

Internal medicine

Problem-based SOAP, for daily rounds and new admissions

Target

3 to 5 minutes for a follow-up, 6 to 8 for a new admission

What your attending listens for

Medicine attendings are listening for your reasoning. They want you to pull data from several organ systems into one clear picture, then give a plan organized by problem and ordered by how sick each problem makes the patient. Never just read the labs. Say what they mean.

The structure

- 1 One-liner**
Age, sex, up to three relevant conditions, and why the patient is here: the symptom and how long it has been going on.
- 2 Overnight and subjective**
Overnight events (fevers, rapid responses, PRN medications given), then how the patient feels: pain, nausea, appetite, bowel movements.
- 3 Objective**
Current vitals with ranges, a focused exam by system, then labs grouped by what they mean (CBC, BMP, troponin or lactate) and the trend in new micro and imaging.
- 4 Summary statement**
One sentence that pulls it together with semantic qualifiers, such as "acute on chronic decompensated HFrEF triggered by dietary indiscretion."
- 5 Assessment and plan by problem**
Problems in order of acuity (#1 acute hypoxic respiratory failure, #2 AKI, #3 hypertension). For each: where it stands, the cause or differential, and a specific plan.
- 6 Prophylaxis, lines and disposition**
DVT and GI prophylaxis, whether every line and the Foley still need to be in, code status, and what stands between the patient and discharge.

Word-for-word example

Morning rounds, hospital day 3. The plan is shown for problem #1; a full presentation goes on through every problem. Fictional patient. Each number marks the step it covers.

- 1** Mr. Smith is a 68-year-old man with HFrEF with an ejection fraction of 30%, stage 3 CKD, and atrial fibrillation on apixaban, admitted for acute on chronic decompensated heart failure. **2** No events overnight. He says his breathing is better and he slept flat for the first time this week. He was net negative 1.8 liters on IV furosemide. **3** He is afebrile at 98.2°F, heart rate 78, blood pressure 118/72, satting 96% on 2 liters nasal cannula, down from 4. JVP is 9 centimeters, his bibasilar crackles are improved, and he has 1+ pitting edema. Creatinine improved to 1.4 from 1.8, and potassium is 4.1.
- 4** In summary, a 68-year-old man with acute on chronic HFrEF from volume overload, diuresing well with improving renal function. **5** #1, acute on chronic HFrEF: he is still about 2 liters above his dry weight. We will continue furosemide 40 milligrams IV twice daily, recheck a BMP and magnesium in the morning, switch to oral torsemide once he is euvoletic, and restart empagliflozin and sacubitril-valsartan once his creatinine is back to baseline.

Ward pearls

- Report 24-hour ins and outs and the net balance on every patient with heart failure, cirrhosis or AKI.
- Never list an abnormal lab in the objective without addressing it in your assessment and plan.
- Group chronic, stable problems at the bottom: "#5, type 2 diabetes, stable on basal insulin; home statin continued."
- Commit to your leading diagnosis first, then explain why it is not #2 or #3.

Classic pimp questions

- Light's criteria: exudative versus transudative effusion
- Corrected calcium, the anion gap and Winter's formula
- The four pillars of GDMT for HFrEF that lower mortality
- FENa versus FEUrea in AKI, and when to use which

Practice it out loud. Present a free case to an AI attending at roundsmedical.com/try. No signup.

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General surgery

Ultra-concise morning rounds and consults

60 to 90 seconds on
morning rounds, 2 to 3
minutes for a consult

What your attending listens for

Surgical teams round fast because the first case starts early. Brevity wins. Lead with the post-op day, then the output from every tube and drain, the return of bowel function, and the one thing keeping the patient in the hospital today.

