

SOAP Case Study - Dermatological Condition - Eczema

Experiment 15 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional dermatological condition - eczema case.

Principle

SOAP separates subjective history (S), objective information (O), assessment (A) and plan (P). A pharmacy case report links medicine-related problems, authorised actions, monitoring and counselling.

Fictional Case and SOAP Guide

Section	Model teaching content
S - history	A fictional adult has an established eczema diagnosis and asks about applying the prescribed topical products.
O - supplied findings	Teaching photographs show a noninfected flare; product potency, site and directions need confirmation.
A - assessment	Review trigger exposure and correct use; distinguish a routine flare from infection or other concerning disease.
P - professional plan	Confirm the clinician's emollient and anti-inflammatory plan for the exact site and product; demonstrate suitable application.

Counselling and Monitoring

Counselling

Explain regular moisturising, gentle skin care and product-specific quantities/duration.

Monitoring

Skin response, correct use and signs of infection or adverse effects.

Urgent Review

Rapid spread, severe pain, fever, extensive blistering or eye-area concerns.

Key Points

- All case details below are hypothetical teaching data.
- Separate known information from missing information that must be confirmed.
- Prioritise urgent problems before routine medicine optimisation.
- The plan documents professional review; it does not issue a new prescription.

Pharmacotherapeutics

Practice Scenario

Original fictional case for discussion only.

Activity Procedure

1. Extract S and O

Read the history and report; identify missing symptoms, medicines, allergies and patient factors.

2. Assess

List the main problem, possible medicine-related issue and supporting evidence.

3. Prioritise

Check emergency/referral needs before routine counselling.

4. Plan

State the authorised review, counselling and monitoring steps.

5. Write

Complete the blank SOAP record and a concise handover using the model guide.

Record and Observations

SOAP field	Student record
S - subjective history	_____
O - objective information	_____
A - assessment / priorities	_____
P - actions / review	_____
Monitoring / follow-up	_____

Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

Precautions

- Do not represent the case as a real patient record.
- Do not invent missing test results or medication doses.

Viva Questions and Answers

1. What belongs in S?

The person's reported symptoms, concerns and relevant history.

2. What belongs in O?

Measured or documented findings such as examination and laboratory reports.

3. What makes a plan useful?

A clear action, responsible professional, monitoring and review timing.

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