

# Listening sub-test Transcript

(FOR MARKERS' USE ONLY)

Sample Test

## **Part A: Kellie and the Physiotherapist**

## OCCUPATIONAL ENGLISH TEST. LISTENING TEST.

This test has two parts. Part A. In this part of the test, you will hear a physiotherapist talking to Kellie, a woman who has lower back pain. 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. Do not waste time writing full sentences. Remember you will hear the consultation once only, and you should write as you listen.

**Now look at question one. Question one has been done for you.**

### PAUSE: 10 SECONDS

Physiotherapist: Alright. Hi there, Kellie. My name is Erica, and I am one of the physiotherapists here.

Kellie: Hi Erica.

Physiotherapist: How could I help you today?

Kellie: Um, I've been getting a pain in my lower back, on the left side, um, around my hip and through the bum cheek area ... um, when I'm running especially.

### PAUSE: 10 SECONDS

**Now look at question two. Take notes on the details of Kellie's symptoms.**

### PAUSE: 10 SECONDS

Physiotherapist: Mmm. OK, that's not sounding terribly comfortable at all. Um, how long has this been going on for?

Kellie: It's something I've had on and off for years. And ... it started off as just a ... a kind of dull pain. Um, a bit of an ache, and now it's ... it really feels like it's spasming or something – it hurts even when I put weight on my left leg. Um, usually I feel it start and if I kind of lie on a tennis ball and massage through the muscle, it goes away. But ... lately it's just been getting worse, and I can feel it's sort of tight through my whole hip area.

### PAUSE: 20 SECONDS

**Now look at question three. Take notes on further details of Kellie's symptoms.**

### PAUSE: 10 SECONDS

Kellie: Um, and I can feel it kind of even when I'm sitting and and sleeping ... or at at night when I'm trying to sleep, if I roll I can feel a kind of ... it's hard to explain, it's like a ... shooting pain that travels down my leg ...

Physiotherapist: OK, so you've described the pain initially as a dull pain...

Kellie: Yeah.

Physiotherapist: ... and also an aching sort of a sensation ...

Kellie: Yep.

Physiotherapist: Is the shooting pain different to that?

Kellie: Yep.

Physiotherapist: Okay, so the shooting pain ... where does that go?

Kellie: *It's ... it starts in the same place, and it goes like down the back of my leg, kinda through the back of my knee, and sometimes down to my ankle area.*

Physiotherapist: Okay, no worries at all. And that would be the shooting pain only? That's not an aching sensation?

Kellie: *No, it's just like ... it feels like a twinge travelling down.*

**PAUSE: 20 SECONDS**

**Now look at question four. Take notes on Kellie's responses to the physiotherapist's questions.**

**PAUSE: 10 SECONDS**

Physiotherapist: Alright, so just coming back to our body chart for a second. So we've talked about two distinct pains I think. There's that dull aching pain sort of around the bum and the lower back and the hip area there. Then there's that shooting pain, or twinging pain that you get that goes right down the back of the left leg down to the calf.

Kellie: Yep.

Physiotherapist: *With the twinging pain, do you have to have the dull pain in your bum ... before you get the twinging pain?*

Kellie: Yep.

Physiotherapist: You have to have that pain first, okay.

Kellie: Yep.

Physiotherapist: Can you ever get the twinging pain by itself?

Kellie: No.

Physiotherapist: No, okay. Can you get the dull pain by itself?

Kellie: Yeah.

Physiotherapist: Yes, okay. So you have to have one to get two.

Kellie: *Yeah, I don't always get the twinging pain. That's usually when it's feeling worse. It gets really tight.*

Physiotherapist: Okay, no worries at all. Um, now ... just to confirm and clear some other areas ... there's no current problems with your left knee?

*Kellie: Nope.*

Physiotherapist: Beautiful. And currently the front of the left hip is fine?

*Kellie: Yeah – feels quite tight through there, but it's not painful.*

Physiotherapist: Mmhmm ... so, tightness.

*Kellie: Yep.*

Physiotherapist: No worries at all. Any pains in the right hip?

*Kellie: Nope.*

Physiotherapist: No. The right knee?

*Kellie: No – the right side's fine.*

Physiotherapist: Completely fine – no pains at all down there.

*Kellie: Yeah ... no.*

Physiotherapist: Any pins and needles or numbness anywhere?

*Kellie: Mm, nope.*

Physiotherapist: No, good.

