MED435.

OSCE TEAM

OBJECTIVE STRUCTURED CLINICAL EXAMINATION

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#1 Take a history related to diarrhea

Diarrhea is subjective and can be defined as an increase in the volume, frequency or fluidity of stool relative to normal conditions.

First introduce yourself to the patient and start:

Personal and Social History: name, age, gender, occupation – Use as your own (Single, living with parents. No tobacco use).

Present complaint: " What brought you here"?

1-When these complaints started? It started early in the morning.

2-How many times do you go to the toilet today? 6 times.

3-How many times did you use to go to the toilet before this problem? Once daily.

4-Can you describe your stool:

a. Is it watery, or bulky? Yes, watery. **b.What color?** Light yellow.

c. Is there any blood or mucous in stool? No. **d.Does it have foul smell?** A little bit.

5-Do you have any additional symptoms - any nausea or vomiting? I vomited twice.

6-Do you have fever? No

7- Is there any pain on passing stools? No, but I have abdominal discomfort.

8-Can you describe what do you mean by abdominal discomfort? Is it located in certain part of the abdomen? When it comes I urgently go to the toilet. It is all around, I can't specify any location.

9-Recent dietary history, consumption of meats (cooked, uncooked) eggs, seafood, or unusual foods? I ate fast food last night in the restaurant.

10-Anyone around you have the same symptoms? No

11-Does anything make it better or worse? I did not recognize anything specific.

12-Are you on any medication? No.

Past medical history: Nothing specific.

Family history: They are healthy. No major disease.

#1 Take a history related to diarrhea

THE SEQUENCE OF THE INTERVIEW:

1. Greeting the patient and establishing rapport
2. Inviting the patient's story
3. Establishing the agenda for the interview
4. Expanding and clarifying the patient's story; generating and testing diagnostic hypotheses
5. Creating a shared understanding of the problem(s)
6. Negotiating a plan (includes further evaluation, treatment, and patient education)
7. Planning for follow-up and closing the interview.

THE TECHNIQUES OF SKILLED INTERVIEWING:

1. Active listening
2. Adaptive questioning
3. Nonverbal communication
4. Facilitation
5. Echoing
6. Empathic responses
7. Validation
8. Reassurance
9. Summarization
10. Highlighting transitions

EXPLORING THE PATIENT'S PERSPECTIVE:

1. The patient's thoughts about the nature and the cause of the problem
2. The patient's feelings, especially fears, about the problem
3. The patient's expectations of the clinician and health care
4. The effect of the problem on the patient's life
5. Prior personal or family experiences that are similar
6. Therapeutic responses the patient has already tried

ADAPTIVE QUESTIONING: OPTIONS FOR CLARIFYING THE PATIENT'S STORY:

1. Directed questioning from general to specific
2. Questioning to elicit a graded response
3. Asking a series of questions, one at a time
4. Offering multiple choices for answers
5. Clarifying what the patient means

THE FORMAT OF THE COMPREHENSIVE HEALTH HISTORY:

Identifying Data: Such as age, gender, occupation, marital status.

Source and Reliability of History: Usually the patient, but can be family member, friend, letter of referral, or the medical record varies according to the patient's memory, trust, and mood.

Chief Complaint: The one or more symptoms or concerns causing the patient to seek care.

#1 Take a history related to diarrhea

THE SEVEN ATTRIBUTES OF A SYMPTOM

1. **Location**. Where is it? Does it radiate?
2. **Quality**. What is it like?
3. **Quantity or severity**. How bad is it? (For pain, ask for a rating on a scale of 1 to 10.)
4. **Timing**. When did (does) it start? How long did (does) it last? How often did (does) it come?
5. **Setting in which it occurs**. Include environmental factors, personal activities, emotional reactions, or other circumstances that may have contributed to the illness.
6. **Remitting or exacerbating factors**. Does anything make it better or worse?
7. **Associated manifestations**. Have you noticed anything else that accompanies it?

Symptom description mnemonic: OPQRST-AAA

One tool that some clinicians find helpful is using the mnemonic **OPQRST-AAA** to elicit the details of a pain complaint. With minimal modifications this mnemonic is easily adaptable to other symptoms (fever, cough, dizziness etc.) The exact content of the mnemonic varies with different sources, but one rendering is:

O-Onset

P-position/pattern (or provocation/palliation, also represented below as A-aggravating/alleviating)

Q-Quality

R-Radiation

S-Severity (or site)

T-Timing

A-Aggravating/alleviating factors

A-Associated symptoms

A-Attributions/adaptations

History of Present Illness:

Amplifies the Chief Complaint, describes how each symptom developed includes patient's thoughts and feelings about the illness may include medications, allergies, habits of smoking and alcohol, since these are frequently pertinent to the present illness

Past Medical History:

Lists childhood illnesses

Lists adult illnesses with dates for at least four categories: medical; surgical; obstetric/gynecologic; and psychiatric includes health maintenance practices such as: immunizations, screening tests, lifestyle issues, and home safety

Family History:

1.Outlines or diagrams of age and health, or age and cause of death of siblings, parents, and grandparents.

