


# PHASE 2



## Combined Medicine & Surgery Clinical Attachment Rotation Guide

## The Oncology Version

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..... **July 2010**

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inc. removal superfluous rotations,  
rearrangement assignment information,  
reordering of relevant appendices

# INTRODUCTION

## General Preamble

It is important that you spend some time before your attachment to explore this guide so that you have an understanding of what is expected for, and from, you during your clinical attachments. You cannot afford to waste a single day of this time as you have so few days in each placement.

There is no possible way that you can expect to see every clinical condition or situation that you will encounter in your early professional life. What is important is that you learn the process for managing patients in a way that is in **their** best interest.

There may be much “general medicine” to learn from a patient who is admitted to an “orthopaedic” ward. Let the patients be your teachers. Patients often have many conditions (co-morbidities) and medically-related matters that can assist your learning – keep your eyes and your minds open!

*“He who studies medicine without books sails an uncharted sea, but he who studies medicine without patients does not go to sea at all.”*

(William Osler [Canadian Physician, 1849-1919](#))

## Explanation of guide content & structure

This additional guide has been developed with the students doing Medicine and Surgery placements at TWH in mind. However, much of the information can be used as a guide for all GSM students in their clinical work.

No list of clinical diagnoses presented to a medical student is meant to be exhaustive or the only things that a student will encounter in their studies but those conditions listed in this guide are a good starting point for your clinical studies.

## How to use this guide

Read it and refer to it! It is a guide to your clinical studies in Phase 2 and beyond.

## Developing a study Program

### The Big 10 Surgery Scenarios

1. Acute abdomen
2. Abdominal mass
3. Altered bowel habit
4. Groin swelling
5. Fall on outstretched hand
6. Fall and can't walk
7. Multiple trauma / Shock
8. Neck lump
9. Breast lump
10. Skin lesion

## **The Big 10+ Surgical Diseases**

### **1. The cancers**

- Breast
- Bowel
- Stomach & oesophagus
- Skin
- Prostate
- Kidney
- Bladder
- Mouth & larynx
- Pancreas
- Liver

### **2. Vasculopathies**

- Arterial occlusion (PVD)
- Aneurysm
- Diabetic foot
- Post phlebitic syndrome
- Varicose veins

### **3. The .....itis's**

- Appendicitis
- Cholecystitis
- Diverticulitis
- Pancreatitis

### **4. Hollow organ obstructions**

- Bowel
- Urinary

### **5. Herniae**

- Inguinal & Femoral
- Hiatal

### **6. Trauma & Burns**

### **7. Infections**

- Eye, ear, salivary gland
- Skin, joints & bone

## **The Big 10+ Surgical Management Issues**

### 1. Prophylaxis

- Infection control
- Surgical site infection
- DVT
- Pressure area
- Respiratory

### 2. Pre-op preparation

### 3. Fluids, electrolytes, acid/base

### 4. Analgesia

### 5. Post-op care

### 6. Post op complications

### 7. Wound care

### 8. Communication & hand-over

### 9. Record keeping

### 10. Informed consent

## **Reference to general phase 2 handbook**

The General Phase 2 handbook is another document with which you need to be familiar. There is some repetition in the guides.

# COMBINED MEDICAL/SURGERY EXPLANATIONS

## Clinical portfolio

This refers to clinical experiences that you should gain to develop your competence in the management of scenarios and diseases commonly seen in surgical & medical wards. It does not refer to the development of skills in performing surgical operations.

**Note:** You are here to learn to manage patients with the diseases and disease complexes seen on the wards, surgical and medical. Do not confuse that with learning to operate. Learning specialist procedures such as operative surgery or endoscopy are essentially post-graduate activities.

The experiences listed should be recorded in your clinical attachment logbook. By simply ticking them off, the portfolio lists in effect become a clinical curriculum guide and the record of your experiences tells you how much you have covered and acts as your student logbook.

The clinical portfolio is mainly for your use, so that you have guidance about what you should see, do and know about. It will function as a cumulative record enabling you to reflect on your experiences, to see what you have done and to be aware of what you have not yet experienced. It should also be available for review by your preceptors and by the UoW academic staff as required.

***The portfolio in surgery & medicine will be made up as follows:***

### **A. Portfolio Cases**

These are specific clinical cases to be encountered/ observed during a clinical attachment in surgery and medicine. Generally this will mean carrying out a case history and physical examination but may also include cases where you have been significantly involved in case management on the wards or in the operating theatre, sufficient to be a significant learning experience about the particular clinical scenario or disease entity and its management. The portfolio cases are suggested in two ways.

- i) Clinical scenarios (disease presentations)**
- ii) Clinical entities (specific diseases)**

### **B. Portfolio Skills**

#### **Clinical Skills**

Specific clinical skills to be acquired/practiced or observed during time with a specific clinical specialty unit

#### **i) To be performed**

**In all cases this will include:**

1. Case histories and physical examination for portfolio scenarios/cases for that unit
2. Assessment for surgery including risk assessment, prophylaxis (E.g.; DVT, infection, respiratory etc), post-op recovery plans (physio etc)
3. Preparation for surgery – medication management, hydration, fasting, co-morbidity minimisation, bowel prep etc
4. Post op management plan – analgesia, prophylaxis, IV fluids & electrolytes, nutrition, rehab etc.
5. Specific skills

#### **ii) To be observed**

**Note:** Witnessing a procedure such as colonoscopy or an operation includes pre and post op management, checking and understanding resulting histopathology and development of treatment plan.

### **C. Imaging skills**

- i. Be able to recognise the study, orient & organise films/move logically through the stored image sequence
- ii. Recognise normal radiological anatomy /expected structures & features
- iii. Understand what abnormalities the study could be used to reveal
- iv. Recognise common significant (major/obvious) abnormalities
- v. Systematically review the study & give an organised opinion
- vi. If possible, view the study being carried out

### **D. Case presentation and discussion skills**

#### **Student Grand Rounds**

- Case presentation and analysis
- Management of case discussion

#### **Other essential activities include:**

Ward round participation

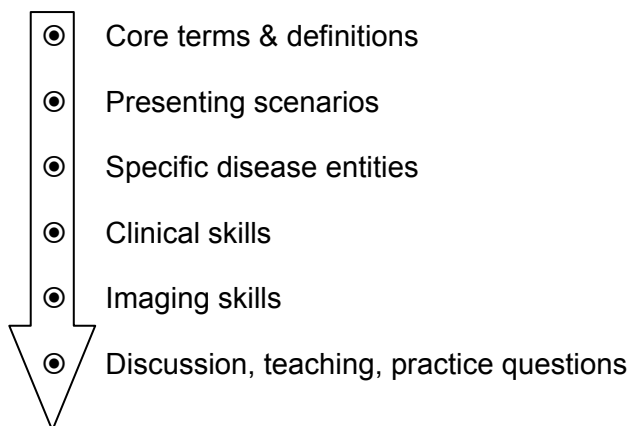
Unit meetings – attendance and participation in case presentations and discussions

Tutorials

## **Developing a Medicine & Surgery Study Program**

Use the scenarios, diseases and skills in the clinical attachment outlines for medical and surgical terms.

