GUIDE TO CLERKING
How to Investigate, Form Differential Diagnoses and a Management Plan

2014-15

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Introduction

What is a “clerking”?  

A clerking is a comprehensive history and full examination of a patient taken when the patient is going to be admitted to hospital. This includes initial investigation results, the team’s differential diagnoses and a management plan. The patient’s concerns should be explored and documented, and a problem list should be created. Clerking is more than an information-gathering exercise and communication with the patient (and family, carers etc where appropriate) is paramount. It is sometimes completed on a proforma, however each hospital works differently. You may have to complete a clerking on blank paper.

Why do we clerk?  

If a patient is to be admitted the clerking is the most thorough history and examination a patient is likely to receive during their time in hospital. It is done with the aim of guiding the team towards the correct diagnosis and patient-centred management, ensuring that nothing important is missed.

When do we clerk?  

When a patient is going to be admitted to hospital, for example from A&E. Patients will also be clerked for day cases such as certain surgeries. and GPs may carry out a variation on a clerking in the community when seeing a new patient for the first time, This document, however, focuses on clerking in the hospital setting.

Who does the clerking?  

The admitting team – the surgical, medical or specialist team on-call (depending on the patient’s most likely working diagnosis based on assessment by the A&E team or GP).

What does a clerking consist of?  

A full history, examinations of all systems, investigations, a differential diagnosis, patient expectations, problem list, and management plan.
How to clerk – an Overview

1. Take a FULL History (see UCL Guide to History Taking and Examination)
   a. Presenting Complaint
   b. History of Presenting Complaint
   c. Past Medical, Surgical and Psychiatric history
   d. Drug History (including allergies)
   e. Family History
   f. Social History
   g. Systems Review
   h. Ideas, Concerns and Expectations

2. Perform a THOROUGH Examination of all systems (see UCL Guide to History Taking and Examination)
   a. General appearance
   b. Cardiovascular
   c. Respiratory
   d. Abdominal
   e. Locomotor
   f. Neurological
   g. Additional relevant examinations e.g. breast, thyroid…

3. Document your findings

4. Perform relevant Investigations

5. Formulate a list of Differential Diagnoses

6. Create a Problem List

7. Decide on a Management Plan

Throughout this process there is an essential component of two-way communication.

The default position when clerking a patient is to examine each system fully, however in some cases this may not apply, e.g. joint position sense in someone with painful joints.
How to Document Your Findings

The majority of clerkings you will perform in Year 4 will be for your own benefit and records. As these will be kept by you and not go into the patient’s notes, they must be anonymised, i.e. without any patient-identifiable details in them. However as you progress through clinical practice your clerkings may be kept in the patient’s notes, in which case you should follow the rules below for documenting medical notes.

Writing in medical notes requires you to have:

- **At the top of the document:**
  - Two patient-identifiable details on each page – name and hospital number
  - Patient’s location in hospital
  - The date and time you are writing
  - Who you are and who the most senior person responsible for care present is

- **At the end of the document:**
  - Your signature
  - Your name (printed)
  - Your grade, e.g. 4th year medical student
  - Your bleep (when you have one)

Remember this is a legal document so it is important to write legibly. If you are writing in retrospect, state so and what time you saw the patient.

Medical documentation contains a host of abbreviations and symbols. While most abbreviations are generally discouraged as they can lead to confusion (for instance CRT can mean capillary refill time or cardiac resynchronisation therapy), it is important to be able to understand what others have written in a patient’s notes before you. Symbols make documenting examination findings quick and easy, and illustrate findings to other healthcare professionals clearly and concisely.

General appearance

- Describe general appearance e.g. well / ill / moribund
- Note any JACCOL:
  - Jaundice
  - Anaemia
  - Clubbing
  - Cyanosis
  - Oedema
  - Lymphadenopathy
Cardiovascular

- Document capillary refill time, pulse rate and rhythm, blood pressure, jugular venous pressure, and peripheral pulses.

