1. Lead examiner **……** **Candidate No:**

2. Co-examiner **……**

Final Mark:

It is 2100hrs in your tertiary Emergency Department. Ambulance bring in a 74 year old lady with a probable acute stroke.
Initials findings: Complete expressive aphasia, dense right hemiplegia. BP 170/95 mmHg; P 100 Sinus Rhythm; O_2 saturation 97% on room air; normothermic.
She has a history of hypertension, but otherwise has no significant past medical history.
She was last seen to be well approximately 2 hours ago, but was found by relatives in her current state.
Question 1: Outline key issues in the care of this patient? (included in stem)

Expected Response	Details & Comments	
Principles	**Initial resus, check glucose, ensure that the patient is stable** **Safe and rapid transport to** CT - potential risks: airway compromise, seizures **Activation of Stroke services**, such as coded response **Liaison with NOK** Managing rest of ED	
Initial Resus	Team approach, take leadership, assign roles ABC	
Safe Transport to CT	Personnel Equipment Drugs Documentation Communication	
Notification / Activation	Notify IP Stroke Services - ? suitable for <u>thrombolysis</u> Radiology Ward ? ICU	
Liaison with NOK	Assign staff member initially Speak with them directly subsequently	
Rest of ED	Competing demands, flow, safety, staff support etc	

Question 2: The CT brain reveals no radiological abnormalities. DISCUSS acute thrombolysis for this patient.

Expected Response	Details & Comments	
Overview	Current evidence for thrombolysis evolving. Therapeutic window of 3 hours post Sx onset being stretched to 6 hours, but remains controversial. CT interpretation preferably requires neuro-radiology; likely not available at 2100hrs. Thrombolysis only initial part of wider therapeutic strategy. Meaningfully improved outcomes also require tertiary level stroke service in acute-subacute phase. **4 out of 6 to pass**	
For Thrombolysis	Most current evidence applies to tPA. If this lady can receive it within 3 hours of possible Sx onset, may have better intermediate – longer term neurological outcome. Raised expectations within medical fraternity and public Allows healthcare professionals a sense of action ("doing something"); there is little if any other meaningful acute Rx	
Against Thrombolysis	Elderly lady at higher risk of ICH, esp if body weight is less than 65kg Need to drop her BP to minimise ICH risk Risk of significant bleed from other sites. Specialised stroke service may not be available at this time. This pt sits at borderline of indication! Positive CT findings may be missed by radiology trainee reading scan after hours	

Question 3. A decision has been made to offer thrombolysis. Outline the issues of consent in this case.

Expected response	Details and comments	
Principles	**Key elements: Informed, specific, freely given, competent.** **3 out of 4 to pass** Difficulties in this scenario: - Time pressure compromises all the above – risks are significant and catastrophic! - Patient not sufficiently competent, so consent has to be by proxy Are there sufficient grounds to act on **implied consent**? Requires sincere belief that benefits are too great to ignore. Enacts paternalistic approach.	
Informed	By senior staff, preferably neurology Benefits vs Risk discussion. Explanation of agent and intended effects. Simple estimate of probability and odds. Alternative treatments Very likely that person granting consent is not fully informed, given time pressure and likely emotions of situation.	
Specific	Risks higher in this patient, esp as she's at borderline of therapeutic window Issue of external validity of current evidence	
Freely Given	Likely to be so in this scenario, by NOK. Time to decide probably greatest impediment	
Competence	If patient not deemed to be so then person granting consent has to be so. Moreover, need to establish if s/he is suitably assumed / appointed proxy.	
Other		

Question 4: Shortly after thrombolysis, the patient suffers a massive haemorrhagic stroke confirmed on CT. Her is GCS is 3 and she is intubated. Outline your management.

Expected Response	Details & Comments	
Issues	**Must have discussion with family** Grim prognosis. Ongoing clinical care; life support. ??Reversal of lytic agent. Liaison with NOK Disposition - ?End of Life discussion. Consider only palliation. Risk Mx: Documentation, notification. Staff support – debrief Critical Incident Review	
Clinical	Supportive measures. Aim for, and maintain normal physiological parameters. ?Reversal of Lysis. Unlikely to be of any benefit in this scenario. Cease anticoagulation agents, and avoid hypertension. Disposition:	
NOK Liaison	Separate room. Clear and simple language. Open disclosure. Explain all events. Allow to grieve. Allow time and contact with pt. Communicate clearly a grim prognosis, and futility of ongoing aggressive Rx	
Quality Issues	Thorough documentation, and critical incident notification Staff support and debrief if required	
Other	Notify other stakeholders: Stroke Service, ICU	

Comments: (if you fail the candidate, please state why)

If the candidate fails the exam overall, what <u>feedback</u> would you suggest regional censor provide for this SCE?

SCENARIO

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- **P 100 Sinus Rhythm**
- **O_2 saturation 97% on room air**
- **Normothermic**

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Question 1: Outline key issues in the care of this patient.