MED435.

OSCE TEAM

OBJECTIVE STRUCTURED CLINICAL EXAMINATION

Endocrine Block.

Done by:
Munerah alomari

Thyroid: history taking

Simulated Patient Case Script:

Weight loss due to hyperthyroidism.

Hyperthyroidism is a condition wherein the thyroid gland produces excessive thyroid hormones resulting to an accelerated body metabolism.

Personal and Social History:
Single, living with parents. No tobacco use.
present complaint:
1- When these complaints started? It started four months ago.
2- How much weight did you lose? I had lost about 10 kilos.
3- Was there any change in your appetite? Not really. My food intake is the same as before.
4- Is there any other symptoms? I noticed that I get tired easily even when I am doing light activity. I also sweat a lot more than before and cannot tolerate heat well. Sometimes I feel pounding on my chest and my heart beats faster.
5- Did you experience this condition before? No, this is the first time.
6- Do you have any medical problems or condition in the past? No, I believe I was perfectly healthy before this.
7- Does anyone in your family with similar condition? No.
8- Are you on any medication? No.Past medical history: Nothing specific, No important disease history, No operation, No current medication, No allergy.Family history: Parents are healthy and alive, no major history of disease.

Thyroid: history taking

	Step/Task	D	PD	ND
	Preparation			
1.	Greet the patient and introduce yourself.			
2.	Explain the procedure, reassure the patient and get patient's consent.			
3.	Make sure the patient is in a comfortable position sitting or lying down.			
4.	Maintain good eye contact and establish rapport with the patient.			
	History			
1.	**Personal information:** Ask for the patient's Name, Age, Gender, Occupation, Nationality, and Address.			
2.	**Presenting Complaint:** Ask the patient about the main problem/s that made him/her went to see the doctor.			
3.	**History of Present Illness:** ● Allow the patient to provide an account of recent events in his/her own words without interruption. ● Ask the patient when the condition started. Ask how much weight was lost. ● Ask any associated signs and symptoms like increased appetite, nervousness, weakness, difficulty in sleeping, hair loss, shortness of breath, diarrhea etc.			
4.	**Past medical history:** ● Ask about any similar episodes in the past. ● Ask about any previous history of goiter or thyroid problems. ● Ask about other medical conditions or congenital problems. ● Ask about any history of surgery particularly in thyroid, parathyroid, or pituitary. ● Ask about any history of radiation. ● Ask about previous hospitalizations, allergy, blood transfusion, and trauma history.			
5.	**Family History:** Ask about significant illness in the family (like Marfan's or Diabetes Mellitus). Similar illness in the family.			

Thyroid: history taking

6.	**Personal and Social History:** ● Ask about use of alcoholic beverages, cigarette smoking or illicit drugs. ● Ask politely about emotional problems at home or at work.			
7.	**Obstetric and Gynecologic History (if patient is female):** ● Ask about the LMP (last menstrual period), regularity and quality of menstruation. ● Ask age of menopause if patient is elderly. ● Ask about number of pregnancy, number of children, and history of complications during pregnancy.			
8.	**Systematic Review (inquiry about all the cardinal symptoms in each of the major systems):** ● **Cardio-respiratory symptoms** Ask about having cough, shortness of breath, chest pain, ankle swelling, etc. ● **GIT symptoms** 1. Ask about having weight loss or weight gain, nausea or vomiting, diarrhea or constipation, abdominal pain, excessive thirst etc. 2. Ask about having loss or increase of appetite. ● **Neurological symptoms** 1. Ask about having nervousness, irritability, fatigue, or seizures. 2. Ask about having headache, dizziness, ringing in the ears, changes in hearing, vision, smell or taste, etc. ● **Urinary and Reproductive symptoms** 1. Ask about having increased frequency of urination. Ask about having burning on passing urine, frequency of urination, blood in the urine, etc. 2. Ask about having penile or vaginal discharge, hesitancy or urgency of urination, poor urine stream or dribbling, etc. ● **Dermatologic symptoms** 1. Ask about having skin rashes, redness, or itchiness, etc. 2. Ask about having skin pigmentation, dryness, or sweating. ● **Musculoskeletal symptoms** 1. Ask about having joint pain or stiffness, muscle pain or weakness, etc. 2. Ask about having overgrowth or shorter stature.			
	Closing			
1.	Make explanations to the patient, answer questions and discuss management plan. If appropriate, order diagnostic investigations (e.g. ultrasound scan, CBC, LFTs, etc.).			
2.	Ensure that the patient is comfortable.			
3.	Thank the patient. Wash hands and document the procedure.			

