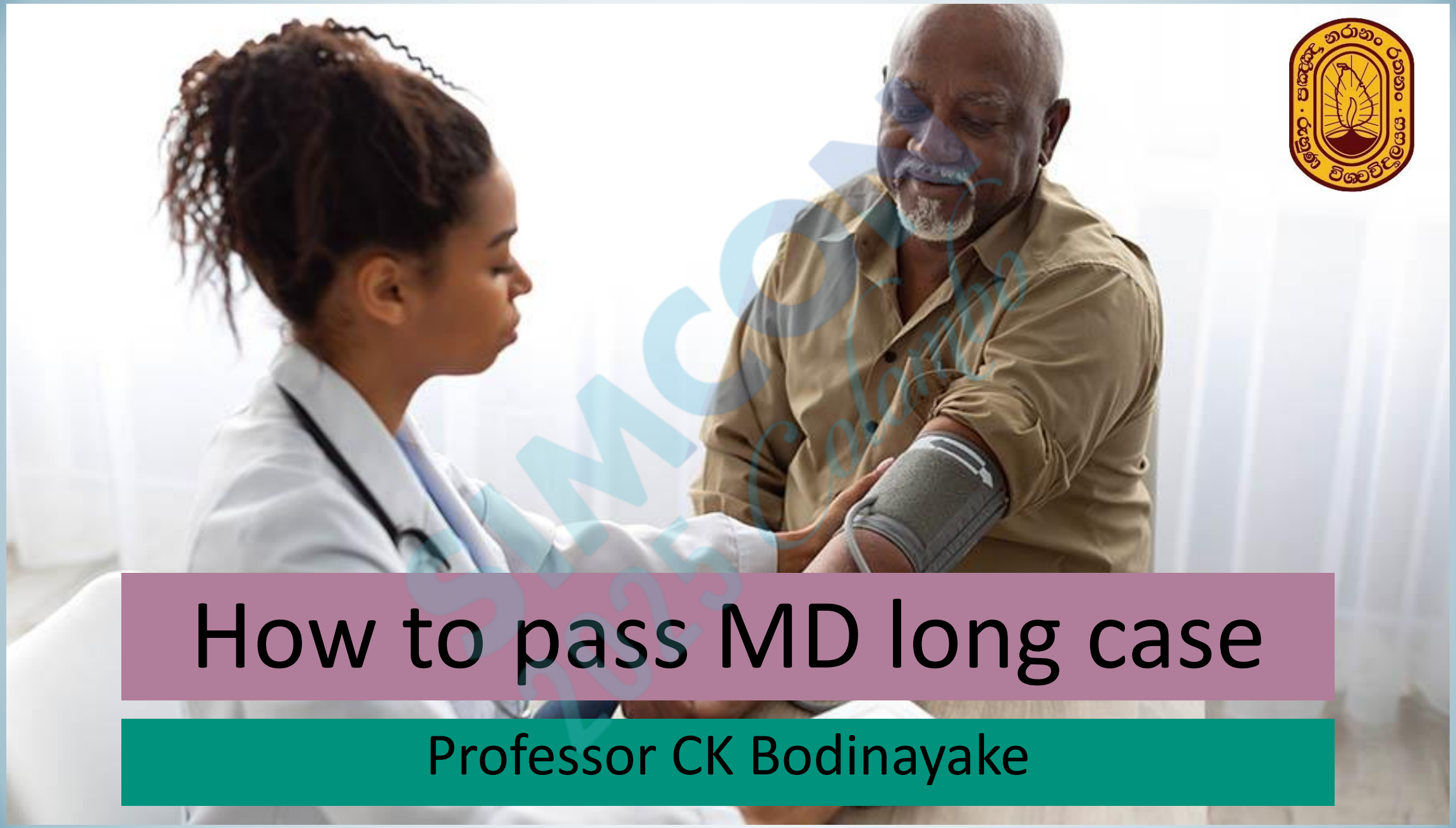

How to pass MD long case

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Session roadmap

- Understanding the Long Case Exam
- Case Scenario
- From findings to framework: building your case and Clinical Reasoning
- Presenting the case to the examiner
- Discussing Management plan
- Common pitfalls and how to avoid them

- Myth: Its difficult to fail a long case

- Truth : It is very possible to fail if your clinical approach is flawed or incomplete

What is expected and assessed in a long case

- Using relevant clinical details to build a diagnostic narrative
- Integration of multisystem clues which are appropriate
- Clear and logical reasoning steps to arrive at a diagnosis and differential
- Clarity and confidence in reasoning
- Structured reasonable management plan

THIS IS A TEST OF CLINICAL REASONING

Competence categories	First place a ✓ mark against the appropriate band and then provide a mark within the band					
	Highly Unsatisfactory	Clear Fail	Bare Fail	Bare Pass	Clear Pass	Excellent
Marks	0-29	30-39	40-49	50-59	60-69	≥70
Gathers information from **history**, presents information and interprets, summarizes and draws a differential diagnosis based on history				✓ 65		
				50		
Gathers information from **physical examination**, presents, and interprets based on history and physical findings, summarizes findings and refines the differential diagnosis / problems				✓		
				50		
Formulates a relevant and logical plan for investigation and treatment				50 ✓		
Demonstrates knowledge of the patho-physiological basis of patient's condition, interpretation of test results and the pharmacological basis of the treatment proposed				50 ✓		

Long Case

- CLINICAL HISTORY -80% diagnosis
- Examination should support or refute the diagnosis
- Clinical reasoning > encyclopedic knowledge
- If you are unsure of diagnosis show logical reasoning

• CASE VIGNETTE – MANAGEMENT

28-year-old female studying overseas presented with worsening leg oedema for two months

She had painful fingers six months ago which was non disabling and was thought to be rheumatoid arthritis .

