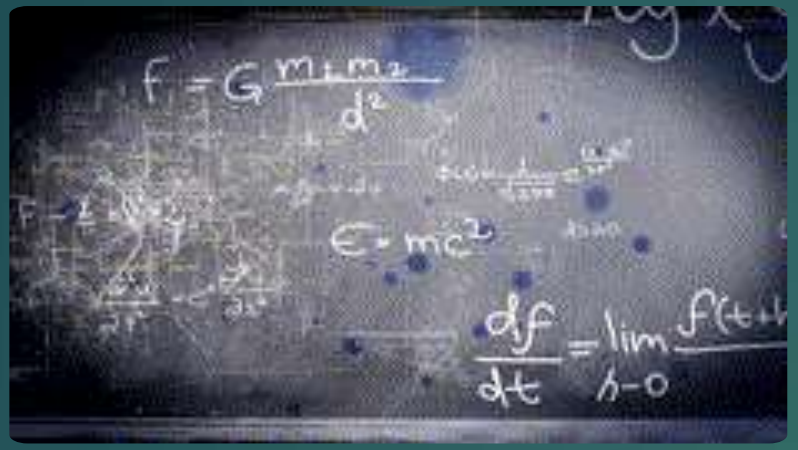
住院病摘



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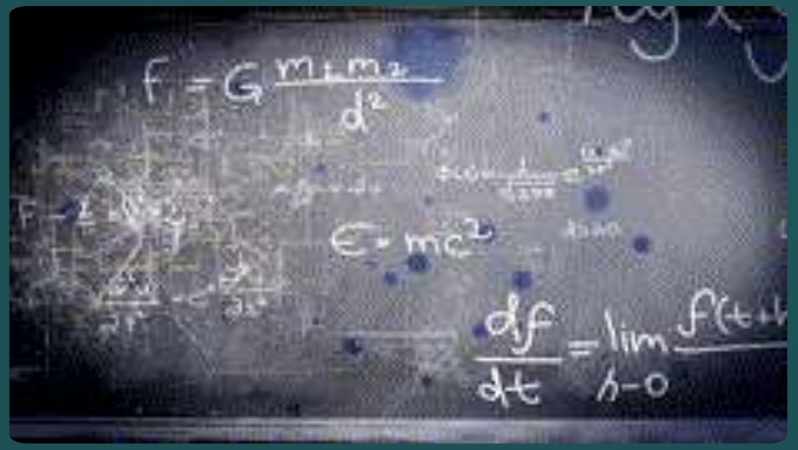
The Medical History

STRUCTURE AND PRINCIPLES



Oral Presentations vs. Written Notes

- Similarities
  - Overall format is identical (i.e. "CC, HPI, PMH, meds, etc…")
- Differences
  - Oral Presentation
    - Rapid communication
    - Real-time decision making
    - Avoid excessive detail
  - Written Note
    - Detailed reference
    - Legal document
    - Comprehensive

入院病摘 – overview of the structure

Reporting section

- History
  - Source of information
  - Chief complaint
  - Present illness
  - Family history
  - Social history
  - Personal health habit
  - Past medical history
  - Review of systems
- Physical examination
- Initial laboratory data

Interpretation section

- Problem list
  - Assessment
    - Differential diagnosis
  - Plan
    - Diagnostic plan
    - Therapeutic plan
    - Educational plan

Source of Information

- Should include the source, and its perceived reliability
- Examples
  - Source is the patient, who appears reliable
  - Source is the patient's spouse, who appears reliable
  - Source is the patient, who appears unreliable, secondary to apparent alcohol intoxication
  - Source is the medical chart, as the patient is unconscious, and no family or friends are immediately available to provide information

主訴 Chief complaint

- 病人最主要之症狀或徵兆
- 一定要註明發病期間
- 儘可能引用病人的表達此次求診的直接原因及自覺症狀
- 以片語表示，並說明發生時間及頻率。避免使用完整句子來描述
  - 例如: Cough with copious yellowish sputum for 5 days (NOT: He has suffered from cough for 5 days.)
- 儘量引用病人的話或較接近事實的字句。避免使用醫學專有名詞
  - 例如: Shortness of breath (NOT: dyspnea); Swelling of the legs (NOT: edema of the lower extremities)
- 不應記述診斷名稱或疾病的本質
  - 例如: Pneumonia told by the local hospital
  - 應為：cough and fever for 5 days

主訴 Chief complaint

Age and gender + Highly relevant PMH + Primary symptoms + Duration

Ms. Chang is a 75 y/o man with diabetes and hypertension, who presents with right arm weakness and difficulty speaking for 2 hours.

