

Ministry of Health of Byelarus

«THE GRODNO STATE MEDICAL UNIVERSITY»

First Department of Surgical Diseases

EDUCATIONAL CASE HISTORY
for the 4th - year study students of the Faculty for
International Students (English medium)

Educational and Methodological Guidelines

Grodno 2015

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УДК
ББК

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Учебно-методические рекомендации предназначены для студентов 4 курса факультета иностранных учащихся с целью совершенствования их работы по написанию учебной истории болезни.

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FROM AUTHORS

Important point of teaching of students of Grodno state medical university at the 1-st department of surgical diseases is acquisition of knowledge in getting up of the medical documentation by them. The basic medical document reflecting difficult process of conducting of the surgical patient is the case history. Detailed reflection of the complaints of patients, the anamnesis data, results of their objective survey, tool investigations, and the spent treatment is present in it. Initially correctly to conduct the clinical case history is difficult enough. It is necessary certain skills for this purpose. For this reason on the second half of medical university education students start writing of the educational case history.

The offered methodical grant is prepared for the purpose of simplification of students work over the educational case history. Authors of the practical grant believe that it will be useful for each student at mastering of rules of getting up the modern medical documentation and acquisition of experience of conducting patients with a various surgical pathology.

*Teaching staff of the
1st Department of surgical
diseases*

«THE GRODNO STATE MEDICAL UNIVERSITY»

FIRST DEPARTMENT OF SURGICAL DISEASES

The chief of the department: (an academic status, a post, name, middle name, surname) _____

The teacher of group: (an academic status, a post, name, middle name, surname) _____

CASE HISTORY

First name, middle initial, last name of the patient

The curator (name, middle name, surname) _____

Course _____ group _____

Date of the attendance: _____

Grodno 201...

I. PASSPORT DATA

1. Surname, name and patronymic of a patient
2. Age, sex
3. A work place, a trade or a post
4. Residence
5. Admission date to hospital
6. Date of discharge from hospital
7. A person who directed a patient and admission diagnosis
8. Clinical diagnosis:
 - Basic diagnosis
 - Complications of the basic disease
 - Diagnosis of concomitant diseases
9. Operations, date of their performance
10. Clinical outcome: recovery, improvement, without changes, deterioration, death
11. Work capacity: restored completely, lowered, lost temporarily, lost constantly

II. COMPLAINTS OF A PATIENT

In this section all complaints of the patient are resulted at admission to clinic. In the beginning the description of the complaints, concerning the basic disease, and then concomitant diseases is given. For the purpose of their revealing the student gives the chance to the patient to give an account of (to state) complaints, and then by means of additional questions specifies necessary details. Presence or absence of a painful syndrome, dyspeptic and dysuric disorders, cardiovascular disorders, respiratory impairment, musculoskeletal (locomotor) apparatus, the general state of health, psychological activity should be found out from each patient.

Painful syndrome: character of a pain (sharp, stupid, burning, aching etc.) is described, its localization, irradiation, prevalence, periodicity (a constant, colicky (cramping) pain), are marked the factors of pain strengthening or reducing. Presence of other unpleasant sensations previous or accompanying a pain (a nausea, vomiting, abdominal swelling, strengthened peristalsis,

infringement of breath, etc.) is found out.

Dyspeptic disorders: appetite, dysphagy (its character), a nausea, vomiting (frequency, volume of vomit masses, their smell, contents; whether vomiting provides (brings) alleviation), stool (constipation, diarrhea, an unstable stool, presence of pathological admixtures in feces), meteorism (local, constant, periodic) and other disorders if they are available.

Dysuric disorders: urination (frequency, force of a stream), gripping pain at it (in the beginning, in the end), quantity of urine (color, presence of pathological impurity: blood, pus, etc.), sensation of опорожнения a bladder emptying (full, incomplete).

Disorders from respiratory organs: presence of dyspnea (in rest, at loading), difficulty of an inspiration (expiration), a pain in a thorax; cough (dry, with allocation of sputum: its quantity, character, a smell), hemoptysis.

