GYNECOLOGY CASE WRITE-UP EVALUATION FORM

STUDENT NAME:_____ DATE SUBMITTED: _____

DISCUSSION TOPIC: _____ See Handbook pp 22-24 for instructions.

ITEMS BELOW ARE COMPLETED BY THE INSTRUCTOR

TIMELY SUBMISSION: ☐Yes ☐No If no, Date/Time complete assignment received: _____

TURNITIN (≤ 15%) _____ ☐FIRST SUBMISSION OR ☐ REWRITE?

A medical student is expected to perform at a score of 3 or better by the end of his/her third year.

HISTORY

1. Chief Complaint and History of Present Illness: begins with the chief complaint (usually in patient's words). Patient introduction includes presence/absence of conditions directly relevant to the assessment, and reason for presentation; identifies history source. History begins with the first change in health status related to the chief complaint and concludes at the time writer assumed patient care including reason for admission.

1	2	3	4	5
Inaccurate, incomplete, and/or includes excessive irrelevant data Gives a diagnosis instead of symptoms		Accurate with most of the pertinent information included and most of the irrelevant data omitted Starts with overview, eg "age, G_x $P_{(TPAL)}$, LMP, presents with ____ " Mostly organized sequence of relevant events with well-characterized symptoms.		Hypothesis (assessment) driven, reader able to develop initial differential based on history presented; concise, comprehensive, organized. Includes full PPQRST (quality, severity, location/radiation, timing, alleviating/aggravating factors) Includes relevant OB and GYN history, deferring less relevant details to #2 below
Notes:				

2. Additional History: Obstetric history, Gynecologic history

1	2	3	4	5
Inaccurate, incomplete, and/or poorly described. Missing major element (ex. menstrual history)		Accurate, complete, age-appropriate. Includes menstrual history, STI history, Pap history, obstetric history. Includes sexual history, contraception if pertinent to presentation Obstetric history includes outcome of each pregnancy, mode of delivery, complications.		Comprehensive, patient specific details as pertinent. Examples: -Complete menstrual history (eg. LMP, age at menarche, cycle length, duration, flow; associated symptoms, age at menopause) -Management of past abnormal Pap -sexual orientation and sexual practices, past/current contraceptive methods -Hormone Therapy past/present if menopausal
Notes:				

3. Additional History: Past Medical History, Past Surgical History, Medications, Allergies, Family History, Social History, Review of Systems

1	2	3	4	5
Inaccurate, incomplete, and/or poorly described. Uses 'non-contributory' or other generic term instead of listing pertinent pos/neg items. Missing major element (ex.PSH, or history of C-section in pt who reports C/S in OB history)		Accurate, complete, age appropriate. Includes PMH, PSH, Meds and Allergies, FamHx, SocHx. focused ROS -Addresses chronic illnesses -Includes pertinent negatives (ex. fam hx ovarian cancer in pt with adnexal mass) -lists all medications, allergies - reaction type -Most medications and surgeries have an associated medical diagnosis in PMH		Comprehensive, organized -Includes PMH, PSH, FH, SH elements directly relevant to the differential and collateral history if indicated. (eg relative's age at CA diagnosis; PSH-route/type of hysterectomy) -Includes thoughtful, pertinent, complete ROS -Social history includes social habits, occupation, domestic status, abuse screen. -All medications and surgeries have an associated medical diagnosis in PMH.
Notes:				

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PHYSICAL EXAM AND DIAGNOSTIC STUDIES

4. Vital Signs and General Physical Exam (other than pelvic exam)

1	2	3	4	5
Inaccurate and/or incomplete Missing major element (ex. abdominal exam)		Accurate with complete vital signs and BMI Describes general appearance Exam appropriate for complaint All pertinent elements of exam with some expanded focus based on presenting symptoms (ex. fluid wave to r/o ascites if ovarian neoplasm)		Hypothesis (assessment) driven, comprehensive, organized. Patient specific (Examples: orthostatic vitals, capillary refill for pt with symptomatic anemia; CVA tenderness in pt with UTI) When appropriate, includes subtle positive/negative findings or findings in other organ systems that would suggest non-gyn diagnosis (ex. sclera, skin rash, dentition)
Notes:				

5. Pelvic Exam and Diagnostic Data

If pelvic exam not done describe why not indicated. If pelvic exam not performed by student, state who performed (ex. RN/resident/attending surgeon) and describe their findings in detail. If pelvic exam documentation by preceptor is cursory, describe the other elements that would be included for a complete pelvic exam.

1	2	3	4	5
Inaccurate and/or incomplete Copied incomplete description of pelvic exam from the medical record. Missing major element (ex. Description of external genitalia or vaginal findings, speculum exam, bimanual exam, description of uterus) In case of no pelvic exam, does not include description of typical pelvic exam components. Diagnostic test results in cut and paste format. Omits imperative result (ex. last Pap for LEEP) Rote listing of all components of panel without identifying most important results. (ex. CMP)		Accurate, complete pelvic exam with some expanded focus based on presenting symptoms. (Examples: gravid uterus and fundal height in obstetric patient; description of discharge and wet mount findings in pt with vaginitis) Accurately reports pertinent positive and negative test results while omitting most of the irrelevant data.		Hypothesis (assessment) driven. -When appropriate, comparisons with past exams, and/or maneuvers that distinguish among diagnoses under consideration. (Examples: cervical motion tenderness, uterosacral ligament nodularity) -When pertinent, includes advanced details for component of exam (ex. uterine size, mobility, tenderness, contour) -Accurately interprets pertinent test results, (ex. thickened endometrium on ultrasound; pathology terminology on biopsy report). -Includes review of past results for comparison when pertinent (ex. trend Hgb in pt with AUB).
Notes:				

INFORMATION SYNTHESIS AND CLINICAL REASONING

6. Assessment and Problem List: Big picture synthesis of collected information leading to the formulation of a prioritized differential and identification of the most likely diagnosis. Identifies, synthesizes and characterizes history AND findings to generate an assessment. Begins with summary statement of 1-3 sentences that condenses the information. (Ex. age, GxPx with [symptoms/findings] and [pertinent history] who presents for [treatment/visit type/scheduled procedure] with a most likely diagnosis….

