

Listening sub-test Transcript

(FOR MARKERS' USE ONLY)

Sample Test

Part A: Lewis & sore back

OCCUPATIONAL ENGLISH TEST. LISTENING TEST.

This test has two parts. Part A. In this part of the test, you will hear a general practitioner talking to Lewis, a man with a sore back. You will hear the consultation once only, in sections. As you listen, you must make notes about the consultation under the headings given on the answer paper. Turn over now and look quickly through Part A. You have one minute to do this.

PAUSE: 60 SECONDS

You must give as much relevant information as you can under each of the headings provided. You may write as you listen, and there will be pauses during the consultation for you to complete your notes under the relevant heading, and to read the following heading. There will also be two minutes at the end of the test for you to check your answers. Give your answers in note form. Don't waste time writing full sentences. Remember you will hear the consultation once only, and you should write as you listen.

Now look at Question 1. Question 1 has been done for you.

PAUSE: 10 SECONDS

GP: Hi, hello – I'm Doctor Mary Flynn, and, can you give me your name please?

Lewis: *Hi, I'm Lewis.*

GP: Hi, welcome. Can you tell me why you've come to see me today, Lewis?

Lewis: *Yep, um, I ... hurt my back recently, it's ... bit sore. I hurt it last week as well, and ... hurt it again.*

PAUSE: 10 SECONDS

Now look at question two. Take notes on Lewis's previous back injury.

PAUSE: 10 SECONDS

GP: Right, so this is something that's happened before, as well?

Lewis: *Um, yeah I've hurt my back before. When I was sixteen I hurt it playing cricket.*

GP: Mm hmm

Lewis: *And, yeah – I don't play cricket anymore. I find it too ... painful.*

GP: Right, so how long..ah..how long's that now, that you haven't been playing cricket?

Lewis: *Um, I hurt it when I was 16 and I'm 21 now, so it'd be about 5 years.*

GP: Right, OK.

PAUSE: 20 SECONDS

Now look at question three. Take notes on Lewis's sporting activities and the nature of his work.

PAUSE: 10 SECONDS

GP: And ... do you play any other sports?

Lewis: *Um, I play football during the winter, and I've just recently taken up surfing, so ...*

GP: Right. And you like sports, and you're pretty keen on sport?

Lewis: *Yeah – I play ... play a lot of sports, really.*

GP: So, having a bad back's not too good for that.

Lewis: *No, and I work at a liquor store, so ... I carry a lot of boxes and stuff.*

GP: Right, so you're always lifting and bending and carrying stuff ...

Lewis: *Yeah.*

GP: Right.

PAUSE: 20 SECONDS

Now look at question four. Take notes on the history of the recent incident.

PAUSE: 10 SECONDS

GP: So, tell me exactly what's happened to your back in this last incident.

Lewis: *Um, well ... I was jumping backwards and forwards over a football at training when we were warming up ...*

GP: Mm hmm

Lewis: *... and, I just felt a twinge in my back, and ... it was quite sore – it was just on ... mainly the lower right-hand-side of my back ... and ... very sore, and couldn't keep training with it. And then ... I went to the physio and ... got some massage and stuff and ... she said to take a week off and hopefully it'll get better, and ... it got better and it was fine for a while – for a week or so and then ... I went ... I was in bed and I moved around in an odd position and my back twinged again.*

GP: Mm hmm

Lewis: *And then ... yeah, I went to football training on Monday night and it was a bit sore and I was kicking with my right foot ... and ... my back started twinging a bit more and it's tightened up and now when I lift my right leg, it's quite ... like, I can feel the pain radiating up.*

PAUSE: 20 SECONDS

Now look at question five. You will hear a discussion about the details of Lewis's pain. First, take notes on Lewis's pain from the current injury.

PAUSE: 10 SECONDS

GP: Right, so when you say you're lifting your right leg, is the pain in that same part of the back it was before?

Lewis: *Yeah ... it's in the, in the right-hand lower back.*

GP: Right, and is it moving down into your buttock?

Lewis: *Um, not really – it's staying mainly in the back.*

GP: Right, but it ... it's more obvious when you move your leg.

Lewis: *Yeah, when it's fully extended, I lift my leg up and it's ...*

GP: It's it's really painful.

Lewis: *Yep.*

GP: What about when you're sitting, like you are now, with your knee bent?

Lewis: *Um, no, it's fine now.*

GP: Mm hmm. And in your ... have you been at work?

