

## Rough Guide To Discussion 1/ Differential Diagnosis Presentation

### Oral Presentation Is Different To Written Presentation:

Oral presentations to your examiners are different to written presentations in that you examiners have one opportunity to hear and talk. They can't re-read what you've said when you've confused them!. So you need to develop a style of case history presentation that ticks all the boxes and satisfies your listeners (examiners/clinic tutors and to a certain extent your patients)

There are two well-know ways to communicate your points effectively.

The first is to **K.I.S.S.** (keep it simple stupid). Focus on getting one to three key points across. For some reason three's seems to work better.. Which is probably why the second style is my preferred method of presenting a patient and listening to a case presentation.

Second, repeat key insights:

**Tell Them What You're Going To Tell Them (Forecast), (Your Presentation Style)**  
**Tell Them, (Your Presentation)**  
**And Tell Them What You Told Them (Summary). (Your Justification)**

So how does this work in a clinical situation....

### Your summation of the patient and their presenting complaint:

Remember that a summary is just that, it's a summary! When you consider that you have 1½ hours to complete you exam process with a new patient, the last thing you want to do would be to regurgitate your entire history verbatim.

Your summary should lead your listener to the same conclusions that you have come to. You examiners don't need to hear every detail just the things you prioritise as been important. If they have a line of enquiry that they want to follow, they will ask. I would encourage you to give them or create, the opportunity to ask questions of you, it involves them in the process.

Remember it's your exam, decide that you are not going to be passive in this process and that you want to show your competence as an osteopath in terms of you ability to analyse and reflect on the information you've gathered and then weighing up the balance of evidence to prioritise you working diagnosis and differentials.

### Your presentation of your diagnostic picture and discussion:

Here's where the above presentation style is incorporated and adapted for the clinical setting.

#### 1. Give them a global picture of how you intend to proceed.

So this is your global picture and sets out the tone for your presentation. It gives your listener an overview of your analytical skill and your ability to process the information you've gathered.

### Sample Statement:

*I'd like to present my differential diagnosis to you by first telling you my current working hypothesis (diagnosis), then my prioritised differential diagnosis, those things I have considered that fall within the scope of my history but I have excluded on the lack of evidence at this stage and the red / yellow flags I'm seeing. Finally I'd like to justify and support my working hypo and prioritised DD*

## **2. Now Tell Them What It Is You've Deduced At This Stage...**

Nothing is cast in stone. This is a fluid scenario as you won't know with any degree of certainty what's wrong until you test your ideas!!

In the presence of many red flags you probably would want to turn this process on its head by presenting them first...

### **Sample Statement:**

#### **Working Hypothesis**

*Weighing up the balance of evidence I think the patient is presenting with a grade 1 muscle strain of the LES as a result of a "lift and twist" injury in the garden cutting and bagging grass. Because of the patients age it is likely that this injury is superimposed on pre-existing degenerative changes which may have predisposed the patient to this type of injury*

#### **Prioritised DD**

*In terms of my differential diagnosis in order of priority I have considered that this pain presentation may be as a result of...(your prioritised list)*

#### **Exclusion Factors**

*Within the scope of the presenting complaint I have considered that there may be visceral referral from the (target organ)/pathology however on follow up questioning and system enquiry I have excluded this as an option at this time.*

#### **Red Flags / Yellow Flags**

*There are a number of red/yellow flags that I would like to discuss with you.....*

## **3. Tell Them What You have Already Told Them (Justification OF DD)**

### **A number of things to note here...**

Don't sell your self short, talk about the sequences behind DDD/IDD, foraminal encroachment, canal stenosis etc., etc if they figure in your DD

Give your listeners the opportunity to check you knowledge by holding back slightly

**EG. Describe a potential spinal anomaly rather than saying spondylolisthesis...**

At which point your examiners will ask for clarification about your understanding of spinal anomalies, giving you the opportunity to rattle off, spina bifida occulta, lumbarised sacrum, sacralised lumbar, hemi vertebrae, retrolisthesis etc...

Go through each point of DD and use your case history to justify your interpretation and analysis of the presenting problem. Therefore the working diagnosis would be that point of DD that has the most supporting factors within the history. Then in descending order the other points slot in with lower priority.

### **Sample Statement:**

*I think it is most likely to be an les muscle strain as we have*

- a PMI over the left L/S without radiculopathy, bowel or bladder dysfunction and is non affected by cough/sneezing bearing down.*
- A clear mode of onset during cutting and bagging grass 3 days previously which in terms of progression is now settling suggesting a muscle strain rather than a disc*
- The daily pattern is one of an inflammatory type which eases with 10 min of movement, gets during periods of prolonged standing/sitting and is described as better for movement*
- Pain is described as a dull ache which initially was sharp on certain movements but this is now resolved and is described as a 3 on a VAS Initially being a 5 (VAS 7+ yellow flag)*

By the time you have gotten to the end of this they will stop you ask you some questions and explore your examination plan

Again nothing is cast in stone and this is a fluid and dynamic process. Be prepared to alter your working diagnosis in the light of your findings as it is the history combined with your examination findings that help you draw your final conclusions.

The process of continued evaluation and reflection is an ongoing one. What might be true of this and other encounters might not always hold true... things change mostly for the better, but sometimes for the worse. Be flexible and manage your patient care accordingly.

### **Think About Your Audience**

Your clinic tutors know you and have a fairly good understanding of your capabilities. In the teaching clinic scenario there is a certain security in knowing that your mentors are making sure you are safe as your competence and skill grows and develops.

Making that shift from student practitioner to practitioner can sometimes be an unexpected one during your final clinical competence exam. Your examiners role is to assess your competencies and not to tutor or mentor you through your exam.

With this in mind a good way to prepare is to practice more autonomy in your clinical situations. As your examiners to treat your new patients as if it was an examination encounter. With your tutors help and support you will begin to take more and more control of the clinical situation and your confidence will build. Getting ready in this way prepares you for your examination but more importantly gets you ready for practice life!!!!

Finally good luck!