

## **PLAB 2 (OSCE): Counselling**

### **Counselling -- Abnormal Cervical smear.**

Hello Mrs. Smith, I am Dr. XYZ, senior house officer in the department of obstetrics and gynaecology. We have got the results of your smear test back. I am afraid we have detected some abnormal cells. Let me explain what it means.

Mild, CIN I: Some of the cells from the cervix have shown some changes. This could be due to infection. So we will check and treat if there is any infection. It is necessary to repeat the cervical smear and then we will decide the further course of action. I would like to reassure you that this is not cancer.

Moderate, CIN II: Some of the cells from the cervix have undergone changes. So we would like to do another test called colposcopy. Here we have a direct look at the cervix with a microscope. At the same time a biopsy can be taken. We will let you know about the biopsy as soon as the report is back. I would like to reassure you that this is not cancer. But it might develop into cancer if left alone untreated. The treatment of abnormal cells is quite a minor one and if the treatment is done early enough, it almost always leads to a complete cure. But you need to have a smear test every year to check that everything is still fine.

Severe dyskaryosis, CIN III: Some of the cells from the cervix have undergone changes. So we would like to do another test called colposcopy. Here we have a direct look at the cervix with a microscope. At the same time a biopsy can be taken. We will let you know about the biopsy as soon as the report is back. I would like to reassure you that this is not cancer. But it might develop into cancer if left alone untreated. The treatment of abnormal cells is quite a minor one. But you need to have a smear test every year to check that everything is still fine.

If not all the cells are removed, I am afraid we would do further tests to know the extent of the disease. You might have to have a hysterectomy then. I am sorry about the bad news. I am going to arrange, for you to have a biopsy. Here are some leaflets to read. If you have further doubts don't hesitate to ask. Thank you.

## **Counselling relative of a patient with Alzheimer's dementia.**

### **POINTS:**

Alzheimer's disease is usually progressive with mental function getting steadily worse. Some problems such as aggression may improve over time. The rate of change and the length of life vary greatly.

Lock up any rooms in the house that are not in use, the patient will not notice this restriction.

This may make the life of the carers easy.

To lock up any drawers which contain important papers or easily spoiled items. This will prevent the patient storing inappropriate things in them.

Remove locks for the lavatory so that the patient cannot get locked in.

Normal sexual relationship will probably stop.

The relative should psychologically prepare for the day when the patient no longer recognizes him. This can be a great blow.

Day care for the patient is available. It will give much needed respite from the thankless task

of looking after the patient (to the carer).  
Advise the relative to apply for an attendance allowance.  
Alzheimer's disease society exists (give phone number).

## Counselling Crohn's.

Good morning Mr. Smith, I am Dr. XYZ senior house officer in the department of medicine, I would like to talk to you about your condition. In view of your symptoms, diarrhoea, weight loss, bleeding, abdominal pain, etc., we have done some investigations. I am afraid we have diagnosed a condition called Crohn's disease. It is also called inflammatory bowel disease.

I am going to explain it to you. This means that the lining of the bowel is inflamed and that is why you are experiencing those symptoms. The cause for the inflammation is not known. Unfortunately there is no cure for this condition, but we can definitely offer you treatment to relieve your symptoms.

We are going to start you on some medication. One of them is prednisolone, which will keep the inflammation under control. The other medicines are called sulphasalazine and azathioprine. We will also give you a course of antibiotics called metronidazole, to get rid of any gut infection.

In addition to these drugs you need to be careful with your diet. The dietitian will talk to you as well.

**Crohn's control:** We will monitor your progress regularly by clinic appointments and blood tests. In some chronic and resistant cases, we sometimes advise surgery. This will involve removing the diseased part of the bowel.

### Ulcerative Colitis: (similar Counselling)

**Surgery:** this would involve removing the diseased end of the bowel and performing an ileostomy. This is when the healthy part of the bowel is brought to the outside through a hole in the abdominal wall. This is called a stoma. You will be opening your bowels through the stoma into a bag attached to it. This stoma stays permanently. I can imagine that it sounds horrible, but we have quite a few patients who have a stoma. The stoma nurse will talk to you about it in detail. There won't be any smell and you carry on your daily activities normally. I will give you some leaflets about stoma care that you can go through. You can meet and talk to other patients with stomas.