Lewis: *Yeah, I've been at work and it's fine as long as I lift properly, there's no pain.*

GP: Right, so as long you're very careful when you're lifting. And the time when you twisted round in bed – have you done any of that sort of twisting at work, or you've been very careful?

Lewis: *I've been very careful not to.*

GP: Yeah, right.

PAUSE: 5 SECONDS

Now, take notes on Lewis's pain from the previous injury.

PAUSE: 5 SECONDS

GP: So ... and is this the same sort of pain that you were having when you were ... you know, five, six years ago when you were playing cricket?

Lewis: *Yeah, it was a very similar sort of pain to this.*

GP: Right, and did it ever get into your ... did it ever sort of go down your leg at all?

Lewis: *Not not ... not really. It mainly stayed in the back.*

GP: Right. And if you ... rested ... did it settle down then?

Lewis: *Yeah, it settled down but it was never good if I tried to play cricket 'cos I was a fast bowler, I was twisting a lot.*

GP: So you were, you were always twisting when you were bowling...

Lewis: *Yep*

GP: ... and therefore making it happen again. Lewis: *Yep.*

GP: And ... they didn't need you just being a fielder.

Lewis: *No, I wasn't much good.*

GP: (laugh)

PAUSE: 20 SECONDS

Now look at question six. Take notes on Lewis's treatment.

PAUSE: 10 SECONDS

GP: Um ... and have you taken any medicines or tablets for this?

Lewis: *Um, I had ... took some Nurofen when I first had it ... and ... so if there was any swelling it might go down a bit, but no ... no medicines apart from that. I went to the physio and they put a bit of heat into it, and some ultrasound ... and that was all.*

GP: Right. And so you haven't been taking Panadol regularly or Nurofen regularly, or anything like that?

Lewis: *No, nothing like that.*

PAUSE: 20 SECONDS

Now look at question seven. Take notes on further details of the problem.

PAUSE: 10 SECONDS

GP: OK. And ... if you're just sitting quietly, as you are now, is it painful at all?

Lewis: *No, but I'm sort of aware that it's not quite right. And, when I was sitting on the couch at home, it doesn't have as good a support for the back as this ...*

GP: Yeah.

Lewis: *... it um ... I could feel it.*

GP: Right. So, and what about lying in bed flat?

Lewis: *Lying in bed flat is fine.*

GP: Ok., and standing up straight?

Lewis: *Standing up straight, I'm aware of it ... like, if I try and stand up really straight, but ... not normally, no.*

GP: Right, so ... and walking?

Lewis: *Walking's fine ... ah, I feel like I'm walking with a slightly different gait to normal.*

GP: Right, so you you you ... you're actually aware of it most of the time now.

Lewis: *Yeah.*

GP: Do you ride a bike at all?

Lewis: *No ... no.*

GP: So, you haven't, mmm ... and driving a car?

Lewis: *Um ... it was it was an issue when I first hurt it – driving a car, extending my leg, and bending it and stuff. And even just getting into the car, lifting the leg up.*

GP: Yeah, and now, right at the moment?

Lewis: *Um, it's still uncomfortable getting into a car.*

GP: Yeah. OK.

PAUSE: 20 SECONDS

Now look at question eight. Take notes on the doctor's initial comments.

PAUSE: 10 SECONDS

GP: So it's really quite, it's it's actually changing the way you live at the moment isn't it?

Lewis: *Yeah.*

GP: Yeah so you're really going to have to have your back in good order to to be able to move around and do all the things you need to do. And it's also important to get it better so that you can play sport properly and keep yourself fit.

Lewis: *Yeah.*

GP: Yeah. OK, so I think you, you prob...obviously I need to examine you and see exactly where this problem is, and see what we can do about it. I think you probably need some physiotherapy, some exercises, and some analgesics to be going on with.

PAUSE: 20 SECONDS

Now look at question nine. You will hear a discussion about the results of the examination. First, take notes on the doctor's explanation of the problem.

PAUSE: 10 SECONDS

GP: OK, so ... now, I've just finished examining you, and it it very much looks as if this is a muscular problem. Um, your, um, reflexes are all normal. Um there's no, oh.. evidence of any nerve damage. Um, I didn't ask you specifically, have you had any trouble passing urine at any stage or with your bowels?

Lewis: *No ... no, they've been fine recently.*

GP: Ok, good, 'cos, you know, very occasionally if you've got a really bad ah problem with your back it can get in your, um ah, spinal cord, but, ah, there's no evidence from your ah reflexes so I don't think, or from your sensation, all of that's normal ... so I think what you've got is a nasty muscle sprain. It's obviously tender when I push there.

