

Oral Case Presentation

Guidelines for 3rd year Medicine Clerkship

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I. Principles

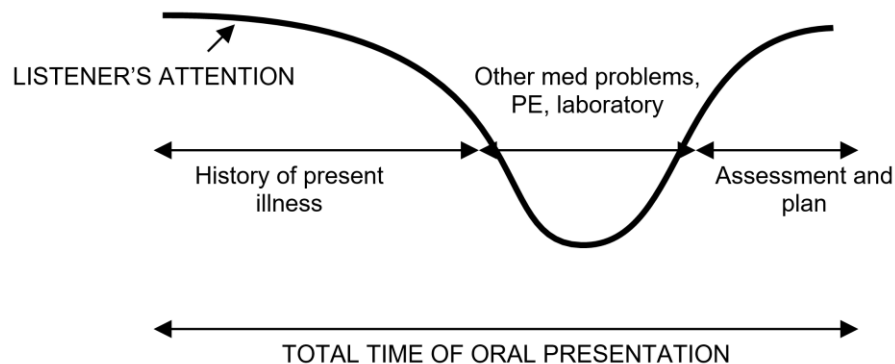
A. Purpose of case presentation – to *concisely summarize* 4 parts of your patient’s presentation: (1) history, (2) physical examination, (3) laboratory results, and (4) your understanding of these findings (i.e., clinical reasoning). The oral case presentation is a story that leads to the diagnosis you have chosen.

B. Basic structure^a

1. Identifying information/chief complaint
2. History of present illness
3. Other *active* medical problems, medications, habits, and allergies
4. Physical examination (key findings only)
5. Laboratory
6. Assessment and plan

C. Basic guidelines

1. The oral presentation is *brief*. Its length is always <5 minutes, and ideally <3 minutes.
2. The oral presentation is *delivered from memory* (it is OK to refer intermittently to note cards). Importantly, you should try to make eye contact with your listeners during the presentation.
3. The oral case presentation *differs* from the written presentation. The written presentation contains *all* the facts; the oral presentation contains only those *few* facts essential to understanding the current issue(s) and your assessment.
4. The oral presentation emphasizes “history of present illness” and “assessment and plan”, and the listener’s attention is most acute during these sections (see below). Consequently, good presenters move as quickly as they can from the end of the “history of present illness” to the “assessment and plan” section.



^a Sections covering family history, social history and review of systems are *excluded* from the case presentation. If a fact from the social history is relevant to the chief complaint (e.g., homelessness), it should appear in the “history of present illness” section

II. Identifying information/chief complaint

A. Content – contains 4 elements, expressed in a single sentence

1. The patient's age and sex
2. The patient's active ongoing medical problems, mentioned by name only, and including only the most important, i.e., no more than 3 or 4
3. The patient's reason for presentation
4. The duration of symptoms

B. Examples:

"Mr Smith is a 42 year old man with diabetes mellitus and hyperlipidemia who presents with 3 days of intermittent chest pain"

"Mrs. White is a 59 year old woman with prior diagnosis of breast cancer, rheumatoid arthritis, and hypertension who presents with 2 months of bilateral leg weakness"

"Mr. Jones is a 48 year old man who is transferred from Juneau General Hospital for further evaluation of a left lung mass"

C. A litmus test for a successful introductory sentence is being able to answer "no" to the following question:

"Do any surprises appear *after* this sentence?"

For example, if a presentation begins with "A 46 year old man presents with 2 weeks of dyspnea" but then reveals 2 minutes later that the patient is "HIV positive", your listener (who has been trying to solve your case from the initial sentence) will suddenly realize that all of his clinical reasoning has been flawed.

III. History of present illness – the fundamental part of the oral presentation and the source of 90% of correct diagnoses.