There is a stoma care helpline as well.

## Counselling: Cleft lip and palate.

Good morning Mrs. Smith I am Dr. XYZ, senior house officer in the department of paediatrics. Congratulations on the birth of your baby boy. I came to talk to you about the defect in his upper lip. This is called a cleft lip. The defect also extends to the roof of his mouth. And this is called a cleft palate. This is due to the failure of fusion of the two parts of lip and the palate in the middle. I understand that you are anxious to know what will happen to him. I would like to reassure you that this is not a life threatening condition.

In the near future he will need surgery to repair the defect. I will show you some photos of babies that have undergone surgery. The operation is performed by plastic surgeons. It is possible to close the defect and leave behind only a very small scar. The lip is repaired at 3 months and the palate at 1 year.

However at this moment it is important to concentrate on his feeding. If you are breast feeding you might need some help from our breast-feeding nurse. If you are planning to bottle feed, he will need a special teat so that the defect of his palate will be covered. This prevents milk from going into his nose. Other than that you need not take any other special precautions. I will also refer you to the CLAPA team cleft lip and palate association. One of the nurses from this team will talk to you again about feeding techniques.

## Counselling - Down's syndrome.

Hello Mrs. Smith I am Dr. XYZ, senior house officer in the department of Paediatrics. Congratulations on the birth of your beautiful boy. I would like to have a little chat to you about him. You might have noted that he looks slightly different to other babies. I have examined him thoroughly and I am sorry to have to tell you that I suspect he has a condition called Down's syndrome. Have you heard about this at all?

Well Down's syndrome is a chromosomal disorder. Now, children with Down's syndrome can have a variety of features. The most obvious ones are the upward slanting eyes. They have a large tongue and can be rather floppy. This might lead to feeding problems in the early life. Occasionally these children can have heart defects and malformations in their guts. This does not seem to be the case with your son, as I have listened to his heart and examined his tummy. However we will arrange a heart scan to make doubly sure. I don't want to paint a very gloomy picture. Children with Down's syndrome are very pleasant and lovable. They enjoy music very much.

At the moment my diagnosis is relying entirely on the clinical features. That why it is important to do a blood test to look at the chromosomes to confirm this.

It must be a lot for you to take in, in one session. I will give some written information to read through and if you have any questions later on we will be happy to help.

Thank you, Mrs. Smith.

## Epilepsy -- Counselling

Good morning Mrs. Smith I am Dr. XYZ, senior house officer in the department of Obstetrics and Gynaecology. You were brought to A and E fitting. It was necessary for us to start you on a medication to control these fits, as they have become more frequent. So we started you on a drug called Carbamazepine. Since then you are doing extremely well. We have also done a few tests like tracing of your brain and a scan. We have come to a diagnosis that you have Epilepsy. Epilepsy means that there is some abnormal electrical activity in your brain. This can be controlled with the help of drugs. Refer: **Epilepsy**.

Unfortunately we don't know the cause.

Mrs. Smith, since you are being discharge today, I have some advice for you.

You have to take your medication regularly. If you suddenly stop them this could precipitate a severe fit. There are also some side-effects. The most common ones are blurring of vision, dizziness and unsteadiness. If you get fever, sore throat, rash, mouth ulcers, bruising or bleeding please contact your GP.

You have to inform the DVLA. You will not be able to drive till you are fit free for a period of one year or you have fits only during sleep for three years.

You shouldn't operate heavy machinery. (Teachers and pilots need to change their profession).

Antiepileptics may reduce the affect of pills.

If you wish to get pregnant, you should discuss this with your doctor first. It is important to take adequate folic acid supplements before and during pregnancy to prevent neural tube defects. Prophylactic Vitamin K is recommended before delivery as there is increased risk of neonatal bleeding. Breast-feeding is acceptable.

Please do not lock bathroom doors.

Avoid swimming and cycling alone.

Wear an epilepsy card or bracelet.

Your GP has been informed of your condition. If you have any questions please feel free to ask

## Counselling -- Febrile convulsions.

### Introduction:

I know Mrs. Smith that was a very frightening experience for you. You may even have thought that your child was dead or dying. Many parents think that when they first see a febrile convulsion. However febrile convulsions are not as serious as they look.