### **Study Progression**



# ONCOLOGY

The Oncology term lasts for 5 weeks, and is structured so that you will spend 2 weeks in Medical Oncology (MO), 2 weeks in Radiation Oncology (RO), and 1 week in hospital based Palliative Care (PC) (See page 25). During these periods, you will attend Outpatient Clinics and be involved in the work of the particular group with which you are involved.

The modus operandi of this term is your assignment to a specialist which is how you will be provided access to clinical work. This will involve observation, participation and interaction with patients. For both MO and RO, there is a large amount of preparation work going into the delivery of patient treatment, and you should have closely watched this part of the process.

For MO this includes interaction with pharmacists and chemotherapy nurses, and for RO includes radiation therapists, radiation physicists and radiotherapy nurses. Also involved in patient management are the Cancer Nurse Coordinators, Oncology Psychologist and Genetic Counsellor. An understanding of these roles is expected.

The senior registrars will also provide weekly oncology tutorials covering common and 'concentrated' cancers such as cancers of the Breast, Colorectal, Lung, Prostate with H&N, and GU. These sessions are to dovetail with the MDTs that students will also be attending.

It is expected that at least once in the 5 weeks (but preferably 3 times), students will present a patient with whom they have been involved at the relevant MDT meeting. In addition, in week 5, each student is to provide a report on a patient journey that covers issues of the disease, its psychosocial and spiritual impact, as well as GP involvement.

Preparation for this term requires that your examination and history taking skills be at a high level. This will form the basis for appreciating the clinical course of cancer and its impact on the patient and family.

## Clinical Unit Details

### 1. Consultants

- Medical Oncologists
  - Professor Phillip Clingan
  - Dr Amanda Glasgow (not formally involved in teaching at this time)
  - Dr David Thomas (not formally involved in teaching at this time)
  - Dr Mori Aghmesheh
- Radiation Oncologists
  - Dr Chris Fox (not formally involved in teaching at this time)
  - Professor Andrew Miller
  - Dr Les Nasser
- Palliative Care Consultants
  - Dr Greg Barclay
  - Dr Frank Formby (David Berry Hospital)
  - Dr Kristen Turner (Wollongong Hospital)

### 2. Oncology Registrars

- Medical Oncology
  - Dr Surinder Singh
- Radiation Oncology
  - Dr Swetha Sridharan
  - Dr Farhannah Aly
  - Dr Sandy Ho
  - Dr Simon Tang

### **3. Clinical Nurse Coordinators**

- Vhari Dixon
- Linda Horning
- Geraldine Beaven
- Steven Dunn
- Bernadette Burgess

### **4. Ward Staff**

- Oncology Ward
  - Ward C7
    - Ward Charge Nurse
      - Nicola
    - Ward Secretary
      - Lyn Sandona
  - Palliative Care Clinical Nurse Consultant
    - Janice Jensen
- Oncology Day Care
  - Level 1, ICCC
    - Charge Nurse
      - Jo Rutledge (on leave)
    - Nurse Educator
      - Verity Gotch
    - Palliative Care Clinical Nurse Consultant
      - Janice Jensen
- Radiation Oncology Nursing
  - Level 2, ICCC
    - Graham/Vesna/Cornelia



# ONCOLOGY (cont.)

## Participation in the Illawarra cancer care Ward

### C7 Participation

#### 1. Student ward rounds

- Daily with resident staff for admitted patients
- Entry of clinical notes mandatory after seeing patient (Learning the technique of problem list generation will make this process more focused)

#### 2. Oncology Day Care

- Daily after inpatient issues have been settled

#### 3. Team ward rounds

- Monday Morning
  - Medical Oncology Ward round at 8:30am in C7
- Tuesday Morning
  - Oncology/Palliative Care Combined Ward Meeting at 9:00am
- Wednesday Morning
  - Medical Oncology Ward round after joint meetings at 11:00am
- Friday morning
  - Medical Oncology Ward round after MDT at 9:30-10am

## Cancer Centre clinical activities

### 1. Multidisciplinary meetings

- Lung Cancer
  - weeks 1 and 3, Friday 8:30am, ICCC, Level 3
- Breast Cancer
  - weeks 2 and 4, Friday 8:30am, ICCC, Level 8
- Lymphoma
  - weeks 1 and 3, Wednesday 8:30am, TWH, Level 8
- Gynaecological Cancer
  - weeks 1, 2, 3 and 4, Monday 5:00pm, video conference, ICCC, Level 3
- Colorectal Cancer
  - weeks 1 and 3, Wednesday 8:00am, TWH, Pathology, level 5
- Urological Cancer
  - weeks 3, Wednesday 7:30am, Southern-IML Pathology, Denison St
- Head and Neck Cancer
  - weeks 1 and 3, Tuesday 8:30am, ICCC, Level 3
- Imaging
  - Wednesday 9:30am
- Rural MDT (Nowra)
  - Friday 1:00 pm, Shoalhaven District Hospital
  - once a month

### 2. Audit Meeting

- Mortality and Morbidity Meeting, week 2, Wednesday 9:30am, ICCC, Level 3
- The medical students will be expected to organise their time to be able to present at useful experiences. The oncologists require:
- presentation of AT LEAST one case at a MDT
  - presence at the Medical Oncology Ward Round each week
  - attendance at the Oncology teaching session with the oncology registrars

## Clinical Log

Specific clinical cases (diseases/clinical scenarios and operations) to be encountered/observed and are expected to be recorded with case history and physical examination completed so that clinicians can check progress. These case notes should be managed in a portfolio by the student during clinical attachments.

The involvement of basic science issues in clinical care should be sought. Where an issue is raised on Day N and the answer is unknown (e.g., what are the cellular features that lead us to call something "Grade 3"?), the answer should be available on Day N+1. To make this a reality, students should have a notebook.

## Clinical scenarios/presentations

Students will find considerable overlap with other disciplines, so we would prefer to highlight a number of scenarios as generic problems which relate to many cancers. General clinical work will cover the common cancers and teach about the integration of different modalities.

