PHC

432 Team

OSCE – Physical Examination

Done & Reviewed By:
Yazeed Alhusainy

COLOR GUID : Not important **Important** Explanation Extra information

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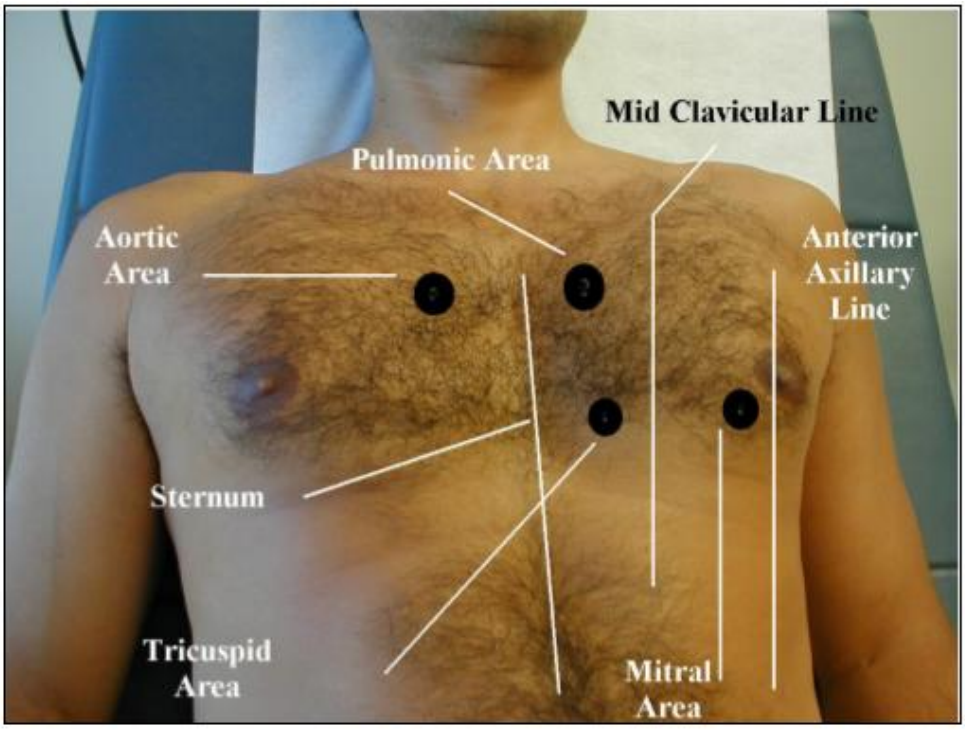
1- CVS Exam:

https://www.youtube.com/watch?v=SJ3UwKkLyy0

	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.	Show the patient each object and allow him/her to touch them to reduce any fear of being hurt during the examination.			
8.	Position the patient in a 45 degree sitting position and uncover his/her upper body.			
	Examination			
	General inspection			
9.	Observe the patient's general appearance *(age, state of health, nutritional status and any other obvious signs e.g. jaundice, cyanosis, dyspnoea).*			
	Hands and pulse			
10.	Pick up the patient's hand; inspect and examine (*Temperature, Color, Nail clubbing, Nail splinter haemorrhages, Nail signs of iron deficiency).*			
11.	Take the patient's radial pulse *(Determine the Rate, Rhythm and the Character of the pulse).*			
	Blood pressure			
12.	Take his/her blood pressure *(Lying and standing or sitting-postural hypotension).*			
	Face			
13.	Inspect the patient's face *(sclerae, pupils, malar rush, mouth, palate, dentition).*			
	Neck			
14.	Assess the jugular venous pressure and the jugular venous pulse form: • Ask the patient to turn his head slightly to one side. • Look at the internal jugular vein medial to the clavicular head of sternocleidomastoid. • Assuming that the patient is at 45 degrees, the vertical height of the jugular distension from the sternal angle should be no greater than 4 cm.			
15.	Locate the carotid pulse and assess its character.			
	Praecordium			
16.	Inspect the patient's chest *(scars, deformity, apex beat, abnormal pulsation, pacemaker).*			
17.	Palpate *(apex beat, thrills, abnormal impulses).*			
	➔ *Continues on the next page*			

