station 1 : O&G
29 y/o currently 37 weeks of gestation
Straight to abdomen. Inspect and tell the findings – linea nigra, striae gravidarum, no scar
SFH : 33 cm, smaller than date. Oblique lie. Fetal head on maternal left upper quadrant, demonstrate to her that it is ballotable, and also show fetal breech. Estimated fetal weight (I tembak 2.5-3 .0, she seems to agree and liquor is adequate).
What would you like to do for this patient currently?
Usual answer, admit cuz it's unstable lie after 36 weeks of gestation. Do U/S. She wants specifically femur length to tell that the baby is correspond to the gestational week after I tembak all the AC, AFI, and BPD. Look at placenta. Look at fetal anomalies. Look at mass.

Station 2 : Lump on the forehead (leaded by Prof Kalai)
Lipoma
Describe all the findings. Do transillumination as well (they all laughed when I took out the black roll of paper and pen torch). Mobility, auscultate (I offer to auscultate but they really want me to put stethoscope on it, just do lar, no bruit)
Final diagnosis : Lipoma
How would you know that the lump is connected to brain o nt? I said cough impulse. Show me how you do it. Ask patient do but there was none. So final diagnosis is lipoma.
How would you manage this patient in outpatient clinic?
If there is no increase in size, non-tender, actually can do nothing bout it.
But what if patient wan it off? Can excise it.
Prof CT Tan: When we cough, our brain pressure got increase o not ar? Got a bit.
Prof Kalai : What is the normal pressure of our brain? We always mention it during wardround. Erm…I hesitated. Then he said 'never mind, that's extra question. Let's move to the next one since you got time.'

Station 3: Right knee OA (leaded by Prof Kwan)
He asked me observe the knee. Squatted down together with me. Got bowing of the knee, what is it called? Varus. Ok good.
Lateral side? Got varicose vein and flexion of right knee. Ok.
He asked the patient to walk but I couldn't appreciate it. He said never mind, now examine the knee.
Inspection. Palpation. All negative findings. Just tenderness over the medial side. Presence of crepitus. Demonstrated to him how to do ACL and PCL tear.
What is the diagnosis? Right knee osteoarthritis. Ok good.
What would you do if you see her in Hosp Sungai Buloh?
Erm give her pain relief. Prof Kwan a bit triggered and he told me 'I'm very sensitive to the word pain relief.' I said analgesia. Isn't it the same as pain relief? Erm, non-steroidal inflammatory drugs. Why give? Cuz got inflammation. What else? Erm, steroid. So another one is? Non-steroidal. OK. What else? Ask patient to rest the join. Ok good. Erm, advise her to ice pack on it. Ok right. Elevate the limb. He said not necessary. Due to his ah ben's English, I could not pick up his English word of weight, I kept hearing him saying vague. "How would you want to reduce the 'vague' to alleviate the pain' I was like puzzled and he repeated twice. Another prof took over, what he meant was how you reduced the weight over the joints. Ohhh, I answer

walking aids. And the bells rings.
They are super nice. And they will prompt you when you have thought block or you are wrong. Hope they are super nice with my marks as well. Good luck to the rest. We shall all pass together as a batch!

nur syazwani abd wahab
prof fatimah prof phillip poi prof azlina pro external

1st case :PCKD
elderly chinese gentlman with AV fistula and technkoff catheter seen over right illiac fossa. hes alert and conscious, looks well nourished, not dehydrated. no significant bedside finding. peripheries: no clubbing leukonychia koilonychia no other sign of chronic liver disease, exmaination of abdomen, presence of bilateral ballotable kidney, no neprectomy scar seen, no cyst can be felt per abdomen, liver and spleen arnt enlarged, no ascites, no pedal edema,

question:
why do i say AV fistula,
where do u check for dupytren contracture
what is tenchkoff cath
why kidney not spleen
can feel the cyst
summarise: ESRF secondary tu polycystic kidney disease .
not so much discussion as i always get interrupted by p.phillip.

station 2instruction: this young gentleman presented with injury to his right knee while playing footbal, please examine the knee
do not straight away go to the knee, do systematic knee examination:
ask pt to stand inspect from front alignment, deformity, swelling, surg scar, no wasting of muscle, from lateral no flexion deformity from the back no swelling over popliteal fossa, no wasting of gastroc, no scar seen.
ask pt to walk: normal gait
ask pt to sit: temperature, crepitus, patellar tracking
ask pt to lie down,fluid shift patellar tap, bengkok 90 degree, tenderness kat semua tempat2 tu, check rom, check sagging and presence of medial step off,do ant drawer test; positive on right sight, varus valgus stress test intact..
dx is acl, ix do mri to see degree of tear , Tx PRICE and acl reconstruction

station 3 ricket ask pt to stand
inspect she is short, child is not obese weight is app to height not syndromic not cushingoid no webbed neck no low hairline no neck swelling looking for hypothrodism genu varus bilateral of legs look for sign of ricket : widening epiphysis at wrist, check for rickety rosary at costochondral jx if infant check craniotabes
question by prof fatimah
what do u think is the dx show ricket sign dont want chovstek sign
show sign of hypothyroid, turner sx,
what ix of ricket (se ca, po4, rft, tft, dont want bone age, knee xray, what to look for? dont want answer osteopenic and osteoarthritic chnges, dont know what she want) dont want vitamin d assay
what types of ricket-hypocalcemic hyperphosphatemic , what else?

hypercalcemic hypophospahtemic ricket??
what is the features hand of turner? i said shortening of 4th metacarpal bone.. hmmmm
..kring

LAM JO EE
examiners :prof leewayseah,prof tankaysin, external guy 1, external guy 2
case 1 : thallasemia- hepatosplenomegaly with scars on abdomen, no thallasemic facies at all
case 2 : multiple pregnancy
case 3 : infective endocarditis - tricuspid regurge
Case 1
Ortho (Dr.A) i dont know her name
Instruction, observer the hands and proceed
My finding: clawing of hand, with surgical scar over ulnar groove (but quite confuses me because the adductor pollicis still fx very well, was quite pning for a while
Q1: show me exactly where is the ulnar nerve sensory distribution (she wants to see the intact sensory over the medial half of the ring finger and loss of sensation over the lateral ring finger area)
Q2: Diff diag (I consider T1 lesion as well because pt has marked wasting over the dorsal interrosei and weak spreading of the fingers)
Q3: what common cause of ulnar nerve palsy (vomit everything)
Q4: Pt has diabetes: what might happen in this pt? (haha, compression over the groove that ulnar nerve passes.. =." just like the carpal tunnel syndrome but this one at diff place =.")

Case 2
Paeds (Dr Hong Kong) dont know his name =."
instruction, this pt has delayed in walking, observe and proceed
Q1: what do u think about his walking? (at first i said foot drop =." that kid walk to fast =." then, i said hemiplegic gait)
Q2: What are the findings? (UMNL findings of lower limb) hv difficulties in assessing the motor because pt doesnt really listen to me.. sad ="
Q3: Diagnosis (he wants left hemiplegic) (i didnt commit CP because i need more evidence =.")
Q4: where is the lesion (right brain, or along the left spinal chords lesion, it can be anywhere as long as it follows the motor tract before nerve root)

Case 3
Surgery? lump and bump (Dr. B) I dont know her as well =."
Instruction, perform abdominal examination.
Findings: on inspection, slight distend (mybe fat) then i realized there is swelling at the left loin area (Thank God i saw it) I perform abdomen examination, deep and superficial palpation is not remarkable, then i proceed on the lump that I saw earlier)
Q1: Provisional diag and diff diag? (lipoma, possible sarcoma, hernia, any diagnosis that I can think in lump and bump)
Q2: What ix would u want to to do? (ultrasound)
Q3: what else? (takes me few secs to tell because i dont want to say FNAC right away, but in the end yes i did say FNAC.
Q4: what findings do u expect from the FNAC? (well, in this case, I would

expect adipose tissue laa.. =.=")
Q5: how would you manage this patient (well, will reassure pt that this condition is benign, can be left alone. But still can resect for cosmetic purposes)
Q6: How likely is it for lipoma to turn malignancy (I said, very unlikely)

SCHEE JIE PING
Case 1 : external examiner
Right (unilateral) lateral neck swelling, NOT THYROID
Didn't get to finish examine, was directed to non-thyroid possible diagnosis
Answered cervical lymphadenopthy, overlying skin free so ruled out sebaceous cyst, in soft tissue offered lipoma, then time out didn't even get to a diagnosis

Case 2 : Prof Azmi
Uterine fibroid – usual examination
Size of a 18 weeks gravid uterus
What other organ would you like to check ? Offered a lot but Prof wanted ureter, with subsequent hydronephrosis
Management

Case 3 : Dr. Don't-Know-Who
Cranial nerve II, III, V and VII palsy
Right claw hand with fixed flexion of index and middle PIJ as well (combined median and ulnar nerve palsy)
Bilateral guttering and wasting of small hand muscles, bilateral ulnar nerve palsy
Charcot joint both ankles
Describe the hand deformities
If suspect ulnar nerve lesion what test to do ? Froment's test.
Describe and demonstrate Froment's test and describe if positive sign, what muscles involved and supplied by ?
What do you expect in this patient ? Right Froment's negative because of the median nerve lesion as well
Multiple CN palsy, peripheral nerves lesion bilateral as stated, charcot joint, diagnosis ??? not MS...

Tan Sye Nee
Case 1: Dr V (Neurosurgeon), Sorry that forget how his full name spelled.
Instruction: Examine the abdomen first and then proceed.
40+ Malay Lady, abdomen is distended with prominent swelling at epigastric region. (I thought it`s a hernia, was so happy..=.=)
The mass is firm, lobulated surface, irregular margin, cover from epigastrium to suprapubic area, especially buldging at epigastric. The patient was vy painful, so i can`t really determine wat is it. Then I very pandai ask patient to cough. OMG~ negative cough impulse. my dream of getting a hernia collapsed >< Then the doc ques me why do cough impulse, I juz find an excuse :p
Dr: What is your DD?
I: Epigastric CA, colon CA, pancreatic CA.. all are not accepted..
He kept asking what else, but I couldn`t think of anything that could give rise to such a big malignant mass.. He asked me to do periphery instead. Not much thing except thr was multiple LN palpable at submandibular region,