### **PAUSE 20 SECONDS**

**Now look at question five. Take notes on the effects of exercise.**

### **PAUSE 10 SECONDS**

Physiotherapist: I see, so would you describe it more like a tightening sensation if you sit for too long ...

*Kellie: Yeah ... yep.*

Physiotherapist: ... but then it's actually the exercise that aggravates it.

*Kellie: Yep.*

Physiotherapist: Okay. Are there particular exercises that do it? You said running before.

*Kellie: Yeah, running and walking. I think walking's even worse, actually.*

Physiotherapist: Mm ... interesting. How long can you walk for before the pain starts?

*Kellie: Um ... I don't know. I kind of don't notice it when I'm walking, it's when I'm when I stop and then start again, like ... yeah. So, I guess if I walked for ... walked every day to work, for example, which is about forty-five minutes each way, and then if I run a couple of times ... and then I'll notice the pain when I'm walking towards the end of the week, and it gets worse with each step as I walk into work.*

Physiotherapist: I see – so it's sort of a cumulative effect, if you will ...

*Kellie: Yeah.*

Physiotherapist: ... so after a whole week's worth of exercise and physical activity,

*Kellie: Yeah.*

Physiotherapist: ... that's when you notice it start to come forward.

*Kellie: Yeah.*

Physiotherapist: Okay. So by the end of the week you're feeling pretty rubbish.

*Kellie: Yeah.*

Physiotherapist: Okay.

**PAUSE: 20 SECONDS**

**Now look at question six. Take notes on Kellie's physical activity.**

**PAUSE: 10 SECONDS**

Physiotherapist: Tell me a little bit about what you are doing for sport and physical activity at the moment.

*Kellie: Um, I ride my bike probably four or five times a week – not very far, maybe just fifteen minutes each time.*

Physiotherapist: Okay, is that sort of more commuting?

*Kellie: Mm hmm*

Physiotherapist: Yep, okay.

*Kellie: And I run probably forty k's a week.*

Physiotherapist: Okay. And what sort of surfaces are you running on?

*Kellie: I run around Princess Park, so it's that kind of hard gravel surface ... ah, maybe once. I run in the gym a couple of times and I have a track which is paved, like a cycle path...*

Physiotherapist: Okay, yep.

*Kellie: ...the other time.*

Physiotherapist: Okay, no worries. And how do you break up that forty k's in the week? Is it two long runs or do you run five days a week?

*Kellie: I usually do two twelve k runs and two eight k runs.*

Physiotherapist: Okay. Are you training for something in particular?

*Kellie: Nup.*

Physiotherapist: Okay. So just for your own fitness kind of a thing.

**TURN OVER**

*Kellie: Yeah, yeah.*

Physiotherapist: Sweet. Now .... Alright. So, other than the riding, which you do to commute, and these long runs that you're doing, do you do any other forms of physical activity at all?

*Kellie: Um, well normally, but I haven't been lately because I've been really busy at work, but in my general routine, I usually swim a couple of times a week as well.*

Physiotherapist: Gosh, you're very active.

*Kellie: Yep.*

Physiotherapist: How far would you swim on a routine basis?

*Kellie: Um, I'd probably do one k per swim.*

Physiotherapist: Yep, okay, cool.

**PAUSE: 20 SECONDS**

**Now look at question seven. Take notes on the onset of the condition and Kellie's medical history.**

**PAUSE: 10 SECONDS**

Physiotherapist: Okay. And you said that you've had this for a few years. What initially brought it on?

*Kellie: Um ... I don't know. I think, when I was younger I used to play soccer and I had an injury where I dislocated my hip, and ... it was really painful, yeah – I couldn't move for like a few weeks and I had a lot of physio and I had a lot of lower back pain after that for maybe a couple of years.*

Physiotherapist: Not surprised.

*Kellie: Yeah.*

Physiotherapist: Good grief.

*Kellie: Yeah, but then it went away, and I haven't really had any major problems since then.*

Physiotherapist: Okay, so coming back again ... back to the start. So, you said before that you dislocated your hip. How ... how old were you when that happened?

*Kellie: Um ... I was 21 ... 21 or 22.*

Physiotherapist: Okay. Any other major medical problems that I should be aware of?

*Kellie: No – I think everything else is fine.*

Physiotherapist: No worries at all. Um, and ... other than this dislocated hip on the same side, have you had any other major problems with your left leg, or with your back, or your hip or anything before?

