MINI-OSCE

MACLEOD

GENERAL

EXAMINATION

Add a heading

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لجنة الطب والجراحة

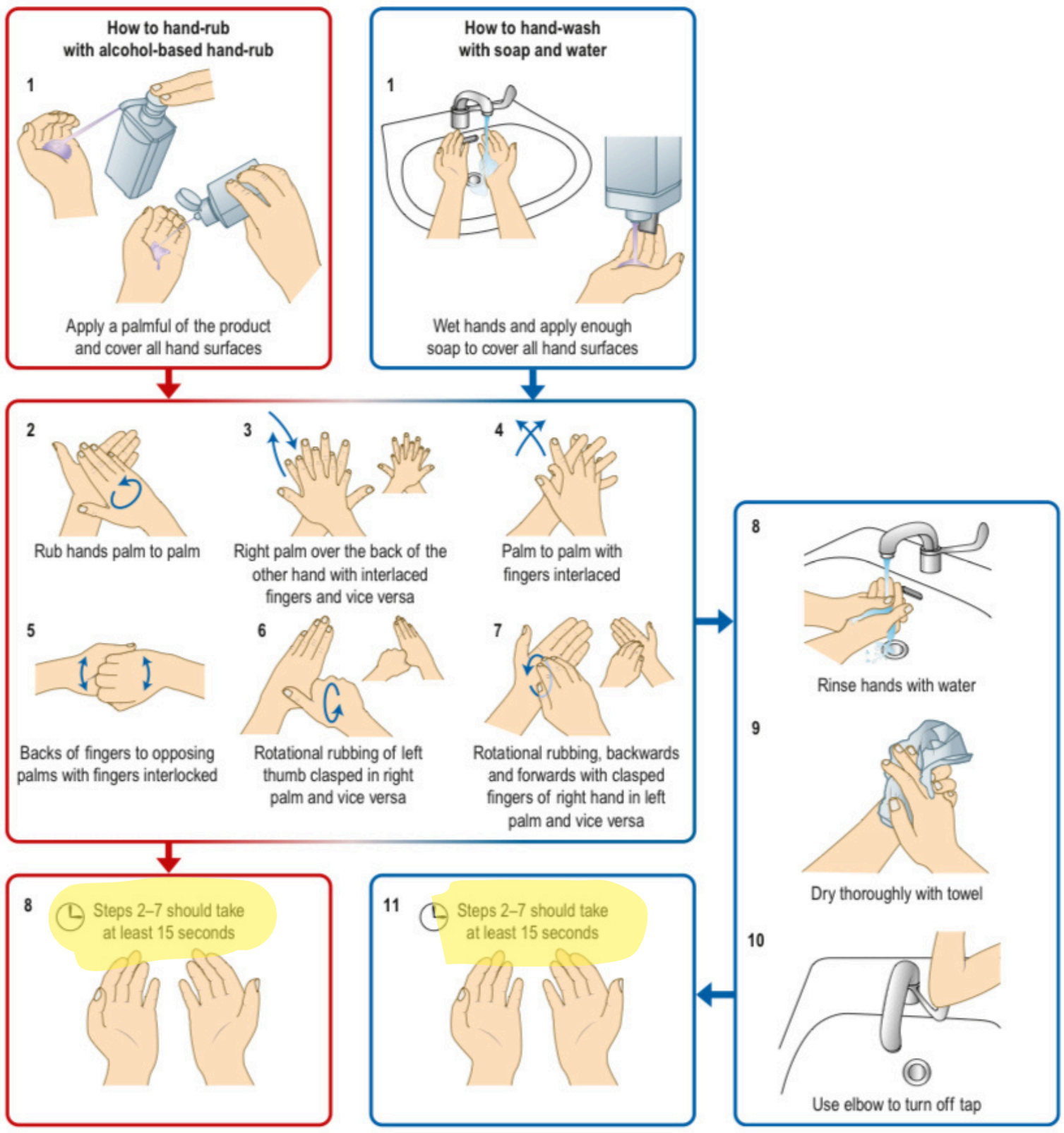


Fig. 3.1 Techniques for hand hygiene. *From WHO Guidelines on Hand Hygiene in Health Care First Global Patient Safety Challenge Clean Care is Safer Care; http://www.who.int/gpsc/clean_hands_protection/en/ © World Health Organization 2009. All rights reserved.*

Fig. 3.2 Tattoos can be revealing.

Fig. 3.3 The linear marks of intravenous injection at the right antecubital fossa. WWW.BOOKBAZ.IR

Scars from deliberate self-harm (cutting).

Fig. 3.5 Dupuytren's contracture.

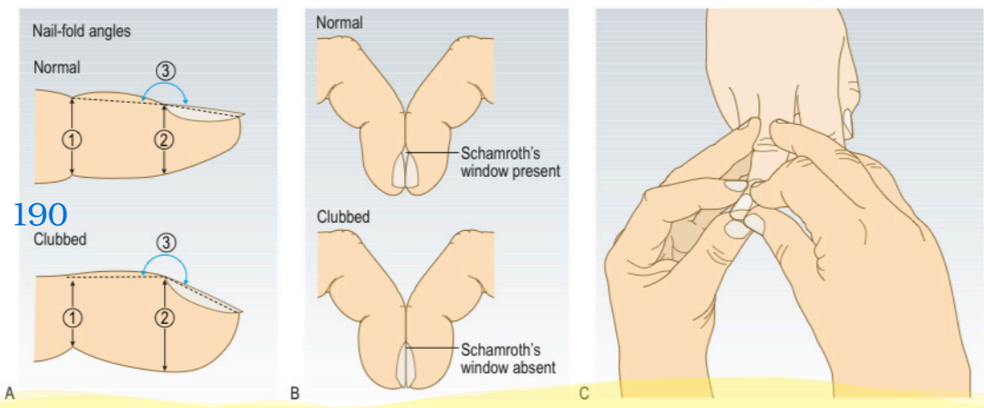
Normal palms. African (*left*) and European (*right*).

A B C D

Fig. 3.7 Nail abnormalities in systemic disease. A Onycholysis with pitting in psoriasis. B Beau's lines seen after acute severe illness. C Leuconychia. D Koilonychia. *(A) From Innes JA. Davidson's Essentials of Medicine. 2nd ed. Edinburgh: Churchill Livingstone; 2016.*

A B

Fig. 3.8 Clubbing. A Anterior view. B Lateral view.



Angle > 190

Fig. 3.9 Examining for finger clubbing. A Assessing interphalangeal depth at (1) interphalangeal joint and (2) nail bed, and nail-bed angle (3). B Schamroth's window sign. C Assessing nail- bed fluctuation.

3.10 Vitiligo.

Autoimmune;DM,pernicious anemia ,thyroid,adrenal disorders

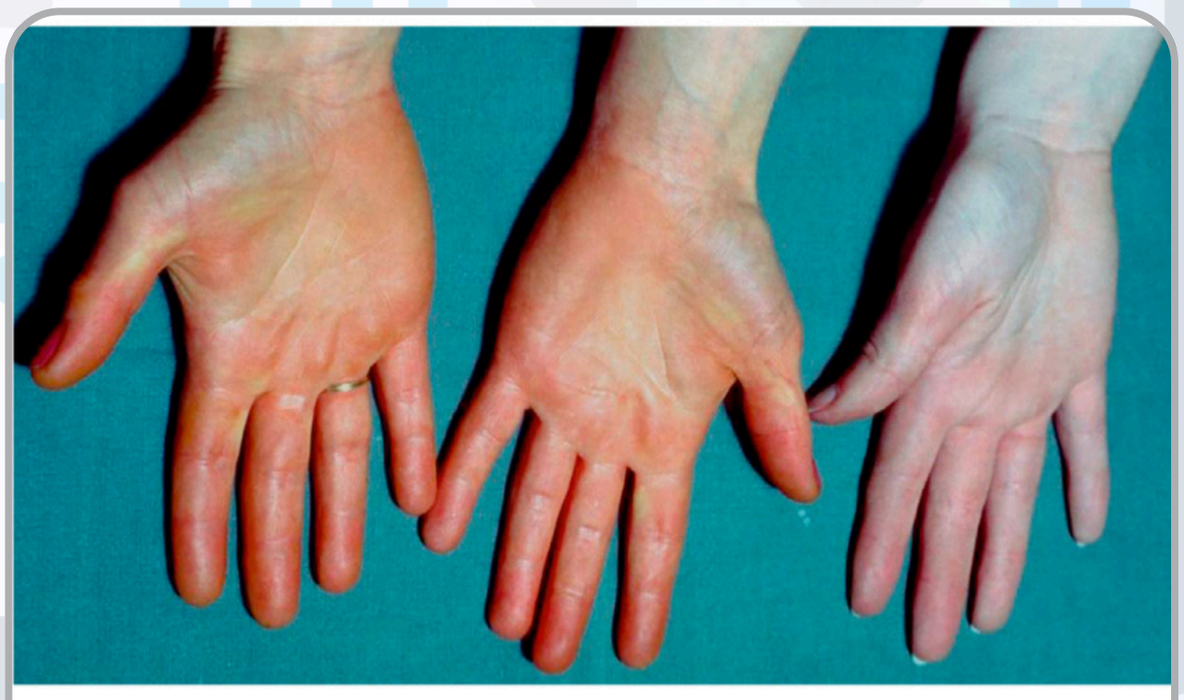
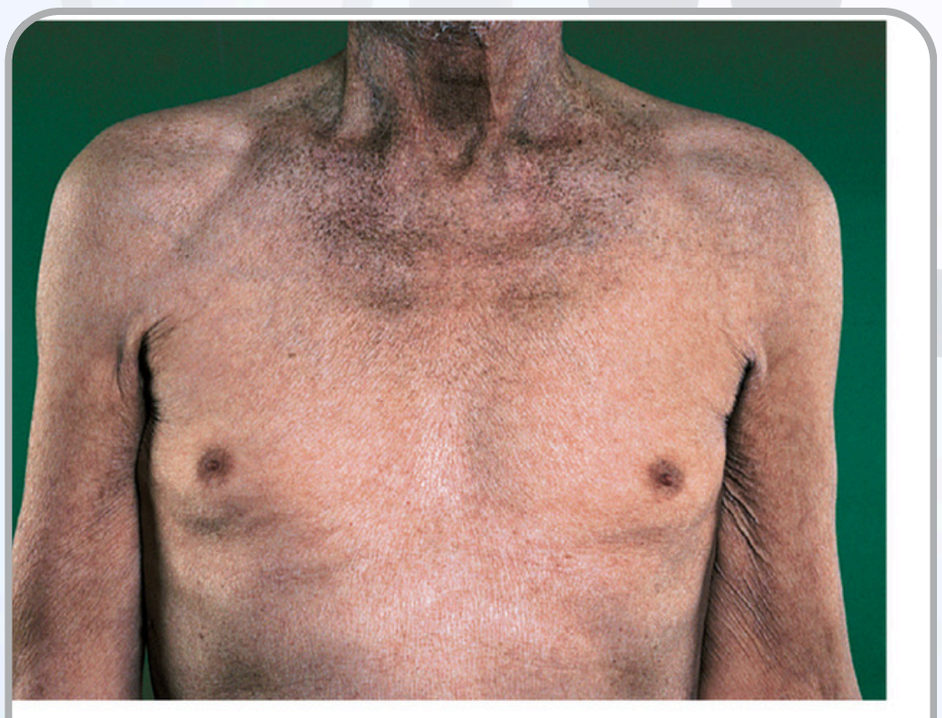


Fig. 3.13 Hypercarotenaemia. A control normal hand is shown on the right for comparison. In hypothyroidism | | not seen in sclera and conjuctiva



1 Haemochromatosis with increased skin pigmentation.

Iron absorption-when deposite in pancreas causes Bronze diabetes

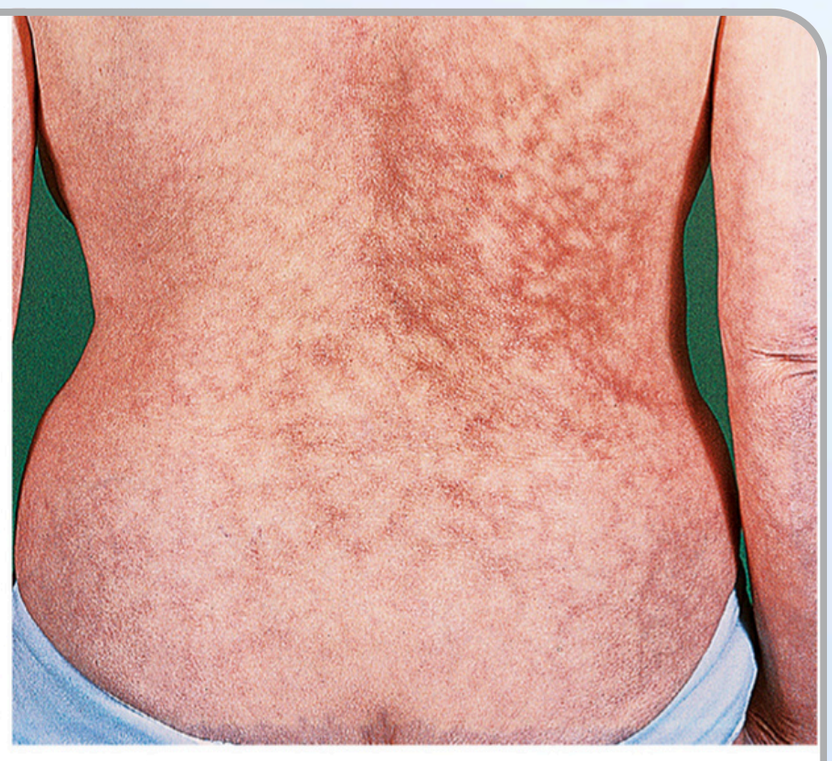


Fig. 3.12 Erythema ab igne. Or granny tartan

Fig. 3.14 Phenothiazine-induced pigmentation. Slate gray

Local deposit of haemosiderin

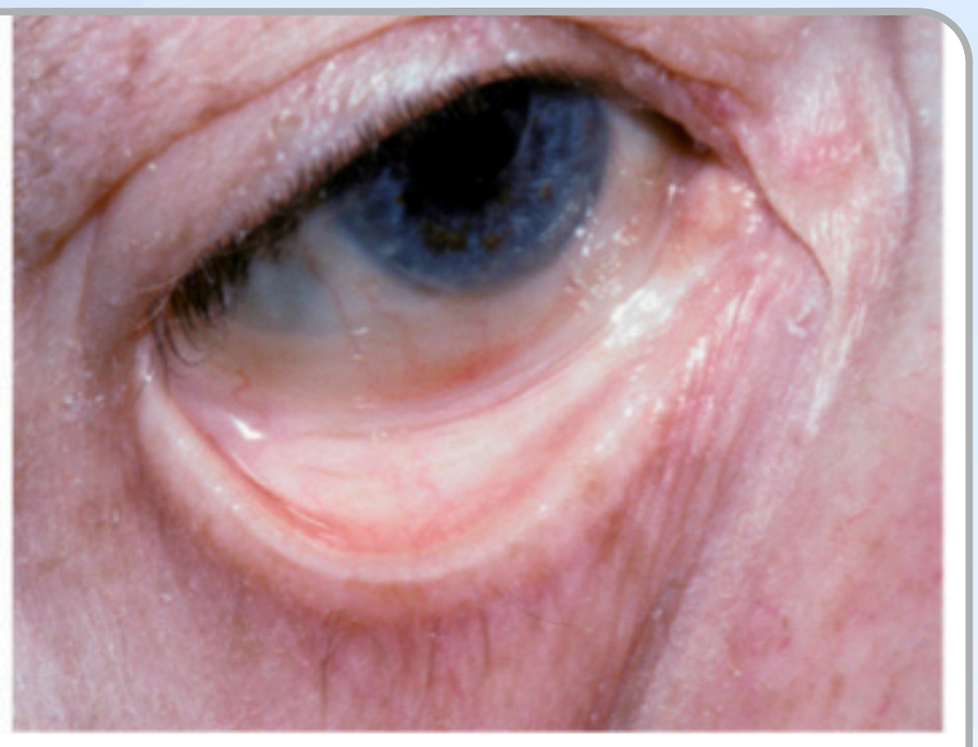


Fig. 3.15 Conjunctival pallor.

Fig. 3.16 Smooth red tongue (glossitis) and angular stomatitis of iron deficiency.

A

B

3.19 **Scurvy.** A Bleeding gums. B Bruising and perifollicular norrhages.

Decreased of vit c

A

B

Fig. 3.17 **Flushing due to carcinoid syndrome.** A Acute carcinoid flush. B Chronic telangiectasia.

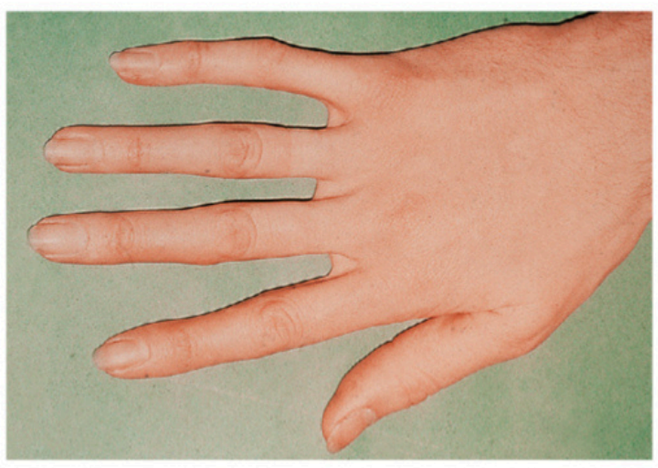
Fig. 3.20 Neurofibromatosis.

3.18 Central cyanosis of the lips.

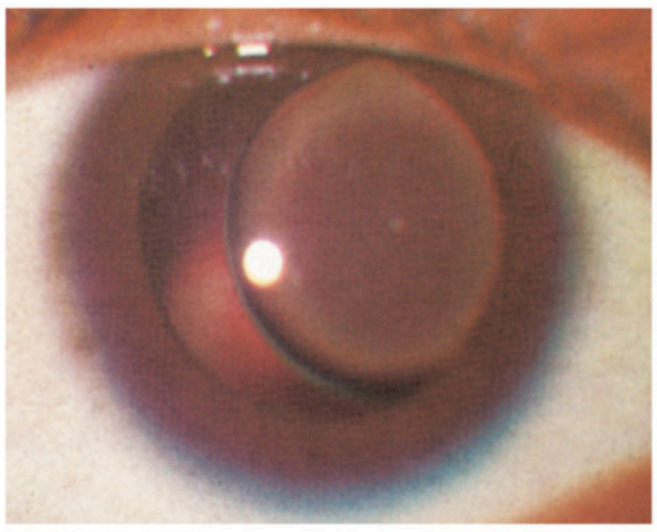
Deoxyhaemoglobin >50g/L,5g/dl

A

C



B



D

Fig. 3.21 Marfan's syndrome, an autosomal dominant condition. A Tall stature, with the torso shorter than the legs (note surgery for aortic dissection). B Long fingers. C High-arched palate. D Dislocation of the lens in the eye. *(A–D) From Forbes CD, Jackson WF. Color Atlas of Clinical Medicine. 3rd ed. Edinburgh: Mosby; 2003.*

Fig. 3.22 Swollen right leg, suggesting deep vein thrombosis or inflammation. Causes include soft tissue infection or a ruptured Baker's cyst.

Fig. 3.23 Lymphoedema of the right arm following right-sided ma tectomy and radiotherapy.

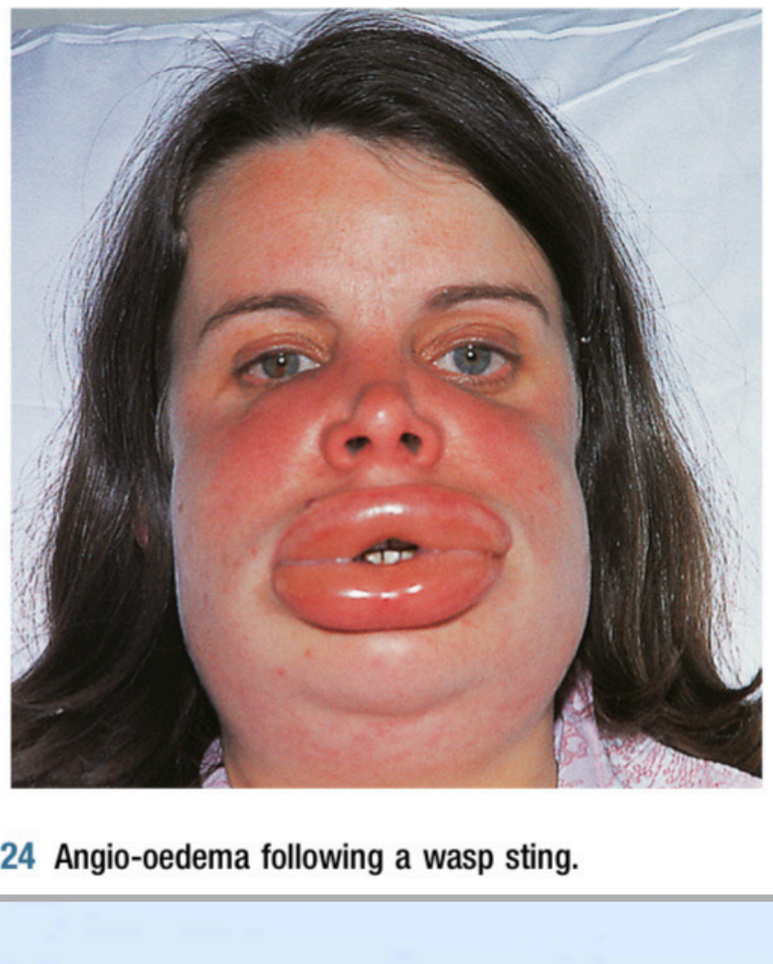


Fig. 3.24 Angio-oedema following a wasp sting.

Fig. 3.25 Blister on a leg.

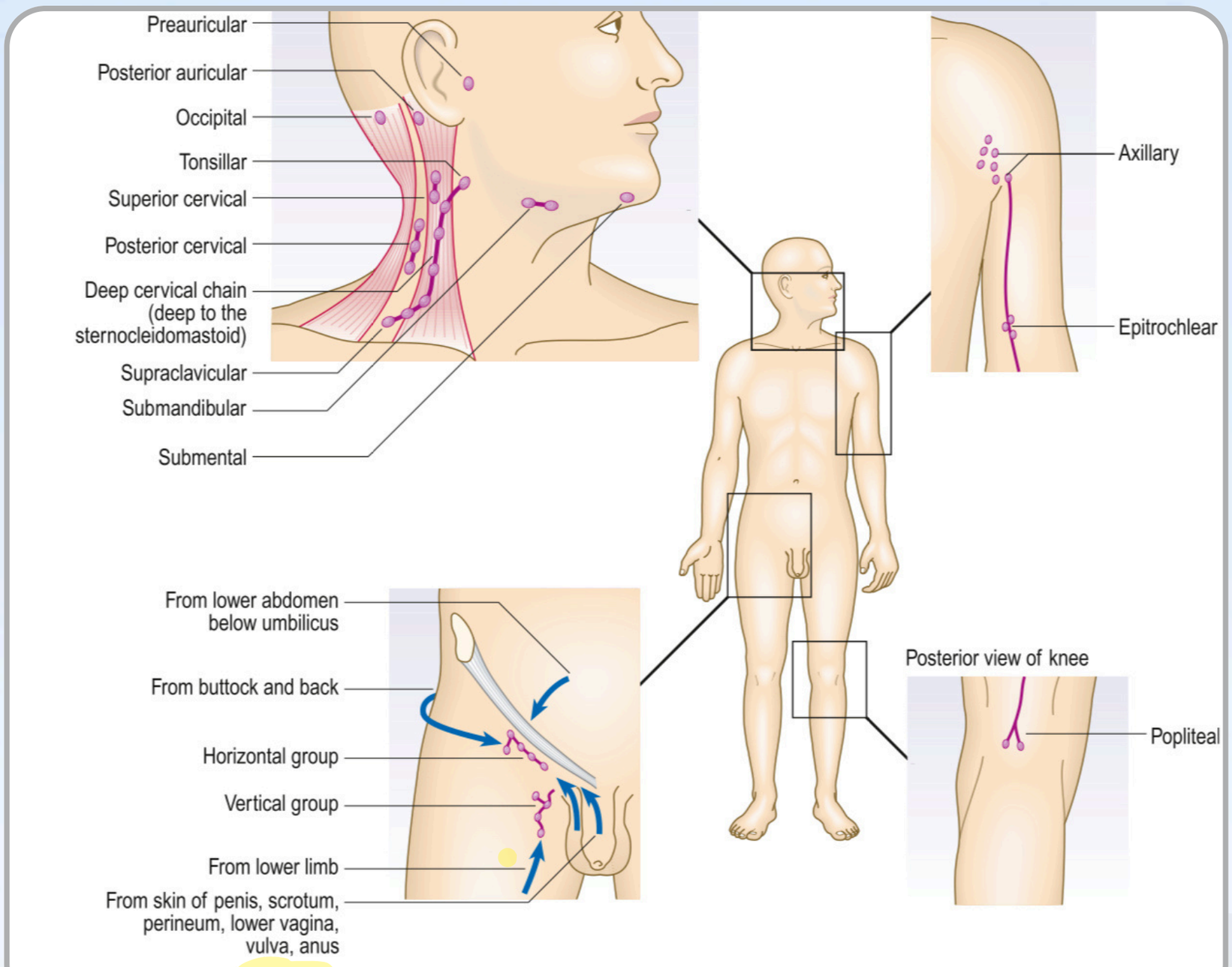


Fig. 3.26 **Distribution of palpable lymph glands.**

Fig. 3.27 **Palpation of the cervical glands.** A Examine the glands of the anterior triangle from behind, using both hands. B Examine for the scalene nodes from behind with your index finger in the angle between the sternocleidomastoid muscle and the clavicle. C Examine the glands in the posterior triangle from the front.

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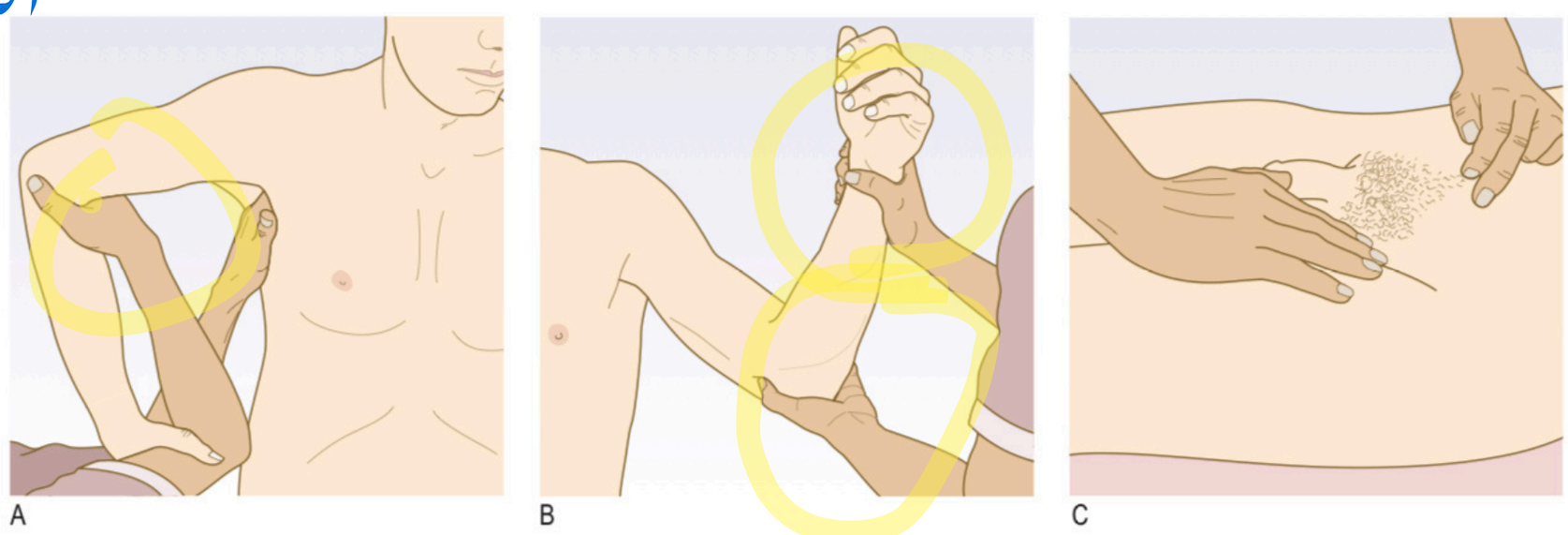


Fig. 3.28 **Palpation of the axillary, epitrochlear and inguinal glands.** A Examination for right axillary lymphadenopathy. B Examination of the left epitrochlear glands. C Examination of the left inguinal glands.

Fig. 3.29 Petechiae.