2.Documents of presence or absence of specific illnesses in family, such as hypertension, coronary artery disease.

Personal and Social History:

Describes educational level, family of origin, current household, personal interests, and lifestyle

#2 Per Rectal (PR) Examination

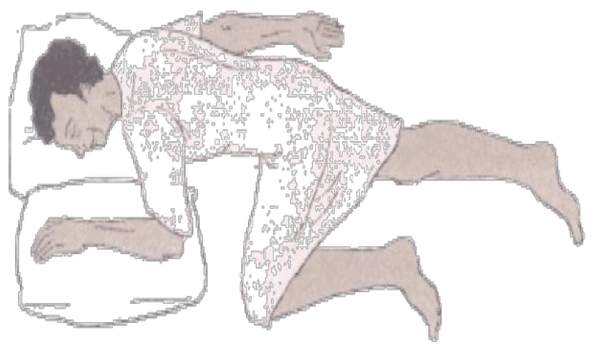
	STEP/TASK	D	PD	ND
	Preparation of the patient			
1	Introduce yourself to the patient and confirm his ID.			
2	Explain the procedure to the patient emphasizing that the examination may be uncomfortable but should not be painful, A chaperone should be offered.			
3	Get the patient consent and ask him to be exposed from the waist down.			
4	Position the patient comfortably in the **left lateral position**. Flex hips and knees and position the buttocks at the edge of the couch, and Put on a pair of gloves			
	The procedure			
5	Gently separate the buttocks and inspect the anus and surrounding skin for any abnormality like; Skin tags, ulcers, fissures, hemorrhoids..etc,			
6	Lubricate the index finger of your right hand and make complete fist with pointing index, Position the finger over the anus as if pointing to the genitalia.			
7	Gently insert the finger into the anus, through the anal canal and into the rectum, Test anal tone by asking the patient to squeeze your finger.			
8	Rotate the finger so as to palpate the entire circumference of the anal canal and rectum. Feel for any masses, ulcers,…etc.			
9	In males comment on the: Size, surface, sulcus, consistency and tenderness of the prostate gland.			
10	Remove the finger and examine the glove and look for: The color of any stool and for any mucous or blood.			
	After the procedure			
11	Clean off any lubricant or feces on the anus or anal margin. Remove the gloves and dispose it.			
12	Give the patient time to put his clothes back on, Ensure that he is comfortable.			
13	Address any questions or concerns that he may have, then Present your findings to the examiner, and offer a differential diagnosis			

What's the best position to do rectal examination?

Left Lateral position.

Rectal Examination - Geeky medics

Lateral Decubitus (Sims) Position



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#3 ABDOMINAL EXAMINATION

	STEP/TASK	D	PD	ND
	Preparation			
1.	Introduce yourself to the patient.			
2.	Confirm patient's ID.			
3.	Explain the procedure and reassure the patient.			
4.	Get patient's consent.			
5.	Wash hands.			
6.	Prepare the necessary materials.			
7.	Position the patient in a lying flat position with the head resting a on a single pillow and uncover his/her upper body.			
	Examination			
	General inspection (1)			
8.	Observe the patient's general appearance *(age, state of health, nutritional status and any other obvious signs e.g. wasting, jaundice, pigmentation, mental status –for encephalopathy–).*			
	Hands (2)			
9.	Pick up the patient's hand; inspect and examine (*Temperature, Color, Nail , Palmar erythema, Dupuytren's contracture,* *Nail signs:* clubbing, leuconychia–*hypoalbuminaemia*, koilonychia–*iron deficiency*).			
10.	Test for flapping tremor.			
	Face (3)			
11.	Inspect the patient's face *(sclerae, pupils, malar rush, mouth, tongue, salivary glands, palate, dentition).*			
	Neck (4)			
12.	Examine the neck for lymphadenopathy.			
13.	Examine the upper body for gynaecomaslia , caput medusae, and spider naevi.			
	Chest (5)			
14.	Inspect the patient's chest *(gynaecomastia, caput medusae, spider naevi).*			
	Abdomen (5) *(should exposed from the nipples to the symphhsis)*			
15.	Inspect the patient's abdomen for *(contours, any obvious distension, localized masses, scars, and skin changes).*			
	(a) **Palpation of the Abdomen**			
16.	Ask the patient if he has any abdominal pain and fix upon his face as you palpate his abdomen. Palpate with the palmar surface of your fingers whilst sitting or kneeling beside the patient.			
17.	**Light palpation** - Begin by examining the segment furthest away from any pain or discomfort and systematically palpate the four quadrants and the umbilical area. Look for tenderness, guarding, and any masses. احرص على ان يكون مكان الالم اخر مكان تفحصه !			
18.	**Deep palpation** - Describe and localize any masses.			

ask ur self ..
* obesity ?
* jaundice ?
* abdominal destintion ?