Age and gender + Highly relevant PMH + Primary symptoms + Duration

ID

CC

ID: Ms. Chang is a 75 y/o man with diabetes and hypertension.
CC: right arm weakness and difficulty speaking for 2 hours

主訴 Chief complaint

Original chief complaint	Error	Revised chief complaint
Mr. Wang is a 65 y/o man with diabetes, presenting with a heart attack.	Includes the presumed diagnosis	Mr. Wang is a 65 y/o man with diabetes, presenting with chest pain for 3 hours.
Miss Lee is a 14 y/o girl, presenting with diarrhea for 1 week and hypokalemia	Includes a lab result that was presumably not known at the time of the patient's arrival.	Miss Lee is a 14 y/o girl, presenting with diarrhea for one week.
Mr. Kuo is a 58 y/o man with peptic ulcer disease, presenting with an acute abdomen.	Includes an interpretation of the exam rather than the patient's presenting symptom.	Mr. Kuo is a 58 y/o man with peptic ulcer disease, presenting with severe epigastric pain for 45 minutes.
Cough and fever	Provides no context for symptoms.	Ms. Chen is a 90 y/o woman with dementia, sent from her nursing home for cough and fever for 2 hours.

主訴 Chief complaint

有誤或不宜的敘述	修正
Pneumothorax one hour before admission	Chest pain one hour before (或prior to) admission
Angina for 2 hours	Precordial pain for 2 hours
Peptic ulcer for one month	Intermittent abdominal pain for one month
Myocardial infarction 2 hours ago	Sudden onset of excruciating precordial pain 2 hours ago
GI bleeding over the past two days	Tarry stool over the past two days
Scarlet fever today	Sudden onset of high fever today

主訴 Chief complaint

- 病人是要來作檢查或治療，並無任何不適，這時候不能寫主訴為
  - for abdominal CT scan
  - for renal biopsy
  - for chemotherapy
- 應寫**為什麼要做檢查或治療**，故於上述三種主訴後，分別加上
  - A hepatic mass found in an echo study two weeks ago
  - Proteinuria for one year
  - Lung cancer diagnosed two weeks ago

主訴 Chief complaint

有誤或不宜的敘述	修正
For abdominal CT scan	For abdominal CT scan: A hepatic mass found in an echo study two weeks ago
For renal biopsy	For renal biopsy: Proteinuria for one year
For chemotherapy	Lung cancer diagnosed two weeks ago, for chemotherapy

現病史
History of present illness (HPI)

- The HPI is like telling a story
- Chronology is extremely important
- It should include key events, and only relevant information
- Symptoms should be described with semantic qualifiers.
  - (e.g. location, onset, duration, severity, quality, context, etc..)
- It should include positive &"pertinent negative" findings
- At the end, one should describe the patient's perception of illness

The History of present illness (HPI) - variation

Listing the HPI as a series of dates and events, rather than prose

- 10 days prior to admission (PTA) – patient noted increased swelling in both feet.
- 7 days PTA – Patient's swelling extended to knees bilaterally. Seen in urgent care clinic, where he was prescribed furosemide 20 mg daily for "edema".
- 3 days PTA – Unable to sleep in bed due to SOB while lying down. Patient increases furosemide to 20 mg 2x/daily on his own.
- 1-2 days PTA – SOB progressively worsening, most predominantly while lying down or with exertion. No longer able to walk up a flight of stairs without resting halfway.
- 3 hours PTA – Patient noted SOB while sitting at rest. Took an extra dose of furosemide, without benefit.