Thyroid 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 and get consent.			
4.	Wash your hand and prepare the necessary material.			
5.	Position the patient in a sitting position and uncover his/her neck and upper body.			
	Examination			
1.	**Inspection:** ● Inspect patient's neck.(Asymmetry, surgical scars, prominent veins, redness, swelling or evident masses). ● Ask the patient to take a sip of water and watch the neck. (Thyroid gland, thyroid cartilage, cricoid cartilage, thyroglossal cyst, lymph nodes are moved upon swallowing).			
2.	**Palpation:** ● Put one hand on either side of his neck and examine the anterior and posterior triangles of the neck with fingertips. ● .Palpate the neck for any masses. (If any; determine its location, size, shape, mobility, tenderness, surface features etc.) ● Palpate the thyroid gland. (If palpable; determine its size, shape, symmetry, consistency, tenderness and mobility). ● Palpate for cervical lymph nodes and describe. ● Palpate for tracheal deviation in the suprasternal notch.			
3.	**Percussion:** Percuss the manubrium sterni from one side to the other.(A change from resonant to dullness indicates possible retrosternal goitre).			
4.	**Auscultation:** Auscultate the thyroid over each lobe for bruits.			
	After examination			
1.	Ensure that the patient is comfortable			
2.	Make explanations to the patient, answer his/her questions and discuss management plan.			
3.	Dispose waste material according to infection control standards, Wash hands then Document the procedure.			

Adrenal: history taking

Simulated Patient Case Script:

Weight gain due to cushing's disease.

Cushing's syndrome is a condition wherein the adrenal glands produces excessive hormones (cortisol) due to drugs or abnormal glands/ tumors.

Personal and Social History:
Single, living with parents. No tobacco use.

present complaint:

1- When these complaints started? It started 8 months ago.
2- How much weight did you ? I have gained about 6-8 kilos.
3- Was there any change in your appetite? I tried controlling my diet but I am tired easily so I eat to feel relaxed.
4- Is there any other symptoms? I noticed that I have difficulty lifting things at work, I used to think maybe I am getting old or just tired.
5- Did you experience this condition before? No, this is the first time.
6- Do you have any medical problems or condition in the past? No, I believe I was perfectly healthy before this.
7- Does anyone in your family with similar condition? No.
8- Are you on any medication? No.

Past medical history:
Nothing specific, No important disease history, No operation, No current medication, No allergy.

Personal and Social History:
I play tennis and usually go to the gym for work-outs, I like to feel fit and healthy that's why this weight gain is bothering me so much.

Family history:
Parents are both hypertensive, and live a healthy lifestyle, no major history of other disease.

Adrenal: history taking

	Step/Task	D	PD	ND
	Preparation			
1.	Greet the patient and introduce yourself.			
2.	Explain the procedure, reassure the patient and get patient's consent.			
3.	Make sure the patient is in a comfortable position sitting or lying down.			
4.	Maintain good eye contact and establish rapport with the patient.			
	History			
1.	**Personal information:** Ask for the patient's Name, Age, Gender, Occupation, Nationality, and Address.			
2.	**Presenting Complaint:** Ask the patient about the main problem/s that made him/her went to see the doctor.			
3.	**History of Present Illness:** ● Allow the patient to provide an account of recent events in his/her own words without interruption. ● Ask the patient when the condition started. Ask how much weight was lost or gained. ● Ask any associated signs and symptoms like increased appetite, nervousness or irritability, weakness, difficulty in sleeping, hair loss, shortness of breath,changes in menstruation for women, skin changes like bruising etc.			
4.	**Past medical history:** ● Ask about any similar episodes in the past ● Ask about any previous history endocrine problems. ● Ask about other medical conditions or congenital problems. ● Ask about any history of surgery particularly in thyroid, parathyroid, pituitary, kidneys/ adrenal.\Ask about any history of radiation. ● Ask about previous hospitalizations, allergy, blood transfusion, and trauma history.			
5.	**Family History:** Ask about significant illness in the family (like Marfan's or Diabetes Mellitus). Similar illness in the family.			