then he asked whr else you want to check. Then I said other LN such as axilla. He asked me to checked and observe the way I checked. I get a LN at medial wall. Then he wanted me to summarise my finding and give him a diagnosis.
I said lymphoma, still wat else.. I said 2ndary mets from somewhr but not sure the primary. wat else.. I said CML.. wat else.. I`m actually waiting for more obvious hints but then he juz discussed on lymphoma.. Tot it`s a surg case ><
Ix: FBC (pancytopenia), LFT (mets), PBF (blast cell), BMA, LN biopsy.. Then they rush me to 2nd case. The bell hasn`t ring pun.. Then I realize forgot mention an important ix - CT scan =.=
Case 2: Ext examiner - Prof Ng (The paeds award winner)
This is a 9 year old child with bilat LL weakness, pls examine his LL.
I started by commenting generally - child is alert conscious... small for his age.
Dr: Pls focus on LL.
Struggle a bit on LL neuro, bcoz the child has genu valgus.
The finding was hypertonia, reduced power R>L, hyperreflexia, no clonus, can`t elicit barbinski (patient kept withdraw)
Dr: What is your impression? CP, Which type? spastic. Which group of spastic? diplegic.
Few ques in the middle of PE: which muscle group that you usually tap for fasciculation on UL? I juz utter honestly, ALL?? He gt mention the real answer, but I was too nervous, din pick it up. Why you think it`s spastic but not rigid? thought block.. Once again, without the bell rang, they rush me to another case. So I thought my diagnosis is correct coz he din ask anything further. (After I went down to quarantine room only found out other prof din accept CP as an answer. it`s actually a spina bifida case..OMG~ I still have 3min left de le, why dun wan prompt me..=.=)
3rd case: Dr Aizura (Uterine fibroid)
Instruction: This patient presented with menorrhagia. Pls examine by starting from peripheral to abdomen. I do the way like obs periphery. Other ppl said their doc want they mention to check thyroid. But I din mention abt it..
1. What is the diff of uterine fibroid and ovarian mass?
2. What ix you want to do? US of pelvis. What you wan to look for? (hmm thought block.>< but she juz skip to next ques)
3. If this patient came in previously with 20th wk of fibroid, now shrink to 14wk, what you think the reason behind? She is on GnRH therapy. What is the pathophy of GnRH? (Seriously after 50% of ques abt pathophy of thal in LC, still wan pathophy in SC =.=)
4. What is the S/E? pseudomenopausal state --> osteoporosis, increased risk of CVS ds.. She waited for smtg, but I couldn`t answer further. I thinkthe answer she wanted might be recurrence after GnRH stopped.
5. She is 47year old. Do you recommend surg for her? I initially said yes.
6. What is the average age of menopause in women in Malaysia? 50 year old So I think after her period stopped, menorrhagia wouldn`t be a prob for her. However if she has compressive sx, I might suggest hysterectomy for her.
Doc nodded and said I can leave now. Then I went back to the waiting place and thr were still 3min left. Still wonder why they were so rushing.. >< but overall they were all nice smiling, at least not poker face. So although I din perform well, I din kena frightened :p

Tan Li Chuang
Prof William (external surgeon), Prof Bee PC (medicine), Prof Ong LC (paediatric), Dr Vally (O&G)
Case 1 Marjolin Ulcer
Instruction: Pls inspect this gentleman's leg and tell me your finding
PE: circumferential ulcer just above the right ankle, irregular in shape, rolled and sloped edge, forget to measure te size, granulation tissue pink in colour, yellowish slough, no exposed bone/tendon, right leg smaller than left, a scar seen over the medial aspect of knee with surrounding skin appeared to be tightening
After finish describing the ulcer, prof asked what do u think te ulcer is? I had no idea.. Prof told me he had some accident during childhood related to te scar.. i said probably burn? Ya.. burn.. so the ulcer is marjolin's ulcer.. wat type of cancer is it? histopathology of marjolin's ulcer? how u want to manage him? i said need to check his leg's neurovascular system to see whether the leg is still viable.. so do capillary refill time, ask me to point out the anatomical landmark of dorsalis pedis and posterior tibialis artery.. i think probably i point wrongly for dorsalis pedis, so prof asked me abt course of dorsalis pedis artery.. how do u want 2 confirm it is marjolin's ulcer? i said biopsy.. prof asked to point out the site that the biopsy will be taken.. after te biopsy is taken and confirmed te dx, how u want to manage? amputation.. asked to describe the scar again.. Kringgg!
Case 2 fibroid (just like all fibroid case.. similar questions)
Case 3 Gouty arthritis
Instruction: describe the patient's hands
PE: multiple swellings seen over the dorsal aspect of hand.. describe one by one.. joint deformity also.. palmar erythema.. check the function..
Prof Bee asked wat is your differential dx? what else do u want to look for tophi? show me.. what is ur advice to this patient? wat medication will u prescribed? wat type of pain killer? i said NSAIDs and colchicine.. side effect of NSAIDs.. how to monitor.. During PE, the patient said he had fracture of wrist during childhood that cause him to have deformity.. prof ong asked wat do u think te fracture is? Colles fracture.. FINISH!

Taye Zhi Ling
Case 1 Paeds (Prof Anna) -- 19yo/I/male, please do an abdominal examination
I start with peripheral (should just focus on abdomen). Prof asked about what am I looking for when I was checking the hand, and asked what is leuconychia and koilonychia. The palm appeared red and said it is palmar erythema. Prof said no and the red colour is because of compression =.= I said patient has sclera icterus but Prof didn't agree with me, even pull the curtain for me to examine under natural light. Abdomen examination revealed hepatosplenomegaly. Spend quite sometime on feeling liver and spleen, liver span 9cm and spleen 5cm below costal margin (mention in cm, not finger breadth. Bell rang when I just finished shifting dullness. Prof said,"owh...", I felt that she had the feeling of "sayang" cox didn't reach discussion. While walking to next patient she quickly asked," if patient has pallor, hepatosplenomegaly, what is your DD?" "Hemoglobinopathy e.g. thal..." "what else?" "Hereditary spherocytosis" (but I think these two is not the answer she wants...) But Prof Anna helps a lot, very nice.

Case 2 Surgery (Dr. Hari) -- around 60yo/M/male, do abdominal

examination.
I straight go to abdomen. Expose, see a swelling on umbilical region (umbilical bulging out). Inspect>comment presence of unbilical swelling. Ask patient cough, cough impulse present. Palpation> I said abdomen soft and non tender (Actually there is a big mass on right lumbar >_< patient is obese, I thought it is adipose tissue.. So please press really really hard and deep enough when patient is obese! Anyway Dr.Hari didn't seem like penalise me on that and he told me he had a mass at that region just before we left) after I comment on presence of cough impulse, reducible, Dr asked for diagnosis.
Me: It is umbilical hernia because it is center, round.
Dr: Dr. Azura (ortho) said it is a paraumbilical hernia.
Me: But paraumbilical hernia usually is crescent shaped...
Dr: Not necessary...
Me: Oh so it is paraumbilical hernia..
Then discuss on causes of hernia, incisional hernia, definition of hernia, pathophysiology of umbilical and paraumbilical hernia, different types of scar on abdomen and its indication, umbilical/paraumbilical which one more dangerous (which has narrower neck), management of hernia. Dr. Hari also very nice :)

Case 3 Medicine (Prof Adeeba) -- Old Chinese lady, c/o SOB, examine the chest.
Expose patient. Prof asked to inspect the leg. presence of unilateral pedal oedema (maybe both leg, but seem like one bigger than the other), with erythematous skin on fore foot, increase warmth.
Prof: Given the SOB and leg condition, anything come true your mind?
Me: DM. (Prof did not have any facial expression change, obviously I had a wrong guess)
Prof: Ok proceed.
Inspect for scar, look under the pendulous breast, then only realised there is a chest tube attached to the back!! (Didn't notice at first cox it is on the left, and when I went to end of the bed for general inspection, prof asked me to stand nearer (at the side) cox end of bed is too far for me to see anything, Prof Anna told me the same thing during the first case)
Prof: What is this? (Pointing at the drainage bottle)
Me: closed system... underwater... seal... drainage system (stammering)
Prof: What is this use for?
Me: Drain excessive fluid or air in pleural cavity
Prof: (=.=') What is that called??
Me: Pneumothorax, pleural effusion
Prof: Ok proceed.
After doing anterior chest wall, I wanted to present but prof want me to check the back first. After finish posterior chest wall, bell rang >_< Prof asked me quickly present finding.
Me: Right lung field appear to be normal; Left lung field has reduced chest expansion, dull on middle zone, stony dull on lower zone, crepitation on middle zone, bronchial breathing on middle zone and reduced breath sound on lower zone. Impression left pleural effusion and consolidation (Of course I didn't present in such systematic way, was totally a mess that time cox time up dy >_<)
Prof: Causes?
Me: Malignancy, parapneumonic effusion (sambil walking sambil cakap)

=THE END=

LEE CHIK SHENG
examiner: prof PC TAN, dr NG CH, dr Shekhar, External
1st case by external. respi examination on a 50+ age malay gentleman (not sure about the diagnosis) reduced chest expansion on right side, fine crep, reduced air entry and LYMPHADENOPATHY. Not much time left after general inspection, ant & post chest and neck examination. was asked for differential diagnosis. i answer pneumonia and lung CA. then proceed to investigation i manage to answer chest x-ray and Ct scan then ringgggg liao... ><

2nd case Prof PC Tan. was ask to do a obstetric examination. remember to ask the patient EDD and calculate GA because Prof purposely din give you anything * thx to LS tan for reminder =P* 30+ malay lady, EDD 36W+6 days. As usual, abdomen have linea nigra, striae gravidarum,..... SFH= 46 weeks!!! on Palpation 3 pole... Stopped by prof half-way and asked to tell the diagnosis >< is a TWIN PREGNANCY.. then prof : "tell me about twin pregnancy?" Start goreng things.. about amnionicity and chorionicity... which one more important? of course chorionicity because risk for TTTS. why twin pregnancy is important for obs? cause increase risk for all complication (PIH, GDM, PP..... basically every complication in pregnancy la) how to manage this patient? basically he wan to hear how to deliver and when to deliver.. the second answer he wan i forgot ady...

3rd case dr Ng CH Gluteul Mass 0.o
20+ years old Malay gentleman.. Right gluteal mass. size 15x 10. lobulated? Granulation, pigmentation and 3 ulcer on the surface. Soft to firm in consistency, limited mobility on both plane, not warm, not really tender, fluctuant, not transluminable, not irreducble, THRILLL(almost miss it), BRUIT (luckily i did put my stethoscope on his ass >.<)... was asked for diagnosis... i answer heamangioma, gluteal abcess, and probably malignant soft tissue tumour(increase blood supply?).. WHAT ELSE?? ==" allow to ask 2 question from patient.. mass swell out since 5 years ago and that time no fever... @@ extra bonus tips by dr Ng, the ulcer was caused by scratching due to itchiness and dr keep on stressing THRILL and BRUIT.. finally i vomit out AVM this word~ Investigation? ultrasound and MRA.. then bell rang!
= the END=

Niki Ho Wai Wye
Examiners: Prof Mary Marret (Paeds), Dr Azura (ortho), External examiner arabian?? (O&G), Dr Sia (neurosurgeon)
Case 1: Paeds
This is a 5 year old boy who came in with shortness of breath. Examine him.
M:On GE, blabla bla.no resp distress.
E: what is the evidence besides not tachypnoeic?
M:no accessory muscle use – supraclav, intercostals n subcostal recessions..Then I said he appears slightly bigger compared to his age, head proportionate to body, also has a high BMI.
E: What is a high BMI?
M: I said body mass index.

