

## ORAL CASE PRESENTATION CONTENT AND SEQUENCE 2007-2008

This section of the ICM-III syllabus is a framework upon which you can organize your oral case presentations. An effective oral presentation is organized, maintains an established format with smooth transitions, and emphasizes only relevant information. The most recognized format is outlined in detail over the next several pages, and generally follows a traditional S-O-A-P note style. In this format the **S**ubjective is the patients' history of present illness (HPI), and the **O**bjective are the physical exam and lab/radiological studies. These sections conclude with a summary statement followed by your **A**ssessment of what is going on with the patient and your **P**lan to further diagnose or treat. For purposes of this course, we will bring you up to the summary statement.

The oral presentation is a synthetic process that requires both communication skills and medical knowledge. Therefore, continued practice and learning are both required to master the skill of oral presentation. As a rule, you should rehearse or at least think through your case presentations in advance, and don't hesitate to practice presenting to your peers.

This outline provides the most basic and fundamental format for an oral case presentation, and can be adapted to nearly any situation or audience by simply changing the length and/or detail of the presentation, or by changing what information you emphasize as relevant. As move on through your third year clerkships, the concept of context in oral case presentations will become clearer.

### STEP 1: The Chief Complaint (CC)

#### 1. MAKE AN OPENING STATEMENT OF THE CHIEF COMPLAINT

The opening statement should be stated in the patients own words if possible. It should **NOT** contain any diagnosis. It should contain the following:

- Age
- Race
- Gender
- Reason For Presentation
- Duration Of The Problem

***THIS IS A*** (age) **YEAR OLD** (race) (gender) **WITH** (if highly relevant: concurrent medical problem), **WHO PRESENTS** (reason for presentation & duration)

#### Examples:

This is a healthy 18 year-old Caucasian male soldier who presents with a chief complaint of "sore throat" for the past two days.

This is a 44 year-old African-American female with a history of Lupus who presents with a chief complaint of "shortness of breath" for the past two weeks.

**NOTE:** You should only include aspects of the patients' past medical history if it is directly related to the chief complaint.

## STEP 2: The History of Present Illness (HPI)

### 1. BRIEFLY SET THE CONTEXT WITHIN WHICH THE PRESENT ILLNESS OCCURS

#### A. BASELINE HEALTH

If the presenting active problem is a component of an on going chronic disease describe briefly:

- Course Of Disease To Present
- Baseline Level Of Function/Activity
- Provide Details Of Current Episode

**THE PATIENT WAS IN HIS/HER USUAL STATE OF (good, compromised) HEALTH (symptoms/able to do what) UNTIL (when). NOW THE PATIENT PRESENTS WITH COMPLAINS OF (symptoms\*\*:**  
*provide details of current episode)*

#### Examples:

The patient was in good health until....

This patient has been on a stable dose of prednisone for her Lupus without complaints for the last 6 months until 2 weeks ago...

### 2. NOW DESCRIBE THE SYMPTOMS

This is arguably the most important section of the oral case presentation. Many experienced clinicians will report that the vast majority of medical problems can be diagnosed by the history alone. Your ability to effectively and accurately relay the patients' story is crucial. Do not be tempted to inject your assessments or differential diagnosis at this stage... you will have plenty of time for that at the end of your presentation. Dedicate this section to the patient and their story.

- A. Start at the beginning of the illness and proceed chronologically
- B. Use OPQRST to characterize the presenting complaint
  - O Onset:** *When did it start? How did it start (suddenness of onset, what were you doing)?*
  - P Palliating/Provoking Factors:** *What makes it better/worse? When do you get it? What brings it on? What have you tried to relieve it?*
  - Q Quality:** *What does it feel like (get a clear description)? How severe (use a numerical scale if appropriate)?*
  - R Region/Radiation:** *Where is it located (get a precise location; if necessary have patient point to the area)? Does it move or radiate to another region?*
  - S Symptoms (associated):** *What other symptoms have you noticed when it occurs?*
  - T Temporal aspects:** *Has anything changed since the first time you had the symptom? Are things better, worse, or about the same? How often does it happen? How long does it last?*

