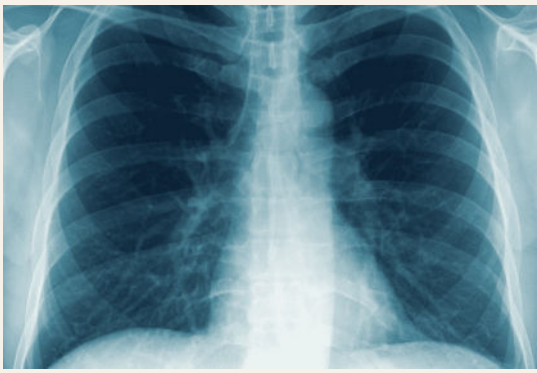
MRCPI GENERAL MEDICINE · PART II CLINICAL

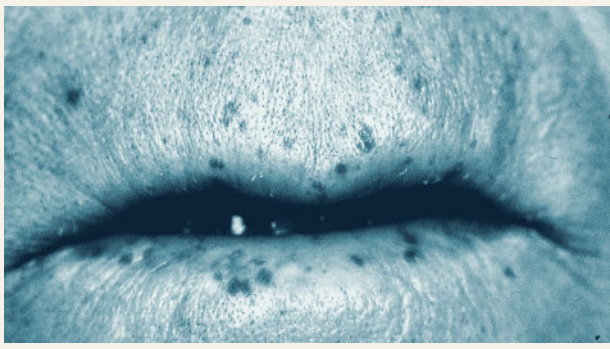
The Companion Handbook for

Bedside Insight

Cases, Signs & Stations for MRCPI





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FIRST EDITION · 2026

TIPS AND TRICKS · LONG CASE

Long case: history, focused exam, plan

25 min: 20 observed + 5 discussion · 10-min warning · CCS · MRP · PE · DD · CJ · MPSQ · IPS not marked

This station works like an outpatient or admissions-unit consultation with a trained surrogate patient. CURRENT The examiner won't tell you the signs, so your examination must follow logically from the history. Here you are marked on reasoning, not on spotting signs.

Run the 20 minutes on a clock

Clock	Goal
0–2	Name and role, confirm who the patient is, then “What's brought you in today?” Listen uninterrupted for the first minute; the agenda usually comes out on its own.
2–11	Characterise the main complaint, then screen for **red flags**. Cover past history, **full drug history** (including over-the-counter and herbal), allergies, family history, social history and function. Use ideas, concerns and expectations (ICE).
10 CURRENT	**Use the 10-minute warning as a checkpoint.** If you're still taking the history, start wrapping up so the examination begins by about minute 11.
11–17	Do a **focused examination aimed at your hypotheses**. Say why: “I'm checking for a goitre and lid lag because of the weight loss.”
17–20	Address the patient's main concern, explain your working diagnosis and plan in lay terms, check understanding and give safety-net advice. Have your one-line synthesis ready to present when the examiner invites it.

History moves that score

- **Deal with the patient's main complaint first.** In acromegaly, for example, address the paraesthesia before showing off the other features.
- Ask about **diabetes in almost every case**, especially eye, neuropathy, renal and cranial-nerve cases.
- Ask the impact questions: work, **driving**, caring roles, pregnancy plans, and how they manage day to day.
- Ask about family history in inherited conditions (retinitis pigmentosa, polycystic kidneys, psoriasis, HCM). Genetic counselling is impossible without the inheritance pattern.
- In blackouts, insist on a **witness account**. Don't assume a seizure.
- In back pain, ask about cord-compression red flags. Showing you're safe is part of the marks.

The 5-minute discussion

1 **Problem list**: active problems first, then background problems.

2 **Leading diagnosis** with your two strongest reasons.

3 **Differentials**: commonest first, plus **one you must not miss**, with your reason.

4 **Investigations in tiers**: bedside → bloods → imaging → specialist tests. Link each to the question it answers.

5 **Management and aftercare**: immediate, definitive, follow-up, MDT, and patient education.

6 If there is a referral letter, **answer the GP's question directly**.

7 · Examination routines

8 six-minute routines, one page each. Rehearse aloud until the order is automatic; adapt the depth to the instruction.

How to use: time yourself with the split at the top of each page. Say what you are looking for as you go only if the examiner asks; otherwise examine quietly and present at the end with the H·E·N·C·E template (Section 11). Fundoscopy is not assessed: say you would perform it.