Pinpoint; haematological feature

A& B autosomal dominant

Fig. 3.30 Characteristic facial features of some disorders. A Blue sclerae of osteogenesis imperfecta. B Telangiectasia around the mouth, typical of hereditary haemorrhagic telangiectasia. C Systemic sclerosis with 'beaking' of the nose and taut skin around the mouth. D Myotonic dystrophy with frontal elding and bilateral ptosis

Trisomy 2 1-47 xx/xy+2 1

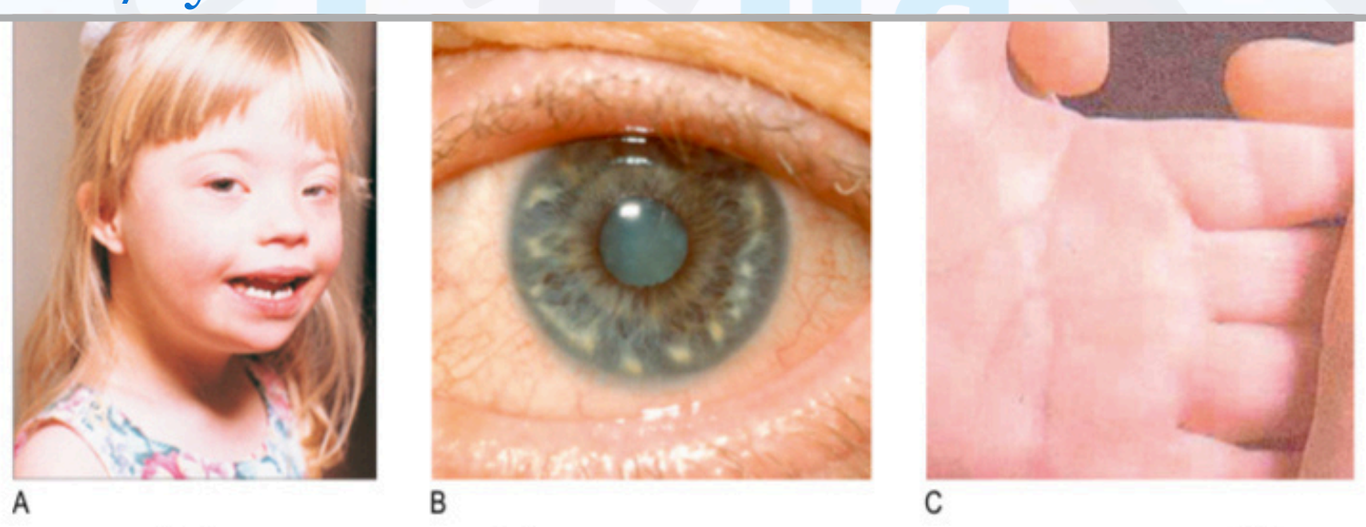


Fig. 3.31 Down's syndrome. A Typical facial appearance. B Brushfield spots: grey–white areas of depigmentation in the iris. C Single palmar crease. *(A) From Phelps K, Hassed C. Genetic conditions. In General Practice: The Integrative Approach. 1st ed. Churchill Livingstone; 2011.*

45 X0

Fig. 3.32 Turner's syndrome. *From Seidel HM, Ball J, Dain J, Benedict GW. Growth and measurement. In: Mosby's Guide to Physical Examination. 6th ed. 2006.*

Shield like chest

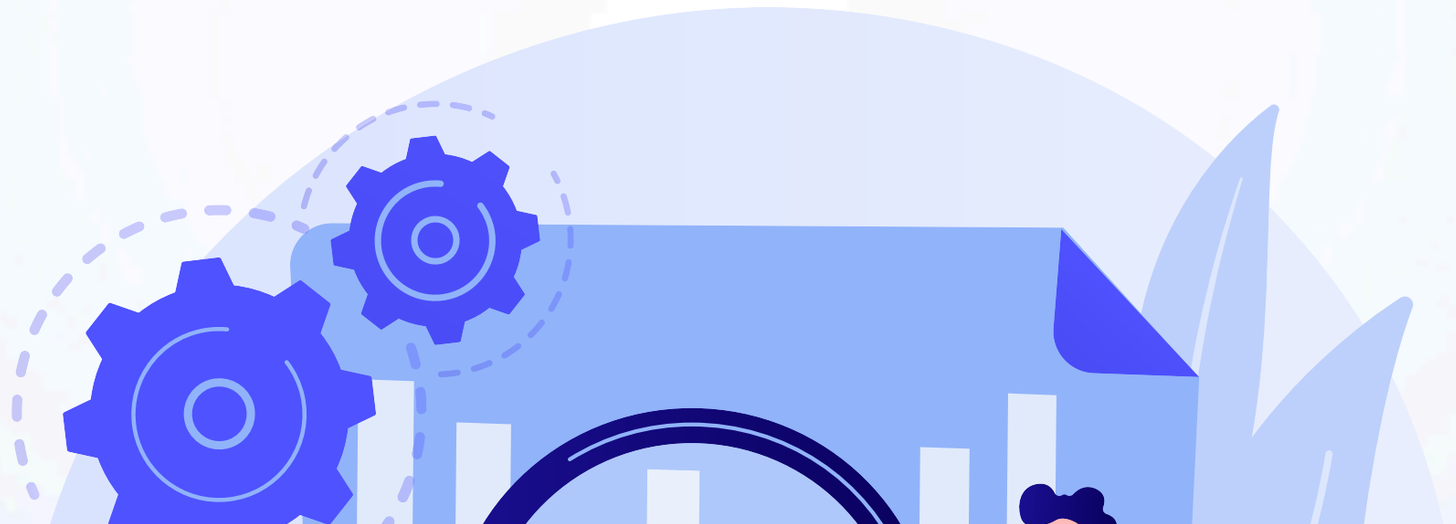
Fig. 3.33 Child with achondroplasia. *From Moore KL, Persaud TVN. Congenital anatomic anomalies or human birth defects. In: Developing Human: Clinically Oriented Embryology. 8th ed. 2008.*

Autosomal dominant of cartilage
mutation of fibroblast growth factor gene
normal trunk , very short and broad limbs
vault of skull is enlarged, the face is small and the bridge of the nose is flat

MINI-OSCE

MACLEOD

LUMPS AND ULCERS



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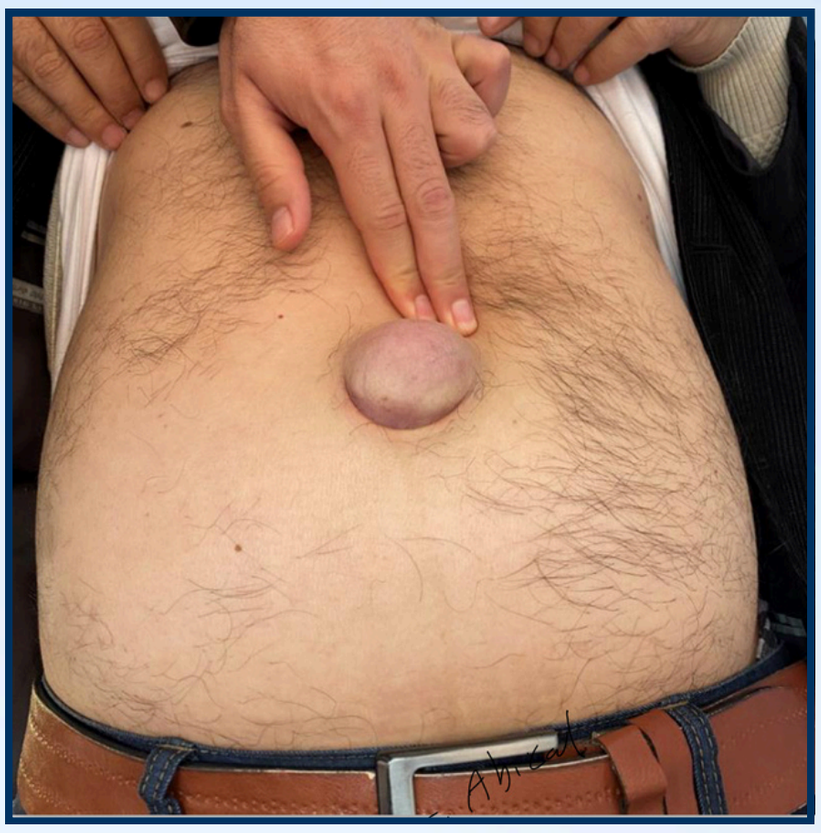
لجنة الطب والجراحة

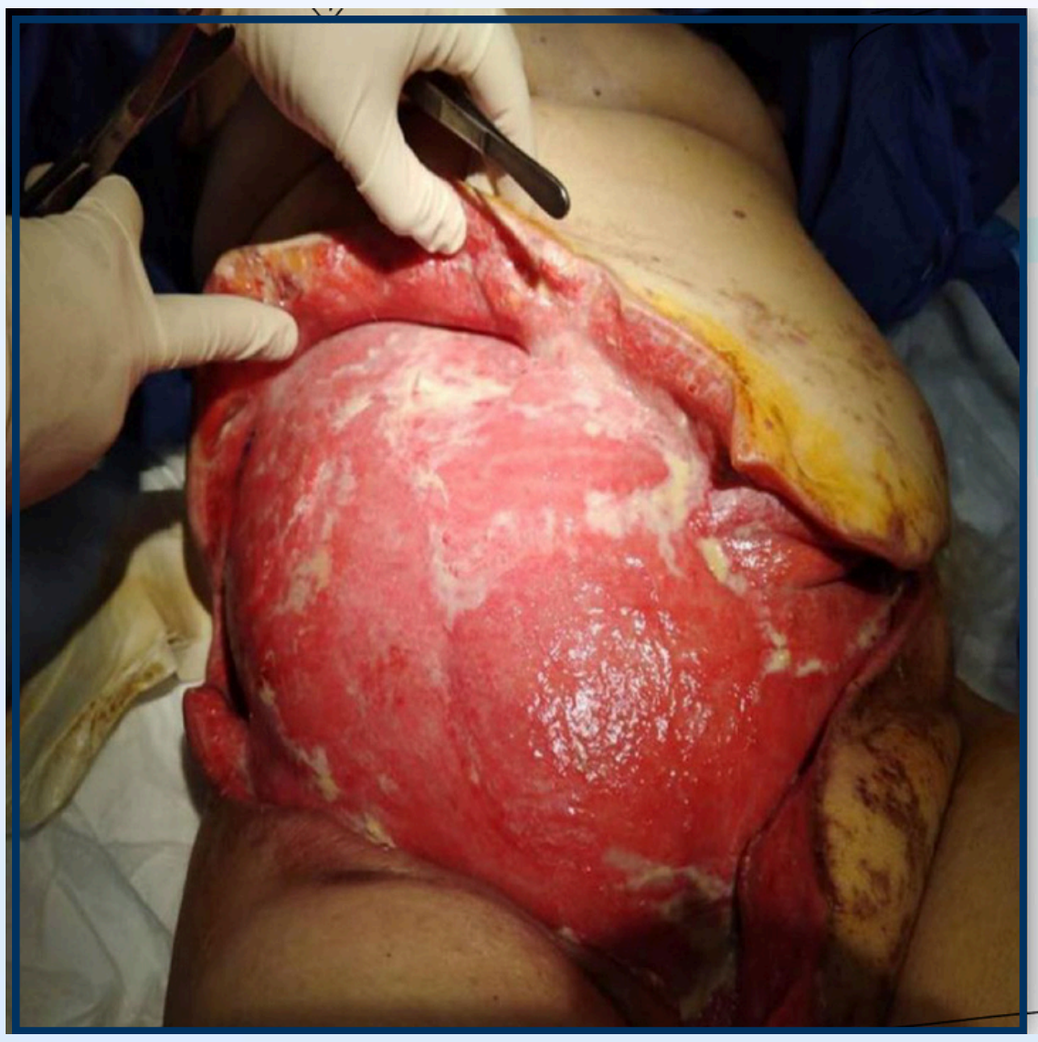


Vascular deformities

Mostly hernia

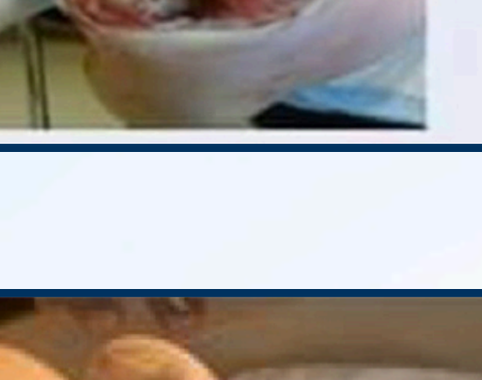
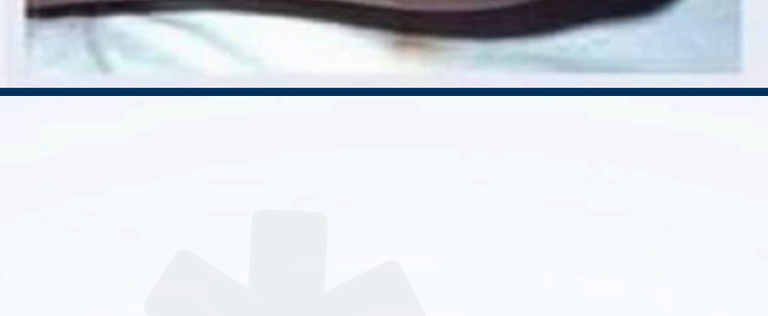
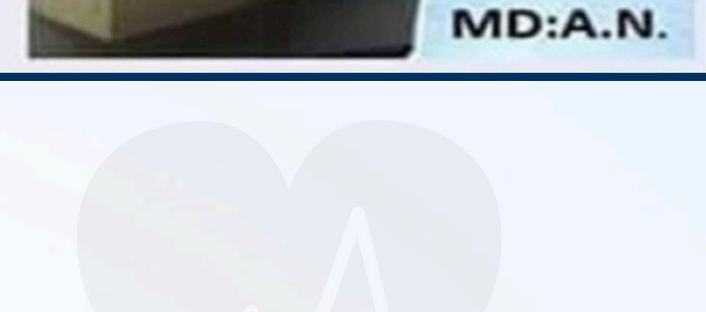
Mostly is cancer in partiod gland or lymph node

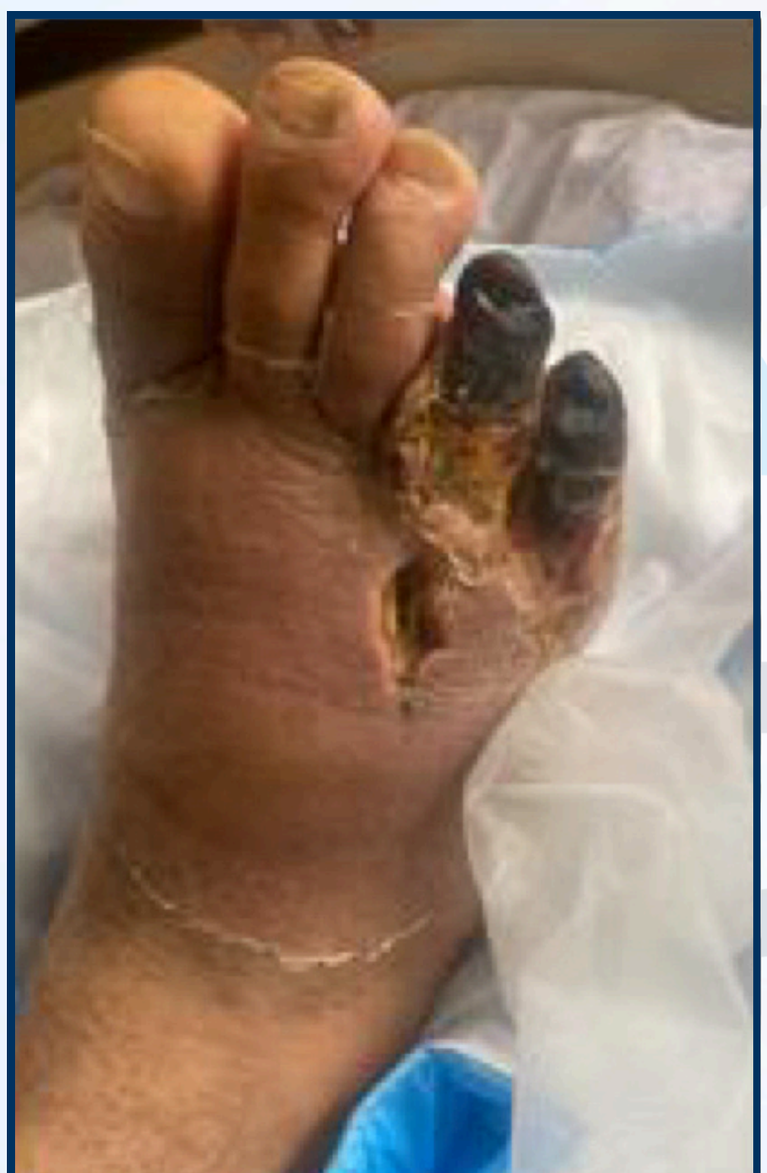
Ulcer

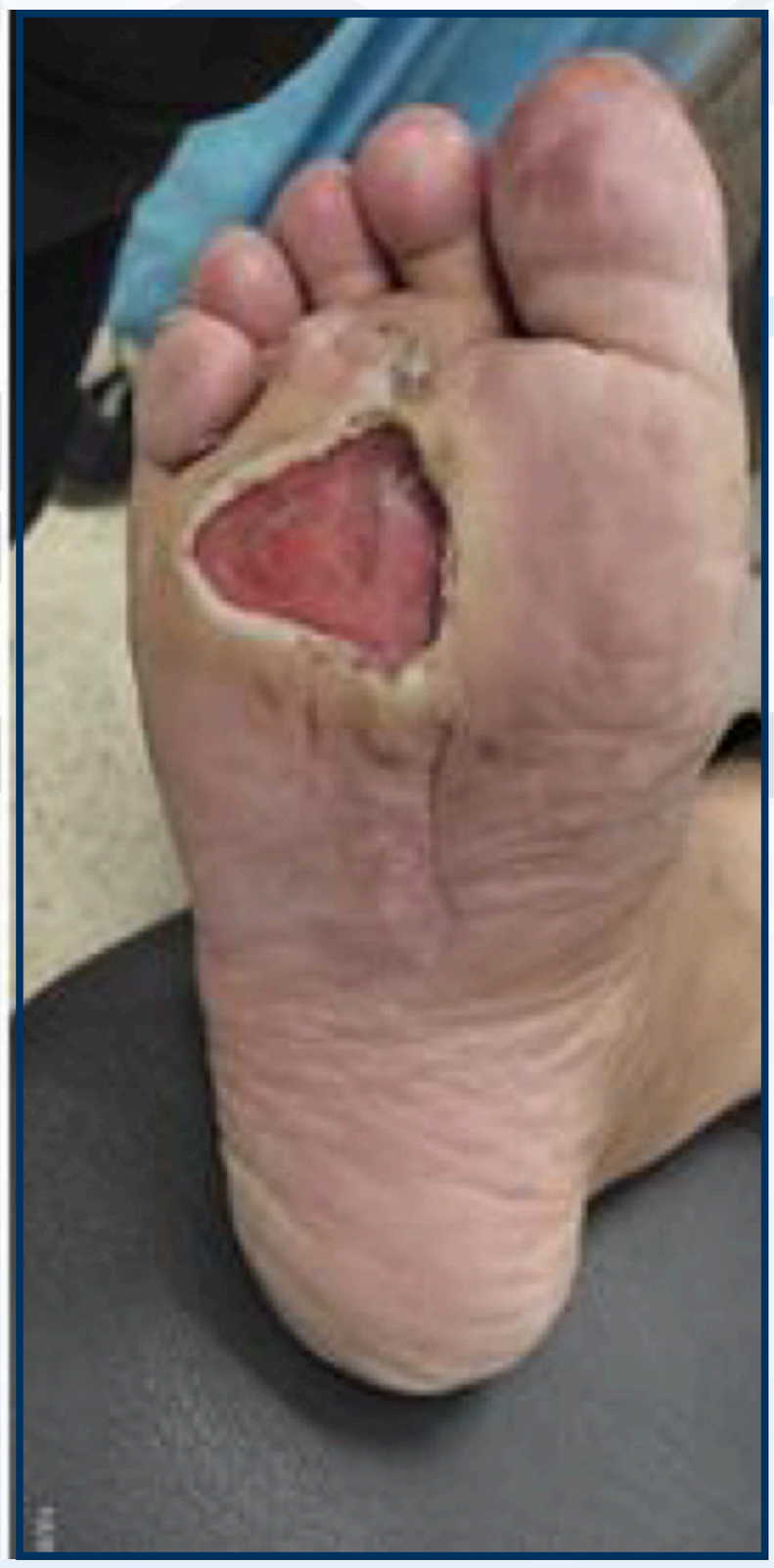


Surgery for cleaning the ulcer till find the healthy base

Wagner classification of diabetic foot ulcers

Grade 0	Grade 1	Grade 2
No ulcer in a high-risk foot	Superficial ulcer involving the full skin thickness but not underlying tissues	Deep ulcer, penetrating down to ligaments and muscle, but no bone involvement or abscess formation
		
Grade 3	**Grade 4**	**Grade 5**
Deep ulcer with cellulitis or abscess formation, often with osteomyelitis	Localized gangrene	Extensive gangrene involving the whole foot
		





ishemic ganglia with ulcer

Diabetes ulcer

Diabetes ulcer with pus discharge

Ulcer with abmputation

Ulcer

VAC-Npwt device which is used for improve the healing of ulcer

Deep ulcer
“““visible tendon”

Ulcer

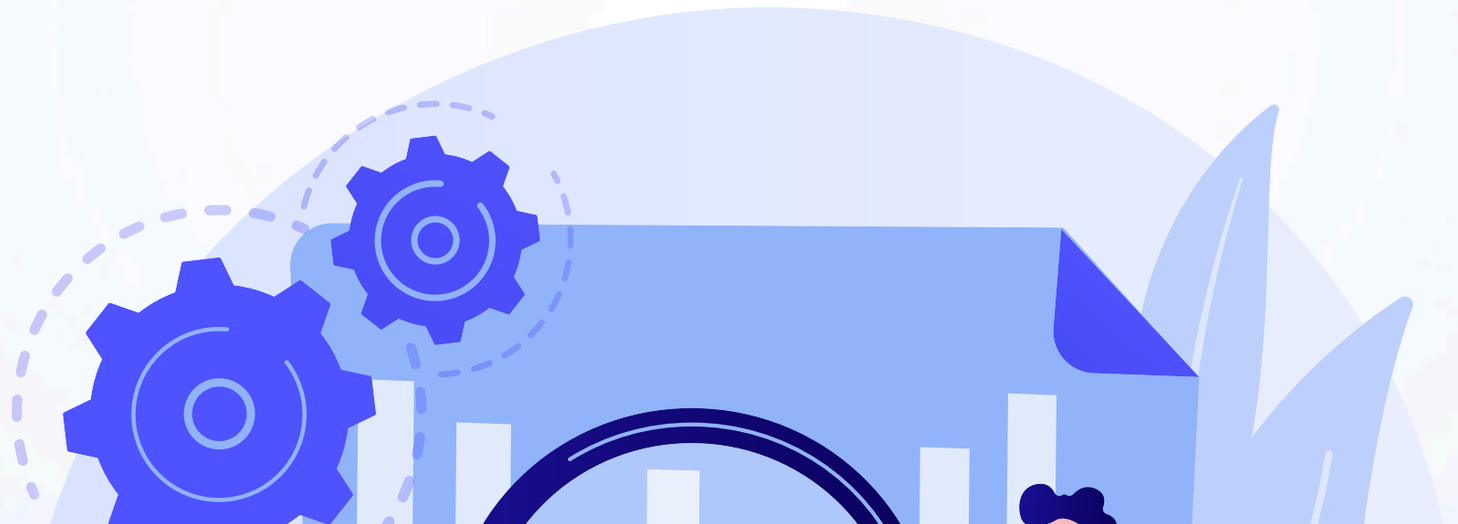
deposition. **B** Venous ulcer. *(A) From Metcalfe M,*

Fig. 10.14 Diabetic foot complications. **A** Infected foot ulcer with cellulitis and ascending lymphangitis. **B** Ischaemic foot: digital gangrene. **C** Charcot arthropathy with plantar ulcer.

MINI-OSCE

MACLEOD

THYROID



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لجنة الطب والجراحة

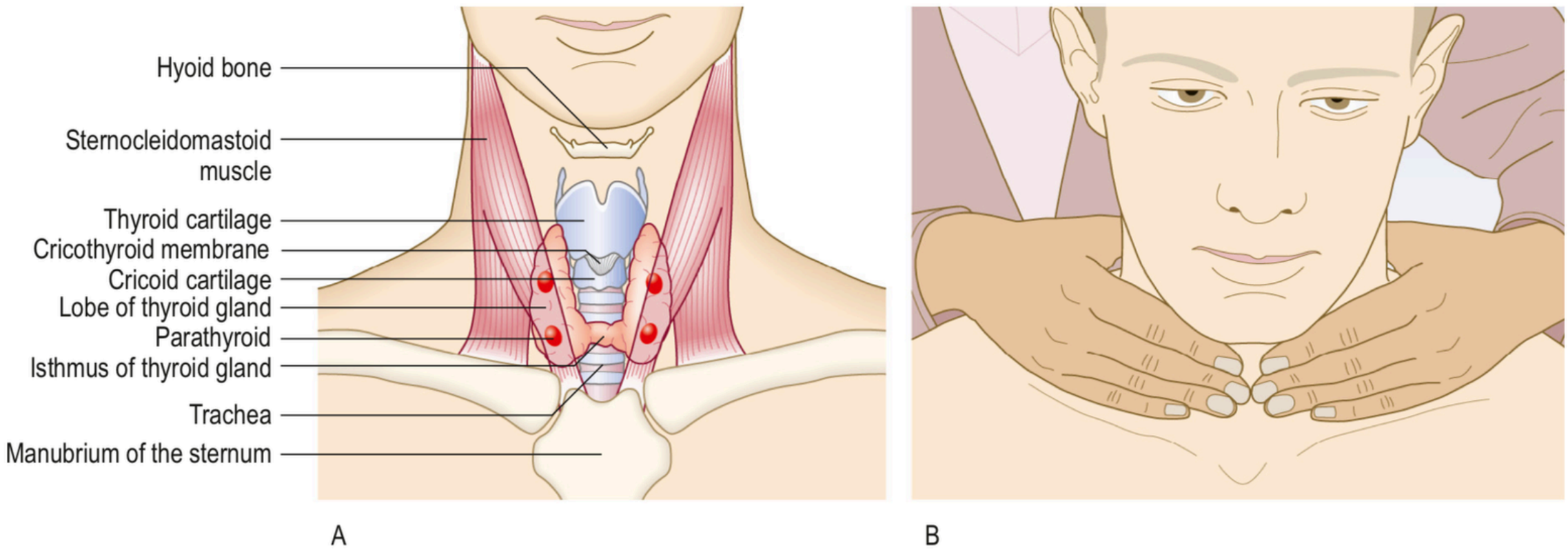
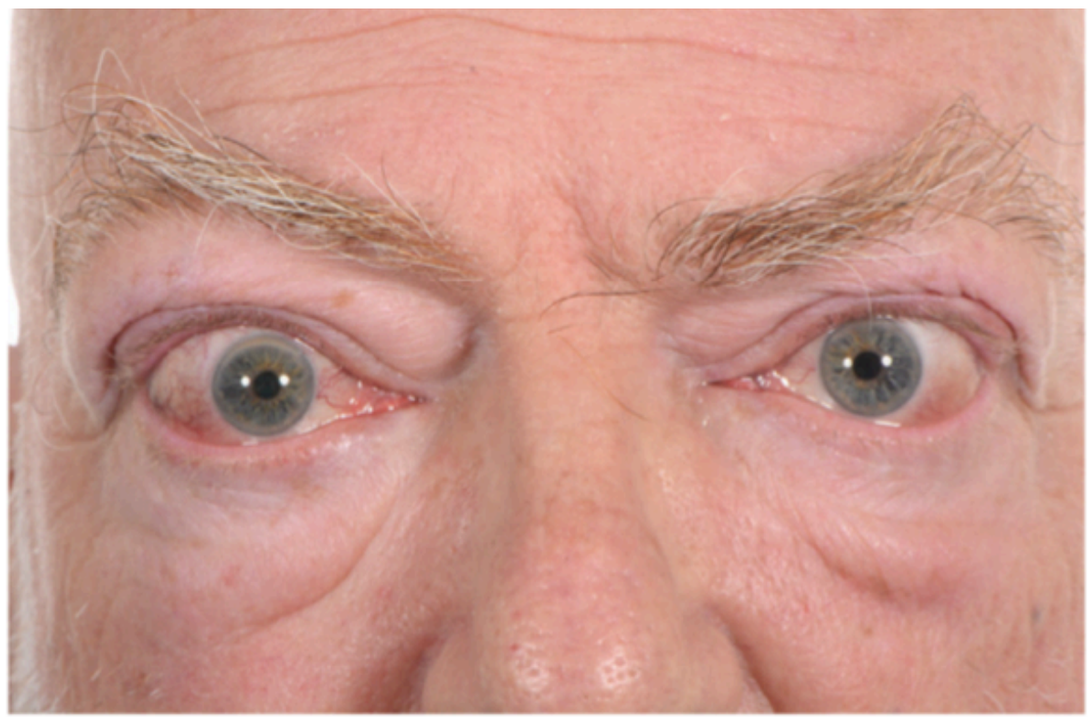


Fig. 10.1 The thyroid gland. A Anatomy of the gland and surrounding structures. B Palpating the thyroid gland from behind.


A

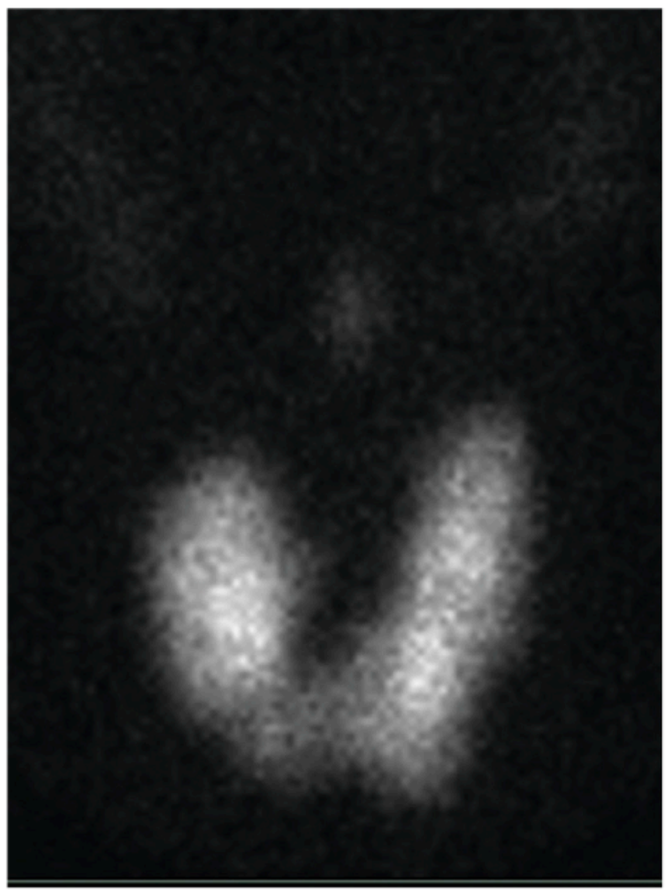

B


C


D

Fig. 10.2 Graves' hyperthyroidism. A Typical facies. B Severe inflammatory thyroid eye disease. C Thyroid acropachy. D Pretibial myxoedema. *(A) From Strachan MWJ, Newell Price JDC. Endocrinology. In Ralston S, Penman I, Strachan MWJ, et al. (eds). Davidson's Principles and Practice of Medicine. 23rd ed. Philadelphia: Elsevier; 2018.*

Thyroid enlargement



A

A)99"Technetium radionuclide scan demonstrating diffuse goitre due to Graves' disease.

