POMR - 如何建立問題清單

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Case #1

a 56 y/o man, with nausea, vomiting for a few hours

- C.C.: nausea and vomiting on this morning
- P.I.:

This 56 y/o man, has been smoked 30-pack-years, presents to ER with nausea and vomiting since this morning. He is a taxi driver and eats out a lot but denies having any uncooked food recently.

He had been well until this morning, when he experienced nausea and vomiting with small amount of acid vomitus. He also reports a few times of small amount of yellowish, loose diarrhea. At the same time, he also had epigastric abdominal pain which is described as dull, non-radiating, and persistent.

Case #1

He denies contact of ill person, recent travel history, nor clustering of similar symptoms among the people he contacted.

The patient presented to ER, with vitals were TPR 35.9/48/18, BP 87/47. On physical exams, auscultation revealed clear breath sound and regular heart beats with no audible murmur, no abdominal tenderness, no mass palpable and normoactive bowel sound.

After 500 ml of N/S challenge, his BP was 117/65. The patient's last time of diarrhea was about three hours ago, but his epigastric dull pain persisted. He was hence admitted to the ward.

Case #1
Preliminary labs – BUS routine

Blood	
Hb	**14.1**
WBC	13,200
Neut	83
Eos	2
Mono	3
Lymph	12
Platelet	177X 10^3

Stool	
OB	**Negative**
Mucus	Negative

Urine	
Sp. Gravity	**1.030**
pH	5.5
Protein	-
Ketone	-
Nitrite	-
Glucose	-
Sediment	
RBC	0
WBC	0
Epith	3

Case #1
Preliminary labs - radiology

- Plain abdomen:
  - shows the bowel gas is unremarkable, there is no suspicious calicification seen.
  - Imp : No significant abnormality seen.

- Chest PA:
  - Chest PA view shows normal mediastinum and heart size, the lung markings in bilateral lung fields are mild increased, please correlate clinically. There is no parenchymal lesion seen.
  - Imp: Mild increased lung markings in bilateral lung fields, please correlate clinically.

Case #1
What's your problem list?

Case #1
Please list the problems:

Problem No.	Problem name	Onset date	Resolved date	Comment
#1.				
#2.				
#3.				
#4.				
#5.				
#6.				
…				

Case #1
Problem list?