Four months ago she was hospitalized with severe headache and was found to be having severe hypertension.

Investigations revealed proteinuria and hematuria. The ANA was positive and a renal biopsy was performed.

She was treated with prednisolone and cyclophosphamide as for Lupus nephritis

The patient had proteinuria and hypertension throughout and was developing progressive oedema. Serum creatinine was persistently elevated.

Examination: Cushingoid appearance. Pitting oedema present in both legs.

Both hands spindled, but no deformities . No rashes oral ulcers

BP 170/90 mm Hg, bpm. Rest of the examination was unremarkable

Problems and differentials ?

- Lupus Nephrits Class IV or above progressing into renal failiure (CKD)
- Treatment failiure or inadequate treatment for lupus nephritis
- Likely need of dialysis and renal replacement therapy for a 28 year old

Interpretation of findings

- Elicit this is clearly SLE with renal disease
- Relate severe hypertension to severe renal disease Such as a diffuse proliferative Class IV or IV+ V
- Is the Disease still active or now advanced to a sclerosing form LN ending with CKD?
- Explore whether RRT is discussed and how much patient is aware about illness in a gentle manner for the discusiion

Presentig your case

- MD case history is an extended summary which is specific to the case
- Examination findings should include relevant negatives
- Link and interpret the important clues to arrive at a diagnosis and assess severity
- Paients ideas concerns and social support need to be brought in to draw a management plan
- Presentation should be a flawless continuum delivered with confidemce at the level of a consultant or SR

Preparation for the discussion – What examiners expect

- Assessment of current disease status . Rv exiting BX and review the need for a repeat biopsy
- Renal function assessment
- Active disease need more aggressive treatment to salvage the kidney
- If no active disease but CKD need RRT
- Transplant considerations
- Reproductive and Psycological concerns

In cases where the diagnosis is The challenge

- Analyze and synthesize **relevant** clinical and lab information to arrive at the most likely diagnosis
- Give 2-3 differentials
- In the case of inability to come to a diagnosis show how you reason out and the need for more information from investigations or a collateral history

- **CASE VIGNETTE DIAGNOSTIC CHALLENGES**

40 -year-old female

Progressive breathlessness and dry cough -6M on steroid inhalers.

No chest pain palpitations or PND. She has no haemoptysis or weight loss.

Arthritis of hand joints -2 years -on weekly methotrexate symptoms better

Erythematous non pruritic rash on legs -2 weeks ago now not visible

Pulmonary TB at age 25y, completed treatment.,

Recurrent UTI

Several episodes of red eyes

Focused history

- SOBE –likely respiratory cause – but not asthma despite inhalers, not bronchiectasis ? post TB fibrosis. No pulmonary hemorrhage crackles Present -but not HF**, likely ILD**,
- Inflammatory arthritis –look for pattern of involvement , EMS, deformities, skin changes
- Red eyes – Uveitis , episcleritis/ scleritis, conjunctivitis
- Rash- ? Vasculitic , maculopapular , nodular – distribution
- Recurrent UTI but no evidence of GN/Hematuria/Protienuria meaning no renal involvement
- Past TB

- **EXAMINER :DOES THE CANDIDATE UNDERSTAND WHAT IS GOING ON?**

Differentials ?

- Asthma , arthritis , rash , red eyes – EGPA
- SOB -ILD + Arthritis (RA) red eyes episclrits + r?ash – RA with ILD +eye
- Arthrits + ILD - Systemic sclerosis
- Arthrits +ILD+ rash + Red eyes -RA and overlap/MCTD (RA+ SS)
- Arthrits + Lung - sarcoid infiltrations + red eyes (Uveitis) + Rash (EN)

Examination: Normal facial appearance. BP 120/80 mm Hg, Pulse 76 bpm, PIP joints both hands were spindled. No rashes

RS-Bilateral fine crackles scattered in both lungs.

CVS- There was no cardiomegaly or murmurs.

NS completely normal . No Nuropathy muscle weakness or sensory loss.

ABD- normal

Exam format

- The examiners are ready to listen to a presentation , They will note your positives and what you missed
- During the first 20 minutes they will revisit your histry and probe in to check your understanding
- If you have missed some information or not gone to depth they will question again to check your understanding
- The examiner will cross check on your physical exam findings for accuracy
- The examiners will question on diagnosis and differentials

- In the next art the examiners change their role
- They will qiestion on your management plan
- Generaly MD attracts worked up and confirmed cases so management plan can start from the current situation or a complication of the illness
- Examinaers will evaluate your approach on management and follow up plan

Common errors by the candidates

- Incomplete or unstructured history.
- Over-reliance on a checklist
- Failure to clarify important points
- Diagnosis is arrived by asking about the diagnosis and the tests done therefore therefore no substantial understanding of the case – examiner will make a note of this
- Overconfidence in single clue

- Lack of integration or connecting the wrong clues
- Inconsistent reasoning – contradicting earlier statement s of findings
- Adjusting the examination findings to fit the diagnosis
- Giving very broad differentials Like Vasculitis , CTD without mentioning what exact

What examiners look for?

- *Clarity and confidence of speech*
- *Expected level of skills in data gathering*
- *Logical flow of reasoning*
- *Integration of system*
- *Relevance and conciseness*
- *Safe, patient-centered management*
- Ability to defend your reasoning politely when challenged

Q and A