OET Reading Part A - Question Paper

20 questions / 15 minutes. Read Texts A-D, then answer using the group instructions. Practise Reading Part A, then check your answers.

Text A: Clinical assessment of dehydration

Use this table together with the history. Weigh the child undressed on arrival; where a recent weight is available, percentage weight loss is the most reliable estimate of fluid deficit.

Children at increased risk of dehydration

- infants under 6 months, particularly those of low birth weight
- six or more diarrhoeal stools in the past 24 hours
- three or more vomits in the past 24 hours
- unable to tolerate fluids before presentation, or breastfeeding stopped during the illness
- signs of malnutrition

Sign	Mild (< 5%)	Moderate (5-9%)	Severe (>= 10%)
Conscious state	Alert and responsive	Lethargic or irritable	Reduced conscious state
Heart rate	Normal	Normal or mildly raised	Tachycardia
Breathing	Normal	Increased rate	Increased rate; deep acidotic breathing
Blood pressure	Normal	Normal	Hypotension
Skin colour and peripheries	Normal; warm	Normal; warm	Pale or mottled; cold; weak pulses
Eyes and fontanelle	Not sunken	Sunken	Deeply sunken
Mucous membranes	Moist	Dry	Dry
Skin turgor	Instant recoil	Mildly decreased	Decreased
Central capillary refill	Normal	Prolonged	Markedly prolonged

Signs in the severe column, particularly markedly prolonged capillary refill, cold mottled peripheries and reduced consciousness, indicate possible hypovolaemic shock. Severe dehydration requires IV fluids (see Text B).

Suspect hypernatraemic dehydration if the child has jittery movements, increased muscle tone, hyperreflexia, seizures or a doughy feel to the skin, and check serum sodium. Bilious (green) vomiting is not consistent with gastroenteritis and needs urgent surgical review.

Text B: Westbrook Children's Hospital - Rehydration protocol

Mild dehydration

Continue breastfeeding (more often than usual) and usual fluids. Give oral rehydration solution (ORS) in small, frequent amounts, aiming for 10 mL/kg/hour, and offer extra after each loose stool or vomit.

Moderate dehydration

- Oral trial: give ORS by syringe or spoon every few minutes, aiming for 10 mL/kg/hour, and reassess after 1 hour.
- If the oral trial fails (refusal or persistent vomiting), insert a nasogastric tube and give ORS at 10-25 mL/kg/hour for 4 hours (rapid NG rehydration). Many infusion pumps cannot exceed 300 mL/hour.
- Use slow NG rehydration for infants under 6 months and children with significant comorbidities or abdominal pain: replace a 5% fluid deficit over the first 6 hours, then clinically reassess. If further hydration support is required, give the daily maintenance volume over the next 18 hours. Any remaining deficit is reassessed and, if still indicated, replaced in the subsequent 24 hours in addition to maintenance.
- Suspected hypernatraemia is not managed on either NG pathway: check serum sodium and arrange senior paediatric review. Correction must be slower (typically over 48 hours), follow an individualised plan and include serial electrolyte monitoring.
- If vomiting occurs during NG rehydration, slow the fluids temporarily and reassess tolerance. Seek senior clinician review for ongoing vomiting or significant abdominal pain.

Severe dehydration and escalation to IV fluids

- Shock: give a 20 mL/kg bolus of 0.9% sodium chloride IV (or intraosseous) and contact the senior registrar. Repeat the bolus if signs of shock persist.
- Start IV rehydration for all children with severe dehydration, and for those who cannot tolerate NG fluids or whose dehydration worsens despite them.
- For IV rehydration use 0.9% sodium chloride with 5% glucose, and measure electrolytes and blood glucose when the cannula is inserted.

Text C: Medication notes

Ondansetron

A single oral dose (wafer) may be given to children aged 6 months and over who are vomiting and at risk of failing oral rehydration. It is not recommended under 6 months. Give ORS 15-30 minutes after the dose.

Weight	Single oral dose
8 to < 15 kg	2 mg
15 to 30 kg	4 mg
> 30 kg	8 mg

Further doses should be discussed with a senior clinician, as ondansetron can increase stool frequency. Use with caution in children with a known prolonged QT interval or those taking other QT-prolonging medicines.

Antidiarrhoeal agents

Loperamide and other antimotility drugs must not be used in children with acute gastroenteritis. They have little effect on fluid losses and have been associated with paralytic ileus, drowsiness and respiratory depression in young children.

Zinc

Zinc supplementation is recommended by the WHO for children with diarrhoea in low- and middle-income settings, where zinc deficiency is common. It is not routinely used in Australia.

Text D: Parent information - Gastro in children: going home

Drinks and food

- Give small amounts of fluid often - for example, a mouthful every few minutes - even if your child is still vomiting.
- Keep breastfeeding. If your baby is bottle-fed, make up formula at its usual strength. Do not water it down.
- Oral rehydration solution from the pharmacy is the best drink. Avoid undiluted fruit juice, soft drinks and sports drinks: they contain too much sugar and can make diarrhoea worse.

Stopping the spread

- Wash hands with soap and water for at least 20 seconds after nappy changes and using the toilet, and before preparing food. Alcohol-based hand gels do not kill all gastro viruses.
- Keep your child home from childcare, kindergarten or school until 48 hours after the last episode of vomiting or diarrhoea.
- No swimming pools for 2 weeks after the diarrhoea has stopped.

Come back to hospital straight away if your child:

- is drowsy, floppy or hard to wake
- has fewer than 4 wet nappies in 24 hours, or passes very little urine
- vomits green fluid or has blood in their poo
- has severe tummy pain or cannot keep any fluids down

See your GP if your child has diarrhoea for more than 7 days or vomiting for more than 2 days.

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 names drugs that should never be given to a child with gastroenteritis? _____
2. Which text lists the factors that make a child more likely to become dehydrated? _____
3. Which text states how long a child should stay away from childcare? _____
4. Which text tells you what to do if a child vomits while receiving fluids through a nasogastric tube? _____
5. Which text describes signs that may indicate an abnormal sodium level? _____
6. Which text explains why certain drinks should not be given? _____
7. Which text refers to a treatment recommended only in certain parts of the world? _____

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. How should a child be dressed when weighed on arrival? _____
9. How is skin turgor described in a child with moderate dehydration? _____
10. What type of vomiting suggests the child's illness is not gastroenteritis? _____
11. What hourly volume of ORS should a child with mild dehydration be aiming to take? _____
12. For how long is rapid NG rehydration given? _____
13. Which fluid is given as a bolus to a child in shock? _____
14. What dose of ondansetron should be given to a child weighing 22 kg? _____

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. Ondansetron is not recommended for infants younger than ___ .
16. After a dose of ondansetron, ORS should be given ___ later.
17. Ondansetron should be used with caution if a child has a known ___ .
18. Parents of bottle-fed babies should be told not to water down the ___ .
19. Parents should be warned that ___ do not kill all gastro viruses.
20. Parents should take their child to a GP if vomiting continues for more than ___ .