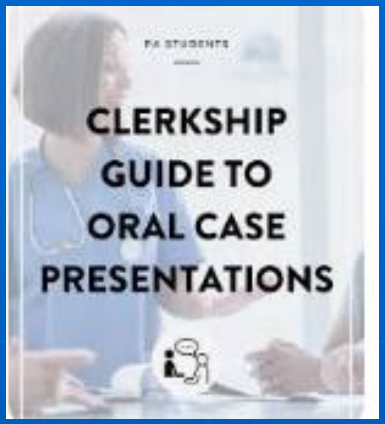
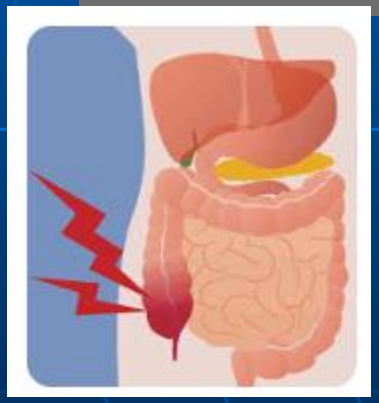
生病的故事

從發病到就醫
的歷程
Symptoms-Dx
And Rx.
response



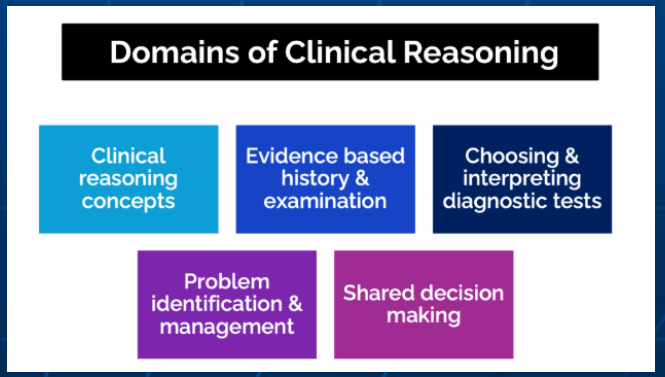
病例報告的技巧

acute appendicitis,
有不同的臨床表現



Cheng-Yi WANG

2025.06.15.



Problem list
Problem: RRSOAP

病人為中心
Patient-centered
care

最常見的病,內科醫師外科醫師都會面對的.

Acute appendicitis, typical and unusual

- a total 7% lifetime risk,
- most likely in adolescents and young adults

一定要會診斷,
一定要會治療.判斷要正確,治療要及時
超過24小時就可能出現合併症及死亡率
一定要找到確切的證據

令人驚訝的是，儘管如此普遍，其病因仍然未知，遺傳的作用也很少受到關注。

Case presentation基於case study的結果

- 最麻煩的是一個病有不同的clinical pictures.
- 以下我們至少找10個acute appendicitis案例,分析臨床的注意要點. 方才能夠及早得到診斷.
- 及早正確治療.

Presentation與communication是一體的兩面

- Effective communication lies at the heart of healthcare services. Whether it's conveying complex medical information to patients, discussing treatment plans with families, or presenting a medical case to colleagues, the ability to deliver clear, concise, and engaging presentations is vital.
- A well-designed presentation template tailored for a Medical Case can significantly enhance the **effectiveness** of a medical case presentation, offering a structured format that aids comprehension and maintains audience engagement.
- **學會presentation就知道病情的重點→溝**

明確說明案例的主要內容

- 也就是presentation的主要內容.
- -→事實上也就是Clinical problem(s)

臨床上一個病就可能有不同的表現ㄧ即有不同 different problems
所以了解問題要比病名診斷診斷重要

How to Prepare the Outline of a Medical Case Presentation?

Structuring Your Presentation

基本要件

先確認要提出的內容,
內容必須切實.詳細.

History taking 主要 symptoms and (signs)
PE– signs observed.
Lab. Data – abnormal data suggested some diseases
Medical images—morphological change and localization

Problem list and problem analysis

How to structure a Case Study presentation?

- 1. Introduction
- 2. Explain the Problem in Question.
  說出案例的問題:
  problem list—history taking
- Problem presentation—RRSOAP
- R—roots
- R-risk factors
- SOAP

SOAP 是現有的資料分析的結果
Roots 是猜測的, 病人只能說出相關的可能因素, 他也不知道病是怎麼發生怎麼來的
Risk factors 倒是比較容易了解 .age. Sex, past diseases, lab data----

History taking to get problems.
很多事實是不可以忽略的

- 1. Family history
- 2. Drug allergy/food allergy
- 3. Medication history: 為什麼在吃這個藥
- Ex.
- (1).瀉藥是因為有便秘
- (2).為什麼在吃plavix---因為冠動脈疾病(心臟病)置放支架
- 所以吃Plavix
- (3). 為什麼吃阿斯匹林100mg/d.-預防中風
- @@@好好詢問, 有系統詢問, 有技巧詢問, 自然可以得到問題的輪廓

困難點是在如何形成問題 formulation of problems.

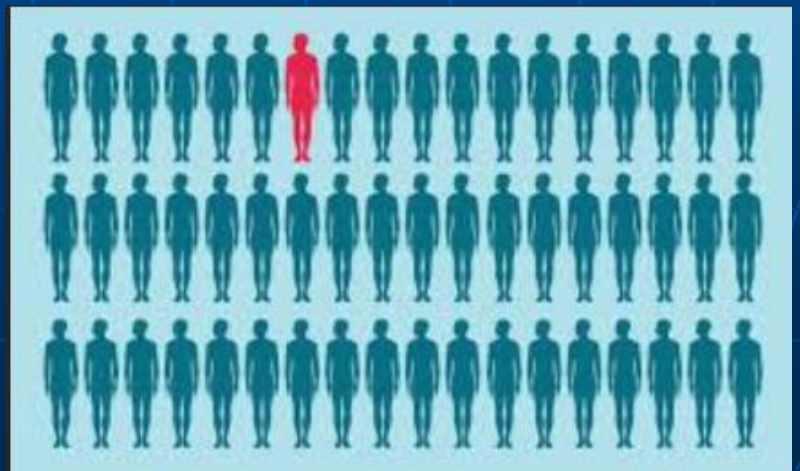
- 主問題比較簡單---最近一直在談的是
- 身體不舒服
- 看病的理由
- 他一定會說---或許講不清楚
- 或許講不出個所以然
- 或許講不出為什麼會這樣 roots.

病人還是關鍵的,不過一 開始連他對病情的發展也沒有很清楚的概念後來被問幾次以後就了解了

看2-3個醫生之後就會慢慢形成一定的前後秩序以及有無變化
Time 是病人慢慢體會的.----而這一部分也是醫師最關心的一
症狀的先後次序
特別是有兩三個不同類型的癥狀.

通常的表現是common, but often uncommon, even rare

- 過在醫學上有一個更大的麻煩就是:不是所有的病都是一個模樣.
- 有typical的pictures也有unusual pictures
- Typical(common) 大約2/3, unusual <1/3,
- Rare+ very rare==少於10 %



急性闌尾炎典型案例(66%)

- 最常見的病因是，腸壁內淋巴組織、腸道內結石等造成闌尾管腔的阻塞，引起感染，細菌迅速繁殖，導致闌尾發炎腫脹。
- 最主要的症狀是腹痛，典型特點是，疼痛可由epigastrium 轉移到腹部的右下側，同時可能會伴有發熱、噁心嘔吐、腹脹等症狀。PE:右；右下腹壓痛；+反彈痛 rebound tenderness.

0-6 hours:上腹部不適, 像胃痛
6-8 hours later
疼痛向右下方移勤/
8-12 hours
腹部右下方疼痛有壓痛
12 hours later.
腹部右下方疼痛有壓痛更加明顯

- 急性闌尾炎的症狀通常包括**轉移性右下腹痛**（最初可能從上腹部或肚臍周圍開始，然後轉移至右下腹）、**噁心、嘔吐、食慾不振**（超過一半的患者會出現這些症狀）、**發燒**（通常在24小時內開始輕微發燒，體溫可能逐漸上升）、以及**便祕或腹瀉**（約10~20%的患者會有這些症狀，但便祕較為常見）。
- 此外，嚴重的病例可能會出現**腹膜炎、腹腔膿腫、門靜脈炎**等併發症，需要及時診治。如果你想了解更多細節或如何區分闌尾炎與腸胃炎，我可以進一步說明！

Meta-Analysis › BMJ Open. 2022 Nov 3;12(11):e056854. doi: 10.1136/bmjopen-2021-056854.

Diagnostic accuracy of blood tests of inflammation in paediatric appendicitis: a systematic review and meta-analysis

David Fawkner-Corbett [1 2 3], Gail Hayward [4], Mohammed Alkhmees [5], Ann Van Den Bruel [6], Jose M Ordóñez-Mena [4 7], Gea A Holtman [4 5]

Affiliations – collapse

Affiliations

1 NIHR Community Healthcare MedTech and IVD Co-operative, Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford OX2 6GG, UK david.fawkner-corbett@imm.ox.ac.uk.

In conclusion, we report the largest study of commonly available blood tests and identify WCC value below 10 000 cells/µL and ANC value below 7500 cells/µL are the best single tests in ruling-out suspected childhood appendicitis.

Review › Dtsch Arztebl Int. 2020 Nov 6;117(45):764-774. doi: 10.3238/arztebl.2020.0764.

Acute Appendicitis in Childhood and Adulthood

Patrick Téoule [1], Jan de Laffolie, Udo Rolle, Christoph Reissfelder

Affiliations – collapse

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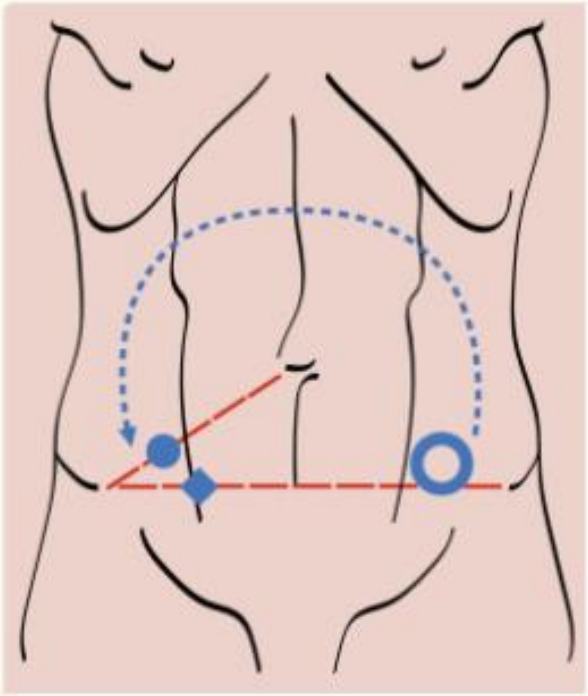
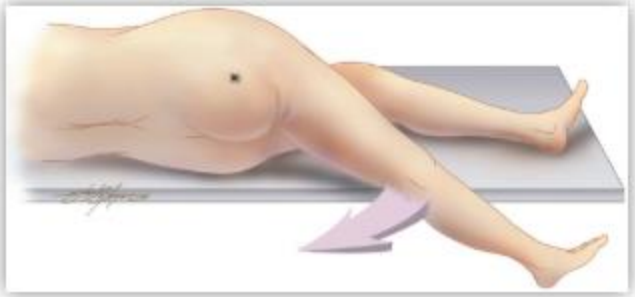
1 Department of Surgery, Universitäts -medizin Mannheim, Medical Faculty Mannheim, Heidelberg UniversityDepartment of General Pediatrics and Neonatology, Pediatric Gastroenterology, University of Giessen, GermanyDepartment of Pediatric Surgery, University Hospital Frankfurt, Goethe-University Frankfurt am Main, Frankfurt, Germany.

在進行任何治療之前，闌尾炎分為單純性闌尾炎和複雜性闌尾炎。對於兩種類型的闌尾炎，手術治療或保守治療的決定必須基於患者的整體臨床表現和風險因素。闌尾切除術是所有年齡層急性闌尾炎的首選治療方法。在德國，闌尾切除術主要在發病率較低的患者中以腹腔鏡進行。在某些情況下，單純性闌尾炎也可以選擇保守治療。



Designation	Location
McBurney's point	A pressure point one-third of the distance from the right anterior superior iliac spine to the umbilicus.
Lanz's point	A pressure point one-third of the distance from the right anterior superior iliac spine to the left anterior superior iliac spine.
Blumberg's sign	Ipsi- or contralateral rebound pain.
Rovsing's sign	Pain in the right lower quadrant induced by deep pressure exerted on the descending colon in the left lower quadrant in a retrograde (i.e., upward) direction.
Psoas sign	Pain in the right lower quadrant induced by flexion of the right hip against resistance (mainly a sign of a retrocecally located appendix)

* Some sources call the midpoint of the segment between these two points McBurney's point



Psoas sign [5]

- Pain upon removal of pressure rather than application of pressure to the abdomen
- Peritonitis and/ or appendicitis

- 臨床上很少人在某一個時間內(1-2 years)
- 看同樣一個病100例,每一個例都親自詳詳細細問病史,區別出不同點.
- simple appendicitis/complicated appendicitis.有不同的臨床表現

Review > Dtsch Arztebl Int. 2020 Nov 6;117(45):764-774. doi: 10.3238/arztebl.2020.0764.

Acute Appendicitis in Childhood and Adulthood

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表 1.單純性與複雜性闌尾炎的標準概述，改編自歐洲內窺鏡外科協會 （EAES） 2016 （12） 以及疑似急性闌尾炎的診斷措施。

	簡單	複雜
單純性闌尾炎 vs. 複雜性闌尾炎的標準		
炎症	+	+
壞疽	–	+
蜂窩織炎	–	+
瞼裂膿腫	–	+
遊離流體	–	+
穿孔	–	+

Typical
有時 very unusal

診斷措施		
歷史	+	+
體格檢查，包括闌尾炎壓迫點	+	+
直腸指檢	−	−
實驗室檢查	+	+
體溫測量	+	+
尿液試紙和妊娠測試*1	+	+
婦科諮詢	±	±
腹部超聲檢查*2	+	+
計算機斷層掃描	−	±
磁共振成像	−	±

Atypical appendicitis
就要有更多的鑒別診斷

表 2.根據 Stundner-Ladenlauf 和 Metzger （e57） 修改的兒童和青少年闌尾炎鑒別診斷清單。

一般兒童和青少年	嬰兒和 6 <兒童	6 至 12 歲	> 12 歲
– 便秘	– 腸扭轉	– 功能性腹痛	– 卵巢扭轉
– 腸胃炎	– 腸套疊–	– 睾丸或卵巢扭轉	– 睾丸扭轉
– 腸梗阻	腸旋轉	– 附睾炎	– 卵巢囊腫
– 肺炎	不良– 絞痛	– 過敏性紫癜	– 排卵痛
– 尿路感染	– 睾丸扭轉	– 腸套疊	– 宮外妊娠
– 創傷	– 附睾炎	– 腸扭轉	– 傳染性單粘液沉積症
– 虐待	– 腹股溝疝		– 慢性炎症性腸病
	– 先天		
	性巨結腸– 便秘		

2. Childhood appendicitis
combined with congenital anomaly

- Mesenteric pseudodycst is a very rare benign childhood tumor, accounting for less than 1 out of 250,000 hospital admissions. We here report a case of giant mesenteric pseudocyst incidentally detected in a 11-year-old boy with acute appendicitis. He complained of persistent abdominal pain for the past 48 hours. He had a **history of intermittent pain** for several months. Physical examination showed fever and abdominal pain. **Ultrasonography showed large peritoneal fluid related to peritonitis probably of appendicular origin**. The patient underwent exploratory laparotomy revealing giant abdominal mesenteric cyst and acute appendicitis. Open resection of the cyst and appendectomy were performed.

Acute appendicitis revealing a giant mesenteric pseudocyst: case report

Salsabil Mohamed Sabounji et al : **Pan Afri Med J :** 2022 Mar 4:41:178.


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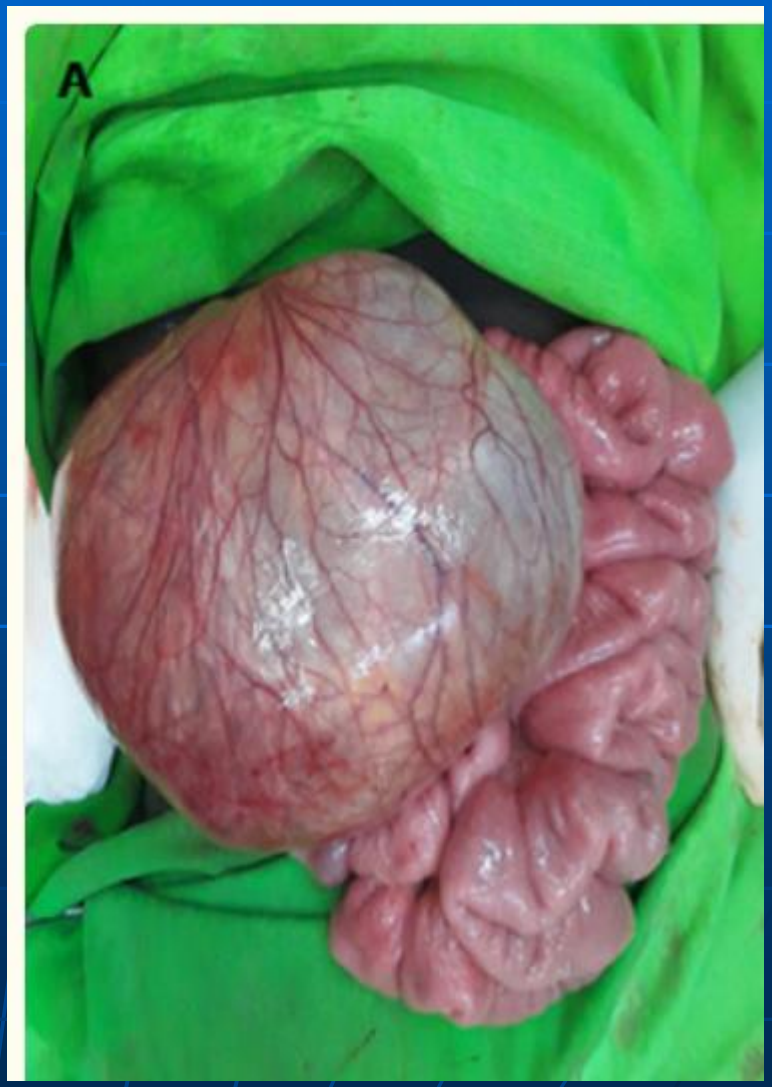
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- a neonate with a history of Down's syndrome and Fallot's tetralogy. Due to her basal cardiopathy, she required surgical intervention to create a systemic-pulmonary fistula, as a temporary bridge until definitive cardiac surgery could be performed.
- In the postoperative period of this surgery she presented fever, acute abdomen and abdominal radiography compatible with pneumoperitoneum. An emergency laparotomy was performed, which revealed peritonitis secondary to a cecal gangrenous appendix with perforation in its middle third.

pediatric appendicitis score

- Points & Pearls • The pediatric appendicitis score (PAS) predicts the likelihood of appendicitis in patients aged 3 to 18 years who present with abdominal pain with a duration of ≤ 4 days. • The PAS stratifies patients as low risk, high risk, or equivocal for appendicitis. • The score includes findings from the history, physical examination, and laboratory testing. • The PAS should not be used in patients who have known gastrointestinal disease, are pregnant, or have had abdominal surgery previously.

