

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 search 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.

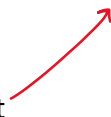
Issues associated with paediatric nasogastric tube feeding include:

- 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.

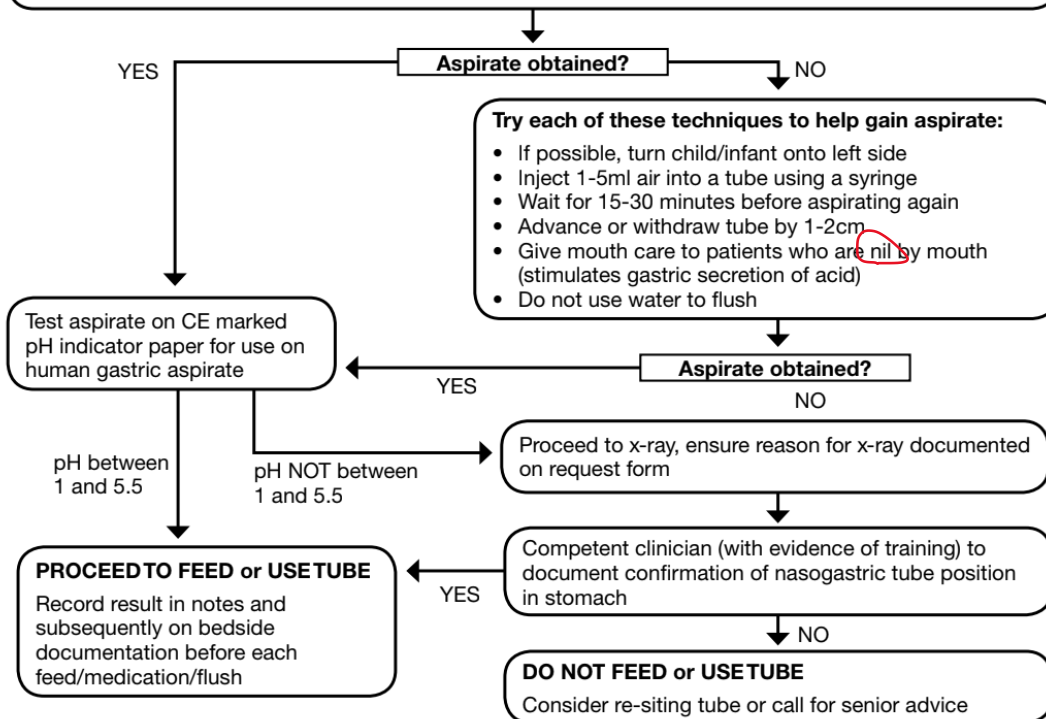
In general, tube sizes of 6 Fr are used for standard feeds, and 7-10 Fr for higher density and fibre feeds. Tubes come in a range of lengths, usually 55cm, 75cm or 85cm.

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

- Estimate NEX measurement (Place exit port of tube at tip of nose. Extend tube to earlobe, and then to xiphisternum)
- Insert fully radio-opaque nasogastric tube for feeding (follow manufacturer's instructions for insertion)
- Confirm and document secured NEX measurement
- Aspirate with a syringe using gentle suction



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									
<p>Text B</p> <p>Tetanus Risk</p> <p>Tetanus is a disease induced by the toxin tetanus bacilli, the spores of which are present in soil.</p> <p>A TETANUS PRONE WOUND IS:</p> <ul style="list-style-type: none"> any wound or burn that requires surgical intervention that is delayed for > 6 hours any wound or burn at any interval after injury that shows one or more of the following characteristics: <ul style="list-style-type: none"> a significant degree of tissue damage contaminated wound particularly where there has been contact with soil or organic matter which is likely to harbour tetanus organisms any wound from compound fractures any wound containing foreign bodies any wound or burn in patients who have systemic sepsis any laceration any wound from both re-implantation <p>Immunosuppressed patients may not be adequately protected against tetanus, despite having been fully immunised. They should be managed as if they were incompletely immunised.</p>	<p>Text C</p> <p>Postric neuralgia (PNA) is an inflammatory disease associated with psoriasis. It is unclear exactly how many patients with psoriasis develop PNA, but it could be as high as 42%. PNA may develop in any time but usually presents between 30-50 years of age. PNA is characterised by pain and stiffness in affected joints. If left untreated, PNA may result in progressive joint damage leading to severe disability. Therefore, early detection and treatment are important. On physical examination, affected joints may have asymmetric, acute pain, joint tenderness and swelling, with approximately 50% of cases affecting the distal interphalangeal (DIP) joints.</p> <p>CASPAR (Classification Criteria for Psoriatic Arthritis) Criteria</p> <p>A patient must have inflammatory articular disease and ≥3 points from the following categories</p> <table border="1"> <thead> <tr> <th>Category</th> <th>Description</th> <th>Points</th> </tr> </thead> <tbody> <tr> <td>Current psoriasis or personal or family history of psoriasis</td> <td>Current psoriasis, skin or nail disease confirmed by rheumatologist or dermatologist, or personal history obtained from family physician, dermatologist, rheumatologist or other qualified health care provider.</td> <td>2 (current) OR 1 (history)</td> </tr> <tr> <td>Psoriatic nail dystrophy on current examination</td> <td>Onycholysis, pitting, hyperkeratosis</td> <td>1</td> </tr> </tbody> </table>	Category	Description	Points	Current psoriasis or personal or family history of psoriasis	Current psoriasis, skin or nail disease confirmed by rheumatologist or dermatologist, or personal history obtained from family physician, dermatologist, rheumatologist or other qualified health care provider.	2 (current) OR 1 (history)	Psoriatic nail dystrophy on current examination	Onycholysis, pitting, hyperkeratosis	1	<p>Text D</p> <p>Administering feeds/fluid via a feeding tube feeds, are ordered through a referral to the dietitian.</p> <p>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.</p> <p>Feed bottles must be changed every six hours, or every four hours for expressed breast milk.</p> <p>Under no circumstances should the feed be decanted from the container in which it is sent up from the special feeds unit.</p> <p>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.</p> <p>The use of this feeding method should be re-assessed, evaluated and recorded daily.</p>	<ul style="list-style-type: none"> Painful muscle contractions that begin in the jaw (lock jaw) Rigidity in neck, shoulder and back muscles Difficulty swallowing Violent generalized muscle spasms Convulsions Breathing difficulties <p>Words in same group</p>
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Current psoriasis or personal or family history of psoriasis	Current psoriasis, skin or nail disease confirmed by rheumatologist or dermatologist, or personal history obtained from family physician, dermatologist, rheumatologist or other qualified health care provider.	2 (current) OR 1 (history)										
Psoriatic nail dystrophy on current examination	Onycholysis, pitting, hyperkeratosis	1										

