CASE PRESENTATION

Activity

Audience- Clinical instructor(s), colleagues, other members of the pharmacist department or team

Duration- a 20-25 minute verbal presentation followed by a 5-10 minute discussion. The maximum presentation time is 30 minutes. If exceeded, the presentation will be **stopped**.

Materials-create slides using a technology platform like PowerPoint. Confirm you are able to access your file at your site before your presentation day. Print these off to serve as a handout. Your references should follow the AMA guidelines.

First Developed by the School of Pharmacy 1992

Presentation Outline

FORMAL PRESENTATION	**DISCUSSION ON THERAPY, RESPONSE, COUNSELING**
Goal is to provide enough pertinent background for a meaningful discussion. **Strict 25-30 minute time limit.** Give warnings: 2 min, **CUT!**	Led by presenting student. Answer questions from the students and clinical instructors. *(about 5 to 10 minutes)*
Patient Case - share background *(about 3 to 5 minutes)*	
Disease State *(about 5 minutes)* etiology pathophysiology/epidemiology symptoms physical findings diagnostic tests/labs (criteria or limits)	
Therapy (about 15 minutes) goals of treatment efficacy time course non- drug treatment mechanism / rationale extent of response drug treatment [Featured medication] mechanism / rationale time course and extent of response pertinent pharmacokinetics[route, starting dose, maximum dose, titration/range rationale] adverse effects/toxicity common adverse effects (and any pertinent rare effects) time course management administration issues alternative drugs mentioned rationale for selected drug Rationale for dose, route, interval	
Summary and Prognosis *(about 1 to 2 minutes)* Summarize the patient's condition compared to the classic case State the prognosis of the patient in qualitative terms	

First Developed by the School of Pharmacy 1992

Detailed instructions

Presentation of the Patient Case

This purpose of this section is to tell the patient's story. It involves the traditional presentation of the patient to include the situation and background (subjective and objective) information**.** You must be in compliance with HIPAA Guidelines The goal of this portion of the presentation is to set the stage for the didactic presentation of the therapy of interest. *For Community Pharmacy sites provide all the appropriate patient data that is available or list what information is necessary and how this information would be accessed. Approximations are acceptable for Community Pharmacy sites.* Essential information to present includes:

A. Demographic data–age, sex, gender identity, race, weight, and service patient is on.
B. Chief complaint. Reason for patient's admission/meeting the patient
C. History--includes present illness (HPI), past medical history (PMH), social history (SH) and family history(FH).
Include surgical procedures and mention previous hospitalizations that have a direct effect on the present illness
C. Medications (include medications prior to admission for hospital cases) Include duration of treatment., Allergies and prior Adverse Drug Reactions--list information that was obtained during medication history. Identify allergic reaction, how treated, if patient rechallenged. Include immunizations.
D. Pertinent physical exam data. Include BMI. Example–Abnormal exam in a patient with congestive heart failure may include the presence of 3+ ankle edema, + HJR, + JVP, and presence of rales in both lung fields. Pertinent negatives should be included also. Example– Normal rate and rhythm in a patient admitted to rule out MI.
E. Pertinent laboratory values. Example–in a patient with anemia the data may include Hgb 8, HCT 25, MCV 75, MCHC 25, serum iron 30, TIBC 400. Again, pertinent negatives also. Include ranges of normal values and units. Include CrCl and LFT if available.
G. A list of the Patient's Problems. This can include conditions currently requiring intervention.

Discussion of Disease State

This section of the presentation should include a general discussion of the disease process including pathologic and physiologic changes, symptoms, physical examination findings and diagnostic tests used to evaluate the disease process. The goal of this section is to identify markers of the disease process and identify symptoms or other outcome measures that can be used to evaluate patient response. This foundation facilitates your discussion of drug therapy and monitoring parameters for both efficacy and toxicity. **Be sure to bring out relevant points from your patient's story**.

First Developed by the School of Pharmacy 1992

Discussion of Therapy

The focus of the presentation is the use of the featured medication in the treatment of the disease highlighted in the case.