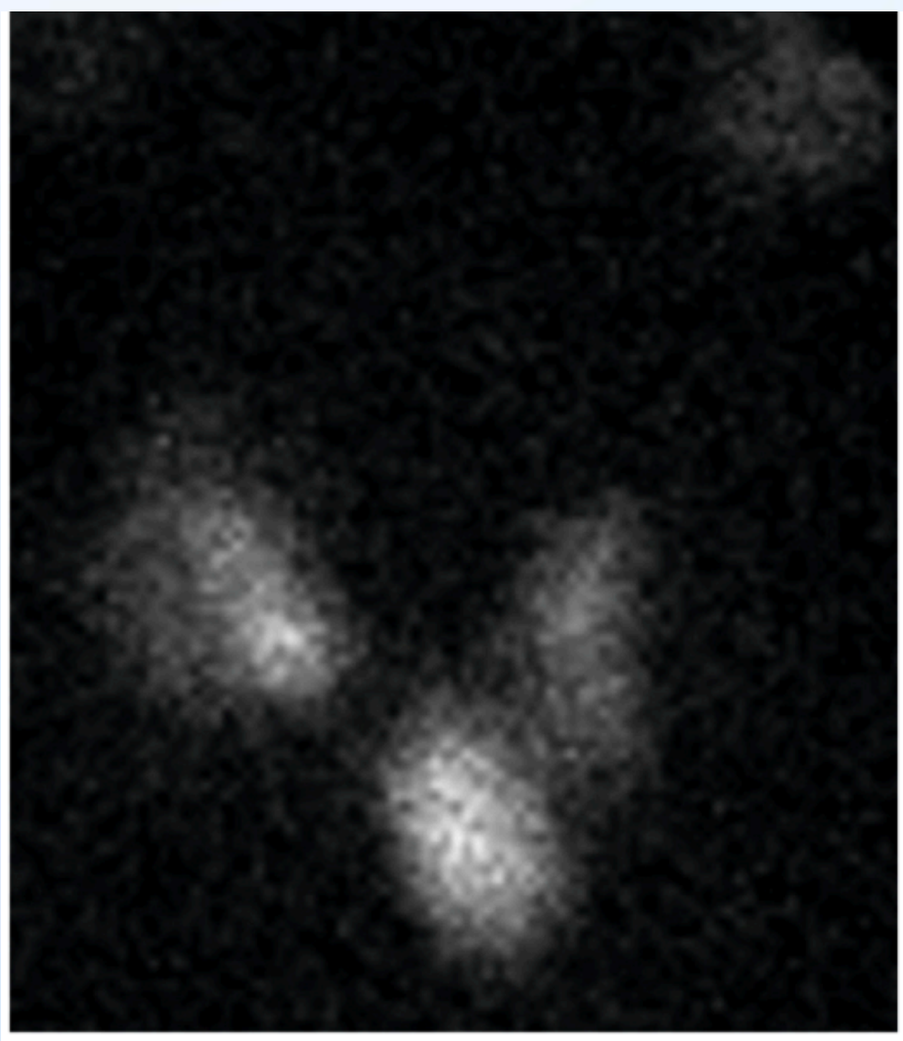
B

B) Diffuse goitre due to Graves' disease

C

C)Solitary toxic nodule.

D)99"Technetium radionuclide scan confirming multinodular goitre.



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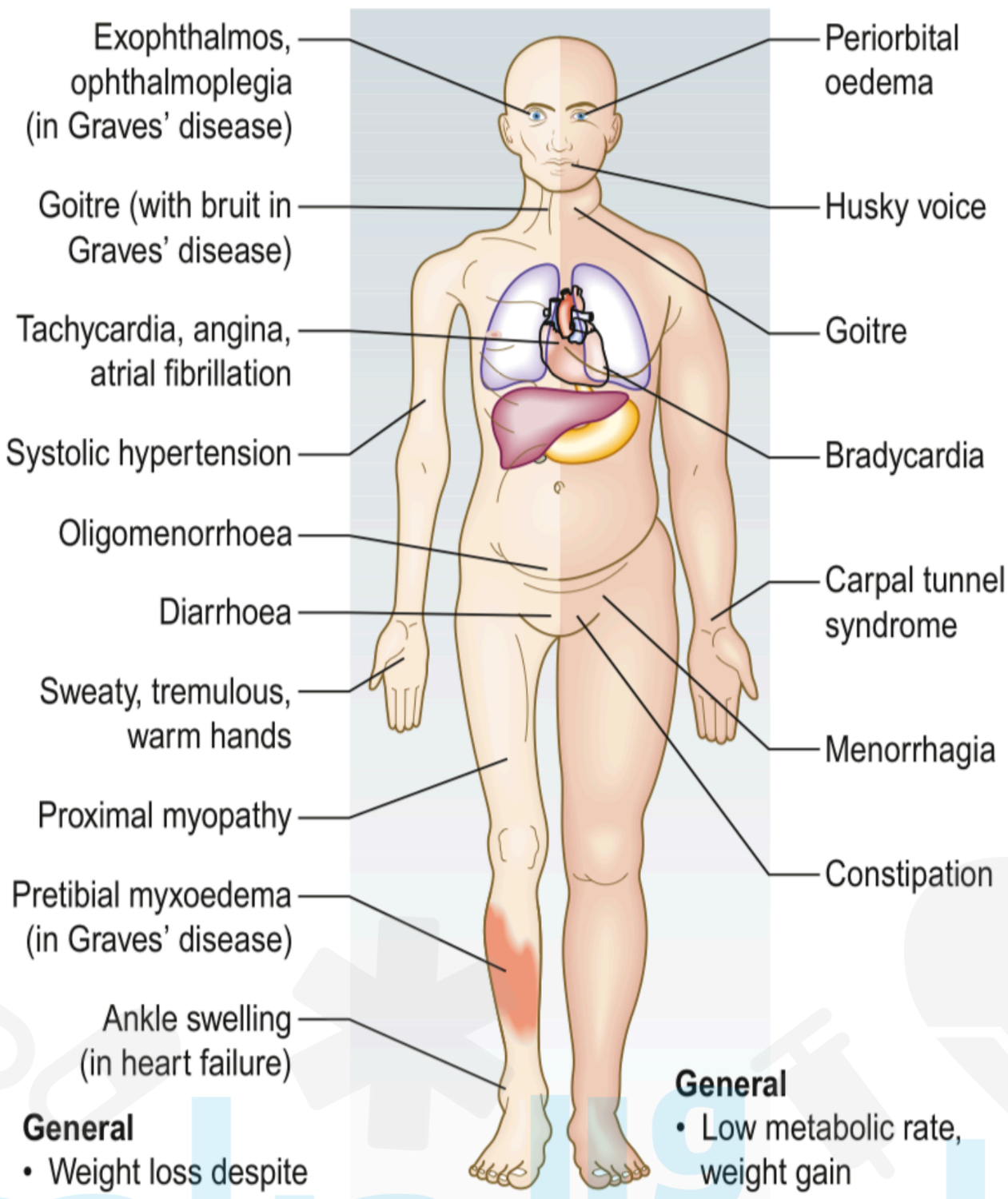
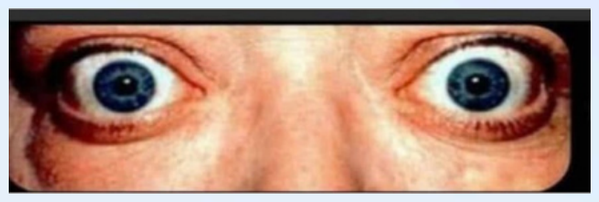


Fig. 10.4 Features of hyper- and hypothyroidism.

g. 10.5 Typical facies in hypothyroidism.

Thyroid Mini OSCE Archive :

1 : 30 years old patient admitted to surgical clinic with neck enlargement, after eye examination shows as in picture: Which wrong about this condition ?



1. Diarrhea is the common bowel habit for this patient.
2. The face is wet and sweaty .
3. Goiter indicated for hyperthyroidism condition. XXX
4. after treatment, exophthalmus not removed.
5. hyperthyroidism associated with arrhythmia, atrial fibrillation or tremor

2 :

1. Deep venous thrombosis.
2. Hypothyroidism
3. Nephrotic syndrome.
4. Graves disease. XXXX
5. Liver cirrhosis

3 :

1. lid lag xxxx
2. Lid retraction

4 : goiter associated with all except :

1)lodin defeciency

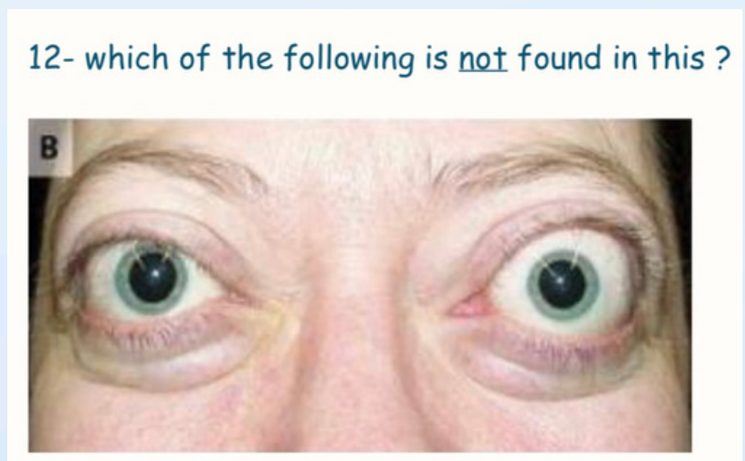
2)Thyrotoxicosis

3)Malignancy

4)Pregnancy "xxxxx

5 :

1. lid lag xxx
2. Lid retraction
3. periorbital edema



MINI-OSCE

MACLEOD

BREAST

الفريق الأكاديمي
لجنة الطب والجراحة

Fig. 11.2 Accessory breast tissue in the axilla.

Fig. 11.5 Inflammatory breast cancer: patchy erythema, flattened nipple, peau d'orange of right breast.

Fig. 11.7 Single duct, blood-stained nipple discharge.

symptoms. Malignant nipple retraction is unlikely to be correctable and often presents with other signs of malignancy.

Fig. 11.4 Breast volume and shape changes to right breast following lumpectomy (scar at upper outer quadrant) and radiotherapy (tattoo indicated by *arrow*). Radiotherapy has also resulted in right breast skin thickening and hyperpigmentation

patient if they have recently changed their bra size. In addition, ask if the changes are:

- unilateral or bilateral,
- recent or longstanding

Breast cancer surgery or treatment, especially radiotherapy, are likely to cause scarring that results in breast skin colour, texture, shape and volume changes (Fig. 11.4).

Breast implant surgery is increasingly common, and changes to breast volume and shape may be a consequence of implant changes, such as capsular contracture or implant rupture.

Fig. 11.6 *Peau d'orange* of the breast.

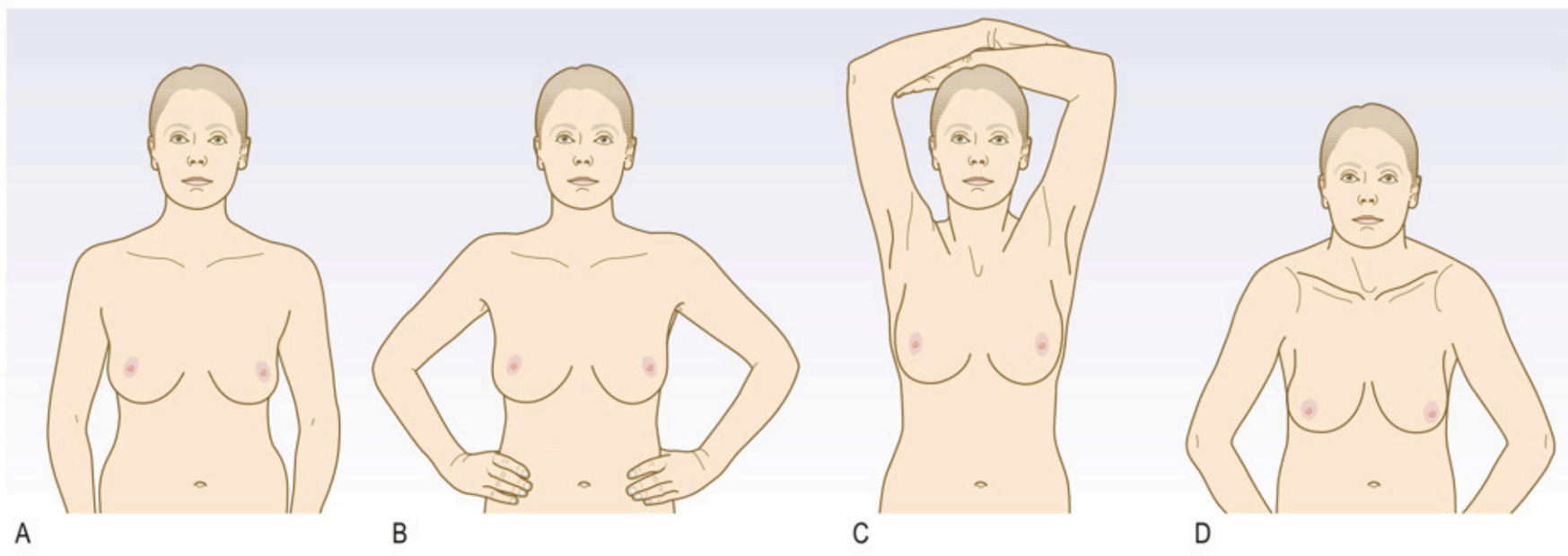


Fig. 11.8 Positions for inspecting the breasts. A Hands resting on the thighs. B Hands pressed on to the hips. C Arms above the head. D Leaning forward with the breasts pendulous.

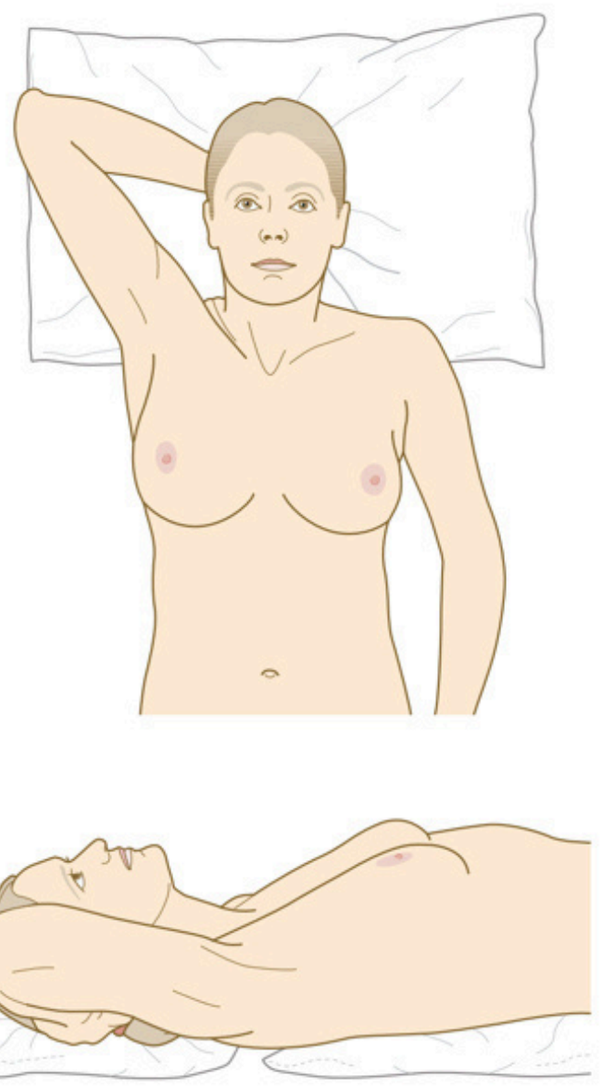


Fig. 11.9 Position for palpation of the right breast.

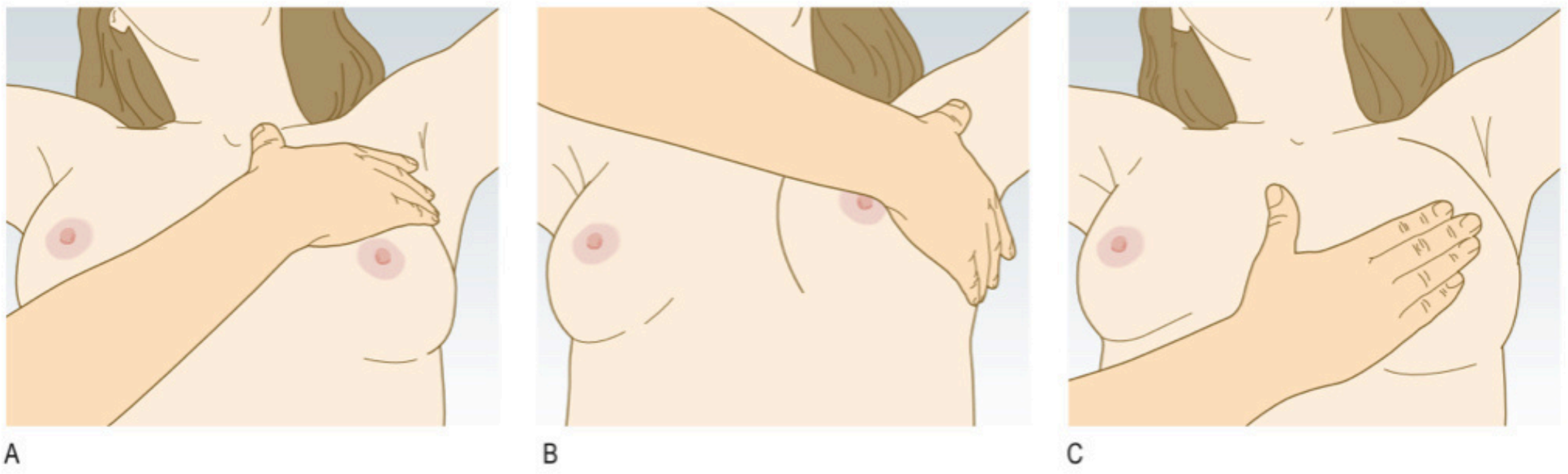


Fig. 11.10 Clinical examination of the breast. Examine each quadrant of the breast systematically, from the outside towards the nipple, including under the nipple.

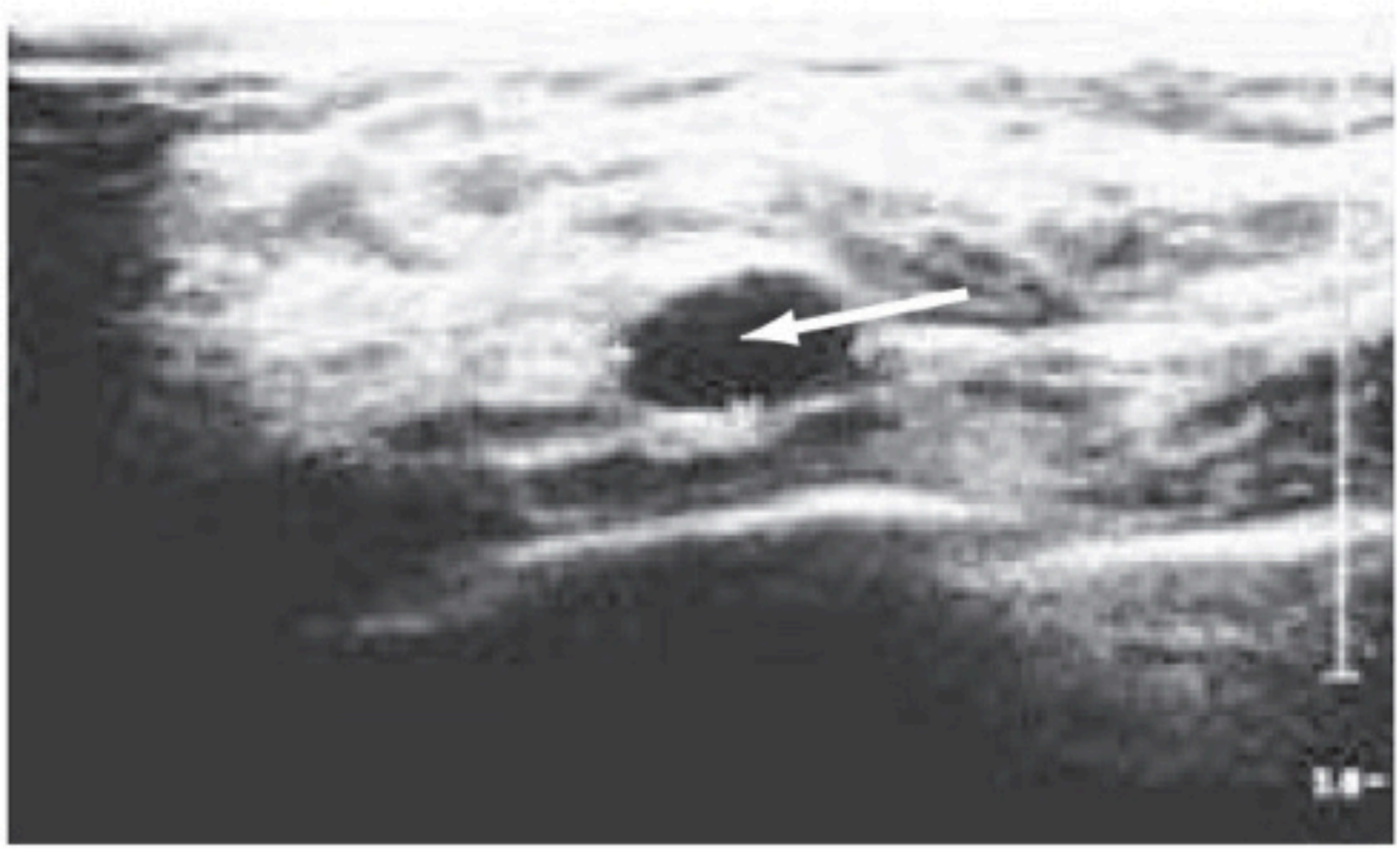


Fig. 11.13 Ultrasound of a breast cyst. A characteristic smooth-walled, hypoechoic lesion *(arrow)*.

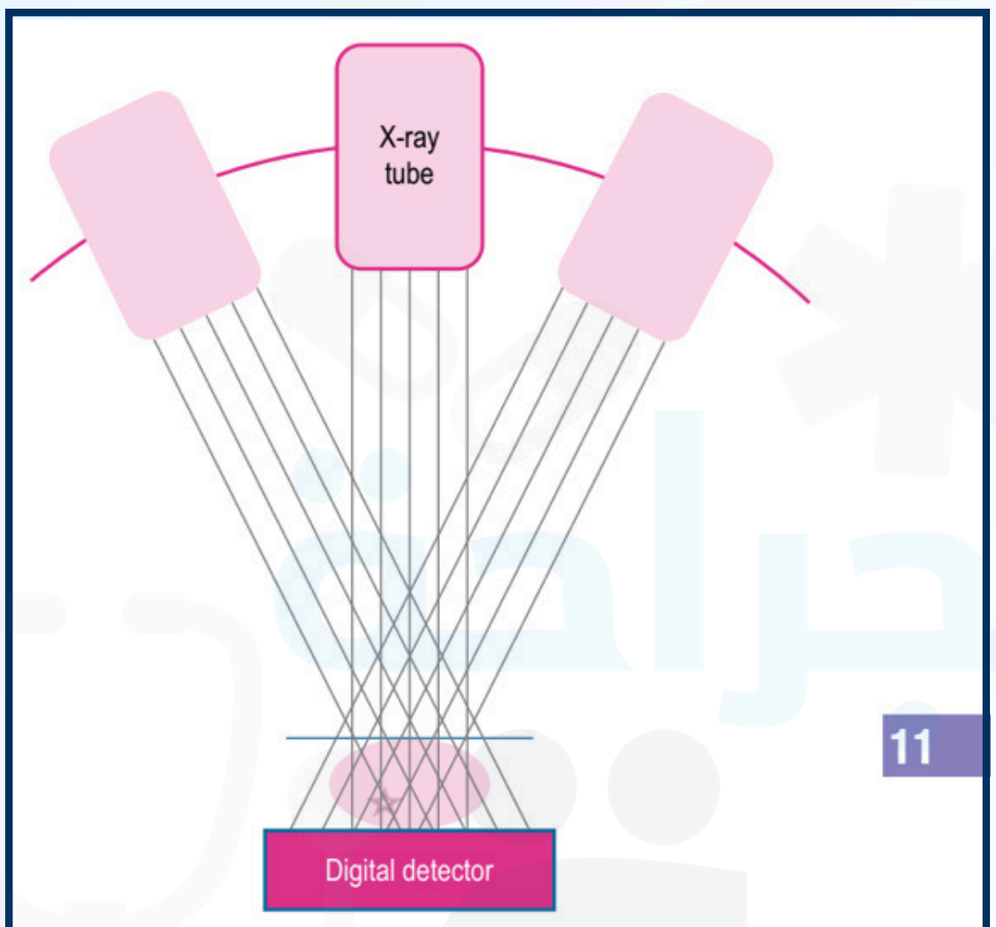


Fig. 11.14 Digital breast tomosynthesis. The x-ray tube moves along an acquisition angle obtaining projectional images (slices) of the compressed breast. These stacked images are then reconstructed to create three-dimensional images of the breast.

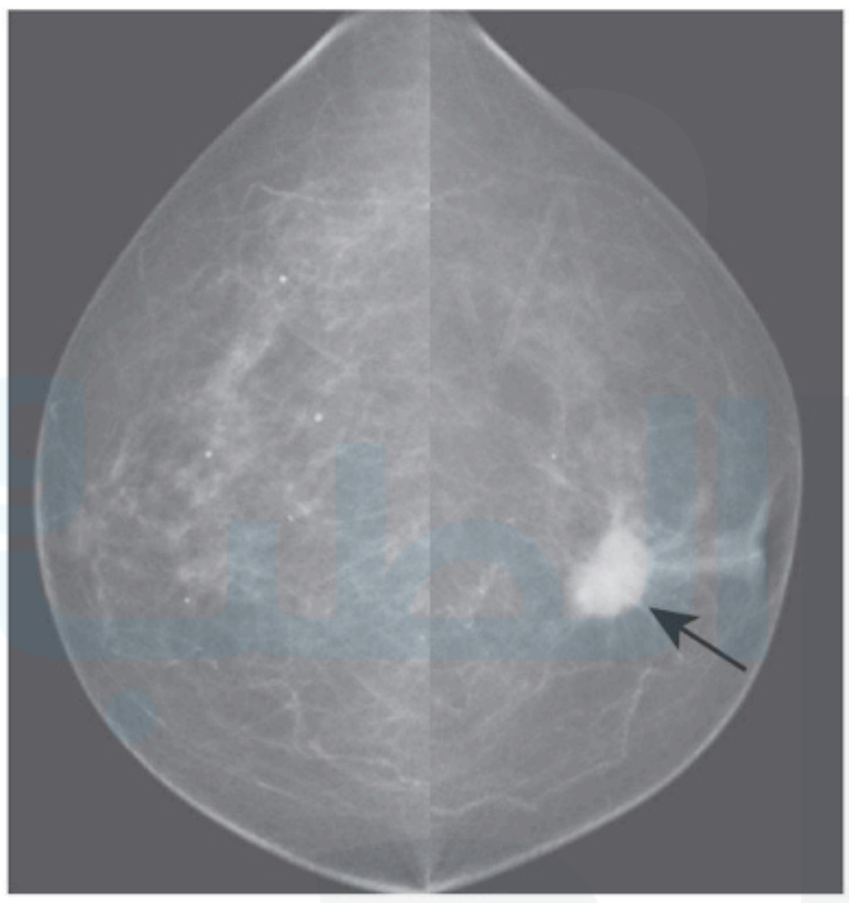


Fig. 11.12 Digital mammogram. A spiculate opacity characteristic of a cancer *(arrow)*.

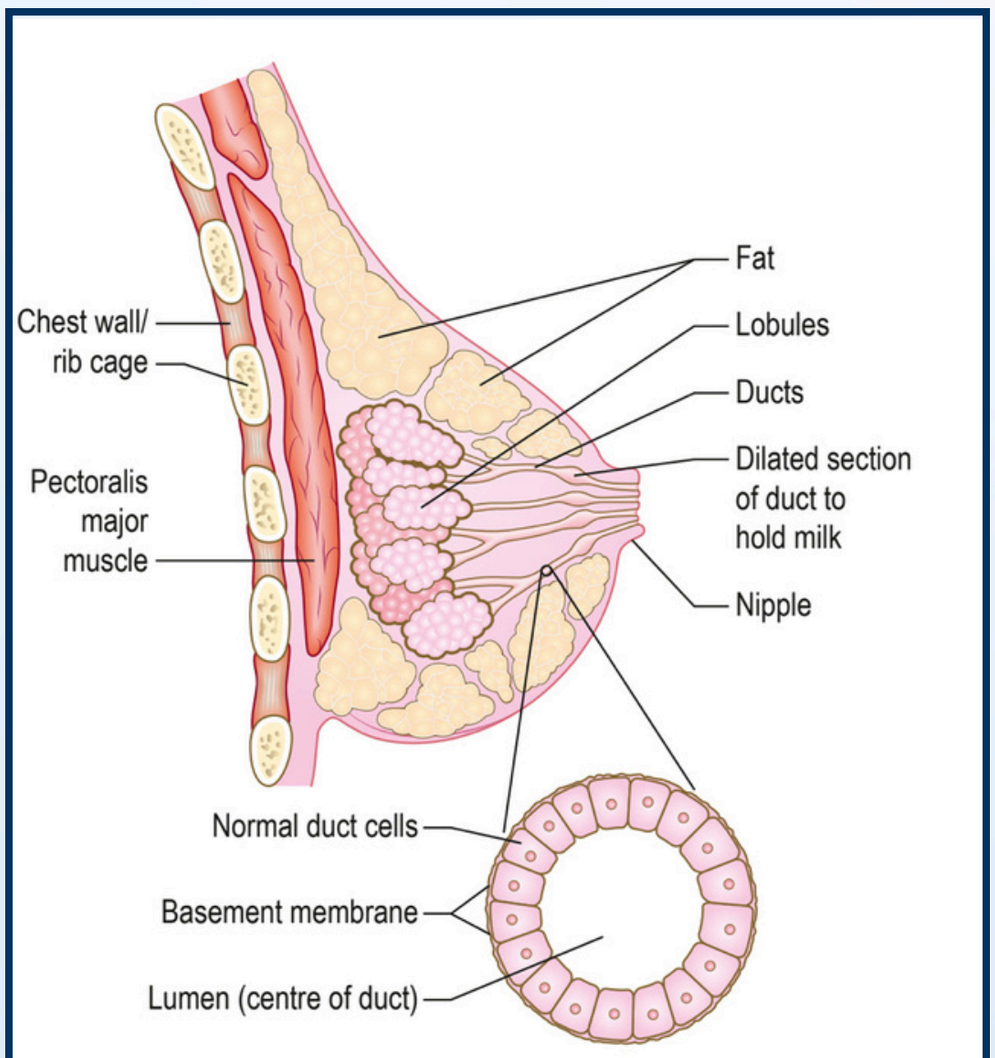


Fig. 11.3 Cross-section of the female breast.