EXAMINATION ROUTINE · CARDIOVASCULAR

Cardiovascular

6 minutes: 0–0:30 introduce, position at 45°, inspect from the end of the bed; 0:30–1:45 hands, pulses, face and neck; 1:45–2:30 praecordium (inspect, palpate); 2:30–4:30 auscultation with manoeuvres; 4:30–5:15 lung bases, sacrum, ankles; 5:15–6:00 thank the patient, stand back, compose the headline.

Start	Introduce, wash hands, consent, ask about pain. Sit at 45°, expose the chest (offer a chaperone). Listen for a metallic click before you touch the patient.
End of bed	Breathlessness at rest, cyanosis, malar flush, Marfanoid or Turner habitus, Down syndrome; GTN spray, oxygen, ankle swelling.
Hands and pulses	Clubbing, splinter haemorrhages, Janeway lesions, Osler's nodes, xanthomata, warfarin bruising. Radial pulse rate and rhythm; radio-radial and radio-femoral delay; collapsing pulse (check shoulder pain first). Ask for the BP.
Face and neck	Conjunctival pallor, jaundice (haemolysis), xanthelasma, dental hygiene. JVP height and waveform (large v waves); carotid character (slow-rising, collapsing, bisferiens).
Praecordium	Scars: midline sternotomy, left thoracotomy (mitral valvotomy, coarctation repair), infraclavicular device box. Apex position and character (heaving, thrusting, tapping); left parasternal heave; thrills.
Auscultate	All four areas with diaphragm, apex with bell; time against the carotid. Then: left lateral, bell at apex in expiration (MS); sit forward, left sternal edge in expiration (AR); carotids and axilla for radiation; inspiration for right-sided murmurs.
Complete	While sitting forward: lung bases (crackles, effusion) and sacral oedema. Ankle oedema; leg vein-harvest scars. Thank the patient and cover them.

Must not miss

- Rate and rhythm: AF changes the differential (mitral disease) and management (anticoagulation).
- Scars and device boxes: a sternotomy means prior valve or bypass surgery; a box means pacemaker or ICD.
- Metallic valve sounds: decide whether the click replaces S1 (mitral) or S2 (aortic).
- Endocarditis stigmata in any murmur or prosthetic valve.
- Heart failure signs: raised JVP, basal crackles, oedema.
- Pulse character and pulse pressure: the bedside markers of severity in AS and AR.

To complete, I would…

- Measure the blood pressure (pulse pressure) and temperature.
- Dip the urine for blood (endocarditis).
- Review a 12-lead ECG and arrange echocardiography.
- Say you would perform fundoscopy (Roth spots, hypertensive change); it is not assessed in the exam.

CASE 18 · MODEL ANSWER

Pacemaker, ICD and CRT device

Linked atlas figures (the full-size image and notes are on the page shown):



Fig 22 · p. 209
CXR: dual-chamber pacemaker

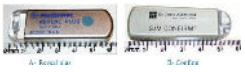


Fig 77 · p. 216
Implantable loop recorder

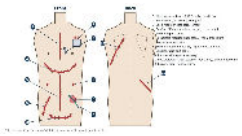


Fig 131 · p. 225
Diagram: surgical scars and devi...



Fig 8 · p. 208
Raised JVP



Fig 9 · p. 208
Pitting oedema

Examination sequence (6 minutes)

1. Introduce, consent, sit at 45°, expose the chest; ask whether the device area is sore.

2. End of bed: breathlessness, oedema, oxygen; scan both infraclavicular areas, the left lateral chest (subcutaneous ICD) and the abdomen (old generators), and look for a loop recorder.

3. Device inspection: site, size and thickness of the box, scar (fresh or healed), erythema, swelling or haematoma, skin thinning, tethering, erosion or discharge.

4. Palpate gently: tenderness, warmth, fluctuance, and whether the box moves freely in its pocket; do not press hard.

5. Pulse rate and rhythm, BP; hands for endocarditis stigmata; JVP (cannon waves suggest AV dissociation).

6. Praecordium: apex position and character, heaves; auscultate for murmurs (functional MR, AS) and note reversed splitting of S2 with RV pacing.

7. Lung bases, sacral and ankle oedema; other scars (sternotomy, vein harvest, thoracotomy). Thank the patient; ask for the ECG, CXR and device check.