Understand that the OPQRST construct is designed as a tool to help you fully characterize the patients' symptoms. If a symptom does not fit this construct (e.g. fatigue), simply fall back to simply asking; who, what, when, where, why, and how to fully characterize the symptoms

- C. State any associated symptoms or associated risk factors
- D. Include "pertinent negatives" in the HPI that help narrow the differential diagnosis

#### Example

This patient has been on a stable dose of prednisone for her Lupus without complaints for the last 6 months until 2 weeks ago. Over the past two weeks she has noticed gradual onset of fatigue, malaise, decreased appetite and a progressive feeling of shortness of breath. The shortness of breath came on gradually, but has steadily worsened over the last two weeks. She is now unable to walk more than 10-20 feet or carry on a conversation due to the shortness of breath. Her symptoms improve with rest or remaining still. She has tried a friend's albuterol inhaler without relief.

Over this same time period, she also noted mild “3 out of 10” stabbing pain in her lower left anterior chest that only occurs when taking a deep breath. The pain is not worsened by exertion, and does not radiate to her arm or jaw.

Of note that the patient's sister and mother also have lupus, and her mother had a “blood clot” in her lungs a few years ago. The patient does not have any personal history of thromboembolic disease, and has not traveled or taken prolonged car rides.

She denies any history of any cough, hemoptysis, orthopnea, paroxysmal nocturnal dyspnea, or pain in her arm or jaw. She denies any fevers or night sweats, hematuria, or edema.

## **STEP 2: CONTEXT of the PATIENT’S LIFE/MEDICAL HISTORY**

Give this portion of the case presentation in 1-2 minutes. While the context of the illness is important for shaping a differential diagnosis and treatment plan, it is only the backdrop for the case at hand. You’ve collected a lot of data, but avoid the temptation to present it all. Present this section in lists. Expand the lists where additional data may be helpful, and be brief.

### **1. ORGANIZED BY SECTION OF THE MEDICAL HISTORY**

- Social History (SHx)
- Past Medical History (PMHx)
- Past Surgical History (PSHx)
- Medications (Meds)
- Allergies and Immunizations
- Family History (FamHx)
- Review of Systems (ROS)

### **2. PRESENT EACH SECTION AS A LIST OF BRIEF “BULLET” STATEMENTS**

### **3. AVOID WANDERING BETWEEN SECTIONS IN YOUR PRESENTATION**

- Sequentially list the SH, then list the PMH, etc
- Avoid wandering statements like “she takes verapamil for hypertension. She also takes aspirin for coronary prevention...”
- Maintain the bullet format

### **4. EMPHASIZE ELEMENTS THAT MAY PERTAIN TO THE PRESENT ILLNESS**

- Pertinent items may need additional details beyond a quick “bullet” statement
  - o In the example, it would be appropriate to include previous complications of Lupus this patient may have had in the past
- Mention, but don’t dwell on non-contributory medical history items

### **5. FOR ROS, STATE ONLY POSITIVE FINDINGS and PERTINENT NEGATIVES**

- State “the ROS was remarkable only for...”
- Or, state “the remainder of the ROS was otherwise non-contributory”
- Remember, if it is directly related to the Chief Complaint, it should be in the HPI

## STEP 3: Physical Exam

### 1. OPENING STATEMENT

GENERAL DESCRIPTION OF APPEARANCE: "Paint a picture" of your patient's overall appearance by telling them your "first glance" impression.

- level of consciousness (alert, obtunded, etc...)
  - obvious features
  - appearance/agreement with stated age
  - level of distress
  - affect
  - estimate of nutritional status, weight
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- Avoid the phrase "well developed, well nourished". It is meaningless, and conveys lack of anything better to say.
  - You do NOT need to include all of the above items in your description. This is a guideline for you to "paint your picture".