E: How do you know if he has a high bmi?
M: He appears that way, but I would like to plot on a growth chart.
E: Besides plotting, just observe and tell me why u say he has a high BMI.
M: I stoned for a while, then she said, its okay, he does look fat. Then I continued.
Check peripheries. Then I did asterixis.
E: Do u need to do this in a child without any resp distress?
M: No (in my head not sure but prompted means wrong ma),so I said no, he probably wouldn't have co2 retention.
E: ok,proceed.
M: Saw some scratch marks over his flexures, commented.
E: Do u think he has eczema?
M: I looked for skin lesions, none were seen..sigh, don't think he had eczema..So I said no. then proceed.
E: Please proceed to chest wall.
M: I said I wanted to lie the patient at a 45 degree angle.
E: No need, lie down supine will do.
M: Then I put the pillow 45 so got some angle for me.
E: Just leave it flat (I feel stupid now =( )
E: please examine the chest straight.
M: I would like to c if trachea is central.
E: It's hard in this kid. Just check the chest. (why am I stupid?stunned lah first case paeds =( )
M: inspection, blab la blab la bla. Then,put my hands on the chest together, examine for chest expansion.
E: Do you look for chest expansion like that in a young child? How would it be better?
M: I would like to just observe.
E: So yeah, do it.
M: Observe. Then I commented it is equal bilaterally. Then I asked kid to say ninety-nine..smart kid said 99 for me, examiners laughed..they said, he didn't say anything for the previous candidate.hahaha.after saying twice, he decided he didn't wanna say, then prof said proceed.
M: percuss. Auscultate….. (Crap, normal findings….did I miss anything??keep listening..normal)
M: I would like to proceed to the posterior chest wall.
E: What are ur findings so far?
M: normal vesicular breath sounds were heard,with no adventitious sounds such as crepitations or rhonchi, there was no prolonged expiratory phase.
E: Ok, it's the same for the back then.
E: What if I tell u he had a prolonged cough for 1 month, n now presents with shortness of breath.
M: On the table, there is also a mdi and aerochamber
E: Yeah, those can be put there just for show…
M: Oh okay, but I would like to think that he has an AEBA.
E: NOW?
M: No, when he first presented. He's well now..
E: so for him, what are u worried of?
M: I'm worried that his asthma is not controlled. Because it can affect his growth and also social life. (don't know what to say, panick, blurt out answers only)
E: Yeah, but for him?
M: He has a 'high bmi' . So I'm worried steroids can worsen his weight

problem.. it can also be due to steroid use.
E: So what are u looking for?
M: any evidence of cushing.
E: is there any?
M: I said I would like to examine, so I said..over face, appears round, no acne or hirsuitism (feel like killing myself, in a kid got acne ar?? Not sure…why did I start here..should just go to the back for pads and also say abd no striae…zzzz)
Kringggg..
M: He is not cushingoid.
E: ok.

Case 2: Ortho
Please examine his back
M: went to the back, looked hard for any swelling..couldn't see..guys, the trick is to angulate, look from different angles..I bent down (flexed knees,almost squatted) ..then I came back up again.. n I saw the lump over the spine of scapula! I said there is a swelling seen over the right scapular region..
E: appears happy!
M: I mentioned, the swelling is located over the right scapula region, appears to be at the spine of scapular part…Size is roughly….
E: u can't really mention now right?
M: yeah, I will mention it when I palpate later.
E: ok
M: So I mentioned, shape, no skin changes, no punctum, no pointing sign with surrounding erythema, no bluish discoloration, no ulceration/discharge, no dilated veins, no satellite nodules, no other obvious swelling anywhere else..
E: Don't assume!
M: okay, sorry, I would like to examine everywhere else before saying that there isn't any other swelling.
E: smile.
M: Then I palpated, I measured 3x4cm. then said the margin is in continuum with the bone, consistency, non-mobile in both planes, no fixity to skin, surface.
E: anything else?
M: Urm, I think I don't need to do other tests like fluctuancy, transillumination etc.
E: ok.what else?
M: asked patient to abduct… then I palpated…it just moved along with the scapular..so I reported..
E: what movement do u call this?
M: urmmm…..
E: nvm, its called scapulothoracic movement.ok.so?
M: So in summary, this is a benign bony lesion, as it is less than 5 cm, has no dilated veins, no skin changes such as ulceration, no fixity to skin, no satellite nodules.
E: So?
M: In this age group, my provisional diagnosis would be a GCT (die..i also found it stupid to say gct first)
E: why GCT?
M: I said its common in the 20-30 age group. My differentials would include

a simple bone cyst, ABC, exostosis.
E: yeah.. Urmm..he's 20. what else?
M: Is there any other lump?Yes, over clavicle… (so, looks like Dr Azura was trying to hint me??..yeah..don't assume guys..makes an ass out of u and me..)
E: ahhh..see..
M: Yeah,I would think it is an exostosis.I would also consider multiple hereditary exostosis..
E: ask the patient a question..
M: ???? is there any pain?any fracture anywhere else before? Any rapid increase in size? He said, nope.
E: no,ask another question….
M: putting my thinking cap on!!!!.. OKAY, any other siblings or parents have swellings like this too??
Answer was no but yeah, I hit the question..she was satisfied..
E: where else u want to look for these bony lesions..
M: Sorry, I'm not so sure, but in the clinics, I've seen quite a few around the knees..
E: Yeah, in the clinics!Hahaha. yeah, it's usually around the joints right?
M: Smile.
E: How would u like to investigate..
M: I would order an x-ray to look for a pedunculated……
E: Pedunculated what?
M: Bone..?Zzz.hahaha..I said, also the real size of the tumour would look bigger than in the x-ray due to the chondral part which is not radio-lucent (I meant it as radio-opaque..she seems to understand what im saying..guess she knows I know so didn't get confuse..hahaha..always see me around in clinic as my last posting was ortho!lol)
E: OK.

Time wasn't up.I was brought to my 3rd station.
3rd station..Obs..
External examiner: This lady is G3P2 at don't know how many weeks.. his pronunciation very hard to catch larrrr.please examine her abdomen.
M: Introduce..then I said, ideally I would like to expose from the nipple line up to the mid thighs..
E: Don't u want to do a general examination first?
M: yes yes yes.. (some examiners don't like u to expose patients,probably especially in obs..be aware of when n what..i don't really know when actually) so I commented on GE.
Next,I went to expose..say again, ideally I would like to……
E: cuts my sentence, please do peripheral please..
M: (in my head, u said abdomen..now peripheral..so confusing..of course they're always right..just be humble k) So I checked peripheries..I said no clubbing.. (after I said that,I also was stunned..crap…)
E: why are u looking for clubbing?
M: kept quiet for 3seconds..
E: just do what is relevant in pregnancy.
M: no nail bed pallor, no palmar crease pallor.
E: where else u want to check for pallor?Demonstrate.
M: check the conjunctiva. (I did one side only)
E: so u check both eyes or one eye only?
M: (prompted means wrong) both eyes..

E: demonstrate.
M: demonstrated. Not pale.
E: so which part of the conjunctiva is this??
M: (I'm in sinking sand..don't give up!) I said I don't know.
E: is it the ocular part????
M: I'm not sure sorry.
E: ocular??? Or palpebrae?
M: palpebrae (vaguely I remember)
E: Ok. (means correct lah, no funny face.. yeah luckily got study a bit of opthalmo!)
E: what else in the arms?
M: stunned for 5 seconds.. (after exam, I think he meant hands lar..palmar erythema..etc..zzz don't know)
E: nevermind.proceed..
M: ideally, I would like to expose..bla bla bla..but I would like to keep it from the braline to slightly below the suprapubic for patient's modesty (I think in pregnancy this is the routine) So I exposed..(wahh..got scar)
E: what is the most obvious thing from this?
M: Oh there is linea nigra and striae gravidarum, and also a pfannenstiel scar.
E: The most obvious is the abdominal distension. The other examiners laughed..
M: Yaya, that's the most obvious (sigh,pregnant ma..too nervous to think of distension, checking for what to comment mah)
E: Ok
M: so the abdomen is distended with the presence of a gravid uterus, evident by the presence of cutaneous manifestations of pregnancy which are linea nigra and striae gravidarum. There is a well healed scar, no hypertrophy or keloid formation. I palpated for tenderness, there wasn't any.
E: What types of striae gravidarum do u know?
M: (diee..why so weird one….) I'm sorry, I don't know..
E: Thee….. new one..and the old one..
M: oh, the new ones are usually redder and the old ones are usually more hypopigmented..
E: seemed to agree…asked me to continue
M: saw fetal movements..commented..he said good.then I asked for pain and wanted to do superficial.
E: please do what is the normal obstetric examination…
M: palpated for fundus..sigh, it was about 30 weeks size..so I didn't start from xipihsternum..I almost reach fundus..then I went back up from xiphisternum..he caught me..
E: So, where do u start?
M: the xiphisternum.
E: ok.
M: so I did again..n demonstrated.. I learnt most of my obstetrics from dr aizura in phase 3A. she expected us to do an estimation.. tips: from what I learnt, umbilicus level (lower border 20 weeks.upper 22weeks..if don't trust me, go find lah..this one is debatable amongst my friends too). Then xiphisternum is 38 weeks..below xiphisternum, 2 fingerbreadths is either 36 or 40..depending on whether there is flank fullness, present in the latter.. Wanted to clinically estimate before measuring..
E: ok nevermind..proceed to palpation..
M : (sad, didn't even get to measure!Now how I know how many

weeks?sad…)
So I palpated lorr..
E: What grip is this?
M: fundal grip.. I feel some fetal movements.
E: Good
M: I said I feel the breech here..because it is wider, softer.not ballotable.
E: what grip is this?
M: lateral grip..I didn't get to do both sides..he interrupted before I finished the other side..
E: what grip is this?
M: pelvic grip..
E: How many pelvic grips are there?
M: 1.. There is also the paulik grip but we r not supposed to do that as medical students as our lecturers here ask us not to do it..
E: why?
M: it may cause pain to the mother as we are not experienced enough.
E: okay, so there are 2 grips!
M: ok.
E: so present.
M: this is a singleton pregnancy in a longitudinal lie with a cephalic presentation, the fetal back is on the maternal left.
E: Left..
M: (not sure correct or not..might have felt wrongly..then only I realized I didn't do the other side..he lahhh…. Sad)
E: So what else?
M: I think the amniotic fluid is adequate..
E: ok what else?
M: (he interrupted a lot so I didn't mention engagement n estimated fetal weight yet..good thing also lah..didn't even finish my pelvic grip..just felt head then he started asking questions d..) I would like to auscultate for fetal heart sounds with a pinard.
E: ok.. So now, she came in at 40 weeks..size corresponds to date..in labour..how to manage her?
M: I would like to take a history to check for all the complications throughout the pregnancy.
E: ok they are normal. How to manage her?
M: I would like to ask for the indication of the previous C-sec.
E: Fetal distress.
M: at term or not at term?
E:why?
M: If at term, I want to know if it is due to CPD causes difficulty in labour and fetal distress..
E: no, just fetal distress.
M: (assume its not CPD I guess) I said, I would like to ask when was the last scar (important for scar rupture ma)
E: okay, she's well, pregnancy normal, prev scar >18m, how to manage?
M: Ok, now I can advise her to do VBAC (he didn't look to happy, I realized the word advice was wrongly used..a better phrasing could be like, I would like to counsel her on her options for delivery, whereby VBAC is included as an option for her)
E: So, what is the percentage of success in VBAC?
M: I'm sorry I don't know the number, but it is high (answer:70%)
E: (didn't look too pleased) ok. What is the risk of scar rupture?

M: Risk of scar rupture is 0.5%-1%.
E: he looked satisfied with my answers lah..
Ok, u're done now.
Time wasn't up..no 4th station lah..means I didn't do so badly, they didn't need to help..not too good lah I know where I stand..so yeah.. hahaha..
Walking back to the room, dr azura pat my back, said, well done! (made me happy all day long, felt confident enough to pass short case lah like that..hahahaha..must be thankful that my case not hard also.

Yeoh Whei Chuern
Examiners : Prof Tan MP, Prof Azlina, Prof Ong LC, External
Case 1 : Thyroid swelling
Q: - diffuse or nodular swelling? (I said diffuse but the external didn't say anything)
- Check thyroid status (did the whole set of examination steps and it took around 6 minutes d)
- Differential diagnoses (I said Graves')
- What is the most common thyroid carcinoma among middle-aged ladies? (Follicular)
- What Ix do you want to do?
Bell rang....