The Past Medical History (PMH or PH)

- Present or write the PMH as a list, rather than prose
- Provide details of each item in proportion to relevance to CC/HPI
- State chronic disease markers when relevant
  - Baseline weight in CHF, ESRD
  - Typical outpatient BPs in hypertension
  - Last HbA1C in diabetes
  - Baseline creatinine level in chronic kidney disease

The Past Medical History (PMH)

- Medical
  - CAD (s/p MI 2010, PCI to LAD in 2012)
  - HTN (baseline SBPs 120s-140s)
- Surgical
  - s/p appendectomy ~ 1960
- OB/Gyn
  - G2P2
  - Post menopausal (2006)
- Psychiatric
  - Depression (no history of SI/SA or hospitalizations)

Medications

- Group meds by common indication
- Include over-the-counter meds and herbal/natural supplements
- Report patient adherence to meds
- Always use generic names of meds
  - Often the medication suffix will help identify the medication class:
    - …olol = a beta-blocker
    - …statin = an HMG CoA reductase inhibitor

Allergies / Adverse Drug Reactions

- Most "allergies" are not true allergies, but they should still be reported here
- It's the clinician's job to sort out adverse drug reactions (more common) from true type I hypersensitivity reactions (less common)

過敏史(allergy history)

- 應確實記錄於舊病歷、住院病歷、門診記錄、病人床頭卡，且告知病人
- Unknown drug → 試圖取得何種藥物
- NKA? (No known allergy)

- 於舊病歷首頁、住院病歷、門診記錄、病人床頭卡之過敏記錄不一致
- 院內已建置共通且一致的過敏註記電子醫令

Social History

- Social history is not limited to bad behaviors
  - (i.e. smoking, alcohol, drugs)
- Also includes: marital status, residential situation, occupation, diet, sexual history, animal exposures, travel history (if relevant)
- For smoking, alcohol, and drugs, always try to quantify:
  - How much?
  - How often?
  - For how long?
  - When was the last time?