Parameter	Score
Anorexia	1
Nausea/ emesis	1
Fever	1
Migration of pain	1
Tenderness in right lower quadrant	2
Cough/ percussion/ hop tenderness	2
Leucocytosis	1
Neutrophilia	1
Total	10

- Migration of pain: It refers to the migration of pain from the umbilicus to the right lower quadrant.[2]
- Cough tenderness: Coughing causes increased pain (Dunphy's sign).[4]
- Neutrophilia and Leukocytosis was defined, depending on the age of the child.[5]

- **Low Risk PAS (< 4 points**) • Patients with low-risk PAS scores have a low likelihood of acute appendicitis. Imaging is usually not warranted in these patients. • There is a higher negative predictive value (95%) with the absence of right lower quadrant pain, the absence of pain with walking, jumping, or coughing, and an ANC of < 6750 cells/mcL. • Other causes of acute abdominal pain should be considered in patients with low-risk scores. **Equivocal PAS (4-6 points)** • Imaging can be helpful in this group of patients. Ultrasound or MRI are preferred for pediatric patients. • Surgical consultation is warranted for patients with equivocal scores.
- **High Risk PAS (≥ 7 points)** • Surgical consultation is warranted for patients with high-risk scores. • Imaging may be pursued for this group of patients, but patients should undergo only ultrasound prior to a surgical consultation. Abbreviations: ANC, absolute neutrophil count; MRI, magnetic resonance imaging; PAS, pediatric appendicitis score

- Neonatal appendicitis is usually associated with diseases such as cystic fibrosis, necrotizing enterocolitis, or Hirschsprung's disease, as in the case of our patient. In neonates with acute abdomen and presence of **pneumoperitoneum**, appendicitis must be part of the differential diagnosis and requires urgent surgical intervention. Despite this, it presents a high rate of morbidity and mortality. Once the definitive diagnosis is made, any basal pathology that justifies its presence should be discarded.

3. Perforated appendicitis

Case Reports > Am J Case Rep. 2022 Jul 6:23:e935405. doi: 10.12659/AJCR.935405.

Unusual Presentation of Perforated Acute Appendicitis: A Case Report

Hutton White [1], Alexandra S Laykova [2], Brendan O'Dowd [2], Tarik Wasfie [3]

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Affiliations

1 Department of Surgery, Ascension Genesys Hospital, Grand Blanc, MI, USA.

急性闌尾炎是迄今最常見的外科急症，考慮到這一點，不尋常的表現也很常見，因此診斷不當（大約發生在 20-40% 的病例中）可能導致延誤治療和不良結果

一名 45 歲男性因疼痛和腹脹 1 周到急診科就診，接受了頻繁的穿刺治療，最近一次引流后疼痛加重，懷疑內臟穿孔。最初的腹部 X 線檢,斷層掃描 （CT） 顯示沿右、左和下腹壁的遊離氣體和大的腎小管液囊聚集。進行膿腫手術引流

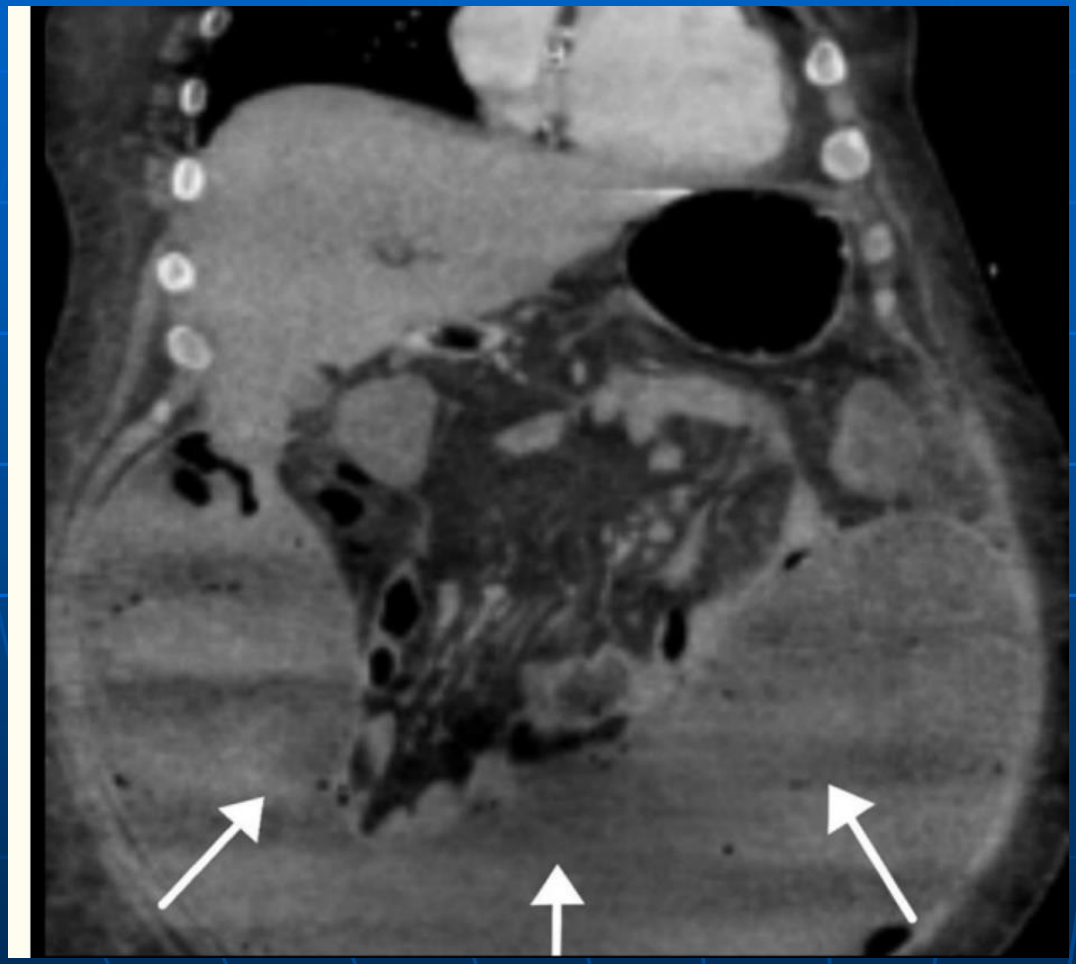
Typical symptoms and unusual manifestations.

典型急性闌尾炎的常見表現與患者的比較。

	急性闌尾炎	病人
臍周疼痛	是的	不
右下腹部壓痛	是的	不
反跳痛	是的	是的
發燒	是的	不
噁心和嘔吐	是的	不
厭食	是的	不
便秘	是的	不
白細胞增多	是的	不
腹部電腦斷層掃描	闌尾發炎	沒有

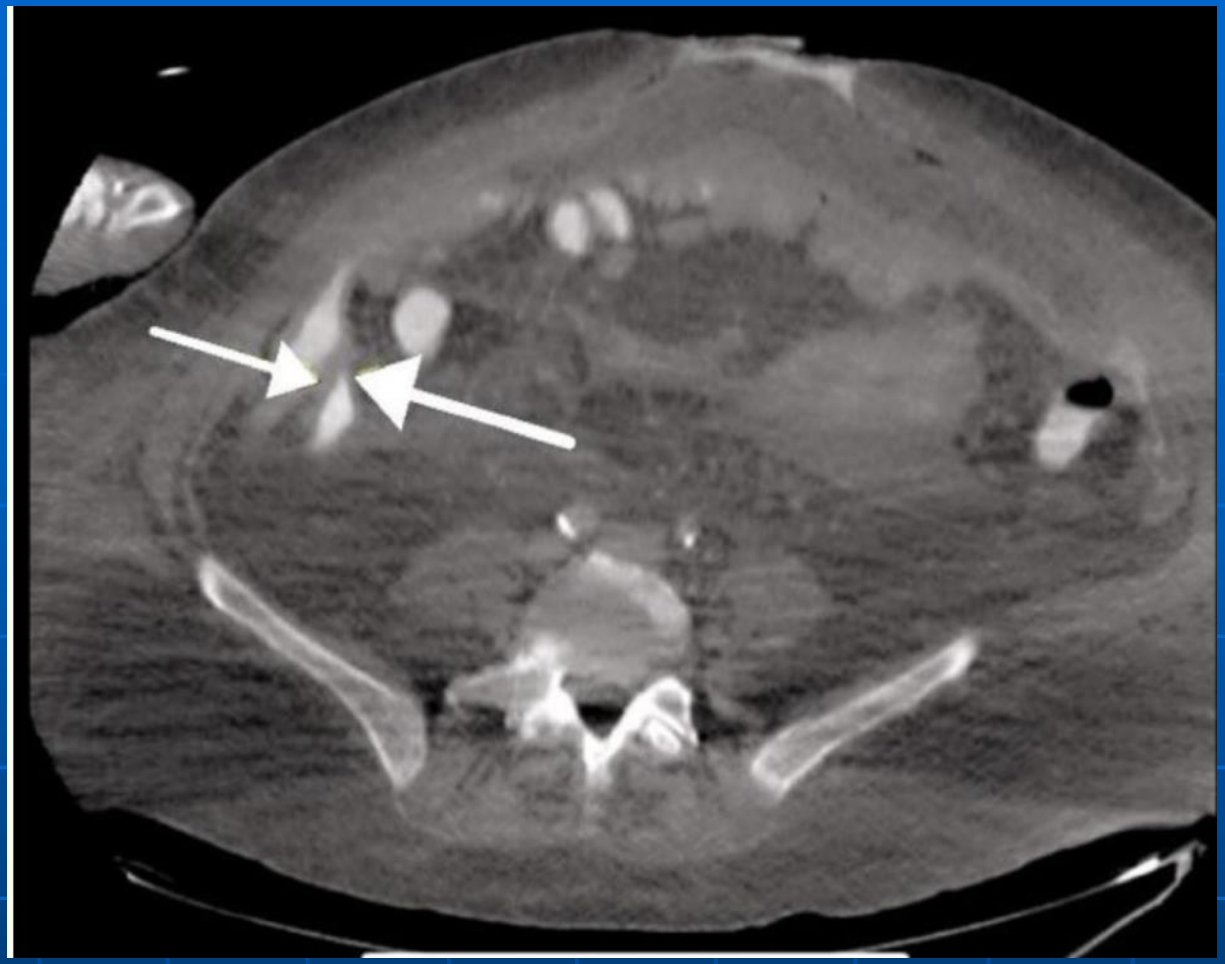
Perforated acute appendicitis

- Perforated acute appendicitis is a life-threatening condition where the infected appendix bursts, spilling its contents into the abdominal cavity. This can lead to peritonitis, a severe abdominal infection, and sepsis. Immediate surgery to remove the appendix and clean the abdominal cavity is crucial to prevent complications and mortality.



CT 掃描顯示大的管狀包膜分隔膿腫（見指示膿腫的箭頭）。

- 到達急診室後 2 小時內被送至手術室（OR）進行剖腹探查術，以引流大腹膿腫並確定穿孔來源。
- 進入腹部后，大約 1.8 升黃色膿性液體立即從佔據腹膜前間隙的大腔中排出。發現網膜粘附在小腸和結腸上，難以分離。有一個厚厚的纖維蛋白囊，包括結腸、小腸和網膜，這阻止了我們分離和識別這些結構。考慮到膿腫的位置，穿孔似乎起源於下腹部或中腹部。由於廣泛的炎症過程，決定徹底沖洗膿腫腔和腹部，並放置 ABThera 傷口真空敷料，以便進行進一步的檢查並計劃進一步的手術。收集膿腫壁標本和液體培養物。



Intraoperatively, the ABThera and wound vacuum were removed and the abdominal cavity was irrigated. The omentum was lifted and lysis of adhesions was performed with manual dissection. Once the fibrinous abscess capsule was broken down, a healthy-looking small bowel was identified

Repeat CT with i.v. and oral contrast on postoperative day 1 showed extraluminal oral contrast filling the decompressed abscess cavity, compatible with an active gastrointestinal tract leak (**Figure 2**). There was opacification of a fistulous tract connecting the cecum and the abscess cavity. The patient was taken back to the OR on that same day.

The appendix appeared to be perforated and had left a draining fistula tract, which was actively draining stool into the abscess cavity. An ileocecectomy and ileostomy was performed

結論(Case 3)

- 1. Abdominal pain secondary to acute appendicitis is by far the commonest surgical condition encountered in the ED. The diagnosis can be challenging and the unusual presentation with spontaneous rupture of the appendix and associated development of retro- and pre-peritoneal abscess should raise the suspicion of the most common surgical cause of abdominal pain, which is acute appendicitis. We recommend that acute appendicitis should be considered high in the list of differential diagnoses of **any patients presenting with abdominal pain with unusual presentation** to the ED.
- 2. Presence of ascites may mask all signs of peritonitis.

Case 4, stump appendicitis

- Appendectomy 后竟然再發生acute appendicitis.

A 32-year-old male patient with a history of appendectomy 3 years ago followed by a stump appendectomy one year later presented to the emergency department with the complaints of vomiting and right lower quadrant pain for the last 2 days. Physical examination revealed a McBurney incision scar. The bowel sounds were hypoactive. Tenderness, defense, and rebound were noted in the right lower quadrant. The temperature was 37.1 ˚C. The C-reactive protein value (2.04 mg/dl) and

Stump appendicitis is a very rare and late complication of appendicitis surgery . It has been reported to occur at any age (11–72 years) and at any time following appendectomy (2 months - to 50 years) The prevalence of stump appendicitis has gradually increased., especially in recent years. The reason may be the use of laparoscopic appendectomy with a narrower field of view and the lack of a 3-dimensional viewing angle . Leaving the stump longer than 5 mm

Yavuz Yuksel et al :Recurrent stump appendicitis. The American Journal of Emergency Medicine Volume 44, June 2021, Pages 481.e3-481.e5

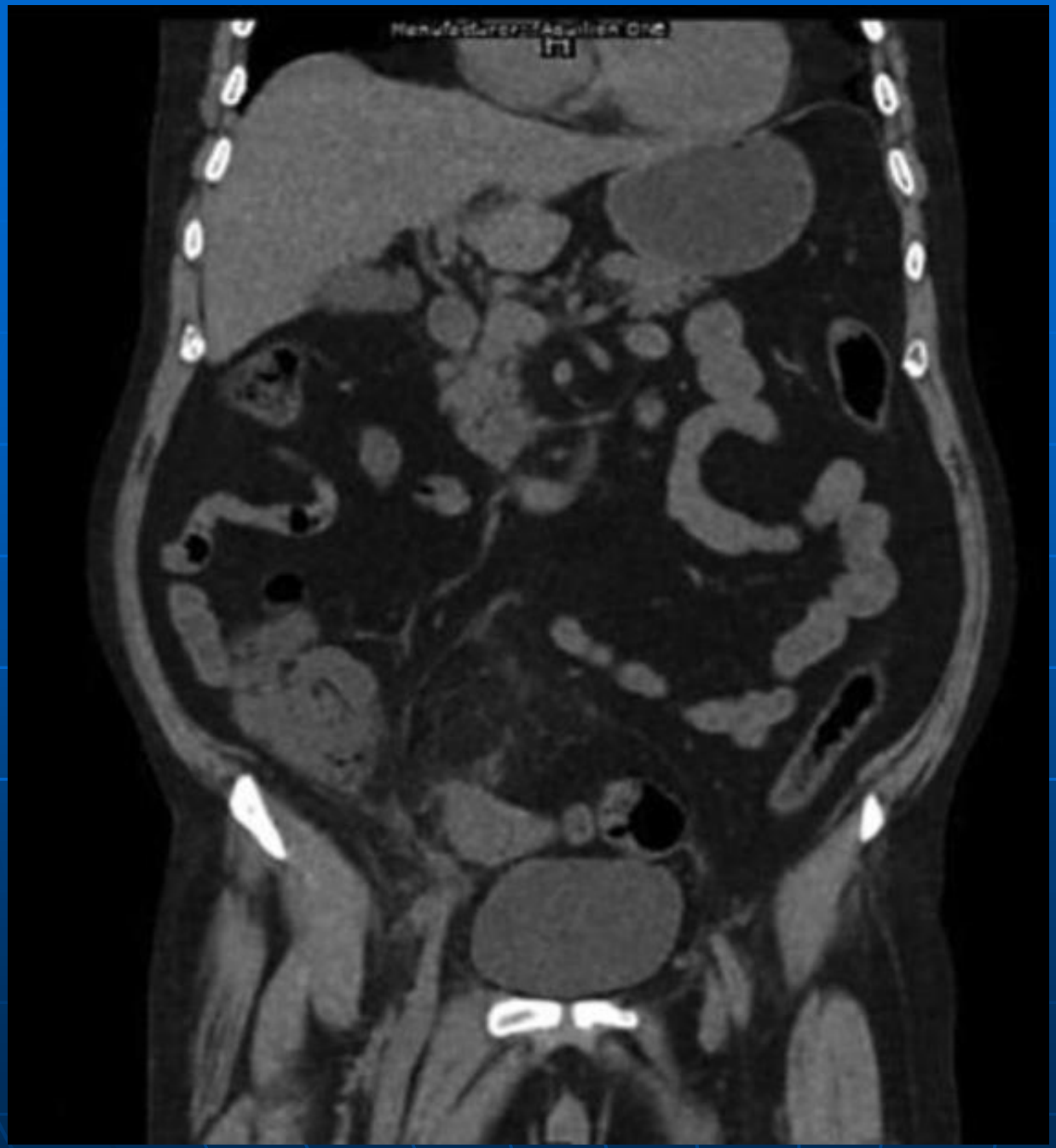
Stump appendicitis (Remnant appendicitis)

- 1. Stump appendicitis (SA) is one of the rare long-term complications under-reported in literature, with the incidence of 1 in 50,000 cases [3].
- 2. clinical presentation similar to that of acute appendicitis ranging from a few days to a few years after the procedure. SA is under-recognized partly due to clinicians' and radiologists' lack of acquaintance with this entity
- 3. a clear history of appendectomy, the emergency physician usually rules out the differential of SA, leading to severe complications like perforation or peritonitis.
- 4 A review of Medline literature was also carried out, from 1945 to 2015, showing 111 cases of stump appendicitis.

G Geraci et al : Clin Ter 2019 Nov-Dec;170(6):e409-e417.
A rare clinical entity: stump appendicitis. Case report and complete review of literature

臨床特點

- 1各年齡層也可能是老人.
- 2. Fever – multiple fever attacks.
- 3. Diarrhea
- 4. Abdominal pain: lower abdominal pain since morning. Initially, the pain was diffuse that later became sharp and localized to the right iliac fossa. It was moderate to severe in intensity, with a subjective pain score of 7 out of 10. sudden onset without any radiation.
- 5. On examination, McBurney's scar was visible in the right iliac fossa. The region was tender with positive Rovsing's sign and rebound tenderness on palpation..
- 6. Leukocytosis, often, neutrophil shift.
- 7. CT.



small appendicular stump with evidence of wall thickening with significant surrounding inflammatory changes suggestive of SA

Case 5,Familial clustering of AP

Case Reports > BMJ Case Rep. 2017 Oct 19:2017:bcr2016218838. doi: 10.1136/bcr-2016-218838.