THERAPEUTIC GOALS: The therapy section should start with the goals of treatment. What changes in the disease state are we hoping to modify or cure? Identify the markers for response and adverse events, the target goals for change and the time frame in which improvement or cure can be expected. As these goals for treatment of a particular disease are not typically unique to the different drugs used in treatment, this section should encompass any of the drug(s) discussed below in this section. If there are differences in the modification of the disease process by different drugs this should be explained.

NON-DRUG TREATMENT: The mechanism and rationale for initial or complementary non-drug treatment of the disease state should be briefly mentioned. If treatment is initiated with non-drug therapy, the expected magnitude and time frame of response should be noted so that the audience will realize when it is time to start treating the disease pharmacologically.

DRUG TREATMENT: This portion of the therapy discussion should focus on 1 primary drug that is being used for the treatment of the disease as highlighted by the presented patient case. Items to be discussed should include:

a) mechanism of action / rationale / literature supporting drug use
b) time course and extent of expected response
c) pertinent pharmacokinetic points (e.g. route of elimination, half-life, etc.)
d) route, starting dose, maximum dose, titration/range rationale
e) adverse effects/toxicity
   common effects (& any pertinent rare/serious effects) time course
   management
f) administration issues (if pertinent idiosyncrasies are expected or observed)
g) alternative drugs mentioned. However, the focus of the presentation is on the primary drug and extensive elaboration should be avoided for the sake of time.

Comparison with the Classic Case and Estimation of Prognosis

Briefly, summarize the presentation of the patient highlighting features of the case that illustrate a classic or atypical presentation of this disease state. Some index of the prognosis of the patient should be stated. A litany of statistical outcomes is not as important as the potential outcomes and a feeling of the probability of these outcomes (e.g. a patient with Functional Class IV heart failure is not likely to live more than 5 years at best without a heart transplant).

To conclude relate this all back to your patient. Summarize the initial drug regimen for the therapeutic topic including the rationale, dose, route, dosing interval and anticipated duration of the featured drug. Any concurrent clinical conditions that resulted in an alteration of the starting dose (e.g. renal dysfunction, hepatic failure, etc.) should be mentioned along with the appropriate method of dosage adjustment. *For 740 students also include the hospital course.*

First Developed by the School of Pharmacy 1992

Question & answers

For the last 5 to 10 minutes of the session, you will be expected to answer questions from the students and clinical instructors attending the student's case presentation. If you are an attendee consider asking clarifying questions and sharing your perspective from your clinical experience.

EXAMPLE OF CASE PRESENTATION

CONGENITAL SYPHILIS

DEMOGRAPHIC DATA: Patient is a female infant who was admitted to the hospital for probable congenital syphilis. Patient weighs 4.2 kg and measures 52.7 cm tall.

CC: Thick green nasal discharge and noisy breathing x4weeks.

HPI: Patient presents to the hospital with a thick green and purulent nasal discharge, occasional cough and noisy breathing which has been persisting for 4 weeks. She also has a diaper rash for one week. Patient is the result of a NSVD and had a normal PE at birth. She was discharged at two days of age. Patient was seen at two weeks of age at the clinic for complaints of nasal discharge and breathing difficulties. Her chest X-ray was unremarkable. Since her clinic visit, the nasal discharge turned from clear and thin to thick and green. Patient has also become quite fussy and "spitty" in the lastweek.

PMH: Unremarkable until two weeks of age.

SH: Patient lives with her 22 year old single mother

FH: Mother tested negative for syphilis in January (early pregnancy) and oneday after patient's birth. Mother developed a rash and lesions on the palms of her hands, soles of her feet, nipples, and genital area about 1 month ago and was tested positive for secondary syphilis at the DERM clinic on the same day patient was admitted. Mother reports having sexual intercourse with a new partner twice during pregnancy.

MEDS: None.

ALLERGIES: NKDA.

IMMUNIZATIONS: Patient has not received her 2 month DTP and OPV.

PE: VS: T 37.8; P 170 (121-179); RR 42 (30-36); BP 64/42 (87/68); Wt. 4.2 kg (3.9-6); Ht. 52.7 cm (52-60)

GA: Awake and alert, congested breathing but NAD, smilingand active.

