Case Presentation Basic Expressions

Qualities of a Good Case Presentation

*If your case presentation does **NOT** contain the following properties, it will make your audience "**SAD**".*

- ***S**tructure: Use the **traditional structure** and the **standard headings.***
- ***A**rgument: Let your audience do the assessment & plan and **include only pertinent items.***
- ***D**elivery: Use **commonly used expressions** and deliver them in an **extemporaneous style.***

Step 1: Structure

*Make your draft based on the **traditional structure.***

Step 2: Argument

*Make **differential diagnoses** and include **only pertinent items.***
Magic Question: "***Is this necessary for your clinical decision making? If so, how?***"

Step 3: Delivery

*Make sure that your case presentation uses **commonly used expressions.***

Step 1: Structure
Traditional Structure

1. ID/Chief Complaint
2. History of Present Illness
3. Past Medical History (Medications & Allergies)
4. Family History
5. Social History
6. Review of Systems
7. Physical Examination
8. Investigations (Labs/Imaging Studies)
9. Summary
10. Problem List
11. Assessment & Plan
12. Conclusion

SNAPPS Format

1. **S**UMMARIZE the **History & Physical Exam** (less than 3 minutes)
2. **N**ARROW the differential diagnosis to 2 or 3 relevant possibilities
3. **A**NALYZE the differential by justifying/comparing and contrasting the possibilities
4. **P**ROBE the preceptor by asking questions about uncertainties, difficulties, or alternative approaches
5. **P**LAN management for the patient's medical issues
6. **S**ELECT a case-related issue for self-directed learning

Step 2: Argument

*Make **differential diagnoses** and include **only pertinent items**.*
Magic Question: "***Is this necessary for your clinical decision making? If so, how?***"

Step 3: Delivery

*Make sure that your case reports uses **commonly used expressions**.*

Commonly Used Expressions

1. ID/Chief Complaint

Chief Complaint includes:

- *Age*
- *Sex*
- *Duration of the problem*
- *Reason for presenting*
- *(Ethnicity)*
- *(Occupation)*

Basic Structure

A (age)-year-old (man/woman/boy/girl) presented with (duration) of (symptom/symptoms).

Example

- *A 27-year-old man presented with 2 days of right lower quadrant abdominal pain.*
- *The patient is a 27-year-old man, who presented with 2 days of right lower quadrant abdominal pain.*
- *A 27-year-old man complains/complaining of (c/o) 2 days of right lower quadrant abdominal pain.*

With Pertinent Past Medical History

A (age)-year-old (man/woman/boy/girl) with (pertinent past medical history) presented with (duration) of (symptoms)

Example

- *A 62-year-old woman with diabetes and hypertension presented with 2 days of intermittent chest pain.*
- *A 31-year-old G1P1A0C1 woman presented with 3 days of uterine bleeding and pelvic pain.*

Referred/Transferred

A (age)-year-old (man/woman/boy/girl) was (referred/transferred) to our department for further evaluation and treatment of (symptom/sign/disease).

Examples

- *An 82-year-old woman was referred to our department for further evaluation and treatment of 3 days of gross hematuria.*
- *A 52-year-old man was transferred to our department for surgical treatment of subarachnoid hemorrhage.*

Ethnicity & Occupation

Examples

- *An 81-year-old Caucasian unemployed man presented with 3 days of melena.*
- *A 26-year-old African American male college student presented with a week of dyspnea.*

2. History of Present Illness

- Chronologic order
- Associated symptoms

History of Present Illness includes:

- Brief health context
- "OPQRST"

Brief Health Context

- *The patient had been (healthy/well) until (onset date), when s/he had (symptom/symptoms).*
- *The patient was in (her/his) usual state of health until (onset date), when s/he had (symptom/symptoms).*

Example

- *The patient had been healthy until 2 weeks ago, when he had dyspnea on exertion.*
- *The patient has been on a stable dose of prednisone for her rheumatoid arthritis without any complaints for the last 4 months until 2 weeks ago, when she noticed progressive dry cough.*

Chronologic Order

The patient had been in his usual state of health until ( ) ago, when he noticed ( ).

