TRANSCRIPT **ONLINE LISTENING 6**

Listening 5 Part A Extract 1. Simon Mortlake

Doctor	Now, Mr Mortlake, I think you've been referred by your GP? I've got your notes here but perhaps you can tell me in your own words what seems to be the problem, what's brought you here today?
Simon Mortlake	Sure. Am, well, it's not the first time I've been to this clinic. I was referred to one of your colleagues about three years ago. I had what I thought was a stomach ulcer which had been troubling me for some time and my GP suggested I came in for tests and I had what he called an endoscopy. You know, when they put a tube down your throat and have a look into your insides. And as part of that, they also did a biopsy to make sure it wasn't something more serious.
Doctor	That's right. And that was clear?
Simon Mortlake	Yes, it was, fortunately. I actually had a condition called helicobacter pylori and I went through the course of tablets for that.
Doctor	Right.
Simon Mortlake	It was cleared up no time, very straightforward. But the consultant did say that I needed to be alert for any further symptoms, you know, there is a greater risk of cancer developing after you've had that. And I should come straight back if I had any problems.
Doctor	Oh, indeed. And have you had any other medical problems since then?
Simon Mortlake	Well, a couple of years back I had a hernia operation. That was also very straightforward. I had that done just after I retired. I expect it was actually an occupational injury of some kind because quite a few of my colleagues have had similar problems. I was a police officer for most of my working life. Other than that, I keep relatively fit. I'm not taking any medication for anything. I've been well until just recently.
Doctor	Ok. So, what's happened to change that?
Simon Mortlake	Well, I started to suffer from indigestion, particularly after lunch or dinner. I get heartburn. You know, pain just here.
Doctor	I see. And are there any other symptoms?
Simon Mortlake	Well, I've also found myself running out of energy. I'm a keen gardener and I'll be digging or whatever, and suddenly I feel a need to take a rest. I mean, that's not like me. I usually want to finish the job once I've started it, you know. But if I try to push myself too much, I start to get breathless and that's a bit worrying, to be honest.

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Doctor	I see. And are you aware of your weight changing at all?
Simon Mortlake	Mm, not really. But what I have noticed is that I just don't seem to have such a good appetite anymore. I mean, that's partly being retired, I'm sure. But I do keep pretty active. It's just that I don't fancy the sort of big meals I used to eat. I start to feel sick if I have too much.
Doctor	And are there any other pains or physical symptoms?
Simon Mortlake	Not really. I've been looking out for things like my stomach swelling up because I know that might be a symptom of something. But to be honest, I can't say I've ever had that.
Doctor	So, what do you think might be the problem?
Simon Mortlake	Well, the thing is my uncle, that's my mom's brother, he had to have a gastrectomy and I remember this is how it all started, I mean the symptoms I've described. Well, these things can run in family, can't they?
Doctor	Well, they can.
Simon Mortlake	Anyway, the real reason that I want to get checked out is because I've got a big trip coming up. The wife and I have booked tickets on a cruise to Antarctica. I mean, it's the trip of a lifetime, we are really excited about it. But I need to make sure I'm well.
Doctor	Ok. Well, I understand your concern. So, what I need to …
	END

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Listening 6 Part A Extract 2. Monica Pattison

Doctor	Hello Mrs. Pattison. Your GP has sent you to see me because of some problems with your legs, is that right?
Monica Pattison	Yes. Varicose veins. And they've just been getting worse and worse.
Doctor	Right. Well, I've got some notes here from your GP. But I wonder if you could tell me in your own words when this started and what's happened so far?
Monica Pattison	Well, I guess the first time I had problems with my legs was ages ago, when I was pregnant. My son's 25 now, so that shows you how long ago it was. But everyone knows that varicose veins goes with that, don't they? They look horrible at the time but they usually disappear again.
Doctor	And... was that the case?
Monica Pattison	Well, by about a year or 18 months later, they'd gone completely. My legs were looking and feeling fine and I was back at work then, too.
Doctor	Aha. And what do you do?
Monica Pattison	I was a chef in quite a busy restaurant. So, there wasn't much opportunity for sitting around in that job, doctor, I can tell you. *(Doctor: (laughs))* But then, it must be getting on for four years ago now, I noticed the veins were coming back. At first, I wasn't too concerned, although they seem to get very scaly and they itched too around the calves. I tried to follow the advice you find on websites, you know, move around at work, try to keep your feet upon a stool, and avoid crossing your legs. And uh, I did insist on getting a bit of exercise every day. I always managed to fit in walking around town after the lunch service, just for about half an hour or so.
Doctor	Good. And what treatments have you had so far, Mrs. Pattison?
Monica Pattison	I first went to see my GP, just because they looked ghastly. And I was a bit worried about them. But he said that he could only recommend a proper treatment when they got worse and were painful oI had any complications. But, um, he did tell me I should lose some weight. That's an occupational hazard in my job.
Doctor	Good advice, though.
Monica Pattison	Well, I did manage to get it down a bit. Anyway, about a year ago my left leg really swelled up. In fact, they both looked pretty nasty with the bulging veins and you can see now my feet and ankles are really swollen up. Also, when I am in bed, I regularly wake up with terrible cramps. Last night I didn't know where to put myself.

