Education and Culture

Programme

Oral Case Presentation Guidelines

EUROPEAN MASTER DEGREE: ORAL LASER APPLICATIONS

Université de Liège

RWTH AACHEN UNIVERSITY

UNIVERSITÀ DEGLI STUDI DI PARMA

Université Nice Sophia Antipolis

SAPIENZA UNIVERSITÀ DI ROMA

UNIVERSITAT DE BARCELONA

Purpose of the case presentation

- Patient's presentation:
  - History of the present illness.
  - Other active medical problems, medications, habits, and allergies.
  - Physical examination.
  - Complementary tests.
- Assessment and Treatment Plan:
  - Differential Diagnosis.
  - Treatment ellection.
- Treatment.
- Discussion.

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Patient presentation

The patient's presentation should c*oncisely summarize* the following 4 sections:

- History
- Physical examination
- Complementary tests
- Interpretation of the findings (e.g. clinical reasoning)

Basic structure:

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

Note

- *Unless any clinical significance, the sections covering family history, social history and extraoral exploration must be 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 the present illness" section.*

Basic guidelines

- The oral presentation has to be *brief*. Its length has to be less than 5 minutes (ideally 3 - 4 minutes) .
- The oral presentation should be known by heart (it is OK to refer intermittently to note cards but without reading all the time).
- The oral case presentation *differs* from the written one. The written presentation contains *all* the facts, while the oral one only contains those *few* essential facts to understand the current issue(s).

Identifying Information/Chief Complaint

- Contents – We should find 3 elements expressed in a single sentence:
  - The patient's age and gender.
  - The name of the most important patient's active medical problems (no more than 3 or 4 issues).
  - The duration of the symptoms (if its relevant)

Examples:

- Mr. J.L. is a 72-year-old man transferred from his General Dentist for further evaluation of an intraoral cavity mass.
- Mr P.G. is a 42-year-old man with diabetes mellitus and hyperlipidemia whose chief complaint is a 3-days-long intermittent gingival bleeding.
- Mrs. M.P. is a 59-year-old woman with prior diagnosis of breast cancer, rheumatoid arthritis, and hypertension who refers 2 months of bilateral intermittent swelling.

A litmus test

for a successful introductory sentence you should answer "no" to the following question:

- For example, if the presentation begins with "A 16-year-old man presents a tongue lesion of 2 week's evolution " and 2 minutes later it is revealed that the patient had "epilepsia", your listeners (who have been trying to solve your case from the initial sentence) will suddenly realize that all of their clinical reasoning have been flawed.

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History of Present Illness (HPI)

- The HPI is the fundamental part of the oral presentation and the source of 90% correct diagnoses.

HPI content:

- All the "positive" elements (e.g. what occurred) precede all the "negative" elements (e.g. what is absent).
- "Positive" statements:
  - Should be presented in *chronological* order.
  - You should *pay attention to details*.

HPI content:

- If the current problem is a direct extension of a previous ongoing active medical problem, the HPI has to begin with one or two summary sentence(s) of that ongoing medical problem. The following "key words“ should be used:
  - Date of diagnosis?
  - How was diagnosis made?
  - Current symptoms and treatment?
  - Are there any complications?
  - Is there any objective measurement of the chronic problem? (e.g. a1c for diabetes)

HPI content:

- "Negative" statements – include 3 categories of findings that, although being *absent*, are important to mention:
  - Constitutional complaints (fevers, sweats, weight change)
  - Symptoms relevant to organ symptom.
  - Important risk factors (ask to yourself the question "what could my patient have been exposed to cause this problem?")
- Prior workup to date (e.g. if the patient is transferred from another center), and status on transfer.

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Other active medical problems, medications, habits, and allergies

- Content
  - Brief summary of other active medical problems mentioned in your identifying information sentence
  - Medication

- Example (patient suspicious of oral cancer)
  - His other problems include a 10-yeared history of diabetes mellitus, without retinopathy, neuropathy or nephropathy. The A1c 6 months ago was of 6.8. His current medications include hs NPH insulin, glyburide, isordil, aspirin, metoprolol, lisinopril, and simvastatin. He does not drink alcohol and has no allergies either.

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Physical examination

- Content
  - Begin with a general description.
  - Include all abnormal findings.
  - Among normal findings, include only those essential to the understanding of the chief complaint.

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 36,2°C and oxygen saturation is 98% .There were no adenopaties on the neck region.

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Complementary tests

- Laboratory.
- Biopsy, if necessary.
- Rx.
- TC.
- Others. (MNR, Doppler, etc)

Content

- Include all abnormal dates, compared to previous value.
- Among normal results, includes only those relevant to the chief complaint

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Assessment and Treatment Plan

- Content
  - Begin with a positive statement of the patient's problem which can be a symptom, a sign, an abnormal complementary test, or a diagnosis.
  - Ask to yourself while you are presenting the case “What is the principal unresolved issue?"
    - Diagnosis.
    - Treatment.

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Differential Diagnosis

- If the principal unresolved issue is the diagnosis, your assessment should focus on a differential diagnosis:
  - List the 3-5 most likely diagnoses.
  - State which diagnosis is most likely and why.
  - State why other diagnostic possibilities are less likely (draw your evidence)
- Show the references used (1-3).

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Treatment ellection:

- If the principal unresolved issue is the treatment, your assessment will depend on:
  - The situation of the diagnosis or problem.
  - The therapy you give or plan to give, and why have you taken this decision.
  - The complications you might anticipate.

- Show the references used (1-3)

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Treatment:

- Treatment protocol:
  - Laser chosen.

Treatment:

- Brief description of the Laser used.
- Emission parameters:
  - CW:
    - Power, Density Power, Time of treatment.
  - Pulsed Lasers:
    - Power/Frequency, Energy per pulse, Density Energy per pulse, Time of treatment.
  - Fiber:
    - Diameter.
    - Initiated?

Infography:

- Before the treatment.
- During the treatment.
- Immediate post-op.
- Follow-up:
  - Depending of the case.
  - Histopathological study.

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Discussion:

- Is the most important part of the clinical case presentation.
- The student must show his knowledge about the pathology being presented.
- Has to show references for each discussion topic.

Conclusion

- The student must conclude the presentation with one sentence, in which he/she should justify the laser used compared to others treatments.
- Is not necessary to give conclusions.


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