CLINICAL STATEMENTS AND DIFFERENTIAL DIAGNOSIS TABLES

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CLINICAL DESCRIPTION OF THE PROBLEM

- Why? This is what master clinicians build a differential diagnosis from.
- Focuses on most serious problem
- Descriptive and concise—should be 2-3 sentences at most
- Uses medical terminology
- Includes significant past medical history-related to the most serious problem
- Includes significant abnormalities in history, physical, labs/studies-related to the most serious problem
- Where? After the PE/labs/studies and before your assessment and plan
- DOES NOT GIVE A DIAGNOSIS

A SUMMARY STATEMENT SHOULD:

- Include accurate information and not include misleading information
- Facilitate understanding of the primary problem and appropriately narrow the differential ddx through inclusion of pertinent key features
- Express key findings in qualified medical terminology; synthesize details into unifying medical concepts
- Use qualitative terms that are more abstract than patient's signs: example acute vs chronic
- From AQUIFER INTERNAL MEDICINE

50 Y.O. FEMALE WITH ACUTE RENAL FAILURE

What do you think about this clinical description/summary?

What is your differential for this?

DIFFERENTIAL DIAGNOSIS OF 50 Y.O. FEMALE WITH ACUTE RENAL FAILURE

Prerenal

Renal

Post renal

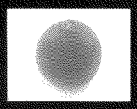
56 Y.O. FEMALE WITH F/C/WT LOSS/HEMOPTYSIS W ARF CR 3 AND UA WITH BLOOD AND PROTEIN

- What do you think about this clinical description/summary?
- What is your differential diagnosis of acute renal failure now?

CLINICAL DESCRIPTION-COMPARE APPLES TO APPLES!

50 y.o. female with Acute Renal Failure

Prerenal

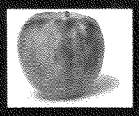


Renal

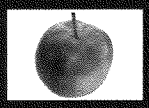
Post renal

56 y.o. female with f/c/wt loss/hemoptysis w ARF Cr 3 and UA with blood and protein

Granulomatosis with Polyangiitis



Microscopic polyangiitis



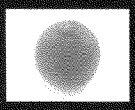
Anti GBM

CLINICAL DESCRIPTION-COMPARE APPLES TO APPLES!

50 y.o. female with arthritis

gout

RA



OA

50y.o. female with acute monoarticular arthritis

gout

pseudogout

Septic arthiritis

TAKE 5 MINUTES----PRACTICE FORMULATING A CLINICAL DESCRIPTION/SUMMARY STATEMENT & 4 DIAGNOSIS DDX (ACS, MI, ANY ISCHEMIA COUNTS AS ONE DX)

CC: My chest hurts and I can't breathe

HPI/ROS: 75 year old male with chest pain and sob that started last night. Pain over the front of his chest. This is the first time this has happened. Pain described as pressure, 7/10. Nothing makes it better, worse with walking. SOB since this started, no nausea, no radiation. No cough, no fever, no hemoptysis, no recent travel/immobilization.

All: none PMH: DM, HTN

Meds: glyburide 5 mg daily, lisinopril 10mg daily, asa 81 mg daily

Social: retired teacher, lives alone, smoker, no alcohol

PE: BP 180/100, HR 104, RR 24, sat 89% RA, T 37.5C

Well nourished, uncomfortable, tachypneic, speaking in full sentences.

Heart: RRR, no murmurs or rubs. Lungs: no rales, no rhonchi Abd: BS+, soft, nt,nd

Labs: cbc normal, BMP normal except for glucose of 140. Troponin 0.2. EKG: NSR, no ST elevation

No idea where to start? Underline/highlight the most important information

PRACTICE FORMULATING A CLINICAL DESCRIPTION/SUMMARY STATEMENT

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CLINICAL DESCRIPTION

75 year old male with hx of DM, HTN, tobacco use with acute onset of diffuse CP worse with exertion. He is hypertensive, tachycardiac, hypoxic with mildly elevated troponin and EKG showing sinus tachycardia but no ST elevation.

FORMULATE A DIFFERENTIAL DIAGNOSIS

- Have at leave 4 diagnoses
- Each diagnosis must explain everything in your illness statement
- Remember to compare apples to apples
- If you have conclusively ruled something out already, it is probably not an apple

FOR EACH DIAGNOSIS CREATE AN ILLNESS SCRIPT

- Typical risk factors and symptoms of the illness
- Typical physical findings of the illness
- Typical lab/study abnormalities
- Typical treatments

THE WORKING DIAGNOSIS

- The most likely diagnosis
- Make a commitment
- Can't treat if you can't diagnose
- In your assessment tell why you have chosen this diagnosis (compare and contrast to your other diagnoses on your differential)

Decide on a working diagnosis

75 year old male with hx of DM, HTN, tobacco use with acute onset of diffuse CP worse with exertion. He is hypertensive, tachycardiac, hypoxic with mildly elevated troponin and EKG showing sinus tachycardia but no ST elevation.

Decide on a working diagnosis- what you think the patient has. No idea? Circle/highlight what symptoms/physical exam findings etc your patient has in the table to help.

