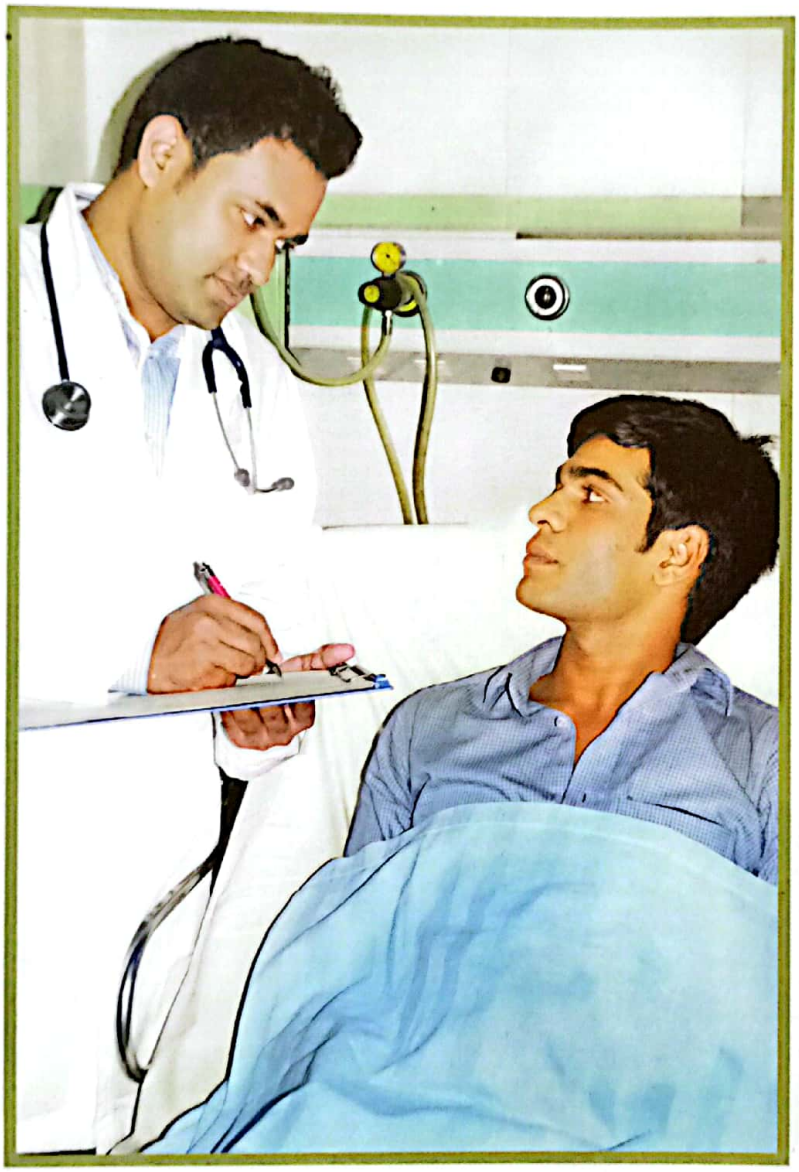
Arts of

History Taking & Symptoms Analysis

3rd Edition



For MBBS and Post Graduate Students

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HEADINGS USED IN HISTORY TAKING

Particulars of patient

- Name:
- Age
- Sex
- Religion
- Occupation
- Marital status:
- Address
  - i. Present
  - ii. Permanent
- Date of admission:
- Date of examination:
- Chief complaints:
- History of present illness:
- History of past illness:
- Family history:
- Drug history
- Personal history
- Dietary history
- Menstrual and obstetric history (In case of female)

Name of student:

Ward:

Unit no.

Bed no.

General examination:

- Appearance
- Physical built
- Nutrition
- Decubitus
- Anaemia

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- Jaundice
- Cyanosis
- Clubbing
- Oedema
- Dehydration
- Koilonychia
- Leukonychia
- Neck vein
- Lymph glands
- Thyroid gland
- Gynaecomastia
- Pigmentation
- Spider naevi
- Palmer erythema
- Distribution of body hair
- Skin condition: Scar mark/rash/swelling
- Pulse
- Blood pressure
- Respiration
- Body temperature

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PROFORMA OF SYSTEMIC EXAMINATION

ALIMENTAY SYSTEM:

General examination: Appearance, anaemia, jaundice, oedema, dehydration, spider naevi, gynaecomastia, leuconychia, koilonychia, clubbing, palmer erythema, body hair distribution

A. Examination of Mouth & Pharynx:

1. Lips:
2. Teeth: Colour, Shape, Number
3. Gums
4. Tongue : Colour, Moistness, Papillae, Deviation, Fasciculation, Atrophy, Sides and undersurface
5. Buccal mucosa: Palate, fauces, tonsils and pharynx.

B. Abdomen proper:

Inspection.

1. Shape of abdomen, May be normal/distended/shrunken
2. Movement of abdomen. Ask the patient to take deep breath in and out. Inspect from either leg or head end to see whether the movement is equal in all sides.
3. Visible peristalsis
4. Visible pulsation (in epigastreum)
5. Umbilicus (inverted or everted)
6. Visible superficial vein, mention location….(central part, flank, below or above umbilicus, around umbilicus). If present, see the flow.
7. If striae, mention the location (colour, size, vertical or horizontal)
8. Any scar mark (due to surgery or trauma), fistula (chrohn's disease) or stoma (colostomy, ileostomy or ileal conduit)
9. Pigmentation (linea nigra from umbilicus, erythema ab agne).
10. Swelling or mass (mention the location…, also mention whether it is intra abdominal or extra abdominal)
11. Hernial orifice (ask the patient to cough),
12. Pubic hair and genitalia (with permission of the patient)

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Palpation:

A. Superficial palpation

1. Temperature
2. Tenderness
3. Muscle guard/Rigidity
4. Hyperasthesia
5. Localized swelling
6. Fluid thrill

B. Deep palpation (Palpation of abdominal organ):

Palpation of abdominal organs:

1. Liver: Note size, margin (round or smooth or sharp), surface (smooth or irregular), tenderness, consistency (soft or firm or hard), upper border of liver dullness, auscultation over liver for bruit or rub.
2. Spleen:
   - Measure in centimeter along its long axis from costal margin in anterior axillary line towards right iliac fossa
   - Feel splenic notch
   - See get above swelling of spleen (insinuate right index finger between spleen and left costal mergin)
   - Percuss over spleen and continue up to left lower part of chest (to see the continuation of splenic dullness)
3. Kidneys: Palpate both right and left kidneys (by ballottement).
4. Gallbladder
5. Urinary bladder
6. Other: (aorta and other vessels, lymph nodes)
7. Any palpable lump:
   Note its Site, Size, Shape, Tenderness, Consistency, Surface, Margin/Edge, Mobility, Bimanually palpable/pulsatile
8. External genitalia: testes, epididymis
9. Succusion splash

Percussion:

1. Percussion note over enlarged organ
2. Upper border of liver dullness
3. Fluid thrill
4. Shifting dullness
5. Percussion note over lump

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Auscultation

1. Bowel sound : Normal / Increased / Diminished / Absent
2. Over liver (hepatic bruit or rub)
3. Renal bruit (2 cm above the umbilicus and lateral to midline)
4. Vascular bruit (bruit of aortic aneurysm), if any
5. Hepatic/splenic rub
6. Venous hum

RESPIRATORY SYSTEM

General Examination : Appearance, anaemia, clubbing, cyanosis, lymph nodes, oedema, decubitus, breathlessness, neck vein.

A. Respiration:

Note Rate, Type, Rhythm

B. Chest:

Inspection:

1. Shape of the chest (asymmetry or deformity or kyphoscoliosis, pectus excavatum or carinatum), flattening and drooping of the shoulder (fibrosis/ collapse)
2. Movement of the chest wall: Normal/ reduced; symmetrical/ asymmetrical
3. Intercostal space (fullness, indrawing of lower ribs)
4. Visible impulse (cardiac impulse and epigastric pulsation)
5. Visible, engorged vein in chest (SVC obstruction)
6. Scar marks (thoracotomy scar and thoracoplasty)
7. Others: Supra-sternal notch & supra clavicular fossae, prominent accessory muscles, gynaecomastia, needle puncture mark and tattooing

Palpation:

1. Position of trachea (central/deviated to right or left)
2. Position of the apex beat (in ….ICS….cm from midline)
3. Chest expansibility: Normal / reduced; symmetrical/ asymmetrical
4. Vocal fremitus: Normal/reduced/increased
5. Tracheal tug (descent of trachea during inspiration, examine by placing fingers over the trachea; it indicates hyperinflation)

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6. Crico-sternal distance (distance between supra sternal notch and cricoids cartilage): Normally 3 fingers or more. If it is less indicates hyperinflation.
7. Rib tenderness due to trauma or fracture, secondary deposit), tenderness in costochondral junction (due to tietze's syndrome).

Percussion:

1. Percussion note (normal resonance, hyper- resonance or stony dull or woody dull, impaired)
2. Upper border of liver dullness
3. Area of cardiac dullness (obliterated due to emphysema or severe asthma)

Auscultation:

1. Breath sound: Vesicular/Bronchial/Vesicular with prolonged expiration
2. Vocal resonance :Normal/increased/decreased/absent
3. Added sound
   a. Rhonchii :Absent/Present
   b. Crepitation /crackles: Fine or coarse or end expiratory. If crepitations are present, ask the patient to cough and see again. Post tussive crepitation appears after cough, sometimes found after cough due to TB.
   c. Pleural rub: Absent/Present

CARDIOVASCULAR SYSTEM

General Examination: Anaemia, Cyanosis, Clubbing, Oedema, Decubitus, Respiratory rate, Pulse, Blood Pressure.

Arterial Pulse:

Rate, Rhythm, Character, Volume, Symmetry, Condition of vessel wall, Radio femoral delay, Radio radial delay, Peripheral Pulses.

Blood pressure:

1. Systolic
2. Diastolic

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Neck vein:

Examination of precordium:

Inspection:

1. Deformity of chest (kyphosis, scoliosis, lordosis, pectus excavatum or carinatum)
2. Visible cardiac impulse (visible apex beat)
3. Other impulses (epigastric pulsation, suprasternal or any other impulse).
4. Scar mark in the midline (valve replacement or coronary artery bypass grafting, CABG), thoracotomy scar (valvotomy in MS)
5. Pacemaker or cardioverter defibrillator box may be seen.

Palpation:

1. Apex beat:
   Site (localize the intercostal space, distance from midline)
   Character (normal, tapping, heaving, thrusting and diffuse)
2. Thrill:
   a. Site (apical or basal or other intercostal space)
   b. Nature (systolic/diastolic): Feel carotid pulse at the same time. If coincides with carotid pulse, it is systolic and if it does not coincide (come after or before) it is diastolic.
3. Left parasternal heave: place the flat of right palm in left parasternal area and feel by giving gentle sustained pressure.
4. Palpable P_2 (if present indicates pulmonary hypertension)
5. Epigastric pulsation:

Percussion:

Usually not done, may be helpful to diagnose pericardial effusion (area of cardiac dullness increased) and emphysema (area of cardiac dullness obliterated)

Auscultation:

1. Heart sounds: See first and second heart sounds in all area. At the same time, palpate right carotid pulse simultaneously with

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thumb. 1st heart sound coincides with carotid pulse, the 2nd heart sound does not (comes after)

2. Murmur:
   - Site (apical/parasternal/aortic/pulmonary)
   - Timing: systolic (pansystolic/ejection systolic), diastolic (mid diastolic murmur or early diastolic murmur by feeling carotid pulse at the same time (systolic coincides with carotid pulse and diastolic does not coincides).
   - Radiation
   - Character: Harsh/blowing/rumbling/rasping
   - Pitch: High pitch/low pitch
   - Relation with respiration (right sided murmur increases on inspiration and left sided murmur increases on expiration)
   - Grading of murmur (grade 1 to grade 6)
3. Added sound (pericardial rub and opening snap)
4. Auscultate the back of chest for crepitations (pulmonary oedema)

NERVOUS SYSTEM

A. Mental function/higher psychic function

1. Appearance and behavior: Normal/abnormal (e.g. Violent)
2. Orientation of time & space
3. Memory: Intact/impaired/lost
4. Level of consciousness: Conscious/semiconscious/ unconscious. Follow Glasgow coma scale (GCS) if consciousness is altered
5. Emotional state of mood: Normal/euphoric/depressed/ anxious /irritable
6. Intelligence
7. Hallucination / Delusion
8. Speech & articulations

B. Examination of Cranial Nerves

Olfactory nerve (Right & Left)

1. Inspection of nostrils
2. Perception of smell

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Optic nerve:

1. Visual field
2. Visiual acquity
3. Colour vision
4. Ophthalmoscopic Exam.
5. Light reflex

Oculomotor, Trochlear, abducent (Right & Left)

i. Ocular movement
ii. Squint/ diplopia /ptosis/ nystagmus
iii. Pupil
- Size-normal 3-5 mm, both equal or not
- Shape: circular or not

vi. Light reflex-direct, consensual
vii. Accommodation reflex

Trigeminal nerve:

1. Sensory function (test along the three division of trigeminal nerve)
2. Motor function
   a. Wasting of muscles of mastication
   b. Clinching of teeth
   c. Jaw movement (Protrution, Retraction, Side to side movement)
3. Reflex function (corneal reflex, jaw jerk)

Facial nerve

Motor

Eye closure
Whistling
Showing teeth

Sensory

Taste sensation in anterior 2/3rd of tongue

Vestibulo cochlear nerve:

a. Tuning fork test
b. Taste of balance

Glossopharyngeal & Vagus nerve:

a. Gag reflex
b. Taste sensaton in posterior 1/3rd of tongue
c. Movement of palate
d. Hoarseness of voice

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Accessory nerve

Shrugging (Trapezius)

Action of sternocleidomastoid muscle

Hypoglossal nerve:

a. Inspection of tongue: Size, Tremor, Fasciculation, Deviation, Atrophy

b. Movement of tongue: (protrusion, side to side movement, waggling of tongue)

C. Motor function

1. Bulk of muscles
2. Tone of muscles
3. Power of muscles
4. Test for clonus (ankle and patella)
5. Reflexes (superficial & deep)
6. Co-ordination

D. Sensory function

1. Pain
2. Touch
3. Temperature
4. Sense of position
5. Sense of vibration
6. Recognition of size & shape, weight & form of object.

E. Signs of meningeal irritation

Neck rigidity

Kernig's sign

Brudzinski's sign

F. Gait

LOCOMOTOR SYSTEM

Joints: (look, feel, move)

Inspection (Look):

1. Skin changes: Absent/present (erythema/atrophy/scars/rashes)
2. Swelling
3. Deformity: Absent/present (fixed or reducible / varus/valgus/ ulnar/ radial deviation/flexion
4. Pattern of joint involvement: Mono-, oligo- or polyarticular-joint/joints involved
5. Wasting of muscles
6. Attitude of the limb

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Palpation (Feel):

1. Skin warmth (temperature)
2. Tenderness: Absent/present (bony/joint line/peri articular)
3. Swelling: absent/present (fluctuant/soft, non-fluctuant/hard)
4. Patellar tap: absent/present
5. Tendon sheath crepitus: Absent/present
6. Muscle power e.g. grip strength
7. Corroboration of the findings of inspection

Movement (both active and passive):

1. Range of movement: Restriction/increased range (hypermobility or instability)
2. Pain during movement
3. Joint crepitus
4. Any associated muscular spasm
5. Stress test

Measure:

1. Length and circumference of the limb
2. Measurement in relation to various body points: Thoracic ankylosis by chest expansion measurement and lumber ankylosis by schober's test

Examination of spines, hands, bones, ligaments, S. I. Joint etc.

Provisional diagnosis:

Differential diagnosis:

Diseases	Points in favor	Points against

Salient features :

Investigations :

Clinical diagnosis :

Treatment :

Advice :

Follow up :

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HOW WILL YOU TAKE HISTORY WITH IMPORTENCE OF ALL HEADINGS

Name:

Importance:

- For identification of the patient
- The patient likes to be asked by name. As for example, "Mr. Baten, how long are you having this problem?" This will help to elicit history properly. The patient is assured that you know him by name.

Age:

Importance:

It is important to know the age of patient. Because some diseases are more common at specific age of life. As for example, breathlessness in childhood usually due to bronchitis, pneumonia etc; but breathlessness in old age is usually due to heart failure, COPD etc. Chest pain in young age is usually due to musculoskeletal chest pain, pneumonia etc; but chest pain in old age is usually due to ischemic heart disease, bronchial carcinoma with metastasis etc.

More in infant:

- Respiratory tract infection
- Diarrhoea
- Urinary tract infection.

More in childhood:

- Appendicitis
- EPI disease
  - i. Measles
  - ii. Mumps (also in young adults)
  - iii. Whooping cough (Pertussis)
  - iv. Diphtheria
  - v. Tuberculosis (also in young adults)
  - vi. Tetanus, also in neonates and adult.
- Epilepsy (onset)
- Rheumatic fever (also in young adult)

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Juvenile idiopathic arthritis
Wilm's tumor (nephroblastoma)

Common in young adult:

- Irritable bowel syndrome
- Appendicitis
- Labyrinthitis (30 to 40 years)
- Reactive arthritis (reiter's disease)
- Rheumatic fever (also in children)

More in middle age:

- Peptic ulcer (also common in young adult and old)
- Bronchial carcinoma
- Gastric carcinoma
- Rheumatoid arthritis (starts at 30 to 50 years of old)
- Migraine headache (first attack at 40 years of old)
- Cholecystitis.

More in old age:

- Cerebrovascular disease e.g. Stroke (over 45 years)
- Peripheral vascular disease (55 to 75years)
- Peptic ulcer, hiatus hernia
- Carcinoma of gall bladder (over 70 years)
- Benign and malignant prostatic hypertrophy

Sex:

Incidence and prevalence of different disease is different in male & female. Example: male female ratio of SLE is 1:9; but male female ratio of reactive arthritis is 15:1. Haemophilia is the disease of male (X-linked disease, female are carrier but male are sufferer).

More in male:

- Bronchial carcinoma
- Gastric carcinoma
- Peptic ulcer
- Benign and malignant prostatic hypertrophy (only in man)
- Ischemic heart disease
- Reactive arthritis

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- Peripheral vascular disease
- Mitral regurgitation
- Hypertension
- Peripheral arterial disease

More in female:

- Gall stone
- Acute & chronic cholecystitis (30-60 years)
- Breast cancer
- Irritable bowel syndrome (IBS)
- Mitral stenosis (66% of cases)
- Rheumatoid arthritis
- SLE

Religion:

Importance:

- Carcinoma of penis, phimosis, subprepucial infection is hardly seen in Muslims and Jews.
- Inflammatory bowel disease is more common in Jews people
- Hindus who are strictly vegetarians may suffer from megaloblastic anaemia due to deficiency of vitamin B12. Vitamin B12 predominantly come from animal source (liver, eggs).

Occupation:

Importance:

It is important to know the occupation of the patient, because many diseases are related to specific occupation.

Occupation	Disease
Worker in jute mills	Bronchial asthma
Welding and electro plating	Chronic obstructive pulmonary diseases (COPD)
Working in dying industry, rubber industry	Carcinoma of urinary bladder
Working for prolonged period in abnormal posture	Disease of joint and muscle
Jobs that involve standing for long period (e.g. traffic police)	Varicose vein

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Marital status:

Importance:

It is important to know (that) whether the patient is married or not. Because there are many diseases which are transmitted sexually. In such case, partner notification is important.

Some sexually transmitted disease:

- Gonorrhoea
- Syphilis
- AIDS
- Non gonococcal urethritis (due to Chlamydia trachomatis), Anogenital herpes simplex, Genital warts
- Hepatitis B & C

So, in these case, partner notification is essential.

Address:

Present:

Permanent:

Importance:

- It is important to know for identification of the patient, communication to and follow up.
- Many diseases have got geographical distribution, e.g
  (a) Goitre, filariasis are common in Northern Bengal (Rangpur etc.)
  (b) Malaria is common in Chittagong & Hill tracts area
  (c) Kala azar is endemic in mymensingh & Rajshahi
  (d) Hepatocellular carcinoma is common in Africa and South East Asia.
  (e) Systemic lupus erythematosus is more common in America and
  (f) Gastric carcinoma is common in China & Japan.

Date of admission:

Date of examination:

Importance:

Symptoms during admission may be changed at the time of examination due to emergency treatment and diagnosis may become difficult. As for example, in case of nephrotic syndrome, edema may present at the time of admission and may be absent at the time of examination. So, date of admission and examination is very important.

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CHIEF COMPLAINTS

Among the presenting complaints, these are chief complaints that compelled the patient to seek medical attention. Chief complaints should three or less in number & should not exceed five.

Questions:

- *What are your main complaints?*
- *For what problems you have come here?*
- *How long have you been suffering for each of these complaints?*

It should be recorded in-patients own words with its duration. As for example, "Breathlessness or shortness of breath for 7 days rather than dyspnoea for 7 days"

If the patient's own words consists of a diagnosis (e.g. Bronchitis, Asthma, Angina) rather than a symptom (Cough, breathlessness, chest pain etc) he must be asked to indicate how this condition affects him. The symptom, not the diagnosis are then recorded.

Cough : 3 months

Chest pain : 1 week

It should be written in chronological order of their appearance or according to their severity.

Example: Mr. Baten complains of fever, nausea, loss of appetite for 7 days. He also complains of chest pain for 5 days and coughing out of blood for 3 days. So chief complaints are (according to duration of symptoms)

1. Fever for 7 days.
2. Chest pain for 5 days
3. Coughing out of blood for 3 days.

Besides this, chief complaint can be written according to the severity of the symptoms.

1. Chest pain for 5 days
2. Cough for 3 days.
3. Fever for 7 days.

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HISTORY OF PRESENT ILLNESS

It is nothing but elaboration of chief complaints.

It includes:

1. Elaboration of chief complaints (use the formula OD PARA)
   - Onset—How did it start? When did it start?
   - Duration—How long?
   - Progression—Is it progressive or static?
   - Aggravating factors—What makes it worse?
   - Relieving factors—What makes you feel better?
   - Anything else—Do you have anything else to mention?
2. Elaboration of other complaints gathered during history taking.
3. Important negative history to exclude differential diagnosis.
4. History of appetite, bowel, bladder and sleep pattern.
5. History of weight loss.
6. History of chronic co-morbid disease like diabetes, hypertension, IHD, CKD should be mentioned.
7. Record the patient's own words, avoid using medical terms. For example, difficulty in breathing instead of dyspnoea, vomiting of blood instead of hematemesis, loss of appetite instead of anorexia.
8. Vague symptoms, such as "not feeling well", "head is hot", "stool is not clear", etc. should be precisely clarified. If a symptom is irrelevant, it may be ignored.

The patient is encouraged to tell his problem in his own words. Encourage patients either to start at the beginning or to describe the particular problem that worries them the most.

Leading question must not be asked. Allow patients to choose their own answers. Do not say, 'Did the pain move to left hand side?' This is a leading question, because it implies that it should have moved in that direction and an obliging patient will sometimes answer yes; just to please you. The patient should be asked whether the pain ever moves. When the answer is yes, the supplementary question is 'where does it go to ?' If however patients fail to understand the question, a number of possible answer may have to be proposed which can then be confirmed or rejected. Alternative question can be offered. As far example, did your pain come suddenly? It is not permitted. But, 'did your pain come suddenly or gradually' is permitted.

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Details which are not relevant can be omitted, but if there is any doubt they should be included. It may be helpful to include other parts of history if particularly relevant, such as smoking history in patients with cardiac or respiratory presentations or family history in those with disorders with a possible genetic trait such as hypercholesterolemia or diabetes mellitus.

Macleod's-295(10th)

When the patient finished history, then he should be asked, "Have you any other problem? Such as bowels, micturition? And he then be asked leading question about other systems to ensure no symptoms has been forgotten.

Chamberlain's - 3(12th)

If the patient is of poor intelligence and unable to explain himself properly, it is essential to ask direct and leading questions, guiding the conversation to obtain clear answers as possible.

A primer of medicine-44(5th)

Systemic inquiry:

System	Question
Cardiovascular	Do yon ever have chest pain or chest tightness? Do you ever wake up during the night feeling short of breath? Have you ever noticed your heart racing or thumping?
Respiratory	Are you ever short of breath? Have you had a cough? Do you ever cough anything up? Have you ever coughed up blood?
Gastrointestinal	Are you troubled by indigestion or heartburn? Have you noticed any change in your bowel habit recently? Have you ever seen any blood or slime in your stools?
Genitourinary	Do you ever have pain or difficulty in passing urine? Do you have to get up at night to pass urine? If so, how often? Have you noticed any dribbling at the end of passing urine? Have your periods been quite regular?
Musculoskeletal	Do you have any pain, stiffness or swelling in your joints? Do you have any difficulty walking or dressing?
Endocrine	Do you tend to feel the heat or cold more than you used to? Have you been feeling thirstier or drinking more than usual?
Neurological	Have you ever had any fits, faints or blackouts? Have you noticed any numbness, weakness or clumsiness in your arms or legs?

Macleod's 13(13th)

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Analysis of a Common Symptom, Pain

Characteristics of pain (SOCRATES)

Site:

- Somatic pain often well localized, e.g. sprained ankle
- Visceral pain more diffuse, e.g. angina pectoris

Onset

- Speed of onset and any associated circumstances

Character:

- Described by adjectives, e.g. sharp/dull, burning/tingling, boring/stabbing, crushing/tugging, preferably using the patient's own description rather than the offering suggestions

Radiation:

- Local extension
- Referred by shared neuronal pathway to a distant unaffected site e.g. diaphragmatic pain at the shoulder tip via phrenic nerve (C_3, C_4)

Associated symptoms:

- Visual aura accompanying migraine with aura
- Numbness in the leg with back pain suggests nerve root irritation.

Timing (duration, course, pattern):

- Since onset
- Episodic or continuous

  If episodic, duration and frequency of attacks

  If continuous, any change in severity

Exacerbating and releiving factors:

- Circumstances in which pain is provoked or exacerbated, e.g. food.

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- Specific activities or postures, and any avoidance measures that have been taken to prevent onset
- Effects of specific activities or postures, including effects of medication and alternative medical approaches

Severity:

- Difficult to assess, as so subjective
- Sometimes helpful to compare with other common pains, e.g. toothache
- Variation by day or night, during the week or month, e.g. relating to menstrual cycle

Macleod's-12(13th)

Presentation of the history of present illness (presentation in present tense or in past tense.)

According to statement of the patient, he was reasonably well 10 days back. Suddenly he developed fever which is continued, high grade in nature, comes with chills and rigor and subsides by taking paracetamol with sweating. Highest recorded temperature is 104◦F. There is no history of traveling to kala azar or malaria endemic zone. He also complains of cough which was initially dry but for the last 7 days, it is productive, yellowish in colour but not foul smelling and not mixed with blood. There is no diurnal variation and no variation with change of posture. He also complains of left sided chest pain, which is sharp, stabbing in nature, aggravates by coughing and deep inspiration and relieves after taking pain killer. There is no radiation of pain. For the last 5 days, he also complains of malaise, generalized bodyache and weakness. There is no history of breathlessness and contact with TB patient. His bowel and bladder habit is normal. There is no history of significant weight loss. He is normotensive and non diabetic. With all of above complaints, he is admitted in this hospital for better management.

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HISTORY OF PAST ILLNESS

It is very important for diagnosis of disease. The previous history should include all important illness, operation and injuries from infancy. If the patient's words consist of diagnosis, it is wise to ask a few questions about the nature of illness to check whether the diagnosis seems likely.

Hutchison's - 8(21st)

Patients often forget transient minor illness, which may have a significant relationship to their presenting problems.

Example:

- Minor dental procedure → May develop sub acute bacterial endocarditis.
- Episode of diplopia → May develop paraplegia due to multiple sclerosis.

Chamberlain's-2(12th)

History of the past illness includes:

- Previous diseases with its details (duration, treatment taken, whether hospitalized).
- History of any operation, injury, trauma and procedure (catheterization, endoscopy, colonoscopy, biopsy).
- History of any investigation
- Ask about diabetes mellitus, hypertension or other chronic illness.
- Incase of CLD, enquire about past history of jaundice or if the patient has cardiac problem, enquire about history of rheumatic fever, hypertension or dyslipidemia.

Question:

- *Have you any serious illness that brought you to see your doctor?*
- *Have you had to take time off work because of ill health?*
- *Have you had any operation?*
- *Have you attended any hospital clinics?*
- *Have you ever been in hospital? If so, why was that?*

Macleod's-13(13th)

It is useful to include important negatives, for example in a patient presenting with chest pain, it is useful to know of any previous myocardial infarction or angina or other risk factors for cardiovascular disease such as hypertension or diabetes mellitus, is present or not.

Macleod's -259(10th)

Presentation of past history: Mr. Baten was suffered from fever & cough 2 years back. For that problem, he was admitted at DMCH and was treated with inj. ceftriaxone 1gm 12 hourly for 7 days.

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Importance:

Importance of past history in cardiovascular disease:

Past history	Presenting disease
Streptococcal pharyngitis	After 2-3 weeks, patient may develop rheumatic fever
Rheumatic fever	After 10-12 year or earlier, it may develop valvular heart disease
Potential cause of bacteremia e.g. skin infection, recent dental work, intra venous drug use or penetrating trauma	May develop infective endocarditis
Connective tissue disease e.g. rheumatoid arthritis	Raynaud's phenomenon and pericarditis
Chronic lung disease	Right sided heart failure (cor pulmonale)
Renal failure or cancer	Pericardial effusion
Radiotherapy	Radiation arteritis

Macleod's 105(13th)

Importance of past history in respiratory disease:

Past History	Present condition
Eczema, hay fever	Allergic tendency relevant to asthma
Whooping cough, measles	Recognized cause of bronchiectasis
Pneumonia, pleurisy	Recognized cause of bronchiectasis
Tuberculosis	Reactivation, relapsed, fibrosis, cor pulmonale, bronchiectasis
Connective tissue disorders, e.g. rheumatoid arthritis	Pulmonary fibrosis, effusion, bronchiectasis
Previous malignancy	Recurrence, metastatic/pleural disease, chemotherapeutic agent causes pulmonary fibrosis, radiotherapy induced pulmonary fibrosis
Recent travel, immobility, cancer	Pulmonary thrombo embolism
Recent surgery, loss of consciousness	Aspiration of foreign body, gastric contents, pneumonia, lung abscess

Macleod's 145(13th)

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Importance of past history in renal disease:

Past History	Present condition
Hypertension	Which may cause or result from renal disease
Diabetes mellitus	Associated with diabetic nephropathy and renovascular disease
Pulmonary tuberculosis or bone tuberculosis even in childhood →	May give rise to tuberculous affection of kidney (even 20 years later) *S.Das-410(5th)*
Vascular disease at other sites	Which makes renovascular disease more likely.
Past history of urinary tract stones or surgery	Which may cause renal disease
Recurrent UTI	May be associated with renal scarring
Upper respiratory tract infection	May be associated with glumerulonephritis and or vasculitis
Anaemia	Which may be due to CKD.

Macleod's 202(13th)

Impotance of past history in gastro intestinal disease:

Presenting disease	Past history
Perforation of peptic ulcer or Gastric outlet obstruction.	History of recurrent epigastric pain, even there may be history of haematemesis and/or melaena. *Davidson-787(19th)*
Appendicitis, biliary colic and renal colic	History of previous attack *s.Das-338(5th)*
Peptic ulcer	H/O recurrent abdominal pain. *Davidson-872(22nd)*
Acute pancreatitis	May be associated with gall stone and post ERCP status. *Davidson-890(22nd)*
Primary biliary cirrhosis and auto immune hepatitis	Are associated with thyroid disease. *Macleod's-178(13th)*
Non alcoholic fatty liver disease (NAFLD)	Are associated with diabetes and obesity. *Macleod's-178 (13th)*
Bleeding peptic ulcer or Inflammatory bowel disease	H/O similar problem *Macleod's-178(13th)*

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Importance of past history in musculoskeletal disease:

Present history	Past history
Reactive arthritis (reiter's disease)	Bacterial dysentery with salmonella, shigella or sexually acquired infection with chlamydia. *Davidson-1110(22nd)*
Psoriatic arthritis	Most patient have pre existing psoriasis (70% of cases). *Davidson-1108(22nd)*
Systemic lupus erythematosus	Past history of spontaneous abortion.
Osteomyelitis	A past history of pneumonia, otitis media, typhoid fever or multiple boils. *S.Das110(5th)*

Importance of past history in neurological disease:

Present condition	Past history
Guillain-Barre Syndrome	History of respiratory or gastro intestinal tract infection (1-3 weeks before). *Harrison-3474 (18th)*
Transverse myelitis	Transverse myelitis usually follows viral illness or vaccination.
Tubercular meningitis	Tubercular meningitis most commonly occurs shortly after a primary infection in childhood or as part of miliary tuberculosis. *Davidson-1204(22nd)*
Herpes zoster (shingles)	Herpes zoster is the result of reactivation of varicella zoster virus that has lain dormant in a nerve root ganglion following chicken pox earlier in life. Reactivation may be spontaneous (as usually occurs in the middle aged or elderly) or due to immunosuppression (as in patients with diabetes, malignant disease or AIDS). *Davidson-1207(22nd)*

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DRUG HISTORY/TREATMENT HISTORY

Ask about prescribed drugs and other medications, including over the counter remedies, herbal and homeopathic remedies, laxatives, analgesics and vitamin/mineral supplements. Note the name of each drugs, dose, dosage regimen and duration of treatment, along with any significant adverse effects. Clarify if necessary with the general practitioner (GP). *Macleod's-13(13th)*

It includes any diagnostic procedures like lymph node biopsy, CSF study etc.

It also includes any intervention like blood transfusion, ascitic and pleural fluid paracentesis etc.

Drug and treatment history includes:

- Details of drugs (previous and present)
- History of drug allergy, drug intolerance or reaction
- Treatment already received for present illness.
- History of any transfusion (blood, plasma, blood product, normal saline or other fluid) received.
- The drug history should include the alternative medicine and herbal remedies. These may contain ingredients with cardiovascular action.

Example of a drug history:

Drug	Dose	Duration	Indication	Side effects
Aspirin	75 mg daily	5 years	Started after AMI	Indigestion
Atenolol	50 mg daily	5 years	Started after AMI	Causes cold hands

Importance:

- History of taking red tablets (NSAID e.g. clofenac) in case of severe abdominal pain possibly due to perforation of stomach.
- An unconscious patient with history of anti hypertensive drugs possibly the case of stroke.
- Recreational drugs such as cocaine and amphetamine can cause arrhythmias, chest pain and even myocardial infraction.

Macleod's 114 (12th edition)

The drug history may also reveal / detect the presence of important chronic disease, the patient may have forgotten to mention.

- Antihypertensive indicates patient is hypertensive
- Hypoglycemic drugs indicates patient is diabetic *Macleod's-72(10th)*

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Presentation of treatment history:

For the presenting complaints, he consulted with a registered doctor and took tablet Levofloxacin 500 mg once daily, Tab. Paracetamol 500 mg three times daily and Cap. Omeprazole (20mg) 2 times daily but he had no significant improvement.

Cardiovascular symptoms related to medication:

Symptoms	Medication
Dyspnoea	• Beta-blocker in patients with asthma • Exacerbation of heart failure by beta-blocker, some calcium channel antagonist (verapamil, diltiazem), NSAID
Dizzinness	• Vasodilator e.g. nitrates, alpha-blocker, ACE inhibitor, ARB
Angina	• Aggravated by thyroxine or drug induced anaemia e.g. aspirin or NSAID
Oedema	• Steroids, NSAID, some calcium channel antagonist e.g. nifedipine, amlodipine
Palpitation	• Tachycardia and /or arrhythmia from thyroxine,β-2 stimulant e.g. salbutamol, digoxin toxicity, hypokalemia from diuretics, tricyclic antidepressants

Macleod's 104(13th)

Respiratory symptoms related to medication:

Respiratory condition	Drug
Bronchoconstriction	Beta-blockers, opoids, NSAIDs
Cough	ACE inhibitor
Bronchiolitis obliterans	Penicillamine
Diffuse parenchymal lung disease (DPLD)	**Cytotoxic agents** : Methotraxate, bleomycin **Anti-inflammatory agents**: sulfasalazine, Penicillamine, gold salts, aspirin **Cardiovascular drugs:** amiodarone, hydralazine **Antibiotics**:nitrofurantoin **Intra venous drug misuse** **Radiation**
Pulmonary thromboembolism	Oestrogens
Pulmonary HTN	Oesrogens, Dexfenfluramine, Fenfluramine
Pleural effusion	Amiodarone, nitrofurantoin, phenytoin, methotraxate
Respiratory depression	Opioids, benzodiazepines

Macleod's-146 (13th)

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Example of drug induced gastrointestinal conditions:

Symptoms	Drugs
Weight gain	Oral corticosteroids
Dyspepsia and gastrointestinal bleeding	Aspirin, NSAIDs
Diarrhoea	Antibiotics, proton pump inhibitors, cytotoxic drugs
Constipation	Opioids
Jaundice:hepatitis	Paracetamol (overdose), pyrazinamide, rifampicin, isoniazid
Jaundice:cholestatic	Flucloxacillin, Chlorpromazine, Co-amoxiclav
Liver fibrosis	Methotraxate

Macleod's 177(13th)

- NSAIDs may cause
  - i. Acute gastritis
  - ii. Peptic ulcer
  - iii. Perforation

Example of drug induced renal disorders:

The kidney is susceptible to damage by drugs because it is the route of excretion of many water soluble compounds including drugs and their metabolites.

Toxic renal damage may occur by a variety of mechanisms. Very commonly, drugs contribute to the development of acute tubular necrosis. **Numerically reaction to NSAIDs & ACE inhibitors are the most common.**

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Mechanisms	Drug or toxin	comments
Haemodynamic	NSAIDs	Reduced renal blood flow due to inhibition of prostaglandin synthesis
	ACE inhibitors	Reduced efferent glomerular arteriolar tone.
	Radiographic contrast media	Multifocal aetiology may include intense vasoconstriction.
Acute tubular necrosis	Aminoglycosides, amphotericin, paracetamol overdose, radiographic contrast media	
Glomerulonephritis (immune mediated)	Penicillamine, Gold	Membranous nephropathy
	NSAIDs	Minimal change nephropathy
Interstitial nephritis	NSAIDs, penicillins, proton pump inhibitors, lithium, ciclosporins, tacrolimus	
Tubular obstruction	Acyclovir, chemotherapy	

Davidson-522(22nd)

Some drugs that require extra caution in patients with renal disease:
Pharmacodynamic effects enhanced:

- ACE inhibitors and ARB (renal impairment and hyperkalemia)
- Metformin (lactic acidosis)
- Spironolactone (hyperkalemia)
- NSAIDs (impaired renal function)
- Sulphonylureas (hypoglycemia)
- Insulin (hypoglycemia)

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Pharmacokinetic handling altered (reduced clearance):

- Aminoglycosides (e.g. gentamicin), vancomycin, ciprofloxacin, cephalosporins, digoxin, lithium, atenolol, allopurinol,
- Methotraxates, Opoids (e.g. morphine)

Davidson-36(22nd)

Musculoskeletal symptoms due to drugs:

Drugs	Possible adverse musculoskeletal effect:
Steroid	Osteoporosis, myopathy, osteonecrosis, infection
Statins	Myalgia, myopathy, Myositis
ACE inhibitors	Myalgia, Arthralgia, positive antinuclear antibody
Antiepileptics	Osteomalacia, Arthralgia
Immunosuppressants	Infections
Quinolones	Tendinopathy, tendon rupture

Macleod's 322(13th)

Neurological symptoms/syndromes due to drugs:

Ataxia:

Phenytoin
Carbamazepine
Lithium

Epileptic seizures

Tricyclic antidepressants
Phenothiazines
Clozapine

Headaches

Glyceryl trinitrate
Dipyridamole
Nifedipine
Sildenafil

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Myopathy

Statins
Corticosteroids

Parkinsonism

Neuroleptics
Prochlorperazine,
Metoclopramide

Peripheral neuropathy

Amiodarone
Antibiotic (dapsone, isoniazide, metronidazole, ethambutol)
Antiretrovirals (stavudine, dideocytapine)
Chemotherapy (vincristine, cisplatine, thalidomide)

Tremor:

Beta agonist e.g. salbutamol, terbutaline
Lithium
Sodium valproate

Macleod's -245(13th) and Davidson-1223(22nd)

FAMILY HISTORY

It is important to know the family history. Because many diseases run in family.

