Clinicopathologic Conference

Overview

Clinicopathologic Conferences (CPCs) are presented by each PGY3 to the department. This tradition started in September 1996. The objectives of CPC's are:

1) to provide PGY3s with an opportunity to analyze an unknown case by
    a. formulate a differential diagnosis
    b. demonstrate diagnostic medical-decision making skills
    c. present a cogent discussion to the entire department
2) to demonstrate pathologic and/or laboratory correlation to the clinical aspects of diseases affecting neonates, children, and adolescents.

The focus is on the diagnostic decision process rather than the outcome. Expected that less than 80% of residents will determine the correct diagnosis, yet 100% of residents should have the correct diagnosis in the top 3 of their differential.

There are 4 people involved in a CPC: the Chief Resident, the Faculty member, the resident, and the Pathologic/Laboratory Correlation Speaker.

Responsibilities

1. The **Chief Resident**, once selected as a PGY3, will coordinate the CPC schedule for the following year. The CR will solicit faculty members and ensure a diverse representation of cases and specialties, to include general primary care pediatrics. Residents may express a desire of the types of CPC cases but there should be no expectation of the specialty or field relevant to the case, just as it is in general practice when a patient presents.

2. The **assigned faculty member** will provide the scheduled PGY-3 with a case summary 1-2 months in advance of their presentation date. An emphasis should be placed on choosing cases for which there is pathologic/laboratory confirmatory correlation. Faculty members have been known to give the resident a copy of the very first clinical note detailing the patient's presentation after removing all patient identifiers. Case histories will include all the information that the patient or parents would be expected to provide to a general pediatrician. Faculty members should try not to hide case details that were available at the time of presentation. Likewise, faculty members should not fabricate details. To allow the resident an unbiased approach to the case, the assigned faculty member may remain anonymous and ask another faculty member from a different specialty to serve as middleman for the case.

The faculty member will contact the appropriate expert for the pathologic/laboratory correlation. Traditionally, this has been a pathologist. However, modern diagnostic techniques of imaging and genomics may be the substitution for the 'pathologic' correlation.

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The faculty member will discuss the case with the resident periodically before the scheduled CPC. The faculty member can guide the resident but should not give the 'answer' even if the resident arrives at the correct diagnosis. The resident should have at least a smidgen of doubt up until the time the pathologic/laboratory correlation occurs.

The faculty member will speak briefly to the department after the resident presentation and pathologic/laboratory correlation. The faculty member should focus on follow-up of the patient and should highlight diagnostic pitfalls that occurred in the real-life workup of the patient. The faculty member should not provide a redundant review of the diagnostic process that the resident presented.

3. The **resident** will review the case, comment as needed on the care provided to the patient, formulate a differential diagnosis, arrive at a likely diagnosis based on the information provided, and present a discussion of the case to the department. The discussion should focus on development of a differential diagnosis, the most likely disease entity, and how the diagnostic decision making process of narrowing down the differential diagnosis occurred. Residents can utilize any resources (including staff) in formulating their discussion, but should not expect staff to provide them with "the answer" to their case. The emphasis in this exercise is more on the thinking process than the answer itself.

The resident will prepare a presentation that presents the case and then outlines their diagnostic decision process. Focus should be on features of the case, epidemiology of considered diagnoses, and pertinent positives and negatives. The resident should suggest the top 3 most likely diagnoses in the differential and proffer a primary diagnosis and a confirmatory procedure or test.

The resident will provide a copy of their CPC presentation to the program coordinator after the presentation.

4. The **pathologist or laboratory correlation speaker** may be a pathologist, other specialist, or pathology resident. The speaker should prepare a presentation showing the results of the confirmatory procedure and the pathologic/laboratory diagnosis.

Logistics

CPC Format:	case presentation	5 minutes
	resident discussion	20 minutes
	pathological review	10-20 minutes
	pediatric staff discussion	15 minutes

Attendees of the CPC are eligible for CME Credit.

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