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	So, uhm, then the doctor did an ultrasound scan to see if there was a blood clot. Thankfully, that was all clear. But we agreed it was time to get my legs sorted. Ahm, the doctor arranged for me to have some injections of foam in the veins. He said it was quite a new treatment. It was just with a local anesthetic and I didn't have to stay overnight, which was good. I had to wear bandages afterwards for a week or so, and then those compression stockings for another week.
Doctor	And since then?
Monica Pattison	Well, that seem to do the trick up first. They felt much better to start with. Although I had awful headaches for the first few days which I gather happens sometimes. Anyway, uh, now they really seem to be worse than ever. So I'm back to square one. I'm thinking that either we have another go with the injections or maybe I need to consider surgery this time. That's obviously more invasive and I know from other people that I'd be very sore afterwards and would have to take time off work. Uh, that's a consideration too. I run my own hotel now, so I can't just close it for weeks on end, can I? So, uh, what do you suggest now doctor?
	END

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Listening 6 Part B (all audios)

	Q. 25
Nurse:	Excuse me, doctor. Can I have a word about a patient?
Doctor:	Sure.
Nurse:	In room 12 we have Mrs Taitt. She's a 35-year-old G3P3 woman who came in yesterday complaining of breast tenderness, bloating and mild nausea. Her last menstrual period was six weeks ago. She's married with three children under 5, uses contraceptive pills for birth control. On physical examination, she is afebrile with a heart rate of 90 and blood pressure of 140 over 80. The urine pregnancy test has resulted positive and transvaginal ultrasound reveals a 6-weeks size gestational sack with a detectable fetal heartbeat. What's concerning me is that she's visibly distressed. The pregnancy was unplanned and she's anxious about the emotional and financial implications. She was on bed rest for six weeks during her last pregnancy and she's aware of the risks and difficulties of carrying this one to term. Would you be able to speak to her?
	Question 26. You hear a senior doctor giving a group of medical students training and how to conduct a physical examination. Now read the question.
	Today I'm going to be demonstrating how to examine a patient's shoulder. So, you've taken a full history which means you've got a fairly good idea what it is you're looking for and it's time for the physical examination. Now, the thing to bear in mind is that the shoulder's an extremely complex joint and there are many specific tests we can apply during an examination. Therefore, it's best not to jump to too many conclusions about the diagnosis. If you just go looking for that one thing then you risk missing something else that might be there. So, how to conduct the examination? Well, you need to be organized and follow a set routine. The first thing is to ask your patient to remove their shirt or whatever, to expose the area you're examining. Watching the patient do this is often quite instructive with shoulder problems because you can pick up whether they're actually guarding their shoulder as they do that. And that might give a clue as to the possible nature of the pain or exactly where it's located.
	Question 27. You hear a GP talking to a patient about his mother. Now read the question.
GP:	So, how can I help you today?
Patient:	I've come about my mom, actually. You know you referred her to the memory clinic.
GP:	Yes, that's right.

Patient:	Well, the thing is she went there and she's been diagnosed with Alzheimer's. I guess we should've known what was coming but it so comes as a bit of a bolt out of the blue, to be honest.
GP:	Oh, yes. I'm sure it has.
Patient:	Mell, mom, seems to be ok with it. It's me really. I mean, I know what Alzheimer's disease but I don't know that much about it really. So, I thought it will be best to come and see what I ought to be doing. My mom lives on her own at the moment. She's coping fine but how long is that gonna be the case? Is there anything I should be doing? You know, is it gonna get worse? I mean, do I need to start putting things in place to help her or is that gonna alarm her? Is she safe to look after herself? Should I be looking out for certain signs or anything?
GP:	Ok. Look, I understand your concerns. Before we go any further...
	Question 28. You hear two nurses discussing a patient's care plan. Now read the question.
Nurse 1:	Shall we go over her care plan next?
Nurse 2:	Sure.
Nurse 1:	I'd say that the priority is some Lovenox training because she is likely to be going home on that. She's been having a little bit of anxiety over this current hospitalization and the recurrence of her condition after a period of remission. She's a high fall risk and she's also been in acute pain. But, uh, so that's been well managed. So it's more about the anxiety.
Nurse 2:	Did you have to give anything for that?
Nurse 1:	She was okay without any pharmacological intervention, actually. We've been doing breathing exercises and they're going well.
Nurse 2:	Ok. Anything else we should be seeing to?
Nurse 1:	If she can show us that she is able to handle the injections then we can go ahead and move to sign off.
Nurse 2:	Ok.
	Question 29. You hear a surgeon briefing his team before an operation. Now read the question.
Surgeon:	I think this patient could be quite a problem post-operatively. Is he taking oral medications?