<table>
<thead>
<tr>
<th>Examination finding</th>
<th>Abbreviation</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capillary refill time</td>
<td>CR &lt; 2s</td>
<td>Capillary refill less than 2 seconds</td>
</tr>
<tr>
<td>Pulse</td>
<td>80 irreg irreg</td>
<td>Pulse 80 beats per minute irregularly irregular</td>
</tr>
<tr>
<td>Jugular venous pressure</td>
<td>JVP ↑ ↔ ↓ (state cm)</td>
<td>Jugular venous pressure height at 45° either raised, normal or reduced</td>
</tr>
<tr>
<td>Normal heart sounds</td>
<td>HS I + II + 0</td>
<td>Heart sounds 1 and 2 no added sounds</td>
</tr>
<tr>
<td>Third heart sound</td>
<td>S1 + S2 + S3 or HS I+II+III</td>
<td>Audible third heart sound</td>
</tr>
</tbody>
</table>

**Murmurs**

- PSM: Pansystolic murmur
- ESM: Ejection systolic murmur
- EDM: Early diastolic murmur
- MDM: Mid-diastolic murmur
- Pansystolic murmur

**Peripheral Pulses (all present):**

N.B. an absent pulse is denoted by -
Respiratory

- Document respiratory rate, tracheal position (central or deviated to left or right), chest expansion, percussion note, breath sounds and any added sounds.

**Clear** chest (you may see an arrow drawn through indicating the chest is clear, however this is considered bad practice)

![Clear chest diagram]

**Crackles** in the right lower zone

![Crackles in right lower zone]

**Wheeze** (diffuse):

![Wheeze diffuse]

**Effusion** in the right base:

**Reduced air entry** in both lower zones:

**Chest drain** and **pleural effusion** in right base:
Abdominal

- Document if the abdomen is: soft, tender, rigid, distended, and the presence of any guarding, masses, organomegaly, scars or hernias.
- Document findings on digital rectal examination (DRE) if carried out

**Normal abdomen** – soft and non-tender (you may see an arrow drawn through indicating the abdominal exam is normal, however this is considered bad practice)

![Diagram of a normal abdomen](image)

**Tenderness** in the left loin and left iliac fossa:

![Diagram of tenderness](image)

**Hepatomegaly:**

![Diagram of hepatomegaly](image)
*Midline laparotomy scar* and *colostomy* in the left iliac fossa:

*Rooftop incision scar.*

*Moderate splenomegaly* and *urinary catheter.*
Locomotor

- Document findings of GALS screen as below:

<table>
<thead>
<tr>
<th></th>
<th>Appearance</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gait</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Arms</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Legs</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Spine</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

The above example shows that gait, arms and spine are all normal on inspection and movement, but that legs are normal on inspection but have impaired movement – the details of this, including which side is abnormal, must be documented below the table.

- Document findings of any individual joint examinations performed in the order of:
  - LOOK (findings on inspection)
  - FEEL (tenderness to palpation, crepitus)
  - MOVE (loss of movements – active +/- passive)
  - FUNCTION & SPECIAL TESTS
Neurological

Cranial Nerves
- Document findings of the cranial nerve (I-XII) examination on the left and right – state if normal or specify if abnormal
- For CN II (Optic nerve):
  - Acuity – give according to result on Snellen chart, e.g. RIGHT 6/6, LEFT 6/60
  - Pupils – “PERLA” = pupils equal and reactive to light and accomodation
  - Fundoscopy:
    - Disc – normal cup, colour & contour
    - Vessels – normal or e.g. tortuous, AV nipping, neovascularisation, microaneurysms
    - Retina – normal or pigmented, hard or soft exudates, cotton wool spots, laser photocoagulation scars
    - Macula – normal or drusen, neovascularisation
  - Fields – full or deficient, e.g. right homonymous hemianopia:

Peripheral Nervous System
- For upper and lower limb document for both left and right:
  - TONE
    - Reduced
    - Normal
    - Increased
    - If increased, state if tone is spastic or rigid
  - POWER – using the MRC grading system:
    - No movement
    - Flicker is detectable
    - Movement only if gravity is eliminated
    - Can move limb against gravity
    - Can move against gravity & some resistance exerted by examiner
    - Normal power
  - CO-ORDINATION
    - Normal or impaired (note if unable to test properly due to weakness)
- REFLEXES

