OET Reading practice test 2

42 questions, 60 minutes, with Part A strictly 15 minutes. Practise in the OET format, then check the answer key.

Part A

Text A: Recognising anaphylaxis

Anaphylaxis is likely when either of the following criteria is met:

- Acute onset of illness with typical skin features (urticaria, erythema/flushing and/or angioedema) PLUS involvement of the respiratory and/or cardiovascular system and/or persistent severe gastrointestinal symptoms
- Acute onset of hypotension, bronchospasm or upper airway obstruction where anaphylaxis is considered possible, even if typical skin features are not present

In reactions to insect stings, abdominal pain and vomiting are signs of anaphylaxis.

Mild to moderate allergic reaction	Anaphylaxis (any one of the following)
Swelling of lips, face or eyes	Difficult or noisy breathing
Hives or welts	Swelling of tongue
Tingling mouth	Swelling or tightness in throat
Abdominal pain, vomiting (except in insect allergy)	Wheeze or persistent cough
-	Difficulty talking or hoarse voice
-	Persistent dizziness or collapse
-	Pale and floppy (young children)

Hypotension: systolic blood pressure thresholds

Patient group	Low systolic blood pressure
Infants 1–12 months	< 70 mmHg
Children 1–10 years	< 70 mmHg + (2 × age in years)
Children 11–17 years	< 90 mmHg
Adults	< 90 mmHg, or a fall of more than 30% from the person's baseline

Text B: Intramuscular adrenaline dosing and positioning

Adrenaline is the first-line treatment for anaphylaxis and must not be delayed. Give adrenaline 1 mg/mL (1:1000) intramuscularly into the anterolateral thigh at a dose of 0.01 mg/kg (0.01 mL/kg), up to a maximum single dose of 0.5 mg (0.5 mL). Repeat every 5 minutes as needed.

Approximate age	Approximate weight	Volume of adrenaline 1 mg/mL
Under 1 year	5–10 kg	0.05–0.1 mL
1–2 years	10 kg	0.1 mL
2–3 years	15 kg	0.15 mL
4–6 years	20 kg	0.2 mL
7–10 years	30 kg	0.3 mL
10–12 years	40 kg	0.4 mL
Over 12 years and adults	Over 50 kg	0.5 mL

Adrenaline autoinjectors

If an ampoule and syringe are not immediately available, use an autoinjector: 0.15 mg for children 7.5–20 kg; 0.3 mg for children over 20 kg and adults; 0.3 mg or 0.5 mg may be used for those over 50 kg. Autoinjectors are not usually prescribed for children under 7.5 kg; below this weight, prescribing is a specialist decision. In an emergency, give adrenaline by syringe using the weight-based volumes above.

Positioning

- Lay the patient flat. Do not allow them to stand or walk.
- If breathing is difficult, allow sitting with legs outstretched.
- Hold young children flat, not upright.
- Position pregnant patients on their left side.

Text C: Harbourview Health Service ED Procedure 17 – Observation and discharge after anaphylaxis

Observation

All patients treated with adrenaline for anaphylaxis must be observed in the department for at least 4 hours after the last dose of adrenaline. Arrange overnight observation in the short-stay unit if any of the following apply:

- more than one dose of adrenaline was required, or an adrenaline infusion was started
- the reaction involved hypotension, collapse or airway swelling
- there is a history of biphasic or protracted reactions
- the patient presented in the evening, lives alone or lives far from emergency care

Mast cell tryptase

- Sample 1: as soon as possible after treatment has started (do not delay resuscitation)
- Sample 2: ideally 1–2 hours after the onset of symptoms, and no later than 4 hours
- Baseline sample: at least 24 hours after full recovery

Medications

An oral non-sedating antihistamine may be given for skin symptoms such as itch or hives. Corticosteroids are not routinely required and should not be relied on to prevent a biphasic reaction.

Before discharge

- Prescribe an adrenaline autoinjector and dispense one device from ED stock.
- Complete an ASCIA Action Plan for Anaphylaxis with the patient or carer.
- Demonstrate autoinjector use and observe the patient or carer practise.
- Refer to a clinical immunologist or allergist. Patients with anaphylaxis caused by an insect sting should be assessed for venom immunotherapy.

