# Patient examination

Department of Trauma Surgery

# Definition

- *A case history is defined as a planned professional conversation that enables the patient to communicate his/her symptoms, feelings and fears to the clinician so as to obtain an insight into the nature of patient's illness & his/her attitude towards them.*

# Objectives

- *To establish a positive professional relationship.*
- *To provide the clinician with information concerning the patient's past medical / surgical & personal history.*
- *To provide the clinician with the information that may be necessary for making a diagnosis.*
- *To provide information that aids the clinician in making decisions concerning the treatment of the patient.*

# Steps - Involved

- *Assemble all the available facts gathered from statistics, chief complaints, history of presenting complaints and relevant history.*
- *Analyze and interpret the Examination details to reach the provisional diagnosis.*
- *Make a differential diagnosis of all possible complications.*
- *Select a closest possible choice-final diagnosis.*
- *Plan a effective treatment accordingly.*

# Components

- *Particulars - Patient*
- *Chief complaint*
- *History of present illness*
- *Past history*
- *Personal history*
- *Family history*
- *Treatment history*
- *General examination*
- *Local examination*
- *Other Systems exam.*
- *Provisional diagnosis*
- *Investigations*
- *Final diagnosis*
- *Treatment plan*

# Self Introduction

- *Greet the patient by name: "Good morning, Mr. X / Mrs. Y ."*
- *Introduce yourself and explain that you are a medical student.*
- *Shake the patient's hand, or if they are unwell rest your hand on theirs.*
- *Ensure that the patient is comfortable.*

# Particulars

- Patient registration number
- Date
- Name
- Age
- Sex
- Address
- Occupation
- Religion

| Pt. Reg. No. | Date |
|---|---|
| *Maintaining a record* | *Time of admission* |
| *Billing purposes* | *Ref.- follow up visits* |
| *Medico legal aspects* | *Record maintenance* |

**Name**

- *To communicate with the patient*
- *To establish a rapport with the patient*
- *Record maintenance*
- *Psychological benefits*

**Age**

- *Age related diseases*
- *For diagnosis*
- *Treatment planning*

## Sex

- *Certain diseases – gender specific*
- *Record maintenance*
- *Psychological benefits*

## Residence / Address

- *For future correspondence*
- *View of socio-economic status*
- *Prevalence & geographical distribution*

## Occupation

- *To assess socio-economic status*
- *Predilection of diseases in different occupations*

## Religion

- *Predilection of diseases in certain Religion*
- *To identify festive periods when religious people are reluctant to undergo treatment*

# Chief Complaints

- *The chief complaint is usually the reason for the patient's visit.*
- *It is stated in patient's own words [No medical terms] in chronological order of their appearance & their severity. { Brief & Duration }*
- *Make clear – patient was free from any complaint before the period mentioned.*
- *The chief complaint aids in diagnosis & treatment therefore should be given utmost priority.*

# History of Present Illness

- *Elaborate on the chief complaint in detail*
- *The symptoms can be elaborated in terms of:-*
  - *Mode & cause of onset*
  - *Course & Duration of disease*
  - *Symptom related & Relation to constitutional factors*
  - *Special character & Effects – nearby structures*
- *Treatment taken*
- *Leading questions – to help the patient*
- *Negative answers – more valuable to exclude the disease*

# Common Chief Complaints

- *Pain*
- *Swelling*
- *Ulcer*
- *Vomiting*
- *Bleeding*
- *Discharge*
- *Deformity*

# Past History

- *Note the past history in chronological order*
- *All diseases – previous to present – noted*

  *{ Attention to diseases like – Diabetes, Bleeding disorders, Tuberculosis, SHT, Asthma etc. }*
- *Previous operations or Accidents – noted*
- *Mneumonic – T H R E A D*

# Personal History

- *Diet*
- *Habit of smoking & drinking of alcohol*
- *Bowel & micturition habits*
- *Sleep*
- *Allergy to any drug [or] diet*
- *Marital status*
- *Females – Menstrual history*
  *[ regularity / menarche ,menopause / no. of pregnancy – normal or LSCS / any discharge PV ]*