Abdominal Examination

	STEP/TASK	D	PD	ND
	Examination			
	(b) Palpation of the organs			
19.	**Liver** - Ask the patient to breathe in and out and, starting in the right lower quadrant, feel for the liver edge using the flat of the hand or the tips of the fingers. If *(the liver edge)* felt, describe in terms of *(regularity, nodularity, and tenderness)*. *(To estimate the liver span, percuss down along the right midclavicular line until the liver dullness encountered and measure from here to the palpable liver edge).*			
20.	**Gallbladder**- Palpate for tenderness over gallbladder region at the tip of the right 9th rib.			
21.	**Spleen** – 1. Palpate the spleen start from right iliac fossa. Advance your right hand to the lower border of left costal margin, and try to palpate the spleen. 2. If spleen palpable comments on consistency, edge, splenic notch, and surface. Check how many figures below the costal margin. 3. If the spleen not palpable turn the patient on right lateral position and use two hand technique. The left hand is placed posterolaterally over the left lower ribs and right hand is placed on the abdomen below the costal margin and check if spleen is palpable 4. Percuss over the Traube's space and check if there is dullness, it is a maneuver to check for early splenomegaly. Traube's space boundaries it is a triangle between six rib anterior, Mid-axillary line, and left costal margin			
22.	**Kidneys** - Position the patient close to the edge of the bed and ballot each kidney using the technique of deep bimanual palpation.			
23.	**Aorta** - Palpate the descending aorta between the thumb and the index of your right hand at a point midway between the xiphisternum and the umbilicus.			
	(c) Percussion of the abdomen			
24.	Percuss down along the right midclavicular line to detect the upper border of liver *(usually found in the fourth intercostal space).*			
25.	Percuss the suprapubic area for undue dullness *(bladder distension)*. If the abdomen appears distended, test for shifting dullness *(ascites)*.			
26.	shifting dullness. To detect the sign percuss from the mildline out to left flank until the dullness is reached. Keep your finguers at that point and ask the patient to roll towards you. Wait 30 seconds and the percussion should be repeated.			
	(d) Auscultation of the abdomen			
27.	• Auscultate in the mid-abdomen for abdominal sounds. *(Listen for 30 seconds to conclude that they are normal, hyperactive, hypoactive or absent).* • Listen over the abdominal aorta for aortic bruits *(arteriosclerosis or aneurysm)*. • Listen for renal artery bruits 2.5 cm above and lateral to the umbilicus *(renal artery stenosis).*			
	After the examination			
28.	Ensure that the patient is comfortable.			
29.	Make explanations to the patient, answer his/her questions and discuss management plan.			
30.	If necessary, order diagnostic investigations.			
31.	Dispose of sharps and waste material according to infection control standards.			
32.	Wash hands.			
33.	Document the procedure.			

Abdominal examination - Geeky medics

#4 ANEMIA

Definition : Anaemia is a condition caused by low haemoglobin levels as a result of decreased production of Red Blood Cells (RBC) or increased destruction/loss of RBC.

- **CASE :** A 22 year old male presenting symptom of **fatigue** described as "easily getting tired and weak." بيوصف لك المشكلة بكلمتين

1) Introduce yourself to your patient.
2) **Take the Personal and Social History (**name, Age, Gender, Occupation,Single, living with parents , Tobacco use).
3) Start asking your patient :

3) Possible questions and answers about your present complaint:	
Questions	**Possible answers**
1- How long have you had these complaints?	For the last 2 months it's bothering me
2- When do you usually feel these symptoms?	Unlike before, every time I do a physical activity like fast walking or climbing the stairs, I feel weak very easily. I start breathing frequently at those times. It's like my breath is not enough. And I feel that it's getting worse.
3- Do you have any additional symptoms?	Sometimes I feel that my heart beats rapidly than usual. Also I feel like that I've lost my energy.
4- Does anything make it better or worse?	Taking a rest makes me feel better. However, I feel more tired with heavier physical activity.
5- Have you noticed a weight loss?	No. It has been the same for at least 5 years.
6- How is your diet like? (Dietary habits) مهم تسألونه عن نمط تغذيته وإذا كان نباتي ولا لا	I am a vegetarian. I eat vegetables only. وصلنا خير
6- Do you have fever?	No, I did not feel any fever.
7- Do you have any bleeding from your body parts recently?	No
8- Have you applied to a doctor with these symptoms?	No, it's my first time.
Past medical history: Nothing specific, No important disease history, No operation, No current medication, No allergy	
9- Do you have or had any major disease or operation?	No
10- Are you on any medication?	No
11- Family history: Parents are healthy and alive, no major history of disease.	

ببساطة : المطلوب منك تعرِّف عن نفسك بالبداية ثم تبدأ بأخذ معلومات المريض (الاسم والعمر كفاية) بعدها تبدأ تسأله عن مشكلته
الحالة واضحة من الكلمتين اللي بيقولهم المريض (easily getting tired and weak) متى بدأت الأعراض ؟ و متى تزداد سوءاً ؟ هل عنده أي أعراض أخرى ؟
نقاط مهم تسألون عنها : نمط التغذية / الوزن / الأدوية / العمليات الجراحية / تاريخ العائلة المرضي
" الأسئلة المذكورة بالجدول أمثلة فقط، اختاروا الصياغة الأنسب لكم + تقدرون تسألون أسئلة إضافية لو فيه وقت"

GOOD LUCK.