Text D: Information for patients and carers – your action plan and EpiPen

How to give an EpiPen

- Form a fist around the EpiPen and pull off the blue safety release.
- Hold the leg still and place the orange end against the outer mid-thigh, with or without clothing.
- Push down hard until a click is heard or felt, hold in place for 3 seconds, then remove it.

Other devices, such as Anapen, use different steps; follow the instructions for your own device.

After giving adrenaline

- Phone an ambulance on 000.
- Stay lying down, even if you start to feel better.
- If there is no improvement after 5 minutes, give a second autoinjector if one is available.
- If you are unsure whether it is asthma or anaphylaxis, give the autoinjector first, then your asthma reliever puffer.

Looking after your autoinjector

- Store it at room temperature, below 25 °C. Do not keep it in the fridge or leave it in a hot car.

- Check the viewing window regularly and replace the device if the solution appears discoloured.
- Practise every few months with a trainer device, which contains no needle.

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.

1. Which text states the minimum length of time a patient must remain under observation after treatment? _____

2. Which text gives blood pressure values that indicate hypotension in different age groups? _____

3. Which text advises what to do when it is unclear whether symptoms are caused by asthma? _____

4. Which text would tell you what volume of adrenaline to draw up for a three-year-old child? _____

5. Which text gives advice on where the medication should be kept? _____

6. Which text explains how a pregnant patient should be positioned? _____

7. Which text explains how the cause of a reaction affects the interpretation of abdominal pain and vomiting? _____

Questions 8-14

Answer each of the questions, 8-14, with a word or short phrase from one of the texts. Each answer may include words, numbers or both.

8. What strength of adrenaline solution should be used for intramuscular injection? _____

9. What is the largest single dose of intramuscular adrenaline, in milligrams, that should be given to any patient? _____

10. What appearance in a young child indicates anaphylaxis rather than a mild reaction? _____

11. By more than what percentage must an adult's systolic blood pressure fall from baseline to be classed as hypotension? _____

12. Ideally, how long after symptoms begin should the second tryptase sample be collected? _____

13. What should patients use to practise giving their autoinjector? _____

14. What position may a patient who is having difficulty breathing adopt? _____

Questions 15-20

Complete each of the sentences, 15-20, with a word or short phrase from one of the texts. Each answer may include words, numbers or both.

15. A patient who presents to the department in the evening should receive ___ observation.

16. Patients whose anaphylaxis was caused by an insect sting should be assessed for ___ .

17. Anaphylaxis is likely when typical skin features occur together with persistent severe ___ symptoms.

18. A patient whose only remaining symptom is hives may be given an oral non-sedating ___ .

19. After the click, the EpiPen should be held in place for ___ .

20. An autoinjector should be replaced if the solution in its viewing window appears ___ .

Part B

Extract 1: Email: Sepsis recognition module

Subject: Sepsis recognition module now mandatory

Dear all,
From 1 March, the online module 'Recognising and Responding to Sepsis' becomes part of the mandatory training package for all clinical staff, including casual and agency nurses. The module takes about 40 minutes and must be completed by 30 April. It does not replace the annual face-to-face deteriorating patient workshop, which continues as before. Staff who completed the pilot version last year will need to do the new module, as the content has been updated to reflect the revised escalation pathway. Time spent on the module can be claimed as paid education time; please record it on your timesheet under code ED4.

Priya Natarajan
Clinical Nurse Educator

21. According to the email, staff who completed the pilot module last year

A can count it towards this year's requirement if they also attend the workshop.
B must complete the new module because its content has since been revised.
C need only complete the section covering the revised escalation pathway.

Extract 2: Thornbury Health Network Policy 6.3: Chaperones for intimate examinations

Patients must be offered a chaperone for any intimate examination, regardless of the gender of the clinician or the patient. The offer, and the patient's response, must be documented in the clinical record, together with the name and role of any chaperone present. Family members or friends may remain to support the patient but should not act as the formal chaperone. A chaperone should be a member of the clinical staff who understands the nature of the examination and can remain for its entire duration. Where a patient declines a chaperone and the clinician is not comfortable proceeding, the examination may be deferred unless delay would compromise care, in which case the reason for proceeding must be recorded.