*Kellie: Oh, no – nothing really.*

Physiotherapist: Okay ... so no other recurring injuries as a result of sport?

Kellie: Nope.

Physiotherapist: Okay.

**PAUSE: 20 SECONDS**

**Now look at question eight. Take notes on Kellie's previous hip treatment.**

**PAUSE: 10 SECONDS**

Physiotherapist: How ... I know that this has been going on for quite a number of years, but, how long has this been a problem where you've sort of felt you need to do something about it? Has it been a matter of weeks, months?

Kellie: *Um, I've been to an osteo a couple of times about it in the past ... um ... just when it gets to this acute stage. So, this time it's only been like a few days that it's been really painful.*

Physiotherapist: Mm hmm, Okay, no worries. And what sorts of things did the osteo do for you in the past?

Kellie: *Um, it was mostly putting pressure through that area, like massage and then ... think she used to just like poke her elbow into my left hip and hold weight there for ages until the spasming stopped.*

Physiotherapist: Okay, no worries. How did you find the effectiveness, ah, how did you find the effectiveness of that? Did it sort of relieve it for you or did it come back fairly quickly after the treatment?

Kellie: *Um, it relieved it. So, basically what normally happens is it's still quite sore for a couple of days after I have treatment, but it doesn't feel so tight. And I usually have to rest off it, um yeah, for at least a few days ... and then it's gone.*

Physiotherapist: Okay, fantastic.

Kellie: *Or maybe it's still there a little bit but it's not like ... doesn't get aggravated, and then it just drifts away.*

Physiotherapist: Yep, sure.

**PAUSE: 20 SECONDS**

**Now look at question nine. Take notes on the details of Kellie's exercises and pain management.**

**PAUSE: 10 SECONDS**

Physiotherapist: Has your osteo given you any exercises in the past for this problem?

Kellie: *Um, I do like a stretch where I kneel down and stretch through my front like hip flex area...*

Physiotherapist: Mm hmm

Kellie: *...and another one where I cross my leg, ... um ... kind of on an angle like that, across my knee, and stretch through there and I can feel that through my bum cheeks.*

Physiotherapist: Oh, good – yep. And you find those two stretches are particularly useful for you.

Kellie: Yep.

Physiotherapist: Have you found anything else that helps the pain go away?

Kellie: *Um ... not really. I mean, if it feels really bad I can take maybe a Nurofen or something and it makes it better ... feel a bit better, but ... no other sort of exercise or stretching.*

Physiotherapist: No worries – have you ever tried any heat or ice, or anything like that?

Kellie: *No, I haven't actually.*

Physiotherapist: Okay, no worries.

### **PAUSE 20 SECONDS**

**Now look at question ten. Take notes on changes to Kellie's footwear and exercise routine.**

### **PAUSE 10 SECONDS**

Physiotherapist: So, with regards to your running, has anything changed in the last few weeks that might've sort of predisposed you to this getting worse? So, what I'm getting at is, have you changed the intensity of your training? Have you changed your footwear, perhaps?

Kellie: *Actually, yeah – I got a new pair of runners, but they're the same as my old runners ... but, yeah, they're a bit more stiff, I guess. Maybe that's made a bit of difference. And, um, yeah, the circuit that I'm doing along the cycle track ... that's new. And there's a couple of hills. I don't know if that would make it any worse.*

Physiotherapist: It certainly would. So this would all be ... you've changed your shoes and changed your routine in the last two weeks?

Kellie: *Yeah.*

Physiotherapist: Okay. Cool. There's definitely some predisposing factors there, I think.

### **PAUSE: 20 SECONDS**

**Now look at question eleven. Take notes on the physiotherapist's comments on the problem.**

### **PAUSE: 10 SECONDS**

Physiotherapist: Well what we might do is I think we probably need to start having a look at some things here, I think. Um, my gut instinct at this point is that it's sounding very much like a tight gluteal that you're probably having some difficulty releasing, and it's probably due to a couple of factors, the first one being your change in your running routine.

Kellie: *Yep.*

Physiotherapist: Will probably have a lot to do with that. Um, 'specially if you're running more hills and with a bit of intensity to it as well. Um, and secondly, probably due to the change in footwear.

*Kellie:* Okay.

