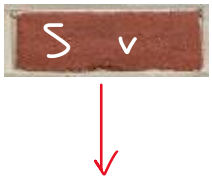
SET English

1 Review ‘blocks’
2 Joining with conjunctions
3 Joining with prepositions

What are the '<u>building blocks</u>' of Writing?

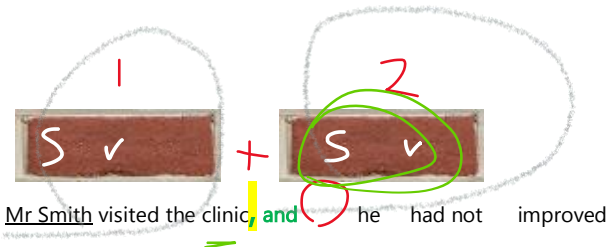


1 Mr Smith / clinic
Mr Smith visited the clinic

2 Mrs Richards / advice
Mrs Richards was advised

3 Mr Smith / prescribe +
Mr Smith was prescribed

2 WAY COMBINING BLOCKS



Mr Smith visited the clinic, and he had not improved

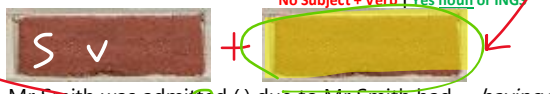
Go to chat box and write 3 sentences:

1 Mr Green / admitted → Mr Green / treated
Mr Green was admitted, and he was treated

2 Mrs Smith / report pain → *no pain killers* / prescribe
Mr Smith reported pain, but painkillers were not prescribed

3 Mr Richards / poor health → Mr Richards / no exercise
Mr Richards has poor health, however, does exercise regularly

Rule: 1. **Delete subject** 2. **Change verb ING**



Mr Smith was admitted (,) due to ~~Mr Smith~~ had = *having* a health issues

1. Mr Green / high BP Mr Green / overweight
Mr Green had high BP, due to he was overweight

2. Mr Smith / no improve preposition Mr Smith take medication
Mr Smith did not improve in spite of taking his medication

3. Mrs Hope / improve diet preposition Mrs Hope improve exercise
Mrs Hope has improved her diet, as well as improving exercise.

Conjunctions

Normal (co-ordinating)	Subordinating
Because And Yet But Or , therefore, , however,	Although If While When
Cannot put them at start	Can go at start or middle

Exceptions

- Pronoun
- *Ellipsis: removing Subject*
- However + Therefore need 2 commas

Prepositions

With On At In For To about Despite Before After Etc.	**Due to = because** In spite of = although **As well as = and**

Exceptions:

- **before / after** = we CAN use S+v

Mrs Hope improved her diet before she went to the doctor

Conjunctions	Not a conjunction
And But Also However Although Because ONE SENTENCE: 2 clause   1. Mr Green is stable, and his wound is healing well	Additionally As well as Due to

CONTEXT	FORM	MEANING
1. Fibromyalgia can be a painful and **debilitating** disease. It really impacts on day-to-day life so that and you become dependent on others for help.	Gerund (adj.)	1. Makes you weaker / reduces ability
2. There was a rapid **escalation** in the symptoms	Noun	1. *Increase* / make higher / make more
3. She initially described her complaint as minor and **erratic** – so it was hard to ***pin it down***	Adjective Idiom	1. Irregular / changing all the time To force someone/something to stop changing: 'pin it down'   = he pinned him down
4. Her symptoms seemed to **correspond** with a decrease in temperature in the winter	Verb	1. Related to / connected to 2. Correlated **3.** Mirror – same on both sides **Common error:** **1. Its mean** = I have this for years! **2. It means** ✓
5. Because the condition isn't visible, there is an **assumption** that you are exaggerating the severity of the pain	Noun	1. When you make a belief without checking first You *ASSUME* it is true usually because it was like that previously **Synonym**: presume
6. Because the condition isn't visible, there is an assumption that you are **exaggerating** the severity of the pain	Gerund (verb)	1. More than real Making it more than it really is Synonym: *overstate*
7. It's **hard to bear** when you're already struggling Bear here = carry	Idiom Phrase	1. Difficult to cope/tolerate/manage
8. She was put onto a therapeutic treatment – did she **supplement** this with drug treatments?	**Verb** (can be noun)	1. Add extra things to it... I am *supplementing* my English study by working in a restaurant speaking English **Noun**: extra thing / additional
9. No, she **turned down** a number of medications we offered	Phrasal verb	1. Reject Often used for **romantic** relationship: He proposed marriage but she *turned him down*
10. She had clearly **done her homework** on the different pharmacological therapies available	Idiom	1. Do the research 2. Study the information