Familial history aggregation on acute appendicitis

Francesc Simó Alari [1], Israel Gutierrez [1], Judit Gimenéz Pérez [2]

Affiliations – collapse

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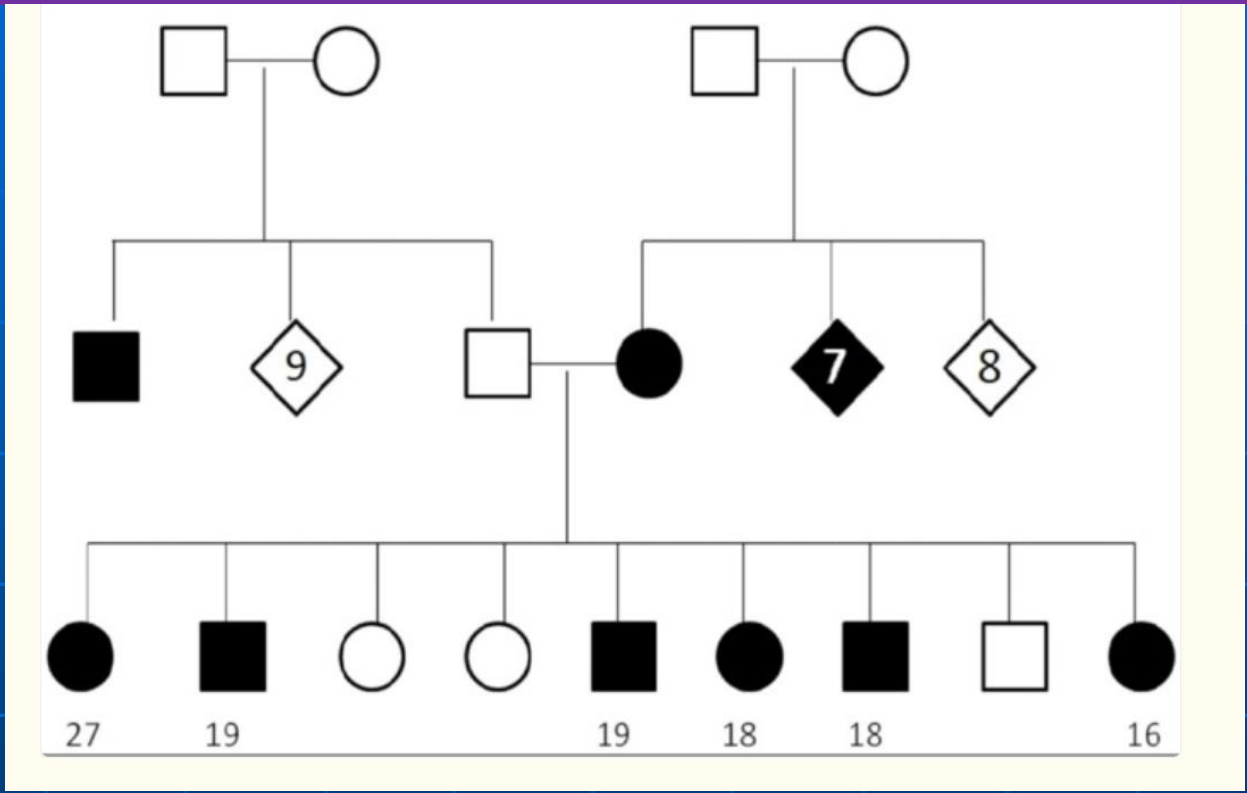
Many factors have been described as predisposing to appendicitis. Several studies have highlighted the influence of genes in the evolution of this disease and its severity, demonstrating a relative risk increase by three when family history is present.Family history of acute appendicitis is an important factor to be taken into consideration during the medical interview. Clinicians attempting to fine-tune their diagnostic accuracy when patients present with acute abdominal pain should inquire about family history of appendicitis.

急性闌尾炎的家族史



第一例是 27 歲女性在分娩后 1 個月，其他 5 例發生在 16 至 19 歲之間。最常見的表現形式是其中 5 例為phlegmonous appendicitis，1 例為化膿性闌尾炎，在手術過程中均未顯示穿孔。所有未報告併發症的病例均進行了腹腔鏡闌尾切除術，中位住院時間為 1.4 天。

Studies demonstrating a genetic influence or familial aggregation in acute appendicitis

	Year	Type of study	n	Studied generations	Results
Andersson *et al*	1979	Prospective C&C	58	Third-degree generation	Suggest family predisposition
Arnbjornsson	1982	C&C	73	Third-degree generation	Suggest family predisposition
Brender	1985	C&C	135	First-degree generation	Significant positive trend
Basta *et al*	1990	C&C	180	Paediatric <16 years third-degree generation	RR 10 (CI 4.7 to 21.4) Polygenic inheritance 56% heritability
Gauderer *et al*	2001	Prospective C&C	59	Paediatric <19 years First-degree generation	OR 2.0–2.9
Rivera-Chavez *et al*	2004	Observational	134	–	IL-6 polymorphism and appendicitis severity
Drescher *et al*	2012	Prospective C&C	116	Third-degree generation	OR 1.74–1.88

- 貝克是第一個在 1937 年描述一個 50% 成員受到影響的家庭中的家庭聚集的人。 Andersson *等人和* Arnbjörnsson 描述了一年級家庭成員中闌尾炎的高發病率。[2]很少有關於同卵雙胞胎同時事件的病例發表。[24 25]

- Oldmeadow 等人通過澳大利亞雙胞胎登記處將煙草描述為闌尾炎的輔助因數，也沒有與其強度或持續時間結紮;此外，戒煙后每年將風險降低15%。[26] Sadr Azodi 通過瑞典雙胞胎登記冊（3441 名同卵雙胞胎和 2429 名異卵雙胞胎）發現闌尾炎風險共有 30% 的遺傳性，女性組更為嚴重。[27]

- Nyboe Andersen 等人[28] 最近通過丹麥國家登記冊對 710 萬人顯示急性闌尾炎和潰瘍性結腸炎（UC）之間存在關聯，表明如果個人在 20 歲之前患有急性闌尾炎或一級親屬患有急性闌尾炎，則患 UC 的風險會降低，尤其是在有 UC 易感性的家庭中。然而，不建議使用闌尾切除術來改善UC患者的病程或防止其在家庭成員中發展。

- Gauderer 等人在一項前瞻性病例對照兒科人群研究中得出結論，“闌尾炎患者有陽性家族史的可能性是右下腹疼痛患者（但沒有闌尾炎）患者的兩倍，有陽性家族史的可能性幾乎是手術對照患者（無腹痛）的三倍”。[29] Drescher 等人在成年人群中得出了類似的結論。[30] 當涉及先天免疫和對局部炎症過程的反應時，Rivera-Chavez 等人證明瞭白細胞介素 6（IL-6）基因（基因座 IL-6 -174 等位基因 C）中單個核苷酸的多態性與單純性闌尾炎風險降低之間的關聯。

多基因模型

- Basta 等人進行，他們撰寫了關於這種常見疾病的第一個正式遺傳分析。通過研究 80 名患者的家庭，他沒有發現涉及主要基因的證據，而是一個多因素或多基因模型，總遺傳力為 56%，相對風險為 **10.0**（95% CI 4.7 至 21.4），與親屬關係等級相關（一級家庭為 21%，二級家庭為 12%，三年級家庭為 7%）。[32] Basta 等人表明，與 O型血組相比，表型 CcD-Ee Rh[33] 與 A 型血之間的關聯，[34] 與對照組相比，闌尾炎患者的比例更高。

Basta M, Morton NE, Mulvihill JJ, et al. Inheritance of acute appendicitis: familial aggregation and evidence of polygenic transmission. Am J Hum Genet 1990;46:377–82.

這是可以再深入探究的問題所以每一個案例都應該好好問 family history 如果有, 隨時可以提出報告

case 6,大腸鏡以後發生急性闌尾炎

Case Reports > ANZ J Surg. 2016 Apr;86(4):309-10. doi: 10.1111/ans.12686. Epub 2014 May 21.

Acute appendicitis post-colonoscopy

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Asian Journal of Surgery

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Review Article

Post-colonoscopy appendicitis: A systematic review

Kostas Tepelenis [a], Christos K. Stefanou [b], Stefanos K. Stefanou [b], Evangelos Sitos [c], Frideriki Steliou [c], Konstantinos Mpakas [d], Dimitra Lepida [d], Theocharis Chatzoglou [e], Thomas Iraklis Smyris [e], Maria Alexandra Kefala [b]

Post-colonoscopy appendicitis

Tepelenis et al, 2025

- ~ 2023 年 12 月 31 日，對 PubMed 和 Embase 進行了檢索。兩名評價員獨立篩選了關於結腸鏡后闌尾炎和摘要數據的任何研究設計的標題/摘要和全文論文。
- 系統評價納入56篇文章，共**67名患者**。中位年齡為54.9歲 （範圍24-84），受影響的男性個體更多 （64.2%）。結腸鏡檢查的主要適應症是檢查（37.3 %）。43 例患者接受了結腸鏡檢查和額外手術 （64.2%）。大多數患者 （79.1%） **在結腸鏡檢查后 2 天內出現癥狀**。臨床表現與急性闌尾炎相同。70.2% 的病例確診為結腸鏡后闌尾炎，主要通過腹部計算機斷層掃描或超聲檢查。大多數患者成功接受了手術治療 （88.1%），包括開放 （56.8 %） 或腹腔鏡闌尾切除術 （31.3 %）。腹腔鏡闌尾切除術的轉化率為 19.2%。17 例患者嘗試了靜脈注射抗生素的非手術治療，成功率為 41.2%。組織病理學顯示 30 例 （44.8%） 為急性闌尾炎，29 例 （49.2%） 為複雜性闌尾炎。在21例 （31.3%） 中發現了糞石。
- **結腸鏡檢查后闌尾炎是結腸鏡檢查的一種罕見但潛在的併發症。結腸鏡檢查后癥狀的出現，尤其是疼痛、發熱、噁心和嘔吐，應引起對該疾病的懷疑。滿意的結果取決於及時診斷和適當的管理。**

臺灣也有報告

Case Reports > Gastroenterol Nurs. 2022 May-Jun;45(3):188-190.
doi: 10.1097/SGA.0000000000000613. Epub 2021 Jul 13.

IS COLONOSCOPY A DANGEROUS ROUTINE PRACTICE THAT INDUCES APPENDICITIS?: A CASE REPORT OF POSTCOLONOSCOPY APPENDICITIS

I-Liang Chen [1]

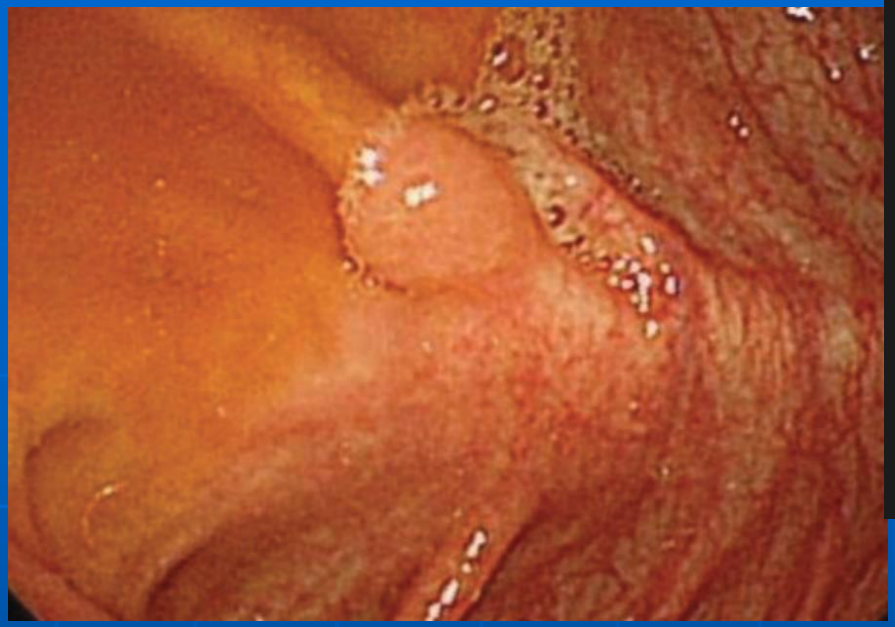
Affiliations – collapse

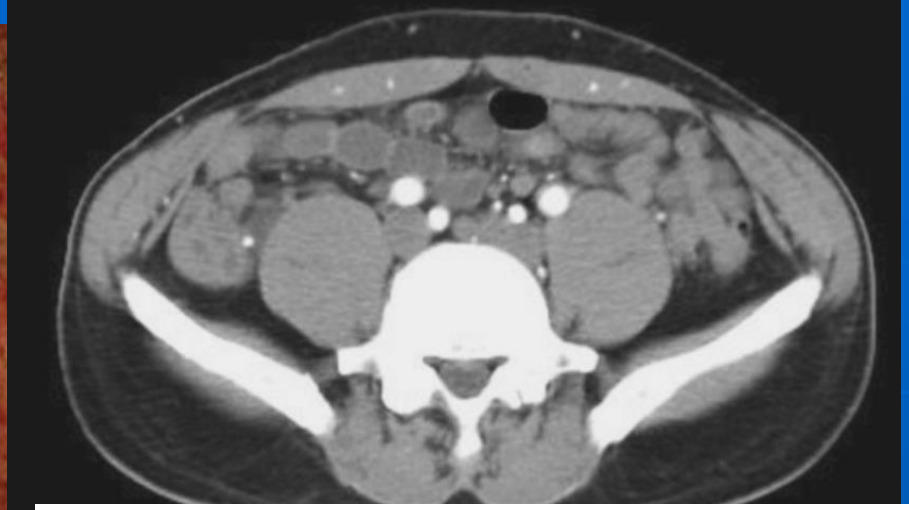
Affiliation

1 I-Liang Chen, MD, is Attending Physician, China Medical University Hospital, Taichung City, Taiwan, R.O.C.

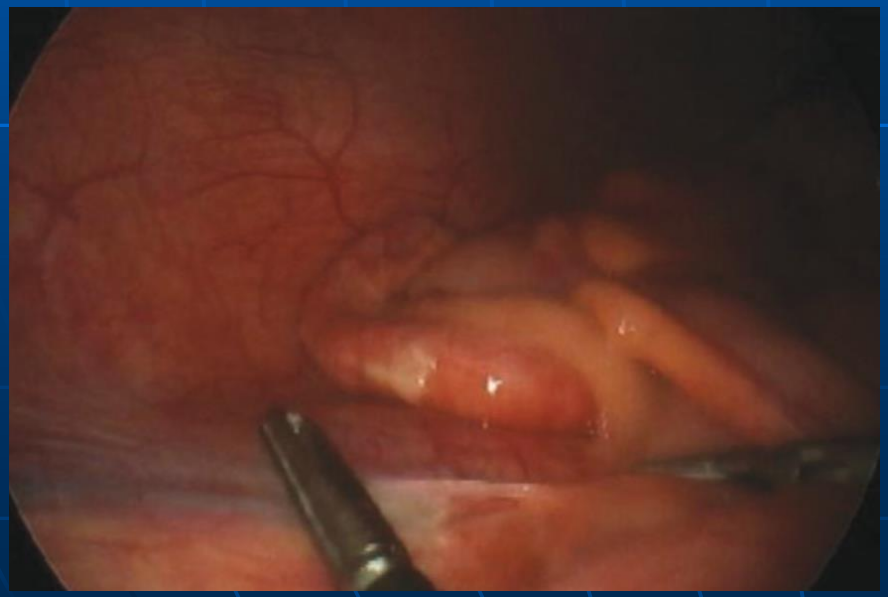
患者是一名 50 歲的男性，沒有糖尿病或高血壓等全身性疾病。他接受了包括結腸鏡檢查在內的健康檢查。結腸鏡檢查顯示盲腸和乙狀結腸有兩個小息肉。盲腸處的息肉遠離闌尾口，直徑約為 2 cm（圖 1），使用活檢鉗切除。手術持續約 16 分鐘（插管時間約為 5 分鐘），術后未立即發現出血或穿孔等明顯併發症。

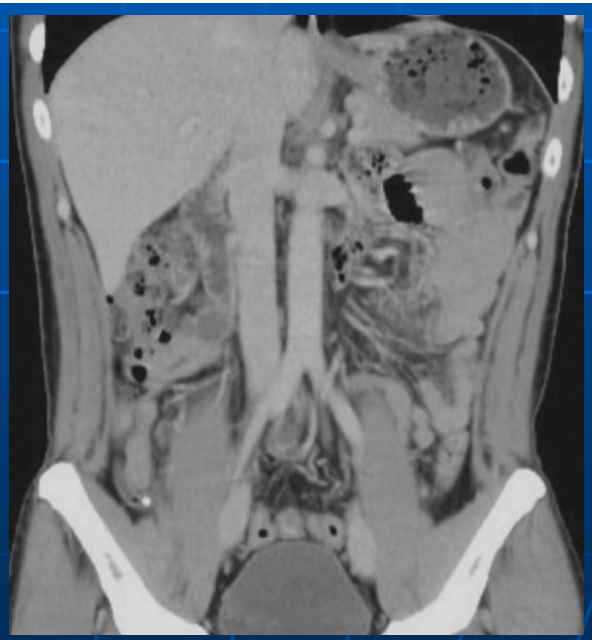
結腸鏡檢查后大約6小時，他開始出現上腹炎伴出汗。未發現胃腸道出血的跡象，例如便血或黑便。他急診科，記錄了以下：體溫，36.2˚C;血壓，122/59 mmHg;心率，56/分鐘。他將腹痛描述為鈍痛和持續痛。實驗室檢查顯示白細胞計數正常，C 反應蛋白水準正常（0.03 mg/dl）和脂肪酶水準正常（15 U/L）。由於癥狀持續存在，他接受了腹部計算機斷層掃描（CT），結果顯示闌尾直徑增加（>7 mm），闌尾內混合了液體和空氣;此外，還注意到兩個闌尾結石（圖 2 和 3）。懷疑闌尾炎，患者接受了闌尾切除術（圖4）。患者手術恢復良好，已出院。





Computed tomography revealed increased diameter of the appendix (>7 mm).





Computed tomography revealed mixed fluid and air inside the appendix, as well as two appendicoliths.

7, Foreign body急性闌尾炎的原因

Case Reports > Tunis Med. 2023 Jun 5;101(6):585-587.

A "fruitful" cause of acute appendicitis

Mona Mlika [1], Imen Ben Ismail [2], Ayoub Zoghlami [2]

水果種子引發急性闌尾炎.在急性闌尾炎的不同原因中，種子 非常罕見
Foreign bodies and especially seeds have been rarely reported as causes of acute appendicitis and account for less than 1% of the different causes.

闌尾腔充滿種子，其特徵是蜱皮（tick coat (arrow) and an endosperm (double arrow（蘇木。闌尾壁呈淋巴樣增生（星形），b/ 闌尾內種子的放大倍數較高（蘇木精伊紅 x250），c/ 厚外套和胚乳的細節

8.高齡者發生急性闌尾炎是比較麻煩的問題

Review > J Med Case Rep. 2021 Apr 17;15(1):203. doi: 10.1186/s13256-021-02703-x.

