FASM1 – Septembre 2020 : Session 1

Nous allons travailler de manière hybride cette année. Merci de bien vouloir prendre connaissance de ces consignes.

Pour chaque séance prévue vous aurez à votre disposition des documents que vous pourriez télécharger depuis mon site web http://l.georges.free.fr. En général chaque cours sera sous format pdf, et sera accompagné d'un travail personnel à faire soit en groupe, soit individuellement.

Pendant les heures prévues sur ADE je serai disponible pour répondre à vos questions et échanger avec vous sur les deux plateformes suivantes :

Google hangouts : lucy.georges@gmail.com
Discord server : https://discord.gg/XsHUQ2Z
Discord ID lucygeorges#0323

En dehors de ces heures vous pouvez évidemment m'écrire à lucy.georges@univ-lorraine.fr ou lucy.georges@gmail.com en prenant soin de bien préciser votre section et la nature de votre requête dans la ligne du sujet. Dans le cas où vous envoyez un document, merci de préférer le format pdf, et de préciser votre identité dans le nom du fichier. Il est également possible de partager un fichier via docs.google.com

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Organisation des séances

1 à 7 se feront à distance, et 8 à 10 en présentiel. L'organisation des évaluations reste à préciser en fonction de l'évolution de la situation sanitaire.

1. Introduction & travail personnel 1
2. L'étude de cohorte 1
3. L'étude de cohorte 2
4. La consultation 1
5. La consultation 2
6. Case report 1
7. Case report 2
8. Evaluations
9. Evaluations
10. Evaluations

Nous travaillerons principalement deux axes cette année.

Communication :
La modulation du langage entre le discours médical et la communication grand publique. Nous utiliserons comme support le document de sortie, la consultation et l'étude de cas. Cette dernière est à la base de l'évaluation qui aura lieu début 2021.

Méthodologie :
L'analyse fonctionnelle de l'article de recherche, ou comment la fonction de chaque section influe sur la langue et l'organisation, avec un regard plus particulier sur l'introduction.

L'évaluation consiste en la présentation en **anglais simplifié** d'une étude de cas (Case Report) celle-ci doit durer 4 minutes maximum, et doit être compréhensible par quelqu'un qui n'a aucune formation médicale. Elle sera suivie de deux ou trois questions. Séances 6 et 7 seront dédiées à vous aider à comprendre ce qui est attendu de vous.

Document 1 : The hospital discharge summary

PHYSICIAN HOSPITAL DISCHARGE SUMMARY

Provider: Ken Cure, MD

Patient: Patient H Sample **Provider's Pt ID:** 6910828 **Sex:** Female

Attachment Control Number: XA728302

HOSPITAL DISCHARGE DX

- 174.8 Malignant neoplasm of female breast: Other specified sites of female breast
- 163.8 Other specified sites of pleura.

HOSPITAL DISCHARGE PROCEDURES

1. 32650 Thoracoscopy with chest tube placement and pleurodesis.

HISTORY OF PRESENT ILLNESS

The patient is a very pleasant, 70-year-old female with a history of breast cancer that was originally diagnosed in the early 70's. At that time she had a radical mastectomy with postoperative radiotherapy. In the mid 70's she developed a chest wall recurrence and was treated with further radiation therapy. She then went without evidence of disease for many years until the late 80's when she developed bone metastases with involvement of her sacroiliac joint, right trochanter, and left sacral area. She was started on Tamoxifen at that point in time and has done well until recently when she developed shortness of breath and was found to have a larger pleural effusion. This has been tapped on two occasions and has rapidly reaccumulated so she was admitted at this time for thoracoscopy with pleurodesis. Of note, her CA15-3 was 44 in the mid 90's and recently was found to be 600.

HOSPITAL DISCHARGE PHYSICAL FINDINGS

Physical examination at the time of admission revealed a thin, pleasant female in mild respiratory distress. She had no adenopathy. She had decreased breath sounds three fourths of the way up on the right side. The left lung was mostly clear although there were a few scattered rales. Cardiac examination revealed a regular rate and rhythm without murmurs. She had no hepatosplenomegaly and no peripheral clubbing, cyanosis, or edema.

HOSPITAL DISCHARGE STUDIES SUMMARY

A chest x-ray showed a large pleural effusion on the right.

