OSCE revision

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A. Breaking bad news:

1. Greet the patient, introduce yourself and take permission.
2. Did anyone come along with you to the clinic? If so, ask about the relation.
3. What do you know about your current condition?
4. Would like to know further information about it?
5. What are you concerned about at this moment? Why are you concerned?
6. What do you expect to happen with such disease?
7. I am sorry to tell you that I came here carrying bad news.
8. Pause.
9. Unfortunately, you lab results show that you have (Name of the disease)
10. Do you know what is (Name of the disease) and its affect?
11. Tell the patient the most appropriate management. (Insulin, surgery, behavioral therapy)
12. As for now, I will refer you to a specialist for assessment and to discuss your management plan.
13. Fortunately, with the proper management plan you would have a good outcome.
14. I am going to book an appointment in 2 weeks for follow up, would that be okay?
15. Would you like me to tell your (who ever came with them)?
16. Ask about Constitutional symptoms, past medical and surgical history, medications, family history and social history.
17. Ask the patients if they have any questions or if they have anything they would like to say.
18. Thank the patient.

B. Use of Inhaler in Asthma:

1. Greet the patient, introduce yourself and take permission.
2. What brought you here today?
3. For how long have you been having this problem? Per day? Per week?
4. Are you taking any medication? Herbal?
5. Do you have any allergies?
6. Smoker? For how long? How much per day?
7. What do you know about the medication that the doctor prescribed you?
8. What are your concerns about this new medication?
9. What do you expect from this new treatment plan?
10. This inhaler has no systemic side effects and less severe than oral therapy. It has rapid onset and the doses are less than oral to achieve relief of symptoms.
11. However, oral medication that its has systemic side effects that affects your bones and your immunity. It usually takes time to achieve its effect.
12. Explain the instructions:
    A. Shake the inhaler.
    B. Remove the cap.
    C. Prime the inhaler. This will insure that the next dose will deliver the proper amount of the medication.
    D. Breathe out all the way.
    E. Insert into the mouth and seal lips around mouthpiece.
    F. Start breathing in and as you are inhaling press the canister and continue inhaling for at least 3-5 seconds more.
    G. Exhale slowly and completely.
    Note: To have a second puff wait at least 1 minute between the two puffs.
    H. Place the cap back for storage.
    Watch this video it is really helpful:

    http://www.youtube.com/watch?v=Rdb3p9RZoR4&list=LLQgsoritrMftt7vRRjI-cBA&feature=share

13. Ask the patient if they have any questions or if there something they would like to say.
14. I'm also going to give you a few pamphlets that have the instructions written so you could read it.
15. Thank the patient.

C. Breastfeeding counseling:

1. Greet the patient, introduce yourself and take permission.
2. What brought here today?
3. Social History:
   What do you do for living?
   What does your husband do for living?
   Do you smoke or live around someone who smokes?
   Do you drink alcohol?
4. Do you have any difficulty with breastfeeding?
5. What is your baby feeding on currently?
6. How's your baby's general health? What about yours?
7. Did you have any complications during pregnancy?
8. Have you ever tried breastfeeding before?
9. Do you know the importance of breastfeeding?
10. Do you have any concerns regarding breastfeeding?
11. What do you expect to happen if you start breastfeeding?
12. Benefits of breastfeeding: It reduces allergies, diabetes, obesity, celiac disease childhood leukemia and infections. As for the mother, it reduces breast cancer, ovarian cancer, and osteoporosis. It also enhances mother-baby bonding.
13. Risks of milk formula: Prone to infections, gastrointestinal problems, allergies, lower IQ, chronic diseases like HTN, DM and mortality.
14. Are you willing to breastfeed your baby? For how long?
15. What do you think might go against breastfeeding your baby?
16. Techniques of breastfeeding:
    A. The mother has to sit comfortably supporting her back and supports the baby's head, neck and back during breastfeeding.
    B. The Baby's mouth should be covering the areola, at start of feeding, compress the nipple and areola between your thumb and index finger to help the baby's suckling.
    C. During the first 2 weeks, feed on demand.
    D. Alternate each breast you start with each time. No more than 5 hours should pass without feeding.
    E. Clean sore nipples with water and use nursing pads.
17. Ask the patient if she have any questions.
18. I'm also going to give you a few pamphlets that have specific information about breastfeeding so you can read more about it.
19. I will book an appointment with you during next week, would that be okay?
20. Thank the patient.