Physiotherapist: Because if the shoes are quite a bit more ... haha ... if they're a new pair of shoes, it sounds like your other ones were quite sloppy and floppy...

*Kellie:* Yeah, that's true.

Physiotherapist: And um, yeah ... so that sudden change in biomechanics by putting on a really good pair of footwear will certainly be a bit of a shock to the system, and it might just cause a bit of a chain reaction up the leg and a bit of tightening as a result of that, simply because the leg is being restricted a bit more in how it's able to move.

*Kellie:* Okay.

Physiotherapist: 'Cos you can imagine that a good new pair of shoes is going to hold your foot in a much more stable position compared to a really old sloppy pair of shoes ...

*Kellie:* Yeah.

Physiotherapist: ... okay? Um ... so there's definitely a couple of trigger factors there that might lead me to think that this is what's caused this problem.

**PAUSE: 20 SECONDS**

**Now look at question twelve. Take notes on the physiotherapist's immediate plans.**

**PAUSE: 10 SECONDS**

Physiotherapist: Um, so probably what I'd like to do today is we'll probably start by having a bit of a look at your posture, then we'll have a look at you walking, maybe have a bit of a jog, okay, see what's going on down there. Um, and then probably what I'd like to do is have a bit of a feel through the area to see if we can find any specific tightnesses, okay?

*Kellie:* Okay.

Physiotherapist: And we might go through a few muscle length tests to see whether or not we can find anything specifically like a muscle that's shortened up, in response to what's going on here, and certainly if you're feeling tight through the front of your hip, you know, that might indicate that something's a bit shorter than the other side.

*Kellie:* Okay.

Physiotherapist: Um, we'll do a few strength tests as well, just to make sure that there's nothing lacking there that's also predisposing you to this problem. Um, and then we'll get on to some exercises.

*Kellie:* Great, OK.

Physiotherapist: Beautiful – alright. So let's get going with that.

**PAUSE: 30 SECONDS**

**That is the end of Part A.**

**PAUSE: 30 SECONDS**

# Listening sub-test Transcript

(FOR MARKERS' USE ONLY)

Sample Test

## **Part B: Congenital heart disease in newborns**

## **OCCUPATIONAL ENGLISH TEST. LISTENING TEST.**

This test has two parts. Part B. In this part of the test, you will hear a talk on congenital heart disease in newborns. 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 talk once only, and you should write as you listen.

**Now read question one. Question one has been done for you.**

### **PAUSE: 15 SECONDS**

*Good morning everyone. My name is Rose Boland, and I am an educator with the Newborn Emergency Transport Service here in Victoria. And today I'm going to be giving you a broad overview about the incidence of congenital heart disease in Australian newborns.*

### **PAUSE: 10 SECONDS**

**Now read question two.**

### **PAUSE: 20 SECONDS**

**Now listen, and answer question two.**

*So, the objectives of this talk are to, firstly, review the risk factors for, and the incidents of, congenital heart disease. Secondly, we do need to go back and review foetal circulation in order to understand why babies present with congenital heart disease when they do. Then we're going to go on to look at ah describing the clinical presentation of the neonate who has suspected congenital heart disease.*

### **PAUSE: 20 SECONDS**

**Now read question three.**

### **PAUSE: 20 SECONDS**

**Now listen, and answer question three.**

So when we go to look ah for risk factors for congenital heart disease, when a woman presents for her first antenatal visit, these are some of the questions ah that we would ask her. Certainly we know that if the mother has congenital heart disease, then her children are more likely to have congenital heart disease. We know that the older a mother gets, that this places her at risk of having a baby who has congenital heart disease, but having said that, we also see a number of younger mothers, um, around the sixteen and seventeen year old age group, who also have babies, um, with congenital heart disease. We know that if you have a previous sibling who has congenital heart disease, then you are four times more likely to have a baby with congenital heart disease in a subsequent pregnancy, as long as that pregnancy is with the same partner. So, ah, again – four times the risk. We know that if mum has diabetes early in pregnancy, and particularly um uncontrolled diabetes very early on in pregnancy, that this places the baby at risk of having congenital heart disease. In pregnancy, we screen women for rubella, for cytomegalovirus, for herpes simplex virus, and for coxsackie B virus, because we know that these viral infections are all associated with congenital heart disease in the babies. We also know that certain drugs that are used or abused by the mother during the pregnancy can result in a baby who is at much greater risk for having congenital heart disease, and the drugs that we look for particularly are high use of alcohol, amphetamines, um but also women who are on some of the older generations of anticonvulsants and on lithium. Um, these women have babies, ah, have a much higher incidence of babies with congenital heart disease.