( ) days later, he visited a local clinic, where he was prescribed for a ( ) course of ( ).

Key Expressions

- *on the following day*
- *over the past ( ) days*
- *( ) days after the initial visit*
- *( ) days prior to admission*
- *on admission*
- *during the follow-up sessions*

OPQRST

- **O**nset
- **P**rovoking & **P**alliating Factors
- **Q**uality
- **R**egion & **R**adiation
- **T**ime

Onset

- *The patient first noticed the (symptom) ( ) days ago.*
- *The patient was in (her/his) usual state of health until (onset date), when s/he had (symptom/symptoms).*

Provoking & Palliating Factors

- *The (symptom) is aggravated by ( ).*
- *The (symptom) is alleviated by ( ).*

Quality

- *The patient describes the pain as ( ).*

Region & Radiation

- *The pain is located in ( ).*
- *The pain is localized in ( ) and does not move anywhere else.*
- *The pain is located in ( ) and moves to ( ).*

Severity

- *The patient rates the pain as ( ) out of 10.*
- *The pain was initially rated as ( ) out of 10, but it progressed to ( ) out of 10 over ( ) minutes.*

Time

- *The pain lasted for ( ) minutes.*

3. Past Medical History

- *Her/His past medical history is significant/remarkable for ( ) years of (disease).*
- *Besides a ( )-year history of ( ), her/his past medical history is insignificant/unremarkable.*
- *Her/His past medical history is insignificant/unremarkable.*
- *The patient was hospitalized for (disease) ( ) years ago.*
- *The patient has a long history of ( ) with ( ) dependence and the requirement for ( ), and three hospital admissions for exacerbations in the last year.*
- *The patient has a two-year history of ( ), felt to be secondary to ( ), characterized by ( ). In addition to his long term therapy with ( ), ( ) was added six months ago. A ( ) four months prior to admission showed ( ).*

Medications (Use generic names. Include OTC drugs and supplements.)

- *She/He is currently on ( ) milligrams per day of ( ).*
- *The patient takes no medications or nutritional supplements.*

Allergies

- *The patient has known allergies to (medication/food), and it caused (past allergic episode).*
- *The patient developed a skin rash approximately ( ) years ago after receiving penicillin and carries the diagnosis of penicillin allergy.*
- *The patient has no known allergies.*
- *The patient has no known drug allergies.*

4. Family History

- *Her/His family history is significant/remarkable for ( ) in her/his (family member).*
- *Her/His family history is insignificant/unremarkable.*
- *Her/His parents are alive and well.*
- *Her/His maternal/paternal grandmother/grandfather died of (disease) at the age ( ).*

5. Social History (SODA)

Smoking

- *The patient has smoked ( ) packs of cigarettes per day for the past ( ) years.*
- *The patient has smoked one pack per day (PPD) for ( ) years.*
- *The patient has a ( ) pack-year history of smoking.*
- *The patient does not smoke./The patient has no smoking history.*

Occupation (Including Sexual History)

- *The patient works as a ( ).*
- *The patient is married and lives with her/his husband/wife and her/his children.*
- *The patient is sexually active only with her/his husband/wife.*

Drugs

- *The patient has no history of illicit drugs.*
- *The patient denies any use of alcohol, cigarettes, or illicit drugs.*
- *The patient uses (marijuana/cocaine) occasionally and last used ( ) days ago.*

Alcohol

- *The patient drinks ( ) milliliters of (alcohol type) per day.*
- *The patient drinks ( ) glass of (alcohol type) on a social basis./The patient has had ( ) can(s) of beer per day for the past ( ) years.*
- *Her/His CAGE questionnaire is ( ) out of 4.*

