The Royal Australian & New Zealand College of Psychiatrists

Candidate's No.:

Modified Essay Questions

SCORING KEY

FEBRUARY 2019

INSTRUCTIONS: 2B PENCIL

- Please use pencil ONLY, preferably 2B
- Do not fold or bend
- Erase mistakes fully
- Make no stray marks
- Completely fill in the oval

Please MARK LIKE THIS ONLY: (0) (1) (3) (4)

Modified Essay 1

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 at a community mental health service. Bill is a 71-year-old widower living alone in his own unit. He presents to his General Practitioner with a three-month history of feeling unwell with constipation, churning stomach and poor sleep. The GP can find no physical cause for Bill's symptoms and commences him on sertraline 50mg daily. After six weeks, Bill is no better and the GP refers him to your clinic. Bill attends your clinic for assessment, although he is sure his GP has missed a physical illness. He describes feeling listless and fatigued, having problems concentrating, and worrying about his physical state. He expresses the view he is a burden on his children and would be better off dead. He has severely restricted his food intake because he believes eating is aggravating his constipation.

Question 1.1

List important factors in assessing Bill's risk of harm to himself. ***(6 marks)***

A.	Older male (higher risk of completed suicide).	(0) (1)
B.	Living alone.	(0) (1)
C.	Depressed mood.	(0) (1)
D.	Possible delusional beliefs (hypochondriasis, guilt).	(0) (1)
E.	Physical deterioration due to food restriction, being elderly.	(0) (1)
F.	Possible recent loss (widowed).	(0) (1)
G.	Expressed suicidal ideas. Past psychiatric history. Passive suicidal ideation.	(0) (1)
H.	Access to weapons or implements to harm himself.	(0) (1)
I.	Side effects of sertraline such as agitation.	(0) (1)
J.	Absence of protective / risk mitigating factors: Social supports; connectedness. Hope for the future.	(0) (1)

K.	**Spare** (only to be used after approval from Co-Chairs, Writtens Subcommittee)	(1)
L.	**Did not attempt**	( )
M.	**Did handwriting affect marking?**	( )

Note to Examiner: Please mark all bubbles even if the total adds up to more than 6.
Note to NDS: Please set the maximum mark to 6.

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0 1 3 4

Modified Essay 1

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

You are a junior consultant psychiatrist at a community mental health service. Bill is a 71-year-old widower living alone in his own unit. He presents to his General Practitioner with a three-month history of feeling unwell with constipation, churning stomach and poor sleep. The GP can find no physical cause for Bill's symptoms and commences him on sertraline 50mg daily. After six weeks, Bill is no better and the GP refers him to your clinic. Bill attends your clinic for assessment, although he is sure his GP has missed a physical illness. He describes feeling listless and fatigued, having problems concentrating, and worrying about his physical state. He expresses the view he is a burden on his children and would be better off dead. He has severely restricted his food intake because he believes eating is aggravating his constipation.

After your initial assessment, you make a provisional diagnosis of major depressive disorder. Bill tells you he does not want to be admitted to hospital for treatment.

Question 1.2

List clinical factors which would be important in determining whether inpatient treatment is required. ***(5 marks)***

A.	How difficult it has been to maintain a therapeutic alliance with Bill? Willingness to accept and availability of outpatient treatment.	0 1
B.	Bill's high risk of suicide, thought and intent.	0 1
C.	Non-response to treatment to date.	0 1
D.	Clear deterioration in physical health.	0 1
E.	Adequacy of functioning at home, ability to self-care, and availability of supports (adult children, community engagement).	0 1
F.	Compliance with medication / treatment adherence.	0 1
G.	Opportunity to observe and complete a battery of investigations such as cognitive assessment.	0 1

H.	**Spare** (only to be used after approval from Co-Chairs, Writtens Subcommittee)	1
I.	**Did not attempt**	○
J.	**Did handwriting affect marking?**	○

Note to Examiner: Please mark all bubbles even if the total adds up to more than 5.
Note to NDS: Please set the maximum mark to 5.