Family history includes:

- Number of family members (parents, spouse, children, etc.)
- Their state of health. Ask- "Are they in good health?" "Do they have any illness?" (e.g. ask about history of tuberculosis, hypertension, diabetes mellitus, dyslipidemia, ischemic heart disease, thyroid disorder, bronchial asthma, etc.)
- If death among family members, enquire the cause of death.
- Ask about hereditary conditions (e.g. thalassemia), inquire regarding marriage among relatives (consanguinity).
- If X-linked disease is suspected, ask specifically about the health of maternal uncles.

Question

- *Are you married?*
- *Is your husband /wife well?*

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- *Do you have children ?(record age and sex)*
- *Have you lost any children? (record age and cause of death)*
- *Do you have brothers or sisters? (record age and sex)*
- *Have they ever been seriously ill? (record details)*
- *Have you lost any brothers or sisters? (record age and cause of death)*
- *Are both your parents living? (if not, record age and cause of death)*
- *Have they ever been seriously ill? (record details)*
- Do *you know of anyone in the family with symptom like yours,*
- Do *you know of any disease affecting more than one member of your family?*

Chamberlain's - 3(12th)

Presentation of family history:

He has parents, one brother and one sister in his family. They are alive and healthy. None of them are suffering from similar type of illness.

Example of single gene inherited disease:

Autosomal dominant:

Adult polycystic kidney disease
Huntington's disease
Myotonic dystrophy
Neurofibromatosis

Autosomal recessive:

Cystic fibrosis
Sicle cell anaemia
Thalassaemia
Alpha-1antitrypsin deficiency

X-linked

Duchenne muscular dystrophy
Haemophilia
Fragile X syndrome

Macleod's-14(13th)

Diseases run in family due to polygenic inheritance:

- Ischemic heart disease
- Diabetes mellitus
- Hypertension
- Bronchial asthma
- Inflammatory bowel disease
- Rheumatoid arthritis

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- Systemic lupus erythematosus (SLE)
- Stroke
- Epilepsy
- Gout

Genetically influenced cardiovascular disorders

Single gene defect	Polygenic inheritance:
Familial hypercholesterolemia Hypertrophic cardiomyopathy Dilated cardiomyopathy (25% of cases) Arrhythmogenic right ventricular cardiomyopathy Marfan's syndrome Muscular dystrophy Long Q-T syndrome	Ischemic heart disease Hypertension Type 2 diabetes mellitus Hyperlipidaemia Abdominal aortic aneurysm

Macleod's-106(13th)

Genetically influenced respiratory disorder:

- Some autosomal recessive disorders:
  - Cystic fibrosis
  - α-1 anti trypsin deficiency (associated with emphysema and COPD)
- Asthma often run in family.
- A family history of tuberculosis can represent significant past exposure that may reactivate later in life.

Macleod's-145(13th)

Genetically influenced gastro intestinal disorder:

- Some GIT disease often runs in family.
  - Inflammatory bowel disease
  - Colorectal cancer
  - Peptic ulcer disease (environmental factors also contribute)
  - Gilbert's syndrome (autosomal dominant)
  - Haemochromatosis (autosomal recessive)
  - Wilson's disease (autosomal recessive)
- Auto immune diseases particularly thyroid disease are common in relatives of those with primary biliary cirrhosis and auto immune hepatitis.
- A family history of diabetes is frequently seen in the context of NAFLD.

Macleod's-178(13th)

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Genetically influenced renal disorder:

Inherited kidney diseases are:

- Adult Polycystic Kidney which may be associated with sub arachnoid haemorrhage from intra cerebral berry aneurysm
- Alport's syndrome which may be associated with sensori neural deafness.

Macleod's 202 (13th)

Genetically influenced neurological disorder:

Many neurological disorders caused by single gene defects. Others have an polygenic influence. Neurological disease may also be caused by mitochondrial DNA abnormalities.

Autosomal dominant:

Myotonic dystrophy
Neurofibromatosis types I and II.
Tuberous sclerosis
Huntington's disease
Charcot-Marie-tooth 1a
Spinocerebellar ataxia
Fascioscapulohumeral muscular dystrophy

Autosomal recessive:

Wilson's disease
Friedreich's ataxia

X-linked recessive:

Duchenne and Becker muscular dystrophy
Fragile X syndrome

Polygenic influence:

Multiple sclerosis *Macleod's -245(13th)*
Alzheimer's disease *Davidson-251(22nd)*

Importance of family history in musculoskeletal disorder:

- Rheumatoid arthritis *Davidson-1096(22nd)*
- Sero negative arthritis *Davidson-1104(22nd)*
- Gout *Davidson-1087(22nd)*
- Psoriasis
- SLE *Davidson-1110(22nd)*
- Osteoarthritis *Davidson-1081(22nd)*

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OCCUPATIONAL HISTORY

Take a full occupational history from all patients.

Work profoundly influences health, while unemployment is associated with increased morbidity and mortality. Some occupation are associated with particular illness.

- Tell me about all the jobs you have done in your working life.
- Clarify what the patient does at work, in particular any chemical or dust exposure.
- Symptoms that improve over the weekend or during holidays suggest an occupational disorder. *Macleod's-13(13th)*

Question:

- *What exactly do you do?*

  Record hours, physical activity, potential hazards/any problem, traveling.
- *How long have you done this job?*
- *What job have you done before, starting when you left school ?*

  Record hours, physical activity, potential hazards or any problem traveling.
- *Is the job dusty, and if so what tools makes the dust?*
- *Are there fumes or vapors, and if so, what are the chemical substance involved ?*
- Was *any similar illness affected a fellow employee?*
- *Ask about unemployment, duration and reason ?*
- *Is protective clothing provided ?*
- *Is a special suit and goggles required and why?*

Importance:

Many problems such as asbestos exposure or silicosis produce effects many years later after exposure. *Hutchison's - 8(21st)*

Most of the toxic substance enters body by inhalation, also some solvents penetrate the skin.

Presentation of occupational history:

He is a worker in a garments factory. He goes to factory at 8:00 AM and returns home at 5:00 PM. He used to weave shirt. There is no history of similar illness in other employee.

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Lung diseases related to occupational exposure:

Lung disease	Exposure	Occupation
Pulmonary fibrosis	Asbestos	Shipyard/construction worker, plumbers, boilermakers
	Quartz (silica)	Stone cutter, stone masons, quarry workers
	Coal	Coal miners
	Beryllium	Nuclear, aerospace industries
COPD	Coal	Coal miners
Malignancy	Asbestos	Shipyard/construction worker, plumbers, boiler makers
	Radon	Metal miners
Asthma	Jute mill dust	Jute mill
	Grains, flour	Farmers, bakers, miller
	Hardwood dusts	Joiners, carpenters
	Colophony	Soldering, welders
	Fomaldehyde, paraldehyde, latex	Hospital worker
Hypersensitivity pneumonitis	Fungal spores of thermophilic actinomycetes or micropolyspora faeni	Farm workers exposed to mouldy hay

Macleod's -146(13th)

Occupational exposure associated with cardiovascular disease:

- Organic solvents (hydrocarbon) : →Arrhythmia, Cardiomyopathy
- Vibrating machine tools : →Raynaud's phenomenon
- Publicans : →Alcoholic cardiomyopathy

Occupational exposure exacerbating preexisting cardiovascular condition

- Cold exposure : → Angina, Raynaud's disease
- Deep sea diving : → Embolism through foramen ovale

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Occupational requirements for high standards of cardiovascular fitness:

- Pilot
- Public transport/heavy good vehicle drivers
- Armed forces
- Police

Macleod's 106(13th)

Occupational exposure associated with renal diseases:

Occupation/ Exposure	Disease
Living or working in hot condition with more concentrated urine	Predispose to renal stone formation
Exposure to organic solvents	May cause glomerulonephritis
Working in aniline dye and rubber industries	Increased incidence of urothelial cancer
Long term exposure to lead and cadmium	May cause renal damage

Macleod's 203 (13th)

Importance of occupational history of musculoskletal disease:

- Working for long hours in un physiological postures causes disease of joint and muscles. *Park's-536(6th)*
- Exposure to vibration may produce injury to the joints of hands, elbow and shoulders. *Park's-537(6th)*

Importance of occupational history in neurological disease:

Occupational factors are relevant to several neurological disorders.

- Lead causes motor neuropathy.
- Manganese causes parkinsonian syndrome. *Macleod's -245(13th)*
- Agricultural pesticides causes neurotoxicity. *Robins -434(7th)*

PERSONAL HISTORY

Personal history includes:

- Occupation (exact nature of work)
- Marital status
- Dietary habit
- Hobby, pet keeping (cows, dog, rabbit, pigeon, etc.), interest, games, any source of entertainment
- Tea or coffee, betel nut

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- Smoking (with number of sticks daily with duration) or tobacco chewing — ask technically specially in females who feel shy. If the patient is an ex-smoker, ask when he has stopped smoking and the number of sticks with duration that he used to smoke. Also, enquire any possibility of passive smoking
- Alcohol (how much and how long, daily, weekly, occasional, place of drinking?—home, outside, alone or socially).
- History of drug abuse including alcohol, intravenous drug use, sharing of needles. Enquire about drug dependency, any social or physical problem arising from drug use. Be careful regarding the confidentiality of the information.
- Sexual exposure or sexual practice including homosexuality, polygamy etc. (ask strategically without embarrassing the patient).

Questions:

In brief:

- *Do you or did you smoke? (record duration, form, number of cigarette/ Biri / Cigars / Pipe per day)*
- *Do you or did you take alcohol ? (Record type and amount)*
- *Do you or did you take drugs of any kind? (Record type and amount)*
- *Do you or did your take caffeine or betel, gool, (record amount) and in case of betel leaf with or without raw-tobacco (zarda).*
- *Have you traveled recently? (Record where & why)*
- *What do you do in your spare time ? (Hobbies, sports)*

In details:

Patient tend to deny or minimize their substance use. So, it is important to seek colateral information from a relative or their general practitioner.

Smoking:

Ask if your patient ever smoked; if so, find out for how long, what form,

Questions:

- *Ask if your patient has ever smoked; determine whether the patient is a smoker, ex-smoker or a life long non-smoker.*
- *If the patient smokes, the following information is required,*
  - *i. What form (Cigarettes, Biri, cigars or pipe)*
  - *ii. How much (Number of cigarettes per day)*
  - *iii. How long duration.*

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- *For smokers, use pack year to estimate the risk of tobacco related health problems.* Most patients with COPD have tobacco consumption 20 pack years.
- *If ex-smoker, the length of time since the patient ceased should be noted.*

Macleod's 11(10th)

- *For non smokers, don't forget to ask about their exposure to environmental tobacco smoke (passive smoking).*

Calculating pack years of smoking:

20 cigarette = 1 packet

$$\text{Pack year} = \frac{\text{Number of cigarettes smoked per day} \times \text{Number of years smoking}}{20}$$

For example, a smoker of 10 cigarettes per day who has smoked for 15 years would have smoked:

$$\frac{10 \times 15}{20} = 7.5 \text{ pack years}$$

Importance:

Tobacco related diseases are given below:

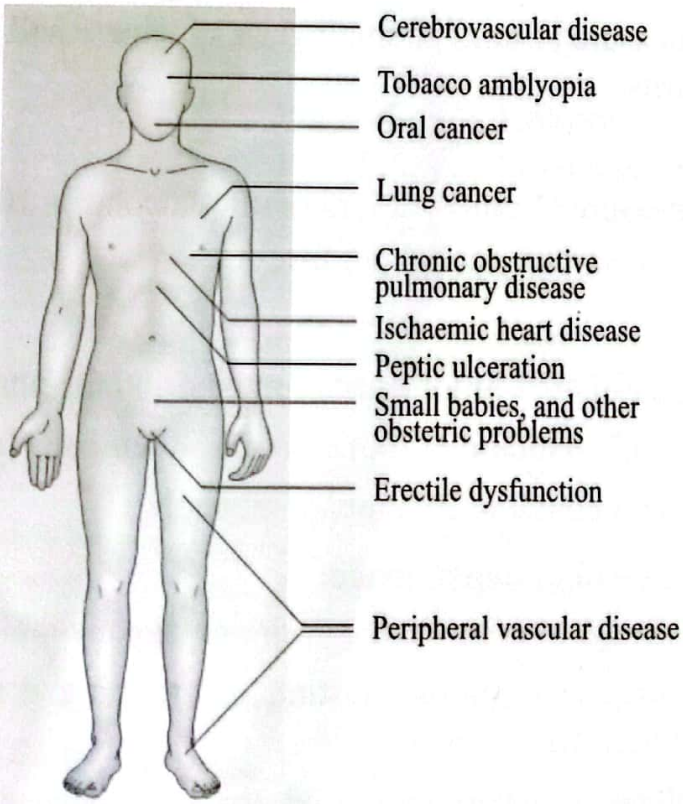

Fig: Tobacco related diseases *Macleod's 17(13th)*

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Alcohol:

Try asking: do you ever drink any alcohol? Use open question, giving permission for patients to tell you, and do not judge them. If yes, then ask;

Question:

- *Quantity and type of drink*
- *Daily or weekly patterns (especially binge drinking or morning drinking)*
- *Usual place of drinking*
- *Alone or accompanied*
- *Purpose*
- *Amount of money spent on alcohol*
- *Attitudes to alcohol*
- *Has he developed alcohol dependence syndrome?*

Alcohol problems:

One unit of alcohol contains 8 gm of ethanol. 14 unit/weak in woman and 21 unit/week in men is generally considered safe.

Davidson 957(22nd)

Calculating units of alcohol

Method 1

Standard measure (1 unit)=1 small glass of wine/1 half pint of beer/1 sorts of spirits

Method 2:

Standard measure (1 unit) = 25 ml of 40% alcohol = 10 ml ethanol

X% proof = x unit of alcohol per litre

Example:

- 1 liter of 40% proof spirits contains 400 ml ethanol or 40 units
- 750 ml (standard bottle) contains 30 unit alcohol
- 500 ml contains 20 units of alcohol

Features of alcohol dependence:

- A strong, over powering desire to take alcohol
- Inability to control starting or stopping drinking and the amount that is drunk
- Tolerance, where increased doses are needed to achieve the effects originally produced by lower doses.

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- Withdrawal state when drinking is stopped or reduced, including tremor, sweating, rapid heart rate, anxiety, insomnia and occasionally seizures, disorientation or hallucination (delirium tremens). It is relieved by more alcohol.
- Neglect of other pleasures and interests
- Continuing drink in spite of being aware of the harmful consequences.
- Binge drinking, involving a large amount of alcohol causing acute intoxication, is more likely to cause problems than if the same amount of alcohol is consumed over 4 to 5 days. Everyone should have at least 2 alcohol free days per week.
- Harmful drinking results in physiological or mental health damage or disruption to social circumstances.
- Alcohol dependence is when alcohol use takes a higher priority over other behaviors that previously had greater value.

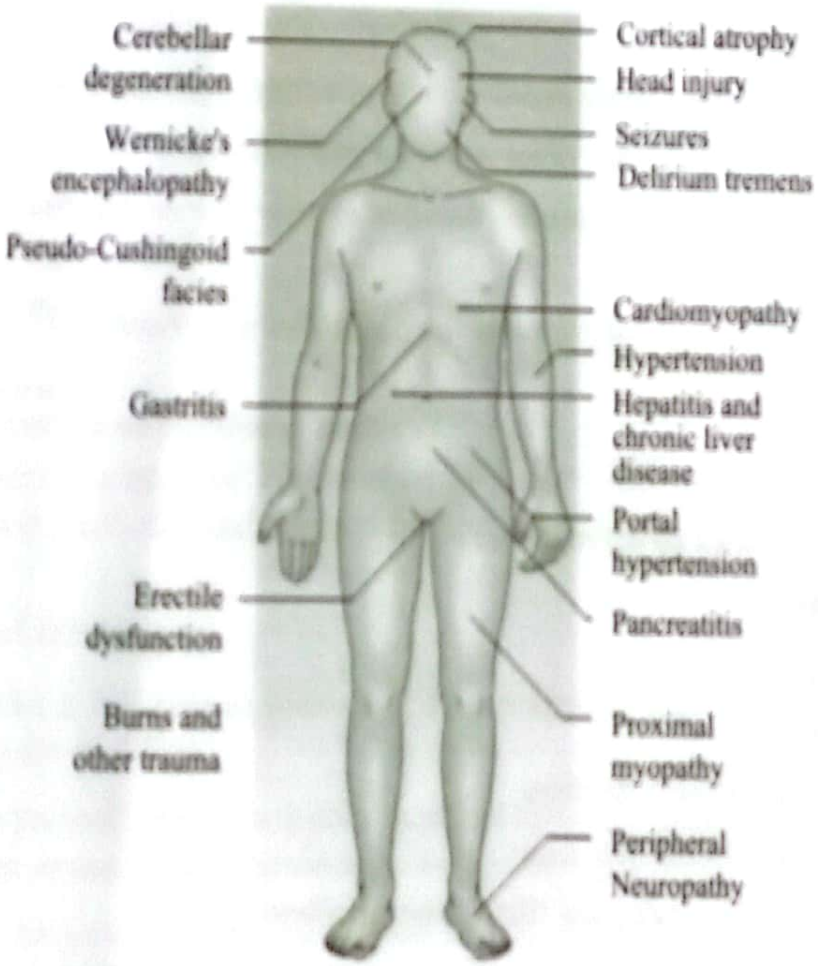

Fig: *Alcohol related diseases*

Macleod's 18(13th)

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Non prescribed drug use:

Ask all patients who may be using drugs about their use of non prescribed drugs. In many situations, questioning is unnecessary and could damage the patient doctor relationship. If there is any doubt, it is advisable to approach the patient with tact and firmness.

Questions:

- *What drugs are you taking?*
- *How often and how much?*
- *How long have you been taking drugs?*
- *Any periods of abstinence? If so, when and why did you start using drugs again?*
- *What symptoms do you have if you cannot get drugs?*
- *Do you ever inject? If so, where do you get the needles and syringes?*
- *Do you ever share needles, syringes or other drug paraphernalia?*
- *Do you see your drug use as a problem?*
- *Do you want to make changes in your life or change the way you use drugs?*
- *Have you been checked for blood-borne viruses?*

Macleod's -I9(13th)

Importance:

Complication of drug misuse:

Infections:

- Hepatitis B & C
- HIV
- Soft tissue infection
- Necrotizing fasciitis
- Septic pulmonary thromboembolism
- Lung abscess
- Aspiration pneumonia

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- Endocarditis
- Tetanus
- Wound botulism
- Sexually transmitted disease: many work in the sex industry to finance their habit

Injury:

- Thrombophlebitis and deep vein thrombosis
- Skin ulceration
- Arterial injury and occlusion

Overdose:

- Rhabdomyolisis and renal failure
- Respiratory failure

Chaotic life style leading to:

- Poor nutrition
- Poor dental hygiene
- Failure to care for dependants
- Debt
- Crime
- Prison

Macleod's I9(13th)

Presentation of personal history:

Mr. Baten is a smoker. He smoked about 10 stick per day for 5 years. He is not alcoholic and there is no history of intra venous drug use.

Sexual history

Only take a full sexual history if this is appropriate (Only in patients with doubt of STD).

Tell the patient "As part of your medical history, I need to ask you some question about your relationship. Is this all right?"

- In your lifetime have your sexual partners been male, female or both?
- Do you have regular sexual partner at present ?

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- If yes:
  - How long have you been together?
  - When did you last have sex with anyone else?
- If no:
  - When did you last have sex?
  - Was this a regular or casual partner?
- Do / did you use a condom?
- Are you ever had a sexually transmitted infection?

Davidson-414(22nd)

Importance:

Sexually transmitted diseases:

- AIDS
- Hepatitis B & Hepatitis C
- Genital herpes simplex
- Human papilloma virus and anogenital warts
- Syphilis
- Gonorrhoea
- Chlamydial infection
- Lymphogranuloma venereum, chancroid and granuloma inguinale

Davidson – 413-426(22nd).

TRAVEL HISTORY

Returning travelers commonly present with illness. They risk unusual or tropical infections, and air travel itself increases certain condition, e.g. middle ear problems or deep vein thrombosis.

- List the countries visited and the dates they were there.
- Enquire about the type of accommodation used and the activities under taken, including sexual contacts.
- Note any travel vaccination or malarial prophylaxis taken.

Macleod's-16(13th)

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Incubation periods of travel-related infections:

Disease	Incubation period	Travel to presentation	Usual symptoms
Falciparum malaria	8-25 days	Up to 6 weeks	Fever
Vivax malaria	8-27 days	Up to 1 year	Fever
Typhoid fever	10-14 days	Up to 3 weeks	Fever, headache
Dengue fever	3-15 days	Up to 3 weeks	Fever, headache
Hepatitis A	28-42 days	Up to 6 weeks	Jaundice
HIV infection	12-26 weeks	Up to 12 years(?)	Weight loss, pneumonia

Macleod's-16(13th)

SOCIO ECONOMIC HISTORY

Question:

- *Ask about monthly income*
- *Ask about house*
  - → *Type of house*
  - → *Owned or rented*
  - → *Size (Rooms)*
  - → *Toilet facilities*
  - → *Problems with the house*
  - → *Water supply*
- *Who is living in the same house ?*
- *Have any been ill recently?*
- *Do you keep animals at home?*

Chamberlain's 3 (12th)

In short:

1. Social position of the patient (upper, middle or lower class)
2. Drinks tube well water or not.
3. Use sanitary latrine or not.

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Presentation of socio economic history:

He belongs to a middle class family, drinks tube well water and uses sanitary latrine.

Importance:

- More in high social status: Acute appendicitis
- More in low social status: Tuberculosis

DIETARY HISTORY

Question:

- *Are your meal times regular or irregular?*
- *What is your main meal?*

Importance:

- High fat intake (e.g. dietary fat representing 40% and containing high proportion of saturated fats) is a major risk factor for coronary heart disease.

  Park's 408(16th)

- Diet deficient in fresh fruit vegetables, polyunsaturated fatty acid, Vit-C and Vitamin-E are associated with high risk of coronary artery disease.

  Davidson – 581(22nd)

- Majority of patients with peptic ulcer have irregular dietary habit, whereas patients with appendicitis or gallbladder disease may maintain regular dietary habit.

  S.das360(5th)

IMMUNIZATION HISTORY

This includes name of the vaccine he/she has taken, commonly ask about EPI schedule & hepatitis B vaccine.

Presentation of immunization history:

The patient is immunized according to EPI schedule. He also took Hepatitis B vaccine.

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SPECIAL NOTE ABOUT HISTORY

In female patient, always remember to ask 3 P

- Period (menstrual history, such as amenorrhoea, polymenorrhoea, menorrhagia)
- Pill (oral contraceptive pill or other contraceptive method) ,
- Pregnancy (obstetric history, e.g. number of child, age of last child, postpartum hemorrhage, abortion or repeated abortion).

To remember the format of history, use the formula:

3P MAFTOSA

- Present history
- Past history
- Personal history
- Medication (Drug)
- Allergy
- Family history
- Traveling history
- Occupation
- Social history
- Anything else (Psychiatric history, extra history in female patient, immunization history, etc.

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EXAMPLE OF A HISTORY

Chief complaints:

1. Fever for 10 days
2. Cough for 7 days
3. Chest pain for 7 days

History of present illness:

According to statement of the patient, he was reasonably well 10 days back. Suddenly he developed fever, which is continued & high grade in nature. Fever comes with chills and rigor and subsides by taking paracetamol with sweating. Highest recorded temperature is 104◦F. There is no history of traveling to kala azar or malaria endemic zone. He also complains of cough which was initially dry but for the last 7 days, it is productive, yellowish in colour but not foul smelling and not mixed with blood. There is no diurnal variation and no variation with postural change. He also complains of left sided chest pain, which is sharp, stabbing in nature, aggravates by coughing and deep inspiration and relieves after taking analgesic drugs.There is no radiation of pain. For the last 5 days, he also complains of malaise, generalized body ache and weakness. There is no history of breathlessness and contact with TB patient. His bowel and bladder habit is normal. There is no history of significant weight loss. He is normotensive and non diabetic. With all of above complaints, he is admitted in this hospital for better management.

Presentation of past history:

Mr. Baten was suffered from fever & cough 2 years back. For that problem, he was admitted at DMCH and was treated with inj. ceftriaxone 1gm 12 hourly for 7 days.

Drug history:

For the presenting complaints, he consulted with a registered doctor and took tablet Levofloxacin 500 mg once daily, Tab. Paracetamol 500 mg three times daily and Cap. Omeprazole (20mg) 2 times daily but he had no significant improvement.

Family history:

He is unmarried. His parents are alive and healthy. He has one bother of 16 years old and one sister of ten years old. They are healthy.

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Personal history:

Mr.Baten is a businessman and smoker. He smokes about 10 sticks per day for 10 years. He is not alcoholic and there is no history of parenteral drug abuse.

Socio economic history:

He is of middle class family. He lives in a brick built house. He drinks tube well water and uses sanitary latrine.

Immunization history:

The patient is immunized according to EPI schedule. He also took Hepatitis B vaccine 2 years back.

General Examination:

Ill looking and toxic

Pulse:120/min

B.P.110/70 mm of Hg

Temperature: 104°F

Respiratory rate: 30/mon

No anaemia, jaundice, cyanosis, clubbing, koilonychia, leukonychia and edema.

No lymphadenopathy or thyromegaly.

Rest of the general examination reveals normal.

Systemic Examination (Supposing in left side) :

Inspection:

- Movement restricted on the left side.

Palpation:

- Trachea: Central in position
- Apex beat: In the left fifth intercostal space medial to mid clavicular line, normal in character
- Vocal fremitus : Increased over the left side from 2nd to 5th intercostal space in the mid clavicular line.

Percussion:

- Percussion note is woody dull over the above mentioned area (2nd to 5th intercostal space)
- Upper border of liver dullness is in right 5th intercostal space in midclavicular line.
- Area of cardiac dullness: normal

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Auscultation:

- Breth sound: High pitched bronchial sound over the 2nd to 5th intercostal space in the left side.
- Vocal resonance: Increased and there is whispering pectorioloquy in the same area.
- There are a few crepitation and pleural rub on the same area.
- Examinatiom of other system reveals no abnormality.

Salient features:

Mr.Baten, 30 years old, Businessman, normotensive, non diabetic, non alcoholic, smoker, hailing from Fatulla, Narayongonj, presented with fever for 10 days, cough for 7 days and chest pain for 7 days. Fever is continued, high grade in nature, comes with chills and rigor and subsides by taking paracetamol with sweating. Highest recorded temperature is 104°F. There is no history of traveling to kala azar or malaria endemic zone. He also complains of cough which was initially dry but for the last 7 days, it is productive, yellowish in colour but not foul smelling and not mixed with blood. There is no diurnal variation and no variation with postural change. He also complains of left sided chest pain, which is sharp, stabbing in nature, aggravates by coughing and deep inspiration and relieves after taking pain killer.There is no radiation of pain. For the last 5 days, he also complains of malaise, generalized bodyache and weakness. There is no history of breathlessness and contact with TB patient. His bowel and bladder habit is normal. There is no history of significant weight loss. Regarding past history, he was suffered from fever & cough 2 years back. For that problem, he was admitted at DMCH and was treated with Inj. Ceftriaxone 1gm 12 hourly for 7 days. Regarding drug history, he consulted with a registered doctor and took tablet Levofloxacin 500 mg once daily, Tab. Paracetamol 500 mg three times daily and Cap. Omeprazole (20mg) 2 times daily but he had no significant improvement. None of his family member is suffering from such type of illness.

On general examination: (As above)

On systemic examination: (As above)

Provisional diagnosis: Pneumonic consolidation

Differential diagnosis:

1. Lung abscess
2. Bronchiectasis with secondary infection
3. Pleural effusion

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QUESTIONS OF ALL SYMPTOMS

CARDIOVASCULAR SYSTEM

Chest pain

(SOCRATES) *(Importance of all questions: see page No. 85)*

1. **S**ite
   Where is it?
2. **O**nset
   Did the pain begin suddenly or gradually?
3. **C**haracter
   What is it like?
4. **R**adiation
   Does it stay in one place or does it move or spread?
5. **A**ssociated symptoms
   Are there any associated symptoms ? (breathlessness, Sweating, vomiting)
6. **T**iming (duration, course, pattern)
   - Since onset
   - Episodic or continuous
     - If episodic, duration and frequency of attack
     - If continuous, any change in severity
7. **E***xacerbating and Relieving factor*
   Exacerbating factor: What brings it on? What makes it worse?
   Relieving factor: What makes it better?
8. **S**everity: Difficult to assess, as so subjective
   Does it interfere with daily activities? Does it keep the patient awake at night?

Question:Macleod's-12(13th)

Breathlessness:

(Importance of all questions: see page No. 92)

1. Ask about mode of onset (sudden/gradual)
2. When does it come on? Is it present at rest or only on exertion?

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3. Severity:
   What degree of exertion is necessary to produce it?
4. Is it related to posture, time of day or night or others?
5. Are there attacks of breathlessness at night or not? (Paroxysmal nocturnal dyspnoea)
6. Does the patient have to sleep sitting up (orthopnoea)?
7. Associated symptoms: (wheeze, cough, haemoptysis)

Harrison-11(15th) Question 1.
Hutchison's (20th) 2, 3, 5, 6
Chamberlain's-7

Palpitation:

(Importance of all questions: see page No. 96)

1. Is the palpitation continuous or intermittent?
2. Is the heart beat regular or irregular?
3. Do the symptoms occur in discrete attack? Is the onset abrupt? How do attack terminate?
4. Precipitating factor: Are there any precipitating factor (exercise, alcohol)?
5. Relieving factors: Are there any relieving factors?
6. Is there any history of structural heart disease e.g. coronary heart disease or valvular heart disease?
7. Ask about associated symptoms:

Question from Davidsion – 556(22nd)

Syncope

(Importance of all questions: see page No. 100)

1. Mode of onset (sudden/gradually)
   Did it begin over a period of seconds or developed gradually during a period of several minutes?
2. What are the preceding events of syncope?
3. What is the position at onset of attack?
4. Ask about associated symptoms: Are there any other problem?

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Oedema:

(Importance of all questions: see page No. 104)

1. Is it localized or generalized?
2. Is it unilateral or bilateral?
3. Which portion is first involved?
4. Whether it is persistent or only after standing?
5. Is it limited to the legs or is the face affected?
6. Ask about associated symptoms: (Have you any other problem?)

Question Hutchison's 2 Harrison-214(14th)

chamberlains-3, 4, 5(12th)

Fatigue:

1. Mode of onset: Did it develop suddenly or gradually?
2. Ask about associated symptoms.

QuestionTabers-1, Heart disease-2

RESPIRATORY SYSTEM

Cough

(Importance of all questions: see page No. 112)

1. How long has the cough been present?
2. Is it dry or productive?
3. Is the cough worst in a particular time of day or night?
4. Aggravating factors: Is it aggravated by anything, for example dust, pollen or cold air ?
5. Is it painful or not?
6. Has any change occurred in voice?

Hutchison's-60(20th) 1, 3, 4

Hutchison's-12(21st) 2, 5

Index of differential diagnosis-6

Breathlessness

(Importance of all questions: see page No. 92)

Scanned with CamScanner

Chest pain

(Importance of all questions: see page No. 85)

Coughing out of blood (haemoptysis)

(Importance of all questions:see page No. 115)

1. Evidence that the blood was coughed
   a. Is it preceded by coughing or vomiting?
   b. Is its colour bright red or altered ?
   c. Is blood associated with frothy sputum or gastric contents ?
2. Amount of blood: Was the sputum subsequently stained ?
3. Ask about duration and frequency
4. Ask about previous symptoms of respiratory or heart disease.

Chamberlain's - 15(12th)

Sputum

(Importance of all questions: see page No. 118)

1. How much sputum are produced?
2. Most produce at what time of day?
3. What is the consistency, colour and odour ?
4. Is it even blood stained and if so, whether with blood streaks or clots and on how many occasions?
5. Is there any relation with posture or anything?

Hutchison's – 12(21st)

Wheeze

(Importance of all questions: see page No. 121)

1. When does wheezing occur?
2. Is it persistent or intermittent?
3. Does anything provoke it?
4. Is it worse at any particular time of day or night?

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ALIMENTARY SYSTEM

Abdominal pain

(Importance of all questions: see page No. 129)

1. **Site**
   Where is it?
2. **Onset**
   Did the pain begin suddenly or gradually?
3. **Character**
   What is it like?
4. **Radiation**
   Does it stay in one place or does it move or spread ?
5. **Associated symptoms**
6. **Timing** (duration, course, pattern)
   - Since onset
   - Episodic or continuous
     - If episodic, duration and frequency of attack
     - If continuous, any change in severity
7. *Exacerbating and Relieving factor*
   Exacerbating factor: What brings it on? What makes it worse?
   Relieving factor: What makes it better?
8. **Severity**: Difficult to assess, as so subjective
   Sometimes helpful to compare with other common pains e.g. toothache
   Does it interfere with daily activities? Does it keep the patient awake at night?

Question:Macleod's-12(13th)

Vomiting

(Importance of all questions: see page No. 136)

1. General characteristics of vomited matter? Amount, colour, Taste, contents, odour.
2. *Ask about relation to meals, time of day, early morning or late evening.*

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3. *Is vomiting associated with dyspepsia or abdominal pain?*
4. *Does it relieve dyspepsia or abdominal pain?*
5. *Whether preceded by nausea or occurring without warning (nausea)?*
6. *What medication has the patient been taking?*
7. *Ask about associated symptoms (headache, tinnitus, diarrhoea).*

Question Macleod's-172(13th)

Diarrhoea

(Importance of all questions: see page No. 140)

1. Is the diarrhoea acute, chronic or intermittent?
2. Is there tenesmus, urgency or incontinence ?
3. Ask about frequency of motion.
4. Ask about character of stool.
   a. Colour of motion
   b. Are they watery, unformed or semisolid?
      Associated with blood, mucous or pus?
   c. Do they float on the lavatory pan or they difficult to flush away?
   d. Volume
4. Ask about food eaten, other persons affected
5. Is sleep disturbed by diarrhoea?
5. Is there history of
   a. Contact with diarrhoea or travel abroad
   b. Relevant sexual contact
   c. Alcohol abuse, relevant drug therapy or use of purgatives e.g. beer which is likely to produce loose motion?
   d. Gastro intestinal surgery, Gastro intestinal disease or inflammatory bowel disease
   e. Family history of gastro intestinal disorder
7. *Ask about associated symptoms, any fever or weight loss.*

Question: Macleod's-174(13th)

Scanned with CamScanner

Haematemesis

(Importance of all questions: see page No. 145)

1. Evidence that blood was vomited
   a. Is it preceded by coughing or vomiting?
   b. Is its colour bright red or altered
   c. Is blood associated with frothy sputum or gastric contents?
2. Ask about amount and character of blood; did the vomitus comprise fresh blood or coffee ground stained fluid?
3. Ask about appearance of stool
4. Is there a history of alcohol, corticosteroid, NSAIDs ingestion?
5. Was the haematemesis preceded by intense retching? (Involuntary attempt to vomit)
6. Is there previous history of dyspepsia, peptic ulceration, gastro intestinal bleeding or liver disease ?

Questions: Macleod's-174 (13th)

Jaundice (yellow colouration of skin, sclera & mucous membrane)

(Importance of all questions: see page No. 148)

1. Has the patient noticed any yellowish colouration of skin or conjunctiva?
2. What is the colour of urine and stool?
3. Ask about drug (e.g. chlorpromazine) or alcohol history
4. Ask about exposure to I/V drug or blood transfusion
5. In there any sexual or contact history?
6. Does the skin itch or presence of rigor?
7. Have there been any other causes of jaundice among family, friends or work mates?
8. Ask about travel or immunization history
9. Ask about history of skin tattooing is present or not.
10. Ask about associated symptoms (pain, gastrointestinal disturbance, rigor etc?)

Question:Macleod's-176(13th

Scanned with CamScanner

Dysphagia

(Importance of all questions : see page No. 151)

1. Is dysphagia painful or not?
2. Is difficulty initiating swallow or food sticking after swallowing?
3. Is dysphagia intermittent or progressive?
4. How long is the history of dysphagia?
5. At what level does food appears to stick?
6. Is dysphagia for solids or liquids?
7. Ask about associated symptoms.

Macleod's all, except – 2 Davidson 612(19th)- 2

Indigestion (dyspepsia): *(Importance of all questions: see page No. 156)*

1. Exact definition:
   What do you mean by indigestion? e.g.
   i. Upper abdominal discomfort
   ii. Regurgitation, heartburn, water brush
   iii. Anorexia, nausea, vomiting
   iv. Bloating, belching, flatulence
2. Relation of symptom to ingestion of food
3. Relation of symptom to specific type of food
4. Aggravating factor
5. Relieving factor
6. Ask about associated symptoms.

Chamberlain's page17Ques.1, 2, 4 Harrison page 239(14th) Q 3, 4

Heart burn

(Importance of all questions : see page No. 158)

1. Does the patient suffer from pain behind the sternum?
2. Does it come specially when lying down?
3. Is it accompanied by water brush or not?
4. Ask about associated symptoms, have you any other problem?

Hutchison's-10(20th)l, 2
Macleod's-151(10th)-3
Index of diff. diag.- 1291 (4th)

Scanned with CamScanner

Constipation

(Importance of all questions: see page No. 159)

1. What is the patients usual bowel habit?
2. Has constipation been lifelong or is it of recent onset ?
3. How much time is spent straining at stool?
4. Has the shape of stool changed?
6. Does the constipation alternate with diarrhoea?
7. Has there been any drug therapy?
4. Is there associated abdominal pain, anal pain on defecation or rectal bleeding?

Questions Macleod's-174(13th)

Fever

(Importance of all questions: see page No. 78)

1. Duration of fever:
2. Grading of fever:
3. Pattern of fever (continued/remittent/intermittent)
4. If intermittent fever then timing of the fever –Whether fever usually comes in the morning, evening or night? How long does it persist (few hours or throughout the day or night)? Is there any evening rise of temperature associated with night sweat?
5. Highest recorded temperature (for grading of temperature)
6. Whether fever comes with chills & rigor? Does it subside with sweating?
7. Is the fever punctuated by apyrexial period?(Undulant or Pel-Ebstain fever)
8. History of traveling to malaria/Kala Azar endemic zone.
9. Is the fever associated with skin rash or purpura?
10. Is there any history of sexual exposure, homosexuality, travel abroad?
11. Are you taking any drugs? (to exclude any drug fever)

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Swelling of abdomen /Ascites

1. Sudden or gradual onset -
2. Total duration
3. Whether the swelling varies in size.
4. Whether associated with abdominal pain or not
5. Whether associated with oliguria, edema
5. Menstrual cycle
6. Alimentary symptoms

Sore tongue and mouth

Ask about

1. Duration
2. Patchy (e.g. ulcer) or diffuse
3. Whether taking any medicine
4. Diet
5. Any dyspepsia?

Chamberlain's -18(12th)

Thirst

Ask about

1. Quantity of fluid intake
2. Is there polyuria
3. Duration

Chamberlain's -19(12th)

Flatulence

Ask about

1. Relation to meals
2. Whether wind belched or passed per anus
3. Is the flatus offensive ?

Chamberlain's -16(12th)

Incontinence of feces:

1. Is the symptom occasional ?
2. Is there a call to stool ?
3. Is the patient conscious on defecation ?

chamberlain's –17(12th)

Scanned with CamScanner

Nausea:

1. Whether related to food.
2. Whether accompanied by vomiting or not
3. Is the patient taking any medicine?

chamberlain's –17(12th)

Obesity:

Ask about

1. Sudden or gradual onset
2. Family history

Chamberlain's-18(12th)

Pallor:

Ask about

1. The patient's usual colour.
2. Whether of sudden or gradual appearance
3. Has there been any haemorrhage ?
4. Any symptom of anaemia

Chamberlain's-16(12th)

URINARY SYSTEM

Haematuria:

(Importance of all questions: see page No. 166)

1. Ask about amount, colour of urine (Bright red, Smoky)
2. Relation to micturition (Initial / total / terminal)
3. Is there associated with pain or not?
4. Is the patient passing clots?
5. Ask about other urinary symptoms.

