CLINICAL METHODS

COMMUNICATION SKILLS IN HISTORY TAKING

By

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Outcomes

Introduction
Definitions
scope

Introduction to clinical methods

The word 'patient' is derived from the Latin *patiens*, meaning sufferance or forbearance. The overall purpose of medical practice is to relieve suffering.

In order to achieve this purpose, it is important to make a diagnosis,

to know how to approach treatment, &

to design an appropriate scheme of management for each patient.

What is clinical methods

The skills clinicians use to achieve diagnosis and patient management.
This aim of excellence in clinical practice - are acquired during a lifetime of clinical work.
They evolve & change as new techniques & concepts arise.
It is acquired by a combination of study & experience, and there is always something new to learn

How to make Diagnosis

Two main steps to making a diagnosis:
To establish the clinical features by history and examination –clin.database
To interpret the clinical database in terms of disordered function &potential causative pathologies, whether physical, mental, social, or a combination of these.

Reasons for consultation

The patient Cannot tolerate ongoing symptoms
Someone else noticing specific problems (e.g. jaundice, pallor,swelling
Another doctor noticing specific problems (e.g. high blood pressure)
Worry about underlying diagnosis (often induced by relatives, friends, books, media or Internet)

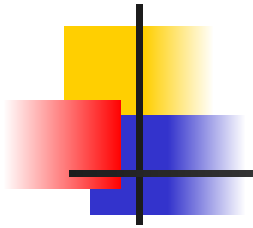
Spouse or relative worried about patient
Cannot work with symptoms
Colleagues/bosses complaining about patient's work or time off
Requirement of others (insurance, employment benefit, litigation)

Communication in history taking: learning outcome

Describe the communication process
Discuss good patient communication P
Describe the RESPECT model in pt com
State the importance of good comm.
Outline requirements for patient encounter
Describe effective listening

Clinicians obligation

Make the care of your patient your first concern
Treat every pt politely and considerately
Respect patients' dignity and privacy
Listen to patients & respect their views
Give patients information in a way they can understand



Respect the right of patients to be fully involved in all decisions about their care
Keep your professional knowledge and skills up to date
Recognize the limits of your professional competency
Be honest and trustworthy
Respect and protect confidential information

5 moral principles

Autonomy
Nonmaleficence
Beneficence
Justice
Fidelity

Expectations

Get Pt encounter Off to a Good Start

- Monitor Your Body Language
- Practice Effective Listening Skills
- Ask Questions That Yield Information and Offer Support
- Give Answers That Will Be Understood
- Partner with Your Patient

