



Rajiv Gandhi University of Health Sciences, Karnataka
4th 'T' Block, Jayanagar, Bangalore – 560 041.

Dr. N Ramkrishna Reddy
Registrar (Evaluation)

E-mail: registrareva@rguhs.ac.in
Ph: 080-29601930

Ref: RGU/DR (1)/Pre-Exam/MBBS/July-2020/02

Date: 20/10/2020

Guidelines to Conduct of Clinical Examinations for MBBS examinations - October 2020

General instructions:

- The Marks awarded by every examiner for each component such as Clinical case (Short case, Long case), Practical activity etc., to be entered in the place specified for entering the marks in the answer booklet.
- Individual examiner's marks awarded for every component to be maintained for the purpose of records.
- In case, marks awarded to any candidate is less than 50% of total marks prescribed for the practical's then it is mandatory to enter remarks in answer booklet of that candidate as specified in it. The same Answer booklet to be signed by all the examiners appointed.
- In case, if any college is attached to other college center for conduct of Practical examinations in the Orthopedics Subject the Internal Examiner are informed to sign for their respective college Students only in Practical Answer Booklet/Viva-voce Sheet and Online freeze Copy of Marks sheet.
- Theory Answer booklet Valuations of all the Internal and external examiners appointed for practical examinations is mandatory. Further it is the responsibility of Director/Dean/Principal/Chief Superintendent to ensure the same.

Regarding conduct of the Clinical Examination:

- The first option would be to conduct the Clinical/practical examination with **actual clinical cases** as per existing regulations of MCI/RGUHS by following safety precautions mentioned below:
 - Discussion shall be carried out in well ventilated area.
 - Distance between the beds in examination hall to be at least 2 meters.
 - Patients selected for Clinical examinations shall be tested for Covid-19.
 - Patients coming from containment area/contacts of Covid-19 positives, Patients with ILI/SARI to be avoided.
 - Patients shall wear the triple layer mask.
 - Any other safety precautions if required.
- **Wherever actual clinical cases are not possible**, the MCI has given relaxation to conduct the practical examination through an advisory No. MCI-(34) (41) (Gen)-Med/2020 / 113080 dated: 04/08/2020 with guidelines as below:
"Since, the objective of the practical examination is to ascertain the skills relevant to the speciality as outlined in the course curricula, alternative methods of skill evaluation which may include OSCE/OSPE, simulations, case scenarios etc. May be used in lieu of clinical cases, wherever later is not feasible, for the examinations"
- If alternative methods of skill assessment are adopted as specified above, the same has to be intimated in writing to exam appearing students prior to practical examinations. Wherever colleges are attached to the different centers the respective attached college internal examiner has to obtain the above alternative methods if adopted and communicate it to the students.
- The viva-voce and other sessions like instruments, specimens, radiology, spotters, slides etc. have to be followed.

This is only a onetime provision due to the prevailing pandemic situation and all other existing MCI/RGUHS guidelines will be applicable.

Guidelines for evaluation by clinical scenarios should have the following components:

1. History of the case:
Detailed clinical history of the case should be provided by the students to evaluate the skill of the candidate in symptom analysis.
2. Clinical features:
Detailed signs should be provided to the students to evaluate the interpretation skill and the ability of the students to arrive at a provisional diagnosis (working diagnosis). The differential diagnosis of the case should be discussed.
3. Provide the laboratory sonological, radiological any other investigation requested by the students so as to evaluate the ability of the student to interpret the investigation report and arriving at the final diagnosis.
4. Discussion on the treatment and other relevant issues pertaining to the case.
5. Clinical scenarios should be created for both long and short cases.
6. Students should be provided the copy of the case scenario which needs to be written in the answer book to facilitate the evaluation of the candidate.
7. The examiner should write their comments in the answer book during evaluation.
8. If the candidate scores less than 50% of maximum marks, the reason should be commented in the specified place of answer booklet.
9. Evaluation of the candidate using clinical scenarios should be similar to that of case-based evaluation.

Model/Sample Clinical Case Scenarios in Various Clinical Department

1.General Medicine

Long case

History:

55yr old male presented with complaints of,

1. Evening rise of temperature since 2 months
2. Dry cough since 2 months
3. Left sided chest pain since past 1 month
4. Breathlessness on exertion since past 15 days

Patient was apparently asymptomatic 2 months ago when developed complaints of low-grade fever with evening rise of temperature. Patient complaints of dry cough since 2 months. Complaints of left sided chest pain since 1 month, non-radiating type of pain, pain increases with deep inspiration and decreases on lying down to left side. Complaints of breathlessness on exertion since 15 days, History of weight loss and loss of appetite present. K/C/O Diabetes mellitus on medication. Chronic smoker since 20 yrs about 1 pack/day and Non-alcoholic.