Problem List enumerated separately OR included within the assessment. Problems linked appropriately at higher diagnostic level based on available information (eg. postcoital bleeding, last Pap with HGSIL, past cone biopsy with positive margins, and known history of HIV linked under problem of cervical dysplasia, possible cervical cancer in immunocompromised patient)

1	2	3	4	5
Absent, unsupported, misses many critical findings, includes excessive irrelevant data, fails to include supporting physical exam/diagnostic study findings, and/or restates findings without synthesis		Identifies some defining history AND physical exam/diagnostic study findings while omitting most of the irrelevant data. Uses some medical terms and semantic qualifiers to synthesize an assessment. (Example: "started today" → acute, P 110, BP 70/40, pale → hemodynamically unstable; rigid abdomen, qHCG 3600 and pregnancy of unknown location → ruptured ectopic pregnancy) Includes most identified problems		Selects critical defining history AND physical exam/diagnostic study findings. Uses appropriate medical terms and semantic qualifiers to synthesize an accurate and concise summary statement. (Ex. refractory to hormonal management with oral contraceptives and progesterone IUD and to conservative surgical management with endometrial ablation, desiring definitive surgical treatment) Includes complete problem list with chronic and acute issues.
Notes:				

Adapted from Marta King, MD, MEd (Academic Pediatrics, 17, King MA, Phillipi CA, Buchanan PM, Lewin LO. Developing Validity Evidence for the Written Pediatric History and Physical Exam Evaluation Rubric, 68-73, 2017)

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7. Differential Diagnosis in Assessment:

1	2	3	4	5
Absent, unsupported, and/or poorly described		Includes a prioritized differential of at least 3 possibilities while committing to a working diagnosis. Supports clinical reasoning with relevant history, physical exam, and diagnostic study elements.		Presents an accurate and concise differential by comparing/contrasting discriminating features of at least 3 diagnoses under consideration. Includes non-gynecological diagnoses in differential of presenting or secondary problem(s) and/or refers to literature when appropriate.
Notes:				

8. Plan: diagnostic, therapeutic, patient education, discharge, and follow-up. Includes decision-making rationale.
If patient had surgical procedure includes a brief summary of operative report and pathology results

1	2	3	4	5
Poorly described, unsupported, and/or does not match the problem list or assessment. Merges plan and assessment. Missing diagnosis or management Missing summary of operative findings or pathology result for surgical patient. Copies operative or pathology report verbatim from medical record.		Addresses most aspects of the identified problems while describing decision making rationale. Includes patient education and discharge/follow-up planning. For surgical patient, summarizes operative course and findings, and pathology result. Differentiates plan from assessment. Avoids duplication of an order set in plan.		Accurately, concisely, and thoroughly addresses all identified problems. Considers patient preferences, cost effectiveness, and/or contingency plans when appropriate. For surgical patient includes components of informed consent including alternative options and risks.
Notes:				

ACADEMIC DISCUSSION

9. Clinical Topic Discussion: for a pertinent diagnosis (eg fibroids) or symptom (eg abnormal uterine bleeding) researches and describes the clinical topic, including elements such as scope of problem or epidemiology, typical/atypical symptoms and findings, diagnostic criteria, possible complications, therapeutic options, natural course and/ or common comorbidities and/or sequelae of problem. Uses at least 2 references from primary sources.

1	2	3	4	5
Poorly described, incorrect, or missing the primary distinguishing diagnostic or therapeutic features of the clinical topic. References limited to review resources and/or patient education materials (eg. UpToDate, CaseFiles, patient FAQ)		Gives a clinically relevant description of the topic Accurate, includes most of the pertinent information listed above. Delineates how to distinguish this diagnosis from its common differential diagnosis (ex. testing options, defining features) Includes at least 2 references from primary resources.		Comprehensive yet focused, includes all of the pertinent information. Could be used by classmates as topic study guide. Considers risks/benefits of each treatment option. Includes multiple primary references from diverse sources.
Notes:				

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10. Topic Discussion - relevance to patient: Selects clinically relevant discussion topic that is pertinent to presented patient, compares this particular patient's presentation to the typical symptoms, findings, and natural course for this diagnosis. Emphasizes importance of this clinical problem. Includes psychosocial and ethical considerations.

1	2	3	4	5
Incomplete and/or not pertinent to the patient case Academic discussion is less than 2 pages in length		Throughout topic discussion, compares and contrasts this patient's presentation to the standard presentation and course of this diagnosis. Considers the impact of disease on the patient: addresses psychosocial impact of the diagnosis for this patient's life and/or analyzes an ethical dimension of the case.		In depth analysis, for example: Considers risk factors specific to the patient. Reviews atypical presentation or rare complication of the condition. Reflects on how the recommendations and management of this patient aligned with or deviated from practice guidelines. References the literature for a challenging or uncertain aspect of the management.
Notes:				

Two things the student did well:

1.

2.

Two things the student should continue to work on:

1.

2.

"Stretch" goal:

1.

Overall Gynecology Case Write-Up score ____ (50 points possible)

- ☐ **Pass** **≥ 30 points (≥ 60%)**
- ☐ **Conditional Pass** **< 30 points**

INSTRUCTOR'S SIGNATURE:_____ DATE: _____

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