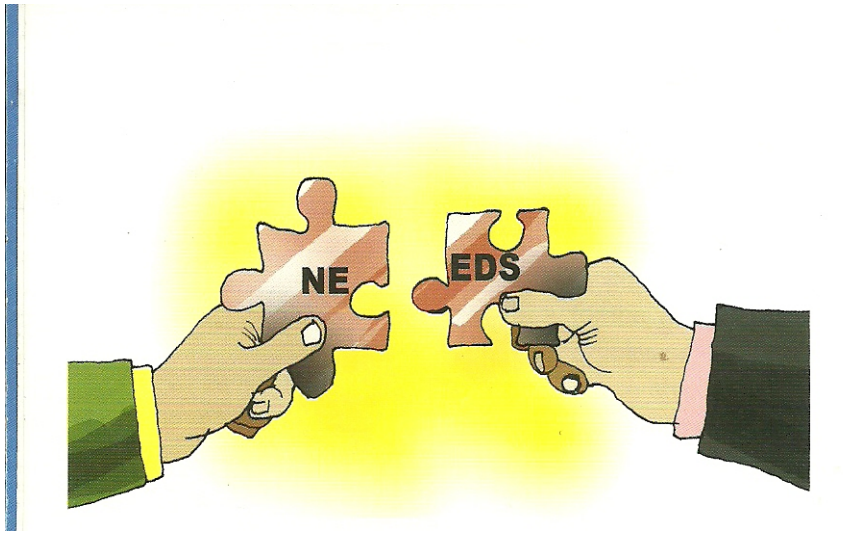
Develop Cultural Competency

- Provide Motivational Counseling
- Demonstrate Empathy and Compassion

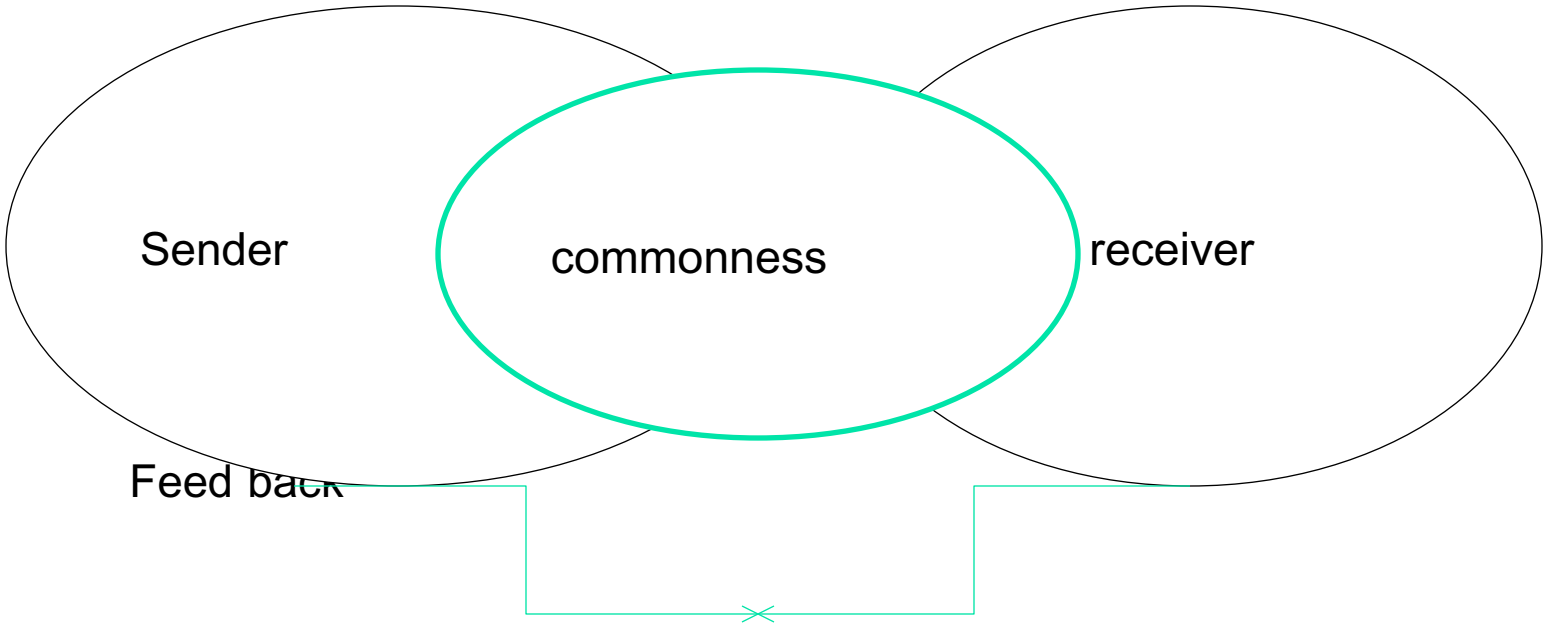
In clinical practice

Communication has been defined as
"the transmission of
information,
thoughts, and
feelings; so that they are
satisfactorily received or understood

There is always an aspect of need in communication



Communication illustrated



Channel

Is a means or medium of relaying the msg

Oral (verbal) --voice, pitch, modulation, intonation, loudness and softness, projection

Written -grammer, structure, paragraph

Edition (writing skills and research)

NON- Verbal –gestures body language

Good clinician-patient communication

It involves recognizing and responding to the patient as a whole person—"patient-centered" care.

It also involves recognizing that in any provider-client interaction two experts are present: the provider who has the clinical knowledge and the client who has the knowledge of the individual and cultural factors that influence effective treatment and care.

RESPECT MODEL

Rapport
Empathy
Support
Partnership
Explanations
Cultural competence
Trust

The RESPECT Model

R --Rapport

Connect on a social level.

See the patient's point of view.

Consciously suspend judgment.

Recognize and avoid making assumptions

RESPECT Model cont

Empathy

Remember that the patient has come to you for help.

Seek out and understand the patient's rational for his/her behaviors or illness.

Verbally acknowledge and legitimize the patient's feelings

S- support

Ask about and understand the barriers to care and compliance.
Help the patient overcome barriers.
Involve family members if appropriate.
Reassure the patient you are and will be available to help.

Partnership

Be flexible with regard to control issues.

Negotiate roles when necessary.

Stress that you are working together to address health problems.

E- explanation

Explanations

Check often for understanding.

Use verbal clarification techniques.

Paraphrasing

Ask checking questions

C -Cultural competence

Respect the patient's cultural beliefs.
Understand that the patient's view of you, may be defined by ethnic or cultural stereotypes.
Be aware of your own cultural biases and preconceptions.
Know your limitations in addressing medical issues across cultures.

C- Understand your personal style and recognize when it may not be working with a given patient.

T- Trust

Recognize that self-disclosure may be difficult

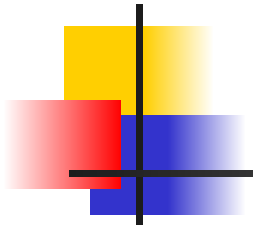
Consciously work to establish trust.

Why good communication is important

Patient satisfaction with the health care they receive & their providers' ability & willingness to communicate and empathize with them

Clinical outcomes improve -Patient outcomes—based on objective, clinical measures—have also been shown to improve with good comm skills

Benefits to practice. = efficiency in practice.



Improve on missed opportunities to gather important patient data.
Better patient retention and reductions in complaints of malpractice

Counselling technique

SOLER

- **S**it upright
- **O**pen your hands
- **L**isten
- **E**ye contact
- **R**elax

Patient encounter

Setting the scene
consultations occur in an outpatient or primary care setting.
Requirements: conducive environment
Atleast -Chairs (3), table, couch, well lit, well ventilated, & equipment (stethoscope, tape measure, pen touch, tonque depressant, emergency tray)

All of the following questions should be quickly assessed: Does the patient smile, or appear furtive or anxious? Do they make good eye contact? Are they frightened or depressed? Are posture and stance normal? Is the patient short of breath, or wheezing? In some conditions It is very important to identify the patient correctly, particularly if they have a name that is very common in the local community. Carefully check the full name, date of birth and address. Make sure any previous records you have are those of

Patient encounter

In clinical encounters, the first impressions matter.

1st step introduction

Focus all your attention on meeting that patient's needs.

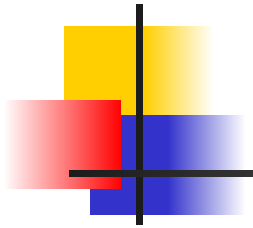
Review the pt's card, Have an open, friendly expression; smile.

Greet the patient by name, referring to the card and using the appropriate title (Mr., Ms., Judge, etc.), before introducing yourself

"Good morning, Mr K; I'm J

Greet anyone accompanying the Pt.

Introduce any colleagues who may accompany you. "This is Siter N"



Exercise caution in touching the pt
Ask permission to conduct an exam, particularly if it is a first visit.

Make eye contact; look at the patient directly. Sit at eye level.
Use facial expressions (active listening
Face the patient while speaking.
Begin history taking

Monitor body language

Keep the chest area open & arms unfolded to avoid setting up a perceived barrier (no arms across the chest

- Maintain a relaxed body position,
- Face the patient directly.

Lean slightly forward when speaking.

Keep an appropriate distance (2-4ft)

- Avoid an authoritarian, superior pose.
- Remain still and focused on the patient

Effective listening skills

Active listening: Respond, nod, body movements, or facial expressions widening of the eyes or, e.g something painful, a wince—to convey listening & recognize the impact and empathize with the patient's experience.

Empathic listening: Addressing the emotional element of a patient's experience demonstrates empathy, encourage pt to talk.