6. Review of systems

• *Review of systems is negative except as mentioned in the history of present illness.*

OB/GYN

• *Her gynecological history is **G1P1A0C1**.*
  - **Gravida**: number of pregnancy
  - **Para**: births
  - **Abortus**: abortion
  - **C**aesarean section

• *Her **TPAL** is 1-0-0-1.*
  - **T**: term births
  - **P**: premature births
  - **A**: abortions
  - **L**: living children

Pediatric Vaccinations

• *The patient has received recommended childhood vaccines, including BCG, DPT, MR, and homophilus influenza type b.*

7. Physical Examination

General (GEN)

- *The patient is not in acute distress (**NAD**).*
- *She/He is alert, awake, and oriented times four (**AAOX4**).*
- *She/He is alert, awake, and oriented to name, place, time, and purpose.*
- *She/He is well developed well nourished (African American female, African American male, white female, white male).*

GEN: NAD, AAOX4, WDWN (AAF, AAM, WF, WM)

Psychiatric (PSYCH)

- *Normal affect*
- *No hallucinations*
- *Normal speech*
- *No dysarthria*

PSYCH: nl affect, Ø hallucinations, nl speech, Ø dysarthria

Head, eyes, ears, nose and throat (HEENT)

- *The head is normocephalic and atraumatic (**NC/AT**).*
- *The mucous membranes are moist (**MMM**).*
- *The extraocular muscles are intact (**EOMI**) bilaterally (**b/l**).*
- *The pupils are equal and round, react to light and accommodation (**PERRLA**) bilaterally (**b/l**).*
- *The bilateral (**b/l**) tympanic membranes (**TM**) are intact.*
- *The bilateral (**b/l**) sclerae are anicteric.*
- *No conjunctival pallor.*

HEENT: NC/AT, MMM, EOMI b/l, PERRLA b/l, b/l TM intact, b/l sclera anicteric, Ø conjunctival pallor

Neck

- *The neck is supple.*
- *No jugular venous distention (**JVD**)*
- *No lymphadenopathy (**LAD**)*
- *No carotid bruits*
- *No goiter*

NECK: Supple, Ø JVD, Ø LAD, Ø carotid bruit, Ø goiter

Cardiovascular (CV)

- *Regular rate and rhythm (**RRR**)*
- *Normal S1 and S2*
- *No murmurs, rubs, or gallops (**m/r/g**)*
- *Point of maximal intensity (**PMI**) is not displaced or not sustained.*
- *Apical impulse is not displaced.*
- *No hepatojugular reflux (**HJR**)*
- *Capillary refill (**CR**) is less than 2 seconds.*

CV: RRR, nl S1/S2, Ø m/r/g, PMI non displaced/non sustained, Ø HJR, CR < 2 secs

Lungs/Chest

- *Clear to auscultation bilaterally (**CTAB**)*
- *No wheezes, rhonchi, or crackles (**w/r/c**)*
- *No egophony*
- *No tactile fremitus*
- *Normal (**nl**) percussion*

Chest: CTAB, Ø w/r/c, Ø egophony, Ø tactile fremitus, nl percussion

Abdomen (ABD)

- *Soft*
- *Non-distended*
- *Non-tender*
- *No rebound or guarding*
- *No pulsatile masses*
- *Positive bowel sounds in all four quadrants*
- *No high pitched or tinkling sounds*
- *Resonant to percussion*
- *No costovertebral angle (**CVA**) tenderness*
- *No hepatosplenomegaly (**HSM**)*

ABD: Soft, ND/NT, Ø rebound/guarding, Ø pulsatile masses, +BS x4, Ø high pitched or tinkling sounds, resonant to percussion, Ø CVA tenderness, Ø HSM

Extremities (EXT)

- *No cyanosis*
- *No clubbing*
- *No edema*

EXT: Ø c/c/e

Neurological (NEURO)

