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How to make a case presentation

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ABSTRACT

Learning to present a case to the teachers and in examinations is a necessity of psychiatric training and vital in mastering the assessment and understanding of patients in psychiatry. In order to present a case, one must have knowledge of psychiatric terminology and phenomenology, be able to detect or elicit necessary data during the interview, and know how to interpret and integrate these data in a clinically meaningful way. Students of psychiatry should learn to describe their findings in a predictable, concise, and unambiguous manner. The vocabulary and organization used in case presentation may vary slightly from one resident to another, but overall it is quite similar. Among several other aims, reaching to a correct diagnosis and making a thorough management plan to help the patient in best possible way is essential while discussions regarding case are done in the clinics or examination. The organization or outline of format of case presentation enables the psychiatrist to describe objectively what has been seen and heard during the interview. Although this text includes few details on eliciting information, it is not intended to instruct the reader in interviewing techniques. A basic system of organization which can be used during case presentation is described in the text below.

Key words: Case presentation, interview in psychiatry, mental status examination, history presentation

Clinical interviewing is central skill of a psychiatrist and development of interviewing skills is the main aim of basic psychiatric training. Interviewing skills are considered both the science and art thus it can't be solely learned from a textbook or reading elsewhere. A trainee psychiatrist should take the opportunity to observe experienced clinicians as they interview patients and most importantly, carry out many clinical interviews and present the results to their teachers. Skills in this area come with experience and practice.

Aim of the clinical interview: The psychiatric interviews are performed with the following aims.

- Assessing history and performing mental status examination
- Understanding personality, social circumstances, life story and possible causative, contributory, perpetuating and maintaining factors of the illness
- Assessing diagnosis and differential diagnosis
- Deciding nature and setting (indoor, outdoor etc) of the treatment required
- Explaining the diagnosis and management plan to the patient
- Discussing future investigations or referral if needed
- Discussing course and prognostic factors of the illness
- Establishing therapeutic alliance, instilling hope and encouraging self help if possible
- Assessing risk to self and others

Case Presentation:

During training, making a case presentation is very important to learn and develop interviewing skills. Below is the format for timely and thoroughly presenting a case during examinations to the examiners and in routine presentations to teachers:

How to present History:

Identifying data (Basic information): Provide a succinct demographic information including Name, age, sex, occupation, residence, domicile, marital status, religion, education, patient's and family income, and current medicolegal status. Also report whether patient came of his own, brought by someone else or referred form somewhere.

Informants detail and their reliability: Present name, age, sex and relationship with the patient of key informants.

Five parameters should be assessed. Consistency, Coherence, Chronological information, Closeness with patient, Concern for patient (5 Cs). Overall decision regarding reliability (reliable, partially reliable or unreliable) should be told.

If the informants are reliable only for particular part of the history, it should be clearly mentioned. Patient should also be an informant till he/she is completely unreliable or uncooperative.

Presenting or chief complaints and summary: Presented in patients own words and in chronological order. One can present both the complaints given by patient even if they appear bizarre or irrelevant and complaints of the informants separately.

Summary is presented under headings of- Onset, course, duration, episode, precipitating factor, treatment taken, compliance and their response.

History of present illness: This part provides a comprehensive and chronological picture of the events leading upto current moments in the patients' life. Therefore, a detailed and well planned presentation is necessary in this part. For each individual complaint report its nature (in the patient's own words as far as possible); chronology; severity; associated symptoms and associated life events occurring at or about the same time. Note precipitating, aggravating, and relieving factors. Patient and family attribution of their symptoms should be described? Each information should be supplemented with adequate evidences and an example preferably in patient's/informant's verbatim.

Neurovegetative functions (Sleep, appetite, sexual interest) should be described in detail. Dysfunction (Social, occupational and personal) and its progressive evolution to current status need to be reported separately.

Details of treatment taken and response to the treatment, compliance, reasons for noncompliance, if so. Any attempts for faith/religious healings etc and their response.