D. Smoking History and Counseling:

1. Greet the patient, introduce yourself and take permission.
2. Take a personal history and social history.
3. Ask about smoking status:
   Do you smoke?
   For how long have you been smoking?
   How many packs a day?
4. What do you know about smoking affect on health?
5. Are you concerned about its effect?
6. What are your expectations towards quitting smoking?
7. Have you ever thought of quitting smoking? If so, what was the reason?
8. Smoking increases your chance of having lung cancer, CFD, stroke, and hypertension. Smoking cessation reduces heart disease and saves money, decreases the discoloration of your teeth, and lips, and your family would appreciate your willingness for quitting smoking.
9. What do you think that might go against your cessation of smoking?
10. Are you willing to quit smoking?
11. Specify a date with you patient to stop smoking and assess his level of depends and give nicotine patches or gum for craving.
12. Arrange follow up appointment, and assign you to a smoking cessation program that will help you quit.
13. Do you have any questions? Do you have anything you want to say?
14. Thank the patient.

E. UTI History and Counseling:

1. Greet the patient, introduce yourself and take permission.
2. What brought you here today?
3. For how long have you been having this problem?
4. Did it happen to you suddenly or gradually?
5. If she's a female ask if she's pregnant.
6. Ask about other urinary symptoms: Dysuria, frequency, urgency, loin pain, and hematuria.
7. Ask about risk factors for diabetes
8. Ask about constitutional symptoms. (Fever, chills, night sweat, appetite, and change in weight)
9. Ask about past medical and surgical history.
10. Ask about medications and allergies.
11. Ask about family history.
12. Do you know what are these symptoms might be?
13. Do you have any concerns regarding your symptom?
14. What are your expectations from the treatment I will provide you?
15. Explains to the patient that they might be suffering from a urinary track infections and it will be clear to you using some tests like that would require a urine sample.
16. Advise the patient that UTIs are very common and are caused by bacteria. The bacteria travels up the irritated urethra. Common irritants are bubble bath and shampoos. Careless wiping after a bowel movement might also cause irritation. With treatment, your symptoms should be better by 48 hours after starting the antibiotics.
17. The management plan includes an antibiotic (Trimethoprim), and Increase fluid intake. And to prevent further infections you might want to urinate frequently, increase your fluid intake and wipe from front to back.
18. Do you have any questions? Do you have anything you want to say?
19. I'm also going to give you a few pamphlets that have specific information about the disease so you can read more about it.
20. I will book an appointment for you next week, would that be okay with you?
21. Thank you.

F. Depression History and Counseling:

1. Greet the patient, introduce yourself and take permission.
2. How are you feeling lately?
3. For how long have you been this way?
4. Was there any possible triggers/stressors/life events that has happened?
5. Ask about current symptoms:
   Core: low mood, energy, enjoyment, helpless, hopeless, worthless, guilty.
   Biological: sleep, appetite, libido.
   Cognitive: poor memory or concentration.
   Psychotic: hallucinations, delusions
6. Asses risks:
   Self: suicide/self-harm/ academic failure/isolation
7. Ask if it has affected his life.
8. Excludes psychotic depression: hallucinations, delusions, and mania.
9. Excludes comorbid substance misuse.
10. Screens relevant other history. (e.g. PPHx/PMHx/FHx)
11. Do you know what are these symptoms might suggest?
12. Do you have any concerns regarding your symptoms?
13. What do you expect from the treatment plan I would provide you with?
14. Depression is a common condition that will affect one in three people at some time in their life. Counseling is effective in treating mild to moderate depression, and is often combined with medication in more severe cases, which is sometimes known as clinical depression. Exercise is increasingly recommended to help combat the effects of depression. Don't worry, depression is very treatable and treatment outcome is high.
15. Do you have any question? Do you have anything you want to say?
16. I'm also going to give you a few pamphlets that have specific information about the disease so you can read more about it.
17. I will book an appointment for you next week, would that be okay with you?
18. Thank you.