Nod your head at key points

Lean slightly forward and make eye contact Offer brief confirmations that An "um-hmm" or "I see"

Reflective listening: Repeating something the patient has said Repeat a key part of the patient's statement.**P***The pain usually starts on the left side*.**C** *On the left side*. Or *Are you saying that the pain …..?"*

Avoid interrupting the patient.

Avoid interrupting colleagues and coworkers as well.

Briefly summarize what the patient has said as a way of clarifying, empathizing, and transitioning to a discussion of next steps, e.g., diagnostics, treatment.

Feedback

Feedback is important and without which communication is incomplete.

How do we get feedback in history taking?

brainstorm

Conclusion

A Clinician's core competence is to make a Dx & manage patients.
History taking using good communication skills, physical examination with the right attitude and knowledge for interpretation of investigations = proper dx and mnx= quality care= Patient satisfaction & /provider job satisfaction

Quiz

What is clinical methods?

State the moral principles?

What are your obligations?

What is communication process to a clin

Describe RESPECT model

What is effective listening?

How does body language affect our communication?

NEXT: HISTORY TAKING

Read on Schema for history taking

Reference – Hutschisons, procedure manual

HISTORY TAKING

LEARNING OUTCOME

Outline the schema for history taking

Schema for history taking

Patient identification data
Chief complains & duration
Hx of presenting illness
Review of systems
Past medical & surgical hx
Personal social economic history
Family history
Obs/gyn in females

Beginning history taking

Introduction

Setting the scene then….

'Before we discuss why you have come today, I want to ask you some background questions‘

List the patient identification data

Patients Identification data

Name Age, sex, weight*,
Occupation, religion
Address (residence, chief, location, phone no.) Informant (name; relationship), Date of admission
Date of history taking,
Ward no. Inpatient no. bed no.

Question

Why is the identification data important in history taking?

Identity

Drug administration

Ward placement

Follow up

Some diseases are associated with age, occupation

Chief complains

List the chief complains and duration

A single open-ended question like:

'Tell me what has led you to come here today?

Example. I have a cough for 2 days now. What else?

Cough

Fever 2/7

History of presenting illiness

Analyze the symptoms
what, when, where, how,
timing,
aggravating factors,
relieving factors,
associated factors

Example: pain as a complain

When did it start?
Where is the pain?
How is the pain?
What time of the day?
What brings it on?
What relieves it?
Is it associated with other symptoms?

Analysis of pain (SOCRATES)

Site - Where is the pain?

Onset - When did the pain start, and was it sudden or gradual? progressive or regressive.

Character - What is the pain like? An ache? Stabbing?

Radiation - Does the pain radiate **A**ssociations - Any other signs

Time course - any pattern?

Exacerbating/Relieving factors - Does anything change the pain?

Severity - How bad is the pain?

Review the systems

R/S

CVS

GIT

GUS

MSS

Nervous system

Note/ review system affected in the HPI

Comment on the HPI

GP:	I gather you've had some chest pain?
Patient:	Yes, it's been quite bad.
GP:	Is it in the middle of your chest?
Patient:	Yes.
GP:	And does it travel to your left arm?
Patient:	Yes - and to my shoulder.
GP:	Does it come on when you walk?
Patient:	Yes.
GP:	And is it relieved by rest?
Patient:	Yes - usually.
GP:	I'm afraid I think this is angina and I will

Lesson learned

The GP has only asked very direct and closed questions.
Each answer has begun with 'Yes'. The patient has already been quite firmly tagged with a 'label' of angina, and anxiety has been raised by the specialist referral.

Systemic review

Respiratory system
Cough
Chest pain
Sputum production
Haemptysis
Dyspnea

CVS

Palpitation
Oedema
Orthopnoea
Nocturnal dyspnoea
Shortness of breath
Cough with or without sputum
Haemoptysis

GIT

Abdominal pain
Dyspepsia
Dysphagia
Nausea and/or vomiting
Change in appetite
Weight loss or gain
Bowel pattern and any change
Rectal bleeding, Jaundice

Genital-urinary system

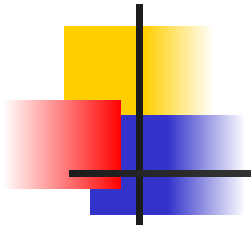
Haematuria
Nocturia
Frequency
Dysuria
Urethral discharge - men
Vaginal discharge

MSS- locomotor

Joint pain
Change in mobility, joint stiffness
Muscle pain
Swelling

Nervous system

Seizures
Collapse or blackouts
Dizziness and loss of balance
Vision
Hearing
Transient loss of function (vision, speech, sight)



Paraesthesiae
Weakness
Wasting
Spasms and involuntary movements
Pain in limbs and back
Headache

PMSHx

No. of admissions
When & why
Surgical operations
Transfusions / donation
Medication
Allergy
Recent travel

Personal social economic history

What is the patient (occupation)
Marital status, occupation of spouse,
No. of children,
Housing (nature, ventilation)
Toilet
Water
Waste disposal
Habbits, hobbies, exercises, drugs, diet

Family history

Position of patient in the family
Siblings health
Parents health
Cause of death if any
Familial diseases –hypertension, diabetes, asthma, heart diseases,
Who in the family has the d'se

Obstetric and gynecological hx

LMP
Menarche (age of onset
Duration
Dysmenorrhea/ any other problem
Contraceptive use
Parity, last delivery, mode of delivery

Task

In groups; Practice history taking and summary
Present your findings

How to write a Summary

Important identification
Complains,
duration,
key attributes,
period in the ward,
progress,
way forward

THE END, THANK YOU

Questions? THANK YOU

CLINICAL METHODS 30HOURS

March 2020Class

Madam Caroline

MODULE UNITS

General Examination and Vital signs

Respiratory System Examination

Cardiovascular System Examination

Digestive System and Abdominal Examination

Neuromuscular System Examination

Genitourinary System Examination

HISTORY-TAKING

Most important communication skill

Patient derived from Latin word *patiens*, meaning sufferance

Overall purpose of medical practice is to relieve suffering

To do this, a diagnosis has to be made, so as to design a proper management scheme

A thorough clinician makes use of history taking skills to elucidate information from patient

Clinical methods is the skills used by clinicians to gather information from patients

HISTORY-TAKING…

Main steps in making a diagnosis

Establish clinical features by history and examination (clinical database)

Interpreting the clinical database

Setting the scene

Most encounters with patients occurs in the outpatient department

Make an early assessment of patients in the waiting bay

Observe

The patients demeanor, their hearing, their walking and the accompanying person to patient

HISTORY-TAKING…

Greet the patient and introduce yourself

- Observe how the patient responds
- Does the patient smile, appear anxious, do they maintain eye contact
- Do they appear frightened or depressed
- Is posture normal?

