

«THE GRODNO STATE MEDICAL UNIVERSITY»

1st Department of surgical diseases

THE EDUCATIONAL CASE HISTORY
for the 5th year study students of Faculty for
international students (English medium)

Educational and Methodological Guidelines

Grodno 2015

УДК
ББК

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Учебно-методические рекомендации
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работы по написанию учебной истории болезни.

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FROM AUTHORS

This practical manual is intended for 5 year students of foreign students' faculty for simplification of writing the educational case history.

The purpose of educational case history writing on 5th year of foreign students' faculty is fixing of rules of filling of the documentation regulated by Ministry of Health of Belarus and experience in inspection of the patients received on 4th year of study. However the patients attended by students of 5th year of foreign student faculty, have more serious surgical pathology (diseases of abdominal and thoracic cavities, vessels). The further development of students' clinical thinking, perfection of already existing and development of new practical skills in diagnostics and treatment of patients are also very important.

The practical manual is made on the analysis of rules and conditions of registration of main medical document – patient's case history, but with elements of the expanded interpretation of some parts. Some sections of the educational case history assume obligatory deep studying of contemporary scientific literature and available electronic media. The practical manual is written with accent on self-independent preparation of written educational and practical work with elements of scientific analysis.

At creation of this practical manual employees of 1st Department of surgical illnesses proceeded from big importance of students' preparation in specific questions of surgery and an intensification of educational process within the medical high school.

*Professors and teaching staff of
1st Department of surgical diseases*

«THE GRODNO STATE MEDICAL UNIVERSITY»

FIRST DEPARTMENT OF SURGICAL DISEASES

Chief of department: (academic status, position, Name) ____

Tutor: (academic status, position, Name) _____

THE CASE HISTORY

First name, middle initial, last name of the patient _____

The curator (First name, middle initial, last name)

Course _____ group _____

Attendance dates: _____

Grodno 20__

PASSPORT PART

1. The Surname, a name and a patronymic of the patient
2. Age, sex
3. A work place, profession, position
4. The residence
5. Admitting date in hospital
6. Discharging date
7. By whom referred
8. The diagnosis at admittance
9. The clinical diagnosis:
 - Main
 - Complications of main diagnosis
 - Comorbidities
10. Operation: the name and date
11. Illness Outcome (possible variants: recover, improvement, without changes, deterioration, death)
12. Work capacity: restored completely, temporal lost, firm lost-disabled (for persons of able-bodied age)

II. COMPLAINTS OF THE PATIENT

In this section complaints of the patient are stated at admittance in the hospital. In the beginning the complaints, concerning main disease and its complications, and then the complaint, concerning comorbidities are described. It is necessary to find out presence or absence of a pain syndrome from the attended patient, dyspeptic and dysuric frustration, infringements of cardiovascular activity, breathing, musculoskeletal system, vitals, general health and physique, psychological status.

At studying *of pain syndrome* it is necessary to pay attention on: character of pain (sharp, dull, burning, aching, constant, paroxysmal), time of its occurrence, localization and irradiation, and also presence of such sensations accompanying pains as a nausea, vomiting, abdominal distention, terms of their occurrence (pains precede or accompany it).

The characteristics of *dyspeptic syndrome* should reflect appetite, presence of nausea, vomiting (its frequency, vomits volume, color, relief after vomiting); presence of dysphagia, abdominal distention (local, diffuse, constant, periodic); bowel habit (constipation, diarrhea);

character of stool presence (blood, mucus, pus).

Disuric frustration: urination character (frequency), pain (in the beginning, in the end), quantity of urine and its color, presence of blood, pus, mucus, feeling of bladder emptying (complete, incomplete).

Respiratory organs dysfunction: shortness of breath (at rest, on exercise), breathlessness, difficult inhalation, exhalation, chest pain.

Cough: dry, productive, expectoration (sputum amount, character, smell), hemoptysis.

Cardiovascular system: chest pain in palpitation (at rest, at physical exercise), heart rhythm disturbance and other unpleasant sensations in the heart area.

To find out complaints, characteristic for *arterial ischemia of lower extremities* (claudication, coldness, paresthesia, etc.), and also a *venous system pathology* (presence of varices, pain and heaviness, throbbing sensation in lower extremities, presence of cramps in gastrocnemius muscles at nights, swelling, its character: firm, constant, passable).

The complaints characterizing the *general condition and psychological status:* weakness, fatigue, sleep and memory disorders, irritability, suspiciousness, weight loss, etc.

Note: *in case history only available complaints should be registered without specifying mentioned above subtitles, in order which from student's point of view is the best way to reflect patient's condition.*

III. THE PRESENT ILLNESS HISTORY

In this part of case history the course of main illness is described in chronological order from the moment of its first signs occurrence till the attendance. All exacerbations and remissions, frequencies, treatment taking place earlier, including surgeries, results should be reflected.

