Oral Presentation Skills Workshop

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Snapshot of Your Abilities

- Attending hears you for 5-10 minutes.
- Knowledge of Patient
- Knowledge of Disease
- Ability to Obtain History and Corroborating Information
- Ability to Perform Accurate and Reliable Exam
- Ability to Synthesize the Case through Pertinent Positives and Negatives. Linking Sections for Symptoms and Signs.
- Thought Process on Localization and Diagnostic Consideration
- Judgment in Plan and Management
- Professionalism in How You Present

Different Approaches

Hallmarks of a Superior Presentation

- Attitude & Composure –
  - Are you excited and interested,
  - Standing/sitting straight, head-up, hands off face,
  - Eye contact?
- Clarity & Concise –
  - Are you speaking clearly, loud, not too fast?
  - Are your sentences succinct without repeating info?
  - Avoid tangential and non-essential info.
- Organization –
  - CC – HPI – PMH – Meds – SH – FH – VS – Gen – MS – Language – CN – Motor – Sensory – Reflexes – Coord – Labs
  - On occasion, exceptions may made for clarity

Hallmarks Cont.

- Logic & Synthesis –
  - Does the time course flow as a natural progression related to the presenting symptom?
  - Is everything interconnected with no loose ends? Does the exam reflect the history? Do the reflexes reflect the motor?

- Forethought & Knowledge
  - Do you know everything about the patient? No “poor historian”, “apparently”, “per the ED resident”.
  - Do you know a little about the differential for the patient and a lot about patient’s diagnosis?
  - Can I see your thought process? Are you previewing the diagnosis throughout the presentation?’

Chief Complaint

- Most Important Element – Sets the Stage.
- No surprises after CC!
- Essential Elements:
  - 1) Neurologic problem
  - 2) Age
  - 3) Gender
  - 4) Basic time course
  - 5) Extremely relevant comorbidities
- Optional Elements:
  - 1) Ethnicity
  - 2) Handedness

The Patient Experience

- What did they experience?
- What were they doing at the time?
- What was the time course?
- How did it effect them?
- Make it unique and memorable.
- Don't tell us about doctors, tests, treatments.

Previewing the Localization & Differential

- In your reading
  - Review key symptoms and findings for differential
  - Add a very select few into your presentation

- VERTIGO
  - Localization:
    - Brainstem: Diplopia, incoordination, lateralpulsion, dysarthria, dysphagia
    - Meninges: Nuchal rigidity, other cranial nerves
    - Inner ear: Hearing loss, tinnitus, ear pain or fullness, discharge
  - Etiologies:
    - Neuronitis: Fevers, sick contact, ear vesicles, vomiting.
    - BPV: Time course, position change, recurrence, Epley maneuver
    - Meniere's Disease: Salt meal, tinnitus, vomiting, time course
    - Toxic: Med list
    - Meningitis: Risks for syphilis, carcinomatous mets, immunocompetency risks,
    - Lateral medullary CVA: Vascular risk factors, neck manipulation