Disorders from cardiovascular system: a pain in the area of heart, palpitation (in rest, at physical activity), rhythm infringement ("intermissions", etc.), other unpleasant sensations.

Complaints, characteristic for an arterial ischemia of the lower limbs (claudication intermittent, chill, paresthesia, etc.) or *for a venous pathology of the lower extremities* (edema, fast fatigability, a pain).

The complaints characterising the general condition and nervous-psycho activity: weakness, rapid fatigability, irritability, memory impairment, suspiciousness, sleep disturbance, loss of weight, etc.

The note: at case history writing are stated the only available complaints without the specified subtitles in such order which, from the point of view of the student, in the best way reflects a condition of the patient.

III. HISTORY OF THE PRESENT DISEASE (THE PRESENT ILLNESS HISTORY)

In this chapter (part) of case history is reflected, since what time (at acute diseases - hour) surveyed considers itself as the sick. In a chronological order occurrence and dynamics of available complaints and other pathological changes, conducted previous

researches and their results are described (if they are known). The diagnoses made (established) at previous medical aid appealability, all treatment taking place earlier, including surgeries, results of the management should be reflected.

IV. HISTORY OF LIFE OF A PATIENT (PATIENT'S LIFE HISTORY)

The transferred diseases, traumas and results of their treatment, bad habits, heredity are reflected as well as financial conditions of life, character of labour activity with revealing possible professional occupational hazards. In this section are reflected allergic and the medicinal anamnesis (tolerance of before accepted medicines, haemotransfusions or other transfusions and their complications).

The gynecologic anamnesis (a current of menstrual cycle, quantity of pregnancies, deliveries, abortions, gynecologic diseases) is gathered in women.

V. PRESENT CONDITION (CURRENT STATE) OF PATIENT *GENERAL EXAMINATION OF THE BODY SYSTEMS*

The estimation of the general condition (state) of the patient is given in the beginning: satisfactory, middle severity, grave (poor).

Position of the patient: active, passive, compelled (to specify what and with what it is connected).

Stature (growth). Weight. A constitution.

Skin and mucous tunics (membranes): colouring (pale, red, cyanotic, icteric, earthy), pigmentation, humidity, appearance of skin rash, scratches, bruises, scars, tumor formations, trophic disorders, etc.). Skin turgor.

Hypodermically-fatty tissue: its development (moderated, weak, excessive; (the thickness of a skin fold on external margin of a direct (straight) muscle of abdomen at navel level) is underlined in cm.

Presence of hypostases and edema, their localization and

extension (the general, local).

Lymph nodes: a palpation of submental, cervical, epi- and subclavicular, axillary, elbow, inguinal nodes; their size, a consistence, morbidity, mobility, cohesion among themselves (matted together lymph nodes) and surrounding tissues.

Research of external orifices (apertures) of inguinal channels.

At women results of visual inspection (survey) and a palpation of mammary glands are described.

The musculoskeletal (locomotor) apparatus: degree of muscle development (moderated, weak, good), presence of deformations, change of a configuration of joints, volume of active and passive movements.

*The **note:** revealed at the subsequent systemic inspection of a patient anomalies in a condition of organs and systems connected with the main pathology, results of the providing specific functional tests and signs are stated in case history section "Local status".*

SYSTEM OF RESPIRATORY ORGANS

Breathing (respiration): a nose, a mouth (free, complicated).

Breathing type: chest, abdominal, mixed. Number of respirations in one minute.

Character of a voice (loud, silent, hoarseness, aphony).

Chest circumference (circle of a thorax) and definition of its respiratory excursions. Participation in breath of both parts (half) of thorax, presence of deformations or other pathological formations of a thorax.

Borders of lungs, mobility of the lower pulmonary margins. Character of a percussion sound. Vocal fremitus. Results lung auscultation (character of breath, presence of rattles, their characteristic and localization).

