433 Team

osce

History & Physical Examination of Respiratory system

Pneumothorax: **Is the presence of air in the pleural cavity causing lung collapse.**

Chief Complain : Shortness of breath & pleuritic chest pain.	
Question	**Indications**
How long have you been short of breath? (Duration).	**sec to min: pneumothorax,**
Did it come on very quickly? Or instantaneously? (Onset: How it started, sudden or gradual?).	***instantaneously*** *(Pneumothorax)*
Is the SOB contentious throughout the day, intermittent? If intermittent When is it worse/better? (frequency)	
Where do you feel the pain?	**Well localized to the side of the pneumothorax**
Progression: become worse with time?	
Severity: affect your work, life? Or NYHA classification).	
Can you tell me how the pain is like?	**Sharp and stabbing (pleuritic pain)**
What makes the pain **worse**?	Respiration or cough
What **relives** the pain?	Holding breath
Other respiratory symptoms?	
Fever, weight loss, loss of appetite, night sweat?	
Risk Factors:	
Trauma? Respiratory disease? Ventilation? Any invasive procedure of the chest such as central venous cannulation?	
Past Medical History:	
Any known respiratory disease?	**Such as asthma, COPD or pleural disease**

	(mesothelioma)
Any previous pneumothorax?	
Dose the patient have diagnosed Marfan's syndrome?	
Drug History	
Family History	
Social History	
Smoking?	(smoking considerably increase the incidence of idiopathic pneumothorax)
Systemic Review	

- **What are the Causes of pneumothorax: (SIT, 3A, 3C)**

Primary:

- **Spontaneous: subpleural bullae rupture** (tall, thin, young male).

Secondary:

- **Iatrogenic**.(insertion of a central venous catheter)
- **Trauma.** (rib fracture, penetrating chest wall injury, or during pleural or pericardial aspiration)
- **Asthma, Alveolitis , AIDS.**
- **COPD, Carcinoma, Cystic fibrosis.**
- Emphysema, Marfan's syndrome.

- **Diagnosis: Chest X-Ray**.
- **Management:**
  If small & asymptomatic patient □observation or small chest tube.
  If large & symptomatic patient □supplemental O_2 & chest tube.

Tension pneumothorax:

Communication between the lung and the pleural space, with a flap of tissue acting as a valve, allowing air to enter the pleural space during inspiration and preventing it from leaving during expiration.

- **What are the Causes of Tension pneumothorax::** Trauma, Mechanical ventilation, Spontaneous.
-

Clinical manifestation: what do you expect when examining the patient?			
Inspection	**Palpation**	**Percussion**	**Auscultation**
Tachypnea. Tachycardia Central cyanosis.	Reduced chest expansion on the affected side. Trachea deviated ***away from*** the affected side	hyperresonant over the affected side.	Absent or reduced breath sound. Absent Vocal resonance. No added sound.

- **Important findings**: subcutaneous emphysema, Increased JVP, Distended neck veins, muffle heart sounds, hematomas.
- **Management :** chest decompression needle, inserted into the pleural cavity through the second intercostal space in the mid- clavicular line.