**PAUSE: 20 SECONDS**

**Now read question four.**

**PAUSE: 20 SECONDS**

**Now listen, and answer question four.**

So, you would think that, um, we probably diagnose congenital heart disease quite well antenatally, and we certainly know that for instance in Queensland, in the most recent statistics, ah, that 99.7% of pregnant women have an obstetric ultrasound. If we compare this to Victoria, we know that in Victoria around 95% of women have an antenatal ultrasound at eighteen weeks, and this is considered the gold standard ah for, um... diagnosing problems with the with the foetus, and certainly the um gold standard of time to perform an ultrasound. What might come as a surprise to people is that despite, ah, our excellent techniques in ultrasonography, that in fact only around 53% of quite significant congenital heart disease is detected.

**PAUSE: 20 SECONDS**

**Now read question five.**

**PAUSE: 20 SECONDS**

**Now listen, and answer question five.**

And to put this into um perspective for you, if we look at the number of babies that the Newborn Emergency Transport Service tra, ah, retrieve every year with congenital heart disease, we know that around 20% of the babies that we retrieve will be born in a level one hospital. Ah, so what do we mean by a level one hospital? A level one hospital is a hospital that's usually in a rural or country area, that is a GP practice, does not have a paediatrician in town, has very limited diagnostic facilities, so may or may not be able to do... ah, a blood gas, ah usually cannot do a cardiac echo postnatally, um and therefore, ah and these places the staff have very limited facilities to deal with a baby who's born who can be really quite ill.

**PAUSE: 20 SECONDS**

**Now read question six.**

**PAUSE: 20 SECONDS**

**Now listen, and answer question six.**

*Around a quarter of the babies that NETS retrieve will be born in a level two hospital. And by level two we mean a hospital that is either public or private, does have a paediatrician who is on call for that hospital and can come in twenty-four hours a day, but these hospitals again are unable to maintain a baby who needs full life support, or who needs intubation and ventilation. So these babies have to be retrieved. So we see that on average, around 45% of babies who are born with very significant congenital heart disease are born outside of a tertiary centre and therefore will require retrieval by the Newborn Emergency Transport Service.*

**PAUSE: 20 SECONDS**

**Now read question seven.**

**PAUSE: 20 SECONDS**

**Now listen, and answer question seven**

*One of the questions we get asked quite often is that why don't these problems present in-utero? Why is it that the baby grows quite normally, ah, is a good size, the mother gets to term, goes into spontaneous pre-term labour, and it's only after the baby's born that we start to see problems. We certainly know that this is because of foetal circulation. So, during foetal life, the placenta is doing the work of oxygenation, and carbon dioxide removal, and the baby really contributes very, very little to its day to day survival. Ah, in foetal life, we have um three ducts which are open – the ductus arteriosus, the foramen ovale, and the the um ductus venosus – and these allow mixing of foetal blood. So we know that in fact very, very little blood flow goes out to the foetal lungs... probably only about 8% because the placenta is oxygenating the blood and therefore the lungs are not acting as an organ of oxygenation. Now, of course, when the baby's born, the baby has to undergo very dramatic physiological and biochemical changes to shift from foetal circulation to an adult type of circulation, and therefore if the baby has congenital heart disease, this is the time period that we're going to suddenly see it. So... when the baby makes the transfer from foetal to postnatal circulation, a couple of things happen. Basically, as the baby takes its first few breaths, and the cord is clamped, there is a sudden ah increase in pulmonary blood flow, and therefore pulmonary-vascular resistance decreases dramatically. At the same time, because the cord has been clamped, there is a huge rise in systemic vascular resistance, and this, in combination with the rise in left atrial pressure, leads to closure of the ductus arteriosus and the foramen ovale.*

**PAUSE: 20 SECONDS**

**Now read question eight.**

**PAUSE: 20 SECONDS**

**Now listen, and answer question eight.**

*Now, contrary to what people have traditionally thought, the ductus arteriosus ah does not necessarily close with the first breaths of life. And in fact we know from ultrasound studies that only about twenty per cent of babies' ducts are closed by twenty-four hours of age... around eighty-two per cent by forty-eight hours, and in some babies ah it takes up to three days for the ductus arteriosus to close completely. And this becomes important when we are thinking about the baby who has congenital heart disease, because ah the timing of the closure of the duct can affect the timing of presentation of the baby to us. So we would expect that by three days of age, that most babies' ducts will close. Anatomically, closure doesn't occur until several weeks' of age, ah, and that is a process by endothelial and fibrous tissue proliferation.*