CARDIOVASCULAR SYSTEM

Pulse, its frequency, rhythm, filling. An arterial blood pressure. Deformations in the area of heart, the characteristic of an

apex beat. Borders of absolute and relative heart dullness. Result of heart auscultation: sounds (loud, muffled, dull), disturbances of a heart rhythm (a tachycardia, a bradycardia, extrasystole, arrhythmia). Noises (murmurs) and their characteristic. Pericardial friction rub.

Functional tests; Shtange's test - a breath delay on a inspiration after two deep respirations - good 40-50 seconds, weak - below 30 seconds. Breathe holding test of Sabrazes - a breath delay on an exhalation after two deep respirations - average value (sizes) 20-25 seconds.

The pulsation of peripheral arteries on the upper and lower extremities is defined. It is provided auscultation in the projection of the main vessels.

In the presence of changes of venous vessels of the lower limbs appearance, an arrangement, expressiveness of varicosis (the dilated veins), hypostases (edema) and other changes of distal segments of the extremities is described.

DIGESTIVE ORGANS

Tongue: humidity, furred (character of incrustation, presence of cracks, ulcers on tongue).

Abdomen: the form, presence of deformations, scars, abdominal swelling, participation of a front abdominal wall in the breath.

Palpation of the abdomen: presence or absence of tension of muscles of front abdominal wall, its localization, prevalence and intensity, morbidity at a palpation (its localization and intensity), presence of symptoms of peritoneal irritation; results of a palpation of a liver, a spleen, kidneys, parts of large intestine; presence of defects in a abdominal wall (their localization and the sizes), tumor formations and infiltrates (masses) (their localization, size, a consistence, mobility, morbidity).

Percussion of abdomen: presence of liquid content in abdominal cavity (dull percussion sound in sloping places of the abdomen, changing the borders at change of position of the body), free gas (disappearance of hepatic dullness, high tympanic resonance in epigastrium), liver borders according to Kurlov, the

sizes of a spleen.

Auscultation of the abdomen: character of intestinal murmur is defined.

Rectum (under indications it is spent together with the teacher (tutor)): survey examination of anal area (presence of external hemorrhoidal piles, condilomas, fissures, fistulas). At manual (finger) research of a rectum the tone of sphincter, a congestion of feces, infiltrates, tumors is described. At men the sizes and elasticity prostatic gland are defined.

URINOGENITAL SYSTEM

Presence of changes of external genitals.

Presence of changes in lumbar area, presence or absence of morbidity at a palpation and pushing in lumbar area.

Gynecologic research (under indications it is spent together with the teacher (tutor)): discharge from a vagina, position of uterus, the size and its consistence, the characteristic of the fornix (free, presence of infiltrates), morbidity at displacement of uterine neck, change of uterine appendages.

ENDOCRINE SYSTEM

Survey and thyroid gland palpation. Character and degree of its enlargement (diffuse, nodular, mixed), a surface (smooth, hilly (tuberosity) consistence, interrelation (communication) with the surrounding tissues displaceability (mobility) at swallowing. The clinical signs testifying to increase of function of a thyroid gland (exophthalmia, symptoms Graefe, Stellwag, Kocher, Mobius, etc.) are described.

PSYCHOLOGICAL ACTIVITY AND SENSE ORGANS

Behavior of the patient: quiet, the raised irritability, suspiciousness, nervousness etc. The relation to the disease (confidence of recover, or on the contrary, propensity to overestimate severity of disease etc.).

Sensitivity: tactile, painful, temperature, deep.

Sight, hearing, sense of smell (the general characteristic, without application of special methods of inspection is given).

VI. LOCAL STATUS

In detail the objective data, concerning parts of a body, system or body which are damaged by acute or chronic disease, received on the basis of survey, palpation, percussion, auscultation and other clinical methods of research are registered. The revealed symptoms and the fulfilled functional tests with decoding of a way of their revealing and value are specified.

VII. PRELIMINARY DIAGNOSIS

In the given section the preliminary diagnosis is proved. It is underlined, on what basis of the concrete complaints, the given anamnesis of disease, the anamnesis of life, results of objective (general clinical) inspections the preliminary diagnosis is exposed. The preliminary diagnosis is exposed taking into account International classification of diseases (ICD) - 10 and classifications accepted in clinic.