# Family History

- *Family members share their genes, as well as their environment, lifestyles and habits.*
- *Certain diseases run in families  - Diabetes, cancers – breast, thyroid, SHT, piles, peptic ulcer etc. should be noted*
- *Enquire about family members – alive or dead / current illnesses / consanguinity among family*

# Treatment or Drug History

- *Ask about the drugs the patient was on.*
- *Special enquiry on – Steroids / Antihypertensives, HRT, contraceptivs pills, Antidiabetic drugs etc.*
- *Treatment for the current illness & doctor treated*

# General Survey or Examination

- *Analyze the patient entering the clinic for gait, built & nutrition, attitude and mental status.*
- *Check for any pallor, cyanosis, jaundice, clubbing, any skin eruptions and edema.*
- *Record vital signs like*

  *T U R P*

# Local Examination

- *Most important part – definite clue to arrive at a diagnosis.*
- *Examination of affected region.*
- *Inspection – looking at affected part*
- *Palpation – feeling of affected part*
- *Percussion – listening to the effects of affected part*
- *Auscultation – listening to the sounds produced*
- *Movements & Measurements*
- *Lymph node examination*

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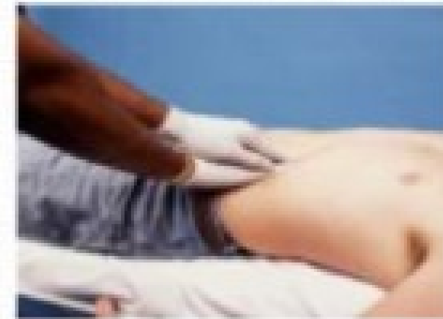
# Palpation

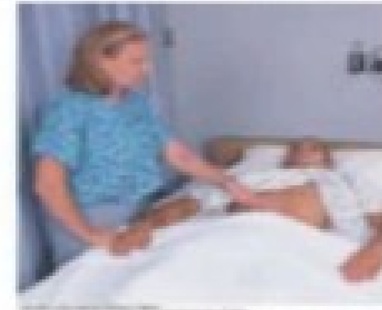
- *A technique in which the hands and fingers are used to gather information by touch.*
- *Palmar surface of fingers and finger pads are used to palpate for*
  - *Texture*
  - *Masses*
  - *Fluid*



- *For assessing skin temperature – dorsal surface*
- *Client should be relax and positioned comfortably because muscle tension during palpation impair its effectiveness.*

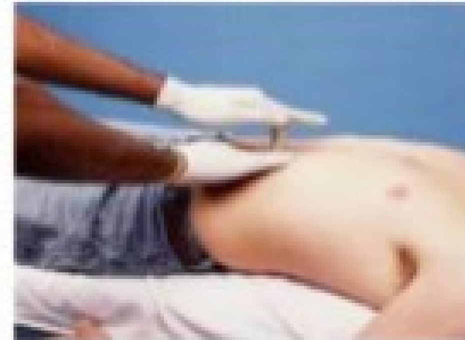
# Palpation - Types

- *Light palpation*
- *Deep palpation*
- *Bimanual palpation*
- *Bidigital palpation*



# Percussion

- *Percussion involve tapping the body with the fingertips to evaluate the size, border and nature of body organs.*



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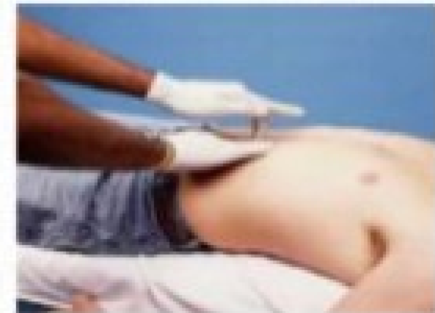