Chamberian's-15(12th)

Pain (like other pain)

(Importance of all questions: see page No. 169)

Urinary incontinence

(Importance of all questions : see page No.170)

1. Does it occur only at night (enuresis) or over the day also?
2. Does the urine dribble away all the time or only periodically?

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Dysuria (Burning pain during micturition)

(Importance all questions -see page NO.172)

1. Ask about exact nature (e.g. in starting, in force of stream or in inhibition)
2. Is it accompanied by pain or not ?

Chamberlain's – (12th)

Retention of urine

(Importance of all questions: see page No. 172)

1. Ask about sudden onset or increasing difficulty (gradually)?
2. Ask about any physical trauma or history of surgery
3. Ask about other symptoms of urological and neurological disease

Chamberlain's - 1 7(1 2th)

Frequency of micturition

(Importance of all questions : see page No. 174)

1. Ask about number of times urine is passed in 24 hours
2. Whether at night or in day time or both
3. Amount of urine passed each time
4. Is it accompanied by pain or not?

Chamberlain's-16(12th)

Decreased quantity of urine (oliguria, anuria)

Ask about

1. Amount passed and frequency
2. Fluid intake
3. Duration of symptom
4. Appearance of urine
5. Other symptoms of renal or heart disease.
6. Drugs eaten.

Chamberlain's-15(12th)

Increased quantity of urine (polyuria)

Ask about

1. Approximate amount passed and frequency
2. Appearance of urine
3. Whether continually or only occasionally present? Mainly day or night.
4. Is there any undue thirst ?

Chamberlain's - 17(1 2th)

Scanned with CamScanner

LOCOMOTOR SYSTEM

Joint swelling / stiffness / function less:

(Importance of all questions: see page No. 180)

1. Ask about the joints which have been affected whether monoarticular (single joint), Oligoarticular (two/three), poly articular (four/more) joints?
2. Ask about mode of onset and duration
3. Whether involvement is symmetrical or asymmetrical?
4. Day to day variation of symptom such as presence or absence of morning stiffness and the response to physical activity.
5. Site: Which joint are involved
6. Ask about the presence of extra articular feature particularly in the skin and eyes.

Question- Macleod 's (10th)

Joint pain

(Importance of all questions: see page No. 183)

1. Site
2. Onset (Mode of onset)
3. Character
4. Radiation
5. Associated condition
6. Timing (duration, variation with time)
7. Effects of activity
8. Exacerbating factor & Relieving factor
9. Severity/Mood disturbance

Macleod's-317(13th)

Rash

(Importance of all questions: see page No. 187)

1. Ask about age at onset and duration of rash.
2. Ask about body site at onset and distribution.
3. Is it itchy?
4. Was there a preceding illness or were systemic symptoms present ?
5. Associated symptoms: Have you any other problems ?

Question's from davidson's 1257 (22nd)

Scanned with CamScanner

NERVOUS SYSTEM

Headache

(Importance of all questions: see page No. 191)

1. **Site:**
   Where is it? Whether headache affects the entire head, half of head or a smaller area of head, neck or face.
   When does it come & when does it go ?
2. **Onset**
   Did the pain begin suddenly or gradually?
3. **Character**
   What is it like?
4. **Radiation**
   Does it stay in one place or does it move or spread?
5. **Associated symptoms**
6. **Timing** (duration, course, pattern)
   - Since onset
   - Episodic or continuous
     - If episodic, duration and frequency of attack
     - If continuous, any change in severity
7. *Exacerbating and Relieving factor*

   Exacerbating factor: What brings it on? What makes it worse?
   Relieving factor: What makes it better?
8. **Severity:** Does it interfere with daily activities? Does it keep the patient awake at night?

Unconsciousness (from attendants):

(Importance of all questions: see page no. 197)

1. Whether the coma was gradual or sudden onset
2. What are the preceding events of coma (e.g. trauma, headache, drug administration etc)
3. If there is a history of trauma or accident present, then the time of onset of unconsciousness should be noted.

Whether appeared with accident or little after or a lucid interval (If the patient become unconscious with the accident, but regain consciousness for some time and again become unconscious) present?

Hutchison's-338 (21st)1.2
S. Das - 196(5th) 3

Scanned with CamScanner

Involuntary movements (tremor, choreiform movement etc):
(Importance: Page No. 199)

1. Ask about parts of body affected
2. Ask about effect of voluntary muscular action and sleep upon
3. Is it continuous or occasional?
4. Detail drug history and family history
6. Enquire about amount of coffee and alcohol intake

chamberlain's-17(12th)

Aphasia / Dysphasia

(Importance of all questions: see page No. 202)

1. Is speech fluent or not?
2. Comprehension: *Does patient understand speech (e.g. touch your ear, stand up then close the door)*
3. Repetition
   Can the patient repeat a sentence?
4. Reading or writing: Is it normal or not
5. Naming
   Can he name common and uncommon things?

Question-oxford hand book of clinical medicire - 344(5th)

Limb weakness

(Importance of all questions: see page No. 203)

1. Is it sudden or gradual?
2. *Ask about portion of body involved and extent (proximal/distal muscle)*
3. Whether maximum at onset or increasing?
4. Previous attack
5. Ask about other symptoms of nervous system

Question-Chamberlain's -17 (12th)

Vertigo

(Importance of all questions: see page No. 205)

1. Ask about duration of the episodes
2. Ask about positional or other precipitating factors ?
3. Ask about associated or fluctuating hearing loss or tinnitus
4. Whether the ear feels full during the episode
5. Whether there is a past history of significant head injury
6. Ask about associated symptoms

Question : Macleod's 300 (13th)

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Double vision (diplopia)

(Importance of all questions: see page No. 207)

1. Is the object seen double with one eye (monocular) or with both eyes (binocular) ?
   (Test objectively)
2. Whether diplopia is intermittent or constant?
3. Whether the images are separated vertically, horizontally, or a combination of both?
4. Any associated pain is noted and whether it is related to eye movement or not ?
5. Does the diplopia increase on looking to the right, left, upwards or downwards?

Question: The mark manual of patient symptoms117

Chamberlain's-16(12th)

Noises in the ears or head

1. Types of noise e.g. singing, buzzing, voices etc.
2. Are they persistent or occasional?

Chamberlain's - 18(12th)

Paresthesia

1. Extent and distribution
2. Sudden or gradual onset
3. Periodic or continuous

Chamberlain's-18(12th)

Unsteadiness in standing or walking:

1. Is it worse in the dark?
2. Is it paroxysmal or persistent?
3. Are there associated symptoms (e.g. motor or sensory disturbance, vertigo, tinnitus or deafness) ?
4. Does the patient tend to fall to one particular side?
5. If of short duration, enquire about possible poisoning, including alcohol and hypnotic drugs.

Chamberlain's - 19(12th)

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Collapse

1. Patients description of what happened?
2. Did he fall? Was he unconscious?
3. Associated symptoms (Dizziness, sweating, pallor, pain, diarrhoea, fever, haemorrhage)
4. Foods or drug taken.
5. Previous health ? Any similar collapse before?

Chamberlain's -15(12th)

Symptoms of surgery

1. All the symptoms of medicine.
2. Presence of lump: Questions with Importance: See page No. 231
3. Presence of ulcer: Questions with Importance: See page No. 233

Symptoms of gynae

Vaginal discharge: See page No. 242

Pain in the lower abdomen: See Page No: 244

Something coming out per vagina: See Page No: 245

Disturbance in menstrual cycle: See Page No: 246

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ANALYSIS OF A COMMON SYMPTOM, FEVER

Questions with importance:

1. ***Duration of fever:***

Importance:

- Fever of less than 7 days is usually due to viral fever,
- Fever more than 7 days is usually due to bacterial cause such as typhoid fever, pneumonia, UTI, malaria etc.
- Fever of more than 1 month may be due to tuberculosis, lymphoma, malignancy, SLE etc.

2. ***Grading of fever:***

Importance :

- Low grade fever: 37.3 to 38◦C (99.2 to 100◦F)
  e.g. Tuberculosis
- Moderate grade fever: 38-39◦C (101◦F to 103.74◦F)
- High grade fever: More than 103.74◦F
  e.g. viral fever, pneumonia, liver abscess, pyelonephritis, malaria, lymphoma

3. ***Pattern of fever (continued/remittent/intermittent)***

Does it subside spontaneously or with antipyretic? If there is spontaneous remission, ask about length of each episode of fever and the duration of the intervening afebrile period. However, if there is no spontaneous remission, ask if the temperature fluctuate more than 2 or not more than 1°C (to find whether the fever is continuous, remittent or intermittent)

Importance :

Fever is of 3 types:

a. Continued:

If fever present for 24 hours of the day, fluctuation of fever is not >1°C (1.5°F), and never touch the base line, it is called continued fever. example: typhoid fever, meningococcal meningitis.

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b. Remittent:

If fever fluctuates >2°C (3°F) but does not touch the base line. This is found in any pyogenic infection (pyogenic liver abscess, acute bronchopneumonia, acute tonsillitis, septicemia, acute pyelonephritis), milliary tuberculosis, lymphoma.

c. Intermittent:

Fever which present only for few hours of the day and touch the base line in the rest of the time.

3. Types:

a. Quotidian: Here paroxysm of fever occurs daily (daily rise and fall) e.g. Kala azar

b. Tertian: Here paroxysm of fever occurs in every alternate day or come on every 48 hours. e.g. benign tertian malaria

c. Quartan: Here paroxysm of fever occurs in every third day or come on every 72 hours. e.g. quartan malaria

4. ***If intermittent fever then timing of the fever –Whether fever usually come in the morning, evening or night? How long does it persist (few hours or throughout the day or night)? Is there any evening rise of temperature associated with night sweat?***

Importance:

- Low grade fever, usually come in the evening, is usually due to tuberculosis.

5. ***Highest recorded temperature.(for grading of temperature)***

Importance:

- Low grade fever: 37.3 to 38°C (99.2 to 100°F) e.g. Tuberculosis
- Moderate grade fever: 38-39°C (101°F to 103.74°F)
- High grade fever: More than 103.74°F e.g. viral fever, pneumonia, liver abscess, pyelonephritis, malaria, lymphoma

6. ***Whether fever comes with chills & rigor? Does it subside with sweating?***

Importance:

- Fever usually comes with chills and rigor in malaria, liver abscess, pneumonia, acute pyelonephritis, acute cholangitis etc.

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7. ***Is the fever punctuated by apyrexial period?(Undulant or pel-Ebstain fever)***

Importance:

- A recurrent bouts of pyrexia followed by apyrexial period is called Pel-Ebstain fever.It is found in hodgkin's disease (10% cases). This type of fever may be found in brucellosis (called undulant fever).

8. ***History of traveling to malaria/Kala Azar endemic zone.***

Importance:

- If the patient develops fever after returning from malaria endemic zone (Khagrachari, Bandarbon, Rangamati, Chittagong, Cox's bazar), then this is usually due to malaria.
- Patient may develops fever after returning from kala azar endemic zone (Mymensingh, Tangail, Shirajgonj, Pabna, Natore, Rajshahi, Jamalpur)

9. ***Is the fever associated with skin rash or purpura?***

Importance:

Fever with skin rash (according to the day of appearance of skin rash)- Remember: Very sick person must take double eggs.

- 1st day-Varicella (chicken pox)
- 2nd day-Scarlet fever
- 3rd day-Pox (small pox)
- 4th day-Measles, German measles (rubella)
- 5th day-Typhus
- 6th day-Dengue
- 7th day-Enteric fever (rose spot)
- Drug rash may appear any time

Other causes of skin rash with fever:

- Infectious nononucleosis
- Steven Johnson syndrome
- Leptospirosis
- Lyme disease
- Meningo coccal septicemia
- SLE
- Still's disease

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- Adult still's disease
- Erythema nodosum
- Erythema multiforme
- Toxic shock syndrome
- Staphylococcal scalded skin syndrome

10. Is there any history of sexual exposure, homosexuality, travel abroad?

11. Are you taking any drugs?(to exclude any drug fever)

Some points about fever:

Normal body temperature is 36.8°C (mouth), 36.4°C (axilla), 37.3°C (rectum). Temperature >37.3°C (in mouth) or 37.7°C (in rectum) is considered as fever.

Hyperpyrexia:

Temperature above 41.1°C is called hyperpyrexia or hyper thermia.

This may occur in severe infection, pontine haemorrhage, heat stroke, malignant hyperthermia, lobar pneumonia, datura poisoning.

Pel-Ebstain fever: A recurrent bouts of fever or pyrexia followed by apyrexial period is called Pel-Ebstain fever. It is found in hodgkin's disease (10% cases).

- Low grade fever with evening rise of temperature:tuberculosis
- Fever with chill and rigor: Acute pyelonephritis, acute cholangitis, subacute bacterial endocarditis. subphrenic abscess, pyogenic lung abscess, septicemia, lobar pneumonia, pyrogenic reaction after transfusion or infusion.
- Fever with chill and rigor that subsided with sweating: Malaria
- Fever with unconsciousness:
  - Cerebral malaria, meningitis, encephalitis,
  - Pontine haemorrhage
- Fever with neck rigidity: Meningitis, encephalitis
- Fever with drenching night sweat: Lymphoma, tuberculosis
- Feverish feeling with excessive sweating: Thyrotoxicosis
- Fever with double rise of temperature: Kala azar
- Step ladder pattern of fever: Enteric fever
- Relapsing fever: malaria, Borreliosis, occasionally lymphoma (HD)
- Fever with myalgia: Viral infection

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- Fever with relative bradicardia: Normally, for 1°F rise in temperature, pulse increases by 10 beats per minute. If the rise of pulse rate is less than that, it is called relative bradicardia. It occurs in viral fever, 1st week of enteric fever, brucellosis, psittacosis, Weil's disease etc.
- Fever with relative tachycardia: if rise in pulse rate is more than that is expected from increased temperature, it is called relative tachycardia. It occurs in acute rheumatic carditis, diptheric myocarditis, severe tuberculosis, poly arteritis nodosa etc.
- Fever may be caused by malignancy, such as hepatocellular carcinoma, bronchial carcinoma, renal cell carcinoma etc.
- Fever with skin rash (according to the day of appearance of skin rash)-Remember: Very sick person must take double eggs.
  - 1st day-Varicella (chicken pox)
  - 2nd day-Scarlet fever
  - 3rd day-Pox (small pox)
  - 4th day-Measles, German measles (rubella)
  - 5th day-Typhus
  - 6th day-Dengue
  - 7th day-Enteric fever (rose spot)
  - Drug rash may appear any time
- Other cause of skin rash with fever:
  - Infectious nononucleosis
  - Leptospirosis
  - Meningo coccal septicemia
  - Still's disease
  - Steven Johnson syndrome
  - Lyme disease
  - SLE
  - Adult still's disease
- Saddle back fever: Fever for few days, then no fever for one or two days followed by reappearance of fever. It occurs in dengue fever, Colorado tick fever, borreliosis, leptospira, yellow fever and influenza.
- Factitious fever: Sometimes patient purposefully show false rise of temperature. Usually found in young woman.

Presentation in history: Suddenly he developed fever which is continued, high grade in nature, comes with chills and rigor and subsides by taking paracetamol with sweating. Highest recorded temperature is 104°F. There is no history of traveling to kala azar or malaria endemic zone.

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CARDIOVASCULAR SYSTEM

Name:

Importance: See page No.23

Age:

Importance:

- It is very important to know the age of the patient. Because certain heart disease occur in certain age group.
- Congenital heart disease usually presents during the first year of life but can present at any age of life. Atrial septal defect may cause no symptoms until adult life.

Common congenital anomaly:

S.N.	Lesion	% of all congenital heart disease
1.	Ventricular septal defect (VSD)	30%
2.	Atrial septal defect (ASD)	10%
3.	Patent ductus arteriosus	10%
4.	Pulmonary stenosis	7%
5.	Coarctation of aorta	7%
6.	Aortic stenosis	6%
7.	Tetralogy of fallot	6%
8.	Complete transposition of great arteries	4%
9.	Others	20%

Davidson 630(22nd)

Congenital heart disease:

Cyanotic congenital heart disease:

1. Tetralogy of fallot
   It comprises: pulmonary stenosis, overriding aorta, VSD, right ventricular hypertrophy

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2. Transposition of great vessels
3. Tricuspid atresia
4. Pulmonary atresia
5. Ebstain's anomaly

Acyanotic congenital heart disease:

- Ventricular septal defect
- Atrial septal defect
- Coarctation of aorta
- Persistent ductus arteriosus

Davidson 631-633(22nd)

More in children or young adults:

- Acute rheumatic fever *Davidson 614 (22nd)*

More in latter age:

- Coronary artery disease
- Stable angina, unstable angina, myocardial infarction
- Cerebral infarction
- Gangrene of legs
- Mesenteric occlusion
- Peripheral vascular disease (55-75) *Davidson 600 (22nd)*
- Abdominal aortic aneurysm (over 60 yrs) *Davidson 604 (22nd)*

Sex:

Importance:

More in male:

- Ischemic heart disease *Davidson 583 (22nd)*
- Peripheral vascular disease *Davidson 600 (22nd)*
- Abdominal aortic aneurysm *Davidson 604 (22nd)*

More in female:

- Chronic rheumatic heart disease *Davidson 616 (22nd)*
- Raynaud's disease *Davidson 602 (22nd)*

Religion:

Importance: see page No. 25

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Marital status:

Importance:

In AIDS patient, cardiomyopathy, pericardial effusion may occur.

HIV is also associated with increased risk of MI due to accelerated atherogenesis caused by inflammatory states. *Davidson 405 (22nd)*

Date of admission:

Date of examination:

Importance:

See page No. 26

Chief complaints:

1. Chest discomfort /chest pain.
2. Breathlessness (Dyspnoea)
3. Palpitation
4. Syncope
5. Edema
6. Fatigue

History of present illness

CHEST PAIN

Causes:

Anxiety/Emotion

Cardiac:

Myocardial ischemia
Myocardial Infarction
Pericarditis
Mitral valve prolapse

Aortic:

Aortic dissection
Aortic aneurysm

Oesophageal

Oesophagitis
Oesophageal spasm
Mallory –Weiss syndrome

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Lungs/Pleura

Bronchospasm
Pulmonary embolism
Pulmonary infarction
Pneumonia
Tracheitis
Pneumothorax
Malignancy
Tuberculosis
Connective tissue disorder

Musculoskeletal

Osteoarthritis
Inter costal muscle injury
Rib fracture/injury
Costochondritis

Neurological

Prolapsed intervertibral disc
Herpes zoster
Thoracic outlet syndrome

Davidson 541(22)

Questions with importance:

1. Site:

Where is it?

The patient is asked to indicate the site of pain with tip of one finger (Pointing test). If the pain is diffused, the patient will obviously use his whole hand instead of one finger to locate its site.

Importance:

- Cardiac pain is usually centrally located in the chest & diffuse.
- Localized pain on skin or superficial structure that can be reproduced by local pressure, it generally arises from chest wall.

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- The pain which vary with posture or movement of the upper body & is sometimes accompanied by local tenderness over a rib or costal cartilage are of musculoskeletal pain e.g.

  Arthritis

  Costochondritis

  Intercostal muscle injury
- Respiratory chest Pain: Localizes to the site of pathology. e.g. infection or pneumothorax.
- Musculoskeletal chest pain: Localizes to site of pathology or injury.
- Peptic ulcer disease and gastro-oesophageal reflux: Lower chest and epigastrium.
- Pericardial pain → Retrosternal or left sided *Macleod's101(13rd)*
- Pain from aortic dissection→Inter scapular or retrosternal

  Harrison 103(18th)
- Pulmonary embolism →often lateral, on the side of embolism

2. Radiation:

Does it stay in one place or does it move or spread?

Importance:

1. Pain of myocardial ischemia radiates to the neck, jaw, teeth, arms or shoulders reflecting the common origin in the posterior horn of the spinal cord of sensory neurons supplying the heart and these areas.

   Harrison 102(18th)

   Occasionally cardiac pain may be experienced only at the sites of radiation or in the back. *Davidson 540(22nd)*
2. Pain of dissection of the aorta → Radiates to back (typically interscapuler region)
3. Nerve root pain: Around the chest wall resulting in a band-like pain sensation

   Macleod's 100(13rd)
4. Peptic ulcer disease and pnacreatitis: Back

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3. Character: ***What is it like?***

Importance:

- Cardiac pain is typically dull, constricting, choking or 'heavy', and is usually described as squeezing, crushing, burning or aching but not sharp, stabbing, pricking or knife-like. The sensation can be described as breathlessness. Patients often emphasize that it is a discomfort rather than a pain. They typically use characteristic hand gestures (e.g. open hand or clenched fist) when describing.

Davidson 540 (22nd)

- Pericarditis → Sharp
- Aortic dissection →Tearing or ripping sensation, Knife like
- Peptic ulcer, Esophageal reflux → Burning pain
- Respiratory and musculoskeletal disease → Sharp and pleuritic
- Pleuritic chest pain (stabbing, related to breathing & coughing) → Pneumonia, pleuritis, spontaneous pneumothorax, pulmonary embolism
- Nerve root pain: Band like shooting pain around the chest

Harrisson 103(18th)

4. Severity:

Does *it interfere with daily activities or keep the patient awake at night?*

Question:

To assess the severity of angina.

- How far can you walk on the flat before experiencing discomfort?
- Do you get discomfort on climbing stairs or hills?
- Do you experience discomfort during gardening, making the bed or other household works?
- Does sexual intercourse produce discomfort or by cold weather ?
- Is the discomfort influenced by meals ?
- Is it influenced by cold weather?

Macleod's-74(10th)

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Importance:

New York Heart Association (NYHA) functional classification	
Grade-1	No limitation during ordinary activity.
Grade-2	Slight limitation during ordinary activity.
Grade-3	Marked limitation of normal activities without symptom at rest.
Grade-4	Unable to perform physical activity without symptoms; symptoms may be present at rest.

Davidson 539(22nd)

Canadian Cardiovascular society: Functional classification of stable angina

Grade -1	Ordinary physical activity, such as walking and climbing stairs does not cause angina. Angina with strenuous or rapid or prolonged exertion at work or recreation.
Grade -2	Slight limitation of ordinary activity. Walking or climbing stairs rapidly, walking uphill, walking or stair climbing after meals, in cold, in wind or when under emotional stress, or only during the few hours after awakening.
Grade -3	Marked limitation of ordinary physical activity. Walking one to two blocks on the level and climbing less than one flight in normal condition.
Grade -4	Inability to carry on any physical activity without discomfort; Angina may be present at rest.

Macleod's-101(13th)

5. Duration:

When does it come & when does it go ?

Importance:

- Angina pectoris → 2-10 minutes
- Unstable angina→ more than 20 minutes
- Myocardial infarction → Variable, often more than 30 min
- Pericarditis → Hours to days ; may be episodic
- Aortic dissection → Abrupt onset of unrelenting pain

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- Pulmonary embolism → Abrupt onset; several minutes to a few hours
- Pneumonia or pleuritis → Variable
- Spontaneous pneumothorax → Sudden onset; several hours
- Peptic ulcer → Prolonged
- Musculoskeletal disease → Variable

Harrisson 103(18th)

6. Aggravating factor:

What brings it on? What makes it worse?

Importance:

- By exertion, emotion, heavy meals → Myocardial ischemia
- By deep breathing, coughing or movement → Pleural, pericardial or musculosketelal pain
- By specific movement (Bending, Stretching, Turning) → Musculoskeletal pain

Davidson 540(22nd)

- Chest pain when moving the neck → May be herniated inter vertibral disc.

7. Relieving factors:

What makes it better ?

Importance:

- Rest & nitroglycerine
  - Cardiac Ischaemic Pain
- By sitting up and leaning forward → Acute pericarditis

Harrison 103(18th)

- By holding breath in deep expiration → Pleurisy
- By food or antacid → Peptic ulcer or gastro-oesophageal reflux

Harrison 103(18th)

- After belching → Upper gastro intestinal disease or anxiety.

Braunwald's Heart Disease - 7(4th)

- Simple analgesic: Musculosketelal pain, respiratory pain & pericarditis.
- Bronchodilator: Asthma or COPD

8. Mode of onset:

Did the pain begin suddenly or gradually?

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Importance:

Sudden onset:

- Myocardial infarction
- Massive pulmonary embolism
- Pneumo thorax
- Aortic dissection

Gradually develop (in proportion to the intensity of exertion):

- It may be due to angina
- Pain that occurs after rather than during exertion is usually musculoskeletal or psychological in origin.

Davidson 540(22nd)

9. Associated symptoms:

Are there any associated symptoms (breathlessness, sweating, vomiting)?

Importance:

- Associated with breathlessness, sweating, nausea and vomiting → Myocardial infarction
- Associated with haemoptysis →
  - i. Pulmonary embolism with infarction
  - ii. Lung tumor
- Associated with fever →
  - i. Pneumonia
  - ii. Pleurisy
  - iii. Pericarditis

Braunwald's Heart Disease – 7(4th)

- History of prodromal viral illness → Pericarditis, Myocarditis
- Features of anxiety or depression → In emotional and psychiatric condition.
- Sudden unilateral chest pain, associated with severe dyspnoea → Spontaneous pneumothorax
- Chest pain associated with difficulty in swallowing: Oesophagitis, oesophageal carcinoma
- Sharp pain with cough: Pneumonia
- Central or retrosternal chest pain associated with repeated coughing : Tracheo bronchitis

Presentation in history: The patient complains of chest pain for 2 months which is retrosternal, compressive in nature, radiates to left arm, aggravates on exertion and relieves by rest.

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BREATHLESSNESS (DYSPNOEA)

Unpleasant subjective awareness of the sensation of breathing is known as dyspnoea.

Common Causes:

Acute dyspnoea:	**Chronic exertional dyspnoea:**
Cardiovascular system Acute pulmonary edema	Chronic heart failure Myocardial ischemia
Respiratory system Acute severe asthma Acute exacerbation of COPD Pneumothorax Pneumonia Pulmonary embolism ARDS Inhaled foreign body Lobar collapse Laryngeal edema (e.g. anaphylaxix)	COPD Chronic asthma Bronchial carcinoma Interstitial lung disease Sarcoidosis, fibrosing alveolitis Extrinsic allergic alveolitis, Pneumoconiosis Chronic pulmonary thromboembolism Lymphatic carcinomatosis Large pleural effusion
Others Metabolic acidosis (e.g. diabetic ketoacidosis, lactic acidosis, uraemia, overdose of salicylates, ethelene glycol poisoning) Psychogenic hyperventilation (anxiety or panic attack)	Severe anaemia, obesity

Davidson 543(22nd)

Questions with importance:

Ask about

1. Mode of onset: *Sudden or gradual.*

Importance:

Sudden developed:

- Acute pulmonary edema
- Acute severe asthma

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- Acute exacerbation of COPD
- Pneumothorax
- Pulmonary embolism
- Inhaled foreign body

Gradually developed:

- Chronic heart failure
- Myocardial ischemia
- COPD
- Chronic asthma
- Bronchial carcinoma
- Interstitial lung disease
- Severe anaemia
- Obesity
- Large pleural effusion

2. When does this come on? Is it present at rest or only on exertion ?

Importance:

Exertional:

- Chronic heart failure
- Myocardial ischemia
- COPD
- Chronic asthma
- Bronchial carcinoma
- Interstitial lung disease
- Severe anaemia
- Obesity
- Large pleural effusion

At rest:

- Acute pulmonary edema
- Acute severe asthma
- Acute exacerbation of COPD
- Pneumothorax
- Pulmonary embolism
- Inhaled foreign body

Davidson 543(22nd)

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3. Severity:

What degree of exertion is necessary to produce it?

Functional assessment of dyspnoea:

- *Is sleep disturbed by breathlessness?*
- *Does breathlessness occur at rest?*
- *Does breathlessness interfere with normal conversation?*
- *Does dressing or washing produce breathlessness?*
- *How far can the patient walk on the flat without stopping?*
- *What activity are avoided because of breathlessness?*

Macleod's - 123(10th)

Importance:

New York Heart Association (NYHA) functional classification

Grade - 1	No limitation during ordinary activity.
Grade - 2	Slight limitation during ordinary activity.
Grade - 3	Marked limitation of normal activities without symptoms at rest.
Grade - 4	Unable to perform physical activity without symptoms; symptoms may be present at rest.

Davidson 539(22nd)

4. Is it related to time of day or night, posture or other.

Importance:

Time:

Nocturnal dyspnoea:

Chronic heart failure, Asthma *Macleod's 102(13th)*

Related to posture:

- More in lying (orthopnoea):
  - i. Pulmonary edema due to LVF & MS
  - ii. Mechanical impairment of the diaphragm associated with obesity

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- Often occur in sitting rather than lying or whether it occurs in particular position suggests:
  i. Left atrial myxoma
  ii. A ball valve thrombus in the left atrium.

  Braunwald's Heart Disease - 4(4th)

  iiii. Hepato pulmonary syndrome

  Harrison 279(18th)
- More marked on lateral position → Pneumothorax

5. ***Are there attack of breathlessness at night or not (Paroxysmal nocturnal dyspnoea) ?***

Importance:

Paroxysmal nocturnal dyspnoea (Sudden breathlessness waking the patient from sleep): It suggests heart failure

Lying flat increases venous return and in patients with left ventricular impairment precipitate pulmonary oedema. It is caused by accumulation of alveolar fluid. Patient sits on the edge of the bed & open windows in attempt to relieve their distress.

It may produce frothy sputum.

It may be confused with asthma: which can also cause night time dyspnoea but associated with chest tightness, cough and wheeze.

Macleod's 102(13th)

6. ***Does the patient have to sleep sitting up (orthopnoea)?***

Importance:

Orthopnoea:

- Dyspnoea in the recumbent position and is relieved by sitting up right & standing.
- Lying flat increases venous return and in patients with left ventricular impairment precipitate pulmonary oedema.

  Macleod's 102(13th)
- Presence of orthopnoea suggests pulmonary edema due to
  i. Left heart failure
  ii. Mitral stenosis

  Braunwald's Heart Disease -3(4th)

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7. *Associated symptoms: (Wheeze, Cough, Haemoptysis)*

Importance:

- Associated with haemoptysis suggests → Pulmonary infarction.
- Associated with chest pain, sweating, vomiting → Acute myocardial infarction
- Dyspnoea with high fever → Pneumonia
- Dyspnoea associated with wheezing: Acute severe asthma, COPD, sometimes acute LVF, anaphylactic reaction
- Dyspnoea with stridor: Foreign body or tumor, acute epiglottitis, anaphylactic reaction, laryngeal trauma.
- Dyspnoea but chest clear: Pulmonary embolism, metabolic acidosis, severe anaemia, shock, pneumocystis jirovecii pneumonia, psychogenic
- Dyspnoea with unilateral sharp chest pain: Spontaneous pneumothorax
- Dyspnoea with seasonal variation: Asthma, chronic bronchitis

Presentation in history: He also complains breathlessness which is gradual in onset, aggravates on lying position and decreased on sitting position. It is so severe that he can not sleep due to breathlessness. It is not associated with chest pain or palpitation.

PALPITATION

Definition:

Unexpected awareness of the heart beating in the chest is known as palpitation.

Macleod's 102(13th)

Causes:

Psychiatric (31%):

Panic attack

Anxiety states

Cardiac (43%):

Atrial fibrillation due to any cause (thyrotoxicosis, valvular heart disease etc).

Atrial ectopic beat

Ventricular ectopic beat

Supra ventricular tachycardia

Ventricular tachycardia

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Mitral valve prolapse

Aortic regurgitation

Atrial myxoma

Hyper dynamic cardiovascular states caused by catecolaminergic stimulation from exercise, stress, phaeochromocytoma

Miscelleneous:

Drugs: Tobacco, Caffeine, Aminophylline, atropine, Thyroxine, cocaine, Amphetamine, Ethanol.

Harrison 295 (18th)

Some causes of palpitation with suggestive findings:

Findings	Possible causes
Occasional skipped beats	PACs, PVCs
Rapid regular palpitation with sudden onset and termination, often history of reccurence	PSVT, ventricular tachycardia, atrial flutter with 2:1 A V block
Syncope following palpitation	Sinus node dysfunction, atrioventricular bypass tract such as WPH syndrome, congenital long QT syndrome
Palpitation during exercise or an emotional episode	Healthy person: sinus tachycardia H/O coronary artery disease: ventricular arrhythmia from exercise induced ischemia
Palpitation following episodic drug use	Drug induced cause
Sense of doom, anxiety, or panic	Suggests (but not confirm) a psychogenic cause
Post operative patient	Sinus tachycardia
Recurrent episodes during childhood	Supra ventricular arrhythmia (e.g. atriventricular nodal reentrant bypass tract, WPH syndrome) congenital long QT syndrome
Family history of syncope or sudden death	Brugada syndrome, long QT syndrome, inherited dilated or hypertrophic cardiomyopathy

Mark manual of patients symptom 414(1st edition)

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Questions with importance:

Palpitation

1. **Ask about onset, duration and frequency of palpitation.**
   a. **Do the palpitation occur gradually or suddenly?**
   b. **How long have you had the palpitations?**
   c. **How often do you experience the palitation?**

Importance:

- Palpitatiom occur since childhood suggest SVT
- Sudden onset & sudden termination suggests : SVT
- Gradual onset & gradual termination suggests sinus tachycarclia

2. **Ask about character of Palpitation**

   What do the palpitation feel like?

Importance:

- Racing or tapping heart suggests fast arrhythmia
- Missed beat followed by more forcefull beat suggests ventricular ectopics
- Pounding in the neck suggests atrioventrialar dissociation
- The pounding feeling in the neck is due to cannon a wave which suggest atrial contraction agairst closed atrioventricular valves
- Rapid & regular pounding in the neck suggest AVNRT

3. **Ask about rate and rhythm:**
   a. **Are the palpitation fast or slow**
   b. **Are the palpitation regular or irregular**

Importance:

- Rapid, regular palpitation suggests sinus tachycardin, SVT and VT
- Irregular palpitation suggest atrial fibrillation or ventricular ectopics

4. **Ask about any precipitating factor**

   Is there any thing that trigger the episodes? such as excecise, stress, alcohol, coffee etc ?

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Importance:

- Cofee, Alcohol may precipitate SVT
- Exercise can precipitale VT
- Recent illness can precipitate AF

5. Ask about any relieving factor

a. How do the palpitation stop ?

b. Have you tried stopping them by straining or holding your breath ?

Importence:

- SVT can be terminated by valsalva manoeuver
- Ectopic beats terminate with exercise

6. Ask about associated symptoms

Importance:

- Dyspnoea occurs with most arrhythmias
- Syncope & presyncopc are signs of haemodynamic compromise necessitating intervention
- Chest pain, nausea and sweating are sign of myocardial ischemia associated with tachyarrhythmia which also requires urgent treatment.
- Associated with throbbing in the neck → Aortic regurgitation
- Associated with polyuria → supraventricular tachycardia
- Psychiatric causes for palpitations more commonly report a longer duration of the sensation (>15 min) and other accompanying symptom of anxiety

Harrison 295(18th)

7. Ask about relevent medical history

Importance:

- Thyrotoxicosis : weight loss, heat intolerance, sweating, tremor
- Hypothyroidism : weight gain, cold intolerance , fatigue, constipation
- Hypoglycaemia: Hunger, headache, irritability, confusion and sweating
- Phaeochromocytoma: Headache, flushing, irritability, confusion and sweating

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8. **Take a thorough drug history enquiring about medications that can precipitate palpitations.**

Importance:

Following drugs may cause palpitation

- Beta agonist
- Theopylline
- Levo thyroxine
- Sympathomimetics such as mono amino oxidase inhibitors
- Drugs that prolong the QT interval may precipitate poly morphic VT such as quinidine, disopyramide, amiodarone, sotalol, erythromycin, azithromycin, clarithromycin, TCA, SSRI,domperidone etc
- Recreational drug such as cocaine, amphetamine.

Davidson 569(22nd)

SYNCOPE

Syncope:

Sudden transient loss of consciousness due to reduced cerebral perfusion is called syncope.

Pre syncope:

Refers to light headedness in which the individual thinks he or she may black out.

Seizure:

A seizure can be defined as the occurrence of sign and /or symptoms due to abnormal, excessive or synchronous neuronal activity in the brain.

There are three principal mechanisms that underlie recurrent pre syncope or syncope.

1. Cardiac syncope: Due to mechanical cardiac disfunction or arrhythmia.
2. Neurocardiogenic syncope: In which abnormal autonomic reflex causes bradycardia and /or hypotension.
3. Postural hypotension: In which physiological peripheral vasoconstriction on standing is impaired lead to hypotension.

Davidson 554(22nd)

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Reduction in systolic blood pressure of at least 20 mm of Hg or diastolic blood pressure of at least 10 mm of Hg within 3 min of standing or head up tilt on a tilt table is known as orthstatic hypotension.

Harrison 174(18th)

Causes of syncope:

Cardiac syncope:

a) Arrhythmia:
   i. Sinus node dysfunction (sinus arrest or sinoatrial block)
   ii. Atrioventriculer dysfunction (Mobitz type-II or complete heart block)
   iii. Supra ventricular tachycardia (SVT)
   iv Ventricular tachycardia (VT)

b) Cardiac structural disease
   i. Aortic stenosis.
   ii. Hypertrophic obstructive cardiomyopathy.

Neurocardiogenic syncope:

Vasovagal syncope

Prolonged standing, fear, pain, anxiety, intense emotion, sight of blood, unpleasant sight and odors.

Situational reflex syncope

Pulmonary

Cough syncope, sneeze syncope, airway instrumentation.

Urogenital

Post micturition syncope, urogenital tract instrumentation, prostatic message

Gastro intestinal

Swallow syncope, Gastrointestinal tract instrumentation, rectal examination, defecation syncope

Carotid

Carotid sinus hyper sensitivity

Orthostatic hypotension

Primary autonomic failure due to neurodegenerative disease

Parkinson's disease

Lewy body dementia

Pure autonomic failure

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Secondary autonomic failure due to autonomic peripheral neuropathy

i. Diabetes mellitus
ii. Hereditary sensory and motor autonomic neuropathy
iii. HIV neuropathy

Iatrogenic

i. Drugs (alpha adrenoceptor antagonist, Nitrate and other vasodilator, tricyclic agent, Phenothiazines)
ii. Volume depletion due to diuretics, haemorrhage, vomiting, diarrhoea, decreased fluid intake

Questions with importance:

1. Mode of onset:

Did it being over a period of seconds or developed gradually during a period of several minutes ?