11. Another drug we offered was known to produce some mild ، ء reactions	Adj.	1. Negative / bad Adverse = harmful, not favourable, preventing success Averse = **strong dislike** or opposition to I am really adverse to this – Im not going to do it.
12. There is always the possibility of · ɔn any prescribed drugs	Noun	1. Too much **reliance on** 2. Addiction
13. She was also encouraged to keep a food diary and ،er symptoms	Verb	1. Register
14. They are under absolutely no that this is the end to their symptoms although it has at least alleviated their pain	Noun	1. No false beliefs

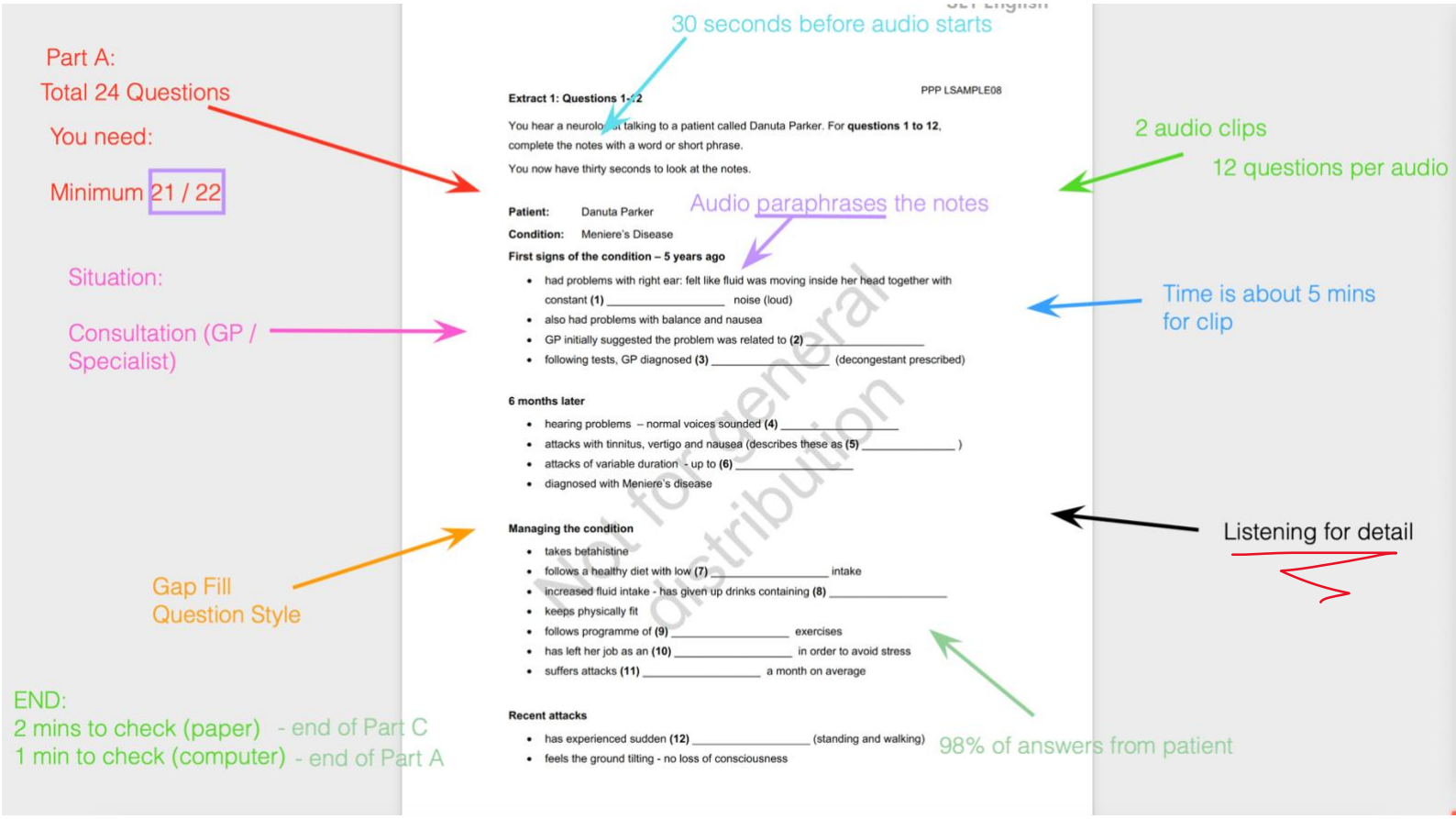
Listening Part A:

1 Format

2 Practice the skill listening for details

3 Mock test

FORMAT:


Part A:
Total 24 Questions
You need:
Minimum 21 / 22
Situation:
Consultation (GP / Specialist)
Gap Fill Question Style
END:
2 mins to check (paper) - end of Part C
1 min to check (computer) - end of Part A
30 seconds before audio starts
Extract 1: Questions 1-12
PPP LSAMPLE08
You hear a neurologist talking to a patient called Danuta Parker. For questions 1 to 12, complete the notes with a word or short phrase.
You now have thirty seconds to look at the notes.
Audio paraphrases the notes
Patient: Danuta Parker
Condition: Meniere's Disease
First signs of the condition – 5 years ago
had problems with right ear: felt like fluid was moving inside her head together with constant (1) _____ noise (loud)
also had problems with balance and nausea
GP initially suggested the problem was related to (2) _____
following tests, GP diagnosed (3) _____ (decongestant prescribed)
6 months later
hearing problems – normal voices sounded (4) _____
attacks with tinnitus, vertigo and nausea (describes these as (5) _____)
attacks of variable duration - up to (6) _____
diagnosed with Meniere's disease
Managing the condition
takes betahistine
follows a healthy diet with low (7) _____ intake
increased fluid intake - has given up drinks containing (8) _____
keeps physically fit
follows programme of (9) _____ exercises
has left her job as an (10) _____ in order to avoid stress
suffers attacks (11) _____ a month on average
Recent attacks
has experienced sudden (12) _____ (standing and walking)
feels the ground tilting - no loss of consciousness
Not for general distribution
2 audio clips
12 questions per audio
Time is about 5 mins for clip
Listening for detail
98% of answers from patient

Now **Skills** Practice:

The activity that you need to be good

When do we listen for details?

Note taking

Context: consultation and the woman is having emotional problems / depression

Write notes: Mrs Doors Dr David Sorry if wasting your time Not sleeping well / exhausted Asked for sleeping tablets **DR:** "It would really help me if I could ask…." = very natural Okay
Longer: • Started: a year ago • Not coping • Tired all the time • Kids & job • Can't sleep **Sleeping?** • I lie awake at night • Don't know how long – goes on and on • Feel dreadful **Appetite?**

- Kids dinner
- Can't be **bothered** = natural language meaning – I don't care

Do you feel like you have lost your 'get up and go'

Repeated 'energy levels'

- Used to enjoy **swimming** with kids

https://www.youtube.com/watch?v=Cg4BbnkBavQ&list=PLpRE0Zu_k-By_X4lNa4WwYFC2MTbkDHok

Transcript:

How can I help you today?

I'm sorry I might be wasting your time a bit but I've come because can't I'm not sleeping very well and just exhausted and I just wanted if you could give me something anything to help me sleep some sleeping tablets

okay it'd really helped me if I could ask a few more questions about how you feeling yeah maybe symptoms and then we can sort of see how can help you would that be okay yes I think yes so what any time of it more about what's brought you here today

um about year ago and her husband was split up and since I just not being coping very much I'm just tired all the time and Kids job and just in very well I can't see okay what are we just look at one of those things at a time

tell me a bit more about see having trouble sleeping?

so I always had no height I don't know what time it is but it seems to go on and on and on the night and must have got sleep in the morning I just feel so dreadful okay I'm problems

with your appetite yeah I think the kids to dinner I just what about life and in general lost he get up and go sorry I don't understand you get up and get your energy levels and yeah finished enjoy the kids and stuff but I just want to be on my own I just can't just not in a very good at the moment as well I just so exhausted really just going back to your sleep can you tell me a bit more about that how much sleep you getting each night so just a lightweight and think about hip and her together things that we used to do I just wake pigs hosted

M: Now, Mrs Parker, I understand from your notes that you have Meniere's disease. But perhaps you could tell me, in your own words, when this all started, what treatment you've had, and anything else you think I should be aware of.

