OSCE – SURGERY

DOSSIER

2022-2023

مقدّمة

بسم الله الرَّحمن الرَّحيم

العلمُ يجلو العَمى عن قلبِ صاحبهِ كما يجلِّي سوادَ الظُّلمةِ القمرُ
والعلم يحيِي قلوب الحاملينَ لهُ كالأرض تحيَا إذا ما مسَّها المطرُ

باسم لجنة الطب والجراحة _الفريق الأكاديمي .. نقدم لكم خلاصةَ جهدٍ مأمول بالنفعِ ، وسعيٍ جل وصولِه تسهيلُ سعيكم ، وبذل سواعدَ عزمت أن تكون في عونكم ، آملين بذلك كله أن نثبت على ما عرفته مؤتة من همتنا ،

فهذه دوسية الجراحة للسيرة المرضية والفَحص السَّريري(History taking & physical Examination) في نسختها الأولى، مجمّعة ومنقّحة وشاملة لجميع المواضيع المطلوبة للسنة الرابعة والسادسة ، لا ننزهها عن الخطأ ولكننا بذلنا في سبيلها أبلغ الطاقات والجهود،

نسأل الله أن تكون رفيقًا معينًا ومهونًا عليكم في وقفات الراوندات وليالي الاوسكيات ،

الشكر الموصول لكل من أعطى وساهم في إنجازها ،

رشا الحرباوي رغد الزغول نعمة عيسى بشرى البشايرة
صفاء مطر منى الزعبي أنسام الزبيدي مي بني عطا
ميساء عيال سلمان نبال هايل رؤى الزواهرة حلا الزيناتي
براء صالح القضاة

كما ونشكر للدكتورة إيناس الظاهر جهودها المتفانية في تدقيق مواضيع الدوسية

وختاماً بمن أشرف على التصميم : أنسام الزبيدي، شهد الأيوبين، حلا محاسنة.

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ملاحظات حول الدوسية

مواضيع الدوسية شاملة لأغلب المواضيع في الجراحة، واللي ممكن ننسأل عنها بالراوندات ، ومش بالضرورة كل هذه المواضيع تكون داخلة في الامتحان ، هي موجودة فقط من باب الشمول لمواضيع الراوندات وليس فقط امتحان الاوسكي

الدوسية مزوّدة بفيديوهات للفحص السريري، موجودين بالصفحة الخاصة بالموضوع ، وكل اللي عليكم تضغطوا على (🧠) ورح ينقلكم للفيديو

.

حاولنا بقدر الامكان نعتمد أفضل المصادر في اختيار المواضيع ، وعدلنا عليها وضفنا بناء على الشغلات اللي ممكن الدكاترة يركزوا عليها ، ودققناهم لحتى نطلعلكم بأفضل شكل ممكن للدوسية.

وأخيرا.. أيُّ صوابٍ فمن الله وأيُّ خطأ فهو منّا .

أي ملاحظات لتحسين الدوسية نستقبلها على هذا الفورم..

https://forms.gle/n3MUmtcYthYmQWY67

part 1

GENERAL SURGERY

اللّهم ليس بجدّي و اجتهادي و إنّما توفيقك و عونك يا معين

Breast Mass- History taking

❖ Patient profile :

- Name
- Age: The risk of ca peaks at ages above 50 y/o.
- Marital status
- Occupation: if involves exposure to radiation.
- Address

❖ Chief complaint + duration :

❖ HOPI :

History of a Lump:

· Timing: when was the lump first noticed?
· How was it noticed?
· Site/size/shape
· Consistency: does the lump feel soft or hard?
· mobility: Is it mobile or fixed?
· Associated lumps: are there any other masses?
· Progression: has the lump changed in size, consistency, or severity of pain with time?
· Does it come and disappear?

Symptoms :

- Fever, weight loss, night sweats, loss of appetite, interference with movement?
- Pain: is the lump painful or painless?
- Skin changes: redness, hotness, ulceration, hardening, dimpling.
- Nipple changes: destruction, discoloration, retraction, duplication, discharge, displacement, deviation.
- Nipple discharge: color, amount, consistency
- Swelling in the axilla.

· Previous trauma

Previous Hx of a similar mass

❖ Gynaecological Hx :

- age of menarche and menopause

early menarche and late menopause are associated with increased incidence of breast cancer.

- How regular the cycle is and what quantity of blood?
- Are the symptoms altered with menses?

it indicates benign disorders usually

❖ Obstetric Hx :

- Age during first pregnancy? (↑ age = ↑ estrogen exposure = ↑ risk of breast ca .)
- Changes in breasts during previous pregnancies?
- No. of children? (↑ No. = decreased incidence of breast cancer.)
- How many of your children did you breastfeed? For how long? (decreases BC risk)

❖ Past medical Hx :

- Chronic diseases (HTN , DM , etc)
- Previous Hx of breast / ovarian masses, cancer ?

❖ Surgical Hx :

- Breast surgery (e.g. mastectomy, lumpectomy, breast reconstruction)

❖ Family Hx:

- Any family history of breast, ovarian or colon cancer/masses?

❖ Drug Hx:

- Contraceptive use (e.g. oral, subcutaneous, IUS)
- Hormone-replacement therapy (HRT)

> Both are associated with an increased risk of breast ca.

- Previous chemo or radiotherapy?

❖ Social Hx :

- Smoking
- Alcohol

❖ Systemic review

Breast examination

1. Wash your hands/hygiene
2. Ensure good light & privacy.
3. Introduce yourself to the patient and briefly explain what the examination will involve.
4. Gain consent to proceed with the examination.
5. Ask for the need for a chaperone.
6. Position the patient sitting upright on the side of the bed.
7. Adequately expose the patient's breasts.
8. Ask if the patient has any pain before proceeding.

❖Inspection

With the patient sitting on the side of the bed

-Inspect the breasts looking for:

· Scars: these may indicate previous breast surgery
· Asymmetry
· Masses: note any visible lumps
· Nipple abnormalities: these can include nipple inversion and discharge (describe its color, consistency, and volume).
· Skin changes: including scaling, erythema, puckering, and peau d'orange.

-Repeat inspection with the patient pressing their hands into their hips to contract the pectoralis muscles.
If a mass is visible, observe if it moves when the pectoralis muscle contracts which suggests tethering to the underlying tissue (e.g. invasive breast malignancy).

- Then, ask the patient to place their hands behind their head and lean forward.
This position exposes the entire breast and will exaggerate any asymmetry, skin dimpling, or puckering.

-Lift the breast with your hand to inspect for evidence of pathology not visible during the initial inspection (e.g. dimpling, skin changes).

❖Breast palpation

Position: lying down at 45°.

1. palpation of the asymptomatic breast first and then repeat all examination steps on the contralateral breast.

- A systematic approach to palpation is essential to ensure all areas of the breast are examined. For example: divide the breast into quadrants and examine each thoroughly or begin palpation at the nipple and work outwards in a concentric circular motion.

- If a mass is detected, assess the following characteristics:
Location/ Size / Shape / Consistency / Mobility / Fluctuance / Overlying skin changes.

2. Palpate each axillary tail .

❖ Palpation of lymph nodes

Axillary lymph nodes

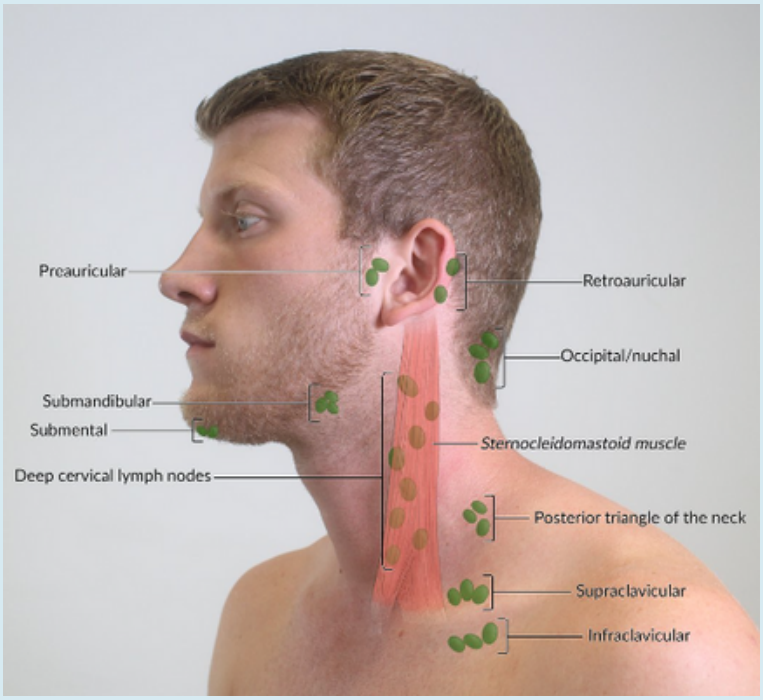
1 . Ask if the patient has any pain in either shoulder before moving the arm.
3. Begin by inspecting each axilla for evidence of scars, masses, or skin changes.
4. When examining the right axilla, use the left hand. The reverse is applied when examining the left axilla.
6. Examination of the axilla should cover the anterior, medial, posterior, lateral, and apical groups of lymph nodes.

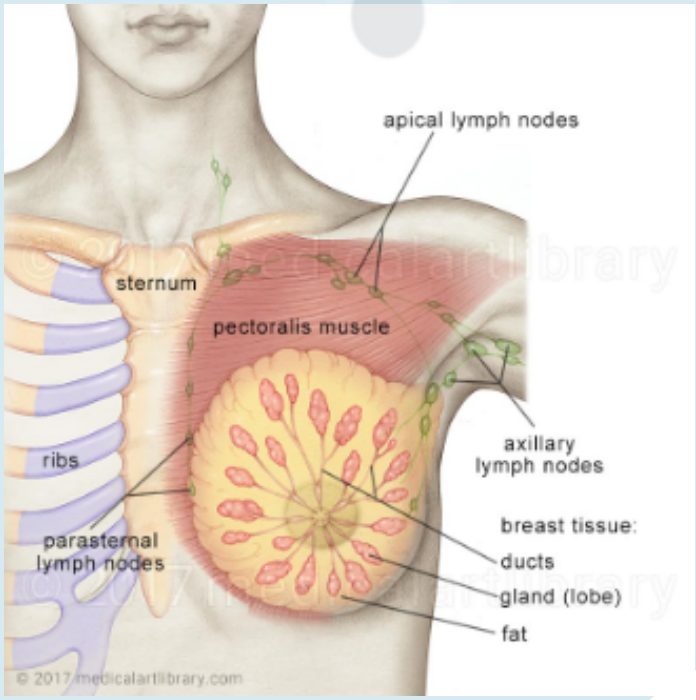
Other lymph nodes

examine the following groups of lymph nodes:
· Cervical lymph nodes
· Supraclavicular lymph nodes
· Infraclavicular lymph nodes
· Parasternal lymph nodes

❖ To complete the examination

- Cover the patient
- Thank the patient
- wash your hands





Neck Lump - History taking

❖ Patient profile :

- Name
- Age: Consider neoplasia first in older patients.
- Marital status
- Occupation: if involves exposure to radiation / Wood dust exposure
- Address

❖ Chief complaint + duration: Malignant masses grow faster!

❖ HOPI :

History of a Lump:

· **Timing:** when was the lump first noticed?
· **How** was it noticed?
· **Site:** anterior triangle, posterior triangle, midline
· **Size**
· **shape**
· **Consistency:** does the lump feel soft or hard?
· **mobility:** Is it mobile or fixed?
· **Associated lumps:** are there any other masses?
· **Progression:** has the lump changed in size, color, or shape?
· **Does it come and disappear?**
· **Previous Hx** of a similar case
· **Hx of trauma**

Associated symptoms :

- **Pain:** is the lump painful or painless? Referred to anywhere? e.g.Otalgia
- **Dysphagia**
- **Hoarseness**
- **Dyspnea, SOB on sleeping, or Stridor**
- Symptoms suggesting infection/inflammation: **fever, rigors, malaise, local** symptoms.
- Symptoms suggesting malignancy: **fever, anorexia, weight loss, night sweats.**

Symptoms of hyperthyroidism :

-Fatigue
-Heat intolerance
-weight loss/ increased appetite
-anxiety / nervousness/ irritability
-tremor
-increased sweating
-increased bowel frequency & diarrhea
-tachycardia or atrial fibrillation (invreased or irrgegular heart rate)
-muscle weakness
-development of goiter (swelling at the front of the neck)

Symptoms of hypothyroidism :

-fatigue / low energy
-cold intolerance
-weight gain
-constipation
-hair loss, dry skin/ hair/ nails
-depression
-bradycardia
-muscle cramps & joint pain
-slow speech, hoarse voice
-menstrual problems & infertility
-elevated cholesterol levels
-low basal body temperature
-development of goiter

❖ Past medical Hx :

- Chronic diseases (HTN, DM , etc)
- Previous History of thyroid disease, any autoimmune or liver diseases?
- Radiation

❖ Surgical Hx

❖ family Hx :

- Any family history of thyroid cancer/masses?

❖ Drug Hx

❖ Social Hx :

- Smoking
- Alcohol

❖ Systemic review

- **Investigations:**

- TSH, T3, T4
- TSH receptor antibody
- Thyroid autoantibodies
- Radioisotope imaging
- Ultrasound
- Fine needle aspiration

Neck lump - examination

1. Wash your hands/hygiene
2. Ensure good light & privacy.
3. Introduce yourself to the patient and briefly explain what the examination will involve.
4. Gain consent to proceed with the examination.
5. Ask the patient to sit on a chair for the assessment.
6. Exposure: Adequately expose the patient's neck to the clavicles.
7. Ask the patient if they have any pain before proceeding with the clinical examination.