#1. Acute gastroenteritis

#2. Leukocytosis

#3. Smoking history

OR

#1. Nausea/vomiting

#2. Diarrhea

#3. Hypotension

#4. Bradycardia

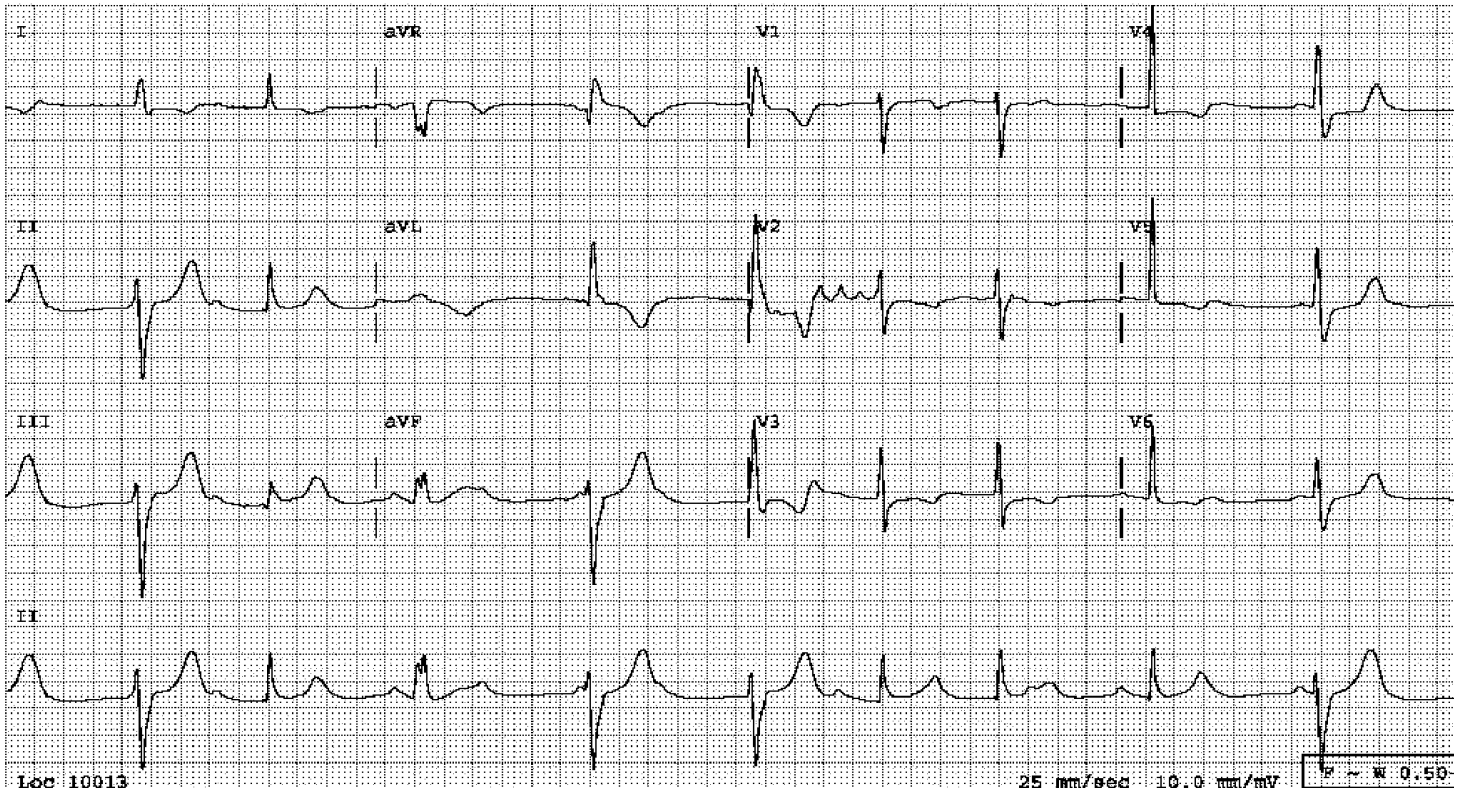
#5. Smoking history

Case #1
Biochemistry – day 1

【SERUM】

BIO comment: Recheck

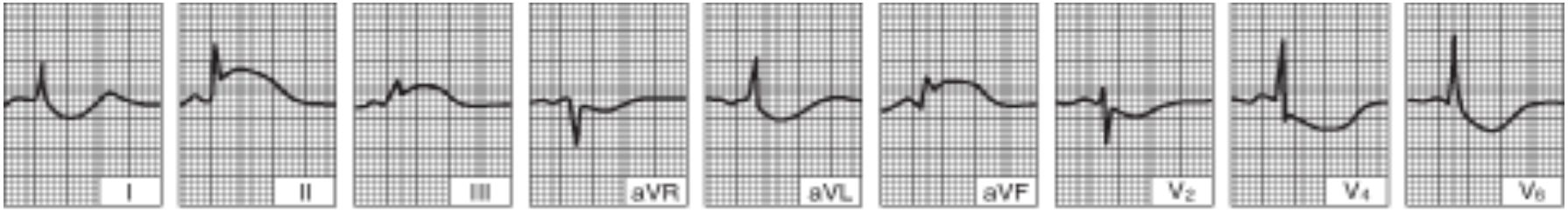
Glucose AC	H 172	mg/dL	70 - 99
AST(GOT)	H 125	IU/L	15 - 41
CK	HH 666	IU/L	38 - 397
Stat CRP	H 1.21	mg/dL	<0.80
Amylase	L 22	U/L	36 - 128
BUN	H 33	mg/dL	8 - 20
Creatinine	H 2.4	mg/dL	0.4 - 1.2
GFR			
Age	56	y/o	
Estimated GFR(MDRD)	28.1	mL/min	
公式=175*Scr^-1.154*Age^-0.203*0.742(if female)			
Potassium	3.8	mEq/L	3.5 - 5.1
Sodium	143	mEq/L	136 - 144
CKMB	HH 75.4	U/L	2.0 - 14.0
Troponin-I	HH 15.51	ng/mL	AMI Cutoff: <0.5 ng/mL
			URL(Upper reference limit): 0.04 ng/mL