The structure

- 1 ID line**
Name, age, and post-op day from the procedure, or hospital day and diagnosis for a patient managed without surgery.
- 2 Overnight and subjective**
Pain control and whether it is oral or IV, nausea or vomiting, flatus or a bowel movement, walking, and how the diet is going.
- 3 Vitals and strict ins and outs**
Tmax and current vitals. Total 24-hour ins and outs, then the breakdown: urine output in mL/kg/hr, NG tube, and each drain by volume and character (serosanguineous, bilious, purulent).
- 4 Focused exam**
The abdomen (soft, distended, tender) and the incision or dressing: clean, dry and intact, or erythema and drainage.
- 5 New labs and imaging**
Only this morning's results that matter: WBC, hemoglobin, platelets, creatinine, potassium, lactate, or a new CT or KUB.
- 6 Plan in three bullets**
Diet, tubes and disposition. Advance the diet? Pull the NG tube, Foley or drain? Switch to oral pain medication? When can the patient go home?

Word-for-word example

Morning rounds, before the first case. Fictional patient. Each number marks the step it covers.

1 Ms. Davis is a 54-year-old woman, post-op day 2 from a laparoscopic cholecystectomy for acute cholecystitis. **2** Overnight she was afebrile. Her pain is controlled on oral acetaminophen and ibuprofen, she is passing flatus, she walked three times, and she is tolerating a regular diet. **3** Tmax 98.8°F, heart rate 74, blood pressure 124/78. Urine output was 1,400 mL over 24 hours, and her JP drain put out 15 mL of serosanguineous fluid. **4** Her abdomen is soft and nontender, and her port sites are clean, dry and intact. **5** White count is down to 8.2 from 13.4, and total bilirubin is 0.8. **6** She is progressing as expected. Today we will pull the JP drain, stop IV fluids, and discharge her home this afternoon with clinic follow-up in 2 weeks.

Ward pearls

- Look at the incision and the drain bulb yourself on prerounds. Never report "dressing intact" without checking.
- Know drain output by shift, so you can say whether it is trending down.
- Put every post-op fever in context with the 5 Ws: wind (POD 1 to 2; think pneumonia and aspiration, since the evidence that atelectasis causes fever is weak), water (POD 3 to 5), wound (POD 5 and later), walking (DVT and PE), and wonder drugs.
- Never say "labs are within normal limits." Give the actual WBC, hemoglobin and creatinine.

Classic pimp questions

- The boundaries of Calot's triangle and the critical view of safety
- The Tokyo Guidelines for acute cholecystitis, Charcot's triad and Reynolds' pentad
- The Holliday-Segar 4-2-1 rule for maintenance fluids, and lactated Ringer's versus normal saline
- Ranson's criteria and the revised Atlanta classification for acute pancreatitis

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The full guide: roundsmedical.com/resources/surgery-oral-presentation

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Pediatrics

Family-centered rounds and weight-based dosing

Target

2 to 4 minutes on inpatient
family-centered rounds

What your attending listens for

Pediatric rounds often happen at the bedside with parents listening. Your attending wants hydration status, feeding and wet diapers, growth, and every number expressed per kilogram: mL/kg/hr for urine and mg/kg/day for medications.

The structure

- 1 ID line and growth context**
Age (in days, weeks or months under age 2), sex, gestational age at birth for children under 2, relevant history, and the presenting problem.
- 2 Overnight and caregiver report**
What the parents are worried about, oral intake (ounces or percent of usual feeds), wet diapers and stools, sleep and activity.
- 3 Vitals and growth**
Today's weight in kilograms and the change from admission, Tmax, heart and respiratory rates against age norms, oxygen saturation and where the oxygen wean stands.
- 4 Exam, general first**
General appearance (playful, consolable or toxic-appearing), work of breathing (retractions, nasal flaring), and hydration (mucous membranes, capillary refill, fontanelle).
- 5 Labs and weight-based ins and outs**
Urine output in mL/kg/hr (a goal of at least 1), total intake in mL/kg/day, and viral testing or labs.
- 6 Plan by system or problem**
Respiratory and oxygen weaning criteria, fluids and feeds (maintenance or bolus), medications in mg/kg, and discharge criteria.

Word-for-word example

Family-centered rounds at the bedside, hospital day 2. Fictional patient. Each number marks the step it covers.