Do they look very sick or have any difficulty in breathing or wheezing

Confirm the full names, age or date of birth, address

Ensure a pleasant surrounding for both patient and clinician to be at ease

HISTORY-TAKING…

Ensure there is adequate privacy for the patient to be confident to open up

Use open ended questions

Establish and maintain eye contact

Read any referral letters if any

Ask patient what brings them to the hospital

BEGINNING THE HISTORY

Greet patient

Get the bio-data

- Name
- Age
- Sex
- date
- Residence
- Religion
- Marital status
- Occupation
- Next of kin

FLOW OF HISTORY TAKING

Chief complaints

What has brought patient to hospital

History of presenting illness

Explore the main complaints

Analyze patient's principal complaints and describe in terms of

- Location
- Quality, quantity or severity
- Timing
- The setting which they occur
- Aggravating and relieving factors

FLOW OF HISTORY TAKING…

Consider course or shape of illness i.e. the progress since it started to the present time

Has it improved or worsened

Any current medication including dose and frequency

Exhaust thoroughly the affected system covering all the relevant findings either positive or negative

Review of the systems

This is arranged under anatomical systems

FLOW OF HISTORY TAKING…

Purpose - ensure no symptom or disorder is neglected and to assess effect of illness on other systems

General

Weight

Sleep

Energy

Cardio-vascular system

Dyspnoea

Pain or tightness

Palpitations

FLOW OF HISTORY TAKING...

Cardio-vascular system..

Cough

Oedema

Lassitude

Respiratory system

Cough

Sputum

Breathing

Wheeze

Chest pain

FLOW OF HISTORY TAKING…

Gastro-intestinal system

Pain
Appetite
Vomitting
Flatulence
Water brash
Heart burn
Dysphagia
Diarrhea
Consitpation
Jaundice - Liver or gall bladder pain

FLOW OF HISTORY TAKING…

Genital system

Puberty onset

Erections

Emmisions

Testicular pain

Libido

In(fertility)

Urinary system

Amount of urine

Nocturia

Color of urine

FLOW OF HISTORY TAKING...

Urinary system..

Continence

Stream

Blood in urine

Dysuria

Frequency

Volume

Undue thirst

Nervous system

Stroke

FLOW OF HISTORY TAKING…

Nervous system…

Epilepsy
Headache
Mental state
Dizziness
Loss of balance
Tremors
ataxia

Loco-motor system

Arthritis
Rheumatic fever
Painful joints

FLOW OF HISTORY TAKING…

Past medical and surgical history

Ask about childhood illnesses and adult illnesses

Surgical illness – include all important operations or injuries from infancy onwards

Beware of ready made diagnoses

History of transfusions or drug allergies

Personal and social history

Get any relevant history about patient as a person

FLOW OF HISTORY TAKING…

Personal history…

- Lifestyle e.g. alcohol consumption and cigarette smoking
- Occupation information

Family history – information about family e.g.

- Parents, alive or dead. If dead, state cause
- Order of birth
- Siblings – alive or dead, if dead state cause of death
- Any illness that runs in family e.g. hypertension, diabetes, asthma

FLOW OF HISTORY TAKING…

Gynecological history

- LMP
- Age of onset
- Regularity of periods
- Amount of bleeding
- Duration of the flow
- Associated problems
- Last delivery
- Mode of delivery

Physical examination
1. General Examination

General survey

Vital signs

Clinical signs

General survey

Look at the patients general appearance…at the face ,hands and body

FIRST IMPRESSION

Decide how sick is your patient?

Is she well, sitting up and talking?

Or ill totally not aware of her surroundings?

General survey cont.

general state of health

Dressing, grooming and personal hygiene

height, weight, build,

motor activity,

facial expression,

state of awareness or level of consciousness.

Clinical signs

Pallor

Jaundice

Cyanosis

Finger clubbing

Oedema

Dehydration

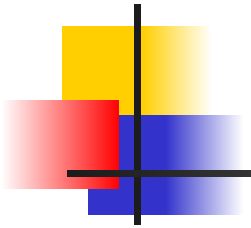
Lymphadenopathy

What is pallor

is the paleness of the skin and mucous membrane due deficiency of haemoglobin in the blood

Pallor is an indication of anaemia= not a disease but rather the expression of an underlying disorder or disease.

The disease can be identified by Hx, PE and laboratory investigations.



Deficiency of haemoglobin can produce pallor of the skin.

Should be noticeable especially in the mucous membranes of the conjuctiva if Hb of less than 7g/L.

Facial pallor can also be seen in patients with shock,due to the reduction of cardiac output. These patients usually appear cold and clammy and significantly hypotensive.

Sites for pallor

Conjunctiva

Mucous membrane

Tongue, gums

Palms

Soles

Skin

Anus

Causes of anaemia

MICROCYTIC ANAEMIA

1)Iron deficiency anaemia

-chronic bleeding

-malabsorption

-hookworm

-pregnancy

2)Thalassemia minor

3)Sideroblastic anaemia

4)Longstanding anaemia of chronic blood loss

Macrocytic anaemia

Megaloblastic bone marrow

1)Vitamin B12 defiency due to

-pernicious anaemia

-gastrectomy

-tropical sprue

-ileal disease;crohns disease,ileal resection

-fish tapeworm

-poor diet in vegetarians

Causes of anaemia

Folate deficiency due to

-dietary defiency in alcoholics

-malabsorption

-increased cell turnover
eg;pregnancy,leukemia,chronic haemolysis

-anti folate drugs –
phenytoin,methotrexate,sulphasalazine

non megaloblastic bone marrow

-alcohol,cirrohis of the liver,hypothyroidism,myelodysplastic syndrome

Normochromic

Bone marrow failure

-aplastic anaemia

-ineffective haematopoiesis

-infiltration

- Anaemia of chronic disease

-chronic inflammation

-liver disease

-malignancies,chronic renal failure

- Haemolytic anaemia

Cyanosis

Blue discolouration of the skin and mucous membranes;

it is due to the presence of deoxygenated haemoglobin in the superficial blood vessels.