Abdominal aortic aneurysm and acute appendicitis: a case report and review of the literature

Rubén Peña [1], Sergio Valverde [1], José A Alcázar [2], Paloma Cebrián [3], José Ramón González-Porras [4], Francisco S Lozano [5]

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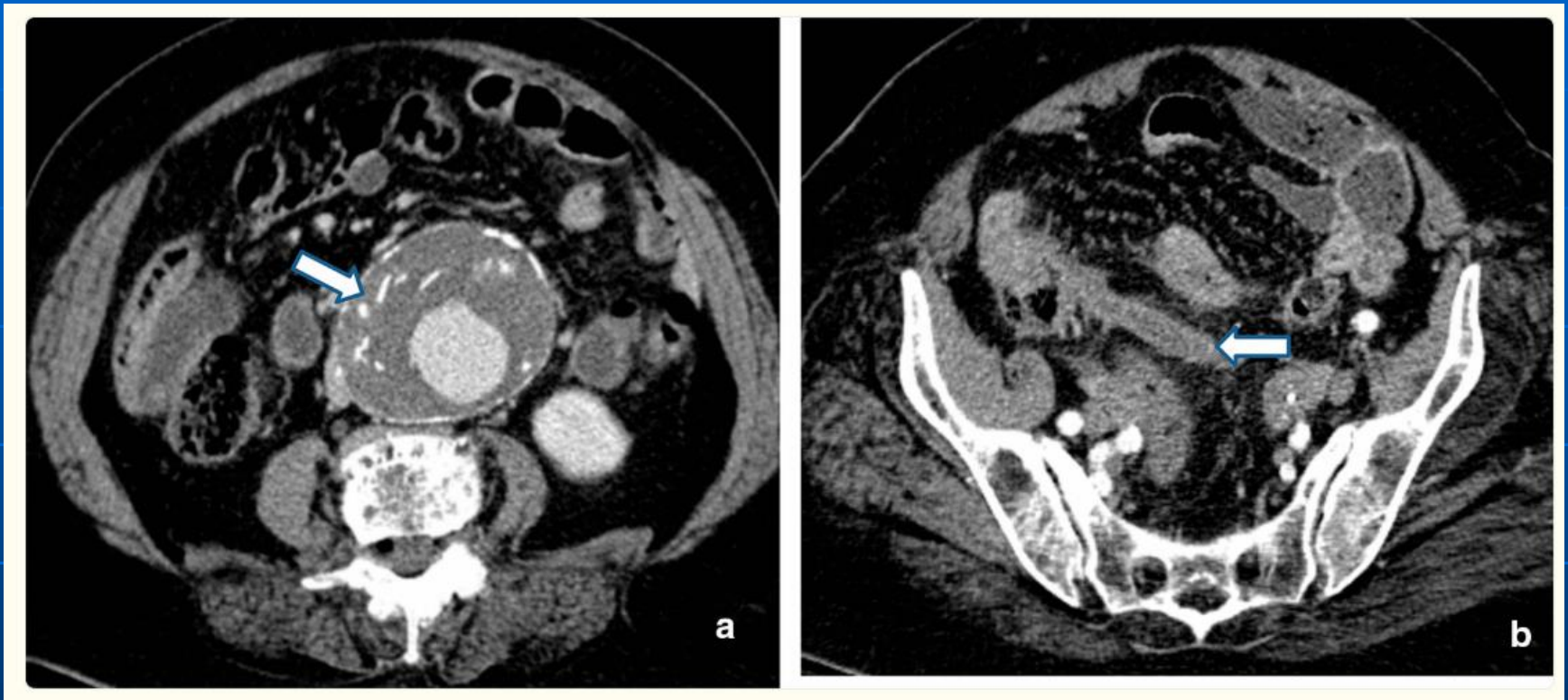
25歲長者知道自己患有腹主動脈瘤但拒絕治療，隨後因急性腹部癥狀被送入醫院急診科。由於動脈瘤的特性，計算機斷層掃描增加了併發症的可能性。然後患者同意緊急手術。剖腹手術顯示存在急性穿孔性闌尾炎，右側髂窩有明顯膿腫和無併發症的動脈瘤。進行闌尾切除術並引流膿腫。術後沒有併發症，患者再次拒絕動脈瘤手術

PH:已知有AAA



Preoperative computed tomography (transverse sections): **a** Aortic abdominal aneurysm of 8 cm (antero-posterior) × 8.5 cm (transversal), without signs of rupture (no free liquid or signs of retroperitoneal hematoma are visible), and radiological signs of intrathrombal hemorrhage (arrow). **b** Thickening of the sigmoid wall and slight increase in the echogenicity of the adjacent fat (5 cm in length). Inflamed appendix and increased echogenicity of adjacent fat (arrows)

- 腹主動脈瘤和闌尾炎是可能影響老年人的眾多腹部病變中的兩種。這些病症通常是孤立發生的，但在極少數情況下，它們可能是相關的，隨著它們的嚴重程度增加。
- 腹主動脈瘤（AAA）

- AAA 是一種幾乎只發生在老年人群中的病理，並且優先發生在男性中。患者最初無癥狀，當癥狀出現時，通常是非特異性的（腹痛或背痛）。如果不進行治療，其自然病程會導致動脈瘤的生長和破裂，死亡率很高。在破損的情況下，腹部、背部或側面的疼痛更加劇烈;典型的三聯征（低血壓、背痛和可觸及腫塊）僅存在於 25-50% 的病例中 [1]，癥狀通常更傾向於膽囊炎、腰痛或腎絞痛。由於這些原因，在非典型病例中，AAA 破裂/滲漏的診斷有時不正確或延遲 [2]。顯然，超聲波或 CT 可以澄清這些疑問。

AAA破裂的因素

- 一篇綜述總結了許多與 AAA 破裂相關的生物學（大直徑和動脈瘤的年生長）、臨床（女性、高血壓、慢性阻塞性肺疾病、吸煙習慣）以及生物力學和酶（基質金屬蛋白酶，MMP）因素的存在 [5]。最近的一項系統評價定義了與 AAA 生長和破裂相關的不同潛在因素（迴圈、生物力學和遺傳）的相關性。根據這篇綜述，已經確定了兩個增加破裂風險的因素：壁上的應力和動脈瘤的直徑 [6]。

- 9 項研究表明，**AAA 的直徑是破裂的重要標誌物** [6]。根據幾項研究的數據，關於 AAA 的年破裂風險與其直徑的關係，甚至達成了共識：對於 40-49 cm 的直徑，年風險為 1%，**而如果直徑超過 7 cm，則上升到 30-33%** [4]。

case 8, 老年人闌尾炎

- 闌尾炎是一般人群急性腹部手術的最常見原因。它在年輕人中比在老年人中更常見，儘管由於預期壽命延長，它在後者群體中變得越來越普遍。老年人闌尾炎的表現（發熱、右髂窩疼痛等）並不常見，因此只有一半的病例初步診斷是正確的 [14]。雖然計算機體層成像可能是一種有用的診斷工具，腹腔鏡闌尾切除術可能適用於特定患者，但在測量併發症發生率和死亡率時，兩者都不影響結局[15]。非典型病例的存在以及診斷和手術的延遲導致穿孔性闌尾炎的發病率增加和死亡率增加 [16]。最近對老年患者的 112 例闌尾切除術的系列顯示穿孔和發病率分別為 40% 和 28%。沒有死亡率 [17]。然而，大約一半的闌尾炎死亡發生在老年人中 [1， 2]。

AAA 與闌尾炎的關聯

- AAA 和各種腹部疾病（膽石症、結腸癌、闌尾炎等）在老年人中很常見，在極少數情況下可能共存。雖然這方面沒有數位，但發現與另一個非血管腹腔內病變區域相關的AAA 在同一患者中越來越常見。在這些情況下，一些外科醫生會在同一手術過程中合併兩項手術。其他人將自己局限於治療最嚴重的病理（通常但不總是 AAA），將其他問題留待以後處理。后一種選擇可以被認為是更謹慎的，因為它不那麼複雜且更快，但手術侵略性也會加劇未經治療的病理。無論如何，最佳決策必須尋求最小化：（1）第一次手術后 AAA 破裂的風險;（2）治療動脈瘤時插入的假體感染的風險;（3）兩種病理導致的術后併發症發生率和死亡率 [18]。正如我們稍後將解釋的那樣，血管內手術的引入肯定會改變這些假設。
- 當決定分期手術時，要治療的第一病變以及第一階段和第二階段之間的時間是正確的，則可以將風險降至最低

事先風險的評估很重要

- 一般來說，應首先治療有癥狀的病變。如果兩種疾病均無癥狀，則應權衡治療的相對風險和獲益與其中一種或兩種疾病出現癥狀的可能性[23]。
- 然而，在某些情況下，可能有兩種癥狀性病變，這兩種病變甚至都需要緊急治療（例如，複雜性 AAA 加結腸穿孔憩室）。這種組合特別致命，可能需要非常激進的同步作。

2009 年，Al Samaraee 等[3] 報導了一例伴有急性闌尾炎的 AAA 病例，在作者看來，這種事件以前從未發表過。該患者是一名 66 歲男性，患有急性腹部癥狀，通過 CT 掃描診斷為急性闌尾炎和腎下 AAA（直徑 6.3 cm）。最初，進行開放性闌尾切除術（蜂窩狀闌尾）;第二次，間隔 10 天后，一旦患者完全康復，就進行開放 AAA 手術。因此，**首先治療有癥狀和危及生命的病理，在不讓患者出院的情況下，繼續治療無癥狀的AAA**，但有明確的手術指征（直徑> 5.5 釐米）稍後。作者認為，同時進行兩種手術會帶來感染的風險。

9. Amebiasis
不是acute appendicitis

Case Reports > Tokai J Exp Clin Med. 2016 Dec 20;41(4):227-229.

Amoebiasis Presenting as Acute Appendicitis

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A 47-year-old man was referred to our hospital with acute right lower abdominal pain. He had no history of recent travel to endemic areas or acquired immunodeficiency syndrome. On admission, his temperature was 36.5°C. Physical examination revealed localized tenderness in the right lower abdomen without muscle guarding or rebound tenderness. Laboratory tests revealed a white blood cell count of 12,800 cells/μL and a C-reactive protein (CRP) level of 1.421 mg/dL. Computed tomography revealed a dilated appendix with a maximum diameter of 15 mm and thickened cecal wall (Fig. 1). He was diagnosed with acute appendicitis and underwent surgery. His appendix showed

一開始就是 RLQ　abdominal pain, no fever
RLQ　有　tenderness but no rebound tenderness.
CRP：1.421 /dl,與一般的AA不同. WBC：12,800

- His appendix showed acute inflammation from the cecum to the root of the appendix, without necrosis, perforation, or formation of localized abscess. There were several ulcers in the inflamed appendix (Fig. 2). Some hematophagous trophozoites of Entamoeba histolytica were suspected in the ulcer bed by pathological examination with hematoxylin and eosin stain (Fig. 3)

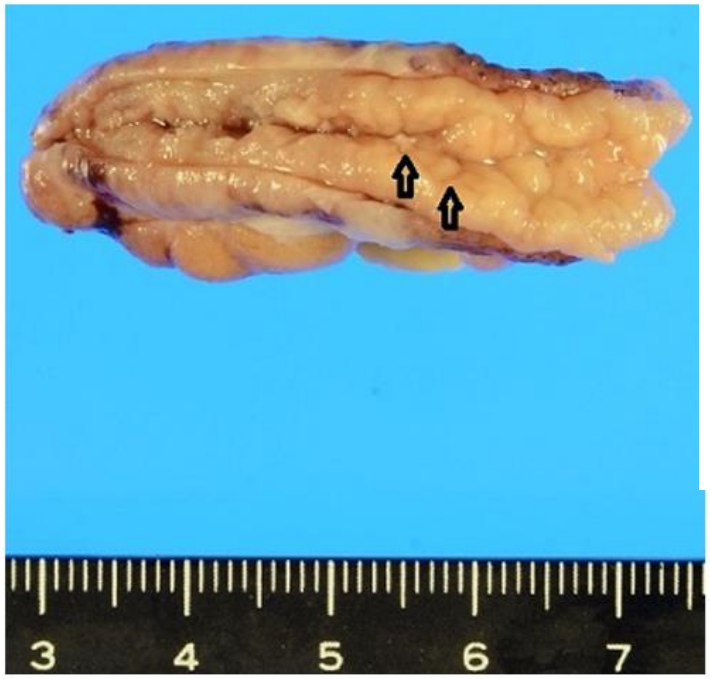
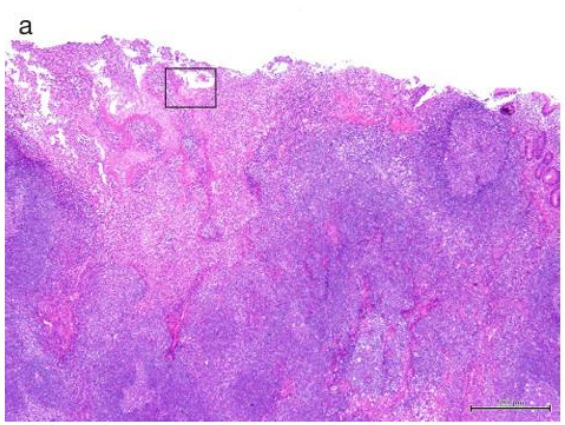


Fig. 2 Resected appendectomy specimen findings were compatible with phlegmonous appendicitis. There were several ulcers (arrows) in the appendix.



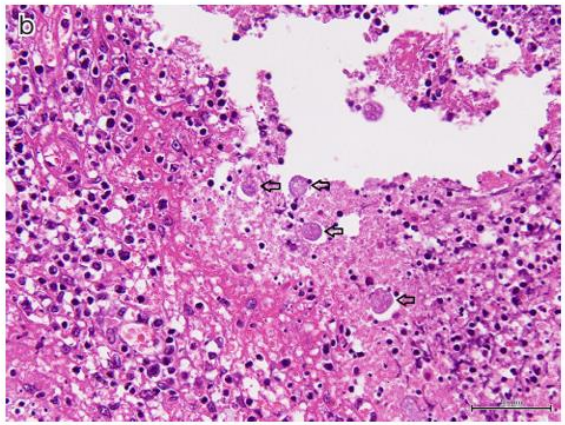
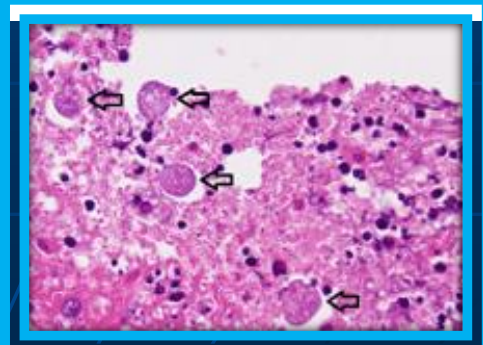


Fig. 3 Histopathological photomicrograph of the hematoxylin and eosin stain suspecting some hematophagous trophozoites of *E. histolytica* (arrows) seen in the ulcer bed [illegible] as the square on Fig. 3a; (a) × 40 and (b) × 400.



- Lastly, treatment only by appendectomy is
- inadequate to cure amoebic appendicitis because cases of amoebiasis restricted to the appendix are rare. Therefore, additional treatment with metronidazole is usually necessary. In the present case, postoperative clinical course was satisfactory, but we thought that metronidazole should be given to the patient who was diagnosed as amoebic appendicitis, as the former reports recommend

  The possibility of amoebic appendicitis should be kept in mind, because the incidence of amoebiasis has been increasing in Japan, and a delay in diagnosis correlates with a poor outcome.

10.Unusual location*(RUQ of abdomen)

Case Reports > Cureus. 2023 Jun 21;15(6):e40772. doi: 10.7759/cureus.40772.
eCollection 2023 Jun.

A Rare Presentation of Chronic Appendicitis in the Right Upper Quadrant: A Case Report

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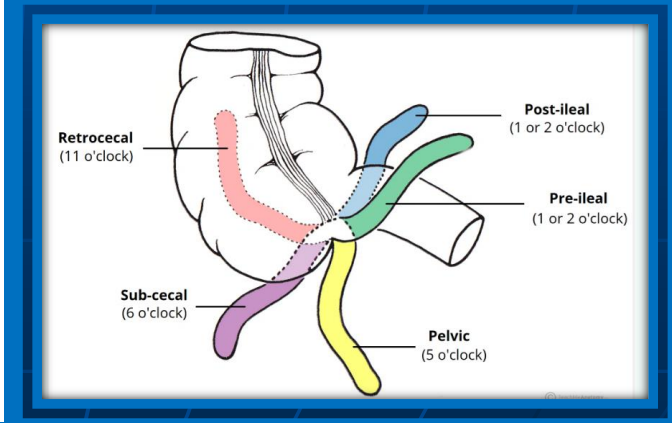
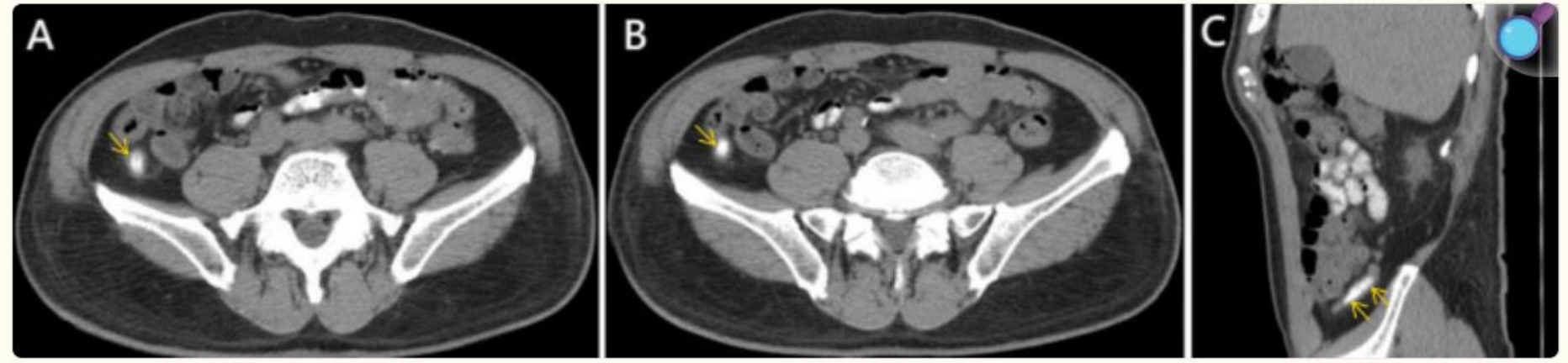
慢性闌尾炎是慢性腹痛的罕見原因，可能難以診斷。我們介紹了一名患有慢性右上腹疼痛的患者，該患者最終被診斷為慢性闌尾炎。這位 71 歲的男性沒有全身性疾病，因右上腹疼痛到我們門診就診一個月。疼痛往往在清晨加重，但可以通過排便、坐起來或走路來緩解。體格檢查、實驗室數據和腹部超聲檢查結果不顯著。上消化道內窺鏡檢查顯示胃竇處有淺表胃潰瘍。然而，埃索美拉唑並未緩解腹痛。計算機斷層掃描 （CT） 掃描顯示闌尾擴張，盲腸后區域有一些闌尾結石。因慢性闌尾炎，患者行腹腔鏡闌尾切除術，切除闌尾的組織病理學檢查證實診斷。手術後腹痛完全消失。對於沒有明確診斷的慢性腹痛患者，應牢記慢性闌尾炎。本病例說明，除了右下腹疼痛外，慢性闌尾炎還可能表現為右上腹疼痛或隱性腹痛。當藥物治療未能產生改善時，CT 掃描對於診斷腹痛非常有價值。



- 一名 71 歲男性因右上腹疼痛 1 個月到我院就診。他既往沒有病史。患者將疼痛描述為間歇性疼痛，具有鈍痛和非放射性，嚴重程度為“6/10”。疼痛持續 1-2 小時，通常在清晨加重，但可以通過排便、坐起或走路來緩解。體格檢查顯示無壓痛或反跳痛。實驗室結果顯示丙氨酸轉氨酶 alanine transaminase [a] (56 U/L) 時輕度升高（正常值：<35 U/L），而白細胞計數、血紅蛋白、血小板、腎功能、肝酶和 C 反應蛋白均正常。腹部超聲檢查顯示肝臟、膽囊和胰腺外觀正常。



A 和 B：橫視圖顯示闌尾壁增厚和闌尾擴張伴闌尾結石（黃色箭頭）。
C：矢狀面顯示闌尾的盲腸後位置（黃色箭頭）。

11, Retrocecal appendicitis最困難診診斷

Case Reports > Cureus. 2024 Jun 6;16(6):e61839. doi: 10.7759/cureus.61839. eCollection 2024 Jun.

