CASE REVIEW INSTRUCTIONS

6 case reviews must be submitted, and passed, during the Urgent Care Course year. One case review is to be submitted for each of these six topics, in any order.

Acute Medical
Acute Surgical
Acute Orthopaedics
Acute Plastics
Acute Paediatrics
Communication

Copies of submitted work should be kept by the candidate in case of dispute or papers going missing.

Any variations from the requirement should be discussed and approved prior to submission of the work.

Retrospective approval will not be given.

DEADLINES FOR CASE HISTORIES:

Cases 1 - 2	**April 30**
Cases 3 – 4	**June 30**
Cases 5	**August 31**
Communication case	**October 30**

LATE ASSIGNMENTS WILL BE PENALISED.

If you anticipate you will have difficulty meeting a particular deadline please contact the College *in advance* to discuss this and apply for an extension of time.

Email to assignments@rnzcuc.org.nz

ASSIGNMENT DELIVERY

EMAIL (PREFERRED)

assignments@rnzcuc.org.nz

POSTAL

Royal New Zealand College of Urgent Care
110 Lunn Ave
Remuera
Auckland 1072

CASE REVIEW INSTRUCTIONS

These are in the format of a case description followed by a brief discussion relating best practice principles to the case at hand.

Word Count Case Description:	**MAXIMUM 250**
Word Count Case Discussion:	**MAXIMUM 400**

An introductory paragraph is not required.

The Case Description should be presented in the usual form that clinical notes take and documented to a high standard – standard terminology should be used, and common abbreviations are accepted. ***Ensure that a diagnosis, working diagnosis / clinical impression, or differential diagnosis is recorded, and it must include a summary of the case outcome.*** It should also give the reader an idea of context – please include a description of the patient seen (NO identifying features should be included), the type facility they presented to, and the day / time seen.

There are several examples of case descriptions in the sample assignments provided.

The discussion should reflect on the issues of the case, and compare actual management to ideal management. A comprehensive literature review is not required – one or two well-chosen references will suffice.

COMMUNICATION CASE HISTORY INSTRUCTIONS

The format of this assignment should follow that of the standard Case Review as above (ie case description followed by brief discussion); however the focal point of the discussion will differ. The important learning point in this case is your communication and self-reflection skills.

Word Count Case Description:	**MAXIMUM 250**
Word Count Case Discussion:	**MAXIMUM 400**

You should choose a "difficult" case – ie conflict within the consultation, complaint generated, or some other communication breakdown resulting in a poor outcome.

An introductory paragraph is not required.

The Case Description should be presented in the usual form that clinical notes take and documented to a high standard – standard terminology should be used, and common abbreviations are accepted. ***Ensure that a diagnosis, working diagnosis / clinical impression, or differential diagnosis is recorded, and it must include a summary of the case outcome.*** It should also give the reader an idea of context – please include a description of the patient seen (NO identifying features should be included), the type facility they presented to, and the day / time seen.

The discussion should define what the poor outcome was (this may not be apparent in the clinical case description), then focus on issues of communication within / or related to the consultation – for example what do you think went wrong? What would you do differently? What have you learnt? What communication strategies would you use next time? It may help to consider all aspects of communication – e.g. verbal and non-verbal cues, written material, clinical team communication, etc.

MARKING SHEET

Structure Word count / outline Grammar / syntax Appropriate references	 **/1 Mark** **/ 1 Mark** **/1 Mark**
Content Topic appropriate / relevant / unambiguous Correct info and / or evidence based and/ or best practice	 **/1 Mark** **/1 Marks**
Subjective marks 'flair' – choose one of the following: Straightforward rehash of topic (1 mark) OR Concise summary of topic with some self-reflection (2 marks) OR Thought provoking concise summary with self-reflection / change my future management (3 marks) OR WOW factor, concise summary, thought provoking discussion, self-reflection, new learning(s), changed my management, reader learns something new. (4-5 marks)	 **1** **2** **3** **4 4.5 5** **/5 Marks**
TOTAL	**/10 Marks**

Marks will be credited for:

- Use of relevant material in each case, with important positive and negative findings included.
- Descriptions of appropriate management of a case, or identifying mistakes in management.
- Accurate terminology.
- Use of relevant and up to date references.
- Willingness to reflect on, and learn from mistakes.
- Higher marks will be awarded where case histories demonstrate that the trainee has considered/researched best practice medicine, and compared this to what actually happened during the course of the consultation.