G. Hypertension History and Counseling:

1. Greet the patient, introduce yourself and take permission.
2. What brought you here today?
3. For how long you have you been diagnosed with hypertension?
4. What is the last known blood pressure?
5. Is your blood pressure regulated?
6. Do you suffer from the following symptoms:
   Muscle weakness, Palpitations, Sweating, Tremor, Headache and dizziness, blindness, chest pain, shortness of breath and pain in calves.
7. Past medical and surgical history.
8. Family history.
9. Medications and allergies. (Corticosteroids, OCPs, NSAIDs)
10. Social history. (Smoking, alcohol, diet, physical activity, life stressors)
11. Do you know anything about hypertension?
12. Do you have any concerns regarding your symptoms?
13. What do you expect from the treatment plan?
14. Hypertension is a very common disease in our country; it is measured by wrapping an inflatable hand cuff around your arm. If hypertension is not controlled there would be long term complications like chronic kidney disease, heart attack, heart failure and stroke. However, maintaining the normal body weight, change of diet, exercise, and medication can control it.
15. Do you have any question? Do you have anything you want to say?
16. I'm also going to give you a few pamphlets that have specific information about the disease so you can read more about it.
17. I will book an appointment for you next week, would that be okay with you?
18. Thank you.

H. Acute Chest Pain History and Counseling:

1. Greet the patient, introduce yourself and take permission.
2. What brought you here today?
3. For how long have you been having this problem?
4. Did it start suddenly or gradually?
5. Could you describe me the pain you are feeling? (Sharp, dull, crushing)
6. Can you locate exactly where is the pain you are feeling?
7. Does the pain move anywhere?
8. Does anything make the pain worse or better?
9. Do you have any other symptom that accompanied this pain?
10. Have you ever experienced this kind of pain before?
11. Have you been diagnosed with the following diseases? (Diabetes, hypertension, hypercholesterolaemia, ischaemic heart disease)
12. Have you ever been admitted to the hospital before?
13. Do you take any medications or have any allergies?
14. Is anyone in your family suffering from any illnesses?
15. Social history. (Smoking, alcohol, stress)
16. Do you know what are these symptoms might be?
17. Do you have any concerns regarding your symptom?
18. What are your expectations from the treatment I will provide you?
19. Explains to the patient that they might be suffering from angina and it will be clear to you using some tests like ECG.
20. Advise the patient that Angina is a condition in which chest pain occurs due to lack of oxygen in a part of the heart muscle generally due to blockage or spasm of the coronary artery, which is the artery that supplies blood to the heart itself.
21. The management plan includes medications to keep the angina under control and prevent further worsening of the condition. You will be most probably given a combination of drugs such as Aspirin, Nitroglycerine tablets. Moreover you must have a healthy diet and do light exercises that you can bear as these strengthen the muscles of your heart.
22. If your Pain feels like crushing and squeezing more sever and radiating to your left arm, not being controlled by nitroglycerine tablets your using then you must immediately call the ambulance.
23. Do you have any questions? Do you have anything you want to say?
24. I'm also going to give you a few pamphlets that have specific information about the disease so you can read more about it.
25. I will book an appointment for you next week, would that be okay with you?
26. Thank you.