IV. THE PATIENT'S LIFE HISTORY

Financial and living conditions are studied and registered, character of labor activity with revealing possible professional harms, medical history, injuries and their treatment results, bad habits, family history and heredity. Besides, in this section allergy and medications anamnesis are reflected (drug allergies, whether blood transfusions or other transfusions and their complications).

In female patients it is necessarily to collect the gynecological anamnesis (current menstrual cycle, pregnancies, childbirths, abortions, gynecological diseases).

V. THE PATIENT'S CURRENT STATE THE GENERAL INSPECTION

The general condition of the patient is estimated: as good, fair, serious or critical.

Position of the patient: active, passive, forced attitude (specify which and what is it related to).

Body constitution type.

Skin and mucosae membranes: coloring (pale, red, cyanotic, icteric, gray), pigmentation, moisture, rashes, maceration, bruises, hems, masses, ulcers, trophic changes, skin turgor.

Subcutaneous fat: its development (moderated, excessive). The thickness of the skin fold on external edge of rectus muscle of abdomen at the umbilicus line.

Presence of swelling and hypostases, localization and prevalence (generalized, local).

Lymph nodes: palpation of submandibular, cervical, supraclavicular, axillar, elbow, inguinal nodes, their size, consistence, pain on palpation, mobility, cohesion with each other and surrounding tissues.

Inspection of superficial inguinal rings.

In female patients results of inspection and palpation of breasts are described.

The musculoskeletal system: degree of development of muscles (moderated, unwell, good), available deformations, change in joints configuration, joint range of active and passive motions.

Note: *organs and systems abnormalities revealed at the subsequent by-systems inspection, results of functional tests are stated in case history's section - "Local status".*

RESPIRATORY SYSTEM

Nose or mouth breathing. Breath type: thoracic, abdominal, mixed. Rate per minute. Voice character (loud, quiet, hoarseness, aphony).

Chest movement in breathing, presence of deformations or other pathological conditions of the thorax, percussion's results.

Lungs auscultation (character of breath, presence of wheezes and crepitating, characteristic and localization).

CARDIOVASCULAR SYSTEM

Pulse (frequency, rhythm, filling). Arterial blood pressure. The characteristic of apex push. Auscultation's results: hearts tones (loud, low, dull), rhythm violation (tachycardia, bradycardia, extrasystoly, vibrating arrhythmia). Pathological heart sounds, characteristics. Pericardial friction rub. Pulsation of peripheral arteries of upper and lower extremities is defined, auscultation of large vessels (aorta, femoral arteries) is performed.

Is there any changes of venous vessels: their appearance, location, expressiveness of varices and other changes are described.

DIGESTIVE SYSTEM

Tongue: damp, furred, character of it, presence of cracks, ulcers.

Abdomen: appearance, presence of deformations, scars, abdominal distention, participation in breathing. Abdominal palpation: presence or absence of muscular guarding of abdominal wall, its localization, prevalence and intensity, pain on palpation, its localization and intensity, presence peritoneal irritation signs; results of palpation of liver, spleen, kidneys, parts of large intestine. Detecting defects in abdominal wall, their localization and sizes; finding abdominal masses and infiltrates (if they present, defining localization, size, consistence, mobility is defined, pain on palpation).

On percussion presence of fluid in abdominal cavity (shortening of percussion sound (duller) in lower part of abdomen, shifting with the change of body position), free gas (disappearance of hepatic dullness, hyper-resonant sound in epigastrium), liver borders by Kurlov, sizes of the spleen.

With the help auscultation character of bowel sounds is defined.

If indicated the student together with the teacher examine the *rectum*: perianal area (external hemorrhoids, genital warts (condylomata acuminata), fissures, fistulas). At digital rectal examination: the anal

sphincter tone, congestion of faeces, infiltrates, tumors are described. For male patients prostate size and elasticity are defined.

URINOGENITAL SYSTEM

Presence of any changes in external genitals.

Inspection of lumbar area, presence or absence of pain on palpation and percussion in lumbar area.

Gynecological examination: (carried out together with teacher) vaginal discharge; uterus position, its size and consistence; characteristic of vesico-uterine and recto-uterine pouches (free, presence of masses); pain on cervix movement; changes of uterine adnexa (if they are palpated).

ENDOCRINE SYSTEM

Thyroid gland inspection and palpation. Character and degree of its enlargement: diffuse, nodular, mixed, surface (smooth, hilly), a consistence, relation with surrounding tissues, moving during swallowing. The clinical presentations of hyperfunction of thyroid gland are described: exophthalmos, Von Graefe's, Stellwag's signs, etc.