22. According to the policy, a relative accompanying the patient

A may act as chaperone if no suitable staff member is available.
B must have their name and relationship recorded in the clinical notes.
C can stay to support the patient but cannot fill the chaperone role.

Extract 3: Memo: Change to insulin pen needles

To: All ward nurse unit managers
From: Pharmacy Department

From 14 July, ward imprest stock of insulin pen needles will change from the current 5 mm standard needles to Clearpoint 4 mm safety pen needles. The new needles are compatible with all insulin pens on the hospital formulary. After injection, a shield covers the needle automatically and locks in place. Staff should not attempt to recap the needle or remove the shield, but should unscrew the needle from the pen and place it directly in a sharps container. With the shorter needle, a skin fold is not normally required for adult patients. Existing stock of 5 mm needles may be used until it runs out. Patients who self-administer using needles brought from home may continue to do so.

23. What does the memo tell staff about the 5 mm needles?

A They must be returned to pharmacy by 14 July.
B They may be used until existing stocks run out.
C They should be kept for patients who self-administer.

Extract 4: Guideline extract: Disposal of cytotoxic waste

Cytotoxic waste includes any item that has come into contact with a cytotoxic drug during preparation, administration or disposal, such as empty vials, giving sets, gloves and gowns. It must be placed in purple bags or purple-lidded containers marked with the cytotoxic symbol, and never in general clinical waste. Sharps contaminated with cytotoxic drugs must go into purple-lidded sharps containers. The body fluids of patients receiving cytotoxic therapy may contain active drug for up to seven days, depending on the agent; staff handling them should wear gloves and a gown, and linen soiled during this period should be bagged as cytotoxic-contaminated. Containers must be sealed when three-quarters full and stored in a designated secure area until collected.

24. The guideline states that cytotoxic waste containers

A must be sealed when they reach three-quarters capacity.

B must be held for seven days before they are collected.

C may also take soiled linen from patients on therapy.

Extract 5: Notice: Visiting hours during the respiratory virus season

From 1 June to 30 September, visiting hours on all inpatient wards will be 2 pm to 8 pm (currently 10 am to 8 pm). Each patient may have two visitors at a time. Anyone with a cough, fever, sore throat or runny nose should not visit, even if they have returned a negative test. Masks are available at all entrances and must be worn on respiratory wards; elsewhere they are strongly recommended. Children under 12 may visit only the paediatric and maternity wards. Exceptions, for example for patients receiving end-of-life care or for a nominated support person of a patient with dementia, can be arranged with the nurse in charge.

25. According to the notice, people with cold symptoms

A may visit wards other than respiratory wards if they wear a mask.

B should not visit, regardless of any negative test result.

C may visit if they test negative and wear a mask throughout.

Extract 6: Manual extract: Bladder scanner calibration check

Check the scanner against the calibration phantom supplied with the device every 30 days, or sooner if it has been dropped or its readings appear inconsistent with catheterised volumes. Place the phantom on a flat surface, fill the scanning well with gel and select 'Calibration check' from the Settings menu. Take three scans. All three readings must fall within ±10% of the volume printed on the phantom. If any reading falls outside this range, repeat the check once. If it fails again, label the device 'Out of service' and contact Biomedical Engineering. Do not attempt to adjust the calibration settings yourself. Record the date, the results and your initials in the log kept with the device.

26. If the scanner fails the calibration check a second time, staff should

A log the results and keep using it until Biomedical Engineering checks it.

B compare its readings with catheterised volumes before reporting it.

C label it out of service and report it to Biomedical Engineering.

Part C

Text 1: When your watch says your heart is out of rhythm

When Dorothy Pemberton's smartwatch vibrated one Sunday afternoon, the message on its screen was brief: possible atrial fibrillation. The 68-year-old retired librarian felt perfectly well. She had no palpitations or breathlessness and had never been told she had a heart problem. By that evening, however, she was sitting in an emergency department waiting room, and over the following fortnight she underwent an electrocardiogram, a 24-hour Holter monitor and an echocardiogram. Every result was normal. 'I was relieved, of course,' she says, 'but I also felt slightly foolish, as though I'd wasted everybody's time because a gadget told me to.'