1 Leo is a 7-month-old boy born at 38 weeks, previously healthy, on hospital day 2 for RSV bronchiolitis with hypoxemia and dehydration. **2** Overnight he weaned from high-flow nasal cannula to half a liter by regular nasal cannula. He took 4 ounces of oral rehydration solution three times without vomiting and had 5 wet diapers. His mom says he is acting more like himself. **3** He weighs 8.2 kilograms, up 100 grams from yesterday. Tmax 99.7°F, heart rate 132, respiratory rate 38, satting 97% on half a liter. **4** He is alert and smiling in his mom's arms, with mild subcostal retractions that are better than yesterday, moist mucous membranes, and capillary refill under 2 seconds. **5** Urine output was 2.4 mL/kg/hr. **6** This is a 7-month-old with improving RSV bronchiolitis. For respiratory, we will trial him off oxygen this morning and watch him on room air. For fluids and nutrition, we will stop IV fluids and let him breastfeed or take formula as he wants. He can go home once he is comfortable on room air and drinking well.

Ward pearls

- Convert raw urine output to mL/kg/hr before rounds.
- On family-centered rounds, face the parents first, skip the jargon ("low oxygen," not "hypoxemia"), and ask for their input before you give the plan.
- For a neonate under 28 days, always include maternal GBS status, the delivery history and where the bilirubin plots.
- State concrete discharge criteria in every pediatric plan.

Classic pimp questions

- The AAP bronchiolitis guideline, and why albuterol, steroids and chest X-rays are not routine
- The PECARN head trauma rules, under age 2 and age 2 and older
- Kawasaki disease criteria (CRASH and Burn) and treatment with IVIG and aspirin
- The febrile infant workup by age: 8 to 21 days, 22 to 28 days, and 29 to 60 days

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OB/GYN

Labor and delivery, postpartum, and GYN triage

60 to 90 seconds on labor and delivery or postpartum, about 2 minutes for a GYN consult

What your attending listens for

OB/GYN moves as fast as surgery, but it runs on exact nomenclature: gravidity and parity, gestational age to the day, the prenatal labs, and a fetal heart tracing described in full.

The structure

- 1 One-liner**
OB: age, G and P (TPAL), gestational age in weeks and days and how it was dated (ultrasound or LMP), and why she is here.
GYN: age, G and P, last menstrual period, and the problem, such as abnormal bleeding or pelvic pain.
- 2 Subjective and labor course**
Labor: contraction frequency, membrane status (spontaneous or artificial rupture, the time, the fluid color), fetal movement, epidural. Postpartum: bleeding (pad count), pain, voiding, breastfeeding, mood.
- 3 Vitals, fetal tracing and exam**
Labor: blood pressure trend, the fetal heart tracing (baseline, variability, accelerations, decelerations, then the category), contractions on toco, and the cervical exam (dilation, effacement, station). Postpartum: fundus, lochia, perineum or incision.
- 4 Prenatal labs and ultrasound**
Blood type and Rh, antibody screen, GBS, HIV, RPR, hepatitis B, rubella, the diabetes screen, and the latest growth ultrasound with estimated fetal weight and presentation.
- 5 Assessment and plan**
Stage and progress of labor, the oxytocin or misoprostol plan, GBS prophylaxis, or the postpartum discharge checklist: Rh immune globulin, contraception, and the MMR vaccine if she is not immune to rubella.

Word-for-word example

Labor and delivery, early morning. Fictional patient. Each number marks the step it covers.

1 Ms. Patel is a 29-year-old G2P1001 at 39 weeks and 2 days, dated by an 8-week ultrasound, admitted for elective induction of labor. **2** She is on oxytocin at 12 milliunits per minute and comfortable with her epidural. Her membranes ruptured spontaneously at 4 a.m. with clear fluid. **3** She is afebrile with a blood pressure of 116/74. The fetal heart tracing is Category I: baseline 135, moderate variability, accelerations present, no decelerations. Toco shows contractions every 2 to 3 minutes. Her cervix at 5:30 was 6 centimeters, 90% effaced, minus 1 station, vertex. **4** Prenatal labs: O positive, antibody screen negative, and GBS positive, so she is getting penicillin G every 4 hours. **5** This is a 29-year-old G2P1 at 39 and 2 in the active phase of the first stage of labor, with reassuring maternal and fetal status. We will keep titrating oxytocin and recheck her cervix in 2 hours, or sooner if she feels the urge to push.