It is an attack brought on by fever in a child usually aged between 6 months and 4 or 5 years. A convulsion is an attack in which the person becomes unconscious and usually stiff, with jerking of the arms and legs. It is caused by a storm of electrical activity of the brain. The words convulsions, fit and seizure mean the same thing.

**Prevention of Febrile convulsions:** If your child is having fever, you can take the temperature by placing the bulb of the thermometer under his armpit for 3 minutes with his arm held against his side. Keep him cool. Don't over clothe him or over heat the room. Give plenty of fluids to drink. Give children's paracetamol medicine to get his temperature down. If he seems ill or has earache or sore throat, let your doctor see him in case he needs any other treatment such as antibiotics.

When your child is fitting you should lay him flat on his side, with his head at the same level or slightly lower than his body. Note the time and wait for the fit to stop. It is not necessary to do anything else. We will give a medicine to insert into your child's bottom. This is called rectal diazepam. If the fit carries for more than 5 minutes give rectal diazepam. This should stop the fit in 10 minutes. If it doesn't bring him up to the hospital or dial 999 if necessary. In any event let your doctor what has happened.

The child doesn't suffer discomfort or pain during a convulsion. The child is unconscious and unaware of what is happening. The convulsion is much more disturbing to you than the child.

Mrs. Smith if you have any doubts please don't hesitate to ask.

Other points:

Incidence: 1 in 30 will have one by the age of 5 years. The risk of having another gets rapidly less after the age of 3 years.

It is not epilepsy. 99 out of 100 children with febrile convulsion never have convulsion after they reach school age, and never have fits without fever.

Febrile convulsions lasting less than 30 minutes will never cause permanent brain damage.

## Counselling -- Inguinal Hernia.

Good morning Mr. Smith I am Dr. XYZ senior house officer in the department of Surgery. I would like to have a chat with you regarding the lump in your groin. You came here with abdominal pain and constipation and after examining you I came to the diagnosis that you are having an inguinal hernia in the right groin. (Other predisposing conditions: chronic cough, urinary obstruction, heavy lifting, ascites and previous abdominal surgery).

The hernia is a defect in the tummy wall through which the contents of the tummy will try to come out when you cough or strain at stool. If we don't treat, it grows and gets twisted thereby reducing the blood supply and causing the death of the tissue. To prevent this the hernia has to be closed surgically. Our consultant Mr. John who is very experienced in this will perform the operation. For the operation you will be put to sleep. Our anesthetist will have a word with you before the operation. It is advisable to stop smoking before the operation. You have to come to the hospital a day before the operation, so that we can prepare your gut for surgery. We may have to transfuse bloods during the operation.

The hernia will be reduced, by incising the skin above the hernia and then the contents are placed back in the abdomen. A nylon mesh is kept in place to strengthen the tummy wall and the skin is closed with sutures. The mesh remains there permanently and will not cause any problem. After the operation you will wake up in the recovery room and you will be attached to an IV cannula and a catheter. You can go home in a day or two, depending on how you recover.

Mr. Smith as with any operation there are few complications associated with this operation. 1) Pain: it will be sore for a few days and we will give painkillers. 2) Infection may develop in the wound which can be controlled with antibiotics. 3) Bleeding or haematoma. In spite of all the care we take there is a slight chance of recurrence of the hernia.

Mr. Smith you can return to work in 4 weeks and full activity in 8 weeks. A follow up will be arranged at 6 weeks.

If you have any doubts please don't hesitate to ask. Thank you.

## Counselling - Birth asphyxia.

(hypoxic ischaemic encephalopathy- HIE)

Hello Mrs. Smith I am Dr. XYZ, senior house officer in the department of paediatrics. I would like to have a little chat with you regarding your son Richard. As you know we have to admit him to the special care baby unit yesterday. Unfortunately he went through a tough time when he was born. He was very distressed because of the cord prolapse and his brain was starved of oxygen for a while. Due to this he was floppy when he came out and needed help with his breathing. As you can see now he is on a ventilator, a machine that breathes for him.

Unfortunately he also started to fit yesterday and he is on medication to control his fits. We have done a scan of his brain, which shows some swelling. We are hoping that this will go down in the next few days.

It is very early and very hard to say what the long term effects of this will be. He might recover with only a minor physical disability or he might be more disabled. It is really hard to say at this point.