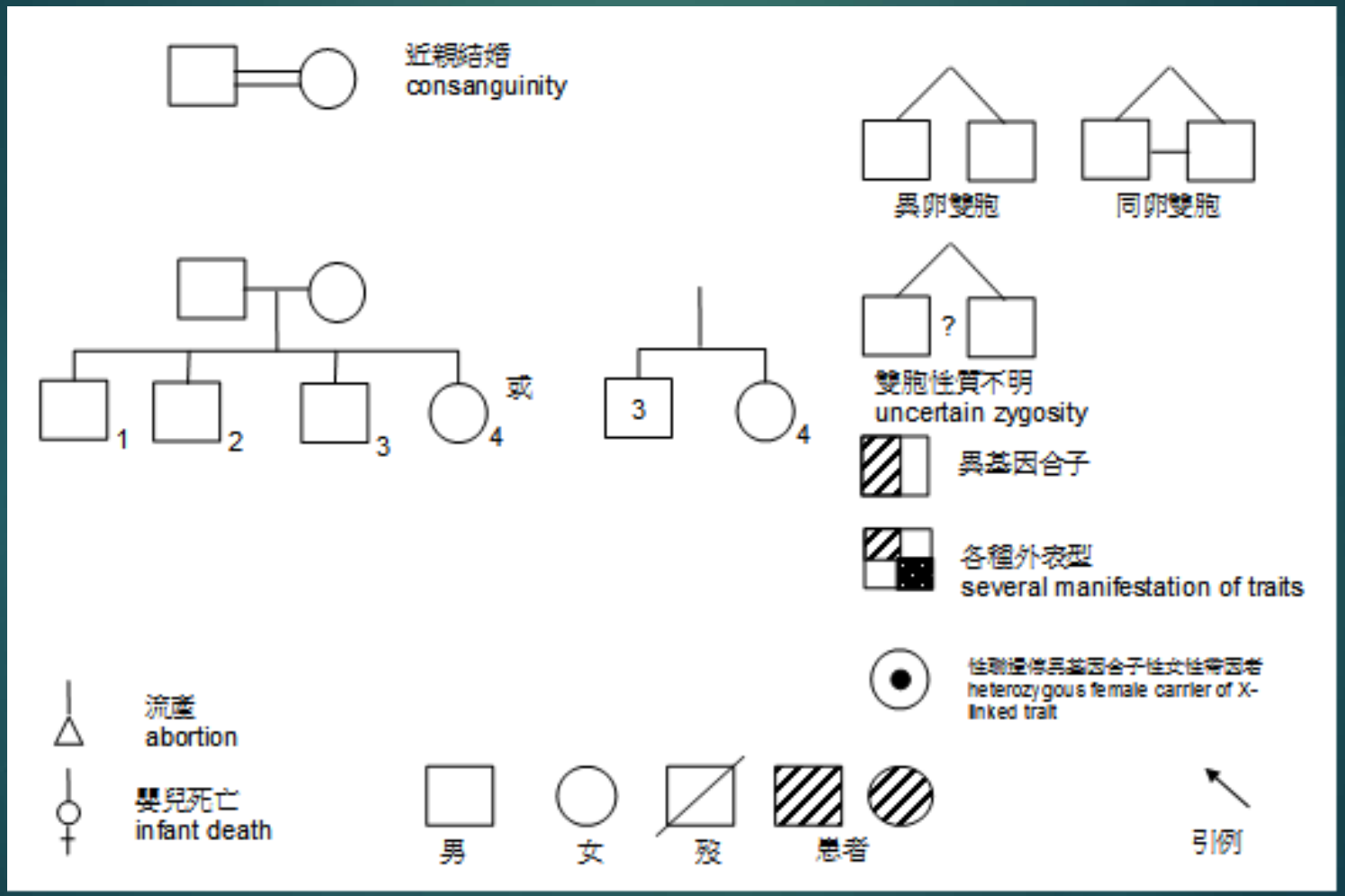
TOCC History

- 旅遊史的重要性
  - 全世界都在擔心communicable disease給禽流感、茲卡病毒感染等之發生
  - 好好問旅遊旅史、可能會早日發現，早日隔離
- 旅遊史要問出何處、何日、多久、作何活動、飲食如何、接觸過哪些人或動物或去過牧場等
- 要徹底地瞭解病人是在何種環境、為何生病、如何生病，以便擬定預防的對策
- 性行為是否妥當或安全
- 群聚：家庭、學校、安親班、工作場所、聚會等
- TOCC history is negative, or unremarkable

Family History

- Focus on 1st and 2nd degree relatives with diseases that are associated with established familial risk (e.g. cancer, cardiovascular disease, diabetes, psychiatric disease, substance abuse)
- For oral presentations, stating family history is "non-contributory" is often appropriate and usually preferred (if true!)
- For written notes, stating "non-contributory" is not acceptable !

Family Pedigree



系統回顧
Review of Systems

- 以系統性的方法去詢問病患來確定是否有其它需要進一步檢查或治療的症狀。
- 和客觀的身體檢查不同，是經由詢問患者來獲得資訊而不是經由你自己的觀察
- 偶爾你也可以在系統回顧中發現甚至比現在疾病還嚴重的問題
- 記錄方法：
  - 當肯定的症狀出現時則必須完整的描述之
  - 若此問題已在現在病史描述過，則寫see PI"或 "see PMH"(但必須確定患者在和PI 或PMH 無關的情況之下沒有類似的症狀)
  - 在填寫此表格時必須誠實，只在你有問過的症狀上做記錄。不實紀錄沒有問過的症狀可能對患者相當危險

身體診察
Physical examination, PE

- 紀錄應該以發現什麼來敘述，不要以正常(normal)，或是無特殊之處(unremarkable)來記錄
- 若有異常發現就寫出異常的敘述，而不是用診斷的名稱
  - 結膜是蒼白的，可能是貧血，但不要就寫anemic，寫pale就好
  - 鞏膜是黃的，不要寫 jaundice，要寫 icteric
- 需丈量時，使用公分，避免用egg-sized, palm-sized等！
- 每項都要詳細描述positive findings及pertinent negative findings
  - 有positive findings，則要作進一步相關檢查
- 以圖表示更好，但要精確！
- 使用適當醫學術語

Physical Exam

CC: 62 y/o woman, with active heroin use, presenting with fever and dyspnea x 4 hours.

General: She is mildly agitated and appears acutely unwell.