Case 2: Down's syndrome with speech delay. Now 5 years old, please do a general inspection and tell me your relevant findings.
- I describe all the features of Down's syndrome to Prof Ong LC
- Asked about the definitions of hypertelorism, low set ears and clinodactylyl
- What else to examine?
(CVS - AVSD, EYes - squint, nystagmus, cataract, Ears - OME, Mouth - enlarged tonsils, leading to OSA, Abdomen)
- What to do if patient has OME? (Grommet's tube)
- Asked to inspect abdomen
(saw a transverse scar over the right hypochondrium area with two other small laparascopic scars seen over the epigastric areas)
- What was the most likely operation that he had? (duodenal atresia, jejunal atresia, tracheoesophageal fistula, Hirchsprung's disease, but i think the answer that she wanted was pyloric stenosis)
- Do a fine motor DA for this patient
- Ask the mother 2 relevant questions (any siblings with the same problem, and what was her age when she conceived this child)
- Her mother was 40 years old
- Asked about the chromosomal abnormalities in Down's syndrome
- The type of inheritance for Down's syndrome
Bell rings....

Case 3 : Please examine this patient's abdominal system.
Relevant findings : Clubbing grade 4, dirty sclera, extremely lethargic, Bilateral pedal edema up to the knee level with some sacral edema, hepatosplenomegaly.
Told to do a full PE. So took up almost 7 to 8 minutes. Present findings almost 9 minutes already.
- Asked about differential diagnosis.
Bell rings... (External examiner told me that this patient had aplastic anemia)

etty salleh
examiners: Prof Aishah(observer), Dr. Hannah (paeds), Prof Sanjiv(med) and external (O&g)

case 1 paeds

-22/I/M, short stature? slate gray+pallor+jaundice+hepatosplenomegaly.(do running commentarily)
-provisional dx: Thalassemia. why?
-differential: malaria. why not? ALL. why not?-what ix to confirm thalassemia?
-when to offer splenectomy? why?
-what hv to educate or inform pt post splenectomy?
-what further mx? (history, other siblings got? family carrier? etc)
-what cx of thalassemia? (iron overload)
-how to check heart failure? show me?

case 2 gynae

-47 lady nulliparous(at first he didnt mention about nulliparous) with abdominal distention
-do inspection at the end of bed. inspection at side of abdomen..have to describe in details about the mass..size in gravid uterus (about 18-20weeks), shape, site
-palpation: simple palpation only..then he close patient's shirt.=.= describe
-GYNAECOLOGICAL differential diagnosis : uterine fibroid (he ask..what is fibroid? huh? actually he wants me to say benign fibroid =.=) adenomyosis (he stressed about nulliparous and can adenomyosis presented bigger like that? lol.oke..change la dx) leiomyosarcoma, ovarian mass.
-what type of ovarian mass?
-at first thought he ask on how to differentiate ovarian mass n uterine mass but actually its not..x faham wehh ape die cakap..maybe he ask what is the RF for this lady to hv ovarian mass kot? we skip that Qs
-if this fibroid what ix? said transabdominal USG for pelvic..he ask about what feature that we can say its fibroid from USG. (actually ingatkan dia tanya about what other ix..hehe..x faham weyhhh!! thanks god Prof Aishah explain to me..hihi)
-how to manage? said hysterectomy. stressed again about nulliparous. oke tukar and said myomectomy..then he asked..what is myomectomy? daaa~~ x tau ape die nak..he said is it removal of myometrium? or excision? what is myometrium? i said layer? no. the said wall? no. then said muscle? no. time ni dah stress n i just said oke do UAE and HIFU. but he said not there yet..and.times up!

case 3 med

-indian gentleman with mid sternotomy scar.
-what is my differential?
-how to differentiate between valve replacement and cabg?
-where to look at cabg scar other than sternotomy scar? what is the name of the scar? what is they take out? artery or vein? other place to look at the scar?(x tau)
-examine pericordium. got apex beat displace with s2 click sound
-what type of valve replacement you know? mechanical and biprostheses
-how to differentiate? mechanical got click sound
-what this gentleman need after do mecahnical valve replacement? said about warfarin and inr and food that shud be avoided
-in what condition hv to perform aortic valve replacement? AS n AR

-why AS and AR can cause apex beat displaced? AS: incr workload..need to increase pressure to pump blood. AR: backflow of blood cause increase...times up..tp prof angguk2 je..x tau la betul ke ape..LOL

Jaimie

1st case - surgery (dr Lau PC)
Examine her peripheries and proceed with neck examination.Euthyroid, diffuse swelling- how to demo tremor? - why thyroglossal cyst move with tongue protrusion?- how to demo pemberton sign?- how to see lid retraction?- forgot to do tracheal deviation. Cannot feel sternal notch also so he also gave up lo.2nd case - Paeds (Prof Ng PC -external)General examination before proceed with abdominal Thallasaemic facies. Hepatosplenomegaly- the boy looked quite normal. So everything also I mention with 'slight' cos he keep prompting me 'what else what else?' but feel like I'm faking signs only. He's like 3 shades fairer than his mother..- signs of iron deposition?- die die must make the kid lie supine with legs and arms flat on the bed before can proceed- how u know it's spleen?- what is that hyperpigmented scar? I said deferral injection site he said this boy is not on chelators. Then he ownself said nvm.3rd case - O&G (dr Nuguelis - got her for long case, really got fate)1 prev scar. Oblique lie- why check for scar tenderness? When will the scar usually be tender?- measure SFH wrongly, so I said large for dates. She made me say causes for large for dates before asking me to remeasure.- mx of oblique lie

Lily

case 1, surgery, examiner: dr ng (breast surgeon)
instruction: examine the patient's gluteal region. the moment i introduced myself to the patient (young malay guy, in his late teens/early 20s), he straight away lie prone and exposed his gluteal region. i started off with a general inspection and proceed to the lump. it was a huge lump measuring 15x15 cm at the lower medial quadrant of the left gluteal region. did the usual lump exam. was asked why i did certain things eg:why do you ask the patient to extend the hip joint? ans: to check for attachment to muscle and relation of lump to muscle. why do you transilluminate the lump? ans: to see if its cystic. why do you wanna auscultate? ans: to listen for a bruit. what do you palpate for before listening for a bruit? ans: thrill or pulsation. ok, palpate. baru perasan there's a thrill. and bruit on auscultation. he asked for differentials. i gave him hemangioma, haemangioblastoma. he asked what else. i tried to sell abscess, he asked abscess ada bruit ke? then i said ok, maybe not. he asked what else. i ans AV malformation. what's AV? ans: arteriovenus. what else would you like to examine if its AVM? ans: pulse? he asked are you sure? what pulse? i dono dr. anything in the lower limb u wanna examine? i dono dr. what investigation you wanna do? ultrasound. doppler ultrasound. CT scan, MRI. what other investigation specific for AVM? i dono. times up!
case 2, paeds, examiner: dr shekar
instruction: the child came in with recurrent chest infection. i want you to auscultate the child's chest from the back. the infant was sleeping, lying prone. told him that i wanna undress the child. he said no need. so i listened over his clothes. dont really know what i was hearing. then the child spontaneously turned to supine. he asked me to auscultate the praecordium.

seriously didnt know what i was hearing. dr shekar even used his paeds stethoscope and held the diaphragm on the child's chest and passed to me the other end to let me hear. i wasnt sure what it was. felt so terrible.. then he asked what if i say this is a systolic murmur? what do you think of? gave him all the differentials for systolic murmur. then he asked me to proceed to peripherals based on my differentials. i did the usual cvs exam. he asked what do i think of now. i said acyanotic heart disease coz no cyanosis. he asked what could be the dx. what cause pulmonary congestion? i said vsd. he asked what else. i said pda. he looked so relieved when i said pda. he asked what is pda. i said a connection between.. then terus habis masa. juniors, pls auscultate enough patients, learn from my mistake. T.T
case 3, med, examiner: external
instruction: do a peripheral examination and examine the chest from the back. Halfway through peripheries, he stopped me and asked me to proceed to the chest, and cont with peripheries relevant to the chest findings. there was coarse creps. he asked inspiratory or expiratory. i said both. he asked really? confirm salah la tu. the relevant peripheral findings i did pedal oedema, apex beat. he said all irrelevant, i'm wasting time. i wasnt really thinking la actually, terlalu nervous bcoz of the previous station. then he asked for differentials. i said bronchiec and pneumonia. he asked what else. i said pulmonary fibrosis, but supposed to be fine creps. then he ased what investigation to diagnose pulmonary fibrosis? i said ct scan. then times up. he cont asking what type of ct scan. i really takde idea, just emm.. he said nevermind. another sad case. T.T

Atikah Samad
Prof Saw(spine ortho), Prof CK liam, Dr from O&N(don't know her name)

Case 1: PCL tear
examine this patient knee
Inspection : some of her toes are shorter than the other
Q : why is that so--> err congenital?-->ok proceed
Q : basically prof will ask every single step of what we are doing..mcm la diorg x tau kite tgh wat ape..ntah pape ntah
Q : why are you doing patellar grinding test? in what condition will patient got pain--> OA of patellafemoral joint
Q : what is the the ROM of the right knee? what is the normal ROM? is it the same for every one? --> no....so how do you want to know if this is normal for this pt?-->compare with the normal leg
Q : what is extension lag
Q : how do you confirm posterior tibial sag. (1.concavity, 2.no step off...show me where you feel for step off..3.ruler...how you interpret, where do you put the ruler?
Q : what does posterior tibial sag mean--> got PCL tear
Q : what is your diagnosis--->kring!!

Case 2: Obs
Dr give the history : 32 POG, previous CS, now placenta previa type 3

Dr keep pushing to do ur examination fast..faster dear faster2!! we want to discuss..menggelabah ayam la kat c2..bace bismillah tibai jek la
basically sume yg tibai 2 salah tapi kesilapan kecik jek la then dr akan ckp are u sure? do u want to cek again? jgn melawan ckp die..ikut jek kalau die

ckp kat situ fundus ke kepala ke angguk jek! jgn degil!
Q : what is the name of the suprapubic scar?-->fenenstiel scar
what is the importance of the scar
what you want to do next? --> palpate for tenderness
so if no tenderness what does it mean
Q: i got SFH 33cm..then Dr took my hand and put it at the xiphisternum..isn't that the fundus? angguk jek la..do you want to measure again? now got 37..what does it mean?
Q: i said head is palpable 3/5..ni pun main tibai jek..Dr ask what is the history i gave to you? PP type 3..so do you think the head can descend?--> no! do you want to palpate again--> head is palpale 5/5--> good!! lol sangat!
Q : what ix you want to do--> u/s to confirm the placenta placement..whatelse?--> kring!

Case 3: Respi
Patient complain of shortness of breath..examine the respi system

inspect..do periphery then prof said just go to the chest
Q : how do you look for symmetrical chest expansion?--> stand at the end of the bed ask pt to take a deep breath 3 time
Q : what is that thing at her posterior chest?--> chest tube
Q : before you do chest expansion what else do you want to palpate?
--> apex beat? ok palpate..
-->i can't appreciate after left lateral also cannot appreciate
Q : if pt got massive Pleural effusion do you expect u can palpate apex beat?--> errkk no?
Q : what other mediasternal structure you want to palpate to confirm the structure has been displaced by massive PE?-->> errkk trachea kot
Q : palpate got stony dull..show where the level
Q: if you got time to auscultate what you expect to find? reduce breath sound
Q: what is the cause of PE?--> transudative and exudative
Q: if massive PE what is the most likely cause? exudative malignancy?
Q: what do you mean by malignancy? --> errkk primary lung tumour or secondary mets?
Q: how malignancy can cause PE?--> kring!!

tips--> stay calm..erkk tapi susah jgk la nk stay calm..make sure you know the significance of all the step for your PE..