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 exanths 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

PPP KSAMPLE 1

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.
 - The onset is rapid, and the symptoms are exacerbated by breathing and physical exertion. The pain radiates to the ipsilateral shoulder.
 - 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.
 - A rim of air is visible or the lung has collapsed.
 - A small pneumothorax may be difficult to detect. A radiograph taken during expiration may be helpful.
 - 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).

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:

- If a patient has been touching _____ or earth, they are more susceptible to tetanus.
- Any _____ lodged in the site of an injury will increase the likelihood of tetanus.
- Patients with _____ fractures are prone to tetanus.
- Delaying surgery on an injury or burn by more than _____ increases the probability of tetanus.
- If a burns patient has been diagnosed with _____ they are more liable to contract tetanus.
- A patient who is _____ or a regular recreational drug user will be at greater risk of tetanus.

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Text A

Tetanus is a severe disease that can result in serious illness and death. Tetanus vaccination protects against the disease.

Tetanus (sometimes called 'lock jaw') is a disease caused by the bacteria *Clostridium tetani*. Spores made by the bacteria attack a person's nervous system. Although the disease is fairly uncommon, it can be fatal.

Early symptoms of tetanus include:

- Painful muscle contractions that begin in the jaw (lock jaw)
- Rigidity in neck, shoulder and back muscles
- Difficulty swallowing
- Painful spasmodic muscle spasms
- Convulsions
- Breathing difficulties

A person may have a fever and sometimes develop abnormal heart rhythms. Complications include pneumonia, broken bones (from the muscle spasms), respiratory failure and cardiac arrest.

There is no specific 'diagnostic laboratory test'; diagnosis is made clinically. The spastic test is useful: touching the back of the pharynx with a spatula elicits a reflex in tetanus, instead of a gag reflex.

Text B

Human Tetanus Immunoglobulin (HTIG)

Indications:

- Treatment of clinically suspected cases of tetanus
- Prevention of tetanus in high-risk, tetanus-prone wounds

Dose:

Adults in tetanus-prone wounds (200U)

Prevention Dose	Treatment Dose
200 IU by IM injection	500 IU by IM injection*
OR	OR
500 IU by IM injection* if <24 hours since injury/trauma of heavy contamination/burns	5,000 - 10,000 IU by IV infusion
OR	OR
100 IU by IM injection (given in multiple doses if IV preparation unavailable)	100 IU by IV infusion (given in multiple doses over 2-3 days)

*Not to exceed 100 IU in one administration over 24 hours

Contraindications:

- Confirmed hypersensitivity reaction to tetanus containing vaccine
- Confirmed anaphylactic reaction to neomycin, sulphamonomethoxime or polygeline B

Adverse reactions:

- Local: pain, erythema, induration (intra-type reactions)
- General: systemic hypersensitivity reactions (anaphylaxis, anaphylactoid crisis)

Text B

Tetanus Risk

Tetanus is an acute disease induced by the toxin tetanospasmin, the spores of which are present in soil.

A TETANUS-PRONE WOUND IS:

- any wound or burn that requires surgical intervention that is delayed for > 6 hours
- any wound or burn at any interval after injury that shows one or more of the following characteristics:
 - a significant degree of tissue damage
 - puncture type wound particularly where there has been contact with soil or organic matter which is likely to harbour tetanus organisms
 - any wound from compound fractures
 - any wound containing foreign bodies
- any wound or burn in patients who have systemic sepsis
- any lacerated
- any wound from both re-implantation

In tetanus-prone wounds, tetanus is a greater risk of tetanus. Every opportunity should be taken to ensure that they are fully protected against tetanus. Booster doses should be given if there is any doubt about their immunisation status.

Immunosuppressed patients may not be adequately protected against tetanus, despite having been fully immunised. They should be managed as if they were incompletely immunised.

Text C

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