	Examination			
	Auscultation of the heart			
18.	Place your stethoscope's diaphragm on auscultation areas and listen for: Heart sounds, additional sounds, murmurs, and pericardial rub. General auscultation areas: • **Aortic area** - right second intercostal space near the sternum. • **Pulmonary area** - left second intercostal space near the sternum. • **Tricuspid area** - left third, fourth, and fifth intercostal spaces near the sternum. • **Mitral area** - left fifth intercostal space, in the mid-clavicular line.			
19.	Ask the patient to turn onto his left side and to hold his breath in expiration. Using the stethoscope's bell, listen in the mitral area for the middiastolic murmur of mitral stenosis.			
20.	Ask the patient to bend forward and to hold his breath in expiration. Using the stethoscope's diaphragm, listen at the left sternal edge in the fourth intercostal space for the mid-diastolic murmur of aortic regurgitation.			
21.	Listen over the carotid arteries for any bruits.			
	Back *(patient is in sitting forward position)*			
22.	Inspect the patient's back *(scars, deformity).*			
23.	Percuss his/her back *(pleural effusion).*			
24.	Auscultate for inspiratory crackles *(left ventricular failure).*			
	Abdomen *(patient is laying down)*			
25.	Inspect the patient's abdomen *(scars, deformity).*			
26.	Palpate his/her abdomen for hepatomegaly *(right ventricular failure),* pulsatile liver *(tricuspid regurgitation),* splenomegaly *(endocarditis)* and aortic aneurysm.			
27.	Ballot the kidneys and listen for any renal artery bruits.			
	Legs *(patient is laying down)*			
28.	Examine all peripheral pulses bilateraly. • Femoral pulses. • Popliteal pulses. • Posterior tibial pulses.• Dorsalis pedis pulses			
29.	Look for peripheral vascular disease, peripheral oedema and clubbing of the toes.			
30.	Cover the patient up.			
	Eyes			
31.	Examine the retina with an ophthalmoscope.			
	After the examination			
32.	Ensure that the patient is comfortable.			
33.	Make explanations to the patient, answer his/her questions and discuss management plan.			
34.	If necessary, order diagnostic investigations.			
35.	Dispose of sharps and waste material according to infection control standards.			
36.	Wash hands.			
37.	Document the procedure.			



2- Chest (Respiratory) Exam:

https://www.youtube.com/watch?v=L19PVsD--KA

	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 45 degree sitting position and uncover his/her upper body.			
	Examination			
	General inspection			
8.	Observe the patient's general appearance *(age, state of health, nutritional status and any other obvious signs e.g. dyspnoea, cyanosis, audible breathing, coughing).*			
9.	Look for: • The rate, depth, and regularity of the patient's breathing. • Any deformities of the chest and spine. • Any asymmetry of chest expansion. • The use of accessory muscles of respiration. • The presence of scars.			
	Hands and pulse			
10.	Pick up the patient's hand; inspect and examine (*Temperature, Color, Nail clubbing, Nail splinter haemorrhages, Nail signs of iron deficiency).*			
11.	Take the patient's radial pulse *(Determine the Rate, Rhythm and the Character of the pulse).*			
12.	Test for flapping tremor.			
	Face			
13.	Inspect the patient's face *(sclerae, pupils, malar rush, mouth, palate, dentition).*			
	Neck			
14.	Assess the jugular venous pressure and the jugular venous pulse form: • Ask the patient to turn his head slightly to one side. • Look at the internal jugular vein medial to the clavicular head of sternocleidomastoid. • Assuming that the patient is at 45 degrees, the vertical height of the jugular distension from the sternal angle should be no greater than 4 cm.			
	➔ *Continues on the next page*			

	Chest			
15.	Inspect the patient's chest *(shape -pectus carinatum, pectus excavatum-, asymmetry, lesions, scars, deformity, movement of the chest).*			
	Palpation of the chest *(Ask the patient if he has any chest pain before palpation).*			
16.	**Trachea:** Look for the position of trachea *(from in front of the patient the forefinger of the right hand is pushed up and backwards from the suprasternal notch until the trachea is felt).*			
17.	Palpate for chest expansion.			
18.	Palpate for the position of the cardiac apex.			
	Carry out all subsequent steps on the front of the chest and once this is done, repeat them on the back of the chest.			
19.	Palpate for equal chest expansion, • Comparing one side to the other. • Using a measuring tape, measure the chest expansion.			
20.	Test for vocal (tactile) fremitus.			
21.	Palpate ribs by gently compressing *(antero-posteriorly and laterally)* the chest wall.			
22.	Palpate the cervical, supraclavicular, infraclavicular, and axillary lymph nodes.			
	Percussion of the chest			
23.	• Percuss the chest. Start at the apex of one lung, and compare one side to the other. • Percuss over the clavicles and on the sides of the chest.			
	Auscultation of the chest *(Ask the patient to take deep breaths through the mouth)*			
24.	*Using the diaphragm of the stethoscope, auscultate the chest.* Start at the apex of one lung and compare one side to the other. Look for the quality, intensity of the breath sounds and any abnormal sounds *(wheezes or crackles).*			
25.	Test for vocal resonance.			
	Remember: Cardiac examination is an essential part of the respiratory assessment and vice versa.			
	After the examination			
26.	Indicate that you would test the urine.			
27.	Ensure that the patient is comfortable.			
28.	Make explanations to the patient, answer his/her questions and discuss management plan.			
29.	If appropriate, order diagnostic investigations. *(e.g. sputum culture, XRay, spirometry, PFT, a CXR, FBC, CRP etc.).*			
30.	Dispose of sharps and waste material according to infection control standards.			
31.	Wash hands.			
32.	Document the procedure.			