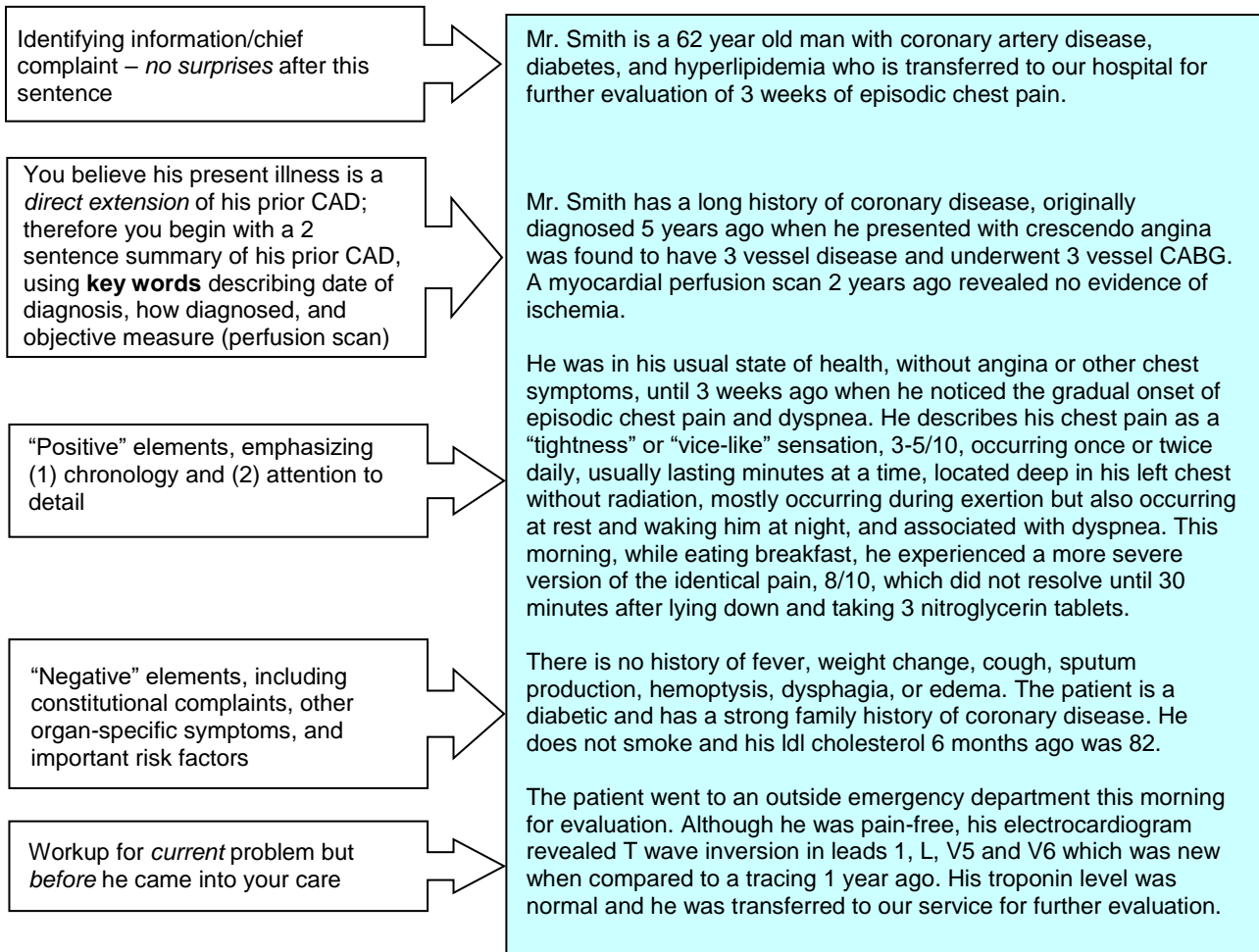
A. Content

1. All "positive" elements (i.e., what occurred) precede all "negative" elements (what was absent)
2. "Positive" statements
 - a. Are presented in *chronologic* order
 - b. Are *attentive to detail*^b
 - c. If the current problem is a direct extension of a previous ongoing active medical problem, the HPI begins with a 1-2 sentence summary of that ongoing medical problem, using "**key words**":
 1. Date of diagnosis?
 2. How was diagnosis made?
 3. Current symptoms and treatment?
 4. Are any complications present?
 5. Are any objective measures of the chronic problem available? (e.g., a1c for diabetes, FEV1 for COPD)

^b Usual descriptors include patient's own words, whether intermittent/constant, duration, frequency, whether changing over time (progressive, stable, improving), aggravating/alleviated features, associated symptoms, prior episodes, attribution (i.e., the patient's own interpretation of his or her symptoms), and, if pain, quality, location, depth, radiation, severity (1-10 scale)

3. "Negative" statements – include 3 categories of findings that, although *absent*, are important to mention
 - a. Constitutional complaints (fevers, sweats, weight change)
 - b. Symptoms relevant to organ symptom (if the patient has chest pain, report here which chest symptoms were absent, i.e., cough, dyspnea, sputum, hemoptysis, dysphagia)
 - c. Important risk factors (ask yourself the question "what could my patient have been exposed to cause this problem?")
4. Briefly describe medical care up until they are in your care. For example, if the patient is transferred from another hospital, what workup did they receive there? If the patient is coming through the Emergency Department (ED), briefly mention key findings, interventions, and the patient's response (e.g., "the patient received continuous Albuterol for 1 hour and Solumedrol 125 mg IV once, with subsequent improvement in her dyspnea." Or, "while in the ED, the creatinine returned at 10 mg/dL, prompting request for admission.")
 Importantly, most ED test results belong *in your "laboratory" section* (later, see VI).

