The Royal Australian & New Zealand College of Psychiatrists

Exam ID:

Modified Essay Questions
MARKING GUIDE
AUGUST 2021

INSTRUCTIONS:

- Please use pencil ONLY.
- Do not fold or bend.
- Erase mistakes fully.
- Completely fill in the oval.

2B PENCIL

Please MARK LIKE THIS ONLY: ⓪ ■ ②

Modified Essay 3

Each question within this modified essay will be marked by a different examiner. The examiner marking this question will not have access to your answers to the other questions. Therefore, please ensure that you address each question separately and specifically. Answer this question fully, even if you believe that you have partly covered its content in your answers to other questions.

You are a junior consultant psychiatrist in a metropolitan mental health service.

During a weekend on call shift, the after-hours Stage 1 trainee contacts you after having reviewed Stephanie on the general medical ward. Stephanie is a 50-year-old woman receiving the Disability Support Pension. She lives with her 11-year-old daughter. Stephanie was admitted the previous day with acute pancreatitis. Earlier today, she appeared agitated and complained of "seeing things". The trainee reports that Stephanie appeared to be in mild alcohol withdrawal.

The trainee asks you for advice about Stephanie's assessment and management.

Question 3.1

Outline (list and justify) the information you would expect the trainee to have obtained.

Please note: a list with no justification will not receive any marks. **(10 marks)**

A.	**Elaboration of current concerns:** To score marks in this domain, the candidate recognises that there may be concerns in addition to agitation and visual phenomena, possibly identified from the patient/carers, ward staff.	⓪ ①
B.	**Clinical history: Drug and alcohol, psychiatric and physical health:** To score marks in this section, the candidate identifies relevant details (including relevant negatives) in the patient's history that contribute to understanding her current clinical presentation. These include: **Drug and alcohol.** Consider: screening questionnaire (e.g. AUDIT CAGE); corroboration of presentation with breath testing; pattern of alcohol use consistent with dependency; last alcohol consumption (withdrawal symptoms typically occur after 8 hours and may peak on day 2); recent onset symptoms (including perceptual and cognitive that may suggest alcohol withdrawal); past alcohol treatments; past presentations of withdrawal (autonomic features, seizures, confusional states); other substance use. **Psychiatric.** Consider: recent onset symptoms; evidence of discrete psychiatric syndromes (e.g. mood disorders, psychotic disorders) and their temporal relationship with alcohol use. **Physical health.** Consider: physical health concerns related to alcohol use disorders including pancreatitis, liver disease, (also hypertension, easy bruising, upper GI/head and neck cancers); history of epilepsy may increase likelihood of withdrawal seizures.	⓪ ① ② ③ ④
C.	**Clinical history: Psychosocial:** To score marks in this section, the candidate identifies relevant details relating to the patient's psychosocial situation and importantly to her dependent. These include: **Current living situation.** Consider: Nature of disability and impact on functioning; available formal and informal supports/contacts; potentially abusive relationships. **Child wellbeing.** Consider: whereabouts and wellbeing of the child; identification of a responsible person or organisation.	⓪ ① ②
D.	**Mental state examination:** To score marks in this section, the candidate identifies relevant findings in the mental state examination that assist in the assessment of the patient, especially in determining likelihood and severity of alcohol use disorder and the consideration of comorbid psychiatric features. **Behaviour.** Consider: restlessness; responding to stimuli. **Cognition.** Consider: orientation, registration, recall, concentration; evidence of anterograde/retrograde amnesia. **Mood/affect.** Consider: agitation; features of mood disorder. **Content.** Consider: risk related concerns; possibility of confabulation. **Perception.** Consider: nature of hallucinations/illusions (clarifying what "seeing things" means.	⓪ ① ②
E.	**Physical examination:** To score marks in this section, the candidate identifies relevant findings in the physical examination (including neurological examination) that assist in the assessment of the patient, especially in determining likelihood and severity of alcohol use disorder. Physical examination findings may be completed by the registrar or have been documented by the treating team. **General physical examination.** Consider: physical examination findings suggestive of pancreatitis; features of withdrawal (tremor, hypertension, tachycardia, increased temperature, increased respiratory rate). **Neurological examination.** Consider: evidence of peripheral neuropathy; features of Wernicke-Korsakoff syndrome (including ataxic gait, sixth nerval palsy).	⓪ ① ②