J. Dyspepsia History and Counseling:

1. Greet the patient, introduce yourself and take permission.
2. What brought you here today?
3. For how long have you been having this problem?
4. Did it start suddenly or gradually?
5. Could you describe me the pain you are feeling?
6. Can you locate exactly where is the pain you are feeling?
7. Does the pain move anywhere?
8. Does anything make the pain worse or better?
9. Do you have any other symptom that accompanied this pain?
10. Have you ever experienced this kind of pain before?
11. Have your weight changed or did you lose your appetite?
12. Have you ever had any excessive worry or history of loss of interest or low mood?
13. Do you have any other medical illnesses? (Cardiac HTN, DM, Renal)
14. Have you ever been admitted to the hospital?
15. Do you take any medications or have any allergies?
16. Is anyone in your family suffering from any illnesses?
17. Social history. (Smoking, alcohol, stress)
18. Do you know what are these symptoms might be?
19. Do you have any concerns regarding your symptom?
20. What are your expectations from the treatment I will provide you?
21. Explains to the patient that they might be suffering from gastric reflux (GERD), which might need some test like PH monitoring and barium swallow.
22. Advise the patient that (GERD) is a condition in which the contents of the stomach are regurgitated back up into the instead of passing down into the small intestine to be digested because the sphincter muscles is weak and fail to close.
23. The management plan involves a combination of medication, weight reduction if necessary, and changes in diet and lifestyle. Avoidance of certain foods (such as caffeinated and/or carbonated drinks, chocolate, fatty foods, alcohol, and spicy foods) and stopping smoking can help to prevent reflux. Eating meals at least three hours before lying down or going to bed and elevating the head of the bed a few inches may also help to prevent stomach contents flowing back up into the esophagus.
24. Do you have any questions? Do you have anything you want to say?
25. I'm also going to give you a few pamphlets that have specific information about the disease so you can read more about it.
26. I will book an appointment for you next week, would that be okay with you?
27. Thank you.

K. Obesity Counseling: (Male group work)

1. Greet the patient, introduce yourself and take permission.
2. Take a personal history and social history.
3. You're a bit overweight and it is important to change that.
4. It's also important that you know why (ask patient what does he/she know about the complications) Excess weight or obesity is associated with a lot of problems: CVD, Stroke, DM, HTN.
5. Have you ever tried losing weight? (What did you do?)
6. What made you want to lose weight? What you made you come here today?
7. How much weight do you expect to lose?
8. How beneficial will your weight reduction be?
9. For your weight loss target: It's best that you lose around 10% of your weight in the next 6 months, after you maintain you weight, this loss will reduce the risk of getting those diseases we talked about earlier.
10. What do you think might go against your weight loss program ?
11. Ok, so the best way to do this is to get you doing regular exercises, and you have to do this regularly, doing regular exercises will make you lose weight, increase muscle mass, and improve your health overall.
    To Start off: I would like you to do exercises 3 – 5 days a week (Walking, Light Cycling) 30 – 60 mins. As far as your diet, you have to do a few changes. The basic principle is that you have to burn more than you take in by food. To do that, I want you to reduce your daily calorie intake by around 500 – 700 calorie by doing this you are looking at loosing almost 1Kg every week, at least at the beginning.Of course you have to stay away from fast/junk food, sweets, fried foods, and high carb food. You should try to replace those with fruits/ vegetables, foods that are high in fiber/ fish. Those foods will make you full without giving you too much calories.
12. I can refer you to a dietitian, if you think that might help. The most important thing is for you lose weight.
13. Do you have any questions? Do you have anything you want to say?
14. I'm also going to give you a few pamphlets that have specific diet regimens that might help.
15. I will book an appointment for you next week, would that be okay with you?
16. Thank you.

L. Irritable Bowel Syndrome History and Counseling:

1. Greet the patient, introduce yourself and take permission.
2. What brought you here today?
3. For how long have you been having this problem?
4. Did it start suddenly or gradually?
5. Could you describe me the character of your stool (liquid, hard)
6. Can you tell me the color of your stool?
7. Does it have any blood or mucus or yellowish fat?
8. How many times you go to the bathroom these days? Did it change from your regular habit?
9. Do you experience any urgency or feeling of incomplete evacuation?
10. Do you have any bloating, pain, nausea, vomiting?
11. Does anything make your symptoms worse or better with defecation, eating, sleep?
12. Does your symptoms awake from sleep?
13. Did your symptoms become worse?
14. Do you have any fever, loss of weight or appetite?
15. Have you ever experienced this kind of symptoms before?
16. Have you been diagnosed with the following diseases? (Diabetes, hypertension, hypercholesterolaemia, ischaemic heart disease)
17. Have you ever been admitted to the hospital before?
18. Do you take any medications or have any allergies?
19. Is anyone in your family suffering from any illnesses?
20. Social history. (Smoking, alcohol, stress)
21. Do you know what are these symptoms might be?
22. Do you have any concerns regarding your symptom?
23. What are your expectations from the treatment I will provide you?
24. Explains to the patient that they might be suffering from IBS which is diagnosed based on clinical symptoms only.
25. Advise the patient is having IBS is a chronic condition of the large intestine in which the food moves either too slowly or more rapidly.
26. The management plan include many options like learning to manage stress and making changes in your diet and lifestyle, eating diet rich with fiber for constipation and drinking more water, moreover you can avoid food that causes your symptoms to increase and there might be some medications like laxatives, paracetamol for the pain.
27. Do you have any questions? Do you have anything you want to say?
28. I will book an appointment for you next week, would that be okay with you?
29. Thank you.