We need to monitor his progress carefully over the next few weeks. We will also be doing more blood tests and head scans. We will let you know any results immediately.

In the mean time try not to worry too much, as these are early days. I know it is hard. We will encourage you to spend as much time with him as possible, here on the baby unit.

Before discharging your baby we will inform the physiotherapist, health visitor, social worker and GP. We will arrange regular appointments for frequent follow up of Richard.

I will give you the telephone number for Cerebral palsy helpline where you can meet parents of children with similar condition.

If there are any questions please ask us. Thank you, Mrs. Smith.

## Counselling -- HIV.

Good morning Mr. Smith I am Dr. XYZ, senior house officer in the department of Medicine. The result of your blood test came today morning. Are you anxious to know the result?

I am afraid to say that the blood test confirmed that you are having the HIV virus which cause AIDS. I can understand that this is very shocking news for you. I would like to ask you a few questions to put things in perspective.

H/o blood transfusion? Do you use any recreational drugs?

Do you practice safe sex? What are your sexual preferences?

Mr. Smith having the virus doesn't mean that you are having AIDS. We really don't know how the disease progresses. Some people can be free of symptoms for a long time. However it is important that you use medication to prevent further deterioration in your condition. The symptoms you might experience could be body aches, lethargy, swelling of your glands, headache, weight loss, skin infection, diarrhoea etc. You will also require regular follow up with us.

Mr. Smith you should practice safe sex. You shouldn't donate blood or share needles and razors. This is an entirely confidential matter but I feel you should tell your GP and your partner.

(vaccinations contraindicated in HIV: BCG, oral polio and yellow fever)

## Counselling -- Leukaemia.

Introduction: Hello Mr. Smith I would like to talk to you about your son's condition. He has been suffering from multiple bruises, body aches and recurrent infections. We have done a few blood tests, which suggest that he have a condition called acute leukaemia. This means that his bone marrow is producing a lot of abnormal white cells. This is why he has been getting frequent infections.

I am sorry to say that this is a form of cancer. However we would first have to confirm the diagnosis by doing a bone marrow test. After that we will start him on chemotherapy to suppress the cancer. There are some side effects from the drugs like hair loss, vomiting, bleeding and diarrhoea. We hope his condition responds to chemotherapy. If not he might need a bone marrow transplant.

I know that this is a lot of information to digest at the moment. We will explain things on a daily basis. If you have any doubts don't hesitate to ask. Thank you.

Refer: AML, CLL, CML and Leukaemia.

## Counselling Mesothelioma.

Hello Mr. Smith I am Dr. XYZ senior house officer in the department of medicine.

I am afraid I have some bad news for you. The biopsy showed that you have a mesothelioma, which is a tumour of the pleura, the lining of the lung. This is the cause of your symptoms. Unfortunately this condition is very hard to treat and the only thing we can do is to try and relieve your symptoms.

You have been admitted with the complaints of breathlessness, chest pain and weight loss. As you know we have done some investigations. In one of them, we removed a bit of tissue from the lining of your lung (biopsy).

This condition is usually seen as a result of chronic exposure to Asbestos. Due to the mesothelioma, there is fluid accumulation in between the layers of the pleura. We can tap this fluid on a regular basis to relieve your breathlessness. There is no cure otherwise.

I am very sorry about the bad news.

(Mean survival: 2-3 years, it occurs 20-40 years after the exposure to asbestos. Get consultant to counsel further).

## Nappy rash -- Counselling.

Hello Mrs. Smith, I am Dr. XYZ, senior house officer in the department of paediatrics. You brought your son Robert as he has a sore bottom. I had a look at him. It appears to me that he has a common condition called ammonical dermatitis.

It is quite commonly seen in small children. It is due to irritation of the skin from the urine in the nappy. However it is a fairly easy condition to treat. You will have to change his nappy frequently. You can apply an emollient cream or a nappy cream to prevent irritation to other areas. Also avoid any tight fitting clothes. If possible give your baby some time off from the nappies if you can. If you are using reusable nappies, you have to wash them thoroughly after use.

This condition should soon go away. However if it is no better in a few days time, please come back to the ward to see me again.

DD, Nappy rash:

Ammonical dermatitis -- spare skin creases,

Seborrheic dermatitis -- involves creases and scalp and face.

Candida -- satellite lesions.