Assistant:	Yes, he is on Phenytoin.
Surgeon:	Ok. So, if his gastrointestinal tract becomes unusable, we need to be ready to deliver that intravenously. The other issue with him is that from his record I can see that he's actually had quite a bad time in the post-operative period on previous occasions. He was a heavy smoker but claims to have cut down considerably. Even so, he is going to have a larger mid-line incision, so he may be someone that you want to consider for an epidural because he is likely to be at the extreme edge of the pain threshold.
Assistant:	We'll see at the beginning with the wound catheters and PCA. If necessary, we can do the epidural in the recovery room, if he is in difficulty.
Surgeon:	Fine.
	Question 30. You will hear a dentist talking to a patient. Now read the question.
Dentist:	So, we're going to fit your implant today. Have you had any problems since your last appointment?
Patient:	Well, there was just one thing. You remember, how hard you had to pull to get the impression off of my teeth once it was set?
Dentist:	Yes, it is a very tenacious material.
Patient:	Well, the next day one of my crowns dropped out. Look, I've got it here. Do you think that was what caused it to happen?
Dentist:	Oh dear, I'm sorry about that. I can probably refix it for you today if you want. These things do happen sometimes, I'm afraid.
Patient:	Oh, thank you. That'd be great. But actually, what I was wondering was if I might have an implant instead of that crown, as well. I mean, it's the second time it's fallen out actually. I've had it years.
Dentist:	Oh, well, in that case, let's have a quick look at the tooth itself and see what might be possible.
Patient:	Thanks.
	END

TRANSCRIPT **LISTENING 5**

Listening 6 Part C Ext 1. Toby Walsh

Host:	My guest today is a sports injury specialist called Toby Walsh. We're going to be talking about hamstring injuries. Toby, hamstring injuries are something sports people at all levels of ability fear getting? Why is this?
Toby Walsh	Well, you're right. Hamstrings are the most significant injury in a number of team sports, including football and rugby. But any sports person could be affected. I think looking at the statistics, hamstring injuries account for the largest number of lost playing hours amongst professional footballers, even though the average injury only takes about three weeks to heal. More worrying for the individual is that once they've had such an injury, the chance of sustaining another one in the same season is as high as 20%. So, it can become the thorn in the player's side. That, I think, accounts for the reputation the injury has.
Host:	So, is this an injury that can affect any of us, at any time?
Toby Walsh	Well, the hamstrings are a group of muscles in the thigh that allow us to bend our legs and knees effectively. Now, some ethnic groups are more predisposed to these injuries than others and everyone's chance of tearing the muscle increases with age. But apart from that the generally results of short bursts of movement like sprinting or suddenly changing direction. And they happen more in certain spots because these are just the sort of movements that players are making. They happen most often at the end of what we call the 'swing phase' of running, just before the out stretched leg hits the ground and the muscles contract to bend a knee.
Host:	But I am sure there are ways to prevent these injuries?
Toby Walsh	Well, looking after the muscle themselves obviously helps here. You can do various exercises that actually strengthen the hamstrings, so make them less prone to injury. And of course, warming up before exercise is crucial in avoiding all sorts of muscles strains. And sports people know that. But that isn't the whole story. One interesting finding is that a lot of people who develop hamstring injuries have coexisting back problems and there would seem to be a correlation. By loosening up the lower back, it also helps the nerves that control the hamstring. Flexibility there allows the muscles to function as they should and there are exercises people can do to help that.
Host:	Umm. And is the risk that hamstring injury something that should be taken into account in training programmes?
Toby Walsh	Well, yes. Intensive training of the sort you do for a team sport like football can put quite a heavy workload on the gluteal muscles which can lead to a tightening around the hip, creating knots known as 'trigger points'. These, in turn, can cause referred pain in the hamstring, reducing flexibility and increasing the risk of straining or tearing it. I mean, basic stretching exercises can help here. But also,