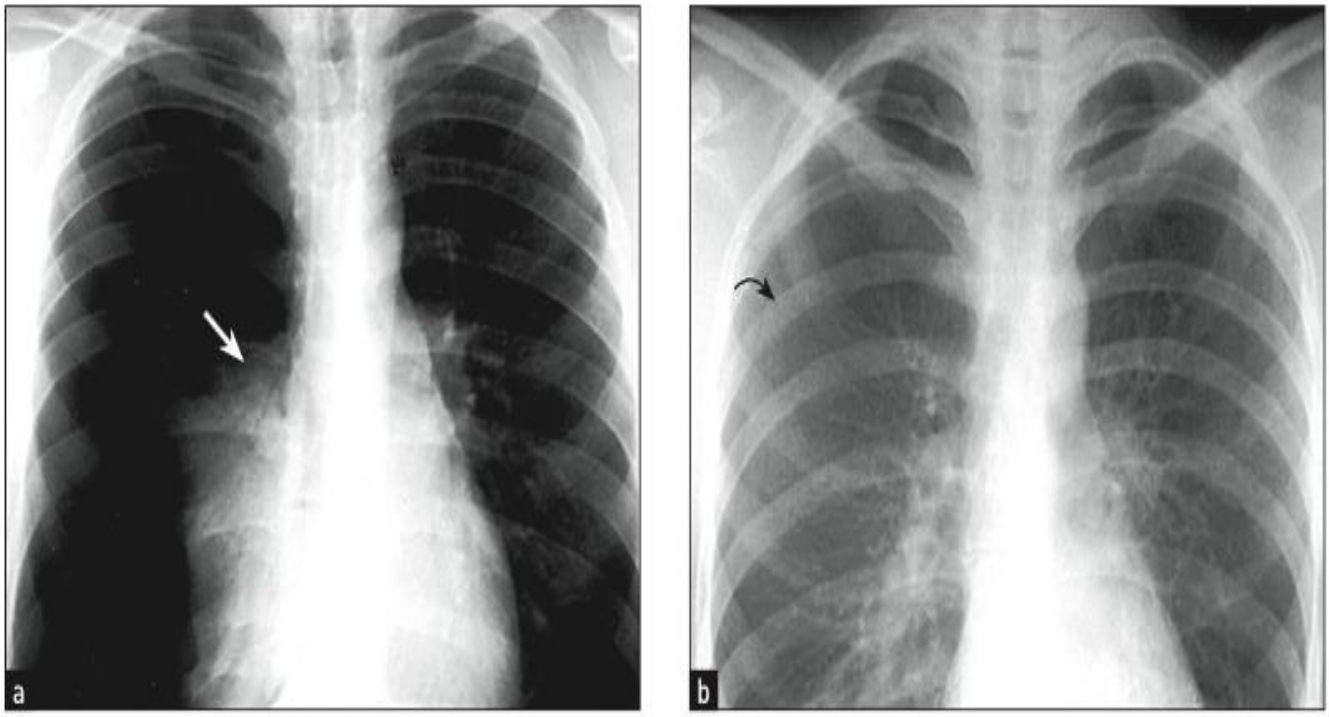
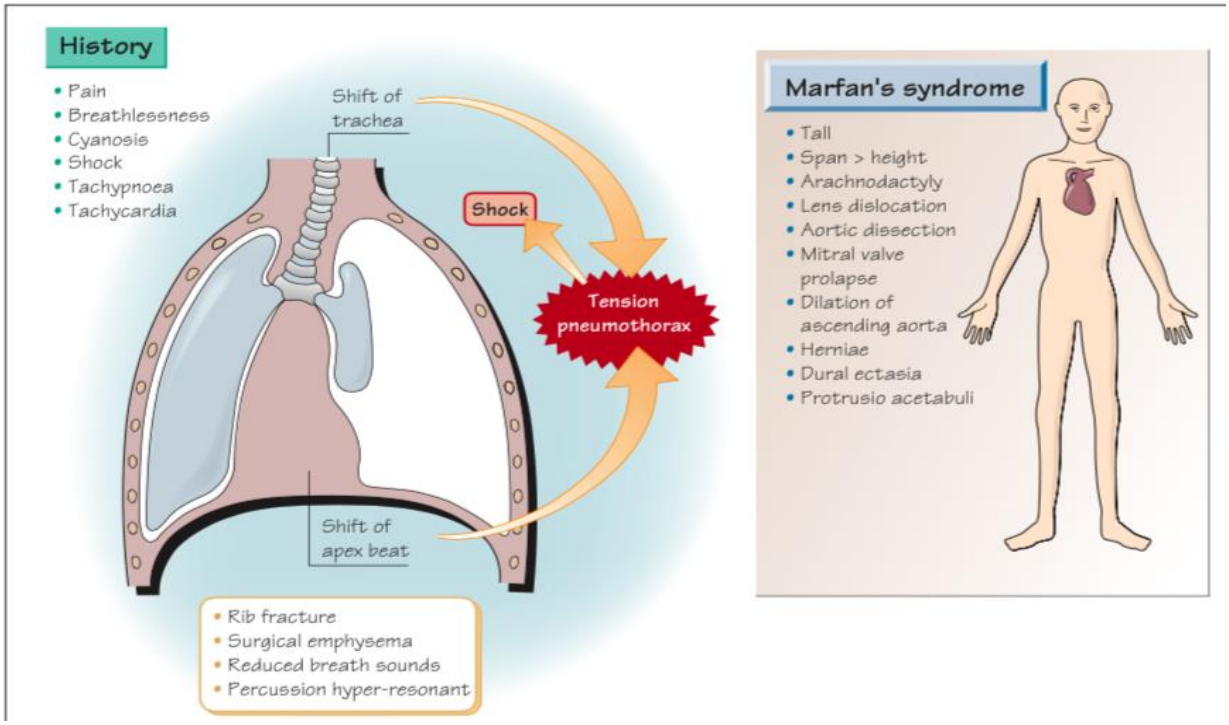


Figure 12.7 Pneumothorax
(a) There is a massive right pneumothorax with collapsed lung seen against the hilum (arrow). There is increased translucency because of the absence of vascular shadows. (b) Different patient with a smaller pneumothorax. Small pneumothoraces are easier to see on an expiratory film as the pneumothorax volume remains constant, surrounding the partly deflated lung. The visceral pleural surface is marked (arrow).

***NOTE:They will show you chest X-Ray (you have to mention the name of patient, date of performing the X-Ray and describe what you see on X-ray).**



Done By:

Anjod Al-Muhareb
Nouf Al-Ballaa
Abdullah al-yahya
Afaf Al-Mutairi