F: Sure. Well, it all started about five years ago – a few weeks after my daughter was born. I realised there was something wrong with my right ear. I couldn't hear as well as normal and it felt like I had fluid sloshing around inside my head. Then I realised I could hear this sort of humming, which didn't stop. It was particularly loud, but I was also having moments when my head was spinning and I was completely off-balance. That made me feel, you know, very sick. The first time I told my GP about it, he thought it might have something to do with hormones, because I'd just had a baby. But the dizziness and sickness actually got worse, so then he did a few tests and told me I had glue ear. He gave me some medication – I think it was called Benadryl.

M: That's a decongestant.

F: Yeah, and it seemed to work for a while. But then six months later, things began to go wrong again. I got worried about my hearing because I was having to strain to catch what people were saying. Everything seemed muffled, unless they were talking loudly. And then suddenly the tinnitus came back, and with it I was getting fits of dizziness and nausea. When it came on, the only thing I could do was lie down. The best word for it is incapacitating. That's what it felt like.

M: How long did these attacks last?

F: They varied. Some were quite brief – maybe half an hour – but the worst ones went on for four or five hours. It got so bad that eventually I was referred to an ENT specialist who diagnosed me with the Meniere's disease. It was explained to me that there's an abnormal build-up of fluid in the inner ear and this affects the organs which regulate hearing and balance. But no-one really knows what the underlying cause is and there's no cure. Is that right?

M: Pretty much, yes. And it's tricky to diagnose, because many of the symptoms are also characteristic of other conditions. But it can be managed. Have you been given medication to take?

F: Yes, betahistine. It's for when I have attacks. It probably helps with the dizziness, but I still feel very nauseous and I don't like the idea of taking it long-term. I was advised to eat lots of vegetables and fruit, and to cut right down on the amount of salt I eat. I was also told it's best not to drink anything alcoholic – that wasn't an issue for me because I never had, but I've been drinking plenty of water and I feel that has made a difference. Also I decided to avoid having anything with caffeine in it and I do think that's been beneficial. I try to stay active – I go to the gym three times a week when I'm feeling normal. I'm also disciplined about doing the exercises that a therapist I went to see gave me – you know, the vestibular ones – that help improve my balance.

M: That all sounds good. Do you work?

F: I'm a trained accountant and I did that sort of work for several years until things got too much for me, what with having two young children and the Meniere's. I'm convinced that stress triggers attacks.

M: How often do you get them?

F: It's quite unpredictable. I might get five in a month and then maybe one in the next six months, but overall it works out at about twice a month. Though things have changed again recently. I generally feel quite confident that I can deal with the Meniere's but, in the last few weeks, I've been getting something new. Without any warning, I have falls – when I'm standing or walking, I just hit the ground. I don't faint but I can't control it. It feels like the ground is tilting and there's nothing I can do. It's frightening.

M: I can imagine. OK, thank you for all that background – that's really useful. From what you've told me I can see that we need to do some tests ..... [fade]

OET Reading Part A:

1. What is Scanning? + Practice
2. What is Skimming? + Practice
3. **Putting it together: Technique**

What is *scanning*?

Read for details / finding a detail

Example:

Scan for specific **name / address**


When we <u>search</u> for an app

OET Reading Text:

GAME: tell me the word before the word I say

Text A

Paediatric nasogastric tube use

Nasogastric is the most common route for enteral feeding. It is particularly useful in the short term, and when it is necessary to avoid a surgical procedure to insert a gastrostomy device. However, in the long term, gastrostomy feeding may be more suitable.