HEAD: Head circumference 35.5 cm (35.5-40)

First Developed by the School of Pharmacy 1992

EYES: PERRLA, EOMI

EARS: TM's clear

NOSE: Crusted discharge around nares, both nares patent.

THROAT: White exudate at back of throat and on tongue.

NECK: Supple, normal ROM.

LUNGS: CTA

CV: RRR, normal S1 and S2; no murmur.

ABD: Soft, NTND, no HSM.

GU: Normal female, erythematous maculopapular rash present with satellite lesions.

EXT: Moves all extremities, RROM, good strength and tone.

SKIN: No rash.

NEURO: Alert, Cranial nerves intact, deep tendon reflex 2+.

LABS: HEME: WBC 7 (5-19.5); RBC 3.2 (3.8); Hgb 11.1 (11.5); Hct 31 (35); MCV 96 (96) MCHC 36 (33); RDW 13.5 (12-15); Plt 391,000 (170,000-380,000).

ABS DIFF: Neutrophils 2100 (1000-9000); Lymphocytes 3900 (2500-16,500); Monocytes 630 (700); Eosinophils 210 (300); Basophils 70.

CSF: Nucleated cells 2; RBC 20; Neutrophils 2%; Lymphocytes 71%; Macrophages 26%.

CHEM AND LYTES: Not available

LFT'S: Not available

PROBLEM LIST: Congenital syphilis?
Oral thrush
Diaper rash

THERAPY INITIATED WITH: Penicillin G Sodium 200,000 units IV every 6 hours.
Nystatin Cream topically to diaper area four times a day.
Nystatin Suspension 1 ml (100,000 units) to each side of mouth four times a day.

REFERENCES

1. Taeusch HW, Ballard RA, Avery ME; eds. Schaffer and Avery's Diseases of the Newborn. 6th ed. Philadelphia: W.B. Saunders Company; 1991:389-391.
2. Grigorian Green M; ed. The Harriet Lane Handbook. 12th ed. St. Louis: Mosby Year Book; 1991:353-354.
3. Forfar JO, Arneil GC; eds. Textbook of Paediatrics, Volume 2. 3rd ed. New York: Churchill Livingstone;1984:1411-1415.

First Developed by the School of Pharmacy 1992

4. Ruiz-Maldonado R, Parish LC, Beare JM; eds. Textbook of Pediatric Dermatology. Philadelphia: Grune and Stratton; 1989:470.
5. Avery ME, First LR; eds. Pediatric Medicine. Baltimore: Williams and Wilkins; 1989:1101-1102.
6. Fischbach F; ed. A Manual of Laboratory and Diagnostic Tests. 4th ed. Philadelphia: J.B. Lippincott Company; 1992:466.
7. Wood VD, Rana S. Congenital syphilis presenting as desquamative dermatitis. Journal of Family Practice. 1992; 35(3):327-329.
8. Frecentese DF, Schreiman JS. Congenital syphilis in Nebraska: a case report. Nebraska Medical Journal. 1991; 76(10):330-334.
9. Coherty JP, Stark AR; eds. Manual of Neonatal Care. 3rd ed. Boston: Little, Brown and Company; 1991:181.
10. Tierney LM, McPhee SJ, Papadakis MA, Schroeder SA; eds. Current Medical Diagnosis and Treatment. Norwalk: Appleton and Lange; 1993:1091-1100.
11. Mandell GL, Douglas RG, Bennett JE; eds. Principles and Practice of Infectious Diseases. 3rd ed. New York: Churchill Livingston; 1990; 1804-1807.
12. Koda-Kimble MA, Young LY; eds. Applied Therapeutics The Clinical Use of Drugs. 5th ed. Vancouver: Applied Therapeutics, Inc; 1992:44.10-44.13.
13. McEvoy GK; ed. AHFS Drug Information. Bethesda: American Society of Hospital Pharmacists; 1989:192-220.

First Developed by the School of Pharmacy 1992