Pemberton's experience is becoming familiar to cardiologists. Many consumer wearables now analyse pulse data from an optical sensor and alert the user to an irregular rhythm suggestive of atrial fibrillation (AF); some also allow the wearer to record a single-lead ECG by holding a finger on the device. AF matters because it increases the risk of stroke around fivefold, and because it is frequently silent: a considerable number of people discover they have it only after they have already had a stroke. In principle, a sensor worn day and night by millions of people is an ideal early-warning system. In practice, the picture is more complicated.

The difficulty lies less in the technology than in the arithmetic. Even a highly accurate algorithm will produce a large number of false alarms when it is used by young, healthy people, among whom AF is uncommon. A 2024 audit of three Melbourne cardiology clinics found that, of 1,240 patients referred after a wearable alert, AF was confirmed in fewer than a third, and in only one in ten of those under 40. 'The device doesn't know who's wearing it,' explains Dr Rohan Chawla, an electrophysiologist in Brisbane. 'In a 75-year-old with high blood pressure, an alert deserves to be taken very seriously. In a healthy 30-year-old, it's far more likely to be harmless extra beats, or simply a poor signal from a loose strap.'

False alarms are not harmless, however. Associate Professor Clare Donnelly, a clinical psychologist who studies health anxiety, says that for a minority of users the device becomes a source of distress rather than reassurance. 'We see people recording an ECG twenty or thirty times a day,' she says. 'Each normal reading brings relief for an hour or so, and then the doubt creeps back. The watch was supposed to give them peace of mind; for some, it has done the opposite.' There are costs to the health system, too. Clinics report growing numbers of referrals from people who are well but worried, and each referral can set off a cascade of tests, some of which turn up incidental findings that then require investigation of their own.

Not every cardiologist regards this as a serious problem. Dr Helen Abara, who runs a rhythm clinic in Adelaide, argues that critics underestimate the value of the recordings themselves. 'Paroxysmal AF is notoriously hard to catch,' she says. 'A patient tells me their heart was racing last Tuesday, and by the time they see me it has stopped. If they've captured a tracing on their watch, I can often make the diagnosis from that alone, provided it's of reasonable quality.' For Abara, the occasional unnecessary consultation is a fair price to pay for diagnoses that would otherwise be missed.

Chawla is less convinced. He accepts that patient-recorded tracings can be useful but stresses that detecting AF is not the same as preventing strokes. 'We know that anticoagulation reduces stroke in people with established AF,' he says. 'What we don't yet know is whether treating the very short episodes these devices pick up in people without symptoms brings the same benefit, and anticoagulants carry a genuine risk of bleeding. Until we have that evidence, a positive alert creates a decision we're not well equipped to make.'

Regulators, meanwhile, have tried to draw a line between wellness products and medical devices. In Australia, the rhythm-detection features of several watches are included on the Australian Register of Therapeutic Goods, meaning that the manufacturer has submitted evidence of their performance. But that listing covers a particular function used in a particular way, usually by

adults with no previous diagnosis of AF, and offers no guidance on what should happen after an alert. 'There's also the issue of updates,' says Dr Simon Fairweather, a consultant on medical-device regulation. 'The software on someone's wrist today may not be the version that was assessed two years ago. Our regulatory systems were designed for products that stay the same once they're on the shelf.'

What would help, most of those interviewed agree, is clearer guidance for users and doctors alike. Donnelly would like manufacturers to explain that most notifications in younger people turn out not to be AF. Abara suggests giving general practitioners a simple pathway for reviewing tracings, so that fewer people are sent straight to emergency departments. Pemberton still wears her watch, although she has switched off the rhythm notifications. 'I like knowing my step count,' she says. 'I've decided I can live without knowing everything else.'

27. What do we learn about Dorothy Pemberton in the first paragraph?

A Her symptoms prompted her to check her watch's reading.
B Her tests revealed a minor abnormality of the heart.
C She was critical of how the hospital responded to her.
D She felt somewhat embarrassed by the outcome.

28. According to the writer, detecting AF is important because

A it accounts for the majority of strokes in people over 65.
B its stroke risk rises sharply once palpitations become frequent.
C many people with it learn of it only after having a stroke.
D treating even brief episodes early has been shown to prevent stroke.

