Focus
Association for Clinical Biochemistry and Laboratory Medicine
National Meeting

CLINICAL CASE PRESENTATION – GUIDELINES

'He who studies medicine without books sails an uncharted sea, but he who studies medicine without patients does not go to sea at all'
William Osler - the Father of Modern Medicine

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Confidentiality

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

Your Abstract title must not have more than 20 words and the actual Abstract text should not be more than 300 words.

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 his/her own differential diagnosis as the story unfolds.
You should consider yourself an advocate who is attempting to persuade an informed, interested judge 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 Proprietary names only

Allergies

Family history

Including coronary heart disease, diabetes and anything relevant to the presenting complaint

Social history

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, e.g. 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

Including 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

Further investigations

Final diagnosis

Progress and management

Key features of final diagnosis, such as pathophysiology and clinical features where relevant

Learning and other key points

References where relevant

Final section - 'Points to remember'