<table>
<thead>
<tr>
<th>Reflexes</th>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>(+++/+++/+/-/±)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biceps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supinator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Triceps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ankle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plantar</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reflexes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>Absent</td>
</tr>
<tr>
<td>+</td>
<td>Reduced</td>
</tr>
<tr>
<td>++</td>
<td>Normal</td>
</tr>
<tr>
<td>+++</td>
<td>Brisk</td>
</tr>
<tr>
<td>±</td>
<td>Present with reinforcement</td>
</tr>
</tbody>
</table>

- SENSATION

- In all modalities:
  - Light touch
  - Pin prick (nociception)
  - Vibration (128 Hz)
  - Proprioception
  - Temperature
- Draw on diagram where losses are
- Note if distribution is dermatomal, glove-and-stocking or individual nerves

- GAIT for lower limb
  - e.g. antalgic, hemiparetic, broad-based, high-stepping, stamping

- Ensure that level of consciousness has been measured, either with AVPU scoring or the Glasgow Coma Scale (GCS):
  - AVPU:
    - A = Alert
    - V = Responds to Voice
    - P = Responds to Pain
    - U = Unresponsive
  - GCS:

<table>
<thead>
<tr>
<th>Glasgow Coma Scale</th>
<th>Eyes</th>
<th>Voice</th>
<th>Motor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>Closed</td>
<td>No sound</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Open to pain</td>
<td>Groans</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Open to voice</td>
<td>Confused words</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Open spontaneously</td>
<td>Confused speech</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Orientated</td>
<td>Localises to pain</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td></td>
<td>Obeys commands</td>
</tr>
</tbody>
</table>
Selecting Appropriate Investigations

There will be a vast quantity of investigations at your disposal in hospital – it is important that you are able to select those relevant to your patient. You must ensure you order all investigations that will give you important information relevant to your patient’s admission, but equally you must be able to justify why you are ordering each test. Investigations can be expensive and can pose a risk to patients, e.g. from radiation exposure, so think about whether each one will aid in diagnosis or guide your management. Bedside tests, however, are quick and easy to perform and expected in many clerkings.

For each of the patients you see you should look at the results of any investigations they have had, and know the normal ranges for common tests.

Investigations can be divided into broad categories. Provided below is a rather inclusive list of investigations, but most patients will require only a few of the common investigations.

**Bedside tests:**
- Urine dipstick
- ECG (electrocardiogram)
- ABG (arterial blood gas) / VBG (venous blood gas)
- CBG (capillary blood glucose - formerly known as BM)
- Peak flow

**Bloods:**
- Full Blood Count (FBC)
  - Hb (haemoglobin)
  - MCV (mean cell volume)
  - WCC (white cell count)
    - Neutrophils
    - Lymphocytes
    - Eosinophils
    - Basophils
    - Monocytes
  - Platelets
- Urea & Electrolytes (U&Es)
  - Urea
  - Creatinine
  - Na⁺ (sodium)
  - K⁺ (potassium)
  - Cl⁻ (chloride)
  - HCO₃⁻ (bicarbonate)
  - Ca²⁺ (calcium)
  - Mg²⁺ (magnesium)
  - PO₄³⁻ (phosphate)
- Liver Function Tests (LFTs)
  - Albumin
  - ALT (alanine aminotransferase)
  - AST (aspartate aminotransferase)
  - ALP (alkaline phosphatase)
  - Bilirubin
  - GGT (gamma-glutamyl transpeptidase)
- Thyroid function tests (TFTs)
  - TSH (thyroid stimulating hormone)
  - Total T4 (thyroxine)
- Free T4
- ESR (erythrocyte sedimentation rate)
- CRP (C-reactive protein)
- Coagulation screen:
  - INR (international normalised ratio)
  - APTT (activated partial thromboplastin time)
  - PT (prothrombin time)
  - TT (thrombin time)
  - Fibrinogen
  - Fibrinogen degradation products
- Metabolic
  - Glucose
  - HbA1c (glycated haemoglobin A1c)
  - Total cholesterol
  - Triglycerides
  - Serum osmolality
- Other
  - Cardiac enzymes – creatinine kinase, troponin T, troponin I
  - Amylase
  - Vitamin B12
  - Folate
  - Iron studies – Ferritin, Iron, TIBC (total iron binding capacity)
  - Endocrine – Cortisol, PTH (parathyroid hormone), Prolactin
  - Urate
  - Lactate
  - Tumour markers – LDH (lactate dehydrogenase), AFP (alpha-fetoprotein), CA125 (cancer antigen 125), CA 15-3, CA 19-9, CEA (carcinoembryonic antigen), PSA (prostate specific antigen)
  - Total protein
  - Immunological – IgG, IgA, IgM, Complement C3, C4