- investigation of a mass
- investigation of weight loss
- use of tumour markers
- investigation of blood from an orifice
- investigation of cancer extent (staging)
- investigation of cancer patient after treatment (follow up)
- management of cancer pain
- breaking bad news
- multidisciplinary management

## Clinical entities (specific diseases)

Students will find that there will be substantial overlap with other disciplines, so the clinical entities which are very common and peculiar to Oncology are to be highlighted. Uncommon cases or exceptional clinical signs should be reported to fellow students cases to watch for include sarcoma and melanoma.

- Breast cancer
- Prostate cancer
- Lung cancer
- Brain cancer
- Upper & Lower GIT cancer (oesophagus, stomach, pancreas, colon, rectum, anus)
- [\*MO] Lymphoma
- [\*RO] Head and Neck cancer
- [\*MO] Testicular cancer
- [\*RO] Skin cancer (SCC, BCC, melanoma)

Students are expected to liaise with the Radiation Oncology registrars for the provision of 1 hour of face-to-face teaching during each week. Publicity regarding the date and time is the responsibilities of the students.

A set of oncology questions will be provided to help you focus on Oncological Issues. Its Completion is not mandatory, but rather as an aid to your unstructured work here.

# SPECIFIC SKILLS IN ONCOLOGY

## Clinical Skills

Specific clinical skills to be acquired/practised or observed during phase 2 clinical attachments, usually during the time with the appropriate clinical specialty unit(s).

To be performed:

1. Case histories and physical examination including scenarios/cases as above
2. Indirect laryngoscopy
3. Oral hygiene and skin care during radiotherapy
4. Control of Nausea and Vomiting during chemotherapy
5. Management of Cancer Pain
6. FNA

To be witnessed

1. Breaking of Bad News
2. Chemotherapy (including treatment decision, preparation, delivery, contamination precautions and spill management)
3. Radiotherapy (including treatment decision, simulation, planning, treatment delivery and radiation protection)
4. PEG insertion
5. PICC line/Portacath/Hickman catheter insertion and access

## Oncological Skills

These Oncological Skills are generic skills that relate to the management of all cancers. There is no requirement that students learn specialised treatment protocols for cancers. The role of each modality will be highlighted in the common malignancies but detailed treatment recommendations are not required. An appreciation of what is done for “early”, “locally advanced” and “metastatic” disease is inevitable.

The Oncology Team is more concerned about the central position of Diagnosis and Staging in their thinking and patient management.

## Imaging skills

- be able to recognise the study, orient and organise Imaging Studies
- be able to recognise normal structures and common (major/obvious) abnormalities.
- identify node bearing regions in cross-sectional studies (neck, supraclavicular fossa, axilla, mediastinum, para-aortic, pelvic, inguino-femoral)
- identify the normal and cancer affected appearance of important & major organs
  - Intra-abdominal organs - liver, spleen, stomach, pancreas, kidneys, ureters, colon, major blood vessels
  - Intra-thoracic organs - major blood vessels, heart, lungs, trachea, oesophagus
  - Head and Neck organs (mandible, tongue, tonsil, larynx, epiglottis, pyriform fossa, parotid & submandibular glands)
  - Cranial organs (eyes, optic tracts, pituitary, cavernous sinus, brainstem, cerebellum, ventricles, ear)
  - Pelvic organs (prostate, seminal vesicles, vaginal, cervix, bladder, rectum, iliac vessels)
- The ability to identify these structures will be directly addressed in Radiation Oncology when patients undergo planning with subsequent contouring of their CT/ MRI/PET images.

# ONCOLOGY CLINIC TIMETABLES

## Medical Oncology [his rooms are at 410 Crown Street, Wollongong, ph 42273733]

### Professor Clingan

	Monday	Tuesday	Wednesday	Thursday	Friday
<b>Morning</b>	MO Ward Round	Rooms	Meetings MO Ward Round	Rooms	
<b>Afternoon</b>	Rooms	Rooms	Research @ UoW	Rooms	
<b>Meetings</b>			1/3 Colorectal 8:00	1/2/3/4 Grand Rounds	1/3 Lung 8:30 2/4 Breast 8:30 RMDT Nowra 1:00

## Radiation Oncology [entire attachment based in ICCC at TWH]

### Dr Foo's replacement

	Monday	Tuesday	Wednesday	Thursday	Friday
<b>Morning</b>	Follow up	O/PC joint meeting		Simulation Treatment review	
<b>Afternoon</b>	New patients	Research @ UoW	Simulation	Treatment review	
<b>Meetings</b>	1/2/3/4 Gynae 5:00		1/3 Lymphoma 11:00	1/2/3/4 grand Rounds	1/3 Lung 8.30 2/4 Breast 8.30

### Assoc. Professor Andrew Miller

WEEK 1	Monday	Tuesday	Wednesday	Thursday	Friday
<b>Morning</b>	Follow up (WLG)	Simulation	Meetings	Treatment review	Research @ UoW
<b>Afternoon</b>				Treatment review	Research @ UoW
WEEK 2	Monday	Tuesday	Wednesday	Thursday	Friday
<b>Morning</b>	Follow up (WLG)	Simulation	Meetings	New patients (NWR)	Research @ UoW
<b>Afternoon</b>	New patients (WLG)			Follow up (NWR)	Research @ UoW
<b>Meetings</b>	Café DSL (UoW)	1/3 H&N 8.30	3 Urology 7.30 1/3 Colorectal 8.00	1/2/3/4 grand Rounds	1/3 Lung 8.30 RMDT Nowra 1.00

### Dr Les Nasser

	Monday	Tuesday	Wednesday	Thursday	Friday
<b>Morning</b>		Treatment review Follow Up	Meetings	New patients	
<b>Afternoon</b>	Simulation	Treatment review	Follow Up	Simulation	
<b>Meetings</b>			1/3 Lymphoma 11:00 3 Urology 7.30	1/2/3/4 Grand Rounds	1/3 Lung 8.30

Sites: New patient & follow: Clinic area (north & west corridor from Reception Desk, Level 2, ICCC)  
Simulation: Simulator (south & west corridor from reception desk, Level 2, ICCC)  
Treatment review: Nurses station (south & east corridor from Reception Desk, Level 2, ICCC)  
Meetings: Level 3, ICCC

# ONCOLOGY STUDENT ALLOCATION TIMETABLE

	Week 1	Week 2	Week 3	Week 4	Week 5
<b>Student 1</b>	RO #1	RO #2	PC	MO (PC)	MO (ward)
<b>Student 2</b>	MO (ward)	RO #1	RO #2	PC	MO (PC)
<b>Student 3</b>	MO (PC)	MO (ward)	RO #1	RO #2	PC
<b>Student 4</b>	PC	MO (PC)	MO (ward)	RO #1	RO #2
<b>Student 5</b>	RO #2	PC	MO (PC)	MO (ward)	RO #1

MO (PC) = week of clinical experience with Professor Clingan  
 MO (ward) = week of clinical experience on Ward C7 and Oncology Day Care (Level 1, ICC)

*The student is to work with chemotherapy nurses, registrar and resident/interns assigned within the hospital, focusing on inpatient management and chemotherapy delivery.*

PC = week of clinical experience with hospital Palliative Care team  
 RO #1 = week of clinical experience with A/Professor Miller  
 RO #2 = week of clinical experience with Dr Foo's replacement or Dr Nasser

On the first day of the Oncology term, students are to decide on their designation ("Am I Student 1, 2 or 3?"), then on the first Tuesday of the 5 week term, make your way to the appropriate place to meet the consultant. We expect that you will be dressed appropriately. If in doubt please over-dress and we can scale back the next day! The following places are good places to start on Tuesday: Prof Clingan – his rooms; Dr Nasser & A/Prof Miller – the Radiation Oncology Department; Dr Kristen Turner – go to the palliative care office on Level 1 of the ICC.