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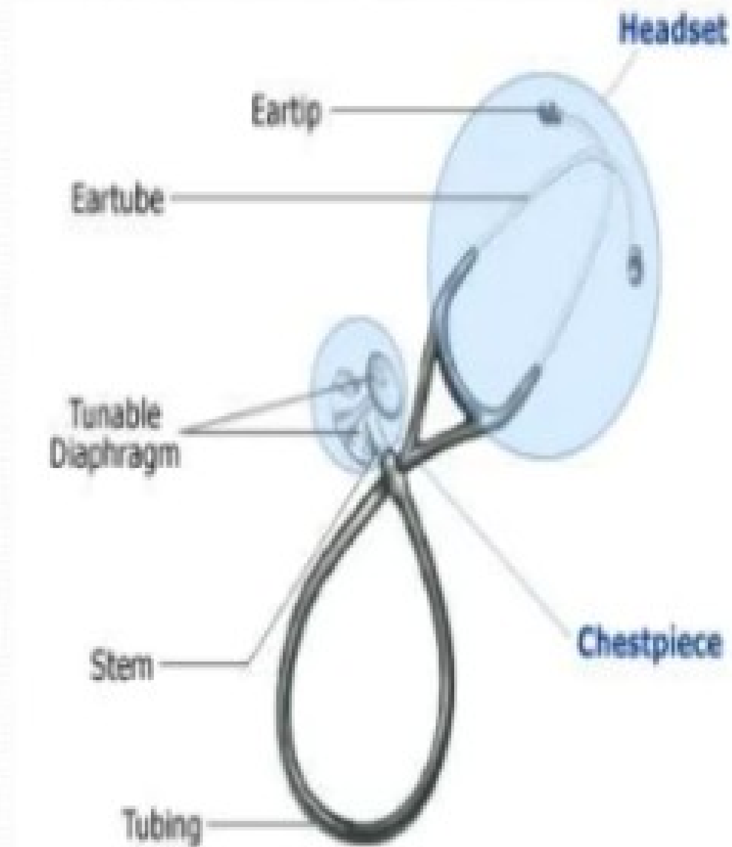
# Auscultation

- *Auscultation is listening to sound produce by the body.*
- *Following characteristics of sound are noted:-*
  - *Pitch*
  - *Loud or soft*
  - *Duration*
  - *Quality*
- *Done by stethoscope.*



# Other systems – Examination

# Head & Neck

- *Cranial nerves –3,4,5,6,7,9,11&12 - examined*
- *Eyes – visual field, pupils, movements*
- *Mouth & pharynx – teeth & gum, tongue & tonsil*
- *Movements of neck, neck veins & lymph glands, carotid pulse & thyroid gland*

# Upper Limbs

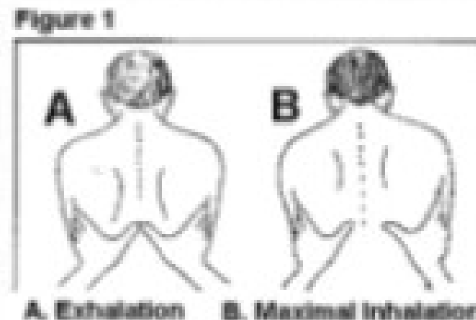
- *Arms & hand – Power, tone, reflexes & sensations*
- *Axillae & Lymph nodes*
- *Joints*
- *Finger nails*

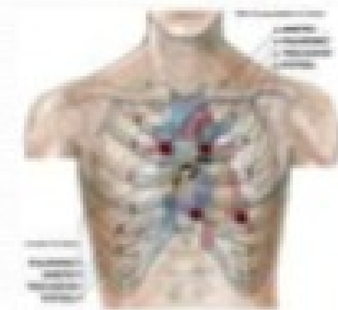
# Lower Limbs

- *Legs & feet – Power, tone, reflexes & sensations*
- *Varicose vein*
- *Joints*
- *Oedema*