Vitals: T 39.4, HR 122, BP 102/76, RR 28, O_2 sat 91% on room air.

HEENT: Neck is supple, oropharynx clear and normal.

Lymph nodes: No cervical, axillary, or inguinal lymphadenopathy.

Pulm: Normal resonance to percussion, mod bibasilar crackles (R=L).

Cardiac: Regular tachycardia with hyperdynamic sounds. No S3 or S4. 2/6 systolic crescendo-decrescendo murmur at the RUSB and 3/6 decrescendo murmur at LLSB. PMI is normal. JVP is 5cm.

Abdomen: No scars, no distention; no tenderness, guarding, or rebound tenderness; normal bowel sounds with auscultation, no splenomegaly, liver span 6cm in the mid clavicular line by percussion, no shifting dullness.

Extremities: No peripheral edema. No clubbing, no splinter hemorrhages, Janeway lesions, or Osler nodes.

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Informs overall severity of illness.

Directly linked to CC/HPI

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Informs overall severity of illness.

Directly linked to CC/HPI

Quick ID of possible complications of 1° dx

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CC: 62 y/o woman, with active heroin use, presenting with fever and dyspnea x 4 hours.

Informs overall severity of illness.

Directly linked to CC/HPI

Quick ID of possible complications of 1° dx

Quick ID of important comorbid conditions

General: She is mildly agitated and appears acutely unwell.

Vitals: T 39.4, HR 122, BP 102/76, RR 28, O_2 sat 91% on room air.

HEENT: Neck is supple, oropharynx clear and normal.

Lymph nodes: No cervical, axillary, or inguinal lymphadenopathy.

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Labs / Diagnostics

- In the presentation, highlight only those results which are relevant to the HPI and/or assessment plan
- In the written note, list all recent results irrespective of immediate relevance
- Summarize diagnostic reports instead of either reciting, or copying and pasting the actual report
- Only binary tests should be reported as “positive” or “negative”

Assessment and Plan

- Should be organized as a prioritized problem list, and not as a list of organ system
- Each problem that is new or directly related to the HPI should have a differential diagnosis, which should include:
  - A discussion and/or list of key features which argue for or against each item on the differential diagnosis
  - A commitment to one diagnosis as the most likely (a.k.a. the "provisional diagnosis"), unless no single diagnosis stands out

Assessment and Plan

- Each problem have a plan divided into:
  - Diagnostic plan – list of additional tests and/or consults to be acquired that will help secure the diagnosis
  - Therapeutic plan – list of medications, IV fluids, special diets, procedures, and/or surgeries that will help treat the patient
  - Educational plan (if relevant) – list of specific topics the patient will need to be educated about prior to discharge

Assessment and Plan

- Sepsis with hypoxic respiratory failure and hemorrhage
  - The acuity of onset, cough, elevated WBC count, and infiltrates on CXR are most consistent with a severe community acquired pneumonia.
  - While the severity of hemoptysis is slightly atypical for this diagnosis, it is within the spectrum of the presentation of this otherwise typical and common diagnosis.
  - Given his history of contact, TB is also a possibility, although the acuity of illness argues against this.
  - A pulmonary embolism could explain the hypoxia and hemoptysis, but is not typically associated with the fever, leukocytosis and CXR findings.
  - Diffuse alveolar hemorrhage would be a don't miss diagnosis which could present with hypoxia and hemoptysis, however, he has no predisposing conditions that would trigger this relatively rate diagnosis.

Assessment and Plan

- Diagnostic plan:
  - Blood and sputum culture
  - Rule out TB with serial sputum collection for AFB smear and culture x 3
  - Daily CBCs
  - Consider chest CT angiogram, if there isn't prompt improvement with antibiotics
  - Consider bronchoscopy if hemoptysis and/or hypoxia continue to worsen

Assessment and Plan

- Therapeutic plan:
  - Piperacillin/Tazobactam + Vancomycin for severe pneumonia requiring ICU level care
  - Avoiding quinolones given possibility of confounding TB treatment
  - Oxygen as needed to keep O2 sat > 92%
  - Will start trial of BiPAP if unable to maintain adequate saturation
  - No need for intubation and mechanical ventilation at present time

Any Questions or Comments