**Imaging:**
- Ultrasound scans
  - E.g. US abdomen, pelvis, neck, chest, breast
- X-rays
  - CXR (chest x-ray)
  - AXR (abdominal x-ray)
  - Bones – skull, limbs, pelvis, joints, spine
  - + contrast e.g. hysterosalpingogram
- CT (computerised tomography)
  - +/- contrast
  - CT head, chest, abdomen, pelvis, spine, KUB (kidneys, ureter, bladder)
  - CT angiography e.g. CTPA (CT pulmonary angiography)
- MRI (magnetic resonance imaging)
  - +/- contrast
  - T1, T2 or T2 FLAIR
  - MR head, neck, chest, abdomen, pelvis, joints, tendons and ligaments
  - MR angiography
  - Specialised MRIs e.g. MRCP (magnetic resonance cholangiopancreatography)
- **Nuclear medicine**  
  - Uses radioactive substances as tracers for functional imaging  
  - E.g. bone scan, myocardial perfusion scan, thyroid scan, V/Q scan, MIBG, PET scan
- **Endoscopy**  
  - GI tract – OGD (oesophagastroduodenoscopy), colonoscopy, sigmoidoscopy, ERCP (endoscopic retrograde cholangiopancreatography)  
  - Respiratory – bronchoscopy  
  - GU tract – cystoscopy, hysteroscopy  
  - Laparoscopy  
  - Arthroscopy – e.g. knee, shoulder

**Microbiology / Virology**
- Microscopy, Culture & Sensitivities (MC&S)  
  - Bodily fluids e.g. blood, urine, CSF, pleural fluid
- Swabs e.g. wound, nasal, throat
- Serological testing for viruses e.g. HIV, CMV, EBV, HBV
- Urine antigen testing e.g. legionella, pneumococcal

**Other:**
- Lumbar puncture
- Lung function tests  
  - Spirometry
- Cardiac:  
  - Echocardiogram  
  - Exercise ECG  
  - Exercise Echocardiogram  
  - 24 hour monitoring for ECG/BP  
  - Tilt-table test
Forming a List of Differential Diagnoses

The differential diagnoses list is a list of possible causes for your patient’s presentation. It can be as long or as short as necessary, but crucially it must include the correct diagnosis.

Top Tips for forming a list of Differential Diagnosis (ΔΔs):

1. Put the most likely diagnosis at the top
2. Remember common things are common, so rare diseases should usually come lower down the list
3. Use the patient demographics to your advantage – age, gender, ethnicity and occupation can provide valuable clues
4. Don’t forget that common diseases may present atypically
5. The list is flexible – diagnoses may be excluded or added as investigation results come through

Below find examples where a differential diagnosis list has been formed based on common presenting complaints, and narrowed down based on findings in the history, examination and investigations:
Narrowing down the differential diagnoses for chest pain

Example 1 (see example clerking):

Take a history

Abbreviated findings:
- 54 year old male
- Central chest pain
- Sudden onset, severe
- Cardiac history
- Has risk factors hypertension, coronary artery disease
- No productive cough or fevers

Examine the patient

Abbreviated findings:
- Appears unwell, clammy
- Complaining of constant chest pain
- Tachycardic and raised blood pressure
- HS: I + II + 0
- Chest – trachea central, percussion resonant throughout

Investigations

Abbreviated findings:
- Raised troponin
- ECG – ST segment elevation in leads I, aVL, V_{2-5}
- CXR- normal sized mediastinum, clear lung markings and fields.