As a learning method, I would suggest that you bring a note book in which to pose questions for yourself to answer when at home. Things like "why does cisplatin cause nerve problems?", "what is the mechanism of chemo-induced vomiting?" etc etc. Your learning will be easier and better if you focus on understanding what you see. To aid with this booklet of questions is provided. These are NOT assessable but an aid for your study. Should you find yourself at a loose end then these questions are useful for pointing towards relevant issues. You can also use them as test questions to gauge your progress and understanding.

*PLEASE NOTE that if your clinician is away, you should approach another oncologist so as not to waste your time or opportunity. There will be times during the rotation when staff members go to conferences and on leave and at these times you should ask the person you are assigned to what you should do, and failing that approach Professor Miller or Dr Foo.*

# PALLIATIVE CARE

Medical students are offered the opportunity to be embedded in the workings of a busy hospital based consultative service in Palliative Care for 1 week. The hospital consultative service consists of Dr Kristen Turner, Palliative Care Specialist who is available part-time and Janice Jensen Palliative Care Clinical Nurse Consultant (Full-time).

Most of the week will be spent on campus at TWH, although there may be opportunity to visit some of the smaller hospitals occasionally. If Dr Turner is on leave for the week, the student will be asked to spend the week at Port Kembla Hospital on the Palliative Care ward under the supervision of the Palliative Care specialist(s) at that location.

The learning experiences will be a little different to other weeks of the Oncology rotation. This service is entirely consultative so that none of the patients being seen are under the care of the Palliative care Specialist in TWH. This means that identifying good learning cases in advance is difficult and that each student will see a different array of cases. This placement is NOT appropriate for practice and assessment of generic clinical admission clerking.

The medical students will be expected to organise their time to be able to be present at useful experiences. The Palliative Care Specialist requires attendance at:

- Clinical Handover meeting (and student welcome) Monday 9am Palliative Care Office Level 1 Cancer Care Centre – next to staffroom.
- Oncology/Palliative Care meeting Tuesday 9am C7 clinical/tutorial room
- Pain assessment and management tutorial 1 hour. Time will be mutually negotiated, preferably when an appropriate case is encountered in the consultations.
- Consultation rounds *at least* 3 sessions a week, where the student accompanies and observes Dr Turner performing consultations. Approximately 50% of the work is on C7 and 50% on other wards.

## Generic Learning opportunities

1. Hospital consultation services. What is the difference between seeing a patient in consultation and having a patients directly admitted under your care? What is a specialist medical consultation and how is it done?
2. Opportunistic case-based learning. Each case seen may throw up different issues with regard to clinical medicine, clinical signs, investigations and management. The consultant will try to identify these for the student in the course of the consultative process. 75% of patients have a cancer diagnosis, with 25% non-cancer, leading to wide variety.
3. Limited active learning opportunities. Whilst Dr Turner is writing up the consult (10-15mins) the student will be asked to perform an active learning task relevant to the case: these may include looking up information on the computer eg drug information, checking old notes, returning to the patient ask collect more relevant history or perform a clinical examination. Students are encouraged to think about what is needed and volunteer rather than always waiting to be directed.

## Palliative care content

Learning opportunities will necessarily be based around palliative medicine, since that is the role of the service. Dr Turner will prefer concentrate on 4 areas that are widely applicable to every medical practitioner.

1. Pain assessment and management (with reference to palliative care as opposed to acute or chronic pain).

2. End of life care. The student will observe a typical end-of life consultation with Dr Turner and Janice Jensen, involving refocusing the goals of care and communication with patient/families. The student should observe the loading of a syringe driver and have a basic understanding of giving medication this way.
3. Recognising suffering
4. Self-care

## Preparation

These activities are not compulsory but the placement will be much more illustrative if the student prepares ahead.

## Pre-reading

- Lickiss JN Approaching cancer pain relief *European Journal of Pain* 2001;5:5-14 Suppl
- NSW Health Guideline for end of life care and decision making *NSW HEALTH* 2005
- Bird S End of life decisions and the laws *Australian Family Physician* 2008;37:155-156
- Cassell EJ Diagnosing Suffering: A Perspective *Annals of Internal Medicine* 1999;131:531-534

Paper copies will be made available at the beginning of each placement, or can be obtained anytime in advance from the Palliative Care Office.

## Important Reflection

The patients seen are unselected with regard to medical student teaching. Some patients/families may be seriously ill, dying or severely distressed.

In preparation the student is invited to consider:

- Societal views on death and dying. Their own views on death and dying. Have they ever considered their own death? If the student is familiar with a Non-English speaking culture what are the differences from traditional Western views?
- Recent or disturbing personal bereavements. Does the thought of seeing dying patients unease with regard to these?

Students who find these issues discomfoting should disclose this to pall care staff confidentially at the beginning of the placement, so that this can be explored and the placement made, as far as possible, a safe and positive experience for the student.

Discomfort is not an indicator that this is not the placement for you. *EVERY* JMO and most senior doctors will be required, on a *regular* basis, to care for patients with pain, suffering and life-limiting illness leading to death. Better you start to learn about how to deal with this in a controlled environment than the first day on the job.

Should you experience distress please let the palliative care staff know confidentially. We are not trained counsellors, but part of our role is to provide first-line support to other staff with regard to palliative care issues – including our students.

## Palliative Care TWH

### Dr Kristen Turner

	Mon	Tues	Wed	Thurs	Fri
Morning	Consults	Consults	Consults	Consults	No Teaching
Afternoon	Consults 3pm finish	Consults 3.00pm finish	Consults 3.00pm finish	3.00pm finish	No Teaching
weekly meetings	9am Pall care Clin. Handover Level 1 CCC	9.30am Oncology Palliative care meeting C7		1pm Grand Rounds Level 8 TWH	

Students should note that apart from Monday, teaching ends at 3.00pm, and there is no teaching on Fridays. If there are other activities they are required to attend it is preferable to schedule them when teaching ends if that is possible. If there are compulsory activities encroaching on teaching time please let Dr Turner know in advance.



