Journal. Moreover, if large Western medical journals were to begin better representing the global burden of disease in the articles they publish, researchers in smaller countries might become more interested in submitting their work to, or serving as reviewers for, these journals.

In the interim, we encourage researchers in smaller countries to continue to publish peer-reviewed studies relevant to local experience of disease in both smaller, local journals such as the *Croatian Medical Journal* and larger Western medical journals.

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Case summaries: another method

The article by Ahmed Bayoumi and Peter Kopplin[1] presents an alternative to traditional case presentations. The authors emphasize presentations that produce "logical flow," "present the most salient information early" and do not "impede effective diagnosis." I agree with this approach and present yet another option.

The usual purpose of oral "morning report" case presentations is to review data (including context) to support diagnosis and management. These data can be delineated by listing problems, beginning with the reason for admission. With each problem (e.g., pneumonia), the supporting findings from the history (e.g., cough, fever), examination (crackles) and tests (leukocytosis, infiltrate) are presented. To avoid premature conclusions before a firm diagnosis has been established, it is appropriate to present symptoms along with their differential diagnosis. For example, cough, fever and hemoptysis should be presented as symptoms until their cause is elucidated. Next, the patient's allergies and medications are reported to identify drug–drug and drug–disease interactions, unnecessary medications and deviations from established protocols. The medication and problem listings should be reconciled. A brief checklist is used to ensure that such items as "code" status, prophylaxis for pressure ulcers and deep vein thrombosis, and pneumococcal vaccination have been addressed. Key situation-dependent parameters are defined and presented, and these almost always include vital signs, weight and renal function. Finally, "experiential text" adds patient and physician perspective.

As such oral presentations are made, I transcribe them (using a laptop computer and a preformatted word-processing document, with one page for each patient) to form the basis for my faculty chart notes. Problem and medication lists for a patient remain reasonably stable and are readily updated as new information accumulates. Key parameters can be compiled in a table, where a week's worth of data are readily visible. With sections for completed and pending test results and daily narratives, an easily updated cumulative note is produced.

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1. Bayoumi AM, Kopplin PA. The storied case report. *CMAJ* 2004;171(6):569-70.

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[The authors respond:]

Gary Fox describes a systematic and thorough method for recording clinical data in an electronic form. His system is concordant with our approach[1] of grouping together logically linked information to "tell a story." We are heartened that he also includes space for experiential text as an essential component of the case history.