IK
dr sia(surg), prof kamarul(ortho), prof wan ariffin(paeds), 1 external
1)inguinal hernia
-examine-exposed,inspect ant+lat
-palpation
-irreducible hernia, causes?
-other examination??-abdomen, pr, respi..why??
-quest: -differ btwn inguinal n femoral hernia
-direct vs indirect, what test?-occlusion test
-anatomical of occlusion test, show examiner
-anatomical direct vs indirect:int/ext inguinal ring
-contents of inguinal canal

-investigation?
-what surgery?open vs laparoscopic
-hernioplasty vs herniorrhaphy
-what nerve injured during operative surgery?
-complication of inguinal hernia n repairs
(dr sia asked so many quest i dont rmmbr much..lol)
2)anterior cruciate ligament tear
-examine-gait,inspect(ptnt got scar, interpret scar on the knee..arthroscopy scar?lol),palpate,drawer tests,lachmann test,stress test (y 30 degree vs 0?)
(im not strong enough to demonstrate drawer n lachmann test, prof kamarul helps me..<3)
-quest: -interpret findings, mode of injury,s&s(pop sound, pain, swelling, instability, give away)
-meniscus tear?
-investigation
-management: REFER!!
3)clubbing,jaundice,splenomegaly(10 years old boy)
-examine-clubbing,jaundice,splenomegaly(dun forget traube space!)
-quest: -causes of jaundice(pre hepatic post)
-history from family(stools,urine)
-unconjugated vs conjugated
-causes of splenomegaly
-discussion is more on biliary atresia
(prof wan is so cool..lol)
tips: stay calm, be confident, just do it!lol

Pang Suan Choo
Examiners : Prof Bee, Prof Ong (Paeds), Prof William(External), dr 'valli'(O&G)
Case 1
Prosthetic heart valve
Questions :
1)location of JVP
2)which valve replacement (aortic)
3)complications
4)if ptt going for operation, how would u mx him?(antibiotic prophylaxis, stop warfarin, start heparin, restart warfarin)

Case 2
Breech presentation
Questions :
1)Why linea nigra present in pregnancy?which hormone?
2)Where would u put the pinard's stethoscope?
3)Ptt came to u at 37 weeks, what inv would u do?
(ultrasound to look for.....+fetal anomaly(dr valli want this asw)
4)how would u mx her? (external cephalic version, if fail--> LSCS)

Case 3
Rooftop scar with splenomegaly
Questions :
1)Why do u think the liver is nt palpable ?(liver cirrhosis-->shrunken)
2)What do u think happen in this ptt? (Biliary atresia--> Kasai procedure-->complicated by portal HPT)

3)What can portal HPT cause?(dilated vein on abd which i missed n eso varices--> massive bleeding)
4)if this ptt going for splenectomy, what would u giv her? (vaccinations.....)
5)prof william : why do v need to giv those vaccination? (overwhelming postsplenectomy infection syndrome)

Syazwani J.
Examiners: A/p frm NUS, dr.nuguelis, another external n 1 our very own surgeon.. he's a dr n i was not sure of his name

Case 1 (Obs).. Instruction: plez do abdominal examination on this patient. She's currently at 37 weeks..
Findings: Transverse lie
Q1: How do u wanna manage dis patient at clinic
Q2: How do u wanna deliver this patient. How do u wanna manage

Case 2 (Surgery) Instruction : Plez examine dis patient's neck
Findings : multinodular thyroid mass.. MNG
Q1: Wat do u think bout da mass?
Q2: Wat investigations u wanna do for
Q3: wat r da signs u wanna look for for hypothyroidism

Case 3 (Medical) Instruction: Plez examine this patient's lower limb
Findings: Bilateral hypotonia, power 0 except for knee flexion which was 2, areflexia, loss of sensation in gloves n socks distribution
Questions n discussions were asked throughout the p.e.
Q1: Do u think dis patient will have sensory levelt? (dis was way before i checked da sensation for dis ptn).. Explain ur answer..
Q2: Do u think dis is a spinal cord lesion?
Q3: in wat spinal cord lesion that could lead to LMN instead of UMN
Q4: wat's ur diagnosis? wat investigations u wanna do..

(Basically for the 3rd station..i almost die d.. horribly done.. it sounded in order in here nut it was totally a mess during the sc.. Good luck guys!!!....)

Sarah Hafiz

1. Polycystic kidney disease (medical) (Dr Ch'ng I think)
- abdomen examination
- findings: AVF fistula, distended abdomen, enlarged bilateral kidneys
(Q)
-differentials for bilateral enlarged kidneys (I gave unilat diffs too)
-complications from pcos + other organ/system involvemet
-how would you manage the patient

2. Multiple lipomatosis (?) (orthopaedics) (Prof Kwan)
- Examine the back. Given a lump at the spine, 4x5 cm, circular, smooth margin, firm, mobile, attach to skin, not attach to bone/muscle.
- (Q) differentials for single lump
- later prof turned the patient and showed multiple lumps on the abdomen
- (Q) what is your differential now?

- What is the genetic predisposition? (autosominal dominant... i couldn't guess it right orz)
- How would you investigate this patient?
- given a scenario: the lump on abdomen has become larger. What is your management?

3. Development assessment (paediatrics) (Prof Wan)
- 5 month old child

Yogitagavari Yoganathan Yahambaram

1. Thalassemia (paeds external examiner)
-a full gastrointestinal examination
-only have hepatoslenomegaly and injection marks on the abdomen
-have to explain from the beginning for everything u check and give reasons
-finally ask differential diagnosis

2. Thyroid (surgery-Dr margaret)
- examine the neck and thyroid status
- Multinodular goiter (describe everything bout it)
-thyroid status examination-euthyroid
-give differential diagnosis
-what investigations : TFT, Ultrasound, FNAC (give reasons)
-management
-advise if patient going for surgery
-complications of thyroidectomy

3. Cardiovascular (medicine prof nortina)
-full cvs examination and do a end commentary
-median sternostomy scar and prosthetic click
-describe about the click, what is the most likely valve involved
-is the patient in failure? why?
krinngggg!!!! all the best everybody

Siti Nurhdayah Zaini

1. Leprosy (ortho external examiner)
- pleaze examine patient hand neurologically (very confuse question)
- i want to do running commentary but the external said do end commentary...very hard to do end commentary becuase i was not present what i suppose to...very sad...
in summary...
- look : bilateral claw hand, wasting of hypothenar muscle..scar at medial side of elbow (i didnt see this but my friend who get the same case see this),
- feel & move :
ulnar nerve : reduced sensation at ulnar nerve (high and low lesion), all motor supply affected (positive froment sign, FCU, interossei,)
median nerve : sensation not affected, unable to complete the examination becoz the external interrupt me while doing examination
radial nerve : unable to do
Q : so what do u think about this pt ?
A : high ulnar nerve palsy

Q : did other nerve affected ?
A : i didnt completed the examination bcoz the examiner interrupt me..(other candidate said median nerve affected)

kringggg.....
Q : what investigation?
A : nerve conduction study
Q : so what do u think the abnormal about this pt ?
A : err.....(on the way to second case)

p/s : plezz do running commentary if it was our examiner...very sad i get external examiner...

2.obs : multiple pregnancy (dr nugulis)
please do abdomen examination .
Inspection : abdomen is distended with gravid uterus evidence by linea nigra and striae gravidarum. no scar noted
palpation : abdomen is soft and non tender. sfh = 46 cm (larger than date). more then 2 pole can be palpate , no fluid thrill elicitet
 Q : causes of larger than date
Q: show me the fetal back (see where the fullness is)
Q : investigation u want to do at clinic ?
A : ultrasound
Q : if this pt coming to u at 38 week and come with sign of labour, what u going to do ?
A : depend on presentation of leading twin, if the leading twin is vertex , can do SVD but if transverse or oblique.. straigth away caesarean section.... after delivery of first baby, clamp the cord... if the second baby is transverse or oblique lie.. can do ECV or internal podalic version (but current not do anymore) just straight away go to OT....

p/s : dr are laughing when i tell them how to do internal podalic version theoritically...practically...they didnt practised it...

3. surgery : lipoma (unsure the surgeon name , new lecturer maybe)
Please examine the abdomen
i inspect the abdomen and palpate as usual.
initially, i noticed already the lump at left flank but i didnt go to that lump bcoz the question is examine the abdomen.
but actually u can straight away go and examine the lump
- describe all about the lump
- Q : so what ur diagnosis
A : benign soft tissue such as lipoma , sebaceous cyst, haemangioma
Q : what is likely
A : lipoma bcoz mobile, postiive transilumnation test, fluctuation test ,and slip sign
Q ; why not sebacous cyst ?
A : No punctum seen
Q : why not haemangioma ?
A : usually the colour of skin is bluish and purplish
Q : investigation ?
A : MRI to look for soft tissue extension
Q : if it extend to other places, what ur diagnosis ?

A : liposarcoma...

the end
p/s : i finish earlier than other..about 2 minute earlier..quite happy...if u all get lump and bump...it was a gift..practise it...sure pass...ok...gud luck

PuteriNadiah
Examiners: Prof Adeeba, Dr Si Lay, Prof Ng Wai Ming, Prof Rahman (external)

1) Obs:
Normal pregnancy, prev. LSCS
Abdomen exam
(obs)
Questions:
Pathophysiology
of linea nigrae, striae albicans, gravidarum
How to test
for scar tenderness, importance
Proper way
to use the Pinard, results/interpretation
Discussion
on vaginal delivery after c-section, risk of uterine rupture
If the
patient comes in with uterine contractions, what will you do?

2)Surgery:
Indirect hernia
Hernia exam
Questions:
Differentials
for inguinal swelling
Difference
between direct and indirect hernia
What other
examinations would you like to do, and why? GI, Resp, PR
Complications
of inguinal hernia
Investigations

3) Ortho:
Look and proceed..hands: a healed scar over the dorsum of the hand and 2 swellings seen.
First: I did
the screening test for radial, median and ulnar nerves (? Scar,finger escape). However, it was normal.
Second:
proceeded with lump examination on both of the lumps seen.
Differentials:
Ganglion cyst, lipoma
Access the
joint function
What else
you would like to do? Neurovascular, lymph nodes, find for other similar

swellings..
Examiner
showed me another swelling with the similar presentation over the ankle and said it was familial. What will be the diagnosis? I said xanthelasma..he said ok..THE END..finished 5 mins earlier..just hoping for the best :D

Ahmad Mahfuz Zamaili
Same examiner with azlan.
1-med
Hepatoslenomegaly,leukonychia,pedal oedema,?kidney-heard prof said about pkd at the back,
Q-diff dx,itu je.sangkut kat cni.no ix n mx
Dunno la

2.obs
Normal preg
Q-if unstable lie-mx
If in labour-what do u want to anticipate
How do u want to deliver-

3-orto
R arm swelling
Attach to bicep
Dx-lipoma

Cheong YW
My case: 2 external, dr nuguelis, dr. PC Lau
First case, multiple sclerosis
Muscle wasting, Fail to elicit hypereflexia and clonus
But examiner kind and lead me to diagnosis. He said let said she got blindness
What investigation: MRI
What else, then kring
Second case, normal pregnancy with one previous scar
How do u know previous surgery is classical or lower segment? I ans based on history. What else? (the answer she want is hospital record, =,=ll)
Counsel her regarding this pregnancy(VBAC, risk of uterine rupture)
Imagine u r the houseman on call, what u want to do? I answer observe carefully, look hard for sign of rupture (the answer she want is insert line and draw blood for cross match and other investigation =.
Third case thalassemia
Frontal bossing, prominent maxillary bone, hepatosplenomegaly and hyper pigmented spot over right iliac fossa. Differential for the pigment spot: I ans iron chelation. He said no.
Ask me about differential (leukemia, lymphoma)
Examiner: So, just now u should palpate lymph node, right? T.T

Ss
1) paeds - examine the abdominal system
just pallor, needle mark at abdomen... prompt by examiner tu percuss trhrobe space again... dull.. Differential - Xpress shortcase ... Ix u want to do. bla bla bla. . if pt Hb 9, wbc 6 pt 300 what do you think... bla bla bla

kringgg!
2) ortho - lump at right arm..... you differential - lipoma, cyst, rhabdomyoma... how u want Ix - u/s, xray, mri, biopsy... type of biopsy - 2, histo cyto bla bla... size of needle use? sorry xknow. kringg!
3 - obs - external examiner cannot understand sgt... start with peripheral, wat need to do, what is this what i that explain everythng about examination technique, transverse lie, how u manage...