NEURO-PSYCHOLOGICAL STRUCTURES AND SENSE ORGANS

Behavior of the patient; quiet, shortness of temper, irritability, suspiciousness, nervousness etc. Attitude toward disease (confidence of recovery, or, opposite, propensity to overestimate severity of disease etc.).

Sensitivity: tactile, painful, temperature, deep.

Sight, hearing, sense of smell (Giving general characteristics, without use of special methods of inspection).

VI. THE LOCAL STATUS

In this section the objective data, concerning part of a body, system or organ which are affected by disease is register in details: the results of general inspection, palpation, percussion, auscultation and other clinical investigation methods. Presenting symptoms, characteristic for this disease, functional tests for pathology of peripheral vessels.

VII. THE PRELIMINARY DIAGNOSIS

In this section the preliminary diagnosis is being proved. It is underlined, on basis of what exact complaints, details of given anamnesis of disease, life anamnesis, results of objective general inspections- the preliminary(presumptive) diagnosis is made.

The formulation of the preliminary diagnosis is done accounting the classifications accepted in clinic and ICD - 10.

VIII. THE INSPECTION PLAN

The plan of inspection of the patient is made taking into account the data necessary for carrying out of the differential diagnosis and studying of patients vitals and functional condition of systems and organs. In it is underlined, what laboratory, radiological, instrumental and other special investigations should be done to the patient.

IX. RESULTS OF LABORATORY AND SPECIAL METHODS OF INVESTIGATION

In this section results of laboratory and special methods of inspection of the supervised patient register. Data undertake from the case history of the patient. Then their analysis with instructions of available deviations from norm is carried out.

X. THE DIFFERENTIAL DIAGNOSIS

Differential diagnostics is spent particularly for the given patient with 4-mja similar diseases on a clinical current. At carrying out of the differential diagnosis it is necessary to compare the clinical picture which is available for the given patient, to the diseases close on the current. It is important to show, what signs are the general for compared diseases and that distinguishes them. The student, comparing complaints available for the patient, results *общеклинического* and special methods in researches with a clinical picture of different diseases, gradually excludes the diseases taken for differential diagnostics.

XI. THE CLINICAL DIAGNOSIS

The clinical diagnosis is formulated developed, taking into account the classifications accepted in clinic and ICD - 10, but not

proved. Its record in the case history is carried out, for example, as following: *on the basis of the complaints, the given anamneses of disease and life, general inspections, results of laboratory and special methods of investigation of the supervised patient, the spent differential diagnosis the clinical diagnosis is made:* obliterating atherosclerosis, stenosis of terminal part of abdominal aorta, occlusion of right and stenosis of left common iliac arteries (Lerish's syndrome), chronic arterial insufficiency of arterial blood circulation of lower extremities 2b stage.

XII. THE AETIOLOGY AND PATHOGENESIS

On the basis of studying of the literature and given other sources of contemporary media the student states an etiology and pathogenesis of given disease with reference to the supervised patient.

XIII. TREATMENT OF THE GIVEN DISEASE

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

At the description of surgical treatment principles of preoperative preparation with instructions of doses and ways of introduction of medications are reflected, all available and existing methods of operative treatment are described. Graphic schemes of operations, principles of conducting the postoperative period with instructions of doses and ways of introduction of preparations are described.

At the description of conservative treatments its principles with instructions of medications, doses and ways of their introduction are specified.

XIV. TREATMENT OF THE SUPERVISED PATIENT

In the beginning of this part of the case history selected (or planned) tactics of treatment of the supervised patient is validated.

If method of choice in treatment of the patient is surgical treatment it is concrete, with reference to the given patient, indications to operative treatment and the chosen method of operation are stated. Preoperative preparation in the form of sheet of appointment with a substantiation of used preparations is described. The characteristic of

planned operation (if it was already carried out to the patient its report corresponds from the case record) is given. Postoperative treatment in the form of sheet of appointment with a substantiation of used medications is resulted.

If a choice method in treatment of the patient is conservative treatment it is concrete, with reference to the given patient, therapy methods are proved. They register in the form of sheet of appointment with a substantiation of used medication.

XV. THE DIARY

Diaries of supervision over the patient are written from the first till the third curation day. In them the condition of the patient at date of supervision is reflected, changes in the general condition are described, dynamics of current disease is underlined (deterioration, improvement, without changes), register diagnostic and medical manipulations, are given concrete indications to the patient.

XVI. EPICRISIS

The short characteristic of a clinical course. In the compressed kind the data of the anamnesis and results of the carried investigation, the established diagnosis are stated. Character and results of the applied treatment. An operation kind, a current of the postoperative period, complications. A condition of the patient at discharge.

The prognosis for life, health and work capacity.

Recommendations to the patient are made at discharge.

Social and labor rehabilitation.

XVII. THE LIST OF THE USED LITERATURE

Date. The signature.

The educational edition

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