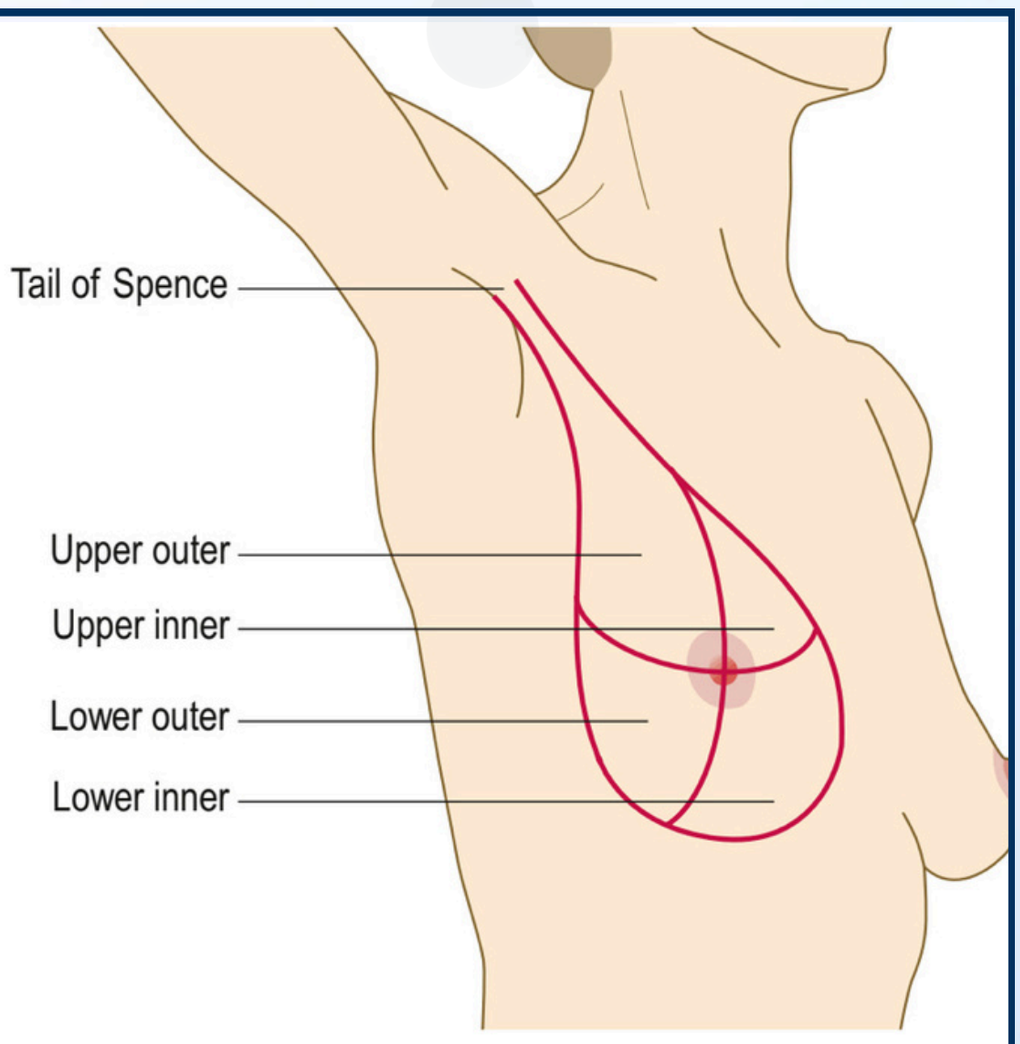
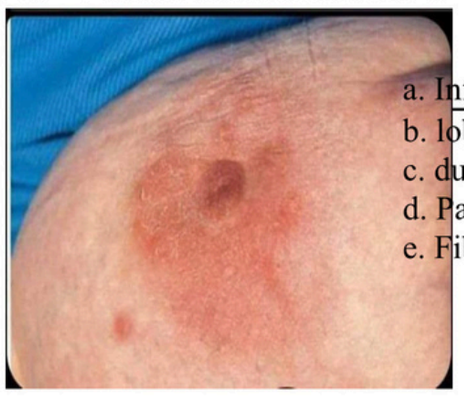


Fig. 11.1 Adult right breast.

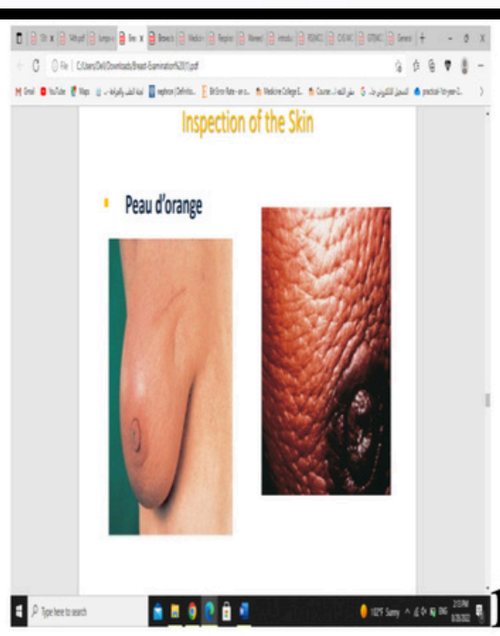
What is the most likely diagnosis ?

1)
2) Peau d'orange of breast
3)
4)

27-Which indicates ?



a. Inflammatory breast carcinoma .
b. lobar infiltrating carcinoma .
c. ductal infiltrating carcinoma .
d. Pagets disease of breast .
e. Fibroadenoma . XXX

2. 

name :
Peudo orange

10- what this indicates ?

a. Breast eczema ✓
b. Breast abscess

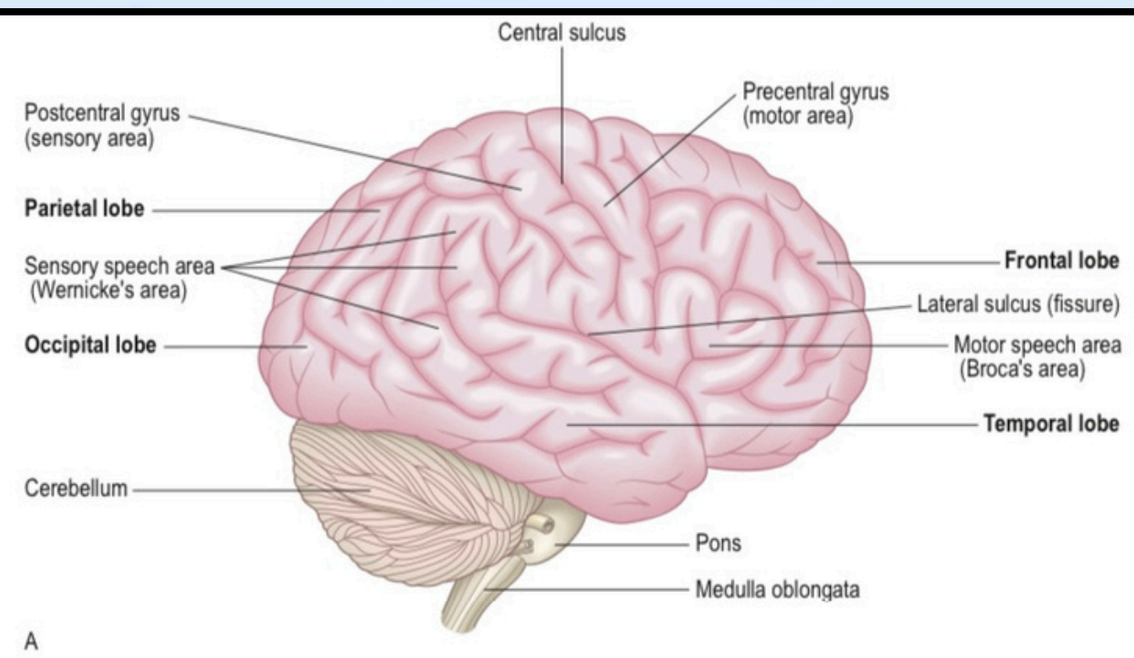
MINI-OSCE

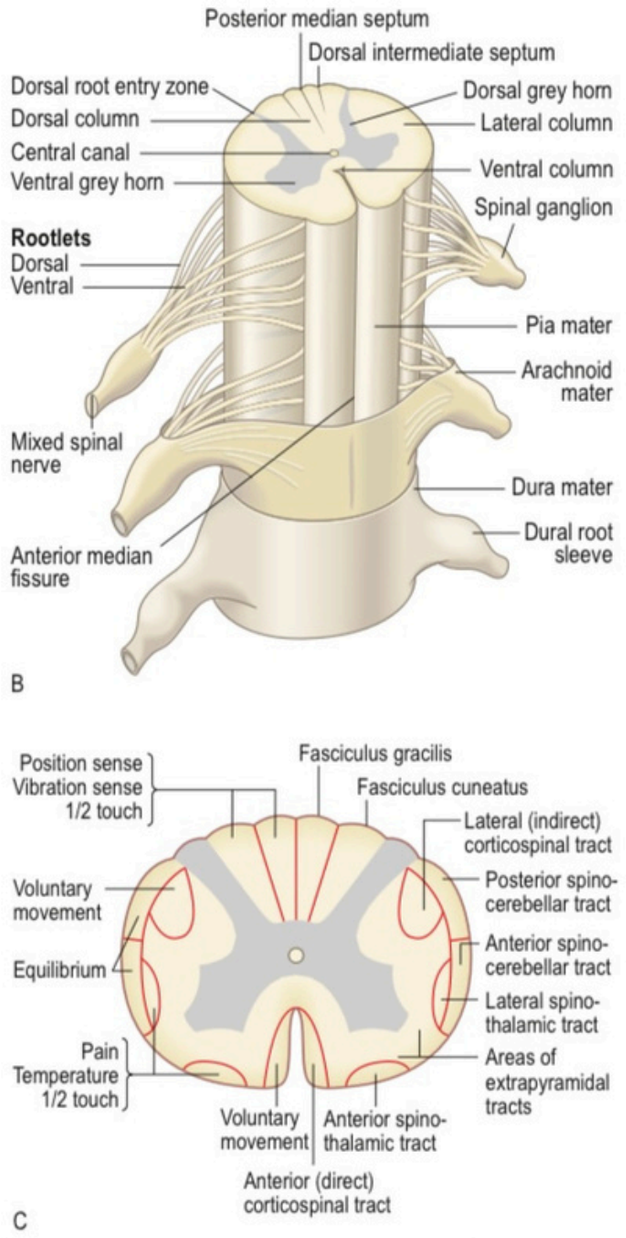
MACLEOD

NERVOUS SYSTEM

الفريق الأكاديمي

لجنة الطب والجراحة





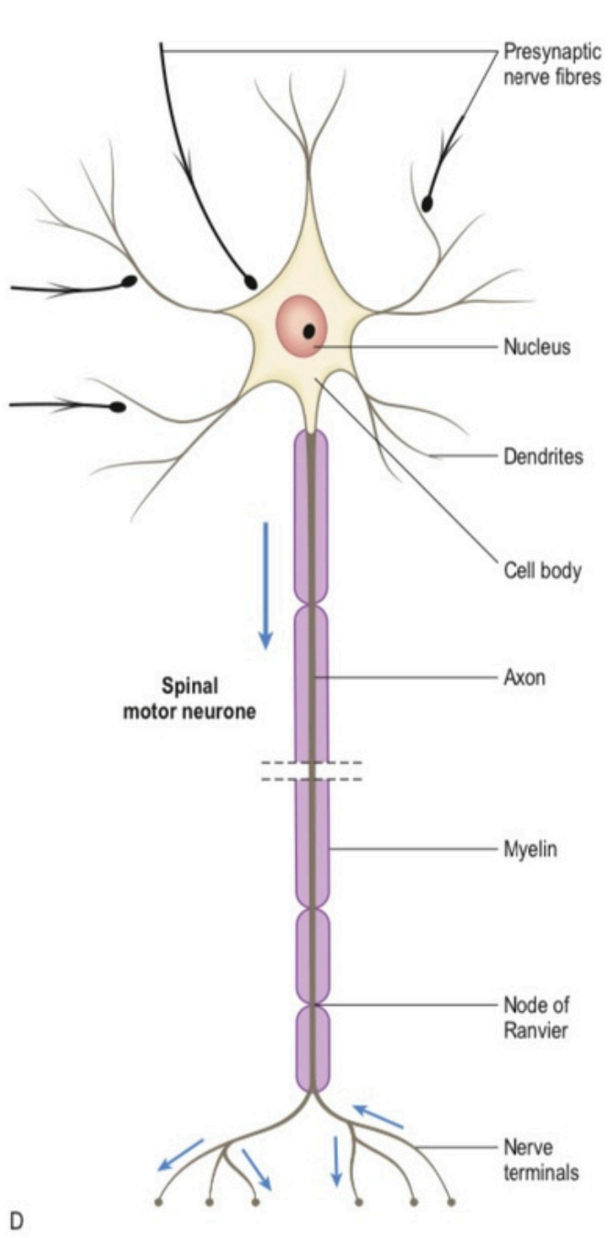


Fig. 7.1 Anatomy of the central nervous system. A Lateral surface of the brain. B Spinal cord, nerve roots and meninges. C Cross-section of the spinal cord. D Spinal motor neuron. The terminals of presynaptic neurons form synapses with the cell body and dendrites of the motor neurons.

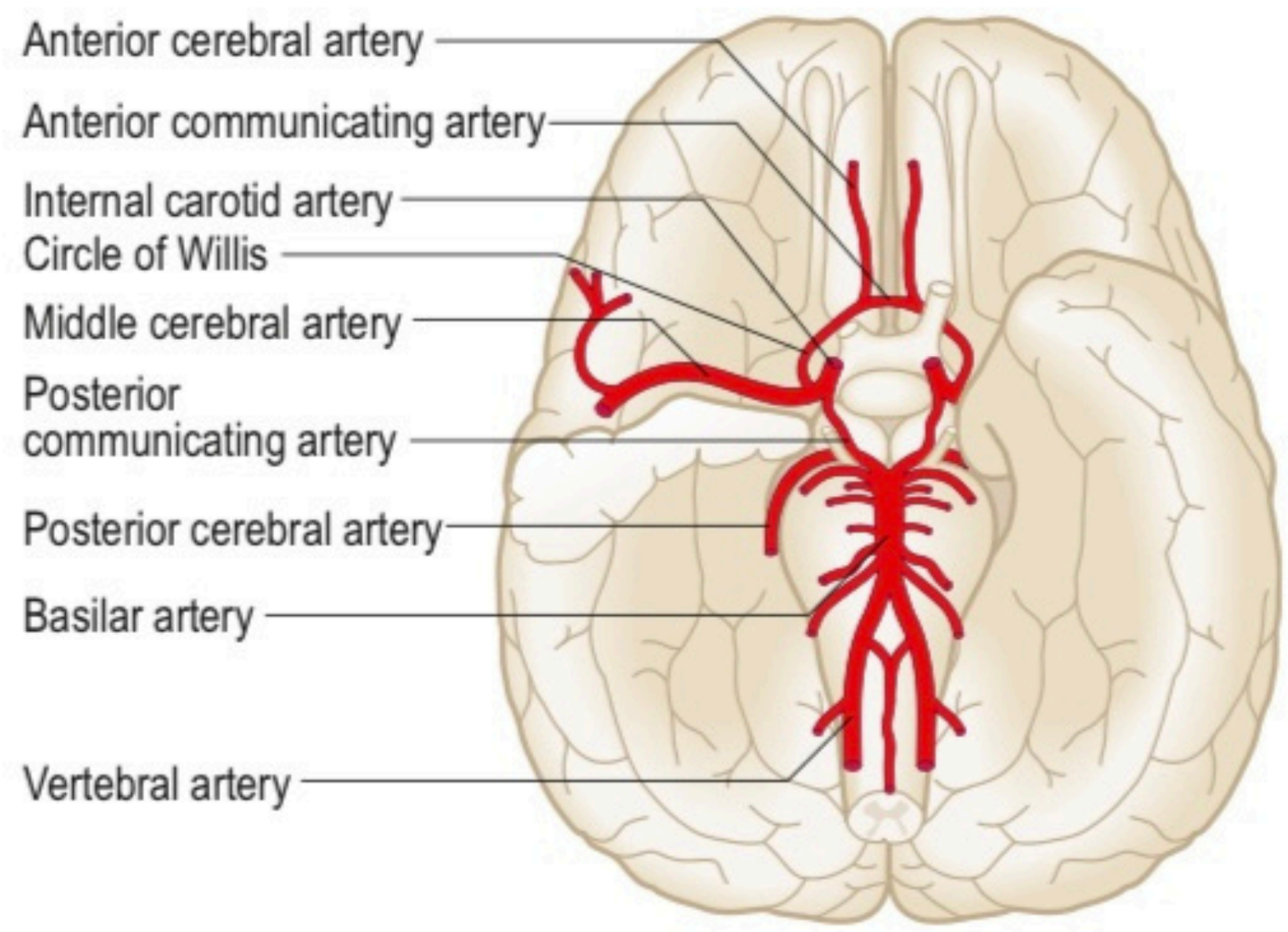


Fig. 7.2 The arterial blood supply of the brain (circle of Willis).

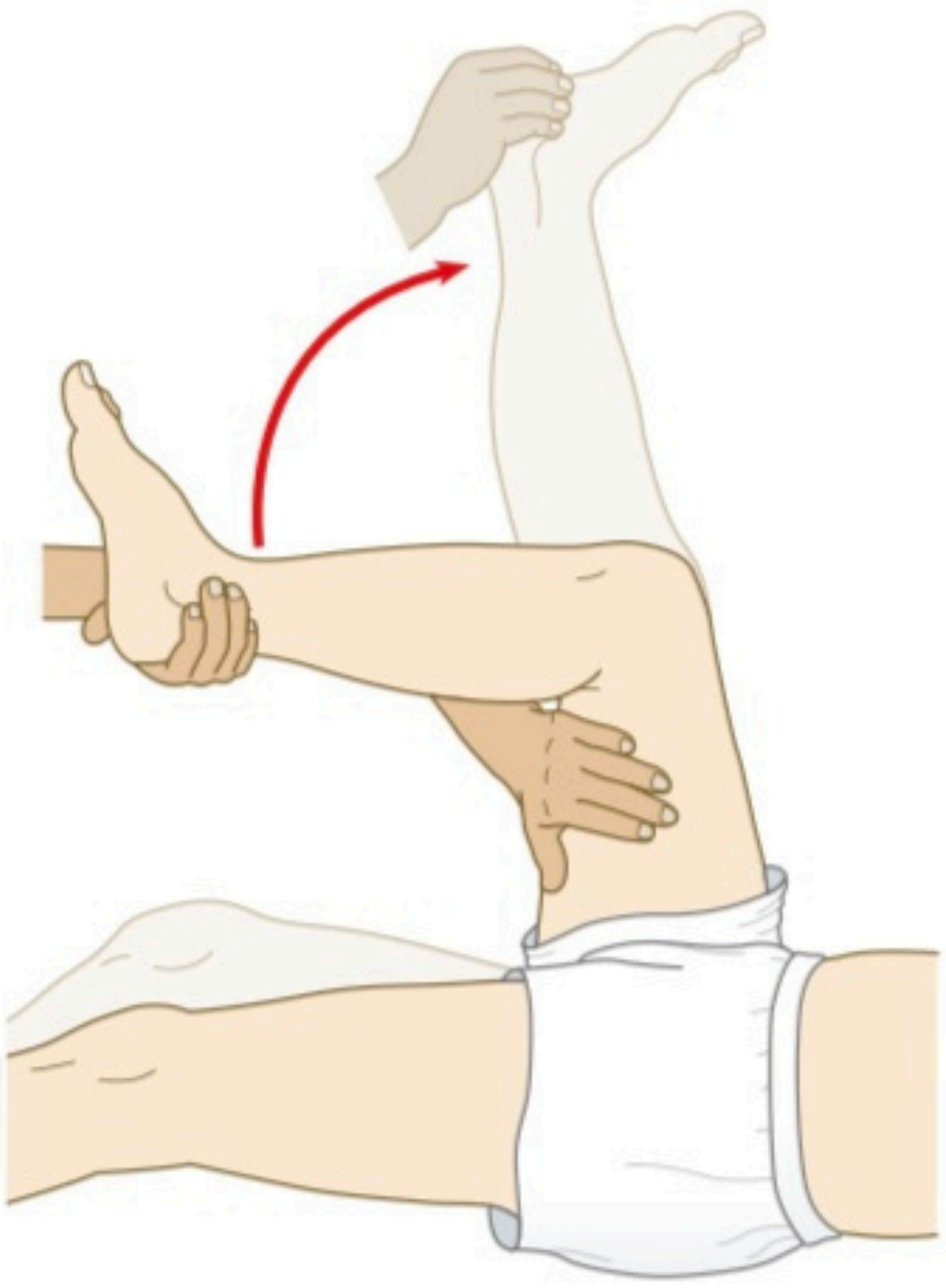


Fig. 7.3 Testing for meningeal irritation: Kernig's sign.

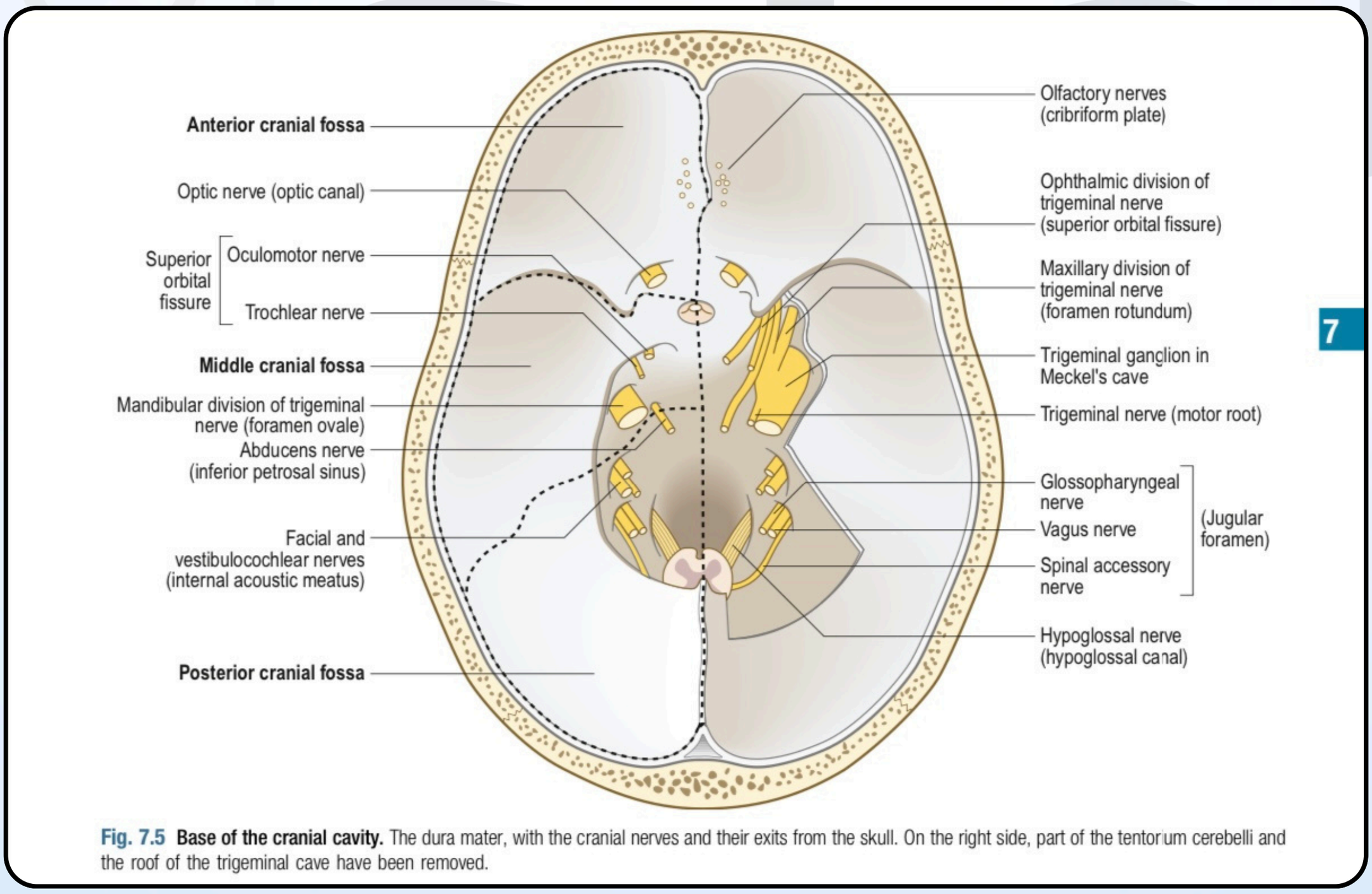


Fig. 7.5 **Base of the cranial cavity.** The dura mater, with the cranial nerves and their exits from the skull. On the right side, part of the tentorium cerebelli and the roof of the trigeminal cave have been removed.

2 Parietal lobe

Dominant side		Non-dominant side	
FUNCTION Calculation Language Planned movement Appreciation of size, shape, weight and texture	LESIONS Dyscalculia Dysphasia Dyslexia Apraxia Agnosia Homonymous hemianopia	FUNCTION Spatial orientation Constructional skills	LESIONS Neglect of non-dominant side Spatial disorientation Constructional apraxia Dressing apraxia Homonymous hemianopia

1 Frontal lobe

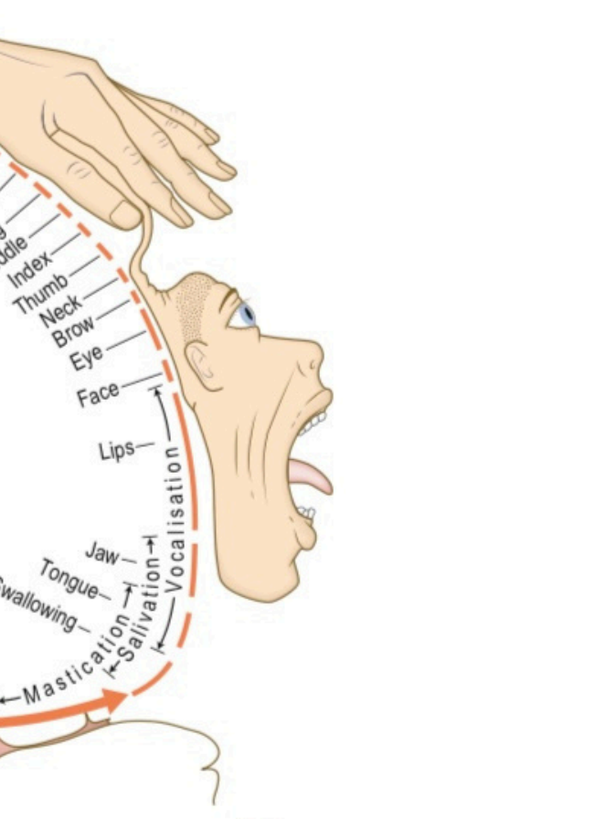
FUNCTION
Personality
Emotional response
Social behaviour

LESIONS
Disinhibition
Lack of initiative
Antisocial behaviour
Impaired memory
Incontinence
Grasp reflexes
Anosmia

3 Occipital lobe

FUNCTION
Analysis of vision

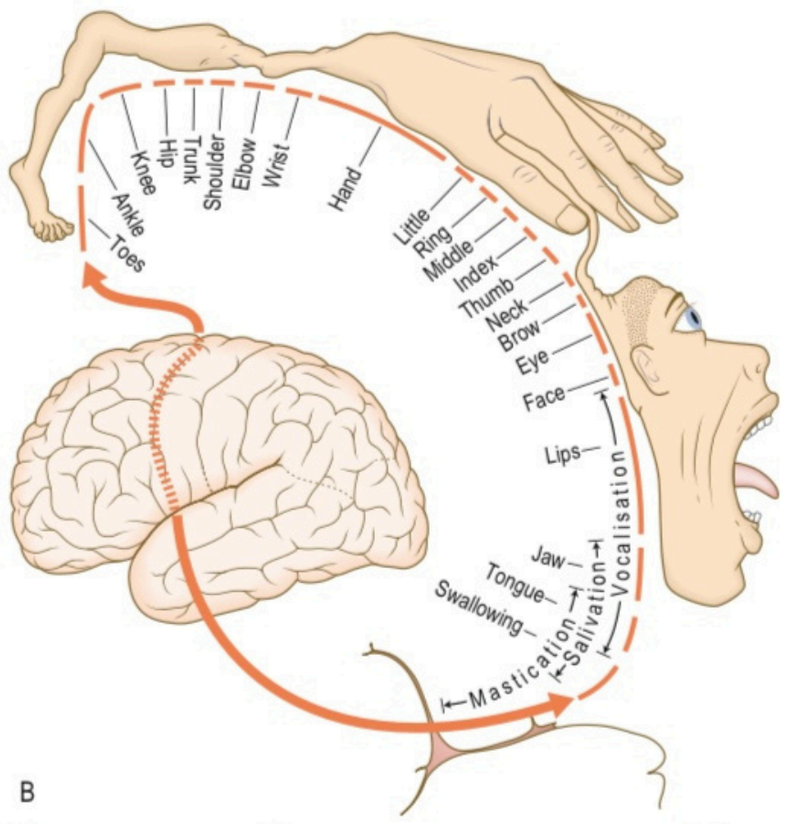
LESIONS
Homonymous hemianopia
Hemianopic scotomas
Visual agnosia
Impaired face recognition (prosopagnosia)
Visual hallucinations (lights, lines and zigzags)



4 Temporal lobe

Dominant side		Non-dominant side	
FUNCTION Auditory perception Speech, language Verbal memory Smell	LESIONS Dysphasia Dyslexia Poor memory Complex hallucinations (smell, sound, vision) Homonymous hemianopia	FUNCTION Auditory perception Music, tone sequences Non-verbal memory (faces, shapes, music) Smell	LESIONS Poor non-verbal memory Loss of musical skills Complex hallucinations Homonymous hemianopia

A



B

Fig. 7.4 Cortical function. A Features of localised cerebral lesions. B Somatotopic homunculus.