EKG on admission

- Complete AV block with ventricular escape rhythm
- Hyperacute T and ST elevation in II, III, aVF with reciprocal change
- Inferior wall myocardial infarction

EKG – acute inferior wall MI



Acute inferior (diaphragmatic) left ventricular infarction (tracing obtained within a few hours of onset of illness).

There is hyperacute ST-segment elevation in leads II, III, and aVF and reciprocal depression in other leads.

Case #1 Biochemistry – day 2

【SERUM】

Glucose AC	H 120	mg/dL	70 -	99
A/G Ratio	2.0		1.1 -	2.0
Protein	L 5.4	g/dL	6.1 -	7.9
Albumin	3.6	g/dL	3.5 -	5.0
Direct Bilirubin	0.2	mg/dL	0.1 -	0.5
Total Bilirubin	1.0	mg/dL	0.3 -	1.2
ALK-Phosphatase	86	IU/L	38 -	126
AST(GOT)	H 243	IU/L	15 -	41
ALT(GPT)	H 63	IU/L	14 -	40
CK	HH 1111	IU/L	38 -	397
Total Cholesterol	137	mg/dL	130 -	200
Triglyceride	73	mg/dL	35 -	150
Uric Acid	7.4	mg/dL	4.4 -	7.6
BUN	H 21	mg/dL	8 -	20
Creatinine	1.0	mg/dL	0.4 -	1.2
GFR				
Age	56	y/o		
Estimated GFR(MDRD)	77.3	mL/min		
公式=175*Scr^-1.154*Age^-0.203*0.742(if female)				
Potassium	3.6	mEq/L	3.5 -	5.1
Sodium	142	mEq/L	136 -	144
Chloride	110	mEq/L	101 -	111
CKMB	HH 91.9	U/L	2.0 -	14.0
HbA1c	5.4	%	4.0 -	6.0

Case #1
Update the problem list

#1. Acute gastroenteritis

#2. Leukocytosis

#3. Smoking history

OR

#1. Nausea/vomiting

#2. Diarrhea

#3. Hypotension

#4. Bradycardia

#5. Smoking history

Case #1
Update the problem list

#1. Nausea/vomiting

#2. Diarrhea

#3. Hypotension

#4. Bradycardia

#5. Smoking history

#1. Nausea/vomiting -> AMI, STEMI, inf wall, with RCA total occlusion; with complete AV block

#2. Diarrhea -> resolved

#3. Hypotension -> resolved as #1.

#4. Bradycardia -> resolved as #1.

#5. Smoking history

#6. Hyperglycemia -> resolved

#7. Impaired renal function -> resolved

Case #1
Final diagnosis

- Acute ST elevation myocardial infarction (STEMI), Killip IV, inferior wall, RCA total occlusion, with RV infarction, s/p PTCA and stenting

Case #1 Discussions

- List all problems including symptoms/signs which are not well explained by current problem list
  - In this case, hypotension & bradycardia
- List disease risk factor – smoking history
- Integrate symptoms/signs to higher level of diagnosis as clarified
  - #1. Nausea/vomiting -> AMI, SETMI, inf wall, with RCA total occlusion; with complete AV block
  - #3. Hypotension -> resolved as #1.
  - #4. Bradycardia -> resolved as #1.