	we know that muscles are more likely to strain if they're fatigued. Often during a period of intensive training, you get cumulative fatigue. This can creep up on an athlete, on their muscular system over number of weeks as the training intensifies.
Host:	And, um, if an athlete does pull a hamstring, how can a sports injury specialists help?
Toby Walsh	Well, they will feel the pain, maybe, maybe even feel a 'pop', and they won't be able to continue because the muscle goes into cramp and spasm. There are three degrees of severity and the treatment will vary according to that. Fortunately, as a sports injury specialist, you often present when the injury occurs or you can see it on video, so, you don't have to rely on a verbal account of symptoms to assess the severity. Initially, you want to stop any swelling as soon as possible, that's your priority. You're going to apply compression bandages, possibly ice. Although there are some debate about that these days, it does ease the discomfort and you'll certainly elevate the leg and make sure the patient rests up.
Host:	And how long will the athlete will be out of action?
Toby Walsh	Well, as I say that going to depend on the severity of the injury. They'll have to rest up to 72 hours, whatever happens, to avoid causing further damage. And things like heat and massage can be just as damaging as movement itself. A Grade 3 injury can take months to heal, and can be career-threatening for top athletes. What's more, lack of use can lead to the development of scar tissue and muscle shrinkage. In other words, the muscles won't return to their former state even if the tear or strain itself heals. So, part of my job is to ensure that doesn't happen by getting the muscles working again in the right way, as soon as possible.
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Listening 6 Part C Extract 2 Emma Royce

Doctor	My name is Emma Royce. And today I'd like to talk about some unanticipated side effects of certain widely-used medications. The side effects that I'm particularly interested in involves changes in a patient's behaviour. In particular, the onset of what's known as compulsive or pathological gambling in patients suffering from Parkinson's disease. Pathological gambling is essentially an addictive disorder in which the patient feels a need to engage in financial risk-taking in the expectation of gaining a reward. It is characterized by both recurrent and persistent behaviours, and can lead to significant distress and the break-up of personal relationships. The condition is thought to affect around 1.4% of the general population, a figure which rises to 7% in Parkinson's patients. It was this finding that led to the realization that there was a link between the medication prescribed for that condition, notably dopamine agonists, and the onset of pathological gambling. So, how common is this side effect of Parkinson's medication? On the surface, it would seem that it remains the exception rather than the rule, only affecting around 1 in 7 users, and not all of those in a severe way. Also, because only a small proportion of patients treated with dopamine agonists develop the symptoms, it may reflex specific predisposing factors. The exact level of incident is unknown, however, and this may be because many cases go unreported. Patients themselves or family members don't admit to the condition out of shame or because their doctors or carers haven't been able to identify it. And this could explain why it doesn't show up more frequently in pharmaco-vigilance reporting systems. Let me give you an example of a typical case. A 74-year-old male, let's call him Harry, who was diagnosed with Parkinson's disease and prescribed the dopamine agonist, Pramipexole. About a month after commencing treatment, he began to feel an increasing need to play slot machines until he was going to a gambling venue every day. At first, Harry was able to conceal his behaviour from family members, another common feature of the condition. His wife did notice other symptoms. Harry was having difficulty sleeping and wasn't finishing his meals. But she put this down to his Parkinson's. It was when Harry began impulsively buying items that he neither needed or wanted that his wife became alarmed. Uh, it was at this point that the hole in his bank balance caused by the gambling came to light. And the couple was able to seek help. In other cases, heightened sexual activity has been identified as an indicator. There are several underlining risk factors for developing pathological gambling. Uh, male gender, a previous or family history of gambling, personality traits such as high impulsivity and high novelty seeking. The risk increases when such people take dopamine agonists as a treatment for Parkinson's disease. Originally, research suggested that the higher the dose and the longer is the duration of the prescription, the greater the likelihood of the compulsive symptoms occurring. More recently, however, research into the use of the medication for another condition - restless leg syndrome or RLS - has shown that symptoms can develop even at low doses. So, what are the long-term effects of these adverse reactions? Pathological

	gambling seems to be reversible when the dose of the dopamine agonist is reduced or the patient is transitioned to an alternative medication. Basically, dopamine agonists help Parkinson's patients by replacing the loss of dopamine in areas of the brain that control the ability to move. But the increased dopamine levels then affect other areas such as the neural system linked to pleasure and reward behaviors, and associated emotions which then manifest themselves as impulsive and compulsive actions. But the effects are not long-lasting. Harry lost all interest in gambling within a month of stopping Pramipexole therapy. But sadly, for many patients, the problem isn't picked up before life-changing disruption is caused, as significant gambling that's develop and relationships become strained. So, what can we do to improve the management of these side effects? There is no doubt that Parkinson's is a serious and degenerative disease, so the drug may represent a reasonable trade-off in terms of risk-benefit analysis. It's hoped that by educating the patients and carers about potential side effects, it'll make them more willing to report changes of behaviour. Patients and their carers should be monitored closely for the symptoms, so as soon as any side effects do emerge the drugs can be tapered or discontinued. For other conditions such as RLS, however, it is open to debate whether the risks associated with compulsive behaviours outweigh the therapeutic advantages of administering the medication. What is needed is further research to establish just how extensive the problem is.
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