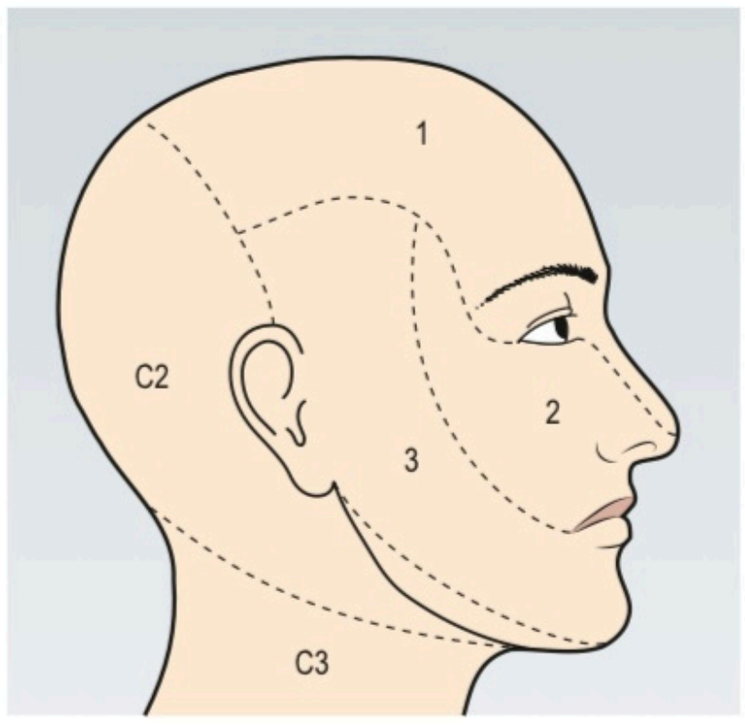


Fig. 7.6 The sensory distribution of the three divisions of the trigeminal nerve. 1. Ophthalmic division. 2. Maxillary division. 3. Mandibular division.

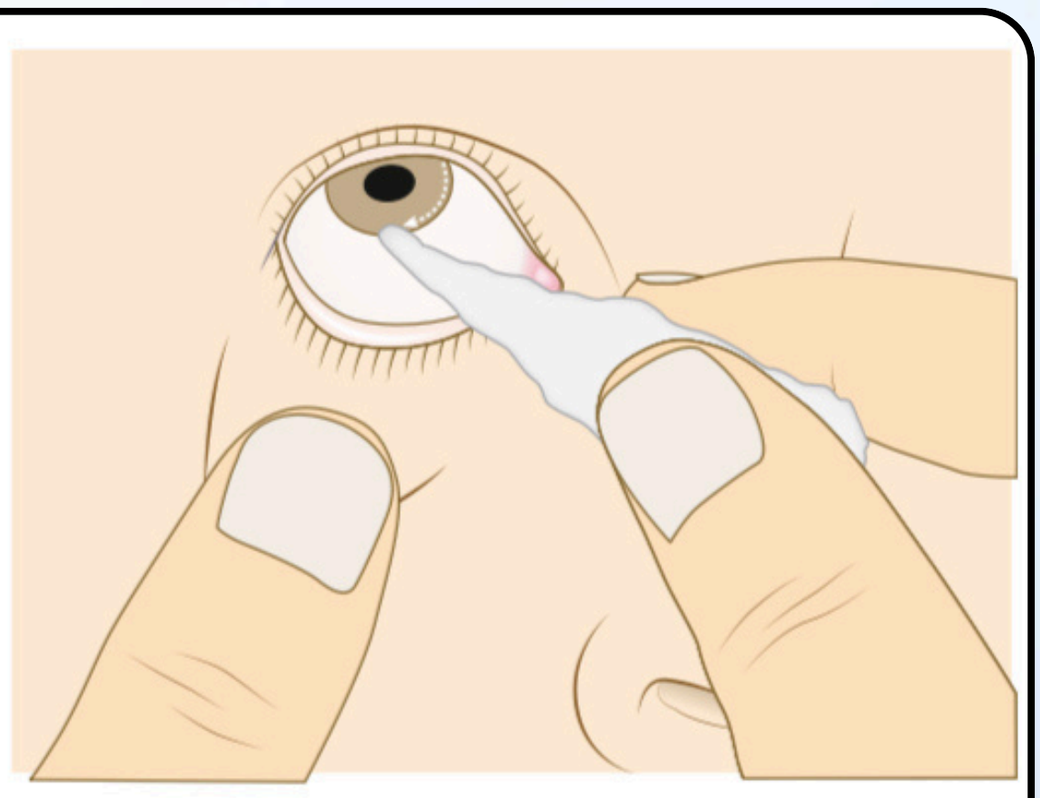


Fig. 7.7 Testing the corneal reflex. The cotton-wool wisp should touch the cornea overlying the iris, not the conjunctiva, and avoid visual stimulus.

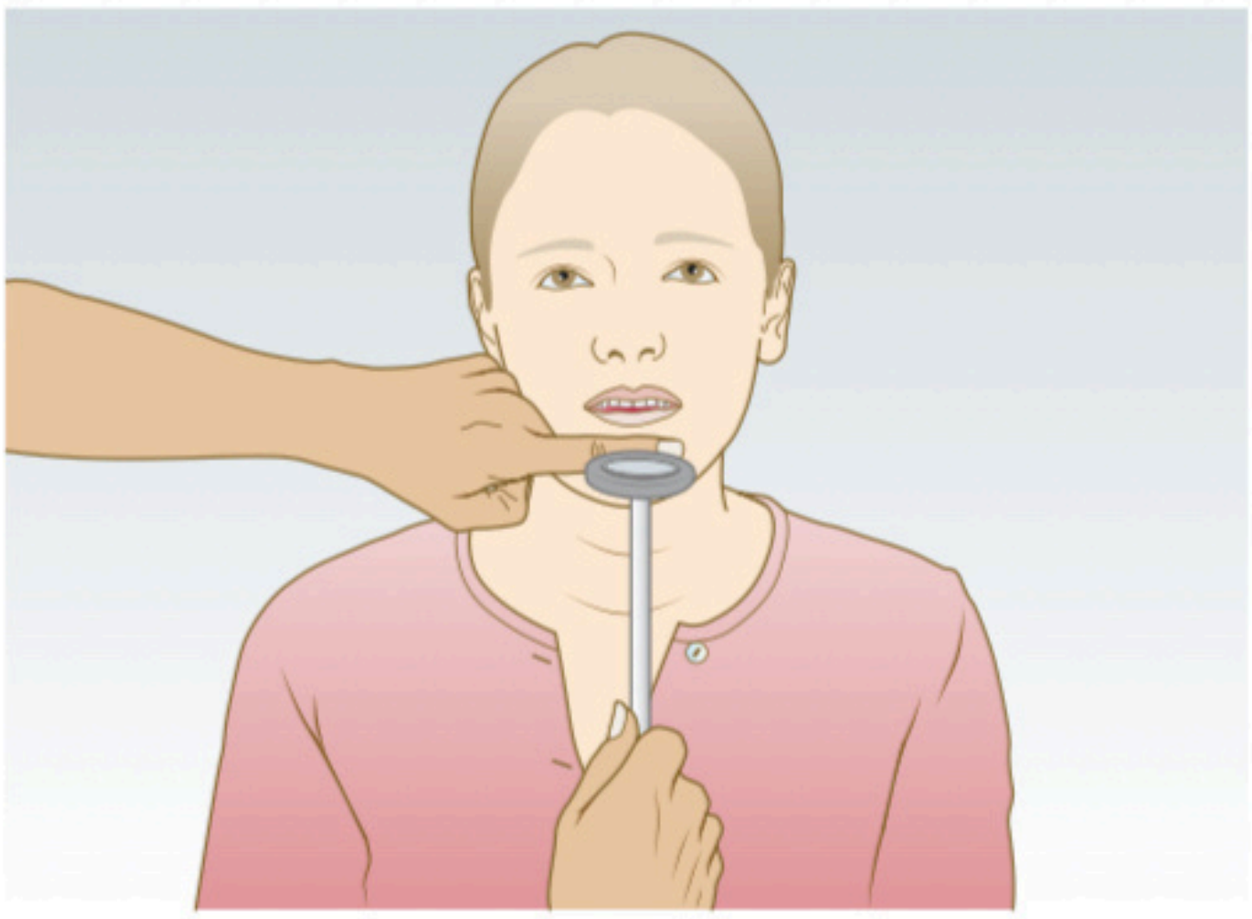


Fig. 7.8 Eliciting the jaw jerk.

Fig. 7.9 **Herpes zoster.** A The ophthalmic division of the left trigeminal (V) nerve is involved. B The maxillary division of the left V nerve. C Cervical spinal root left C4. D Thoracic spinal root right T5.

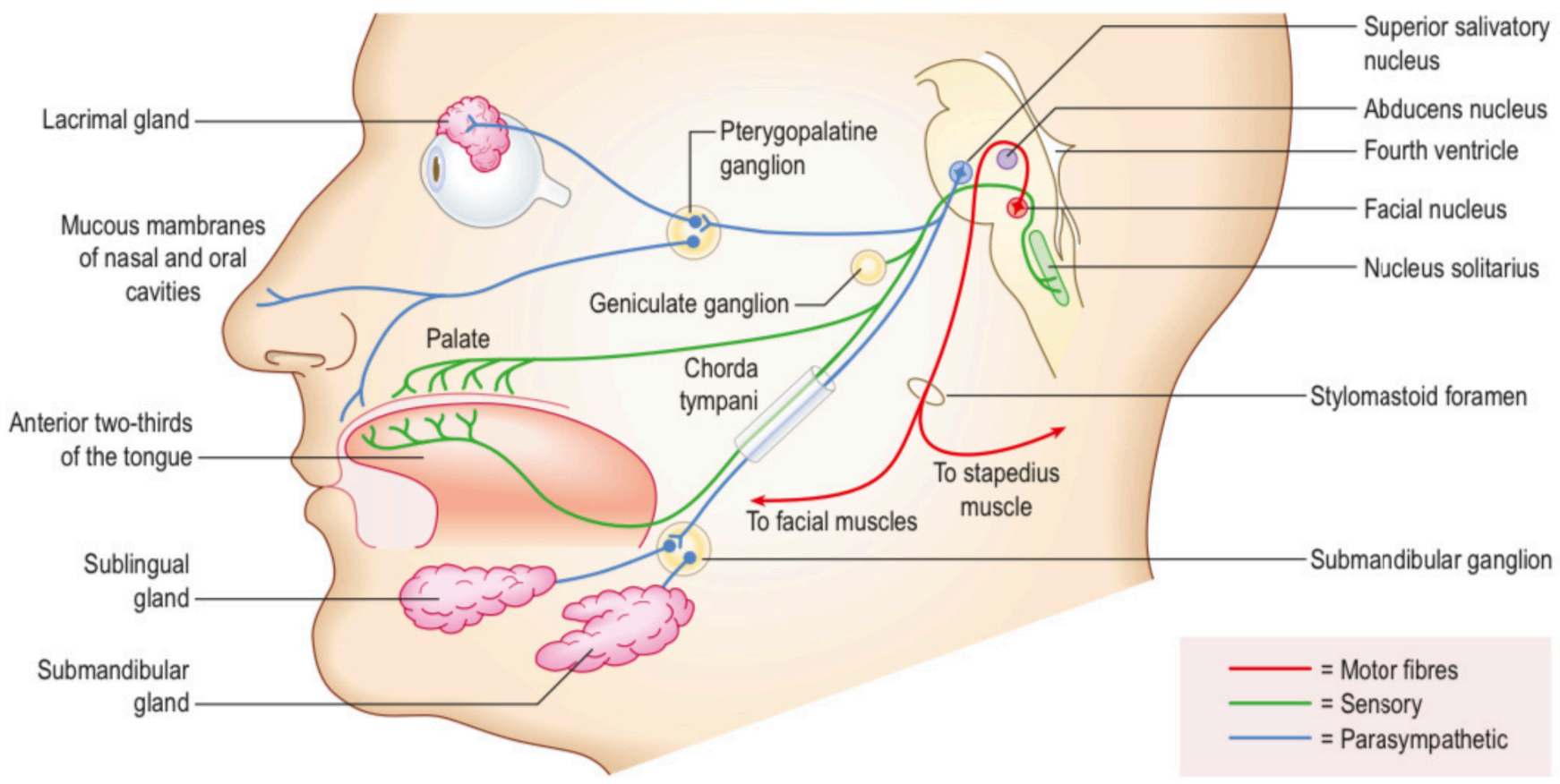


Fig. 7.10 **Component fibres of the facial nerve and their peripheral distribution.**

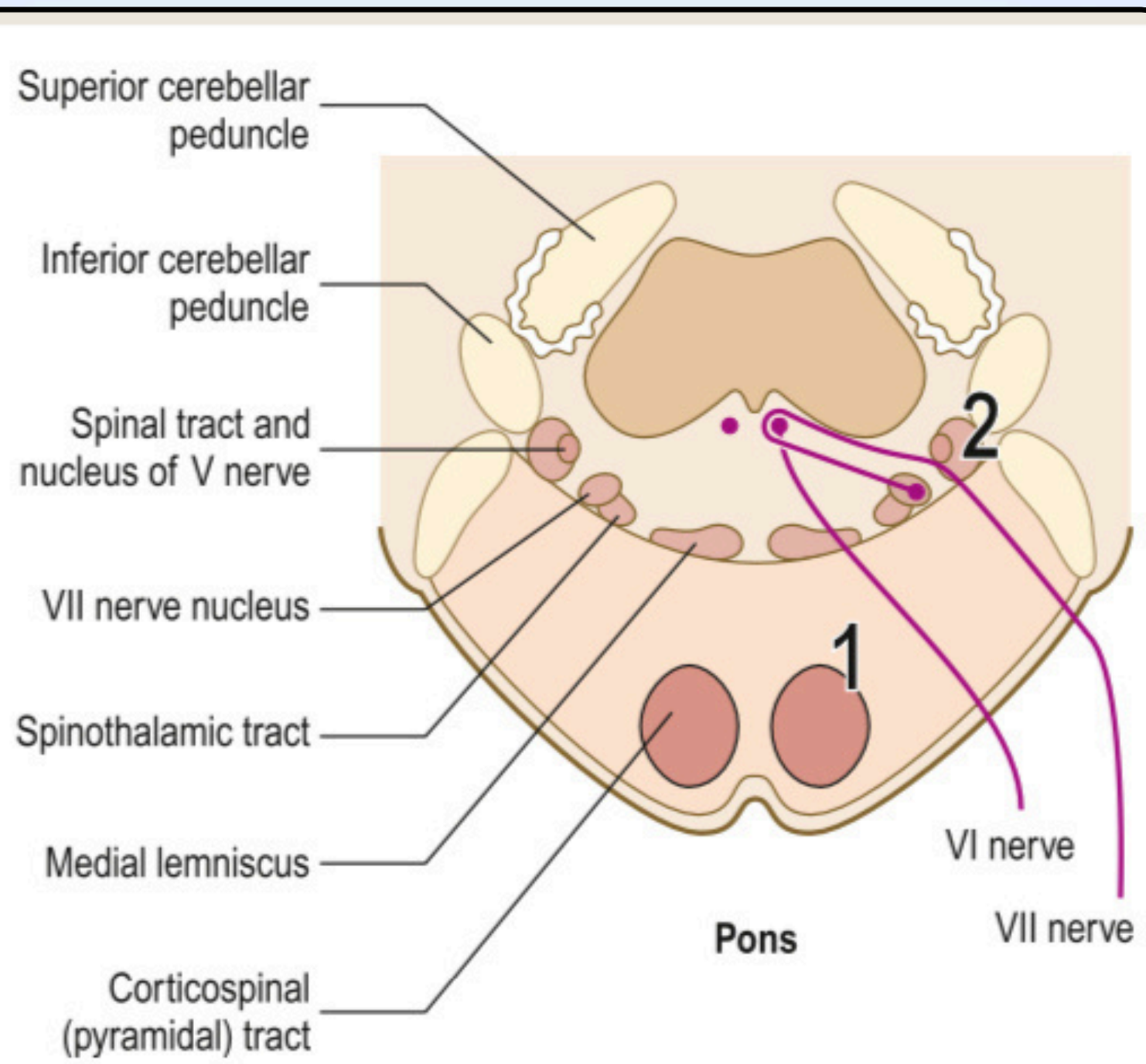


Fig. 7.11 Lesions of the pons. Lesions at (1) may result in ipsilateral VI and VII nerve palsies and contralateral hemiplegia. At (2) ipsilateral cerebellar signs and impaired sensation on the ipsilateral side of the face and on the contralateral side of the body may occur.

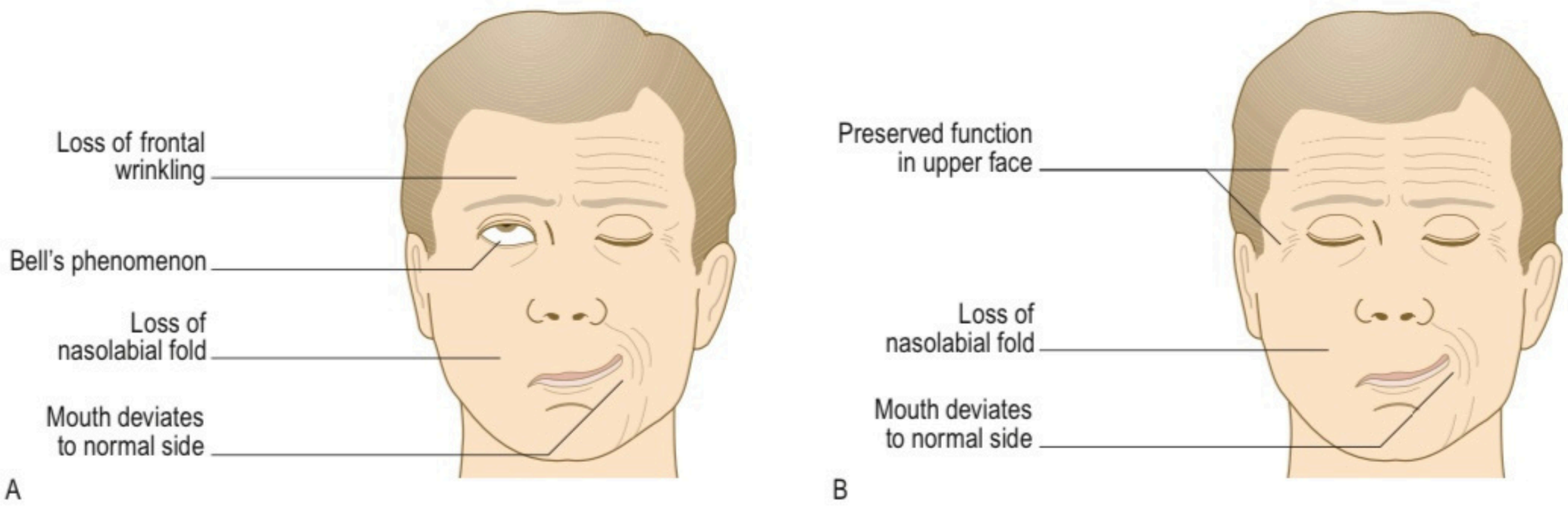


Fig. 7.12 Types of facial weakness. A Right facial weakness due to right lower motor neurone lesion. B Right facial weakness due to left upper motor neurone lesion.

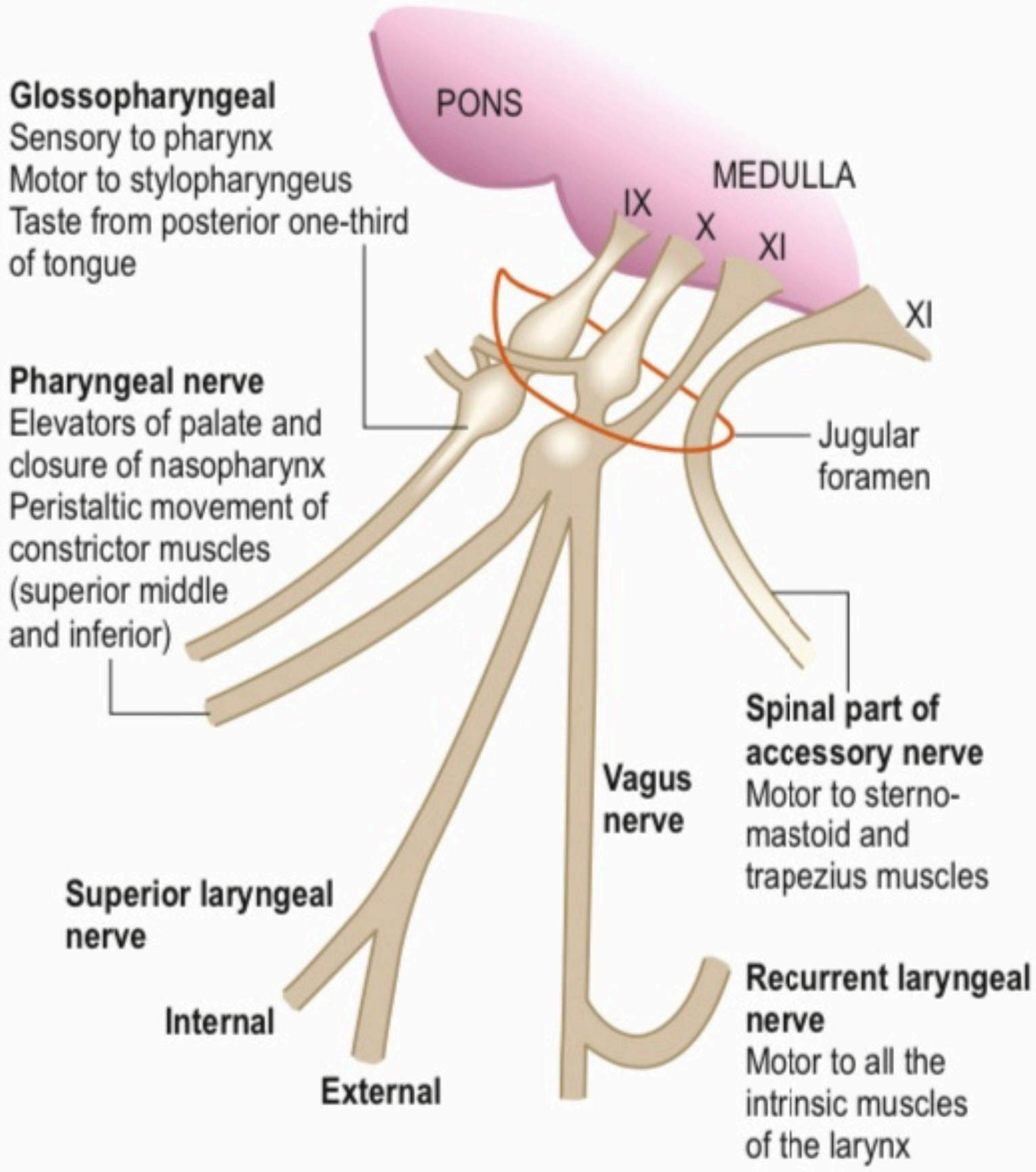


Fig. 7.13 The lower cranial nerves: glossopharyngeal (IX), vagus (X) and accessory (XI).

Fig. 7.14 **Left hypoglossal nerve lesion.** *From Epstein O, Perkin GD, de Bono DP, et al. Clinical Examination. 2nd ed. London: Mosby; 1997.*

Fig. 7.15 Principal motor pathways.

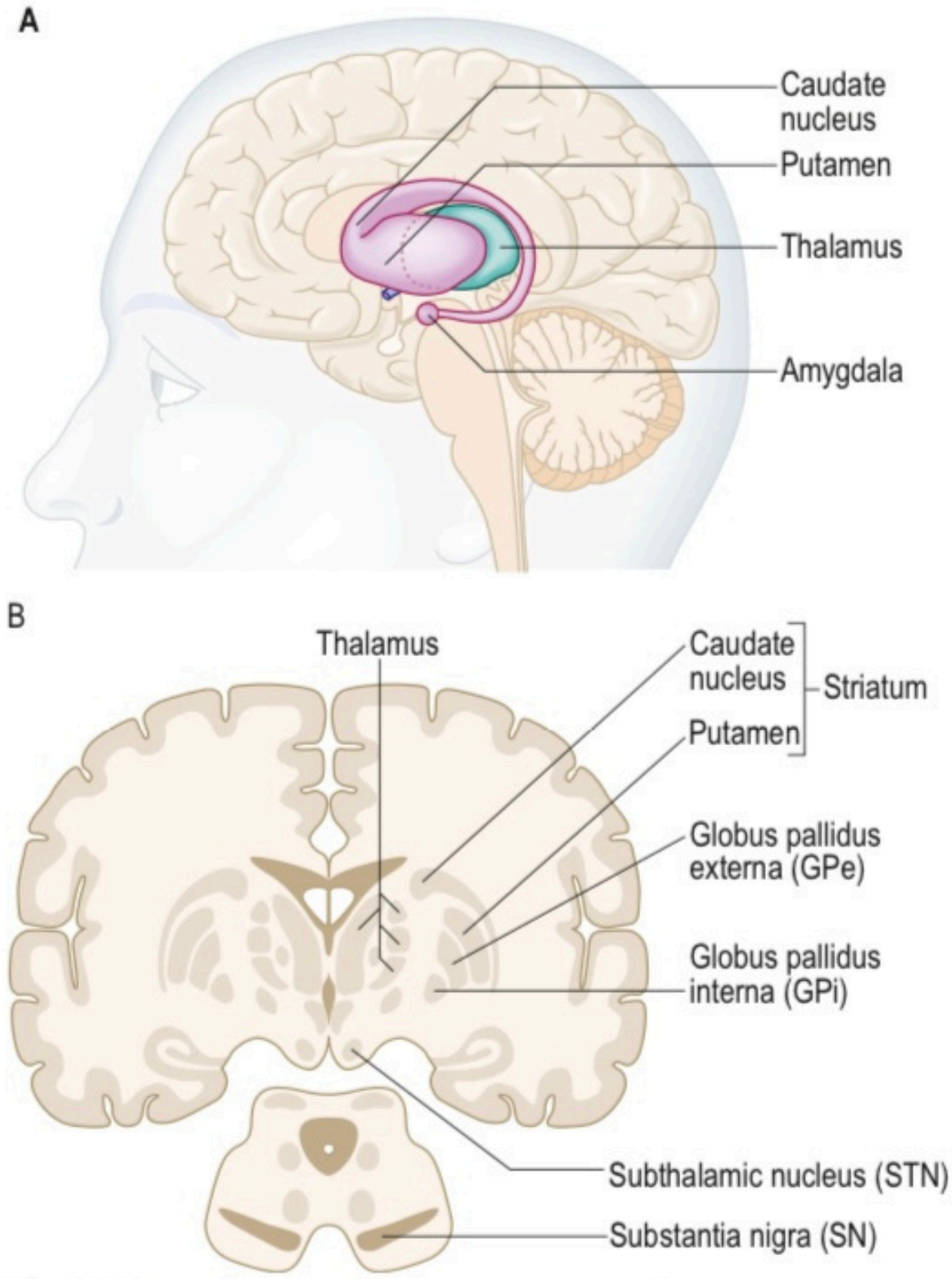
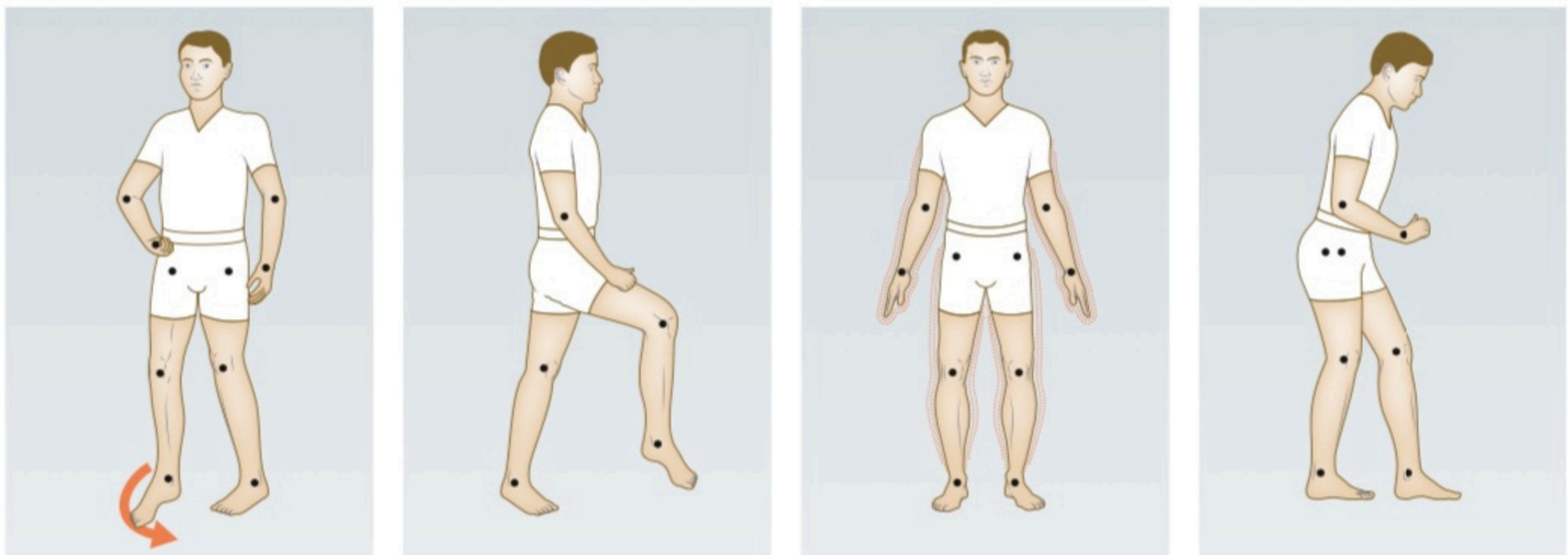


Fig. 7.16 Basal ganglia. A Anatomical location. B Coronal view.