M. Headache history and Counseling:

1. Greet the patient, introduce yourself and take permission.
2. What brought you here today?
3. Can you tell me the location of your pain?
4. Did it start suddenly or gradually?
5. Does the pain move anywhere?
6. Does it increase or decrease in severity?
7. For how long have you been having this problem?
8. Could you describe me the pain you are feeling? (thromping, pressure, dull, sharp)
9. Does anything make the pain worse or better?
10. Do you have any other symptom that accompanied this pain? (Visual Symptoms, Photophobia, Neck Muscle Tension, Tears/ Runny Nose, Nausea, Vomiting)?
11. Does it affect your daily life and your work?
12. Is your headache come after drinking caffeine, alcohol, fasting or smoking?
13. Do you experience any aura before the attack?
14. Have you ever experienced this kind of pain before?
15. Have you been diagnosed with the following diseases? (Diabetes, hypertension, Migraine, Obesity, URTIs)
16. Have you ever been admitted to the hospital before?
17. Do you take any medications or have any allergies?
18. Is anyone in your family suffering from any illnesses or migraine?
19. Social history. (Smoking, alcohol, stress)
20. Do you know what are these symptoms might be?
21. Do you have any concerns regarding your symptom?
22. What are your expectations from the treatment I will provide you?
23. Explains to the patient that they might be headache.
24. Advise the patient that is headache is a very common disease and some headache types have symptoms like flashes and teary eyes and runny nose.
25. The management plan includes pain medication stress relief and exercise can help.
26. Do you have any questions? Do you have anything you want to say?
27. I'm also going to give you a few pamphlets that have specific information about the disease so you can read more about it.
28. I will book an appointment for you next week, would that be okay with you?
29. Thank you.

N. Diabetic foot examination:

1. Greet the patient and introduces him/her 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 between the toes for any signs of infections.
4. Palpation:
   Palpate for temperature and tenderness.
   Palpate for peripheral pulses, dorsalis pedis / posterior tibial
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 L/R)
7. Using Monofilament:
   Ask the patient to close their eyes & inform you when they feel their foot being touched.
   Place the monofilament on 5 areas across each sole (as shown in the diagram).
   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 their eyes
   Tap a 128hz tuning fork
   Place onto patients sternum & confirm patient can feel it buzzing
   Ask patient to tell you when they can feel it on their 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 - e.g. proximal phalanx etc
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 they watch)
   Then ask patient to close their eyes & state if you are moving the toe up or down.
   If the patient is unable to correctly identify direction of movement, move to a 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 patient to stands with feet together, eyes open and hands by the sides then ask him to closes the 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.

O. Blood pressure measurement:

STEP/TASK
Preparation of the patient
Introduce yourself to the patient.
Explain the examination and ask for his consent to carry it out. Tell him that he might be feeling some discomfort during the test but it won't be painful. Tell him that you might need to repeat the test.
Ask him to expose his arm up to shoulder.
Sit him in a chair. Position at the level of the heart.
The procedure
Ask him if there is any tenderness in his arms.
Select correct size of cuff and place lower edge of cuff 2.5 cm (1 in.) above crease of elbow, centred over brachial artery
Places the stethoscope over the brachial artery pulse, ensuring that it does not touch the cuff.
Reduces the pressure in the cuff at a rate of 2-3 mmHg.
Records the BP as the systolic reading over the diastolic reading.
f the BP is higher than 140/90 indicates that he might take a second reading after giving the patient a one minute rest.
Tell the patient that you might take the blood pressure from the other arm.
After the procedure
Ensure that he is comfortable.
Ask him if he has any questions or concerns.
Thank him.
Offer a diagnosis or differential diagnosis.
Give suggestions for further management. e.g. TFT, thyroid antibodies,iodine thyroid scan, fine needle aspiration cytology.