There are 2 Types-

- Central cyanosis and
- Peripheral cyanosis

Cyanosis

Bluish discoloration of nail beds and fingertips, usually associated with hypoxemia and/or hypoperfusion.

Causes of central cyanosis

1)Decreased arterial oxygen saturation.

-high altitude

-lung diseases

-Cyanotic congenital heart diseases

2)Polycythaemia

3)Haemoglobin abnormalities;

methaemoglobinemia,

sulphaemoglobinemia

Peripheral cyanosis

1)All the causes of central cyanosis

2)Exposure to cold

3)Reduced cardiac output

-left ventricular failure

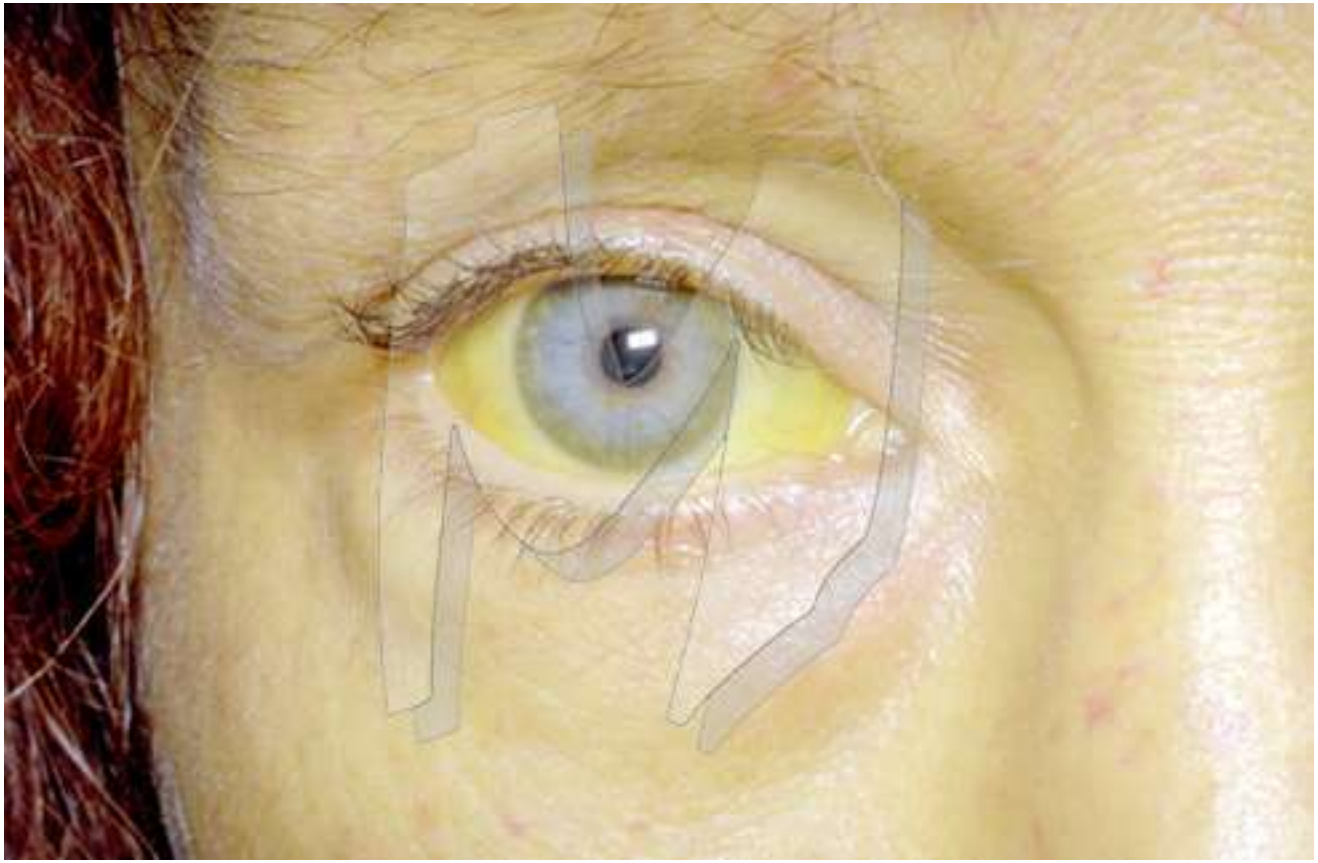
-shock

4)Arterial or venous obstruction

Sites for cyanosis?

- Central cyanosis – tongue & oral mucosa, Lips, Frenulum
- Peripheral cyanosis - Finger tips
  - Nails beds
  - Toes (Extremities)
  - Ear lobes