- assessing tone
- testing movement and power
- examining reflexes
- testing coordination.



A Spastic hemiparesis
One arm held immobile and close to the side with elbow, wrist and fingers flexed
Leg extended with plantar flexion of the foot
On walking, the foot is dragged, scraping the toe in a circle (circumduction)
Caused by upper motor neurone lesion, e.g. stroke

B Steppage gait
Foot is dragged or lifted high and slapped on to the floor
Unable to walk on the heels
Caused by foot drop owing to lower motor neurone lesion

C Sensory or cerebellar ataxia
Gait is unsteady and wide-based. Feet are thrown forward and outward and brought down on the heels
In sensory ataxia, patients watch the ground. With their eyes closed, they cannot stand steadily (positive Romberg sign)
In cerebellar ataxia, turns are difficult and patients cannot stand steadily with feet together whether eyes are open or closed
Caused by polyneuropathy or posterior column damage, e.g. syphilis

D Parkinsonian gait
Posture is stooped with head and neck forwards
Arms are flexed at elbows and wrists. Little arm swing
Steps are short and shuffling and patient is slow in getting started (festinant gait)
Caused by lesions in the basal ganglia

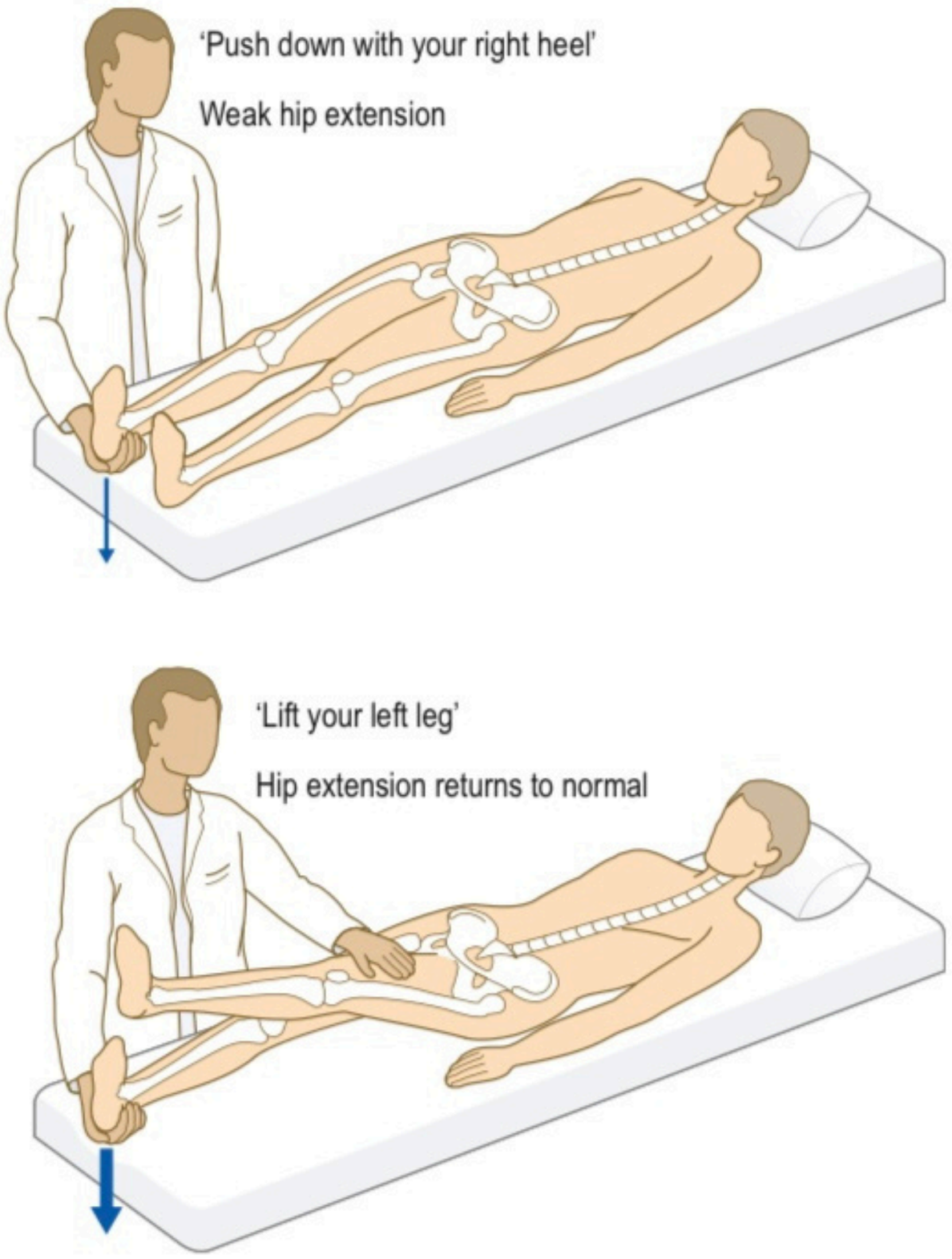


Fig. 7.18 Hoover's sign.

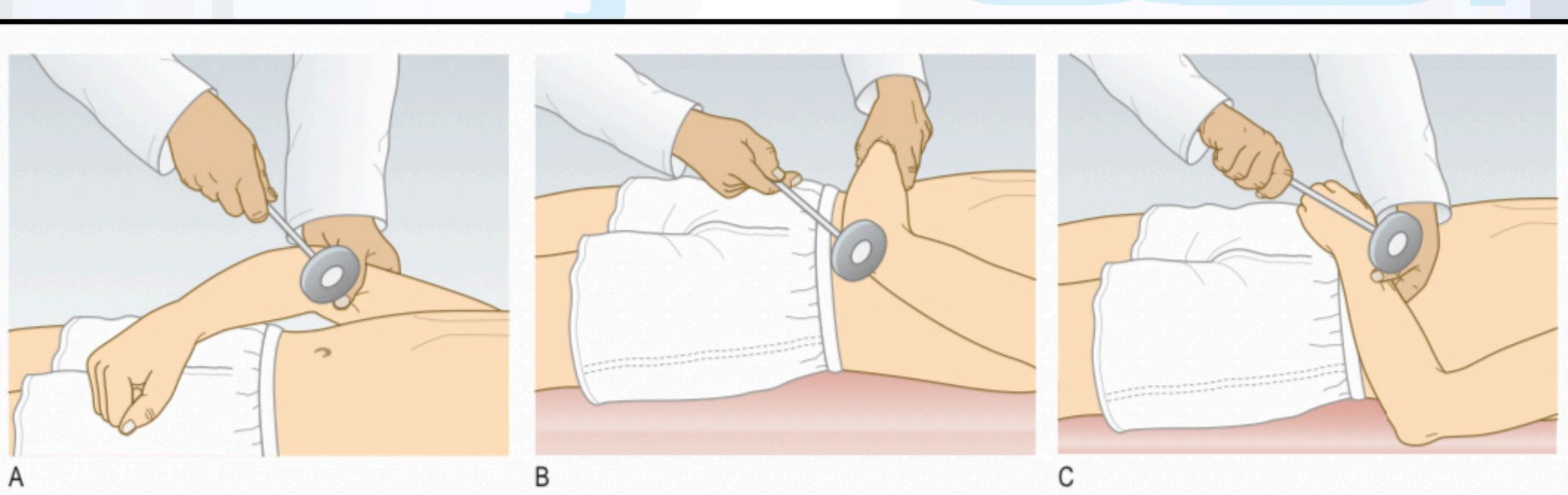


Fig. 7.19 **Testing the deep tendon reflexes of the upper limb.** A Biceps jerk, C5. B Triceps jerk, C7. C Supinator jerk, C6.

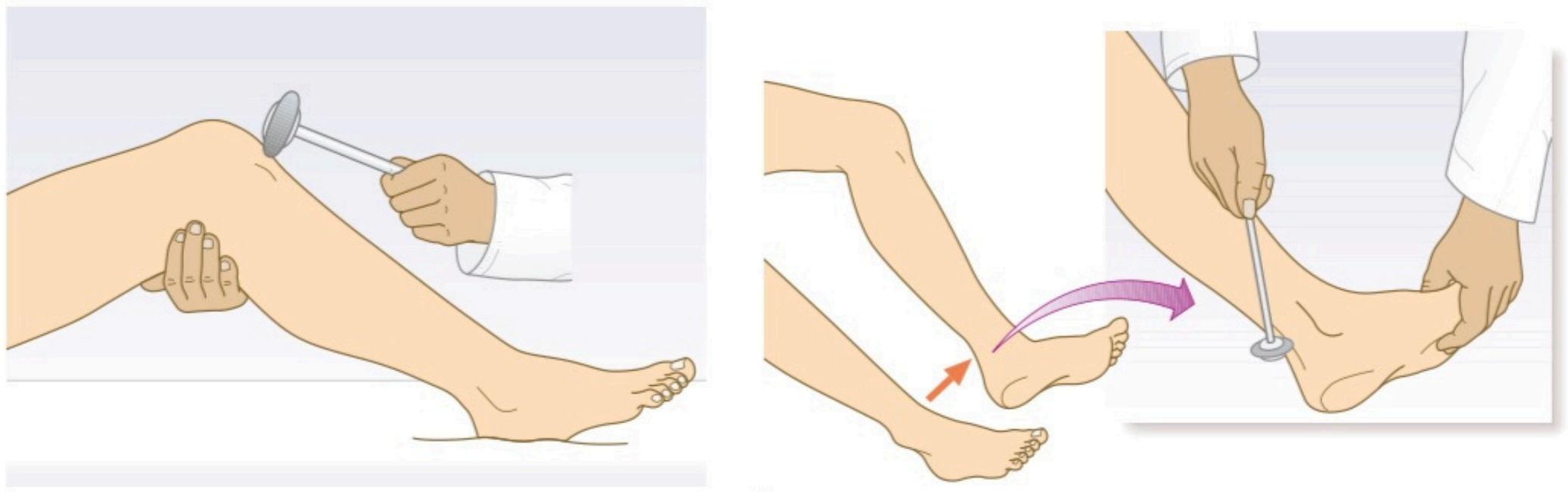


Fig. 7.20 **Testing the deep tendon reflexes of the lower limb.** A Knee jerk (note that the patient's legs should not be in contact with each other), L3, L4. B Ankle jerk of the recumbent patient, S1.

Fig. 7.21 Eliciting the plantar reflex.

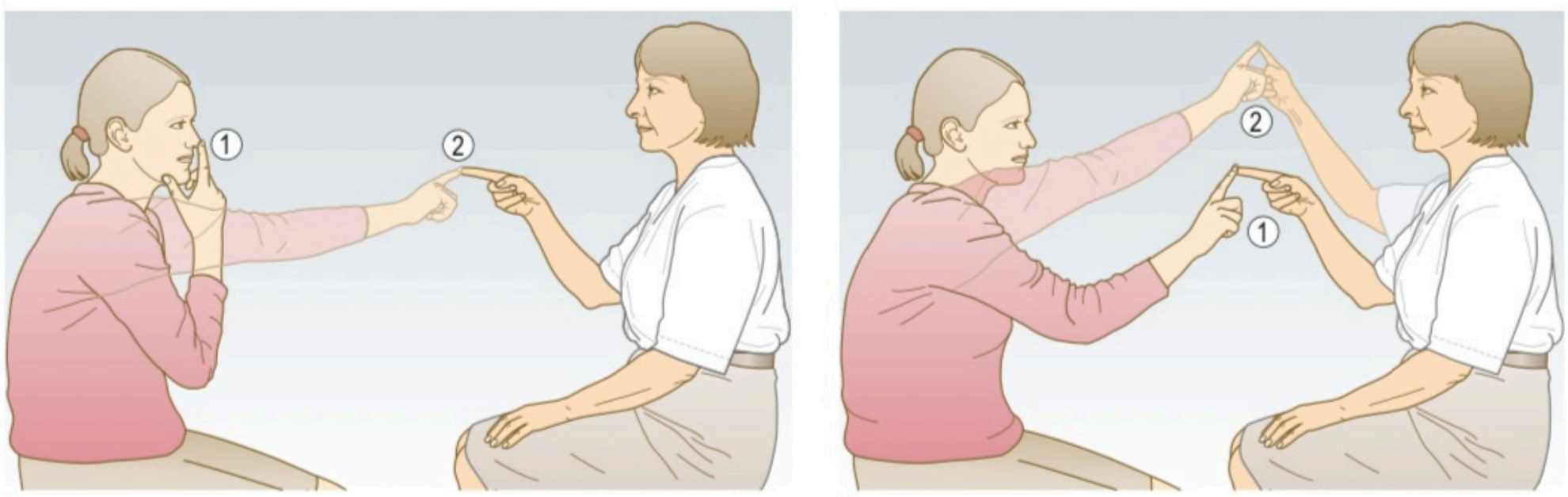


Fig. 7.22 **Finger-to-nose test.** A Ask the patient to touch the tip of their nose (1) and then your finger (2). B Move your finger from one position to another, towards and away from the patient (1), as well as from side to side (2).

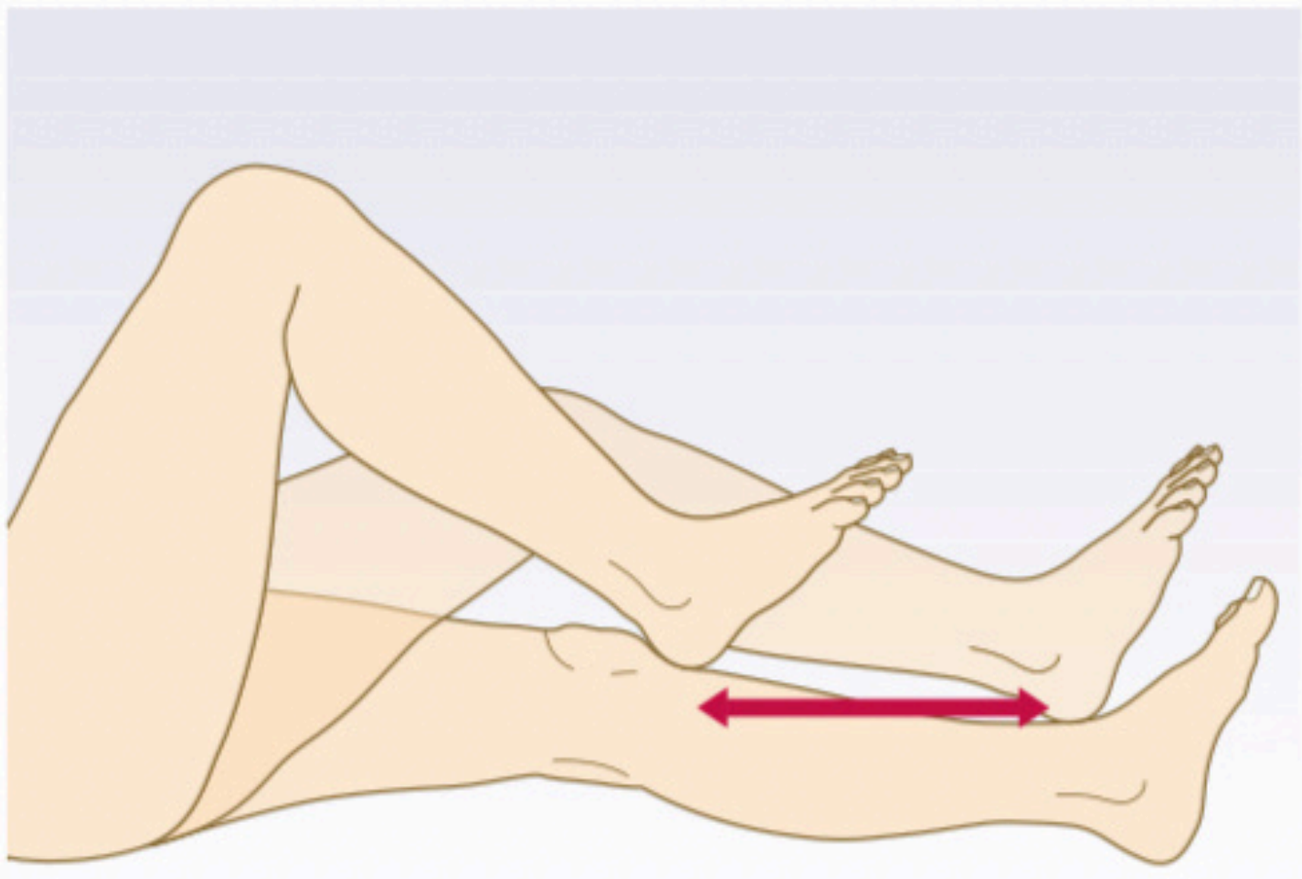


Fig. 7.23 Performing the heel-to-shin test with the right leg.

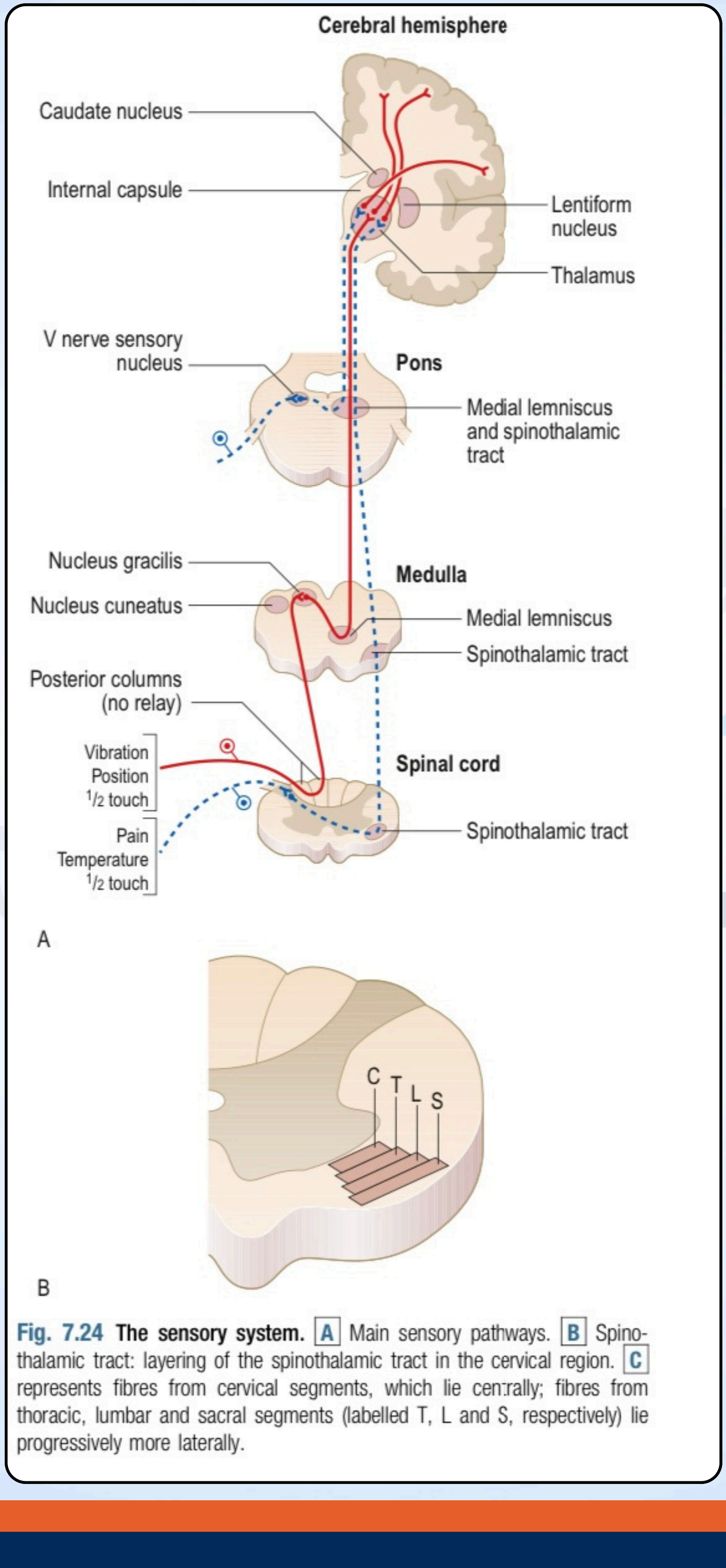


Fig. 7.24 The sensory system. A Main sensory pathways. B Spinothalamic tract: layering of the spinothalamic tract in the cervical region. C represents fibres from cervical segments, which lie centrally; fibres from thoracic, lumbar and sacral segments (labelled T, L and S, respectively) lie progressively more laterally.

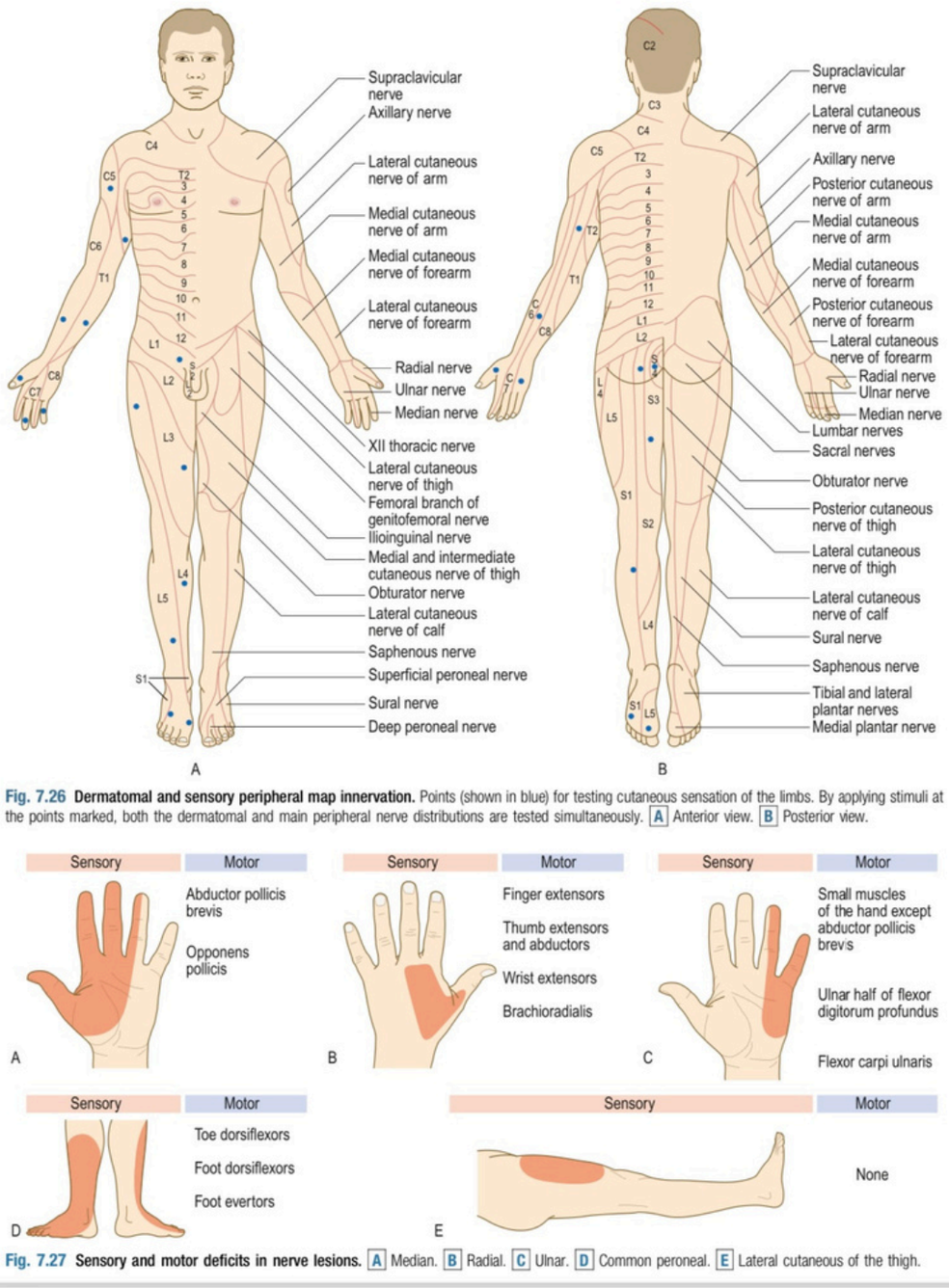


Fig. 7.26 Dermatomal and sensory peripheral map innervation. Points (shown in blue) for testing cutaneous sensation of the limbs. By applying stimuli at the points marked, both the dermatomal and main peripheral nerve distributions are tested simultaneously. A Anterior view. B Posterior view.

Fig. 7.27 Sensory and motor deficits in nerve lesions. A Median. B Radial. C Ulnar. D Common peroneal. E Lateral cutaneous of the thigh.

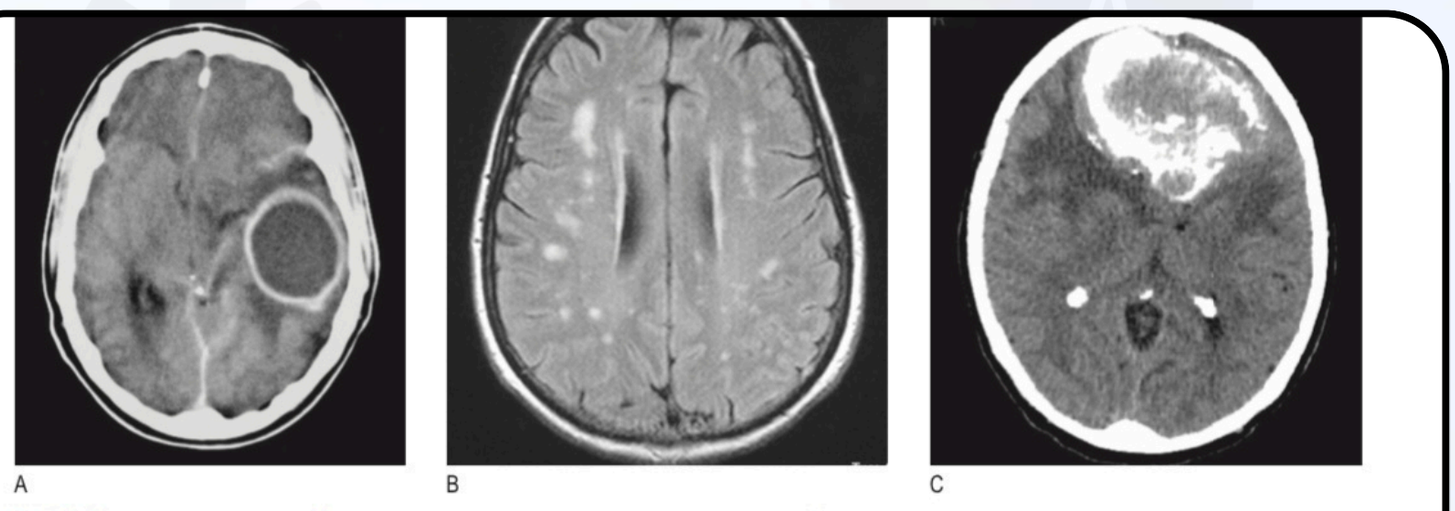


Fig. 7.29 Imaging of the head. A Computed tomogram (CT) showing a cerebral abscess. B Magnetic resonance scan showing multiple sclerosis with white demyelinating plaques. C CT scan showing a large meningioma arising from the olfactory groove.

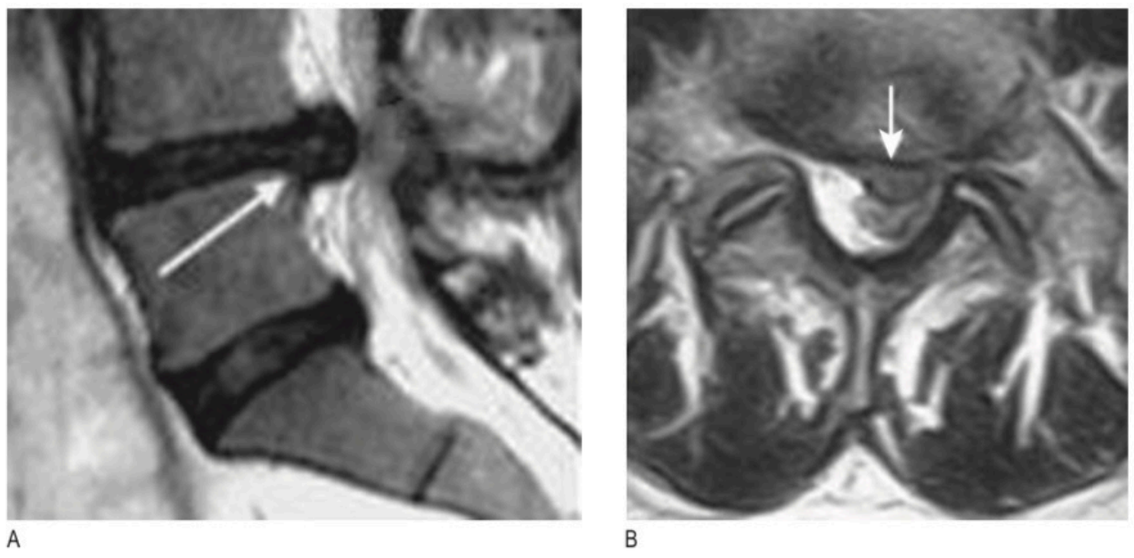


Fig. 7.30 T2 magnetic resonance images showing a large left paracentral L4–5 disc protrusion *(arrowed)* compressing the L5 nerve root. A Sagittal section. B Axial section.