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F.	**Investigations to date:** To score marks in this section, the candidate identifies relevant investigations that assist in the assessment of the patient. **Markers of heavy drinking.** Consider: GGT; MCV; uric acid; ALT/AST. **Evidence of pancreatitis.**	0 1
G.	**Management to date:** To score marks in this section, the candidate identifies relevant issues relating to management prior to this consultation. Pain management. Consider: choice of analgesia (including use of opioid analgesia).	0 1
H.	**Assessment of capacity:** To score marks in this section, the candidate considers the patient's understanding of her condition and her capacity to consent to treatment.	0 1

I.	**SPARE**	1
J.	**CANDIDATE DID NOT ATTEMPT**	
K.	**DID HANDWRITING AFFECT MARKING?**	

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The information that is presented in italics in this question is a repetition of the earlier sections of the case vignette.

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The trainee asks you for advice about Stephanie's assessment and management.

The trainee informs you that the patient is not really hallucinating but has double vision on lateral gaze. Her blood alcohol had been 0.04% the day before, at the time of presentation.

Question 3.2

Outline (list and justify) the differential diagnoses you would consider.

Please note: a list with no justification will not receive any marks. **(6 marks)**

A.	Wernicke's encephalopathy (AKA Wernicke fluent encephalopathy) characterised by acute confusion, ataxia and ocular motility disturbance (eye signs such as diplopia and nystagmus on lateral gaze).	⓪ ① ②
B.	**Alcohol withdrawal (mild or moderate)** Consider: recency of alcohol cessation; withdrawal may include hallucinations/visual disturbance, agitation and physical signs. **Alcohol withdrawal (severe)** Consider: extreme autonomic dysfunction, agitation, confusion; alcohol withdrawal delirium indicating greater severity (includes criteria for delirium as well as withdrawal); includes delirium tremens (extreme autonomic hyperactivity, tremulousness, hallucinations/illusions/delusions, associated with heavy drinking).	⓪ ① ② ③
C.	Acute or chronic head injury (extradural, subdural) as falls are common in those with alcoholism.	⓪ ①
D.	Delirium associated with other causes: acute pancreatitis, postictal or hepatic encephalopathy as she is confused, seizures are common in alcohol dependence as is liver disease.	⓪ ①
E.	**Other disorders:** Consider: other disorders that may be associated with alcohol use (e.g. anxiety disorders, mood disorders, trauma-related syndromes); other disorders that may explain symptoms (e.g. primary psychotic disorder, intellectual disability).	⓪ ①

F.	**SPARE**	①
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H.	**DID HANDWRITING AFFECT MARKING?**	○

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The trainee asks you for advice about Stephanie's assessment and management.

The trainee informs you that the patient is not really hallucinating but has double vision on lateral gaze. Her blood alcohol had been 0.04% the day before, at the time of presentation.

A diagnosis of alcohol withdrawal with features of Wernicke's encephalopathy is made. The trainee asks you to clarify the recommendations to be made to the treating team on the general medical ward.