Issues associated with paediatric nasogastric tube feeding include:

- The procedure for inserting the tube is traumatic for the majority of children.
- The tube is very noticeable.
- Patients are likely to pull out the tube making regular re-insertion necessary.
- Aspiration, if the tube is incorrectly placed.
- Increased risk of gastro-esophageal reflux with prolonged use.
- Damage to the skin on the face.

- Read in an S shape
- Repeat the word in your head...
- Max 20 seconds to find a word

In OET we scan for the **key** word...

Important

Text B

Inserting the nasogastric tube

All tubes must be radio opaque throughout their length and have externally visible markings.

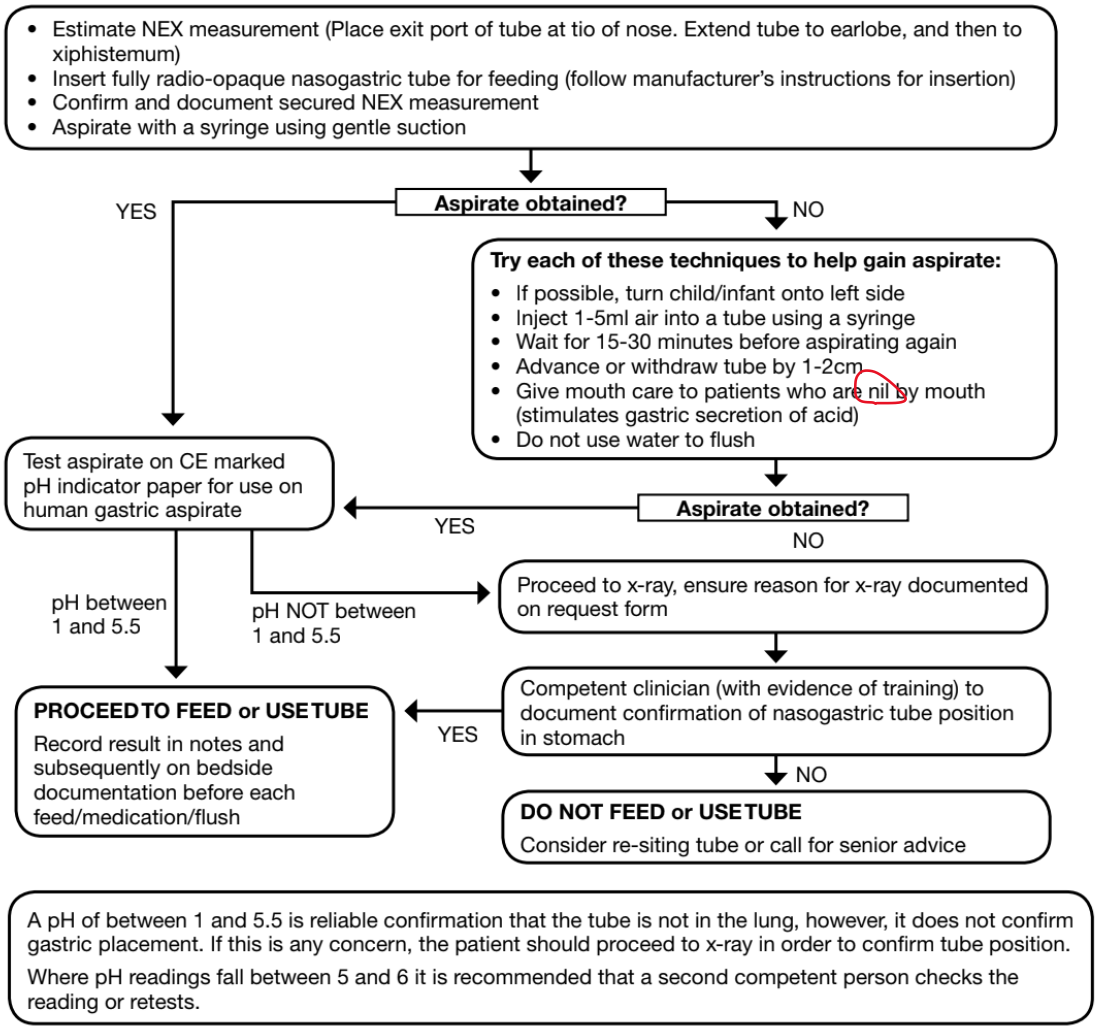
1. Wide bore:
   - for short-term use only.
   - should be changed every seven days.
   - range of sizes for paediatric use is 6 Fr to 10 Fr.
2. Fine bore:
   - for long-term use.
   - should be changed every 30 days.