29. Dr Chawla's comments in paragraph 3 suggest that

A a loose strap is the commonest cause of false alerts in young users.
B alerts in older patients with hypertension usually turn out to be AF.
C algorithms ought to be adjusted to take account of the wearer's age.
D how an alert should be interpreted depends on who is wearing the device.

30. In paragraph 4, 'it' in 'it has done the opposite' refers to

A the returning doubt.
B each normal ECG reading.
C the user's watch.
D repeated ECG recording.

31. According to Associate Professor Donnelly, why do some users keep recording ECGs?

A They doubt whether the device is recording accurately.
B They want a collection of tracings to show their doctor.
C The relief that a normal result gives them soon fades.
D An earlier alert has left them afraid of missing an episode.

32. What is Dr Abara's view of wearable rhythm recordings?

A Even a poor-quality watch tracing is usually enough for diagnosis.
B Their diagnostic value outweighs the cost of some needless visits.
C Critics have overstated how often the alerts prove to be false.
D Their main value lies in reassuring patients whose symptoms have stopped.

33. What is Dr Chawla's main reservation in paragraph 6?

A Evidence is lacking on whether treating brief, symptomless episodes helps.
B Watch tracings are not detailed enough to confirm a diagnosis of AF.
C Bleeding risk makes anticoagulation unsuitable for most older patients.
D The short episodes that devices pick up carry little risk of stroke.

34. What point does Dr Fairweather make about regulation?

A Approved features have been shown to work in all age groups.

B Manufacturers must tell users how to act on an alert.

C The software that was assessed may be updated later on.

D Wellness products should be removed from the register.

Text 2: The pill with nothing in it

For most of the history of modern medicine, the placebo has carried a faint air of trickery. In clinical trials it is indispensable, the inert comparison against which a new drug must prove its worth. At the bedside, however, it has long been viewed with suspicion: a doctor who knowingly prescribes a sugar pill while implying that it contains an active drug risks undermining the very trust on which the relationship with a patient depends. So when researchers began, little more than a decade ago, to give patients placebos and tell them so, many in the profession expected the idea to fail. Why would a pill work if the person taking it knew there was nothing in it?

The results have been more interesting than the sceptics predicted. In a trial published last year by the Kingsmere Pain Research Centre, 260 adults with chronic low back pain were randomly assigned either to continue their usual care or to add capsules, openly labelled as placebo, taken twice a day. Before starting, participants in the second group were told four things: that the capsules contained only cellulose, that placebo effects can be powerful, that the body can respond automatically to the routine of taking medication, and that a positive attitude might help but was not necessary. After three weeks, the placebo group reported pain reductions roughly 30% greater than the usual-care group. Improvements in disability scores were smaller, but still statistically significant.

How might an openly inert capsule have any effect at all? Professor Lena Hartmann, who led the study, points to two mechanisms: expectation, and a form of conditioning built up over a lifetime of taking tablets that have helped. 'Patients don't need to believe the capsule contains a drug,' she says. 'They need only to take part in the ritual, and the ritual seems to do something by itself.' She is careful, though, to define the limits. The effects, she says, are concentrated in symptoms that the brain strongly modulates, such as pain, fatigue and nausea, rather than in the underlying disease. 'Nobody should imagine that a placebo will shrink a tumour or lower a cholesterol level.'

Others are more cautious about the findings. Dr Marcus Afolabi, an epidemiologist who specialises in trial design, points out that open-label studies cannot be blinded. Participants know which group they are in, and those given capsules, together with a careful explanation from an enthusiastic researcher, may report improvement because they expect to feel better or because they wish to please. 'When your outcome is a self-reported pain score, you're measuring what people say, which isn't always the same as what they feel,' he says. 'The fair comparison is with a control group that gets just as much time and attention, not with people sent home with nothing new.'

Supporters argue that open-label placebos resolve the ethical difficulty that has always surrounded placebo use, because there is no deception. Some ethicists think the matter is less straightforward. Dr Anna Sorensen, a bioethicist, notes that the script read to participants, with its emphasis on 'powerful' effects, is itself a persuasive framing intended to raise expectations. 'It's honest in the narrow sense that nobody is lying about what's in the capsule,' she says. 'But we're still deliberately shaping belief, and patients should understand that this is how it works.' She is also concerned about what she calls the 'cheap substitute' problem: in an overstretched health system, a placebo could become a convenient way of dismissing patients whose symptoms are poorly understood, rather than investigating them properly.

