

## Clinical case presentation guidelines

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### **Confidentiality**

All clinical notes contain confidential information and it is important that you protect this confidentiality.

### **Word limit for abstract**

Your Abstract title must not have more than 20 words and the actual Abstract text should not be more than 300 words. The Abstract should include a synopsis of the salient points of the case, such as: presentation, initial investigations and results, working diagnosis, follow-up including treatment, etc.

### **For the oral presentation**

In order to give an oral presentation, you need to compress the patient's medical illness and the physical findings into a concise recitation of the most essential facts. You need to give all of the relevant information without extraneous details so that the person reading it should be able to construct their own differential diagnosis as the story unfolds. You should consider yourself an advocate who is attempting to persuade an informed, interested judge of the merits of your argument/presentation without distorting any of the facts.

Here are the other headings that you should include, where relevant, in an Abstract.

### **History of present complaint (HPC)**

This should be signs and symptoms along with a summary of the patient's problems in chronological order, e.g. Mrs. AB a 43 year old primary school teacher has a 3-month history of intermittent abdominal pain and weight loss of ½ stone. Avoid presentation of distracting information, such as an overly detailed discussion of the patient's medical problems in your introductory HPC.

### **Past medical history**

This should be in chronological order – only use proprietary name of drugs.

### **Drug history**

Use proprietary names only.

### **Family history**

This can include coronary heart disease, diabetes and anything relevant to the presenting complaint.

### **Social history**

This can include, for example: lives with partner, occupation, smoker/non-smoker, alcohol consumption per week, ? vegetarian .

### **Subsequent questioning (SQ)**

This should only include specific systems that are relevant to the case. For example, if it is related to the gastrointestinal system, you should include weight, dysphagia, abdominal pain, vomiting, nausea, bowel habits.

### **Physical exam (O/E)**

Include BMI, blood pressure, pulse rate, relevant findings (or their absence). Mention only the relevant positive findings and the relevant negative findings, e.g. in a female with amenorrhoea the relevant findings would be ? euthyroid, presence of hirsutism, the presence of galactorrhoea, etc.

### **Initial investigations**

Include laboratory and imaging where relevant. For the laboratory investigations, make sure you use correct units and give reference intervals. For imaging, use positive statements, such as 'chest x-ray shows normal heart size'. This is better than 'chest x-ray shows no cardiomegaly'.

### **Working diagnosis**

Specify your most likely diagnosis/differential diagnosis.

### **Further investigations**

Include laboratory and any imaging investigations.

### **Final diagnosis**

### **Progress and management**

This will include any treatment and follow-up.

### **Key features of final diagnosis**

For example, include pathophysiology and clinical features where relevant.

### **Finally**

To conclude, include:

- Learning and other key points
- References where relevant
- Final section - 'Points to remember'