# ONCOLOGY CLINICAL LEARNING

## Oncology Questions

- Explain in terms of basic biology of neoplasia why people often have multiple basal cell carcinomas of the skin, but not multiple lung cancers.
- Explain in terms of basic biology of malignant neoplasia why a primary breast cancer might be oestrogen receptor positive and a metastasis of that cancer oestrogen receptor negative.
- Explain in terms of basic biology of malignant neoplasia why early presentation in cancer is rare.
- Explain in terms of basic biology of malignant neoplasia why a small cell carcinoma of the lung that shows a complete clinical response after treatment with adriamycin will, in general, not respond to that drug if it recurs.
- How do malignant tumours spread? What are the main routes of dissemination? How do carcinomas differ from sarcomas in their mode of spread?
- What do we mean by grading and staging of cancer? How do we assess them? What is the clinical significance of the system?
- What is a pre-malignant condition? How do we recognise it clinically and pathologically? What are the main sites of such lesions?
- What is a paraneoplastic syndrome? How does it come about? What are the main paraneoplastic syndromes and how do they occur?
- Do human tumours develop as a result of genetic anomaly? Give examples of specific chromosomal and genetic changes seen regularly in neoplastic conditions.
- What is an oncogene? What is a proto-oncogene? Discuss how the products of oncogenes may lead to the malignant phenotype.
- Define the involvement of industrial exposure in cancer for the following cases:
  - • A 50 year old man with multiple bladder papillomata.
  - • A 65 year old boiler maker who retired from the Navy 5 years ago.
  - • A 35 year old radiographer who develops acute lymphatic leukaemia.
- Define the involvement of the following substances in cancer – aflatoxin, poly-aromatic hydrocarbons, azo dyes, selenium, saturated fat, dietary fibre.
- Define the involvement of the following biological agents in cancer – EBV, HPV, Herpes, Influenza.
- What issues with regard to cancer prevention would you raise with the following patients:
  - • A champion fair skinned teenage tennis player
  - • A 45 year old man (how would that differ from a 65 year old man?)
  - • A 45 year old woman (how would that differ from a 65 year old woman?)
  - • A 22 year old sexually active female
- How would you attempt to stop a teenager from smoking?
- Describe in principle the information you would seek to evaluate a report of a new screening test for cancer.
- How much of cancer care should be undertaken in the community?
- Outline the role of the GP and oncologist in the prevention of cancer.
- Discuss the attitudes and fears which different types of cancer may produce for an individual; and their family.
- Discuss some of the common perceptions of cancer treatment. For each modality, describe how these perceptions can be true and false.

- Outline the types of psychosocial assessment that should be carried out with a patient who may be diagnosed with a malignant neoplasia.
- Discuss the coordinating role of the GP for patients and their families who require medical, psychological and social support.
- Describe in general terms the pathological causes of intractable pain in a patient with cancer.
- How is information concerning the histological type of lung carcinoma of value in patient management?
- What clinical or diagnostic features contraindicate the use of surgery, radiotherapy or chemotherapy in a patient with lung carcinoma?
- Describe the difference between radical/curative/definitive and palliative surgery.
- Describe the difference between radical/curative/definitive and palliative radiotherapy.
- Describe the difference between radical/curative/definitive and palliative chemotherapy.
- What tumours are cured by surgery alone?
- What tumours are cured by radiotherapy alone?
- What tumours are cured by chemotherapy alone?
- Provide an example where the use of two or more modalities has improved treatment outcomes for patients with cancer.
- Compare and contrast the immediate, short term and long term side effects of surgery, radiotherapy and chemotherapy.
- Describe the management of patients at high risk for development of colorectal carcinoma.
- Describe how findings in a pathology report after breast surgery for a carcinoma may assist in subsequent management of breast cancer? [use the synoptic profile]
- What factors may influence the time taken before consulting a doctor with a testicular lump? What are the two pathological types of testicular tumour? How does their management differ?
- Categorise the biology of non-Hodgkin's lymphoma and how this is related to the histological classification.
- What are the differences in distribution and biological behaviour between the three common skin cancers?
- What are the historical and physical characteristics that make you decide to observe or excise a pigmented skin lesion? Compare and contrast the various types of leukaemia in children and adults.
- Briefly describe Bone Marrow Transplantation and its complications.
- Compare and contrast the management and outcome of kidney, brain, soft tissue sarcoma in paediatric and adult populations.
- What findings on examination or imaging of a patient with cervical carcinoma will influence subsequent management of the cervical carcinoma with surgery, radiotherapy and/or chemotherapy?

# PHARMACOTHERAPEUTICS

## Pharmacology and Therapeutics Timetable

### Group A

- 1. Therapeutics tutorial with pharmacy grads at TWH**
  - 0830hrs – Thursdays Block C, Level 8
  - Small Groups once a week for 5 weeks (*see your Timetable*)
  - Students to bring a case with multiple drugs
  - Disease state – to be discussed by med students.
  - Pharmacology discussed by pharmacy grads.
  - Convenor to have input into therapeutics of drugs listed (drug interactions/dosing/ADRS etc)
  - Also to cover Medication Histories, Drug Protocols Scenarios, Cardiac Arrest Drugs

**\*\*AMH and eTg's main references\*\***

### Group B

- 2. ED Ward rounds at TWH with convenor**
  - 0800hrs - Tuesdays – ED Ward (*see attached Student Roster*)
  - 2-4 students for 1 hour for 4 weeks (commencing 2<sup>nd</sup> week of Term).
  - Therapeutics of interest observed e.g. Use of thrombolysis or treatment of DKA, toxicology, Arrest trolleys drugs etc.

*Each student to get one round for their medicine rotation at TWH.*

### Group A and Group B

- 3. GIL days**

NPS modules, 4 modules on non rounds day in Library e.g.

  - Module 1 COPD
  - Module 2 Confusion
  - Module 3 ACS
  - Module 4 DVT prophylaxis
  - Or any other module you might wish to do
- 4. P FORMULARY**
  - 1-2 drugs per week per student, to be handed in at the end of each week, feedback to students following week.
  - Reminder Please remember to do Q 13 Prescription writing
- 5. STUDENT GRAND ROUNDS**
  - 1030-1200 Thursdays-TWH Block C, Level 8, Auditorium (*see your Timetable*)
  - Facilitate discussion on pharmacology and therapeutics
- 6. ROUNDS WITH SPECIALIST PHARMACISTS**

***Phone or page them and a set time:***

  - **ICU** (Sonja - page# 572 )
  - **CCU** (Marian – page# 571)
  - **ONCOLOGY** (Mair – page# 584/Vicki - ext 5777 )

#### **Purpose**

- Observe Cytotoxic drug reconstitution and administration
- Observe TPN preparation
- Introduction to ICU drugs

# ASSESSMENTS

## **Clinical clerking – 1 submitted per week**

One **full** clinical clerking, in the format described in Appendix 4, is to be submitted each week. It will be marked and comments written.