❖ General inspection :

Inspect the patient, looking for clinical signs suggestive of underlying pathology:
- Scars / Cachexia / Hoarse voice / Dyspnoea or stridor
- Behaviour: anxiety and hyperactivity are associated with hyperthyroidism. Hypothyroidism is more likely to be associated with low mood.
- Clothing: may be inappropriate for the current temperature. Patients with hyperthyroidism suffer from heat intolerance whilst patients with hypothyroidism experience cold intolerance.
- Exophthalmos: associated with Graves' disease.

· Assessment of the neck lump

1. Neck lump inspection

Inspect the neck lump from the front and side, noting its location (e.g. anterior triangle, posterior triangle, midline).

· Swallowing

Ask the patient to swallow some water and observe the movement of the mass:
-Thyroid gland masses (e.g. goiter) and thyroglossal cysts typically move upwards with swallowing.

· Tongue protrusion

Ask the patient to protrude their tongue:
-Thyroglossal cysts will move upwards noticeably during tongue protrusion.
-Thyroid gland masses and lymph nodes will not move during tongue protrusion.

2.Neck lump palpation

Palpate the neck lump by assessing the following:

-Site: assess the lump's location in relation to other anatomical structures (e.g.anterior triangle, posterior triangle, midline).
-Size
-Shape
-Edges: regular/ irregular
-Consistency: soft (e.g. cyst), hard (e.g. malignancy), or rubbery (e.g. lymph node).
-Mobility: mobile or tethered to other local structures.
-Tenderness: may indicate infection and/or inflammation
-Overlying skin changes: such as erythema(e.g.inflammation/infection).
-Temperature: increased warmth may suggest an inflammatory or infective cause
-Fluctuance: hold the lump by its sides and then apply pressure to the center of the mass with another finger. If the mass is fluid-filled (e.g. cyst) then you should feel the sides bulging outwards.
-Pulsatility: suggests vascular origin (e.g. carotid body tumor, aneurysm).
-Transillumination: apply a light source to the lump, if it is illuminated it suggests the lump is fluid-filled (e.g. cyst)

3.Neck lump auscultaltion

auscultate the lump to listen for a bruit suggestive of vascular cause (e.g. carotid artery aneurysm).

· Assessing the thyroid gland

-Palpation of the thyroid gland:

Palpate each of the thyroid's lobes and the isthmus:
1. Stand behind the patient and ask them to tilt their chin slightly downwards.
2. Place the three middle fingers of each hand along the midline of the neck below the chin and Locate the upper edge of the thyroid cartilage ("Adam's apple") with your fingers.
4. Move your fingers inferiorly until you reach the cricoid cartilage.
5. Palpate the thyroid isthmus using the pads of your fingers.
6. Palpate each lobe of the thyroid in turn by moving your fingers out laterally from the isthmus.
7. Ask the patient to swallow some water, whilst you feel for the symmetrical elevation of the thyroid lobes (asymmetrical elevation may suggest a unilateral thyroid mass).
8. Ask the patient to protrude their tongue (if a mass represents a thyroglossal cyst, you will feel it rise during tongue protrusion).

- When palpating the thyroid gland, assess the following characteristics:

-Size
-Symmetry (asymmetry indicates unilateral enlargement that may be caused by a thyroid nodule or malignancy)
-Consistency
-Masses
-Palpable thrill (caused by increased vascularity of the thyroid gland due to hyperthyroidism, suggestive of Graves' disease).

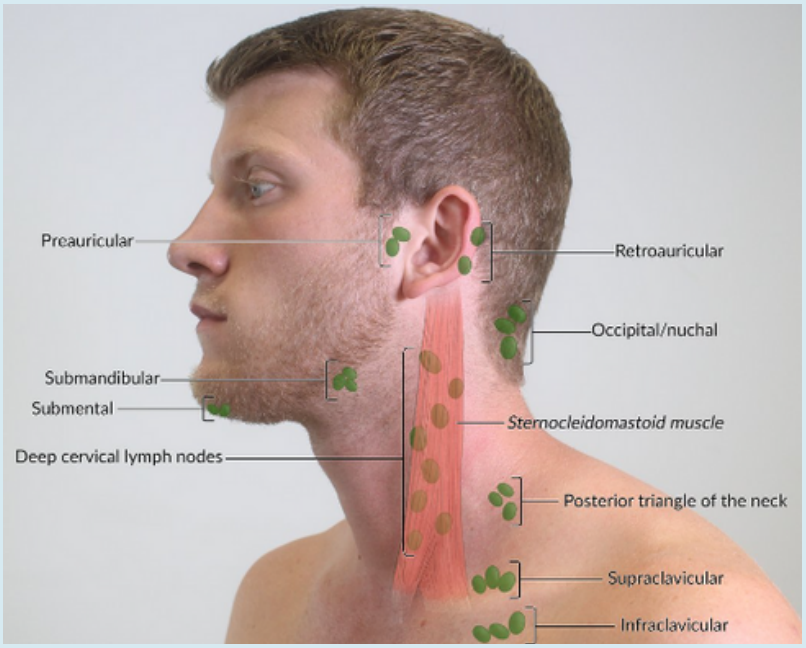
· Assessing cervical lymph nodes

1. Position: the patient sitting upright.
Ask the patient to tilt their chin slightly downwards
2. Stand behind the patient and use both hands to start palpating the neck.
3. Use the pads of the second, third and fourth fingers.
4. Start in the submental area and progress through the Submandibular, Tonsillar, Parotid, Pre-auricular, Post-auricular, Superficial cervical, Deep cervical, Posterior cervical, Occipital, and Supraclavicular.

· For any palpable lymph node, it's important to assess the following characteristics :
-Site
-Size
-Shape
-Consistency: soft, hard or rubbery.
-Tenderness
-Mobility: assess if the lymph node feels mobile or is tethered to other local structures.
-Overlying skin changes: note any overlying skin changes such as erythema.

❖ To complete the examination :

- Explain to the patient that the examination is now finished.
- Thank the patient.
- wash your hands.



Thyroid -History taking

❖ Patient profile :

- Name
- Age
- Gender
- Marital status
- Occupation
- Address
- Date and route of admission

❖ Chief complaint:

(Painful/painless) Swelling in the lower part front of the neck / Duration

❖ HOPI:

● (Swelling)

- Site: lower part in front of neck / unilateral or bilateral
-Size
-Shape: H-shaped (Butterfly), Diffuse Goiter, Nodular Goiter
-Number: Single or Multiple (lymph nodes)
- Onset: when was the swelling first noticed?
-How was it noticed?
-Who noticed it?
-Consistency: Soft or hard
-Mobility: mobile or fixed
-Progression: Has the lump changed in size, color, or shape?

The rapid increase in size may indicate infection, bleeding, or malignant change.

Slowly increasing size in neoplasm

- What increase/decrease it?
- Previous Hx of a similar case
- Associated lump: Are there any other masses?
- Apparent cause : (Trauma - pregnancy – emotional stress – irradiation)

❖ Associated symptoms:

- Pain:

painful = acute lymphadenopathy, thyroiditis, bleeding in goiter

painless = chronic lymphadenopathy, goiter, branchial cyst

- Dysphagia
- Change in voice or hoarseness
- Dyspnea, SOB on sleeping, or stridor

❖ Toxic manifestation

(Hypothyroidism)

♦ Tiredness, fatigue and lethargy
♦ Psycological – poor memory, concentration and low mood
♦ Weight gain
♦ Neck Swelling
♦ Hoarse voice
♦ Puffy face and hands (peri – orbital swelling)
♦ Dry Skin
♦ Hair loss
♦ Cold Intolerance
♦ Constipation
♦ Menorrhagia / infertility

(Hyperthyroidism)

♦ Agitaed, nervous
♦ Excessive tiredness (poor sleep)
♦ Neck Swelling (goiter)
♦ Eye symptom – protruding eye – red painful eye - double vision
♦ Tremor
♦ Palpitations (tachycardia, atrial fibrillation)
♦ Weight loss and increased appetite
♦ Heat Intolerance and excessive sweating
♦ Muscle Weakness
♦ Diarrhea
♦ Irregular or no periods (oligomenorrhoea)

❖ Risk factors for thyroid cancer :

- History of thyroid irradiation
- Age<20, Male sex
- Family history of thyroid cancer of multiple endocrine neoplasms
- A solitary nodule
- Dysphagia, Dyspnea
- Increasing size (particularly rapid growth or growth while receiving thyroid suppression treatment)

❖ Past history :

- Chronic illness (HTN, DM, Asthma, TB, Hepatitis): When Where&How Diagnosed?
- Similar condition
- Previous Hospital admission
- Previous Operation
- Previous Blood transfusion

❖ Drugs & Allergies History :

- Amiodarone and lithium are associated with hypothyroidism
- Antithyroid drugs
- Allergy to certain food or medication

❖ Family History :

- Chronic disease (HTN, DM, Asthma, TB, Hepatitis)
- Similar condition
- Inherited / Genetic disease
- Thyroid or autoimmune disease

❖ Social History :

- Smoking - Alcohol - Diet - Living in an area with iodine deficiency

❖ Systemic review

Thyroid Examination

1. Wash your hands/hygiene
2. Ensure good light & privacy.
3. Introduce yourself to the patient and briefly explain what the examination will involve.
4. Gain consent to proceed with the examination.
5. Ask the patient to sit on a chair for the assessment.
6. Exposure: the neck & upper sternum
7. Ask the patient if they have any pain before proceeding with the clinical examination.

Mention if the patient is oriented or not, shivering, sweating (when you shake his hand)

❖General examination:

Clinical signs

Inspect the patient, looking for clinical signs suggestive of underlying pathology:

- Weight: weight loss is typically associated with hyperthyroidism (increased metabolism), whilst weight gain is associated with hypothyroidism (decreased metabolism).
- Behavior: anxiety and hyperactivity are associated with hyperthyroidism (due to sympathetic overactivity). Hypothyroidism is more likely to be associated with low mood.
- Clothing: may be inappropriate for the current temperature. Patients with hyperthyroidism suffer from heat intolerance whilst patients with hypothyroidism experience cold intolerance.
- Hoarse voice: caused by compression of the larynx due to thyroid gland enlargement (e.g. thyroid malignancy).

Hands:

- Thyroid acropachy: similar in appearance to finger clubbing but caused by periosteal phalangeal bone overgrowth secondary to Graves' disease.
- Onycholysis: painless detachment of the nail from the nail bed associated with hyperthyroidism.
- Palmar erythema: reddening of the palms associated with hyperthyroidism, chronic liver disease, and pregnancy.
- Peripheral tremor: it is a feature of hyperthyroidism reflecting sympathetic nervous system overactivity.
- Radial pulse: assess the rate and rhythm.

In healthy adults, the pulse should be between 60-100 bpm.

Face : inspect for:

- **Dry skin: associated with hypothyroidism.**
- **Excessive sweating: associated with hyperthyroidism.**
- **Eyebrow loss: the absence of the outer third of the eyebrows is associated with hypothyroidism**

Eyes:

- **lid retraction**
- **lid lag**
- **Ophthalmoplegia**
- **Exophthalmos**
-

❖ Thyroid examination:

❖ inspection:

- inspect the midline of the neck for masses & scars
- if the mass is identified mention (site, size, color..)
-Ask the patient to swallow some water and observe the movement of the mass:

- **Thyroid gland masses (e.g. a goiter) and thyroglossal cysts typically move upwards with swallowing.**
- **Lymph nodes will typically move very little with swallowing.**
- **An invasive thyroid malignancy may not move with swallowing if tethered to surrounding tissue.**

-Ask the patient to protrude their tongue:

- **Thyroglossal cysts will move upwards noticeably during tongue protrusion.**
- **Thyroid gland masses and lymph nodes will not move during tongue protrusion.**

❖ Palpation:

a- Palpate each of the thyroid's lobes and the isthmus:

1. Stand behind the patient and ask them to tilt their chin slightly downwards to relax the muscles of the neck to aid the palpation of the thyroid gland.
2. Place the three middle fingers of each hand along the midline of the neck below the chin.
3. Locate the upper edge of the thyroid cartilage ("Adam's apple") with your fingers.
4. Move your fingers inferiorly until you reach the cricoid cartilage. The first two rings of the trachea are located below the cricoid cartilage and the thyroid isthmus overlies this area.
5. Palpate the thyroid isthmus using the pads of your fingers.
6. Palpate each lobe of the thyroid in turn by moving your fingers out laterally from the isthmus.
7. Ask the patient to swallow some water, whilst you feel for the symmetrical elevation of the thyroid lobes (asymmetrical elevation may suggest a unilateral thyroid mass).
8. Ask the patient to protrude their tongue (if a mass represents a thyroglossal cyst, you will feel it rise during tongue protrusion).

Characteristics of the thyroid gland

When palpating the thyroid gland, assess the following characteristics:

- **Size: note if the thyroid gland feels enlarged.**
- **Symmetry: assess for any evidence of asymmetry between the thyroid lobes (unilateral enlargement may be caused by a thyroid nodule or malignancy).**
- **Consistency: assess the consistency of the thyroid gland tissue, noting any irregularities (e.g. a widespread irregular consistency would be suggestive of a multinodular goiter).**
- **Masses: note if there are any distinct palpable masses within the thyroid gland's tissue (e.g. solitary thyroid nodule or thyroid malignancy).**
- **Palpable thrill: assess for evidence of a palpable thrill caused by increased vascularity of the thyroid gland due to hyperthyroidism (suggestive of Graves' disease).**

Characteristics of a thyroid mass

If a thyroid mass is noted assess its position, shape, consistency, and mobility (i.e. is it tethered to underlying tissue).

b-Lymph node palpation

Assess for local lymphadenopathy which may indicate the metastatic spread of primary thyroid malignancy.