# Thorax

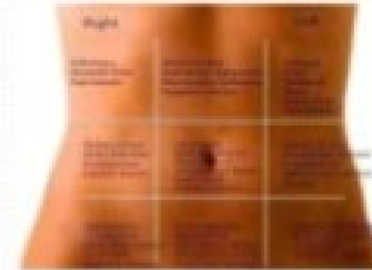
- *Type of chest*
- *Breasts*
- *Dilated vessels & pulsations*
- *Position of trachea*
- *Apex beat*
- *Lungs – whole*
- *Heart – whole*



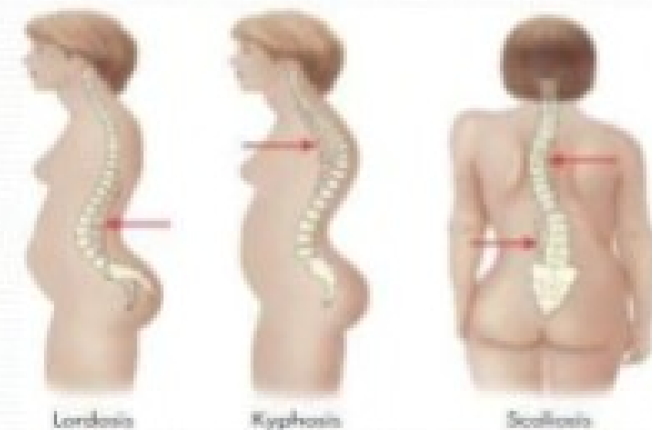
# Abdomen

- *Abdominal wall – umbilicus, scars, dilated veins*
- *Visible peristalsis or pulsations*
- *Hernial orifices*
- *Generalised examination*
- *Inguinal glands*
- *Rectal examination*
- *Gynaecological examination – if required*



# Spine

- *Curvature of spine observe for:-*
- *Lordosis / Scoliosis / Kyphosis*
- *Pain & Tenderness*
- *Swellings*



# Provisional Diagnosis

- *It is also called tentative diagnosis or working diagnosis.*
- *It is formed after evaluating the case history & performing the physical examination.*

# Investigations

**Routine**

- *Blood*
  - *CBP/TC/DC/ESR*
  - *BT/CT*
  - *Sr. Electrolytes / RFT*
- *Urine complete*
- *Pus – C/S*
- *X-ray*

**Special**

- *FNAC*
- *Doppler*
- *U/S*
- *CT*
- *MRI*
- *Invasive procedures*

# Differential Diagnosis

- *The process of listing out of 2 or more diseases having similar signs and symptoms of which only one could be attributed to the patient's disease.*

# Final Diagnosis

- *The final diagnosis can usually be reached following chronologic organization and critical evaluation of the information obtained from the :*
  - *patient history*
  - *physical examination and*
  - *the result of radiological and laboratory examination.*

- *The diagnosis usually identifies the diagnosis for the patient primary complaint first, with subsidiary diagnosis of concurrent problems.*

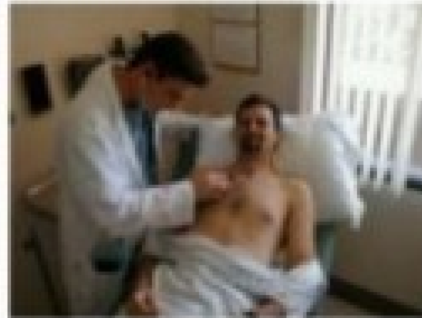
# Treatment Plan

- *The formulation of treatment plan will depend on both knowledge & experience of a competent clinician and nature and extent of treatment facilities available.*
- *Evaluation of any special risks posed by the compromised medical status in the circumstance of the planned anesthetic diagnostic or surgical procedure.*
- *Medical assessment is also needed to identify the need of medical consultation and to recognize significant deviation from normal health status that may affect management.*

# Prognosis

- *It is defined as act of foretelling the course of disease that is the prospect of survival & recovery from a disease as anticipated from the usual course of that disease or indicated by special features of the case.*

- *Clinical diagnosis is an art, and the mastery of an art has no end; you can always be a better diagnostician.*



- **Logan Clendening**