	ACS	PE	Dissection	Pericarditis
Hx	substernal CP, pressure, tightness, SOB, nausea, diaphoresis, radiation to neck/arm, inc w exertion, RF dm, tobacco, HTN	sudden onset , SOB, may have CP, hemoptysis, leg swelling, LOC if massive RF immobilization, active cancer, prior clots	CP sudden onset, sharp more often than tearing, ant CP more common than back pain. RF: cocaine, preexist aortic aneurysm, vasculitis, collagen disorder	CP often sudden onset, sharp, pleuritic, dec with sitting up and leaning forward, can be dull and rad to shoulders
PE	uncomfortable, diaphoretic, altered mental status, LOC, possible rales, S3	Tachycardic, hypoxic, may have signs of associated DVT	pulse deficit, BP difference >20 mmHg between arms	pericardial friction rub, can be febrile, could have pericardial effusion
Labs/studies	ECG: may or may not have ST elevation, new LBBB, troponin may be elevated	ECG: sinus tach most common, can have S1Q3T3, troponin may be elevated. Echo can show right heart strain, VQ scan if contraindication to contrast, CT angio	CXR mediastinal and/or aortic widening, CT angio or TEE.	ECG: widespread ST elevation, or PR depression-atypical ECG in 40%. Inc trop in 32% (myopericarditis), inc WBC, inc ESR/CRP
Treatment	ASA, O2, nitrate, morphine, plavix , therapeutic anticoagulation heparin/enoxaparin, cath if STEMI or NSTEMI and unstable.	therapeutic anticoagulation with heparin product, lytics if refractory hypotension	blood pressure management-IV beta blocker drip and nitroprusside if bp not controlled, type A surgery, type B medical	nsaids, cholchicine, steroids

Use the table to help you organize the H&P

This information is what goes into your HPI-this is your HPI focus in an oral presentation

If it doesn't fit here, it belongs in your ROS

This is the most important part of your physical exam- your PE in an oral presentation

Anything you circled is a **pertinent positive**, what isn't circled is a **pertinent negative**.

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Increasing Complexity

Read horizontally-a little bit about each diagnosis in your differential

Read vertically-in depth about the working diagnosis

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CLINICAL ILLNESS SUMMARY AND DDX WORKSHEET REQUIREMENTS

- Complete one a week during weeks 1-3—due Fridays by 8 am
- Use for a H&P, new or worsening problem on existing patient, cross cover encounter.
- Attach H&P or cross cover note to worksheet; do not deidentify H&P, PN or X cover note, no patient name on worksheet
- This should be YOUR note, submit the version not edited by resident
- Make sure you have the illness summary somewhere on the DDX/illness script form (ok it is it on the back)
- Complete DDX table using ONLY blue or black ink
- Turn in paper version in Internal Medicine Department
- Electronic submission discouraged unless instructed by Dr. Novoa (see specifics in your BUMCP orientation handout)

GOALS OF THE CLINICAL ILLNESS STATEMENT/DDX EXERCISE

- Help you communicate more effectively with master clinicians
- Expand the number of illness scripts in your library
  - Coming up with differentials is hard (getting #3 and #4 'all apples' is honors)
  - Can search google (example stroke mimics) or look at ddx listed for your working dx in UTD or a medicine textbook
  - Will help you become a master clinician more quickly, no matter your chosen field
- Shelf/step study tool
- Dr. Novoa will meet with you several times during the block to give you feedback

FAQS

HOW DO I SELECT WHICH PATIENT TO WRITE UP

- Do not submit repeat of the class exercise DDX
- Chose something that is 'bread and butter medicine'
- Chose symptoms or problems that will be on the shelf or step exam!

I HAVE HAD A COUPLE OF PATIENTS WITH THE SAME CHIEF COMPLAINT, CAN DO THIS ON SOMETHING ELSE?

- YES
- What will you choose?
- Can select another problem the patient has and do that even though it may not be problem #1 on the problem list
- Be sure to write me a brief note on what you chose to do this and what you want to focus your ddx on (eg dyspnea failing to improve in pt with COPD or evaluation of microytic anemia, etc)

HOW MUCH INFORMATION DO I PUT INTO THE ILLNESS STATEMENT?

- How much information you put in (results of various tests) will clearly form the differential diagnosis
- DDX has to explain everything in your illness statement
- The more information you put in, the more advanced the ddx becomes (example renal failure and the fruit basket to systemic vasculitis with pulmonary and renal manifestations being all apples)
- YOU DECIDE how much you will put in….but if you decide to leave things out (lab test, radiologic findings), write me a note why you did that and what you want your ddx to focus on

HOW MUCH DETAIL DO I PUT INTO THE ILLNESS SCRIPTS PARTICULARLY DIAGNOSTIC TESTS AND TREATMENTS

- Think of this as a board study tool or a teach stool if you were to be teaching upcoming medical students
- Definitely want to focus on things that 'nail' the diagnosis—you'll be given test questions where they will expect you to make the diagnosis based on the diagnostic results they give you but they won't give you the actual diagnosis and then expect you to make a treatment decision
- Start working on management now, if you want honors in your sub I, you have to be managing. Be specific about what type of antibiotics, don't just list antibiotics (eg abx for CAP vs HAP are different)