Clinical clerking is an important clinical skill and occasionally you will be invited to discuss your clerking with the marker (usually Dr Fardy). This is a learning exercise and often a conversation is the best way of clarifying and conveying information – so, if offered, take the opportunity!

## **P-formulary 1-2 drugs per week**

At the end of each week, a P-formulary of 1-2 (new) drugs per week per student is to be handed in with feedback provided to students in following week.

## **Mini CEXs (proportion of clinical log – minimum of 1 a week for 5 weeks)**

Each student should aim to have one mini-CEX completed, and submitted, each week. All submitted mini-CEXs should appear in the student's Clinical Log.

## **PPD form – Student Performance Review (SPR) from Preceptors**

One PPD /SPR form is to be submitted to the site clinical placements facilitator after each rotation.

# STUDENT GRAND ROUNDS

## Presenting a long case in the TWH/UoW Student Grand Rounds

The aims of presenting a case for discussion in this forum include:

1. Collect, record & use a clinically & legally adequate clinical case record
2. Integrate clinical science, research & clinical practice (in real time = *patient care*)
3. Structure a clinical case presentation
4. Discuss clinical information in an organised, confident, professional manner
5. Reason clinically
6. Accept, share & hand-over patient care
7. Developing and practicing communications skills:
  - case notification & handover using **ISOBAR**
  - gaining informed consent
  - explanations to patient and family

Taking a clinical history, conducting a clinical examination, organising information from a history and clinical examination, requesting and interpreting investigations are all essential steps in reaching a provisional diagnosis, an orderly differential diagnosis list, management priorities and a management plan. Clinical discussion in any form or forum should reflect all this and also reflect your ability to integrate experience, science, current trends, research and many other issues into a live, interactive clinical case discussion.

The aim of the long case presentation is to develop these using a standardised format with which you will become familiar and which will help you to conduct confident, organised, clear clinical discussions with your professional colleagues. This methodology will be the backbone of your professional communications now and throughout your professional life. It is as important for you to know how to do this and to be skilful in its use as is it for you to know why cardiac murmurs occur and how to use a stethoscope.

The Thursday case presentation meeting at TWH is more about learning to manage this process than it is about learning the clinical science in the case although you will learn an enormous amount of clinical science and practice – if you pay attention!

You should always take a history and do a physical examination as if you are taking over a case or taking responsibility for a significant part of the case management. You should give a case history as if those who are listening will be taking the case over from you or will be sharing in the development of a case management plan. You should listen to a long case presentation as if you will be taking responsibility for that case or contributing to the case management plan. Those who are listening to you will be expecting information to be delivered in a standard, easily understood, well organised way; in a way that answers most of the listener's questions as the presentation unfolds. There should be sufficient detail in the case presentation to allow a safe case hand-over but irrelevant information should be minimised and boredom among the listeners should be avoided. There should be adequate time left for discussion with little time wasted on un-necessary clarifications during, or at the end of, a case presentation.

While there is a general structure for a long case presentation, covering all details of clinical history and examination, most cases will require some degree of tailoring or focus to condense irrelevant information, to package relevant negatives and to allow full development of details of the active features of the case.

A long case presentation should take about 20 minutes. Ten (10) minutes for presentation of the case including full history, examination, summary and DD/PD list. The remaining time (usually at least 10 minutes) should be for discussion of clinical priorities, management plan etc. In fact, in our forum we will allow quite a bit more time for clarifications and discussion during and at the end of a case presentation. But, ideally a well managed case presentation should be structured (see below) to meet these requirements and still only take about 10 minutes.

One medical and one surgical case per week is presented at Student Grand Rounds (1030 - 1200 hrs) on a Thursday morning. For the first 4 rotations of Phase 2, each case will be presented over 45 minutes. In rotations 5-7, each case will take 30 minutes. Discuss with your mentors (Profs Tait and Yeo or Dr Fardy) how this is to go.

There will be a presentation by one of the senior clinicians on a topic. (This is NOT the responsibility of the students). The general theme will be: "Why we do what we do." Later in Phase 2, there may be didactic presentations on a range of topics within the time allocated to Student Grand Rounds.

Students choose a patient they have seen. When you have chosen a case that you would like to present, please discuss it with your mentors.

Working in pairs, students will do a full clerking (history and examination) on the patient. It is expected that a medication list (drug method of administration, dose and dosing frequency) will be collected as will results of imaging and other investigations. A Medical Record Number (MRN) is required so that Imaging can be viewed via the PACS system.

At the "Student Grand Round", the case (history, examination and problem list) will be presented orally (with minimal PowerPoint) but slides are necessary for the medication list. Results of imaging and other investigations must be accessible. If not, this information must be presented on slides. After the presentation and discussion, 2 students in the audience will be asked to do a 'mock' clinical handover of the case and another 2 students to inform relatives of the clinical situation.

For each term, a random number is given to a student in relation to this task and if a number of students have already done a presentation, the allocation of the additional (subsequent) ones will fall to the student(s) with the lower random number. Some students may be required to do a number of presentations over Phase 2.

Students will be informed at orientation about who is presenting.

Students need to notify Jenny Deura by the **Friday preceding presentation** of the topic and case outline.

### **Readings to help prepare for Student Grand Rounds case presentations**

#### **1. Kumar & Clarke: Clinical Medicine**

- **Chapter 1 – pages 8 - 18**

#### **2. Epstein: Clinical Examination**

- **Chapter 1 – The Medical Interview**
- **Chapter 2 – The General Examination**

# APPENDIX F Student Grand Rounds

## Presenting a long case in the TWH/UoW Student Grand Rounds

The aims of presenting a case for discussion in this forum include:

1. Learning to collect, record and use a clinically and legally adequate clinical case record
2. Learning the usual structure of a clinical case presentation
3. Learning to manage and discuss clinical information in an organised, confident, professional manner
4. Developing real-time integration of clinical science, research & clinical practice
5. Developing clinical reasoning skills

Taking a clinical history, conducting a clinical examination, organising information from a history and clinical examination, requesting and interpreting investigations are all essential steps in reaching a provisional diagnosis, an orderly differential diagnosis list, management priorities and a management plan. Clinical discussion in any form or forum should reflect all this and also reflect your ability to integrate experience, science, current trends, research and many other issues into a live, interactive clinical case discussion.