PAUSE: 5 SECONDS

Now, take notes on the suggested course of action.

PAUSE: 5 SECONDS

TURN OVER

GP: So I think you do need to go and see a physio ... um, to get some massage and some heat treatment to start with, and then get some exercises and build those up gradually, um, so you probably might need to see the physio two or three times a week for a little while to build that up. Um, and I think you probably better give up footy ... at least for a couple of weeks 'til we've got this a bit settled.

Lewis: Yep.

GP: Um ... and then perhaps come back and see me after you've seen the physio ... um ... talk to the physio about when ah, he or she thinks you, you know, need to come back and see me and see how you're going.

PAUSE: 20 SECONDS

Now look at question ten. You will hear a discussion about analgesics. First, take notes on the suggested use of painkillers and the reasons given.

PAUSE: 10 SECONDS

GP: So, Lewis, I I'm ... pretty keen that you actually take some regular medicine, some pain killers um, for a while, ah while your back's sore. Um ... and I'd suggest that you, it's probably sensible to take both Panadol and Nurofen. Um, they work differently, they and they work cooperatively better um together than separately. Um, but you actually need to take them, and you need to take them regularly. So, the Nurofen, you know, two or three times a day, and the Panadol... probably two tablets four times a day ... um, until your back is feeling better, and then you can taper off. But worth doing it for two or three days, because if your back is less painful, you then start walking normally again, which stops you putting abnormal pressures on your back. So the reason for the ... for taking the painkillers is to help you get back into a normal way of walking.

PAUSE: 5 SECONDS

Now, take notes on potential side effects.

PAUSE: 5 SECONDS

GP: Nurofen can cause a bit of an upset tummy, it can work, um, it can upset the lining of your stomach and give you, um, indigestion and can in fact give you gastritis which is actually ah, um, inflammation of the lining of your stomach which is, can be very uncomfortable, um so ... important to take it after you've eaten ... on a full stomach. So, people will normally take it, you know, after breakfast, after lunch, after tea at night?

Lewis: *And, is it worse if I take it for a long period of time, is that more likely to happen?*

GP: Yeah – it's the sort of thing that can, um, build up.

PAUSE: 5 SECONDS

Now, take notes on using painkillers with alcohol.

PAUSE: 5 SECONDS

Lewis: *What about alcohol? I probably shouldn't drink, or?*

GP: Um, look it it's ... neither of them are contraindicated, you know, in terms of drinking ... and it's not as if they'll make you sleepy and therefore adding them in, like say an antihistamine or something to the alcohol makes you more likely to go to sleep or be dangerous driving or using machinery. But, um, I guess because alcohol can also give you a bit of trouble with the lining of your stomach, adding that into Nurofen ... um, at large

TURN OVER

doses of both of them, may not be so clever. So, probably better to, ah, again, drink moderately, um ... rather than large amounts all of a sudden.

Lewis: *Yep, alright. I'll keep that in mind.*

PAUSE: 20 SECONDS

Now look at question eleven. Take notes on Lewis's answers to follow-up questions and the doctor's response.

PAUSE: 10 SECONDS

GP: Is there any other things that you're worried about? Anything that's been a problem?

Lewis: *Um no, that's pretty much it at the moment. I've been in pretty good health apart from that.*

GP: Right, and your weight hasn't changed at all, or ...

Lewis: *No, nothing really like that. I've still been tryin'a keep active.*

GP: Good. And your diet's reasonable?

Lewis: *Um, it's reasonable. It's not ... not flash.*

GP: Right. Um, how about things like drinking alcohol and smoking?

Lewis: *Um, I don't smoke and ... I drink a fair bit ... so, I ... I work at a liquor store and it's easily available.*

GP: Right. And do you tend to binge drink or do you tend to drink sort of reasonably regularly?

Lewis: *More binge drinking than drinking regularly.*

GP: Right. OK. And, again I guess just ... ongoing binge drinking isn't good for the brain in a long term sense, but also ... if you're a bit, um, drunk, you're more likely again to move abnormally and not sort of think about it and not be as aware how you're back is. Ah just something to think about, really.

GP: Okay so probably if you, as you're going out make an appointment to see me in three weeks but obviously if it gets worse or anything else happens come back and see me earlier than that.

Lewis: *Thanks very much Dr Mary.*

GP: Fine, thanks Lewis. Bye.

PAUSE: 30 SECONDS

END OF PART A.

