Psychiatry Rotation

Hey everyone

Psych is generally quite "laid back". The hours are very reasonable. The longest days are spent while rotating throught TDH/SBAH, when you finish around 15:00. Calls are also quite chilled. You do two "calls" at WKH, when you have to stay until all the patients are clarked. We generally finished around 16:00 or 17:00. Then you do two more calls at TDH/SBAH, but none of us were ever called out during these. Calls end at 16:00 (but most of the time you knock off even before that).

As far as the work is concerned, they give you NBs throughout the rotation, esp prof Roos and prof Pretorius – so listen carefully and take notes.

I think the tests for psych change with every rotation, but for what it's worth, this is what we got:

Progress test:

Apparently this doesn't count, unless you are borderline pass, borderline promote or borderline distinction, in which case they do take it into consideration.

- First question was the case history with symptoms given, as well as that the patient had suicidal ideation. Follow-up questions were to give a differential diagnosis of GROUPS of disorders to consider (i.e. just "psychotic disorder", but not specifically SCZ or SAD, or "mood disorder" but not specifically MDD or BMD, etc.); as well as risk factors for suicide.
- Second question was to say how you would explain in layman's terms to someone with no medical knowledge what psychosis is. Follow-up question was to list further symptoms of SCZ that you have not mentioned in the first part of the question.
- Then there was a question of a pt with a history of an eating disorder. They asked what is BMI, how it is calculated, what is normal BMI and the subtypes of anorexia nervosa.
- There was a question of an elderly lady with delirium. You were asked to make the diagnosis from the case history, as well as mention risk factors for delirium in the specific pt in the case.
- Management of acute dystonia: generic name, trade name, dosage and route of administration.

Case exam:

This is a paper case, not "real life patient", but it's not the same as for block 15. You don't prepare anything before hand, you get the case in the test and you have an hour to answer questions. It was quite tricky. Most of the time you don't *really* understand what exactly they are actually asking, so you kind of just put everything down you can think of and hope for the best...!

- Case was the history of a pt shoing signs of mania with psychotic features. First you had to name the episode (which they called something strange like "syndromic event", not "mood episode") – i.e. manic episode. Then they asked to list the typical features of this specific type of "syndromic event" that were not listed in the case history ... except, pretty much ALL the typical symptoms of mania were already named in the case. They also asked for a differential diagnosis of 4 things that could also possibly explain the pt's symptoms, as well

as to name “medical, social, treatment and biological” (or something along those lines) risk factors and/or complications applicable to the pt in the case specifically.

- Follow-up questions were a bit more straightforward: signs and symptoms of cannabis intoxication; side effect of benzo’s, etc.
- MHCA: they sketched two types of scenarios and asked how you would admit the patient in each, to motivate your answer, and then explain the procedure. In of of them, the pt was aggressive, so you had to also bring in the management of acute aggression with all the other MHCA stuff.
- Then they asked how you would go about starting the patient on Valproate: special investigations and work-up before starting treatment, starting dosage, how to titirate it upwards, etc.

Written test:

Prof Roos had a session with us the week before the test during which he basically gave us the WHOLE test. So it was fairly easy.

- Case history of a psychotic pt, asked to give the diagnosis (delusional disorder), subtypes of this disorder, as well as what subtype the specific pt most likely suffered from.
- List the clinical presentation of MDD.
- 5 indications for SSRIs.
- 10 indications for ECT.
- Case scenario of a pt with symptoms of epilepsy, but no signs of epilepsy on EEG. Then they changed one little sentence every time, and you had to give the most probable diagnosis. I.e, you had to be able to differentiate between factitious disorder, malingering, conversion disorder, etc. Also some other case histories where all you had to do, was give the Dx, but it was *really* easy – we got ASD and dementia.
- How to distinguish between hypomania and mania; define rapid cycling.
- Stages of alcohol intoxication.
- Management of panic disorder, combined with questions on what psycho-education you would give a pt with panic disorder.

Oral examination:

Prof Pretorius has sessions during the rotation to prepare you for this. Try to attend these, even if you are rotating at WKH/SBAH – it’s worth the drive to WKH.

The examiners get handed a list of topics that were not covered in the tests, and then each one decides what he/she wants to ask, so students do not all get asked the same questions. Some people were asked management, including lots of drugs and dosages, while other people weren’t asked on drugs at all, but more definitions and to explain the disorders themselves. Only about 4 people per examiner; 20 minutes per student. Some of the things that came up, included:

- Case history if a pt with MDD and suicidal ideation – asked the management. (many scenarios given were “you are in a small town, you are alone and you cannot refer – how would you manage this pt?)

- Case history of pt becoming aggressive after a minor surgical procedure. Pt has a strong family Hx of BMD (but no personal Hx). Don't let the family Hx distract you – what they want is basically that you would consider alcohol withdrawal delirium first, how you would confirm this and how you would manage it.
- What is NMS, what does it present like and how do you manage it.
- Case history of pt with intrusive, recurrent thoughts that he feels he cannot control. Asked the DDx. Then given more info on the case as you go on, asked the Rx of OCD, why the content of the intrusive thoughts would be important, what co-morbidities to consider and whatever else they can think of.
- SCZ – age of onset in males, DDx of social withdrawal in a 19 yr old boy. Biological Mx of SCZ (list typical atypical) with dosages and side effects of each.
- 78 yr old confused lady. She is forgetful and suddenly thinks about the death of her daughter. Asked DDx, side room investigations how to differentiate between stuff in your DDx
- Suicide: risk factors, assessment, management (if, once again, ou are far away from a hospital somewhere out in the bundu's).
- MHCA: how to admit, which forms to use, etc.
- Dementia: dementia vs delirium, causes of dementia, etc.
- Some of the 6th year SICs were asked questions on child psych, specifically ADHD, including first line and second line treatment, and mechanism of actions of the drugs.

This list is by no means complete, but hopefully it gives more or less an idea of what to expect. They are really not out to get you in the orals, and if you miss something, they very subtly nudge you in the right direction.

Compilation of marks:

- 20% case exam
- 20% oral exam
- 40% written test
- 10% "participation mark" at adult firms
- 10% "participation mark" at child/adolescent unit. When rotating in this unit, you need to hand in two assignments: ours were on MDD in children, and on ADHD. The secretary kind of hinted towards them actually using the marks you get for these assignments to get your "participation mark" for child/adolescent.

You do the case exam on the last week Wednesday, then have the Thursday off, and do the written and oral on the Friday, unless there are public holidays during that week.

The secretary emailed me the list of students who did not promote on the same day we did the written and oral exams, so at least you don't wait long to know!

Hope it helps! ☺