The aim of the long case presentation is to develop these using a standardised format with which you will become familiar and which will help you to conduct confident, organised, clear clinical discussions with your professional colleagues. This methodology will be the backbone of your professional communications now and throughout your professional life. It is as important for you to know how to do this and to be skilful in its use as it is for you to know why cardiac murmurs occur and how to use a stethoscope. The Thursday case presentation meeting at TWH is more about learning to manage this process than it is about learning the clinical science in the case. You should always take a history and do a physical examination as if you are taking over a case or taking responsibility for a significant part of the case management. You should give a case history as if those who are listening will be taking the case over from you or will be sharing in the development of a case management plan. You should listen to a long case presentation as if you will be taking responsibility for that case or contributing to the case management plan.

Those who are listening to you will be expecting information to be delivered in a standard, easily understood, well organised way; in a way answers most of the listener's questions as the presentation unfolds. There should be sufficient detail in the case presentation to allow a safe case hand-over but irrelevant information should be minimised and boredom among the listeners should be avoided. There should be adequate time left for discussion with little time wasted on un-necessary clarifications during or at the end of a case presentation.

While there is a general structure for a long case presentation, covering all details of clinical history and examination, most cases will require some degree of tailoring or focus to condense irrelevant information, to package relevant negatives and to allow full development of details of the active features of the case.

A long case presentation should take about 20 minutes. Up to 10 minutes for presentation of the case including full history, examination, summary and DD/PD list. The remaining time (usually at least 10 minutes) should be for discussion of clinical priorities, management plan etc. In fact, in our forum we will allow quite a bit more time for clarifications and discussion during and at the end of a case presentation. But, ideally a well managed case presentation should be structured (see below) to meet these requirements and still only take about 10 minutes.

## Long Case - Outline of structure

### History

**PP**            **Presenting problem** (Also PI, Presenting Illness acceptable)

**HPI or HPP**   **History of the presenting illness (HPI)**  
                  **History of the presenting problem (HPP)**

**PH**            **Past history –attempt to present in chronological order**

#### Medical History

- Non-surgical problems
- Usual divided into specialty or system areas such as neuro, cardiac, respiratory, endocrine, renal, MSK

#### Surgical history

- surgical or surgically relevant illnesses
- operations, timing & sequence
- outcomes & complications & on-going issues

#### Gynae/Obstetric history

- menarche, menstrual history, gravida, parity,
- menopause, gynae diseases/problems
- medical/surgical interventions etc

**FH**            **Family history**

**Meds**        **Medications/Drug history**

**Allx**        **Allergies/Sensitivities**

**SH**        **Social history**  
- ETOH, smoking, occupation, domestic circumstances

**SR**        **Systems Review**

On completion of the history, to ensure no major symptom/illness points are missed, carry out a Systems Review. Work briefly through all body systems to ensure all significant or potentially significant symptoms/problems/illnesses are included in the case history, checked in the physical examination, reported in the subsequent case presentation and given appropriate weight in the management plan.

### Physical Examination

**OE**            **On Examination**

Follow the system of:

Inspection (Observation) / Palpation / Percussion / Auscultation (in that order)

For joints: look, feel, move

Work from peripheral (including noting observations done by others E.g.; nursing obs) to central and work through the body systems logically, taking note of the history features and the likely nature of the problem to help focus and organise the examination efficiently and to group parts of the examination logically.



As with the history, the procedure of physical examination should be thorough and comprehensive but should be reported concisely, using appropriate groupings of relevant negatives and focussing in more depth in the areas relevant to the problem(s) to be managed/ discussed.

Use diagrams where relevant. For example, to document and report chest, abdominal, breast examinations.

Where sides are compared (E.g. arterial pulses, reflexes) use a grading system

Use a grading system for murmurs and bruits

Cardiac murmurs can be represented diagrammatically

Use standard description methods for masses/tumours

Use medical terminology ('the language of the trade')

Do not point at or indicate on your own body (we all tend to do this subconsciously)

Remember also that in clinical practice the case history and examination is used as an aid to case management, as an aid to case handover and clinical discussion, as a record and gauge of clinical progress and as a legal document.

Summarise the history & examinations findings to lead the presentation into a logical, graded list of:

#### **Diagnostic possibilities**

**PD** (Provisional or working diagnosis; more likely diagnosis on basis of history and examination) and

**DD** (differential Diagnoses; other possible diagnoses on the basis of history and examination), listed in descending order of likelihood)

#### **Management Plan**

An equally logical list of management and investigation priorities & strategies: comment on how you will monitor/review these and how they might be expected to unfold in the short, medium and long term.

**Readings** re history & examination for construction of a clinical case record and managing presentation of a clinical case history

#### **Kumar & Clarke**

##### **Clinical Medicine**

**Chapter 1** - A good description of how to take a history

But does not give a clear outline about how to structure the recording of a case history and examination or how to use that record in case presentations for meetings or for case management

#### **Epstein**

##### **Clinical Examination**

**3<sup>rd</sup> edition**

##### **Chapter 1 – The Medical Interview**

An excellent practical outline of the structure of a medical interview and the structure of a medical case history as it might appear in a case record

More structured than the section in Kumar & Clarke, Includes a good outline of the *Systems Review*.

Also gives a useful example of a patient history (as a standardised document) as it might be found in a clinical record (such as a hospital or practice medical record) or used in a case presentation.

The point-form review summary at the end of the chapter also should be valuable.

##### **Chapter 2 – The General Examination**

Similar to chapter 1 with a good explanation of the structure used to guide the conduct and recording of a physical examination. Look at the point-form review at the end of the chapter to get an idea about how to record and report a physical examination.

# APPENDIX G – Medical Sample Clerking

The setting out is important. We abide by a convention in how the history and examination is laid out so that another medical practitioner knows where to look to find out what they need.

Hospital No: x349282 \*\*\*\*

J.B. \*\*\*\*

58 year old man \*\*\*\*

01/01/04 07.20 Referred by General practitioner

**1. Presenting complaint should be brief, but it is helpful to mention relevant background information.**

PC Shortness of breath

HPC 4 -day history of worsening dyspepsia. Gradual onset over hours. Initially noted while climbing stairs at home. Over the last 12 hours has become short of breath at rest. No periods of relief since onset.

Relieving / exacerbating factors:

Relieved by rest. Exacerbated by exertion.

Associated symptoms:

Cough productive of green sputum for 3 days.

Sharp left sided posterior chest pain worsened by coughing and inspiration.

Feels 'feverish'.

Relevant direct questions:

Usually unlimited exercise tolerance

Lifelong non-smoker

No asthma, tuberculosis exposure, occupational exposure to Chemicals or asbestos.

