Effective Case Presentations

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自治医科大学さいたま医療センター外科では、4年前から術前症例カンファランスおいてレジデントによる英語でのプレセンテーションを導入し、昨年4月から著者の一人であるAlan Leforの指導のもと、毎週月曜日の朝に英語でのプレゼンテーションをおこなっている。最近は国際学会において、英語で発表し英語で討論をする機会が増えており、このようなトレーニングは将来役に立つことと思われる。
英語のプレゼンテーションのキーポイントは、プレセンテーションの標準的スタイルを熟知することと英語力を身につけることの両者にある。また、プレゼンテーションの内容は、英語であれ日本語であれ、患者さんの治療方針を決定する上に重要であるので、レジデントは上級医の指導のもとに綿密に準備することが必要である。症例呈示は、十分な病歴聴取と理学的所見や検査所見の検討に基づいて行われなければならない。特に、病歴聴取と理学的所見は診断や治療上重要であり、これらの所見によって多くの疾患は診断されうるとも考えられる。実際のカンファランスにおいては、プレセンテーションに必要とされる事項を簡潔にまとめ、さらに、質問に答えられるように準備しなければならない。プレゼンテーションの内容により、レジデントが如何に的確に患者さんの病態を理解しているかが評価できる。
このシリーズでは、第一報として基本的プレゼンテーションの方法を述べ、第二報では、誤って使われる傾向がある英語の字句や言い回しについて解説し、第三報において、英語のプレゼンテーションを導入して成功させるためのノウハウについて述べる。

1. History

The complete medical history always should have six parts It begins with the Chief Complaint, followed by the History of Present Illness, the past Medical History, the Family History, Social History and Review of Systems. The most important thing about the history is that it is complete. There are many different “styles” and no single style is best for everyone. Rather, it is important to develop your own style that you can easily and almost “automatically” perform without missing any of the parts. Presented here is just one style for the history that is complete.

(1) Chief Complaint (CC): The presentation should begin with the Chief Complaint (CC), which is usually best stated in the patient’s own words, for example , “The patient comes in complaining that ‘my leg hurts’ “.　患者さんによる症状の表現は様々であるが、

患者さんの使った言葉をそのまま伝える事が重要である。Some people begin the Chief Complaint with patient identification which is also acceptable.

(2)History of Present Illness (HPI): This is a chronologic account of the course of the patient's problem from its beginning to the present time, stated in medical language. It should begin with information that identifies the patient, such as "The patient is a 35 year old man who presents with a three day history of abdominal pain". The person writing the history should go back in time to the point when symptoms began, and then move forward, telling a story, until the time that the patient is being seen. It is critically important to remember that the History of Present Illness is written for communication with other health professionals and therefore is written strictly in medical terms. One should avoid jargon and common words. For example, the words "felt like a heart attack" should not be used in this section; rather "angina pectoris" should be used if appropriate.

The remainder of the HPI details the course of the symptoms to the present time. Pain of any kind should be completely characterized by Location (anatomic description), Onset (abrupt or gradual), Radiation (if it radiates and where), Character (sharp or dull), Alleviating factors (things that make it feel better), Aggravating factors (things that make it worse such as movement or eating), Course (is it generally getting better or worse?), and Associated symptoms (such as nausea, vomiting, fever, etc). Details about any medical care sought recently, or treatment given should be included, again, using medical terminology. The HPI should be written as a clear chronologic description of what happened to the patient starting at the moment when they last felt well (e.g. "The patient was in his normal state of health until after breakfast on the day of admission when he noted the onset of dull peri-umbilical abdominal pain…").

In addition, the last part of the HPI should contain a review of the affected system. For example, if the patient comes in with complaints of abdominal pain, then this section must contain a complete review of the gastrointestinal system with answers to all of the questions regarding the gastrointestinal tract such as the presence of nausea, vomiting, dysphagia, odynophagia（嚥下痛）, dyspepsia, jaundice, change in stool habits, change in stool caliber, etc. One can simply use the list of symptoms from the Review of Systems section (below), for the affected system. The presence or absence of any associated symptoms are an important part of the HPI. During an oral case presentation, the HPI should be completely presented, since everything in the HPI is relevant to the audience gaining a full understanding of the case. "Review of affected system"とは、現病歴において問題となっている疾患の臓器等に関連する症状の有無を聴取することで、腹痛を主訴として来院した患者さんについては、消化器症状について詳細に聴取し、その要点を簡潔に述べる。

(3)Past Medical History (PMH): includes five sections: **M**edications, **I**llnesses (medical illnesses), **S**urgery (previous operations), **I**njuries (major accidents for which the patient had medical attention or hospitalization), and **A**llergies. Note that these five sections can be remembered easily with the mnemonic "MISIA", the name of a well-known Japanese singer! "ミーシャ"（おぼえるための略語として便利です）For women, the PMH also contains a brief gynecologic history (menarche, menstrual history, age at menopause, pregnancy history). The section on Medications should contain the name, dosage and frequency for each medication taken by the patient at that time. Be sure to ask about over-the-counter medications as well as nutritional supplements. There should be sufficient information to write the orders so the patient can continue to take their medications, as indicated. The sections on Illnesses, Surgery,

and Injuries are rather straightforward. When eliciting information about allergies, it is not sufficient to simply write “Allergies: Penicillin”. If the patient reports an allergy, then the physicaina must get more information, especially as to the exact nature of the allergic response (e.g. a skin rash, anaphylaxis, etc) as well as the approximate number of times this has occurred.