Psoriasis -- skin lesions elsewhere on the body.

Treatment for candida: surface swabs, start topical nystatin for 5 days. Check for oral thrush, if present - oral nystatin and topical nystatin.

## Counselling -- Needle stick injury.

Hello Mrs. Smith I am Dr. XYZ, senior house officer in this A & E department. I can see you have brought your little boy Thomas. I understand he pricked himself with a needle. I need to ask you a few questions.

Do you know whom the needle belongs to? Where has he found it?

How long ago did the injury happen? Have you cleaned the wound?

When did he last have his tetanus immunization?

(if mother knows the owner, ask whether that person is HepB+ve. If HepB+ve, the child needs HIBG along with vaccine).

There are a few things we need to do. We will dispose of the needle for you. Thomas needs a blood test to check his hepatitis status. We will then give him the first dose of the vaccine. He will need two further boosters at 1st month and 2nd month, which he should get from your GP. He will also need another blood test after the vaccination. Regarding the risk of AIDS, I can reassure you that the risk is very small.

I hope I have cleared all your doubts. I will write to your GP about what needs to be done. It is important that Thomas receives the full course of the immunization.

I will give you an information leaflet as well. If you have any doubts later please don't hesitate to contact us.

Thank you Mrs. Smith.

## Counselling: Pre-eclampsia.

(BP: systolic  $>130$  and diastolic  $>20$  over booking BP or BP  $>160/100$  or BP  $140/90$  with proteinuria).

Good morning Mrs. Smith I am Dr. XYZ senior house officer in the department obstetrics and gynecology. You are now 30 weeks pregnant and we have been monitoring your BP closely over the last 2 weeks. I am sorry to say that your BP is still high. This condition is called Pre-eclampsia or pregnancy induced hypertension. This condition needs to be managed very carefully to prevent any complications to you or your baby. I am afraid that we will have to admit you to the hospital to control your BP. You need to take bed rest. We'll also start you on medication to lower your BP. It is important to test your urine and blood regularly. We'll also check the well being of the baby by CTG and scan. We hope that your BP will be controlled by these measures.

If how ever there is a problem we might need to deliver the baby early.

**Pre-eclampsia:** PIH with proteinuria  $\pm$  oedema. The arterial wall doesn't distend enough to allow sufficient blood flow to the placenta in late pregnancy, and increasing BP is a mechanism, which partially compensates for this.

Symptoms: headache, fever, chest pain, epigastric pain, vomiting and visual disturbance. There may be tachycardia, shaking, hyperreflexia, irritability and papilloedema.

Effects: plasma volume is reduced, increased peripheral resistance. If BP is  $>180/140$  microaneurysms develop in the arteries. DIC may develop. Uric acid level is increased.

Management: admit, measure BP 2-4 hourly. Weigh daily, test urine for protein, monitor fluid balance, check uric acid, renal, liver and platelet function. Do regular CTG and USG to check growth and biophysical profiles.

Methyldopa to reduce BP. If signs worsen delivery is the only cure (give H<sub>2</sub>-blockers if they go into labour).

Symptomatic pre-eclampsia and eclampsia: diazepam + hydralazine. Labetalol provides an alternative. Visual symptoms, twitching or ankle clonus indicate that the baby must be delivered urgently (by caesarean section).

Ergometrine should not be used for the third stage. Syntocinon may be used. Ergometrine further increases BP so would risk stroke.

## Counselling Sterilization.

**MALE:** Hello Mr. Smith I am Dr. XYZ, senior house officer in the department of Surgery. I understand that you wish to have a sterilization operation.

I would like to ask you a few questions: have you completed your family? How many children have you got? What is the age of the last child? Have you considered other methods of contraception? Have you discussed this with your partner?

Sterilization is essentially irreversible. It involves a small operation on the tubes that carry sperm from the testicles to where they are mixed with the semen. These tubes will be cut or blocked. This doesn't effect your sexual function. You will still produce semen, but with no sperm in it.

The operation can be done under a local anaesthetic. A small cut is made on both sides of the scrotum. The tubes are then tied and cut. You can go home the same day. There shouldn't be any complications. You might be having some bruising or pain, which will resolve in a few days time.

You'll need to use some form of contraception for 2-3 months after the operation, because you will still be producing sperms. We will do a semen analysis and let you know when you are sterile. It is important that you understand that this procedure is permanent and irreversible.