B. Example



IV. Other active medical problems, medications, habits, and allergies

A. Content:

1. Brief summary (using **key words**, see previous) of other *active* medical problems *mentioned in your identifying information* sentence but not discussed in HPI.
2. Medications - Some teachers want to hear actual dosages; others do not. Ask ahead of time

B. Example:

His other problems include a 10 year history of diabetes mellitus, without retinopathy, neuropathy or nephropathy. An A1c 6 months ago was 6.8. His current medications include glargine insulin, isosorbide mononitrate, aspirin, metoprolol, lisinopril, and atorvastatin. He does not drink alcohol and has no allergies.

V. Physical examination

A. Content

1. Begin with "general description and vital signs"
2. Include all abnormal findings
3. Among normal findings, include only those essential to the understanding of the chief complaint

B. Example:

On physical examination, he appeared in no distress and was pain free. His blood pressure was 120/80, pulse 80 and regular, respirations 18, temperature 98.4 and oxygen saturation is 98% on 2L. There is no goiter. His lungs are clear. Estimated central venous pressure is 8 cm water. There is no precordial pulsation or chest wall tenderness. There is a left ventricular S4 but no murmurs or rubs. His abdominal examination is normal and there is no edema

VI. Laboratory

A. Content

1. Include all abnormal labs, with comparison to previous value
2. Among normal labs, includes only those relevant to the chief complaint
3. Any labs presented should appear in traditional order (electrolytes/creatinine/glucose, complete blood count, other chemistries, urinalysis, CXR, ECG, gram stains and analysis of body fluids)

B. Example

On laboratory testing, his metabolic panel is normal except for a glucose of 160 and creatinine of 1.4 (his creatinine 6 months ago was 1.3). CBC was normal. Troponin at admission and 8 hours later is normal. CXR revealed wires from his CABG, normal heart size, and clear lungs. ECG revealed the inverted T waves in the anterolateral leads as previously described.

VII. Assessment and plan

A. Content

1. Begin with a positive statement of the patient's problem, which is either a (1) symptom, (2) sign, (3) abnormal laboratory test, or (4) diagnosis. Choose the highest number on this list that no one could argue with (e.g., if the patient has dyspnea and a large pleural effusion, the assessment focuses on the abnormal lab "Left pleural effusion").
2. Ask yourself "At the moment I am presenting the case, what is the principal unresolved issue?"
 - a) If the principal unresolved issue is *diagnosis*, your assessment focuses on differential diagnosis: (i) list the 3-5 most likely diagnoses, (ii) state which diagnosis is most likely and why, and (iii) state why other diagnostic possibilities are less likely (draw your evidence from the H and P you just presented)
 - b) If the principal unresolved issue is *therapy*, your assessment should: (i) state the diagnosis or problem, (ii) state which therapy you gave or plan to give, and why you made this decision, (iii) state which complications you might anticipate.
3. If you are presenting the morning after overnight call, the case presentation usually ends with a 1-2 sentence summary of what happened overnight, after implementation of your initial decisions.
4. The assessment and plan focus only on those active issues keeping the patient in the hospital (stable outpatient problems are included in your write-up are omitted in the inpatient case presentation).

- B. Example** (in this patient, the principal unresolved issue is whether the patient's pain represents recurrent life-threatening coronary stenoses)

In summary, the patient has progressive episodic chest pain that is classic for crescendo angina because of its exertional nature and the patient's known coronary disease. Pericarditis is less likely because of the absence of characteristic rub, pleuritic pain and ECG of pericarditis. Dissecting aortic aneurysm is unlikely because the pain is episodic and there is no pulse differential on examination and no widened mediastinum on CXR. Pulmonary embolism is unlikely because he has no risk factors and we have a better alternative diagnosis.

We treated him overnight as unstable angina, using enoxaparin, aspirin, and metoprolol. He had no further pain and overnight telemetry revealed only sinus rhythm. This morning's ECG is unchanged from admission. We plan to obtain cardiac catheterization later today to better define the etiology of his pain.