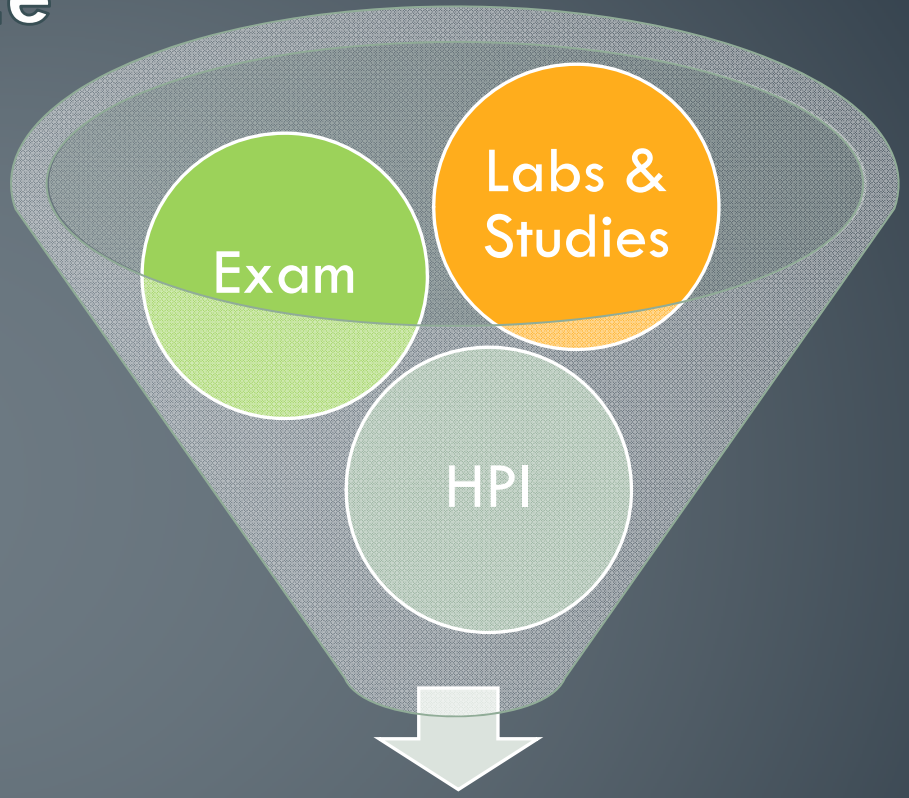
Pertinent Positives and Negatives

- Add pertinent +s and –s throughout the HPI and PE, to answer the listeners questions related to localization and diagnosis.
- Pertinent negatives demonstrate you understand the case and appreciate the key pieces of information for making decisions.
- Don't need to overdo it. If you say no tongue biting or incontinence, we know you are thinking of a seizure.
- ROS kills presentations. Don't devote a section to ROS. Incorporate +s and –s at key points in history.

Outlining and Rehearsing

- After the write-up, decide upon the order and key points to highlight. How will you put your differential into HPI and PE?
- Don't read from your note. You know the case.
- Many students do OK with HPI, then go into "reading mode" for PMH through labs
  - "Social history: No alcohol or tobacco use"
- Outline will organize your thoughts, give confidence when nervous.
- Outline should be bullet points, not sentences.
- Meds and labs don't need to be memorized.

Synthesize



Diagnoses that are most likely, treatable, and most dangerous.

How are you going to differentiate these?

How will we get the patient better?

Chief Complaint

- State Symptom in Context of Problem Based Approach which matches your Differential
- Brief Time Course
- Identifying Information
  - "Chief complaint is numbness and weakness in legs with trouble walking for the past two days. This is a 43 year old woman with multiple sclerosis who presents with concerns for a relapse."
- Extremely Relevant PMH and Risk Factors (relevant to problem and differential)
  - Everything here must be important to understand the problem, differential, or reason for consultation
  - Rarely, you should mentions imaging or labs if critical to understanding the case
    - "We were consulted for the incidental finding of an asymptomatic intracerebral hemorrhage"

HPI First Paragraph

- Briefly summarize USOH
  - "Normal, active, fully functional"
  - "Residual mild right hemiparesis and can ambulate 50 feet with walker"
  - "At baseline, per the daughter, is oriented to self, transfers by lift, and no longer recognizes family members"

- Concisely and Chronologically describe Present Symptoms and Patient Experience which Prompted Medical Attention

- PLAN AHEAD: Pertinent negative symptoms which relate to differential and localization at the moment
- Add functional impact of symptoms (ADLs, ambulation, ability to get back up from fall, etc)
- Differential should be clear at this stage, exam findings should be predictable, no surprises after this
  - Strive to have minimal interruptions (varies by attendings).
  - If resident feels need to clarify, then you may not be conveying the key information
  - Your job is to lead listener to your localization and differential

HPI 2nd Paragraph

Pre-existing condition or illness with direct bearing on HPI

- Put present symptoms in context of pre-existing chronic illness. If the chronic illness is neurological, how was it diagnosed/confirmed
  - Show you read about the illness, reviewed the records, and whether you agree/disagree with the diagnosis
  - "MS was diagnosed 5 years ago based upon an episode of optic neuritis in the left eye, confirmed by MRI with an enhancing optic nerve and typical periventricular white matter lesions, two of which were enhancing. There was a cord lesion at C4,5, and CSF was positive for oligoclonal bands, IgG index, and IgG synthesis rate. She started Avonex at that time and…"
- DECISION POINT: If pre-existing conditions are complex or unsettled, may need to provide pretext before present symptoms
  - "The patient has a complicated history of sphenoid osteomyelitis after a motor vehicle accident in 2003. Two years later, in 2005, she developed headaches and was discovered to have had a cerebral venous thromobosis. Her headaches at that time were characterized by… She was treated for 6 months with…"