Marks will be deducted for:

- Inappropriate issues or cases.
- Incomplete clinical notes (case description).
- Unsafe practice, where this is not acknowledged.
- Poor referencing.
- Excessive length.
- Late assignments.
- Directly copying reference material / textbooks in the discussion. Remember to discuss "Best Practice" and compare to your individual case, i.e. what was done well and what wasn't and what was learnt.

TITLE PAGE

Each assignment should be typed, and accompanied by a Title page with the following information:

Urgent Care Course Assignment:	Type of case and number e.g. Acute Medicine
Name:	
Date:	
Word count case description:	Maximum of 250 words.
Word count discussion:	Between 300-400 words.

REFERENCING AND PLAGIARISM

These assignments should be your own work, based on a case you have seen.

Where you include information from another source, this should be duly recognised using standard medical referencing format. Presenting someone else's material without acknowledging them (ie referencing) is considered plagiarism, and will not be tolerated.

Some examples of plagiarism could be:

Direct copying, or "cutting and pasting".
Not using quotation marks or paraphrasing when including someone else's work.

Where plagiarism is detected, the assignment will fail.

For more information and examples of referencing go to The US National Library of Medicine guide:

http://www.nlm.nih.gov/bsd/uniform_requirements.html

Additionally the University of Auckland has very good referencing resources which may be useful:

http://www.library.auckland.ac.nz/subject-guides/med/setref-vancouver.htm

Or

http://www.cite.auckland.ac.nz/index.php?p=overview

LITERATURE SEARCH AND ARTICLE APPRAISAL

For more information about searching for articles in a medical database (e.g. PubMed), read the following:

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2127107/pdf/9251552.pdf

For more information about appraising articles here are a couple of articles to get you started:

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2127173/pdf/9253275.pdf

http://www.sma.org.sg/smj/4603/4603ebm1.pdf

CASE HISTORY EXAMPLE 1 - PAEDIATRICS

Case History - A case of croup.

Master GW. 3 yr. old boy. Presented to the After-hours clinic with father. 29/5/2011, Sunday 2300hrs

PC- SOB and stridor

HPC- Cough, runny nose one day. No fever. Tonight woke up distressed, SOB and barking cough. Parents tried to give him paracetamol but he got very upset. Father put him in the car and brought him in. Continued to have barking cough and continued to get worse. Now lethargic, difficult and noisy breathing. No drooling, not blue.

Past Hx-Nil. No Hx of Asthma. Fully immunised.

Meds-Nil, NKDA

Social Hx-lives with parents. Six year old brother also has a cold

O/E

Looks floppy, unwell, very distressed. Father carrying patient. Pale not cyanotic.

No drooling

Inspiratory and Expiratory stridor audible

Marked sternal wall retractions

Temp 37.6 C

HR 200/min, warm peripheries.

Sats 82% on RA, RR 40/min

Throat-no asymmetry. Injected mucosa.

Chest - transmitted upper airway noises. Reduced AE.

HS 1+2

Impression- Severe Croup with significant airway compromise and at risk of respiratory arrest.

Management- Ambulance called. Sitting up with dad, 5mg of nebulised adrenalin with oxygen 6L. IV line placed. Improved immediately. Given oral dexamethasone 15mg (0.6mg/kg). Referred to Paediatrics for on-going care via ambulance on oxygen.

Discussion

For patients with croup the differential to exclude are bacterial tracheitis, epiglottitis, retropharyngeal abscess and foreign body inhalation. Bacterial tracheitis is accompanied by high fever and toxic appearance. Epiglottitis has more sudden onset of high fever, dysphagia, drooling, sitting forward in 'sniffing' position. This patients' history is suggestive of typical croup with low grade fever, rhinorrhoea and cough.