Current medical conditions, their status and medications. Any possible correlation with psychiatric symptomatology.

Present relevant negative history to clarify possible differential diagnosis.

Past psychiatric and medical history

Previous psychiatric diagnoses. Chronological list of episodes of psychiatric inpatient and outpatient care. Chronological list of episodes of medical or surgical illness. Episodes of symptoms for which no treatment was sought. Any illnesses treated by doctors. Previous psychiatric drug treatments. History of adverse reactions or drug allergy. Any non-prescribed or alternative medications taken.

Family history

Family tree with details of names, ages and relationship needs to be drawn. Examiners might see the family tree or may ask the examinee to draw one. Are there any familial psychiatric or medical illnesses and their treatment details?

The patient may be more likely to respond with few psychotropic medications (i.e. lithium, antidepressants etc) which were useful in their family members.

Living conditions, nature of relationships among family members, family members' understanding and acceptance of illness, social support system. Details regarding history of origin are presented here. History of substance abuse, suicide, absconding or missing person in the family.

Personal/Developmental history:

Perinatal period (Antenatal, natal and postnatal), Developmental milestones. Childhood and adolescence history, education, occupation, sexual and menstrual history.

Marital and history of family by procreation: Details like duration of marriage, quality of relationships, relevant/important qualities of spouse and offspring. Other details like family history of origin needs to presented.

Medicolegal history : any medico-legal issues.

History of psychoactive substance abuse: Details regarding initiation, current pattern of use, withdrawal, tolerance, impairment in personal, social and occupational spheres are presented. Any implication on current illness may be described.

Premorbid personality (Adopted from Slater E. and Roth M. 1999):

Presented under headings of

1. Relationships with friends and family (social relations)
2. Predominant mood
3. Intellectual activities, Hobbies and interest
4. Character-
    a. Interpersonal relationship
    b. Attitude towards work and responsibility
    c. Energy levels and work initiatives
    d. Moral, religious and health related activities
5. Fantasy life

Assessment of personal and premorbid personality is likely to take significant time and it is often not possible to go in very much details during time bound interview of examinations. Descriptions don't satisfy with series of adjectives and epithets so illustrative anecdotes and statements from life of the patient should be quoted as evidences. Briefly the aim is to assess:

I) Recurring patterns of behavior and experiences in relationship and jobs in life.

ii) An evolving sense of personal identity across the nonvegetative spheres of human behavior- namely, relationships, work, and enjoyment.

Physical examination: Present assessment of overall general health, monitoring of vitals and systemic examination. If organic etiology is possible, detailed assessment of that particular system should be presented (i.e CNS examination in dementia, CVS examination in Panic disorder etc).

Mental Status Examination:

General appearance and behavior: Describe appearance, predominant physical characteristics, cleanliness, hair, clothes and style of dressing, any unusual dressing or ornaments, apparent age and general physical health, any involuntary movement.

Eye to eye contact, facial expression, use of posture and gestures.

Behavior and psychomotor activity, attitude towards examiner, cooperativeness and openness in conversation.

Speech (volume, rate, tone, prosody, fluency).

Rapport could be established or not. If not, the effort made by the examinee to establish rapport should be described.

Consciousness and orientation: Alertness and awareness of surrounding.

Orientation to time, place and person .

Attention and concentration: Attention is described as easily arousable or arousable with difficulty.

Digit span test, 100-7 test or 40-3 test.

Months/weekdays names forward or backwards may be useful in illiterate or less educated patient.

Mood and Affect: Subjective and objective assessment (based on facial expressions, vocal tone modulations, gestures and posture).

Describe predominant mood (euthymic, depressed, elevation, elation, anxious, distressed etc).

Describe stability, intensity or depth, range, reactivity, appropriateness to thought content and setting

Thinking:

Flow- Increased, Decreased or Normal

Form- Relevant, coherent, Degree of connectedness (loose associations, tangentiality, derailment etc.), Presence of peculiarities (clang associations, punning, neologisms, etc.)