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26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

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Modified Essay 1

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You are a junior consultant psychiatrist at a community mental health service. Bill is a 71-year-old widower living alone in his own unit. He presents to his General Practitioner with a three-month history of feeling unwell with constipation, churning stomach and poor sleep. The GP can find no physical cause for Bill's symptoms and commences him on sertraline 50mg daily. After six weeks, Bill is no better and the GP refers him to your clinic. Bill attends your clinic for assessment, although he is sure his GP has missed a physical illness. He describes feeling listless and fatigued, having problems concentrating, and worrying about his physical state. He expresses the view he is a burden on his children and would be better off dead. He has severely restricted his food intake because he believes eating is aggravating his constipation.

After your initial assessment, you make a provisional diagnosis of major depressive disorder. Bill tells you he does not want to be admitted to hospital for treatment.

Question 1.3

Discuss (list and debate) possible strategies for pharmacological management of Bill's illness.

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

A.	Increase sertraline dose having regard to side effects in older people e.g. agitation, hyponatraemia, and falls (trial of sertraline to date has been inadequate in dose).	0 1 2
B.	Alternative strategies: • Consider alternative antidepressant strategies with differing mode of action such as SNRI, tricyclic antidepressant (severe depression with melancholic features may respond preferentially to therapy targeting more than one neurotransmitter system but there is a risk of lethality in overdose). • Consider the addition of an antipsychotic medication in low dose, such as risperidone (possible psychotic symptoms) but there is a risk of anticholinergic side effects. Consider olanzapine for its antiemetic effects and increase in appetite. • Short-term addition of short-acting benzodiazepine in low dose for anxiety, agitation (e.g. oxazepam) and sleep disturbance (e.g. temazepam). Can cause confusion in the elderly. • Consider use of non-benzodiazepine hypnotic (e.g. zopiclone) but risk of side effects such as constipation, agitation. Smaller risk of dependence. Or consider adding in agomelatine as useful for sleep and good antidepressant. Or melatonin as less likely to have cognitive problems than benzodiazepines.	0 1 2 3 4 5 6 7 8
C.	Pharmacological management of physical health problems like constipation and other comorbid medical problems. Consider nutritional supplements.	0 1 2

D.	**Spare** (only to be used after approval from Co-Chairs, Writtens Subcommittee)	1
E.	**Did not attempt**	
F.	**Did handwriting affect marking?**	

Note to Examiner: Please mark all bubbles even if the total adds up to more than 10.
Note to NDS: Please set the maximum mark to 10.

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Modified Essay 1

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After your initial assessment, you make a provisional diagnosis of major depressive disorder. Bill tells you he does not want to be admitted to hospital for treatment.

In collaboration with Bill's general practitioner, you decide Bill should be admitted to hospital, to which he eventually agrees. He is admitted to the general acute mental health unit under your team.

Question 1.4

Describe (list and explain) the instructions you would give to the nursing staff in their assessment of Bill.
Please note: a list with no explanation will not receive any marks. ***(10 marks)***

A.	Regular physical observations (pulse, postural blood pressure, temperature).	0 1 2
B.	Monitor oral intake, fluid intake, and urine output – food restriction, constipation.	0 1 2
C.	Urine collection for microscopy & culture.	0 1
D.	Regular visual observations (e.g. each 15 minutes) – risk of harm to self; new environment may add to confusion in the elderly.	0 1 2
E.	Baseline and regular weight monitoring – food restriction.	0 1 2
F.	Monitor sleep – insomnia is common in the elderly.	0 1
G.	Mental status observations for mood, evidence of psychosis, suicidal ideas, cognition and any evidence of delirium, emergence of guilt or nihilistic delusions.	0 1 2
H.	General behavioural observations e.g. interactions, ADL's, changes at twilight which may be evident in delirium.	0 1 2
I.	Regular standardised assessment tools if staff are trained in the conduct of these assessments (e.g. Geriatric Depression Scale – self-administered, Hamilton Rating Scale for Depression – observer rated; MMSE – for cognitive assessment).	0 1 2 3
J.	**Spare** (only to be used after approval from Co-Chairs, Writtens Subcommittee)	1
K.	**Did not attempt**	○
L.	**Did handwriting affect marking?**	○

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