Start in the submental area and progress through the various lymph node chains.

-Submental -Submandibular -Pre-auricular -Post-auricular -Superficial cervical -Deep cervical -Posterior cervical -Supraclavicular

c- Tracheal deviation

❖ Percussion:

Percuss the sternum moving downwards from the sternal notch to assess for retrosternal dullness.

- **Retrosternal dullness may indicate a large thyroid mass extending posteroinferiorly to the manubrium.**

❖ Auscultation:

Auscultate each lobe of the thyroid gland for a bruit using the bell of the stethoscope.

- **A bruit indicates increased vascularity, which typically occurs in Graves' disease.**

Check the lower limbs for pretibial myxoedema

Further assessments and investigations

- **Thyroid function tests: these include TSH, T3, and T4.**
- **ECG: should be performed if an irregular pulse was noted to rule out atrial fibrillation.**
- **Further imaging: an ultrasound scan of the neck to further assess any thyroid lumps**

Hernia - History taking

❖ Patient profile :

- Name
- Age
- Gender
- Marital status
- Occupation
- Address
- Date and route of admission

❖ Chief complain + duration

❖ HOPI :

- How he observes it.
- Any changes in the size.
- Any other swelling
- When he observes it.
- Any associated symptoms such as pain, fever, vomiting, constipation abdominal pain, or distention.
- If the patient presents with pain analyze it with SOCRATES
- Ask about symptoms of complications as symptoms of intestinal obstruction: Vomiting, abdominal pain, constipation, and distension.
- Ask about the predisposing factors for the hernia as General factors:

§ Lifting heavy objects. § Chronic cough. § Chronic constipation.

§ Abdominal distention (ascites or mass).

-Constitutional symptoms: Fever, loss of appetite, loss of weight.

❖ Past medical history:

- Abdominal surgery or trauma.
- Muscles disease.
- Previous lump or hernia.

❖ Past surgical history

❖ Family Hx of hernia

❖ Drug Hx:

ACE inhibitors " chronic cough"

❖ Systemic review

Hernia - Examination

1. Wash your hands/hygiene
2. Ensure good light & privacy.
3. Introduce yourself to the patient and briefly explain what the examination will involve.
4. Gain consent to proceed with the examination.
5. position: lying down (if the examiner asks you to examine the hernia ask the patient to stand up then he can be in the supine position for abdominal examination).
6. Exposure: from the nipples to the mid-thigh
7. Ask the patient if they have any pain before proceeding with the clinical examination.

❖Inspection & Palpation:

A useful aide-memoire to ensure all potential aspects of a lump are covered is "3 Students and 3 Teachers go for a CAMPFIRE":

- Site – Assess where the lump is located and its relationship to surrounding key anatomical structures (e.g. 3cm superior to the left medial epicondyle)
- Size – Estimate the size of the lump in at least two dimensions (e.g. 4x6cm mass); if particularly large, consider using a ruler for greater accuracy
- Shape – Use geometric terms to describe the dimensions of the lump (e.g. round, irregular, lobulated)
- Tenderness – Is the lump painful on palpation? Ask the patient directly if there is any tenderness when gently pressing the lump
- Temperature – Is the lump warm to the touch?
- Transillumination – Apply a light source to the lump using a pen torch; fluid-filled lumps will allow light to pass through (e.g. hydrocoele)
- Consistency – Describe how the lump feels, such as soft (e.g. lipoma), firm (e.g. lymph node), or fluctuant (e.g. hydrocoele)
- Attachment – Is the lump fixed to other structures or can it be moved freely from underlying tissues?
- Mobility – Is the lump freely mobile or fixed in place?
- Pulsation – Check if the lump is pulsating, as this suggests a vascular etiology (e.g. peripheral aneurysm)
- Fluctuation – Hold the lump on opposite sides and apply downward pressure with one finger, and if it fluctuant then this suggests a fluid-filled component
- Irreducibility – Can the lump be reduced? Apply gentle pressure to the lump, and if it disappears then it is reducible (e.g. inguinal hernia)
- Regional lymph nodes – Assess the lymph nodes which drain the site of the lump; any regional lymph nodes commonly suggest either an infective or malignant pathology
- Edges – Assess how well-demarcated the lump is, whether the borders are regular or irregular.

Differentiating a hernia from other types of lumps:

-Begin by assessing the groin lump to determine if it is a hernia or some other type of pathology (e.g. testicular mass, lipoma, abscess, lymph node).

-You should always assess both sides of the groin when assessing for hernias to avoid missing pathology.

Hernias of the groin typically present with the following clinical features:

- **Single lump in the inguinal region**
- **Positive cough impulse (unless incarcerated)**
- **Soft on palpation**
- **Reducible (unless incarcerated)**
- **Unable to get above the lump during palpation**
- **Painless (unless incarcerated)**
- **Bowel sounds on auscultation (may be absent if incarcerated)**

If any of the following clinical features are present, you should consider an alternative diagnosis:

- **Multiple lumps (e.g. lymphadenopathy)**
- **Hard or nodular consistency (e.g. malignancy)**
- **Able to get above the lump during palpation (e.g. scrotal mass)**
- **Transillumination (hydrocoele)**
- **Bruit on auscultation (e.g. arteriovenous malformation)**

Differentiating hernia subtypes

Position of the hernia

Assess the **anatomical relationship** of the **hernia** in relation to the **pubic tubercle**:

- Inguinal hernias are typically located above and medial to the pubic tubercle.
- Femoral hernias are typically located below and lateral to the pubic tubercle.

Reducibility

A **reducible hernia** is one which can be **flattened out** with **changes in position** (e.g. lying supine) or the **application of pressure**.

To assess the **reducibility of a hernia**:

1. Ask the patient to lay supine and observe for evidence of spontaneous reduction.

2. If the hernia is still present, try to manually reduce it using your fingers.

The hernia may **re-appear** if the patient **stands up**, **coughs,** or the **application of pressure is removed**.

A hernia that is **tender** and **irreducible** may be **strangulated** and requires **urgent surgical review**.

Direct vs indirect inguinal hernias

If you suspect a hernia is **inguinal** in origin (i.e. it is located above and medial to the pubic tubercle) you should then try to determine if it is **direct** or **indirect**.

To **differentiate** between **direct** and **indirect inguinal hernias**:

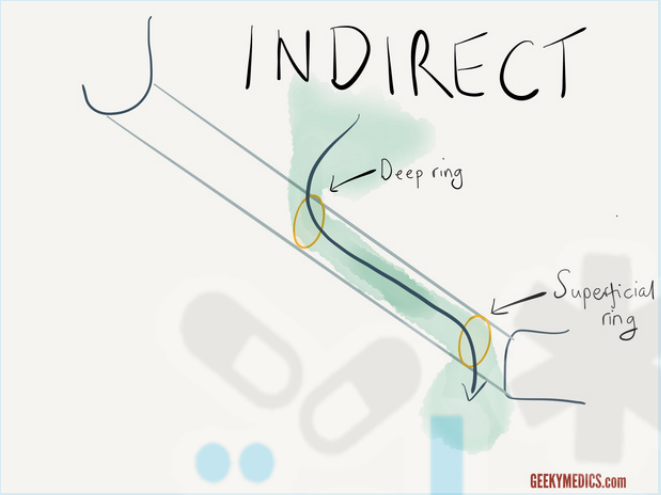
1. Locate the deep inguinal ring (midway between the anterior superior iliac spine and pubic tubercle).

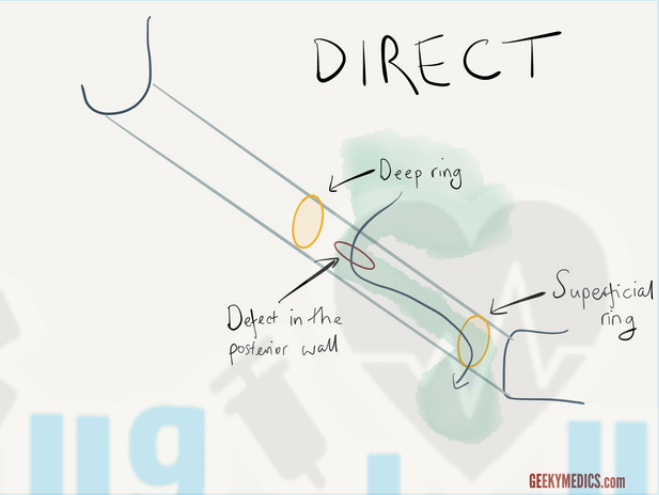
2. Manually reduce the patient's hernia by compressing it towards the deep inguinal ring starting at the inferior aspect of the hernia.

3. Once the hernia is reduced, apply pressure over the deep inguinal ring and ask the patient to cough.

Interpretation

If a hernia reappears it is more likely to be a direct inguinal hernia whereas if it does not, it is more likely to be an indirect inguinal hernia.
In the latter case, release the pressure from the deep inguinal ring and observe for the hernia to reappear (further supporting the diagnosis of an indirect inguinal hernia).
It should be noted that this clinical test is unreliable and further imaging (e.g. ultrasound scan) would be required before any management decisions were made.





Scrotal examination

Inguinal hernias can **extend into the scrotum**. If a **testicular swelling** is noted or there is suspicion of an **inguinal hernia**, **palpation of the scrotum** should be performed with the patient's consent.
When **palpating** an **inguinal hernia** in the **scrotum** you will **not be able to get above the mass**.

To complete the examination

Explain to the patient that the examination is now **finished**.
Thank the patient for their time.
Dispose of PPE appropriately and **wash your hands**.
Summarise your findings.

Constipation - History taking

❖ Patient profile :

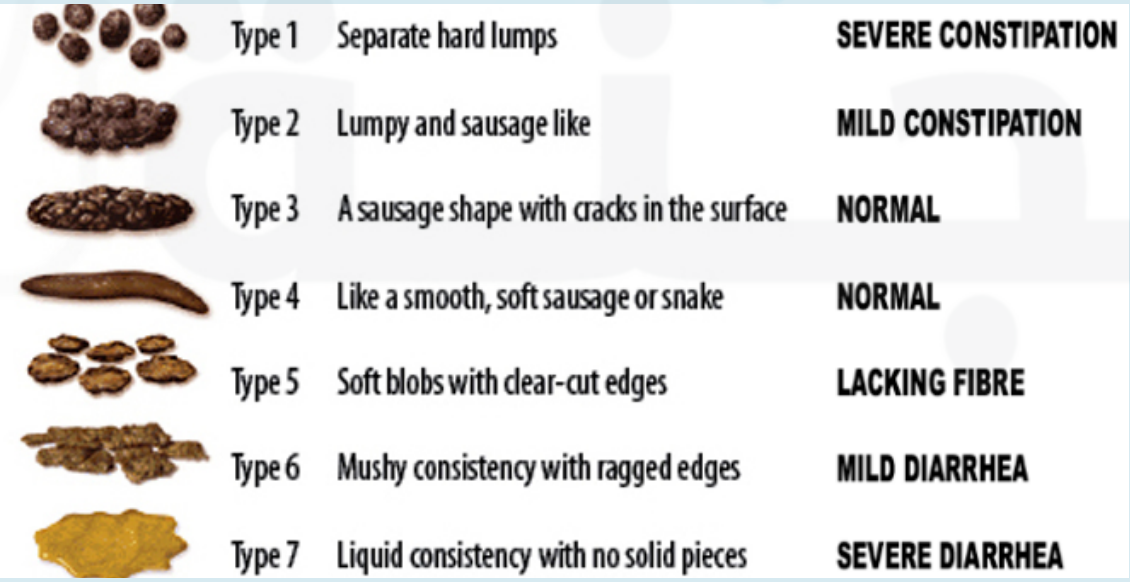
- Name
- Age
- Gender
- Marital status
- Occupation
- Address
- Date and route of admission

❖ Chief complaint + duration:

Infrequent passage of hard stool / Duration

❖ HOPI :

- **Onset:** Lifelong or of recent onset
- **Stool frequency:** How often the patient moves their bowels each week and how much time is spent straining at stool?
- **Shape of stool:** for example, pellet lie
- **Associated symptoms:** such as abdominal pain, pain on defecation or rectal bleeding, tenesmus, anesmus , obstipation, vomiting, distention, no flatus or bowel movement
- **Drugs:** that may cause constipation (opiates, iron)



❖ Past history :

- Chronic illness (HTN, DM, Asthma, TB, Hepatitis): When Where & How Diagnosed?
- Similar condition
- Previous Hospital admission
- Previous Operation
- Previous Blood transfusion
- Colorectal cancer, hypothyroidism, IBS, Parkinson's disease

❖ Drugs & Allergies History :

- Long-term drugs
- Short-term drugs
- Iron and opiates
- Allergy to certain food or medication

❖ Family History :

- Chronic disease (HTN, DM, Asthma, TB, Hepatitis)
- Similar condition
- Inherited / Genetic disease
- Colorectal cancer, IBS

❖ Social History :

- Smoking - Alcohol - Diet

❖ Systemic review :

- endocrine: Weight gain, Puffy face and hands (peri–orbital swelling), Dry Skin, Hair loss, Cold Intolerance, Constipation, Menorrhagia/infertility, fatigue

- CNS: Headache, Dizziness, Change In Behavior, Loss Of Consciousness, Weakness, Abnormal Movement.

- GIT: Dysphagia, Heartburn, Jaundice, Hematemesis, Constipation, Diarrhea, Melena, Bleeding Per Rectum.

- Cardio-Pulmonary: Cough, Hemoptysis, Dyspnea, Chest Pain, Palpitations, Syncope, Claudication.

- Urogenital: Loin Pain, Dysuria, Polyuria, Hematuria, Urethral Discharge.