Case #2

A 65 y/o man, presents with melena since last night

Date of admission: 2011-06-01

- C.C.: melena for 3 times since last night
- P.I.:

  This 65 y/o man, has smoked 1.5 PPD for 40 years, was brought to ER due to melena for 3 times since last night.

  He has 10-year-history of hypertension, 3-year-history of type II DM and hyperlipidemia. He experienced episode of substernal chest pain on exertion one year earlier, which was diagnosed as ischemic heart disease and has been on aspirin therapy since then. The hypertension and DM are under good control with HbA1C at 6.9% checked in last month.

Case #2
Present illness

- He had been well until one week ago, when he began to have acid regurgitation and hunger epigastralgia which were relieved by antacids.
- Last night, he noticed 3 times of melena, associated with dizziness and nausea, but there was no vomiting or abdominal pain. He denies of chest pain, shortness of breath, weight loss, or decreased appetite recently.
- He was brought to the ER by his family. The vitals were TPR 37.4/96/20, BP 132/78. The PEs at ER were unremarkable except for pale conjunctivae. Upper GI endoscopy reveals an active gastric ulcer (A1).

Case #2
Preliminary labs – BUS routine

Blood	
Hb	**7.8**
Ht	24.0
WBC	10,400
Neut	78
Eos	1
Mono	3
Lymph	18
Platelet	243X 10^3

Occult blood	
Stool	**4+**
Gastric juice	3+

Urine	
Sp. Gravity	**1.030**
pH	6.5
Protein	-
Ketone	-
Nitrite	-
Glucose	-
Sediment	
RBC	1
WBC	3
Epith	6

Case #2
Please list the problems:

Problem No.	Problem name	Onset date	Resolved date	Comment
#1.				
#2.				
#3.				
#4.				
#5.				
#6.				
…				

Case #2
Please list the problems:

Problem No.	Problem name	Onset date	Resolved date	Comment
#1.	GU with bleeding	2011-06-01		
#2.	Hypertension	2011-06-01		
#3.	Type II DM	2011-06-01		
#4.	Hyperlipidemia	2011-06-01		
#5.	Ischemic heart disease	2011-06-01		
#6.	???			
…				

Case #2
Please list the problems:

Problem No.	Problem name	Onset date	Resolved date	Comment
#1.	GU with bleeding	2011-06-01		
#2.	Hypertension	10 years ago		
#3.	Type II DM	3 years ago		
#4.	Hyperlipidemia	3 years ago		
#5.	Ischemic heart disease	One year ago		
#6.	Smoking history	40 years		60 pack-year
…				

Case #2
Hospital course

- On admission, he was put on NPO except medications. Intravenous fluid supplement and IV PPI were administered. Two units of packed red cell was transfused, and the rechecked Hb was 10.0 gm/dL on the next day. The BP and blood sugar by surestep are under satisfactory control.
- The stool color became yellowish and he was on soft diet on the 3rd hospital day.
- He asked for discharge on the 3rd hospital day. But the ward doctor found the report of admission chest film showed abnormal findings …

Case #2
Preliminary labs - radiology

- Plain abdomen
  - There was no abnormal bowel gas or density.
  - Imp : No significant abnormality seen.
- Chest PA:
  - Borderline cardiomegaly in configuration.
  - Several nodular lesions up to 1.2 cm in size, involving bilateral hemilungs indicate metastases. Please correlate clinically.

Case #2
Updated problem list …

Problem No.	Problem name	Onset date	Resolved date	Comment
#1.	GU with bleeding	2011-06-01		
#2.	Hypertension	10 years ago	2011-06-04	
#3.	Type II DM	3 years ago	2011-06-04	
#4.	Hyperlipidemia	3 years ago		
#5.	Ischemic heart disease	One year ago		
#6.	Smoking history	40 years		60 pack-year
#7.	Suspect metastatic lung cancer	2011-06-04		