Adrenal: history taking

6.	**Personal and Social History:** ● Ask about use of alcoholic beverages, cigarette smoking or illicit drugs. ● Ask about use of drugs to improve physical appearance, exercise or workout. ● Ask politely about emotional problems at home or at work.			
7.	**Obstetric and Gynecologic History (if patient is female):** ● Ask about the LMP (last menstrual period), regularity and quality of menstruation, Ask age of menopause if patient is elderly. ● Ask about number of pregnancy, number of children, and history of complications during pregnancy.			
8.	**Systematic Review (inquiry about all the cardinal symptoms in each of the major systems):** ● **Cardio-respiratory symptoms:** Ask about having cough, shortness of breath, chest pain, ankle swelling, etc. ● **GIT symptoms:** 1. Ask about having weight loss or weight gain, nausea or vomiting, diarrhea or constipation, abdominal pain, excessive thirst etc. 2. Ask about having loss or increase of appetite. ● **Neurological symptoms:** 1. Ask about having nervousness, irritability, fatigue, or seizures. 2. Ask about having headache, dizziness, ringing in the ears, changes in hearing, vision, smell or taste, etc. ● **Urinary and Reproductive symptoms:** 1. Ask about having increased frequency of urination. Ask about having burning on passing urine, frequency of urination, blood in the urine, etc. 2. Ask about having penile or vaginal discharge, hesitancy or urgency of urination, poor urine stream or dribbling, etc. ● **Dermatologic symptoms:** 1. Ask about having skin rashes, redness, or itchiness, etc. 2. Ask about changes in skin color, darkness or lightness 3. Ask about having skin pigmentation, dryness, or sweating. ● **Musculoskeletal symptoms:** 1. Ask about having joint pain or stiffness, muscle pain or weakness, etc. 2. Ask about having overgrowth or shorter stature.			
	Closing			
1.	Make explanations to the patient, answer questions and discuss management plan. If appropriate, order diagnostic investigations (e.g. ultrasound scan, CBC, LFTs, etc.).			
2.	Ensure that the patient is comfortable.			
3.	Thank the patient. Wash hands and document the procedure.			

History related to Diabetes mellitus

Simulated Patient Case Script:

Frequent urination.

Diabetes mellitus is a condition associated with increased blood glucose levels caused by absence or insufficient amount of Insulin in the body.

Personal and Social History:
Single, living with parents. No tobacco use.
present complaint:
1. When these complaints started? It started two months ago.
2. How frequent do you go to the bathroom to urinate? More than 8 time a day.
3. Do you get up at night while sleeping just to urinate? Yes, sometimes 2-3 times.
4. Was there any change in the volume of urine you pass out? Yes, the amount was greatly increased. I think I pass about 1-2 Litres each time.
5. Do you experience burning when you urinate? No.
6. Do you have fever? No.
7. Is there any other symptoms? I noticed that I get thirsty all the time. I also feel hungry more than before. I easily get tired and have frequent headaches.
8. Was there any change in your appetite? Yes, I eat a lot now.
9. Did you experience this condition before? No, this is the first time.
10. Do you have any medical problems or condition in the past? No.
11. Does anyone in your family with similar condition? No.
12. Are you on any medication? No.

History related to Diabetes mellitus

	Step/Task	D	PD	ND
	Preparation			
1.	Greet the patient and introduce yourself.			
2.	Explain the procedure, reassure the patient and get patient's consent.			
3.	Make sure the patient is in a comfortable position sitting or lying down.			
4.	Maintain good eye contact and establish rapport with the patient.			
	History			
1.	**Personal information:** Ask for the patient's Name, Age, Gender, Occupation, Nationality, and Address.			
2.	**Presenting Complaint:** Ask the patient about the main problem/s that made him/her went to see the doctor.			
3.	**History of Present Illness:** ● Allow the patient to provide an account of recent events in his/her own words without interruption. ● Ask the patient when the condition started. ● Ask the patient how many times he/she urinates in a day. Ask the amount or volume in comparison before. ● Ask to describe the urine's appearance. (Color, texture, and smell) ● Ask any associated signs and symptoms like increased appetite/hunger, increased thirst, weight loss, fatigue, blurred vision, headache, dry mouth, etc.			
4.	**Past medical history:** ● Ask about any similar episodes in the past. ● Ask about other medical conditions or congenital problems. ● Ask about history of surgery, previous hospitalizations, allergy, blood transfusion, and trauma.			
5.	**Family History:** Ask about significant illness in the family like Diabetes Mellitus, Hypertension, etc..			
6.	**Personal and Social History:** ● Ask about use of alcoholic beverages, cigarette smoking or illicit drugs. ● Ask politely about emotional problems at home or at work.			