- *Cranial Nerve (CN) II through XII are intact.*
- *No focal deficit*
- *Deep tendon reflexes: symmetric 2+ in all extremities*
- *Cerebellar: negative Romberg, rapid alternating movements and heel-to-shin test are normal and symmetric*
- *Sensation: intact to pinprick and soft touch*

NEURO: CN II-XII intact, no focal deficit, DTRs: 2+ in all extremities, Cerebellar: negative Romberg, rapid alternating movements and heel-to-shin test normal and symmetric, Sensation: intact to pinprick and soft touch

Skin
- *Intact*
- *No rashes*
- *No lesions*
- *No erythema*

SKIN: Intact, Ø rashes, Ø lesions, Ø erythema

Genitourinary (GU) = Male Reproductive
- *No rashes*
- *No penile discharge*
- *Penile shaft without (**w/o**) masses or lesions*
- *No inguinal hernia*
- *No inguinal lymphadenopathy (**LAD**)*
- *Bilateral (**b/l**) testicles normal (**nl**) in consistency without (**w/o**) hydrocele or varicocele*
- *No hypospadias or epispadias*

GU: Ø rashes, Ø penile discharge, penile shaft w/o masses or lesions, Ø inguinal hernia, Ø inguinal LAD, b/l testicles nl in consistency w/o hydrocele or varicocele, Ø hypospadias/ epispadias

Pelvic
- *No rashes*
- *Normal (**nl**) bartholin gland*
- *Vaginal mucosa of normal (**nl**) consistency without (**w/o**) atrophy or discharge*
- *Cervical os without (**w/o**) discharge*

Pelvic: Ø rashes, nl bartholin gland, vaginal mucosa nl consistency w/o atrophy or discharge, cervical os w/o discharge

Bimanual
- *No cervical motion tenderness (**CMT**)*
- *No vaginal bleeding (**VB**)*
- *No discharge*
- *No masses*

Bimanual: Ø CMT, Ø VB, Ø discharge, Ø masses

Rectal
- *No bright red blood per rectum (**BRBPR**)*
- *No melena*
- *No masses*
- *Normal sphincter tone*
- *No external or internal hemorrhoids*
- *Prostate walnut size without (**w/o**) nodularity or hypertrophy*
- *No prostate tenderness*

RECTAL: Ø BRBPR, Ø melena, Ø masses, nl sphincter tone, Ø ext/int hemorrhoids, prostate walnut size w/o nodularity or hypertrophy, Ø prostate tenderness

Musculoskeletal (MSK)
- *Normal range of motion (**ROM**)*
- *No joint swelling or erythema*

MSK: nl ROM, Ø joint swelling or erythema

8. Workup (Labs/Imaging Studies)

Laboratory

- *Laboratory studies show a CBC with WBC ( )/μL, hemoglobin ( ) g/dL, hematocrit ( )%, and platelets ( )/μL..*
- *CBC: four point eight (WBC), fourteen point two (hemoglobin), forty two (hematocrit), and two twenty (platelets).*
- *Chemistry studies demonstrate sodium of ( ) mEq/L, potassium ( ) mEq/L, chloride ( ) mEq/L, bicarbonate ( ) mEq/L, BUN ( ) mg/dL, creatinine ( ) mg/dL, and blood glucose ( ) mg/dL.*
- *Chem-7: one forty two (sodium) over four (potassium), one oh two (chloride) over twenty five (bicarbonate), fifteen (BUN) over oh point eight (creatinine), and one oh two (blood glucose).*
- *CBC and chemistry are all within normal limits.*
- *The CBC was notable for a white blood cell count of ( ). The blood chemistry, urinalysis, and coagulation studies were within normal limits.*
- *The patient had an antinuclear antibody, which was negative, PPD was negative and he had normal serum and urine protein electrophoresis.*

