OET
OCCUPATIONAL ENGLISH TEST

RSAMPLE5

READING SUB-TEST – TEXT BOOKLET: PART A

CANDIDATE NUMBER:
LAST NAME:
FIRST NAME:
MIDDLE NAMES:
PROFESSION:
VENUE:
TEST DATE:

Candidate details and photo will be printed here.

Passport Photo

CANDIDATE DECLARATION
By signing this, you agree not to disclose or use in any way (other than to take the test) or assist any other person to disclose or use any OET test or sub-test content. If you cheat or assist in any cheating, use any unfair practice, break any of the rules or regulations, or ignore any advice or information, you may be disqualified and your results may not be issued at the sole discretion of CBLA. CBLA also reserves its right to take further disciplinary action against you and to pursue any other remedies permitted by law. If a candidate is suspected of and investigated for malpractice, their personal details and details of the investigation may be passed to a third party where required.

CANDIDATE SIGNATURE: ______________________

INSTRUCTIONS TO CANDIDATES

You must **NOT** remove OET material from the test room.

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Cellulitis: Texts

Text A

Cellulitis: definition and aetiology

Cellulitis is an acute bacterial infection of the dermis and subcutaneous tissue which presents with an acute onset of red, painful, hot, swollen, and tender skin, sometimes with blister formation. Fever and nausea may accompany or precede skin changes.

By far the commonest organisms that cause cellulitis are *Streptococcus pyogenes* and *Staphylococcus aureus*. Other, less common organisms include *Aeromonas hydrophila* (caused by exposure to fresh water), *Pasteurella multocida* and anaerobes (caused by mammalian bites), *Vibrio vulnificus* (caused by exposure to salt water), and *Pseudomonas aeruginosa* (caused by use of hot tubs).

The leg is the most commonly affected site, with unilateral presentation the norm. Bilateral leg cellulitis can occur but is extremely rare. Infection arises from an identifiable break in the skin from trauma.

Recurrent cellulitis is more common in people who have chronic lymphoedema, especially in those with a history of venectomy for coronary artery bypass grafting, mastectomy, or pelvic surgery.

Text B

Severity of cellulitis

The Eron Classification system can help to guide admission and treatment decisions:

Class I	There are no signs of systemic toxicity, and the person has no uncontrolled co-morbidities.
Class II	The person is either systemically unwell or systemically well but with a co-morbidity, e.g., peripheral arterial disease, chronic venous insufficiency, or morbid obesity, which may complicate or delay resolution of infection.
Class III	The person has significant systemic upset such as acute confusion, tachycardia or hypotension, or a limb-threatening infection due to vascular compromise.
Class IV	The person has a severe life-threatening infection such as necrotizing fasciitis.

In suspected cases of cellulitis, immediately hospitalise anyone with Class III or IV. In addition, anyone who is immunocompromised, has facial cellulitis, is very young (under 12 months) or elderly and frail, or whose cellulitis is rapidly deteriorating must be hospitalised.

Note that many other common conditions, including deep vein thrombosis (DVT), share the same symptoms (unilateral redness and/or swelling) as cellulitis. The same is also true for rare, serious conditions, such as metastatic cancer.

Text C

Suitable drug therapy for typical cellulitis		
	First line	**Second line**
Class 1	Flucloxacillin 500 mg 4x/day PO	Penicillin allergy: Clarithromycin 300 mg 2x/day PO
Class 2	Flucloxacillin 1 g 4x/day IV **or** * Ceftriaxone 1 g 1x/day IV (OPAT only) **(Must not be used in penicillin anaphylaxis)**	Penicillin allergy: Clarithromycin 500 mg 2x/day IV **or** Clindamycin 600 mg 4x/day IV
Class 3	Flucloxacillin 1 g 4x/day IV	Penicillin allergy: Clarithromycin 500 mg 2x/day IV **or** Clindamycin 600 mg 4x/day IV
Class 4	Benzylpenicillin 2.4 g 2-4 hourly IV + Ciprofloxacin 400 mg 2x/day IV + Clindamycin 600 mg–1.2 g 4x/day (If allergic to penicillin use Ciprofloxacin and Clindamycin only) **NB: Discuss with local Medical Microbiology Service**	
Suitable drug therapy for atypical cellulitis		
Risk Factor	**First line**	**Penicillin allergy**
Human bite	Co-amoxiclav 625 mg 3x/day PO	Clarithromycin 500 mg 2x/day PO **or** Doxycycline 100 mg 2x/day PO **and** Metronidazole 400 mg 3x/day PO
Cat/dog bite	Co-amoxiclav 625 mg 3x/day PO	Doxycycline 100 mg 2x/day PO **and** Metronidazole 400 mg 3x/day PO
Exposure to fresh water at site of skin break	Ciprofloxacin 750 mg 2x/day PO **and** Flucloxacillin 500 mg 4x/day PO	Ciprofloxacin 750 mg 2x/day PO **and** Clarithromycin 500 mg 2x/day PO

Text D

Management of the locally affected area

- Prescribe analgesia to ensure pain relief. Review the appropriateness of anti-inflammatory drugs, and if initiating an anti-inflammatory is obligatory, use ibuprofen (1200 mg per day or less) or naproxen (1000 mg per day or less).
- Take account of drug interactions; for example, co-prescribing anti-inflammatories with ACE inhibitors or angiotensin receptor blockers may pose particular risks to renal function.
- Avoid the use of topical antibiotics as these are unsuitable for the management of any class of cellulitis.
- Monitor temperature and consider hydration.
- Elevate the affected limb and use a bed cradle to avoid irritation or increased pain caused by contact with sheets.
- Conduct pro-active management of blistering, including aseptic aspiration, but if in doubt, seek specialist advice.
- There may be diffuse redness or a well-demarcated edge that can be marked with a pen in order to monitor progress.
- Once the critical stage of swelling and redness has subsided, assess the patient for compression bandaging.

END OF PART A
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