Case #2
Updated problem list …

Problem No.	Problem name	Onset date	Resolved date	Comment
#1.	GU with bleeding	2011-06-01		
#2.	Hypertension	10 years ago	~~2011-06-04~~	
#3.	Type II DM	3 years ago	~~2011-06-04~~	
#4.	Hyperlipidemia	3 years ago		
#5.	Ischemic heart disease	One year ago		
#6.	Smoking history	40 years		60 pack-year
#7.	Multiple lung nodules	2011-06-04		

Case #2
Further studies -

- CEA: 15.6
- Abdominal sonography: multiple tumors scattered in both lobes of liver, favor of metastatic tumors to the liver
- Colonfiberscopy:
  - A tumor found in the ascending colon, biopsy was taken
  - Pathology: adenocarcinoma
- Abdominal CT: multiple liver metastasis

Case #2
Updated problem list …

Problem No.	Problem name	Onset date	Resolved date	Comment
#1.	GU with bleeding	2011-06-01		
#2.	Hypertension	10 years ago		
#3.	Type II DM	3 years ago		
#4.	Hyperlipidemia	3 years ago		
#5.	Ischemic heart disease	One year ago		
#6.	Smoking history	40 years		60 pack-year
#7.	Multiple lung nodules →ascending colon adenoCa with lung & liver mets	2011-06-04		

Case #2 Discussions

- Causally organized problem list
  - In this case, GU with bleeding
- Problem onset date ≠ date of admission
- Active problems vs. Inactive problems
  - Type II DM and hypertension are Active problems
- Avoid diagnostic guesses in the problem list
  - Suspect metastatic lung cancer ➔ multiple lung nodules
- Update problem name by ➔+ new problem name
  - Multiple lung nodules ➔ascending colon adenoCa with lung & liver mets

Checklist for POMR record

1. 是否有問題一覽表
2. 問題發生日期是否正確被紀錄
3. 問題序號與問題名稱是否前後一致
4. 當症狀、檢查、檢驗等問題進一步釐清診斷時，問題清單是否適時更新
5. 個別問題是否分開記錄（每個問題個別記錄**SOAP**）
6. 問題名稱與**SOAP**內容是否相符
7. **(A)ssessment** 需針對 **(S)ubjective/(O)bjective findings** 予以評估
8. **(P)lan** 需針對問題擬出適切治療計畫，達成診斷及實施處置之合理思考邏輯
9. 無變化問題不須列出（不要**copy-paste**無變化之問題）
10. 正確區分活動性問題與非活動性問題

馬偕紀念醫院 一般醫學內科訓練示範病房(13C)
住院 POMR 病歷審查表

床號：_____ 病患姓名：_____ 病歷號碼：_____ 入院日期：_____

科別：_____ 主治醫師：_____ 審查醫師：_____ 審查日期：_____

一、問題一覽表：

	劣	可	中	良	優
評分	1	2	3	4	5
1. 所有異常資料是否都被標示於問題中？					
2. 問題清單是否不包括猜測、印象、排除的成分在內？					
3. 問題發生日期是否正確被紀錄？					
4. 當症狀、檢查、檢驗等問題進一步釐清為診斷時，問題清單是否適時更新？					
5. 新問題產生時，問題清單是否適時更新？					
6. 對於已解決問題，是否予以標示，並於備註欄中說明？					

二、病程記錄：

	劣	可	中	良	優
評分	1	2	3	4	5
1. 問題序號與問題名稱是否前後一致？					
2. 個別問題是否分開記錄 SOAP？					
3. 每筆 progress note 是否與問題清單適當連結？					
4. SOAP記錄實質內容是否與問題名稱相符？					
5. Assessment 是否有對 Subjective、Objective 內容加以評析、判讀？					
6. Assessment 是否有記錄病程之變化，或疾病之鑑別診斷？					
7. Plan 是否包括診斷、治療、衛教三大項？					
8. 是否未 copy-paste 未變化之問題？					

整體評量: □優良病歷； □尚可； □不良病歷

需特別注意改正之處：_____

總　分：_____ 評分者：_____

Any Questions or Comments