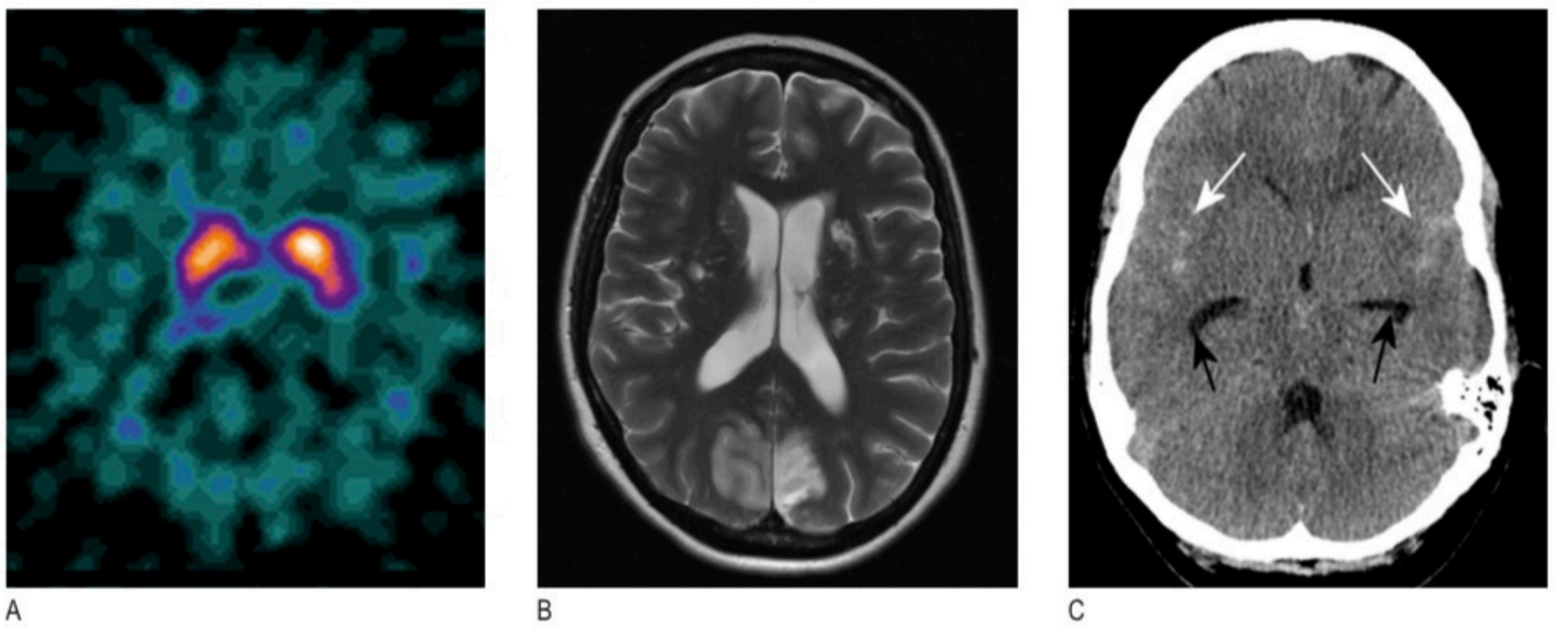


Fig. 7.28 Imaging of the head. A DaTscan showing uptake of tracer (dopamine receptors) in the basal ganglia on cross-section of the brain. B Magnetic resonance scan showing ischaemic stroke. T2 imaging demonstrates bilateral occipital infarction and bilateral hemisphere lacunar infarction. C Unenhanced computed tomogram showing subarachnoid blood in both Sylvian fissures *(white arrows)* and early hydrocephalus. The temporal horns of the lateral ventricles are visible *(black arrows)*.

1-The confrontation test used for assess of :

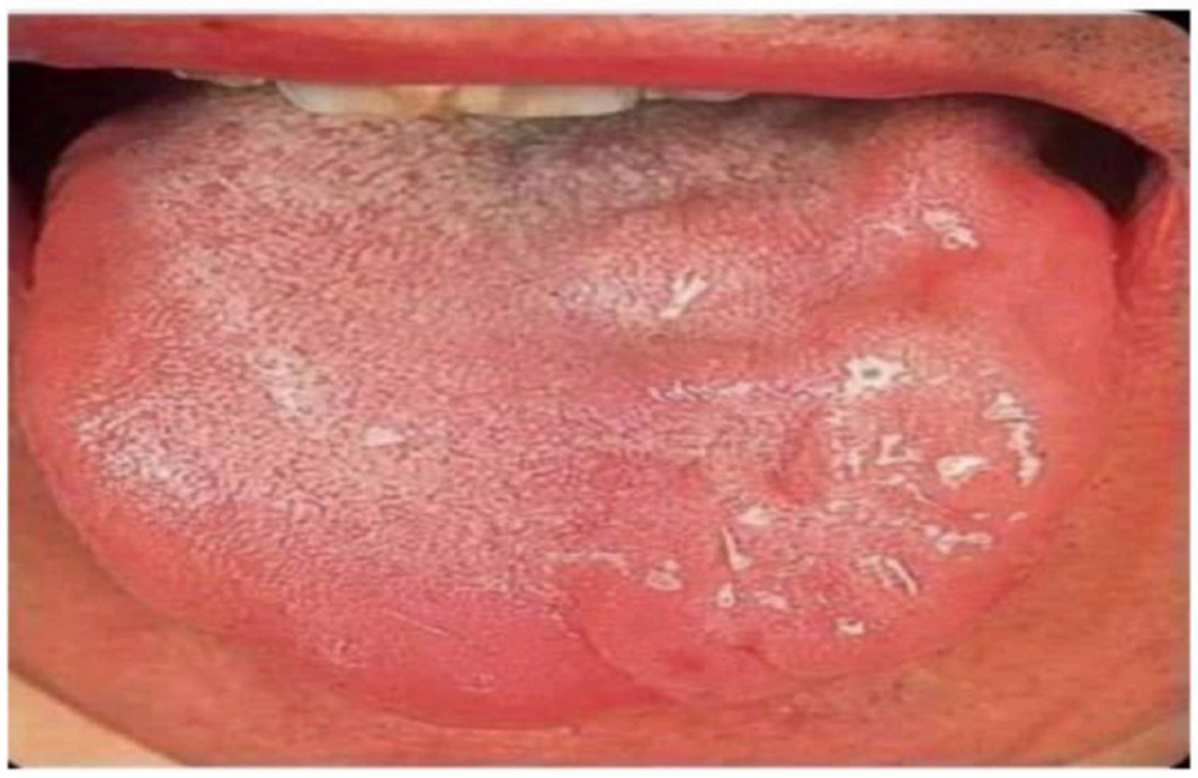
A. Visual acuity .

B. Visual color .

C. Ophthalmoplegia

D. Visual field . XXXX

E. Accommodation reflex .



3-Which is damaged nerve ?

A. Left trochlear nerve .

B. Left oculomotor nerve .

C. Left optic nerve .

D. Left abducent nerve . XXXX

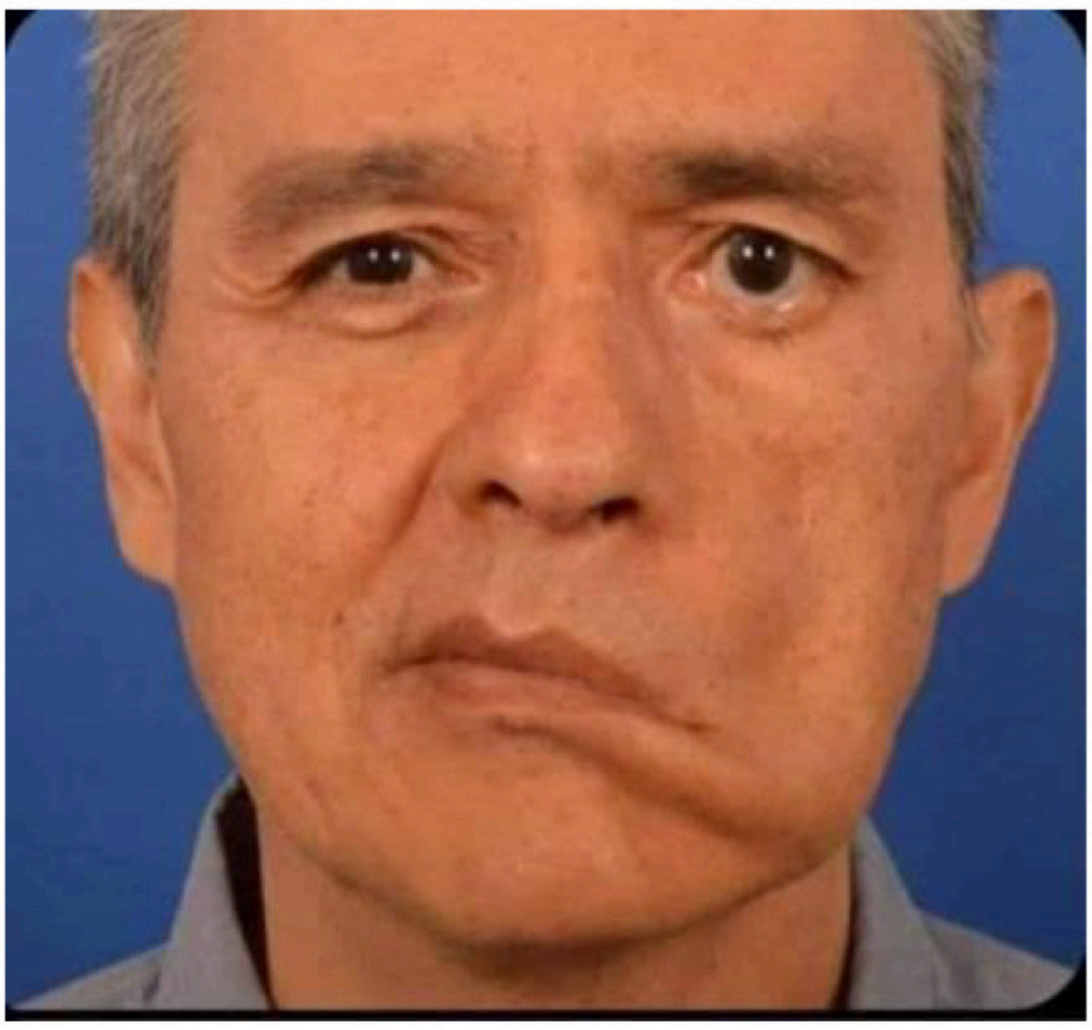
E. Right abducent nerve .

4- All of following are dxx for this sign except ?

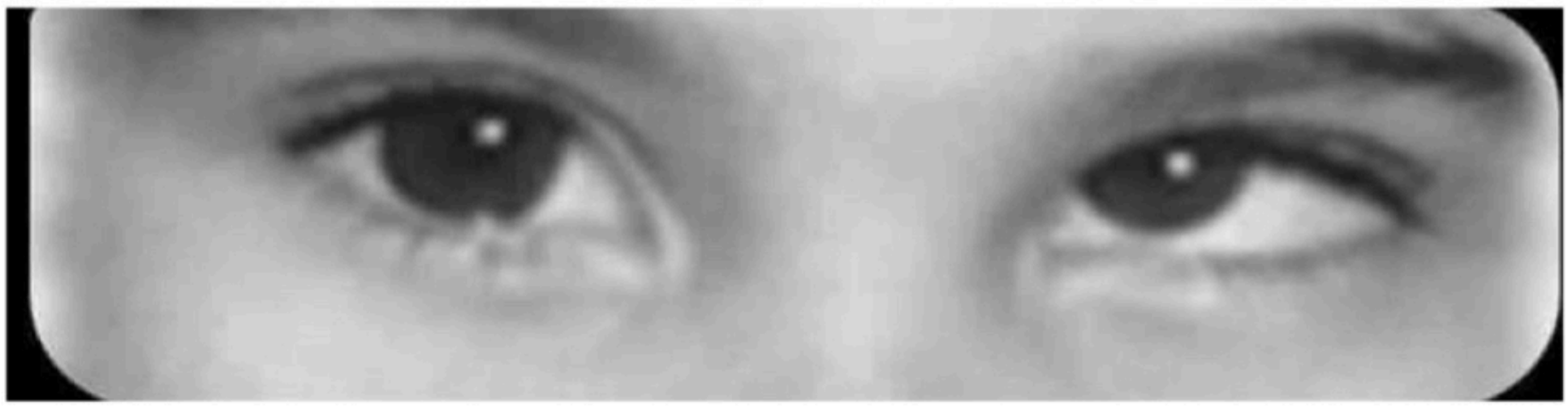
a) Right ventricular failure .
b) Acute bronchitis .
c) Mitral stenosis .
d) Acute thrombophelibitis . XXX ???????
e) Idiopathic pulmonary fibrosis .

8-Which is damaged cranial nerve

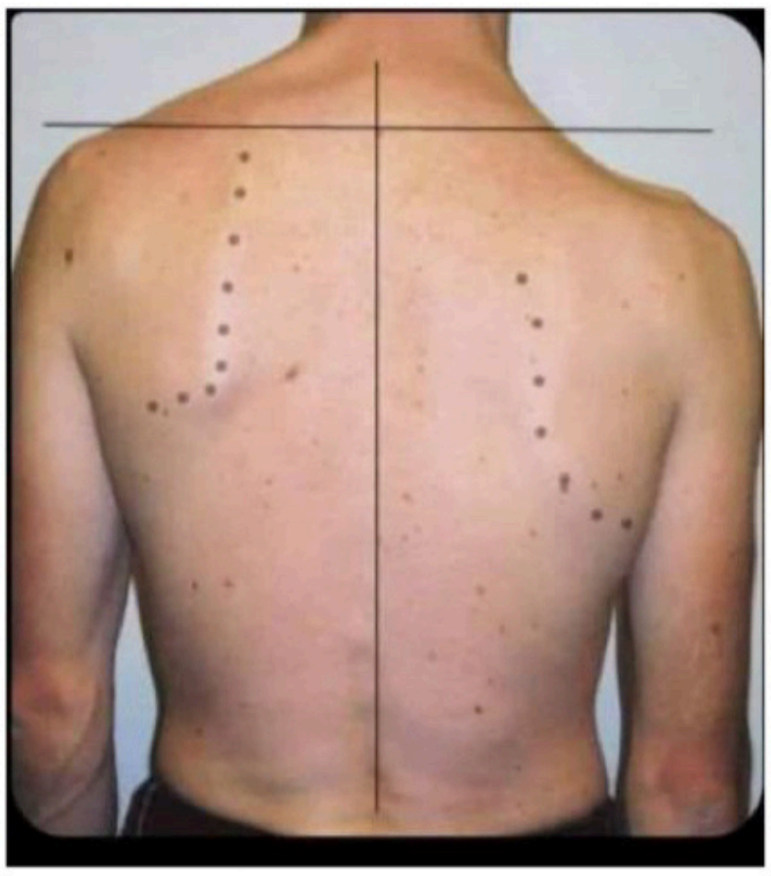
a. Right hypoglossal nerve .
b. Left vagus nerve .
c. Right trigeminal nerve .
d. Left hypoglossal nerve .
e. Left trigeminal nerve . XXX



10-Which is damaged cranial nerve



a. Right oculomotor nerve .
b. Left trochlear nerve . XXXX
c. Right trochlear nerve .
d. Left abducent nerve .
e. Left trigeminal nerve .



a. Spinal root of accessory nerve . XXX
b. Thoracodorsal nerve .
c. Long thoracic nerve .
d. Axillary nerve .
e. Glossopharyngeal nerve

.

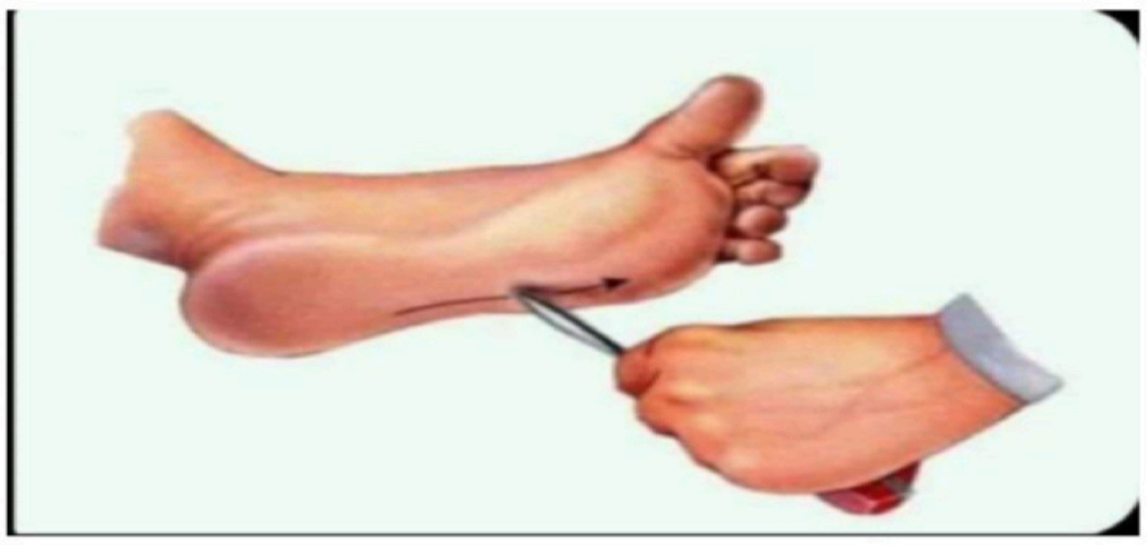
13-Which is damage nerve for this patient ?

a. Spinal root of accessory nerve .
b. Thoracodorsal nerve .
c. Long thoracic nerve . XXX
d. Axillary nerve .
e. Glossopharyngeal nerve .

14- Which is damaged cranial nerve

a. Right hypoglossal nerve .
b. Left vagus nerve .
c. Right vagus nerve . XXX
d. Left hypoglossal nerve .
e. Left trigeminal nerve .

28-Which correct about this test ?



a. Indicated lower neuron lesion
b. associated with sensory ataxia
c. Indicated upper neuron lesion XXXX
d. Indicated polyneuropathy .
e. Abnormal in neonate .

11- what is the name of this nerve ?

a. Accessory nerve ✓
b. Vagus nerve
c. Hypoglossal nerve

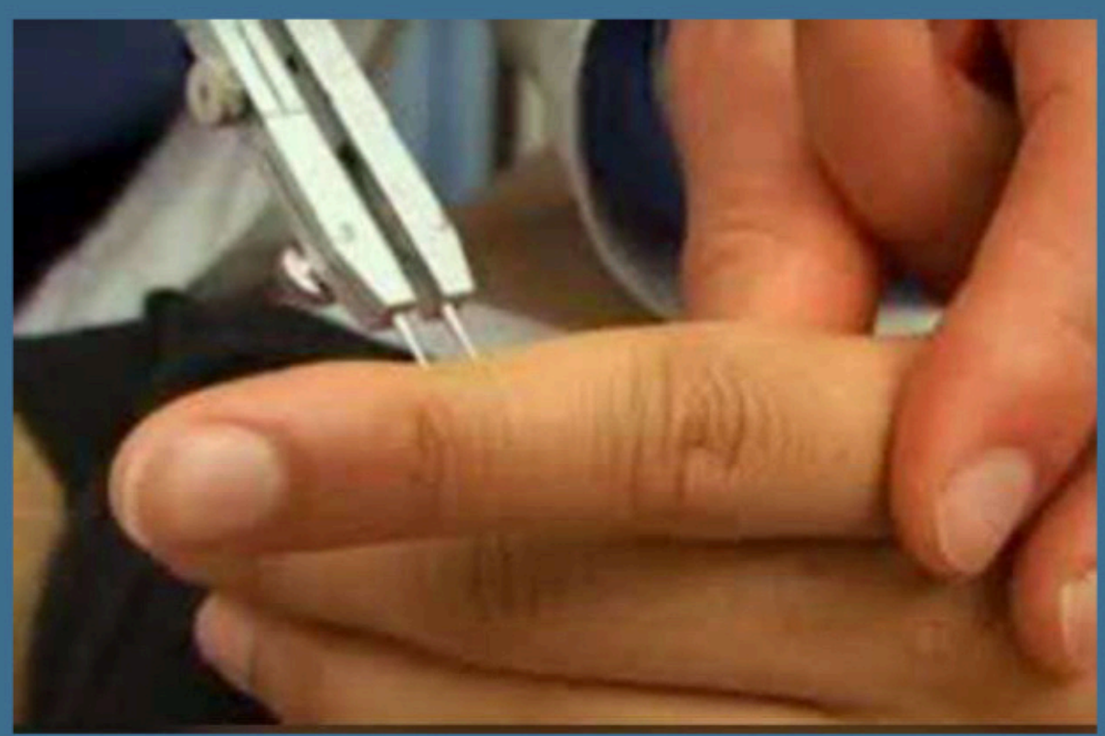
مساعدة : بمر على ال sternocleidomastoid muscle

18.

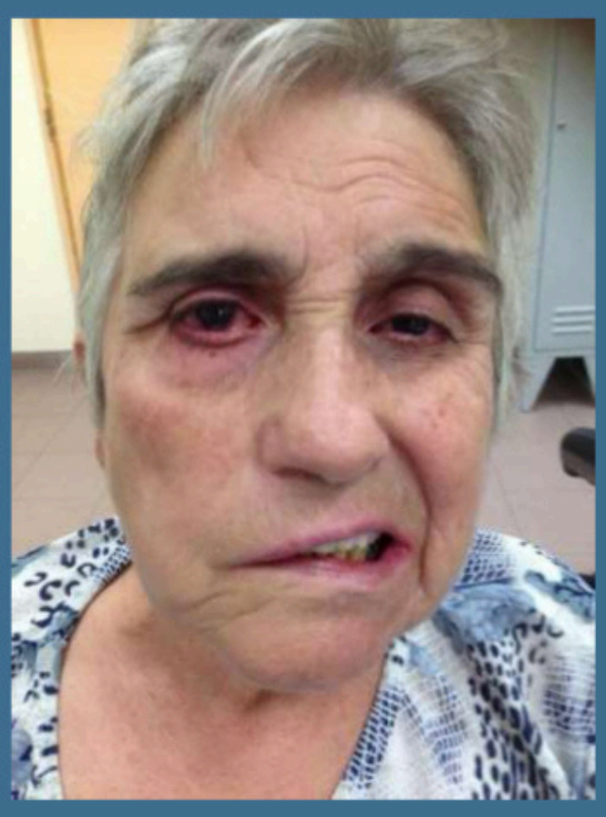
7th nerve pulsy

Name of the test?

1) Two point discrimination (high cortical function)
2) pain
3) Touch test



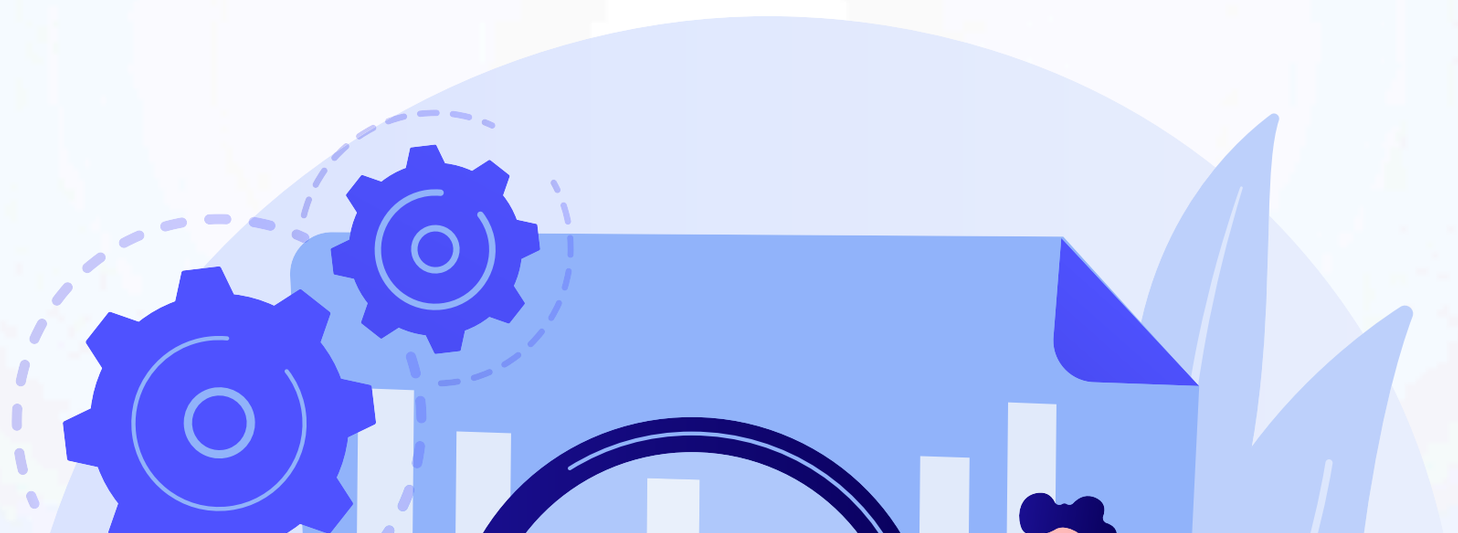
Right bells palsy (VII nerve)



MINI-OSCE

MACLEOD

ENT



الفريق الأكاديمي
لجنة الطب والجراحة

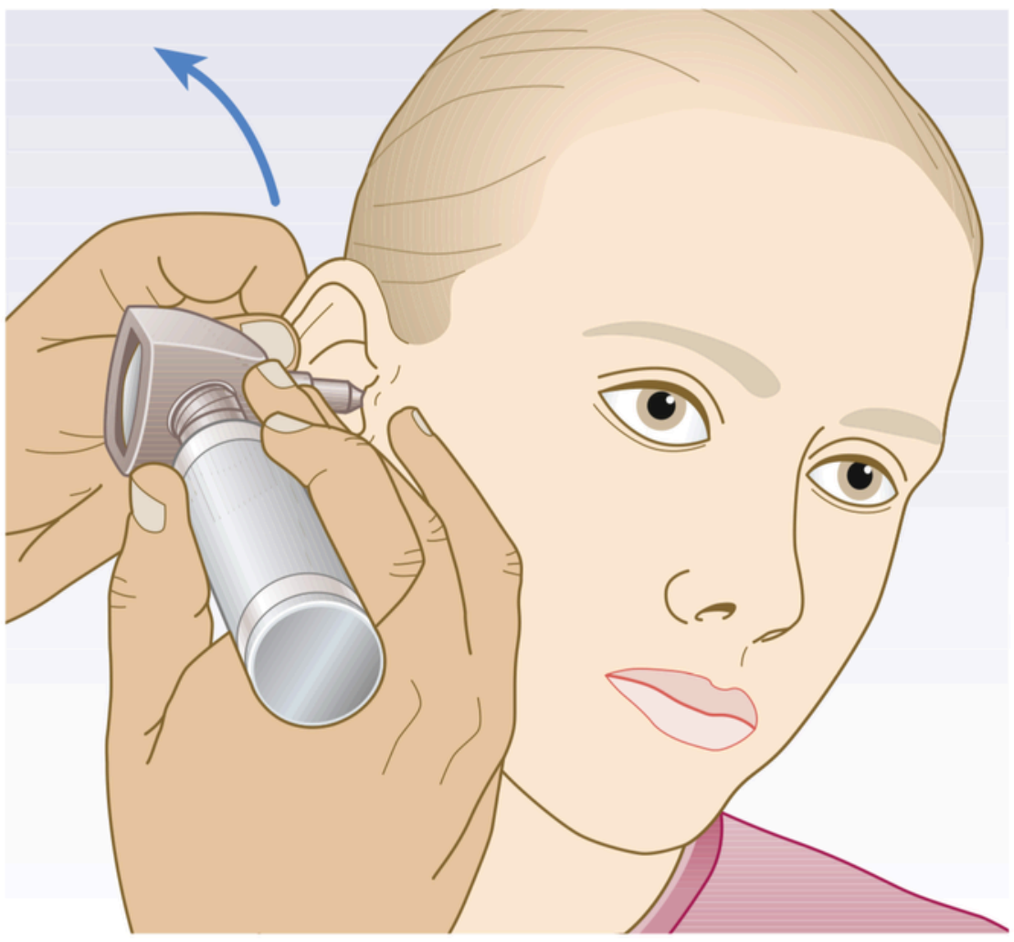
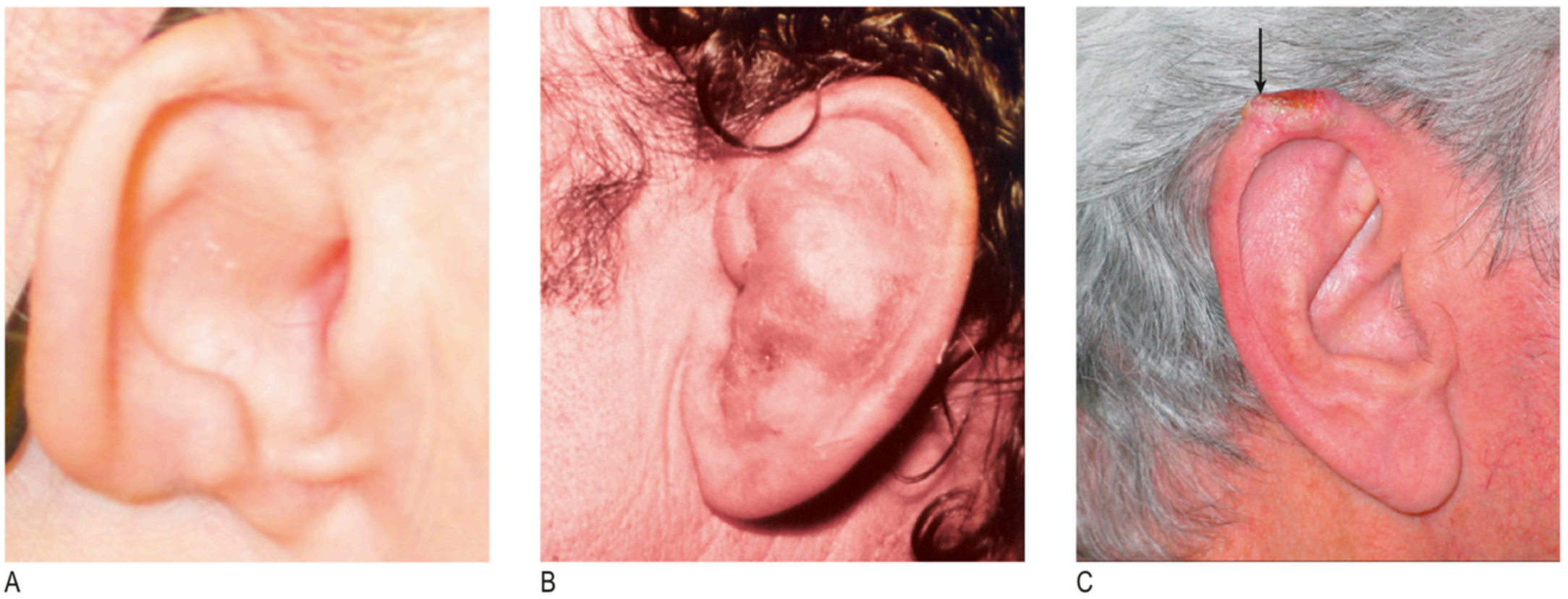


Fig. 9.3 Examination of the ear using an otoscope.