**FEMALE:** Hello Mrs. Smith I am Dr. XYZ, senior house officer in the department of Obstetrics and gynaecology.

I understand that you wish to undergo a sterilization operation. Have you completed your family? Are you in a stable relationship? How many children have you got? How old is your last child? Have you considered other modes of contraception? Have you discussed this decision with your partner?

I must tell you that this is a permanent and irreversible procedure. It involves a small operation on your tubes. The tubes will be blocked so that the egg cannot travel down the tube. However you will still continue to have your periods. There are several ways of performing the operation. We will make a small incision on your abdomen and clip the tubes (mini-laparoscopy). You will need a general anaesthetic for the procedure. You can go home the next day.

I must tell you that there is a very small failure rate, i.e. 1-3 in 1000 chance of pregnancy.

Overall you will continue to have periods and your sexual activity should not be effected.

## Counselling -- Termination of pregnancy.

Introduction:

Questions to be asked before TOP:

How are you? Are you sure that you are pregnant?

Why do you want a termination? I don't mean to be intrusive but why have you considered this?

You have to live with the decision for the rest of your life. Have you discussed with your partner?

Have you considered the other alternatives like adoption of the baby?

If she chooses TOP: I will have to examine you and do a screen to confirm that you are pregnant. (Investigations: chlamydia, cervical smear, bloods for Rh and grouping. If Rh -ve give Anti D to prevent problems in the future).

When was your last cervical smear?

Is your menstrual cycle's regular? LMP?

Are you on any contraception?

Is this a planned or unplanned pregnancy?

Any previous TOP?

Are you having any medical problems? Are you on any medication?

H/o smoking and alcohol.

Mrs. Smith as you are >9 weeks pregnant the TOP is done under general anesthesia. The (neck of the womb) cervix is dilated and the womb is evacuated. When you wake up it may be sore and bleed. If there are no problems you can go home the same day.

The complications associated with TOP are heavy bleeding, rarely perforation of the womb, infection (affects the tubes and may lead to infertility) and rarely incomplete removal.

Contraception: You can start the pill tomorrow if you wish.

For 2nd trimester abortions, labour is induced using intravaginal prostaglandin gel or pessaries eg. Gemeprost. Oxytocin to stimulate contractions and surgical removal of retained placenta.

After 14 weeks mortality and morbidity raises steeply with gestation.

4-stage medical TOP: (gestation <9wks) Counselling and USG, supervised mifepristone 600mg PO disimplants the conceptus (CI: smokers >35yrs old; avoid aspirin and NSAID's for 12 days). A gemeprost 1mg pessary 36-48h later completes abortion. Follow up and scan at 12 days.

## Counselling: TURP.

Hello Mr. Smith I am Dr. XYZ, senior house officer in the department of Surgery. I understand that you have a problem when passing urine. Your stream is not very good. You have also said that you need to go very often to the toilet. We have examined you and found that your prostate is enlarged. As it is a benign enlargement, we would like you to undergo an operation called TURP, transurethral resection of the prostate.

This means that we will insert a small cystoscope through your urethra. The end of the cystoscope has a heated cutting loop with which we can remove all the abnormal tissue. The procedure will be done under general anesthesia. The anesthetist will come and have a word with you.

There are a few risks associated with this operation. There is a small chance that you may become infertile after the operation. You might notice some blood in your urine for the first 2 weeks.

After the operation, you should not drive for 2 weeks. You need to avoid sex for 2 weeks. Your ejaculate may be decreased and this is due to backward flow into the bladder. This can make the urine look cloudy. You might have to go to the toilet more frequently, but this should settle in a few weeks time.

Do you have any questions? Thank you Mr. Smith.

For carcinoma of the prostate: do PSA and serum alk phos to confirm metastatic Ca. Treatment options: Radiotherapy and analgesics for pain and Hormonal therapy with stilbesterol. If there is no metastasis prostatectomy and stilbesterol (orchidectomy can be an option).

## Child with Diabetes - history taking and counselling.

### Introduction:

How old is he?  
Is he lethargic and drowsy?  
Is he having temperature and any coughs and colds?  
How much does he drink? How often does he go for a wee?  
Does he wake up at night for a drink?  
How is his appetite? Weight loss?  
H/o diarrhoea?  
Does it sting during wee?  
H/o recurrent UTI?  
Past h/o similar illness? H/o head injury, meningitis?  
H/o Immunization?  
Family history of DM.