Retrocecal Appendicitis Post-blunt Abdominal Trauma: A Case Report

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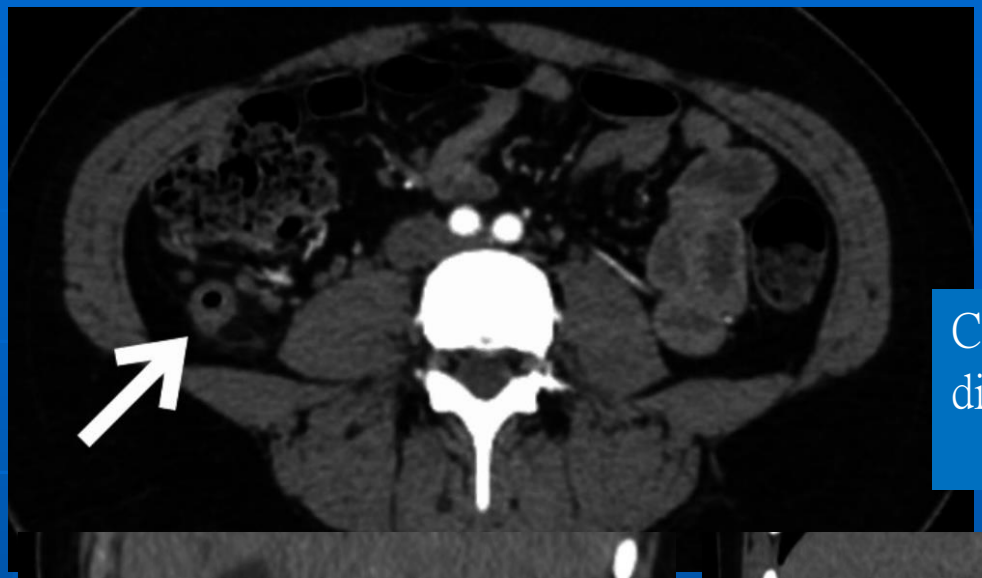
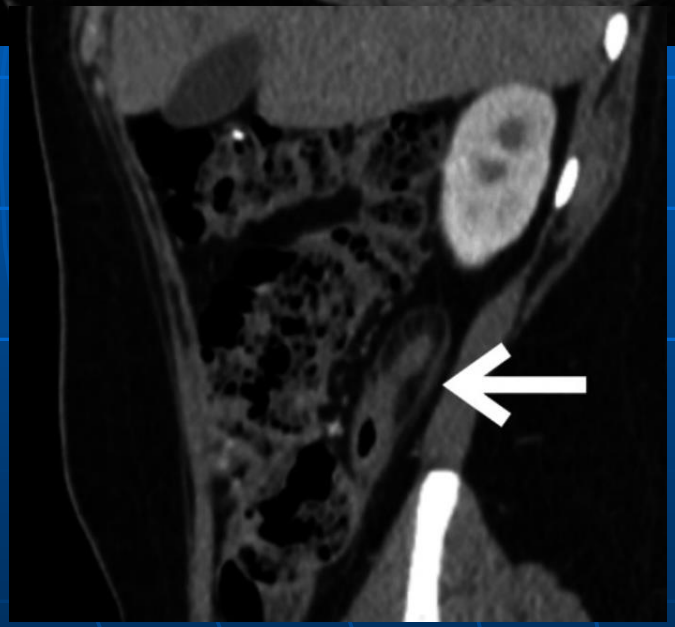
An 18-year-old female developed retrocecal appendicitis following blunt abdominal trauma, a rare occurrence with significant diagnostic challenges. Initial symptoms mimicked upper abdominal trauma, evolving to classic signs of appendicitis within hours. Despite a negative pre-trauma history of abdominal pain, clinical evaluation led to a suspicion of appendicitis. Contrast-enhanced CT scan confirmed the thickening of the cecal appendix, prompting urgent surgical intervention. An open appendectomy revealed a congested retrocecal appendix, supporting the diagnosis.

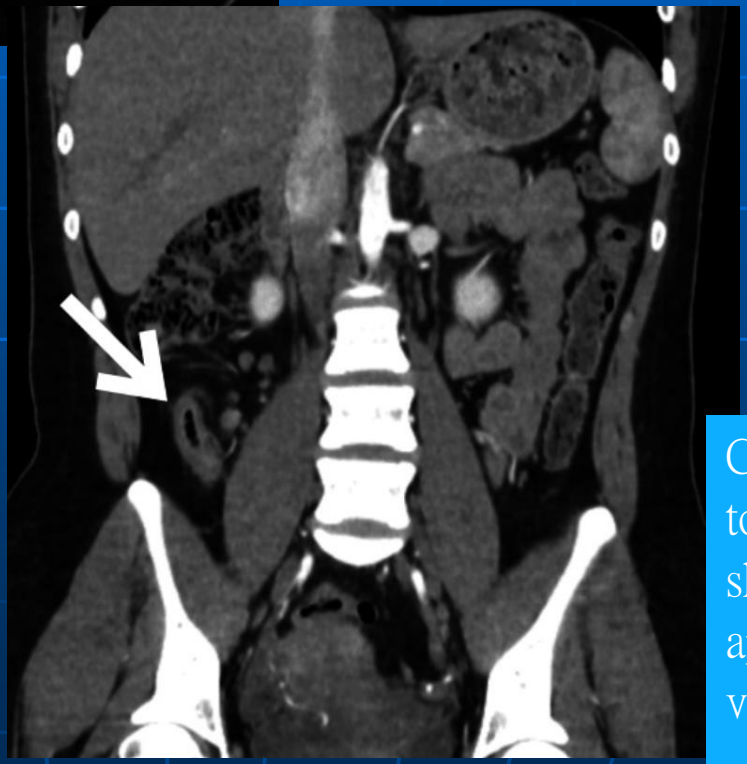
- 一名 18 歲未產婦，無明顯病史，在她作為乘客時發生高速車撞后，右側 moderate to severe pain in the right hypochondrial and flank regions 中度至重度疼痛到急診科就診。入院時，系統審查為陰性，患者否認在車禍前出現過任何癥狀。最初，疼痛局限於上腹部，但 6 小時後，疼痛遷移到右側髂窩(right iliac fossa_)並加劇。患者描述疼痛持續而鈍痛，伴有厭食、噁心和嘔吐。檢查生命體征后，她的體溫為 36.5°C，脈率為每分鐘 75 次，血壓為 115/75 毫米汞柱，呼吸頻率為每分鐘 18 次呼吸，血氧飽和度為 98%，FiO2 為 21%。檢查時發現右側髂窩有壓痛，隨著腰大肌手法的增加而增加，但最初沒有反彈性壓痛。實驗室檢查結果顯示輕度白細胞增多和中性粒細胞增多，腎功能正常，凝血時間正常。



Computed tomography scan showing a dilated appendix, axial view (white arrow).

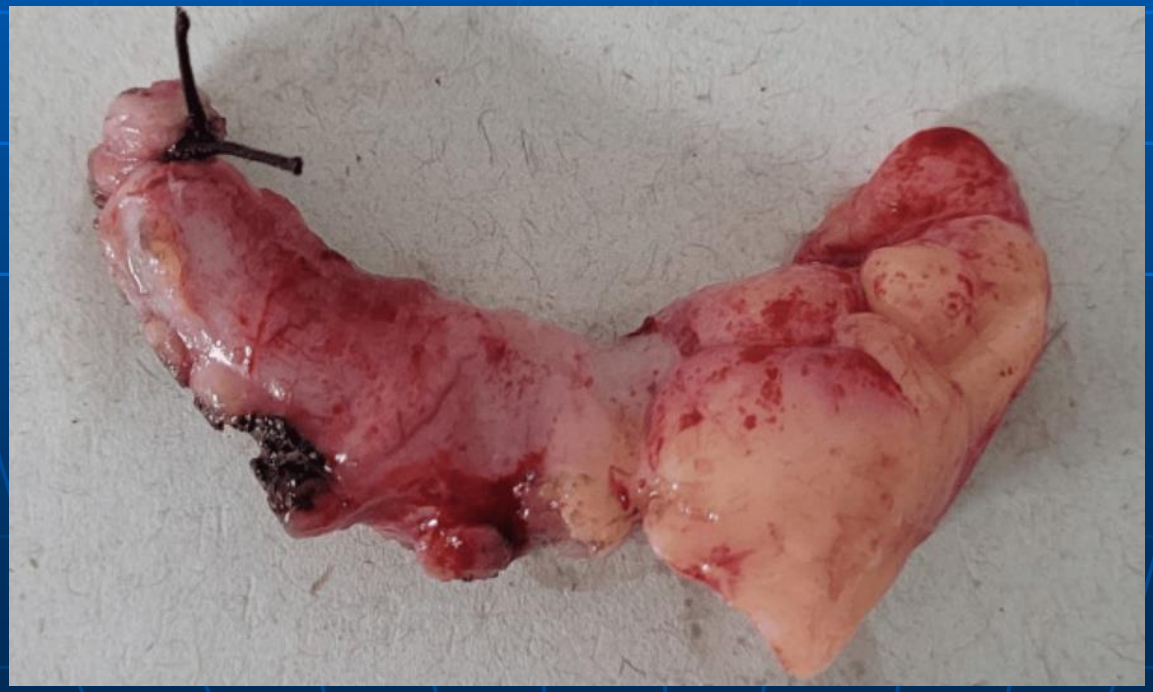


Computed tomography scan showing a dilated appendix, sagittal view (white arrow).



Computed tomography scan showing a dilated appendix, coronal view (white arrow).

- Twelve hours after her admission, an urgent anesthesia consultation was conducted, without contraindications to surgical management.



Retrocecal appendicitis, perforated

Case Reports > Radiol Case Rep. 2022 Jun 2;17(8):2754-2758. doi: 10.1016/j.radcr.2022.04.053. eCollection 2022 Aug.

Perforated retrocecal appendicitis presenting with lung abscess–A case report

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Retrocecal appendicitis usually presents with atypical signs and symptoms which may lead to delayed diagnosis, perforation and serious complications.

- 在 5-15% 的病例中，鈍性腹部創傷與腸道損傷有關;
- 然而，腹部鈍挫傷後的繼發性闌尾炎並不常見，估計發病率不到 1%。
- 大約 8.6% 的男性和 6.7% 的女性會在他們生命中的某個時刻發生闌尾炎 [7]，
- 盲腸后闌尾炎的發病率低至 2.5% [8]。儘管如此，由於其發病率低，其發生在腹部創傷后一直存在爭議和爭議 [9]。然而，Fowler 在醫學文獻中進行了首次報告，並在文獻中報導的 48 例闌尾炎病例中描述了 13,496 例腹腔創傷后闌尾炎病例。他們描述了診斷時需要考慮的四個因素 (1）外傷前無腹痛，（2）有劇烈的腹部鈍挫傷史，有足夠的能量到達盲腸闌尾，（3）存在闌尾炎的典型癥狀和體征，以及（4）闌尾炎的手術證據。

- The rare incidence of acute appendicitis resulting from external trauma. Fowler RH. Ann Surg. 1938;107:529–539.

THE RARE INCIDENCE OF ACUTE APPENDICITIS RESULTING FROM EXTERNAL TRAUMA

ROYAL H. FOWLER, M.D.
NEWARK, N. J.

THE correct evaluation of external trauma in acute appendicitis is important. Traumatic influences should be judged only on a very critical basis. This is purely a medical problem from the legal viewpoint. Court decisions rest entirely upon expert testimony, and the surgeon who appears as a witness should do so for the purpose of throwing light upon a subject of which the court is ignorant. These decisions are influenced by the attitude of expert witnesses who should be enlightened, frank and helpful. The court expects integrity, and looks to the physician for real information. The broadened conception of the Compensation Law takes cognizance of the secondary, aggravating or contributing effects of injury upon disease. Decisions should rest upon proven facts, not theoretic opinions. Evidence should be overwhelming and leave no doubt. This study was prompted in order to determine the relation of external trauma to the occurrence of acute appendicitis, and was based upon: (1) nine personal cases; (2) a review of continental and American literature; (3) 48 litigated cases; and (4) a survey of current surgical thought.*

It is conceded that the appendix is not immune to injury. It is believed, however, that the majority of cases reported as traumatic appendicitis are misnamed. In the evaluation of traumatic influence, five essentials must be united and correlated: *i.e.*, (1) the history; (2) the force; (3) the mechanism; (4) elapsed time between the accident; the development of the disease and operation; (5) the pathology demonstrated at operation.

The History.—The fact that appendicitis may have antedated the accident may be withheld by the patient, in an attempt to place the entire blame upon the injury. It is stressed, therefore, that the history in such cases may be entirely valueless. In several of my cases, an accident was first blamed, and later when the patient entered the hospital for operation, no mention was made of the accident, to the intern who took the history. The previous state of health in Kelly's series is not mentioned in 35 cases. It was reported "good" in 13. It is noted that a history of previous attacks was obtained in only two cases.

The Force.—The application of blunt force, over the appendix region, run-over accidents of crushing violence or pinioning the abdomen against an immovable object with sudden disturbance of intra-abdominal pressure, are direct types. Indirect forms of violence of less significance are falls upon regions other

外傷後可以根據以下症狀和自我檢查來判斷是否可能患有闌尾炎。

典型症狀

1.腹痛：通常從肚臍周圍開始，然後轉移到右下腹部，這是非常典型的「轉移性腹痛」特徵。

2.反彈疼痛：當按壓右下腹部時，可以感覺到壓痛，放開時疼痛會加劇，這是判斷的一個重要指標。

3.噁心和嘔吐：許多患者會感到噁心，有些可能會嘔吐。

4.食慾不振：通常伴隨腹痛的出現，患者會感到食慾減少。

5.發燒：在24小時內，體溫可能會上升，輕微發燒是一個關鍵症狀。

6.便秘或腹瀉：有些患者可能會面臨這些情況。

12 Pregnancy and acute appendicitis

Case Reports > Ulus Travma Acil Cerrahi Derg. 2016 Nov;22(6):545-548.

doi: 10.5505/tjtes.2016.58458.

Acute appendicitis during pregnancy: case series of 20 pregnant women

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急性闌尾炎 （AA） 是妊娠期急腹症的最常見原因。闌尾炎的大多數發生在正常妊娠期間，妊娠期闌尾炎的診斷仍然具有挑戰性

在20例患者中，16例 （80%） 接受了開放性闌尾切除術，4 例 （20%） 接受了腹腔鏡闌尾切除術。患者的平均年齡為29.6±5.6歲。最常見的癥狀是腹痛 （95%）。6 例 （30%） 患者為妊娠早期，9 例 （45%） 患者為妊娠中期，5 例 （25%） 患者為妊娠晚期。闌尾切除術陰性率為 30%

13.Ectopic gestation or acute appendicitis

Int J Surg Case Rep. 2021 Oct:87:106438. doi: 10.1016/j.ijscr.2021.106438. Epub 2021 Sep 21.

Tubal abortion masquerading as an acute appendicitis with a negative urine pregnancy test: A case report

Shiva Aryal [1], Bibek Man Shrestha [2], Sunita Lamsal [3], Milan Regmi [1], Anurag Karki [1], Neeta Katuwal [3]

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1 Maharajgunj Medical Campus, Institute of Medicine, Kathmandu, Nepal.

- Ectopic pregnancy presenting as a right iliac fossa pain can mimic acute appendicitis. An abnormal β-hCG pattern/level which doesn't correspond to the gestational age suggests the likely diagnosis of ectopic gestation. Transvaginal ultrasound is the preferred imaging modality for the evaluation of patients with suspected ectopic gestation. A urine pregnancy kit cannot always exclude an underlying ectopic pregnancy because of the associated false-negative results.

腹痛女病人一定要詢問 Gyn history
1.懷孕生產史 2. LMP 3, vaginal spotting
4.結婚史 5.有無使用任何避孕藥具

Case history

- 一名 30 歲未產婦，無任何合併症史和既往手術史，因主訴**右髂窩**腹部(pain at right iliac fossa, RLQ)疼痛 1 天到急診科就診，發作急性，鈍痛型，非放射性，非遊走性，
- 無發熱、厭食、噁心或嘔吐。
- 患者在就診期間沒有陰道出血，但在急診就診前 7 天有每次陰道點滴出血的病史，持續 3 天。
- 她的週期為 28 ± 5 天，血流持續 4-5 天。
- 她的末次月經是在就診當天前 44 天。
- 她已經結婚 2 年了，沒有使用任何避孕藥具。過去的病史對於輕度 COVID-19 ，16 天前她已經完全康復。一年前，她給出了下腹痛和陰道分泌物惡臭的模糊病史，這些分泌物在藥物后消退，這表明過去可能被診斷為盆腔炎性疾病。

PE

- 經檢查，她面色不佳，貧血,血壓為 110/60 毫米汞柱，脈率為 92 次/分鐘，呼吸頻率為 20 次/分鐘，室內空氣中的 Sp02 為 94%，溫度 – 98 °F。 每次腹部檢查時，腹部輕度膨脹，Mc Burney 點有壓痛，還存在反彈性壓痛。她的腸鳴音正常。每次陰道檢查和其他全身檢查均無異常。
- Hb : -10 g/dl, HT: 29 %, WBC: 10300，
- The urine pregnancy test was negative
- 腹部超聲顯示右髂窩有一個直徑為 13.3 毫米的管狀、不可壓縮、非蠕動結構，周圍有少量液體和水腫的網膜

OP. Findings

- 闌尾看起來正常。術中 gyanecologic 會診是在發現受孕產物後進行的。子宮很大，雙側卵巢和左輸卵管正常。術中診斷為右側輸卵管流產，為此進行了右側輸卵管切除術

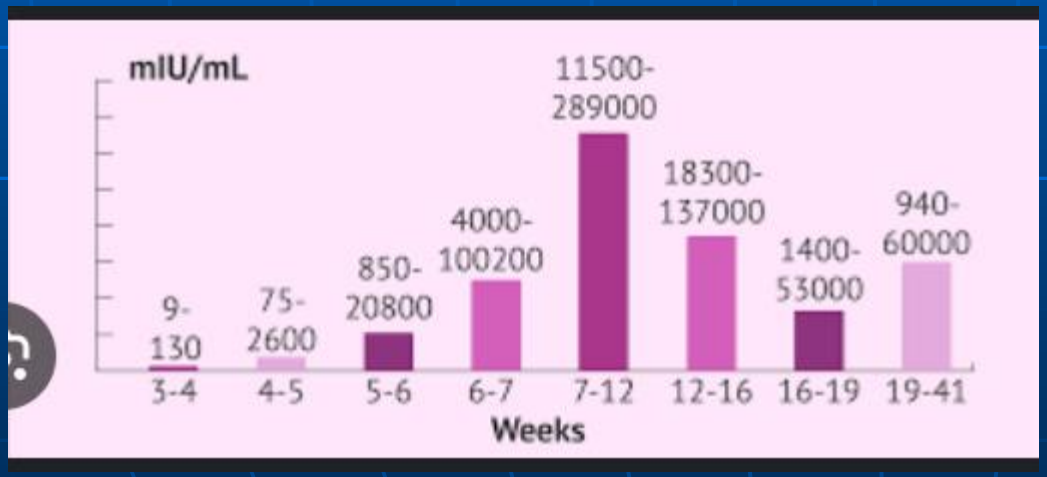
術后第 2 天重複尿妊娠試驗，試驗陽性。患者術后恢復良好，術后第 3 天出院。

育齡婦女，正確診斷可能很困難，因為排卵、月經癥狀、急性闌尾炎、異位妊娠、盆腔感染，都在某種程度上表現相似。
急性闌尾炎是全球緊急腹部手術的最主要原因和適應症之一，England 每年有超過 40,000 人入院，而異位妊娠是孕產婦死亡的主要原因，佔所有妊娠相關死亡的 4-10%