Pey Pey Yap
Case1(prof pc tan): normal pregnancy with 1 previous scar-discuss about the five-fifth palpable, engagement, concern for this patient.
Case2(prof shahrul): Adult bilateral Polycystic kidney disease-causes of ballotable kidneys, ix
Case3(prof ng wm): ACL tear, not obvious, i think.
Good luck to whoever reading this!

Wei Chun Gan
case1(prof Ong)-examine the patient neck..thyroid mass..check the thyroid status...what is ur differentials...investigation...case2(prof Khong)-examine the patient abdomen..start with periphery..is a pregnant lady..what is the cause of polyhydramnions and its mx..case3(extenal)-observe the patient gait and proceed...parkinsons disease...investigation for wilson..mx...

Lee Yin Yee

Prof Azlina
1) Pt had an accident pls do a right knee examination. (PCL tear-Posterior sagging, loss of medial step off)
Q: do u think there is ACL tear as well? PCL tear usually associated with MCL or LCL tear? Y need to do stress test in 0 and 30 degree? What investigations? Can arthroscopy be diagnostic and therapeutic tools in this case? (yes) Do u wan to do mri first or arthroscopy first? How u wan to manage the pt? (physioT) If physioT did not work, what u wan to do? (repair)
Prof Fatimah
2) Please assess this child growth (13 yo)-When wan measure pt height and weight, notice she has bow leg and short stature.
Q: what do u think the causes of bow leg? What else u wan to check if pt got rickets? (Rickety rosary, widened wrist) do u think pt got widen wrist? Blaunt dz cause unilateral or bilateral bow leg? what ur bone contain other than calcium? (Phosphorus) What causes rickets? (actually she wan the genetic x linked hypophosphatemia I think) What investigations to do in rickets? (serum calcium, vit D, phosphorus, PTH, ALP) what is the fxn of PTH? ALP level increase or decrease? What other causes of short stature? (I mention Turner) do u think this girl has turner? (no web neck, no widely space nipple, no 2nd sexual characteristic) what u wan to check for 2nd characteristic? (pubic hair, breast development et) pt had breast tissue, do u think the dx of

turner fit? (no) what else u wan to check for turner? (cubital valgus)- and prof F relieve
External – not really understand his language, bt our profs are happy to help translate (Prof Phillip)
3) Examine this woman (G2P1 @ 38 weeks POA), start from peripheral
Q: what do u think the scar is due to? The abd is more full on maternal right, do u think is normal? how many types of striae gravidarum? (
I answer 2 because during LC, chiew yen got him as examiner and he told her got
2 types, however I only able to name one type- striae gravidarum albica, the other forgot what he told me liao) how do u listen for fetal heart sound? (he got his own method @@) how do u want to manage this pt?
Profs ll guide u if u got thought block… good luck

Rahmah Rambli
Examiners: Prof KJ Goh, Dr Valli, Dr Hannah, Prof April

Case 1 (medicine prof kj goh): Proceed with respi examination
- right tracheal deviation
- mid to lower zone coarse crepts
Q: is it normal to hv tracheal deviation? Which side? - yes, to the right
Q: present ur finding. Dx? - bronchiectasis bcoz of coarse crepts but no clubbing. Can be also dt lung fibrosis however lung fibrosis usually hv fine crepts.
Q: how to diff bronchiec w fibrosis? – look for presence of sputum mug w copious sputum (bronchiec)
Q: causes of lung fibrosis. – SCART RASIO (refer talley).
Q: So what do u think the dx of this pt? – lung fibrosis with RA
Q: how u want to confirm that? – check hand. (go n check hand-some arthritic changes)
Q: if u palpate this part of the finger (pointing to the deformity), what will happen? – pt will hv pain if acute arthritis. (prof agrees)

Case 2 (obs dr valli): 34 weeks G2P1. Examine abdomen.
- 39cm SFH which is larger than date. Singleton, oblique lie etc..but actually it is a multiple pregnancy case.
Q: other than peripheral examination, what other thing u want to check in pregnant lady? - Thyroid n breast. Why breast? To look for any lump & look at the nipple whether it is inverted or everted, impt for breastfeeding later. (she agrees)
Q: causes of larger than date. Elicit polyhydroamnions – do fluid trill
Q: assume this is multiple preg, what r the cx – divide into maternal (anaemia, gdm, pih, preterm labour, pph, PP) & fetal (preterm, discordant growth, TTTS)
Q: type of twin that u know – monozygotic mcda mcma dcda & dizygotic
Q: how to diff? when? – usg at 10-12 weeks, lambda sign in dizy & T sign in monozy.
Q: TTTs occurs in which type of twin preg? MCDA

Case 3 (paeds dr hannah): 6months old, examine CVS

- ESM at LSE, 4/6
Q: what else u want to check? – apex beat for cardiomegaly: displaced to 5th ISC ant axillary line
Q: what else can u see? - Subcostal recession. So what do u think? - This pt is in failure.
Q: So what do u want to do? Check for cyanosis, hepatomegaly, crepts. (check all the signs)
Q: dx: PDA, ASD in failure (however i mention vsd as my 1st dx as i cannot diff esm or psm initially :D)

Amirul Amzar

Examiner: Prof Ong paeds, Prof Wilson external surgery, Dr Azlina ortho

Case 1 ortho: An indian gentleman with lump above elbow, soft in consistency, measures about 15x20cm, non tender, no skin changes, not transluminate, slip sign i'm unable to elicit since too big of a mass
Q: what else u want to do? check whether intramuscular or extramuscular. How? by flexing the muscle and feel the mass
Q: DD? Lipoma, sebaceous cyst but unlikely since not attached to skin and no punctum.
Q: Ix? US and MRI coz more sensitive to soft tissue
Q: MRI done and most likely is lipoma, how manage? Depends on the preference of the patient and whether slow growing or fast growing. Explain to the patient about the choice of treatment
Q: if fast growing what u worry of? malignancy

Case 2 surgery: A malay gentleman with stoma on LIF and big mass around the stoma and also laparotomy scar. Also got left lower limb swelling. Inspect the patient and proceed. I inspect and say wanna proceed with stoma examination, he said good and said inside the stoma got feces. I answered that hence it is most likely colostomy.
Q: What else u want to know? by presence of spout and nature of the orifices either single or double.
Q: what u want to do else? I asked the uncle to cough and seems to be positive cough impulse around the mass and stoma, i commit to parastomal herniation.
Q: good, why this patient have this? Probably intraabdominal mass or prolong coughing, and also this patient is obese.
Q: what else u want to do? I percuss the mass and auscultate and commit that the content is omentum
Q: why do u think the patient have colostomy, i said APR since got laparoscopic scar.
Since we got time left, lets check the leg
Q: Explain the finding. From inspection i commit that this is a cellulitis since unilateral left lower limb swelling with erythematous skin changes and shiny skin.
Q: Good, why do u think this patient have this in relation to the prev operation? Probably previous DVT causing chronic venous insufficiency hence causing slugish flow and now infected.
Q: What else u expect in chronic venous insufficiency? presence of chronic venous ulcer which i point out neear the 5th fingers

Q: What organism causing the cellulitis? Staph or strep. In this case it is more localized so staph or strep? i answer strep.. he asked Are u guessing now? I am completely guessing now prof..haha, all other examiner laugh and he explained that staph infection would be localized and strep more spread.
Q: antibiotic given to this patient? luckily I got cellulitis after sukmum before and i answered cloxaxillin. Very good.
Now, let's check the ulcer, lucky me the bell ring.

Case 3 paeds: A 5 yo down syndrome came in with diff in hearing and speech. Inspect and explain. I tell all the features of down which have and dont have in this patient. The patient got hypertelorism and flat nasal bridge, small mouth and protruding tongue, flat occiput but no low set ears, single palmar crease and clinodactaly and also wide sandal gap.
Q: What are the complication or down and show how u wanna examine? heart for avsd and vsd since 60% of down got congenital heart disease, ear for OME, eye for strabismus, abdomen for scar for hirschsprung or duodenal atresia repair in infancy, liver and spleen which may enlarged in leukemia (which also will present with bruises and anemia) and lastly i would like to assess the development since most of down syndrome will have delayed development and IQ less than 80.
Q: u said u want to see the scar, can u examine the abdomen? i asked the child to lift the shirt and lucky me he comply, he lay down and pull up his shirt and miraculously like i guess there's a scar on the left lumbar to umbilicus. What do u think the scar most likely? Since on left side most likely coz of duodenal atresia. Good.
Q: now assess the fine motor. Reaching for my DA set i noticed that i left it on the 2nd station and start panic already. Then prof laugh and said it's ok, do with anything u have, i reach for the patient's cube (too big to use) and also a pen and paper. Prof ask me what u expect the child can do? a 5 yo can stack up to 9 cube and can draw circle, cross, triangle and square. Then last bell rang...yay...!!! Alhamdulillah..

P/S
1) examiner are there to help u, they will help u in any way they can, just show them ur smile and they'll calm u with their smile too.
2) for me short case is an enjoyable experience since in a sort of way u can show to examiner that u r thinking. plus, if u forgot sumting and struggle to remember it, and finally u blurt it out, the examiner laugh..their laugh made the session enjoyable.
3) be humble, do not be arrogant, treat the short case as one of the learning session too. if the lecturer show u new things, gladly accept it.
4) for me u can perform short cases in 2 way, either u show them ur great PE skill or u show them that u r thinking, i believe the latter is better since i'm not confident on my PE technique. for me, if we think of what we should do and why we do it, we can skip most of the PE and just mention it only, this will save a lot of time and impress the examiner on ur way of thinking.
5) u dont need to do all the PE steps to survive the short case. My examiner seems to be satisfied with the relevant PE only as long as u justify them.
Gudluck guys!!!