Ward pearls

- Know the five parts of a fetal heart tracing cold: baseline, variability, accelerations, decelerations, and the category (I, II or III).
- State Rh and GBS status on every labor and postpartum patient.
- On a GYN consult in the ED, rule one is a pregnancy test, urine or serum hCG, before anything else.
- On postpartum rounds, always ask about mood, contraception plans, voiding and passing gas.

Classic pimp questions

- VEAL CHOP: what causes each fetal heart rate pattern and how to manage it
- Preeclampsia with severe features: systolic 160 or diastolic 110 or higher, platelets under 100,000, creatinine over 1.1, transaminases twice normal, pulmonary edema, new headache or visual changes
- The 4 Ts of postpartum hemorrhage (tone, trauma, tissue, thrombin) and the contraindications to each uterotonic
- PALM-COEIN for abnormal uterine bleeding

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The full guide: roundsmedical.com/resources/ob-gyn-oral-presentation

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Psychiatry

Inpatient rounds, the mental status exam, and the formulation

Target

3 to 5 minutes on inpatient rounds or a consult

What your attending listens for

Psychiatry presentations center on legal hold status, the safety assessment (suicidal and homicidal ideation, hallucinations), how the patient behaved on the unit, and a precise mental status exam.

The structure

- 1 Legal and psychiatric ID line**
Age, sex, psychiatric diagnoses, legal status (voluntary, or the day of an involuntary hold), and why the patient was admitted: suicidal ideation, mania, psychosis.
- 2 Unit events and subjective**
Hours of sleep, percent of meals eaten, medication adherence, PRN medications for agitation, group participation, and the patient's own words about mood and goals.
- 3 Mental status exam**
Appearance, behavior and psychomotor activity, speech (rate, volume, tone), mood in the patient's words, affect (range and congruence), thought process, thought content (SI, HI, delusions), perception (hallucinations), insight and judgment.
- 4 Vitals, labs and drug levels**
Vitals, with orthostatics or signs of autonomic instability, urine drug screen, alcohol level, TSH, B12, the QTc on the ECG, and lithium, valproate or clozapine levels.
- 5 Formulation and risk**
The biological, psychological and social factors behind this admission, then the acute and chronic risk of suicide or violence.
- 6 Three-part plan**
Medications (titration and side effect monitoring), therapy and the milieu, and disposition with safety planning.

Word-for-word example

Inpatient psychiatry rounds, day 3 of the hold. Fictional patient. Each number marks the step it covers.

1 Mr. Jordan is a 26-year-old man with bipolar I disorder, admitted involuntarily and now on day 3 of his hold, for a manic episode with psychotic features after he stopped his medications. **2** Overnight he slept 5 hours, up from 2 on admission. He took all his scheduled medications, needed no PRN haloperidol, and ate all of his meals. **3** On mental status exam he is casually dressed and mildly restless. Speech is rapid but interruptible, improved from pressured. Mood is "great," and affect is expansive. Thought process is circumstantial, with fading grandiose delusions. He denies suicidal ideation, homicidal ideation and hallucinations. Insight is limited; judgment is improving. **4** His lithium level this morning is 0.8, creatinine is 0.9, and his QTc is 428. **5** This is a 26-year-old man with bipolar I disorder in an acute manic episode, triggered by stopping his medications and responding to lithium and olanzapine. His acute risk on the unit is low. **6** We will continue lithium 600 milligrams twice daily, which puts him at the low end of the therapeutic range, and olanzapine 15 milligrams at bedtime. He will keep attending groups, and we will hold a family meeting tomorrow before he steps down.