History related to Diabetes mellitus

7. Obstetric and Gynecologic History (if patient is female):

- Ask about the LMP (last menstrual period), regularity and quality of menstruation, Ask age of menopause if patient is elderly.
- Ask about number of pregnancy, number of children, and history of complications during pregnancy like Gestational Diabetes

8. Systematic Review (inquiry about all the cardinal symptoms in each of the major systems):

- **Cardio-respiratory symptoms:**

Ask about having cough, shortness of breath, chest pain, ankle swelling, etc.

- **GIT symptoms:**

1. Ask about having weight loss or weight gain, nausea or vomiting, diarrhea or constipation, abdominal pain, excessive thirst etc.
2. Ask about having loss or increase of appetite.

- **Neurological symptoms:**

1. Ask about having nervousness, irritability, fatigue, or seizures.
2. Ask about having headache, dizziness, ringing in the ears, changes in hearing, vision, smell or taste, etc.

- **Urinary and Reproductive symptoms:**

1. Ask about having increased frequency of urination.
2. Ask about having burning on passing urine, frequency of urination, blood in the urine, etc.
3. Ask about having penile or vaginal discharge, hesitancy or urgency of urination, poor urine stream or dribbling, etc.

- **Dermatologic symptoms:**

1. Ask about having skin rashes, redness, or itchiness, etc.
2. Ask about having skin pigmentation, dryness, or sweating.

- **Musculoskeletal symptoms:**

1. Ask about having joint pain or stiffness, muscle pain or weakness, etc.
2. Ask about having overgrowth or shorter stature.

Closing

1. Make explanations to the patient, answer questions and discuss management plan. If appropriate, order diagnostic investigations (e.g. ultrasound scan, CBC, LFTs, etc.).

2. Ensure that the patient is comfortable.

3. Thank the patient. Wash hands and document the procedure.

MED435.

OSCE TEAM

OBJECTIVE STRUCTURED CLINICAL EXAMINATION

Reproductive Block.

Done by:

Munerah alomari

Abdulrahman Yaslam

MATERIALS:

Examination of Male Genital System	Proper Light equipment, clean gloves and lubricant, tissues for clean up.
Bimanual Vaginal (PV) Examination	Proper Light equipment, clean gloves and lubricant, tissues for clean up.
Taking a Pap Smear	Gloves , speculum, lubricant, a cervical brush, a pot of cytology preservative solution and a light source
Obstetric History Taking	-
Breast examination	Gloves, Swabs and Cytology slides.

speculum

cervical brush

Examination of Male Genital System

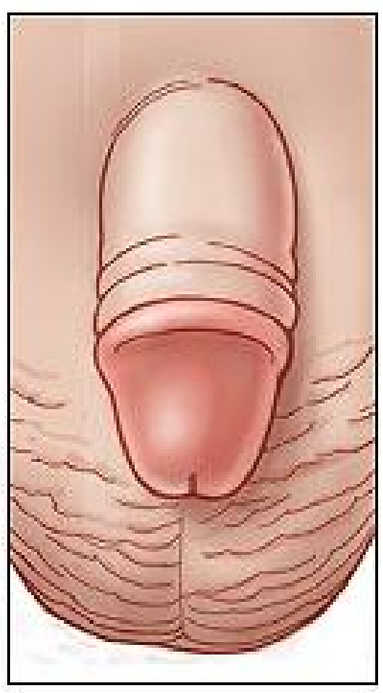
	Step/Task	D	PD	ND
	Preparation			
1.	Introduce yourself to the patient and confirm his ID.			
2.	Explain the procedure, reassure the patient and get his consent. Explain that he may feel little discomfort and that the examination should be over fairly quickly.			
3.	The patient should be exposed from the waist down.			
4.	The examination is easier to perform with the patient standing while you are seated in front of him. In this position, it is easier to examine the testes, evaluate for inguinal hernias and perform the rectal exam. However, if the patient is unable to stand, it can be performed while they lie on the exam table.			
	Examination			
5.	**Wash your hands**, put on clean gloves and observe for any bulges or scars in the inguinal region or any obvious skin abnormalities on the penis, scrotum or surrounding areas. Note if there are any bulges or scars in the inguinal region, consistent with current or past hernias. Any obvious penile or scrotal abnormalities? Any obvious skin abnormalities on the penis, scrotum or surrounding areas?			
6.	**Examination of the Penis:** Examine the glans (i.e. the head) of the penis. If the patient is uncircumcised, draw back the foreskin so that you can look at the glans in its entirety. Observe any superficial lesions and palpate any obvious lesions for induration and tenderness. Compress the glans anteroposteriorly between the thumb and forefinger to open and inspect the meatus and terminal urethra.			
7.	**Examination of the Scrotum:** The scrotum is examined by inspection and palpation. Transillumination is readily performed; it is most informative for examining the scrotal contents..			
8.	**Examination of testes:** Gently feel the testes, palpating the tissue between the thumb and next 2 fingers of your examining hand. Each should be of the same consistency and size. Examine for any discrete lumps or bumps within the body of the testis.			
9.	**Examination of the Epididymis:** Locate each epididymis by palpating the smooth testis to find a vertical ridge of soft nodular tissue beginning at the upper pole and extending to the lower pole. Usually the epididymis is behind the testis			