Content- Predominant topic or issues, Overvalued ideas, Beliefs, Delusions, Preoccupations, Ruminations, Obsessions, Suicidal/homicidal ideation, Phobias

Describe frequency, intensity/severity and impairment due to each problem in thought content

Possession of thoughts- Thought broadcast, Thought block, Thought withdrawal, Thought insertion

Perception: Illusions, Hallucinations, Depersonalization, Déjà vu

The sensory system involved (e.g., auditory, visual, taste, olfactory, or tactile) and the content of the illusion or the hallucinatory experience should be described. Circumstances of the occurrence of hallucinations like relation to sleep or stress should be described. Clearly differentiate between hallucinations, pseudohallucinations or imagery. Describe frequency, intensity/severity and impairment due to each of the above symptom in perception

Intelligence: Test of intelligence should be performed according to educational and sociocultural background of the patient. Examinee should describe

1) *Abstract thinking*- Similarities, proverb interpretation
2) *Arithmetic calculation*- Addition, subtraction, multiplication etc as per educational background
3) *General fund of Knowledge*- Useful tests for illiterate or less educated patients are naming of five major rivers, five big cities, vegetables and fruits

   Asking about current events, famous persons in country and politicians also helps to know and report general awareness of the patients

Memory: Immediate registration and recall (3 unrelated words like coin, cycle and tomato are given. Describe ability to register and recall after 5 minutes)

Recent memory (describe food items ingested in the morning and yesterday night, recent visitors, route and ways of travel to hospital etc)- applies on the scales of minutes to days

Remote memory (dates of important life events, important events of national/international interest of the past)- encompasses months to years

Information asked in recent and remote memory should be cross checked with an informant of the patient

Judgement: Personal and social judgment (Reasoning regarding current important issues, Ideas about decisions or actions to be taken including a current illness, Evidence from past judgments as clues to current thinking, social behavior and evidences from direct observation)

Test judgment- Addressed and stamped letter test, Fire test

Insight: Grade I to VI

Diagnostic formulation: Often the examiners ask for a diagnostic formulation. It is brief outline of overall case where only relevant positive and negative aspects from history and MSE are presented to the examiner so that important clinical decisions like diagnosis and management can be planned.

Diagnosis and differential diagnosis: Discuss the points in favor and in against for each diagnosis being considered

Management: Consider following points

Setting of the treatment- Place of the management (indoor, outdoor) should be discussed with the reasons for the same.

Investigations required- Relevant and necessary investigations for diagnosis and differential diagnosis required should be described

Biochemical- Blood and Urine investigations etc

Radiological- CT scan, MRI scanning, EEG etc

Psychological- Rorschach inkblot test, Thematic Apperception Test, Bender Gestalt Test etc

Treatment- Discussed in two broad headings

Pharmacological- Group of medications and name, dose of initiation and maintenance, precautions before starting medication

Non pharmacological- Type of approaches required, psychoeducation, Cognitive behavior therapy etc and strategies for rehabilitation.

Personal suggestions:

- Before starting interview, keep a format for history and MSE ready so that during interview the trainee should be able to record information as it comes. Most part of MSE can be completed during history taking itself with this strategy and a lot of time can be saved.
- Appear unhurried: Despite time limitations appearing unhurried will help the patient and attendant to be at ease and time taken to complete interview is also not prolonged much. In hurry, people often make careless mistakes leading to ultimately more loss of time.
- It may not be possible at times to take satisfactory details of personal or family history and premorbid personality in few cases with long history. In such cases it is prudent to report to the examiner about the same but also emphasizing at the same time areas which you like to enquire in details in future assessments.
- Practice finishing history and MSE in 45 minutes. Rest of the time should be utilized to revise the information elicited, to gather the thoughts regarding case and writing diagnostic case formulation etc.

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