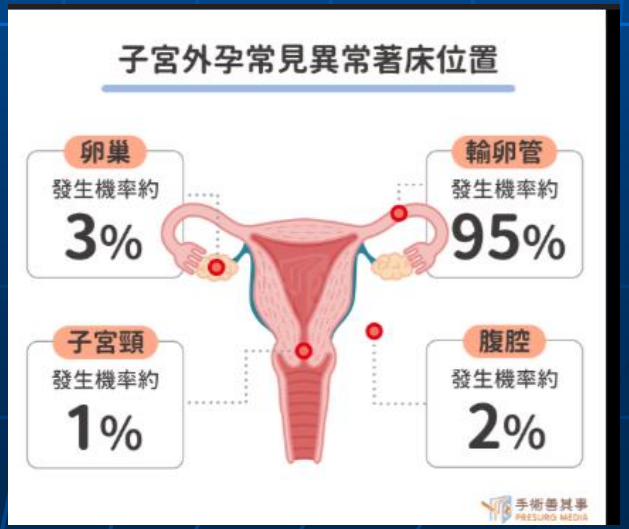
- β-hCG 在前 5 周内每 1.5 天翻倍，7 周後每 3.5 天翻倍。70% 的宫外妊娠偏離了這種模式。與胎齡不符的異常 β-hCG 模式/水準提示異位妊娠 [13]
- 受孕后 10-14 天達到的血清 β-hCG 水準為 1500 mIU/mL

在急診科就診的患者並未常規進行連續定量血清 β-hCG 和 TVS

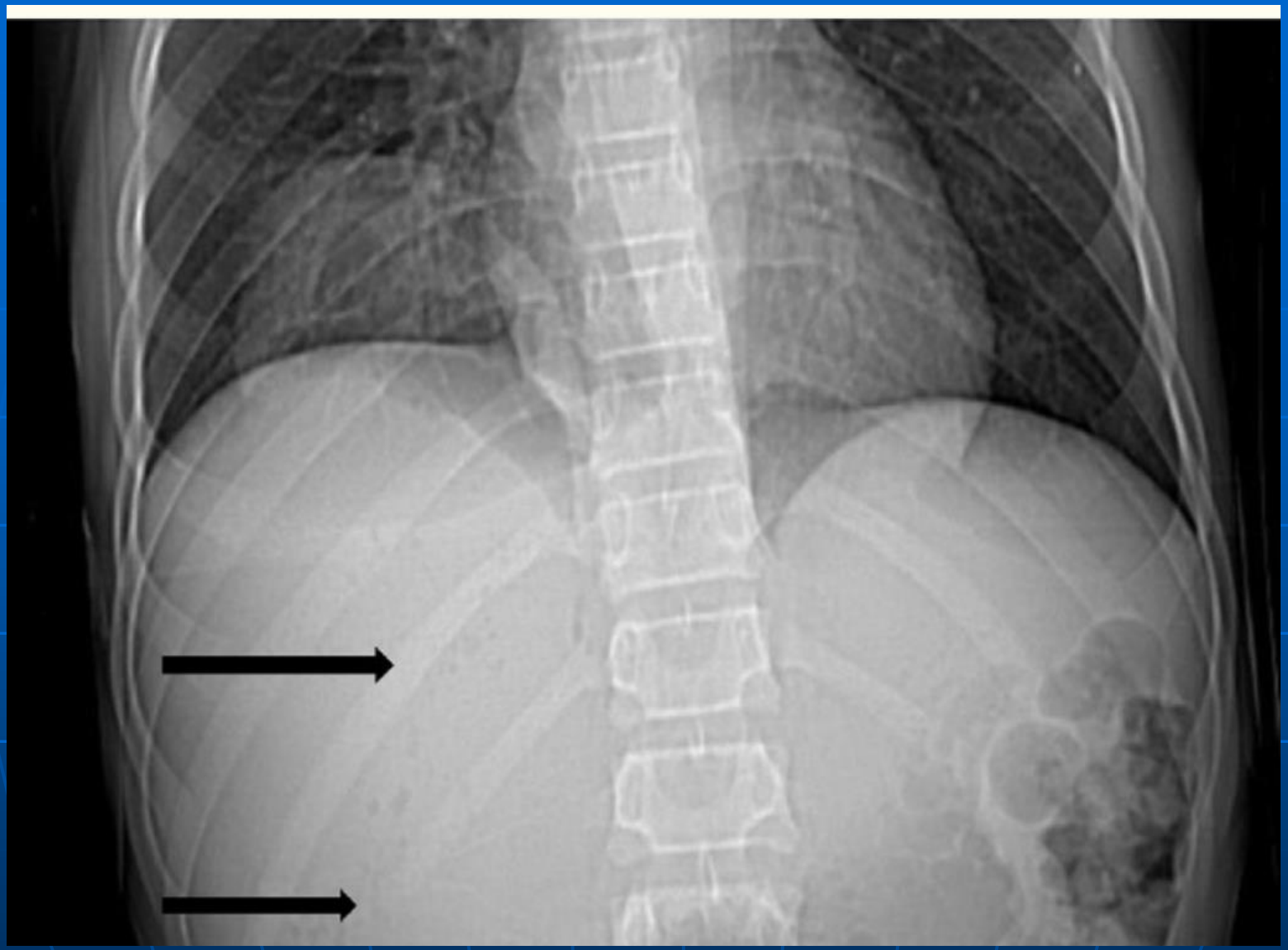
正常懷孕時，beta-hCG 上升快速且明顯，但子宫外孕時，beta-hCG 的上升速度和幅度可能低於預期，甚至停滞或下降。



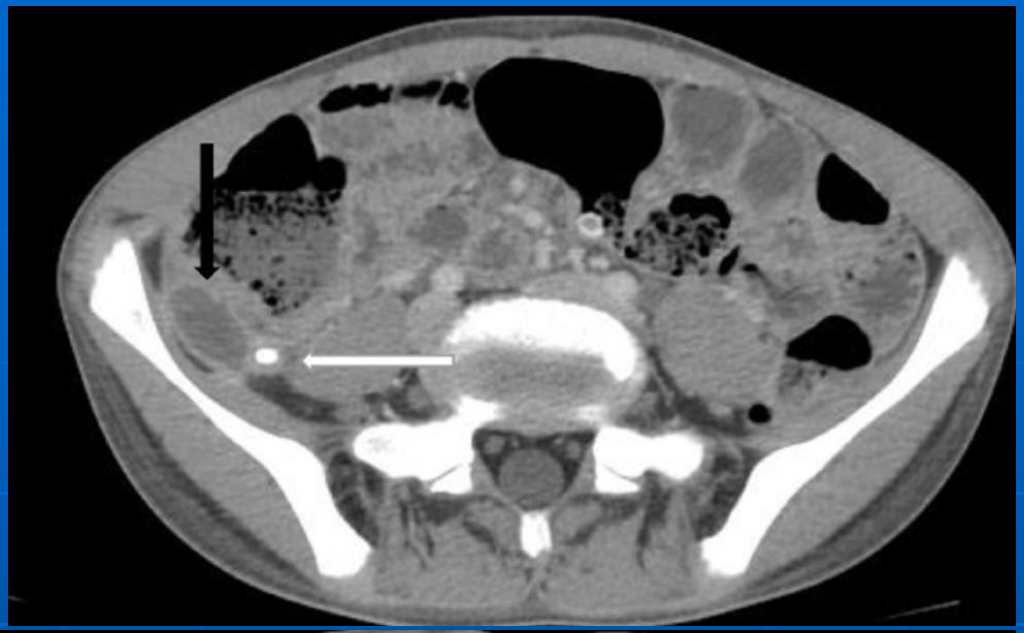
Non-pregnant：
<200



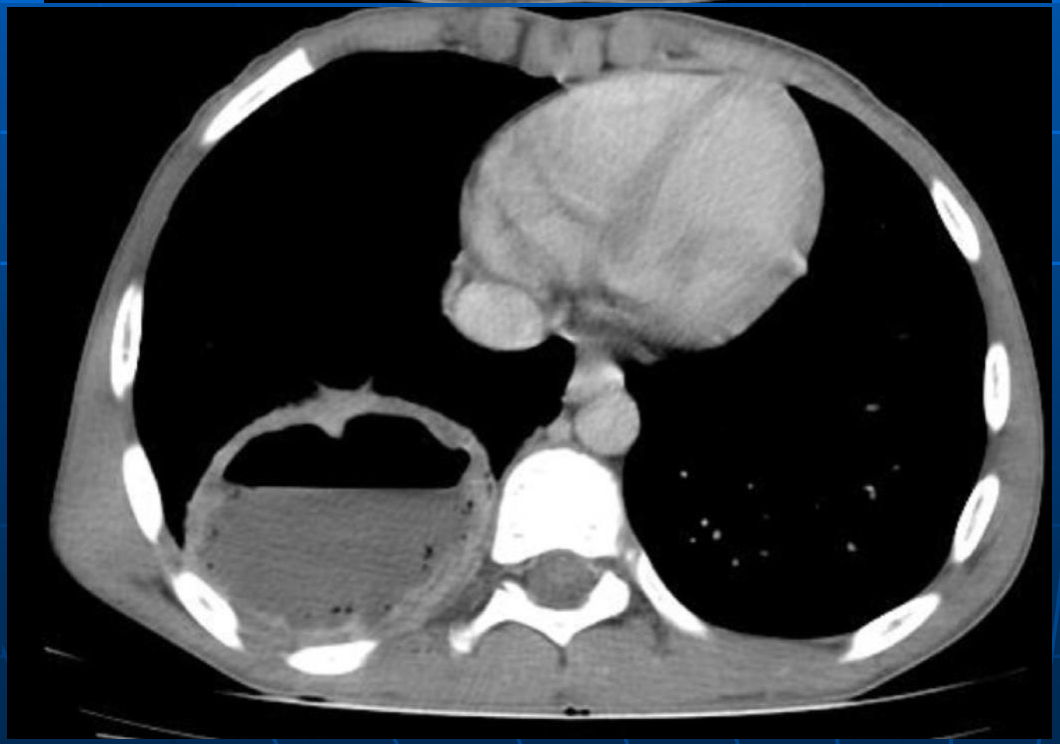
- 15 歲男童，臨床表現為胸痛、咳嗽、發熱、腹痛模糊，急診處理。體格檢查發現呼吸音減弱，右肺底部有濕囉音，右側腹部有輕度壓痛。實驗室檢查結果顯示 ESR、CRP 和白細胞增多增加。患者接受了造影劑增強胸部和腹部 CT。



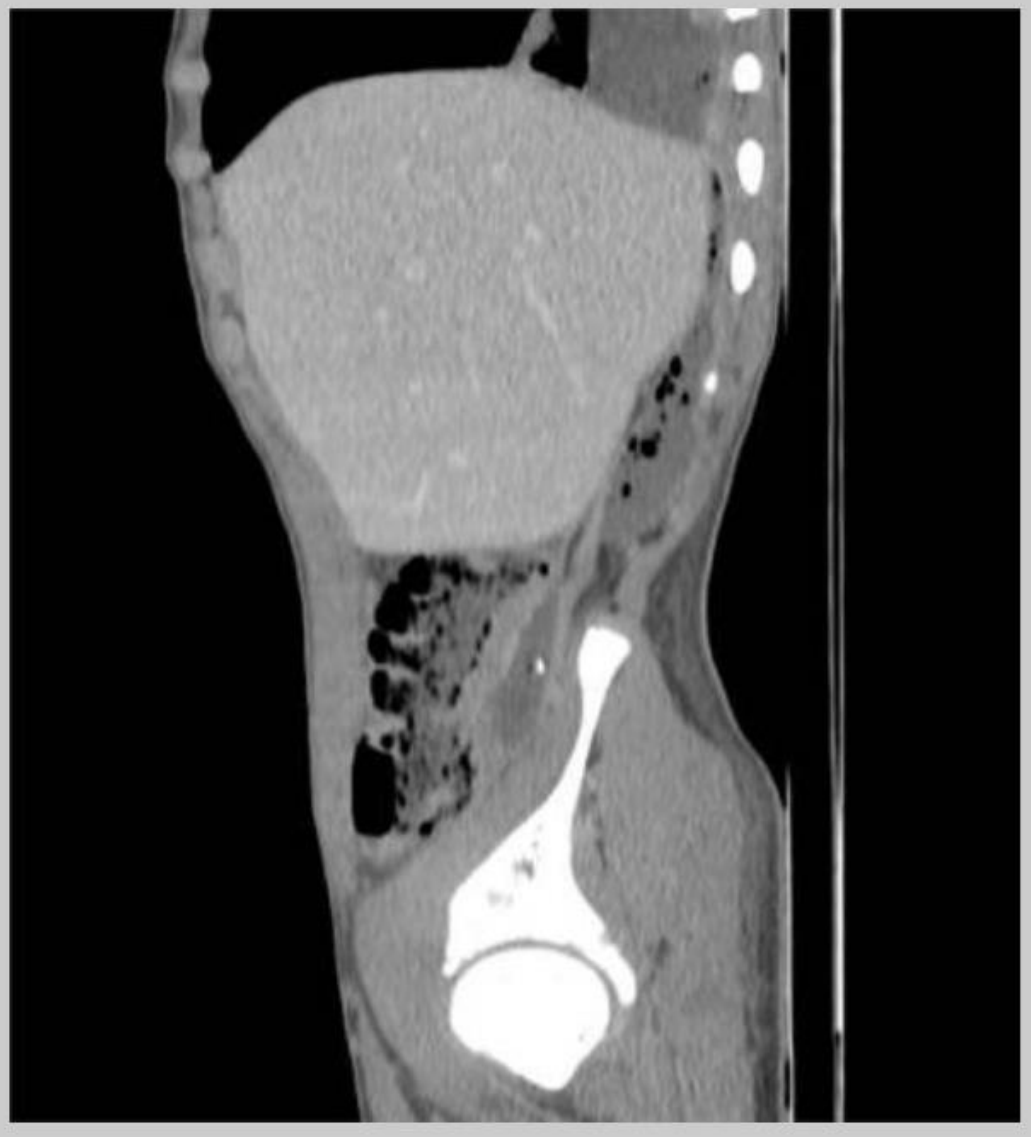
Scout view at the level of lower chest and upper abdomen demonstrates a faint rounded opacity in the right lower zone, with well-defined superior and lateral margins. There are multiple tiny air bubbles projected over the liver (arrows).



Selected contrast-enhanced axial section from the lower abdomen demonstrates a collection in the right iliac fossa (black arrow) with focal calcification representing appendicolith (white arrow).



Selected contrast-enhanced axial section from the lower chest demonstrates a thick-walled cavitary lesion with air-fluid level in the right lung base consistent with lung abscess.



Reformatted contrast-enhanced selected sagittal section from the abdomen and lower chest demonstrates a collection in the right retroperitoneal collection with focal calcification extending all the way up to the subdiaphragmatic location communicating with lung abscess.

The patient underwent appendectomy with complete drainage of entire retroperitoneal and lung abscesses. The patient was discharged with a satisfactory condition.

同一個疾病的主要問題(原因) 可能還不相同

- 原因—search—define-eradicated and or treated.
- 必須找出來

Detail the Solutions to Solve the Problem
如何解決問題

- 3,. Detail the Solutions to Solve the Problem.

  如何解決問題 (A+P),第一是確立診斷

- Assessment→ diagnosis
- raise three possible diagnosis
- 找証據
- Differential diagnosis
- 確定其中之一個:敘明理由
- Decision making

Plan and action

- 4. **Management—plan**
- **Comparisons of different methods**
- **Effectiveness and side effects.**
- **Communication/shared decision making**
- Key Stakeholders Involved 爭執重點
- Severity and outcome predicted
- 5. Start action/Orders/Response to
- the treatment –
- describe in **Course and treatment**.

Course and treatment

- 病人住院後的病情發展--Changes
- 1. 簡化診斷/病情複雜下仍要把握主診斷要
- 簡單化.
- 診斷形成依據.
- DD:要排除不成立的診斷
- 2.治療; according to the guidelines
- 3. Response: assessment parameters
- 4:風暴—changes and complications.
- 5. Final outcome

6. Discussion
這是presentation的重點

- Discuss the Key Results & Outcomes
- (1.)為什麼作這個診斷:必須寫出依據
- Why?
- From the history
- From the physical findings
- According to the laboratory findings
- Corresponding medical imaging findings
- Comparisons with some other common
- diagnosis

- (2.) Cause (s) of the problem
  Probable推斷原因--會比較難
  可能後果outcome
- (3) Explain the risk factors.
- 影響症狀預後

@@@, (1)(2)(3)三大項的次序可依 presenter 作彈性調整

Dx. And Mx knowledge, experience /references

- (4). Include Visuals to Support Your Analysis
- 說明支持分析之依據或理由
- **引經據典,自圓其說**
- references不嫌多.
- **至少3篇**,也可以7~8篇

Check(search) the current literatures.

Course and treatment Recommendations and Next Step

- (5).Recommendations and Next Step
- 下一步要怎麼作呢?
- 1)More examinations更多的檢查, Dx.
- 2) Consultation—including second opinion
- 3) Follow up symptoms-clinical progress
- 4) Notify the parameters
- 5) Status related to Changing medications
- 6) Evaluate the clinical progress and change therapeutic plan.

很重要的決定

- 臨床變化要及時因應,
- Decision making→會有遲疑hesitation

  左右為難-

  →最後決定的理由

多思考
問老師
Consultation

- (6) Other problems or co-mobilities

逐一分析,提建議

EX. DM—治療效果不佳, HB A1c > 8.0
EX. Obesity：ＢＭＩ　> 30 for several YEARS
Ex. Severe anemia, <8.0 not corrected
EX. Heavy proteinuria resulted in hypoalbuminemia

7. Final remarks

- 結論=心得報告
- Take home message
- 謝謝指導者:
- VS, Residents, PGY-1,2
- Others
- @ diagnosis
- @ Interpretation of laboratory data
- @ Interpretation of medical imaging
- 問題:####看不出學習者與老師間的互動

表達感想與心得
形式上的Thanks,不需要

- 查書的樂趣--恍然大悟
- 同學之間討論後得到的心得
- 特別是與病人之互動
- 如果還有一些疑問---我要怎麼辦才好,請教在座各位

- Case presentation不必一直review,像上課那樣.只要說出重點.
- @選擇診斷
- @選擇治療方式
- @提示outcome

問題###最常利用Up to date--占時間.又偏離主題

- 找文獻,包括textbook and current
- literatures.

問題:與老師的互動不夠

- Attending VS是最好的Clinical teacher.
- **###presentation中很少說出老師指導的經過及內容.**
- **至少說說VS round時提出什麼意見**
- (這是最重要的每日互動)
- 我的方法:不得已(have to)一增加或提示VS comment:→要問問VS的看法,
- **Minimum-師生互動要2次,**
- **1)告知要present at the conference**
- **2)請老師comment--事實上也包括改protocol**
- (a)怎麼知道有效?
- (b)現在狀況不佳,要怎麼辦
- (c)何時要手術
- (d) XX怎麼跟病人說明/解釋
- --------

時間分配:大約1小時的討論

- 特別演講—50-55分+5分提問
- Demonstration性質(special topic)
- 45分+10-15分討論
- 一般案例(Clinical case)
- 報告者是醫師(*R/VS)--35 ~40 min.
- **報告者是medical students**
- **30分+-5 min.**
- 25分以上 Discussion

- 在一定的時間內,暢快地(也很得意地)表露您的努力).
- 不要怕留時間太多,被電的時間越多.
- 討論時間越多,您收獲越多

可以利用protocol表露出您的企圖,描繪討論的內容.