No pets or travel abroad

No Haemoptysis, worsening of chest pain on exertion, ankle swelling, calf pain, No Palpitations, trauma to chest wall, orthopnoea or paroxysmal nocturnal dyspepsia.

**2. Mention only the relevant negatives.**

PMH 1963 appendectomy  
1972 duodenal ulcer (no symptoms since)

**3. A useful way of recording important negatives on one line.**

No diabetes, hypertension, rheumatic heart disease, epilepsy, jaundice, cerebrovascular disease

S/E General- fatigue lately, appetite unchanged, weight stable, no sweats or pruritus

CVS - as above

RS - as above

GIT - no current indigestion. No symptoms like previous duodenal ulcer.  
- No vomiting / dyspnoea/ abdominal pain.

GUS - No urinary symptoms

NS - No headache/syncope. No dizziness/ limb weakness/ sensory loss.  
- No disturbed vision/ hearing/ smell/ speech

MS - No joint pain/ stiffness/swelling. No Disability

Skin - No rash/ pruritus bruising

**4. Always record the dose and frequency of any drugs – remember you'll be writing the drug chart later! Always document that you have asked about druua alleraiies.**

DH No regular or over the counter medication

Allergy Penicillin allergy - facial swelling and rash as a young child  
 Fam HX Father died of 'heart attack' aged 52  
 Mother died of 'old age' at 88

Social HX Lives with wife who is fit and well  
 Own house. Stairs  
 Completely Independent  
 Never smoked  
 Alcohol: 24 units per week  
 Sexual History: not appropriate (unless it is appropriate as it relates to the PC)  
 No recent overseas travel  
 No pets  
 Occupation: Hotel Porter

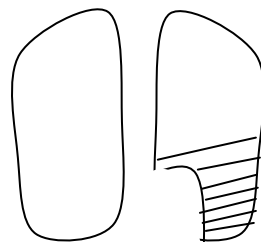
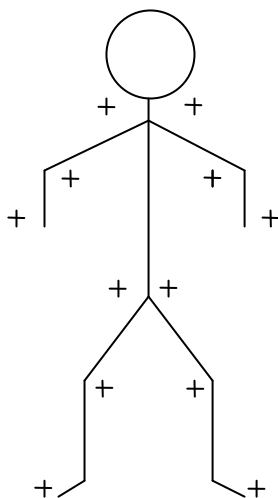
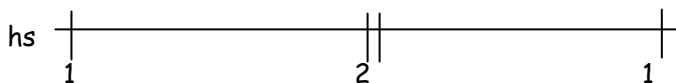
O/E : Observations BP, PR, T, O<sub>2</sub> saturation, RR  
 pulse 104 bpm regular, normal character  
 BP 110/70 mmHg (right); Temperature: 38.5°C  
 Respiratory rate is 28/min

**5. Record your initial observations – they are important. 'Alert and chatty' or 'Distressed and looks unwell' tell you a lot about the patient.**

General Unwell, short of breath. Can complete sentences. Not  
 Using accessory muscles of inspiration. Sweaty.  
 No cyanosis or clubbing. No pallor

CVS JVP normal  
 No praecordial scars/chest deformities  
 Apex beat normal position and character  
 No parasternal heave/thrills  
 Auscultation; heart sounds normal. No added sounds. No oedema  
 Peripheral pulses palpable.

**6. You can use diagrams to clarify your examination findings.**



Dull percussion  
 Note  
 ↑ vocal fremitus  
 Bronchial breath  
 Sounds  
 ↑ vocal resonance  
 Whispering  
 Pectoriloquy  
 No pleural rub

RS Trachea central

Expansion symmetrical and normal  
 Vocal fremitus increased at left base posteriorly  
 Dull percussion note at left base posteriorly  
 Bronchial breath sounds at left base with increased vocal resonance and whispering pectoriloquy

Abdomen Appendectomy scar right iliac fossa. No veins/ distension  
 Palpation: soft and non-tender. No palpable masses or organomegaly  
 Percussion note normal  
 Auscultation bowel sounds normal  
 Genitalia not examined  
 Rectal examination: not performed  
 \*\*\*N.B.: examination of the genitalia or rectal examina should not be done under any circumstances by the student alone or with another student as chaperone. These should only be performed if directed to do so by the preceptor and under the preceptor's direct supervision. These sensitive examinations are not expected to be done on the wards.

NS Higher function normal  
 Cranial nerves: I: normal  
 II: PERLA (Pupils equal in reaction to light accommodation) Normal fundi and visual fields  
 III, IV, VI: no diplopia/nystagmus  
 V, VII, VIII, IX, X, XI, XII: Normal  
 Upper and lower limbs: power, tone, coordination, sensation all normal

Reflexes	<u>Right</u>	<u>Left</u>
Biceps (C 5,6)	++	++
Supinator (C 6)	++	++
Triceps (C 7,8)	++	++
Knee (L 3,4)	++	++
Ankle (S 1,2)	+	+
Plantar	↓	↓

Joints and skin Normal

If the history is suggestive of an haematological problem, examination should include specific attention to (and noting of) regional lymphadenopathy, hepatomegaly, splenomegaly and the skin changes associated with haematological disease.

Summary 58 year male non-smoker presents with a 4 day history of worsening exertional dyspnoea Associated with a productive cough, pleuritic left sided chest pain and symptoms of fever. On examination he is short of breath and tachypnoeic. He has a pyrexia and signs of consolidation at the left base.

PD: (L) sided pneumonia (community acquired)

DD: Pulmonary embolus

- Problem List
- Acute coronary syndrome
  - 1. Dyspnoea
  - 2. Productive cough
  - 3. Left pleuritic chest pain
  - 4. Fever temp 38.5°C
  - 5. Penicillin Allergy
  - 6. Previous duodenal ulcer (1972)
  - 7. Appendectomy (1963)
- } left basal pneumonia

7. Sign your notes, including printed surname and pager number.

*J Bloggs*

J. Bloggs, Pager: 552

**The Problem list is the most important part of the clerking.**

**It shows your thinking and lists the problems that need to be addressed on the first and subsequent ward rounds.**

**Include the presenting complaint with a provisional and differential diagnosis; active problems within the PMH; important drugs that may influence management decision, e.g. on anticoagulation; red flag symptoms picked up on systems enquiry; abnormal physical signs that need explanation.**

**It would not be uncommon to list 8-10 problems in a patient >65 years ill enough to be admitted to hospital.**

**Professor Wilf Yeo**

**\*\*\*\* N.B. for insertion into the medical records, full identifiers are needed but for student clerkings that are for student learning, the regulations pertaining to privacy apply (omitting or modifying patient identifier)**