The Westley scale is used to assess the severity of croup. This is based on the degree of inspiratory stridor, retractions, air entry, cyanosis and level of consciousness. This patient falls in the category of severe croup. IV line was inserted in case of circulatory collapse. In hindsight it was not necessary to insert the IV line as it made him more distressed

likely worsening his symptoms. IV interventions perhaps should be reserved for altered mental status, dusky appearance, decreased retractions, decreased breath sounds or decreasing stridor which support imminent respiratory arrest.

Management of this patient otherwise was appropriate. I did have a dilemma about what dose of adrenalin to use having remembered dose of racemic adrenalin 1:1 in which case 0.5ml only should be administered via neb in comparison to 5ml of 1:1000. However the clinic guidelines as per the Starship guidelines recommends 1:1000 preparation 0.5ml/kg/dose, (max 5ml).

All patients with croup should receive dexamethasone as it prevents deterioration on day 2 or 3. A single oral dose of 0.15mg/kg is just as effective. Most research has been on 0.6mg/kg so the recommendation is still to use 0.6mg/kg for moderate to severe croup. Up to date recommends a maximum of 10mg and Starship guidelines recommend 12mg of dexamethasone. This patient received 15mg of oral dexamethasone. Perhaps a maximum of 12mg as per Starship should be used in future.

The other treatments such as nebulised Budesonide is as effective but not better than dexamethasone. Had the patient vomited this would have been an appropriate treatment. This is costly and not available at our clinic. IM or IV dexamethasone is another option.

This young patient with croup responded well to the adrenalin nebuliser. If he continued to deteriorate the paediatric team would have needed to be warned to have a paediatric anaesthetist ready for likely a difficult intubation.

References

Alberta Clinical Guidelines Group: Guidelines for the diagnosis and management of Croup. Revised Jan 2008. http://www.albertadoctors.org

Muniz A, Molodow RE, Defendi GL: Medscape. Pediatric Croup. Updated May 2011.

http://emedicine.medscape.com/article/962972-clinical#a0217

Shephard M, Gavin R: Starship guidelines. Croup. Dec 2009.

http://www.starship.org.nz/assets/Uploads/Starship-Hospital-Content/Health-Professionals/Clinical-Guidelines/Croup.pdf

Woods CR, Kaplan SL, Tochia MM: Approach to the management of Croup. Uptodate online. Jan 2011. http://www.uptodate.com

CASE HISTORY EXAMPLE 2 - SURGERY

Case History – Abdominal pain

Mrs AR 55YO female seen in Coastcare A&M at 1900 on 01/03/11

PC
Left sided abdo pain

HPC
5/7 generalised abdo pain

Pain now localising in LIF and extends around to the R hypochondrium

Bowels opened yesterday

Also c/o of RUQ pain with shoulder tip pain

No fevers or jaundice

Prone to constipation, passing hard stools

PMHx
Multiple previous bowel surgery? what

Hx of adnexal pathology

Type 2 diabetic

MEDS
Simvastatin, metformin, aspirin

O/E
Alert and interactive

Afeb, HR 85/min BP 140/85, CRT <2sec

Chest clear

Soft abdo, tender LIF with mass, RUQ tenderness? Murphies +ve, BS present

IMP
? Biliary colick

?Constipation

?Obstruction

PLAN
1. Enema
2. Buscopan
3. C/U recent bloods
4. Analgesia

No improvement with microlax. Pt to get fleet enema and have one tonight and tomorrow. To get FBC, LFT's done tomorrow and advised to attend NSH if pain intensifies. Pt called the following day. Good result with phosphate enema and pain resolved.

Discussion

Abdominal pain is a common presentation to both emergency departments and community doctors making up 5% and 1.5% of visits respectively (1). Most are benign but 10% of these will require surgery for a severe or life threatening cause (1).

This case report exemplifies the dilemma faced by community Urgent Care physicians when working up abdominal pain. Diagnosing the cause of abdominal pain can be difficult and pre-existing morbidity can further confound the diagnostic process (2). Unfortunately no single test exists that is perfect for investigating abdominal pain. One study has demonstrated that 1 in 4 cases of appendicitis present with a normal white cell count (1) and only consensus opinion exists with regard to appropriate modalities of imaging. Even when investigated extensively, up to 40% of patients admitted to hospital with abdominal pain have no cause found (2).

