


OET Reading Part A

- 1 Format: groups
- 2 Technique Overview
- 3 Diagram & 1 – 7 questions



What is 'format'? What the exam is like....

Format

How many questions are there?

20 questions

How many much time?

15 mins

What question types are there?

3 types:

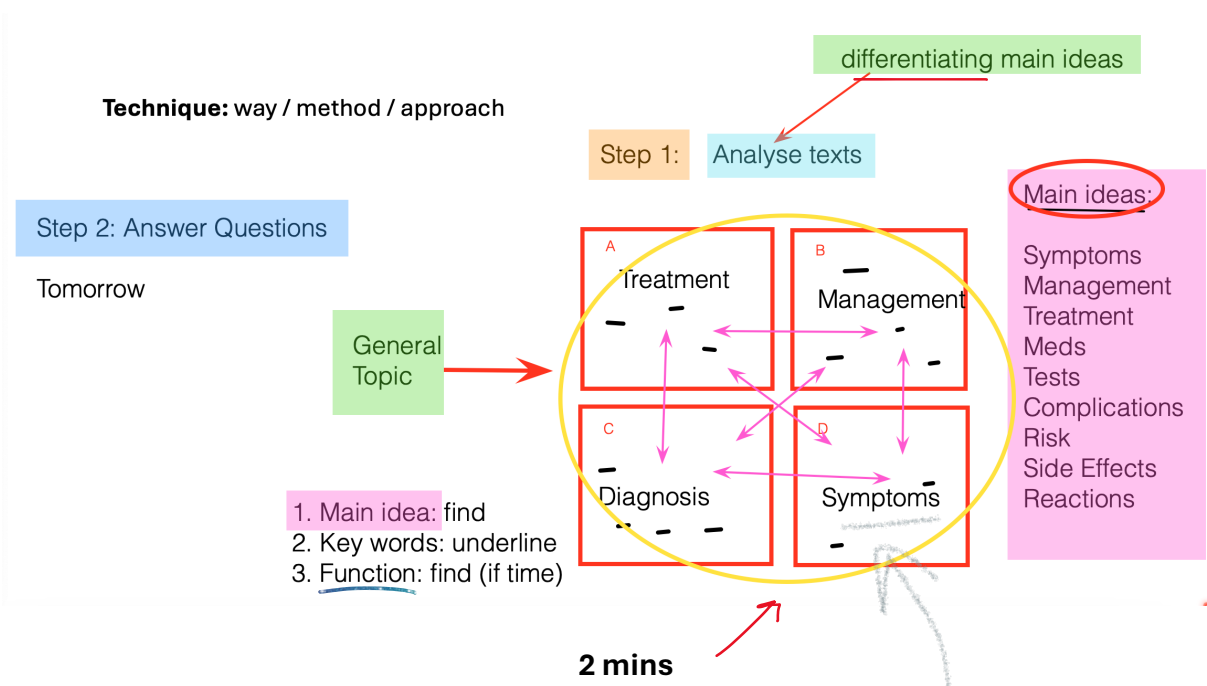
Matching, short answer & Gap Fill

How many texts?

4

What are the main challenges?

- Finding main ideas
- Choosing key words (tomorrow)
- Time management
- Finding words quickly (scanning)