Jaundice

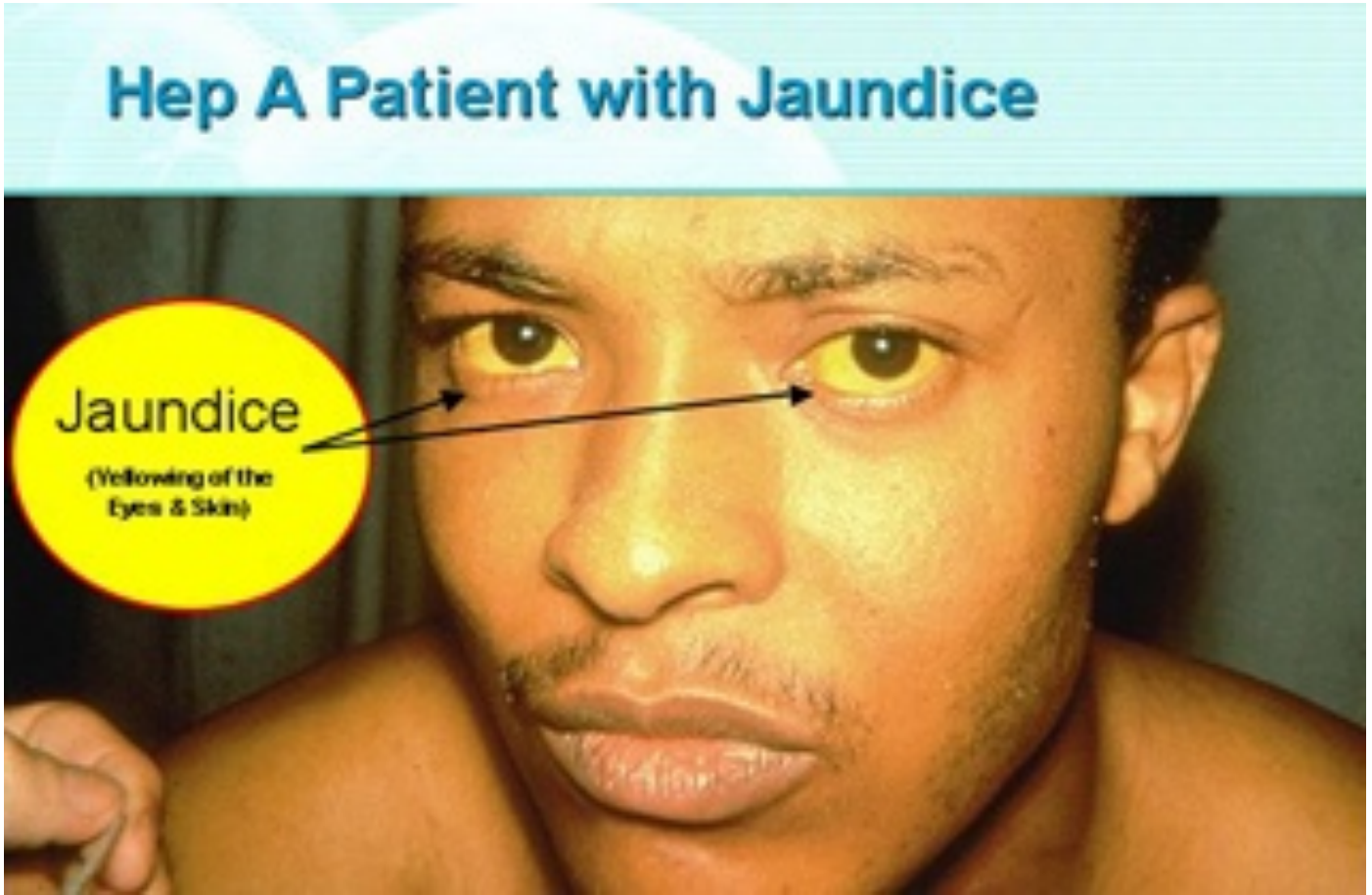


What is jaundice

It is the yellowish discolouration of a patient's skin and sclera that results from hyperbilirubinemia.

It happens when the serum bilirubin level rises twice above the normal upper limit.

It is deposited in the tissues of the body that contains elastin.


Hep A Patient with Jaundice
Jaundice
(Yellowing of the Eyes & Skin)

Causes of jaundice

ABO/Rhesus incompatibility in a newborn

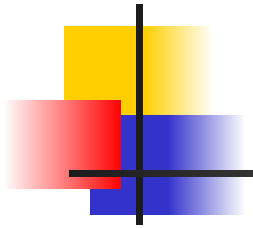
Neonatal infections (TORCHESAS)

Biliary atresia

Hepatitis

Liver cirrhosis

Hepatoma



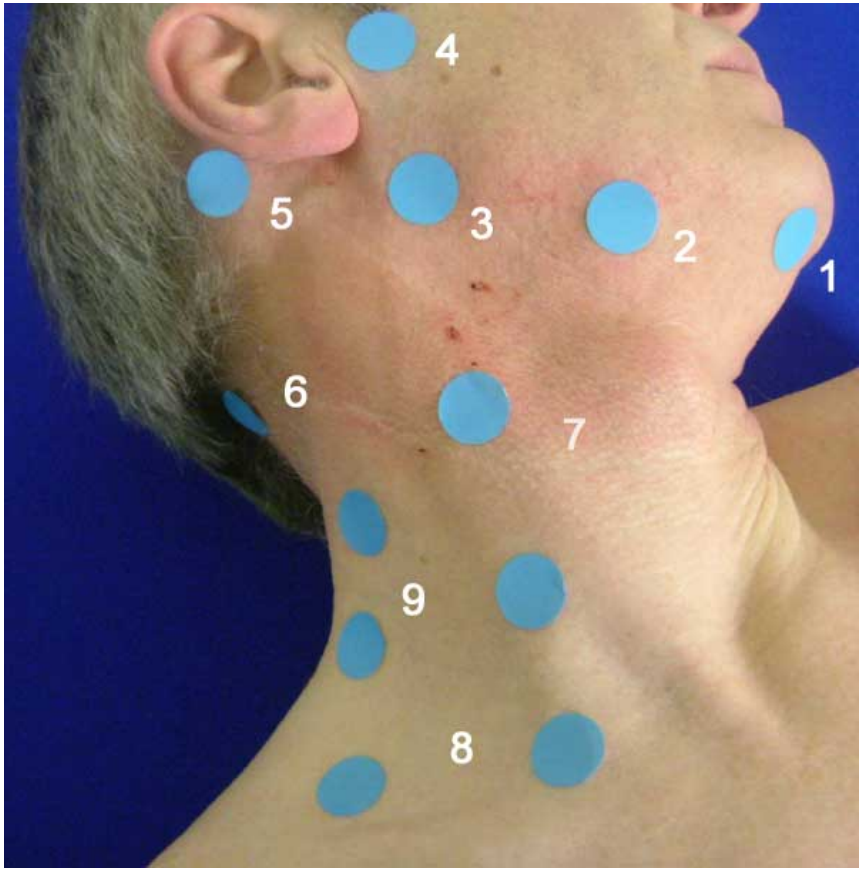
Haemolytic anaemias (SCD, Spherocytosis,G6PD deficiency.