Aljera ibah

Examination of Male Genital System

10.	**Examination of the Spermatic Cord:** With the thumb in front and the forefinger behind the scrotum, gently compress the cord, then have the patient bear down to increase the intra abdominal pressure. The normal vas deferens is felt as a distinct hard cord, which can be separated from other cord structures. Compare the spermatic cords by simultaneously grasping each at the neck of the scrotum.			
11.	The hernial orifice examination should be performed on all male patients, regardless of whether you suspect any underlying abnormality. Before palpating this region, have the patient cough while you look at the inguinal region.			
12.	**Rectal/Prostate Exams:** This will be covered with the PR examination.			
	After the procedure			
13.	Summarize your findings and offer a differential diagnosis if needed.			
14.	On completion of the examination, either clean the patient or provide tissue to the patient.			
15.	Cover the patient up. Thank him and ensure that he is comfortable			

Natural penis



Circumcised penis

The Doctor said it's important to know how the penis looks like before and after circumcision .

Bimanual Vaginal (PV) Examination

	Step/Task	D	PD	ND
	Preparation			
1.	Introduce yourself to the patient and confirm her ID.			
2.	Explain the procedure, reassure the patient and get his consent. Explain that he may feel little discomfort and that the examination should be over fairly quickly, The patient should be exposed from the waist down.			
3.	Ask her to lie on her back, ankles together and to let her knees fall apart as much as possible. You should try to maintain some of her modesty by putting a cover over her. A chaperone is required for this examination.			
	Examination			
4.	**Wash your hands**, Wash your hands, put on clean gloves and inspect the outside of the vagina. Check the labia and clitoris looking for any obvious abnormalities such as erosions.			
5.	Lubricate the index and middle finger of your right hand. Explain to the patient that you are about to start the procedure			
6.	Use the thumb and index finger of your left hand to separate the labia majora and **firstly insert your index finger, checking for any cervical excitation.** If none is present, **then insert your middle finger.**			
7.	Palpate all of the vaginal walls as you advance your fingers feeling for any obvious abnormalities.			
8.	Slide your fingertips, palpate the **cervix**, feel for its size, shape and mobility – check with the patient if it is tender.			
9.	**Bimanual pelvic examination:** At this point palpate the **uterus** by pressing it between your **right middle and index** fingers and your **left hand placed on the lower abdomen.** Feel for any masses.			
10.	**palpate each of the ovaries**: This is done by placing your internal fingers in the right fornix and trying to press the ovary between them and your left hand placed in the right iliac fossa. Do the same for the left ovary. Note any tenderness or masses which you may feel			
11.	Once complete, remove your fingers, check your glove for any discharge or blood, and then discard your gloves in the clinical waste bin.			
12.	If needed or indicated perform a Vaginal Speculum Examination and collect sample for cytological and bacteriologic tests and for biopsies when indicted.			
13.	Offer the patient a tissue, cover her up and thank her. You should now report your findings to the examiner.			