[Discuss about additional information required, the interpretation of symptoms and possible diagnosis by symptoms]

GENERAL PHYSICAL EXAMINATION:

Pulse – 98/min, regular rhythm, BP- 130/80mmhg in all 4 limbs, Spo2- 96% at room air, Afebrile. Respiratory rate- 28/min, abdomino-thoracic, Lymphadenopathy present – left supraclavicular, firm in consistency, matted lymph nodes present on left side. [2x1.5cm].

RESPIRATORY EXAMINATION:

INSPECTION: Trachea deviated to right, apical impulse not seen, Traube sign positive, Chest movement – decreased in left mammary, infra-axillary, inter-scapular and infra-scapular area, Intercostal spaces – fullness seen.

PALPATION: Trachea deviated to right, Apex beat could not be localised, Decreased chest expansion [2cm] on left side, Measurements – Right-hemithorax :28cm, Left-hemithorax : 30cm,Vocal Fremitus decreased in mammary, infra axillary, infra scapular and inter scapular areas on left side, On **PERCUSSION**, dull note heard in left mammary infra-axillary, infra scapular, inter-scapular area, Traube space – dull, On **AUSCULTATION**, absent breath sounds in left mammary, infra-axillary, infra-scapular, inter scapular areas, **VOCAL RESONANCE** decreased on left mammary, infra-axillary, infra scapular and inter scapular area.

Other system: Within normal limits

[Discuss what other additional examination findings are required to make a clinical diagnosis. Discuss about differential diagnosis].

[Discuss on investigations required, interpretations, final diagnosis and treatment options]

Short case

History:

A 65-year-old male, presented with complaints of progressive breathlessness and dry cough since 6 months, With past history of pulmonary tuberculosis 1year ago, received treatment for 6 months.

[Discuss about additional information required, the interpretation of symptoms and possible diagnosis by symptoms]

On Examination:

On **GENERAL PHYSICAL EXAMINATION:** pulse 88/min, Bp: 110/70mmHg, Spo2:97 under RA, afebrile, RR:28/min, pallor present, lymphadenopathy present in left supra clavicular area 2×1 cm.

On **INSPECTION** left side supra clavicular hollowing and infra clavicular flattening present, trachea shifted to left side, apical impulse seen in left 5th ICS 1cm lateral to mid clavicular line, rib crowding present and narrowing inter costal spaces on left side, with decreased chest movements on left side, on **PALPATION** trachea shifted to left side with apex beat in left 5th ICS 1 cm lateral to mid-clavicular line, with decreased chest movements on left side and decreased chest expansion: 2.5 cm with measurements :right hemi-thorax: 32cm, left hemi-thorax is 27cm,with decreased vocal fremitus on left side all lung fields, On **PERCUSSION** impaired note present on left side clavicular percussion, also on left supra-clavicular, infra-clavicular , mammary, axillary ,infra-axillary, supra-scapular, inter scapular, infra scapular areas, On **AUSCULTATION** , decreased intensity of breath sounds on left side in all lung fields, and decreased vocal resonance in all lung fields on left side with fine inspiratory crepitation heard on left side mammary, axillary, infra axillary and infra scapular area

Other system: WNL

[Discuss what other additional examination findings are required to make a clinical diagnosis. Discuss about differential diagnosis.]

[Discuss on investigations required, interpretations, final diagnosis and treatment options]

2. General Surgery

Long case

History:

A 48-year-old male patient with complaints of a swelling in the left inguinoscrotal region for duration of 4 years. It used to appear on straining and coughing and used to disappear completely on lying down. It started descending down into the scrotum a year ago. Swelling became bigger on straining for the last three months. Patient is unable to reduce it completely. No H/O chronic cough or breathlessness, No H/O LUTS, No H/O constipation

[Discuss about additional information required, the interpretation of symptoms and possible diagnosis by symptoms]

On Clinical Examination:

General condition satisfactory. Left sided inguinoscrotal swelling extending from above the groin crease to the bottom of the scrotum. 15x10 cm, pyriform in shape, smooth surface, expansile on coughing, visible peristalsis noted over the swelling skin stretched, non-tender, consistently soft, swelling reduced with some amount of difficulty. On deep ring occlusion test the swelling did not appear when the patient was asked to cough.

[Discuss what other additional examination findings are required to make a clinical diagnosis. Discuss about differential diagnosis.]

[Discuss on investigations required, interpretations, final diagnosis and treatment options]

Short case

History:

A 52-year-old man manual labourer by occupation presents with swelling over the nape of the neck since 2 years, insidious in onset and gradually progressive in nature, initially it was size of marble gradually increased to current size of lemon. No history of sudden increase in the size of swelling. No history of loss of weight.