Protocol 要怎麼寫

- 不是病歷的翻板.要注意個人隱私
- 把想法說出來,
- 可以套用標準模式--應有的內容

Personal data
Problem list and problem descriptions—RRSOAP
Diagnosis, and diagnostic evidence
    Why I Make this diagnosis
Treatment options and shared decision making
Clinical response—Course and treatment
 @@assessment parameters.
 @@ improved or deteriorated?
 @@ next steps—check data again, references
                ask instructors
                consultation
Future plan---discharge plan and home care
My learning from this case—take home message

沒有一定的模式或最好的模式.
把臨床推理的依據說出來就對了

Presentation

- 1, Power point slides: 要另外下功夫寫
- 2. Direct download from Electronic
- medical records---revised

Case conference

- 會,是大家的,出力越多的人收獲越多,
- 既然花時間參加,就要帶收獲回去
- **1.來自present的人—take heme**
- **message**
- **2.來自討論**
- **-意見不同處→怎麼決定**
- **3.來自主席或指導者 conclusive**
- **remarks.**

At the meeting,
您重點放在那一項?好好準備

自己決定

疾病的歷史,(historical review of the disease)
病因想法改變 about pathogenesis
Differential diagnosis
治療改變 About treatment
Epidemiology?
Taiwan experience
Management guidelines
可參考較新的文獻 2021,2022, 2023.
告訴別人新的觀念

寫成protocol or power point之注意事項

- 病情是個人隱私.

1.姓名,住址,出生年月日
2. Chart No. ID No.住址
3.職業,特殊地位,
4.個人的情感生活,性伴侶,婚外情
5.疾病(special disease)(HIV,VD, Cancer)

6. BW
7. Personal income
8. Rich or poor
9. Blood type

法規名稱：個人資料保護法 EN

修正日期：民國 112 年 05 月 31 日

生效狀態：※本法規部分或全部條文尚未生效，最後生效日期：未定 連結舊法規內容

本法 112.05.31 增訂之第 1-1 條條文，施行日期，由行政院定之。

56. 本法施行日期，由行政院定之

個人資料：指自然人之姓名、出生年月日、國民身分證統一編號、護照號碼、特徵、指紋、婚姻、家庭、教育、職業、病歷、醫療、基因、性生活、健康檢查、犯罪前科、聯絡方式、財務情況、社會活動及其他得以直接或間接方式識別該個人之資料。

以病為師:最真的事實-
不是瞎造的

- The primary objective of a **case study** is to provide an extensive and profound comprehension of the chosen topic. This is achieved through the incorporation of empirical data, expert insights and real-life instances.
- 清楚明白,前因後果,**時間次序不可倒置----要好好看,要下工夫**
- **-----**前前後後至少五次到**bedside**請教病人
-

Purpose of presenting a Case Study

- 案例研究對許多人來說可以作為社會證明。呈現案例研究的主要目的是提供全面的、基於證據的論點，以告知、說服和吸引觀眾。無論您是試圖說服您的客戶或顧客購買產品的產品經理，還是在學術界解釋您的研究結果的重要性，執行良好的案例研究都可以實現多個目標。
- 1. 首先，它可以讓你**深入研究特定問題**、挑戰或機會的複雜性，從不同的角度來檢視。這種深度探索有助於更全面地理解問題。
- 2.其次，它提供了一個結構化的平台來**展示您的分析能力和思考過程**。案例研究使您能夠展示如何得出結論，從而**提高決策過程的透明度及完整性**
- 3,展示案例研究讓您有機會以引人入勝的敘述方式將數據和現實世界場景聯繫起來。它有助於使你的論點更有相關性和可理解性，從而增加對聽眾的影響。

Stories of the disease.
-鍛練臨床推理的技巧

- 瞭解病情-problems
- 知道病因,(roots)
- 病人有無潛在之危險問題(risks)

UGI bleeding 原因:

1. Peptic ulcer, and life stress
2. Medicine, aspirin, NASID----
3. Food,nutrients
4. Alcohol-drinking
5. Procedure-biopsy
6. Others

1. Management of disease
2. Understand risk potential—risk evaluation
3. Expectation of clinical progress.
4. Explanation to the family

Assessment and planning

History taking from the patient and the family members.
Watch the expression of the patient—tachycardia, hypotension and consciousness---also frequency/amount of tarry stool passage
Review previous records and lab data, medications.

綜合判斷

RR-SOAP

- Present condition,
- Changes?
- Continuous bleeding or cease bleeding
- Blood transfusion
- Surgical consultation
- →Operation
- death

Rebleeding-Forrest classification

- Outcome-- prognosis

Follow up check

1. Symptoms: tarry stool or hematemesis--stop bleeding
2. Pulse and BP
   hypovolemia
   tachycardia >100/min.
   考慮輸血
3. Hospitalization—ICU
   Endoscopy to find the site of bleeding and to stop it.
4. Operative approach.

故事裡的主角不同,(原因各異,症狀也差異)結局也不一樣

- 從發病到就醫的歷程
- Symptoms-Dx And Rx.

1.清醒->自己決定(就醫〉
2.清醒, 但衰弱->家人協助送醫
3.昏迷不醒,一事->送醫急救-

@@@Time to Emergency,
半夜(11 -pm-5 am)
一定比較緊急及危險

- 某種原因 known or unknown
- Symptoms onset—time
- Feeling-experience
- Symptoms—distress
- 解決問題-自行用藥/忍耐-
- 就醫-就近診所,
- 熟習的醫院
- "大”醫院(Medical center)急診

臨床推理是要下工夫,好好想一想

1. Symptoms 要量化
2. time of occurrence and change
3. Some treatment might modify the feature—antibiotics and analgesic.
4. Age factor– memory might be lightly impaired.

Total amount of tarry stool was estimated to be about 1,200 ml

- Frequent passage of moderate amount of tarry stool from 8pm on 2023.10.17.
- Last episode of tarry stool passage occurred 3 hours before entry.
- About 8 times of tarry stool passage.
- ½ bowel each. (120-150 ml)

Present illness

- 從發病到就醫,對病人的影響 fainting, dizziness,sweating---
- **Time of onset**
- **Roots of the problem**
- **Changes of symptoms**
- **How to manage the problem—personally and by health care persons.**如何處理又就診時醫師如何處理
- **Previous episodes ?**
- 對病人的影響

至少要問present condition.

- 1. 是否尚有 active bleeding(一小時內有吐血或解黑便都是)
- 2. 醫師說什麼原因呢
- 3, CBC check?---Hb 多少,
- 4. 有沒有**輸血. Any side effect after BT**
- 5.有特別做些什麼交代?
- @有沒有Azotemia
- @從前有什麼特別疾病

Past medical history

- 1. **Roots of the problem,**
- **previous episodes**
- **risk factors—lab.**
- **symptoms, images**
- **co-mobilities**
- **altitude of the patient/family**
- **to the disease**
- **To get more information about**
- **the health of the patient**
-

Family history

- Family tendency—hereditary, genetic
- environmental factors
- contact and infected.
- Altitude to health care, man power, age factors and past experience
- herb?之使用.
- 醫療的態度: active treatment/對手術的接受度
- 還是相對對醫療冷漠.
- 大概與過去對醫療的觀念有關/ good or bad
- impression to the medical care

Medication history 一定問
Medications related problems

- Side effects, allergy
- Complications
- Drug interactions.
- Masked diseases—Acetaminophen/
- NSAID
- Steroid

Risk factors,
Underline diseases
Co-morbility

Medications (esp. NSAID, antiplatelet agents)能橫生枝節

Major Risk Factors for Upper GI Clinical Events With NSAID Use

Risk Factor	Risk Increase
Prior upper GI clinical event	2.5- to 4-fold
Older age	2- to 3.5-fold (>65 years)
Anticoagulation (eg, warfarin)	3-fold
Corticosteroid therapy	2-fold
High-dose/multiple NSAIDs (eg, NSAID + low-dose aspirin)	2- to 4-fold (vs aspirin alone)

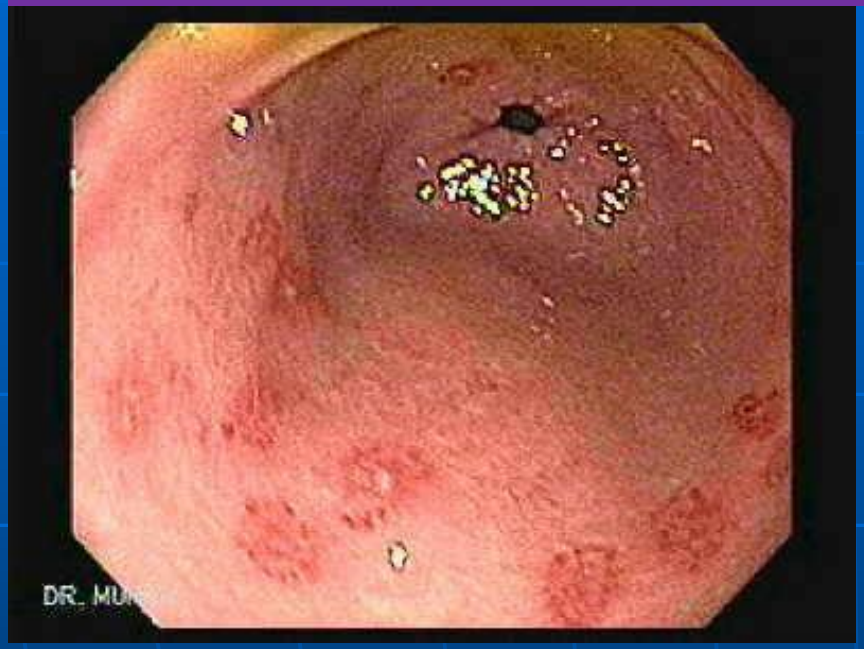
Laine L. *Rev Gastroenterol Disord.* 2003;3(suppl 4):S30–S39

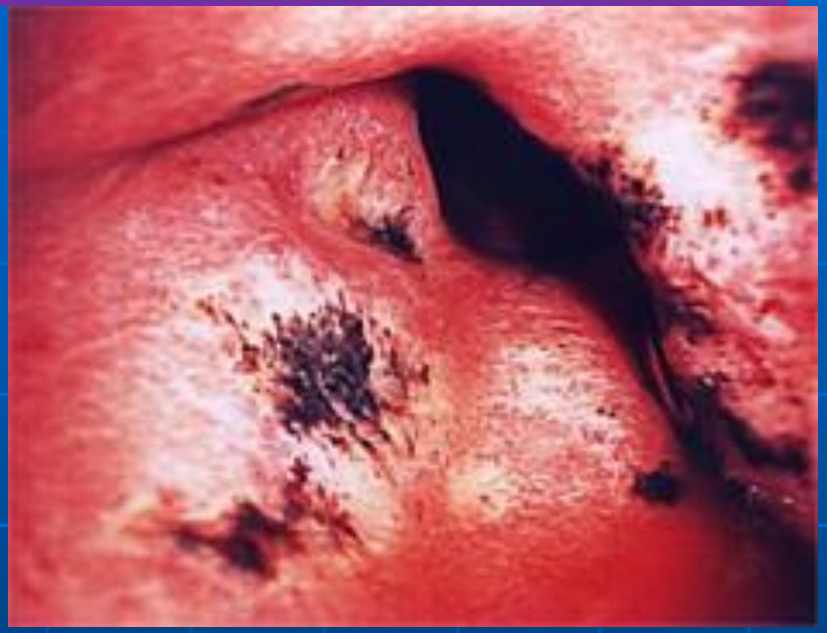
NASID GI toxicity

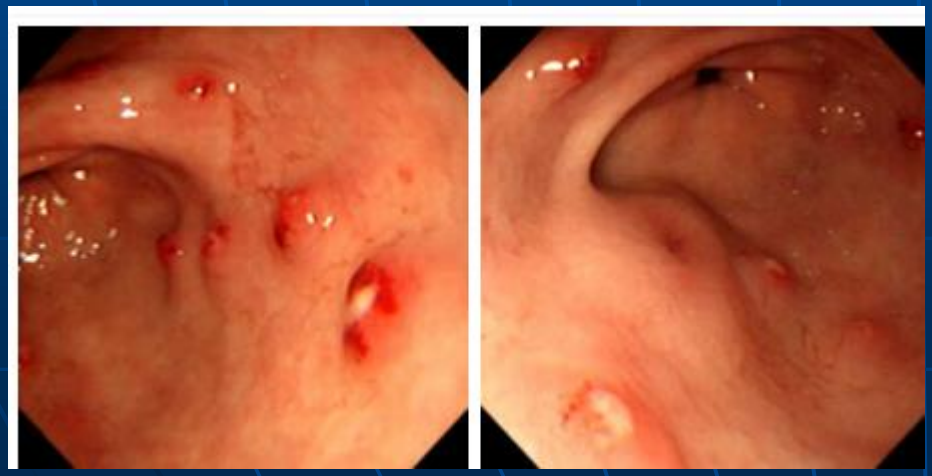
Patients at increased risk for NSAIDs GI toxicity

High risk	1. History of complicated ulcer especially recent 2. Multiple (> 2 risk factors)
Moderate risk (1 – 2 risk factors)	1. Age > 65 years 2. High dose NSAID therapy 3. Previous history of uncomplicated ulcer 4. Concurrent use of aspirin 5. Concurrent use of corticosteroids 6. Concurrent use of anticoagulants
Low risk	No risk factors

Erosive gastritis







Erosive Gastritis mit Hämatinauflagerungen

Chronic erosive gastritis of the antrum with nodules presenting a central erosion and hemorrhagic borders.

必需詢問:服用 NASID?
服用NSAID 的人很多,1/3-1/4 人口

Table 2: NSAID-related deaths and admissions to hospital

Event	UK	USA	Canada
Annual NSAID prescriptions	25 million	70 million	10 million
NSAID-related admissions	12,000	100,000	3,900
NSAID-related deaths	2,600	16,500	365

Pharmacoepidemiol Drug Saf. 2018 Nov;27(11):1223-1230. doi: 10.1002/pds.4663. Epub 2018 Sep 19.

Comparative safety of NSAIDs for gastrointestinal events in Asia-Pacific populations: A multi-database, international cohort study.

Lai EC[1,2,3], Shin JY[4], Kubota K[5], Man KKC[6], Park BJ[4,7], Pratt N[8], Roughead EE[8], Wong ICK[9], Kao Yang YH[1,9], Setoguchi S[3,10,11].

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3 Duke Clinical Research Institute, Duke University School of Medicine, Durham, NC, USA.
4 Department of Preventive Medicine, Seoul National University College of Medicine, Seoul, South Korea.
5 Department of Pharmacoepidemiology, University of Tokyo, Tokyo, Japan.

We identified 9879 patients in Japan, 70 492 in Taiwan, 263 741 in Korea, and 246 in Hong Kong who initiated an NSAID, and 44 013 patients in Australia, a predominantly Caucasian population. The incidence of gastrointestinal hospitalization was 25.6 per 1000 person-years in Japan, 32.8 in Taiwan**, 11.5 in Korea, 484.5 in Hong Kong, and 35.6 in Australia. Compared with diclofenac, the** risk of gastrointestinal events with loxoprofen was significantly lower in Korea (hazards ratio, 0.37; 95% CI, 0.25-0.54) but not in Japan (1.65; 95% CI, 0.47-5.78). The risk of gastrointestinal events with mefenamic acid was significantly lower in Taiwan (0.45; 95% CI, 0.26-0.78) and Korea (0.11; 95% CI, 0.05-0.27) but not Hong Kong (2.16; 95% CI, 0.28-16.87), compared with diclofenac.

CONCLUSIONS:

Compared with diclofenac, loxoprofen was associated with a lower risk of gastrointestinal hospitalizations in Korea and mefenamic acid with a lower risk in Taiwan and Korea.

NSAID and aspirin users.

- **Epidemiology of non-steroidal anti-inflammatory drugs consumption in Spain. The MCC-Spain study.**
- Gómez-Acebo I[1,2], Dierssen-Sotos T[3,4], de Pedro M[4,5 et al:] BMC Public Health. 2018 Sep 21;18(1):1134.

Four thousand sixty participants were selected using a pseudorandom number list from Family Practice lists in 12 Spanish provinces.

1. Women consumed more non-aspirin NSAIDs (38.8% [36.7-41.0]) than men (22.3 [20.5-24.2]), but men consumed more aspirin (11.7% [10.3-13.2]) than women (5.2% [4.3-6.3]).

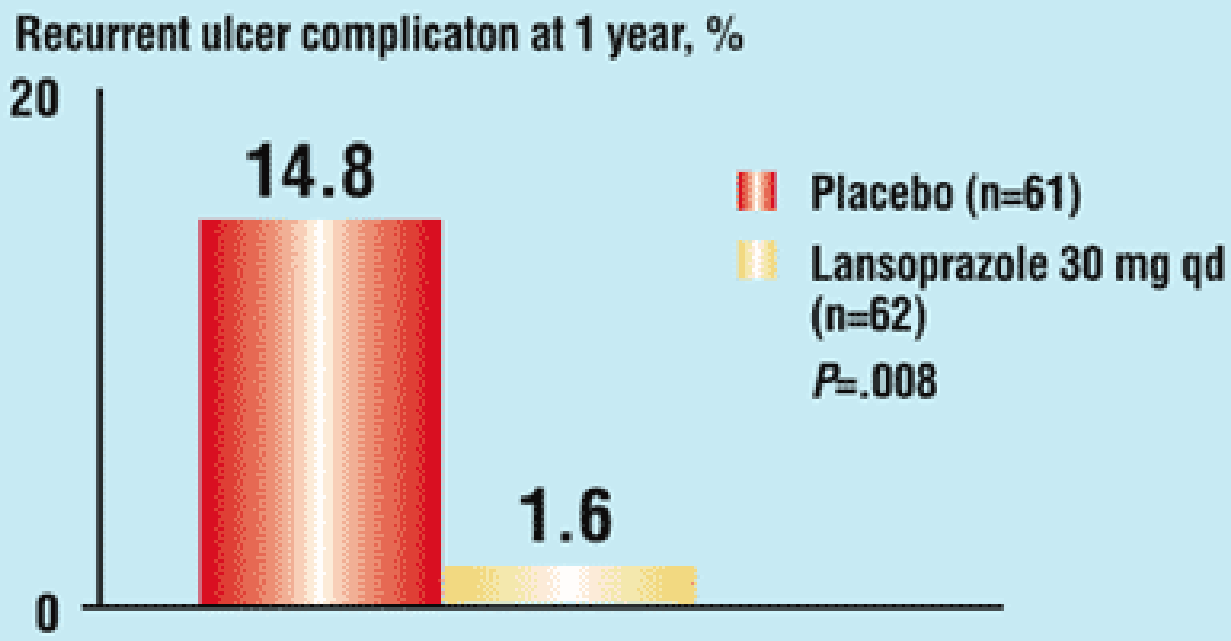
2. Consumption of non-aspirin **NSAIDs decrease with age** from **44.2%** (39.4-49.1) in younger than 45 to 21.1% (18.3-24.2) in older than 75, but the age-pattern for **aspirin usage was the opposite**.