HPI 3rd Paragraph

Hospital Course

- Most relevant information (vital signs, early exam, treatments, response to therapy, symptom evolution) upon medical evaluation (EMS, ED, hospitalization).
- JUDGEMENT: Almost always leave labs and studies to after exam, unless they are critical to understanding why certain actions were done
  - "Head CT was initially read as normal, and tPA was administerd. However, on formal review a small sub-dural hematoma was appreciated…"
- DECISION POINT: If hospital course is more important than pre-existing condition information, may need to move hospital course before

History

PMH

- Review any other significant medical problems, provide details only if relevant.
  - "The patient had a stroke in 2006 with mild dysarthria, left-sided facial weakness and left arm clumsiness. The diagnosis was confirmed by diffusion MRI, and at the time, carotids, echo, and telemetry were normal. He was discharged on an aspirin, atorvastatin, and lisinopril, and recovered with no deficits."
  - Do not need to list everything (i.e. PUD, s/p appendectomy…)

Meds

- List medications (doses for pertinent ones only)
  - May mention compliance, affordability, or other related issues
  - Do not list allergies unless pertinent to your plan

SH

- Length may vary by attending.
  - Occupation, education, living arrangements, marriage and support, stressors.

FH

- Keep it brief and highly relevant
  - "No pertinent family history upon detailed review"
  - "His grandfather on his father's side, father, and 2 brothers of 5 total sibling have/had a similar disorder"

ROS

- Don't do ROS in oral presentation. Cover pertinent positives and negatives in HPI

Exam

- VSS or list vital signs (orthostatics if pertinent, trends since admission if pertinent)
  - Include vitals in stroke, syncope, delirium/encephalopathy.
- General appearance if pertinent (i.e. cachectic, agitated, hallucinating, depressed mood, etc)
- Concisely summarize general exam, add couple pertinent negative.
  - If normal, concisely state that "General medical exam normal".
  - "notably, heart was RRR, there was no signs of CHF, and no peripheral stigmata of endocarditis"
- If neuro exam is all normal and diagnosis is such that we expect a normal neuro exam (headaches, seizures), can say:
  - "Complete neuro exam is entirely normal".
  - Don't say "Neuro exam is intact" or "non-focal".

Exam

- Mental Status
  - If highly pertinent, list what you did and the response
  - If not pertinent and negative, say either “complete mental status screen was normal”, or “mental status was normal, including orientation, attention, and memory”
  - If seeing someone for mental status changes and inattention, and everything else is normal, can list mental status findings and state “complete neuro exam was otherwise non-lateralizing”.
  - Don’t say “Patient was uncooperative”. Can say “Patient was inattentive and had difficulty consistently following commands.”
- Language
  - If highly pertinent, list what you did and the response
  - If not pertinent and negative, say “complete aphasia screen was normal” or “language had normal comprehension, repetition, fluency, naming”

Exam

- CN
  - List pertinent positives and negatives
    - " Cranial nerves were all normal. Of note, optic nerves were flat with good venous pulsations, eye movements were full, face was symmetric, there was no dysarthria."
  - Additional diagnosis-specific maneuvers if pertinent (Dix-Hallpike, INO by saccades, pupil asymmetry in dark, tongue fasciculations, red desaturation, ptosis with prolonged upgaze)
- Motor
  - "Motor is completely normal"
  - Central disease = summarize patterns of weakness; peripheral disease = list muscles involved.
  - Add tone, atrophy, bradykinesia, drift, fine finger and toe tapping as needed
  - Additional maneuvers (apraxias)
- Reflexes
  - Summarize patterns
  - "All normal and symmetric with down toes"

Exam

- Sensory
  - "Detailed sensory exam was normal" or summarize patterns
  - Additional maneuvers (neglect, cortical sensory)

- Coordination and gait
  - "Coordination and gait were normal"
  - F-N, RAM, HNK, stance/Romberg, walking, heels toes
  - Gait descriptions: Initiation, speed, stride length, base, arm swing, foot/toe clearance, asymmetries, steps to turn, pain, cautious, spastic/scissoring, staggering, fatigability, posture