Interpretation: signs, negatives and what they mean

Finding	Meaning
Generator larger and thicker than a pacemaker; RV lead with a thick radio-opaque coil	Defibrillator function: the coil delivers shocks. A pacing-only lead has no coil.
Third lead passing into the coronary sinus	LV lead for biventricular pacing (CRT). With the shock coil, this is a CRT-D.
Healed scar, no erythema, thinning, tethering or tenderness	No clinical sign of pocket infection, haematoma or impending erosion. Any exposed hardware means device infection until proven otherwise.
Displaced apex and soft apical pansystolic murmur	Dilated left ventricle with probable functional mitral regurgitation: the HFrEF substrate for CRT-D.
Regular pulse at 70	Pacing cannot be confirmed at the bedside; the 12-lead ECG shows pacing spikes and paced QRS morphology.
Mild ankle oedema, JVP not raised, clear chest	Mild fluid retention without clinical decompensation; review diuretic and foundational therapy.

Model presentation (about 60 seconds)

> “This gentleman has a cardiac resynchronisation therapy device with a defibrillator, a CRT-D, in the left infraclavicular region, and signs of a dilated left ventricle, consistent with heart failure with reduced ejection fraction. The generator is larger than a standard pacemaker and sits under a well-healed scar with no erythema, thinning or tenderness to suggest infection, haematoma or erosion. The chest X-ray shows three leads: right atrial, right ventricular with a shock coil, and a coronary sinus lead to the left ventricle. His pulse is regular at 70 and his blood pressure is 112/70. The apex is displaced to the anterior axillary line, with a soft apical pansystolic murmur, probably functional mitral regurgitation. The JVP is not raised and the chest is clear, but there is mild ankle oedema. There is no sternotomy scar. To complete, I would review a 12-lead ECG, an echocardiogram and the latest device check, and ask about shocks.”

ROLE-PLAY 1 · ROLE-PLAYER BRIEF AND MODEL APPROACH

Breaking bad news and open disclosure: methotrexate dosing error

Role-player instructions

Who you are	Tom Byrne, 74, retired farmer, widower. Daughter Aoife is with you.
Opening	'Nobody's telling me straight. Why did I get so sick?'
If told clearly with an apology	Becomes quiet, then angry: 'So the hospital poisoned me?' Settles if the doctor listens and does not get defensive.
Concerns	Is he going to be all right? Will his arthritis tablets be safe in future? Does he need to make a complaint? Aoife asks who will be 'held responsible'.
If the doctor blames another person or uses jargon	Becomes more distressed and asks for someone senior.

Opening approach

- Check the setting (private, seated, bleep handed over), introduce yourself and your role.
- Confirm he wants Aoife present.
- Ask what he already knows and what he would like to know.
- Warning shot: 'I'm afraid I need to tell you about something that went wrong with your care.'

Likely concerns and adaptable responses

Concern	Response (adapt to the person)
Why did this happen?	Say plainly that his methotrexate was prescribed daily instead of weekly on his last discharge, that this was an error, and that it caused the drop in his white cells and the infection.
Apology	'I am very sorry this happened to you.' An apology is part of open disclosure (Medical Council Guide §4).
Is he going to be OK?	Explain his current progress, the treatment (antibiotics, folinic acid, blood count monitoring) and what to expect.
Who is responsible?	Avoid blaming individuals; explain that the incident has been reported and is being reviewed, and that he will be told what is learned and what will change.
Complaint	Respect his right to complain; give information on the hospital's patient liaison service and how to contact them.
Future medicines	Methotrexate will be stopped for now; rheumatology will review; any future prescription will be clearly weekly, with a named day and written information.

Check understanding

- Ask him to tell you in his own words what happened.
- Ask what questions he and Aoife have.
- Check how he is feeling.

Closing plan

- Summarise.
- Offer a follow-up meeting with the consultant.
- Give a named contact.
- Document the conversation in the notes, including the apology and what was disclosed.

Irish law and guidance to mention

- Open disclosure is a professional duty for all patient-safety incidents (Medical Council Guide, 9th ed., §4).
- The Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 (commenced 26 Sep 2024) mandates a formal disclosure procedure for incidents listed in Schedule 1 (e.g. unanticipated death).

12F · Locomotor and rheumatology (SC4)



Fig 105 · Rheumatoid hands
Look for: Symmetrical MCP and PIP synovitis, ulnar deviation, wasting.

→ Case 10 → Case 1 Self-test Q28

Dr. Gannavarapu Narasimhamurthy · Wikimedia Commons · CC0



Fig 106 · Swan-neck deformity
Look for: PIP hyperextension with DIP flexion.

→ Case 10

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Fig 107 · Boutonnière deformity
Look for: PIP flexion with DIP hyperextension.