Working Δ: STEMI
Example 2 (see example clerking):

Take a history

Abbreviated findings:
- 70 year old male
- Onset over days
- Productive cough
- Fevers
- History of respiratory disease e.g. COPD (chronic obstructive pulmonary disease)
- History of smoking

Examine the patient
Abbreviated findings:
- Appears unwell, sweaty
- Coughing
- Tachycardic and hypotensive
- Tachypnoeic and hypoxic
- Chest – coarse crackles, right base

Investigations
Abbreviated findings:
- Bloods – raised WCC (neutrophilia) and CRP
- CXR – hyperexpansion and consolidation over right lower zone

Revised ΔΔ:
- Exacerbation of COPD (newly added ΔΔ)
- Community acquired pneumonia (CAP)

Working Δ: Community acquired pneumonia
### Narrowing the differential diagnoses for abdominal pain

<table>
<thead>
<tr>
<th>Initial ΔΔ:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Gastro-intestinal</td>
<td></td>
</tr>
<tr>
<td>o GORD</td>
<td></td>
</tr>
<tr>
<td>o PUD (peptic ulcer disease)</td>
<td></td>
</tr>
<tr>
<td>o Gastroenteritis</td>
<td></td>
</tr>
<tr>
<td>o Appendicitis</td>
<td></td>
</tr>
<tr>
<td>o IBD (inflammatory bowel disease)</td>
<td></td>
</tr>
<tr>
<td>o IBS (irritable bowel syndrome)</td>
<td></td>
</tr>
<tr>
<td>o Gallstones</td>
<td></td>
</tr>
<tr>
<td>o Hepatitis</td>
<td></td>
</tr>
<tr>
<td>o Ascending cholangitis</td>
<td></td>
</tr>
<tr>
<td>o Pancreatitis</td>
<td></td>
</tr>
<tr>
<td>- Genitourinary</td>
<td></td>
</tr>
<tr>
<td>o Ruptured ectopic pregnancy</td>
<td></td>
</tr>
<tr>
<td>o Menstrual</td>
<td></td>
</tr>
<tr>
<td>o Mittelschmerz</td>
<td></td>
</tr>
<tr>
<td>o UTI (urinary tract infection)</td>
<td></td>
</tr>
<tr>
<td>- Other</td>
<td></td>
</tr>
<tr>
<td>o Pneumonia</td>
<td></td>
</tr>
<tr>
<td>o ACS (acute coronary syndrome)</td>
<td></td>
</tr>
<tr>
<td>o Anxiety</td>
<td></td>
</tr>
</tbody>
</table>

#### Example 1 (see example clerking):

**Take a history**

**Abbreviated findings:**
- 18 year old female
- Pain central abdomen
- Came on over the last couple of days
- Nausea and vomiting
- Low grade fever
- No jaundice, no recent travel

**Examine the patient**

**Abbreviated findings:**
- Appears unwell
- Tachycardic, pyrexic
- Soft, tender abdomen with guarding in RIF
- Rebound tenderness
- Rovsing’s sign positive

#### Investigations

**Abbreviated findings:**
- Bloods – raised WCC (neutrophilia) and CRP
- Pregnancy test negative

**Refined ΔΔ:**
- Gastroenteritis
- Appendicitis
- Ruptured ectopic pregnancy
- GORD
- Menstrual
- PUD
- Pancreatitis

**Working Δ:** Appendicitis
Example 2:

Take a history

Abbreviated findings:
- 23 year old male
- Cramping pain central abdomen
- Came on a week ago
- Non-bloody diarrhoea, feels bloated
- Nausea, no vomiting
- Low grade fever
- Has spent the last month in Turkey on work placement

Examine the patient

Abbreviated findings:
- Appears well but slightly dehydrated
- Mildly pyrexic
- Soft, diffusely tender abdomen
- DRE – watery stools, foul-smelling

Investigations

Abbreviated findings:
- Bloods – slightly anaemic, slightly raised WCC and CRP
- Stool culture- negative
- Stool microscopy (including ova, cysts and parasites (O,C&P)) - giardiasis seen