- Skin & Musculoskeletal: Pain, Muscle Wasting, Pigmentation, Ulcers.

- Hematology: Easy Fatigability, Petichiae, Gum Bleeding, Pallor

Dysphagia - History taking

❖ Patient profile :

- Name - Age
- Gender - Marital status
- Occupation - Address
- Date and route of admission

❖ Chief complaint + duration:

❖ HOPI :

-The duration
- Onset: recent or longstanding
- Difficulty swallowing solids, liquids, or both?
- Order them, which occurred first
- At what level does the food stick? (oropharyngeal or esophageal dysphagia)
- Nature: Intermittent vs. Progressive
- What do you think caused this?
- Timing:
Is it worse over the course of the day? (Myasthenia Gravis)
- Progression of the symptoms
- Alleviating or Exacerbating Factors - Relieved by sitting forward?

Associated With

- Odynophagia - Site - Only on swallowing
- Coughing or Choking on swallowing
- When? Is it nocturnal
- Chest Pain; SOB; Stridor
- Regurgitation: - Undigested? Bad Smell? When?
- Symptoms of metastasis
- Does the skin around the lips or fingers feel tight? (sclerosis)
- Heartburn, belching, waterbrash
- Lump in the throat (Globus)
- Neck Bulge (Pouch)
- Halitosis (Zencker)
- Weight Loss
- Appetite
- General weakness or mental status change
- Anemia Symptoms: Tongue sores, Tingling in the leg, SOB, Dizziness, Fatigue, and Weakness (Plummer Vinson)
- Ask about previous attacks

❖ Medical and Surgical History:

-Previous esophageal disease
-Previous Stroke or Neurologic Disease (Myasthenia Gravis, Bulbar Palsy)
-HIV

❖ Family History:

Cancer

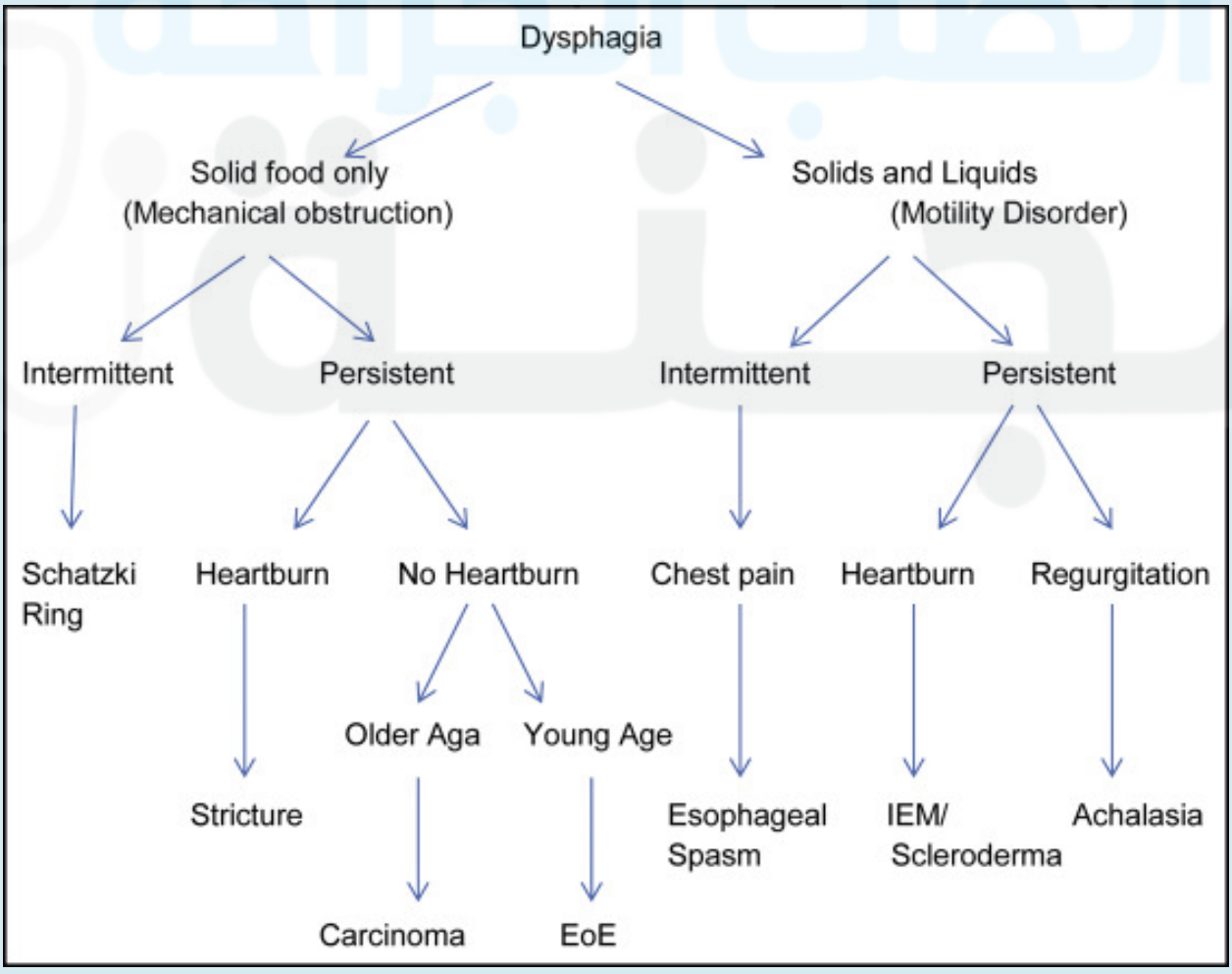
❖ Drug history:

-NSAIDs -Steroids -Iron Tablets (Plummer Vinson) - Pills taken without water

❖ Social History:

-Smoking -Alcohol -Diet

❖ Systemic review



Upper GI bleeding - History

❖ Patient profile :

- Name
- Age
- Gender
- Marital status
- Occupation
- Address
- Date and route of admission

❖ Chief complaint + duration:

the cc will be hematemesis coffee ground vomitus, melena... etc

❖ HOPI :

-Onset and duration
-Color: Is it bright red (fresh) or dark (coffee ground vomitus)?
-Character: does it have any clots or foul-smelling?
-Amount: What's the amount of blood in the vomit?
-Force: Any forceful vomiting with blood (Mallory Weiss tear)?
-Aggravating factors: Any history of stress (peptic ulcer)? toxins ingestion?
-Food: Any history of red food ingestion (spinach, blueberries)?
-Drugs: Any history of ingestion of NSAIDs?
-Pain: Is it painful or painless?
-Associated: Any associated melena? fresh blood per rectum? bruises? epistaxis? pallor? jaundice?
-Bleeding from other sites: Any bleeding from other sites?
-Any history of Soft tissue bleeding: Gum bleeding, bleeding after dental procedures, hemarthrosis? (hemophilia)
-Dizziness: Do you feel faint or dizzy when you stand or sit?

❖Associated symptoms:

(Ask about differential diagnosis):

-PUD: Any history of epigastric pain related to meals, heartburn, or family history?
-Varices: Any history of excessive hematemesis, lightheadedness, or loss of consciousness?
-Gastroduodenal erosions: Any history of dyspepsia, bloody stool, nausea?
-Mallory Weiss tearing: any history of forceful vomiting? recurrent vomiting '?
-Esophagitis: any history of difficult swallowing, painful swallowing, heartburn, or food impaction?
-Aortoenteric fistulas: any history of abdominal mass, abdominal pain, or increased heart rate?
-Gastric cancer: fatigue, fever, rigors, night sweats, weight loss, loss of appetite, rashes, joint pain?

-Drugs: anticoagulants, antiplatelet, NSAIDS
-Hemobilia: Any history of jaundice, upper abdominal pain, and UGIB? (Quincke triad)
-Dieulafoy's vascular malformation: Any history of Recurrent hematemesis with melena, painless bleeding?
-Osler weber rendu syndrome: Any history of frequent nose bleeding? enlarged abdominal mass (live)? any history of seizures? SOB? pallor?
-Zollinger Ellison syndrome: Any history of burping (non-projectile vomiting), acid reflux, and heartburn? upper abdominal pain?

❖ Past medical & surgical history:

Don't forget to ask these questions!

Is there any history of:
- epistaxis - peptic ulcers - liver disease
- renal failure - jaundice - blood transfusion
- hematological abnormalities such as hemophilia, or von Willebrand disease

❖Drug history:

- aspirin - NSAIDs - anticoagulants
- iron - steroids -bismuth (causes dark stool)

❖ Family history:

- peptic ulcer - liver disease -bleeding disorders or coagulopathy
- Osler weber rendu syndrome

❖Social history:

- history of contact with hepatitis patient
- history of Alcohol or smoking

❖ Systemic review

8.19 Causes of upper gastrointestinal bleeding

- Gastric or duodenal ulcer
- Mallory–Weiss oesophageal tear
- Oesophagitis, gastritis, duodenitis
- Oesophagogastric varices
- Oesophageal or gastric cancer
- Vascular malformation

8.18 Symptom checklist in haematemesis and melaena

- Is there a previous history of dyspepsia, peptic ulceration, gastrointestinal bleeding or liver disease?
- Is there a history of alcohol, NSAIDs or corticosteroid ingestion?
- Did the vomitus comprise fresh blood or coffee ground-stained fluid?
- Was the haematemesis preceded by intense retching?
- Was blood staining of the vomitus apparent in the first vomit?

Lower GI Bleeding - History

❖ Patient profile :

- Name
- Age
- Gender
- Marital status
- Occupation
- Address
- Date and route of admission

❖ Chief complaint + duration:

the cc will be melena, bleeding per rectum .. etc

❖ HOPI :

-Onset and duration

-Character: Is it bright red blood or dark red? melena? currant jelly-like stool? mucous?

-Amount: What's the amount of blood?

-Pain: Is it Painful and painless?

-Mixed:

- Is the blood mixed with stool? (suggest colitis)
- coating outside the stool (suggest anal fissure) or occurs just after defecation?

-Stool consistency:

- diarrheal bleeding (colitis)
- hard stool bleeding (anal fissure)

-Stool caliber: Any changes to stool caliber?

-Bowel habits: any changes to bowel habits?

-Associated: Any associated hematemesis? fresh blood vomiting? bruises? epistaxis? pallor? jaundice?

-Bleeding from other sites: Any bleeding from other sites?

-Any history of Soft tissue bleeding: hemarthrosis? (for hemophilia)

❖Associated symptoms:

(Ask about differential diagnosis):

- Anal lesions (hemorrhoids, fissures):

- Any history of fresh bleeding per rectum?
- is it associated with pain?
- do you have any swelling in your anal region?
- any itchiness?

-Rectal trauma: Any history of recent trauma?

-Proctitis:

- Any history of the frequent need to empty the bowel?
- Any history of pain while defecating?
- Any history of pain on the left side of the abdomen?
- Any feeling of fullness in the rectum?
- Any passing of mucous with defecation?

-IBD: Any history of lower right or left quadrant pain, bloody stool, diarrhea, oral ulcers, or eye problems?

- Infectious colitis:

- any history of diarrhea more than 3 times per day?
- any low-grade fever?
- any headache, or abdominal pain?
- any mucous or blood in the stool?

- Colonic polyps or carcinoma: Any changes to bowel habits or changes to stool color? (red streaks of blood in stool)

- Angiodysplasia: Any history of black sticky shiny stool tarry foul smelling? any history of difficulty concentrating, headache, or weakness?

- Diverticulosis: Any history of LLQ pain, constipation, or diarrhea? bloating? family history?

- Anticoagulation: Any history of drug intake?

-post polypectomy: Any history of fever, tachycardia, and generalized abdominal pain, following surgery in the past few days?

❖ Past medical & surgical history:

Is there any history of:

- epistaxis - peptic ulcers - liver disease
- renal failure - jaundice - blood transfusion
- hematological abnormalities such as hemophilia, or von Willebrand disease

❖Drug history:

- aspirin - NSAIDs - anticoagulants
- iron - steroids -bismuth (causes dark stool)

❖ Family history:

- peptic ulcer - liver disease -bleeding disorders or coagulopathy
- Osler weber rendu syndrome

❖Social history:

- history of contact with hepatitis patient
- history of Alcohol or smoking

❖ Systemic review

Abdominal pain - History

❖ Patient profile:

- Name
- Age
- Gender
- Marital status
- Occupation
- Address
- Date and route of admission

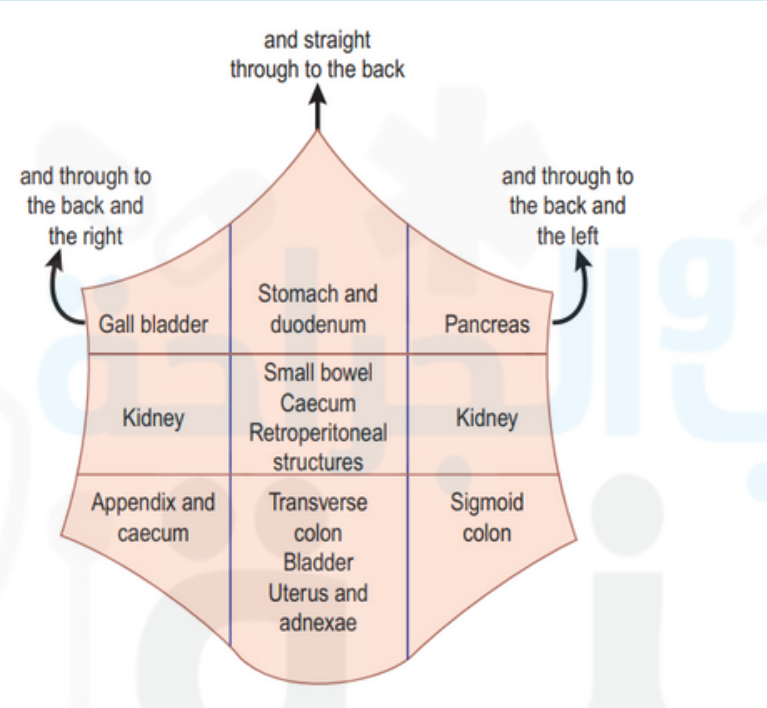
❖ Chief complaint:

Abdominal Pain (site) + duration

❖ HOPI:

Characterize the pain using SOCRATES

- Site (Epigastrium, Umbilical region , Rt/Lt Iliac fossa)



- Onset
- Character (burning, throbbing, stabbing, constricting, colicky, aching)
- Radiation
- Associated symptoms (e.g. vomiting, diarrhea, painful micturition, missed or absent periods)
- Timing (does it occur at mealtime? at night? morning)
- Exacerbating and relieving factors
- Severity

Also, ask about :

- Progression: Is it progressive?
- Bowel movements: Any changes in bowel habits?
- Recurrent vomiting (may suggest pancreatitis)

- DON'T forget to ask about symptoms B : (Fever documented or not, Fatigue, Rigors, night sweating, weight loss, loss of appetite, rashes, and joint pain)

❖ FOR Differential dx

1-GERD: history of heartburn, difficulty swallowing, regurgitation of food, the sensation of a lump in the throat?
2-Peptic ulcer: history of hematemesis, poor appetite, nausea and vomiting, dark tarry stool?
3-Gastric cancer symptoms B
4-Acute appendicitis: any history of poorly localized periumbilical pain, usually migrates to the RIF, exacerbated by Movement or cough, ass with anorexia, nausea, and vomiting, which typically follow the onset of pain; low fever?