Taking a Pap Smear

	Step/Task	D	PD	ND
	Preparation			
1.	Introduce yourself to the patient and confirm her ID.			
2.	Explain the procedure, reassure the patient and get his consent. Explain that he may feel little discomfort and that the examination should be over fairly quickly.			
3.	The patient should be exposed from the waist down. Ask her to lie on her back, ankles together and to let her knees fall apart as much as possible. You should try and maintain some of her modesty by putting a cover over her. A chaperone is required for this examination..			
	Examination			
5.	**Wash your hands**,Wash your hands, put on some gloves and inspect the outside of the vagina. Check the labia and clitoris looking for any obvious abnormalities such as erosions			
6.	warm the blades of the **speculum** with warm water. The water also acts to **lubricate** the speculum but you may also like to apply some lubricant. **Ensure the lubricant is not placed at the end of the speculum as this may alter the result**.			
7.	Inform the patient that you are about to start the procedure. Use your left hand to part the labia minora and **insert the speculum with the screw facing sideways.**			
8.	As you advance the speculum, turn it so that the **screw faces upwards.** Open the blades and fix them open with the screw. Ensure that you can see well by adjusting the light source. Check for any gross pathology and identify the transition zone.			
9.	Place the tip of the cervical brush into the external cervical os and rotate it **three times through 360 degrees** ensuring that it is always in contact with the cervix.			
10.	Remove the brush ensuring it does not wipe against anything. Tap the brush 10 times on the edge of the pot of cytology medium			
11.	Release the screw on the speculum and carefully remove it from the vagina, completing the examination.			
12.	Offer the patient some tissue, cover the patient, and thank her. You should explain to the patient that her smear results will be sent to them in approximately 6 weeks thus ensuring appropriate follow-up.			

Obstetric History Taking

	Step/Task	D	PD	ND
	Preparation			
1.	Introduce yourself to the patient and confirm her ID.			
2.	Gain consent and explain the need to take history.			
3.	Ensure the patient is comfortable			
	History			
5.	**Personal information:** Ask for the patient's Name, Age, Gender, Occupation, Nationality, and Address.			
6.	**Chief Complaint:** Short statement of the problem that brought the patient, better recorded in the patient's own words.			
7.	**History of Present Illness:** Use open questioning to elicit the patient's presenting complaint like 'what brought you here'. For each complaint enquire about the following: ● Onset – when did the symptom start? / was the onset acute or gradual? Duration – minutes / hours / days / weeks / months / years ● Severity – e.g. if symptom is vaginal bleeding – how many sanitary pads are they using? ● Course – is the symptom worsening, improving, or continuing to fluctuate? Intermittent or continuous? – is the symptom always present or does it come and go? Precipitating factors – are there any obvious triggers for the symptom? ● Relieving factors – does anything appear to improve the symptoms ● Associated features – are there other symptoms that appear associated e.g. ● Previous episodes – has the patient experienced these symptoms previously			
8.	**Pregnancy related questions:** ● Nausea / vomiting – if severe may suggest hyperemesis gravidarum ● Abdominal pain – may suggest the need for imaging ● Vaginal bleeding – fresh red blood / clots / tissue ● Dysuria / urinary frequency – urinary tract infectionFatigue – may suggest anaemia ● Headache / visual changes / swelling – pre-eclampsia ● Systemic symptoms – fever / malaise			

Obstetric History Taking

9. History of current pregnancy:

- Is this the patient's first pregnancy?
- Last menstrual period (LMP) – first day of the LMP E
- Estimated date of delivery (EDD) – estimated by scan or via dates (LMP + 9 months + 7 days)
- Did the patient take folic acid during the first trimester? Any other scans or tests whilst been pregnant? – dating scan / anomaly scan
- Fetal movements – usually experienced at around 18-20 weeks gestation
- Labour pains – more relevant in the third trimester
- Planned method of delivery – vaginal / c-section
- Medical illness during pregnancy – if so are they taking any medications?

10. Past Obstetric history

- Gravidity – defined as the number of times a woman has been pregnant regardless of the outcome
- Parity – X = (any live or stillbirth after 24 weeks) | Y = (number lost before 24 weeks)
- Details of each pregnancy including the mode of delivery and any complications (antenatal, intranatal or postnatal)

11. Gynaecological History:

- Previous cervical smears if done and results
- Previous gynecological problems & treatments – STDs / PID / Ectopic pregnancy
- Current or previous contraception
- Any Gynaecological surgery in the past.

12. Past Medical History:

- PE / DVT – high risk for further events in following pregnancy
- Diabetes – tight glycaemic control is essential – risk of congenital defects / macrosomia
- Epilepsy – some antiepileptics are teratogenic
- Hypothyroidism – need close monitoring
- Previous pre-eclampsia– higher risk to develop it in the current pregnancy
- Other relevant medical conditions

13. Drug History:

Document all regular medications like iron, folic acid. Over the counter drugs – ensure nothing is unsafe / teratogenic