Ward pearls

- Never confuse mood and affect. Mood is subjective, in the patient's words and in quotation marks ("depressed"). Affect is what you observe ("constricted, dysphoric, mood-congruent").
- Always say whether suicidal ideation is passive ("I wish I wouldn't wake up") or active, with intent, a plan, or access to means.
- Check and report the QTc before you start or increase an antipsychotic or citalopram.
- Report sleep hours and meal intake every morning. They are the most objective vital signs in inpatient psychiatry.

Classic pimp questions

- Neuroleptic malignant syndrome versus serotonin syndrome: lead-pipe rigidity versus clonus and hyperreflexia
- The timeline of extrapyramidal symptoms: acute dystonia, akathisia, parkinsonism, tardive dyskinesia
- Clozapine monitoring: the ANC for severe neutropenia, myocarditis, and seizures
- DSM-5 duration criteria: a major depressive episode 2 weeks, mania 1 week, hypomania 4 days, schizophrenia 6 months

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The full guide: roundsmedical.com/resources/psychiatry-oral-presentation

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Neurology

Localization first, for inpatient and stroke rounds

3 to 5 minutes on
inpatient rounds, under
a minute in a stroke alert

What your attending listens for

Neurology attendings want localization first: where the lesion is and which findings put it there. Give the exam in the same order every time, and for a possible stroke, last known well and the NIHSS.

The structure

- 1 One-liner with tempo**
Age, sex, handedness, risk factors, and the deficit with its tempo: sudden suggests stroke or seizure, days to weeks inflammation, infection or a mass, months degeneration.
- 2 History and overnight**
For stroke, last known well to the minute and any thrombolysis or thrombectomy. How the deficit evolved, antithrombotics, and on follow-up, overnight neuro checks.
- 3 The exam, in a fixed order**
Blood pressure and glucose; for stroke, the NIHSS and what scored. Then mental status, cranial nerves, motor (0 to 5 by muscle), sensation, reflexes (0 to 4+) and plantar responses, coordination, gait.
- 4 Imaging and studies**
What the CT, CTA or MRI shows and where, then telemetry, echo, EEG or lumbar puncture.
- 5 Localization, then the cause**
The level (cortex, subcortex, brainstem, cord, root, nerve, neuromuscular junction or muscle) and the findings that put it there, then the likely cause and the differential.
- 6 Plan**
Acute treatment, remaining workup, secondary prevention, a swallow screen before anything by mouth after a stroke, therapies, disposition.

Word-for-word example

Stroke service rounds, the morning after a stroke alert. Fictional patient. Each number marks the step it covers.

1 Ms. Rivera is a 71-year-old right-handed woman with hypertension and type 2 diabetes, admitted for sudden aphasia and right arm weakness treated with tenecteplase. **2** Last known well was 5:10 p.m. yesterday; at 5:40 her husband found her unable to get words out, dropping things from her right hand. No anticoagulant. Tenecteplase at 6:35, 85 minutes after last known well. Neuro checks stable overnight. **3** Blood pressure 152/84, glucose 164. NIHSS 3, down from 7: 1 each for aphasia, facial droop and arm drift. Alert, nonfluent, with poor naming and intact comprehension. Right lower facial droop sparing the forehead. Right arm drift with 4 out of 5 triceps and finger extensors; legs full strength. Sensation intact. Reflexes 2+ and symmetric, right toe upgoing. No ataxia; gait deferred. **4** CT showed no hemorrhage; CTA, no large vessel occlusion or carotid stenosis. A1c 7.6%, LDL 138. Sinus rhythm on telemetry; MRI and echo pending. **5** Nonfluent aphasia with right face and arm weakness sparing the leg, and an upgoing toe, localizes to the left frontal lobe, superior division of the left MCA. A cortical stroke without large vessel disease suggests an embolus, so we are looking for atrial fibrillation. **6** If her 24-hour scan at 6:35 tonight shows no hemorrhage, we start aspirin. Atorvastatin 80 milligrams today, blood pressure under 180/105 until then, and telemetry, with a 30-day monitor if no atrial fibrillation shows up. She passed her swallow screen; speech, PT and OT today.