5-Acute cholecystitis: any history of RUQ or epigastrium pain; may radiate to right shoulder or interscapular area, exacerbated by deep breathing, associated with nausea, vomiting, fever; no jaundice?

6-Acute pancreatitis: any history of epigastric pain, may radiate straight to the back or other areas of the abdomen, exacerbated by lying supine; medications, high triglycerides, relieved by leaning forward?

7- Biliary colic: any history of epigastric or RUQ pain; may radiate to the right scapula and shoulder, exacerbated by fatty meals but also fasting; often precedes cholecystitis, cholangitis, pancreatitis

8-Acute Diverticulitis: any history of left lower quadrant pain relived by Analgesia, bowel rest, antibiotics, associated with Fever, and constipation. Also nausea, vomiting, abdominal mass with rebound tenderness?

9-Acute bowel obstruction: any history of periumbilical or upper abdominal or lower abdominal or generalized abdominal pain, exacerbated by Ingestion of food or liquids?

10 -Mesenteric ischemia: any history of periumbilical pain at first, then diffuse; then postprandial?

11-IBD: any history of lower right or left abdominal pain, persistent diarrhea, rectal bleeding/, or weight loss. ? 12-Cholangitis: any history of RUQ pain, jaundice, fever, shock, or loss of consciousness?

12- Genitourinary system:

- **Pyelonephritis: any history of intense pain along the side of your body between your ribs and hip, or in your lower abdomen. pain that spreads to your back or groin. ?**

- **Ovarian torsion (young woman): any history of abnormal bleeding, pelvic pain, or adnexal mass? 3-Testicular torsion: any history of swelling of the scrotum, fever, frequent urination?**

13-CVS:

- **Lower inferior MI: any history of heavy central chest pain that radiates to arms, jaw, or teeth? how long does it stay ? doesn't relieve by rest? doesn't exacerbate by exertion?**

- **Pulmonary embolism: any history of pleuritic chest pain? sudden onset SOB? cough? hemoptysis? syncope or LOC**

❖Past medical and surgical history:

-Are there any history of peptic ulcers, or IBS?

❖Drug history:

- Does the patient take NSAIDS, laxatives, aspirin, narcotics

❖Family history:

-Are there any family history of, peptic ulcer, celiac disease, GASTRIC CA,...etc?

❖Social history:

-Smoking?
-Any history of alcohol ingestion? TO exclude pancreatitis

❖ Systemic review

Abdominal Examination

1. Wash your hands/hygiene
2. Ensure good light & privacy.
3. Introduce yourself to the patient and briefly explain what the examination will involve.
4. Gain consent to proceed with the examination.
5. Ask for the need for a chaperone.
6. Position: supine
7. Adequately expose the patient's abdomen (nipples to the midthigh)
8. Ask if the patient has any pain before proceeding.

❖ Inspection:

Start by standing from the foot of the bed and comment on:
1) Symmetry of the abdomen
2)Normal pattern of breathing
3)The umbilicus (normally central inverted)
4)The shape of the abdomen (normal is a flat-like shape)
5)Hernias, ask him to cough.
6)Visible peristalsis

Then move to the right side of a patient and say:
-scars, masses, abnormal pulsation or dilated veins or caput medusa or spider nevi, dressings, stomas, or drains.
-Bruises in the flank region such as Grey Turner's sign and under the umbilicus such as Cullen's sign.

❖ Palpation:

Firstly, You have to do 5 steps:
-Warm your hands,
-ask the patient if he feels any pain in the abdomen & keep an eye to eye contact
-sit at the level of the patient's abdomen (SAY IT OR DO IT),
-ask the patient to relax his abdomen
- finally, start from the RIGHT LOWER QUADRANT then move counter-clockwise of the abdomen.

A. Superficial Palpation: you do it to feel any superficial pain and masses.
Here, perform light touch without any pressing on the patient's abdomen and watch his facial expressions.
Here you have to say: "By superficial palpation of the abdomen, there's no superficial mass or pain and the patient's facial expressions look normal "

B. Deep Palpation: you do it to feel any deep pain, masses, guarding, and rigidity.Same as superficial, but here your press your hands deeply.
-Here you have to say: " By deep palpation of the abdomen there's no deep masses deep tenderness, there's no guarding (voluntary) which indicates peritonitis and there's no rigidity (involuntary) which indicates appendicitis "

*If you find a mass, comment on the following:
its site, size, shape, Consistency, Mobility on respiration, tender or not. -

C. Deep organ palpation :

1) Liver palpation:

RULE: press on inspiration, move with expiration. ask the patient to breath starting from the RIGHT lower quadrant upward by asking the patient to take a deep breath to let the diaphragm pushes the liver down.
*The percussion part of the liver:
Start from the 2"d or 3rd intercostal space and move downward, there's a normal resonant sound, keep moving downward till you hear a dull sound, get a meter, and measure the liver span. (normally liver dullness starts at begins at the 5 intercostal space and continues just below the costal margin.)

2) SPLEEN palpation:

normally it's not palpable, if it's palpable it must be 2-3 times enlarged.-
-ask the patient to breathe, starting from the RIGHT lower quadrant and moving diametrically to the spleen (to the left subcostal area), And Measure the degree of extension below the costal margin (in cm) in the mid-clavicular line.
-Here you have to say: "The spleen has normal extent and dullness sound, it isn't dilated and it isn't painful."

8.36 Differentiating a palpable spleen from the left kidney

Distinguishing feature	Spleen	Kidney
Mass is smooth and regular in shape	More likely	Polycystic kidneys are bilateral irregular masses
Mass descends in inspiration	Yes, travels superficially and diagonally	Yes, moves deeply and vertically
Able to feel deep to the mass	Yes	No
Palpable notch on the medial surface	Yes	No
Bilateral masses palpable	No	Sometimes, e.g. polycystic kidneys
Percussion resonant over the mass	No	Sometimes
Mass extends beyond the midline	Sometimes	No (except with horseshoe kidney)

❖ Percussion:

Percuss the entire abdomen and listen to the percussion note. It is normally resonant; dull over an enlarged spleen, liver, mass, or full bladder; and hyper-resonant over a distended bowel loop with gas.

A. Bladder percussion :

Here you do percussion starting from above the umbilicus till you reach surface of the pubis, it should be a tympanic sound if the bladder is empty and it will be pelvic but if the sound is dull then the bladder is full and it's abdominal.

Here you have to say:
"By percussion to the bladder starting from the right side, the sound is tympanic so the bladder is pelvic (or you say the sound is dull so the bladder is abdominal and it's filled).
"

B. Shifting dullness for ASCITES:

the child should be supine, do percussion from below the xiphisternum till your reach the most tympanic sound and move to right or left, if there are ascites, the sound will change from tympanic to dull, if that occurs, fix your hand to that site of the change of the sound and ask the patient to roll on his opposite site, wait 20 seconds, and do percussion again at that point, the dullness sound will disappear if there's fluid has shifted to the other side.

C. Transmitted Thrills for ASCITES:

the child should be supine, ask him to place the ulnar aspect of his/her hand longitudinally and firmly on the midline of the abdomen to prevent the transmission of the impulse through the subcutaneous fat of the abdominal wall, feel for the fluid thrill by placing the palm of your left hand flat on the left side of the child's abdomen and flicking the finger of your right hand on the right side of the abdomen; the movement of the fluid may be felt by your left hand.

❖ Auscultation:

You should hear the bowel sounds for 1 minute, if you didn't hear them, listen for 2-3 minutes, normally it is 4-6 bowel sounds per minute.
Auscultate Using the DIAPHRAGM of the stethoscope.

WHERE to do Auscultation?

1) ileocecal valve at the right iliac fossa (for bowel sounds)
2) Abdominal Aorta (2 inches above the umbilicus, for Aortic bruits or thrills)
3) Renal Arteries (2 inches above umbilicus laterally on each side (left & right)
4) Right and Left common iliac arteries (2 inches under umbilicus and 2 inches laterally on each side (left and right)).
5) Liver and spleen (For hemangiomas / for hepatic and splenic rub)

Here you have to say:
By Auscultation using the diaphragm, There's no Abdominal aortic aneurysm, there's no bruits, there's no renal artery stenosis there's no arteriovenous malformation.

Signs of appendicitis:

1. Wash your hands/ hygiene.
2. Ensure good light & privacy.
3. Introduce yourself to the patient and briefly explain what the examination will involve.
4. Gain consent to proceed with the examination.
5. Position: 45 degree.
6. Exposure: from the nipple to the mid-thigh.
7. Don't forget to ask about pain.

الفحص هذا لا يعتبر كجزء من ال abdominal exam في الامتحان ، فما تعملوه الا اذا انطلب منكم

Signs of appendicitis:

- Low-grade fever
- Increase in the pulse rate

- Muscle guarding: do superficial palpation.

- Rebound tenderness or Dunphy's sign:

Asking the patient to cough (Dunphy) or gentle percussion over the site of maximum tenderness will elicit rebound tenderness.

- Pointing sign:

The patient is asked to point to where the pain began and where it moved.

- Rovsing's sign:

Deep palpation of the left iliac fossa may cause pain in the right iliac fossa.

- Obturator sign:

Hip flexion, knee flexion then hip internal rotation cause pain in the hypogastrium (the obturator test).

- Psaos sign:

A) Pain on Active flexion of right hip against resistance. Pt. lies supine (patient action)
B) Pain on Passive extension of the right thigh, pt. lies on the left side (examiner action)

Signs of cholecystitis

1. Wash your hands/ hygiene.
2. Ensure good light & privacy.
3. Introduce yourself to the patient and briefly explain what the examination will involve.
4. Gain consent to proceed with the examination.
5. Position: 45 degree.
6. Exposure: from the nipple to the mid-thigh.
7. Don’t forget to ask about pain.

الفحص هذا لا يعتبر كجزء من ال abdominal exam في الامتحان ، فما تعملوه الا اذا انطلب منكم

- **Murphy's sign:**

As the patient takes a deep breath in, gently palpate in the right upper quadrant of the abdomen; the acutely inflamed gallbladder contacts the examining fingers, evoking pain with the arrest of inspiration.

Stoma examination

1. Wash your hands/hygiene
2. Ensure good light & privacy.
3. Introduce yourself to the patient and briefly explain what the examination will involve.
4. Gain consent to proceed with the examination.
5. Ask for the need for a chaperone.
7. Adequately expose the patient's abdomen and stoma
8. position: lying flat on the bed
9. Ask if the patient has any pain before proceeding.

❖ Inspection :

- site : usually LIF(ileostomy), RIF(colostomy)
- Shape: flush
- Effluent : solid or semisolid
- Number of opening
- Color: Red, black
- Output: episodic, not continuous.
- Surrounding skin: clean and dry
- Spout: present or not
- Any evidence of complication: hernia, prolapse

❖ Palpation:

- Feel around the stoma site for any tenderness
- Ask the patient to cough and feel for a cough impulse for any parastomal hernia

❖ Auscultation:

- Auscultate for bowel sound

❖ Digital rectal exam:

- It includes the insertion of a gloved lubricated index finger into the stoma lumen.
- At times, this may be all that is needed due to adhesions or fibrosis.
- The removed gloved finger is then inspected for feces, blood, or mucus.

	Ileostomy	Colostomy
Site	Right lower quadrant	Left lower quadrant
Output	500-1300ml/day	200-700ml/day
Stool	Liquid / mushy	Semi-formed

Post op. History taking

❖Patient profile:

- Name - Age
- Sex - Occupation
- Address - Marital status
- date of admission and how (ER, outpatient clinic)

❖About the surgery:

- Date - time - POD?! - major or minor surgery
- procedure (if the pt. knows) - past surgical hx - Type of anesthesia
- Complications during surgery(especially if there was bleeding and need blood units)
- after surgery: you should ask about (ambulation, defecation, and urination) and if there is any pain analyze it

❖Think of SOAP:

- **Subjective:**

The subjective section of your documentation should include how the patient is currently feeling and how they've been since the last review in their own words.
As part of your assessment, you may ask:
"How are you today?"
"How have you been since the last time I reviewed you?"
"Have you currently got any troublesome symptoms?"
"How is your nausea?"
If the patient mentions multiple symptoms you should explore each of them, having the patient describe them in their own words.