Ru hoi
Dr YB Chong, Prof Eugene Leong, Dr Choo YM and Prof Azad (aiya didnt get

him... coz my long case was Surgery)

1. Dr YB Chong (Med)
'This patient is well with no chief complaint coming for exam purpose. Please examine the respiratory system'
Findings: Elderly chinese gentleman, alert conscious comfortable not in distress, no clubbing, no Horner syndrome, everything normal in the periphery. When i wanted to palpate for apex beat, Dr asked me straight away examine posterior chest wall. The only finding is fine crepitations from middle to lower zones in both lung fields.
- So what is your conclusion? Pulmonary fibrosis as evidenced by presence of fine crepitations
- Initially i said there was reduced chest expansion at the L side, after I said fine crepitations both sides he asked if i still think that there is reduced chest expansion then i said no
- So what are the causes of lung fibrosis. Idiopathic, CT disease, silicosis, asbestosis (follow NK chew :))
- So what are the 2 investigations that you want to do? I said CXR and HR CT. Then he asked if you are at A&E no HR CT what would you like to do? That time bell rang already and we were rushing to other station and I said PEFR >< Mayb be ABG if pt is in respiratory distress, Im not sure

2. Prof Eugene Leong (O&G)
' Please examine this lady's abdomen'
I felt a bit insecure, so i asked just abdomen? He said yes then i proceed. Inspection, abdomen distended with gravid uterus as evidenced by presence of linea nigra and striae gravidarum. No scars seen.
- superficial palpation abdomen soft non tender
- SFH 41cm
- If i tell you she is 36 weeks, what do you think? uterus larger than date, discuss the causes. Polyhydramnios, pelvic mass, multiple pregnancy
- Palpation can feel multiple poles but i was scared to commit so initially i said singleton cephalic. Prof said do you want to check again? of course! lol
- Then changed my answer to multiple poles felt, suggestive of twin pregnancy
- How do you confirm your findings? i said US? How? Initially i said lambda sign and T sign. HAHAHA and he said but term already how to see that. LOL then i said see 2 fetus, separating membrane cause i really dont know >< He said nevermind...
- If this patient is well and uncomplicated, how do you manage? I said can wait until 38 weeks and if leading twins is cephalic, can deliver via SVD. Is that what we normally do? I said here we do elective CS at 38 weeks. He asked are you sure? Hesitated a bit but then it rang~~~ So move to other station.

3. Dr Choo YM (Paeds)
Please assess this patient's development.
I think this pt is about 1 to 2 years old looking at the size. (I didnt say this out of course)
He was sitting on the bed playing his toys and when the mom comes he start to cry ask mom to pick him up. then I asked the mother to let him walk but Dr said no need. Then asked mother put him to sit on the bed again but he started crying again >< very irritable child. So nvm let the mother hold him.

Then i started take out my toys. Initially he didnt seem to be interested but as i took out more he was thrilled. palmar grasp ok. Fine pincer grip ok. But he was very attracted to my red pin. I thought it was quite dangerous to hold the red pin so i took it back and he started his tantrum again >< couldnt really proceed further. So Dr say nvm you observe what he can do. Next thing the mother took out his own toys and he played with toys again. I just told him what I saw but not so conclusive.. Then Dr asked what do you think about the language? Didnt hear a single word with meaning throughout the few minutes. Then at last summarise. Worst station. lol

All the best everyone! Hope we all pass together!
To juniors, take a deep breath after every station, dont ever let the previous one affect you. Good Luck!

Syamimi
Examiners: Prof Azad, Dr Choo, Dr YB Chong, Prof Eugene

Case1 (not sure either surgery/ortho): Do neck examination....
A lady with a neck lump over the right clavicle area (just lateral to the sternal angle),not move with swallowing or protruding tounge, no scar,erythematous area, firm in consistency, non tender, not warm, smooth suface, well defined margin, non mobile, no skin tethering, not transluminable, size of 4x3.5cm,
Q: Give ddx + ix to confirm dx

Case2 (paeds): a boy with hepatosplenomegaly + small bruise over left side periumbilical area.
Q: discuss about signs, give differential dx, what dx is most likely in this patient

Case3 (medicine): examine this patient hand- RA
comment all the RA stuffs seen on this pt, jt deformity, thenar+hypothenar muscle wasting, guttering, nail changes (to exclude psoriasis), no tenderness on palpation of every jt, presence of subluxation, hand movements, assess hand fx (ask pt to hold pen n write, holding glass, button/unbutton shirt), check elbow for rheumatoid nodules n psoriatic plaques, also inspect scalp. look at other jt- this lady also has RA changes of both feet.
Q: Dx-RA, Differentials...

RJ
Case 1
Dr lau pc (surgery) – parastomal hernia
Q: Do general inspection and proceed with abdominal examination
abdomen findings: parastomal hernia on the left iliac fossa with laparotomy scar
Q: what are the other complications of colostomy?
A: bowel prolapsed, stenosis, itchiness, infection, fistula(he said fistula very rare)
Q: how to differenciate bet colostomy and ileostomy
A: colostomy- left iliac fossa, content is faeces, no spouting..ileostomy- right site, fluid content, spouting
Q: what do u think of the age of this patient?
A: 50-60

Q: if patient comes to emergency with obstruction, what do u think this pt hv?
A: intestinal obs secondary to colon ca

Case 2
?external (paeds) - thal
Q: do general examination and abdominal examination
finding: pt got palmar crease pallor, multiple ict scar surrounding his umbilical,no organomegaly
Q: can u show me the edge of the liver? (still can't find the hepatomegaly..then he show me the exact edge..juz below the subcostal)
Q: can u examine the spleen again (struggling..even wif right lateral position, i still can't feel the splenic notch..then he try and say sumthing to the other examiners..hmm)
Q: What do u think this patient hv?
A: i think this patient hv thalassaemia bcoz the scar suggestive of subcutaneous injection of the ict
Q: what thalassaemia?
A: β-major
Q: do you think this pt is α thal?
A: no
Q: why?
A: it is rare..they usually die at early age (juz give my opinion..dunno laa)

Case 3
Dr.nuguelis (o&g)
Q: this lady is in 36 wks of gestation..plz examine her abdomen
My finding: larger than date, singleton, longitudinal lie, cephalic, -ve fluid thrill
Q: why u do fluid thrill?
A: it is larger than date so i would like to elicit fluid thrill for poly
Q: what is the cause of larger than date?
A: bla3..
Q: so u already exclude poly..what do you think this pt have? Would you like to examine it again (oh no! It must be multiple preg..but i still cannot really appreciate it)
Q: since u r still confuse..what would u do?
A: confrm the date frm the hx..1st lmp, quickening..then u/s
Q: what would u like to look for frm u/s
A: no of fetal, AFI, amniotic, chorionic

<u>Gerald</u>
Case 1
Ortho (Dr.A) i dont know her name
Instruction, observer the hands and proceed
My finding: clawing of hand, with surgical scar over ulnar groove (but quite confuses me because the adductor pollicis still fx very well, was quite pning for a while
Q1: show me exactly where is the ulnar nerve sensory distribution (she wants to see the intact sensory over the medial half of the ring finger and loss of sensation over the lateral ring finger area)
Q2: Diff diag (I consider T1 lesion as well because pt has marked wasting over the dorsal interrosei and weak spreading of the fingers)

Q3: what common cause of ulnar nerve palsy (vomit everything)
Q4: Pt has diabetes: what might happen in this pt? (haha, compression over the groove that ulnar nerve passes.. =.=" just like the carpal tunnel syndrome but this one at diff place =.=")

Case 2
Paeds (Dr Hong Kong) dont know his name =.="
instruction, this pt has delayed in walking, observe and proceed
Q1: what do u think about his walking? (at first i said foot drop =.=" that kid walk to fast =.=" then, i said hemiplegic gait)
Q2: What are the findings? (UMNL findings of lower limb) hv difficulties in assessing the motor because pt doesnt really listen to me.. sad =="
Q3: Diagnosis (he wants left hemiplegic) (i didnt commit CP because i need more evidence =.=")
Q4: where is the lesion (right brain, or along the left spinal chords lesion, it can be anywhere as long as it follows the motor tract before nerve root)

Case 3
Surgery? lump and bump (Dr. I dont know her as well =.="
Instruction, perform abdominal examination.
Findings: on inspection, slight distend (mybe fat) then i realized there is swelling at the left loin area (Thank God i saw it) I perform abdomen examination, deep and superficial palpation is not remarkable, then i proceed on the lump that I saw earlier)
Q1: Provisional diag and diff diag? (lipoma, possible sarcoma, hernia, any diagnosis that I can think in lump and bump)
Q2: What ix would u want to to do? (ultrasound)
Q3: what else? (takes me few secs to tell because i dont want to say FNAC right away, but in the end yes i did say FNAC.
Q4: what findings do u expect from the FNAC? (well, in this case, I would expect adipose tissue laa.. =.=")
Q5: how would you manage this patient (well, will reassure pt that this condition is benign, can be left alone. But still can resect for cosmetic purposes)
Q6: How likely is it for lipoma to turn malignancy (I said, very unlikely)

Jie Ping

Case 1 : external examiner
Right (unilateral) lateral neck swelling, NOT THYROID
Didn't get to finish examine, was directed to non-thyroid possible diagnosis
Answered cervical lymphadenopthy, overlying skin free so ruled out sebaceous cyst, in soft tissue offered lipoma, then time out didn't even get to a diagnosis

Case 2 : Prof Azmi
Uterine fibroid – usual examination
Size of a 18 weeks gravid uterus
What other organ would you like to check ? Offered a lot but Prof wanted ureter, with subsequent hydronephrosis
Management

Case 3 : Dr. Don't-Know-Who
Cranial nerve II, III, V and VII palsy
Right claw hand with fixed flexion of index and middle PIJ as well (combined median and ulnar nerve palsy)
Bilateral guttering and wasting of small hand muscles, bilateral ulnar nerve palsy
Charcot joint both ankles
Describe the hand deformities
If suspect ulnar nerve lesion what test to do ? Froment's test.
Describe and demonstrate Froment's test and describe if positive sign, what muscles involved and supplied by ?
What do you expect in this patient ? Right Froment's negative because of the median nerve lesion as well
Multiple CN palsy, peripheral nerves lesion bilateral as stated, charcot joint, diagnosis ??? not MS...

Fairuz Rani
Examiners: dr external Arab o&g guy, prof sanjiv, dr hannah, prof aishah

Case 1: o&g. Dr External Arab guy. This lady is pregnant. Please examine the abdomen. After inspection etc i wanted to do superficial palpation but he stopped me and said just do an obstetric examination. Then was gonna do SFH then he said assume that it is according to her POG. Then every grip I was doing he stopped me asked what it's called (fundal, lateral, pelvic)
How many types of pelvic grip? Err a few? (Hahaha)
Apparently got two types la but I really don't know
Then he asked what I want to do next : listen to fetal heart rate with pinnard. Where? Fetal shoulder.
Then summarise. Got the presentation wrong, it was breech but I thought it was cephalic. Haih. Then he asked how you'd manage if she's breech and she's in labour. Caesarean. If she's not in labour? Evc. How's evc done? How to get consent for cesarean?