8. How will the patient present?

<p style="text-align: center;">MAIN IDEAS</p> <p>(Texts can have 2 main ideas! Just get the <u>majority</u>.)</p>	<p>1. Heading (10 seconds): title / sub title of text</p> <p>No heading (30 seconds):</p> <p>A. Read first line</p> <p>B. Repeated words</p> <p>C. Thematic words: Table, chair, sofa = furniture</p> <p>Answers question: What is this about?</p>	<p>Text C Laboratory diagnosis for malaria Both thick and thin blood smears show...</p> <p>Text A Diagnosis of cutaneous psoriasis is usually straightforward based on the clinical appearance. The most frequent presentation is chronic plaque psoriasis (psoriasis vulgaris) and is characterized 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 pustules within plaques of psoriasis or on <u>well-demarcated</u> skin. This may occur acutely and be associated with fever. The differential diagnosis includes pyogenic infection, vasculitis and drug eruptions.</p> <p>Main about: Treatment, symptoms, diagnosis, management, medication, etc.</p>
<p style="text-align: center;">KEY WORDS</p>	<p>We are looking for:</p> <ul style="list-style-type: none"> • Numbers • Brackets • Abbreviations (WHO, USA, MRI) • Technical words • Names (drugs) <p>Anything <u>suspicious</u>...</p>	<p>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 <i>Anopheles</i> mosquito, which results in infection of the red blood cell. Five main species of the malaria parasite infect humans: <i>Plasmodium falciparum</i> (the severest form), <i>Plasmodium vivax</i>, <i>Plasmodium ovale</i>, <i>Plasmodium malariae</i>, <i>Plasmodium knowlesi</i>.</p> <p>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 Northern Queensland. Severe malaria may lead to fetal loss and high maternal mortality due to hypoxaemia 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.</p> <p>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.</p> <p>Underline max. 5</p>
<p style="text-align: center;">FUNCTION</p>	<p>Similar to the main idea but...</p> <p>Answers the question: What is this text doing?</p> <p>1. Information</p> <p>Look for numbers, facts, details, often present is used, often lots of 'be'...</p> <p>2. Advice</p> <p>Look for should, must, have to, need to NEVER, do not order and sequences conditionals imperatives</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>In a febrile patient, three negative malaria smears 12 to 24 hours apart rules out the diagnosis of malaria.</p> <p>Rapid diagnostic tests (RDTs) for malaria antigens should also be requested.</p> <p>Other tests should include complete blood count, urea, creatinine, electrolytes, liver function tests, serum glucose, venous pH, serum lactate and coagulation studies.</p> <p>Information: description, definition, classification</p> <p>Advice: guidelines, protocol, instructions, recommendations</p>

Varicose Veins: Texts

Text A

Causes, risk factors and symptoms

Varicose veins are a chronic venous disease (CVD), which occurs when one-way valves in superficial, deep and/or perforating veins fail to close properly, causing blood to return and accumulate, rather than follow its normal path. This leads to a rise in venous pressure and distension, often resulting in veins being noticeable and presenting as twisted and enlarged.

Valvular dysfunction may be caused by congenital defects or weakening of the vein walls. Most commonly found in females and in the legs, common risk factors are advancing age, high body mass index, smoking, family history, history

of trauma to lower extremities, previous venous thrombosis and pregnancy. It is estimated that 3 to 6 percent of people who have varicose veins in their lifetime will develop venous ulcers.

Some patients are asymptomatic, but others are impacted by painful, heavy, burning or throbbing legs, muscle cramps, and dry, itchy and thin skin over the affected area. Varicose veins often become more severe over time and can lead to complications such as alterations in skin pigmentation, bleeding, venous ulceration and tissue alteration and loss.

Text B

Initial examination

Take the patient's history:

Take a full history, bearing in mind that pelvic masses, trauma, and previous deep venous thrombosis are recognised causes. Determine whether the patient has aching leg pain (legs fatigue easily, feel heavy or are swollen). If they do, find out whether symptoms worsen as the day progresses especially with long periods of standing. In extreme cases, patients may describe venous claudication; acute, bursting pain on walking that can be alleviated by elevating the lower limbs. Patients with severe venous hypertension may complain of skin changes including venous eczema and ulceration, typically below the knee and above the ankle. Ask about any previous treatments.

Inspection:

Where possible, start with the patient standing with both legs bare to the groin. Gently press the affected areas, release, and observe the varicosities refill. Consider whether they are warmer than surrounding skin by using the back of the hand. Determine whether varicosities follow the long or short saphenous vein. Varicosities in the short saphenous vein are seen only below the knee and are usually at the back and to the outer edge of the leg (posterolateral). Long saphenous varicosities may be found along the length of

the leg, usually on the medial aspect. Some people have a large accessory vein on the back (posterior) part of the thigh, which may become varicose.