Importance:

Over a period of seconds indicates

i. Postural hypotension
ii. Sudden AV block (Stokes - adams attack)
iii. Asystole
iv. Ventricular tachycardia
v. Ventricular fibrillation
vi. Neurological (seizure disorder)

Braunwald's Heart Disease -7(4th)

Develops gradually over a period of minutes indicates:

i. Hypoglycemia
ii. Hyperventilation

Braunwald's Heart Disease -9(4th)

2. What are the perceding events of syncope?

Importance:

- After sudden unexpected pain, unpleasent sight, sound, or smell → vasovagal syncope
- During or immediately after micturition, cough, swallow or defecation → satutuational syncope
- Following antihypertensive agents → drug induced syncope

Braunwald's Heart Disease - 8(4th)

- Following emotional stress → Vasovagal syncope
- After prolonged standing → Vasovagal syncope

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- Just after standing form sitting or supine position → Orthostatic hypotension
- During or immediately after exertion suggests
  i. Aortic stenosis
  ii. Hypertrophic obstructive cardiomyopathy
- Sudden movement of head, shaving the neck or wearing a tight collar → Carotid sinus hypersensitivity

Braunwald's Heart Disease - 8(4th)

- Syncope associated with chest pain → Acute MI with complete heart block.
- Following insulin administration → Hypoglycemia
- Following changing position (from sitting to lying, bending, turning over in bed) → Atrial myxoma, thrombus
- Associated with vertigo, dysarthria, diplopia → TIA, stroke
- With arm exercise → Subclavian steal syndrome

Braunwald's Heart Disease - 8(4th)

3. *What is the position at onset of attack?*

Importance:

- After changing from recumbent to standing position → Orthostatic hypotension
- After prolonged standing → May be vasovagal syncope
- Syncope occurring upon bending, leaning or assuring a particular body position →
  i. Left atrial myxoma ii. A ball valve thrombus

Braunwald's Heart Disease - 8(4th)

- Independent to position
  i. Stokes Adams attack ii. Hyperventilation
  iii. Epilepsy iv. Hypoglycemia

Harrison 103(14th)

4. Associated symptoms: have you any other problems?

Importance:

- Associated with urinary incontinence, tongue biting injury → Neurological cause (Epilepsy).
- A history of syncope since childhood suggests cardiovascular anomaly:
  i. Aortic stenosis
  ii. Hypertrophic obstructive cardiomyopathy

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OEDEMA

Causes:

Generalized:

1. Heart failure
2. Renal failure
3. Cirrhosis of liver
4. Hypoproteinaemia due to any cause such as nephrotic syndrome, cirrhosis of liver, protein losing enteropathy, Severe malnutrition
5. Hypothyroidism

Localized:

1. Lymphatic obstruction due to any cause such as filariasis, lymphogranuloma venereum, Malignancy, Radiation injury
2. Venous obstruction due to any cause such as deep venous thrombosis, chronic venous insufficiency
3. Localized infection

On the other way

Pitting oedema:

1. Heart failure
2. Renal failure
3. Cirrhosis of liver
4. Hypoproteinaemia due to any cause such as nephrotic syndrome, cirrhosis of liver, protein losing enteropathy, Severe malnutrition

Non pitting oedema

1. Lymphatic obstruction
2. Myxoedema

Questions with importance:

1. Is it localized or generalized?

Importance:

Generalized:

- Congestive heart failure
- Hypoproteinaemia →
  - → Cirrhosis of liver
  - → Nephrotic syndrome
  - → Protein losing gastro enteropathy
  - → Severe malnutrition

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Localized:

i. Lymphatic obstruction → Chronic lymphangitis / Filariasis / Resection of regional lymphnode

ii. Venous obstruction, DVT, chronic venous insufficiency

Harrison - 2[4(14th)]

2. *Is it unilateral or bilateral?*

Importance:

Unilateral / restricted to one extremity

- Venous thrombosis
- Lymphatic obstruction of that extremity

Braunwald's Heart Disease - 9(4th)

Bilateral / Symmetrical

- Cardiac causes, Renal cause, Liver cause
- Hypoproteinaemia

3. *Which portion is first involved?*

Importance:

- Face → Kidney cause; Face → leg → abdomen
- Dependent part of body (leg) → Heart cause; Leg → face → abdomen.
- In the abdomen (Ascites) → Liver cause; abdomen → Leg → face.

4. *Whether it is persistent or only after standing?*

Importance:

- Edema with prolonged standing suggests chronic venous insufficiency

Heart disease -9(4th)

- Edema in the legs most pronounced in the evening suggests
  - i. Heart failure
  - ii. Chronic venous insufficiency

5. *Is it limited to the legs or in the face affected?*

Importance:

- A history of edema around the eyes and face suggests
  - i. Nephrotic syndrome
  - ii. Acute glomerulonephritis
  - iii. Myxoedema
  - iv. Angioneurotic edema

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- A history of edema restricted to the face, neck & upper arm suggests obstruction of superior venacava most commonly by
  i. Carcinoma of lung.
  ii. Lymphoma
  iii. Aneurysm of aortic arch

Braunwald's Heart Disease - 9(4th)

6. Associated symptoms:

Have you any other problem ?

Importance:

- Associated with dyspnoea suggests
  i. Heart failure (in most cases)
  ii. Pleural effusion
  iii. Elevation of diaphragm due to ascites

Braunwald's Heart Disease -9(4th)

- When dyspnoea precedes edema (dyspnoea before edema)

  It indicates.
  i. Left ventricular dysfunction
  ii. Mitral stenosis
  iii. Chronic lung disease with corpulmonale

- A history of jaundice suggests edema is hepatic in origin

Braunwald's Heart Disease - 9(4th)

- Associated with history of ulceration and pigmentation of skin of the leg suggests
  i. Chronic venous insufficiency
  ii. Post phlebitic syndrome.

Braunwald's Heart Disease -9(4th)

- A history of ascites preceding edema (Ascites occurred before oedema) suggests cirrhosis of liver.

Braunwald's Heart Disease -9(4

- A history of ascites following edema (Edema occurred before ascites) indicates cardiac or renal disease.

Braunwald's Heart Disease -9(4th)

Presentation in history:

The patient also complained of gradual swelling of whole body which was first appeared in both leg then spread all over the body. It was not associated with any change in volume and colour of urine. He did not give any H/O of jaundice, bloody vomiting, black tarry stool or cold intolerance.

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History of past illness:

Ask about rheumatic fever or heart murmurs during childhood and associated conditions including hypertension, diabetes, kidney disease, thyrotoxicosis (atrial fibrillation), Marfan's syndrome (aortic regurgitation or aortic dissection).

In suspected infective endocarditis ask about potential causes of bacteraemia e.g. skin infection, recent dental procedure, intra venous drug use or penetrating trauma.

Importance:

Past history	Presenting disease
Streptococcal pharyngitis	After 2-3 weeks patient may develop rheumatic fever
Rheumatic fever	After 10-12 year or earlier it may develop valvular heart disease
Potential cause of bacteraemia e.g. skin infection, recent dental work, intra venous drug use or penetrating trauma	May develop infective endocarditis
Connective tissue disease e.g. rheumatoid arthritis	Raynaud's phenomenon and pericarditis
Chronic lung disease	Right sided heart failure (cor pulmonale)
Renal failure or cancer	Pericardial effusion
Radiotherapy	Radiation arteritis

Macleod's 105(13th)

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Family History:

Importance:

Genetically influenced cardiovascular disorders:

Single gene defect	Polygenic inheritance:
Familial hypercholesterolemia Hypertrophic cardiomyopathy Dilated cardiomyopathy (25% of cases) Arrhythmogenic right ventricular cardiomyopathy Marfan's syndrome Muscular dystrophy Long Q-T syndrome	Ischemic heart disease Hypertension Type 2 diabetes mellitus Hyperlipidaemia Abdominal aortic aneyrysm

Macleod's 106(13th)

Occupational history:

Importnace:

Occupational exposure associated with cardiovascular disease:

- Organic solvents (hydrocarbon) : → Arrhythmia, Cardiomyopathy
- Vibrating machine tools : → Raynaud's phenomenon
- Publicans : → Alcoholic cardiomyopathy

Occupational exposure exacerbating preexisting cardiovascular condition

- Cold exposure : → Angina, Raynaud's disease
- Deep sea diving : → Embolism through foramen ovale

Occupational requirements for high standards of cardiovascular fitness:

- Pilot
- Public transport/heavy good vehicle drivers
- Armed forces
- Police

Macleod's 106(13th)

Scanned with CamScanner

Personal history/social history

This is very important, because many cardiovascular disease occur due to smoking, alcohol consumption etc.

- Smoking → Ischemic heart disease
  - Peripheral vascular disease
  - Cerebrovascular disease
  - Cor pulmonale (due to COPD)

  Macleod's-173(13th)
- Excessive alcohol → DCM
  - Portal hypertension
  - Hypertension, obesity

  Macleod's -18 (13th)
- Amphetamine, cocaine → DCM

  Harrison 1959(18th)
- Intra venous drug use → Infective endocaditis

Drug history:

Importance:

Drug history is important for proper diagnosis. Some drug may responsible for aggravating the symptoms. The drug history should include the alternative medicine and herbal remedies, these may contain ingredients with cardiovascular action.

- Starting thyroxine for hypothyroidism may precipitate or exacerbate angina.
- Beta-blocker and antihypertensives may impair the peripheral circulation and aggravate symptoms of intermittent claudication.
- Recreational drugs such as cocaine and amphetamine can cause arrhythmias, chest pain and even myocardial infraction.

Macleod's 114 (12th edition)

The drug history may also reveal / detect the presence of important chronic disease that the patient may have forgotten to mention.

- Antihypertensive indicates patient is hypertensive
- Hypoglycemic drugs indicates patient is diabetic *Macleod's-72(10th)*

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Symptoms related to medication:

Symptoms	Medication
Dyspnoea	• Beta-blocker in patients with asthma • Exacerbation of heart failure by beta-blocker, some calcium channel antagonist (verapamil, diltiazem), NSAID
Dizzinness	• Vasodilator e.g. nitrates, alpha-blocker, ACE inhibitor, ARB
Angina	• Aggravated by thyroxine or drug induced anaemia e.g.aspirin or NSAID
Oedema	• Steroids, NSAID, some calcium channel antagonist e.g. nifedipine, amlodipine
Palpitation	• Tachycardia and /or arrhythmia from thyroxine, β-2 stimulant e.g. salbutamol, digoxin toxicity, hypokalemia from diuretics, tricyclic antidepressants

Macleod's -104(13th)

Dietary history:

Importance:

- High fat intake is a major risk factor for coronary heart disease
- Diet deficient in fresh fruit, vegetables and polyunsaturated fatty acids are associated with an increased risk of coronary heart disease.

Davidson-581(22nd)

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RESPIRATORY SYSTEM

Name:
Importance: See page No : 23

Age:
Importance:

- Pneumonia is common at extreme of age e.g. in children and in old age.

Davidson-862(22nd)

- Lung cancer is rare below age 40, rates increasing until age 80, after which rate taper off.

Harrison's 737(18th)

Sex:
Importance:
More in male:

- Bronchial carcinoma.

Davidson-700 (22nd)

Religion:
Importance: See page No:25

Occupation:
Importance: See page No: 125

Marital Status:
Importance:

In AIDS patient, pneumocystis jirovecii pneumonia, Pulmonary TB and bacterial pneumonia are very common

Davidson-400(22nd)

So, partner notification is important in this case.

Address:
Present :
Permanent :
Importance: See page No: 26

Date of admission:
Date examination:
Importance: See page No:26

Chief complaints:

1. Breathlessness
2. Cough
3. Sputum
4. Haemoptysis
5. Wheezing
6. Chest pain

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History of present illness

It includes:

1. Elaboration of chief complaints.
2. Elaboration of other complaints gathering during history taking.
3. Important negative history to exclude differential diagnosis.
4. History of appetite, bowel, bladder and sleep pattern.
5. History of weight loss
6. History of chronic co-morbid disease like diabetes, hypertension, IHD, CKD should be mentioned.

COUGH

Common causes:

Origin	Common cause	Clinical features
Pharynx	Post nasal drip	History of chronic rhinitis
Larynx	Laryngitis, tumor, whooping cough,	Voice or swallowing altered, harsh or painful cough, paroxysm of cough, often associated with stridor
Trachea	Tracheitis	Raw retrosternal pain with cough
Bronchi	Bronchitis (acute) and COPD	Dry or productive, worse in morning
	Asthma	Usually dry, worse at night
	Eosiniphilic bronchitis	Features similar to asthma but airway hyper reactivity absent
	Bronchial carcinoma	Persistent (often with haemoptysis)
Lung parenchyma	Tuberculosis	Productive (often with haemoptysis)
	Pneumonia	Dry initially, productive later
	Bronchiectasis	Productive, changes in posture induce sputum production
	Pulmonary oedema	Often at night (may be productive of pink, frothy sputum)
	Interstitial lung disease	Dry and distressing
Drug side effect	ACE inhibitor	Dry cough

Davidson-654(22nd)

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Questions with importance:

1. How long has the cough been present?

Importance:

Acute (3 week):

i. Respiratory tract infection
ii. Aspiration event
iii. Inhalation of noxious chemicals or smoke

Sub acute (3-8 weeks):

- Residual product from tracheobronchitis
- Post viral bronchial hyperresponsiveness

Harrison-283(18th)

Chronic (>8 weeks):

Wide variety of cardio pulmonary disease including inflammatory, infection, neoplastic and cardiovascular cause:

i. Chronic bronchitis
ii. Asthma
iii Bronchiectasis
iv. Chronic heart failure
v. Pulmonary TB
vi. Lung tumor
vii. Intestitial lung disease

Chamberlain's-103(12th)

2. Is it dry or productive?

Importance:

Dry cough:

- Interstitial lung disease
- Early stage of pulmonary infection
- ACE inhibitor
- Bronchial carcinoma (may be productive)

Chamberlain's - 103(12th)

Productive:

- Chronic bronchitis
- Bronchiectasis
- Lung abscess
- Pulmonary edema

3. Is the cough worst in a particular time of day or night ?

Importance:

- In the morning → COPD
- In the early morning (At 2 to 4 am) → Asthma
- At night → Heart failure

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- Related to posture, aggravates on lying → Bronchiectasis / Heart failure

Index of differential diagnosis of disease 132(13th)

4. Is it aggravated by anything, for example dust, pollen or cold air ?

Importance:

- Aggravates by dust, pollen or cold air suggests asthma

Davidson-667(22nd)

5. Is it painful or not?

Importance:

Painful cough:

- Tracheitis
- Laryngitis
- Bronchial carcinoma (may be painless)

6. Is any change in voice?

Importance:

- A change in character of a smoker's cough particularly associated with other new symptoms raises the suspicion of bronchial carcinoma.

Davidson-700(22nd)

- In bronchial carcinoma, involvement of left recurrent laryngeal nerve causes vocal cord paralysis, voice alteration and bovine cough.

Davidson-701(22nd)

- Chronic hoarseness of voice occur in
  - i. Chronic laryngitis
  - ii. Tumor of the larynx
  - iii. Laryngeal TB
  - iv. Laryngeal paralysis

Davidson-727(22nd)

Question: Hutchison's (20th)page60(q.1, 3, 4)page 12(q.2, 5), IDDD-6(13th)

Presentation in history:

The patient also complained of cough which was productive in nature. The sputum was copious in amount, yellowish in colour, foul smelling and more marked on lying position. He did not give any history of coughing out of blood.

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COUGHING OUT OF BLOOD (HAEMOPTYSIS)

Common causes:

Bronchial disease:

- Bronchial carcinoma
- Bronchiectasis
- Acute bronchitis
- Bronchial adenoma
- Foreign body

Parenchymal disease:

- Tuberculosis
- Suppurative pneumonia
- Parasites (e.g. hydatid disease, flukes)
- Lung abscess
- Trauma
- Actinomycosis
- Mycetoma

Lung vascular disease:

- Pulmonary infarction
- Good pasture's syndrome
- Polyarteritis nodosa
- Idiopathic pulmonary haemosiderosis

Cardiovascular disease:

- Acute left ventricular failure
- Mitral stenosis
- Aortic aneurysm

Blood disorders:

- Leukaemia
- Haemophilia
- Anticoagulants

Davidson-659(22nd)

Questions with importance:

1. **Ask about evidence the blood was coughed.**

a. **Is it preceded by coughing or vomiting ?**

Importance:

- By coughing → Haemoptysis
- By vomiting → Haematemesis

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b. Is its colour bright red or altered?

Importance:

- Bright red →Usually haemoptysis
- Altered blood →Usually haematemesis

c. *Is blood associated with frothy sputum or gastric contents ?*

Importance:

- Associated with frothy sputum →Haemoptysis
- Associated with gastric contents →Haematemesis

2. *Amount of blood: Was the sputum subsequently stained ?*

Importance:

- A history of repeated small haemoptysis, or blood-streaking of sputum, is highly suggestive of bronchial carcinoma.

  Davidson-658(22nd)

- Haemoptysis with purulent sputum suggest infection
- Coughing up large amounts pure blood is rare but potentially life threatening, causes are:
  i. Lung cancer
  ii. Bronchiectasis
  iii. Pulmonary tuberculosis
  iv. Lung abscess
  v. Aortobronchial fistula
  vi. Wegner's granulomatosis
  vii. Mycetoma, Cystic fibrosis

  Macleod's-142(13th)

- Intermittent haemoptysis associated with copious purulent sputum over years → Bronchiectasis

  Macleod's-142(13th)

- Blood streaking of mucopurulent or purulent sputum, regular in the morning often suggests →Bronchitis

  Harrison-206(15th)

- Haemoptysis associated with current or former cigarette smoking most commonly due to bronchial carcinoma, chronic bronchitis.

  Harrison-285(18th)

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3. *Ask about duration and frequency*

Importance:

- Daily haemoptysis for a week or more
  i. Lung cancer
  ii. Pulmonary TB
  iii. Lung abscess
- Intermittent haemoptysis associated with copious purulent sputum over year:Bronchiectasis
- Single episode of haemoptysis associated with pleuritic chest pain and dyspnoea suggests pulmonary embolism and infarction. *Macleod's-142(13th)*
- Monthly haemoptysis in a woman suggests catamenial haemoptysis from pulmonary endometriosis. *Harrison-285(18th)*

4. *Ask about previous symptoms of respiratory or heart disease*

Importance:

- Haemoptysis associated with low grade fever, night sweat and weight loss suggests pulmonary tuberculosis. *Davidson-658(22nd)*
- Fever and foul smelling of sputum indicates lung abscess, bronchiectasis
- Fever and copious sputum production suggests bronchiectasis
- Associated with arthralgia, myalgia, weight loss, fever, H/O hepatitis B → Poly arteritis nodosa
- Associated with haematuria → Good pasture's syndrome, bleeding disorder
- Assoiated with skin/mucous membrane bleeding → Bleeding disorders
- Associated with epistaxis → Wegner's granulomatosis, hereditary haemorrhagic telangiectasia, bleeding disorder.
- Associated with H/O rheumatic fever or chronic rheumatic heart disease and with other features of MS → May be due to mitral stenosis. *Questions: Chamberlain's-15(12th)*

Presentation of haemoptysis: He also complains of coughing out of blood for last 7 days which is bright red in colour, scanty in amount and blood streaking of sputum. It is not associated with red urine or bleeding from any site of body.

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SPUTUM

Sputum: Sputum is mucous produced from respiratory tract.

Macleod's-140(13th)

Questions with importance:

1. How much sputum is produced (amount)?

Importance:

- Increased amount:
  - i. Bronchiectasis
  - ii. Lung abscess
  - iii. When empyema ruptures in to bronchus
  - iv. Resolution stage of pneumonia

Chamberlain's-103(12th)

- Often a cupful → Bronchiectasis
- Scanty amount → Asthma
- Suddenly coughing up large amounts of purulent sputum on a single occasion suggests rupture of a lung abscess or empyema in to bronchial tree.
- Large volume of watery sputum with a pink tinge in an acutely breathless patient suggests pulmonary edema, but if occurring over weeks (bronchorrhoea), suggests alveolar cell cancer.

Macleod's-141(13th)

2. What is the consistency, colour and odour

Importance:

Consistency:

- Serous (Clear, frothy) → Acute pulmonary edema
- Mucoid (clear, gray, white, may be frothy or black)
  - i Chronic bronchitis/COPD
  - ii. Chronic asthma

Colour:

- **Clear, watery, frothy (may be blood streaked or pink):** Acute pulmonary edema.
- **Clear or mucoid**: Chronic bronchitis, COPD with no active infection
- **White, viscid**: Asthma

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- **Yellow**: acute lower respiratory tract infection (live neutrophil) and in asthma (due to eosinophils)
- **Green purulent sputum (dead neutrophils)**:

  Longer standing infection

  i. Pneumonia
  ii. Bronchiectasis
  iii. Lung abscess

  Purulent sputum is green because lysed neutrophils release the green pigmented enzyme, verdoperoxidase.
- **Rusty red**: Pneumococcal pneumonia

Macleod's-141(13th)

Taste or smell:

Foul smelling sputum suggests anaerobic bacterial infection and occurs in:

i. Bronchiectasis
ii. Lung abscess
iii. Empyema (When empyema ruptures in to bronchus)

In bronchiectasis, a change of sputum taste may indicate an infective exacerbation.

Macleod's-141(13th)

Types of sputum:

Type	Appearance	Cause
Serous	Clear, watery Frothy, pink	Acute pulmonary edema, Alveolar cell cancer
Mucoid	Clear, gray	Chronic bronchitis/COPD
	White, viscid	Asthma
Purulent	Yellow	Acute bronchopulmonary infection, asthma (eosinophils)
	Greeen	Longer standing infection, Pneumonia, Bronchiectasis, Lung abscess
Rusty	Rusty red	Pneumococcal pneumonia

Macleod's-141(13th)

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3. ***Most produce at what time of day?***

Importance:

- In the morning
  - i. Bronchitis
  - ii. Bronchiectasis

4. ***Is it even blood stained and if so, whether with streaks or clots and on how many occasions?***

Importance:

- Blood streaked clear sputum or clots in sputum for more than a week suggests lung cancer
- Haemoptysis with purulent sputum suggests infection
- Coughing up large amounts of pure blood is rare but potentially life threatening, causes are:
  - i. Lung cancer
  - ii. Bronchiectasis
  - iii. Pulmonary tuberculosis
  - iv. Lung abscess
  - v. Aortobronchial fistula
  - vi. Wegner's granulomatosis
  - vii. Mycetoma
  - viii. Cystic fibrosis

Macleod's-141+142(13th)

- Recurrent episodes of haemoptysis for many years usually associated with purulent sputum indicates → Bronchiectasis

Macleods-120(10th)

- Blood streaking of mucopurulent or purulent sputum regular in the morning often suggests →Bronchitis

Harrison-206(15th)

- Haemoptysis associated with current or former cigarette smoking most commonly due to bronchial carcinoma.

Harrison-285(18th)

5. ***Relation: Is it related with posture or anything?***

Importance:

- Varies with posture → Bronchiectasis, pulmonary oedema

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WHEEZE (RHONCHI)

Definition:

Wheeze is a high-pitched whistling sound produced by air passing through narrowed small airways.

Some causes of wheezing:

Causes	Suggestive findings
Acute bronchitis	URTI symptoms, no known history of lung disease
Allergic reaction	Sudden onset, usually within 30 minute of exposure to known or potential allergen. Often accompanied by nasal congestion, urticaria, itchy eyes and sneezing
Asthma	Often known history of asthma. Wheezing arises spontaneously or after exposure to specific stimuli (e.g. allergen, URTI, cold, exercise)
COPD exacerbation	Middle aged or elderly patient. Often known history of COPD, extensive smoking history
Bronchiolitis	In children<18 months; usually upper RTI symptoms, tachypnoea
Foreign body	Sudden onset in a young child who has no URTI or allergic symptoms
Endobronchial tumor	Fixed and constant inspiratory and expiratory wheezes, especially in a patient with risk factors for or sign of cancer (e.g. smoking history, night sweat, weight loss, haemoptysis)
LVF/Pulmonary edema (cardiac asthma)	Crakles and sign of central or peripheral volume overload (e.g. elevated neck veins, peripheral edema); dyspnoea with lying flat (orthopnoea) or that appears 1-2 hours after falling asleep (PND).
GERD with chronic aspiration	Chronic or recurrent wheezing; often with heart burn, nocturnal cough; no URTI or allergic symptoms
Drugs (e.g. ACE inhibitor, Aspirin, β-Blocker, NSAIDS	Recent initiation of new drug, most often in a patient with a history of reactive airway disease.

The mark manual of patient symptoms page 597 (1st)

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Questions with importance:

1. When does wheezing occur ?

Importance:

- Wheeze on exercise is common in asthma and COPD.
- Night wakening with wheeze suggests asthma or parosymal nocturnal dyspnoea, but wheeze after wakening in the morning suggests COPD.

Macleod's-140(13th)

Expiratory wheezing:

- Asthma
- Emphysema

Inspiratory wheezing:

- Tracheal or laryngeal obstruction.

2. Is it constant or intermittent?

Importance:

Acute wheezing:

- Sudden onset of wheezing in the absence of URTI symptoms suggests an allergic reaction or impending anaphylaxis especially if urticaria or angioedema is present.
- Associated with fever and URTI symptoms suggests infection
  - Acute bronchitis in older children and adult
  - Bronchiolitis in children <2 years
- Associated with crackles, distended neck veins and peripheral edema suggests heart failure
- Wheezing associated feeding in infants can be a result of gastroesophageal reflux disease.

Intermittent wheezing: It indicates asthma

Persistent wheeze:

- Localized persistent wheezing suggests focal bronchial obstruction by a tumor or foreign body.
- Persistent wheezing manifesting very early in life suggests a congenital or structural abnormality.
- Persistent wheezing with sudden onset is consistent with foreign body aspiration, whereas the slowly progressive onset of wheezing may be sign of extraluminal bronchial obstruction.

The mark manual of patient symptoms page 598

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3. ***Does anything provoke it?***

Importance:

- Cold air, dust or exercise provoke wheeze in asthma.

4. ***Is it worse at any particular time of day or night?***

Importance:

- Night wakening with wheeze suggests asthma.
- Wheeze after awakening in the morning suggests COPD

Macleod's-140(13th)

Breathlessness: See page No : 92
Chest pain: See page No : 85

History of past illness:

Importance:

Enquire about previous respiratory and non respiratory illness.

Past History	Present condition
Eczema, hay fever	Allergic tendency relevant to asthma
Recurrent childhood viral-associated wheeze	Relevant to adult-onset (recurrence of) asthma
Whooping cough, measles	Recognized cause of bronchiectasis
Pneumonia, pleurisy	Recognized cause of bronchiectasis
Tuberculosis	Reactivation, relapsed, fibrosis, corpulmonale, bronchiectasis
Connective tissue disorders, e.g. rheumatoid arthritis	Pulmonary fibrosis, effusion, bronchiectasis
Previous malignancy	Recurrence, metastatic/pleural disease, chemotherapeutic agents causes pulmonary fibrosis, radiotherapy induced pulmonary fibrosis
Recent travel, immobility, cancer	Pulmonary thromboembolism
Recent surgery, loss of consciousness	Aspiration of foreign body, gastric contents, pneumonia, lung abscess
Neuromuscular disorders	Respiratory failure, Aspiration

Macleod's-145(13th)

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Drug history

Importance:

Examples of drug induced respiratory disease:

Respiratory condition	Drug
Bronchoconstriction	Beta-blockers, Opoids, NSAIDs
Cough	ACE inhibitor
Bronchiolitis obliterans	Penicillamine
Diffuse parenchymal lung disease (DPLD)	**Cytotoxic agents**:Methotraxate, bleomycin **Anti-inflammatory agents**: Sulfasalazine, Penicillamine, gold salts, aspirin **Cardiovascular drugs:** Amiodarone, hydralazine **Antibiotics**: Nitrofurantoin **Intra venous drug misuse** **Radiation**
Pulmonary thromboembolism	Oestrogens
Pulmonary hypertension	Oestrogens, Dexfenfluramine, Fenfluramine
Pleural effusion	Amiodarone, nitrofurantoin, phenytoin, methotraxate
Respiratory depression	Opioids, benzodiazepines

Macleod's-146(13th)

Family history:

Importance:

- Some autosomal recessive disorders:
  - Cystic fibrosis
  - α-1 anti trypsin deficiency (associated with emphysema and COPD)
- Asthma often run in family.
- A family history of tuberculosis can represent significant past exposure that may reactivate later in life.

Macleod's-145(13th)

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Occupational history:

Importance:

Many problems such as asbestos exposure or silicosis produce effects many years later after exposure.

Hutchison's - 8(21st)

Most of the toxic substance enters body by inhalation, also some solvents penetrate the skin.

Example of occupational lung disease:

Lung disease	Exposure	Occupation
Pulmonary fibrosis	Asbestos	Shipyard/construction worker, plumbers, boiler makers
	Quartz (silica)	Stone cutter, stone masons, quarry workers
	Coal	Coal miners
	Beryllium	Nuclear, aerospace industries
COPD	Coal	Coal miners
Malignancy	Asbestos	Shipyard/construction worker, plumbers, boiler makers
	Radon	Metal miners
Asthma	Jute mill dust	Jute mill
	Grains, flour	Farmers, bakers, millers
	Hardwood dusts	Joiners, carpenters
	Colophony	Soldering, welders
	Fomaldehyde, paraldehyde, latex	Hospital worker
Hypersensitivity pneumonitis	Fungal spores of thermophilic actinomycetes or micropolyspora faeni	Farm workers exposed to mouldy hay

Macleod's -146(13th)

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Example of lung disease caused by organic dust:

Disorder	Occupation deals with
Asthma	Jute mills *Parks 559(16th)*
Byssinosis i. Chronic bronchitis ii. Emphysema	Textile industry *Parks 559(16th)*
Bird fancier's lung	Avian excreta, proteins and feathers
Farmer's lung	Mouldy hay, straw, grain

Davidson-719(22nd)

Example of lung disease caused by inorganic dust:

Cause	Occupation	Description	Characteristics pathological features
Coal dust	Coal mining	Coal workers pneumoconiosis	Focal and interstitial fibrosis, centrilobular emphysema, progressive fibrosis
Silica	Mining, stone dressing, metal grinding, pottery, boiler scalding	Silicosis	Focal and interstitial fibrosis, centrilobular emphysema, progressive fibrosis
Asbestos	Ship breaking, manufacture of fireproof insulating materials, pipe and boiler lagging	Asbestos related disease	Pleural plaques, diffuse pleural thickening, acute benign pleurisy, carcinoma of lung, interstitial fibrosis, mesothelioma
Iron oxide	Arc welding	Siderosis	Mineral deposition only
Tin oxide	Tin mining	Stannosis	Tin –laden macrophages
Beryllium	Aircraft atomic energy and electronics industries	Berylliosis	Granulomas, interstitial fibrosis

Davidson-717(22nd)

Personal history:

Importance:

- Smoking: Bronchial carcinoma, COPD

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ALIMENTARY SYSTEM

Name:

Importance: See page No: 23

Age:

Importance:

More in infant:

- Diarrhoea *Davidson -306(22nd)*
- Wilm's tumor
- Midgut volvulus
- Hypertrophic pyloric stenosis *Bailey & love's-809(23rd)*

More in children:

- Appendicitis
- Round worm intestinal obstruction

More in young adult:

- Irritable bowel syndrome
- Appendicitis. *Bailey & love's-1078(23rd)*
- Apthous ulcer

More in middle age:

- Peptic ulcer, also in young adult & old age
- Zollinger ellision syndrome (30 to 50 year of age)
- Achalasia (Between 25-60 years of age) *Harrison-2340(18th*
- Diverticulosis *Davidson -916(22nd)*
- Primary biliary cirrhosis *Davidson -963(22nd)*

More in old age:

- Hiatus hernia (over 50 years of age) *Davidson -865(22nd)*
- Carcinoma of gallbladder (over 70 years)
- Colorectal cancer (>50 years of age) *Davidson 912(22nd)*
- Gastric carcinoma (>50 years of age) *Davidson 877 (22nd)*

Sex:

Importance:

More in male:

- Peptic Ulcer *Davidson 872(22nd)*
- Gastric carcinoma *Davidson -789(19th)*
- Whipple's disease *Davidson - 884(22nd)*

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More in female:

- Gall stone *Davidson 981(22nd)*
- Carcinoma of gall bladder *Davidson 985(22nd)*
- IBS *Davidson 907(22nd)*
- Auto immune hepatitis *Davidson 962(22nd)*
- Primary biliary cirrhosis *Davidson 963 (22nd)*
- Apthous ulcer *Davidson 863 (22nd)*

Religion:

Importance:

- Infection with tapeworm, Taenia solium is not found in Muslims, because its intermediate host is pig.
- Infection with Taenia saginata is not found in Hindus, because its intermediate host is cow & buffalo. *K.D.Chatterjee116(12th)*
- Inflammatory bowel disease is more common in Ashkenazi jews. *Davidson-898(22nd)*

Marital status:

Importance:

- Chronic diarrhoea is a very common presenting problem in patients with advanced HIV.
- Concomitant oral candidiasis is present in about 70% of patients. *Davidson-399(22nd)*

So, in case of AIDS, partner notification is essential.

Address:

Importance:

1. For identification of the patient, communication to and follow up.
2. Geographical importance:
   - Gastric carcinoma is common in china, Japan, Korea and parts of South America. *Davidson-877(22nd)*
   - Carcinoma of oesophagus is common in Iran, South Africa & China. *Davidson-870(22nd)*
   - Coeliac disease is more common in Northern Europe. *Davidson-880(22nd)*

Date of admission:

Date of examination:

Importance: See page No: 26

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Chief complaints:

- Abdominal pain
- Vomiting
- Diarrhoea
- Constipation
- Haematemesis
- Melaena
- Dysphagia
- Heartburn
- Indigestion
- Abdominal distension
- Flatulence

History of present illness

It includes:

1. Elaboration of chief complaints.
2. Elaboration of other complaints gathering during history taking.
3. Important negative history to exclude differential diagnosis.
4. History of appetite, bowel, bladder and sleep pattern.
5. History of weight loss.
6. History of chronic co-morbid conditions like diabetes, hypertension, IHD, CKD should be mentioned.

ABDOMINAL PAIN

Non alimentary causes of abdominal pain:

Disorder	Clinical features
Myocardial infarction	Epigastric pain without tenderness, anger animi (feeling of impending death), hypotension, cardiac arrhythmia
Dissecting aortic aneurysm	Tearing inter scapular pain, anger animi, hypotension, asymmetry of femoral pulses
Pleurisy	Lateralized pain on coughing, chest sign e.g. pleural rub
Acute vertebral collapse	Lateralized pain, restricting movement, tenderness overlying the involved vertibra
Cord compression	Pain on percussion of thoracic spine, hyperesthesia in dermatomal distribution, spinal cord signs
Herpes zoster	Hyperesthesia in dermatomal distribution, vesicular eruption
Diabetic keto acidosis	Cramp like pain, vomiting, air hunger, tachycardia, ketonic breath
Salpingitis or tubal pregnancy	Supra pubic and iliac fossa pain, localized tenderness, nausea, vomiting, fever
Torsion of testis or ovary	Lower abdominal pain, nausea, vomiting, localized tenderness

Macleod's -171(13th)

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Common causes of acute abdomen:

Pathology	Disease
Inflammation	Acute appendicitis Acute cholecystitis Acute pancretitis Diverticulitis Salpingitis
Obstruction	Intestinal obstruction Biliary obstruction Ureteric obstruction Urinary retention
Ischemia	Strangulated hernia Volvulous Thromboembolism Torsion of overian cyst
Perforation	Perforated peptic ulcer Perforated diverticulum Perforated cancer Biliary peritonitis
Rupture	Ruptured ectopic pregnancy Ruptured aneurysm

Macleod's -189(13th)

Questions with importance:

1. Site:

Where is it?

The patient is asked to indicate the site of pain with tip of one finger (pointing test). If the pain is diffuse, the patient will obviously use his whole hand instead of one finger to locate its site.

Importance:

- Visceral abdominal pain from distension of hollow organs, mesenteric traction or excessive smooth muscle contraction is deep and poorly localized in midline. It is conducted by sympathetic splanchnic nerve.
- Somatic pain from parietal peritoneum and abdominal wall is lateralized and localized to the area of inflammation. It is conducted by intercostal nerve.
- Pain above umbilicus arises from foregut structure (stomach, pancrease, liver and biliary system).

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- Central abdominal pain arises from midgut structures (small bowel and appendix).
- Lower abdominal pain arises from hind gut structures (colon).
- Pain at the flank → Renal origin is considered.
- Pain below the right costal margin → Liver or gall bladder disease is suspected.
- Localized pain on skin or superficial structure which can be reproduced by local pressure → Abdominal wall pain.

Macleod's -169(13th)

Pain in epigastric region:

- Peptic ulcer
- Pancreatitis
- Myocardial infarction
- Biliary colic
- Ruptured aortic aneurysm
- Acute cholecystitis (70% of cases)

Pain in right hypochondrium:

- Acute cholecystitis (20% cases)
- Hepatitis
- Right kidney pathology
- Subphrenic abscess
- Colonic cancer at hepatic flexure

Pain in left hypochondrium:

- Renal colic.
- Carcinoma of stomach
- Carcinoma of colon (at splenic flexure)
- Large kidney or spleen

Pain in left iliac fossa:

Acute:

- Ureteric colic
- Diverticulitis
- Salpingitis
- Volvulus
- Pelvic abscess

Chronic:

- Constipation
- Irritable bowel syndrome
- Inflammatory bowel disease
- Carcinoma of large intestine
- Hip pathology

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Pain in right iliac fossa:

- All causes of left iliac fossa except diverticulitis
- Acute appendicitis

2. Character: ***What is it like?***

Importance:

- Description of the character of a pain (e.g. stabbing, burning, pricking and gnawing) may be helpful.
- Inflammation usually produces constant pain exacerbated by movement or coughing.
- Colicky pain arises from hollow structure e.g. small or large bowel obstruction, uterus, ureter etc.

Colicky pain

Sharp intermittent gripping pain which come on suddenly & disappears suddenly.

It indicates

- Obstruction to a hollow organ
  a. Intestinal obstruction
  b. Biliary colic
  c. Renal colic
  d. Ureteric colic
- Bacillary dysentery *Davidson-345(22nd)*
- Irritable bowel syndrome *Davidson-907(22nd)*

Burning pain

- Peptic ulcer

Throbbing pain

- Suggests inflammation
  a. Hepatitis
  b. Cholecystitis

3. Radiation:

Does it stay in one place or does it move or spread?

Importance:

- Acute cholecystitis → From right hypochondrium to tip of the right shoulder and interscapular region. *Davidson-983(22nd)*
- Renal colic →Pain radiating from loin to groin & genitalia.
- Acute appendicitis → Central abdominal pain which later shift to right iliac fossa.

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- Acute pancreatitis → Central upper abdominal pain radiating to the back which partially relieved by leaning forward.
- The combination of severe back and abdominal pain may indicate ruptured or dissecting abdominal aortic aneurysm.

Macleod's-170(13th)

- Biliary colic → Inferior angle of right scapula.

4. Onset & duration:

When & how did it start (suddenly or gradually) ? Has it changed since it began ? When does it come and when does it go?

Importance:

- A sudden onset of severe abdominal pain which progresses rapidly → suggests.
  i. Perforation of a hollow viscus
  ii. A ruptured abdominal aortic aneurysm
  iii. Mesenteric arterial occlusion
- Prior dyspepsia suggests peptic ulceration is the cause of perforation. Preceding constipation suggest colorectal cancer or diverticular disease is the cause of perforation.
- Coexisting peripheral vascular disease, hypertension, heart failure or atrial fibrillation may suggest aortic aneurysm or mesenteric ischemia.
- Development of circulatory failure following onset of pain suggest intra abdominal sepsis or bleeding e.g. ruptured aortic aneurysm or ectopic pregnancy.
- Torsion of the testis or ovary produces severe acute abdominal pain and nausea.
- Torsion of the caecum or sigmoid colon (volvulus) presents with sudden abdominal pain associated with acute intestinal obstruction.

Macleod's-169(13th)

- Pain of slower onset that progress over hour or days suggests Inflammatory disorder
  i. Acute cholecystitis
  ii. Acute appendicitis

Macleod's-171(13th)

- Pain due to gastric or other visceral carcinoma often starts gradually and become more severe and continues as time go on.

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5. Periodicity:

Does the patient have interval of freedom? If so for how long?

Importance:

Peptic ulcer is a chronic condition with spontaneous relapse and remission lasting for decades. The most common presentation is recurrent abdominal pain which has three notable characteristics; localization to the epigastrium, relationship to the food and episodic occurrence.

Davidson-873(22nd)

6. Aggravating factors:

What makes it worse? Any particular kind of food precipitate it?

Importance:

- Walking & sudden movement
  - i. Acute cholecystitis
  - ii. Acute appendicitis
  - iii. Ureteric colic
- Stooping (Bending forward) → Hiatus hernia, Reflux oesophagitis
- Act of micturition → Ureteric colic, Pelvic appendicitis, pelvic abscess
- Spicy food → Peptic ulcer

S. Das - 337(5th)

7. Relieving factors:

What makes it better?

Importance:

- Vomiting → Peptic ulcer (Gastric rather than duodenal ulcer)

Davidson -634(19th)

- Vomiting relieves pain temporarily which reappears immediately → In colics
- Relieves by defecation → Irritable bowel syndrome
- Mohammedans prayer position (knee elbow position) →Pancreatitis
- Evacuation of bladder or rectum → These organ is source of origin

S.Das-337(5th)

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8. Severity:

Does it interfere with daily activities?

Does it keep the patient awake at night?