Listening sub-test Transcript

(FOR MARKERS' USE ONLY)

Sample Test

Part B: Cardiac investigations

Occupational English test. Listening test. This test has two parts. Part B. In this part of the test you will hear a talk on cardiac investigations. You will hear the talk once only, in sections. As you listen, you must answer the questions in the spaces provided on the answer paper. Turn over now and look quickly through Part B. You have one minute to do this.

PAUSE: 60 SECONDS

You may write as you listen and there will be pauses during the talk for you to complete your answers and to read the following question. Remember, you will hear the tape once only and you should write as you listen. **Now read Question 1. Question 1 has been done for you.**

PAUSE: 15 SECONDS

My name's Doctor Neil Strathmore ... I'm a cardiologist, and today I'm going to talk about cardiac investigations ... and try and tell you which test is right for which patient.

PAUSE: 10 SECONDS

Now read question two.

PAUSE: 20 SECONDS

Now listen, and answer question two.

Patients who present with heart problems present with a variety of symptoms, such as chest pain, shortness of breath, palpitations, syncope, and oedema. In addition patients come along because a problem has been picked up ... by another doctor, such as high blood pressure, a heart murmur, an abnormal lipid profile, or patients present for assessment of cardiac risk to see whether they're likely to have a heart attack.

PAUSE: 20 SECONDS

Now read question three.

PAUSE: 20 SECONDS

Now listen, and answer question three.

Let's look at the most common cardiac symptom that presents, which is chest pain. Obviously, the first thing to do is to take a careful history of the pain – where it is, and how severe it is, and in particular its relationship to exertion. Often patients don't describe this as a pain but as a pressure. The examination is often not helpful in ah trying to sort out the cause of chest pain, but one should note the blood pressure and see if there're any cardiac murmurs because aortic stenosis can also cause chest pain. It's important to note the risk factors: a technique that's very useful for assessing cardiac risk is to use the, ah, population data from the Framingham study in the United States to assess five- and ten-year cardiovascular risk. It's important to remember that women often have an atypical history of pain.

PAUSE: 20 SECONDS

Now read question four.

PAUSE: 20 SECONDS

Now listen, and answer question four.

So the next step is to do some sort of test to look for the cause of the chest pain, and most of the tests are what are called functional tests which see the effect of stress or exercise on the heart, and see whether that changes something which can give us a diagnosis. The simplest test is an exercise ECG. The patient exercises on a bicycle or a treadmill while an ECG is being recorded. The parameters that are measured are the heart rate and blood pressure, and then changes on the ECG, in particular ST depression. ST depression occurs because ischemia occurs during exercise. This is a relatively simple test and inexpensive. The main problem is that its sensitivity and specificity are probably only of the order of seventy to eighty percent, and seem to be a lot lower in women. Remembering that the test can be inaccurate, means that even a patient who has a very good story of chest pain, that sounds like angina and has multiple risk factors, should still be considered to have angina, even if the exercise test is negative.

PAUSE: 20 SECONDS

Now read question five.

PAUSE: 20 SECONDS

Now listen, and answer question five.

A more accurate test is an exercise echocardiogram. This is a more complex test in that the patient has an echocardiogram looking at the heart, particularly the left ventricular size and function, before they exercise and then immediately after they finish the exercise on the treadmill or the bicycle. It's much more accurate, with sensitivity and specificity above ninety percent, and it gives much more information ... it ... particularly about the heart size and the heart function, about the nature of the heart valves, and the presence of previous myocardial infarction. This is obviously done in addition to the ECG so it gives additional information to the exercise ECG.

PAUSE: 20 SECONDS

Now read question six.

PAUSE: 20 SECONDS

Now listen, and answer question six.

Another test that's very accurate and is widely done is an exercise nuclear scan. Here the patient is, as in the previous tests, exercised in the same way as in the previous tests, but is given a radioactive tracer. The tracers that are commonly used are thallium, or a more recent tracer called sestamibi, which is bound to radioactive technetium. These tracers go to the heart muscle in proportion to the degree of blood flow. So the test, so usually the patient is stressed, and then at the height of stress is given an injection of the tracer. The patient is then placed under a gamma camera, and images are taken. These days, the images can be done in the same form as a CT scan, so slices of the heart in all three dimensions can be obtained. In a patient who has ischemia, there'll be less blood flow in that area and therefore less tracer, and this will show up on the gamma camera picture. In a patient who's had a myocardial infarction, however, there's obviously no blood flow to that area and so that area will remain without tracer.