14. Family and Social History:

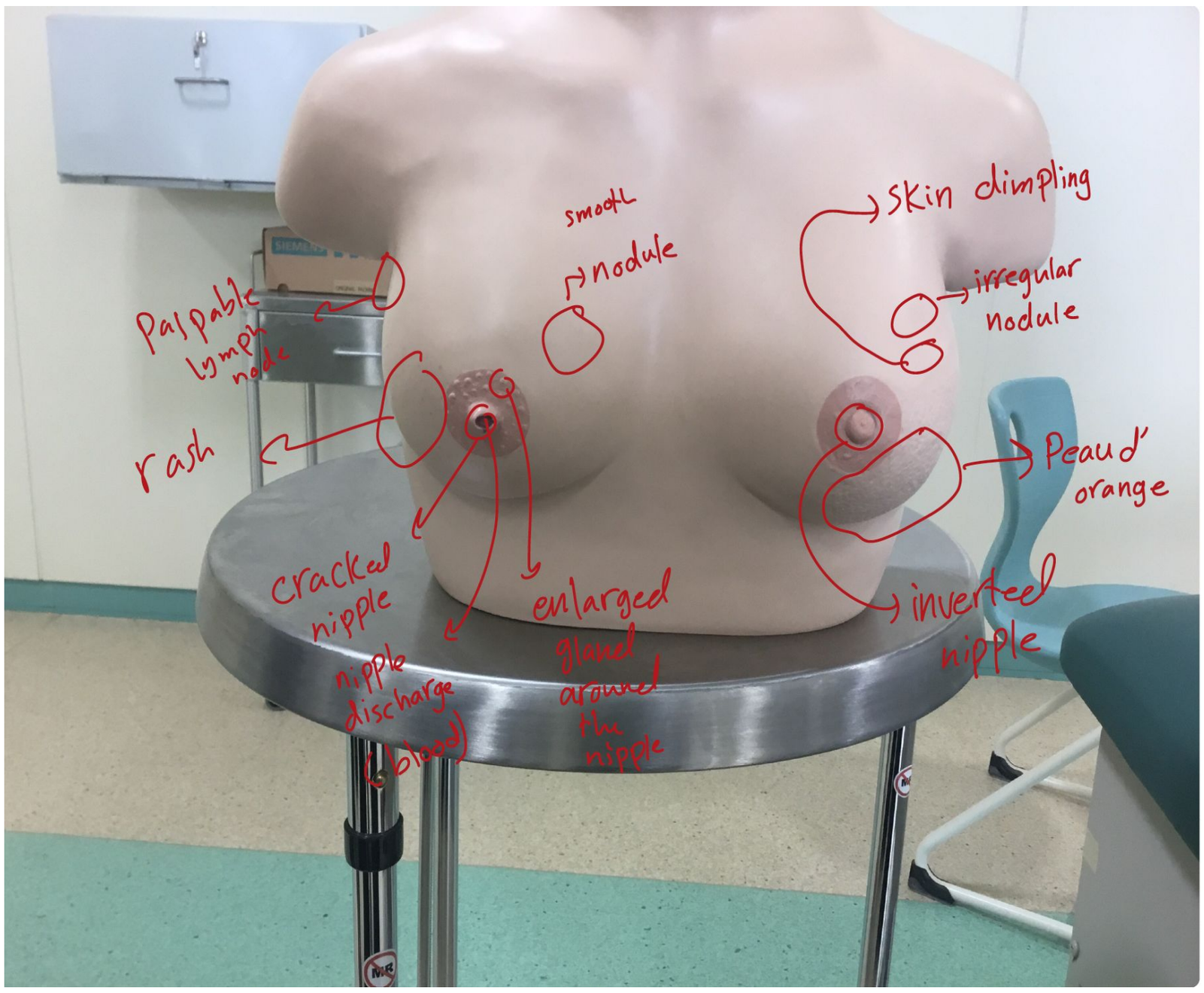
- Inherited genetic conditions – cystic fibrosis
- Pregnancy loss – recurrent miscarriages in mother & sisters
- Pre-eclampsia – in mother or sister – increased risk
- Enquire about Smoking, alcohol,Recreational drug use – All can affect the fetus adversely.
- Living situation Who lives with the patient? – important for care on discharge from hospital
- Occupation.