Importance:

- In duodenal ulcer, patient awaken at night.
- Pain of perforation, intestinal obstruction are so severe that any physical activity is not possible.
- Excruciating pain, poorly relieved by opioid analgesia, suggests an ischemic event, e.g. bowel infarction or ruptured abdominal aortic aneurysm.

9. Associated symptoms:

Have you any other problems?

Importance:

- Associated with vomiting / Diarrhoea/ Constipation → Disorder of intestinal tract.
- Associated with fever → suggest inflammation e.g.

  Acute appendicitis, acute cholecystitis
- Nausea and vomiting may accompany any very severe pain
- Abdominal pain due to irritable bowel syndrome, diverticular disease or colorectal cancer is invariably accompanied by alteration in bowel habit.
- Severe vomiting without significant pain suggests gastric outlet or proximal small bowel obstruction.

Macleod's-171(13th)

Presentation in history: The patient complains of right upper abdominal pain which is throbbing in character and radiates to tip of right shoulder. Pain aggravates by taking fatty food and reduces on empty stomach.

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VOMITING

Expulsion of gastric contents via mouth is called vomiting.

Macleod's-172(13th)

Non alimentary causes of vomiting:

Neurological:

- Raised intracranial pressure, e.g. meningitis, brain tumor
- Labyrinthitis and meniere's disease
- Migraine
- Vasovagal syncope, shock, fear and severe pain e.g. renal colic, myocardial infarction

Drugs:

- Alcohol, opioids, theophylline, digoxin, cytotoxic agents, antidepressants

Metabolic/endocrine

- Pregnancy
- Diabetic ketoacidosis
- Renal failure
- Liver failure
- Hypercalcemia
- Addison's disease

Psychological

- Anorexia nervosa
- Bulimia

Macleod's-172(13th)

Questions with importance:

1. General characteristics of vomited matter.

A. Amount:

Importance:

- Large amount
  - i. Pyloric stenosis
  - ii. Gastroparesis

Harrison 231(14th)

B. Colour

Importance:

Greenish/Bilous colour (indicates presence of bile):

- Intestinal obstruction (distal to pylorus)
- Gastro colic fistula

Macleod's-172(13th)

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Coffee ground/dark brown (due to degradative action of gastric pepsin)

- Bleeding from stomach

C. Taste:

Importance:

Bitter taste (due to presence of bile)

- Indicates obstruction distal to pylorus.

Macleod's-172(13th)

D. Contents:

- Undigested food :
  Regurgitation secondary to
  a. Achalasia
  b. Oesophageal stricture
- Gastric contents (not bile stained):
  Peptic ulcer
  Gastric outlet obstruction
- Bile stained vomit
  Obstruction distal to pylorus.
- In intestinal obstruction

At first stomach contents, then duodenal contents (bile stained), lastly intestinal contents.

E. Odour

Importance:

Foul smelling:

- Pyloric stenosis.
- Carcinoma of stomach (due to excessive fermentation of gastric contents).
- Gastrocolic fistula

Feculent:

- Distal small bowel obstruction
- Colonic obstruction
- Gastrocolic fistula

2. ***Ask about relation to meals, time of day, early morning or late evening.***

Importance:

Relation to meals:

- During or soon after meal
  i. Psychogenic
  ii. Peptic ulcer with pyloric spasm

Oxford -1820(3rd)

Scanned with CamScanner

- Delayed vomiting - (more than 1 hour after meal)
  i. Carcinoma of stomach
  ii. Gall bladder disease
  iii. Intestinal obstruction
  iv. Peptic ulcer *Oxford -1820 (3rd)*
- Vomiting occurs 4-6 hours or longer after eating (large quantities)
  i. Pyloric stenosis
  ii. Gastroparesis
  iii. Achalasia *Harrison-231(14th)*

Relation to time of day:

- Early morning
  i. Pregnancy
  ii. Alcoholism
  iii. Metabolic disturbance such as uraemia *Oxford-1820(3rd)*
- Latter part of the day → Pyloric stenosis

Each meal adds to the gastric content & vomiting may not occur until a large quantity accumulated. *Chamberlain's-54(12th)*

3. Is vomiting associated with dyspepsia or abdominal pain?

Importance:

- Vomiting associated with abdominal pain → Gastro intestinal origin *Macleod's-172(13th)*
- Painless vomiting → Neurogenic disorder
- Associated with severe abdominal pain -
  i. Intestinal obstruction
  ii. Renal & biliary colic
  iii. Myocardial infarction
  iv. Metabolic disorder *Macleod's-172(13th)*

4. Does it relieve dyspepsia or abdominal pain?

Importance:

- Vomiting relieves pain in peptic ulcer, intestinal obstruction
- In colics, vomiting relieves pain temporarily. So that it reappears immediately. *S.Das- 338(5th)*
- Vomiting has no effect on cholecystitis and pancreatitis pain *Harrison 309(18th)*

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6. ***Whether preceded by nausea or occurring without warning (nausea)?***

Importance:

- Vomiting is typically preceded by nausea.
- Vomiting without nausea → Raised intracranial pressure due to any cause:
  i. Intracranial tumor
  ii. Encephalitis
  iii. Hydrocephalus

Index of differential diagnosis of disease — 71(1 3th)

- Migraine, Acute meningitis, Meniere's disease, Acute labyrinthitis → Associated with nausea & vomiting

6. **What medication has the patient been taking?**

Importance:

- Drugs causing dyspepsia:

  Alcohol, opioids, theophylline, digoxin, cytotoxic agents, antidepressants and may consider any drug.

7. ***Ask about associated symptom (headache, tinnitus, diarrhoea)***

Importance:

- Associated with headache and visual field defects → Intra cranial source is considered
- Associated with pronounced weight loss raises the possibility of malignancy or intestinal obstruction.
- Associated with fever suggest inflammation
- Associated with vertigo & tinnitus. → Labyrinthine disease

Harrison 302(18th)

Question Macleod's-172(13th)

Presentation in history: He complains of vomiting for about 5-6 times per day for last 2 days. Vomitus contains undigested food material, moderate in amount, not foul smelling, not bile stained and does not contain any blood.

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DIARRHOEA

- Diarrhoea is the frequent passage of loose stools.
- Normal bowel frequency ranges from three times daily to once every 3 days.

Macleod's-172(13th)

- Diarrhoea is loosely defined as passage of abnormally liquid or unformed stool at increased frequency. *Harrison 309(18th)*
- Diarrhoea is defined as passage of more than 200 gm of stool daily. *Davidson-857(22nd)*

Common causes:

Acute:

Infective gastroenteritis

Drugs: antibiotics, cytotoxic drugs, PPIs and NSAIDs

Chronic:

Irritable bowel syndrome

Inflammatory bowel disease

Parasytic infestation e.g. giardia lamblia, amoebiasis, cryptosporidium spp.

Colorectal cancer

Autonomic neuropathy (especially diabetic)

Laxative abuse and other drug therapies

Hyperthyroidism

Constipation and foecal impaction (overflow)

Malabsorption, e.g. lactase deficiency, coliac disease

Macleod;s-174(13th)

Questions with importance:

1. Is the diarrhoea acute, chronic or intermittent ?

Importance:

Acute:

More than 90% of acute diarrhoea are caused by infectious agents; these cases are often accompanied by vomiting, fever and abdominal pain. The remaining 10% or so are caused by medications, toxic ingestions, ischemia and other conditions. *Harrison 309(18th)*

Scanned with CamScanner

Chronic or relapsing diarrhea:

The most common cause is irritable bowel syndrome, which can present with increased frequency of defecation and loose, watery or pellety stools. Diarrhoea rarely occurs at night and is most severe before and after breakfast. At other times, the patient is constipated and there are other characteristic symptom of IBS. The stool often contains mucous but never blood and 24 hour stool volume is less than 200 gm.

Davidson-857(22nd)

A. Acute (2 weeks):

a. Infectious (Bacterial or viral):

- Amoebic dysentery
- Bacillary dysentery
- Cholera

b. Drug induced

- Antibiotics
- NSAIDs
- Cytotoxic drugs.

B. Chronic:

Colonic (blood & mucous in stool except in IBS, cramping lower abdominal pain)

- Irritable bowel syndrome
- Inflammatory bowel disease
  - a. Ulcerative colitis
  - b. Crohn's disease
- Neoplasia of colon
- Ischemia of colon

Malabsorption (steatorrhoea, undigested food in stool, weight loss and nutritional disturbances)

Pancreatic:

- Chronic pancreatitis
- Carcinoma of pancrease

Enteropathy:

- Coeliac disease
- Tropical sprue
- Lymphoma

Scanned with CamScanner

Small intestinal (large volume, watery stool, abdominal bloating, cramping mid abdominal pain)

- Crohn's disease
- VIPoma
- Drugs : NSAIDs, Aminosalisylates SSRIs

Others:

- Autonomic neuropathy
- Metabolic disorder e.g. thyrotoxicosis
- Osmotic laxatives
- Infections (invasive bacteria, viruses, parasites, HIV)
- Radiation injury
- Cholecystectomy
- Ileal resection *Davidson-857(22nd) and Harrison 313(18th)*

C. **Intermittent:** (Alternate constipation with diarrhoea)

- Irritable bowel syndrome *Davidson-907(22nd)*
- Carcinoma of alimentary tract (altered bowel habit) *Davidson-914(22nd)*
- Chronic intestinal pseudo obstruction.
- Amoebic dysentery *Davidson-367(22nd)*

2. ***Is there tenesmus, urgency or incontinence?***

Importance:

Tenesmus often present in bacillary dysentery. *Davidson-345(22nd)*

3. ***Ask about frequency of motion.***

Importance:

- Normal bowel frequency ranges from three times daily to once every 3 days. *Macleod's-173(13th)*
- Diarrhoea is the frequent passage of loose stools.

4. ***Ask about character of stool***

Importance:

a. **Colour of motion:**

- In most cases of diarrhoea, stool are paler than normal especially in steatorrhoea.
- Typical rice water colour: Cholera

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b. Are they watery, unformed or semisolid? Associated with blood, mucous or pus?

- Watery → In infectious diarrhoea (most cases)
- Acute mucous and bloody diarrhoea → Amoebic infection.
  Davidson-367(22nd)
- Chronic mucous and bloody diarrhoea → Ulcerative colitis.
  Davidson-899(22nd)
- Contain blood and purulent exudate with little foecal material → Bacillary dysentery *Davidson-345(22nd)*
- Acute only bloody diarrhoea → Mesenteric arterial or venous thrombosis. *Harrison 310(18th)*
- Pellet like stool → Irritable bowel syndrome

c. Volume

- Large volume & not excessively frequent → Small intestinal disease
- Small volume & excessively frequent → Large intestinal disease

d. Do they float on the lavatory pan or they difficult to flush away?

- In malabsorption (steatorrhoea) stools are greasy, foul smelling, float on the lavatory pan and difficult to flush away
  Harrison 313(18th)

5. *Ask about food eaten, other persons affected.*

Importance:

- Occurrence of symptoms in more than one member of house hold indicates diarrhoea due to food poisoning.

Foods associated with infectious illness, including gastroenteritis:

- Raw sea food (norovirus, Hepatitis A, Vibrio spp.)
- Raw eggs (salmonella spp.)
- Undercooked meat or poultry (salmonella spp., campylobacter spp., EHEC, *C.perfringes*)
- Unpasteurized milk or juice (salmonella spp., campylobacter spp., EHEC., *Y. enterocolitica*)
- Unpasteurized soft cheeses (salmonella spp., campylobacter spp.,)
  Davidson-307(22nd)

6. Is sleep disturbed by diarrhoea?

Importance:

It suggests organic disease *Macleod's-174(13th)*

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7. **Is there a history of :**

a. **Contact with diarrhoea or of travel abroad?**

- Person to person spread suggests certain infection, such as shigellosis or cholera *Davidson-306(22nd)*
- Traveler's diarrhea:

Nearly 40% of tourists to endemic regions of Latin America, Africa and Asia develop so called traveler's diarrhoea, most commonly due to E.coli, Campylobacter, shigella, salmonella, aeromonas, norovirus, corona virus. Visitor to Russia (especially Petersburg) may have increased risk of giardia associated diarrhoea.

Harrison's -310 (18th)

b. **Relevant sexual contact**

- Gay bowel syndrome & human immune deficiency virus infection may occur.

c. **Alcohol abuse or relevant drug therapy**

- Antibiotics, NSAIDs, Cytotoxic drugs may cause diarrhoea

d. **Gastro intestinal surgery, Gastro intestinal disease or inflammatory bowel disease**

- Cholecystectomy, Ileal resection, vagotomy cause diarrhoea

e. **Family history of gastro intestinal disorders**

- In case of gluten enteropathy & crohn's disease family history is often positive.

f. **Any other gastrointestinal symptoms e.g. abdominal pain and vomiting?** It suggests GIT cause more likely.

g. **Systemic disease suggested by other symptoms e.g. arthralgia or artaritis ?** It suggests IBD

7. ***Ask about associate symptoms, any fever or weight loss?***

Importance:

- Associated with weight loss
  - i. Carcinoma *Chamberlain's- 76(12lh)*
  - ii. Malabsorption
  - iii. Crohn's disease
- Associated with fever suggests infectious cause.

Harrison 310(18th), Question: Macleod's-174(13th

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HAEMATEMESIS

Bleeding from gastrointestinal tract may present in 5 ways:

1. Haematemesis:Vomitus of red blood or coffee ground material
2. Melaena:Melaena is black, tarry, foul smelling stool.
3. Haematochezia: Is the passage of bright red or maroon blood from the rectum.
4. Occult G I bleeding may be identified in the absence of overt bleeding by fecal occult blood test or the presence of iron deficiency.
5. Patient may present with only symptoms of blood loss or anaemia such as lightheadedness, syncope, angina or dyspepsia.

Harrison-320(18th)

Common causes of haematemesis:

1	Peptic ulcer (35 - 50%)	Dyspepsia or history of previous ulcer pain.
2	Gastric erosion (10-20%)	Associated with NSAIDs and alcohol
3	Oesophagitis (10%)	Heartburn present.
4	Mallory weiss tear (5%)	Follows vomiting and retching (involuntary attempt to vomit)
5	Varices (2-4%)	Usually with evidence of liver disease.
6	Carcinoma of oesophagus or stomach (2%)	Chronic blood loss is usually present.
7	Vascular malformations (5%)	Associated with aortic valve disease or hereditary haemorrhagic telangiactasia
8	Aorto enteric fistula - (1%)	Who presents after aortic graft surgery.

Daviason-854(22nd)

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Questions with importance:

1. **Evidence that the blood was vomited.**

a. ***Is it preceded by coughing or vomiting?***

Importance:

- By coughing →Haemoptysis
- By vomiting → Haematemesis.

b. ***Is it's colour bright red or altered?***

- Bright red → May be haemoptysis.
- Altered blood → Haematemesis.

c. ***Is blood associated with frothy sputum or gastric contents?***

Importance:

- With frothy sputum → Haemoptysis.
- With gastric contents → Haematemesis

2. **Ask about amount and character of blood**

Did the vomitus comprise fresh blood or coffee ground stained fluid?

Importance:

- Fresh blood →
  - If the source of bleeding is above the gastrooesophageal sphincter, e.g. from oesophageal varices
  - If bleeding from upper GIT is rapid and profuse.
- Dark brown (Coffee grounds)
  In less severe or in less acute upper Gl bleeding

Davidson-854(22nd)

3. **Ask about appearance of stool.**

Importance:

- Melaena (passage of black, tarry, foul smelling stool containing altered blood) is due to upper GI bleeding, although haemorrhage from the right side of the colon is occasionally responsible.

  The characteristic colour and smell are the result of action of digestive enzymes and of bacteria upon haemoglobin.

Davidson 854(22nd)

- Severe upper GI bleeding sometimes cause maroon or bright red stool.

Davidson 854(22nd)

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4. **Is there previous history of dyspepsia, peptic ulceration, gastrointestinal bleeding or liver disease?**

Importance:

- It suggests peptic ulcer.
- History of liver disease suggests bleeding due to ruptured oesophageal varices.

5. **Is there a history of alcohol, NSAIDs or corticosteroid ingestion?**

Importance:

Alcohol abuse
↓
Cirrhosis of liver
↓
Portal hypertension
↓
Variceal bleeding.

Davidson 942-945 (22nd)

- NSAIDs (Diclofen etc), corticosteroid causes gastric erosions as well as haematemesis.

6. **Was the haematemeses preceded by intense retching (Involuntary attempt to vomit)?**

Importance:

It suggests mallory-weiss tears.

It occurs due to lower oesophageal mucosal tear due to the trauma of forceful retching (Mallory-weiss syndrome). The patient vomits forcefully several times and fresh blood only appears after the patient has vomited several times.

Macleod's-174(13th)

Questions: Macleod's-172(13th)

Presentation in history: He also complains of vomting out of blood 3 times a day for 2 days. It is moderate in amount, coffee ground in colour and mixed with undigested food material. He also complains of passage of black tarry stool for last one day. He does not give any history of taking pain killer but he gives the history of jaundice 2 years back.

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JAUNDICE

Common causes:

A. Increased bilirubin production:

Haemolysis (unconjugated hyperbilirubinaemia)

B. Impaired bilirubin excretion:

Congenital:

Gilbert's syndrome (unconjugated)

Hepatocellular

Viral hepatitis
Cirrhosis
Drugs
Autoimmune hepatitis

Intrahepatic cholestasis

Drugs
Primary biliary cirrhosis

Extrahepatic cholestasis

Gall stone
Carcinoma of head of pancrease
Cholangiocarcinoma

Macleod's-175(13th)

Questions with importance:

1. Has the patient noticed any yellowish colouratinon of conjunctiva or skin?

Importance:

This feature suggests jaundice

2. What is the colour of urine and stool?

Importance:

- In haemolytic jaundice, colour of urine and feces is normal, though urine may darken on standing due to oxidation of excess urobillinogen.
- In hepatocellular jaundice,

  Urine → Dark or normal (dark due to presence of conjugated bilirubin, if cholestasis occur.)

  Feces → Normal.

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- In obstructive jaundice
  Urine → Very dark (conjugated bilirubin, no urobilinogen)
  Feces → Pale (Lighter colour than normal)

Macleod's-176(13th)

3. Ask about drug and alcohol history

Importance:

- Drugs e.g. rifampicin, isoniazide, paracetamol (over dose), chlorpromazine, amiodarone, statins, Co-amoxiclav, methotraxate may cause jaundice. *Daviason-971(22nd)*
- Alcohol is one of the most common cause of chronic liver disease. *Daviason-957(22nd)*

4. Ask about exposure to I/V drug or blood transfusion.

Importance:

- Hepatitis B and C may occur from transfusion of infected blood or by injection with contaminated needles.

5. Is there any sexual or contact history?

Importance:

- HBsAg or HBV-DNA present in the body fluid such as saliva, urine, semen and vaginal secretion.
- So, personal contact (lip kiss), sexual intercourse (homosexual & hetero sexual) is the route of Hepatitis B and C transmission.

6. *Does the skin itch or presence of rigor?*

Importance:

- Itching occurs in obstructive jaundice and occasionally in hepatocellular jaundice (if cholestasis occur) due to deposition of bile salts in skin. *Daviason-937(22nd)*
- Jaundice associated with the sudden onset of severe upper quadrant pain & shaking chills suggests choledo-colithiasis and ascending cholangitis. *Harrison 327(18th)*

7. Have there been any other cases of jaundice among family, friends or work mates?

Importance:

- From family history : Congenital haemolytic jaundice due to
  a. Hereditary spherocytosis
  b. Thalassaemia
  c. Sickle cell anaemia
- From friends, work mates as well as family → Viral hepatitis

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8. Ask about travel history and immunization history.

Importance:

- Hepatitis A and E are transmitted by faecal-oral route.
- Hepatitis E is endemic in india and middle east.

So, increase in chance of infection is seen in travelers from an endemic area. *Davidson-955(22nd)*

9. Ask about history of skin tattooing is present or not.

Importance:

- Tattooing means procedure to produce a certain design, picture or name in skin, which is done commercially.
- Hepatitis B or C can occur by this way.

Macleod's-176(13th)

10. Ask about any history of gastrointestinal bleeding, previous jaundice or hepatitis

Importance:

- H/O gastrointestinal bleeding, previous jaundice or hepatitis suggests CLD

11. Ask about associated symptoms (Pain, Gastrointestinal disturbance, Rigor)

Importance:

- Associated with impairment of taste, nausea, vomiting & upper abdominal discomfort suggest → hepatocellular jaundice
- Obstructive jaundice may be accompanied by pruritus (generalized itch) due to skin deposition of bile salt.
- Obstructive jaundice with abdominal pain is usually due to gall stone; if fever or rigor also occur, ascending cholangitis is likely. *Macleod's-176(13th)*
- Painless obstructive jaundice suggests malignant biliary obstruction e.g. cholangiocarcinoma or cancer of head of pancrease. *Macleod's-176(13th)*
- Associated with other stigmata of CLD → Cirrhosis of liver

Question:Macleod's-176(13th

Presentation in history: He also complains of yellowish coloration of skin, sclera and mucous membrane for 7 days. It is associated with intense itching all over the body, pale stool and dark urine. He did not give any history of bloody vomiting, black, tarry stool, or any kind of hepatotoxic drug ingestion. He did not give any history of blood transfusion, needle sharing during intra venous drug abuse, or unprotected sexual exposure.

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DYSPHAGIA

Common Causes:

Oral:

- Tonsilitis, peritonsillar abscess, pharyngitis, glandular fever
- Painful mouth ulcer

Neurological

- Bulbar or pseudobulbar palsy,
- Cerebrovascular accidents

Neuromuscular:

- Achalasia
- Myasthenia gravis
- Oesophageal dysmotility
- Pharyngeal pouch

Mechanical:

- Oesophageal cancer
- Peptic oesophagitis
- Benign peptic stricture
- Other benign strictures e.g. after prolonged nasogastric intubation
- Extrinsic compression e.g. lung cancer, thyroid carcinoma
- Systemic sclerosis
- Gastric carcinoma at cardiac end

Macleod's-172(13th)

Questions with importance:

1. Is dysphagia painful or painless?

Importance:

Painful dysphagia

- Tonsilitis, peritonsillar abscess, glandular fever, candidiasis
- Painful mouth ulcer
- Infectious or pill induced oesophagitis
- Caustic injury, chemotherapy induced mucositis
- Sclerotherapy
- Crohn's disease, behcet's syndrome

Harrison-300(18th)

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Painless dysphasia:

- Tumor → Oesophageal carcinoma
  → Gastric carcinoma
  → Bronchial carcinoma (By extrinsic compression).
- Denervation of oesophagus

2. Is difficulty initiating swallow or food sticking after swallowing?

Imporatnce:

- Difficulty in initiating swallow indicates oropharyngeal dysphagea.

  Patient also complains of choking, nasal regurgitation or tracheal aspiration.
- Difficulty or food sticking after swallow indicates oesophageal dysphagia.

Davidson 852(22nd)

Some causes of oropharyngeal dysphagia:

Neurologic:

- Stroke
- Parkinson's disease
- Multiple sclerosis
- Some motor neuron disorders (amyotrophic lateral sclerosis, progressive bulbar palsy, pseudobulbar palsy)
- Bulbar poliomyelitis

Muscular:

- Myasthenia gravis
- Dermatomyositis
- Muscular dystrophy
- Cricopharyngeal incoordination

Some causes of oesophageal dysphagia

Motility disorder:

- Achalasia
- Diffuse oesophageal spasm
- Systemic sclerosis
- Eosinophilic esophagitis

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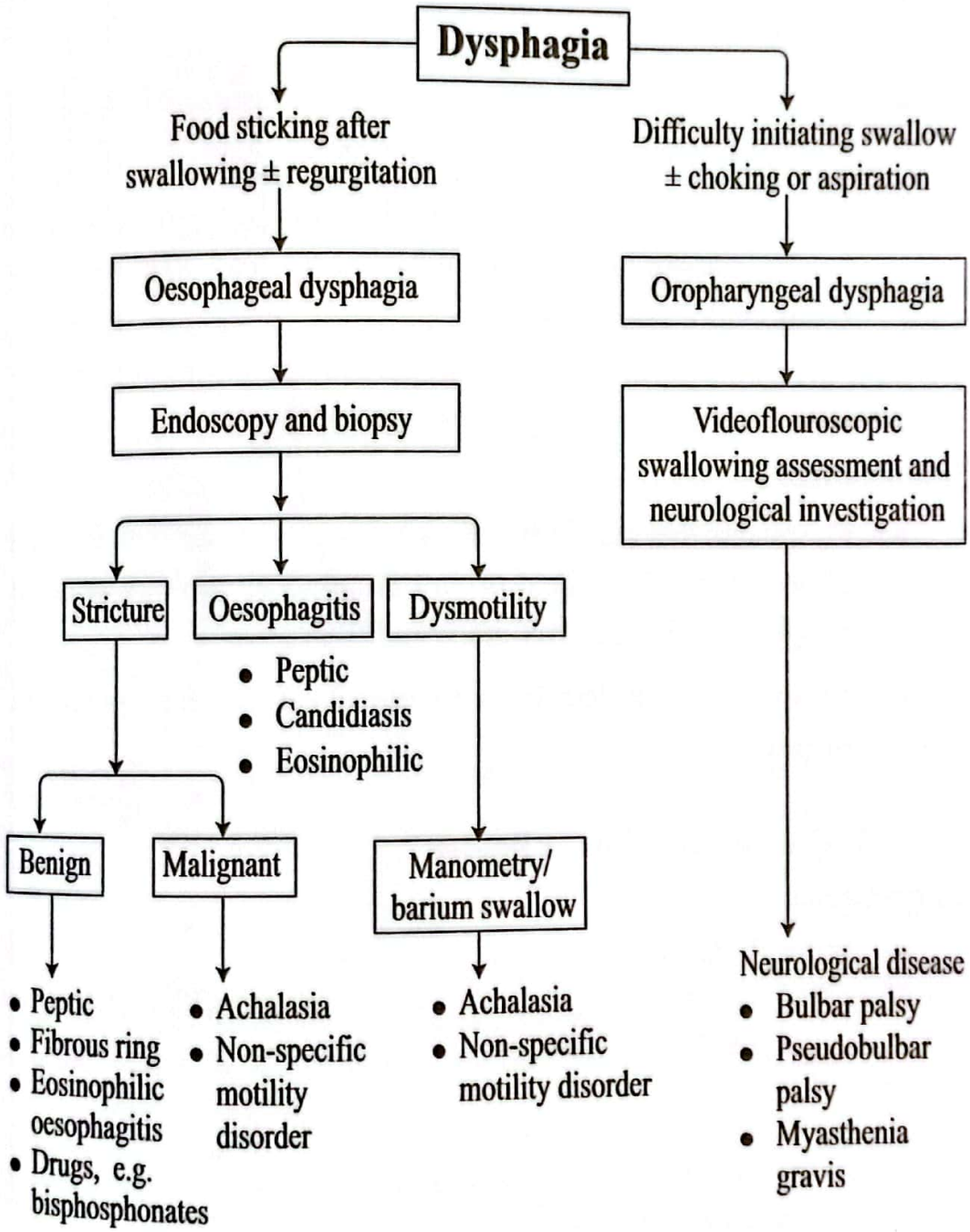
Mechanical obstruction:

- Peptic stricture
- Esophageal cancer
- Lower esophageal rings
- Extrinsic compression (e.g. from enlarged left atrium, aortic aneurysm, aberrant subclavian artery).
- Caustic ingestion



Davidson's 852(22nd)

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3. Is dysphagia intermittent or progressive?

Imporatnce:

- Intermittent dysphagia → A benign disease of lower oesophageal ring
- Progressive dysphagia → Carcinoma of oesophagus

Harrison-299(18th)

4. *How long is the history of dysphagia?*

Importance:

- Transient dysphagia of short duration → Inflammatory process (tonsillitis)
- Dysphagia that is progressive over the course of weeks to months suggests → Carcinoma of oesophagus.
- Episodic dysphagia to solids lasting several years indicates a benign disease of lower oesophageal ring (schatzki's ring) or eosinophilic esophagitis.

Harrison -299 (18th)

5. At what level does food appears to stick?

Importance:

- Dysphagia that localizes to the suprasternal notch may indicate either an oropharyngeal or an oesophageal etiology as distal dysphagia referred proximally in 30% cases.
- Dysphagia that localizes to the chest is oesophageal in origin.

Harrison -299 (18th)

6. Is dysphagia for solids or liquids ?

Importance:

- In mechanical obstruction:
  Initially difficulty occurs only with solids but in advanced stage of dysphagia, difficulty occurs with liquids as well as solids.
- In neurological disorder:
  In most cases, difficulty with fluids rather than solids or equal difficulty with fluids and solids from very onset.

Harrison's -299 (18th)

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7. Ask about associated symptoms.

Importance:

- Associated with nasal regurgitation and tracheobronchial aspiration with swallowing indicates,
  - i. Oropharyngeal paralysis
  - ii. Tracheo oesophageal fistula.
- Associated with severe weight loss →Carcinoma.
- A prolonged history of heart burn preceding the onset of dysphagia suggestive of
  - i. Peptic stricture
  - ii. Oesophageal adenocarcinoma
- Associated with hoarseness of voice → Laryngeal disorder or involvement of recurrent laryngeal nerve by extension of oesophageal carcinoma beyond the walls of oesophagus.
- When hoarseness of voice precede dysphagia; the primary lesion is usually laryngeal. When hoarseness of voice occur after the development of dysphagia; compression of recurrent laryngeal nerve by a malignancy.

Harrison's -299 (18th)

- A history of prolonged nasogastric intubation, oesophageal or head & neck surgery, ingestion of caustic agents or pills, previous radiation or chemotherapy→ Benign stricture of oesophagus.

Harrison's -300 (18th)

- Chest pain frequently associated with dysphagia whether it is related to motor disorder, structural disorder or reflux disease.

Harrison's -299 (18th)

Questions Macleod's-176 (13th)

Presentation in history:

He also complains of difficulty in swallowing for 2 months. It is retrosternal, painless and progressively increasing day by day. Initially it was only for solid but for last 15 days it is for solid as well as for liquid. He also complains of marked weight loss which is about 6 Kg in last 2 months.

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INDIGESTION/DYSPEPSIA

Dyspepsia describing symptoms such as discomfort, bloating and nausea which are thought to originate from upper gastro intestinal tract.

Common causes:

Upper gastro intestinal disorder:

- Peptic ulcer disease
- Acute gastritis
- Gall stone
- Carcinoma of stomach
- Oesophageal spasm
- Non ulcer dyspepsia
- Irritable bowel syndrome

Other gastro intestinal disorder:

- Pancreatic disease (cancer, chronic pancreatitis)
- Colonic carcinoma
- Hepatic disease (hepatitis, metastasis)

Systemic disease:

- Renal failure
- DM (due to gastroparesis)
- Hypercalcemia
- Scleroderma

Drugs:

- NSAIDs
- Corticosteroids
- Iron and potassium supplements
- Digoxin

Others:

- Psychological (anxiety, depression)
- Alcohol

Davidson 852(22nd)

Questions with importance:

1. Ask about relation of symptom to ingestion of food

Importance:

- Discomfort after few time of ingestion of food indicates
  - i. Oesophageal disease
  - ii. Gastric ulcer
  - iii. Acute gastritis
  - iv. Gastric carcinoma

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- Discomfort occuring after several hours of eating suggests
  i. Duodenal ulcer
  ii. Gastric outlet obstruction
  iii. Gastroparesis
  iv. Pancreatic insufficiency

3. Ask about relation of symptom to specific type of food

Importance:

- Citrus food (low pH) provokes symptom in
  i. Peptic ulcer
  ii. Reflux oesophagitis
- Milk provokes symptom in
  i. Pancreatic disease
  ii. Biliary tract disease
  iii. Lactase deficient patient

4. Ask about relieving factor:

Importance:

- Food or antacid (due to neutralization of acid) → Duodenal ulcer
- Rest → Myocardial ischemia.

5. Ask about aggravating factor:

Importance:

- Food → Gastric ulcer

6. Ask about associated features:

- Recurrent upper abdominal pain, increased by fasting, decreased by meal/PPI→ Duodenal ulcer
- Recurrent upper abdominal pain, increased by meal, decreased by fasting/PPI→ Gastric ulcer
- Severe discomfort, not responding to high dose of PPI → ZES
- Right hypochondriac pain, radiated to right shoulder, decreased by antispasmodic → Gall stone
- Colicky abdominal pain, abdominal bloating, alteration of bowel habit for long time, no weight loss → Irritable bowel syndrome
- Recurrent upper abdominal pain, bulky offensive stool, weight loss, DM → Chronic pancreatitis
- Chronic bloody diarrhoea, weight loss → Carcinoma of colon

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HEART BURN

Common causes:

1. Reflux oesophagitis
2. Hiatus hernia
3. Peptic ulcer
4. During pregnancy
5. Following weight gain.

Questions with importance:

1. Does the patient suffer from pain behind the sternum?

Importance:

It suggests:

- Hiatus hernia
- Reflux oesophagitis
- Peptic ulcer
- During pregnancy
- Following recent weight gain

2. Does it come specially when lying down?

Importance:

It suggests:

- Reflux oesophagitis
- Hiatus hernia.

3. Is it accompanied by water brush or not?

(The mouth fills with tasteless saliva).

Importance:

It indicates peptic ulcer.

4. *Ask about associated symptoms*

Importance:

- When upper abdominal discomfort and heartburn coexist → Gastric or duodenal ulcer

Index of differential diagnosis -29(13th)Question

Hutchison's-10(20th)l, 2

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CONSTIPATION

Infrequent passage of hard stool is known as constipation.

Macleod's-176(13th)

Common causes:

Gastro intestinal disorder:

Dietary:

- Lack of fibre and/or fluid intake

Motility:

- Irritable bowel syndrome
- Chronic intestinal pseudo obstruction
- Drugs

Structural:

- Colonic carcinoma
- Hirschsprung's disease

Defecation:

- Anorectal disease (crohn's fissure, haemorrhoids)
- Obstructed defecation

Non gastro intestinal disorder

Drugs:

- Opiates
- Anti cholenergics
- Calcium antagonists
- Iron supplements
- Aluminium containing antacids

Neurological

- Multiple sclerosis
- Spinal cord lesions
- Cerebro vascular accidents
- Parkinsonism

Metabolic/endocrine

- Diabetes mellitus
- Hypercalcemia
- Hypothyroidism, Pregnancy

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Others:

- Any serious illness with immobility, especially in the elderly
- Depression

Davidson-860(22nd)

Questions with importance:

1. What is the patient's usual bowel habit?

Importance:

- Normal bowel frequency ranges from three times daily to once every 3 days.

Macleod's-173(13th)

- A careful history should explore the patients symptoms & confirm whether he or she is indeed constipated based on frequency (fewer than three bowel movement/week), consistency (lumpy/hard), excessive straining, prolonged defecation time or need to support the perineum or digitate the anorectum.

Harrison's -317 (18th)

2. Has constipation been lifelong or is it of recent onset ?

Importance:

Recent onset of constipation

- Colonic neoplasm
- Colonic obstruction due to neoplasm, stricture, ischemic, diverticular or inflammatory cause
- Anal sphincter spasm due to anal fissure, painful haemorrhoid
- Medication

Chronic constipation:

- Irritable bowel syndrome (constipation predominant)
- Medication (calcium channel blocker, antidepressant)
- Colonic pseudo obstruction (slow transit constipation, megacolon)
- Disorder of rectal evacuation (rectal mucosal prolapse, rectocele)
- Endocrinopathy (hypothyroidism, hypercalcemia, pregnancy)
- Psychiatric disorder (depression, eating disorder, drugs)
- Neurologic disease (Parkinsonism, Multiple sclerosis, Spinal cord injury)

Harrison's -317(18th)

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3. ***How much time is spent straining at stool?***

Importance:

It indicates the degree of constipation

4. ***Has the shape of the stool changed?***

Importance:

- In irritable bowel syndrome, stool becomes pellet like

5. ***Does the constipation alternate with diarrhoea?***

Importance:

It indicates.

- Irritable bowel syndrome.
- Carcinoma of alimentary tract

Index of differential diagnosis of disease— 155(13th)

6. ***Has there been any drug therapy?***

Importance:

These drugs cause constipation.

- Opiates
- Anti cholinergics
- Calcium antagonists
- Iron supplements
- Aluminium containing antacids

Davidson-860(22nd)

7. ***Is there associated abdominal pain, anal pain on defecation or rectal bleeding?***

Importance:

- Absolute constipation (no gas or bowel movement) associated with abdominal pain, vomiting and abdominal distension suggests intestinal obstruction.

  Macleod's-174(13th)

- Associated with anal pain on defecation or rectal bleeding
  i. Thrombosed haemorrhoid
  ii. Anal fissure.
- Associated with tenesmus (the sensation of needing to defecate although the rectum is empty) suggests rectal inflammation or tumor.

  Macleod's-174(13th)

Questions Macleod's-174(13th)

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History of past illness

Importance:

- History of similar problem may suggest the diagnosis, for example, bleeding peptic ulcer or inflammatory bowel disease.
- Primary biliary cirrhosis and auto immune hepatitis are associated with thyroid disease.
- Non alcoholic fatty liver disease (NAFLD) are associated with diabetes and obesity.
- Ask about previous abdominal surgery and radiological and other investigations. *Macleod's-178(13th)*

Presenting disease	Past history
Perforation of peptic ulcer or Gastric outlet obstruction.	History of recurrent epigastric pain, even there may be history of haematemesis and/or melaena. *Davidson-787(19th)*
Appendicitis, biliary colic and renal colic	History of previous attack s.Das-338(5th)
Peptic ulcer	H/O recurrent abdominal pain. *Davidson-873(22nd)*
Acute pancreatitis	May be associated with gall stone and post ERCP status. *Davidson-890(22nd)*
Primary biliary cirrhosis and auto immune hepatitis	Are associated with thyroid disease. *Macleod's-178(13th)*
Non alcoholic fatty liver disease (NAFLD)	Are associated with diabetes and obesity. *Macleod's-178(13th)*
CLD	Past history of jaundice (by hepatitis B or C)
Haemochromatosis	H/O repeated blood transfusion causing parenteral iron loading *Davidson-972(22nd)*

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Family history

Importance:

Some diseases often run in family.

- Inflammatory bowel disease
- Colorectal cancer
- Peptic ulcer disease (environmental factors also contribute)
- Gilbert's syndrome (autosomal dominant)
- Haemochromatosis (autosomal recessive)
- Wilson's disease (autosomal recessive)

Macleod's-178(13th)

Social history/Personal history:

Importance:

Smoking →
- → Esophageal cancer
- → Colorectal cancer
- → Peptic ulcer
- → Crohn's disease

Alcohol →
- → Gastritis
- → Hepatitis
- → Cirrhosis of liver
- → Fatty liver disease
- → Pancreatitis

Macleod's 18+178(13th)

- In patients with liver disease, ask about specific risk factors such as I/V drug use, blood transfusion, multiple sexual partner, sex between men or with prostitute, tattoos etc.

Macleod's 177(13th)

- Many disorders particularly irritable bowel syndrome and dyspepsia are exacerbated by stress and emotional ill health. Ask about potential source of stress as well as about the symptoms of anxiety and depression.
- Foreign travel is important in relation to diarrhoeal illness.

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Drug history:

Importance:

Example of drug induced gastrointestinal conditions:

Symptoms	Drugs
Weight gain	Oral corticosteroids
Dyspepsia and gastrointestinal bleeding	Aspirin, NSAIDs
Diarrhoea	Antibiotics, proton pump inhibitors, cytotoxic drugs
Constipation	Opioids
Jaundice:hepatitis	Paracetamol (overdose), pyrazinamide, rifampicin, isoniazid
Jaundice: cholestatic	Flucloxacillin, chlorpromazine, co-amoxiclav
Liver fibrosis	Methotraxate

Macleod's 177(13th)

- NSAIDs may cause
  - i. Acute gastritis
  - ii. Peptic ulcer
  - iii. Perforation

Dietary history:

Importance:

- Patients with irritable bowel syndrome often report specific food intolerance, including wheat, dairy products and others.
- Painless diarrhoea may indicate high alcohol intake, lactose intolerance or gluten enteropathy. *Macleod's 178(13th)*
- Lack of fibre and / or fluid intake cause constipation.