Question 3.3

Describe (list and explain) the immediate management recommendations you would address with the trainee.
Please note: a list with no explanation will not receive any marks. **(10 marks)**

A.	**Context of request:** Identifies and addresses the consultation question of the treating general medical team	⓪ ①
B.	**Decision to admit:** Admission justified – e.g. diplopia (possible Wernicke's) and perceptual symptoms (possible delirium) suggest possible severe withdrawal.	⓪ ①
C.	**Care approach on unit:** *To score marks in this section, the candidate recognises the role in recovery of the physical space, of key relationships with the patient whilst in hospital, and activities/routines whilst an inpatient.* • **Environment.** Safe, calm environment supports recovery from delirium. Consider: avoid stimulus overload and stimulus deprivation; single room, close observations; daytime/night-time cues assist sleep wake cycle, clock/calendar/date visible. • **Staffing.** Optimise staff continuity (medical, nursing) so patient is familiar with staff; calm supportive stance; avoid non-related conversations in earshot. • **Family and trusted others.** Presence of family members experienced as safe may assist in supporting the person (minimising escalations) and in orientation. Opportunity to support key family/social network members. • **Communication and physical wellbeing.** Consider: need for glasses/hearing aids; pen/paper as alternative to verbal communication; where possible encourage physical activity to avoid pressure sores, assist with orientation; ensure adequate rest. • **Monitoring and observations.** Alcohol withdrawal scale or equivalent; observations.	⓪ ① ② ③ ④ ⑤
D.	**Medication options:** *To score marks in this section the candidate identifies key medications that target potentially serious adverse outcomes and considers other pharmacotherapeutic options that assist in supporting the person symptomatically and promote recovery.* • **Thiamine.** For example, 500mg intravenous bd/tds for 3-5 days to avoid Wernicke-Korsakoff syndrome. The immediate management is intravenous thiamine. Thiamine is useful in preventing Wernicke encephalopathy and Korsakoff Syndrome. W.E is an acute disorder due to thiamine deficiency manifested by confusion, ataxia, and ophthalmoplegia. K.S. is manifested by memory impairment and amnesia. Thiamine has no effect on the symptoms or signs of alcohol withdrawal or on the incidence of seizures or DTs. Oral Thiamine is poorly absorbed enterally in those with alcohol abuse histories. • **Benzodiazepines.** For example, diazepam, lorazepam. Preventative for delirium tremens. Preventative for withdrawal-induced seizure risk (peaks on day 2 in mild withdrawal, or days later in severe withdrawal). Consider intravenous loading dose and as per protocol. • **Multivitamin/folate.** Where concerned about diet. Folate deficiency may lead to peripheral neuropathy; B group vitamins and minerals (e.g. Mg) may affect lipid and glucose metabolism. • **Symptomatic treatments.** Fluids/electrolytes if dehydrated; antiemetics for nausea/vomiting; paracetamol, NSAIDs for aches/pains; night sedation; acute sedation options e.g. benzodiazepines, haloperidol; sleep e.g. temazepam. • **Medication precautions.** (If raised, may contribute to this section.) For example propranolol, clonidine may mask features of withdrawal.	⓪ ① ② ③ ④ ⑤

P.T.O. →

E.	**Capacity and consent:** • Note risk of loss of capacity e.g. unidentified disability and potential for delirium. • Consider: invite collaboration in considering options; identify substitute decision maker; discuss advance statements.	0 1
F.	**Parental responsibility and child wellbeing:** • Eleven-year-old daughter is a minor who's only identified carer is hospitalised. • Clarify child's whereabouts and suitability or otherwise of care arrangements. • Note statutory obligations e.g. mandatory reporting.	0 1 2

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References:

Shuckit, M.A. (2017). 11.2 - Alcohol related disorders. In: Sadock, B., Sadock, V., & Ruiz, P. *Kaplan & Sadock's comprehensive textbook of psychiatry* (Tenth edition, 50th anniversary edition.). Wolters Kluwer.

Fabian, T.J., Solai, L.K. (2017). 10.2 – Delirium. In: Sadock, B., Sadock, V., & Ruiz, P. *Kaplan & Sadock's comprehensive textbook of psychiatry* (Tenth edition, 50th anniversary edition.). Wolters Kluwer.

Duong, T., Vytialingam, R., & O'Regan, R. (2018). A brief guide to the management of alcohol and other drug withdrawal. Perth, Western Australia: Mental Health Commission. ISBN: 978-0-9944434-3-4