- **Objective:**

The objective section needs to include your objective observations, which are things you can measure, see, hear, feel, or smell.

-Appearance:

Document the patient's appearance (e.g. "The patient appeared to be very pale and in significant discomfort.").

-Vital signs:

Document the patient's vital signs:
Blood pressure
Pulse rate
Respiratory rate
SpO2 (also document supplemental oxygen if relevant)

-Fluid balance:

An assessment of the patient's fluid intake and output including:
-Oral fluids
-Nasogastric fluids/feed
-Intravenous fluids
-Urine output
-Vomiting
-Drain output/stoma output

-Clinical examination findings:

Some examples of clinical examination findings may include:
-"Widespread expiratory wheeze on auscultation of the chest."
-"The abdomen was soft and non-tender."
-"The pulse was irregular."
-"There were no cranial nerve deficits noted."

-Investigation results:

Some examples of investigation results include:
-Recent lab results (e.g. blood tests/microbiology)
-Imaging results (e.g. chest X-ray/CT abdomen)

- **Assessment:**

The assessment section is where you document your thoughts on the salient issues and the diagnosis (or differential diagnosis), which will be based on the information collected in the previous two sections.

- Summarise the salient points:

"Productive cough (green sputum)"
"Increasing shortness of breath"
"Tachypnea (respiratory rate 22) and hypoxia (SpO2 87% on air)"
"Right basal crackles on auscultation"
"Raised white cell count (15) and CRP (80)"
"Chest X-ray revealed increased opacity in the right lower zone, consistent with consolidation"

- Document your impression of the diagnosis (or differential diagnosis):

- **"Impression: community-acquired pneumonia"**

- If the diagnosis is already known and the findings of your assessment remain in keeping with that diagnosis, you can comment on whether the patient is clinically improving or deteriorating:

"On day 3 of treatment for community-acquired pneumonia"
"Reduced shortness of breath and improved cough"
"Oxygen saturations 98% on air, respiratory rate 15"
"CRP decreasing (20), white cell count decreasing (11)"
"Impression: resolving community-acquired pneumonia"

- **Plan:**

The final section is the plan, which is where you document how you are going to address or further investigate any issues raised during the review.

Items you to include in your plan may include:
-Further investigations (e.g. laboratory tests, imaging)
-Treatments (e.g. medications, intravenous fluids, oxygen, nutrition)
-Referrals to specific specialties
-Review date/time (e.g. "I will review at 4 pm this afternoon.")
-Frequency of observations and monitoring of fluid balance
-Planned discharge date (if relevant)

Post op. pyrexia History taking

❖Patient profile:

- Name
- Age
- Sex
- Occupation
- Address
- Marital status
- date of admission and how (ER, outpatient clinic)

❖Chief complaint:

1) Fever in the first 24-48h after surgery
2) Fever post-op. day 3
3) Fever post-op. day 5
4) Fever post-op. day 8
5) Fever at any postoperative period

❖Think of the 5 W's:

Wind-atelectasis (24-48 h)
Water- UTI (POD #3)
Wound- wound infection (POD #5)
Walking- DVT/ thrombophlebitis (POD #7- #10)
Wonder drugs- drug fever (anytime)

❖History of present illness:

Case 1:

Pain, sudden dyspnea, wheezing, hypotension, tachycardia, fever, shock, cough, rapid shallow breath, type of surgery.

Case 2:

History of previous UTI, prostate status, anorectal surgery, dysuria, urgency, frequency.

Case 3:

DM, wound discharge, pain, fever, malaise, vomiting, and anorexia.
(The wound is swollen, painful, red, hot, and tender)

Case 4:

Age (old age), previous DVT, OCPs, pain in the calf, unilateral swelling, edema, hotness, tenderness.

Case 5:

Anesthetic drugs (don't forget to ask about a family history of malignant hyperthermia),
Antimicrobial – vancomycin and beta-lactams,
Anticonvulsant – phenytoin.
Ask about any drug allergies.

Don't forget:

-Past medical hx
-Surgical hx
-Family hx
-Drug hx
-Social hx (smoking)
-Systemic review

Vomiting - History taking

❖Patient profile:

- Name
- Age
- Sex
- Occupation
- Address
- Marital status
- date of admission and how (ER, outpatient clinic)

❖Chief Complaint

❖HOPI:

-What do you mean by vomiting (retching or nausea or vomiting)?
- Onset: Is it acute or chronic?
- Timing: Is it early morning or late night vomiting?
- Progression: is it progressive?
- Characters: does it have any blood or mucous? amount? any clots? color? Contents? does it have undigested food? milk? Is it foul-smelling? does it contain any coffee ground clots?
-Difficulty eating: Does the patient has any sign of difficulty swallowing(dysphagia)? pain on swallowing (odynophagia)?
- Pain: is it painful vomiting?
- Relation to Meals: is it related to eating meals? caused by eating meals? is the vomiting preceded by nausea or not?
- Relation to posture: Are you managing to drink and keep any fluids down?
- Exacerbating factors: Does anything precipitate the vomiting? Movement or eating?
- Any associated: anorexia, bloating, indigestion, abdominal distension, weight loss?
- Previous attacks: any history of previous attacks

❖Past medical and surgical history :

-Are there any history of DM, peptic ulcer, eczema (suggest food allergy), jaundice ... etc?
-Is there any history of GI disorders (e.g. pancreatitis, known bowel malignancy?
-Is there any history of previous abdominal surgery?
-Is there any history of previous episodes of bowel obstruction due to, for example, adhesions?

❖Drug history:

-any history of antibiotics chemotherapy, anticholinergic, opiates ...etc

❖Family history:

-Are there any family history of DM, or peptic ulcer ...?

-Any history of cancer in the family?

❖Social history:

-Any history of travel? pet contact ? smoking? Alcohol?

❖ Systemic review

Trauma - History taking

❖Patient profile:

- Name - Age
- Sex - Occupation
- Address - Marital status
- date of admission and how (ER, outpatient clinic)

❖Chief Complaint

❖HOPI:

> Mechanism of injury:

- Type of tool? (in penetrating injury:

- Type of weapon, knife, handgun, shotgun.
-length of the knife,-no. of stabs, no. of shot fired)

- When and how did the incident occur?
- What exactly happened to limb?
- How much force was applied?
- Has the bone or joint ever been damaged before?
- When trauma is falling ask about? - The height, - The ground - Way of fall

> Pain:

- Site: where exactly is the pain?
- Nature: can you describe the pain?
- Duration: how long have you had the pain?
- Radiation: dose it go anywhere else?
- Frequency: how often do you get the pain?
- Aggravating factor: what makes the pain worse?
- Relieving factor: what makes the pain reduced?
- Severity

>loss of movement:

- Time of loss of movement
- Was there a dislocation?
- Symptoms of neurological deficit?
- Symptom of tendon ruptured? (ruptured mainly of biceps and Achilles tendon?

> joint swelling:

- Has there been much swelling?
- How much?
- Has it changed?

❖ In Road Traffic Accidents:

1-rusk factor: car speed, rolled over the car, dead passenger, car indentation more than 30cm, extraction time more than 2o m
2- seatbelt?
3-did you lose of your consciousness? If yes did you remember what happened before and after the duration?
4-injury from an accident is single or multiple?
5- GCS
6- is there any bleeding?
7-did you need a blood transfusion?
8- did you need a cricothyrotomy or tracheostomy or ETT?
9- AMPLE ?(Allergy, PAST medical and surgical history, last food and drink ,Event leading to this situation.

>And ask about any stridor, tachycardia, chest pain, neck pain, signs of basal skull fracture, diplopia, blindness, hearing loss, malocclusion, or rhinorrhea.

Don't forget to ask about:

-Past medical
-Past surgical
-family history
-drug history
-social history
-systemic review

Trauma - Examination

Exposure: full body exposure

Inspection:

- Ecchymotic area, abrasion
- steering wheel-shaped contusion,
- seat belt sign: indicates intra-abdominal injury in about one-third of patients.
- skin discoularation
- abdominal distension

Palpation:

1. Haemodynamic instability.
2. Signs of peritoneal irritation: guarding, rigidity tenderness, rebound.
3. Crepitus at the lower thoracic cage
4. Pelvic instability
5. Abdominal distension
6. Evisceration
7. Per digital rectal exam.

Parotid gland - Examination

1. Wash your hands/hygiene
2. Ensure good light & privacy.
3. Introduce yourself to the patient and briefly explain what the examination will involve.
4. Gain consent to proceed with the examination.
5. Ask for the need for a chaperone.
6. Position the patient sitting on a chair
7. Exposure: above the nipple
8. Ask if the patient has any pain before proceeding.

- **Extraoral Examination :**

❖Inspection:

Inspect both parotid regions including the preauricular and postauricular regions on both sides

Notice the extent, size, shape, and surface of the swelling and the skin overlying the swelling and surrounding the swelling

Notice the scar, pulsation of mass

❖Palpation

Before palpation ask the patient if there is any pain.

Palpation should be carried out wearing gloves.

- temperature (dorsal of your hand)
- tenderness

-measure the swelling in at least two dimensions with a small tape

-palpate for consistency of swelling, and overlying skin for any fixation with the swelling

-examine the mobility of the swelling in both vertical and horizontal planes

-do the transillumination test (if the swelling is cystic in consistency)

- **Intraoral Examination:**

Should be examined with a proper light

❖Inspection:

Looking for the Stenson's duct

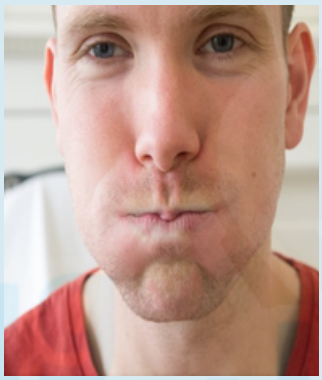
(the duct lies in the cheek mucosa opposite to the upper 2nd molar teeth, it may be red congested in the inflammatory condition of the parotid and may express a few drops of pus in pyogenic condition)

Notice the movement of the tongue

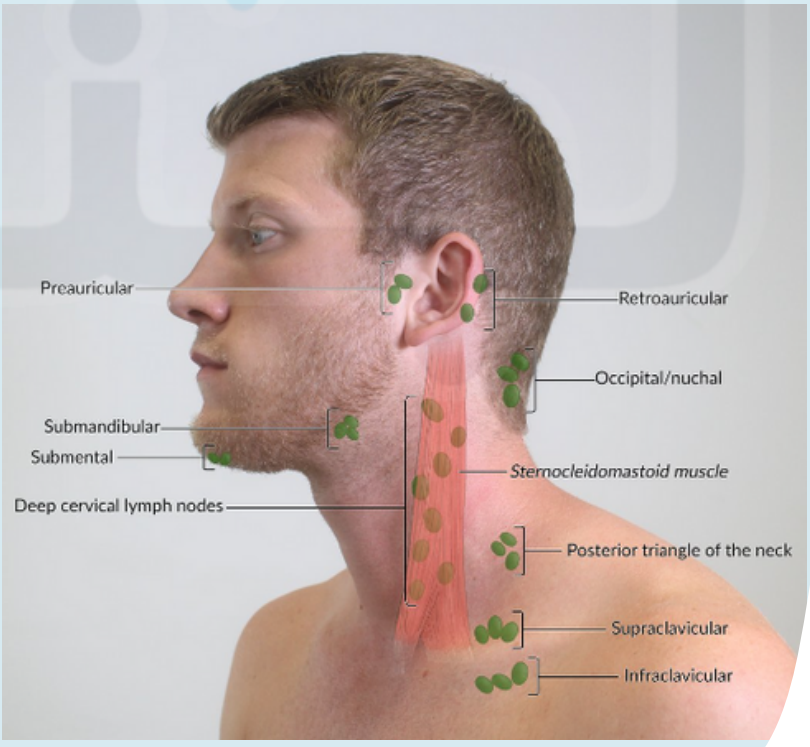
❖Palpation:

-The deep lobe of the parotid can be palpated bimanual (by one hand outside on the patient's cheek or jaw and a finger of your other hand inside the mouth)

-examine for facial nerve

Crease up the forehead	Keep eyes closed against resistance	Puff out the cheeks	Reveal the teet
			

-examine the lymph nodes



Diabetic foot - History taking

❖Patient profile:

- Name
- Age
- Sex
- Occupation
- Address
- Marital status
- date of admission and how (ER, outpatient clinic)

❖Chief Complaint

diabetic foot

❖HOPI:

- When and how was the ulcer first noticed ?
- any Pain?
- Discharge
- Progression : How the ulcer change in size ,depth,shape .size.

Neuropathic symptoms: Burning or shooting pain, electrical or sharp sensations , numbness.

• ASK about Symptoms of peripheral vascular /ischemic problems:

1. Claudication
2. Rest pain
3. Nonhealing ulcer
4. Contributing factor
5. Current ulcer

Diabetic History:

1. Duration of diabetes
2. Type of treatment
3. History of poor glycemic conrole
4. Diabetes complications: Renal insufficiency, visual impairment

Ask about :

- Previous ulcer or amputation
- Trauma or burn
- Foot deformity
- Symptoms of peripheral neuropathy :

❖Social History: Smoking

❖Medical History: Hypertension

❖Surgical history

❖Druge history, allergy.