Imaging and labs

- Summarize, keep it concise and pertinent
  - "CBC, BMP, TSH, EKG, Head CT were all normal"
  - "CBC was notable for a WBC of 2.0, ALC of 120, and platelets 42. CMP was notable for creatinine of 2.6, …"

Assessment

Summarize

- Only need summary statement if complex case

Localization

- Provide top localizations and rationale based upon exam and co-localizing findings
  - "Based upon symmetric leg weakness, urinary retention, and thoracic sensory level, the most like localization is spinal cord. However, reflexes are absent, so we should also consider a polyradiculitis or peripheral nerve"

Differential

- Most likely, most dangerous, most treatable, couple zebras
- Use history, exam, studies to support rationale and prioritization
  - "The three most likely and important diagnoses would be ischemic stroke, seizure, or migraine. The diagnosis of stroke is supported by… The most likely type of stroke would be cardioembolic based upon… With his fever and white count, we should also consider the stroke may be due to endocarditis, meningitis, or vasculitis..."
  - "The diminished vibration and proprioception, loss of pin sensation in a stocking-glove distribution, distal weakness with diminished reflexes and no UMN signs points to a neuropathy. Possible etiologies suggested by the history include..."

Plan

- Keep it tight, focus on diagnostic testing and acute treatment
  - "We were able to get the spine MRI done last night, and the patient is first on the list to get nerve studies to evaluate for demyelination. Based upon the CSF demonstrating high protein with no cells, and rapidly evolving weakness with lost reflexes, we already contacted VIR and lab medicine to get everything in place for his initial plasma exchange later today. We are monitoring Nifs and FVC for signs of deterioration, and will transfer to the ICU if they trend downward."
- If time permits and pertinent, speak to discharge planning and follow-up

Literature

- High Impact: NEJM, Neurology, Brain, Annals of Neurology, Lancet Neurology, Lancet, JAMA
- Recent RCTs related to management, recent pubs related to patients presentation and prognosis, guidelines, consensus statements
  - "American Academy of Neurology recently reviewed all the evidence for treatment of Bell's palsy and emphasized… For our patient, we should…"
  - "In 2010, Chernyshev et al in Neurology evaluated outcomes of inadvertently administering tPA for patients with conversion disorder and stroke mimics, and found no ICH in a cohort of 512 patients. With regards to our patient…"
  - "A recent clinical trial in Neurology randomized patients with GBS to receive either plasma exchange or IVIG, found that the outcome was no different at 6 months, and emphasized tailoring the decision based upon several key patient factors… Because our patient has…"
- Google scholar lists most cited at top
- Review articles, general approach articles, meta-analyses not as useful for rounds
- Keep it very brief. Be mindful of time needed for rounding
- NOTE: Literature may go before plan if it directly impacts the plan (ding-ding-ding)

Evaluation

Composure
- Stands straight, relaxed, not too nervous
- Speaks clearly with good volume and speed
- Does not read from note
- Varies eye contact for attention
- Appears prepared, confident, enthusiastic

Beginning
- Chief complaint is problem based and pertinent
- Summary of course stated (sudden, progressive over 6 months)
- Identifying info is concise and pertinent

HPI
- Provides brief background level of health before presenting symptoms
- Thoroughly describes the symptoms the patient experienced
- Describes the time course of the different symptoms
- Symptoms were presented in a logical manner
- Relates symptoms to functional impairments (i.e. walking, stairs, lifting groceries)
- Pertinent negatives that relate to co-localizing signs
- Pertinent negatives that relate to differential
- If medical history is pertinent, this went after the symptoms
- No gaps in information from incomplete history
- Did not use equivocating words (i.e. apparently, poor historian, per the chart)

PMH/Meds/SH/ROS
- PMH was pertinent and included the necessary details to understand impact and severity
- Meds listed were pertinent if not complete
- Understood about the person and their life circumstances
- ROS not presented; already incorporated into HPI

Exam
- General exam was summarized with pertinent positives and negatives.
- Neuro exam was logical and organized
- Pertinent positives and negatives on exam were included
- Neuro exam was appropriately summarized
- Detail was there when necessary
- No equivocating unless appropriate

Localization
- All possibilities are discussed based upon synthesis of data
- Priorities are provided if multiple
- Differential
- Comprehensive
- Relevant
- Prioritized and logically presented

Plan
- How to hone differential
- Short, medium, long-term treatment plans
- Discharge planning