B

B Normal tympanic membrane.

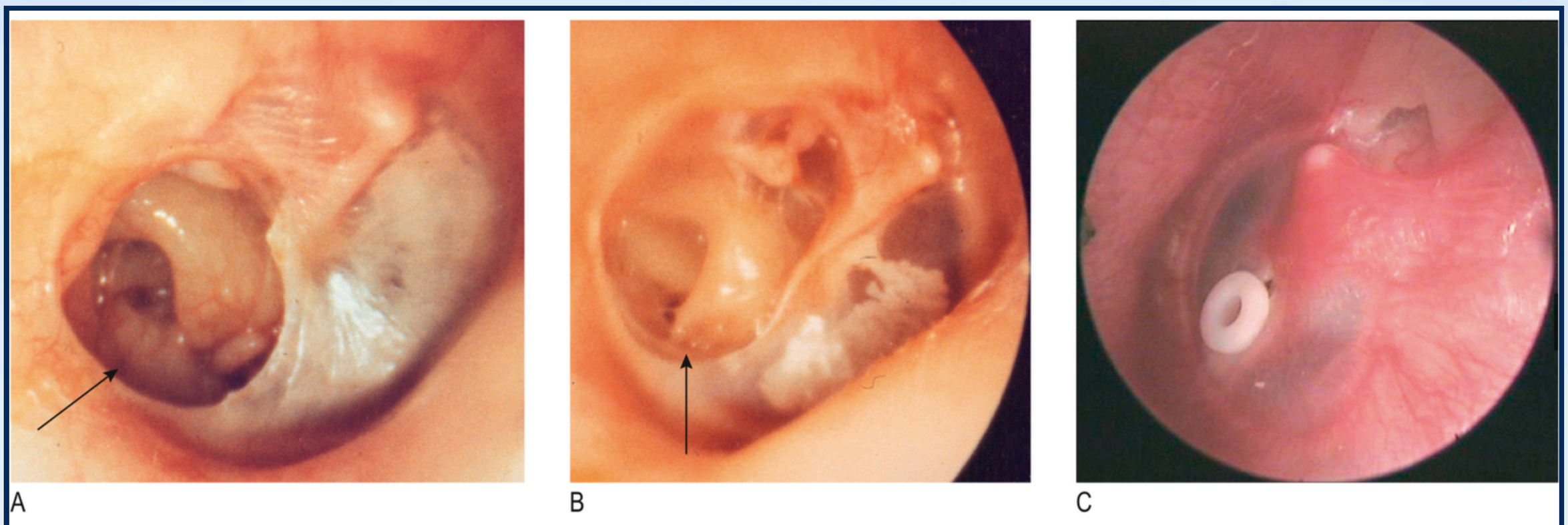


A B C

Fig. 9.4 **The pinna.** A Microtia. B Haematoma. C Squamous cancer *(arrow)*.

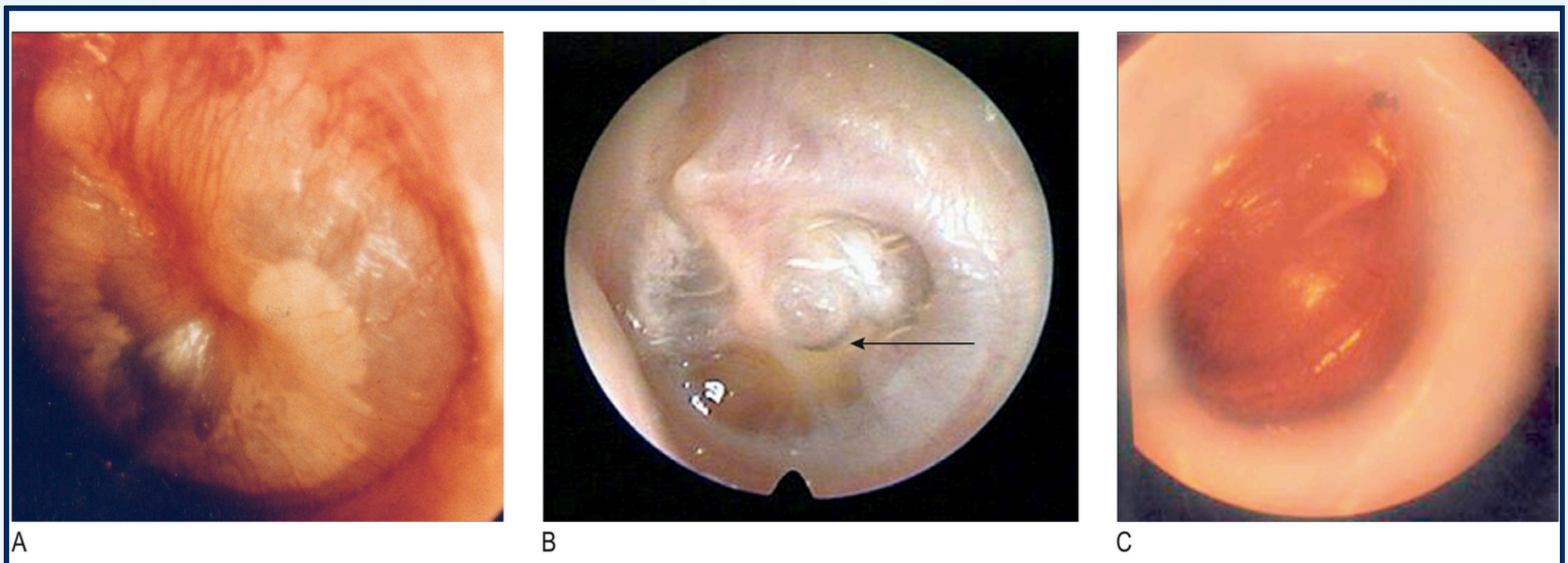
A B C

Fig. 9.5 **Auditory canal abnormalities.** A Otitis externa. B Exostosis of the external auditory meatus. C Cholesteatoma.



A B C

Fig. 9.6 Tympanic membrane abnormalities. A Tympanic membrane perforation *(arrow)*. B Retraction pocket of the pars tensa *(arrow)*. C Grommet in situ.



A B C

Fig. 9.7 Otitis media. A With effusion. B Fluid level behind the tympanic membrane *(arrow)*. C Acute otitis media.

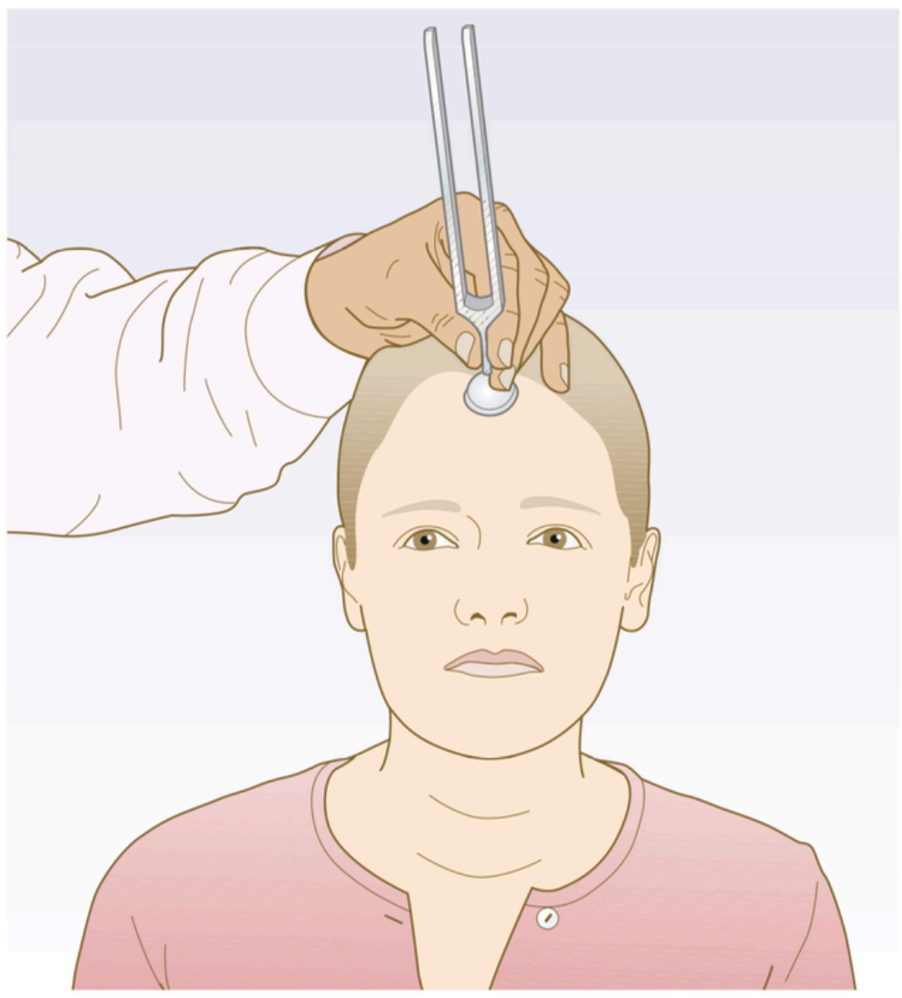


Fig. 9.8 Weber's test.

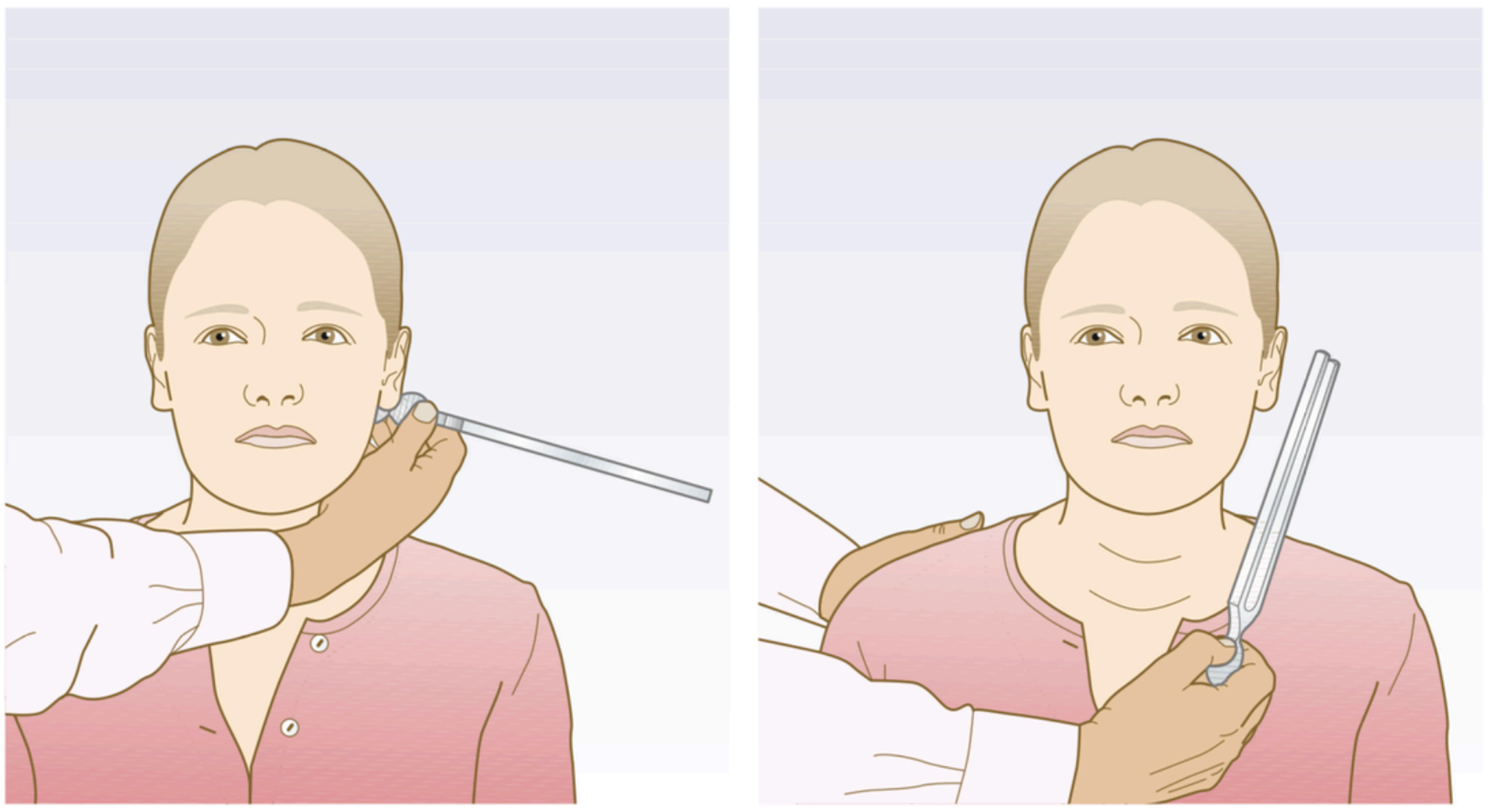


Fig. 9.9 **Rinne's test.** A Testing bone conduction. B Testing air conduction.

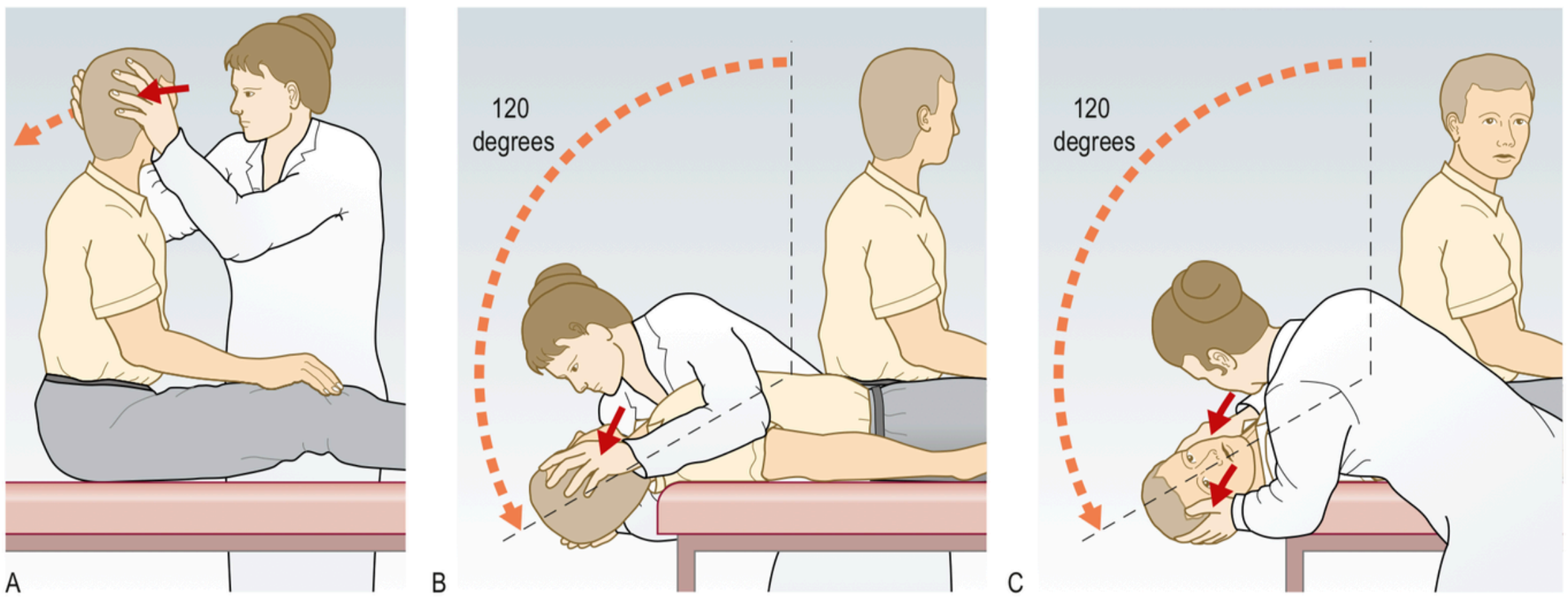


Fig. 9.10 **Dix–Hallpike position test.** The examiner looks for nystagmus (usually accompanied by vertigo). Both nystagmus and vertigo typically decrease (fatigue) on repeat testing. See text for details.

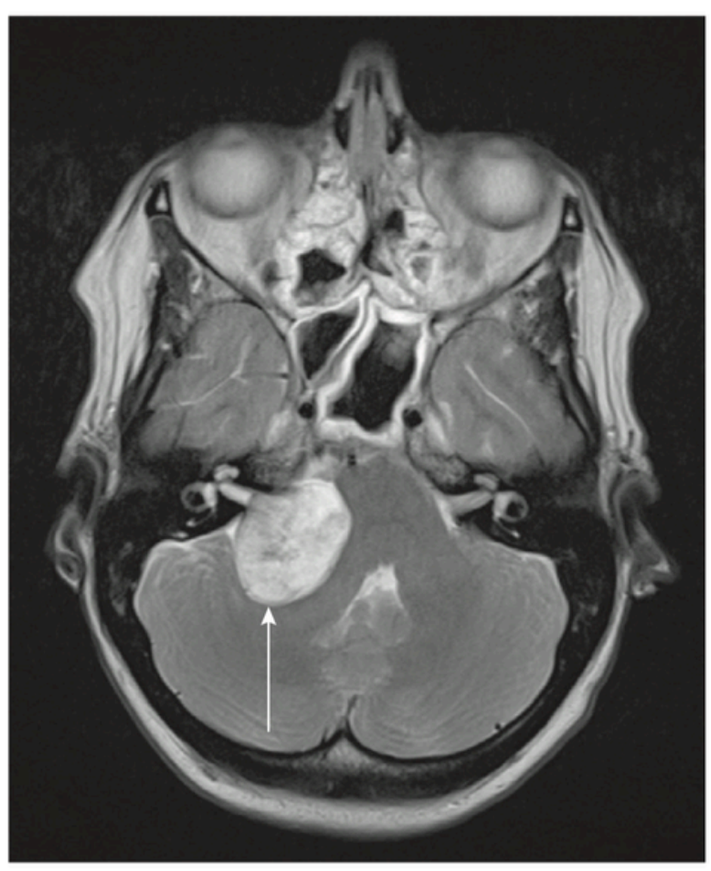


Fig. 9.11 Magnetic resonance image showing a right acoustic neuroma *(arrow)*.

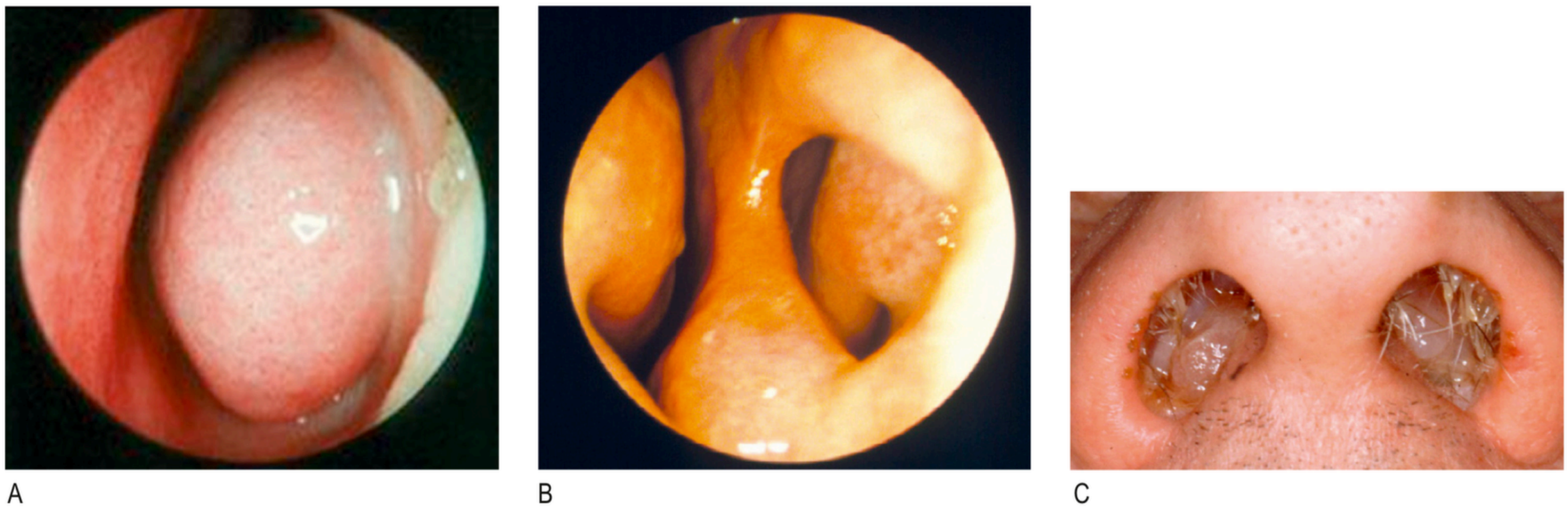


Fig. 9.14 Nasal abnormalities. A Turbinate hypertrophy. B Nasal septum perforation post-surgery. C Nasal polyps.

Fig. 9.15 Rhinophyma as a complication of rosacea.

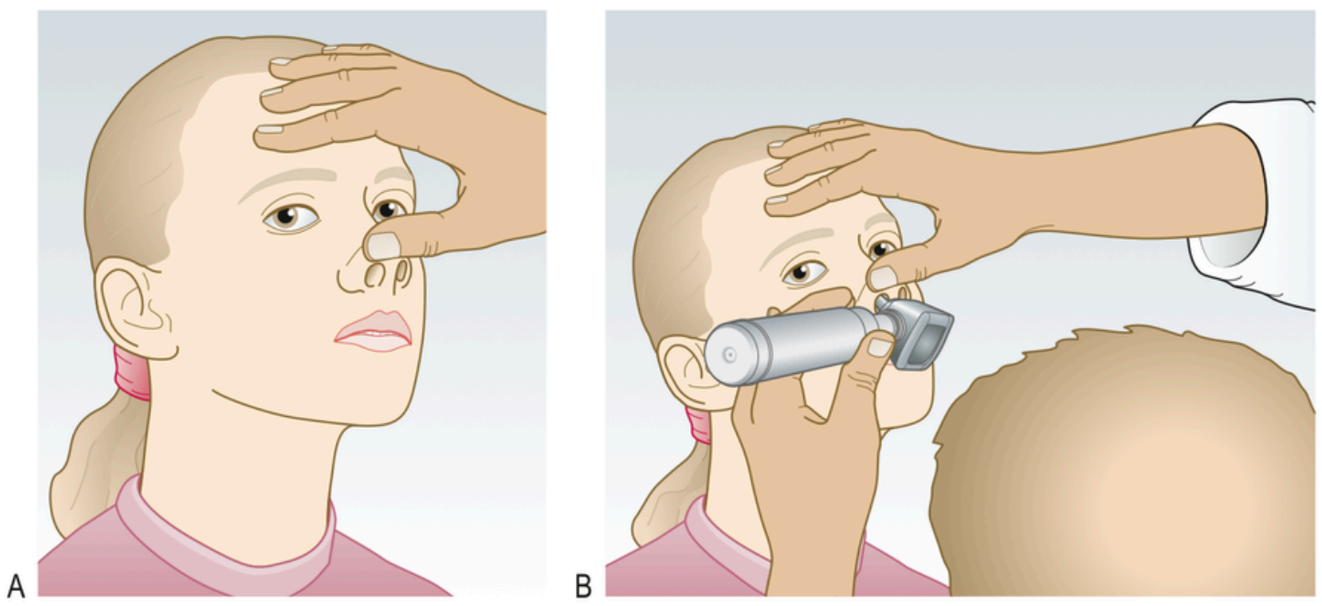


Fig. 9.16 Nasal examination. A Elevation of the tip of the nose to give a clear view of the anterior nares. B Anterior rhinoscopy using an otoscope with a large speculum.

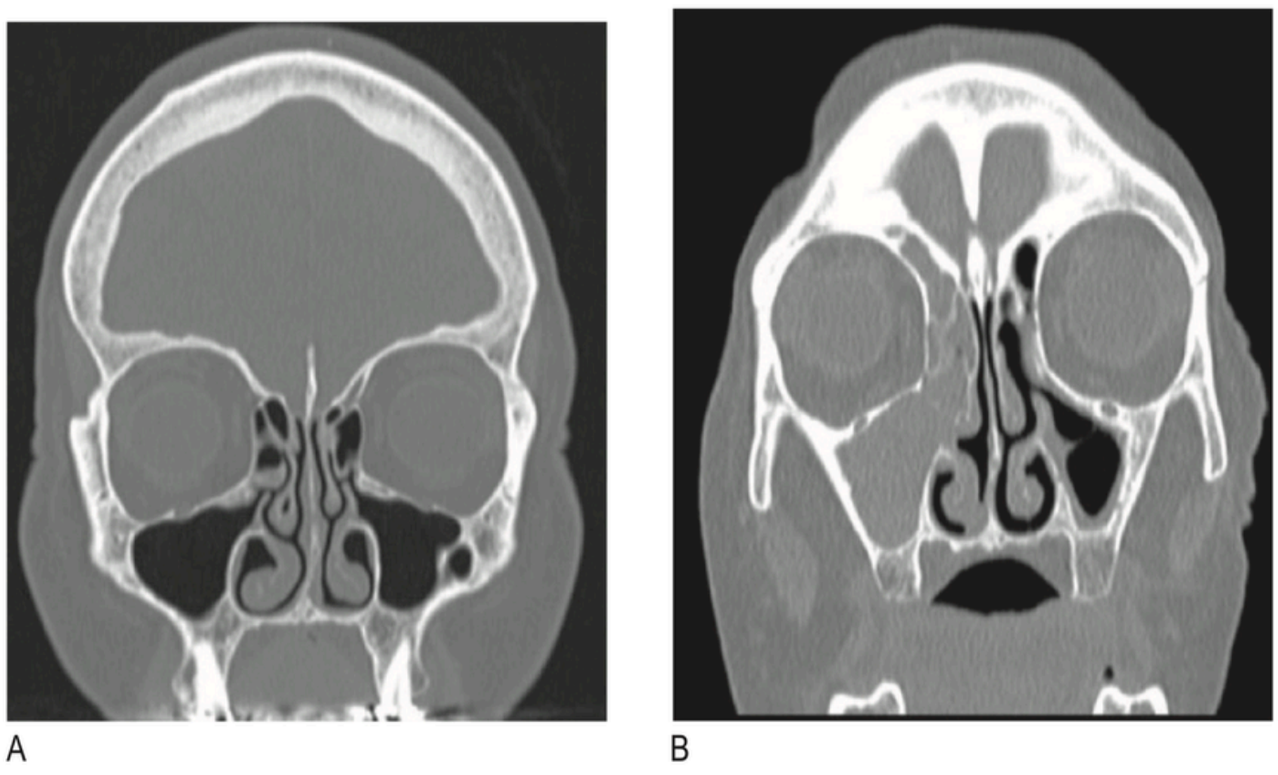
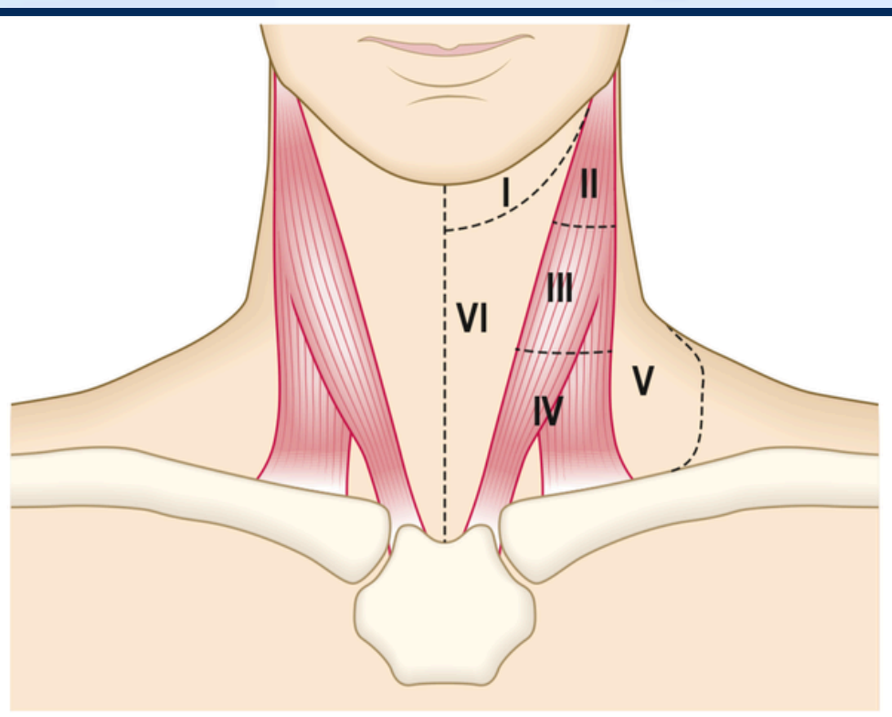


Fig. 9.17 Computed tomograms of the paranasal sinuses. A Normal scan. B Right-sided chronic sinusitis.



I Submental and submandibular nodes
II Upper third sternocleidomastoid (SCM) muscle
III Middle third SCM (between hyoid and cricoid)
IV Lower third SCM (between cricoid and clavicle)
V Posterior to SCM (posterior triangle)
VI Midline from hyoid to manubrium

g. 9.22 Cervical lymph node levels.

Fig. 9.24 Pus discharging from the parotid duct.

Fig. 9.28 Thyroglossal cyst.

A C

Fig. 9.23 **Sore throat.** A Acute tonsillitis. The presence of pus strongly suggests a bacterial (streptococcal) aetiology. B Glandular fever showing palatal petechiae. C A left peritonsillar abscess. (A) From Bull TR. Color Atlas of ENT Diagnosis. 3rd edn. London: Mosby–Wolfe; 1995.