Davidson-860(22nd)

- Majority of patients with peptic ulcer observe irregular diet.
- Patients suffering from duodenal ulcer are accustomed to take spicy foods.

S.Das-360(5th)

Menstrual history: (In case of female)

Importance:

- A history of missed period is often present in rupture of ectopic pregnancy.

S.Das-338(5th)

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URINARY SYSTEM

Name :

Importance: see page no. 23

Age:

Importance:

More in infant:

- Urinary tract infection *Mr. Khan-Pediatrics 71 (2nd)*

More in children:

- Wilm's Tumor *Davidson-632 (19th)*

More in adult:

- Renal Stone *Davidson-507 (22nd)*
- Renal adenocarcinoma *Davidson-515 (22nd)*
- Testicular tumor (20 - 40 years)
- Polycystic kidney disease (after 20 years); Before 20 years, it is asymptomatic. *Davidson-505+506 (22nd)*

More in old age:

- Benign prostatic hypertrophy *Davidson-514 (22nd)*
- Prostatic carcinoma *Davidson-517 (22nd)*

Sex:

Importance:

More in male

- Benign prostatic hypertrophy (exclusively in male)
- Prostatic carcinoma (exclusively in male)
- Testicular tumor (exclusively in male)
- Renal adenocarcinoma *Davidson-515 (22nd)*

More in female:

- Urinary tract infection

Occupation:

Importance: See page No: 177

Marital status:

Importance:

- In gonorrhoea,anterior urethritis causes dysuria and purulent discharge.
- In reiter's disease, urethritis is common. So partner notification is essential in these case. *Davidson-1107 (22nd)*

Scanned with CamScanner

Address :
Present :
Permanent :

Importance:
In developing country, bladder stone is common, particularly in children.
Davidson-632 (19th

Date of Admission :
Date of Examination :
Importance: See page no. 26

Chief complaints:

i. Pain
ii. Haematuria (Blood in urine)
iii. Oliguria/Anuria
iv. Polyuria
v. Frequency of micturition
vi. Nocturia (need to rise during hours of sleep to empty the bladder)
vii. Dysuria (Painful micturition)

History of present illness

HAEMATURIA

Common causes of haematuria:

- Trauma
- Tumor (in the Kidney, Ureter, Urinary bladder, Prostate)
- Stone in the urinary tract
- Infection
  i. Cystitis
  ii. Pyelonephritis
  iii. Tuberculosis
- Cyst in the Kidney
- Acute glomerulonephritis
- Prostatitis
- Urethral stricture
- Bleeding disorders

Current emergency diagnosis and treatment

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Questions with importance:

1. ***Ask about amount, colour of urine (bright red, smoky)***

Importance:

- Bright red (not intimately mixed with urine) → Derived from bladder or urethra.
- Reddish brown (smoky) or pink (intimately mixed) → Derived from kidney.

Chamberlain's -94 (12th)

Abnormalities of urine colour

Orange brown	Conjugated bilirubin Concentrated normal urine (due to very low water intake), Rhubarb, Senna, Drugs: sulfasalazine
Red brown	Blood, myoglobin, free Hb, porphyrins, Beetrot, black berries, Drugs: Rifampicin
Brown black	Conjugated bilirubin, Drugs: Levodopa, metronidazole, nitrofurantoin, chloroquine, primaquine
Blue green	Propofol, fluorescein

Macleod's - 201 (13th)

2. ***Relation to micturition (initial / total / terminal)***

Importance:

- Initial haematuria → From urethra
- Total haematuria → From Kidney or Urinary bladder
- Terminal haematuria → From urinary bladder as bladder contracts

Bailey & love's -163 (23rd)

3. ***Is there associated with pain or not:***

Importance:

Painless haematuria:

- Glomerulonephritis
- Tumors of the kidney, ureter, bladder or prostate (Unless they produce obstruction or extend beyond the primary organ to involve adjacent nerve)
- Tuberculosis

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- Schistosomiasis
- Hypertensive nephrosclerosis
- Interstitial nephritis (unless very acute or severe)
- Acute tubular necrosis
- Renal ischemia (renovascular disease)
- Distance running or other severe exercise
- Coagulation disorders, anticoagulant therapy

Painful haematuria:

- Urinary tract infection.
- Renal stones with obstruction
- Loin pain haematuria syndrome

May be either:

- Urinary tract infection
- Reflux nephropathy and renal scarring
- Adult polycystic kidney disease
- Renal stone without obstruction

Macleod's - 201 (13th)

4. *Is the patient passing clots?*

Importance:

- Gross haematuria with blood clots suggests post renal source.
- RBC of glumerular origin are often dysmorphic
- Haematuria with dysmorphic RBC, RBC cast and protein excretion >500 mg/day is diagnostic of glomerulonephritis.
- WBC cast with bacteria are indicative of pyelonephritis.
- WBC and /or WBC cast are also seen in tubulo interstitial process such as interstitial nephritis and acute glumerulonephritis.
- In chronic renal disease, degenerated cellular cast called waxy cast, can be seen in urine.

Harrison-339 (18th)

5. *Ask about other urinary symptoms.*

Importance:

- Associated with frequency, urgency and dysuria suggests acute bacterial cystitis.

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- A single urine analysis with haematuria is common and can result from menstruation, viral illness, allergy, exercise or on mild trauma.
- Persistent or significant haematuria (>3/HPF) or three urinalysis, a single urinalysis with >100/HPF or gross haematuria is associated with significant renal or urologic lesion.

Harrison-339 (18th)
Campbell's Urology - 309 (6th) Questions
Chamberlain's - 1, 2, 3, 4, 5
Campbell's - 309 (6th)-4

LOIN PAIN

1. *Site: Where is it ?*

Importance:

Renal pain:

Flank region or in loin.

Ureteric pain:

Starts from the renal angle and radiates to the groin, base of the penis and to the scrotum in case of male and to the labia majora in case of female and to inner side of upper part of thigh.

S. DAS – 405 (5th)

Bladder pain

Suprapubic, except pain of carcinoma of bladder which is usually in loin.

N. L. Browse – 419, 420 (3rd)

2. Radiation:

Importance:

- Renal pain my radiate anteriorly to the lumber region.
- Ureteric pain → radiates towards groin, scrotum (male), labia majora (in case of female) and inner side of upper part of thigh.
- In cystitis pain may be referred to tip of the penis.

s. das- 405 (5th)

3. Character:

Importance:

- Renal pain → Persistent pain in the loin which is usually dull.
- In bladder calculi → Suprapubic stabbing pain
- In cystitis → Burning pain along the length of urethra during micturition

N. L. Browse -419 (3rd)

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- In urethritis → Burning or scalding pain during or at the end of micturition.
- Ureteric pain → Colicky pain.

S. Das- 408 (5th)

4. *Ask about relation with micturition*

Importance:

- Vesical pain relieved by urination

S.Das -408 (5th)

5. Severity:

Importance:

- Pain of ureteric colic is extremely severe.
- Renal pain vary from dull ache to very severe pain.

N. L. Browse - 144 (3rd)

6. Aggravating factor:

Importance:

- Jolting or sudden movements →Ureteric colic
- Running & jolting → Renal colic

chamberlain's-53 (12th)

7. Relieving factor:

Importance:

- By rolling around the bed → Ureteric colic.

URINARY INCONTINENCE

Involuntary leakage of urine is known as incontinence of micturition.

Questions with importance:

1. Does it occur only at night (enuresis) or over the day also?

Importance:

- Urinary incontinence (enuresis) in children is normal.
- Incontinence at day as well as at night:
  - i. Diabetic autonomic neuropathy
  - ii. Benign prostatic hypertrophy
  - iii. Porstatic carcinoma
  - iv. Cystitis
  - v. Sensory denervation
  - vi. Loss of motor control

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2. *Does the urine dribble away all the time or only periodically?*

Importance:

All time (continual incontinence):

- Ectopic ureter
  When ureter opens into the vagina in female or in to the urethra beyond the sphincter apparatus in both sex.
- Vesicovaginal fistua, uretero vaginal fistula
- Fistula between urinary tract and uterus.

Periodically:

- Diabetic autonomic neuropathy
- Benign prostatic hypertrophy
- Prostatic carcinoma
- Cystitis
- Atonic bladder

Index of differential diagnosis of disease – 684 (4th)

Stress incontinence:

Incontinence during coughing, sneezing or exertion.

Stress incontinence occurs when passive bladder pressure exceeds the urethral pressure due to poor pelvic floor support or a week urethral sphincter. Stress incontinence is very common in woman and seen most frequently following child birth. It is rare in male & usually follow surgery to the prostate.

Davidson-473 (22nd)

Overflow incontinence:

It occurs when bladder becomes chronically over distended and may be associated with acute kidney injury.

Cause:

- BEP or bladder neck obstruction
- Atonic bladder due to damage to pelvic nerve (due to surgery, trauma or infection) or from compression of the cauda equina (by disk prolapse, trauma or tumor)

Urge incontinence:

This occurs because of detrusor over activity which produces an increased bladder pressure that overcome the urethral sphincter.

Cause:

- Idiopathic
- Spina bifida, multiple sclerosis
- UTI or bladder stone

Davidson-473 (22nd)

Questions Chamberlain's-17

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DYSURIA (BURNING PAIN DURING MICTURITION)

Cause:

- Cystitis
- Vesical stone, if causes cystitis
- Urethritis
- Acute pyelonephritis
- Carcinoma of bladder
- Gonorrhoea

Questions with importance:

1. ***Ask about exact nature (e.g. in starting, in force of stream, in inhibition)***

Importance:

- Pain occurring at the start of micturition indicates urethral pathology.
- Pain occurring at the end of micturition indicates bladder origin.

Campbell's urology - 309 (12th)

2. ***Is it accompanied by pain or not?***

Importance:

- Accompanied by loin pain
  - i. Pyelonephritis *N. L. Browse - 417 (3rd)*
  - ii. Carcinoma of bladder *N. L. Browse - 420 (3rd)*
- Accompanied by supra pubic pain → cystitis *Davidson-511 (22nd)*

Questions: Chamberlain's-16 (12th)

RETENTION OF URINE

Common Causes:

Mechanical

- Urinary bladder - Stone, tumor, blood clot etc.
- Prostate - Prostatic abscess., benign and malignant enlargement.
- Urethra - Urethral stricture, trauma, urethritis.
- From outside - Pregnancy, Ovarian Cyst, Carcinoma of cervix and rectum.

Neurogenic:

- Spinal cord injury
- Spinal cord disease

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Others:

- Surgical operation.
- Anaesthesia.
- Drugs: Anti cholinergic, Smooth muscle relaxants etc.

S.Das-432 (5th)

Questions with importance:

1. Ask about sudden onset or increasing difficulty ?

Importance:

Sudden onset / Acute retention:

- After surgical operation
- Anaesthesia
- Injury to urethra.

Norman N. L. Browse - 420 (3rd)

Increasing difficulty / Chronic retention:

- The patient may be unawared of his chronic retention but complains of symptom related to the cause of retention such as:
  i. Increased frequency
  ii. Difficulty with micturition (Delays on starting, a poor stream and a dribbling finish)
- Commonest cause of chronic retention is benign hypertrophy of prostate

Norman L. Browse-422 (3rd)

NB - Acute retention is painful and chronic retention is painless.

2. Ask about any physical trauma

Importance:

- Physical trauma may causes acute retention of urine.

3. Ask about other symptoms of urological and neurological disease.

Importance:

It detects the exact cause of retention.

- Increased frequency, delays on starting, a poor stream, a dribbling finish → Benign hypertrophy of prostate
- These symptoms appear suddenly and get worse rapidly → Carcinoma of prostate.

Norman N. L. Browse - 422 (3rd)

- Associated with exaggerated deep tendon reflex and definite sensory level → spinal cord compression, acute transverse myelitis.

Questions: Chamberlain's 17 (12th)

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FREQUENCY OF MICTURITION

Frequency as well as total urine out put increased

- Increased fluid intake
- Diabetes mellitus
- Chronic interstitial nephritis.

Frequency increased but total urine out put normal

- Renal: Pyelonephritis, stone, TB
- Ureteric: Stone
- Vesical: Cystitis, stone.
- Prostatic: Prostatitis, Benign and malignant enlargement of prostate.
- Urethral: Urethritis (gonococcal), stone, phimosis.
- Inflammatory condition of pelvis - e.g. Salpingitis, appendicitis.

S.Das-433 (5th)

Questions with importance:

1. ***Ask about voiding of urine (number of times urine is passed) in 24 hours.***

Importance:

- Normal: 5 - 6 times/day

S.Das-433 (5th)

2. ***Whether at night or at day time or both.***

Importance:

- At day time:
  Vesical calculus (due to irritation of trigone in erect position)
- Nocturnal frequency:
  Complained by an elderly man due to benign enlargement of prostate
- Equally marked by day and night:
  Cystitis

3. ***Amount of urine passed each time:***

Importance:

Total urine out put increased:

- Increased fluid intake
- Diabetes mellitus
- Chronic interstitial nephritis

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Total urine output normal

- Cystitis
- Pyelonephritis
- Stone in ureter, kidney and bladder
- Benign & malignant enlargement of prostate
- Posterior urethritis.

4. ***Is it accompanied by pain or not?***

Importance:

Painless frequency:

- Benign enlargement of prostate.

Painful frequency (either in loin or supra pubic etc.):

- Pyelonephritis
- Cystitis
- Vesical calculus

Questions: Chamberlain's -16 (12th)

History of past illness

Importance:

Past condition	Present status
Hypertension	Which may cause or result from renal disease
Diabetes mellitus	Associated with diabetic nephropathy and renovascular disease
Pulmonary tuberculosis or bone tuberculosis, even in childhood	May give rise to tuberculous affection of kidney (even 20 years later) *S.Das-410 (5th)*
Vascular disease at other sites	Which makes renovascular disease more likely.
Past history of urinary tract stones or surgery	Which may cause renal disease
Recurrent UTI	May be associated with renal scarring
Upper respiratory tract infection	May be associated with glumerulo-nephritis and /vasculitis
Anaemia	Which may be due to CKD.

Macleod's 202 (13th)

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Family history:

Importance

- Inherited kidney diseases are:
  i. Adult Polycystic Kidney which may be associated with sub arachnoid haemorrhage from ruptured berry aneurysm
  ii. Alport's syndrome which may be associated with sensori neural deafness.

Macleod's 202 (13th)

Drug history:

Importance:

The kidney is susceptible to damage by drugs because it is the route of excretion of many water soluble compounds including drugs and their metabolites.

Toxic renal damage may occur by a variety of mechanisms. Very commonly, drugs contribute to the development of acute tubular necrosis. **Numerically reaction to NSAIDs & ACE inhibitors are the most common.**

Mechanisms	Drug or toxin	Comments
Haemodynamic	NSAIDs	Reduced renal blood flow due to inhibition of prostaglandin synthesis
	ACE inhibitors	Reduced efferent glomerular arteriolar tone.
	Radiographic contrast media	Multifocal aetiology may include intense vasoconstriction.
Acute tubular necrosis	Aminoglycosides, amphotericin, Paracetamol overdose, radiographic contrast media	
Glomerulonephritis (immune mediated)	Penicillamine, Gold	Membranous nephropathy
	NSAIDs	Minimal change nephropathy
Interstitial nephritis	NSAIDs, penicillins, proton pump inhibitors, lithium, ciclosporins, tacrolimus	
Tubular obstruction	Acyclovir, chemotherapy	

Davidson-522 (22nd)

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Some drugs that require extra caution in patients with renal disease:

Pharmacodynamic effects enhanced:

- ACE inhibitors and ARB (renal impairment and hyperkalemia)
- Metformin (lactic acidosis)
- Spironolactone (hyperkalemia)
- NSAIDs (impaired renal function)
- Sulphonylureas (hypoglycemia)
- Insulin (hypoglycemia)

Pharmacokinetic handling altered (reduced clearance):

- Aminoglycosides (e.g. gentamicin), vancomycin, ciprofloxacin, cephalosporins, digoxin, lithium, atenolol, allopurinol, methotraxates, opoids (e.g. morphine)

Davidson-36 (22nd)

Occupational history:

Importance:

Occupation/ Exposure	Disease
Living or working in hot condition with more concentrated urine	Predispose to renal stone formation
Exposure to organic solvents	May cause glomerulonephritis
Working in aniline dye and rubber industries	Increased incidence of urothelial cancer
Long term exposure to lead and cadmium	May cause renal damage

Macleod's 203 (13th)

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LOCOMOTOR SYSTEM

Name:
Importance: See page No: 21

Age:
Importance:

More in childhood:
- Juvenile idiopathic arthritis *Davidson 1095 (22nd)*
- Osteomyelitis. *Davidson 614 (22nd)*
- Rheumatic fever

More in young adult:
- Reactive arthritis (between 16 and 35) *Davidson 1107 (22nd)*
- Psoriatic arthritis (between 25 and 40) *Davidson 1108 (22nd)*
- Ankylosing spondylitis (Peak of onset in 20 - 30 years of age) *Davidson 1105 (22nd)*
- SLE (Between 20 & 30 years) *Davidson 1110 (22nd)*

More in middle age:
- Rheumatoid arthritis (between 25 and 55 years) *Harrison - 2738 (18th)*
- Gout (Middle aged to elderly men and post menopausal woman) *Harrison - 2837 (18th)*
- Systemic sclerosis (4th and 5th decade) *Davidson 1112 (22nd)*

More in elderly:
- Osteomalacia *Davidson 11251 (22nd)*
- Osteo arthritis *Davidson 1081 (22nd)*
- Gout
- Osteoporosis

Sex:
Importance:
More in male:
- Gout *Davidson 1087 (22nd)*
- Reactive arthritis (Male: Female = 50: 1) *Davidson 1105 (22nd)*
- Ankylosing spondylitis (Male: Female = 3: 1)

More in female:
- Rheumatoid arthritis (Female : Male = 3: 1) *Davidson 1096 (22nd)*
- Juvenile idiopathic arthritis (in children) *Davidson 1104 (22nd)*
- Systemic lupus erythematosus (SLE) (Female : Male = 9: 1)

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- Osteoarthritis (except Hip OA, where men are equally affected)

Davidson 1081 (22nd)

- Osteoporosis *Davidson 1120 (22nd)*
- Systemic sclerosis *Davidson 1112 (22nd)*
- Fibromyalgia *Davidson 1092 (22nd)*

Religion:

Importance: See page No: 25

Occupation:

Importance: See page No: 188

Marital status:

Importance:

- Reiter's disease is sexually transmitted disease.
- In syphilis- Arthiritis, periostitis occur, so, partner notification is essential.

Davidson-I86 (19th)

Address:

i. Present

ii. Permanent:

Importance:

It is important for identification of the patient, communication and follow up.

Paget's disease in more common in caucasians.

Date of admission:

Date of examination:

Importance: See Page No: 26

Chief complaints:

i. Joint pain

ii. Swelling

iii. Stiffness

iv. Bone pain

v. Muscle weakness.

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History of present illness

SWELLING / STIFFNESS / FUNCTION LESS

Questions with importance:

1. ***Ask about the affected joints, whether monoarticular (single joint), Oligoarticular (two/three), poly articular (four/more) joints?***

Importance:

Poly articular:

- Rheumatoid arthritis
- Viral arthritis,
- Osteoarthritis,
- Systemic lupus erythematosus
- Polymyalgia rheumatica,
- Systemic sclerosis.

Oligoarticular:

- Sero negative arthritis
  - Reactive arthritis (Reiter's disease)
  - Psoriatic arthritis
  - Ankylosing spondylitis
  - Arthopathy associated with IBD
- Osteoarthritis
- Oligo articular presentaiton of poly arthritis

Monoarticular:

- Septic arthritis
- Traumatic arthritis
- Gout
- Pseudo gout
- Haemarthrosis
- Monoarticular presentation of oligo or polyarthritis

2. ***Ask about mode of onset and duration:***

Importance:

Acute (<6weeks):

- Septic arthritis *Davidson-1094 (22nd)*
- Viral arthritis *Davidson-1095 (22nd)*
- Acute gout *Davidson-1088 (22nd)*
- Pseudogout *Davidson-1090 (22nd)*
- Reactive arthritis (Reiter's syndrome) *Davidson-1107 (22nd)*
- Initial presentation of chronic arthritis

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Chronic (gradual onset): 6 weeks or more:

- Rheumatoid arthritis (6 weeks or more)
- Ankylosing spondylitis
- Osteoarthritis
- SLE
- Psoriatic arthritis
- Enteropathic arthritis

3. ***Whether involvement is symmetrical or asymmetrical***

Importance:

Typically symmetrical:

- Rheumatoid arthritis
- Viral arthritis
- Osteoarthritis
- Juvenile idiopathic arthritis
- Systemic lupus erythematosus

Typically asymmetrical:

- Seronegative arthritis
  - Ankylosing spondylitis (typically lower limb)
  - Psoriatic arthritis
  - Reactive arthritis
  - Enteropathic arthritis
- Rheumatic fever

4. ***Day to day variation of symptoms such as presence or absence of morning stiffness and the response to physical activity***

Importance:

Inflammatory arthritis presents with early morning stiffness that takes at lest 30 minutes to relieve with activity.

Non inflammatory arthritis such as mechanical arthritis, osteoarthritis has stiffness after rest which lasts only few minutes on movement (also known as gel phenomenon).

Morning stiff ness occur in:

Inflammatory arthritis:

- Rheumatoid arthritis *Davidson-1097 (22nd)*
- Seronegative spondylo arthritis *Davidson-1110 (22nd)*
- SLE *Davidson-1113 (22nd)*
- Systemic sclerosis

In osteo arthritis only brief morning stiffness (<15 min) occur. *Davidson-1082 (22nd)*

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5. ***Site: Which joint are involved ?***

Importance:

- Proximal interphalangeal joint, metacarpo phalangeal joint with small joints of hand, feet and wrist →Rheumatoid arthritis. *Davidson-1097 + 1098 (22nd)*
- Distal interphalangeal joint associated with nail changes → Psoriatic arthritis. *Davidson-1108 (22nd)*
- Acute monoarthritis of 1st metatarsophalangeal joint (great toe) → Acute gout. *Davidson-1088 (22nd)*
- Predominantly affecting sacroiliac joint and spine → Ankylosing spondylitis. *Davidson-1105 (22nd)*
- Finger interphalangeal joint with posterolateral swelling on each side of extensor tendon which slowly enlarge and harden to become haberdens (distal IPJ) and bouchard (proximal IPJ) nodes → Nodal generalized osteoarthritis. *Davidson-1082+ 1083 (22nd)*

6. ***Ask about the presence of extra articular feature, particularly in the skin and eyes.***

Importance:

In rheumatoid arthritis :

Subcutaneous rheumatoid nodule, episcleritis, dry eyes, pulmonary fibrosis, pleural effusion, small vessel vasculitis, splenomegaly, raynaud's phenomenon, fever, weight loss, fatigue & malaise

In reactive arthritis:

Urethritis, mouth and or genital ulcers, conjunctivitis.

In ankylosing spondylitis:

Enthesopathy, iritis, aortic regurgitation, pulmonary fibrosis.

In gout:

Tophi, sign of renal failure or alcoholic liver disease.

In septic arthritis:

Fever, malaise or source of infection.

Question- Macleod 's

Presentation in history:

She also complains of pain and swelling of multiple joints of both hands and feet, predominantly upper limb, symmetrical in nature, mostly involving the small joints of both hand.Initially pain was mild but gradually it has become severe. The pain is associated with morning stiffness that persists for about 2 hours and is relieved by activity or exercise. The pain does not relieve by rest but reduces with pain killer.

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JOINT PAIN

Questions with importance:

1. Site where is it ?

Importance :

- Proximal interphalangeal joint, metacarpo phalangeal joint with small joints of hand, feet and wrist → Rheumatoid arthritis. *Davidson-1097 + 1098 (22nd)*
- Distal interphalangeal joint associated with nail changes → Psoriatic arthritis. *Davidson-1108 (22nd)*
- Acute monoarthritis of 1st metatarso phalangeal joint (great toe), → Acute gout. *Davidson-1088 (22nd)*
- Predominantly affecting sacroiliac joint and spine → Ankylosing spondylitis. *Davidson-1105 (22nd)*
- Finger interphalangeal joint with posterolateral swelling on each side of extensor tendon which slowly enlarge and harden to become haberdens (distal IPJ) and bouchard (proximal IPJ) nodes → Nodal generalized osteoarthritis. *Davidson-1082+1083 (22nd)*

Typically symmetrical:

- Rheumatoid arthritis
- Viral arthritis
- Osteoarthritis
- Juvenile idiopathic arthritis
- Systemic lupus erythematosus

Typically asymmetrical:

- Seronegative arthritis
  - Ankylosing spondylitis (typically lower limb)
  - Psoriatic arthritis
  - Reactive arthritis
  - Enteropathic arthritis
- Rheumatic fever

Poly articular:

- Rheumatoid arthritis
- Viral arthritis,
- Osteoarthritis,
- Systemic lupus erythematosus
- Polymyalgia rheumatica
- Systemic sclerosis.

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Oligoarticular:

- Sero negative arthritis
  - Reactive arthritis (Reiter's disease)
  - Psoriatic arthritis
  - Ankylosing spondylitis
  - Arthropathy associated with IBD
- Osteoarthritis
- Oligo articular presentaiton of poly arthritis

Monoarticular:

- Septic arthritis
- Traumatic arthritis
- Gout & Pseudo gout
- Haemarthrosis
- Monoarticular presentation of oligo or polyarthritis

2. ***Ask about radiation:***

Does it stay in one place or does it move or spread?

Importance:

Pain from nerve compression radiates to the distribution of affected nerve.

In cervical radiculopathy: Pain in the neck radiates along the distribution of affected nerve root. *Davidson-1219 (22nd)*

In PLID : Constant aching pain in the lumber region radiates to the buttock, thigh, calf & foot. *Davidson-1219 (22nd)*

Hip pain : Usually felt in the groin but may radiate to the thigh or knee. *Macleod's 319 (13th)*

Common pattern of referred and radicular musculoskeletal pain:

Site of pathology:	Perceived at:
Cervical Spine:	
C1/C2	Occiput
C3, C4	Interscapuler region
C5	Tip of shoulder, upper outer aspect of fore arm
C6, C7	Inter scapular region or the radial fingers and thumb
C8	Ulner side of fore arm, ring and little finger
Thoracic Spine	Chest
Lumber spine	Buttock, knees, leg
Shoulder	Lateral aspect of upper arm
Elbow	Fore arm
Hip	Anterior thigh, Knee
Knee	Thigh, knee

Macleod 319 (13th)

Scanned with CamScanner

3. *Mode of onset:*

Importance :

Acute (<6 weeks):

- Septic arthritis *Davidson-1094 (22nd)*
- Viral arthritis *Davidson-1095 (22nd)*
- Acute gout *Davidson-1088 (22nd)*
- Pseudo gout *Davidson-1090 (22nd)*
- Reactive arthritis (Reiter's syndrome) *Davidson-1107 (22nd)*
- Initial presentation of chronic arthritis

Chronic (gradual onset): 6 weeks or more:

- Rheumatoid arthritis (6 weeks or more)
- Ankylosing spondylitis
- Osteoarthritis
- SLE
- Psoriatic arthritis
- Enteropathic arthritis

4. *Character:*

Importance:

- Bone pain is penetrating, deep or boring & is characteristically worse at night.
- Fracture pain is sharp and stabbing, aggravates by attempted movement or use & relieves by rest and splintage.
- Muscle pain is poorly localized, deep and aggravates by use of the affected muscle.
- Generalized bony condition such as osteomalacia usually causes diffuse pain.
- Localized pain suggests tumor, osteomyelitis or osteonecrosis.
- Shooting pain is caused by mechanical impingement of a peripheral nerve or nerve root e.g. In PLID, buttock pain which shoots down the back of the leg.
- Neurological involvement in DM, Leprosy, Syringomyelia & syphilis (Tabes dorsalis) may cause loss of joint sensation, so pain is less than expected from examination.

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- Pain disproportionately greater than expected in compartment syndrome.
- Chronic pain syndrome (Fibromyalgia) causes widespread, unremitting pain with little diurnal variation that is poorly controlled by conventional analgesics. *Macleod's 319 (13th)*

5. ***Severity/Mood disturbance:***

Does it interfere with daily activities or keep the patient awake at night?

Importance:

Most severe pain occurs in

- Trauma
- Septic arthritis
- Crystal arthritis such as gout, pseudo gout.

Macleod's 320 (13th)

6. ***Variation with time:***
   - Diurnal variation of pain & stiffness occur in chronic inflammatory lesion such as rheumatoid arthritis (more in morning).

7. ***Effects of activity / Aggravating factor***

Importance:

- Pain caused by mechanical problem aggravates by movement or activity.
- Symptoms of osteoarthritis aggravates by movement and relieves by rest

Davidson-1082 (22nd).

- Pain due to inflammation such as sero negative arthritis exacerbates by inactivity and relieves by movement.
- Pain from septic joint is present both at rest and with movement. *Macleod's 320 (13th)*

8. ***Relieving factor:***

Importance:

- Relieves by rest : Mechanical pain e.g. Osteoarthritis.
- Relieves by activity : Inflammatory pain e.g. seronegative arthritis, rheumatoid arthritis.

Question: Hutchison' (as pain) 4, 8, 9, Macleod's-Page-260 (10th)

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RASH

Questions with importance:

1. ***Ask about age at onset and duration of rash.***

Importance:

- Atopic eczema often starts in early childhood and psoriasis starts between 15 and 40 years, and both may be chronic.
- Infective or drug-induced rashes are more likely to be of short duration and the latter occur in relation to drug ingestion.

2. ***Ask about body site at onset and distribution.***

- Flexural sites are involved in atopic eczema.
- Extensor surface and scalp are involved in psoriasis.
- Symmetrical → Endogenous disease such as psoriasis.
- Asymmetrical → Exogenous causes such as contact dermatitis and bacterial, viral or fungal infection.
- Dermatological distribution suggests → Herpes zoster

Davidson-1257 (22nd)

3. ***Is it itchy?***

Importance:

- Eczema is usually extremely itchy.
- Psoriasis and pityriasis rosea are not so itchy.

4. ***Was there a preceding illness or were systemic symptoms present ?***

Importance:

- Guttate psoriasis is often preceded by a beta-haemolytic streptococcal sore throat.
- Infectious mononucleosis treated with amoxicilline, will develop an erythematous maculo papuler eruption.
- The rash of syphilis follows a history of chancre at sites of inoculation.
- Malaise and arthralgia are common in drug eruptions and vasculitis.

Davidson-1257 (22nd)

5. **Associated symptom:** ***Have you any other problems ?***

Importance:

Associated with fever, headache, myalgia, cough, constipation, vomiting, relative bradycardia & splenomegaly may be → Typhoid fever.

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History of past illness

Present history	Past history
Reactive arthritis (reiter's disease)	Bacterial dysentery with salmonella, shigella or sexually acquired infection with chlamydia. *Davidson-1107 (22nd)*
Psoriatic arthritis	Most patient have pre existing psoriasis (70% of cases). *Davidson-1108 (22nd)*
Systemic lupus erythematosus	Past history of spontaneous abortion.
Osteomyelitis	A past history of pneumonia, otitis media, typhoid fever or multiple boils. *S.Das110 (5th)*

Family history:

Importance:

Family history is important in these disease:

- Rheumatoid arthritis *Davidson-1096 (22nd)*
- Sero negative arthritis *Davidson-1104 (22nd)*
- Gout *Davidson-1087 (22nd)*
- Psoriasis
- SLE *Davidson-1110 (22nd)*
- Osteoporosis
- Osteoarthritis *Davidson-1081 (22nd)*

Occupational history:

Importance:

- Working for prolonged period in abnormal postures causes disease of joint and muscles. *Park's-536 (6th)*
- Exposure to vibration may produce injury to the joints of hands, elbow and shoulders. *Park's-537 (6th)*

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Social / Personal history:

Importance:

- Smoking → Osteoporosis *Davidson-1120 (22nd)*
- Alcohol → osteoporosis and gout Davidson-1120+1087 (22nd)
- Sexual exposure (promiscuity)→ Reactive arthritis (Reiter's disease) *Davidson-1107 (22nd)*

Dietary history:

Importance:

- Vitamin - D deficiency causes rickets & osteomalacia

Davidson-1125 (22nd

Treatment history:

Importance:

Drugs	Possible adverse musculoskeletal effect:
Steroid	Osteoporosis, myopathy, osteonecrosis, infection
Statins	Myalgia, myopathy, myositis
ACE inhibitors	Myalgia, arthralgia, positive antinuclear antibody
Antiepileptics	Osteomalacia, arthralgia
Immunosuppressants	Infections
Quinolones	Tendinopathy, tendon rupture

Macleod's 322 (13th)

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NERVOUS SYSTEM

Name:
See page no.23

Age:
More in childhood:

- Epilepsy (onset)

More in young:

- Idiopathic intracranial hypertension (obese young woman) *Davidson-1217 (22nd)*
- Migraine (usually appears before middle age) *Davidson-1176 (22nd)*

More in middle age:

- Myasthenia gravis *Davidson-1226 (22nd)*
- Herpes zoster (middle aged or elderly) *Davidson-1207 (22nd)*
- Sub arachnoid haeomorrhage (before the age of 65) *Davidson-1246 (22nd)*

More in old age:

- Motor neuron disease (>50years) *Davidson-1200 (22nd)*
- Alzheimer's disease *Harrison-3305 (18th*
- Parkinson's disease *Davidson-1195 (22nd)*
- Stroke *Davidson-1237 (22nd)*

Sex:
Importance:
More in male:

- Stroke (except in the very young and very old) *Davidson-1237 (22nd)*
- Cluster headache (Male: Female = 5: 1) *Davidson-1177 (22nd)*
- Motor neuron disease *Davidson-1200 (22nd)*

More in female:

- Migraine (20% of female, 6% of male) *Davidson-1176 (22nd)*
- Sub arachnoid haemorrhage *Davidson-1246 (22nd)*
- Multiple sclerosis (Female: Male = 2: 1) *Davidson-1188 (22nd)*
- Mysthenia gravis *Davidson-1226 (22nd)*
- Idiopathic intracranial hypertension *Davidson-1217 (22nd)*

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Occupation:
Importance: See page No: 211

Address:
Present
Permanent:

Importance:
For identification of patient, communication and follow up.

Chief complaints:
1. Headache
2. Pain (face, trunk, and limbs)
3. Unconsciousness / Coma
4. Involuntary movement
5. Aphasia/Dysphasia
6. Dizziness / Vertigo

History of present illness

HEADACHE

Primary and secondary headache syndrome:
Primary headache syndrome:
- Migraine (with or without aura)
- Tension type headache
- Trigeminal autonomic cephalagia (including cluster headache)
- Primary stabbing/coughing/exertional /sex-related headache
- Thunderclap headache
- New daily persistent headache syndrome

Secondary causes of headache:
- Medication overuse headache (chronic daily headache)
- Intra cerebral bleeding (subdural haematoma, subarachnoid or intracerebral haemorrhage)
- Raised intra cranial pressure (brain tumor, idiopathic intracranial hypertension)
- Infection (meningitis, encephalitis, brain abscess)
- Inflammatory disease (temporal arteritis, other vasculitis, arthritis)
- Referred pain from other structures (orbit, temporomandibular joint, neck)

Davidson-1156 (22nd)

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Questions with importance:

1. Site:

Where is it? Whether headache affects the entire head, half of the head or a smaller area of the head, neck or face.

Importance:

Disorders	Site
Sub arachnoid haemorrhage	Bilateral, generalized or nuchal
Tension headache	Bilateral, generalized or nuchal
Migraine	Unilateral, different site on different occasion
Cluster headache	Unilateral, eye, nose, cheek
Cranial arteritis	Unilateral with scalp tenderness
Trigeminal neuralgia	Unilateral; maxillary or mandibular branch of trigeminal nerve
Post herpatic neuralgia	Unilateral, ophthalmic branch of trigeminal nerve

Macleod's 187 (10th)

2. Onset : Is it sudden or gradual?

Importance:

Acute single episode:

- Sub arachnoid haemorrhage
- Epidural or subdural haematoma
- Cerebral venous sinus thrombosis
- Acute meningitis, encephalitis

Acute recurrent:

- Migraine
- Tension type headache
- Cluster headache

Sub acute progressive:

- Raised intra cranial pressure (tumor, abscess, hydrocephalus, idiopathic intra cranial hypertension)
- Infections (meningitis, encephalitis)
- Temporal arteritis

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Chronic:

- Chronic daily headache syndrome
- Chronic migraine
- Medication overuse headache
- Cervicogenic headache
- Drugs, e.g. nitrates, dipyridamole *Macleod's 241 (13th)*

3. **Character:** What is it like ?

Importance:

- Dull, tight or like a pressure and there may be a sensation of a band round the neck or pressure at the vertex → Tension headache *Davidson-1176 (22nd)*
- Throbbing, dull aching → Migraine headache *Harrison-117 (18th)*
- Lancinating, paroxysmal pain like red-hot needles, thrust through the face → Trigeminal neuralgia

Migraine headache:

Migraine headache is usually severe and throbbing with photophobia, phonophobia and vomiting lasting from 4 to 72 hours, 20% of patient experience an aura, movement makes the pain worse and patient prefer to lie in a quiet and darkroom. *Davidson-1177 (22nd)*

Headache can be initiated or amplified by various triggers, including glare, bright light, sounds, hunger, excess stress, stormy weather, menstruation, lack of or excess sleep, alcohol or other chemical stimulation. *Harrison-114 (18th)*

Tension type headache:

Tension type headache is characterized as dull, tight or like a pressure and there may be a sensation of a band round the neck or pressure at the vertex. It is of constant character and generalized. In contrast to migraine, the pain can remain static for weeks or months, although the severity may vary and there is no associated vomiting or phonophobia. The pain is less severe in early part of day and become more troublesome as the day go on. Tenderness may present over the skull vault or in the occiput. *Davidson-1176 (22nd)*

Cluster headache:

Cluster headache is strikingly periodic, featuring runs of identical headaches beginning at the same hour for weeks at a time (the

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eponymous cluster). Patient may experience either one or several attack within a 24 hour period. Cluster headache causes severe unilateral periorbital pain with autonomic features such as unilateral lacrimation, nasal congestion and conjunctival injection. The pain though severe, is characteristically brief (30-90 minute).In contrast to migraine patient, the patient are often highly agitated during the headache phase. The cluster period is typically a few weeks followed by remission for months to years. *Davidson-1177 (22nd)*

Trigeminal neuralgia:

This is characterized by unilateral, lancinating facial pain, most commonly involving the second and / or third division of trigeminal nerve, usually the patient over 50 years. *Davidson-1178 (22nd)*

The pain is repetitive, severe and very brief. It may be triggered by touch, a cold wind or eating. *Davidson-1178 (22nd)*

Primary stabbing headache:

The essential features of primary stabbing headache are stabbing pain confined to the head or rarely the face lasting from 1 to many seconds or minutes and occurring as a single stab or a series of stab, absence of associated cranial autonomic features, absence of cutaneous triggering of attack and pattern of recurrence at irregular interval (hours to days). *Davidson-1176 (22nd)*

Primary cough headache: It is a generalized headache that begins suddenly, lasts for several minutes and precipitated by coughing.

Primary exertional headache: It is precipitated by any form of exertion. *Harrison-127 (18th)*

Primary sex headache: This type of headache is precipitated by sexual excitement. *Harrison-127 (18th)*

4. Radiation:

Does it stay in one place or does it move or spread?

Importance:

- Radiating to neck with neck muscle tenderness → Tension headache.
- Unilateral pain, radiating to ear, nose, throat (E.N.T), cheek or face → May be neuralgia. *Macleod's-187 (10th)*

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5. Severity:

Does it interfere with daily activities? Does it keep the patient awake at night ?

Importance:

- Sleep disturbance occurs in brain tumor.
- Paroxysm of severe pain may cause the patient wince and cry out momentarily may be due to → Trigeminal neuralgia.

Macleod's 188 (10th)

6. Duration:

When does it come and when does it go ?

Importance:

- Migraine attacks typically last 4 - 72 hours.

Davidson-1177 (22nd)

- Episode of cluster headache usually last 30-90 minutes.