What patients think may ultimately settle the question. In a recent survey of 1,100 Australian adults, a clear majority said they would be willing to try an open-label placebo for a long-term condition if their doctor recommended it. Yet fewer than one in five said they would be comfortable to learn that a doctor had given them a placebo without telling them. Dr Fiona Castell, a general practitioner who took part in a pilot programme, believes the conversation matters more than the capsule. 'When I offer it, I'm also telling the patient that I believe their pain

is real and that I'm not giving up on them,' she says. 'If it's presented as "there's nothing else we can do", it fails, and frankly it deserves to.'

For now, open-label placebos remain largely confined to research. Afolabi wants larger trials with attention-matched controls before they are used in routine care, and Hartmann agrees that the evidence is not yet strong enough to justify clinical guidelines. But she argues that the research has already taught clinicians something valuable: that the manner in which any treatment is delivered, including the time taken, the explanation offered and the expectations conveyed, has measurable effects of its own. 'Even if no one ever prescribes a sugar pill,' she says, 'every prescription comes with a placebo attached. We might as well make it a good one.'

35. According to the first paragraph, doctors have traditionally been wary of using placebos in everyday practice because

A their benefits had only been demonstrated under trial conditions.
B implying they were active could damage patients' trust in doctors.
C they might delay the use of a drug that had proven its worth.
D patients were thought to stop responding if they suspected the truth.

36. What were participants in the placebo group told before the trial?

A Their pain was likely to ease noticeably within three weeks.
B Their response would depend mainly on their own expectations.
C They could benefit without feeling optimistic about the treatment.
D The capsules would only work if taken at the same times each day.

37. Professor Hartmann emphasises that open-label placebos

A depend mainly on patients expecting that they will feel better.
B are most effective in people who have taken many tablets in the past.
C have been shown to improve measurable markers of disease in some patients.
D are likely to change how patients feel more than the course of their illness.

38. According to Dr Afolabi, a fair test of open-label placebos would compare the placebo group with

A patients continuing their usual care with nothing added.
B patients given an active painkiller instead of the capsules.
C patients who did not know whether their capsules were inert.
D patients receiving the same amount of time and attention.

39. When Dr Sorensen says the approach is 'honest in the narrow sense', she means that

A nobody is misled about the capsule, but expectations are deliberately raised.
B the script is accurate, although it exaggerates the strength of placebo effects.
C deception is avoided, but patients' symptoms may still go uninvestigated.
D the contents are disclosed, but the evidence of benefit is still limited.

40. What is Dr Sorensen's 'cheap substitute' concern?

A Patients might feel dismissed even when a placebo is a reasonable option.
B Services might offer placebos in place of proven treatments to save money.
C Clinicians might rely on a standard script instead of spending time with patients.
D Doctors might use placebos instead of looking into unexplained symptoms.

41. What does the survey in paragraph 6 suggest about patients?

A Most would accept a placebo as long as it relieved their symptoms.
B Only a minority would try a placebo, even if their doctor suggested it.
C Their acceptance depends largely on whether the placebo is disclosed.
D Most would try a placebo for a short-term rather than a long-term problem.

42. Professor Hartmann's final comment implies that

A the way any treatment is presented can influence how well it works.

B clinicians should reserve placebos for symptoms the brain strongly modulates.
C delivery matters most when no effective drug is available for a condition.
D doctors should tell patients when a treatment may act partly as a placebo.

Answer key

Check after you finish. For the evidence and an explanation of each answer, submit the same test free online.

1. C
2. A
3. D
4. B
5. D
6. B
7. A
8. 1 mg/mL
9. 0.5 mg
10. pale and floppy
11. 30%
12. 1–2 hours
13. trainer device
14. sitting with legs outstretched
15. overnight
16. venom immunotherapy
17. gastrointestinal
18. antihistamine
19. 3 seconds
20. discoloured
21. B
22. C
23. B
24. A
25. B
26. C
27. D
28. C
29. D
30. C
31. C
32. B
33. A
34. C
35. B
36. C
37. D
38. D
39. A
40. D
41. C
42. A