Abdominal pain therefore does not lend itself easily to algorithmic evaluation. Best practice suggests that assessing abdominal pain requires an approach that relies on the likelihood of disease, patient history, physical examination, laboratory tests, and imaging studies (1). Over reliance on one particular arm of this assessment tree can lead to misdiagnosis and delays in the treatment and referral of sinister causes of abdominal pain. This is highlighted by the statistic that one in three patients that require surgery for abdominal pain present with at least one atypical feature on initial presentation (2).

The fulcrum around which these diagnostic tools must hinge therefore is the physician's intrinsic assessment of what lies before them. Simply put this is the physician's gut feeling or gestalt and its importance cannot be overstated in this situation. Evaluation of abdominal pain particularly in the community can be difficult and frightening. However reliance on your accumulated wisdom along with objective measures can ensure that the more serious cases are not missed.

References

1. Cartwright SL, Knudson MP: Evaluation of acute abdominal pain in adults: Am Fam Physician. 2008 Apr 1;77(7): 971-8
2. Tsipouras S: Non abdominal causes of abdominal pain, finding your heart in your stomach: Aust Fam Physician. 2008 Aug;37(8): 620-2

CASE HISTORY EXAMPLE 3 - COMMUNICATION

History:

Mr. C, 34 yo man presents to the ED at 2AM on a Sunday with a traumatic amputation of his R little finger.

PMHx:

Normally fit and well, no regular medications, NKDA, +smoker, +casual marijuana smoking, unemployed, heavily tattooed, RH dominant, immunised, no recent ADT.

HOPC:

Patient stated that he had been chopping meat with a butcher's knife and accidentally severed his R 5th digit. His wife "freaked out" and threw the finger out the window. Finger not retrieved after one hour search. Compression with kitchen towel used to control bleeding. No other injuries.

O/E:

Alert, agitated, some angry outbursts

T=37.3C, P=86, BP=130/76, RR=22, SatO2=98%, GCS=15/15, PERLA+6mm

R little finger amputated approximately 1cm above 5th MCPJ with 0.5cm of exposed bone cut obliquely. Some maceration and bruising of wound edge. No frank arterial bleeding. Some mild venous ooze. Capillary refill of distal stump 1sec, sensation intact. 5th MCPJ not involved. No other abnormality of hand, forearm, or arm noted.

Xray: Oblique amputation of proximal phalanx of R little finger at midpoint. Minimal fragmentation of remaining bone. No other fractures noted.

Impression: Traumatic amputation of proximal phalanx of R little finger

Plan:

Ring block and pressure irrigation

Analgesia

Augmentin 1.2g IV stat

NBM

ADT

Non-circumferential sterile pressure bandage + elevation

Outcome:

Patient referred to Plastics Registrar. Prior to Plastics review, the patient became verbally abusive to staff and self-discharged. He returned at 8AM was seen directly by the day Plastics Registrar and the digit terminalised in the OR that morning.

CASE DISCUSSION

Most people who amputate a digit are compliant and appreciative of treatment. Mr C was not one of these patients. The poor outcome in his case was a delay in treatment and an increase in the possibility of complications (e.g. blood loss, infection). A further poor outcome was the stress created in the staff managing this patient. These poor outcomes, I feel, arose largely from a deficiency of communication between the patient and me.

Firstly, Mr C was terse which in turn made me frustrated and impatient. Also, I was doubtful of the veracity of the patient's story (i.e. how was he able to cleanly cut off only the little finger of his dominant hand if he was using a butcher's knife?). Although I was not accusatory in my history-taking, I could sense that the patient was aware of my suspicions. His tattooed appearance increased my bias. Although my questioning was relatively open-ended, the tone was not empathetic and my body language was closed (i.e. arms crossed, leaning against the wall). As my bias increased, it was difficult to perform a decent H+P and to have the patience to explain carefully to Mr R his need for further care. The consultation broke down and Mr R became increasingly impatient and aggressive. He made statement such as, "I've been waiting forever and none of you seem to be doing anything." Although I did try to assure him that that we were taking his case seriously, my tone and body-language, told a different story.

