CASE SUMARY GUIDE

Libyan International Medical University
Faculty of pharmacy
Pharm D Program
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How to write a case summary:

The ability to summarize a case reflects the degree of understanding of the student about the given case, and his ability to organize, synthesize and briefly present the key points of the case in order to provide a background for his argument.

Steps to summarize a case:

1. Read the case carefully more than once to understand it properly. This is a crucial step because an incomplete reading could lead to an inaccurate summary.
2. Aggregate the important (relevant) information, including the important (relevant) negative information.
3. Organize the aggregated information into categories (personal profile, chief complaint, other important complaints, past medical history, drug, history, family history, social history, clinical examination investigations)
4. Reduce the information in each category by using the minimum possible words.
5. Synthesize your summary in less than 200 words using the following order:
    a. Personal profile
    b. Chief complaint,
    c. Other important complaints,
    d. Past medical history,
    e. Drug history,
    f. Important family history,
    g. Important social history,
    h. Important clinical examination findings
    i. Important investigations
    j. Working diagnosis

Example:

a. **Personal profile:** Mrs. A. H. R. is a 50 years old Libyan lady
b. **Chief complaint:** she was admitted with 2 days history of headache, vomiting & dyspnea.
c. **Other important complaints:** She also has palpitation, epigastric pain and constipation. She had no chest pain or loss of consciousness.
d. **Past medical history:** She has history of Hypertension for the last 20 years and Diabetes mellitus for the last 5 years. She has multiple previous admissions to the hospital (no mentioned reason), also she has been operated for carpal tunnel syndrome and left breast abscess.

e. **Drug history:** Her drug history includes: Tab. Lisinopril 5 mg OD, S/C Insulin NPH 20IU, 10IU Regular (Morning time), 20 IU NPH at Night.
f. **Important family history:** no significant history

g. **Important social history:** no significant history
h. **Important examination findings:** On admission her blood pressure found to be high (227/111 mmHg), she was conscious, oriented, with bilateral lower limbs edema. Chest and CVS examination were normal.
i. **Important investigations:** Her blood tests showed: Hb 12.2, WBC 7.3, PLT 262, normal urea, creatinine, sodium & potassium. Her blood glucose was 421mg/dl, cholesterol 276 mg/dl, LDL 177 mg/dl & TG 265 mg/dl.
j. **Working diagnosis:** She was diagnosed as a case of hypertensive emergency and managed accordingly

Case summary:

Mrs. A. H. R. is a 50 years old Libyan lady, she was admitted with 2 days history of headache, vomiting & dyspnea. She also has palpitation, epigastric pain and constipation. She had no chest pain or loss of consciousness. She has history of Hypertension for the last 20 years and Diabetes mellitus for the last 5 years. She has multiple previous admissions to the hospital (no mentioned reason), also she has been operated for carpal tunnel syndrome and left breast abscess. Her drug history includes: Tab. Lisinopril 5 mg OD, S/C Insulin NPH 20IU, 10IU Regular (Morning time), 20 IU NPH at Night. On admission her blood pressure found to be high (227/111 mmHg), she was conscious, oriented, with bilateral lower limbs edema. Chest and CVS examination were normal. Her blood tests showed: Hb 12.2, WBC 7.3, PLT 262, normal urea, creatinine, sodium & potassium. Her blood glucose was 421mg/dl, cholesterol 276 mg/dl, LDL 177 mg/dl & TG 265 mg/dl. She was diagnosed as a case of hypertensive emergency and managed accordingly