Case 2:medicine. Prof sanjiv
Please inspect this gentlemans chest. Midline sternotomy scar. What could that be due to?valve replacement or CABG. If CABG where else u wanna look ? Legs for scar. (Long saphenous vein). If there's not scar there can u say for sure that he didn't have a CABG? No they can take another vein. What vein? Not sure. Nvm please examine the praecordium. Displaced apex beat. Prosthetic clic heard at aortic area. What valve? Why do I think it's aortic valve? Which heart sound does it coincide with? Tell me the different types of valves. What kind do I think it is in this gentleman ? Why? What are the complications of valve replacement (express book) ? How to monitor warfarin? (INR 2-3 or 2.5-3.5) why does he have displaced apex beat? (previous heart failure maybe due to IE or rheumatic heart dis? Dunno)

Case 3: paeds. Dr hannah
Please inspect and proceed.
Super hyperpigmented girl, malocclusion, no frontal bossing but there's maxillary prominence. Examine abdomen- scar at left hypochondrium. Hepatomegaly. Couldn't feel the spleen. Kidneys not ballot able I think. No shifting dullness. Think there was splenectomy. What are the complications with splenectomy? Predisposed to infection. What organisms. Encapsulated

like meninggococcal, pneumococcal and Hib. What else u wanna check. Pallor, jaundice. What are your differentials? How to confirm your diagnosis of thalassemia? What are the complications of thalassemia? (hypopituitrim, diabetes mellitus, liver cirrhosis)

All the best friends

Tan ChoonYean
1. ortho, prof kamarul, knee examination, PCL tear. lol was so slow i only manage to do until anterior/posterior drawer test, but manage to get to diagnosis so its ok la.
2. gynae, prof eugene, abdomen. suprapubic fullness, paramedian scar. no cutaneous stigmata of pregnancy. palpation, firm, 18cm, cant get below but can get above, mobile horizontally but not vertically. at this point he asked for differential, so uterine mass like fibroid, uterine tumour, adenomyosis, pregnancy, etc. lets say uterine fibroid how would u like to manage. the normal stuff.
3. surg, external(old western man look like angel), lump examination at left iliac fossa. so its a lipoma. and further ask what to advice, and how to manage. so i said reassure the pt its benign, he kpt saying patient say no i tink its malignant can you do smtg for me, i say FNAC, so what i expect to find, i said lipocytes, he said good, then patient still not satisfy, stil keep saying its malignant how, i say ask her go for 2nd opinion, and the whole cubicle LOL. actually they want me to say offer surgical remover. dont really know how to describe the whole senario but yea, that's my 30 minutes.

Adam
prof Anna, one guy from ortho and one from surgery

1st case - abdomen kid ~10 years old, came with haematochezia, has splenomagaly. Prof Anna did a lot of prompting on every step of the examination, could'nt read diff diagnosis

2nd case - cervical myelopathy, elderly malay man with dystrophia myotonica facies. Bilateral median nerve palsy evident by bilateral wasting of thenar eminences and gutterage of the first interosseus space. got really blur, he asked hand examination, the patient had hand deformity and foot swelling, i thought gouty arthritis... then he asked to do neuro go blur. burned this station

3rd case - swelling between the eyebrows. lump bump case. Its was a dermoid cyst or a myelomeningoceole. Didn't get diagnosis

Ong Chiew Sern
Examiner aka angels-prof siti, prof Kalai, prof Kwan,case 1-fibroid,differentials,why do you said it's fibroid,Ix..case 2-multinodular goiter,differentials,Ix,case 3-Pcl tear-asked on scars of fasciotomy and symptoms of compartment syndrome before proceeding to knee exam..(all examiners are very helpful,and patients' sign are very obvious,good luck guys and all the best!!)

Kweh Ting Yi
Prof Imran (med), Prof Law (surgery), Dr ?? (O&G), Prof Fatimah (Paeds)

1. Medicine - transplanted kidney
>Clear cut case: scar and palpable mass on left iliac fossa
>Provisional: transplanted kidney secondary to CKD
>Causes for CKD: HPT, DM, GN
>Issue to be concerned: immunosuppressed
>Eg of immunosuppressive drugs and the S/E: cyclosporin, gum hypertrophy

2. Surgery - breast CA with lung mets (stunted in this station, cannot recall much what had been discussed)
>Examination of breast lumps

3. Gynae - fibroid
>Signs of anaemia, midline laparotomy scar, palpable mass in the suprapubic region
>Provisional and Differential
>Investigations
>Management

Chai Boon Ceng
Prof Rokiah panjang(TT),Prof Jessie,Dr Margaret,Dr Si Lay

1. Med
Hepatosplenomegaly.tinge of scleral jaundice
Q:What is yr diff dx
Q:Since she has tinge of jaundice,would u like to rearrange yr diff dx?(she wants the answer of hemolytic jaundice)
Q:what is the pathophysiology behind deep jaundice and tinge like jaundice?
Q: What types of hemolytic jaundice that u know of?
Q: If u r posted to gua musang ,hw would u Ix her jaundice?

2.Paeds
Q: please assess this kid's DA
A: she looked pretty normal to me initially,fed by her mum on her mum's lap..gross motor delayed as still can't walk at age of 2, n while doing fine pincer grip,forgot to do another hand!! And it's the other hand that has gt problem...hand preference!!
Q: what did u notice so far?
A: patient's. Right wrist and elbow jts seem to be flexed and moved less cf the the left hand.She didn't utter a word Oso..n I forgot to test hearing..
Q:would u like to do a neuro exam on her?
A: manage to elicit hypertonia..no fasciculation,reflex can't gt it for both hands then Kring d
Arghh,this station really fail truck,if prof Jessie din help me I thnk I will be dead..haiz

3.surgery
Big,hard mass in epigastrium,mass in liver n spleen as well.n multiple submandibular LN
Q: what r the diff dx that u can thnk of?
A: I basically have listed out ALL the diff dx that I know of (NK chew book) bt

still couldnt get the answer that they want..haiz..time is passing so fast n hv to end this station without getting to the real dx TT

Really a sad day for sc..case difficult plus malignant Rokiah but luckily get thru it in the end

Edmund Chan
med- prof kl goh- pansystolic murmur,mainly on technique surgery- prof azad- indirect inguinal hernia, technique, and what else to look for beside examine hernia(cough, bph) pead- prof lee- thallasemia-hepato splenomegaly, causes, types of thallasemia, features of thallasemia

Lim Chee Sem
1st SC - Med - Prosthetic heart valve disease (examine pt's lower limb for any CABG, then wat is the abn heart sound heard) 2nd SC - Gynae- Uterine Fibroid (examine the neck and the mass, different diagnosis and investigation) 3rd SC- Ortho- Exotoses (examine the swelling, provisional diagnosis, wat else u want to check) Prof Wan (cardio), Prof Woo (O&G), Dr Chris (Ortho)

Ai Yun Loh
1st SC- Surg: Incisional hernia. (instruction: examine the patient's abd.) One midline scar seen so I asked pt to cough. then the hernia bulging out. then describe the hernia and tell about complication of hernia. 2nd SC- Transverse Lie. (instruction: this pt is a primigravida, with due date on 20 April. Examine her.) so, I said at 38th week, her sfh is 36cm, and found to be transverse lie. then ques are cause of transverse lie, complication and management. 3rd SC- Paed: Ricket. (instruction: this is a 15 years old girl, came in with short stature, examine her.) I ask pt to walk 1st, normal gait. then I am kind of not sure how to proceed. luckily prof gives hint. Finding: genu valgus. then prof ask me 5 causes of short stature and then I had to explain how to examine each cause. In the end, I mention ricket which is the correct answer.

Sooklin Loo
lst case thalassaemia: pls inspect then proceed. (present whatever findings then discussion on it) tanner staging 2nd case multinodular goiter : inspect then proceed with related finding, investigation, provisional diagnosis, lymphatic drainage of thyroid, what physical examination, management 3rd case prosthetic heart valve: inspection of chest(look for the midline sternotomy scar), possible causes for the scar, look forsite of saphenous harvest, precordium examination, what type of valve replacement, reason, types of prosthetic valve available, complication

Mohd Syazwan
i have 4 examiner- Dr Si lay(OnG),Prof Jessie(Paeds),Dr margaret(surgery),Prof rokiah(medicine..thx god i already had medicine as long case)

1st(OnG) Dr Si lay(very superb nice)
normal pregnancy at 37th POG,with previous lscs scar.
1)if u are her doctor,let say u already pass(tq Dr!!hehe)..how do u want to manage her?
2)let say if the previous scar is from the something about uterine rupture(i dont understand),would u deliver her normally?
3)when do u want to do emergency LSCS?--i answer during 2nd stage but she not satisfied yet
4)yes during 2nd stage,according to?how do u monitor the baby?yess...CTG and etc..she said good...tq dr for guiding me!!

2nd(paeds) Prof Jessie
inspect her face and proceeds(Dx:thalassemia)
so it very obvious she had all features of thalassemia except frontal bossing,so after i comment
all the features i juz commit this is thalassemia pt..
so she ask what else u want to do to confirm ur dx?i answer do abdominal examination and check for hepatosplenomegaly
and i wait there for next question but actually after u answer it,u must do it!!plz remember that...i lost many precious time
just standing there do nothing wait for instruction...
so i did abdominal examination,there is splenectomy scar...
1)so u said she has hepatomegaly?how did u know it is liver...explain the characteristic of liver
2)u said she splenectomy...why did she had splenectomy?so tell about the indication of
in thalassemia pt..they really want to hear prone to rupture during trauma..
3)why she had splenomegaly in 1st place?what happen if she had hypersplenism?
4)what are u worried of after splenectomy?infection..so give prophylaxis antibiotic...
she ask what antibiotic...my answer so wrong that she stopped mw from answer it..
tq prof for saving me from digging my own grave!

3rd(surgery) Dr margaret..
Dx : brachial cyst
very obvious lump at the anterior triangle of the neck..
i finish lump examination very fast but i really dont know about brachial cyst...after 5minute of prompting
she said..."u must had missed a lecture in Klang that covered about lump at head n neck"..damn...
well...even the nurse behind the curtain is giving me hint...but i really dunno it didnt cross my mind.
so...i nver got to discuss about this case.no mx no ix nothing...but all the examiner very nice..
even prof rokiah is very nice,she prompt me and give me chance to ask question to pt..

overall..examiner were very nice they tried hard to help us...if u want to pray something be4
going for short case...my advice is pray that u get nice and helpful examiner...gud luck juniors!!

Nadzrah Wan Yong
prof kwan,prof ?? (med), prof siti, prof kalai- 2nd day morning. 1) cvs-yg malay man,median sternotomy scar,very low pulse volume.got murmur but not sure wut lol.lots of interruption erghhhh 2) gynae-middle age wif menorrhagia, 18 wk gestation mass.all features of uterine mass.ix.if TRO malignancy how to ix and examine for signs of mets 3) surgery-middle age lady breasts examination.all about breasts dx, triple ass, n nd to perform abd examination lol

Rosgayah Majid
1)paeds(dr hani):cvs with murmur,thrill,not sure wat it is..2)surgery(prof april):stoma bag.describe,ask bout hartmann procedure,anterior resection,apr,.3)obs(dr valli):fibroid in pregnancy.ask bout the differntial dx,how to differentiate uterine mass n ovarian mass,effect of pregnancy towards fibroid vice versa,..

Mohammad Afiq Abd Latif
(examiner: prof lucy, prof ong, prof external from NUS n prof Kong) 1) paeds- inspect n proceed, a girl wif bowing of leg,what other thing to look,how u ix,mx.. dx:rickets 2)surgery(prof ong) - exmine swelling at inguinal area, dx: inguinal hernia, anatomy landmark, other thing to examine, mx 3) med(NUS) - inspect n exmine abdomen, bilateral ballotable kidneys, dx-PCKD, ix, n hx to ask... prof are very nice one...tenang je...good luck!!!=)

Firdaus Hariri
Examiner: Prof. Rokiah, Prof. Jesse, Dr. Margaret, Dr. Si Lay
Station 1: middle age lady with splenomegaly? Not many questions asked..stucked & screwed big time here. Discussion more on how to differentiate massive mass of the left quadrant.
Station 2: Obs 36 pog..ceph/breech? I sticked with cephalic..causes of smaller than date, management of breech
Station 3: mid age man with non healing ulcer on the right leg, describe ulcer, gait assessment, differential diagnosis, treatment of non healing ulcer based on differential diagnoses