❖Systemic review

Leg ulcer - History taking

❖Patient profile:

- Name - Age
- Sex - Occupation
- Address - Marital status
- date of admission and how (ER, outpatient clinic)

❖Chief Complaint

❖HOPI:

How long do you have this ulcer?
-timing: when did you first notice ?
-cause: what makes you care (pay attention)about this ulcer ?
What do you think the cause of it?
-site: where is the ulcer ?unilateral or bilateral ?
-size: what is the size of ulcer when it first note.
-number: how many ulcer do you have?
-pain: is it painful or painless?
-characteristics: (color , function,discharge, shape, itching, bleeding,foul smelling, borders(regular or not))
-recurrence: Are there reccurent ulcer ?
-Disappearance: does the ulcer ever disappear?
-any changes: did the ulcer change with time?
-aggravating and relieving factor: what aggravates the ulcer?what relieves it?
-progression: is it progressive ?any fast increase in size?
-trauma: any history of trauma.
-severity: How does the ulcer affect yours life?
-wound care: do you always take care of your ulcer?
Is it controlled ulcer?
-Charcot's joint: any history of joint disloocation,pathologic fractures, and deblitating deformities?.

- Ask about:

weight loss ,anorexia,numbness ,parasthesia,nephropathy,neuropathy, retinopathy claudication,weakness in lower limb,rest pain,palpitation.

Ask about diffrential diagnosis

>Arterial causes :

Atherosclerosis

Burgers disease : any history of finger or toes that appear pale, red,or bluish?cold hand or feet?pain in the hands and feet that may feel like burning or tingling?

Vasculitis

>venous causes:

Venous insufficiency:any history of pain when walking that stop when you rest?any history of swelling in your leg or ankles? Tight feeling in your calves or itchy,painful leg? bown skin color?

>neuropathic causes

❖Medical & Surgical history:

-how many time did you enter the hospital for this reason?how many time did you receive the treatment?

-any history of ,hyoertention,IHD,TIA,MI,DM?

-any history of trauma?

❖Druge history :

Any history of NSAIDS?aspirin?Beta blocker? Steroid?

❖family history

❖Social history

❖Systemic review

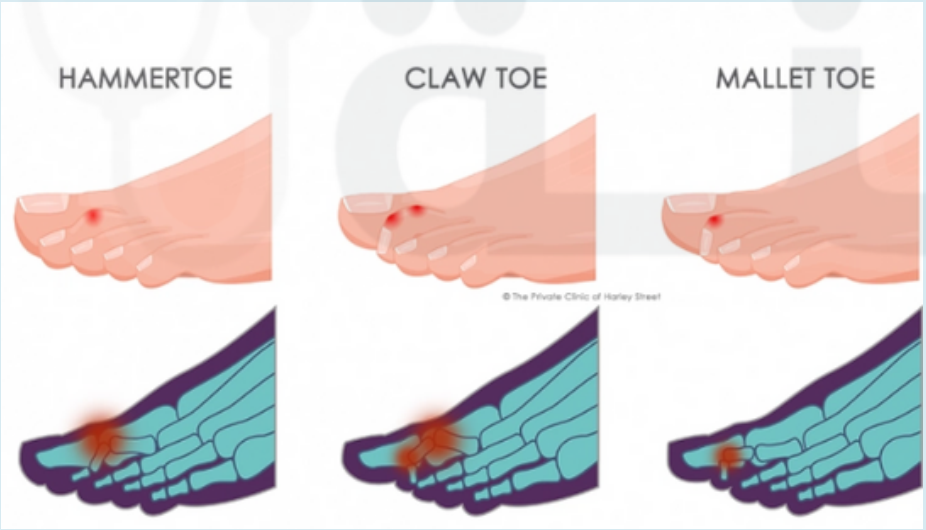
Diabetic foot - Examination

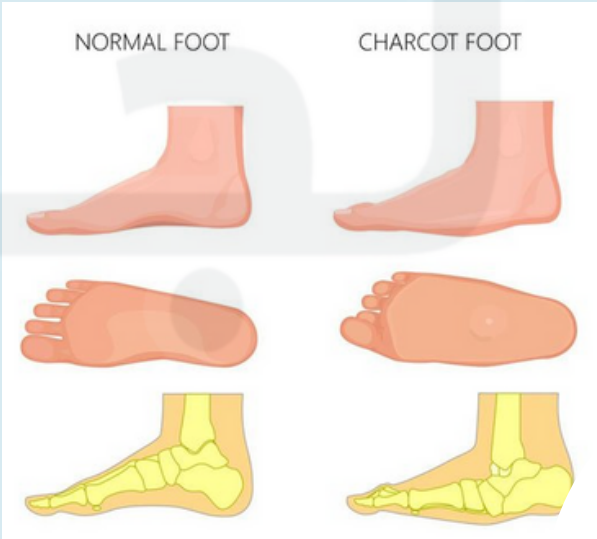
1. Wash your hands/hygiene
2. Ensure good light & privacy.
3. Introduce yourself to the patient and briefly explain what the examination will involve.
4. Gain consent to proceed with the examination.
5. Ask the patient to sit on a chair for the assessment.
6. Exposure: Adequately expose the patient's neck to the clavicles.
7. Ask the patient if they have any pain before proceeding with the clinical examination.

❖Inspection:

Expose both legs

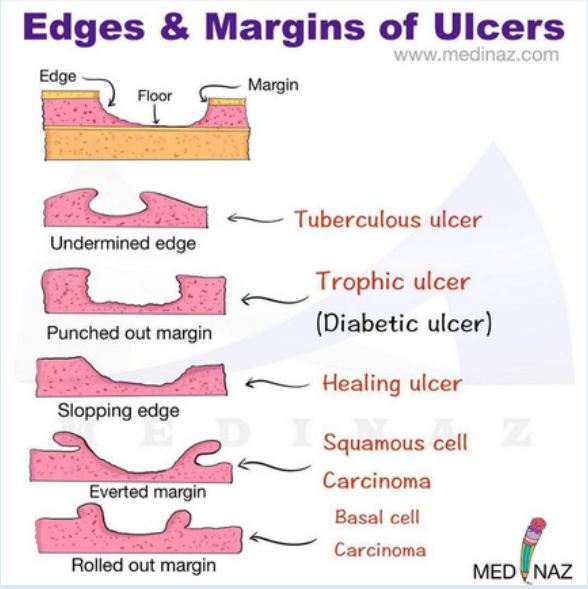
- look for symmetry, amputation, and edema
- Skin: assess the skin on the foot;top, bottom, and sides including between toes: intact, callus(ulcer may be embedded under a thickened callus) and fungus formation, hair loss, and gangrene.
- Color changes: erythema, pallor, pigmentation, or cyanosis.
- Nails: assess the toenails to see if they're brittle or thickened.
- Check for any ulcers
- Hair loss.
- Any deformities: claw toes, hammer toes, rocker-bottom foot, loss of arch, Charcot changes.





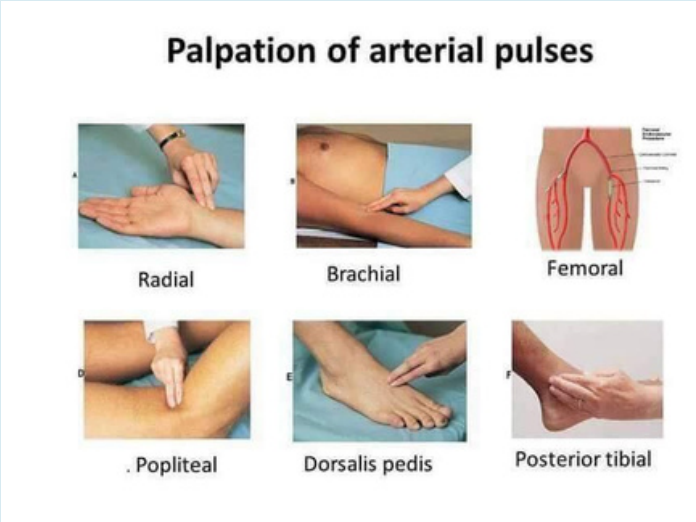
If there are any ulcers:

- Site, shape, size, margin, the skin around the ulcer whether it's healthy or unhealthy: cyanosed, gangrenous, hyperemic, hyperkeratosis.
- Edge: sloping, punched out, undermined, rolled
- Floor what you see
- necrotic tissue, granulation tissue, discharge
- Base: what you palpate
- Bad smell is an indication of infection



❖Palpation

-Temperature: cold /warm
-Tenderness of ulcer and the surrounding skin
-Edema
-Base of ulcer (squeezing):
Pus oozing
Contact bleeding
Indurated, fluctuate, fixation(mobility)



❖Vascular examination

Capillary refilling time: Normally < 2 seconds
Palpation of pulses :

- Dorsalis pedis
- Posterior tibial
- Popliteal
- Femoral

Dont forget ABPI

Changes of ischemia: skin atrophy, nail atrophy, Decreased pedal hair, abnormal wrinkling.

Arteries	Location for palpation
Superficial temporal artery	Felt just in front of tragus
Common carotid artery	Felt in the carotid triangle, just in front of sternomastoid muscle against carotid tubercle of sixth cervical vertebra
Subclavian artery	Felt just above the middle of the clavicle
Brachial artery	Felt in front of elbow just medial to the tendon of Biceps
Radial and ulnar arteries	Felt in wrist on lateral and medial sides of volar aspect respectively
Femoral artery	Felt at the groin just below the inguinal ligament midway between anterior superior iliac spine and the symphysis pubis
Popliteal artery	Palpated by turning the patient into prone position and by feeling the artery with finger tips after flexing the knee passively with another hand
Anterior tibial artery	Felt in midway anteriorly between the two malleoli against the lower end of tibia just above the ankle joint and just lateral to the tendon of extensor hallucis longus .
Posterior tibial artery	Felt just behind medial malleolus , midway between it and tendo achillis
Dorsalis pedis artery	Felt just lateral to the Extensor hallucis longus tendon.

❖Neurological examination:

Sensory:

- Vibration perception :Tuning fork 128H
- Pressure and touch:Cotton wool(light),Simmes Weinstein 10gram monofilament.
- Two point discrimination
- Pain (pin prirk) ;using sharp and blunt tool
- Temprature perception(Hot/Cold)
- Monofilament test:10g monofilament test , the device is palaced perpendicular to the skin, with pressure applied until the monfilament buckles.It shouldbe held in place for < 1 second and then released,

Motor:

- Deep Tendon Reflex(DTR)-achilles tendon
- Abnormal gait.

❖MSS examination:

- **Structural deformities:**

· Hammer toes
· Charcoot deformity
· Loss of arch

- **Small muscle atrophy**
- **Limited joint movement**
- **Probe to bone test**
- **Prior amputation**

Lower limb ischemia - Examination

Firstly: You have to maintain privacy by closing the door, washing your hands with Alcohol then introducing yourself to the patient, doing handshaking with the patient and gain consent (All of these should occur SIMULTANEOUSLY).
Secondly: you have to ask the patient about his name, age and expose the patient's neck
-Ask for a chaperone.
-Ask for permission.
-Ask for the patient's name and age.

❖General Examination:

The patient looks well, awake (not comatose), conscious, oriented, breathing comfortably, not in pain, not pale, not jaundiced, no IV lines, dressings, 02 masks or drains, and there's no any sign of lethargy, apathy or restlessness.

❖Specific Examination:

Exposure: whole lower limbs
Position: Flat

• Inspection:

-Site, size, shape, symmetry, swelling, deformities, discoloration, Scars, dilated veins, hair distribution, discharges.
- Nails, between toes for ulcers.
- Sole of the foot (elevate patient's legs), lateral aspect of the foot, medial and lateral malleoli for ulcers, bed sores (sole of the foot).
- Discoloration, varicosities, guttering of veins.
- Shinny erythematous edematous skin.
- No signs of muscle wasting.
- Floor, edge, margins, and base of the foot look normal.
- Amputations, nails, between toes.

-Here you have to say:
"By inspection of pt's legs, they are symmetrical, with no swellings no deformities no discoloration, no scar or dilated veins, normal hair distribution, nails looks normal, there are no ulcers, sole of the foot look normal, there are no bed sores, no shiny erythematous edematous skin ."

Notes:
Ulcers could be: Arterial: at tip of fingers Venous: gutter area (medial malleolus)

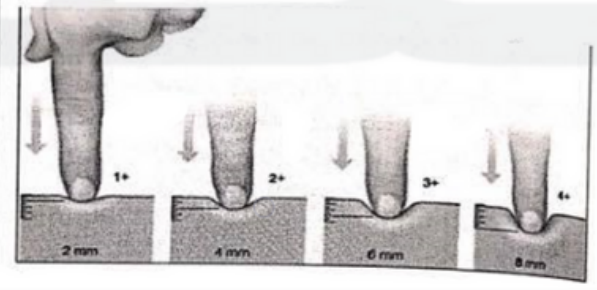
- **Palpation:** 2p, 2 T, 2 C, L, S, B.

start by saying: " By palpation of the lower limb, I will check:

-Pulses (Femoral, popliteal, posterior tibial, dorsalis pedis).
-Pitting Edema by compressing against tibia (it has 4 grades, for every 0.2 cm of edema, it develops a new grade)
-Temperature (from knee moving downward, DO IT on BOTH SIDES).
-Tenderness. (Calf tenderness, do eye to eye contact)."
-Capillary refill time (should be less than 2 seconds).
- Circumference for leg swelling:
imagine a line between tibial tuberosity and media1 malleolus, locate tibial tuberosity, go down 10 cm, and locate the circumference
*Result: If there's a difference of more than 3 cm from both legs, THIS IS SIGNIFICANT and it might indicate DVT!
-Lymph node examination. (Say it or do it)
-Sensation test: has 2 parts:

- First: touch the patient's legs and ask him which part you touched
- Second: make a continuous & interrupted sensation on his legs, from below the knee to the ankle, ask him to tell you when the sensation has stopped when you removed your hand

1+	2mm depression, barely detectable. Immediate rebound.
2+	4mm deep pit. A few seconds to rebound.
3+	6mm deep pit. 10-12 seconds to rebound.
4+	8mm deep pit. >20 seconds to rebound.