### Points in Counselling:

Due to the lack of insulin, which is produced by the pancreas, the blood sugar always remains high. The child may pass a lot of urine and he may be dehydrated. There is an increased risk of infection and boils. It can't be cured but can be kept under control by insulin injections. The cause of this is not known. The good news is he can grow as a normal child with insulin. It is important that he takes insulin regularly. He should not skip meals. It is advisable to always carry sugary drinks or chocolate. He will go into hypoglycaemia if he skips a meal. Hypoglycaemia presents as irritability, sweating, drowsiness, light-headedness and abdominal pain. It is important to recognise these symptoms. If he is ill he should still take insulin regularly with sugary drinks. Diet: advice from a dietitian, high-refined food and plenty of starches. Our diabetic nurse will have a word with you. Regular monitoring of blood glucose levels. Hyperglycaemia will cause damage to the body organs in the long run. So it is important to keep the blood sugar within the normal range. He will have regular follow ups. His GP will be informed. Here are some leaflets to know more about his condition. If you have any doubts please don't hesitate to ask. Thank you.

## Hormone Replacement Therapy.

Introduction: (Good morning Miss Tracy, I am Dr. XYZ Senior house officer in the department of Obstetrics and Gynaecology. I would like to have a little chat with you regarding HRT, Hormone replacement therapy.)

Age? When was the last period? Menstrual irregularities?

Are you on any contraception?

Any (vasomotor disturbances like) hot flushes, sweating and palpitations? Fractures? (prone to osteoporosis)

Any (vaginal dryness) vaginal and urinary infections, dyspareunia, bleeding, stress incontinence and prolapse? (also atrophy of breast, genitalia and skin.)

Psychosocial problems like irritability & depression.

Smoking, Hysterectomy and oophorectomy?

H/o DM, Heart disease, thyroid and psychiatric problems?

There are a few contraindications to HRT.

Were you diagnosed as having breast carcinoma or undiagnosed PV bleeding? (also breast feeding) and h/o clots in the legs (DVT or PE)?

There are a few SE like weight gain, cholestasis and vomiting.

Hot flushes and vaginal dryness respond to HRT. HRT postpones menopausal bone loss and protects against cardiovascular disease and ovarian carcinoma.

Women with uterus should receive oestrogen and progesterone preparations. This pill is similar to OCP but in very low dose. If you notice any bleeding consult your GP. (endometrial biopsy).

Types of HRT: Oral, creams, pessaries, rings, transdermal patches and oestradiol implants.

When is HRT particularly desirable: - Premenopausal bilateral oophorectomy, hysterectomy, increased risk of osteoporosis eg: inactive or smokers, Ischaemic heart disease or risk factors like DM and hypercholesterolaemia and Rheumatoid arthritis.

Rule out thyroid and psychiatric problems before starting HRT as they present similarly.

Counselling helps psychosocial problems, contraception should be continued for a year after the last period (PoP, IUCD and barrier methods are suitable.)

Refer: [HRT](#).

# History taking and Counselling: IUCD.

Introduction:

Questions to be asked before inserting IUCD:

How old are you?

Have you completed your family? How many children have you got?

Are the deliveries normal?

Menstrual history? LMP?

H/o ectopics? H/o fibroids?

When was your last cervical smear?

Have you been treated for any genital infection?

H/o heart disease, DM and Wilson's disease?

Are you on any medication?

IUCD is a small plastic and copper device with two soft threads on the ends. It is in the shape of the letter 'T'. It stops the sperm from reaching the egg. It prevents the egg from settling in the womb. The IUCD doesn't interfere with sex. It needs to be changed once in 3-5 years.

Disadvantages of IUCD: the periods may be heavier or longer or painful. There is a small chance of infection. In the first 20 days your womb may expel the IUCD out. There is a rare chance of perforation. If you do become pregnant (1%) there is the risk of an ectopic pregnancy. The IUCD doesn't protect against STD.

Follow up: immediately after the next period and then once every 6 months. Regularly feel for the tail. Come immediately to the hospital if the tail is lost, excessive bleeding, pain and fever.

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