EKG

- *An EKG shows sinus rhythm at a rate of 88 beats per minute.*
- *An EKG is notable for sinus rhythm with diffuse T-wave inversions throughout the precordium.*
- *An EKG shows ST depressions in V4 through V6 and in I and aVL.*

Chest X-ray

- *A chest X-ray shows no cardiomegaly.*
- *The chest radiograph shows clear lungs with well-defined costophrenic angles and a cardiothroacic ratio of 0.41.*

CT

- *A CT showed a ( ) millimeter-by-( ) millimeter tumor, which invades the ( ) without evidence of metastasis to the local lymph nodes.*
- *A CT revealed filling defects in the ( ).*

MRI

- *T1/T2-weighted images revealed a low/high-intensity mass in the ( ).*

9. Summary

In summary, this is a ( )-year-old man/woman with (pertinent past medical history), who presents with (chief complaint) and (other symptoms).

Physical examination is significant for (abnormal physical findings). (Workup) revealed (abnormal workup results).

Example

In summary, this is a 62-year-old man with 10 years of hypertension and diabetes, who presents with 5 days of dyspnea on exertion. Physical examination is significant for notable jugular venous pressure 7 cm and S4 heart sound. Chest X-ray revealed cardiomegaly without heart failure, and EKG shows ST depressions in V4 to V6 and in I and aVL as well as T wave inversion in the lateral leads.

10. Problem list

Problem list includes: #1 (chief complaint), #2 (other symptom), and #3 (other diagnosis)

Example

Problem list includes: #1 dyspnea on exertion, #2 hypertension, and #3 diabetes mellitus with retinopathy

11. Assessment & plan

#1 (problem): I believe this (problem) is due to (diagnosis). (Symptoms), (physical findings), and (workup results) suggest this diagnosis.

Other diagnosis we need to consider include (differential diagnosis 1), (differential diagnosis 2), and (differential diagnosis 3).

These diagnosis are less likely due to the (negative symptoms), (negative physical findings), and (negative workup results).

We are treating the patient as using (medications). The patient will receive (diagnostic/therapeutic procedure) today. We will consider (diagnostic/therapeutic procedure) depending on (diagnostic procedure).

#2 (problem): The patient has been treated by (doctor/hospital/clinic). The next consultation is (date).

#3 (problem): We need to discuss the issue with our medical social workers.

12. Conclusion

This is a patient with (diagnosis). We will perform (therapy). We will consider (other therapy) depending on the (test). (Social aspects) is important in follow-up.

Patient Note

History: *Describe the history you just obtained from this patient. Include only information (pertinent positives and negatives) relevant to this patient's problem(s).*

History of Present Illness (HPI):

Review of Systems (ROS):

Allergies:

Medications:

Past Medical History (PMH):

Past Surgical History (PSH):

Family History (FH):

Social History (SH):

Physical Examination: *Describe any positive and negative findings relevant to this patient's problem(s). Be careful to include only those parts of examination you performed in* ***this*** *encounter..*

Data Interpretation: *Based on what you have learned from the history, list up to* ***3 diagnoses*** *that might explain this patient's complaint(s). List your diagnoses from most to least likely. For some cases, fewer than 3 diagnoses will be appropriate. Then, enter the positive or negative findings from the history (if present) that support each diagnosis. Lastly, list initial diagnostic studies (if any) you would order for each listed diagnosis.*

Diagnosis #1:

History Finding(s)	Physical Exam Finding(s)
1.	1.
2.	2.
3.	3.

Diagnosis #2:

History Finding(s)	Physical Exam Finding(s)
1.	1.
2.	2.
3.	3.

Diagnosis #3:

History Finding(s)	Physical Exam Finding(s)
1.	1.
2.	2.
3.	3.

Diagnostic Studies

1.
2.
3.