VIII. PLAN OF INVESTIGATIONS

The plan of inspection of the patient is made with the account - of the data necessary for acknowledgement of the preliminary diagnosis, for carrying out the differential diagnosis, for studying functional condition of vital organs and systems. In the given section of the educational case history it is underlined, what general clinical laboratory, radiological, tool and other special methods of research should be spent to the supervised patient and sequence of their conduction (carrying out).

IX. RESULTS OF LABORATORY AND SPECIAL METHODS OF INVESTIGATIONS AND TESTS

In this section results of laboratory and special methods of inspection of the supervised patient, available in its real case history are registered. Then their analysis with instructions of deviations from "norm" and an explanation of mechanisms of occurrence is carried out.

X. DIFFERENTIAL DIAGNOSIS

Differential diagnostics is spent with 3(three), the most similar on a clinical current, diseases. At carrying out of the differential diagnosis the curator (student), comparing the complaints revealed at the patient, results of general clinical , laboratory and special methods of research with those at the diseases chosen for carrying out the differential diagnosis, excludes their presence.

XI. CLINICAL DIAGNOSIS

The clinical diagnosis is proved in short. In the clinical diagnosis are resulted: the basic disease, complications of the basic disease, accompanying diseases with their complications. For example, in a diagnosis substantiation it is written that *on the basis before the exposed preliminary diagnosis, taking into account the given, laboratory and special methods of research (with their concrete instructions), the spent differential diagnosis the clinical diagnosis will be next: Cholelithiasis(gallstone disease), chronic calculous cholecystitis.*

XII. AETIOLOGY AND PATHOGENESIS

On the basis of studying of the literature and given other accessible modern news media the student states modern views on an ethiology and pathogenesis of the given disease in general, and concretely on causative moments in the supervised patient.

XIII. TREATMENT OF THE GIVEN DISEASE

On the basis of the literary data and given other information sources indications to operative and conservative treatment of the given disease in general are stated.

At the description of surgical treatment principles of preoperative preparation (with instructions of used preparations (drugs), doses and ways of introduction), existing methods of operative treatment are reflected. Graphic schemes of operations, principles of conducting the postoperative period (with instructions of used preparations, doses and ways of introduction) are resulted.

Characterizing conservative treatment, the curator results its principles, specifies medical preparations, doses and ways of

their introduction.

XIV. TREATMENT OF A SUPERVISED PATIENT

In this section selected or planned tactics of treatment of the patient (surgical or conservative) is proved. Particularly, with reference to the given patient, available indications to surgical or conservative treatment are stated.

At carrying out of surgical treatment the volume of preoperative preparation in the form of appointment sheet is described, the choice of a method of operation is proved. If operation at the time of attendance has been already performed, the student corresponds it's operative notes from the real case history of the patient.

The variant of planned operation is resulted in the form of the title (for example: performance of a resection of a stomach on Bilrot-2 in modification of Gophmeister-Finsterer is planned). Treatment of the patient in the postoperative period in the form of appointment sheet is characterized.

At carrying out of conservative treatment the curator describes it in the form of sheet of appointment with instructions of doses and ways of introduction of preparations, proves the purpose of appointment of each of them.

XV. DIARY

Diaries of supervision over the patient are written from the first to the third day of attendance. In diaries the condition of the patient at date of survey is reflected, changes in the general condition and the local status are described, dynamics of a current of disease is underlined (deterioration, improvement, without changes), diagnostic and medical manipulations are registered, concrete appointments to the patient are given.

XVI. EPICRISIS

The clinical course at the supervised patient is described. In the short form the complaints, data of the anamnesis and results of fulfilled investigations, the established diagnosis, character and results of surgical or conservative treatment, variant of the operation, a current of the postoperative period, the developed

complications are stated, the condition of the patient is reflected at discharge from the hospital.

The prognosis for life, health and work capacity of the patient is made.

Recommendations to the patient are made at discharge.

The plan of sociolabor rehabilitation is offered.

XVII. LIST OF THE USED LITERATURE

Date. Signature.

Educational edition

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