-palpate behind the knee to exclude Becker's cyst.

- ***Special test:***

A. Hoffman's test: (not used anymore):
-Ask the patient to extend his knees, the examiner raises the patient's leg straight to 10 degrees then passively and abruptly dorsiflexion the foot and squeezes the calf with another hand.
Results: Deep calf pain indicating DVT!
B. Burger's Test:
If there's any problem in the capillary refill (if it's more than 3 seconds), Do Burger's test!

Varicose veins - Examination

1. Wash your hands/hygiene
2. Ensure good light & privacy.
3. Introduce yourself to the patient and briefly explain what the examination will involve.
4. Gain consent to proceed with the examination.
5. Position and exposure: expose the patient's legs and examine them with the patient standing and then lying supine.
6. Ask the patient if they have any pain before proceeding with the clinical examination.

❖Inspection:

from distal to proximal (remember when describing veins they arise at the bottom of the leg and go upward to the groin),
front, side, and back of the legs
the patient's standing position (lying down will empty the varices)
Looking along the distribution of the long saphenous vein (medical side, length of the leg)
Short saphenous vein (below the knee, posterior and lateral aspect of the leg)
Look For large visible dilated veins and skin changes :
1. Scare ...previous surgery
2. Skin pigmentation.... Brown pigmentation (hemosiderin deposition)

3. Venous stars

4. venous eczema

5. venous ulcer

6. Thrombophlebitis:

superficial red painful lump

7. Lipodermatosclerosis:

Progressive sclerosis of cutaneous fate,
the ankle becomes thin and hard,
the area above becomes edematous

8. Ankle swelling and edema

❖Palpation:

Ask the patient about any pain

- **Palpate the veins (to confirm are intact when pressed and remove it refill) and any visible varicosities**
(assess temperature, the texture of the skin, and tenderness).
- **Palpate SFJ saphenofemoral junction**
(4cm lateral and 4cm below pubic tubercle) and saphenous varix
(dilation of the saphenous vein at its junction with a femoral vein in the groin)
- **Cough test: fingers over SFJ, ask the patient to cough, If you feel an impulse over the SFJ this indicates saphenous varix.**
- **Pitting edema**
- **Lower limb pulses (femoral, popliteal, posterior tibial, dorsalis pedis arteries).**

❖Percussion:

Tape test

- **Place the fingers with small pressure onto SFJ,**
- **tap the varicose vein,**
- **if your fingers over SFJ detect a thrill suggest incompetence.**

❖Auscultation:

Placing the bell of the stethoscope in varicose vein and listening to the bruit >> Arteriovenous malformation

❖Special Tests:

Trendelenburg test (tourniquet test):

One leg should be assessed at a time.
1. Position the patient lying flat,
2. lift the patient's leg up *empty the superficial veins,
3. place the tourniquet over SFJ ,
4. ask the patient to stand and observe for filling of the vein :
● At this point, if the veins have not filled and remain collapsed, it indicates the incompetent venous valves were at the level of the SFJ.
● If the veins have filled up again, it indicates the incompetent valves are inferior to the SFJ (perforator veins – veins that drain venous blood from superficial to deep veins within the muscle).
5. Repeat the test with the patient lying flat, placing the tourniquet 3cm lower than the previous position ask the patient to stand and observe venous filling, and repeat this sequence until filing stops and the location of the incompetent venous valves is localized.

Perthe's test :

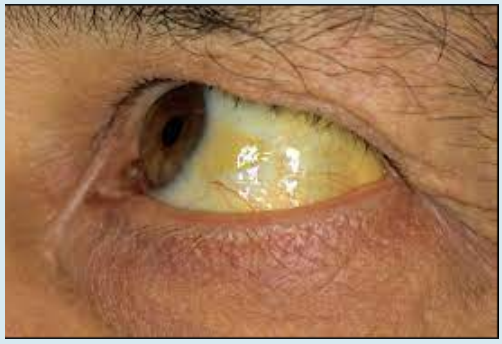
Used to distinguish between venous valvular insufficiency in the deep, perforator and superficial venous system.
● Ask the patient to stand up
● Tourniquet round mid-thigh
● Raised onto toes 10 times or walk around room for 5 minute
● If the vein empty....deep system fine
● If the veins swell and become painful....deep veins occlusion
To complete examination
● Abdominal examination
● Scrotal, vaginal, and rectal examination
*(increased pressure in the abdomen or pelvis can occlude venous return from the legs leading to venous hypertension and varicose veins.)
● Arterial examinations

And thank the patient for their time and wash your hands.
-Investigation
-Duplex ultrasonography
-Venography

Jaundice - History taking

❖Patient profile:

- Name - Age
- Sex - Occupation
- Address - Marital status
- date of admission and how (ER, outpatient clinic)



❖Chief Complaint

-What brings you here today?
-For how long do you have these symptoms?

❖HOPI:

Onset: acute (1 week), chronic (3 weeks), sudden (Hepatitis A, Autoimmune hepatitis, gallstone disease), or gradual (carcinoma)?
Duration: for how long do you have these symptoms?
Course: intermittent or continuous (constant or progressive)?
Manner: How did you notice it?
Site and distribution: skin and eyes? Or both?
Associated symptoms: nausea, vomiting, changes in bowel habits, abdominal pain, itching, abdominal distention, melena, hematemesis, bleeding per rectum, and changes in the color of stool or urine.

- Fatigue, SOB, pallor >> pre hepatic
- Pruritis, pale stool, and dark urine >> Post hepatic

Constitutional symptoms: weight loss, loss of appetite, fever, night sweats, fatigue?
Previous episodes: any history of previous attacks?
Contact: any history of contact with an infected person? (Hepatitis A).
For the pain do SOCRATES!

6.6 Common causes of jaundice

Increased bilirubin production
- Haemolysis (unconjugated hyperbilirubinaemia)

Impaired bilirubin excretion
- Congenital:
  - Gilbert's syndrome (unconjugated)
- Hepatocellular:
  - Viral hepatitis
  - Cirrhosis
  - Drugs
  - Autoimmune hepatitis
- Intrahepatic cholestasis:
  - Drugs
  - Primary biliary cirrhosis
- Extrahepatic cholestasis:
  - Gallstones
  - Cancer: pancreas, cholangiocarcinoma

6.7 Urine and stool analysis in jaundice

	Urine			Stools
	Colour	Bilirubin	Urobilinogen	Colour
Unconjugated	Normal	–	++++	Normal
Hepatocellular	Dark	++	++	Normal
Obstructive	Dark	++++	–	Pale

❖Past medical history:

Any history of previous jaundice? Viral hepatitis? Liver disease? Hemolytic anemia?
Any history of blood transfusion?

❖Past surgical history:

Any procedure to the liver?
Splenectomy?
Gall bladder removal?

❖Drug history:

Any history of taking: antibiotics, isoniazid, halothane, methyldopa, MAOIs, oral contraceptives, paracetamol, sulfa drugs, phenytoin, or valproic acid?

❖Family history:

Any family history of liver diseases, autoimmune diseases, hemolytic diseases, history of G6PD, or sickle cell anemia?

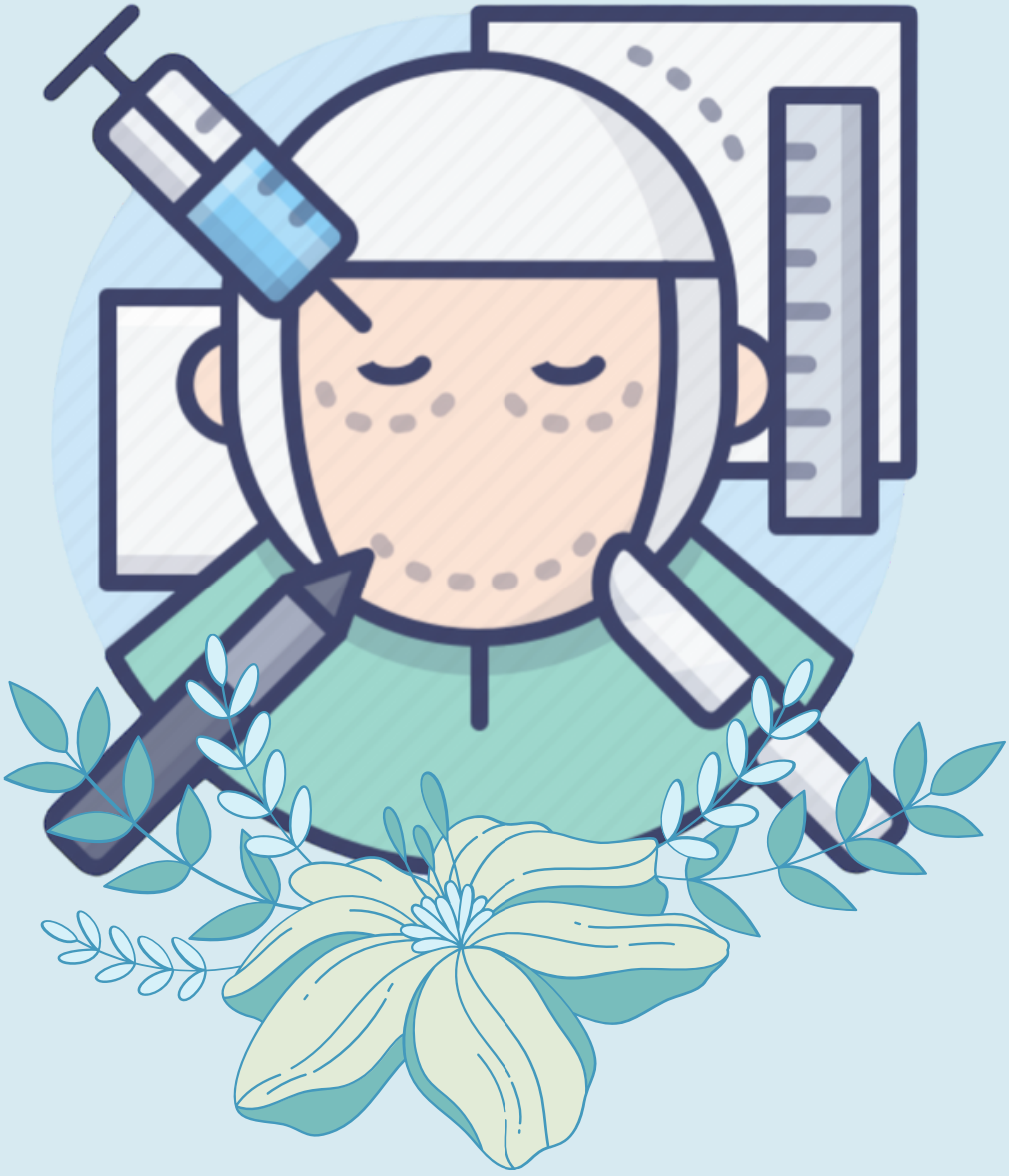
❖Social history:

Any history of contact with Jaundiced patients?, or IV drug abuse? Skin tattoos?
Alcohol drinking?
History of recent travel.
Hepatitis vaccinations

❖Review of systems

Part 2

PLASTIC SURGERY



وتولّني، ويسّر لي كُل ما يشقّ عليّ

Burn injury - History taking

❖Patient profile:

- Name
- Age
- Sex
- Occupation
- Address
- Marital status
- date of admission and how (ER, outpatient clinic)

❖Chief Complaint

❖HOPI:

-Date and time of burn injury
-Mechanism of injury (in detail)
-a place of injury (open or closed)
-Duration of exposure to agent
-unconsciousness during the incidence
-Associated symptoms (pain, SOB)
-ask about trauma

❖History of inhalational injury:

a- Closed place
b- face burns
c- SOB(hypoxia)
d-Carbonaceous Sputum

Also, we can determine the cause of burn injury by mechanism :
Flame—damage from superheated oxidized air
Scald—damage from contact with hot liquids
Contact—damage from contact with hot or cold solid materials
Chemicals—contact with noxious chemicals
Electricity—conduction of electrical current through tissues

The history of a patient with chemical injury should include :
1-Offending agent, concentration, physical form, pH
2-Route of exposure
3-Time of exposure
4-volume of exposure
5-The timing and extent of irrigation

Maxillofacial injuries - History taking

❖Patient profile :

- Name – Age
- Gender – Marital status
- Occupation - Address
- Date and route of admission

❖Chief complaint:

Facial Trauma (Fracture) / Duration

❖HOPI:

-The mechanism of injury determines the degree of force (penetrating, blunt)
a. Interpersonal violence (usually low energy)
b. Motor vehicle accident (usually higher energy)
-History, prior facial trauma
-Time of injury
-Loss of consciousness?
-complaints: Diplopia, blindness, hearing loss, malocclusion, neck pain, and rhinorrhea
-Environmental considerations: Chemical exposure?
-Was the patient under influence of alcohol?
-Note any “old” injuries, for example, a tooth previously fractured or previous facial injuries

❖Past history:

- Chronic illness (HTN, DM, Asthma, TB, Hepatitis): When Where&How Diagnosed?
- Similar condition
- Previous Hospital admission
- Previous Operation
- Previous Blood transfusion

❖Drugs & Allergies History :

- Long term drug
- Short term drug
- Allergy to certain food or medication

❖Social History :

- Smoking
- Alcohol

❖Family History :

- Chronic disease (HTN, DM, Asthma, TB, Hepatitis)
- Inherited / Genetic disease

(وَآخِرُ دَعْوَاهُمْ أَنِ الْحَمْدُ لِلَّهِ رَبِّ الْعَالَمِينَ)

تمّ بحمد الله