Refined ΔΔ:
- Gastroenteritis
- IBD (inflammatory bowel disease)

Working Δ: Gastroenteritis - giardiasis
Narrowing the differential diagnoses for breathlessness

Initial ΔΔ:
  Respiratory
  ▪ pneumonia
  ▪ asthma
  ▪ COPD
  ▪ pleural effusion, pleural disease
  ▪ pulmonary fibrosis
  ▪ pulmonary embolism
  ▪ anaphylaxis
  ▪ pneumothorax (simple or tension)
  ▪ foreign body inhalation
  ▪ pulmonary hypertension
  Cardiac
  ▪ arrhythmia
  ▪ heart failure – LVF, CCF
  Anatomical
  ▪ obesity
  ▪ neuromuscular disease
  ▪ chest wall or spinal disease e.g. kyphoscoliosis
  ▪ ascites
  Other
  ▪ anaemia
  ▪ metabolic acidosis e.g. acute salicylate overdose, DKA
  ▪ shock
  ▪ psychogenic

Take a history (see example clerking)

Abbreviated findings:
  • 68 year old male
  • onset over days
  • productive cough – green/yellow sputum
  • feels hot and sweaty
  • known COPD – wheezing is worse
  • exercise tolerance reduced
  • smoker with 50 pack year Hx
  • PMHx: COPD, HTN, OA, hypercholesterolaemia

Examine the patient

Abbreviated findings:
  • tachycardic, tachypnoeic, mildly hypotensive, pyrexic
  • diffuse wheeze, crackles over right lower zone

Investigations

Abbreviated findings:
  • raised WCC (neutrophilia), urea & CRP
  • CXR shows hyperexpansion + consolidation over right lower zone

Revised ΔΔ:
  ▪ community acquired pneumonia (CAP)
  ▪ COPD exacerbation
  ▪ pleural disease e.g. empyema

Refined ΔΔ:
  ▪ CAP
  ▪ COPD exacerbation

Working Δ: Community acquired pneumonia
Creating a Problem List

A problem list encompasses anything that has arisen following the history, examination, and investigations which need to be addressed. It is a dynamic list which can alter daily as problems are resolved, or new ones occur. It should be written numerically in order of importance, which again may change as the admission progresses.

Things to include:

- The immediate medical/surgical problem
- Underlying chronic conditions not adequately managed or that impact on the current problem
- Patient concerns
- Social factors e.g. smoking, alcohol consumption, housing issues
- Other conditions that may be highlighted following investigations
- Any problems with mobility – consider physiotherapy input
- Any concerns with self-care – consider occupational therapy input

Things not to include:

- Chronic conditions which are adequately managed and which do not impact the current problem

Example Problem List

Abbreviated history: Patient presents with epigastric pain which is worse when eating. He also mentions he has been feeling short of breath recently. His past medical history includes COPD and he is a current smoker with a 30 pack year history. He is concerned about becoming unwell as he is his mother’s primary carer. Investigations show a decreased GFR.

1) Peptic ulcer disease
2) Worsening COPD
3) Smoking
4) Requiring more help with his mother?
5) AKI (acute kidney injury) - ?CKD
Deciding on a Management Plan

The management plan is set to enable the problems highlighted to be resolved. It may also encompass further investigations that are required to narrow down the differential diagnoses if a diagnosis has not been reached. As with the problem list, the management plan will change throughout the admission and should be written numerically in order of importance. The management plan should focus on the main presenting problem, but there should also be consideration given to other issues on the problem list.

Things to include:

- Further investigations required
- Detailed treatment plan of the diagnosis (if reached) e.g. antibiotics, insulin, appendicectomy
- Referral to/discussion with other teams if necessary
- What needs to be prescribed including medication they were having on admission
- Review of medication
- Observations and how frequently they need to be
- Involvement of other healthcare professionals e.g. physiotherapy (PT), occupational therapy (OT), speech and language therapy (SALT)
- Discussion with seniors
- Communication of management options with patient and, where appropriate, family
- Discharge planning