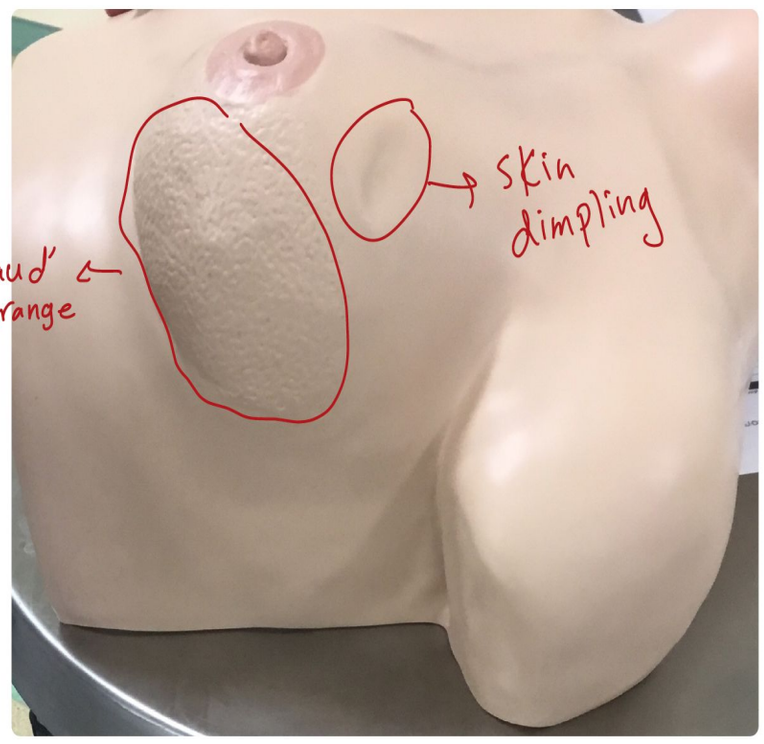
Breast Examination

	Step/Task	D	PD	ND
	Preparation			
1.	Introduce yourself to the patient and confirm her ID.			
2.	Explain the procedure to the patient and get her consent.			
3.	The patient should be exposed from the waist up. Hand her a drape/blanket to protect her modesty.			
4.	Ask her to sit on the edge of the couch and ensure that she is comfortable.			
	Examination			
5.	**General inspection:** From a distance, observe the patient's general appearance, state of general health, obvious signs that can be apparent on inspection.			
6.	**Local Examination:** • **Inspection:** 1. Position the patient to sit upright with her chest fully exposed. 2. Make a general inspection of both breasts. 3. **Look at the nipples for:** Retraction, Redness or Bleeding around the area. Any visible discharge. 4. **Look at the skin for**: Any visible veins, skin dimpling, peau d' orange. Ask the patient to lift 5. **Ask the patient to raise her arms above her head and lower slowly to look for:** Tethering of the nipples or skin, Shift in position of the nipples or a fixed mass distorting the shape of the breast. Look for any apparent masses in the Axilla. 6. **Ask the patient to rest her hands on her hips and press her hands against her hips. Check for:** Any Dimpling or Fixation • **Palpation of the Breast:** 1. Examine each breast individually. 2. Ask the patient to lie down. If the breasts are large you may ask the patient to place her hand on her forehead when you are examining the lateral side and bring her elbow to level with her shoulder when examining the medial side. 3. Ensure that there is no chest/breast pain. 4. Gently and using the pulp of your 3 middle fingers: **Start with the normal breast** if there is some suspicion of abnormality on the other side Palpate each quadrant 3 times with increasing pressure towards the chest wall using an even rotary movement. 5. Check the concentric trail. 6. **If a mass is found, assess for:** Position (in terms of quadrant and proximity to the nipples), Size, Shape, and Consistency, Tenderness, Fixation to the skin			

Breast Examination

7	• **Palpation of the Nipple:** 1. Hold the Nipple between the thumb and the forefinger and gently compress it to express any discharge. Alternatively, you can ask the patient to express any discharge she might have. 2. Any fluid discharged should be Swabbed for Microbiology Investigations and Smeared for Cytology. 3. Feel the area behind the Nipples for any Lumps. • **Palpation of the Axillae:** 1. Ask the patient to sit up at the side of the bed Make sure she is comfortable, explain to her how you are going to examine her axillae and why 2. Hold the left hand arm of the patient with your left hand asking the patient to relax at the shoulder and let her arm rest on yours 3. Palpate the left axilla with your right hand, feeling for any masses with the tip of the fingers in a rolling motion all around.Repeat with the other hand on the other side in the same way 4. End the examination with palpation of the supraclavicular fossa with behind asking the patient to hunch her shoulders up and relax the neck muscles.			
	After the procedure			
8.	Cover up the patient and thank her.			
9.	Answer her queries and make sure she is comfortable			
10.	Document the examination.			
11.	Wash hands			





The Doctor said breast examination will be abnormal so check the picture.

Special thanks to Atheer Aljeraibah for sharing the pictures.