(4)Family History (FH): contains basic information about both parents and all siblings (alive or dead, current age or age at death, cause of death, chronic illnesses). Unless the patient is adopted and may not know their birth family, everyone has a Family History, so it is not correct to state “None”. Sometimes, the family history is not relevant to the present problem, in which case we say that it is “Non-contributory”. Information about the health of children belongs in the Social History section. After eliciting information about the specific family members, one should ask if any diseases are common in the family such as heart disease, cancer, diabetes, etc.

(5)Social History (SH): describes the patient’s habits including alcohol use and amount, tobacco use and amount and the use of any illicit drugs. Information about the health of children can be included here as well as information about employment (e.g. works with a lot of chemicals, etc.) and living situation. Information about lifestyle issues such as sexual activity, sexual preferences, etc. can also be included here.

(6)Review of Systems (ROS): is a long list of questions to conduct a “head-to-toe” review of each body system generally in the same order as a complete physical examination (General, Skin, Head / Eyes / Ears/ Nose/ Throat, Neck, Back, Breasts, Respiratory, Cardiovascular, Gastrointestinal, Genitourinary, Endocrine, Extremities / Vascular and Neurologic / Psychiatric). The patient is asked about the presence or absence of symptoms in each body system. For example, in the “Respiratory” system,

one should ask about the presence of cough, sputum, hemoptysis, wheezing, dyspnea, exercise tolerance and pleurisy. Information for a woman's gynecologic history can be included here, or in the PMH section.

While it is common for younger doctors to claim that this important process cannot be done because it "takes too much time", experienced clinicians know that the entire ROS can be performed efficiently in about 2 minutes, if done correctly. This level of efficiency can only be achieved by repetition and practice, doing it the same way every time. In a formal oral presentation, it is reasonable to only state pertinent positive items from these portions of the history.

"Review of systems"は、本邦ではなじみのない言葉であるが、これは、全身的に各臓器に関連する症状の有無について患者さんに質問することであり、米国においてはルチーンに行われている。症状の有無については、主訴に直接的な関わりがないと思われるものも含めて全身的かつ系統的に聴取するが、もちろん、プレセンテーションの時には問題となる症状のみについて述べることが適切である。

2. Physical Examination

Although the written report of the physical examination must be thorough, the description of the physical examination during an oral case presentation should be limited to what is important for evaluating the patient, but this includes important negative items as well. It is important to think like a member of the audience, who will want to hear all that is important to evaluate the patient and arrive at a reasonable plan of treatment. For example, in any case of a patient with a malignancy, it would almost always be important to describe the existence of any masses as well as the presence or

absence of palpable lymph nodes. In a patient with heart disease, the cardiac exam should be presented even if the chief complaint relates to abdominal pain. The presenter must give the audience sufficient information. Patients for whom surgery is planned should always have a thorough description not only of the affected area, but also of any significant findings that could affect surgical morbidity such as physical findings consistent with chronic obstructive pulmonary disease. By the same reasoning, the presenter should include clear lung fields and a normal cardiac exam as well. If non-operative treatment is planned for a patient because they have major illnesses that increase surgical risk, then the presenter must give the audience the information to know that this patient has significant co-morbidities. The oral description of the physical examination must include anything that is relevant to the proposed plan of treatment.

プレゼンテーションにおける理学的所見は、治療の対象となっている疾患に関連した所見および問題となる全身的合併症（併存疾患）に焦点を当てて述べ、特に治療方針決定に関連する所見が明確になるように説明する。

3.Laboratory and Imaging Studies

Prior to the actual case presentation, be sure that you have all relevant laboratory results and imaging studies available. If you are using a projector and/or computer, be sure that it is working and that you can use it properly and smoothly. As with the physical examination, results that are appropriate should be mentioned including positive and negative results. It is not important to mention every result obtained, but the presented information should support the diagnosis and the proposed

plan of treatment. You should show only the appropriate images. It is not acceptable to be sorting through dozens of images during the case conference to find the one important image that demonstrates the pathology of interest. It is important to indicate the site of the abnormal findings on the screen with a pointer so that the audience could have a good understanding. Therefore images to present should carefully be selected in the process of preparation. This information should give the audience the data required to support the plan of treatment that you will outline at the end of the presentation.
CT, MRI , 超音波、内視鏡などの画像診断は、外科診療において益々重要な役割を占めている。プレゼン―ションを準備するにあたって重要な画像を綿密に選択しておき、選択した画像をスクリーンに出して異常所見の部位をポインターで指し示しながら説明することが重要である。

4, Assessment and Therapeutic Plan

This portion of the presentation requires the presenter to summarize in a logical manner and explain in an orderly way how the proposed treatment plan was decided upon, based on the history, physical examination and appropriate studies. It should be easy to understand how this conclusion was reached from the information given. In some situations, this portion of the presentation is greatly enhanced by the use of the literature to support a particular plan of treatment. This is particularly beneficial when one is proposing a plan of treatment that may not seem to be used in typical situations. 言うまでもなく、プレゼンテーションの中で最も重要な点であり、時に文献的検討やその部門での過去の治療データの分析なども必要となる。