Severe malaria

Lymphadenopathy

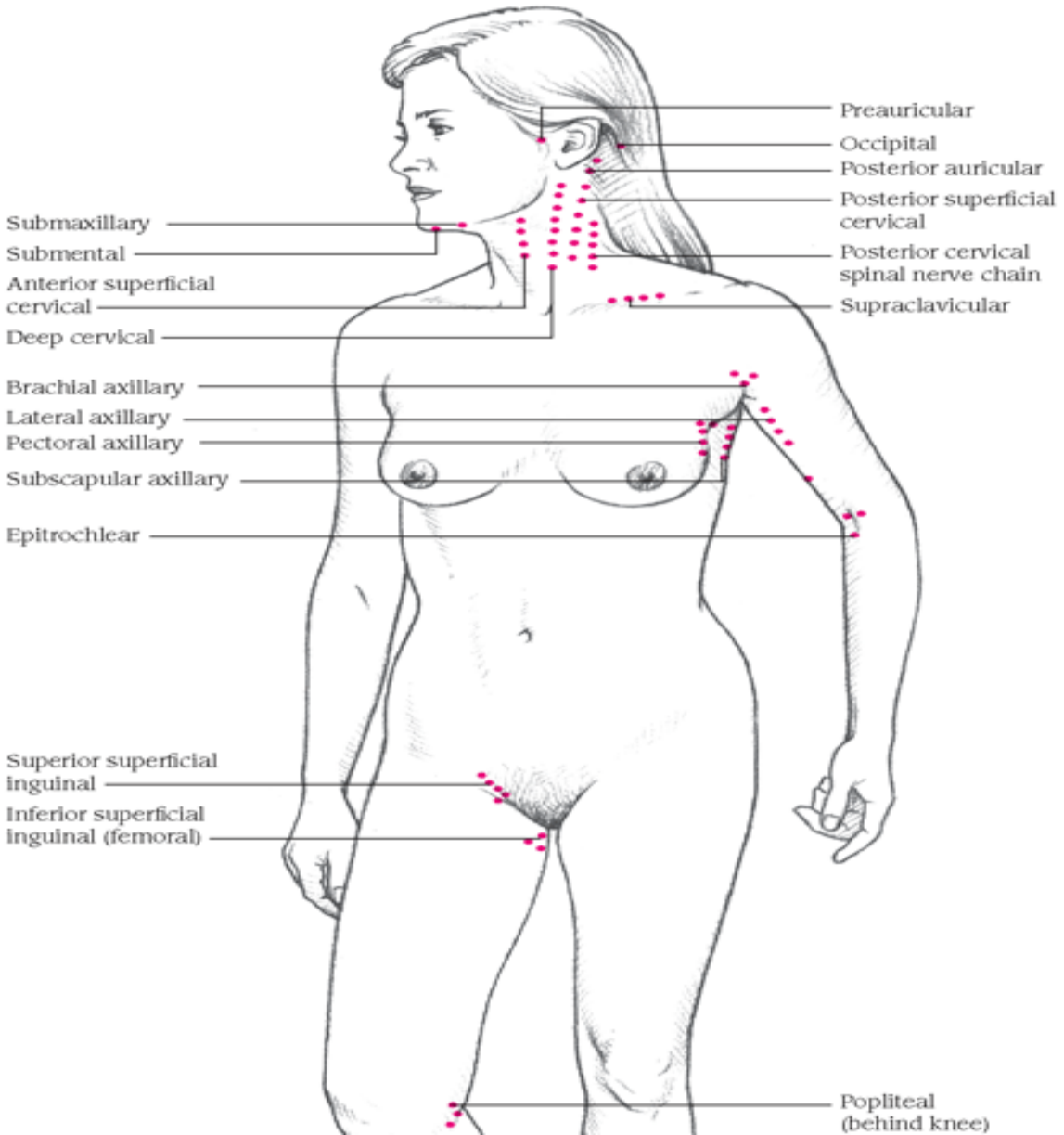
- Using the pads of your index and middle fingers, move the skin over the underlying tissues in each area
  - The patient should be relaxed, with neck flexed slightly forward and slightly toward the side being examined.
  - Note the **size, shape, mobility, consistency and any tenderness**. Small, mobile, discrete, nontender nodes are frequently found in normal persons.
    - Tender nodes suggest inflammation
    - Hard or fixed nodes suggest malignancy

Sites for lymphadenopathy



Areas of localized lymphadenopathy

When you detect an enlarged lymph node, palpate the entire lymph node system to determine the extent of lymphadenopathy. Include the lymph nodes indicated below in your assessment.



Causes of lymphadenopathy

GENERALISED

-lymphoma

-leukemia

-infections

-viral;infectious mononucleosis,CMV,HIV

-bacterial;tuberculosis,syphilis

-protozoal;toxoplasmosis

-connective tissue disease

-infitration;sarcoidosis

-drugs;phenytoin

Localised

Local or acute infection

Metastasis from carcinoma or other solid tumour

Lymphoma especially Hodgkin's disease

Finger clubbing

-Increase in the soft tissue of the distal part of the fingers or toes.

CAUSES

1)Cardiovascular cyanotic congenital heart disease, Infective Endocarditis

2) Respiratory-- lung carcinoma, bronchiectasis, lung abscess, emphysema, lung fibrosis