In general, tube sizes of 6 Fr are used for standard feeds, and 7-10 Fr for higher density and fibre feeds. Tubes come in a range of lengths, usually 55cm, 75cm or 85cm.

Wash and dry hands thoroughly. Place all the equipment needed on a clean tray.

- Find the most appropriate position for the child, depending on age and/or ability to co-operate. Older children may be able to sit upright with head support. Younger children may sit on a parent's lap. Infants may be wrapped in a sheet or blanket.
- Check the tube is intact then stretch it to remove any shape retained from being packaged.
- Measure from the tip of the nose to the bottom of the ear lobe, then from the ear lobe to xiphisternum. The length of tube can be marked with indelible pen or a note taken of the measurement marks on the tube (for neonates: measure from the nose to ear and then to the halfway point between xiphisternum and umbilicus).
- Lubricate the end of the tube using a water-based lubricant.
- Gently pass the tube into the child's nostril, advancing it along the floor of the nasopharynx to the oropharynx. Ask the child to swallow a little water, or offer a younger child their soother, to assist passage of the tube down the oesophagus. Never advance the tube against resistance.
- If the child shows signs of breathlessness or severe coughing, remove the tube immediately.
- Lightly secure the tube with tape until the position has been checked.

Text C



A pH of between 1 and 5.5 is reliable confirmation that the tube is not in the lung, however, it does not confirm gastric placement. If this is any concern, the patient should proceed to x-ray in order to confirm tube position.

Where pH readings fall between 5 and 6 it is recommended that a second competent person checks the reading or retests.

Text D

Administering feeds/fluid via a feeding tube

Feeds are ordered through a referral to the dietitian.

When feeding directly into the small bowel, feeds must be delivered continuously via a feeding pump. The small bowel cannot hold large volumes of feed.

Feed bottles must be changed every six hours, or every four hours for expressed breast milk.

Under no circumstances should the feed be decanted from the container in which it is sent up from the special feeds unit.

All feeds should be monitored and recorded hourly using a fluid balance chart.

If oral feeding is appropriate, this must also be recorded.

The child should be measured and weighed before feeding commences and then twice weekly.

The use of this feeding method should be re-assessed, evaluated and recorded daily.

Scanning is like a muscle... GYM

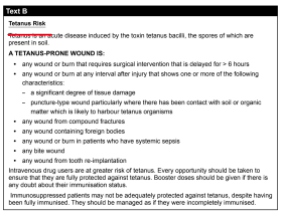
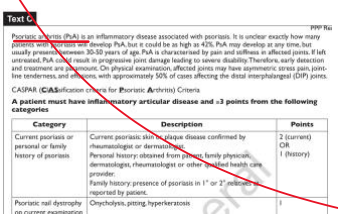
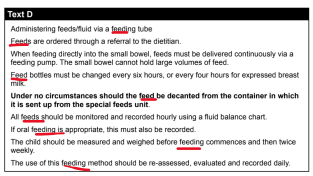
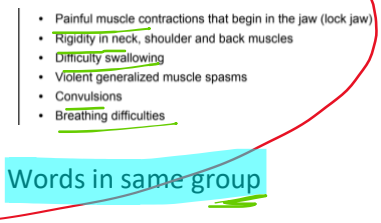
What is skimming? (not scanning)

Reading for main ideas / function

In OET we usually see the same MAIN IDEAS or FUNCTION...

Main idea	Function
Answers question: what is it about?	Answers question: What is it DOING?
Treatment	Classification (Types)
Symptoms	Information
Management	Description
Risks	Definition
Investigations	Instructions
Advice	Guidelines
Procedures	
Medication	

4 KEY WAYS TO SKIM:

TITLE	FIRST LINE	REPEAT	THEMATIC
			

Is this clear?