#### VITAL SIGNS

- pulse
- blood pressure
- respiration
- temperature

#### Example

This is an alert, thin, female who appears older than her stated age and in moderate distress. She is unable to speak without stopping to catch her breath,

Patient has an irregularly irregular pulse at a rate of 120 beats/min with a blood pressure seated of 100/50 mm hg, a respiratory rate of 30 per minute, and an axillary temperature = 99.2° f.

### 2. REPORT YOUR PHYSICAL FINDINGS

#### A. PROCEED FROM HEAD TO TOE

#### B. DESCRIBE IN DETAIL ONLY PERTINENT FINDINGS

These are limited to only relevant positives and negatives. Normal findings not related to the presenting problem may be either omitted or described as "within normal limits."

#### C. EMPHASIZE PARTS OF THE EXAM DIRECTLY RELATED TO THE CHIEF COMPLAINT

For example, if the patient presents with chest pain, you should probably describe the findings of your chest, lung, and cardiac exams in detail, even if normal.

Example (note the emphasis on the lung and heart exam given the chief complaint of shortness of breath with chest pain and elevated heart rate)

Examination of the head, eyes, ears, nose, and throat were unremarkable. The jugular venous distension was 4 cm measured at 30 degrees. Lungs were normal to percussion and auscultation bilaterally. No crackles were appreciated. Cardiac exam revealed normal S1 and a loud S2, and mild tachycardia with an irregularly irregular rhythm. No murmurs, rubs, or gallops were appreciated. Abdomen was soft, non-tender and non-distended with normal bowel sounds. No rashes were appreciated.

## **STEP 4: ANCILLARY DATA (LABORATORY, RADIOLOGIC)**

Limit presentation to relevant normal labs and all abnormal results. Be cautious about “normal” lab values. You need to look at the trends of values for each patient to truly determine what is normal or abnormal.

### Example

The CBC was notable for a white blood cell count of 17 thousand with a leftward shift. The blood chemistry, urinalysis, and coagulation studies were within normal limits. The EKG revealed...

## **STEP 5: SUMMARY**

Complete the presentation with a brief, one sentence summation of only the most critical detail from the H&P. This is THE SECOND MOST IMPORTANT component of your case presentation, and deserves careful preparation.

The summary statement accomplishes two tasks. First, a well-stated summary identifies the key data necessary for your audience to form an accurate differential diagnosis. Second, a powerful summary statement conveys your ability to clinically reason. As a general rule, if you can't state your summary in one breath, it's too long. Include only the most crucial facts from the database you've collected.

Up to this point in the presentation, you've been simply reporting, albeit in a well-organized format, your findings. You have appropriately limited the discussion to “just the facts” as observed. The summary statement is the first time in the presentation where you tie all the facts you feel strengthen your opinion of the correct diagnosis into one coherent thought. You should avoid making a diagnosis at this point, but it should be obvious to your audience what you believe your number one diagnosis will be.

### Example

In summary, this is a 44 year-old woman with risk factors for venous thrombo-embolic (VTE) disease, who now presents with sub-acute onset of dyspnea, hypotension, a loud S2 with clear lungs, and right heart strain on EKG.

*Note how key findings in this case have been combined from isolated facts (risk factors for VTE, right heart strain), and that syndromes (hypotension, dyspnea) have been defined. Also note while you haven't specifically stated your diagnosis, it seems obvious you believe this could be a pulmonary embolism.*

## **STEP 6: DIFFERENTIAL DIAGNOSIS AND PLAN**

Usually, your audience will ask you to pause after making a summary statement (remember, 5-7 minutes at this point) to allow discussion of the case. If you are not stopped, proceed to your differential diagnosis and plan.

Note that by selecting data elements to include/omit from your presentation, you've already implicitly revealed your differential diagnosis, and if you have given an effective presentation, your audience has arrived at a similar differential diagnosis. Now is the time to explicitly state your prioritized differential, and argue your case for the most likely diagnosis in addition to your plan for further tests and/or treatment.

This part of the oral case presentation is not practiced in ICM-III. Use the skills you are learning in ICR when you are asked to present your differential diagnosis during your clerkships.