Ward pearls

- Report last known well, not when symptoms were found. For a deficit found on waking, it is the last time anyone saw the patient normal.
- Grade strength by muscle (0 to 5) and reflexes (0 to 4+), with plantar responses. "Weak on the right" localizes nothing.
- In Guillain-Barré syndrome or myasthenic crisis, report the vital capacity and negative inspiratory force; oxygen saturation falls late.

Classic pimp questions

- Upper versus lower motor neuron signs, and where each puts the lesion
- Stroke syndromes by artery (MCA, ACA, PCA) and the lacunar syndromes
- Thrombolysis within 4.5 hours and its contraindications; who gets thrombectomy, up to 24 hours
- Status epilepticus: a benzodiazepine at 5 minutes, then levetiracetam, fosphenytoin or valproate

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The full guide: roundsmedical.com/resources/neurology-oral-presentation

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Family medicine

The outpatient SOAP visit, presented between patients

Target

2 to 3 minutes to your
preceptor, between visits

What your attending listens for

Family medicine preceptors are seeing their own patients while they listen to you. They want why the patient came in today, the few findings that matter for each problem, and a plan you commit to, including what the patient wants when there is a real choice. Then the preventive care that is due, and the follow-up.

The structure

- 1 One-liner and agenda**
Age, sex, relevant chronic conditions, and why the patient came in. If they brought several concerns, say which you agreed to address today.
- 2 Subjective, by problem**
For each problem: symptoms, home readings, adherence and side effects, and pertinent positives and negatives. Only the history that bears on today.
- 3 Objective**
Vitals with BMI (repeat a high blood pressure), a focused exam, and results since the last visit, such as a point-of-care A1c, a BMP or the urine albumin-to-creatinine ratio.
- 4 Assessment and plan, with shared decisions**
For each problem: at goal or not, why, and the change you would make. When there is a real choice, name the options you discussed and what the patient prefers.
- 5 Preventive care due**
The screenings and vaccines due for age and risk, and what the patient accepted or declined. Keep it to a line at a visit for an acute problem.
- 6 Follow-up and return precautions**
When to come back and what to check before then, and the symptoms that should bring the patient in sooner.

Word-for-word example

Clinic, presenting to the preceptor between visits. Fictional patient. Each number marks the step it covers.

1 Mr. Brooks is a 56-year-old man with type 2 diabetes and hypertension, here for a 3-month diabetes follow-up. He also raised knee pain; we agreed to book a separate visit for it. **2** Home fasting sugars run 150 to 180, with no lows. He takes metformin 1,000 milligrams twice daily, missing about one dose a week, plus lisinopril and atorvastatin. No polyuria, foot numbness or vision changes. Home blood pressures average 124/78. He has gained 6 pounds and wants help losing weight. **3** Blood pressure 128/78, BMI 33. Normal monofilament exam, 2+ pedal pulses, no foot ulcers. A1c today is 8.4%, up from 7.6% in July, when his eGFR was 88 and urine albumin-to-creatinine ratio 12. **4** #1, type 2 diabetes, above his goal of under 7% on metformin. We discussed a weekly GLP-1 receptor agonist injection, which also helps with weight, or a daily SGLT2 inhibitor pill; he prefers the injection. With no personal or family history of medullary thyroid cancer or MEN2, I would start semaglutide 0.25 milligrams weekly, increasing every 4 weeks as tolerated. #2, hypertension, at goal. **5** He has never had colon cancer screening and chose a FIT kit over colonoscopy. He wants his flu shot and first shingles vaccine dose today, and needs a diabetic eye exam. **6** Follow-up in 3 months with an A1c, sooner for severe abdominal pain or vomiting that keeps him from drinking.