P. Chest examination: (Medical education checklist)

Preparation of the patient
Introduce yourself to the patient.
Explain the examination and ask for his consent to carry it out
Position him at 45 degrees. and ask him to remove his topes).
The examination
General inspection
From the end of the couch, observe the patient's general appearance: • Age. State of health, nutritional status, and any other obvious signs. • Breathless or cyanosed • Audible breathing • Coughing
Note: • 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.
Inspection and examination of the hands
Take both hands and assess them for color and temperature.
Look for clubbing.
Determine the rate, rhythm, and character of the radial pulse.
Test for flapping tremor.
Inspection and examination of the head and neck
Inspect the sclera and conjunctivae for signs of anemia.
Inspect the mouth for signs of central cyanosis.
Assess the jugular venous pressure and the jugular venous pulse form.
Palpate the cervical. supraclavicular, infraclavicular, and axillary lymph nodes.
Palpation of the chest Ask the patient if he has any chest pain before palpation. Palpate for tracheal deviation.
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.
Palpate for equal chest expansion, • Comparing one side to the other. • Using a measuring tape, measure the chest expansion.
Test for tactile fremitus
Percussion of the chest
• 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 • using the diaphragm of the stethoscope, • Auscultate the chest. Start at the apex of one lung, and compare one side to the other. And give the comment about breath sound or any abnormal sounds.
Test for vocal resonance by asking the patient to say, "ninety nine". (Only if not already tested for tactile fremitus.)
After the procedure
If appropriate, order some key investigations e.g. sputum culture ,PFT, a CXR.,FBC, CRP, etc.
Cover the patient up.
Thank the patient.
Summarize your findings and offer a differential diagnosis.

Q. Cardiovascular examination:

Preparation of the patient
Introduce yourself to the patient.
Explain the examination and ask for his consent to carry it out.
Position him at 45 degrees and ask him to remove his top(s).
General inspection
From the end of the couch, observe the patient's general appearance (age, state of health, nutritional status. and any other obvious signs). (Is the patient breathless or cyanosed)
Inspect the precordium for the presence of any abnormal pulsation and the chest for any scars, or a pacemaker if it is there!
Inspection and examination of the hands
Take both hands comment on : • Temperature and Color. • Nail clubbing • Nail splinter hemorrhages • Nail signs of iron deficiency.
Determine the • Rate, rhythm. and character of the radial pulse. • Take the pulse in both arms.
Record the blood pressure
Inspection and examination of the head and neck
Inspect the sclera and conjunctivae for signs of anemia
Inspect the mouth for signs of central cyanosis.
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.
Palpation of the heart
Ask the patient if he has any chest pain.
Determine the location and character of the apex beat.
Place your hand over the cardiac apex and on either side of the sternum and feel for any heaves and thrills.
Auscultation of the heart
Listen for Heart sounds, additional sounds, murmurs, and pericardial rub**.** Using the stethoscope's diaphragm, listen in the: • ***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.
Chest examination
Percuss and auscultate the chest especially at the bases of the lungs. Heat failure can cause pulmonary edema and pleural effusions.
Ankle edema
Test for the dependent or "pitting" edema of cardiac failure.
Peripheral pulses
Feel the temperature of the feel and then palpate the: • Popliteal pulses. • Dorsalis pedis pulses
After the procedure
Indicate that you would test the urine. Examine the retina with an ophthalmoscope and if appropriate, order some key investigations, e.g. ECG,CXR , echocardiogram.
Cover the patient up.
Thank the patient.
Summaries your findings and offer a differential diagnosis.