Aspirin was reported by about 11% patients, as being twice as used in men (11.7%) than in women (5.2%); its consumption increased with age from 1.7% (< 45 years old) to 12.4% (≥75 years old). Aspirin was strongly associated with the presence of cardiovascular risk factors or established cardiovascular disease, reaching odds ratios of 15.2 (7.4-31.2) in women with acute coronary syndrome, 13.3 (6.2-28.3) in women with strokes and 11.1 (7.8-15.9) in men with acute coronary syndrome.

如果加 PPI→減少潰瘍的發生

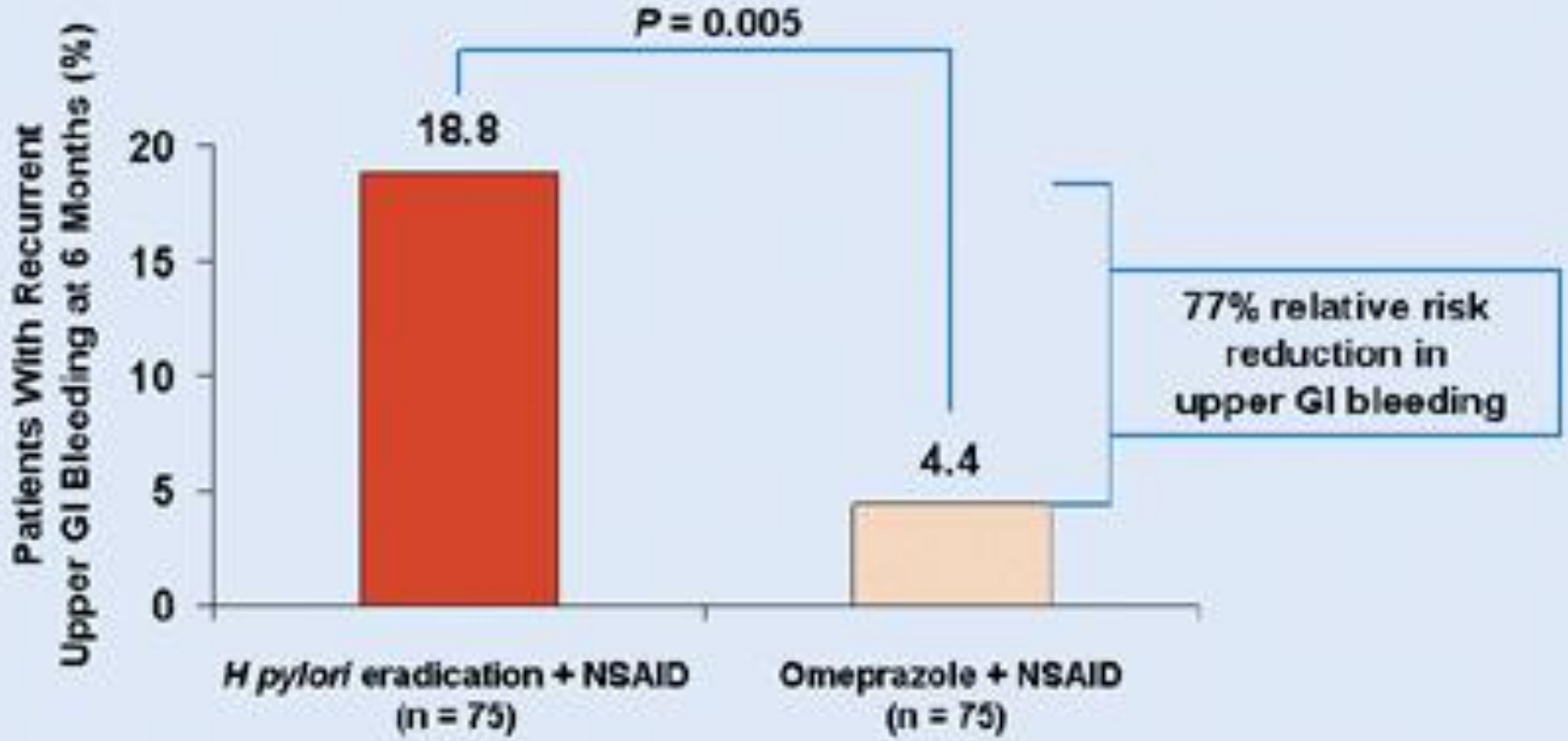
Figure 8. **PPIs Prevent ASA-Associated Ulcers**

- Patients with complicated ulcers on low-dose ASA
- *H pylori* treated; ASA restarted; randomized to lansoprazole/placebo

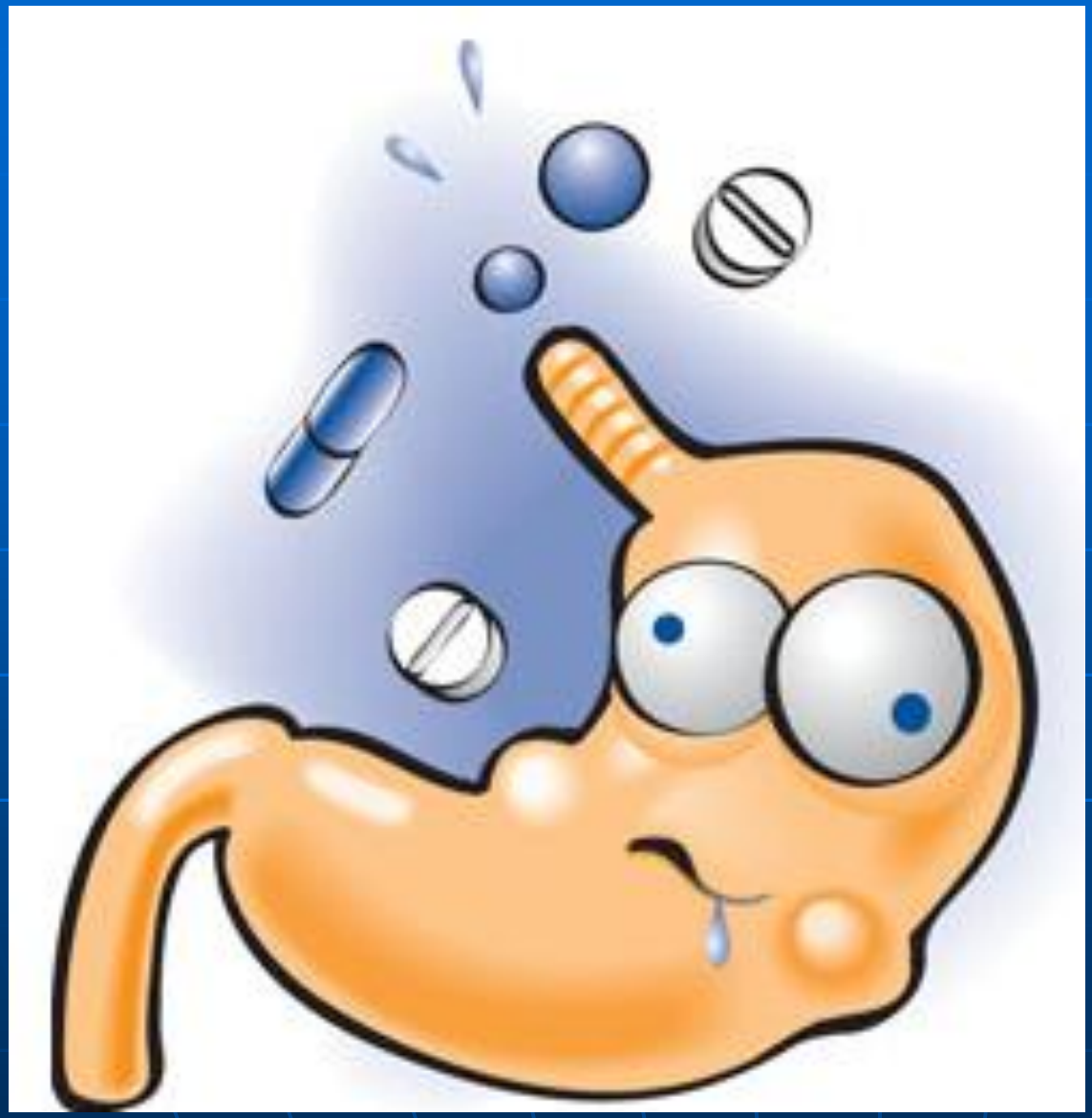


Source: Lai et al. *N Engl J Med*. 2002;346:2033.

PPI Prevents Recurrent Ulcer Bleeding in NSAID Users



Chan et al. *N Engl J Med*. 2001;344:967-973.



注意事項

- Taking NSAIDs with a meal will reduce the risk for NSAID

Physical findings-1

- BW: 65 Kg,(present, 2024.10.16)
- **BMI: 22.5**
- 70 .2 Kg. (past reading,
- 2021.01)
- 68.1 Kg. (past reading, 2018.3)

Why?

1. Swallowing pain
2. Abdominal discomfort
3. Weakness and malaise
4. Dyspnea
5. Food? amount?
6. Depression/psychological

問出體重的變化還要知曉為何會如此

Problem list of this patient
summary of present illness

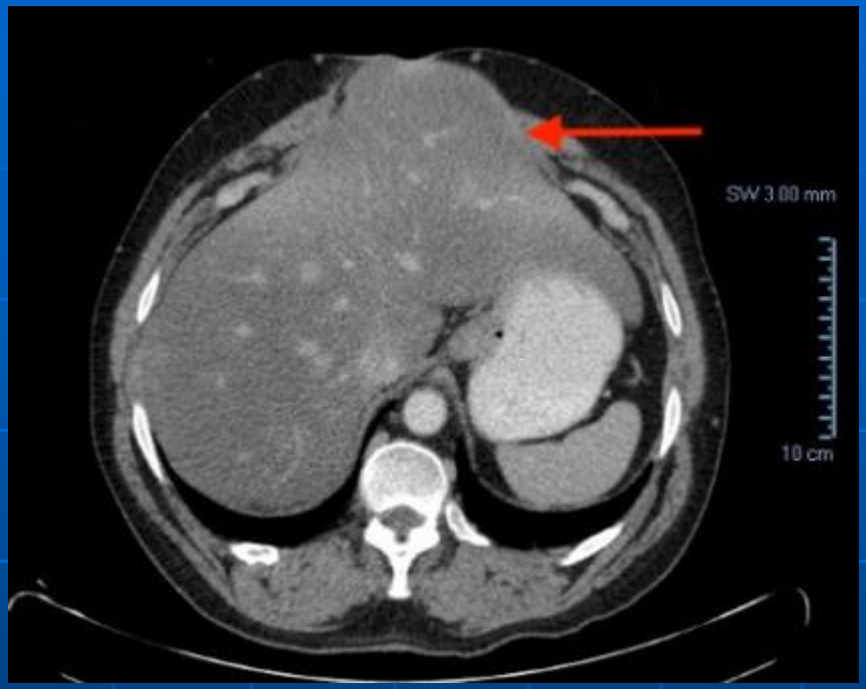
- P1(major one)
- P2
- P3
- P4
- P5
- ---

全人醫療的重心就要看
Problem list 完不完全

Medical images-1

- Abdominal CT
- Date examined: xxxx
- Major findings:

一定要寫出finding
以及判斷.
一定要寫清楚.



Anterior hepatic herniation.

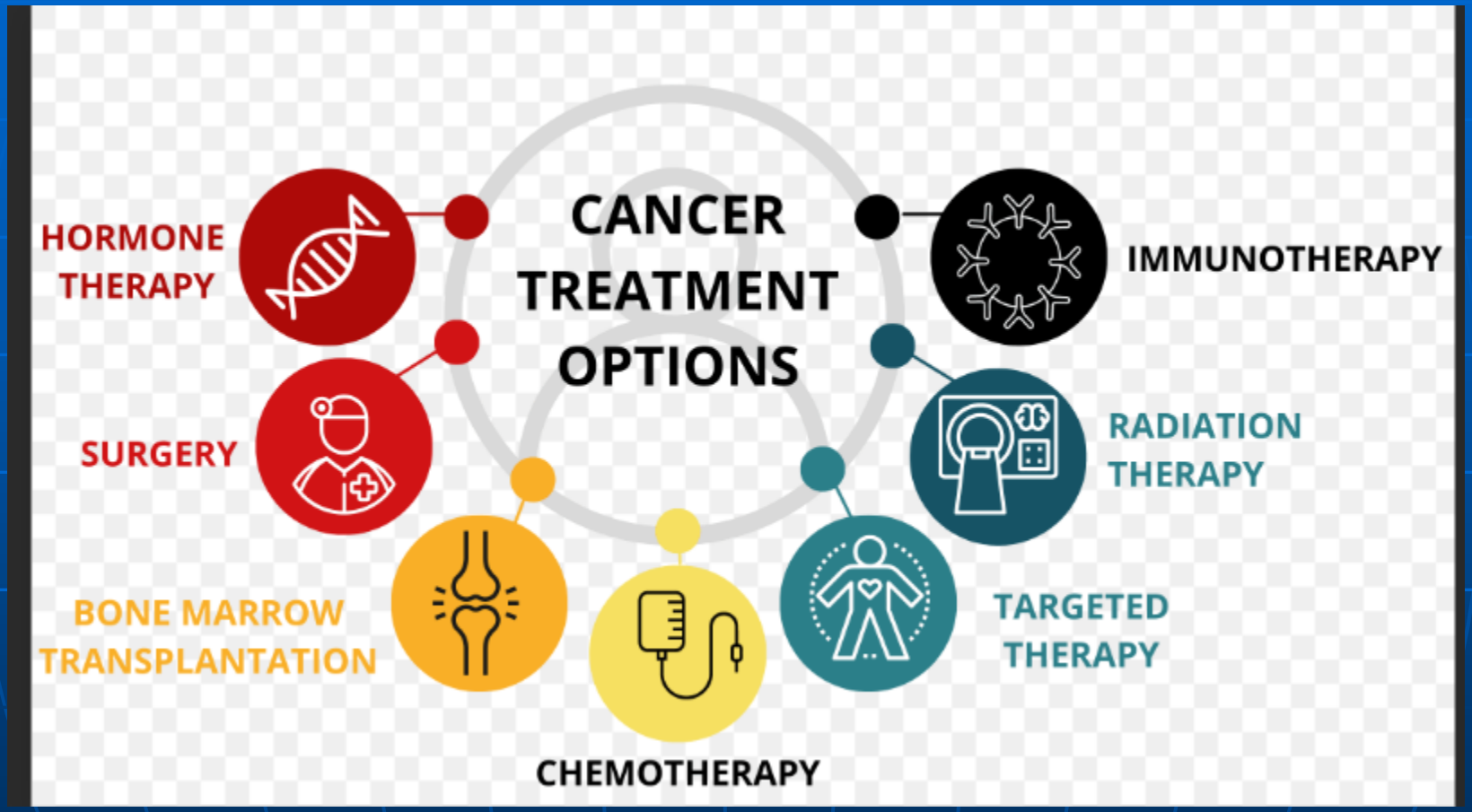
Then E O, John F, Ofosu A, et al. (February 13, 2019) Anterior Hepatic Herniation: An Unusual Presentation of Abdominal Incisional Hernia. Cureus 11(2): e4066. doi:10.7759/cureus.4066

-
- Diagnosis:
  Recommendations or suggestions by radiologist.:

Diagnosis made (changed)after clinical study

- 一定要說理由.
- @@@診斷依據
- Change management too.

Treatment done for the patient- medical or surgical



@@@比較及選擇:不同方法有優點也有劣點

Comparison的工作相當難,但要作.

說明有優劣點,讓病家了解

- 手術
- 口服藥物治療
- 檢查內視鏡說不定可以內視鏡止血,
- 說不定會自己止血-→觀察看看
- 先輸血讓血紅素達到十以上. 看是否繼續出血再決定下一步驟

Response
dramatic improvement noticed

- Parameters Clinical response

- 1. Fever, subsided from Oct.16, 2023
- 2. Symptom-1
- epigastralgia much less from 2023.10.16
- almost no pain from 2023.10.18
- 3. Appetite improved much from 2023.10.17
- 4. Jaundice decreased on 2023.10.17 (from 6.5)
- (total bilirubin: 2.8 mg/dl)
- 5. Lab.
- Biliary enzyme reduced much on 2023.10.17
- GGT was 149 on 2023.10.17(from 438)
- 6. WBC : reduced much, from 16500 to 9800 on 2023.10.17
- 7. CRP reduced much from 12.3 to 3.8 on 2023.10.17

選parameters也難

- 1.靠深入瞭解病情,最重要
- symptoms/signs.
- 2.看書查報告/case report之敘述
- 3 previous experience
- 4. VS的意見.一定要多請教,多討論
- 5----學長的意見/護理師的看法

1.4到6小時未再出現tarry stool
2. Pulse 減少了 120→104/min.
3. BP 穩定下來 >100 mm Hg.
4. Cold sweating subsided.

In upper G-I bleeding with shock.

All problems listed should have recommendations.

- 1. active or inactive,
- 2, undertreatment with xxxx, or no more treatment
- 3.related diagnosis and personal altitude to the problems.
- DM-diet control
- Obesity-exercise

一大堆的DD

- 一大堆的DD-→輕輕鬆鬆地說
- 這不像,
- 這不可能,
- 可能性不大
- ----
- (隨隨便便就排除診斷這個習慣不好)
- 挑3個比較可能的病

VS 常需要做decision making

- 自己的經驗,能力→常決定一病例選擇選擇

Conclusion from the clinical course

- About diagnosis
- Severity and outcome
- Effectiveness
- Complications
- Changes of symptoms, response
- And changes of management
- Warning signs and risk factors.

Treatment will be continued until he can be discharged when?

Case : gall stone with obstructive jaundice

- Present condition　　conditions to be discharged
- (2023.10.20)
- 　No fever　　〃
- 　No more pain　　〃
- Serum bilirubin
- 　2.8----------1.5 or less
- GGT　149　　60 or less

好好思考可以出院的條件

Effective communication

- **Effective communication** lies at the heart of healthcare services. Whether it's conveying complex medical information to patients, discussing treatment plans with families, or presenting a medical case to colleagues, the ability to deliver clear, concise, and engaging presentations is vital.
- A well-designed presentation template tailored for a Medical Case can significantly enhance the effectiveness of a medical case presentation, offering a structured format that aids comprehension and maintains audience engagement.

Conclusion

- Delivering an effective medical case presentation is no small feat, but with the right tools and strategies, it becomes much more manageable. Using a Medical Case PowerPoint template for your medical case presentations can save you time, enhance your professionalism, and boost clarity.
- With careful planning, a clear structure, and a strong PowerPoint template, you can transform your medical case presentations from good to great. Remember, the goal is not just to share information, but to do so in a way that engages your audience and promotes clear understanding. Happy presenting!

結論-1,(2025.06.15.)

- 1.Clinical case presentation是醫學生在醫院實習非常重要的項目.要多練習.醫學生的生涯中至要十次以上.
- 2.Case presentation要用心準備,好好詢問病史,注意身體的表徵,分析檢驗數據,醫學影像異常之確認. 提出病人的各個問題(problem list)並就各個問題依據RRSOAP作說明.
- 3.確定診斷前應提出相關之証據

結論-2,(2025.06.15)

- 4. 確定診斷後要給予治療.不同方法應作比較Comparisons並告知病家作清楚的溝通.再施行.共享決策是一貫的原則.
- 5.師生之互動,同組同學間之討論是
- presentation是否成功的關鍵因素.
- 6.Case presentation可以依據標準模式.重點則依病情個別選定.
- 7.Case presentation對學習至為重要.