Look for:

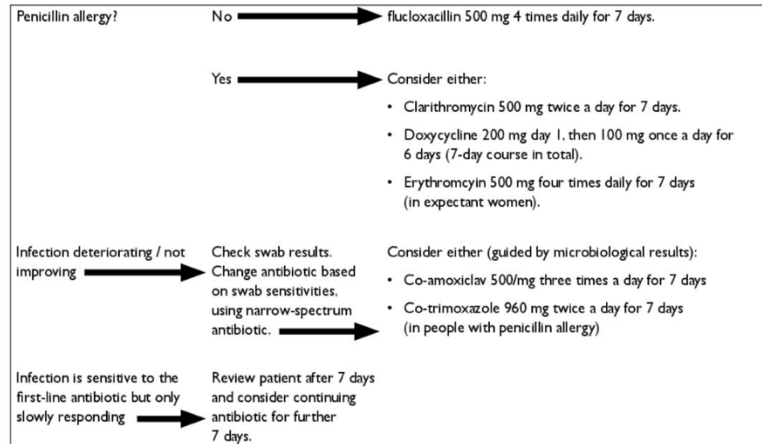
- Venous stars (venulectasias) - bluish vessels that may distend above skin surface. Usually 1-2 mm in diameter
- Superficial thrombophlebitis - red, painful lump
- Brown pigmentation caused by haemosiderin deposits
- Venous eczema - red or brown on lighter skin, dark brown, purple or grey on darkly pigmented skin*
- Ulceration and scarring from previous ulceration, especially in the gaiter area
- Lipodermatosclerosis; caused by chronic venous hypertension, results in sclerosis of skin and subcutaneous fat
- Scars from previous vein surgery (look for harvesting of vein grafts for coronary artery bypass grafting).

* venous eczema on darkly pigmented skin may be more difficult to see

Text C

Antibiotic treatment for Infected venous leg ulcers

Consider referring if the patient has a high risk of complications, infection of the lymph vessels, if infection is spreading and not responding to oral antibiotics or if the patient is unable to take oral antibiotics (where appropriate, explore locally available options for giving intravenous antibiotics at home or in a health centre, rather than in the hospital). Arrange urgent hospital referral if the patient has any symptoms or signs suggesting a more severe condition such as sepsis, necrotising fasciitis or osteomyelitis.



NB: routine long-term use of topical antiseptics and/or antimicrobials is not recommended

Text D

Interventional treatment options

Both **Endothermal ablation** and **Endovenous laser ablation** are minimally invasive catheter-based procedures in which thermal energy is delivered into the vein wall (intima), causing inflammation, which results in closure of the vein.

Endothermal ablation: The long saphenous vein is accessed above or below the knee, either percutaneously via an intravenous cannula/venepuncture sheath or via a small incision. The catheter is manually withdrawn at 2.5–3 cm/minute, and the vein wall temperature is maintained at 85°C.

Endovenous laser ablation:

A laser fibre is passed through the vein and positioned below the saphenofemoral junction. An anaesthetic agent is then injected and the fibre is slowly withdrawn while

energy from a diode laser 810 or 940 NM wavelength is applied in short pulses. This is repeated along the full length of the vein until the long saphenous vein is sealed from the saphenofemoral junction to the point of access.

Ultrasound-guided foam sclerotherapy: Sclerosant foam is injected into the affected veins, causing an inflammatory reaction in the vein wall, scarring and eventual closure of the treated varicose vein. May be carried out under local anaesthesia. Compression bandages are applied after the procedure and are typically worn for between one and four weeks.

Duplex ultrasound guidance is the gold standard for assessment and diagnosis of superficial venous incompetence and is used to guide all the above interventions.

Part A

TIME: 15 minutes

- Look at the four texts, **A–D**, in the separate **Text Booklet** that precedes the questions.
 - For each question, **1–20**, look through the texts, **A–D**, to find the relevant information.
 - Write your answers on the spaces provided in this **Question Paper**.
 - Answer all the questions within the 15-minute time limit.
 - Your answers should **only** be taken from texts **A–D** and must be correctly spelt.
-

Varicose Veins: Questions

Questions 1–7

For each question, **1–7**, decide which text (**A, B, C** or **D**) the information comes from. You may use any letter more than once.

In which text can you find information about

- | | | |
|---|---|-------|
| 1 | the best way to position a patient for an assessment? | _____ |
| 2 | the best technology for visualising the veins? | _____ |
| 3 | reasons why varicose veins protrude? | _____ |
| 4 | why varicose veins can cause skin to change colour? | _____ |
| 5 | when a patient requires specialist medical advice? | _____ |
| 6 | how varicose veins are likely to progress? | _____ |
| 7 | methods of blocking varicose veins? | _____ |