3)Gastrointestinal

-cirrhosis,

Coeliac disease

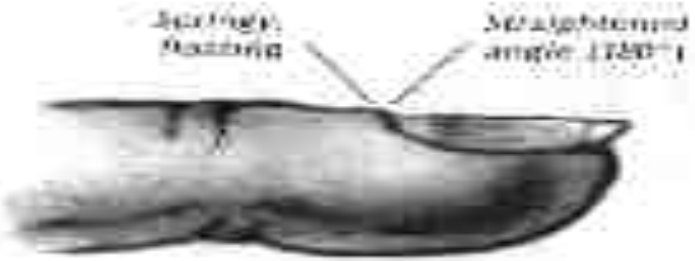
4)Thyrotoxicosis

5)Familial

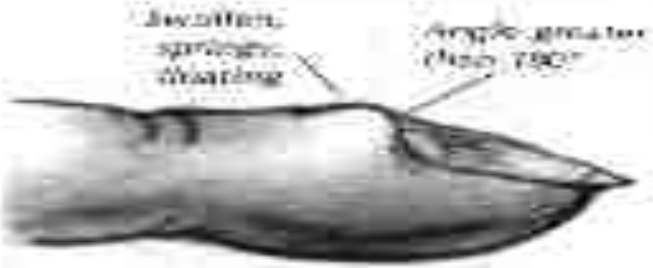
CLUBBING OF THE NAILS

NORMAL

EARLY CLUBBING



LATE CLUBBING



CURVED NAILS

Blue nails-cyanosis,wilson ds

Red nails-polycythaemia,CO poisoning

Yellow nails- yellow nail syndrome

Splinter haemorrhages-IE,vasculitis

Koilonychia-iron def anaemia,fungal infection,raynauds

Onycholysis-thyrotoxicosis,psoriasis

Leuconychia-hypoalbuminemia

Nailfold erythema-SLE

Plummer Wilsons

psoriasis

Onychomycosis, paronychia, onycholysis

Oedema

Accumulation of fluid in the subcutaneous tissue

Causes

Malnutrition

Renal disease

Heart disease

Liver disease

Sites for oedema

Extremities – dorsum

Pedal

Face

Abdomen

Sacral

Dehydration

Excessive loss of body fluids due to

Reduced intake

Diarrhoea & Vomiting

Excess losses = exposure, breathing, fever,

Signs for dehydration

Sunken eyes

Reduced skin turgor (>2 seconds)

Reduced capillary refill

Shock

Irritability

Drinking eagerly or thirsty

Sunken fontanel in babies, anuria

Vital signs

Temperature

Pulse

Blood pressure

Respiration

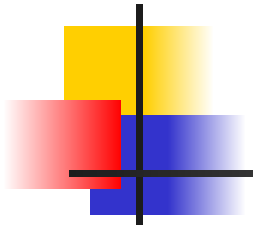
Temperature

Normal body temperature – 36.5 c—37.4 c

Sites: axillary, rectal, oral or digital

Axillary temperature is about 0.5 c less than the oral

A patient is said to be febrile when temp exits 37.5 c



When temperature is lower than normal is called hypothermia

When temperature is high = fever or pyrexia

Pulse (radial)

Rate

Rhythm

Radio-femoral delay

Character

Volume

Condition of the vessel wall

Rate (60—100)

Bradycardia < 60beats/min

Causes: Physiological (athletes, sleep)

Drugs (beta blockers, digoxin amiodarone) ; Hypothyroidism

Hypothermia; Severe jaundice,

Raised intracranial pressure

Heart block, MI, Vasovagal syncope, hypoxia, acute hypertension

Tachycardia =pulse >100/min

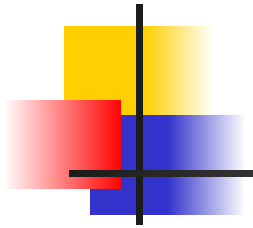
Causes

Hyperdynamic circulation: exercise/emotion, fever, pregnancy, thyrotoxicosis, anaemia, arterivenous fistula, beriberi (thiamine deficiency)

CCF

Constrictive pericarditis

Drugs (salbutamol, atropine



Normal variant

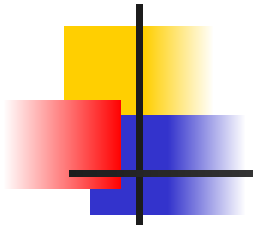
Hypovalaemic shock

Artrial flutter

Irrregular rhythm: atrial fibrillation

Myocardial ischaemia, mitrial valve disease, thyrotoxicosis, hypertension, pulmonary embolism, myocarditis, fever, acute hypoxia, or hypercapnia

Multifocal atrial tachycardia



Radio-femoral delay

= coarctation of the aorta

Character and volume

Collapsing pulse -- aortic regurgitation,

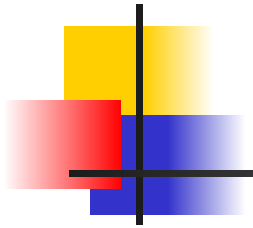
Pulsus alternans - left ventricular failure

BLOOD PRESSURE

Systolic blood pressure = peak pressure that occurs in the artery following ventricular systole

Diastolic blood pressure: level to which arterial pressure falls during ventricular diastole

Normal = < 140/90mmHg



Brachial artery is found in the cubital fossa. First get an approximate estimation of systolic BP

Cuff is inflated, deflated slowly until radial pulse returns; then get more accurate estimate- cuff is inflated and then deflated slowly using the stethoscope's diaphram

5 different korotkoff sounds will be heard as the cuff is released

Pulsus paradoxus

Is a fall in arterial pulse pressure on inspiration of more than 10mg.

During inspiration, systolic and diastolic pressure normally increased because intrathoracic pressure is reduced and blood pools in the pulmonary vessels, hence left heart filling is reduced; if the reduction in BP is exaggerated over the normal, the term pulsus paradoxus is applied

Causes of pulsus paradoxus

Constrictive pericarditis

Pericardial effusion

Severe asthma

Postural hypotension

Is a fall of > 15 in systolic or 10 diastolic (BP taken when standing and lying)

Causes: Hypovalaemic (dehydration, bleeding)

Drugs (vasodilators)

Addisons' disease

Hypopituirism, Neuropathy (diabetes mellitus, amyloidosis)

NECK: Carotid arteries

Location: medial to sternomastoid muscle

Carotid pulse gives information about left ventricle and aorta

Never palpate both carotid arteries at once

Anacrotic pulse: small volume, slow uptake, notched wave on upstroke caused by **arotic stenosis**

Plateau pulse: slow upstroke =aortic stenosis

Bisferiens pulse: anacrotic and collapsing, cause: aortic stenosis

Collapsing pulse; causes

Aortic regurgitation

Hyperdynamic circulation

Patent ductus arteriosus

Collapsing pulse:

peripheral arteriovenous fistula,

Arteriosclerotic aorta

Small volume pulse

Aortic stenosis

Pericardial effusion

Pulsus alternans (alternating strong & weak beats) cause- L ventricular Failure

Jerky pulse:

Cause: Hypertrophic cardiomyopathy

SYSTEMIC EXAMINATION

Each system shall be described using four elements;(IPPA)

- looking/inspection
- feeling/palpation
- tapping/percussion
- listening/auscultation
- assessment of function