Davidson-1177 (22nd)

- In trigeminal neuralgia, each paroxysm lasts only seconds.
- Tension headache lasts for weeks or months.

Davidson-1176 (22nd)

7. Frequency and periodicity:

Is it continuous or periodic?

Importance:

- Pain free intervals lasting weeks or months
  - i Migraine
  - ii Trigeminal neuralgia
  - iii Cluster headache.
- Migraine attacks are often cyclical, occurring weekly or monthly and are frequently premenstrual in woman.
- Sub acute onset but are continuous
  - i. Post herpetic neuralgia
  - ii. Cranial arteritis

Macleod's 188 (10th)

8. Occurrence /Aggravating factor:

What brings it on? What makes it worse?

Importance:

- Pain precipitated by facial movement such as eating, drinking, shaving or brushing the teeth suggests →
  - i. Trigeminal neuralgia
  - ii. Glosso pharyngeal neuralgia.

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- Jaw pain during chewing → May be cranial arteritis.
- Pain increasing by bending, straining, coughing → Raised intracranial pressure.
- Precipitated by bright light, loud noise, strong odour, changes in weather, contraceptive pills → Migraine headache.

Macleod's-188 (10th)

9. Relieving factors:

What makes it better?

Importance:

- Responsive to analgesic → Migraine headache

Macleod's-188 (10th)

10. Associated phenomena:

Have *you any other problems?*

Importance:

- Nausea, vomiting, photophobia, phonophobia → Migraine.
- Watering of eye or nose, or even ptosis of an eyelid → Cluster headache.
- Projectile vomiting (without nausea) → Raised intracranial pressure.
- Acute severe headache associated with stiff neck and fever suggests meningitis
- Acute severe headache associated with stiff neck but without fever suggests SAH.

Question - Macleod's -187 (10th)

Presentation in history: The patient complains of headache for 3 days, which is unilateral, throbbing in character. It does not radiate to any other site. Headache is aggravated by excessive sound and in bright light and relieves by taking analgesics. He also gives the history of similar attack of headache several times. Each attack persisted for 2-3 days and sometimes was associated with vomiting.

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UNCONSCIOUSNESS/COMA

(Persistent loss of consciousness)

Common causes of coma:

Metabolic disturbance:

i. Drug over dose (including alcohol, insulin)
ii. Diabetes mellitus (hypoglycemic coma, Ketoacidosis, hyperosmolar coma)
iii. Hepatic failure
iv. Uraemia
v. Respiratory failure
vi. Hyponatremia
vii. Hypothermia
viii. Hypothyroidism
ix. Thiamin deficiency

Trauma

i. Cerebral contusion
ii. Extradural haematoma
iii. Subdural haematoma

Cerebrovascular disease

i. Subarachnoid haemorrhage
ii. Intra cerebral haemorrhage
iii. Brainstem infarction/haemorrhage
iv. Cerebral venous sinus thrombosis

Infection:

i. Meningitis
ii. Encephalitis
iii. Cerebral abscess
iv. Septicemia

Others:

i. Epilepsy
ii Brain tumor
iii Functional (pseudocoma)

Davidson1160 (22nd)

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Questions with importance: (From attendant)

1. ***Whether the coma was gradual or sudden onset.***

Importance:

Sudden onset:

Suggests vascular event or seizure

i. Sub arachnoid haemorrhage
ii. Cerebral haemorrhage
iii. Cerebellar haemorrhage
vi. Cerebral infarction
v. Seizure

Differential diagnosis 68 (3rd)

Develops gradually over a period of minutes → hypoglycemia.

Braunwald Heart disease - 9 (4th)

2. ***What are the preceding events of coma (e.g. trauma, headache, drug administration etc.)***

Importance:

- A prolonged history of headache before coma suggests → Intracranial space occupying lesion due to any cause

Hutchison's – 338 (21st)

- SAH typically presents with sudden, severe thunderclap headache (often occipital), which lasts for hours or even days, often accompanied by vomiting, raised blood pressure and neck stiffness or pain. It commonly occurs on physical exertion, straining and sexual excitement. There may be loss of consciousness.

Davidson-1246 (22nd)

- The combination of severe headache and vomiting at the onset of the focal deficit is suggestive of intracerebral haemorrhage.

Davidson-1240 (22nd)

- After insulin administration → Hypoglycemic coma.

Braunwald Heart disease - 8 (4th)

3. ***If there is a history of trauma/ accident is present, the time of onset of unconsciousness should be noted. Whether appeared with accident or little later or lucid interval present.***

Importance:

- A few days later by the fluctuating drowsiness and stupor suggests → Subdural haematoma.
- If it is followed by a brief lucid interval (If the patient become unconscious with the accident, but regain consciousness for a while and again become unconscious) → Extradural haematoma.

Differential diagnosis 68 (3rd)

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INVOLUNTARY MOVEMENTS

(Tremors, choreiform movement etc.)

Disorder of movement leads to either extra, unwanted movement (hyperkinetic disorders) or too little movement (hypokinetic disorders). In either case the lesion often localizes to the basal ganglia, although some tremors are related to cerebellar or brainstem disturbance. Functional movement disorders are common and may mimic all of the organic syndromes below.

Davidson1165 (22nd)

Movement disorders:

Hyperkinetic disorders:

Description	Features	Examples
Tremor	Rhythmical oscillation of body part caused by alternating agonist/antagonist muscle contraction	Essential tremor, Parkinson's disease Drug induced
Chorea	Jerky, brief, purposeless, involuntary movements	Huntington's disease Drug induced
Tics	Stereotyped, repetitive movements such as blinking, winking, head shaking, or shoulder shrugging. Unlike dyskinesia, the patient may be able to suppress them, although only for short time.	Tourette's syndrome
Myoclonus	Brief, isolated, random jerks of muscle groups	Epilepsy, Hypnic jerks, focal cortical disease
Dystonia	Sustained involuntary muscle contraction that causes abnormal posture or movement	Genetic, generalized dystonic syndromes, focal dystonia in adult
Athetosis	Slower, writhing movement of the limbs, often combined with chorea and having similar causes.	
Ballism	A more dramatic form of chorea, causing often-violent flinging movement of one limb (monoballism) or one side of the body (hemiballism)	The lesion localizes to the contralateral subthalmic nucleus and the most common cause is stroke.

Davidson1166 + 1167 (22nd)

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Hypokinetic disorders :

Description	Features	Examples
Parkinsonism	Akinesia, rigidity, tremor, loss of postural reflexes, other features depending upon cause	i. Idiopathic Parkinson's disease ii. Other degenerative syndromes iii. Drug induced
Catatonia	Mutism, sustained posturing and waxy flexibility	Usually psychiatric; if neurological, is most commonly of vascular origin

Davidson1166 + 1167 (22nd)

Causes of chorea:

Hereditary:

Huntington's disease & HD like syndromes

Wilson's disease

Neuro acanthocytosis

Cerebral birth injury (including kernicterus)

Cerebral trauma

Drugs: Levodopa, antipsychotics. anti convulsants, oral contraceptives

Metabolic:

Disorders affecting thyroid, parathyroid, glucose, sodium, calcium and magnesium balance

Auto immune:

Post streptococcal (sydenham's chorea)

Anti phospholipids antibody syndrome

Systemic lupus erythematosus

Structural lesion of basal ganglia:

Vascular demyelation

Brain tumor

Davidson1167 (22nd)

Common causes of tremor:

- Essential tremor
- Anxiety
- Thyrotoxicosis
- Parkinson's disease
- Cerebellar disease
- Multiple sclerosis
- Heavy metal poisoning
- Drugs: beta-2 agonist, theophylline, thyroxine, sodium valproate, lithium, tricyclic antidepressants, recreational drugs (e.g. amphetamine), alcohol, caffeine etc.

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Questions with importance:

1. ***Ask about parts of body affected***

Importance:

Tremor : Rhythmical oscillation of the affected part of body by alternating agonist/antagonist muscle contraction.

Chorea : Jerky, brief, purposeless, involuntary movement, appearing as fidgety movements affecting different areas.

Davidson-1176 (22nd)

2. ***Ask about of voluntary muscular action and sleep upon***

Importance:

- Occur predominantly at rest and reduced by voluntary movements → Parkinson's disease (Rest tremor)
- Present only during movement → Cerebellar disease.

Hutchison's-274 (21st)

- Maximum, while limb posture is actively maintained against gravity → Asterixis (Flapping tremor) e.g.
  - i. Renal failure
  - ii. Liver failure
  - iii. Hypercapnia
  - iv. Drug toxicity e.g. phenytoin

Davidson-1139 (I9th)

3. ***Is it continuous or occasional ?***

Importance:

In epilepsy occasional tremor may occur.

4. ***Detailed drug history and family history***

Importance:

- Beta-2 agonist, theophylline, caffeine, dopamine agonist, phenothiazines, amphetamines etc. cause tremor
- Up to one third of patients with benign essential tremor have a family history.

5. ***Enquire about the amount of coffee and alcohol intake***

Importance:

Excessive coffee or alcohol may cause tremor.

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APHASIA / DYSPHASIA

1. ***Is speech fluent or not ?***

Importance:

- Fluent dysphasia, also called receptive aphasia (normal or increased number of wrong words) → Lesions on posterior to the central fissure in speech area.
- Non fluent dysphasia, also called expressive aphasia (Verbal output reduced) → Lesions anterior to the central fissure in speech area. *Davidson – 1149 (19th)*

2. **Comprehension:** ***Does the patient understand speech (e.g. touch your ear, stand up then close the door)***

Importance:

- Difficulty with speech comprehension → Lesion in the superior part of posterior temporal lobe or adjoining part of the parital lobe. *Davidson – 1149 (19th)*
- In broca's dysphasia, though non fluent speech, malformed words (spoot for spoon) are produced, reading or writing impaired but comprehension is relatively intact.
- In wernicke's dysphasia → Fluent dysphasia with impaired comprehension. *Oxford hand book of clinical medicine~344 (5th)*

3. **Repetition:** ***Can the patient repeat a sentence?***

Importance:

- In conduction aphasia, repetition impaired, but in trans cortical dysphasia, repetition intact. *Oxford hand book -344 (5th)*
- Patients with lesions around the sylvian fissure (lateral fissure) will have difficulty with repetition, whilst those with lesions away from the sylvian fissure can repeat. *Davidson-114 (19th)*

4. **Reading and writing:** ***Is it normal or not***

Importance:

- In both broca's dysphasia and wernicke's dysphasia, reading & writing impaired. *Oxford hand book -344 (5th)*

5. **Naming:** ***Can he name common and uncommon things ?***

Importance:

- Naming is impaired in all dysphasia, but in anomic aphasia, left temporoparital lesion especially occur.

Question: Oxford handbook of clinical medicine - 344 (5th)

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LIMB WEAKNESS

Questions with importance:

1. Is it sudden or gradual

Importance:

Sudden onset (over minutes)

- Stroke
- Arterial ischemia (associated with pain & numbness)
- Spinal cord compression (associated with incontinence and definite sensory level)

The mark manual of patient symptoms589 (1st)

Weakness that progress over hours to days may be caused by **acute or subacute disorder:**

- Spinal cord compression
- Guillain-Barre Syndrome
- Critical illness
- Rhabdomyolysis
- Botulism
- Tick paralysis
- Organo-phosphorous poisoning

Weakness that progress over weeks to months

Sub acute or chronic disorder

- Cervical myelopathy
- Myasthenia gravis
- Motor neuron disease
- Acquired myopathy
- Most tumors
- Most inherited and acquired polyneuropathy

Weakness that fluctuates from day to day

- Multiple sclerosis
- Metabolic myopathy

Weakness that fluctuates over the course of a day

- Myasthenia gravis
- Eaton –lambert syndrome
- Periodic paralysis

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2. ***Ask about portion of body involved and extent (proximal/distal muscle)***

Importance:

- Weakness in only some muscles in a limb → Problems in the peripheral nerves or motor root (s)
- Weakness of the whole of one limb → Problems in the brachial or lumbosaccral plexus or due to central lesion
- Weakness in both lower limbs (Paraparesis) and all four limbs (tetraparesis) →
  i. Spinal cord lesion
  ii. A diffuse peripheral nerve problem e.g. Guillain Barre syndrome.
- Weakness down one side of body suggests.
  i. Cerebral hemisphere lesion,
  ii. Spinal cord or brain stem lesion. *Davidson-1137 (19th)*

Proximal muscle weakness disproportionately impairs reaching upward (e.g. combing hair, lifting object over head), ascending stairs, or standing from a squatting or sitting position;

- This is typical of myopathies.

Distal muscle weakness disproportionately impairs tasks such as stepping over a curb, holding a cup, writing, buttoning, or using a key;

- This is typical of polyneuropathies and also myotonic dystrophy.

3. ***Whether maximum at onset or increasing.***

Importance:

Increasing → Neoplastic lesion

4. ***Previous attack***

Importance:

In multiple sclerosis →

i. Lesion in more than one anatomical site at more than one time,
ii. Recurrence occur after a variable interval often within 2 years.

5. ***Ask about other symptoms of nervous system.***

Importance:

- Absence of sensory involvement → MND, Myopathy, Myasthenia gravis. *Question-Chamberlain's -17 (12th)*

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VERTIGO

Definition:

Abnormal perception of movement of the environment or self is called vertigo.

Davidson-1167 (22nd)

Sensation of movement relative to surrounding.

Macleod's 299 (13th)

Common causes:

Peripheral vertigo:

- Benign positional vertigo
- Vestibular neuronitis
- Drugs, e.g. gentamicin, anticonvulsants
- Meniere's disease
- Trauma

Central vertigo

- Brain stem ischemia or infarction
- Migraine
- Multiple sclerosis

Macleod's 300 (13th)

Questions with importance:

1. ***Ask about duration of the episodes***

Importance:

- Vertigo caused by labyrinthine disorder is usually short lived (lasts days at a time), though it may recur.
- Vertigo due to central disorder (brainstem) is often persistent and accompanied by other brainstem sign.

Davidson-1168 (22nd)

2. ***Ask about positional or other precipitating factors ?***

Importance:

- In benign paroxysmal positional vertigo, the history is diagnostic; transient (seconds) vertigo precipitated by movement

Davidson-1168 (22nd)

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3. ***Ask about associated or fluctuating hearing loss or tinnitus***

Importance:

- In meniere's disease, episodes of vertigo accompanied by tinnitus and fullness in the ear, each attack typically lasting a few hours. Over the years, patient may develop progressive deafness.

  Davidson-1186 (22nd)

- In labyrinthitis, hearing loss and tinnitus may occur.

  Mark manual of patient symptoms 122 (1st edition)

4. ***Whether the ear feels full during the episode***

Importance:

- Meniere's disease causes episodic fullness in the ear with tinnitus, severe vertigo and headache. *Macleod's 300 (13th)*

5. ***Whether there is a past history of significant head injury***

Importance:

- BPPV may follow minor head injury but typically is spontaneous.

  Davidson-1186 (22nd)

- Associated with restricted neck movement suggests → Cervical spondylosis.

6. ***Associated symptoms***

Importance:

- Associated with hearing loss & tinnitus → Labyrinthitis (Viral or bacterial)
- Recurrent episodes of unilateral tinnitus, hearing loss, earfullness → Meniere's disease
- Sudden, incapacitating, severe vertigo, without hearing loss or other findings → Vestibular neuronitis
- Associated with earache and discharge from ear → Otitis media
- Sudden onset and associated with ataxia and other cerebellar findings → Cerebellar haemorrhage or infarction
- Associated with other brain stem sign → Brain stem haemorrhage or infarction
- Episodic, recurrent vertigo associated with headache, photophobia, phonophobia → Migraine
- Associated with varied CNS motor and sensory deficits, with remission and recurring exacerbations → Multiple sclerosis.

  The mark manual of patient symptoms123 (1st edition)

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DIPLOPIA

Diplopia may be reported as blurred rather than double vision and most commonly arises from misalignment of the eyes.

Monocular diplopia:

The most common causes:

- Cataract
- Abnormal shape of cornea, such as keratoconus
- Uncorrected refractive error, usually astigmatism
- Corneal scarring
- Dislocated lens

Binocular diplopia:

- Cranial nerve palsy (3rd, 4th & or 6th)
- Myasthenia gravis
- Graves disease
- Multiple sclerosis
- Botulism
- GBS, Miller Fisher variant
- Cerebro vascular disease affecting midbrain or pons
- Orbital infiltration (thyroid infiltrative opthalmopathy, orbital pseudo tumor).

The mark manual of patient symptoms117

Questions with importance:

1. ***Whether diplopia involve one or both eyes?***

Importance:

Monocular diplopia is rare and indicates ocular disease.

Binocular diplopia suggests probable neurological cause. It may result from central disorders or from disturbance of the ocular motor nerves, muscles or the neuromuscular junction.

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2. ***Whether diplopia is intermittent or constant?***

Importance:

- Intermittent diplopia occurs in myasthenia gravis & in multiple sclerosis.

The mark manual of patient symptoms117

- In myasthenia gravis, worsening the symptoms towards the end of the day or following exercise is characteristics.

Davidson-1226 (22nd)

3. ***Whether the images are separated vertically, horizontally, or a combination of both?***

Importance:

- Vertical diplopia occurs in 4th cranial nerve palsy.

4. ***Any associated pain is noted and whether it occurs with or without eye movement?***

Importance:

Associated with pain:

- Graves' disease
- Orbital myositis
- Cavernous sinus thrombosis,
- Compressive lesion such as aneurysm, tumor

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5. ***Does the diplopia increases on looking to the right, left, upwards or downwards?***

Importance:

- Trochlear nerve palsy presents with vertical diplopia (especially noticeable during going down stairs),
- Abducent nerve palsy causes horizontal double vision when trying to look towards the side of the lesion.
- Complete oculomotor nerve lesion causes ptosis (eye rest in down & out position).

4th nerve palsy: Vertical diplopia worse on downward gaze, patients tilt head to improve vision

In 6th nerve palsy : Eye deviated medially, diplopia worse on lateral gaze, patient turns head to improve vision.

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In 3rd nerve palsy: Lid droop, eye deviated laterally and down, sometimes pupillary dilatation.

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Question: The mark manual of patient symptoms117

History of past illness

Importance:

A history of recovered visual loss (optic neuritis) in a patient now presenting with numbness suggests multiple sclerosis.

A history of trauma in a patient presenting with paraplegia and urinary retention suggests spinal cord compression. *Macleod's 244 (13th)*

Present condition	Past History
Guillain-Barre Syndrome	History of respiratory or gastro intestinal tract infection (1-3 weeks before). *Harrison-3474 (18th)*
Transverse myelitis	Transverse myelitis usually follows viral illness or vaccination.
Tubercular meningitis	Tubercular meningitis most commonly occurs shortly after a primary infection in childhood or as part of miliary tuberculosis. *Davidson-1204 (22nd)*
Herpes zoster (shingles)	Herpes zoster is the result of reactivation of varicella zoster virus that has lain dormant in a nerve root ganglion following chicken pox earlier in life. Reactivation may be spontaneous (as usually occurs in the middle aged or elderly) or due to immunosuppression (as in patients with diabetes, malignant disease or AIDS). *Davidson-1207 (22nd)*

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Family History:

Importance:

Many neurological disorders are caused by single gene defects. Others have an polygenic influence. Neurological disease may also be caused by mitochondrial DNA abnormalities.

Autosomal dominant:

Myotonic dystrophy
Neurofibromatosis types I and II.
Tuberous sclerosis
Huntington's disease
Charcot-Marie –tooth 1a
Spinocerebellar ataxia
Fascio scapulo humeral muscular dystrophy

Autosomal recessive:

Wilson's disease
Friedreich's ataxia

X-linked recessive:

Duchenne and Becker muscular dystrophy
Fragile X syndrome

Polygenic influence:

Multiple sclerosis *Macleod's -245 (13th)*
Alzheimer's disease *Davidson-251 (22nd)*

Drug history:

Importance:

Always consider drugs, including prescribed, over the counter and complementary therapies, as they may cause many neurological symptoms.

Neurological symptoms/syndromes due to drugs:

Ataxia:

Phenytoin
Carbamazepine
Lithium

Epileptic seizures

Tricyclic antidepressants
Phenothiazines, Clozapine

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Headaches

Glyceryl trinitrate, Dipyridamole
Nifedipine, Sildenafil

Myopathy

Statins, Corticosteroids

Parkinsonism

Neuroleptics
Prochlorperazine, Metoclopramide

Peripheral neuropathy

Amiodarone
Antibiotic (dapsone, isoniazide, metronidazole, ethambutol)
Chemotherapy (vincristine, cisplatine, thalidomide)
Vitamin deficiency (thiamin, vitamin B12, pyridoxine, vitamin E)

Tremor:

Beta agonist e.g. salbutamol, terbutaline
Lithium
Sodium valproate

Macleod's -245 (13th) and Davidson-1223 (22nd)

Occupational history:

Importance:

Occupational factors are relevant to several neurological disorders. Toxic peripheral neuropathy occurs due to exposure to heavy or organic metals e.g.

- Lead causes motor neuropathy
- Manganese causes parkinsonian syndrome. *Macleod's -245 (13th)*
- Agricultural pesticides causes neurotoxicity. *Robins -434 (7th)*

Personal history:

Importance:

Neurological disease caused by ethanol abuse:

Cerebellar degeneration
Peripheral neuropathy
Wernicke syndrome
Korsakoff syndrome
Alcoholic dementia, Delirium tremens
Withdrawal convulsion, Proximal myopathy

Macleod's -18 (13th)

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Example of history of Medicine

Respiratory System:

Chief complaints:

1. Fever for 10 days
2. Cough for 7 days
3. Chest pain for same duration

History of present illness:

According to statement of the patient, he was reasonably well 10 days back. Suddenly he developed fever, which is continued & high grade in nature. Fever comes with chills and rigor and subsides by taking paracetamol with sweating. Highest recorded temperature is 104°F. There is no history of traveling to kala azar or malaria endemic zone. He also complains of cough which was initially dry but for the last 7 days, it is productive, yellowish in colour but not foul smelling and not mixed with blood. There is no diurnal variation and no variation with postural change. He also complains of left sided chest pain, which is sharp, stabbing in nature, aggravates by coughing and deep inspiration and relieves after taking analgesic drugs.There is no radiation of pain. For the last 5 day, she also complains malaise, generalized body ache and weakness. There is no history of breathlessness and contact with TB patient. His bowel and bladder habit is normal. There is no history of significant weight loss. He is normotensive and non diabetic. With all of above complaints, he is admitted in this hospital for better management.

History of past illness:

He was suffered from fever & cough 2 years back. For that problem, he was admitted at DMCH and was treated with Inj. Ceftriaxone 1gm 12 hourly for 7 days.

Drug history:

For the presenting complaints, he consulted with a registered doctor and took tablet Levofloxacin 500 mg once daily, Tab. Paracetamol 500 mg three times daily and Cap. Omeprazole (20mg) 2 times daily but he had no significant improvement.

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Family history:

He is unmarried. His parents are alive and healthy. He has one bother of 16 years old and one sister of ten years old. They are healthy.

Personal istory:

Mr.Baten is a businessman and smoker. He smokes about 10 sticks per day for 5 years. He is not alcoholic and there is no history of parenteral drug abuse.

Socio economic history:

He is of middle class family. He lives in a brick built house. He drinks tube well water and uses sanitary latrine.

Immunization history:

The patient is immunized according to EPI schedule. He also took Hepatitis B vaccine 2 years back.

General Examination:

Ill looking and toxic

Pulse: 120/min

B.P. 110/70 mm of Hg

Temperature: 104°F

Respiratory rate: 30/min

No anaemia, jaundice, cyanosis, clubbing, Koilonychia, Leukonychia and edema.

No lymphadenopathy or thyromegaly.

Rest of the general examination reveals normal.

Systemic Examination (Supposing in left side) :

Inspection:

- Movement restricted on the left side.

Palpation:

- Trachea: Central in position
- Apex beat: in the left fifth intercostal space, medial to mid clavicular line, normal in character
- Vocal fremitus: increased over the left side, from 2nd to 5th intercostal space, in the mid clavicular line.

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Percussion:

- Percussion note is woody dull over the above mentioned area (2nd to 5th intercostal space)
- Upper border of liver dullness is in right 5th intercostal space, in midclavicular line.
- Area of cardiac dullness: normal

Auscultation:

- Breath sound: High pitched bronchial sound over the 2nd to 5th intercostal space in the left side.
- Vocal resonance: Increased and there is whispering pectorioloquy in the same area.
- There are a few crepitation and pleural rub on the same area.

Examination of other systems reveals no abnormality.

Salient features:

Mr.Baten, 30 years old, Businessman, normotensive, non diabetic, non alcoholic, smoker, hailing from Fatulla, Narayongonj, presented with fever for 10 days, cough for 7 days and chest pain for same duration.

Fever is continued & high grade in nature. Fever comes with chills and rigor and subsides by taking paracetamol with sweating. Highest recorded temperature is 104°F. There is no history of traveling to kala azar or malaria endemic zone. He also complains of cough which was initially dry but for the last 7 days it is productive, yellowish in colour but not foul smelling and not mixed with blood. There is no diurnal variation and variation with postural change. He also complains of left sided chest pain, which is sharp, stabbing in nature, aggravates by coughing and deep inspiration and relieves after taking pain killer. There is no radiation of pain. For the last 5 days, he also complains of malaise, generalized bodyache and weakness. There is no history of breathlessness and contact with TB patient. His bowel and bladder habit is normal. There is no history of significant weight loss. Regarding past history, he was suffered from fever & cough 2 years back. For that problem, he was admitted at DMCH and was treated with Inj. Ceftriaxone 1gm 12 hourly for 7 days. Regarding treatment history, he consulted with a registered doctor and took tablet Levofloxacin 500 mg once daily, Tab. Paracetamol 500 mg three times daily and Cap. Omeprazole (20mg) 2 times daily but he had no

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significant improvement. The patient is immunized according to EPI schedule. He also took Hepatitis B vaccine 2 years back.

On general examination: (As above)

On systemic examination: (As above)

Provisional diagnosis: Pneumonic consolidation

Differential diagnosis:

1. Lung abscess
2. Bronchiectasis with secondary infection
3. Pleural effusion

Hepato biliary system:

Chief complaints:

1. Yellow coloration of sclera and urine for 1 year,
2. Swelling of abdomen for 3 months

History of present illness:

According to the statement of the patient, he was reasonably well 1 year back. Then he developed yellow coloration of sclera and urine. It is not associated with itching. His stool colour is normal. There is no history of any injection, infusion, blood transfusion, I/V drug abuse or sharing of needles. But he gives the history of unprotected sexual contact 2 years back. He also complains of swelling of abdomen for last 3 months. It is gradually increasing day by day. It is not associated with abdominal pain but there is sense of heaviness. He does not give any H/O of scanty micturition. There is no history of haematemesis, melaena or loss of consciousness. The patient does not give any history of fever, shortness of breath, cough, puffiness of face, joint pain, skin rash, pigmentation etc. His bowel and bladder habit is normal.

History of past illness:

He suffered from jaundice 5 years back that lasted for about 2 months. At that time, he took herbal medicine. He did not give any H/ O HTN, DM, IHD, Rheumatic fever and pulmonary tuberculosis.

Personal history:

He is a smoker and smokes about 10 sticks per day for 2 years. He is non alcoholic and not I/V drug abuser.

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Family history:

He is unmarried. His parents are alive and healthy. He has one brother of 15 years old and one sister of 10 years old. They are healthy. There is no H/O such type of illness in his family.

Drug and treatment history:

He consulted with a local physician for abdominal swelling and took Tab. Frusemide but there was no significant improvement.

General examination:

Appearance: Anxious, ill looking, cachectic, with hepatic facies characterized by pinched face, sunken eye, hollowed temporal fossa, malar prominence and muddy complexion of the skin.

Decubitus : On choice
Body built : Below average
Nutrition: Below normal
Anaemia: Mild
Jaundice: Mild
Cyanosis: Absent
Clubbing : Present
Oedema: Present (++), pitting
Dehydration: Mild
Koilonychia: Absent
Leukonychia: Present
Neck vein : Not engorged
Lymph glands : Not palpable
Thyroid glands : Not palpable
Gynaecomastia : Present
Pigmentation : Hyperpigmentation present mainly on abdomen
Spidernaevi : Present in chest and shoulder,
Palmer erythema: Absent
Flapping tremor: Absent
Distribution of body hair : Reduced, especially axillary and pubic hair
Pulse : 96/min, regular
Blood pressure : 110/70 mm of Hg
Respiration : 18/min
Body temperature : Normal

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Systemic examination:

Gastro intestinal system

Lips, gum, teeth, tongue and oral cavity-normal

Abdomen proper:

Inspection:

- Shape of the abdomen: Generalized distension
- Flanks: Full
- Umbilicus: Centrally placed, inverted, transversely slited
- Skin condition: Stria present, skin is smooth and shiny
- Visible engorged vein : Present on whole over the abdomen, especially around the umbilicus
- Axillary and pubic hair : Absent

Palpation:

Fluid thrill : Present

Liver: Not palpable

Spleen is palpable, 4 cm from the left costal margin in anterior axillary line, towards the right iliac fossa. The surface is smooth, firm in consistency and non tender.

Kidneys: Not ballotable

Testes: Both testes are small in size & firm in consistency.

Percussion :

General percussion note over the abdomen: Tympanic in midline, dull in the flunks

Shifting dullness is present

Auscultation:

Bowel sound present

Renal bruit and splenic rub : Absent

Examination of other systems reveals no abnormality.

Salient features:

Mr. Kamal, 30 years old, business man, normotensive, non diabetic, smoker, non alcoholic, hailing from comilla, presented with yellow coloration of sclera and urine for 1 year and swelling of abdomen for

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3 months. According to the statement of the patient, he was reasonably well 1 year back. Then he developed yellow coloration of sclera and urine. It is not associated with skin itching. His stool colour is normal. There is no history of any injection, infusion, blood transfusion, I/V drug abuse or sharing of needles. But he gives the history of unprotected sexual contact 2 years back. He also complains of swelling of his abdomen for last 3 months. It is gradually increasing day by day. It is not associated with abdominal pain but there is sense of heaviness. He does not give any H/O of scanty micturation. There is no history of haematemesis, melaena or loss of consciousness. The patient does not give any history of fever, shortness of breath, cough, puffiness of face, joint pain, skin rash, pigmentation etc. His bowel and bladder habit is normal. Regarding past history, he suffered from jaundice 5 years back that lasted for about 2 months. At that time, he took herbal medicine. He did not give any history of HTN, DM, IHD, Rheumatic fever and pulmonary tuberculosis. He is non alcoholic and not I/V drug abuser. There is no H/O such type of illness in his family. He consulted with a local physician for abdominal swelling and took Tab. Frusemide but there was no significant improvement.

On Examination –

General examination :

The patient is ill looking and emaciated, hepatic facies characterized by pinched face, sunken eye, hollowed temporal fossa, malar prominence, muddy complexion of the skin. He is mildly anaemic and mildly icteric. Moderate pitting oedema, clubbing, leukonychia and gynaecomastia are present. Reduced body hair, especially axillary and pubic hair. Spidernaevi present in chest and shoulder, no lymphadenopathy and no thyromegaly. Pulse: 96/ min. B.P. 110/ 80 mm of Hg. Rest of the general examination reveals normal.

On systemic examination (mention as above)

Clinical Diagnosis: Cirrhosis of liver with portal hypertension

Differential diagnosis:

Intra abdominal tuberculosis

Intra abdominal malignancy

Congestive heart failure

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Nervous system

Chief complaints:

Weakness of both lower limb and difficulty in walking for 1 month.
Inability to void urine for 2 weeks
Low back pain for same duration
Tingling and numbness of both lower limb for 10 days

History of present illness:

According to the statement of the patient, he was reasonably well 1 month back. Since then he has been suffering from weakness of both lower limb, which is gradually increasing. Initially he could walk with help of walking aid but for the last 15 days, he is unable to move his lower limb and can not walk at all. He also complains of difficulty in micturition and urinary incontinence for the last 1 month.

The patient also complains of low back pain for last 2 weeks, which is increased even with minor activities and on movement. For the last 10 days, he also experiences tingling and numbness on both lower limb. On query, he gives the history of trauma during heavy weight lifting 1 month back but he does not give any history of fever, weight loss, cough, burning in micturition or pain on other area. His bowel habit is normal.

History of past illness:

He has no such events earlier, no visual complaints, and no history of vaccination.

Family history:

There is no history of such illness in his family.

Drug and treatment history:

He consulted with local physician and took some vitamins but there was no improvement.

Personal history:

He is a smoker and smokes 5 sticks per days for 2 years.. He is non alcoholic and there is no history of I/V drug use.

Socio economic history:

He is of middle class family. He uses sanitary latrine and drinks tube well water.

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General examination:

- Ill looking, anxious and bed ridden
- Mildly anaemic
- No jaundice, cyanosis, clubbing, koilonychia, leukonychia or edema
- No lymphadenopathy or thyromegaly
- Urinary catheter in situ
- Pulse 72/min
- BP: 120/70 mm of Hg
- Temperature: Normal
- Respiration: Normal

Systemic examination:

- Higher cerebral function: Normal
- Cranial nerve including fundoscopy: Intact

Motor system:

Bulk of the muscle: Normal in both upper and lower limb

Muscle tone-increased in both lower limb, normal in upper limb

Muscle power: diminished (grade 0/5 in both lower limb, normal in both upper limb

Reflex:

Jerks	Biceps	Triceps	Supinator	Knee	Ankle	Planter
Right	Normal	Normal	Normal	Exaggerated	Exag.	Extensor
Left	Normal	Normal	Normal	Exaggerated	Exag.	Extensor

Coordination: Normal in upper limb, heel shin test could not be done due to weakness.

Rombergism could not be evaluated

Gait: Could not be evaluated due to weakness

Involuntary movement: Absent

Cerebellar function: Intact

Sensory system: Sensory perception of all modalities is impaired below 10th thoracic dermatome and intact above it. There is some paresthesia along the 10th thoracic dermatome

Salient features:

Mr. Tomal of 30 years old male, normotensive, non diabetic, non alcoholic, smoker, presented with weakness of both lower limb and

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difficulty in walking for 1 month, inability to void urine for 2 weeks, low back pain for same duration, tingling and numbness of both lower limb for last 10 days. According to the statement of the patient, he was reasonably well 1 month back. Since then he has been suffering from weakness of both lower limb, which is gradually increasing. Initially he could walk with help of walking aid but for the last 15 days, he is unable to move his lower limb and can not walk at all. He also complains of difficulty in micturition and urinary incontinence for the last 2 weeks. The patient also complains of low back pain for last 2 weeks, which is increased even with minor activities and on movement. For the last 10 days, he also experiences tingling and numbness on both lower limb. On query, he gives the history of trauma during heavy weight lifting 1 month back but he does not give any history of fever, weight loss, cough, burning in micturition or pain on other area. His bowel habit is normal. Regarding past history, he has no H/O such events earlier, no visual complaints, and no history of vaccination. He consulted with local physician and took some vitamins but there was no improvement. There is no history of such illness in his family.

On general examination: He is Ill looking, anxious and bed ridden. Mildly anaemic but not icteric, Urinary catheter in situ, No jaundice, cyanosis, clubbing, koilonychia, leukonychia or edema, no lymphadenopathy or no thyromegaly, Pulse 72/min, BP: 120/70 mm of Hg, Rest of the general examination reveals normal.

On systemic examination:

Higher cerebral function: normal, Cranial nerve including fundoscopy: intact, Bulk of the muscle are normal in both upper and lower limb.

Muscle tone-increased in both lower limb, normal in upper limb. Muscle power: diminished (grade 0/5 in both lower limb, normal in both upper limb, ankle jerk and knee jerk are exacerbated in both lower limb, planter are extensor bilaterally. Coordination: normal in upper limb, heel shin test could not be done due to weakness. Rombergism could not be evaluated. Gait: Could not be evaluated. Involuntary movement: absent. Cerebellar function: intact.

Sensory system: sensory perception of all modalities is impaired below 10th thoracic dermatome and intact above it. There is some paresthesia along the T_{10} dermatome

Clinical diagnosis: Spastic paraplegia

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Cardiovascular system

Presenting complaints:

1. Breathlessness for 2 years
2. Occasional chest pain for 2 years
3. History of 2 episodes of transient loss of consciousness within last one year.

History of present illness:

According to the statement of the patient, she was reasonably well 2 years back. Then she developed breathlessness which is increasing day by day, initially it was only on severe exertion but now it tends to occur with mild exertion. She does not give any history of breathlessness in lying position or at night bed time. Breathlessness has no seasonal variation or diurnal variation and not exaggerated by cold, dust, fume etc. It is not associated with fever, cough, wheeze and sputum production. She also complains of occasional chest pain for 2 years which is mild, retrosternal, constricting in nature, radiates to left shoulder and jaw; aggravates by exertion and relieves by rest. Chest pain is not associated with nausea, vomiting or sweating. Her attendants gives history of two episodes of unconsciousness within last 6 months. Each episodes of unconsciousness persisted for few seconds, always was exertional and in upright posture, preceded by lightheadedness. She also complains of generalized weakness and poor effort tolerance. Her bowel and bladder habit is normal.

History of past illness:

The patient and her attendant give a history of migratory polyarthritis, chest pain, palpitation and purposeless, involuntary choreiform movement of the hands, feet and face in her childhood suggestive of rheumatic fever.

She does not give any history of HTN, DM, stroke, TB, liver disease, bronchial asthma, COPD or any lung disease.

Drug history :

She took oral penicillin for rheumatic fever but treatment course was not completed.

Family history :

She has one brother of 10 years old and he is healthy. Her parents are alive and healthy. No history of similar type of illness in her family member.

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Personal history:

She is not a smoker, not alcoholic and not I/V drug abuser.

Socio economic history :

She is of middle class family. Their house is made up of bricks. She drinks tube well water and uses sanitary latrine.

General examination:

Appearance: Anxious and ill looking
Decubitus : On choice
Cooperation: Cooperative
Body built : Below average
Nutrition: Below normal
Anaemia: Absent
Jaundice: Absent
Cyanosis: Absent
Clubbing : Absent
Oedema: Absent
Dehydration: Absent
Koilonychia: Absent
Leukonychia: Absent
Neck vein : Not engorged
Lymph glands : Not palpable
Thyroid glands : Not palpable
Gynaecomastia : Absent
Pulse : 96/min, regular
Blood pressure : 100/80 mm of Hg
Respiration : 18/min
Body temperature : Normal

Systemic examination:

Cardiovascular examination:

A. **Pulse :** Pulse is 80 beat per min, regular, low volume, slow rising, symmetrical on both sides, no radiofemoral delay, condition of vessel wall normal.

B. **Jugular venous pressure:** not raised

C. **Peripheral pulses :** All peripheral pulses are present, no carotid or femoral bruit.

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D. Blood Pressure: 100/80 mm of Hg (narrow pulse pressure)

E. Examination of precordium:

Inspection

1. Size & Shape : Normal
2. Deformities: Absent
3. Scar mark: Absent
4. Visible cardiac impulse : Present in mitral area
5. Visible engorged vessel: Absent

Palpation:

1. Apex beat: Located at left 5th intercostal space, 9 cm from midline and just medial to mid clavicular line, heaving in character
2. Thrill: Systolic thrill is present in aortic area and in the neck.
3. Left parasternal heave: Absent
4. Palpable heart sound at the base of the heart: Absent
5. Epigastric pulsation: Absent

Percussion:

Area of cardiac dullness: Normal

Auscultation:

1. **Heart sounds**

   First heart sound (S1): Normal in all four auscultatory area

   Second heart sound (S2): A 2 soft in all areas, P2 is normal

2. **Murmur:**

   There is a low pitched systolic murmur at aortic area ; best heard with diaphragm of the stethoscope, in leaning forward position with breath hold in expiration, radiates to the neck.