PAUSE: 20 SECONDS

Now read question seven.

PAUSE: 20 SECONDS

Now listen, and answer question seven.

The other problems that patients present with, such as shortness of breath or palpitations, or a heart murmur, are best looked at by doing an echocardiogram. An echocardiogram is an ultrasound of the heart and is done using a, often using Doppler ... technology, and this gives the ... a ah, very good idea of cardiac structure and function ... in fact it's the best test for structure and function. A particular use of echocardiography is in patients who present with shortness of breath. The question is, is the shortness of breath due to heart failure? Well, the echo is really the best test. You should look for reduced left ventricular function, or left ventricular hypertrophy, but other..other things can cause shortness of breath that can be seen on an echo, such as pulmonary hypertension, valve disease, or congenital defects. Echocardiography is the definitive test for diagnosing heart murmurs. These days, we would not rely just on the stethoscope to diagnose a heart murmur, and we would definitely want to use an echo to measure the severity of any valve lesion, rather than just on clinical parameters, which are not as reliable. In hypertension, the echo is helpful because it can measure left ventricular hypertrophy. For arrhythmias, particularly atrial fibrillation, the echo can look for associated cardiac defects. A particular, ah, issue is the question of whether a patient has endocarditis. The patient who presents with a fever plus a heart murmur, or with a fever of unknown origin, may well have endocarditis – an infection on the heart valves – and an echocardiogram can be very helpful to look at the valves and to see whether there are any vegetations.

PAUSE: 20 SECONDS

Now read question eight.

PAUSE: 20 SECONDS

Now listen, and answer question eight.

Patients who have, ah, palpitations, arrhythmias, or blackouts ... also need to be assessed very carefully. It's often hard to pick ah, the time when a patient will have these symptoms. Twenty-four hour ambulatory ECG monitoring, or Halter monitoring is used. Halter was the doctor who invented the technology. The patient wears an ECG monitor connected to a tape recorder or electronic disc, which measures their heart rhythm over a twenty-four hour period. The patient can press a button if they have a symptom, and that will be recorded on the tape. At the end of the, ah, twenty-four hours the patient hands back the device and that's scanned with a computer looking for abnormal rhythms, and also looking for the times when at when the patient pressed the button. This gives an excellent correlation between symptoms and rhythm. Sometimes patients have a symptom, but their rhythm is normal. Sometimes they have an abnormal rhythm, but no symptoms. However, because these symptoms are intermittent, it's sometimes hard to pick them up just on twenty-four hours. An event monitor is something the patient can wear for a week or two weeks. It's a much smaller device and has a usually only two electrodes that the patient can change each day after they've had a shower. The patient presses the button when, on the monitor, when they have an event, when they have a symptom ... and that stores the ah rhythm immediately before and immediately after the event. So, the device isn't recording the whole rhythm for seven days, just for the few minutes around each event. The ultimate way of testing for these sort of of very rare events, is to implant a loop recorder. This is a small device that is implanted under the skin on the chest that can measure the heart ah ECG and can record either when the patient places a a device over this to trigger it, or if the recorder automatically picks up an arrhythmia. For patients with very ah rare rhythms, this is a ... a device which can be very, very helpful.

PAUSE: 20 SECONDS

Now read question nine.

PAUSE: 20 SECONDS

Now listen, and answer question nine.

Some other tests that are being looked at include CT scanning to look at the coronary arteries. This this sort of test is now being done in a number of centres and can give very accurate pictures of the coronary arteries. However, it hasn't quite reached the degree of experience that the other tests have, and so we're not using it as frequently, and in addition it exposes the patient to quite a high radiation dose from the CT scan. MRI scanning is very useful for cardiac structure and also for cardiac function. Ah, it may be useful for the coronary arteries in the future, but isn't quite at that stage yet. Some patients find the MRI scan quite difficult to take because of claustrophobia.

PAUSE: 20 SECONDS

Now read question ten.

PAUSE: 20 SECONDS

Now listen, and answer question ten.

A number of other tests are being trialled ... and, and looked at, trying to get an idea particularly of the coronary arteries, ah, and to try and predict which patients will have a..have a myocardial infarct. At the moment we can't see small plaques in the coronary arteries, and that really is the gold standard in the future, if we were able to predict which patients would have a heart attack. Thank you for your attention.

PAUSE: 20 SECONDS

That is the end of Part B. You now have 2 minutes to check your answers.

PAUSE: 120 SECONDS

That is the end of the listening test.