→ Case 10

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Fig 108 · Rheumatoid nodules
Look for: Firm, non-tender subcutaneous nodules over the olecranon and extensor forearm. Seropositive RA; also lung nodules (Caplan's).

→ Case 25 → Case 10

Bulbin B et al. 2025 · PMC · CC BY



Fig 109 · X-ray: rheumatoid hand
Look for: Periarticular osteopenia, erosions, joint-space loss, subluxation.

→ Case 10

Hellerhoff · Wikimedia Commons · CC BY-SA 4.0



Fig 110 · Sclerodactyly
Look for: Tight shiny skin over the fingers, flexion contractures. Systemic sclerosis.

→ Case 15 → Case 1 Self-test Q29

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Fig 111 · Digital ulcers / pitting scars
Look for: Fingertip ulcers and pulp loss. Systemic sclerosis.

→ Case 15

Almeida I et al. 2025 · PMC · CC BY

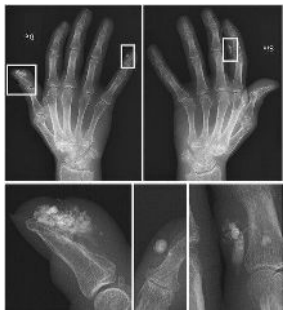


Fig 112 · Calcinosis
Look for: Hard white subcutaneous deposits. Limited cutaneous SSc (CREST).

→ Case 15

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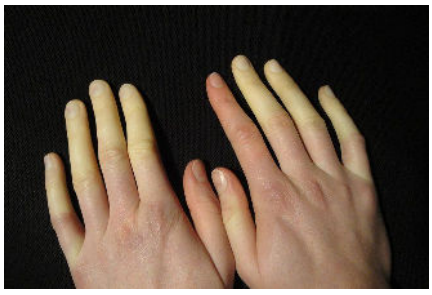


Fig 113 · Raynaud's phenomenon
Look for: White-blue-red colour change of the digits.

→ Case 15

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15 · Station sheets for the final week

9 one-page sheets: the six-minute sequence, three findings to prioritise, a 60-second framework and the viva questions you are most likely to meet.

STATION SHEET · SC2 · CARDIOLOGY

SC2 · Cardiology

Six-minute sequence

0:00–0:45	Introduce, consent, 45°, expose; end of bed: scars, GTN, oxygen, Marfan or Turner habitus.
0:45–1:45	Hands (clubbing, splinters, Janeway), radial pulse rate and rhythm, radio-radial delay; collapsing pulse; say you would take the BP.
1:45–2:30	Face and neck: conjunctival pallor, mouth, JVP with hepatojugular reflux, carotid character.
2:30–3:30	Praecordium: inspect for sternotomy and left thoracotomy scars and a device box; apex position and character, heaves, thrills.
3:30–5:15	Auscultate all four areas with the diaphragm, apex with the bell, timing against the carotid; left lateral (MS), sitting forward in expiration (AR), axilla and carotids.
5:15–6:00	Lung bases, sacral and ankle oedema; thank the patient and compose the headline.

Three findings to prioritise

1. Rhythm and the first heart sound
AF, a metallic click or a soft S1 changes the whole differential and the anticoagulation discussion.

2. The murmur: timing, site, radiation, manoeuvres
Systolic versus diastolic, and where it goes, separates AS, MR, AR and MS.

3. Complications and interventions
Heart failure, endocarditis, pulmonary hypertension; sternotomy, prosthetic click, device.

Common viva questions

- How do you grade aortic stenosis severity on echo?
- When is valve intervention indicated in an asymptomatic patient?
- Mechanical or tissue valve: how do you decide?
- Who needs antibiotic prophylaxis before dental work?
- How do you assess stroke risk in AF?
- What are the signs of severe mitral regurgitation?
- What are the complications of a prosthetic valve?

60-second framework (H·E·N·C·E)

This **[age]**-year-old **[man/woman]** has **[lesion]**, in **[rhythm]**, with **[no / signs of]** heart failure. Evidence: **[pulse, apex, heart sounds, murmur]**. Negatives: **[no endocarditis stigmata, no pulmonary hypertension]**. Cause: **[degenerative / rheumatic / prosthetic]**. Next: ECG, transthoracic echo, **[anticoagulation decision]**.

See also — full routine: page 36 · presenting script: page 202.

END OF THE FREE SAMPLE

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You have seen 6 of the book's 276 pages; the footer page numbers refer to the full book.

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