R. Thyroid Examination:

STEP/TASK
Preparation of the patient
Introduce yourself to the patient.
Explain the examination and ask for his consent to carry it out.
Ask him 10 expose his neck and upper body.
Sit him in a chair.
The procedure
Inspection
Inspect the patient generally. in particular looking for any signs of thyroid disease.
Inspect the neck, tooking for asymmetry, scars, or other lesions.
Ask the patient to take a sip of water. The following structures move upon swallowing: thyroid gland. thyroid cartilage. cricoid cartilage. thyroglossal cyst,lymph nodes.
Ask him to stick his tongue out if there is midline swelling.
Position yourself behind the patient and inspect for proptosis.
Palpation
Ask him if there is any tenderness in the neck area.
Putting one hand on either side of his neck.
examine the anterior and posterior triangles of the neck with fingertips.
For any mass, determine its • Size, consistency, and fixity.
Palpate the thyroid gland. (If palpable) Try to determine its: • Size, symmetry, and consistency, tenderness.
Palpate the cervical lymph nodes.
Palpate for tracheal deviation in the suprasternal notch
Percussion
Percuss for the dullness of a retrosternal goitre over the sternum and upper chest.
Auscultation
Auscultate over the thyroid for bruits.
After the procedure
Help the patient to put his clothes back on.
Ensure that he is comfortable.
Ask him if he has any questions or concerns.
Thank him.
Offer a diagnosis or differential diagnosis.
Give suggestions for further management. e.g. TFT, thyroid antibodies,iodine thyroid scan, fine needle aspiration cytology.

S. Abdominal Examination:

Preparation of the patient
Introduce yourself to the patient.
Ask the patient for permission to examine his abdomen.
Say to the patient that you would normally expose the patient from nipples to groins.
Position the patient so that he is lying flat on the couch. with his arms at his side and his head supported by a pillow.
The examination
General inspection
• From the end of the couch, observe the patient's general appearance (age, state of health, nutritional status, and any other obvious signs). • Inspect the abdomen for its (contours and any obvious distension. Localized masses, scars, and skin changes. Ask the patient to lift his head to tense the abdominal muscles.
Inspection and examination of the hands
Take both hands, looking for: • Clubbing. • Palmar erythema (liver disease). • Dupuytren's contracture (cirrhosis). • Nail signs (leukonychia - hypoalbuminaemia, koilonychia - iron deficiency).
Test for asterixis or "liver flap"
Inspection and examination of the head and neck and upper body
Inspect the sclera and conjunctivae for signs of jaundice or anaemia.
Inspect the mouth, looking for ulcers, angular stomatitis, atrophic glossitis , furring of the tongue, and the state of the dentition.
Examine the neck for lymphadenopathy.
Examine the upper body for gynaecomaslia , caput medusae, and spider naevi.
Palpation of the abdomen
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.
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.
Deep palpation - Describe and localize any masses.
Palpation of the organs
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. The liver edge. if felt, can be described in terms of (regularity. nodularity. and tenderness).
Gallbladder- Palpate for tenderness over the gallbladder region at the tip of the right ninth rib.
Spleen - Palpate for the spleen as for the liver, again starting in the right lower quadrant.
Kidneys - Position the patient close to the edge of the bed and ballot each kidney using the technique of deep bimanual palpation.
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
Percuss the liver area, also remembering to detect its upper border (usually found in the fourth intercostal space).
Percuss the suprapubic area for undue dullness (bladder distension).
If the abdomen appears distended, test for shifting dullness (ascites).
Auscultation
Auscultate in the mid-abdomen for abdominal sounds. listen for 30 seconds before concluding that they are normal, hyperactive, hypoactive. or absent.
Listen over the abdominal aorta for aortic bruits suggestive of arteriosclerosis or an aneurysm.
listen for renal artery bruits 2.5 cm above and lateral to the umbilicus - a bruit suggests renal artery stenosis.
After the procedure
Cover the patient up and thank them.
Ask the patient if he has any questions or concerns.
State that you would test the urine and order some key investigations, e.g. ultrasound scan. CBC, LFTs, etc
Summarize your findings and offer a differential diagnosis.

The topics that we did not cover:
1. Back pain history and counseling.
2. Back examination.
3. History of anemia.
4. History of upper respiratory infections and counseling.
5. Diabetes history and counseling.
6. Joint pain history and counseling.

Good luck!
Don’t forget us in your prayers. <3