HOSPITAL COURSE

The patient was admitted. A CT scan was performed which showed a possibility that the lung was trapped by tumor and that there were some adhesions. The patient then underwent thoracoscopy which confirmed the presence of a pleural peel of tumor and multiple adhesions which were taken down. Two chest tubes were subsequently placed. These were left in place for approximately four days after which a TALC slurry was infused and the chest tubes were removed the following day. Because of the significant pleural peel and the trapped lungs, it is clearly possible that the pleurodesis will not be successful and this was explained to the patient and the family prior to the procedure.

Of note, we started her on Megace during this hospitalization because she was having significant nausea and vomiting with the Arimidex that she had been taking.

HOSPITAL DISCHARGE FOLLOWUP

The patient is being transferred to an extended-care facility near her home, where she will remain until she has enough strength to go home. It is possible that the fluid may reaccumulate and require repeat tapping despite the pleurodesis that was performed. Hopefully, however, with the combination of pleurodesis and the Megace that she was started on, she will have improvement of her cancer and a decrease in her pulmonary symptomatology. Overall, however, her prognosis is poor because of her debilitated state and the status of her lungs.

She is being discharged on Tylenol with Codeine as needed for pain, Megace, and a Multivitamin. She will have a follow-up appointment with Dr. Follow in three weeks with a chest x-ray. They have been instructed to call us in the interim should there be any problems.

Signed by: Ken Cure, MD on 30 Oct 1998 12:53

FASM1 – Septembre 2020 : Session 1

This document is sent to the referring physician when a patient is discharged from hospital. It is therefore written in technical language since the patient is seen as a subject. There is a growing number of doctors, in particular a UK movement based at the Academy of Medical Royal Colleges, who are calling for a more direct approach by addressing the document directly to the patient. For more information see the link below.

https://www.aomrc.org.uk/reports-guidance/please-write-to-me-writing-outpatient-clinic-letters-to-patients-guidance/

The document you have read above is a fictitious example in which we can observe the basic structure in three parts:

Identification

Clinical information

Future

These parts are further divided into subsections:

Identification

This part contains three main subheadings, and it is used for conveying administrative information.

Patient information

In this section we will find the patient's name and a reference number in most cases. We may also be provided with the patient's date of birth, address, and the name of the referring GP

Hospital information

The ward (or hospital department) will figure here, along with the name of the consultant or specialist and the dates of hospitalisation

Summary

This is merely where the author, and date at which the document was produced can be found. In some cases, the author will be the same as the consultant mentioned in the hospital information, but this is not systematically the case.

Clinical information

This part contains the "meat" of the document and will provide an account, usually in chronological order, of the patient's hospital stay. It can be subdivided into a number of parts

Diagnosis

In this part the diagnosis will be provided. Sometimes there will be an initial diagnosis dating from the patient's admission and another diagnosis which has been established in the course of investigations. Any relevant comorbidities will also be mentioned.
So that the diagnosis can be easily understood, most physicians will use the ICD, which is a system developed by the World Health Organisation for the International Classification of diseases. The sample document uses the ICD-9 codes, although the current version is ICD-10. ICD-11, which has been developed to evolve with computer systems and for better integration with the DSM codes is due to come into effect in 2022, although it is unlikely to be fully adopted immediately. The ICD system was initially invented by a Frenchman, Jacques Bertillon, in the late nineteenth century and was essentially used for classifying cause of death. It was developed in response to a call from Florence Nightingale, the famed British Crimean war nurse, for a universal system. The WHO took charge of the system from version 6 onwards, back in 1949.

FASM1 – Septembre 2020 : Session 1

Presentation

This section outlines the initial observations at admission. Here we will find information that was gathered at admission, such as the patient's history as well as the first examination of the patient

Investigations and procedures

Any laboratory tests, imaging, or interventions will be described in this part.

Future

This part concerns the outpatient phase and is generally divided into two subsections

Management

Here we will find any follow-up appointments for treatment or examinations that have been planned, as well as any actions the GP needs to undertake, such as scheduling bloodwork at a particular point in time for example.

Medication

In this section the author will include any drugs that have been given thus far as well as any additional treatment that needs to be initiated once the patient leaves the hospital or in the weeks that follow.

Today's task:

You may work in pairs for this task if you wish. Write a discharge summary based on a case you have seen during an internship, or on a plausible invented case.

You may send me the document in pdf format, if you would like feedback.

Don't forget that I'm available via the two platforms mentioned at the beginning of the document if you have any questions whatsoever.