All texts: psoriasis

Text A

PPP Reading09

Diagnosis of cutaneous psoriasis is usually straightforward based on the clinical appearance. The most frequent presentation is chronic plaque psoriasis (psoriasis vulgaris) and is characterised by well demarcated bright red plaques covered by adherent silvery white scales. These may affect any body site, often symmetrically, especially the scalp and extensor surfaces of limbs. The differential diagnosis includes eczema, tinea, lichen planus and lupus erythematosus. The appearance of the plaques may be modified by emollients and topical treatments, which readily remove the scale. Scaling is reduced at flexural sites, on genital skin and in palmoplantar disease. Guttate psoriasis describes the rapid development of multiple small papules of psoriasis over wide areas of the body. The differential diagnosis includes pityriasis rosea, viral exanthems and drug eruptions. Generalised pustular psoriasis is rare and is characterised by the development of multiple sterile non-follicular pustules within plaques of psoriasis or on red tender skin. This may occur acutely and be associated with fever. The differential diagnosis includes pyogenic infection, vasculitis and drug eruptions.

All texts: Malaria

Text A

Malaria occurs mainly in the tropical areas of Africa, Asia and ~~Latin America.~~ Malaria is a parasitic disease spread by the bite of the female *Anopheles* mosquito, which results in infection of the red blood cell. Five main species of the malaria parasite infect humans: *Plasmodium falciparum* (the severest form), *Plasmodium vivax, Plasmodium ovale, Plasmodium malarie, Plasmodium knowlesi*.

Australia was declared malaria-free by the World Health Organization in 1981, and since then, only a small number of cases of locally acquired malaria have been reported from North Queensland. Severe malaria may lead to foetal loss and high maternal mortality due to hypoglycaemia and acute respiratory distress syndrome (ARDS). All forms of malaria in pregnancy may adversely affect the mother and foetus. The main complications are: miscarriage, stillbirth, preterm birth, low infant birth weight, severe maternal and neonatal anaemia.

Pregnant women should be advised to avoid travel to malaria-endemic areas. For pregnant women who cannot avoid travelling, the medical officer should consult with an Infectious Diseases specialist or experienced Travel Medicine doctor to determine the appropriate chemoprophylaxis agent.

Text C

Laboratory diagnosis for malaria

Both thick and thin blood smears should be prepared. They should be stained with a Romanowsky stain so as to maximise the occurrence of diagnostic criteria such as stippling on the infected red blood cell.

Blood specimens can be taken directly onto a slide from a finger or an earlobe, or by venepuncture into a tube containing an anticoagulant such as heparin or EDTA. From infants, the blood is best obtained from the heel.

If blood in anticoagulant is being used, the smears should be made as soon as possible after collection because the parasite morphology deteriorates markedly with time. Blood specimens older than 12 hours should be rejected and a new specimen collected.

In a febrile patient, three negative malaria smears 12 to 24 hours apart rules out the diagnosis of malaria

Rapid diagnostic tests (RDTs) for malaria antigens should also be requested.

Other tests should include complete blood count, urea, creatinine, electrolytes, liver function tests, serum glucose, venous pH, serum lactate and coagulation studies.

This is a **muscle**...

All texts: pneumothorax

Text C

PPP RSAMPLE11

- Sharp chest pain, dyspnoea and cough irritation are the main symptoms.
  - o The onset is rapid, and the symptoms are exacerbated by breathing and physical exertion. The pain radiates to the ipsilateral shoulder.
  - o The symptoms may be alleviated within 24 h due to adaptation.
- A small pneumothorax may be asymptomatic or cause very mild symptoms.