In the future such situations, I will seek to be more patient, use broad open questions, allow the patient to speak openly, and acknowledge the patients feelings. (1, 2) Providing the patient information in different forms—e.g. written summary of the surgery— might also be helpful. Also, I've noted the importance of keeping an 'open' body language, especially with patients that I may not inherently 'like' to avoid verbal-nonverbal mismatch. (3) Lastly, I have learnt that though I may not always like the patient I am seeing, they deserve respect, compassion and treatment to the best of my ability.

REFERENCES:

1. Plutchik R. Emotions in the Practice of Psychotherapy; Chapter 9: Therapeutic communication. Arlington (VA), USA. American Psychiatric Press; 2001. 149-168.

2. Techniques of Therapeutic Communication. Available from: http://www.lscc.edu/academics/nursing/CN%20I%20Forms/techstherapeuticcommunication.pdf

3. Quill TE. Recognizing and adjusting to barriers in doctor-patient communication. Annals of Internal Medicine [1989, 111(1):51-57]

CASE HISTORY EXAMPLE 4 -COMMUNICATION

History

A 9 year old girl is brought in by ambulance after a school yard accident in which she has been hit across the forehead by a boy swinging a cricket bat. She suffered a 3cm laceration over the left eye brow, and was not knocked out.

PMHx: nothing of note, no medications and no allergies

SHx: She arrived with a Whanau member, and legal guardian could not be located.

Exam: Gaping 3cm wound, parallel to the left eyebrow. Bleeding was controlled by pressure. No forehead numbness. Periosteum was intact

Imp: There was no closed head injury. This was a simple forehead laceration.

Plan: This required anaesthetic, cleaning and suturing. The Whanau member had already written a letter of complaint during their wait, voicing her concern over the delay in treatment, giving her diagnosis and that the treatment should be to transfer her mokopuna to a plastic surgeon (over 500km away) for skin grafting.

Outcome: This was an angry, pushy patient (Whanau member) demanding inappropriate treatment requesting on behalf of a minor. I wanted to manage the child and asked that she leave to find the child's guardian. Anticipating a problem, I had the on call surgeon assess the child and confirm my treatment plan. A grandmother eventually arrived but not before a second letter of complaint was written again angry at the delay and saying that she was going to sue me if any scar was left. The child was brave and the wound was stitched without complication.

CASE DISCUSSION

From the first moment I did not recognise this as a difficult situation. This was my first mistake. I identified my patient as the 9 year old with a "simple" head laceration requiring suturing. I was happy to proceed not appreciating that the challenge was the Whanau member, not the child.

I am not good at managing difficult patients. When they come at me with accusations of poor medical skills, I tend to reply defensively. This was my second mistake. This wasn't an emergency, and instead of stopping and taking the time with this lady, I minimised her issues and simply pushed on with my agenda. This simply escalated the confrontation with her rising anger matched only by her rising voice.

When things are going well and rapport is good you find that you can rapidly assess and treat these patients. But there must be a "plan B", for when it all goes sour.

"REBELS" (1) is a simple acronym that I have since learnt whose application would have been good for this situation. The model works to first **R**ecognise there is a problem, express **E**mpathy, establish clear **B**oundaries, **E**mphasise the patients best interest using inclusive **L**anguage, and finally to focus on **S**olutions. This may provide an approach to situations of challenging communication, the aim being a smooth consultation and better outcome. I failed to **recognise** the problem and simply pushed on with my agenda. Not addressing this gave the impression I was oblivious to her feelings.

I believe that she was demanding an inappropriate treatment. I tried to be clear with my **boundaries** but instead of dogmatically stating these, it may have been better to have acknowledged her plan, **emphasize** that we both had the child's best interest at heart and offered options, **including** her in the decision.

By generating **solutions** together, and not excluding her as I did, she may have come around to my treatment plan and adopted it as her idea.

I handled this poorly I can see that now. By not at first recognising the difficult interaction I just continued on and everything snowballed from there. These patients are infrequent but make up the predominant source of complaints and I now feel better prepared for the next one

References:

1) Hawkin SJ, Fox R, van den Brink R, Moir F. REBELS: An Approach to communication challenges in the consultation. NZFP Vol 35 number 4. August 2008: 274-277