**PAUSE: 20 SECONDS**

**Now read question nine.**

**PAUSE: 20 SECONDS**

**Now listen, and answer question nine.**

*So, what happens if the baby has congenital heart disease? How're we going to know it, and when are we going to see these babies present with it? Well, basically, it all depends upon what the defect affects. So, if the defect obstructs normal circulation, then we're going to see symptoms very, very early in the newborn period – basically in the period between the time the baby's born and the time that the ductus arteriosus closes. So conditions like transposition of the great arteries will present very, very early within the first few hours of the baby being born. As opposed to some of the other conditions which appear as anatomical changes occur such as the duct closing um after three days of age, so this would be um conditions such as coarctation of the aorta. And this can typically present around day seven or day um up to day ten of life, and typically after the baby has in fact gone home. So this might be picked up by the parents who notice that the baby is mottled, is um feeding poorly, seems cool to touch peripherally, um, is very, very tired and lethargic between feeds, and seems to be breathing up... ah, quite markedly.*

**PAUSE: 20 SECONDS**

**Now read question ten.**

**PAUSE: 20 SECONDS**

**Now listen, and answer question ten.**

*When we talk about structural congenital heart disease, ah we used to divide them into two groups we used to talk about acyanotic congenital heart disease, and cyanotic congenital heart disease. But this... really is quite a confusing and conflicting term, because some conditions can be described as both. And so more recently when we classify congenital heart disease, we now use three physiological headings. We talk about congenital heart disease with decreased pulmonary blood flow, congenital heart disease with increased pulmonary blood flow, and congenital heart disease with obstruction to systemic blood flow.*

**PAUSE: 20 SECONDS**

**Now read question eleven.**

**PAUSE: 20 SECONDS**

**Now listen, and answer question eleven.**

*So, how're we going to make a definitive diagnosis of congenital heart disease, and especially out in a small hospital or a GP's surgery where they may not have... um, gold standard tools. We certainly know that the gold standard for diagnosing congenital heart disease is echo by a paediatric cardiologist after birth, but these facilities are really only available at the major tertiary teaching hospitals such as the Royal Children's. And so until a cardiac echo can be performed, we really have to rely on our clinical signs to try and differentiate congenital heart disease from some of the other causes of cyanosis and collapse in the newborn period... and this can be really quite challenging. The reason for that is that there are a number of conditions in which a baby can appear cyanosed, and, ah, they are not all to do with congenital heart disease. We know that around three to four per cent of babies ah will be cyanosed in the in the period of time after of birth and this can be due to a number of causes including sepsis, such as group B streptococcus, ah primary pulmonary disease where the baby has primary surfactant deficiency or meconium aspiration syndrome... a baby who has a metabolic disorder, a baby who has persistent pulmonary hypertension of the newborn, or a baby with congenital heart disease. So the take-home message here is being cyanosed in the newborn period does not equate to having congenital heart disease necessarily.*

**PAUSE: 20 SECONDS**

**Now read question twelve.**

**PAUSE: 20 SECONDS**

**Now listen, and answer question twelve.**

*So, a just a couple of concluding thoughts on congenital heart disease to wrap up this session. We, in Australia, see congenital heart disease in around eight out of every 1,000 live births, so it is a very significant birth defect. Some congenital heart disease is certainly on the increase, particularly hypoplastic left heart syndrome, and this is a very, very complex congenital heart disease that involves multiple surgeries over multiple years and um... these children ah at this stage really don't ah live beyond their late teenage years despite the many surgeries that they have. We know that more than 50% of babies who have congenital heart disease will not have their condition diagnosed antenatally, and will therefore be born in hospitals ah with resources that are less than desirable ah to comp ah to care for a very sick baby ah in the early days. And we know that survival is largely dependent on early recognition, so it's extremely important for staff working in hospitals and for GPs to be quite cognisant of the early signs of a baby who potentially might have congenital heart disease, and refer these babies very early to a paediatric cardiologist for an echo.*

**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.**