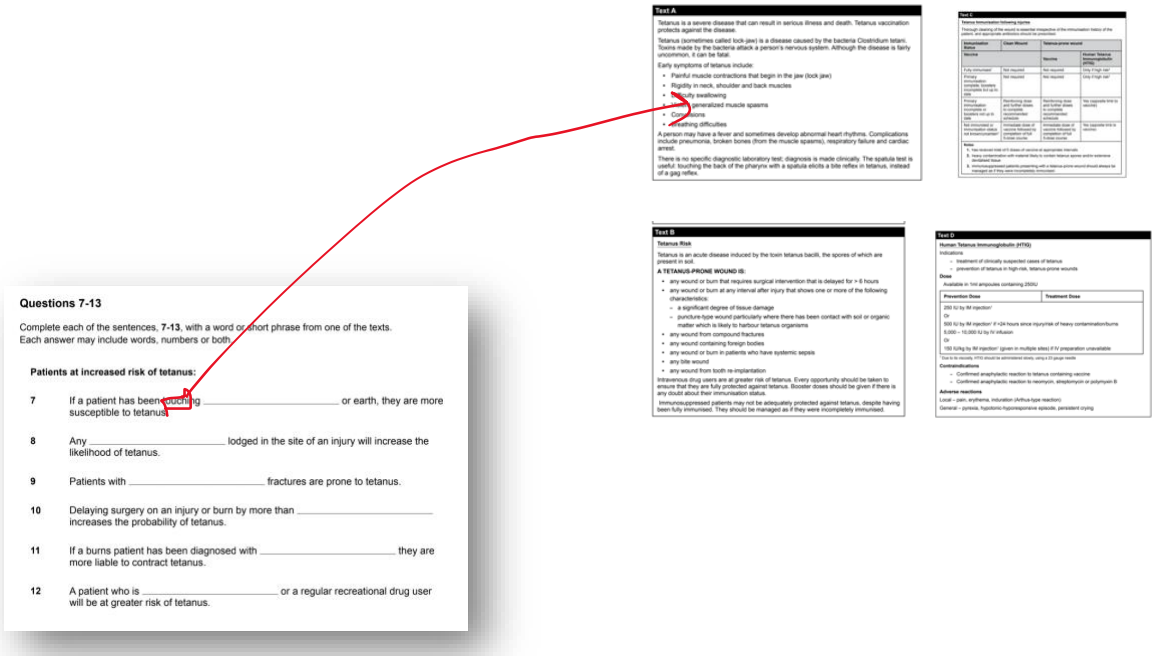
Clinical signs

- Suppressed or missing respiratory sounds, impaired chest mobility, and hollow echoing (hyperresonance) percussion sounds are often observed.
- Chest movement may be asymmetric.
- The clinical findings can be normal in a small pneumothorax.
- Tachycardia, cyanosis, and hypotension can be observed in tension pneumothorax.
- Subcutaneous emphysema may be present (a crepitation on pressing the skin).
- Signs of injury (haematoma, crepitation from a broken rib, etc.) may be visible on the chest.

- A chest x-ray (preferably posteroanterior, standing) or ultrasound examination is always necessary to confirm the diagnosis.
  - o A rim of air is visible or the lung has collapsed.
  - o A small pneumothorax may be difficult to detect. A radiograph taken during expiration may be helpful.
  - o A large emphysematous bulla may resemble pneumothorax and cause misinterpretation.
- In special cases a CT scan may be necessary (diagnostic problems, planned surgery, investigation of aetiology).

SET English

TECHNIQUE:



Questions 7-13

Complete each of the sentences, **7-13**, with a word or short phrase from one of the texts.
Each answer may include words, numbers or both.

Patients at increased risk of tetanus:

7 If a patient has been touching _____ or earth, they are more susceptible to tetanus.

8 Any _____ lodged in the site of an injury will increase the likelihood of tetanus.

9 Patients with _____ fractures are prone to tetanus.

10 Delaying surgery on an injury or burn by more than _____ increases the probability of tetanus.

11 If a burns patient has been diagnosed with _____ they are more liable to contract tetanus.

12 A patient who is _____ or a regular recreational drug user will be at greater risk of tetanus.

Questions 7-13

Complete each of the sentences, **7-13**, with a word or short phrase from one of the texts.
Each answer may include words, numbers or both.

Patients at increased risk of tetanus:

7 If a patient has been touching _____ or earth, they are more susceptible to tetanus.

8 Any _____ lodged in the site of an injury will increase the likelihood of tetanus.

9 Patients with _____ fractures are prone to tetanus.

10 Delaying surgery on an injury or burn by more than _____ increases the probability of tetanus.

11 If a burns patient has been diagnosed with _____ they are more liable to contract tetanus.

12 A patient who is _____ or a regular recreational drug user will be at greater risk of tetanus.