3. **Pericardial rub: Absent**

Examination of other system: Reveals no abnormality

Salient feature:

Mrs. Sanjida Begum Mila of 30 years old, female, normotensive, non diabetic, non alcoholic, non smoker, hailing from Jamalpur, presented with breathlessness for 2 years, occasional chest pain for 2 years and history of 2 episodes of transient loss of consciousness within last one

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year. According to the statement of the patient, she was reasonably well 2 years back. Then she developed breathlessness which is increasing day by day, initially it was only on severe exertion but now it tends to occur with mild exertion. She does not give any history of breathlessness in lying position or at night bed time. Breathlessness has no seasonal variation or diurnal variation and not exaggerated by cold, dust, fume etc. Breathlessness is not associated with fever, cough wheeze and sputum production. She also complains of occasional chest pain for 2 years. Chest pain is mild, retrosternal, constricting in nature, radiating to left shoulder and jaw; aggravates by exertion but not by deep breathing and relieves by rest. Chest pain is not associated with nausea, vomiting or sweating. Her attendants give history of two episodes of unconsciousness within last 6 months. Each episode of unconsciousness persisted for few seconds, always was exertional and in upright posture, preceded by lightheadedness. She also complains of generalized weakness and poor effort tolerance. Her bowel and bladder habit is normal. Regarding past history, she gives the history of rheumatic fever in her childhood. She took oral penicillin for rheumatic fever but treatment course was not completed. No history of similar type of illness in her family member.

On General Examination:

Patient is dyspnoeic, Pulse is 80/min, regular, low volume with slow rising, B.P. 100/80 mm of Hg, JVP not raised, rest of the general examination reveals normal. On systemic examination: Apex beat is located at left 5th intercostal space, 9 cm from midline and just medial to mid clavicular line, heaving in character, systolic thrill is present in the aortic area and in the neck, 1st heart sound normal in all area, A2 soft, P 2 normal, there is a harsh ejection systolic murmur, loudest in aortic area, best heard with diaphragm of the stethoscope, in leaning forward position with breath holding in expiration which radiates to the neck. Rest of the systemic examination reveals normal.

Clinical diagnosis:

Aortic stenosis of rheumatic origin

Differential diagnosis:

Hypertrophic obstructive cardiomyopathy

Aortic sclerosis

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Musculoskeletal system:

Chief complaints:

Pain in multiple joints for 3 months
Skin rash for same duration
Fever for same duration
Oral ulcer for 2 months

History of present illness:

According to statement of the patient, she was reasonably well 3 months back. Since then she has been suffering from pain in multiple small and large joints of both lower and upper limb, predominantly lower limb, mostly involving the hands, wrists, knees, ankles and small joints of feet. The pain persists throughout the day and night, more marked in the morning and associated with morning stiffness. The pain does not releive by rest but reduces with pain killer. She also notices skin rashes on the face, arms and legs for the last 2 months that aggravates on exposure to sunlight. The patient also complains of fever for the last 2 months which is low grade and continued in nature. Highest recorded temperature is 100°F. Fever does not associated with chills and rigor and subsides with paracetamol. There is no history of night sweat. The patient also complains of marked weight loss and weakness. She also complains of recurrent oral ulcer for 2 months which is painless. On query, she also complains of hairloss for last 1 month. There is no history of spontaneous abortion, bleeding, venous thrombosis, convulsion and unconsciousness. Her bowel and bladder habit is normal.

History of past illness:

Nothing significant.

Drug history:

She was treated by multiple drug but she could not the mention the name of those drugs.

Family history:

She has one brother of 10 years old and he is healthy. Her parents are alive and healthy. No history of similar type of illness in her family member.

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Socio economic history:

She is of middle class family, She lives in a brick built house. She drinks tube well water and uses sanitary latrine.

Menstrual history:

The patient complains of occasional irregular menstruation, sometimes associated with menorrhagia.

General examination:

- Ill looking and emaciated.
- Alopecia is present on scalp.
- Butterfly rash is present on the face over the cheek, nasal bridge, sparing the nasolabial folds that are fixed, erythematous, some are flat, some are raised. Also maculo papular skin rashes are present on the dorsum of the hands and legs, some of these are pigmented and scaly.
- Oral ulcer present on inner side of lips and cheeks, some are coated with whitish discharge and irregular margin.
- Moderately anaemic
- No jaundice, cyanosis, clubbing, koilonychias, leukonychia or edema.
- No lymphadenopathy or thyromegaly
- Pulse: 88/min
- BP: 100/60 mm of Hg
- Temperature 99°F

Systemic examination:

- Both knee and ankle joint are swollen and tender
- Wrist, MCP and IP joint of both hands –slightly swollen and tender but no deformity

Gastro intestinal system: No abnormality detected

Eyes: No abnormality detected

Respiratory system: No abnormality detected

Cardiovascular system: No abnormality detected

Nervous system: No abnormality detected

Bed side urine examination: Normal (mention protenuria if present)

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Salient feature:

Mrs. Tamanna Robbany of 33 years old female, house wife, normotensive, non smoker, hailing from Tangail, presented with pain in multiple joints for 3 months, skin rash for same duration, fever for same duration & oral ulcer for 2 months. According to the statement of the patient, she was reasonably well 3 months back. Since than she has been suffering from pain in multiple small and large joints of both lower and upper limb, predominantly lower limb, mostly involving the hands, wrists, knees, ankles and small joints of feet. The pain persists through out the day and night, more marked in the morning and associated with morning stiffness. The pain does not releive by rest but reduces with pain killer. She also notices skin rashes on the face, arms and legs for the last 2 months that aggravates on exposure to sunlight. The patient also complains of fever for the last 2 months which is low grade and continued in nature. Highest recorded temperature is 100°F. Fever is not associated with chills and rigor and subsides with paracetamol. There is no history of night sweat. The patient also complains of marked weight loss and weakness. She also complains of recurrent oral ulcer for 2 months which is painless. On query, she also complains of hairloss for last 1 month. There is no history of spontaneous abortion, bleeding, venous thrombosis, convulsion and unconsciousness. Her bowel and bladder habit is normal. She complains of occasional irregular menstruation, sometimes associated with menorrhagia. There is no similar illness in her family. She was treated by multiple drug but she could not mention the name of those drugs.

On examination:

General examination: (As above)

Systemic examination: (As above)

Clinical diagnosis:

Systemic lupus erythematosus

Differential diagnosis:

Dermatomyositis

Mixed connective tissue disease

Sarcoidosis

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HISTORY TAKING OF SURGERY

Name:

Importance: See page No: 23

Age:

Importance:

More in children:

- Appendicitis *S. Das-335(5th)*
- Round worm intestinal obstruction *S. Das-335(5th)*
- Ranula (mucous containing cyst in floor of mouth) *N.L. Browse – 248(3rd)*
- Papillary carcinoma (also in young adult) *Norman L. Browse- 287(3rd)*

More in middle age:

- Carcinoma of stomach (more in male)
- Acute & chronic cholecystitis (more in female)
- Peptic ulcer
- Perforated peptic ulcer (40 -60 years old)
- Acute pancreatitis (40 - 50 years old)
- Varicose ulcer *S. Das-73(5th)*
- Venous ulcer *N.L. Browse -187(3rd)*
- Sub mandibular salivary calculi *Norman L. Browse -222(3rd)*
- Renal and ureteric calculi (30 to 50) *Norman L. Browse -418(3rd)*
- Carcinoma of rectum *Norman L. Browse -431(3rd)*

More in elderly:

- Gastric ulcer (40 - 60 years old) and duodenal ulcer (20-60 years old)
- Abdominal aortic aneurysm (more than 60 years old)
- Diverticular disease (50 - 70 years old)
- Carcinoma of colon (over 50 years old)
- Acute parotitis *Norman. Browse-227(3rd)*
- Carcinoma of parotid gland (over 50 years old) *Norman L. Browse - 131(3rd)*
- Carcinoma of tongue (between 60 to70) *Norman L. Browse-139(3rd)*

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- Carcinoma of tonsil — *Norman. L. Browse-413(3rd)*
- Femoral hernia — *Norman L. Browse -330(3rd)*
- Carcinoma of rectum — *Norman.L. Browse – 431(3rd)*
- Carcinoma of gallbladder (over70 years age) — *Davidson 734(19th)*
- Hiatus hernia — *Davidson -775 (19th)*

Sex:

More in male:

- Carcinoma of stomach (2 - 3 times)
- Peptic ulcer
- Basal cell carcinoma
- Carcinoma of kidney — *Norman.L.Browse -117(3rd)*
- Renal and ureteric calculi (slightly more) — *Norman.L.Browse-418(3rd)*
- Carcinoma of bladder — *Norman L. Browse -419(3rd)*
- Benign hypertrophy of prostate gland — *Norman L. Browse -422(3rd)*
- Carcinoma of prostate

More in female:

- Acute and chronic cholecystitis (30 - 60 years)
- Gall stone
- Breast cancer
- Diverticular disease
- Varicose vein (10 times) — *Norman. L. Browse-186(3rd)*
- Venous ulcer — *Norman. L. Browse-186(3rd)*
- Goiter — *Norman. L. Browse-280(3rd)*
- Thyrotoxicosis (10 times more) — *Norman. L. Browse-284(3rd)*
- Papillary carcinoma (3-4 times) — *Norman. L. Bmwse-280(3rd)*
- Femoral hemia — *Norman L. Bmwse-280(3rd)*
- Carcinoma of gallbladder — *Davidson – 886 (19th)*

Occupation:

Importance: See page No: 25

Religion:

Importance:

- Carcinoma of penis, phimosis, subprepucial infection is hardly seen on Muslims and Jews. — *S. Das – 1(5th)*

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Address:

Present:

Permanent:

Importance:

Basal cell and squamus cell carcinoma is more common in countries that have much bright sunlight. *Normal N. L. Browse 62+66(3rd)*

Chief complaints:

- All the complaints which are described in medicine section.
- Presence of lump
- Presence of ulcer

History of present illness

PRESENCE OF LUMP

Questions with importance:

1. Duration:

When was the lump first noticed ?

Do not write "the lump first appeared 6 months ago" you should write "the lump was first noticed 6 months ago". Many lumps may exist for months, even years, before the patient notice them.

Importance:

- Lumps with shorter duration and pain are mostly inflammatory (acute)
- Lumps with longer duration without pain possibly neoplastic (benign)
- Lumps with longer duration with slight pain → Chronic inflammatory swelling.
- Lumps with shorter duration mostly malignant. *S.Das-117(5rd)*

2. First symptom

What made the patient notice the lump?

Importance:

- There are three common answers to this question:
  i. I felt/saw it when washing.
  ii. I had a pain and found lump when I felt the painful area.
  iii. Some one else noticed it and told me about it.

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- Neoplasm is mostly noticed suddenly and the patient says "I felt it during washing or some one else noticed it first and told me about it.

3. Progression:

Has the lump changed since it was first noticed?

Importance:

- Benign tumor grows in size very slowly and sometimes may remain static for a long time.
- Malignant tumor grows very quickly. Sometimes the swelling suddenly increases in size after remaining stationary for a long period.
- If decreases in size → Inflammatory lesion. *S.Das-18,19(5th)*

4. Persistence:

Has it ever disappeared (e.g. on lying down, on exercise)

Importance:

- Direct inguinal hernia disappears automatically as soon as the patient lies down.

5. Multiplicity:

Has the patient any other lump?

Importance:

Neurofibromatosis, diaphyseal aclasis etc, will always have multiple swelling.

6. Other symptoms:

What symptom does it cause, (e.g. pain, fever, weight loss etc. record the history of each symptom)

Importance:

Pain:

- Pain absent in neoplastic swelling, particularly in early stage
- Throbbing pain suggests inflammation
- Pain appears before swelling → Inflammation
- Swelling appears before pain → Tumor

Fever:

- Associated with fever → Inflammatory, Abscess

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Weight loss:

- Associated with weight loss in
  i. Malignant tumor
  ii. Cold abscess with generalized TB.

7. Cause:

What does the patient think caused it?

Importance:

- Lumps occasionally follow injuries or systemic illness known to the patient

Questions: Norman N.L. Browse-12(3rd)

PRESENCE OF AN ULCER

Questions with importance:

1. Duration:

When it was first noticed (when it began or whether it was present for sometime before he noticed it)

Importance:

- The patient noticed an ulcer suddenly which was present for some time → often occur in neurotrophic ulcers at the sole of the foot.

Norman N.L Browse -12(3rd)

2. First symptom:

What drew the patient's attention to the ulcer?

Importance:

- The commonest reason is pain.
- In squamus cell carcinoma, bleeding and discharge occur from ulcer.

3. Other symptoms:

What symptom does it cause, (e.g. pain, fever, weight loss etc. record the history of each symptom)

Importance:

Painful ulcer:

- Only those associated with inflammation

Painless ulcer:

- Syphilic ulcer
- Trophic ulcer resulting from nerve disease (peripheral neuritis, tabes dorsalis).

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- Ulcer from malignant disease such as basal cell carcinoma, squamus cell carcinoma, are painless to start and become painful if they invade deep structures.

S.Das-45(5th)

4. ***Has the ulcer changed since it first appeared ?***

Importance:

- Neoplastic ulcer is usually progressive in nature.

5. ***Has the patient ever had a similar ulcer on the same site or, else where?***

Importance:

- Tuberculous ulcer and varicose ulcer may be more than one.

6. ***What does the patient think caused the ulcer?***

Importance:

- Many patients believe they know the cause of ulcer and are often right. The commonest initiating cause is trauma.

Questions: Norman N. L. Browse- 13(3rd)

History of past illness

Presenting Disease	Past History
Perforation of peptic ulcer	Ulcer pain, haematemesis, melaena
In case of acute appendicitis, biliary and renal colics.	History of previous attack
Intestinal obstruction	May have a history of previous abdominal operation.
Acute cholecystitis	There may be a past history of biliary colic, high rise of temperature
Gall bladder disease	Typhoid fever S.Das-359(5th)
Renal tuberculosis	Pulmonary TB S.Das-459(5th)
Peripheral nerve lesion	History of trauma or injection S.Das-90(5th)
Acute osteomyelitis	Past history of pneumonia, typhoid fever, otitis media, multiple boils. S.Das-110(5th)
Fistula formation	TB, Crohn's disease, Ulcerative colitis, Carcinoma of rectum
Arterial occlusion	Previous cardiac attack or embolic syndrome S.Das-359(5th)

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EXAMPLE OF A HISTORY OF SURGERY

Particulars of patient:

Name	:	Mr. Ismail Hossain.
Age	:	60 years.
Sex	:	Male
Religion	:	Islam
Occupation	:	Businessman
Marital Status	:	Married.

Address

Present	:	Road # 2, House # 123, Mujgunni R/A, Boyra, Khulna.
Permanent	:	Village: Khilgati, P.O. Khilgati Atimkhana P.S. Ghatail, District:- Tangail

Date of Admission : 21/01/2015
Date of Examination : 22/01/2015

Chief complaints:

1. Abdominal pain for 6 months.
2. Lump in the upper abdomen for 4 months.
3. Vomiting of several episodes for same duration
4. Loss of appetite and weight loss for same duration.

History of present illness:

According to the statement of the patient, he was reasonably well 6 months back. Gradually he developed pain in the upper abdomen which is dull aching in nature. There is no radiation of pain, no relation to food or fatty meal, no specific aggravating or relieving factor. Pain does not relieve by taking omeprazole or antacids and not associated with fever, chill and rigor. He also notices a lump in the upper abdomen for last 4 months, which is gradually enlarging in size. He also complains of vomiting of several times for same duration. Vomitus is profuse in amount, foul smelling, projectile, sour in taste but not bile stained and not mixed with blood. Vomitus contains digested and undigested food material that he took previously. Patient also complains of significant weight loss which is about 6 kg in last 4 months (>10% of previously normal weight). His bowel and bladder habit is normal. He has no history of cough, chest pain, haemoptysis, jaundice, haematemesis or melaena.

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History of past illness:
There is a history of recurrent abdominal pain for 2 years which settled spontaneously.

Drug history:
He took omeprazole for pain but pain not subsided.

Family history:
He is married. His wife is healthy. He has one son, age 30 years and one daughter, age 25 years. They are well. His mother is alive and healthy but his father died from stroke.

He has one sister of 45 years of old, who is healthy at present. She suffered from headache at past.

None of his family member is suffering from such type of illness.

Occupational history:
He is a grocer. He goes to his shop at 10:00 A.M. and returns home at 9: 00 P.M.

Personal history:
He has been smoking for 15 years and puffs about 20 sticks per day.

Socio economic condition:
He is of middle class family. His house is made up of bricks. It is his own house. He uses sanitary latrine and drinks tube-well water.

Dietary history:
He takes rice 3 times a day and timely.

General Examination:

- Appearance: Anxious and ill looking
- Physical built: Average
- Nutrition : Average
- Anaemia : Moderate
- Jaundice: Absent
- Cyanosis: Absent
- Clubbing: Absent
- Oedema: Absent
- Dehydration: Mildly dehydrated

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- Neck vein : Not engorged
- Lymph glands : Left supraclavicular lymph node are palpable, size 2x3 cm, fixed to underlying structure and overlying skin and non tender.
- Pulse : 92/min
- Blood pressure: 120/80 mm of Hg
- Respiration: 18/min
- Body temperature: 98°F

Systemic examination:

Abdomen:

Inspection:

- Shape of the abdomen: Normal (Scaphoid)
- Flanks: Not full
- Umbilicus: Centrally placed, inverted, vertically slit
- Skin condition: Normal, no scarmark
- Hair distribution: normal
- Visible peristalsis: Present from left to right
- Visible pulsation: Absent
- Visible engorged vein: Absent
- Groins: Normal

Palpation:

- Temperature: Normal
- Tenderness : Present in epigastric region
- Muscle guard : Absent
- There is intra abdominal lump in epigastric region. Measuring about 5X6 cm, Surface irregular, Margin ill defined, Mildly tender, Hard in consistency, Non pulsatile, Moves with respiration and Not fixed with overlying skin
- Liver, gall bladder and spleen : not palpable
- Kidneys: not palpable or ballotable
- No other palpable lump in the abdomen
- Succussion splash: present

Auscultation:

- Bowel sound : present

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Salient features:

Mr. Ismail, 60 years old, came from Boyra, Khulna, presented to me with the complaints of abdominal pain for 6 months, lump in the upper abdomen for 4 months, vomiting of several episodes for same duration, loss of appetite and weight loss for same duration. According to the statement of the patient, he was reasonably well 6 months back. Gradually he developed pain in the upper abdomen which is dull aching in nature. There is no radiation of pain, no relation to food or fatty meal, no specific aggravating or relieving factor and pain is not relieved by taking omeprazole or antacids. Pain is not associated with fever, chill and rigor. He also notices a lump in the upper abdomen for last 4 months, which is gradually enlarging in size. He also complains of vomiting of several times for same duration. Vomitus is profuse in amount, foul smelling, projectile, sour in taste but not bile stained and not mixed with blood. Vomitus contains digested and undigested food material that he took previously. Patient also complains of significant weight loss which is about 6 kg in last 4 months (>10% of previously normal weight). His bowel and bladder habit is normal. He has no history of cough, chest pain, haemoptysis, jaundice, haematemesis or melaena. There is a history of recurrent abdominal pain for 2 years. He took omeprazole for pain but pain did not subsided. None of his family member is suffering from such type of illness.

On general examination: He is moderately anaemic, not icteric, mildly dehydrated and nutritional status below average. Pulse: 76/min, Blood Pressure: 110/70 mm of Hg. Left supraclavicular lymph node is palpable, size 2x3 cm, fixed to underlying structure and overlying skin and non tender.

Rest of the general examination reveals normal.

On Systemic examination : Visible peristalsis present which moves from left to right. There is an intra abdominal lump which is in epigastric region, measuring about 5cmX6cm, Surface irregular, margin ill defined, mildly tender, hard in consistency, non pulsatile, moves with respiration and not fixed with overlying skin. There is no organomegaly. Succusion splash present but shifting dullness or fluid thrill absent. Digital rectal examination shows normal findings. **Other systemic examination reveals no abnormality.**

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Clinical or provisional diagnosis:

Gastric outlet obstruction due to carcinoma of stomach

Differential diagnosis:

1. Chronic duodenal ulcer
2. Pancreatic carcinoma
3. Carcinoma of transverse colon

Investigations:

Treatment:

Advice:

Follow up:

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HISTORY TAKING OF GYNAECOLOGY

Name:

Importance: see page no. 23

Age:

Importance:

- Carcinoma of cervix has two peaks. One at about 35 years and another at about 50 -55 years.

Jeffecoate's 448(6th)

- Trichomonus vaginitis and urethritis are more common in young adult.
- Sexually transmitted diseases usually occur between 18 to 24 years old.
- Leiomyoma (Benign tumor of uterus) is approximately 20% of woman over 20 years and 40% of woman over 40 years of old.
- Cervical intra epithelial neoplasia is more in woman less than 30 years old.

Religion:

Impotence:

- In Muslims and in Jewish, carcinoma of cervix is rare. Because, their husbands are subjected to ritual circumcisions in childhood or to strict avoidance of coitus during menstruation.

Jeffcoate's-448(6th)

- Endometrial carcinoma is more common in Jewish.

Jeffcoate's-448(6th)

Occupation:

Importance : See occupational history.

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Marital status :

Importance:

- Carcinoma of cervix is rare in virgin.

Jeffcoate's-448(6th)

- In case of sexually transmitted disease (Syphilis, Gonorrhoea, AIDS, genital warts, ano genital herpes simplex, Scabies etc.), partner notification is essential.

Davidson-184-90(19th)

Address:

Importance:

1. It is important to know for identification of the patient, communication and follow up.
2. Geographical importance:
   Leiomyoma is common in Africa.

J effcoate's-469(6th)

Date of admission:

Date of Examination:

Importance: See page No: 26

Chief Complaints:

1. Disturbance in menstrual cycle
2. Vaginal discharge.
3. Pain in the lower abdomen.
4. Swelling or mass in the lower abdomen.
5. Something coming out per vagina
6. Postmenopausal bleeding.
7. Failure to conceive.
8. Difficulty in micturition.
9. Difficulty in defaecation

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History of present illness

VAGINAL DISCHARGE

The following points should be asked.

- Amount (scanty or copious)
- Colour (White, yellow, greenish, blood stained, Purulent)
- Odor (odorless or offensive)
- Consistency (Watery or thick)
- Associated with pruritus
- Relationship with menstruation, pregnancy or oral pill.

Questions with importance:

1. Amount:

Importance:

Amount of discharge is judged by the need to wear a sanitary pad and by staining of under clothing.

- Profuse amount:
  - i. Trichomonus and monilial infection of vagina.
  - ii. Acute and chronic vaginitis *Shaw's Text Book of Gynaecology (10th)*

2. Colour:

Importance:

Purulent:

- Vaginitis *Jeffcoate's-432(6th)*
- Cervicitis
- Endometritis *Jeffcoate's 440(6th)*
- Septic abortion
- After evacuation of pelvic abscess in to the vagina

Greenish:

- Acute gonorrhoea

Whitish:

- At puberty, during pregnancy and at the time of menopause.
- In anaemic and constipated patients
- With mucous polipi of cervix, glandular erosion of cervix.

Shaw's Text Book of Gynaecology (10th)

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Blood stained:

- Neoplastic cause

3. Odor:

Importance:

Offensive: (infection, neoplasm or foreign body)

- Carcinoma of cervix, vagina
- Septic abortion
- Septic myomatous polipi
- Sarcoma of uterus
- When foreign bodies such as pessaries, tampoon have been forgotten and retained in the vagina

Shaw's textbook of gynaecology-III

Odorless:

- Leucorrhoea

4. Consistency:

Importance:

Watery:

- Urinary fistula
- During pregnancy

Thick:

- Trichomonous vaginitis *Jeffcoate's-332(6th)*
- Lucorrhoea (may be watery also) *Nurjahan-92*
- Cervicitis

5. Pruritus:

Importance:

Associated with pruritus:

- Trichomonus vaginitis
- Moniliasis *Jeffcoate's-332(6th)*

Never pruritus

- Leucorrhoea

6. Ask about relation with menstruation, pregnancy and oral pill.

Importance:

Chronic cervicitis tend to be worse premenstrually *Jeffcoate's-339(6th)*

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PAIN IN THE LOWER ABDOMEN

1. Site:

Where is it?

Importance:

- Ovarian and tubal pain → Over inguinal ligament
- Uterine pain → Hypogastric and diffuse
- Cystitis → Supra pubic
- Utero vaginal prolapse →Lower abdominal pain & backache

2. Duration:

Importance:

- Pain of chronic pelvic inflammatory disease is continuous in nature.

3. Mode of onset:

Importance:

- Sudden and colicky abdominal pain → Ectopic pregnancy

Nurjahan 42(3rd)

4. Severity:

Importance:

- Severe pain → Occurs in ectopic pregnancy

5. Character:

Importance:

- Colicky abdominal pain
  - Abortion
  - Ectopic pregnancy
- Dull, constant pain:
  - Endometriosis
  - Chronic pelvic inflammatory disease *Nurjahan-43(3rd)*
- Throbbing Pain → Bartholinitis

6. Radiation:

Importance:

Pain of primary dysmenorrhoea referred to front aspect of thigh

Jeffcoate's - 339(6lh)

7. Ask about relation with menstruation

- Chronic cervicitis → Worse premenstrually *Jeffcoate's-339(6th)*
- A pain which equally before through and after menstruation suggests → psychic origin. *Jeffcoate's 581(6th)*

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SOMETHING COMING OUT PER VAGINA

Causes:

- Uterovaginal prolapse
- Elongated cervix
- Periurethral cyst
- Vulval tumors
- Chronic inversion of the uterus
- Gartner duct cyst etc.

Questions with importance:

1. ***Duration:***

Importance:

It indicates severity

2. ***Ask about parity of patient.***

Importance:

- In 95% of cases of prolapse, the patient is multiparous.

Jeffcoate's~269(6th)

3. ***Relation to delivery***

Importance:

- Prolapse some times suddenly appears 3 or 4 weeks after delivery.

Jtffcoate's-271(6th)

4. ***Ask about micturition problem:***

Importance:

- In uterovaginal prolapse, frequency, urgency, difficulty in emptying of the bladder is common.

5. ***Ask about defecation problem.***

Importance:

- Uterovaginal prolapse causes difficultly in emptying the rectum.

6. ***Ask about vaginal discharge:***

Importance:

- In utero vaginal prolapse, some times vaginal discharge occur.

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DISTURBANCE IN MENSTRUAL CYCLE

1. **Amenorrhoea:**

   Causes:

   i. Pregnancy before puberty, after menopause
   ii. Obstructive lesion at lower genital tract
   iii. Uterine cause (Tuberculous endometritis, follicular cyst, corpus luteum cyst)
   iv. Hypothyroidism
   v. Cushing syndrome
   vi. Systemic cause like Enteric fever, Pneumonia, TB

2. **Oligomenorrhoea:**
   - Mensturation at intervals longer than 35 days.

3. **Hypomenorrhoea:**

   Scanty menstrual loss in duration and amount

Causes:

- Occurring regular: Normal
- Sometimes oral contraceptive pill causes it.

4. **Poly menorrhoea:**

   Too frequent menstruation at regular intervals of two weeks but less than 3 weeks

Cause:

i. Endocrine disorder
ii. Chronic pelvic inflammatory disease, chocolate cyst of ovary

5. **Metrorrhagia:**

   Inter menstrual irregular uterine bleeding.

Cause:

i. Carcinoma
ii. Uterine polyps

6. **Menorrhagia:**

   It is a cyclical bleeding coming every month, lasting longer time and / or excessive amount e.g.

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Common causes:

1. Uterine fibroid
2. Pelvic inflammatory disease e.g. chronic salpingo oophoritis, chronic endometritis (tubercular)
3. Pelvic endometriosis e.g. adenomyosis, chocolate cyst of ovary
4. Ovarian tumor, carcinoma of endometrium
5. Chronic hypertension, heart disease with chronic congestive heart failure
6. Chronic nephritis

Dawn. 149 - 176(12th)

7. **Dysmenorrhoea:**
   Painful menstruation is called dysmenorrhoea.

Menstrual history:

Inquiry should be made about:

- Age of onset of first period (menarche)
- Regularity of cycle
- Duration of period
- Length of the cycle
- Amount of bleeding (Excess is indicated by the passage of clots or number of pads used)
- First day of the last menstrual period (LMP)

Obstetric history:

Following point should be noted as:

- How long she has been married.
- Number of delivery after 28th weeks of pregnancy as well as number of pregnancies terminated before 28th weeks of pregnancy. This is to be expressed as Para 1+1 (termination after 28 weeks) + (termination before 28 weeks)
- Gravida (in case of presence of pregnancy).
- Age of last child should also be mentioned

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History of past illness:

- Record any previous illness like TB, heart disease, Sexually transmitted diseases (Syphilis, gonorrhoea etc.).
- History of pelvic operation
- History of blood transfusion

Family history:

History of tuberculosis, hypertension, diabetes, carcinoma are to be enquired.

Importance

- Malignancy of breast, colon, ovary or other genital organ are often related *Dawn -112*
- Tubercular affection of any family member can give a clue in diagnosis of pelvic tuberculosis *Datta - 91 (3rd)*
- Endornetriosis, adenomyosis often affect more than one member of family *Jeffcoate's-358(6th)*

Personal history:

i. Smoking
ii. Alcohol
iii. Marital status (Married / widow / divorced)
If married, details of sexual life should be noted, especially in case of infertility)
iv. Contraceptive practice *Datta-9I (3rd)*

Importance:

- Smoking → Small babies and other obstetric problem *Macleod,s - I2(10th)*

Drug history :

- This should include use of anti hypertensives, hypoglycaemic agents, corticosteroid, drug allergy etc.

Socio economic condition :

Importance:

- Endometriosis is common in high income group
- TB, carcinoma of cervix, PID are common in low income groups. *Jeffcoate's-3S8(6th)*

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A HISTORY OF GYNAE

Particulars of the patient:

Name	:	Maya Akhter Batul
Husband's Name	:	Md. Baynozir Hassan (Joy)
Age	:	45 years
Sex	:	Female
Religion	:	Islam
Occupation	:	House wife
Marital Status	:	Married

Address:

Present	:	Road # 2 ; House # 123; Mujgunni Residential Area, Boyra, Khulna
Permanent	:	Do
Date of Admission	:	21/05/15
Date of Examination	:	22/05/15

Chief complaints:

1. Lump in lower abdomen for 2 months
2. Pain in lower abdomen for same duration
3. Excessive menstrual bleeding for same duration

History of present illness:

The patient states that she was reasonably well about 2 months back. There after she noticed a lump in the lower abdomen which is gradually increasing in size. She feels downwards dragging sensation during walking. She complains of lower abdominal pain which usually starts 3 days before the menstrual period and aggravates with bleeding and gradually relieves after menstrual period. She had normal menstrual cycle with normal flow 2 month back. For last 8-9 days, she notices that menstrual flow is increased in amount and sometimes there is passage of blood clots. With these complaints, the patient admitted in KMCH for better management.

History of past illness:

She gave the H/O appendicectomy 4 years back.

Family history:

Nothing significant

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Drug history : Nothing significant

Immunization history : Well immunized.

Drug history : Nothing significant.

Personal history : Contraceptive not practiced,
Sleep : Normal,
Drug allergy: Absent,
Bowel habit: Regular

Socio economic status : She is of middle class family

Menstrual history :

Age of menarche : 13 years.
Menstrual cycle : Regular (32 ±2 days).
Menstrual period : 9 to 10 days.
LMP : 18.04.15.

Obstetric history :

Marital status : Married for 25 years.
Para : (4+1)
Age of last child : 18 years
Still born : Nil

General Examination

- Appearance : Ill looking.
- Decubitus : On choice.
- Body built : Average.
- Nutritional status : Average.
- Anaemia : Severe
- Jaundice : Absent.
- Cyanosis : Absent
- Clubbing : Absent
- Koilonychia : Absent.
- Oedema : Absent.
- Dehydration : Absent.
- Mouth cavity and teeth : Normal & healthy
- Lymph nodes : Not palpable
- Neck vein : Not raised.

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- Thyroid gland : Not enlarged
- Breast and nipples : Normal.
- Varicose vein : Absent.
- Weight : 55kg.
- Heart : Heart sound is audible in all cardiac area, no added sound.
- Lungs : Lung fields are clear.
- Liver : Not enlarged
- Spleen : Not palpable.
- Ascites : Absent.
- Respiration : 22/min
- Pulse : 80/min.
- B.P : 110/70 mm of Hg.
- Temperature : Normal.

Per abdominal examination :

Inspection :

Lower abdomen is distended

Flank are not full.

Umbilicus: Centrally placed everted.

Scar mark of appendisectomy: present,

Stria: Present.

Palpation:

A mass in lower abdomen in midline.

- Size : 10 cmx8cm
- Shape : Rounded
- Margin : Regular
- Surface : Smooth
- Fixity : Not fixed, moves side to side but restricted above down wards
- Consistency : Firm
- Height of fundus : Corresponds with 14 weeks of pregnancy
- Tenderness : Absent

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Percussion:

Over the mass	:	Dull.
Others	:	Tympanic.

Auscultation:

Bowel sound	:	Present.
Vascular bruit	:	Absent.

Per vaginal examination:

On inspection	:	Vulva & vagina appears normal.
Cervix	:	Firm
Uterus	:	Enlarged, mass is continuous with uterus, fornix are free.

Salient features:

Maya Akhter Batul, age 45 years, came from Tangail, admitted in this hospital with the complaints of a lump in the lower abdomen which is gradually increasing in size. She feels downwards dragging sensation during walking. She complains of lower abdominal pain which usually starts 3 days before the menstrual period and aggravates with bleeding and gradually relieves after menstrual period. She had normal menstrual cycle with normal flow 2 month back. For last 8-9 days, she notices that menstrual flow is increased in amount and sometimes there is passage of blood clots. On examination, there is a lump in lower abdomen, size 10cmx8 cm, rounded, margin is regular, surface is smooth, firm in consistency, non tender, not fixed with skin and mobile side to side and restricted above downwards, height of the uterus corresponds with 14 weeks of pregnancy.

Provisional diagnosis :

- Fibroid uterus

Differential diagnosis:

- Ovarian tumor
- Adenomyosis
- Full bladder

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A HISTORY OF OBSTETRICS

Particulars of the patient:

Name	:	Bithi Akter Belly
Husband's Name	:	Md. Baynozir Hassan (Joy).
Age	:	45 years.
Sex	:	Female.
Religion	:	Islam.
Occupation	:	House wife.
Marital Status	:	Married.

Address:

Present	:	Road # 2; House # 123; Mujgunni Residential Area, Boyra, Khulna.
Permanent	:	Do
Date of Admission	:	09/11/14
Date of Examination	:	09/11/14

Chief complaints:

i. Amenorrhoea for 36 weeks,
ii. Diarrhoea & Vomiting for 1 day.
iii. Loss of foetal movement for 8 hours.

History of present illness:

The patient states that she is amenorrhoic for 36 weeks; she developed morning sickness at 6 weeks, which disappeared at 12 weeks. She had regular antenatal cheek up. She felt foetal movement at 20 weeks. She took two TT at 20 & 24 weeks. But in last 1 day, she developed diarrhoea and vomiting. The frequency of loose motion was 15 times which was watery in nature, foul smelling and associated with vomiting. In last 8 hours, she feels loss of foetal movement. With this complaints, she admitted at KMCH for better management.

History of past illness	:	Nothing significant.
Family history	:	Nothing significant
Socio-economic history	:	Middle class.
Personal history	:	
Sleep	:	Normal.
Diet	:	Normal.
Bowel & bladder	:	Regular.
Contraceptive	:	Condom practiced.

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Menstrual History:

Age of menarche	:	13 year.
Menstrual cycle	:	28 ±2 days.
Menstrual period	:	4±1day.
Menstrual flow	:	Average.
LMP	:	03-03-14.
EDD	:	10-12-14.

Obstetric history :

Married for 2 years

Para	:	Nil.
Gravida	:	1st

General Examination:

Appearance	:	Ill looking.
Body built	:	Average.
Nutrition	:	Average.
Anaemia	:	Mild
Jaundice	:	Absent.
Oedema	:	Absent.
Dehydration	:	Present.
Heart	:	NAD
Lungs	:	NAD
Pulse	:	110/min
Blood pressure	:	100/60 mm of Hg
Respiratory Rate	:	22/min
Temperature	:	98.6°F

Abdominal examination:

Inspection:

Shape	:	Uniformly distended.
Linea niagra	:	Present.
Stria graviderum	:	Present
Skin Condition	:	Normal

Palpation:

Fundal height	:	34 weeks size.
Fundal grip	:	Broad, soft, irregular mass suggestive of breech

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Lateral grip	:	Smooth, curved on left side suggestive of back, irregular knob like structure on right side suggestive of limb.
1st pelvic grip	:	Round, hard globular structure suggestive of head.
2nd pelvic grip	:	Head is not engaged.

Auscultation:

Fetal heart sound	:	Absent

Salient feature:

Bithi Akter Belly, 20 years, came from Boyra, Khulna,got admitted into KMCH on 9th Nov, 2014 with the complaints of amenorrhoea for 36 weeks ; diarrhoea & vomiting for 1 day and loss of fetal movement for 8 hours. The patient states that she is amenorrhoic for 36 weeks; she developed morning sickness at 6 weeks, which disappeared at 12 weeks. She had regular antenatal cheek up. She felt foetal movement at 20 weeks. She took two TT at 20 & 24 weeks. But in last 1 day, she developed diarrhoea and vomiting. The frequency of loose motion was 15 times which was watery in nature, foul smelling and associated with vomiting. In last 8 hours, she feels loss of foetal movement. With this complaints, she admitted at KMCH for better management.

On examination, she is dehydrated, mildly anaemic, pulse 110/min, B.P. 110/80 mm of Hg, rest of the general examination reveals normal. On systemic examination, abdomen is uniformly distended, Linea niagra & stria graviderum present. Fundal height 34 weeks size, fundal grip is broad, soft; irregular mass suggestive of breech, On lateral grip: smooth, curved on left side suggestive of back; irregular knob like structure on right side suggestive of limb. On 1st pelvic grip: round, hard globular structure suggestive of head, On 2nd pelvic grip: head is not engaged, fetal heart sound absent.

Clinical diagnosis:

36 weeks pregnancy with intrauterine death.

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HISTORY TAKING OF PAEDIATRICS

Particulars of patient

- Name
- Age
- Sex
- Religion
- Address
  i. Present
  ii. Permanent
- Date of admission
- Date of examination
- Chief complaints

History of present illness

Elaboration of chief complaints, any treatment given?

History of past illness:

- How was child's previous health? Make a note of duration, dates and types of various illness. Also write, if any treatment was given. *Guptae-23(7th)*

Birth history:

Antenatal:

- Mothers health during pregnancy
- How was her diet? *Guptae-22(7th)*
- Any history of illness such as rubella, syphilis, toxemia, diabetes, hypertension, heart disease, Tuberculosis, Exposure to radiation or drug intake should be noted.

Natal:

- Was it hospital or home delivery ?
- Who conduct it ? (Qualified doctor or midwife or simple untrained dai)
- Was the delivery normal or not ?
- What was baby's birth weight?
- Did he look healthy or sick ?
- Any cyanosis, any respiratory distress ?

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Post natal:

- Any jaundice, cyanosis, convulsions, congenital anomalies of birth injury noticed during neonatal period.
- How was the umbilical stump cut ?
- Any sucking difficulty ?
- Was excessive cut loss ?

Developmental milestone:

- When the child gave first social smile ?
- When did he learn head holding, sitting with or without support,
- Standing and walking with or without help, talking meaningful words or sentences.
- Any dental eruption and smiling.
- Also ask about control over bowel, and bladder, both during day and night?

Guptae - 22(7th)

Immunization history:

- Ask about the various vaccinations received by the child with dates.
- If certain vaccination has been omitted, find out why ?
- Also ascertain if any vaccination caused a complication ?

Personal history:

- How are children relation with sibs, other family members and children in the school ?
- Is he a difficult child ?
- Is he outgoing ?

Family History:

- The health status of his brothers or sisters, parents and grandparents should be recorded.
- In case of infectious and familial disease, history of such illness in the family members must be pointedly sought.

Guptae-22(7th)

Dietary history:

- Was the child breast or bottle-fed.
- If on formula, how was it prepared?

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- Any feeding difficulties?
- When were semisolid and solid introduced?
- Find out more details about the weaning foods and how they were given and in what quantity ?

Socio economic condition:

- How much is the family income ?
- Ask about occupation of parents and housing, school and play facilities available to the child.

Be colored by the color of Allah

- Al- QURAN

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