Ward pearls

- Commit to an assessment and a plan before you are asked. Many preceptors teach with the one-minute preceptor model, which starts there.
- Say what the patient wants: "he prefers a pill" or "she wants 3 months of diet and exercise first" is part of the plan.
- Ask about adherence and cost before adding a drug. Missed doses and unaffordable refills explain many numbers above goal.
- Check what preventive care is due before you walk in, so you can offer it in the room.

Classic pimp questions

- Colorectal cancer screening from age 45: colonoscopy every 10 years, FIT every year, or stool DNA-FIT every 1 to 3 years
- The USPSTF lung cancer screening criteria: age 50 to 80, 20 pack-years, and smoking now or quit within the past 15 years
- Type 2 diabetes: who needs a GLP-1 receptor agonist or SGLT2 inhibitor whatever the A1c (ASCVD, heart failure, CKD)
- Hypertension: confirming it outside the office, the goal of under 130/80, and the first-line drug classes

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Emergency medicine

The 90-second ED presentation, worst first

Target

60 to 90 seconds, leading with sick or not sick

What your attending listens for

ED attendings are juggling a full board. Don't tell the story in order from 2018. Lead with the chief complaint, the abnormal vitals and the can't-miss differential, then say exactly what you want to order and where you think the patient is going.

The structure

- 1 Room, acuity and one-liner**
The room, who the patient is, the chief complaint and how long, and whether the patient looks sick or well.
- 2 Focused HPI and red flags**
OPQRST of the main symptom, plus the pertinent positives and negatives that rule the deadly diagnoses in or out: radiation to the back, pleuritic pain, syncope, focal deficits.
- 3 Vitals and high-yield exam**
Every abnormal vital sign, then only the exam findings that rule emergencies in or out: equal pulses in both arms, clear lungs, no peritoneal signs.
- 4 Worst-first differential**
Never lead with reflux or musculoskeletal pain. Name the life threats you are ruling out: ACS, PE, aortic dissection, esophageal rupture.
- 5 Plan and disposition**
Bedside now (ECG, point-of-care ultrasound, IV, oxygen, monitor), labs and imaging (troponin, D-dimer, CT angiography), symptom control, and the expected disposition: admit, or discharge if the workup is negative.

Word-for-word example

Presenting to the ED attending at the workstation. Fictional patient. Each number marks the step it covers.

1 Dr. Lee, Room 12 is a 48-year-old woman with a prior DVT, off anticoagulation, with sudden pleuritic right-sided chest pain and shortness of breath for 3 hours. She looks uncomfortable, and she is tachycardic and hypoxic. **2** The pain is sharp, 7 out of 10. No hemoptysis and no recent surgery, but she flew 8 hours from London two days ago. **3** Heart rate is 114, she is satting 91% on room air, blood pressure is 126/80, and she is afebrile. Her heart is tachycardic but regular, her lungs are clear, and her right calf is mildly swollen and tender. **4** My top concern is pulmonary embolism, with ACS and pneumothorax next. Her Wells score is 9, so PE is likely. **5** I'd like a stat ECG, 2 liters of oxygen, a CBC, BMP, troponin and BNP, and to go straight to a CT pulmonary angiogram without a D-dimer. Unless you see a bleeding risk, I'd start heparin now rather than wait for the scan, and admit her to medicine if the CT is positive.

Ward pearls

- Say whether the patient looks sick or well in your first sentence, so the attending knows whether to walk into the room right now.
- Use decision rules out loud (HEART, Wells, PERC, NEXUS, Canadian C-spine, Ottawa ankle) to justify ordering an image, or skipping one.
- Finish with a conditional disposition: "If his repeat troponin at 3 hours is negative, he can go home with cardiology follow-up."

Classic pimp questions

- The HEART score for chest pain: history, ECG, age, risk factors, troponin
- PERC versus Wells for pulmonary embolism
- NEXUS versus the Canadian C-spine rule for imaging after trauma
- STEMI equivalents and high-risk ECG patterns: Wellens, de Winter T waves, Sgarbossa criteria in LBBB, posterior MI

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