Auscultation areas of the chest

3- Abdominal Exam:

https://www.youtube.com/watch?v=QO8r_xqamyc

	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			
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			
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			
11.	Inspect the patient's face *(sclerae, pupils, malar rush, mouth, tongue, salivary glands, palate, dentition).*			
	Neck			
12.	Examine the neck for lymphadenopathy.			
13.	Examine the upper body for gynaecomaslia , caput medusae, and spider naevi.			
	Chest			
14.	Inspect the patient's chest *(gynaecomastia, caput medusae, spider naevi).*			
	Abdomen *(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).*			
	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.			
18.	**Deep palpation** - Describe and localize any masses.			
	➔ *Continues on the next page*			

	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)*.			
20.	**Gallbladder**- Palpate for tenderness over the gallbladder region at the tip of the right ninth rib.			
21.	**Spleen** - Palpate for the spleen as for the liver, again starting in the right lower quadrant.			
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.			
	Percussion of the abdomen			
24.	Percuss the liver area and detect its upper border *(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)*.			
	Auscultation of the abdomen			
26.	• 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			
27.	Indicate that you would test the urine.			
28.	Ensure that the patient is comfortable.			
29.	Make explanations to the patient, answer his/her questions and discuss management plan.			
30.	If appropriate, order diagnostic investigations *(e.g. ultrasound scan, CBC, LFTs, etc.)*.			
31.	Dispose of sharps and waste material according to infection control standards.			
32.	Wash hands.			
33.	Document the procedure.			

4- Diabetic foot Exam:

1. Greet the patient and introduces your self

2. Take permission for the examination, wash your hands and insure privacy.

3. Inspection all sides:

    Comment on color, no dry skin, no hair loss, no deformity, callous or ulcer, muscle wasting. Inspect b/w the toes for any signs of infections (both sides)

4. Palpation:

    Palpate for temperature and tenderness. Palpate for peripheral pulses, dorsalis pedis / posterior tibial (both sides)

5. Check capillary refill (both sides)

6. Sensation:

    Assess Soft touch sensation – use cotton wisp – assess lower limb dermatomes (compare L/R)

    Pain sensation (sharp) \ neurotip \ assess lower limb dermatomes (compare)

7. Using Monofilament:

    Ask the patient to close his eyes & inform you when he feels his foot being touched. Place the monofilament on 5 areas across each sole. Press firmly so that the filament bends. Hold the monofilament against the skin for 1\2 seconds

8. Assess vibration sensation:

    Ask patient to close his eyes, Tap the tuning fork Place onto patient's sternum & confirm patient can feel it buzzing. Ask patient to tell you when he can feel it on his foot & to tell you when it stops buzzing. Place onto the distal phalanx of the great toe, if sensation is impaired, continue to assess more proximally.

9. Assess Proprioception:

Hold the distal phalanx of the great toe by its sides, demonstrate movement of the toe “upwards” & “downwards” to the patient (whilst he watch), then ask the patient to close his eyes & state if you are moving the toe up or down. If the patient is unable to correctly identify direction of movement, move to more proximal joint.

10. Assess Ankle jerk reflex:

Dorsiflex the foot, tap tendon hammer over the achilles tendon, observe the calf for contraction \ normal reflex.

11. Checks Romberg’s sign:

Ask the patient to stands with his feet together, eyes open and hands by the sides then ask him to close his eyes while observing for a full minute for balance.

12. Examine shoes:

Note pattern of wear on soles \ asymmetrical wearing – suggestive of gait abnormality, ensure the shoes are the correct size for the patient, note any holes / material inside the shoes that could cause rubbing / foot injury

13. Wash your hand.

14. Thank the patient.

https://www.youtube.com/watch?v=p20gAwHNKgU

5- Low Back Exam:

1) Meets and greets the patient and introduces him/her self

2) Takes permission appropriately for the back examination.

3) Inspection while standing and bending

4) Palpation of the spines and the Paraspinal muscles.

5) Movement of the spine; flexion, extension, lateral flexion and the rotation.

6) SLR (straight leg rise) (both sides)

7) Ankle; Dorsiflexion and the plantar flexion against resistance. Tip toe and heel walk.

8) Sensation of the lower limb (cotton wool)

9) Ankle jerk (bilateral)

10) Gentle and sympathetic towards patient

11) Thanks the patient

https://www.youtube.com/watch?v=MsUmSdHxR8E

For any feedback:
phcteams@gmail.com