[Discuss about additional information required, interpretation of symptoms and possible diagnosis of symptoms]

On Examination:

Swelling was noted over the nape of the neck, solitary, size of about 6*4 cm, oval in shape, margins are well defined, surface is smooth, plane of the swelling is subcutaneous, soft in consistency, mobile in all directions, edge slips under palpating finger.

[Discuss what other additional examination findings are required to make a clinical diagnosis. Discuss about differential diagnosis.]

[Discuss on investigations required, interpretations, final diagnosis and treatment options]

3. Orthopaedics

Short case

History:

A 40-year-old male patient comes with complaints of discharging wound and pain in right leg 1 year with H/o of RTA 1 year back- open wound and patient had Undergone IMIL nailing of Right lower limb.

[Discuss about additional information required, the interpretation of symptoms and possible diagnosis by symptoms]

On Examination:

Wasting present

Antalgic gait

Surgical scar – inferior to patella

Tenderness present

No abnormal mobility

Discharging Sinus present at the junction of middle and distal third of tibia

Bone thickened.

[Discuss what other additional examination findings are required to make a clinical diagnosis. Discuss about differential diagnosis.]

[Discuss on investigations required, interpretations, final diagnosis and treatment options]

4(a) OBG (Obstetrics case)

History:

A 26-year-old Primigravida with H/O Amenorrhoea of 8 months presented with complaints of easy fatigability and tiredness since 15 days and her LMP was on 02/03/2020.

[Discuss about additional information required, the interpretation of symptoms and possible diagnosis by symptoms]

On Examination:

Ht. 154cms, Wt. 56 kgs, Pallor - Present.

Per Abdomen:

Uterus - 32 weeks, cephalic presentation, FHR -130/min heard in left spino umbilical line.

[Discuss what other additional examination findings are required to make a clinical diagnosis. Discuss about differential diagnosis.]

[Discuss on investigations required, interpretations, final diagnosis and treatment options]

4(b). OBG (Gynaecology case)

History:

A 40 years old female, P2 L2 presented with c/o of heavy menstrual bleeding for past 6 months and also complains of pain during menstrual cycles. And cycles were regular.

[Discuss about additional information required, the interpretation of symptoms and possible diagnosis by symptoms]

On Examination:

Wt. 58 kgs, Ht. 150cms, BP - 130/80

Pallor - present

Per Abdomen:

An intraperitoneal mass corresponding to 18 weeks size of uterus, firm, non-tender, mobile transversely, lower border not felt.

[Discuss what other additional examination findings are required to make a clinical diagnosis. Discuss about differential diagnosis.]

[Discuss on investigations required, interpretations, final diagnosis and treatment options]

5(a) Paediatrics

History:

A 3-year-old boy who presents to the paediatric OPD with a 2-day history of puffy eyes. With insidious onset of abdominal distension and swelling of limbs. He is otherwise well. He has h/o asthma, He is on no other medication.

[Discuss about additional information required, the interpretation of symptoms and possible diagnosis by symptoms]

On Examination:

He looks well and is afebrile. He has puffy eyes and pitting pedal oedema. heart rate is 112 beats/min, blood pressure is 96/64 mmHg. There is abdominal distension, No tenderness or organomegaly. However, his scrotum appears oedematous. Respiratory rate is 28 breaths/min and there are no respiratory signs.

[Discuss what other additional examination findings are required to make a clinical diagnosis. Discuss about differential diagnosis.]

Investigations:

Haemoglobin - 15.2 mg/dL

White cell count: 11700/micro lit

Urea: 23 mg/dl

Creatinine: 1.3 mg/dl

Albumin: 1.9 g/L

Urine examination:

Protein 4+

[Discuss on investigations required, interpretations, final diagnosis and treatment options]

5(b) Paediatrics case

History:

A 4-year-old male child presenting with pallor, decreased activity and past history of repeated blood transfusions since 10 months of age.

[Discuss about additional information required, the interpretation of symptoms and possible diagnosis by symptoms]

On Examination:

The child weighs 12kgs, height 90cms,
Liver is 3cms below the right costal margin and spleen is 4cms below the left costal margin.

[Discuss what other additional examination findings are required to make a clinical diagnosis. Discuss about differential diagnosis.]

Investigations:

Haemoglobin - 6.2 mg/dL
White cell count - 20700 cells/micro lit
Reticulocyte count - 0.6%
MCV - 55 fl

[Discuss on additional investigations required, interpretations, final diagnosis and treatment options]

Clinical case Scenarios can be prepared on the similar lines for other clinical subjects with suitable modification required for their specialities.

Sd/-

REGISTRAR EVALUATION