Common Abbreviations for the Patient Note

http://www.usmle.org/pdfs/step-2-cs/cs-info-manual.pdf

yo: year old	*CT: computed tomography*	*LP: lumbar puncture*
m: male	*CVA: cerebrovascular accident*	*MI: myocardial infarction*
f: female	*CVP: central venous pressure*	*MRI: magnetic resonance imaging*
b: black	*CXR: chest x-ray*	*MVA: motor vehicle accident*
w: white	*DM: diabetes mellitus*	*Neuro: neurologic*
L: left	*DTR: deep tendon reflexes*	*NIDDM: non-insulin-dependent diabetes mellitus*
R: right	*ECG: electrocardiogram*	*NKA: no known allergies*
hx: history	*ED: emergency department*	*NKDA: no known drug allergies*
h/o: history of	*EMT: emergency medical technician*	*NL: normal/normal limits*
c/o: complaining of	*ENT: ears, nose, and throat*	*NSR: normal sinus rhythm*
∅: without or no	*EOM: extraocular muscles*	*P: pulse/heart rate*
+: positive	*ETOH: alcohol*	*PA: posteroanterior*
-: negative	*Ext: extremities*	*PERLA: pupils equal, react to light and accommodation*
Abd: abdomen	*FH: family history*	*po: orally*
AIDS: acquired immune deficiency syndrome	*GI: gastrointestinal*	*PT: prothrombin time*
AP: anteroposterior	*GU: genitourinary*	*PTT: partial thromboplastin time*
BUN: blood urea nitrogen	*HEENT: head, eyes, ears, nose, and throat*	*RBC: red blood cells*
CABG: coronary artery bypass grafting	*HIV: human immunodeficiency virus*	*SH: social history*
CBC: complete blood count	*HTN: hypertension*	*SOB: shortness of breath*
CCU: cardiac care unit	*IM: intramuscularly*	*TIA: transient ischemic attack*
CHF: congestive heart failure	*IV: intravenously*	*U/A: urinalysis*
cig: cigarettes	*JVD: jugular venous distention*	*URI: upper respiratory tract infection*
COPD: chronic obstructive pulmonary disease	*KUB: kidney, ureter, and bladder*	*WBC: white blood cells*
CPR: cardiopulmonary resuscitation	*LMP: last menstrual period*	*WNL: within normal limits*

Commonly Used Expressions for Ward Round Presentation

SNAPPS Sample Phrases

Summary

Refer to the ***History (1-6) & Physical Examination (7)***.

Narrow

- *"My list of differential diagnoses includes…"*
- *"(Differential) is one differential diagnosis I am considering."*
- *"After obtaining the history and physical exam findings (differential) is a possible cause."*
- *"My top differential diagnosis at this time would be (differential)."*
- *"(Differential) is a diagnosis we would need to exclude/consider."*
- *"(Differential) is one of the most likely causes of (symptom)."*

Analyze

- *"I think (differential) is a possible diagnosis because the patient has (history finding) and a history of (history finding: past medical history)."*
- *"(Differential) is a possible diagnosis because the patient displayed (history finding) and had (physical exam finding) on examination."*
- *"(Differential) needs to be excluded/considered because patients with (differential) often present with (history findings and physical exam findings)."*

Probe

- *"Are there any other possible diagnoses you think I should consider?"*
- *"Are there any areas of the history/physical examination that I might have missed?"*
- *"I'm not sure if I should request (diagnostic study). Do you think this is necessary/ important?"*
- *"Is (treatment/medication) suitable for this patient?"*

Plan

- *"My proposed management plan is (plan)."*
- *"I discussed starting (plan) with the patient and we agreed on this course of treatment."*
- *"I'm not certain what the correct management plan is for this patient, but I was thinking about (plan)."*
- *"I would like to start (plan) because (reason why)."*

Select

- *"After seeing this patient I think I need to study/research/look-up (topic) in more detail."*
- *"For next time I will read-up on (diagnosis/treatment)."*
- *"For my self-directed study I will find more information on (diagnosis/treatment).*